Sanford Medical Center Fargo
2016 Community Health
Needs Assessment

SANFORD®
HEALTH

Sanford Broadway Medical Center Fargo

Community Health Needs Assessment
2016

Dear Community Members,

Sanford Fargo is pleased to present the 2016 Community Health Needs Assessment.

Part of the comprehensive assessment work is to formally identify unmet health needs in the community. Community stakeholders helped to prioritize the unmet needs for further implementation strategy development. We are grateful to all the community members who joined us in this important work.

During 2015 members of the community were asked to complete a generalizable survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. Additional surveys included key stakeholders from Cass and Clay counties and the assessment of American Indian residents. Sanford further analyzed the data, identified unmet needs, and partnered with key community stakeholders to develop a list of resources and assets that were available to address each need. A gap analysis and prioritization exercise was also conducted to identify the most significant health needs and to further address these needs through the implementation strategies that are included in this document.

Sanford Fargo has set strategy to address the following community health needs:
- Depression
- Hypertension
- Flu shots

The report focuses on community assets as well as community health needs. The asset map/resource list is included in this document along with the action steps that will be taken to address each identified need.

At Sanford Fargo, patient care extends beyond our bricks and mortar. As a not-for-profit organization, ensuring that the benefits of health care reach the broad needs of communities is at the core of who we are. Through our work with communities, we can bring health and healing to the people who live and work across our communities. Together, we can fulfill this mission.

Sincerely,

Paul Richard
President
Sanford Medical Center Fargo

Sanford Broadway Medical Center Fargo

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

Sanford Broadway Medical Center Fargo

Community Health Needs Assessment
2016

Purpose

A community health needs assessment is critical to a vital Community Benefit Program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment helps the community build capacity to support policy, systems, environmental changes and community health improvement. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining not-for-profit status.

The purpose of this 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 to develop a Community Benefit plan of action. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunity to identify and address public health issues from a broad perspective.

Study Design and Methodology

1. **Generalizable Survey**
    A generalizable survey was conducted of residents in Cass County, North Dakota and Clay County, Minnesota. The purpose of the generalizable survey of residents in the greater Fargo-Moorhead area (i.e., Cass County, North Dakota and Clay County, Minnesota) was to learn about the perceptions of area residents regarding community health, their personal health, preventive health, and the prevalence of disease.

    Staff at the North Dakota State University Center for Social Research, along with members of the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative, created the survey tool and cover letter. Elements of informed consent were included in the letter ensuring that the NDSU Institutional Review Board requirements were met and the protection of human subjects maintained.

Obtained through a qualified vendor, the sample was a stratified random sample to ensure that appropriate proportions from each of the two counties were included. A total of 1,500 records with names, addresses, and a few demographic indicators were included in the sample. A total of 398 paper surveys were returned for scanning and an additional 3 surveys were completed on-line for a total of 401; the response rate was 27 percent. It was apparent that elderly and male respondents were overrepresented in the scanned results. Therefore, post-stratification weights were used to ensure proper representation of the population with respect to age and gender. Respondents who did not enter a gender and age response were eliminated from the analysis. A total of 382 surveys were analyzed, providing a generalizable sample with a confidence level of 95 percent and an error rate of plus or minus 5.2 percentage points.

A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by Sanford and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. **Non-Generalizable Survey**
An online non-generalizable survey was conducted on-line through a partnership between the Greater Fargo-Moorhead Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various agencies, at times using a snowball approach**.** Data collection occurred throughout the month of June 2015 and a total of 51 respondents participated in the on-line survey.

The purpose of this non-generalizable survey of community leaders in the greater Fargo-Moorhead area (i.e., Cass County, North Dakota and Clay County, Minnesota) was to learn about the perceptions of area community leaders regarding community health, their personal health, preventive health, and the prevalence of disease. This group included community leaders, legislators, and agency leaders representing chronic disease and disparity.

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3. **Community Stakeholder Meeting**
Community stakeholders were invited to a meeting to review the early findings from the generalizable survey and to discuss the top health issues or health-related issues facing the community. Over 200 individuals were invited to attend from county commissions, city councils, school boards, and agencies representing the chronic disease groups and disparity. There were 53 attendees at the July 2015 community stakeholder meeting and the discussion helped to determine key priorities for the community.

4. **Community Asset Mapping**
Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources were available in the community to address the needs. Once gaps were determined the group

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

5. **Secondary Research**

   2015 Assessment of American Indian Residents
   Persons who self-identified as American Indian/Alaska Native were targeted for this study. Survey data was collected in July 2015 during the Fargo-Moorhead "Honoring Traditions of Health Wellness Community Health Fair" at Carl Ben Eielson Middle School in Fargo, North Dakota. There were 96 participants in this study.

   The secondary data includes community health profiles from the North Dakota Department of Health for Cass County, North Dakota and the Minnesota Department of Health for Clay County Minnesota. The indicators that were reviewed for this assessment include: population data, vital statistics, adult behavioral risk factors, crime and child risk. Additionally, the County Health Rankings were included in the findings.

Key Findings – Primary Research

The key findings are based on the generalizable and the non-generalizable survey data. Key indicators were ranked on a 1-5 Likert scale, with 5 being the highest concern ranking. Survey results that rank 3.5 or higher are considered to be high ranking concerns for both the generalizable survey and the key stakeholder non-generalizable survey.

1. **Economics:** Respondents were most concerned about affordable housing and hunger in regards to economics in Cass and Clay County. Homelessness is a moderate concern and was the third highest concern in the area of community economics.

2. **Aging:** The number one ranking concern among respondents overall is the cost of long term care. The availability of memory care and the availability of long term care also rank as top concerns for the aging.

3. **Children and Youth:** When considering children and youth, bullying ranks highest of the concerns for respondents. The cost of quality child care and the availability of quality infant care are also ranked as high concerns.

4. **Safety:** The presence of street drugs and alcohol in the community, the presence of drug dealers in the community, crime, child abuse and neglect, domestic violence and sex trafficking are the highest safety concerns of the respondents.

5. **Health Care:** The health care indicator addressed access to health care and cost concerns. Access to affordable health insurance, access to affordable health care, access to affordable prescription drugs, cost of affordable dental insurance coverage, and the cost of affordable vision insurance coverage are the highest concerns among the respondents.

6. **Physical Health**: Cancer, chronic disease, inactivity and lack of exercise, obesity, poor nutrition and eating habits, and infectious disease such as flu are the highest physical health concerns.

7. **Mental Health/Behavioral Health**: Depression, dementia and Alzheimer's, stress, underage drug use and abuse, underage drinking, suicide, drug use and abuse, and alcohol use and abuse are the highest concerns for mental health/behavioral health.

Key Findings – Secondary Research Based on the 2015 County

Health Rankings

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcomes indicate that North Dakota as a state has more premature deaths (6,388 per 100,000) than Minnesota (5,038 per 100,000). Clay County, Minnesota has a higher rate (5,563 per 100,000) than Cass County, North Dakota (5,153).

Poor or fair health: 10% of adults in Cass County and 11% in Clay County report poor or fair health compared to 10% for the nation, 12% in North Dakota and 11% in Minnesota.

The average number of days reported in the last 30 as unhealthy mental health days is 2.4 in Cass County and 2.8 in Clay County. The state of North Dakota reports 2.4 days, and Minnesota reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 6.5% in Cass County and 6.7% in Clay County. Both North Dakota and Minnesota report 6.5%.

Health Factors

The percent of adults who are currently smoking is 16% in Cass County and 17% in Clay County. The state of North Dakota reports 18% of adults are current smokers and in Minnesota the percent of current adult smokers is 16%.

27% of the adult population in Cass County, and 30% in Clay County are considered obese with a BMI over 30. This compares with North Dakota at 30% and Minnesota at 26%.

The percent of adults reporting excessive or binge drinking is 21% in Cass County and 23% in Clay County. North Dakota reports 22% statewide and Minnesota reports 19%.

Driving deaths that have alcohol involvement is at 30% in Cass County and 22% in Clay County. North Dakota as a whole is at 46% and Minnesota is at 31%.

Sexually transmitted infections rank substantially higher than the national benchmark (138) for North Dakota (416), Minnesota (336), and Cass (445) and Clay Counties (316).

The teen birth rate is higher in North Dakota (28) and Minnesota (24) than the national benchmark, but is lower in Cass (19) and Clay Counties (15).

The clinical care outcomes indicate that North Dakota (12%) and Cass County (11%) have a higher percentage of uninsured adults, while Minnesota (9%) and Clay County (8%) have lower percentages.

The ratio of population to primary care physicians is 1,279:1 in North Dakota and 1,113:1 in Minnesota. Clay County's ratio is 1,045:1, while Cass County's ratio is more favorable at 863:1. The ratio of population to mental health providers is 638:1 in North Dakota and 529:1 in Minnesota. Clay County's ratio is 386:1 and Cass County is at 400:1.

The number of professionally active dentists is 1,710:1 North Dakota, 1,529:1 in Minnesota, 1,404:1 in Cass County, and 1,377:1 in Clay County.

Preventable hospital stays are better in Cass (46) and Clay (39) counties than in North Dakota (56) and Minnesota (45).

Diabetic screening is at 88% in Cass County and 86% in North Dakota. Clay County is slightly lower at 87% and Minnesota is at 88%.

Mammography screening is at 70.8% in Cass County and 68% in North Dakota while Clay County is at 70.7% and Minnesota is at 66.7%.

The social and economic factor outcomes indicate that North Dakota is at 85% and Minnesota is at 78% for high school graduation. The high school graduation rate in Cass County is 85% and Clay County has a graduation rate of 87%**.**

Post-secondary education (some post-secondary education) is at 81.1% in Cass County, 74.4% in North Dakota, 73.2% in Clay County, and 73.3% in Minnesota.

The unemployment rate is 2.9% in North Dakota, 3% in Cass County, 5.1% in Minnesota, and 3.7% in Clay County.

The percentage of child poverty is 12% in North Dakota and 11% in Cass County. Child poverty is 13% in Clay County and 14% in Minnesota.

Social associations are defined as the number of membership associations per 10,000 populations and is higher in North Dakota at 17.3 than in Cass County at 11.4. Minnesota is higher at 13.2 than Clay County at 11.6.

The percentage of children in single parent households is 25% in Cass County, 26% in North Dakota, 25% in Clay County and 28% in Minnesota.

Violent crime is higher in Cass County at 284 per 100,000 population than in North Dakota at 240 per 100,000 population. Minnesota has 229 cases per 100,000 and Clay County is at 115 per 100,000 population.

Youth account for 21.9% of the population in Cass County and 23% of the population in Clay County. Elderly account for 10.5% of the population in Cass County and 12.4% of the population in Clay County.

The rural population of Cass County is 10.4%. The rural population of Clay County is 27.9%.

The following needs ranked highest and were brought forward for prioritization:
- Economics – affordable housing and hunger
- Aging – cost and availability of long term care and availability of memory care

- Children and Youth – cost and availability of quality child care and quality infant care, bullying
- Safety – presence of drug dealers in the community and the presence of street drugs and alcohol in the community
- Health Care Access – access to affordable health care and affordable health insurance
- Physical Health – cancer, chronic disease, obesity, poor nutrition and inactivity
- Mental Health – depression, stress, substance use and abuse
- Preventive Health – flu vaccines

Members of the collaborative determined that flu vaccines are a top unmet need. Community stakeholders also rated chronic disease and mental illness as top priorities.

Sanford has determined the 2016-2019 implementation strategies for the following needs:
- Hypertension
- Depression
- Flu vaccines

Implementation Strategies

1. **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 has prioritized hypertension as a top priority 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.

2. **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. But 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 nine whose six-month PHQ-9 score is less than five.

3. **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.

Sanford Broadway Medical Center Fargo

Community Health Needs Assessment 2016

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  - o *Methodology*
  - o *Survey Results*
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- *Clay County, Minnesota and Cass County, North Dakota Comparison*

Sanford Broadway Medical Center Fargo

Community Health Needs Assessment
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Purpose of the Community Health Needs Assessment

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The purpose of this 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 to develop a Community Benefit plan of action. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunity to identify and address public health issues from a broad perspective.

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

Acknowledgements

Sanford Health would like to acknowledge and thank the Steering Committees for their assistance and expertise while performing the assessment and analysis of the community health data. The assessment provides support for the future direction of our work.

- Kim Jacobson, Traill County Public Health
- Kip Littau, South Dakota State University
- Marnie Walth, Sanford Health
- Mary Michaels, Sioux Falls Public Health
- Nancy Fahrenwald, South Dakota State University
- Renae Moch, Burleigh County Public Health
- Roger Baier, Sanford Health
- Ruth Bachmeier, Fargo Cass Public Health
- Sandra Melstad, Public Health Consultant, South Dakota Department of Health
- Stan Kogan, Sioux Falls Public Health
- Stephen Pickard, PhD, North Dakota Department of Health
- Susan Kahler, Burleigh County Public Health
- Teresa Miller, Avera Health

We extend a special appreciation to Maylynn Warne, Executive Director of the North Dakota Public Health Association for her leadership of the 2015 Greater Fargo-Moorhead Community Health Needs Assessment of American Indian Residents, and for sharing the report with us.

We extend special thanks to the state legislators, mayors, city council/commission members, physicians, nurses, university presidents, school superintendents and school board members, representatives from the Native American community, representatives for the mentally and physically disabled, social services, non-profit organizations, and public health officers 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 Fargo-Moorhead, Cass and Clay County Key Community Stakeholders participated in community discussions and helped to formulate the priorities for future work.
- Ann Malmberg, Essentia Health
- Anna Frissell, Red River Children's Advocacy Center
- Anne Blackhurst, MSUM
- Annette Thompson, American Cancer Society
- Ben Lien, MN State Representative
- Brie Taralson, Essentia Health
- Carol Roth, Fargo Cass Public Health
- Chip Ammerman, Cass Co. Social Services
- Dan Griebling, Essentia Health
- Diane Solinger, Jeremiah Program
- Dinah Goldenberg, Fargo School Board
- Gina Nolte, Clay Co. Public Health
- Greg Glasner, Essentia Health
- Jaimie Witt, Center for Rural Health
- Jessie Doschadis, Family HealthCare Center
- John Vastag, ND IPAT
- Julie Hinkel, Gladys Ray Shelter
- Justin Bohrer, Fargo Cass Public Health
- Kaitlyn Kline, Kevin Cramer's office
- Karen Nitzkorski, Clay Co. Public Health
- Kathy Anderson, Clay Co. Public Health

- Kathy McKay, Clay Co. Public Health
- Katie Nystuen, SE Human Services
- Kay Schwarzwalter, NDSU Center for Social Research
- Kaylin Frappier, Family HealthCare Center
- Keely Ihry, Dakota Medical Foundation
- Keith Bennett, Essentia Health
- Kent Eken, MN State Senator
- Kim Lipetzky, Fargo Cass Public Health
- Kristen Limb, Essentia Health
- Kristi Halvarson, Community Health Service Inc.
- Kristie Invie, Sanford Health
- Leah Siewert, Gladys Ray Shelter
- Linda Bartholomay, Sanford Health
- Lindsey Miller, Dakota Medical Foundation
- Lynne Kovash, Moorhead Schools
- Mari Dailey, Moorhead City Council
- Mark Altenburg, M State
- Maryann Harris, Clay Co. Public Health
- Mike Williams, Fargo City Commissioner
- Paul Richard, Sanford Health
- Rick Axelson, NDSU Center for Social Research
- Ruth Bachmeier, Fargo Cass Public Health
- Ryan Nagle, Heidi Heitkamp's office
- Sara Stolt, Dakota Medical Foundation
- Shannon Bacon, American Cancer Society
- Shirley Dykshoorn, LSS of ND
- Sue Oatey, Concordia College
- Tiffany Knauf, Center for Rural Health
- Tiffany Lawrence, Sanford Health
- Tim Mahoney, Mayor of Fargo
- Tim Sayler, Essentia Health
- Tom Jones, American Heart Association

Description of Sanford Fargo Broadway Medical Center

Sanford Broadway Medical Center is a 583-bed tertiary medical center in Fargo, ND. It provides comprehensive, multi-specialty care for patients from across the Midwest, with over 50 percent of patients coming from outside the Fargo-Moorhead metropolitan area. It is the largest hospital in North Dakota and the region's busiest Level II Trauma Center, serviced by AirMed air ambulance program that extensively covers the vast geographic region.

As a provider of highly specialized services, Sanford Broadway Medical Center includes Sanford Children's Hospital, Sanford Heart Center, Sanford Orthopedic Hospital, Roger Maris Cancer Center, Sanford Women's, Brain and Spine Center, Same Day Surgery and numerous high-level services in over 80 medical specialties. Sanford employs 8,000 people in Fargo-Moorhead, including 500 board-certified physicians and 200 advanced practice providers (APPs). All Sanford entities are accredited by The Joint Commission.

Sanford Broadway Medical Center Fargo is a major teaching hospital in partnership with area universities and the University of North Dakota School of Medicine and Health Sciences to provide clinical training for hundreds of medical students, medical residents, nurses and students in numerous health care and non-health care fields. Sanford also offers many activities and programs to attract high school and younger students to the health care field.

Community involvement has played an important role in Sanford Medical Center's mission for over 100 years. Beyond providing medical care, Sanford supports and partners with local and national organizations that know and serve the communities across our region. Together, we work to provide health care awareness, education, prevention, fundraising and research for the health care issues that matter most to our communities. Sanford also supports the region's Critical Access Hospitals so they can continue to provide vital services in their communities, ensuring that all people have access to high-quality health care close to home.

Sanford Health is the largest employer in the Fargo-Moorhead community with a stable and growing workforce. One out of every 27 people in Fargo-Moorhead currently works at a Sanford facility, which is 3.7 percent of the population.

Community Served – Fargo-Moorhead-West Fargo

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 2015 had a population of 225,000.

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 has 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 30,000 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.
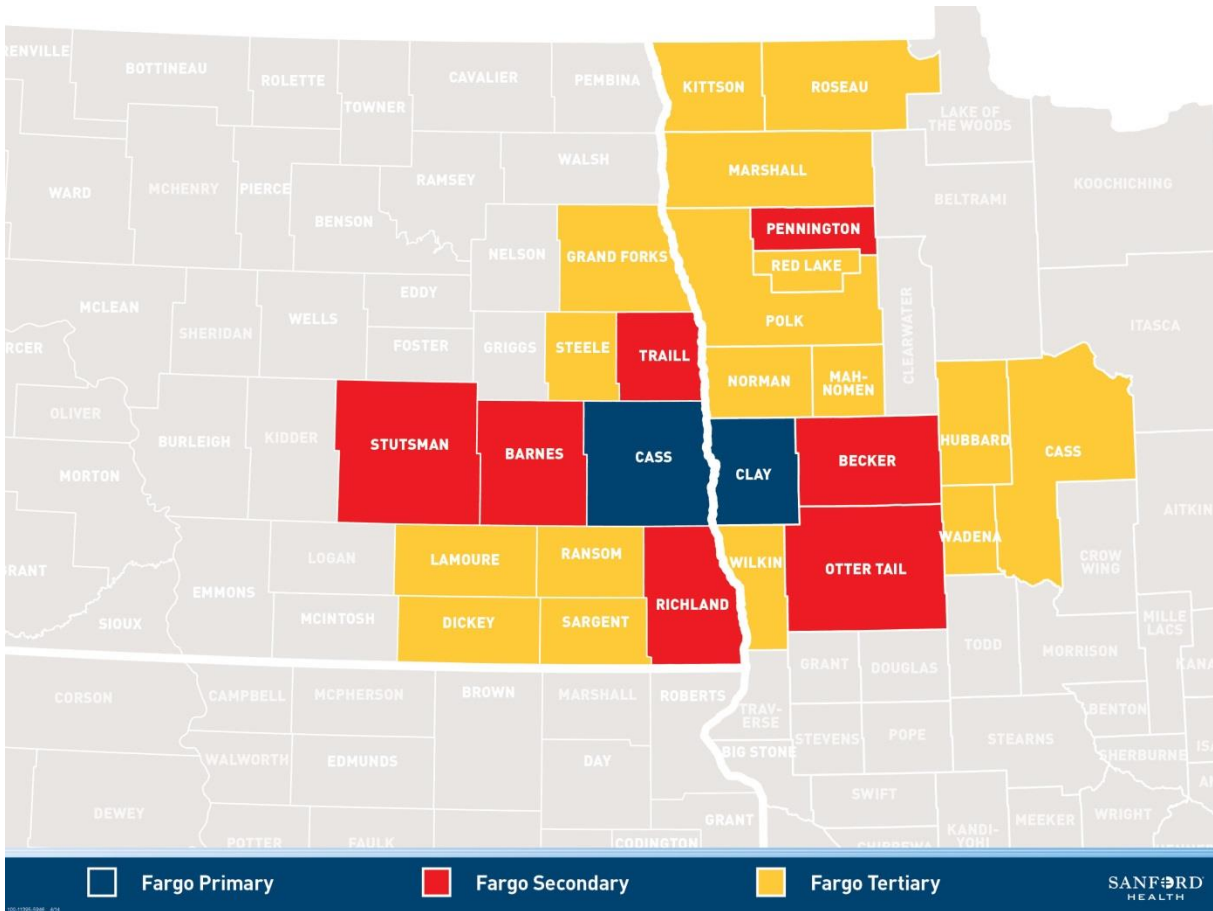
Fargo Primary | **Fargo Secondary** | **Fargo Tertiary**

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    Staff at the CSR, along with members of the collaborative, created the cover letter. Elements of informed consent were included in the letter ensuring that the NDSU Institutional Review Board requirements were met and the protection of human subjects maintained.

    The survey instrument was designed as a scannable 8-page mail survey containing 54 questions. The questions focused on general community concerns, community health and wellness concerns, personal health, preventive health, and demographic characteristics.

Obtained through a qualified vendor, the sample was a stratified random sample to ensure that appropriate proportions from each of the two counties were included. A total of 1,500 records with names, addresses, and a few demographic indicators were included in the sample.

Residents listed in the sample were first mailed an introductory postcard briefly explaining the project and notifying them that a survey packet would be arriving in their mail. Survey packets, which contained the cover letter, scannable paper survey, and a pre-paid return envelope, were mailed three days after the introductory postcards. Two percent of the packets were returned as undeliverable. A reminder postcard, containing a link to an on-line version of the survey, was mailed to non-responders approximately 10 days after the initial survey was mailed. A total of 398 paper surveys were returned for scanning and an additional 3 surveys were completed on-line for a total of 401; the response rate was 27 percent. It was apparent that elderly and male respondents were overrepresented in the scanned results. Therefore, post-stratification weights were used to ensure proper representation of the population with respect to age and gender. Respondents who did not enter a gender and age response were eliminated from the analysis. A total of 382 surveys were analyzed, providing a generalizable sample with a confidence level of 95 percent and an error rate of plus or minus 5.2 percentage points.

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   Community stakeholders were invited to a meeting to review the early findings from the generalizable survey and to discuss the top health issues or health-related issues facing the community. Over 200 individuals were invited to attend from county commissions, city councils, school boards, and agencies representing the chronic disease groups and disparity. There were 53 actual attendees at the July 2015 community stakeholder meeting and the discussion helped to determine key priorities for the community.

4. **Community Asset Mapping**

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

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

5. **Secondary Research**

2015 Assessment of American Indian Residents

Persons who self-identified as American Indian/Alaska Native were targeted for this study. Survey data was collected in July 2015 during the Fargo-Moorhead "Honoring Traditions of Health Wellness Community Health Fair" at Carl Ben Eielson Middle School in Fargo, North Dakota. There were 96 participants in this study.

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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. However, when comparing certain demographic characteristics (i.e., age, income, minority status) with the current population estimates from the U.S. Census Bureau, it was evident that older, white, more highly educated, and higher income earners were overrepresented. Overrepresentation of this nature is typical in health needs assessments.

Literature reviews indicate that there are nonresponse rate issues among younger respondents. In particular, response rates to health care and community health needs assessment surveys have often been found to be higher for older respondents. Studies have also shown lower response rates for socially disadvantaged groups (i.e., socially, culturally, or financially).

A good faith effort was made to secure input from a broad based of the community. Invitations were extended to county and community leaders, organizations and agencies representing diverse populations and disparities. A total of 53 attended the community stakeholder discussion.

The findings of the American Indian Resident survey only represent American Indian participants attending the health fair and may not be representative of other American Indians in the Fargo-Moorhead area. A total of 96 American Indian residents participated in the survey.

Additional data was reviewed through secondary research. The data for the secondary research was secured from the North Dakota Department of Health and the Minnesota Department of Health.

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

Sanford extended a good faith effort to engage all of the aforementioned community representatives in the survey process. In some cases there were surveys that were submitted without names or without a specified area of expertise or affiliation. We worked closely with public health experts throughout the assessment process.

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

Key Findings

Community Health Concerns

Aging Population

The greatest area of concern among respondents is for the aging population, including the cost and availability of long term care. The availability of memory care is also a significant concern. Secondary research finds that 10.5 percent of the population in Cass County and 12.4 percent of the population in Clay County are over 65 years of age.

Level of concern with statements about the community regarding the AGING POPULATION
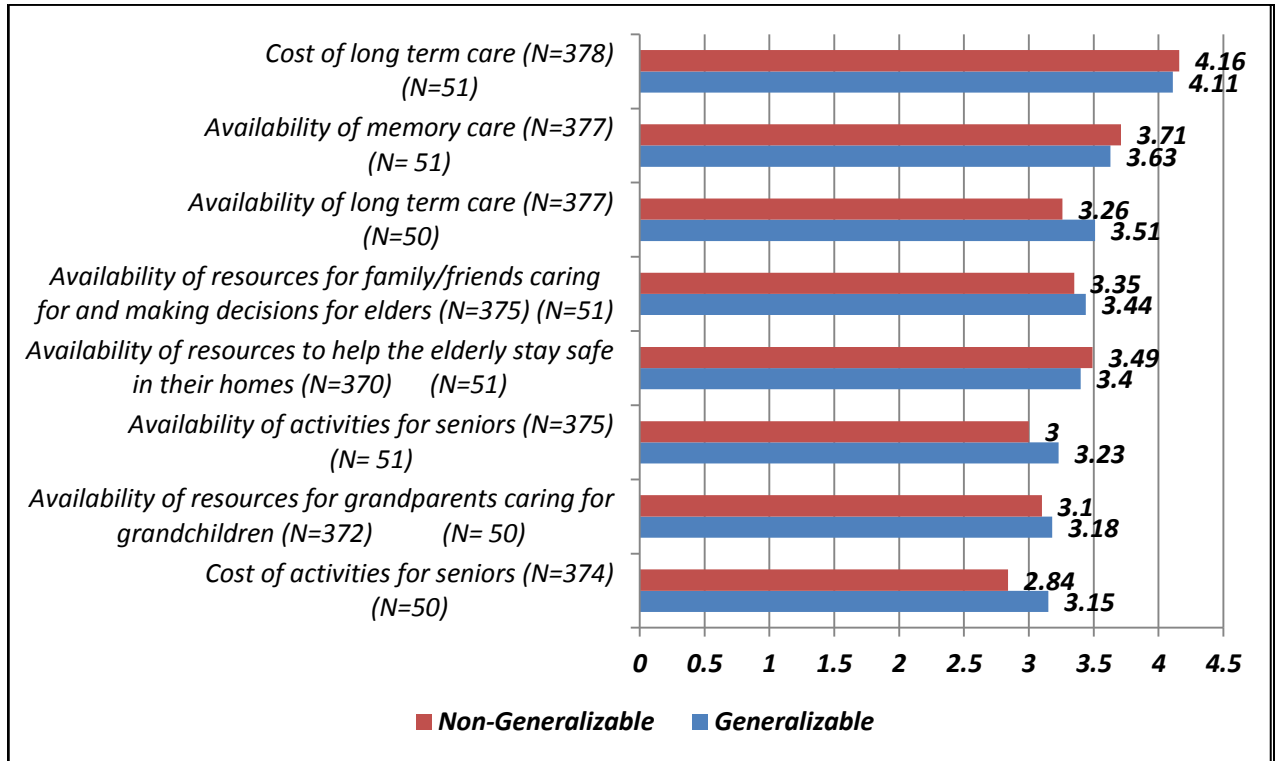
The North Dakota Long Term Care Association states that a primary reason for the concern about the cost of long term care is because people are not purchasing long term care insurance. Once long term care services are required it may be a surprise to learn the true cost of the service.

Resources for family/friends and resources for the elderly to help them stay in their homes are becoming widely available through programs such as the North Dakota State University Extension Office and the Sanford Faith Community Nurse Program.

American Indian (AI) Survey Responses

AI respondents had higher mean scores for level of concern for most issues related to the aging population as compared to generalizable survey respondents (OA) respondents for most issues, except for long term care.

Level of concern with statements about the community regarding the AGING POPULATION

	Overall	American Indian
Cost of long term care (n: AI=89, OA=378)	4.11	3.86
Availability of long term care (n: AI=93, OA=377)	3.51	3.76
Availability of memory care (n: AI=89, OA=377)	3.63	3.74
Availability of resources to help the elderly stay safe in their home (n: AI=93, OA=370)	3.40	3.71
Availability of resources for grandparents caring for grandchildren (n: AI=93, OA=372)	3.18	3.70
Availability of resources for family/friends caring for and making decisions for elders (n:…	3.44	3.67
Availability of activities for seniors (n: AI=92, OA=375)	3.23	3.67
Cost of activities for seniors (n: AI=95, OA=374)	3.15	3.65

Mean
(1=Not at All; 5=A Great Deal)

Health Care Access and Cost

Top priorities among residents (generalizable survey) relate to cost issues (i.e., access to affordable health insurance, affordable health care, and affordable prescription drugs), whereas top priorities among community leaders (non-generalizable survey) relate to service delivery (i.e., timely access to mental health providers, access to substance use providers, and the use of emergency room services for primary health care).

Secondary research through the 2015 County Health Rankings finds that 7% in Cass County and 6% in Clay County report that they could not see a doctor due to the cost. (See Appendix)

Level of concern with statements about the community regarding HEALTH CARE

Access to affordable health insurance (N=374) (N=51): Non-Generalizable 3.67, Generalizable 4.04
Access to affordable health care (N=378) (N=51): Non-Generalizable 3.55, Generalizable 3.92
Access to affordable prescription drugs (N=377) (N=51): Non-Generalizable 3.65, Generalizable 3.9
Cost of affordable dental insurance coverage (N=376) (N=51): Non-Generalizable 3.43, Generalizable 3.83
Cost of affordable vision insurance (N=377) (N=51): Non-Generalizable 3.25, Generalizable 3.66
Timely access to doctors, physician assistants, or nurse practitioners (N=378) (N=48): Non-Generalizable 3.23, Generalizable 3.3
Timely access to physician specialists (N=375) (N=49): Non-Generalizable 3.27, Generalizable 3.29
Use of emergency room services for primary health care (N=373) (N=47): Non-Generalizable 3.72, Generalizable 3.27
Availability of non-traditional hours (e.g., evenings, weekends) (N=377) (N=50): Non-Generalizable 3.28, Generalizable 3.14
Coordination of care between providers and services (N=372) (N=49): Non-Generalizable 3.51, Generalizable 3.14
Providers not taking new patients (N=375) (N=50): Non-Generalizable 3.12, Generalizable 3.12
Timely access to mental health providers (N=372) (N=50): Non-Generalizable 4, Generalizable 2.98
Timely access to substance abuse providers (N=369) (N=50): Non-Generalizable 3.82, Generalizable 2.87
Timely access to dental care providers (N=376) (N=49): Non-Generalizable 2.71, Generalizable 2.79
Availability of transportation (N=377) (N=50): Non-Generalizable 3.1, Generalizable 2.74
Timely access to prevention programs and services (N=366) (N=50): Non-Generalizable 2.8, Generalizable 2.66
Distance to health care services (N=376) (N=51): Non-Generalizable 2.76, Generalizable 2.66
Timely access to vision care providers (N=372) (N=48): Non-Generalizable 2.4, Generalizable 2.56
Timely access to transportation (N=363) (N=49): Non-Generalizable 2.76, Generalizable 2.37
Timely access to registered dietitians (N=361) (N=48): Non-Generalizable 2.48, Generalizable 2.32
Timely access to exercise specialists or personal trainers (N=367) (N=49): Non-Generalizable 2.16, Generalizable 2.22
Timely access to bilingual providers and/or translators (N=370) (N=48): Non-Generalizable 2.79, Generalizable 2.11

Legend: Non-Generalizable, Generalizable

Access to care includes the ability to gain entry into a health system or provider service. Access can include the availability of health care providers and a workforce available to address the needs. Limited access can challenge the ability to receive appropriate levels of care and may pave the way to the utilization of higher cost entry points into the system through the emergency room.

The cost of care may influence the health of individuals. A Dartmouth study finds that North Dakota is considered a high quality state for health care in comparison to other states. North Dakota is also considered to deliver health care at a low cost in comparison to other states.

American Indian Survey Reponses

AI respondents had a higher level of concern than OA respondents for the majority of health care-related issues with the exception of access to affordable health insurance, access to affordable prescription drugs, and access to affordable health care. The issues which resulted in the greatest difference between AI and OA mean scores were timely access to exercise specialists or personal trainers.

Level of concern with statements about the community regarding HEALTH CARE

Statement	Overall	American Indian
Cost of affordable dental insurance…	3.83	3.94
Access to affordable health insurance (n:…	4.04	3.87
Access to affordable prescription drugs (n:…	3.90	3.86
Cost of affordable vision insurance (n:…	3.66	3.84
Access to affordable health care (n: AI=93,…	3.92	3.75
Timely access to dental care providers (n:…	2.79	3.74
Timely access to substance abuse providers…	2.87	3.73
Timely access to doctors, physician…	3.30	3.73
Timely access to mental health providers (n:…	2.98	3.68
Timely access to physician specialists (n:…	3.29	3.67
Providers not taking new patients (n: AI=94,…	3.12	3.67
Timely access to exercise specialists or…	2.22	3.64
Availability of non-traditional hours (n:…	3.14	3.62
Timely access to registered dietitians (n:…	2.32	3.60
Distance to health care services (n: AI=94,…	2.66	3.60
Availability of transportation (n: AI=92,…	2.74	3.57
Coordination of care between providers and…	3.14	3.57
Timely access to vision care providers (n:…	2.56	3.55
Timely access to transportation (n: AI=95,…	2.37	3.54
Timely access to prevention programs and…	2.66	3.54
Timely access to bilingual providers and/or…	2.11	3.51
Use of emergency room services for primary…	3.27	3.51

Mean
(1=Not at All; 5=A Great Deal)

Sanford provides a Community Care Program and financial assistance policy to address assistance to all who qualify for charity care. During fiscal year 2015 Sanford contributed over $58 million for charity care for our patient population that 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.

One example of a community resource that is addressing the access needs of patients is Sanford's My Sanford Nurse Program (formerly called Ask-A-Nurse). My Sanford Nurse served 324,295 individuals from throughout the footprint and nation during fiscal year 2014 and provided a community benefit of over $1.8M with more than 45,965 nursing staff hours. There is no fee for this service.

Timely access for mental health and behavioral health providers continues to remain a concern across the community. Workforce gaps among mental health and behavioral health providers remain a challenge. Sanford has an aggressive recruiting program and continues to recruit these experts to our community. The North Dakota Human Services Behavioral Health Interim Committee is also focused on developing the behavioral health workforce for the state in the areas of adult psychiatry, child and adolescent psychiatry, and substance abuse providers. Sanford leaders are serving on the stakeholder group with this interim committee, along with other community providers.

Physical and Mental Health

Both community leaders and residents have moderately high levels of concern for physical and mental health issues. The top concern among community leaders is depression, whereas the top concerns among residents are cancer and chronic disease. Additional high ranking concerns include Inactivity and lack of exercise, obesity, poor nutrition, infectious disease, dementia and Alzheimer's disease, stress, and suicide.

- Community leaders have slightly higher levels of concern than residents about inactivity and lack of exercise, poor nutrition eating habits, and obesity.
- Depression and stress are moderately high mental health concerns among residents. However, community leaders are more concerned than residents about suicide.

Secondary research through the 2015 County Health Rankings find that the average number of self-reported mentally unhealthy days reported in the last 30 days is at 2.4 days in Cass County and 2.8 days in Clay County. Cass County residents reporting poor or fair health is at 10 percent and Clay County is at 11 percent. Cass County residents reporting that they are obese is at 27 percent; Clay County is at 30 percent. Cass County residents who report being physically inactive is at 21 percent; 24 percent of the residents in Clay County report being physically inactive. (See Appendix)

The North Dakota Department of Health reports that 6.2 percent of Cass County residents have been told by their health provider that they have cancer (excluding skin cancer). (See Appendix)

Level of concern with statements about the community regarding PHYSICAL AND MENTAL

	Non-Generalizable	Generalizable
Cancer (N=372) (N=51)	3.39	3.97
Chronic disease (e.g., diabetes, heart disease, multiple…	3.47	3.81
Depression (N=378) (N=51)	3.94	3.78
Inactivity and lack of exercise (N=376) (N=51)	3.82	3.78
Dementia and Alzheimer's disease (N=374) (N=50)	3.34	3.76
Stress (N=377) (N=51)	3.61	3.65
Obesity (N=375) (N=51)	3.75	3.64
Poor nutrition and eating habits (N=377) (N=51)	3.76	3.62
Infectious diseases such as the flu (N=374) (N=49)	2.98	3.5
Suicide (N=376) (N=51)	3.65	3.38
Other psychiatric diagnosis (N=373) (N=50)	3.64	3.11
Sexually transmitted diseases (e.g., AIDS, HIV, chlamydia)…	2.88	2.92

American Indian Survey Reponses

AI respondents had a higher level of concern than OA respondents for the majority of physical and mental-health related community issues with the exception of cancer and dementia and Alzheimer's disease.

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Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

Statement	Overall	American Indian
Other psychiatric diagnosis (n: AI=93, OA=373)	3.11	4.13
Suicide (n: AI=93, OA=376)	3.38	4.11
Stress (n: AI=94, OA=377)	3.65	4.10
Depression (n: AI=95, OA=378)	3.78	4.03
Poor nutrition and eating habits (n: AI=96, OA=377)	3.62	4.00
Inactivity and lack of exercise (n: AI=94, OA=376)	3.78	3.94
Chronic disease (n: AI=95, OA=377)	3.81	3.92
Obesity (n: AI=96, OA=375)	3.64	3.88
Cancer (n: AI=94, OA=372)	3.97	3.77
Sexually transmitted diseases (n: AI=95, OA=370)	2.92	3.75
Infectious diseases such as the flu (n: AI=93, OA=374)	3.50	3.73
Dementia and Alzheimer's Disease (n: AI=96, OA=374)	3.76	3.57

Mean
(1=Not at All; 5=A Great Deal)

Concerns about cancer: The prevalence of cancer among our community members is on the minds of our residents. Cancer is the second leading cause of death in the United States for the adult population. According to the UND School of Medicine and Health Sciences 2015 Biennial Report, digestive system cancer is the most commonly diagnosed cancer in our state, followed by breast cancer. The study finds that the risk of cancer in North Dakota is higher than in the rest of the nation.

Sanford is committed to serving the cancer needs of our community through the Roger Maris Cancer Center and the 13 medical oncologists/hematologists, 5 radiation oncologists, 2 pediatric oncologists/hematologists, 7 palliative care board certified physicians, 1 oncology clinical psychologist, 1 medical geneticist, 3 genetic counselors, 1 doctor of nursing practice, 2 physician assistants, 2 nurse practitioners, 7 pharmacists, 4 radiation oncology medical physicists, and several hundred nurses.

Sanford's Roger Maris Cancer Center holds a number of accreditations including Joint Commission Accreditation, the American College of Surgeons Commission on Cancer – Silver Commendation, the National Accreditation Program for Breast Cancer through the American College of Surgeons Accreditation by the American College of Radiology – Radiation Oncology, Edith Sanford Breast Health Comprehensive Center recognized as a Certified Quality Breast Center of Excellence through the National Consortium of Breast Centers, Breast Imaging Center of Excellence through the American College of Radiology, Certification by the Quality Oncology Practice Initiative through the American Society of Clinical Oncology, and the Advanced Care Certification by The Joint Commission for Palliative Care Services.

The Sanford Roger Maris Cancer Center desires to detect cancer at earlier stages when there is a better chance for cure. One example of the Center's focus on early detection is for colorectal screenings.   Colorectal cancer screenings can detect precancerous colorectal polys which, if removed, can prevent colorectal cancer and reduce an individual's colorectal cancer risk by 50 percent.

In 2014 at Sanford Roger Maris Cancer Center there were 158 colorectal cancer cases, 74 (47%) of which were more advanced (stage 3 or 4). Treatment results compared favorably with other cancer centers in the region and nationally. North Dakota is at the bottom third of the country for colorectal cancer screenings, which leads to later detection and more advanced colorectal cancer stages. Having one of the familial cancer syndromes increases the likelihood of developing cancer. The Roger Maris Cancer Center has a familial cancer syndrome clinic, where the team assists in coordinating care and helping individuals with an increased risk of cancer to plan for future screenings, and customizes the patient's treatment plan. Genetic risk assessment is an important component of the care at the Sanford Roger Maris Cancer Center.

Concerns about other chronic diseases: The top chronic diseases among respondents and community leaders include hypercholesterolemia, hypertension, asthma and arthritis. Respondents were also concerned about comorbidities such as obesity, poor nutrition and lack of physical activity.

The North Dakota Department of Health reports that 22.5 percent of Cass County residents have been diagnosed with arthritis and 8.5 percent of residents currently have asthma. The state health data also reports that 63.6 percent of Cass County residents are overweight or obese. The percentage of Cass County residents who report that they have been told by their provider that they have hypertension is 27.7 percent, and 33.2 percent report the same for high cholesterol. Additionally, 22.8 percent of Cass County residents report never having a cholesterol test. (See Appendix)

Whether respondents have any of the following chronic diseases
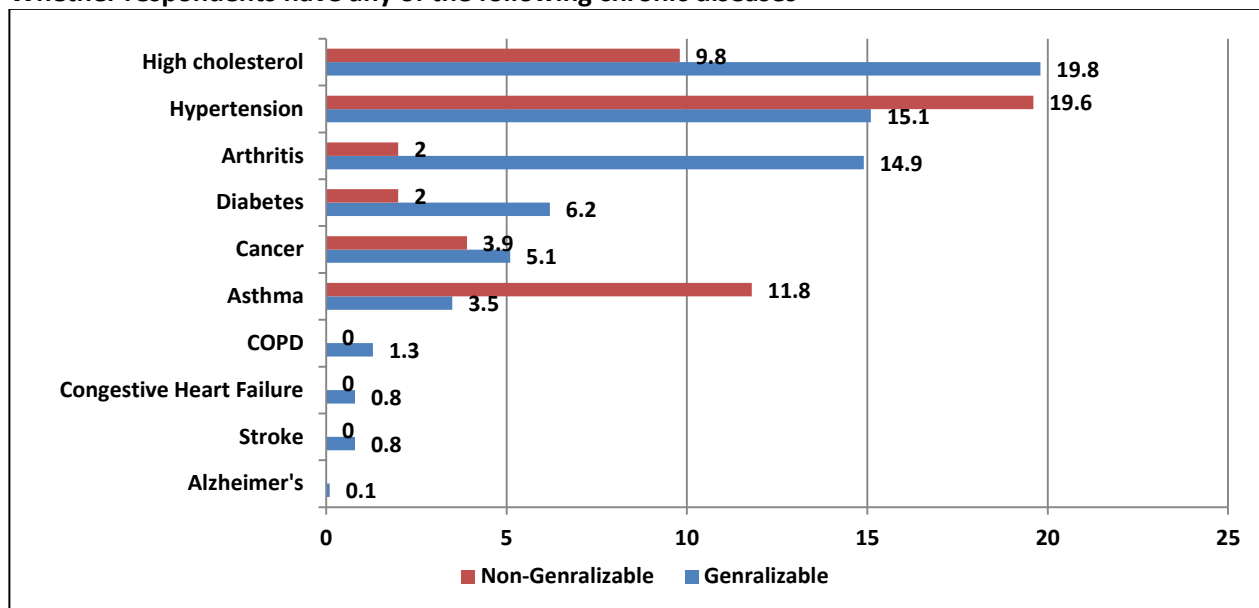
American Indian Survey Reponses

Respondents were asked if they have any of the following chronic diseases: hypertension, arthritis, diabetes, high cholesterol, asthma, COPD, congestive heart failure, stroke, Alzheimer's, or cancer. AI respondents were most likely to state they have hypertension or arthritis (16.7%, respectively) (Table 8, Appendix Table 18). None of the AI respondents stated they have cancer or Alzheimer's.

AI respondents were much more likely than OA respondents to state they have diabetes (15.6% vs. 6.2%), while OA respondents were more likely than AI respondents to state they have high cholesterol (19.8% vs. 12.5%).

Presence of Chronic Diseases

	Percent*	
Chronic diseases	**American Indian (n=96)**	**Overall (n=382)**
Hypertension	16.7	15.1
Arthritis	16.7	14.9
Diabetes	15.6	6.2
High cholesterol	12.5	19.8
Asthma	10.4	3.5
COPD	2.1	1.3
Congestive heart failure	1.0	0.8
Stroke	1.0	0.8
Alzheimer's	0.0	0.1
Cancer	0.0	5.1

*Percentages do not total 100.0 due to multiple responses.

Chronic diseases are among the most common, costly, and preventable of health problems. According to the Center for Disease Control and Prevention (CDC) about 50% of all adults or over 117 million people have one or more chronic health conditions. One in four adults have two or more chronic health conditions (2012 data).

Sanford is actively working to address chronic disease through programs and quality indicators. The optimal vascular care includes 4 criteria: BP < 140/90, statin use (as recommended), daily aspirin, and no use of tobacco. Execution of these criteria has created positive outcomes for the patients with vascular (including hypercholesterolemia) issues.

Cardiovascular disease refers to any disease of the heart or vascular system, including heart attack, stroke, coronary heart disease, atherosclerosis, hypertension, and congestive heart failure. Heart disease and stroke continue to be the leading cause of death and disability across the United States.

Concern about cholesterol: The Sanford Heart Center in Fargo provides a comprehensive team of specialists and therapists who use advanced technology and proven treatments that beat national standards in speed and survival and above average outcomes.

Medical services specialties offered in the Fargo market include:
- Cardiac Electrophysiology
- Cardiac Rehabilitation
- Cardiology
- Cardiovascular Surgery
- Interventional Cardiology
- Left Atrial Appendage Occlusion
- Nuclear Cardiology
- Thoracic Surgery
- Trans catheter Aortic Valve Replacement (TAVR)

Sanford Heart is committed to continuous improvement, through expanding services and treatment options, clinical trials, and technological medical advancements.

Center for Screening

Prevention is the best way to ward off heart disease. Sanford has made a great effort to help the community by offering a convenient and inexpensive heart assessment which includes calcium scoring. The Heart Screen at the Sanford Center for Screening uses advanced tools and diagnostics to uncover critical details about the health of your heart. Our screenings include:

- CT calcium score
- EKG
- Non-fasting cholesterol
- Blood pressure
- Body Mass Index (BMI)
- Framingham Score (risk estimate for developing heart disease in the next 10 years)

http://www.sanfordhealth.org/fargo/services/heart-vascular-screenings

Concerns about hypertension: Hypertension is also known as high blood pressure. Often there are no symptoms with this condition which is why it is called the "silent killer". The American Heart Association reports that 1 in three adults, or approximately 80 million people in the United States will have high blood pressure. Other than pregnancy, hypertension is the most common reason for adult office visits. Despite the number of resources used to treat hypertension, only about 50 percent of hypertensive patients have their BP under control using the definition of less than 140/90.

Studies show 35 to 60 percent of health care professionals measure BP incorrectly. Surprisingly, even a small difference in measurement can have a considerable impact on the prevalence of cardiovascular events and life expectancy. Researchers approximate overestimating BP could lead to nearly 30 million Americans receiving inappropriate treatment each year, unnecessarily exposing them to potential adverse side effects and increased health care costs. On the other hand, measuring BP even 5 mmHg too low will miss as many as 21 million people with hypertension in the U.S. each year.

Hypertension is addressed at Sanford through a standardized protocol, frequent blood pressure monitoring, and referral throughout all department. Continued improvement has been realized since the implementation of the standardized protocol.

Heart Check Centers at West Acres Mall and Airport

As a benefit to the community of Fargo, Sanford Health has placed blood pressure kiosks in the West Acres Mall and at Hector Airport.

The blood pressure kiosks offer a place for members of the community to go to freely test their blood pressure. The kiosk at the West Acres Mall now offers additional information regarding blood pressure, weight management, orthopedic services, how to find a doctor and information about heart and stroke warning signs. Should participants choose to input an email address, additional health information about Sanford will be sent to them. The kiosk at the mall has historically serviced about 100 people daily.

Concerns about asthma: Asthma is addressed through the Sanford respiratory care asthma educators. The quality plan uses the asthma control test and seeks to reduce the percentage of patients with persistent asthma and elevated exacerbations. Additionally the Sanford chronic obstructive pulmonary disease (COPD) program was designated a "Best Practice" by the Advisory Board. The COPD program reduced readmission rates from 28% to 7% and care compliance increased from 58% to 93% after new standardized protocol was implemented.

Concerns about diabetes: Sanford offers a comprehensive diabetes education program. Sanford diabetes clinics and centers are dedicated to empowering people with diabetes to feel better and prevent long-term complications. Sanford offers assessment and personalized education care to give patients and their families the tools they need to manage diabetes while living well. Endocrinologists, certified diabetes nurses and certified diabetes dieticians provide diagnosis, assessment, one-on-one education, and instruction.

The chronic disease self-management Better Choices, Better Health Program at Sanford is offered free of charge to community members. Better Choices, Better Health is modeled after Stanford University's chronic disease self-management program. The workshops are 2½ hours long and meet weekly for 6 weeks. The program is facilitated by two trained lay leaders and one or both have a chronic condition. Research has found that after participating in the program individuals are better able to manage their symptoms, communicate more easily with their doctors, are less limited by the disease, and generally feel better.

Concerns about obesity, poor nutrition and lack of physical activity: Sanford Enterprise chose obesity as an implementation strategy for the 2013 CHNA. Strategies included an annual obesity symposium for providers and monthly education programs for community members. The Sanford obesity symposium was attended by more than 400 registrants during April 2013 and March 2015. The symposium will be held again during March 2016. The symposium is evidence based. Sanford providers and national experts serve as faculty for the symposium.

The YMCA Family Wellness Center in Fargo, in partnership with Sanford Health, offers many classes each week that address wellness for children and families. The Family Wellness Center has multiple group exercise rooms as well as classrooms for educational events. Children and families have numerous fitness options as well as classes that address health, healthy nutrition and healthy cooking. The Family Wellness Center is a place for the entire family with drop-in child care, a kid-friendly pool with water slide, swimming lessons, and an open gym for free play.

Sanford Fargo provides numerous services, classes and events to address obesity. During FY 2014 Sanford dietitians and exercise specialists provided leadership for the Schools Alive events at more than a dozen schools. The Sanford Health Fargo Region licensed registered dietitians and exercise physiologists provided expert clinical guidance for the new Family *fit* Night programs in area schools. These programs, scheduled on a monthly basis, provided educational sessions on health, nutrition and physical fitness, as well as providing a time for creative physical activity with children and family members. The local elementary schools were selected in partnership with Sanford, TNT Kids Fitness, and the Boys and Girls Club. Over 2,200 parents and children attended these events in 2014.

The adult weight management program "Honor Your Health" is a comprehensive wellness program developed by Sanford Health Fargo Region which focuses on evidenced-based nutrition standards, physical activity and behavioral health. This class is offered for adults and provides a basis for young parents as well as all adults to learn about health and wellness. This program is a comprehensive approach to healthy lifestyle practices and may facilitate healthy behaviors for families.

The Sanford athletic training coverage at high school, college and local sporting events promotes wellness and fitness. During fiscal year 2014 the Fargo athletic trainers contributed over $1,300,000 in community benefit to local sports teams at sporting events. Sanford supports physical activity through sponsorships of numerous active living and sporting events and numerous local sports teams.

Camp Fuel is a program for youth focusing on healthy self-esteem and body image and includes curriculum for healthy nutrition and activity. The camp promotes a positive self-image and strives to create an understanding that the body requires "fuel" from the foods we eat and burn. Topics covered in this camp include portions, dining out choices, label reading to create knowledge of purchasing options, increasing activity and the importance of an active lifestyle, behaviors that promote a healthy lifestyle, positive self-esteem, and body image. This camp is conducted at the Family Wellness Center during the summer months.

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for children, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* Initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents benefit from their own set of resources where they can find tips and tools on becoming

healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites including videos, slideshows, games, articles, and even *fit* songs!

- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.

- *fit*4Schools – *fit*4Schools includes unique *fit*-based lessons integrated into daily classroom activities. *fit*4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:
  - o Reached 50,000 schools
  - o 180,000 page views from educators across the country
  - o 12,000 lesson plan downloads, representing 600,000+ students

  We are also reaching thousands of students through several pilot school programs.
  - o *fit*4Schools – *fit*4Schools, which includes unique *fit*-based lessons integrated into daily classroom activities, is in its final phase of development. It is being piloted in seven elementary schools in the Sanford region.

- Community
  - o The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint! *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
  - o Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
  - o MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.
  - o eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward
  - o *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:
    - Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between health care providers and families.
    - Health Coaches – Exploring meaningful ways for health coaches to promote healthy choices with children and adults.
    - Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach efforts.

- *fit*Club 4 Boys – 10-week after school program for boys, ages 8-12, to develop knowledge of *fit* principles and healthy behavior choices.
- *fit* Parent/child – Class for parents and children to understand healthy choices and the benefits of living a healthy lifestyle.

Concerns about mental/behavioral health: A second implementation strategy set by Sanford is to fully integrate behavioral health services or access to behavioral health outreach in all regional clinic sites in the Fargo, Sioux Falls, Bismarck and Bemidji regions.

A key implementation strategy for Sanford Health is to fully integrate behavioral health services into all primary care clinics. Sanford One Care is a new approach to addressing behavioral health in primary and specialty care clinics and medical centers. Sanford One Care uses technology to conduct behavioral health screenings in order to identify behavioral health concerns as early as possible. Through deployment of Medical Home with fully integrated behavioral health care services, Sanford is providing patient-centered care collaborative teams to meet the needs of Sanford patients.

- Depression is addressed at Sanford through PHQ-9 screening at the primary care office followed by management of the disease through a health care team.

- During 2015 Sanford hosted a behavioral health symposium. The symposium was designed to enhance the competence of health care professionals in the identification, treatment and management of behavioral health issues impacting specialty and primary care.

Sanford behavioral health experts are serving on the North Dakota Behavioral Health Stakeholders Advisory to the Department of Human Services Legislative Interim Committee to shape policy. The North Dakota Behavioral Health Stakeholders group works to address unmet needs in behavioral health in North Dakota. Using a Substance Abuse and Mental Health Services Administration (SAMHSA) template of the components of a comprehensive system of behavioral health care, the group has identified needs in North Dakota and is working on solutions to meet those needs. Types of behavioral health services addressed by this group include adult mental health, children's mental health, substance abuse, and workforce development.

Safety

Respondents have moderately high levels of concern with respect to safety issues (i.e., presence of street drugs, prescription drugs, and alcohol in the community; crime; presence of drug dealers in the community; domestic violence; child abuse and neglect). Regarding safety issues overall, residents have higher levels of concern than community leaders. However, the presence of street drugs, prescription drugs, and alcohol in the community is the top safety concern among both residents and community leaders. Crime, the presence of drug dealers in the community, child abuse and neglect, presence of gang activity, sex trafficking, and domestic violence are other moderately high concerns among residents and community leaders, although at higher levels of concern among residents.

Secondary research finds that alcohol-impaired driving deaths have reached 30 percent in Cass County and 22 percent in Clay County. (See Appendix)

Level of concern with statements about the community regarding SAFETY
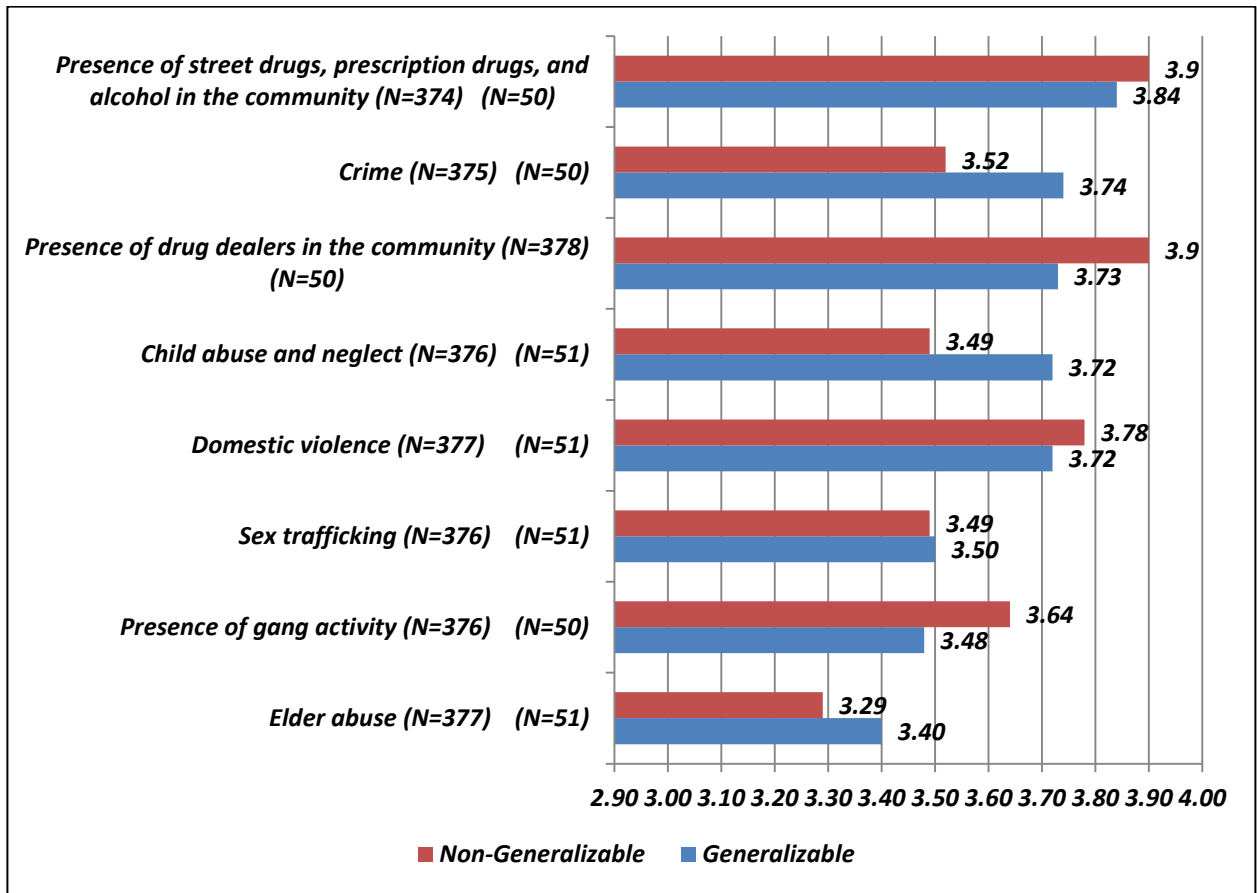
American Indian Survey Reponses

The safety-related community issue which had the highest mean score in regard to level of concern among both AI and OA respondents was presence of street drugs, prescription drugs, and alcohol in the community.

Level of concern with statements about the community regarding SAFETY
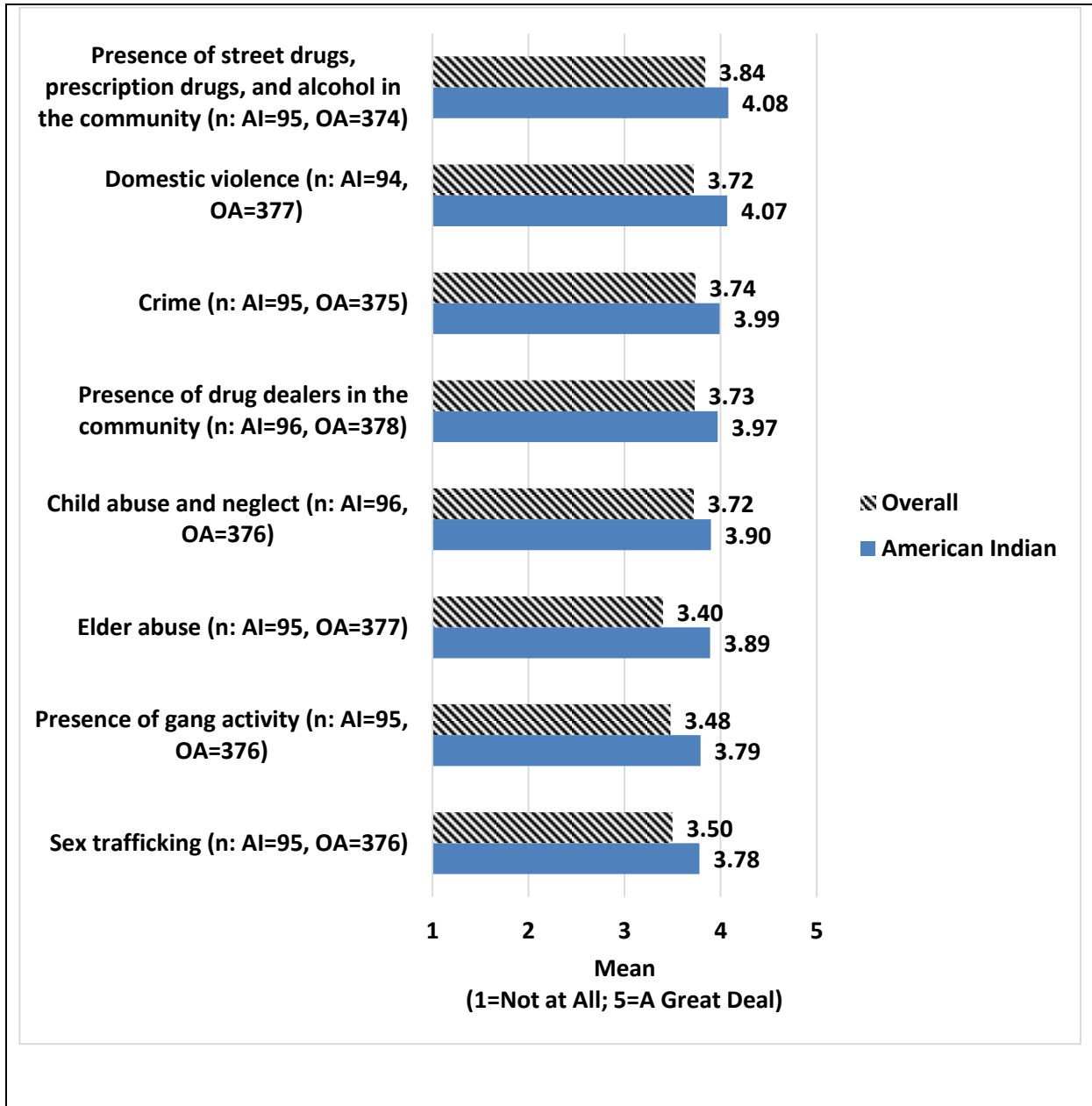
Statement	Overall	American Indian
Presence of street drugs, prescription drugs, and alcohol in the community (n: AI=95, OA=374)	3.84	4.08
Domestic violence (n: AI=94, OA=377)	3.72	4.07
Crime (n: AI=95, OA=375)	3.74	3.99
Presence of drug dealers in the community (n: AI=96, OA=378)	3.73	3.97
Child abuse and neglect (n: AI=96, OA=376)	3.72	3.90
Elder abuse (n: AI=95, OA=377)	3.40	3.89
Presence of gang activity (n: AI=95, OA=376)	3.48	3.79
Sex trafficking (n: AI=95, OA=376)	3.50	3.78

Mean
(1=Not at All; 5=A Great Deal)

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.

Sanford is also working closely with the Rape and Abuse Crisis Center, the Red River Human Trafficking Response Team, and the Cross Borders Children's Action Network.

Concerns about substance use and abuse: Community leaders are more concerned than residents about adult alcohol use and abuse and adult drug use and abuse. Residents, on the other hand, are more concerned than community leaders about underage usage of drugs and alcohol than about adult usage.

Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE
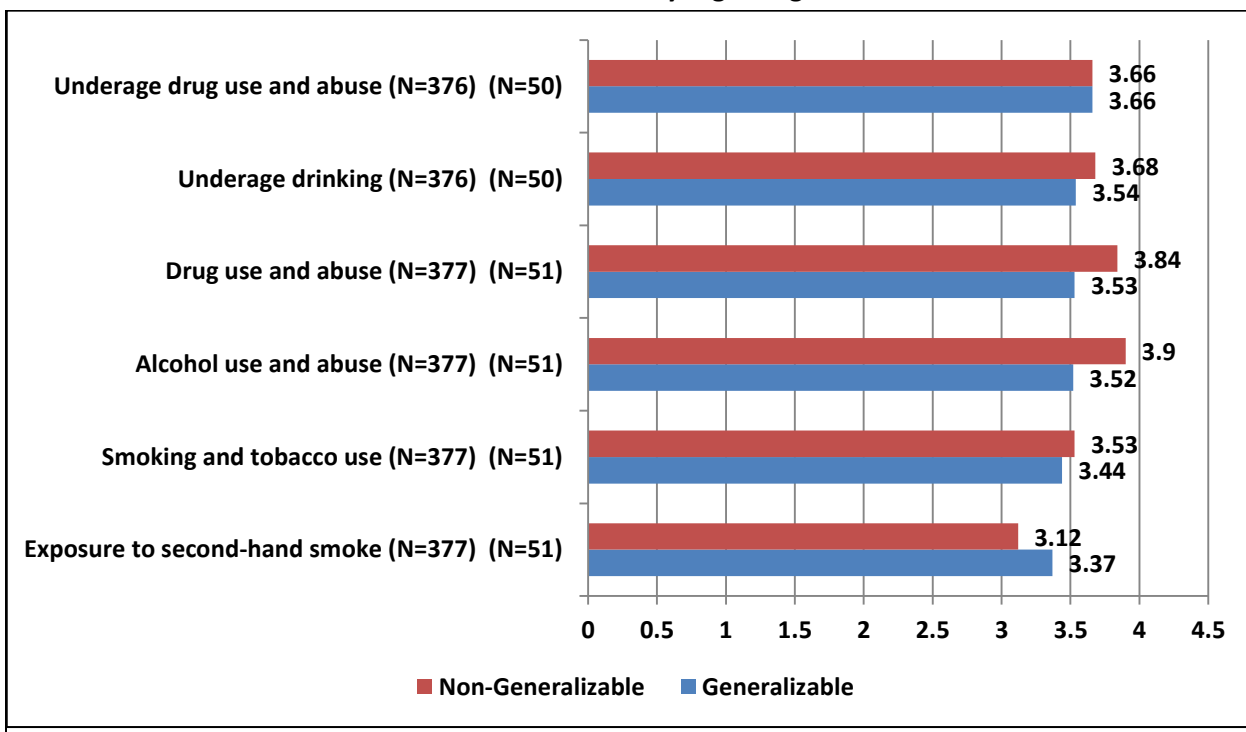
American Indian Survey Reponses

The substance use and abuse-related community issue which had the highest mean score in regard to level of concern among AI respondents was exposure to second hand smoke (mean=4.11), while for OA respondents, underage drug use and abuse had the highest mean score (Figure 9, Appendix Table 1)

The substance use and abuse-related community issue which had the lowest mean score in regard to level of concern among AI respondents was underage drinking (mean=3.98), whereas for OA respondents, exposure to second hand smoke had the lowest mean score (mean=3.37).

AI respondents had a higher level of concern than OA respondents for all of the substance use and abuse-related issues.

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

Exposure to second hand smoke (n: AI=96, OA=377)
- Overall: 3.37
- American Indian: 4.11

Drug use and abuse (n: AI=96, OA=377)
- Overall: 3.53
- American Indian: 4.04

Alcohol use and abuse (n: AI=95, OA=377)
- Overall: 3.52
- American Indian: 4.04

Underage drug use and abuse (n: AI=96, OA=376)
- Overall: 3.66
- American Indian: 4.00

Smoking and tobacco abuse (n: AI=96, OA=377)
- Overall: 3.44
- American Indian: 3.99

Underage drinking (n: AI=96, OA=376)
- Overall: 3.54
- American Indian: 3.98

Mean
(1=Not at All; 5=A Great Deal)

Concerns about children and youth: Bullying is ranked as the main childhood concern among residents. The costs and availability of quality child and infant care are ranked as top concerns among community leaders and residents; however, community leaders have higher levels of concern in these areas. The cost and availability of services for at-risk youth is also a moderately high concern among community leaders; however, residents rank the issue as a moderate concern.

Level of concern with statements about the community regarding CHILDREN AND YOUTH

Bullying (N=371)... Non-Generalizable 3.57, Generalizable 3.82
Cost of quality child care (N=370)... Non-Generalizable 3.53, Generalizable 3.86
Cost of quality infant care (N=365)... Non-Generalizable 3.88, Generalizable 3.5
Youth crime (N=368)... Non-Generalizable 3.34, Generalizable 3.49
Cost of activities for children and youth (N=367)... Non-Generalizable 3.31, Generalizable 3.44
Availability of quality infant care (birth to 2 years)... Non-Generalizable 3.84, Generalizable 3.4
Availability of quality child care (N=369)... Non-Generalizable 3.84, Generalizable 3.4
Availability of activities for children and youth... Non-Generalizable 3.18, Generalizable 3.39
Cost of services for at-risk youth (N=369)... Non-Generalizable 3.55, Generalizable 3.18
Teen pregnancy (N=370)... Non-Generalizable 3.06, Generalizable 3.14
Availability of services for at-risk youth (N=371)... Non-Generalizable 3.71, Generalizable 3.13
School dropout rates (N=370)... Non-Generalizable 3.02, Generalizable 3.12
School absenteeism (N=369)... Non-Generalizable 3, Generalizable 2.94
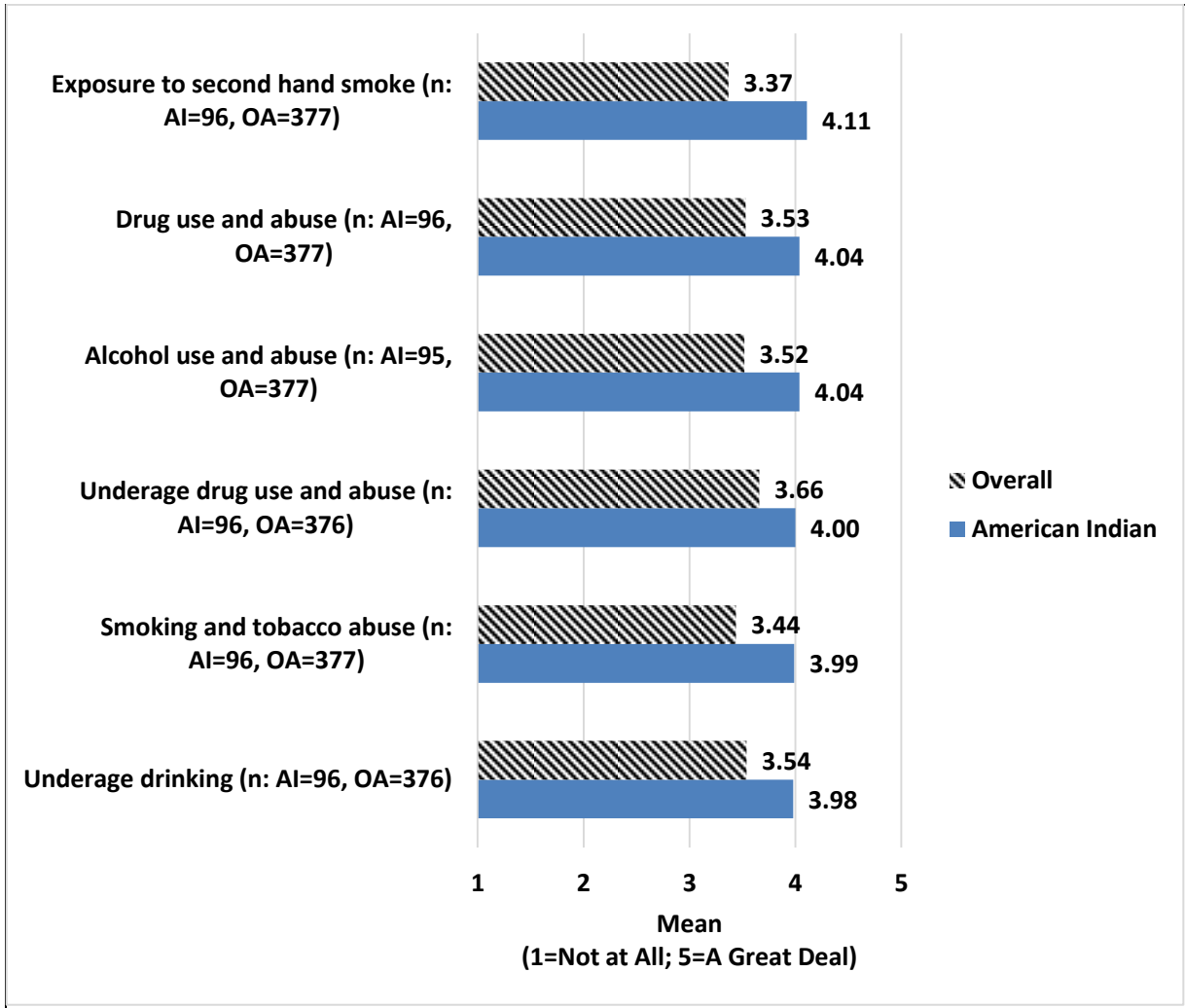
■ Non-Generalizable   ■ Generalizable

American Indian Survey Reponses

The children and youth-related community issue which had the highest mean score in regard to level of concern among AI respondents was cost of quality child care (mean=4.09), while the children and youth-related community issue which had the lowest mean score for AI respondents was availability of services for at-risk youth (mean=3.62).

