Sanford Health Network
Community Health Needs Assessment
2012-2013

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HEALTH

Sanford Canton-Inwood Medical Center

Community Health Needs Assessment
2012-2013

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Purpose

Sanford Canton-Inwood Medical Center is part of Sanford Health, an integrated health system headquartered in the Dakotas and the largest, rural, not-for-profit health care system in the nation with locations in 126 communities in eight states.

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

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

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

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

Acknowledgements

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

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

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

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

The following key community stakeholders participated in this assessment work:
- Lisa Alden, Director, Chamber of Commerce, Canton, SD
- Arne Anderson, Pharmacist, Haisch Pharmacy, Canton, SD
- Farrell Anderson, Field Advisor, Tremco, Inc., Canton, SD
- Valerie Anderson, Loan Officer, Farmers State Bank, Canton, SD
- Nancy Bitterman, President, First Bank & Trust, Canton, SD
- Brenda Ask, Lawyer, Frieberg, Neson & Ask, LLP, Canton, SD
- Leon Eich, President, Security Savings Bank, Canton, SD
- Kari Elrod, City Commissioner & Self-Employed Jewelry Artist, Canton, SD
- Cathy Hennies, Family Medicine Physician, Sanford Canton Clinc, Inwood, IA & Canton, SD
- Verdona Kelly, Secretary, Inwood Kiwanis Club, Inwood, IA
- Paul Kippley, City Attorney, Inwood, IA
- Marcene Klarenbeek, Legal Secretary, Inwood, IA
- Richard Kooistra, Rretired Pastor, Inwood, IA
- Mike Knobloch, President, Canton-Inwood Area Health Foundation, Inwood, IA
- Cory Langerock, Sales/Marketing, Hilltop Custom Cabinetry, Canton, SD
- Sandy Lantz, Teacher, West Lyon Community School, Canton, SD
- Joan Lier, Medical Secretary, Kaystone Treatment Center, Canton, SD
- Julie Marko, Administrator, Good Samaritan Society, Canton, SD
- Pamela S. Moen, Retired Elementary Teacher, Inwood, IA
- Jane Mutschelknaus, Nurse Practitioner, Sanford Canton Clinic, Canton, SD
- Harlan Paulson, Sanford Canton-Inwood Medical Center Board Member, Hudson, SD
- Douglas Robinson, Vision Rehabiitation Therapy, Inwood, IA
- Hennie Serck, Graphics, Farm Country Trader, Inwood, IA
- Eugene Ver Steeg, Business Owner, Inwood, IA
- Mike Ver Steeg, Owner, Prestige Pork, Inc., Inwood, IA
- Boyd Steensland, Retired, Canton, SD

Sanford Canton-Inwood Medical Center
Community Health Needs Assessment
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Executive Summary

Purpose

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

Study Design and Methodology

The following qualitative data sets were studied:
- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:
- 2011 County Health Profiles for Lincoln, SD and Lyon, IA
- Aging Profiles for Counties of Lincoln, SD and Lyon, IA
- Diversity Profiles for Counties of Lincoln, SD and Lyon, IA

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

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

Key Findings – Primary Research

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

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

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

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

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

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

Respondents were most concerned about affordable housing, low wages, employment opportunities, youth activities, resources to meet the needs of the aging population and cost and availability of elder care. Respondents were also concerned with issues regarding children and youth (e.g. availability and cost/quality of child care, bullying, availability and cost of services for youth, and child abuse and neglect). Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the cost of health care, insurance and prescription drugs. The adequacy of health insurance (e.g. amount of co-pays and deductibles) and access to health insurance coverage (e.g. pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis) stress and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about patient confidentiality and distance to health care services.

Respondents had moderate levels of concern with respect to economic disparities between higher and lower classes, hunger, homelessness, poverty and the cost of living.

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

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

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

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

Less than 50% (44.4%) of respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because their doctor had not suggested it or it was considered not necessary. Also stated was the cost of the services. Fear, unfamiliarity with recommendations, and not knowing who to see were not reasons that the majority of respondents gave.

A majority of respondents (67.9%) said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income and private health insurance, Medicare and Medicaid health care benefits were also used.

Key Findings – Secondary Research

Health Outcomes

Mortality

The Mortality health outcomes indicate that South Dakota as a state has more premature deaths than the national benchmark. While the state has more premature deaths than the national benchmark, Lincoln County, South Dakota has a lower rate than the national benchmark. The Mortality health outcomes indicate that Iowa as a state has more premature deaths than the national benchmark. However, Lyon County, Iowa has a lower rate than the national benchmark.

Morbidity

The Morbidity health outcomes indicate that South Dakota citizens report more days of poor health than the national benchmark but Lincoln County reports slightly better health days. The Morbidity health outcomes indicate that Iowans report more days of poor health than the national benchmark while Lyon County, Iowa reports a lower percentage of poor health days than the national benchmark.

Poor physical health days indicate that South Dakota has a slightly increased percentage of the national benchmark while Lincoln County shows considerably less than the national benchmark. Poor physical health days indicate Iowa has a slightly increased percentage of the national benchmark while Lyon County shows a considerably less percentage of poor physical health days than the national benchmark.

South Dakota reports slightly more mentally unhealthy days than the national benchmark, while Lincoln County reports a lower percentage of mentally unhealthy days than the national benchmark. Iowa reports slightly more mentally unhealthy days than the national benchmark, while Lyon County reports substantially better mental health days.

South Dakota has a higher percentage of low birth weight than the national benchmark with Lincoln County showing just above the national benchmark. Iowa has a higher percentage of low birth weight than the national benchmark with Lyon County slightly below the national benchmark.

Health Factors

Health Behaviors

The Health Behavior outcomes indicate that South Dakota as a state has a higher percentage of adult smokers than the national benchmark. However, Lincoln County has a lower percentage than the national benchmark. Iowa's Health Behavior outcomes indicate the state, as well as Lyon County report a higher percentage than the national benchmark.

Adult obesity is higher in the state of South Dakota than the national benchmark, while Lincoln County reports a slightly lower percentage of the national benchmark. Iowa's adult obesity is one point higher than Lyon County's percentage but both are higher than the national benchmark.

Physical inactivity for Lincoln County is slightly higher than the national benchmark with the state of South Dakota showing several points higher than the national benchmark. Iowa's percentages for physical inactivity are exactly the same but report higher than the national benchmark.

South Dakota reports a little over double the national benchmark in excessive drinking while Lincoln County is higher by four percent than the state of South Dakota. Iowa's state report is over twice the percentage of the national benchmark, while Lyon County is three percent less than the state's percentage.

Motor vehicle crash and death rate for South Dakota came in much higher than the national benchmark while Lincoln County was slightly higher than the national benchmark. In Iowa, the national benchmark was 3.2% lower than the state of Iowa's percentage with no information available for Lyon County.

Sexually transmitted infections rank substantially higher than the national benchmark for South Dakota (371.3 vs. national benchmark of 83.0). Similar percentages were reported for Iowa in that the state showed 313.6 compared to the national benchmark of 83.0. Lyon County came in at a much lower percentage of 26.7.

The teen birth rate is higher in South Dakota than the national benchmark but the percentage for Lincoln County is lower than the national benchmark. Iowa's state teen birth rate is higher than the national benchmark but the percentage for Lyon County is lower than the national benchmark.

The Clinical Care outcomes indicate that South Dakota has a higher percentage of uninsured adults than the national benchmark, while Lincoln County is lower than the national benchmark. Iowa's state numbers are the same for the national benchmark while Lyon County shows a higher percentage of uninsured adults.

South Dakota reports the same percentage as Lincoln County for uninsured youth, which is higher than the national benchmark. For Iowa, the state percentage is lower than the national benchmark while Lyon County is higher than the national benchmark for percentage of uninsured youth.

The ratio of total population to primary care physicians is higher in South Dakota but lower in Lincoln County than the national benchmark. The ratio of total population to primary care physicians in Iowa is higher than the national benchmark while Lyon County shows considerable higher percentage than the national benchmark.

The ratio of population to mental health providers is much higher in South Dakota than the national benchmark. However, Lincoln County is substantially better than the national benchmark. Iowa's ratio of population to

mental health providers is substantially higher than the national benchmark with Lyon County showing a lower percentage than the state of Iowa but much higher than the national benchmark as well.

The ratio of population to active dentists is lower than the national benchmark while Lincoln County reports a higher percentage than the national benchmark. In Iowa, the percentages are somewhat lower than the national benchmark as is the case with Lyon County as well.

South Dakota reports preventable hospital stays at a higher percentage than the national benchmark but with Lincoln County slightly lower than the state. Iowa reports preventable hospital stays very close in percentages to Lyon County but both numbers are higher than the national benchmark.

Diabetes screening rates in South Dakota were less than the national benchmark but Lincoln County showed a 2% difference from the national benchmark. Diabetes screening showed both the state of Iowa and Lyon County close in comparison but both a bit lower than the national benchmark.

South Dakota reports the state's percentage of mammography screening was lower than the national benchmark while Lincoln County's number was slightly higher. Iowa reported the state percentage of mammography screening at a lower percentage than the national benchmark while the percentage for Lyon County was slightly higher.

The Social and Economic Factor outcomes indicate that South Dakota and Lincoln County both have a lower high school graduation rate than the national benchmark. The Social and Economic Factor outcomes indicate that Iowa as a state has a lower graduation percentage than the national benchmark but Lyon County has a higher percentage than the national benchmark.

As a state, South Dakota shows a lower percentage of those with some college than the national benchmark while Lincoln County has a higher percentage than the national benchmark. Some college education shows the national benchmark at a higher percentage for both the state of Iowa and Lyon County.

Unemployment numbers for South Dakota and Lincoln County are lower than the national benchmark. For Iowa, the percentage of unemployment is higher than the national benchmark while Lyon County's numbers are lower than the national benchmark.

Child poverty in South Dakota is higher than the national benchmark but lower for Lincoln County than the national benchmark. Child poverty in Iowa is higher than the national benchmark. Lyon County is slightly lower than the national benchmark.

South Dakota reports that inadequate social support for the state is higher than the national benchmark while Lincoln County is lower. The national benchmark for inadequate social support is two points lower than the state's percentage but two points higher than Lyon County.

The percentage of children in single parent households in South Dakota is higher for the state than the national benchmark but for Lincoln County, the number is slightly lower than the national benchmark. For the state of Iowa, the percentage of children in single parent households is higher for the state and half the percentage of the national benchmark for Lyon County.

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in South Dakota and Lincoln County while the state of Iowa shows 1% above the national average.

Access to healthy food is ranked far below the national benchmark for the state of South Dakota and Lincoln County. However, access to healthy food is in Lyon County is rated very near the national benchmark but the state of Iowa falls much lower than the national benchmark.

Access to recreational facilities ranks lower than the national benchmark for South Dakota and Lincoln County. Access to recreational facilities ranks lower in the state of Iowa than the national benchmark compared to higher in Lyon County than the national benchmark.

As for demographics, the percent of total population of youth account for 29% of the population in Lincoln County, which is higher than the national benchmark. For the state of South Dakota, the percentage is slightly higher than the national benchmark. The percent of total population of youth in Iowa equals the national benchmark with the number in Lyon County showing slightly higher.

Elderly account for 14% of the population in South Dakota with 6% of the population in Lincoln County. Rural area living shows 48% for South Dakota with 61% living in Lincoln County, which is compared to 21% overall for the national benchmark.

Iowa's elderly population account for 15% with Lyon County at 17% compared to the national benchmark of 13%. The number of rural elderly in Iowa is 39%, with 21% being the national benchmark. The elderly living in Lyon County far surpasses the national benchmark as the percentage is 100%.

Only 2% of South Dakotans and 1% of Lincoln County population is not proficient in English compared to the national benchmark of 9%. South Dakota's illiteracy rate is 7% and Lincoln County is at 5%, compared to the national benchmark of 15%.

Three percent (3%) of Iowans are not proficient in English compared to the national benchmark of 15%, while Lyon County shows only 1%.

Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:
- Cost Involved Preventing Individuals from Seeking Medical Services
- Obesity in Children

Implementation Strategy: Cost of Health Care
- Run story in newspaper on how preventative medicine helps reduce potential of future large medical bills.
- Run "Did You Know" articles in newspaper and provide narrative on preventative medicine visits and the resulting benefits.
- Presentation to community groups about the actual cost of health care and how it increases if you do not go to the doctor for regular check-ups (e.g. getting a flu shot will help prevent the flu. The cost of the flu shot is "x" versus if you get sick and have to go to the doctor, there would be an appointment cost plus the cost of the medication).
- Work with Sanford Patient Financial Services to provide education for patients regarding our financial assistance options.
- Potentially offer a "cash only" office visit or physical exam at discounted fee.

Implementation Strategy: Obesity in Children
- Promote Sanford WebMD FitKids website in local schools.
- Brainstorm ideas to sponsor an awareness day/week at the schools that promote exercise along with healthy eating habits.
- Explore the possibility of having local Sanford Canton-Inwood rehab therapist or health coach/athletic trainer give presentations at schools.
- Offer classes on healthy eating by Sanford.
- Sponsor classes on healthy eating in Canton and Inwood for the parents and/or children to provide awareness.
- Explore hosting a bike-a-thon for elementary grades where kids would ride their bikes up and down a specific one-mile road and at the end of the event prizes would be given for each age group (ex. new bike) and participation prizes for all participants. This is something we could potentially ask the foundation to help sponsor as this would address the foundation's mission statement.
- Cover healthy eating habits at our annual health fair.
- Distribute recipes featuring healthy snacks.

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

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

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

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

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

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

Description of Canton-Inwood Medical Center

Sanford Canton-Inwood Medical Center is a modern facility that offers excellent care by a dedicated staff. While focusing on our mission statement "Dedicated to the Work of Health and Healing", we pride ourselves in caring for the individuals and communities we serve.

Through a partnership with Canton-Inwood Memorial Hospital Association and Sanford Health, we have an established, strong, community-based health care facility focused on providing quality health care right here close to home with the convenience of the patient in mind.

Sanford Canton-Inwood Medical Center is an 18-bed, Critical Access Hospital located in a beautiful rural setting just east of Canton next to the Canton community golf course.

Description of the Community Served

Canton, South Dakota, population 3,057, is located just 10 miles east of Interstate 29 on US Highway 18. The community is approximately 20 miles south of Sioux Falls and is surrounded by Newton Hills State Park, Big Sioux River, and the rolling hills of the Sioux Valley. Canton is the county seat of Lincoln County. An $8.9 million dollar expansion of the courthouse was completed in 2009 and added much needed space to this historic building. The community has a welcoming atmosphere and a rich, 150-year history.

The earliest known visitor to the area was Lewis P. Hyde, who first came to the area in 1866. The first actual settler was August Linderman, and by 1868, there were 35 people living in Lincoln County. The residents named the community Canton, believing the location to be the exact opposite of Canton, China. By the summer of that year, a caravan of 180 Norwegian settlers crossed the Big Sioux River to make their home in Canton. In 1880, the Chicago, Milwaukee, St. Paul and Pacific Railroad crossed the Big Sioux River to reach Canton. The city still has an active rail freight service. The city has many historical homes and buildings dating back to the late 1800s. The Kennedy Mansion, on Dakota Street, is a must to see as well as the Historical Society House built in 1886. Two of Canton's historical sites are the Lincoln County Courthouse built in 1889 and the Canton Lutheran Church which was built in 1908.

Canton is home to six industries. The longest active company has been the Eastern Farmers Co-op built in 1860, which employs approximately 54 people. Adams Thermal Systems, a company of approximately 1,100 employees, manufactures oil coolers, radiators and other engine cooling systems and components primarily for use in off-highway vehicles such as agricultural and construction equipment. Another employer is Bid-Well, a Terex Company, which specializes in concrete paving equipment. This business, founded in Canton, employs 49 people. Johnson Feed, Inc. distributes a wide range of salt products, as well as baler twine, tires, dog food and other items. They employ approximately 350 people and have over 250 trucks going to 48 states. Fastek Products and its Midwest Molding division is owned and operated in Canton and employs about 100 people. Fastek specialize in die cast items, plastic injection molding, and parts for the window industry. Legacy Electronics builds memory modules, circuit boards and other computer components and employs approximately 75 people.

The community has several restaurants, including a steak house, and sandwich shops, pizza, fast food and a locally owned café which offers home cooking. Canton has approximately 200 businesses that includes 4 banks, a hardware store, a farm and home store, several antique and gift shops, 2 discount stores, a greenhouse, florist, car wash, 3 gas stations, 3 convenience stores, funeral home, several real estate offices, a grocery store, 5 insurance agencies, local newspaper, a veterinarian, bowling alley, many auto sales and repair

shops, 4 law offices, a motel, 2 video rental stores, and a medical equipment supplier. Many other small businesses are not listed, such as plumbers, electricians, contractors, hair salons, and day care providers.

Study Design and Methodology

In May 2011 Sanford Health convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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

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

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

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

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

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

The following qualitative data sets were studied:
- Survey of Key Stakeholders

The following quantitative data sets were studied:
- 2011 County Health Profiles for Lincoln, SD and Lyon, IA
- Aging Profiles for Lincoln, SD and Lyon, IA
- Diversity Profiles for Lincoln, SD and Lyon, IA

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

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

Canton-Inwood Community Health Needs Assessment of Community Leaders

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

The community leaders' survey included a set of questions at the end relating to the respondent's name, title, affiliation, area of expertise, city/town, and state. These questions were included to fulfill the current interpretation of IRS requirements for non-profit hospitals conducting community health needs assessments as part of the new compliance requirements imposed by the Patient Protection and Affordable Care Act signed into law on March 23, 2010.

A total of 30 surveys were completed through a Survey Monkey link. The purpose of this survey was to learn about the perceptions of area key stakeholders regarding the prevalence of disease and health issues in their community.

2011 County Health Profiles

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

Aging Profiles

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

Diversity Profiles

The Diversity Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on

sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

Limitations

The Sanford Health Community Health Needs Assessment Steering Group attempted to survey key community leaders and stakeholders for the purpose of determining the needs of the community. While 30 surveys were returned, there were still many key stakeholders who did not complete the survey.

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

Primary Research

Summary of the Survey Results

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

Respondents were most concerned about affordable housing, low wages, employment opportunities, youth activities, resources to meet the needs of the aging population and cost and availability of elder care. Respondents were also concerned with issues regarding children and youth (e.g. availability and cost/quality of child care, bullying, availability and cost of services for youth, and child abuse and neglect). Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the cost of health care, insurance and prescription drugs. The adequacy of health insurance (e.g. amount of co-pays and deductibles) and access to health insurance coverage (e.g. pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis) stress and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about patient confidentiality and distance to health care services.

Community Assets/Best Things about the Community

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

People

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

Statement	Mean
People are friendly, helpful, supportive (N=30)	4.63
There is a sense of community/feeling connected to people who live here (N=30)	4.20
There is a sense that you can make a difference (N=30)	4.03
There is an engaged government (N=30)	3.97
People who live here are aware of/engaged in social, civic, or political issues (N=29)	3.83
There is tolerance, inclusion, open-mindedness (N=29)	3.52
The community is socially and culturally diverse (N=30)	2.93

Mean (1=not at all, 5=a great deal)*

*Means exclude "do not know" responses.

Services and Resources

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

Statement	Mean
There are quality school systems and programs for youth (N=30)	4.57
There is quality health care (N=30)	4.43
There is access to quality food (N=30)	4.07
There is effective transportation (N=30)	3.53
There are quality higher education opportunities and institutions (N=29)	2.69

Mean (1=not at all, 5=a great deal)*

*Means exclude "do not know" responses.

Quality of Life

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

*Means exclude "do not know" responses.

Geographic Setting

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

*Means exclude "do not know" responses.

Activities

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

There are many activities for families and youth (N=29) — 3.83

There are great events and festivals (N=30) — 3.70

There are many recreational and sports activities (e.g., outdoor recreation, parks, bike paths, and other sports and fitness activities) (N=30) — 3.70

There are many activities for seniors (N=24) — 3.21

There are quality arts and cultural activities (N=29) — 3.07

Mean (1=not at all, 5=a great deal)*
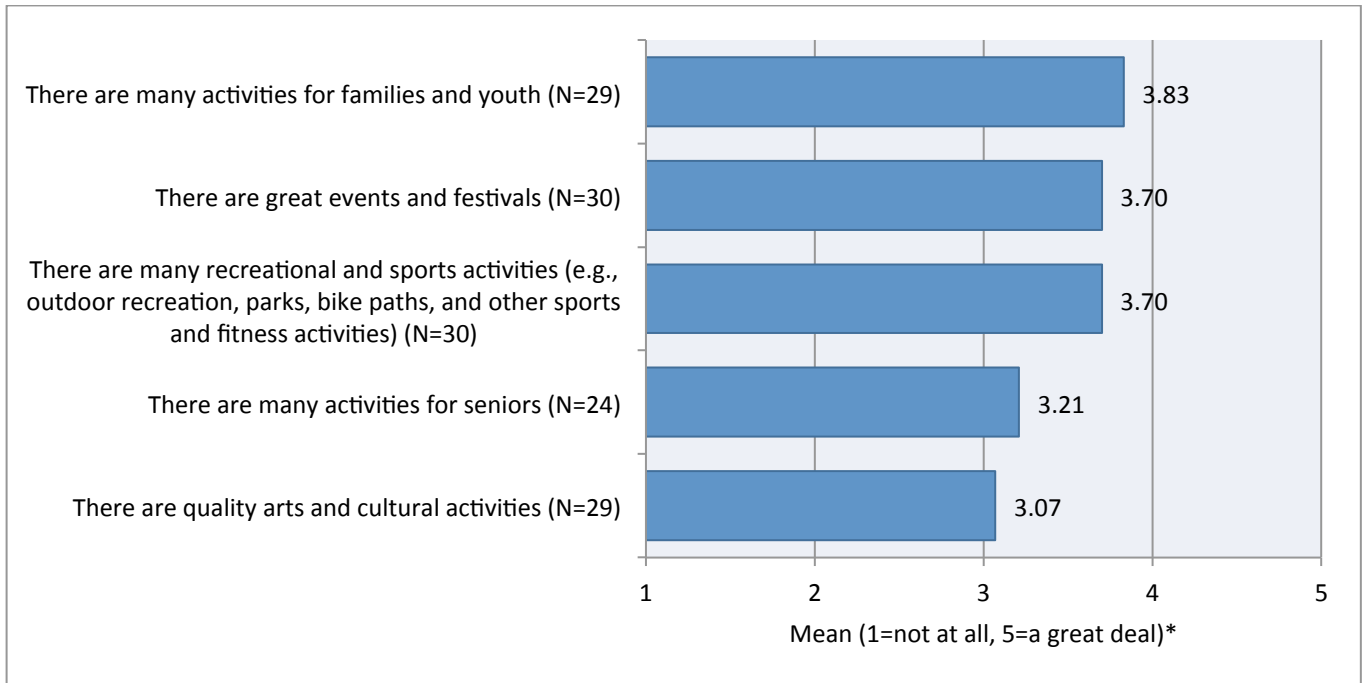
*Means exclude "do not know" responses.

General Concerns about the Community

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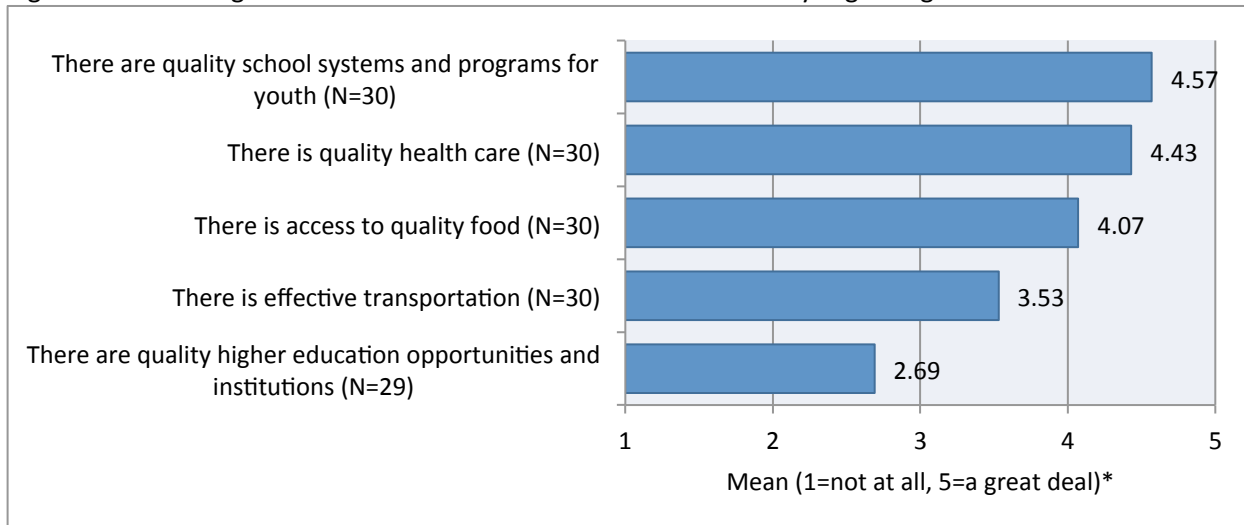
Economic Issues

Figure 6: Level of concern with statements about the community regarding ECONOMIC ISSUES
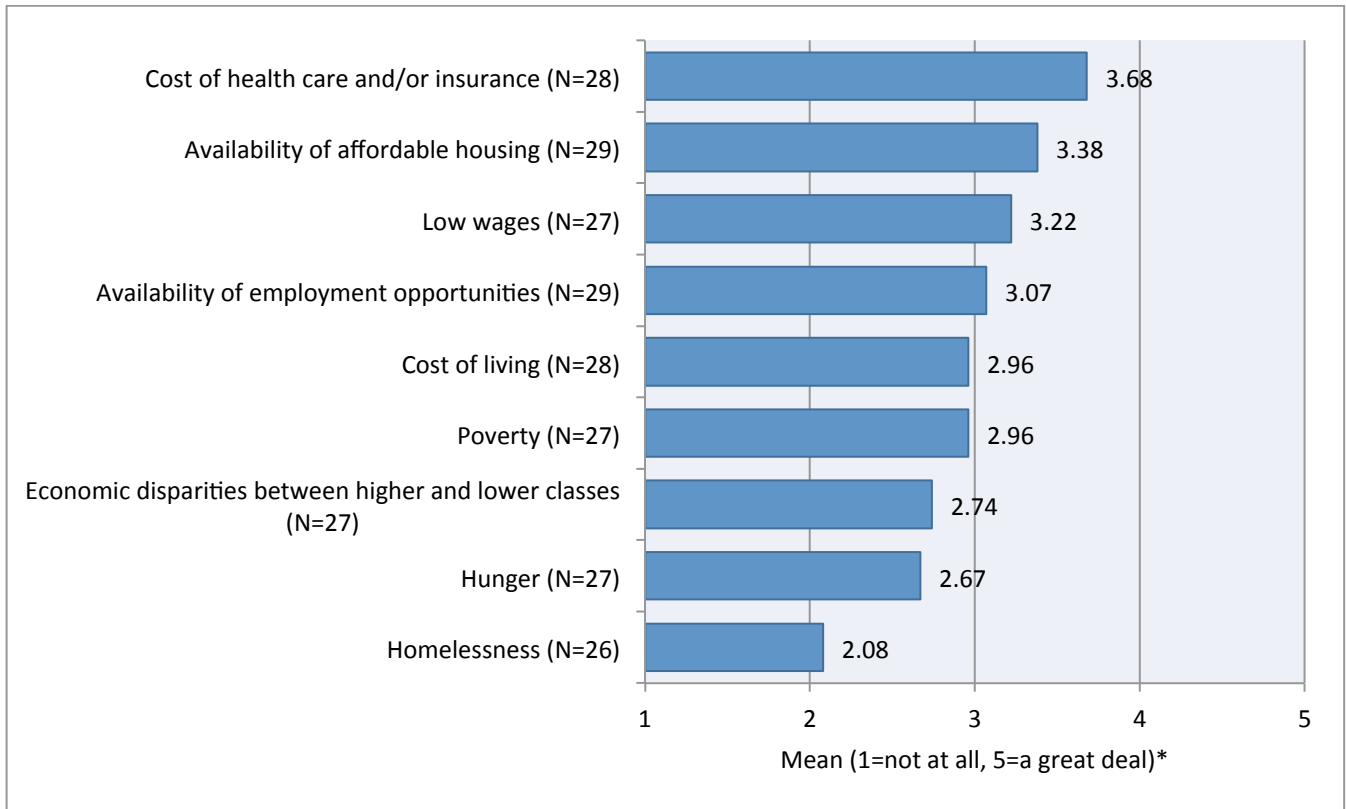
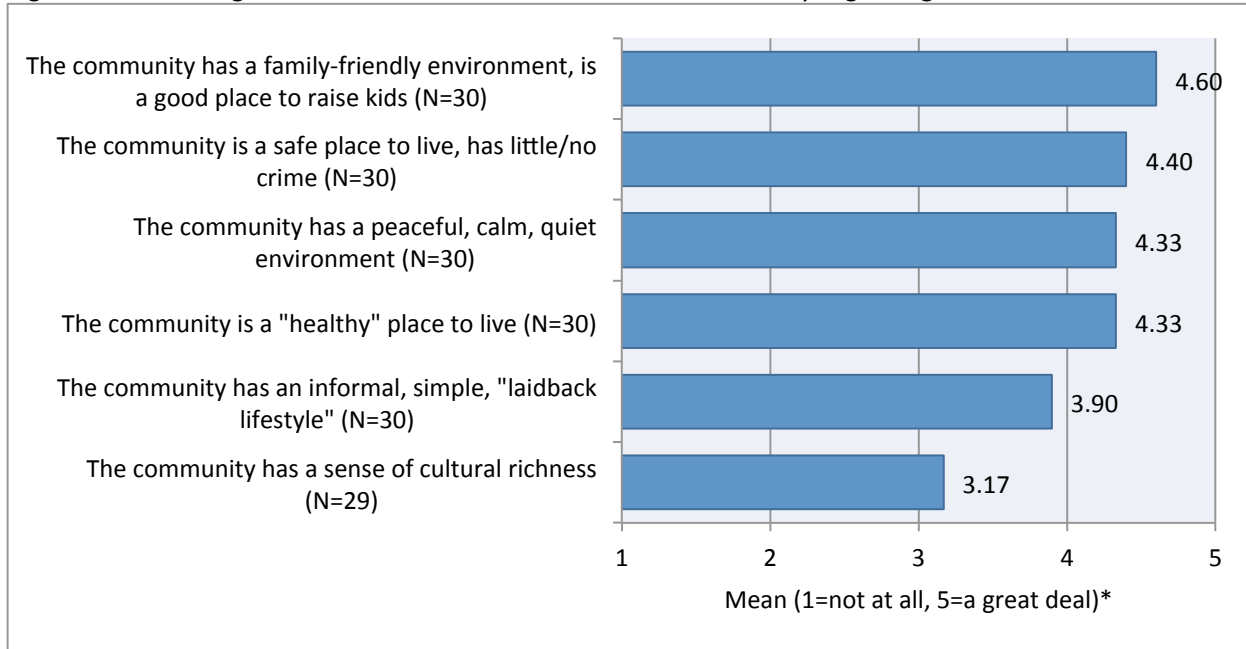*Means exclude "do not know" responses.

