



Sanford Health Network
Community Health Needs Assessment
2012-2013

dba Sanford Worthington Medical Center EIN# 46-0388596

Sanford Worthington Medical Center

Community Health Needs Assessment
2012-2013

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Sanford Worthington Medical Center Community Health Needs Assessment 2012-2013

Purpose

Sanford Worthington 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 Worthington 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.

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

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

Our Guiding Principles:

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

The following key community stakeholders participated in this assessment work:

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Sanford Worthington Medical Center Community Health Needs Assessment 2012-2013

Executive Summary

Purpose

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

Study Design and Methodology

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 Nobles County
- Aging Profiles for Nobles County
- Diversity Profiles for Nobles County

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

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

Key Findings – Primary Research

Sanford Worthington Medical Center distributed the community health needs assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the Worthington community.

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

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

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

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

Respondents had high levels of agreement that the people in their community are socially and culturally diverse, friendly, helpful and supportive, there is quality health care, the community is a good place to raise kids and is a safe and healthy place to live with quality higher education opportunities, school systems and programs for youth. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness, a sense that you can make a difference and effective transportation.

Respondents were most concerned about substance abuse, child abuse and neglect and domestic violence. Respondents were also concerned with issues regarding children and youth (e.g. teen pregnancy, availability and cost of quality child care, bullying, availability and cost of services for youth, and child abuse and neglect). Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health insurance (e.g. amount of co-pays and deductibles) and access to health insurance coverage (e.g. pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis), stress and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about patient confidentiality and distance to health care services.

Respondents had moderate levels of concern with respect to the availability of employment opportunities and low wages, economic disparities between higher and lower classes, hunger, poverty and the cost of living. Respondents were least concerned with homelessness.

Respondents were moderately concerned with the availability of public transportation, road conditions and road rage. Respondents were least concerned with traffic congestion.

Respondents were not very concerned with environmental issues in their community. There is high agreement that the community has a general cleanness.

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

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

Respondents were asked which provider they used for their primary health care. Fifty-one percent (51%) of respondents said they use Sanford Health as their primary health care provider. The other 49% listed other providers.

Key Findings – Secondary Research

Health Outcomes

The Mortality health outcomes indicate that Minnesota as a state has less premature deaths than the national benchmark. Nobles County is slightly higher than Minnesota but is below the national benchmark for premature deaths.

The Morbidity health outcomes indicate that Minnesota citizens report more days of poor health than the national benchmark; however, Nobles County reports less days of poor health when compared to both Minnesota and the national benchmark. Minnesota and Nobles County both report more physically unhealthy days than the national benchmark.

Minnesota reports more mentally unhealthy days than the national benchmark, but Nobles County reports substantially better mental health days than the national benchmark.

Minnesota and Nobles County have a higher percentage of low birth weight than the national benchmark.

Health Factors

The Health Behavior outcomes indicate that Minnesota has higher percentages of adult smokers than the national benchmark; however, Nobles County has the same rate as the national benchmark. Adult obesity is also higher in the state of Minnesota and Nobles County. Minnesota has a lower percentage of physical inactivity than the national benchmark, while Nobles County is equal to the national benchmark.

Minnesota and Nobles County have higher percentages of binge drinking reports than the national benchmark; however, Nobles County has a lower rate than Minnesota. Motor vehicle crash death rates are nearly double the national benchmark in Nobles County, while Minnesota is equal the national benchmark.

Sexually transmitted infections rank substantially higher than the national benchmark for Minnesota (276.1 vs. the national benchmark of 83.0), and Nobles County (314.3). The teen birth rate is higher in Minnesota but Nobles County is more than double the national benchmark.

The Clinical Care outcomes indicate that Minnesota has a lower percentage of uninsured adults than the national benchmark, while Nobles County has a larger percentage. The percentage of uninsured youth in Minnesota is slightly lower than the national benchmark, but is higher in Nobles County.

The ratio of population to primary care physicians is about the same comparing Minnesota to the national benchmark, but this ratio is higher in Nobles County.

The ratio of population to mental health providers is much lower in Minnesota than the national benchmark; however, Nobles County is substantially higher than the national benchmark. The number of professionally active dentists is lower than the national benchmark in Minnesota and Nobles County. Preventable hospital stays are higher than the national benchmark in Minnesota and Nobles County.

Diabetes screening in Minnesota is slightly lower than the national benchmark, but Nobles County is slightly higher than the national benchmark.

The Social and Economic Factor outcomes indicate that Minnesota and Nobles County both have a lower high school graduate rate than the national benchmark, and Minnesota has a higher percent while Nobles County has a lower percentage of post-secondary education than the national benchmark. The unemployment rate was higher in Minnesota but the same in Nobles County when compared to the national benchmark. The percentage of child poverty is the same in Minnesota as the national benchmark; however, Nobles County is higher than the national benchmark for child poverty.

Inadequate social support is the same in Minnesota compared to the national benchmark. Nobles County had no data for comparison.

The percentage of children in single parent households is higher than the national benchmark in Minnesota and Nobles County. The number of homicide deaths in Minnesota is higher than the national benchmark, but no data was available for Nobles County.

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

Youth account for 28% of the population in Nobles County. Elderly account for 16% of the population in Nobles County. Forty-seven percent (47%) of Nobles County is rural compared to 29% of Minnesota and 21% as the national benchmark.

Four percent (4%) of Minnesotans and 10% of Nobles County population is not proficient in English compared to the national benchmark of 9%. Minnesota's illiteracy rate is 6% and Nobles County is at 12% compared to the national benchmark of 15%.

Nobles County has 3% of the population older than 85 years of age, and 16% older than 65 years of age.

The gender distribution is 51% male and 49% female for Nobles County.

The majority of individuals in Nobles County (68%) own their homes.

According to the 2010 Census Data, the population of working age in the labor force is 68% in Nobles County. The percentage of those who are living at less than 100% of the poverty level is 18% in Nobles County. In Nobles County, 40% are at less than 200% of the poverty level.

The median annual household income in Nobles County is \$43,040.

The population distribution by race demonstrates that Nobles County is predominantly white, followed by Hispanic origin of any race, Asian alone, Black alone and American Indian alone.

Implementation Strategy

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

- Youth - Obesity
- Elderly
- New American/Immigrants

Implementation Strategy: Youth - Obesity

- Establish a youth program (K-4) that will involve District 518, YMCA and local Sanford Worthington Clinic Pediatricians and staff.
- Action plans include focusing on kids with a BMI above a certain percentage.
- Program to include physical activity for the kids as well as an educational component for parents.
- Curriculum is currently being developed.
- Review of program will occur and any changes will be implemented.

Implementation Strategy: Elderly

- Review and define the current socioeconomic health status of the elderly in the community and develop an implementation strategy for need or needs identified.
- Actions include releasing summary of survey data to agencies that participated in the primary source community survey.
- Identify agencies within the community and begin the assessment of elderly status. Agencies may include Nobles County Public Health, Nursing Homes, City of Worthington and Sanford. Others will be invited as identified.

Implementation Strategy: New American/Immigrants

- Increase SWMC and Sanford Worthington Clinic providers and staff awareness of the various cultures and nationalities currently in the SWMC market area as they affect the delivery of health care to these groups of community members.
- Actions include creating periodic education and competencies for all staff on the various cultures in the Worthington area. Focus will be given to those cultures with the largest population base in our market area.

Sanford Worthington Medical Center Community Health Needs Assessment 2012-2013

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

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

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

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

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

Our Values:

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

Our Promise: *Deliver a flawless experience that inspires*

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

Guiding Principles:

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

Description of Sanford Worthington Medical Center

Sanford Worthington is located in Worthington, MN and includes Sanford Worthington Medical Center, Sanford Worthington Clinic, Sanford Worthington Acute Care Clinic, Sanford Worthington Surgery Clinic, Sanford Worthington Outreach Specialty Clinic, Sanford Worthington OB/GYN Clinic, Sanford Worthington Orthopedics and Sports Medicine, and Sanford Cancer Center. As members of the Sanford Health system, Sanford Worthington is dedicated to providing the best health care services to Worthington and the surrounding communities.

Sanford Worthington Medical Center is a 48-bed facility with more than 50 services including medical, diagnostic, therapy and outreach. Specialty services include general and same day surgery, general 27-bed medical/surgical unit, women's health care, outpatient dialysis, outpatient treatment and infusion center, home care services, intensive care unit, laboratory services, medical imaging including x-ray, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound and digital mammography, oncology services including chemotherapy and radiation therapy, and 24/7 in-house physician coverage of our emergency department. An acute care clinic is also located at the hospital which provides walk-in, after hour and weekend services. As part of the Sanford Health system, Sanford Worthington Medical Center includes 20 active medical staff and 350 employees. For more information about Sanford Worthington, visit sanfordworthington.org.

Description of the Community Served

Worthington is the largest city in Nobles County and is the county seat. As of the 2010 census data, Nobles County had 21,378 residents with 12,764 living in Worthington.

Worthington is a regional economic hub for southwestern Minnesota and is nestled in the southwest corner of Minnesota at the intersection of Interstate 90 and Minnesota State Highway 60. Worthington has a strong agricultural presence from row crops to various kinds of livestock, and has attracted large corporations involved in the processing, research and shipping to locate in the community. Worthington is home to research companies that are actively discovering new technologies in the bio-science field, as well as several manufacturing companies that are involved in building homes, commercial buildings, and plastic products.

Worthington has an excellent school system along with the Minnesota West Community and Technical College, two clinics, and a progressive growing hospital. Worthington also has a wide variety of recreation activities that include Lake Okabena, bike paths, 19 city parks, soccer fields, hockey arena, tennis courts, baseball and softball fields, and a disc golf course, in addition to two regular 18-hole golf courses. The City also partnered with the YMCA and others to build a new \$9.5 million YMCA in Worthington.

For the arts, Worthington recently renovated the art deco War Memorial Auditorium that offers a great variety of shows, plus the many festivals that our city hosts throughout the year.

The city boasts a healthy retail sector with some of the best shopping areas, with over 30 restaurants, many representing foods from other ethnic cultures. The city is home to JBS, an international company that employs over 2,400 workers. Manufacturing companies include Bedford Industries, a worldwide leader in the packaging industry with 269 employees; Highland Manufacturing, an industry leading in manufactured housing with 150 employees; and Merck Animal Health, a manufacturer of livestock vaccines with 60 employees.

Worthington is home to many festivals and community activities throughout the year, but most notable is the September celebration of King Turkey Days. This event alone can bring up to 30,000 people to Worthington to participate in this annual celebration.

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

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 Nobles County
- Aging Profiles for Nobles County
- Diversity Profiles for Nobles County

Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. The process implemented in this work was based on the McKnight Foundation model - Mapping

Community Capacity by John L. McKnight and John P. Kretzmann, Institute for Policy Research at Northwestern University.

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

Worthington Community Health Needs Assessment of Community Leaders

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

The community leaders' survey 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.

A total of 262 surveys were completed through a Survey Monkey link. The purpose of this survey was to learn about the perceptions of area key stakeholders regarding the prevalence of disease and health issues in their community.

2011 County Health Profiles

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

Aging Profiles

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

Diversity Profiles

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

Limitations

The Sanford Health Community Health Needs Assessment Steering Group attempted to survey key community leaders and stakeholders for the purpose of determining the needs of the community. While 262 surveys were returned, there were still many key stakeholders who did not complete the survey.

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

Primary Research

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

Summary of the Survey Results

Respondents had very high levels of agreement that their community has educational opportunities and programs, the community is a good place to raise kids, and there is quality health care. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community, and that there is effective transportation.

Respondents were most concerned about child abuse and neglect, substance abuse, domestic violence, and issues regarding the aging population (e.g. availability and cost of long-term care and availability of resources to help the elderly stay in their homes). Respondents were also concerned with issues regarding children and youth (e.g. availability and cost of quality child care, teenage pregnancy and bullying). Environmental issues regarding garbage and litter, water quality, air quality, and noise levels as well as transportation issues were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy and cost of health care and insurance (i.e., amount of co-pays and deductibles) and access to health insurance coverage (e.g. pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, cancer) and stress were also among the top health and wellness concerns among respondents. Respondents were least concerned about patient confidentiality and distance to health care services.

Community Assets/Best Things about 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 or best things about the community were:

- The community is socially and culturally diverse
- In the community, it is a short commute/convenient access to work and activities
- There is quality health care
- There are quality school systems and programs for youth

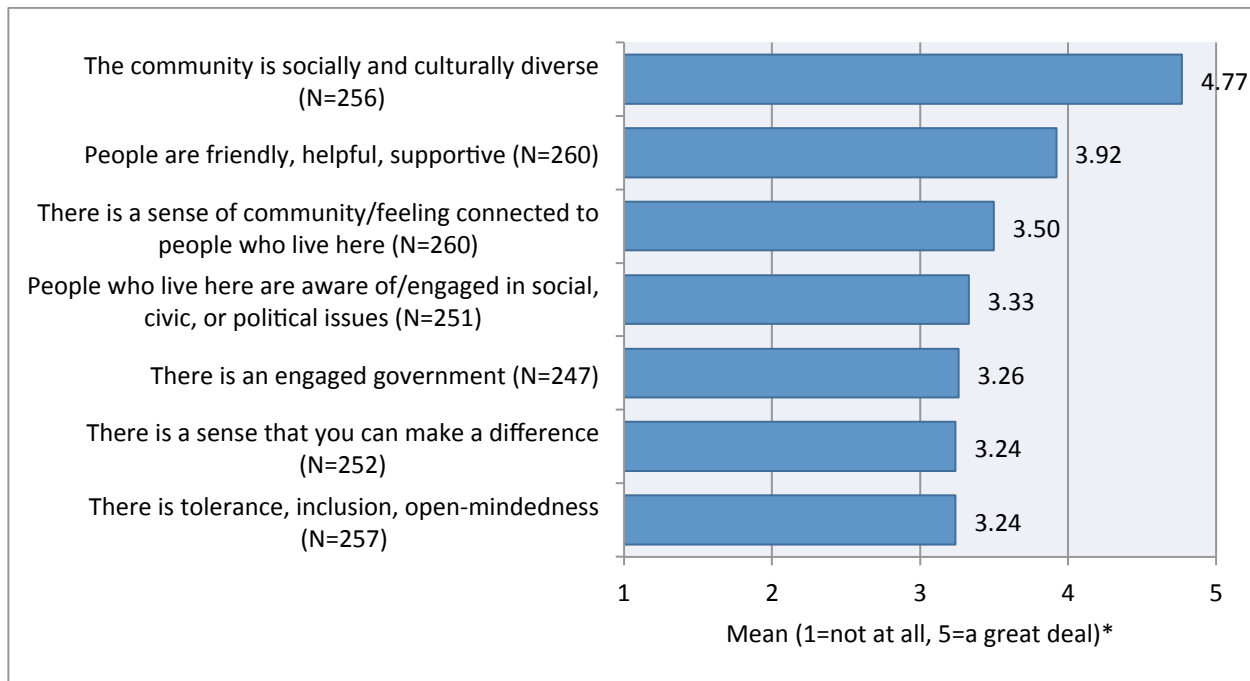
- There is access to quality food

Overall, respondents had moderately high levels of agreement regarding positive statements that reflect the people in their community (Figure 1).

- On average, respondents agreed the most that people in their community are friendly, helpful and supportive.
- Respondents also had a moderately high level of agreement that there is a sense of community or feeling connected to people who live here.
- Although still a moderate level of agreement, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community.

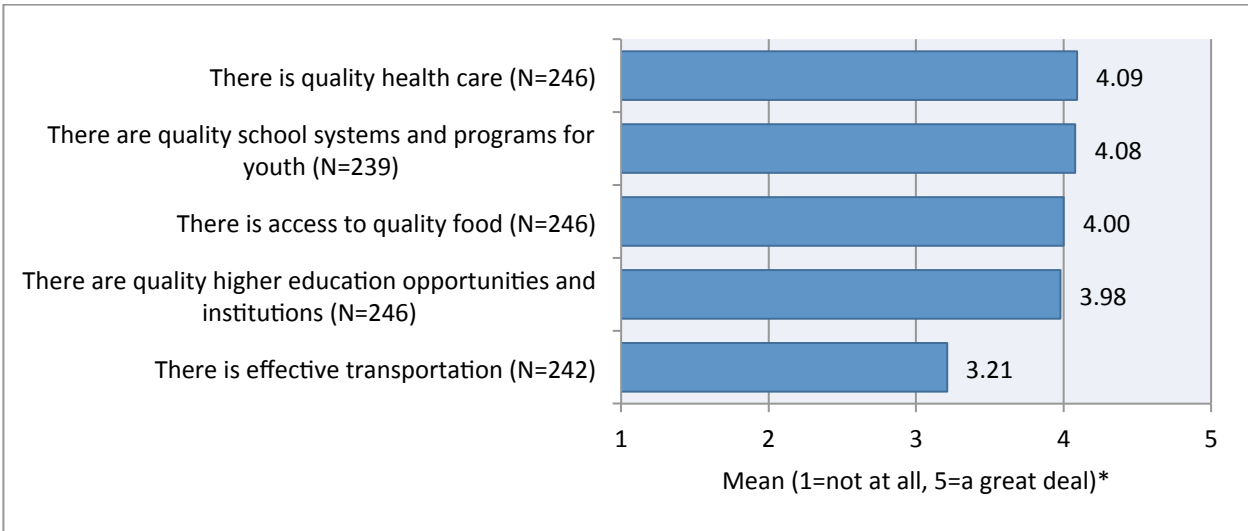
Respondents were asked to rate their level of agreement with various statements regarding PEOPLE, SERVICES AND RESOURCES, QUALITY OF LIFE, GEOGRAPHIC SETTING, and ACTIVITIES in their community.

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



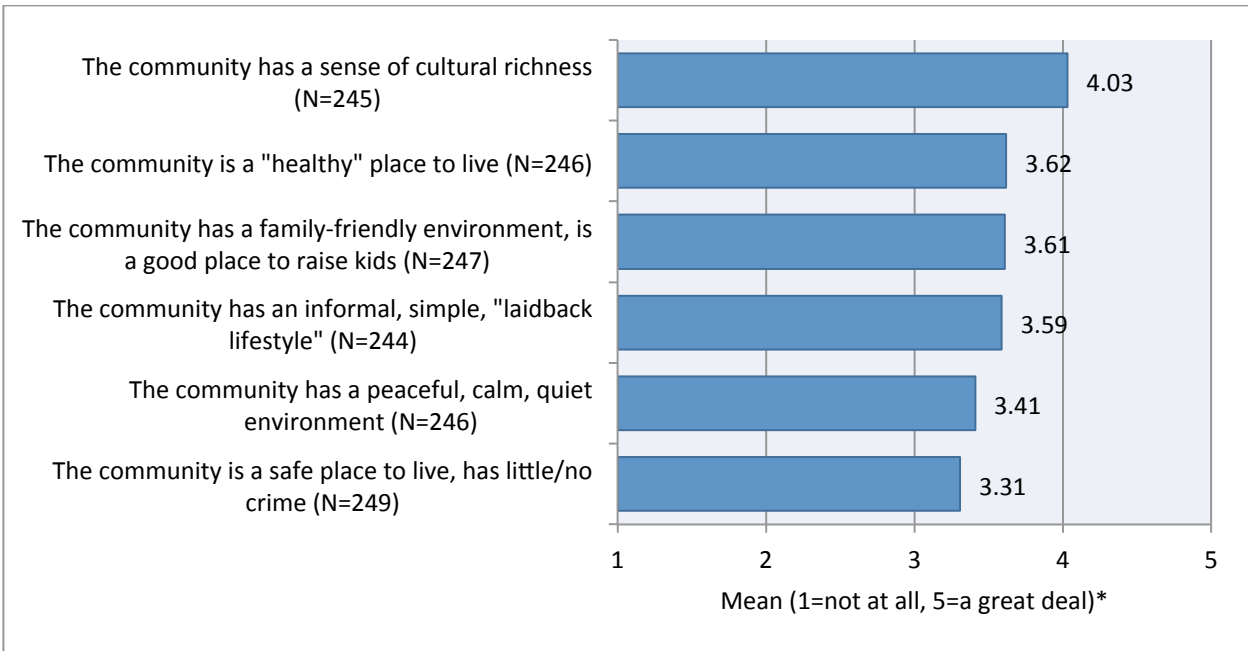
*Means exclude "do not know" responses.

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



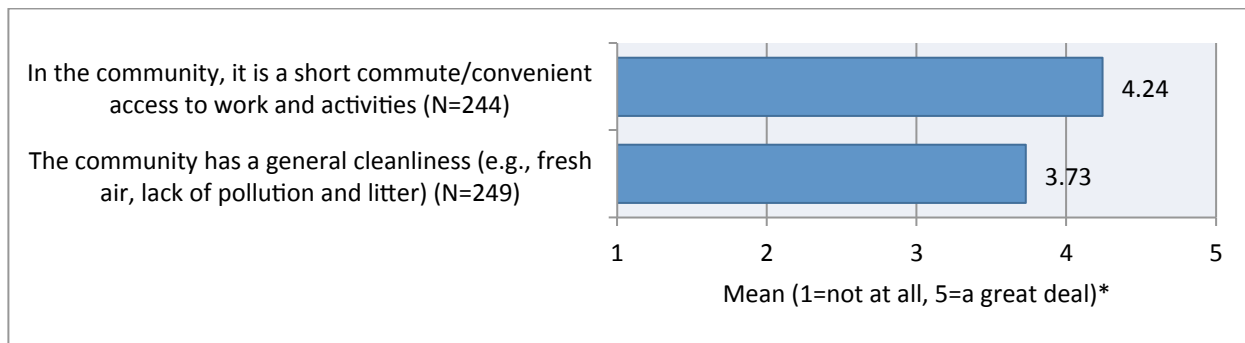
*Means exclude "do not know" responses.

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



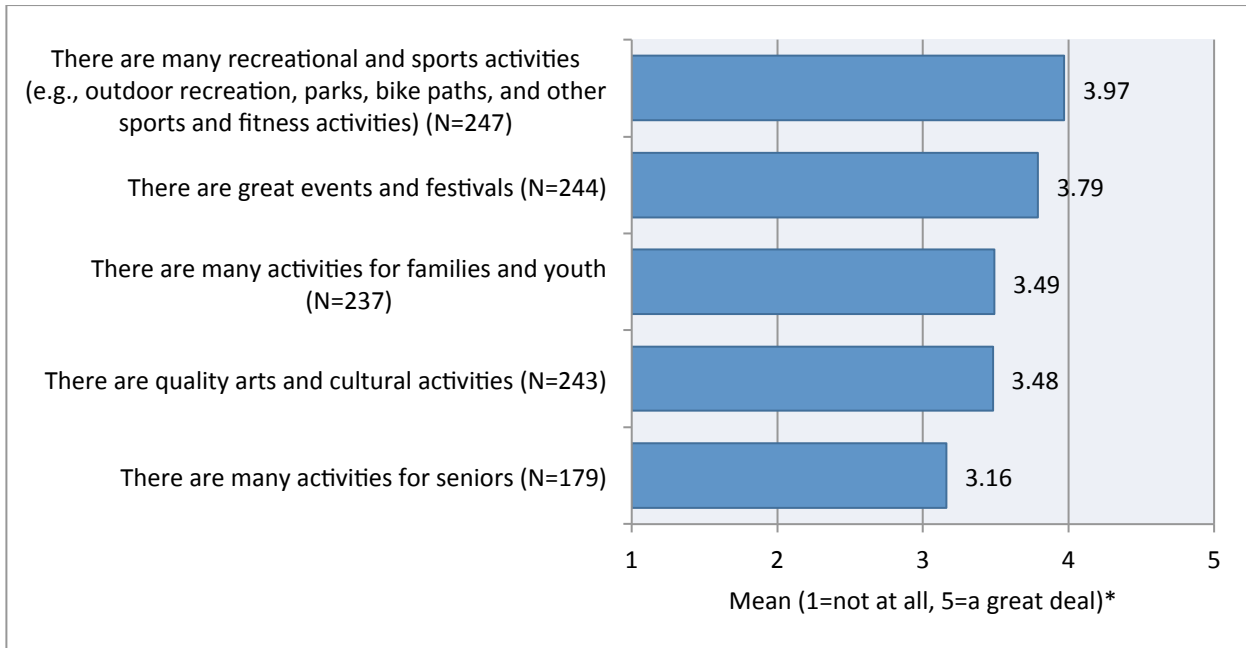
*Means exclude "do not know" responses.

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



*Means exclude "do not know" responses.

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

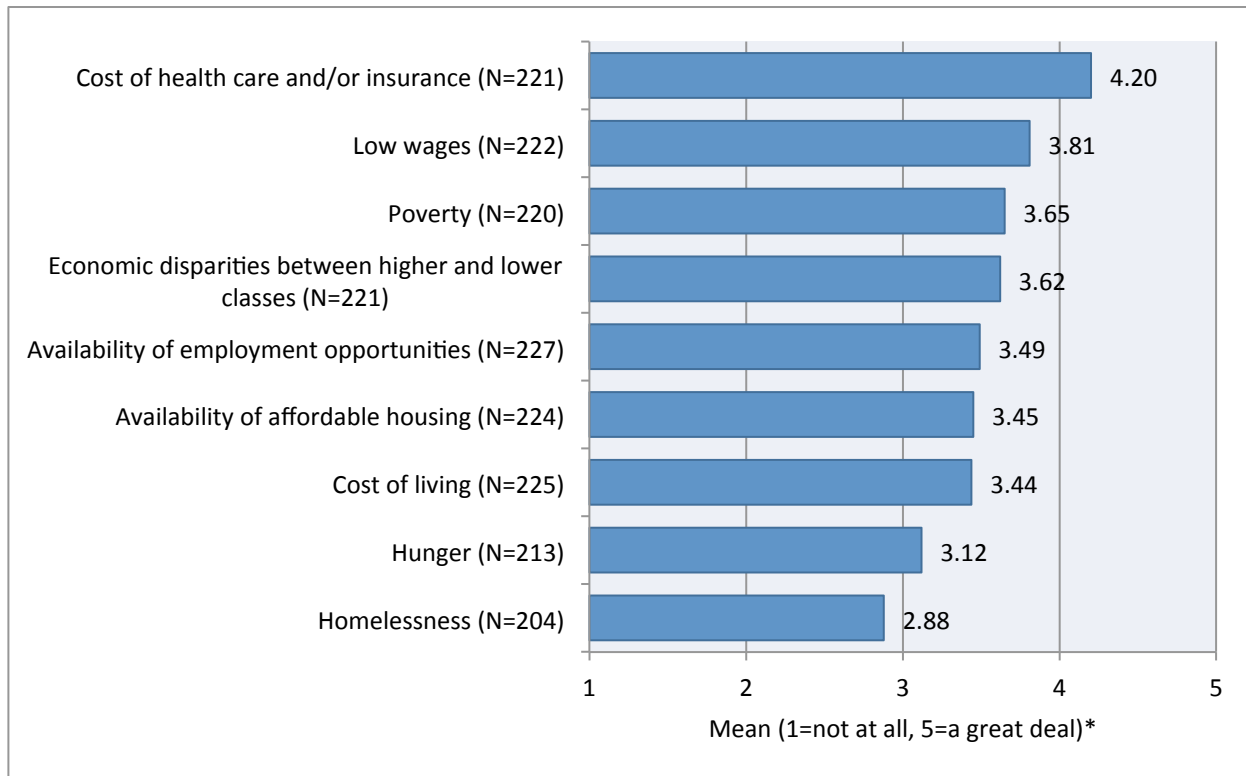


*Means exclude "do not know" responses.

General Concerns about the Community

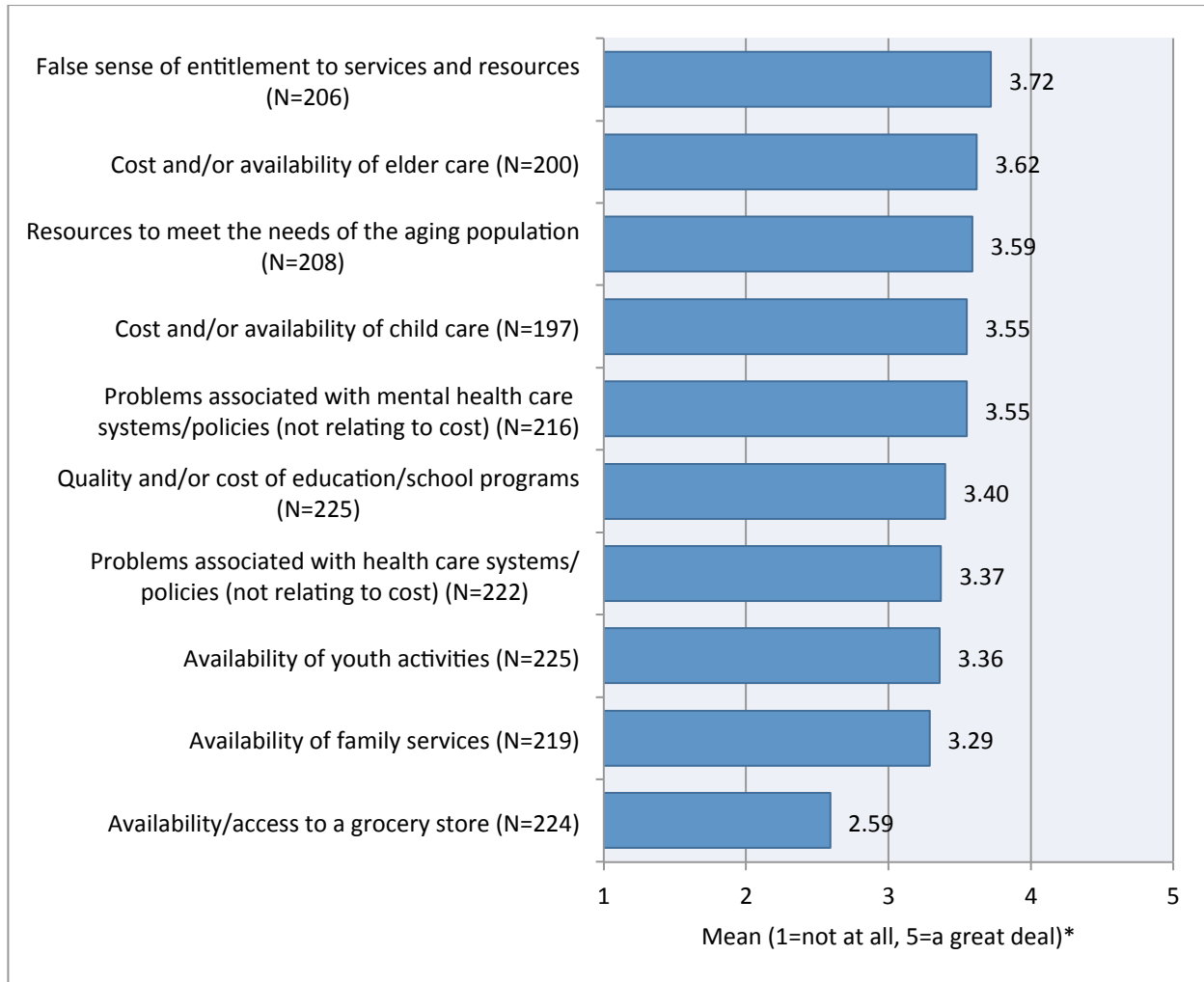
Respondents were asked to rate their level of concern with various statements regarding ECONOMIC ISSUES, SERVICES AND RESOURCES, TRANSPORTATION, ENVIRONMENTAL POLLUTION, YOUTH CONCERNS, and SAFETY CONCERNS in their community.