Level of concern with statements about the community regarding CHILDREN AND YOUTH

Bar chart showing mean level of concern (1=Not at All; 5=A Great Deal) comparing Overall and American Indian responses:

Statement	Overall	American Indian
Cost of quality child care (n: AI=92, OA=370)	3.53	4.09
Bullying (n: AI=93, OA=371)	3.82	4.03
Availability of quality child care (n: AI=93, OA=369)	3.40	3.97
Teen pregnancy (n: AI=91, OA=370)	3.14	3.94
Cost of quality infant care (n: AI=93, OA=365)	3.53	3.90
Availability of quality infant care (birth to 2 yrs) (n: AI=92, OA=370)	3.40	3.88
School dropout rates (n: AI=92, OA=370)	3.12	3.88
School absenteeism (n: AI=93, OA=369)	2.94	3.87
Cost of activities for children and youth (n: AI=92, OA=367)	3.44	3.81
Availability of activities for children and youth (n: AI=93,…)	3.39	3.77
Cost of services for at-risk youth (n: AI=93, OA=369)	3.18	3.75
Youth Crime (n: AI=93, OA=368)	3.49	3.72
Availability of services for at-risk youth (n: AI=95, OA=371)	3.13	3.62

Mean
(1=Not at All; 5=A Great Deal)

Economics

Community leaders are more concerned than residents about economic issues. Community leaders are most concerned about the availability of affordable housing and homelessness. Although a moderate level of concern, residents are most concerned about homelessness and hunger.

Secondary research through the 2015 County Health Rankings finds the percent of household with overcrowding, high housing costs, or lack of kitchen or plumbing facilities is at 14 percent in Cass County and 15 percent in Clay County. (See Appendix)
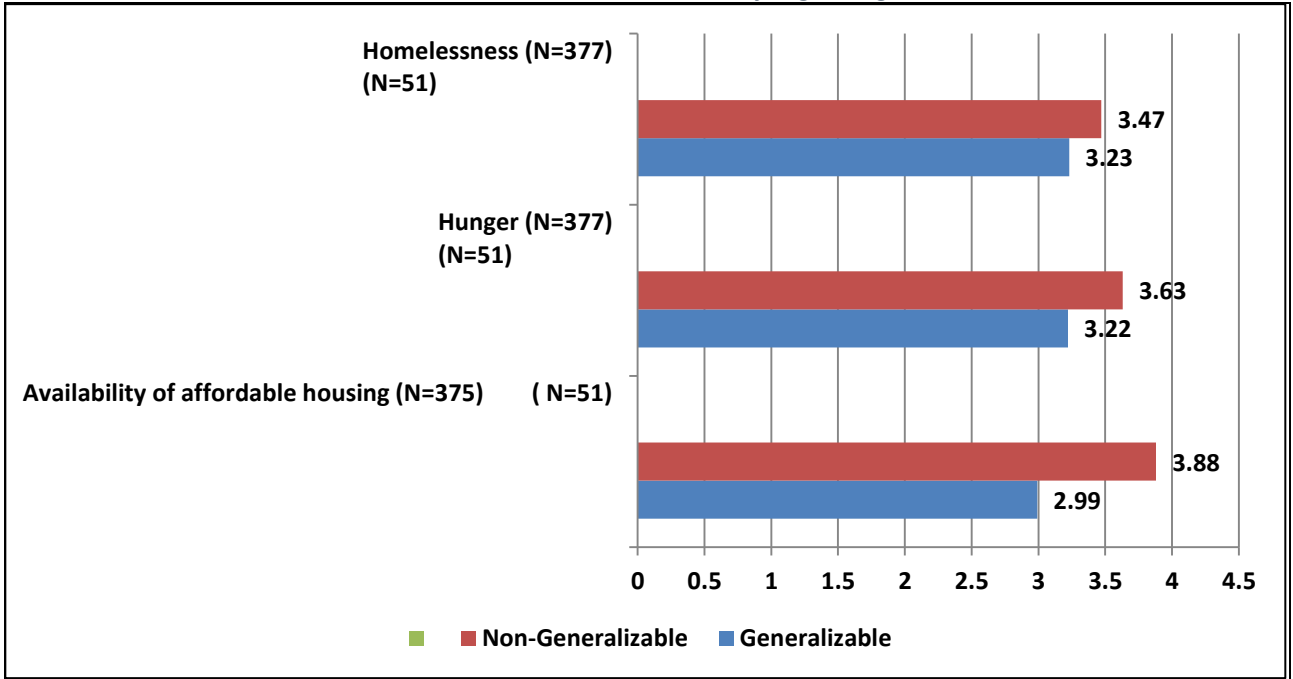
Level of concern with statements about the community regarding ECONOMICS

American Indian Survey Reponses

The economic-related community issue which had the highest mean score in regard to level of concern among American Indian (AI) respondents was homelessness (mean=4.08), followed by hunger (mean=3.83), and availability of affordable housing (mean=3.81) (Figure 1, Appendix Table 1).

Level of concern with statements about the community regarding ECONOMICS
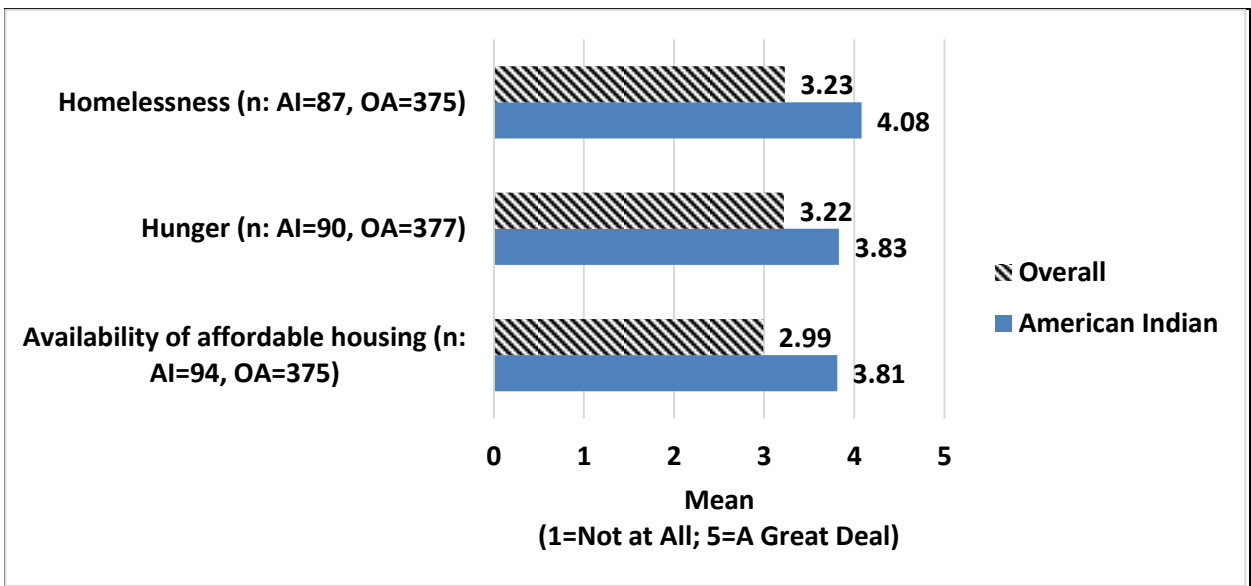
The Sanford Shelter Faith Community Nurse program for homeless shelters is located at the YMCA and at Churches United for the Homeless. The shelter nurse meets with patients, providing assessments, making referrals for services in the community or providing education regarding personal health. The

shelter nurse works with those who are homeless and refers them to resources in a timely manner to address health issues and reduce the risk of unnecessary admissions or readmissions to the hospital. The shelter nurses provide nursing care for over 8,200 interventions annually.

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, Churches United for the Homeless, and Gourmet Soup Kitchen. Sanford supports the Great Plains Food Bank and the Daily Bread Program.

Personal Health Concerns

Respondents' Personal Health Status

The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the metro area are overweight or obese. However, the vast majority of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, three in four respondents visited a doctor or health care provider for a routine physical and the vast majority visited a dentist or dental clinic.

Respondents' rating of their health in general
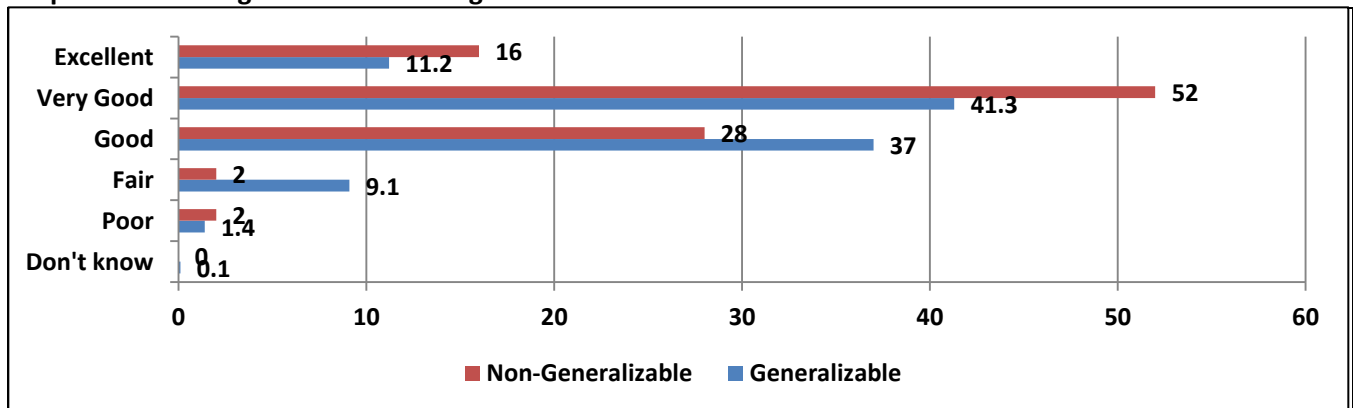
- *89.5%* of the generalizable respondents rate their health as good or better
- *96*% of the key stakeholder% of respondents reported that their health is good or better

American Indian Survey Reponses

Respondents were asked to rate their health. Nearly 40 % of AI respondents stated their health was "Fair" or "Poor", compared to 10.5% of OA respondents (Figure 10, Appendix Table 2). OA respondents were more than 2.5 times as likely as AI respondents to state their health was "Very Good" or "Excellent" (52.5% vs. 19.1%).

Respondents' rating of their health in general
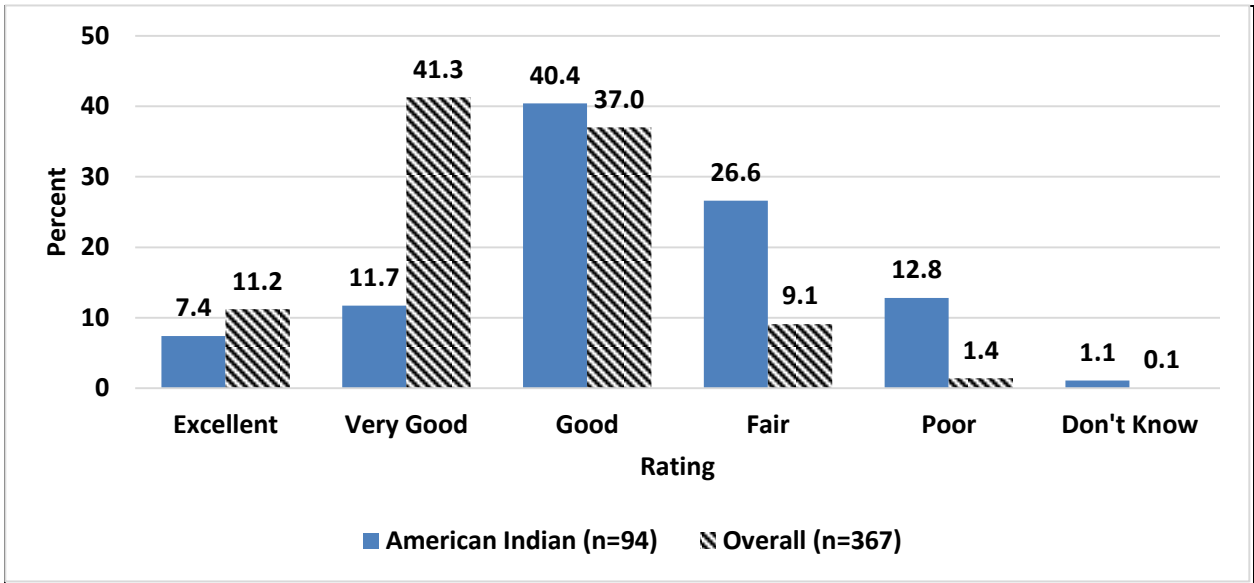
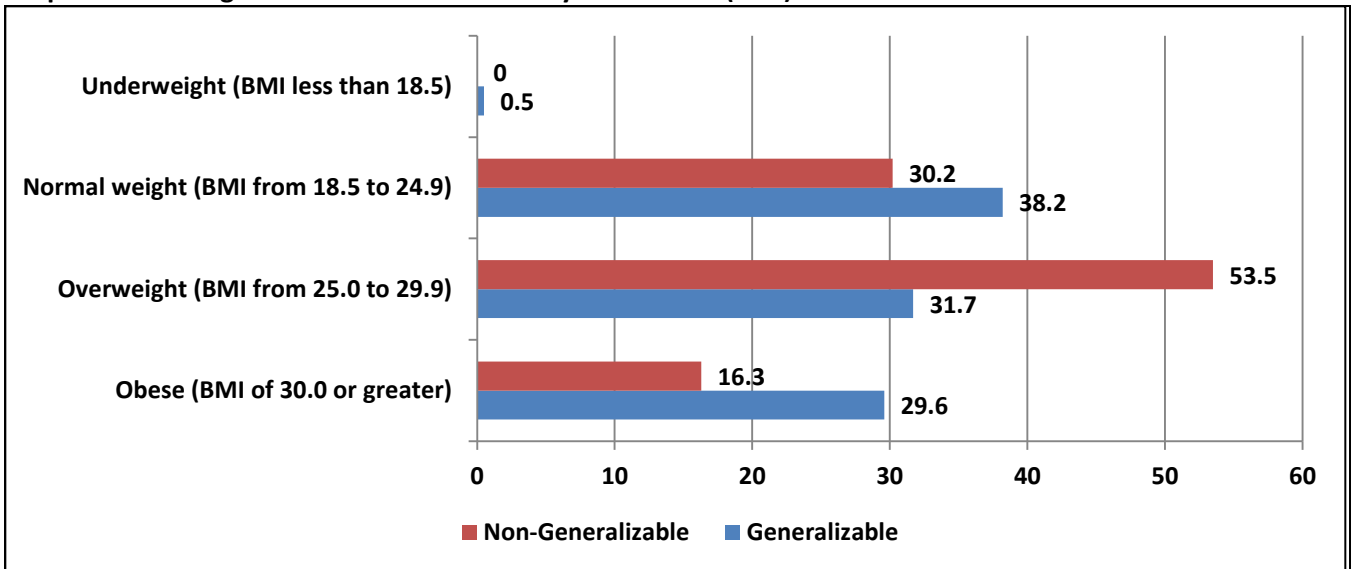**Respondents' weight status based on the Body Mass Index (BMI) scale**

- *69.5 % report a BMI that is overweight or obese in the non-generalizable group*
- *61.3% in the generalizable group*

American Indian Survey Reponses

Respondents were asked to report their current height and weight. Using this information, body mass index (BMI) was calculated for each respondent. More than half (51.8%) of AI respondents were considered to be obese (BMI of 30.0 or greater), while less than one-third (29.6%) of OA respondents were considered to be obese. OA respondents were three times as likely as AI respondents to have a normal weight.

Respondents' weight status based on the Body Mass Index (BMI) scale
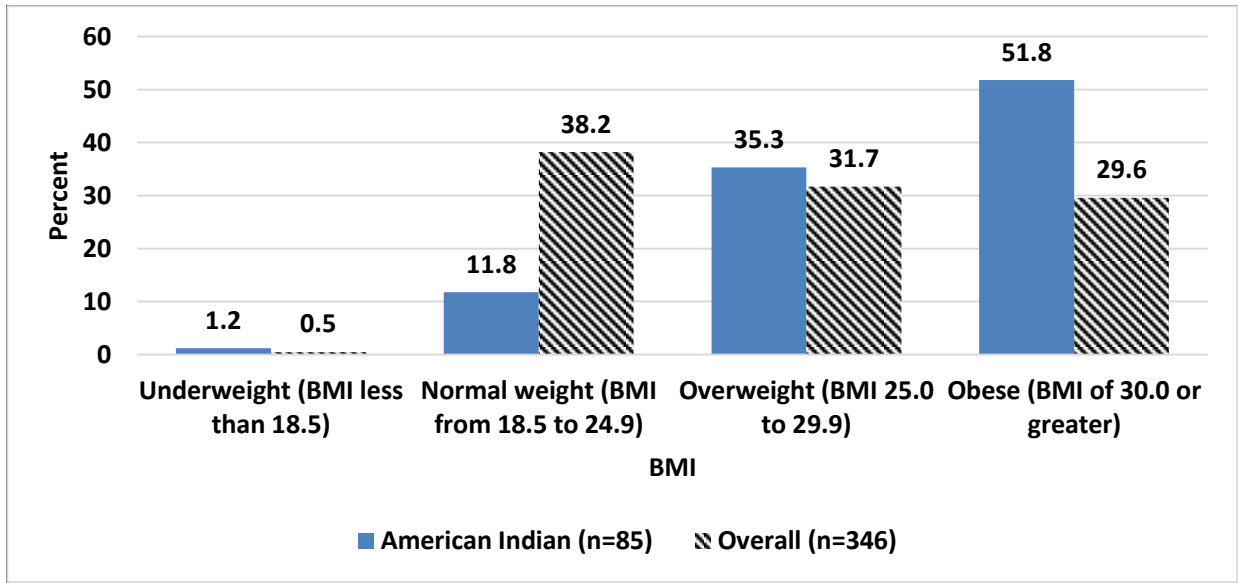
Obesity is a common, but serious disease. Obesity can have adverse effects on health and lead to a reduced life expectancy. Adults with a BMI over 25 are considered overweight and adults with a BMI over 30 are considered obese. According to the CDC, obesity and overweight are the second leading cause of preventable deaths, tagging close behind tobacco use.

Health conditions related to obesity:
- Coronary heart disease
- Type 2 diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension
- Dyslipidemia
- Stroke
- Liver and gallbladder disease
- Sleep apnea and respiratory problems
- Osteoarthritis
- Gynecological problems

Nationally, more than 30 percent of adults, 17 percent of youth age 6 – 19 years, and more than 8 percent of children 2 to 5 years of age are obese.
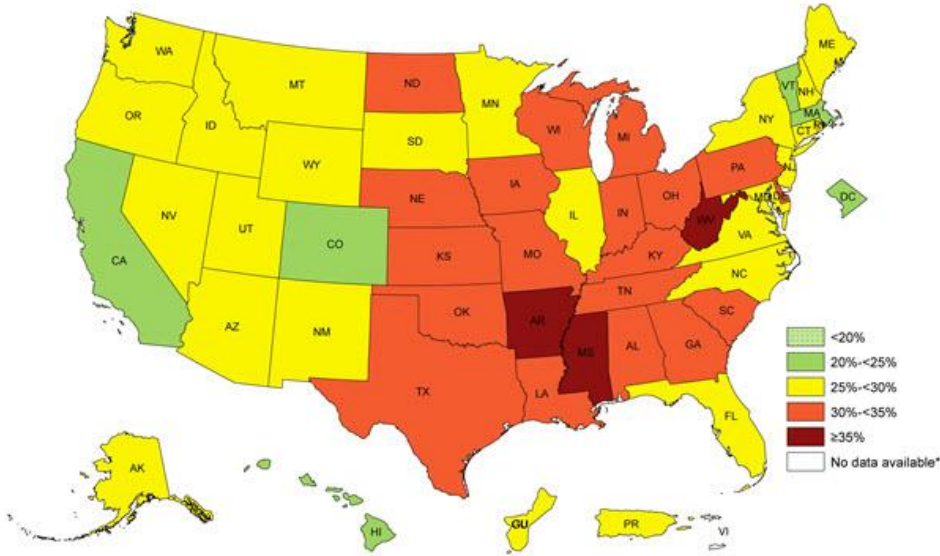
Source: Behavioral Risk Factor Surveillance System, CDC

The Midwest had the highest prevalence of obesity (30.7%), followed by the South (30.6%), the Northeast (27.3%), and the West (25.7%).

Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason
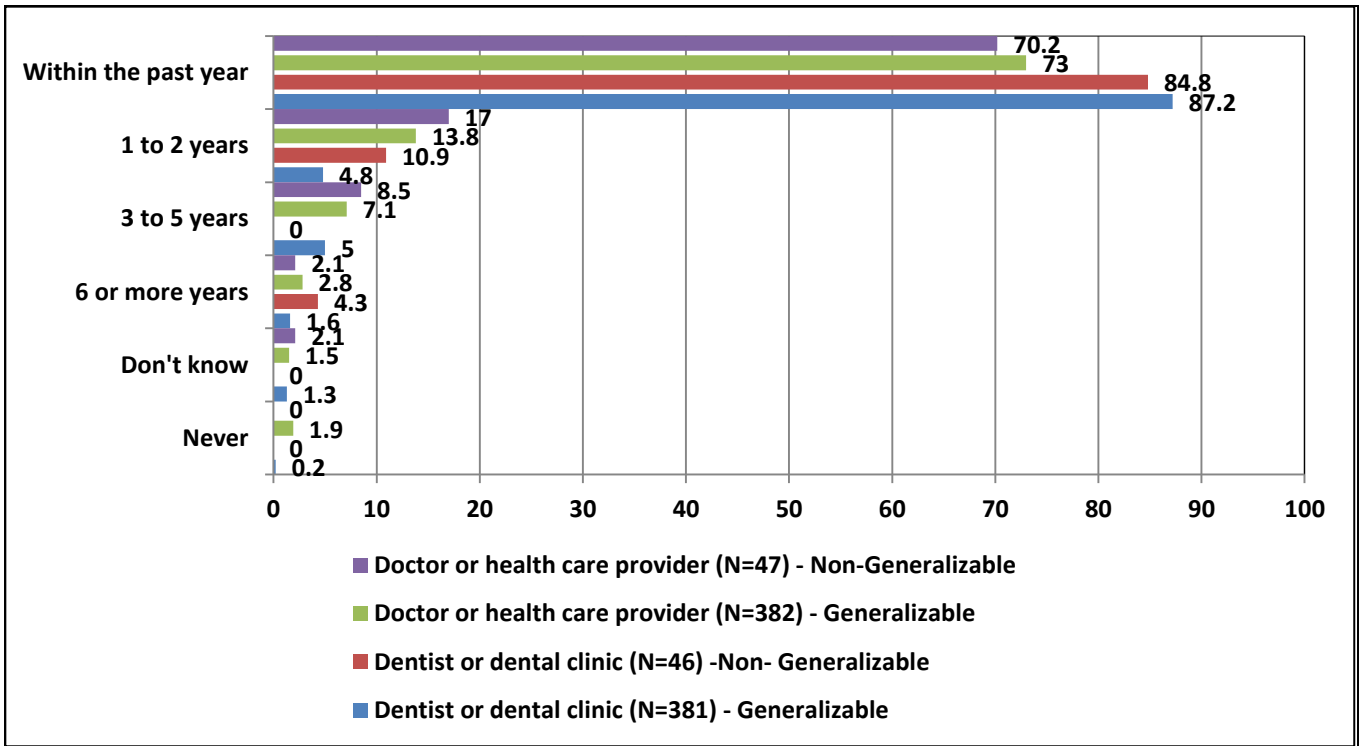
- *23.7% of the generalizable respondents have waited longer than a year to visit a doctor or health care provider compared to 27.6% of the non-generalizable respondents*
- *10.8 % of the generalizable respondents have waited more than a year to see a dentist or dental clinic compared to 15.2% of non-generalizable respondents*

American Indian Survey Reponses

Respondents were asked to specify when they had last visited a doctor/health care provider for a routine physical exam, or a dentist/dental clinic for any reason. Two-thirds (65.3%) of AI respondents stated they had visited a doctor/health care provider in the past year, while less than 52% stated they had visited a dentist/dental clinic for any reason in the past year.

Length of time since respondents last visited a doctor/health care provider for routine exam and since they last visited a dentist/dental clinic

Care provider type	Percent											
	Length of time since last visit											
	Within the past year		1 to 2 years		3 to 5 years		6 or more years		Don't Know		Never	
	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Doctor/ health care provider *(n: AI=95, OA=382)*	65.3	73.0	15.8	13.8	9.5	7.1	2.1	2.8	3.2	1.5	4.2	1.9
Dentist/ dental clinic *(n: AI=93, OA=381)*	51.6	87.2	18.3	4.8	20	5.0	5.4	1.6	1.1	1.3	3.2	0.2

Preventive Health

Preventive health care promotes the detection and prevention of illness and disease and is another important component of good health and well-being. Community results indicate that within the past year, the majority of respondents had a blood pressure screening, blood sugar screening, cholesterol screening, dental screening, flu shot, pelvic exam (females), breast cancer screening (females), and cervical cancer screening (females). However, there are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, cardio screening, glaucoma test, hearing screening, immunizations, STD test, vascular screening, colorectal cancer screening, prostate cancer screening (males), and skin cancer screening in the past year. Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate.

Whether or not respondents have had preventive screenings in the past year, by type of screening

Type of screening	Yes Generalizable	Yes Non-Generalizable	No Generalizable	No Non-Generalizable
GENERAL SCREENINGS				
Blood pressure screening (N=380)	84.3	89.4	15.7	10.6
Blood sugar screening (N=379)	58.7	68.1	41.3	31.9
Bone density test (N=367)	10.8	8.5	89.2	91.5
Cardiovascular screening (N=373)	26.4	42.6	73.6	57.4
Cholesterol screening (N=378)	62.3	70.2	37.7	29.8
Dental screening and X-rays (N=378)	86.4	85.1	13.6	14.9

Type of screening	Yes Generalizable	Yes Non-Generalizable	No Generalizable	No Non-Generalizable
Flu shot (N=380)	62.1	80.9	37.9	19.1
Glaucoma test (N=374)	46.7	51.1	53.3	48.9
Hearing screening (N=377)	17.8	14.9	82.2	85.1
Immunizations (tetanus, hepatitis A or B) (N=374)	19.3	42.6	80.7	57.4
Pelvic exam (N=189 Females)	67.0	73.9	33.0	26.1
STD (N=369)	4.2	6.5	95.8	93.5
Vascular screening (N=368)	11.3	17.4	88.7	82.6
CANCER SCREENINGS				
Breast cancer screening (N= 189 Females)	65.2	73.9	34.8	26.1
Cervical cancer screening (N=185 Females)	63.4	63.6	36.6	36.4
Colorectal cancer screening (N=368)	32.3	40.0	67.7	60.0
Prostate cancer screening (N=182 Males)	39.4	59.1	60.6	40.9
Skin cancer screening (N=365)	22.5	37.2	77.5	62.8

- *For most types of screenings, the most common reasons for not getting the test or procedure are that it is not necessary and the doctor has not suggested one*
- *For dental screening and x-rays, the most common reason for not being tested is cost*
- *For the flu shot screening, most respondents cite other reasons for not getting the shot*
- *72% of the generalizable survey respondents were under 55 years of age, and 55.3% of the non-generalizable respondents were under 55 years of age*

Whether respondents had cancer preventive screenings in the past year, by gender and age

Type of screening	Age of respondent	Percent of respondents within age group			
		Males		Females	
		Yes	No	Yes	No
Breast cancer screening	Ages 45 and older	5.8	94.2	76.6	23.4
	45 to 54 years of age	0.0	100.0	85.0	15.0
	55 to 64 years of age	2.8	97.2	78.8	21.2
	65 to 74 years of age	3.4	96.6	72.7	27.3
	75 years or older	26.7	73.3	71.9	28.1
Cervical cancer screening	Females ages 25 and older	na	na	49.4	50.6
	25 to 34 years of age	na	na	100.0	0.0
	35 to 44 years of age	na	na	66.7	33.3
	45 to 54 years of age	na	na	78.9	21.1
	55 to 64 years of age	na	na	53.8	46.2
	65 to 74 years of age	na	na	40.6	59.4
	75 years or older	na	na	21.9	78.1
Colorectal cancer screening	Ages 55 and older	64.6	35.4	47.5	52.5
	55 to 64 years of age	58.6	41.4	46.2	53.8
	65 to 74 years of age	65.0	35.0	54.5	45.5
	75 years or older	71.7	28.3	42.4	57.6
Prostate cancer screening	Males ages 55 and older	75.1	24.9	na	na
	55 to 64 years of age	69.0	31.0	na	na
	65 to 74 years of age	83.1	16.9	na	na
	75 years or older	73.1	26.9	na	na
Skin cancer screening	Ages 18 and older	41.7	58.3	24.8	75.2
	18 to 24 years of age	0.0	100.0	50.0	50.0
	25 to 34 years of age	0.0	100.0	0.0	100.0
	35 to 44 years of age	40.0	60.0	22.2	77.8
	45 to 54 years of age	17.9	82.1	10.0	90.0
	55 to 64 years of age	33.9	66.1	26.4	73.6
	65 to 74 years of age	51.7	48.3	25.8	74.2
	75 years or older	56.9	43.1	31.3	68.8

American Indian Survey Reponses

Provided a list of preventive screenings (listed in Table 6), respondents were asked if they had received any of the specified screenings in the past year. A majority of all AI respondents, and AI respondents of specific age/gender, stated they received the following screenings in the past year: blood pressure (81.8%), breast cancer (64.7% of females aged 45 or older), and pelvic exam (58.5% of females). AI respondents were least likely to have received skin cancer screening in the past year (6.0%).

OA respondents were more likely than AI respondents to receive the following screenings: pelvic exam (for females) (67% vs. 58.5%), cervical cancer screening (for females) (63.4% vs. 41.5%), flu shot (62.1% vs. 40.4%), cholesterol screening (62.3% vs. 39.8%), prostate cancer screening (for males) (39.4% vs. 20.6%), and skin cancer screening (22.5% vs. 6.0%).

AI respondents were much more likely than OA respondents to receive a STD screening (43.7% vs. 4.2%).

Respondents who have had preventive screenings in the past year, by type of screening

Type of preventive screening	AI
Blood pressure screening (n: AI=88, OA=380)	81.8
Breast cancer screening (female, age 45 or older) (n: AI=17, OA=189)	64.7
Pelvic exam (female) (n: AI=53, OA=189)	58.5
STD screening (n: AI=87, OA=369)	43.7
Cervical cancer screening (female) (n: AI=53, OA=185)	41.5
Flu shot (n: AI=89, OA=380)	40.4
Cholesterol screening (n: AI=88, OA=378)	39.8
Immunizations (n: AI=86, OA=374)	37.2
Colorectal cancer screening (age 45 or older) (n: AI=30, OA=368)	26.7
Hearing screening (n: AI=86, OA=377)	22.1
Prostate cancer screening (male) (n: AI=34, OA=182)	20.6
Vascular screening (n: AI=71, OA=368)	12.3
Bone density test (n: AI=85, OA=367)	8.2
Skin cancer screening (n: AI=83, OA=365)	6.0

Respondents who did not receive specific screenings were asked to identify the reasons why they did not (Table 7). AI respondents stated they did not receive the following screenings because their doctor had not suggested it: cholesterol screening, hearing screening, immunizations, pelvic exam, or colorectal cancer screening. AI respondents stated they did not receive the following screenings because they were not necessary: blood pressure screening, bone density test, STD screening, vascular screening, cervical cancer screening, prostate cancer screening, and skin cancer screening.

OA and AI respondents both were most likely to state they did not receive screenings because they were not necessary or because their doctor had not suggested them.

Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents													
	Reasons													
	Not necessary		Doctor hasn't suggested		Cost		Fear of procedures		Fear of the results		Unable to access care		Other reason	
	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Blood pressure screening	43.8%	60.8%	31.3%	23.0%	6.3%	5.5%	6.3%	0.0%	0.0%	0.0%	0.0%	0.8%	12.5%	21.3%
Bone density test	25.6%	48.8%	23.1%	44.6%	2.6%	1.1%	1.3%	0.0%	0.0%	0.0%	2.6%	0.2%	1.3%	3.6%
Cholesterol screening	20.8%	50.7%	30.2%	35.8%	3.8%	4.6%	1.9%	0.0%	0.0%	0.0%	1.9%	0.1%	5.7%	10.5%
Flu shot	24.5%	40.9%	17.0%	3.9%	7.5%	0.3%	1.9%	0.7%	1.9%	1.3%	1.9%	0.3%	9.4%	51.6%
Hearing screening	20.9%	54.2%	22.4%	36.1%	1.5%	1.8%	1.5%	0.0%	0.0%	0.1%	1.5%	0.0%	7.5%	6.4%
Immunizations	18.8%	67.6%	18.5%	21.9%	1.9%	1.3%	1.9%	0.0%	1.9%	0.0%	3.7%	0.0%	9.3%	6.6%
Pelvic exam (female)	4.5%	60.2%	13.6%	12.1%	9.1%	1.6%	9.1%	0.7%	0.0%	0.0%	9.1%	0.0%	4.5%	14.3%
STD screening	14.3%	84.9%	10.2%	7.2%	6.1%	0.0%	2.0%	0.0%	0.0%	0.0%	2.0%	0.0%	4.1%	2.8%
Vascular screening	22.5%	56.0%	18.3%	34.3%	2.8%	1.2%	1.4%	1.0%	0.0%	0.0%	1.4%	0.2%	5.6%	4.7%
Breast cancer screening (female, age 45 or older)	0.0%	35.5%	0.0%	28.3%	16.7%	11.4%	16.7%	0.0%	0.0%	5.0%	16.7%	0.0%	16.7%	20.0%
Cervical cancer screening (female)	19.4%	53.6%	9.7%	24.9%	6.5%	0.0%	9.7%	0.0%	0.0%	0.0%	3.2%	0.0%	3.2%	9.2%
Colorectal cancer screening	9.1%	54.1%	22.7%	25.2%	9.1%	1.0%	9.1%	4.7%	0.0%	0.3%	4.5%	0.0%	4.5%	14.8%
Prostate cancer screening (male)	29.6%	44.1%	11.1%	38.9%	0.0%	0.6%	0.0%	3.9%	3.7%	0.2%	3.7%	0.0%	0.0%	13.4%
Skin cancer screening	24.4%	46.4%	16.7%	38.7%	3.8%	1.6%	1.3%	0.2%	0.0%	1.2%	2.6%	1.3%	2.6%	9.2%

Screenings

- Breast cancer screening: According to the Center for Disease Control (CDC), a mammogram is an X-ray of the breast. Mammograms are the best way to find breast cancer early, when it is easier to treat and before it is big enough to feel or cause symptoms. Having regular mammograms can lower the risk of dying from breast cancer. The United States Preventive Services Task Force recommends that if you are 50 to 74 years old, be sure to have a screening mammogram every two years. If you are 40 to 49 years old, talk to your doctor about when to start and how often to get a screening mammogram.

- Cervical cancer screening: Cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up. Two screening tests can help prevent cervical cancer or find it early:
    - The Pap test (or Pap smear) looks for *pre-cancers,* cell changes on the cervix that might become cervical cancer if they are not treated appropriately.

- - The HPV test looks for the virus that can cause these cell changes (human papillomavirus) (http://www.cdc.gov/cancer/hpv/basic_info/)
  - The Pap test is recommended for all women between the ages of 21 and 65 years old, and can be done in a doctor's office or clinic.

- Colorectal cancer screening: Colorectal cancer almost always develops from *precancerous polyps* (abnormal growths) in the colon or rectum. Screening tests can also find colorectal cancer early, when treatment works best. Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 and continuing until age 75.

- Prostate cancer screening: The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:
  - Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.
  - Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than age 65).
  - Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).

After this discussion, those men who want to be screened should be tested with the prostate-specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as a part of screening.

If, after this discussion, a man is unable to decide if testing is right for him, the screening decision can be made by the health care provider, who should take into account the patient's general health preferences and values.

Assuming no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test:
- Men who choose to be tested who have a PSA of less than 2.5 ng/mL may only need to be retested every 2 years.

Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.
Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone, is important when making decisions about screening.

Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing

becomes available. Further discussions are also needed to take into account changes in the patient's health, values and preferences.

- o Skin cancer screening: The U.S. Preventive Services Task Force (USPSTF) has concluded there is not enough evidence to recommend for or against routine screening (total body examination by a doctor) to find skin cancers early. The USPSTF recommends that doctors:
  - Be aware that fair-skinned men and women aged 65 and older, and people with atypical moles or more than 50 moles, are at greater risk for melanoma.
  - Look for skin abnormalities when performing physical examinations for other reasons.

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the generalizable survey indicate that 37% of respondents did not have a flu shot last year.
The Center for Disease Control states that influenza is a serious disease that can lead to hospitalization and sometimes even death. Even healthy people can get sick from the flu and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies provide protection against infection with the viruses that are in the vaccine.

Sanford Health is addressing flu vaccines in the 2016 implementation strategy. Employees are required to have an annual flu vaccine as a protective measure for our patients as well as our staff. Sanford holds annual flu blitz events to increase the number of community members both pediatric and adult who receive the flu vaccine.

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 24.1% of respondents in the generalizable group reported having 3 or more servings of vegetables the prior day, and 39.4% in the non-generalizable group, while only 20.1% of the generalizable group reported having 3 or more servings of fruits the prior day, and 14.3% in the non-generalizable group.

According to the U.S. Department of Health and Human Services, U.S. Department of Agriculture Dietary guidelines for Americans, it is recommended that individuals consume 3 to 5 servings of vegetables per day and 2 to 4 servings of fruit per day depending on age. A diet high in fruits and vegetables is associated with decreased risk for chronic diseases. In addition, because fruits and vegetables have low energy density (i.e., few calories relative to volume), eating them as part of a reduced-calorie diet can be beneficial for weight management.

Secondary research provided by the North Dakota Department of Health finds that 84.2 percent of residents in Cass County report not getting 5 fruits and vegetables each day. (See Appendix)

Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday
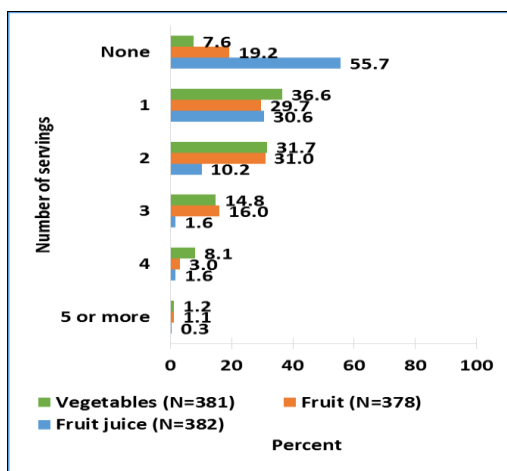
Generalizable survey group
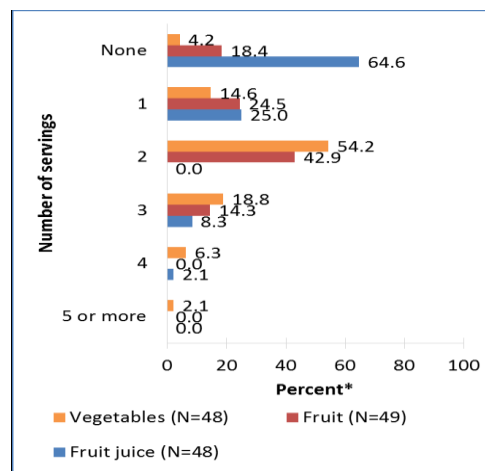
Non-generalizable group (community leaders)

American Indian Survey Reponses

Respondents were asked the number of servings of vegetables, fruits, and fruit juice they had consumed the previous day. One-fifth (21.1%) of AI respondents stated they had at least three servings of vegetables in the previous day. One-fourth (25.1%) of AI respondents stated they had at least three servings of fruits in the previous day.

Responses for AI and OA respondents were comparable for fruits and vegetable intake. AI respondents reported a higher intake of fruit juice than OA respondents.

Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday

|	Percent of respondents										
	Servings										
	None		1		2		3		4		5 or more	
Type of Food/ Drink	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Vegetables	16.8	7.6	27.4	36.6	34.7	31.7	15.8	14.8	3.2	8.1	2.1	1.2
Fruit	15.6	19.2	26.0	29.7	33.3	31.0	18.8	16.0	4.2	3.0	2.1	1.1
Fruit Juice	36.5	55.7	33.3	30.6	14.6	10.2	11.5	1.6	3.1	1.6	1.0	0.3

Vegetables - n: AI=95, OA=381; Fruit – n: AI=96, OA=378; Fruit Juice – n: AI=96, OA=382

Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines. In the generalizable group, 48.3% of respondents engage in moderate activity 3 or more times per week and 21% engage in vigorous activity 3 or more times per week. In the non-generalizable group, 51% engage in moderate activity 3 or more times per week and 20% in vigorous activity 3 or more times per week.

Guidelines from the Centers for Disease Control and Prevention recommend that individuals participate in 150 minutes of moderate physical activity per week or 75 minutes of vigorous physical activity per week to help sustain and improve health.

Number of days in an average week respondents engage in MODERATE and VIGOROUS activity
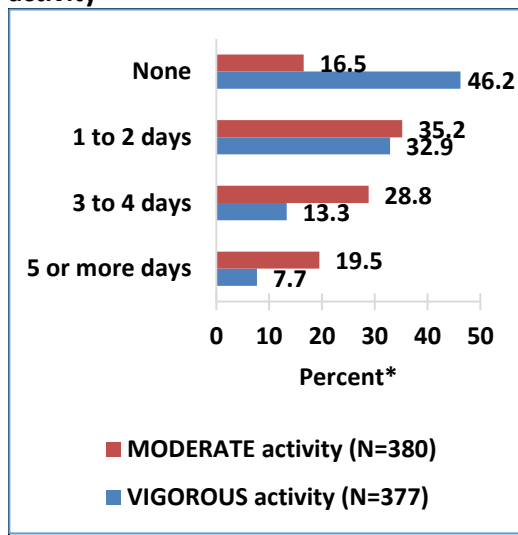
Generalizable survey group
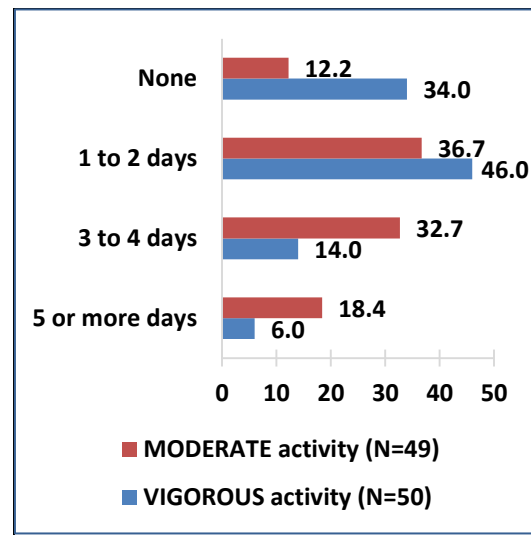
Non-generalizable group (community leaders)

American Indian Survey Reponses

Respondents were asked the number of days they get at least 30 minutes of moderate or vigorous activity, with moderate activity defined as causing light sweating and small increases in breathing or heart rate and vigorous activity causing heavy sweating and large increases in breathing or heart rate. Nearly one-third (29.2%) of AI respondents stated they participate in moderate activity at least five days a week, with more than one-fifth (12.5%) stating they participate in vigorous activity a minimum of five days a week (Table 2, Appendix Table 5).

AI respondents were more likely than OA respondents to participate in either moderate (29.2% vs. 19.5%) or vigorous (12.5% vs. 7.7%) activity most days of the week.

Number of days in an average week respondents engage in MODERATE or VIGOROUS activity

	Percent of respondents							
	Frequency of Weekly Activity							
	None		1 to 2 days		3 to 4 days		5 or more days	
Activity Level	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Moderate Activity	3.1	16.5	39.6	35.2	28.1	28.8	29.2	19.5
Vigorous Activity	18.8	46.2	54.2	32.9	14.6	13.3	12.5	7.7

Moderate activity – n: AI=96, OA=380; Vigorous activity – n: AI=96, OA=377

Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users. However, one in three respondents has smoked at least 100 cigarettes in their lifetime, which indicates former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the 2015 County Health Rankings finds that 16 percent of Cass County residents and 17 percent of Clay County residents are current smokers.

Whether respondents have smoked at least 100 cigarettes in their entire life
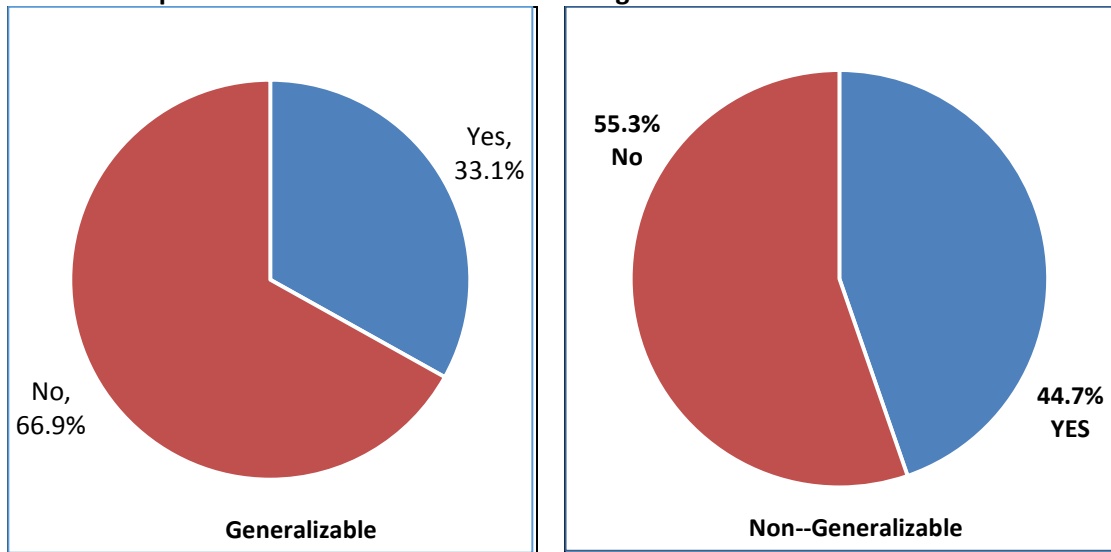
Yes, 33.1%

No, 66.9%

Generalizable

55.3% No

44.7% YES

Non--Generalizable

American Indian Survey Reponses
AI respondents were twice as likely as OA respondents to state they have smoked at least 100 cigarettes (5 packs of cigarettes) in their lifetime (67.4% vs. 33.1%).
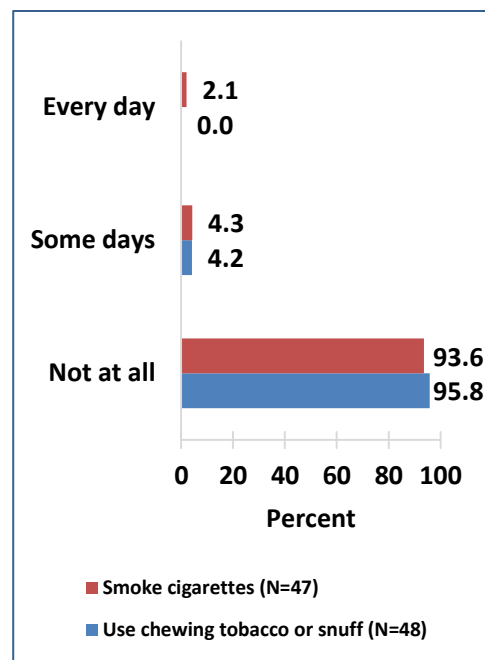
Whether respondents have smoked at least 100 cigarettes in their lifetime
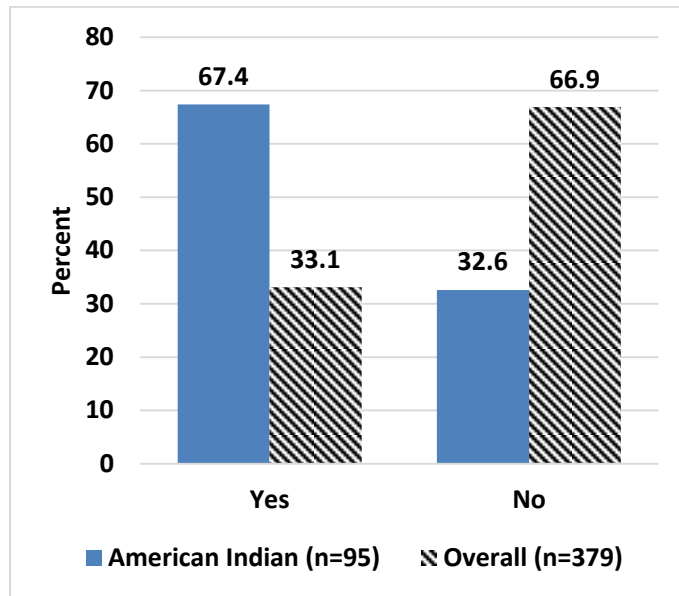
How often respondents currently smoke cigarettes and use chewing tobacco or snuff
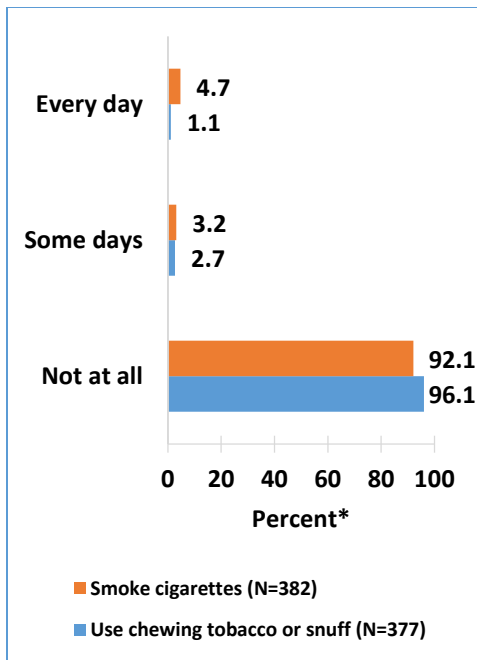
Generalizable

Non-Generalizable

American Indian Survey Reponses

Respondents were asked the frequency with which they smoke cigarettes or use chewing tobacco or snuff. Nearly 29% (38.9%) of AI respondents stated they smoke cigarettes every day, with 7.4% stating they use chewing tobacco or snuff every day.

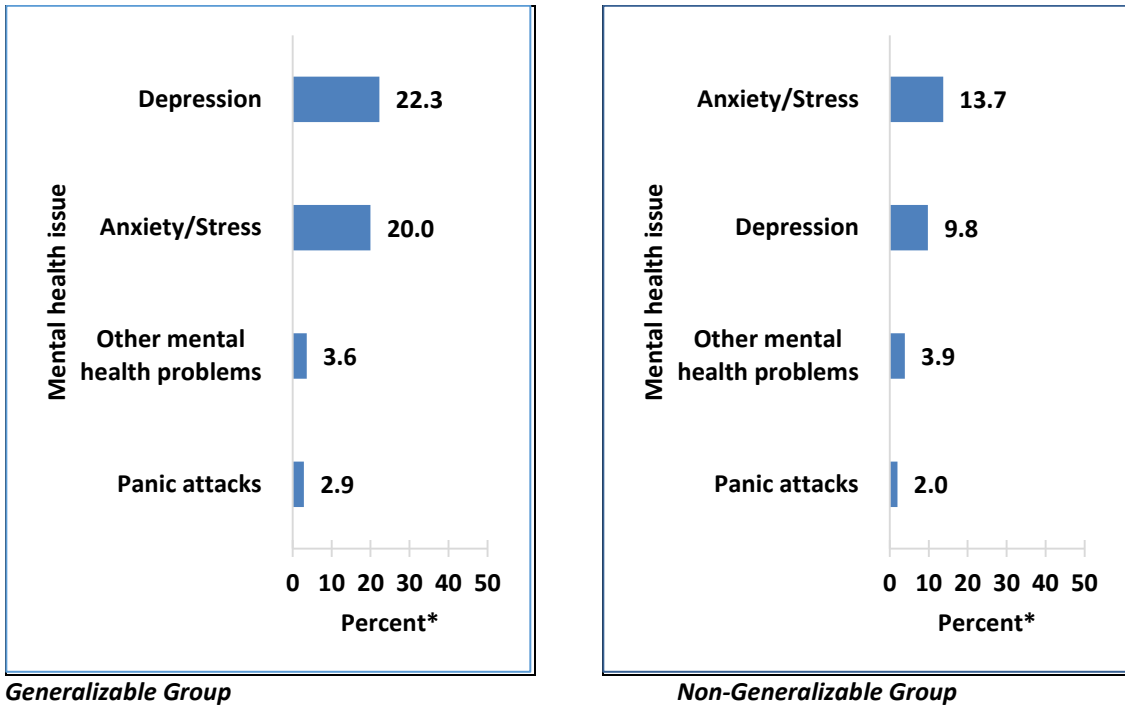**Frequency of cigarette and chewing tobacco/snuff use**

	Percent of respondents					
	Frequency					
	Everyday		Some days		Not at all	
Tobacco type	AI	Overall	AI	Overall	AI	Overall
Cigarettes (n: AI=95, OA=382)	38.9	4.7	20.0	3.2	41.1	92.1
Chewing tobacco/snuff (n: AI=95, OA=377)	7.4	1.1	9.5	2.7	83.2	96.1

Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others. Among Fargo-Moorhead respondents, mental health is a moderately high area of concern, particularly depression, dementia and Alzheimer's disease. One in five respondents has been told or diagnosed by a doctor or health professional that they have anxiety or stress and a similar proportion has been told they have depression. In addition, half of respondents self-report that in the last month, there were days when their mental health was not good. 49.5% of the generalizable respondents reported days in the past month when their mental health was not good. 17.5% reported over 7 days. 58.3% of the non-generalizable respondents reported days in the past month when their mental health was not good, and 25% reported having over 7 days in the past month when their health was not good.

One in 10 respondents reported that their mental health was not good for at least half of the days in the last month. Furthermore, when asked specifically about particular mental health issues, one in five respondents reported little interest or pleasure in doing things for several days or more in the last two weeks and one in six respondents say that for at least several days in the last two weeks they were feeling down, depressed or hopeless.

Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue


Generalizable Group

Non-Generalizable Group
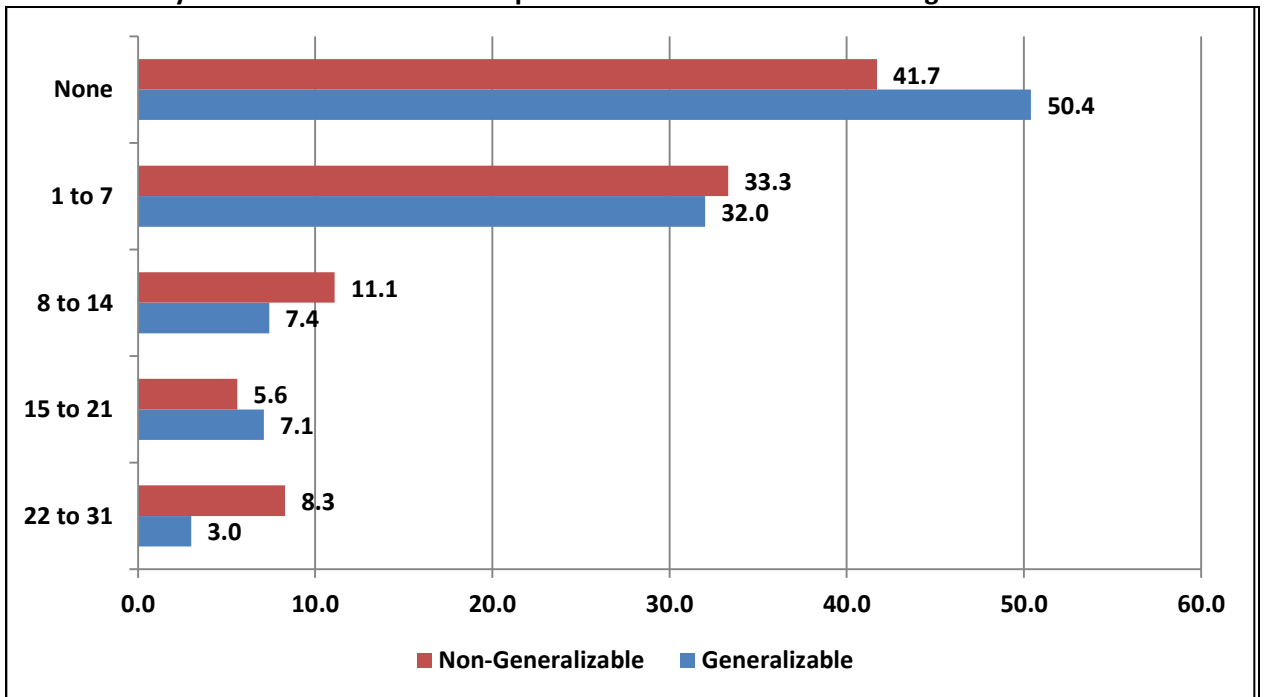
American Indian Survey Reponses

Respondents were asked if they had been told by a doctor or health professional they have any of the following conditions: depression, anxiety/stress, panic attacks, or any other mental health problem. More than half of AI respondents stated they had been diagnosed with anxiety/stress (54.2%), while 46.9% stated they had been diagnosed with depression, 28.1% with panic attacks, and 22.9% with other mental health problems.

AI respondents were twice as likely to state they had been diagnosed with depression as OA respondents (46.9% vs. 22.3%), 2.5 times as likely to state they had been diagnosed with anxiety/stress (54.2% vs. 20.0%), nearly 10 times as likely to state they had been diagnosed with panic attacks (28.1% vs. 2.9%), and 6 times as likely to have been diagnosed with other mental health issues (22.9% vs. 3.6%).

Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue
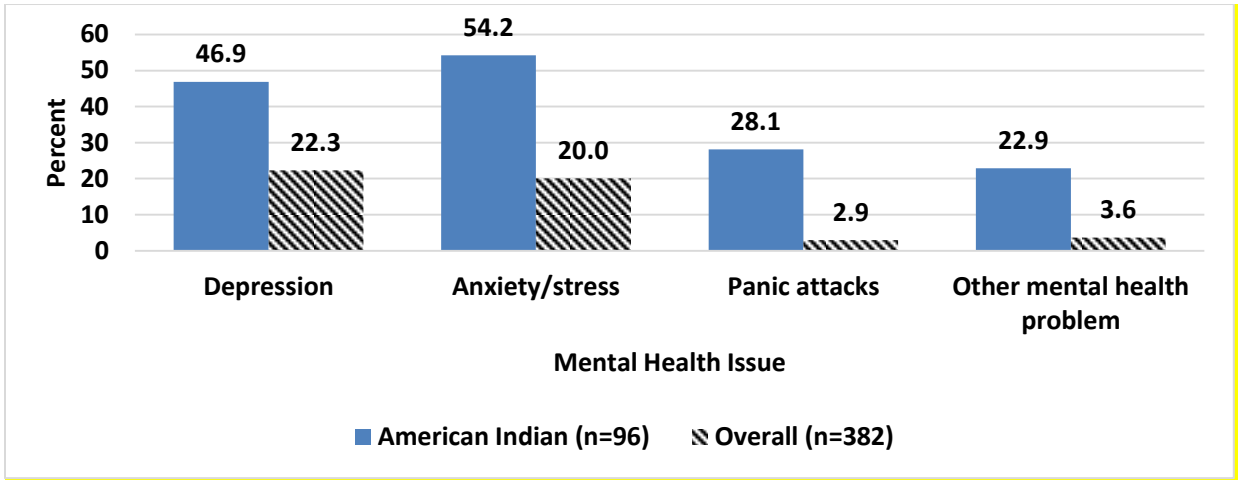

Number of days in the last month that respondents' mental health was not good

American Indian Survey Reponses

Respondents were asked to specify the number of days in the past 30 days they felt their mental health was not good, including stress, depression, and problems with emotions. More than 84% (84.2%) of AI respondents stated their mental health was not good on at least one day in the past 30 days. One-third (31.6%) stated their mental health was not good on at least half of the last 30 days.

**Number of days in the last month that respondents' mental health was not good**
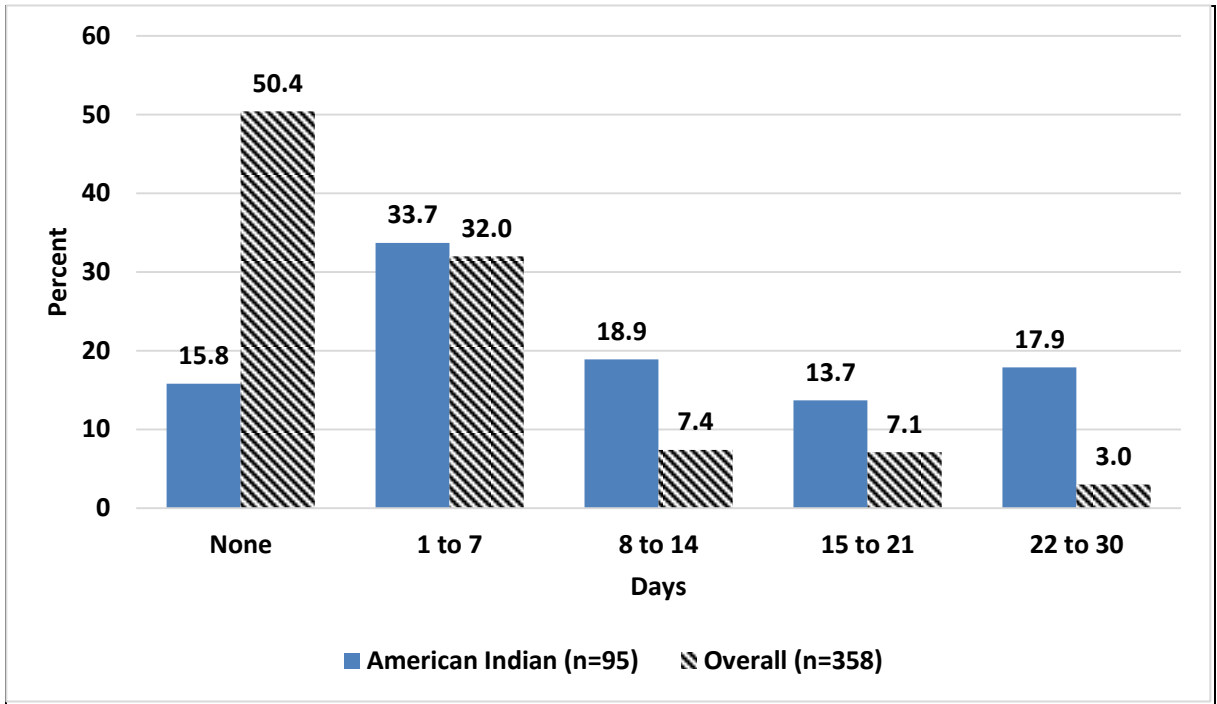
Substance Abuse Responses

Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In the Fargo-Moorhead community, one in five respondents drank alcoholic beverages on at least half of the days in the last month. On days they drank, one in eight respondents drank an average of four or more drinks per day. In regards to binge drinking, one in three respondents report binge drinking at least once per month. Specifically, 5 percent say they binge drink 2 to 3 times a week and an additional 3 percent binge drank almost every day in the past month. 33.2% of respondents report drinking at a binge level in the generalizable group and 21% in the non-generalizable group at least once per month.

Secondary research through the 2015 County Health Ranking indicates that 21 percent of Cass County and 23 percent of Clay County residents report binge drinking. (See Appendix)

Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (Binge drinking is defined by the CDC as 4 drinks for females, 5 drinks for males) on the same occasion
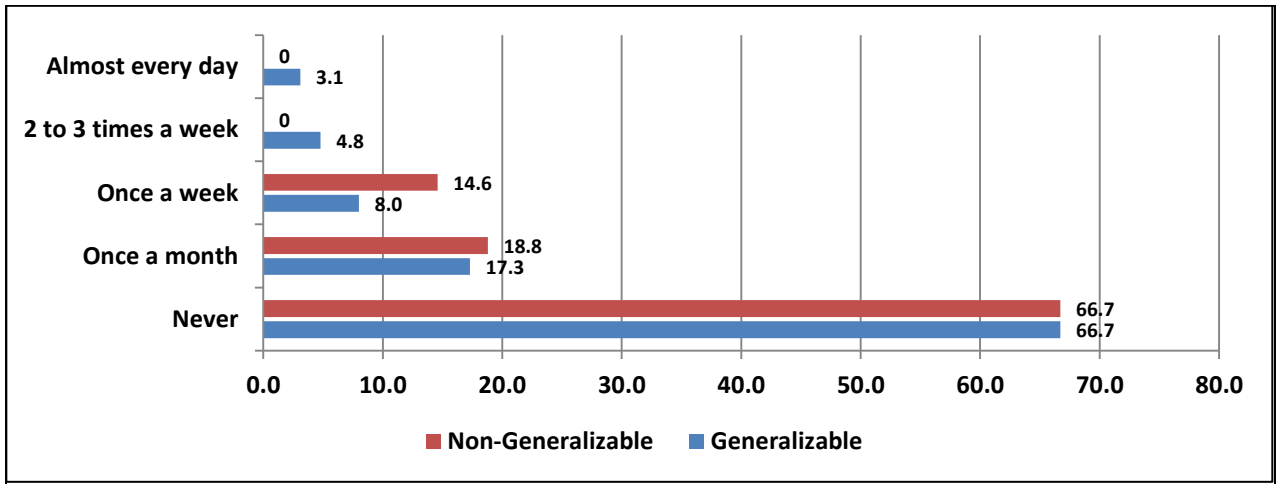

American Indian Survey Reponses

Respondents were asked to specify the number of times in the past month they consumed at least 4 (for females) or 5 (for males) alcoholic drinks on the same occasion. More than 17% (17.4%) of AI respondents stated they never had four or five drinks on the same occasion, while 6.5% stated they had four or five drinks almost every day.

AI respondents were 3.5 times as likely as OA respondents to state they had 4 or 5 drinks on one occasion at least once a week (56.5% vs. 15.9%).

Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion
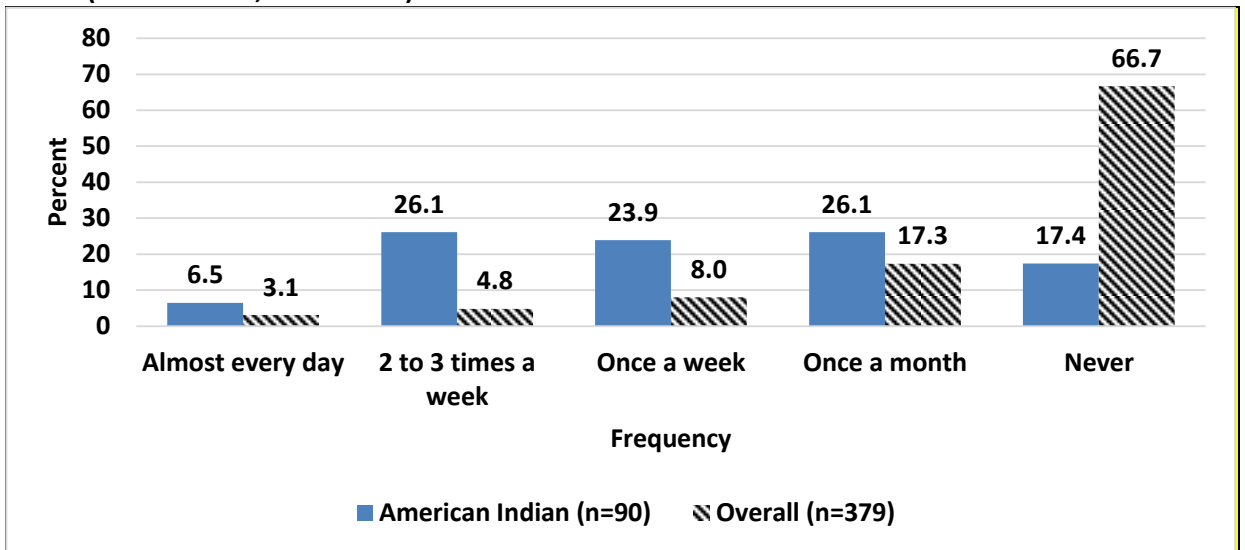
Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse
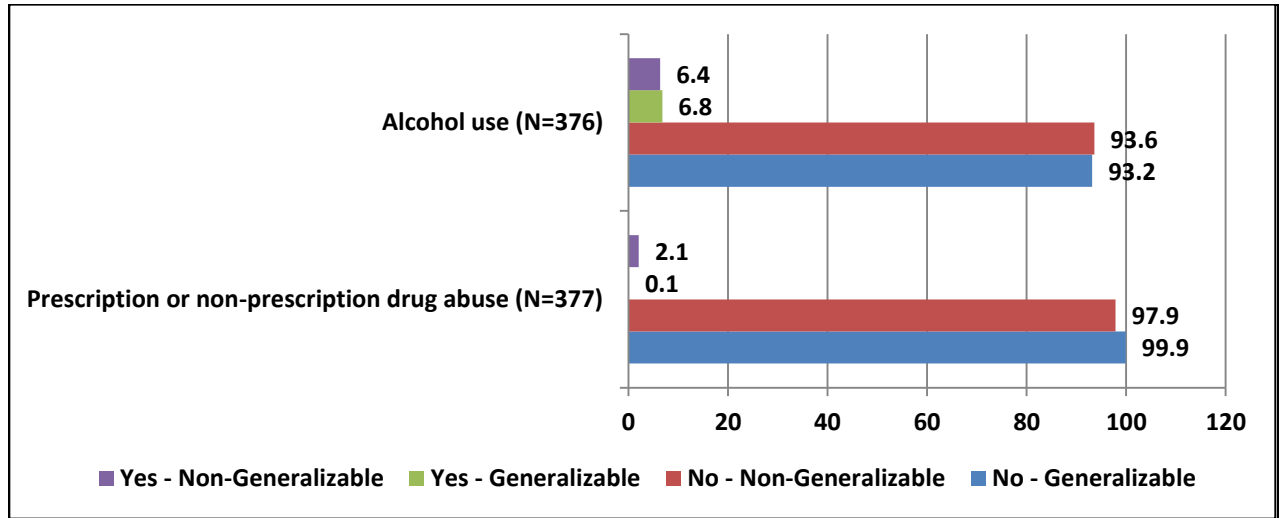
Less than 7 percent of respondents from either group reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking. Overall, one in six respondents report alcohol use has had harmful effects on themselves or a family member.

Other forms of substance abuse include the use of prescription or non-prescription drugs. No respondents in the metro area reported having had a problem with prescription or non-prescription drug abuse. However, respondents say prescription or non-prescription drug abuse has had harmful effects on themselves or a family member.

American Indian Survey Reponses

Respondents were asked if they had a problem with alcohol use or prescription/non-prescription drug abuse and if so, if they got the help they needed. More than half of AI respondents (51.6%) stated they had a problem with alcohol use, and of these respondents, 56.3% stated they received the help they needed. More than one-fourth of AI respondents (26.4%) stated they had a problem with prescription/non-prescription drug abuse, and of these respondents, half stated they received help.
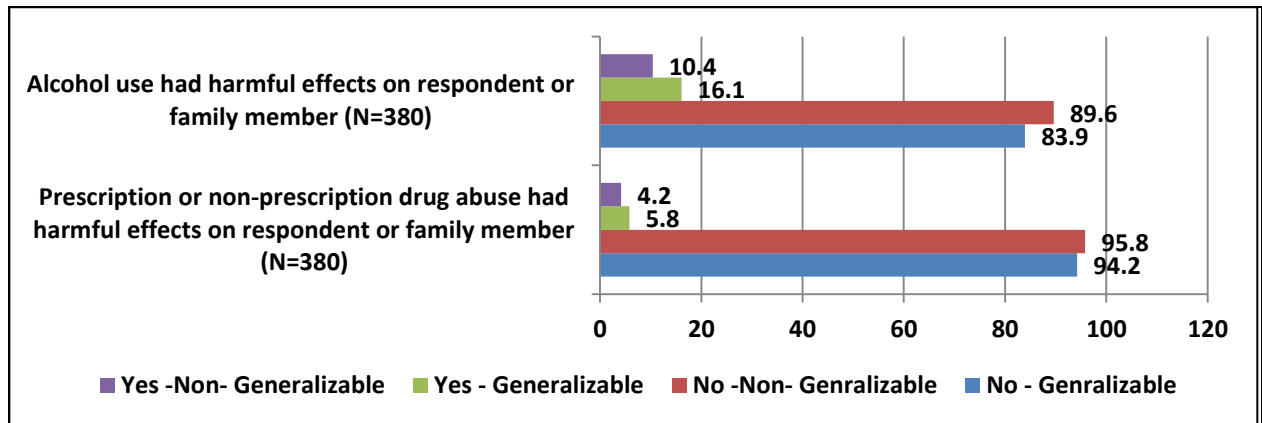
AI respondents were much more likely than OA respondents to report having a problem with alcohol use (51.6% vs. 6.8%) or prescription/non-prescription drug abuse (26.4% vs. 0.1%). AI respondents with alcohol use problems were more likely than OA respondents to receive the help they needed (56.3% vs. 25.6%), while OA respondents were more likely to state they didn't need help (43.8% vs. 14.6%).

