Sanford Health Network

Community Health Needs Assessment

2012-2013

dba Sanford Rock Rapids Medical Center EIN# 46-0388596

SANFORD HEALTH

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Purpose

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

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

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

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

Acknowledgements

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

Sanford Enterprise Steering Group:

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

Sanford Sioux Falls Network Steering Group:

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

Sanford Rock Rapids Steering Group:

- Tammy Loosbrock, CEO
- Stan Knobloch, CFO
- Jack Johnson, CNO
- Laurie Jensen, Director of Clinic Operations
- Jill Funke, Marketing coordinator
- Sanford Rock Rapids Department managers

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, faith and community leaders, as well as legal services, 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:

- Kristi Baker, City Clerk, Doon, IA
- Marlene Bowers, Retired, Rock Rapids, IA
- Wendee Chase, Pharmacist, Lewis Family Drug, Rock Rapids, IA
- Sandi DeSmet, City Clerk, Larchwood, IA
- Stacy Dieren, Accountant, Rock Rapids, IA
- Darcy Gerber, Lester, IA
- Josh Feucht, City Council, Larchwood, IA
- Cody Hoefert, Chiropractor, Lyon County Chiropractic, Rock Rapids, IA
- Beverly Hoing, Retired Educator, George, IA
- Angie Jager, Consumer Council Member, Rock Rapids, IA
- April Jennings, Administrator, Lyon Manor, Rock Rapids, IA
- Amber Kellenberger, Rock Rapids, IA
- Derek Knobloch, Owner, Farm, Lester, IA
- Desiree Kopp, Director, Rock Rapids Kids Club, Rock Rapids, IA
- Jordan Kordahl, City Administator, Rock Rapids, IA
- Dale Lint, Pastor, Zoar Presbyterian Church, George, IA
- Tim Mantel, Mayor, Doon, IA
- Harold Meester, Retired, Lester, IA
- Merlin Meyer, Finance, Rock Rapids, IA
- Jesse L. Moser, General Manager, Lester Feed & Grain Co., Lester, IA
- Marlin Overman, VP, DeWild Grant Reckert & Associates, Rock Rapids, IA
- Yvonne Rozeboom, Clinic Supervisor, Avera Medical Group, Larchwood, IA
- Marge Smith, Nurse, Sanford Hospice, Rock Rapids, IA
- Melissa Stillson, Public Health Nurse, Rock Rapids, IA
- Carol Vander Kolk, City Clerk, Inwood, IA
- James Vander Woude, Retired, Rock Rapids, IA
- Merlin Ver Steeg, Business Owner, Corner Service, Inc., Little Rock, IA
- Kelly Volk, Pastor, United Church of Christ, Larchwood, IA
- Bernette Weier, George, IA
- Jackie Wells, Business Manager, Central Lyon CSD, Rock Rapids, IA
- Susan Wiertzema, Geriatrics Director of Nursing, Little Rock, IA
- Kristi Wright, Rock Rapids, IA

Sanford Rock Rapids Medical Center
Community Health Needs Assessment
2012-2013

Executive Summary

Purpose

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

Study Design and Methodology

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Lyon County
- Aging Profiles for Lyon County
- Diversity Profiles for Lyon County

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

Each unmet need was researched to determine what resources were available in the community to address the needs. The Sanford Rock Rapids 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 Rock Rapids 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 Lyon county 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 their community has quality educational opportunities and programs, there is access to quality food, and there is quality health care. Respondents felt strongly that the community was a safe place to live, family friendly, with a healthy environment that has a laidback lifestyle and is peaceful and quiet. The respondents agreed that people within the community are helpful and supportive, there is a sense of engagement within the community, and that people felt connected to the people that live within the community. Respondents also had a high level of agreement that the community is clean, convenient access to work and activities, and that there are many recreational/sports activities available.

Respondents were most concerned about cost and availability of child care and bullying among the youth. Respondents were also concerned with issues regarding substance abuse within the community. Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health and dental insurance (i.e., amount of co-pays and deductibles) ,access to health insurance coverage (e.g. pre-existing conditions), and availability of doctors and specialists as well as chronic disease (e.g. diabetes, heart disease, multiple sclerosis), prevalence of cancer, and mental health treatment and programs were also among the top health and wellness concerns among respondents. Respondents had very high levels of agreement that access to emergency services, such as ambulance and 911 services, is very well addressed. Respondents were least concerned with the availability of translators, providers not taking new patients, confidentiality, and distance to health care services.

Respondents mentioned the community is a great place to live and raise a family with a sense of support for each other. Respondents had fairly high levels of agreement that people in their community are friendly, helpful,

and supportive and that there is a sense of community or feeling connected to people who live here. Among issues regarding people in the community, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community. Respondents also said that having the "Rides" bus available is a big asset.

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

Respondents were most concerned with availability of good walking or biking options. Respondents were least concerned with traffic congestion.

The levels of concern among respondents regarding substance use were fairly high. Respondents were most concerned about drug use and abuse and moderately concerned about smoking and alcohol use and abuse.

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

Seventy percent (70%) of the respondents said they had not had a cancer screening or cancer care in the past year. The most common reasons for not having done so was because the doctor hadn't suggested it or because it was not necessary. Fear, cost, and unfamiliarity with recommendations were also reasons respondents gave.

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

Respondents were asked which provider they used for their primary health care. Two out of three respondents said they use Sanford Health as their primary health care provider. One in three said they use Avera health system.

Key Findings – Secondary Research

Health Outcomes

The Mortality health outcomes indicate that Iowa as a state has more premature deaths than the national benchmark; however, Lyon County is less than the national benchmark.

The Morbidity health outcomes indicate that Iowa citizens report more days of poor mental and physical health than the national benchmark; however, Lyon County residents report better than national benchmark physical and mental health.

Lyon County has a similar percentage of low birth weight as the national benchmark and Iowa has higher percentages of low birth weight.

Health Factors

The Health Behavior outcomes indicate that Iowa and Lyon County have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in Iowa and Lyon County. Iowa and Lyon County have a higher percentage of physical inactivity than the national benchmark.

Iowa and Lyon County have higher percentages of binge drinking reports than the national benchmark. Motor vehicle crash death rates are higher than the national benchmark in Iowa.

Sexually transmitted infections rank substantially higher than the national benchmark for Iowa; however, significantly lower than the national benchmark for Lyon County. The teen birth rate is higher in Iowa than the national benchmark, but is significantly lower in Lyon County.

The Clinical Care outcomes indicate that Lyon County has a higher percentage of uninsured adults and youth than the national benchmark, while Iowa as a state has similar percentages as the national benchmark.

The ratio of population to primary care physicians is significantly higher in Lyon County than the national or state benchmark. The ratio of population to mental health providers is much higher in Iowa and Lyon County than the national benchmark. The number of professionally active dentists is lower than the national benchmark in Iowa and Lyon County. Preventable hospital stays are higher than the national benchmark in Iowa and Lyon County.

Diabetes screening in Iowa and in Lyon County is slightly lower than the national benchmark. Lyon County ranks higher than the national benchmark for mammography screenings, while Iowa is slightly under the national benchmark.

Implementation Strategy

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

- Facility upgrades to enhance quality and health care access
- Increase knowledge and awareness of services available within the community

Facility Upgrades to Enhance Quality and Health Care Access

Work related to this need will be done jointly by the Sanford Rock Rapids leadership team, Sanford Health Network, and MPCH Association Board as the MPCH Association Board maintains ownership of the building and grounds.

- Develop bridge plan for existing facility to maintain patient safety through reinvestment of lease proceeds during renovation/construction
- Review existing renovation plan and evaluate other options for facility changes with the MPCH Association
- Review existing construction finance plan and update financing plan to account for market changes (comparing budgeted performance with actual performance) /building program changes
- MPCH Association and Sanford Health Network communicate and agree on plan to upgrade facility infrastructure

Increase Knowledge and Awareness of Services Available within the Community

- Internal team to analyze available resources and determine how to access resources
- External group/Lyon County Collaborative to review existing list of community resources and determine modifications that need to be made
- Design/print resource materials with Sanford marketing
- Share resource tool with key community stakeholders/access points to care

Sanford Rock Rapids Medical Center

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

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

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

Our Values:

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

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

Guiding Principles:

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

Description of Sanford Rock Rapids Medical Center

Sanford Rock Rapids is located in Rock Rapids, IA, and includes Sanford Rock Rapids Medical Center, Sanford Rock Rapids Clinic, Sanford George Clinic, and Sanford Rock Rapids Fitness Center. A member of Sanford Health, Sanford Rock Rapids serves most of Lyon County, IA, with its primary service area including Rock Rapids, George, Little Rock, Lester, Alvord and Doon, and its secondary service area including Larchwood, Steen (MN) and Ellsworth (MN). Sanford Rock Rapids Medical Center is a 16-bed Critical Access Hospital, providing medical, diagnostic, therapy and outreach services. Sanford Rock Rapids has over 100 employees. Sanford Rock Rapids Clinic and Sanford George Clinic provide family medicine services. Sanford Rock Rapids Fitness Center offers members 24-hour access to meet their various wellness needs.

Description of the Community Served

Rock Rapids is the county seat of Lyon County Iowa. As of the 2010 census, Rock Rapids' population was 2,549 with a county population of 11,581.

Rock Rapids is located in extreme northwest Iowa, at the junction of Iowa Highway 9 and US Highway, 75 32 miles southeast of Sioux Falls, South Dakota, and only 15 miles south of Interstate 90.

There are many recreational opportunities in the area. Fishing, swimming, soccer, baseball, skate park, softball, museums, snowmobiling, ice skating and more are all available in Rock Rapids. Rock Rapids is promoted as the City of Murals. Rock Rapids is predominately an agricultural community. Larger employers with the community are Sanford Rock Rapids, GlyLyon, and Central Lyon School.

Study Design and Methodology

Community Health Needs Assessment of Community Leaders and Focus Studies of Key Stakeholders

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

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

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

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

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

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

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

The following qualitative data sets were studied:

- Survey of Key Stakeholders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Lyon County
- Aging Profiles for Lyon County
- Diversity Profiles for Lyon County

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

Each unmet need was researched to determine what resources were available in the community to address the needs. The Sanford Rock Rapids Executive leadership and management team performed the asset mapping and reviewed the findings. Findings were also reviewed with key community stakeholders. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the executive leadership team proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

2011 County Health Profiles

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

Aging Profiles

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

Diversity Profiles

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

Limitations

The Sanford Rock Rapids planning committee Collaborative attempted to survey 100 key community and county stakeholders for the purpose of determining the needs of the community. There were 43 members of this key stakeholder group who completed 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 their community has quality educational opportunities and programs, there is access to quality food, and there is quality health care. Respondents felt strongly that the community was a safe place to live, family friendly, with a healthy environment that has a laidback lifestyle and is peaceful and quiet. The respondents agreed that people within the community are helpful and supportive, there is a sense of engagement within the community, and that people felt connected to the people that live within the community. Respondents also had a high level of agreement that the community is clean, convenient access to work and activities, and that there are many recreational/sports activities available.

Respondents were most concerned about cost and availability of child care and bullying among the youth. Respondents were also concerned with issues regarding substance abuse within the community. Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health and dental insurance (e.g. amount of co-pays and deductibles), access to health insurance coverage (e.g. pre-existing conditions), and availability of doctors and specialists as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis), prevalence of cancer, and mental health treatment and programs were also among the top health and wellness concerns among respondents. Respondents had very high levels of agreement that access to emergency services, such as ambulance and 911 services, is very well addressed. Respondents were least concerned with the availability of translators, providers not taking new patients, confidentiality, and distance to health care services.

Community Assets/Best Things about the Community

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

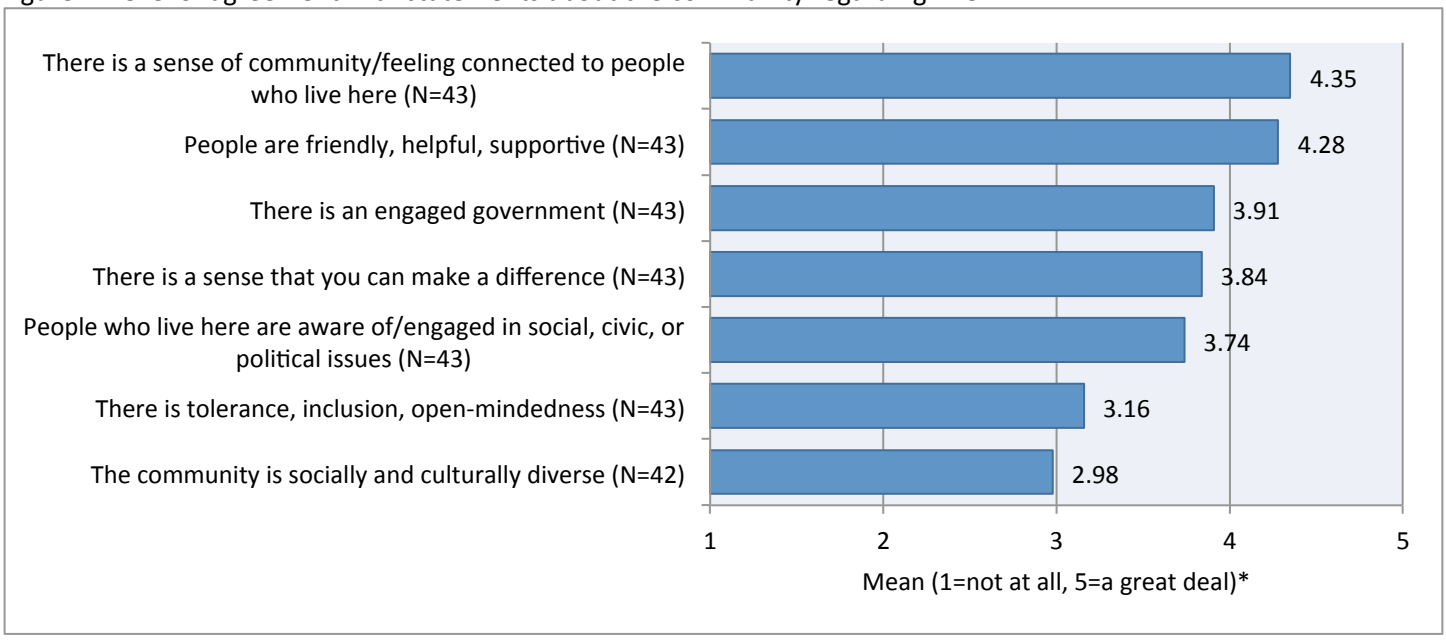
Respondents indicated the top five community assets or best things about the community were: the community is a good place to raise kids, there are quality school systems and programs for youth, there is quality health care, and people are friendly, helpful, and supportive.

People

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

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

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

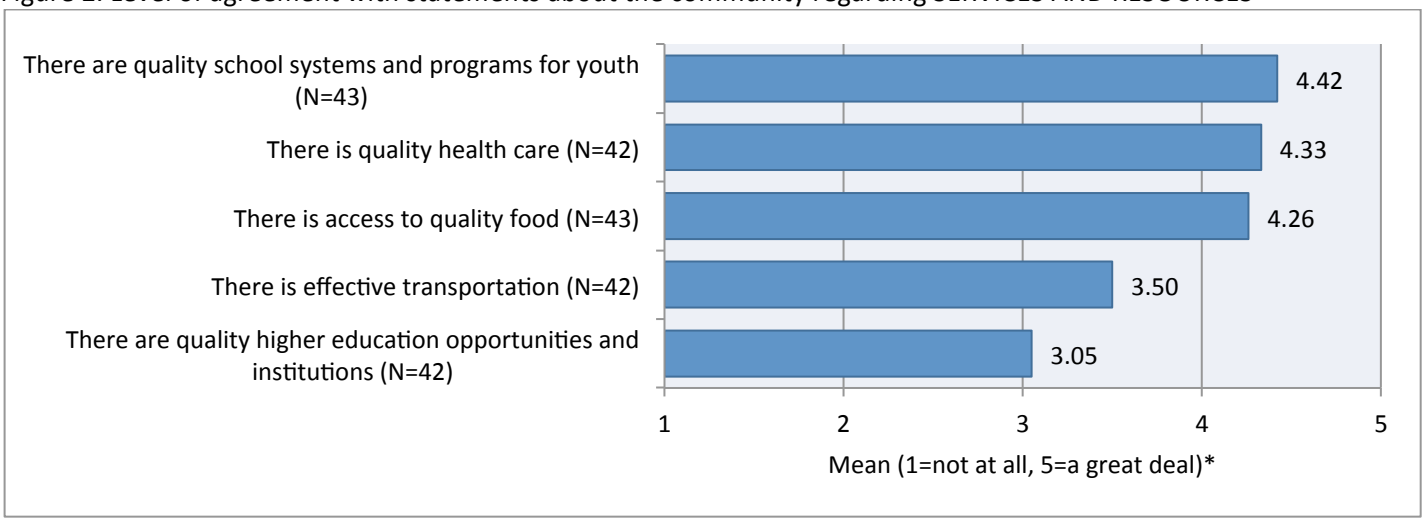


*Means exclude "do not know" responses.

Services and Resources

Respondents had high levels of agreement that there are quality school systems and programs for youth in their community as well as quality health care. *(Figure 2)* Although still a moderate level of agreement, respondents agreed the least that there are quality higher education opportunities and institutions within the community. .

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

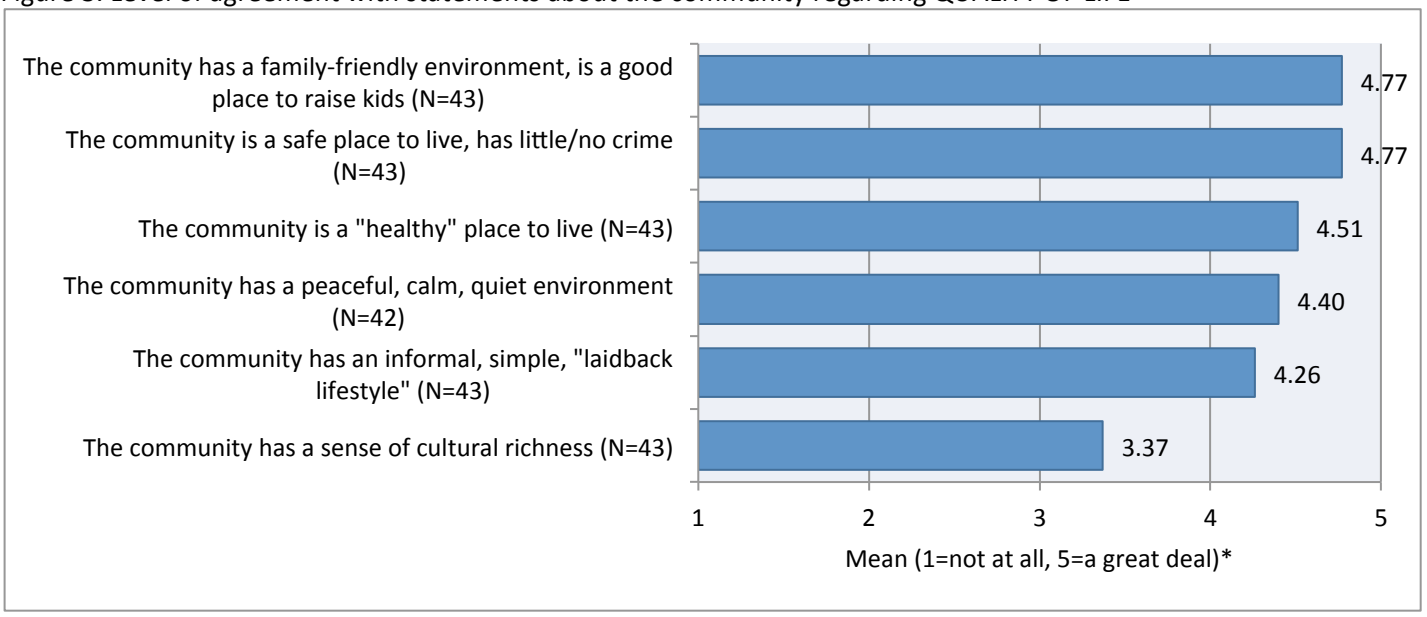


*Means exclude "do not know" responses.

Quality of Life

Respondents had a very high level of agreement that their community is a good place to raise kids. Respondents had high levels of agreement with the remaining components of quality of life issues in their community *(Figure 3).* Means ranged from 4.77 to 4.26 with respect to the community being a healthy place to live; the community being a safe place to live with little or no crime; the community having a peaceful, calm, and quiet environment; and the community having many recreational, exercise, and sports activities/opportunities. The respondents gave the lowest score (3.37) to the cultural richness of the community

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



*Means exclude "do not know" responses.

General Concerns about the Community

Respondents had high levels of agreement that people in their community are friendly, helpful, and supportive and that there is a sense of community or feeling connected to people who live here. Among issues regarding people in the community, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community and that the community is culturally diverse.

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various statements regarding ECONOMIC ISSUES, TRANSPORTATION, ENVIRONMENT, CHILDREN AND YOUTH, THE AGING POPULATION, and SAFETY in their community.

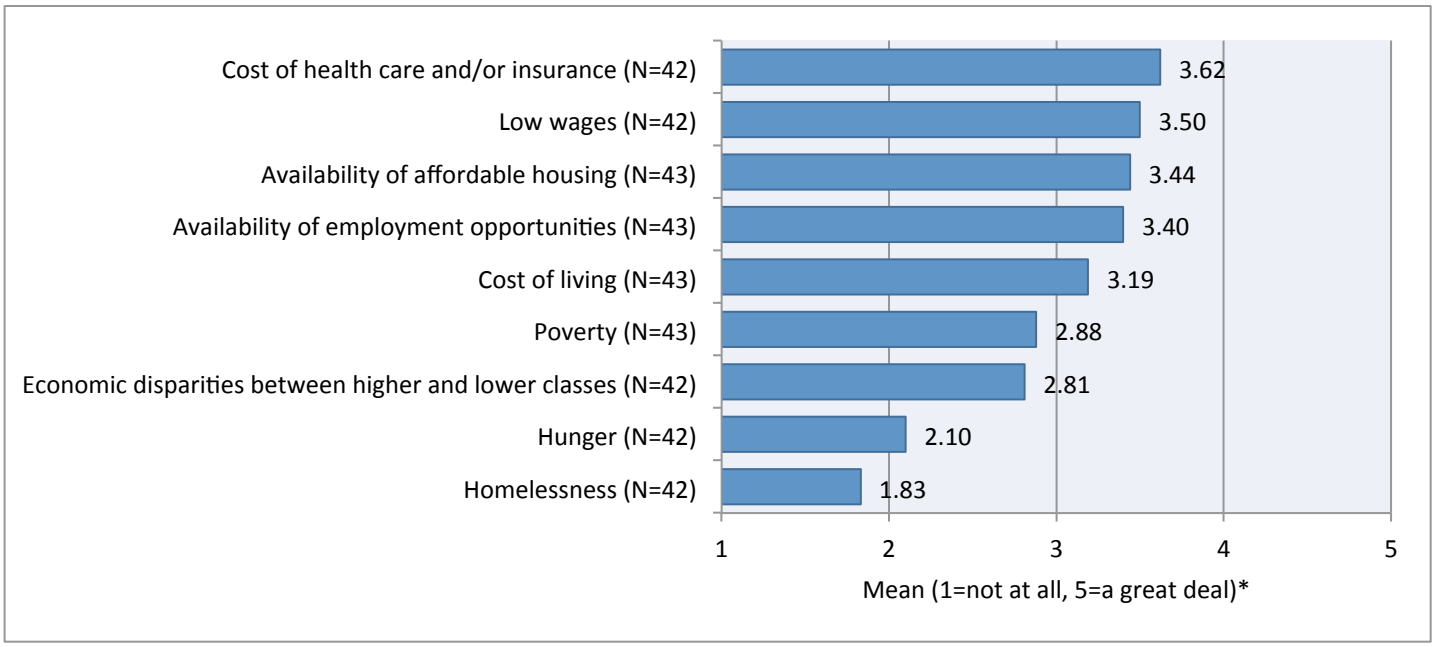
Economic Issues

Respondents had moderate levels of concern with cost of health care and/or insurance, low wages, with respect to the availability of affordable housing and employment opportunities. Respondents were least concerned with homelessness. *(Figure 4)*

Overall, respondents had a moderate level of concern with economic issues in their community.

- On average, respondents were most concerned with the cost of health care and/or insurance, low wages, and the availability of affordable housing and employment opportunities.
- Respondents were least concerned with homelessness within the community.