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



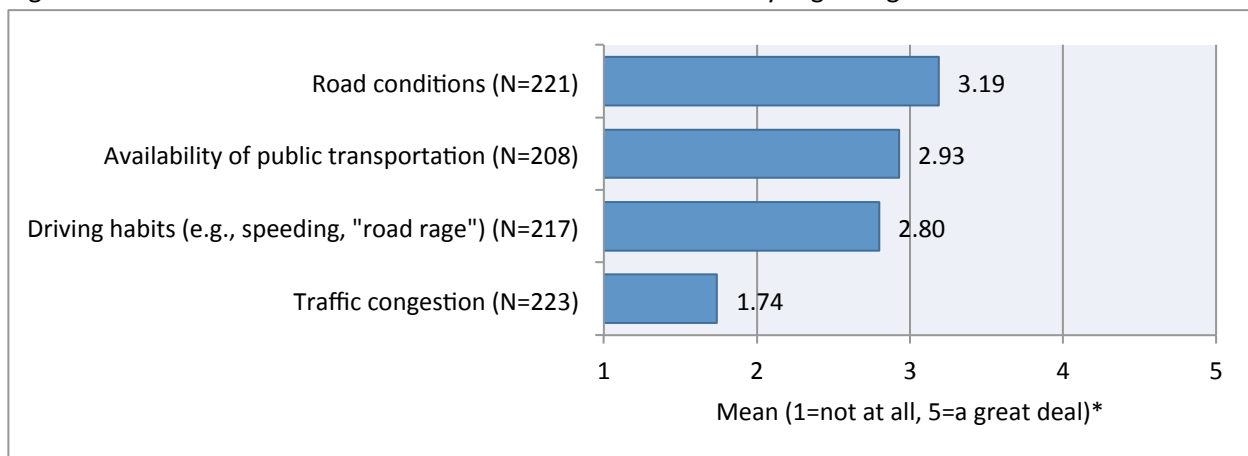
*Means exclude "do not know" responses.

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



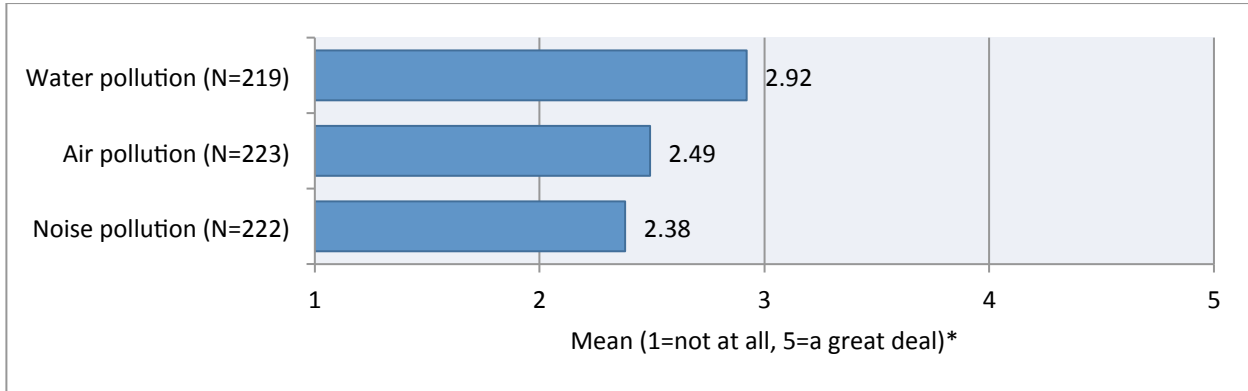
*Means exclude "do not know" responses.

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



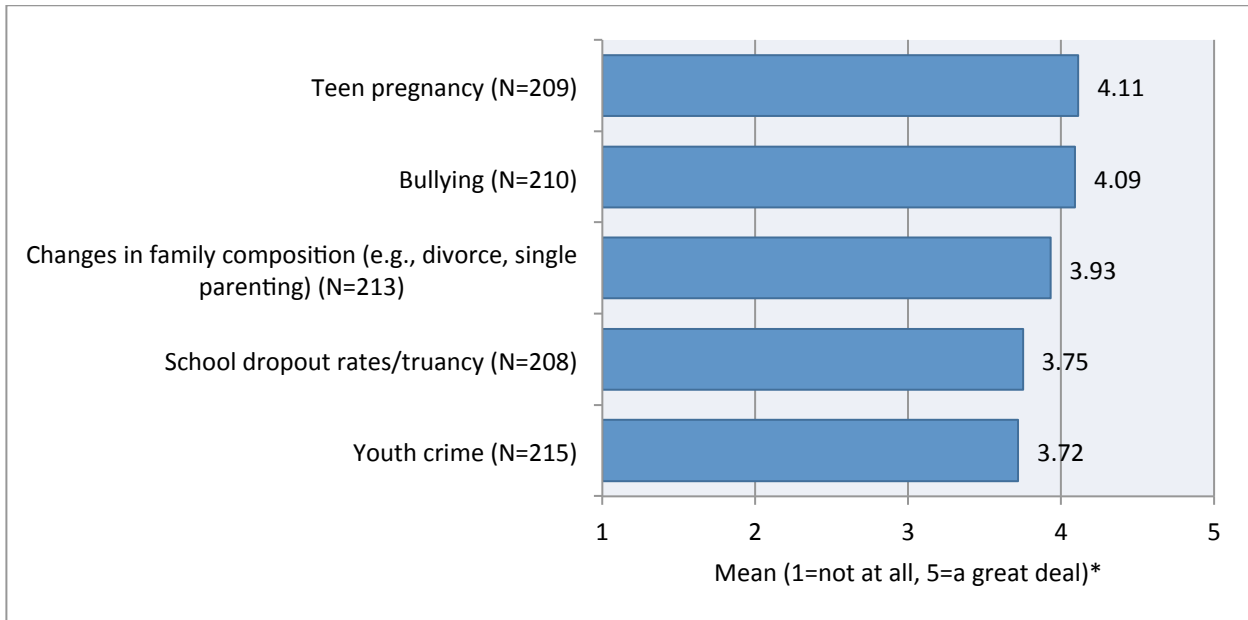
*Means exclude "do not know" responses.

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



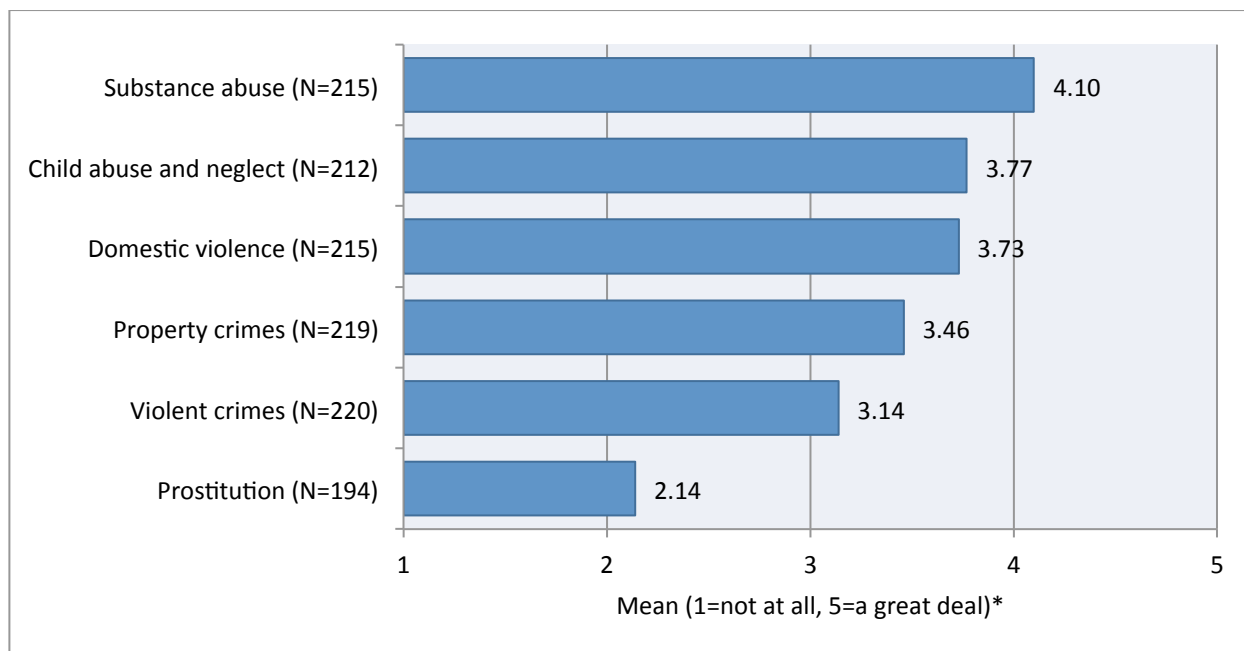
*Means exclude "do not know" responses.

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



*Means exclude "do not know" responses.

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

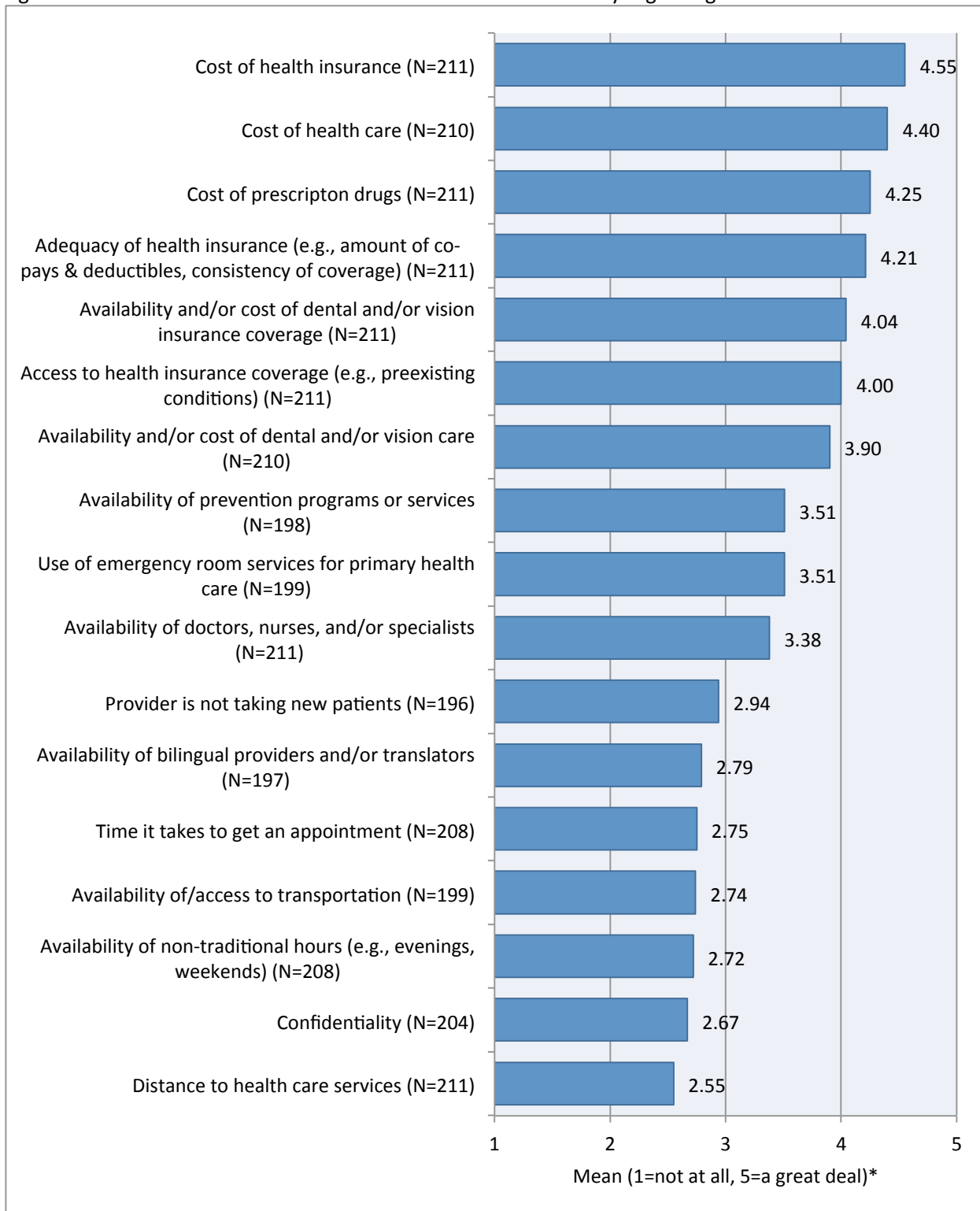


*Means exclude "do not know" responses.

Community Health and Wellness Concerns

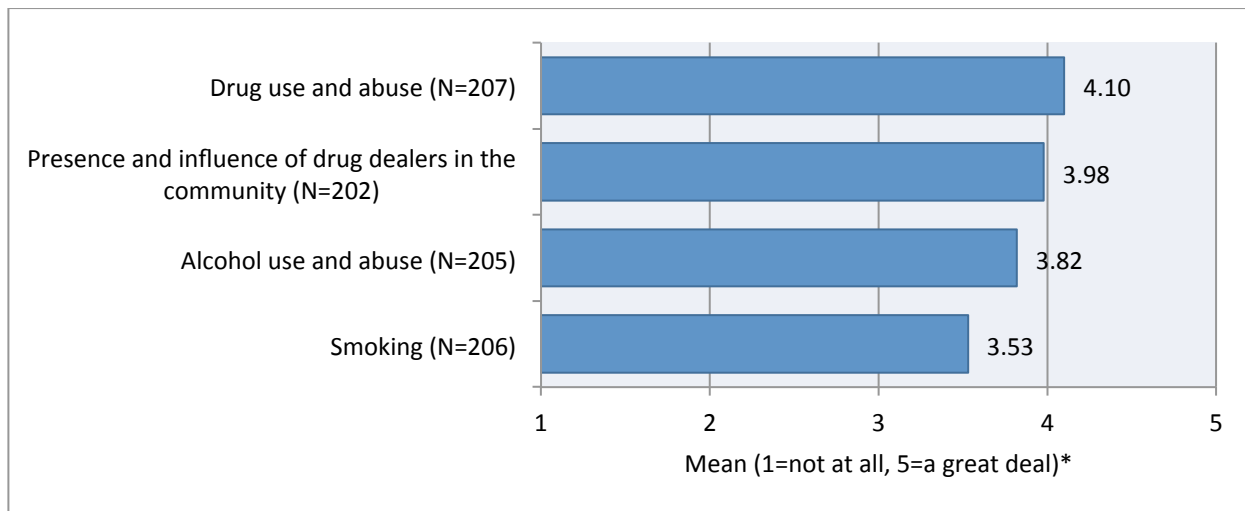
Respondents were asked to rate their level of concern about health and wellness issues in their community re: ACCESS TO HEALTH CARE, SUBSTANCE USE AND ABUSE, PHYSICAL HEALTH, MENTAL HEALTH, and ILLNESS.

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



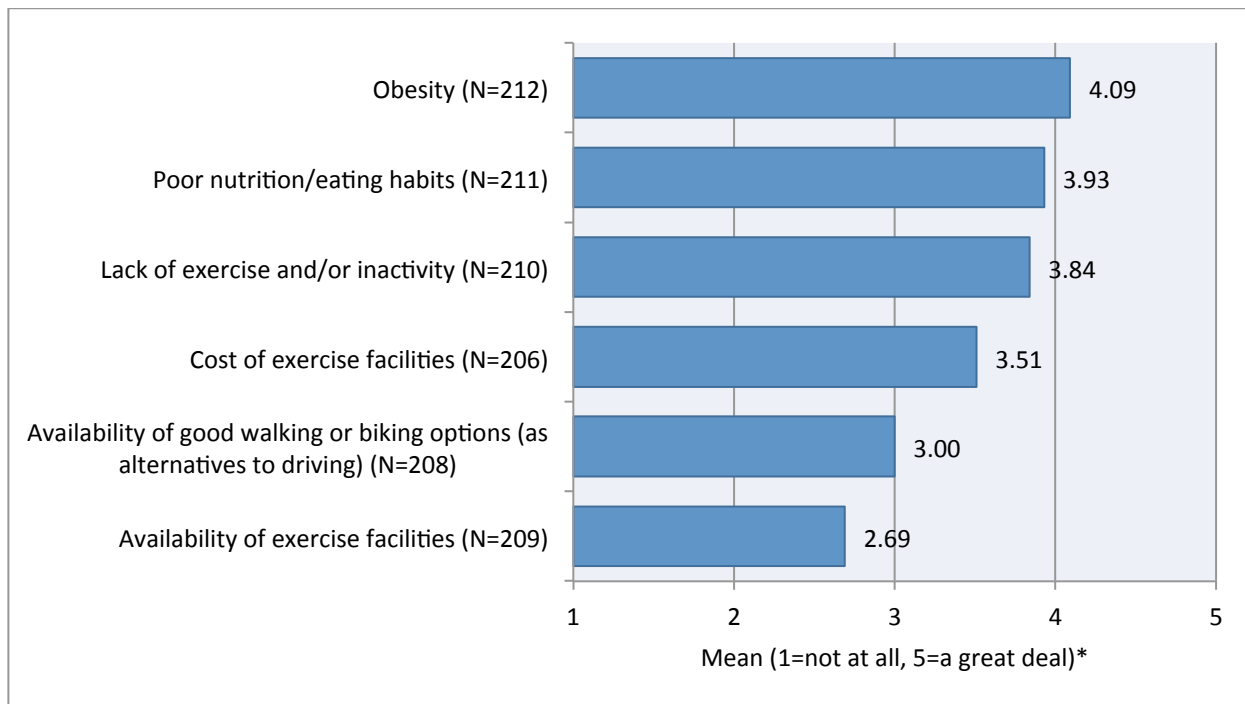
*Means exclude "do not know" responses.

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



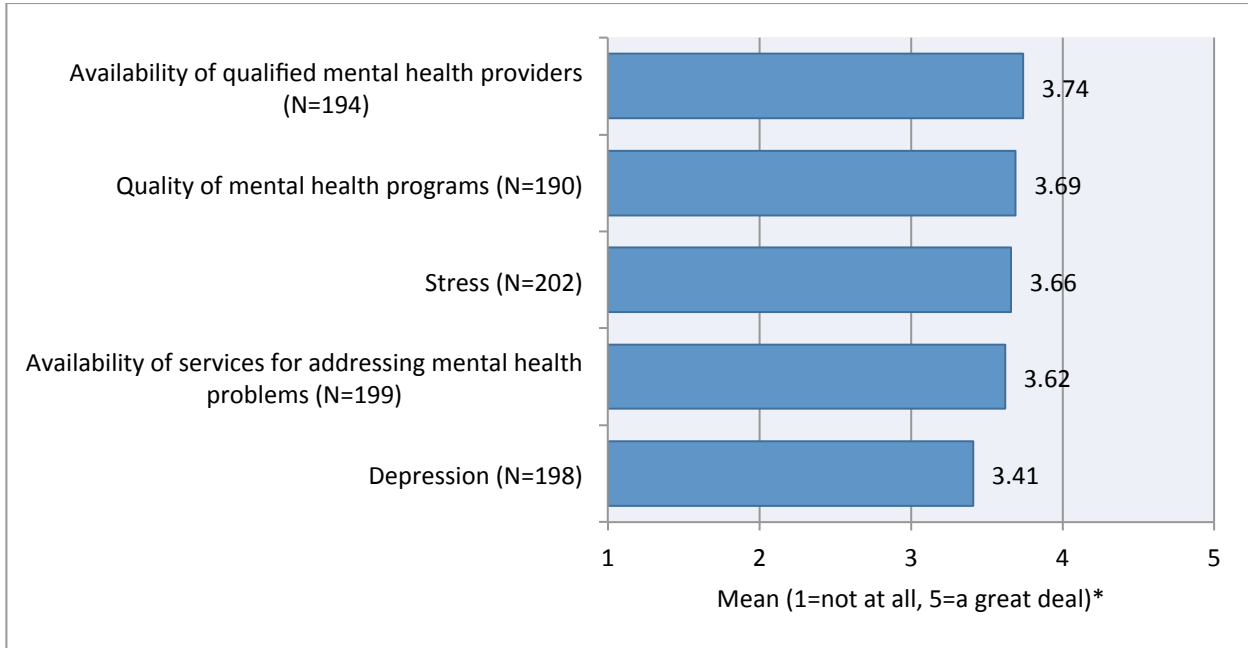
*Means exclude "do not know" responses.

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



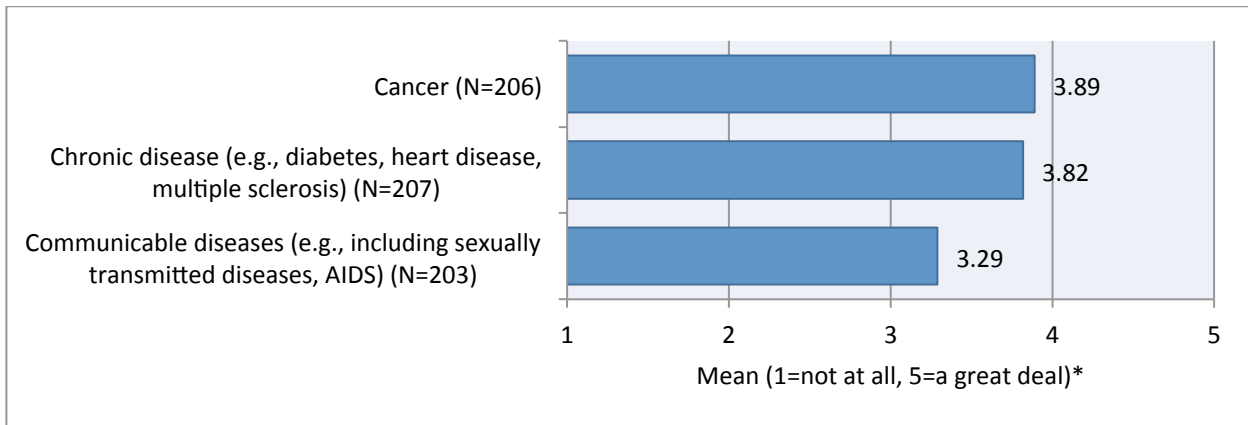
*Means exclude "do not know" responses.

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



*Means exclude "do not know" responses.

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

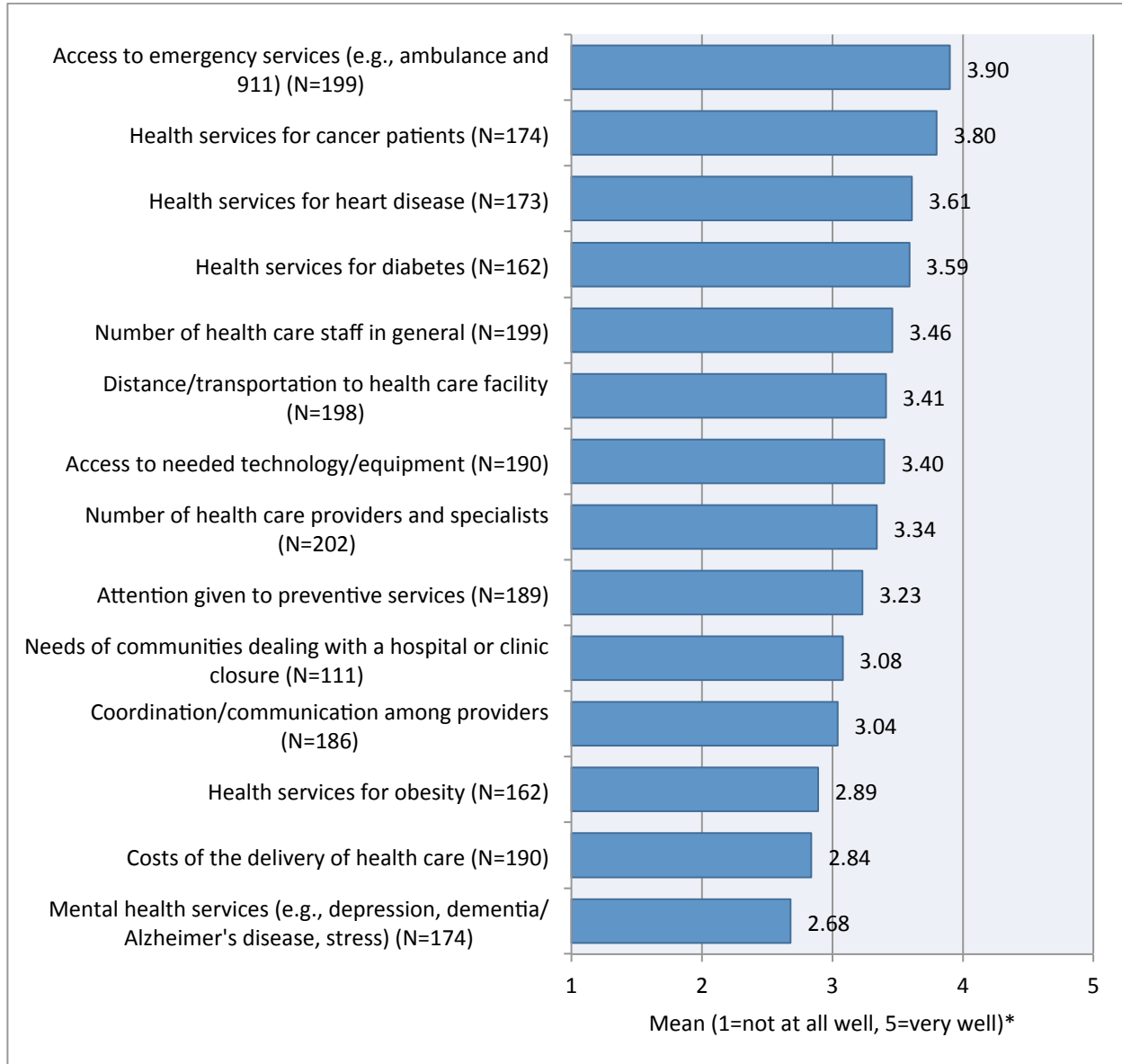


*Means exclude "do not know" responses.

Delivery of Health Care in the Community

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

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



*Means exclude "do not know" responses.

Personal Health Care Information

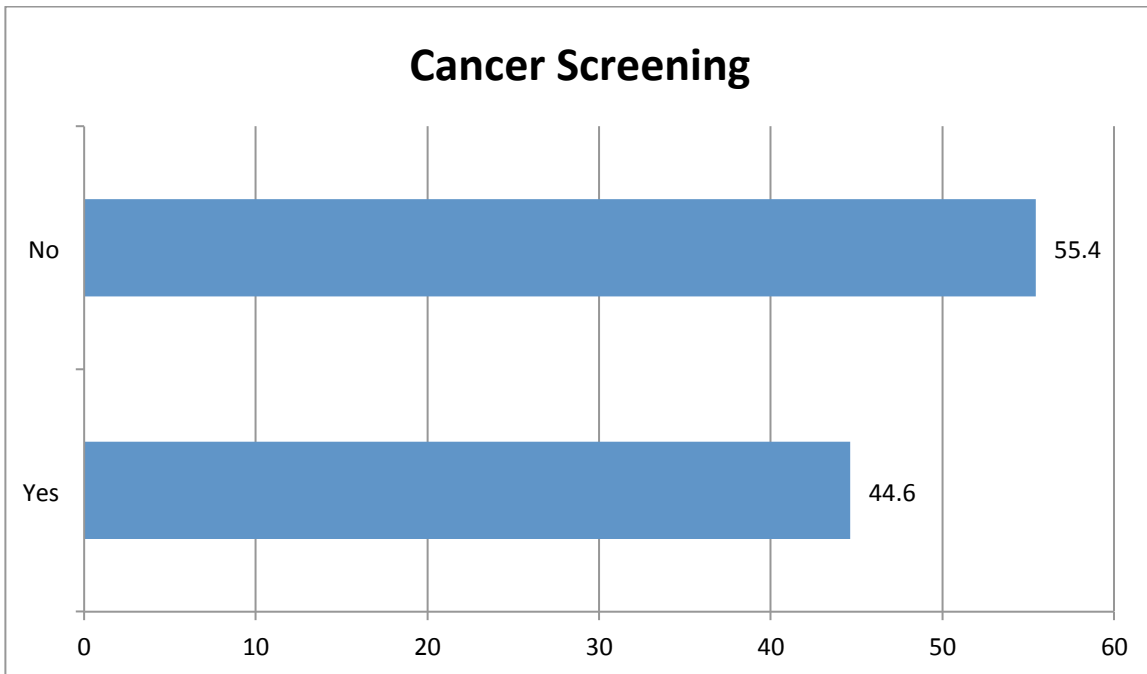
The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services.

Just under half (44.6%) of the respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because it was not necessary. Because their doctor did not suggest was also a reason respondents gave.

Because their doctor did not suggest it and cost were the responses least given.

Respondents were asked whether they had a cancer screening or cancer care in the past year, and if they had not, reasons for not having done so.

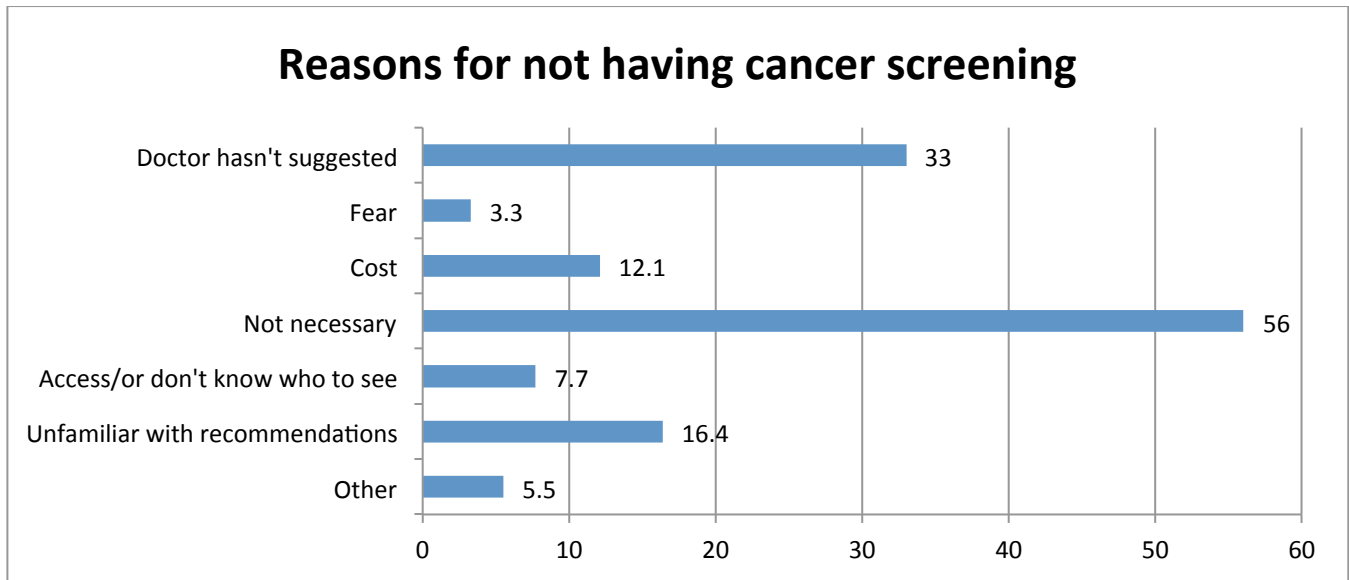
Figure 18. Whether respondents had a cancer screening or cancer care in the past year



Cancer Screening

Among respondents who had not had a cancer screening or cancer care in the past year, 56.0% said it was not necessary.

