Sanford Health Network
Community Health Needs Assessment
2012-2013

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HEALTH

Sanford Westbrook Medical Center

Community Health Needs Assessment 2012-2013

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Purpose

Sanford Westbrook 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 Westbrook 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

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

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

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

The following Sanford Westbrook Steering Committee members participated in this assessment work:
- Pat Stewart, Administrator, Cottonwood Jackson Community Health Services
- Stacy Barstad, MHA, CEO, Sanford Tracy and Westbrook Medical Centers
- Lori Hebig, Marketing/Community Relations Manager, Sanford Westbrook and Tracy Medical Centers
- Laurie Stenke, Director of Clinic Operations, Sanford Windom, Mt. Lake, Tracy, and Westbrook
- Angela Nelson, MSW, LGSW, Sanford Westbrook and Tracy Medical Centers
- Nate Knakmuhs, Chairman, Sanford Westbrook Hospital Board
- Krista Kopperud, MPH, Marketing Coordinator, Sanford Westbrook and Tracy Medical Centers

The following key community stakeholders participated in this assessment work:
- Elmer J. Anderson, Westbrook, MN
- Casie Bangasser, Teacher, Tracy Elementary School, Tracy, MN
- Harry Baulisch, Westbrook, MN
- Cynthia Gohman, Westbrook, MN
- Jan Johnson, Bank Midwest, Westbrook, MN
- Angeline Kirst, Homemaker, Jeffers, MN
- Nate Knakmuhs, Owner/Insurance Agent, Knakmuhs Agency, Walnut Grove, MN
- Steve LeBoutillier, Teacher, Westbrook/Walnut Grove Schools, Westbrook, MN
- Bret Lindaman, Farmer, Westbrook, MN
- Gene Lindaman, Farmer, Westbrook, MN
- Jan Lindaman, Retired, Homemaker, Westbrook, MN
- Aleshia Torres Lopez, Sales Associate, Walmart, Storden, MN
- Maria Martin, Homemaker, Jeffers, MN
- Tom Merchant, Managing Editor, Sentinel Tribune, Westbrook, MN
- Donna Nelsen, Retired, Homemaker, Westbrook, MN
- Marlowe Nelsen, Retried County Commissioner, Westbrook, MN
- Kelly Quade, Teacher, Westbrook/Walnut Grove Schools, Westbrook, MN
- Roann Rettmann, MN Department of Public Safety, Storden, MN
- Tina Richards, Art Teacher, Walnut Grove, MN
- John Rupp, Westbrook, MN
- Katie Steen, Westbrook, MN
- Elizabeth Stumpf, Jeffers, MN
- Leo Theisen, Westbrook/Walnut Grove Schools, Walnut Grove, MN

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Executive Summary

Purpose

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

Study Design and Methodology

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

The following quantitative data sets were studied:
- 2011 County Health Profile for Cottonwood County
- Aging Profile for Cottonwood County
- Diversity Profile for Cottonwood County

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

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

Key Findings – Primary Research

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.

Respondents believed that Westbrook is a friendly community where people feel connected. They also felt the current school system and health care facility are quality institutions within the community. Overall, respondents felt that Westbrook is a safe, clean, and healthy community to live in. They also felt that the community is "family-friendly" and that people tend to live a simple lifestyle. Surveyors also mentioned that they are happy that there are activities available for seniors and families, including recreational sport activities.

Regarding economics, respondents listed health care and/or insurance and low wages as the top concerns in the community. Poverty and availability of affordable housing and economic disparities between the higher and lower classes also topped the list. Respondents also showed concern about the cost and/or availability of elder care, availability of youth activities, changes in family composition, substance abuse, and physical health in Westbrook. Specific to community health and wellness, the cost of health insurance, prescription drugs, and health care were the top three concerns in the community. Adequacy of health insurance, access to health insurance coverage, availability and/or cost of dental and/or vision care also were major concerns. Chronic disease and cancer were the top concerns for illness in the community. Respondents cited obesity, lack of exercise and/or inactivity and poor nutrition/eating habits as their top concerns regarding physical health.

Surveyors felt that Sanford Westbrook could improve in delivery of health care to the community through additional health services for obesity, diabetes, mental health, and eye and dental care. Respondents also felt that the hospital could work towards improving the cost of the delivery of health care.

When choosing a primary care provider, the respondents said that location, availability of services, and quality of services were the top three reasons for their decision.

Eight-five percent (85%) of respondents utilized Sanford Westbrook Medical Center for their primary health care facility. Marshall, Springfield and Windom were the other locations of primary care.

Over half of respondents of the survey did not have a cancer screening in the past year. The top three reasons were: not medically necessary, no recommendation from physician, and unfamiliarity of cancer screening guidelines.

Key Findings – Secondary Research

HEALTH OUTCOMES

The Mortality outcomes show Minnesota having less than the national benchmark for premature death. However, Cottonwood County has a much higher rate of premature death than the national benchmark and Minnesota as a whole. The Morbidity health outcomes indicate that Minnesotans, and specifically Cottonwood County citizens, report more days of poor physical and mental health than the national benchmark. Of interest, Cottonwood County reports higher days of poor physical health than the state and national benchmarks.

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

HEALTH FACTORS

Health Behaviors
- Adult obesity and physical inactivity are higher in Cottonwood County than the state benchmark. Adult obesity, though, is higher than the state and national benchmark.
- Percent of adults reporting binge drinking and heavy drinking is higher in Cottonwood County than the national benchmark.
- The teen birth rate in Cottonwood County is higher than the national benchmark.

Clinical Care
- The percentages of uninsured adults and youth are higher than the Minnesota benchmarks and the same as the national benchmarks.
- The ratio of mental health providers to total population is lower than the national and Minnesota rates. Primary Care physician ratio to total population shows a more positive trend than the national and Minnesota rates.
- The number of professionally active dentists per 100,000 population is lower than the national and Minnesota rates.
- Mammography screening and diabetes screenings in Cottonwood County Medicare enrollees are higher than the national and state benchmarks.

Social and Economic Factors
- The percent of adults aged 25-44 living in Cottonwood County with some post-secondary education is lower than the state and national percentages. However, the percentage of ninth grade cohort in public schools that graduates from high school in four years is higher than the national and Minnesota data.
- The percent of children ages 0-17 living below the Federal poverty line in Cottonwood County is higher than the state and national benchmarks. The percent of children in single-parent households is also higher than the national benchmark, but lower than the state.

Physical Environment
- There is no air or ozone pollution in Cottonwood County.
- Cottonwood County citizens have less access to recreational facilities than those benchmarks from the state and national data.

Demographics
- The total percentages of youth (ages 0-17) and elderly (aged 65+) in Cottonwood County are higher than the United States and Minnesota benchmarks. Cottonwood County as a whole has a higher percentage of total population living in a rural area than the national and Minnesota benchmarks. Cottonwood County also has a higher illiteracy rate than the state benchmark, but lower than the national benchmark.

Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:
- Access to Health Care
- Oncology Services
- Obesity

Implementation Strategy: Access (dental, mental health, general physician)
- Work on partnership or any opportunities with Bruce Mathiason, local dentist in Walnut Grove, to offer some free or reduced cost clinics.
- Seek out possibilities with Open Door Dental to come to Westbrook.
- Recruit general family practice physician to work in Westbrook.
- Increase Mental Health providers available to the Sanford Westbrook service area.
- Obtain certification of Medical Home and implement Health Care Coach to help with resources and guidance for patients.

Implementation Strategy: Oncology Services
- Pursue discussion with Sanford Worthington Oncologist and opportunities to partner and expand services to Westbrook.
- Increase utilization of tele-oncology from Sioux Falls through marketing

Implementation Strategy: Obesity
- Increase awareness and utilization of Medical Home and Health Care Coach to reach obese patients.
- Increase referrals from providers to Medical Home and Health Care Coach.
- Work with Sanford Fit Kits to bring more visibility to the community.
- Encourage providers to distribute Sanford Fit Kits and other Sanford weight-management tools to patients.
- Work with WWG School District on Wellness Center opportunities- reduced rates, etc.
- Look at possibility of increasing dietician hours and access for community and patients.
- Explore utilization of new Sanford Profile

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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 the Hospital

Sanford Westbrook is an 8-bed, not-for-profit, Critical Access Hospital located in southwest Minnesota, Cottonwood County, city of Westbrook. Sanford Westbrook is a community-owned facility leased to the Sanford Health Network, Sioux Falls, SD. It is 97 miles from Sioux Falls, South Dakota, a metropolitan community of 153,888, and 172 miles southwest of Minneapolis/St. Paul, Minnesota. Located in an area classified as a Health Professional Shortage Area (HPSA) and Manpower Underserved Area (MUA), Sanford Westbrook employs 50+ individuals.

Sanford Westbrook, originally known as Henry Schmidt Memorial Hospital, was built in 1950 and through a comprehensive community effort was remodeled and expanded into the current single-site health care facility that includes an attached medical clinic and 21-one unit senior housing facility. The service area of Sanford Westbrook includes the communities of Currie, Dovray, Jeffers, Storden and Westbrook and covers parts of Cottonwood, Redwood and Murray counties with a combined population of 3,600+ persons.

Community Description

The city of Westbrook is located in southwestern Minnesota in Cottonwood County. As of the census in 2010, there were 739 people, 345 households, and 192 families residing in the city. The racial makeup of the city was 97.7% White, 0.4% Native American, 0.9% Asian, 0.7% from other races, and 0.3% from two or more races. Hispanic or Latino of any race were 2.2% of the population.

Out of the 345 households, 18.0% had children under the age of 18 living with them, 46.7% were married couples living together, 5.2% had a female householder with no husband present, 3.8% had a male householder with no wife present, and 44.3% were non-families. 40.9% of all households were made up of individuals and 23.4% had someone living alone who was 65 years of age or older. The average household size was 2.04 and the average family size was 2.71.

The median age in the city was 54 years. Residents under the age of 18 numbered 18.7%; 4.8% were between the ages of 18 and 24; 17.6% were from 25 to 44; 25% were from 45 to 64; and 33.8% were 65 years of age or older. The gender makeup of the city was 44.2% male and 55.8% female.

Westbrook is home to the Westbrook Walnut-Grove High School, Sanford Westbrook Medical Center, Maynard's Food Center, Thrifty White Pharmacy, and other businesses. There are also multiple churches, a community center, park, swimming pool, and other recreational amenities. Several active organizations in the community include: Kiwanis, American Legion, Lions Club, Heritage Healthcare Foundation, Westbrook Area Volunteers (WAV), and Westbrook Women's Club.

Study Design and Methodology

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

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

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

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

A 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 Profile for Cottonwood County
- Aging Profile for Cottonwood County
- Diversity Profile for Cottonwood 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. A key group of Sanford Westbrook community stakeholders 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.

Westbrook Community Health Needs Assessment of Stakeholders

The purpose of the stakeholder survey was to explore the views of key leaders in the Westbrook area (health professionals, social workers, educators, elected leadership, and non-profit leaders, etc.) regarding the resident population's health and the prevalence of disease and health issues within the community.

The survey instrument was an Internet-based survey tool (i.e. Survey Monkey) designed by the Greater Fargo Moorhead Community Health Needs Assessment Collaborative with 30 questions focusing on community assets, general concerns about communities, community health and wellness concerns, and demographic information.

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

The survey was forwarded to key contacts within the Westbrook area and then disseminated throughout the community. Data was collected through late April. A total of 34 surveys were completed through the Internet link. The purpose of this survey was to learn about the perceptions of area key stakeholders and community members regarding the prevalence of disease and health issues in their community.

2011 County Health Profiles

The County Health Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), 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. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

Limitations

Sanford Westbrook gathered data from community stakeholders for the purposes of determining the needs of the community. There were 34 surveys completed. Because of the small sample size, it is important to note that this data

may not represent all residents of the Westbrook area. This data will serve as additional insight into prevalence of disease and health issues in the Westbrook area as highlighted by statistics from the Minnesota Department of Health, The Centers for Disease Control and Prevention, and U.S. Census Bureau.

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 believed that Westbrook is a friendly community where people feel connected. They also felt the current school system and health care facility are quality institutions within the community. Overall, respondents felt that Westbrook is a safe, clean, and healthy community to live in. They also felt the community is "family-friendly" and people tend to live a simple lifestyle. Surveyors also mentioned they are happy there are activities available for seniors and families including recreational sport activities.

Respondents of the survey listed health care and/or insurance and low wages as the top concerns in the community regarding economics. Poverty and availability of affordable housing and economic disparities between the higher and lower classes also topped the list. Respondents also showed concern about the cost and/or availability of elder care, availability of youth activities, changes in family composition, substance abuse, and physical health in Westbrook.

Specific to community health and wellness, the cost of health insurance, prescription drugs, and health care were the top three concerns in the community. Adequacy of health insurance, access to health insurance coverage, availability and/or cost of dental and/or vision care also were major concerns. Chronic disease and cancer were the top concerns for illness in the community. Respondents cited obesity, lack of exercise and/or inactivity and poor nutrition/eating habits as their top concerns regarding physical health.

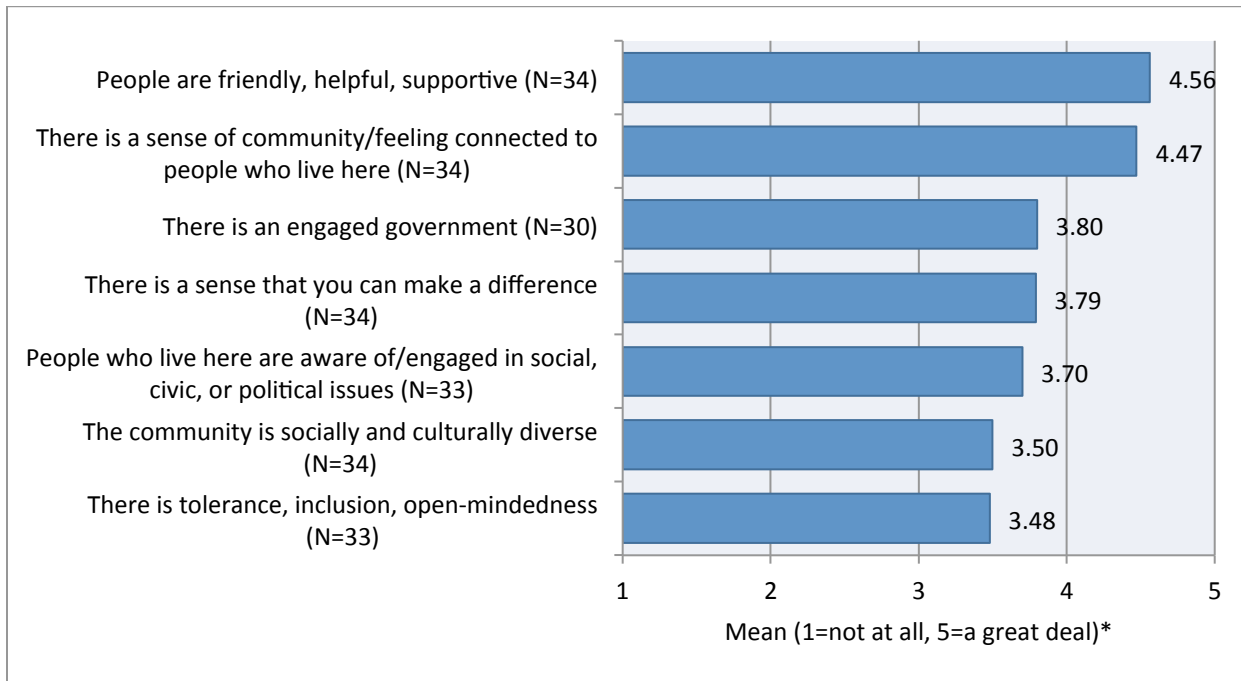*Community Assets/Best Things about the Community*

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 of best things about the community were: people are friendly, helpful, supportive, there is a sense of community/feeling connected to people who live here, there is an engaged government, there is a sense that you can make a difference, and people who live here are aware of/engaged in social, civic, or political issues.

Overall, respondents had moderately high levels of agreement regarding positive statements that reflect the people in their community. (*Figure 2)*
- The majority of respondents found that people in Westbrook are friendly, helpful, and supportive. They also felt there is a sense of community/feeling connected to people who live here.
- Respondents also had a fairly high level of agreement that there is tolerance, inclusion, and open-mindedness in the community and they feel as those there is a sense that you can make a difference.

**Figure 2. Level of agreement with statements about the community regarding PEOPLE**

People are friendly, helpful, supportive (N=34) — 4.56
There is a sense of community/feeling connected to people who live here (N=34) — 4.47
There is an engaged government (N=30) — 3.80
There is a sense that you can make a difference (N=34) — 3.79
People who live here are aware of/engaged in social, civic, or political issues (N=33) — 3.70
The community is socially and culturally diverse (N=34) — 3.50
There is tolerance, inclusion, open-mindedness (N=33) — 3.48

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

Services and Resources

Respondents had high levels of agreement that there are quality school systems and programs for youth in their community. They also agreed that there is quality health care and access to quality food in the community.

Although still a moderate level of agreement, respondents agreed the least there is effective transportation and quality higher education opportunities and institutions in the community. (*Figure 3*)

Figure 3. Respondents' level of agreement with statements about their community regards SERVICES and RESOURCES

There are quality school systems and programs for youth (N=29) — 4.52
There is quality health care (N=31) — 4.52
There is access to quality food (N=32) — 4.16
There is effective transportation (N=30) — 3.17
There are quality higher education opportunities and institutions (N=30) — 2.70

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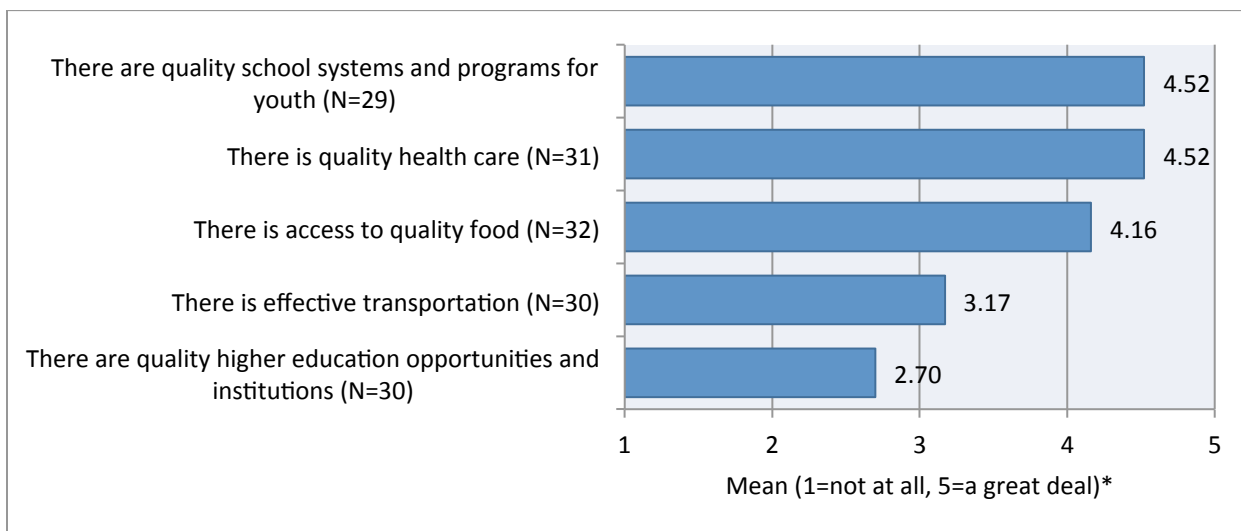
Quality of Life

Overall, respondents had a very high level of agreement that their community is safe and a healthy place to live. Means ranged from 4.50 to 3.73, with the community having a sense of cultural richness ranked the lowest.

Figure 4. Level of agreement with statements about the community regarding QUALITY OF LIFE
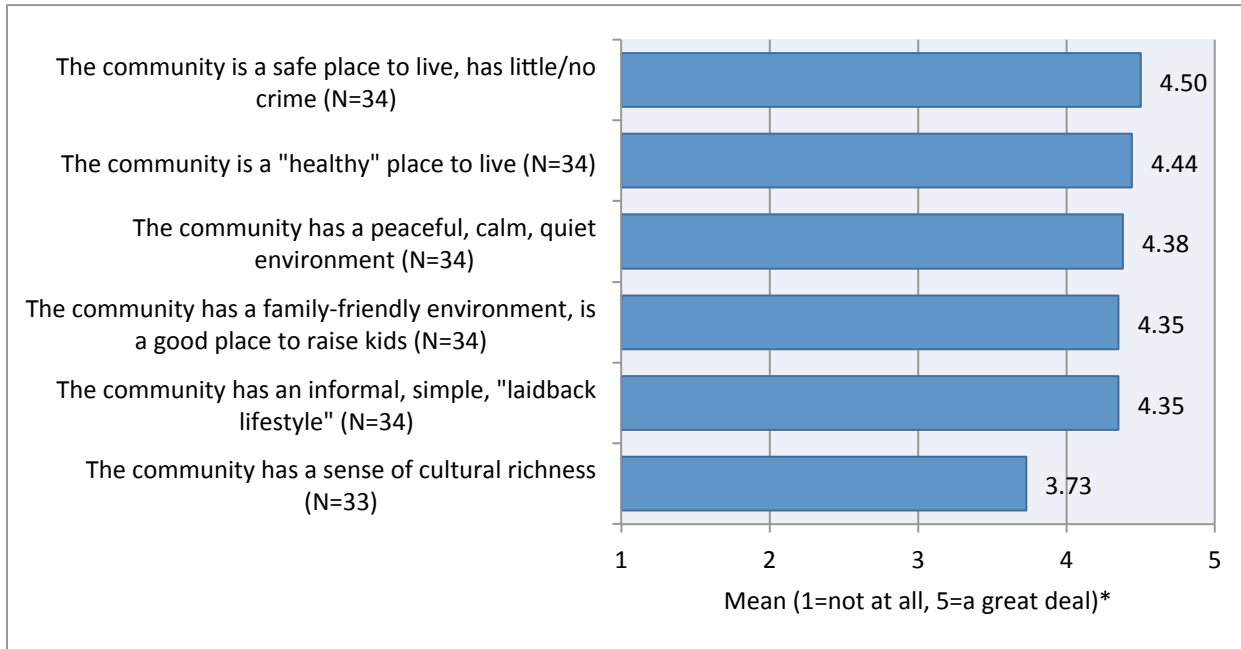
Respondents were asked to describe other best things about their community.
- Amenities (grocery store, drug store, medical facility, golf course, swimming pool, park).
- Sense of family and genuine concern for wellbeing of people.
- Community rallies behind its youth.