Whether respondents have ever had a problem with alcohol use or prescription/ non-prescription drug abuse and if so, if they got the help they needed

	Percent of respondents									
	Problem				If yes, received help					
	Yes		No		Yes		No		Didn't Need Help	
Type of use/abuse	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Alcohol use	51.6	6.8	48.4	93.2	56.3	25.6	29.2	30.5	14.6	43.8
Prescription/non-prescription drug abuse	26.4	0.1	73.6	99.9	50.0	0.0	21.9	0.0	28.1	0.0

Ever had problem with alcohol use - n: AI=95, OA=376; Ever had problem with presc/non-presc drug use - n: AI=91, OA=377; Received help with alcohol - n: AI=48, OA=25; Received help for presc/non-presc drug use - n: AI=32, OA=0

Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years


American Indian Survey Reponses

Respondents were asked if alcohol use or prescription/non-prescription drug abuse had harmful effects on themselves or a family member over the past two years. Two-thirds of AI respondents stated they felt alcohol use has had harmful effects either on themselves or on a family member over the past two years, while 57% stated prescription/non-prescription drug abuse has had harmful effects on the same populations over the same period of time.

AI respondents were 4 times as likely as OA respondents to state that alcohol use has had harmful effects either on themselves or a family member over the past two years (67% vs. 16.1%). AI respondents were nearly 10 times as likely to state that prescription/non-prescription drug abuse has had harmful effects on either themselves or a family member over the past two years (57% vs. 5.8%).

Alcohol use or prescription/non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years
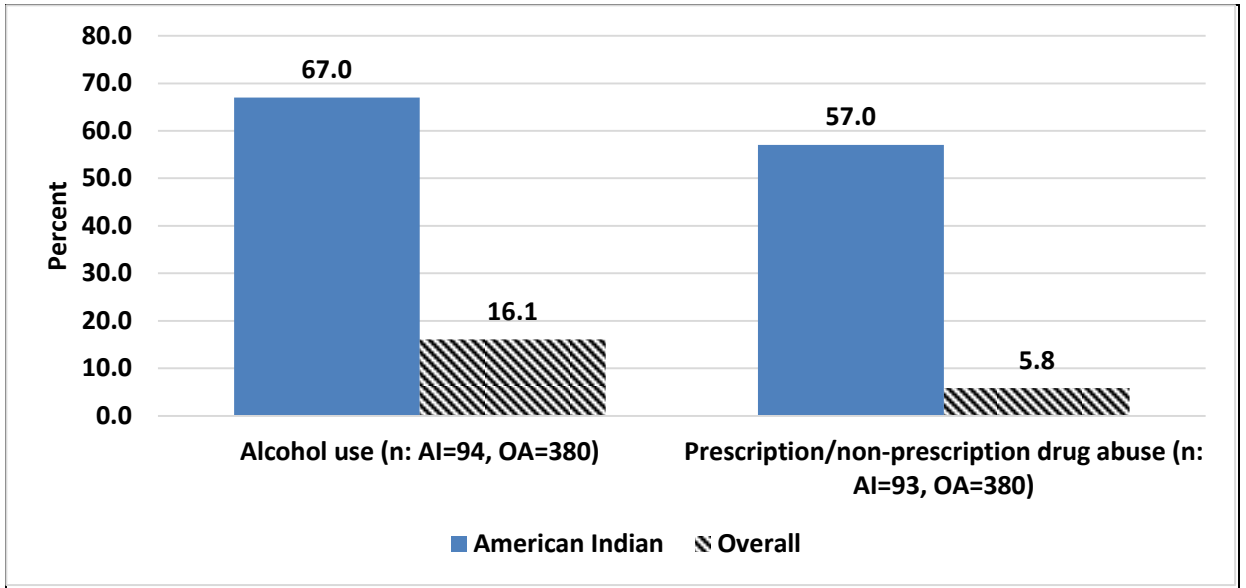
Demographics

Total Population – 2010 U.S. Census Bureau

- **Cass County: 149,778**
- **Clay County: 58,999**

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	Cass: 10,415 Clay: 4,056	Cass: 7 Clay: 6.9	Cass: 5,313 Clay: 2,120	Cass: 3.5 Clay: 3.6	Cass: 5,102 Clay: 1,936	Cass: 3.4 Clay: 3.3
5-9	Cass: 8,841 Clay: 3,772	Cass: 5.9 Clay: 6.4	Cass: 4,466 Clay: 1,911	Cass: 3.0 Clay: 3.2	Cass: 4,375 Clay: 1,861	Cass: 2.9 Clay: 3.2
10-14	Cass: 8,378 Clay: 3,686	Cass: 5.6 Clay: 6.2	Cass: 4,277 Clay: 1,904	Cass: 2.9 Clay: 3.2	Cass: 4,101 Clay: 1,782	Cass: 2.7 Clay: 3.0
15-19	Cass: 10,856 Clay: 5,445	Cass: 7.2 Clay: 9.2	Cass: 5,519 Clay: 2,610	Cass: 3.7 Clay: 4.4	Cass: 5,337 Clay: 2,835	Cass: 3.6 Clay: 4.8
20-24	Cass: 18,392 Clay: 7,147	Cass: 12.3 Clay: 12.1	Cass: 9,560 Clay: 3,535	Cass: 6.4 Clay: 6.0	Cass: 8,832 Clay: 3,612	Cass: 5.9 Clay: 6.1
25-29	Cass: 14,221 Clay: 4,121	Cass: 9.5 Clay: 7.0	Cass: 7,427 Clay: 2,138	Cass: 5.0 Clay: 3.6	Cass: 6,794 Clay: 1,983	Cass: 4.5 Clay: 3.4
30-34	Cass: 11,331 Clay: 3,671	Cass: 7.6 Clay: 6.2	Cass: 6,000 Clay: 1,839	Cass: 4.0 Clay: 3.1	Cass: 5,331 Clay: 1,832	Cass: 3.6 Clay: 3.1
35-39	Cass: 9,536 Clay: 3,311	Cass: 6.4 Clay: 5.6	Cass: 4,978 Clay: 1,681	Cass: 3.3 Clay: 2.8	Cass: 4,558 Clay: 1,630	Cass: 3.0 Clay: 2.8
40-44	Cass: 8,826 Clay: 3,211	Cass: 5.9 Clay: 5.4	Cass: 4,529 Clay: 1,621	Cass: 3.0 Clay: 2.7	Cass: 4,297 Clay: 1,590	Cass: 2.9 Clay: 2.7

	Number	Percent	Males	Percent	Females	Percent
45-49	Cass: 9,429 Clay: 3,671	Cass: 6.3 Clay: 6.2	Cass: 4,815 Clay: 1,824	Cass: 3.2 Clay: 3.1	Cass: 4,614 Clay: 1,847	Cass: 3.1 Clay: 3.1
50-54	Cass: 9,594 Clay: 3,890	Cass: 6.4 Clay: 6.6	Cass: 4,723 Clay: 1,894	Cass: 3.2 Clay: 3.2	Cass: 4,871 Clay: 1,996	Cass: 3.3 Clay: 3.4
55-59	Cass: 8,832 Clay: 3,412	Cass: 5.9 Clay: 5.8	Cass: 4,440 Clay: 1,725	Cass: 3.0 Clay: 2.9	Cass: 4,392 Clay: 1,687	Cass: 2.9 Clay: 2.9
60-64	Cass: 6,577 Clay: 2,528	Cass: 4.4 Clay: 4.3	Cass: 3,338 Clay: 1,277	Cass: 2.2 Clay: 2.2	Cass: 3,329 Clay: 1,251	Cass: 2.2 Clay: 2.1
65-69	Cass: 4,070 Clay: 1,858	Cass: 2.7 Clay: 3.1	Cass: 2,026 Clay: 909	Cass: 1.4 Clay: 1.5	Cass: 2,044 Clay: 949	Cass: 1.4 Clay: 1.6
70-74	Cass: 3,104 Clay: 1,561	Cass: 2.1 Clay: 2.6	Cass: 1,350 Clay: 714	Cass: 0.9 Clay: 1.2	Cass: 1,754 Clay: 847	Cass: 1.2 Clay: 1.4
75-79	Cass: 2,639 Clay: 1,320	Cass: 1.8 Clay: 2.2	Cass: 1,146 Clay: 579	Cass: 0.8 Clay: 1.0	Cass: 1,493 Clay: 741	Cass: 1.0 Clay: 1.3
80-84	Cass: 2,335 Clay: 1,149	Cass: 1.6 Clay: 1.9	Cass: 904 Clay: 468	Cass: 0.6 Clay: 0.8	Cass: 1,431 Clay: 681	Cass: 1.0 Clay: 1.2
85 and over	Cass: 2,402 Clay: 1,190	Cass: 1.6 Clay: 2.0	Cass: 740 Clay: 388	Cass: 0.5 Clay: 0.7	Cass: 1,662 Clay: 802	Cass: 1.1 Clay: 1.4
Median age	Cass: 31.5 Clay: 31.6		Cass: 30.9 Clay: 30.9		Cass: 32.2 Clay: 32.3	

Population by Race

	Cass	Percent	Clay	Percent
White	137,308	91.7	54,684	92.7
Black or African American	3,428	2.3	842	1.4
American Indian or Alaska Native	1,827	1.2	803	1.4
Asian	3,532	2.4	846	1.4
Native Hawaiian or other Pacific Islander	52	0.0	8	0.0
Hispanic or Latino	3,015	2.0	2,056	3.5

The per capita personal income in Cass County, North Dakota is $52,711. The per capita personal income in Clay County, Minnesota is $24,550. Those living below the poverty level are 13% in Cass County and 12.3% in Clay County. The unemployment rate in Cass County is 1.6% and the unemployment level in Clay County is 3%.

Health Needs and Community Resources Identified

One of the requirements for a community health needs assessment is to identify the resources that are available in the community to address unmet needs. Asset mapping was conducted 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 were available in the community to address the needs.

The Greater Fargo Moorhead Community Health Needs Assessment Collaborative participated in the asset mapping and reviewed the research findings. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

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

The asset map includes identified needs from the following:
- Identified needs from the generalizable survey
- Identified needs from the non-generalizable survey
- Concerns expressed by the key stakeholder group
- Secondary research data
- Community resources that are available to address the need(s)

(See Appendix for the asset map.)

Prioritization

The following needs were brought forward for prioritization:
- Economics – affordable housing and hunger
- Aging – cost and availability of long term care and availability of memory care
- Children and Youth – cost and availability of quality child care a quality infant care, bullying
- Safety – presence of drug dealers in the community and the presence of street drugs and alcohol in the community
- Health Care Access – access to affordable health care and affordable health insurance
- Physical Health – cancer, chronic disease, obesity, poor nutrition and inactivity
- Mental Health – depression, stress, substance use and abuse
- Preventive Health – flu vaccines

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 these findings with community leaders and experts who can best focus on a solution to the concern.

A document that shares what Sanford is doing to address the need or defends why Sanford is not addressing the need can be found in the Appendix.

Members of the collaborative determined that flu vaccines are a top unmet need. Community stakeholders also rated chronic disease and mental illness as top priorities.

Sanford has determined the 2016-2019 implementation strategies for the following needs:
- Hypertension
- Depression
- Flu vaccines

How Sanford is Addressing the Needs

Identified Concerns	How Sanford is Addressing the Needs
Economics • Availability of affordable housing • Homelessness	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 is located at the YMCA 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, Churches United for the Homeless, and Gourmet Soup Kitchen. Sanford supports the Great Plains Food Bank and the Daily Bread Program. Sanford will also address these needs by sharing the results of the CNHA with community leaders.
Aging • Cost of long term care • Availability of memory care • Availability of long term care	Sanford will address this need by sharing the results of the CHNA with community leaders.
Children and Youth • Bullying • Cost of quality child care • Availability of quality infant care	Sanford will address this need by sharing the results of the CHNA with community leaders.
Safety • Presence of street drugs and alcohol in the community	Sanford is participating in the North Dakota "Reducing Pharmaceutical Narcotics in our Communities – Through Education and Awareness" committee. The committee has as four-pillar approach including: education and awareness, prescription drug-take back program, law enforcement, pharmacy partnership, and the prescription drug monitoring program.

Identified Concerns	How Sanford is Addressing the Needs
• Presence of drug dealers in the community • Crime • Child abuse and neglect • Domestic violence • Sex trafficking	Sanford is also working closely with the Rape and Abuse Crisis Center, the Red River Human Trafficking Response Team, and the Cross Borders Children's Action Network. Sanford will also address this need by sharing the results of the CNHA with community leaders and legislators.
Health Care • Access to affordable health insurance • Access to affordable health care • Access to affordable prescription drugs • Cost of affordable dental insurance coverage • Cost of affordable vision 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 2014 Sanford contributed over $51 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. Sanford will also address this need by sharing the results of the CHNA with community leaders and legislators.
Physical Health • Cancer • Chronic disease • Inactivity/lack of exercise • Obesity • Poor nutrition and eating habits • Infectious disease such as flu	Sanford has set hypertension and flu vaccines as key implementation strategies for 2016-2019. Sanford is committed to serving the cancer needs of our community through the Roger Maris Cancer Center and the 13 medical oncologists/hematologists. 5 radiation oncologists, 2 pediatric oncologists/hematologists, 7 palliative care board-certified physicians, 1 oncology clinical psychologist, 1 medical geneticist, 3 genetic counselors, 1 doctor of nursing practice, 2 physician assistants, 2 nurse practitioners, 7 pharmacists, 4 radiation oncology medical physicists, and several hundred nurses. Sanford is actively working to address chronic disease through programs and quality indicators. The chronic disease self-management program at Sanford (Better Choices, Better Health) is offered free of charge to community members. Better Choices, Better Health is modeled after the Stanford University chronic disease self-management program. The workshops are 2-1/2 hours long and meet weekly for 6 weeks. Sanford Enterprise chose obesity as an implementation strategy for the 2013 CHNA. Strategies included an annual obesity symposium for providers and monthly education programs for community members. The Sanford obesity symposium was attended by more than 400 registrants during April 2013 and March 2015. The symposium will be held again during

Identified Concerns	How Sanford is Addressing the Needs
	March 2016. The symposium is evidence-based and Sanford providers and national experts serve as faculty.

The Family Wellness Center in Fargo offers many classes each week that address wellness for children and families in partnership with Sanford Health and the YMCA. The facilities have multiple group exercise rooms as well as classrooms for educational events. Children and families have numerous fitness options as well as classes that address health, healthy nutrition and healthy cooking. The Family Wellness Center is a place for the entire family, with drop-in child care, a kid-friendly pool with water slide, swimming lessons, and an open gym for free play.

The adult weight management program "Honor Your Health" is a comprehensive wellness program developed by Sanford Health Fargo Region which focuses on evidence-based nutrition standards, physical activity and behavioral health. This class is offered for adults and provides a basis for young parents as well as all adults to learn about health and wellness. This program is a comprehensive approach to healthy lifestyle practices and may facilitate healthy behaviors for families.

The Sanford Health *fit* initiative, a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life. |
| **Mental Health**
• Depression
• Dementia and Alzheimer's
• Stress
• Underage drug use and abuse
• Underage drinking
• Suicide
• Drug use and abuse
• Alcohol use and abuse | Sanford has prioritized depression as a key implementation strategy for 2016-2019.

A key implementation strategy during 2013-2016 for Sanford Health is to fully integrate behavioral health services into all primary care clinics. Sanford One Care is a new approach to addressing behavioral health in primary and specialty care clinics and medical centers. Sanford One Care uses technology to conduct behavioral health screenings in order to identify behavioral health concerns as early as possible. Through deployment of Medical Home with fully integrated behavioral health care services, Sanford is providing patient-centered care collaborative teams to meet the needs of Sanford patients. |

Identified Concerns	How Sanford is Addressing the Needs
	Sanford behavioral health experts are serving on the North Dakota Behavioral Health Stakeholders Advisory to the Department of Human Services Legislative Interim Committee to shape policy. The committee is addressing substance abuse, workforce, child and adolescent services and adult services. Sanford leaders also serve on the North Dakota Reducing Pharmaceutical Narcotics in Our Communities – Through Education and Awareness" committee. During 2015 Sanford hosted a behavioral health symposium. The symposium was designed to enhance the competence of health care professionals in the identification, treatment and management of behavioral health issues impacting specialty and primary care. Sanford will also address this need by sharing the results of the CHNA with community leaders and legislators

2016-2019 Implementation Strategies

Implementation Strategies

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 has prioritized hypertension as a top priority 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.

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. But 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 indicate 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 a 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 nine whose six-month PHQ-9 score is less than five.

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.

Community Health Needs Assessment – Implementation Strategy for Fargo Medical Center

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	Measureable Outcomes	Dedicated Resources	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 has 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	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Develop Sanford My Chart 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 5.	Mallory Koshiol	Dr. Heidi Twedt	Fist Link
Provide education on workflow to all health coaches and panel specialists to standardize workflow	All health coaches in primary care receive education on workflow	Mallory Koshiol All health coaches	Dr. Heidi Twedt	

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	Measureable Outcomes	Resources	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 given 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	

2013 Implementation Strategy Impact

The 2013 Community Health Needs Assessment served as a catalyst to lift up obesity and mental health services as implementation strategies for the 2013-2016 timespan. The following strategies were implemented:

Implementation Strategy to Address Obesity
- Develop CME curriculum and annual symposium to address weight management and obesity for providers and interdisciplinary teams inclusive of medical, nutrition, nursing, and behavioral health professionals.
- Develop community education programming focusing on prevention and treatment of obesity. Include the following program options in the curriculum to create awareness of existing resources
    - Family Wellness Center Resources to leverage
        - Kids Fitness Classes
        - Kids cooking class (includes family)
        - Body Works
        - Camp Fuel
    - TNT Fitness for Children
    - Honor Your Health Program
    - WebMD Fit Program
    - Bariatric Surgery
    - Eating Disorder Institute/Behavioral Health
    - Profile

- Actively participate in community initiatives to address wellness, fitness and health living.

Implementation Strategy for Mental Health Services – Sanford One Mind
- Completion (to the extent resources allow) of full integration of behavioral health services in all primary care clinics in Fargo
- Completion (to the extent resources allow) of full integration of behavioral health services or access to behavioral health outreach in all clinic sites
- Complete presentation of outcomes of first three years of integrated behavioral health services
- Establish "Clara's House" (to the extent that resources allow)
- Completion (to the extent resources allow) of American Indian Behavioral Health Service serving the Enterprise
- Design Team for Inpatient Psychiatric Unit, Partial Hospitalization and Clinic Space for Fargo present recommendations for design of new spaces
- Participate in a leadership role with the Fargo Moorhead Mental Health Strategic Planning Collaborative

The 2013 strategies have served a broad reach across our community and region. The impact has been positive and the work will continue into the future through new or continued programming and services.

Impact of the Strategy to Address Obesity

The obesity initiative addressed education for providers and education for patients and community members. The first annual Sanford obesity symposium was held in 2014. Over 400 health care professionals from the region and beyond registered for the 2014 and the 2015 symposium. The

purpose of the symposium is to enhance the knowledge and competence of participants by providing an update on the latest research associated with the prevention, treatment and management of obesity. The target audience includes primary care physicians, pediatricians and specialty care providers, advanced practice providers, licensed registered dietitians, nurses, and other interested health care professionals.

The symposium is an opportunity to provide prevention and treatment practice guidelines for the adult and pediatric population. The planning committee includes several published providers who are sought after nationally and internationally for their expertise.

The Family Wellness Center offers nutrition and fitness classes each month for community members. Cooking classes for children and parents, and nutrition classes for the general public are offered independent of membership. The Family Wellness Center is partnering with local schools to bring classes and services into the schools.

Camp Fuel is a program for youth focusing on healthy self-esteem and body image and includes curriculum for healthy nutrition and activity. The camp promotes a positive self-image and strives to create an understanding that the body requires "fuel" from the foods we eat and burn. Topics covered in this camp include portions, dining out choices, label reading to create knowledge of purchasing options, increasing activity and the importance of an active lifestyle, behaviors that promote a healthy lifestyle, positive self-esteem, and body image.   This camp is conducted at the Family Wellness Center during the summer months. Camp Fuel has been at capacity each time it is offered, and fitness classes specifically for children are also well attended and continue to serve community members.

Sanford Fargo provides numerous services, classes and events to address obesity. During FY 2014 Sanford dietitians and exercise specialists provided leadership for the Schools Alive events at more than a dozen schools. The Sanford Health Fargo Region licensed registered dietitians and exercise physiologists provided expert clinical guidance for the new Family *Fit* Night programs in area schools. These programs, scheduled on a monthly basis, provided educational sessions on health, nutrition and physical fitness, as well as providing a time for creative physical activity with children and family members. The local elementary schools were selected in partnership with Sanford, TNT Kids Fitness, and the Boys and Girls Club. Over 2,200 parents and children attended these events in 2014.

The adult weight management program "Honor Your Health" is a comprehensive wellness program developed by Sanford Health Fargo Region which focuses on evidenced-based nutrition standards, physical activity and behavioral health. This class is offered for adults and provides a basis for young parents as well as all adults to learn about health and wellness. This program is a comprehensive approach to healthy lifestyle practices and may facilitate healthy behaviors for families.

The Sanford Health initiative, a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

In 2016 a new *fit* initiative will be available for 20,000 classroom teachers. The classroom curriculum has numerous modules that teachers can access and implement in part or comprehensively.

Sanford's Weight Loss Surgery Program is designated as a national Bariatric Center of Excellence and designation of Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program Accredited Centers. Sanford's Weight Loss Surgery Program emphasizes clinical research. Through Sanford's relationship with the Neuropsychiatric Research Institute, our program is one of only six clinical centers in the United States selected by the National Institutes of Health to participate in a bariatric research study known as LABS – short for Longitudinal Assessment of Bariatric Surgery. This study brings together experts in weight loss surgery, obesity research, internal medicine and other related fields to analyze the risks and benefits of weight loss surgery and its impact on patients' health and quality of life and to identify which patients would most likely benefit from weight loss surgery.

Sanford's Eating Disorders specializes in diagnosing and treating eating disorders in adolescents and adults. Clinical services to treat anorexia nervosa, bulimia nervosa, binge eating disorder and related forms of disordered eating are available at Sanford. Treatment options include outpatient, partial hospital or full inpatient services. The goal is to help patients regain control of their lives and overcome the potentially life-threatening consequences of living with an eating disorder. Programs are open to adolescents and adults and family involvement is encouraged each step of the way.

Profile by Sanford is a personalized retail weight loss program designed by Sanford Health physicians and scientists to be *simple, effective and sustainable*. With a certified Profile coach, personalized meal plans and smart technology to track progress, members see real results. Each weight loss plan is designed with a focus on *nutrition, activity and lifestyle*.

Sanford is taking a comprehensive and multi-faceted approach to obesity prevention and treatment. The impact is demonstrated through the lives of our community members who have had positive outcomes because of our programs and services.

Impact of the Strategy to Address Mental Health Services

Behavioral health services have been integrated into primary care settings across the clinics in the Fargo Region. The measures that were executed to measure outcomes include:
- Depression (teens)
- Anxiety (teens)
- Substance abuse (teens)
- Behavioral health disorder (teens)
- Depression (adults)
- Anxiety (adults)
- Drug abuse/dependence (adults)
- Behavioral health disorder (adults)
- Patients Encountering Behavioral Health Providers (all)
- Patients Encountering Behavioral Health Providers (chronic)
- Patients Accessing Patient Portal (all)
- Patients Accessing Patient Portal (chronic)

With the exception of teen substance abuse, all indicators show statistically significant improvement.

Additional impact is noted in the six-month depression remission, avoidable ED utilization, and avoidable hospitalizations.

Community Feedback

from the 2013

Community Health Needs

Assessment

Sanford Health is prepared to accept feedback on our 2013 Community Health Needs Assessment and has provided on-line comment fields for ease of access on our website. There have been no comments to date aside from a question asked about the service area for this report. A reader wanted to know if a separate report was developed for the Lisbon, North Dakota area. Since there is no hospital in Lisbon, a community health needs assessment was not conducted solely for that community.

APPENDIX

Primary Research

Fargo/Moorhead/Cass/Clay Asset Mapping

Identified concern	Community resources that are available to address the need	Gap?
Economics	**Affordable Housing resources:**	X
	• **Cass Co. Social Services (help w/utility costs) 701-241-5765**	
	• **Down payment & Closing Costs Assistance Program 1-800-292-8621**	
	• **Wells Fargo Assist (to help those with payment challenges)**	
	• **Home Key Program 701-238-8080**	
	• **Housing Rehab Program 701-241-1474**	
	• **Lake Agassiz Habitat for Humanity 218-284-5253**	
	• **Presentation Partners in Housing 701-235-6861**	
	• **ReStore (thrift store for construction, homes, etc.) 218-284-5253**	
	• **Salvation Army (provides assistance with hsg.)& utilities 701-232-5565**	
	• **SENDCAA weatherization program & low income hsg. 701-232-2452**	
	• **Xcel Energy Share Program**	
	• **1-866-837-9762**	
	• **YWCA Supportive & Transitional Hsg 701-232-3449**	
	Subsidized public housing:	
	• **Cass Co. Housing Authority 701-282-3443**	
	• **Fargo Housing & Redevelop. Authority 701-293-6262**	
	• **ND Housing & Finance Agency 701-239-7255**	
	• **Century Square 701-287-4775**	
	• **Community Homes 701-293-6014**	
	• **Lashkowitz High Rise 701-293-6262**	
	• **New Horizons Manor 701-293-7870**	
	• **Pioneer Manor 701-293-7870**	
	• **River Square apts. 701-364-2620**	
	• **The 400 701-232-9412**	
	• **Trollwood Village 701-293-6843**	
	• **University Drive Manor 701-232-4423**	
	• **VA Housing for Homeless Vets 701-239-3700 ext. 9-3472**	
	• **Windwood Townhomes 701-232-1887**	
	• **Moorhead Public Housing 218-299-5458**	
	• **Lakes & Prairies Community Action Partnership 218-299-7314**	
	• **Arbor Park Village 218-359-9999**	
	• **Fieldcrest Townhomes 701-232-1887 (Metro Mgmt.**	
	• **Parkview Terrace Apts. 218-233-8548**	
	• **Riverview Heights 218-299-5458**	
	Homeless resources (Shelters/	
	Food Pantries):	
	• **Fraser, Ltd. Transitional Living/Emergency Shelter 701-356-8585**	
	• **Gladys Ray 701-364-0116**	
	• **New Life Center 701-235-4453**	
	• **Youthworks (youth transitional housing) 701-232-8558**	
	• **YWCA Women's Shelter 701-233-3449**	
	• **Churches United (shelter, food baskets, meals) - 218-236-0372**	
	• **Clay Co. Social Service Center 218-299-7057**	
	• **Lakes & Prairies CAP (transitional hsg. program) 218-299-7014**	
	• **Motivation, Education & Training (emergency shelter) 218-299-7262**	
	• **Dorothy Day House (shelter, meals, food pantry) 218-285-8895**	
	• **New Life Center (shelter & meals) - 701-235-4453**	
	• **Salvation Army (shelter & meals) - 701-232-5565**	
	• **Faith Home & Love church 218-236-7692**	
	• **Centro Cultural 218-236-7318**	

Identified concern	Community resources that are available to address the need	Gap?
Aging population	**Nursing Homes – Cass County:** • **Bethany 701-239-3000 / 701-478-8900 (2 locations)** • **Ecumen Evergreens – 701-239-4524** • **Edgewood Vista – 701-365-4742** • **Elim 701-271-1800** • **Eventide @ Sheyenne Crossings – 701-478-6000** • **Good Samaritan (Arthur) – 701-967-8316** • **ManorCare 701-237-3030** • **Maple View Memory Care – 701-478-8655** • **Prairie Villa (Arthur) – 701-967-8316** • **Rosewood 701-277-7999** • **Villa Maria 701-293-7750** **Nursing Homes – Clay Co:** • **Eventide 218-233-7608** • **Golden Living Center 218-233-7578** **Alzheimer's/Dementia resources:** • **After the Diagnosis Support Group – 701-277-9757 (Sanford)** • **Alzheimer's Support Group (Hjemkomst Center) – 701-277-9757** • **Early Onset Memory Loss Support Group – 701-277-9757** • **Morning Out (for those who have Alzheimer's or other dementia) – 218-233-7521** • **Alzheimer's Assn – 701-277-9757** • **Arbor Park Village – 218-359-9999** • **Eventide/Fairmont – 218-233-8022** • **River Pointe – 218-287-6900** • **Evergreens, Mhd. – 218-287-6900** • **Bethany – 701-239-3000** • **Edgewood Vista – 701-365-8200** • **Elim – 701-271-1800** • **Evergreens, Fargo – 701-239-4524** **Caregiver resources:** • **Community of Care (Casselton) – 701-347-0032** • **Caregiver Support & Respite program – 1-800-488-4146** • **Caregivers Support Group – 701-261-3142** • **Caregiver Discussion Group – 218-233-7521** • **Mhd Caregiver Discussion Group – 218-233-7521** • **Rural Cass Caregivers – 877-815-8502** • **Support Group for Alzheimer's Caregivers (young onset) – 701-277-9757** • **Alzheimer's Support Group for those with family member in Eventide – 218-233-7508** • **Family Caregiver Support program – 701-298-4480** • **Hospice support for widows & widowers – 701-356-1500** **Elder Abuse resources:** • **Adult Protective Services – Fargo - 701-241-5747** • **Adult Protective Services - Moorhead – 218-299-5200** • **Rape & Abuse Center (Abuse in Later Life Advocate) – 701-293-7273** • **Clay Co. Elder Abuse Project – 218-299-7542** • **Protection & Advocacy Project – 701-239-7222** • **Guardian & Protective Services – 701-297-8988** **Resources to assist the elderly in staying in their homes:** • **Community of Care (Casselton) – 701-347-0032** • **Sanford Healthcare Accessories – 701-293-8211**	**X**

- **Sanford Home Care – 701-234-4900**
- **Sanford Personal Care – 701-232-2452**
- **Access – 218-233-3991**
- **Care 2000 – 218-233-1000**
- **Change is Good – 218-329-7442**
- **Homewatch – 218-233-1667**
- **LSS Caregiver Respite Services – 218-233-7521**
- **Midwest Community Residential Services – 218-287-5422**
- **Accent Multi Services – 701-293-6000**
- **Active at Home Helpers – 701-200-4328**
- **At Home Caregiver Services – 701-293-7294**
- **Comfort Keepers – 701-237-0004**
- **Community Living Services – 701-232-3133**
- **C & R Quality Living – 701-235-5744**
- **Ebenezer Human Care – 701-412-5525**
- **Heart 2 Heart – 701-200-7828**
- **Sisters of Mary Home Care – 701-235-5750**
- **Home Instead Home Care – 701-478-1010**
- **Prairieland Home Care – 701-293-8172**
- **Tami's Angels – 701-237-3415**
- **Lincare – 701-235-0175**
- **HERO – 701-212-1921**
- **Coram Healthcare – 218-233-2210**
- **Griswold Home Health – 218-639-4419**
- **LSS Senior Companion Program – 701-271-3247**
- **LSS Senior Nutrition Program – 218-233-7521**
- **Meals on Wheels – 701-293-1440 (Fargo)**
- **Meals on Wheels – 218-287-0434 (Mhd.)**
- **Outreach Assistance – 701-293-1440**

Elderly Nutrition Services:
- **Cash Wise (grocery delivery)**
- **Hornbachers (grocery delivery)**
- **SunMart (grocery delivery)**
- **LSS Senior Nutrition Program 218-233-7521**
- **Meals on Wheels (Fargo, W Fargo & Moorhead)**
- **Congregate Meals (Fargo, W Fargo & Moorhead)**

Elder Care (adult day care):
- **Bethany Day Services 701-239-3544**
- **Cass Co. Social Services 701-241-5747**
- **Home Instead Senior Care 701-478-1040**
- **Johnson Elder Care Home 701-277-7195**
- **Kinder-er Care Home 701-281-3016**
- **Rainbow Square (adult daycare at Rosewood) 701-277-7999**
- **Villa Maria Club Connection 701-293-7750**
- **Adult Life Program 701-299-5600**
- **Arbor Park 218-359-9999**
- **Evergreens 218-233-1535**
- **Fairmont Adult Day Care 218-233-8022**
- **Four Seasons 218-359-9999**
- **Home Appeal 218-227-5274**
- **River Pointe 218-287-6900**

Identified concern	Community resources that are available to address the need	Gap?
Children and Youth	Resources for at risk children & youth: • Center for Parenting & Children 218-233-6258 (Moorhead); 701-235-6433 (Fargo) • Stepping Stones Resource Center 701-356-8585 • Clay Co. Social Services 218-299-5200 • Cass Co. Social Services 701-241-5761 • Catholic Family Services 701-235-4457 • Early Intervention Program • 218-284-3800 • Follow Along Program 218-299-5200 • Head Start 218-299-7002 • Lutheran Social Services of MN 218-236-1494 • Lutheran Social Services of ND 701-235-7341 • Village Family Service Center 218-451-4900 • Caring Program for Children 701-277-2227 • Cass Co. Parenting, Children & Family Resources 701-241-5765 / 241-5775 • CHARISM 701-241-8570 • Christian Family Life Services 701-237-4473 • Family HealthCare Center 701-241-1360 • Fargo Youth Commission 701-235-2147 • Head Start 701-235-8931 • Infant Development (SEHSC) 701-298-4471 • Nokomis 701-232-5635 • North Dakota Kids Count 701-231-5931 • Right Tracks 701-793-3722 • SENDCA 701-232-2452 • Youthworks 701-232-8558 • FirstLink – 701-293-6462 Infant Child Care resources: • Child Care Resource & Referral 218-299-7026 • Child Care Assistance Program 701-328-2332 • Child Care Aware 1-800-997-8515 • Baby Bloomers 701-356-1299 • Lots-4-Tots 701-235-5789 • Tot Spot 701-232-6999 • Hope Lutheran 701-235-6629 • Children of Hope 701-936-9616 • Cobber Kids' Corner 218-299-4204 • Centered on Kids 218-284-2774 • YMCA 701-293-9622 • Our Redeemer 218-233-8270 • ABC Sandcastle 701-293-0149 Poverty resources: • Caring Closet (free clothes) 701-235-6848 • Family HealthCare Center 701-241-1360 • Clay Co. Social Services 218-299-5200 • Cass Co. Social Services 701-241-5761 • Lutheran Social Services of ND 701-235-7341 • Lutheran Social Services of MN 218-236-1494 • Village Family Service Center 218-451-4900 • Lakes & Prairies Community Action Partnership 218-299-7314 • Child Care Assistance Program 701-328-2332 • Homeless Shelters • Food Pantries	X

Identified concern	Community resources that are available to address the need	Gap?
Crime/ Safety	**Cass County Sheriff** **701-241-5800** **Clay County Sheriff** **218-299-5151** **Fargo Police 701-235-4493** **Moorhead Police 218-299-5120** **ND Crime Victim & Witness Assistance Program – 701-241-5850** **Child Abuse & Neglect resources:** • **Sanford Child & Adolescent Maltreatment Center – 701-234-4580** • **Red Flag Green Flag program – 701-293-7298** • **Protection & Advocacy Project – 701-239-7222** • ***Guardian & Protective Services – 701-297-8988** **Domestic Violence resources:** • **Rape & Abuse Crisis Center** • **701-293-7273** • **YWCA Shelter 701-232-3449** • **ND Victim Assistance Assn.** • **701-241-5850** • **Migrant Health Hispanic Battered Women & Children Program 218-236-6502** • **Community Health Services, Inc. Domestic Violence Community Advocacy Program 218-236-6502** • **Clay Co. Crime Victim Advocacy Program. 218-299-7513** • **Churches United 218-236-0372** • **Mujeres Unidas del Red River Valley 218-236-9884** **Alcohol abuse resources:** • **AA Red Road to Sobriety 701-298-8233** • **Alcoholics Anonymous (more than 50 groups in the area) 701-235-7335 / 701-232-9930** • **Celebrate Recovery 701-232-0003** • **Codependents Anonymous 701-235-73335** • **SMART Recovery 701-235-5229** • **ADAPT, Inc. 701-232-1225** • **Centre Inc. 701-237-9340** • **Chris Shiaro Counseling 701-271-0600** • **Cass Co. Public Health (detox) 701-364-0116** • **Claudia McGrath Counseling 701-277-0654** • **Dakota Foundation (detox) 701-223-4517** • **Discovery Counseling 701-237-4542** • **Drake Counseling 701-293-0736** • **VA Substance Abuse Treatment Program. 701-239-3700** • **First Step Recovery 701-293-3384** • **Lynn W. Olund DUI Seminar Program 701-298-3874** • **Pathways Counseling & Recovery Center 701-232-5955** • **PSJ Dui Seminar 701-476-7200** • **ShareHouse 701-282-6561** • **Sister's Path 701-478-8440** • **Prairie St. Johns 701-476-7200** • **Simon Chemical Dependency Services 701-298-8108** • **SE Human Service Center 701-298-4500**	X
Cost/	**Affordable health care resources:**	X

Identified concern	Community resources that are available to address the need	Gap?
Access to Healthcare	• **Community Care/Charity Care programs at Sanford & Essentia** • **Family HealthCare Center – 701-271-3344** • **Fargo Cass Public Health - 701-241-1360** • **Clay Co. Public Health – 218-299-5220** • **Prescription Assistance Program – 701-364-0398** • **Salvation Army prescription assistance program - 701-232-5565** **Reduced cost dental resources:** • **RRV Dental Access – 701-364-5364** • **Family HealthCare Center – 701-271-3344** • **Apple Tree Dental – Hawley -(218) 483-1038**	
Physical Health	**Obesity resources** • **Sanford Dietitians** • **Sanford Eating Disorders & Wt. Management Center – 701-234-4111** • **Eating Disorders Support Group – 701-234-4111** • **Gastric Bypass Support Group – 701-235-8502** • **Valley Fitness – 701-277-9010** • **Planet Fitness (Fargo) – 701-478-3300** • **Planet Fitness (Mhd) – 218-477-1955** • **Courts Plus – 701-237-4805** • **Core Fitness – 701-356-2044** • **Anytime Fitness (Fargo) – 701-566-8507** • **Anytime Fitness (Mhd) – 218-227-0010** • **2020** • **Sanford Family Wellness Center – 701-234-2400** • **Touchmark Fitness – 701-526-1055** • **TNT Kids' fitness – 701-365-8868** • **YMCA – 701-232-2547** • **Max Training – 701-359-0220** • **Metro Rec Center – 701-235-9211** **Farmers Markets:** • **Great Plains Community Farmers Market – 701-793-5532** • **New Festival – 7801-588-4316** • **Hildebrant's – 701-281-1539** • **Farmer's Market & Beyond – 701-433-5360** • **Mhd Center Mall Market – 218-299-5296** • **Farmers Market & Beyond – 701-433-5360** • **FM Farmers Market – 701-281-1539** • **Ladybug Acres produce stand – 701-799-3787** • **Red River Farmer's Market – 701-491-8892** • **Sydney's Health Market – 218-233-3310** • **Veggie Bus – 701-799-3787** • **Whistle Stop Farmers Market – 701-367-0490** • **Old Trail Market/Legacy Garden – 701-361-2111 or 701-361-3028** **Chronic Disease resources:** • **Sanford Dietitians** • **Sanford Better Choices, Better Health** • **Adult Connect Support Group (for epilepsy/seizure disorders) – 701-429-1165** • **Epilepsy Support Group – 701-232-8521** • **Parkinson's Support Group – 701-365-8200** • **Young Onset Parkinson's Support Group – 701-261-3142** • **FM Pelvic Pain Support Group – 218-790-0432** • **Post-Polio Support Group – 701-232-8417**	X

Identified concern	Community resources that are available to address the need	Gap?
	• Hepatitis Support Group – 701-234-2353	
	• Life Threatening Illness Support Group – 218-233-3875	
	• HIV/AIDS Support Group – 218-287-4636	
	• Huntington's Disease Support Group – 701-492-3123	
	• Fibromyalgia Support Group – 701-235-9359 (First Luth.)	
	• Fibromyalgia Support Group – 701-799-4200 (Sanford)	
	• American Chronic Pain Assn. support group – 701-280-2472	
	• Chronic Pain Support Group- 701-234-6600 (Sanford)	
	• Chronic Pain Support Group – 701-261-3142 (HeartSprings Community Healing Center)	
	• Crohn's & Colitis Support Group – 701-388-4025 (Sanford)	
	• Diabetes Support Group – 701-364-8900 (Essentia)	
	• Diabetes Support Group – 701-234-2245 (Sanford)	
	• American Diabetes Association – 701-235-3080	
	• NDSU Extension "dining with diabetes" class – 701-231-8944	
	• Celiac Support Group – 701-232-3896	
	• Red River Celiacs – 701-235-6603	
	• Multiple Sclerosis Support Group – 701-293-5605	
	• Sleep Disorders Support Group – 218-233-7918 (Grace Methodist in Mhd.)	
	• Sleep Disorders Support Group – 701-297-7540 (Benson Psych. Services, Fgo.)	
	• Stroke Support Group (Essentia) – 701-364-7752	
	• Stroke Support Group (Sanford) – 701-234-5770	
	• FirstLink – 701-293-6462	
	Cancer resources:	
	• Sanford Roger Maris Cancer Center – 701-234-6161	
	• Essentia Cancer Center – 701-364-8910	
	• Atonement Cancer Care Support Group – 701-237-9651	
	• Cancer Support Group – 218-236-1333	
	• Us Too Support Group (for prostate cancer survivors) – 218-233-1176	
	• Embrace Cancer Survivorship Program – 701-234-7463	
	• American Cancer Society – 701-232-1385	
Mental Health/ Behavioral Health	**Mental Health resources:**	X
	• Alzheimer's Association – 701-277-9757	
	• ARC of West Central MN – 218-233-5949	
	• Catholic Family Services – 701-235-4457	
	• CCRI – 218-236-6730	
	• Clay Co. Public Health – 218-299-5220	
	• Clay Co. Social Services – 218-299-5200	
	• Community Outreach Ctr at MSUM – 218-477-2513	
	• Crisis Responders – 800-223-4512	
	• Drake Counseling Services – 701-293-5429	
	• EAP in the workplace	
	• Essentia (Fargo & Mhd locations)	
	• Fargo Cass Public Health – 701-241-1360	
	• FirstLink – 701-293-6462	
	• Human Service Associates – 218-291-1658	
	• Lakeland Mental Health – 218-233-7524	
	• Lutheran Social Services of MN – 218-236-1494	
	• Lutheran Social Services of ND – 701-235-7341	
	• Mental Health Association (Mental Health America) – 701-237-5871	
	• Mobile Mental Health Crisis Team – 800-223-4512	
	• Prairie St. John's (Mhd Clinic) – 218-284-0300	
	• Prairie St. John's (Fargo clinic) – 701-476-7216	
	• Rape & Abuse Crisis Center – 701-293-7273	
	• Safe Harbour – 218-287-2593	

Identified concern	Community resources that are available to address the need	Gap?
	• **Sanford Health Behavioral Health – 701-234-6000**	
	• **SE Mental Health – 701-298-4500**	
	• **SENDCA – 701-232-2452**	
	• **Social Connection – 218-284-6069**	
	• **Solutions – 218-287-4338**	
	• **Tran$ Em (Transitional Supported Employment of MN) – 218-233-7438**	
	• **VA – 701-239-3700 ext. 9-3150**	
	• **Village Family Service Center – 701-451-4900**	
	• **Vosburg Counseling for Seniors – 701-235-2092**	
	Substance Abuse/Addictions resources:	
	• **AA Club House – 701-232-9930**	
	• **Anchorage, The – 218-287-1500**	
	• **Centre Detox – 701-237-3341**	
	• **Clay Co. Chemical Dependency Services – 218-299-5200**	
	• **Clay County Detox – 218-299-5171**	
	• **Clay Co. Public Health 218-299-5220**	
	• **Clay Co. Social Services – 218-299-5200**	
	• **First Step Recovery – 701-293-3384**	
	• **Gamblers Choice – 701-235-7341**	
	• **Gambling Problem Hotline – 800-472-2911**	
	• **Lost & Found Ministry/ Recovery Worship – 218-287-2089**	
	• **Prairie St. John's (Mhd Clinic) – 218-284-0300**	
	• **Prairie St. John's (Fargo clinic) – 701-476-7216**	
	• **Safe Harbour – 218-287-2593**	
	• **Sharehouse Wellness Center – 218-233-6398**	
	• **Prairie St. John's – 701-476-7216**	
	• **SE Human Service Center – 701-298-4500**	
	• **Sexaholics Anonymous – 701-235-5303**	
	• **Sharehouse OP & Residential Addiction Services – 701-282-6561**	
	• **Simon Chemical Dependency Services – 701-298-8108**	
	• **Sister's Path – 701-478-6562**	
	• **VA – 701-239-3700**	
	• **Village, The – 701-451-4900**	
	Smoking Cessation resources:	
	• **BAN Program (Break Away from Nicotine) – 701-476-4083 (City of Fargo program)**	
	• **ND Quits (ND Dept. of Health) – 701-214-4170**	
	• **Sanford Health – 701-234-5191 (tobacco cessation counselor)**	
	• **Sanford Health – 701-234-6452 (tobacco & asthma education)**	
	• **Fargo Cass Public Health (health educator) – 701-241-1367**	
	• **Essentia Health (tobacco treatment specialist) – 701-364-4524**	
Preventive health	Sanford Clinics – 701-234-2000	X
	Essentia Clinics – 701-364-8000	
	Family HealthCare Center – 701-271-3344	
	Fargo Cass Public Health – 701-241-1383	
	Clay Co. Public Health – 218-299-7777	

Fargo/Moorhead 2016 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
Economics • Availability of affordable housing 3.88 (7) • Hunger 3.63			
Aging • Cost of long term care 4.16 (1) • Availability of memory care 3.71 • Availability of LTC 3.51			
Children and Youth • Bullying 3.82 (10) • Cost of quality child care 3.86 (8) • Cost of quality infant care 3.99 (7) • Availability of quality child care 3.84 (9) • Availability of quality infant care 3.84 (9) • Cost of services for at risk youth 3.55			
Safety • Presence of street drugs and alcohol in the community 3.84 (9) • Presence of drug dealers in the community 3.9 (6) • Crime 3.74 • Child abuse and neglect 3.72 • Domestic violence 3.78 • Presence of ganga activity in the community 3.64 • Sex trafficking 3.50			
Health care • Access to affordable health insurance 4.04 (2) • Access to affordable health care 3.92 (5) • Access to affordable prescription drugs 3.9 (6) • Timely access to substance abuse providers 3.82 • Cost of affordable dental insurance coverage 3.8 • Use of emergency room for primary care 3.72 • Cost of affordable vision insurance 3.6			

Physical Health
 • Cancer 3.97 (3)
 • Chronic disease 3.81
     ○ High Cholesterol
     ○ Hypertension
     ○ Arthritis
 • Inactivity and lack of exercise 3.82 (10)
     ○ 48% report moderate activity 3x/week
 • Obesity 3.75
     ○ 61.3% of respondents report they are overweight or obese
 • Poor nutrition and eating habits 3.76
     ○ Only 24.1% report having 3 or more vegetables/day
     ○ Only 20.1% report having 3 or more fruits/day
     ○ High Cholesterol
     ○ Hypertension
 • Infectious disease such as flu
	#2 priority		

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Mental Health • Depression 3.94 (4) • Dementia and Alzheimer's 3.76 • Stress 3.65 • Suicide 3.65 • Underage drug use and abuse 3.66 • Underage drinking 3.68 • Drug use and abuse 3.84 (9) • Alcohol use and abuse 3.9 (6) o 33.2% of respondents report binge drinking • Smoking and tobacco use 3.53	#1 priority		
Preventive Health • Flu shots 37.9% of respondents report not having a flu shot last year	#3 priority		

Present: Please see the list of community stakeholders on pages 19-20

Community Health Needs Assessment

Facilitated Discussion Summary
July 15, 2015

What surprised you about what you've heard this morning?
- Knowing what CDC data is – showing differences between community vs. national states
- Difference between community and shareholder concerns vs. reality (2 responses)
- Stats re: feeling healthy but not getting follow-up; not thinking long term; fear of dentist
- The number of people who think they are healthy but have health risks
- Concern regarding healthcare/long term care costs (2 responses)
  - Affordability still seems to be a big issue – new generation will not have enough
  - Respondents appear to be uninformed/confused about insurance
  - Cost and affordability even in sectors that may be considered
  - Disconnect in affordability
- Blood pressure status – doctor hasn't suggested
- Where are community healthcare / Family HealthCare Center?
- 3% say they binge drink on a daily basis (2 responses)
- Low reporting on prescription drug misuse and abuse (is an issue in rural areas) (2 responses)
  - Is low reporting rate due to self-reporting?
- 92% reported not using tobacco – lower than expected
- The smoking prevalence
- Lack of transportation – survey didn't identify this as a priority, esp. in rural areas (2 responses)
- Mental health for minors not emphasized
- Surprised that mental health did not come up as much this time, but depression was mentioned – did respondents not realize that depression is a mental illness?
- Homelessness/lack of affordable housing
- Child care
- Responses on elder care
- Reimbursement for parish nurse programs
- Rapid growth of the communities (mostly the priority population) and how CHNA data could affect funding in the areas needing the most work but isn't representative of the data
- Everyone was impressed with all of the initiatives and the work being done through them; didn't know they were happening – how does the general public find out about all of this (2 responses)

Based on the results, what do you feel is the biggest need for dedicated work in our community?
- Affordability seems to be a concern
  - Affordable care (esp. long term care) - based on results, although high percentage is insured
  - Long term care cost
  - Underinsured; uninsured
- Need more information: oral care, mental health (critical due to less stigma with self-reporting)
- Cancer screening rates issues statewide (wasn't teased out of survey)

105

- New American services / cultural awareness and sensitivity
- Community-based services need to be emphasized

- Aging issues in general
  - Elderly nutrition – case management & prevention; tie to concern about growing costs of nursing home care
  - Elder care/long term care
  - Aging life case management services at LSSND should be publicized more among partners
  - What are we doing to keep seniors in their homes to avoid the increasing cost of long term care?
  - No clear communication plan for aging issues and unsure how to support
  - Long term care cost
  - The public can't respond to questions when they don't know about the problem; example: elder abuse - it's happening but people don't know about it.
- Education is extremely important – example: 51% didn't get a flu shot for "another reason" – why?
- More prevention
- Too much duplication/inefficiency in ND
- Not leveraging small size of ND – when we put our minds to it, we can really get things done
- Blue ribbon commission and state level coordination
- Legislators need to listen!
- Healthy initiatives - we are not making an impact on obesity and healthy habits – we need to kick start! Pull all organizations together to think about new ways of doing things
- Still need mental health support and it interacts with other healthcare issues
- Binge drinking issue – how do we change the norm?
- Mental health (3 responses)
- Chronic disease
- Affordable housing
- Active living
- Obesity
- Cancer
- Worksite health
- Community walkability
- Physical health issues
- Does homelessness show anywhere?

How can your organization address this need internally?
- If we work on prevention, this will impact long term care/healthcare
- Work with key members on efforts with the City of Fargo
- Use data and research available
- Create policies in the workplace

- Offer a confidential Employee Assistance Program
- Determine what is available collectively – what is working on other organizations?

What ideas do you have in ways your role/organization could partner with other community resources to impact this need?

- SEHS mobile crisis unit home support, safety net including linking to services
- Better access to care plans for mental health; shared EHR
- Integrating behavioral health into all departments
- Being involved in collaboration
  - Volunteering time, working with your organization to offer time off for volunteering (i.e. City allows 1 hr./wk. to volunteer)
  - Collaboration between mainstream health organizations and community organizations in communicating the true needs of the population
  - Learn about other organizations - what is available, costs
  - Better integration needed between services still siloed – don't feel we are moving together and increasing integration
- Reduce or reallocate resources (especially unnecessary ones; ex: ambulance calls for non-emergency needs). I asked about the necessity of community paramedics and everyone agreed that services rendered by CHW or CP will definitely reduce cost and also provide the needed services to priority population that has not been met in the past.
- Advertise or educate more about the assessment overall
  - Create comprehensive ways of delivering health info to the community.
  - Collaborate between three major universities and use college students for the work. College students are more willing, they have the time, and they need to be exposed to the realities of life in order to advocate for change through systems or policies.
- Change methodology of survey
  - Go door to door to reach more priority populations
  - Tap into community data through other organizations (may get more info on prioritized populations)
  - Reduce # of pages of survey (it's burdensome even for the educated population)
  - Incorporate information from school health survey or find other ways of reaching younger populations
- Utilize high risk care managers

How do you plan to communicate the information from today to your organization?

- Engage with nursing/dental students to help them understand need for all hands on board publicly to address needs
- Provide minority Native American viewpoint through NDSU study
- Inform staff about the survey results
- Focus on the elderly refugee mental health initiative - small numbers, manageable and very successful
- Discuss these issues/ideas with our organization
- Most want the needs of the people they serve to be reflective of the overall data, so finding ways to get involved so that their voices are heard will be a priority
- Conduct all-staff meetings; communicate with other members of our organization

- Look at it as for a higher income concern
- Share true information with the different businesses that they contact with

OTHER

Comments about the survey tool/how the survey was done/how to make it better
- The survey is a good starting point; improve the survey with a deeper dive
- How do we get a better representation over the next three years (use incentives to get better response rate, i.e. $10 to take the survey – funding: Essentia, Sanford, DMF?)
- Inconclusive results to the general population.
- How favorable the data is to these communities when the reality of these communities is far from what is presented
- Pattern of respondents from stakeholders and residents (explains the similarities in priorities)
- Was there a question that asked about social connectedness?
- Comments about who took the survey
    - o Higher income self-reporting tool may not reflect reality
    - o 99% of respondents are insured which means lots of people were missed
    - o Limitations of the study (ethnicity, income, education, age). A lot of our discussion was focused on limitations because organizations at my table represented populations that weren't included.
    - o Lack of focus on students, Native Americans, other races, all ages
    - o There was discussion related to who answered the survey – higher income, higher educated, older
    - o Low percentage of rental income individuals represented (93% own their own homes)
    - o Concerns about the younger population being excluded

Miscellaneous comments (didn't fit into the categories)
- Could do some really good research
- Talked about community paramedic opportunities
- Community awareness is very important
- Great to have local data to work with

Generalizable Survey Results

General Health and Wellness Concerns about the Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various statements regarding ECONOMICS, TRANSPORTATION, the ENVIRONMENT, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTH CARE, PHYSICAL AND MENTAL HEALTH, and SUBSTANCE USE AND ABUSE.

Figure 1. Level of concern with statements about the community regarding ECONOMICS

Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

Statement	Mean
Bullying (N=371)	3.82
Cost of quality child care (N=370)	3.53
Cost of quality infant care (N=365)	3.50
Youth crime (N=368)	3.49
Cost of activities for children and youth (N=367)	3.44
Availability of quality infant care (birth to 2 years) (N=370)	3.4
Availability of quality child care (N=369)	3.40
Availability of activities for children and youth (N=367)	3.39
Cost of services for at-risk youth (N=369)	3.18
Teen pregnancy (N=370)	3.14
Availability of services for at-risk youth (N=371)	3.13
School dropout rates (N=370)	3.12
School absenteeism (N=369)	2.94

Mean
(1=Not at All; 5=A Great Deal)

Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

Statement	Mean
Cost of long term care (N=378)	4.11
Availability of memory care (N=377)	3.63
Availability of long term care (N=377)	3.51
Availability of resources for family/friends caring for and…	3.44
Availability of resources to help the elderly stay safe in their…	3.40
Availability of activities for seniors (N=375)	3.23
Availability of resources for grandparents caring for…	3.18
Cost of activities for seniors (N=374)	3.15

Mean
(1=Not at All; 5=A Great Deal)

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

Mean
(1=Not at All; 5=A Great Deal)

Figure 7. Level of concern with statements about the community regarding HEALTH CARE

Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

Statement	Mean
Cancer (N=372)	3.97
Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (N=377)	3.81
Depression (N=378)	3.78
Inactivity and lack of exercise (N=376)	3.78
Dementia and Alzheimer's disease (N=374)	3.76
Stress (N=377)	3.65
Obesity (N=375)	3.64
Poor nutrition and eating habits (N=377)	3.62
Infectious diseases such as the flu (N=374)	3.50
Suicide (N=376)	3.38
Other psychiatric diagnosis (N=373)	3.11
Sexually transmitted diseases (e.g., AIDS, HIV, chlamydia) (N=370)	2.92

Mean
(1=Not at All; 5=A Great Deal)

Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

Underage drug use and abuse (N=376)   3.66
Underage drinking (N=376)   3.54
Drug use and abuse (N=377)   3.53
Alcohol use and abuse (N=377)   3.52
Smoking and tobacco use (N=377)   3.44
Exposure to second-hand smoke (N=377)   3.37

Mean
(1=Not at All; 5=A Great Deal)

General Health

Figure 10. Respondents' rating of their health in general

Excellent   11.2
Very Good   41.3
Good   37.0
Fair   9.1
Poor   1.4
Don't know   0.1

Percent*

N=367

Figure 11. Respondents' weight status based on the Body Mass Index (BMI) scale

Figure 12. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday

Vegetables (N=381)   Fruit (N=378)   Fruit juice (N=382)
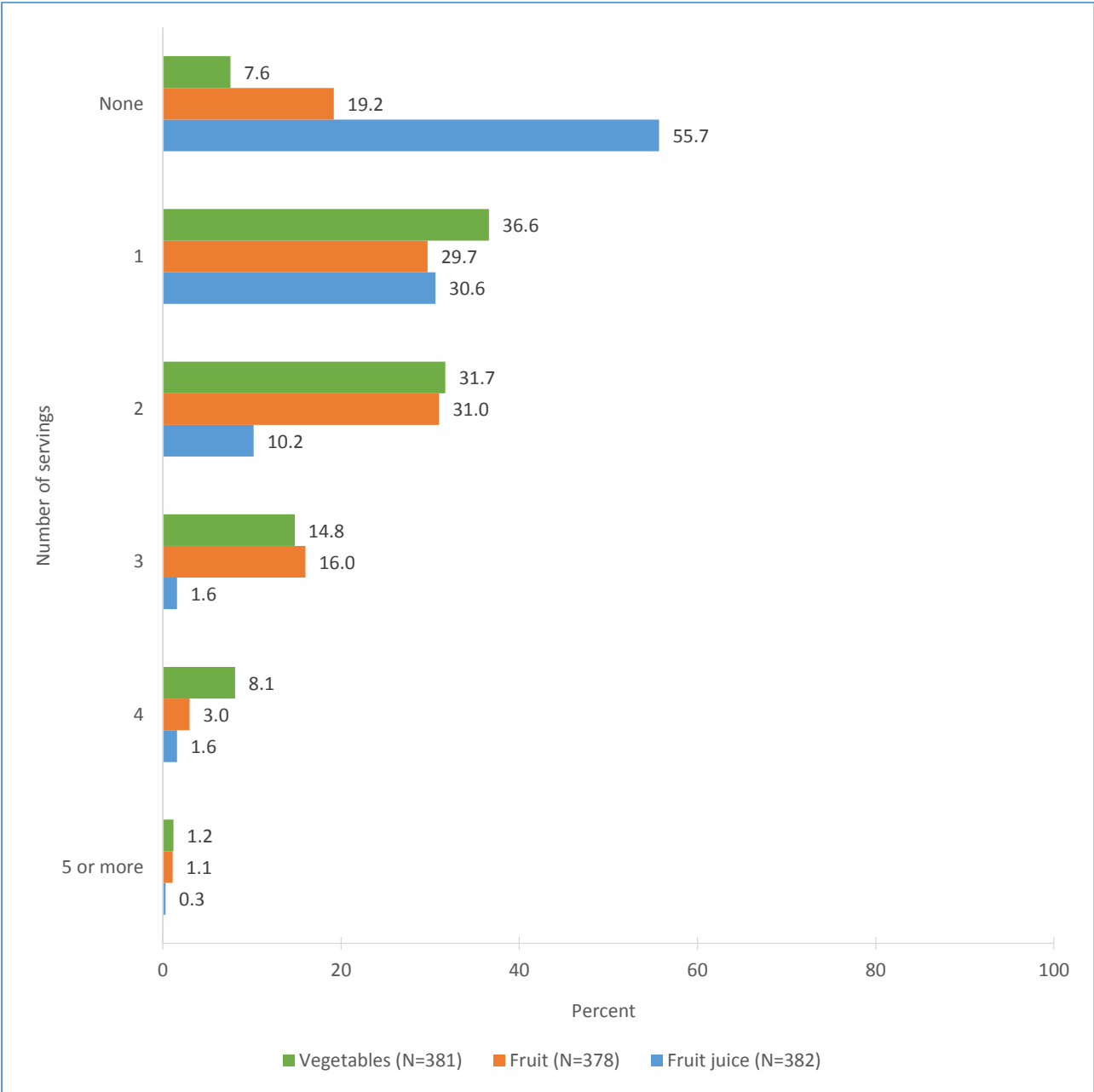
Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity
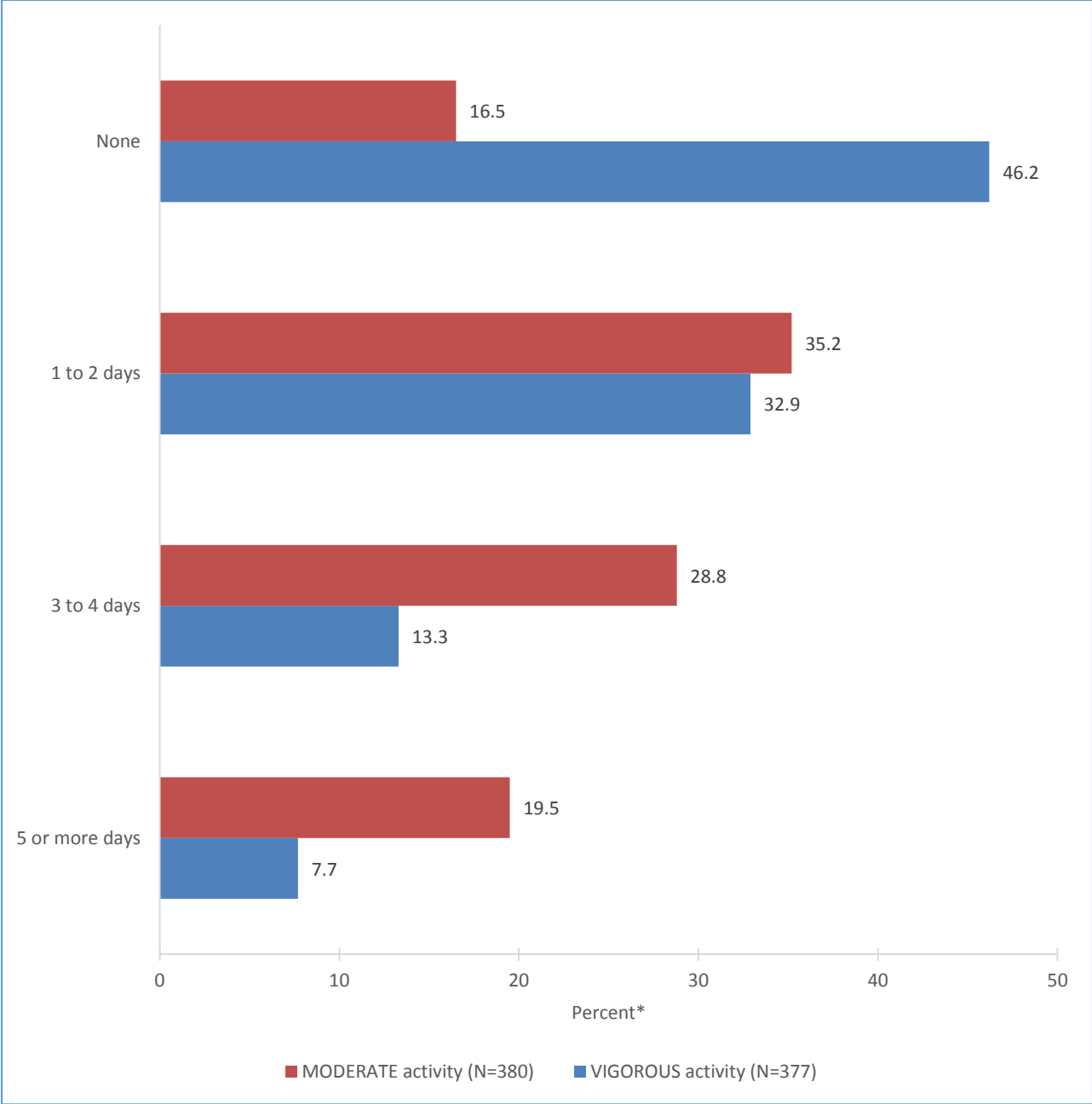
*Percentages may not total 100.0 due to rounding.

Mental Health

Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue
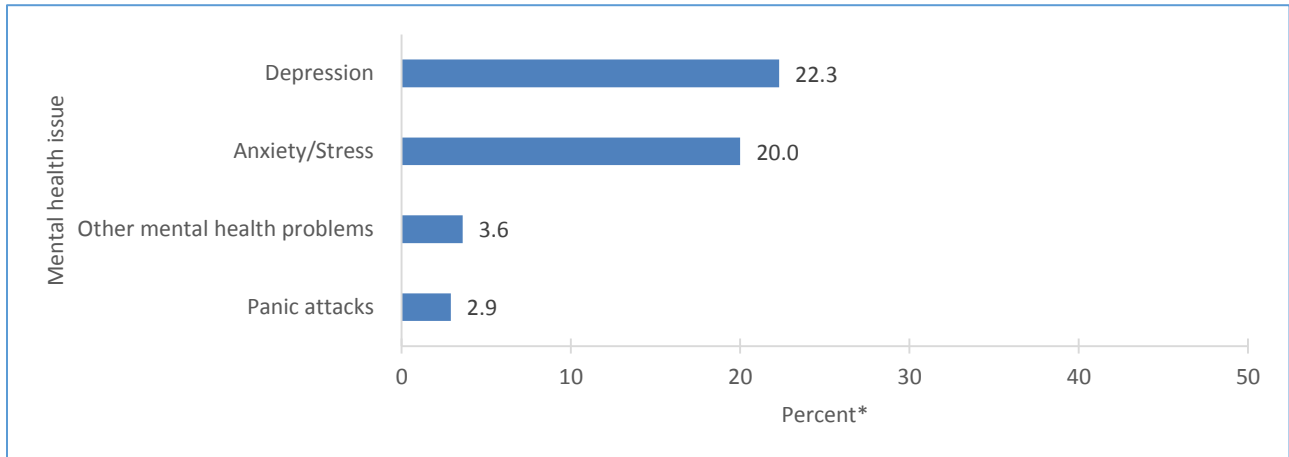
N=382

*Percentages do not total 100.0 due to multiple responses.

Figure 15. Number of days in the last month that respondents' mental health was not good
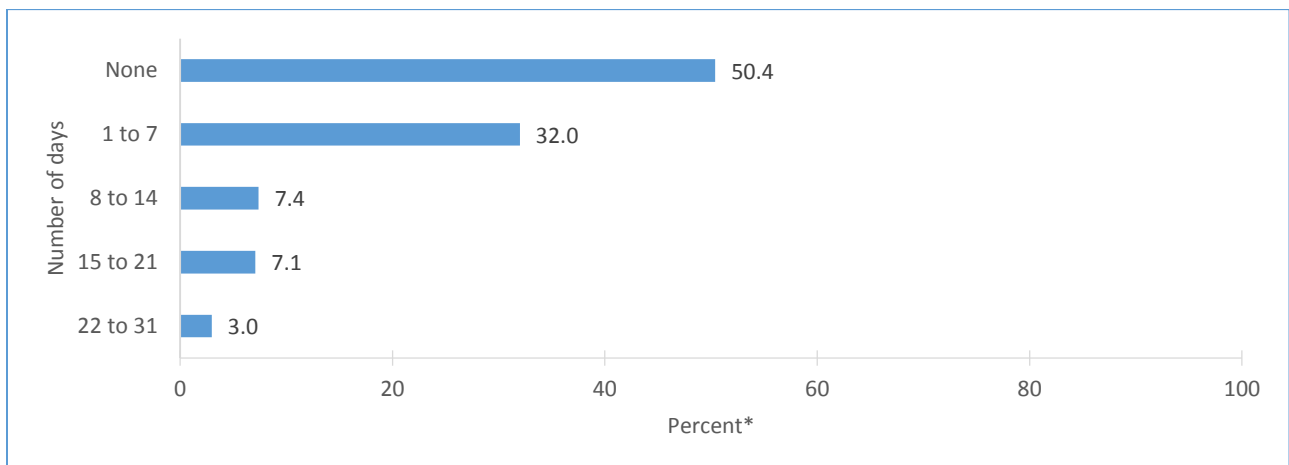
N=358

*Percentages do not total 100.0 due to rounding.

Figure 16. How often, over the past two weeks, respondents have been bothered by mental health issues
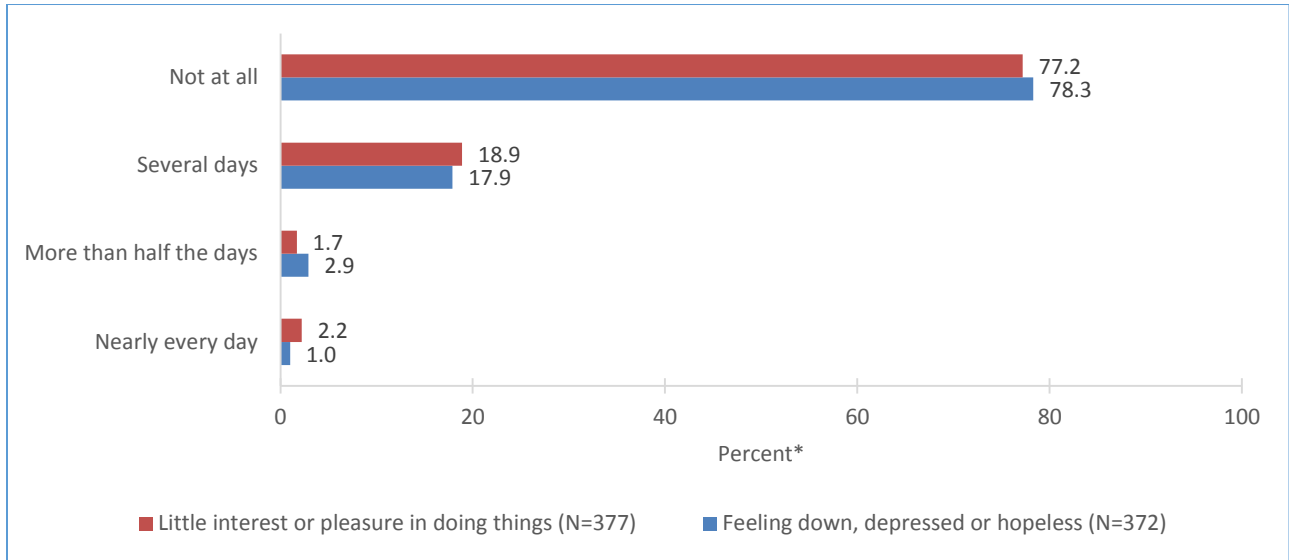
*Percentages may not total 100.0 due to rounding.

