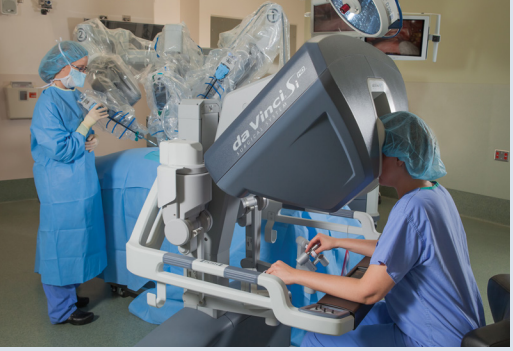

























SANFORD HEALTH

Sanford South University

2018 Community Health Needs Assessment

dba Sanford South University EIN # 45-0226909

Dear Community Members,

Sanford South University Medical Center Fargo is pleased to present the 2018 Community Health Needs Assessment (CHNA).

Sanford completes a community health needs assessment every three years. It is through this work that we identify the unmet needs in the community and strategically plan how we can best address those needs. The CHNA process aligns with Sanford's mission - *Dedicated to the work of health and healing.*

During 2017 and 2018, members of the community were invited to complete a survey to help identify the unmet needs. Key stakeholders completed a survey to identify concerns for the community related to economic well-being, transportation, children and youth, the aging population, safety, and access to mental and behavioral health. Sanford analyzed the data from the primary research and met with key stakeholders to prioritize the identified needs. Our strategies to address the needs are included in this report.

Sanford will address the following health needs through a formalized implementation strategy for the 2019-2021 fiscal years:

- Access
- Mental Health and Substance Abuse

The CHNA also focused on the strengths of our community. The many community assets that are available to address the community health needs are included in the asset map. We have also included an impact report from our 2016 implementation strategies.

Sanford Fargo is committed to extending care beyond our bricks and mortar. We are committed to meeting the health care needs of the broader community. Together, we can fulfill our mission.

Sincerely,

Nate White
President and Chief Operating Officer
Sanford South University Medical Center Fargo

Table of Contents

Sanford South University Medical Center Fargo

Community Health Needs Assessment

2018

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 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 the not-for-profit status, and create opportunity to identify and address public health issues from a broad perspective. A community health needs assessment identifies the community's strengths and areas for improvement. 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.

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 are essential to success
- Sanford Health is invited into the communities we serve

Regulatory Requirements

Federal regulations stipulate that non-profit medical centers conduct a community health needs assessment at least once every three years and prioritize the needs for the purpose of implementations strategy development and submission in accordance with the Internal Revenue Code 501(r).

The Internal Revenue Code 501(r) 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.

The regulations stipulate that each medical center take into account input from persons who represent the broad interests of the community. We are required to seek at least one state, local, tribal or regional government public health department or state Office of Rural Health with knowledge, information or expertise relevant to the health needs of the community.

Non-profit hospitals are required to seek input from members of medically underserved, low income, and minority populations in the community, or organizations serving or representing the interest of such

populations, and underserved populations experiencing disparities or at risk of not receiving adequate care as a result of being uninsured or due to geographic, language or financial or other barriers.

The community health needs assessment includes a process to identify community resources that are available to address the assessed needs and to prioritize the needs.

Hospitals are to address each and every assessed needs or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on the IRS 990 and a status report must be provided each year on IRS 990 Schedule H.

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for the report. Sanford places the CHNA reports and the implementation strategies on the Sanford website. Hospitals are required to keep three cycles of assessments on the web site. The 2018 report will be Sanford's third report cycle since the requirements were enacted in 2010.

Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholders' concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health and Cass and Clay Public Health distributed the survey link via email to stakeholders and key leaders located within the Fargo/Moorhead community and Cass and Clay counties. Data collection occurred from December 2017 to January 2018. A total of 222 community stakeholders participated in the survey.

   B. *Resident Survey*
   The resident survey tool included questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the State Health Improvement Program (SHIP) surveys and those questions were included in the resident survey. The North Dakota Public Health Association developed an Addendum to the survey with questions specific to the American Indian population. The survey was sent to a representative sample of the Cass County and Clay County populations secured through Qualtrics, a qualified vendor. A total of 547 community residents participated in the survey.

   C. *Community Asset Mapping*
   Asset mapping was conducted to find the community resources available to address the assessed needs. Each unmet need was researched to determine what resources were available to address the needs. Once gaps were determined, the prioritization exercise followed with key stakeholder groups determining the top needs.

D. *Community Stakeholder Discussions*
Community stakeholders were invited to attend a presentation of the findings of the CHNA research. Facilitated discussion commenced and each participant was asked to consider his or her top two or three priorities that should be further developed into implementation strategies. The meeting served to inform the group of the findings but also served as a catalyst to drive collaboration.

E. *Prioritization Process*
The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to complete the multi-voting exercise.

2. Secondary Research
   A. The 2018 County Health Rankings
   B. The U.S. Census Bureau estimates
   C. *Community Commons* were reviewed and specific data sets were considered. The *Community Commons* link is https://www.communitycommons.org/maps-data/
   D. The *Fargo Cass Pubic Health – Cass County Community Health Profiles* – April 2018
   E. *Greater Fargo Moorhead Community Needs Assessment Secondary Data: Cass and Clay Counties* was reviewed and presented to key stakeholders. The data is available in the Appendix.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Cass County, North Dakota and Clay County, Minnesota. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs but there is still a need to capture demographic that better represents the community. This is part of our CHNA continuous improvement process.

Internal Revenue Code 501 (r) 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; and 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. We worked closely with public health experts throughout the assessment process.

Public comments and responses to the community health needs assessment and the implementations strategies are welcome on the Sanford website or contact can be made at https://www.sanfordhealth.org/contact-us/form .

Key Findings

Community Health Concerns
The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.5 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.5; however, the high ranking needs of 3.5 or above are considered for the prioritization process. The resident survey addresses personal health needs and concern. The secondary research provides further understanding of the health of the community and in many cases the indicators are aligned and validate our findings.

Economic Well-Being
Community stakeholders are most concerned that there is a need for housing that accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence (ranking 4.22), affordable housing (4.21), high concern for homelessness (3,88), and hunger (3.64).

People in Cass County and Clay County are struggling with food insecurity - 30% of resident survey report that their food did not last until they had money to buy more.

Transportation
Community stakeholders are most concerned about the need for door-to-door transportation for community members who do not drive (3.55).

Children and Youth
Community stakeholders are most concerned about the availability and cost of services for at-risk youth (4.11), the cost and availability of quality childcare (4.08), substance abuse by youth (3.89), teen suicide (3.89), childhood obesity (3.86), and bullying (3.65).

Aging Population
Community stakeholders are most concerned about the cost of long term care and memory care (4.15), the cost of in-home services (3.83), the availability of resources for family and friends caring for elders (3.58), and the availability of resources to help the elderly stay safe in their homes (3.52).

Safety
Community stakeholders are most concerned about abuse of prescription drugs (4.15), a culture of excessive and binge drinking (3.81), domestic violence (3.80), child abuse and neglect (3.68), sex trafficking (3.59) and the presence of street drugs (2.55).

Health Care Access
Community stakeholders are most concerned about the availability of mental health providers (4.28), the availability of behavioral health (substance abuse) providers (4.21), access to affordable health insurance (4.05), access to affordable health care (4.01), access to affordable prescription drugs (3.91), access to affordable dental insurance (3.82), the availability of non-traditional hours (3.63), access to affordable vision insurance (3.58), the use of emergency room services for primary health care (3.53), the availability of health care services for Native American people (3.50), and coordination of care between providers and services (3.50).

Mental Health and Substance Abuse
Community stakeholders are most concerned about drug use and abuse (4.40), alcohol use and abuse (4.15), depression (4.10), suicide (4.01), stress (3.81), and dementia and Alzheimer's (3.61).

Resident survey participants are facing the following issues:

- 66% report that they are overweight or obese
- 50% self-report binge drinking at least 1X/month
- 46% have been diagnosed with anxiety
- 40% have been diagnosed with depression
- 30% have not visited a dentist in more than a year
- 30% report running out of food before having money to buy more
- 29% have been diagnosed with high cholesterol
- 26% have a diagnosis of hypertension and
- 21% report that alcohol use has had a harmful effect on them or a member of their family in the past two years
- 21% currently smoke cigarettes
- 17% self-report that they have drugs in their home they are not using

Community stakeholders worked through a multi-voting prioritization process to determine the top priorities and needs of the community.

Sanford Fargo will address the following health needs in a formalized implementation strategy for the 2019-2021 fiscal years:

- *Health Care Access*
- *Mental Health/Behavioral Health and Substance Abuse*

Implementation Strategies

Priority 1: Health Care Access

According to the County Health Rankings for Clinical Care, access to affordable health care is important to physical, social, and mental health. Health insurance, local care options, and a usual source of care help to ensure access to health care. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met.

Sanford has made health care access a significant priority and has developed strategies to promote and improve access to services. It is Sanford's goal that all patients requiring access to health care are successful in securing timely appointments.

Priority 2: Mental Health/Behavioral Health and Substance Abuse

Mental health is important at every stage of life and affects how people think, feel, and act. According to the National Institute of Mental Health, depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors. Depression is among the most treatable of mental disorders.

Sanford has made mental health a significant priority and has developed strategies to reduce mortality and morbidity from mental health and behavioral health and substance abuse. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by addiction and mental illness.

Sanford South University Medical Center Fargo

Community Health Needs Assessment

2018

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 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 the not-for-profit status and create opportunity to identify and address public health issues from a broad perspective. A community health needs assessment identifies the community's strengths and areas for improvement. 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.

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 are essential to success
- Sanford Health is invited into the communities we serve

Regulatory Requirements

Federal regulations stipulate that non-profit medical centers conduct a community health needs assessment at least once every three years and prioritize the needs for the purpose of implementations strategy development and submission in accordance with Internal Revenue Code 501(r).

The Internal Revenue Code 501(r) 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. The regulations stipulate that each medical center take into account input from persons who represent the broad interests of the community. We are required to seek at least one state, local, tribal or regional government public health department or state Office of Rural Health with knowledge, information or expertise relevant to the health needs of the community.

Non-profit hospitals are required to seek input from members of medically underserved, low income, and minority populations in the community, or organizations serving or representing the interest of such populations, and underserved populations experiencing disparities or at risk of not receiving adequate care as a result of being uninsured or due to geographic, language or financial or other barriers.

The community health needs assessment includes a process to identify community resources that are available to address the assessed needs and to prioritize the needs.

Hospitals are to address each and every assessed need or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on the IRS 990 and a status report must be provided each year on the IRS 990 Schedule H.

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for the report. Sanford places the CHNA reports and the implementation strategies on the Sanford website. Hospitals are required to keep three cycles of assessments on the web site. The 2018 report will be Sanford's third report cycle since the requirements were enacted in 2010.

Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholders' concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health, and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health, Cass County Public Health and Clay County Public Health distributed the survey link via email to stakeholders and key leaders located within the Cass and Clay counties. Data collection occurred from December 2017 to January 2018. A total of 222 community stakeholders participated in the survey.

   B. *Resident Survey*
   The resident survey tool included questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. The North Dakota Public Health Association developed an Addendum to the survey with questions specific to the American Indian population. The survey was sent to a representative sample of the populations secured through Qualtrics, a qualified vendor. A total of 547 community residents participated in the survey.

   C. *Community Asset Mapping*
   Asset mapping was conducted to find the community resources available to address the assessed needs. Each unmet need was researched to determine what resources were available to address the needs. Once gaps were determined, the prioritization exercise followed with key stakeholder groups determining the top needs.

   D. *Community Stakeholder Discussions*
   Community stakeholders were invited to attend a presentation of the findings of the CHNA research. Facilitated discussion commenced and each participant was asked to consider his or her top two or three priorities that should be further developed into implementation strategies. The meeting served to inform the group of the findings but also served as a catalyst to drive collaboration.

   E. *Prioritization Process*
   The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to complete the multi-voting exercise.

2. Secondary Research
   A. The *2018 County Health Rankings* were reviewed and included in the report and in the asset mapping process.
   B. The U.S. Census Bureau estimates were reviewed.
   C. *Community Commons* were reviewed and specific data sets were considered. The *Community Commons* link is https://www.communitycommons.org/maps-data/
   D. *The Fargo Cass Public Health-Cass County Community Health Profile – April 2018* was reviewed and is included in the Appendix
   E. *Greater Fargo Moorhead Community Needs Assessment Secondary Data: Cass and Clay Counties* was reviewed and presented to key stakeholders. The data is available in the Appendix.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Cass County, North Dakota and Clay County, Minnesota. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs but there is still a need to capture demographic that better represents the community. This is part of our CHNA continuous improvement process.

Internal Revenue Code 501(r) 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; and 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. We worked closely with public health experts throughout the assessment process.

Public comments and responses to the community health needs assessment and the implementations strategies are welcome on the Sanford website or contact can be made at https://www.sanfordhealth.org/contact-us/form .

Acknowledgements

Sanford Health would like to thank and acknowledge the Steering Committees for their assistance and expertise while conducting the assessment and analysis of the community needs.

Sanford Steering Group:

- Sara Ballhagen, Administrative Assistant, Sanford Wheaton
- Stacy Barstad, Senior Director, Sanford Tracy and Sanford Westbrook
- Rob Belanger, Clinic Director, Sanford Bagley
- Catherine Bernard, Tax Manager, Corporate Accounting, Sanford Health
- Michelle Bruhn, Senior Vice President, Finance, Health Services Division, Sanford Health
- Randy Bury, Chief Administrative Officer, Sanford Health
- Brian Carlson, Executive Director, Sanford Thief River Falls

- Denise Clouse, Marketing Coordinator, Sanford Tracy
- Ashley Erickson, Senior Director, Sanford Aberdeen
- JoAnn Foltz, Senior Director, Sanford Wheaton
- Isaac Gerdes, Senior Director, Sanford Webster
- Paul Gerhart, Director of Fiscal Services, Sanford Canton
- Julie Girard, Improvement Advisor, Sanford Vermillion
- Paul Hanson, President, Sanford Sioux Falls
- Joy Johnson, VP of Operations, Sanford Bemidji
- JoAnn Kunkel, Chief Financial Officer, Sanford Health
- Mary Lake, Executive Assistant, Sanford Health Network Fargo Region
- Amber Langner, Senior Director of Finance, Corporate Accounting, Sanford Health
- Scott Larson, Senior Director, Sanford Canton
- Tiffany Lawrence, VP, Finance, Sanford Fargo
- Martha Leclerc, VP, Corporate Contracting, Sanford Health
- Tammy Loosbrock, Senior Director, Sanford Luverne and Sanford Rock Rapids
- Carrie McLeod, Sanford Community Health Improvement/Community Benefit - CHNA Director
- Jac McTaggart, Senior Director, Sanford Hillsboro and Sanford Mayville
- Rick Nordahl, Senior Director, Sanford Sheldon
- Erica Peterson, Senior Director, Sanford Chamberlain
- Gwen Post, Director of Nursing and Clinical Services, Sanford Worthington
- Dawn Schnell, Senior Director, Sanford Jackson
- Lori Sisk, Senior Director, Sanford Canby and Sanford Clear Lake
- Jennifer Tewes, Clinic Supervisor, Sanford Jackson
- Tim Tracy, Senior Director, Sanford Vermillion
- Ruth Twedt, Manager of Ancillary Services, Sanford Clear Lake
- Marnie Walth, Senior Legislative Affairs Specialist, Sanford Bismarck
- Jennifer Weg, Executive Director, Sanford Worthington

We express our gratitude to the following community collaborative members for their expertise during the planning, development and analysis of the community health needs assessment:

- Clinton Alexander, Fargo Moorhead Native American Center
- Kristin Bausman, Becker County Public Health
- Justin Bohrer, Fargo Cass Public Health
- Cynthia Borgen, Beltrami Public Health
- Jackie Buboltz, Essentia Health
- Anita Cardinal, Pennington County Public Health
- Leah Deyo, Essentia Health
- Peter Ekadu, Nobles County Public Health
- Stacie Golombiecki, Nobles County Public Health
- Christian Harris, New American Consortium
- Caitlyn Hurley, Avera Health
- Deb Jacobs, Wilkin County Public Health
- Joy Johnson, Sanford Health
- Ann Kinney, Minnesota Department of Health
- Krista Kopperud, Southwest Health and Human Services
- Ann Malmberg, Dakota Medical Foundation Mayors' Blue Ribbon Commission on Addiction

- Kathy McKay, Clay County Public Health
- Jac McTaggert, Sanford Health
- Mary Michaels, Sioux Falls Department of Health
- Teresa Miler, Avera Health
- Renae Moch, Burleigh County Public Health
- Brittany Ness, Steel County Public Health
- Ruth Roman, Fargo Cass Public Health
- Kay Schwartzwalter, Center for Social Research, NDSU
- Becky Secore, Beltrami Public Health
- Julie Sorby, Family HealthCare Center
- Brenda Stallman, Traill County Public Health
- Diane Thorson, Ottertail County Public Health
- Juli Ward, Avera Health
- MayLynn Warne, North Dakota Public Health Association

We extend our special thanks to the community and county leaders, public health administration, physicians, nurses, legislators and community representatives for diverse populations for their participation in this work. Together we are reaching our vision "to improve the human condition through exceptional care, innovation and discovery."

The following Cass County and Clay County community stakeholders participated in community discussions and helped to formulate the priorities for our implementation strategies:

- Chip Ammerman, Director, Cass County Social Services
- Shannon Bacon, Health Systems Manager, North Region American Cancer Society
- Roshelle Badu, Health Partners
- Vern Bennett, Cass County Commissioner
- Brian Berg, Clay County Administrator
- Anne Blackhurst, President, MSUM
- Justin Bohrer, Fargo Cass Public Health
- Jackie Buboltz, Director of Mission Integration, Essentia Health
- Leah Deyo, Program Manager, Community Health, Essentia Health
- Darla Dobberstein, Executive Director, Sanford Health
- Kari Duong-Topp, Health Partners
- Josh Ebert, Clay Co. Public Health
- Jan Eliassen, Gladys Ray Shelter
- Sonja Ellner, Executive Director, Dorothy Day House
- Desi Fleming, Fargo Cass Public Health
- Kaylin Frappier, COO/Deputy CEO, Family HealthCare Center
- Abbey Fraser, American Cancer Society
- Anna Frissell, Executive Director, Red River Child Advocacy Center
- Greg Glasner, MD, Essentia Health
- Dinah Goldenberg, Fargo Board of Health
- Cindy Gray, Executive Director, FM MetroCog
- Tony Grindberg, Fargo City Commissioner

- Robert Grosz, Associate Superintendent, Fargo Public Schools
- Ron Guggisberg, Fargo Fire Department
- Jamie Hennen, Clay Co. Public Health
- Thomas Hill, Community Impact Director, United Way
- Susan Jarvis, COO, Sanford Health
- Charley Johnson, Pres/CEO, FM Visitors and Convention Bureau
- Amy Klein, Family Services Manager, Jeremiah Program
- Rebecca Knutson, Fargo School Board
- Tiffany Lawrence, Sanford Health CFO
- Gerri Leach, Executive Director, Jail Chaplains
- Kim Lipetzky, City of Fargo
- Karen Lloyd, Health Partners
- Ann Malmberg, Mayors' Blue Ribbon Commission on Addiction
- Meagan Maritato, Dietetic Intern
- Tim Mathern, ND State Senator
- Chelsey Matter, Blue Cross Blue Shield
- Kathy McKay, Clay Co. Public Health
- Carrie McLeod, Sanford Health
- Cindy Miller, Executive Director, FirstLink
- Colleen Murray, Lakes and Prairies Community Action Partnership
- Tess Natterstad, Sanford Health Intern
- Lillian Okla, Health and Nutrition Lead Coordinator, SENDCAA Head Start
- Jenny Satter, HR Director, Fargo Park District
- Tim Sayler, Essentia Health
- Ahman Shiil, Community Impact Manager, United Way
- Melissa Sobolik, Great Plains Food Bank
- Julie Sorby, Dir. of Community Development, Family HealthCare Center
- Ron Sorvaag, ND State Senator
- Kale Syverson, Sanford Health
- Sherm Syverson, Sanford Health and FM Ambulance
- Julie Waldera, Sanford Health
- Sara Watson Curry, Moorhead City Council
- Sharon Whitebear, Native American Commission
- Carrie Whitehill, SENDCAA Head Start
- Grace Wolhowe, Essentia Health

Description of Sanford South University Medical Center Fargo

Sanford South University Medical Center is one of three Sanford Health medical center campuses in Fargo. It has 170 licensed beds and serves as a hub for orthopedic surgery and rehabilitation with inpatient units for these services. The South University campus will eventually become a stand-alone orthopedics and sports medicine clinic and hospital, the only one in the state of North Dakota. Work is already in progress.

South University also currently houses highly specialized services, including a behavioral health inpatient and partial hospitalization unit, an eating disorder inpatient and a partial hospitalization unit, ophthalmology, a center for cardiac and vascular screening, and a bio-skills and cadaver lab for medical residents.

Sanford Health is a major teaching hospital in partnership the University of North Dakota School of Medicine and Health Sciences. They recently collaborated to launch an orthopedic residency program that began in summer 2018 at Sanford South University Medical Center. This first-of-its-kind program in North and South Dakota creates three residency positions per year that will study in both Fargo and Sioux Falls, eventually resulting in 15 residents training at a time during the five-year program.

Residents will see a wide range of orthopedic disorders for adults and pediatric patients that include adult reconstruction, orthopedic trauma, spine, hand, foot, ankle, amputations, athletic injuries and orthopedic oncology. They will also focus on research and improving patients' care and treatments.

Sanford Health is the largest employer in the Fargo metro area with 9,400 Sanford employees in Fargo-Moorhead-West Fargo, including 500 board-certified physicians and 200 advanced practice providers (APPs). It is accredited by The Joint Commission.

Description of the Community Served

Fargo is a diverse, dynamic, family-oriented community on the eastern border of North Dakota. It is the largest city in North Dakota, accounting for nearly 16 percent of the state population and the county seat of Cass County. Fargo and its twin city of Moorhead, Minn., and adjacent West Fargo, N.D. and Dilworth, Minn., form the core of the metro area, which in 2018 has a population of 240,000.

Founded in 1871, Fargo is the economic center of southeastern ND. It is a cultural, retail, health care, educational and industrial hub for the region. The Fargo-Moorhead metro area is home to three universities: North Dakota State University, Concordia College, Minnesota State University Moorhead, and numerous other private and state colleges and technical schools and is home to over 38,000 students.

Although the economy of the Fargo area has historically been dependent on agriculture, the city now has a growing economy based on food processing, manufacturing, technology, retail trade, higher education and health care. *US News & World Report* ranked Fargo as the #1 city for finding a job, Farmers Insurance named it the #3 most secure places to live, and Moving.com named it #5 on its list of best places to live in America.

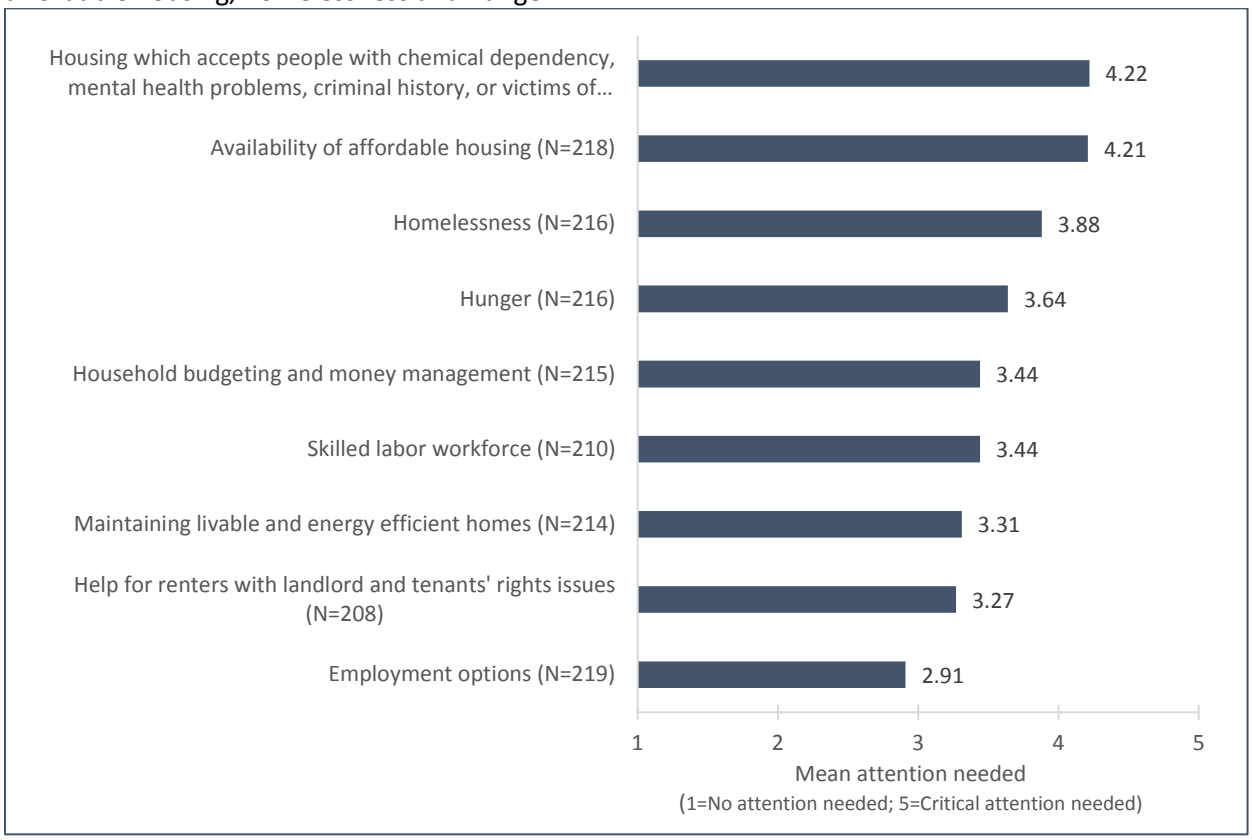
Fargo-Moorhead is home to a growing number of innovative technology and biomedical companies, attracted to the community by its educated workforce, low labor costs, favorable tax climate, advanced telecommunications infrastructure and available energy and water supplies. Education and health services account for the largest non-agricultural industries.

Key Findings

Community Health Concerns

The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.5 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.5; however, the high ranking needs of 3.5 or above are considered for the prioritization process. The resident survey addresses personal health needs and concerns. The secondary research provides further understanding of the health of the community, and in some cases, the indicators align with and validate our findings.

Economic Well-Being: The concern for the community's economic well-being is focused on the need for housing that accepts people in recovery, mental illness, criminal history of victims of domestic abuse, affordable housing, homelessness and hunger.

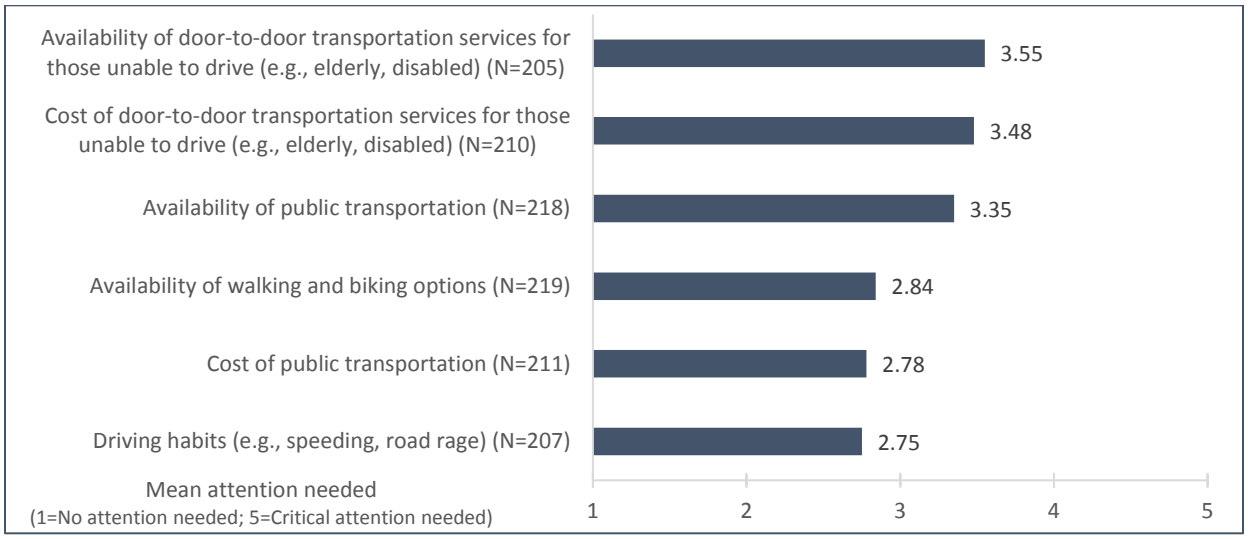


Healthy People 2020 has defined the social determinants of health. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." The patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe

and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

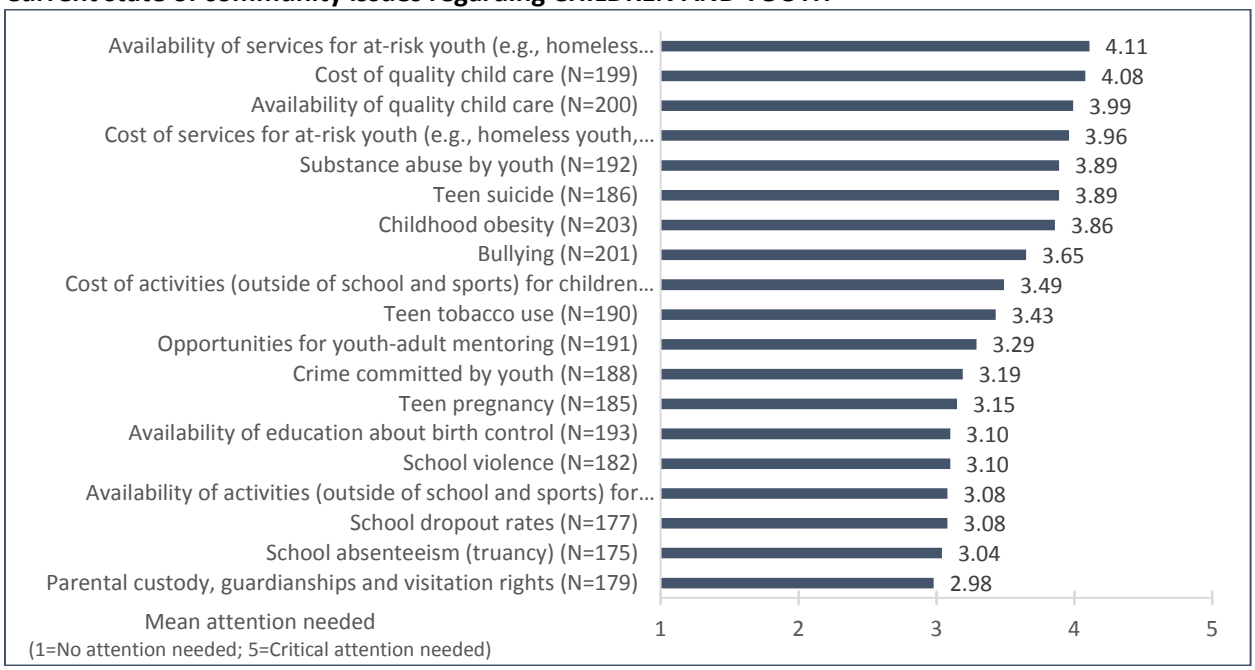
Transportation: The concern for transportation focuses on the need for door-to-door transportation for those unable to drive.

Current state of community issues regarding TRANSPORTATIAON



Children and Youth: The highest concerns for children and youth are numerous and include the need for services for at-risk youth, the cost and availability of quality childcare, substance abuse by youth, teen suicide, childhood obesity, and bullying.

Current state of community issues regarding CHILDREN AND YOUTH



According the U.S. Department of Drug Enforcement Administration (DEA), nationally almost 20 percent of students surveyed admit to using marijuana at least once during the last 30 days, and 13 percent of students surveyed admitted driving when they used marijuana within the last 30 days.

Researchers have identified *risk factors* that can increase a person's chances for misuse, and *protective factors* that can reduce the risk. However, many people with risk factors do not abuse substances. The risk factors for substance abuse among youth include boredom, stress, curiosity, the desire to feel grown up, or to lessen peer pressure.

Youth may also be more likely to try drugs because of circumstances or events called risk factors. Examples of risk factors include:

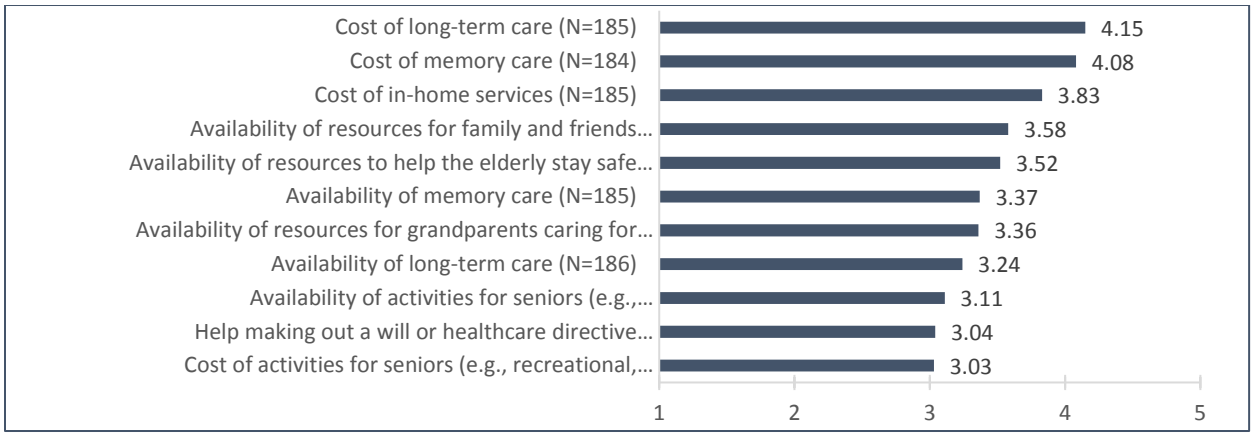
- Poor grades in school
- Engaging in alcohol or drug use at a young age
- Friends and peers who engage in alcohol or drug use
- Persistent, progressive, and generalized substance use, misuse, and use disorders by family members
- Conflict between parents or between parents and children, including abuse or neglect
- Bullying

Protective factors include:

- Having high self-esteem
- Attending a school with policies against using alcohol and drugs
- Having an adult role model who doesn't use tobacco or drugs or misuse alcohol
- Participating in athletic, community, or faith-based groups
- Living in a community with youth activities that prohibit drugs and alcohol

Aging Population: The cost of long term care and memory care are top concerns once again and were top concerns during the 2016 CHNA cycle. The cost of in-home services and the availability of resources for family and friends helping to make decisions for elders and resources to help the elderly stay safe in their homes are also high concerns.