Services and Resources

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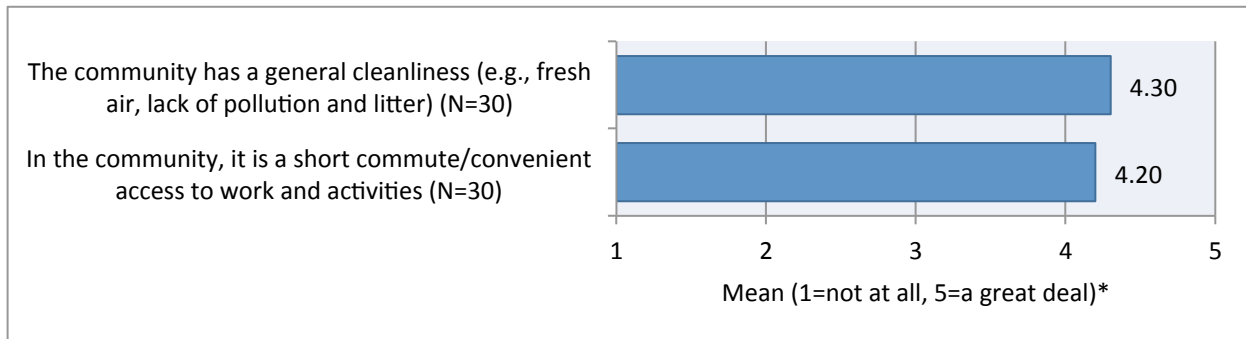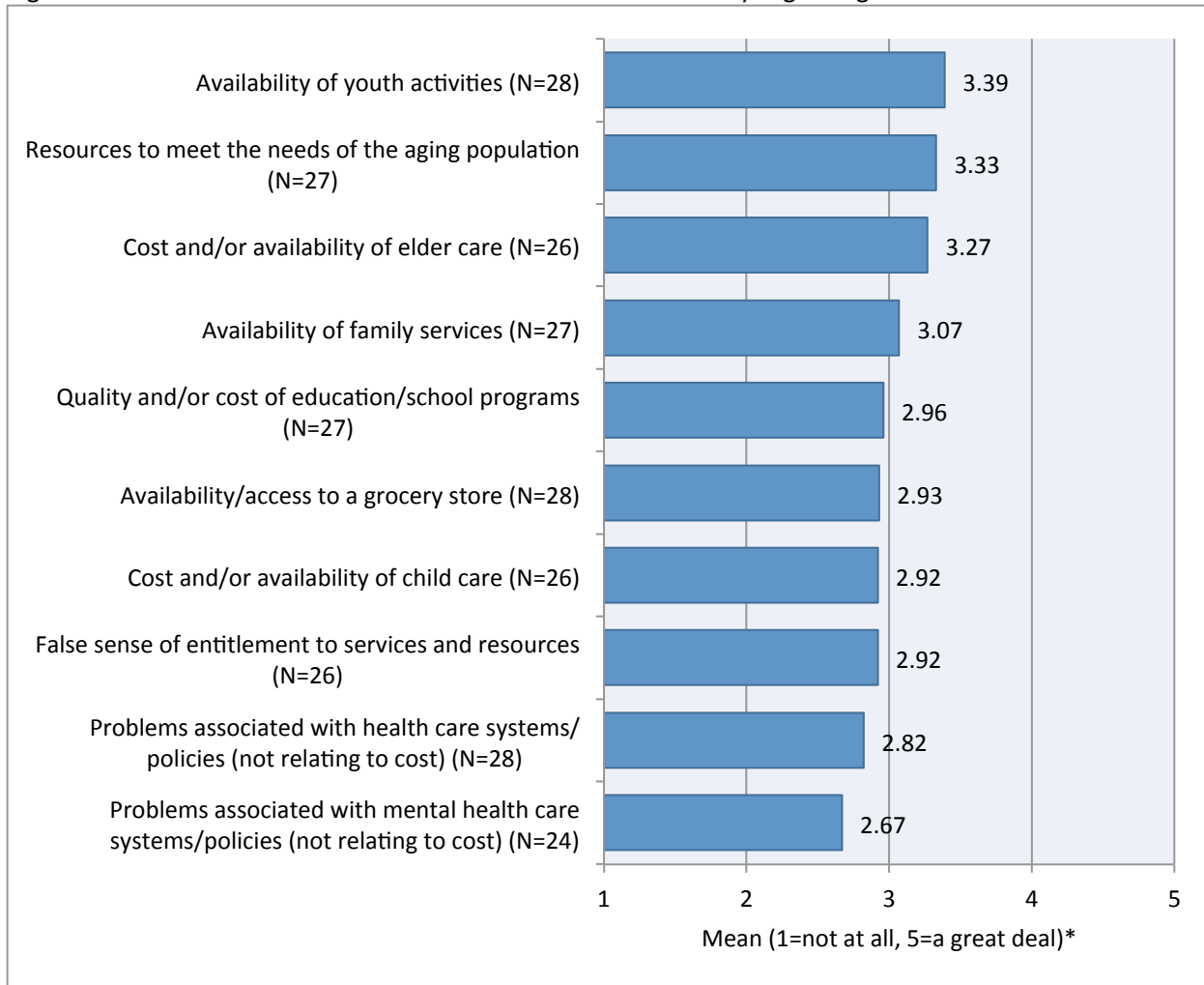

*Means exclude "do not know" responses.

Transportation

Figure 8: Level of concern with statements about the community regarding TRANSPORTATION
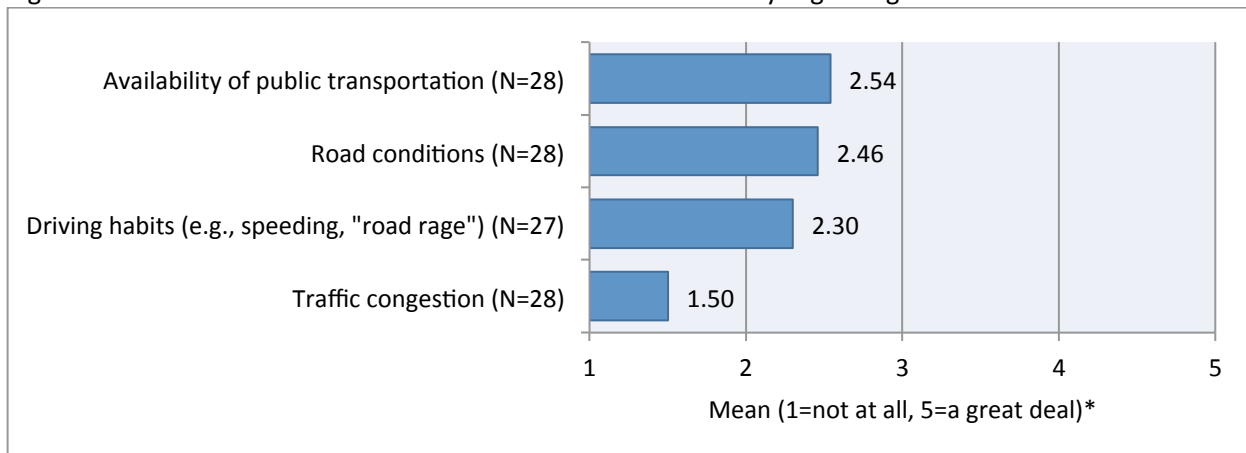
*Means exclude "do not know" responses.

Environmental Pollution

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

Water pollution (N=28) 2.11
Air pollution (N=28) 1.93
Noise pollution (N=28) 1.71

Mean (1=not at all, 5=a great deal)*
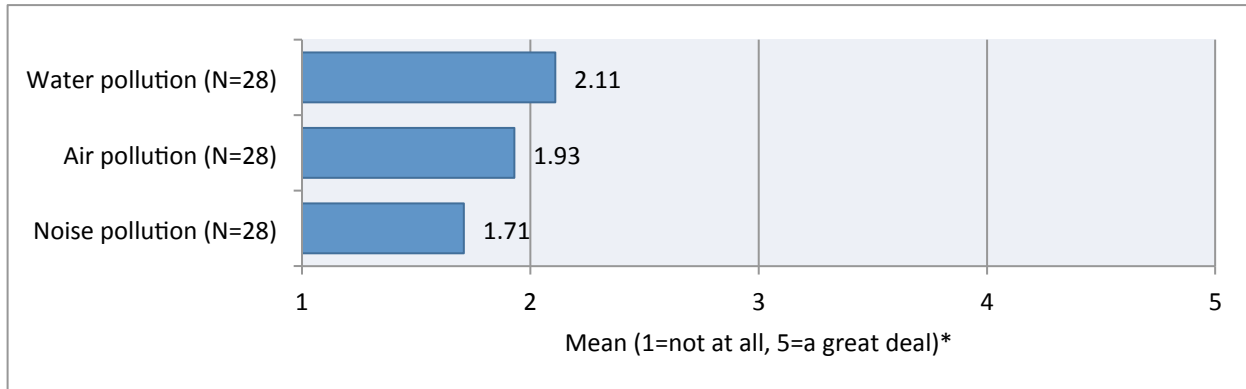
*Means exclude "do not know" responses.

Youth Concerns

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

Changes in family composition (e.g., divorce, single parenting) (N=27) 3.44
Bullying (N=28) 3.43
Teen pregnancy (N=27) 3.26
Youth crime (N=27) 3.07
School dropout rates/truancy (N=28) 2.79

Mean (1=not at all, 5=a great deal)*
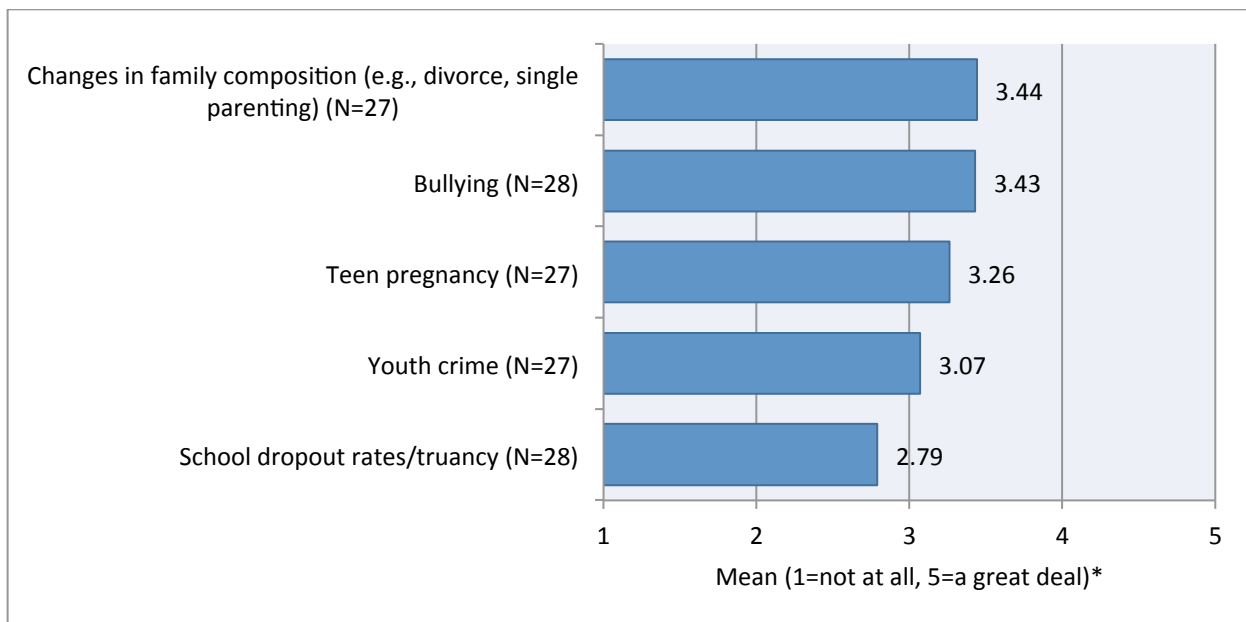
*Means exclude "do not know" responses.

Safety

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

Category	Mean
Substance abuse (N=28)	3.46
Child abuse and neglect (N=27)	3.00
Domestic violence (N=27)	3.00
Property crimes (N=28)	2.86
Violent crimes (N=28)	2.25
Prostitution (N=27)	1.89

Mean (1=not at all, 5=a great deal)*
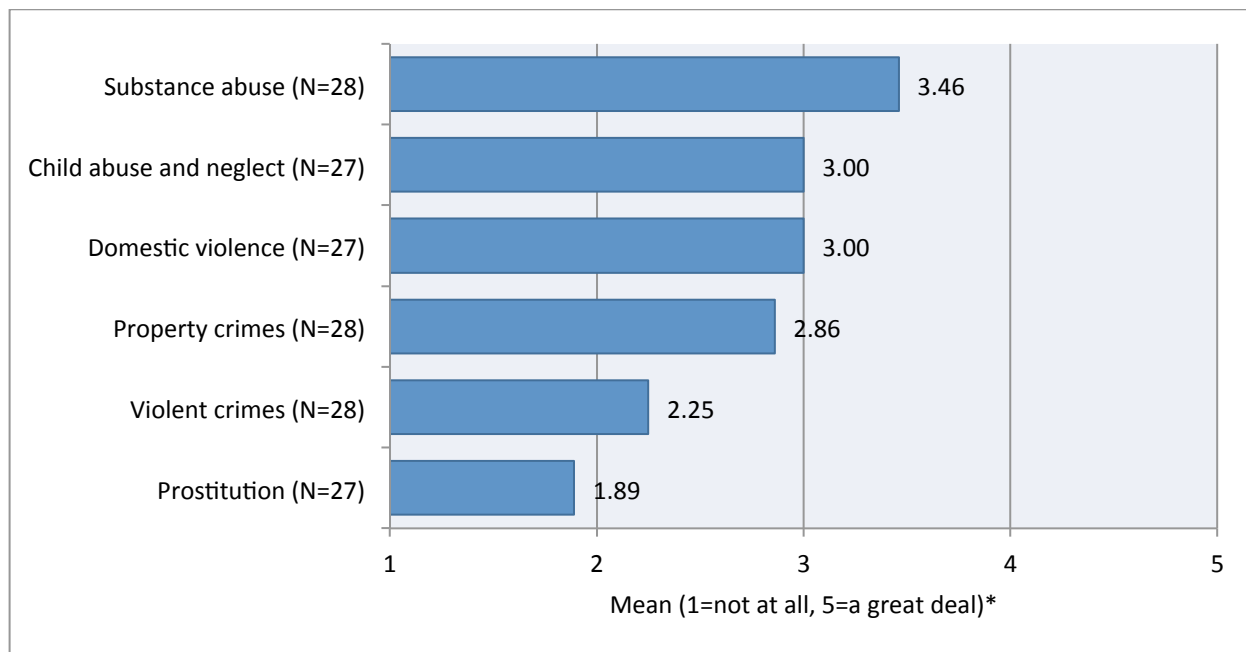
*Means exclude "do not know" responses.

Community Health and Wellness Concerns

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

Access to Health Care

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

Statement	Mean
Cost of health insurance (N=27)	4.30
Cost of health care (N=27)	4.04
Cost of prescripton drugs (N=27)	3.85
Adequacy of health insurance (e.g., amount of co-pays & deductibles, consistency of coverage) (N=25)	3.52
Access to health insurance coverage (e.g., preexisting conditions) (N=25)	3.44
Availability and/or cost of dental and/or vision care (N=27)	3.30
Availability and/or cost of dental and/or vision insurance coverage (N=26)	3.15
Availability of prevention programs or services (N=27)	3.15
Availability of doctors, nurses, and/or specialists (N=28)	2.93
Use of emergency room services for primary health care (N=26)	2.77
Availability of/access to transportation (N=28)	2.39
Availability of non-traditional hours (e.g., evenings, weekends) (N=27)	2.33
Availability of bilingual providers and/or translators (N=26)	2.12
Distance to health care services (N=27)	2.11
Time it takes to get an appointment (N=28)	2.11
Confidentiality (N=28)	1.93
Provider is not taking new patients (N=26)	1.92

Mean (1=not at all, 5=a great deal)*
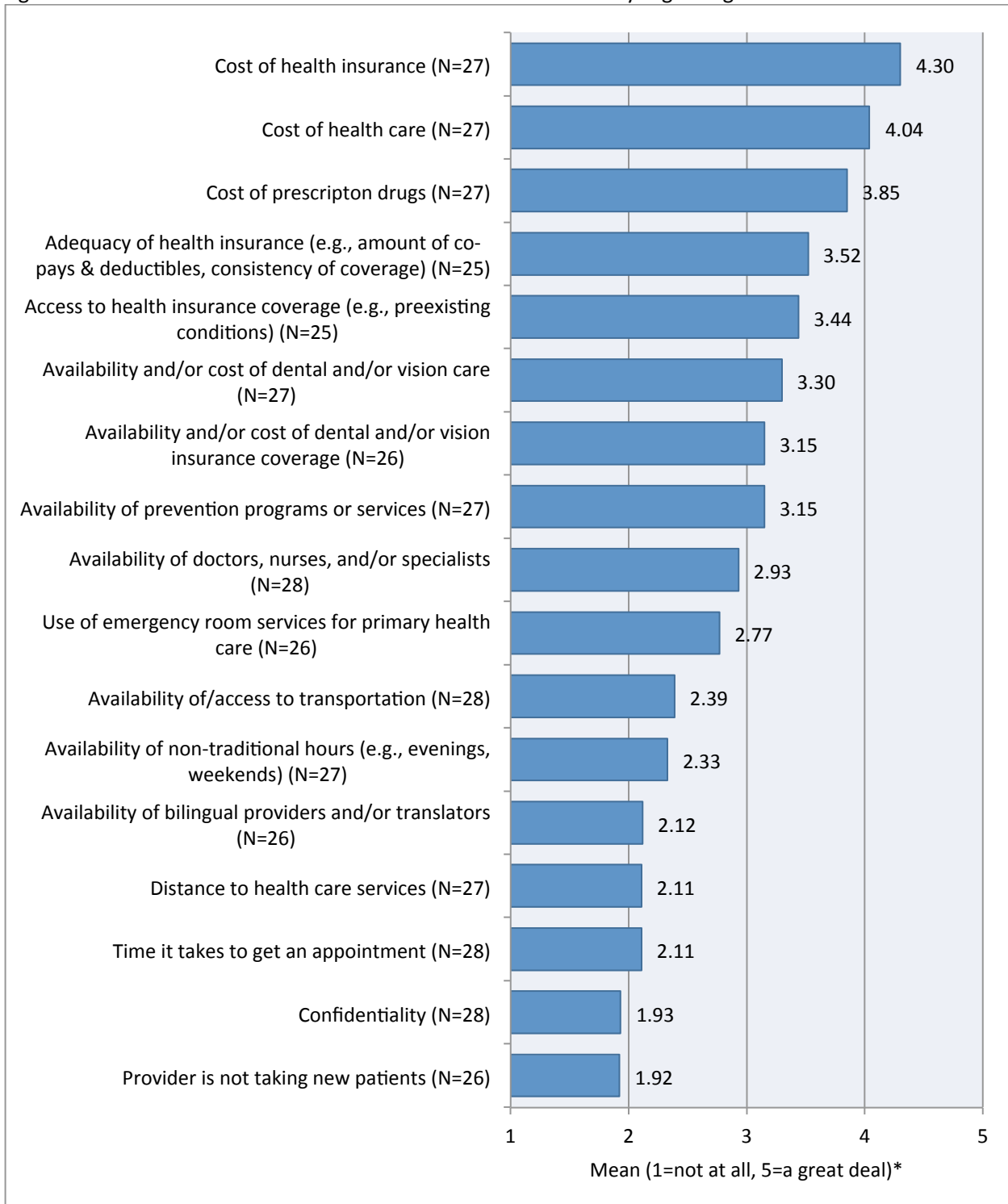
*Means exclude "do not know" responses.

26

Substance Use and Abuse

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

Drug use and abuse (N=27) — 3.56
Alcohol use and abuse (N=28) — 3.39
Presence and influence of drug dealers in the community (N=25) — 3.16
Smoking (N=28) — 3.11

Mean (1=not at all, 5=a great deal)*
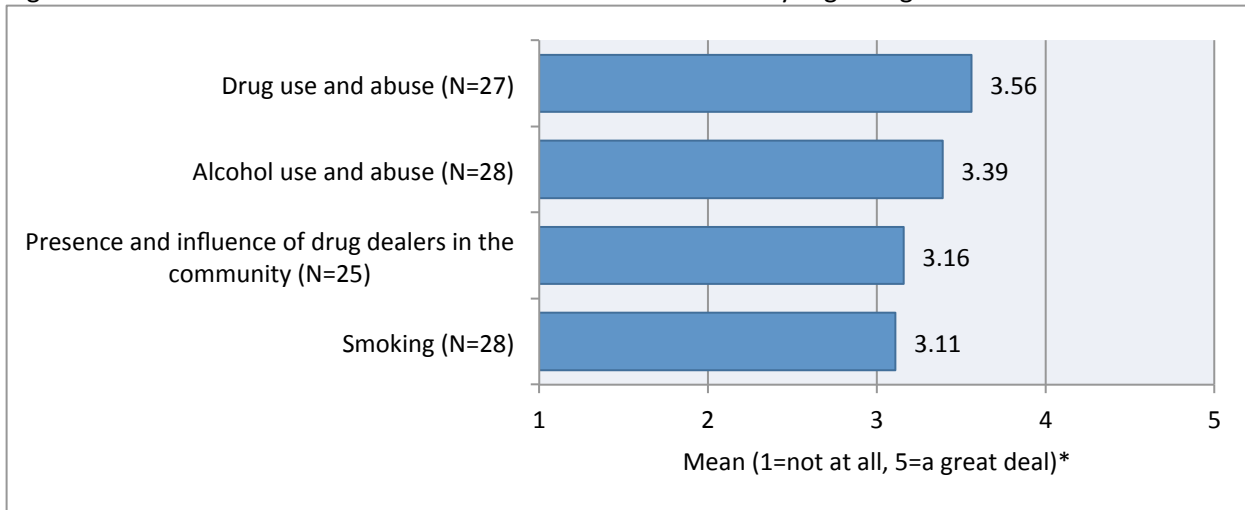
*Means exclude "do not know" responses.

Physical Health

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

Obesity (N=28) — 3.64
Lack of exercise and/or inactivity (N=28) — 3.61
Poor nutrition/eating habits (N=28) — 3.61
Availability of good walking or biking options (as alternatives to driving) (N=27) — 3.56
Availability of exercise facilities (N=28) — 3.04
Cost of exercise facilities (N=27) — 2.85

Mean (1=not at all, 5=a great deal)*
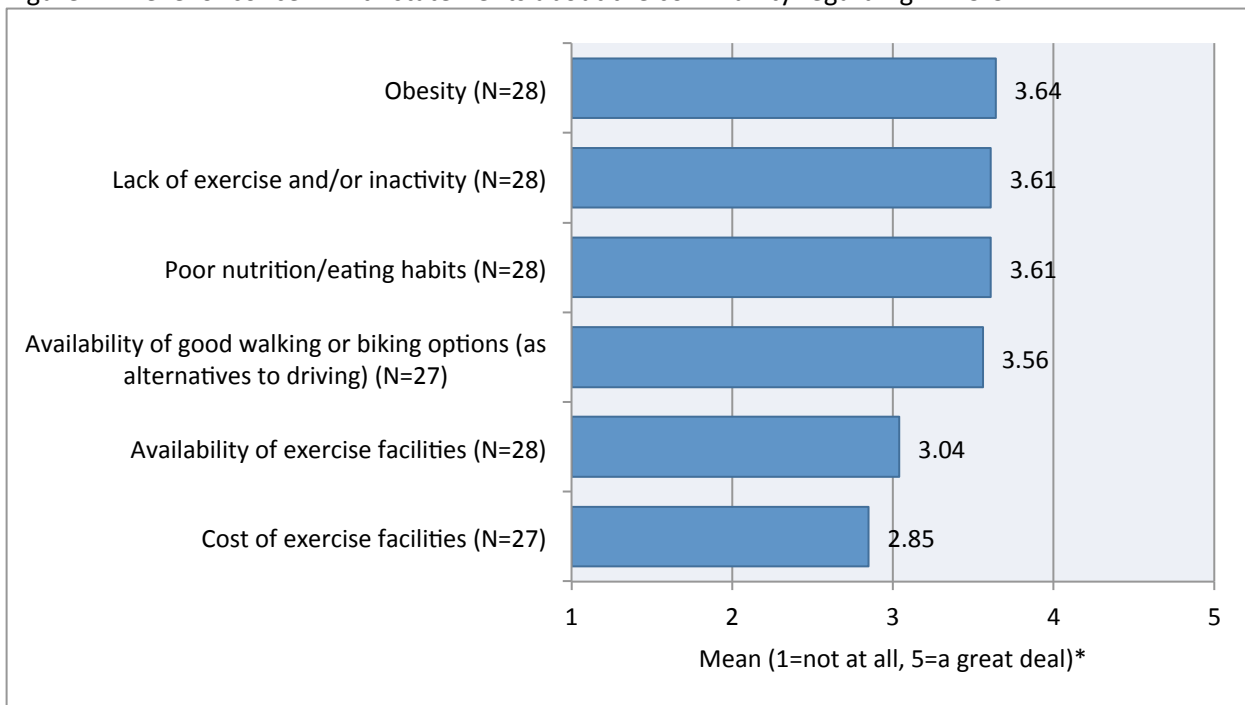
*Means exclude "do not know" responses.