Figure 4. Level of concern with statements about the community regarding ECONOMIC ISSUES



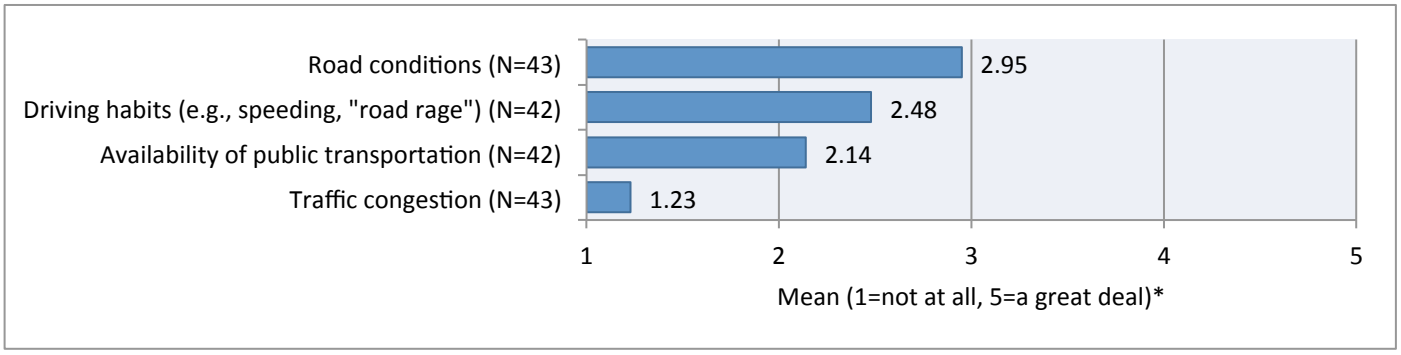
*Means exclude "do not know" responses

Transportation
Respondents were most concerned with road conditions. Respondents were least concerned with traffic congestion.

Overall, respondents had a moderate level of concern with transportation issues in their community (*Figure 5*).

- On average, respondents had moderate concern with road conditions, driving habits, and availability of public transportation.
- On average, respondents had low levels of concern with traffic congestion.

Figure 5. Respondents' level of concern with statements about their community regarding TRANSPORTATION



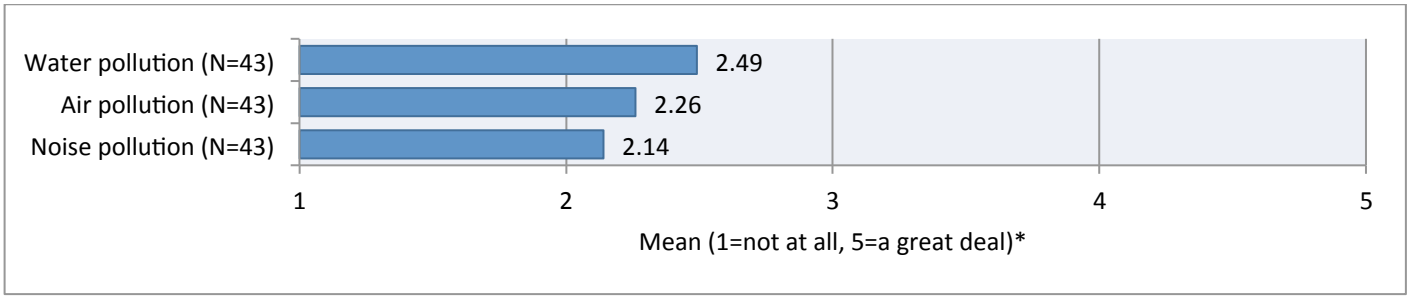
*Means exclude "do not know" responses.

Environment
Respondents on average had moderate to low concern with environmental issues in their community.

Overall, respondents were not that concerned with environmental issues in their community (*Figure 6*).

- On average, respondents had a higher level of concern with water pollution.

Figure 6. Respondents' level of concern with statements about their community regarding ENVIRONMENTAL POLLUTION



*Means exclude "do not know" responses.

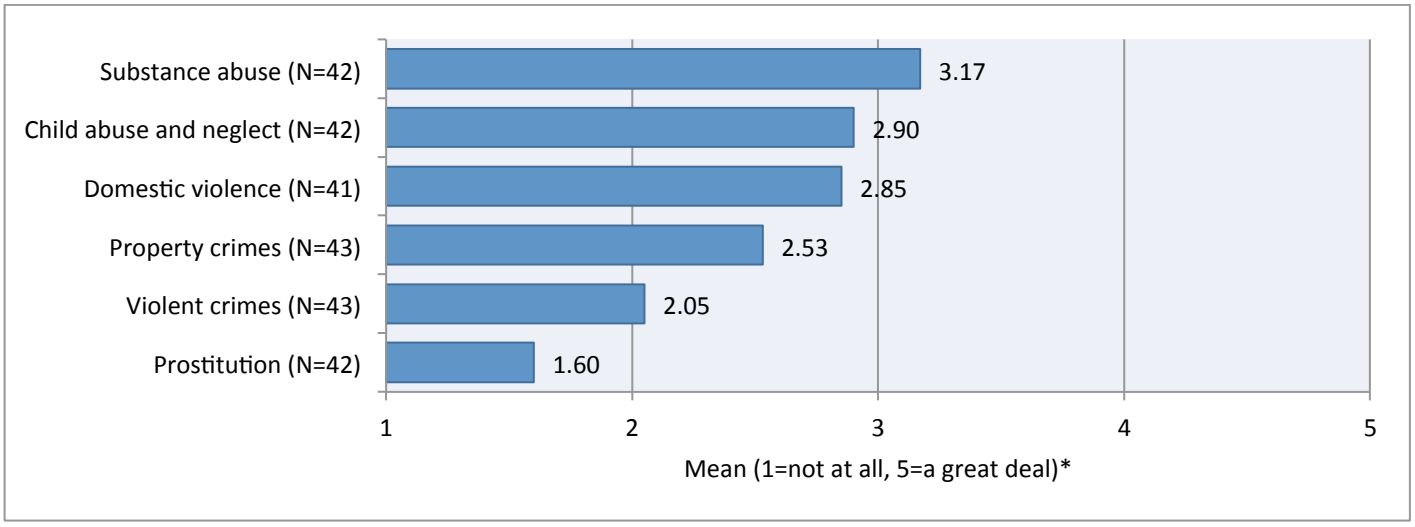
Safety

Regarding safety issues in their community, respondents were most concerned with substance abuse, child abuse and neglect and domestic violence. Respondents were least concerned with prostitution.

Overall, respondents had a moderate level of concern with safety issues in their community (*Figure 7*).

- On average, respondents were most concerned with substance abuse, child abuse and neglect and domestic violence.
- On average, respondents had low levels of concern about violent crimes and prostitution.

Figure 7. Respondents' level of concern with statements about their community regarding SAFETY



*Means exclude "do not know" responses.

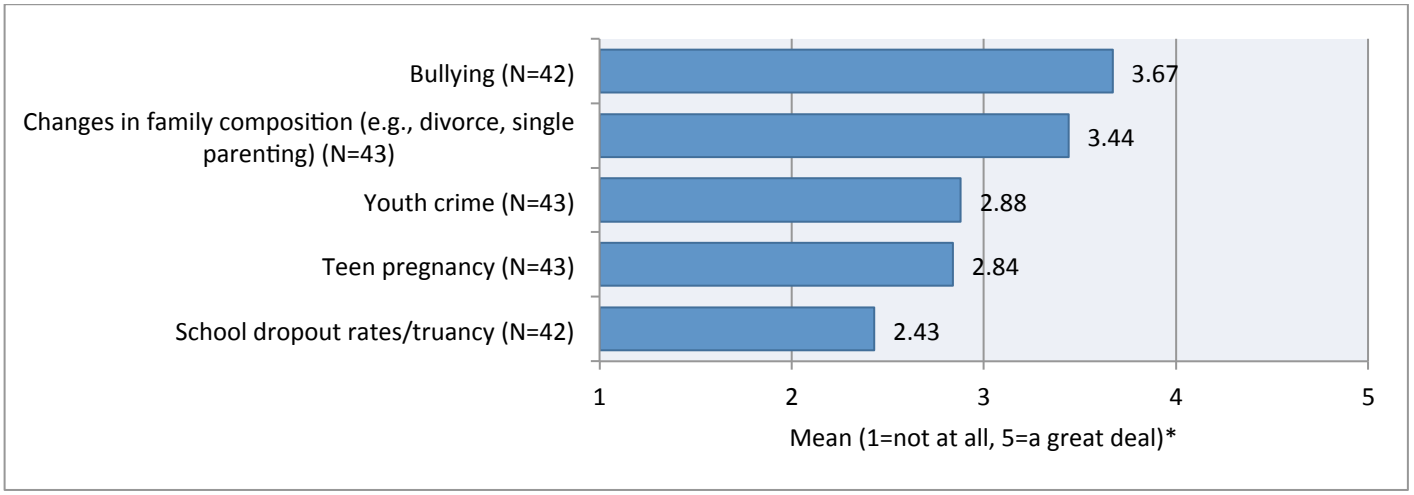
Children and Youth

Regarding children and youth, respondents were most concerned with bullying and the changes in family composition (e.g. divorce, single parent, etc). Respondents were least concerned with school dropout rates/truancy.

Overall, respondents had a moderate level of concern with issues relating to children and youth in their community. (*Figure 8*)

- On average, respondents were most concerned about bullying and the changes in family composition (e.g. divorce, single parent, etc).
- Respondents had a moderate level of concern regarding youth crime and teen pregnancy
- Respondents had a moderately low level of concern with school dropout rates/truancy

Figure 8. Respondents' level of concern with statements about their community regarding YOUTH CONCERNS



*Means exclude "do not know" responses.

Community Health and Wellness Concerns

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

The top six health and wellness concerns among community leaders were:

- cost of health insurance
- cost of health care
- cost of prescription drugs
- stress related issues
- adequacy of health insurance coverage
- adequacy of dental/vision coverage

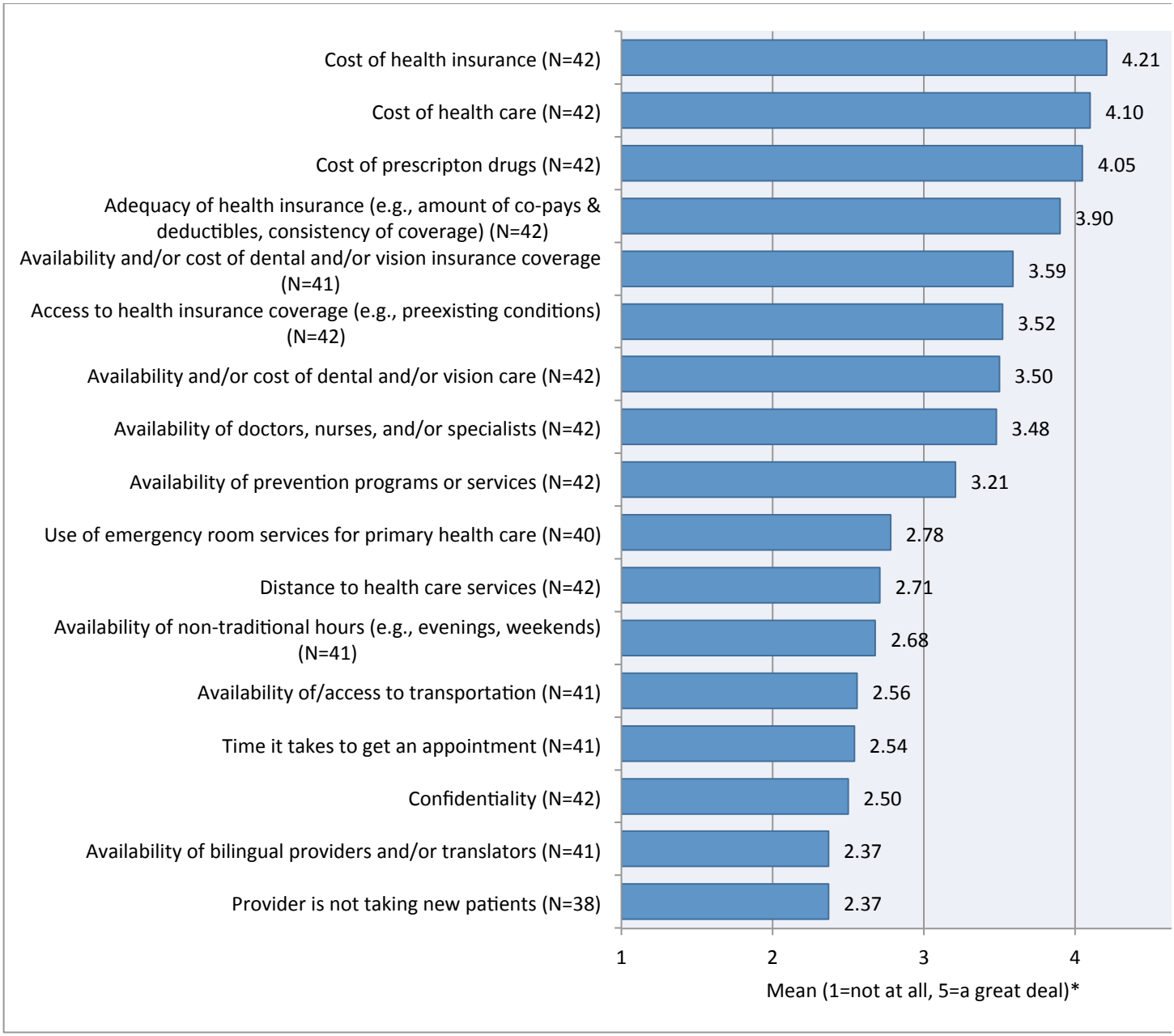
Access to Health Care

Respondents had high levels of concern with respect to costs associated with health and wellness in their community. Cost of health insurance, cost of health care, and cost of prescription drugs were the top three concerns. *(Figure 9)*

Respondents also had concerns with respect to access and the availability of health and wellness service providers in their community. Access to health insurance coverage, availability of prevention programs, availability and cost of dental and vision care, availability of and cost of dental and vision insurance coverage, coordination of care, and availability of mental health services and providers were all well above average in level of concern.

Respondents had below average levels of concern with distance to health care services and patient confidentiality.

Figure 9. Respondents' level of concern with statements about their community regarding ACCESS TO HEALTH CARE



*Means exclude "do not know" responses.

Physical and Mental Health

Regarding physical and mental health issues, respondents had the highest levels of concern with stress related mental health issues, availability of providers and services to address mental health issues, obesity, poor nutrition and eating habits, and inactivity and lack of exercise facilities. Respondents were least concerned with availability of good walking or biking options *(Figures 10 and 11).*

Figure 10. Level of concern with statements about the community regarding PHYSICAL HEALTH

*Means exclude "do not know" responses.

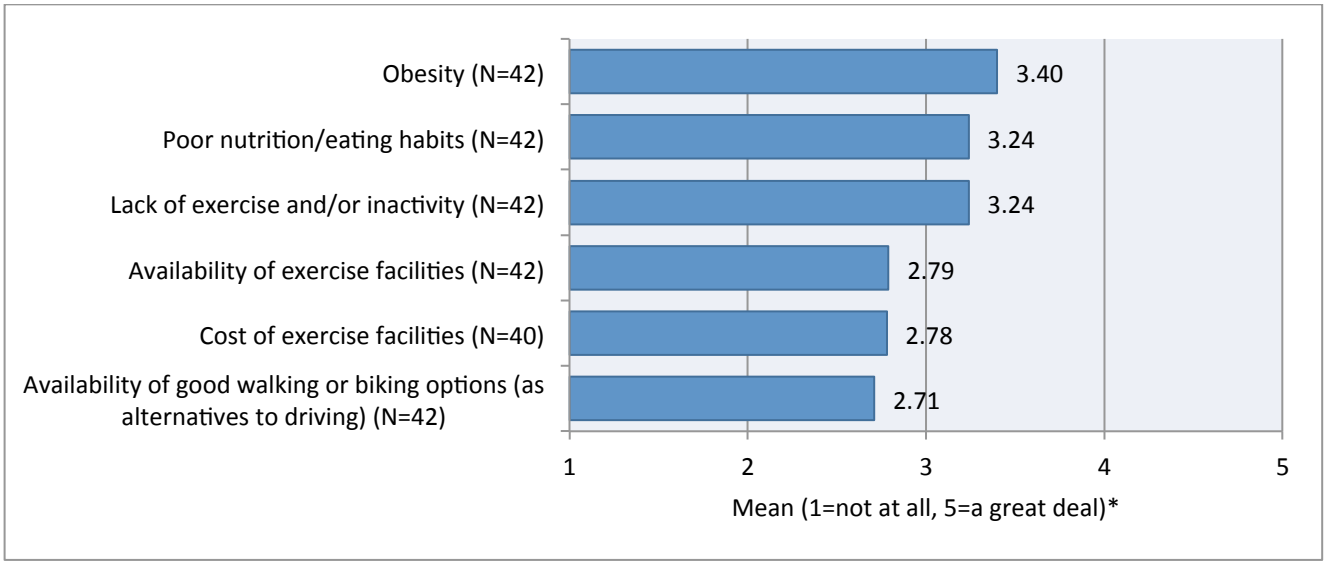
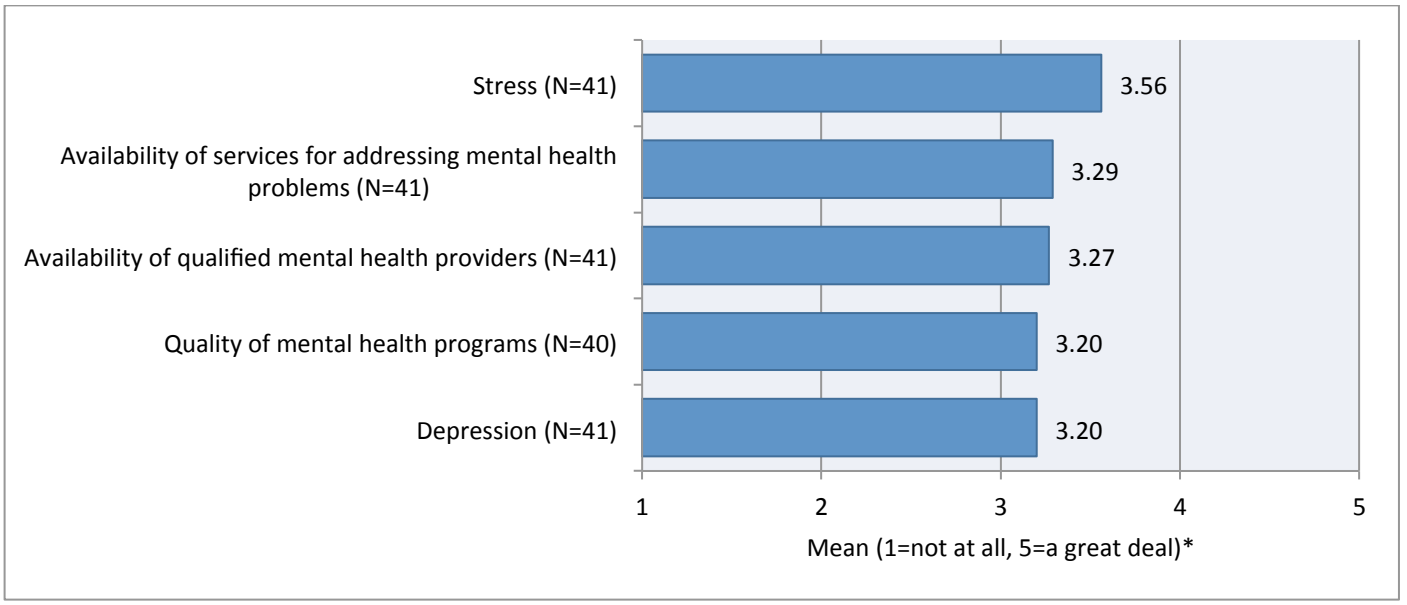


Figure 11. Level of concern with statements about the community regarding MENTAL HEALTH

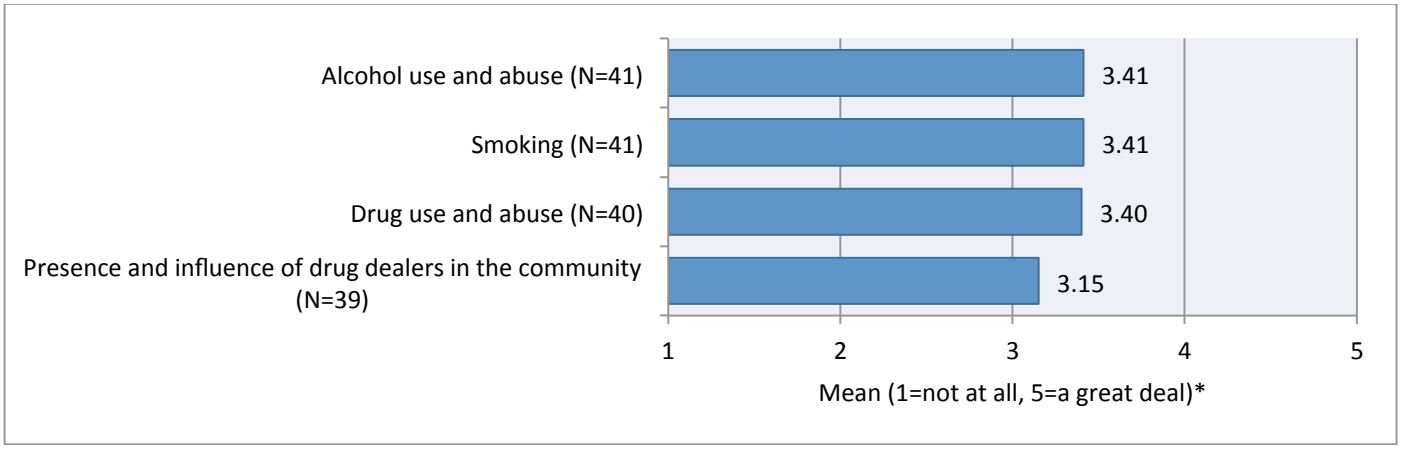


*Means exclude "do not know" responses.

Substance Use and Abuse

The levels of concern among respondents regarding substance use, smoking, and drug use and abuse issues in their community were fairly high. Respondents were most concerned about alcohol use and abuse. Although still moderately high, respondents were least concerned about presence and influence of drug dealers in the community. *(Figure 12)*

Figure 12. Respondents' level of concern with statements about their community regarding SUBSTANCE USE AND ABUSE



*Means exclude "do not know" responses.

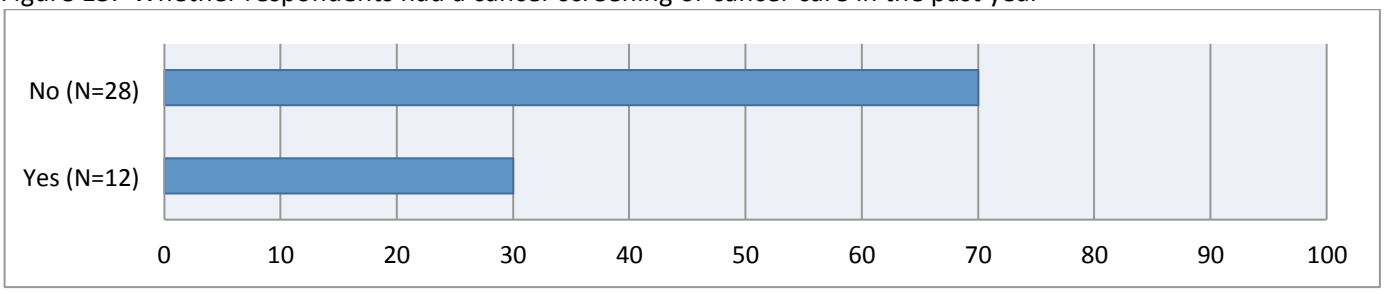
Personal Heath Care Information

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

Less than one in five respondents said they had not had a cancer screening or cancer care in the past year. *(Figure 13.* The most common reason for not having done so was because it was not necessary. Fear, unfamiliarity with recommendations, and not knowing who to see were also 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. One in three respondents said they had not had a cancer screening or cancer care in the past year.

Figure 13. Whether respondents had a cancer screening or cancer care in the past year

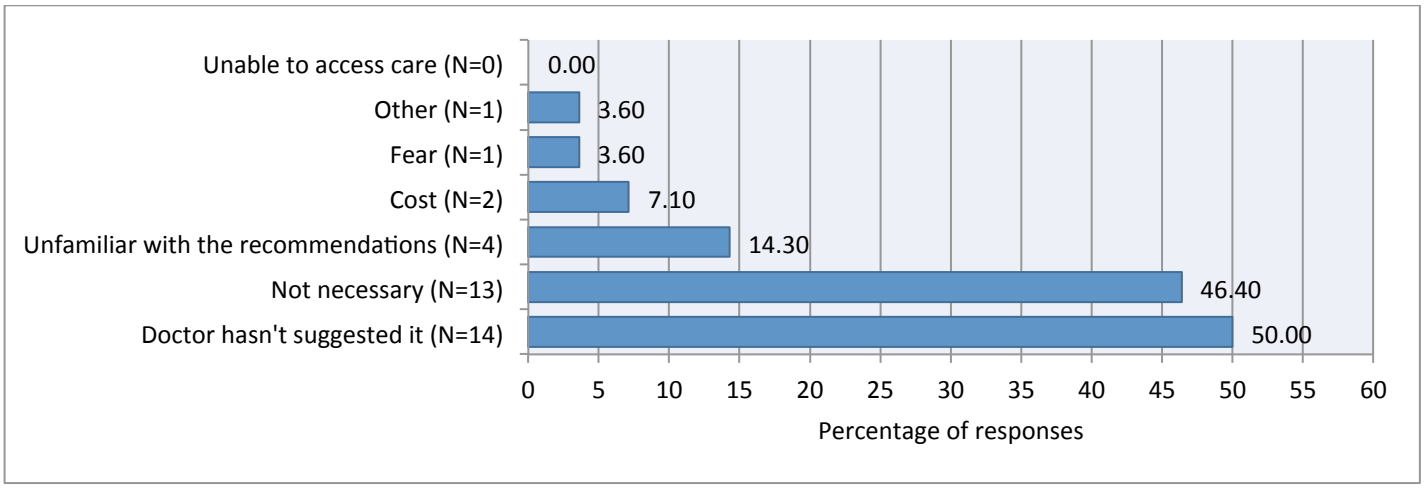


*Means exclude "do not know" responses.