Current state of community issues regarding the AGING POPULATION

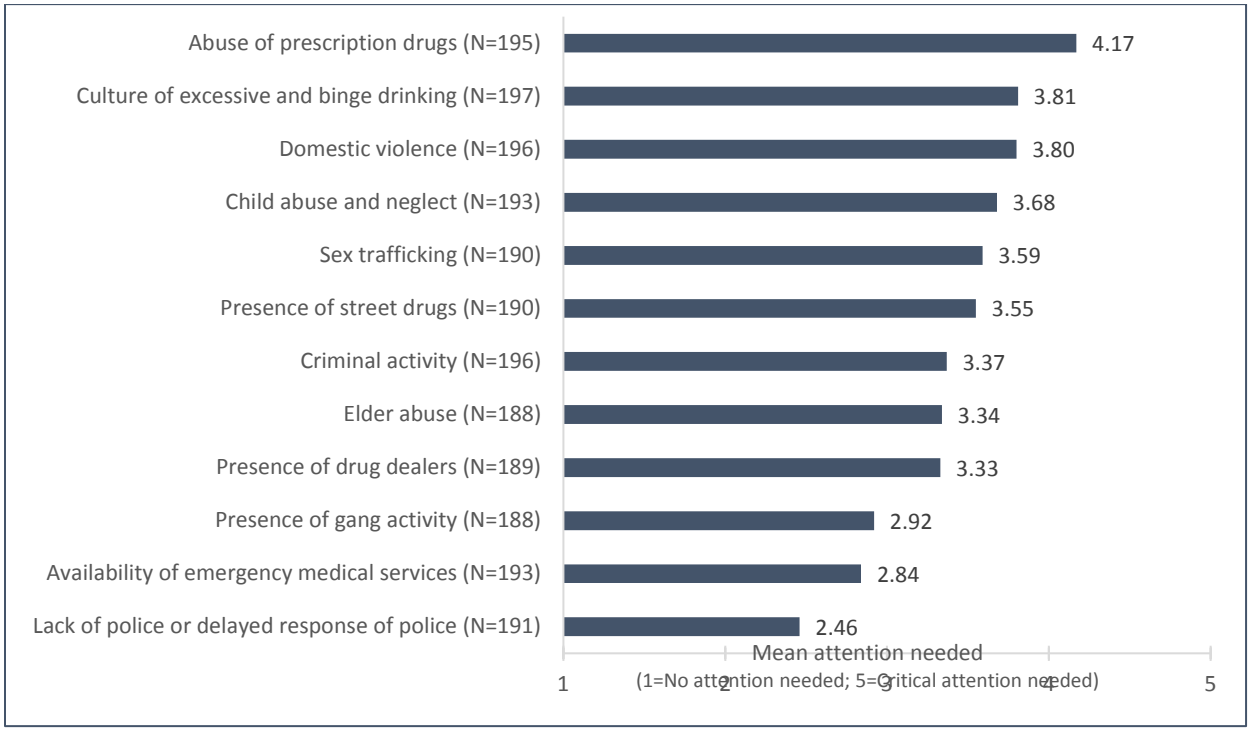


Acording to the U.S. Health and Human Services Administration on Aging, the cost of long term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford

providers work to help seniors live healthy independent lives. Sanford social workers, case managers, and discharge planners refer patients to area service providers to make certain that patients receive a safe discharge and transition to the appropriate levels of care.

Safety: The abuse of prescription drugs, the culture of excessive drinking, domestic violence, child abuse and neglect, sex trafficking and the presence of street drugs are top concerns for safety in the community.

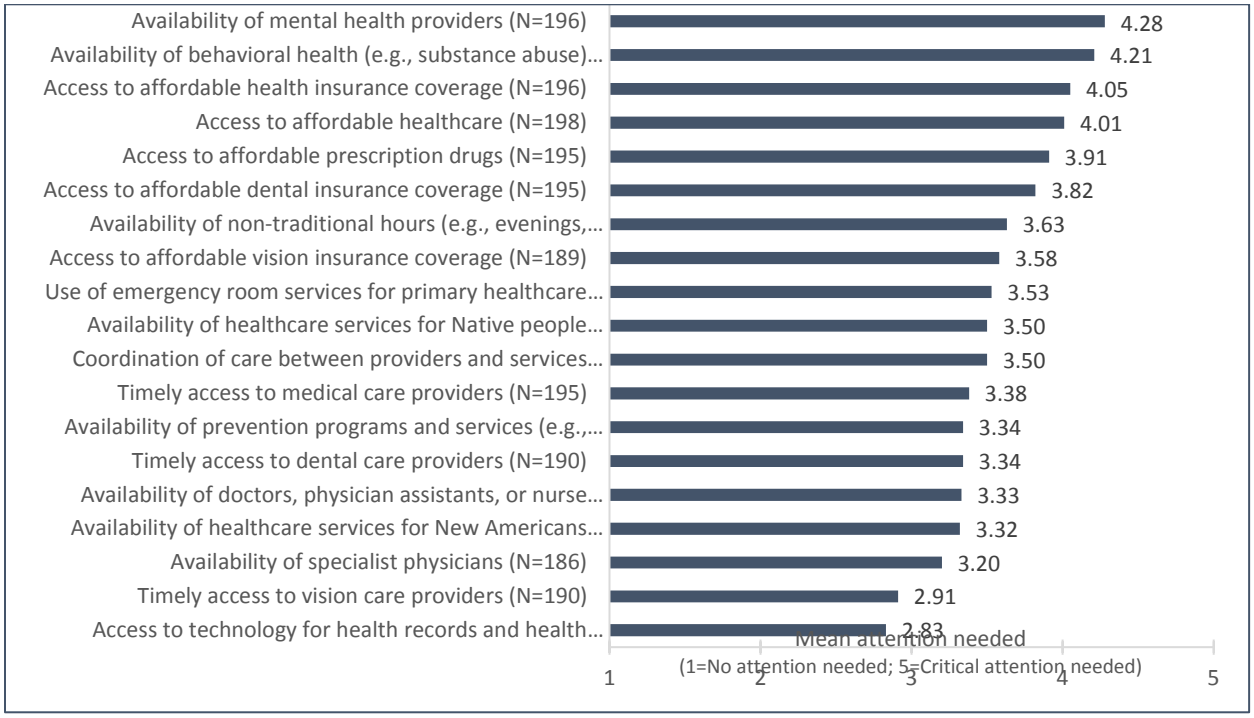
Current state of community issues regarding SAFETY



The National Institute on Drug Abuse states that the misuse of prescription drugs means taking a medication in a manner or dose other than what was prescribed; or taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high). The term *non-medical use* of prescription drugs also refers to these categories of misuse. The three classes of medication most commonly misused are opioids, central nervous system depressants (this category includes tranquilizers, sedatives, and hypnotics) and stimulants - most often prescribed to treat attention deficit hyperactivity disorder (ADHD). Prescription drug misuse can have serious medical consequences. Providers at Sanford Health have reduced opioid prescriptions over the last three years in an effort to have fewer pills in circulation and a reduced opportunity for misuse.

Health Care and Wellness: The availability of mental health and behavioral health providers are ranked very high among the top concerns for the community. Access to affordable health insurance and affordable health care, affordable prescription drugs, affordable dental and vision insurance, availability of non-traditional hours, the use of the emergency room for primary health care, the availability of healthcare for Native people and the coordination of care between providers and community services Are all high concerns for community stakeholders.

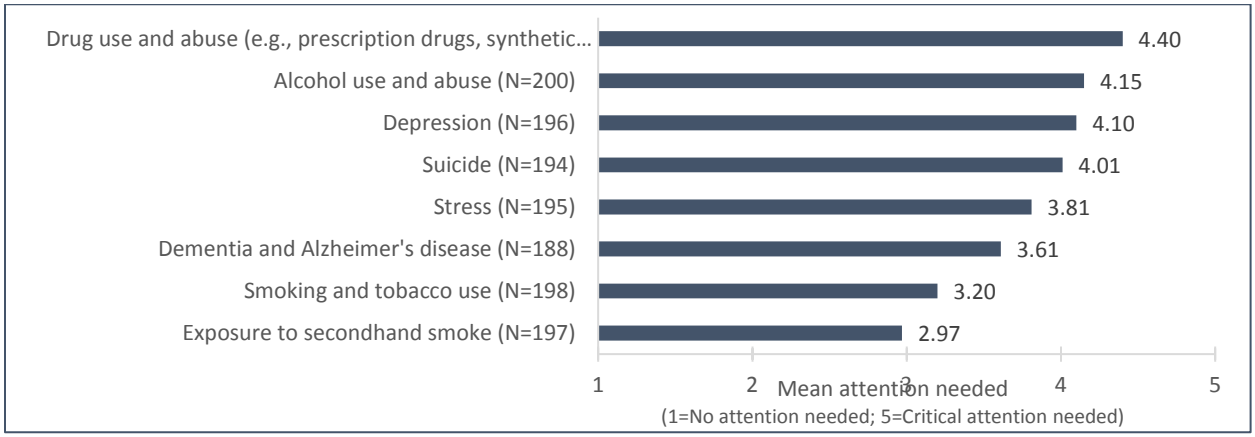
Current state of community issues regarding HEALTH CARE AND WELLNESS ACCESS



According to the Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. The 2016 HRSA report projected that the supply of workers in selected behavioral health professions would be approximately 250,000 workers short of the projected demand by 2025.

Mental Health and Substance Abuse: Drug use and abuse, alcohol use and abuse, depression, suicide, stress, dementia and Alzheimer's are top concerns for the community.

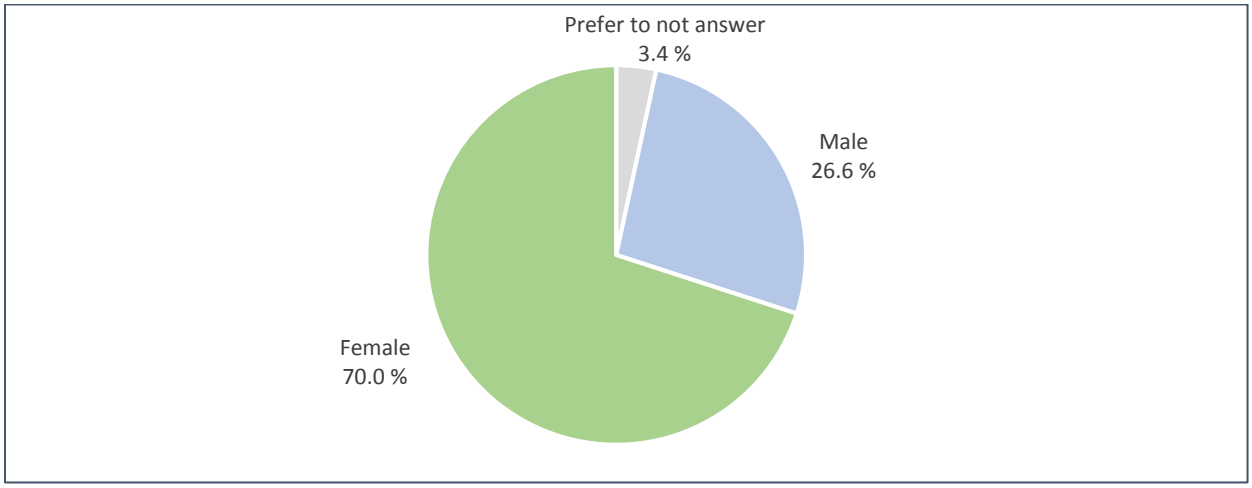
Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



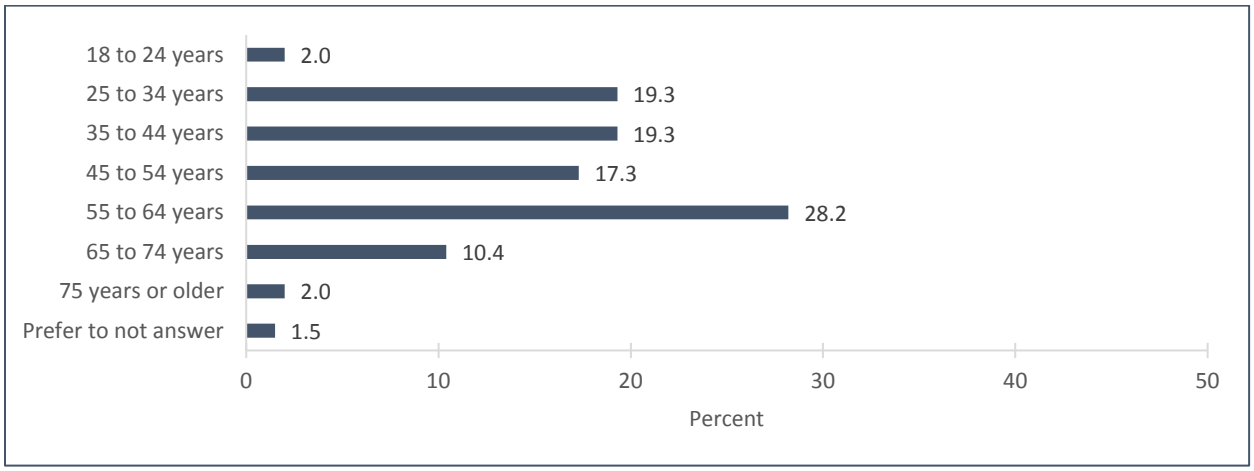
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental illness, 1.7 million of whom were age 18 to 25. Additionally, 15.7 million adults (age 18 or older) and 2.8 million youth (age 12 to 17) had a major depressive episode during the past year. In 2014, an estimated 22.5 million Americans age 12 and older self-reported needing treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing mental health treatment or counseling in the past year. These disorders are among the top conditions that cause disability and carry a high burden of disease in the United States, resulting in significant costs to families, employers, and publicly funded health systems. By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide."

Demographic Information for Key Stakeholder Participants

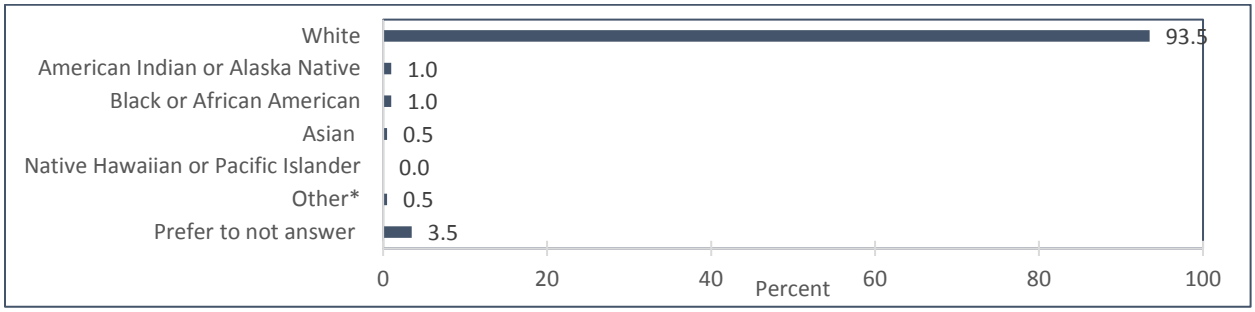
Biological Gender



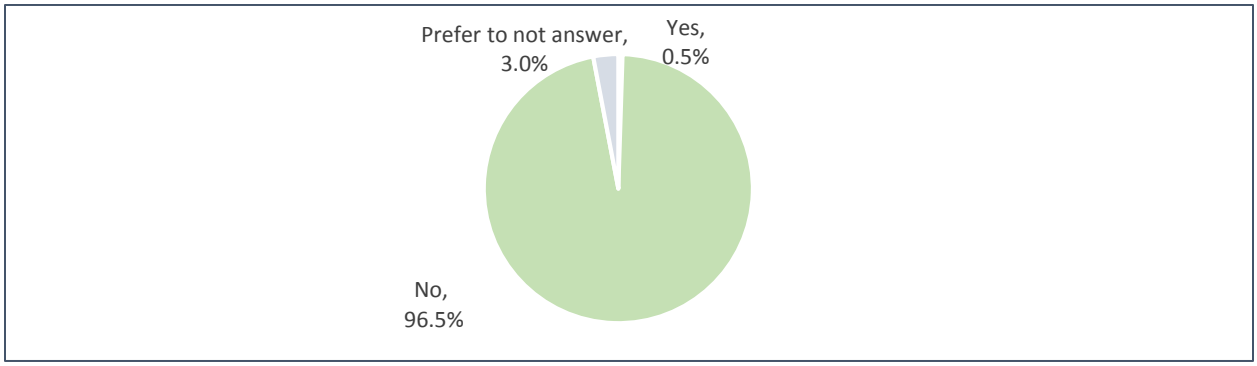
Age of Participants



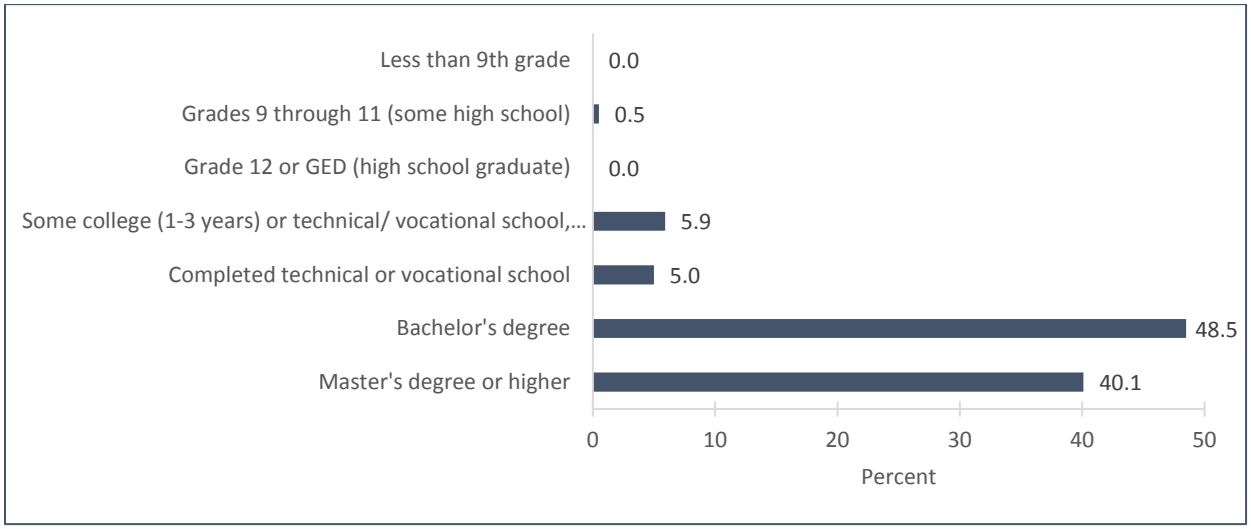
Race of Participants



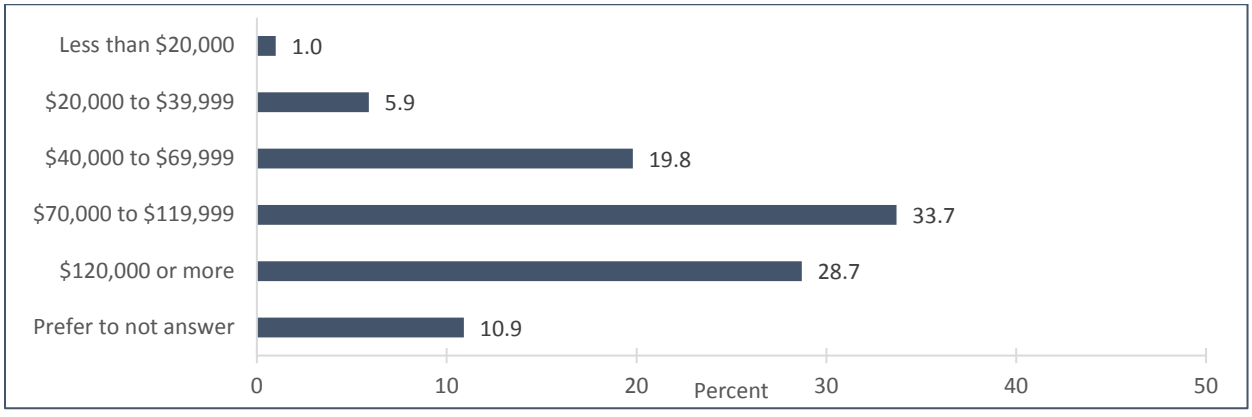
Whether Respondents are of Hispanic or Latino Origin



Highest Level of Education Completed



Annual Household Income of Respondents, From All Sources, Before Taxes



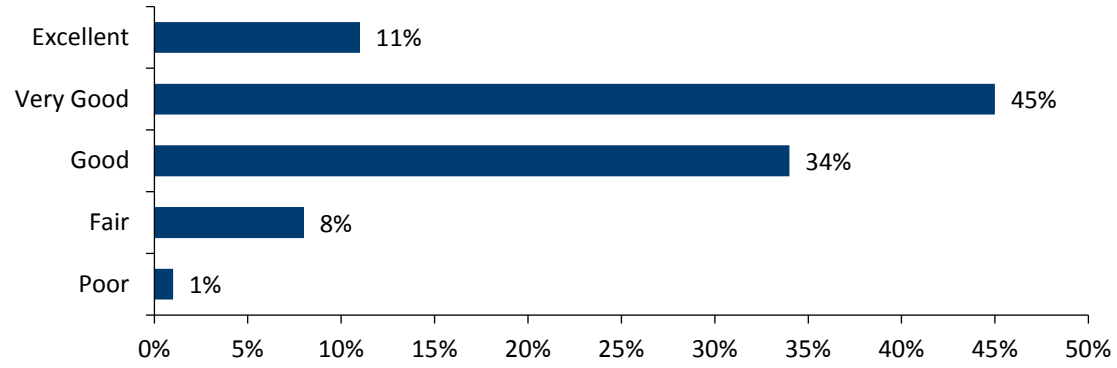
Residents' Health Concerns

Health is personal and it starts in our homes, schools, workplaces, neighborhoods, and communities. Eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor for routine check-ups can positively influence our health.

The resident survey asks questions specific to the participant's personal health and health behaviors.

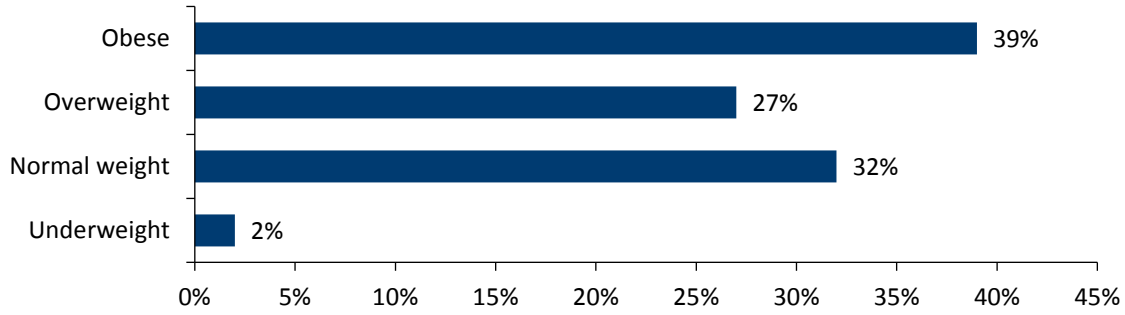
How would you rate your health?

Ninety-one percent of survey participants rated their health as good or better.



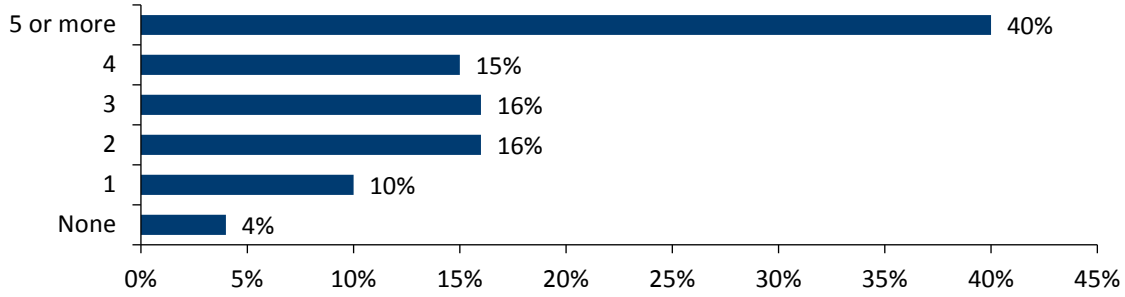
Body Mass Index (BMI)

Sixty-six percent are either overweight or obese.



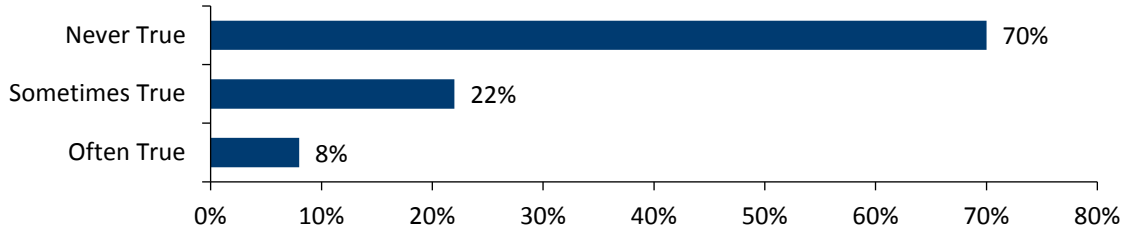
Total Daily Servings of Fruit and Vegetables

Sixty percent of residents are not getting the recommended five or more servings of fruits/vegetables per day.



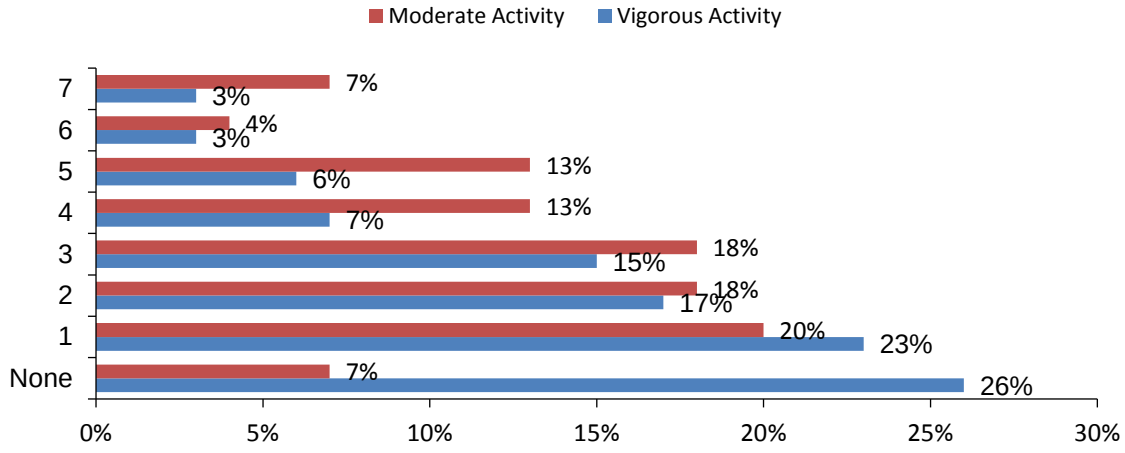
The food that we bought just did not last and we did not have money to get more.

Thirty percent run out of food before having money to buy more.



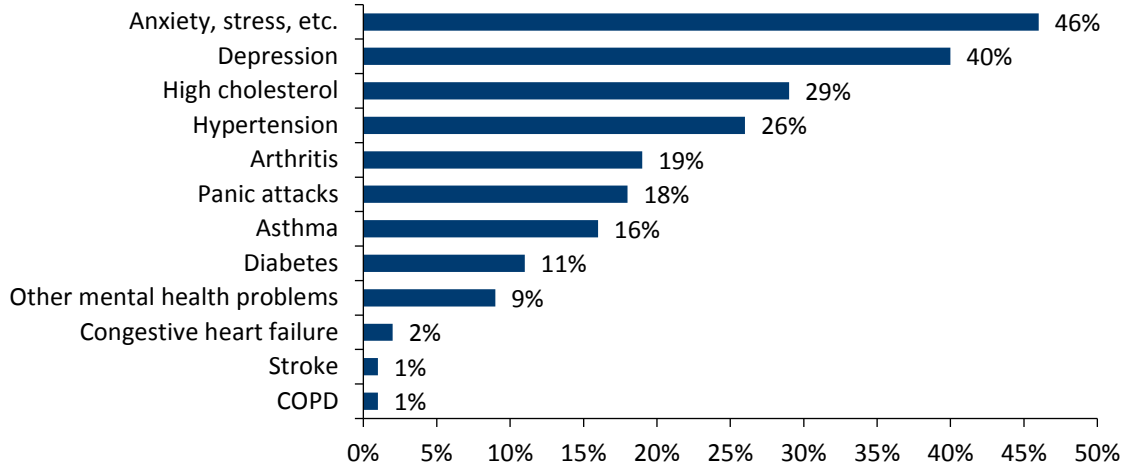
Days per Week of Physical Activity

Fifty-five percent of residents report moderate exercise on three of more days each week.

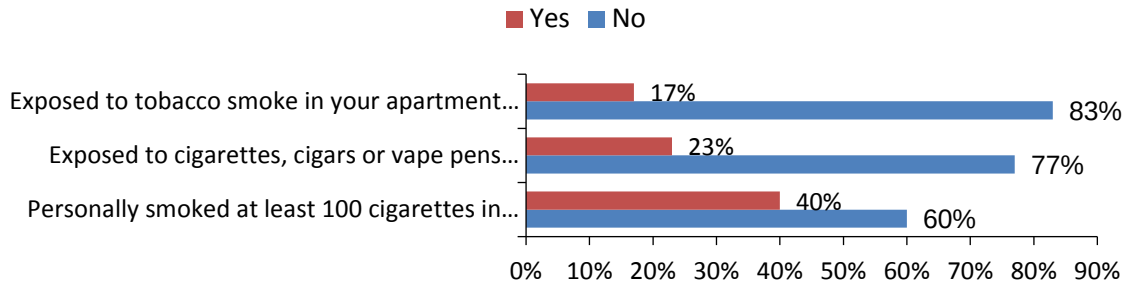


Past Diagnosis

Anxiety and depression diagnosis are very high ranking in comparison to the national statistics. The Substance Abuse and Mental Health Services Association (SAMHSA) reports an estimated 16.2 million adults in the United States had at least one major depressive episode in 2016. This number represented 6.7% of all U.S. adults.

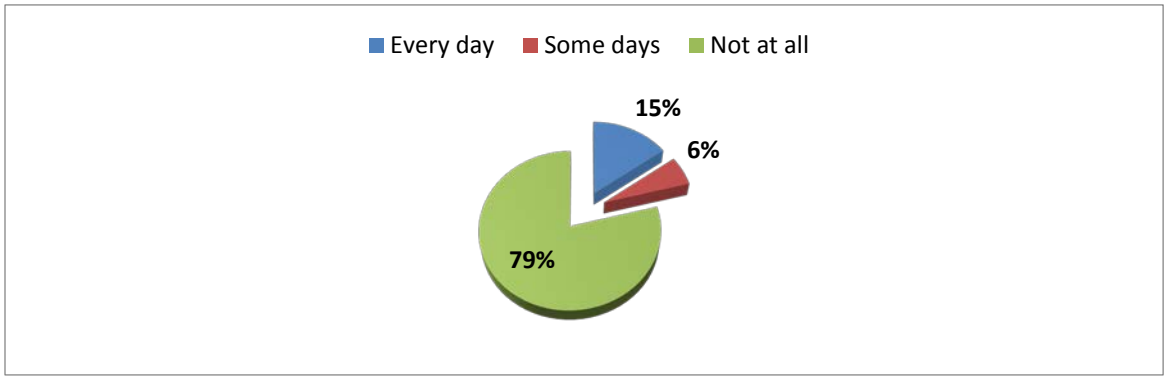


Exposure to Tobacco Smoke

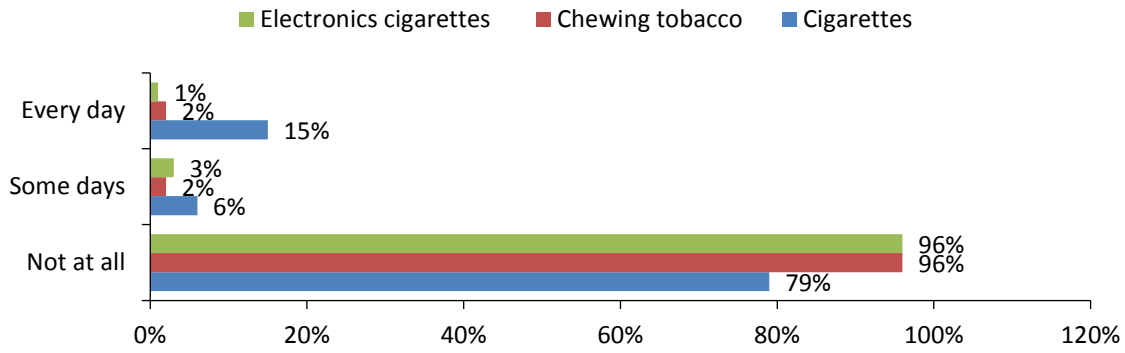


Do you currently smoke cigarettes?

Twenty-one percent smoke cigarettes with fifteen percent smoking every day.

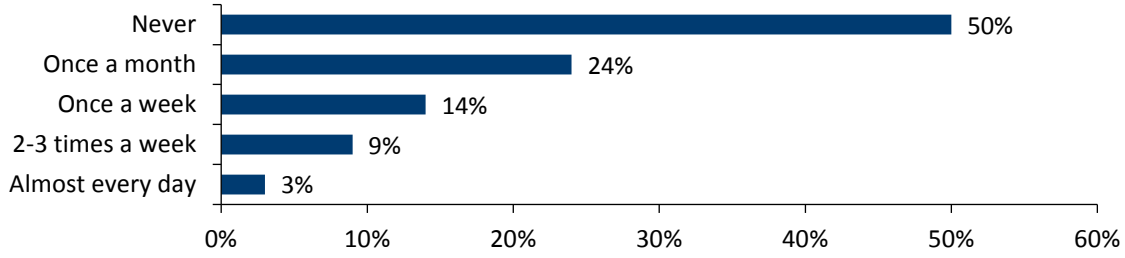


Current Tobacco Use



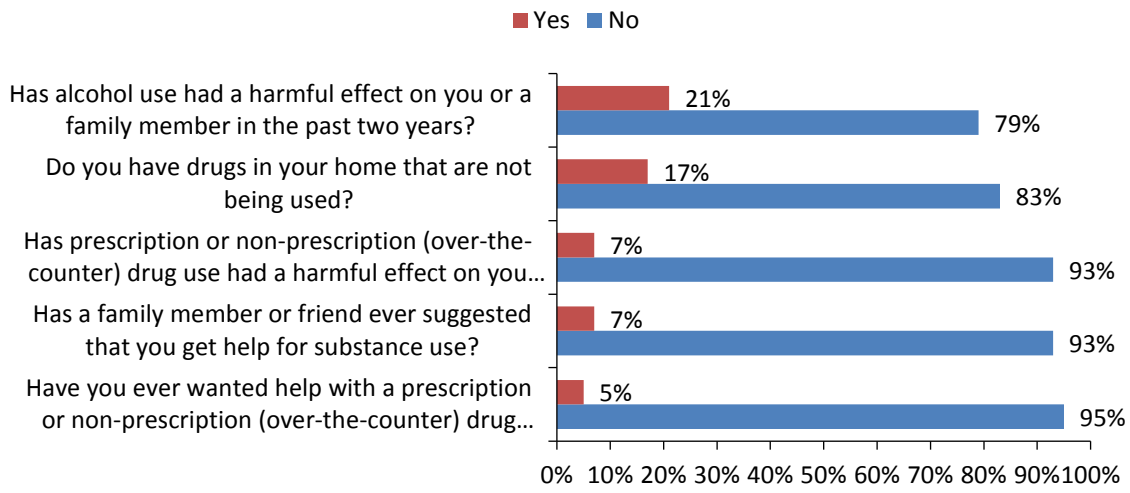
Binge Drinking

Fifty percent of resident report binge drinking at least one time per month.