Mental Health

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

	Mean (1=not at all, 5=a great deal)*
Depression (N=24)	3.33
Stress (N=24)	3.29
Availability of services for addressing mental health problems (N=24)	3.08
Availability of qualified mental health providers (N=23)	3.00
Quality of mental health programs (N=23)	2.74
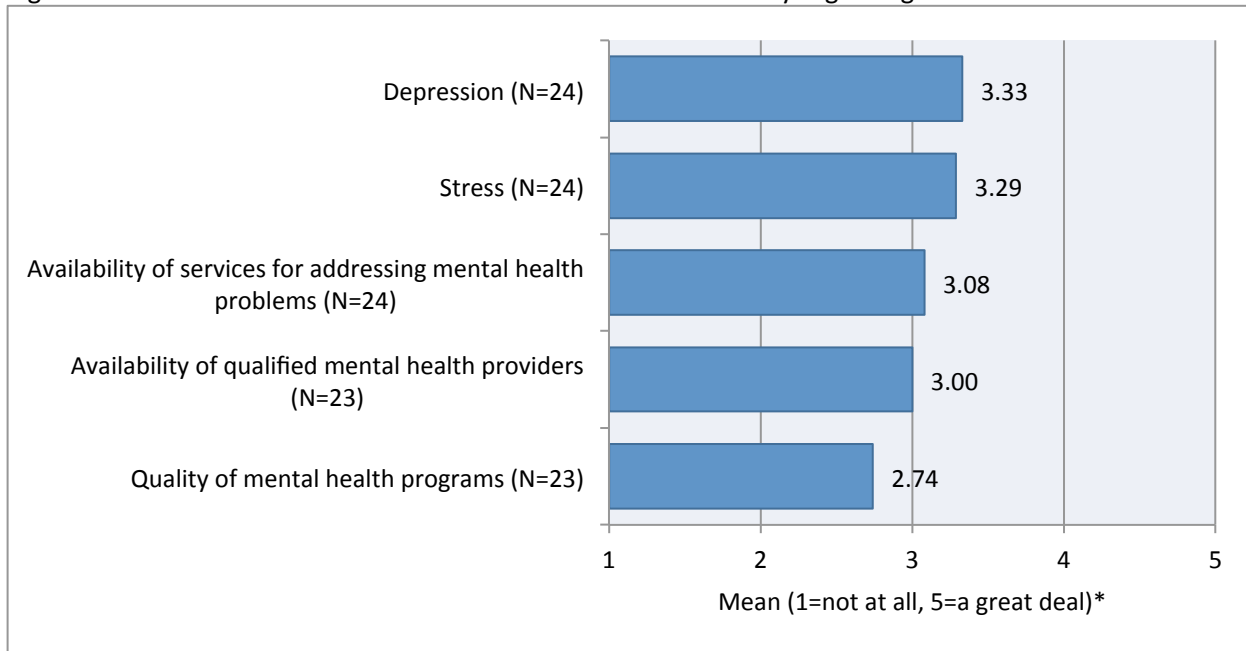
*Means exclude "do not know" responses.

Illness

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

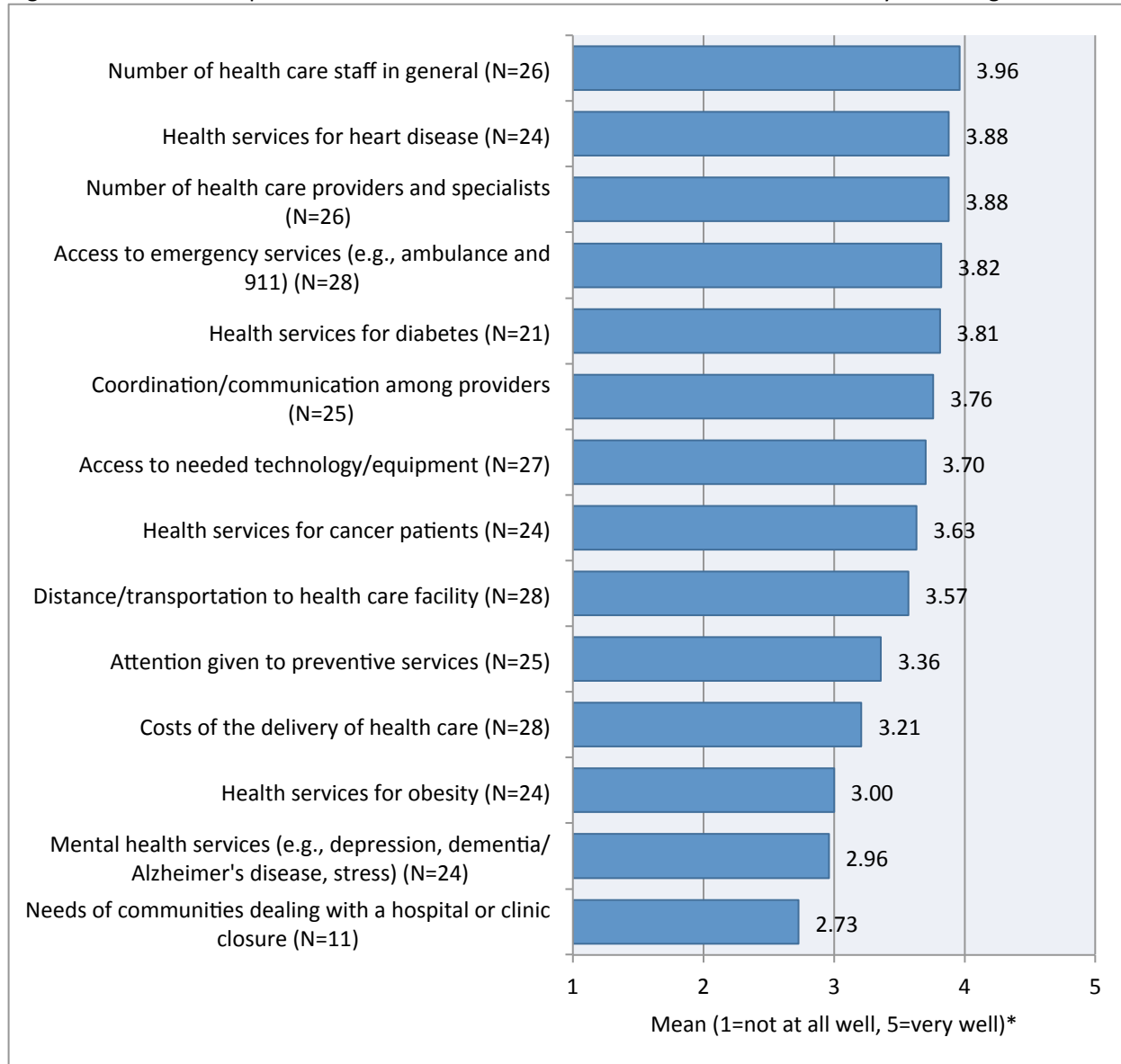|	Mean (1=not at all, 5=a great deal)*
Cancer (N=28)	3.71
Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (N=28)	3.61
Communicable diseases (e.g., including sexually transmitted diseases, AIDS) (N=26)	2.50
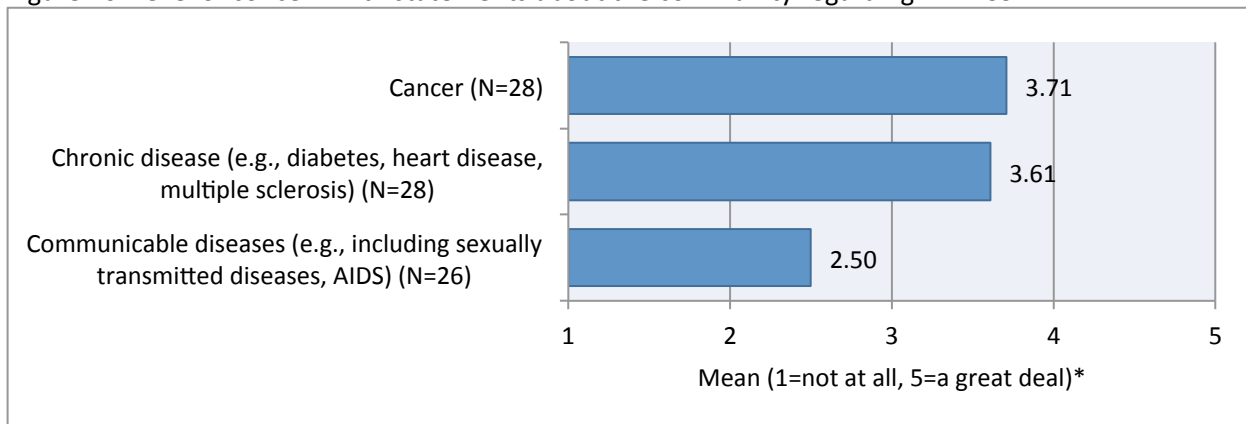
*Means exclude "do not know" responses.

Delivery of Health Care in the Community

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

Delivery of Health Care

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

Topic	Mean
Number of health care staff in general (N=26)	3.96
Health services for heart disease (N=24)	3.88
Number of health care providers and specialists (N=26)	3.88
Access to emergency services (e.g., ambulance and 911) (N=28)	3.82
Health services for diabetes (N=21)	3.81
Coordination/communication among providers (N=25)	3.76
Access to needed technology/equipment (N=27)	3.70
Health services for cancer patients (N=24)	3.63
Distance/transportation to health care facility (N=28)	3.57
Attention given to preventive services (N=25)	3.36
Costs of the delivery of health care (N=28)	3.21
Health services for obesity (N=24)	3.00
Mental health services (e.g., depression, dementia/ Alzheimer's disease, stress) (N=24)	2.96
Needs of communities dealing with a hospital or clinic closure (N=11)	2.73

Mean (1=not at all well, 5=very well)*

*Means exclude "do not know" responses.

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and sense of being valued as a patient.

Cancer Screening

More than 50% of respondents said that they did have a cancer screening or cancer care in the past year. The most common reason for not having done so was because the doctor had not recommended it and they thought it was not necessary. Fear and not knowing who to see were not considered to be the main reasons respondents gave.

Respondents were asked whether they had a cancer screening or cancer care in the past year, and if they had not, reasons for not having done so. Over 50% said they that they did have a cancer screening or cancer care in the past year.

Figure 18. Whether respondents had a cancer screening or cancer care in the past year
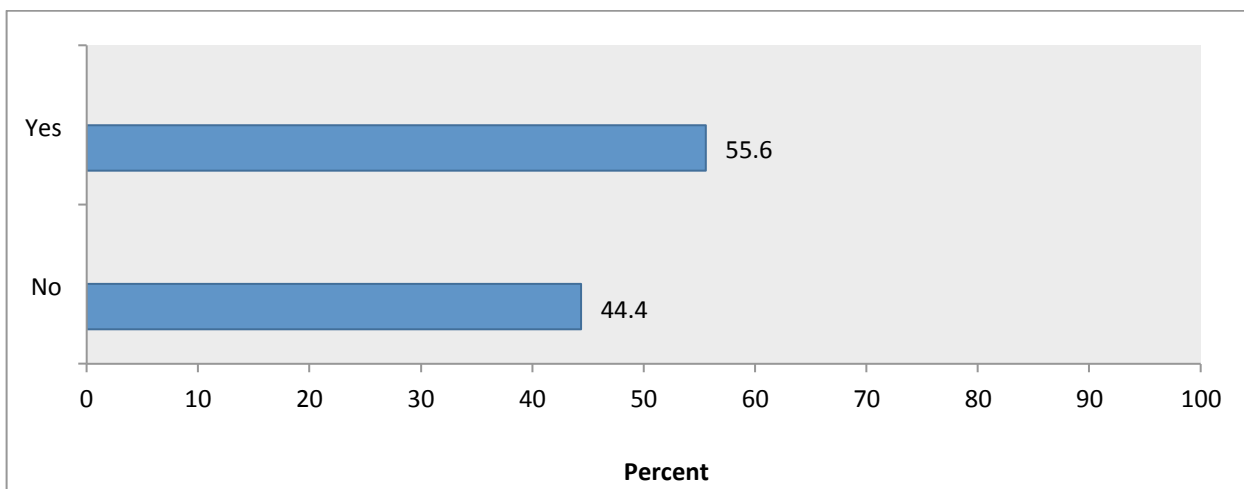
Among respondents who had not had a cancer screening or cancer care in the past year, 42% said they had not done so because their doctor had not suggested it. Over 16% stated that cost was a factor. Forty two percent (42%) of respondents stated that they thought the cancer screening was not necessary. Fear was not considered a reason for respondents to not have the screening. (Figure 19)

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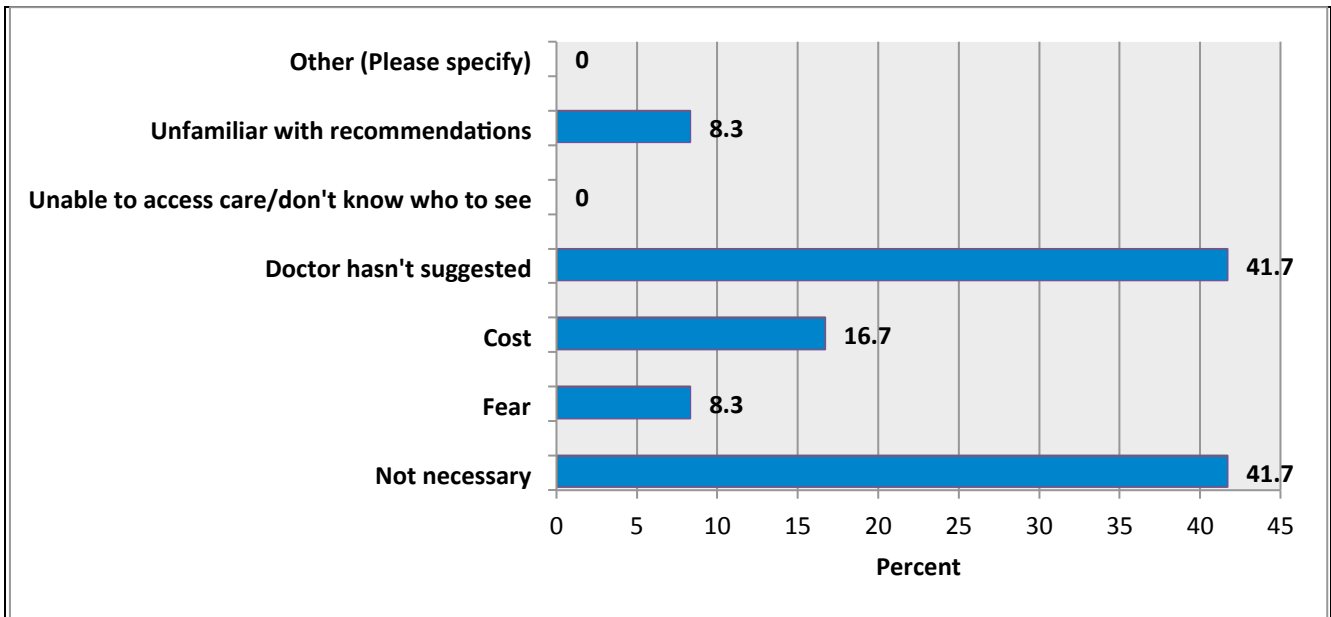

Percentages do not equal 100.0 due to multiple responses.

Health Care Coverage

Respondents were asked how they had paid for health care costs, for themselves or family members, over the last 12 months. A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income and private health insurance were also used. Medicare was used by 14% of respondents and Medicaid by nearly 4%.
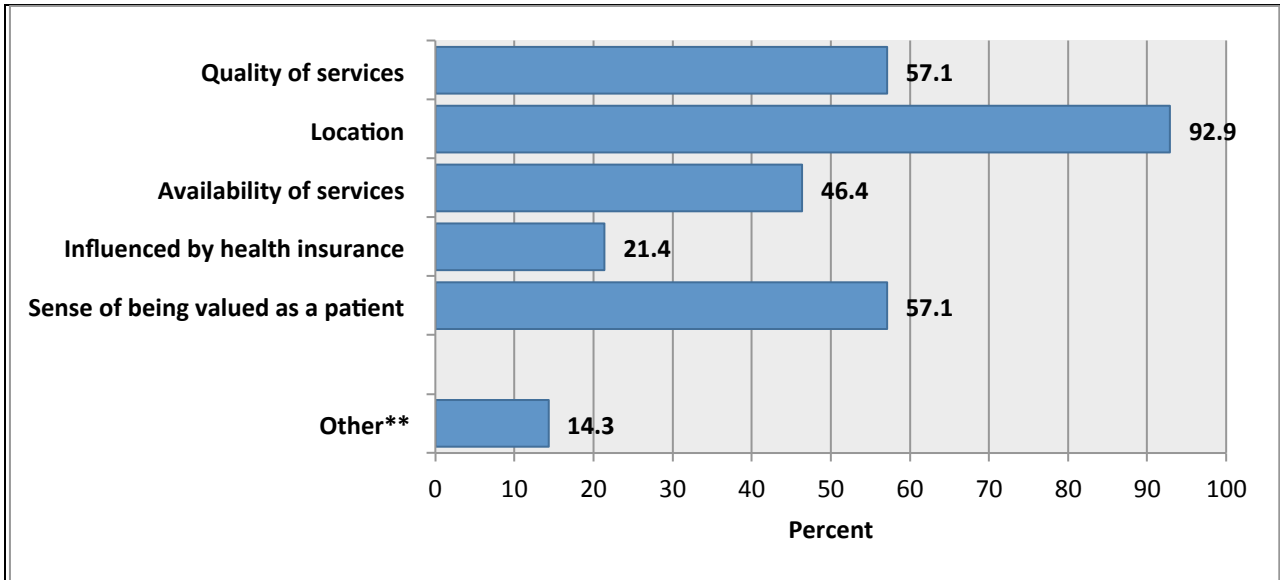
Figure 20. Methods respondents have used to pay for health care costs over the last 12 months
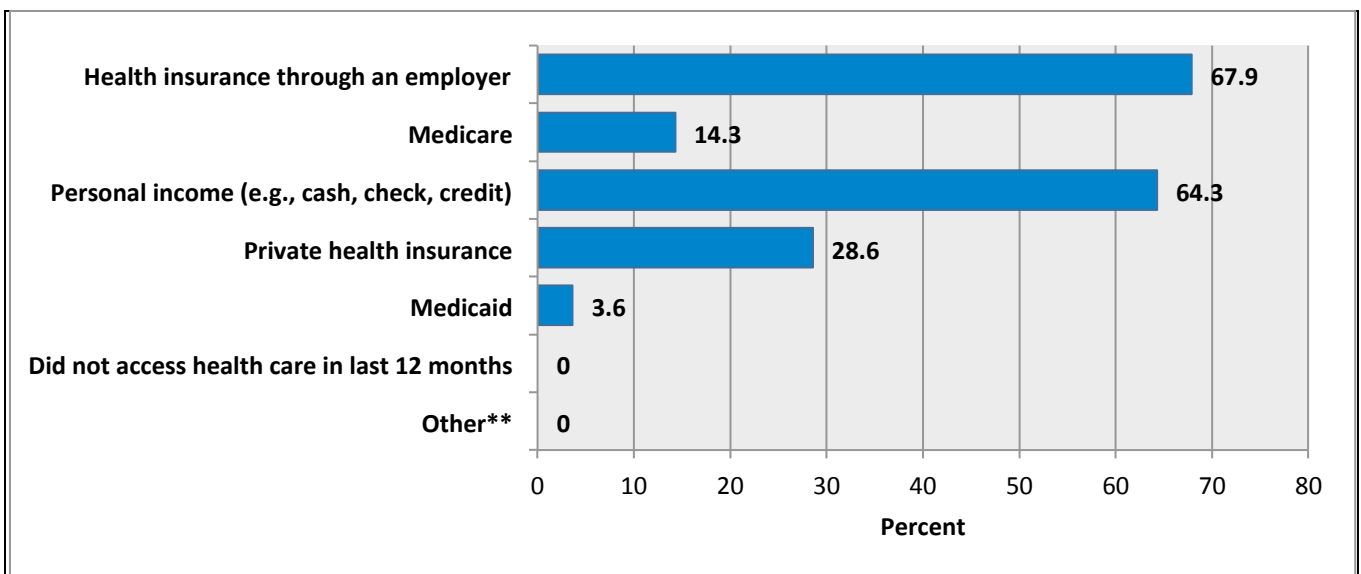
Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and being valued as a patient. (*Figure 21)*

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

Respondent's Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. One hundred percent (100%) of respondents said they use Sanford Health as their primary health care provider, although 22% accessed care at Sanford facilities in Sioux Falls. Many respondents stated multiple Sanford sites as their primary health care provider. (*Figure 22*)

Figure 22. Respondent's primary health care provider
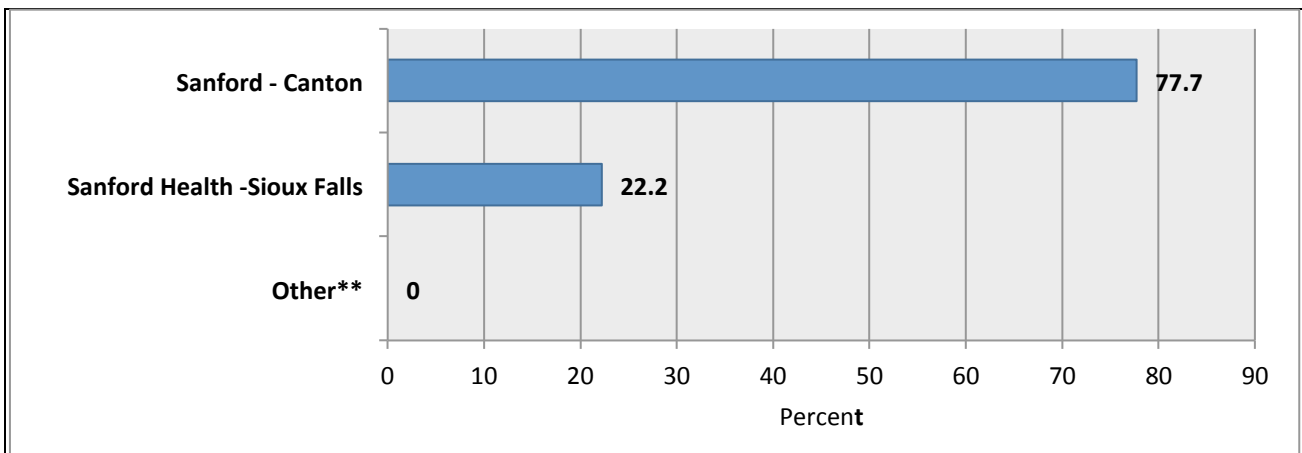
Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight control received the most responses with 14.8% of participants selecting this condition. The chronic diseases found among respondents include arthritis, asthma, cancer, heart disease, diabetes, Alzheimer's, hypertension and depression. (Figure 23)
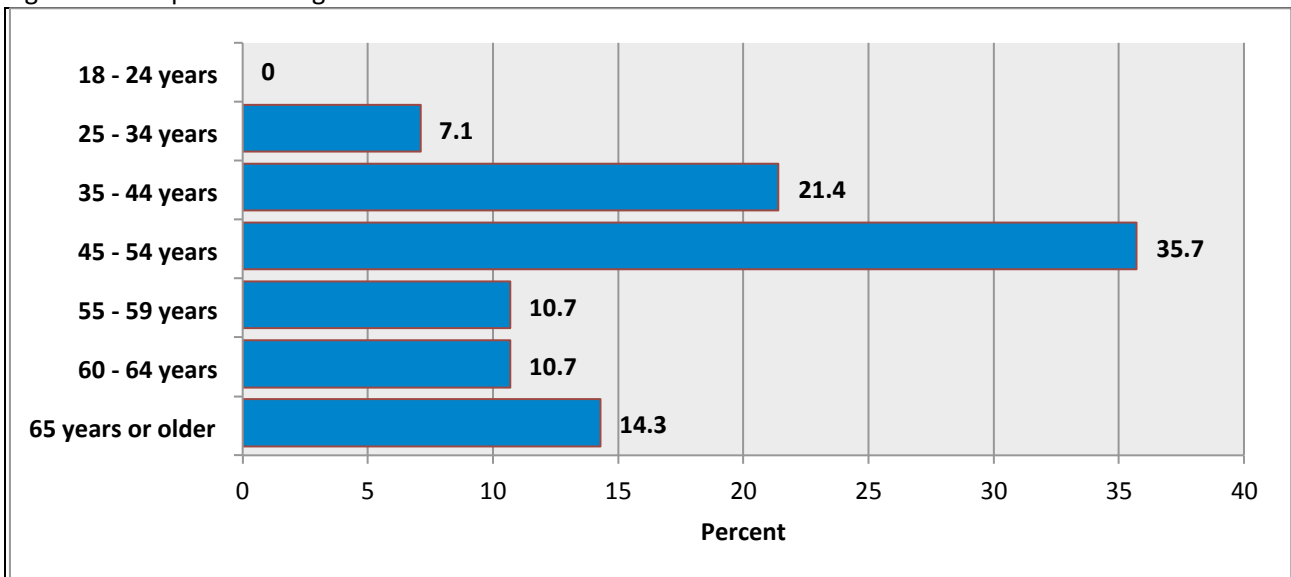
Figure 23. Respondent's health/chronic diseases
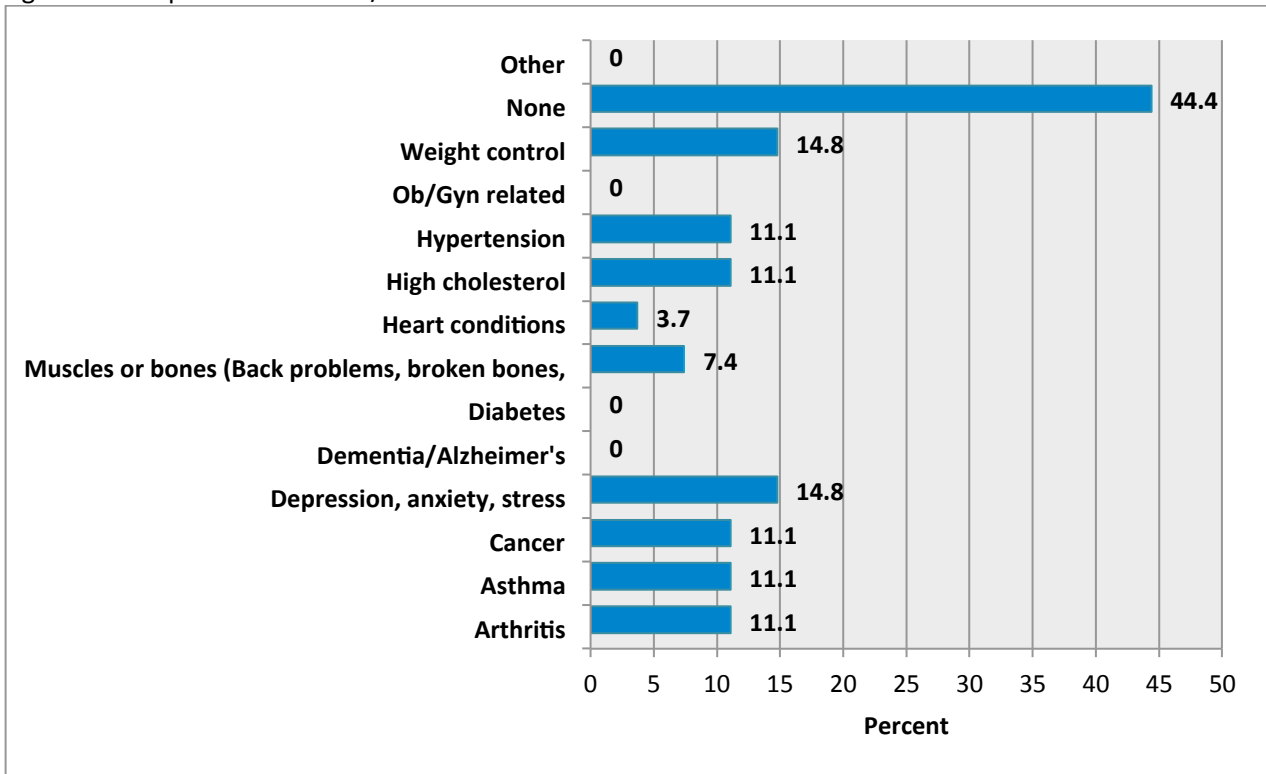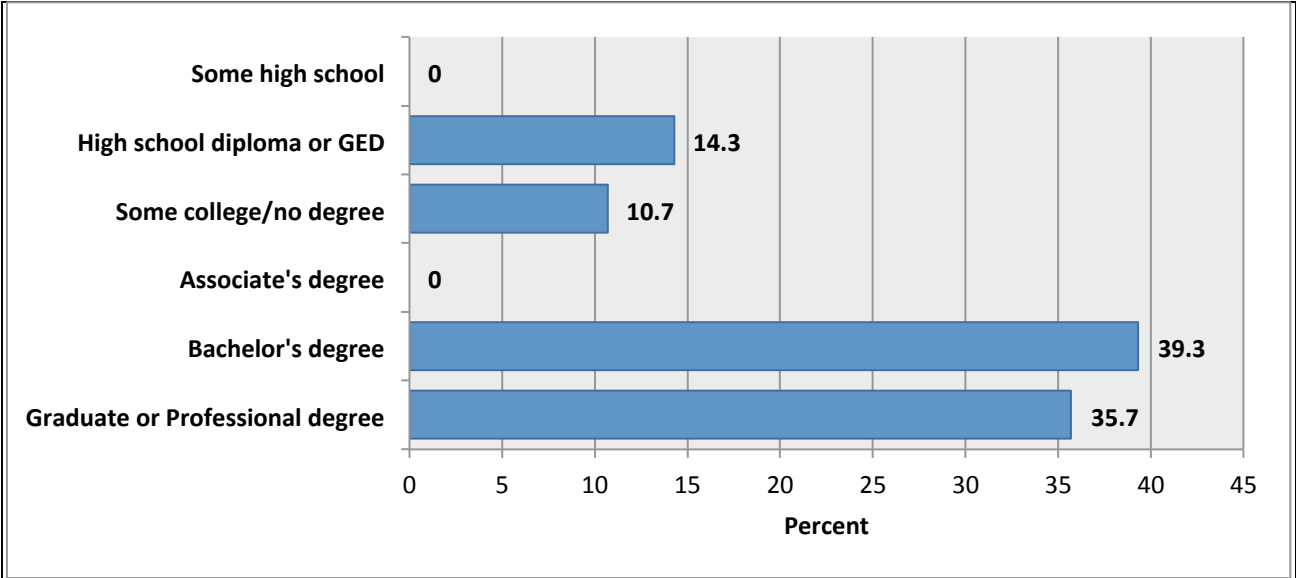

Demographic Information

The majority of respondents are 35 to 54 years old.
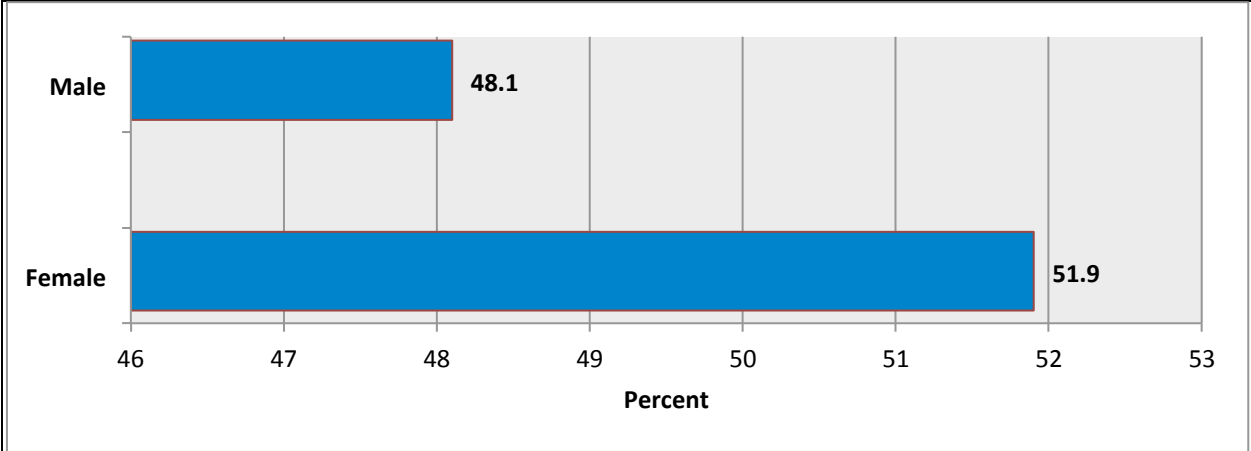Figure 24. Respondents' age distribution

Most respondents have a Bachelor's degree or higher, including nearly 36% who have a graduate or professional degree.