Tobacco Use

Figure 17. Whether respondents have smoked at least 100 cigarettes in their entire life
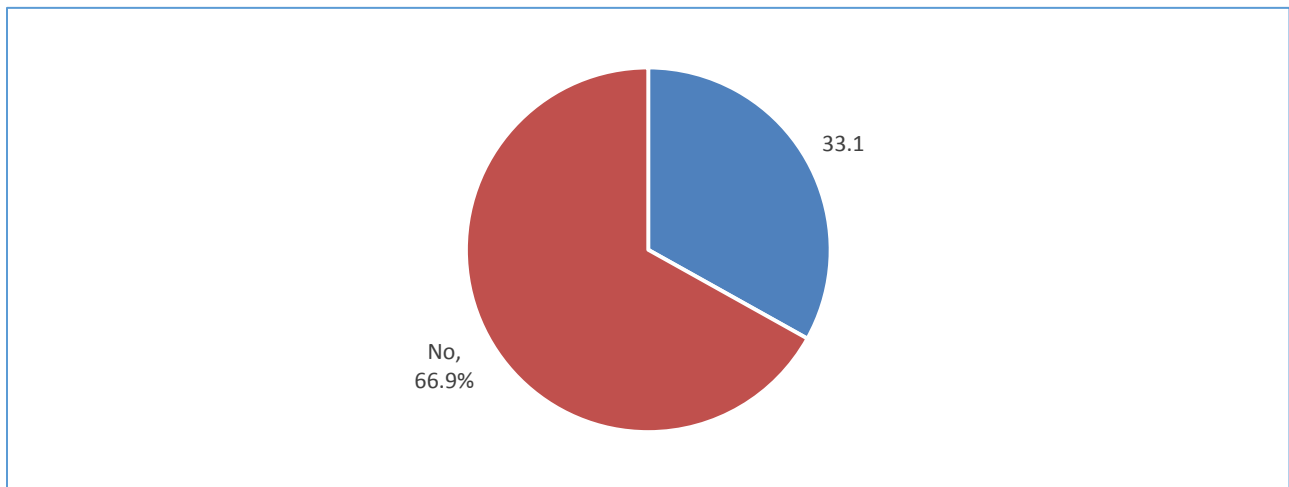
N=379

Figure 18. How often respondents currently smoke cigarettes and use chewing tobacco or snuff

Every day
4.7
1.1

Some days
3.2
2.7

Not at all
92.1
96.1

0   20   40   60   80   100

Percent*

■ Smoke cigarettes (N=382)   ■ Use chewing tobacco or snuff (N=377)
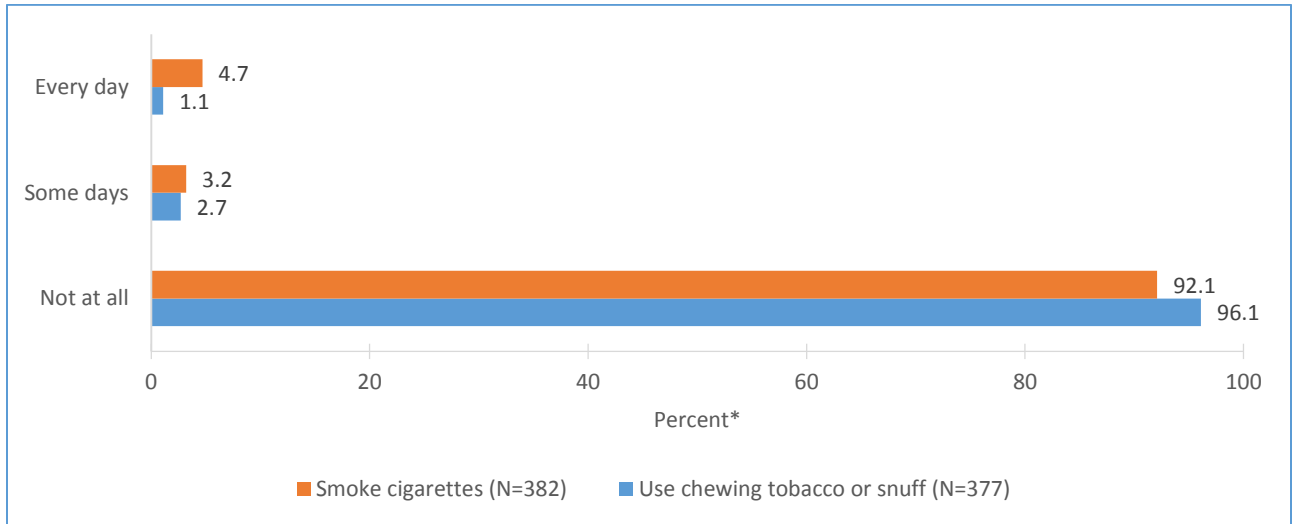
*Percentages may not total 100.0 due to rounding.

Figure 19. Location respondents would first go if they wanted help to quit using tobacco

Quitline   5.9
Doctor   9.9
Pharmacy   0.6
Private counselor/therapist   0.1
Health Department   0.1
Don't know   7.2
Not applicable   71.9
I don't want to quit   0.5
Other*   3.8

0   20   40   60   80   100

Percent

N=349

121
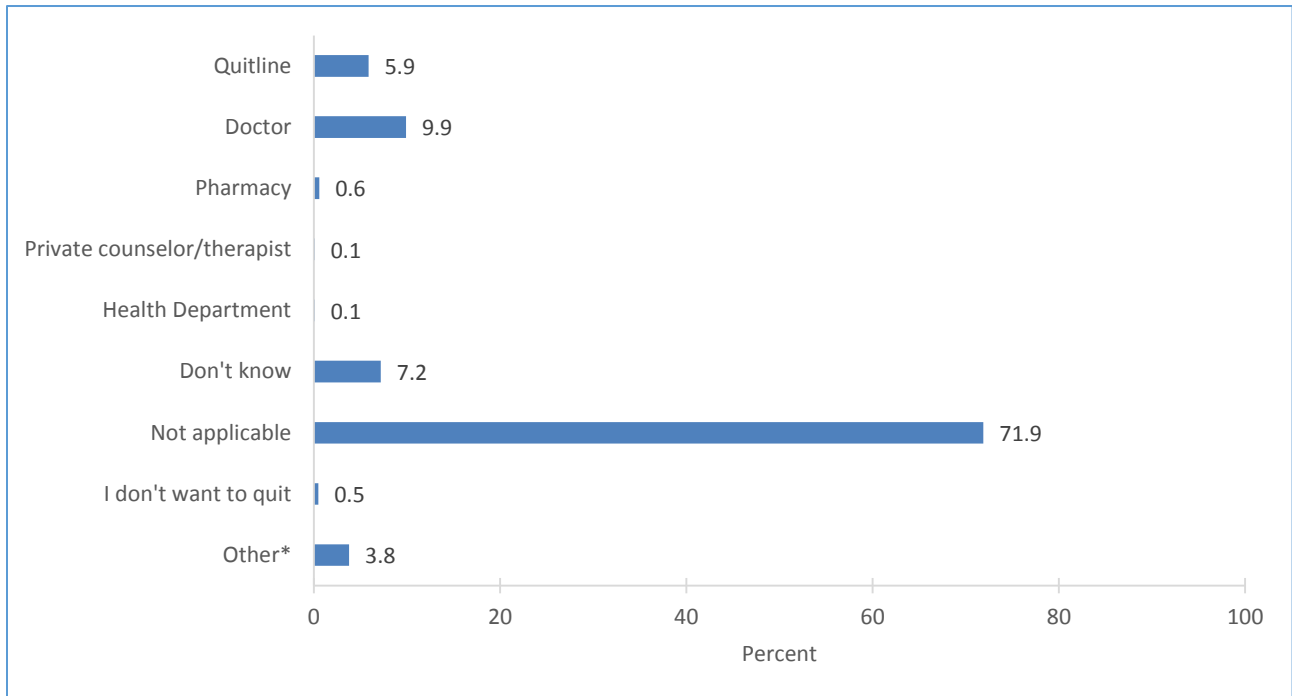
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

Figure 20. Number of days during the past month that respondents had at least one drink of any alcoholic beverage
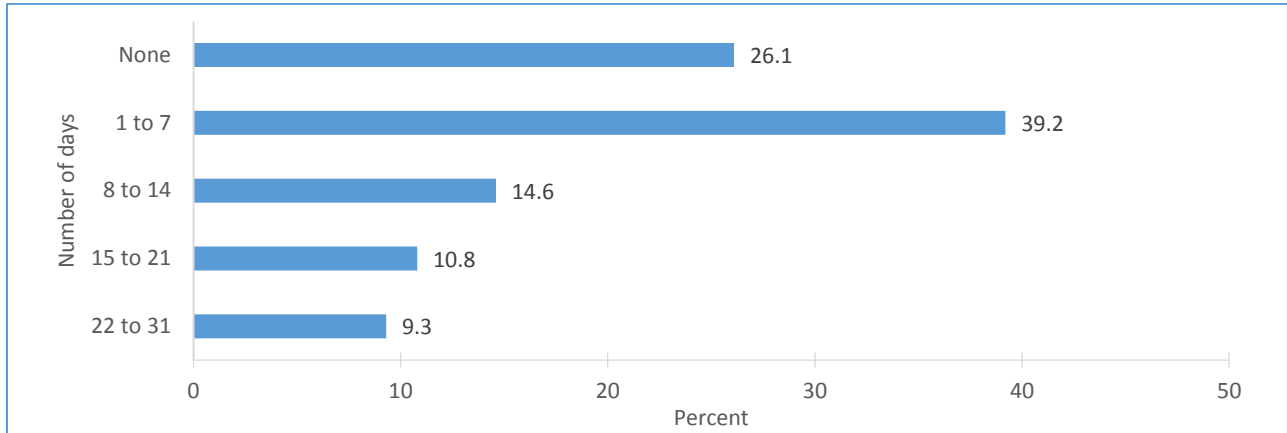
N=376

Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed
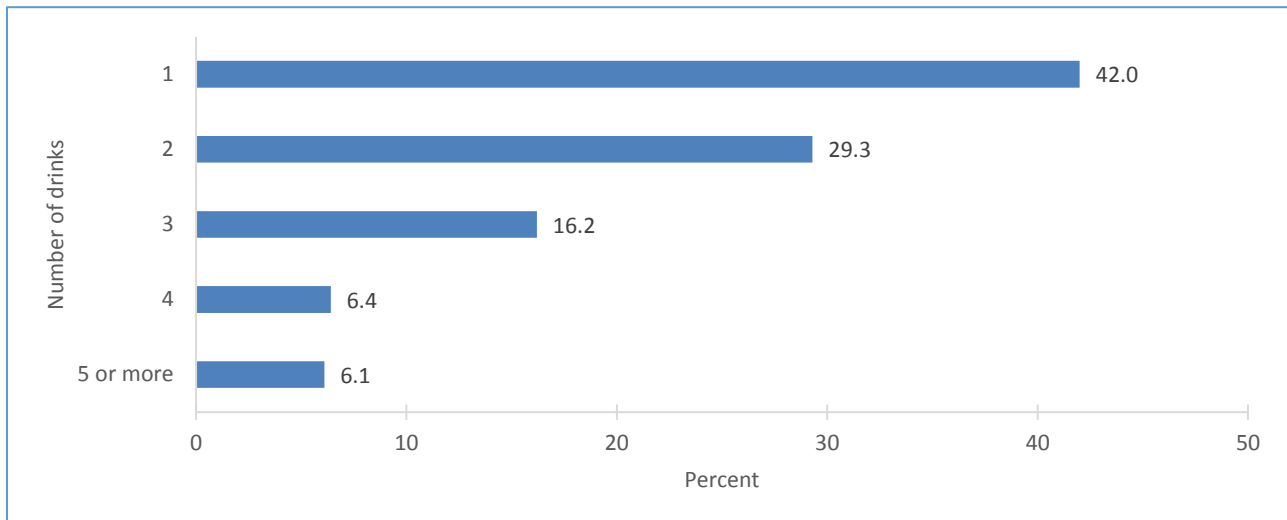
N=277

Figure 22. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion
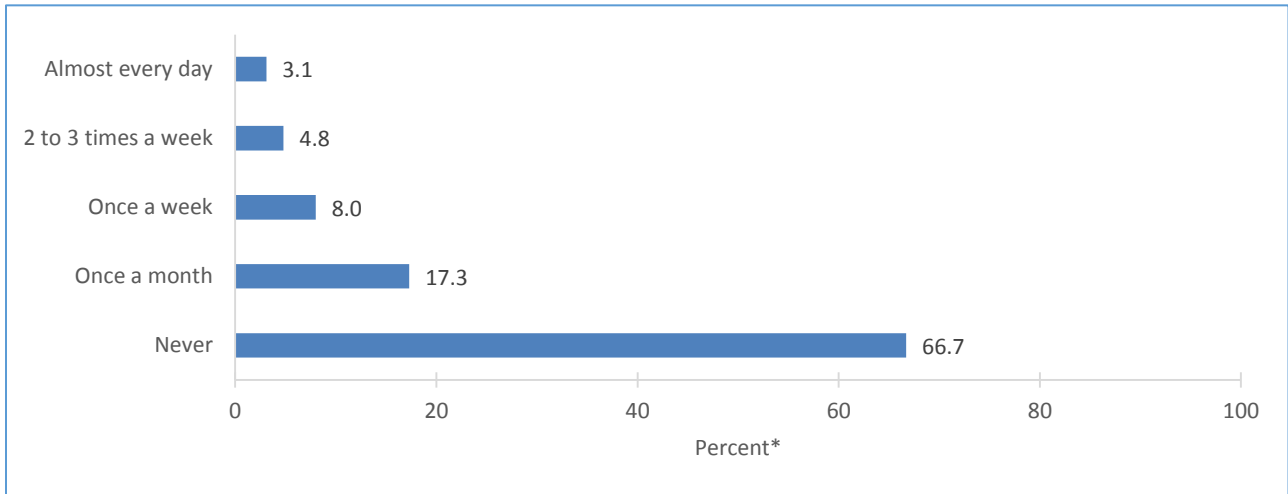
N=379

*Percentages do not total 100.0 due to rounding.

Figure 23. Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse
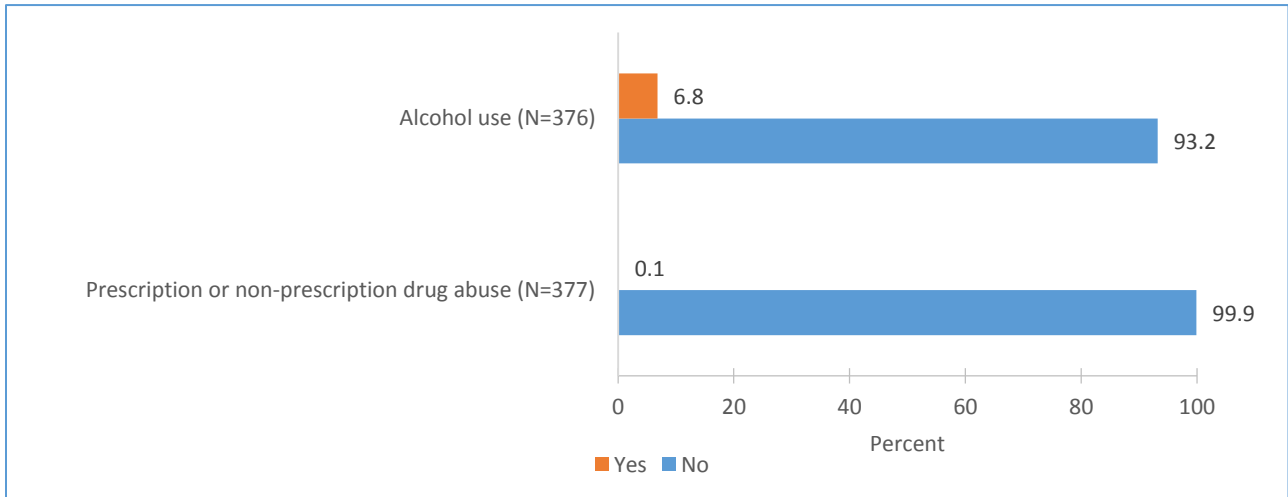
Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed
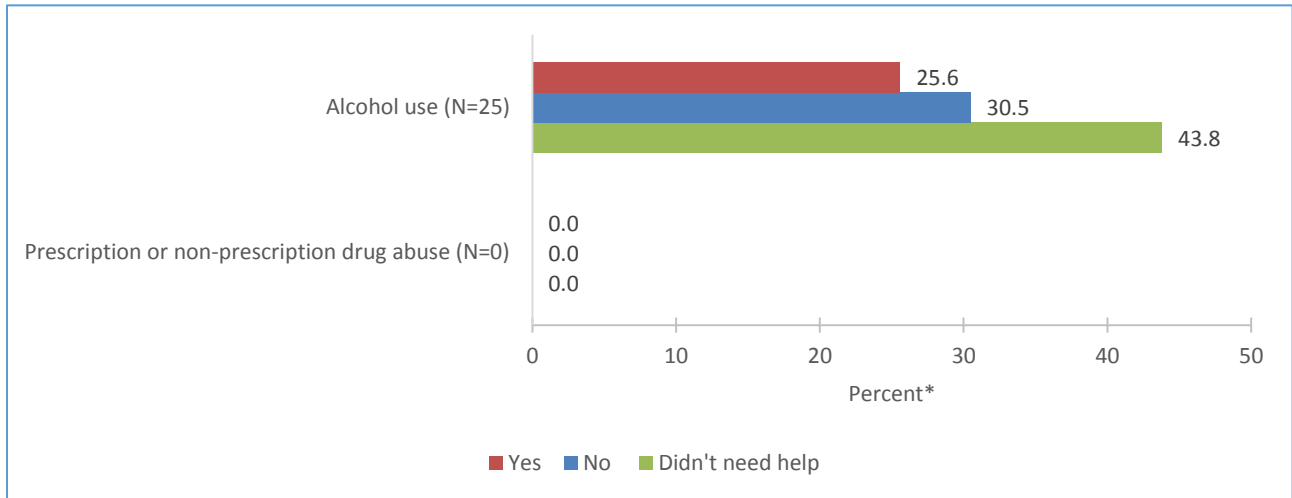
*Percentages do not total 100.0 due to rounding.

Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years
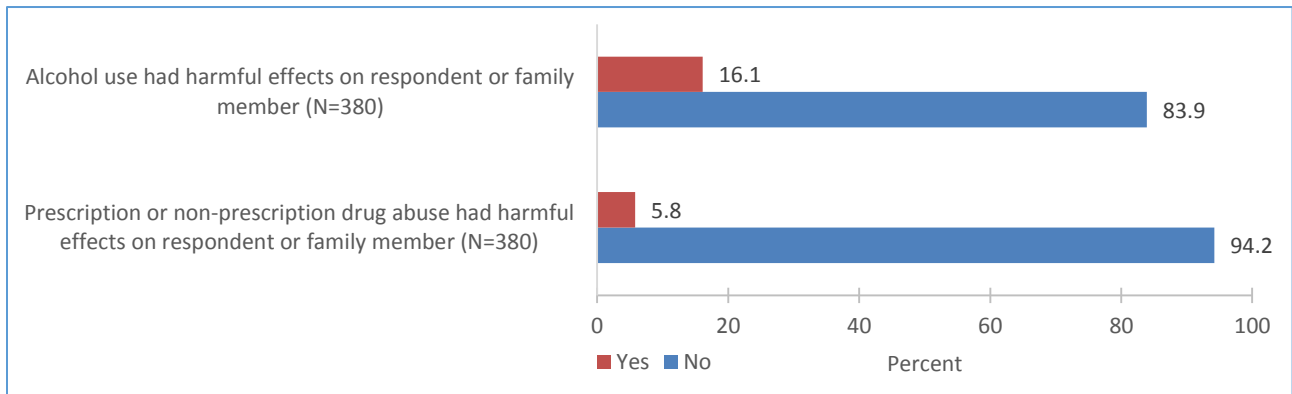
Preventive Health

Table 1. Whether or not respondents have had preventive screenings in the past year, by type of screening

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=380)	84.3	15.7	100.0
Blood sugar screening (N=379)	58.7	41.3	100.0
Bone density test (N=367)	10.8	89.2	100.0
Cardiovascular screening (N=373)	26.4	73.6	100.0
Cholesterol screening (N=378)	62.3	37.7	100.0
Dental screening and X-rays (N=378)	86.4	13.6	100.0
Flu shot (N=380)	62.1	37.9	100.0
Glaucoma test (N=374)	46.7	53.3	100.0
Hearing screening (N=377)	17.8	82.2	100.0
Immunizations (tetanus, hepatitis A or B) (N=374)	19.3	80.7	100.0
Pelvic exam (N=189 Females)	67.0	33.0	100.0
STD (N=369)	4.2	95.8	100.0
Vascular screening (N=368)	11.3	88.7	100.0
CANCER SCREENINGS			
Breast cancer screening (N= 189 Females)	65.2	34.8	100.0
Cervical cancer screening (N=185 Females)	63.4	36.6	100.0
Colorectal cancer screening (N=368)	32.3	67.7	100.0
Prostate cancer screening (N=182 Males)	39.4	60.6	100.0
Skin cancer screening (N=365)	22.5	77.5	100.0

Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=60)	60.8	23.0	5.5	0.0	0.0	0.8	21.3
Blood sugar screening (N=157)	49.6	36.8	2.1	0.0	0.0	0.4	6.7
Bone density test (N=327)	48.8	44.6	1.1	0.0	0.0	0.2	3.6
Cardiovascular screening (N=274)	45.4	47.3	2.9	0.0	0.0	1.5	3.8
Cholesterol screening (N=143)	50.7	35.8	4.6	0.0	0.0	0.1	10.5
Dental screening and X-rays (N=52)	23.1	9.0	28.9	14.7	0.4	0.0	33.4
Flu shot (N=144)	40.9	3.9	0.3	0.7	1.3	0.3	51.6
Glaucoma test (N=199)	51.9	23.9	4.0	0.0	0.0	0.1	17.6
Hearing screening (N=310)	54.2	36.1	1.8	0.0	0.1	0.0	6.4
Immunizations (N=302)	67.6	21.9	1.3	0.0	0.0	0.0	6.6
Pelvic exam (N=62 Females)	60.2	12.1	1.6	0.7	0.0	0.0	14.3
STD (N=353)	84.9	7.2	0.0	0.0	0.0	0.0	2.8
Vascular screening (N=326)	56.0	34.3	1.2	1.0	0.0	0.2	4.7
CANCER SCREENINGS							

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Breast cancer screening (N=66 Females)	35.5	28.3	11.4	0.0	5.0	0.0	20.0
Cervical cancer screening (N=68 Females)	53.6	24.9	0.0	0.0	0.0	0.0	9.2
Colorectal cancer screening (N=249)	54.1	25.2	1.0	4.7	0.3	0.0	14.8
Prostate cancer screening (N=110 Males)	44.1	38.9	0.6	3.9	0.2	0.0	13.4
Skin cancer screening (N=282)	46.4	38.7	1.6	0.2	1.2	1.3	9.2

*Percentages do not total 100.0 due to multiple responses.

Figure 26. Whether respondents have any of the following chronic diseases
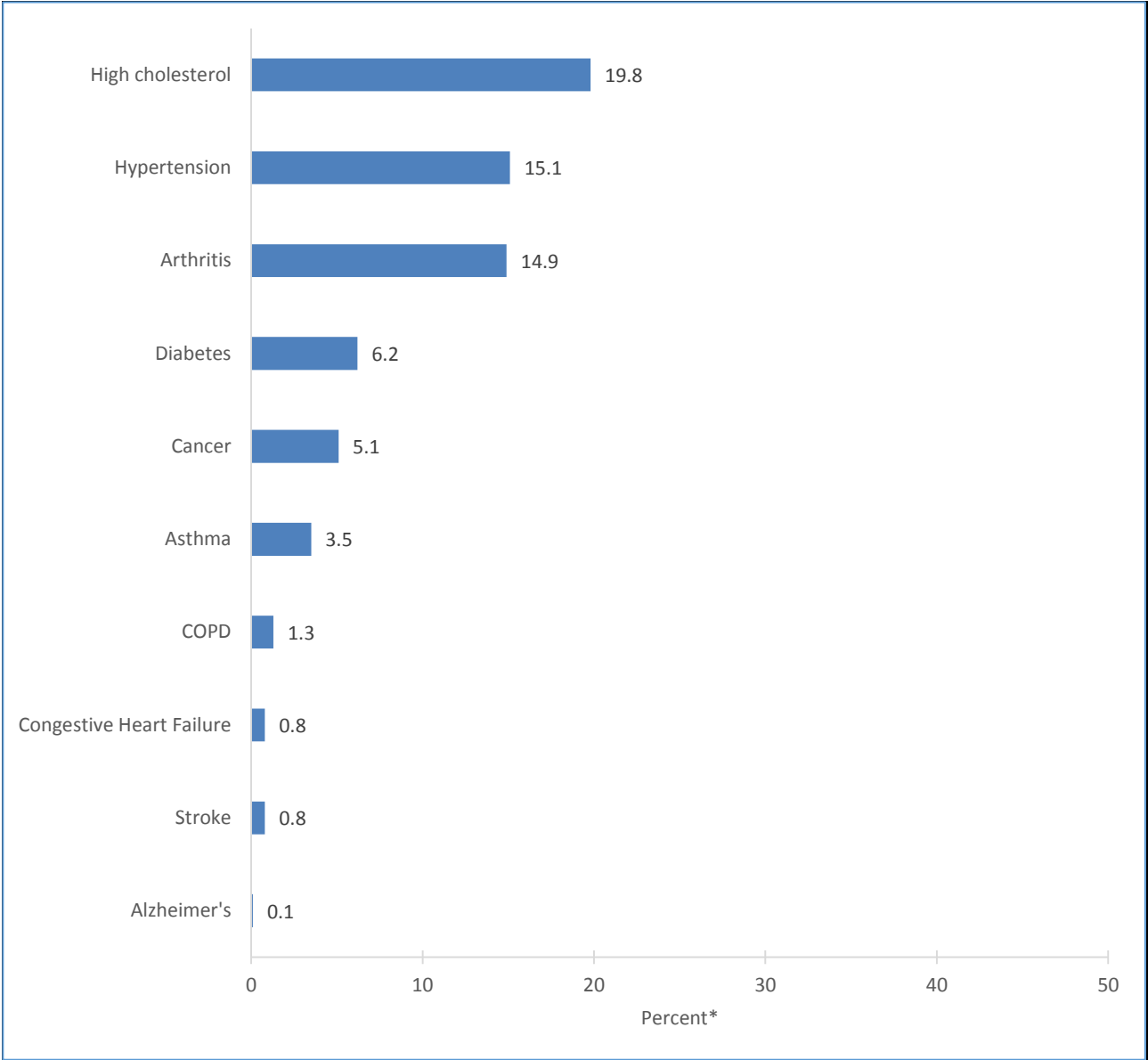
N=382

*Percentages do not total 100.0 due to multiple responses.

Figure 27. Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason
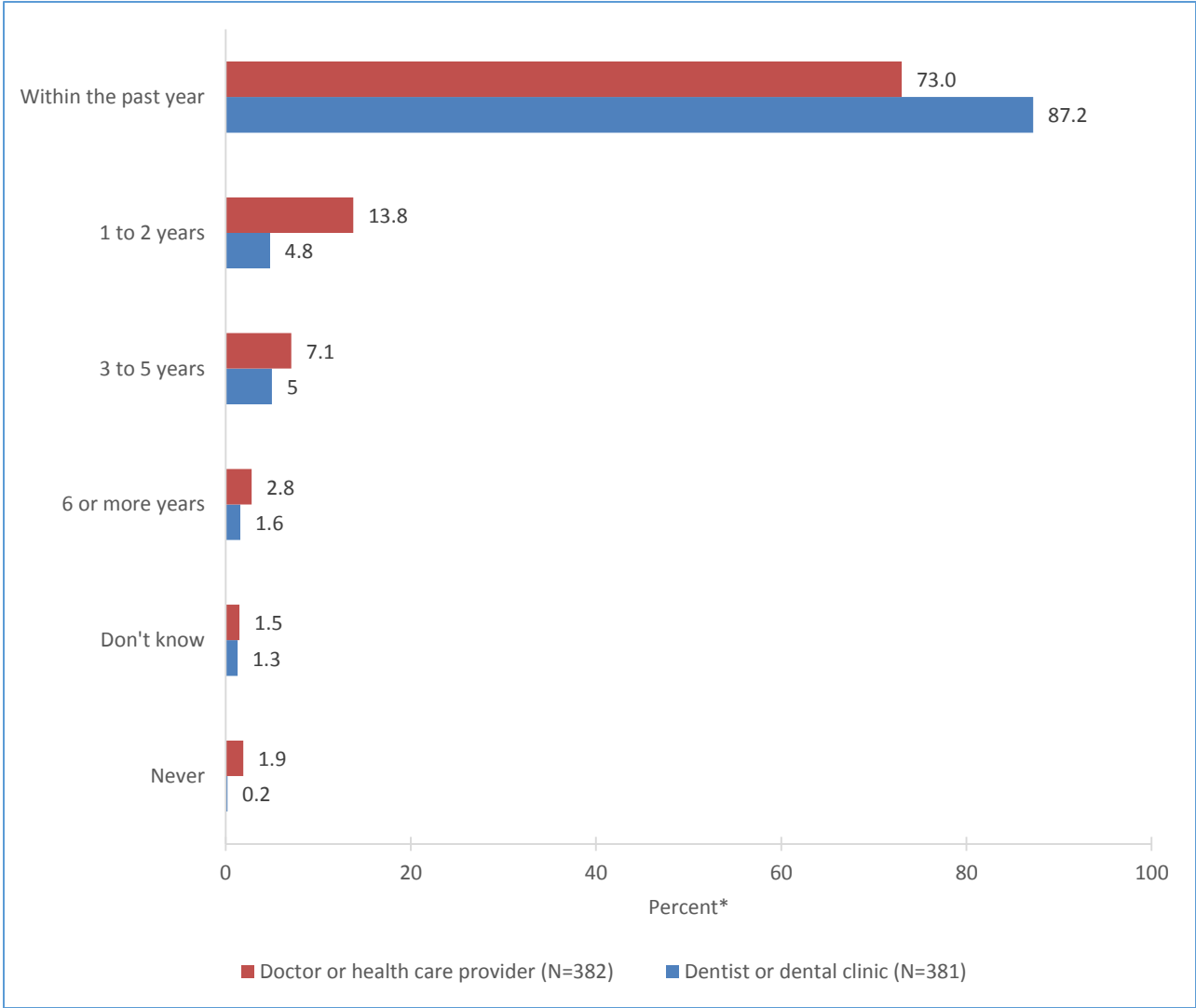
*Percentages do not total 100.0 due to rounding.

Figure 28. Where respondents get most of their health information
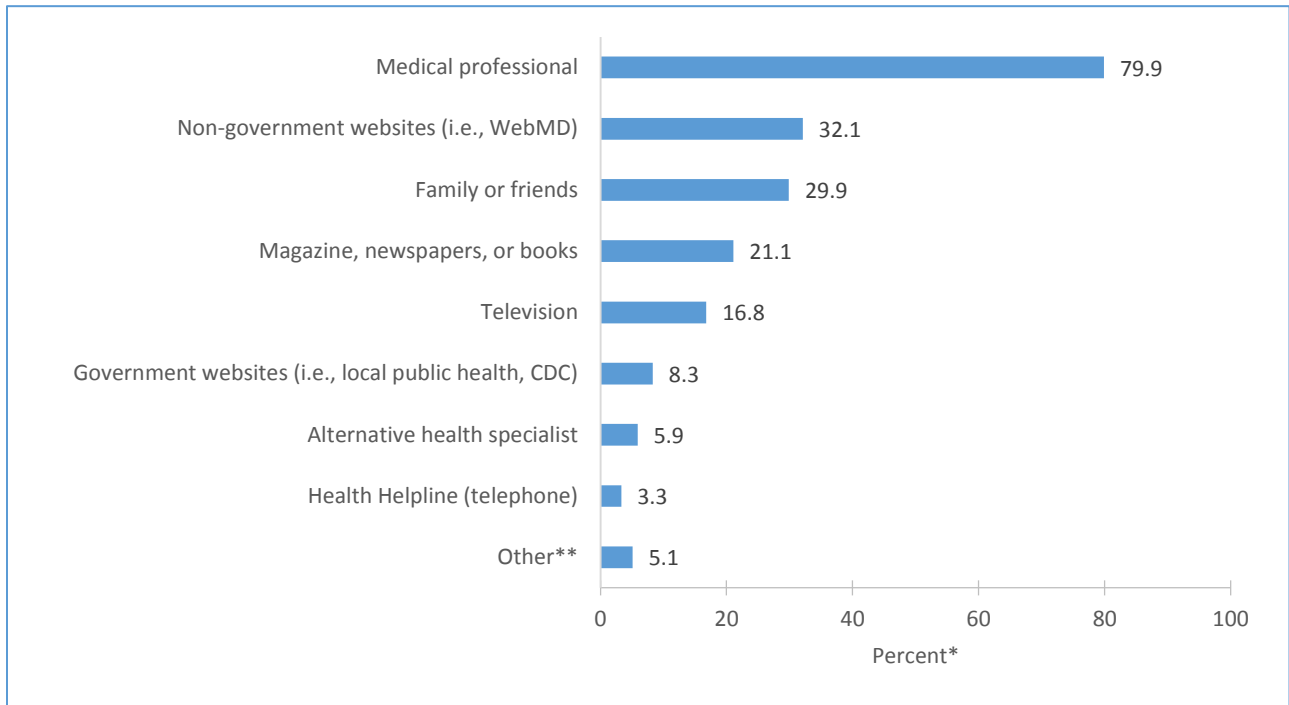
N=382

*Percentages do not total 100.0 due to multiple responses.

Figure 29. Best way for respondents to access technology for health information
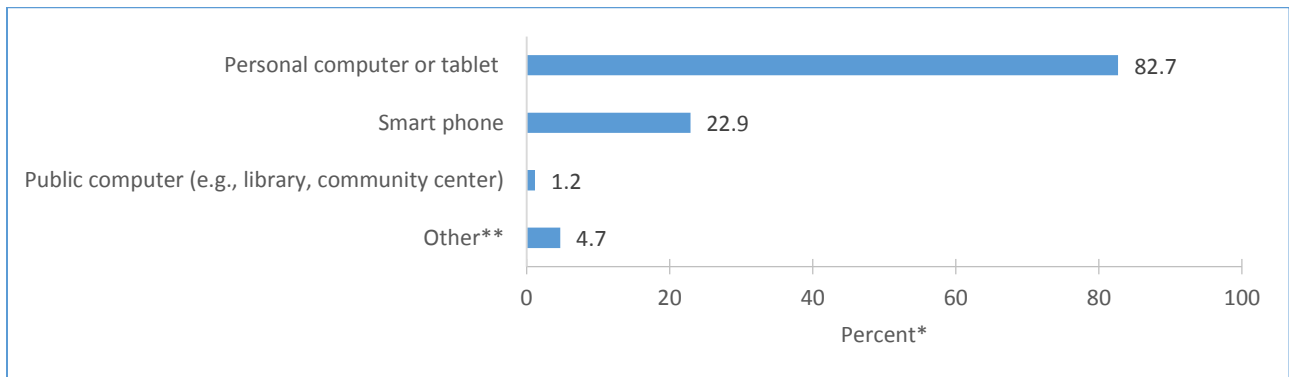
N=382

*Percentages do not total 100.0 due to multiple responses.

Demographic Information

Figure 30. Age of respondents
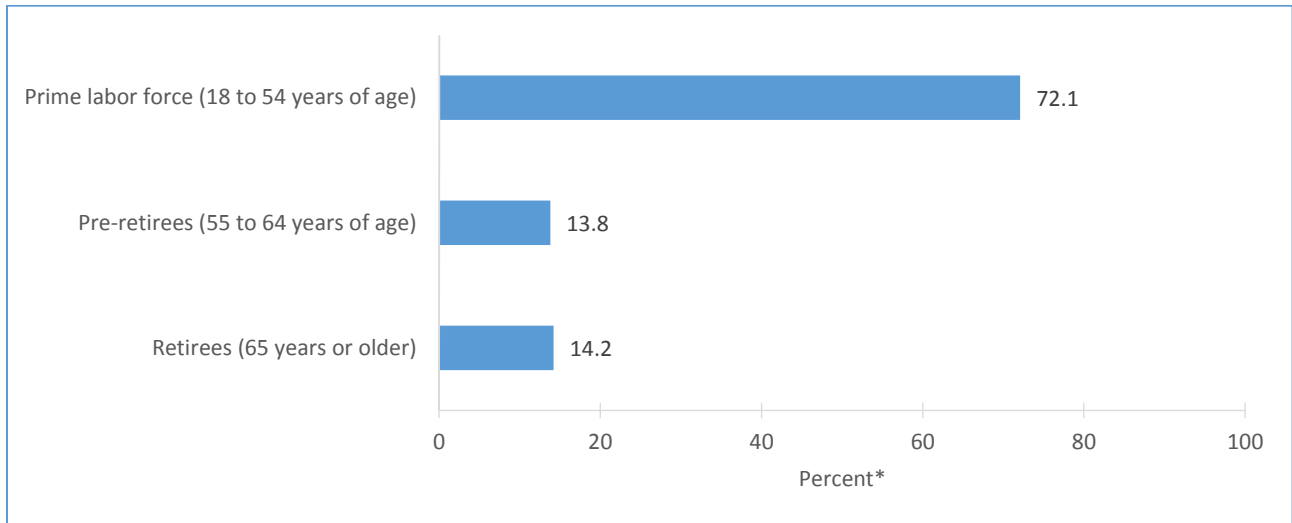
N=382

*Percentages do not total 100.0 due to rounding.

Figure 31. Highest level of education of respondents
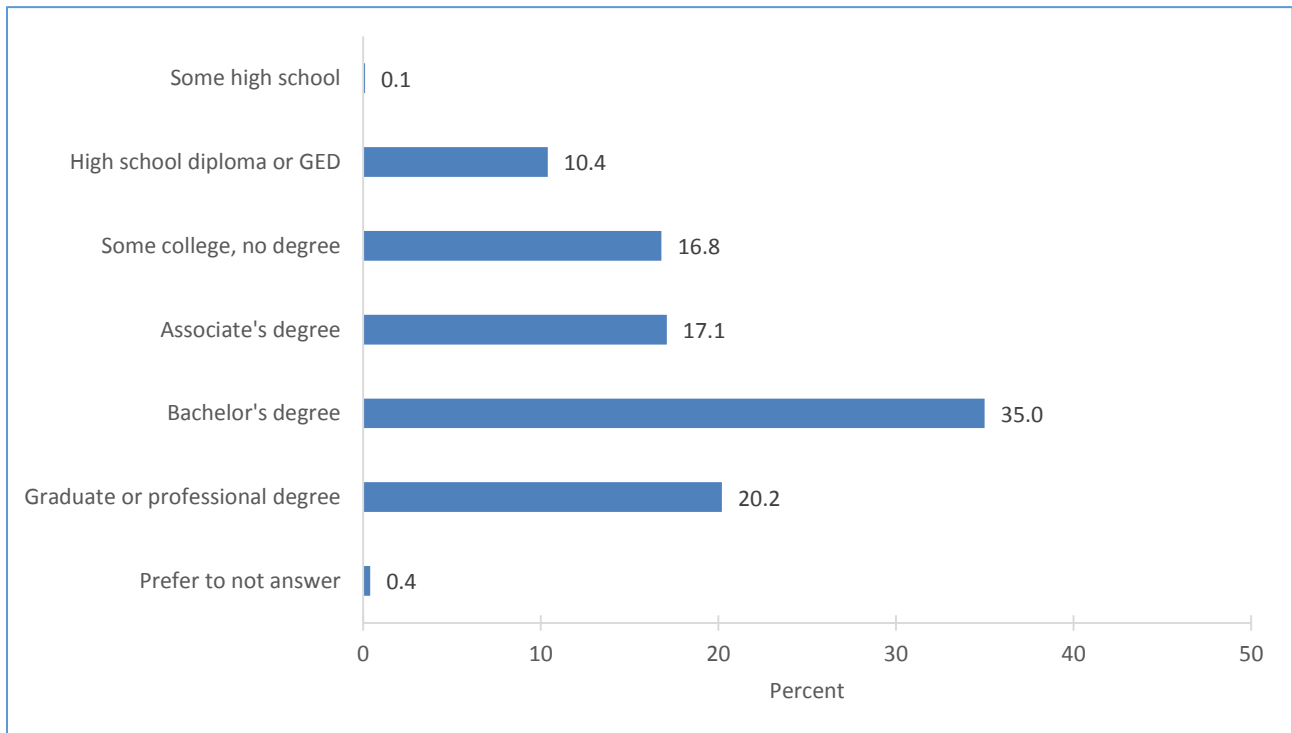
N=379

Figure 32. Gender of respondents
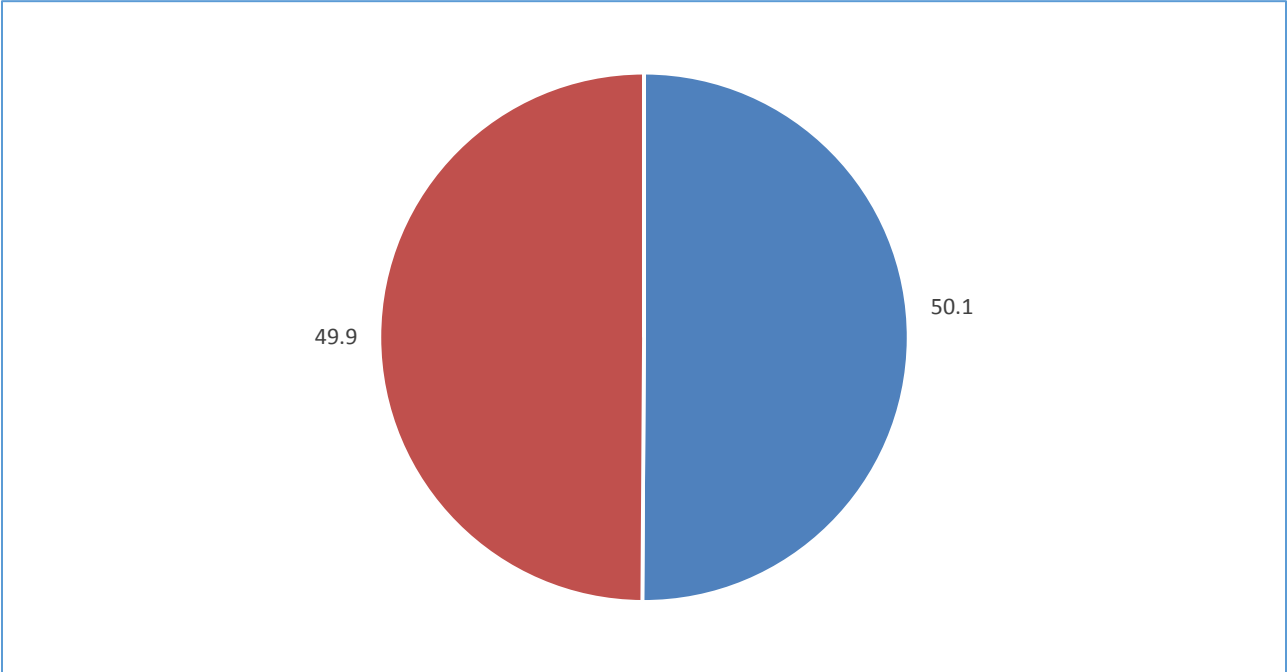
N=382

Figure 33. Race and ethnicity of respondents
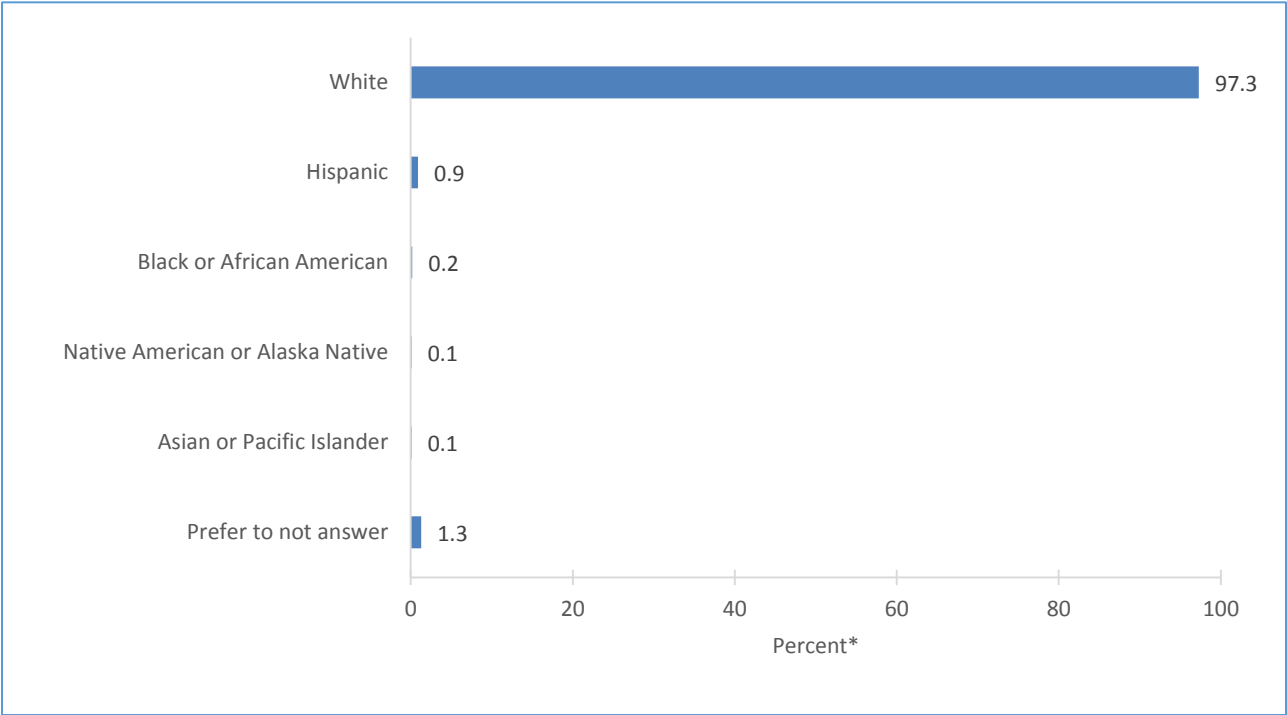
N=372 *Percentages do not total 100.0 due to multiple responses.

Figure 34. Annual household income of respondents
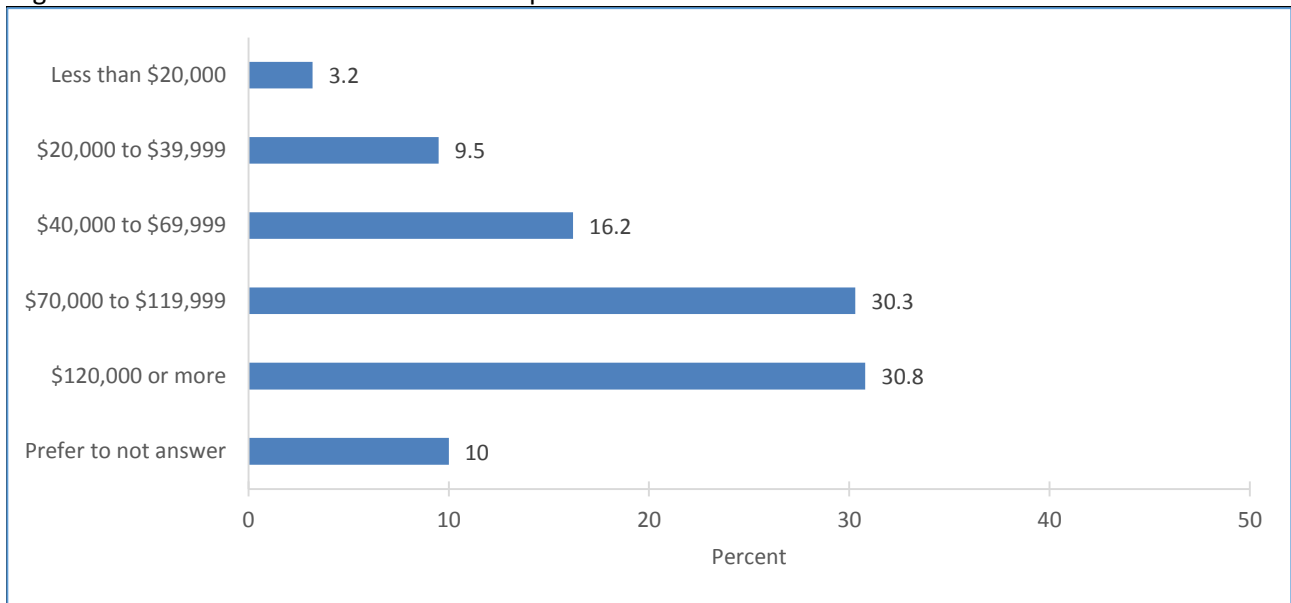
N=378

Figure 35. Employment status of respondents
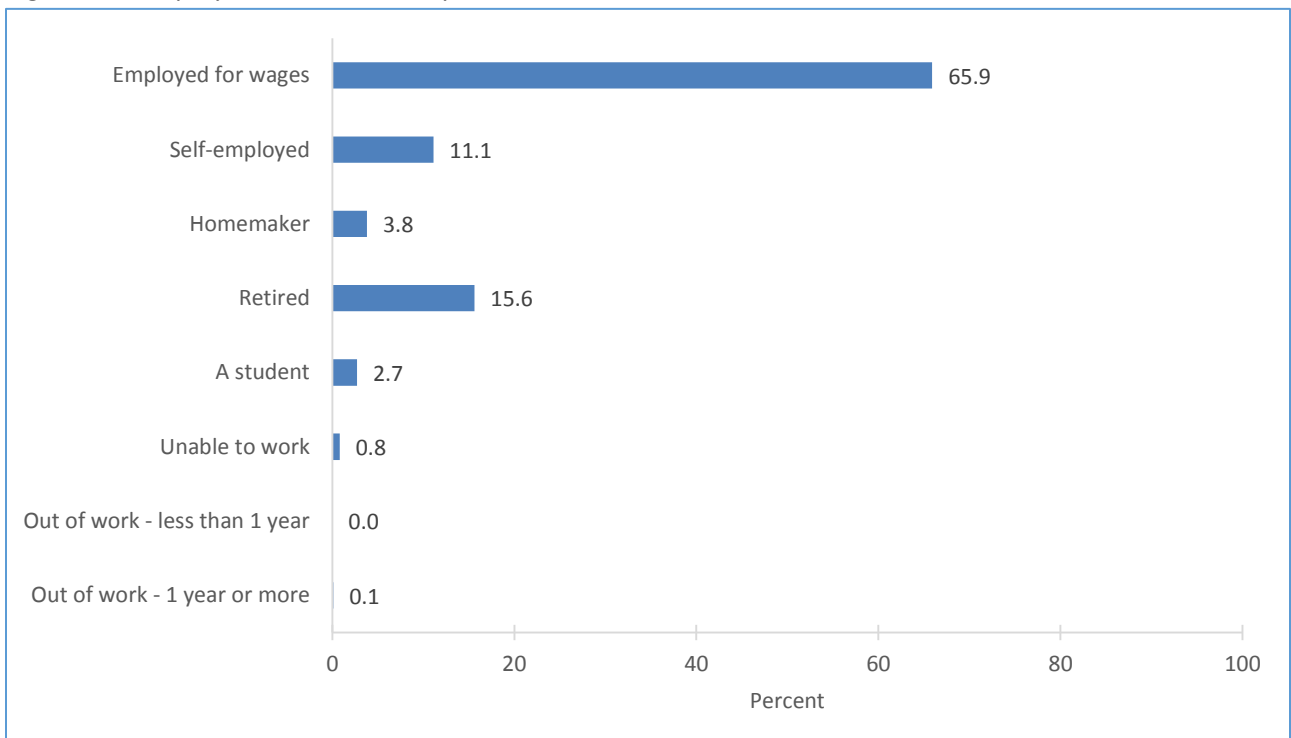
N=371

Figure 36. Length of time respondents have lived in their community

Less than 2 years 3.7

2 to 5 years 5

More than 5 years 91.3

Percent
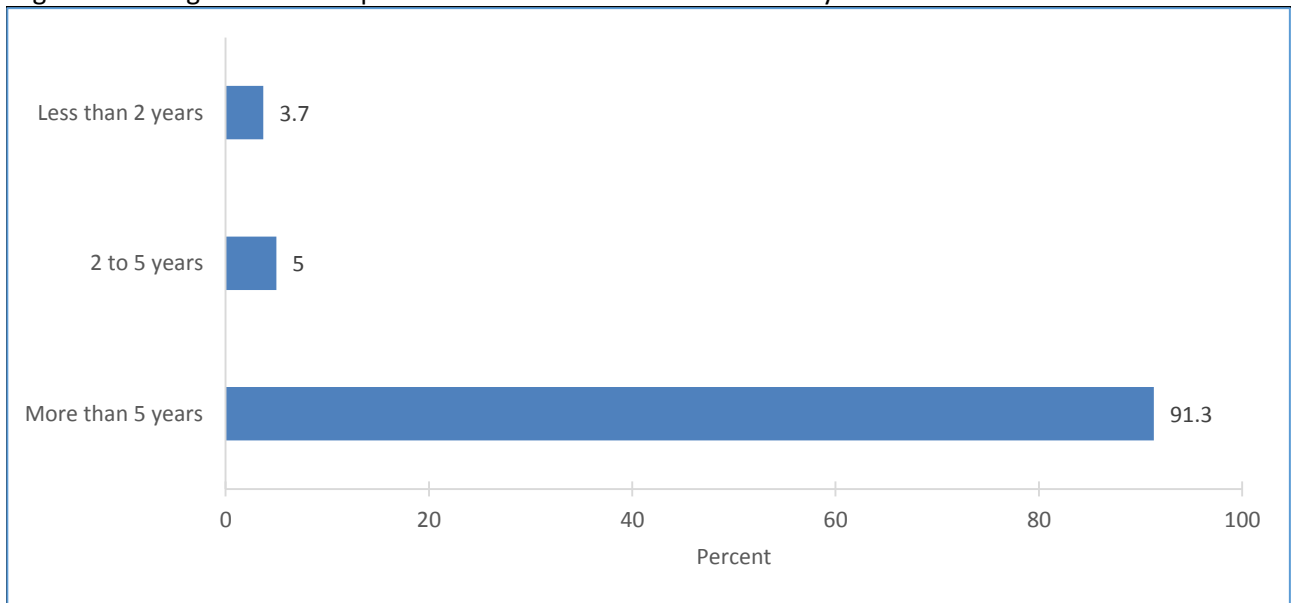
N=381

Figure 37. Whether respondents own or rent their home

Own 93.3

Rent 6.6

Prefer to not answer 0.1

Other 0.0

Percent
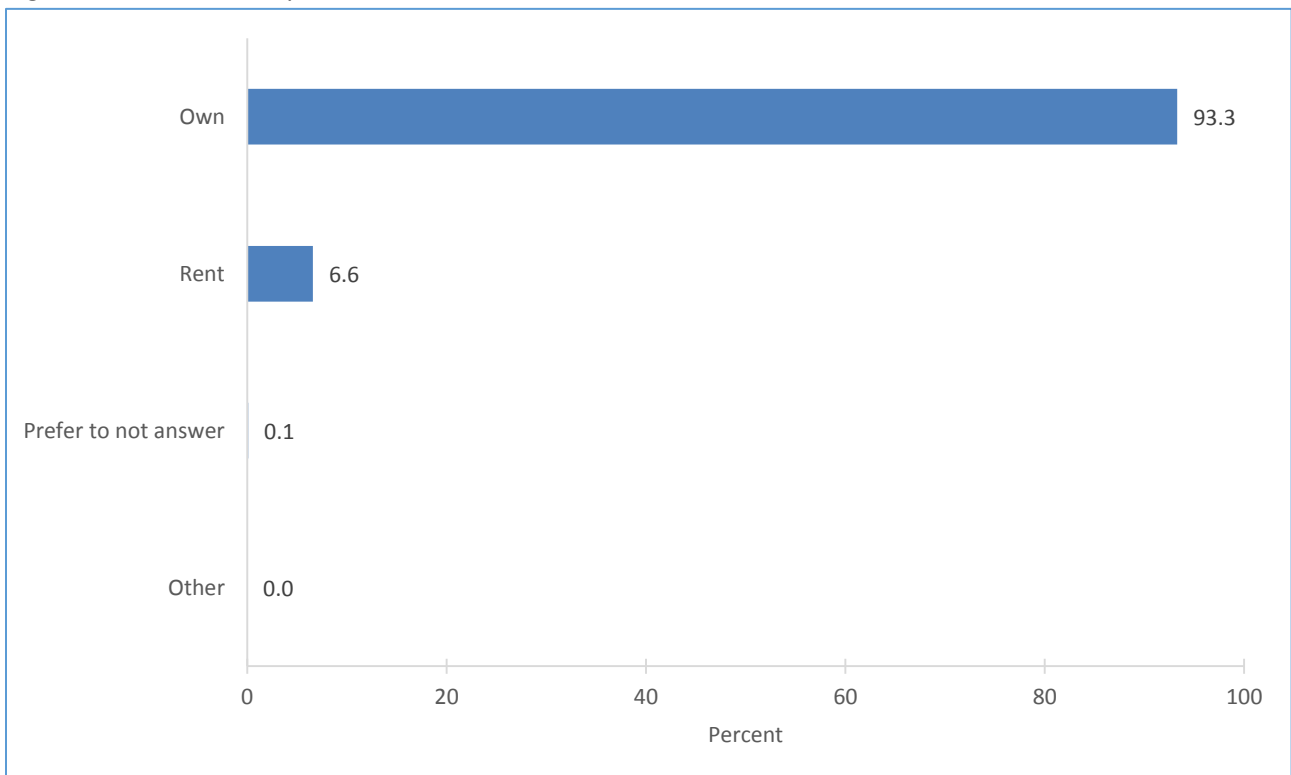
N=381

Figure 38. Whether respondents have health insurance (private, public, or governmental) and oral health or dental care insurance coverage
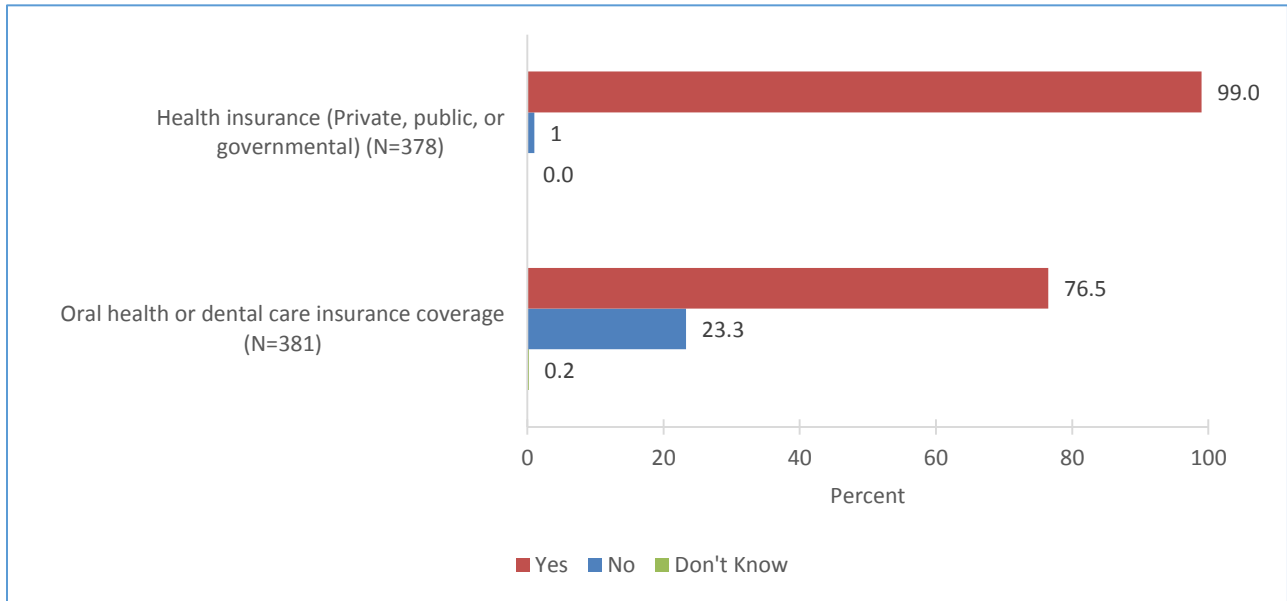
Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider
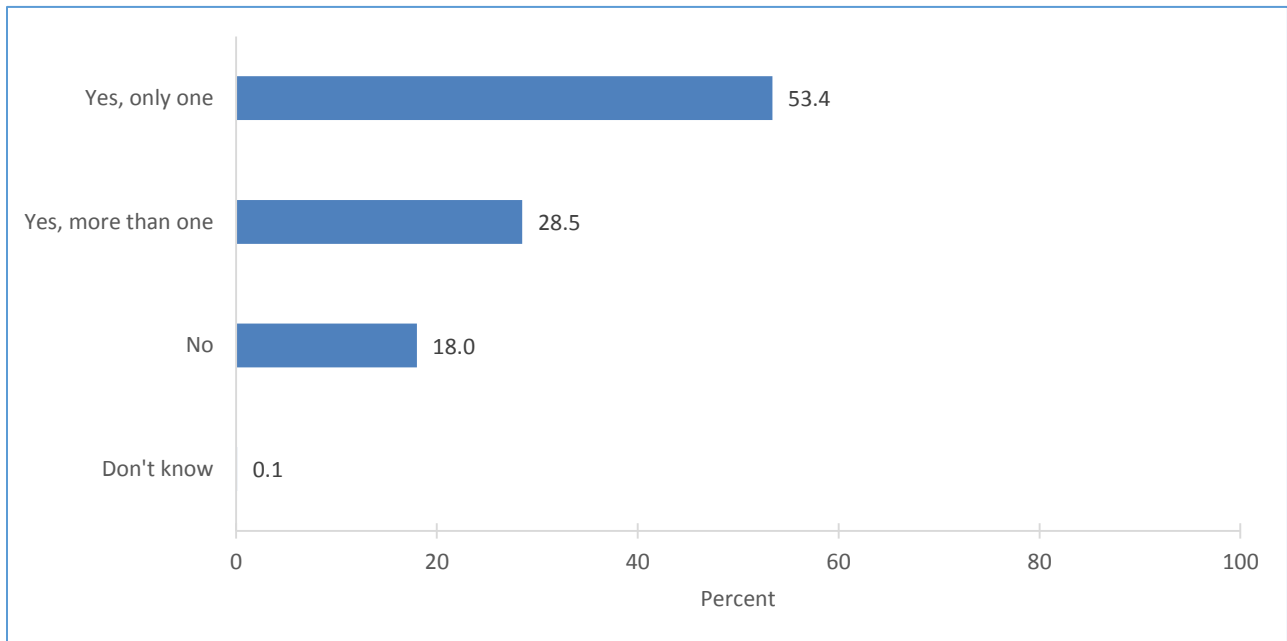
N=379

Figure 40. Facilities that respondents go to most often when sick and take their children when they are sick
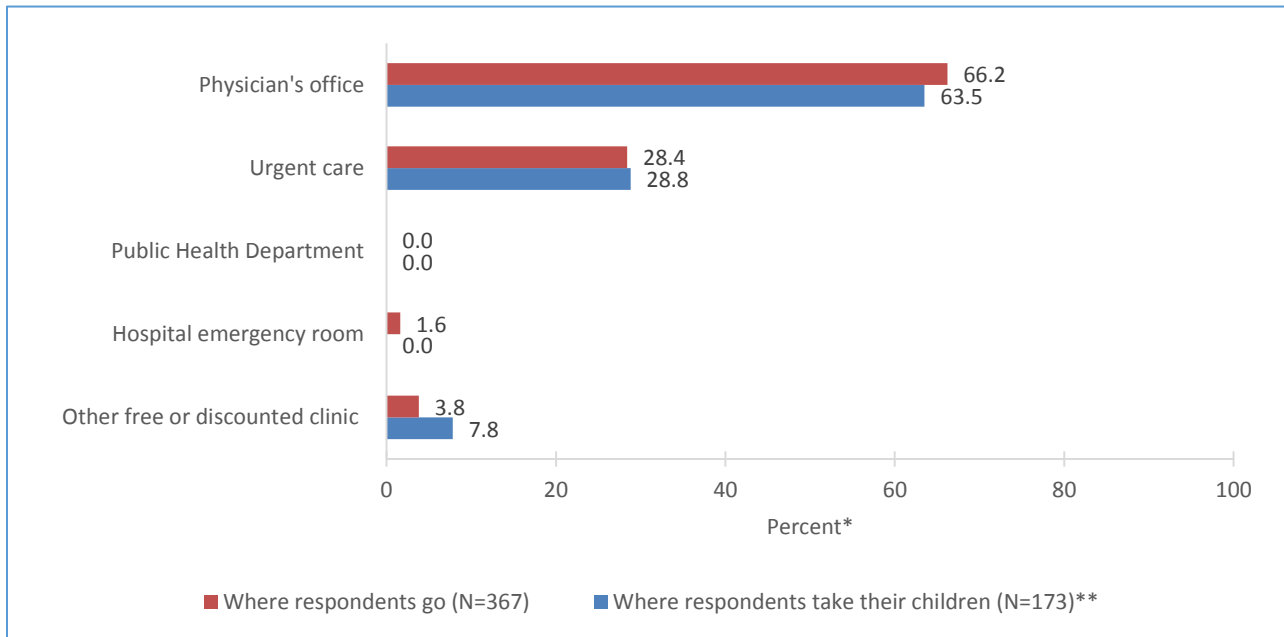
*Percentages may not total 100.0 due to rounding.

Figure 41. Number of children younger than 18 and number of adults age 65 or older living in respondents' household
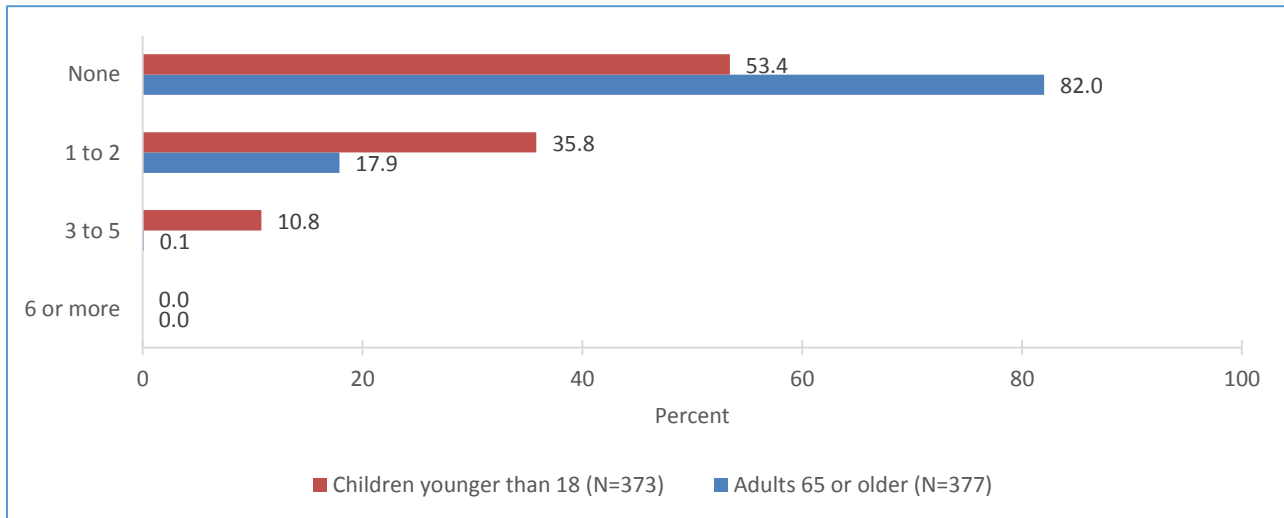
Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year
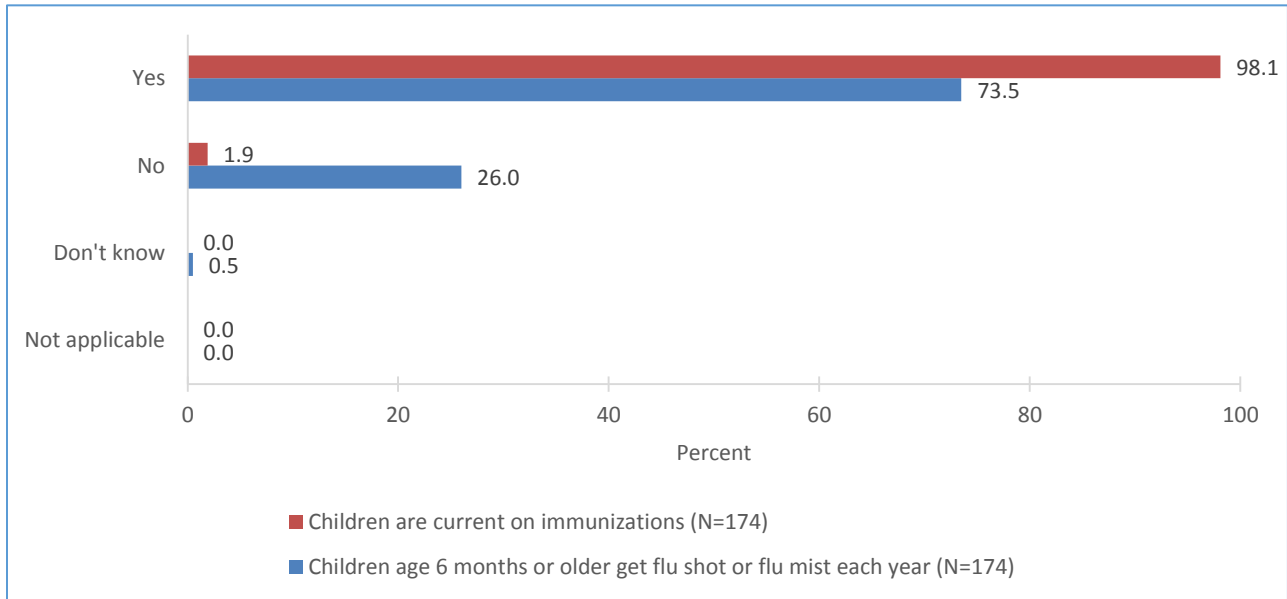
Table 3. Location of respondents based on zip code

	Percent of respondents*
Cass County, ND	69.3%
North Fargo	11.5%
South Fargo	30.1%
West Fargo	14.5%
Rural	13.2%
Clay County, MN	28.4%
Moorhead	16.3%
Rural	12.1%
Unknown or missing	2.7%

N=382 *Percentages do not total 100.0 due to rounding.

Non-Generalizable (Key Stakeholders) Survey Results

General Health and Wellness Concerns about the Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various statements regarding ECONOMICS, TRANSPORTATION, the ENVIRONMENT, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTH CARE, PHYSICAL AND MENTAL HEALTH, and SUBSTANCE USE AND ABUSE.