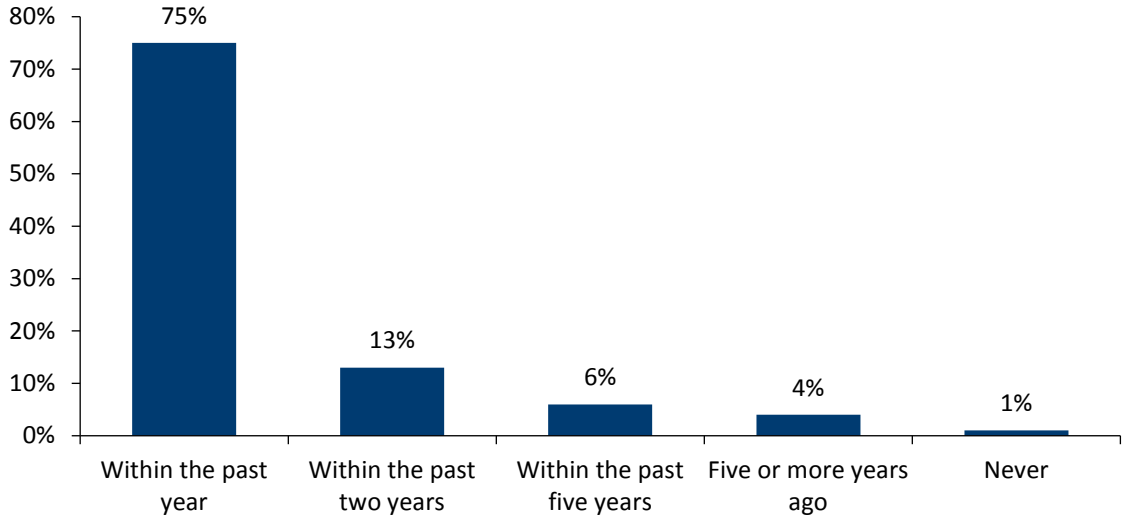
Drug and Alcohol Issues

North Dakota is ranked the #1 binge drinking state in the nation and Minnesota is #9. https://www.cbsnews.com/pictures/ booziest-states-in-America-who-binge-drinks-most/26/.



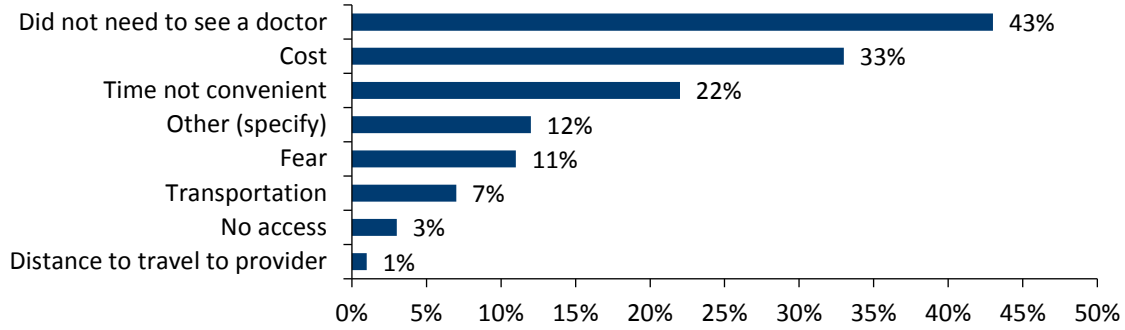
How long has it been since you last visited a doctor or health care provider for a routine checkup?

Twenty-four percent have not had a routine check-up in more than a year.



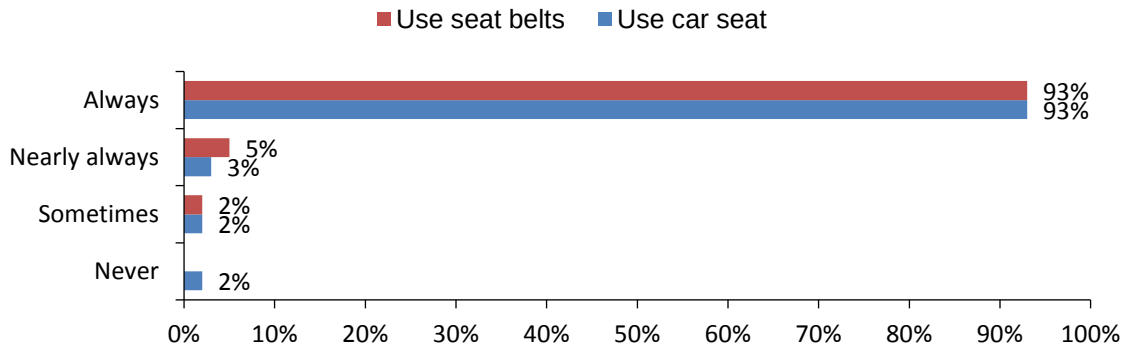
Barriers to a Routine Check-up

Forty-three percent of resident participants perceive that they do not need to see a doctor for a routine check-up.

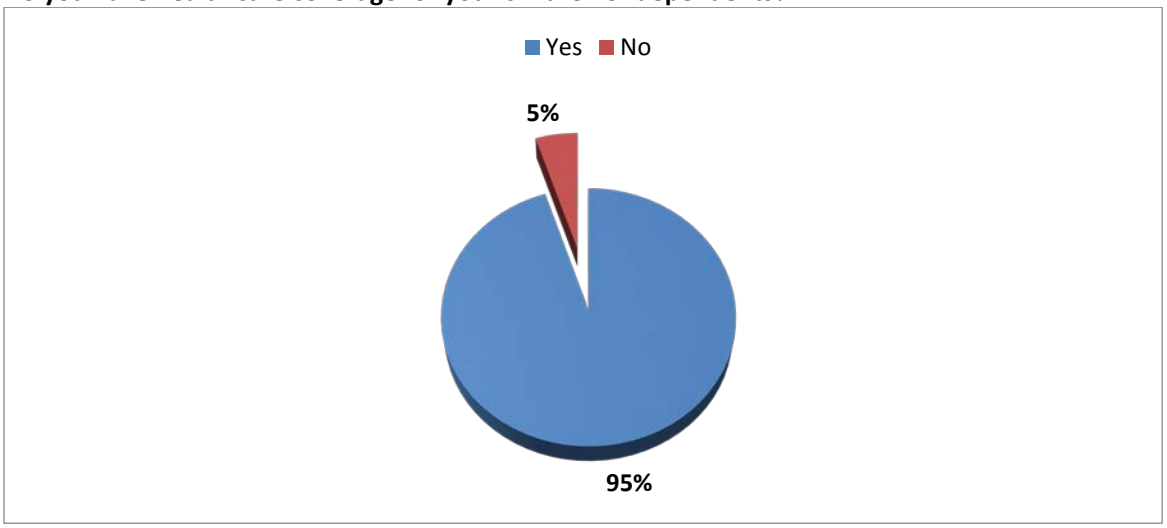


Children's Car Safety

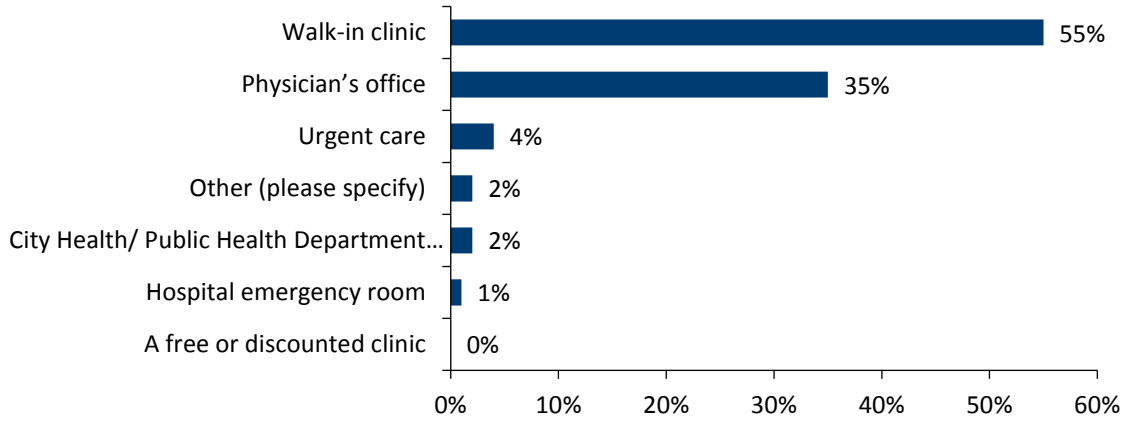
Seven percent do not always use seat belts or car seats for their children.



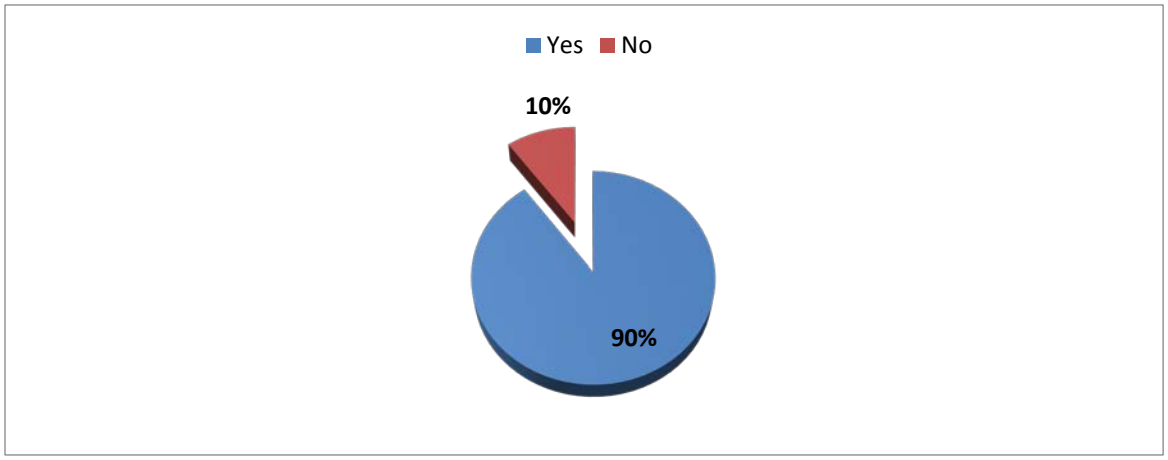
Do you have health care coverage for your children or dependents?



Where do you most often take your children when they are sick and need to see a health care provider?

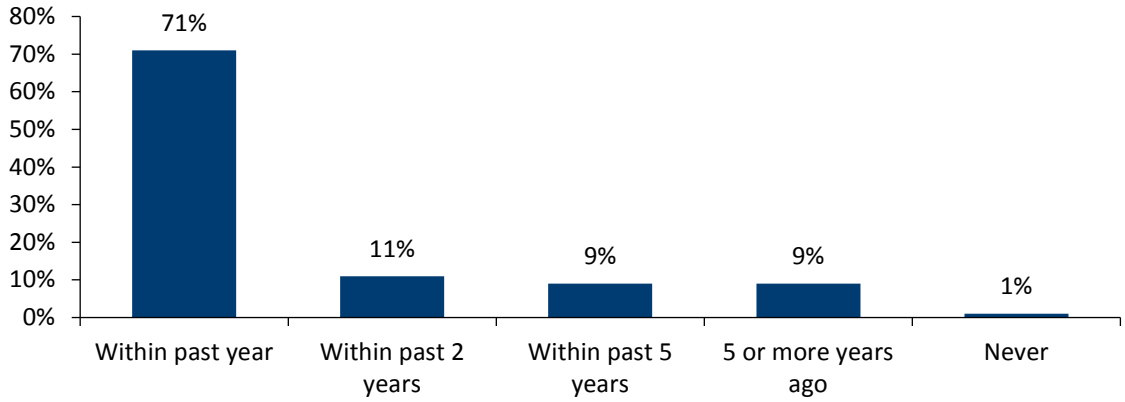


Do you currently have any type of health insurance?

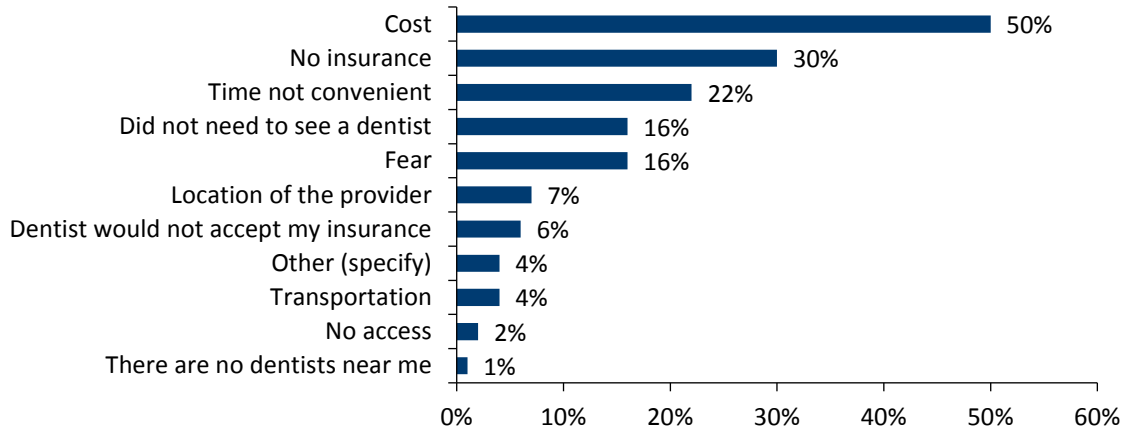


How long has it been since you last visited a dentist?

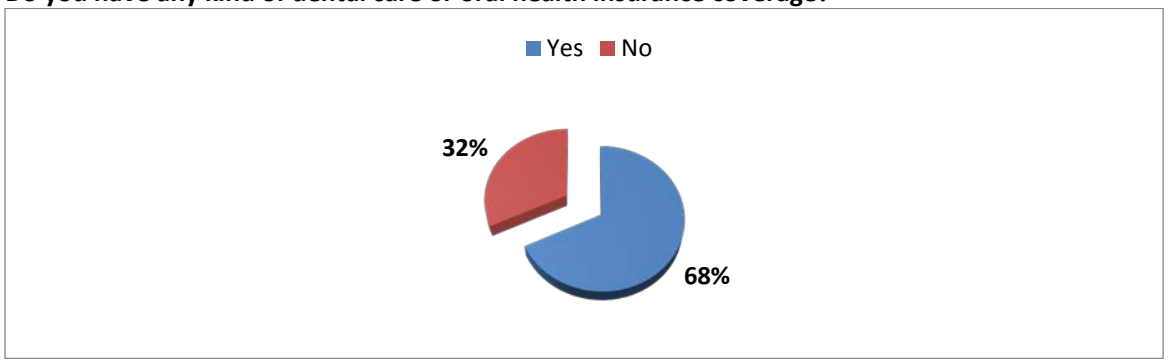
Thirty percent have not visited their dentist in more than a year.



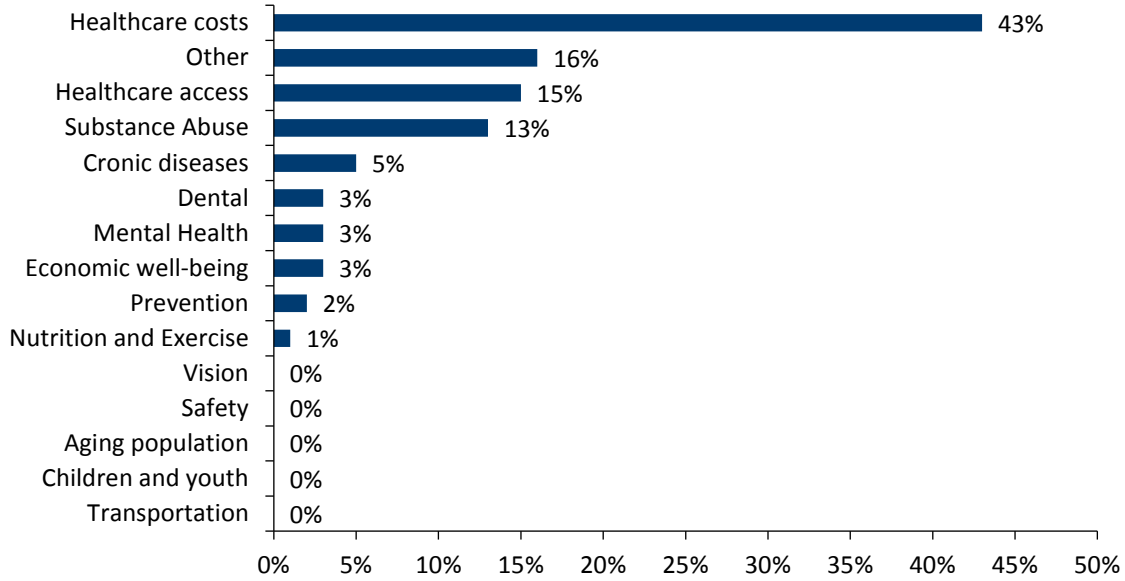
Barriers to Visiting the Dentist



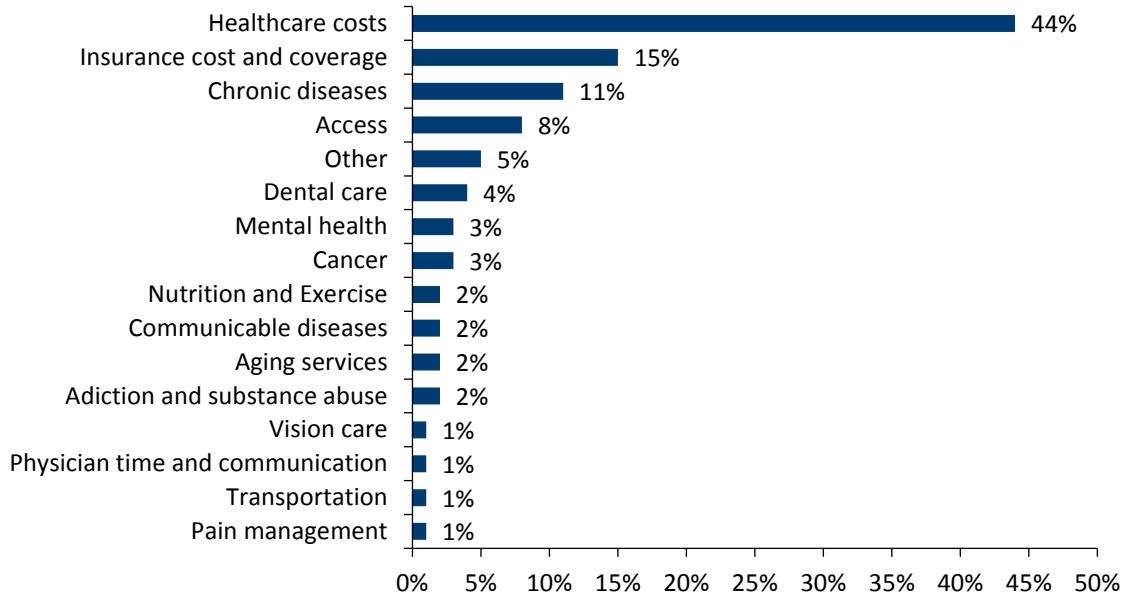
Do you have any kind of dental care or oral health insurance coverage?



What do you see as the Most Important Community Issues?



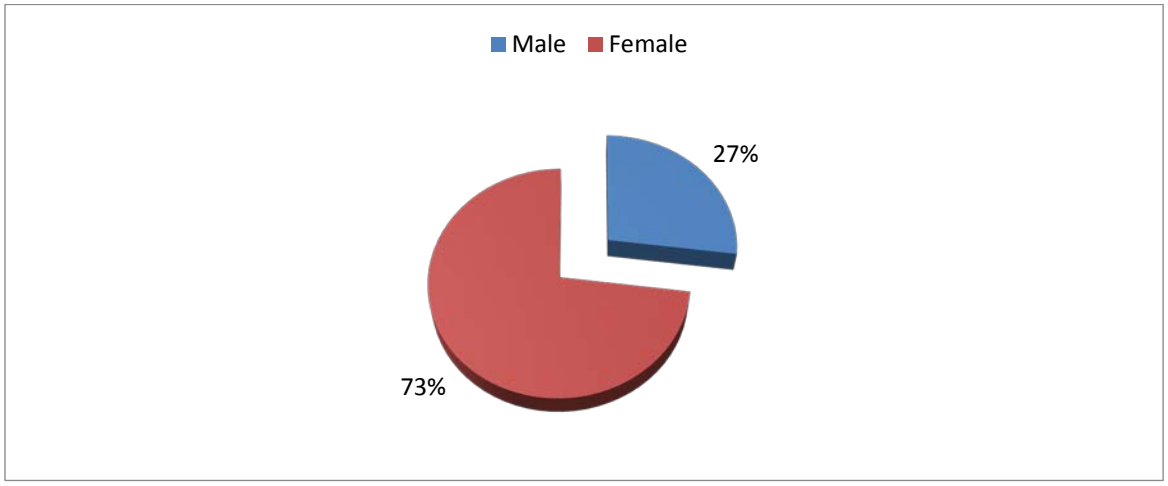
What do you see as the Most Important Issue for Family?



Demographic Information for Community Resident Participants

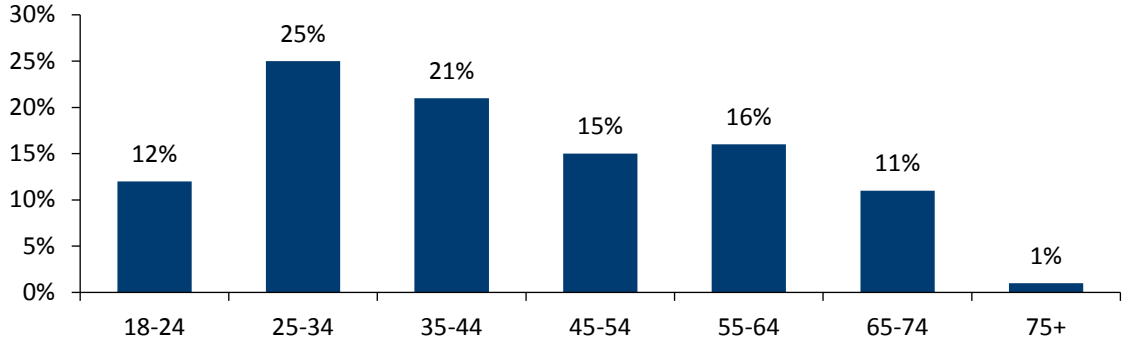
Biological Gender

Only 27% of the survey participants were male.

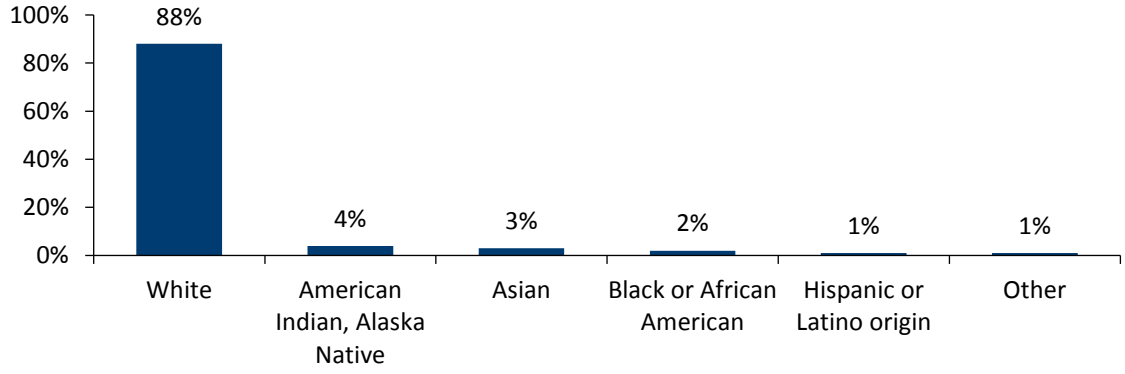


Age

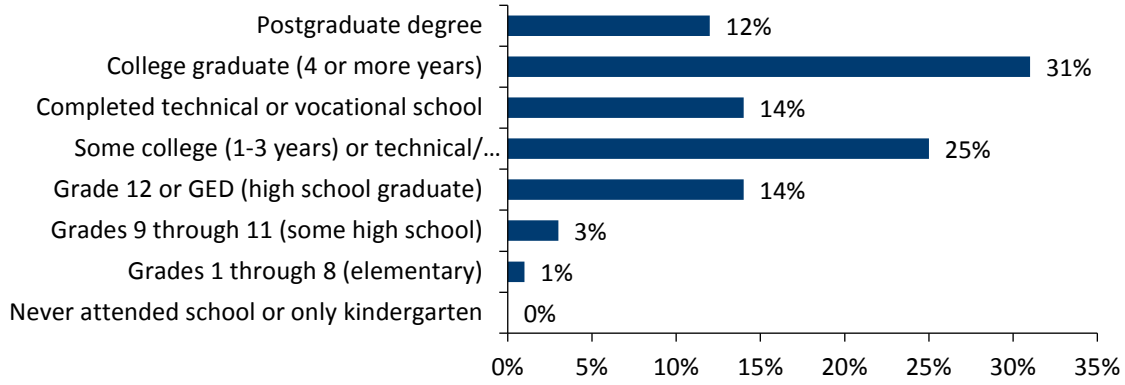
Every age group is represented among the survey participants; however, only 1% fell into the 75+-year age.



Ethnicity

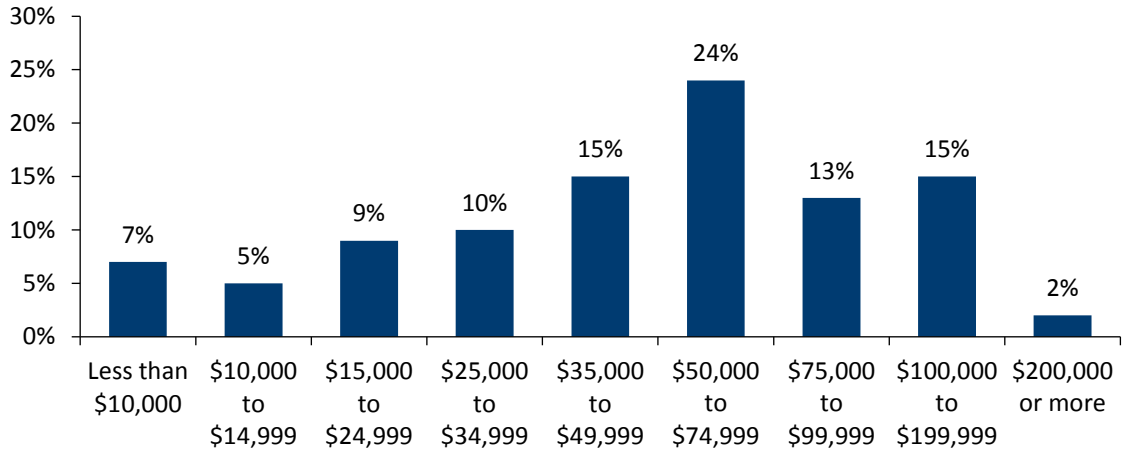


Education Level



Total Annual Household Income

Twenty-one percent of survey participants have an annual household income at or below the Federal Poverty Level for a family of four ($25,100 in 2018).



Secondary Research Findings

Census Data

Population of Cass County, North Dakota and Clay County, Minnesota	241,346
% below 18 years of age	23.3% Cass 24.4% Clay
% 65 and older	11.7% Cass 13% Clay
% White – non-Hispanic	85.4% Cass 87.3% Clay
American Indian	1.4% Cass 1.8% Clay
Hispanic	2.7% Cass 4.5% Clay
African American	5.7% Cass 3.3% Clay
Asian	3.3% Cass 1.4% Clay
% Female	49.3% Cass 50.6% Clay
% Rural	10.4 Cass 27.9% Clay

County Health Rankings

	Cass County	State of North Dakota	Clay County	State of Minnesota	U.S. top Performers
Adult smoking	15%	20%	15%	15%	14%
Adult obesity	30%	32%	28%	27%	26%
Physical inactivity	19%	24%	21%	20%	20%
Excessive drinking	25%	26%	25%	23%	13%
Alcohol-related driving deaths	35%	48%	39%	30%	13%
Food insecurity	9%	8%	10%	10%	10%
Uninsured adults	8%	9%	5%	6%	7%
Uninsured children	6%	8%	2%	3%	3%
Children in poverty	11%	12%	13%	13%	12%
Children eligible for free or reduced lunch	28%	31%	34%	38%	33%
Diabetes monitoring	91%	87%	89%	88%	91%
Mammography screening	71%	69%	66%	65%	71%
Median household income	$59,700	$61,900	$59,900	$65,100	$65,600

Health Needs and Community Resources Identified

The Internal Revenue Service requires that a community health needs assessment include an inventory of resources that are available to address the unmet needs. This document is referred to as an asset map. Sanford Health conducted asset mapping by reviewing the primary and secondary research and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources are available in the community and county to address the needs. The asset map was reviewed by Sanford leadership and by community key stakeholders to validate the assets. The asset map helped to identify gaps in services. Once gaps were determined the key stakeholder group proceeded to the prioritization discussion and multi-voting exercise. The group was asked to prioritize the top two concerns that would be further developed into implementation strategies.

The process executed in the work was based on the McKnight Foundation model "Mapping Community Capacity" by John L. McKnight and John Kretzmann, Institute for Policy Research at Northwestern University.

The asset mapping process identified needs from the following:

- Key stakeholder survey
- Resident survey
- Facilitated discussion by the key stakeholders
- Secondary research
- Community resources that are available to address the needs

Please see the asset map in the Appendix.

Prioritization

A multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to discuss community needs and complete the multi-voting exercise.

The following needs were brought forward for prioritization:

Health Indicator/Concern
Economic Well-Being • Housing which accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence 4.22 • Availability of affordable housing 4.21 • Homelessness 3.88 • Hunger 3.64 35% report not having enough food
Transportation • Availability of door-to-door transportation services for those unable to drive 3.55
Children and Youth • Availability of services for at-risk youth 4.11 • Cost of quality childcare 4.08 • Availability of quality childcare 3.99 • Cost of services for at-risk youth 3.96 • Substance abuse by youth 3.89 • Teen suicide 3.89 • Childhood obesity 3.86 • Bullying 3.65
Aging Population • Cost of long term care 4.15 • Cost of memory care 4.08 • Cost of in-home services 3.83 • Availability of resources for family and friends caring for and helping make decisions for elders 3.58 • Availability of resources to help the elderly stay safe in their homes 3.52
Safety • Abuse of prescription drugs 4.17 • Culture of excessive and binge drinking 3.81 • Domestic violence 3.80 • Child abuse and neglect 3.68 • Sex trafficking 3.59 • Presence of street drugs 3.55
Health Care Access • Availability of mental health providers 4.28 • Availability of behavioral health providers 4.21 • Access to affordable health insurance coverage 4.05 • Access to affordable health care 4.01 o 24% report not having seen a health care provider in > 1 yr. • Access to affordable prescription drugs 3.91

Health Indicator/Concern
• Access to affordable dental insurance coverage 3.82   o 30% report not having seen a dentist in >1yr • Availability of non-traditional hours 3.63 • Access to affordable vision insurance coverage 3.58 • Use of emergency room services for primary health care 3.53 • Availability of healthcare services for Native people 3.50 • Coordination of care between providers and services 3.50
Mental Health and Substance Abuse • Drug use and abuse 4.40 • Alcohol use and abuse 4.15   o 50% report binge drinking • Depression 4.10 • Suicide 4.01 • Stress 3.81 • Dementia and Alzheimer's Disease 3.61 • Tobacco use 21%
Health and Wellness • 60% Not getting enough fruits and vegetables • 45% Not getting enough exercise • Only 57% report having flu shot in the last year • 27% Overweight 39% obese • High cholesterol • Hypertension

Please see the multi-voting prioritization worksheet in the Appendix.

How Sanford is Addressing the Needs

Sanford is addressing all of the assessed needs that fall within our scope of work. In some cases, the need is one where we do not have the expertise to adequately address the need. However, Sanford leaders will communicate the findings to community experts and leaders.