Figure 25. Respondents' education

Over 50% of respondents are female.

Figure 26. Respondents' gender distribution

Secondary Research

HEALTH OUTCOMES

Mortality

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,564	6,815	5,190	5,976	5,011

Morbidity

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	10%	12%	8%	12%	6%
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.8	1.9	2.8	1.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.3	2.6	1.9	2.7	0.9
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.0%	6.8	6.1	6.8	5.9

HEALTH FACTORS

Health Behaviors

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	20%	13%	20%	21%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	25%	29%	26%	28%	27%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	26%	21%	25%	25%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, (consuming >4 for women and >5 for men on a single occasion) 2003-2009	8%	19%	23%	20%	17%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	12.0	23.7	13.1	15.2	-
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	83.0	371.3	60.4	313.6	26.7
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	22.0	38.7	18.2	32.0	16.4

Clinical Care

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	16%	12%	13%	20%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	7%	9%	9%	6%	13%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	631:1	769:1	451:1	984:1	2,797:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	2,242:1	3,544:1	1,280:1	14,190:1	11,189:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	69.0	50.0	78.1	54.0	53.4
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.0	68.6	65.7	67.5	69.4
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	83%	91%	86%	85%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	68%	76%	67%	77%

Social and Economic Factors

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years 2006-2007	92%	83%	85%	87%	95%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	64%	72%	66%	61%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009 May of 2012	5.3%	4.8%	4.2%	6.0%	4.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	18%	5%	14%	10%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	17%	12%	16%	12%
Children in single parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	20%	29%	17%	26%	10%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	1.0	2.5	-	1.9	-

Physical Environment

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0	1	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e. grocery store or produce stand/farmers market), 2008	92%	42%	50%	39%	86%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	17.0	13.0	15.0	12.0	18.0

Demographics

Youth account for 29% of the population in Lincoln County and 27% of Lyon County. Elderly account for 6% of the population in Lincoln County and 17% of the [population in Lyon County.

One hundred percent (100%) of Lyon County is rural compared to 48% of South Dakota and 21% as the national benchmark. Lincoln County is 61% rural.

Only 2% of South Dakotans and 1% of the Lincoln and Lyon County population is not proficient in English compared to the national benchmark which is 9%.

South Dakota has a 7% illiteracy rate compared to the national benchmark of 15%. The illiteracy rate in Lincoln County is 5% and in Lyon County is 7%.

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

		National Benchmark	SD	Lincoln County	Iowa	Lyon County
Youth	Percent of total population ages 0-17, 2009	24%	25%	29%	24%	27%
Elderly	Percent of total population ages 65 and older, 2009	13%	14%	6%	15%	17%
Rural	Percent of total population living in rural area, 2000	21%	48%	61%	39%	100%
Not English Proficient	Percent of total population that speaks English less than "very well". 2005-2009	9%	2%	1%	3%	1%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	7%	5%	8%	8%

The population for this area is relatively young with only 1% older than 85 years of age in Lincoln County and 3% in Lyon County. In Lincoln County only 9% are older than 65 years of age compared to 17% in Lyon County.

The gender distribution is 50-50 in Lyon County.

Population by Age

	SD	Lincoln County	Lyon County
Total population	814,180	44,828	11,581
Percent ages 65 and older	14%	9%	17%
Percent 85 and older	2%	1%	3%
Percent male	50%	50%	50%
Percent female	50%	50%	50%

Based on 2010 Census data

The majority of individuals in these counties own their homes and the rates of home ownership are much higher than the state benchmark.

Housing

	SD	Lincoln County	Lyon County
Percent of occupied housing that is owner-occupied	68%	78%	83%
Percent of occupied housing that is renter-occupied	32%	22%	17%

Based on 2010 Census data

According to the 2010 Census Data, the population of working age in the labor force is 69% in South Dakota, 80% in Lincoln County, and 72% in Lyon County. The percentage of those who are living at less than 100% of the federal poverty level range is 14 % in South Dakota, with 33% living at less than 200% of the poverty level. Lincoln County has only 4% with income less than 100% of the federal poverty rate while Lyon County has 6%. Lincoln County has 17% with income less than 200% of the federal poverty rate while Lyon County has 28%.

The median household in South Dakota is $46,369 annual income. Lincoln County falls above this benchmark at $67,365 annual income and Lyon County is at $49,506.

	SD	Lincoln County	Lyon County
Percent of working age population in the labor force	69%	80%	72%
Percent of total population with income less than 100% of poverty	14%	4%	6%
Percent of total population with income less than 200% of poverty	33%	17%	28%
Median household income	$46,369	$67,365	$49,506
Owner occupied housing units	217,250	12,017	3,567
Percent spending 30% or more income toward housing costs	20%	20%	18%
Renter occupied housing units	98,218	3,765	789
Percent renters spending 30% or more of income toward housing costs	35%	39%	17%

The population distribution by race demonstrates that Lincoln County, Lyon County, and the state of South Dakota are predominantly white. In Lincoln County and in Lyon County, the Hispanic population is the second largest population followed by Asian, Black and American Indian in that order.

Diversity Profile

	SD	Lincoln County	Lyon County
Total population	814,180	44,828	11,581
White alone	699,392	43,068	11,340
Asian alone	7,610	462	25
Black alone	10,207	320	10
Hispanic origin – of any race	22,119	553	212
American Indian	71,817	228	9

Health Needs Identified

The identified needs from the surveys and analysis of secondary data indicated the following needs:
- Access to Health Care/Physicians
- Concern about cancer in the community
- Day Care
- Economic Issues- cost of health care
- Mental Health – Binge drinking
- Physical Health/Obesity/Nutrition Education

Community Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. Community experts were asked to complete the asset mapping exercise. Individuals who contributed to this work include the health department, social services, education, community members and leaders from the health care facilities within the county.

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

An informal gap analysis was conducted at the conclusion of the asset mapping work. The gap analysis determined that there were three main areas to focus attention. A multi-voting prioritization process determined the priority of the remaining needs.

The priorities that remain include:
- Obesity
- Cost of Health Care

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

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Sanford Canton-Inwood Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:
- Cost Involved Preventing Individuals from Seeking Medical Services
- Obesity in Children

Implementation Strategy: Cost of Health Care
- Run story in newspaper on how preventative medicine helps reduce potential of future large medical bills.
- Run "Did You Know" articles in newspaper and provide narrative on preventative medicine visits and the resulting benefits.
- Presentation to community groups about the actual cost of health care and how it increases if you do not go to the doctor for regular check-ups (e.g. getting a flu shot will help prevent the flu. The cost of the flu shot is "x" versus if you get sick and have to go to the doctor, there would be an appointment cost plus the cost of the medication).
- Work with Sanford Patient Financial Services to provide education for patients regarding our financial assistance options.
- Potentially offer a "cash only" office visit or physical exam at discounted fee.

Implementation Strategy: Obesity in Children
- Promote Sanford WebMD FitKids website in local schools.
- Brainstorm ideas to sponsor an awareness day/week at the schools that promote exercise along with healthy eating habits.
- Explore the possibility of having local Sanford Canton-Inwood rehab therapist or health coach/athletic trainer give presentations at schools.
- Offer classes on healthy eating by Sanford.
- Sponsor classes on healthy eating in Canton and Inwood for the parents and/or children to provide awareness.
- Explore hosting a bike-a-thon for elementary grades where kids would ride their bikes up and down a specific one-mile road and at the end of the event prizes would be given for each age group (ex. new bike) and participation prizes for all participants. This is something we could potentially ask the foundation to help sponsor as this would address the foundation's mission statement.
- Cover healthy eating habits at our annual health fair.
- Distribute recipes featuring healthy snacks.

2013 Community Health Needs Assessment
Enterprise Implementation Strategy

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

- Mental Health Services
- Obesity

Implementation Strategy: Mental Health Services - Sanford One Mind

- Completion (to the extent resources allow) of full integration of Behavioral Health services in all primary care clinics in Fargo and Sioux Falls
- Completion (to the extent resources allow) of full integration of Behavioral Health services or access to Behavioral Health outreach in all regional clinic sites in the North, South and Bemidji regions
- Complete presentation of outcomes of first three years of integrated Behavioral Health services
- Implementation of integrated Behavioral Health into clinics in new regions
- Design Team for Inpatient Psychiatric Unit, Partial Hospitalization and Clinic Space for Fargo presents recommendations for design of new spaces
- Design Team for Sioux Falls Inpatient Psychiatric Units and Partial Hospitalization

Implementation Strategy: Obesity

- Medical Management for Obesity
  - o Develop CME curriculum for providers and interdisciplinary teams across the enterprise inclusive of medical, nutrition, nursing, and Behavioral Health professionals
- Develop community education programming
  - o Include the following program options in the curriculum to create awareness of existing resources:
    - ➢ Family Wellness Center
    - ➢ Honor Your Health Program
    - ➢ WebMD Fit Program
    - ➢ Bariatric Services
    - ➢ Eating Disorder Institute
    - ➢ Mental Health/Behavioral Health
    - ➢ Profile
- Actively participate in community initiatives to address wellness, fitness and healthy living

APPENDIX

2011 County Health Profile
An adaptation of the County Health Rankings Project for the Fargo-Moorhead
Community Health Needs Assessment Collaborative

Lincoln County

South Dakota

HEALTH OUTCOMES

		Lincoln	*National Benchmark	South Dakota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,190	5,564	6,815
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	8%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.9	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.9	2.3	2.6
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.1%	6.0%	6.8%

HEALTH FACTORS

		Lincoln	*National Benchmark	South Dakota
Health Behaviors				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	13%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	26%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	21%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	23%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	13.1	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	60.4	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	18.2	22.0	38.7
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	12%	13%	16%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	9%	7%	9%
Primary care physicians	Ratio of total population to primary care physicians, 2008	451:1	631:1	769:1
Mental health providers	Ratio of total population to mental health providers, 2008	1,280:1	2,242:1	3,544:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	78.1	69.0	50.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	65.7	52.0	68.6
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	91%	89%	83%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	76%	74%	68%

HEALTH FACTORS (continued)

		Lincoln	*National Benchmark	South Dakota

Social and Economic Factors

		Lincoln	*National Benchmark	South Dakota
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	85%	92%	83%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	72%	68%	64%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	4.2%	5.3%	4.8%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	5%	11%	18%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	12%	14%	17%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	17%	20%	29%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5

Physical Environment

		Lincoln	*National Benchmark	South Dakota
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	50%	92%	42%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	15.0	17.0	13.0

Demographics

		Lincoln	United States	South Dakota
Youth	Percent of total population ages 0-17, 2009	29%	24%	25%
Elderly	Percent of total population ages 65 and older, 2009	6%	13%	14%
Rural	Percent of total population living in a rural area, 2000	61%	21%	48%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	2%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	5%	15%	7%

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

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

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2011 County Health Profile

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

Lyon County

Iowa

HEALTH OUTCOMES		Lyon	*National Benchmark	Iowa
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,011	5,564	5,976
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	6%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.8	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	0.9	2.3	2.7
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	5.9%	6.0%	6.8%

HEALTH FACTORS

Health Behaviors		Lyon	*National Benchmark	Iowa
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	21%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	27%	25%	28%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	25%	20%	25%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	17%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	15.2
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	26.7	83.0	313.6
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	16.4	22.0	32.0
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	20%	13%	13%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	13%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	2,797:1	631:1	984:1
Mental health providers	Ratio of total population to mental health providers, 2008	11,189:0	2,242:1	14,190:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	53.4	69.0	54.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	69.4	52.0	67.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	85%	89%	86%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	77%	74%	67%

HEALTH FACTORS (continued)

Social and Economic Factors

		Lyon	*National Benchmark	Iowa
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	95%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	61%	68%	66%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	4.0%	5.3%	6.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	10%	11%	14%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	12%	14%	16%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	10%	20%	26%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	1.9

Physical Environment

		Lyon	*National Benchmark	Iowa
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	1
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	86%	92%	39%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	18.0	17.0	12.0

Demographics		Lyon	United States	Iowa
Youth	Percent of total population ages 0-17, 2009	27%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	17%	13%	15%
Rural	Percent of total population living in a rural area, 2000	100%	21%	39%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	3%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	8%	15%	8%

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

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

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Definitions of Health Variables

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

Aging Profile

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

Lincoln County

South Dakota

CHARACTERISTICS	Total	AGE Less than 65 Years	AGE Ages 65 and Older
Population [1]			
Total population	44,828	40,796	4,032
Percent ages 65 and older	9%	-	100%
Percent ages 85 and older	1%	-	16%
Percent male	50%	50%	45%
Percent female	50%	50%	55%
Living Arrangements			
Total households (by age of householder) [1]	16,649	14,107	2,542
Percent with family households (i.e., at least two people who are related)	74%	77%	56%
Percent with householder living alone	20%	16%	42%
Grandparents living with their grandchildren* [2]	243	178	65
Percent who are responsible for their grandchildren	49%	56%	31%
Housing [1]			
Percent of occupied housing that is owner-occupied	78%	79%	74%
Percent of occupied housing that is renter-occupied	22%	21%	26%
Economic Security [2]			
Percent of working-age population in labor force	80%	88%	20%
Percent of total population with income less than 100% of poverty	4%	4%	7%
Percent of total population with income less than 200% of poverty	17%	17%	25%
Median household income (by age of householder)	$67,365	$63,320	$38,750
Owner-occupied housing units (by age of householder)	12,017	10,402	1,615
Percent spending 30% or more of income toward housing costs	20%	20%	24%
Renter-occupied housing units (by age of householder)	3,765	3,060	705
Percent spending 30% or more of income toward housing costs	39%	32%	69%

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

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

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Aging Profile

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

Lyon County

Iowa

CHARACTERISTICS	Total	AGE Less than 65 Years	AGE Ages 65 and Older
Population [1]			
Total population	11,581	9,633	1,948
Percent ages 65 and older	17%	-	100%
Percent ages 85 and older	3%	-	19%
Percent male	50%	51%	42%
Percent female	50%	49%	58%
Living Arrangements			
Total households (by age of householder) [1]	4,442	3,199	1,243
Percent with family households (i.e., at least two people who are related)	73%	80%	55%
Percent with householder living alone	25%	17%	44%
Grandparents living with their grandchildren* [2]	94	75	19
Percent who are responsible for their grandchildren	29%	36%	0%
Housing [1]			
Percent of occupied housing that is owner-occupied	83%	81%	86%
Percent of occupied housing that is renter-occupied	17%	19%	14%
Economic Security [2]			
Percent of working-age population in labor force	72%	87%	19%
Percent of total population with income less than 100% of poverty	6%	5%	9%
Percent of total population with income less than 200% of poverty	28%	27%	37%
Median household income (by age of householder)	$49,506	$47,880	$26,875
Owner-occupied housing units (by age of householder)	3,576	2,684	892
Percent spending 30% or more of income toward housing costs	18%	19%	14%
Renter-occupied housing units (by age of householder)	789	629	160
Percent spending 30% or more of income toward housing costs	17%	10%	45%

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

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

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Diversity Profile

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

Lincoln County

South Dakota

CHARACTERISTICS	Total	RACE White alone	RACE Black alone	RACE American Indian alone	RACE Asian alone	ETHNICITY Hispanic Origin - of any race
Population [1]						
Total population	44,828	43,068	320	228	462	553
Percent ages 0 to 17	30%	29%	38%	39%	33%	48%
Percent ages 18 to 44	39%	39%	43%	39%	41%	39%
Percent ages 45 to 64	23%	23%	15%	17%	21%	10%
Percent ages 65 and older	9%	9%	3%	5%	5%	3%
Median age (in years)	32.8	33.2	26.5	25.6	33.9	19.4
Living Arrangements						
Total households [1]	16,649	16,233	90	57	144	118
Percent with householder living alone	20%	20%	12%	14%	13%	18%
Percent with families with children ages 0 to 17	40%	39%	59%	46%	59%	46%
Grandparents living with their grandchildren [2]	243	243	0	0	0	19
Percent who are responsible for grandchildren	49%	49%	-	-	-	0%
Housing [1]						
Percent occupied housing that is owner-occupied	78%	79%	47%	60%	78%	59%
Percent occupied housing that is renter-occupied	22%	21%	53%	40%	22%	41%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	96%	96%	75%	92%	84%	83%
Percent of persons ages 25 and older with Bachelor's degree or higher	37%	37%	46%	40%	46%	49%
Economic Security [2]						
Unemployment rate	3%	2%	0%	0%	3%	4%
Median household income	$67,365	$67,491	-	$57,944	$83,125	$73,026
Percent of households with income <$25,000	12%	11%	55%	30%	0%	22%
Percent of persons with income <100% poverty	4%	4%	29%	14%	5%	14%
Percent of children ages 0 to 17 in families with income <100% poverty	5%	5%	63%	0%	11%	23%
Percent of elderly ages 65 and older with income <100% poverty	8%	7%	-	100%	-	0%

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

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Diversity Profile

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

Lyon County

Iowa

CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
Population [1]						
Total population	11,581	11,340	10	9	25	212
Percent ages 0 to 17	28%	27%	50%	11%	28%	43%
Percent ages 18 to 44	30%	29%	40%	78%	44%	43%
Percent ages 45 to 64	26%	26%	10%	0%	16%	11%
Percent ages 65 and older	17%	17%	0%	11%	12%	2%
Median age (in years)	38.7	39.3	19.5	36.5	25.5	22.3
Living Arrangements						
Total households [1]	4,442	4,393	2	2	3	52
Percent with householder living alone	25%	25%	100%	50%	0%	17%
Percent with families with children ages 0 to 17	32%	32%	0%	50%	0%	56%
Grandparents living with their grandchildren [2]	94	94	0	0	0	0
Percent who are responsible for grandchildren	29%	29%	-	-	-	-
Housing [1]						
Percent occupied housing that is owner-occupied	83%	83%	50%	100%	67%	35%
Percent occupied housing that is renter-occupied	17%	17%	50%	0%	33%	65%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	86%	86%	0%	100%	55%	85%
Percent of persons ages 25 and older with Bachelor's degree or higher	16%	16%	0%	0%	0%	0%
Economic Security [2]						
Unemployment rate	3%	3%	0%	0%	0%	0%
Median household income	$49,506	$49,535	-	-	-	$71,667
Percent of households with income <$25,000	20%	20%	-	-	0%	13%
Percent of persons with income <100% poverty	6%	5%	0%	100%	0%	4%
Percent of children ages 0 to 17 in families with income <100% poverty	6%	5%	0%	-	0%	0%
Percent of elderly ages 65 and older with income <100% poverty	9%	9%	-	100%	-	-

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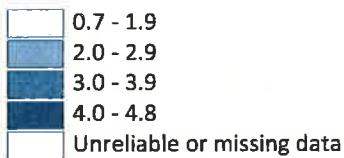
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Map 1

Premature Death - A health outcome measure focusing on mortality

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
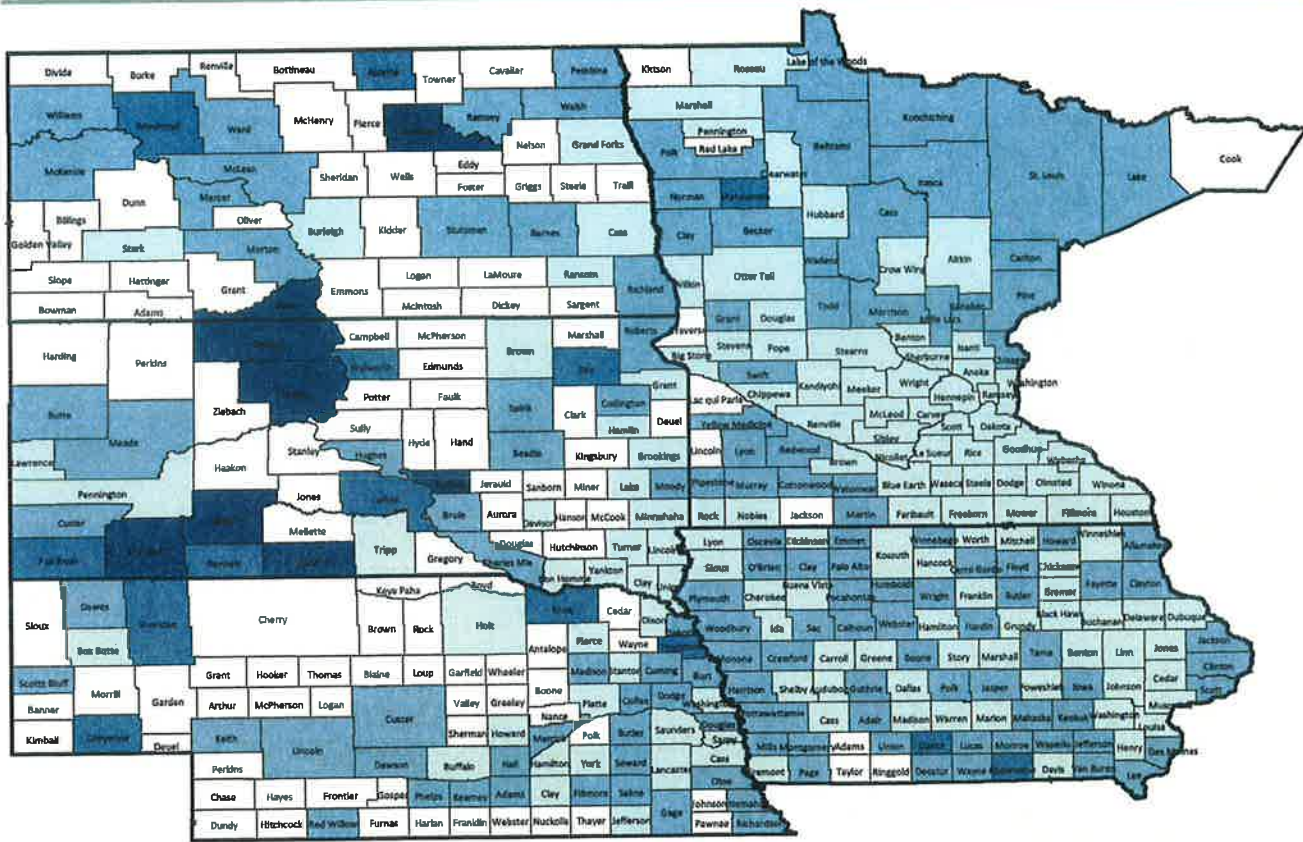
Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007

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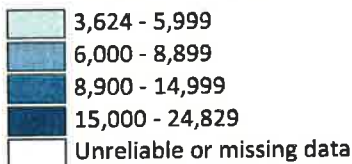
CONTEXT

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

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

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

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

Map 2

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

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

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

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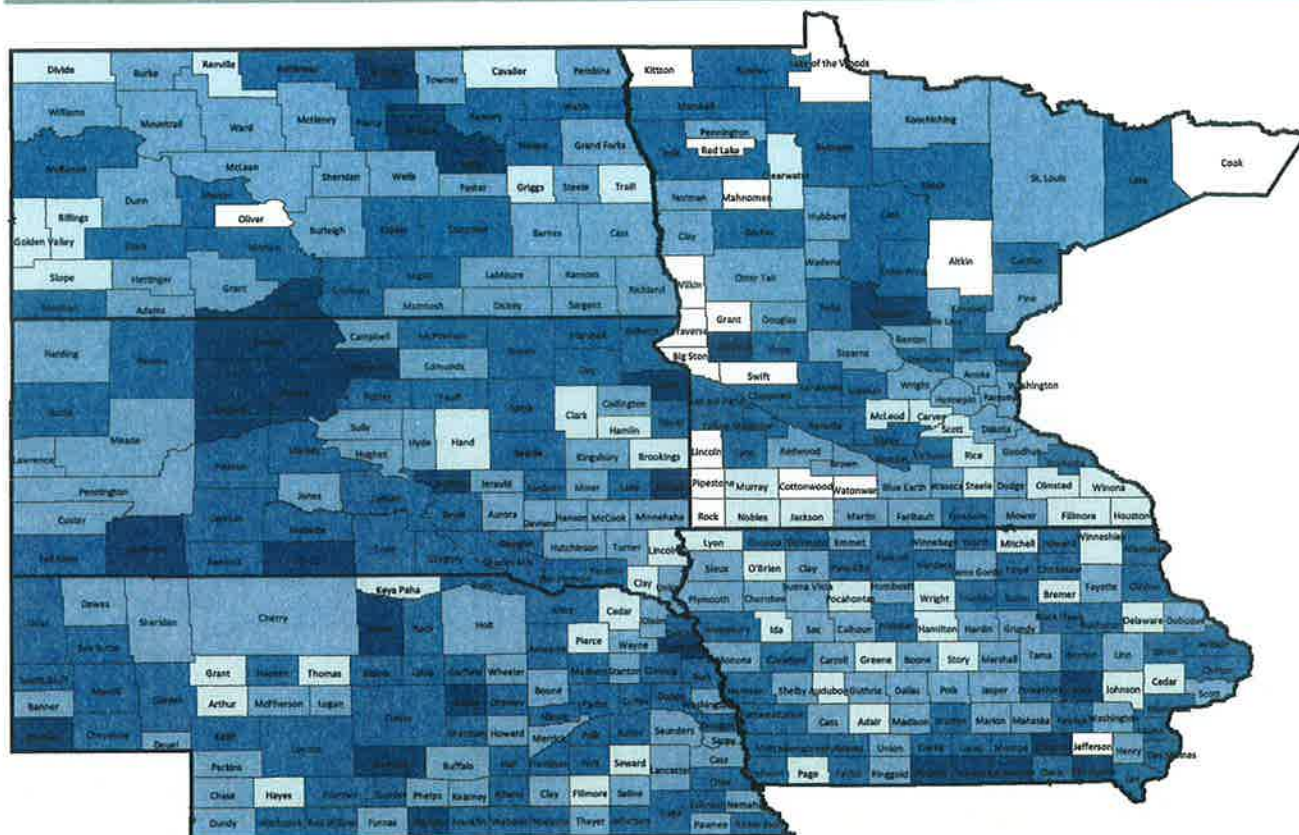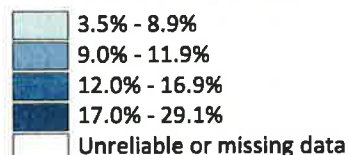
CONTEXT