Cancer Screening

Among respondents who had not had a cancer screening or cancer care in the past year, one in two said they had not done so because their doctor had not suggested it. Not necessary or unfamiliar with the recommendations were also reasons for some respondents. *(Figure 14)*

Figure 14. Respondents cited reason for not having cancer screening or cancer care in the past year

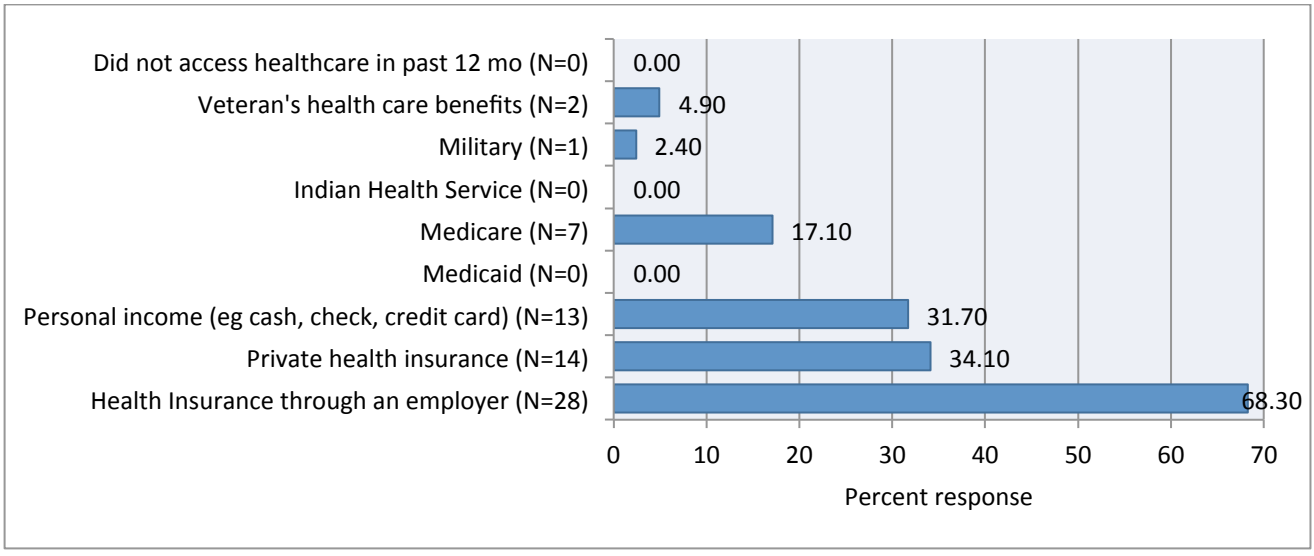


*Means exclude "do not know" responses.

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. Private insurance, personal income and Medicare were also used. *(Figure 15)*

Figure 15. Methods respondents have used to pay for health care costs over the last 12 months

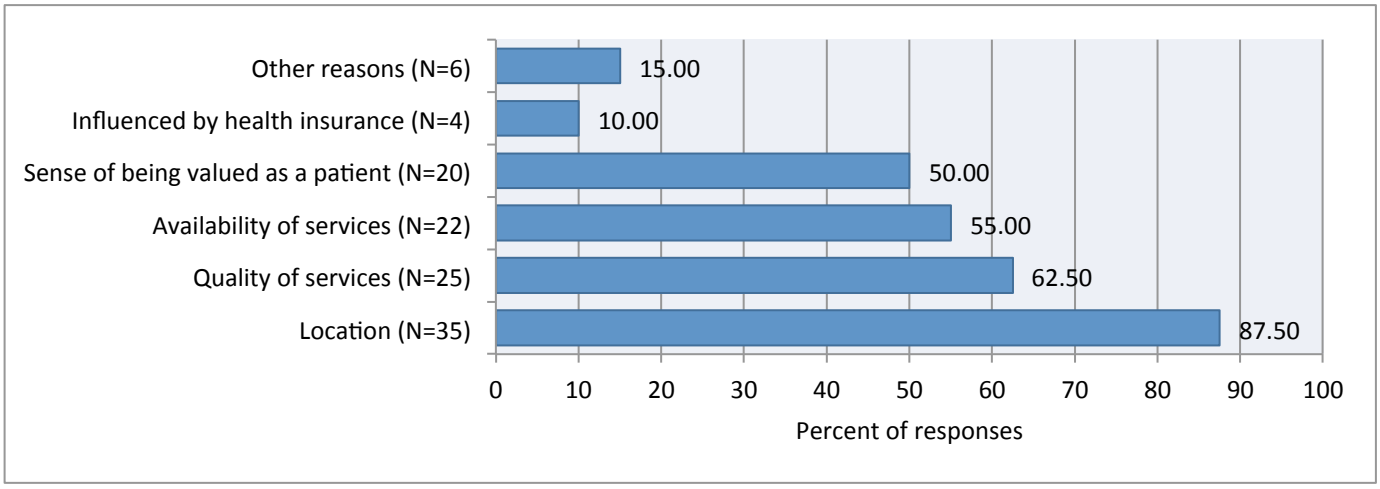


*Means exclude "do not know" responses

Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services. (*Figure 16)* Influenced by health insurance was not an issue in choosing a provider for most respondents.

Figure 16. Respondents' reasons for choosing primary health care provider

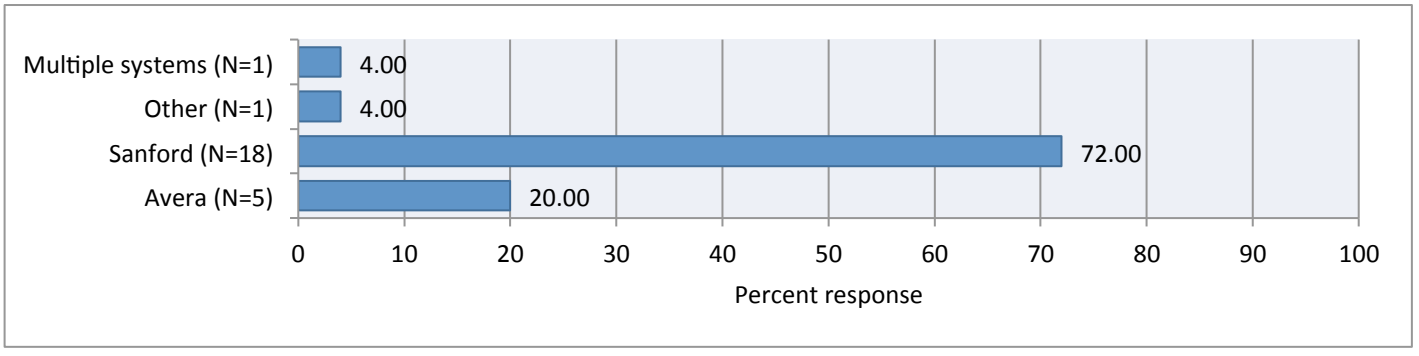


*Means exclude "do not know" responses.

Respondents' Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. Seventy two percent (72%) of respondents said they use Sanford Health as their primary health care provider. One in five said they use Avera Health. (*Figure 17*)

Figure 17. Respondents' primary health care provider

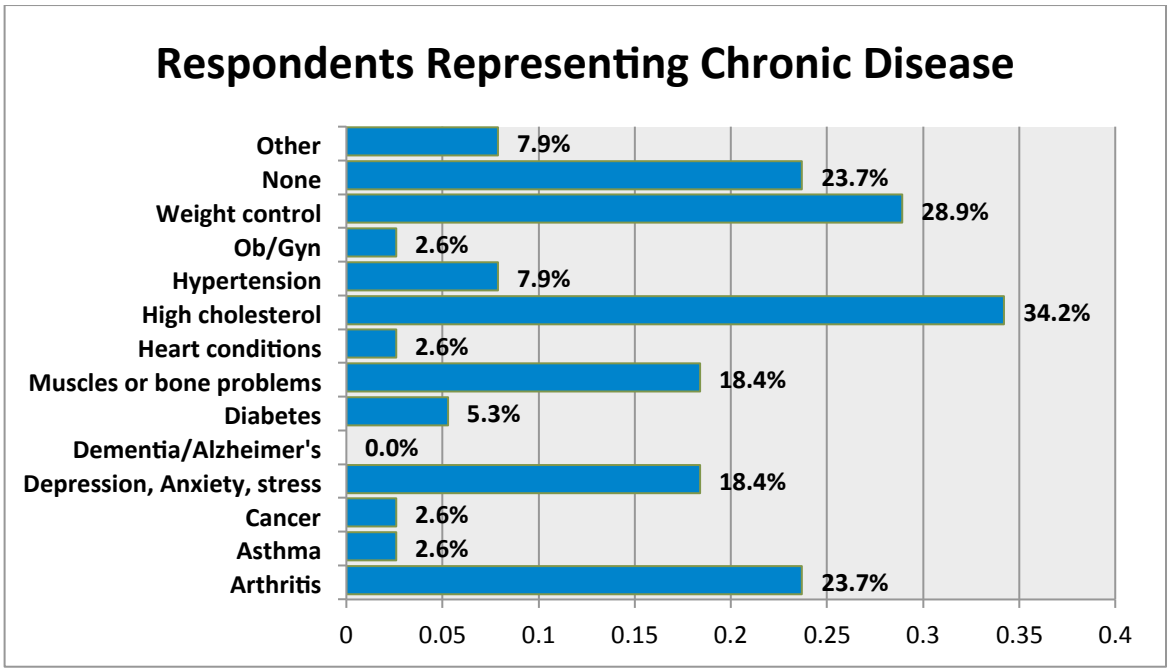


*Means exclude "do not know" responses.

Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. High cholesterol received the most responses with 34.2 % of participants selecting this condition. The chronic diseases found in the highest percentage among respondents include, arthritis, depression, anxiety, stress, muscles or bone problems, and hypercholesterolemia. (Figure 18)

Figure18. Respondent's health/chronic diseases



Demographic Information

Sixty percent (60%) of the respondents were female, 40% were male, and 100% were white. The age of the respondents ranged from 25 years to over 65 years old; with 22.5% of respondents between 25-34 years, 25% between 35-44 years, 10% between 45-54 years, 2.5 % between 55-59 years, 12.5% between 60-64 years, and 17.5% were 65 years and older. Respondents' education: 20% had high school education or GED equivalent, 12.5% have had some college with no degree, 12.5% have an Associate level degree, 37.5% have a Bachelor's degree, and 17.5% have a graduate or professional level degree.

Secondary Research

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

Health Outcomes

Mortality
The Mortality health outcomes indicate that Iowa as a state has more premature deaths than the national benchmark; however, Lyon County is less than the national benchmark.

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

Morbidity
The Morbidity health outcomes indicate that Iowa citizens report more days of poor mental and physical health than the national benchmark; however, Lyon County residents report better than national benchmark physical and mental.

Lyon County has a similar percentage of low birth weight as the national benchmark and Iowa has higher percentages of low birth weight.

		Lyon County	National Benchmark	IA
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 physical 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 birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	5.9%	6.0%	6.8%

Health Factors

Health Behaviors
The Health Behavior outcomes indicate that Iowa and Lyon County have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in Iowa and Lyon County. Iowa and Lyon County have a higher percentage of physical inactivity than the national benchmark.

Iowa and Lyon County have a higher percentage of binge drinking reports than the national benchmark. Motor vehicle crash death rates are higher than the national benchmark in Iowa.

Sexually transmitted infections rank substantially higher than the national benchmark for Iowa; however, significantly lower than the national benchmark for Lyon County. The teen birth rate is higher in Iowa than the national benchmark, but is significantly lower in Lyon County.

Sexually transmitted infections rank substantially lower than the national benchmark for Iowa and the national benchmark. The teen birth rate is higher in Iowa than the national benchmark but is lower in Lyon County. Maps 6-12 in the Appendix provide county views of the Health Behavior indicators within NW Iowa.

		Lyon County	National Benchmark	IA
Adult smoking	Percent of adults who 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 physical activity, 2008	25%	20%	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	17%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	Unreliable or missing data	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 100,000 females ages 15-19, 2001-2007	16.4	22.0	32.0

Clinical Care

The Clinical Care outcomes indicate that Lyon County has a higher percentage of uninsured adults and youth than the national benchmark, while Iowa as a state has similar percentages as the national benchmark.

The ratio of population to primary care physicians is significantly higher in Lyon County than the national or state benchmark. The ratio of population to mental health providers is much higher in Iowa and Lyon County than the national benchmark. The number of professionally active dentists is lower than the national benchmark in Iowa and Lyon County. Preventable hospital stays are higher than the national benchmark in Iowa and Lyon County.

Diabetes screening in Iowa and in Lyon County is slightly lower than the national benchmark. Lyon County ranks higher than the national benchmark for mammography screenings, while Iowa is slightly under the national benchmark.

		Lyon County	National Benchmark	IA
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.	13%	7%	6%
Primary Care Physicians	Ratio of 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	11,189:1	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
Diabetes screening	Percent of Medicare enrollees with diabetes 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%

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Iowa and Lyon County have a higher high school graduation rate than the national benchmark; however, they have a lower percentage of post-secondary education than the national benchmark.

The unemployment rate was slightly higher in Iowa than the national benchmark during 2009; however, it was below the national benchmark for Lyon County.

The percentage of child poverty is less in Lyon County and Iowa than the national benchmark.

Inadequate social support is lower in Iowa and Lyon County than the national benchmark.

The percentage of children in single parent households is significantly lower in Lyon County than the national benchmark or Iowa.

The number of homicide deaths in Lyon County is not available as data is unreliable or missing. The number for Iowa is almost twice the national benchmark for 2001-2007.

Maps 21-27 in the Appendix provide county views of the Social and Economic indicators within the five-state region.

		Lyon County	National Benchmark	IA
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 rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	Unreliable or missing data	1.0	1.9

Physical Environment

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked slightly below the national benchmark, but significantly better than Iowa as a whole.

Access to recreational facilities ranks similar to the national benchmark for Lyon County but lower than the benchmark for Iowa data in 2008.

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

		Lyon County	National Benchmark	IA
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	10
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
Youth account for 27% of the population in Lyon County. Elderly account for 17% of the population in Lyon County. One hundred percent (100%) of Lyon County is rural compared to 39% of Iowa and 21% as the national benchmark. Only 1% of Lyon county residents and 3% of Iowans are not proficient in English compared to the national benchmark, which is 9%. Lyon County and Iowa have a low illiteracy rate (8%) compared to the national benchmark of 15%.

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

		Lyon County	National Benchmark	IA
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 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%

Population by Age
County Aging Profile data is included in the Appendix. The population for this area has 3% older than 85 years of age and 17% older than 65 years of age. The state of Iowa has 15% over 65 and 3% over the age of 85 years of age.

The gender distribution is 50-50 in Lyon County and in the state of Iowa.

	Lyon County	Iowa
Total population	11,581	3,046,355
Percent ages 65 and older	17%	15%
Percent 85 and older	3%	3%
Percent male	50%	50%
Percent female	50%	50%

Based on 2010 Census data

Housing
A significant number of individuals (83%) in this region own their homes.

	Lyon County	Iowa
Percent of occupied housing that is owner-occupied	83%	72%
Percent of occupied housing that is renter-occupied	17%	28%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 69% in Iowa and 72% in Lyon County. The percentage of those who are living at less than 100% of the Federal poverty level is 12% in Iowa and significantly less in Lyon County (6%). Twenty-eight percent (28%) of Lyon County residents and 29% of Iowans are at less than 200% of the Federal poverty level.

The median household income in Iowa is $47,872 with Lyon County at $49,506 median annual income.

	Lyon County	Iowa
Percent of working age population in the labor force	72%	69%
Percent of total population with income less than 100% of poverty	6%	12%
Percent of total population with income less than 200% of poverty	28%	29%
Median household income	$49,506	$48,872
Owner occupied housing units	3,576	889,912
Percent spending 30% or more income toward housing costs	18%	20%
Renter occupied housing units	789	326,042
Percent renters spending 30% or more of income toward housing costs	17%	40%

Diversity Profile

The population distribution by race demonstrates that Lyon County is significantly white (98%), followed by Hispanic. Iowa is slightly more diverse with 91% white followed by Hispanic. (See Appendix)

	Lyon County	Iowa
Total population	11,581	3,046,355
White alone	11,340	2,781,561
Asian alone	25	53,094
Black alone	10	89,148
Hispanic origin – of any race	212	151,544
American Indian	9	11,084

Health Needs Identified

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

- Facility upgrades to enhance quality and health care access
- Increase knowledge and awareness of services available within the community
- Obesity specific to poor nutrition, inactivity and chronic disease and care coordination for these services
- Mental health and care coordination for mental health services

Community Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. An informal gap analysis was conducted at the conclusion of the asset mapping work. Identified needs that were related to other groups within the community will be shared with that group.

Table 4 in the Appendix displays the concerns and assessed needs that were determined by the assessment and includes the assets in the community that address the needs.
The priorities that remain include:

- Facility upgrades to enhance quality and health care access
- Increase knowledge and awareness of services available within the community

The Sanford Rock Rapids leadership team is establishing key initiative strategies to address the first two identified needs. Sanford Rock Rapids leadership will be partnering with system leadership from Sanford Health to work on the system level priorities of obesity and mental health.

Table 5 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 Rock Rapids Implementation Strategy

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

- Facility upgrades to enhance quality and health care access
- Increase knowledge and awareness of services available within the community

Facility Upgrades to Enhance Quality and Health Care Access

Work related to this need will be done jointly by the Sanford Rock Rapids leadership team, Sanford Health Network, and MPCH Association Board as the MPCH Association Board maintains ownership of the building and grounds.

- Develop bridge plan for existing facility to maintain patient safety through reinvestment of lease proceeds during renovation/construction
- Review existing renovation plan and evaluate other options for facility changes with the MPCH Association
- Review existing construction finance plan and update financing plan to account for market changes (comparing budgeted performance with actual performance) /building program changes
- MPCH Association and Sanford Health Network communicate and agree on plan to upgrade facility infrastructure

Increase Knowledge and Awareness of Services Available within the Community

- Internal team to analyze available resources and determine how to access resources
- External group/Lyon County Collaborative to review existing list of community resources and determine modifications that need to be made
- Design/print resource materials with Sanford marketing
- Share resource tool with key community stakeholders/access points to care

2013 Community Health Needs Assessment
Enterprise Implementation Strategy

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

- Mental Health Services
- Obesity

Implementation Strategy: Mental Health Services - Sanford One Mind

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

Implementation Strategy: Obesity

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

APPENDIX

2011 County Health Profile

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

Lyon County
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				
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%	8%
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%

2011 County Health Profile (Page 2)

Lyon County
Iowa

HEALTH FACTORS (continued)		Lyon	*National Benchmark	Iowa
Social and Economic Factors				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	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				
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

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

Lyon County
Iowa

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	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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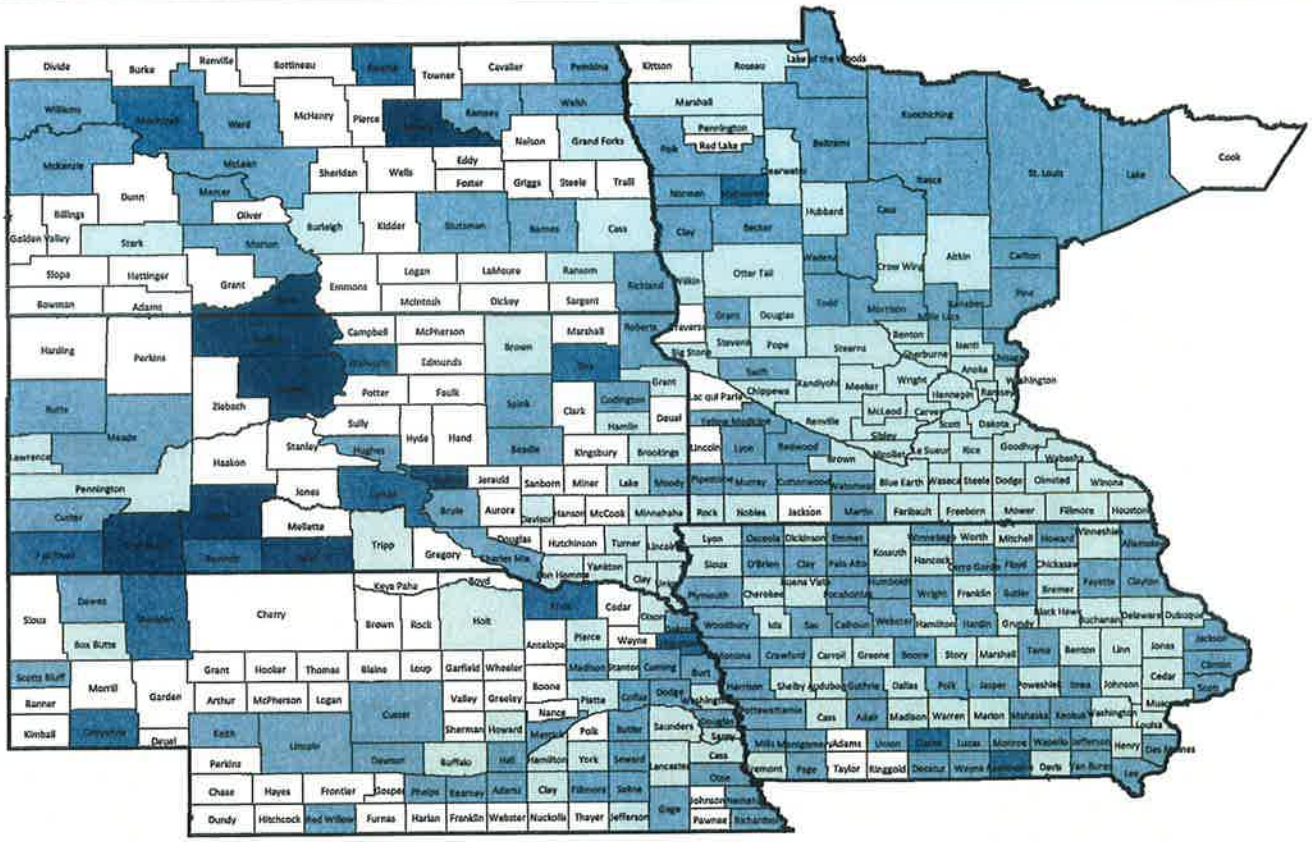
Map 1

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/.

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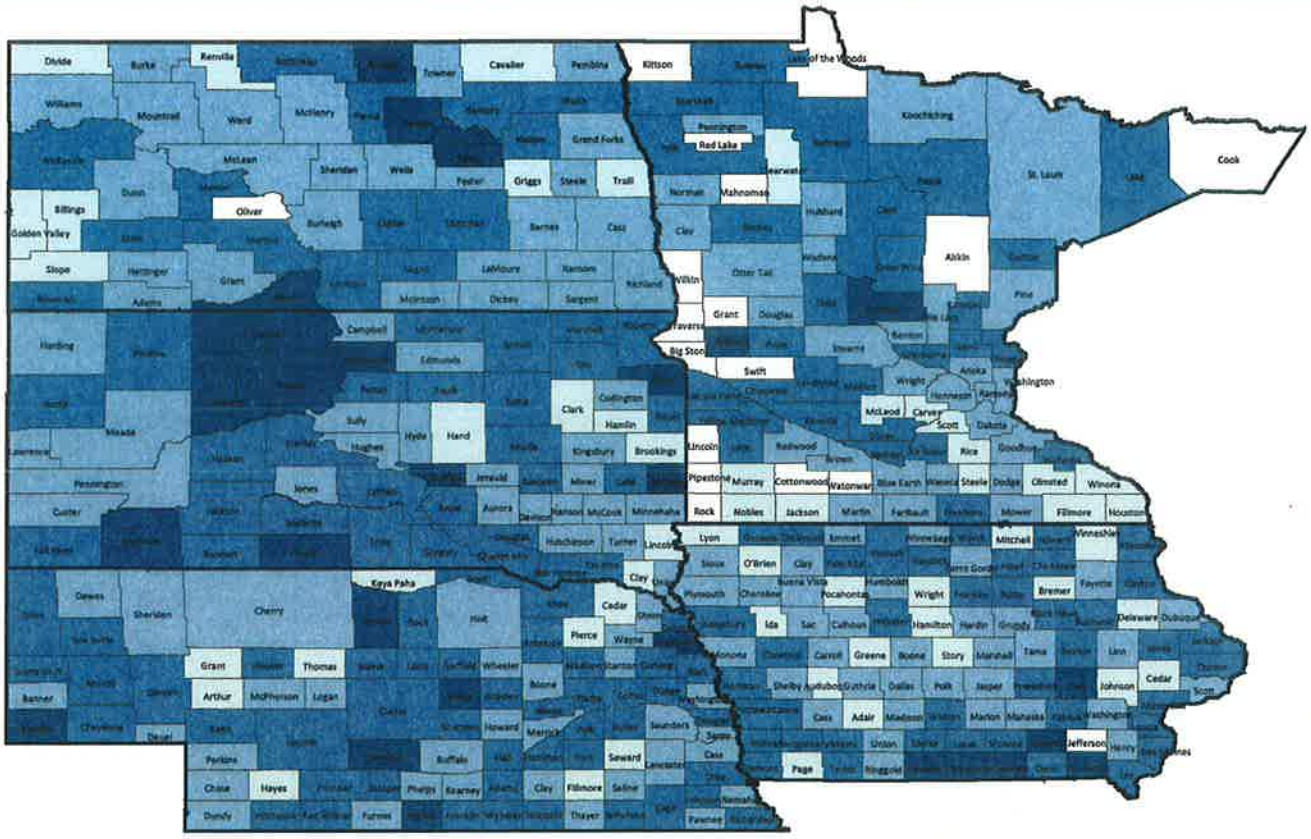
Poor or Fair Health - A health outcome measure focusing on morbidity

Map 2

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/.