General Concerns about their Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of agreement with various statements regarding ECONOMIC ISSUES, SERVICES AND RESOURCES, YOUTH CONCERNS, and SAFETY CONCERNS in their community.

Economic Issues

Respondents showed moderate levels of concern with respect to cost of health care and/or insurance, low wages, poverty, availability of affordable housing, and economics disparities between higher and lower classes. (*Figure 5*)

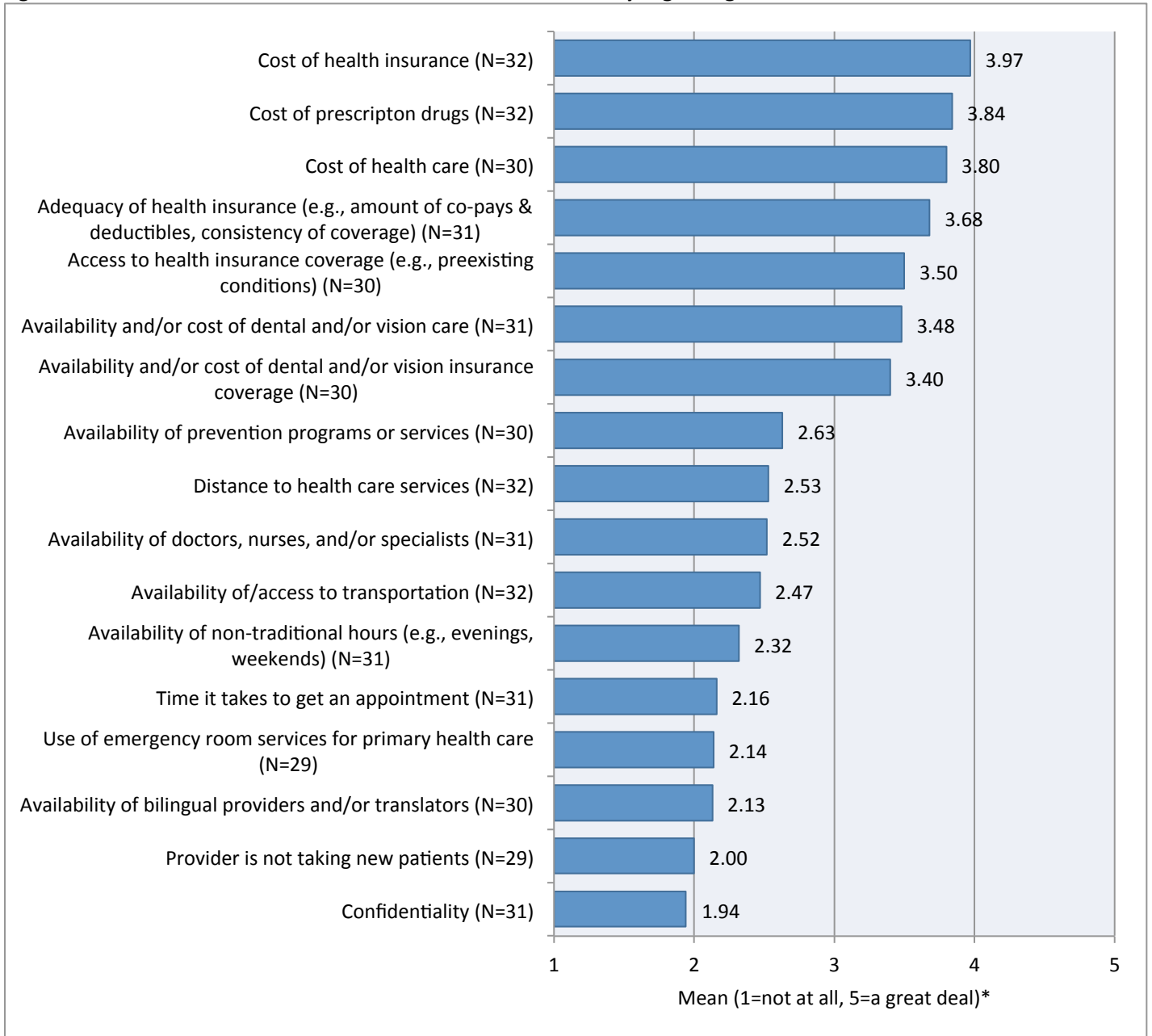**Figure 5. Level of concern with statements about the community regarding ECONOMIC ISSUES**

Cost of health care and/or insurance (N=29)   3.79
Low wages (N=28)   3.32
Poverty (N=29)   3.21
Availability of affordable housing (N=31)   3.10
Economic disparities between higher and lower classes (N=28)   3.04
Cost of living (N=29)   2.76
Hunger (N=30)   2.73
Availability of employment opportunities (N=30)   2.70
Homelessness (N=27)   1.96

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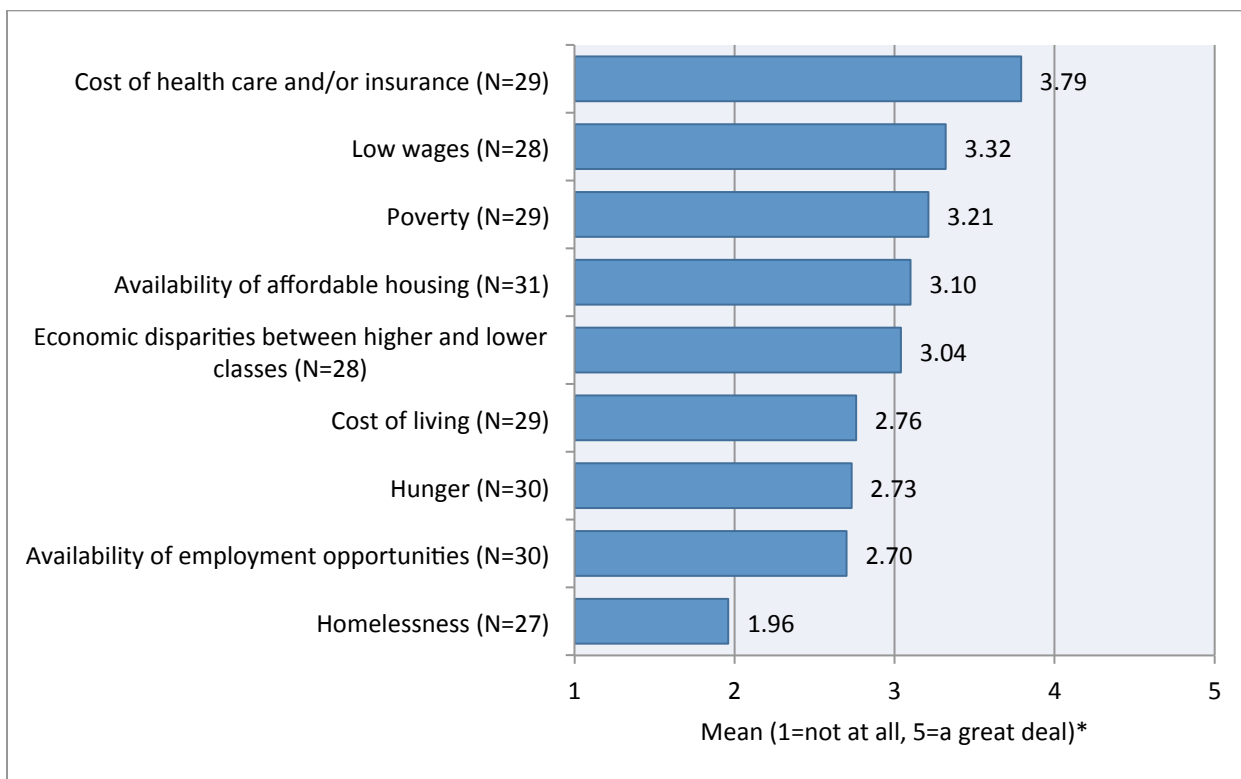
Services and Resources

Respondents were mostly concerned about the cost and/or availability of elder care and the availability of youth activities. *(Figure 6)*

Figure 6. Level of concern with statements about the community regarding SERVICES AND RESOURCES

Cost and/or availability of elder care (N=26) — 3.35
Availability of youth activities (N=28) — 3.11
Resources to meet the needs of the aging population (N=25) — 2.92
Problems associated with mental health care systems/policies (not relating to cost) (N=29) — 2.90
Availability of family services (N=29) — 2.79
False sense of entitlement to services and resources (N=29) — 2.79
Problems associated with health care systems/ policies (not relating to cost) (N=30) — 2.70
Cost and/or availability of child care (N=24) — 2.63
Availability/access to a grocery store (N=32) — 2.34
Quality and/or cost of education/school programs (N=27) — 2.33

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

Children and Youth

Respondents showed moderate concern with changes in the family composition (e.g. divorce, single-parenting), bullying, and teen pregnancy. (*Figure 7*)

Figure 7. Level of concern with statements about the community regarding YOUTH CONCERNS
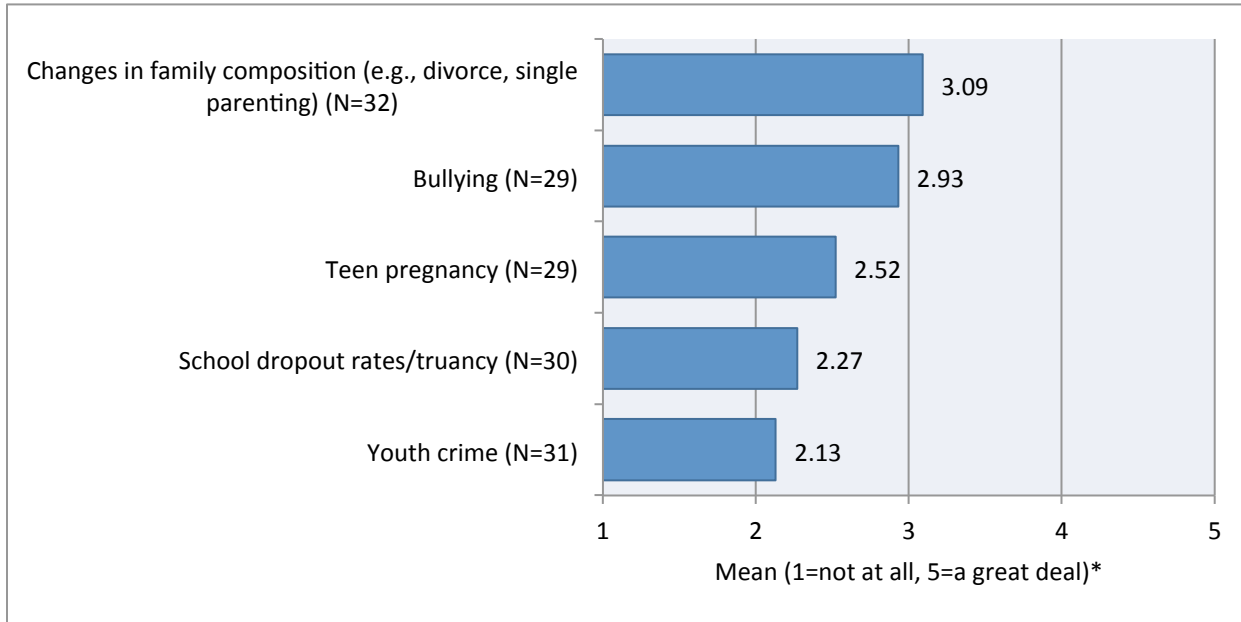
Safety Concerns

The top two safety concerns in the community are substance abuse and child abuse and neglect. Respondents are least concerned with prostitution and violent crimes. (*Figure 8*)

Figure 8. Level of concern with statements about the community regarding SAFETY CONCERNS
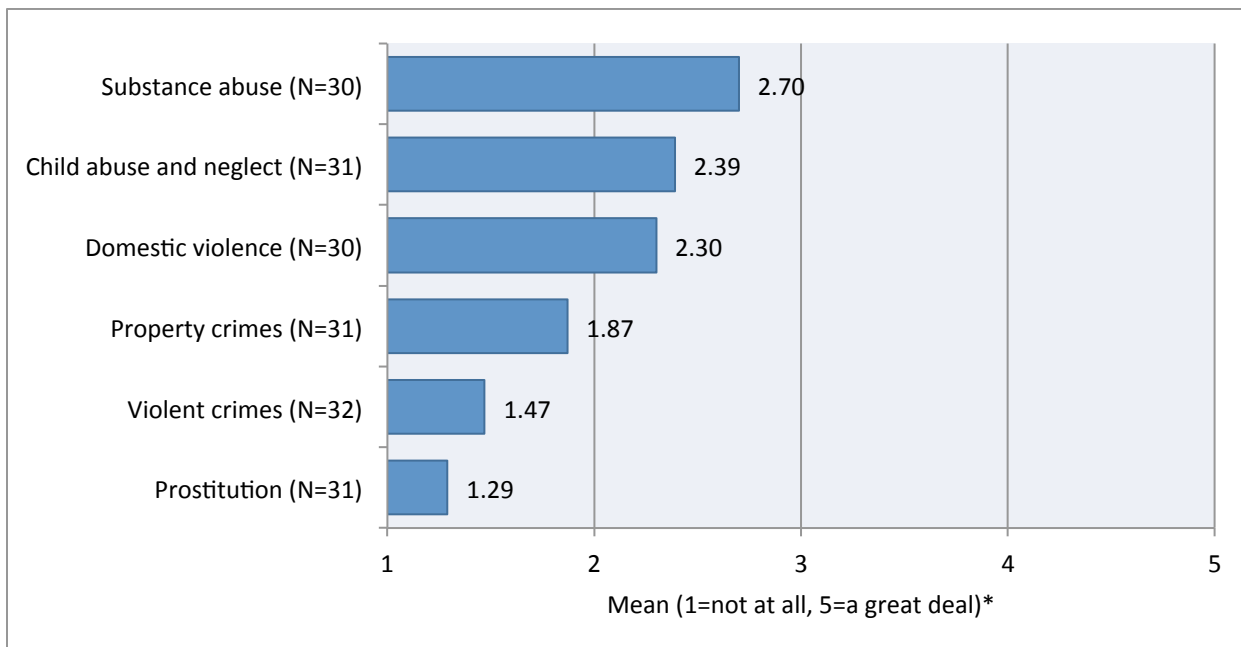
Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various health and wellness issues with respect to access to health care, physical and mental health, illness, substance use, and delivery of healthcare.

Access to Health Care

Respondents had moderate levels of concern with respect to costs associated with health and wellness in their community. Cost of insurance, cost of prescription drugs, and cost of health care were the top three concerns. Adequacy of health insurance, access to health insurance coverage, and availability and/or cost of dental and/or vision care were also above average for level of concern.

Respondents were least likely to be concerned with a provider's availability of accepting new patients and patient confidentiality. (*Figure 9*)

Figure 9. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE

Statement	Mean
Cost of health insurance (N=32)	3.97
Cost of prescripton drugs (N=32)	3.84
Cost of health care (N=30)	3.80
Adequacy of health insurance (e.g., amount of co-pays & deductibles, consistency of coverage) (N=31)	3.68
Access to health insurance coverage (e.g., preexisting conditions) (N=30)	3.50
Availability and/or cost of dental and/or vision care (N=31)	3.48
Availability and/or cost of dental and/or vision insurance coverage (N=30)	3.40
Availability of prevention programs or services (N=30)	2.63
Distance to health care services (N=32)	2.53
Availability of doctors, nurses, and/or specialists (N=31)	2.52
Availability of/access to transportation (N=32)	2.47
Availability of non-traditional hours (e.g., evenings, weekends) (N=31)	2.32
Time it takes to get an appointment (N=31)	2.16
Use of emergency room services for primary health care (N=29)	2.14
Availability of bilingual providers and/or translators (N=30)	2.13
Provider is not taking new patients (N=29)	2.00
Confidentiality (N=31)	1.94

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

Physical Health

The top three concerns respondents had in regards to physical health included obesity, lack of exercise and/or inactivity and poor nutrition/eating habits. (*Figure 10*)

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

Statement	Mean
Obesity (N=32)	3.28
Lack of exercise and/or inactivity (N=32)	3.25
Poor nutrition/eating habits (N=32)	3.16
Cost of exercise facilities (N=30)	2.63
Availability of good walking or biking options (as alternatives to driving) (N=31)	2.58
Availability of exercise facilities (N=32)	2.56

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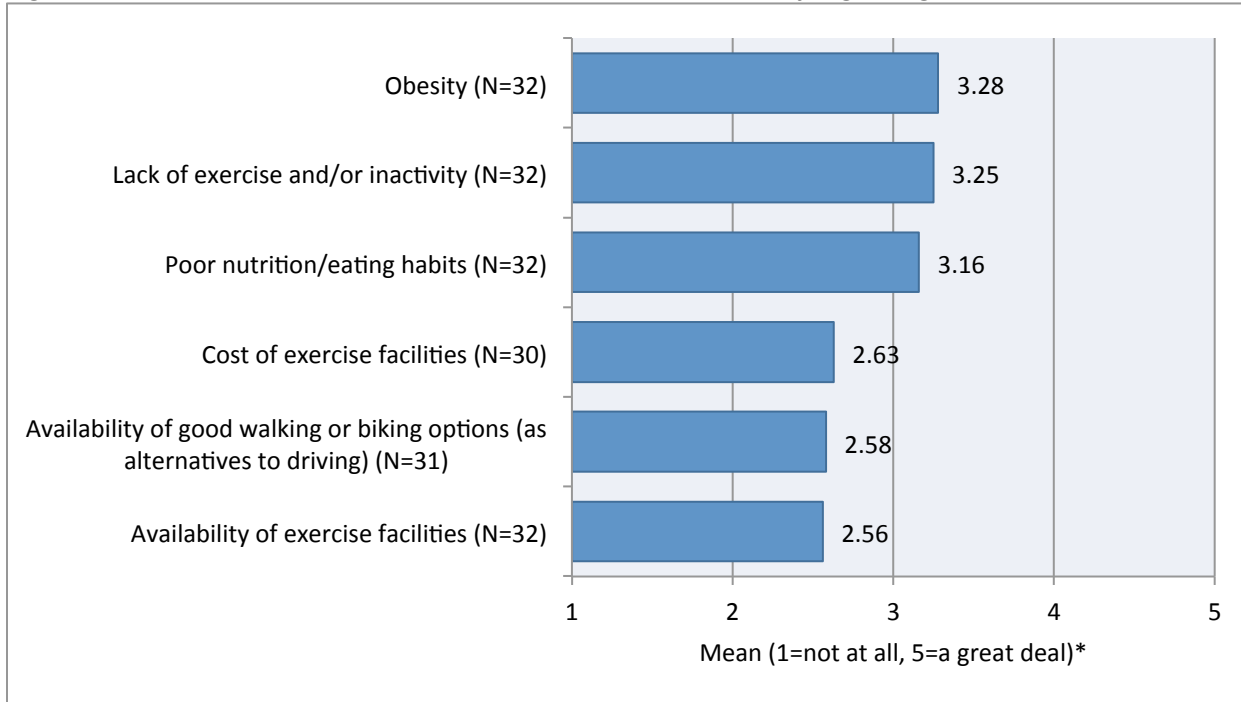
Mental Health

Respondents were equally concerned about the mental health issues presented in the survey. (*Figure 11*)

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

Statement	Mean
Stress (N=32)	2.84
Availability of qualified mental health providers (N=28)	2.75
Depression (N=31)	2.74
Availability of services for addressing mental health problems (N=28)	2.64
Quality of mental health programs (N=25)	2.64

Mean (1=not at all, 5=a great deal)*
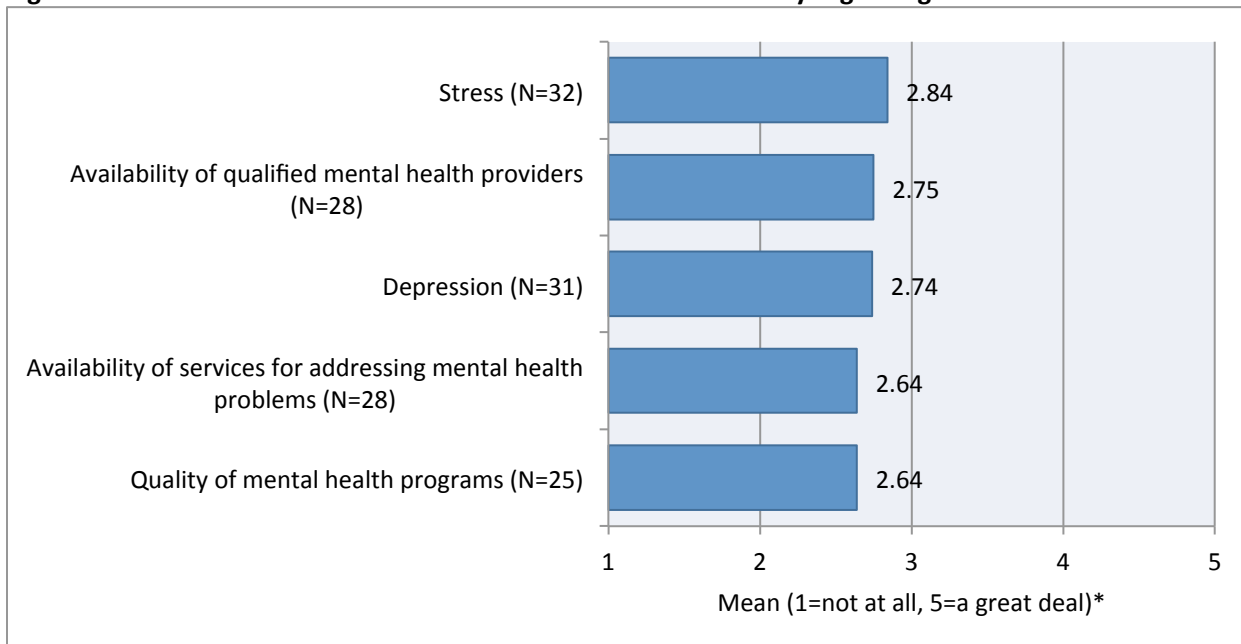
Substance Use and Abuse

Respondents were moderately concerned about smoking and alcohol use and abuse in the community. (*Figure 12*)