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

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

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

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

Map 3

Poor Physical Health Days - A health outcome measure focusing on morbidity
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

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

CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
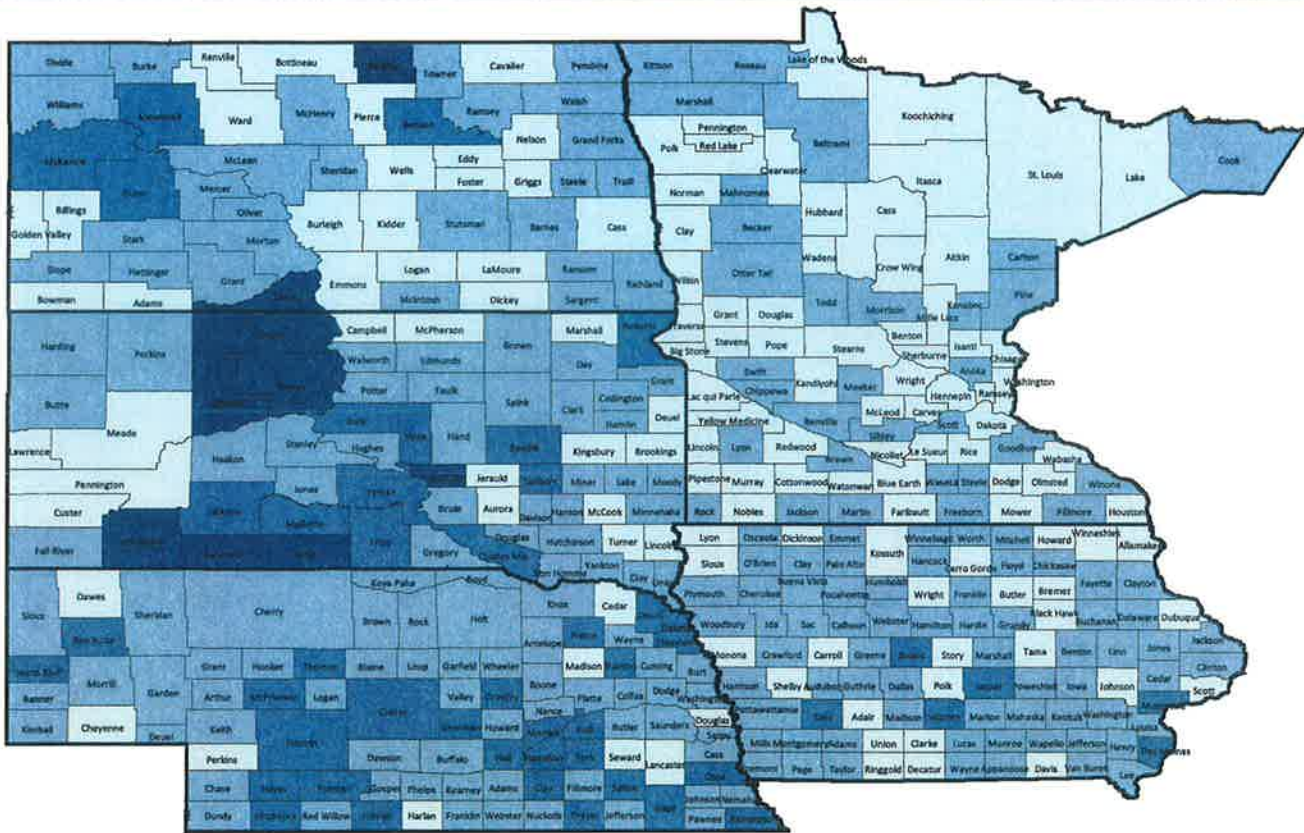
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Map 4

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

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

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

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

CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
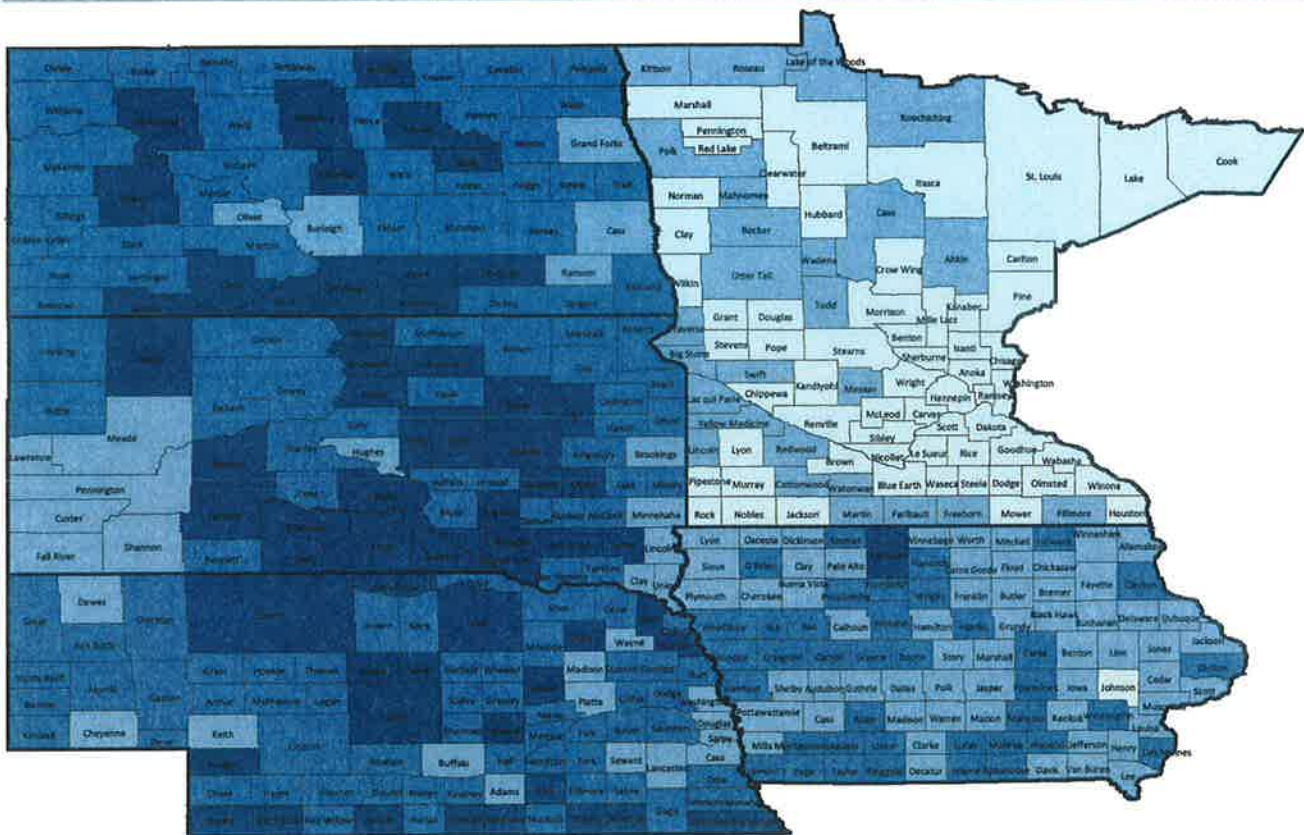
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Map 5

Low Birthweight - A health outcome measure focusing on morbidity

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

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

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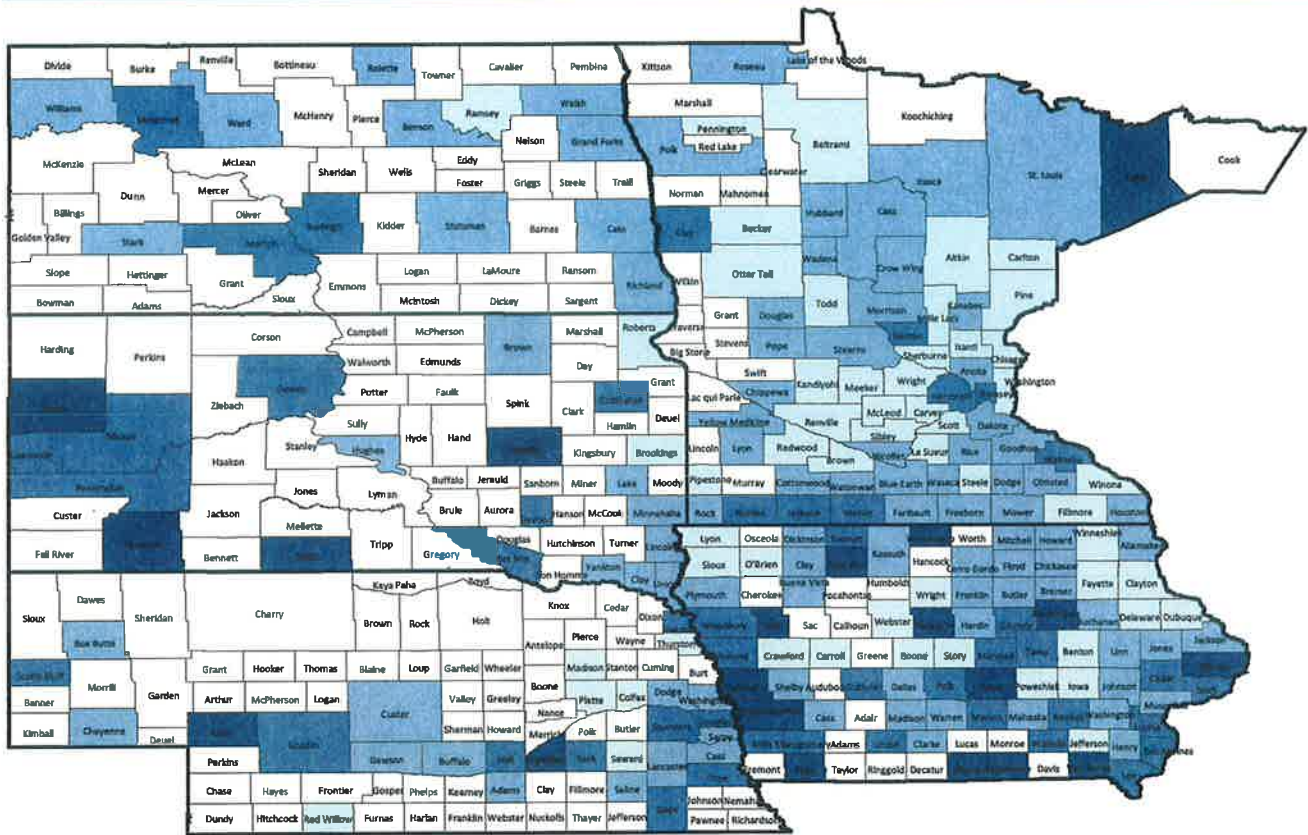
CONTEXT

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

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

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

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

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Map 6

Adult Smoking - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
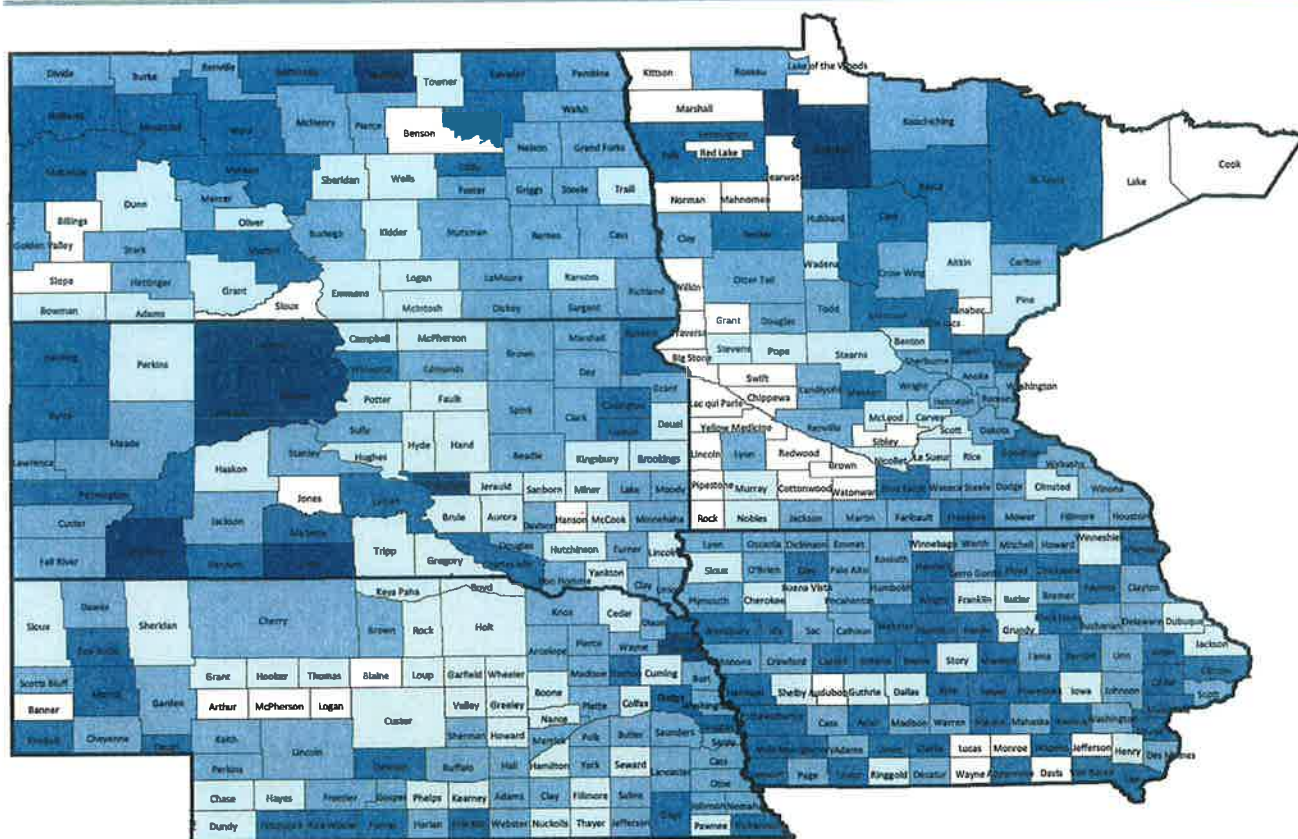
Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

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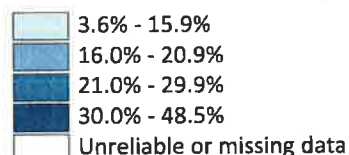
CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
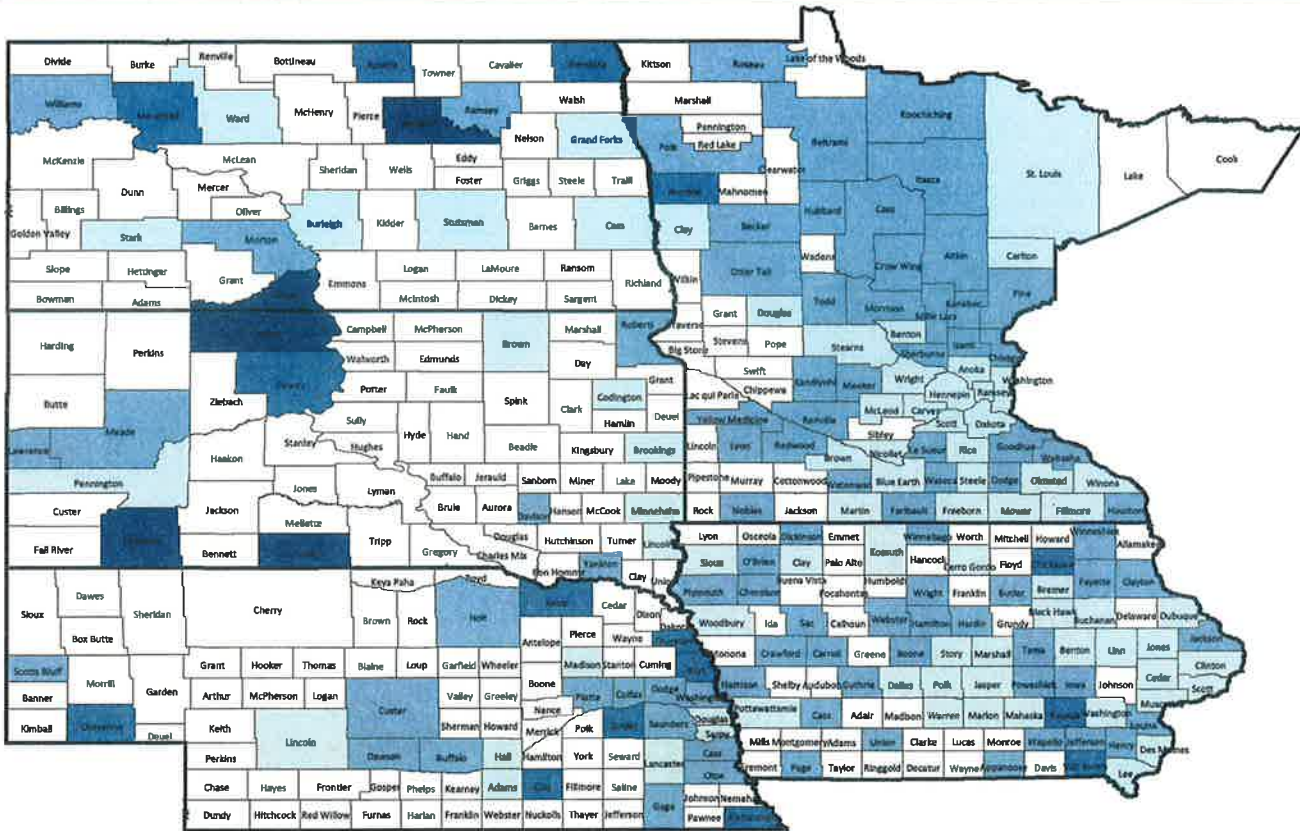
Map 7

Adult Obesity - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

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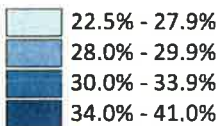
CONTEXT

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

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

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

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

Map 8

Physical Inactivity - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Percent of adults reporting no leisure time physical activity, 2008

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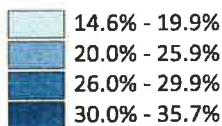
CONTEXT

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

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

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

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

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Map 9

Excessive Drinking - A health factor measure focusing on health behaviors

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

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

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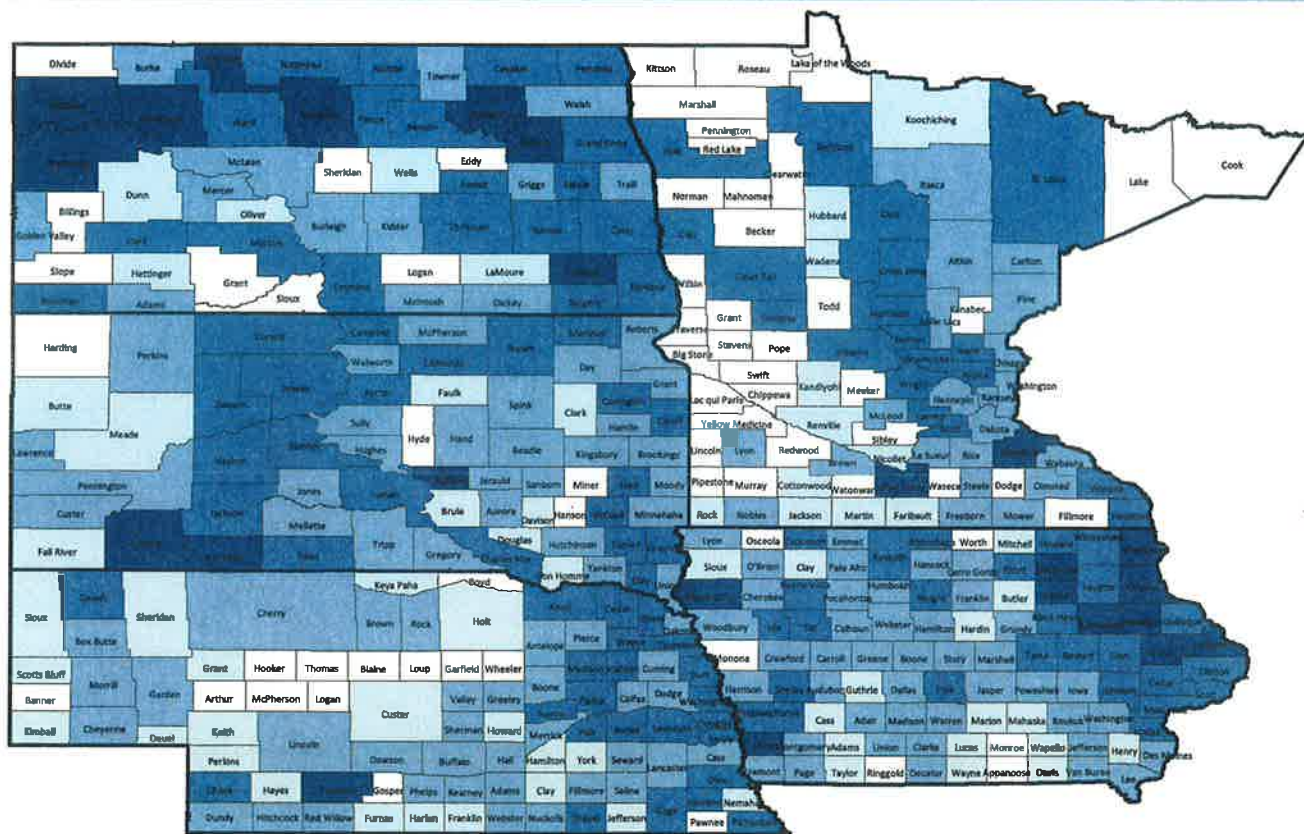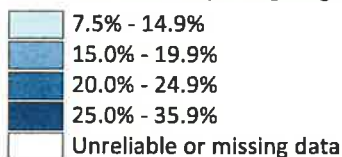
CONTEXT

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

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

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

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

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Map 10

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

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

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

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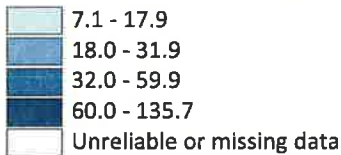
CONTEXT

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

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

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

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

Map 11

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

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

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

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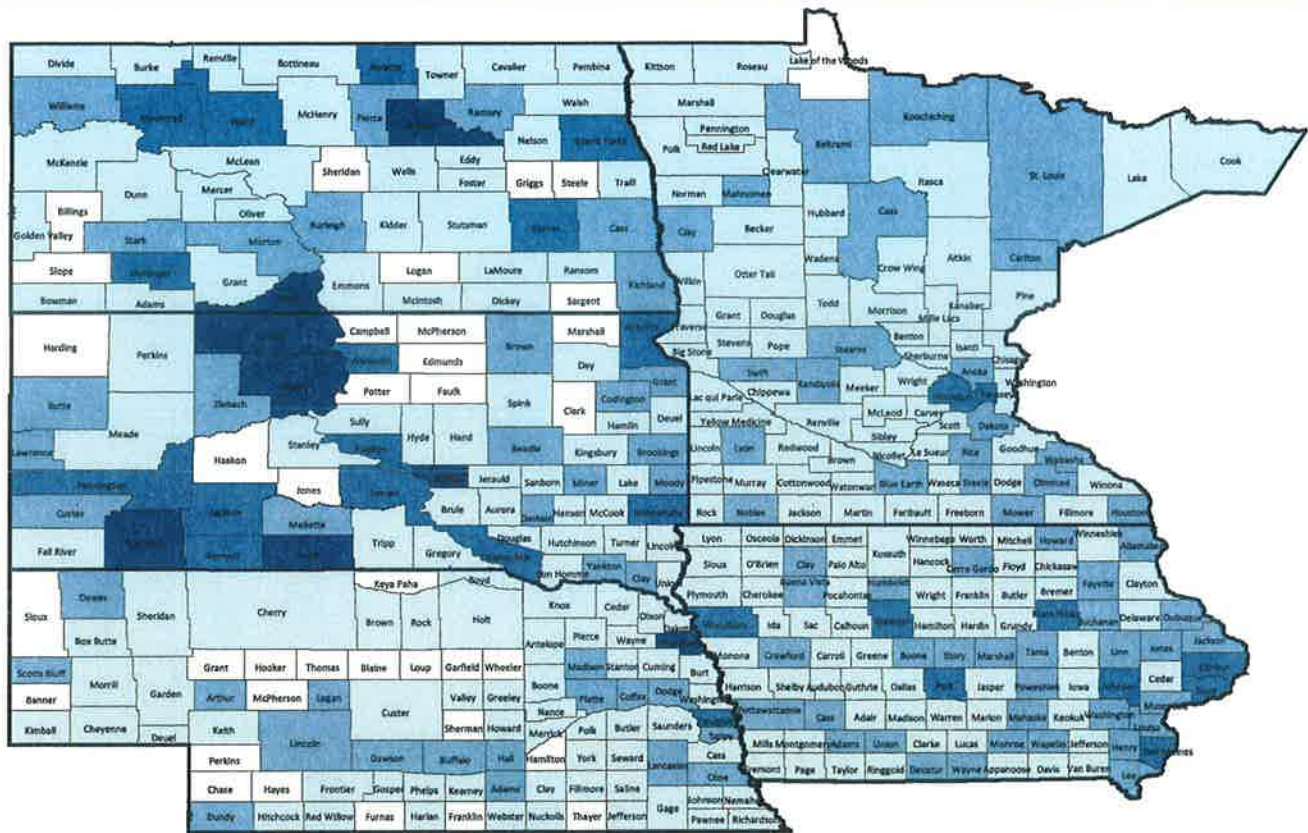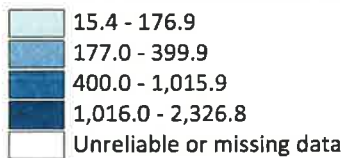
CONTEXT