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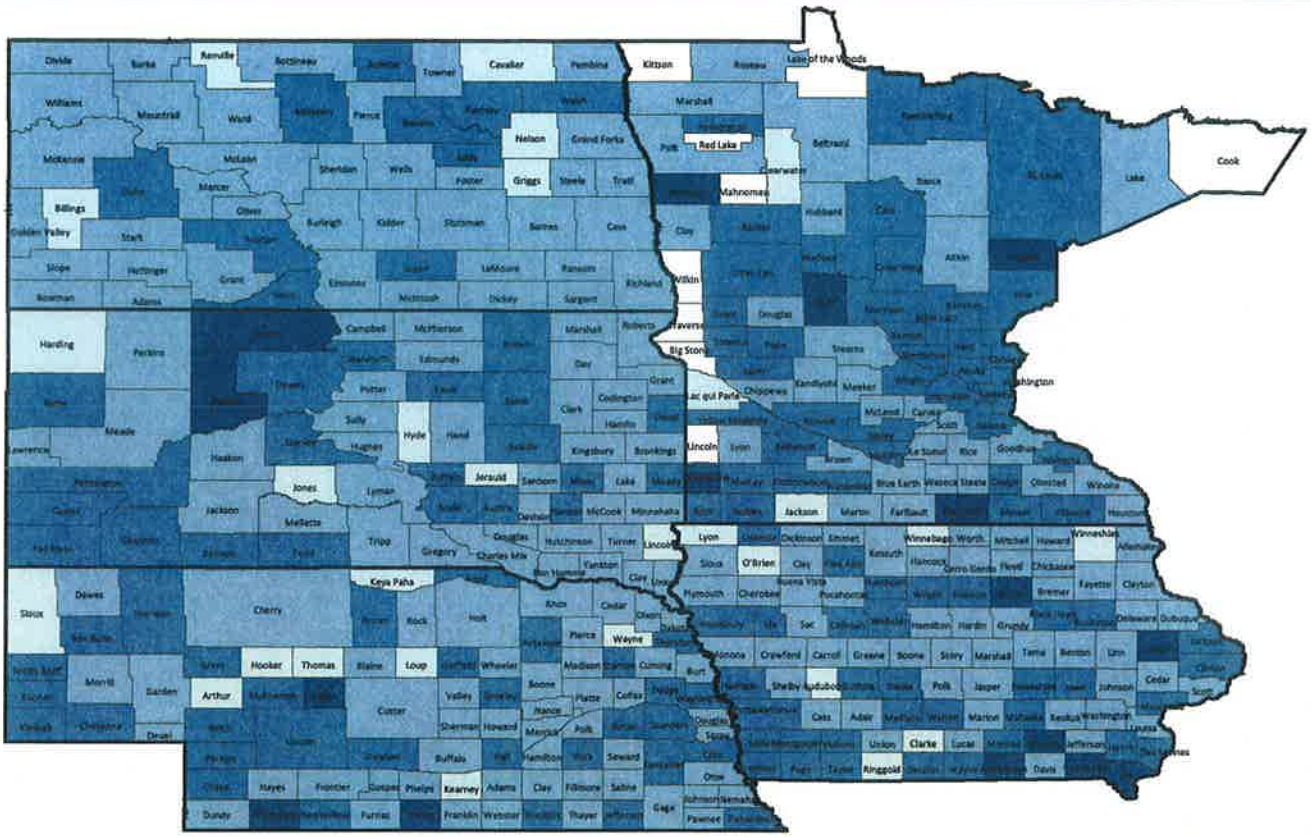
Map 3

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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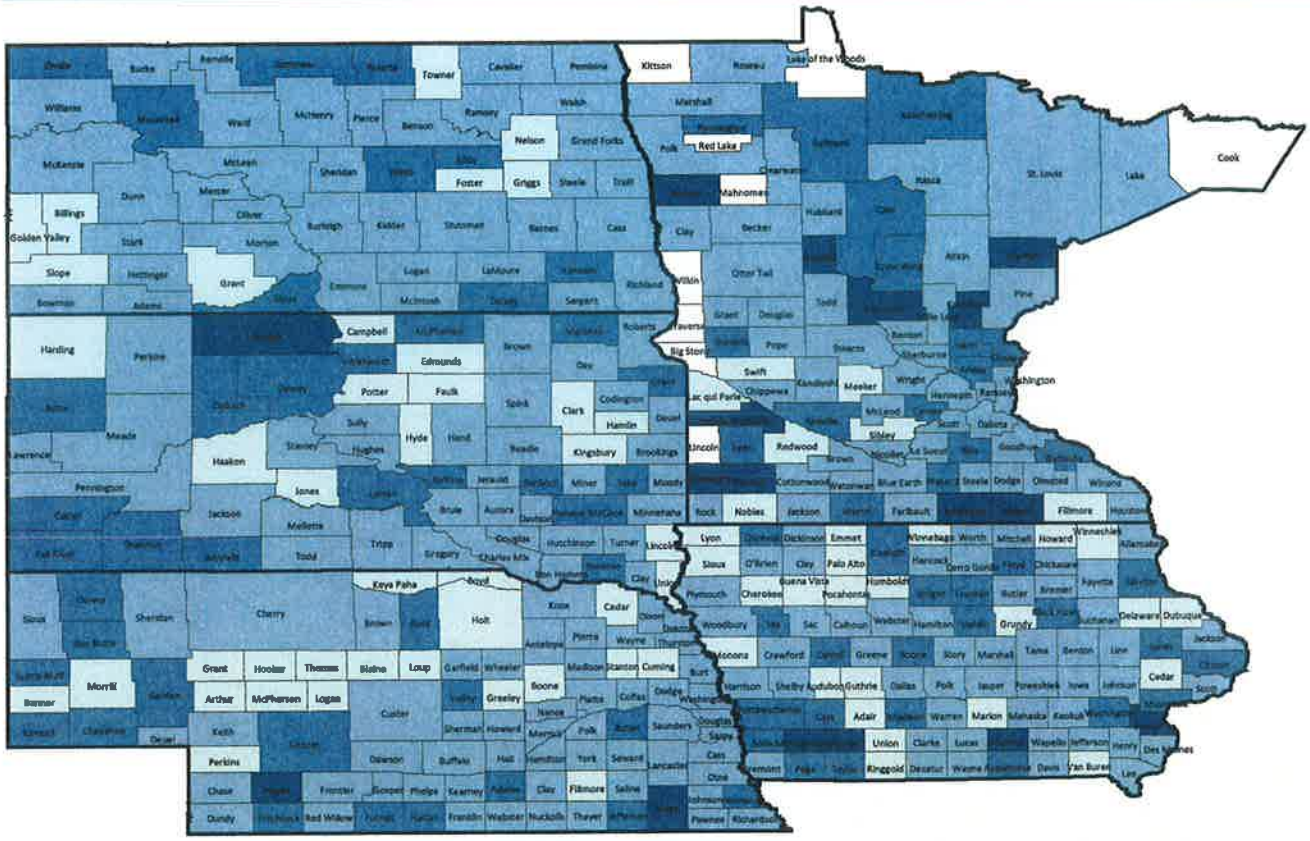
Map 4

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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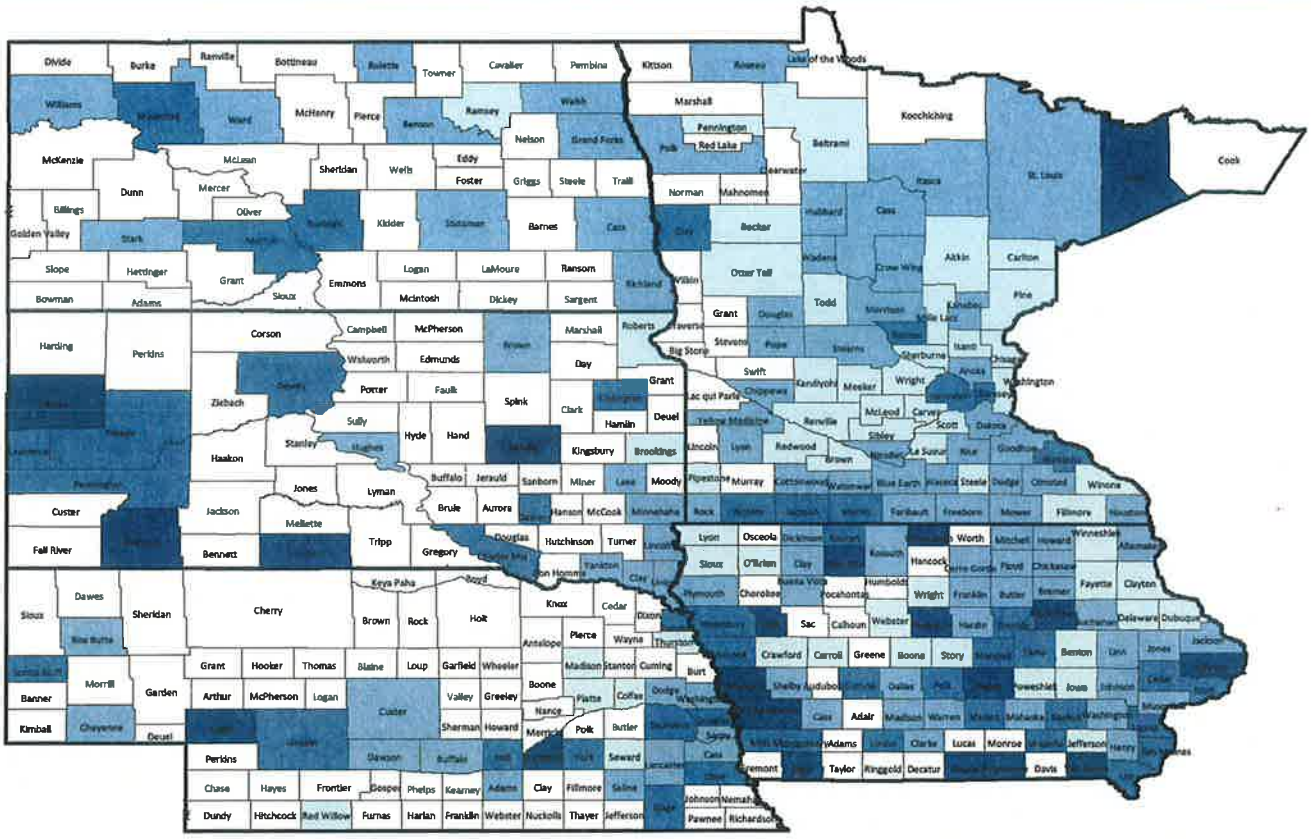
Low Birthweight - A health outcome measure focusing on morbidity

Map 5

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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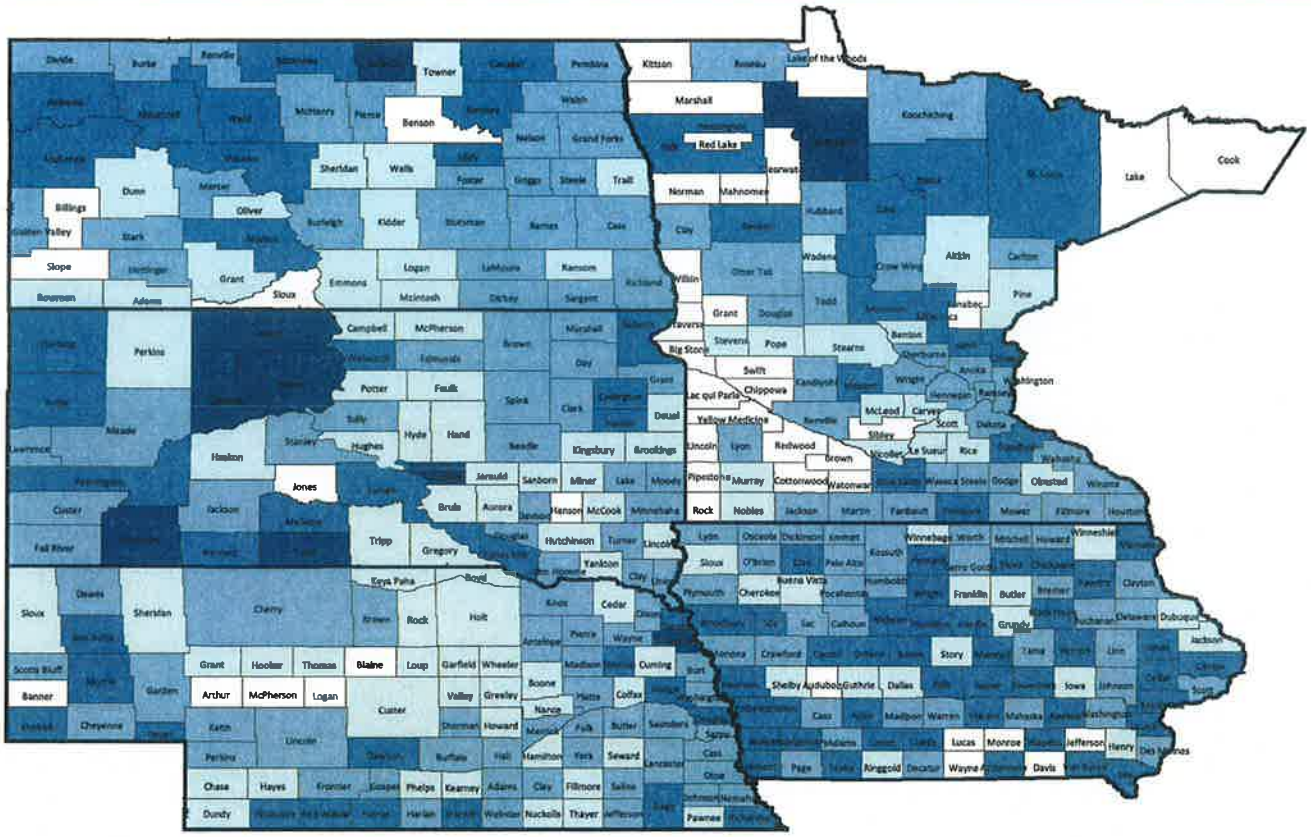
Map 6

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/.

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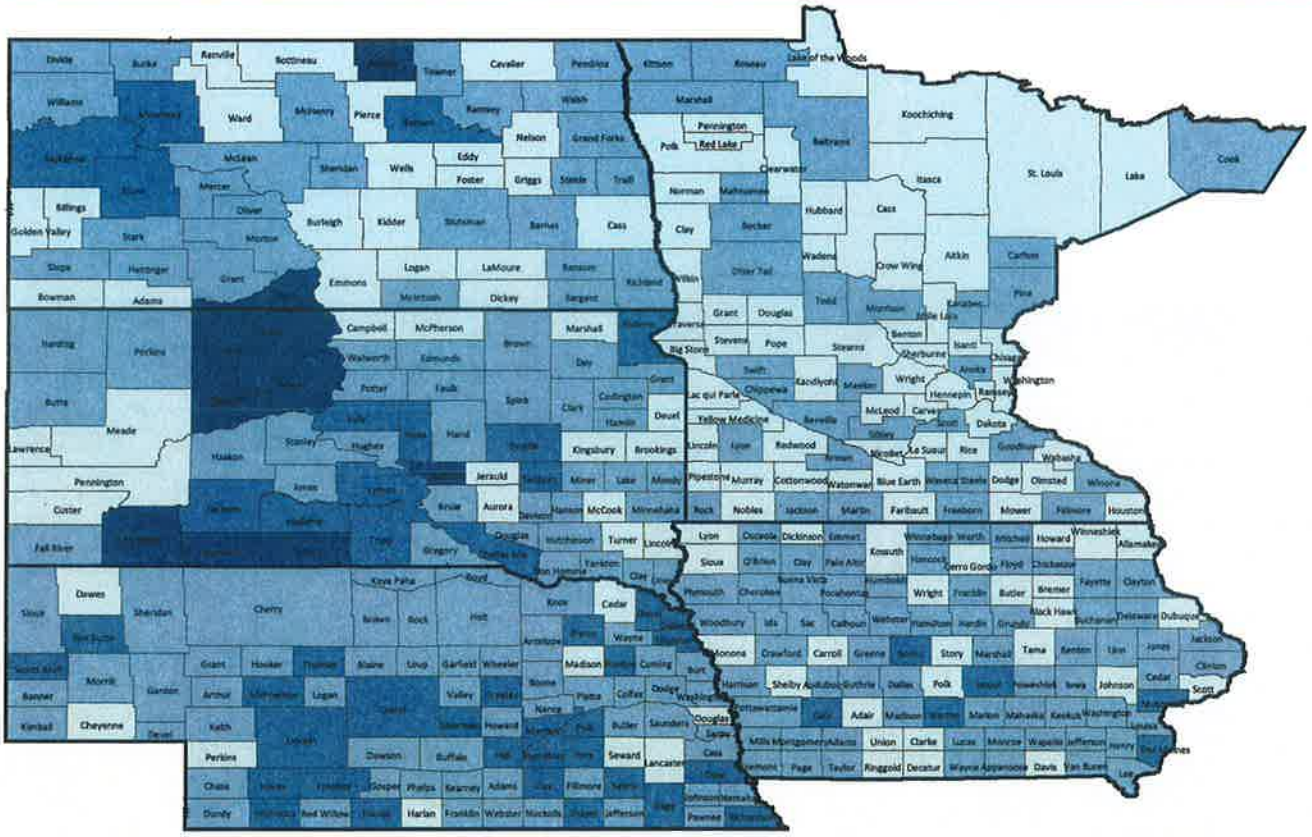
Map 7

Adult Obesity - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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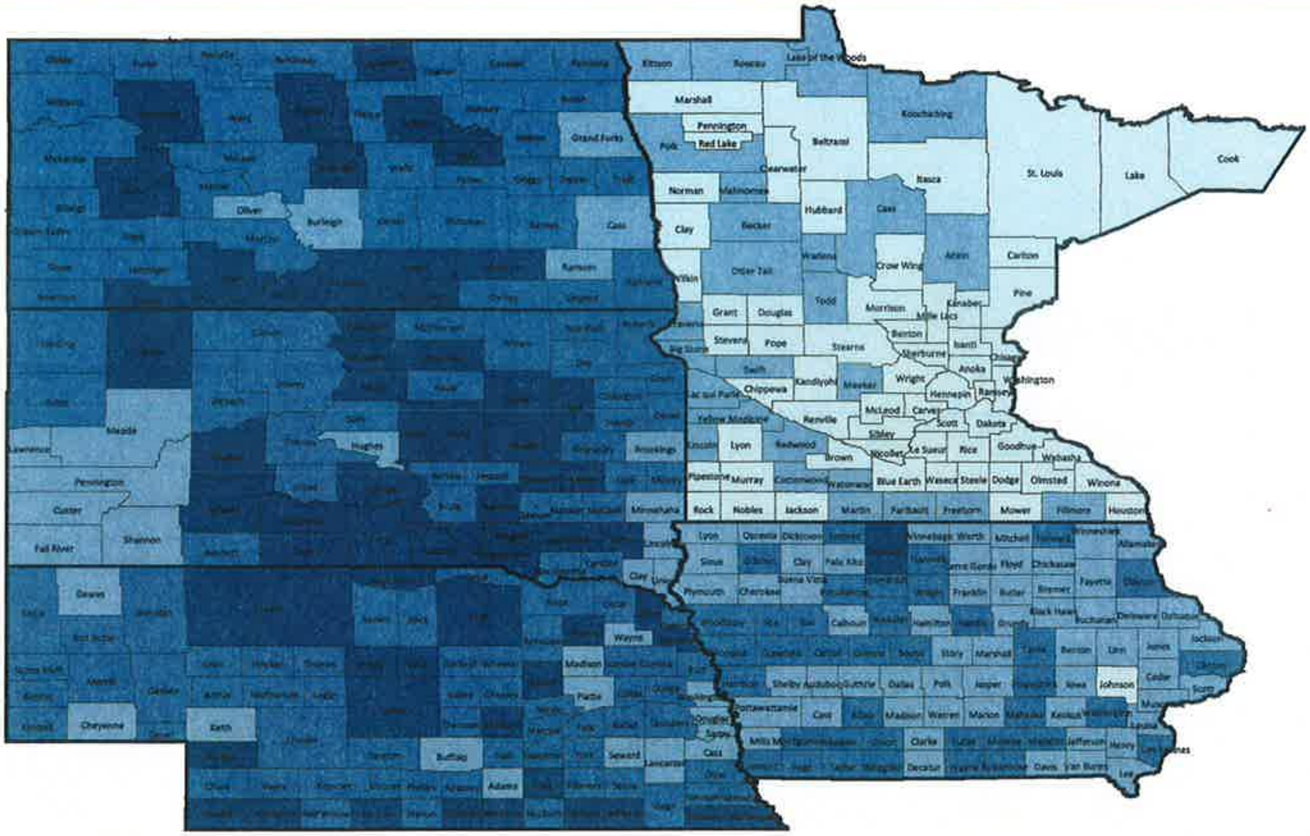
Physical Inactivity - A health factor measure focusing on health behaviors

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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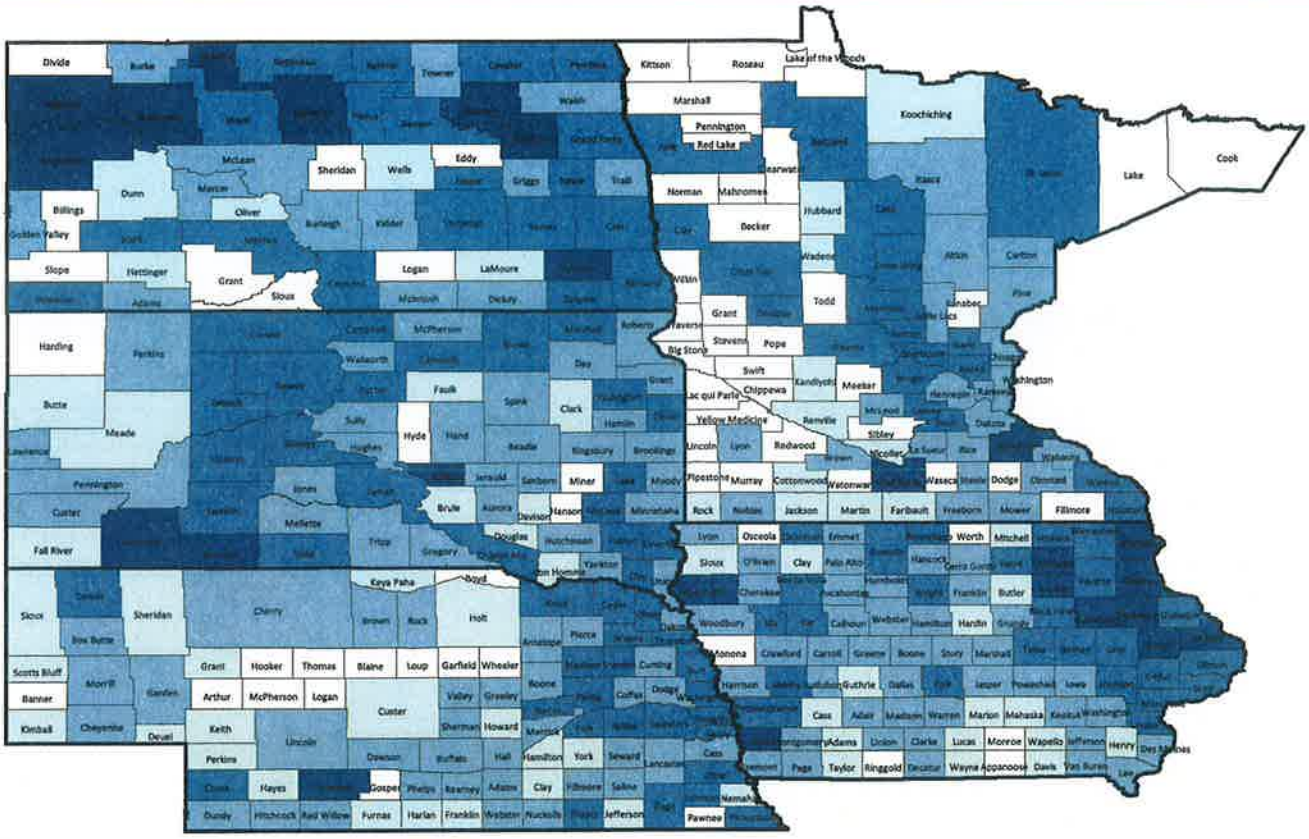
Map 9

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.