Figure 12. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

Smoking (N=31) 3.03
Alcohol use and abuse (N=31) 3.00
Drug use and abuse (N=31) 2.87
Presence and influence of drug dealers in the community (N=29) 2.31

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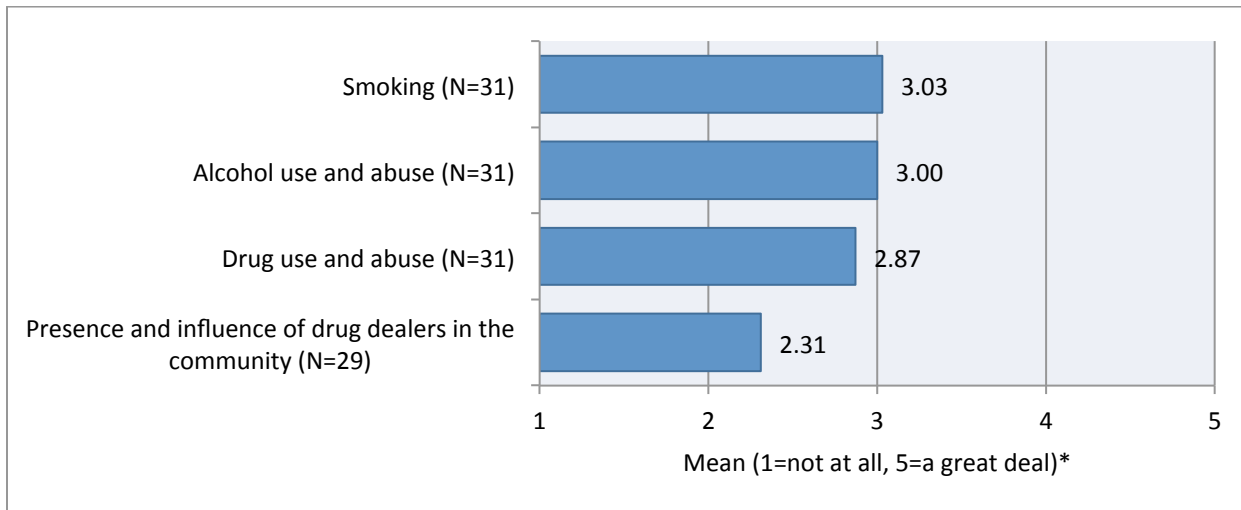
Illness

Chronic disease was the number one concern of respondents regarding illness in the community. Cancer was second. *(Figure 13)*

Figure 13. Level of concern with statements about the community regarding ILLNESS

Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (N=32) 3.09
Cancer (N=32) 3.00
Communicable diseases (e.g., including sexually transmitted diseases, AIDS) (N=30) 2.17

Mean (1=not at all, 5=a great deal)*
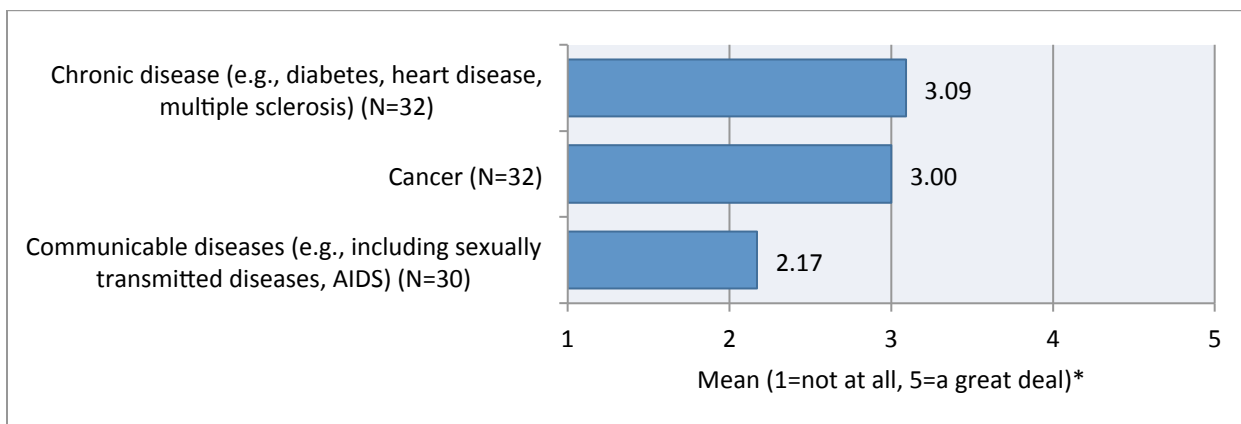
Delivery of Health Care

Respondents were asked how well the medical center is doing to meet the needs of health and illness in the community. Heart disease, access to emergency services, coordination/communication among providers, and health services for cancer patients were the top rated services.

Respondents felt that health services for obesity and mental health services could be improved upon. (*Figure 14*)

Figure 14. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed

Topic	Mean
Health services for heart disease (N=25)	4.08
Access to emergency services (e.g., ambulance and 911) (N=30)	4.07
Coordination/communication among providers (N=27)	4.04
Health services for cancer patients (N=24)	4.00
Number of health care staff in general (N=29)	3.97
Number of health care providers and specialists (N=29)	3.97
Distance/transportation to health care facility (N=30)	3.83
Health services for diabetes (N=24)	3.79
Access to needed technology/equipment (N=28)	3.75
Attention given to preventive services (N=28)	3.54
Needs of communities dealing with a hospital or clinic closure (N=16)	3.19
Costs of the delivery of health care (N=27)	3.04
Mental health services (e.g., depression, dementia/Alzheimer's disease, stress) (N=21)	3.00
Health services for obesity (N=24)	2.71

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

Personal Heath Care Information

Cancer Screening

Over half of respondents did not have cancer screening or cancer care in the past year. *(Figure 15)*

Figure 15. Cancer Screening or Cancer Care in the Past Year

34. Have you personally had a cancer screening or cancer care in the past year?

	Response Percent	Response Count
Yes (skip to Q36)	46.9%	15
No ---------------->	53.1%	17
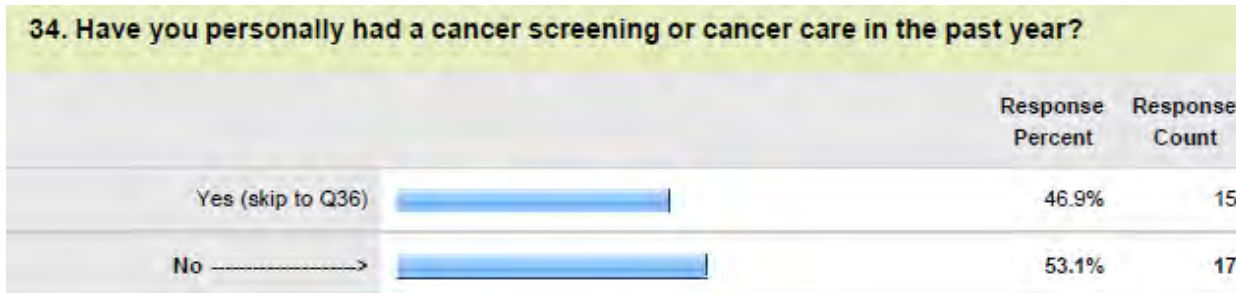
Of those respondents who did not have a cancer screening or cancer care in the past year, the majority did not because it was not medically necessary. The second reason was based on the lack of provider recommendation/referral. A small percentage did not have a cancer screening due to cost and lack of knowledge with screening guidelines. *(Figure 16)*

Figure 16. Reason for Not Receiving a Cancer Screening in Past 12 Months

35. If you have NOT had a cancer screening or cancer care in the past year, why not? (choose all that apply)

	Response Percent	Response Count
Not necessary	60.0%	9
Fear	0.0%	0
Cost	6.7%	1
Doctor hasn't suggested	46.7%	7
Unable to access care/I don't know who to see	0.0%	0
Unfamiliar with recommendations	6.7%	1
Other (please specify)	0.0%	0
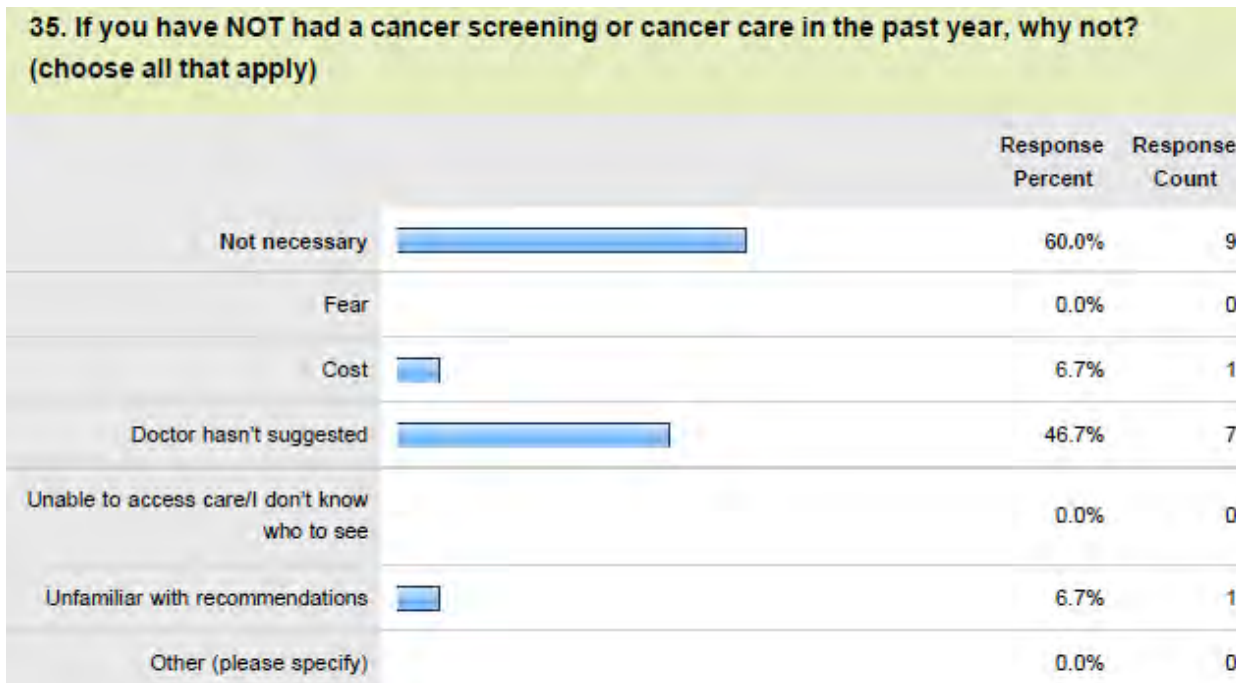
Health Care Coverage

Over half of respondents utilized employer-based health insurance to pay for medical costs. Personal income was second, followed by Medicare. *(Figure 17)*

Figure 17. Health Care Coverage

36. Over the past 12 months, how have you paid for health care costs (for you or family members)? (choose all that apply)	Response Percent	Response Count
Health insurance through an employer	51.6%	16
Private health insurance	25.8%	8
Personal income (e.g., cash, check, or credit card)	41.9%	13
Medicaid	16.1%	5
Medicare	22.6%	7
Indian Health Service (IHS)	0.0%	0
Military	0.0%	0
Veteran's health care benefits	3.2%	1
Did not access health care in the last 12 months	0.0%	0
Other (please specify)		1

Primary Care Provider

Eighty-five percent (85%) of respondents go to Sanford Westbrook for primary care services. They choose their primary care location based on location and availability of services. Health insurance does not seem to be a factor when picking a primary care location. (*Figure 18*)

Figure 18. Choice Primary Care Location

25. Why did you choose this facility/location? (choose all that apply)	Response Percent	Response Count
Location	87.5%	28
Quality of services	46.9%	15
Availability of services	59.4%	19
Sense of being valued as a patient	43.8%	14
Influenced by health insurance	0.0%	0
Other reasons (please specify)	15.6%	5

Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. High cholesterol received the most responses with 32.3 % of participants selecting this condition. The chronic diseases found in the highest percentage among respondents include arthritis, depression, anxiety, stress, diabetes, hypertension and hypercholesterolemia. (Figure 19)

Figure 19. Respondent's health/chronic diseases

Respondents Representing Chronic Disease

Category	Percentage
Other	12.9%
None	32.3%
Weight control	29.0%
Ob/Gyn	9.7%
Hypertension	19.4%
High cholesterol	32.3%
Heart conditions	6.5%
Muscles or bone problems	9.7%
Diabetes	19.4%
Dementia/Alzheimer's	0.0%
Depression, Anxiety, stress	19.4%
Cancer	6.5%
Asthma	3.2%
Arthritis	16.1%
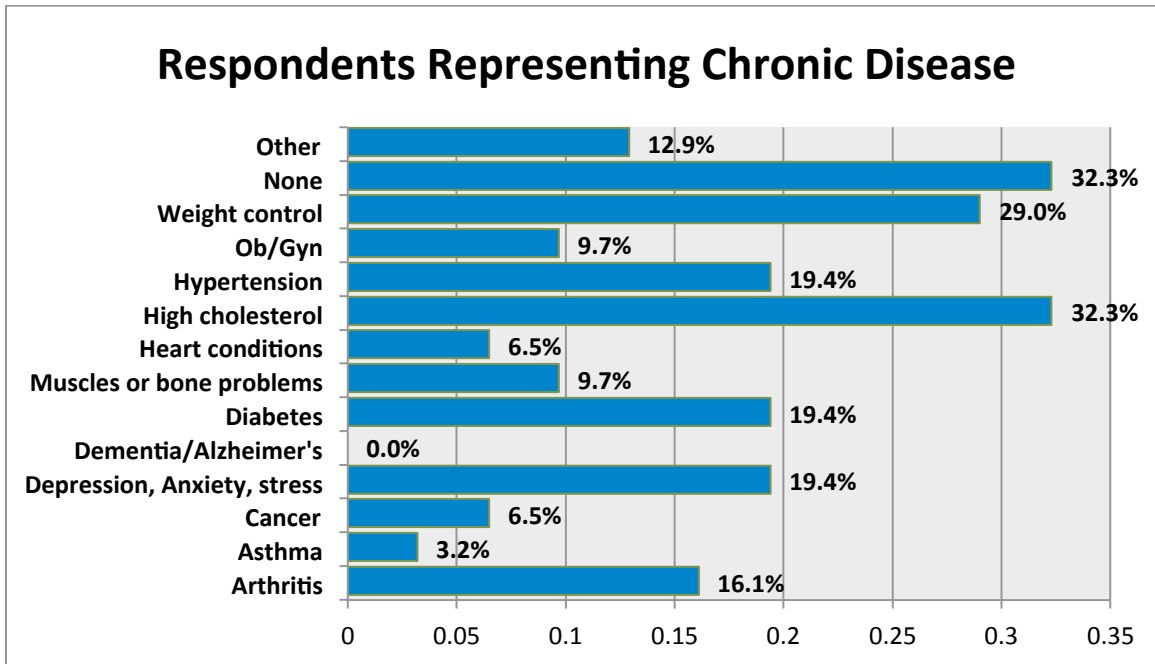
Demographic Information

Respondents of the survey were evenly distributed at each age bracket. (*Figure 20*) They were also more likely to be female (*Figure 20*) and have a Bachelor's degree. (*Figure 21)*

Figure 20. Age of Respondents

27. What is your age?

		Response Percent	Response Count
18 to 24 years		12.5%	4
25 to 34 years		18.8%	6
35 to 44 years		18.8%	6
45 to 54 years		15.6%	5
55 to 59 years		12.5%	4
60 to 64 years		3.1%	1
65 years and older		18.8%	6

Figure 21. Gender of Respondents

28. What is your gender?

		Response Percent	Response Count
Male		37.5%	12
Female		62.5%	20
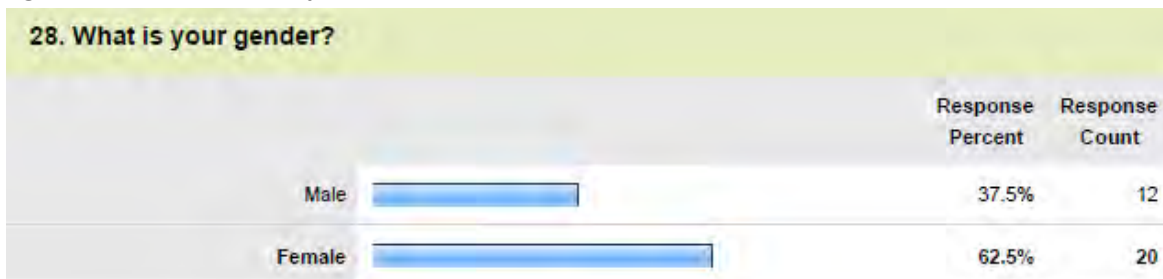
Figure 22. Educational Status of Respondents

29. What is your highest level of education?

		Response Percent	Response Count
Some high school		3.1%	1
High school diploma or GED		12.5%	4
Some college/no degree		21.9%	7
Associate's degree		12.5%	4
Bachelor's degree		37.5%	12
Graduate or Professional degree		12.5%	4
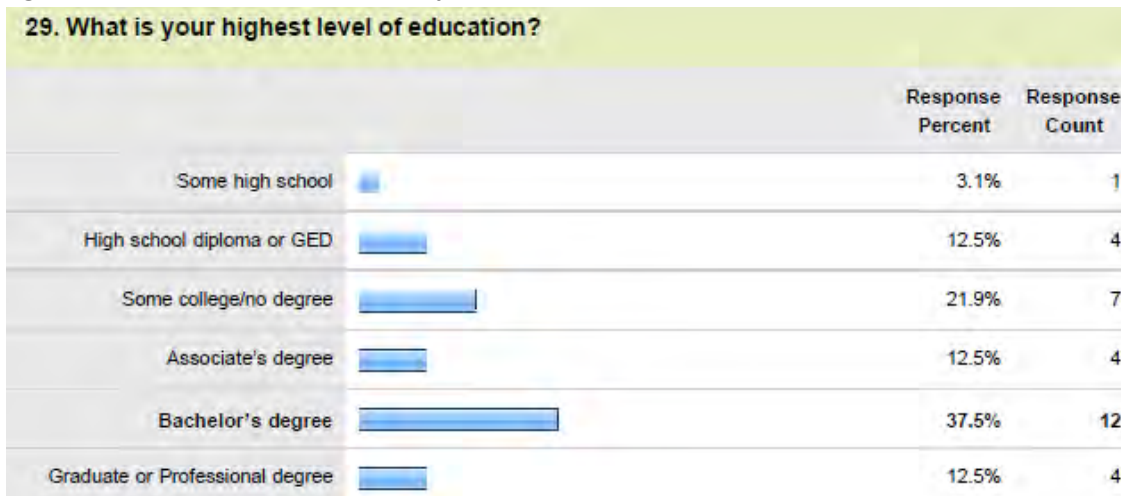
Secondary Research

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.

HEALTH OUTCOMES

Mortality

The Mortality health outcomes indicate that Minnesota as a state has fewer premature deaths than the national benchmark. Cottonwood County, however, has a much higher rate than the national and state benchmark. (*Figure 24*)

Figure 24. Mortality in Cottonwood County

		Cottonwood County	National Benchmark	Minnesota
Premature Death	Years of potential life lost before 75 per 100,000 (age-adjusted), 2005-2007	7,277	5,564	5,272

Morbidity

The Morbidity health outcomes indicate that Minnesota citizens report more days of poor health than the national benchmark. Cottonwood County and Minnesota citizens report more physically unhealthy days than the national benchmark. They also report a slightly increased number of poorer mental health days than the national benchmark.

Cottonwood County residents have a lightly lower percentage of low birth weight infants than the Minnesota benchmark, but higher than the national benchmark. (*Figure 25*)

Figure 25. Morbidity in Cottonwood County

		Cottonwood County	National Benchmark	Minnesota
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	-	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.6	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.3	2.8
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.2%	6.0%	6.5%

HEALTH FACTORS

Health Behaviors

The Health Behavior outcomes indicate that Minnesota has a higher percentage of adults who currently smoke than the national benchmark.

Adult obesity rates in Cottonwood County and Minnesota are higher than the national benchmark. However, physical inactivity is higher than both the Minnesota and national benchmarks.

The percentage of adults reporting binge drinking and heavy drinking is higher in Cottonwood County than the national benchmark, but lower than the state benchmark.

Sexually transmitted infections rank significantly lower than the national and state benchmarks.

The teen birth rate in Cottonwood County is higher than the national benchmark, but lower than the state data. (*Figure 26*)

Figure 26. Health Behaviors Data in Cottonwood County

		Cottonwood County	National Benchmark	Minnesota
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	-	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	22%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, 2003-2009	12%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	12.9
Sexually Transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population, 2008	53.2	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	26.4	22.0	27.5

Clinical Care

The Clinical Care outcomes indicate that Cottonwood County has the same percentage of uninsured adults as the national benchmark, but higher than the state benchmark. The same is true for the percentage of uninsured youth in Cottonwood County.

The ratio of total population in Cottonwood County to primary care physicians is lower than the national and Minnesota ratios. The ratio of total population to mental health providers is much higher than the national and state data.

The number of professionally active dentists is lower than the state and national data.

Preventable hospital stays in Cottonwood County are slightly higher than the national benchmark, but lower than the state data.

Cottonwood County has a higher percentage of diabetes screening in the Medicare population than the national and state benchmarks. Mammography screening in Medicare enrollees shows a similar trend. (*Figure 27*)

Figure 27. Clinical Care Data in Cottonwood County

		Cottonwood County	National Benchmark	Minnesota
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	7%	6%
Primary care physicians	Ratio of total population to mental health providers, 2008	591:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,616:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	53.2	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	52.0	56.5
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	92%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	79%	74%	73%

Social and Economic Factors

The Social and Economic Factor outcomes indicate that Cottonwood County has a higher percentage of high school graduates than the national and state benchmarks. However, it has a lower percentage of adults with some post-secondary education.

The 2009 unemployment rate of Cottonwood County was higher than the national benchmark, but lower than the state benchmark.

2008 data also showed the percentage of children living in poverty in Cottonwood County was significantly higher than the national and state percentages.

The percentage of children in single parent households in Cottonwood County is higher than the national benchmark, but lower than the state benchmark.

The number of homicide deaths in Minnesota is higher than the national benchmark. (*Figure 28*)

Figure 28. Social and Economic Factors

		Cottonwood County	National Benchmark	Minnesota
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	54%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	6.5%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	16%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes et the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	23%	20%	25%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5

Physical Environment

The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Data shows that Cottonwood County citizens have greater access to healthy foods than the state benchmark. However, this is lower than the national benchmark.