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
Housing that accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence	Sanford supports the local YWCA and the efforts to provide safe housing for women and children. Sanford also supports the New Life Center and provides options for safe housing for men. Sanford is serving on the Mayors' Blue Ribbon Commission on Addiction where recovery supportive housing is one of the focused strategies of the expert panel for treatment and recovery. Sanford recently partnered to help fund a position at FirstLink through the Mayors' Blue Ribbon Commission on Addiction partnership to launch a Community Navigator position.
Availability of affordable housing	Sanford supports numerous community organizations that provide affordable housing and solutions to community members in need of housing. Examples of community organizations that are supported include The Greater Fargo/Moorhead Economic Development Corporation, Habitat for Humanity, The Fargo, Moorhead, West Fargo Chamber of Commerce, and the United Way of Cass and Clay. The Sanford Shelter Faith Community Nurse program for homeless shelters is located at the YWCA Cass Clay, New Life Center, and at Churches United for the Homeless. Sanford supports other services for the homeless population in our area including the Cooper House, the Coalition for Homeless, the Community of Care Task Force, and the Churches United for the Homeless Gourmet Soup Kitchen.
Homelessness	Sanford serves on the Homeless Coalition. The Sanford Shelter Faith Community Nurse program for homeless shelters is located at the YMCA, New Life Center, and at Churches United for the Homeless. Sanford supports other services for the homeless population in our area including the Cooper House, the Coalition for the Homeless, the Community of Care Task Force, and the Churches United for the Homeless Gourmet Soup Kitchen. Sanford supports the Great Plains Food Bank and the Daily Bread Program.
Hunger	Sanford has a partnership with the Great Plains Food Bank and supports the agency. A new initiative to screen all expectant women at their prenatal visits about their food availability was initiated in 2017. Women who do not have sufficient food at home are provided with food baskets provided to our Sanford locations from the Great Plains Food Bank. Sanford also supports the Daily Bread Program and various "Feed My Starving Children" efforts.
Availability of door-to-door transportation services for those unable to drive	Sanford provides Ready Wheels for those who are in need of transportation and are unable to drive themselves. Sanford also provides taxi fares and vouchers for those who need transportation to medical visits.
Availability of services for at-risk youth	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders. Sanford has a variety of services available that can positively influence some of the identified concerns, e.g., outpatient mental health services, residential treatment programs, and continues to develop more services that will influence children and youth. Sanford supports organizations like Youthworks, Imagine

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
	Thriving, and the Village Family Services to name a few. Also, we support TNT Kids' Fitness that offers their facilities to kids of all abilities, including social and physical challenged children and adults, and we also have a great partnership with the Red River Children's Advocacy Center.
Cost of quality childcare	Dollars raised by employee campaigns as well as our Sanford corporate gift goes to help United Way Cass Clay address the issue of quality and affordability for childcare in our communities.
Availability of quality childcare	Sanford will address this need by sharing the results of the CHNA with community leaders.
Cost of services for at-risk youth	Sanford's Child Advocacy Center is a nationally accredited Child Advocacy Center that provides medical evaluations for children who may be victims of abuse and neglect.
Substance abuse by youth	Sanford supports Face it Together, a behavioral health approach to recovery. Youthworks is an organization that provides numerous services to youth who need additional resources. Imagine Thriving focuses on mental well-being and in their efforts, often they help youth who have addictions. At Sanford, the BHTT serves as an integral core team member within the patient-centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, onsite crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. Sanford will also provide the results of the survey to our local schools and County Health Department.
Teen suicide	Sanford has implemented the Columbia Suicide Severity Rating Scale for evaluation in the clinic setting and has trained First Responders in the community on the assessment tool. Sanford refers patients to the First Link Suicide Prevention Program for close monitoring after discharge.
Childhood obesity	Sanford is addressing childhood obesity in many ways, including the Sanford *fit* program that is available online free of charge. Sanford has made this program available to the local schools for classroom use. In partnership with Sanford *fit*, we also partner with the local SchoolsAlive! program to make sure teachers and para-

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
	professional have resources in order to get kids moving throughout their days. Sanford Wellness Center has a focus on children and youth. Sanford has clinical dietitians, exercise physiologists and primary care providers who are available to work on obesity issues from primary prevention through medical treatment.
Bullying	Sanford will address this need by sharing the results of the CHNA with education and community leaders. The Sanford *fit* program provides positive messages for children and helps them to understand their mood and take positive action.
Cost of long term care	Sanford providers work with patients to help them remain healthy with the ability to live independently. The recent Good Samaritan affiliation will provide the organization with expertise in the area of long term care and assisted living services and help to create efficiencies for members in the communities that we serve.
Cost of memory care	The recent Good Samaritan affiliation will provide the organization with expertise in the area of long term care and assisted living services and help to create efficiencies for members in the communities that we serve.
Cost of in-home services	Sanford provides home health services and participates in the Community Collaborative on Aging. The collaborative provides resource information for seniors and partner organizations provide training on Powerful Tools for Caregivers.
Availability of resources for family & friends caring for & helping make decisions for elders	Sanford participates in the Aging Services Collaborative with membership in the Statewide Aging Collaborative, Quality Health Associates, and the Coalition of Service Providers for the Elderly. The group is dedicated to supporting caregivers and creating awareness of the services that are available to help seniors and their families.
Availability of resources to help the elderly stay safe in their homes	Sanford participates in the Aging Services Collaborative with membership in the Statewide Aging Collaborative, Quality Health Associates, and the Coalition of Service Providers for the Elderly. The group is dedicated to creating awareness of the services that are available to help seniors and their families.
Abuse of prescription drugs	The Sanford Quality Cabinet has implemented a program to reduce opioid prescriptions. At Sanford Fargo, the amount of opioids prescribed during FY 2019 has been reduced by 40%. Sanford provides a take back site at several locations in the community. Sanford is participating in the North Dakota "Reducing Pharmaceutical Narcotics in Our Communities - Through Education and Awareness" committee. The committee has a four-pillar approach including education and awareness, prescription drug take back program, law enforcement, pharmacy partnership, and the prescription drug-monitoring program.
Culture of excessive and binge drinking	Sanford is participating in the Mayors' Blue Ribbon Commission on Addiction.
Domestic violence	YWCA Cass Clay supports women and children escaping domestic violence situations; we partner financially as well as through our Shelter Nurse support.
Child abuse and neglect	Sanford provides financial support and medical experts for the Red River Child Advocacy Center, the multidisciplinary team that coordinates the community's responses to incidents of child abuse.
Sex trafficking	Sanford participates in the SANE nurse program and has a Pediatric and Adolescent Sexual Assault Nurse Examiner available to address women and children who have been trafficked. Sanford is also working closely with the Rape and Abuse Crisis Center, Youthworks, YWCA Cass Clay, the Red River Human Trafficking Response Team, and the Cross Borders Children's Action Network

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
Presence of street drugs	Sanford is participating in the North Dakota "Reducing Pharmaceutical Narcotics in Our Communities -Through Education and Awareness" committee. The committee has a four-pillar approach including education and awareness, prescription drug take back program, law enforcement, pharmacy partnership and the prescription drug monitoring program.
Availability of mental health providers	Sanford has recruited both adult and child psychiatry. Sanford has also invested in placing behavioral health triage therapists in all primary care clinics. They serve to provide immediate access to mental health screening as need is identified. In 2017, Sanford was able to help fund half of a position in the West Fargo Public Schools for a Student Wellness Facilitator position, in partnership with Imagine Thriving and the United Way Cass Clay.
Availability of behavioral health providers	Sanford has embedded Integrated Health Therapists into all primary care locations. Sanford Health Psychiatry and Psychology provides a Licensed Addiction Counselor to provide outpatient addiction/chemical dependency care
Access to affordable health insurance coverage	Sanford contributed nearly $300 million in Community Care (charity care) during FY2017. The charity care contribution in Fargo was $139 million. Financial counselors are available to help patients who need free or discounted care.
Access to affordable health care	Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations. The Sanford Health Plan is available for people seeking affordable health insurance coverage. Sanford provides the Community Care Program and a financial assistance policy to address financial assistance to all who qualify for charity care. During fiscal year 2017, Sanford contributed over $139 million for charity care for our patient population who required care without the ability to pay for services. Sanford has financial counselors available at all clinic and medical center facilities to assist patients with applications for assistance and access needs.
Access to affordable prescription drugs	Sanford's formulary addresses the cost of drugs and includes the highest quality medications at affordable prices. A drug replacement and subsidy program for cancer patients is available for infusion and oral chemotherapy.
Access to affordable dental insurance coverage	Sanford will also address this need by sharing the results of the CHNA with community leaders and legislators.
Availability of non-traditional hours	Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations.
Access to affordable vision insurance coverage	Sanford will also address this need by sharing the results of the CHNA with community leaders and legislators.
Use of emergency room services for primary health care	Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations.
Availability of health care services for Native people	Sanford has several Native American providers and has worked to create cultural competency training for employees and staff.
Coordination of care between providers & services	Sanford has care coordinators who assist patients in securing their needed services.

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
Drug use and abuse	At Sanford, the BHTT serves as an integral core team member within the patient-centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, onsite crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.
Alcohol use and abuse	The BHTT serves as an integral core team member within the patient centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key points: • BHTT role is patient centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.
Depression	Sanford performs a PHQ-9 depression assessment at each primary care visit. Patients have a care plan and the severity of depression is tracked to determine improvement.

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
	At Sanford, the Behavioral Health Triage Therapist (BHTT) serves as an integral core team member within the patient centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, onsite crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community-based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.
Suicide	Sanford has implemented the Columbia Suicide Severity Rating Scale for evaluation in the clinic setting and has trained First Responders in the community on the assessment tool .Sanford refers patients to the First Link Suicide Prevention Program for close monitoring after discharge. Sanford also supports the Out of the Darkness Walk each year in the Fargo-Moorhead community.
Stress	At Sanford, the Behavioral Health Triage Therapist (BHTT) serves as an integral core team member within the patient centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, onsite crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community-based resources.

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
	• They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.
Dementia & Alzheimer's Disease	At Sanford, the Behavioral Health Triage Therapist (BHTT) serves as an integral core team member within the patient centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, onsite crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community-based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.
Not getting enough fruits/vegetables – 60%	Sanford has shared these results with Cass County Public Health, Clay County Public Health, the Cass Clay Hunger Coalition, and other community leaders. Sanford dietitians counsel patients on the importance of consuming adequate amounts of fruits and vegetable and the Sanford Wellness Center provides nutrition classes to engage community members on healthy meal plans.
Not getting enough exercise – 45%	Sanford has invested in athletic facilities to promote activity. Sanford provides one on one nutrition counseling and offers nutrition classes at the Family Wellness Center. The Sanford *fit* program is available online and free of charge to parents and children.
Flu shot – 57%	Sanford providers offer flu shots to all patients. Sanford has also shared these results with Cass County Public Health Clay County Public Health. The *Boo to the Flu* event at Sanford Children's Clomoc provides a fun environment for kids to attend to get their flu shots but also have fun dressing up and playing games, etc.
Overweight or obese – 66%	Sanford offers a multidisciplinary approach to weight management. Individuals may choose one-on-one nutrition therapy services or group meetings to address nutrition, exercise, behavioral health and medical management.
High cholesterol	Sanford providers provide medical management of patients with high cholesterol. Sanford has a quality plan in place to address cardiovascular health. The chronic disease self-management program *Better Choices, Better Health* at Sanford is offered free of charge to community members. *Better Choices. Better Health* is modeled after the Stanford University's chronic disease self-management program. The workshops are 2 ½ hours long and meet weekly for 6 weeks.

Identified Concerns	How Sanford Fargo is Addressing the Community Needs
Hypertension	Sanford providers provide medical management of patients with high cholesterol. Sanford has a quality plan in place to address cardiovascular health. The chronic disease self-management program *Better Choices, Better Health* at Sanford is offered free of charge to community members. *Better Choices. Better Health* is modeled after the Stanford University's chronic disease self-management program. The workshops are 2 ½ hours long and meet weekly for 6 weeks.

Implementation Strategies

2018

Implementation Strategies - 2018

Priority 1: Health Care Access

According to the County Health Rankings for Clinical Care, access to affordable health care is important to physical, social, and mental health. Health insurance, local care options, and a usual source of care help to ensure access to health care. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met.

Sanford has made health care access a significant priority and has developed strategies to promote and improve access to services. It is Sanford's goal that all patients requiring access to health care are successful in securing timely appointments.

Priority 2: Mental Health/Behavioral Health and Substance Abuse

Mental health is important at every stage of life and affects how people think, feel, and act. According to the National Institute of Mental Health, depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors. Depression is among the most treatable of mental disorders.

Sanford has made mental health a significant priority and has developed strategies to reduce mortality and morbidity from mental health, behavioral health and substance abuse. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by addiction and mental illness.

Implementation Strategies Action Plan 2019 - 2021

<u>Priority 1</u>: Health Care Access

Projected Impact: Patients requiring access to health care are successful in securing timely appointments

Goal 1: increase availability of mental health/behavioral health providers

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
A recruitment plan is in place to add behavioral health care providers in the Fargo setting	One provider per year is recruited during 2019, 2020 and 2021	Physician Recruitment team Brad Kohoutek, MD Sherm Syverson	Brad Kohoutek, MD Susan Jarvis	Medical residency program partners
Promote role expansion of Advanced Practice Providers to improve access	# of APPs providing specialty care for behavioral health in 2019, 2020, 2021	Brad Kohoutek,MD Sherm Syverson	Brad Kohoutek,MD Susan Jarvis Brittany Montecuollo	
Improve access through primary care, emergency department and walk-in clinics	# of patients referred to behavioral health services in 2019, 2020, and 2021 from primary care, ED, and walk-in clinics	Cyndy Skorick Andrew Larson Sherm Syverson	Susan Jarvis Brittany Montecuollo	

Goal 2: Provide non-traditional hours in primary care and walk-in clinics

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Explore the need for additional hours	Patient access is monitored in primary care clinic and walk-in clinics to determine the need for additional hours	Andrew Larson Colleen Hughes	Cyndy Skorick	

Goal 3: Decrease the use of emergency services for primary health care

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Monitor ED usage to determine acuity and admit percentage for appropriateness of utilization	ED billed level of care Admission percentage	EDI	Sherm Syverson	
Create a plan to educate patients (decision path) on primary care and walk-in clinic options	# of media posts that provide education on where to go for primary care and for emergency services	Marketing	Cyndy Skorick	

Goal 4: Coordination of care between providers and services

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Provide care coordination/care plan development and referral to internal/external services	# of patients referred to internal services # of patients referred to external services	Care Coordinators	Beth Ashmore	

Priority 2: Mental Health and Substance Abuse

Projected Impact: Comprehensive services are available for patients with mental health and substance abuse diagnosis.

Goal 1: Reduce the opportunity for drug use and abuse

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Continue prescription stewardship initiative to reduce opioid/narcotic prescriptions	# of prescriptions reduced # of pills reduced	Jesse Breidenbach All providers	Doug Griffin, MD	
Explore medication assisted treatment by increasing the number of certified providers	# of providers certified to prescribe suboxone	Andrew Larson	Doug Griffin, MD Jesse Breidenbach	

Goal 2: Patients with alcohol use and abuse receive services through internal or external services

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
IHT services are provided in all Sanford primary care settings	# of visits for alcohol use and abuse	IHT EDA	Cyndy Skorick Andrew Larson	
Assess and refer to medical detox or the withdrawal management unit	# of patients referred for Medical Detox # referred to WMU	ED staff	Sherm Syverson	

Goal 3: Reduce the severity of depression for patients with a PHQ-9 score greater than 9

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Patients with a PHQ-9 score >9 work with IHT and other providers to reduce the severity of depression	# of patients with a PHQ-9 score >9 who achieve a score < 5	IHT Primary care	Mallory Koshiol	

Goal 4: Patients assessment is in place to determine the patients' risk of suicide

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
The Columbia Suicide Severity Rating Scale is executed across primary care clinics in the Fargo market	# of patients who are rated at risk	IHT Emily Guard	Jon Ulven	

Reporting Impact from the 2016 Implementation Strategies

FY 2017 - 2019 Action Plan

Priority 1: Hypertension

Projected Impact: Reduction in the number of patients with uncontrolled hypertension

Goal 1: Protocol-based care

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Nurses are educated on protocol for blood pressure checks and rechecks Standardized nursing protocol for rechecks and referral will be implemented throughout all departments	The number of patients who have blood pressure < 140/90	Melodi Krank All nurses	Roberta Young, CNE Tracy Kaeslin, VP	Resources: American Heart Association North Dakota Hypertension Task Force

Priority 2: Depression Remission

Projected Impact: Reduction in the severity of depression

Goal 1: Improve PHQ-9 scores for patients with depression

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Develop Sanford MyChart capabilities for depression assessment	Percentage of patients with major depression or dysthymia and an initial PHQ-9 score greater than 9 whose 6-month PHQ-9 score was less than five	Mallory Koshiol	Heidi Twedt, MD	First Link
Provide education on workflow to all RN Health Coaches and panel specialists to standardize workflow	All RN Health Coaches in primary care receive education on workflow	Mallory Koshiol All RN Health Coaches	Heidi Twedt, MD	

Priority 3: **Flu Vaccines**

Projected Impact: Reduction of influenza cases in our community through more community members obtaining an annual flu vaccine

Goal 1: Increase the number of flu vaccines provided to community members

Actions/Tactics	Measurable Outcomes and Timeline	Dedicated Resources/ Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Develop consumer education materials about the importance of the annual flu vaccine Conduct flu blitz clinics at various clinic locations in the community	Number of flu vaccines give to the adult population	Melodi Krank Sanford Nurses Employee Health Coding Guest Services	Roberta Young, CNE Tracy Kaeslin, VP	Community volunteers
Provide flu vaccines to the pediatric population	Number of flu vaccines given to the pediatric population	Melodi Krank Sanford Nurses Employee Health Coding Guest Services	Roberta Young, CNE Tracy Kaeslin, VP	

Demonstrating Impact – Addressing the Needs
FY 2017 – 2019 Action Plan

Priority 1: Hypertension

Hypertension is a risk factor for cardiovascular disease and contributes to premature death from heart attack, stroke, diabetes and renal disease. The North Dakota Department of Health reports that 27.7% of the population in Cass County has been told by their provider that they have hypertension.

Sanford prioritized hypertension as a top priority for 2017-2019 and has set strategy to standardize nursing protocol for blood pressure checks and rechecks. The goal is to reduce the number of patients with uncontrolled hypertension. The measureable outcome is the number of patients with blood pressure < 140/90. This goal has been reached for 87.8% of patients with hypertension.

Priority 2: Depression

Depression is a common but serious illness that can interfere with daily life. Many people with a depressive illness never seek treatment. However, the majority, even those with the most severe depression, can get better with treatment. The North Dakota Department of Health reports that 11.9% of residents in Cass County have reported fair or poor mental health days. County Health Rankings for Clay County indicates that 11% of the residents have fair or poor mental health.

Sanford has prioritized depression as a top priority and has set strategy to perform assessments for depression and to improve PHQ-9 scores for patients who are diagnosed with depression. The goal is to improve PHQ-9 scores for patients with depression. The measurable outcome is the percentage of patients with major depression or dysthymia and an initial PHQ-9 score greater than 9 whose 6-month PHQ-9 score is less than 5. This goal has been reached by 10.7% of patients with a depression diagnosis.

Priority 3: Flu Vaccines

The CDC states that influenza is a serious disease that can lead to hospitalization and sometimes even death. Every flu season is different, and influenza infection can affect people differently. Even healthy people can get very sick from the flu and spread it to others. The North Dakota Department of Health reports that 33.5% of adults age 65 and older did not receive a flu vaccine in the past year. Respondents to the CHNA generalizable survey report that 26% of children 18 years and younger did not receive a flu vaccine in the past year.

Sanford has prioritized flu vaccines as a top priority and has set strategy to increase the number of flu vaccines provided to community members. The goal is to increase the number of flu vaccines provided to community members. The measurable outcomes are the number of flu vaccines given to adults each year and the number of flu vaccines given to the pediatric population each year. The combined number of flu vaccines given in FY 2016 was 2675, in FY 2017, it was 2518 and in FY 2018, the total was 2017.

Community Feedback from the 2016 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on the 2016 Community Health Needs Assessment and has provided online comment fields on our website for ease of access. There have been no comments or questions about the Sanford Medical Center's CHNA.

Appendix

Primary Research

Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Economic Well Being	• Housing that accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence 4.22 • Availability of affordable housing 4.21 • Homelessness 3.88 • Hunger 3.64			Housing resources: • Cass Co. Housing Authority, 230 – 8th Ave. W., West Fargo • Cass Co. Social Services (help w/utility costs), 1010 – 2nd Ave. S., Fargo • Clay Co. Hsg. & Redevelopment Authority, 116 Center Ave. E., Dilworth • Down payment & Closing Costs Assistance Program, ND Housing & Finance Agency, 2624 Vermont Ave., Bismarck • Fargo Hsg. & Redevelopment Authority, 325 Broadway, Fargo • Home Key Program, ND Housing & Finance Agency, 2624 Vermont Ave., Bismarck • Housing Rehab Program, 200 – 3rd St. N., Fargo • Jeremiah Program, 3104 Fiechtner Dr., Fargo • Lake Agassiz Habitat for Humanity, 210 N. 11th St., Moorhead • LSS HUD Housing Counseling, 1325 – 11th St. S., Fargo • Moorhead Public Housing, 800 – 2nd Ave. N., Moorhead • ND Housing & Finance Agency, 2624 Vermont Ave., Bismarck • Presentation Partners in Housing, 1101 – 32nd Ave. S., Fargo • Rental Assistance - ND Dept. of Commerce, 1600 E. Century Ave., Bismarck • ReStore (thrift store for construction, homes, etc.), 210 N. 11th St., Moorhead • Salvation Army (provides assistance with hsg. &	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				utilities), 304 Roberts St., Fargo • Section 8 Hsg. Choice Voucher Program, 325 Broadway, Fargo • SENDCAA weatherization program & low income hsg., 3233 University Dr. S., Fargo • SENDCA (emergency rent/ utilities), 3233 S. Univ. Dr., Fargo • Village HUD Housing Counseling, 1201 – 25th St. S., Fargo • Wells Fargo Assist (to help those with payment challenges), 1-800-678-7986 Transitional housing resources: • Centre, Inc., 123 – 15th St. S., Fargo • Lakes & Prairies Transitional Housing Program, 715 – 11th St. N., Moorhead • Red River Recovery Center, 701 Center Ave. E., Dilworth • SE Human Service Center Alcohol & Drug Abuse Unit, 2624 – 9th Ave. S, Fargo • ShareHouse, 4227 – 9th Ave., Fargo • YMCA, 3100 – 12th Ave. N., Fargo • Youthworks, 317 S. University, Fargo Low income/subsidized housing resources: • Amber Valley Apts., 4854-5150 Amber Valley Pkwy S., Fargo • Arbor Park Village, 530 – 30th St. N., Moorhead • Bluestem Townhomes, 4518 Blue Stem Ct. S., Fargo • Burrel Apts., 409 – 4th St. N., Fargo • Candlelight, 2000-2100 – 21st Ave. S., Fargo • Century Square, 3820 – 25th St. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Chestnut Ridge, 3141 – 32nd St. S, Fargo • Church Townhomes, 1538 – 16-1/2 St. S., Fargo • Colonial Apts., 355 – 4th Ave. N., Fargo • Community Homes I, 702 – 23rd St. S., Fargo • Community Homes II, 2210 – 6th Ave. S., Fargo • Cooper House, 414 – 11th St. N., Fargo • Country Edge Townhomes, 3066 – 34th St. S., Fargo • Crossroads Senior Living, 1670 E Gateway Cir. S., Fargo • Fieldcrest Townhomes, 1801 Belsly Blvd., Moorhead • Fieldstone Village, 4574 – 44th Ave. S., Fargo • Fraser Hall, 717 Univ. Dr. S., Fargo • Graver Inn, 123 Roberts St., Fargo • Hazelwood Townhomes, 3031 – 33rd St., Fargo • Jadestone, 1544 E. Gateway Cir. S., Fargo • Lashkowitz High Rise, 101 – 2nd St. S., Fargo • Maybrook, 3219 – 18th St. S., Fargo • New Horizons, 2525 N. Bdwy, Fargo • Northland Apartments, 1115 -23rd St. S., Fargo • Park Place, 2701 – 32nd Ave. S., Fargo • Park View Terrace Apts., 100 – 3rd St. N., Moorhead • Riverview Hts, 800 - 2nd Ave. N., Moorhead • River Square I & II, 1250-1251 – 54th Ave. S., Fargo • Sunrise North, 350 – 26th Ave. N., Fargo • Sterling Park, 3140-3160 – 33rd St. S., Fargo • The 400, 400 Broadway, Fargo • University Drive Manor, 1201 – 2nd Ave. N., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Village Green Manor, 3501 Village Green Dr., Moorhead • Windwood Townhomes, 4427 – 44th St. S., Fargo Homelessness resources: • Churches United, 1901 – 1st Ave. N., Moorhead • Cooper House, 414 – 11th St. N., Fargo • Dorothy Day House, 714 – 8th St. S., Moorhead • Family HealthCare Center (main clinic), 301 NP Avenue, Fargo • FHC Moorhead Dental Clinic, 715 -11th St. N., Moorhead • FHC S. Fargo clinic, 4025 – 9th Ave. S., Fargo • FHC West Fargo clinic, 726 – 13th Ave. E., West Fargo • Fraser, Ltd., 2902 S. Univ., Fargo • Gladys Ray shelter & Veteran Drop In Center, 1519 – 1st Ave. S., Fargo • Homeless Health Services, 311 NP Avenue, Fargo • Open Doors, 213 NP Ave., Fargo • Myrt Armstrong Recovery Center, 1419 – 1st Ave. S., Fargo • Native American Center, 109 – 9th St. S. Fargo • New Life Center, 1902 – 3rd Ave. N., Fargo • Stepping Stones, 2901 S. Univ., Fargo • Youthworks, 317 S. University, Fargo • YWCA Shelter, 3000 S. University, Fargo Hunger resources: • Churches United food baskets, 1901 – 1st Ave. N., Moorhead • Dorothy Day West food baskets, 2820 Bluestem Dr., West Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• YWCA food baskets, 3000 S. Univ., Fargo • New Life Center meals & bagged lunches, 1902 – 3rd Ave. N., Fargo • Salvation Army meals, 304 Roberts St., Fargo • Grocery Stores o Family Fare (various locations) o Hornbacher's (various locations) o Cash wise (various locations) o Prairie Roots Food Co-op, 1213 NP Ave., Fargo o Natural Grocers, 4517 – 13th Ave. S., Fargo o Tochi, 1111 – 2 Ave., N., Fgo • Food Pantries: o Dorothy Day Food Pantry, 1308 Main Ave., Moorhead o Churches United Food Pantry, 1901 – 1st Ave. N., Moorhead o Centro Cultural de Fgo/Mhd, 1014 - 19th St. S., Moorhead o Emergency Food Pantry, 1101 – 4th Ave. N., Fargo o Emergency Food Pantry, 1438 – 10th St. N., Fargo o Great Plains Food Bank, 1720 – 3rd Ave. N., Fargo o Family Worship Center Food Pantry, 1419 – 17th St. S., Fargo o 1st Assembly Food Pantry, 3401 – 25th St. S., Fargo o Latter Rain Ministries Food Shelf, 1603 – 5th St. N., Fargo o New Life Center Food Shelf, 1902 – 3rd Ave. N., Fargo o YWCA Emergency Food Pantry, 3000 S. University Dr., Fargo o Salvation Army Food Pantry, 304 Roberts St., Fargo o SENDCA Food Pantry, 3233 S. Univ. Dr., Fargo o Bosnian & Herzegovian Community Food Pantry, 303 Roberts St., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Farmers Markets: o Farmers Market @ Blue Cross, 45th St. & 13th Ave. S., Fargo o NoMo Farmers Market, 14156 – 1st Ave. N., Moorhead o Red River Market, 4th Ave. & N. Bdwy, Fargo o Ladybug Acres, 2110 Univ. Dr. S., Fargo o Hildebrant Farmers Market, 349 Main Ave. E., West Fargo o Moorhead Farmer Market, 4th & Center Ave., Moorhead o Farmers Market @ West Acres, 3902 – 13th Ave. S., Fargo o Farmers Market & Beyond, 500 -1 3th Ave. W., West Fargo o Dilworth Farmers Market, 4th St. NE & Hwy. 10, Dilworth	
Transportation	• Availability of door-to-door transportation services for those unable to drive 3.55			Transportation resources: • Anytime Transportation, 1403 – 13-1/2 St. S., Fargo • CareAVan Mobility 4U Inc., 2626 S. Bay Dr., Fargo • Doyle Taxi, 1418 Main Ave., Fargo • Handi-Wheels, 2525 Bdwy. N., Fargo • Lucky 7 Taxi, 909 – 14th St. N., Fargo • Metro Senior Ride Service, 2801 – 32nd Ave. S., Fargo • Metro Area Transit (regular buses), 650 – 23rd St. N., Fargo • Metro Transit (paratransit buses), 650 – 23rd St. N., Fargo • Ready Wheels, 2215 – 18th St. S., Fargo	
Children and Youth	• Availability of services for at-risk youth 4.11 • Cost of quality child care 4.08 • Availability of quality child care 3.99			Services for at-risk youth: • Boys & Girls Club, 2500 – 18th St. S., Fargo • Cass Co. Social Services, 1010 – 2nd Ave S., Fargo • Cass Co. Family Services Division, 211 – 9th St. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	• Cost of services for at-risk youth 3.96 • Substance abuse by youth 3.89 • Teen suicide 3.89 • Childhood obesity 3.86 • Bullying 3.65			• Cass Co. Youth Commission, 211 – 9th St. S., Fargo • Catholic Family Services, 5201 Bishops Blvd., Fargo • CHARISM, 122-1/2 N. Bdwy, Fargo • Christian Family Life Services, 2360 – 7th Ave. E., West Fargo • Clay Co. Social Services, 715 – 11th St. N., Moorhead • Early Intervention Program, SE Human Service Center, 2624 – 9th Ave. S., Fargo • Family HealthCare Center, 301 NP Avenue., Fargo • Fargo Youth Commission, 2500 – 18th St. S., Fargo • Fargo Youth Initiative, 200 -3rd St. N., Fargo • FM Youth Center, 2500 – 18th St. S., Fargo • Follow Along Program, MN Department of Health, Box 64975, St. Paul, MN • Head Start, 3233 S. Univ., Fargo • Head Start, 715 – 11th St. N., Fargo • Lutheran Social Services of MN, 3508 – 10th Ave. S., Moorhead • Lutheran Social Services of ND, 3911 – 20th Ave. S., Fargo • Parenting Resource Center (NDSU Extension), 1010 – 2nd Ave. S., Fargo • Right Track (ND Dept. of Human Services), 2624 – 9th Ave. S., Fargo • SENDCA, 3233 Univ. Dr. S., Fargo • Village Family Service Center, 1201 – 25th St. S., Fargo • Stepping Stones Resource Center, 2902 S. Univ., Fargo • Youthworks, 317 S. Univ., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Youth Center @ Rose Creek, 4809 S. University, Fargo Child care resources: • ABC Sandcastle, 2502 – 18th St. S., Fargo • ABC 123, 1700 Center Ave. W., Dilworth • ABC Infant Daycare, 3505 – 8th St. S., Moorhead • Academy for Children, 20 – 8th St. S., Fargo • Beginnings, 521 – 32nd Ave. W., West Fargo • Betty's Busy Bees, 1426 – 16-1/2 St. S., Fargo • • Bright Futures, 2600 -52nd Ave. S., Fargo • Centered on Kids, 861 Belsly Blvd., Moorhead • • Child Care Aware, 3911 – 20th Ave. S., Fargo • Child Care Resource & Referral, 715 – 11 St. N., Fargo • Child Care Assistance Program, ND Dept. of Health Services, 600 E. Blvd., Bismarck • Cobber Kids, 1306 – 3rd St. S., Moorhead • Curious Kids, 1109 – 19th Ave. N., Fargo • Early Explorers, 2935 – 13th St. S., Moorhead • Early Years, 1209 Center Ave. W., Dilworth • Elim Children's Center, 3534 University Dr. S., Fargo • Great Beginnings, 121 – 17th St. N., Moorhead • Happy Days, 2824 Bdwy, Fargo • Here We Grow, 3247 – 39th St. S., Fargo • Here We Grow, 3247 – 39th St. S., Moorhead • Hope Lutheran, 2900 Broadway, Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Kids Being Kids, 1004 Westrac Dr. S., Fargo • Kiddiland, 1027 – 15 St. S., Fargo • Sanford Child Care, 502 – 7th St. N., Fargo • Lil Bloomers, 4656 – 40th Ave. S., Fargo • Lil Bloomers, 5170 Prosperity Way, Fargo • MSUM Early Education Center, 1213 – 6th Ave. S., Moorhead • Our Redeemer, 100 – 14th St. S., Moorhead • Small Wonders, 4745 Amber Valley Pkwy, Fargo • Sorock Premier Nanny Services, 200 – 5th St. S., Moorhead • Tot Spot, 820 Page Dr., Fargo • Tracy McDougall's Kids, 3411 – 12th St. S., Moorhead • WeeKare Childcare Center, 23002 – 30-1/2 Ave. S., Fargo • YMCA, 400 – 1st Ave. S., Fargo Substance abuse resources: • AA, 1112 – 3rd Ave. S., Fargo • AA Red Road to Recovery, 109 – 9th St. S., Fargo • AA Club House, 1112 – 3rd Ave. S., Fargo • ADAPT, Inc., 1330 Page Dr., Fargo • Anchorage, 725 Center Ave., Moorhead • Burl, Eddie DUI Seminar, 1351 Page Dr., Fargo • Cass Co. Public Health Detox, 1240 – 25th St. S., Fargo • Celebrate Recovery, 21 – 9th St. S., Fargo • Centre, Inc., 123 – 15th St. N., Fargo • Clay Co. Chemical Dependency, 715 – 11th St. N., Moorhead	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Clay County Detox, 715 – 11th St. N., Moorhead • Clay Co. Social Services, 715 – 11th St. N., Moorhead • Codependents Anonymous, 1330 S. University Dr., Fargo • Discovery Counseling, 115 N. University, Fargo • Drake Counseling, 1202 - 23 St. S., Fargo • First Step Recovery, 409 – 7th St. S., Fargo • Gamblers Choice, LSS, 3911 – 20th Ave. S., Fargo • Gull Harbor Apts., 1704 Belsly Blvd., Moorhead • Howe, Robert E., 1445 – 1st Ave. N., Fargo • Journey Counseling, 222 N. Broadway, Fargo • Lost & Found Ministry, 111 – 7th St. S., Moorhead • McGrath, Claudia Counseling, 417 – 38th St. S., Fargo • Narcotics Anonymous, 18 – 18th St. S., Fargo • New Hope Recovery, 118 Bdwy, Fargo • Only Human Counseling, 118 Bdwy, Fargo • Pathways Counseling & Recovery Center, 1306 – 9th St. N., Fargo • Positive Solutions, 6245 – 16th St. S., Fargo • Prairie St. John's, 510 - 4th St. S., Fargo • Prairie St. John's, 2925 – 20th St. S., Moorhead • Safe Harbor, 810 – 4th Ave. S., Moorhead • Sanford Behavioral Health Center, 100 – 4th St. S., Fargo • SE Human Service Center, 2624 – 9th Ave. S., Fargo • Sexaholics Anonymous, 701-235-7335 • ShareHouse, 4227 – 9th Ave. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• ShareHouse Wellness Center, 715 N. 11th St., Moorhead • Simon Chemical Dependency Services, 3431 – 4th Ave. S., Fargo • SMART Recovery, 1260 N. University Dr., Fargo • SMART Recovery, 200 – 5th St. S., Moorhead • Shiaro, Chris Counseling, 4227 – 9th Ave. S., Fargo • Sister's Path, 4219 – 9th Ave. S., Fargo • Veterans Administration, 2101 N. Elm, St., Fargo • Village Family Service Center, 1201 – 25th St. S., Fargo • Village Family Service Center, 1401 – 8th St. S., Moorhead • Vosburg Counseling for Seniors, 810 – 4th Ave. S., Moorhead Mental Health resources: • Alzheimer's Association, 2631 – 12th Ave. S., Fargo • ARC of West Central MN, 810 – 4th Ave. S., Moorhead • Catholic Family Services, 5201 Bishops Blvd., Fargo • Clay Co. Public Health, 715 – 11th St. N., Moorhead • Clay Co. Social Services, 715 – 11th St. N., Moorhead • Community Outreach Center (on MSUM Campus), Lommen Hall 113, Moorhead MN • Creative Care for Reaching Independence (CCRI), 2903 – 15th St. S., Moorhead • Drake Counseling Services, 1202 – 23rd St. S., Fargo • Essentia (Fargo & Mhd locations) • Fargo VA, 2101 Elm St. N., Fargo • Fargo Cass Public Health, 1240 – 25th St. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• FirstLink, 4357 – 13th Ave. S., Fargo • Human Service Associates, 403 Center Ave., Moorhead • Heartland Industries, 2600 – 16th Ave. S., Moorhead • Lakeland Mental Health, 1010 - 32nd Ave. S., Moorhead • Living Free, Jail Chaplains, P. O. Box 6444, Fargo o Insight (women) o Stepping into Freedom (men) o Anger: Our Master (men) • Lutheran Social Services of ND, 3911 – 20th Ave. S., Fargo • Lutheran Social Services of MN, 715 – 11th St. N., Moorhead • Mental Health America, 112 N. University, Fargo • Mobile Mental Health Crisis Team, 2624 – 9th Ave. S., Fargo • Prairie St. John's, 510 - 4th St. S., Fargo • Prairie St. John's, 2925 – 20th St. S., Moorhead • Rape & Abuse Crisis Center, 317 – 8th St. N., Fargo • Red River Health Services Foundation, 1104 – 2nd Ave. S., Fargo • Safe Harbour, 1003 – 18-1/2 St. S., Moorhead • Sanford Health Behavioral Health, 100 – 4th St. S., Fargo • SENDCA, 3233 S Univ., Fargo • SE Human Services, 2624 – 9th Ave. S., Fargo • Solutions, 891 Belsly Blvd., Moorhead • Tran$ Em (Transitional Supported Employment of MN), 810 – 4th Ave. S., Moorhead	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Village Family Service Center, 1201 – 25th St. S., Fargo • Village Family Service Center, 1401 – 8th St. S., Moorhead • Vosburg Counseling for Seniors, 810 – 4th Ave. S., Moorhead Smoking Cessation resources: • BAN Program (Break Away from Nicotine) – Fargo Cass Public Health, 1240 – 25th St. S., Fargo • ND Quits (ND Dept. of Health) – 600 E. Blvd. Ave., Bismarck • Sanford Health – 701-234-5191 (tobacco cessation counselor) • Sanford Health – 701-234-6452 (tobacco & asthma education) • Fargo Cass Public Health (health educator), 1240 – 25th St. S., Fargo • Essentia Health (tobacco treatment specialist), 3000 – 32nd Ave. S., Fargo • Fargo VA, 2101 Elm St. N., Fargo • Breath ND, Fargo Cass Public Health, 1240 – 25th St. S., Fargo • Clay Co. Public Health, 715 – 11th St. N, Moorhead Obesity resources: • Anytime Fitness, 1801 – 45th St. S., Fargo • Anytime Fitness, 5050 Timber Pkwy S., Fargo • Anytime Fitness, 2614 N. Bdwy, Fargo • Anytime Fitness, 935 – 37th Ave. S., Moorhead • Core Fitness, 2424 – 13th Ave. S., Fargo • Cold Fusion, 114 Bdwy, Fargo • Courts Plus, 3491 S. Univ., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Cross Fit, 1620 – 1st Ave. N., Fgo. • Curves, 123 – 21st St. S., Mhd. • Eating Disorders Support Group, Sanford, 1720 S. University, Fgo. • Edge Fitness, 6207 – 53rd Ave. S., Fargo • Elements Fitness, 3120 – 25th St. S., Fargo • Fargo Park District, 701 Main Ave., Fargo • Fitness 52, 2600-52nd Ave. S. Fgo. • Fitness 4 Life, 1420 – 9th St. E., West Fargo • Gastric Bypass Support Group, Atonement Lutheran, 4201 S. University, Fargo • Health Pros personal training, 2108 S. University, Fargo • LA Weight Loss Center, 5050 – 13th Ave. S., Fargo • Ladies Workout Express, 1420 – 9th St. E., West Fargo • Max Training, 1518 - 29th Ave. S., Moorhead • Metro Rec Ctr., 3110 Main, Fgo • Moorhead Park District, 324 – 24th St. S., Moorhead • No More Diets Support Group, • Overeaters Anonymous, OA.org • Planet Fitness, 4325 – 13th Ave. S., Fargo • Planet Fitness, 800 Holiday Dr., Moorhead • Red River Traditional Tae Kwon Do, 1335 Main, Fargo • Sanford Dietitians, 801 Bdwy, Fargo • Sanford Eating Disorders & Wt. Management Center, 1717 S. University, Fargo • Sanford Family Wellness Center, 2960 Seter Parkway, Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Slim Ambition, 1365 Prairie Pkwy, Fargo • Snap Fitness, 4265 - 45th St. S., Fargo • Take Off Pounds Sensibly, TOPS.org • TNT Kids' Fitness, 2800 Main, Fargo • Total Balance, 1461 Bdwy N., Fgo • Total Woman Fitness, 508 Oak St. N., Fargo • Touchmark Fitness, 1200 Harwood Dr. S., Fargo • Valley Fitness, 3820 – 12th Ave. N., Fargo • Welcyon Fitness, 2603 Kirsten Lane S., Fargo • West Fargo Fitness Center, 215 Main Ave., West Fargo • YMCA, 400 – 1st Ave. S., Fargo • YMCA, 4243 – 19th Ave. S., Fargo Safety (bullying) resources: • Cass Co. Sheriff, 1612 – 23rd Ave. N., Fargo • Clay Co. Sheriff, 915 – 9th St. N., Moorhead • Moorhead Police, 915 – 9th Ave. N., Moorhead • Fargo Police, 222 – 4th St. N., Fgo	
Aging Population	• Cost of long term care 4.15 • Cost of memory care 4.08 • Cost of in-home services 3.83 • Availability of resources for family & friends caring for & helping make decisions for elders 3.58 • Availability of resources to help the elderly stay safe in their homes 3.52			Nursing Home resources: • Bethany, 201 S. University, Fargo • Bethany, 4255 – 30 Ave. S., Fargo • Ecumen Evergreens, 1401 W. Gateway Circle, Fargo • Ecumen Evergreens, 503 – 3rd Ave. S., Moorhead • Edgewood Vista, 4420 – 37th Ave. S., Fargo • Elim Care, 3524 S. Univ., Fargo • Eventide, 225 – 13th Ave. W., West Fargo • Eventide, 3225 – 51st St. S., Fargo • Eventide, 1405 – 7th St. S., Mhd.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Eventide, 801 – 2nd Ave. N., Mhd. • Farmstead Care, 3200 – 28th St. S., Moorhead • Farmstead Estates, 3433 – 28th St. S., Moorhead • ManorCare, 1315 S. Univ., Fargo • Maple View Memory Care, 4552 – 36th Ave. S., Fargo • Moorhead Rehab & Healthcare Center, 2810 – 2nd Ave. N., Mhd. • Rosewood, 1351 N. Bdwy., Fargo • Villa Maria, 3102 S. Univ., Fargo Alzheimer's/Dementia resources: • After the Diagnosis Support Group (for those diagnosed with Alzheimer's & dementia), 736 Broadway, Fargo • Alzheimer's Caregiver Support Group, 2702 – 30th Ave. S., Fargo • Alzheimer's Support Group, 202 – 1st Ave. N., Moorhead • Alzheimer's Assn., 2631 – 12 Ave. S., Fargo • Arbor Park Village, 520 - 28 St. N., Moorhead • Bethany – 201 S. Univ., Fargo • Early Onset Memory Loss Support Group, 701-277-9757 • Edgewood Vista, 4420 – 37 Ave. S., Fargo • Elim Care, 3534 S. Univ., Fargo • Eventide/Fairmont, 801 – 2nd Ave. N., Moorhead • Evergreens, 503–3rd Ave. S., Mhd • Evergreens, 1401 W. Gateway Circle, Fargo • Morning Out (for those who have Alzheimer's or other dementia), 610 -13th St. N., Mhd.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• River Pointe, 2401 – 11th St. S., Moorhead Resources to assist the elderly in staying in their homes: • Access, 403 Center Ave., Mhd. • Active at Home Helpers, 417 Main Ave., Fargo • Care 2000, 725 Ctr. Ave., Mhd. • Change is Good (helping the elderly to downsize), 9533 – 70 St. S., Sabin MN • Comfort Keepers, 12205 - 4 Ave. S., Fargo • Community Living Services, 1001 – 28 St. S., Fargo • Coram Healthcare, 2901 S. Frontage Rd., Mhd. • C & R Quality Living, 1336 – 25 Ave. S., Fargo • Griswold Home Health, 819 – 30 Ave. S., Moorhead • Heart 2 Heart, 701-200-7828 • HERO, 5012 – 53 St. S., Fargo • Home Instead Home Care, 505 Broadway, Fargo • Lincare, 1609 – 323 Ave. S., Fargo • LSS Senior Companion Program, 3911 – 20 Ave. S., Fargo • LSS Senior Nutrition Program, 715 – 11 St. N., Moorhead • LSS MN Caregiver Respite Services, 715 – 11 St. N., Mhd. • Meals on Wheels, 2801 – 32 Ave. S., Fargo • Meals on Wheels, 465 Rensvold Blvd., Moorhead • Midwest Community Residential Services, 800 Holiday Dr., Mhd. • Prairieland Home Care, 1202 Page Dr., Fargo • Right at Home, 15 Bdwy., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?