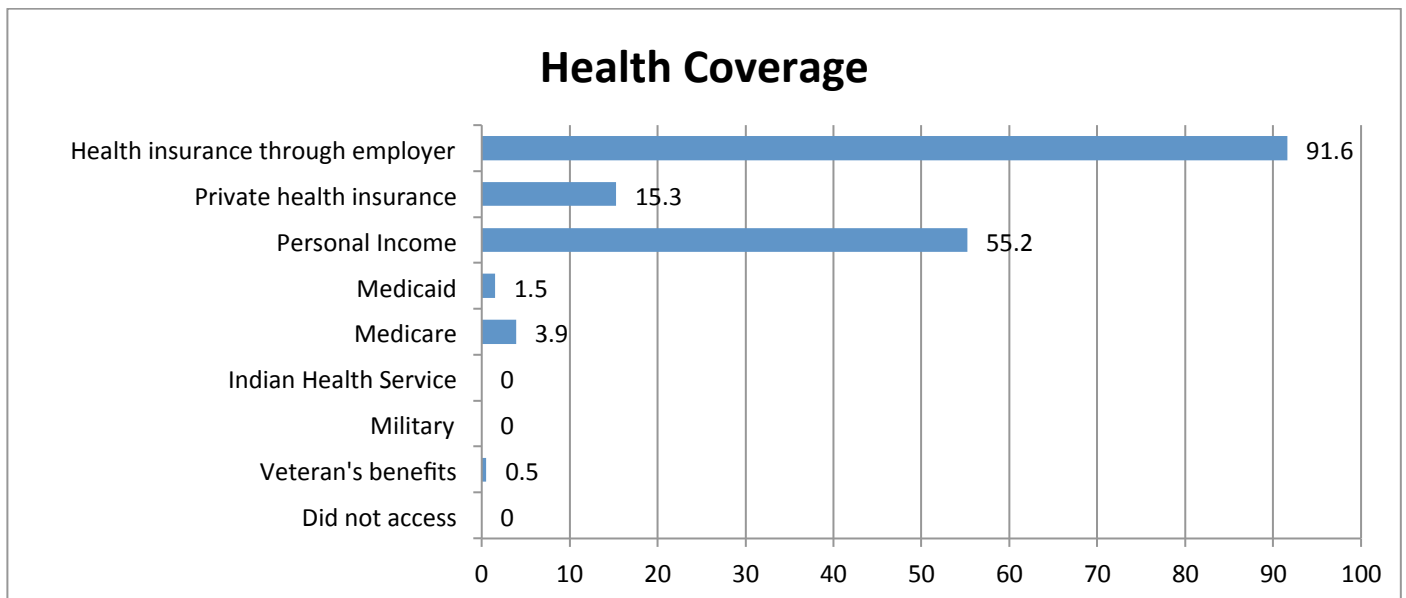
Figure 19. Among respondents who have not had a cancer screening or cancer care in the past year, reasons for not having done so



Health Care Coverage

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

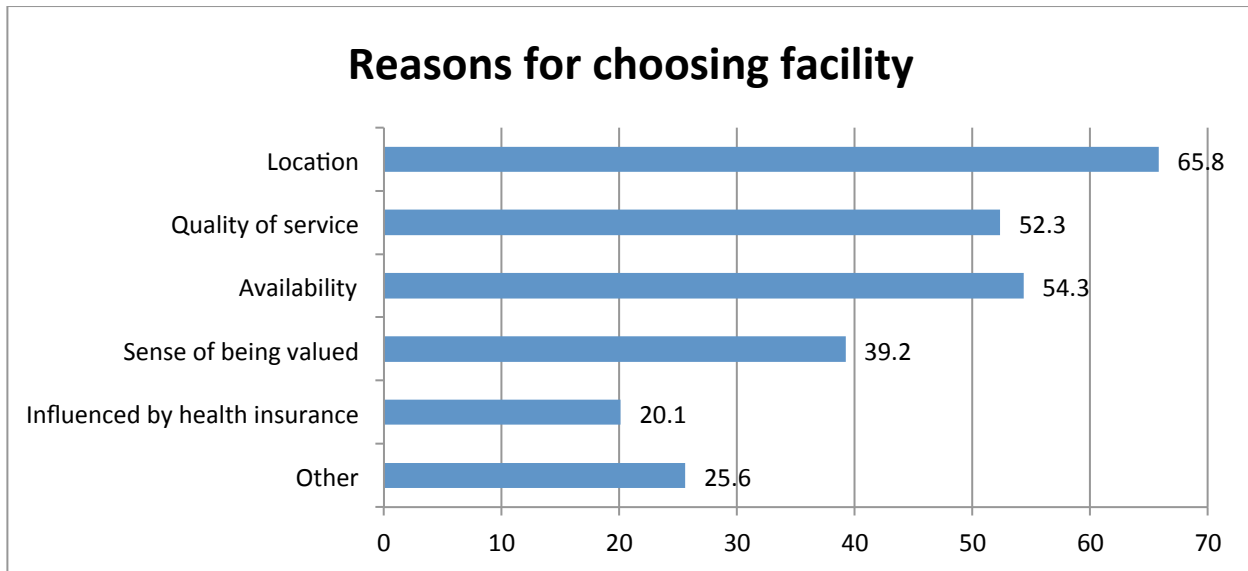
Figure 20. Methods respondents have used to pay for health care costs over the last 12 months



Primary Care Provider

The top reasons respondents gave for their choice of primary health care provider were location, availability and quality of services, and sense of being valued as a patient (Figure 21). One in four respondents said choosing their primary health care provider was influenced by their health insurance.

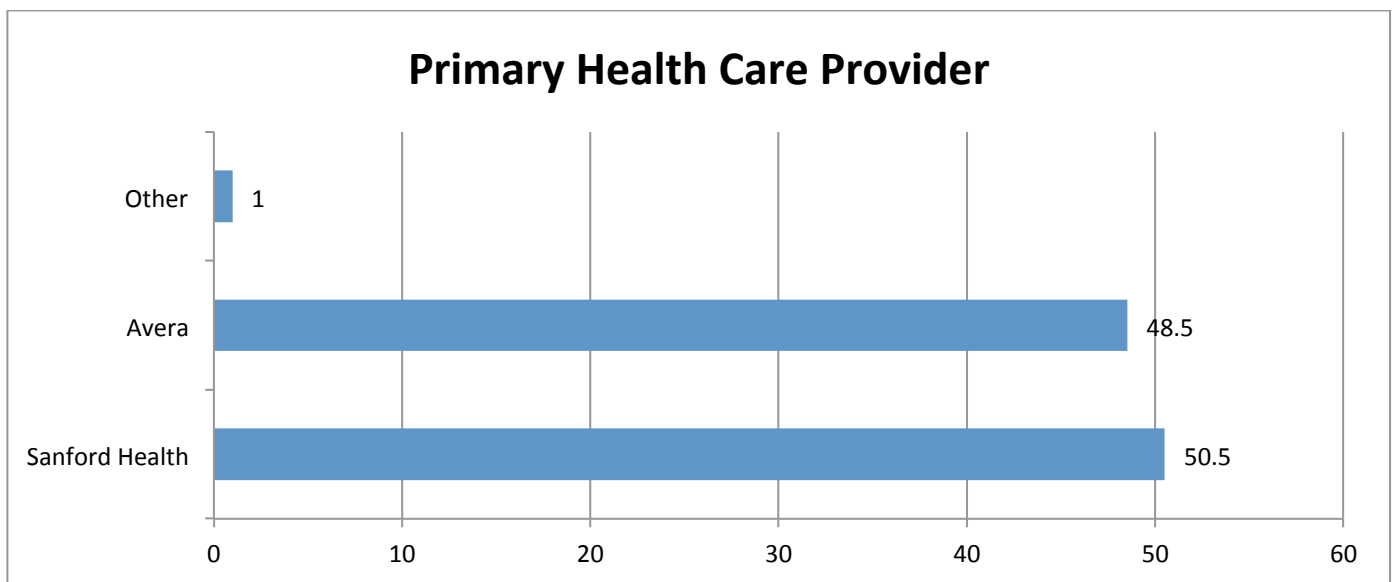
Figure 21. Respondents’ reasons for choosing primary health care provider



Respondent’s Primary Care Provider

Respondents were asked which provider they used for their primary health care. A little over one-half of the respondents said they use Sanford Health as their primary care provider.

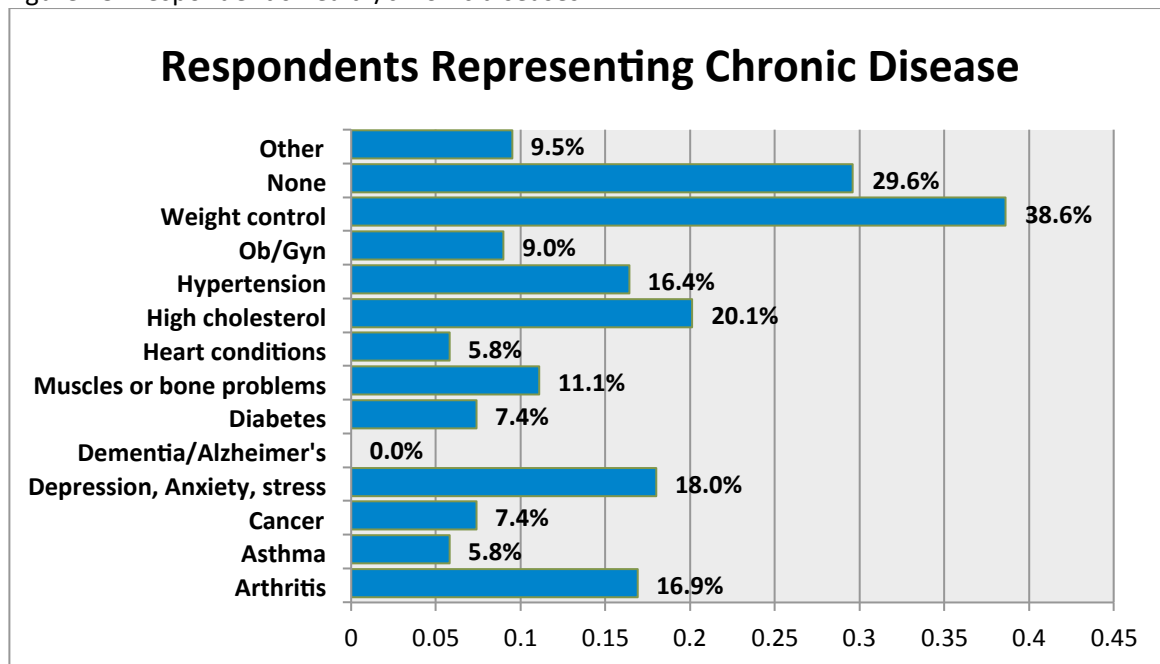
Figure 22. Primary Health Care Provider



Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. High cholesterol received the most responses with 38.6% of participants selecting this condition. The chronic diseases found in the highest percentage among respondents include, arthritis, depression, anxiety and stress, hypertension and hypercholesterolemia. (Figure 23)

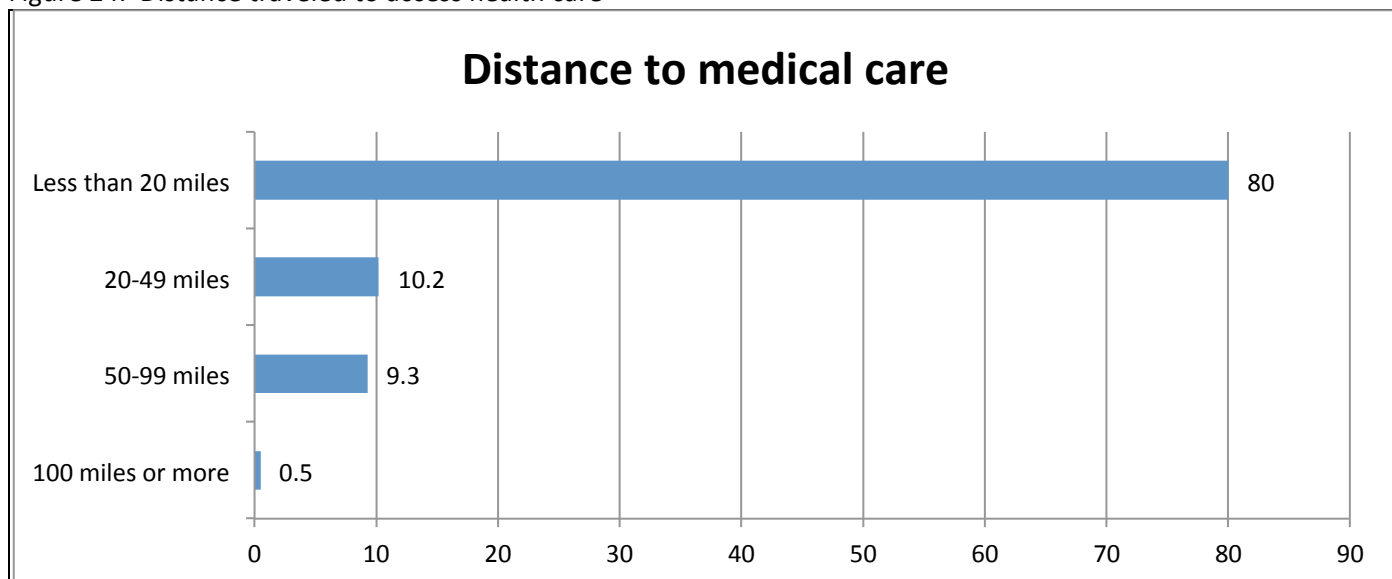
Figure 23. Respondent's health/chronic diseases



Distance to Access Medical Care

Respondents were asked how far they have to drive to access medical care. Over 80% responded that they had less than 20 miles to drive. Nineteen and one-half percent (19.5%) reported that they drive 20-99 miles.

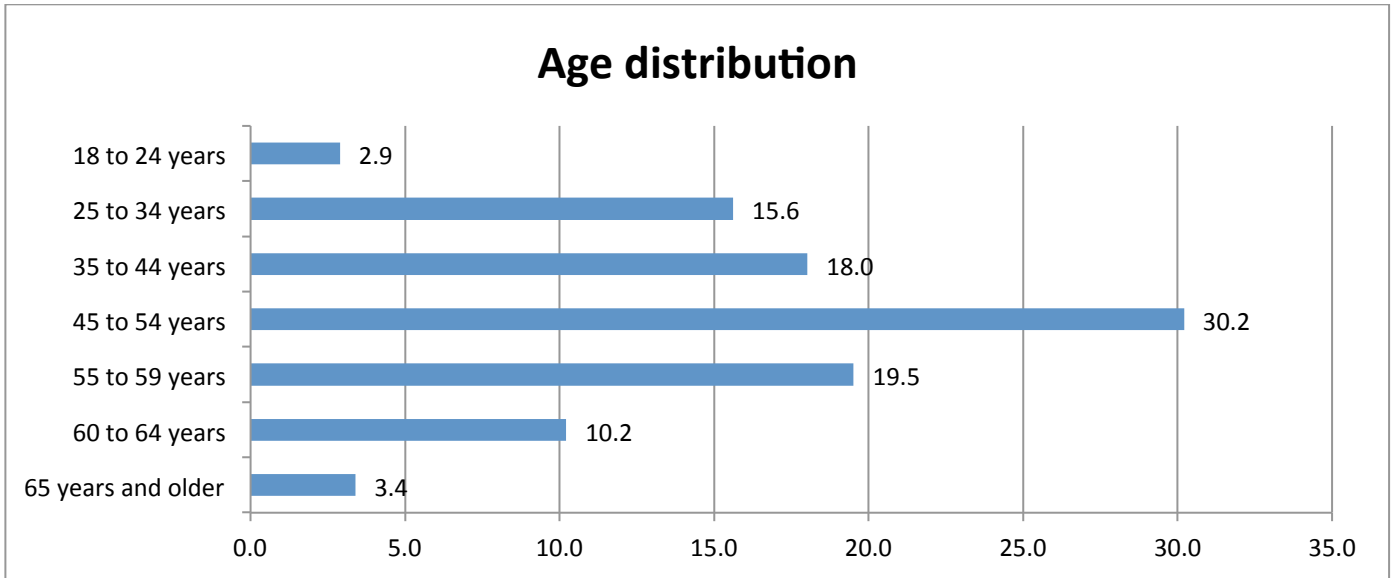
Figure 24. Distance traveled to access health care



Demographic Information

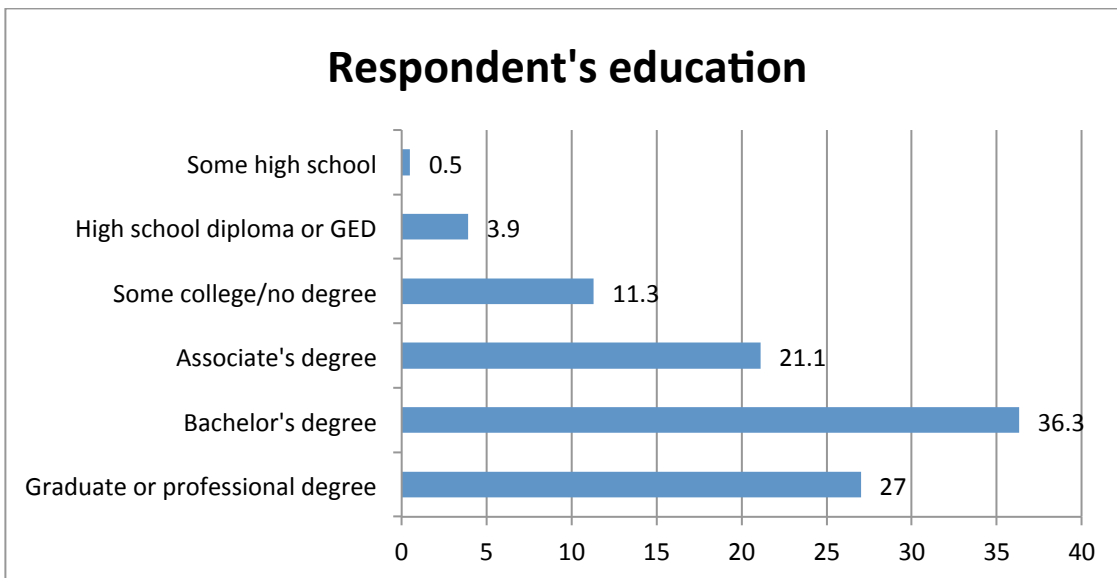
The largest group of respondents is between the ages of 45 and 59, with 30.2% falling between 45 and 54 years of age.

Figure 25. Respondents' age distribution



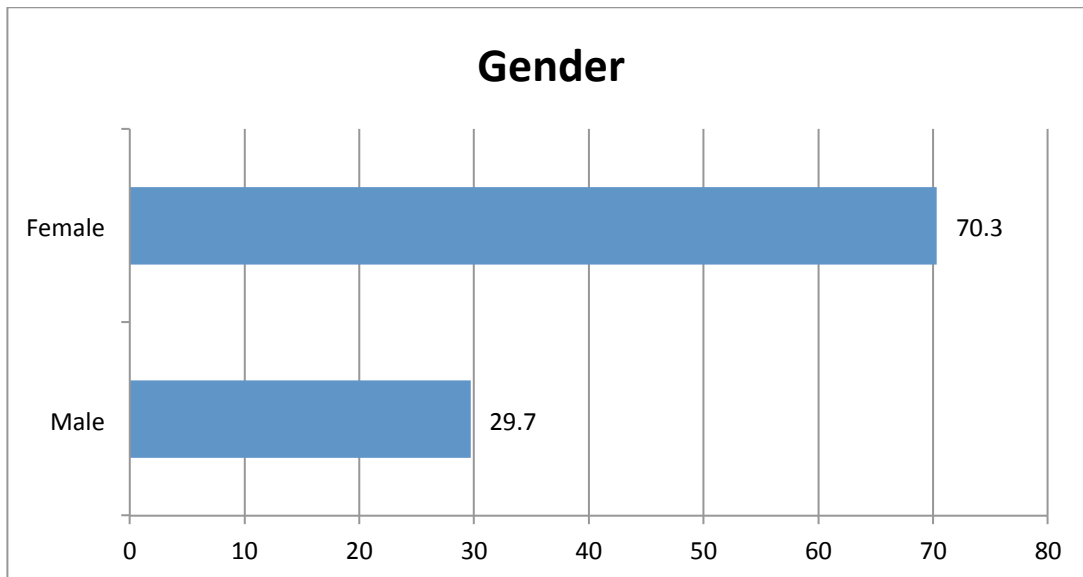
Over one-half of the respondents (63.3%) have a Bachelor's degree or higher. A Bachelor's degree was held by 36.3% of respondents and 27.0% have a graduate or professional degree.

Figure 26. Respondent's education



More females responded to the survey than males (29.7% males compared to 70.3% females).

Figure 27. Respondents by gender



Secondary Research

Sanford Worthington Medical Center analyzed the 2011 County Profiles for Nobles County and secured benchmarking data for the state of Minnesota and for the United States as a whole. 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 more premature deaths than the national benchmark. While the state of Minnesota and Nobles County have more premature deaths than the national benchmark, Nobles County has a lower rate than the national benchmark and Minnesota as a whole. Map 1 in the Appendix provides a county view of the premature deaths within the five-state region.

		National Benchmark	Minnesota	Nobles County
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,564	5,272	5,247

Morbidity

The Morbidity health outcomes indicate that Nobles County citizens report less days of poor health (self-reported) than the national benchmark and Minnesota. Minnesota and Nobles County report more physically unhealthy days than the national benchmark.

Nobles County reports less mentally unhealthy days (self-reported) than the national benchmark and Minnesota.

Minnesota and Nobles County have higher percentages of low birth weight than the national benchmark. Maps 1-2 in the Appendix provide county views of the Morbidity indicators within the five-state region.

		National Benchmark	Minnesota	Nobles County
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	10%	11%	8%
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	3.1	3.0
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.3	2.8	1.4
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.0%	6.5%	7.1%

Health Factors

Health Behaviors

The Health Behavior outcomes indicate that Nobles County has a lower percentage of adult smokers (equal to or greater than 100 cigarettes) than Minnesota but equal to the national benchmark. Adult obesity (greater than or equal to 30 BMI) is also higher in Minnesota and Nobles County. Minnesota has a lower percentage of physical inactivity than the national benchmark and Nobles County is equal to the national benchmark.

Minnesota (20%) and Nobles County (16%) all have a much higher percentage of binge drinking reports (more than four drinks on one occasion for women and more than five for men) than the national benchmark (8%).

Motor vehicle crash death rates are higher than the national benchmark (12) in Minnesota (12.9); however, the rate is substantially higher than the national benchmark in Nobles County (26.0).

Sexually transmitted infections rank substantially higher than the national benchmark (83) for Minnesota (276.1) and Nobles County (314.3).

The teen birth rate is higher in Minnesota (27.5) and substantially higher in Nobles County (54.2) than the national benchmark (22). Maps 6-12 in the Appendix provide county views of the Health Behavior indicators within the five-state region.

		National Benchmark	Minnesota	Nobles County
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	19%	15%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m ² , 2008	25%	26%	28%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	17%	20%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, (consuming >4 for women and >5 for men on a single occasion) 2003-2009	8%	20%	16%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	12.0	12.9	26.0
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	83.0	276.1	314.3
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	22.0	27.5	54.2

Clinical Care

The Clinical Care outcomes indicate that Minnesota has a lower percentage of uninsured adults than the national benchmark while Nobles County has a higher percentage. This is the same trend for the uninsured youth in Minnesota and Nobles County when compared to the national benchmark.

The ratio of population to primary care physicians is about equal in Minnesota to that of the national benchmark; however, Nobles County has a less positive ratio.

The ratio of population to mental health providers is more positive in Minnesota but less positive in Nobles County than the national benchmark.

The number of professionally active dentists is lower than the national benchmark in both Minnesota and Nobles County.

Preventable hospital stays are higher than the national benchmark in Minnesota and Nobles County.

Diabetes screening in Minnesota is lower than the national benchmark. The rate of diabetes screening is higher in Nobles County than the national benchmark.

Minnesota ranks lower than the national benchmark for mammography screenings, while Nobles County ranks higher than the national benchmark.

Maps 13-19 in the Appendix provide county views of the Clinical Care indicators within the five-state region.

		National Benchmark	Minnesota	Nobles County
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	11%	18%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	7%	6%	11%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	631:1	636:1	786:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	2,242:1	1,306:1	3,404:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	69.0	61.0	44.2
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.0	56.5	55.6
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	88%	94%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	73%	80%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that both Minnesota and Noble County have lower high school graduation rates than the national benchmark. Nobles County has a lower percentage of post-secondary education than the national benchmark while Minnesota is higher.

The unemployment rate was higher in Minnesota than the national benchmark during 2009, and was equal to the national standard in Nobles County.

The percentage of child poverty is equal in Minnesota to the national benchmark. The percentage of child poverty is higher in Nobles County.

Inadequate social support is equal in Minnesota to the national benchmark; however, there is no data for Nobles County.

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

The number of homicide deaths in Minnesota is higher than the national benchmark. There was no data for homicide deaths in Nobles County.

Maps 20-26 in the Appendix provide county views of the Social and Economic indicators within the five-state region.

		National Benchmark	Minnesota	Nobles County
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years 2006-2007	92%	87%	85%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	72%	55%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009	5.3%	8.0%	5.3%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	15%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	14%	n/a
Children in single parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	20%	25%	27%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	1.0	2.5	n/a

Physical Environment

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

Access to recreational facilities ranks lower than the national benchmark for Minnesota and Nobles County.

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

		National Benchmark	Minnesota	Nobles County
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e. grocery store or produce stand/farmers market), 2008	92%	54%	27%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	17.0	12.0	10.0

Demographics

Youth account for 28% of the population in Noble County. Elderly account for 16% of the population in Nobles County.

Forty seven percent (47%) of Nobles County is rural compared to 29% of Minnesota and 21% as the national benchmark.

Only 4% of Minnesotans are not proficient in English while 10% of Nobles County’s population is not proficient in English compared to the national benchmark, which is 9%.

Minnesota at 6% each and Nobles County at 12% have low illiteracy rates compared to the national benchmark of 15%.

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

		National Benchmark	Minnesota	Nobles County
Youth	Percent of total population ages 0-17, 2009	24%	24%	28%
Elderly	Percent of total population ages 65 and older, 2009	13%	13%	16%
Rural	Percent of total population living in rural area, 2000	21%	29%	47%
Not English Proficient	Percent of total population that speaks English less than "very well". 2005-2009	9%	4%	10%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	6%	12%

Population by Age

The population for this area is relatively young with only 11% older than 65 years of age.

The gender distribution is 51-49 % for Nobles County, which is the opposite of the national percentages.

	National Benchmark	Minnesota	Nobles County
Total population	308,745,538	5,303,925	21,378
Percent ages 65 and older	13%	13%	11%
Percent 85 and older	2%		
Percent male	49%		51%
Percent female	51%		49%

Based on 2010 Census data

Housing

The majority of individuals in this region own their home which is equal to the Minnesota percentages and higher than the national standard.

	National Benchmark	Minnesota	Nobles County
Percent of occupied housing that is owner-occupied	65%	73%	73%
Percent of occupied housing that is renter-occupied	35%	27%	27%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 71% in Minnesota. The percentage of those in Minnesota who are living at less than 100% of the federal poverty level is 11%, and 26% are at less than 200% of the federal poverty level. The median household annual income in Minnesota is \$57,243.

	National Benchmark	Minnesota	Nobles County
Percent of working age population in the labor force	65%	71%	68%
Percent of total population with income less than 100% of poverty	14%	11%	18%
Percent of total population with income less than 200% of poverty	32%	26%	40%
Median household income	\$51,914	\$57,243	\$43,040
Owner occupied housing units	76,089,650	1,548,127	5,901
Percent spending 30% or more income toward housing costs	30%	28%	21%
Renter occupied housing units	38,146,346	537,790	2,164
Percent renters spending 30% or more of income toward housing costs	47%	46%	41%

Diversity Profile

The population distribution by race demonstrates that Nobles County is predominantly white, followed by Hispanic, Asian, Black and American Indian.

	National Benchmark	Minnesota	Nobles County
Total population	308,745,538	5,303,925	21,378
White alone	223,553,265	4,524,062	16,206
Asian alone	14,674,252	214,234	1,168
Black alone	38,929,319	274,412	743
Hispanic origin – of any race	50,477,594	250,258	4,820
American Indian	2,932,248	60,916	111

Health Needs Identified

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:

- Youth - Obesity
- Services for the elderly
- New Americans/Immigrants

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

Sustainable Community Collaborative

Sanford Health continues to work in partnership with the collaborative and will incorporate additional strategies from the developing plans as appropriate to the medical center implementation strategies.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment Sanford Worthington Implementation Strategy

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

- Youth - Obesity
- Elderly
- New American/Immigrants

Implementation Strategy: Youth - Obesity

- Establish a youth program (K-4) that will involve District 518, YMCA and local Sanford Worthington Clinic Pediatricians and staff.
- Action plans include focusing on kids with a BMI above a certain percentage.
- Program to include physical activity for the kids as well as an educational component for parents.
- Curriculum is currently being developed.
- Review of program will occur and any changes will be implemented.

Implementation Strategy: Elderly

- Review and define the current socioeconomic health status of the elderly in the community and develop an implementation strategy for need or needs identified.
- Actions include releasing summary of survey data to agencies that participated in the primary source community survey.
- Identify agencies within the community and begin the assessment of elderly status. Agencies may include Nobles County Public Health, Nursing Homes, City of Worthington and Sanford. Others will be invited as identified.

Implementation Strategy: New American/Immigrants

- Increase SWMC and Sanford Worthington Clinic providers and staff awareness of the various cultures and nationalities currently in the SWMC market area as they affect the delivery of health care to these groups of community members.
- Actions include creating periodic education and competencies for all staff on the various cultures in the Worthington area. Focus will be given to those cultures with the largest population base in our market area.