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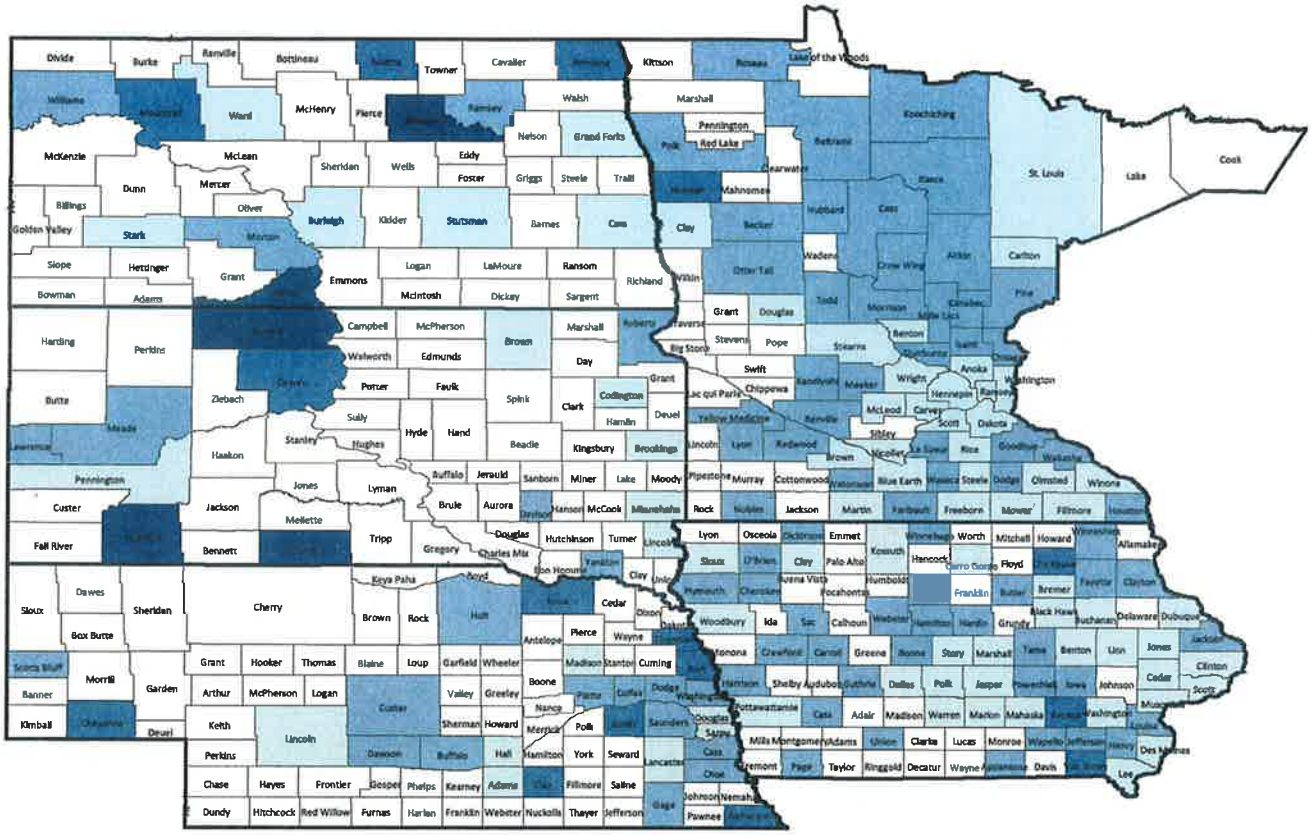
Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

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



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

- 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/.

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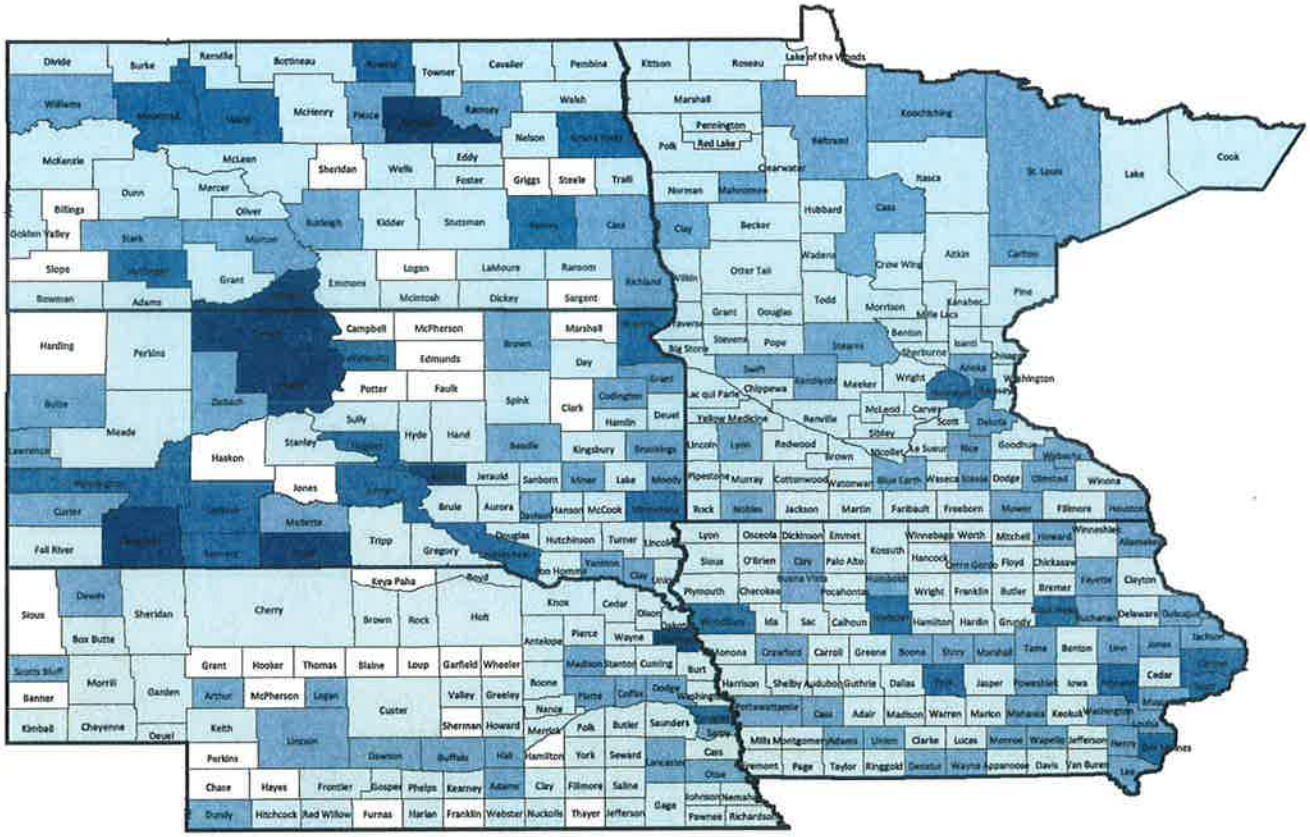
Sexually Transmitted Infections - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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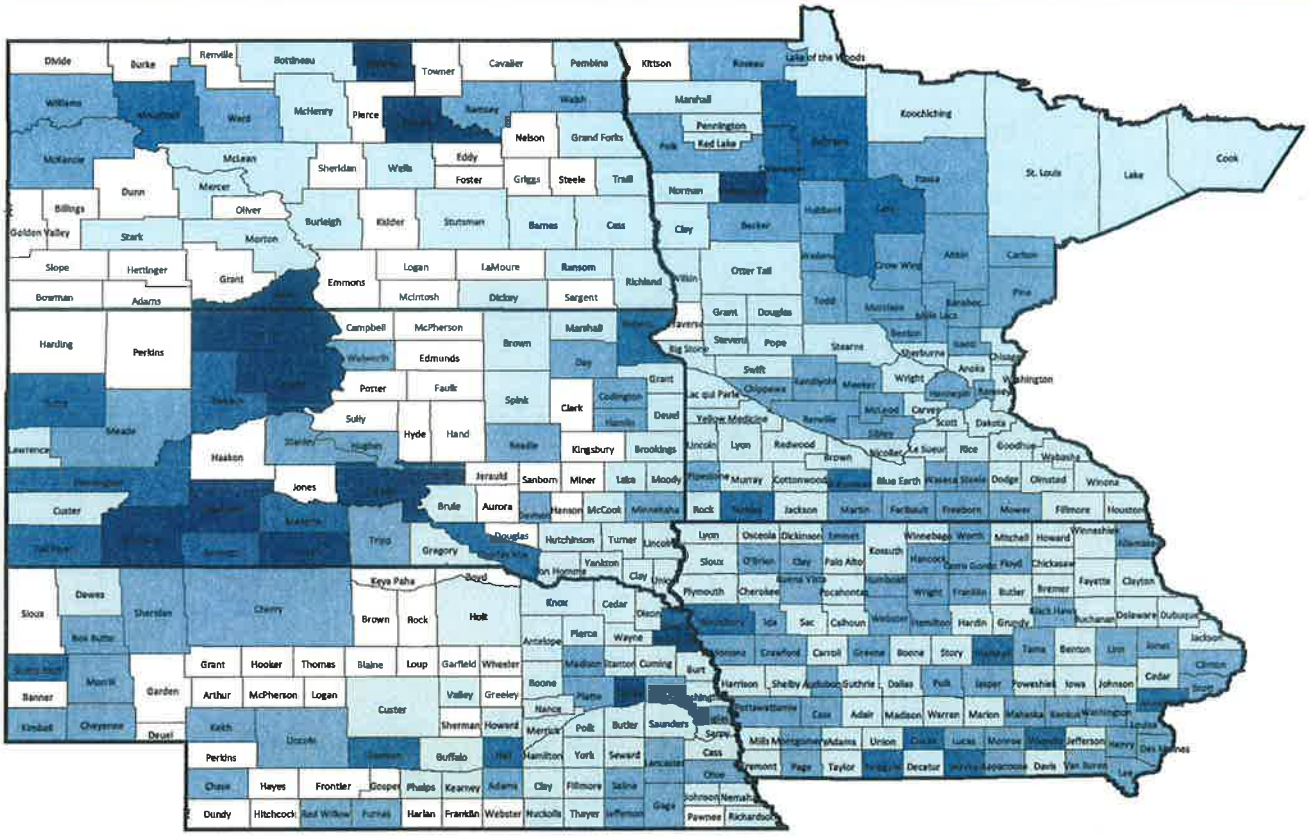
Map 12

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

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



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

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

CONTEXT

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

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

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

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

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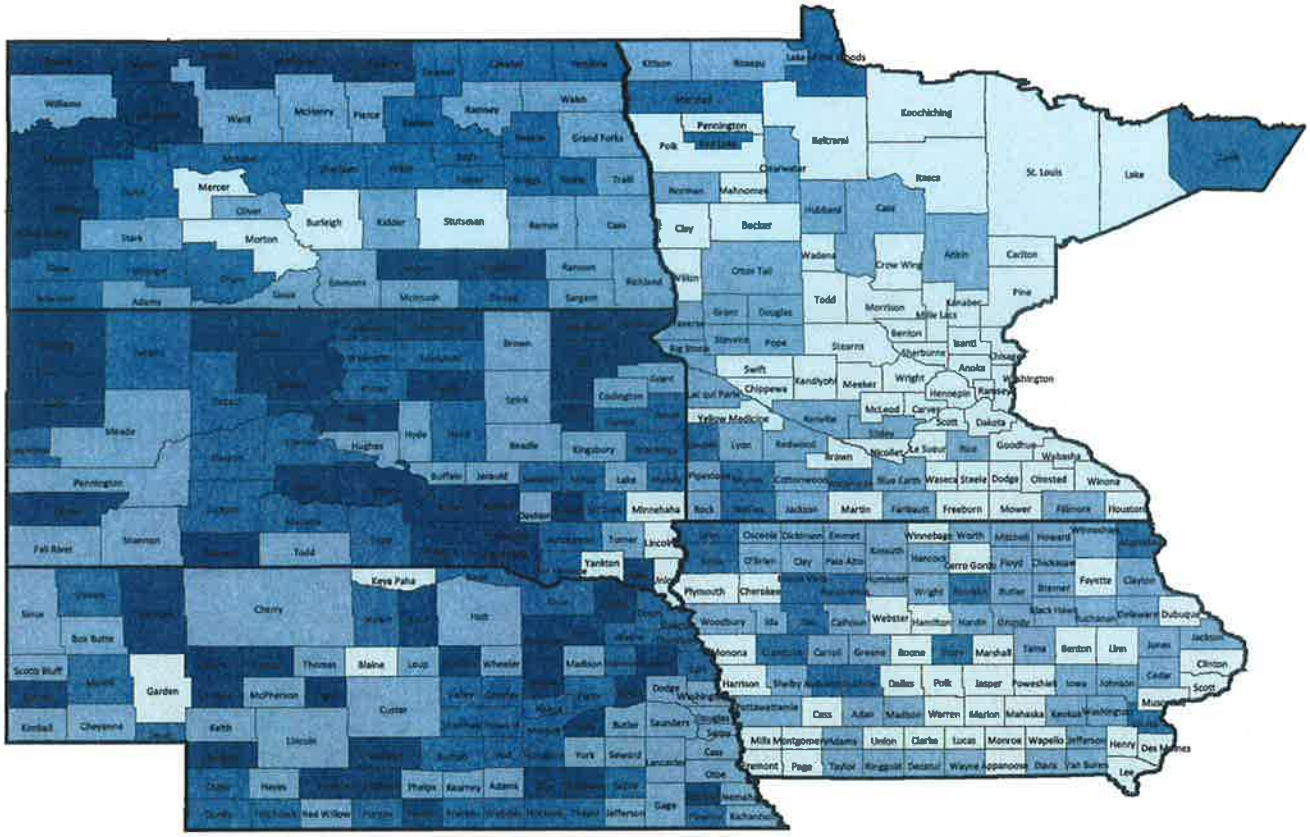
Uninsured Adults - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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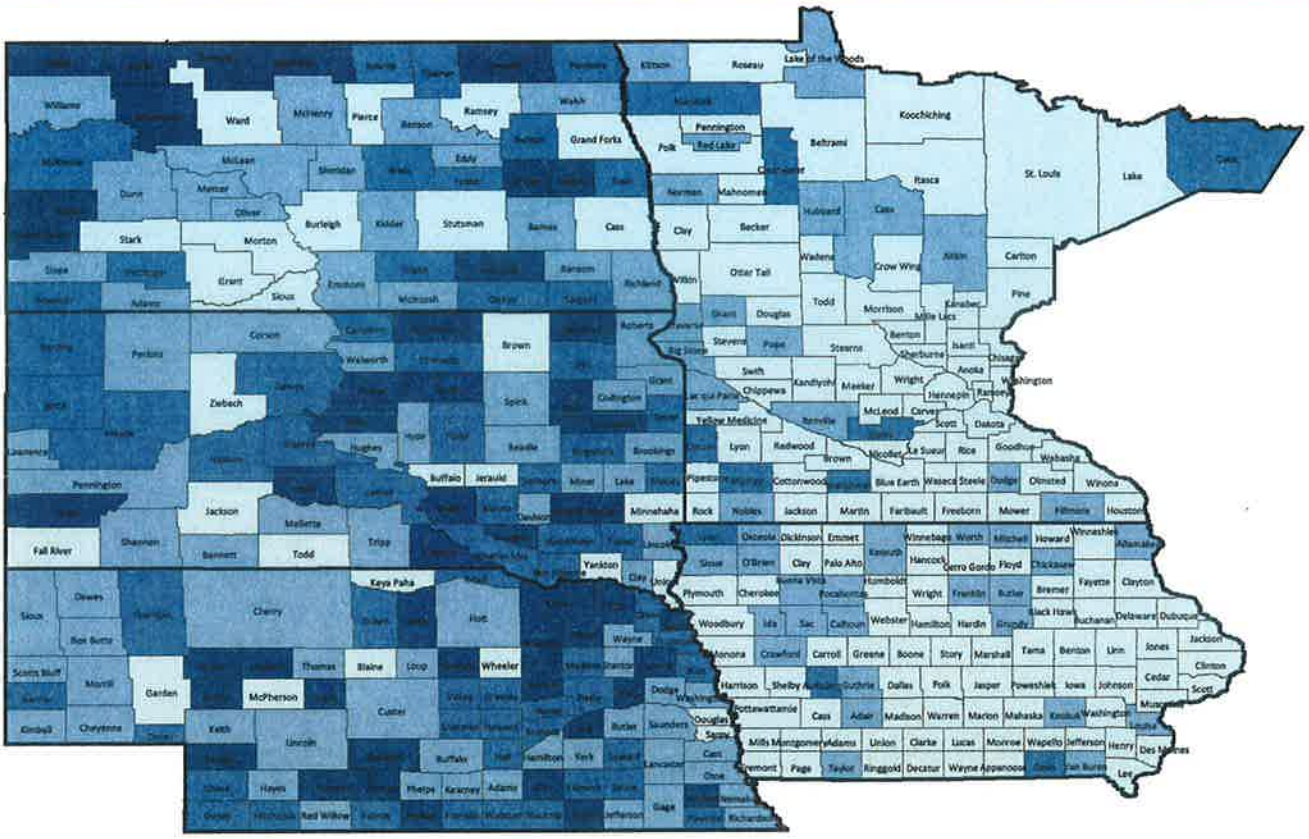
Uninsured Youth - A health factor measure focusing on clinical care

Map 14

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



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

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

CONTEXT

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

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

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

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

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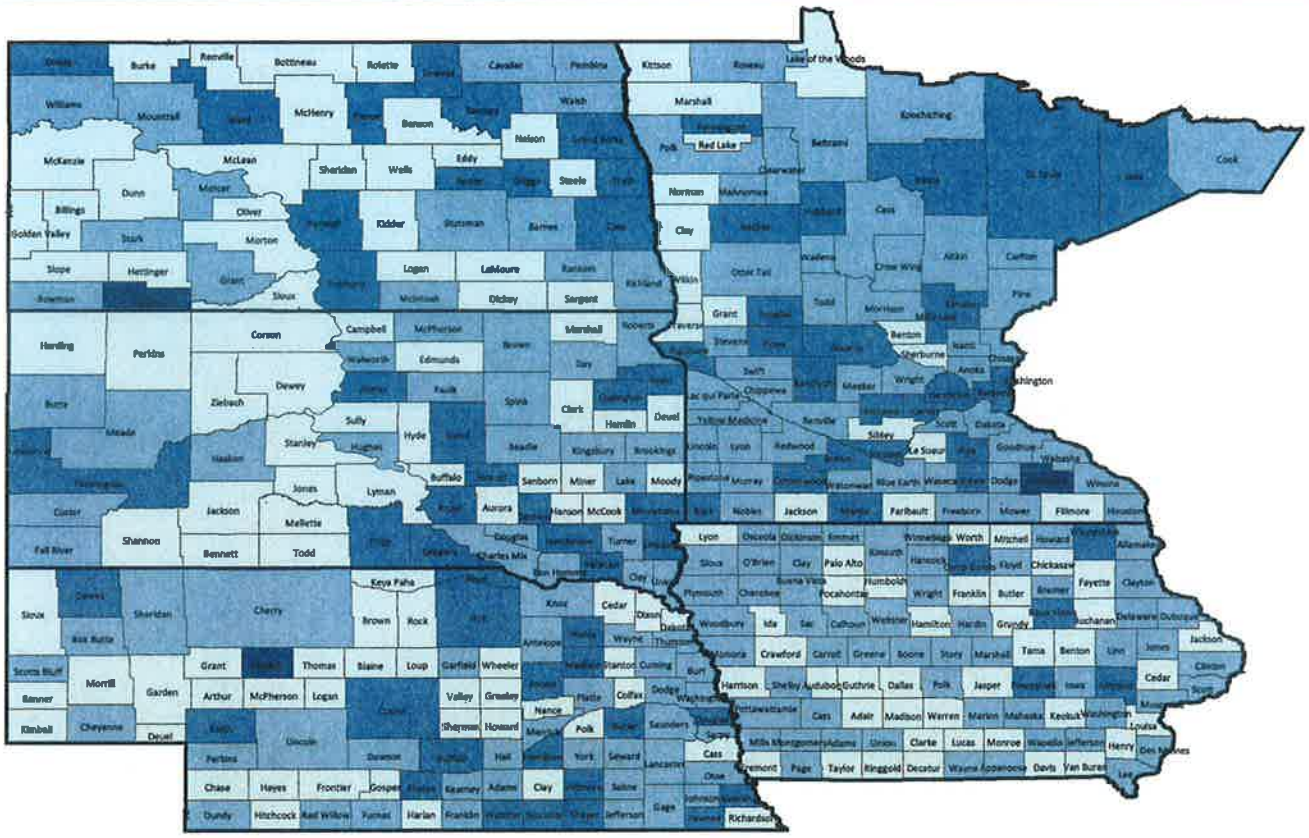
Primary Care Physicians - A health factor measure focusing on clinical care

Map 15

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



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

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

CONTEXT

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

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

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

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

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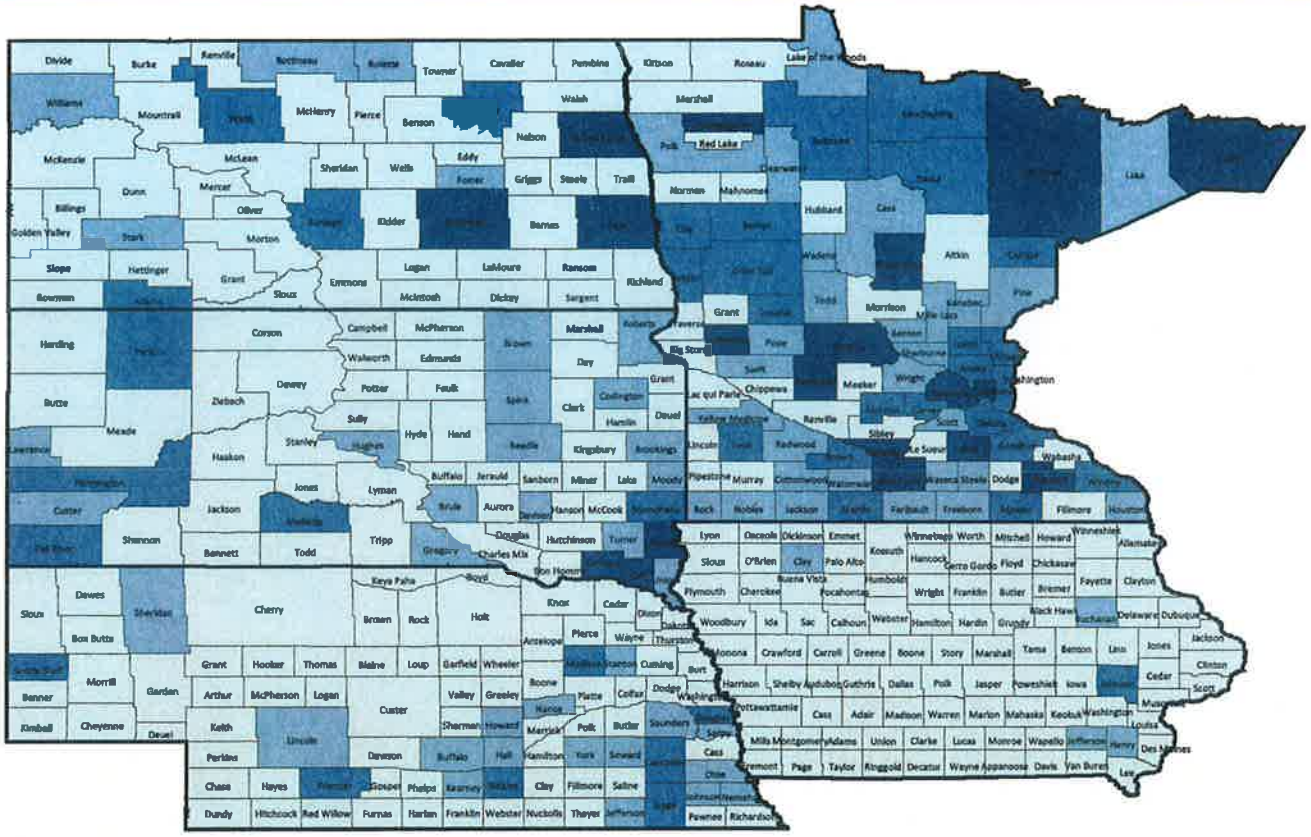
Map 16