				• Sanford Healthcare Accessories, 3223 – 32 Ave. S., Fargo
				• Sanford Home Care, 100 – 4 St. S., Fargo
				• Sanford Personal Care, 100 – 4 St. S., Fargo
				• Sisters of Mary Home Care, 1202 Page Dr., Fargo
				• Tami's Angels, 624 Main Ave., Fargo
				• Caregiver resources:
				  • Alzheimer's Caregiver Support Group, 2702 – 30 Ave. S., Fargo
				  • Alzheimer's Support Group for those with family member in Eventide, 801 – 2 Ave. N., Mhd.
				  • Caregiver's Support Group, 2010 Elm St., Fargo
				  • Caregiver Support & Respite Program, 218 – 10th St. S., Mhd
				  • Family Caregiver Support Program, ND Dept. of Human Services, 1237 W. Divide Ave., Bismarck
				  • FamilyHospice support for widows & widowers, 1701 – 38 St. S., Fgo.
				  • Mhd Caregiver Discussion Group, 210 – 7th St., S, Mhd.
				  • Support Group for Alzheimer's Caregivers (young onset)
				• Elderly Nutrition Services:
				  • Cash Wise (grocery delivery – several locations)
				  • Congregate Meals (Fargo, W Fargo & Moorhead)
				  • Family Fare (grocery delivery – several locations)
				  • Hornbacher's (grocery delivery – several locations)
				  • LSS Senior Nutrition Program, 715 – 11 St. N., Moorhead
				  • Meals on Wheels, 2801 – 32 Ave. S., Fargo
				  • Meals on Wheels, 465 Rensvold Blvd., Moorhead	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Elder Care (adult day care): • Adult Life Program (Heartland Industries), 2600 – 16 Ave. S., Moorhead • Arbor Park, 520 28 St. N., Fgo • Bethany Day Services, 201 S. University, Fargo • Cass Co. Social Services, 1010 – 2 Ave. S., Fargo • Evergreens, 1401 W. Gateway Cir., Fargo • Evergreens, 502–3 Ave. S., Mhd • Fairmont Adult Day Care, 801 – 2 Ave. N., Moorhead • Home Appeal, 3805 – 43 Ave S., Moorhead • Home Instead Senior Care, 505 Broadway, Fargo • Kinder Care Home, 2235 Shiloh St., West Fargo • Rainbow Square (adult daycare at Rosewood), 1351 Bdwy, Fgo • River Pointe, 2401 – 11 St. S., Moorhead • Villa Maria Club Connection, 31102 S. Univ., Fargo	
Safety	• Abuse of prescription drugs 4.17 • Culture of excessive & binge drinking 3.81 • Domestic violence 3.80 • Child abuse & neglect 3.68 • Sex trafficking 3.59 • Presence of street drugs 3.55			Substance Abuse resources: • AA, 1112 – 3rd Ave. S., Fargo • AA Red Road to Recovery, 109 – 9th St. S., Fargo • AA Club House, 1112 – 3rd Ave. S., Fargo • ADAPT, Inc., 1330 Page Dr., Fargo • Anchorage, 725 Center Ave., Moorhead • Burl, Eddie DUI Seminar, 1351 Page Dr., Fargo • Cass Co. Public Health Detox, 1240 – 25th St. S., Fargo • Celebrate Recovery, 21 – 9th St. S., Fargo • Centre, Inc., 123 – 15th St. N., Fargo • Clay Co. Chemical Dependency, 715 – 11th St. N., Moorhead • Clay County Detox, 715 – 11th St. N., Moorhead • Clay Co. Social Services, 715 – 11th St. N., Moorhead	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Codependents Anonymous, 1330 S. University Dr., Fargo • Discovery Counseling, 115 N. University, Fargo • Drake Counseling, 1202 - 23 St. S., Fargo • First Step Recovery, 409 – 7th St. S., Fargo • Gamblers Choice, LSS, 3911 – 20th Ave. S., Fargo • Gull Harbor Apts., 1704 Belsly Blvd., Moorhead • Howe, Robert E., 1445 – 1st Ave. N., Fargo • Journey Counseling, 222 N. Broadway, Fargo • Lost & Found Ministry, 111 – 7th St. S., Moorhead • McGrath, Claudia Counseling, 417 – 38th St. S., Fargo • Narcotics Anonymous, 18 – 18th St. S., Fargo • New Hope Recovery, 118 Bdwy, Fargo • Only Human Counseling, 118 Bdwy, Fargo • Pathways Counseling & Recovery Center, 1306 – 9th St. N., Fargo • Positive Solutions, 6245 – 16th St. S., Fargo • Prairie St. John's, 510 - 4th St. S., Fargo • Prairie St. John's, 2925 – 20th St. S., Moorhead • Safe Harbor, 810 – 4th Ave. S., Moorhead • Sanford Behavioral Health Center, 100 – 4th St. S., Fargo • SE Human Service Center, 2624 – 9th Ave. S., Fargo • Sexaholics Anonymous, 701-235-7335 • ShareHouse, 4227 – 9th Ave. S., Fargo • ShareHouse Wellness Center, 715 N. 11th St., Moorhead • Simon Chemical Dependency Services, 3431 – 4th Ave. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• SMART Recovery, 1260 N. University Dr., Fargo • SMART Recovery, 200 – 5th St. S., Moorhead • Shiaro, Chris Counseling, 4227 – 9th Ave. S., Fargo • Sister's Path, 4219 – 9th Ave. S., Fargo • Veterans Administration, 2101 N. Elm, St., Fargo • Village Family Service Center, 1201 – 25th St. S., Fargo • Village Family Service Center, 1401 – 8th St. S., Moorhead • Vosburg Counseling for Seniors, 810 – 4th Ave. S., Moorhead Domestic violence resources: • City of Fargo Victim Support Services, 200 – 3rd St. N., Fargo • CAWS North Dakota, 521 E. Main, Bismarck • Guardian & Protective Services, 112 N. University, Fargo • Protection & Advocacy Project, 1351 Page Dr., Fargo • Rape & Abuse Center, 317 – 8th St. N., Fargo • YWCA Shelter, 3000 S. Univ., Fgo • MN Coalition for Battered Women, 60 E. Plato Blvd., St. Paul, MN • Victim Advocacy Program (Community Health Service), 810 – 4th Ave. S., Moorhead Child abuse/neglect resources: • Cass Co. Child Abuse/Neglect office, 1011 – 2nd Ave. S., Fargo • Guardian & Protective Services, 112 N. University, Fargo • ND Child Protection Program, 600 E. Blvd. Ave., Bismarck	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Protection & Advocacy Project, 1351 Page Dr., Fargo • Red Flag Green Flag Advocacy Project, 317 – 8th St. N., Fargo • Red River Children's Advocacy Center, 100 – 4th St. S., Fargo • Sanford Child & Adolescent Maltreatment Center, 100 - 4th St. S., Fargo Elder Abuse resources: • Adult Protective Services, 715 – 11 St. N., Moorhead • Cass Co. Sheriff, 1612 – 23rd Ave. N., Fargo • Clay Co. Elder Abuse Project, 715 – 11 St. N., Moorhead • Clay Co. Sheriff, 915 – 9th St. N., Moorhead • Fargo Police, 222 – 4th St. N., Fgo • Guardian & Protective Services, 112 N. University, Fargo • Moorhead Police, 915 – 9th Ave. N., Moorhead • Protection & Advocacy Project, 1351 Page Dr., Fargo • Rape & Abuse Center (Abuse in Later Life Advocate), 317 – 8 St. N., Fargo Sex Trafficking resources: • Breaking Free, P. O. Box 4366, St. Paul, MN • Cass Co. Sheriff, 1612 – 23rd Ave. N., Fargo • Clay Co. Sheriff, 915 – 9th St. N., Moorhead • Fargo Police, 222 – 4th St. N., Fgo • FUSE (ND), 701-526-4863 • Moorhead Police, 915 – 9th Ave. N., Moorhead Street Drugs resources:	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Cass Co. Sheriff, 1612 – 23rd Ave. N., Fargo • Clay Co. Sheriff, 915 – 9th St. N., Moorhead • Fargo Police, 222 – 4th St. N., Fgo • Moorhead Police, 915 – 9th Ave. N., Moorhead	
Health Care Access	• Availability of mental health providers 4.28 • Availability of behavioral health providers 4.21 • Access to affordable health insurance coverage 4.05 • Access to affordable health care 4.01 • Access to affordable prescription drugs 3.91 • Access to affordable dental insurance coverage 3.82 • Availability of non-traditional hours 3.63 • Access to affordable vision insurance coverage 3.58 • Use of emergency room services for primary health care 3.53 • Availability of health care services for Native people 3.50 • Coordination of care between providers and services 3.50			Mental Health/Behavioral Health resources: • Alzheimer's Association, 2631 – 12th Ave. S., Fargo • ARC of West Central MN, 810 – 4th Ave. S., Moorhead • Catholic Family Services, 5201 Bishops Blvd., Fargo • Clay Co. Public Health, 715 – 11th St. N., Moorhead • Clay Co. Social Services, 715 – 11th St. N., Moorhead • Community Outreach Center (on MSUM Campus), Lommen Hall 113, Moorhead MN • Creative Care for Reaching Independence (CCRI), 2903 – 15th St. S., Moorhead • Drake Counseling Services, 1202 – 23rd St. S., Fargo • Essentia (Fargo & Mhd locations) • Fargo VA, 2101 Elm St. N., Fargo • Fargo Cass Public Health, 1240 – 25th St. S., Fargo • FirstLink, 4357 – 13th Ave. S., Fargo • Human Service Associates, 403 Center Ave., Moorhead • Heartland Industries, 2600 – 16th Ave. S., Moorhead • Lakeland Mental Health, 1010 - 32nd Ave. S., Moorhead • Living Free, Jail Chaplains, P. O. Box 6444, Fargo o Insight (women) o Stepping into Freedom (men) o Anger: Our Master (men)	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Lutheran Social Services of ND, 3911 – 20th Ave. S., Fargo • Lutheran Social Services of MN, 715 – 11th St. N., Moorhead • Mental Health America, 112 N. University, Fargo • Mobile Mental Health Crisis Team, 2624 – 9th Ave. S., Fargo • Prairie St. John's, 510 - 4th St. S., Fargo • Prairie St. John's, 2925 – 20th St. S., Moorhead • Rape & Abuse Crisis Center, 317 – 8th St. N., Fargo • Red River Health Services Foundation, 1104 – 2nd Ave. S., Fargo • Safe Harbour, 1003 – 18-1/2 St. S., Moorhead • Sanford Health Behavioral Health, 100 – 4th St. S., Fargo • SENDCA, 3233 S Univ., Fargo • SE Human Services, 2624 – 9th Ave. S., Fargo • Solutions, 891 Belsly Blvd., Moorhead • Tran$ Em (Transitional Supported Employment of MN), 810 – 4th Ave. S., Moorhead • Village Family Service Center, 1201 – 25th St. S., Fargo • Village Family Service Center, 1401 – 8th St. S., Moorhead • Vosburg Counseling for Seniors, 810 – 4th Ave. S., Moorhead Affordable Insurance resources: • Blue Cross, 4510 – 13th Ave. S., Fargo • Medica, 1711 Gold Dr., Fargo • Sanford Health Plan, 1749 – 38 St. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				Affordable Health Care resources: • Essentia Charity Care program (all locations) • Essentia Clinics (several locations) • Fargo HealthCare Center, 301 NP Ave., Fargo • Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo • Health Care for Homeless Veterans, 2101 N. Elm, Fargo • Homeless Health, 311 NP Ave, Fargo • Sanford Charity Care program (all locations) • Sanford Clinics (several locations) • VA Clinic, 2101 N. Elm, Fargo Prescription Assistance resources: • Fargo Area Prescription Assistance, 505 N. Bdwy, Fargo • Fargo HealthCare Center, 301 NP Ave., Fargo • Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo • Homeless Health, 311 NP Ave, Fargo • Prescription Assistance Program, 624 Main Ave., Fargo • Prescription Connection, 600 E. Blvd. Ave., Bismarck • Salvation Army prescription assistance program, 304 Roberts, Fargo Affordable Dental resources: • Family HealthCare Center dental clinic, 715 N. 11th St., Moorhead	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Fargo HealthCare Center, 301 NP Ave., Fargo • Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo • Homeless Health, 311 NP Ave, Fargo • RRV Dental Access Project, 715 – 11th St. N., Moorhead Affordable Vision coverage: • Fargo HealthCare Center, 301 NP Ave., Fargo • Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo Affordable Health Care Services for Native people: • Fargo HealthCare Center, 301 NP Ave., Fargo • Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo • Homeless Health, 311 NP Ave, Fargo	
Mental Health and Substance Abuse	• Drug use and abuse 4.40 • Alcohol use and abuse 4.15 • Depression 4.10 • Suicide 4.01 • Stress 3.81 • Dementia and Alzheimer's Disease 3.61			Substance Abuse services: • AA, 1112 – 3rd Ave. S., Fargo • AA Red Road to Recovery, 109 – 9th St. S., Fargo • AA Club House, 1112 – 3rd Ave. S., Fargo • ADAPT, Inc., 1330 Page Dr., Fargo • Anchorage, 725 Center Ave., Moorhead • Burl, Eddie DUI Seminar, 1351 Page Dr., Fargo • Cass Co. Public Health Detox, 1240 – 25th St. S., Fargo • Celebrate Recovery, 21 – 9th St. S., Fargo • Centre, Inc., 123 – 15th St. N., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Clay Co. Chemical Dependency, 715 – 11th St. N., Moorhead • Clay County Detox, 715 – 11th St. N., Moorhead • Clay Co. Social Services, 715 – 11th St. N., Moorhead • Codependents Anonymous, 1330 S. University Dr., Fargo • Discovery Counseling, 115 N. University, Fargo • Drake Counseling, 1202 - 23 St. S., Fargo • First Step Recovery, 409 – 7th St. S., Fargo • Gamblers Choice, LSS, 3911 – 20th Ave. S., Fargo • Gull Harbor Apts., 1704 Belsly Blvd., Moorhead • Howe, Robert E., 1445 – 1st Ave. N., Fargo • Journey Counseling, 222 N. Broadway, Fargo • Lost & Found Ministry, 111 – 7th St. S., Moorhead • McGrath, Claudia Counseling, 417 – 38th St. S., Fargo • Narcotics Anonymous, 18 – 18th St. S., Fargo • New Hope Recovery, 118 Bdwy, Fargo • Only Human Counseling, 118 Bdwy, Fargo • Pathways Counseling & Recovery Center, 1306 – 9th St. N., Fargo • Positive Solutions, 6245 – 16th St. S., Fargo • Prairie St. John's, 510 - 4th St. S., Fargo • Prairie St. John's, 2925 – 20th St. S., Moorhead • Safe Harbor, 810 – 4th Ave. S., Moorhead • Sanford Behavioral Health Center, 100 – 4th St. S., Fargo • SE Human Service Center, 2624 – 9th Ave. S., Fargo • Sexaholics Anonymous, 701-235-7335	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• ShareHouse, 4227 – 9th Ave. S., Fargo • ShareHouse Wellness Center, 715 N. 11th St., Moorhead • Simon Chemical Dependency Services, 3431 – 4th Ave. S., Fargo • SMART Recovery, 1260 N. University Dr., Fargo • SMART Recovery, 200 – 5th St. S., Moorhead • Shiaro, Chris Counseling, 4227 – 9th Ave. S., Fargo • Sister's Path, 4219 – 9th Ave. S., Fargo • Veterans Administration, 2101 N. Elm, St., Fargo • Village Family Service Center, 1201 – 25th St. S., Fargo • Village Family Service Center, 1401 – 8th St. S., Moorhead • Vosburg Counseling for Seniors, 810 – 4th Ave. S., Moorhead Mental health resources: • Alzheimer's Association, 2631 – 12th Ave. S., Fargo • ARC of West Central MN, 810 – 4th Ave. S., Moorhead • Catholic Family Services, 5201 Bishops Blvd., Fargo • Clay Co. Public Health, 715 – 11th St. N., Moorhead • Clay Co. Social Services, 715 – 11th St. N., Moorhead • Community Outreach Center (on MSUM Campus), Lommen Hall 113, Moorhead MN • Creative Care for Reaching Independence (CCRI), 2903 – 15th St. S., Moorhead • Drake Counseling Services, 1202 – 23rd St. S., Fargo • Essentia (Fargo & Mhd locations) • Fargo VA, 2101 Elm St. N., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Fargo Cass Public Health, 1240 – 25th St. S., Fargo • FirstLink, 4357 – 13th Ave. S., Fargo • Human Service Associates, 403 Center Ave., Moorhead • Heartland Industries, 2600 – 16th Ave. S., Moorhead • Lakeland Mental Health, 1010 - 32nd Ave. S., Moorhead • Living Free, Jail Chaplains, P. O. Box 6444, Fargo o Insight (women) o Stepping into Freedom (men) o Anger: Our Master (men) • Lutheran Social Services of ND, 3911 – 20th Ave. S., Fargo • Lutheran Social Services of MN, 715 – 11th St. N., Moorhead • Mental Health America, 112 N. University, Fargo • Mobile Mental Health Crisis Team, 2624 – 9th Ave. S., Fargo • Prairie St. John's, 510 - 4th St. S., Fargo • Prairie St. John's, 2925 – 20th St. S., Moorhead • Rape & Abuse Crisis Center, 317 – 8th St. N., Fargo • Red River Health Services Foundation, 1104 – 2nd Ave. S., Fargo • Safe Harbour, 1003 – 18-1/2 St. S., Moorhead • Sanford Health Behavioral Health, 100 – 4th St. S., Fargo • SENDCA, 3233 S Univ., Fargo • SE Human Services, 2624 – 9th Ave. S., Fargo • Solutions, 891 Belsly Blvd., Moorhead • Tran$ Em (Transitional Supported Employment of MN), 810 – 4th Ave. S., Moorhead	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Village Family Service Center, 1201 – 25th St. S., Fargo • Village Family Service Center, 1401 – 8th St. S., Moorhead • Vosburg Counseling for Seniors, 810 – 4th Ave. S., Moorhead Alzheimer's/Dementia resources: • After the Diagnosis Support Group (for those diagnosed with Alzheimer's & dementia), 736 Broadway, Fargo • Alzheimer's Caregiver Support Group, 2702 – 30th Ave. S., Fargo • Alzheimer's Support Group, 202 – 1st Ave. N., Moorhead • Alzheimer's Assn., 2631 – 12 Ave. S., Fargo • Arbor Park Village, 520 - 28 St. N., Moorhead • Bethany – 201 S. Univ., Fargo • Early Onset Memory Loss Support Group, 701-277-9757 • Edgewood Vista, 4420 – 37 Ave. S., Fargo • Elim Care, 3534 S. Univ., Fargo • Eventide/Fairmont, 801 – 2nd Ave. N., Moorhead • Evergreens, 503–3rd Ave. S., Mhd • Evergreens, 1401 W. Gateway Circle, Fargo • Morning Out (for those who have Alzheimer's or other dementia), 610 -13th St. N., Mhd. • River Pointe, 2401 – 11th St. S., Moorhead	
Health & Wellness	• 60% not getting enough fruits & vegetables • 45% not getting enough exercise			Healthy Food resources: • Cash Wise (several locations) • Family Fare (several locations)	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	• Only 57% report having flu shot • 27% overweight/39% obese • High cholesterol • Hypertension			• Hornbacher's (several locations) • Tochi, 1111 – 2nd Ave. N., Fargo • Prairie Roots Food Co-op, 1213 NP Ave., Fargo • Natural Grocers, 4517 – 13th Ave. S., Fargo • Farmers Market @ Blue Cross, 45th St. & 13th Ave. S., Fargo • NoMo Farmers Market, 14156 – 1st Ave. N., Moorhead • Red River Market, 4th Ave. & N. Bdwy, Fargo • Ladybug Acres, 2110 Univ. Dr. S., Fargo • Hildebrant Farmers Market, 349 Main Ave. E., West Fargo • Moorhead Farmer Market, 4th & Center Ave., Moorhead • Farmers Market @ West Acres, 3902 – 13th Ave. S., Fargo • Farmers Market & Beyond, 500 -1 3th Ave. W., West Fargo • Dilworth Farmers Market, 4th St. NE & Hwy. 10, Dilworth Nutrition Information: • Cass Co. Extension Service nutrition classes, 1010 – 2nd Ave. S., Fargo • Cass Co. SNAP, 1010 – 2nd Ave. S, Fargo • Cass Co. WIC, 1240 – 25th St. S., Fargo • Clay Co. Public Health, 715 - 11th St. N., Moorhead • Clay Co. SNAP, 715 – 11th St. N., Moorhead • Clay Co. WIC, 715 – 11st St. N., Moorhead • Complete Nutrition, 4302 – 13 Ave. S., Fargo • Essentia Dieticians, 3000 – 32 Ave. S., Fargo • Fargo Cass Public Health, 1240 – 25th St. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Nutrition Zone, 1801 – 45 St. S., Fargo • Sanford Dieticians, 801 Bdwy. N., Fargo Fitness resources: • Anytime Fitness, 1801 – 45th St. S., Fargo • Anytime Fitness, 5050 Timber Pkwy S., Fargo • Anytime Fitness, 2614 N. Bdwy, Fargo • Anytime Fitness, 935 – 37th Ave. S., Moorhead • Core Fitness, 2424 – 13th Ave. S., Fargo • Cold Fusion, 114 Bdwy, Fargo • Courts Plus, 3491 S. Univ., Fargo • Cross Fit, 1620 – 1st Ave. N., Fgo. • Curves, 123 – 21st St. S., Mhd. • Edge Fitness, 6207 – 53rd Ave. S., Fargo • Elements Fitness, 3120 – 25th St. S., Fargo • Fargo Park District, 701 Main Ave., Fargo • Fitness 52, 2600-52nd Ave. S. Fgo. • Fitness 4 Life, 1420 – 9th St. E., West Fargo • Health Pros personal training, 2108 S. University, Fargo • LA Weight Loss Center, 5050 – 13th Ave. S., Fargo • Ladies Workout Express, 1420 – 9th St. E., West Fargo • Max Training, 1518 - 29th Ave. S., Moorhead • Metro Rec Ctr., 3110 Main, Fgo • Moorhead Park District, 324 – 24th St. S., Moorhead • No More Diets Support Group, • Overeaters Anonymous, OA.org • Planet Fitness, 4325 – 13th Ave. S., Fargo	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Planet Fitness, 800 Holiday Dr., Moorhead • Red River Traditional Tae Kwon Do, 1335 Main, Fargo • Sanford Family Wellness Center, 2960 Seter Parkway, Fargo • Slim Ambition, 1365 Prairie Pkwy, Fargo • Snap Fitness, 4265 - 45th St. S., Fargo • Take Off Pounds Sensibly, TOPS.org • TNT Kids' Fitness, 2800 Main, Fargo • Total Balance, 1461 Bdwy N., Fgo • Total Woman Fitness, 508 Oak St. N., Fargo • Touchmark Fitness, 1200 Harwood Dr. S., Fargo • Valley Fitness, 3820 – 12th Ave. N., Fargo • Welcyon Fitness, 2603 Kirsten Lane S., Fargo • West Fargo Fitness Center, 215 Main Ave., West Fargo • YMCA, 400 – 1st Ave. S., Fargo • YMCA, 4243 – 19th Ave. S., Fargo Obesity resources: • Eating Disorders Support Group, Sanford, 1720 S. University, Fgo. • Essentia Dieticians, 3000 – 32nd Ave. S., Fargo • Gastric Bypass Support Group, Atonement Lutheran, 4201 S. University, Fargo • Sanford Dietitians, 801 Bdwy, Fargo • Sanford Eating Disorders & Wt. Management Center, 1717 S. University, Fargo Flu Shot resources: • Clay Co. Public Health, 715 - 11th St. N., Moorhead • Essentia Health clinics (several locations)	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo • Fargo Cass Public Health, 1240 – 25th St. S., Fargo • Fargo HealthCare Center, 301 NP Ave., Fargo • Fargo VA, 2101 Elm St. N., Fgo • Homeless Health, 311 NP Ave, Fargo • NDSU Student Service, 1707 Centennial Blvd., Fargo • Sanford Health clinics (several locations) • Thrifty White, 1401-33 St. S., Fgo • Thrifty White, 4255 – 30 Ave. S., Fargo • Thrifty White, 1100 – 13th Ave. E., West Fargo • Walgreens, 4201–13 Ave. S., Fgo. • Walgreens, 900 Main Ave., Mhd. Health care resources for high cholesterol/hypertension: • Clay Co. Public Health, 715 - 11th St. N., Moorhead • Essentia Health clinics (several locations) • Family HealthCare Center, 301 NP Ave., Fargo • Family HealthCare Center, 4025 – 9th Ave. S, Fargo • Family HealthCare Center, 726 – 13th Ave. E., West Fargo • Fargo Cass Public Health, 1240 – 25th St. S., Fargo • Fargo VA, 2101 Elm St. N., Fgo • Homeless Health, 311 NP Ave, Fargo • Sanford Health clinics (several locations)	

Key Stakeholder Survey

Sanford Fargo-Moorhead Medical Center

Community Health Needs Assessment
Results from a November 2017 Non-Generalizable
Online Survey of Community Stakeholders

December 2017

SANFORD

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a November 2017 online survey of community leaders and key stakeholders identified by Sanford Fargo-Moorhead Medical Center. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders located within various agencies throughout Cass County, North Dakota and Clay County, Minnesota, and asked them to complete the online survey. **Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred during the month of November and the first two weeks of December. A total of 222 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

Current State of Health and Wellness Issues Within the Community

Using a 1 to 5 scale, with 1 being “no attention needed”; 2 being “little attention needed”; 3 being “moderate attention needed”; 4 being “serious attention needed”; and 5 being “critical attention needed,” respondents were asked to, based on their knowledge, select the option that best describes their understanding of the current state of each issue regarding ECONOMIC WELL-BEING, TRANSPORTATION, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTHCARE AND WELLNESS, and MENTAL HEALTH AND SUBSTANCE ABUSE.