Figure 1. Level of concern with statements about the community regarding ECONOMICS

Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH
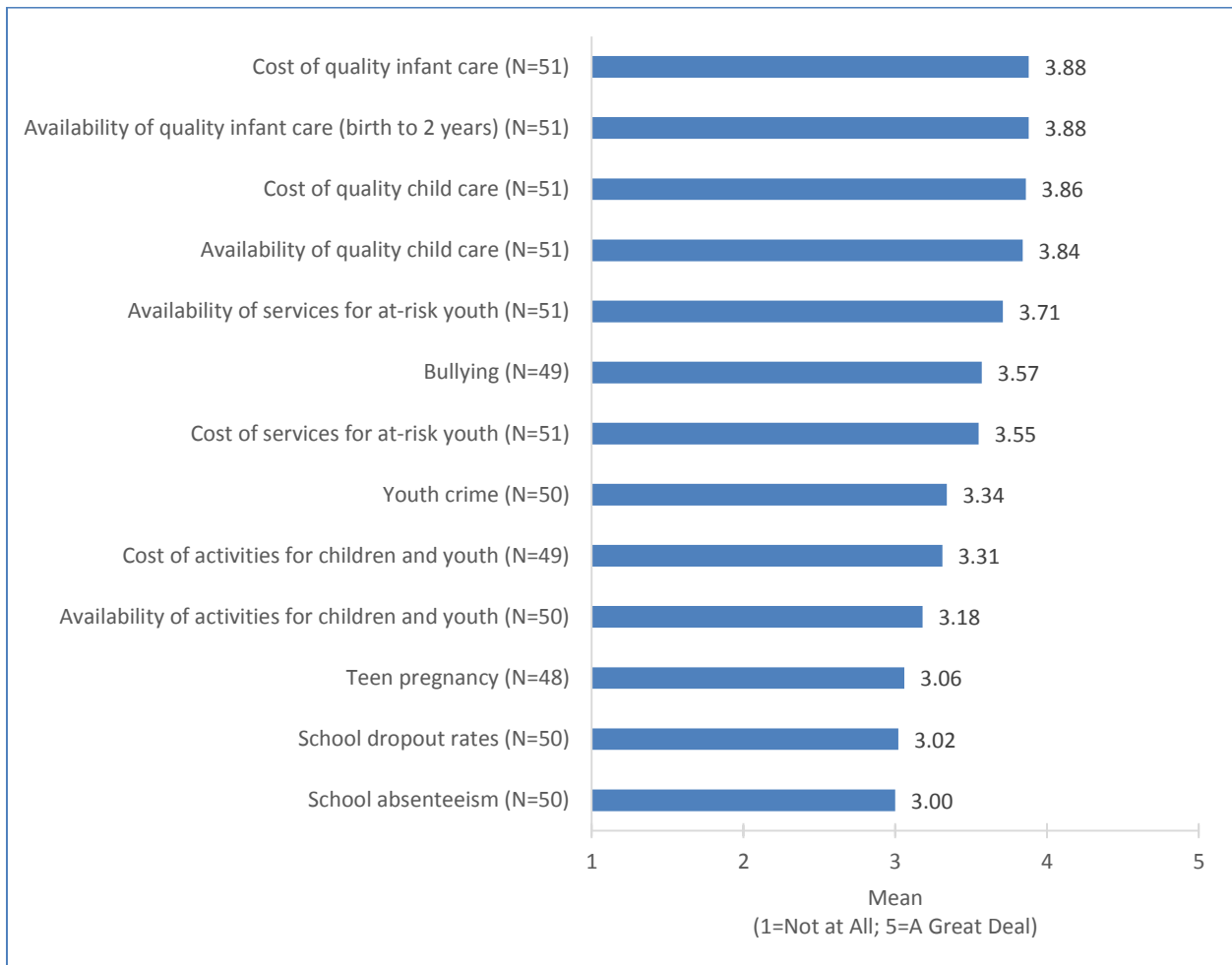
Figure 5. Level of concern with statements about the community regarding the AGING POPULATION
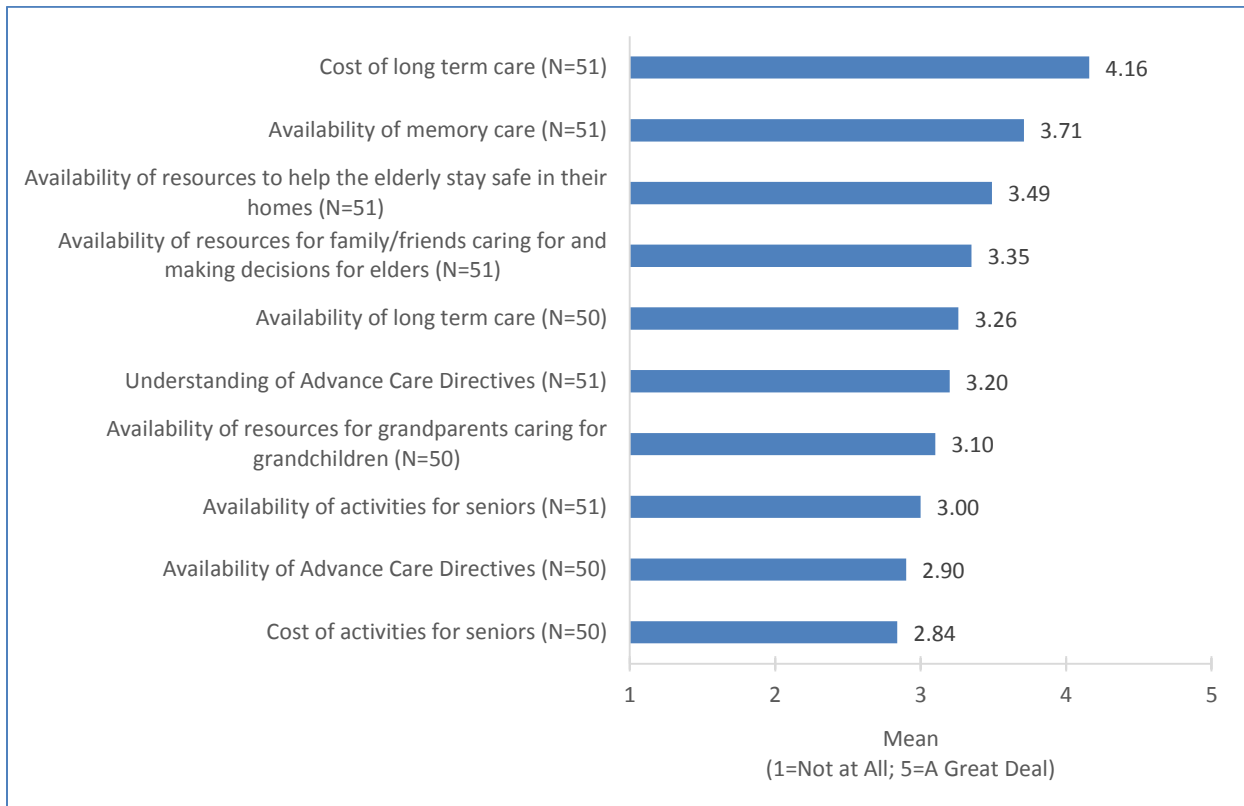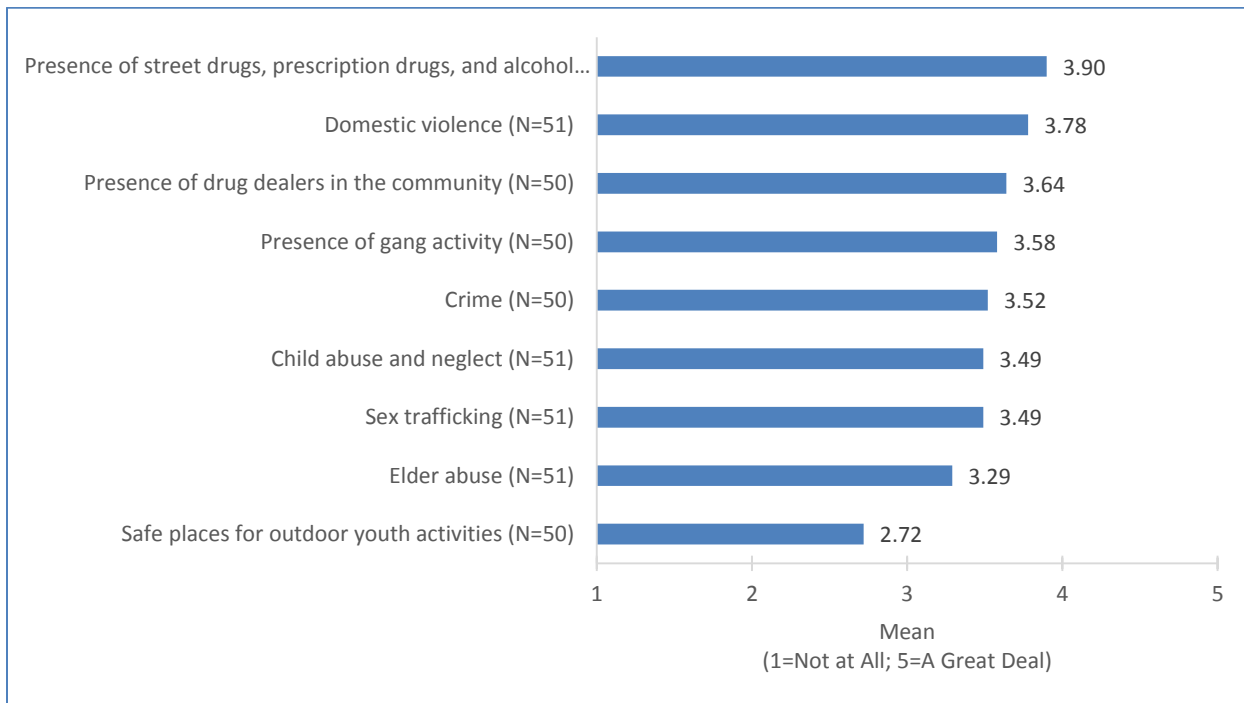

Cost of long term care (N=51) — 4.16
Availability of memory care (N=51) — 3.71
Availability of resources to help the elderly stay safe in their homes (N=51) — 3.49
Availability of resources for family/friends caring for and making decisions for elders (N=51) — 3.35
Availability of long term care (N=50) — 3.26
Understanding of Advance Care Directives (N=51) — 3.20
Availability of resources for grandparents caring for grandchildren (N=50) — 3.10
Availability of activities for seniors (N=51) — 3.00
Availability of Advance Care Directives (N=50) — 2.90
Cost of activities for seniors (N=50) — 2.84

Mean
(1=Not at All; 5=A Great Deal)

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

Presence of street drugs, prescription drugs, and alcohol… — 3.90
Domestic violence (N=51) — 3.78
Presence of drug dealers in the community (N=50) — 3.64
Presence of gang activity (N=50) — 3.58
Crime (N=50) — 3.52
Child abuse and neglect (N=51) — 3.49
Sex trafficking (N=51) — 3.49
Elder abuse (N=51) — 3.29
Safe places for outdoor youth activities (N=50) — 2.72

Mean
(1=Not at All; 5=A Great Deal)

Figure 7. Level of concern with statements about the community regarding HEALTH CARE
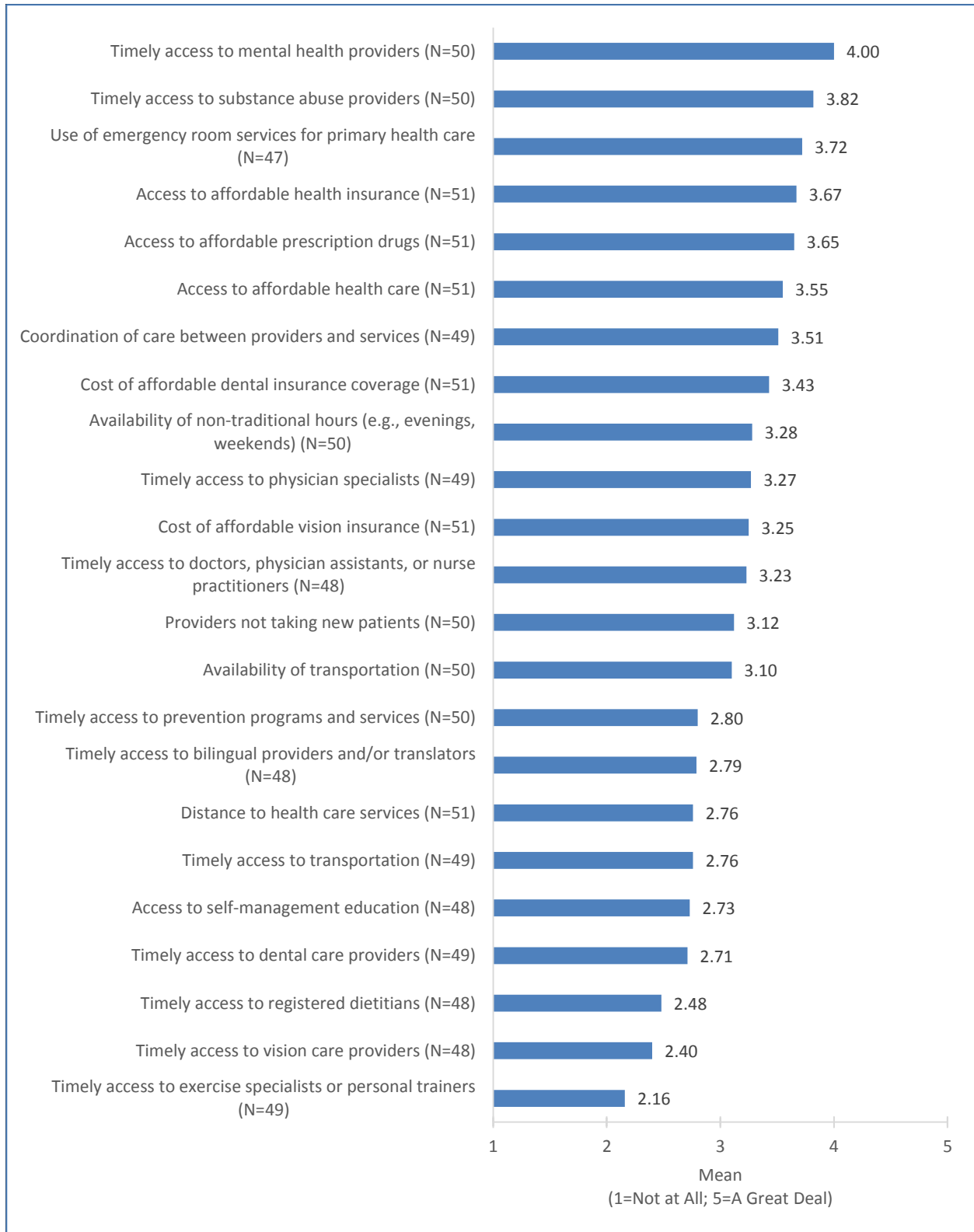
Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH
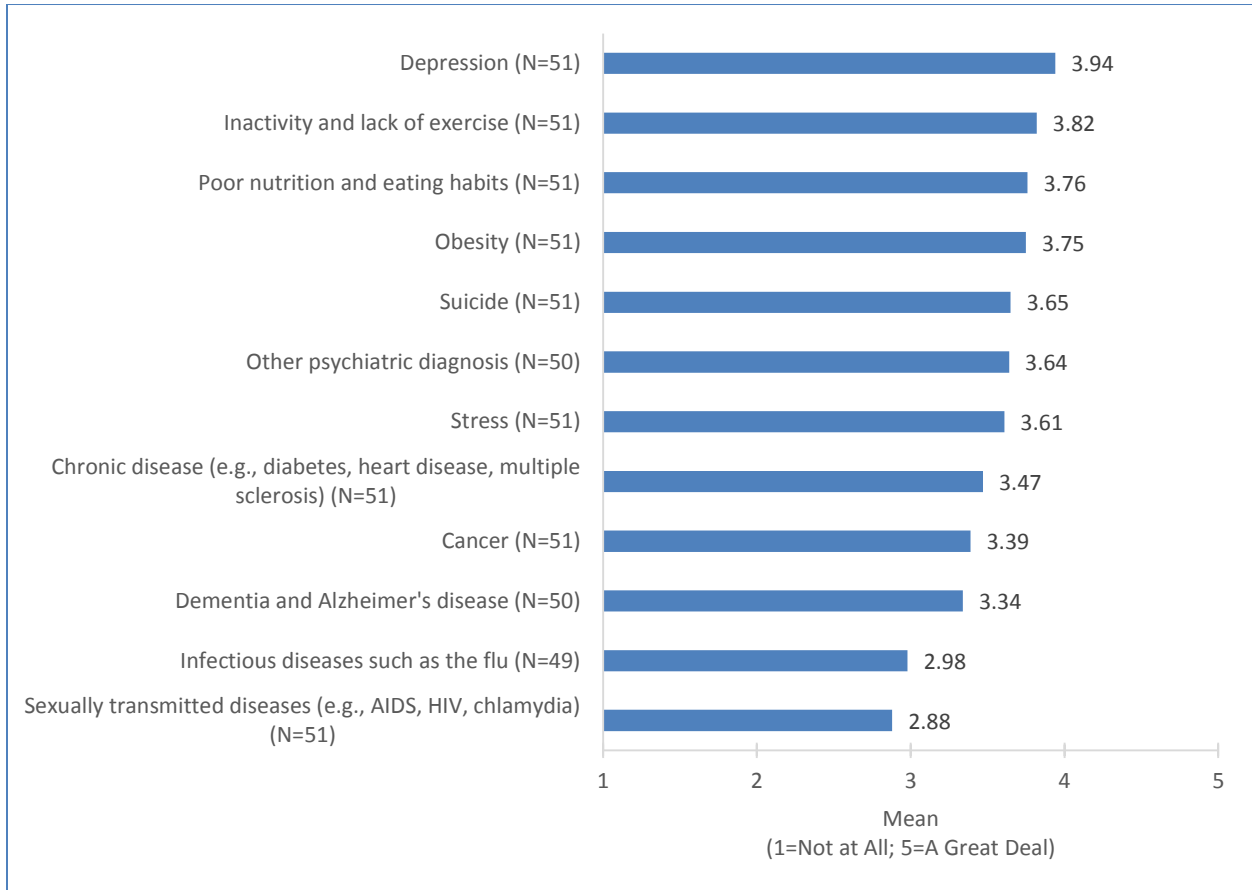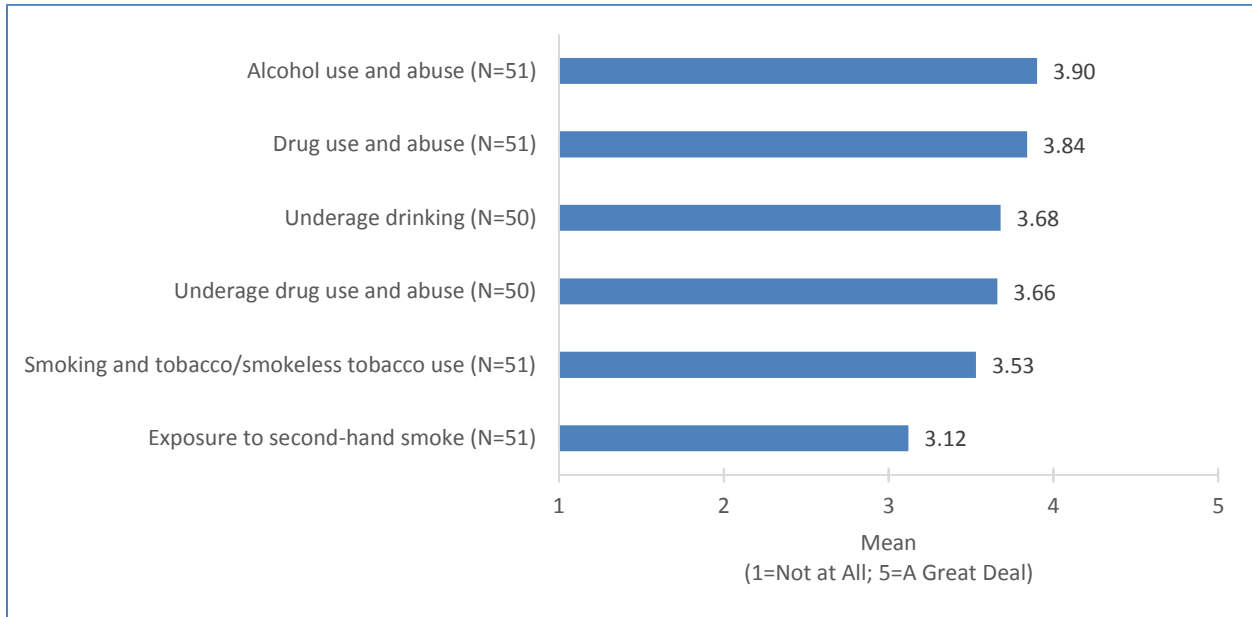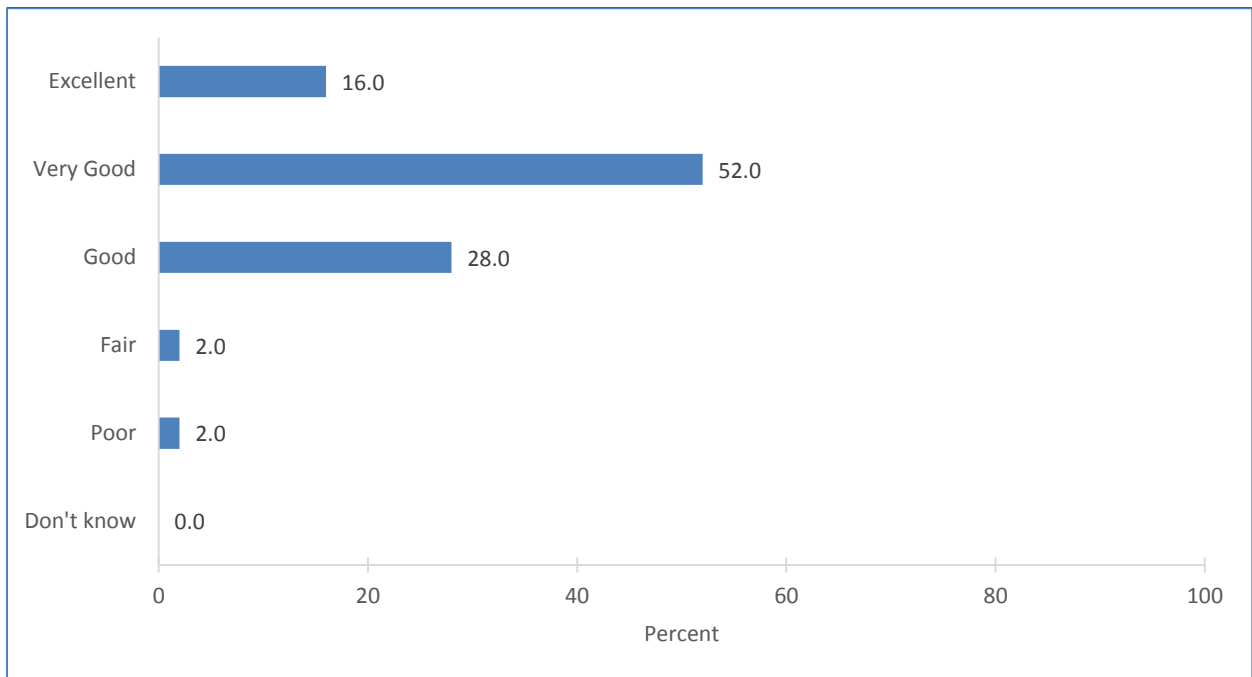
Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE
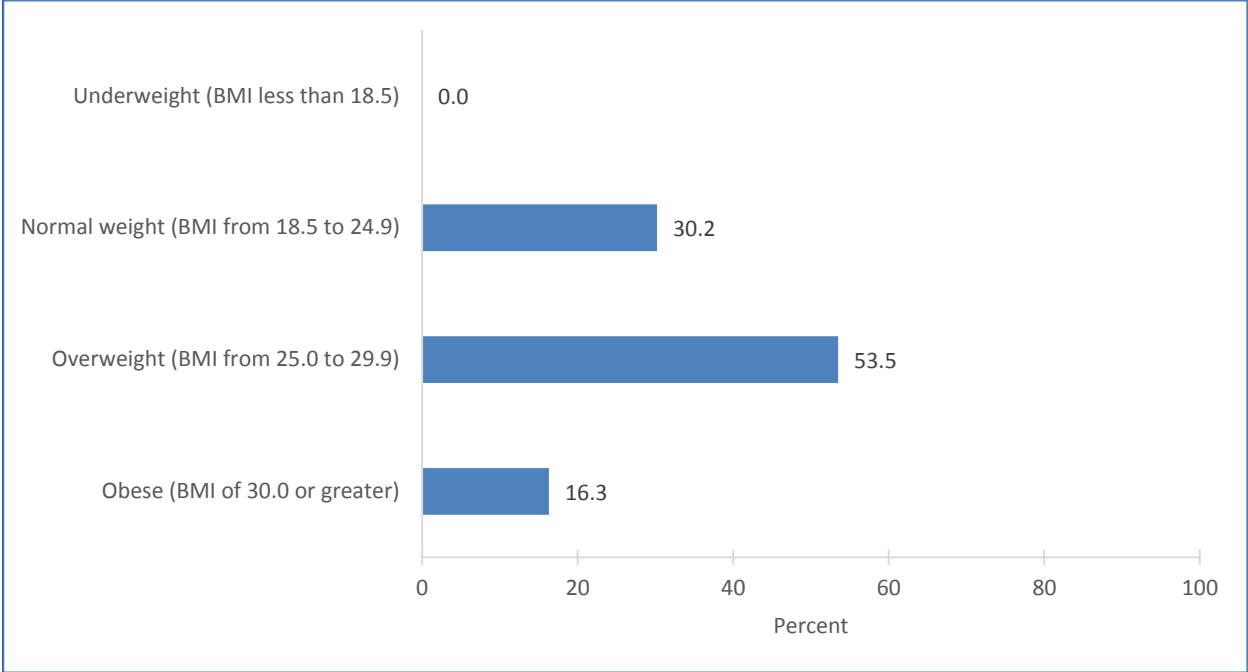

General Health

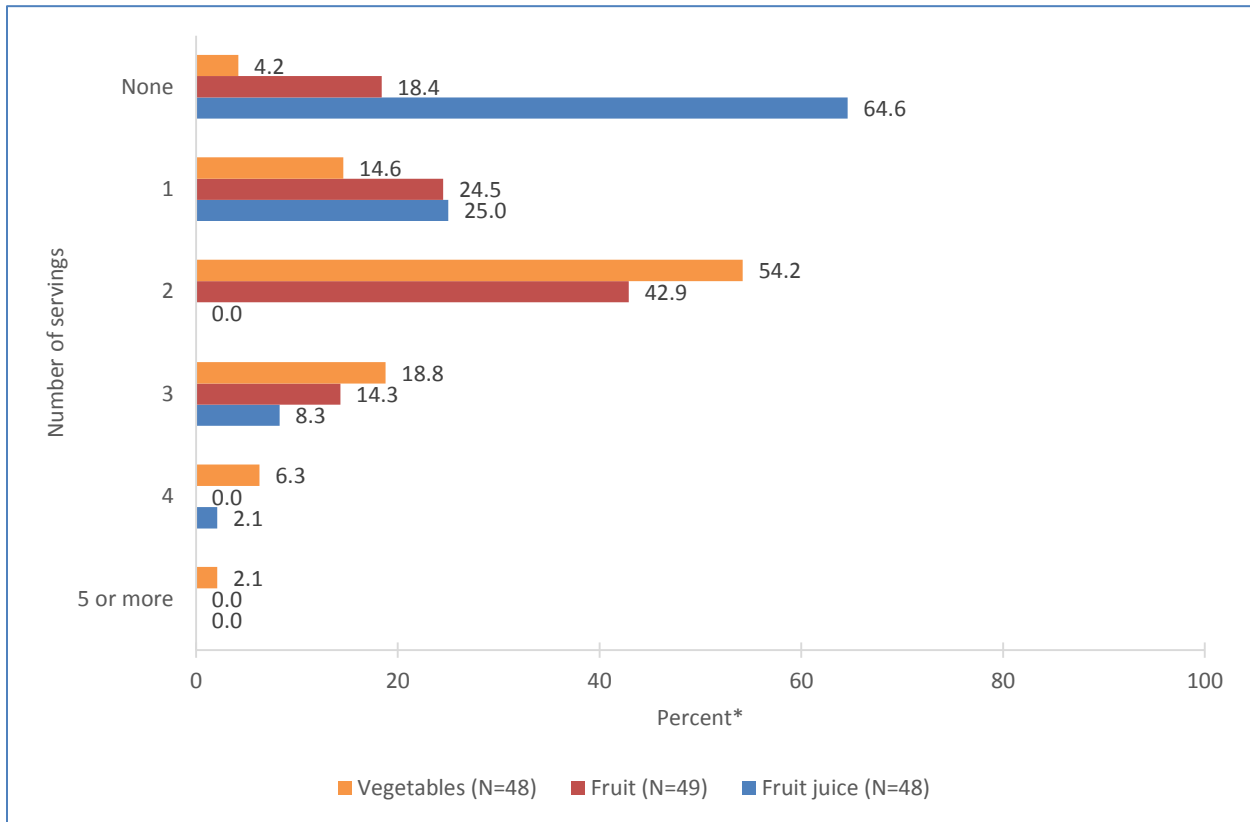Figure 10. Respondents' rating of their health in general

N=50

Figure 11. Respondents' weight status based on the Body Mass Index (BMI) scale
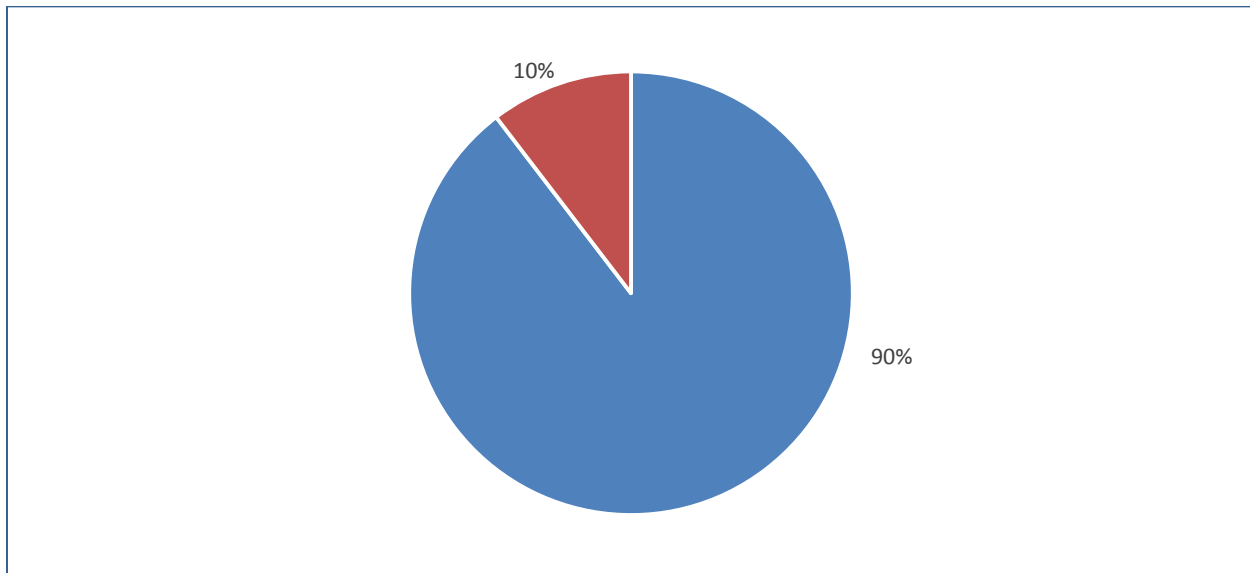

N=43

Figure 12. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday
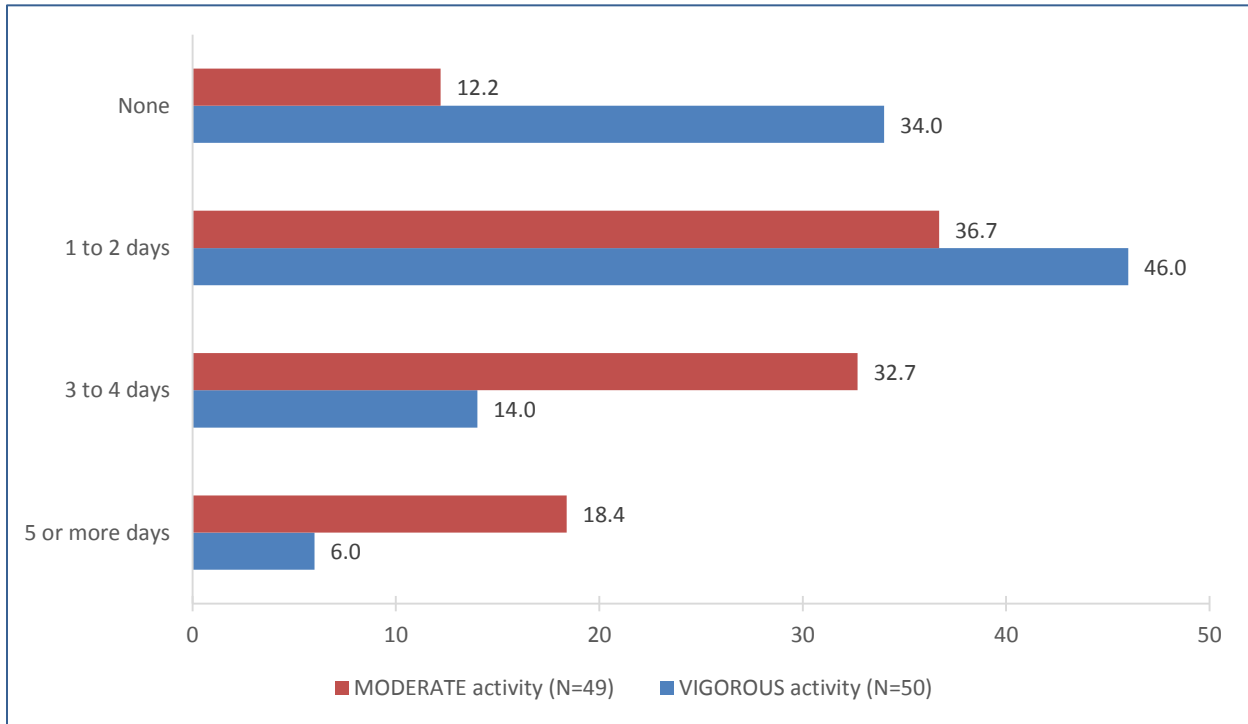

*Percentages may not total 100.0 due to rounding.

Figure 13. Whether respondents, other than their regular job, participated in any physical activity exercises such as running, calisthenics, golf, gardening, or walking for exercise
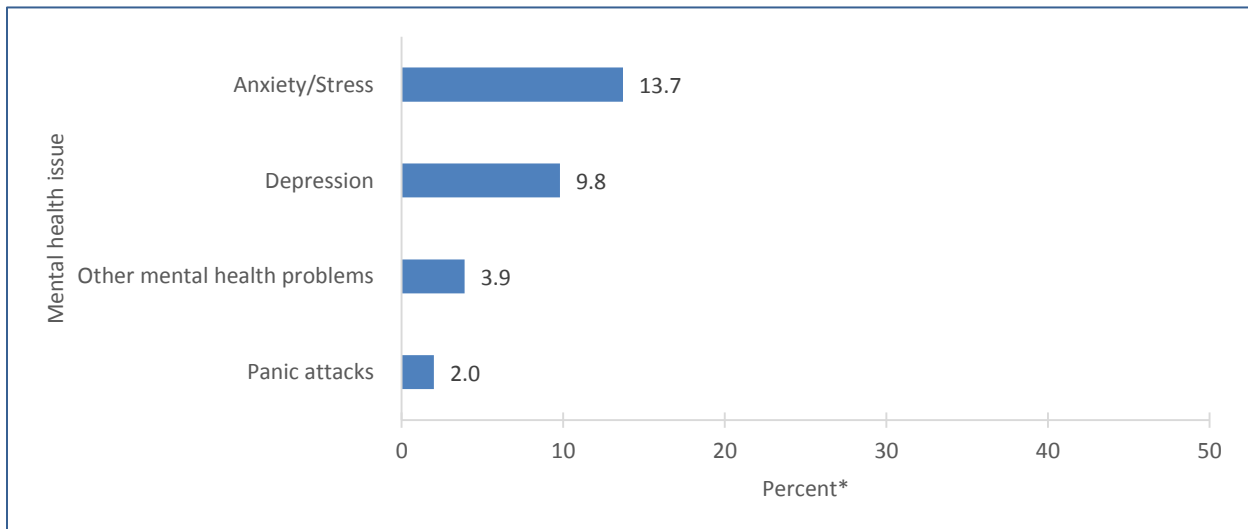

N=48

Figure 14. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity

Legend: MODERATE activity (N=49), VIGOROUS activity (N=50)

| Days	MODERATE activity	VIGOROUS activity
None	12.2	34.0
1 to 2 days	36.7	46.0
3 to 4 days	32.7	14.0
5 or more days	18.4	6.0

Mental Health

Figure 15. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue


Mental health issue	Percent*
Anxiety/Stress	13.7
Depression	9.8
Other mental health problems	3.9
Panic attacks	2.0

N=51

*Percentages do not total 100.0 due to multiple responses

147

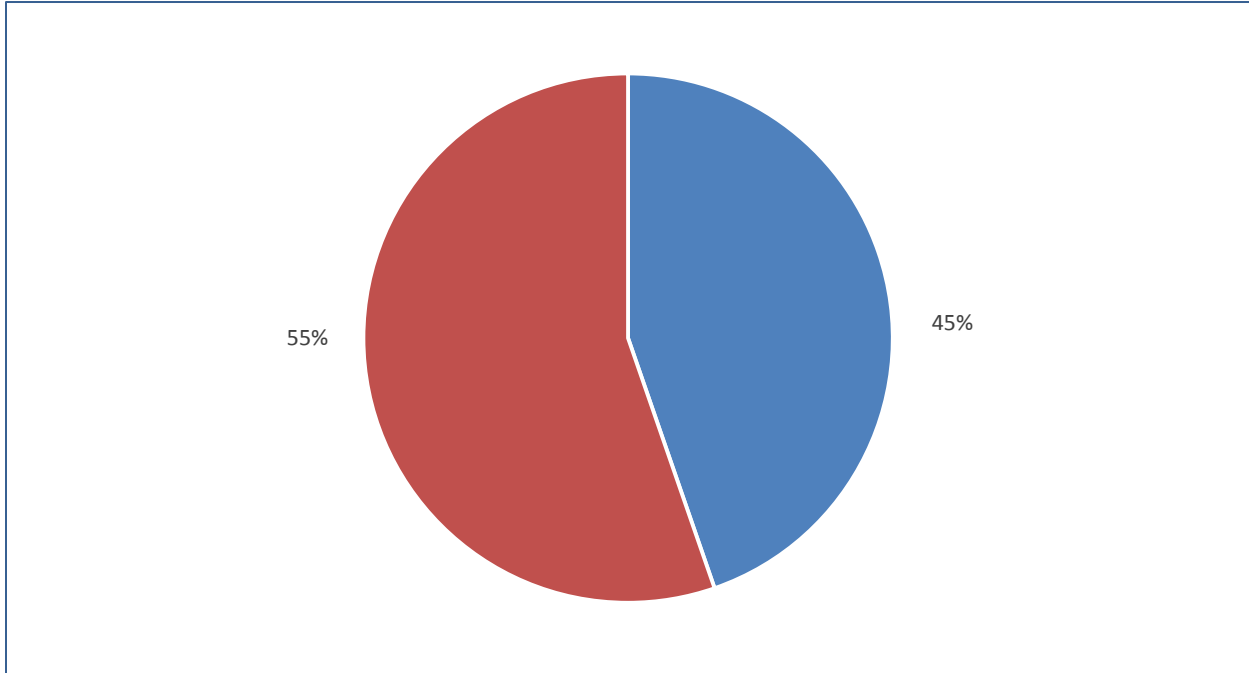Figure 16. Number of days in the last month that respondents' mental health was not good
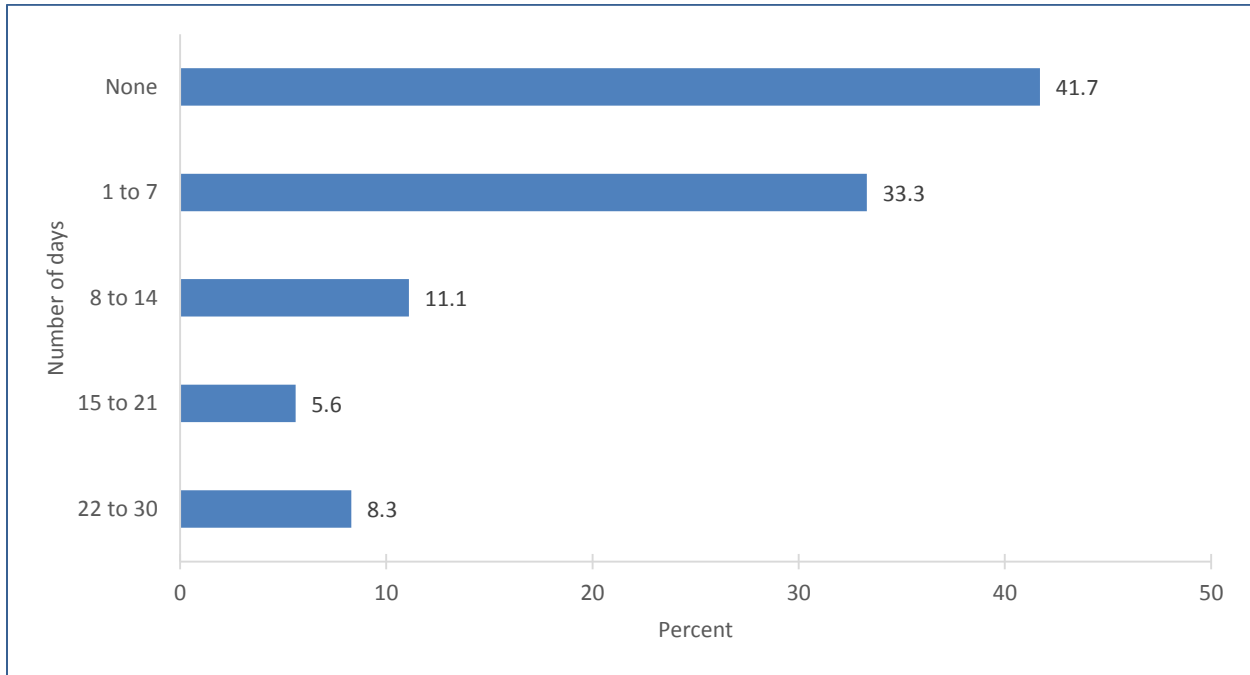
N=36

Figure 17.How often, over the past two weeks, respondents have been bothered by mental health issues
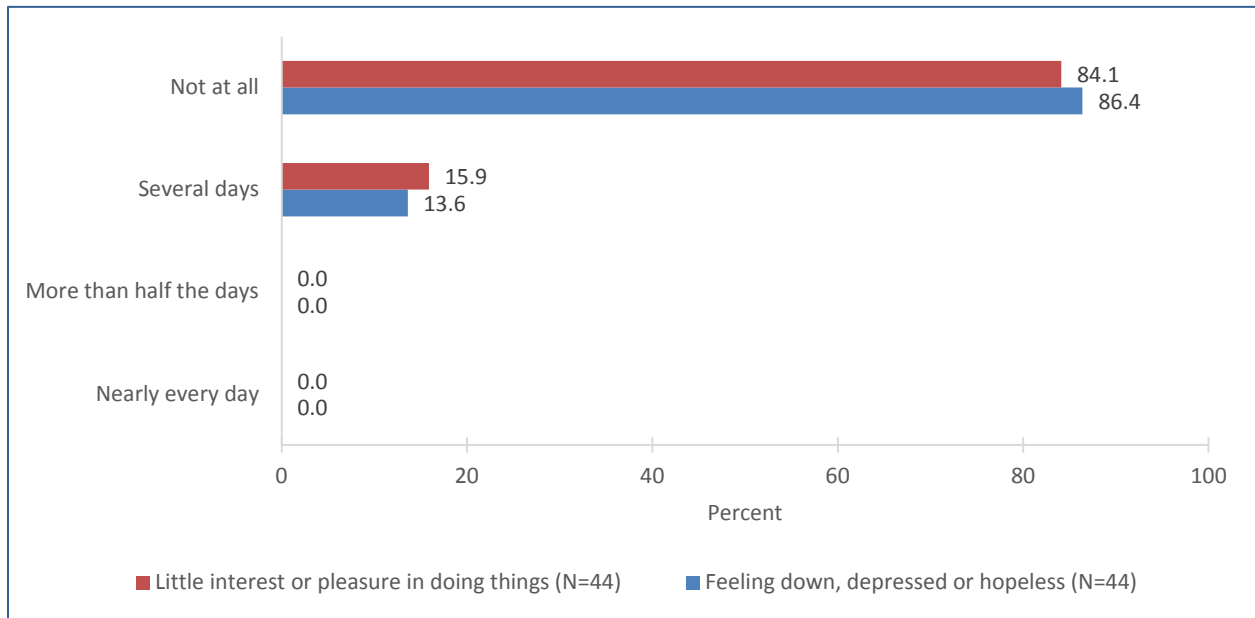
Tobacco Use

Figure 18. Whether respondents have smoked at least 100 cigarettes in their entire life

N=47

Figure 19. How often respondents currently smoke cigarettes and use chewing tobacco or snuff
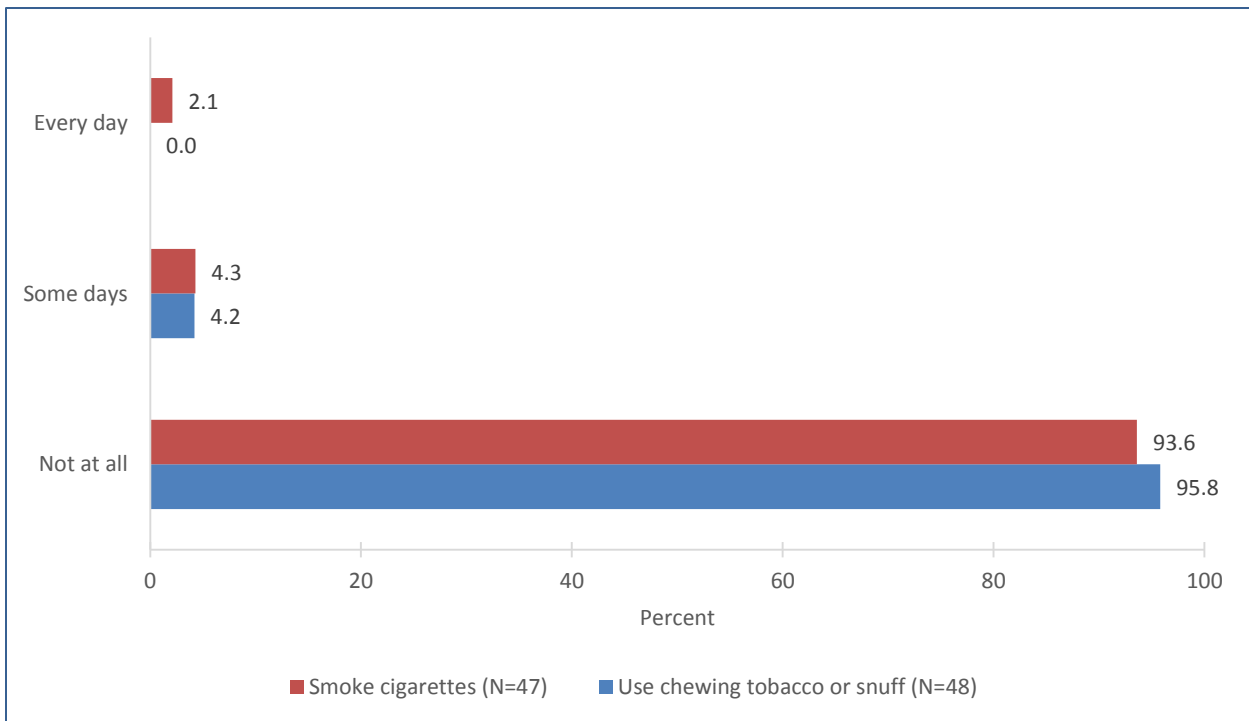
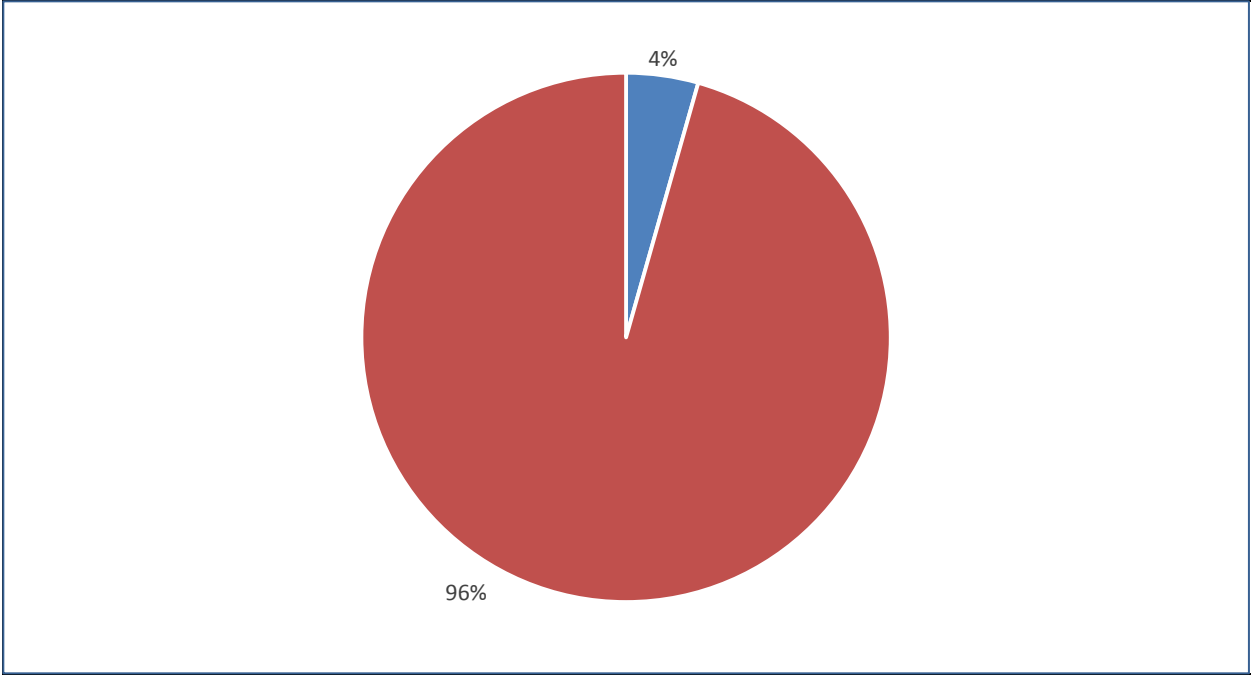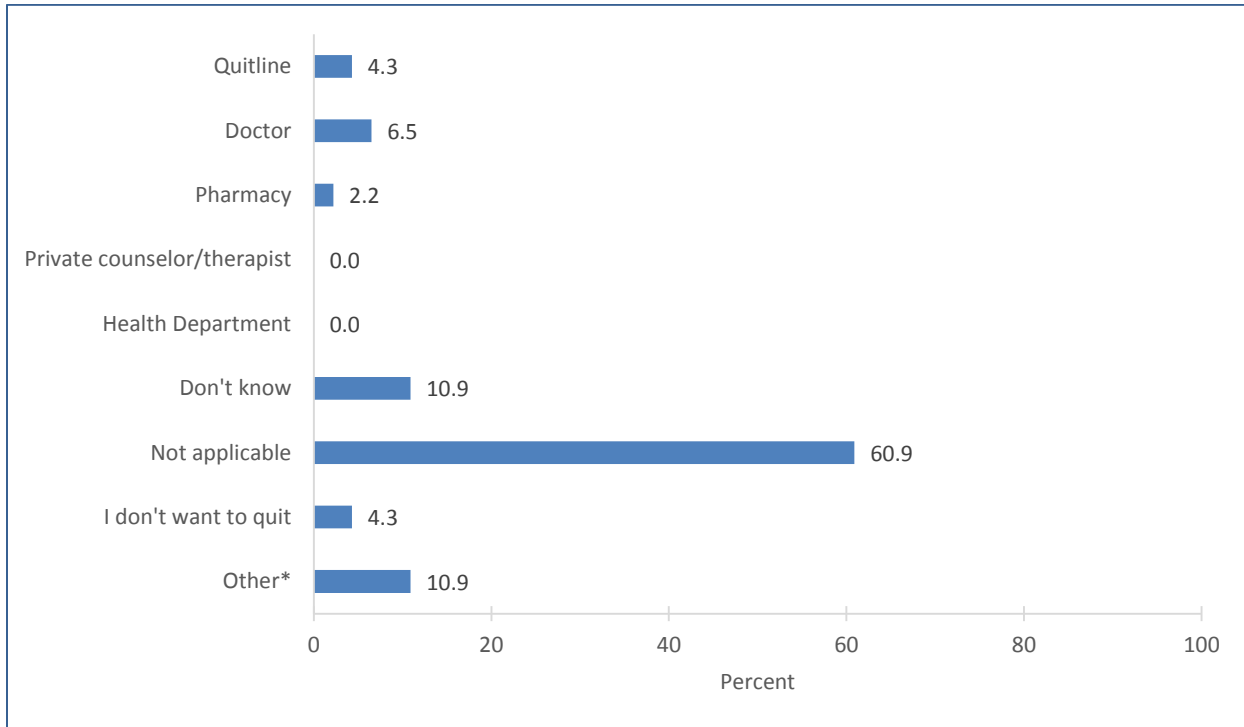Figure 20. Whether respondents, during the past 12 months, have stopped smoking for one day or longer because they were trying to quit

N=45

Figure 21. Location respondents would first go if they wanted help to quit using tobacco

N=46

Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

Figure 22. Number of days during the past month that respondents had at least one drink of any alcoholic beverage
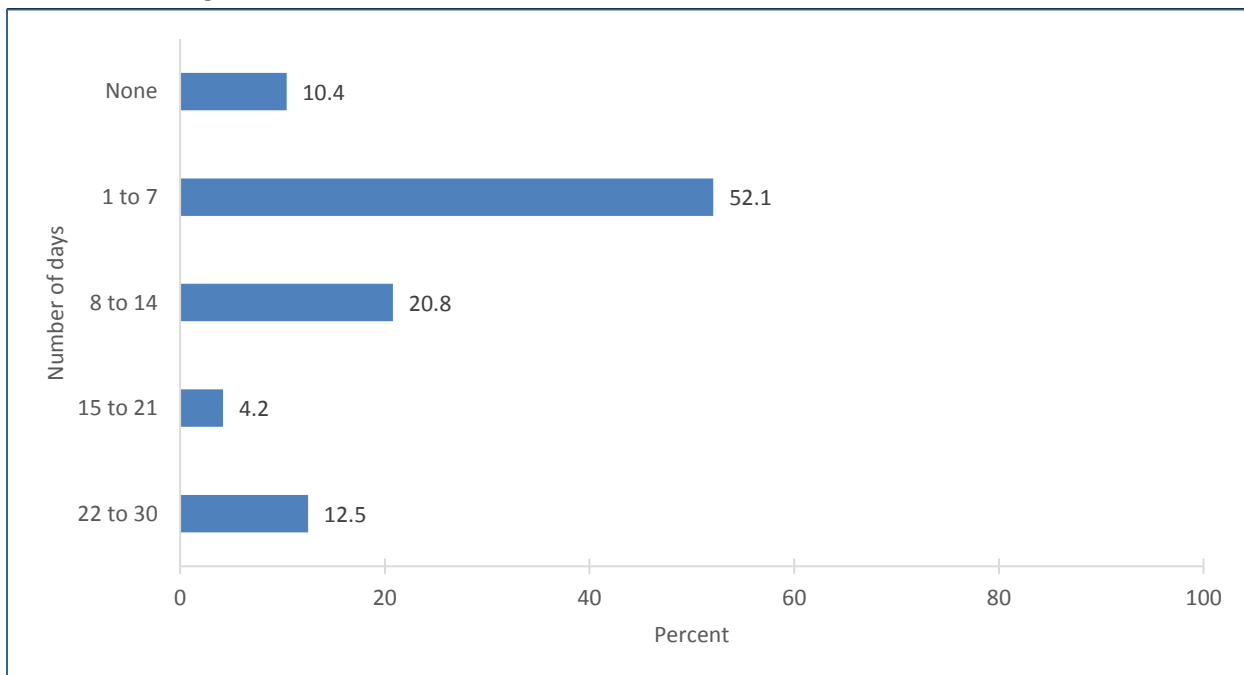
N=48

Figure 23. During the past month on days that respondents drank, average number of drinks per day respondents consumed
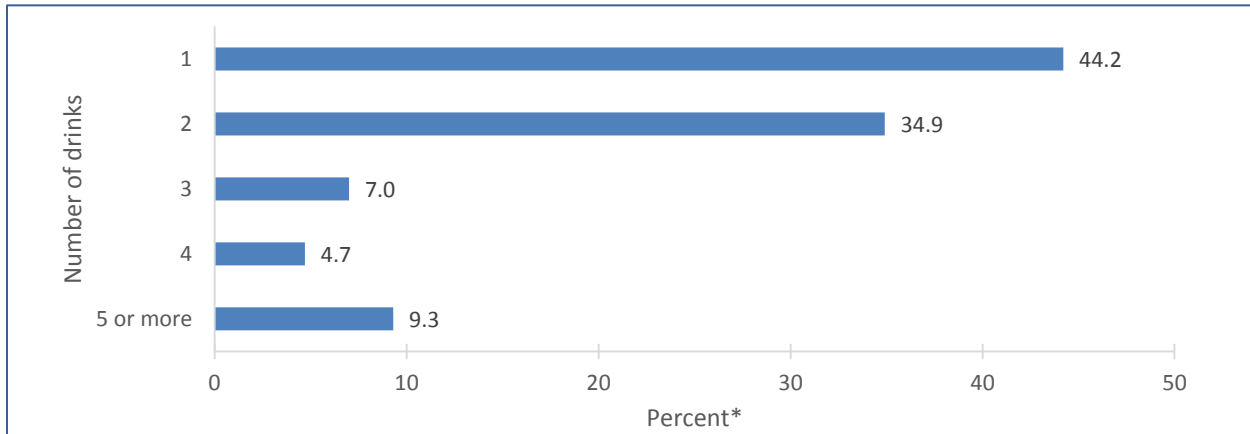
N=43

*Percentages do not total 100.0 due to rounding.

Figure 24. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion

N=48
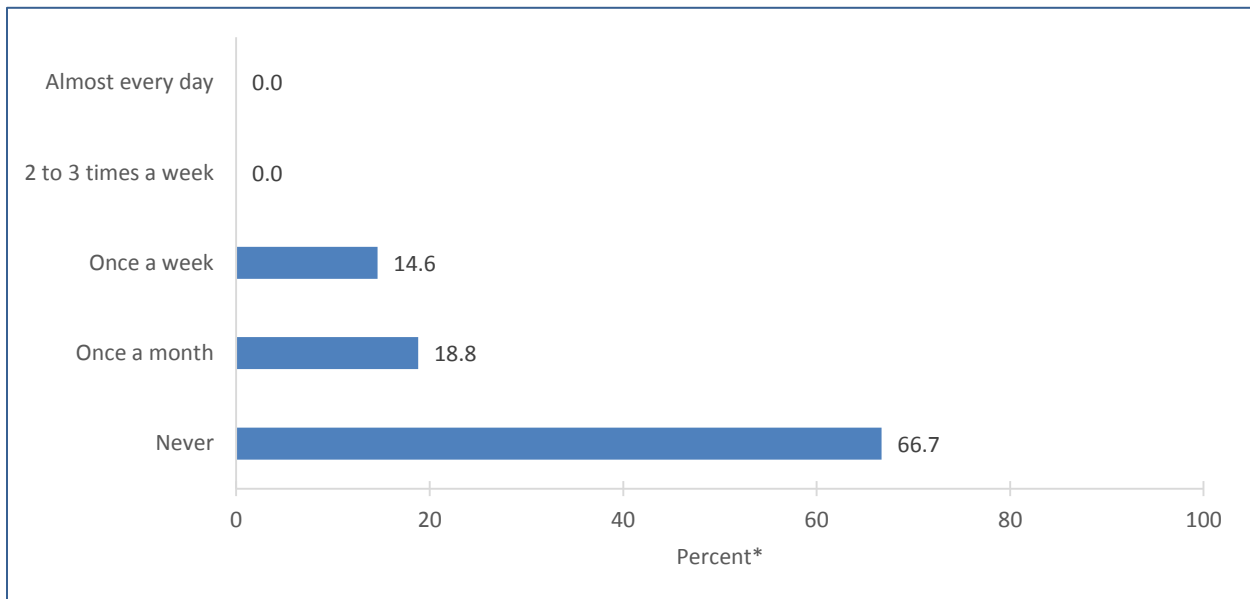
*Percentages do not total 100.0 due to rounding.

Figure 25. Whether respondents have ever had a problem with alcohol use or used prescription medication in ways other than they were prescribed
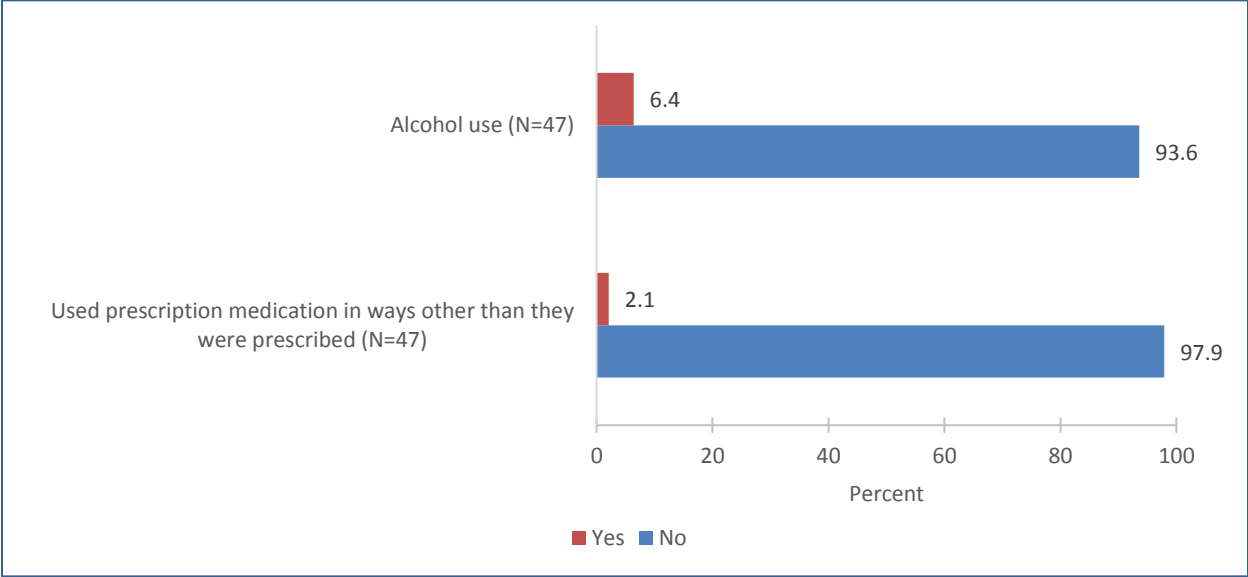
Figure 26. Of respondents who ever had a problem with alcohol use, whether respondents got the help they needed

N=3

Figure 27. Whether alcohol use or prescription or non-prescription drug abuse has caused issues for respondents, their family, or work over the past two years

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Preventive Health

Table 1. Whether or not respondents have had preventive screenings in the past year, by type of screening

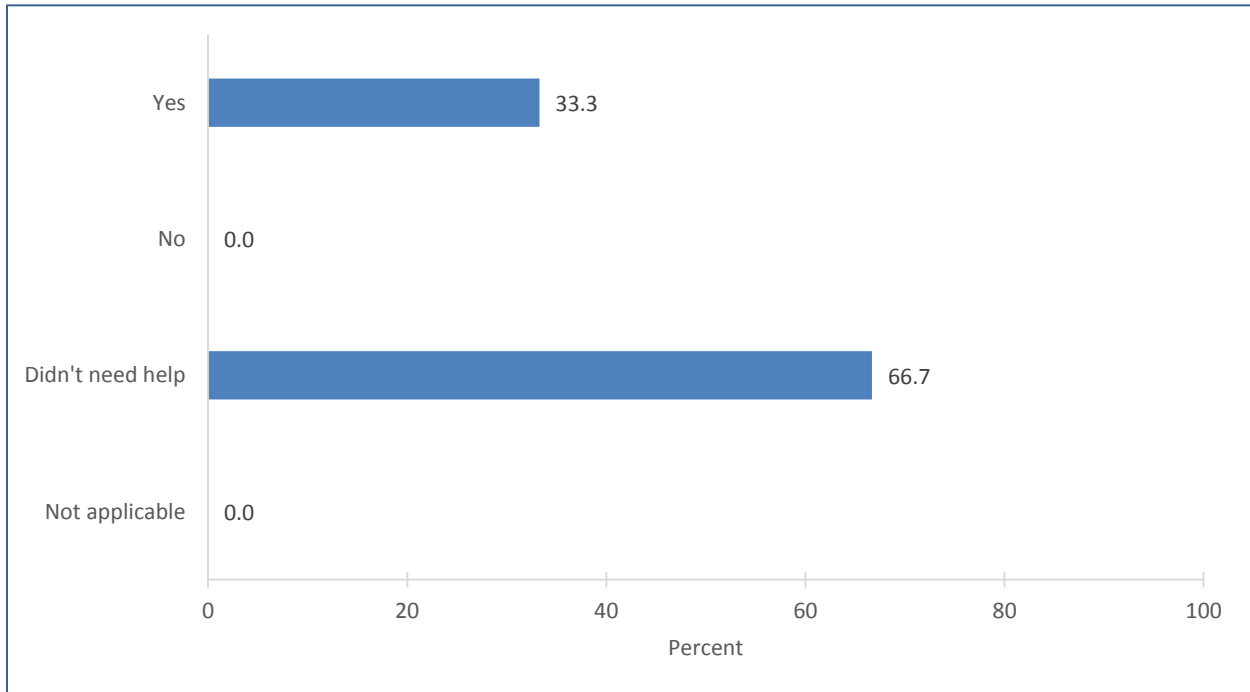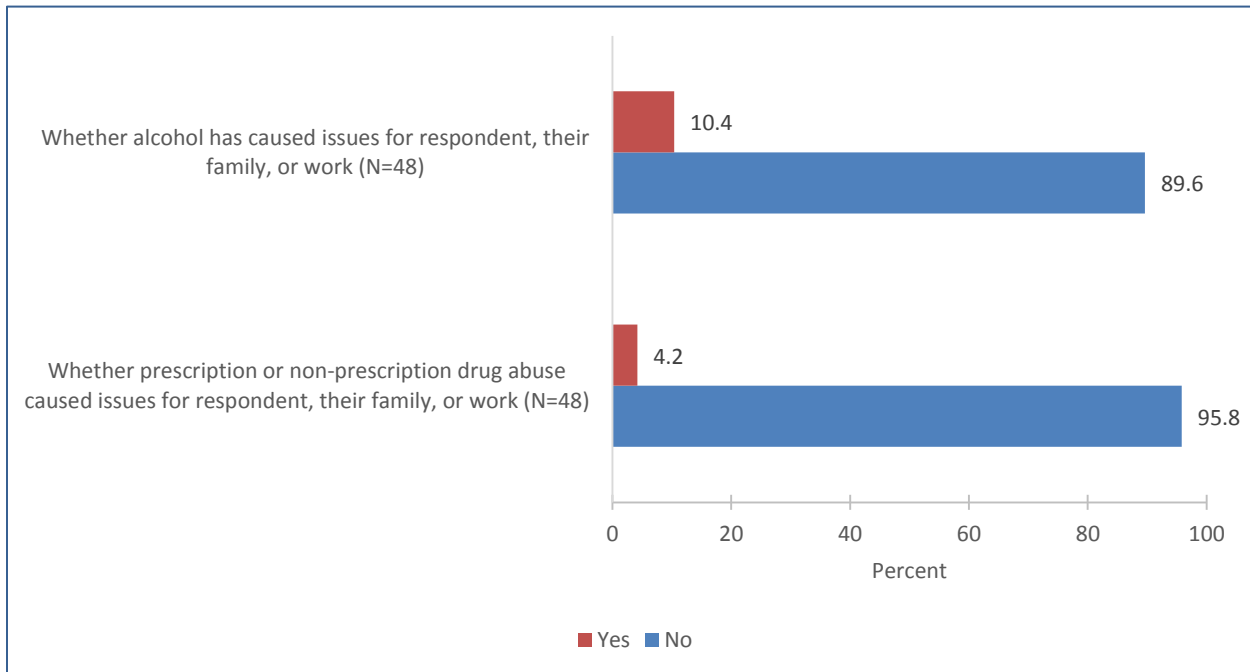| Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=47)	89.4	10.6	100.0
Blood sugar screening (N=47)	68.1	31.9	100.0
Bone density test (N=47)	8.5	91.5	100.0
Cardiovascular screening (N=47)	42.6	57.4	100.0
Cholesterol screening (N=47)	70.2	29.8	100.0
Dental screening and X-rays (N=47)	85.1	14.9	100.0
Flu shot (N=47)	80.9	19.1	100.0
Glaucoma test (N=47)	51.1	48.9	100.0
Hearing screening (N=47)	14.9	85.1	100.0
Immunizations (N=47)	42.6	57.4	100.0
Pelvic exam (N=23 Females)	73.9	26.1	100.0
STD (N=46)	6.5	93.5	100.0
Vascular screening (N=46)	17.4	82.6	100.0
CANCER SCREENINGS			
Breast cancer screening (N=23 Females)	73.9	26.1	100.0
Cervical cancer screening (N=22 Females)	63.6	36.4	100.0
Colorectal cancer screening (N=45)	40.0	60.0	100.0
Prostate cancer screening (N=22 Males)	59.1	40.9	100.0
Skin cancer screening (N=43)	37.2	62.8	100.0

Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=5)	60.0	20.0	0.0	0.0	20.0	0.0	0.0
Blood sugar screening (N=15)	46.7	13.3	6.7	0.0	6.7	0.0	20.0
Bone density test (N=43)	48.8	34.9	4.7	0.0	0.0	0.0	7.0
Cardiovascular screening (N=27)	51.9	25.9	0.0	0.0	0.0	0.0	11.1
Cholesterol screening (N=14)	50.0	14.3	7.1	0.0	0.0	0.0	21.4
Dental screening and X-rays (N=7)	28.6	0.0	14.3	0.0	0.0	0.0	42.9
Flu shot (N=9)	44.4	0.0	0.0	0.0	0.0	0.0	44.4
Glaucoma test (N=23)	43.5	21.7	0.0	0.0	0.0	0.0	17.4

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Hearing screening (N=40)	52.5	35.0	0.0	0.0	0.0	0.0	7.5
Immunizations (N=27)	59.3	11.1	0.0	0.0	0.0	0.0	11.1
Pelvic exam (N=6 Females)	33.3	0.0	0.0	0.0	0.0	0.0	33.3
STD (N=43)	60.5	9.3	0.0	0.0	0.0	0.0	9.3
Vascular screening (N=38)	47.4	34.2	0.0	0.0	0.0	0.0	10.5
CANCER SCREENINGS							
Breast cancer screening (N=6 Females)	83.3	33.3	0.0	0.0	0.0	0.0	16.7
Cervical cancer screening (N=8 Females)	62.5	12.5	0.0	0.0	0.0	0.0	25.0
Colorectal cancer screening (N=27)	74.1	18.5	0.0	0.0	0.0	0.0	3.7
Prostate cancer screening (N=9 Males)	77.8	22.2	0.0	0.0	0.0	0.0	0.0
Skin cancer screening (N=27)	44.4	44.4	0.0	0.0	0.0	0.0	14.8

*Percentages may not total 100.0 due to multiple responses.

Figure 28. Whether respondents have any of the following chronic diseases

N=51
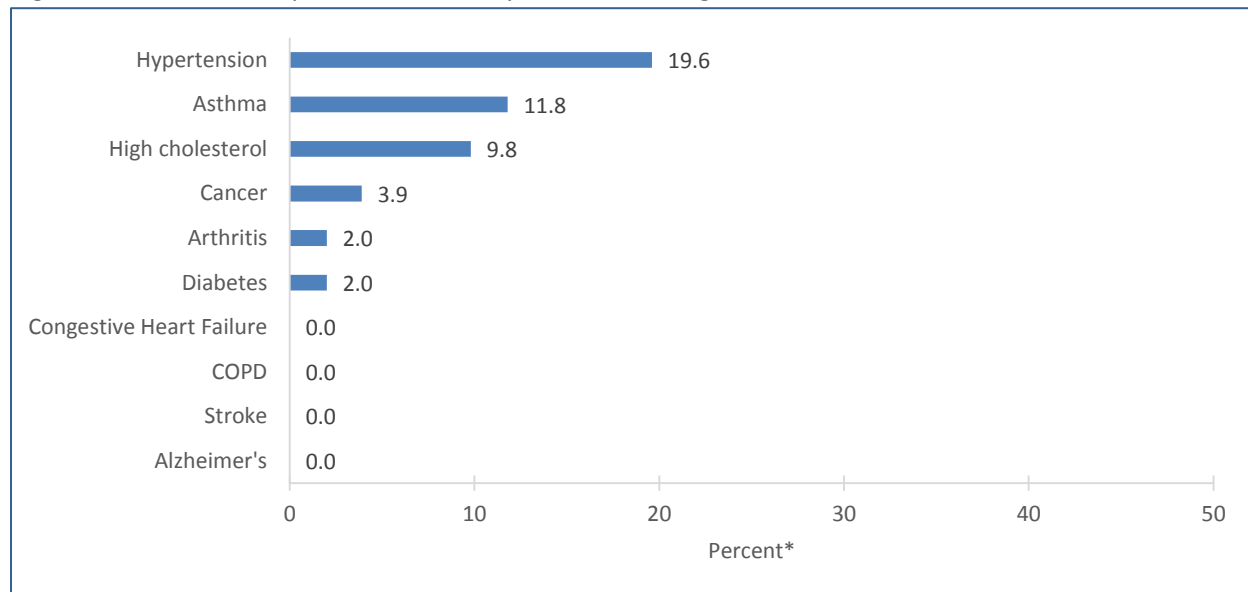
*Percentages do not total 100.0 due to multiple responses.