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

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

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

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

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Map 12

Teen Birth Rate - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
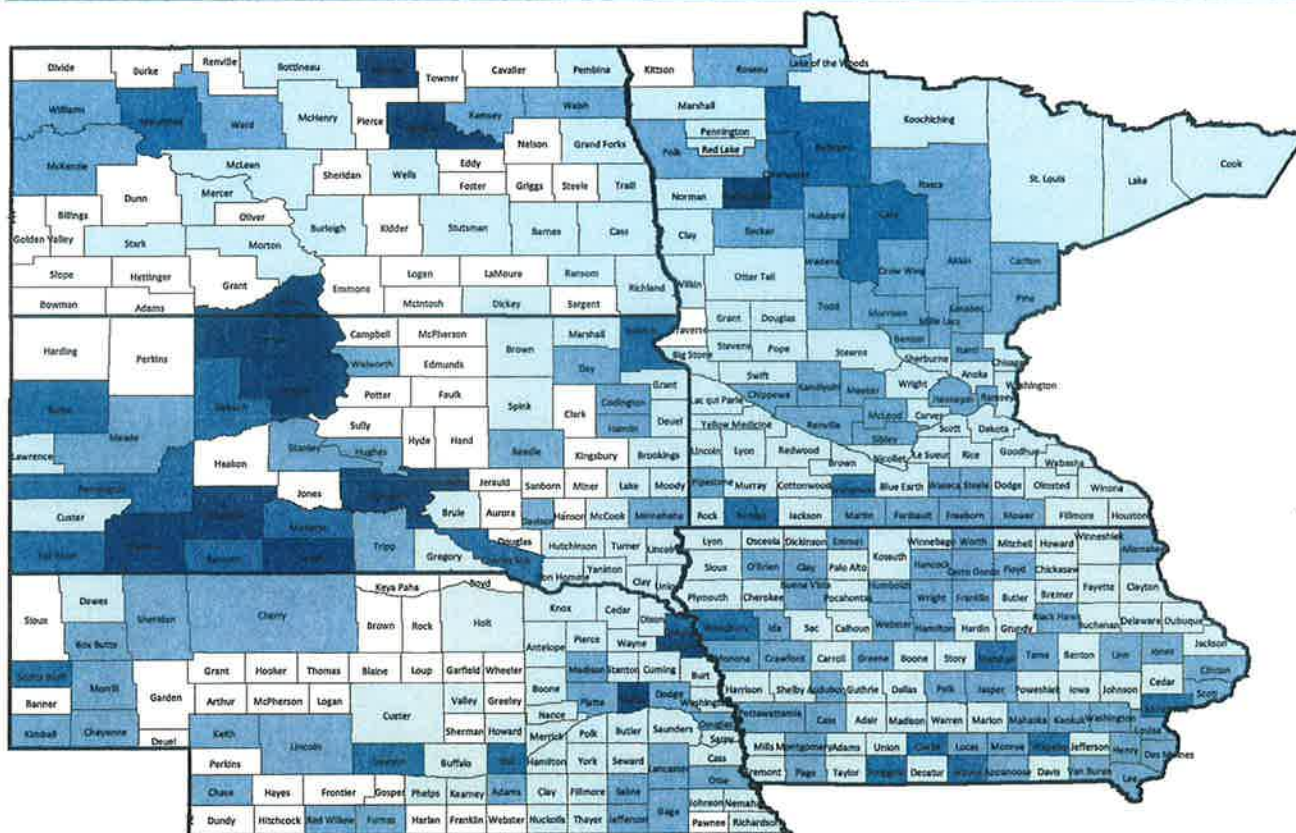
Number of teen births per 1,000 females ages 15 through 19, 2001-1007

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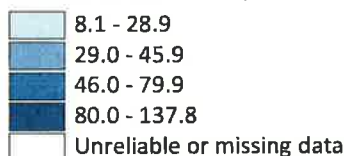
CONTEXT

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

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

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

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

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Map 13

Uninsured Adults - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
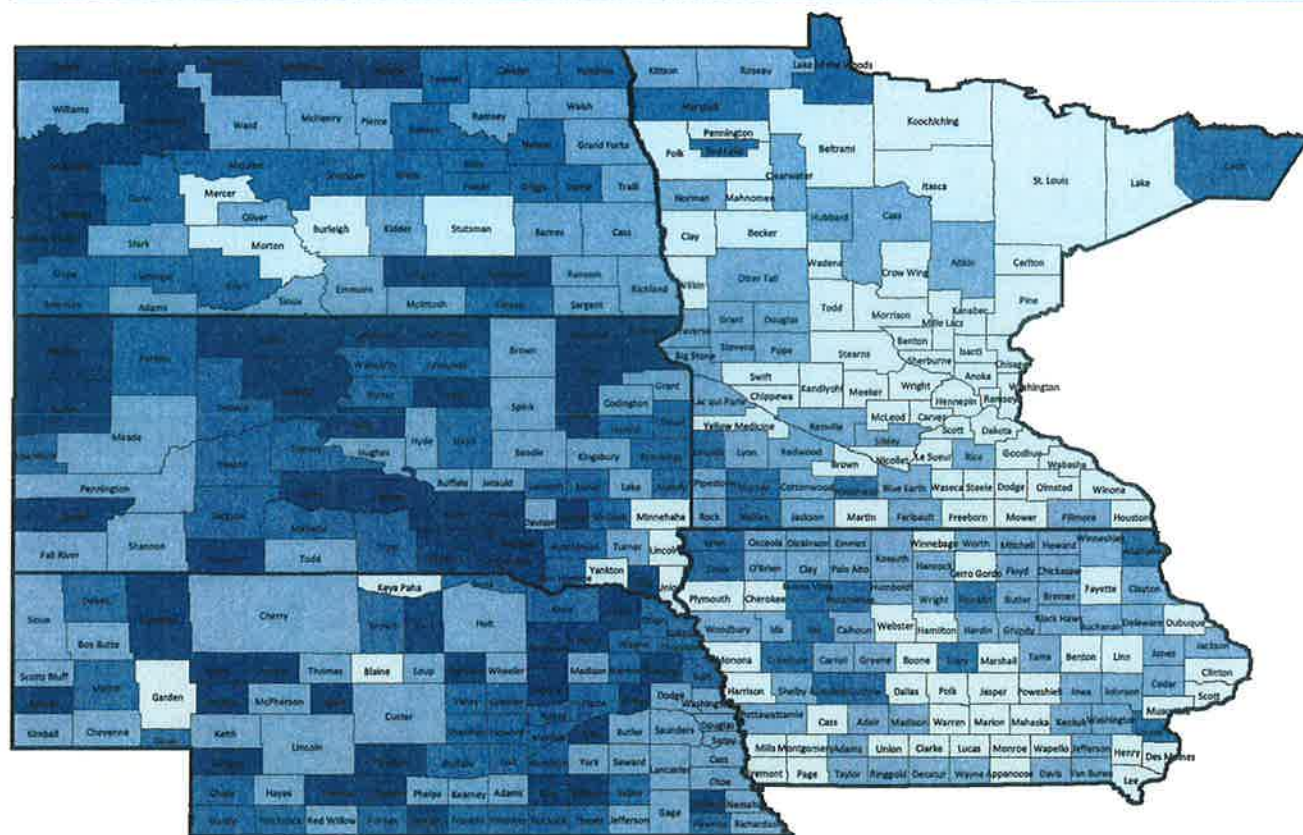
Percent of adult population ages 18 through 64 without health insurance, 2007

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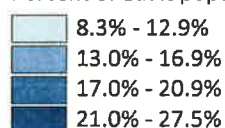
CONTEXT

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

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

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

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

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Uninsured Youth - A health factor measure focusing on clinical care

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

Map 14

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

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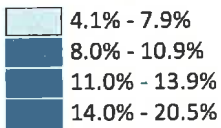
CONTEXT

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

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

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

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

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Map 15

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
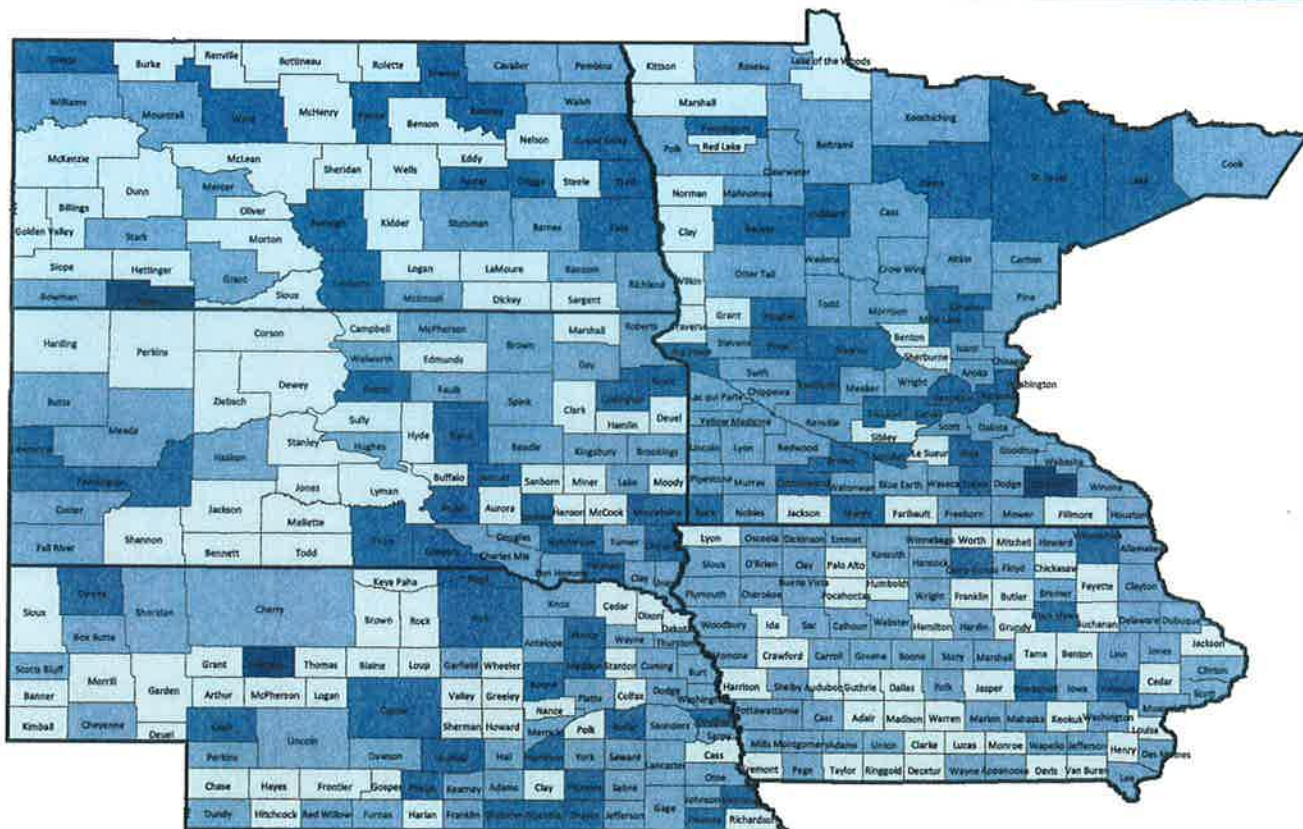
Number of primary care physicians per 100,000 population, 2008

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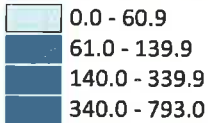
CONTEXT

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

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

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

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

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Map 16

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

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

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

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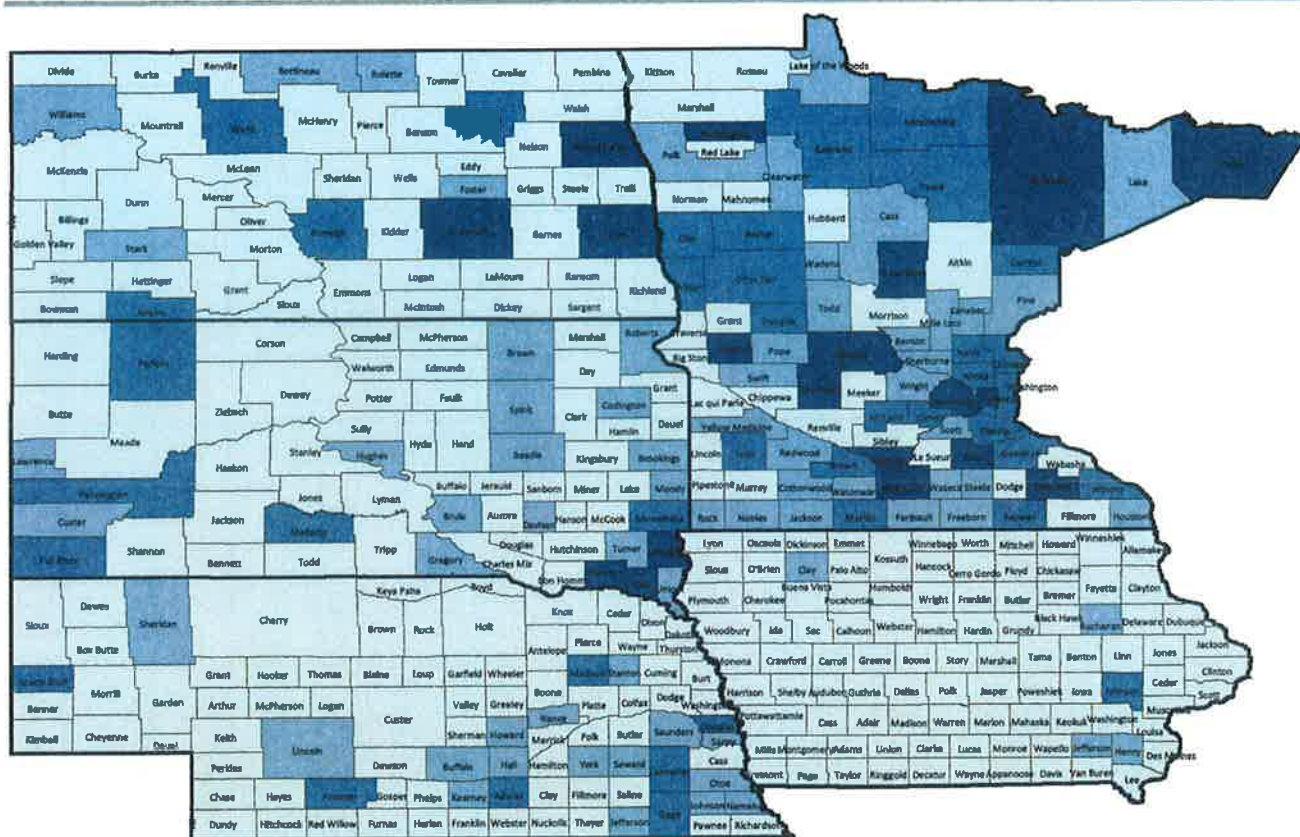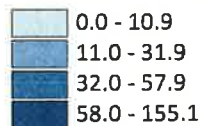
CONTEXT

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

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

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

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

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Map 17

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

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

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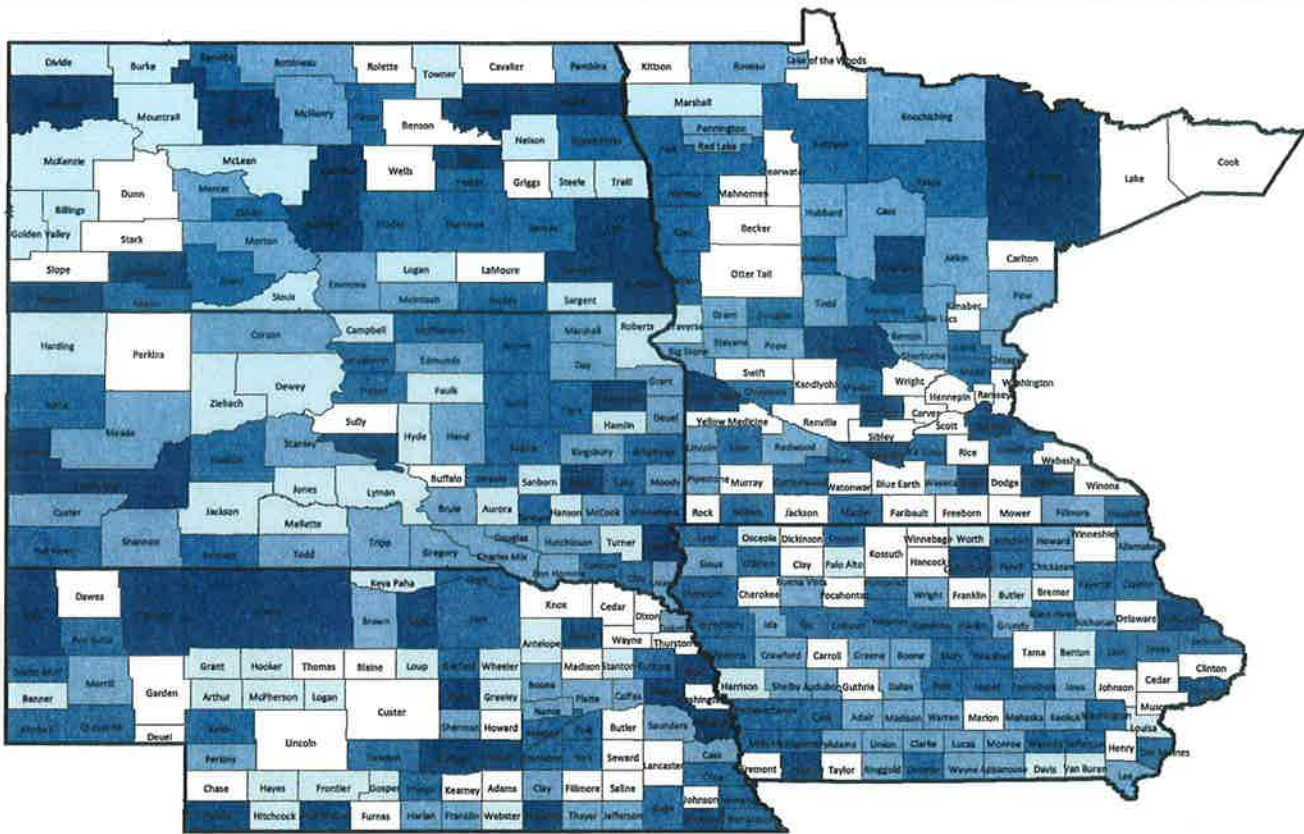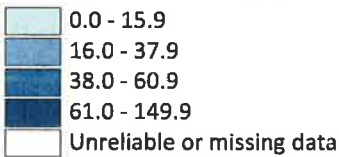
CONTEXT

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

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

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

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

Map 18

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

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

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

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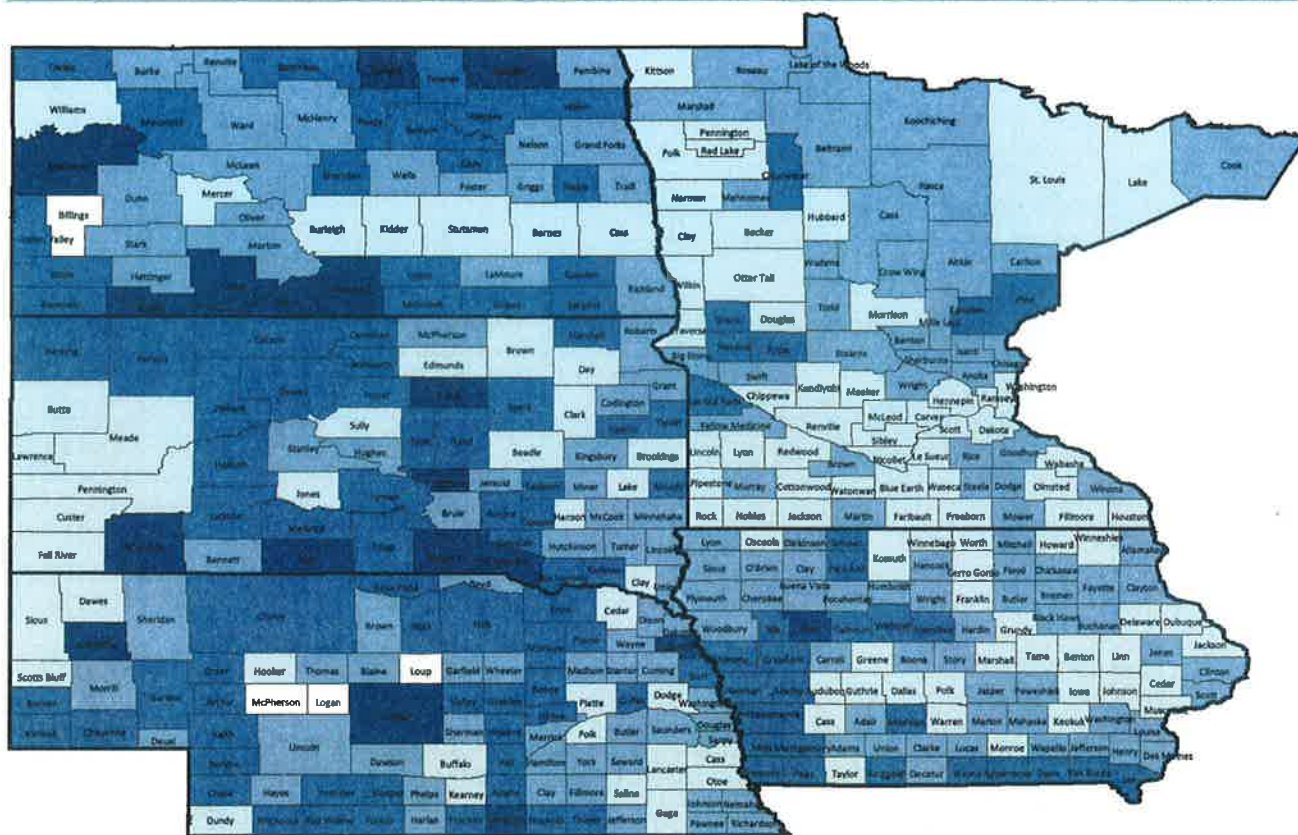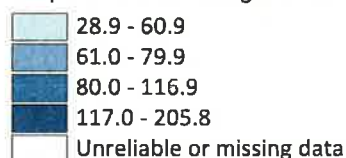
CONTEXT

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

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

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

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Map 19

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

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

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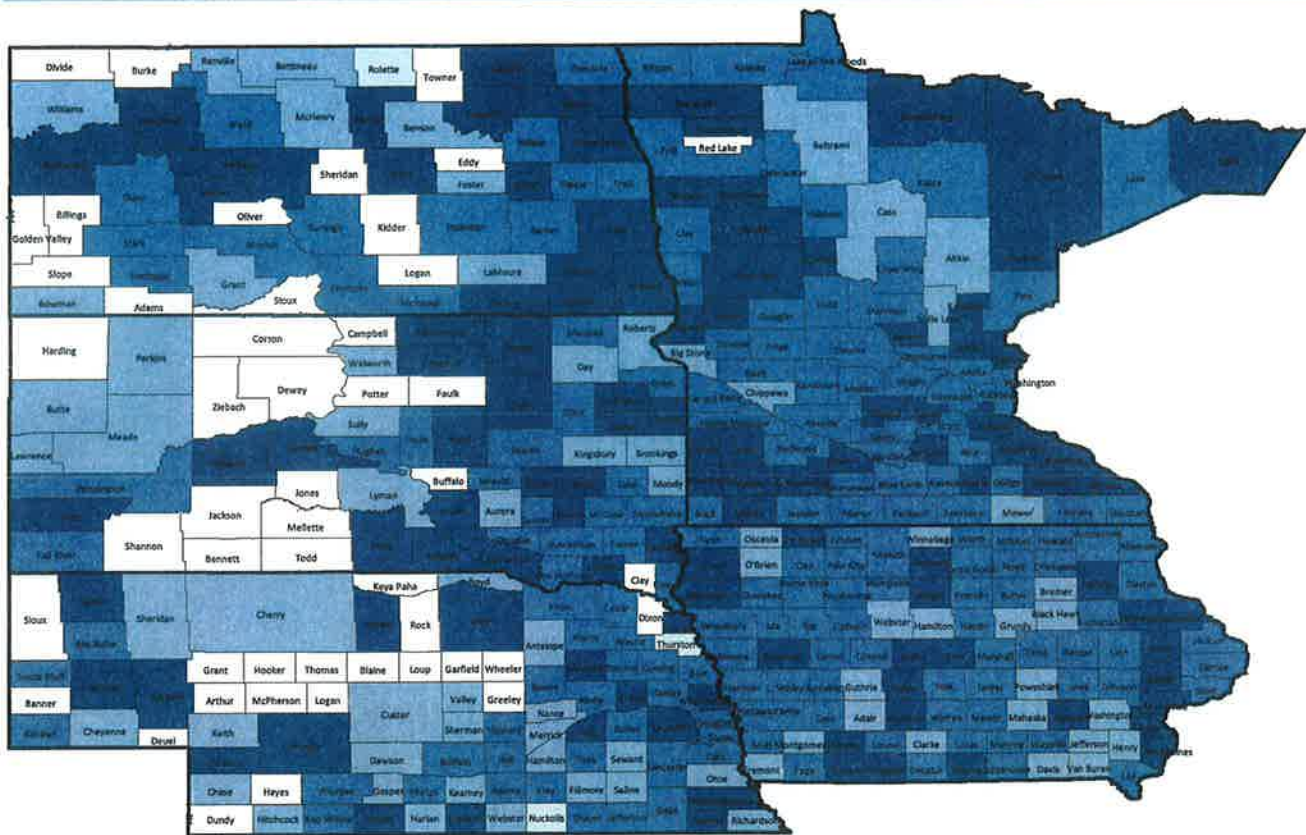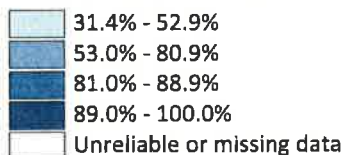
CONTEXT

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

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

Importance: Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented.
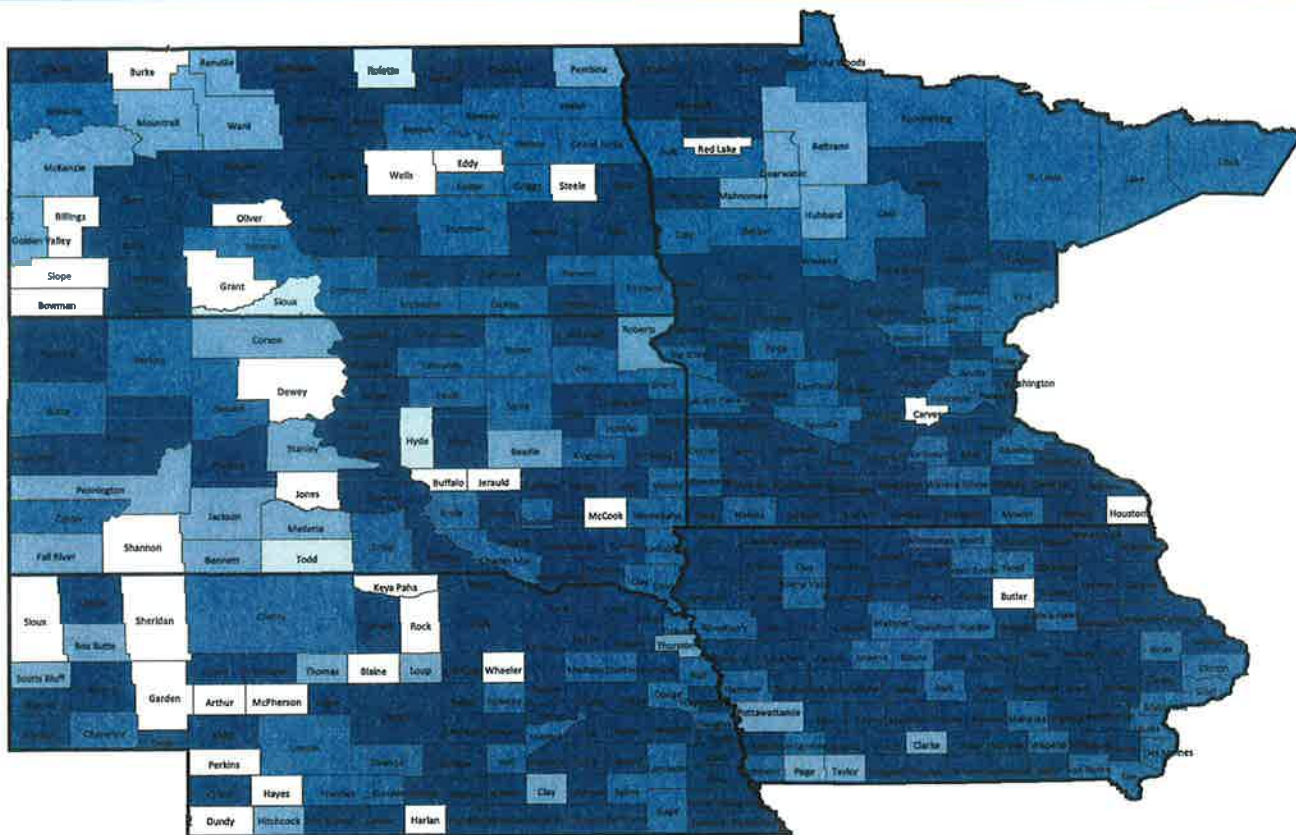
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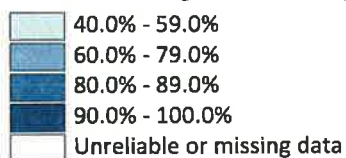
Map 20

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

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

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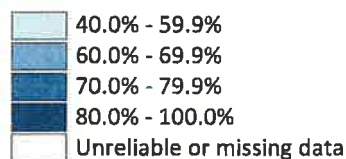
CONTEXT