Access to recreational facilities in Cottonwood County is lower than the state and national benchmarks. (*Figure 29*)

Figure 29. Physical Environment Data

		Cottonwood County	National Benchmark	Minnesota
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	67%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	9.0	17.0	12.0

Demographics

Cottonwood County has a higher percentage of youth living in the county than the state and national benchmarks. Elderly account for 19% of the population, which is higher than the Minnesota and national benchmarks.

Cottonwood County is mostly rural as 66% of its population lives in a "rural" area.

Two percent (2%) of Cottonwood County residents are not considered "proficient" in English. Minnesota benchmarks 29%, while the national benchmark is 21%.

Cottonwood County has a lower literacy rate (8%) than the national benchmark. However, it is higher than the Minnesota benchmark, 6%. (*Figure 30*)

Figure 30. Demographic Data for Cottonwood County

		Cottonwood County	National Benchmark	Minnesota
Youth	Percent of total population ages 0-17, 2009	25%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	19%	13%	13%
Rural	Percent of total population living in a rural area, 2000	66%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	2%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy	8%	15%	6%

Population Age

The population for Cottonwood County is relatively older than the rest of Minnesota and has a lower percentage of younger aged children than the state and national benchmarks.

The gender distribution in the county is similar to the Minnesota and national percentages: more female than male.

Figure 31. Breakdown of Population in Cottonwood County

	Cottonwood County	National Benchmark	Minnesota
Total population	11,686	311,591,917	5,344,861
Percent ages 65 and older	21.4%	13.3%	13.1%
Percent 5 years and under	6.0%	6.5%	6.6%
Percent male	49.3%	49.2%	49.7%
Percent female	50.7%	50.8%	50.3%

2011 US Census

Housing and Economic Security

Cottonwood County has a higher percentage of individuals who own a home than the state and national benchmarks.

The average cost for a home in the County is $83,100, which is lower than the rest of Minnesota and the nation.

The median household income in Cottonwood County is $43,111, which is also lower than the Minnesota and national benchmarks.

The percentage of Cottonwood County residents living below the poverty level is 11.7%, which is lower than the national benchmark of 14.3% and slightly higher than the Minnesota benchmark.

Figure 32. Housing and Economic Data in Cottonwood County

	Cottonwood County	National Benchmark	Minnesota
Housing Units	5,407	132,312,404	2,354,034
Homeownership rate, 2007-2011	79.6%	66.1%	73.6%
Median value of owner-occupied housing units, 2007-2011	$83,100	$186,200	$201,400
Median household income	$43,111	$52,762	$58,476
Persons below poverty level, percent, 2007-2011	11.7%	14.3%	11%

2011 US Census

Diversity Profile

The population distribution by race demonstrates that Minnesota and Cottonwood County are predominately white, followed by Hispanic and Asian populations. The percent of Hispanic people in Cottonwood County is greater than the Minnesota benchmark of 4.9%.

Figure 33. Diversity Profile of Cottonwood County

	Cottonwood County	National Benchmark	Minnesota
Total population	11,686	311,591,917	5,344,861
White persons, percent, 2011	94.6%	78.1%	86.9%
Black persons, percent, 2011	0.9%	13.1%	5.4%
American Indian and Alaska Native	0.3%	1.2%	1.3%
Asian persons, percent, 2011	2.8%	5.0%	4.2%
Persons of Hispanic or Latino origin, percent, 2011	6.6.%	16.7%	4.9%

2011 US Census

Health Needs Identified

The identified needs from the surveys and analysis of secondary data indicated the following needs:
- Access
- Cancer
- Economics
- Emergency Services
- Healthcare and Insurance Cost
- Health Factors
- Morbidity and Mortality
- Obesity
- Snow Removal
- Transportation
- Youth

Community/Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. An informal gap analysis was conducted at the conclusion of the asset mapping work.

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

The priorities that remain include:
- Access to health care providers including: Mental Health providers, General Practitioners, Dentist, and specialists
- Cancer: Accessing additional services for patients with cancer
- Obesity: Expanding services to meet the needs of overweight patients

Sanford Westbrook Medical Center is establishing key initiative strategies to address these three priority areas listed. The Medical Center has developed an implementation strategy and has begun to work to address these gaps.

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

Implementation Strategy

<u>Access</u>

Sanford Westbrook Medical Center will be pursuing opportunities to partner with local dentists and dental services to offer free/reduced cost clinics for patients. The Medical Center will also be looking to recruit mental health and general practice providers to bring additional services to the patients of the Westbrook area. Finally, we will be utilizing our new Medical Home services and increasing referrals to our RN Health Coach.

<u>Oncology Services</u>

Sanford Westbrook will be looking at new opportunities to partner with other local Sanford Health facilities. We also want to increase our utilization of our current oncology services including tele-oncology.

<u>Obesity</u>

Sanford Westbrook is aiming to increase awareness and utilization of Medical Home services and the RN Health Coach. We are also going to be working with our medical providers to encourage usage of the WebMD Fit Kids program and other Sanford Health-based weight programs. Finally, we will pursue additional opportunities to expand our current weight loss services (access to dieticians, etc.).

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Sanford Westbrook Implementation Strategy

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

- Access to Health Care
- Oncology Services
- Obesity

Implementation Strategy: Access (dental, mental health, general physician)
- Work on partnership or any opportunities with Bruce Mathiason, local dentist in Walnut Grove, to offer some free or reduced cost clinics.
- Seek out possibilities with Open Door Dental to come to Westbrook.
- Recruit general family practice physician to work in Westbrook.
- Increase Mental Health providers available to the Sanford Westbrook service area.
- Obtain certification of Medical Home and implement Health Care Coach to help with resources and guidance for patients.

Implementation Strategy: Oncology Services
- Pursue discussion with Sanford Worthington Oncologist and opportunities to partner and expand services to Westbrook.
- Increase utilization of tele-oncology from Sioux Falls through marketing

Implementation Strategy: Obesity
- Increase awareness and utilization of Medical Home and Health Care Coach to reach obese patients.
- Increase referrals from providers to Medical Home and Health Care Coach.
- Work with Sanford Fit Kits to bring more visibility to the community.
- Encourage providers to distribute Sanford Fit Kits and other Sanford weight-management tools to patients.
- Work with WWG School District on Wellness Center opportunities- reduced rates, etc.
- Look at possibility of increasing dietician hours and access for community and patients.
  Explore utilization of new Sanford Profile

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

Cottonwood County

Minnesota

HEALTH OUTCOMES		Cottonwood	*National Benchmark	Minnesota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	7,277	5,564	5,272
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	-	10%	11%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.6	2.6	3.1
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.3	2.8
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.2%	6.0%	6.5%

HEALTH FACTORS

		Cottonwood	*National Benchmark	Minnesota
Health Behaviors				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	-	15%	19%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	28%	25%	26%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	22%	20%	17%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	12%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	12.9
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	53.2	83.0	276.1
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	26.4	22.0	27.5
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	13%	11%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	591:1	631:1	636:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,616:1	2,242:1	1,306:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	53.2	69.0	61.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.7	52.0	56.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	92%	89%	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	79%	74%	73%

HEALTH FACTORS (continued)

		Cottonwood	*National Benchmark	Minnesota

Social and Economic Factors

		Cottonwood	*National Benchmark	Minnesota
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	54%	68%	72%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	6.5%	5.3%	8.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	16%	11%	11%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	14%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	23%	20%	25%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5

Physical Environment

		Cottonwood	*National Benchmark	Minnesota
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	67%	92%	54%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	9.0	17.0	12.0

Demographics

		Cottonwood	United States	Minnesota
Youth	Percent of total population ages 0-17, 2009	25%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	19%	13%	13%
Rural	Percent of total population living in a rural area, 2000	66%	21%	29%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	2%	9%	4%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	8%	15%	6%

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

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

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

Definitions of Health Variables

Definitions of Health Variables from the *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

Cottonwood County

Minnesota

CHARACTERISTICS	Total	AGE	
		Less than 65 Years	Ages 65 and Older
Population [1]			
Total population	11,687	9,205	2,482
Percent ages 65 and older	21%	-	100%
Percent ages 85 and older	4%	-	20%
Percent male	49%	51%	43%
Percent female	51%	49%	57%
Living Arrangements			
Total households (by age of householder) [1]	4,857	3,252	1,605
Percent with family households (i.e., at least two people who are related)	64%	71%	52%
Percent with householder living alone	32%	24%	48%
Grandparents living with their grandchildren* [2]	89	53	36
Percent who are responsible for their grandchildren	13%	23%	0%
Housing [1]			
Percent of occupied housing that is owner-occupied	77%	77%	79%
Percent of occupied housing that is renter-occupied	23%	23%	21%
Economic Security [2]			
Percent of working-age population in labor force	64%	81%	20%
Percent of total population with income less than 100% of poverty	11%	12%	7%
Percent of total population with income less than 200% of poverty	31%	29%	39%
Median household income (by age of householder)	$40,292	$37,980	$27,407
Owner-occupied housing units (by age of householder)	3,909	2,535	1,374
Percent spending 30% or more of income toward housing costs	23%	23%	23%
Renter-occupied housing units (by age of householder)	1,003	702	301
Percent spending 30% or more of income toward housing costs	33%	23%	58%

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.
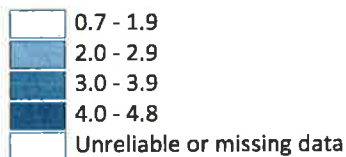
Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. The Aging Profile was prepared by researchers at North Dakota State University in Fargo for Sanford Health. May 2012

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

Cottonwood County

Minnesota

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	11,687	10,773	87	27	317	720
Percent ages 0 to 17	24%	22%	30%	37%	29%	48%
Percent ages 18 to 44	27%	26%	48%	37%	33%	41%
Percent ages 45 to 64	28%	28%	18%	22%	31%	9%
Percent ages 65 and older	21%	23%	3%	4%	7%	2%
Median age (in years)	44.2	45.9	28.5	39.3	33.2	18.6
Living Arrangements						
Total households [1]	4,857	4,600	36	10	105	158
Percent with householder living alone	32%	33%	42%	20%	29%	11%
Percent with families with children ages 0 to 17	26%	25%	22%	20%	32%	63%
Grandparents living with their grandchildren [2]	89	79	0	0	0	0
Percent who are responsible for grandchildren	13%	15%	-	-	-	-
Housing [1]						
Percent occupied housing that is owner-occupied	77%	80%	11%	50%	50%	43%
Percent occupied housing that is renter-occupied	23%	21%	89%	50%	50%	57%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	85%	87%	-	100%	33%	29%
Percent of persons ages 25 and older with Bachelor's degree or higher	16%	16%	-	0%	5%	0%
Economic Security [2]						
Unemployment rate	4%	3%	0%	5%	48%	0%
Median household income	$40,292	$41,279	-	-	$39,688	$35,018
Percent of households with income <$25,000	29%	28%	-	100%	26%	28%
Percent of persons with income <100% poverty	11%	9%	11%	44%	8%	51%
Percent of children ages 0 to 17 in families with income <100% poverty	14%	12%	0%	0%	5%	57%
Percent of elderly ages 65 and older with income <100% poverty	7%	7%	-	-		0%

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

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Map 1

Premature Death - A health outcome measure focusing on mortality

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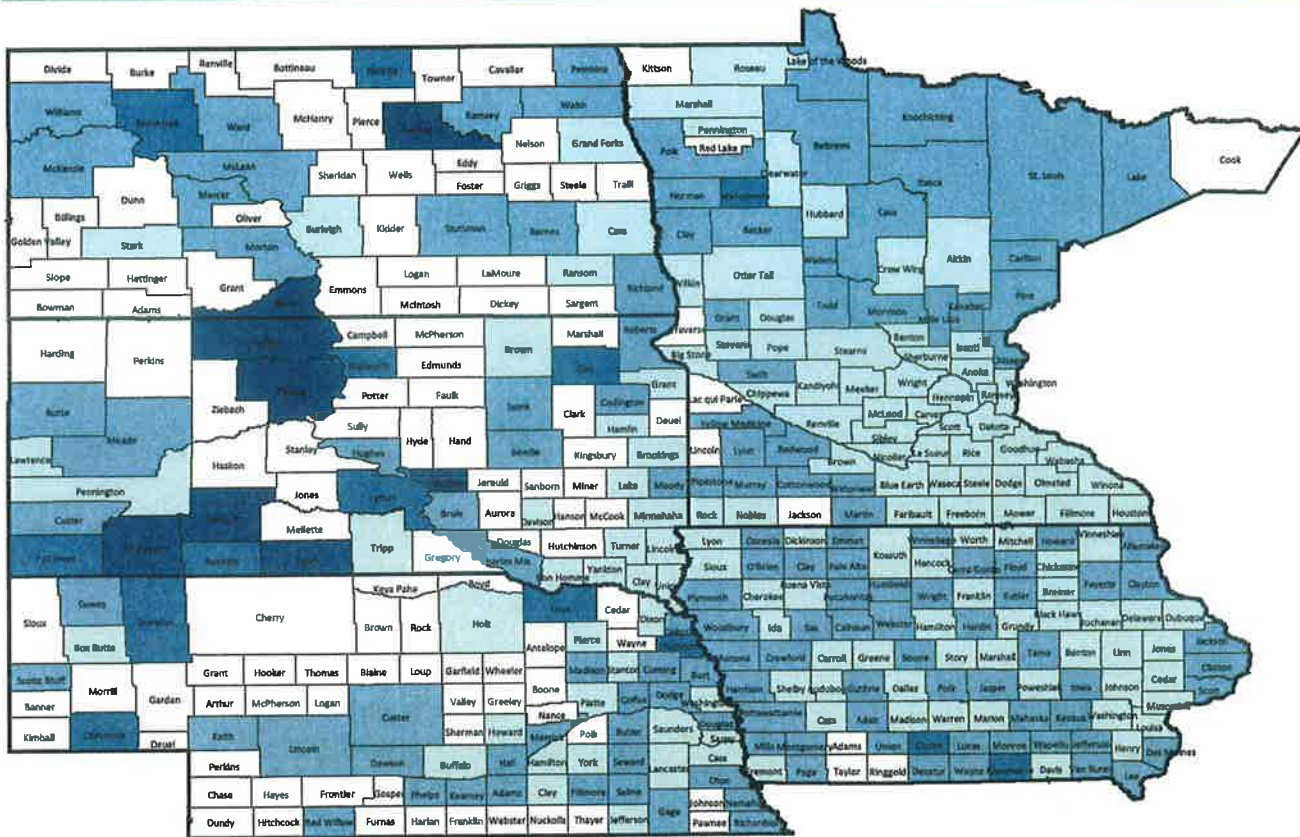
Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007

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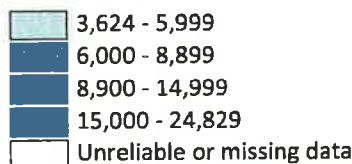
CONTEXT

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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Map 2

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

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

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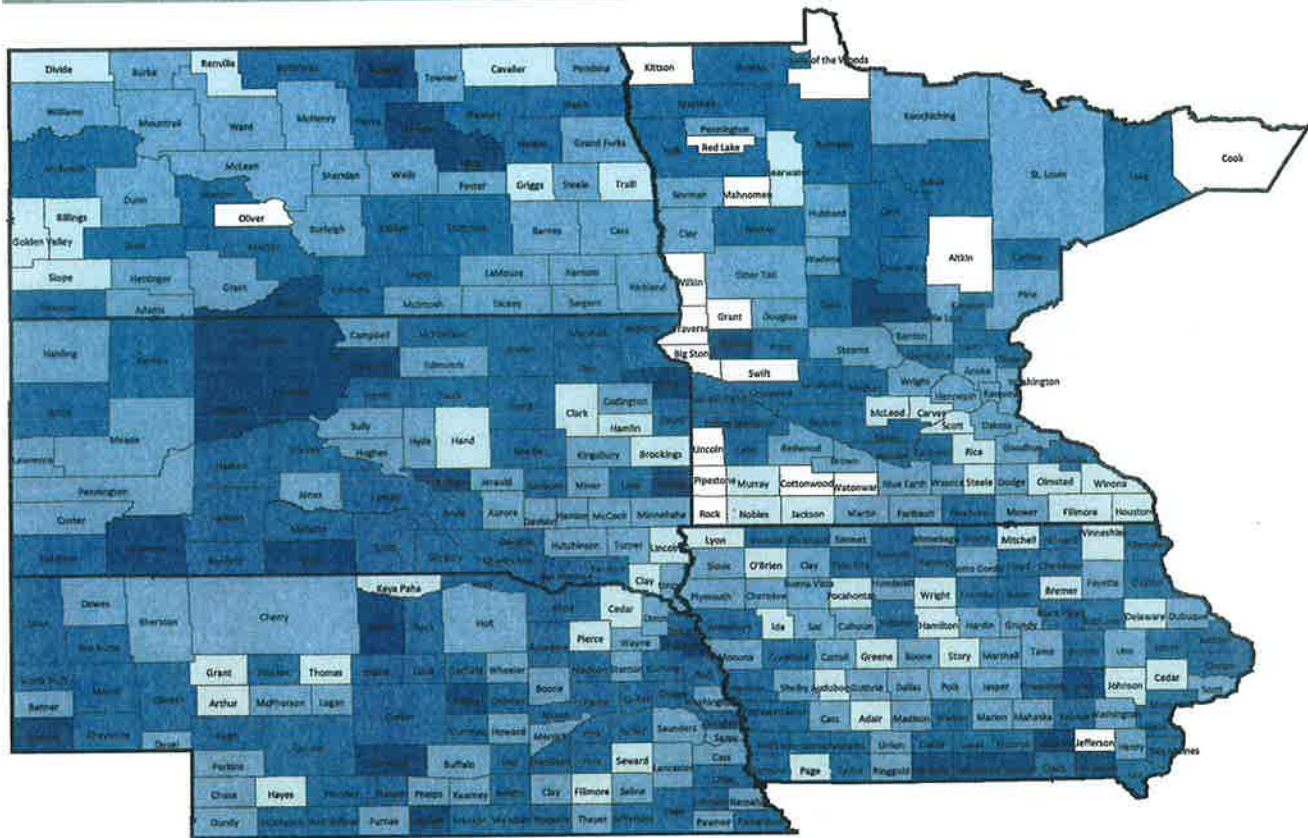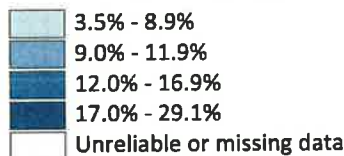
CONTEXT

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

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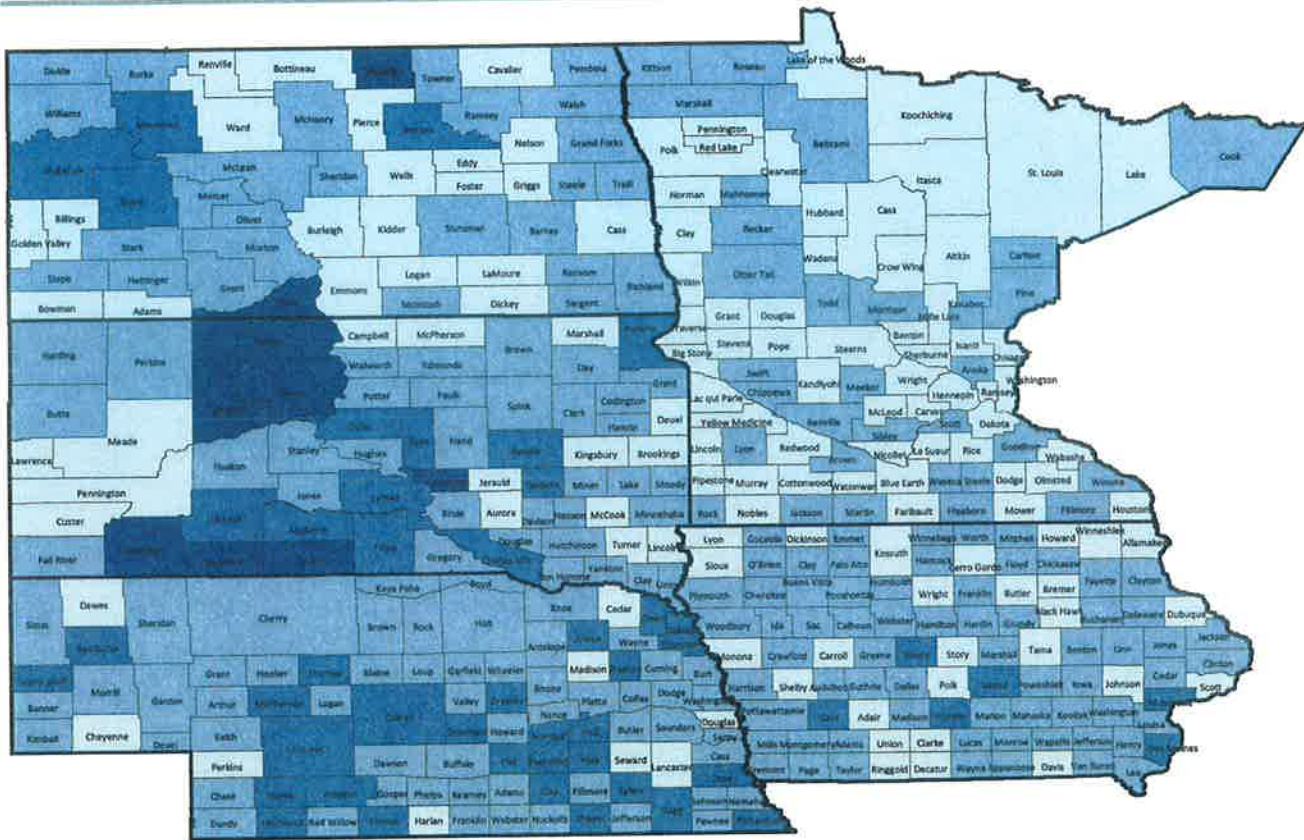n households with a land-line telephone. Seven years of data are used to generate more stable estimates of self-reported health status.