Figure 29. Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason
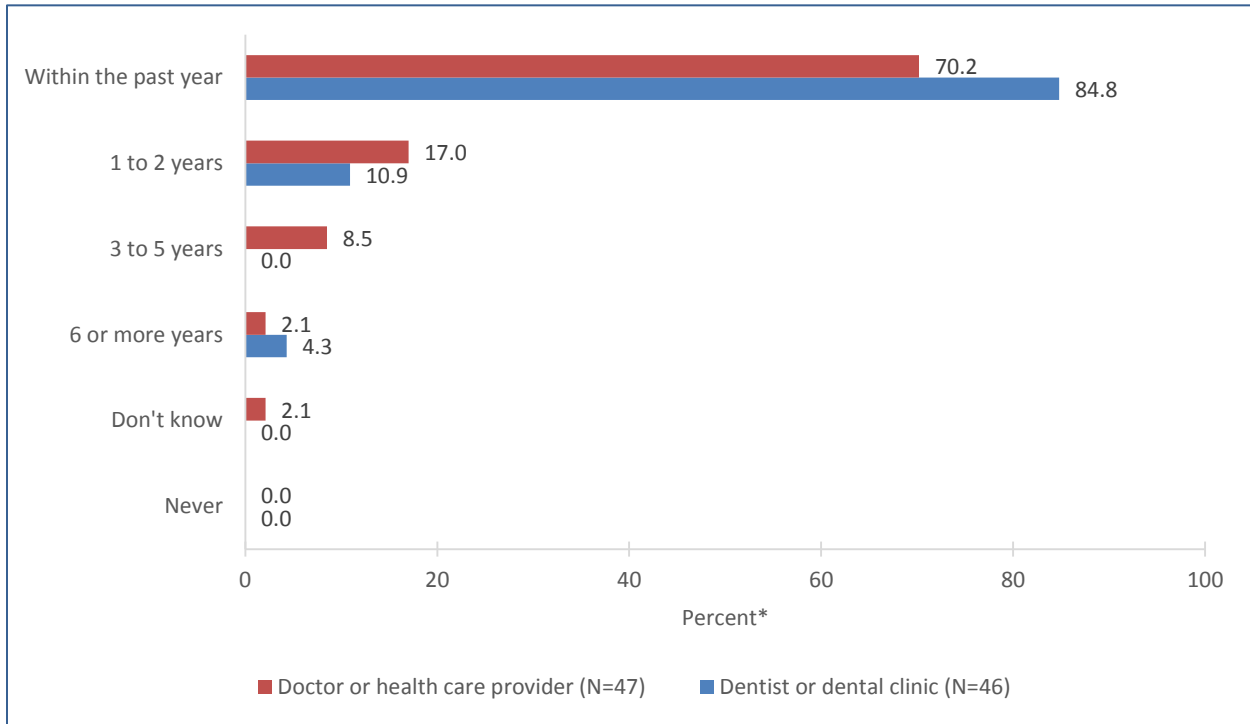
*Percentages may not total 100.0 due to rounding.

Figure 30. Where respondents get most of their health information

N=51
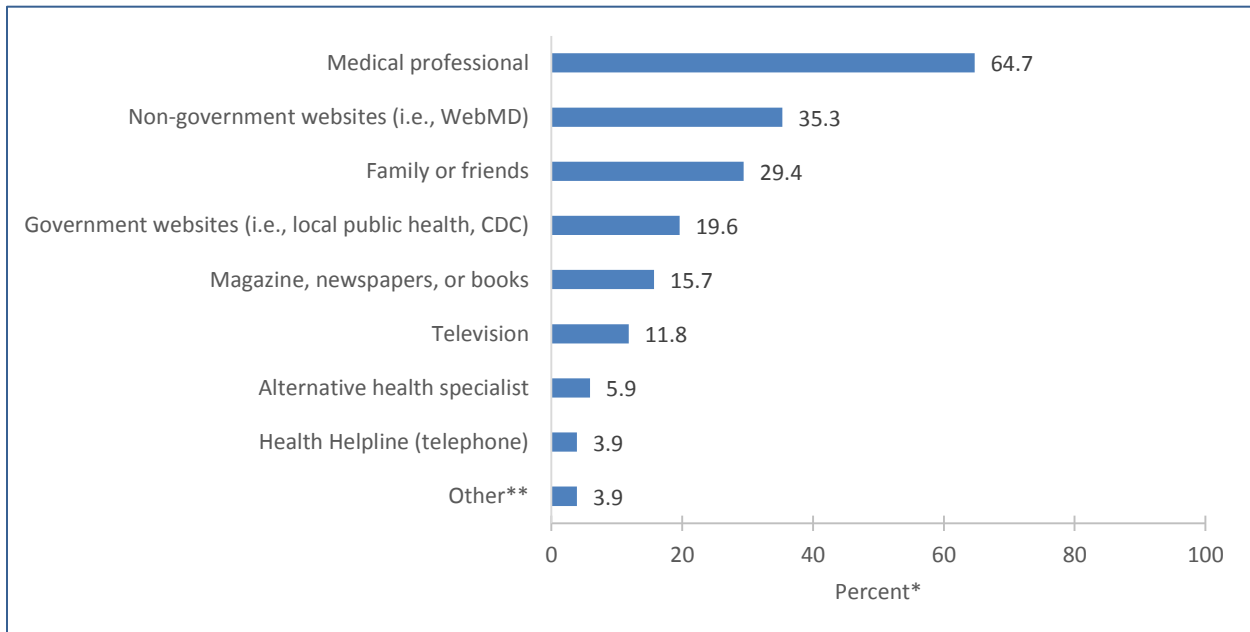
*Percentages do not total 100.0 due to multiple responses.

Figure 31. Best way for respondents to access technology for health information
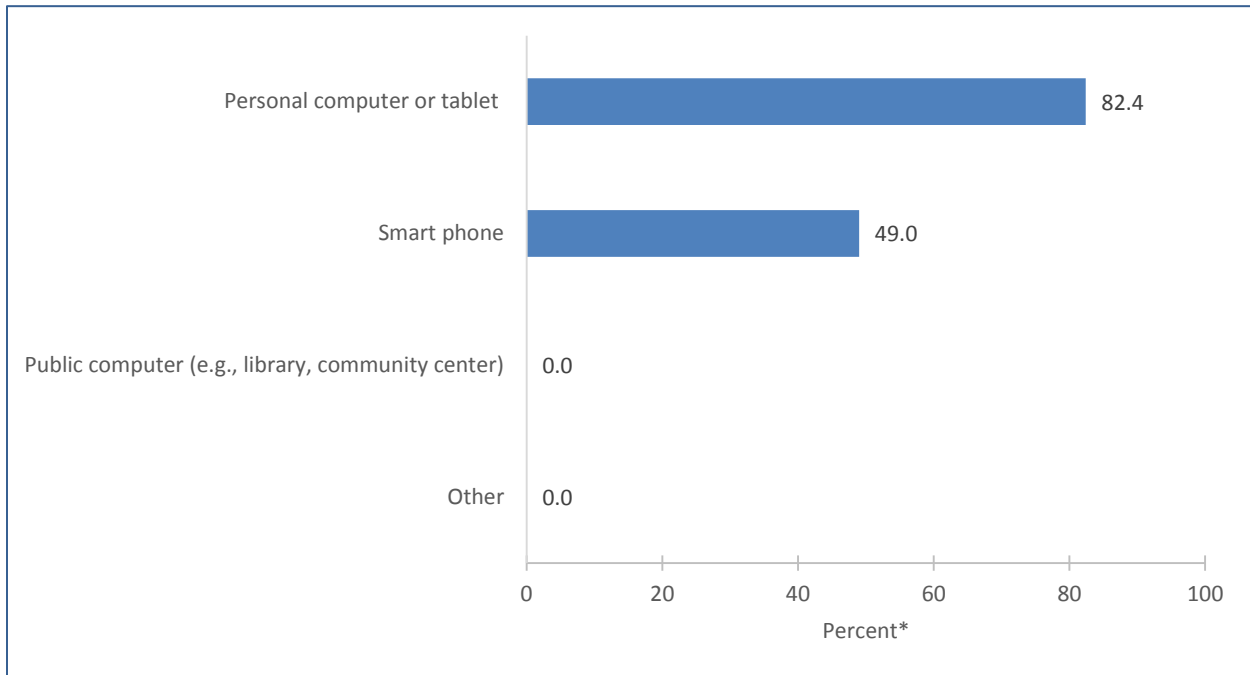
N=51

*Percentages do not total 100.0 due to multiple responses.

Demographic Information

Figure 32. Age of respondents
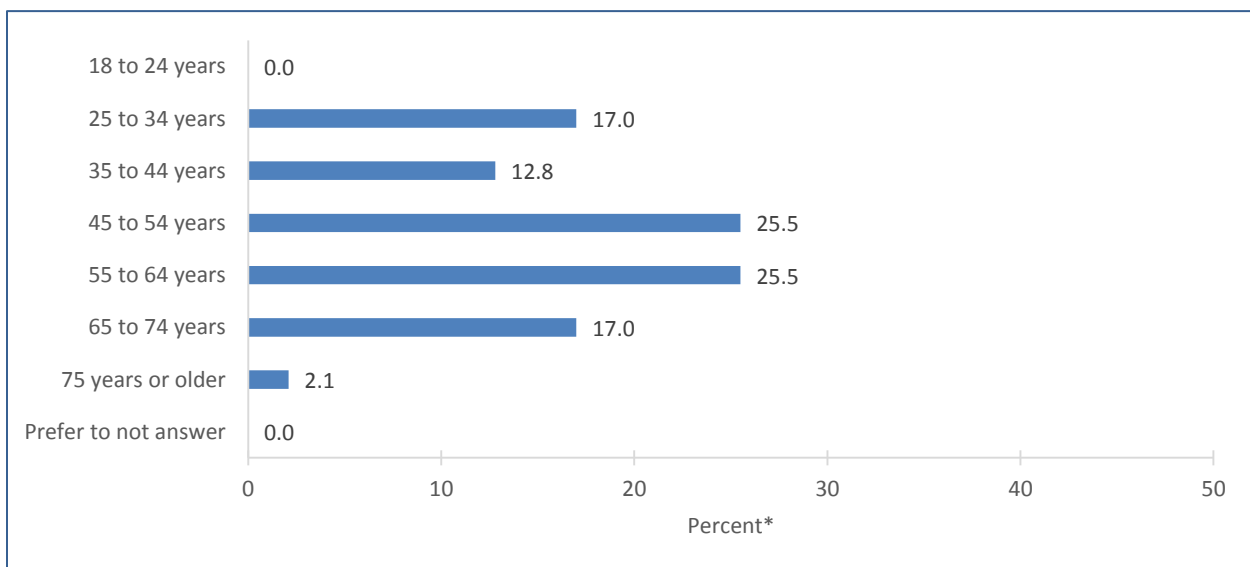
N=47

*Percentages do not total 100.0 due to rounding.

Figure 33. Highest level of education of respondents

Education Level	Percent*
Some high school	0.0
High school diploma or GED	4.2
Some college, no degree	2.1
Associate's degree	2.1
Bachelor's degree	31.3
Graduate or professional degree	58.3
Prefer to not answer	2.1
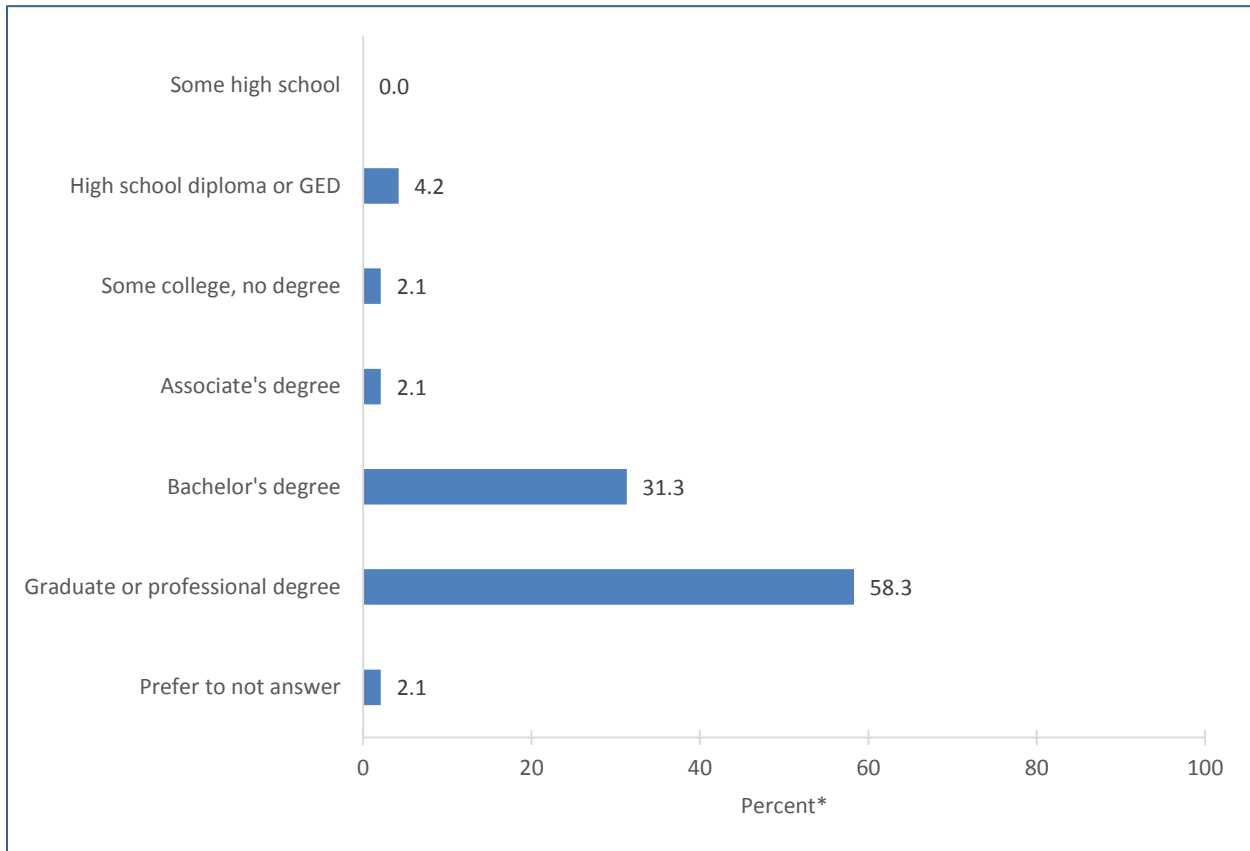
N=48   *Percentages do not total 100.0 due to rounding

Figure 34. Gender of respondents
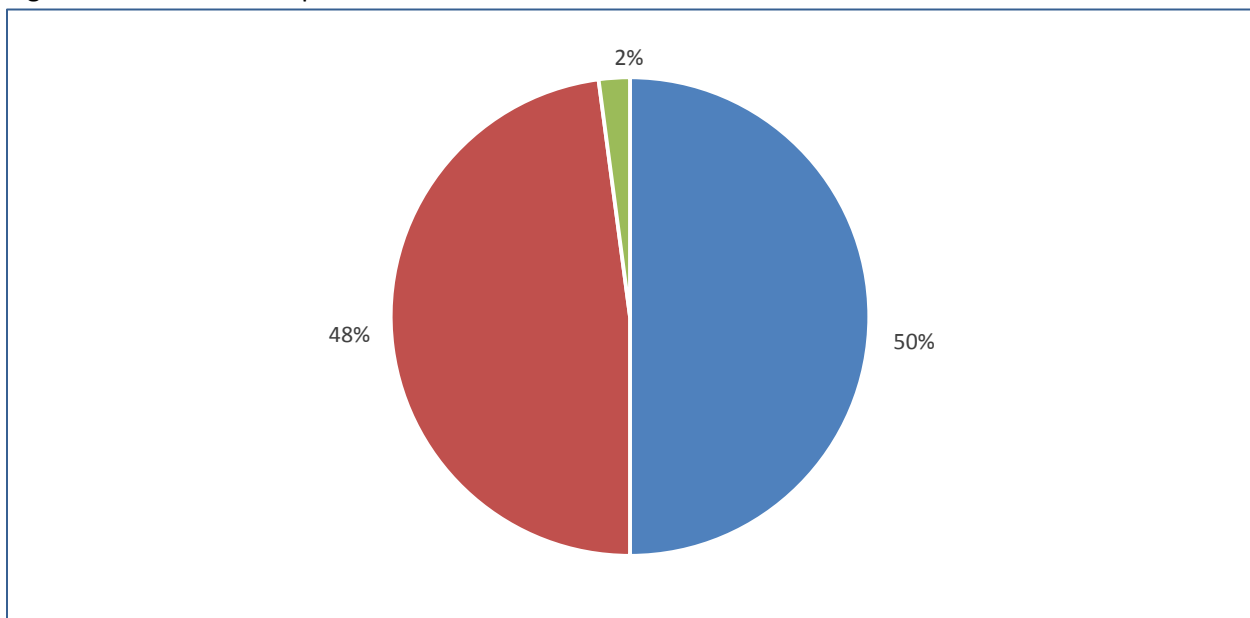
N=48

Figure 35. Race and ethnicity of respondents

N=51
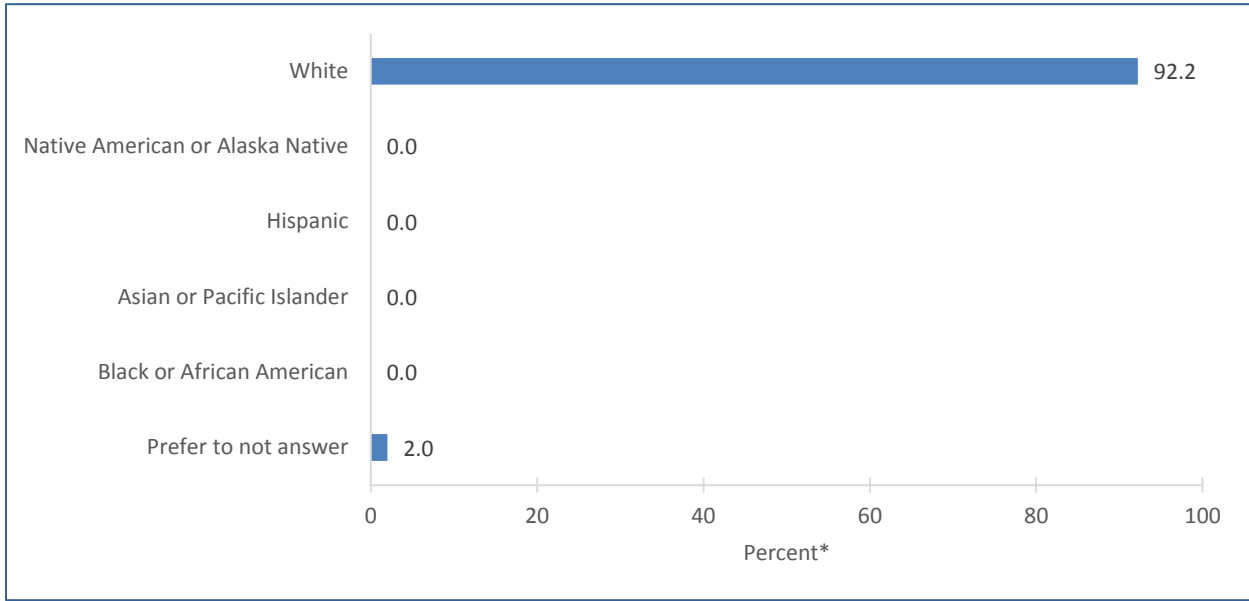
*Percentages do not total 100.0 due to multiple responses.

Figure 36. Annual household income of respondents
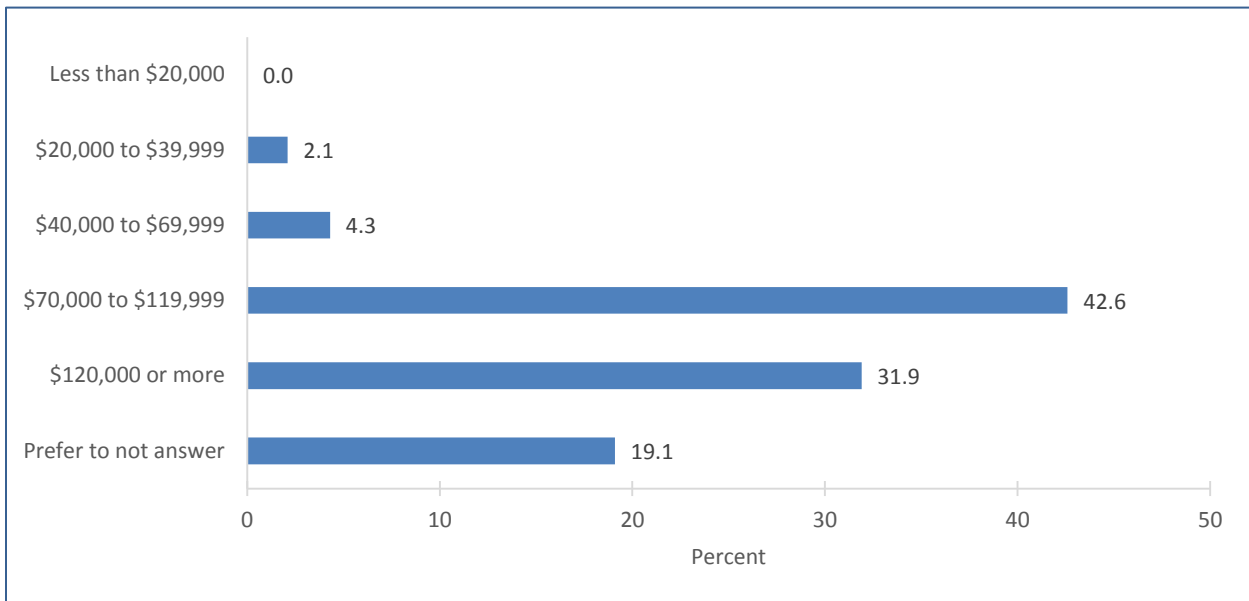
N=47

Figure 37. Employment status of respondents
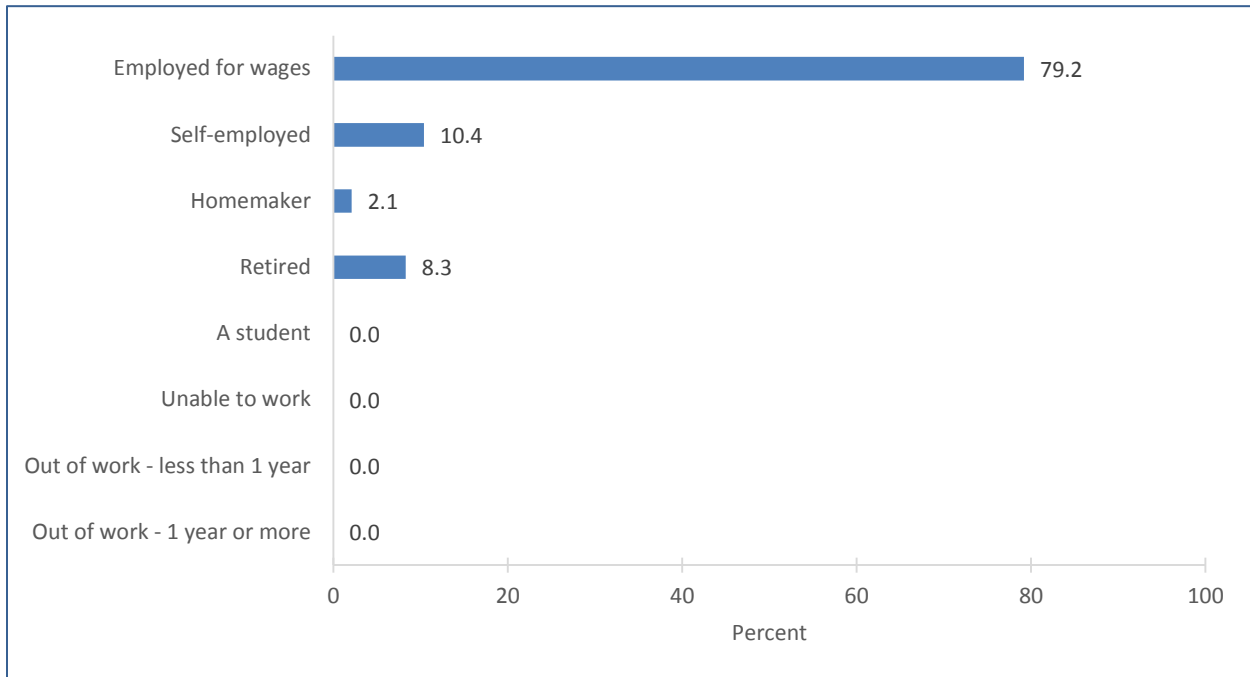
N=48

Figure 38. Length of time respondents have lived in their community
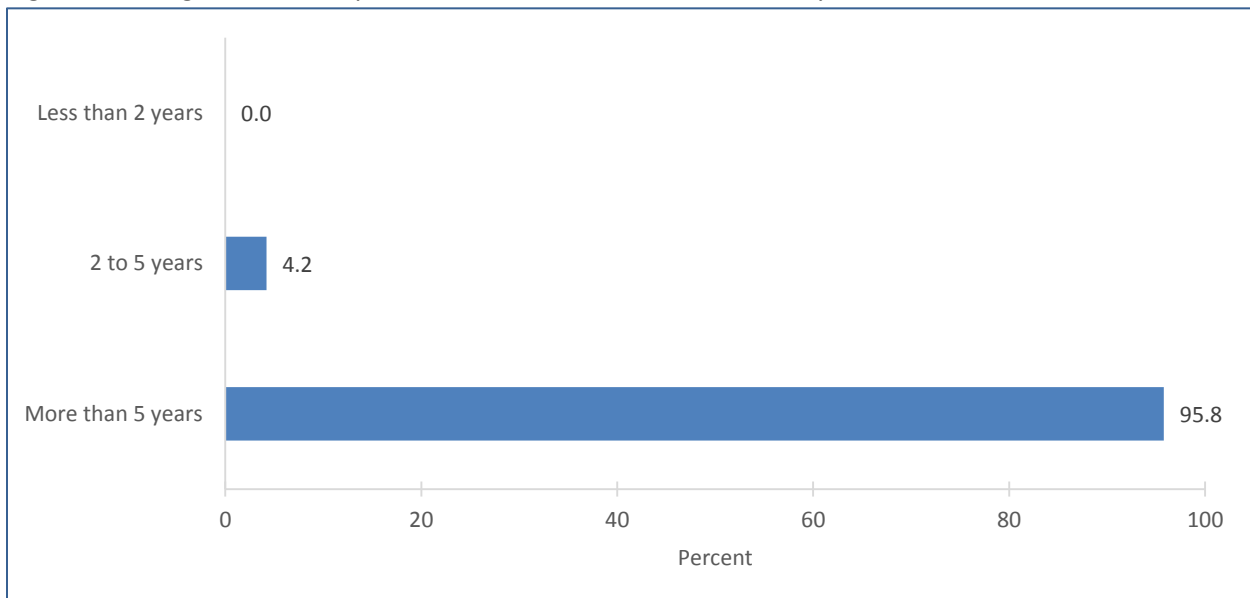
N=48

Figure 39. Whether respondents own or rent their home

N=48
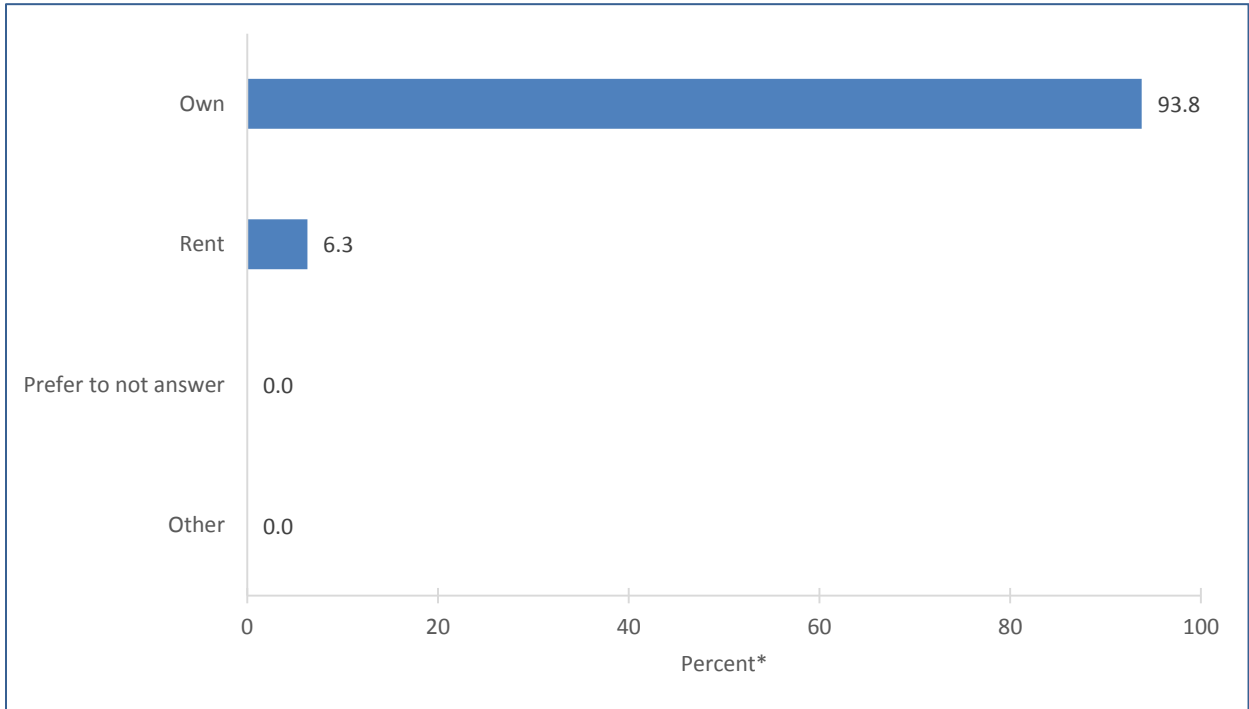
*Percentages do not total 100.0 due to rounding.

Figure 40. Whether respondents have health insurance (private, public, or governmental) and oral health or dental care insurance coverage

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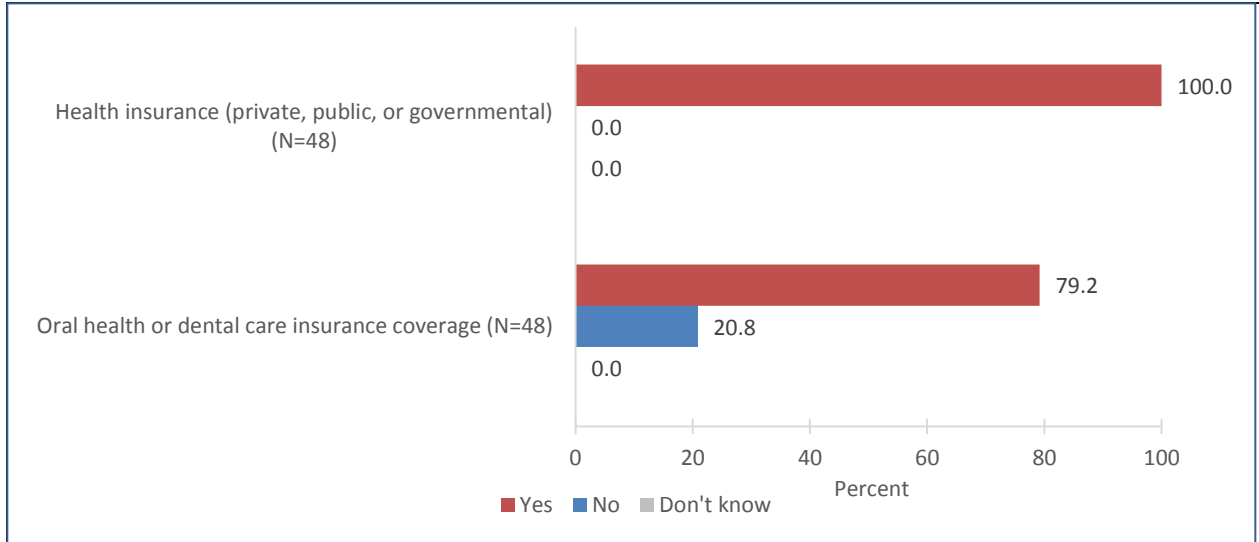
Figure 41. Whether respondents have one person who they think of as their personal doctor or health care provider

Yes, only one — 56.3
Yes, more than one — 22.9
No — 20.8
Don't know — 0.0

Percent
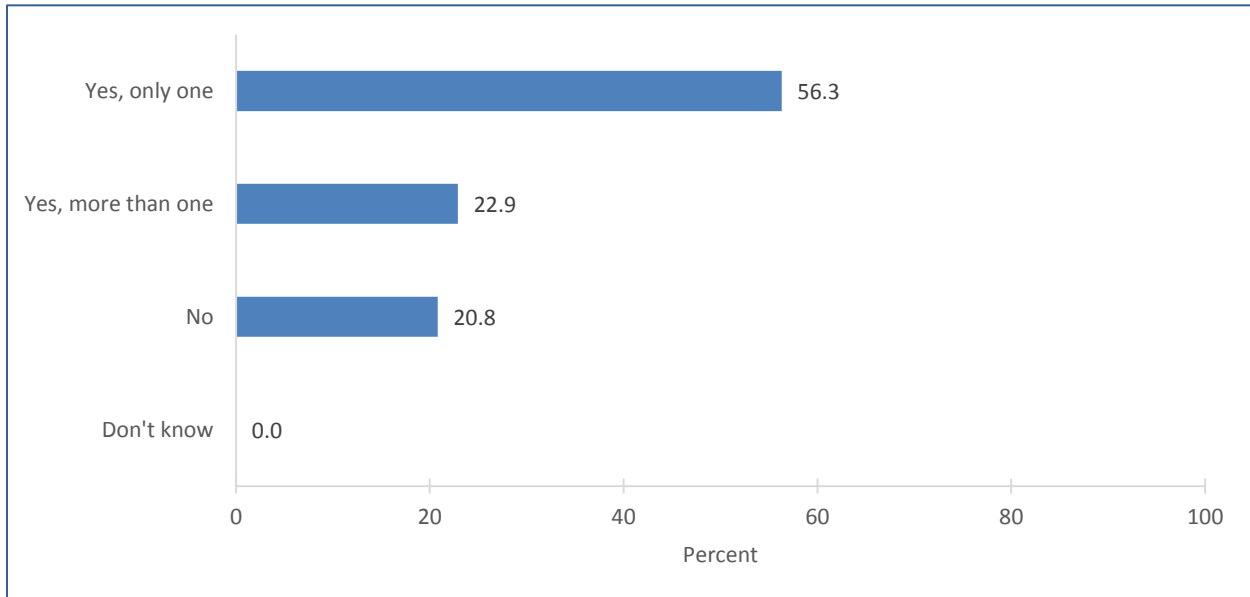
N=48

Figure 42. Facilities that respondents go to most often when sick and take their children when they are sick

Physician's office — 62.5 / 77.8
Urgent care — 37.5 / 22.2
Public Health Department — 0.0 / 0.0
Hospital emergency room — 0.0 / 0.0
Other free or discounted clinic — 0.0 / 0.0

Percent

■ Where respondents go (N=48) ■ Where respondents take their children (N=18)*
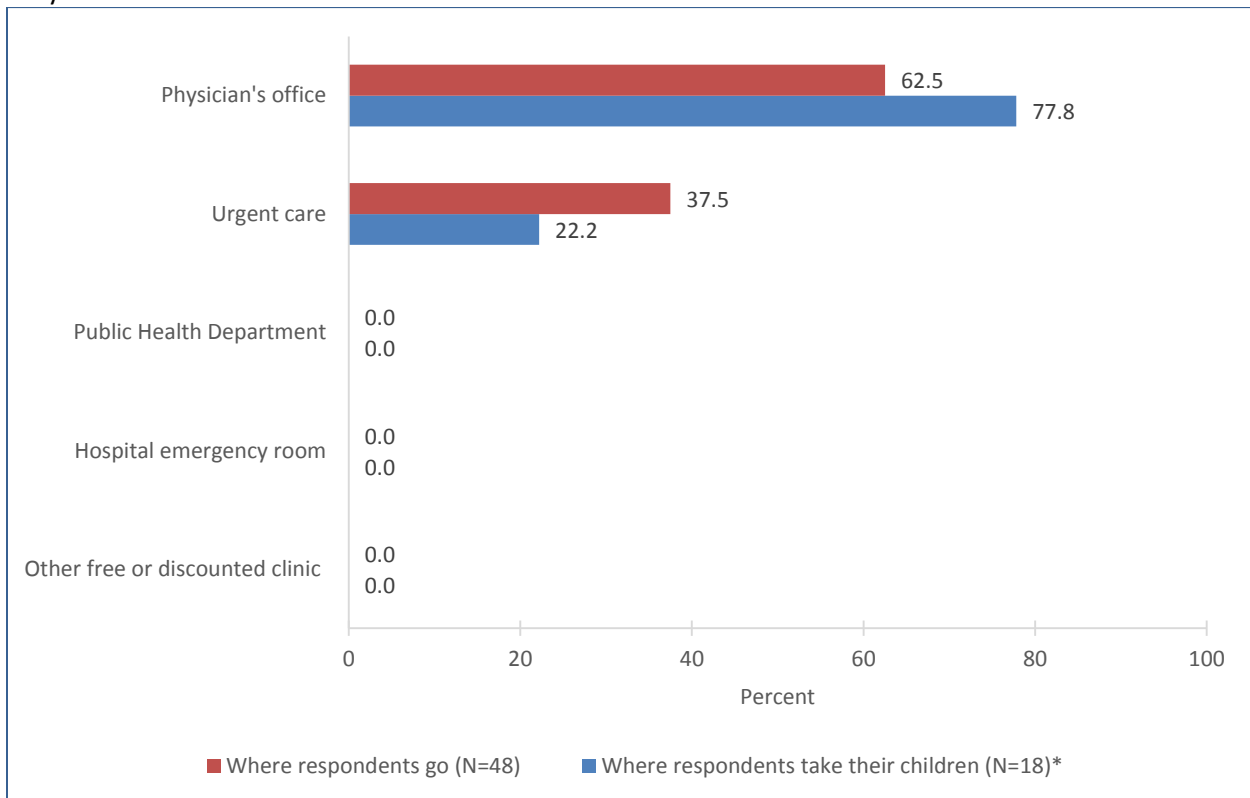
Figure 43. Number of children younger than 18 and number of adults age 65 or older living in respondents' household
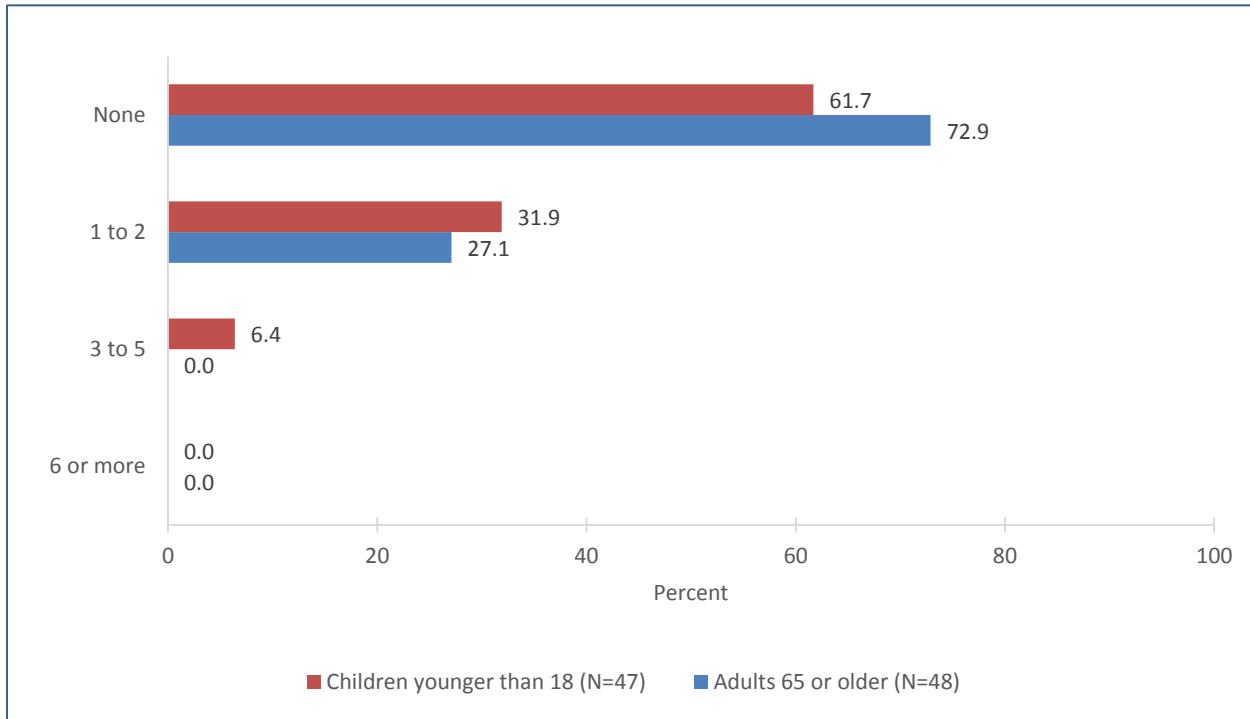
Figure 44. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year
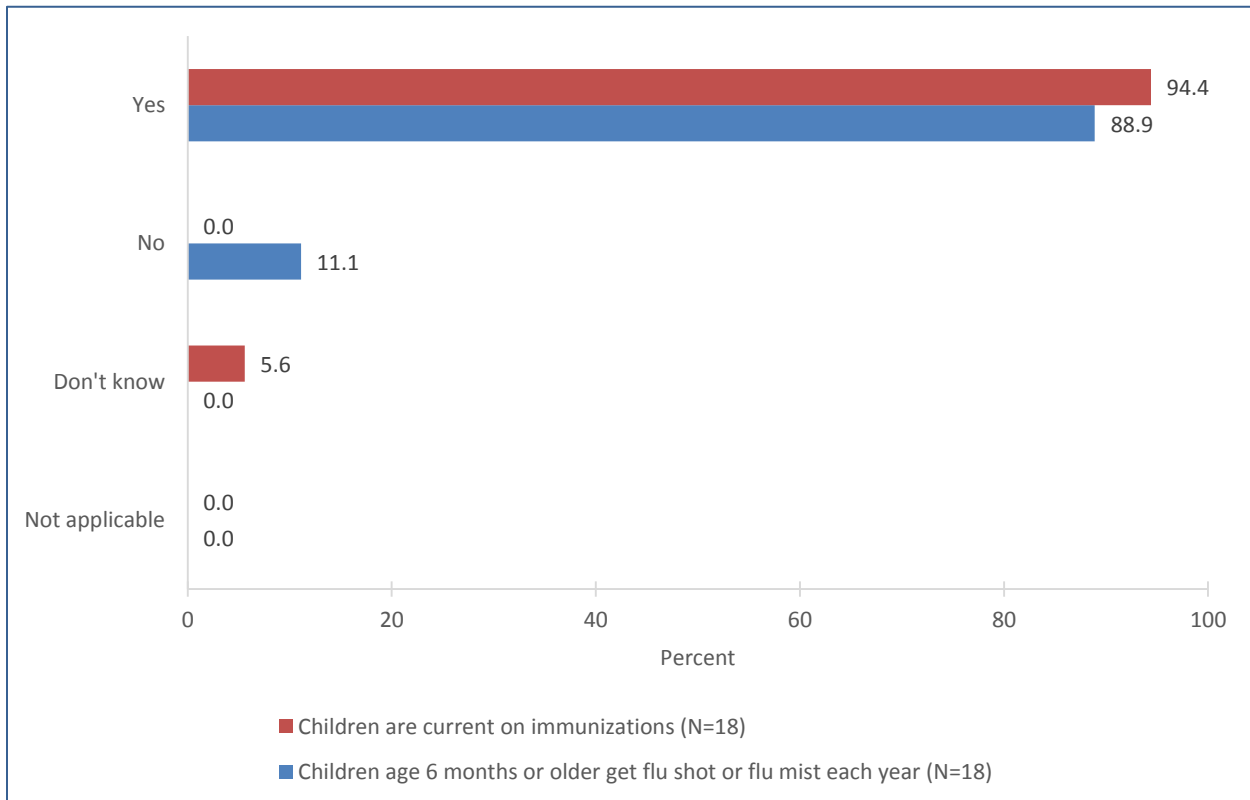
Table 3. Zip code of respondents

Zip code	Number of respondents
58104	12
56560	11
58103	7
58078	4
56549	2
58102	2
56514	1
58004	1
58006	1
58012	1
58038	1
58048	1
58107	1
58701	1

N=46

Secondary Research

2015 Greater Fargo-Moorhead Community Health Needs Assessment of American Indian Residents

January 2016

Table of Contents

Executive Summary

Introduction

The purpose of this survey was to obtain information related to perceptions of American Indian residents of Fargo, North Dakota and Moorhead, Minnesota regarding community health, their personal health, preventive health, and disease prevalence. The American Indian population was under-represented in previous health needs assessments conducted in the Fargo-Moorhead area (2013 and 2015). The current health needs assessment sought to obtain perceptions related to health needs specific to the American Indian population. The purpose of a health needs assessment is to promote health equity and access to health care and health coverage. Health needs assessments lacking accurate data from disparate populations makes community planning efforts applicable only to the larger community.

Primary Data Collection Methods

Instrument Development

Researchers utilized the survey tool originally created for the 2015 Greater Fargo-Moorhead Community Health Needs Assessment of Residents.

Sampling and Procedure

Survey data was collected in July 2015 during the Fargo-Moorhead "Honoring Traditions of Health Wellness Community Health Fair" at Carl Ben Eielson Middle School in Fargo, North Dakota. Persons who self-identified as American Indian/Alaska Native were targeted for this study and respondents received a $10 incentive for survey completion. Surveys were completed in paper format and survey data were entered manually into an Excel spreadsheet.

Data Analysis

All data were analyzed using SPSS version 23.0.

Limitations

These findings only represent American Indian participants attending a health fair in Fargo, North Dakota and may not be representative of other American Indians in the Fargo-Moorhead area.

Survey Results

It should be noted that within the survey results and appendix tables, specific abbreviations are used. American Indian is abbreviated to AI, and Overall, indicating the results from the 2015 Greater Fargo-Moorhead Community Health Needs Assessment, is abbreviated OA. In addition to being discussed as stand-alone results, the AI results will also be compared to the OA results.

I.   Level of Concern with Specific Issues

On a scale from one to five with one being "not at all" and five being" a great deal", respondents were asked to rate their level of concern with specific statements related to larger community issues including: economics, transportation, the environment, children and youth, the aging population, safety, health care, physical and mental health, and substance use and abuse.

Economics

The economic-related community issue which had the highest mean score in regard to level of concern among American Indian (AI) respondents was homelessness (mean=4.08), followed by hunger (mean=3.83), and availability of affordable housing (mean=3.81) (Figure 1, Appendix Table 1).

As compared to the AI results, the mean scores for the overall results (OA) for specific community issues related to economics was lower for all issues (Homelessness: AI=4.08 vs. OA=3.23; Hunger: AI=3.83 vs. OA=3.22; Availability of affordable housing: AI=3.81 vs. OA=2.99).

Figure 1. Level of concern with statements about the community regarding ECONOMICS
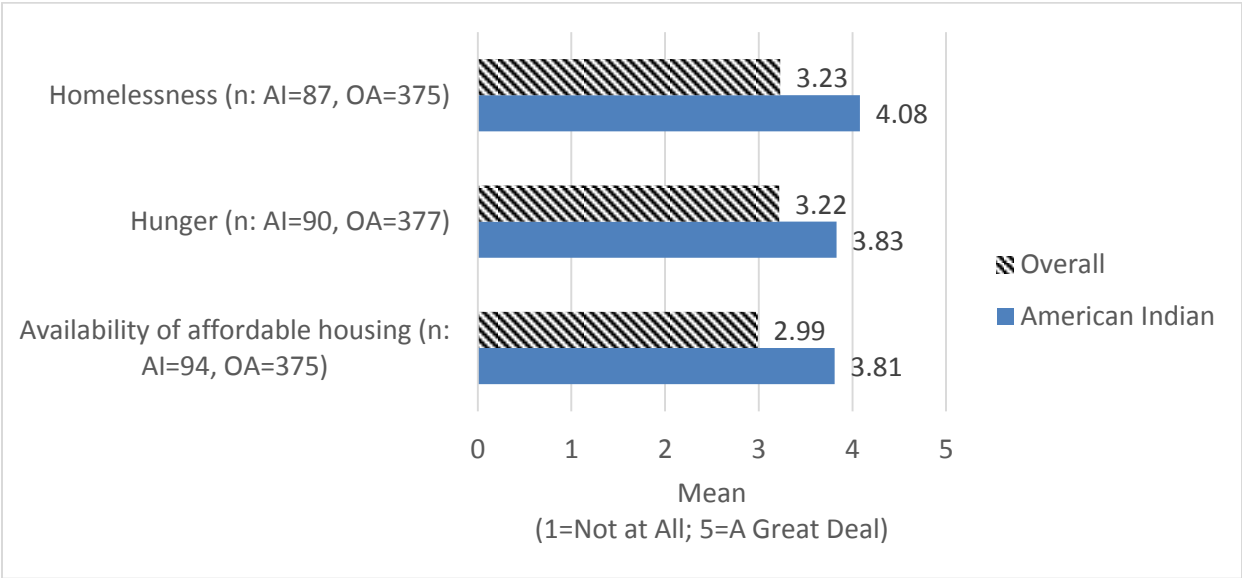
Transportation

The transportation-related community issue which had the highest mean score in regard to level of concern among AI respondents was availability of good walking or biking options (mean=3.27), as compared to the OA results, where driving habits had the highest mean score in regard to level of concern (mean=3.12) (Figure 2, Appendix Table 1).

The transportation-related community issues which had the next highest mean scores among AI respondents in regard to level of concern were: cost of public transportation (mean=3.13), driving habits (mean=3.01), and availability of public transportation (mean=2.98).

The mean scores in regard to level of concern regarding transportation-related community issues were lowest for AI respondents for availability of public transportation (mean=2.98), whereas the lowest mean scores for OA respondents were for cost of public transportation (mean=2.45).

AI respondents had higher mean scores for level of concern than OA respondents for most transportation-related issues, with the exception of driving habits.

Figure 2. Level of concern with statements about the community regarding ENVIRONMENT

Environment

The environment-related community issue which had the highest mean score in regard to level of concern among AI respondents was air quality (mean=3.16), whereas for OA respondents the issue which had the highest mean score was water quality (mean=3.41) (Figure 3, Appendix Table 1).

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The environment-related community issue which had the lowest mean score for both AI and OA respondents was home septic systems, although the mean score for AI respondents was higher than for OA respondents (mean: AI=2.93 vs. OA=2.40).

AI respondents had higher mean scores OA respondents for level of concern related to most environment-related issues, with the exception of water quality.

Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT
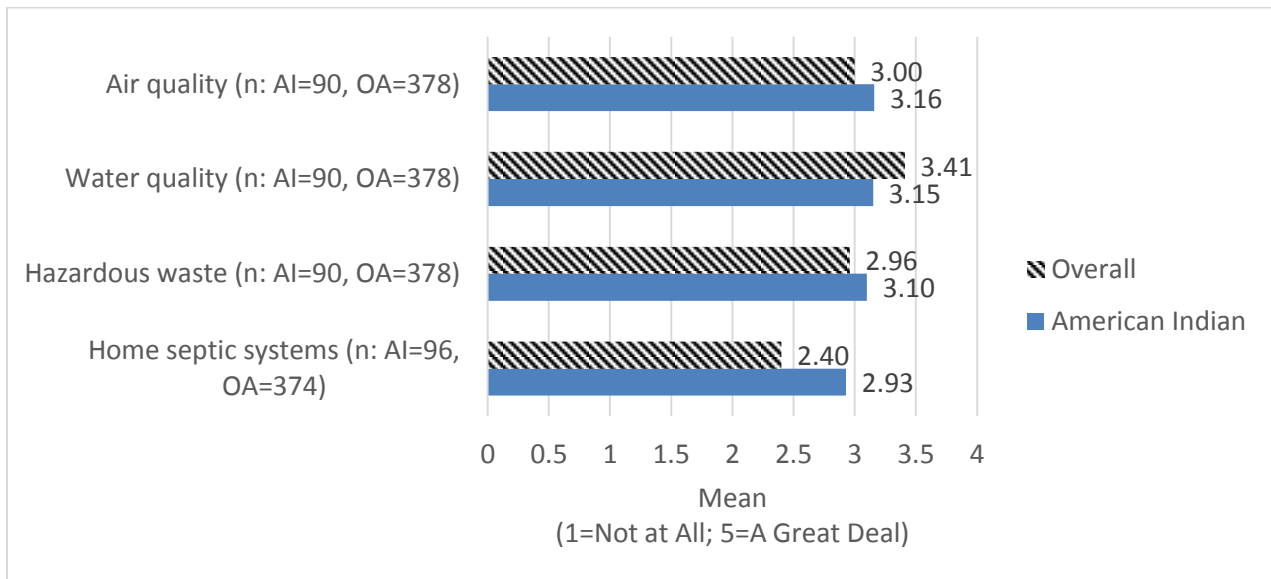
Children and Youth

The children and youth-related community issue which had the highest mean score in regard to level of concern among AI respondents was cost of quality child care (mean=4.09), while for OA respondents the issues which had the highest mean score was bullying (mean=3.53) (Figure 4, Appendix Table 1).

The children and youth-related community issue which had the lowest mean score for AI respondents was availability of services for at-risk youth (mean=3.62), whereas for OA respondents school absenteeism had the lowest mean score (mean=2.94). AI respondents had higher mean scores for level of concern for all issues related to children and youth as compared to OA respondents.

Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

Aging Population
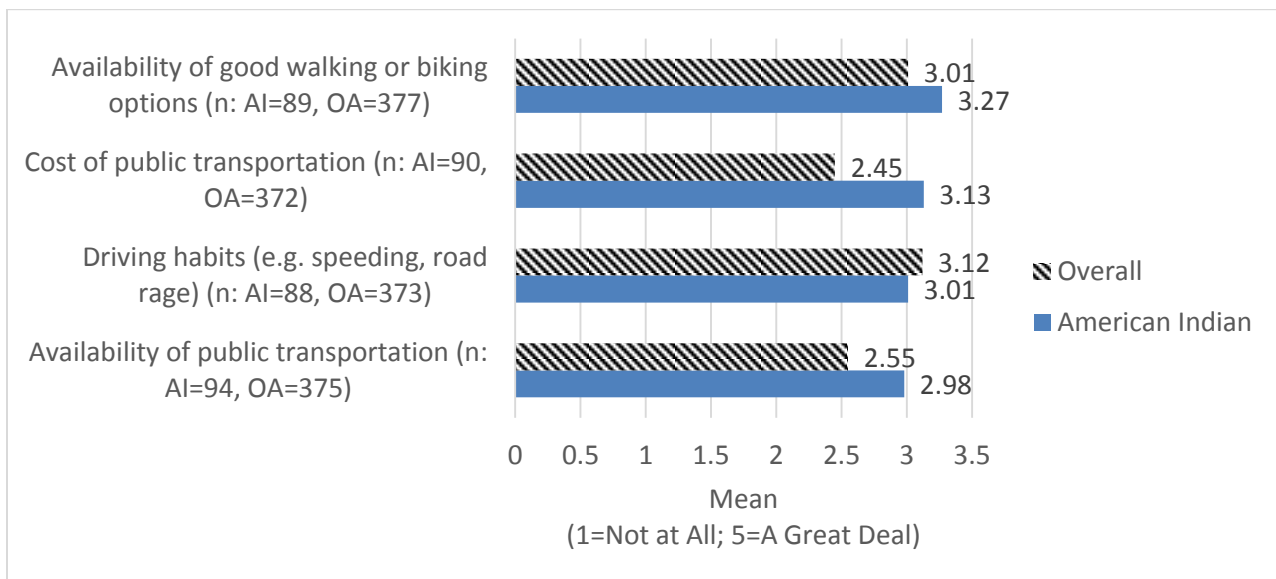
The aging population-related community issue which had the highest mean score in regard to level of concern among both AI and OA respondents was cost of long term care (mean: AI=3.86 vs. OA=4.11) (Figure 5, Appendix Table 1).

The community issue related to the aging population which had the lowest mean score in regard to level of concern among both AI and OA respondents was cost of activities for seniors (mean: AI=3.65 vs. OA=3.15).

AI respondents had higher mean scores for level of concern for most issues related to the aging population as compared to OA respondents for most issues, except for long term care.

Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

Cost of long term care (n: AI=89, OA=378)
- Overall: 4.11
- American Indian: 3.86

Availability of long term care (n: AI=93, OA=377)
- Overall: 3.51
- American Indian: 3.76

Availability of memory care (n: AI=89, OA=377)
- Overall: 3.63
- American Indian: 3.74

Availability of resources to help the elderly stay safe in their home (n: AI=93, OA=370)
- Overall: 3.40
- American Indian: 3.71

Availability of resources for grandparents caring for grandchildren (n: AI=93, OA=372)
- Overall: 3.18
- American Indian: 3.70

Availability of resources for family/friends caring for and making decisions for elders (n: AI=91, OA=375)
- Overall: 3.44
- American Indian: 3.67

Availability of activities for seniors (n: AI=92, OA=375)
- Overall: 3.23
- American Indian: 3.67

Cost of activities for seniors (n: AI=95, OA=374)
- Overall: 3.15
- American Indian: 3.65

Mean
(1=Not at All; 5=A Great Deal)

Legend: Overall, American Indian

Safety

The safety-related community issue which had the highest mean score in regard to level of concern among both AI and OA respondents was presence of street drugs, prescription drugs, and alcohol in the community (mean: AI=4.08 vs. OA=3.84) (Figure 6, Appendix Table 1).

The safety-related community issue which had the lowest mean score in regard to level of concern for AI respondents was sex trafficking (mean=3.78), while for OA respondents elder abuse had the lowest mean score (mean=3.40). AI respondents had higher mean scores for level of concern for all safety-related issues as compared to OA respondents.

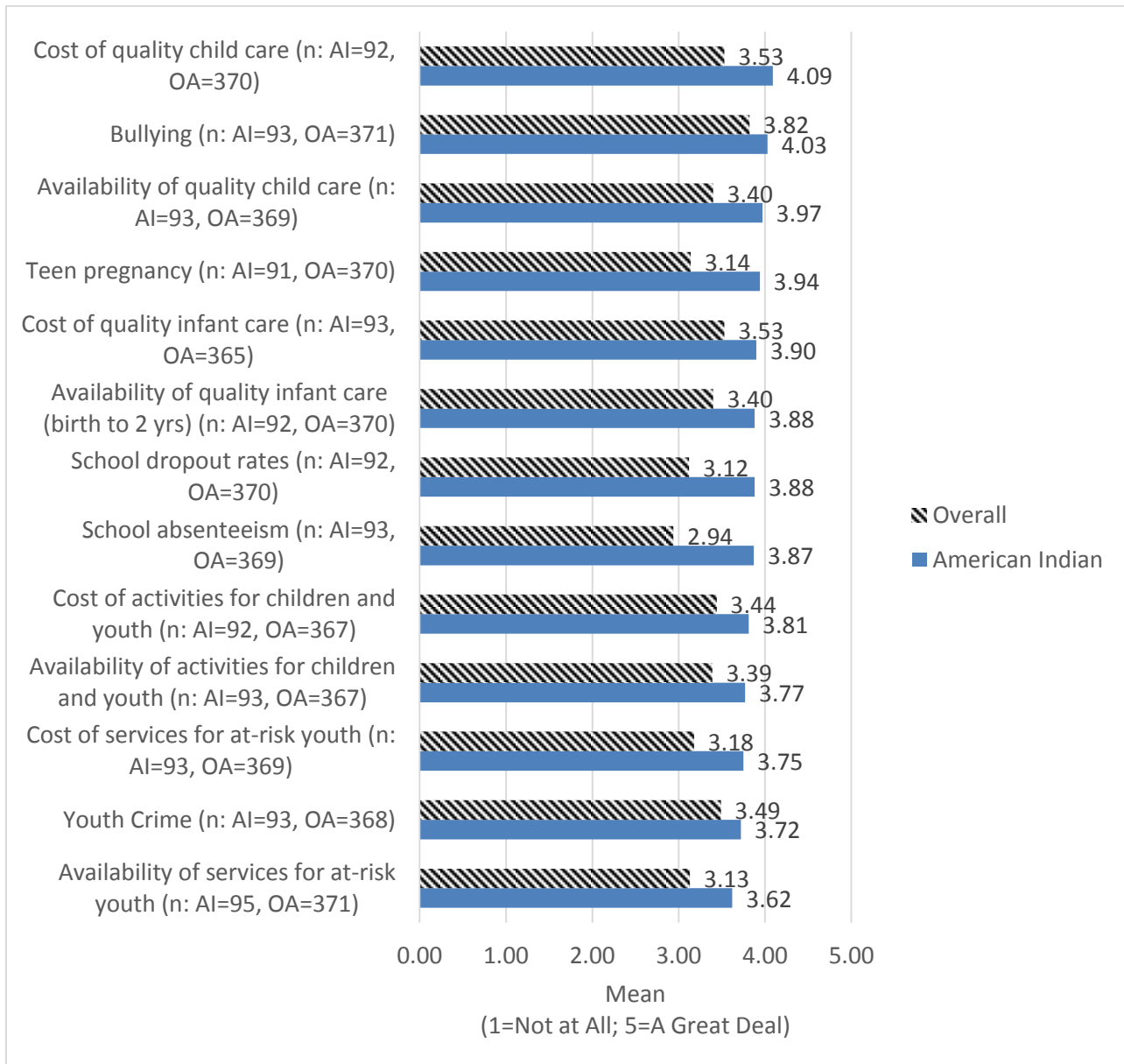Figure 6. Level of concern with statements about the community regarding SAFETY

Health Care

The health care-related community issue which had the highest mean score in regard to level of concern among AI respondents was cost of affordable dental insurance coverage (mean=3.94), while for OA respondents, access to affordable health insurance had the highest mean score (Figure 7, Appendix Table 1).

The health care-related community issue which had the lowest mean score for AI respondents was emergency room services for primary health care (mean=3.51), whereas for OA respondents, timely access to bilingual providers and/or translators had the lowest mean score (mean=2.11).

AI respondents had a higher level of concern than OA respondents for the majority of health care-related issues with the exception of access to affordable health insurance, access to affordable prescription drugs, and access to affordable health care.

The issues which resulted in the greatest difference between AI and OA mean scores were timely access to exercise specialists or personal trainers (mean: AI=3.64 vs. OA=2.22) and timely access to bilingual providers and/or translators (mean: AI=3.51 vs. OA=2.11).

The mean scores for AI respondents ranged from a low of 3.51 to a high of 3.94 – a difference of 0.43. The mean scores for OA respondents ranged from a low of 2.11 to a high of 4.04 – a difference of 1.93.

Figure 7. Level of concern with statements about the community regarding HEALTH CARE

Cost of affordable dental insurance coverage (n: AI=94, OA=376) — 3.83 / 3.94
Access to affordable health insurance (n: AI=93, OA=374) — 4.04 / 3.87
Access to affordable prescription drugs (n: AI=94, OA=377) — 3.90 / 3.86
Cost of affordable vision insurance (n: AI=93, OA=377) — 3.66 / 3.84
Access to affordable health care (n: AI=93, OA=378) — 3.92 / 3.75
Timely access to dental care providers (n: AI=94, OA=376) — 2.79 / 3.74
Timely access to substance abuse providers (n: AI=94, OA=369) — 2.87 / 3.73
Timely access to doctors, physician assistants, or nurse practitioners (n: AI=93, OA=378) — 3.30 / 3.73
Timely access to mental health providers (n: AI=92, OA=372) — 2.98 / 3.68
Timely access to physician specialists (n: AI=94, OA=375) — 3.29 / 3.67
Providers not taking new patients (n: AI=94, OA=375) — 3.12 / 3.67
Timely access to exercise specialists or personal trainers (n: AI=94, OA=367) — 2.22 / 3.64
Availability of non-traditional hours (n: AI=94, OA=377) — 3.14 / 3.62
Timely access to registered dietitians (n: AI=94, OA=361) — 2.32 / 3.60
Distance to health care services (n: AI=94, OA=376) — 2.66 / 3.60
Availability of transportation (n: AI=92, OA=377) — 2.74 / 3.57
Coordination of care between providers and services (n: AI=94, OA=372) — 3.14 / 3.57
Timely access to vision care providers (n: AI=94, OA=372) — 2.56 / 3.55
Timely access to transportation (n: AI=95, OA=363) — 2.37 / 3.54
Timely access to prevention programs and services (n: AI=94, OA=366) — 2.66 / 3.54
Timely access to bilingual providers and/or translators (n: AI=94, OA=370) — 2.11 / 3.51
Use of emergency room services for primary health care (n: AI=96, OA=373) — 3.27 / 3.51

Overall
American Indian

Mean
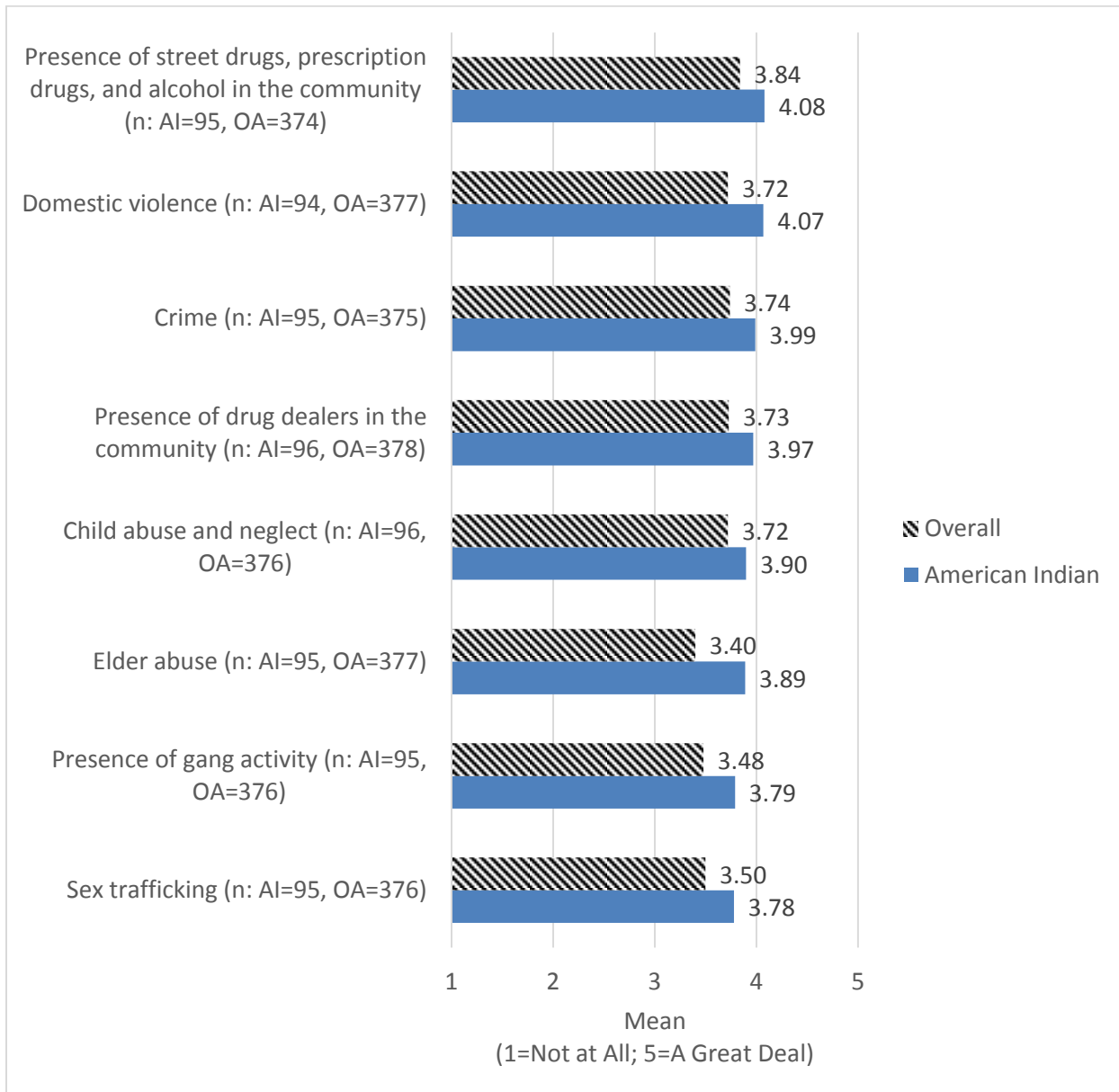(1=Not at All; 5=A Great Deal)

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Physical and Mental Health

The physical and mental health-related community issue which had the highest mean score in regard to level of concern among AI respondents was other psychiatric diagnosis (mean=4.13), whereas for OA respondents, cancer had the highest mean score (mean=3.97) (Figure 8, Appendix Table 1).

The physical and mental health-related community issues which had the lowest mean score in regard to level of concern among AI respondents was dementia and Alzheimer's disease (mean=3.57), while for OA respondents, sexually transmitted diseases had the lowest mean score (mean=2.92).

AI respondents had a higher level of concern than OA respondents for the majority of physical and mental-health related community issues with the exception of cancer and dementia and Alzheimer's disease.

The issue which resulted in the greatest difference between AI and OA mean scores was other psychiatric diagnosis (mean: AI=4.13, OA=3.11).

Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

Substance Use and Abuse

The substance use and abuse-related community issue which had the highest mean score in regard to level of concern among AI respondents was exposure to second hand smoke (mean=4.11), while for OA respondents, underage drug use and abuse had the highest mean score (Figure 9, Appendix Table 1)
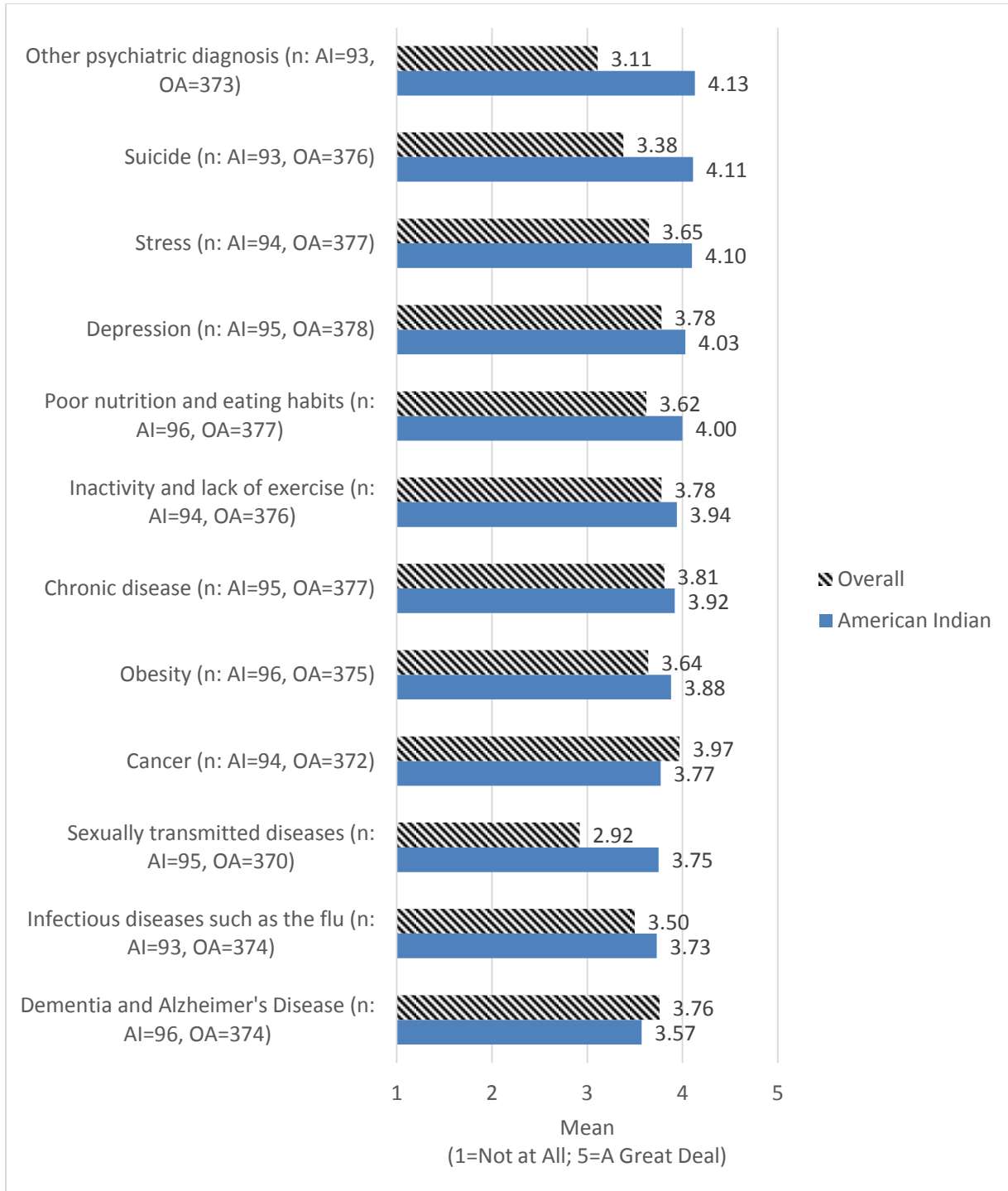
The substance use and abuse-related community issue which had the lowest mean score in regard to level of concern among AI respondents was underage drinking (mean=3.98), whereas for OA respondents, exposure to second hand smoke had the lowest mean score (mean=3.37).

AI respondents had a higher level of concern than OA respondents for all of the substance use and abuse-related issues.