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

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

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

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

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

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

CONTEXT

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

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

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

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Map 22

Some College - A health factor measure focusing on education

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
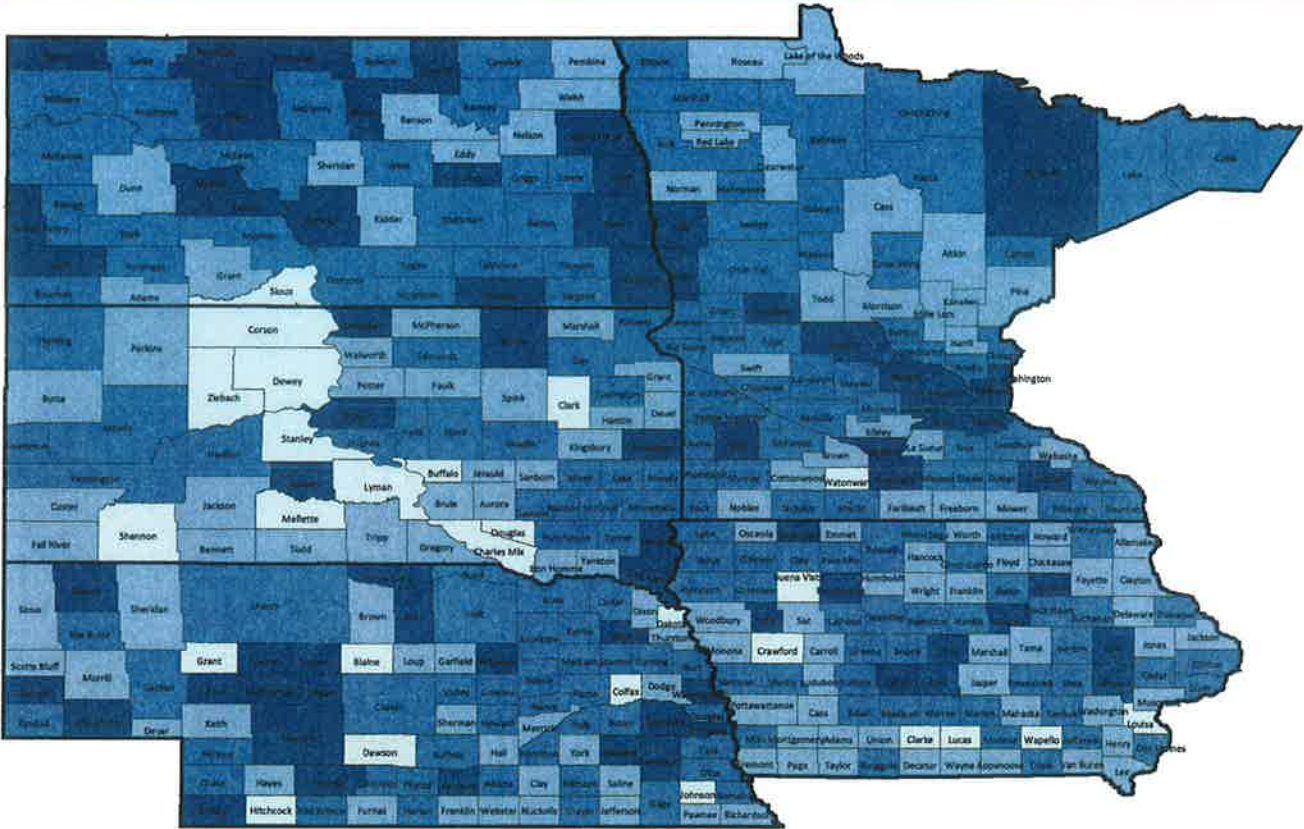
Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009
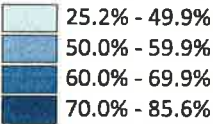
- 25.2% - 49.9%
- 50.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 85.6%

CONTEXT

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

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

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

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

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Map 23

Unemployment - A health factor measure focusing on labor

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
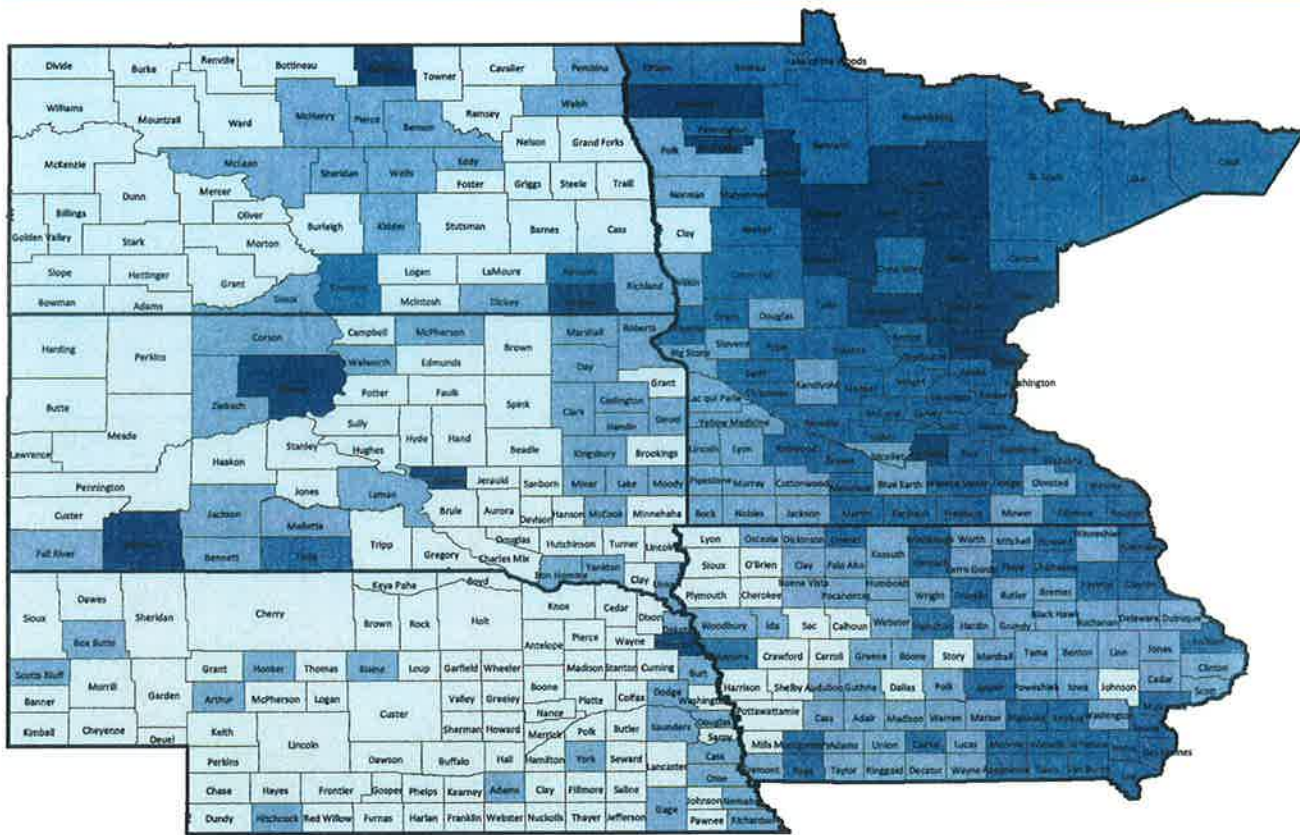
Percent of population ages 16 and older that is unemployed but seeking work, 2009

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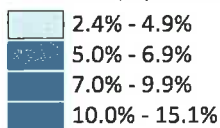
CONTEXT

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

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

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

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

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Map 24

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
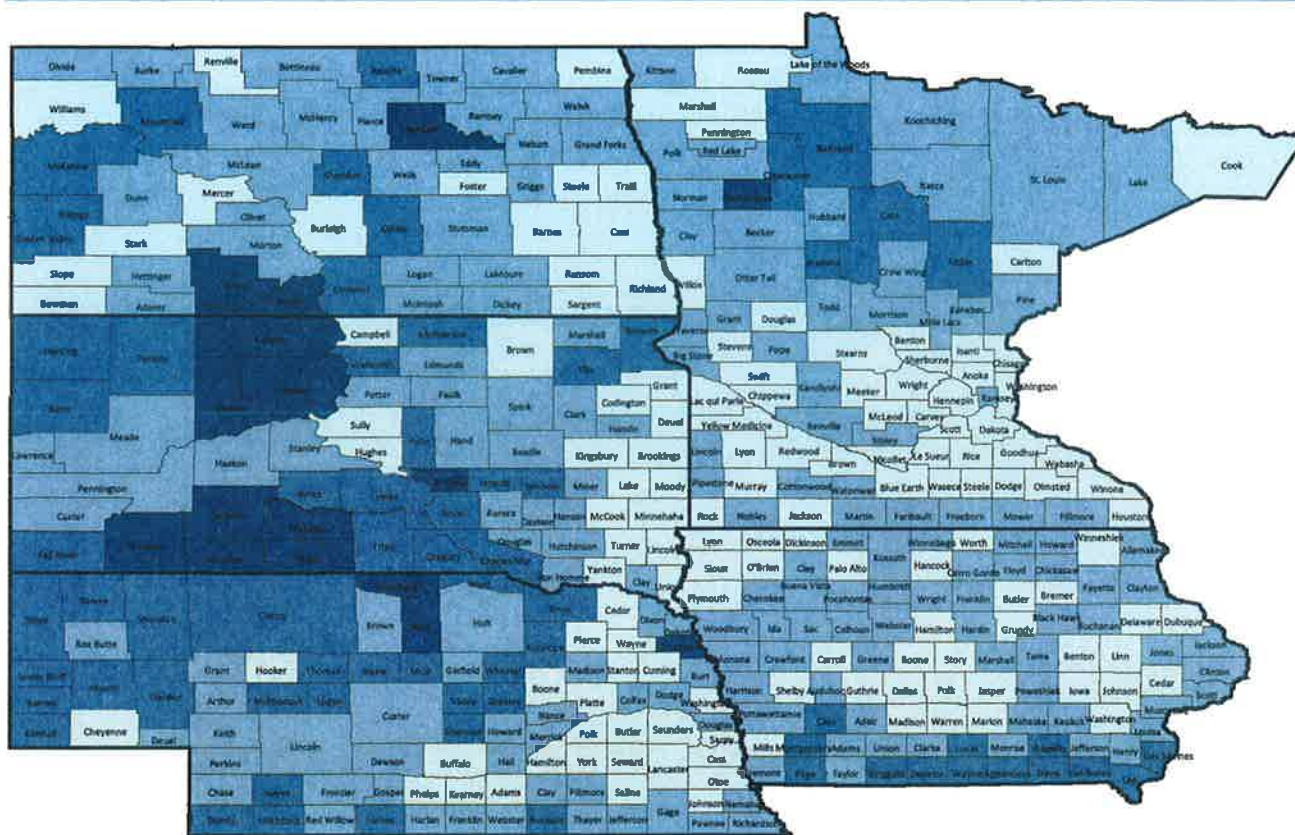
Percent of children ages 0 through 17 living below the Federal Poverty Line, 2008

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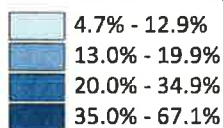
CONTEXT

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

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

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

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Map 25

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
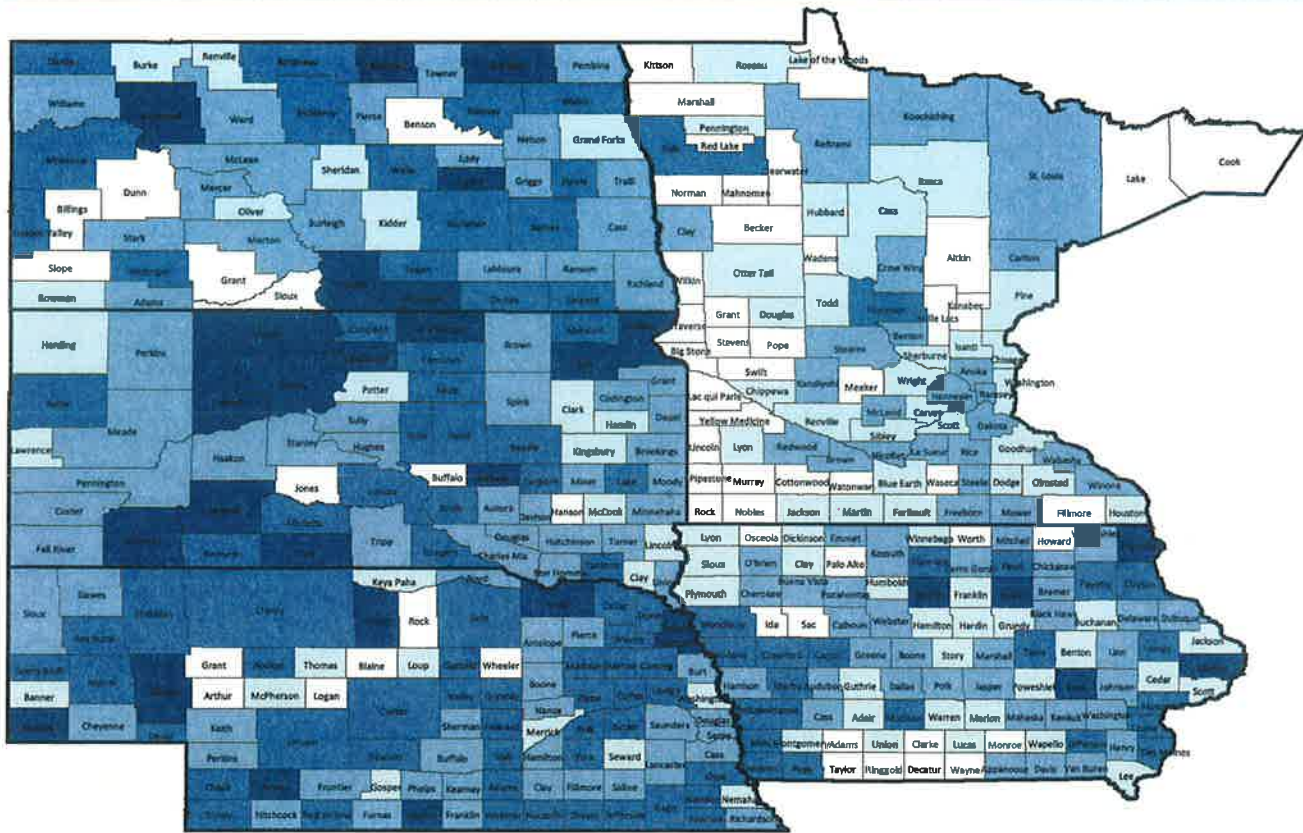
Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009

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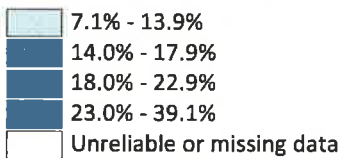
CONTEXT

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

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

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

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Map 26

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
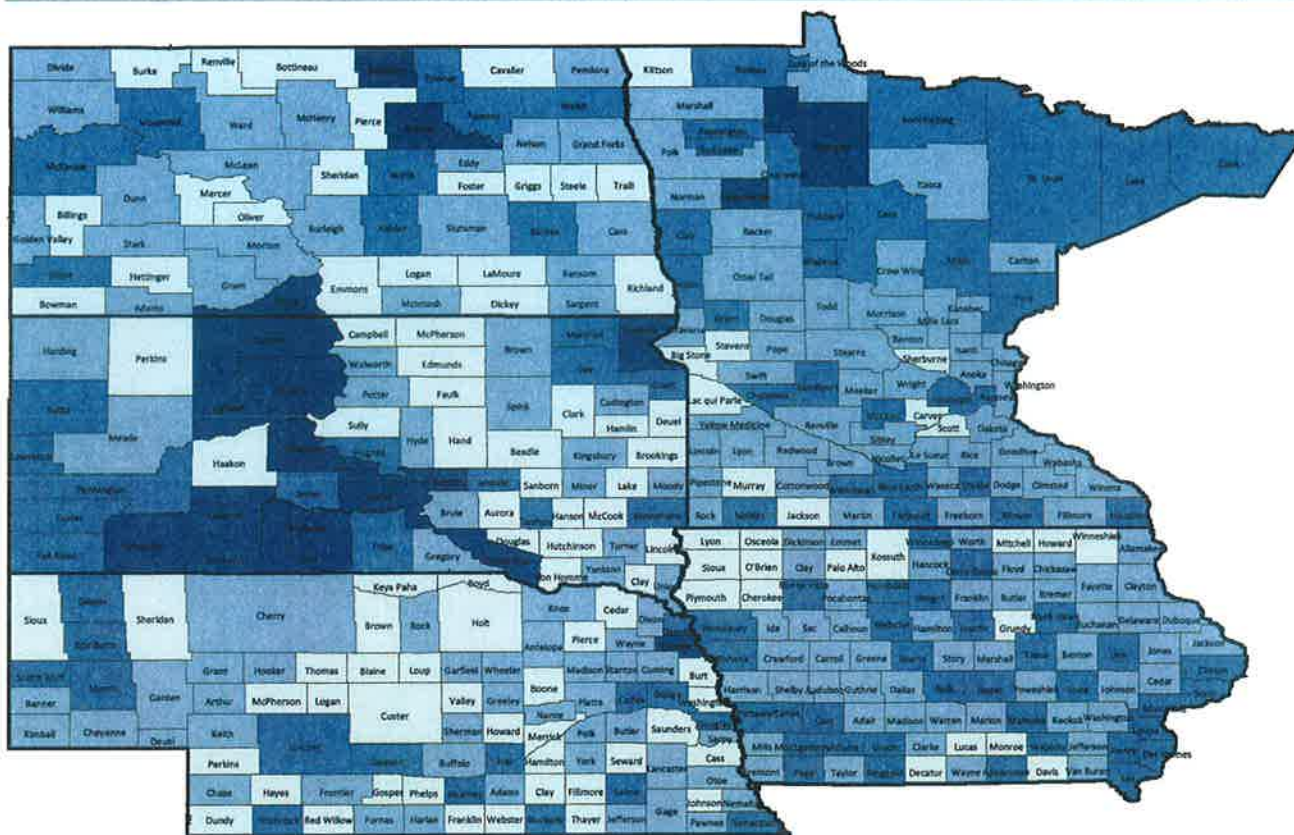
Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009

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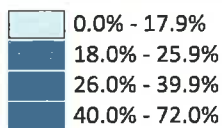
CONTEXT

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

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

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

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

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Map 27

Homicide Rate - A health factor measure focusing on violent crime

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
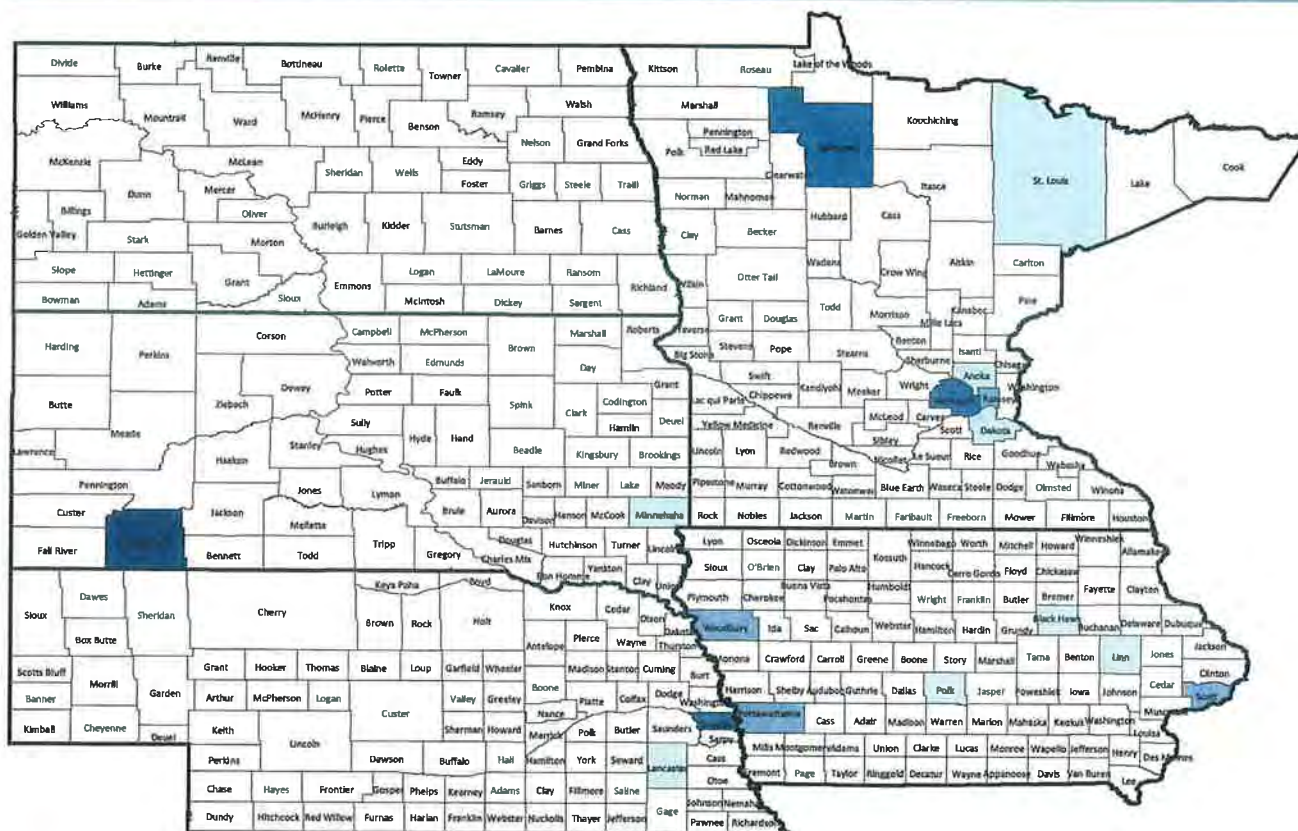
Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

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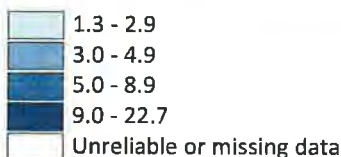
CONTEXT

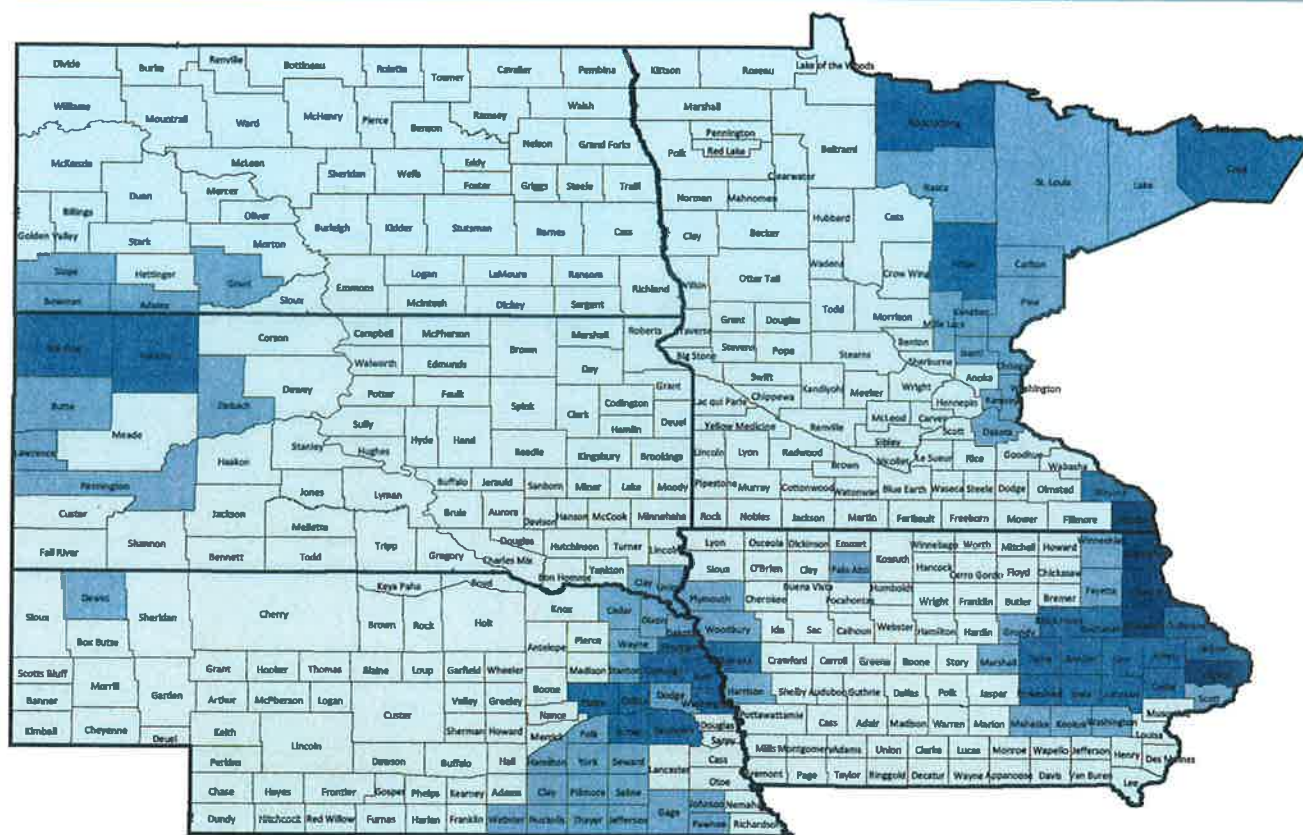**What It Is:** Homicide is represented as a crude death rate due to murder or non-negligent manslaughter per 100,000 population.