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

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



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

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

CONTEXT

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

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

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

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

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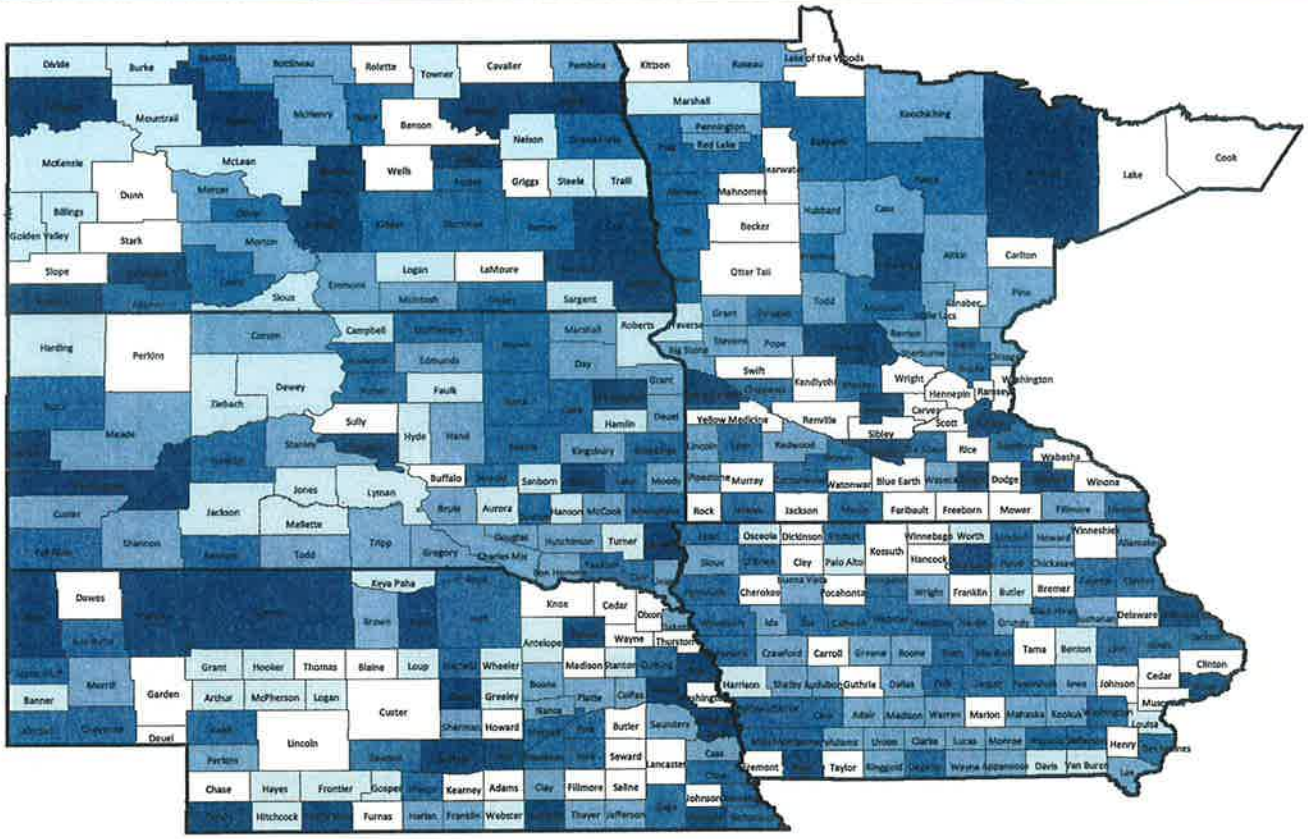
Map 17

Dentist Rate - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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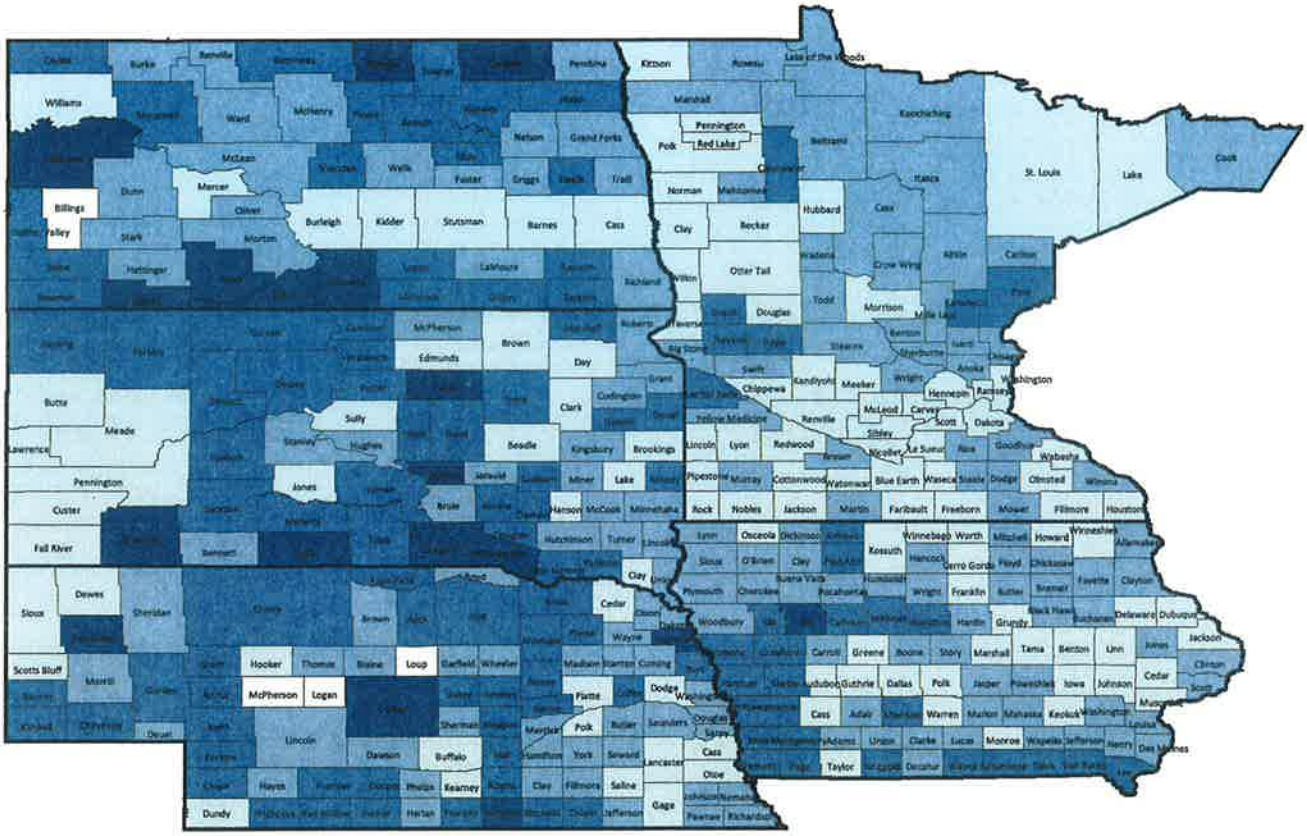
Map 18

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

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



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

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

CONTEXT

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

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

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

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

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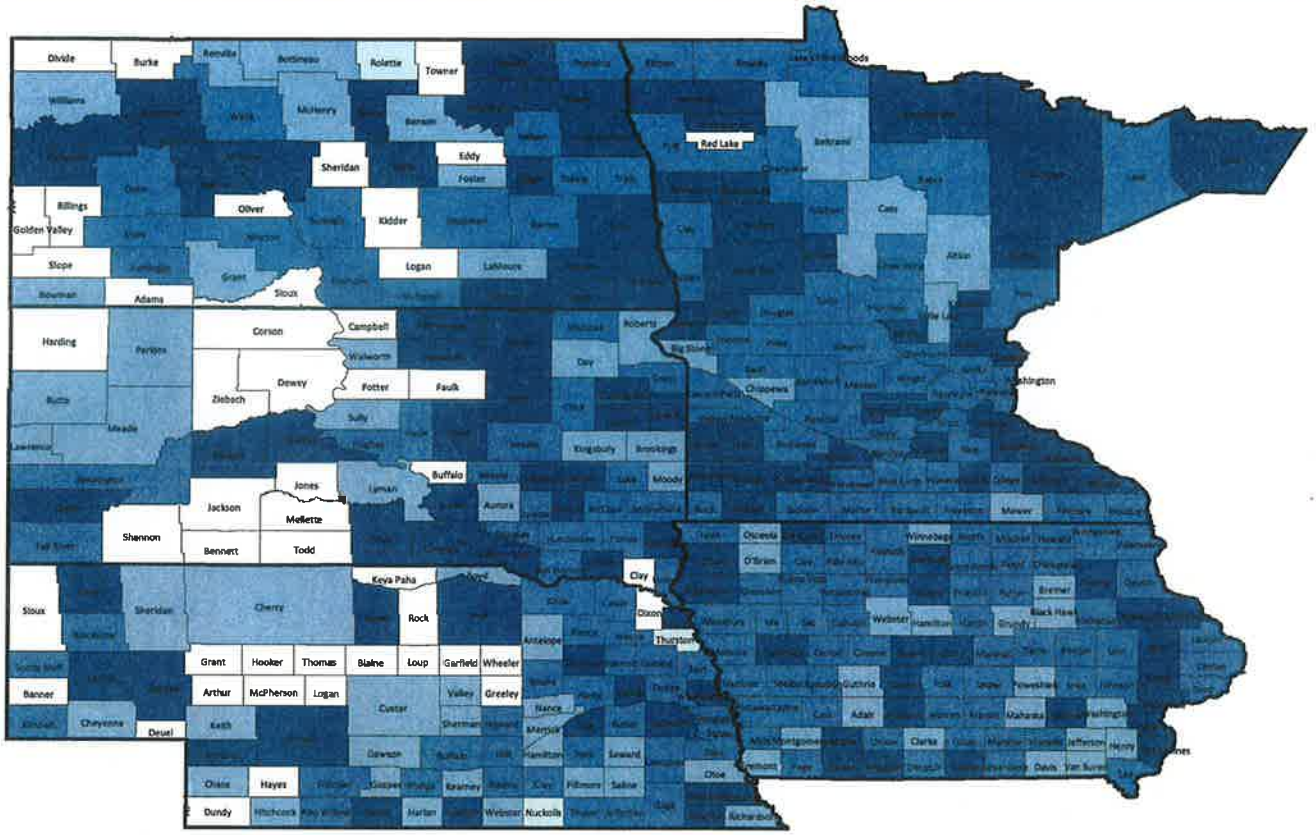
Map 19

Diabetic Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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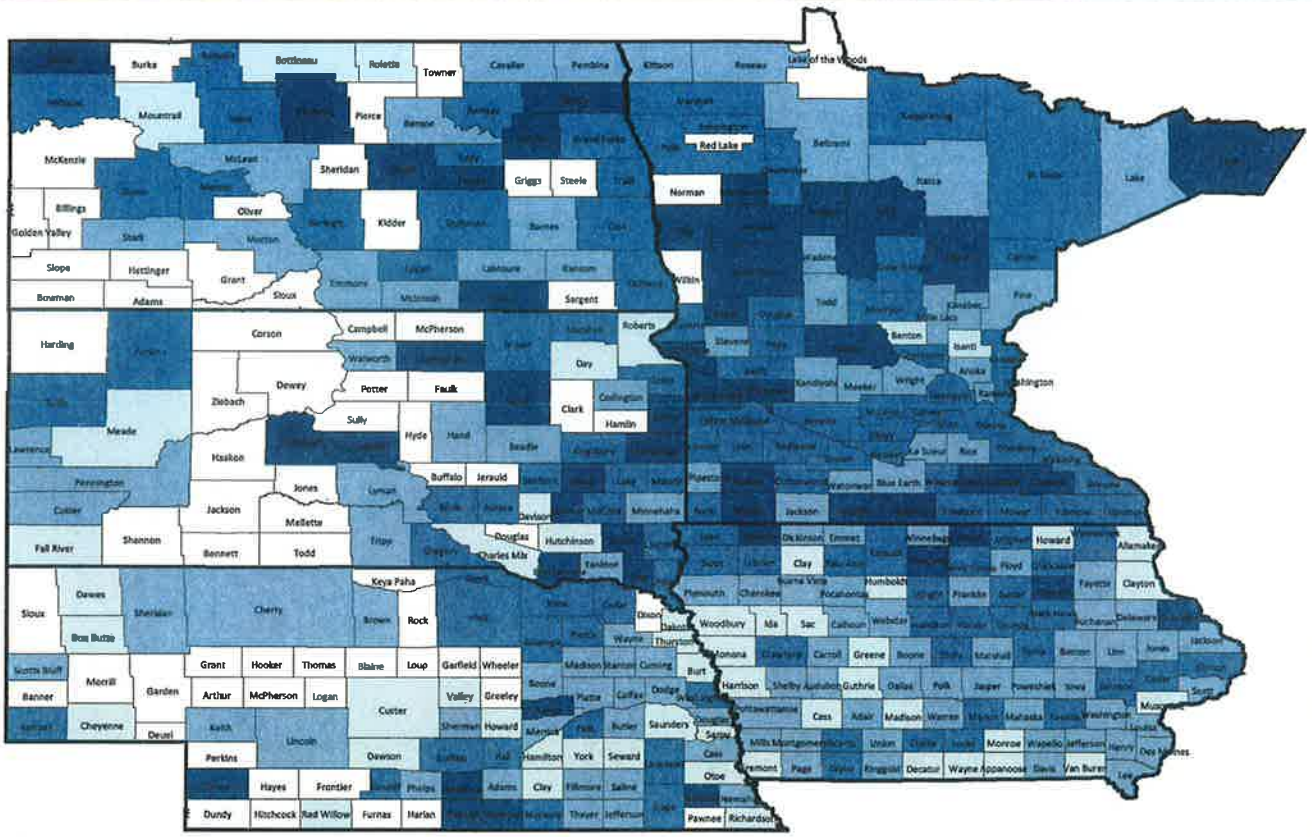
Mammography Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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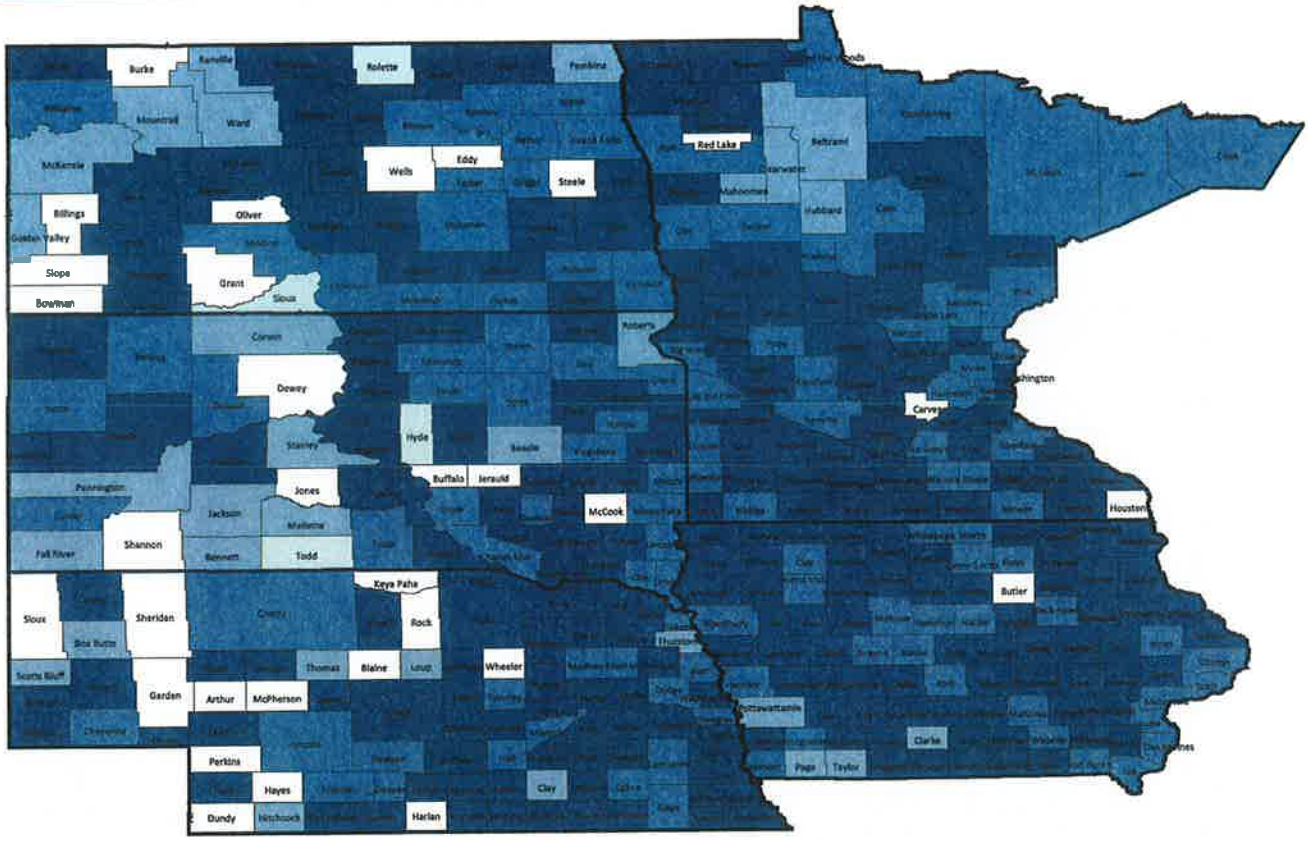
High School Graduation - A health factor measure focusing on educaton

Map 21

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



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

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

CONTEXT

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

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

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

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

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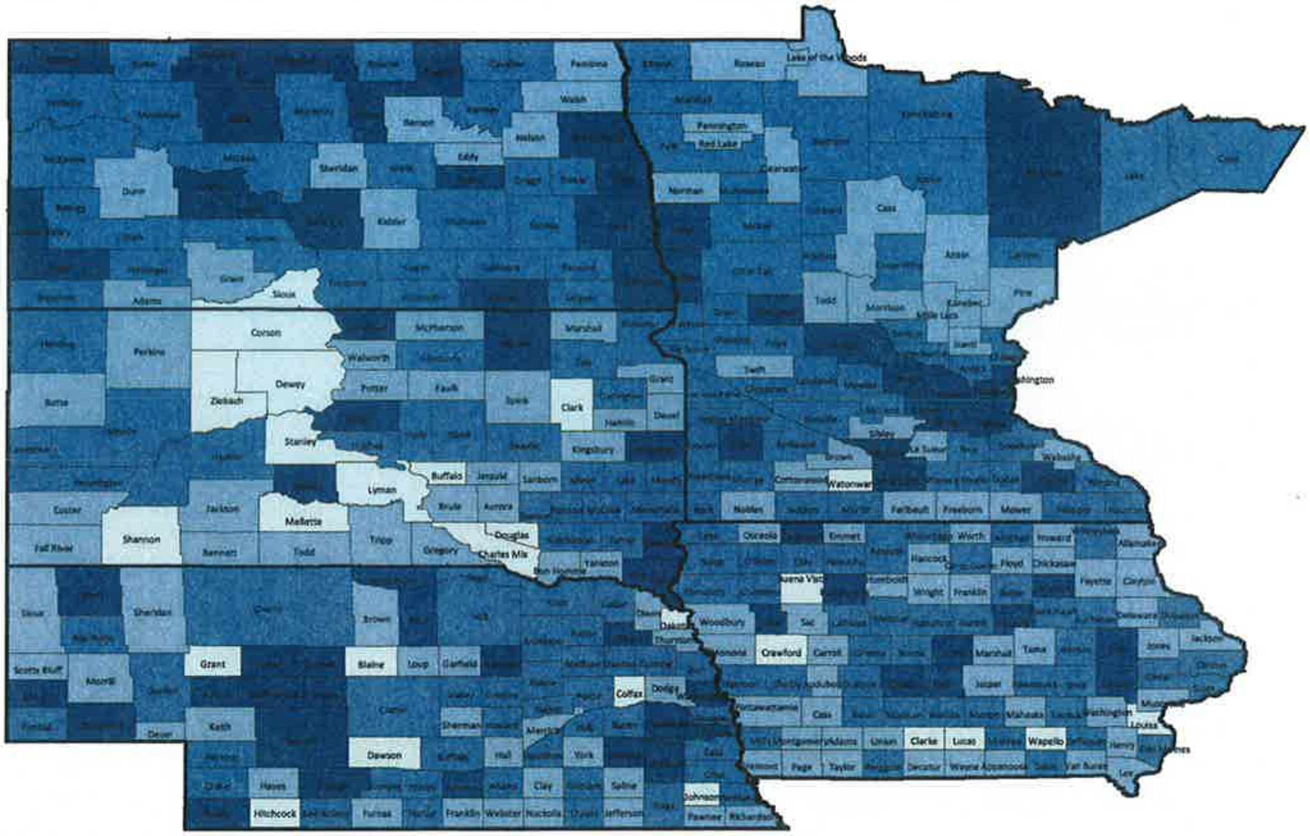
Some College - A health factor measure focusing on education

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



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

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

CONTEXT

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

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

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

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

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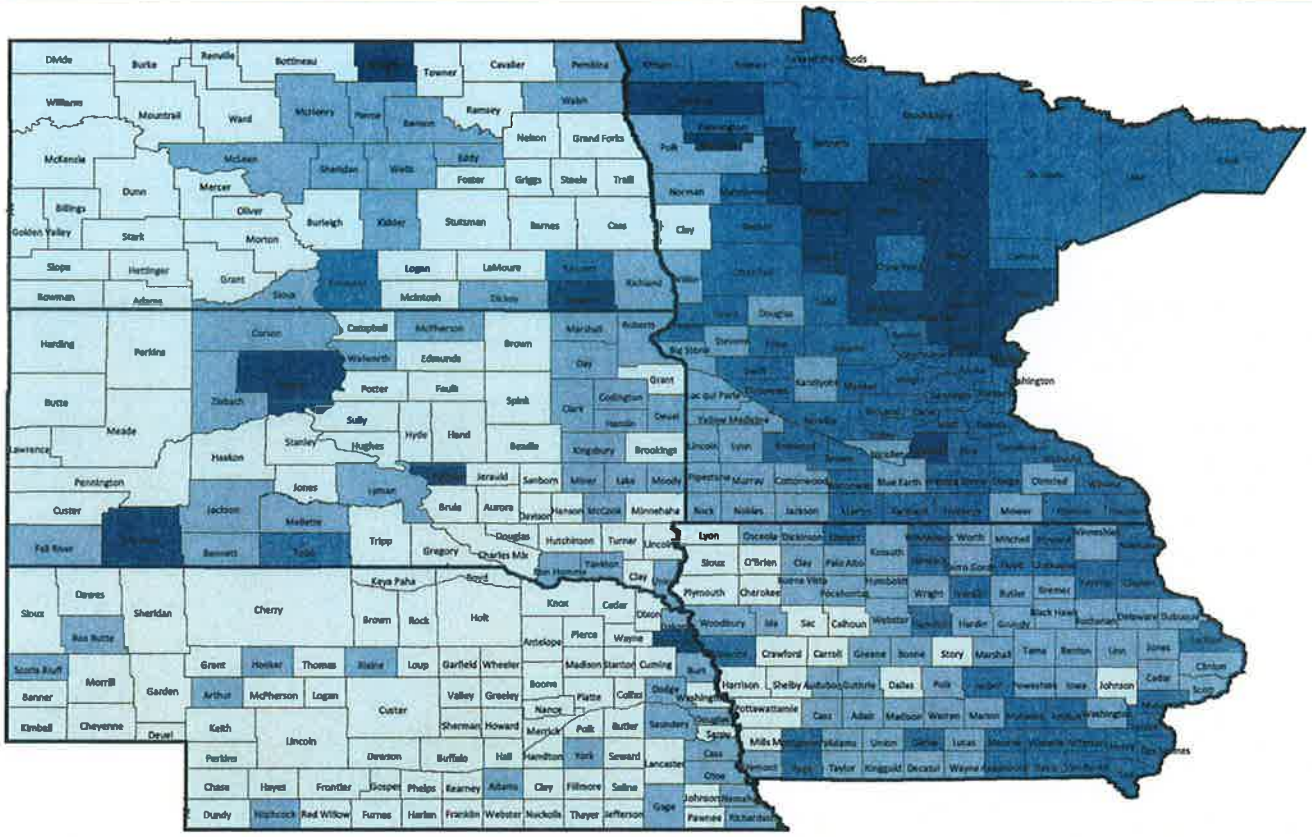
Map 23