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

Nobles County

Minnesota

HEALTH OUTCOMES		Nobles	*National Benchmark	Minnesota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,247	5,564	5,272
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	8%	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	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	1.4	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	7.1%	6.0%	6.5%
HEALTH FACTORS				
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m ² , 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	20%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	16%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	26.0	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	314.3	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	54.2	22.0	27.5
<i>Clinical Care</i>				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	18%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	11%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	786:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	3,404:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	44.2	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	55.6	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	94%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	80%	74%	73%

HEALTH FACTORS (continued)

Nobles *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	85%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	55%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	5.3%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	15%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	27%	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	27%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	10.0	17.0	12.0

Demographics

Nobles United States Minnesota

Youth	Percent of total population ages 0-17, 2009	28%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	16%	13%	13%
Rural	Percent of total population living in a rural area, 2000	47%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	10%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	12%	15%	6%

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

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

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

Definitions of Health Variables

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

Aging Profile

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

Nobles County

Minnesota

AGE

CHARACTERISTICS

	Total	Less than 65 Years	Ages 65 and Older
<i>Population</i> ¹			
Total population	21,378	17,958	3,420
Percent ages 65 and older	16%	-	100%
Percent ages 85 and older	3%	-	20%
Percent male	51%	53%	43%
Percent female	49%	47%	57%
<i>Living Arrangements</i>			
Total households (by age of householder) ¹	7,946	5,753	2,193
Percent with family households (i.e., at least two people who are related)	68%	74%	53%
Percent with householder living alone	27%	19%	46%
Grandparents living with their grandchildren * ²	336	299	37
Percent who are responsible for their grandchildren	29%	32%	8%
<i>Housing</i> ¹			
Percent of occupied housing that is owner-occupied	73%	69%	83%
Percent of occupied housing that is renter-occupied	27%	31%	17%
<i>Economic Security</i> ²			
Percent of working-age population in labor force	68%	81%	17%
Percent of total population with income less than 100% of poverty	18%	19%	11%
Percent of total population with income less than 200% of poverty	40%	41%	37%
Median household income (by age of householder)	\$43,040	\$41,710	\$28,773
Owner-occupied housing units (by age of householder)	5,901	4,162	1,739
Percent spending 30% or more of income toward housing costs	21%	19%	25%
Renter-occupied housing units (by age of householder)	2,164	1,813	351
Percent spending 30% or more of income toward housing costs	41%	41%	42%

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

Source: U.S. Census Bureau, ¹2010 Census Summary File 1 and ²2006-2010 American Community Survey 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable.

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Diversity Profile

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

Nobles County

Minnesota

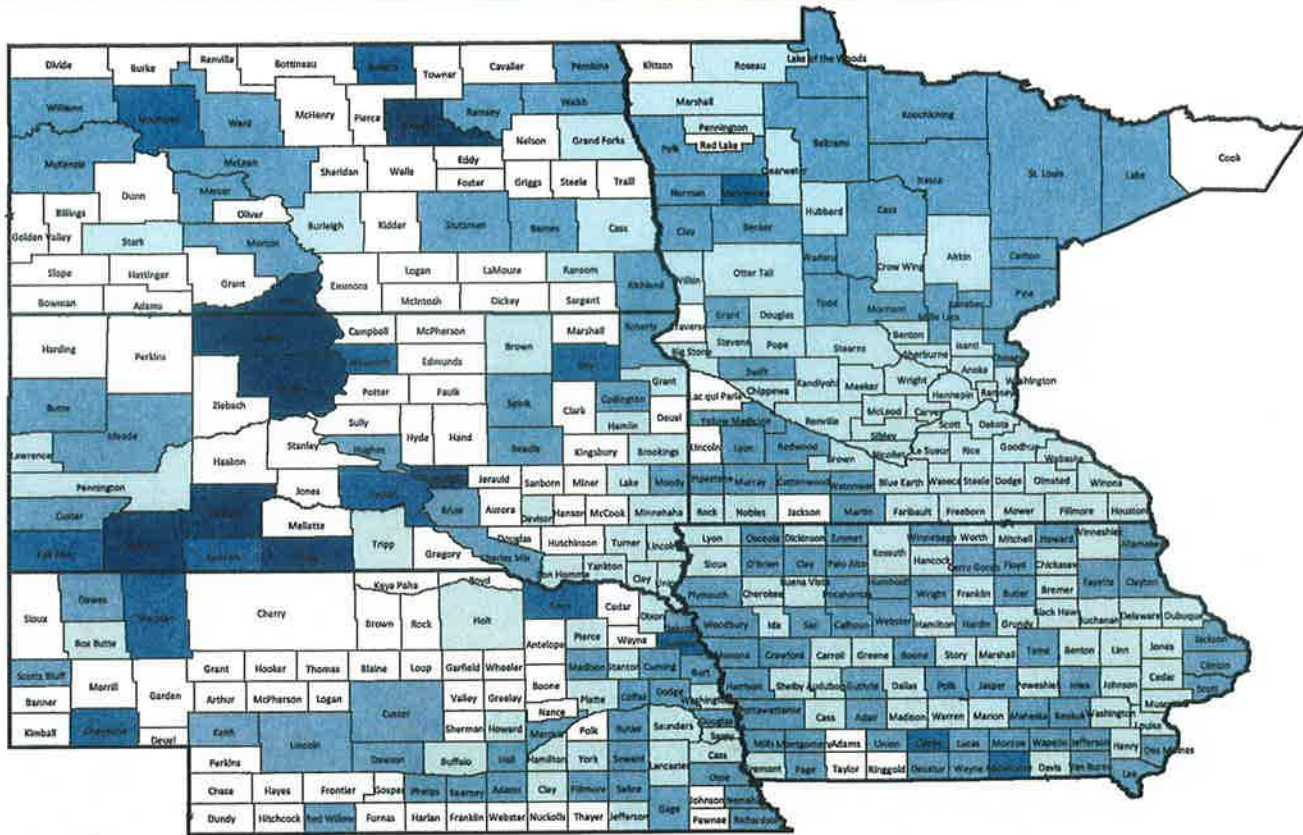
CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
<i>Population</i> ¹						
Total population	21,378	16,206	743	111	1,168	4,820
Percent ages 0 to 17	26%	22%	33%	41%	31%	40%
Percent ages 18 to 44	33%	28%	52%	42%	45%	48%
Percent ages 45 to 64	25%	29%	14%	14%	20%	11%
Percent ages 65 and older	16%	21%	1%	4%	5%	1%
Median age (in years)	37.5	44.5	26.3	25.5	26.9	23.2
<i>Living Arrangements</i>						
Total households ¹	7,946	6,727	235	31	277	1,022
Percent with householder living alone	27%	29%	26%	35%	10%	7%
Percent with families with children ages 0 to 17	30%	25%	37%	42%	51%	66%
Grandparents living with their grandchildren ²	336	255	36	0	34	175
Percent who are responsible for grandchildren	29%	22%	100%	-	0%	23%
<i>Housing</i> ¹						
Percent occupied housing that is owner-occupied	73%	79%	14%	42%	56%	46%
Percent occupied housing that is renter-occupied	27%	21%	86%	58%	44%	54%
<i>Educational Attainment</i> ²						
Percent of persons ages 25 and older with high school degree or higher	79%	80%	74%	96%	72%	28%
Percent of persons ages 25 and older with Bachelor's degree or higher	16%	15%	51%	0%	26%	4%
<i>Economic Security</i> ²						
Unemployment rate	5%	4%	0%	0%	4%	13%
Median household income	\$43,040	\$43,627	\$22,917	\$95,052	\$55,993	\$32,179
Percent of households with income <\$25,000	29%	29%	70%	34%	18%	38%
Percent of persons with income <100% poverty	18%	16%	68%	8%	3%	44%
Percent of children ages 0 to 17 in families with income <100% poverty	25%	23%	63%	20%	2%	52%
Percent of elderly ages 65 and older with income <100% poverty	13%	12%	-	-	66%	35%

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

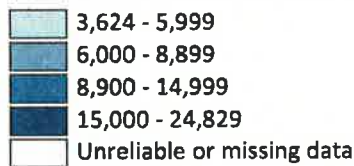
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Premature Death - A health outcome measure focusing on mortality

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



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



CONTEXT

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

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

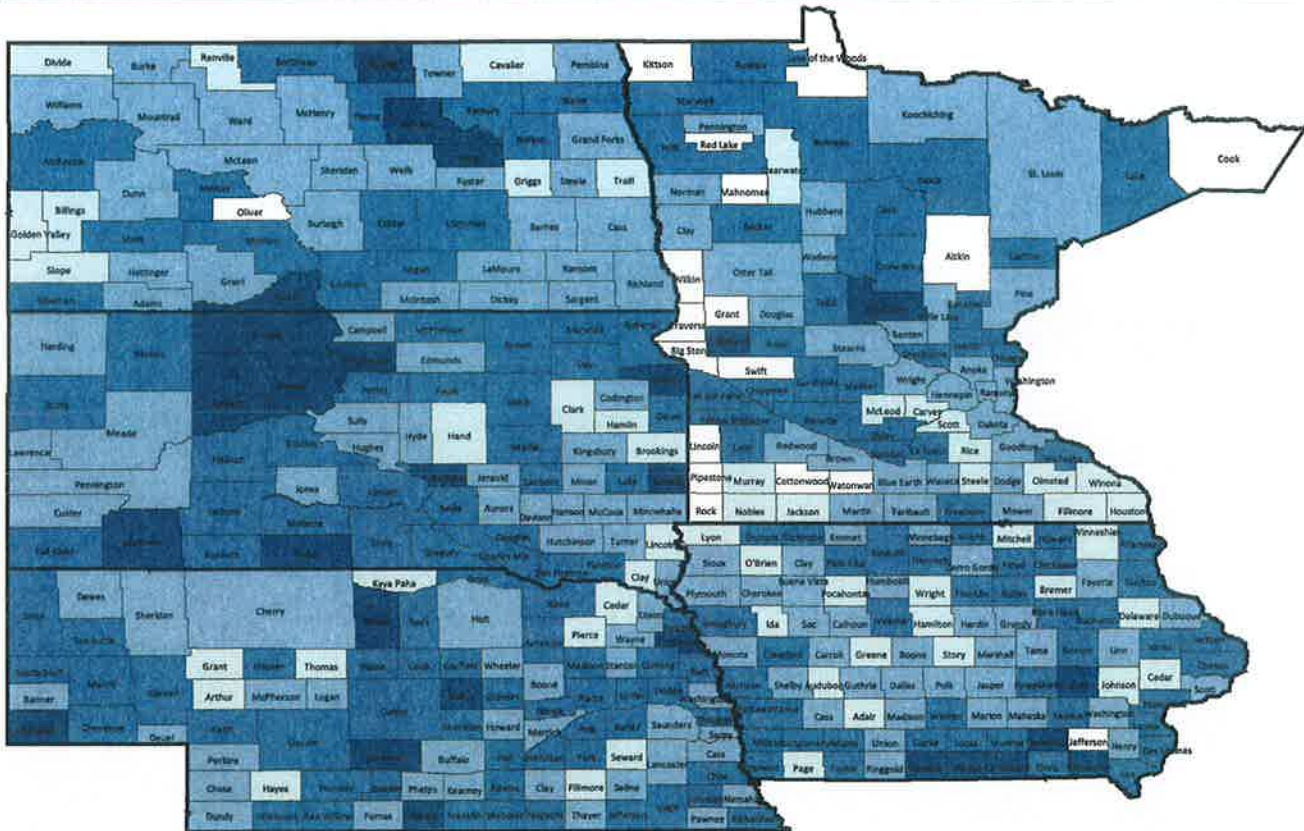
Importance: Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

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

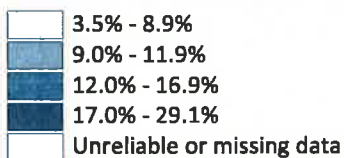
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are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

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

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



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



CONTEXT

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

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

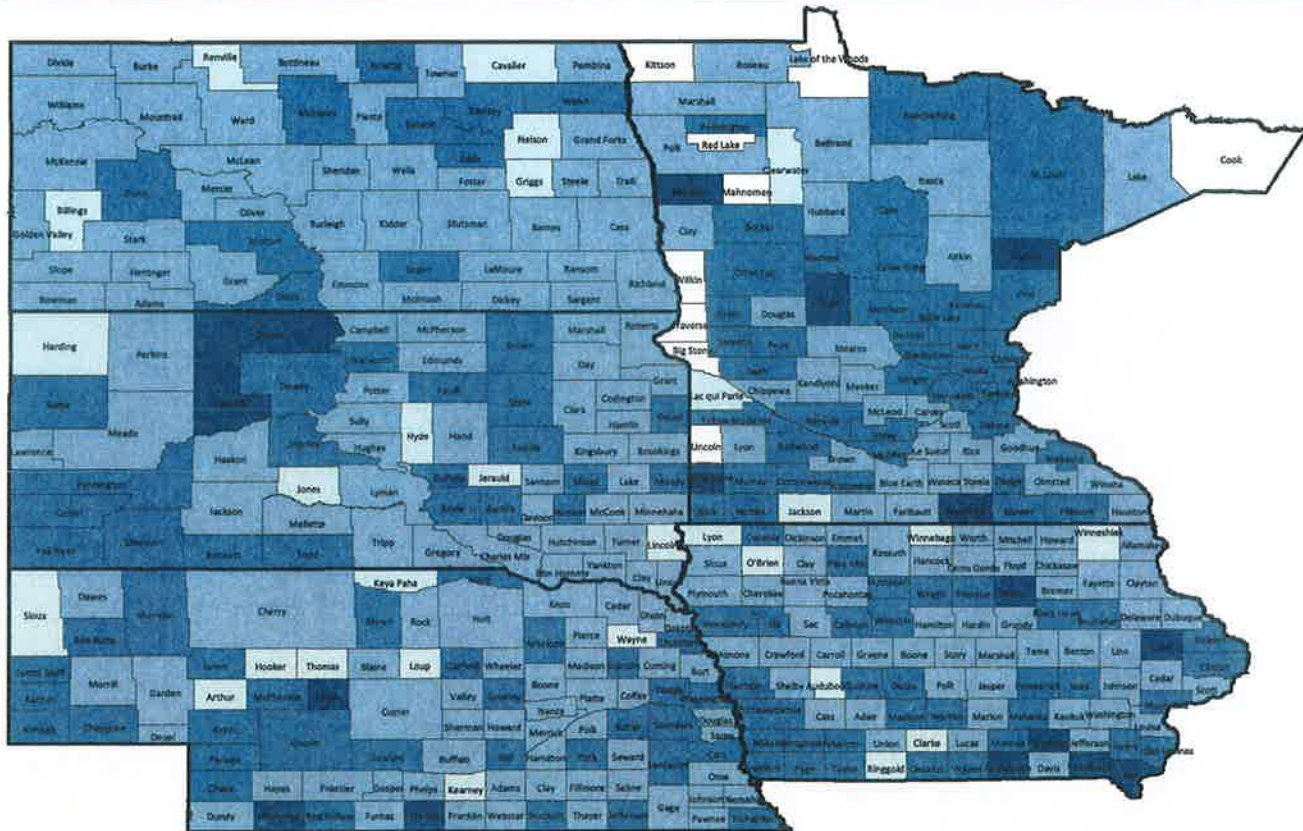
Importance: Self-reported health status is a widely used measure of people’s health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable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

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

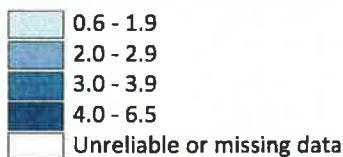
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Poor Physical Health Days - A health outcome measure focusing on morbidity

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



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



CONTEXT

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

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

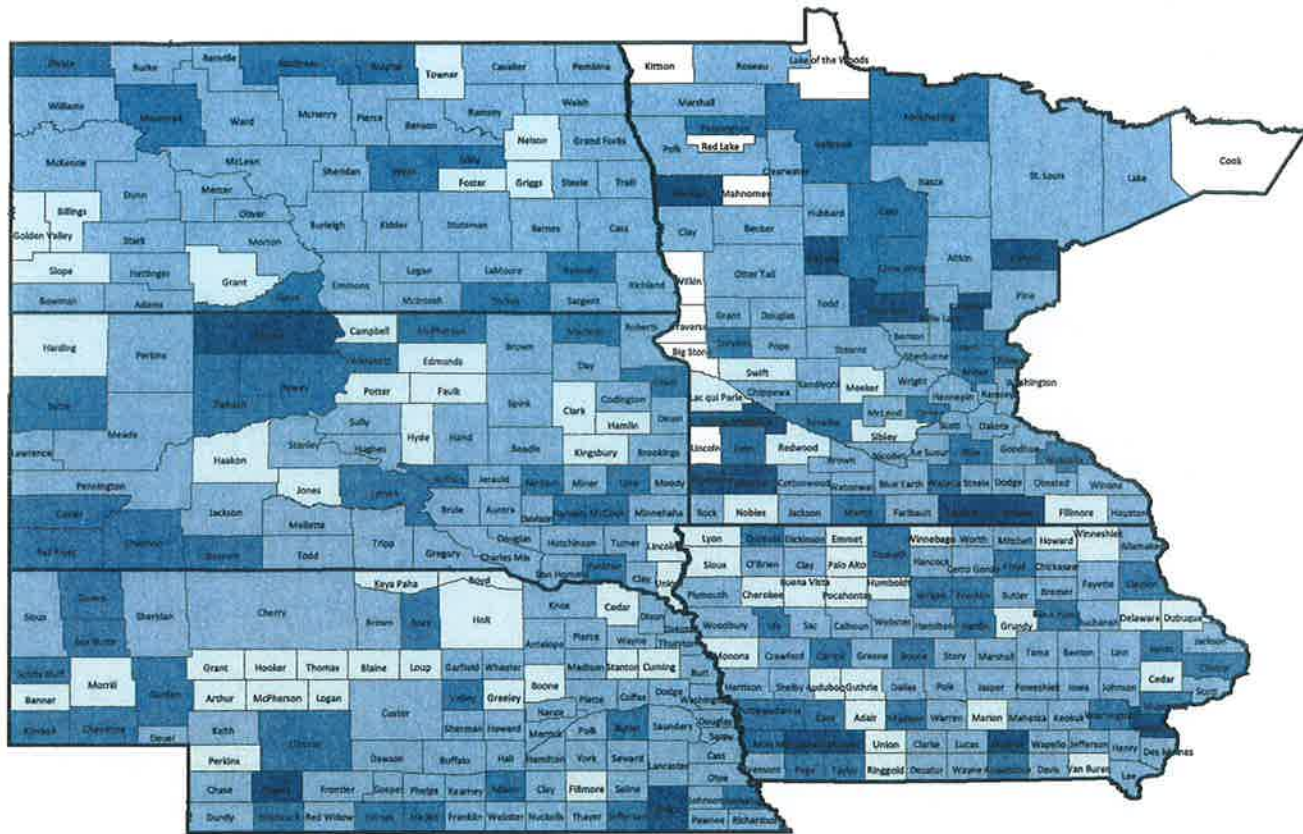
Importance: In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive – people’s reports of days when their physical health was not good are a reliable estimate of their recent health.

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

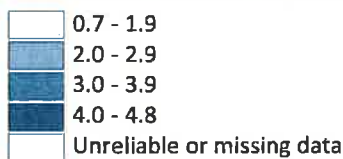
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Poor Mental Health Days - A health outcome measure focusing on morbidity

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



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



CONTEXT

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

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

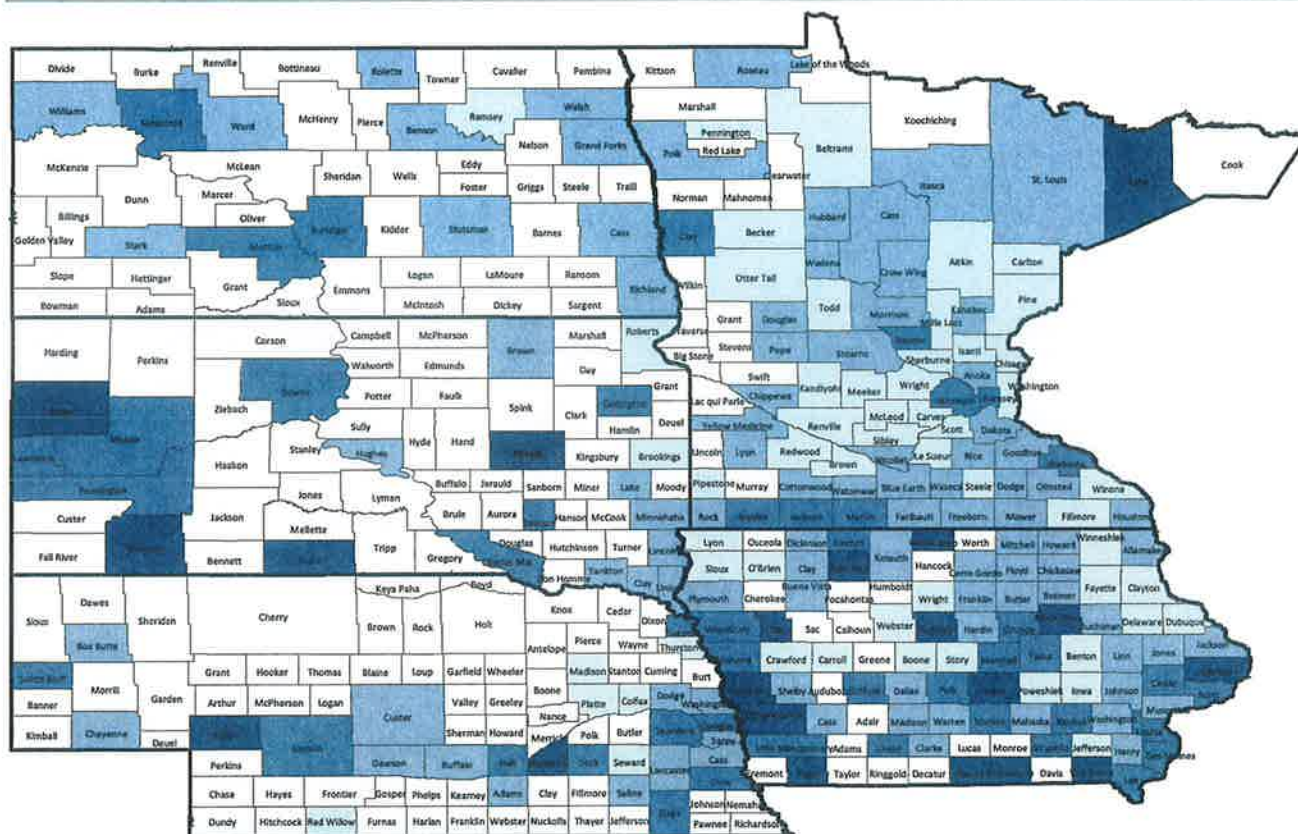
Importance: Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represent an important facet of health-related quality of life. The County Health Rankings considers health-related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

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

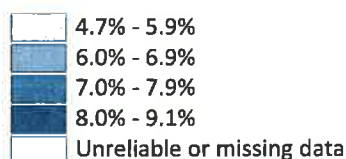
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Low Birthweight - A health outcome measure focusing on morbidity

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



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



CONTEXT

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

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

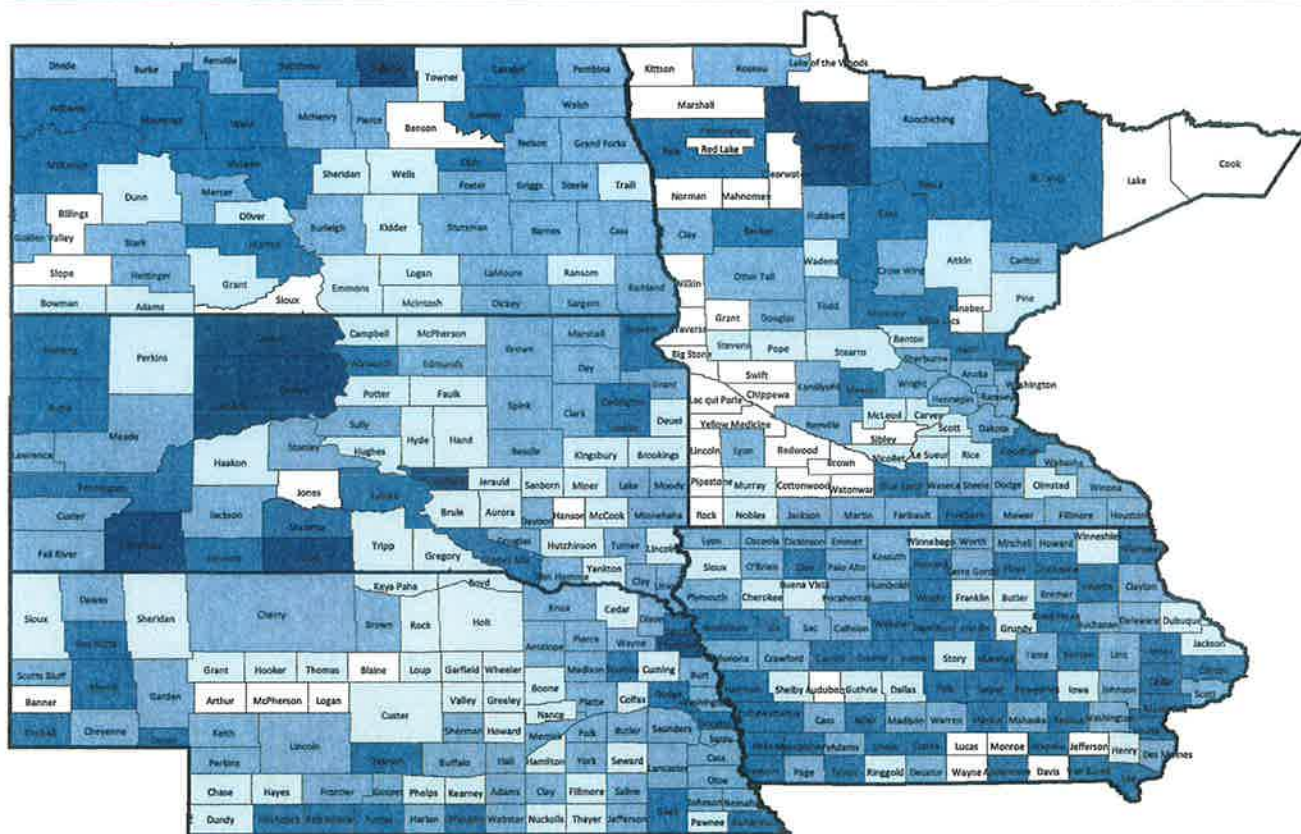
Importance: Low birthweight represents two factors: maternal exposure to health risks and an infant’s current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

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

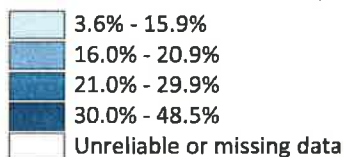
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Adult Smoking - A health factor measure focusing on health behaviors

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



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



CONTEXT

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

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

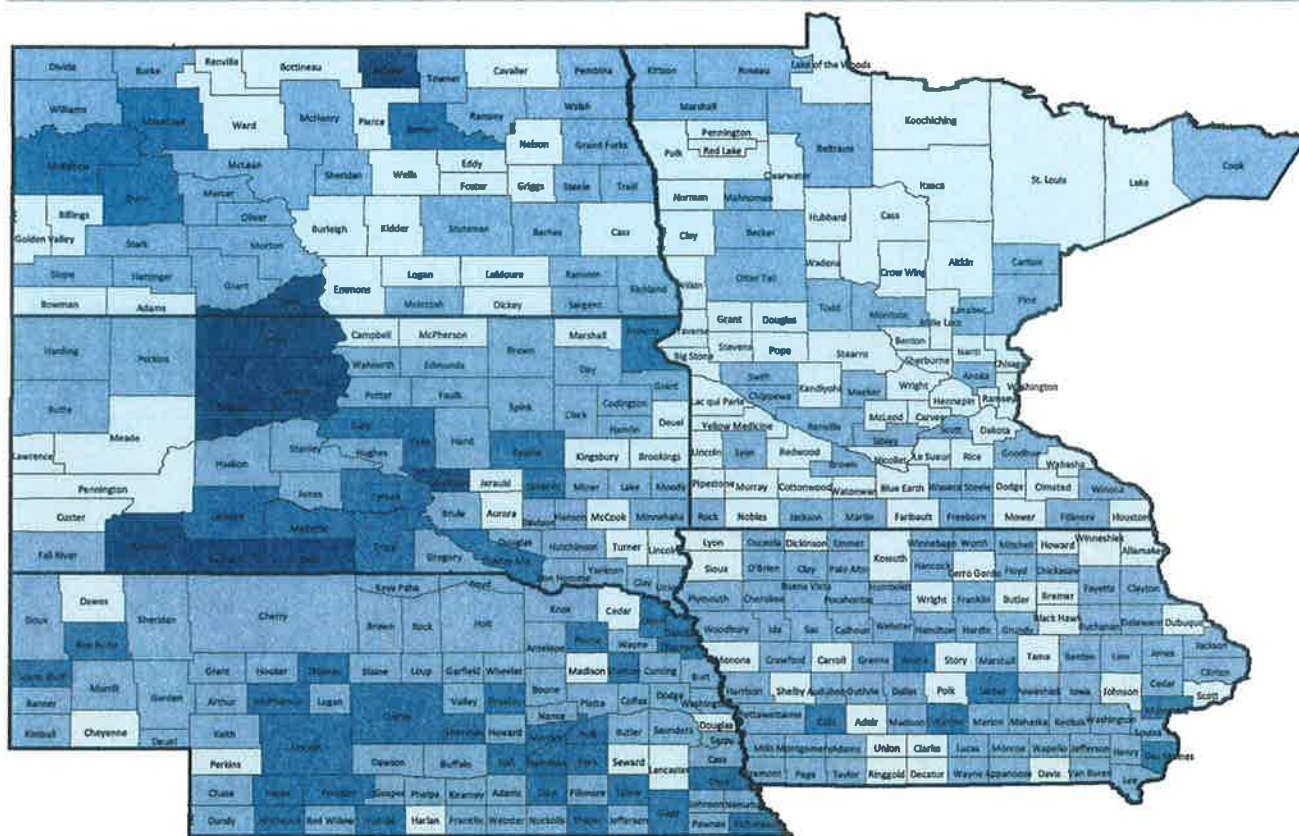
Importance: Each year approximately 443,000 premature deaths occur in the U.S. primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birthweight, and other adverse health outcomes. Measuring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

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

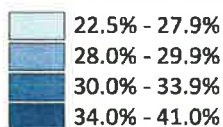
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Adult Obesity - A health factor measure focusing on health behaviors