Figure 1. Current state of community issues regarding ECONOMIC WELL-BEING

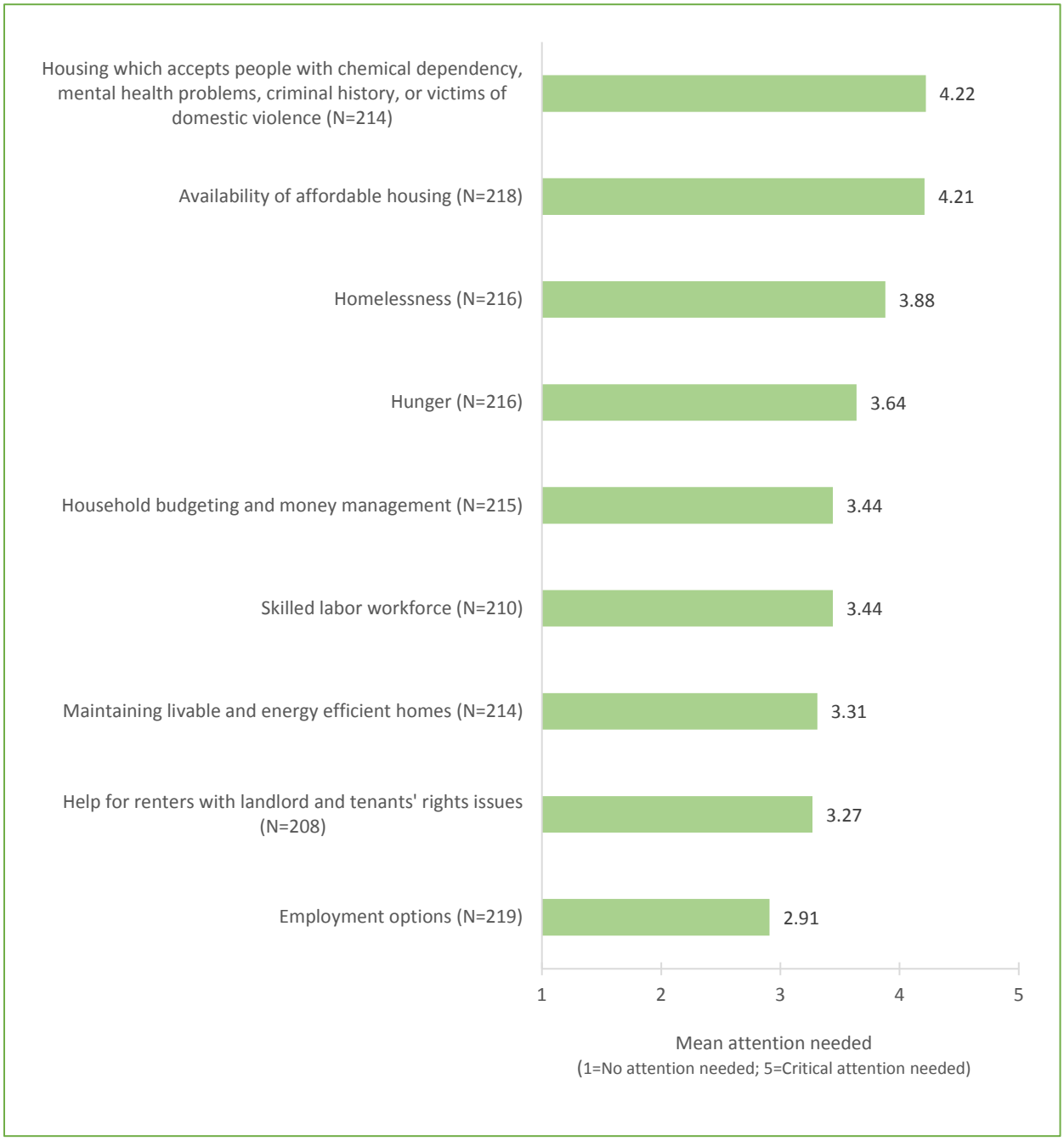


Figure 2. Current state of community issues regarding TRANSPORTATION

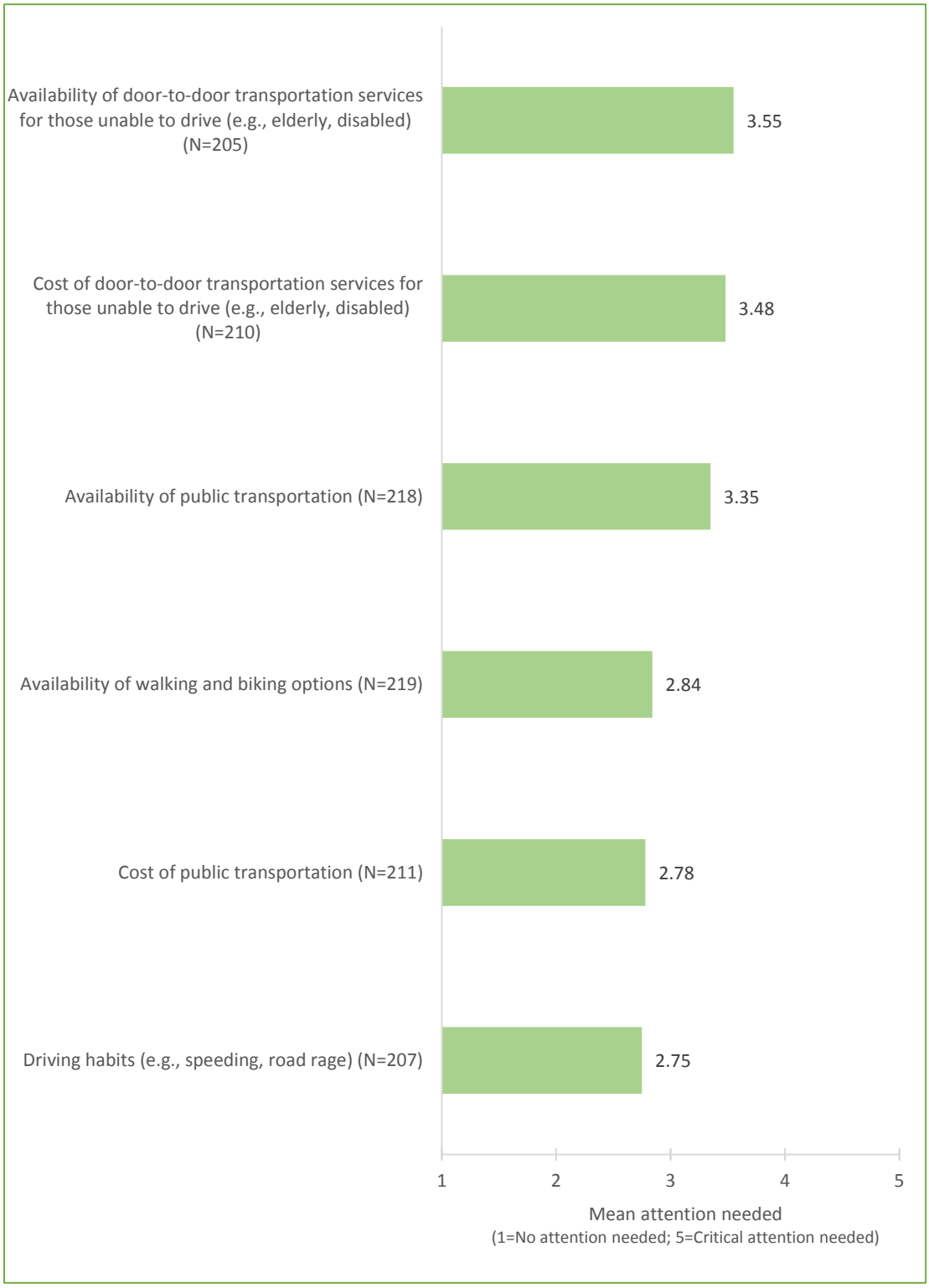


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

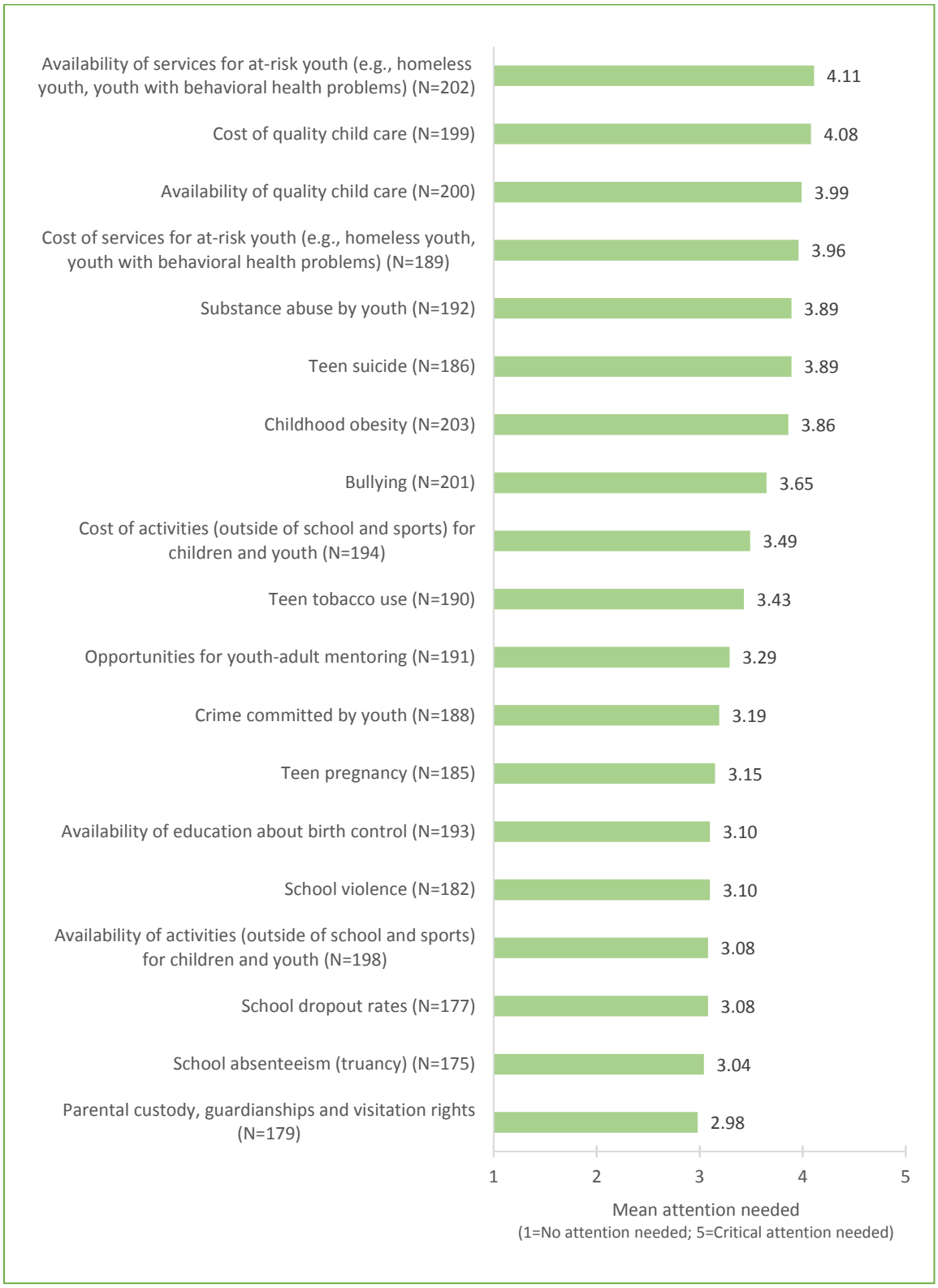


Figure 4. Current state of community issues regarding the AGING POPULATION

Figure 5. Current state of community issues regarding SAFETY

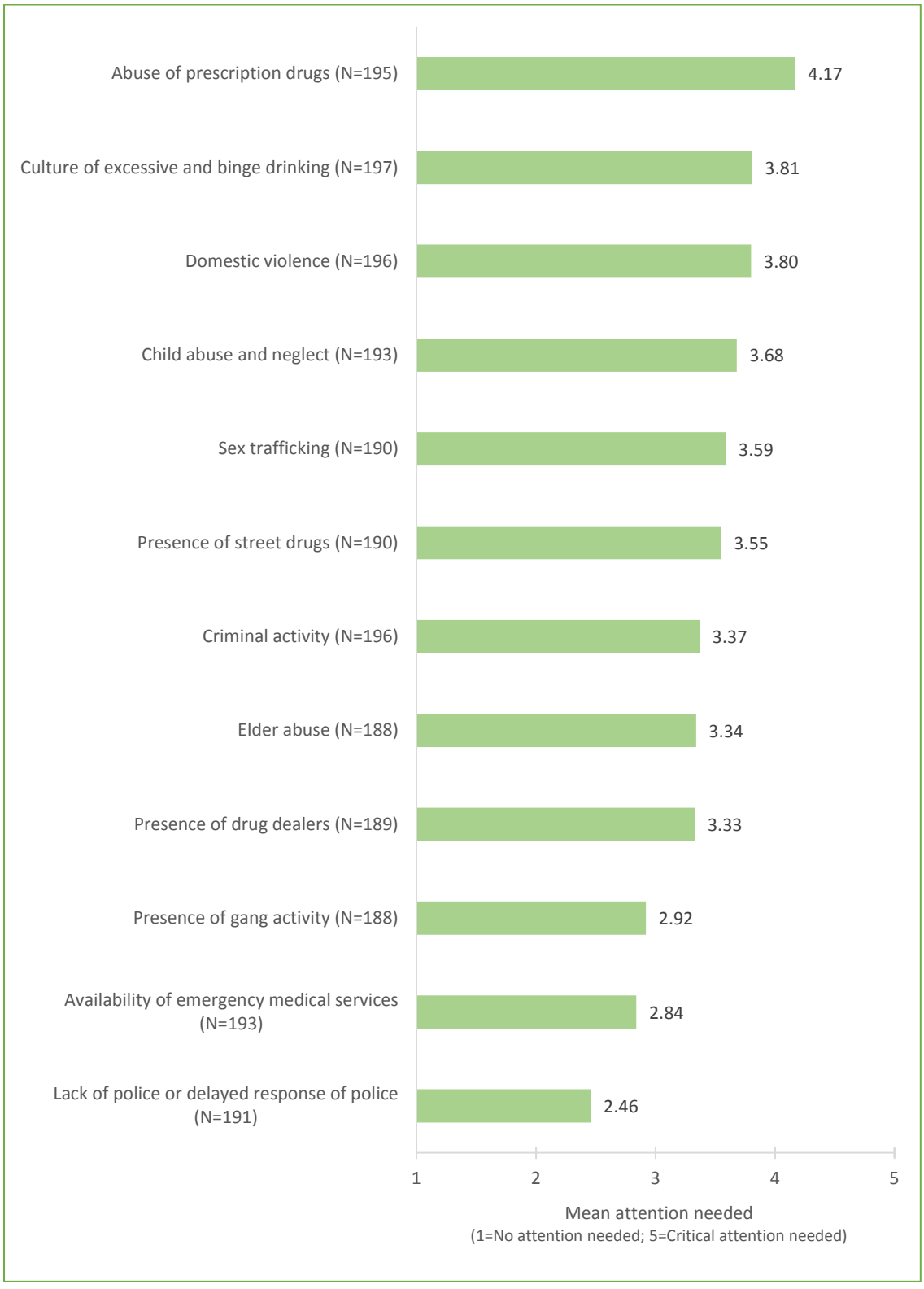
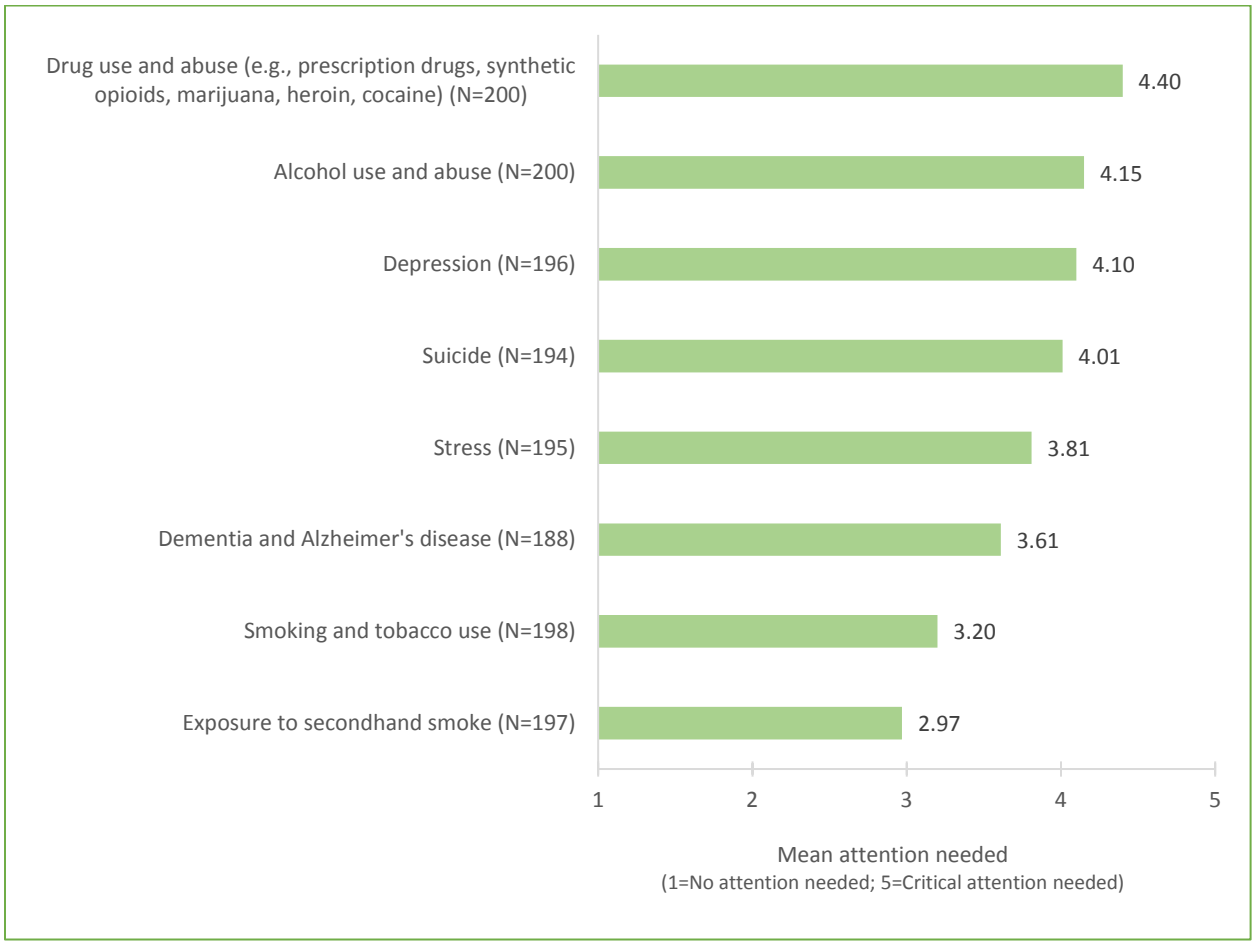


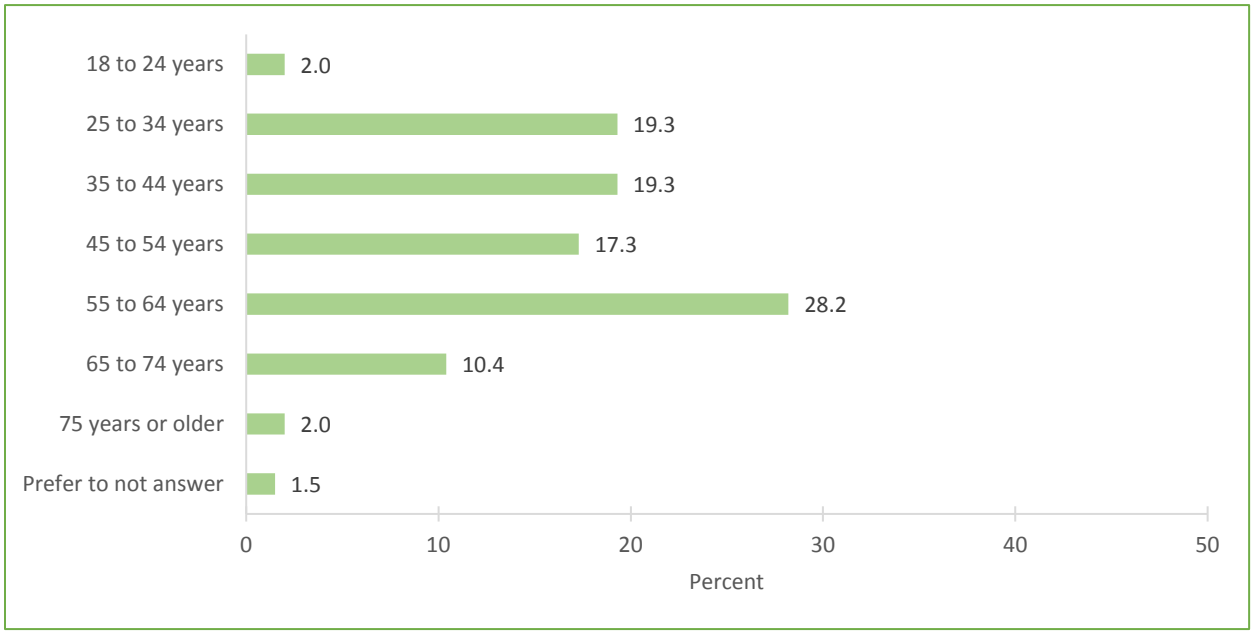
Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

Figure 7. Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



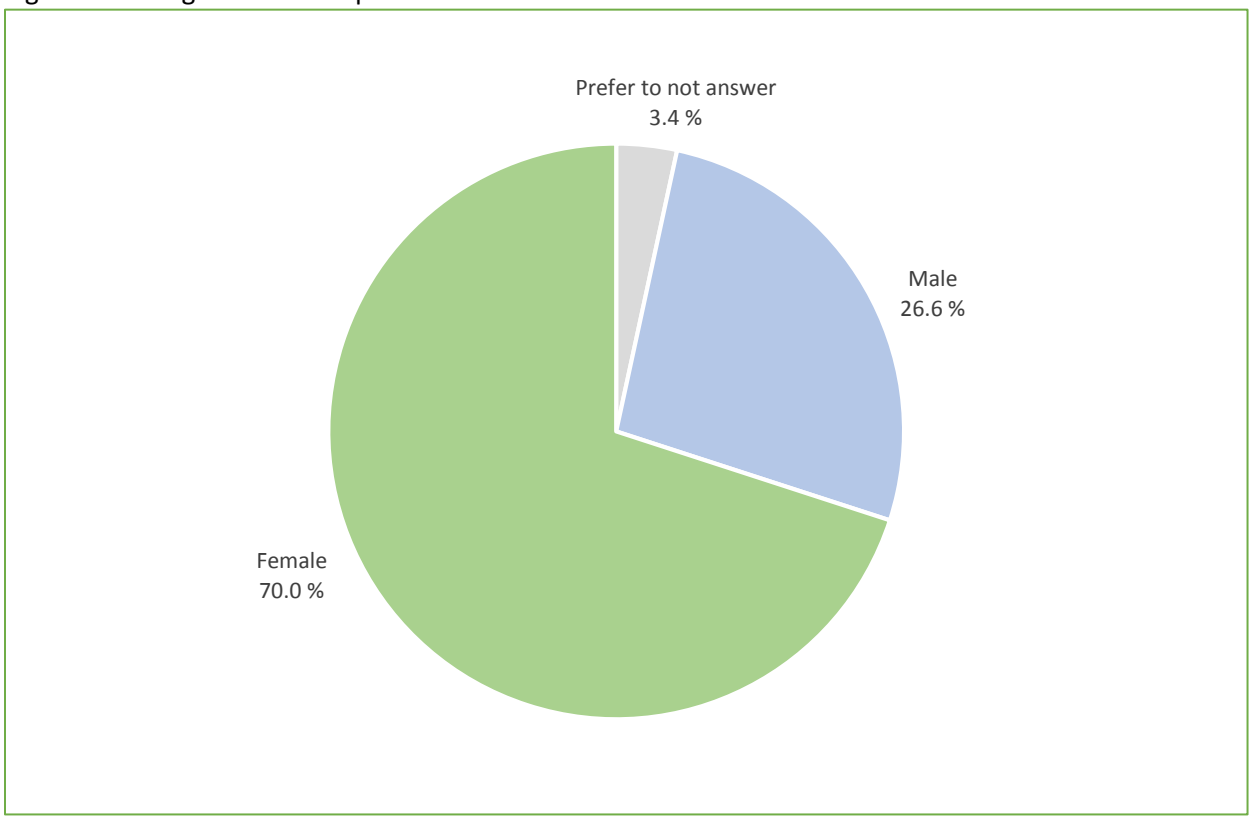
Demographic Information

Figure 8. Age of respondents



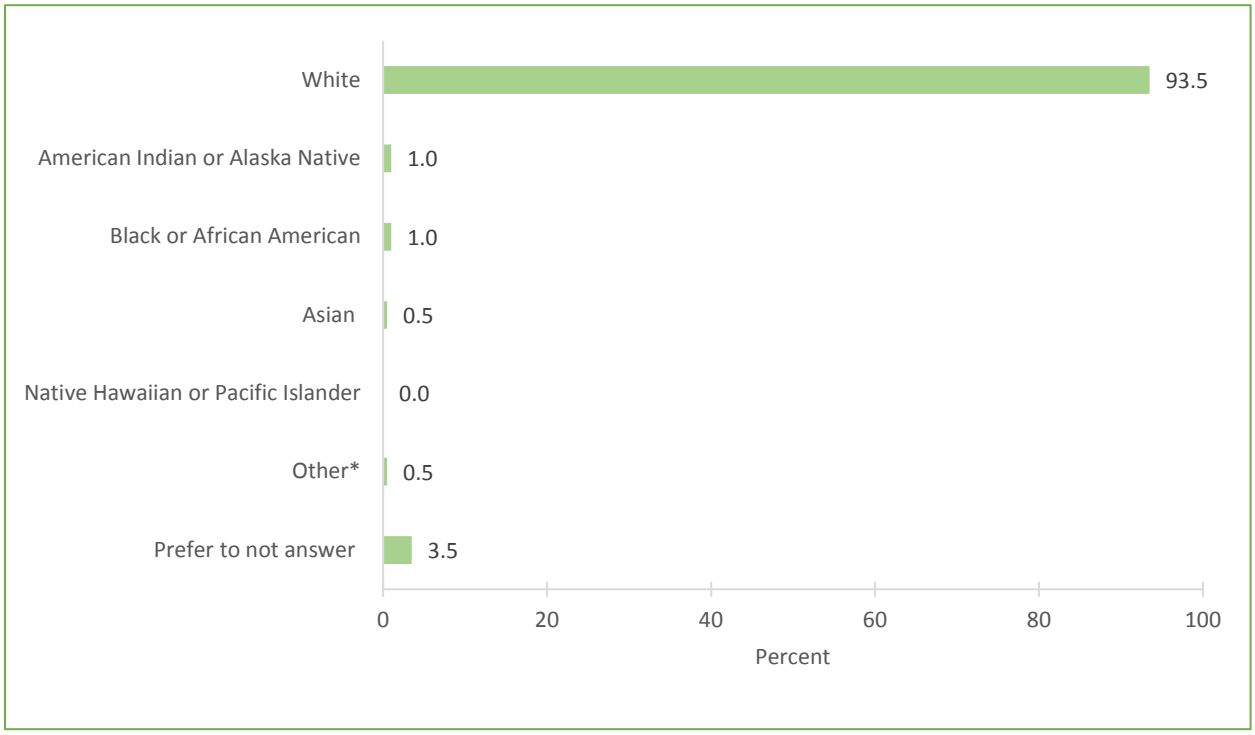
N=202

Figure 9. Biological sex of respondents



N=203

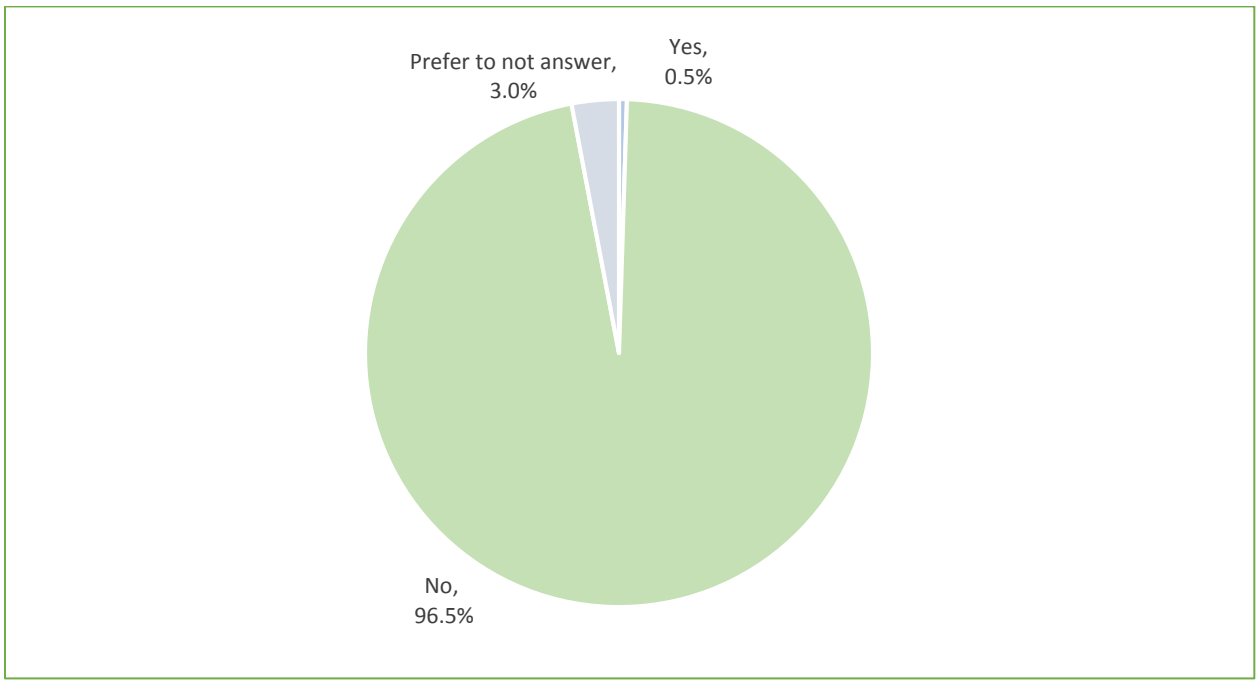
Figure 10. Race of respondents



N=200

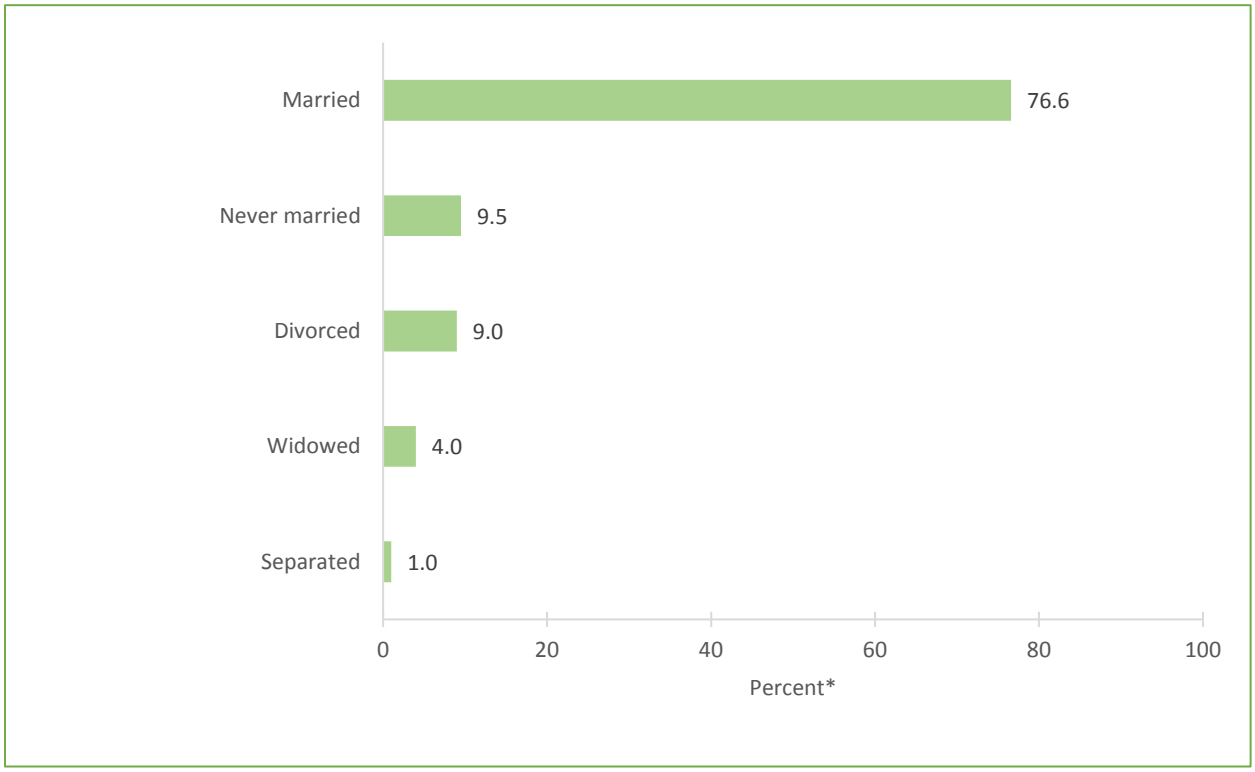
*There was no response entered for “other”.

Figure 11. Whether respondents are of Hispanic or Latino origin



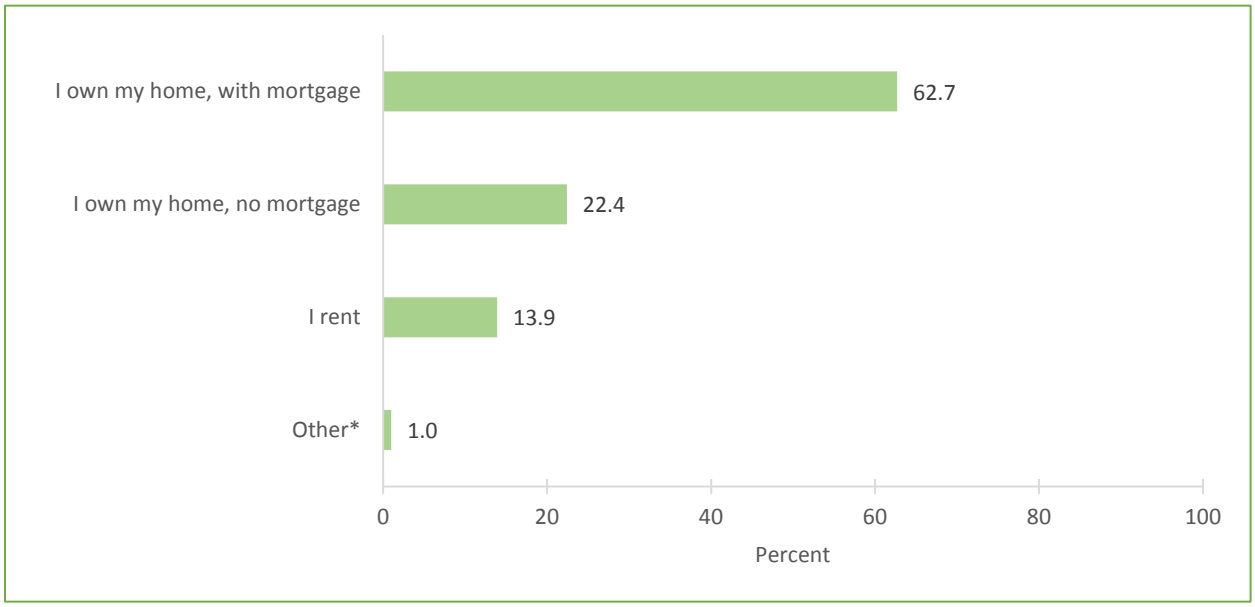
N=199

Figure 12. Marital status of respondents



N=201
*Percentages do not total 100.0 due to rounding.