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

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

Map 3

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

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

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

CONTEXT

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

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 1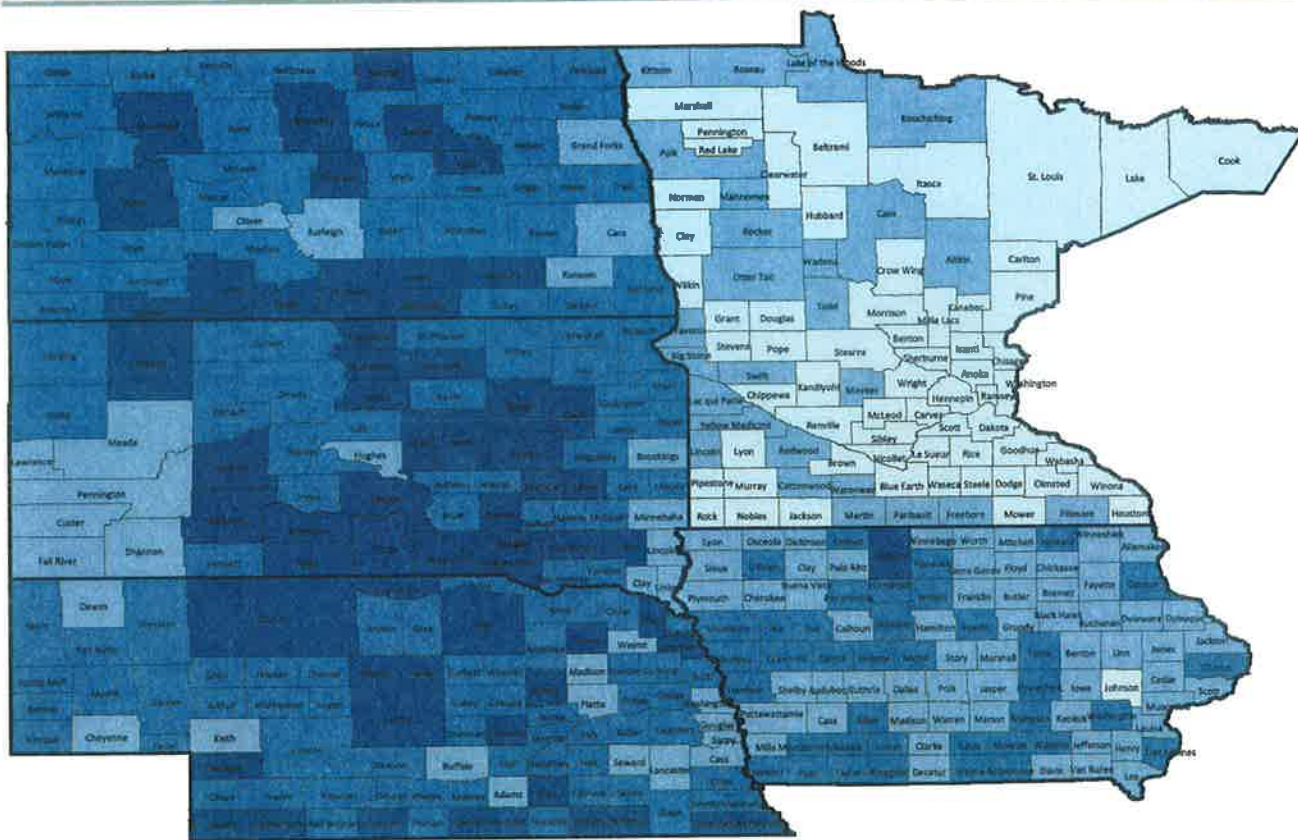8 and older living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of poor physical health days.

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/.

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 1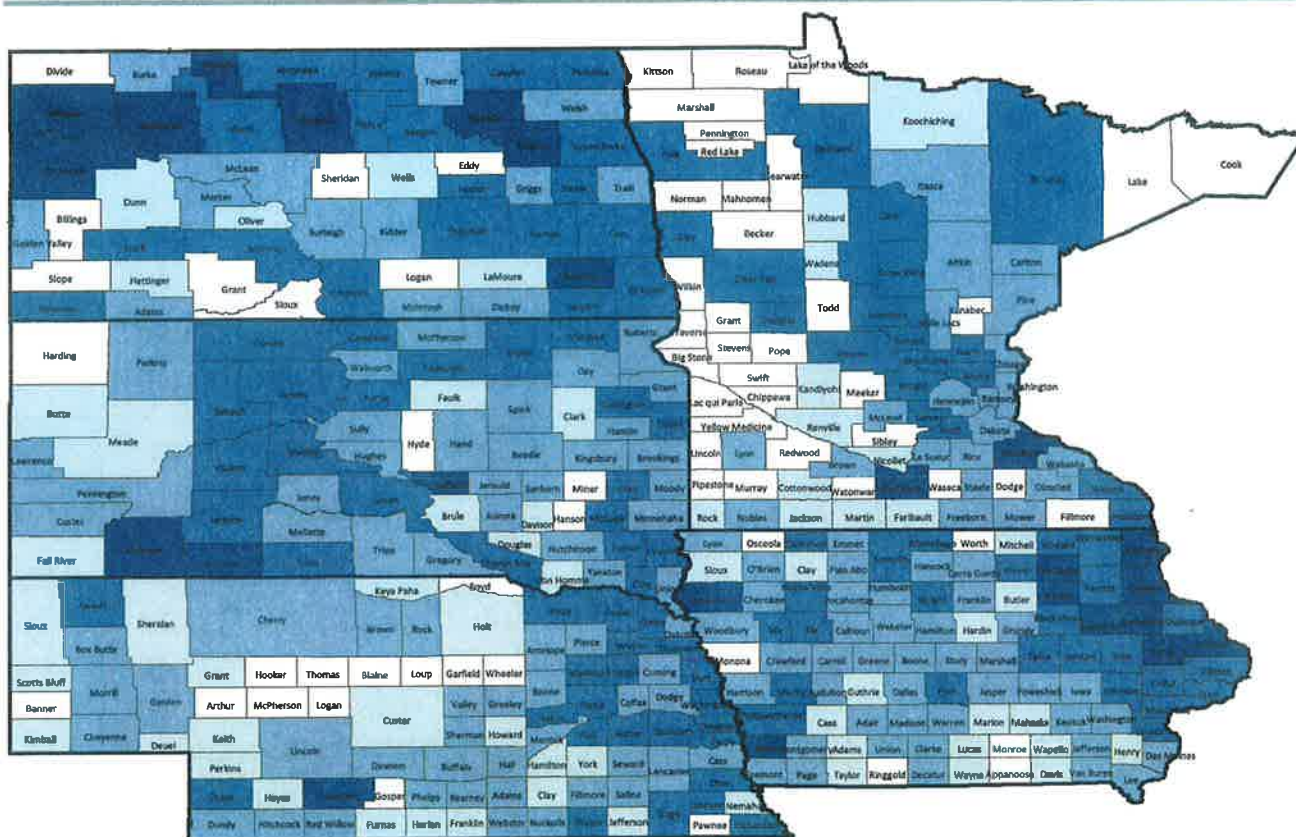8 and older living in households with a land-line telephone. NCHS used seven years of data to generate more stable estimates of poor mental health days.

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

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

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Map 5

Low Birthweight - A health outcome measure focusing on morbidity

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

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

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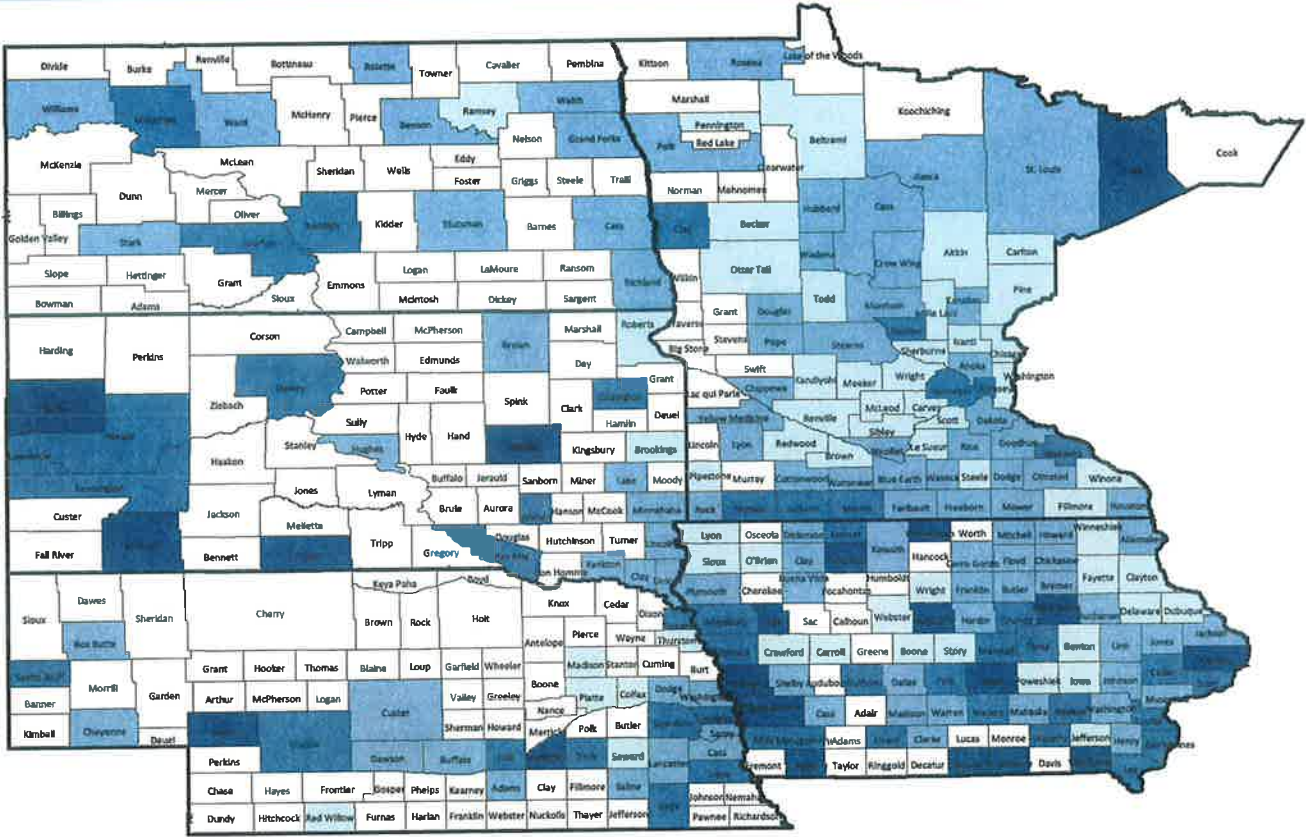
CONTEXT

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

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

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

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

Map 6

Adult Smoking - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
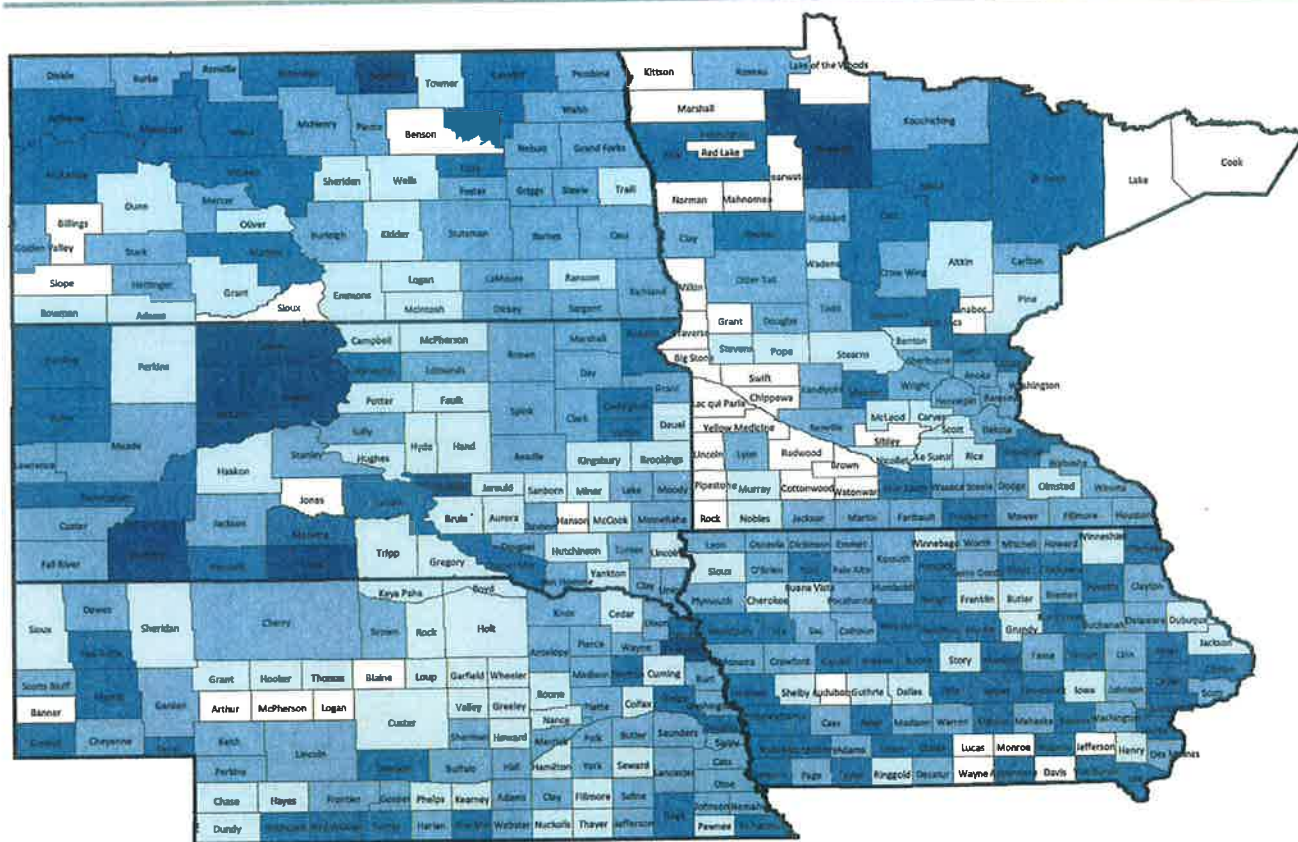
Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

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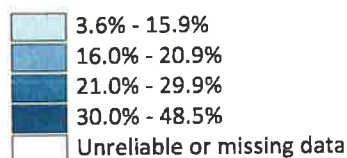
CONTEXT

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%
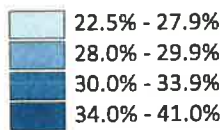
CONTEXT

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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Map 8

Physical Inactivity - A health factor measure focusing on health behaviors

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

Percent of adults reporting no leisure time physical activity, 2008

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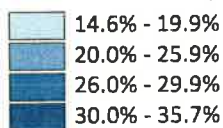
CONTEXT

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

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

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

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

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Map 9

Excessive Drinking - A health factor measure focusing on health behaviors

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

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

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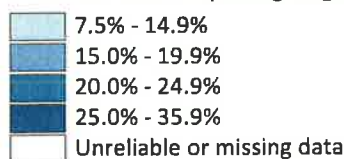
CONTEXT

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

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

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

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

Map 10

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

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

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

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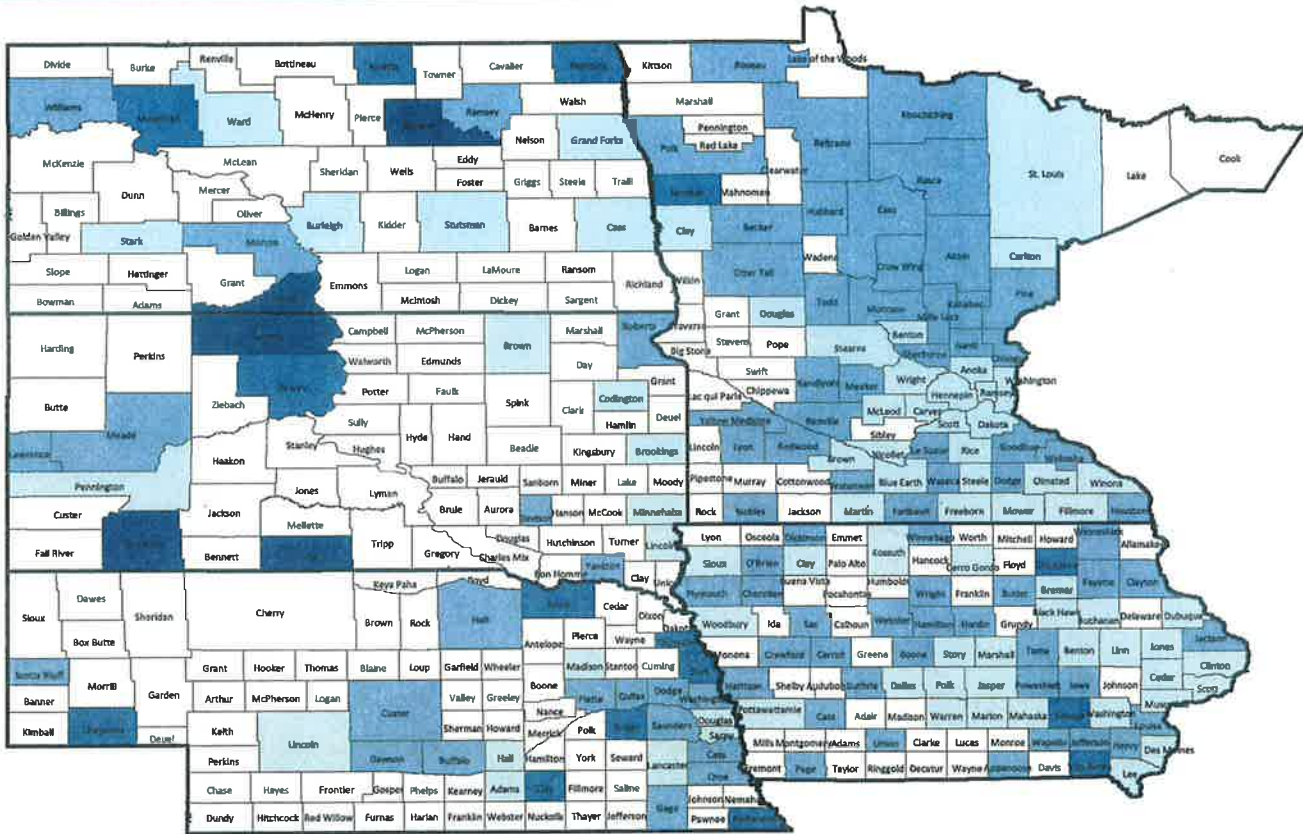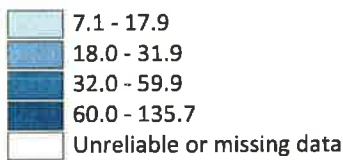
CONTEXT

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

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

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

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

Map 11

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

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

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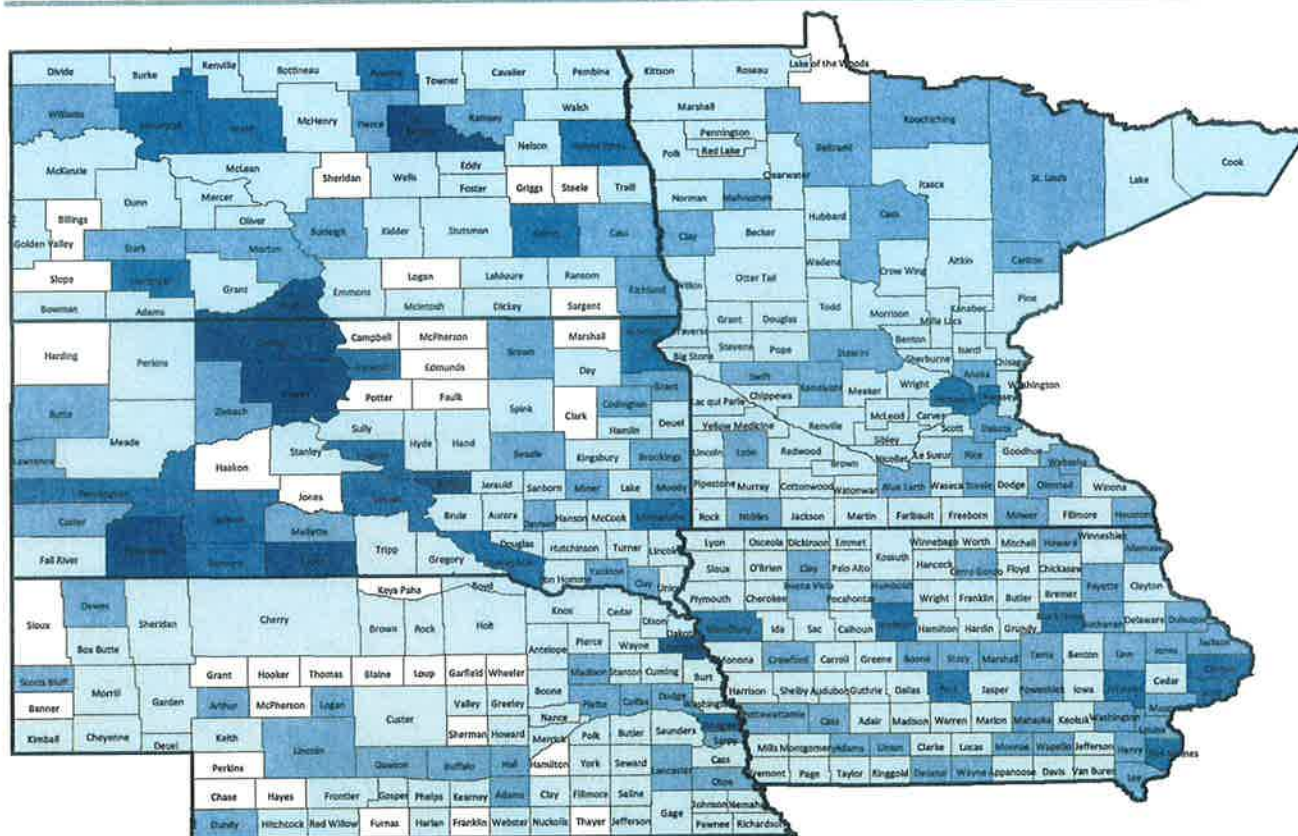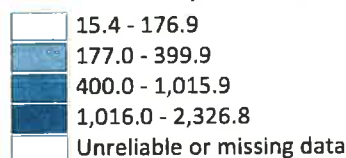
CONTEXT