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



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



CONTEXT

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

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

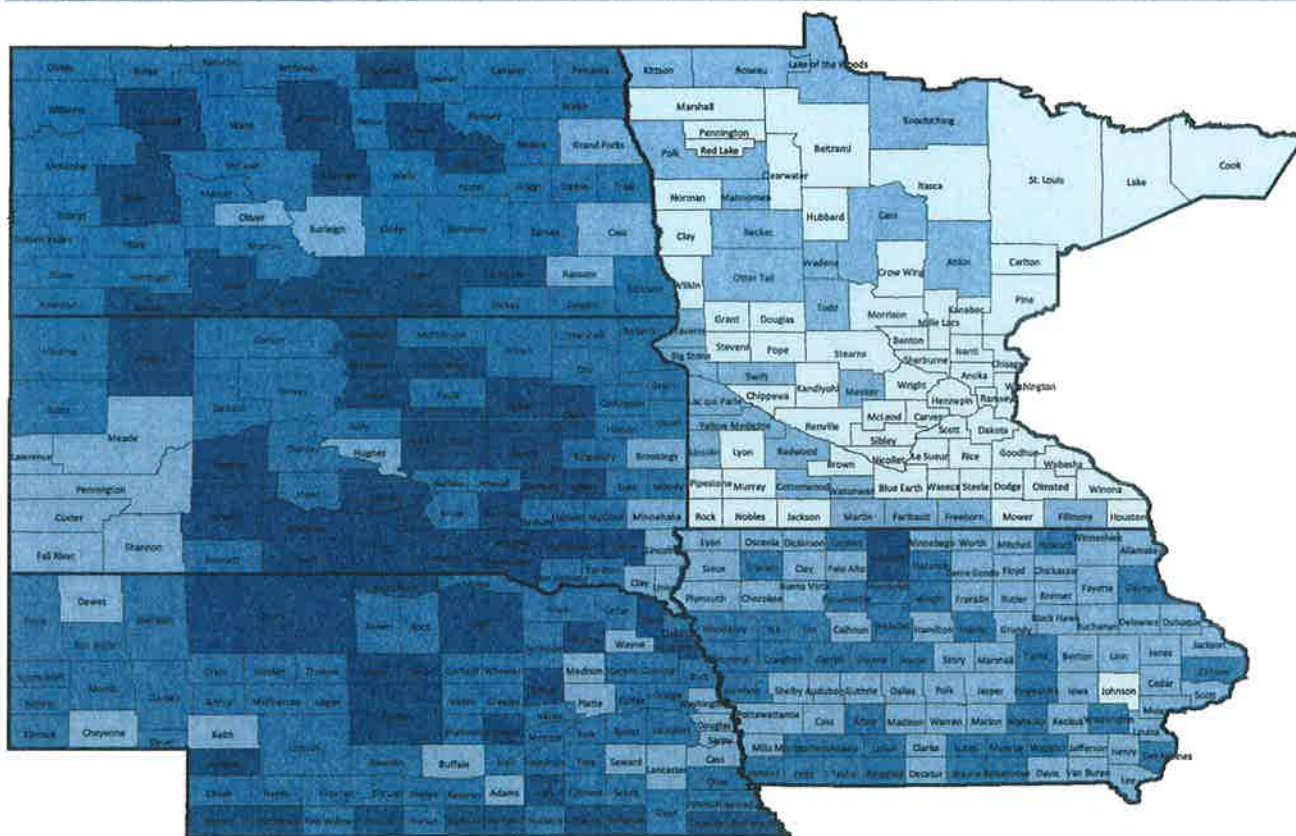
Importance: Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep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

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

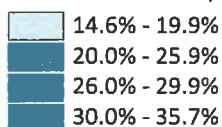
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Physical Inactivity - A health factor measure focusing on health behaviors

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



Percent of adults reporting no leisure time physical activity, 2008



CONTEXT

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

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

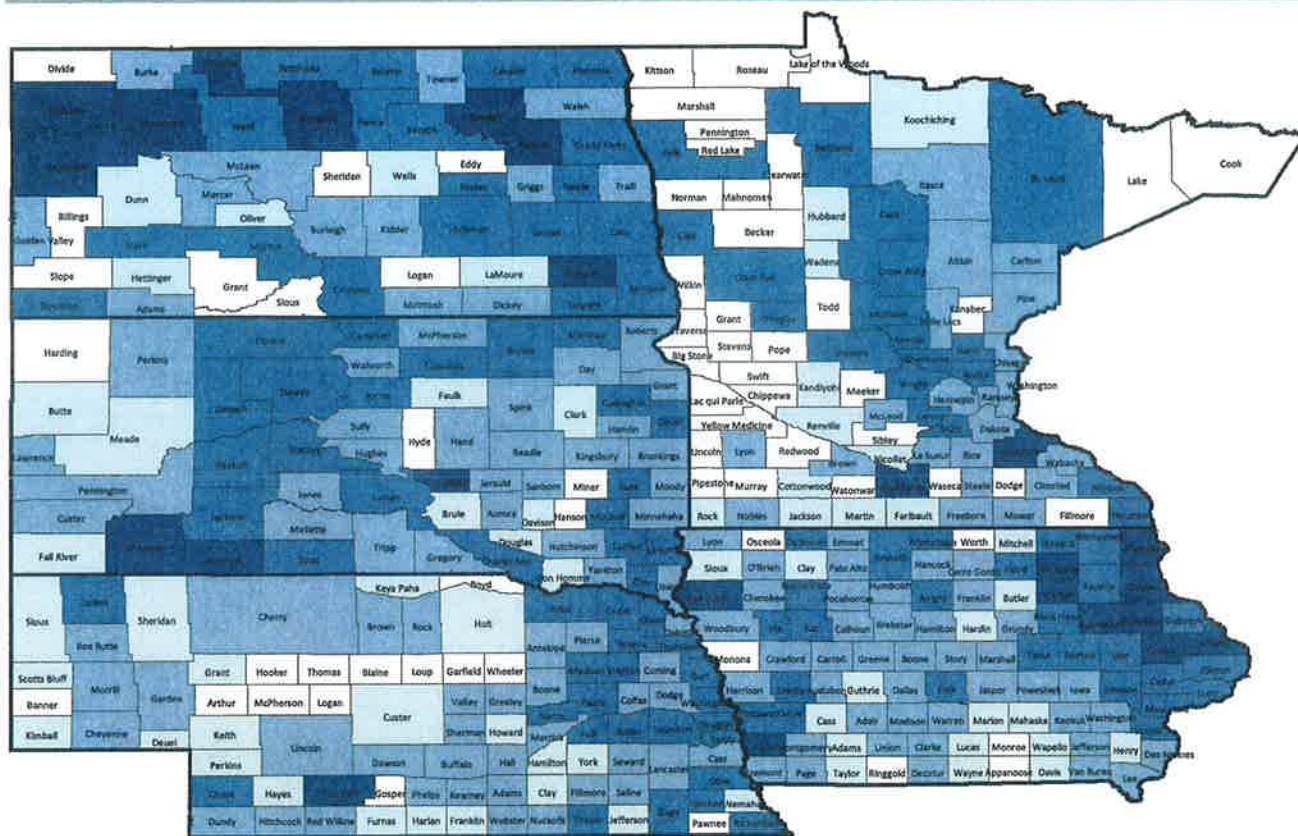
Importance: Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental health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

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

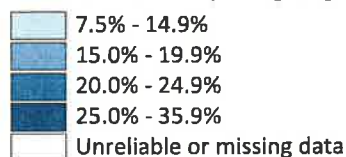
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Excessive Drinking - A health factor measure focusing on health behaviors

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



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



CONTEXT

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

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

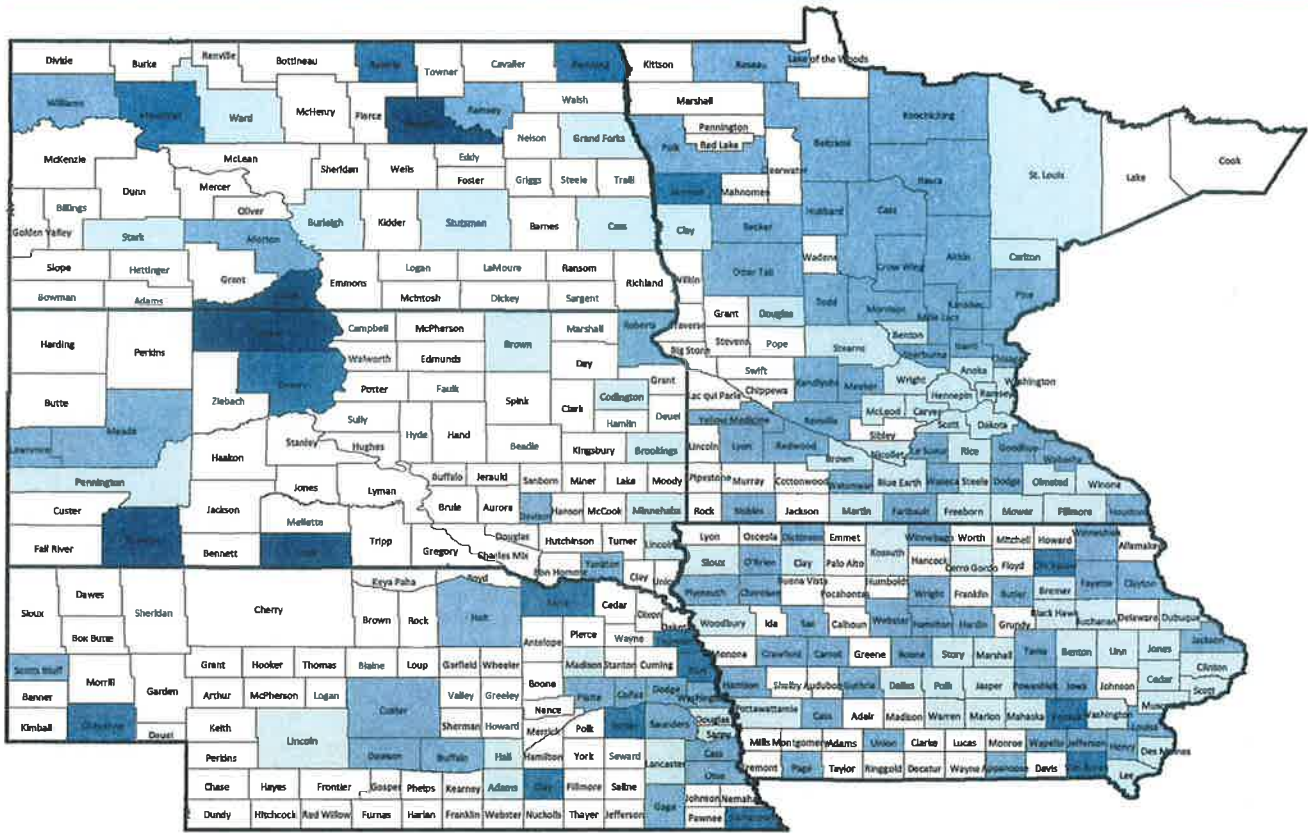
Importance: Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and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

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

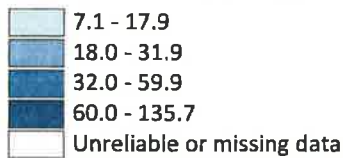
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Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

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



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



CONTEXT

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

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

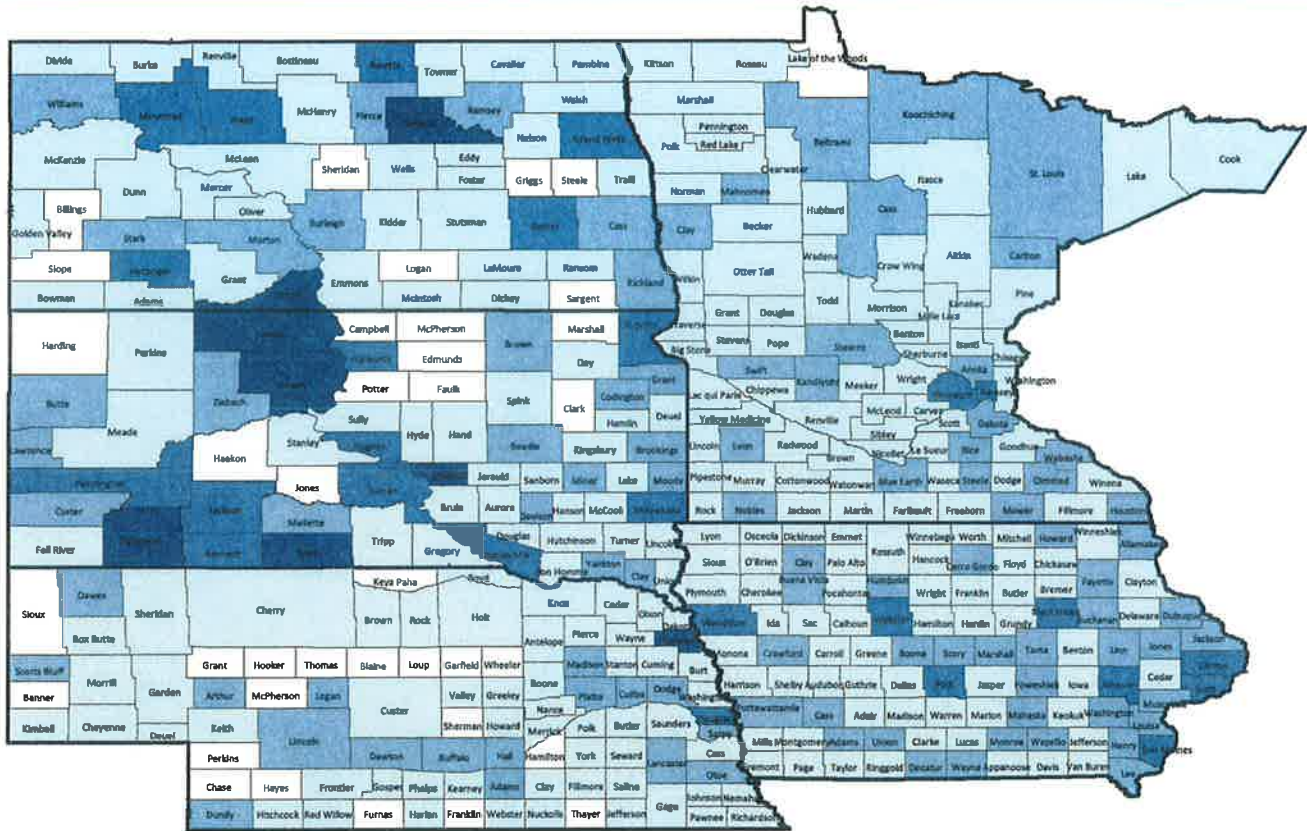
Importance: A strong association has been demonstrated between excessive drinking and alcohol-impaired driving, with approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.

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

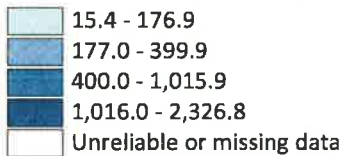
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Sexually Transmitted Infections - A health factor measure focusing on health behaviors

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



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



CONTEXT

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

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

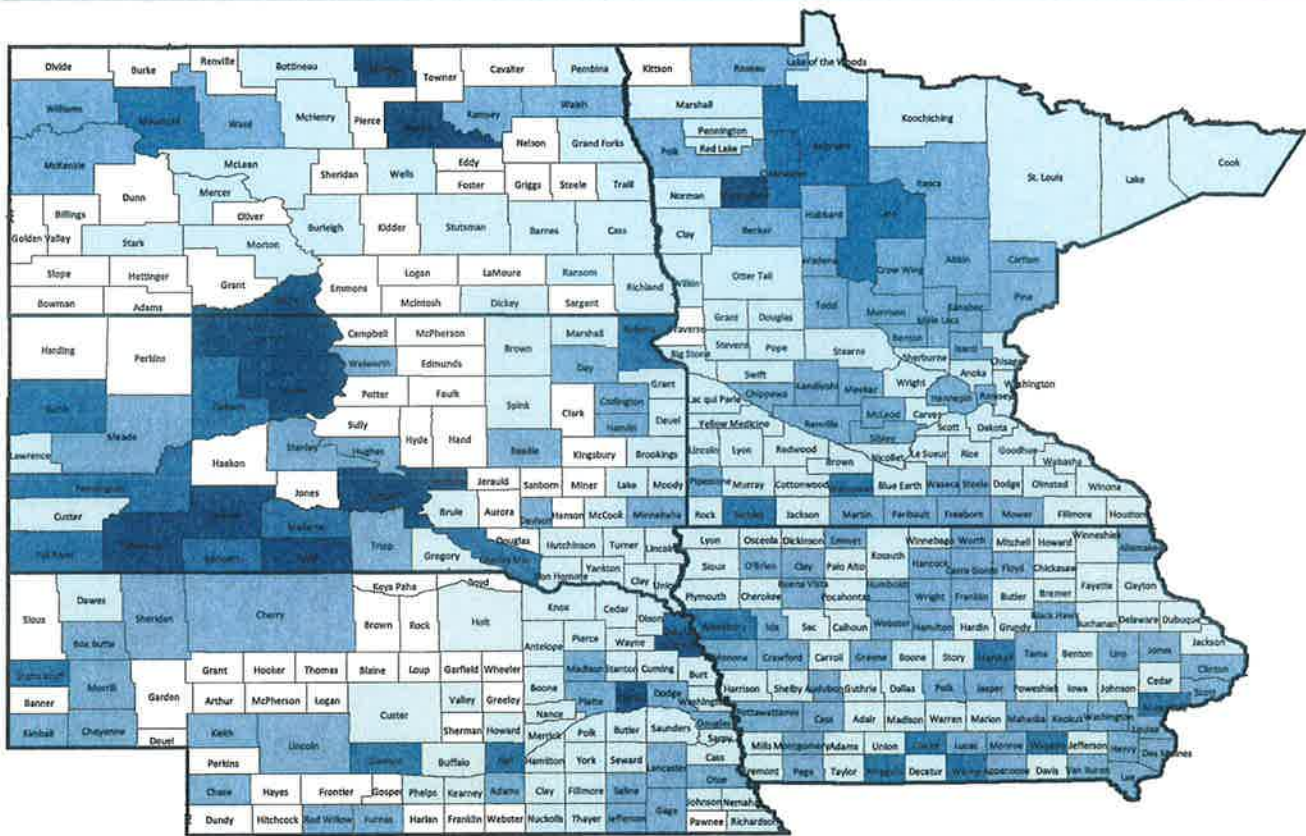
Importance: Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including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

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

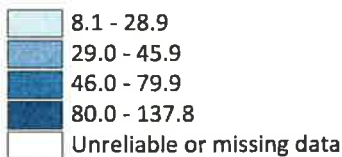
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Teen Birth Rate - A health factor measure focusing on health behaviors

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



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



CONTEXT

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

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

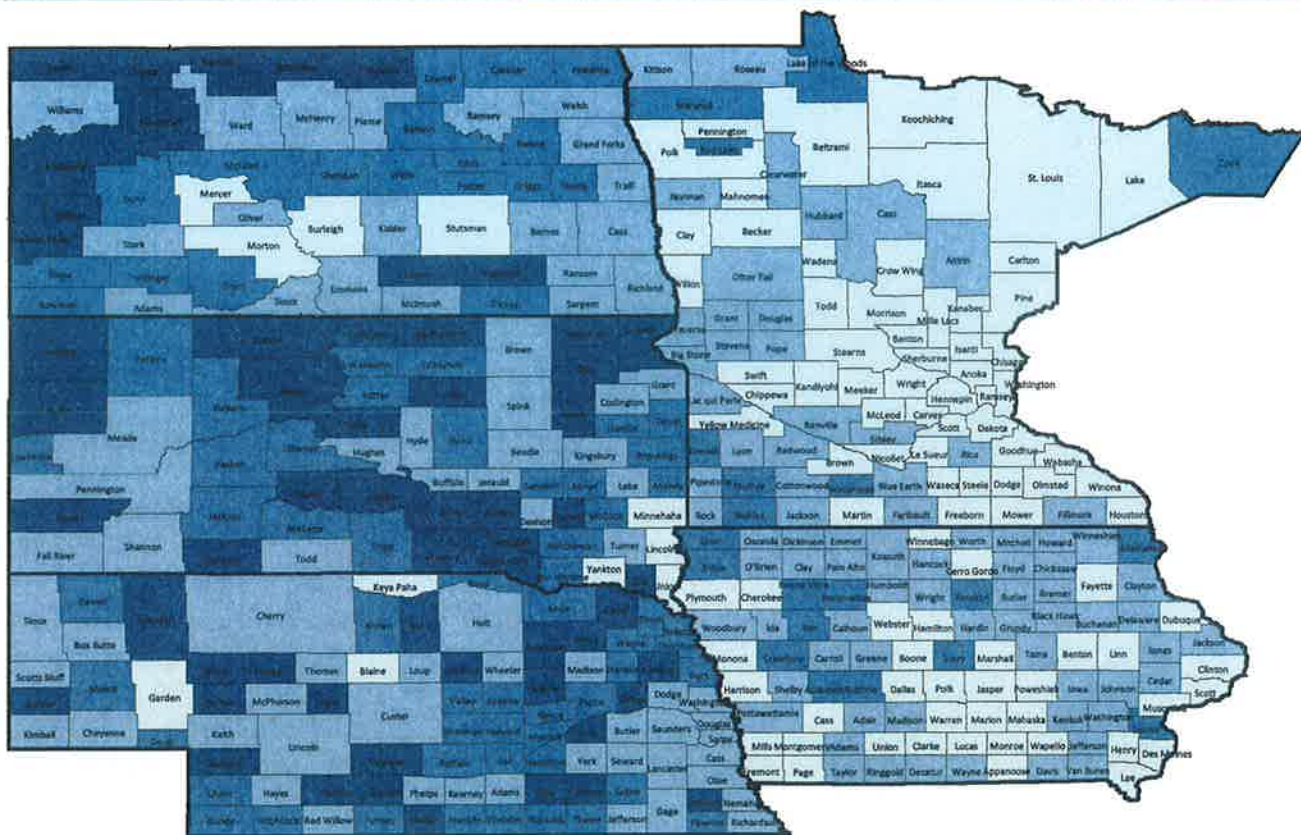
Importance: Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery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

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

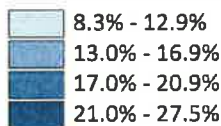
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Uninsured Adults - A health factor measure focusing on clinical care

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



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



CONTEXT

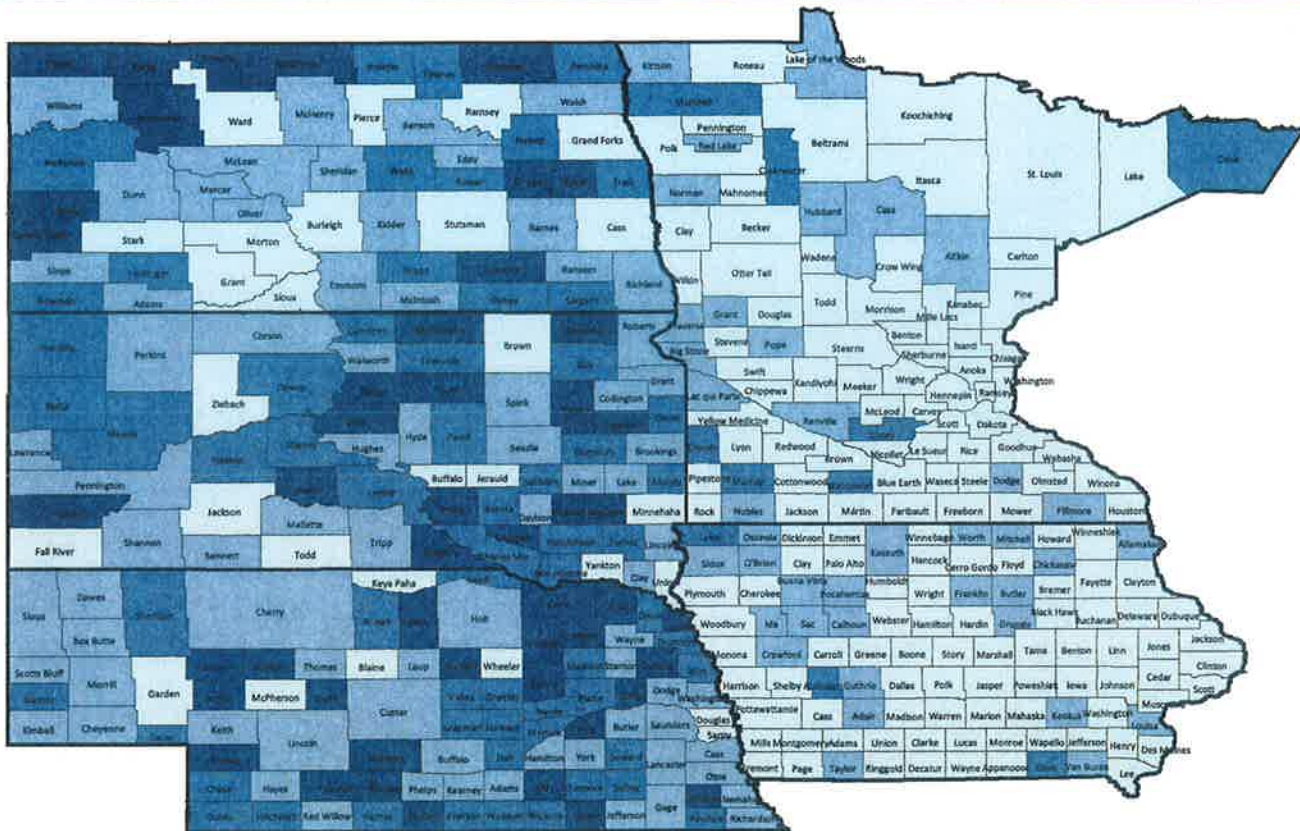
What It Is: The uninsured adults measure represents the estimated percent of the adult population under age 65 that has no health insurance coverage.

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

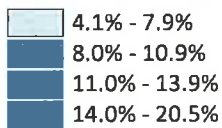
Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

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

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



CONTEXT

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

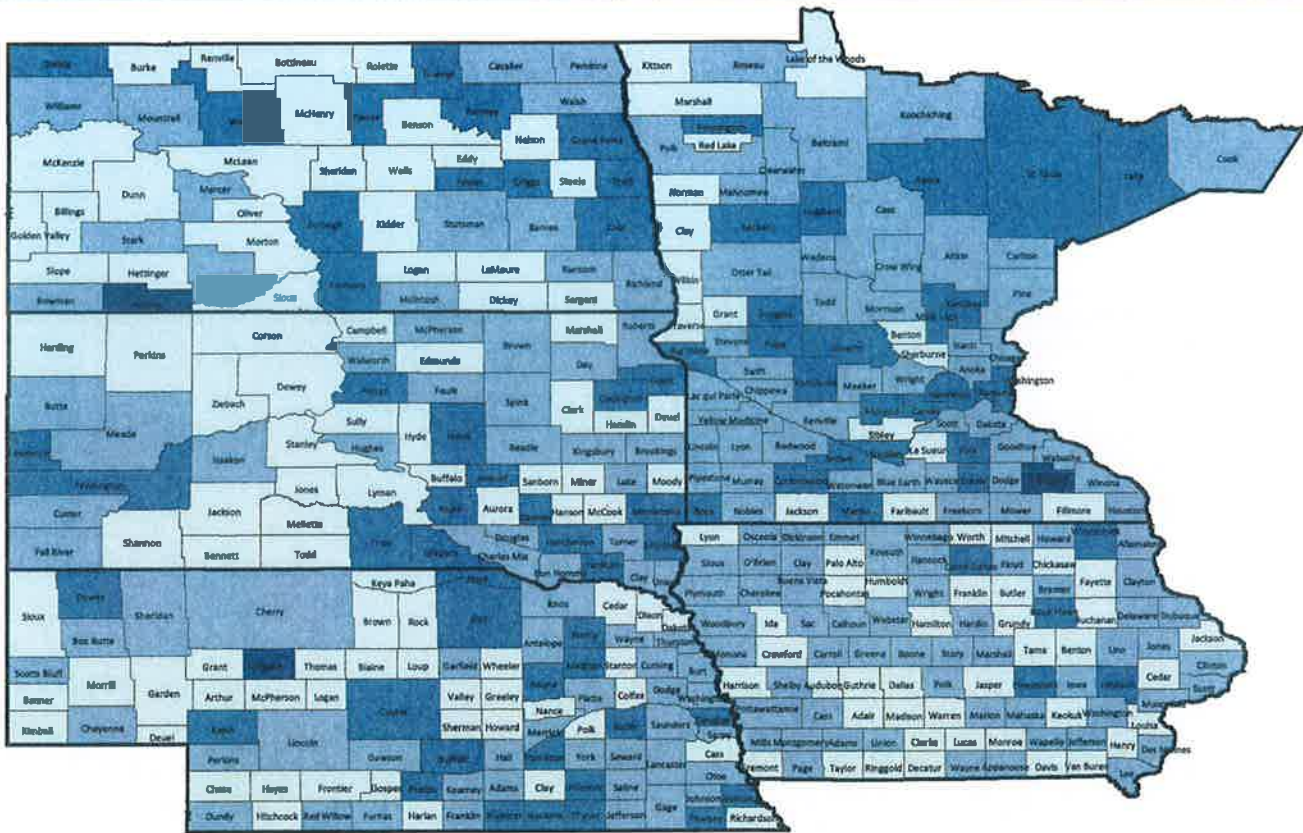
Where It Comes From: The Small Area Health Insurance Estimates from the U.S. Census Bureau provide annual estimates of the population without health insurance coverage for all U.S. states and their counties. The estimates used are for the most recent year for which reliable county-level estimates are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

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

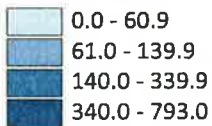
- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, <http://www.census.gov/did/www/sahie/>.