Figure 9. Level of concern with statements about the community regarding
SUBSTANCE USE AND ABUSE
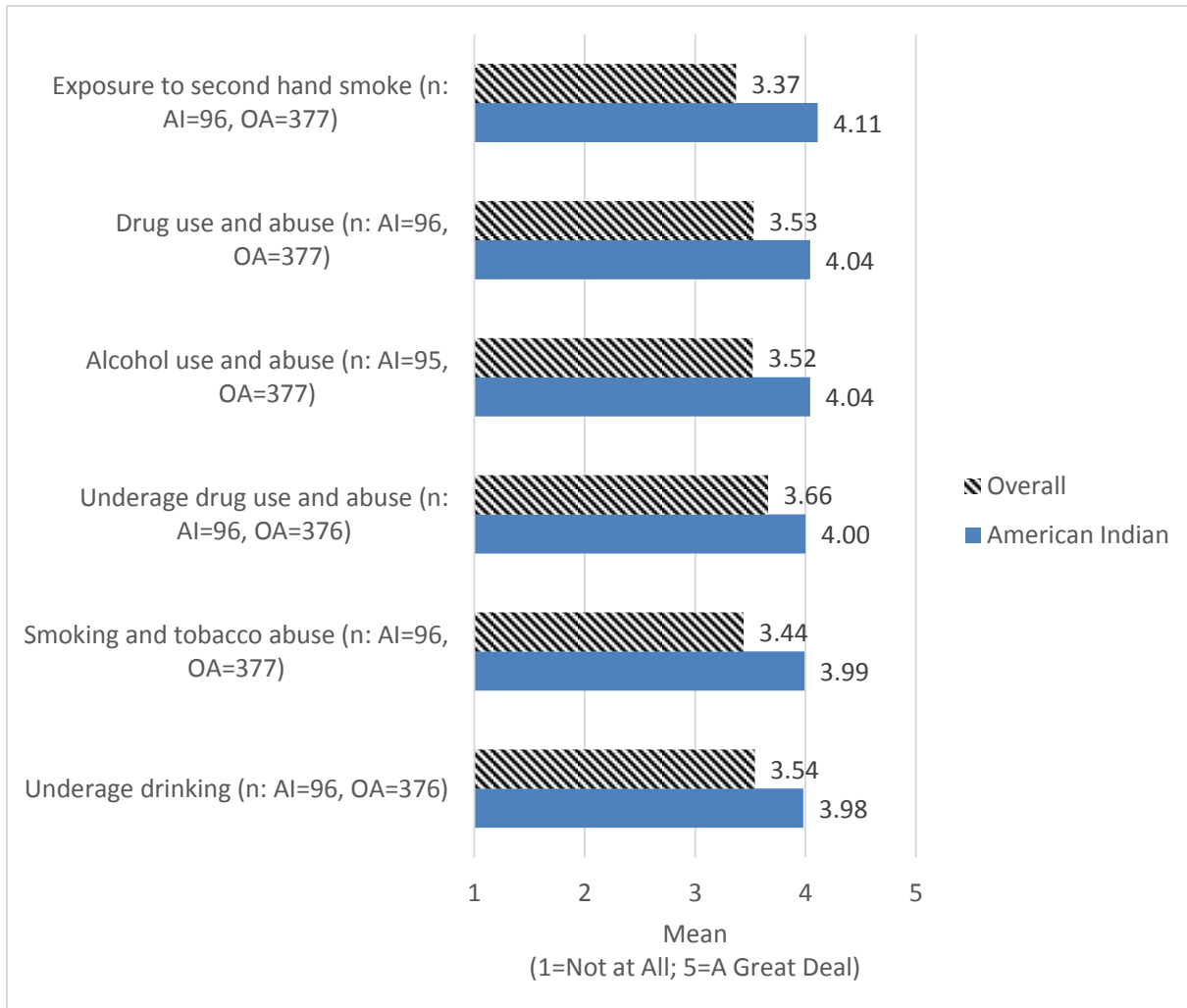
II. General Health

Respondents were asked to rate their health. Nearly 40 percent (29.4%) of AI respondents stated their health was "Fair" or "Poor", compared to 10.5% of OA respondents (Figure 10, Appendix Table 2). OA respondents were more than 2.5 times as likely as AI respondents to state their health was "Very Good" or "Excellent" (52.5% vs. 19.1%).

Figure 10. Respondents' rating of their health in general
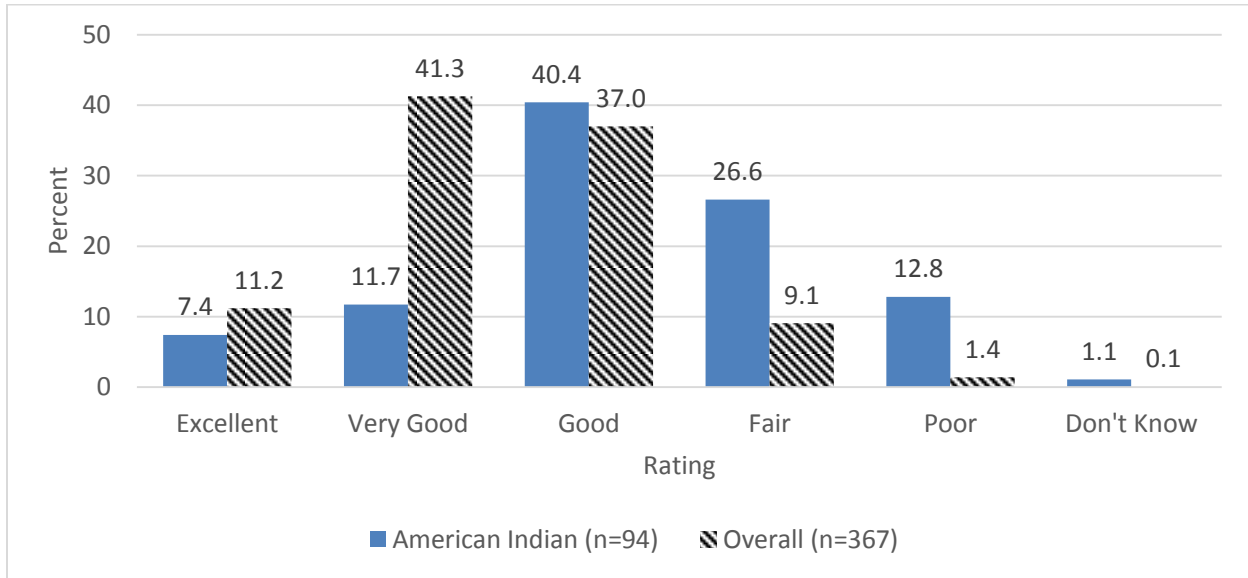
Respondents were asked to report their current height and weight. Using this information, body mass index (BMI) was calculated for each respondent. More than half (51.8%) of AI respondents were considered to be obese (BMI of 30.0 or greater), while less than one third (29.6%) of OA respondents were considered to be obese (Figure 11, Appendix Table 3). OA respondents were three times as likely as AI respondents to have a normal weight (BMI from 18.5 to 24.9) (BMI of 38.2 vs. 11.8).

Figure 11. Respondents' weight status based on the Body Mass Index (BMI) scale
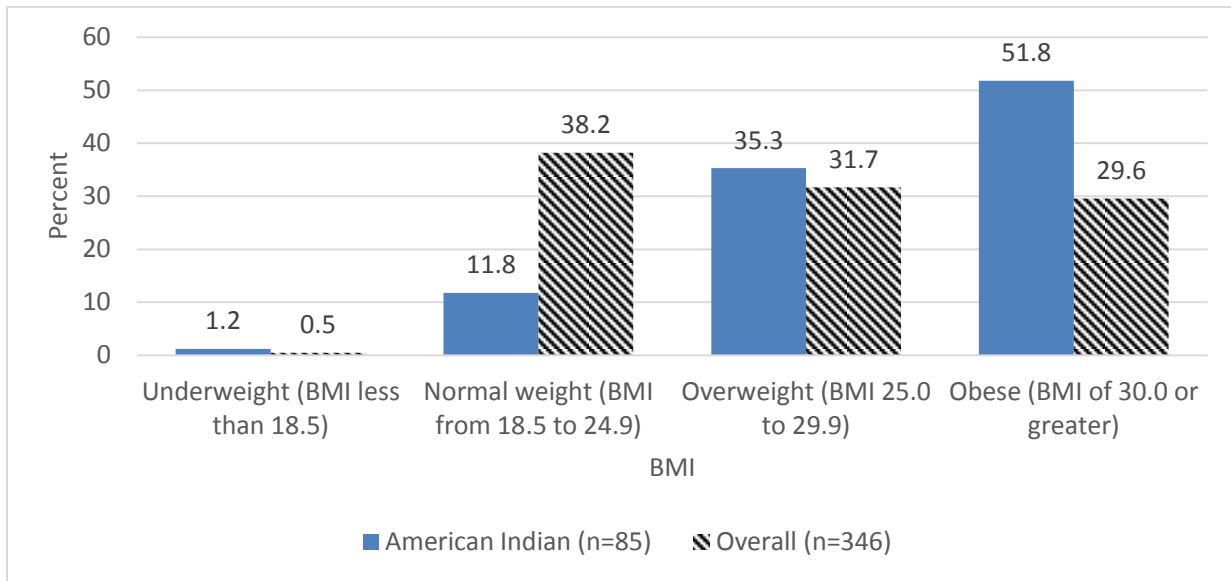
Respondents were asked the number of servings of vegetables, fruits, and fruit juice they had consumed the previous day. One-fifth (21.1%) of AI respondents stated they had at least three servings of vegetables in the previous day (Table 1, Appendix Table 4). One-fourth (25.1%) of AI respondents stated they had at least three servings of fruits in the previous day.

Responses for AI and OA respondents were comparable for fruits and vegetable intake. AI respondents reported a higher intake of fruit juice than OA respondents.

Table 1. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday

Type of Food/ Drink	Percent of respondents											
	Servings											
	None		1		2		3		4		5 or more	
	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Vegetables	16.8	7.6	27.4	36.6	34.7	31.7	15.8	14.8	3.2	8.1	2.1	1.2
Fruit	15.6	19.2	26.0	29.7	33.3	31.0	18.8	16.0	4.2	3.0	2.1	1.1
Fruit Juice	36.5	55.7	33.3	30.6	14.6	10.2	11.5	1.6	3.1	1.6	1.0	0.3

Vegetables - n: AI=95, OA=381; Fruit – n: AI=96, OA=378; Fruit Juice – n: AI=96, OA=382

Respondents were asked the number of days the get at least 30 minutes of moderate or vigorous activity, with moderate activity defined as causing light sweating and small increases in breathing or heart rate and vigorous activity causing heavy sweating and large increases in breathing or heart rate.

Nearly one-third (29.2%) of AI respondents stated they participate in moderate activity at least five days a week, with more than one-fifth (12.5%) stating they participate in vigorous activity a minimum of five days a week (Table 2, Appendix Table 5).

AI respondents were more likely than OA respondents to participate in either moderate (29.2% vs. 19.5%) or vigorous (12.5% vs. 7.7%) activity most days of the week.

Table 2. Number of days in an average week respondents engage in MODERATE or VIGOROUS activity

| | Percent of respondents | | | | | | | |
| | Frequency of Weekly Activity | | | | | | | |
| | None | | 1 to 2 days | | 3 to 4 days | | 5 or more days | |
Activity Level	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Moderate Activity	3.1	16.5	39.6	35.2	28.1	28.8	29.2	19.5
Vigorous Activity	18.8	46.2	54.2	32.9	14.6	13.3	12.5	7.7

Moderate activity – n: AI=96, OA=380; Vigorous activity – n: AI=96, OA=377

III.   Mental Health

Respondents were asked if they had been told by a doctor or health professional they have any of the following conditions: depression, anxiety/stress, panic attacks, or any other mental health problem. More than half of AI respondents stated they had been diagnosed with anxiety/stress (54.2%), while 46.9% stated they had been diagnosed with depression, 28.1% with panic attacks, and 22.9% with other mental health problems (Figure 12, Appendix Table 6).

AI respondents were twice as likely to state they had been diagnosed with depression as OA respondents (46.9% vs. 22.3%), 2.5 times as likely to state they had been diagnosed with anxiety/stress (54.2% vs. 20.0%), nearly 10 times as likely to state they had been diagnosed with panic attacks (28.1% vs. 2.9%), and 6 times as likely to have been diagnosed with other mental health issues (22.9% vs. 3.6%).

Figure 12. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue
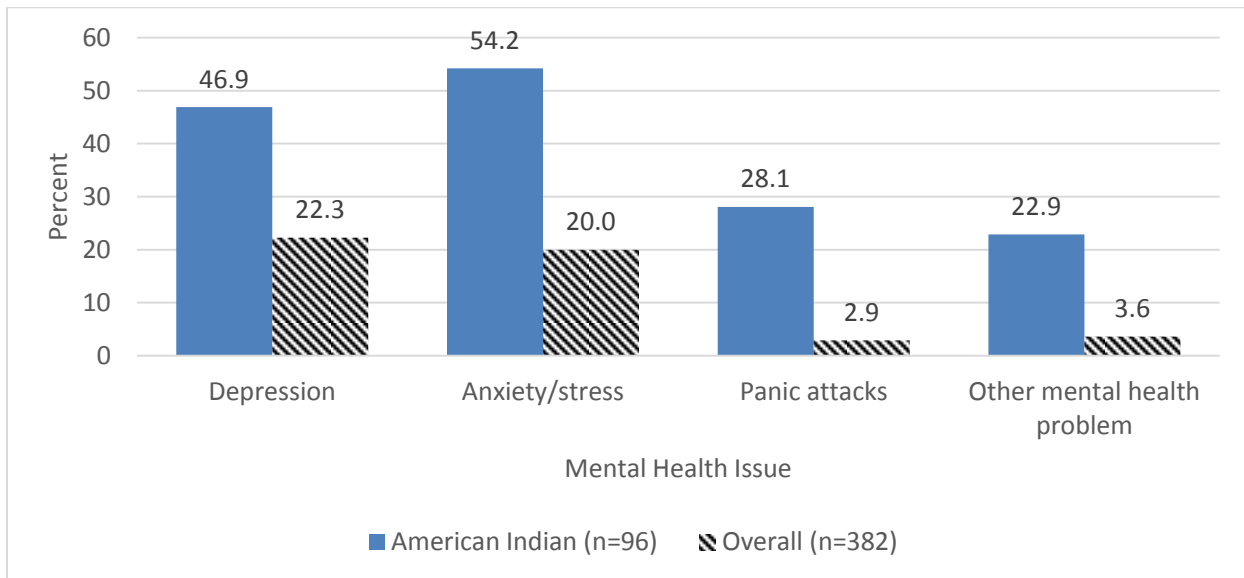
Respondents were asked to specify the number of days in the past 30 days they felt their mental health was not good, including stress, depression, and problems with emotions. More than 84% (84.2%) of AI respondents stated their mental health was not good on at least one day in the past 30 days (Figure 13, Appendix Table 7). One-third (31.6%) stated their mental health was not good on at least half of the last 30 days.

AI respondents were much more likely than OA respondents to state their mental health was not good on at least one day in the past 30 days (84.2% vs. 49.6%).

Figure 13. Number of days in the last month that respondents' mental health was not good
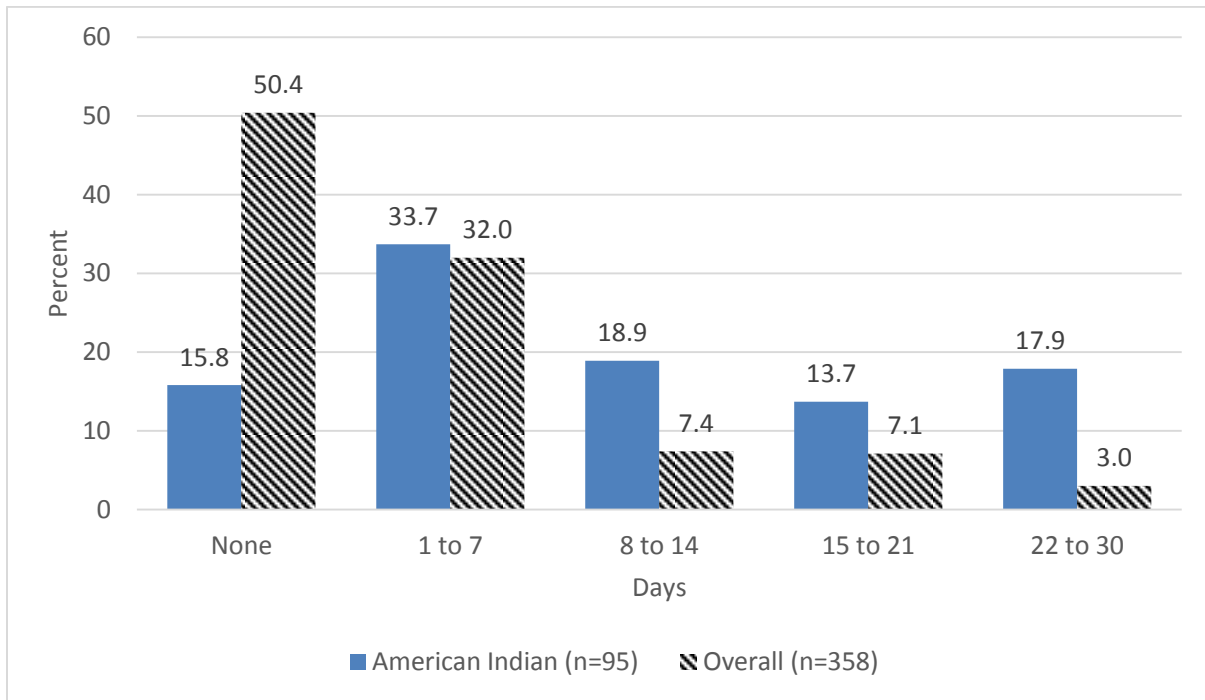
Respondents were asked how frequently in the past two weeks they have been bothered by either of the following: 1) little interest or pleasure in doing things or 2) feeling down, depressed, or hopeless. More than one-third of AI respondents stated they had little interest or pleasure in doing things and felt down, depressed, or hopeless for several days in the past two weeks (36.2% and 33.7%, respectively) (Table 3, Appendix Table 8).

Responses for AI and OA respondents were comparable for both issues.

Table 3. How often, over the past two weeks, respondents have been bothered by mental health issues

	Percent of respondents							
	Frequency							
	Not at all		Several days		More than half the days		Nearly every day	
Mental health issues	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Little interest or pleasure in doing things (n: AI=94, OA=377)	43.6	77.2	36.2	18.9	11.7	1.7	8.5	2.2
Feeling down, depressed or hopeless (n: AI=92, OA=372)	42.4	78.3	33.7	17.9	16.3	2.9	7.6	1.0

IV.   Tobacco Use

AI respondents were twice as likely as OA respondents to state they have smoked at least 100 cigarettes (5 packs of cigarettes) in their lifetime (67.4% vs. 33.1%) (Figure 14, Appendix Table 9).

Figure 14. Whether respondents have smoked at least 100 cigarettes in their lifetime
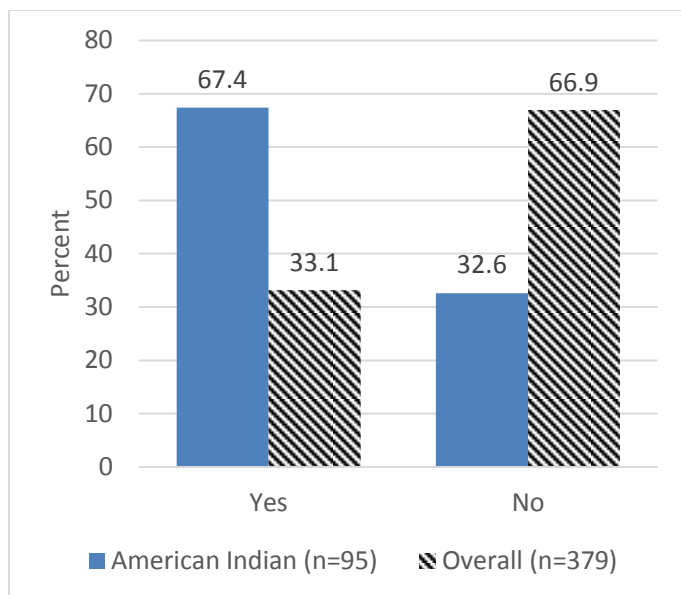
Respondents were asked the frequency with which they smoke cigarettes or use chewing tobacco or snuff. Nearly 29% (38.9%) of AI respondents stated they smoke cigarettes every day, with 7.4% stating they use chewing tobacco or snuff everyday (Table 4, Appendix Table 10).

As compared to OA respondents, AI respondents are more than 8 times as likely to state they smoke cigarettes daily (38.9% vs. 4.7%), and 6.7 times as likely to state they use chewing tobacco or snuff every day (7.4% vs. 1.1%).

Table 4. Frequency of cigarette and chewing tobacco/snuff use

	Percent of respondents					
	Frequency					
	Everyday		Some days		Not at all	
Tobacco type	AI	Overall	AI	Overall	AI	Overall
Cigarettes (n: AI=95, OA=382)	38.9	4.7	20.0	3.2	41.1	92.1
Chewing tobacco/snuff (n: AI=95, OA=377)	7.4	1.1	9.5	2.7	83.2	96.1

Respondents were asked where they would go for help if they wanted to quit using tobacco. Nearly 15% (14.7%) of respondents stated they would use a Quitline, followed by 12.6% who stated they would go to their doctor, and 7.4% would go to a health department (Figure 15, Appendix Table 11). More than 10% (10.5%) do not want to quit using tobacco, and 16.8% do not know where they would go for help to quit using tobacco.

While AI respondents were more likely to use a quitline as a primary source of help to quit using tobacco, OA respondents were more likely to go to a doctor as a primary source.

Figure 15. Primary source of help to quit using tobacco
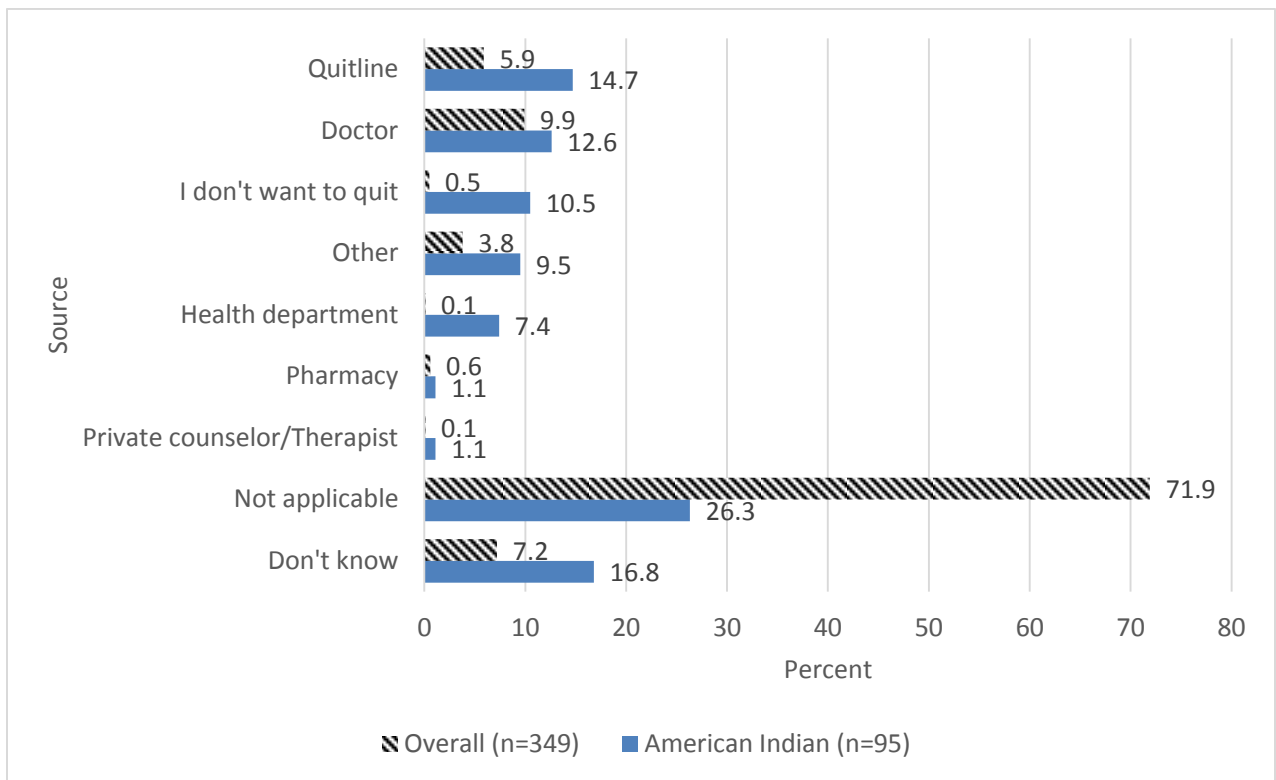
V. Alcohol Use and Prescription/Non-Prescription Drug Abuse

Respondents were asked to specify the number of days in the past 30 days they had at least one drink of any alcohol beverage. More than 46% (46.3%) of respondents stated they had not had a drink at all in the past 30 days, with 12.6% stating they had a drink on at least half of the past 30 days (Figure 16, Appendix Table 12).

OA respondents were more likely than AI respondents to have a drink on at least one of the past 30 days.

Figure 16. Number of days during the past month that respondents had at least one drink of any alcoholic beverage
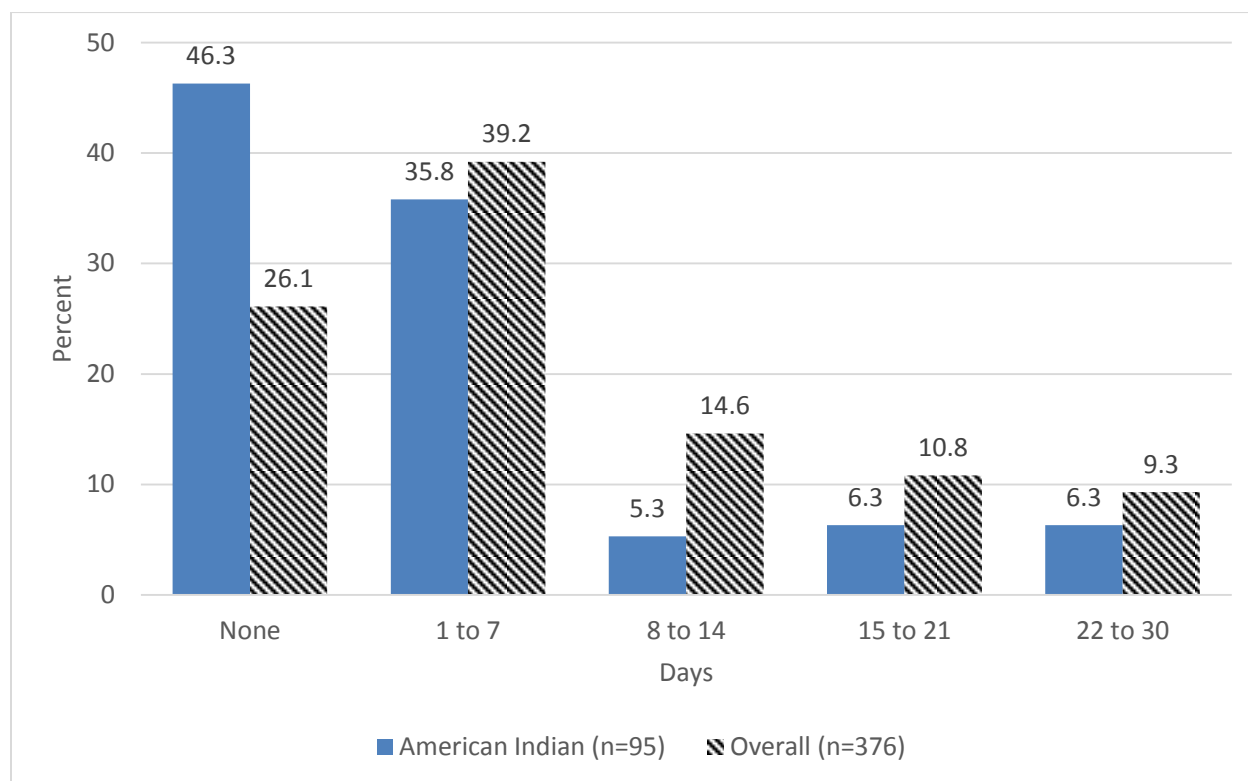
Respondents who drank an alcoholic beverage at least once in the past 30 days were asked to specify the average number of drinks they consumed on the days they drank alcohol. More than one-third of AI respondents (34.4%) stated that on the days they drank they had at least 5 drinks, on average (Figure 17, Appendix Table 13).

On the days they drank alcoholic beverages in the past 30 days, OA respondents were more likely than AI respondents to have between 2 and 5 drinks (51.9% vs. 17.2%), on average, while AI respondents were more likely than OA respondents to either have one drink (48.4%) or 5 or more drinks (34.4%).

Figure 17. During the past month, on days that respondents drank, average number of drinks per day respondents consumed
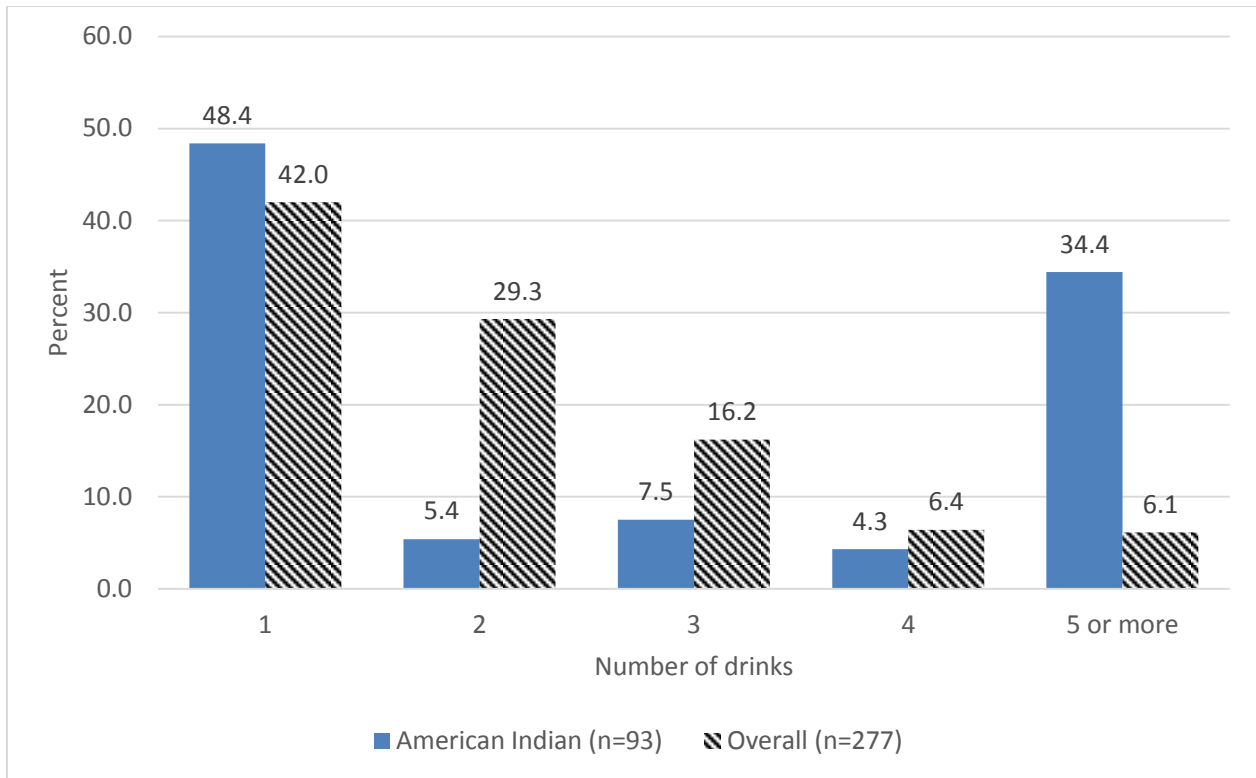
Respondents were asked to specify the number of times in the past month they consumed at least 4 (for females) or 5 (for males) alcoholic drinks on the same occasion. More than 17% (17.4%) of AI respondents stated they never had four or five drinks on the same occasion, while 6.5% stated they had four or five drinks almost every day (Figure 18, Appendix Table 14).

AI respondents were 3.5 times as likely as OA respondents to state they had 4 or 5 drinks on one occasion at least once a week (56.5% vs. 15.9%).

Figure 18. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion
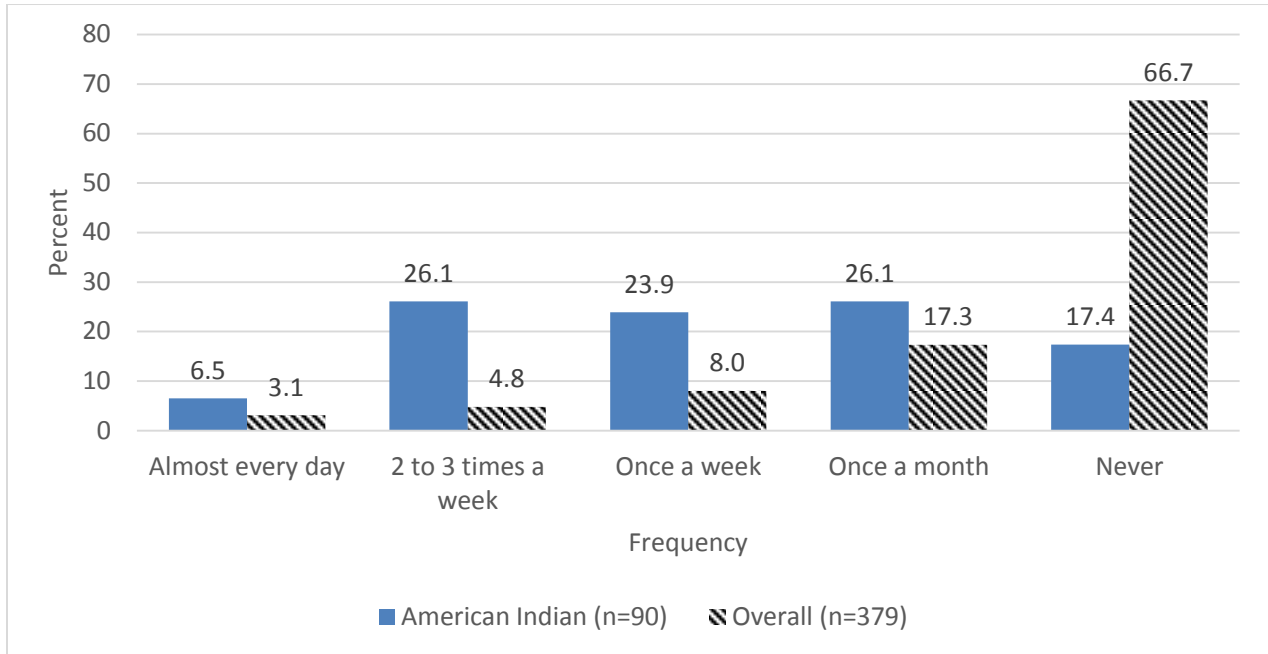
Respondents were asked if they had a problem with alcohol use or prescription/non-prescription drug abuse and if so, if they got the help they needed. More than half of AI respondents (51.6%) stated they had a problem with alcohol use, and of these respondents, 56.3% stated they received the help they needed (Table 5, Appendix Table 15 and 16). More than one-quarter of AI respondents (26.4%) stated they had a problem with prescription/non-prescription drug abuse, and of these respondents, half stated they received help.

AI respondents were much more likely than OA respondents to report having a problem with alcohol use (51.6% vs. 6.8%) or prescription/non-prescription drug abuse (26.4% vs. 0.1%). AI respondents with alcohol use problems were more likely than OA respondents to receive they help they needed (56.3% vs. 25.6%), while OA respondents were more likely to state they didn't need help (43.8% vs. 14.6%).

Table 5. Whether respondents have ever had a problem with alcohol use or prescription/ non-prescription drug abuse and if so, if they got the help they needed

Type of use/abuse	Percent of respondents									
	Problem				If yes, received help					
	Yes		No		Yes		No		Didn't Need Help	
	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Alcohol use	51.6	6.8	48.4	93.2	56.3	25.6	29.2	30.5	14.6	43.8
Prescription/non-prescription drug abuse	26.4	0.1	73.6	99.9	50.0	0.0	21.9	0.0	28.1	0.0

Ever had problem with alcohol use - n: AI=95, OA=376; Ever had problem with presc/non-presc drug use - n: AI=91, OA=377; Received help with alcohol - n: AI=48, OA=25; Received help for presc/non-presc drug use - n: AI=32, OA=0

Respondents were asked if alcohol use or prescription/non-prescription drug abuse had harmful effects on themselves or a family member over the past two years. Two-thirds of AI respondents stated they felt alcohol use has had harmful effects either on themselves or on a family member over the past two years, while 57% stated prescription/non-prescription drug abuse has had harmful effects on the same populations over the same period of time (Figure 19, Appendix Table 17).

AI respondents were 4 times as likely as OA respondents to state that alcohol use has had harmful effects either on themselves or a family member over the past two years (67% vs. 16.1%). AI respondents were nearly 10 times as likely to state that prescription/non-prescription drug abuse has had harmful effects on either themselves or a family member over the past two years (57% vs. 5.8%).

Figure 19. Alcohol use or prescription/non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years
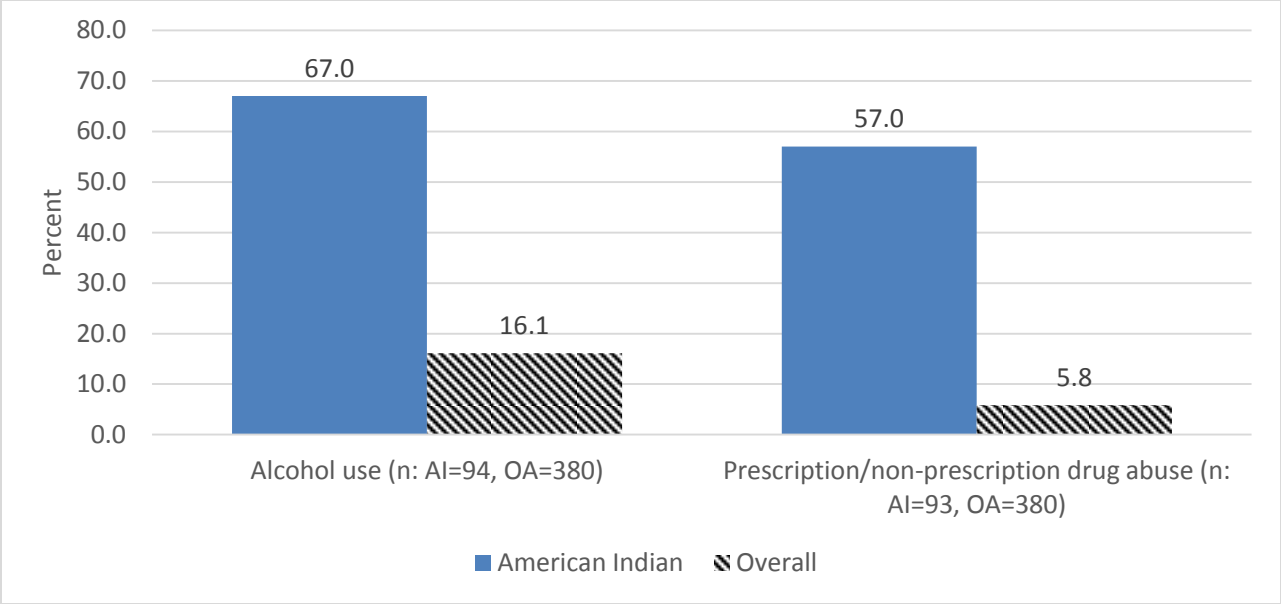
VI.   Preventive Health

Provided a list of preventive screenings (listed in Table 6), respondents were asked if they had received any of the specified screenings in the past year. A majority of all AI respondents, and AI respondents of specific age/gender, stated they received the following screenings in the past year: blood pressure (81.8%), breast cancer (64.7% of females aged 45 or older), and pelvic exam (58.5% of females). AI respondents were least likely to have received skin cancer screening in the past year (6.0%).

OA respondents were more likely than AI respondents to receive the following screenings: pelvic exam (for females) (67% vs. 58.5%), cervical cancer screening (for females) (63.4% vs. 41.5%), flu shot (62.1% vs. 40.4%), cholesterol screening (62.3% vs. 39.8%), prostate cancer screening (for males) (39.4% vs. 20.6%), and skin cancer screening (22.5% vs. 6.0%).

AI respondents were much more likely than OA respondents to receive a STD screening (43.7% vs. 4.2%).

Table 6. Respondents who have had preventive screenings in the past year, by type of screening

Type of preventive screening	Percent	
	AI	Overall
Blood pressure screening (n: AI=88, OA=380)	81.8	84.3
Breast cancer screening (female, age 45 or older) (n: AI=17, OA=189)	64.7	65.2
Pelvic exam (female) (n: AI=53, OA=189)	58.5	67.0
STD screening (n: AI=87, OA=369)	43.7	4.2
Cervical cancer screening (female) (n: AI=53, OA=185)	41.5	63.4
Flu shot (n: AI=89, OA=380)	40.4	62.1
Cholesterol screening (n: AI=88, OA=378)	39.8	62.3
Immunizations (n: AI=86, OA=374)	37.2	19.3
Colorectal cancer screening (age 45 or older) (n: AI=30, OA=368)	26.7	32.3
Hearing screening (n: AI=86, OA=377)	22.1	17.8
Prostate cancer screening (male) (n: AI=34, OA=182)	20.6	39.4
Vascular screening (n: AI=71, OA=368)	12.3	11.3
Bone density test (n: AI=85, OA=367)	8.2	10.8
Skin cancer screening (n: AI=83, OA=365)	6.0	22.5

Respondents who did not receive specific screenings were asked to identify the reasons why they did not (Table 7). AI respondents stated they did not receive the following screenings because their doctor had not suggested it: cholesterol screening, hearing screening, immunizations, pelvic exam, or colorectal cancer screening. AI respondents stated they did not receive the following screenings because they were not necessary: blood pressure screening, bone density test, STD screening, vascular screening, cervical cancer screening, prostate cancer screening, and skin cancer screening.

OA and AI respondents both were most likely to state they did not receive screenings because they were not necessary or because their doctor had not suggested them.

Table 7. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

	Percent of respondents												
	Reasons												
	Not necessary		Doctor hasn't suggested		Cost		Fear of procedures		Fear of the results		Unable to access care		Other reason	
Type of screening	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Blood pressure screening	43.8%	60.8%	31.3%	23.0%	6.3%	5.5%	6.3%	0.0%	0.0%	0.0%	0.0%	0.8%	12.5%	21.3%
Bone density test	25.6%	48.8%	23.1%	44.6%	2.6%	1.1%	1.3%	0.0%	0.0%	0.0%	2.6%	0.2%	1.3%	3.6%
Cholesterol screening	20.8%	50.7%	30.2%	35.8%	3.8%	4.6%	1.9%	0.0%	0.0%	0.0%	1.9%	0.1%	5.7%	10.5%
Flu shot	24.5%	40.9%	17.0%	3.9%	7.5%	0.3%	1.9%	0.7%	1.9%	1.3%	1.9%	0.3%	9.4%	51.6%
Hearing screening	20.9%	54.2%	22.4%	36.1%	1.5%	1.8%	1.5%	0.0%	0.0%	0.1%	1.5%	0.0%	7.5%	6.4%
Immunizations	18.8%	67.6%	18.5%	21.9%	1.9%	1.3%	1.9%	0.0%	1.9%	0.0%	3.7%	0.0%	9.3%	6.6%
Pelvic exam (female)	4.5%	60.2%	13.6%	12.1%	9.1%	1.6%	9.1%	0.7%	0.0%	0.0%	9.1%	0.0%	4.5%	14.3%
STD screening	14.3%	84.9%	10.2%	7.2%	6.1%	0.0%	2.0%	0.0%	0.0%	0.0%	2.0%	0.0%	4.1%	2.8%
Vascular screening	22.5%	56.0%	18.3%	34.3%	2.8%	1.2%	1.4%	1.0%	0.0%	0.0%	1.4%	0.2%	5.6%	4.7%
Breast cancer screening (female, age 45 or older)	0.0%	35.5%	0.0%	28.3%	16.7%	11.4%	16.7%	0.0%	0.0%	5.0%	16.7%	0.0%	16.7%	20.0%
Cervical cancer screening (female)	19.4%	53.6%	9.7%	24.9%	6.5%	0.0%	9.7%	0.0%	0.0%	0.0%	3.2%	0.0%	3.2%	9.2%
Colorectal cancer screening	9.1%	54.1%	22.7%	25.2%	9.1%	1.0%	9.1%	4.7%	0.0%	0.3%	4.5%	0.0%	4.5%	14.8%
Prostate cancer screening (male)	29.6%	44.1%	11.1%	38.9%	0.0%	0.6%	0.0%	3.9%	3.7%	0.2%	3.7%	0.0%	0.0%	13.4%
Skin cancer screening	24.4%	46.4%	16.7%	38.7%	3.8%	1.6%	1.3%	0.2%	0.0%	1.2%	2.6%	1.3%	2.6%	9.2%

Respondents were asked if they have any of the following chronic diseases: hypertension, arthritis, diabetes, high cholesterol, asthma, COPD, congestive heart failure, stroke, Alzheimer's, or cancer. AI respondents were most likely to state they have hypertension or arthritis (16.7%, respectively) (Table 8, Appendix Table 18). None of the AI respondents stated they have cancer or Alzheimer's.

AI respondents were much more likely than OA respondents to state they have diabetes (15.6% vs. 6.2%), while OA respondents were more likely than AI respondents to state they have high cholesterol (19.8% vs. 12.5%).

Table 8. Presence of chronic diseases

	Percent*	
Chronic diseases	American Indian (n=96)	Overall (n=382)
Hypertension	16.7	15.1
Arthritis	16.7	14.9
Diabetes	15.6	6.2
High cholesterol	12.5	19.8
Asthma	10.4	3.5
COPD	2.1	1.3
Congestive heart failure	1.0	0.8
Stroke	1.0	0.8
Alzheimer's	0.0	0.1
Cancer	0.0	5.1

*Percentages do not total 100.0 due to multiple responses.

Respondents were asked to specify when they had last visited a doctor/health care provider for a routine physical exam, or a dentist/dental clinic for any reason. Two-thirds (65.3%) of AI respondents stated they had visited a doctor/health care provider in the past year, while less than 52% stated they had visited a dentist/dental clinic for any reason in the past year (Table 9, Appendix Table 19).

OA respondents were more likely than AI respondents to have visited either a doctor/health care provider (73% vs/ 65.3%) or dentist/dental clinic (51.6% vs. 87.2%) in the past year.

Table 9. Length of time since respondents last visited a doctor/health care provider for routine exam and since they last visited a dentist/dental clinic

Care provider type	Percent											
	Length of time since last visit											
	Within the past year		1 to 2 years		3 to 5 years		6 or more years		Don't Know		Never	
	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Doctor/ health care provider *(n: AI=95, OA=382)*	65.3	73.0	15.8	13.8	9.5	7.1	2.1	2.8	3.2	1.5	4.2	1.9
Dentist/ dental clinic *(n: AI=93, OA=381)*	51.6	87.2	18.3	4.8	20	5.0	5.4	1.6	1.1	1.3	3.2	0.2

Respondents were asked to specify where they receive most of their health-related information. Approximately 40% of AI respondents receive most of their health-related information from medical professionals, followed by family or friends (31.3%) (Table 10, Appendix Table 20). AI respondents were least likely to receive health information from a health helpline (8.3%).

OA respondents were twice as likely as AI respondents to state they receive most of their health-related information from medical professions (79.9% vs. 40.6%) or non-government websites (32.1% vs. 16.7%). AI respondents were much more likely than OA respondents to receive most of their health information from government websites (25.0% vs. 8.3%).

Table 10. Source of health information

Sources	Percent*	
	American Indian (n=96)	Overall (n=382)
Medical professionals	40.6	79.9
Family or friends	31.3	29.9
Government websites	25.0	8.3
Non-government websites	16.7	32.1
Magazines, newspapers, books	16.7	21.1
Television	10.4	16.8
Alternative health specialists	9.4	5.9
Health helpline (telephone)	8.3	3.3
Other	5.2	5.1

*Percentages do not total 100.0 due to multiple responses.

Respondents were asked to specify the best way to access technology for health information. More than half (52.1%) of AI respondents stated the best way to access health information is via a smart phone (Figure 20, Appendix Table 21).

The majority of OA respondents stated they best way for them to access health information is via a personal computer or tablet (82.7%), while AI respondents prefer using a smart phone (52.1%)

Figure 20. Respondent technology preference to access health information
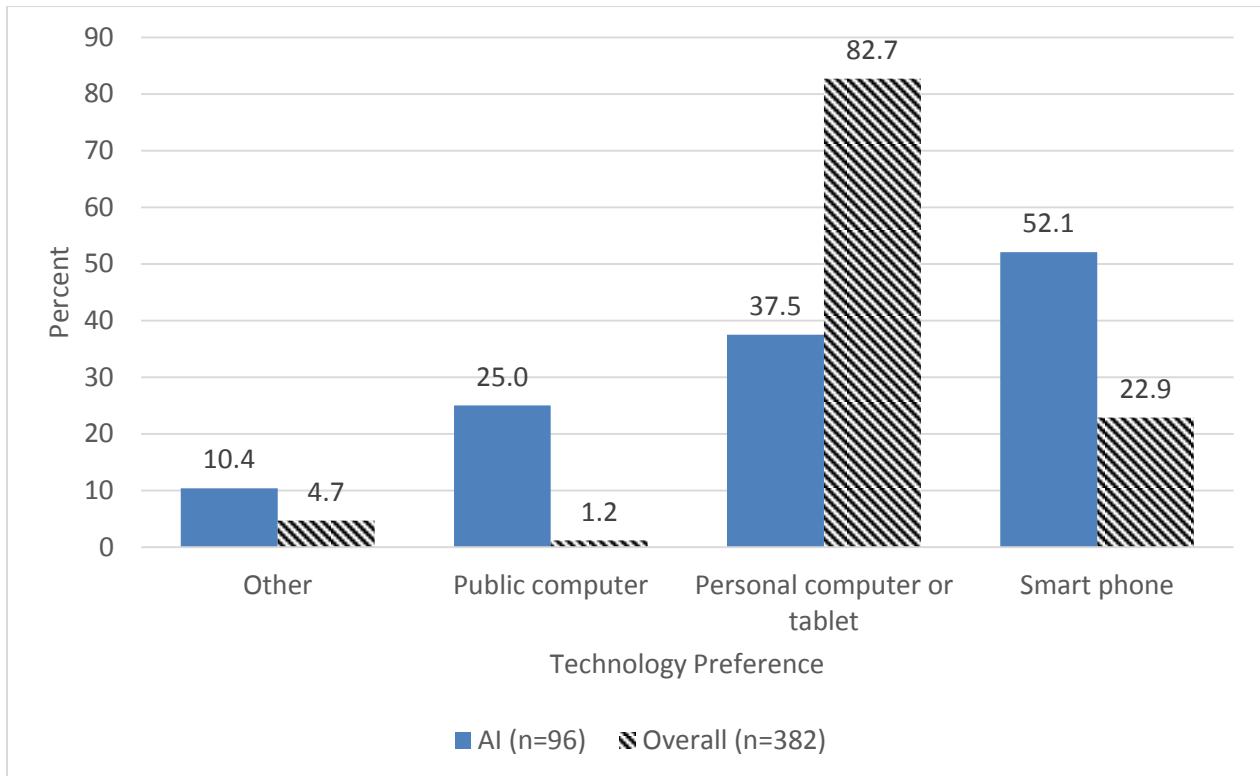
VII.   Demographics

More than three-fourths of the AI respondents were between the ages of 18 to 54 (83.0%), while less than three fourths of OA respondents were of similar age (72.1%) (Figure 21, Appendix Table 22). More OA respondents were aged 65 or older than AI respondents (14.2% vs. 1.1%).

Figure 21. Respondent age
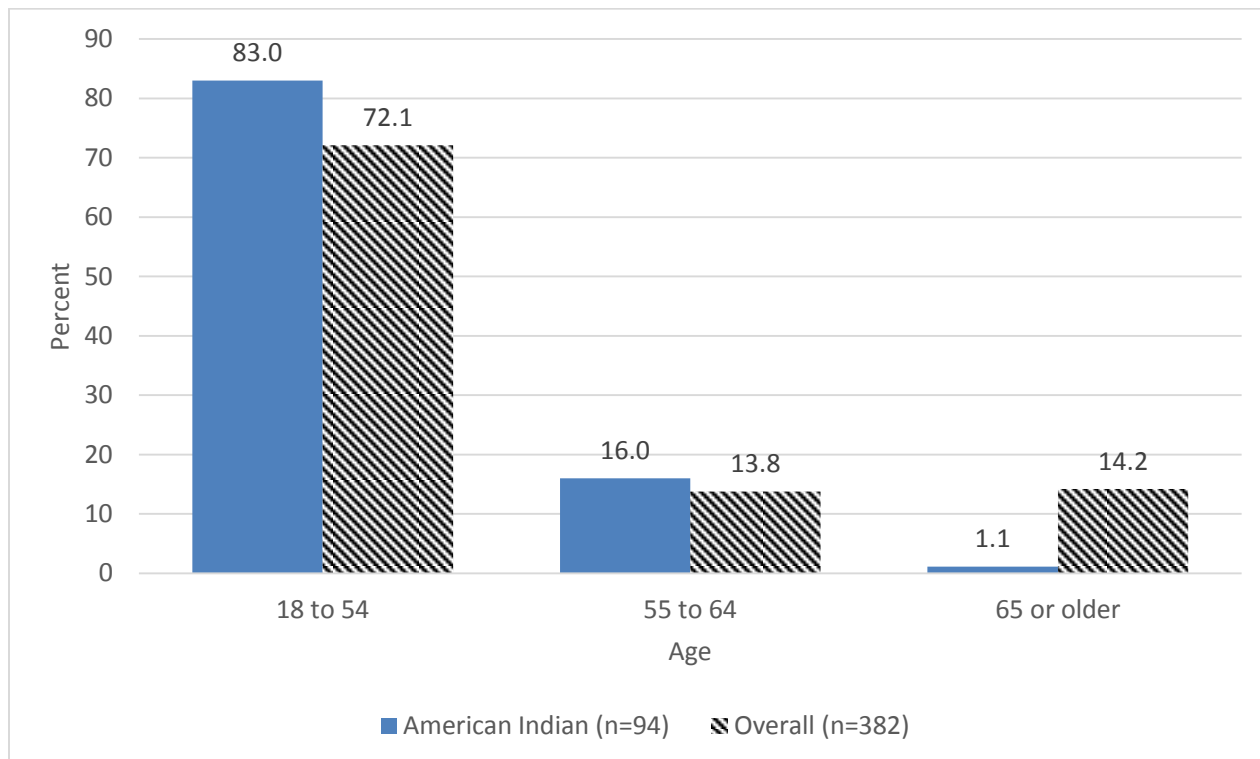
One-fifth of AI respondents had an Associate's degree or higher (20.8%), while nearly three fourths of OA respondents had a similar education level (72.3%) (Figure 22, Appendix Table 23).

Figure 22. Respondent education
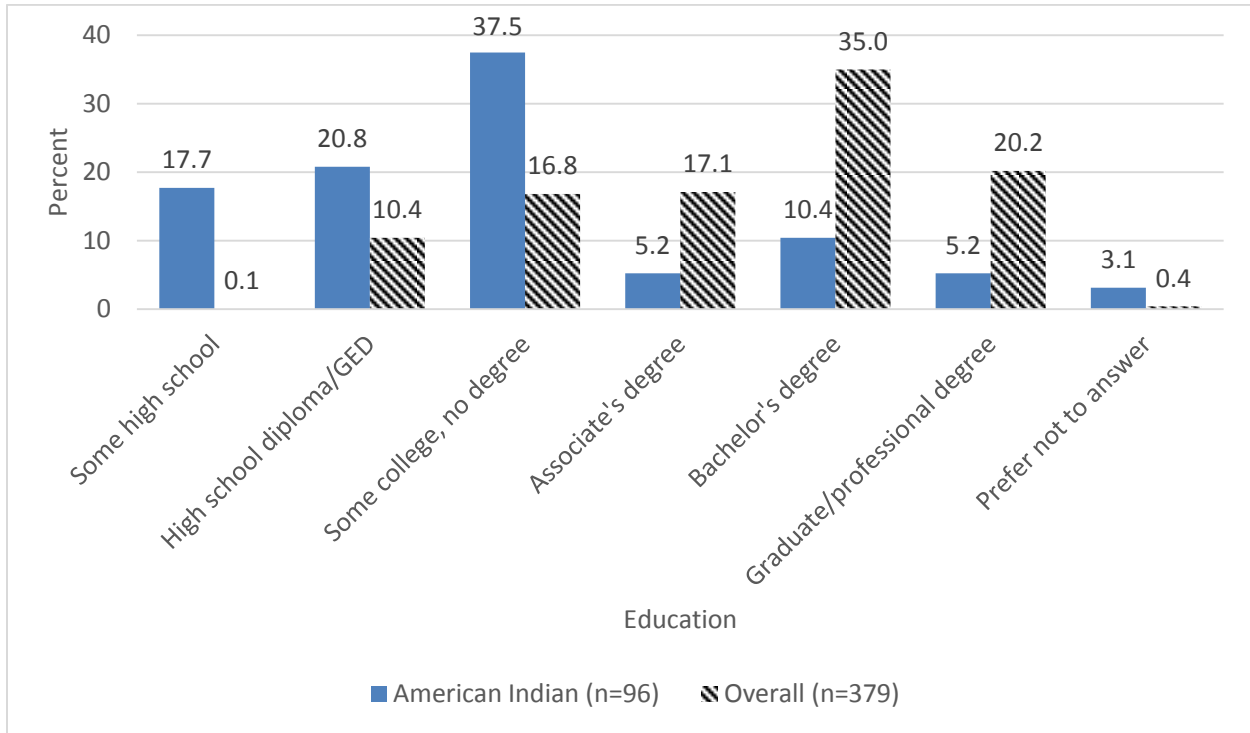
Nearly 58% of AI respondents were female (57.3%), while slightly more than OA respondents were female (50.1%) (Figure 23, Appendix Table 24).

Figure 23. Respondent gender
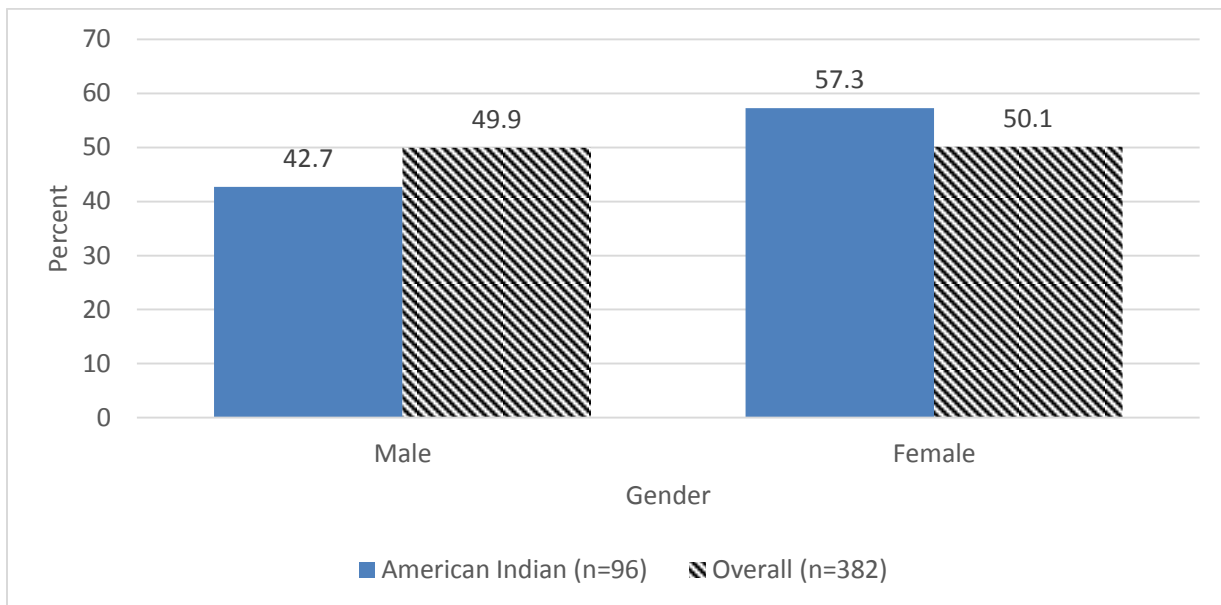
All of the AI respondents identified as Native American/Alaska Native, while only 0.1% of the OA respondents identified as a similar race/ethnicity (Figure 24, Appendix Table 25).

Figure 24. Respondent race/ethnicity
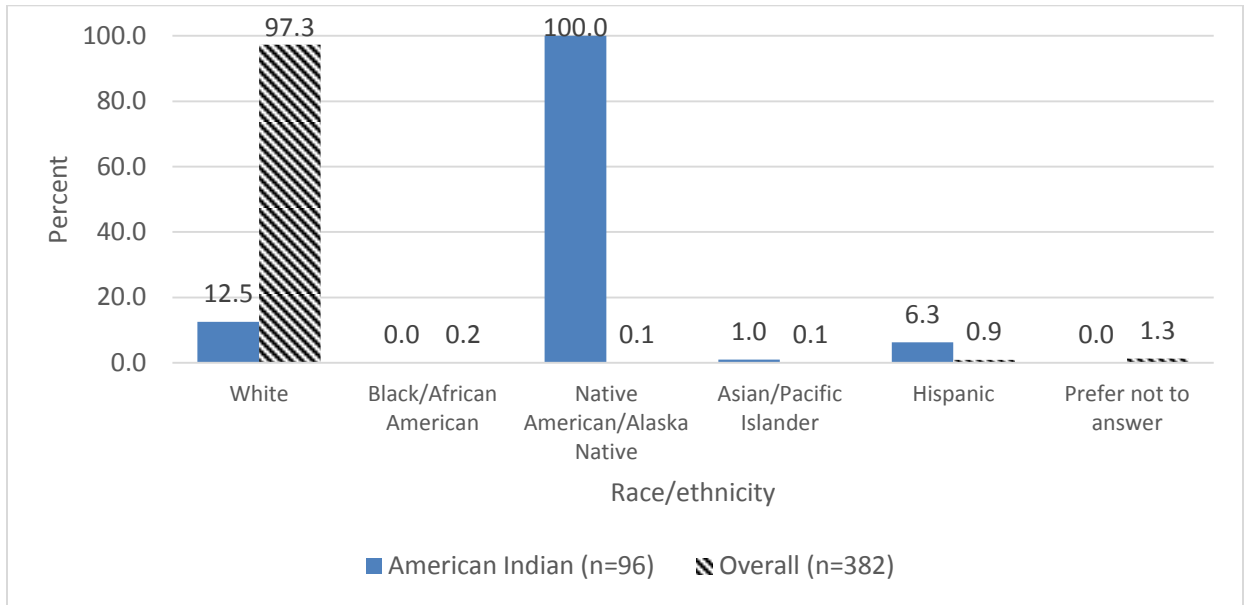
The majority of AI respondents had an annual household income of less than $20,000 (51.1%), while the majority of OA respondents had an annual household income of $70,000 or more (71.1%) (Figure 25, Appendix Table 26).

Figure 25. Respondent annual household income
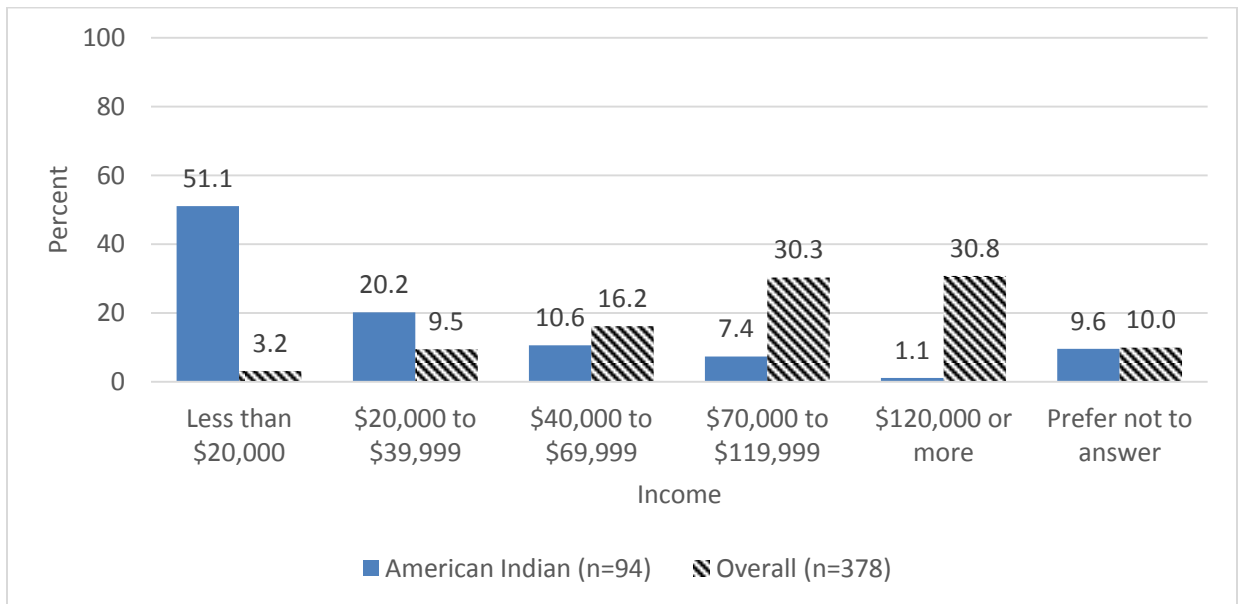
Nearly 44% of AI respondents were employed for wages, while two-thirds of the OA respondents were employed for wages (65.9%) (Table 11, Appendix Table 27). AI respondents were more likely to have been out of work for any period of time than OA respondents (AI=17% vs. OA=0.1%).

Table 11. Respondent employment status

	Percent	
Employment status	**American Indian (n=94)**	**Overall (n=371)**
Employed for wages	43.6	65.9
Self-employed	8.5	11.1
Homemaker	8.5	3.8
Retired	3.2	15.6
Student	3.2	2.7
Unable to work	16	0.8
Out of work - less than 1 year	6.4	0.0
Out of work - 1 year or more	10.6	0.1
TOTAL	*100.0*	*100.0*

OA respondents were more likely to have been in the community for more than 5 years than AI respondents (OA=91.3% vs. AI=50.0%) (Figure 26, Appendix Table 28).

Figure 26. Length of time in community
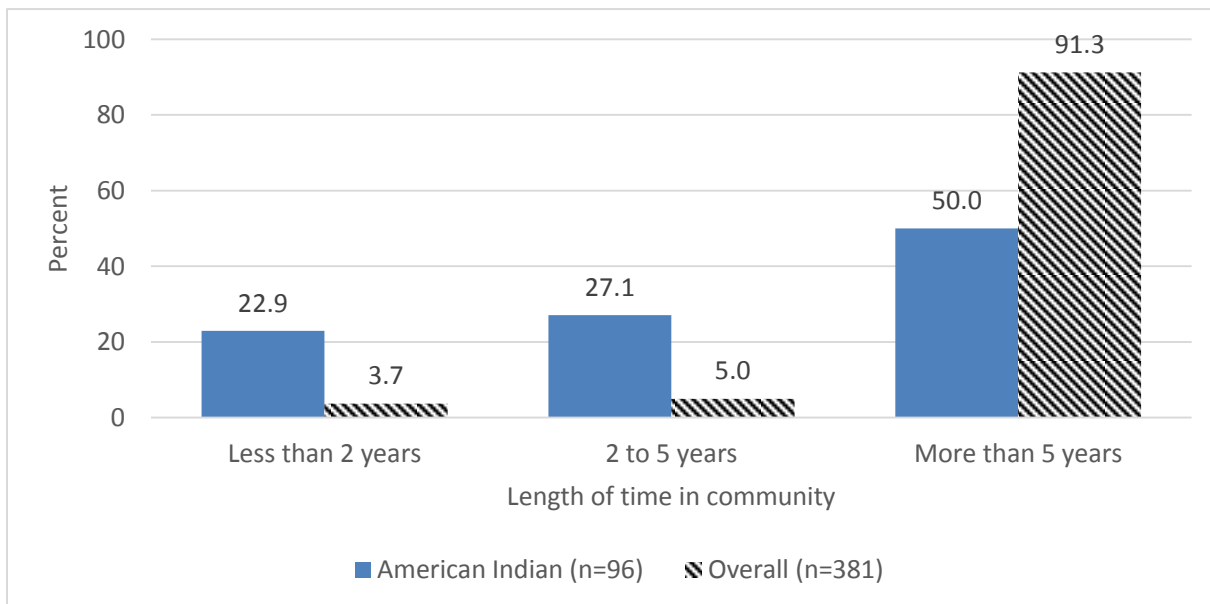
AI respondents are more likely to rent vs own than OA respondents (AI=51.6% vs. OA=6.6%) (Figure 27, Appendix Table 29). OA respondents are nearly five times as likely to own their own home than AI respondents (OA=93.3% vs. AI=20.0%).

Figure 27. Home ownership status
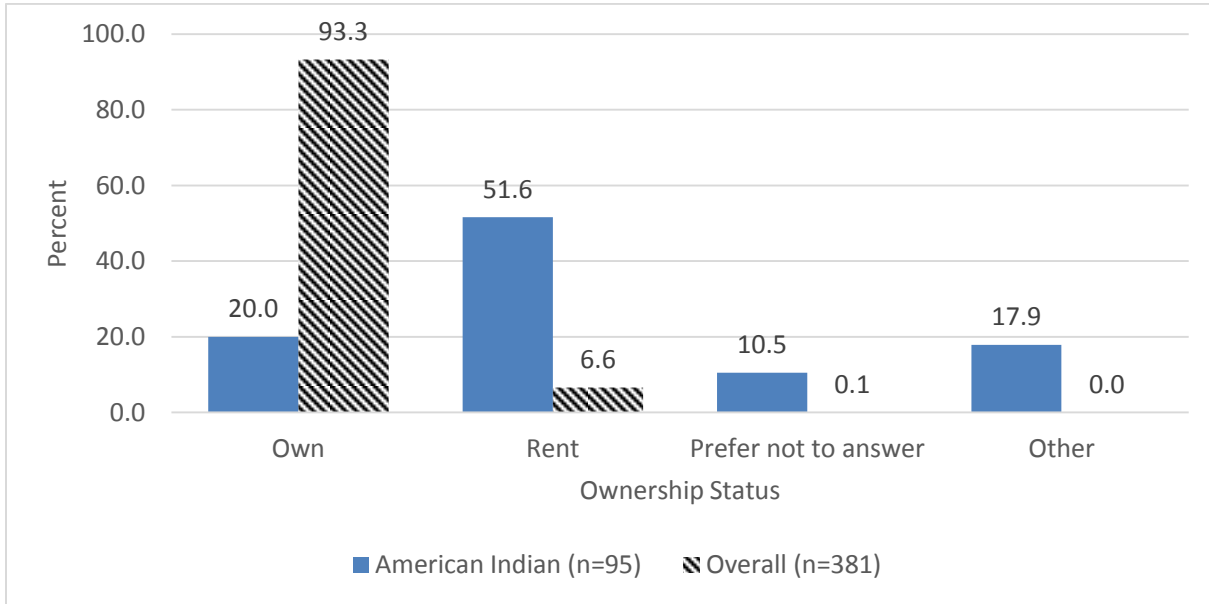
Two thirds of AI respondents stated they had health insurance, while nearly all of the OA respondents stated they have health insurance (AI=68.8% vs. OA=99.0%) (Table 12, Appendix Table 30). Nearly half of AI respondents stated they have oral health or dental health insurance, while more than three fourths of OA respondents stated they had this type of insurance (AI=49.5% vs. OA=76.3%).

Table 12. Respondent insurance status

	Percent					
	Response					
	Yes		No		Don't know	
Type of insurance	AI	Overall	AI	Overall	AI	Overall
Health insurance (n=96)	68.8	99.0	28.1	1.0	3.1	0.0
Oral health/dental care (n=95)	49.5	76.5	43.2	23.3	7.4	0.2

More than half of AI respondents stated they have at least one person who they think of as their personal doctor or health care provider (52.1%), as compared to nearly 82% (81.9%) of OA respondents (Figure 28, Appendix Table 31).