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

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

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

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

Map 12

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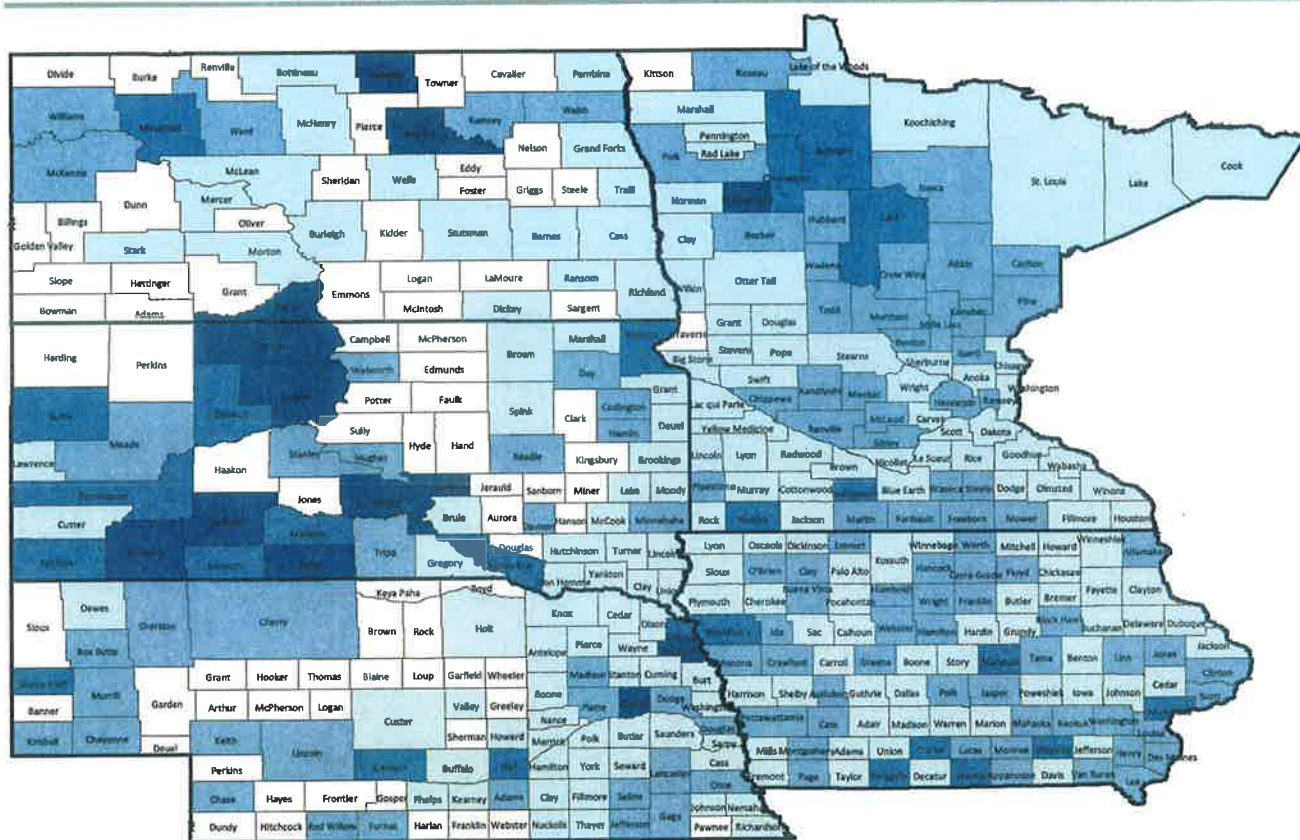
Number of teen births per 1,000 females ages 15 through 19, 2001-1007

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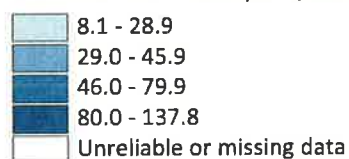
CONTEXT

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

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

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

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

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Map 13

Uninsured Adults - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
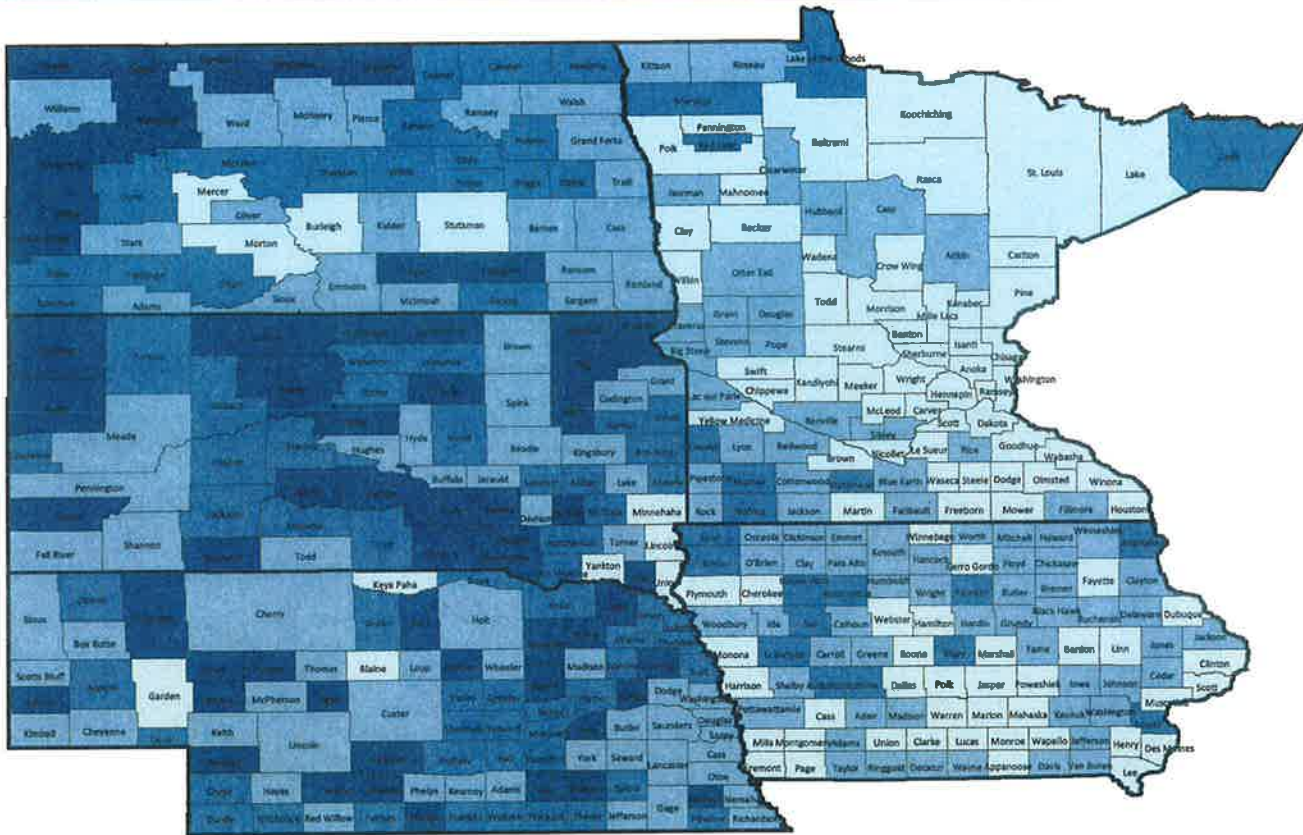
Percent of adult population ages 18 through 64 without health insurance, 2007

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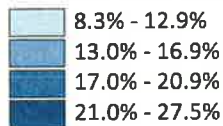
CONTEXT

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

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

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

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

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Map 14

Uninsured Youth - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
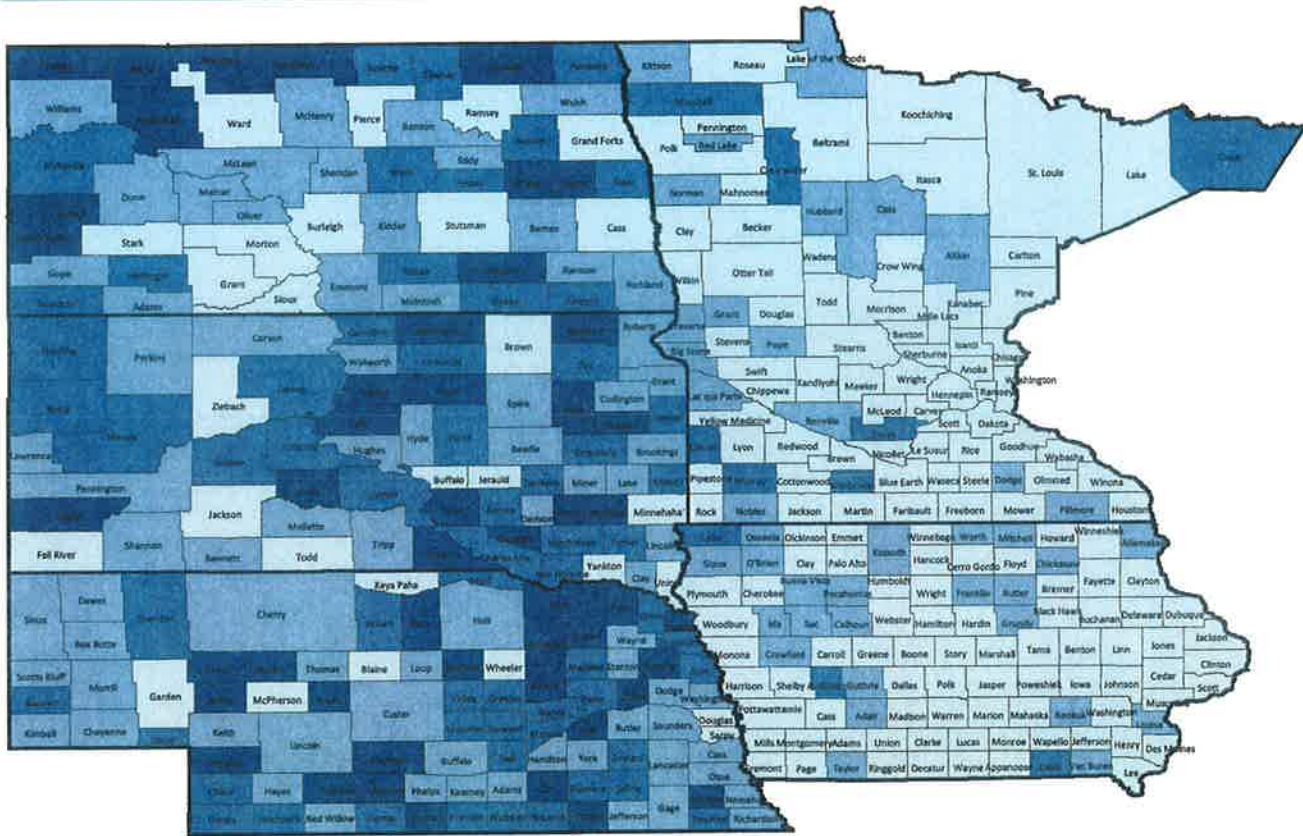
Percent of youth ages 0 through 18 without health insurance, 2007

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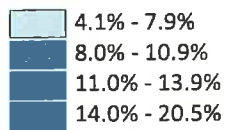
CONTEXT

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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Map 15

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

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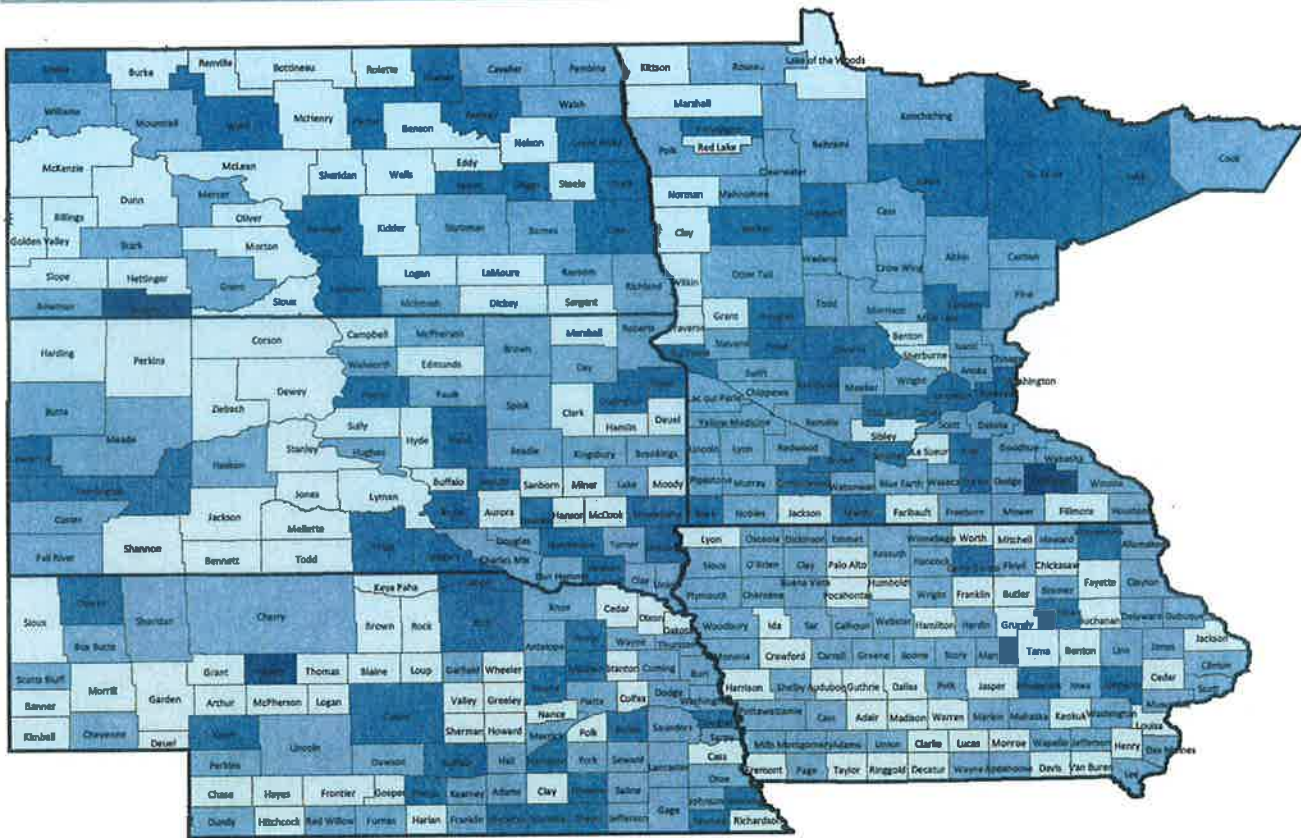
Number of primary care physicians per 100,000 population, 2008

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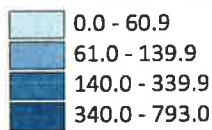
CONTEXT

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

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

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

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

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Map 16

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

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

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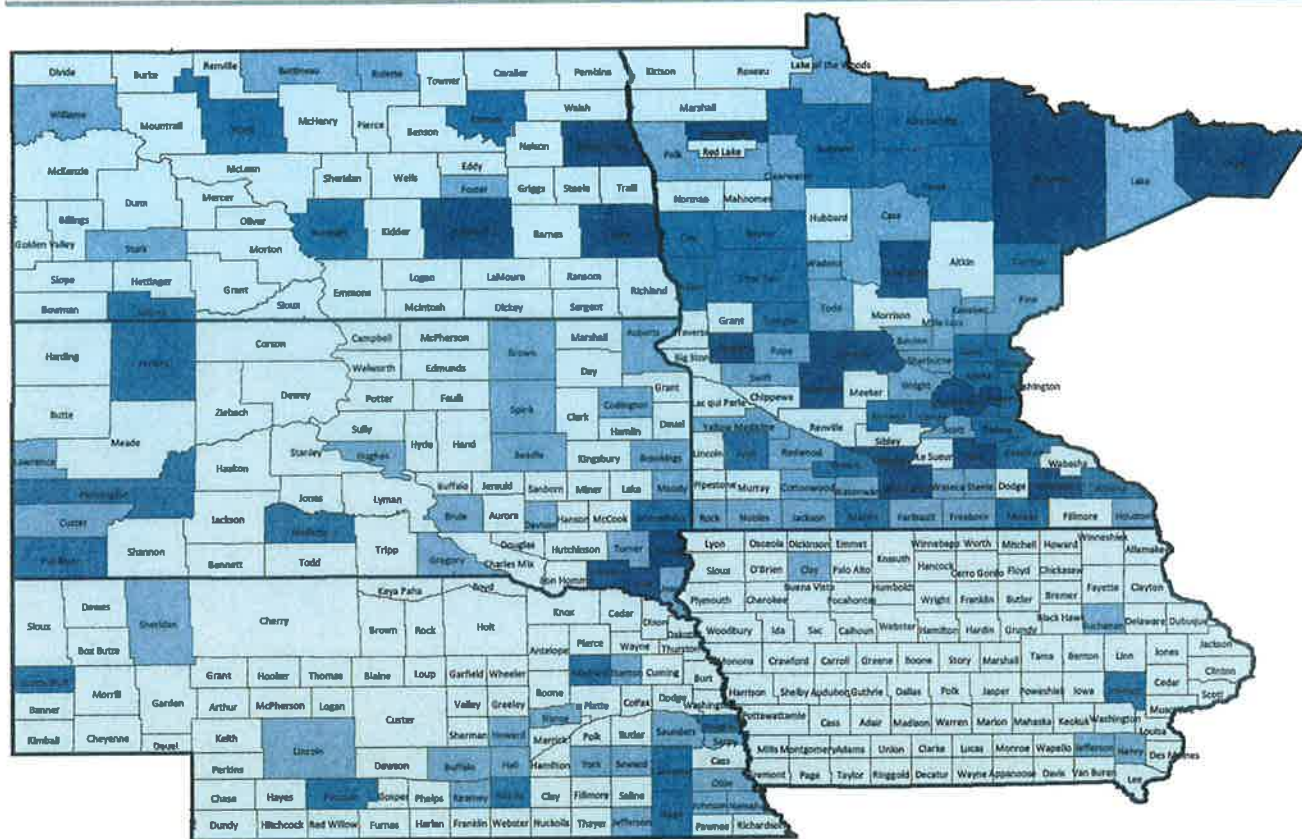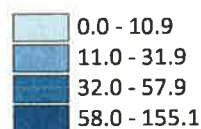
CONTEXT

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

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

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

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

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Map 17

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

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

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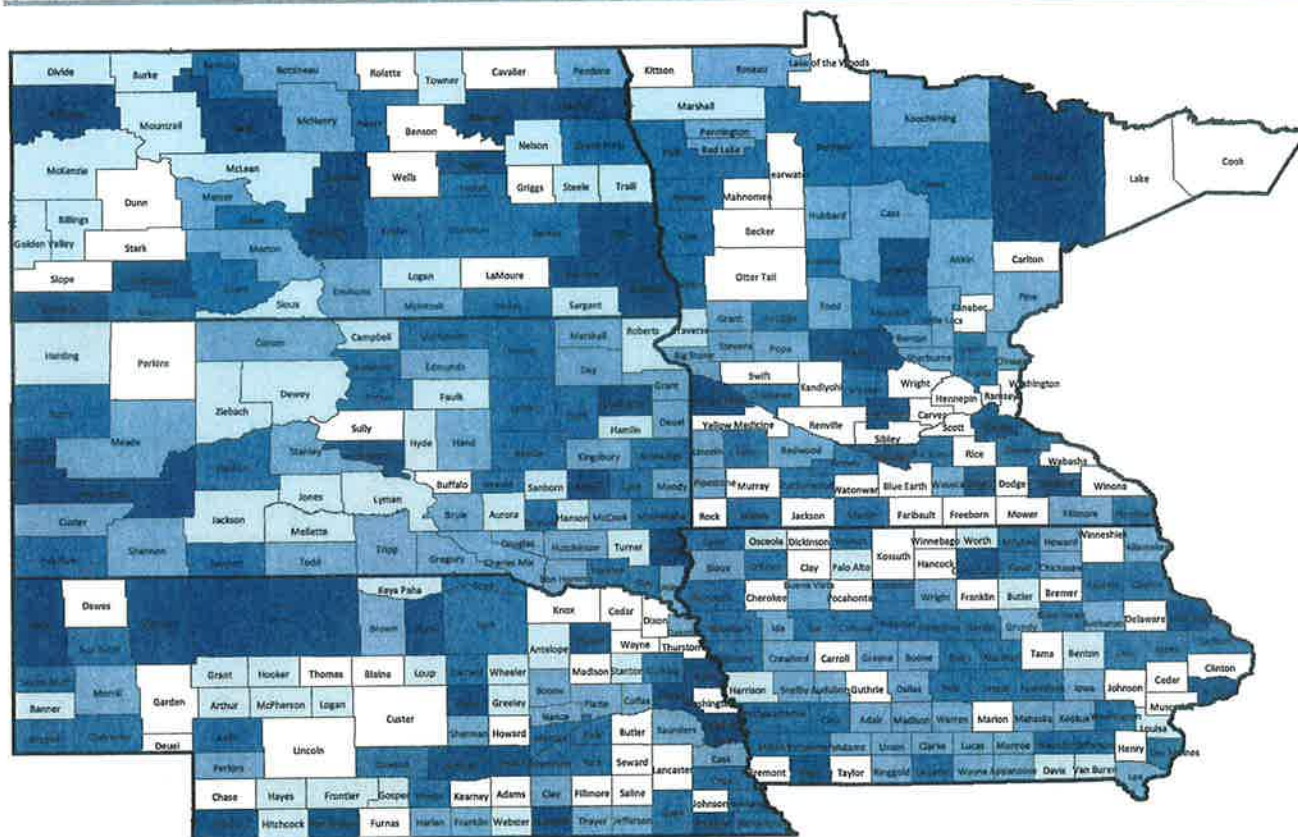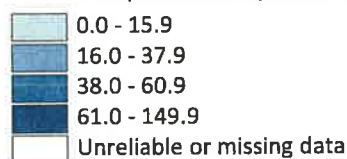
CONTEXT