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



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



CONTEXT

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

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

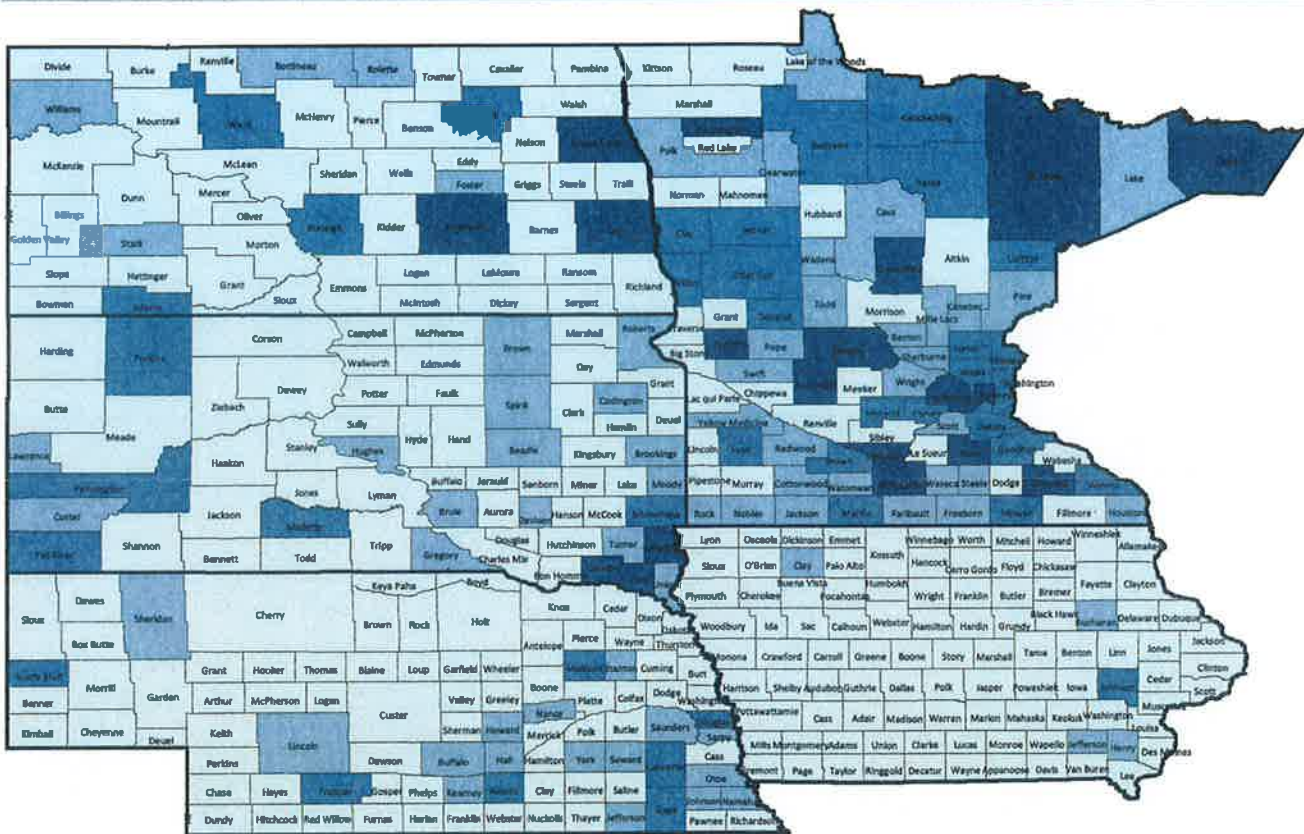
Importance: Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential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

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

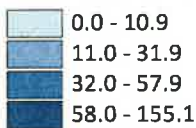
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Mental Health Providers - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

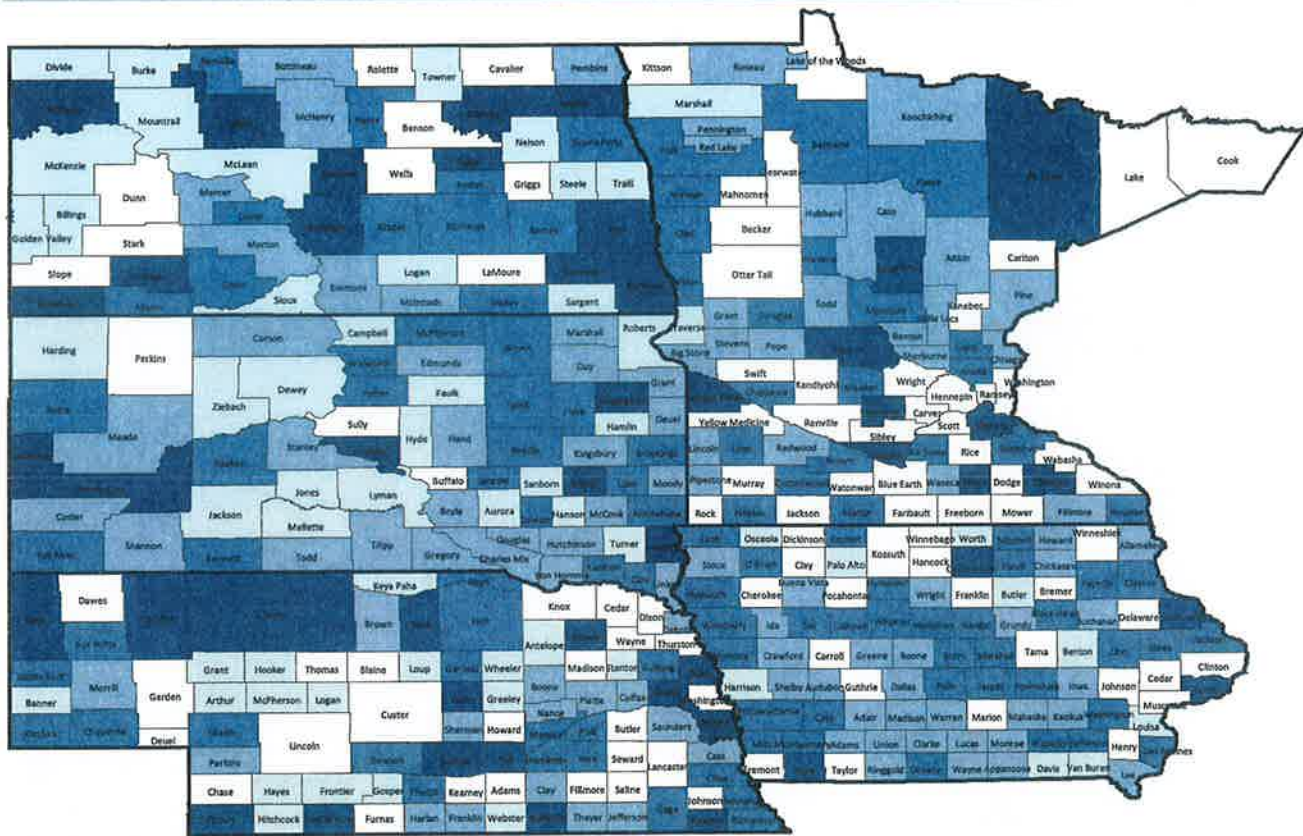
Importance: Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on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

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

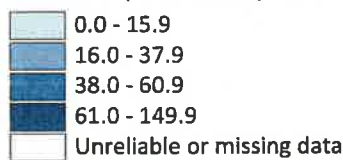
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Dentist Rate - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

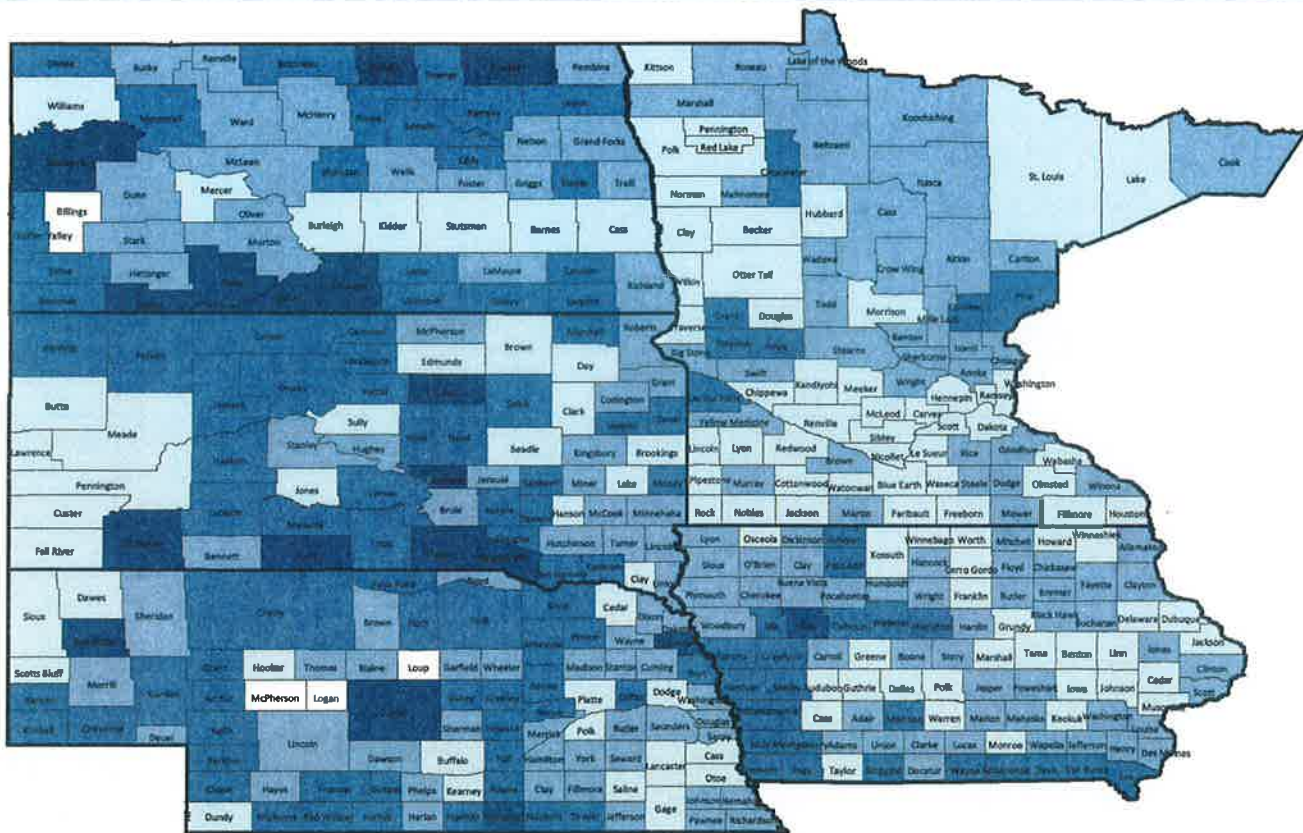
Importance: Today, thanks to fluoride, healthier lifestyles and quality dental care, more people than ever before are keeping their natural teeth throughout their lifetime. Yet for those who live in areas where a dentist is not available or those who cannot afford treatment, getting dental care can be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

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

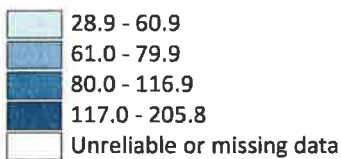
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Preventable Hospital Stays - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

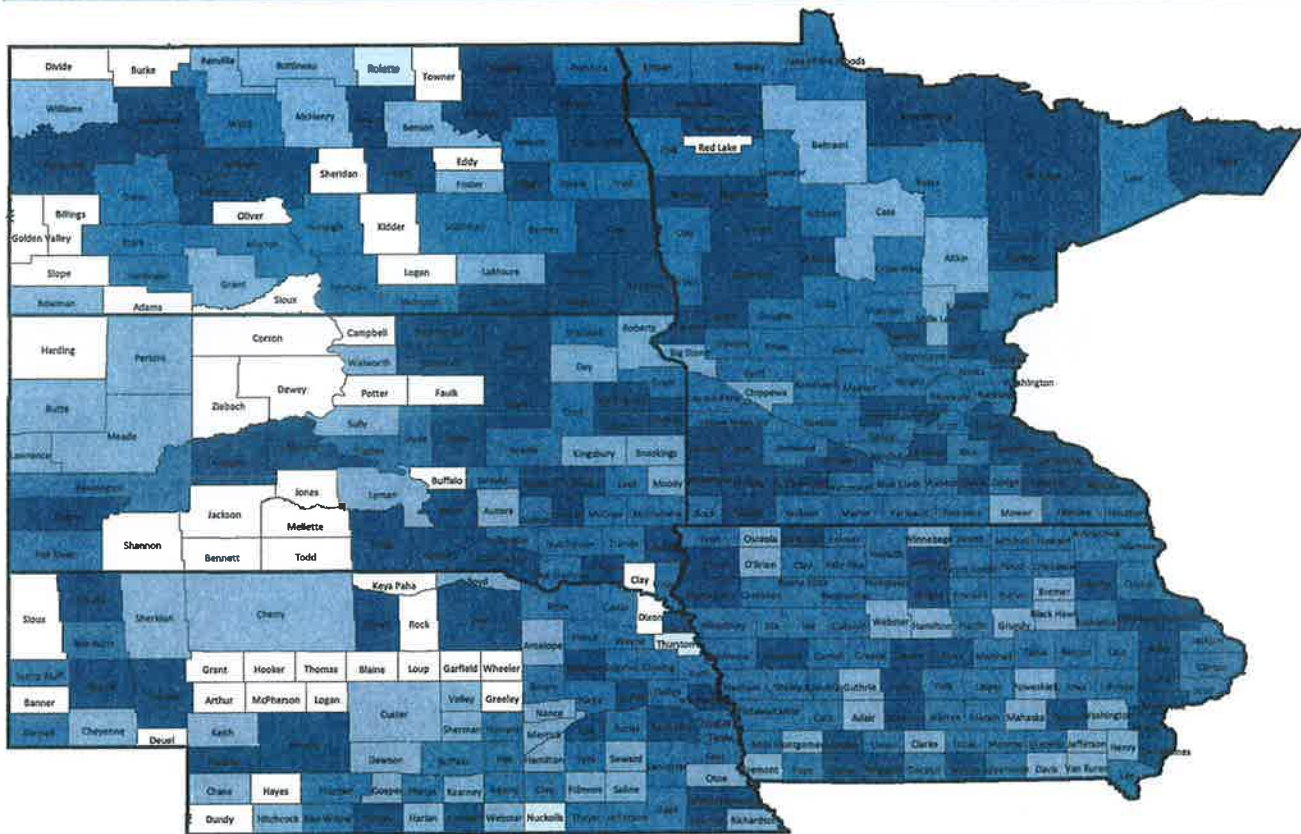
Importance: Hospitalization for diagnoses amenable to outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent the population’s tendency to overuse the hospital as a main source of care.

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

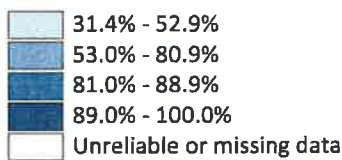
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Diabetic Screening - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

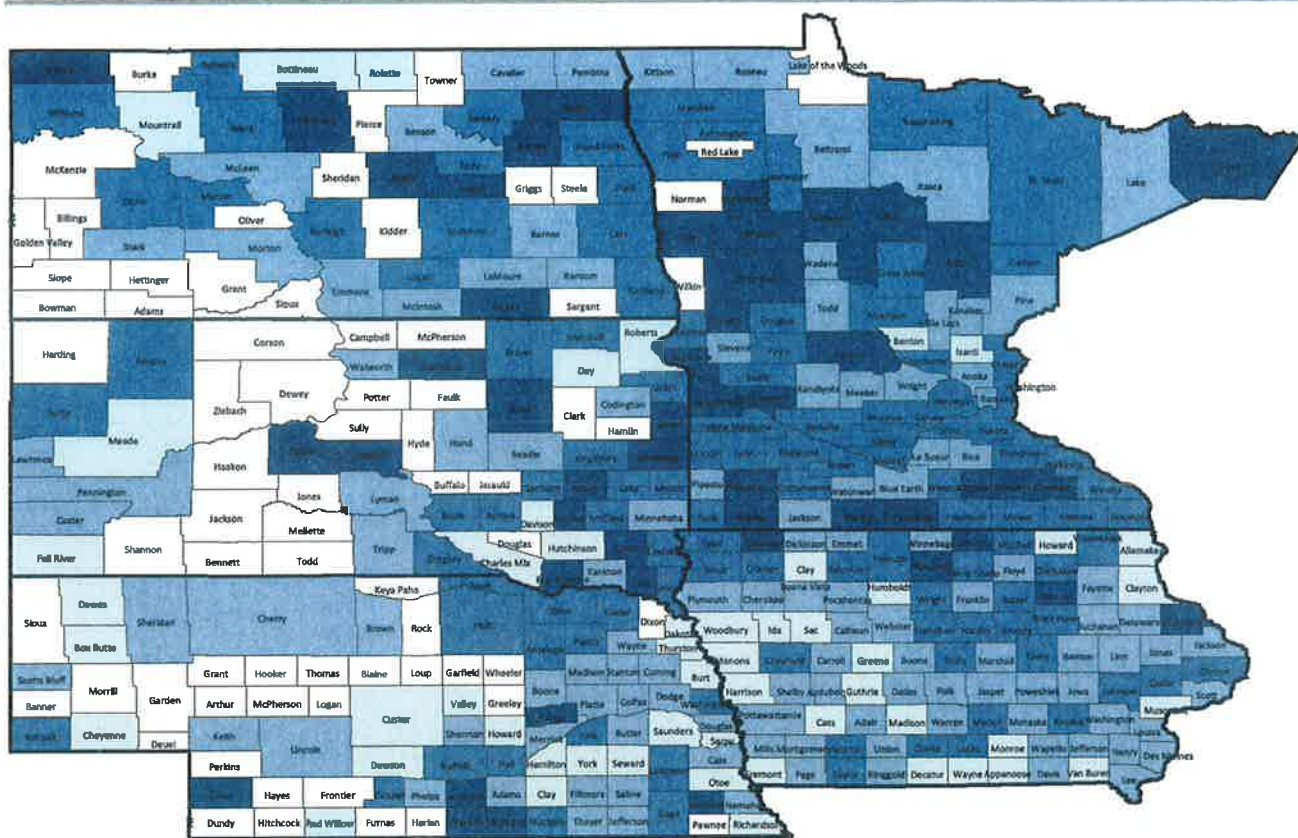
Importance: Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed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

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

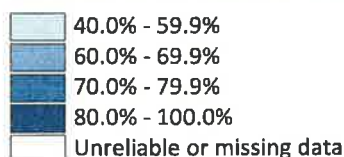
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Mammography Screening - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

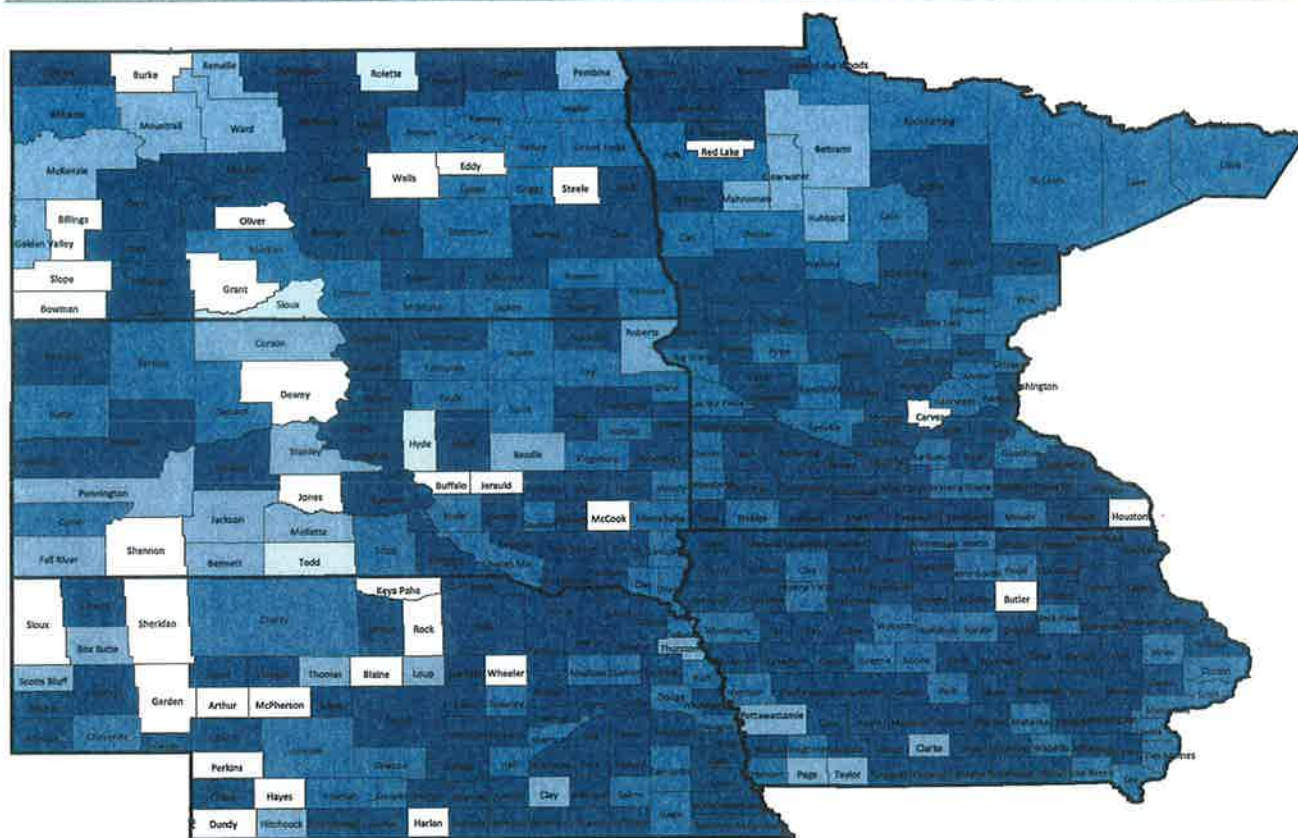
Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician’s recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40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

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

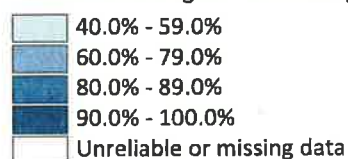
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High School Graduation - A health factor measure focusing on education

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



CONTEXT

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

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

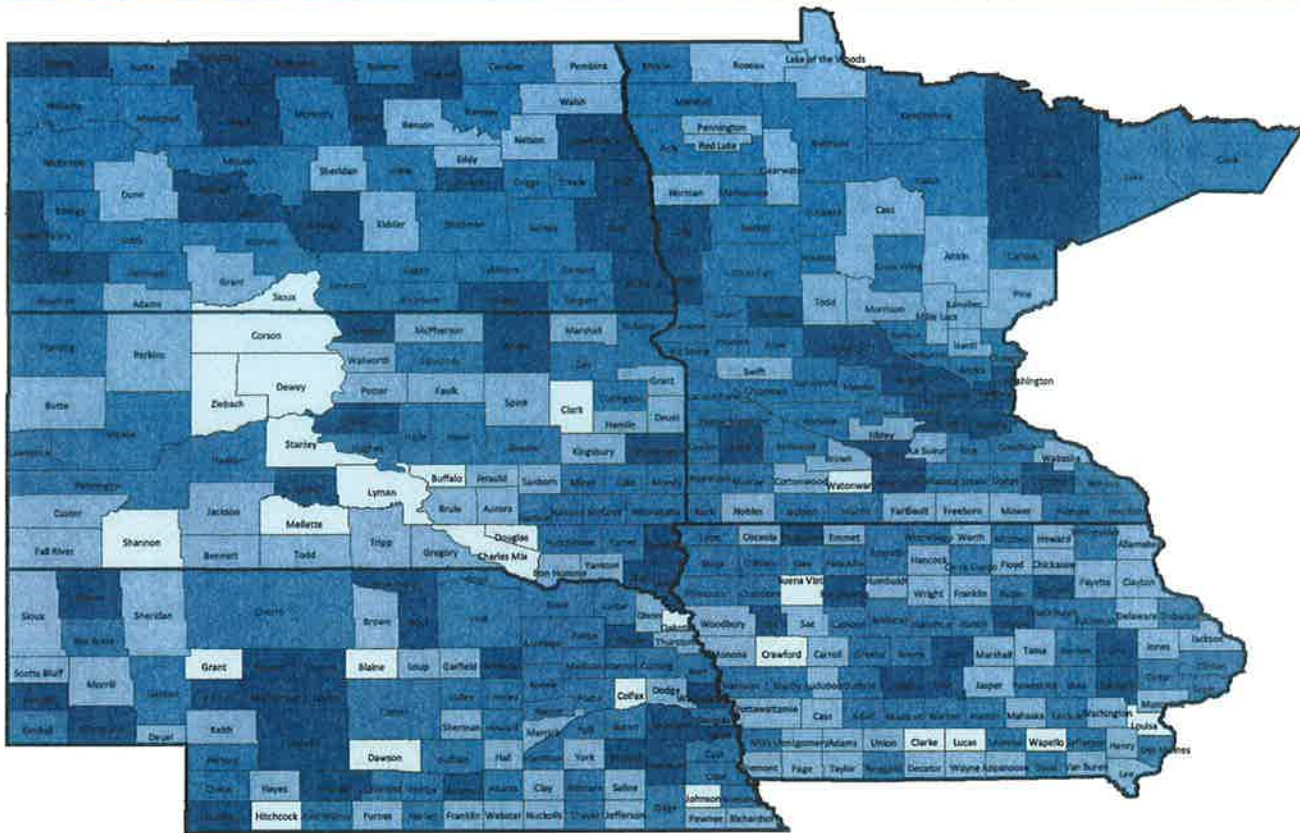
Importance: The relationship between more education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

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

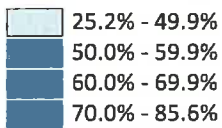
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Some College - A health factor measure focusing on education

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



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



CONTEXT

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

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

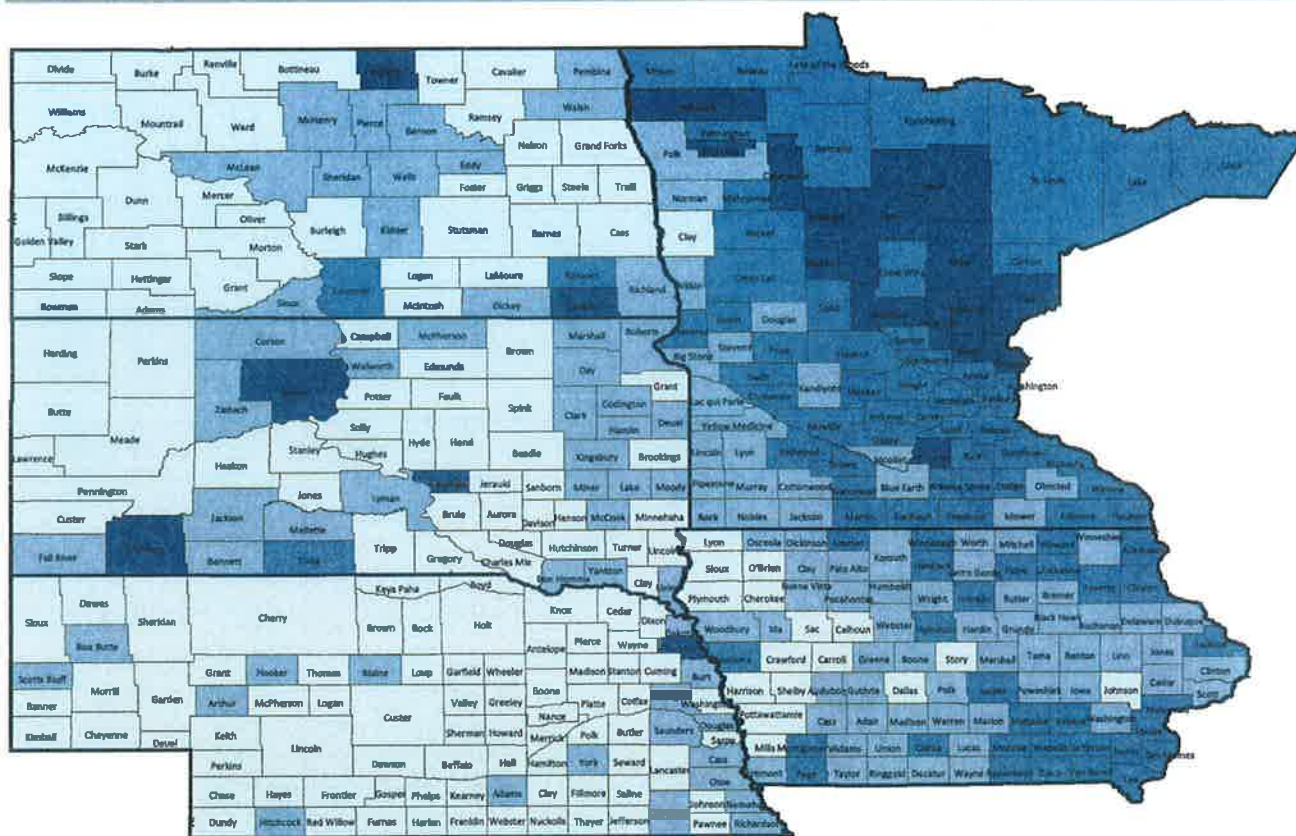
Importance: The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

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

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Unemployment - A health factor measure focusing on labor

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



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



CONTEXT

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

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

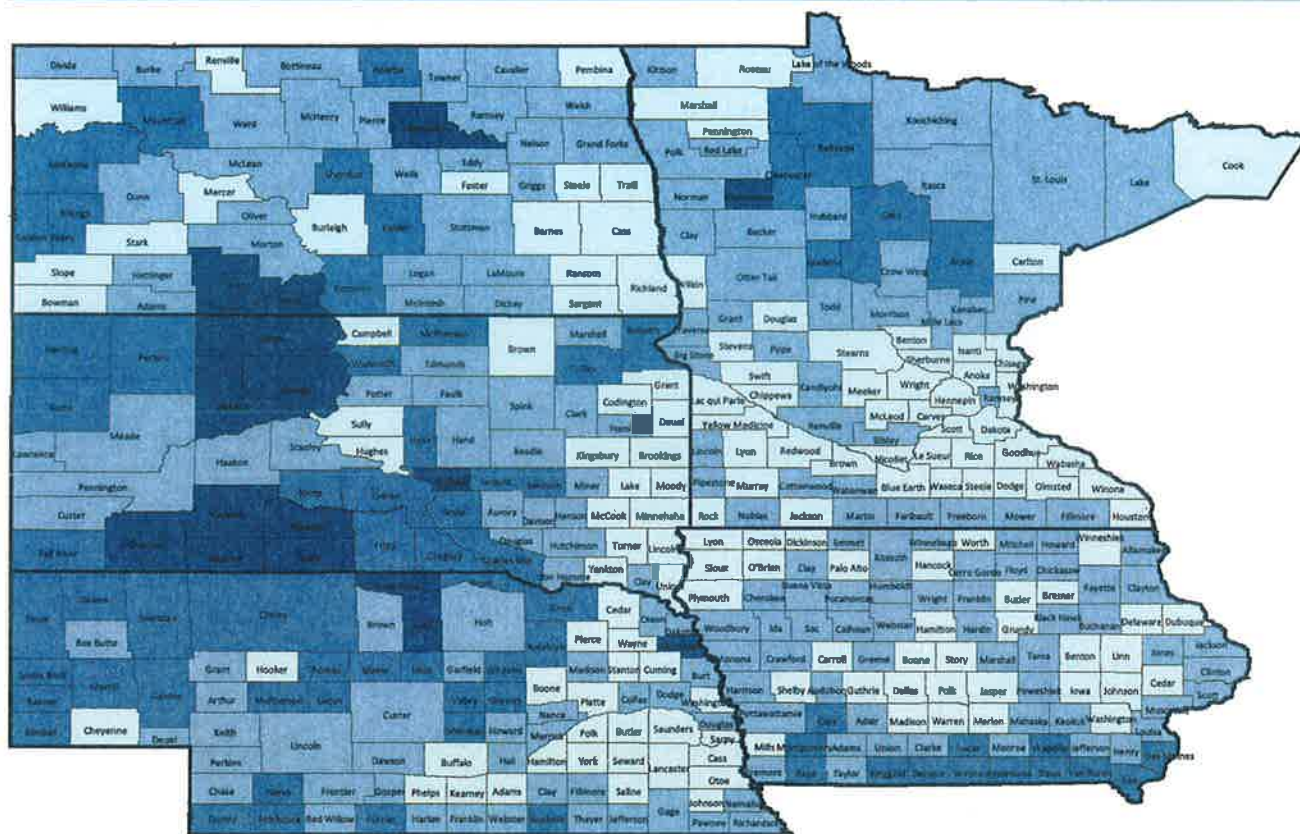
Importance: Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors,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

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

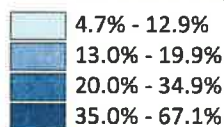
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Children in Poverty - A health factor measure focusing on income and poverty

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



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



CONTEXT

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

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

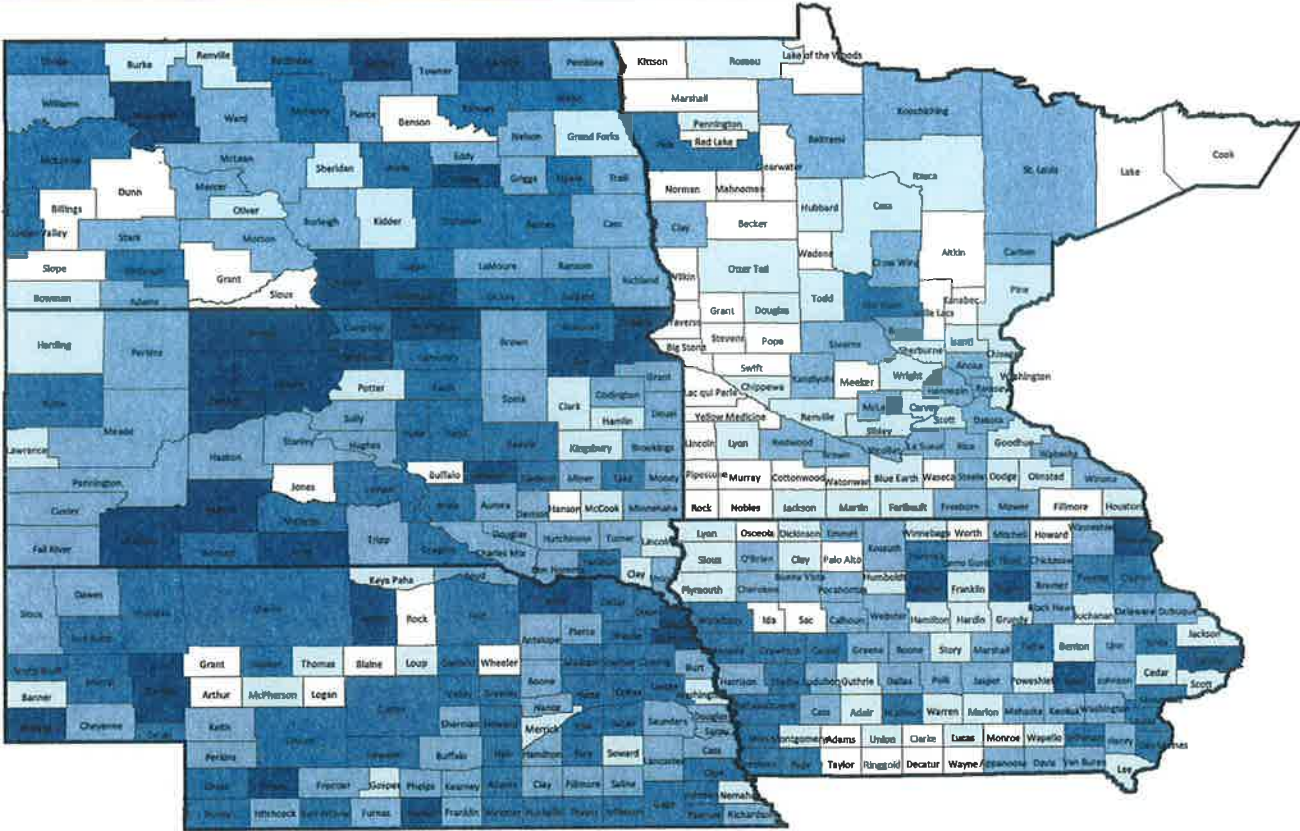
Importance: Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. While negative health effects resulting from poverty are present at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

- 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/>.