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

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

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

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Map 28

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

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

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

- 0
- 1
- 2
- 3 - 4
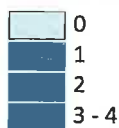
CONTEXT

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

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

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

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

Map 29

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

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

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

- 0
- 1
- 2
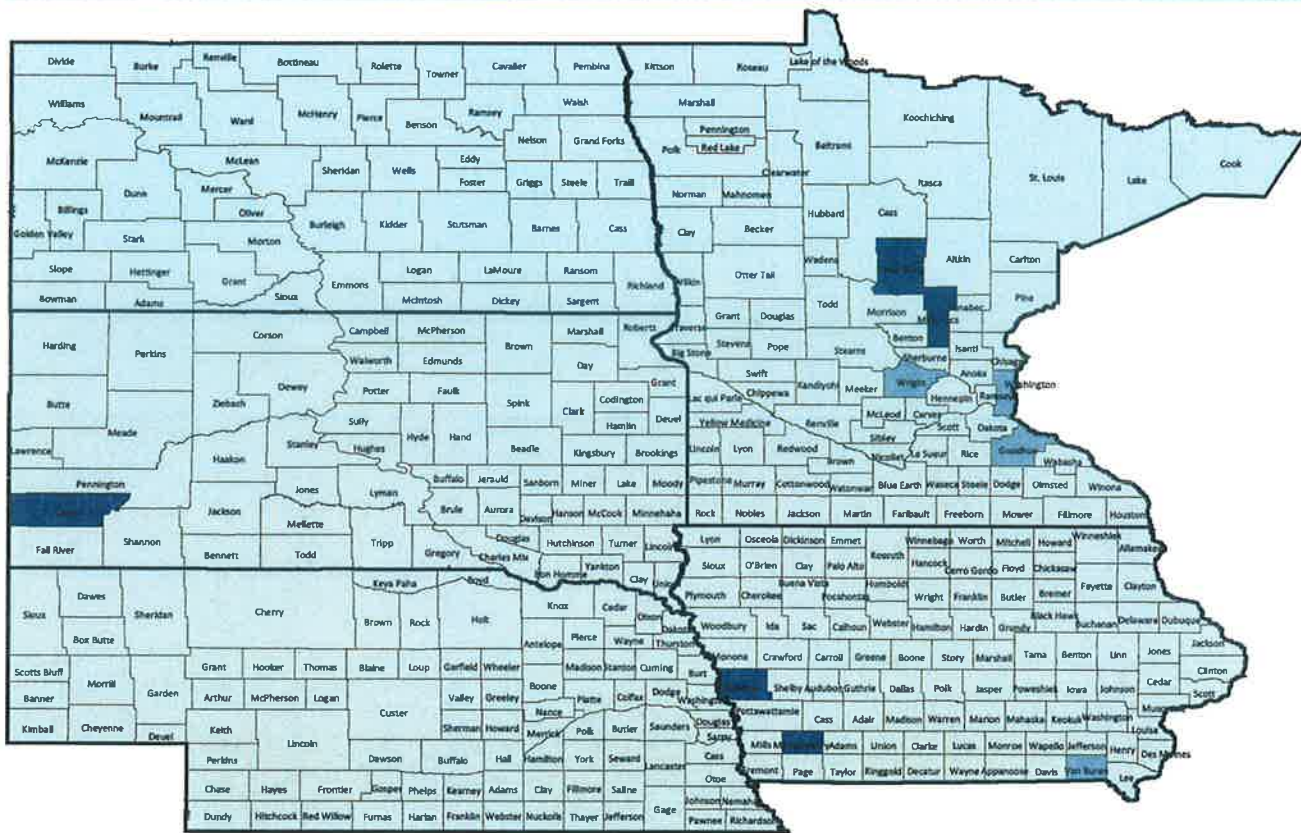
CONTEXT

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

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

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

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

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

Map 30

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
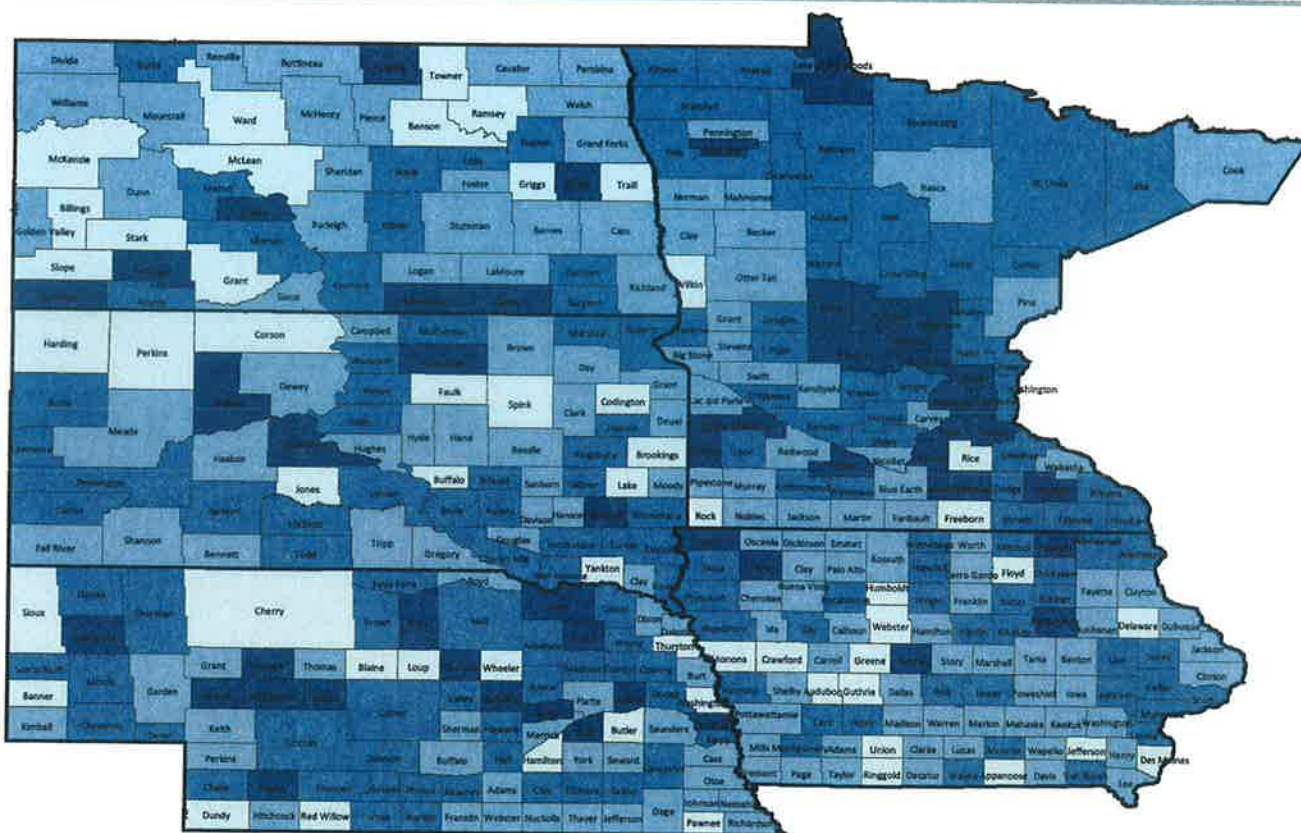
Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008

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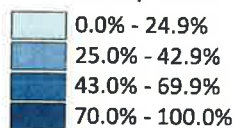
CONTEXT

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

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

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

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

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Map 31

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

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

Number of recreational facilities per 100,000 population, 2008

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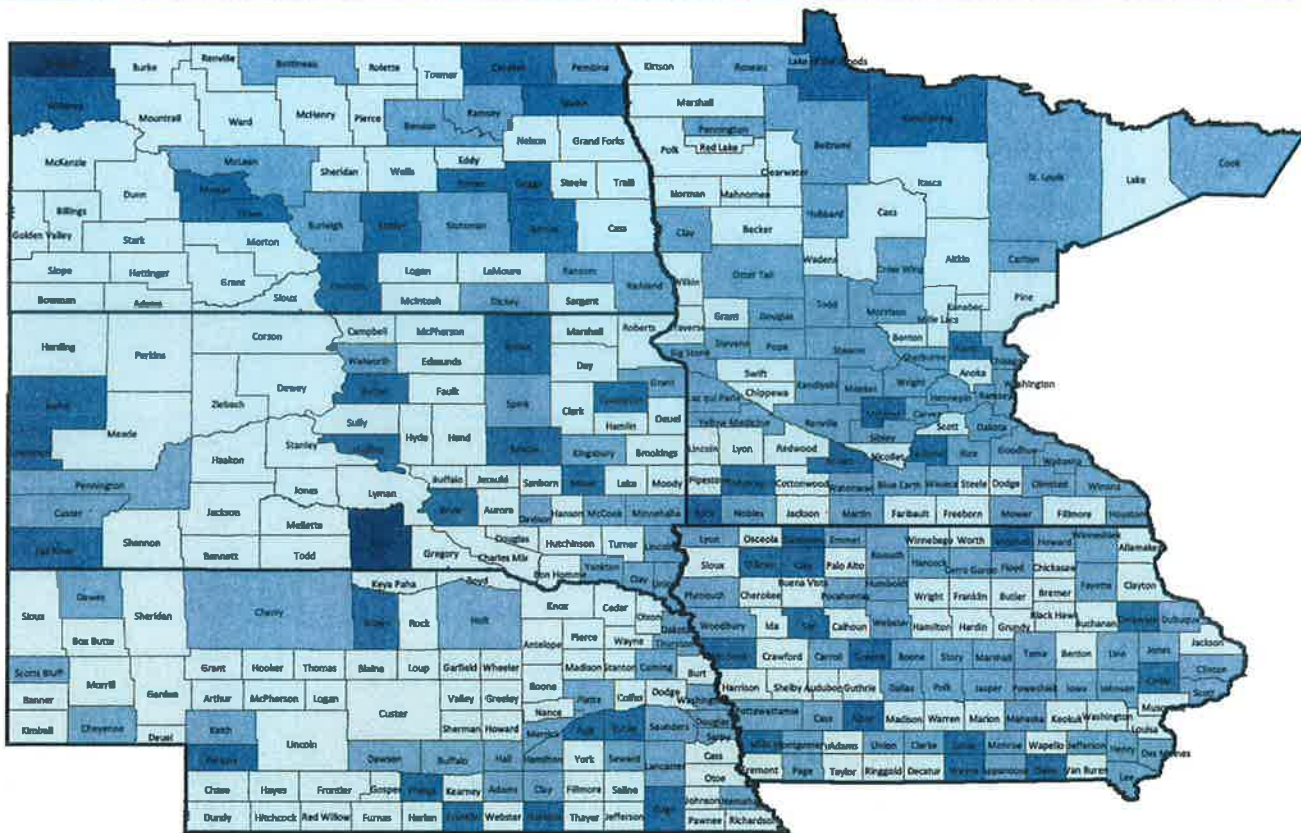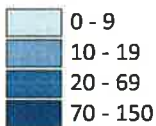
CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
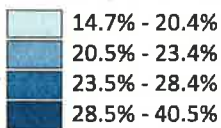
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 32

Youth - A demographic measure

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

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

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

CONTEXT

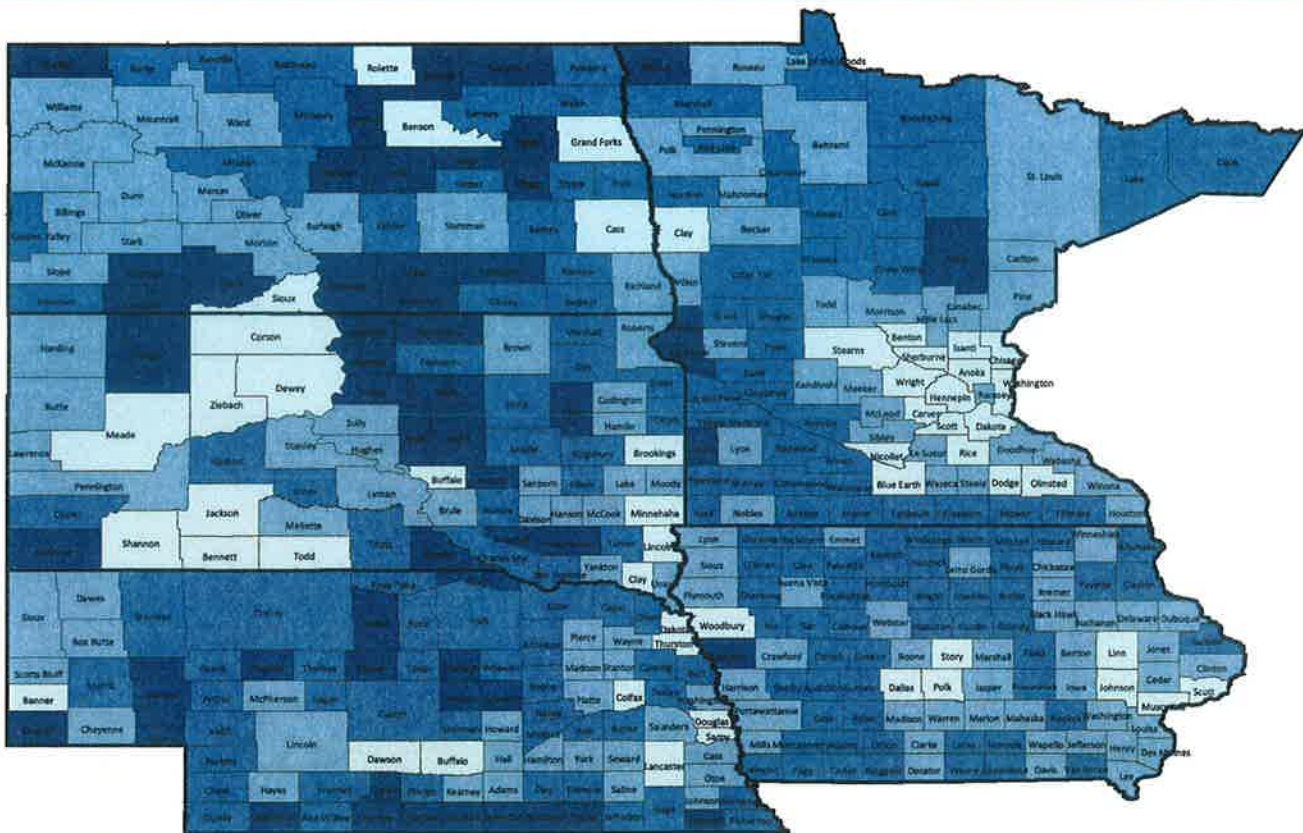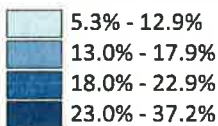**What It Is:** This measure represents the percent of a county's population that is less than 18 years of age.

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

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

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Map 33

Elderly - A demographic measure
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

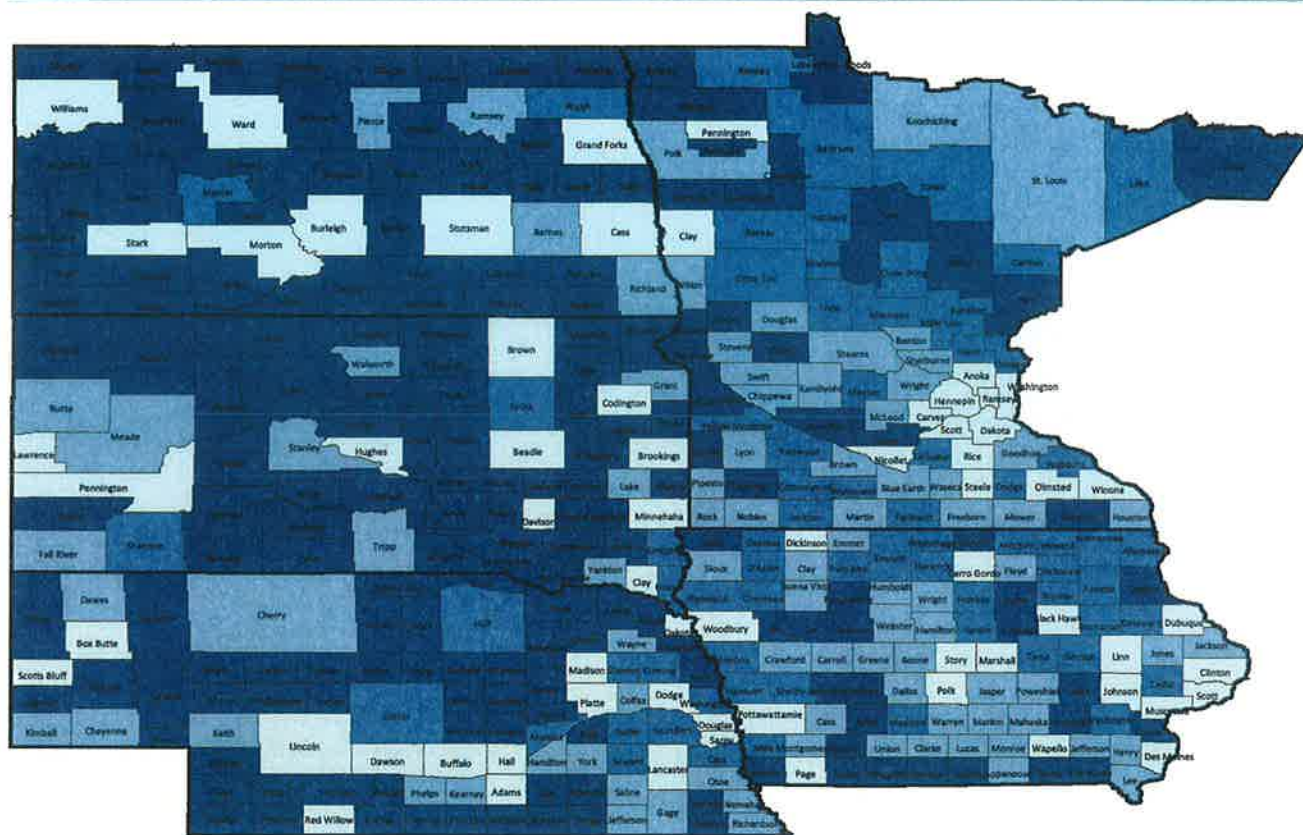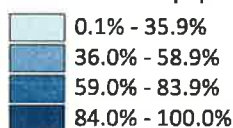Persons ages 65 and older as a percent of the total population, 2009

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

CONTEXT

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

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

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

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Map 34

Rural - A demographic measure

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

Percent of total population living in a rural area, 2000

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

CONTEXT

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

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

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

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Map 35

Not English Proficient - A demographic measure
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

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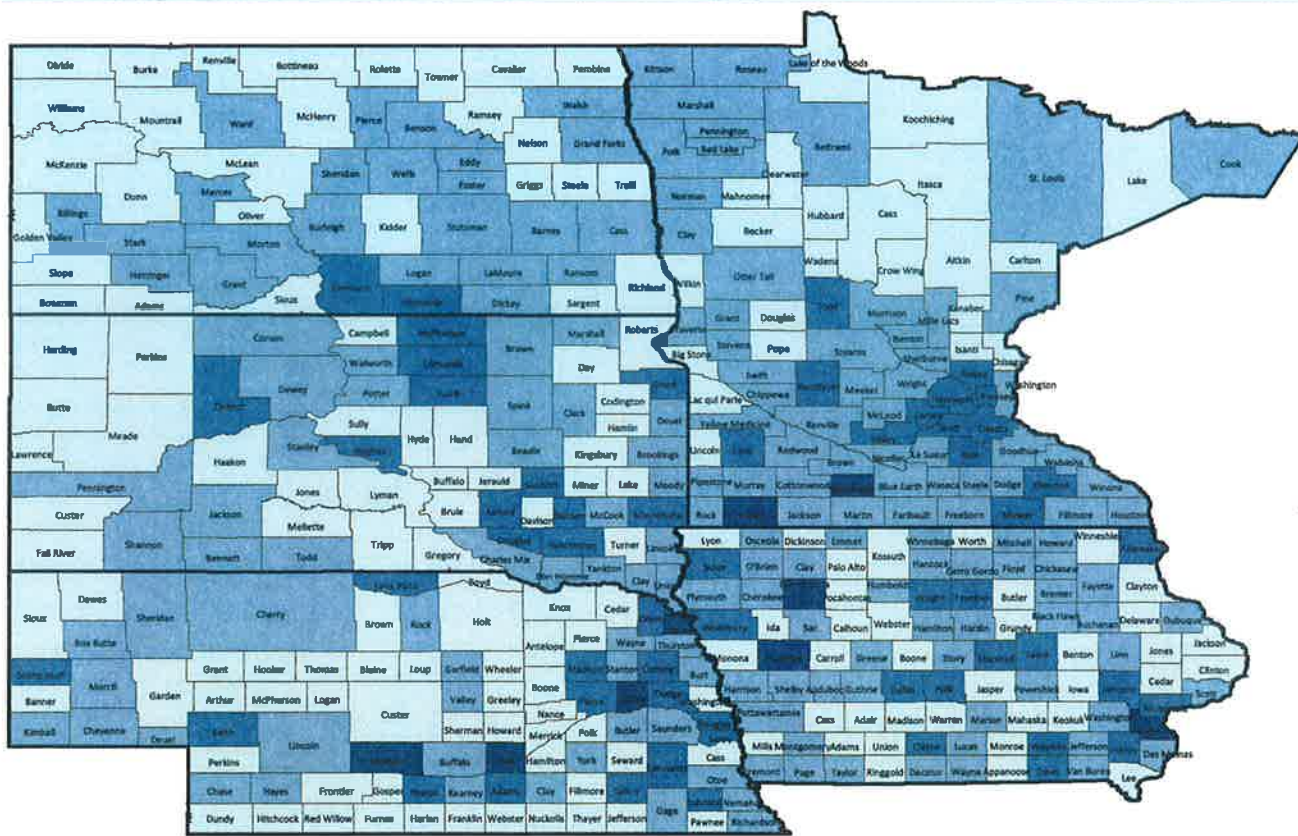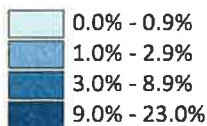
CONTEXT

What It Is: This measure represents the percent of the total population that reports speaking English less than "very well."
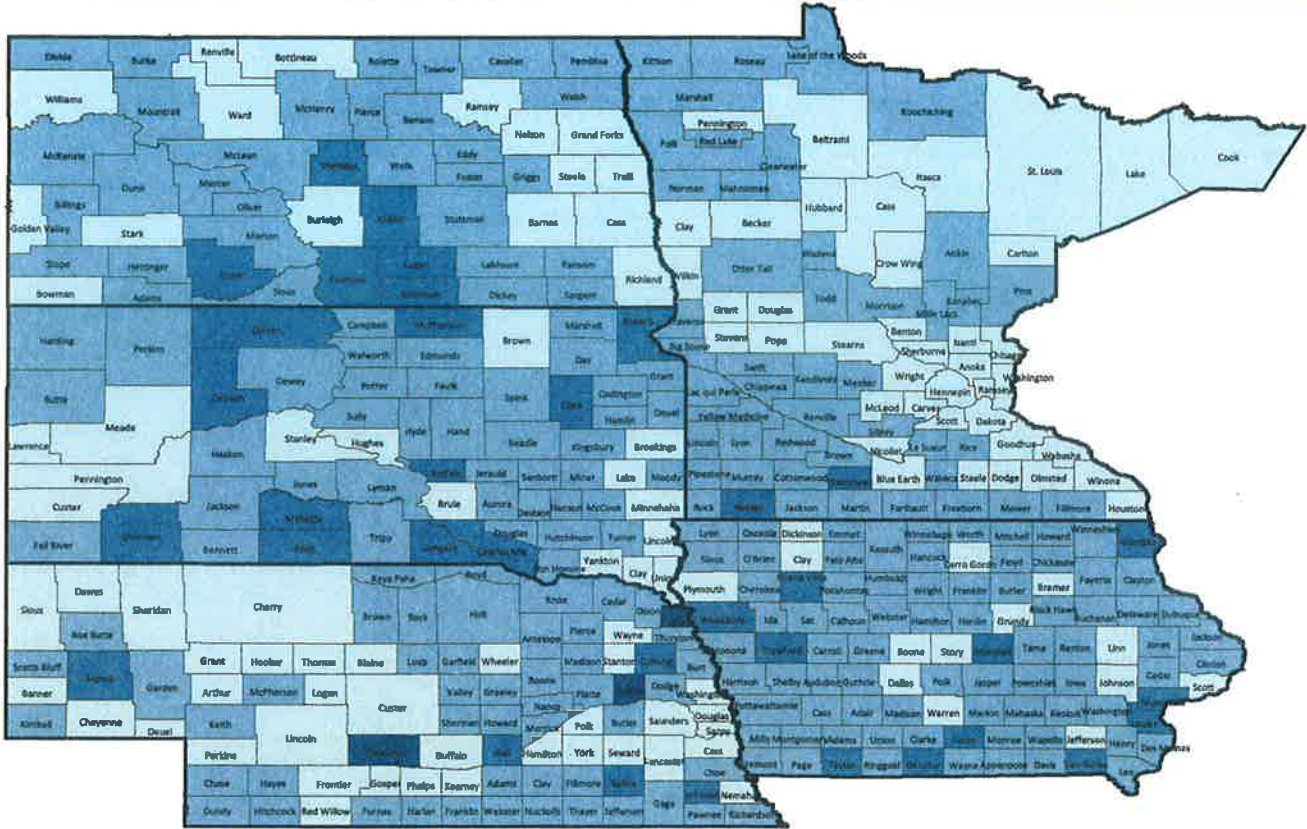
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
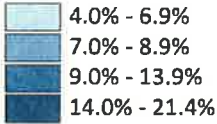
Map 36

Illiteracy - A demographic measure

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

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

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

CONTEXT

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

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

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

SANFORD HEALTH™

Table 1

Community Health Needs Assessment Asset Mapping
Canton-Inwood Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Access	• Need access close to home but within a short distance of a major medical center for more acute needs • Need a male physician for those who would like to be seen by a male	We are constantly recruiting and looking for new providers	
Cancer	• High concern of cancer in the community	Sanford Cancer Biology Research Center	
Chronic Disease	• Concern about chronic disease	Sanford Medical Home RN Health Coach	
Day Care	• Day care for sick children so parents can still go to work	Will share with city leadership	
Elderly	• Elder care	Good Sam and Fellowship Village, LOVE Inc., MOW	
Economic Situation/ Business community	• Need for ongoing economic growth / business growth in the community • Need to provide more jobs so as to keep people in the town • Concern about people on fixed incomes being able to maintain their lifestyle • Need a quality local grocery store	Will share this information with community leaders	
Emergency Care	• Concern about Medicare & Medicaid patients abusing the EC	Sanford Community Care Program	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Healthcare Cost/Insurance Cost	• Cost of healthcare & health insurance • Concern about those who avoid the doctor because of cost • The cost of healthcare insurance is a tremendous burden for small businesses • Concern about the money Avera & Sanford spend on advertising instead of keeping costs lower	Sanford Community Care Program Financial counselors	
Health Factors	• Binge drinking • Preventable hospital stays – 65% compared to 52% nation wide	Sanford One Care	
Healthy Nutrition	• Need a quality local grocery store • Concern about too many junk food options • Need nutritional education • Poor people have little access to quality food • 50% of survey respondents report access to healthy food	Will share with Dietician	
Mental Health	• Concerned about depression • Concern about mental health issues going unacknowledged (cultural norm) • Mental health services not immediately available • Need community education on mental health & how it ties in with physical health • Domestic violence • Drug and alcohol abuse	Sanford One Care Sanford Canton Becky comes 2nd & 4th Tuesday/Thursday afternoons Keystone	
Obesity	• Concern about rising rates of obesity	Sanford WebMD Fit Kids Changed school lunch menu	
Pollution	• Constant grain elevator noise & dust • Pervasive hog & cattle odors • Airborne ag particles • Manure going onto the land	Will share this information with community leaders	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Poverty	• Concern about people on fixed incomes being able to maintain their lifestyle • There are probably more needs in the low income population than are recognized • Concern that low income families are not accepted in the community • Concern about diseases that can be spread when a family has no regular healthcare provider because they cannot afford one (head lice, etc.) • Poor people have little access to quality food	LOVE Inc. Lincoln County DSS Interlakes Community Action Sanford Community Care Program Will share this information with community leaders, public health, social services	
Safety	• Domestic violence (infrequent but significant when it does occur). No community effort to address this. • Sex offenders living in the community	Children's Inn(SF) Will share this information with community leaders, public health, social services	
Social Problems	• Gambling – new casino	Keystone Will share this information with community leaders, social services	
Technology	• Access to needed technology because not available in a smaller community	Will share this information with community leaders	
Traffic/ City Infrastructure	• Concern about texting & talking on cell phones while driving	Will share this information with community leaders,	
Transportation	• Need public transportation – locally & between towns • No public transportation on weekends	Will share this information with community leaders, public health, social services	
Wellness	• Walking options exist but are not encouraged – concern about attitude	Sanford WebMD Fit Kids for children and parents	
Youth	• Drug & alcohol use • Cost of sending kids to college – affects our choices • Latchkey kids on their own after school • Concern about diet outside of school • Concern about obesity in children/teens	Sanford WebMD Fit Kids for children and parents Keystone Recently changed school lunch program Feeding SD(back pack program) Will share this information with community leaders,	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	• Need a good school lunch program • Need weekend backpack program to augment poor diet at home • Need mental health education • Need programs that promote a positive self-image • Bullying • Teen pregnancy • Youth crime • Child abuse and neglect • HS Graduation rate is 85% compared to 92% nation wide	public health, social services	

6/26/12

Table 2
Prioritization Worksheet

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

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

Health Indicator/Concern (from asset mapping and gaps analysis worksheet)	Round 1 Vote	Round 2 Vote	Round 3 Vote
• Need access close to home but within a short distance of a major medical center for more acute needs • Need a male physician for those who would like to be seen by a male	II		
• High concern of cancer in the community	IIII		
• Concern about chronic disease			
• Concern about Medicare & Medicaid patients abusing the EC			
• Cost of healthcare & health insurance • Concern about those who avoid the doctor because of cost • The cost of healthcare insurance is a tremendous burden for small businesses	IIII	III	III

Health Indicator/Concern (from asset mapping and gaps analysis worksheet)	Round 1 Vote	Round 2 Vote	Round 3 Vote
• Concern about the money Avera & Sanford spend on advertising instead of keeping costs lower			
• Binge drinking • Preventable hospital stays – 65% compared to 52% nation wide	I		
• Need a quality local grocery store • Concern about too many junk food options • Need nutritional education • Poor people have little access to quality food • 50% of survey respondents report access to healthy food	III	I	
• Concerned about depression • Concern about mental health issues going unacknowledged (cultural norm) • Mental health services not immediately available • Need community education on mental health & how it ties in with physical health • Domestic violence • Drug and alcohol abuse	III IIII IIII	I I	
• Concern about rising rates of obesity	II		
• Walking options exist but are not encouraged – concern about attitude			
• Drug & alcohol use • Cost of sending kids to college – affects our choices • Latchkey kids on their own after school • Concern about diet outside of school • Concern about obesity in	III	I	

Health Indicator/Concern (from asset mapping and gaps analysis worksheet)	Round 1 Vote	Round 2 Vote	Round 3 Vote
children/teens	III	III	I
• Need a good school lunch program			
• Need weekend backpack program to augment poor diet at home	III		
• Need mental health education	II		
• Need programs that promote a positive self-image	III		
• Bullying			
• Teen pregnancy	IIII	I	
• Youth crime			
• Child abuse and neglect			
• HS Graduation rate is 85% compared to 92% nation wide			