Figure 28. Presence of personal doctor or health care provider
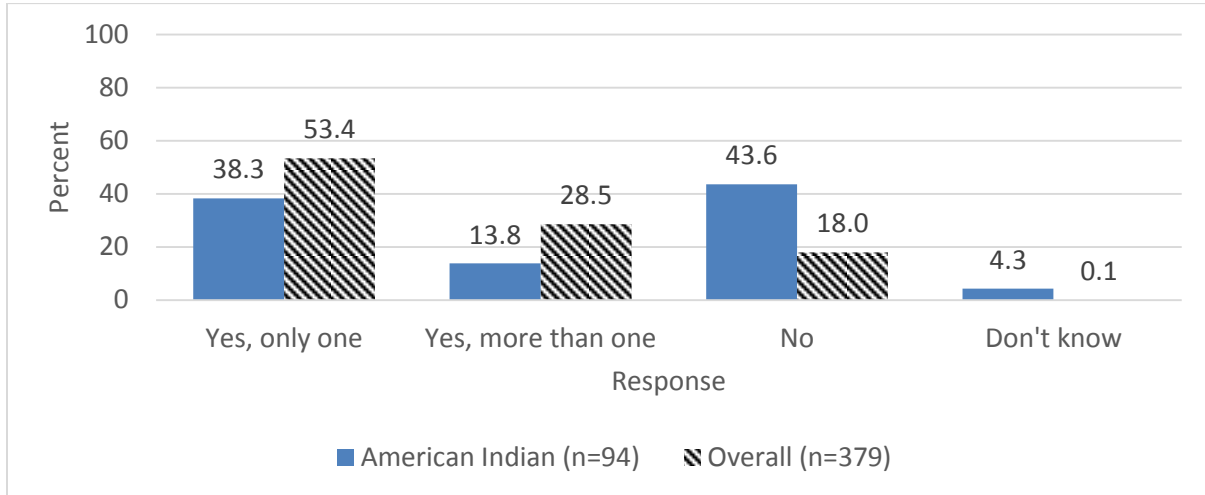
Both AI (30.5%) and OA (66.2%) respondents were most likely to go to a physician's office to seek care when they are sick, and both AI (43.8%) and OA (63.5%) respondents were most likely to take their children to a physician's office when they are sick (Table 13, Appendix Table 32).

Table 13. Location to which respondents go to most often and take their children most often when sick

Person for which care is being sought	Locations									
	Percent									
	Physician Office		Urgent Care		Public health department		Hospital emergency room		Other free or discounted clinic	
	AI	Overall	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Respondents (n: AI=95, OA=367)	30.5	66.2	15.8	28.4	11.6	0.0	22.1	1.6	20.0	3.8
Children (n: AI=48, OA=173)	43.8	63.5	12.5	28.8	8.3	0.0	28.2	0.0	6.3	7.8

More than half of AI respondents (52.6%) stated they have at least one person aged 18 or younger living in their home, and nearly 14% (13.7%) stated they have at least one person aged 65 or older in their household (Table 14, Appendix Table 33).

Table 14. Presence and number of persons aged 18 or younger and aged 65 or older living in respondents' household

	Percent							
	Number of persons							
	None		1 to 2		3 to 5		6 or more	
Age of person	AI	Overall	AI	Overall	AI	Overall	AI	Overall
Younger than 18 years of age (n: AI=95, OA=373)	47.4	53.4	27.4	35.8	22.1	10.8	3.2	0.0
Aged 65 or older (n: AI=95, OA=377)	86.3	82.0	11.6	17.9	2.1	0.1	0.0	0.0

Of the AI respondents who have children aged 18 or younger in their home, 80% stated all children are current on immunizations, as compared to 98.1% of OA respondents. Of the AI respondents who have children aged 18 or younger in their home, 48% stated children aged 6 months or older get an annual flu shot or mist, as compared to 73.5% of OA respondents (Table 15, Appendix Table 33).

Table 15. Whether all children in home are current on immunizations and children aged 6 months or older get an annual flu shot/mist

	Percent							
	Status							
	Yes		No		Don't know		Not applicable	
Age of person	AI	Overall	AI	Overall	AI	Overall	AI	Overall
All children current on immunizations (n: AI=50, OA=174)	80.0	98.1	10.0	1.9	4.0	0.0	6.0	0.0
Aged 6 months or older get annual flu shot/mist (n: AI=50, OA=174)	48.0	73.5	32.0	26.0	10.0	0.5	10.0	0.0

Appendices

Appendix Tables

Appendix Table 1. Level of concern with statements about the community

Statements	Mean	Percent of Respondents*					
		Level of Concern (1=not at all, 5=a great deal)					Total
		1	2	3	4	5	
ECONOMICS							
Availability of affordable housing (n=94)	3.81	5.3	10.6	23.4	19.1	41.5	99.9
Homelessness (n=90)	4.08	7.8	10.0	7.8	15.6	58.9	100.1
Hunger (n=87)	3.83	9.2	12.6	9.2	24.1	44.8	99.9
TRANSPORTATION							
Availability of public transportation (n=94)	2.98	19.1	12.8	38.3	10.6	19.1	99.9
Cost of public transportation (n=88)	3.13	15.9	12.5	34.1	18.2	19.3	100.0
Driving habits (e.g. speeding, road rage) (n=90)	3.01	18.9	15.6	27.8	21.1	16.7	100.1
Availability of good walking or biking options (n=89)	3.27	13.5	10.1	37.1	14.6	24.7	100.0
ENVIRONMENT							
Water quality (n=96)	3.15	16.7	18.8	22.9	16.7	25.0	100.1
Air quality (n=90)	3.16	21.1	12.2	23.3	16.7	26.7	100.0
Home septic systems (n=90)	2.93	22.2	16.7	25.6	16.7	18.9	100.1
Hazardous waste (n=90)	3.10	22.2	14.4	20.0	17.8	25.6	100.0
CHILDREN AND YOUTH							
Availability of services for at-risk youth (n=95)	3.62	8.4	7.4	33.7	14.7	35.8	100.0
Cost of services for at-risk youth (n=93)	3.75	7.5	2.2	34.4	19.4	36.6	100.1
Youth Crime (n=93)	3.72	7.5	4.3	32.3	20.4	35.5	100.0
School dropout rates (n=93)	3.88	5.4	7.5	23.7	20.4	43.0	100.0
School absenteeism (n=92)	3.87	4.3	7.6	25.0	22.8	40.2	99.9
Teen pregnancy (n=93)	3.94	5.4	4.3	25.8	20.4	44.1	100.0
Bullying (n=92)	4.03	3.3	8.7	20.7	16.3	51.1	100.1
Availability of activities for children and youth (n=92)	3.77	2.2	9.8	30.4	23.9	33.7	100.0
Cost of activities for children and youth (n=93)	3.81	5.4	7.5	25.8	23.7	37.6	100.0
Availability of quality child care (n=91)	3.97	4.4	5.5	23.1	23.1	44.0	100.1
Cost of quality child care (n=93)	4.09	2.2	7.5	18.3	23.7	48.4	100.1
Availability of quality infant care (birth to 2 yrs) (n=93)	3.88	5.4	9.7	18.3	24.7	41.9	100.0
Cost of quality infant care (n=92)	3.90	5.4	6.5	22.8	22.8	42.4	99.9
AGING POPULATION							
Availability of activities for seniors (n=95)	3.67	4.2	12.6	23.2	31.6	28.4	100.0
Cost of activities for seniors (n=92)	3.65	5.4	9.8	29.3	25.0	30.4	99.9
Availability of resources to help the elderly stay safe in their home (n=91)	3.71	7.7	9.9	22.0	24.2	36.3	100.1
Availability of resources for family/friends caring for and making decisions for elders (n=93)	3.67	5.4	10.8	23.7	32.3	28.0	100.2
Availability of resources for grandparents caring for grandchildren (n=93)	3.70	6.5	12.9	20.4	24.7	35.5	100.0
Availability of long term care (n=89)	3.76	5.6	9.0	24.7	24.7	36.0	100.0

Statements	Mean	Percent of Respondents*					
		Level of Concern (1=not at all, 5=a great deal)					
		1	2	3	4	5	Total
Cost of long term care (n=93)	3.86	3.2	12.9	23.7	15.1	45.2	100.1
Availability of memory care (n=89)	3.74	4.5	10.1	27.0	23.6	34.8	100.0
SAFETY							
Child abuse and neglect (n=96)	3.90	9.4	5.2	20.8	15.6	49.0	100.0
Elder abuse (n=95)	3.89	8.4	9.5	14.7	18.9	48.4	99.9
Domestic violence (n=94)	4.07	7.4	3.2	16.0	21.3	52.1	100.0
Presence of street drugs, prescription drugs, and alcohol in the community (n=95)	4.08	7.4	4.2	17.9	13.7	56.8	100.0
Presence of drug dealers in the community (n=96)	3.97	9.4	4.2	15.6	21.9	49.0	100.1
Presence of gang activity (n=95)	3.79	9.5	7.4	18.9	23.2	41.1	100.1
Crime (n=95)	3.99	5.3	6.3	16.8	27.4	44.2	100.0
Sex trafficking (n=95)	3.78	12.6	9.5	11.6	20.0	46.3	100.0
HEALTH CARE							
Access to affordable health care (n=96)	3.75	6.3	10.4	26.0	16.7	40.6	100.0
Access to affordable prescription drugs (n=94)	3.86	7.4	7.4	22.3	17.0	45.7	99.8
Access to affordable health insurance (n=94)	3.87	6.4	5.3	27.7	16.0	44.7	100.1
Cost of affordable vision insurance (n=95)	3.84	6.3	5.3	29.5	15.8	43.2	100.1
Cost of affordable dental insurance coverage (n=94)	3.94	6.4	6.4	22.3	17.0	47.9	100.0
Distance to health care services (n=94)	3.60	7.4	8.5	35.1	14.9	34.0	99.9
Providers not taking new patients (n=92)	3.67	7.6	12.0	21.7	22.8	35.9	100.0
Coordination of care between providers and services (n=94)	3.57	10.6	7.4	24.5	28.7	28.7	99.9
Availability of non-traditional hours (n=94)	3.62	7.4	8.5	31.9	19.1	33.0	99.9
Availability of transportation (n=94)	3.57	7.4	12.8	25.5	23.4	30.9	100.0
Use of emergency room services for primary health care (n=94)	3.51	7.4	12.8	28.7	23.4	27.7	100.0
Timely access to vision care providers (n=94)	3.55	7.4	9.6	36.2	13.8	33.0	100.0
Timely access to dental care providers (n=94)	3.74	6.4	7.4	27.7	22.3	36.2	100.0
Timely access to prevention programs and services (n=92)	3.54	6.5	13.0	31.5	17.4	31.5	99.9
Timely access to bilingual providers and/or translators (n=93)	3.51	9.7	9.7	31.2	19.4	30.1	100.1
Timely access to transportation (n=94)	3.54	10.6	9.6	27.7	19.1	33.0	100.0
Timely access to doctors, physician assistants, or nurse practitioners (n=94)	3.73	6.4	9.6	24.5	23.4	36.2	100.1
Timely access to physician specialists (n=93)	3.67	8.6	7.5	28.0	20.4	35.5	100.0
Timely access to registered dietitians (n=93)	3.60	10.8	6.5	25.8	25.8	31.2	100.1
Timely access to exercise specialists or personal trainers (n=94)	3.64	9.6	6.4	27.7	23.4	33.0	100.1
Timely access to mental health providers (n=93)	3.68	9.7	7.5	26.9	17.2	38.7	100.0
Timely access to substance abuse providers (n=94)	3.73	8.5	6.4	26.6	20.2	38.3	100.0

Statements	Mean	1	2	3	4	5	Total
		Percent of Respondents*					
		Level of Concern					
		(1=not at all, 5=a great deal)					
PHYSICAL AND MENTAL HEALTH							
Obesity (n=96)	3.88	7.3	6.3	18.8	27.1	40.6	100.1
Poor nutrition and eating habits (n=93)	4.00	4.3	5.4	19.4	28.0	43.0	100.1
Inactivity and lack of exercise (n=95)	3.94	5.3	6.3	17.9	30.5	40.0	100.0
Cancer (n=94)	3.77	9.6	9.6	16.0	24.5	40.4	100.1
Chronic disease (n=96)	3.92	9.4	7.3	12.5	24.0	46.9	100.1
Sexually transmitted diseases (n=95)	3.75	11.6	4.2	23.2	20.0	41.1	100.1
Infectious diseases such as the flu (n=94)	3.73	8.5	7.4	21.3	27.7	35.1	100.0
Dementia and Alzheimer's Disease (n=96)	3.57	9.4	9.4	26.0	25.0	30.2	100.0
Depression (n=95)	4.03	10.5	2.1	14.7	18.9	53.7	99.9
Stress (n=94)	4.10	7.4	3.2	17.0	17.0	55.3	99.9
Suicide (n=93)	4.11	9.7	3.2	9.7	21.5	55.9	100.0
Other psychiatric diagnosis (n=93)	4.13	8.6	2.2	15.1	16.1	58.1	100.1
SUBSTANCE USE AND ABUSE							
Alcohol use and abuse (n=96)	4.04	10.4	3.1	16.7	11.5	58.3	100.0
Drug use and abuse (n=96)	4.04	10.4	3.1	14.6	15.6	56.3	100.0
Underage drinking (n=96)	3.98	8.3	5.2	16.7	19.8	50.0	100.0
Underage drug use and abuse (n=95)	4.00	7.4	5.3	16.8	21.1	49.5	100.1
Smoking and tobacco abuse (n=96)	3.99	8.3	5.2	17.7	16.7	52.1	100.0
Exposure to second hand smoke (n=96)	4.11	5.2	6.3	18.8	11.5	58.3	100.1

*Percentages do not total 100.0 due to rounding.

Appendix Table 2.
Respondents'
Rating of Their
Health in General

Response	Percent of respondents
Excellent	7.4
Very Good	11.7
Good	40.4
Fair	26.6
Poor	12.8
Don't Know	1.1
TOTAL	*100.0*

n=94

Appendix Table 3. Respondents' weight status based on the
Body Mass Index (BMI) scale

Weight/BMI status	Percent of respondents*
Underweight =BMI less than 18.5	1.2
Normal weight = BMI from 18.5 to 24.9	11.8
Overweight = BMI from 25.0 to 29.9	35.3
Obese = BMI of 30.0 or greater	51.8
TOTAL	*100.1*

n=85

*Percentages do not total 100.0 due to rounding.

Appendix Table 4. Number of servings of vegetables, fruit, and fruit juice that respondents had
yesterday

	Percent of respondents						
	Number of servings						
Type of servings	None	1	2	3	4	5 or more	*TOTAL*
Vegetables consumed yesterday (n=95)	16.8	27.4	34.7	15.8	3.2	2.1	*100.0*
Fruit consumed yesterday (n=96)	15.6	26.0	33.3	18.8	4.2	2.1	*100.0*
Fruit juice consumed yesterday (n=96)	36.5	33.3	14.6	11.5	3.1	1.0	*100.0*

Appendix Table 5. Number of days in an average week respondents engage in moderate and vigorous
physical activity

	Percent of respondents*			
	Number of days			
Type of exercise	None	1 to 2 days	3 to 4 days	5 or more days	*TOTAL*
At least 30 minutes of MODERATE activity in an average week (n=96)	3.1	39.6	28.1	29.2	*100.0*
At least 30 minutes of VIGOROUS activity in an average week (n=96)	18.8	54.2	14.6	12.5	*100.1*

*Percentages do not total 100.0 due to rounding.

Appendix Table 6. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue

Mental health issue	Percent of respondents*
Depression	46.9
Anxiety/stress	54.2
Panic attacks	28.1
Other mental health problems	22.9

n=96

*Percentages do not total 100.0 due to multiple responses.

Appendix Table 7. Number of days in last month when respondents' mental health was not good

Number of days	Percent of respondents
None	15.8
1 to 7 days	33.7
8 to 14 days	18.9
15 to 21 days	13.7
22 to 31 days	17.9
TOTAL	*100.0*

n=95

Appendix Table 8. How often, over the past two weeks, respondents have been bothered by mental health issues, by specific issue

Issues	Percent of respondents				
	Not at all	Several days	More than half the days	Nearly every day	TOTAL
Little interest or pleasure in doing things (n=94)	43.6	36.2	11.7	8.5	*100.0*
Felling down, depressed, or hopeless (n=92)	42.4	33.7	16.3	7.6	*100.0*

*Appendix Table 9. Whether respondents have smoked at least 100 cigarettes in their entire life

Response	Percent of respondents
Yes	67.4
No	32.6
TOTAL	*100.0*

n=95

Appendix Table 10. How often respondents currently smoke cigarettes and use chewing tobacco or snuff

Tobacco Use	Percent of respondents*			
	Every day	Some days	Not at all	TOTAL
Cigarettes (n=95)	38.9	20.0	41.1	100.0
Chewing tobacco or snuff (n=95)	7.4	9.5	83.2	100.1

*Percentages do not total 100.0 due to rounding.

Appendix Table 11. Location respondents would go first if they wanted help to quit using tobacco

Resources	Percent of respondents
Quitline	14.7
Doctor	12.6
Pharmacy	1.1
Private counselor/therapist	1.1
Health department	7.4
Don't know	16.8
Not applicable	26.3
I don't want to quit	10.5
Other:	9.5
Candy (1)	
Homeless health (1)	
Myself (4)	
Non-smoker (1)	
Vapor (1)	
TOTAL	100.0

n=95

Appendix Table 12. Number of days during the past month that respondents have had at least one drink of any alcoholic beverage

Number of days	Percent of respondents
None	46.3
1 to 7 days	35.8
8 to 14 days	5.3
15 to 21 days	6.3
22 to 31 days	6.3
TOTAL	100.0

n=95

Appendix Table 13. During the past month on days when respondents drank, average number of drinks per day respondents consumed

Number of drinks	Percent of respondents
1	48.4
2	5.4
3	7.5
4	4.3
5 or more	34.4
TOTAL	*100.0*

n=93

Appendix Table 14. Number of days during the past month that respondents consumed at least 4 or 5 alcohol drinks (4 for females, 5 for males) on the same occasion

Frequency	Percent of respondents*
Almost every day	4.4
2-3 times a week	14.4
Once a week	12.2
Once a month	14.4
Never	54.4
TOTAL	*99.8*

n=90

*Percentages do not total 100.0 due to rounding.

Appendix Table 15. Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug use

Had a problem with:	Percent of respondents		
	Yes	No	*TOTAL*
Alcohol use (n=95)	51.6	48.4	*100.0*
Prescription or non-prescription drug use (n=91)	26.4	73.6	*100.0*

Appendix Table 16. Of respondents who have ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

Got help needed for:	Percent of respondents*			
	Yes	No	Didn't need help	*TOTAL*
Alcohol use (n=48)	56.3	29.2	14.6	*100.1*
Prescription or non-prescription drug use (n=32)	50.0	21.9	28.1	*100.0*

*Percentages do not total 100.0 due to rounding.

Appendix Table 17. Whether alcohol use or prescription or non-prescription drug abuse had harmful effects on respondents or a family member over the past two years

Over the past two years:	Percent of respondents		
	Yes	No	*TOTAL*
Alcohol use has had harmful effects (n=94)	67.0	33.0	*100.0*
Prescription or non-prescription drug use has had harmful effects (n=93)	57.0	43.0	*100.0*

Appendix Table 18. Whether respondents have any of the following chronic diseases

Chronic diseases	Percent of respondents*
Diabetes	15.6
Hypertension	16.7
High cholesterol	12.5
Congestive heart failure	1.0
COPD	2.1
Arthritis	16.7
Alzheimer's	0.0
Asthma	10.4
Stroke	1.0
Cancer	0.0

n=96

*Percentages do not total 100.0 due to multiple responses.

Appendix Table 19. Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason

Length of time since:	Percent of respondents*						
	Within the past year	1 to 2 years	3 to 5 years	6 or more years	Don't Know	Never	*TOTAL*
Visiting a doctor or health care provider (n=95)	65.3	15.8	9.5	2.1	3.2	4.2	*100.1*
Visiting a dentist or dental clinic (n=93)	51.6	18.3	20.4	5.4	1.1	3.2	*100.0*

*Percentages do not total 100.0 due to rounding.

Appendix Table 20. Where respondents get most of their health information

Sources of health information	Percent of respondents*
Government websites (i.e. CDC)	25.0
Non-government websites (i.e. WebMD)	16.7
Television	10.4
Magazine, newspapers, or books	16.7
Medical professional	40.6
Alternative health specialist	9.4
Family or friends	31.3
Health helpline (Telephone)	8.3
Other:	5.2
Google	
Homeless health/family health	
Myself	

n=96

*Percentages do not total 100.0 due to multiple responses.

Appendix Table 21. Best way for respondents to access technology for health information

Type of technology	Percent of respondents*
Personal computer or tablet	37.5
Public computer (e.g. library, community center)	25.0
Smart phone	52.1
Other:	10.4
Home computer	
Don't know	
Other doctor	
Phone	
Public health	
Social media	

n=96

*Percentages do not total 100.0 due to multiple responses.

Appendix Table 22. Respondent age

Age	Percent of respondents*
18 to 24 years	16.0
25 to 34 years	26.6
35 to 44 years	21.3
45 to 54 years	19.1
55 to 64 years	16.0
65 to 74 years	1.1
75 years or older	0.0
TOTAL	*100.1*

n=94

*Percentages do not total 100.0 due to rounding.

Appendix Table 23. Respondent education

Education	Percent of respondents*
Some high school	17.7
High school diploma or GED	20.8
Some college, no degree	37.5
Associate's degree	5.2
Bachelor's degree	10.4
Graduate or professional degree	5.2
Prefer not to answer	3.1
TOTAL	**99.9**

n=96

*Percentages do not total 100.0 due to rounding.

Appendix Table 24. Respondent gender

Gender	Percent of respondents
Male	42.7
Female	57.3
TOTAL	**100.0**

n=96

Appendix Table 25. Respondent race/ethnicity

Race/ethnicity	Percent of respondents*
White	12.5
Black or African American	0.0
Native American or Alaska Native	0.0
Asian or Pacific Islander	100.0
Hispanic	6.3
Prefer not to answer	0.0

n=96

*Percentages do not total 100.0 due to multiple responses.

Appendix Table 26. Respondent income

Income	Percent of respondents
Less than $20,000	51.1
$20,000 to $39,999	20.2
$40,000 to $69,999	10.6
$70,000 to $119,999	7.4
$120,000 or more	1.1
Prefer not to answer	9.6
TOTAL	*100.0*

n=94

Appendix Table 27. Respondent employment status

Employment status	Percent of respondents
Employed for wages	43.6
Self-employed	8.5
Homemaker	8.5
Retired	3.2
A student	3.2
Unable to work	16.0
Out of work - less than 1 year	6.4
Out of work - 1 year or more	10.6
TOTAL	*100.0*

n=94

Appendix Table 28. Length of time respondents have lived in their community

Length of time in community	Percent of respondents
Less than 2 years	22.9
2 to 5 years	27.1
More than 5 years	50.0
TOTAL	*100.0*

n=94

Appendix Table 29. Whether respondents own or rent their home

Response	Percent of respondents
Own	20.0
Rent	51.6
Prefer not to answer	10.5
Other	17.9
Homeless (8)	■
TOTAL	*100.0*

n=95

Appendix Table 30. Respondent health insurance and dental insurance status

	Percent of respondents*			
Type of coverage	Yes	No	Prefer not to answer	*TOTAL*
Health insurance (n=96)	68.8	28.1	3.1	*100.0*
Dental insurance (oral health or dental care coverage) (n=95)	49.5	43.2	7.4	*100.1*

*Percentages do not total 100.0 due to rounding.

Appendix Table 31. Whether respondents have one person who they think of as their personal doctor or health care provider

Response	Percent of respondents
Yes, only one	38.3
Yes, more than one	13.8
No	43.6
Don't know	4.3
TOTAL	*100.0*

n=94

Appendix Table 32. Facilities to which respondents go most often when sick and take their children when sick

Location	Percent of respondents*	
	Where respondents go (n=95)	Where respondents take their children (n=48)
Physician office	30.5	43.8
Urgent care	15.8	12.5
Public health department	11.6	8.3
Hospital emergency room	22.1	29.2
Other free or discounted clinic	20.0	6.3
TOTAL	*100.0*	*100.1*

*Percentages do not total 100.0 due to rounding.

Appendix Table 33. Number of persons aged 18 or younger and aged 65 or older living in respondents' household

Number of persons	Percent of respondents*	
	Persons younger than 18 in household (n=95)	Persons aged 65 or older in household (n=95)
None	47.4	86.3
1 to 2	27.4	11.6
3 to 5	22.1	2.1
6 or more	3.2	0.0
TOTAL	*100.1*	*100.0*

*Percentages do not total 100.0 due to rounding.

Appendix Table 34. Whether all children in home are current on immunizations and children aged 6 months or older get an annual flu shot/mist

Response	Percent of respondents	
	Children are current on immunizations (n=50)	Children aged 6 months or older get annual flu shot/mist (n=50)
Yes	80.0	48.0
No	10.0	32.0
Don't know	4.0	10.0
Not applicable	6.0	10.0
TOTAL	*100.0*	*100.0*

Survey Instrument

2015 Community Health Needs Assessment

Q1 Considering your community, what is your level of concern with....

Q2 ECONOMICS

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Availability of affordable housing (1)	❍	❍	❍	❍	❍
Homelessness (2)	❍	❍	❍	❍	❍
Hunger (3)	❍	❍	❍	❍	❍

Q3 TRANSPORTATION

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Availability of public transportation (1)	❍	❍	❍	❍	❍
Cost of public transportation (2)	❍	❍	❍	❍	❍
Driving habits (e.g., speeding, road rage) (3)	❍	❍	❍	❍	❍
Availability of good walking or biking options (as alternatives to driving) (4)	❍	❍	❍	❍	❍

Q4 ENVIRONMENTAL

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Water quality (1)	❍	❍	❍	❍	❍
Air quality (2)	❍	❍	❍	❍	❍
Home septic systems (3)	❍	❍	❍	❍	❍
Hazardous waste (4)	❍	❍	❍	❍	❍

Q5 CHILDREN AND YOUTH

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Availability of services for at-risk youth (1)	❍	❍	❍	❍	❍
Cost of services for at-risk youth (2)	❍	❍	❍	❍	❍
Youth crime (3)	❍	❍	❍	❍	❍
School dropout rates (4)	❍	❍	❍	❍	❍
School absenteeism (5)	❍	❍	❍	❍	❍
Teen pregnancy (6)	❍	❍	❍	❍	❍
Bullying (7)	❍	❍	❍	❍	❍
Availability of activities for children and youth (8)	❍	❍	❍	❍	❍
Cost of activities for children and youth (9)	❍	❍	❍	❍	❍
Availability of quality child care (10)	❍	❍	❍	❍	❍
Cost of quality child care (11)	❍	❍	❍	❍	❍
Availability of quality infant care (birth to 2 years) (12)	❍	❍	❍	❍	❍
Cost of quality infant care (13)	❍	❍	❍	❍	❍

Q6 THE AGING POPULATION

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Availability of activities for seniors (1)	❍	❍	❍	❍	❍
Cost of activities for seniors (2)	❍	❍	❍	❍	❍
Availability of resources to help the elderly stay safe in their home (3)	❍	❍	❍	❍	❍
Availability of resources for family/friends caring for and making decisions for elders (4)	❍	❍	❍	❍	❍
Availability of resources for grandparents caring for grandchildren (5)	❍	❍	❍	❍	❍
Availability of long term care (6)	❍	❍	❍	❍	❍
Cost of long term care (7)	❍	❍	❍	❍	❍
Availability of memory care (8)	❍	❍	❍	❍	❍

Q7 SAFETY

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Child abuse and neglect (1)	❍	❍	❍	❍	❍
Elder abuse (2)	❍	❍	❍	❍	❍
Domestic violence (3)	❍	❍	❍	❍	❍
Presence of street drugs, prescription drugs, and alcohol in the community (4)	❍	❍	❍	❍	❍
Presence drug dealers in the community (5)	❍	❍	❍	❍	❍
Presence of gang activity (6)	❍	❍	❍	❍	❍
Crime (7)	❍	❍	❍	❍	❍
Sex trafficking (8)	❍	❍	❍	❍	❍

Q8 HEALTH CARE

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Access to affordable health care (1)	○	○	○	○	○
Access to affordable prescription drugs (2)	○	○	○	○	○
Access to affordable health insurance (3)	○	○	○	○	○
Cost of affordable vision insurance (4)	○	○	○	○	○
Cost of affordable dental insurance coverage (5)	○	○	○	○	○
Distance to health care services (6)	○	○	○	○	○
Providers not taking new patients (7)	○	○	○	○	○
Coordination of care between providers and services (8)	○	○	○	○	○
Availability of non-traditional hours (e.g., evenings, weekends) (9)	○	○	○	○	○
Availability of transportation (10)	○	○	○	○	○
Use of emergency room services for primary health care (11)	○	○	○	○	○
Timely access to vision care providers (12)	○	○	○	○	○

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Timely access to dental care providers (13)	○	○	○	○	○
Timely access to prevention programs and services (14)	○	○	○	○	○
Timely access to bilingual providers and/or translators (15)	○	○	○	○	○
Timely access to transportation (16)	○	○	○	○	○
Timely access to doctors, physician, assistants, or nurse practitioners (17)	○	○	○	○	○
Timely access to physician specialist (18)	○	○	○	○	○
Timely access to registered dietitians (19)	○	○	○	○	○
Timely access to exercise specialists or personal trainers (20)	○	○	○	○	○
Timely access to mental health providers (21)	○	○	○	○	○
Timely access to substance abuse providers (22)	○	○	○	○	○

Q9 PHYSICAL AND MENTAL HEALTH

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Obesity (1)	❍	❍	❍	❍	❍
Poor nutrition and eating habits (2)	❍	❍	❍	❍	❍
Inactivity and lack of exercise (3)	❍	❍	❍	❍	❍
Cancer (4)	❍	❍	❍	❍	❍
Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (5)	❍	❍	❍	❍	❍
Sexually transmitted diseases (e.g., AIDS, HIV, Chlamydia) (6)	❍	❍	❍	❍	❍
Infectious diseases such as the flu (7)	❍	❍	❍	❍	❍
Dementia and Alzheimer's disease (8)	❍	❍	❍	❍	❍
Depression (9)	❍	❍	❍	❍	❍
Stress (10)	❍	❍	❍	❍	❍
Suicide (11)	❍	❍	❍	❍	❍
Other psychiatric diagnosis (12)	❍	❍	❍	❍	❍

Q10 SUBSTANCE USE AND ABUSE

	Not at All 1 (1)	2 (2)	3 (3)	4 (4)	A Great Deal 5 (5)
Alcohol use and abuse (1)	○	○	○	○	○
Drug use and abuse (2)	○	○	○	○	○
Underage drinking (3)	○	○	○	○	○
Underage drug and abuse (4)	○	○	○	○	○
Smoking and tobacco use (5)	○	○	○	○	○
Exposure to second hand smoke (6)	○	○	○	○	○

Q11 PERSONAL HEALTH

Q12 In general, how would you rate your health?

○ Excellent (1)
○ Very Good (2)
○ Good (3)
○ Fair (4)
○ Poor (5)
○ Don't know (6)

Q13 About how much do you weight without shoes?

Q14 About how tall are you without shoes?

    Feet (1)
    Inches (2)

Q15 A serving of vegetables is one cup of salad greens or a half cup of vegetables - not including French fries. How many servings of vegetables did you have yesterday?

○ None (1)
○ 1 (2)
○ 2 (3)
○ 3 (4)
○ 4 (5)
○ 5 or more (6)

Q16 A serving of fruit is a medium sized piece of fruit or a half cup of chopped, cut or canned fruit. How many servings of fruit did you have yesterday?

○ None (1)
○ 1 (2)
○ 2 (3)
○ 3 (4)
○ 4 (5)
○ 5 or more (6)

Q17 A serving of 100% fruit juice is 6 ounces. How many servings of fruit juice did you have yesterday?

○ None (1)
○ 1 (2)
○ 2 (3)
○ 3 (4)
○ 4 (5)
○ 5 or more (6)

Q18 MODERATE activity causes only light sweating and a small increase in breathing or hear rate. During an average week, other than your regular job, how many days do you get at least 30 minutes of MODERATE activity?

○ None (1)
○ 1 to 2 days (2)
○ 3 to 4 days (3)
○ 5 or more days (4)

Q19 VIGOROUS activity causes heavy sweating and a large increase in breathing or hear rate. During an average week, other than your regular job, how many days do you get at least 30 minutes of VIGOROUS activity?

❍ None (1)
❍ 1 to 2 days (2)
❍ 3 to 4 days (3)
❍ 5 or more days (4)

Q20 Have you ever been told by a doctor or health professional that you have any of the following? (Chose all that apply)

❑ Depression (1)
❑ Anxiety/Stress (2)
❑ Panic attacks (3)
❑ Other mental health problems (4)

Q21 Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

- ○ 0 (1)
- ○ 1 (2)
- ○ 2 (3)
- ○ 3 (4)
- ○ 4 (5)
- ○ 5 (6)
- ○ 6 (7)
- ○ 7 (8)
- ○ 8 (9)
- ○ 9 (10)
- ○ 10 (11)
- ○ 11 (12)
- ○ 12 (13)
- ○ 13 (14)
- ○ 14 (15)
- ○ 15 (16)
- ○ 16 (17)
- ○ 17 (18)
- ○ 18 (19)
- ○ 19 (20)
- ○ 20 (21)
- ○ 21 (22)
- ○ 22 (23)
- ○ 23 (24)
- ○ 24 (25)
- ○ 25 (26)
- ○ 26 (27)
- ○ 27 (28)
- ○ 28 (29)
- ○ 29 (30)
- ○ 30 (31)

Q22 Over the past two weeks, how often have you been bothered by any of the following issues?

	Not at all (1)	Several days (2)	More than half the days (3)	Nearly every day (4)
Little interest or pleasure in doing things (1)	○	○	○	○
Feeling down depressed or hopeless (2)	○	○	○	○

Q23 Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = 5 packs)

○ Yes (1)
○ No (2)

Q24 How often do you currently smoke cigarettes?

○ Every day (1)
○ Some days (2)
○ Not at all (3)

Q25 How often do you currently use chewing tobacco or snuff?

○ Every day (1)
○ Some days (2)
○ Not at all (3)

Q26 Where would you first go for help if you wanted to quit using tobacco? (Choose ONE answer)

○ Quitline (1)
○ Doctor (2)
○ Pharmacy (3)
○ Private counselor/Therapist (4)
○ Health Department (5)
○ Don't know (6)
○ Not applicable (7)
○ I don't want to quit (8)
○ Other: (9) _____

Q27 During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage?

- ○ 0 (1)
- ○ 1 (2)
- ○ 2 (3)
- ○ 3 (4)
- ○ 4 (5)
- ○ 5 (6)
- ○ 6 (7)
- ○ 7 (8)
- ○ 8 (9)
- ○ 9 (10)
- ○ 10 (11)
- ○ 11 (12)
- ○ 12 (13)
- ○ 13 (14)
- ○ 14 (15)
- ○ 15 (16)
- ○ 16 (17)
- ○ 17 (18)
- ○ 18 (19)
- ○ 19 (20)
- ○ 20 (21)
- ○ 21 (22)
- ○ 22 (23)
- ○ 23 (24)
- ○ 24 (25)
- ○ 25 (26)
- ○ 26 (27)
- ○ 27 (28)
- ○ 28 (29)
- ○ 29 (30)
- ○ 30 (31)

Q28 During the past 30 days, on the days when you drank, about how many drinks did you drink on average? A drink is one can of beer, one glass of wine, or a drink with one shot of liquor.

○ 0 (1)
○ 1 (2)
○ 2 (3)
○ 3 (4)
○ 4 (5)
○ 5 (6)
○ 6 (7)
○ 7 (8)
○ 8 (9)
○ 9 (10)
○ 10 or more drinks (11)

Q29 During the past 30 days, how many times did you consume at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same time occasion (at the same time, or within a couple of hours of each other)?

○ Almost every day (1)
○ 2 to 3 times a week (2)
○ Once a week (3)
○ Once a month (4)
○ Never (5)

Q30

	Have you ever had a problem with....		If yes, did you get the help you needed?		
	Yes (1)	No (2)	Yes (1)	No (2)	Didn't need help (3)
Alcohol use? (1)	○	○	○	○	○
Prescription or non-prescription drug abuse? (2)	○	○	○	○	○

Q31 Over the past two years…

	Yes (1)	No (2)
Has alcohol use had harmful effects on you or a family member? (1)	○	○
Has prescription or non-prescription drug abuse had harmful effects on your or your family member? (2)	○	○

Q32 PREVENTIVE HEALTH

Q33 Below is a list of preventive screenings and procedures that you may have had in the last year. Please tell usa) Whether or not you had each of the procedures in the last year, andb) If you did not have the procedure, why not? (Choose all that apply)

	Have you had this procedure in the past year?		If you have not had this procedure in the past year, why not? (Choose all that apply for each procedure)						
	Yes (1)	No (2)	Not necessary (1)	Doctor hasn't suggested (2)	Cost (3)	Fear of procedure (4)	Fear of the results (5)	Unable to access care (6)	Other reason (7)
General Screenings Blood pressure screening (1)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Bone density test (2)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Cholesterol screening (3)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Flu shot (4)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Hearing screening (5)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Immunizations (tetanus, hepatitis A or B) (6)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Pelvic exam (women's health) (7)	❍	❍	❑	❑	❑	❑	❑	❑	❑
STD (sexually transmitted disease screening) (8)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Vascular screening (9)	❍	❍	❑	❑	❑	❑	❑	❑	❑
Cancer Screenings Breast cancer screening (i.e., Mammogram, breast exam, women, age 40+) (10)	❍	❍	❑	❑	❑	❑	❑	❑	❑

	Have you had this procedure in the past year?	If you have not had this procedure in the past year, why not? (Choose all that apply for each procedure)						
Cervical cancer screening (i.e., pap smear with 3 years of first sexual intercourse or by age 21 every 1-3 years depending on risk factors) (11)	○ ○	❑	❑	❑	❑	❑	❑	❑
Colorectal cancer screening (i.e., colonoscopy every 10 years beginning at age 50, fecal occult blood test every year, barium enema every 5 years) (12)	○ ○	❑	❑	❑	❑	❑	❑	❑
Prostate cancer screening (13)	○ ○	❑	❑	❑	❑	❑	❑	❑
Skin cancer screening (14)	○ ○	❑	❑	❑	❑	❑	❑	❑

Q34 Do you have any of the following chronic diseases? (Choose all that apply)

- ❑ Diabetes (1)
- ❑ Hypertension (2)
- ❑ High Cholesterol (3)
- ❑ Congestive Heart Failure (4)
- ❑ COPD (5)
- ❑ Arthritis (6)
- ❑ Alzheimer's (7)
- ❑ Asthma (8)
- ❑ Stroke (9)
- ❑ Cancer (10)

Q35 About how long has it been since you last visited a doctor or health care provider for a routine physical exam?

- ❍ Within the past year (1)
- ❍ 1 to 2 years (2)
- ❍ 3 to 5 years (3)
- ❍ 6 or more years (4)
- ❍ Don't know (5)
- ❍ Never (6)

Q36 About how long has it been since you last visited a dentist or dental clinic for any reason?

- ❍ Within the past year (1)
- ❍ 1 to 2 years (2)
- ❍ 3 to 5 years (3)
- ❍ 6 or more years (4)
- ❍ Don't know (5)
- ❍ Never (6)

Q37 Where do you get most of your health-related information? (Choose all that apply)

- ❑ Government websites (i.e., local public health, CDC) (1)
- ❑ Non-government websites (i.e., WebMD) (2)
- ❑ Television (3)
- ❑ Magazine, newspapers, or books (4)
- ❑ Medical professional (5)
- ❑ Alternative health specialist (6)
- ❑ Family or friends (7)
- ❑ Health Helpline (Telephone) (8)
- ❑ Other: (9) _____

Q38 What is the best way for you to access technology for health information? (Choose all that apply)

- ❑ Personal computer or tablet (1)
- ❑ Public computer (e.g., library, community center) (2)
- ❑ Smart phone (3)
- ❑ Other: (4) _____

Q39 DEMOGRAPHIC INFORMATION - Please tell us about yourself

Q40 What is your age?

- ○ 18 to 24 years (1)
- ○ 25 to 34 years (2)
- ○ 35 to 44 years (3)
- ○ 45 to 54 years (4)
- ○ 55 to 64 years (5)
- ○ 65 to 74 years (6)
- ○ 75 or older (7)
- ○ Prefer to not answer (8)

Q41 What is your highest level of education?

- ◯ Some high school (1)
- ◯ High school diploma or GED (2)
- ◯ Some college, no degree (3)
- ◯ Associate's degree (4)
- ◯ Bachelor's degree (5)
- ◯ Graduate or professional degree (6)
- ◯ Prefer to not answer (7)

Q42 What is your gender?

- ◯ Male (1)
- ◯ Female (2)
- ◯ Prefer to not answer (3)

Q43 What best describes your race/ethnicity? (Choose all that apply)

- ❑ White (1)
- ❑ Black or African American (2)
- ❑ Native American or Alaska Native (3)
- ❑ Asian or Pacific Islander (4)
- ❑ Hispanic (5)
- ❑ Prefer to not answer (6)

Q44 What is your approximate annual household income before taxes?

- ◯ Less than $20,000 (1)
- ◯ $20,000 to $39,999 (2)
- ◯ $40,000 to $69,999 (3)
- ◯ $70,000 to $119,999 (4)
- ◯ $120,000 or more (5)
- ◯ Prefer to not answer (6)

Q45 How would you best describe your current employment status?

- ○ Employed for wages (1)
- ○ Self-employed (2)
- ○ Homemaker (3)
- ○ Retired (4)
- ○ A Student (5)
- ○ Unable to work (6)
- ○ Out of work-less than 1 year (7)
- ○ Out of work-1 year or more (8)

Q46 How long have you lived in your community?

- ○ Less than 2 years (1)
- ○ 2 to 5 years (2)
- ○ More than 5 years (3)

Q47 Do you own or rent your home?

- ○ Own (1)
- ○ Rent (2)
- ○ Prefer to not answer (3)
- ○ Other: (4) _____

Q48 Do you have health insurance (Private, public, or governmental)?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know (3)

Q49 Do you have oral health or dental care insurance coverage?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know (3)

Q50 Do you have one person who you think of as your personal doctor or health care provider?

❍ Yes, only one (1)
❍ Yes, more than one (2)
❍ No (3)
❍ Don't know (4)

Q51 Where do you go most often when you're sick? (Choose ONE)

❍ Physician office (1)
❍ Urgent care (2)
❍ Public Health Dept. (3)
❍ Hospital emergency room (4)
❍ Other free or discounted clinic (5)

Q52 Where do you most often take your child when they are sick? (Choose ONE)

❍ Physician office (1)
❍ Urgent care (2)
❍ Public Health Dept (3)
❍ Hospital emergency room (4)
❍ Other free or discounted clinic (5)

Q53 How many children younger than 18 years of age live in your household?

❍ None (1)
❍ 1 to 2 (2)
❍ 3 to 5 (3)
❍ 6 or more (4)

Q54 How many adults age 65 or older live in your household?

❍ None (1)
❍ 1 to 2 (2)
❍ 3 to 5 (3)
❍ 6 or more (4)

Q55 Are all children in your home current on their immunizations?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know (3)
- ○ Not applicable (4)

Q56 Do all children in your home, age 6 months or older get a flu shot or flu mist each year?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know (3)
- ○ Not applicable (4)

Q57 What is your home zip code?

Q58 Additional Comments

Cass County Community Health Profile

April 13, 2015

Stephen Pickard, MD
North Dakota Department of Health

TABLE OF CONTENTS

POPULATION DATA

Population by Age Group, 2013 ACS Estimates				
	Cass County		North Dakota,	
Age Group	Number	Percent	Number	Percent
0-9	19,858	12.2%	91,871	12.7%
10-19	22,753	14.0%	93,318	12.9%
20-29	34,585	21.2%	124,424	17.2%
30-39	23,691	14.5%	91,148	12.6%
40-49	17,566	10.8%	79,573	11.0%
50-59	19,786	12.2%	101,998	14.1%
60-69	13,216	8.1%	69,446	9.6%
70-79	5,987	3.7%	41,233	5.7%
80+	5,387	3.3%	31,829	4.4%
Total	162,829	100.0%	724,840	100.0%
0-17	35,518	21.8%	161,317	22.3%
65+	17,010	10.4%	102,722	14.2%

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 2013 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 table showing percent population change uses census data from 2000 also. Tables present 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 which is in poverty (e.g., percentage of children under five years in poverty).

Age Group As Percentage of Total

Cass County 2010   Cass County 2000
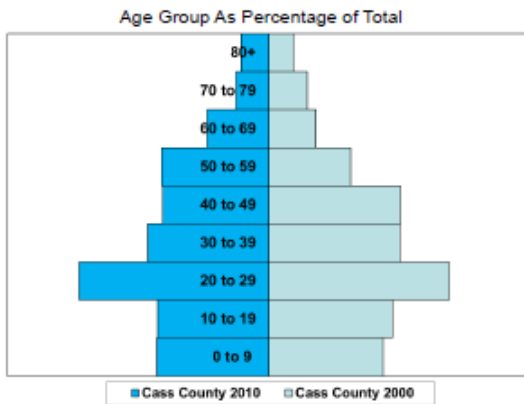
Female Population and Percentage Female by Age, 2013 ACS Estimates				
	Cass County 2009-2013		North Dakota, 2013	
Age Group	Number	Percent	Number	Percent
0-9	10,346	52.1%	45,342	49.4%
10-19	10,608	46.6%	44,988	48.2%
20-29	16,056	46.4%	55,615	44.7%
30-39	11,684	49.3%	41,092	45.1%
40-49	7,985	45.5%	39,675	49.9%
50-59	9,822	49.6%	50,656	49.7%
60-69	6,723	50.9%	34,361	49.5%
70-79	3,258	54.4%	21,254	51.5%
80+	3,698	68.6%	20,546	64.5%
Total	80,180	49.2%	353,530	48.8%
0-17	17,231	48.5%	78,484	48.7%
65+	9,541	56.1%	50,201	48.9%

Decennial Population Change, 1990 to 2000, 2000 to 2010				
Census	Cass County	10 Year Change (%)	North Dakota	10 Year Change (%)
1990	18,148		638,800	
2000	17,998	-0.8%	642,200	0.5%
2010	16,321	9.3%	672,591	4.7%

POPULATION DATA

Race, 2013 ACS Estimates

Race	Cass County		North Dakota	
	Number	Percentage	Number	Percentage
Total	162,829	100.0%	723,393	100.0%
White	148,391	91.1%	643,478	89.0%
Black	4,729	2.9%	10,827	1.5%
Am.Indian	1,643	1.0%	40,214	5.6%
Asian	4,218	2.6%	9,096	1.3%
Pac. Islander	28	0.0%	371	0.1%
Other	410	0.3%	4,620	0.6%
Multirace	3,410	2.1%	29,574	4.1%

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Household Populations, 2011-2013 ACS Three Year Estimates

	Cass County		North Dakota	
	Number	Percent	Number	Percent
Total	162,829	100.0%	703,203	100.0%
In Family Households	116,558	71.6%	530,615	75.5%
In Non-Family Households	41,060	25.2%	146,330	20.8%
Total In Households	157,618	96.8%	676,945	96.3%
Institutionalized*	1042	0.6%	9,675	1.4%
Non-institutionalized*	4,169	2.6%	16,583	2.4%
Total in Group Quarters	5,211	3.2%	26,258	3.7%

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Marital Status of Persons Age 15 and Older, 2011-2013 ACS Estimates

	Cass County		North Dakota	
Marital Status	Number	Percent	Number	Percent
Total Age 15+	128,233	100.0%	561,346	100.0%
Never Married	49,370	38.5%	177,385	31.6%
Now Married	60,270	47.0%	291,900	52.0%
Separated	1,282	1.0%	5,052	0.9%
Widowed	5,514	4.3%	33,681	6.0%
Divorced	11,926	9.3%	53,328	9.5%

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Educational Attainment Among Persons 25+, 2013 ACS Estimates

	Cass County		North Dakota	
Education	Number	Percent	Number	Percent
Total	99,532	100.0%	457,771	100.0%
Less than 9th Grade	3,085	3.1%	19,226	4.2%
Some High School	2,787	2.8%	21,057	4.6%
High school or GRE	20,703	20.8%	125,429	27.4%
Some College / Asso. Degree	36,429	36.6%	168,002	36.7%
Bachelor's degree	26,774	26.9%	89,723	19.6%
Post Graduate Degree	9,754	9.8%	34,791	7.6%

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POPULATION DATA

Persons with Disabilty, 2013 ACS Estimates

Group	Cass County		North Dakota	
	Number	Percent	Number	Percent
Total	161,730	100.0%	688,158	100.0%
Any Disability	16,792	10.4%	72,762	10.6%
No Disability	144,938	89.6%	615,396	89.4%
Self Care Disability	3,344	2.2%	11,274	1.6%
0-17 with any disability	924	2.6%	4,677	2.9%
18-64 with any disabilty	10,631	9.7%	35,931	7.8%
65+ with any disability	5,237	32.1%	32,154	31.3%

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Income and Poverty Status by Age Group, 2013 ACS Estimates

	Cass County		North Dakota	
Median Household Income	$52,015		$54,920	
Per Capita Income	$29,681		$30,436	
	Number	Percent	Number	Percent
Below Poverty Level	23,213	14.7%	80,644	11.9%
Under 5 years	2,160	20.1%	7,714	16.9%
5 to 11 years	1,935	14.4%	7,944	13.2%
12 to 17 years	981	8.9%	5,776	11.8%
18 to 64 years	17,253	16.2%	49,568	11.6%
65 to 74 years	232	2.7%	3,448	7.0%
75 years and over	652	8.5%	6,194	13.7%
Total Known Children in Poverty	5,076	14.3%	21,434	13.3%
Total Known Age 65+ in Poverty	884	5.2%	9,642	9.4%

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Family Poverty and Childhood and Elderly Poverty, 2013 ACS Estimates

	Cass County		North Dakota	
	Number	Percent*	Number	Percent*
Total Families	38,170	100.0%	176,378	100.0%
Families in Poverty	3,054	8.0%	13,052	7.4%
Families with Own Children	19,808	51.9%	80,964	45.9%
Families with Own Children in Poverty	2,634	6.9%	10,121	5.7%
Families with Own Children and Female Parent Only	3,943	10.3%	16,716	9.5%
Families with Own Children and Female Parent Only in Poverty	1,723	4.5%	6,452	3.7%

* Percent family poverty is percent of total families

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Age of Housing ,2013 ACS Estimates

	Cass County		North Dakota	
	Number	Percent	Number	Percent
Housing units: Total	72,503	100.0%	329,970	100.0%
1980 and Later	40,702	56.1%	128,111	38.8%
1970 to 1979	12,467	17.2%	66,396	20.1%
Prior to 1970	19,334	26.7%	135,463	41.1%

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Vital Statistics Data

BIRTHS AND DEATHS DEFINITIONS

Vital Statistics Data comes from the birth and death records collected by the State of North Dakota aggregated over a five year period. All births and deaths represent the county of residence not the county of occurrence. The number of events is blocked if fewer than five. Formulas for calculating rates and ratios are as follows:

Birth Rate = Resident live births divided by the total resident population x 1000.

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

Pregnancy Rate = Total pregnancies divided b the total resident population x 1000.

Fertility Rate = Resident live births divided by female population (age 15-44) x 1000.

Teenage Birth Rate = Teenage births (age <20) divided by female teen population x 1000.

Teenage Pregnancy Rate =
Teenage pregnancies (age<20) divided by female teen population x 1000.

Out of Wedlock Live Birth Ratio =
Resident OOW live births divided by total resident live births x 1000.

Out of Wedlock Pregnancy Ratio =
Resident OOW pregnancies divided by total pregnancies x 1000.

Low Weight Ratio =
Low weight births (birth weight < 2500 grams) divided by total resident live births x 1000.

Infant Death Ratio = Number of infant deaths divided by the total resident live births x 1000.

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

Births, 2009-2013	Cass County		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio
Live Births and Rate	11,391	14	47,959	14
Pregnancies and Rate	12,855	16	52,505	15
Fertility Rate		61		72
Teen Births and Rate	478	7	2,118	12
Teen Pregnancies and Rate	622	10	3,725	21
Out of Wedlock Births and Ratio	3,162	278	15,686	327
Out of Wedlock Pregnancies and Ratio	4,379	341	19436	370
Low Birth Weight Birth and Ratio	713	63	3,078	64

Child Deaths, 2009-2013	Cass County		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio
Infant Deaths and Ratio	46	4	286	6
Child and Adolescent Deaths and Rate	23	11	270	32
Total Deaths and Crude Rate	4,385	539	29,616	866

Deaths and Age Adjusted Death Rate by Cause, 2009-2013	Cass County Number (Adj. Rate)	North Dakota Number (Adj. Rate)
All Causes	4379 (651)	29,581 (702)
Heart Disease	980 (144)	6,762 (154)
Cancer	964 (148)	6,315 (156)
Stroke	204 (30)	1,664 (37)
Alzheimers Disease	307 (44)	2,189 (45)
COPD	237 (37)	1,707 (41)
Unintentional Injury	202 (28)	1,625 (44)
Diabetes Mellitus	122 (19)	1,022 (24)
Pneumonia and Influenza	99 (15)	682 (15)
Cirrhosis	56 (8)	394 (11)
Suicide	97 (13)	551 (16)

Vital Statistics Data

BIRTHS AND DEATHS

Leading Causes of Death by Age Group for Cass County, 2009-2013

Age	1	2	3
0-4	Anomaly 8 / Prematurity 8	Unintentional Injury 6	SIDS 5
5-14	Cancer	Unintentional Injury	Pneumonia/Flu
15-24	Unintentional Inj 15 / Suicide 15	Cancer	Anomaly / Pneumonia/Flu
25-34	Unintentional Injury 25	Suicide 19	Heart 8
35-44	Suicide 24	Unintentional Injury 23	Heart 21
45-54	Heart 77	Cancer 62	Unintentional Injury 26
55-64	Cancer 195	Heart 122	COPD 31
65-74	Cancer 232	Heart 131	COPD 44
75-84	Cancer 236	Heart 211	COPD 89
85+	Heart 409	Alzheimer's Dz 216	Cancer 209

Leading Causes of Death by Age Group for North Dakota, 2006-2010

Age	1	2	3
0-4	Congenital Anomaly 69	Prematurity 44	SIDS 40
5-14	Unintentional Injury 26	Cancer 10	Congenital Anomaly 6
15-24	Unintentional Injury 184	Suicide 109	Cancer 20
25-34	Unintentional Injury 166	Suicide 91	Heart 32
35-44	Unintentional Injury 173	Heart 94	Cancer 88
45-54	Cancer 493	Heart 335	Unintentional Injury 194
55-64	Cancer 1001	Heart 579	Unintentional Injury 137
65-74	Cancer 1562	Heart 843	COPD 313
75-84	Cancer 1992	Heart 1797	COPD 626
85+	Heart 3421	Alzheimer's Dz 1391	Cancer 1352

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ADULT BEHAVIORAL RISK FACTORS DEFINITION

The following three pages represent data received from the Adult Behavioral Risk Factor Surveillance Survey. The Adult Behavioral Risk Factor data are derived from aggregated data (the number of years specified is in the table) continuously collected by telephone survey from persons 18 years and older. All data is self-reported data. 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 intervals 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 prevalences in the two populations.

8.....9.....10.....11.....12.....

ADULT BEHAVIORAL RISK FACTORS, 2011-2013

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	ALCOHOL	**Cass County 2011-2013**	**North Dakota 2011-2013**
Binge Drinking	Respondents who reported binge drinking (5 drinks for men, 4 drinks for women) one or more times in the past 30 days.	26.9 (24.4-29.3)	24.2 (23.2-25.1)
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	8.4 (6.7-10.0)	6.8 (6.2-7.4)
Drunk Driving	Respondents who reported driving when they had too much to drink one or more times during the past 30 days	NA	1.9 (1.5-2.4)
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.	22.5 (20.6-24.4)	25.1 (24.3-25.9)
Activity Limitation Due to Arthritis	Respondents who reported being limited in any usual activities because of arthritis or joint symptoms.	7.6 (6.4-8.8)	8.3 (7.8-8.8)
ASTHMA			
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma.	11.6 (10.0-13.3)	11.5 (10.7-12.2)
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.	8.5 (7.1-10.0)	8.1 (7.5-8.7)
BODY WEIGHT			
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	36.1 (33.6-38.6)	36.7 (35.7-37.7)
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	27.5 (25.2-29.7)	29.4 (28.5-30.4)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	63.6 (61.0-66.1)	66.1 (65.1-67.2)
CANCER			
Ever Cancer	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had cancer (excluding skin cancer).	6.2 (5.2-7.1)	6.4 (6.0-6.8)

ADULT BEHAVIORAL RISK FACTORS, 2011-2013

	CARDIOVASCULAR	Cass County 2011-2013	North Dakota 2011-2013
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack.	3.1 (2.4-3.8)	4.3 (3.9-4.6)
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina.	3.4 (2.7-4.1)	4.1 (3.7-4.4)
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke.	2.2 (1.5-2.8)	2.3 (2.0-2.5)
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.	6.0 (5.1-7.0)	7.6 (7.1-8.0)
CHOLESTEROL			
Never Cholesterol Test	Respondents who reported never having a cholesterol test	22.8 (19.9-25.7)	22.3 (21.1-23.4)
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	26.9 (23.9-29.9)	26.7 (25.5-27.9)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol.	33.2 (30.4-36.0)	36.6 (35.4-37.8)
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?	4.4 (3.4-5.3)	4.6 (4.2-5.0)
COLORECTAL CANCER			
Fecal Occult Blood	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years.	82.4 (78.6-86.3)	86.2 (84.8-87.6)
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	36.6 (31.0-42.1)	38.0 (35.9-40.2)
Up to date for Colorectal Screening	Respondents age 50 and older who are up to date according to recommended screening guidelines for colorectal screening	61.6 (56.0-67.2)	59.1 (56.9-61.3)
DIABETES			
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	7.5 (6.4-8.6)	8.5 (8.0-9.0)
FRUITS AND VEGETABLES			
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	84.2 (82.0-86.4)	85.9 (85.0-86.7)

ADULT BEHAVIORAL RISK FACTORS, 2011-2013

20	**GENERAL HEALTH**	**Cass County 2011-2013**	**North Dakota 2011-2013**
Fair or Poor Health	Respondents who reported that their general health was fair or poor	11.9 (10.3-13.5)	14.0 (13.3-14.7)
Poor physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good	10.8 (9.4-12.3)	11.6 (11.0-12.3)
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good	11.9 (10.2-13.6)	10.8 (10.2-11.5)
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.	7.3 (6.0-8.6)	7.1 (6.6-7.6)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem.	17.7 (15.9-19.5)	17.9 (17.2-18.7)
HEALTH CARE ACCESS			
Health Insurance	Respondents who reported not having any form or health care coverage	12.1 (10.2-14.0)	12.4 (11.6-13.1)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost.	8.2 (6.8-9.7)	8.1 (7.4-8.7)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	27.0 (24.6-29.4)	26.0 (25.0-26.9)
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.	27.7 (25.3-30.1)	29.5 (28.6-30.6)
IMMUNIZATION			
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	33.5 (29.1-37.9)	40.3 38.6-42.0)
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	22.9 (18.8-27.0)	29.4 (27.8-31.0)
INJURY			
Fall	Respondents 45 years and older who reported that they had fallen in the past 12 months	26.9 (22.4-31.5)	27.8 (25.9-29.6)
Seat Belt	Respondents who reported not always wearing their seatbelt	19.5 (17.3-21.7)	32.6 (31.6-33.6)

ADULT BEHAVIORAL RISK FACTORS, 2011-2013

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	ORAL HEALTH	Cass County 2011-2013	North Dakota 2011-2013
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	25.7 (21.6-29.9)	32.8 (31.0-34.7)
Tooth Loss	Respondents who reported they ever had a permanent tooth extracted.	36.3 (32.1-40.5)	43.2 (41.4-45.0)
	PHYSICAL ACTIVITY		
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	52.2 (49.1-55.4)	53.8 (52.6-55.1)
Inactive	Respondents reporting little or no physical activity	25.0 (22.3-27.8)	30.4 (29.3-31.6)
	TOBACCO		
Current Smoking	Respondents who reported that they smoked every day or some days	19.3 (17.2-21.5)	21.6 (20.6-22.5)
	WOMEN'S HEALTH		
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	25.5 (18.4-32.5)	23.7 (20.9-26.5)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	23.3 (16.9-29.8)	26.4 (24.0-28.9)

Cass County

	2009	2010	2011	2012	2013	5 year	5-Year Rate
Murder	3	0	1	2	3	9	1.2
Rape	68	58	55	79	74	334	43.9
Robbery	39	39	52	54	63	247	32.4
Aggrev. Assualt	262	273	359	345	365	1,604	210.6
Violent crime	372	370	467	480	505	2,194	288.1
Burglary	876	632	585	617	904	3,614	474.6
Larceny	2,870	2,777	2,698	2,799	2,831	13,975	1835.1
Motor vehicle theft	296	216	164	198	224	1,098	144.2
Property crime	4,042	3,625	3,447	3,614	3,959	18,687	2453.9
Total	4,414	3,995	3,914	4,094	4,464	20,881	2742.0

North Dakota

	2009	2010	2011	2012	2013	5 year	5-Year Rate
Murder	15	11	15	20	14	75	2.2
Rape	206	222	207	243	237	1,115	32.6
Robbery	102	85	91	117	151	546	16.0
Aggrev. Assualt	795	847	1,040	1,071	1,156	4,909	143.6
Violent crime	1,118	1,165	1,353	1,451	1,558	6,645	194.3
Burglary	2,180	1,826	2,227	2,200	2,656	11,089	324.3
Larceny	8,699	8,673	9,344	10,184	10,243	47,143	1378.6
Motor vehicle theft	854	825	763	854	1,228	4,524	132.3
Property crime	11,733	11,324	12,334	13,238	14,127	62,756	1835.2
Total	12,851	12,489	13,687	14,689	15,685	69,401	2029.5

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CHILD HEALTH INDICATORS

Child Indicators: Education 2013	Cass County		North Dakota	
	Number	Percent	Number	Percent
Enrolled in Special Education Ages 3-21 (Number and percent of total school enrollment)	2,637	12%	13,399	13.0%
High School Dropouts (Dropouts per 100 persons Grades 9-12)*	157	2.3%	888	2.8%
Average Expenditure per Student in Public School	$9,725		$10,964	

Child Indicators: Economic Health 2013	Cass County		North Dakota	
	Number	Percent	Number	Percent
TANF Recipients Ages 0-19 (Percentage of persons ages 0-19)	1,008	2.6%	5,358	2.9%
Food Stamp (SNAP) Recipients Ages 0-18 (Percentage of all children ages 0-19)	8,133	23%	37,826	23%
Children Receiving Free or Reduced Price Lunch (Percentage of total school enrollment)	6,290	27%	34,381	31%
Medicaid Recipients Ages 0-20 (Percentage of all persons ages 0-20)*	11,251	26%	53,814	27%
Children Ages 0-17 Living in Extreme Poverty (Percentage of children 0-17 for whom poverty is determined)	1,505	4.5%	10,114	6.2%
Median Income for Families with Children Ages 0-17 (Percentage of all women with children ages 0-17)	$75,119		$70,530	

Child Indicators: Families and Child Care 2013	Cass County		North Dakota	
	Number	Percent	Number	Percent
Mothers in Labor Force with a Child Ages 0-17 (Percentage of all mothers with a child ages 0-17)	14,015	84%	57,908	81%
Children Ages 0-17 Living in a Single Parent Family (Percentage of all children ages 0-17)	7,616	23%	34,591	23%
Children in Foster Care (Percentage of children ages 0-18)*	388	1.1%	2,019	1.2%
Children Ages 0-17 with Suspected Child Abuse or Neglect (Percentage of children 0-17)	1,505	4.5%	6,170	4.0%
Children Ages 0-17 Impact by Domestic Violence (Percentage of all children ages 0-17)**	658	2.1%	4,739	2.9%
Births to Mothers with Inadequate Prenatal Care (Percentage of Total Births)	65	2.6%	508	4.8%

**2010

Child Indicators: Juvenile Justice 2013	Cass County		North Dakota	
	Number	Percent	Number	Percent
Children Ages 10-17 Referred to Juvenile Court (Percentage of all children ages 0-17)	815	6.0%	3,789	5.8%
Offense Against Person Juvenile Court Referral (Percentage of total juvenile court referral)	248	16%	689	9.8%
Alcohol-Related Juvenile Court Referral (Percentage of all juvenile court referrals)*	127	8.2%	909	13%

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		Cass County	ND	Rank (of 47)	Clay County	MN	Rank (of 87)
Health Outcomes				10			57
Quality of Life				20			68
Poor or fair health -	% of adults reporting fair or poor health	10%	12%		11%	11%	
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	2.6	2.7		3.2	2.8	
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	2.4	2.4		2.8	2.6	
Low birthweight	% of live births with low birthweight (< 2500 grams)	6.50%	6.50%		6.70%	6.50%	
Health Factors				5			22
Health Behaviors				3			48
Adult smoking	% of adults who are current smokers	16%	18%		17%	16%	
Adult obesity	% of adults that report a BMI ≥ 30	27%	30%		30%	26%	
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	8.8	8.5		8.4	8.3	
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	21%	25%		24%	19%	
Access to exercise opportunities	% of population with adequate access to locations for physical activity	83%	68%		81%	85%	
Excessive drinking	% of adults reporting binge or heavy drinking	21%	22%		23%	19%	
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	30%	46%		22%	31%	
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	445	416		316	336	
Teen births	# of births per 1,000 female population ages 15-19	19	28		15	24	
Clinical Care				2			18
Uninsured	% of population under age 65 without health insurance	11%	12%		8%	9%	
Primary care physicians	Ratio of population to primary care physicians	863:1	1,279:1		1,045:1	1,113:1	
Dentists	Ratio of population to dentists	1,404:1	1,710:1		1,377:1	1,529:1	
Mental health providers	Ratio of population to mental health providers	400:1	638:1		386:1	529:1	
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	46	56		39	45	
Diabetic monitoring	% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	88%	86%		87%	88%	
Mammography screening	% of female Medicare enrollees ages 67-69 that receive mammography screening	70.8%	68%		70.7%	66.7%	
Social & Economic Factors				19			21
High school graduation	% of ninth-grade cohort that graduates in four years	85%	85%		77%	78%	
Some college	% of adults ages 25-44 with some post-secondary education	81.1%	74.4%		73.2%	73.3%	
Unemployment	% of population aged 16 and older unemployed but seeking work	3%	2.9%		3.7%	5.1%	
Children in poverty	% of children under age 18 in poverty	11%	12%		13%	14%	
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.3	4.4		4.2	4.3	
Children in single-parent households	% of children that live in a household headed by single parent	25%	26%		25%	28%	
Social associations	# of membership associations per 10,000 population	11.4	17.3		11.6	13.2	
Violent crime	# of reported violent crime offenses per 100,000 population	284	240		115	229	
Injury deaths	# of deaths due to injury per 100,000 population	39	64		48	56	
Physical Environment				44			23
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	11.1	10		11.6	12	
Drinking water violations	% of population potentially exposed to water exceeding a violation limit during the past year	0%	3%		0%	1%	
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	14%	11%		15%	15%	
Driving alone to work	% of workforce that drives alone to work	83%	79%		79%	78%	
Long commute - driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	9%	13%		18%	29%	

* 90th percentile, i.e., only 10% are better.

Note: Blank values reflect unreliable or missing data

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 2015 *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:

Outcomes & Factors Rankings

Outcomes & Factors Sub Rankings

Ranked Measures Data (including measure values, confidence intervals* and z-scores**)

Additional Measures Data (including measure values and confidence intervals*)

Ranked Measure Sources and Years

Additional Measure Sources and Years

*   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	# Deaths	Number of deaths under age 75
	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)
Poor or fair health	Sample Size	Number of respondents
	% Fair/Poor	Percent 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	Sample Size	Number of respondents
	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	Sample Size	Number of respondents
	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.
	# Low Birthweight Births	Number of low birthweight births
	# Live births	Number of live births
	% LBW	Percentage of births with low birth weight (<2500g)
	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)
Adult smoking	Sample Size	Number of respondents
	% 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	Number of people with 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	Sample Size	Number of respondents
	% 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
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases / Population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	Teen Births	Teen birth count, ages 15-19
	Teen Population	Female population, ages 15-19
	Teen Birth Rate	Teen births / females ages 15-19 * 1,000
	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)
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	(Number of PCP/population)*100,000
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	(Number of dentists/population)*100,000
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	(Number of MHP/population)*100,000
	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/Medicare Enrollees * 1,000
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetic 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)
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)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
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	Number of children (under age 18) living 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	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
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 / Population * 10,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes/population * 100,000

	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	Pop. In Viol	Average annual population affected by a water violation
	% Pop in Viol	Population affected by a water violation/Total population with public water
	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	Number of people who drive alone to work
	# Workers	Number of workers in labor force
	% 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)
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

	Cass County	Trend(Click for info)	Error Margin	Top U.S. Performers*	North Dakota	Rank (of 47)
Health Outcomes						10
Length of Life						4
Premature death	5,153	∿	4,754-5,553	5,200	6,388	
Quality of Life						20
Poor or fair health	10%		9-12%	10%	12%	
Poor physical health days	2.6		2.4-2.9	2.5	2.7	
Poor mental health days	2.4		2.1-2.7	2.3	2.4	
Low birthweight	6.5%		6.1-6.9%	5.9%	6.5%	
Health Factors						5
Health Behaviors						3
Adult smoking	16%		15-18%	14%	18%	
Adult obesity	27%	∿	25-29%	25%	30%	
Food environment index	8.8			8.4	8.5	
Physical inactivity	21%	∿	19-23%	20%	25%	
Access to exercise opportunities	83%			92%	68%	
Excessive drinking	21%		19-23%	10%	22%	
Alcohol-impaired driving deaths	30%			14%	46%	
Sexually transmitted infections	445	∿		138	416	
Teen births	19		18-20	20	28	
Clinical Care						2
Uninsured	11%	∿	10-13%	11%	12%	
Primary care physicians	863:1			1,045:1	1,279:1	

	Cass County	Trend(Click for info)	Error Margin	Top U.S. Performers*	North Dakota	Rank (of 47)
Dentists	1,404:1			1,377:1	1,710:1	
Mental health providers	400:1			386:1	638:1	
Preventable hospital stays	46	〜	43-50	41	56	
Diabetic monitoring	88%	〜	82-93%	90%	86%	
Mammography screening	70.8%	〜	65.3-76.3%	70.7%	68.0%	
Social & Economic Factors						19
High school graduation	85%				85%	
Some college	81.1%		77.6-84.5%	71.0%	74.4%	
Unemployment	3.0%	〜		4.0%	2.9%	
Children in poverty	11%	〜	9-14%	13%	12%	
Income inequality	4.3		4.1-4.5	3.7	4.4	
Children in single-parent households	25%		22-29%	20%	26%	
Social associations	11.4			22.0	17.3	
Violent crime	284	〜		59	240	
Injury deaths	39		34-43	50	64	
Physical Environment						44
Air pollution - particulate matter	11.1	〜		9.5	10.0	
Drinking water violations	0%			0%	3%	
Severe housing problems	14%		13-16%	9%	11%	
Driving alone to work	83%		82-84%	71%	79%	
Long commute - driving alone	9%		8-10%	15%	13%	

Clay (CL)

	Clay County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Health Outcomes						57
Length of Life						49
Premature death	5,563	∿	4,886-6,240	5,200	5,038	
Quality of Life						68
Poor or fair health	11%		8-15%	10%	11%	
Poor physical health days	3.2		2.3-4.1	2.5	2.8	
Poor mental health days	2.8		2.0-3.6	2.3	2.6	
Low birthweight	6.7%		6.0-7.3%	5.9%	6.5%	
Health Factors						22
Health Behaviors						48
Adult smoking	17%		12-23%	14%	16%	
Adult obesity	30%	∿	25-35%	25%	26%	
Food environment index	8.4			8.4	8.3	
Physical inactivity	24%	∿	20-28%	20%	19%	
Access to exercise opportunities	81%			92%	85%	
Excessive drinking	23%		18-30%	10%	19%	
Alcohol-impaired driving deaths	22%			14%	31%	
Sexually transmitted infections	316	∿		138	336	
Teen births	15		13-17	20	24	
Clinical Care						18
Uninsured	8%	∿	7-9%	11%	9%	
Primary care	3,760:1			1,045:1	1,113:1	

	Clay County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
physicians						
Dentists	1,784:1			1,377:1	1,529:1	
Mental health providers	518:1			386:1	529:1	
Preventable hospital stays	39	～	34-44	41	45	
Diabetic monitoring	87%	～	76-97%	90%	88%	
Mammography screening	70.7%	～	59.0-82.4%	70.7%	66.7%	
Social & Economic Factors						21
High school graduation	77%				78%	
Some college	73.2%		69.1-77.3%	71.0%	73.3%	
Unemployment	3.7%	～		4.0%	5.1%	
Children in poverty	13%	～	10-17%	13%	14%	
Income inequality	4.2		3.9-4.6	3.7	4.3	
Children in single-parent households	25%		20-30%	20%	28%	
Social associations	11.6			22.0	13.2	
Violent crime	115	～		59	229	
Injury deaths	48		40-56	50	56	
Physical Environment						23
Air pollution - particulate matter	11.6	～		9.5	12.0	
Drinking water violations	0%			0%	1%	
Severe housing problems	15%		13-16%	9%	15%	
Driving alone to work	79%		77-81%	71%	78%	
Long commute - driving alone	18%		16-19%	15%	29%	