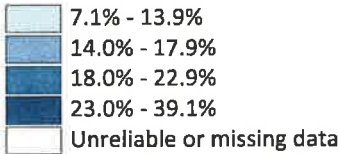
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Inadequate Social Support - A health factor measure focusing on social networks

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



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



CONTEXT

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

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

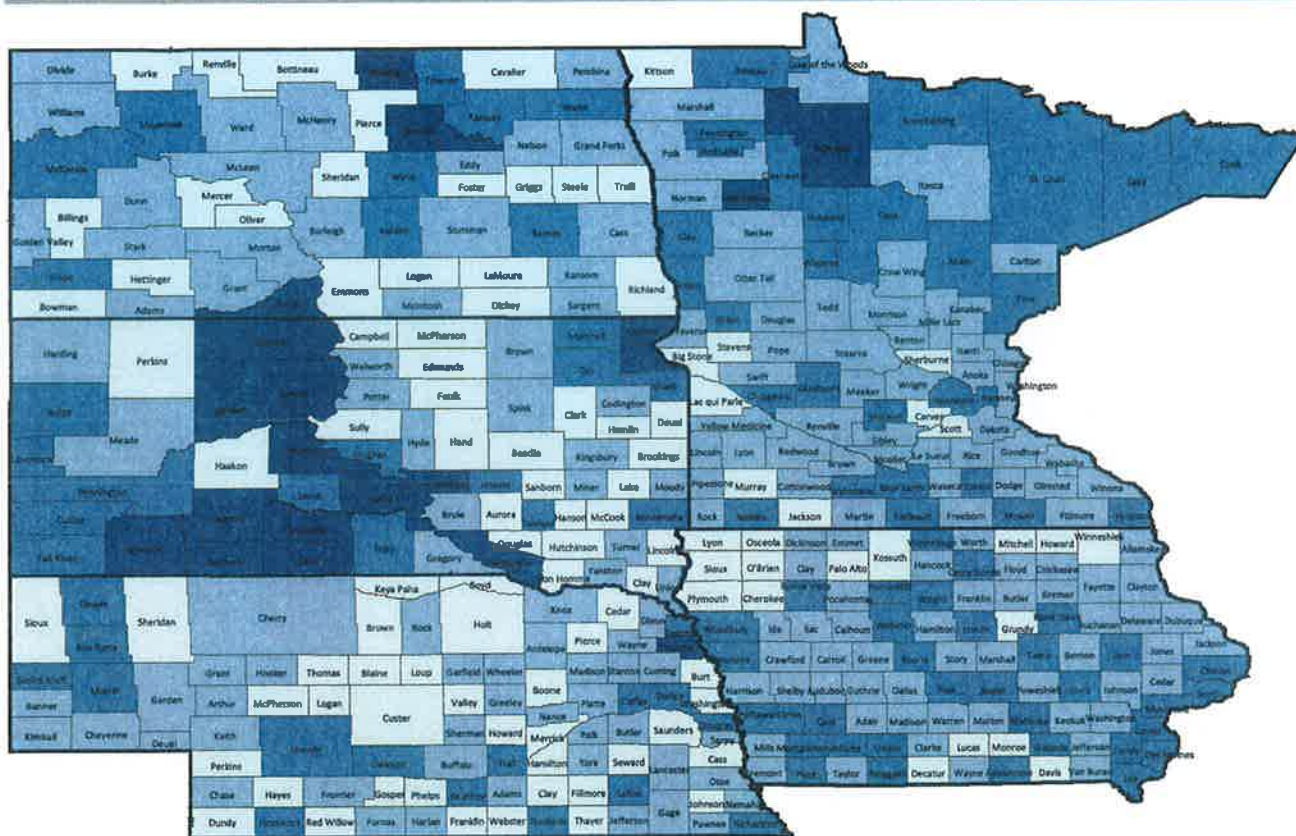
Importance: Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore, social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without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

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

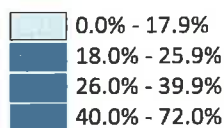
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Children in Single-Parent Households - A health factor measure focusing on families

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



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



CONTEXT

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

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

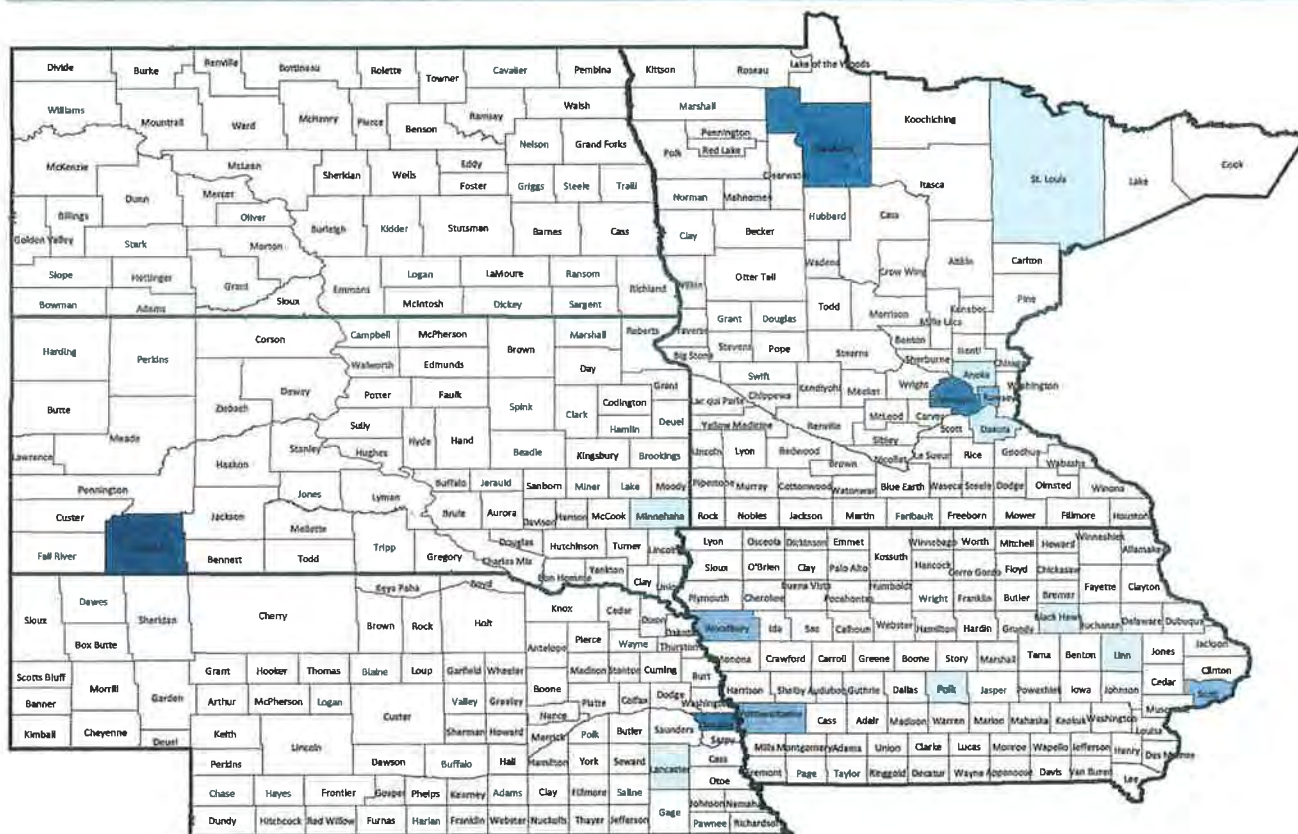
Importance: Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

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

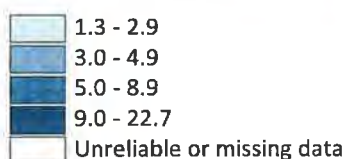
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Homicide Rate - A health factor measure focusing on violent crime

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



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



CONTEXT

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

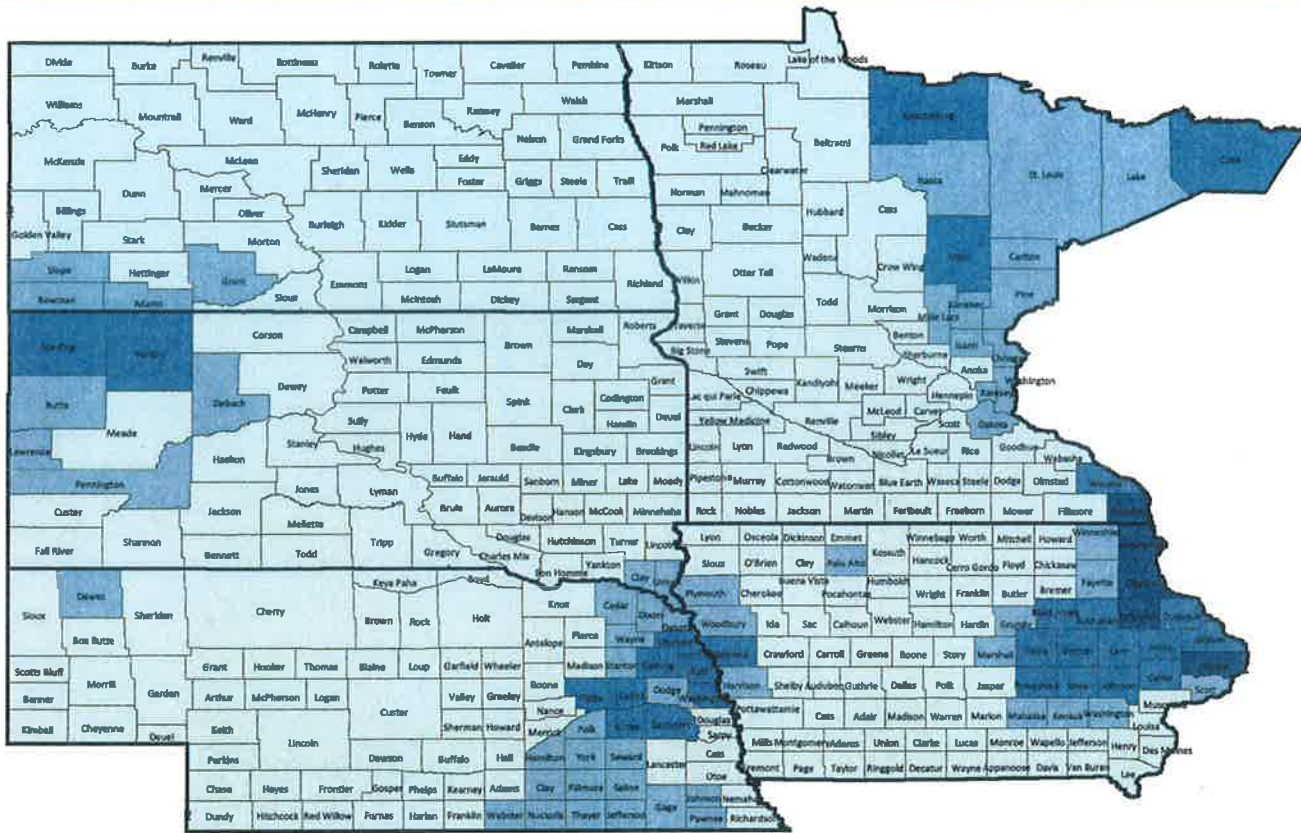
Where It Comes From: These data were calculated by National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC) using data from the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates of cause-specific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

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

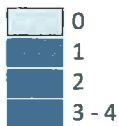
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Air Pollution-Particulate Matter Days - A health factor measure focusing on physical environment
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



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



CONTEXT

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

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

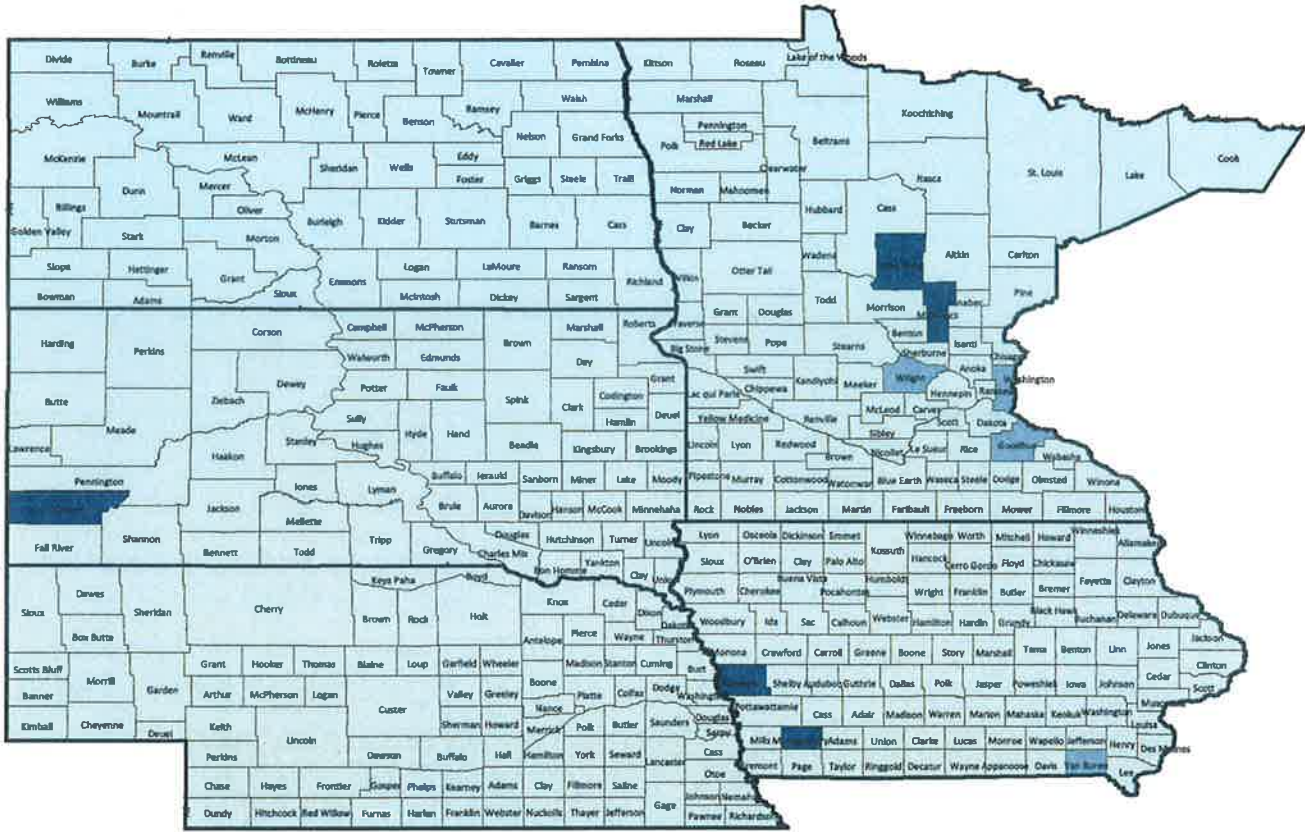
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

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

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

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



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



CONTEXT

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

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

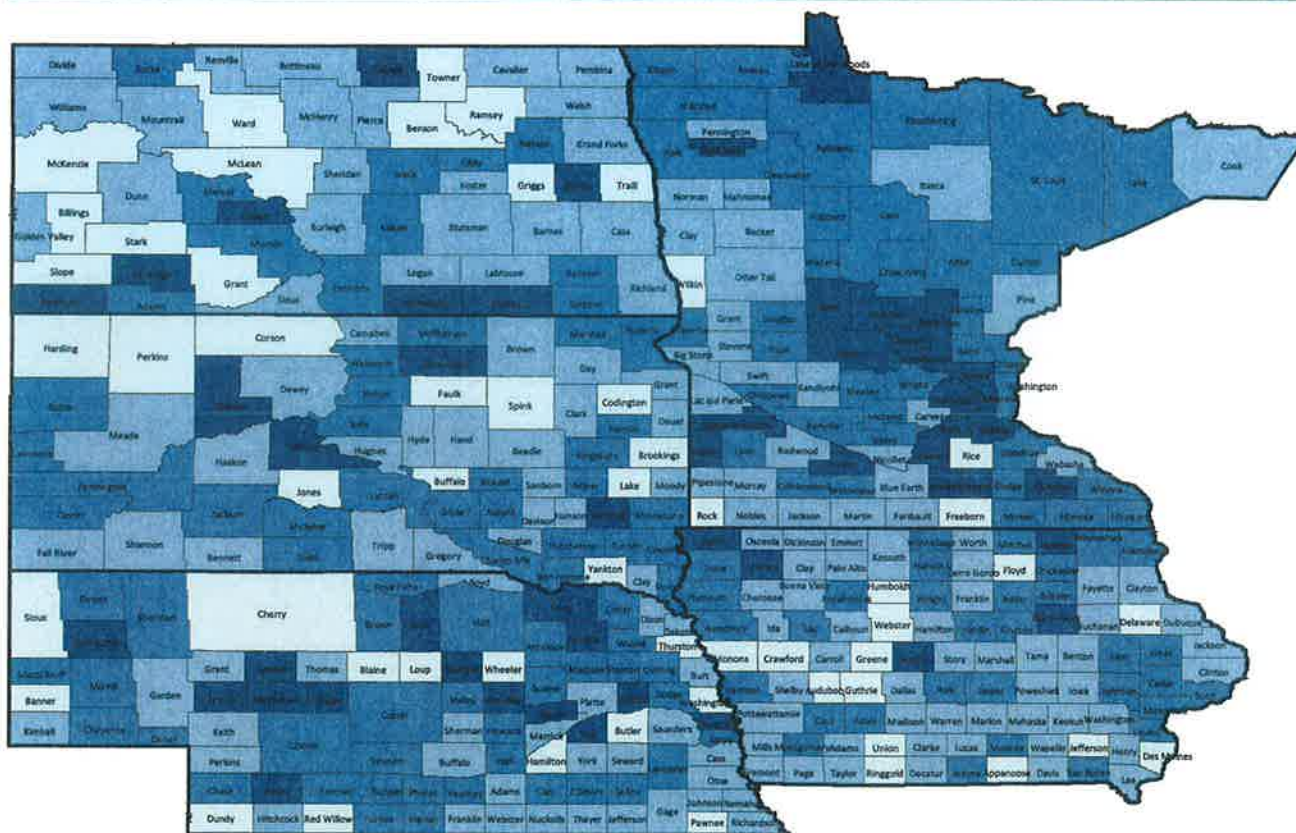
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

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

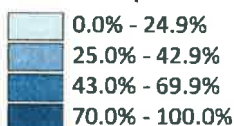
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Access to Healthy Foods - A health factor measure focusing on physical environment

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



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



CONTEXT

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

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

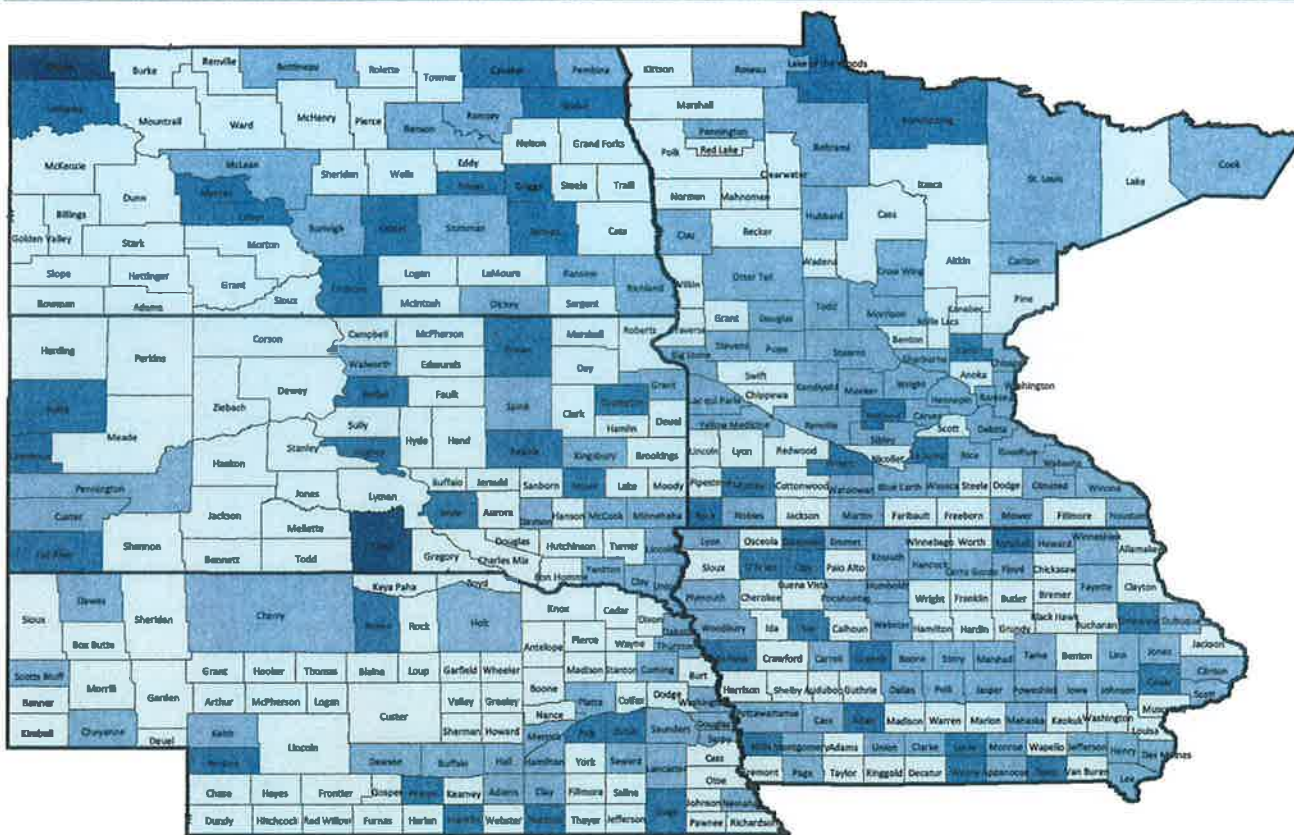
Importance: Studies have linked the food environment to consumption of healthy food and overall health outcomes.

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

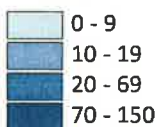
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Access to Recreational Facilities - A health factor measure focusing on physical environment

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



Number of recreational facilities per 100,000 population, 2008



CONTEXT

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

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

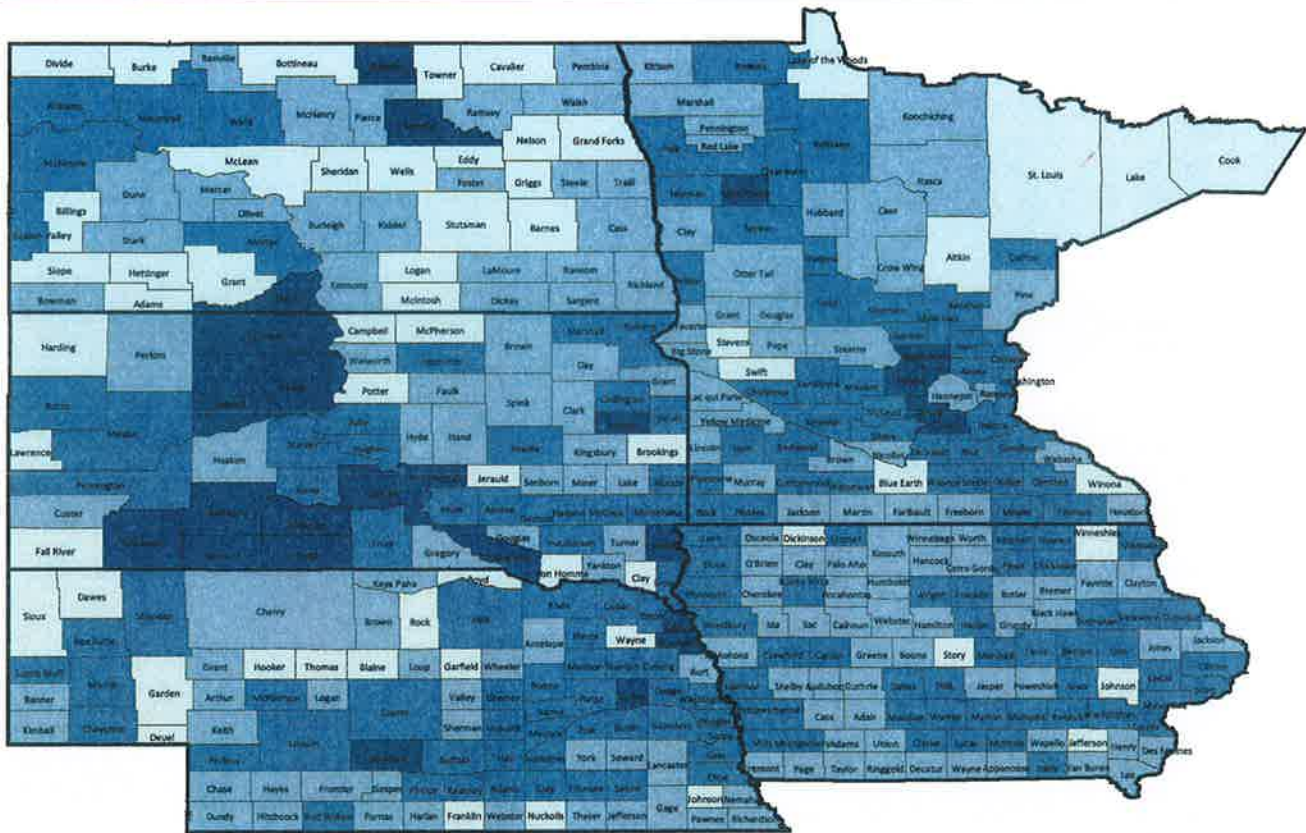
Importance: The availability of recreational facilities can influence individuals’ and communities’ choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health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

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

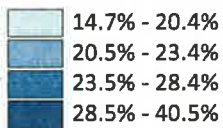
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are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

Youth - A demographic measure

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



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



CONTEXT

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

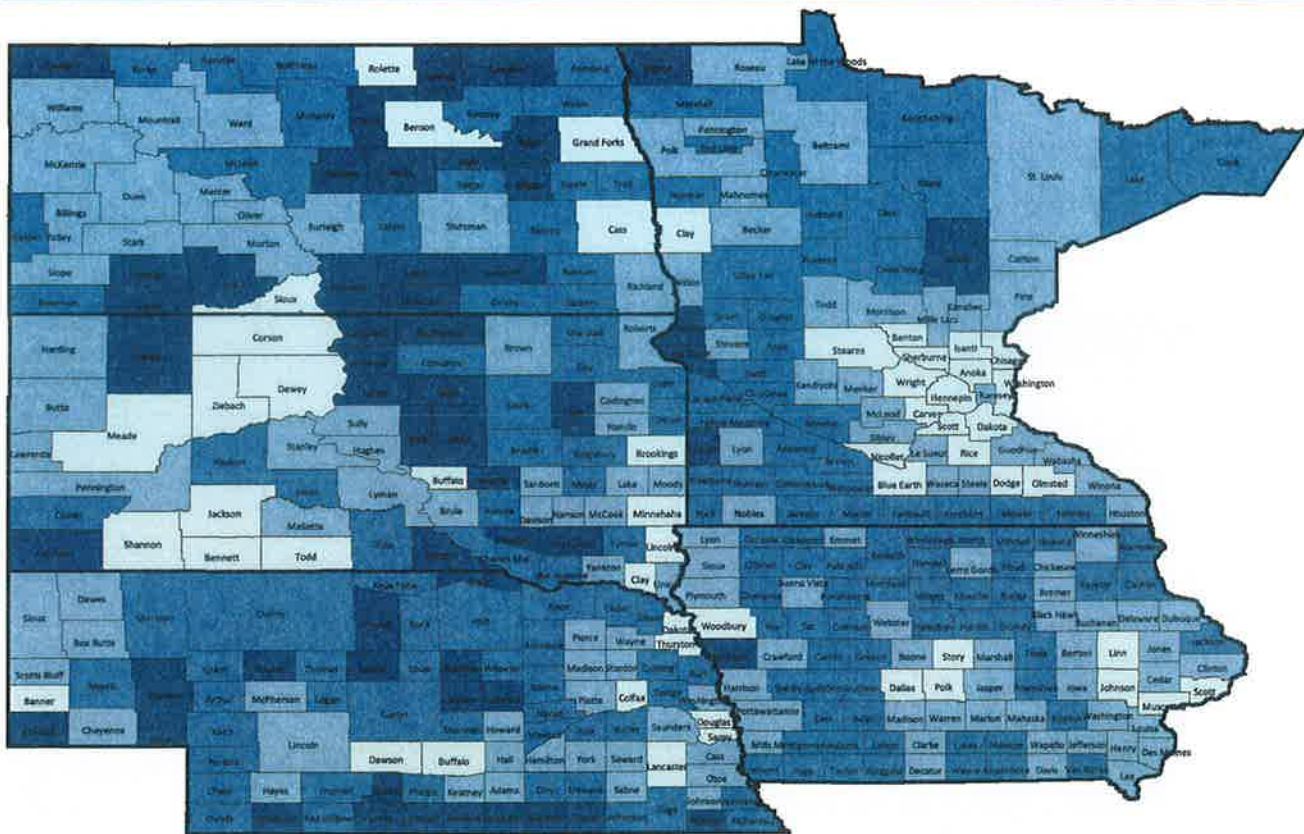
Where It Comes From: County demographic figures come from the U.S. Census Bureau’s annual population estimates.