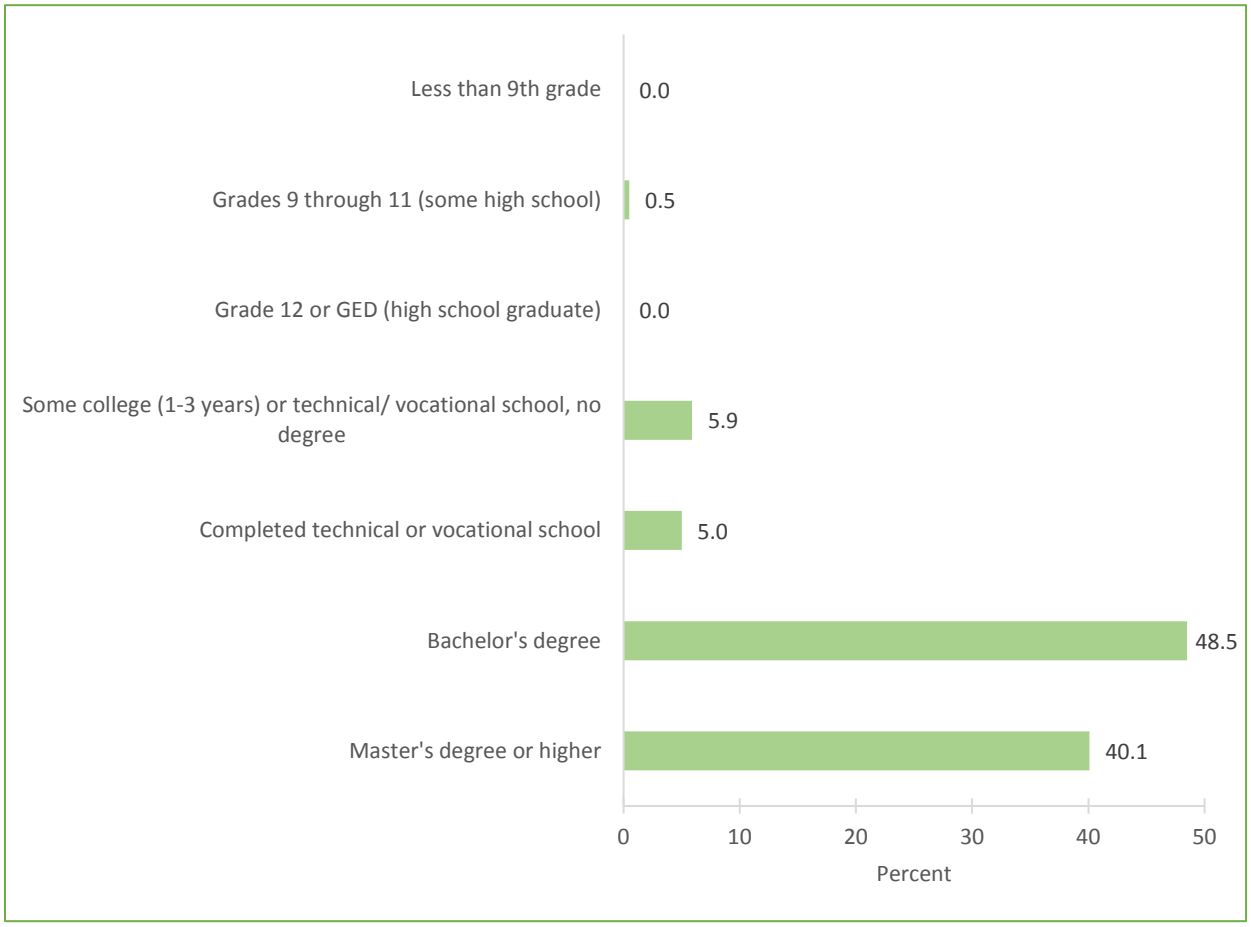
Figure 13. Living situation of respondents



N=201

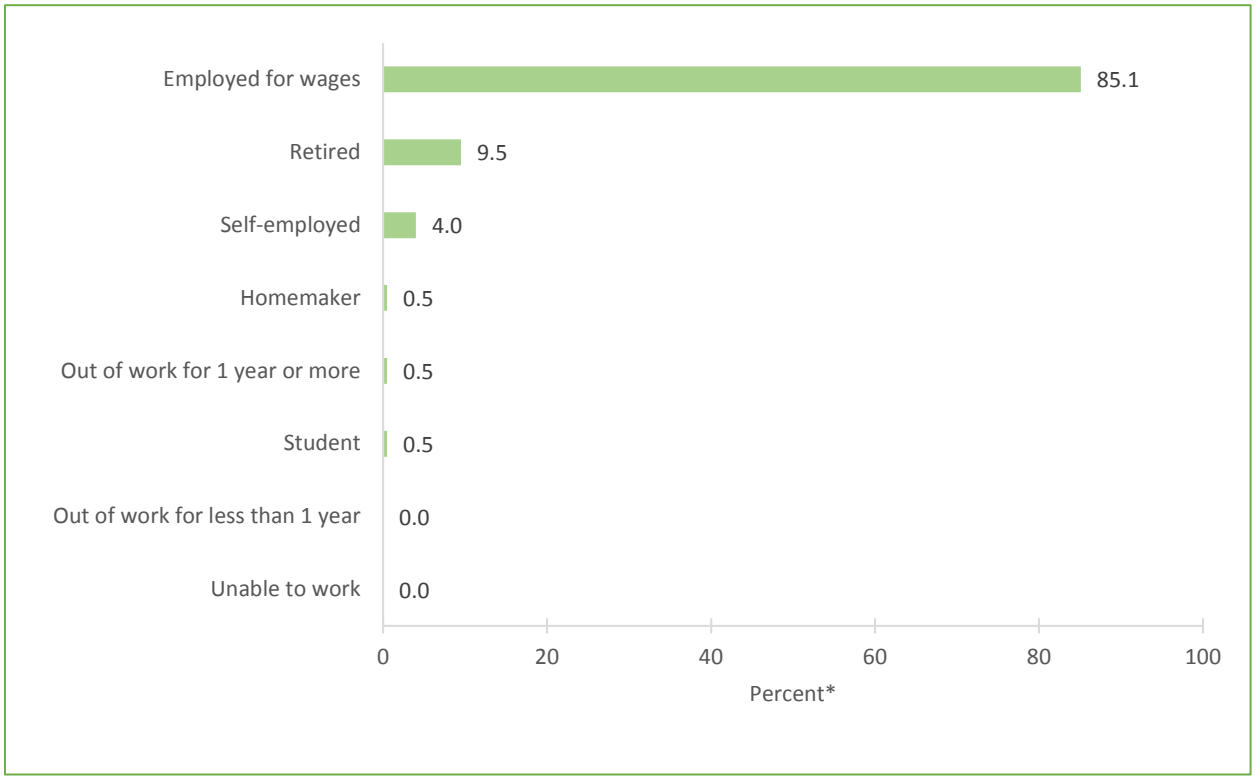
*Other response is “apartment”.

Figure 14. Highest level of education completed by respondents



N=202

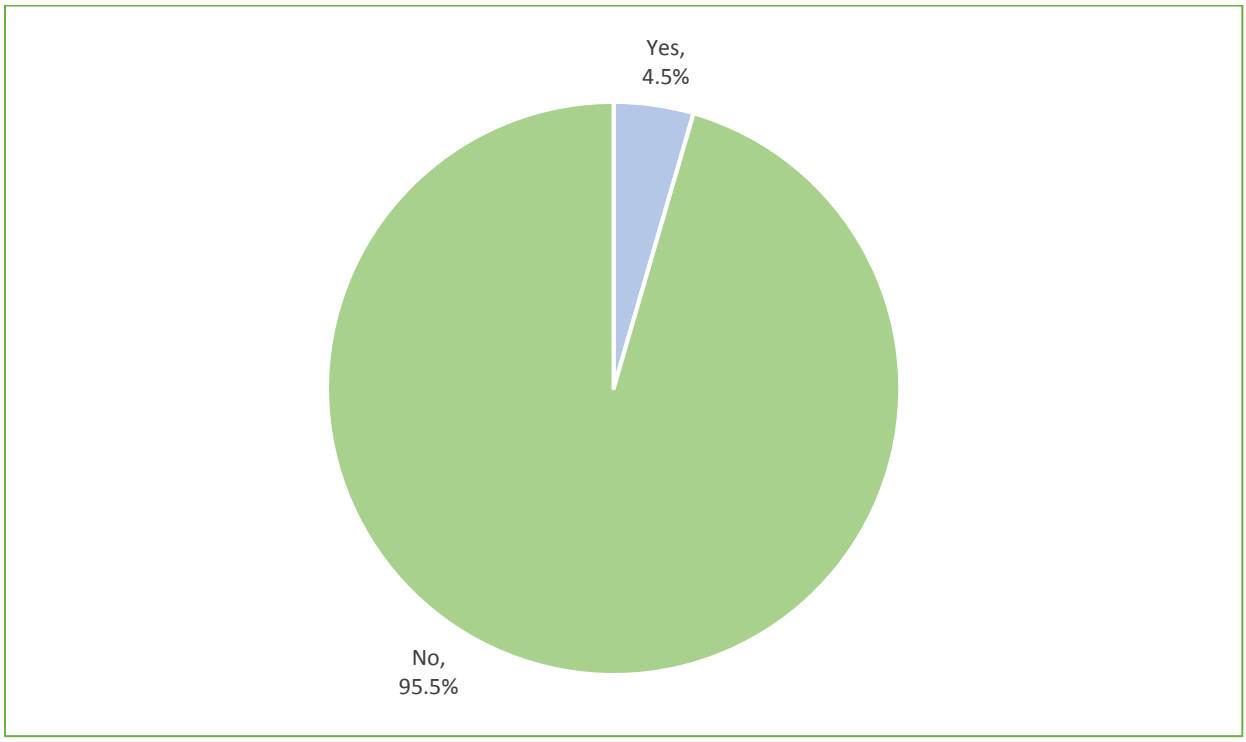
Figure 15. Employment status of respondents



N=201

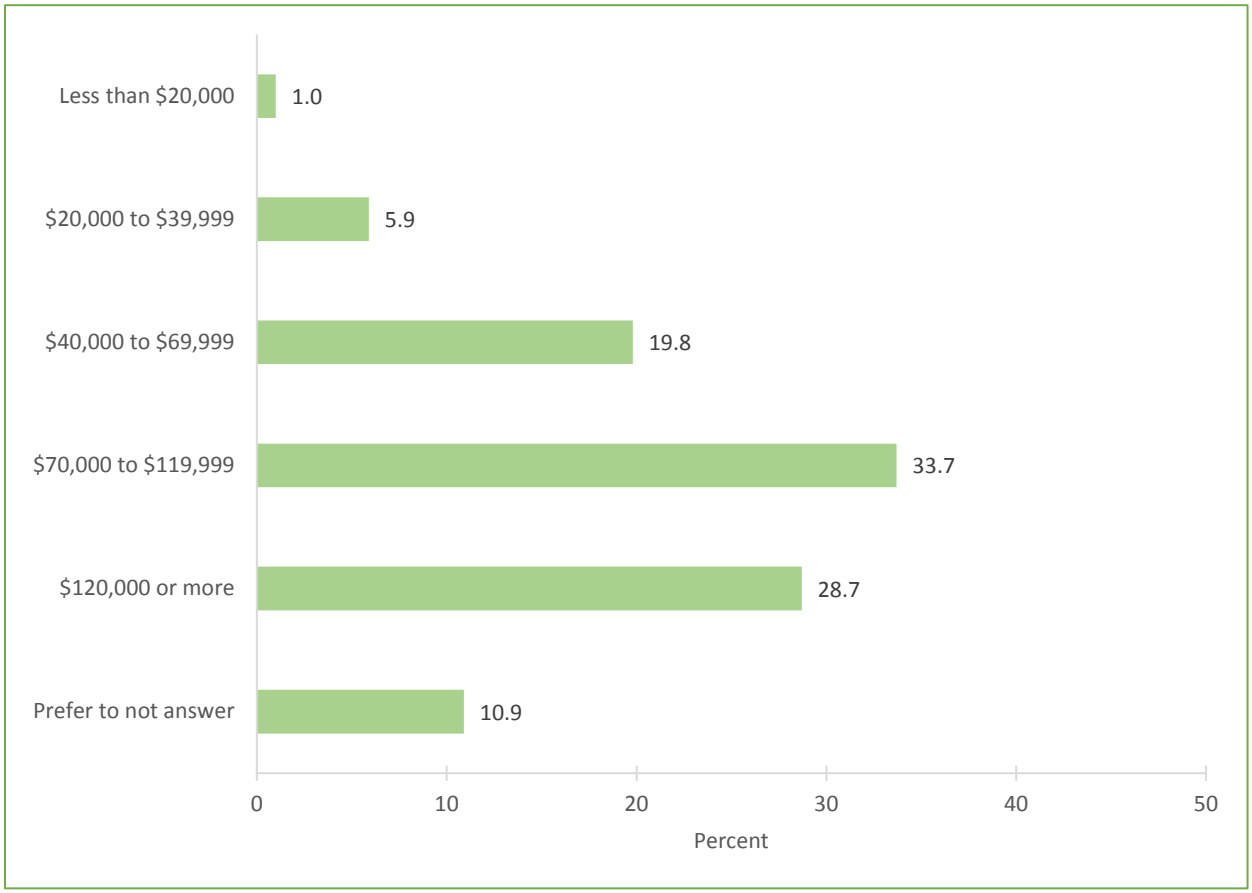
*Percentages do not total 100.0 due to rounding.

Figure 16. Whether respondents are military veterans



N=199

Figure 17. Annual household income of respondents, from all sources, before taxes



N=202

Table 1. Zip code of respondents

Zip code	Number of respondents
56560	41
58103	34
58104	31
58078	23
58102	18
58047	5
58042	2
56529	1
56549	1
58005	1
58006	1
58012	1

N=159

Table 2. Comments from respondents

Comments
Affordable health and mental health services and affordable/accessible housing are MUCH NEEDED!!
Any examination of issues and/or accompanying policies should be intersectional - that's critical!
High need for behavioral health support in schools.
Homeless seniors (over age 60) is a critical and growing issue -- getting bigger all the time.
I believe in universal health care like the rest of the civilized world has.
I do not work directly with homeless youth, but I work with homeless adults and incarcerated persons. Behavioral Health and affordable housing with support services are critical needs, but homeless youth are even more neglected it seems. Family HealthCare is the only option for affordable, sliding scale care, and even with insurance people can't afford care or medications sometimes, get bumped off their insurance because they don't follow up, etc. Politicians continue to try to cut services to the ones who need them the most, and it's infuriating. I am happy to meet with anyone in person to discuss finer details for the purpose of this study.
I wish NA would have been explained. There were several, I didn't feel qualified to answer but did because that option wasn't listed.
In regards to mental health, there is a great need in schools to identify children needing mental health services and provide these services within the context of the school day.
It occurs to me that several of the questions about serious/moderate situations are serious, but a small percentage of people have the serious level of the problem. However, to them it is a serious problem.
Mental illness / wellness is a critical concern for youth - as we help them now, we help the future.
Money has been cut for homeless youth for sex trafficking. Needs to be restored and fund both.
Not enough questions regarding mental health needs.
On the subject of non-school activities for young people they also need down time; they do not have to be over-booked like their parents. No one should be in an unsafe environment - drug dealer[s] need to be removed from society. No one should be abused or neglected and go into the highest need category.
Re: housing that takes those with CD/other issues. The problem is paying for full-time staff to monitor activity for safety of all residents, and to deal with the numerous issues.
Seems like FirstLink is a great resource for continued care, open 24/7.
Sexual assault/rape is a huge issue in the FM area, especially at bars and at the college campuses. This is something that needs to be addressed!
Special needs based services were not addressed in the survey. To include: ASD, Down Syndrome, Multiply impaired, Intellectual Disability, and EBD. I know that the schools are very taxed currently with the demands of supporting the diverse population. My question is are we addressing support and interventions for the special needs population post academic age.
Substance abuse programs tend not to use best practices...seem to be stuck in the 1930's...very unproductive.
The way our cities are built (sprawling/car-dependent) significantly impacts the physical and economic health of our population, especially the low-income and disabled population. If our cities were built in a more-dense and livable way, all populations could feasibly walk, bike, and use public transportation. Currently we are mandated to own and pay for a car in order to maintain a normal lifestyle. (The average American pays over $8,000 per year to own and maintain a car - Source AAA.)
Transportation to medical care.
We need a television channel that constantly scrolls events, information, and news regarding all of the above issues as well as short video clips about injuries, how to fill out forms, correct ways to raise children, or help the elderly, etc.
We need more effort to prevent age 12 to 18 from ending up in detention centers.
Yes when looking at the challenges with our aging population, it is a matter of not just finding them a place to live, it is finding them a place to live if they have been kicked out of a nursing care facility and need a higher level of care, but nowhere to go. More homes and respite care for seniors

APPENDIX TABLE

Appendix Table 1. Current state of health and wellness issues within the community

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=220)	4.21	0.0	1.4	22.7	28.6	46.4	0.9	100.0
Employment options (N=221)	2.91	5.0	24.9	48.0	16.3	5.0	0.9	100.1
Help for renters with landlord and tenants' rights issues (N=214)	3.27	0.5	18.7	45.3	19.6	13.1	2.8	100.0
Homelessness (N=218)	3.88	0.5	6.9	29.4	29.8	32.6	0.9	100.1
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=217)	4.22	0.9	3.2	15.2	32.7	46.5	1.4	99.9
Household budgeting and money management (N=218)	3.44	0.0	10.1	46.3	30.7	11.5	1.4	100.0
Hunger (N=219)	3.64	0.5	10.5	34.2	32.4	21.0	1.4	100.0
Maintaining livable and energy efficient homes (N=216)	3.31	0.5	17.1	44.9	24.1	12.5	0.9	100.0
Skilled labor workforce (N=216)	3.44	2.8	9.7	40.3	30.6	13.9	2.8	100.1
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=212)	3.55	2.4	10.8	32.1	34.4	17.0	3.3	100.0
Availability of public transportation (N=219)	3.35	3.7	16.0	36.5	28.8	14.6	0.5	100.1
Availability of walking and biking options (N=220)	2.84	7.3	27.3	44.1	16.4	4.5	0.5	100.1
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=217)	3.48	2.3	14.3	30.0	35.5	14.7	3.2	100.0
Cost of public transportation (N=217)	2.78	4.1	34.6	40.6	14.3	3.7	2.8	100.1
Driving habits (e.g., speeding, road rage) (N=216)	2.75	7.4	34.3	33.3	16.2	4.6	4.2	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=207)	3.08	3.4	21.3	41.5	23.2	6.3	4.3	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Availability of education about birth control (N=202)	3.10	2.5	25.2	36.6	22.3	8.9	4.5	100.0
Availability of quality child care (N=206)	3.99	0.0	2.9	25.2	39.3	29.6	2.9	99.9
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=206)	4.11	0.0	2.9	16.5	45.6	33.0	1.9	99.9
Bullying (N=204)	3.65	1.0	7.4	34.8	37.7	17.6	1.5	100.0
Childhood obesity (N=205)	3.86	0.0	7.3	23.9	43.4	24.4	1.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=204)	3.49	0.5	10.8	38.2	32.4	13.2	4.9	100.0
Cost of quality child care (N=207)	4.08	0.0	3.4	19.3	39.6	33.8	3.9	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=200)	3.96	0.0	3.5	23.0	41.5	26.5	5.5	100.0
Crime committed by youth (N=199)	3.19	0.5	16.6	46.7	25.6	5.0	5.5	99.9
Opportunities for youth-adult mentoring (N=198)	3.29	1.0	13.6	45.5	29.3	7.1	3.5	100.0
Parental custody, guardianships and visitation rights (N=194)	2.98	2.1	19.6	51.0	17.5	2.1	7.7	100.0
School absenteeism (truancy) (N=193)	3.04	1.6	21.8	43.0	20.2	4.1	9.3	100.0
School dropout rates (N=194)	3.08	1.5	23.7	39.7	18.0	8.2	8.8	99.9
School violence (N=197)	3.10	2.0	20.3	43.1	20.3	6.6	7.6	99.9
Substance abuse by youth (N=200)	3.89	0.5	6.0	24.5	37.5	27.5	4.0	100.0
Teen pregnancy (N=196)	3.15	0.5	23.0	40.8	21.9	8.2	5.6	100.0
Teen suicide (N=195)	3.89	0.5	9.2	20.5	35.4	29.7	4.6	99.9
Teen tobacco use (N=199)	3.43	1.5	17.6	30.2	31.2	15.1	4.5	100.1
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=200)	3.11	2.5	16.0	51.5	19.0	6.0	5.0	100.0
Availability of long-term care (N=199)	3.24	2.5	21.6	33.2	23.6	12.6	6.5	100.0
Availability of memory care (N=198)	3.37	2.0	13.6	38.9	25.8	13.1	6.6	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=197)	3.58	0.5	11.7	33.5	28.4	19.3	6.6	100.0
Availability of resources for grandparents caring for grandchildren (N=199)	3.36	1.0	18.6	33.2	26.6	13.6	7.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Availability of resources to help the elderly stay safe in their homes (N=195)	3.52	1.0	13.3	35.4	25.6	19.5	5.1	99.9
Cost of activities for seniors (e.g., recreational, social, cultural) (N=193)	3.03	2.6	21.8	45.1	16.1	6.7	7.8	100.1
Cost of in-home services (N=196)	3.83	0.5	9.7	23.5	32.1	28.6	5.6	100.0
Cost of long-term care (N=196)	4.15	0.0	6.6	16.3	27.6	43.9	5.6	100.0
Cost of memory care (N=197)	4.08	0.0	7.6	16.2	30.5	39.1	6.6	100.0
Help making out a will or healthcare directive (N=196)	3.04	1.0	25.0	43.4	16.8	7.1	6.6	99.9
SAFETY								
Abuse of prescription drugs (N=199)	4.17	0.0	4.0	15.1	39.2	39.7	2.0	100.0
Availability of emergency medical services (N=196)	2.84	4.1	36.7	36.7	12.8	8.2	1.5	100.0
Child abuse and neglect (N=195)	3.68	1.0	5.1	36.4	38.5	17.9	1.0	99.9
Criminal activity (N=197)	3.37	1.0	14.7	42.6	28.4	12.7	0.5	99.9
Culture of excessive and binge drinking (N=199)	3.81	1.0	8.0	27.1	35.7	27.1	1.0	99.9
Domestic violence (N=199)	3.80	0.5	5.0	30.2	40.7	22.1	1.5	100.0
Elder abuse (N=193)	3.34	2.1	16.6	38.3	26.9	13.5	2.6	100.0
Lack of police or delayed response of police (N=195)	2.46	12.8	42.1	31.8	7.7	3.6	2.1	100.1
Presence of drug dealers (N=194)	3.33	3.1	17.0	37.6	24.2	15.5	2.6	100.0
Presence of gang activity (N=194)	2.92	6.7	28.9	35.6	17.0	8.8	3.1	100.1
Presence of street drugs (N=195)	3.55	2.6	13.8	29.7	29.7	21.5	2.6	99.9
Sex trafficking (N=194)	3.59	2.1	11.9	33.0	27.8	23.2	2.1	100.1
HEALTHCARE AND WELLNESS								
Access to affordable dental insurance coverage (N=199)	3.82	1.5	10.1	24.1	31.7	30.7	2.0	100.1
Access to affordable health insurance coverage (N=200)	4.05	1.0	5.0	17.5	39.0	35.5	2.0	100.0
Access to affordable healthcare (N=201)	4.01	1.5	5.0	21.4	34.3	36.3	1.5	100.0
Access to affordable prescription drugs (N=199)	3.91	1.0	7.0	24.6	32.7	32.7	2.0	100.0
Access to affordable vision insurance coverage (N=192)	3.58	2.1	12.5	32.3	29.2	22.4	1.6	100.1
Access to technology for health records and health education (N=192)	2.83	5.7	31.3	38.5	16.1	5.2	3.1	99.9
Availability of behavioral health (e.g., substance abuse) providers (N=201)	4.21	0.5	5.0	16.4	28.4	48.3	1.5	100.1

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Availability of doctors, physician assistants, or nurse practitioners (N=195)	3.33	3.1	16.4	37.9	25.1	14.9	2.6	100.0
Availability of healthcare services for Native people (N=195)	3.50	4.6	12.3	29.7	22.1	22.6	8.7	100.0
Availability of healthcare services for New Americans (N=194)	3.32	5.2	16.5	33.0	23.2	17.0	5.2	100.1
Availability of mental health providers (N=197)	4.28	1.0	4.1	17.8	19.8	56.9	0.5	100.1
Availability of non-traditional hours (e.g., evenings, weekends) (N=197)	3.63	3.0	11.7	31.0	26.4	26.9	1.0	100.0
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=193)	3.34	2.6	16.1	42.5	21.2	17.1	0.5	100.0
Availability of specialist physicians (N=192)	3.20	3.6	24.5	31.8	22.4	14.6	3.1	100.0
Coordination of care between providers and services (N=196)	3.50	1.5	16.3	32.1	28.1	20.4	1.5	99.9
Timely access to medical care providers (N=197)	3.38	3.6	19.3	31.0	25.9	19.3	1.0	100.1
Timely access to dental care providers (N=193)	3.34	5.2	21.2	26.9	24.9	20.2	1.6	100.0
Timely access to vision care providers (N=194)	2.91	6.7	31.4	34.5	14.9	10.3	2.1	99.9
Use of emergency room services for primary healthcare (N=193)	3.53	2.1	14.5	30.6	31.1	19.7	2.1	100.1
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=202)	4.15	0.5	2.5	17.3	40.6	38.1	1.0	100.0
Dementia and Alzheimer's disease (N=194)	3.61	1.0	8.8	30.9	42.8	13.4	3.1	100.0
Depression (N=198)	4.10	0.5	2.0	17.2	46.5	32.8	1.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=202)	4.40	0.5	2.0	7.9	36.1	52.5	1.0	100.0
Exposure to secondhand smoke (N=199)	2.97	5.0	25.6	40.2	23.1	5.0	1.0	99.9
Smoking and tobacco use (N=200)	3.20	3.5	19.0	39.5	28.5	8.5	1.0	100.0
Stress (N=197)	3.81	1.0	6.1	30.5	34.5	26.9	1.0	100.0
Suicide (N=197)	4.01	0.5	2.5	26.4	35.0	34.0	1.5	99.9

*Percentages may not total 100.0 due to rounding.

**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflect total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

Fargo Resident Survey goes here

Fargo/Moorhead 2018 Community Health Needs Assessment
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 (Ebola 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	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economic Well-Being • Housing which accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence 4.22 • Availability of affordable housing 4.21 • Homelessness 3.88 • Hunger 3.64 35% report not having enough food			
Transportation • Availability of door-to-door transportation services for those unable to drive 3.55			
Children and Youth • Availability of services for at-risk youth 4.11 • Cost of quality childcare 4.08 • Availability of quality childcare 3.99 • Cost of services for at-risk youth 3.96 • Substance abuse by youth 3.89 • Teen suicide 3.89 • Childhood obesity 3.86 • Bullying 3.65			
Aging Population • Cost of long term care 4.15 • Cost of memory care 4.08 • Cost of in-home services 3.83 • Availability of resources for family and friends caring for and helping make decisions for elders 3.58 • Availability of resources to help the elderly stay safe in their homes 3.52			
Safety • Abuse of prescription drugs 4.17 • Culture of excessive and binge drinking 3.81 • Domestic violence 3.80 • Child abuse and neglect 3.68 • Sex trafficking 3.59 • Presence of street drugs 3.55			
Healthcare Access • Availability of mental health providers 4.28 • Availability of behavioral health providers 4.21 • Access to affordable health insurance coverage 4.05 • Access to affordable health care 4.01 o 24% report not having seen a health care provider in > 1 yr. • Access to affordable prescription drugs 3.91 • Access to affordable dental insurance coverage 3.82 o 30% report not having seen a dentist in >1yr • Availability of non-traditional hours 3.63 • Access to affordable vision insurance coverage 3.58 • Use of emergency room services for primary health care 3.53 • Availability of health care services for Native people 3.50 • Coordination of care between providers and services 3.50	#1 Priority		

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Mental Health and Substance Abuse • Drug use and abuse 4.40 • Alcohol use and abuse 4.15 o 50% report binge drinking • Depression 4.10 • Suicide 4.01 • Stress 3.81 • Dementia and Alzheimer's Disease 3.61 • Tobacco use- 21%	#2 Priority		
Health and Wellness • 60% Not getting enough fruits and vegetables • 45% Not getting enough exercise • Only 57% report having flu shot in the last year • 27% Overweight 39% obese • High cholesterol • Hypertension			

Greater Fargo Moorhead Key Stakeholder Meeting

July 31, 2018

SUMMARY

CHNA Key Stakeholders Facilitated Discussion

July 31, 2018

Biggest needs in the community

- Transportation
  - Transportation is needed to all services, food, appointments
  - MAT bus needs to travel to more areas of town
  - Hard for families with language barriers to figure out the MAT schedule
  - Cap on # of free passes offered on MAT buses

    - Transportation to health care for low income families; also a challenge for the elderly; need transportation but not eligible for MA medical transportation

- Child Care
    - Quality, affordable and accessible child care
    - Child care with structure-based early childhood standards is a priority issue
    - Housing/childcare – can't address other needs until these are met (i.e. Jeremiah Program)

- Affordable Health Care / Access to Health Care
    - Affordable health care and access is a top concern
    - Access to providers
    - Dental care for birth to age 5 – need dental providers who take Medicaid (only 3 with open slots/only take certain amounts)
    - How to get care if not MA eligible due to rising cost and high deductibles
    - People are waiting too long to get health care - going to the walk-in clinic instead of the ER; too many ambulance transports to the ER from the walk-in

- Substance Abuse
    - Percentage may be low but the ripple effect is huge in how it affects the community
    - Connection between mental health issues and substance abuse issues
    - Too many bars and liquor stores
    - Smoking, drinking and obesity seem to be ongoing and significant issues and addressing these issues must be community-based
    - Basic health care needs to support treatment and Social Determinants of Health must be considered in this process

- Poverty/Homelessness
    - Hunger in school age kids
    - 30% of families do not have enough food
    - Affordable housing – to decrease homelessness
    - Housing and food for the Native American community
    - Housing/Childcare – can't address other needs until these are met
    - Cap on # of free passes offered on MAT buses

- Obesity
    - Education on healthy food choices
    - Availability of healthy food choices
    - Proper nutrition for kids in school
    - More walking and biking trails
    - Obesity has a connection with mental health
    - Smoking, drinking and obesity seem to be ongoing and significant issues and addressing these issues must be community-based

- Mental Health
    - Mental health can correlate with trauma experiences
    - Availability of mental health professionals in schools
    - Depression – 40%
    - Early intervention/prevention/treatment – prenatal, children, assess risk factors, positive parenting
    - Mental health is the #1 issue – it leads to other issues
    - Shortage of mental health providers; barrier of credentials, reimbursement (rate of pay for providers, plus insurance providers)

    - Integrate mental health services with where people access other care
    - Basic health care needs to support treatment and Social Determinants of Health must be considered in this process
    - Connection between mental health issues and substance abuse issues
    - Essentia, Sanford and FM Ambulance should screen for mental health & refer as appropriate
    - Dual diagnosis – mental health/substance abuse (most challenging; need more supports)
    - FM Ambulance – same 10 clients served over a 10-year period – total cost $800,000
    - Teen suicide prevention education and resources needed on the ND side; better support on the Minnesota side
    - Mental health telehealth for rural communities

- Family Issues
    - Can be difficult to be a part of the community
    - Social media can be a negative resource
    - Lack of relationships and social connections (neighbors knowing neighbors)
    - Stability of the family is a key support issue – lack of relationships, community support

- General
    - More jobs can help decrease many of these problems
    - Need to get resources out to the people who need them
    - Discussion on community values
    - Increased violence
    - Consumer involvement/peer involvement (peer support)

Suggestions for addressing the needs

- Childcare
    - Need affordable childcare providers - Jeremiah Project

- Affordable Health Care / Access to Health Care
    - Accessibility – getting to appointments
    - Navigators – helping someone get to the services – help them take the right steps
    - Work with health care organizations when it comes to insurance
    - Consider partnering child check-ups with adult check-ups so the adults receive care and not just the children
    - Move health care to the schools
    - Basic education on health care and use of health care systems
    - Dental – need to spread awareness of the need for seeing children on Medicaid (some kids need several trips a year to the dentist); dental association helping to pay but that is not enough. Consider retired dentists – example: VA and chiropractor; waiver to sign to decrease malpractice insurance.
    - Being proactive with seniors – baby boomers are coming
    - Evening and weekend hours at clinics & walk-in clinics

- Substance Abuse
    - Decrease binge drinking – have activities for them to do instead of drinking
    - Engage faith communities – Living Free (72 people, 32 churches – small groups); increased relationships and connections
    - More funding for community paramedic program

- Poverty/Homelessness
    - Affordable housing

    - Find ways to support ending homelessness (even if we have to live next to it – i.e. the furor over the Churches United project)
    - Maybe each city should mandate a percentage of affordable housing in each development
    - Research on how to provide cheaper housing – granny flats (zoning allows this), tiny houses
    - SNAP program is doing great things; Essentia Health is partnering with the SNAP program

- Obesity
    - Healthy choices / easier choices

- Mental Health
    - Educate people to break down the fear barrier
    - Need community resources to integrate mental health
    - More community funding for community paramedic program
    - More education and resource awareness in schools & community to promote teen suicide prevention

- Children
    - How do we use our language; how do we equip kids to handle stress and pressure?
    - Slow down the chaos, slow down all the messaging – involve inter-generations
    - Media connections are very different – adaptations are needed
    - Consequences for disrespect

- Education / Publicity
    - Education for the providers
    - Education of the community to support ongoing efforts
    - Develop a uniform messaging and public information campaign to educate and inform the public; advertise the programs we have to offer
    - Basic education on health care and use of health care systems
    - Create the "flood" to mobilize the community – involve schools, government, faith communities, etc.

- Community Collaboration
    - Look for causes to address – early intervention
        - Homelessness
        - Substance abuse
        - Mental health
        - Political health
        - Social media
    - Partnerships / relationship building with different programs
    - Government is a part but not the sole resource to solve this
    - Mental health type groups (like *Re-Think Mental Health)* may be a way to network and support key objectives and goals. Need to take local and regional partnerships to the next level and use our strong collaborative approach to support these initiatives. Piggyback off our strong local collaborative relationships to support ongoing efforts.
    - Compare and contrast with other communities like ours to see what is or is not working or what could work
    - We can solve this if we get together
    - Get at the root causes, intervene, get people connected
    - United Way has programs that help with these issues and problems; would not always need to create a new program; identify programs that are best at doing this

- General

- Support outreach programs
- Bring services to the people
- Catalysts are law enforcement
- Decrease polarization; no trust because of different messages
- Consider how public policy supports and/or complicates these issues. Testimonies and stories and inclusion from frontline responders and people would help support this process.

Secondary Data

Secondary Data:
Cass and Clay Counties,
Fargo-Moorhead

Insert Greater Fargo Moorhead CHNA doc here in PDF form

Fargo Cass Public Health

Cass County Community Health Profile

Authors:

Tracy K. Miller, PhD, MPH
State Epidemiologist

Kodi Pinks, MPH
Epidemiologist

April 2018

NORTH DAKOTA DEPARTMENT *of* HEALTH

TABLE OF CONTENTS

Data Sources

The Demographic Section of this report comes from the US Census Bureau (www.census.gov). Most tables are derived either from the census estimates for 2015 or from the Community Population Survey aggregated over a several year period. The table header describes the specific years from which the data is derived. The tables present the number of persons and percentages which in almost all circumstances represent the category specific percentage of all persons referenced by the table (e.g., percentage of persons age 15 and older who are married). Age specific poverty rates represent the percentage of each age group in poverty (e.g., percentage of children under five years in poverty).

The **Vital Statistics** section of this report comes from the birth and death records collected by the North Dakota Department of Health Vital Records. This data is aggregated over a five year period. All births and deaths represent the county of residence not the county of occurrence. In order to maintain a person's confidentially, the number of events is blocked if fewer than six.

The **Adult Behavioral Risk Factor** section of this report is derived from the North Dakota Department of Health's Behavioral Risk Factor Surveillance Survey. The aggregated data (the number of years specified in the table) is continuously collected by telephone survey from persons 18 years and older residing in North Dakota. All data is self-reported data.

Data presented in the **Crime** section of this report is collected from the North Dakota Attorney General website located at: www.ag.nd.gov/Reports/BCIReports/CrimeHomicide/CrimeHomicide.htm.

Data presented in the **Child Health Indicators** section of this report is collected from the Kids Count Data Center website located at: www.datacenter.kidscount.org.