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

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

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

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

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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
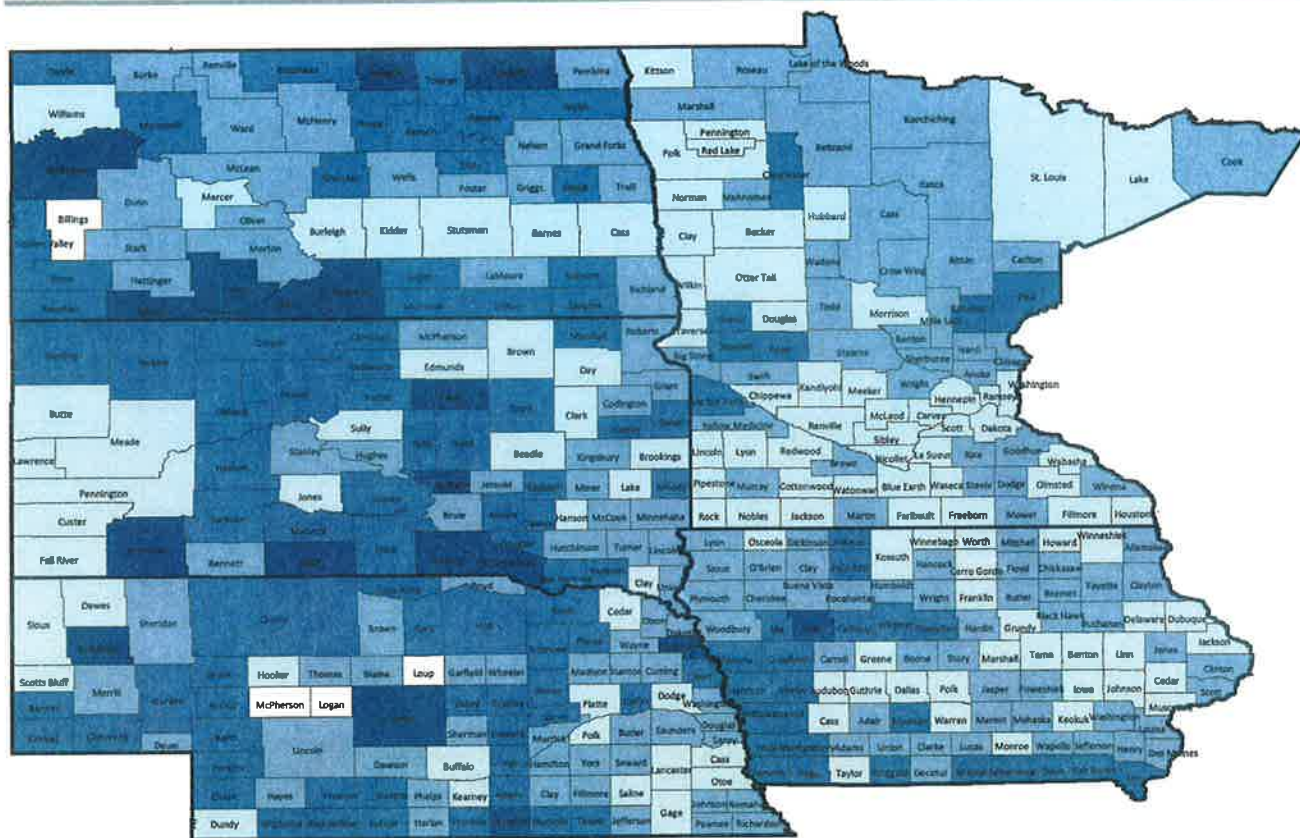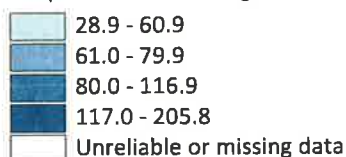
CONTEXT

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/.
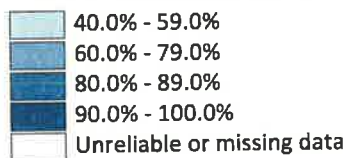
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Map 19

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
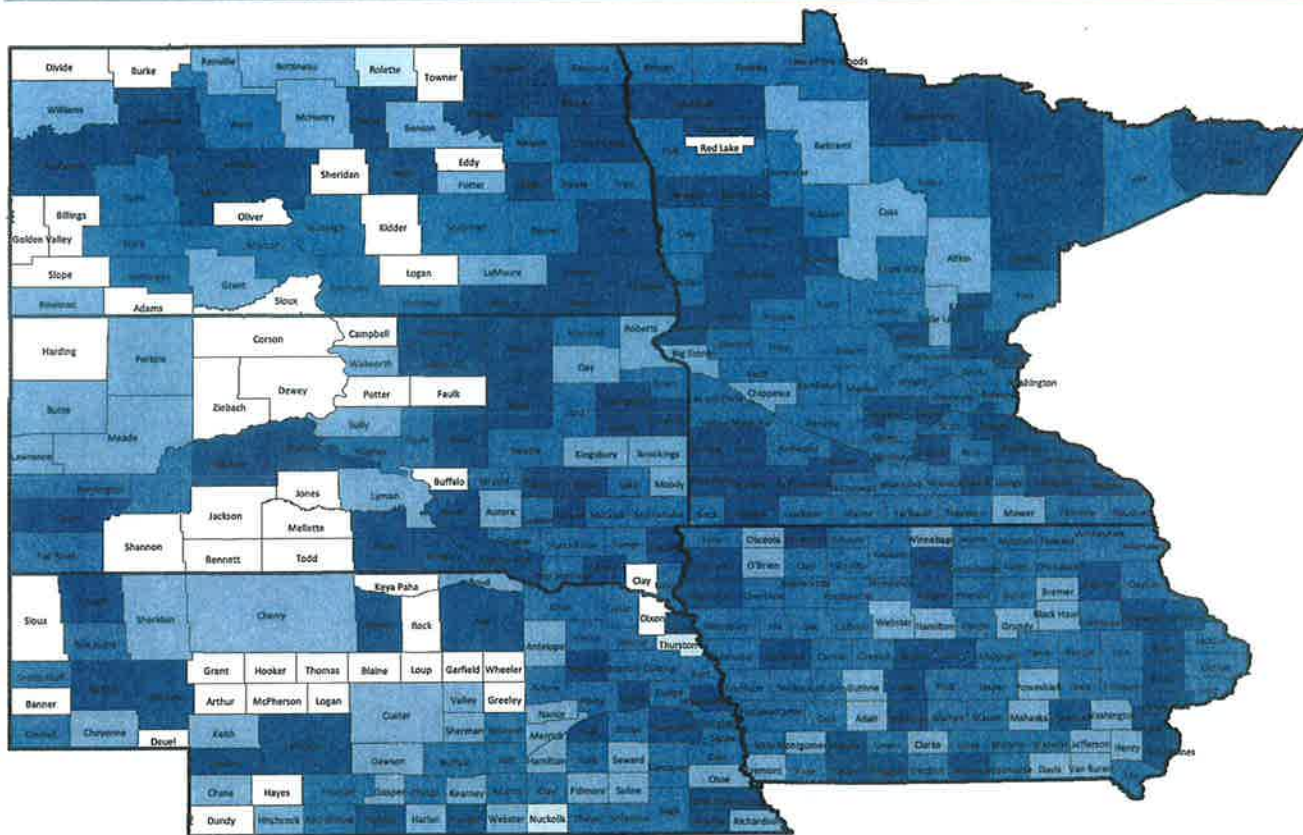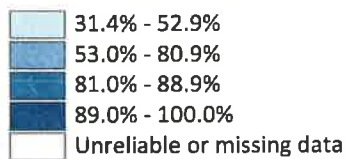
CONTEXT

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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Map 20

Mammography Screening - A health factor measure focusing on clinical care

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

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

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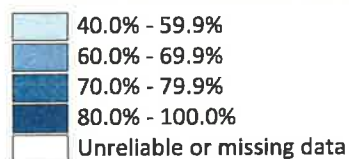
CONTEXT

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

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

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

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

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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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Map 22

Some College - A health factor measure focusing on education

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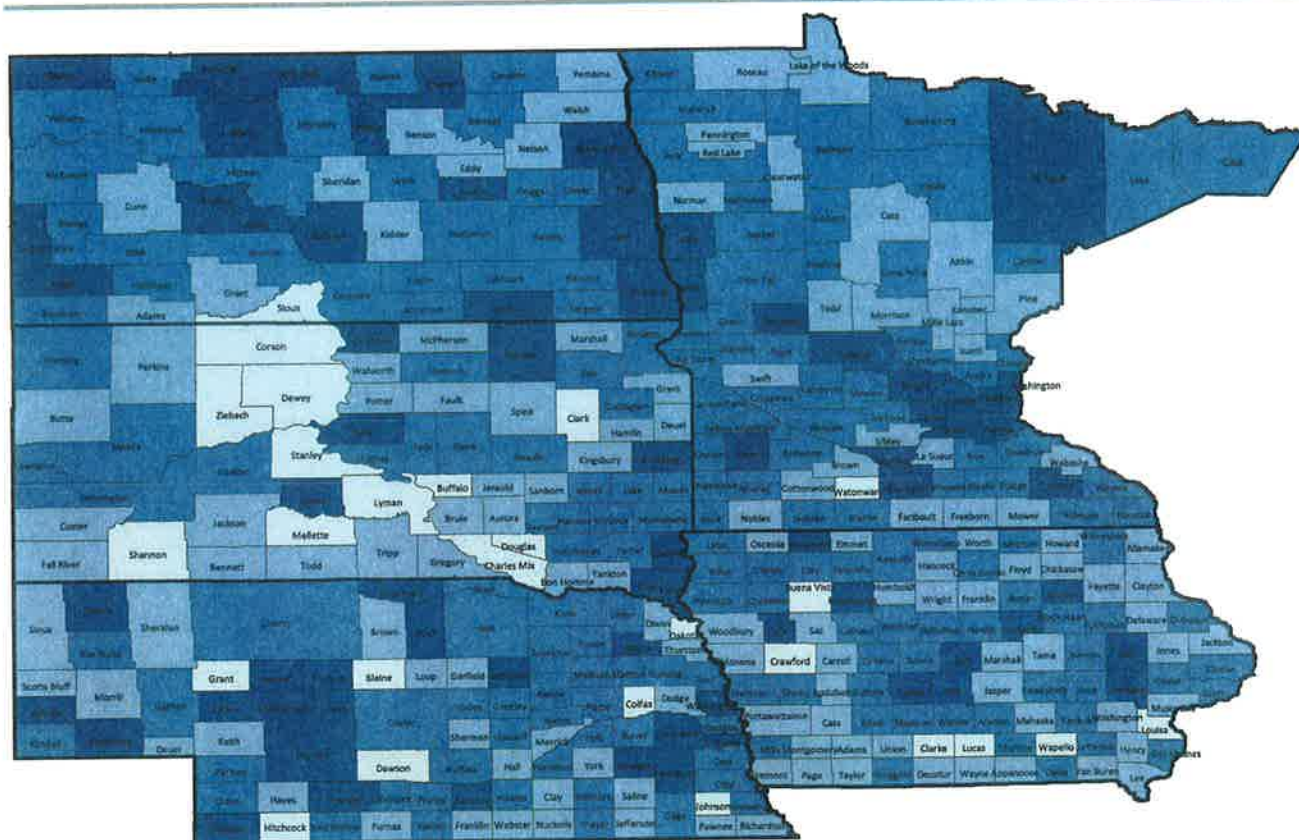
Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009
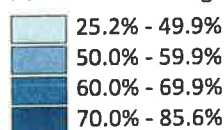
- 25.2% - 49.9%
- 50.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 85.6%

CONTEXT

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

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

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

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

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Map 23

Unemployment - A health factor measure focusing on labor

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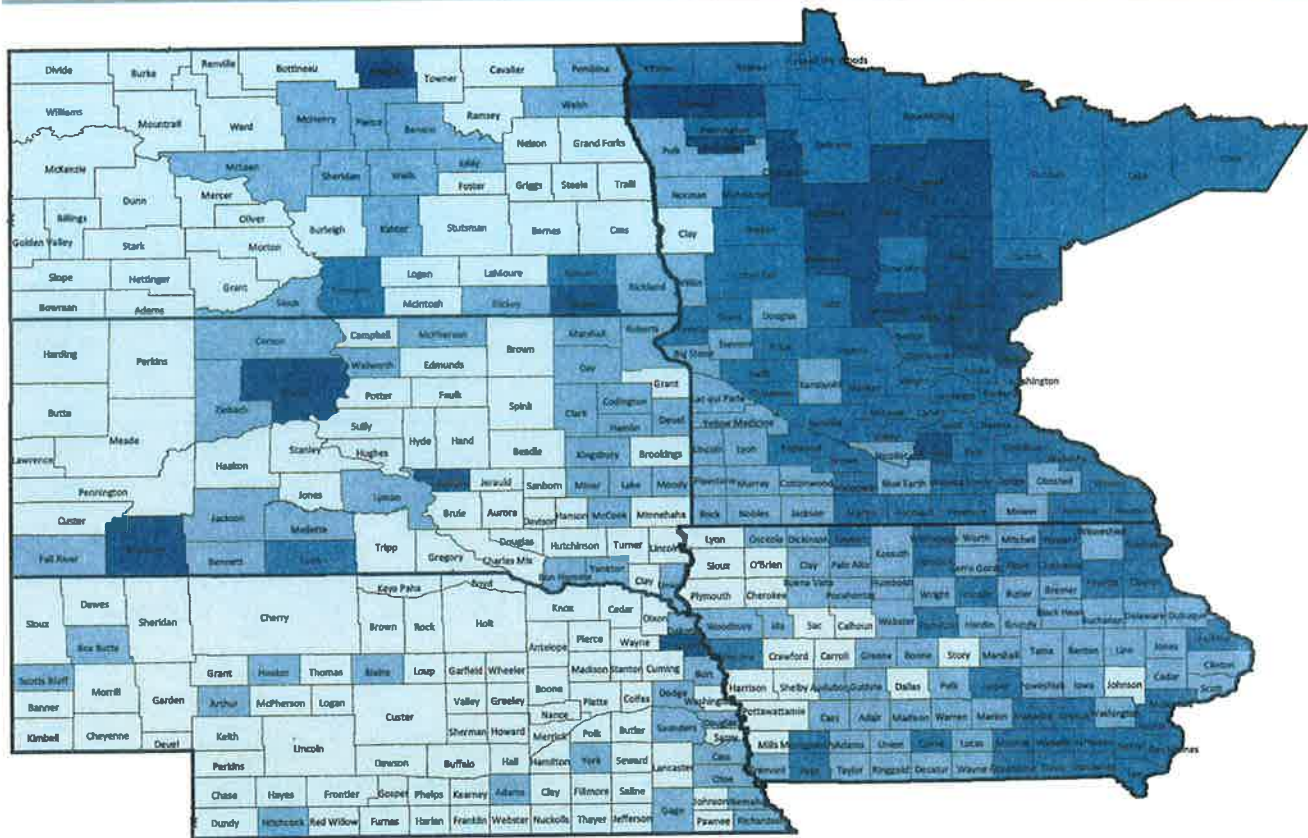
Percent of population ages 16 and older that is unemployed but seeking work, 2009

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

CONTEXT

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

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

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

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

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Map 24

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

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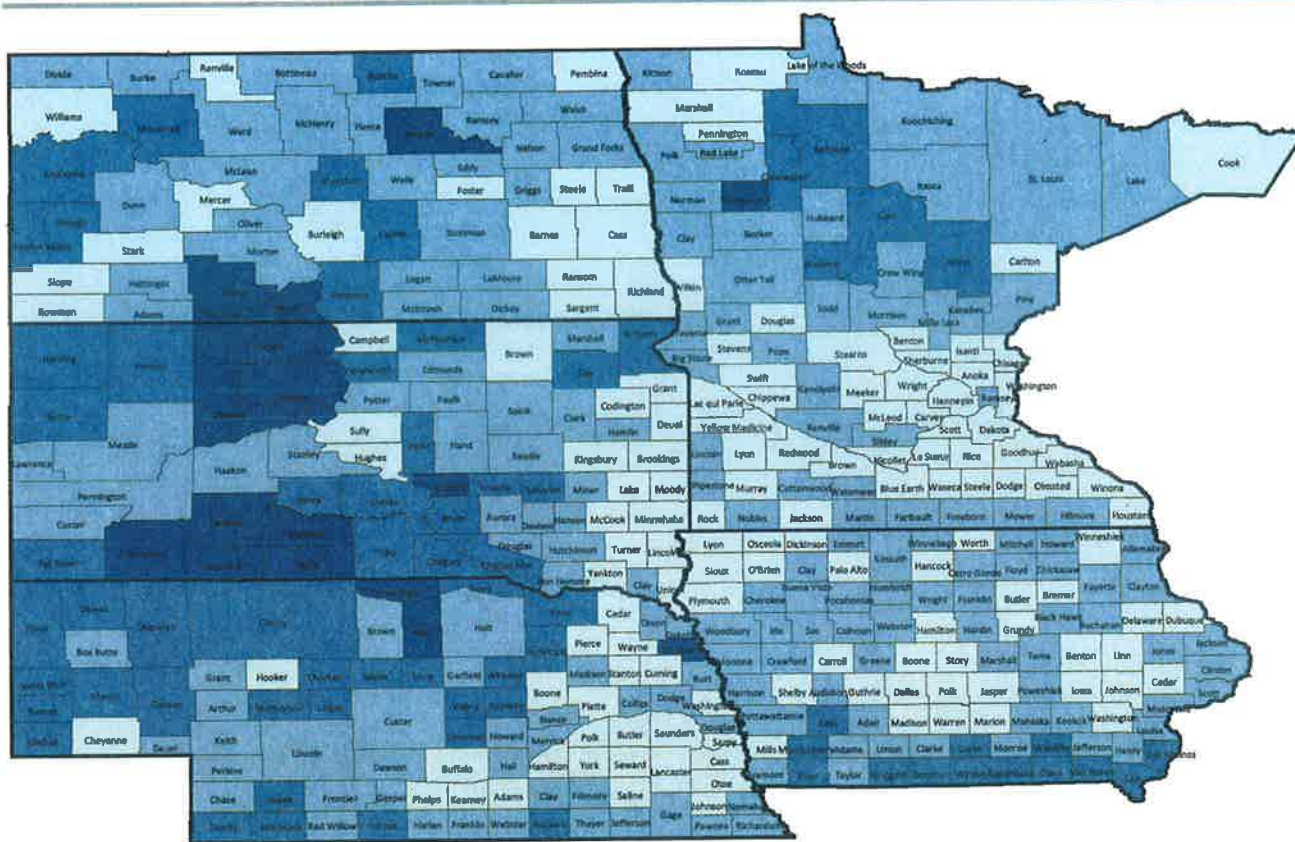
Percent of children ages 0 through 17 living below the Federal Poverty Line, 2008

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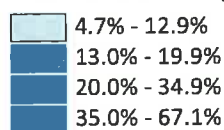
CONTEXT

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

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

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

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

Map 25

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

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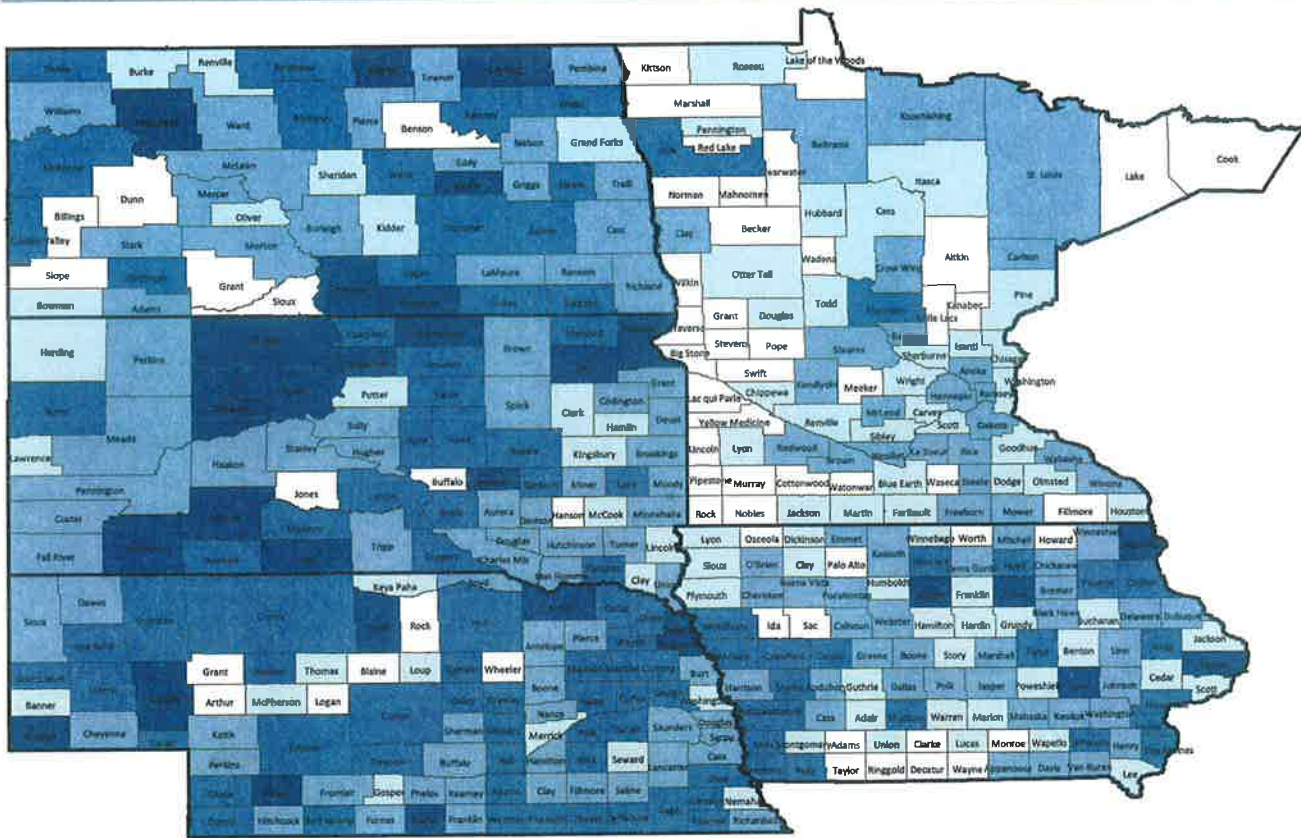
Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009

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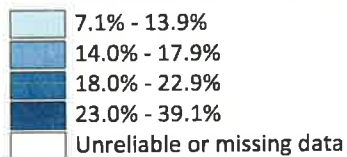
CONTEXT