Unemployment - A health factor measure focusing on labor

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



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

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

CONTEXT

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

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

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

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

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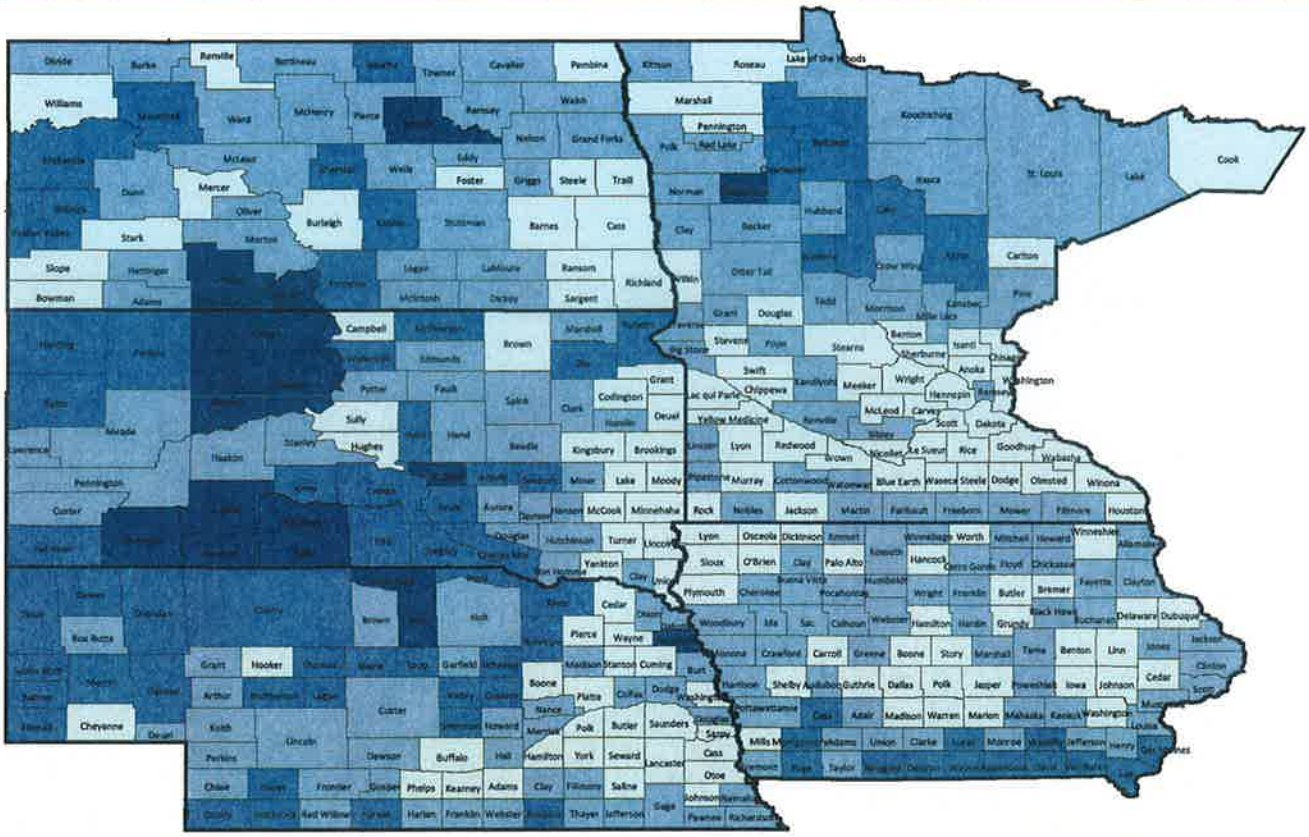
Children in Poverty - A health factor measure focusing on income and poverty

Map 24

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



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

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

CONTEXT

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

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

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

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

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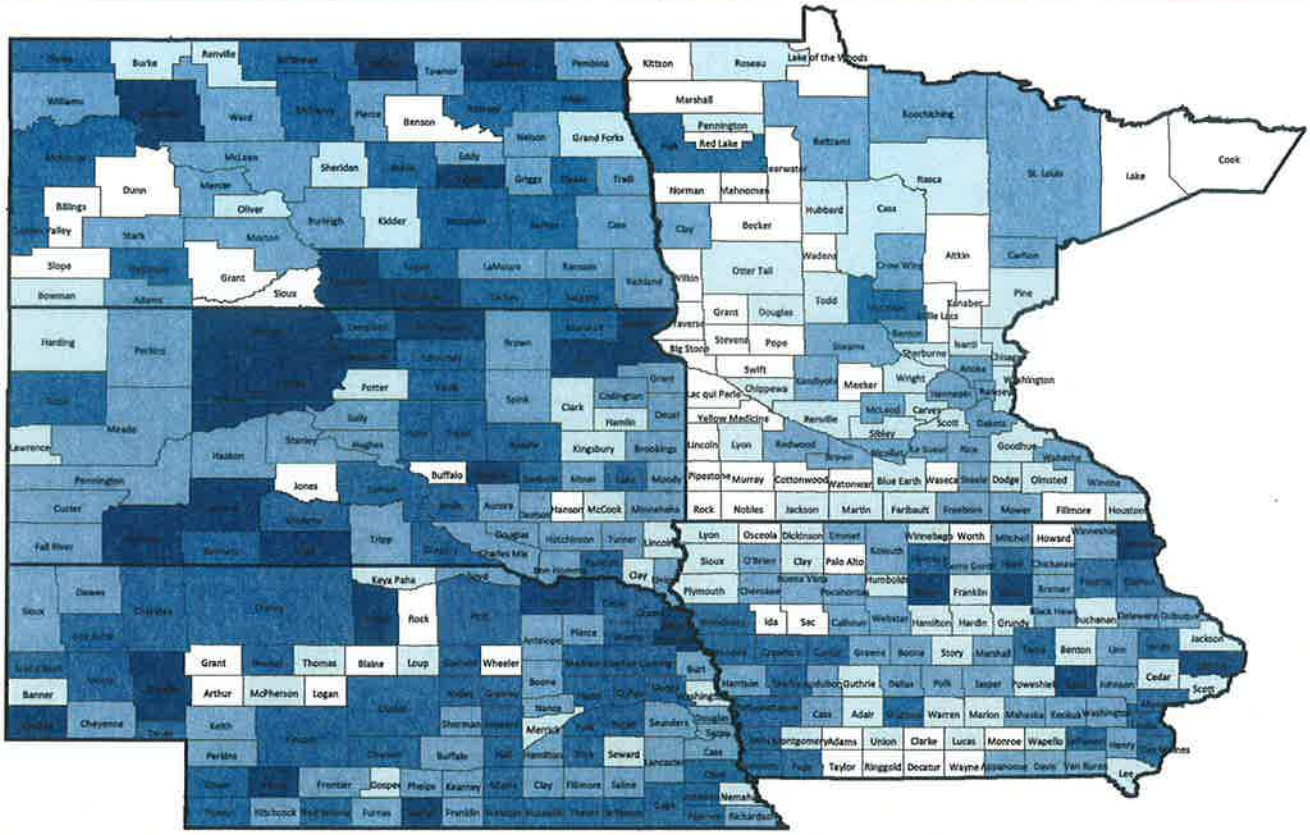
Inadequate Social Support - A health factor measure focusing on social networks

Map 25

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



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

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

CONTEXT

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

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

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

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

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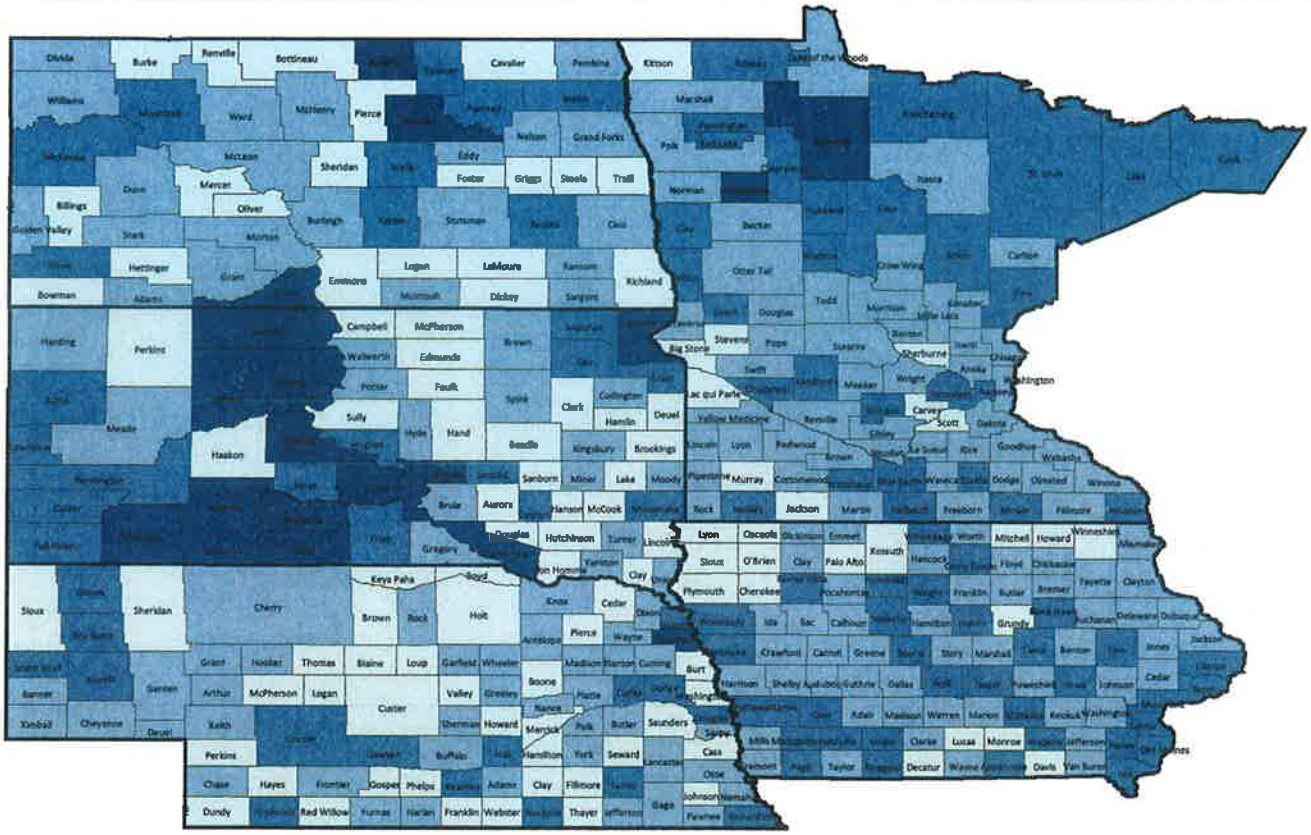
Children in Single-Parent Households - A health factor measure focusing on families

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



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

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

CONTEXT

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

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

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

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

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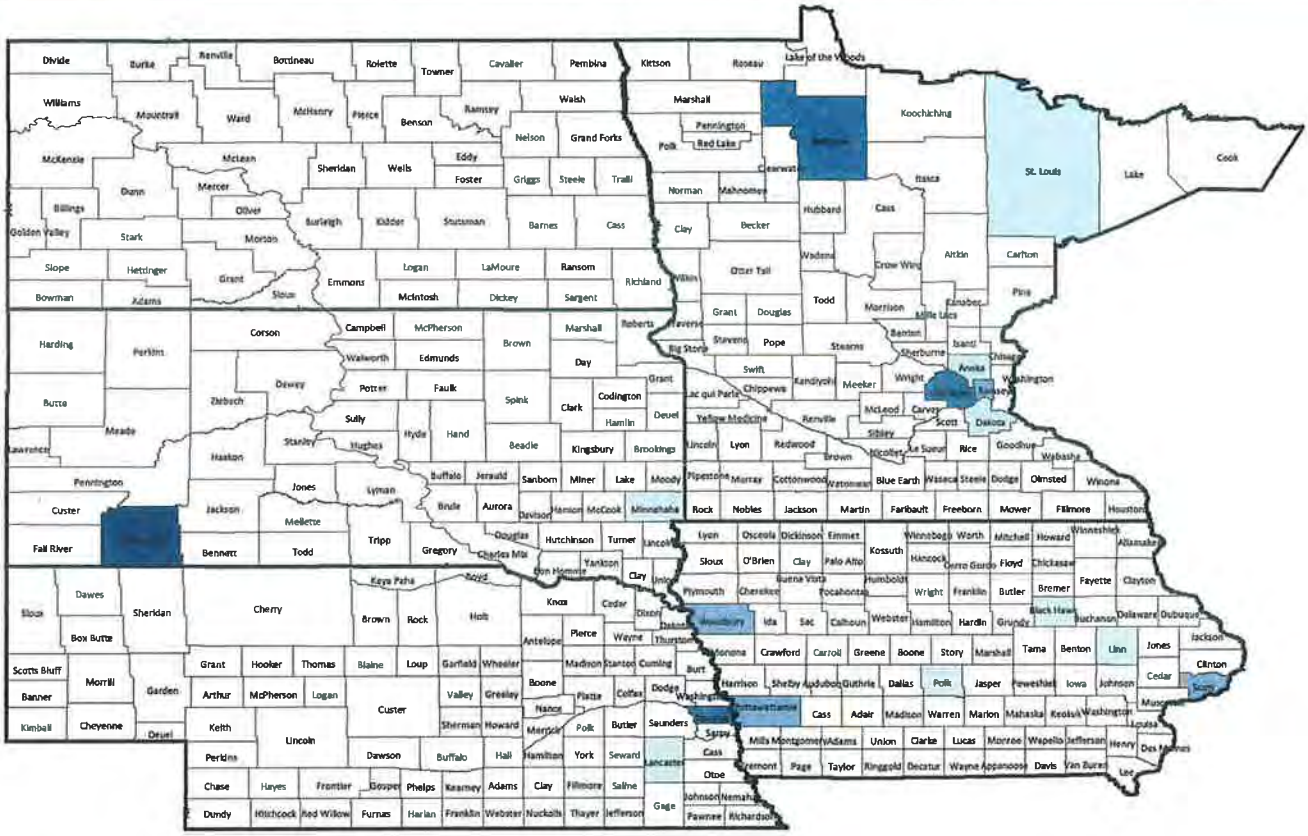
Map 27

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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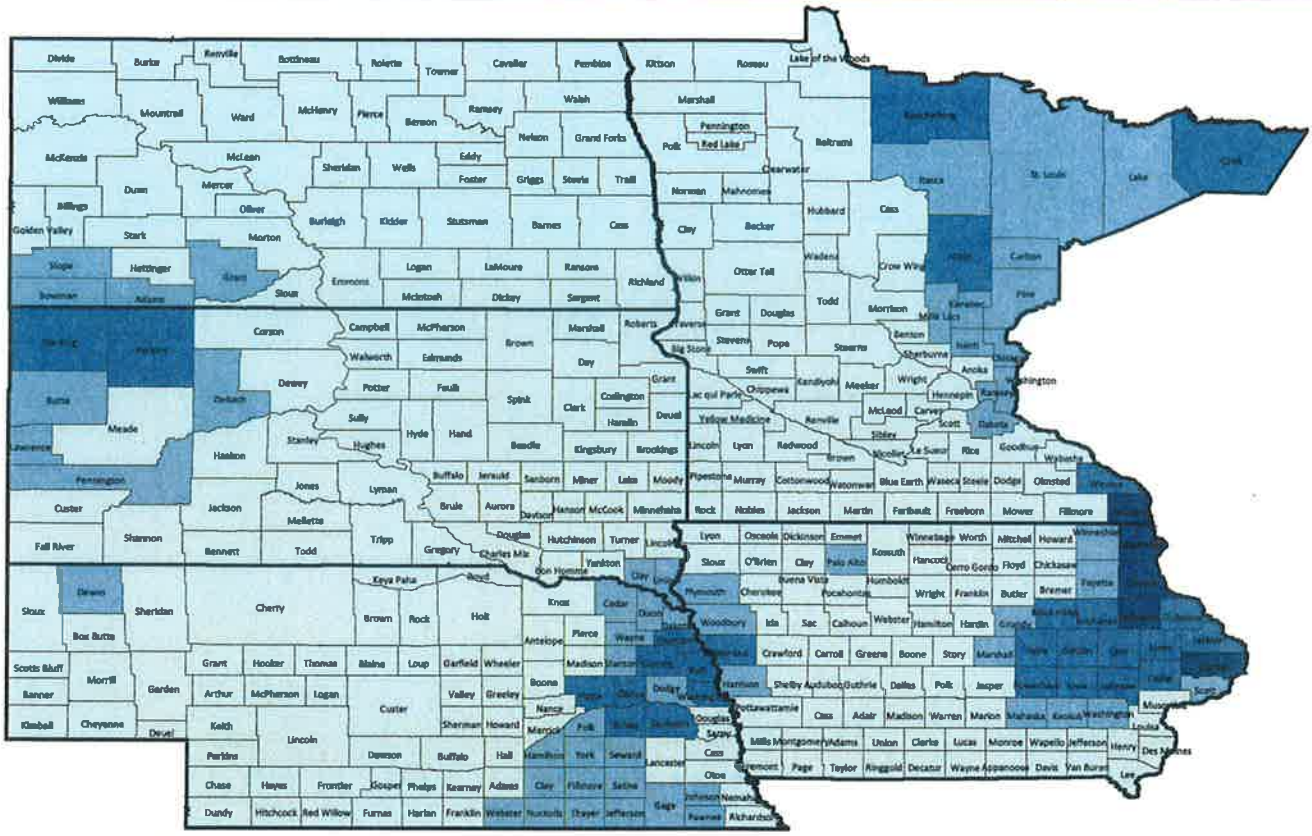
Map 28

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/.

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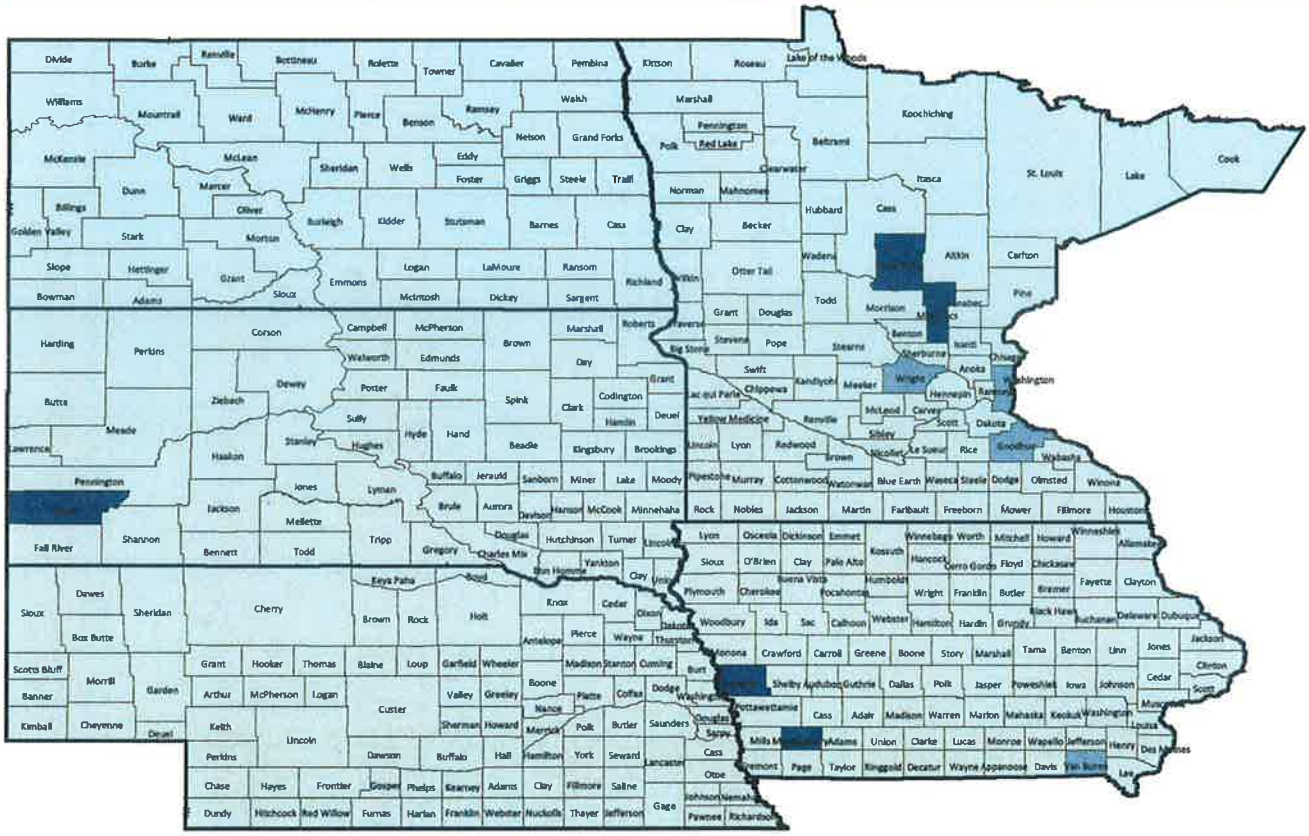
Air Pollution-OzoneDays - A health factor measure focusing on physical environment

Map 29

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



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

0
1
2

CONTEXT

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

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

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

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

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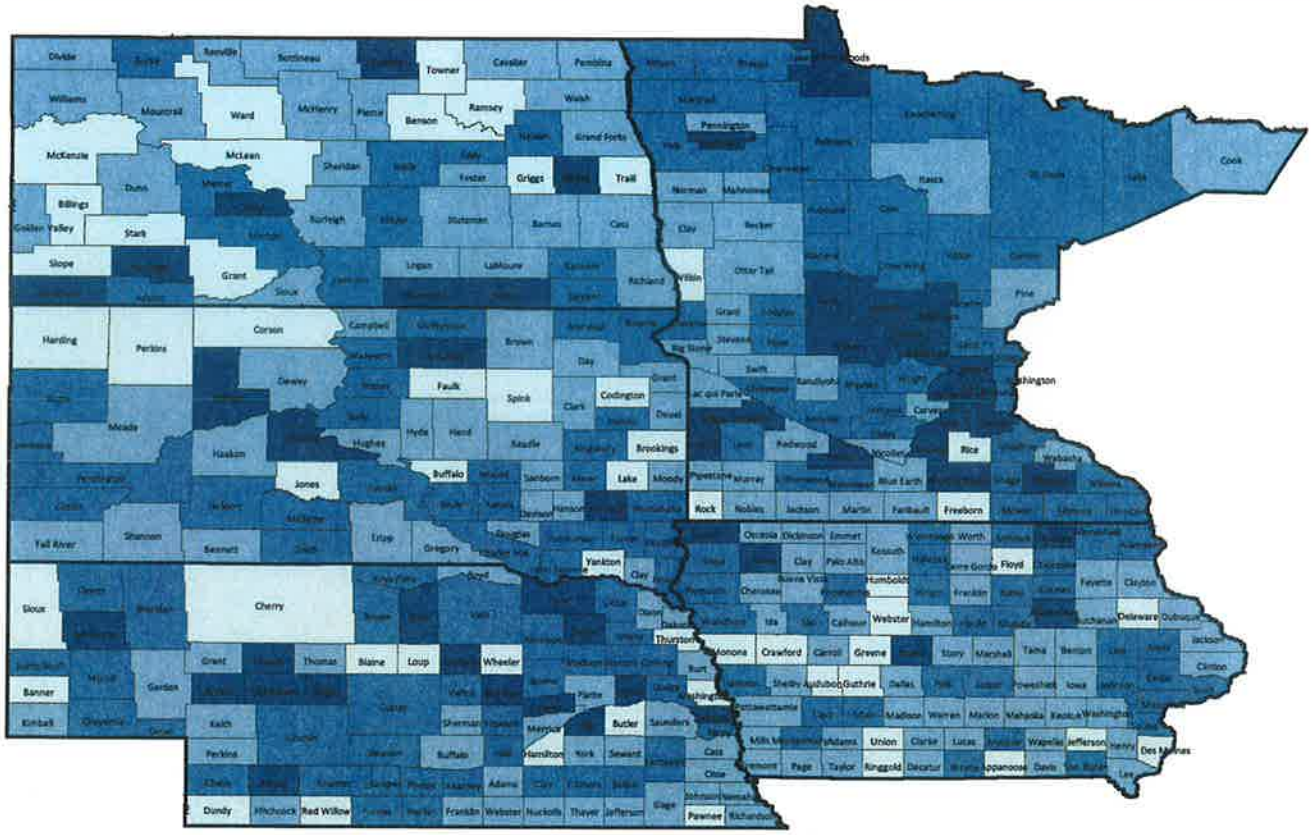
Access to Healthy Foods - A health factor measure focusing on physical environment

Map 30

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



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

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

CONTEXT

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

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

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

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

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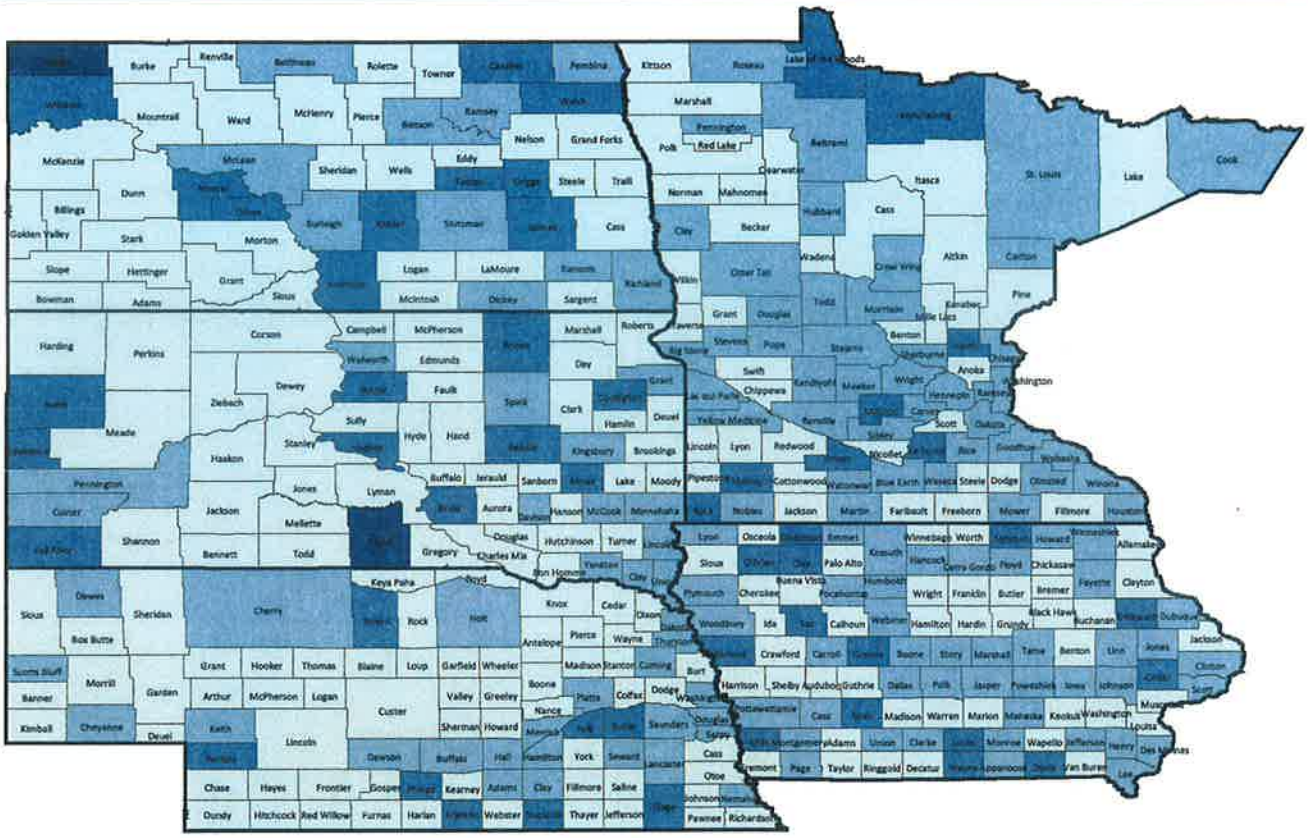
Access to Recreational Facilities - A health factor measure focusing on physical environment

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



Number of recreational facilities per 100,000 population, 2008

- 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/.