Photography Credits

Permission to use cover photos granted by:

- Scott Thomas Photography - Theodore Roosevelt National Park in Winter
  www.sthomasphotos.com/
- Jerry Blank – Lightening Storm north of Williston and Sunset over Little Missouri river
  www.jerryblank.us/gallery-nd.html
- ND Department of Commerce – Oil wells
  www.commerce.nd.gov/news/MediaGallery/
- ND Tourism Division – All other photos
  www.ndtourism.com/

POPULATION DATA

Table 1

Population by Age Group, 2016 Census Estimates				
Age Group	Cass County		North Dakota	
	Number	Percent	Number	Percent
0-9	23,859	13.6%	102,979	13.6%
10-19	21,406	12.2%	94,131	12.4%
20-29	36,407	20.8%	131,448	17.4%
30-39	26,477	15.1%	98,952	13.1%
40-49	19,127	10.9%	80,020	10.6%
50-59	19,300	11.0%	98,117	13.0%
60-69	15,888	9.1%	77,221	10.2%
70-79	7,199	4.1%	41,309	5.5%
80+	5,586	3.2%	32,750	4.3%
Total	175,249	100.0%	756,927	100.0%
0-17	39,231	22.4%	173,926	23.0%
65+	19,767	11.3%	107,281	14.2%

Table 2

Female Population and Percentage Female by Age, 2016 Census Estimates				
Age Group	Cass County		North Dakota	
	Number	Percent	Number	Percent
0-9	11,581	13.4%	50,339	13.7%
10-19	10,424	12.1%	45,524	12.4%
20-29	17,537	20.3%	59,466	16.2%
30-39	12,432	14.4%	46,021	12.5%
40-49	9,163	10.6%	38,369	10.4%
50-59	9,660	11.2%	48,072	13.1%
60-69	8,045	9.3%	37,852	10.3%
70-79	3,918	4.5%	21,927	6.0%
80+	3,556	4.1%	20,504	5.6%
Total	86,316	100.0%	368,074	100.0%
0-17	19,155	22.2%	84,955	23.1%
65+	10,963	12.7%	58,828	16.0%

Table 3

Race, Five Year Estimates (2012-2016)				
Race	Cass County		North Dakota	
	Number	Percentage	Number	Percentage
Total	166,852	100%	721,640	100%
White	148,944	89.3%	640,208	88.7%
Black	6,371	3.8%	11,872	1.6%
American Indian	1,813	1.1%	38,286	5.3%
Asian	4,640	2.8%	8,979	1.2%
Pacific Islander	8	0.0%	304	0.0%
Other	840	0.5%	5,859	0.8%
Multi-race	4,236	2.5%	16,132	2.2%

POPULATION DATA

Table 4

Household Populations, 2011 ACS Five Year Estimates	Cass County		North Dakota	
	Number	Percent	Number	Percent
Total	147,222	100.0%	666,783	100.0%
In Family Households	104,374	70.9%	509,097	76.4%
In Non-Family Households	38,060	25.9%	132,651	19.9%
Total In Households	142,434	96.7%	641,748	96.2%
Institutionalized	1042	0.7%	9,675	1.5%
Non-institutionalized	3746	2.5%	15,360	2.3%
Total in Group Quarters	4788	3.3%	25,035	3.8%

Table 5

Population Change 2000-2015				
Census	Cass County	5 Year Change (%)	North Dakota	5 Year Change (%)
2000	123,138		642,200	
2005	132,551	7.6%	636,677	-0.9%
2010	144,410	8.9%	674,530	5.9%
2015	162,500	12.5%	756,927	12.2%

Table 6

Marital Status of Persons Age 15 and Older, 2016 ACS Five Year Estimates	Cass County		North Dakota	
Marital Status	Number	Percent	Number	Percent
Total Age 15+	135,241	100.0%	584,052	100.0%
Never Married	52,068	38.5%	185,144	31.7%
Now Married	63,293	46.8%	304,875	52.2%
Separated	1,217	0.9%	5,256	0.9%
Widowed	5,951	4.4%	33,875	5.8%
Divorced	12,713	9.4%	54,901	9.4%

Table 7

Educational Attainment Among Persons 25+, 2016 ACS Five Year Estimates	Cass County		North Dakota	
Education	Number	Percent	Number	Percent
Total	103,797	100.0%	468,030	100.0%
Less than 9th Grade	2605	2.5%	18,153	3.9%
Some High School	3,136	3.0%	20,552	4.4%
High school or GRE	21,534	19.5%	128,248	27.4%
Some College/Assoc. Degree	37,739	36.4%	171,543	36.6%
Bachelor's Degree	27,277	26.3%	93,946	20.1%
Post Graduate Degree	11,506	11.1%	35,588	7.6%

POPULATION DATA

Table 8

Persons with Disability, 2016 ACS Five Year Estimates				
Group	Cass County		North Dakota	
	Number	Percent	Number	Percent
Total	165,567	100.0%	706,307	100.0%
Any Disability	16,875	10.2%	74,348	10.5%
No Disability	148,692	89.8%	631,959	89.5%
Self Care Disability	2,458	1.6%	10,879	1.7%
0-17 with any disability	1,009	6.0%	4,816	6.5%
18-64 with any disability	9,454	56.0%	36,427	49.0%
65+ with any disability	6,412	38.0%	33,105	44.5%

Table 9

Income and Poverty Status by Age Group, 2016 ACS Five Year Estimates				
	Cass County		North Dakota	
Median Household Income	$54,926		$57,181	
Per Capita Income	$32,485		$32,035	
	Number	Percent	Number	Percent
Below Poverty Level	19,089	11.8%	79,758	11.5%
Under 5 Years	1,803	9.4%	7,710	9.7%
5 to 11 Years	1,717	9.0%	8,335	10.5%
12 to 17 Years	810	4.2%	5,671	7.1%
18 to 64 Years	13,577	71.1%	48,857	61.3%
65 to 74 Years	499	2.6%	3,470	4.4%
75 Years and Over	683	3.6%	5,715	7.2%

Table 10

Family Poverty and Childhood and Elderly Poverty, 2016 ACS Five Year Estimates				
	Cass County		North Dakota	
	Number	Percent	Number	Percent
Total Families	39,335	100.0%	181,864	100.0%
Families in Poverty	2,675	6.8%	13,094	7.2%
Families with Own Children	19,979	50.8%	83,864	46.1%
Families with Own Children in Poverty	2238	5.7%	10,231	5.6%
Families with Own Children and Female Parent Only	4,520	11.5%	23,496	28.0%
Families with Own Children and Female Parent Only in Poverty	1347	3.4%	8,881	4.9%
Total Known Children in Poverty	4,330	11.0%	21,716	12.5%
Total Known Age 65+ in Poverty	1,182	6.0%	9,185	8.6%

* Percent family poverty is percent of total families

Table 11

Age of Housing, 2016 ACS Five Year Estimates				
	Cass County		North Dakota	
	Number	Percent	Number	Percent
Housing Units: Total	75,400	100.0%	341,062	100.0%
1980 and Later	43,609	57.8%	139,698	41.0%
1970 to 1979	12,245	16.2%	67,404	19.8%
Prior to 1970	19,546	25.9%	133,960	39.3%

Vital Statistics Data

BIRTHS AND DEATHS DEFINITIONS

Formulas for calculating rates and ratios are as follows:

Birth Rate = Resident live births divided by the total resident population x 1,000.

Pregnancies = Live births + Fetal deaths + Induced termination of pregnancy.

Pregnancy Rate = Total pregnancies divided by the total resident population x 1,000.

Fertility Rate = Resident live births divided by female population (age 15-44) x 1,000.

Teenage Birth Rate = Teenage births (age <20) divided by female teen population x 1,000.

Teenage Pregnancy Rate = Teenage pregnancies (age<20) divided by female teen population x 1,000.

Out of Wedlock (OOW) Live Birth Ratio = Resident OOW live births divided by total resident live births x 1,000.

Out of Wedlock Pregnancy Ratio = Resident OOW pregnancies divided by total pregnancies x 1,000.

Low Weight Ratio = Low weight births (birth weight < 2,500 grams) divided by total resident live births x 1,000.

Infant Death Ratio = Number of infant deaths divided by the total resident live births x 1,000.

Childhood & Adolescent Deaths = Deaths to individuals 1 - 19 years of age.

Childhood and Adolescent Death Rate = Number of resident deaths (age 1 - 19) divided by population (age 1 - 19) x 100,000.

Crude Death Rate = Death events divided by population x 100,000.

Age-Adjusted Death Rate = Death events with age specific adjustments x 100,000 population.

Vital Statistics Data

BIRTHS AND DEATHS

Table 12

Births, 2012-2016	Cass County		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio
Live Births and Rate	12,585	16.8	52,514	15.6
Pregnancies and Rate	14,091	18.8	57,065	17.0
Fertility Rate	71.6		81.3	
Teen Births and Rate	409	15.3	2,876	25.2
Teen Pregnancies and Rate	538	20.2	3,377	29.6
Out of Wedlock Births and Ratio	3,372	267.9	17,005	323.8
Out of Wedlock Pregnancies and Ratio	4,601	326.5	20,769	364.0
Low Birth Weight Birth and Ratio	793	63.0	3,299	62.8

Table 13

Child Deaths, 2012-2016	Cass County		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio
Infant Deaths and Ratio	51	4.1	290	5.5
Child and Adolescent Deaths and Rate	28	15.4	249	30.6
Total Deaths and Crude Rate	4,912	655.9	29,930	890

Table 14

Deaths and Age Adjusted Death Rate by Cause, 2012-2016	Cass County		North Dakota	
	Number	Adj. Rate	Number	Adj. Rate
All Causes	4,944	556.5	30,082	558.2
Heart Disease	999	114.2	6,576	701.5
Cancer	1,033	118.5	6,312	719.5
Stroke	207	22.2	1,574	161.7
Alzheimer's Disease	343	36.6	2,196	211.3
COPD	270	26.9	1,655	178.0
Unintentional Injury	256	31.4	1,665	214.6
Diabetes Mellitus	113	12.8	953	107.0
Pneumonia and Influenza	140	14.6	770	79.6
Cirrhosis	84	11.1	413	55.8
Suicide	117	15.1	610	88.7
Hypertension	82	9.0	455	46.2

NR-Not Reportable

Table 15

Leading Causes of Death by Age Group for Cass County, 2012-2016			
Age	1	2	3
0-4	Congenital Anomaly 7	Unintentional Injury 7	Prematurity*
5-14	Heart*	Cancer*	Diseases of Other Arteries*
15-24	Suicide 22	Unintentional Injury 15	Cancer*
25-34	Unintentional Injury 29	Suicide 25	Heart 12
35-44	Unintentional Injury 37	Heart 20	Cancer 13
45-54	Cancer 59	Heart 52	Cirrhosis 33
55-64	Cancer 199	Heart 121	Unintentional Injury 30
65-74	Cancer 277	Heart 117	COPD 97
75-84	Cancer 257	Heart 189	Alzheimer's Disease 77
85+	Heart 486	Alzheimer's Disease 250	Cancer 213

*Numbers less than six are not listed.

Table 16

Leading Causes of Death by Age Group for North Dakota, 2011-2015			
Age	1	2	3
0-4	Congenital Anomaly 70	Prematurity 64	Sudden Infant Death 47
5-14	Unintentional Injury 19	Homicide 7	Cancer*
15-24	Unintentional Injury 200	Suicide 120	Cancer 17
25-34	Unintentional Injury 195	Suicide 111	Heart 47
35-44	Unintentional Injury 157	Suicide 103	Heart 99
45-54	Cancer 378	Heart 311	Unintentional Injury 201
55-64	Cancer 1,069	Heart 624	Unintentional Injury 169
65-74	Cancer 1,540	Heart 871	COPD 332
75-84	Cancer 1,853	Heart 1,467	COPD 592
85+	Heart 3,149	Alzheimer's Disease 1,628	Cancer 1,327

*Numbers less than six are not listed.

ADULT BEHAVIORAL RISK FACTORS DEFINITION

The following three pages represent data received from the Adult Behavioral Risk Factor Surveillance Survey. Numbers given are point estimate percentages followed by 95% confidence intervals. Statistical significance can be determined by comparing confidence intervals between two geographic areas. To be statistically significant, confidence may not overlap. For example the confidence intervals 9.3 (8.3-10.2) and 10.8 (10.0-11.6) overlap (see picture below) so the difference between the two numbers is not statistically significant. That means that substantial uncertainty remains whether the apparent difference is due to chance alone (due to sampling variation) rather than representing a true difference in the prevalence of the condition in the two populations. The less they overlap, the more likely it is that the point estimates represent truly different prevalence's in the two populations.

ADULT BEHAVIORAL RISK FACTORS, 2011-2015

Table 17

ALCOHOL		Cass 2011-2015	North Dakota 2011-2015
Binge Drinking	Respondents who reported binge drinking (5 drinks for men, 4 drinks for women) one or more times in the past 30 days.	27.3 (25.3-29.2)	24.1 (23.3-24.9)
Heavy Drinking	Respondents who reported heavy drinking (more than 2 drinks per day for men, more than 1 drink per day for women) during the past 30 days.	7.7 (6.5-8.9)	6.7 (6.3-7.2)
Drunk Driving	Respondents who reported driving when they had too much to drink one or more times during the past 30 days.	3.2 (1.8-4.5)	3.4 (2.8-3.9)
ARTHRITIS			
Doctor Diagnosed Arthritis	Respondents who reported ever have been told by a doctor or other health professional that they had some form or arthritis.	20.4 (19.0-21.8)	24.6 (24.0-25.2)
Activity Limitation Due to Arthritis	Respondents who reported being limited in any usual activities because of arthritis or joint symptoms.	45.4 (40.7-50.1)	47 (45.2-48.9)
ASTHMA			
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma.	11.1 (9.9-12.4)	11.9 (11.3-12.4)
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma.	8.1 (7.0-9.1)	8.4 (7.9-8.9)
BODY WEIGHT			
Overweight, Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight).	35.8 (33.9-37.7)	36.5 (35.7-37.3)
Obese	Respondents with a body mass index greater than or equal to 30 (obese).	27.4 (25.6-29.1)	30.3 (29.6-31.1)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese).	63.2 (61.2-65.2)	66.8 (66.0-67.7)
CANCER			
Any Cancer	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had cancer (excluding skin cancer).	5.4 (4.7-6.1)	6.4 (6.1-6.7)
CARDIOVASCULAR			
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack.	3.2 (2.6-3.7)	4.3 (4.0-4.5)
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina.	3.2 (2.7-3.8)	4.0 (3.7-4.2)
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke.	2.0 (1.5-2.5)	2.4 (2.2-2.6)
Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following: heart attack, angina or stroke.	5.8 (5.1-6.6)	7.5 (7.2-7.8)

ADULT BEHAVIORAL RISK FACTORS, 2011-2015

Table 18

	CHOLESTEROL	Cass 2011-2015	North Dakota 2011-2015
Never Cholesterol Test	Respondents who reported never having a cholesterol test.	24.8 (22.3-27.2)	22.8 (21.8-23.8)
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years.	28.5 (26.0-31.0)	27.2 (26.2-28.3)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol.	33.8 (31.4-36.2)	36.1 (35.1-37.1)
	CHRONIC LUNG DISEASE		
COPD	Respondents who have ever been told by a doctor, nurse or other health professional ever told you that they have COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis.	3.5 (2.9-4.1)	4.7 (4.4-5.0)
	COLORECTAL CANCER		
No Colorectal Cancer Screening within Recommended Timeframe	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years.	34.1 (29.8-38.4)	40.0 (38.3-41.7)
	DIABETES		
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	6.8 (6.0-7.6)	8.5 (8.2-8.9)
	FRUITS AND VEGETABLES		
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day.	15.1 (13.3-16.9)	13.9 (13.2-14.6)
	GENERAL HEALTH		
Fair or Poor Health	Respondents who reported that their general health was fair or poor.	11.8 (10.5-13.0)	14.0 (13.5-14.6)
Poor Physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good.	9.9 (8.8-11.0)	11.3 (10.8-11.8)
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good.	12.1 (10.7-13.4)	11.4 (10.9-12.0)
Activity Limitation Due to Poor Health	Respondents who reported they had 8 or more days in the last 30 when poor physical or mental health kept them from doing their usual activities.	13.0 (11.1-14.8)	13.6 (12.8-14.4)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem.	31.3 (29.5-33.2)	31.3 (30.6-32.1)

ADULT BEHAVIORAL RISK FACTORS, 2011-2015

Table 19

HEALTH CARE ACCESS		Cass 2011-2015	North Dakota 2011-2015
Health Insurance	Respondents who reported not having any form or health care coverage.	11.3 (9.9-12.8)	10.8 (10.2-11.3)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost.	8.5 (7.3-9.7)	7.8 (7.3-8.3)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	29.8 (27.9-31.7)	26.7 (25.9-27.5)
HYPERTENSION			
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure.	26.7 (24.7-28.7)	29.9 (29.0-30.7)
IMMUNIZATION			
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year.	34.1 (30.8-37.4)	40.1 (38.9-41.4)
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	21.8 (18.9-24.7)	28.5 (27.3-29.7)
INJURY			
Falls	Respondents 45 years and older who reported that they had fallen in the past 12 months.	26.1 (22.9-29.2)	27.4 (26.2-28.7)
Seatbelt Use	Respondents who reported not always wearing their seatbelt.	68.9 (66.9-70.8)	61.4 (60.6-62.3)
ORAL HEALTH			
Dental Visit	Respondents who reported that they have not had a dental visit in the past year.	27.8 (24.8-30.8)	33.7 (32.4-35.0)
Tooth Loss	Respondents who reported they ever had a permanent tooth extracted.	10.0 (8.3-11.6)	14.3 (13.6-15.1)
PHYSICAL ACTIVITY			
No Leisure Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity.	19.7 (18.2-21.3)	25.1 (24.4-25.8)
TOBACCO			
Current Smoking	Respondents who reported that they smoked every day or some days.	18.2 (16.5-19.8)	20.6 (19.9-21.4)
WOMEN'S HEALTH			
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years.	24.8 (19.7-29.8)	25.1 (23.1-27.1)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years.	24.9 (20.6-29.2)	27.0 (25.4-28.6)

CRIME

Data presented on the North Dakota Attorney General website changed from previous years. In an effort to continue to provide this data, the 2015 variables are defined as follows which differs slightly from the 2010-2013 data:

- Rape: includes statutory rape and forcible rape
- Assault: only includes aggravated assault

Table 20

Cass County							
	2012	2013	2014	2015	2016	5 Year	5-Year Rate
Murder	2	3	4	5	4	18	2.2
Rape	79	74	103	117	106	479	57.3
Robbery	54	63	80	56	75	328	39.2
Assault	345	365	310	339	361	1,720	205.7
Violent crime	480	505	497	517	546	2,545	304.4
Burglary	617	904	725	879	770	3,895	465.9
Larceny	2,799	2,831	1,478	1,670	1,911	10,689	1,278.6
Motor vehicle theft	198	224	283	345	412	1,462	174.9
Property crime	3,614	3,959	2,486	2,894	3,093	16,046	1,919.3
Total	4,094	4,464	2,983	3,411	3,639	18,591	2,223.8

* Crime data from the North Dakota State University's Police Department is included.

Table 21

North Dakota							
	2012	2013	2014	2015	2016	5 Year	5-Year Rate
Murder	20	14	19	21	17	91	2.5
Rape	243	237	389	428	365	1,662	44.9
Robbery	117	151	166	157	181	772	20.9
Assault	1,071	1,156	1,145	1,185	1,132	5,689	153.7
Violent crime	1,451	1,558	1,719	1,791	1,695	8,214	222.0
Burglary	2,200	2,656	2,490	3,212	3,051	13,609	367.8
Larceny	10,184	10,243	5,214	6,181	6,157	37,979	1,026.4
Motor vehicle theft	1,031	1,228	1,462	1,725	1,887	7,333	198.2
Property crime	13,415	14,127	9,166	11,118	11,095	47,826	1,292.5
Total	14,866	15,685	10,885	12,909	12,790	54,345	1,468.7

CHILD HEALTH INDICATORS

The following information is no longer available on the website:

High school dropouts (dropouts per 1000 persons Grades 9-12)
Children Ages 0-17 Impact by Domestic Violence (Percentage of all children ages 0-17)
Offenses Against Person Juvenile Court Referral (Percentage of total juvenile court referral)
Alcohol-Related Juvenile Court Referral (Percentage of juvenile court referrals)

Table 22

Child Indicators: Education 2016	Cass County		North Dakota	
Children ages 3 to 21 enrolled in special education in public schools	2,965	12.4%	14,426	13.2%
Four-year high school cohort graduates	88.2%		87.3%	
Average expenditure per student in public school	$11,141		$11,945	

Table 23

Child Indicators: Economic Health 2016	Cass County		North Dakota	
TANF recipients ages 0-19 (Percentage of persons ages 0-19)	881	2.0%	4,649	2.4%
SNAP recipients ages 0-18 (Percentage of all children ages 0-19)	8,483	20.9%	37,758	20.5%
Eligible recipients of free or reduced price lunch	7,104	27.8%	37,928	32.6%
Medicaid recipients ages 0-20 (Percentage of all persons ages 0-20)	12,726	26.6%	59,156	28.1%
Median income for families with children ages 0-17 (Percentage of all women with children ages 0-17)	$74,245		$75,818	
Children ages 0 to 17 living in low-income families (<200% of poverty)	10,300	28.2%	50,147	30.5%

Table 24

Child Indicators: Families and Child Care 2016	Cass County		North Dakota	
Women in labor force, by age of children (ages 0-17)	15,024	83.3%	59,532	79.4%
Children ages 0-17 living in a single parent family (Percentage of all children ages 0-17)	9,708	26.3%	39,192	23.4%
Children in foster care (Percentage of children ages 0-18)	370	0.9%	2,381	1.3%
Victims of child abuse and neglect - services required (Percent of suspected victims)	211	13.6%	1,805	27.2%
Births to mothers receiving prenatal care beginning after first trimester or not at all	179	6.8%	1,612	14.2%

Table 25

Child Indicators: Juvenile Justice 2016	Cass County		North Dakota	
Children ages 10-17 referred to juvenile court (Percentage of all children ages 0-17)	795	5.3%	3,471	4.9%

*LNE-Low Number Events

Definitions of Key Indicators

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in
calculating the 2018 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County*
Health Rankings web site for your state.

For additional information about how the *County Health Rankings* are calculated, please visit www.countyhealthrankings.org

Contents:

* 95% confidence intervals are provided where applicable and available.
** Z-scores are "adjusted" z-scores (e.g., multiplied by -1 if a positively framed measure, set to zero for missing and unreliable
values for ranked counties, and truncated at -3 or +3 if county population is less than 20,000).

Measure	Data Elements	Description
Geographic identifiers	**FIPS**	Federal Information Processing Standard
	State	
	County	
Premature death	**Years of Potential Life Lost Rate**	Age-adjusted YPLL rate per 100,000
	95% CI - Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Years of Potential Life Lost Rate (Black)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Blacks
	Years of Potential Life Lost Rate (Hispanic)	Age-adjusted YPLL rate per 100,000 for Hispanics

Measure	Data Elements	Description
	Years of Potential Life Lost Rate (White)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Whites
Poor or fair health	**% Fair/Poor**	Percentage of adults that report fair or poor health
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor physical health days	**Physically Unhealthy Days**	Average number of reported physically unhealthy days per month
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor mental health days	**Mentally Unhealthy Days**	Average number of reported mentally unhealthy days per month
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Low birthweight	Unreliable	Value reported but considered unreliable since based on counts of twenty or less.
	% LBW	Percentage of births with low birth weight (<2500g)
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% LBW (Black)	Percentage of births with low birth weight (<2500g) for non-Hispanic Blacks
	% LBW (Hispanic)	Percentage of births with low birth weight (<2500g) for Hispanics
	% LBW (White)	Percentage of births with low birth weight (<2500g) for non-Hispanic Whites

Measure	Data Elements	Description
Adult smoking	**% Smokers**	Percentage of adults that reported currently smoking
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Adult obesity	**% Obese**	Percentage of adults that report BMI >= 30
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Food environment index	**Food Environment Index**	Indicator of access to healthy foods - 0 is worst, 10 is best
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Physical inactivity	**% Physically Inactive**	Percentage of adults that report no leisure-time physical activity
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Access to exercise opportunities	**% With Access**	Percentage of the population with access to places for physical activity
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Excessive drinking	**% Excessive Drinking**	Percentage of adults that report excessive drinking
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Alcohol-impaired driving deaths	# Alcohol-Impaired Driving Deaths	Number of alcohol-impaired motor vehicle deaths
	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	95% CI - Low	

Measure	Data Elements	Description
	95% CI - High	95% confidence interval using Poisson distribution
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	**Teen Birth Rate**	Births per 1,000 females ages 15-19
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Teen Birth Rate (Black)	Births per 1,000 females ages 15-19 for Black non-Hispanic mothers
	Teen Birth Rate (Hispanic)	Births per 1,000 females ages 15-19 for Hispanic mothers
	Teen Birth Rate (White)	Births per 1,000 females ages 15-19 for White non-Hispanic mothers
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance
	95% CI - Low	95% confidence interval reported by SAHIE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	PCP Rate	Primary Care Physicians per 100,000 population
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	Dentists per 100,000 population
	Dentist Ratio	Population to Dentists ratio

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	Mental Health Providers per 100,000 population
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	# Medicare Enrollees	Number of Medicare enrollees
	Preventable Hosp. Rate	Discharges for Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetes monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Receiving HbA1c (Black)	Percentage of Black diabetic Medicare enrollees receiving HbA1c test
	% Receiving HbA1c (White)	Percentage of White diabetic Medicare enrollees receiving HbA1c test
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)

Measure	Data Elements	Description
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Mammography (Black)	Percentage of Black female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	% Mammography (White)	Percentage of White female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in poverty	**% Children in Poverty**	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Children in Poverty (Black)	Percentage of non-Hispanic Black children (under age 18) living in poverty - from the 2012-2016 ACS
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty – from the 2012-2016 ACS
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2012-2016 ACS
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations per 10,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes per 100,000 population

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000.
	95% CI - Low	95% confidence interval as reported by the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**Presence of violation**	County affected by a water violation: 1-Yes, 0-No
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	**% Drive Alone**	Percentage of workers who drive alone to work
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Drive Alone (Black)	Percentage of non-Hispanic Black workers who drive alone to work

Measure	Data Elements	Description
	% Drive Alone (Hispanic)	Percentage of Hispanic workers who drive alone to work
	% Drive Alone (White)	Percentage of non-Hispanic White workers who drive alone to work
Long commute - driving alone	# Workers who Drive Alone	Number of workers who commute in their car, truck or van alone
	% Long Commute - Drives Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Cass County Health Rankings

	County	State
Population	175,249	757,952
% below 18 years of age	22.4%	23.3%
% 65 and older	11.3%	14.5%
% Non-Hispanic African American	5.1%	2.8%
% American Indian and Alaskan Native	1.4%	5.5%
% Asian	3.2%	1.5%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	2.7%	3.6%
% Non-Hispanic white	86.1%	85.0%
% not proficient in English	1%	1%
% Females	49.3%	48.7%
% Rural	10.4%	40.1%

		Cass County	Trend (Click for info)	Error Margin	Top U.S. Performers	North Dakota	Rank (of 49) (Click for info)
		Cass County	Trend (Click for info)	Error Margin	Top U.S. Performers	North Dakota	Rank (of 49) (Click for info)
Health Outcomes							8
Length of Life							3
Premature death	(Click for info)	5,200		4,800-5,600	5,300	6,600	
Years of Potential Life Lost Rate		5,200	x				
Years of Potential Life Lost Rate (Black)		5,800					
Years of Potential Life Lost Rate (Hispanic)		10,700					

		County	State			
Years of Potential Life Lost Rate (White)	5,100					
Quality of Life						17
Poor or fair health	12%		12-13%	12%	14%	
Poor physical health days	2.6		2.4-2.7	3.0	3.0	
Poor mental health days	2.7		2.5-2.8	3.1	3.1	
Low birthweight	6%		6-7%	6%	6%	
% LBW	6%					
% LBW (Black)	8%					
% LBW (Hispanic)	6%					
% LBW (White)	6%					
Additional Health Outcomes (not included in overall ranking)						
Premature age-adjusted mortality	280		260-300	270	320	
Age-Adjusted Mortality	280					
Age-Adjusted Mortality (Black)	410					
Age-Adjusted Mortality (Hispanic)	320					
Age-Adjusted Mortality (White)	270					
Child mortality	50		40-60	40	60	
Infant mortality	5		4-7	4	7	
Frequent physical distress	8%		8-8%	9%	9%	
Frequent mental distress	9%		8-9%	10%	9%	
Diabetes prevalence	7%		6-8%	8%	8%	
HIV prevalence	82			49	53	
Health Factors						4
Health Behaviors						2
Adult smoking	15%		14-15%	14%	20%	
Adult obesity	30%		28-32%	26%	32%	

		County	State		
Food environment index		8.9		8.6	9.1
Physical inactivity		19%	18-20%	20%	24%
Access to exercise opportunities		88%		91%	75%
Excessive drinking		25%	24-25%	13%	26%
Alcohol-impaired driving deaths		35%	24-45%	13%	48%
Sexually transmitted infections		507.8		145.1	427.2
Teen births		16	15-17	15	25
Teen Birth Rate	16				
Teen Birth Rate (Black)	42				
Teen Birth Rate (Hispanic)	46				
Teen Birth Rate (White)	12				
Additional Health Behaviors (not included in overall ranking) +					
Food insecurity		9%		10%	8%
Limited access to healthy foods		3%		2%	7%
Drug overdose deaths		9	7-12	10	8
Drug overdose deaths - modeled		6-7.9		8-11.9	10.6
Motor vehicle crash deaths		6	5-8	9	16
Insufficient sleep		27%	26-27%	27%	29%
Clinical Care					2
Uninsured		8%	7-8%	6%	9%
Primary care physicians		970:1		1,030:1	1,330:1
Dentists		1,280:1		1,280:1	1,550:1
Mental health providers		390:1		330:1	610:1

		County	State		
Preventable hospital stays	38		35-41	35	49
Diabetes monitoring	91%		86-97%	91%	87%
Mammography screening	71%		66-76%	71%	69%
Additional Clinical Care (not included in overall ranking)					
Uninsured adults	8%		7-9%	7%	9%
Uninsured children	6%		5-7%	3%	8%
Health care costs	$8,386				$8,341
Other primary care providers	642:1			782:1	838:1
Social & Economic Factors					6
High school graduation	87%			95%	85%
Some college	80%		77-84%	72%	73%
Unemployment	2.3%			3.2%	3.2%
Children in poverty	11%		9-13%	12%	12%
% Children in Poverty	11%	x			
% Children in Poverty (Black)	49%				
% Children in Poverty (Hispanic)	33%				
% Children in Poverty (White)	6%				
Income inequality	4.2		4.0-4.4	3.7	4.3
Children in single-parent households	29%		26-33%	20%	28%
Social associations	10.4			22.1	15.7
Violent crime	307			62	260
Injury deaths	47		43-52	55	68
Additional Social & Economic Factors (not included in overall ranking) +					
Disconnected youth	5%			10%	8%
Median household income	$59,700		$55,200-64,200	$65,100	$61,900

			County	State		
Household Income	$59,700		x			
Household income (Black)	$24,100					
Household income (Hispanic)	$29,400					
Household income (White)	$58,200					
Children eligible for free or reduced price lunch		28%			33%	31%
Residential segregation - black/white		44			23	57
Residential segregation - non-white/white		30			14	46
Homicides		1		1-2	2	2
Firearm fatalities		7		6-9	7	12
Physical Environment						49
Air pollution - particulate matter		9.0			6.7	7.5
Drinking water violations		Yes				
Severe housing problems		13%		12-14%	9%	11%
Driving alone to work		83%		82-84%	72%	80%
% Drive Alone	83%					
% Drive Alone (Black)	72%					
% Drive Alone (Hispanic)	62%					
% Drive Alone (White)	85%					
Long commute - driving alone		9%		7-10%	15%	14%

Clay County Health Rankings

	County	State
Population	62,875	5,519,952
% below 18 years of age	23.9%	23.3%
% 65 and older	12.9%	15.1%
% Non-Hispanic African American	2.6%	6.0%
% American Indian and Alaskan Native	1.8%	1.3%
% Asian	1.4%	4.9%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	4.5%	5.2%
% Non-Hispanic white	88.0%	80.6%
% not proficient in English	1%	2%
% Females	50.6%	50.2%
% Rural	27.9%	26.7%

	Clay County	Trend	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
	Clay County	Trend	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
Health Outcomes						67
Length of Life						53
Premature death	5,900		5,200-6,600	5,300	5,100	
Quality of Life						70
Poor or fair health	12%		12-13%	12%	12%	
Poor physical health days	3.0		2.9-3.2	3.0	3.0	
Poor mental health days	3.0		2.9-3.2	3.1	3.2	
Low birthweight	7%		6-8%	6%	6%	

			CountyState		
% LBW	7%		x		
% LBW (Black)	11%				
% LBW (Hispanic)	9%				
% LBW (White)	7%				
Additional Health Outcomes (not included in overall ranking)					
Premature age-adjusted mortality		320	300-350	270	260
Child mortality		30	20-50	40	40
Infant mortality		5	4-8	4	5
Frequent physical distress		9%	9-9%	9%	9%
Frequent mental distress		9%	9-10%	10%	10%
Diabetes prevalence		6%	5-8%	8%	8%
HIV prevalence		45		49	171
Health Factors					27
Health Behaviors					49
Adult smoking		15%	15-16%	14%	15%
Adult obesity		28%	24-32%	26%	27%
Food environment index		8.8		8.6	8.9
Physical inactivity		21%	18-24%	20%	20%
Access to exercise opportunities		84%		91%	88%
Excessive drinking		25%	24-26%	13%	23%
Alcohol-impaired driving deaths		39%	26-51%	13%	30%
Sexually transmitted infections		427.5		145.1	389.3
Teen births		11	10-13	15	17
Teen Birth Rate	11				
Teen Birth Rate (Black)	25				
Teen Birth Rate (Hispanic)	50				

			County	State	
Teen Birth Rate (White)	8				
Additional Health Behaviors (not included in overall ranking) +					
Food insecurity	10%		10%	10%	
Limited access to healthy foods	2%		2%	6%	
Drug overdose deaths	18	12-25	10	11	
Drug overdose deaths - modeled	12-13.9		8-11.9	12.5	
Motor vehicle crash deaths	6	4-9	9	8	
Insufficient sleep	27%	26-28%	27%	30%	
Clinical Care					33
Uninsured	4%	4-5%	6%	5%	
Primary care physicians	3,900:1		1,030:1	1,110:1	
Dentists	1,960:1		1,280:1	1,440:1	
Mental health providers	450:1		330:1	470:1	
Preventable hospital stays	40	35-46	35	37	
Diabetes monitoring	89%	78-100%	91%	88%	
Mammography screening	66%	54-77%	71%	65%	
Additional Clinical Care (not included in overall ranking) +					
Uninsured adults	5%	4-6%	7%	6%	
Uninsured children	2%	2-3%	3%	3%	
Health care costs	$8,528			$8,250	
Other primary care providers	3,493:1		782:1	1,020:1	
Social & Economic Factors					19
High school graduation	82%		95%	83%	
Some college	78%	73-82%	72%	74%	
Unemployment	3.5%		3.2%	3.9%	

			County	State
Children in poverty	13%	10-17%	12%	13%
% Children in Poverty	13%			
% Children in Poverty (Black)	42%			
% Children in Poverty (Hispanic)	27%			
% Children in Poverty (White)	9%			
Income inequality	4.3	3.9-4.6	3.7	4.4
Children in single-parent households	22%	18-26%	20%	28%
Social associations	11.1		22.1	13.0
Violent crime	120		62	231
Injury deaths	56	48-64	55	62
Additional Social & Economic Factors (not included in overall ranking) +				
Disconnected youth	6%		10%	9%
Median household income	$59,900	$55,000-64,900	$65,100	$65,600
Household Income	$59,900			
Household income (Hispanic)	$36,700			
Household income (White)	$62,000			
Children eligible for free or reduced price lunch	34%		33%	38%
Residential segregation - black/white	46		23	62
Residential segregation - non-white/white	30		14	49
Homicides			2	2
Firearm fatalities	5	3-8	7	7
Physical Environment				

			CountyState		
Air pollution - particulate matter		9.1		6.7	9.3
Drinking water violations		No			
Severe housing problems		14%	12-16%	9%	14%
Driving alone to work		80%	79-81%	72%	78%
% Drive Alone	80%				
% Drive Alone (Hispanic)	60%				
% Drive Alone (White)	76%				
Long commute - driving alone		18%	16-19%	15%	30%

Note: Blank values reflect unreliable or missing data

SANFORD HEALTH

019012-00347 9/18