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

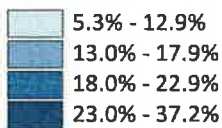
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Elderly - A demographic measure

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



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



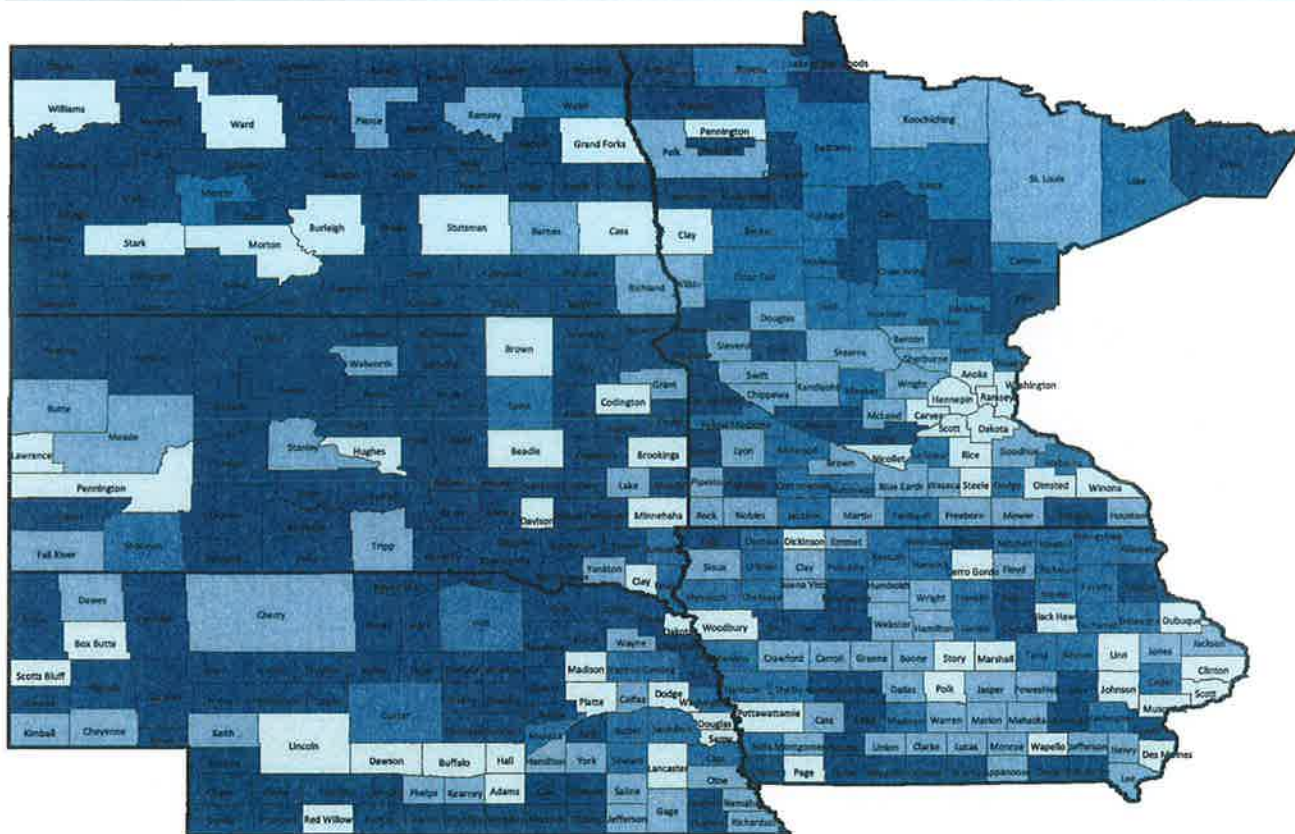
CONTEXT

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

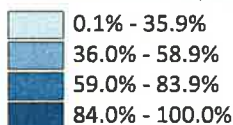
Where It Comes From: County demographic figures come from the U.S. Census Bureau's annual population estimates.

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

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Percent of total population living in a rural area, 2000



CONTEXT

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

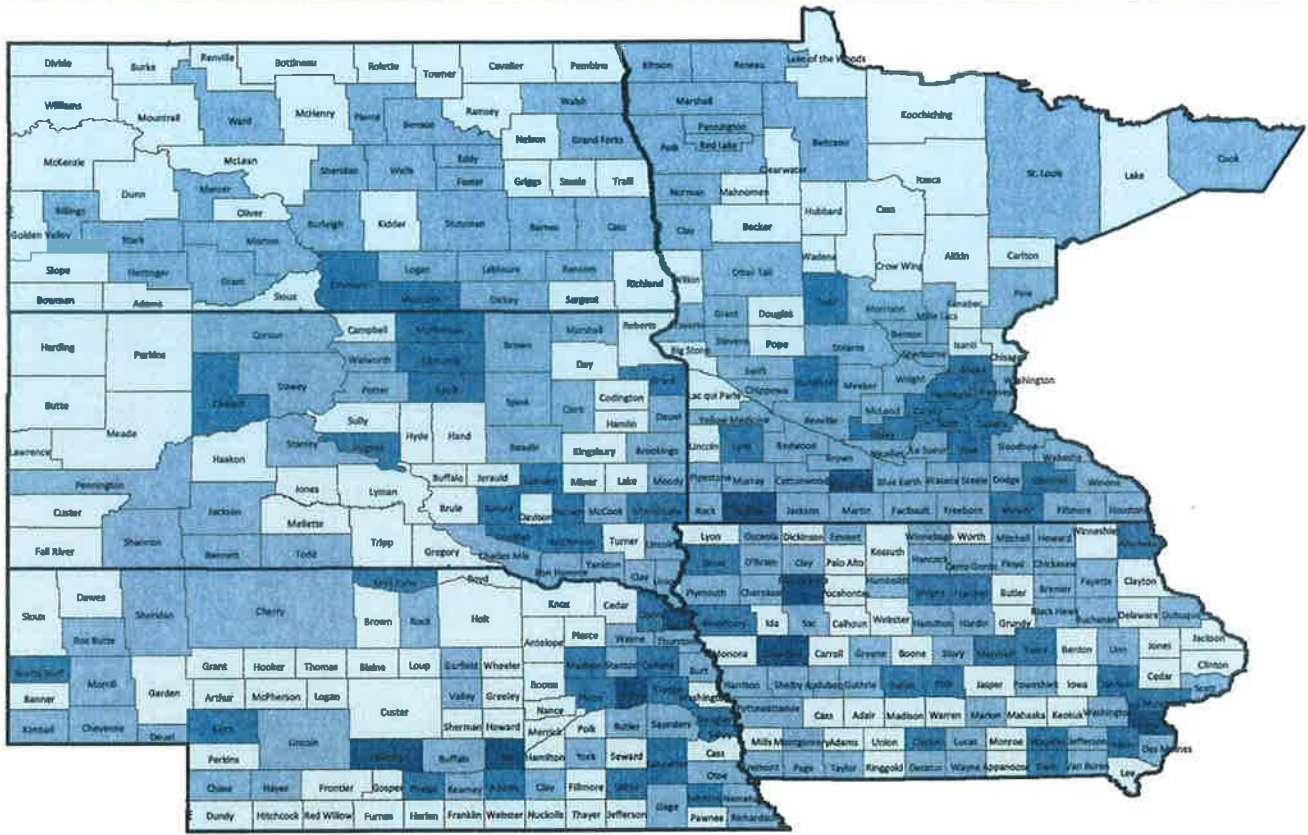
Where It Comes From: This measure is calculated by the U.S. Census Bureau using data from 2000.

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

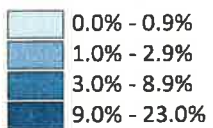
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Not English Proficient - A demographic measure

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



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



CONTEXT

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

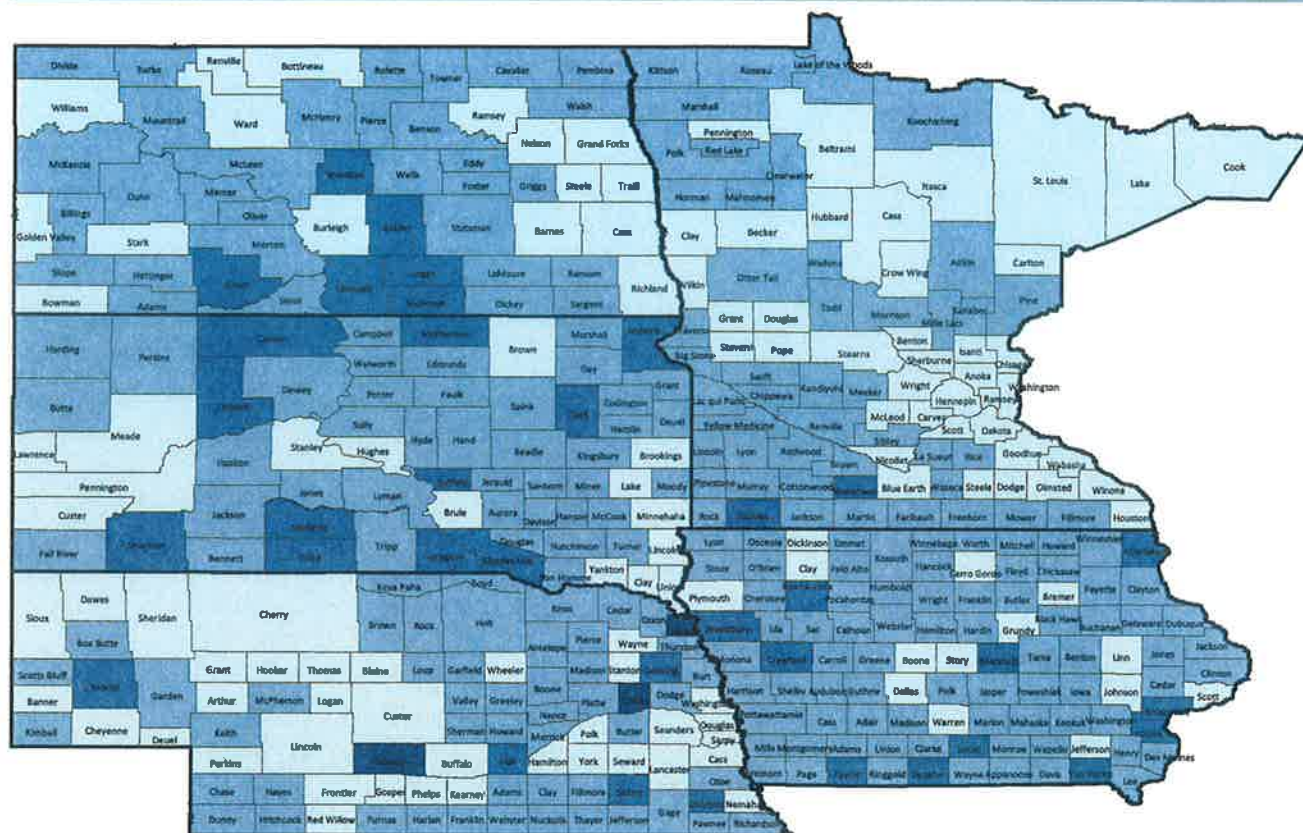
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

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

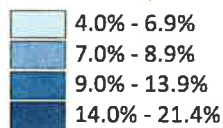
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are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

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



CONTEXT

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

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

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

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Table 1
Community Health Needs Assessment Asset Mapping
Worthington Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
<p>Access</p>	<ul style="list-style-type: none"> • Access to more specialists: Female GP, Internal Medicine, dermatologist, nephrologist. Lack of specialty healthcare in Worthington requires patients to go to Sioux Falls. • Specialists who pick & choose which patients they will see – disregarding primary care providers' concerns 	<ul style="list-style-type: none"> • Current Sanford Medical Staff recruitment plan includes additional FP's and Medical Oncologist. • Increased number of specialty Sanford outreaches to Worthington including, Cardiology, ENT, Pulmonology, Nephrology, Neurology, Physical Medicine, Allergy, Ophthalmology and Pediatric Cardiology have been established or enhanced this last year. • Avera Health has similar list of specialists visiting Worthington as well. • TeleHealth Strategy of Sanford currently being set-up to offer additional access to specialist in hospital and clinic. 	
<p>Addictions</p>	<ul style="list-style-type: none"> • Concern with drug, alcohol, smoking addictions 	<ul style="list-style-type: none"> • Both Narcotics Anonymous and Alcoholic Anonymous available in Worthington. • SWMC has smoking cessation program to offer businesses or individuals. • DARE program active in Worthington Middle School. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Cancer	<ul style="list-style-type: none"> Administration of cancer treatments in our community (chemo) 	<ul style="list-style-type: none"> Sanford Cancer Biology Research Center Sanford Worthington Cancer Center (Radiation Center) Sanford Worthington Medical Center Infusion Center (OPTIC) – chemo administration. SWMC recruitment plan has a Medical Oncologist in this fiscal year. 800 telephone number available to community for American Cancer Society. Sanford TeleHealth strategy includes cancer and cancer treatment. Sanford Clinic participates in SAGE – a program to offer mammography services to women without ability to pay. 	
Child Care	<ul style="list-style-type: none"> Need more quality, licensed day care facilities Need safe & affordable day care facilities Need facilities that take infants 	<ul style="list-style-type: none"> Will share the results with the City of Worthington, Southwest Minnesota Opportunity Council Child Resource and Referral program and Nobles County Community Services. 	
Chronic Disease City Services County Services City Govt.	<ul style="list-style-type: none"> No local provider for those with epilepsy City leaders don't listen to public input – don't spend public money wisely – no thought given to our current economy when making financial decisions Concern about high level of taxes (same size house in Twin Cities has lower property tax) Concern about the City building a new liquor store in a different location – not a wise use of community resources Snow plows need to be out earlier in the morning Public Library needs a larger facility 	<ul style="list-style-type: none"> Sanford Medical Home Refer results of survey to City of Worthington and Nobles County. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> Lack of or inadequate communication between groups regarding projects. It takes us too long to get a new project accomplished. Better use of money to support the population's needs Concern that State Legislature may discontinue the funding for the Integration Collaborative Concerned about changes in Public Health (services have decreased) 		
Competition	<ul style="list-style-type: none"> Concern over the two healthcare systems competing with one another. Perception that Sanford & Avera are not working well together to provide the best care for all residents. Inability of Sanford to work with Avera in creating cost-effective services & eliminating duplication of services Difficulty in getting records transferred from Sanford to Avera & vice versa – need a better working relationship 	<ul style="list-style-type: none"> Joint ventures between Sanford and Avera exist for CT scan and MRI. Sanford and Avera provide a school nurse to Worthington District 518 school district. Blood that is used at SWMC comes from the joint Sanford and Avera blood bank. Sanford Medical Home initiative will help in the communication between Sanford and Avera regarding records. 	
Dental Care	<ul style="list-style-type: none"> No dental care available for Medicaid, Blue Plus, UCare patients Need dentists willing to see children on Medical Assistance Dental care should be part of the healthcare insurance plan Orthodontist – FT (not just 1 day per week) 	<ul style="list-style-type: none"> Mankato offers free dental clinic. UCare does provide periodically a bus in the Worthington area for dental care. 	
Diabetes	<ul style="list-style-type: none"> Youth obesity leading to diabetes Diabetes in the Hispanic population 	<ul style="list-style-type: none"> The Sanford Project – to cure Type 1 Diabetes in Denny Sanford's lifetime. Sanford Medical Home. Sanford WebMD Fit Kids. YMCA Healthy Kids initiative. Prairie Kids Health Club – (4th and 5th graders). 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
<p>Economic Situation/Business community</p>	<ul style="list-style-type: none"> • Need more full-time jobs • Most local businesses cannot provide much chance of advancement because they are too small • Concern about the level of median income needed to attract new stores & businesses • Concern about lack of professional jobs • Locally-owned businesses will dwindle in the future as owners retire – the ability to sell the business is a concern • Need companies that will employ people who want to live in our town & the surrounding area. We have missed out on good companies that have gone elsewhere. • City government/Economic Development does nothing to promote new businesses – our location should have attracted higher-end industry • Need a grocery store located near the downtown area • Need Sterling Drug to be open on Sundays & late Saturday evenings • Wish the Country Club’s golf course could be preserved • Why build a new YWCA when the community has an inadequate outdoor pool? • Lack of higher-end amenities to attract/retain young adults & professionals 	<ul style="list-style-type: none"> • Will share with the following entities: • City of Worthington • Worthington Chamber of Commerce • Worthington Economic Regional Development Corporation • Specific Business listed 	
<p>Education</p>	<ul style="list-style-type: none"> • Concern over lower educational levels leading to lack of qualified employees • Concern about ESL classes • Concern about new school buildings • Kindergarten readiness – need to reach out to minorities & educate re importance of preschool 	<ul style="list-style-type: none"> • Will share results with Worthington District 518 and Minnesota West Technical College administrations. • District 518 has extensive ESL (limited English speaking) classes at all levels. • HeadStart program available in Wgtn. • Early Childhood Family Education (ECFE) program available in Worthington. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> • Too much money going to non-English speaking youth; not much left for our gifted youth • Need parent support groups • Need education for adolescents about drugs • Expand partnerships with 4-year colleges so that students could go to MN West & then continue taking classes in Worthington, towards earning a degree from another institution • Prairie Elementary could use a clinic or nurses room at the school 		
Elderly	<ul style="list-style-type: none"> • Need lower cost housing & services for the elderly • Retirement & cost of living for seniors • Should be more concern for wellness of senior citizens – their healthcare needs are just as important as those of younger people • Not enough community activities for the elderly population 	<ul style="list-style-type: none"> • Atrium Apartments (Low income for seniors). • Golden Horizons (Assisted Living). • Ecumen (Assisted Living). • Living Life Adult Day Care. • SWMC Wellness Partners (free senior health care). • New Senior Center currently being built in Worthington. • Mobile Meals available through SWMC. • Senior Linkage line – 800 number for one stop senior shopping. • YMCA – many senior health programs. • Several other private health clubs in Worthington. 	
Emergency Care	<ul style="list-style-type: none"> • Concern about those who use the EC as their primary care 	<ul style="list-style-type: none"> • Sanford Medical Home. • Sanford Acute Care and Avera Urgent Care (after hour and weekend clinics). • Ask a Nurse program available through SWMC ED. • Poison control hotline available. • Crisis hotline available. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Healthcare Cost/Insurance Cost	<ul style="list-style-type: none"> • Need affordable healthcare – cost is prohibitive • Cost of taking care of basic problems – ear infections, colds • Need insurance to cover preventive care (not exclude parts of the body from coverage, such as dental) • Insurance plans/employers should have a gym membership benefit in their plan 	<ul style="list-style-type: none"> • Sanford Health Care Grant available to those that qualify. • Sanford and Avera after hour and weekend clinics available. • Sanford financial counselors available. • Minnesota Medical Assistance program. • State funded vaccination program. • Worthington Health Care Foundation funding for flu shots in the Worthington schools. 	
Health Factors	<ul style="list-style-type: none"> • Binge drinking • Sexually transmitted infections • Low rate of mammograms • Only 40% report having access to healthy foods 	<ul style="list-style-type: none"> • Sanford nurse participates in the Sexually Healthy Youth coalition in Worthington. • DARE program in Worthington Middle School. • Numerous health classes offered by Worthington District 518 school district. • Pediatric physicals include conversations on health and sex related topics. • Numerous churches in Worthington have active youth groups. • Helping Hands Pregnancy Center in Worthington. • Sanford Clinic participates in the SAGE – a program to offer mammography services to women without ability to pay. • Two food pantries located in Worthington. • Senior dining available in Worthington. • Mobile Meals available in Worthington. • District 518 school district offers reduced lunches and breakfast. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Home Care	<ul style="list-style-type: none"> • Availability & cost of home care 	<p>Alignment with Sanford resources or other community resource partners</p> <ul style="list-style-type: none"> • SWMC has a home care and homemaker services available. • Sanford Health Care grant available for Home Care Services for those that qualify. • 6 other Home Care agencies in the Worthington area. • Nobles County Long Term Care consultation and elderly variance available. • Lutheran Social Service available in Worthington. 	
Housing	<ul style="list-style-type: none"> • Need adequate and safe housing – lack of housing is a serious problem in the community • Need quality apartments for young couples & new residents 	<ul style="list-style-type: none"> • Will share with City of Worthington and Worthington Housing Authority. 	
Healthy Nutrition	<ul style="list-style-type: none"> • Need a grocery store located near the downtown area • Good eating habits need to start in the school environment (healthier choices, not so much prepackaged food) • Need nutrition education for the whole community to combat obesity 	<ul style="list-style-type: none"> • Nobles County Extension offers programs and education on healthy nutrition. • Dietitians employed by Sanford, Avera and Hy-Vee in Worthington providing individual and community education on healthy nutrition. • Nobles County WIC program. • District 518 reduced breakfast/lunches available. • SWMC has local support group for patients who have had bariatric surgery. 	
Judicial / Police	<ul style="list-style-type: none"> • Poor corrections department (they do very little) • Let the police do their job – enforce the rules & laws • Courts need to be tougher (too many “slaps on the wrist”) 	<ul style="list-style-type: none"> • Will share results with City of Worthington, City of Worthington Police, Nobles County Sheriff and Nobles County Public Attorney. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Mental Health	<ul style="list-style-type: none"> • Need early childhood mental health professionals • Need more counseling services (especially faith-based counseling) • Lack of mental health services, including emergency mental health care • Need high quality psychiatric counseling • Those with mental health issues who are “on the street” • Lost our mental health unit in the hospital to Marshall (this is not OK) • Need behavioral health services for those under 18 	<ul style="list-style-type: none"> • Sanford One Care. • Sanford Medical Home allows for recruitment of one clinical psychologist and one clinical social worker this fiscal year. • Sanford TeleHealth strategy includes making mental health professionals available in Worthington. • Avera has one employed psychologist and one employed behavioral health nurse practitioner. • SouthWest Mental Health Center (SWMHC) is a county consortium of mental health providers with offices and services available in Worthington. • Crisis team available through SWMHC. • Prairie Rose Counseling Service available in Worthington (private company). 	
New Americans/ Immigrants	<ul style="list-style-type: none"> • Concerns about immigration – influx of so many different nationalities • Concerns with lack of English-speaking employees & residents - immigrants need to learn to speak English • Concern about child care tax fraud by illegal immigrants • Concern about fraud by illegal immigrants using assumed names • Concern about the financial burden on Social Services, schools & hospitals/clinics to accommodate the diverse population • Need more testing for TB • Minority kids need to be involved in sports at an early age • Post Traumatic Stress Disorder – especially in those who have been in refugee camps 	<ul style="list-style-type: none"> • Refer survey results with Nobles County Attorney, Nobles Public Health and Legal Aide. • SWMC and Sanford Clinic have professional agency for interpreters (ARCH). • Avera Clinic has employed interpreters. • Worthington has local Community Connectors program to assist new residents of basic needs in Worthington. • District 518 School District has many programs for non or limited English speaking students and parents (e.g. ESL). • Sanford Clinic physician serves as Civil Surgeon for Nobles County. • Sanford and Avera clinics have some bilingual physicians. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Nursing Homes	<ul style="list-style-type: none"> Available, cost & quality of nursing home care 	<ul style="list-style-type: none"> Local churches offer many programs and services for the different nationalities represented in Worthington. Crossroads Care Center and South Shore Care Center are located in Worthington. 17 other nursing homes located within 45 minutes of Worthington. Nobles County Long Term Care consultation and elderly variance available. Minnesota Medical Assistance available for those that qualify. 	
Obesity	<ul style="list-style-type: none"> Youth obesity leading to diabetes Need nutrition education for the whole community to combat obesity 	<ul style="list-style-type: none"> Sanford WebMD Fit Kids. Sanford Medical Home. YMCA Healthy Kids initiative. Prairie Kids Health Club – (4th and 5th graders). Diabetic education available in Sanford and Avera clinics. Dietitians available in Sanford and Avera clinics. Minnesota Extension office offers nutrition programs. District 518 health programs and classes offered. 	
Physical Activity	<ul style="list-style-type: none"> Need a decent outdoor pool Have a great lake, but no safe walking path around it Many exercise facilities but only one available for our youth who have no transportation to & from home Better biking, rollerblading, walking paths – both in town & in the country Year-round after-school activities for kids (open gym, etc.) Wellness facilities are good, but too high-priced 	<ul style="list-style-type: none"> Refer survey results to City of Worthington and Nobles County. Sanford WebMD Fit Kids. New YMCA in Worthington. Summer recreational program for kids is run by the YMCA – offers many different choices. City and Nobles county have expanded the bike trails in Worthington and Nobles County. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
<p>Physicians</p>	<ul style="list-style-type: none"> Minority kids need to be involved in sports at an early age Too much turnover/ too many locums – need docs who will stay in town Need physicians who will do the care here & not send patients to Sioux Falls for procedures that can be done locally Specialists who pick & choose which patients they will see – disregarding primary care providers' concerns Hard to understand them if they come from another country (especially for the elderly) 	<ul style="list-style-type: none"> City parks have all been re-done with new playground equipment for children. Several private fitness centers in Worthington. Sanford and Avera continue to recruit physicians to Worthington through their respective recruitment plans. Sanford Medical Home. Sanford TeleHealth Strategy for specialists is in the implementation stages. 	
<p>Pollution</p>	<ul style="list-style-type: none"> Noise pollution - from the races, from cars without mufflers, neighbors who play radios loudly, loud radios in cars Radon levels Litter Recycling Smell of the hog confinement buildings Okabena Lake needs to be cleaned up Odor from meat processing plant 	<ul style="list-style-type: none"> Will share with the City of Worthington and Nobles County Commissioners 	
<p>Poverty</p>	<ul style="list-style-type: none"> Poorer sections of town are starting to look really bad Concern about the sense of entitlement that prevails (driving an expensive car, but expect a free lunch) Concern about welfare fraud not being pursued Concern about child care tax fraud by illegal immigrants Concern about the median income needed to attract new stores & businesses Too many people on public assistance because of diverse cultures & lower economic status 	<ul style="list-style-type: none"> Sanford Health Care grant is available for those that qualify. Sanford financial counselors available to help with payments and methods of payments Will share results with Nobles County Family Services and Public Health. Love Inc. is available and is a consortium of support from local churches to help those in need in the Worthington community. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> • Need adequate winter clothing for children • Food stamps being used for junk food – should be limited to healthy food • Need for dentists willing to see children on Medical Assistance 	<ul style="list-style-type: none"> • Salvation Army support is available in Worthington. • Two local food shelves centers are located in Worthington. • Many church support groups available for those in need. 	
Prevention Services	<ul style="list-style-type: none"> • Need more preventive services 	<ul style="list-style-type: none"> • School physical requirements completed by Sanford and Avera physicians. • Sanford Medical Home. • SWMC Wellness Partners for seniors is available in Worthington (4 locations), Fulda and Lakefield. • Family planning available in Worthington. • DARE program in Middle School. • Sanford Clinic participates in SAGE – a program to offer mammography services to women without ability to pay. 	
Substance Abuse	<ul style="list-style-type: none"> • High degree of drug & alcohol use among youth & young adults • Use of public money & time to try to control behaviors (smoking) • Need education for adolescents about drugs 	<ul style="list-style-type: none"> • Sanford One Care. • Sanford Medical Home. • DARE program in Middle School. • Narcotics Anonymous and Alcoholics Anonymous available in Worthington. • SWMC smoking cessation program available for individuals and/or businesses. • Woodstock offers programs for substance abuse. 	
Traffic/ City Infrastructure	<ul style="list-style-type: none"> • Walkers, bikers & rollerbladers go on the wrong side in traffic • Signs regarding Hwy. 60 detour are confusing • High level of residents who drive without a license or insurance 	<ul style="list-style-type: none"> • Will share results with City of Worthington Police and Nobles County Sheriff departments. • 55 Alive driving program offered routinely to seniors in the Worthington area. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> • Elderly who drive too slow (15 mph) • People who don't use turn signals • Not enough resources to monitor driving habits (not obeying traffic laws, etc.) • Driving while texting • Those who cannot read the English traffic signs 		
Transportation	<ul style="list-style-type: none"> • Cost of public transportation • Affordable transportation for children who wish to participate in summer & after school activities • Affordable public transportation for low income (so they would not have to rely on a taxi) • Availability of taxi service (hours) • Local taxi is a monopoly 	<ul style="list-style-type: none"> • Will share results with City of Worthington and Nobles County Commissioners. • Heartland Express is a county run transportation program and available in Worthington. • Worthington taxi service is a private company in Worthington. • Medi-Van is a private company that offers medical transportation in the Worthington area. • People Express offers transportation in the Worthington area. • MN managed care provides reimbursement for transportation. 	
Youth	<p>Sexual activity</p> <ul style="list-style-type: none"> • Too many teenage pregnancies • Concern about STDs • Sexual activity among teens • Sex education should be taught at a very young age <p>Addictions</p> <ul style="list-style-type: none"> • High degree of drug & alcohol use among youth & young adults • Need education for adolescents about drugs <p>Physical Activity/Obesity</p> <ul style="list-style-type: none"> • How to engage kids in non-computer game activities 	<ul style="list-style-type: none"> • Sanford One Care. • Sanford WebMD Fit Kids. • School physical for children involve conversation with their Sanford or Avera pediatricians on many of these subjects. • Sanford nurse on Sexually Health Youth coalition in Worthington. • Sanford's Family First (a program for new or high risk moms) available in Worthington. • DARE program in Middle School. • Local churches have many active youth programs. 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> • Minority kids need to be involved in sports at an early age • Youth obesity, inactivity - leads to diabetes <p>Other issues</p> <ul style="list-style-type: none"> • Concern about bullying • Concern about girls not valuing themselves & their abilities • Teens who do not attend school unless mandated by the courts to do so • School drop out • Concern about neglect, abuse, sexual abuse of kids • Need to have hearing & vision screenings in school as in the past • Need behavioral health services for those under age 18 • Child abuse and neglect 	<ul style="list-style-type: none"> • Schools do some testing at various ages for hearing and vision. • Will refer survey results to District 518 School District administration. 	
Sanford Specific	<ul style="list-style-type: none"> • Perception that Sanford Hospital is a high-priced hospital • Perception that Sanford & Avera are not working well together to provide the best care for all residents • Sanford needs to be more proactive in getting & keeping doctors in the community • Sanford should not have removed inpatient mental health services from the hospital • Sanford Clinic professionals make mistakes in their documentation • Would like to have a Surgery Center • Concern that Sanford will continue to downsize & drop services 	???	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> • Would like to see Sanford provide more community services (low income housing, food shelf, money to fix up houses) • Hard to get through to the Sanford Clinic on the telephone (always get a recording) 		

6/14/12

Table 2

Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern <i>(from asset mapping and gaps analysis worksheet)</i>	Round 1 Vote	Round 2 Vote	Round 3 Vote
Dental Care	1	0	
Competition	2	0	
Elderly	4	7	
Health Care Costs	3	1	
Mental Health	3	1	
New American/Immigrants	5	6	
Obesity/Youth	4	6	
Physicians	1	0	

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