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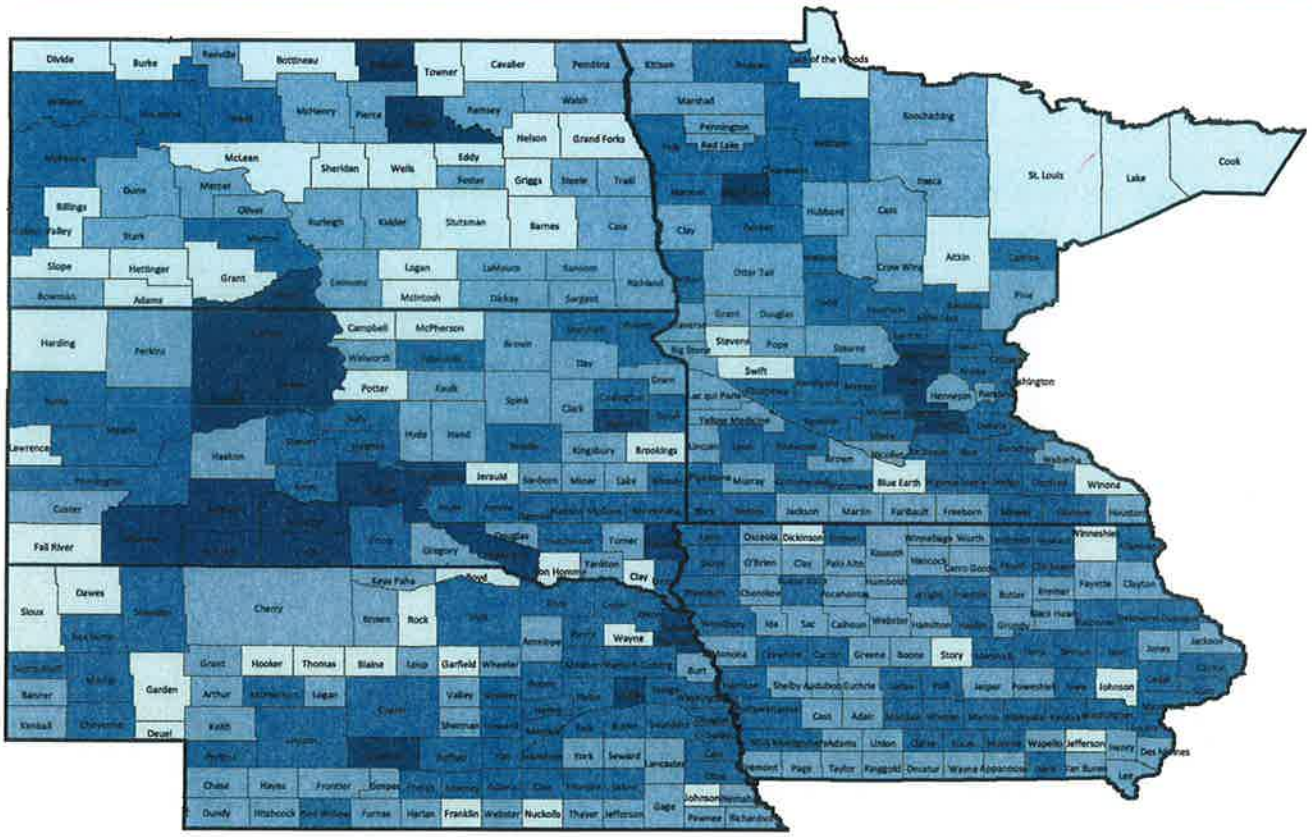
Youth - A demographic measure

Map 32

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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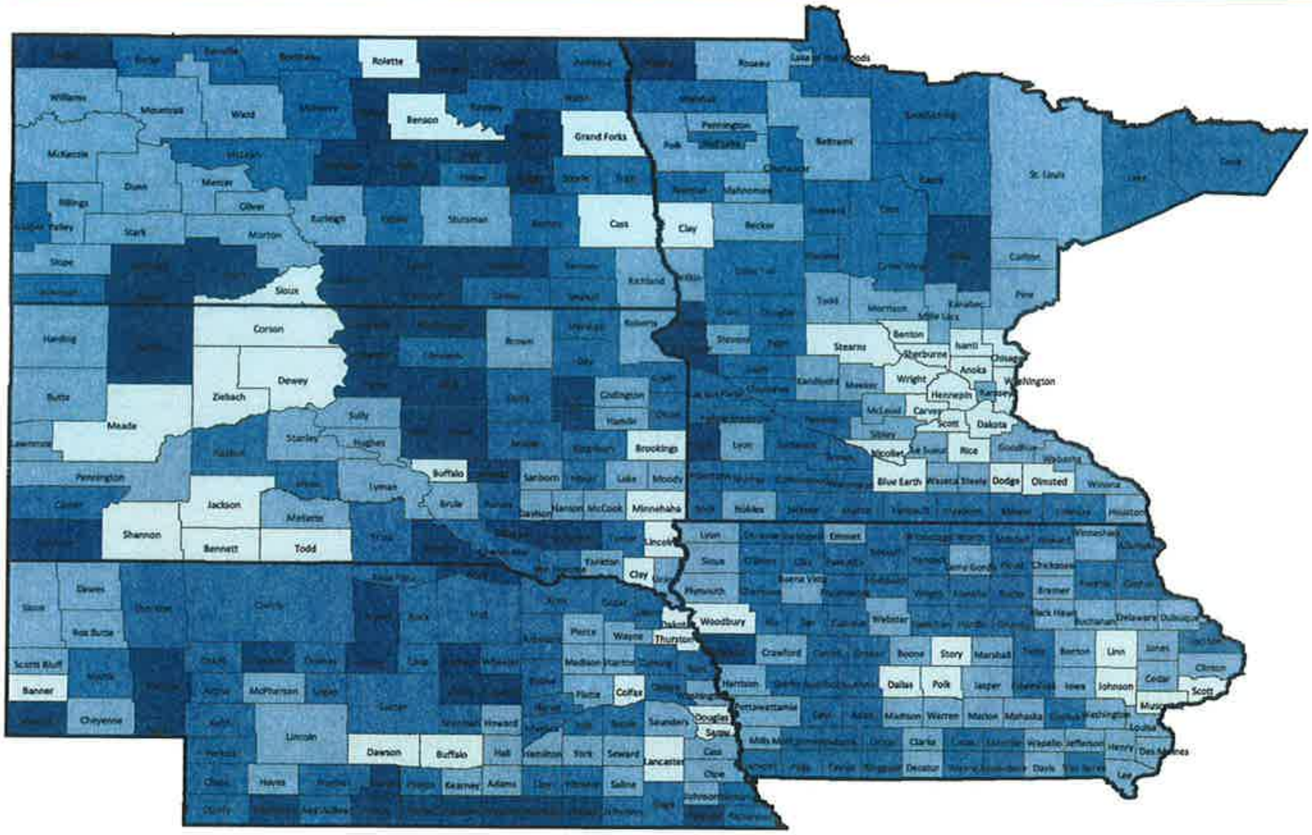
Elderly - A demographic measure

Map 33

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



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

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

CONTEXT

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

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

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

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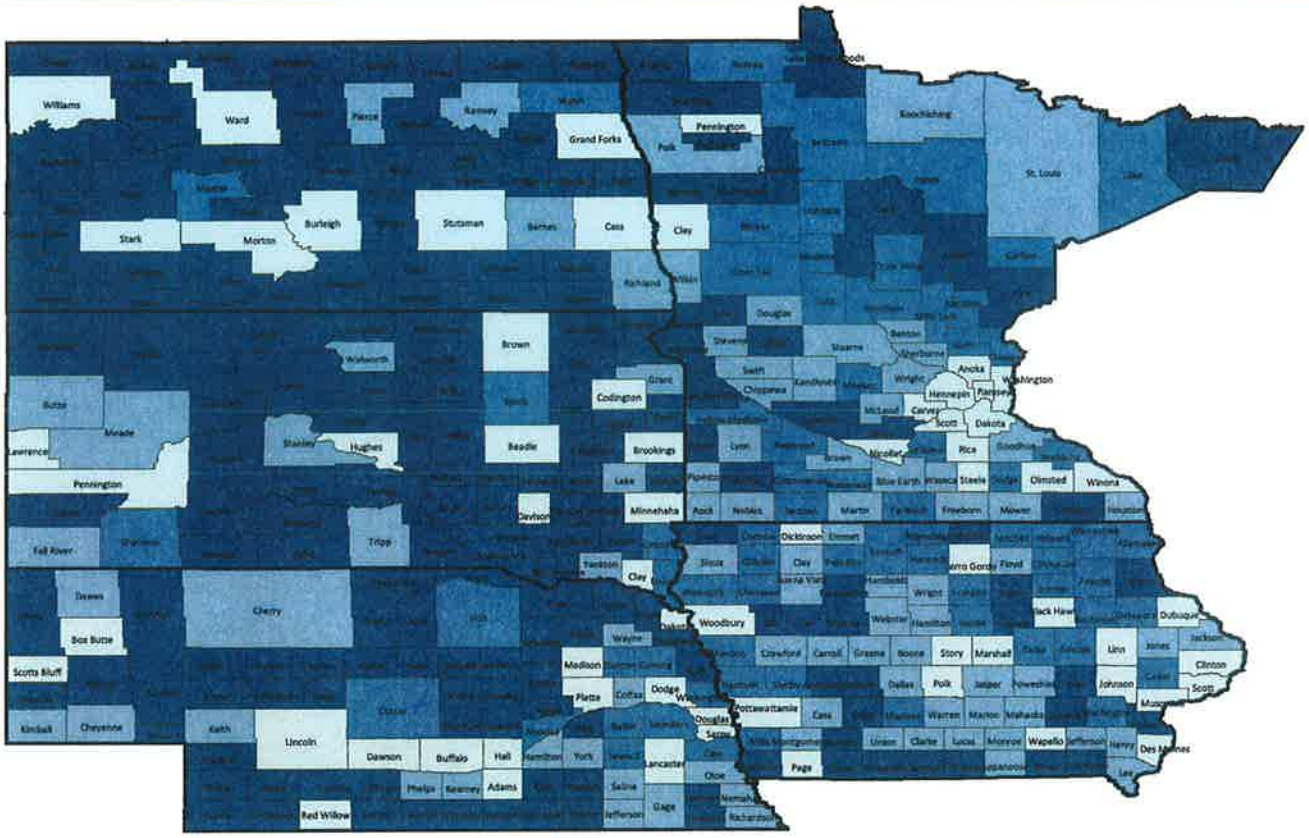
Rural - A demographic measure

Map 34

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



Percent of total population living in a rural area, 2000

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

CONTEXT

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

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

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

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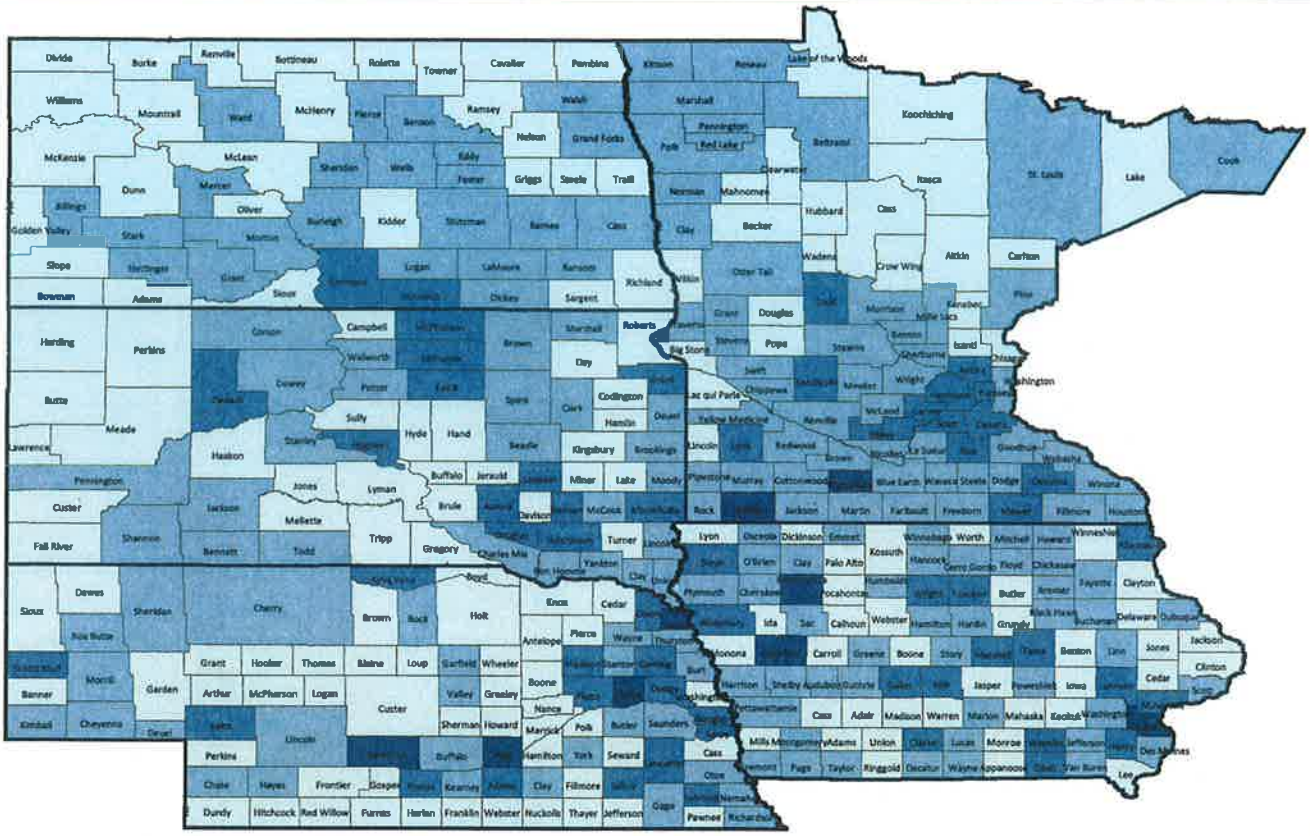
Not English Proficient - A demographic measure

Map 35

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



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

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

CONTEXT

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

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

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

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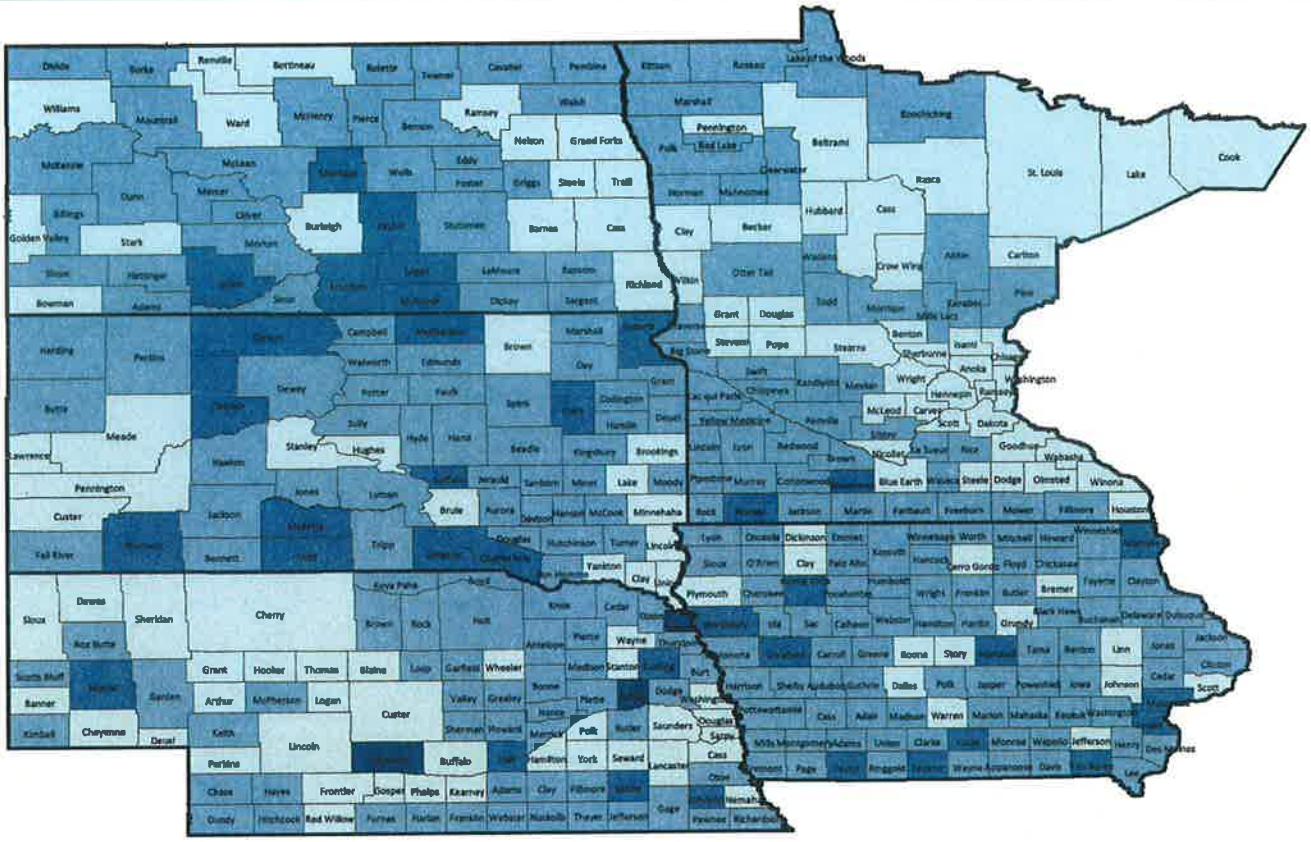
Map 36

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/.

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SANFORD HEALTH

Table 1
Community Health Needs Assessment Asset Mapping
Rock Rapids Stakeholders

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

Access	• Concern about the number of healthcare providers & specialists
	  ○ A 3rd FT physician is needed
	  ○ Need expanded outreach specialists – availability and type
	• Local in-town services needed:
	  ○ Cataract eye surgery
	  ○ Dialysis
	  ○ Hearing specialist
	  ○ Eye specialist
	  ○ No services for mental health
	• Lack of local dentist and optometrist that accept Medicaid patients
		• Sanford Rock Rapids actively recruited 3rd physician
		• Specialty physicians available in Sioux Falls, Sanford Rock Rapids is expanding ortho outreach, has increased general surgery coverage
		• Not in town – within 30-45 minutes drive
		• Sanford Sioux Falls
		• Sioux Falls, NW IA Dialysis center
		• Sioux Falls
		• Hope Haven outreach, Seasons Mental health, IA plan, Sanford shared psychologist/psych telehealth
		• Dr. Murphy – local dentist for Medicaid. No optometrist. Share with RR development corp	

Cancer	• High concern about cancer	Sanford Cancer Biology Research Center, CDC has been connected and monitoring, American Cancer Society/Research center	
Chronic Disease	• High concern about chronic disease ○ Diabetes, heart disease, MS • Diabetes screening	Sanford Medical Home, Health coach at SRR clinic Outreach coordinator Sanford RR (REC, Lyon Co employees, SRR)	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Elderly	• Lack of housing for senior citizens (asst living, apts, condos) • Need good nursing home care • Need better senior housing options in Larchwood • Lack of transportation to access health care for the elderly	• Development Corp • Refer comment • Refer comment to city of Larchwood • Rides Bus, Wheelchair express, Ministerial association	
Emergency Services	• Access to emergency services	Local EMS/FF; More info on services	
Healthcare Cost/Insurance Cost	• Concern about healthcare cost & insurance cost • Concern about the many who don't have to pay & those who are average working citizens must make it up (taxes) • Concern over the cost of prescription drugs • Concern over access to coverage for health and dental insurance • Concern over availability and cost of dental and vision care • High number of uninsured adults • High number of uninsured youth	• SRR Community Care program • Health Reform • IA State insurance exchange • HAWK-I • Health Coach – resources if can't afford meds • Lewis club card	
Health Factors	• Adult smoking • Physical inactivity • Excessive drinking • Preventable hospital stays • Inadequate youth and adult immunization rates – only 1% on 2010 CoCASA report for Health Services of Lyon County	• Lyon County tobacco coalition • 2 fitness center opportunities in RR, 1 in George, 1 in Larchwood, Little Rock community center with fitness equipment • Central Lyon open to walk at school, Doon community center gym open for walking • Compass Pointe outreach education program • IA State community extension services programs – share info • SRR decrease readmissions program – Iowa Healthcare Collaborative	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		• Immunizations - well child checks/preventative visits, Health Services of Lyon County, school and community vaccination programs	
Hospice	• Need hospice services	• Sanford Hospice • Iowa Hospice • Care Initiatives Hospice	

Mental Health	• Need more mental health services
	  ○ Mental health screenings
	  ○ Family support groups
	  ○ Support for families
	• Need insurance to cover mental health services
	• Need more for stress management
	• Domestic Violence
	• Child abuse
	• Concern about depression
		• Seasons Mental Health Counseling –4 days per week
		• Area 4 provides psychologist to school
		• Domestic Violence Shelter – Sioux Center
		• Family Crisis Centers of NW Iowa- Rock Rapids
		• Sanford One Care – Sanford Rock Rapids mental health triage therapist/psychologist/telehealth psych
		• Lyon County Mental Health Services for county payment for low income to cover mental health
		• Hope Haven outreach
		• Atlas of Lyon County – Family
		• Health Services of Lyon County – Healthy Families program for child abuse prevention	

Obesity	• Obesity • Poor nutrition • Lack of exercise/activity	• Sanford WebMD Fit Kids • Fitness centers • Sanford RR Health Coach • Jo nutrition pieces for community ed	
Pollution/ Environment	• Concern about pesticides & insecticides • Concern about smell from hog farms	Refer to county ISU extension agency	
Substance Abuse	• Need an AA support group • Concern about substance abuse	• AA support group Monday night in RR UCC church • DARE program • Compass Pointe group and individual substance abuse counseling	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		• Lyon County Tobacco coalition • SRR Health Coach • SRR committing smoking program – enhance? Julia?	
Technology	• Concern about the distance needed to travel to use specialized medical equipment	Sioux Falls less than 45 minutes away, Wheelchair Express offers transport, area church volunteers to assist with transport	
Youth	• Concern about bullying (esp. on Facebook/computer) • Need after-school programs for youth • Concern about lack of healthy choice programs for youth • Concern over access to child care (availability/cost) • Bullying • Teen pregnancy •	• Refer to school • Sanford WebMD Fit Kids • DARE program • Kids club offers after school program • School lunch federal guidelines • Kids club looking at expansion • County list of registered daycares	
Sanford Specific	• Need to upgrade the hospital & clinic facilities –	MPCH Association	X

SANFORD HEALTH

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 to upgrade facility through a remodel or building project	XXX		
Need to increase knowledge and awareness of services available within the community		XXX	

Rock Rapids priority list:

1. Need to upgrade facility through a building or remodel project
2. Need to increase knowledge and awareness of services available within the community

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