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

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

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

- 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 26

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

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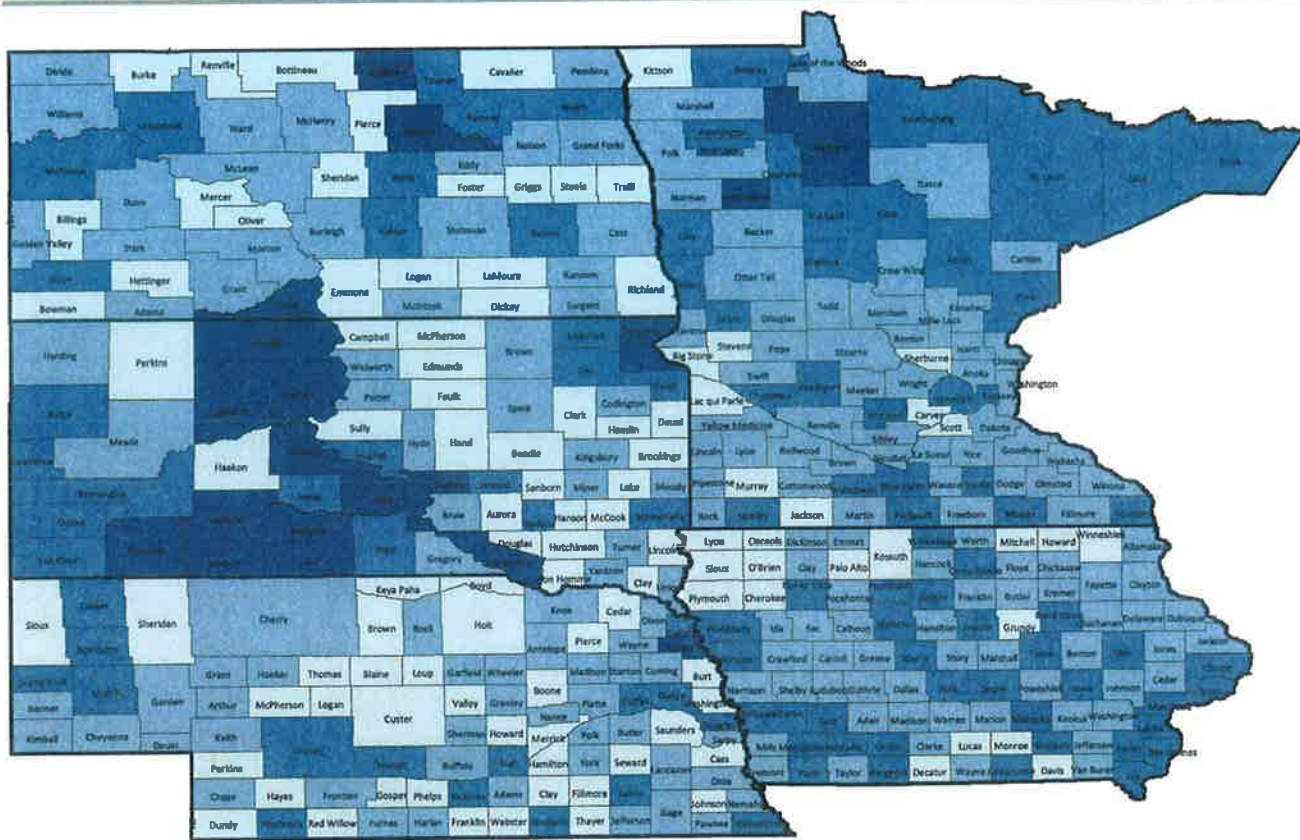
Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009

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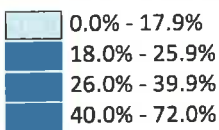
CONTEXT

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

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

Importance: Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.
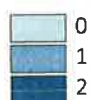
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 27

Homicide Rate - A health factor measure focusing on violent crime
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
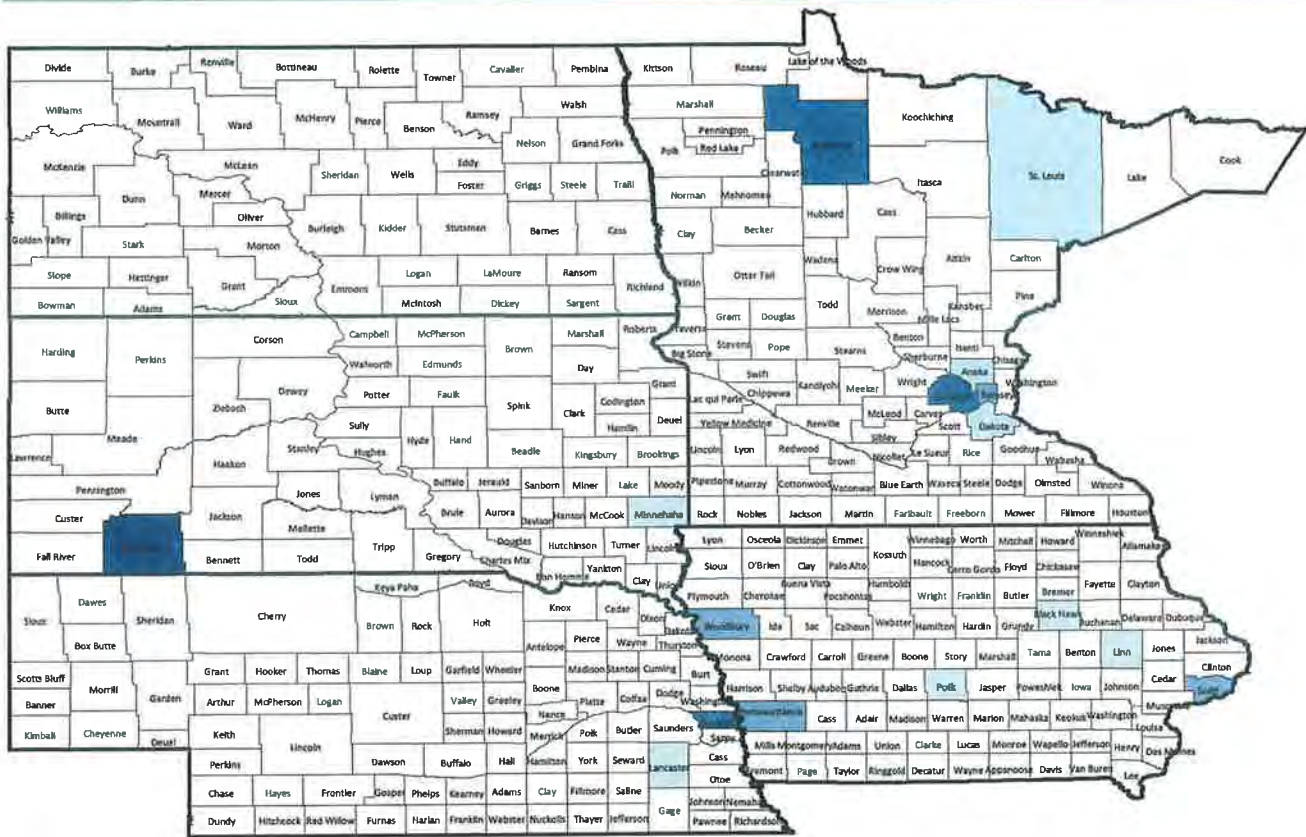
Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

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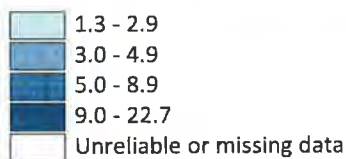
CONTEXT

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

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

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

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

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
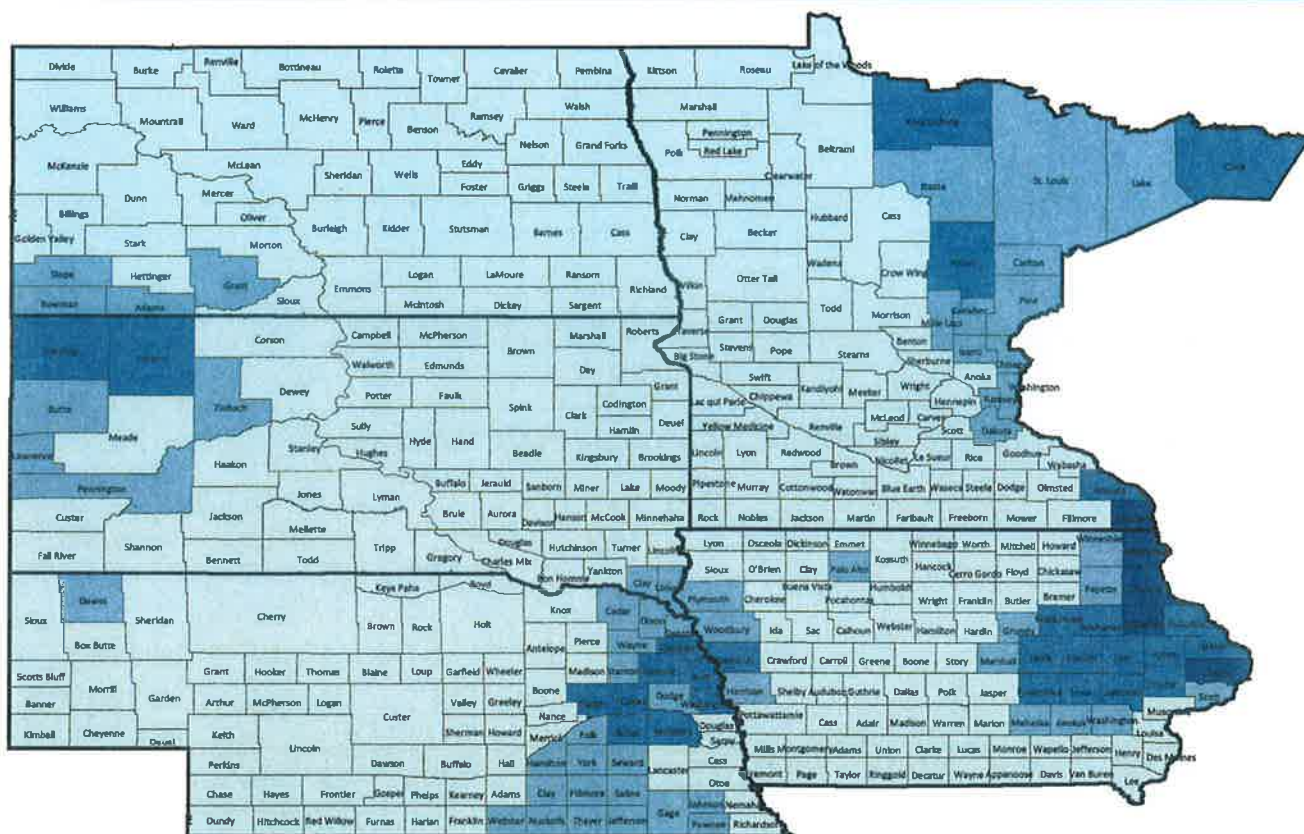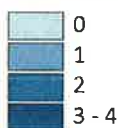
CONTEXT

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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Map 29

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

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

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

- 0
- 1
- 2

CONTEXT

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

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

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

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

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Map 30

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

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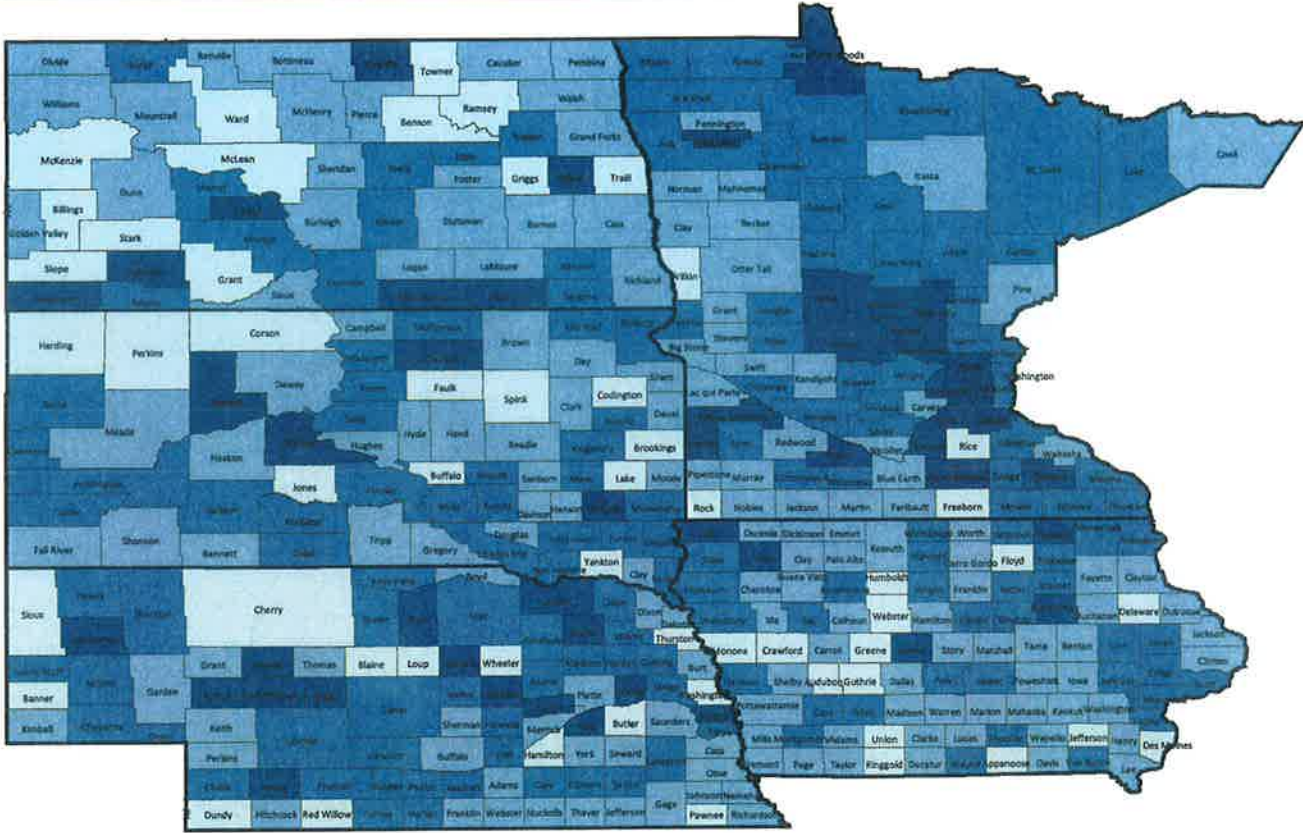
Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008

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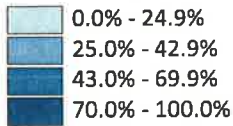
CONTEXT

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

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

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

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

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Map 31

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

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

Number of recreational facilities per 100,000 population, 2008

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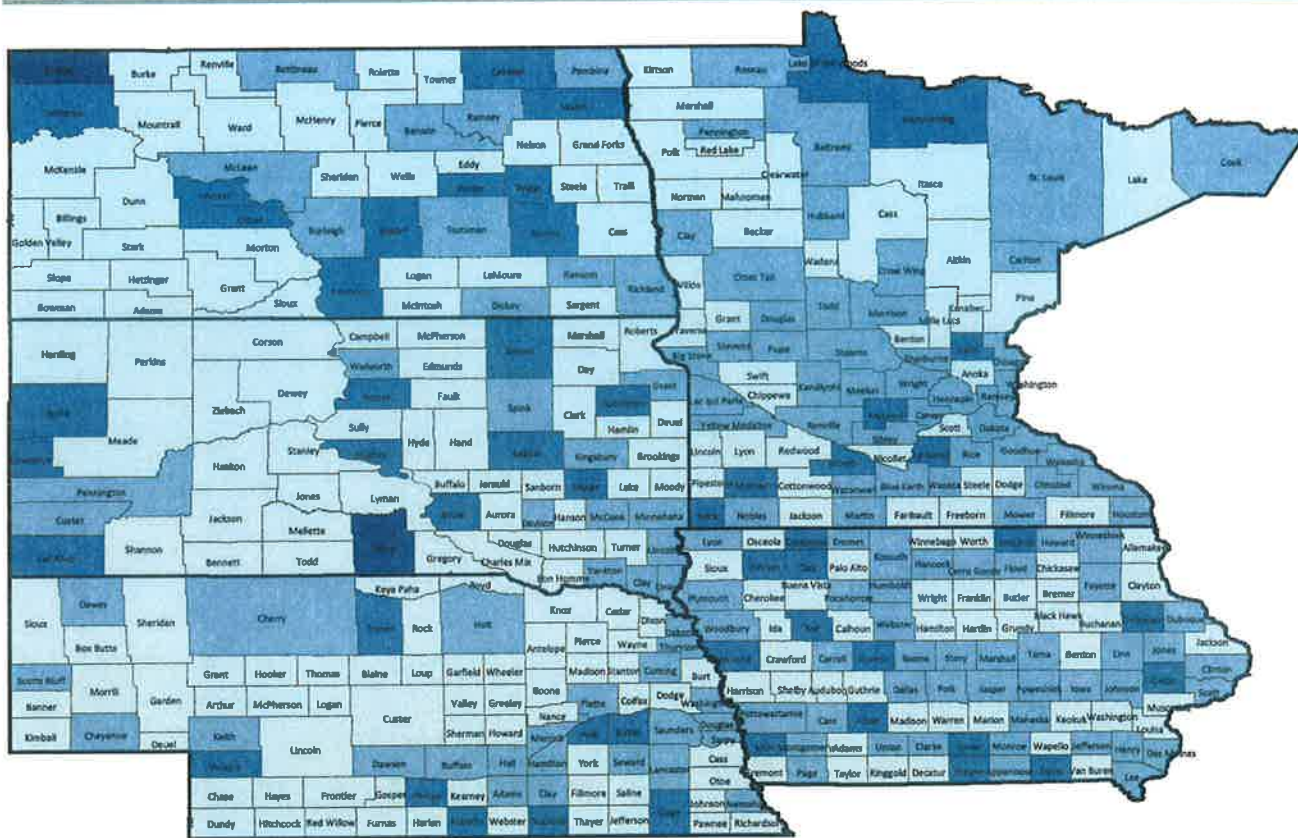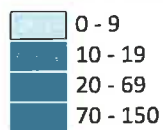
CONTEXT

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

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

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

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

Map 32

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

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

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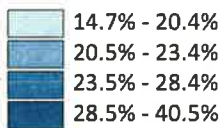
CONTEXT

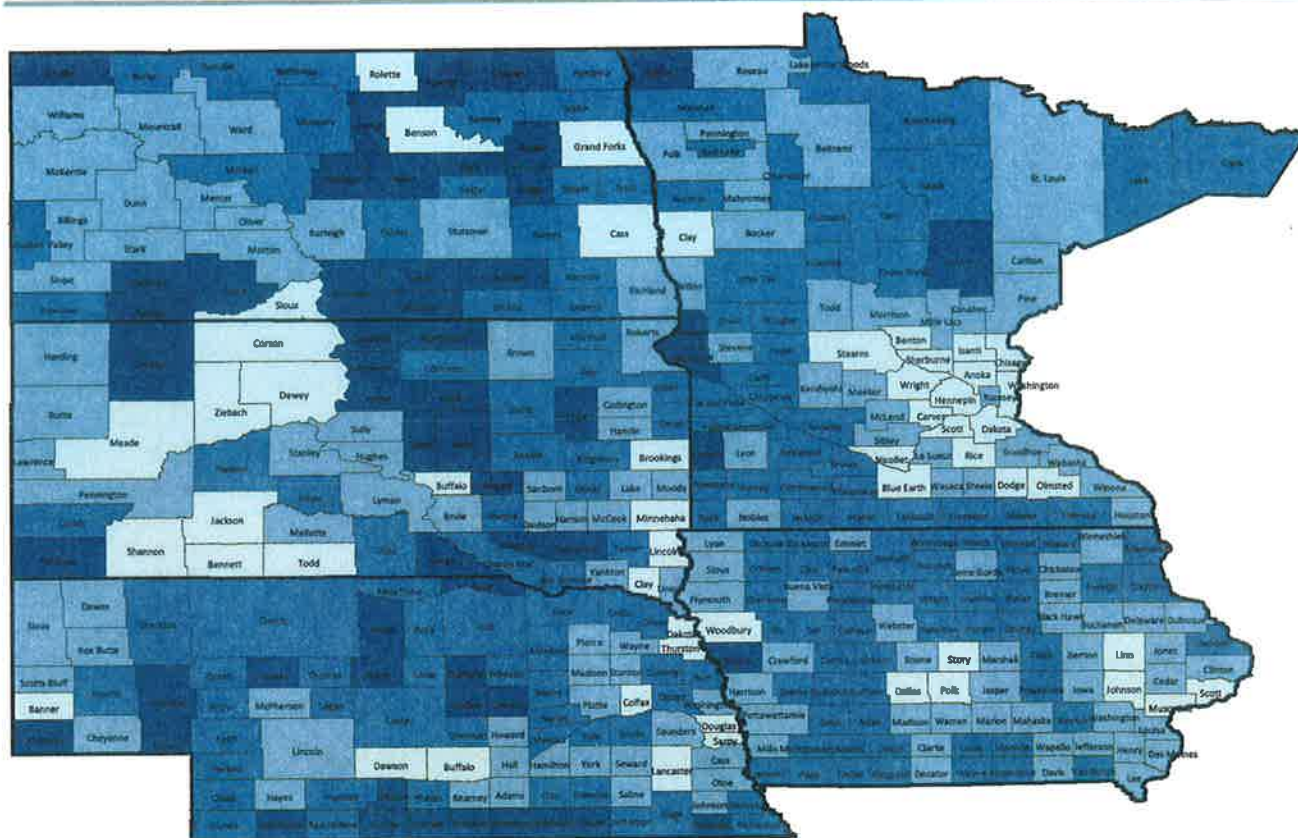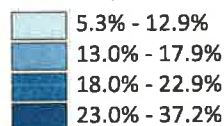**What It Is:** This measure represents the percent of a county's population that is less than 18 years of age.

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
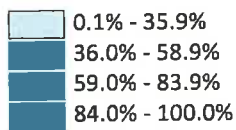
Map 33

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

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

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

CONTEXT

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

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

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

Map 34

Rural - A demographic measure

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

Percent of total population living in a rural area, 2000

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

CONTEXT

What It Is: This measure represents the percent of a county's population that lives in a rural area, which the U.S. Census Bureau defines as all territory located outside of urbanized areas and urban clusters. Urbanized areas and urban clusters are geographic areas with a core population density of at least 1,000 people per square mile that are surrounded by areas with an overall population density of at least 500 people per square mile.
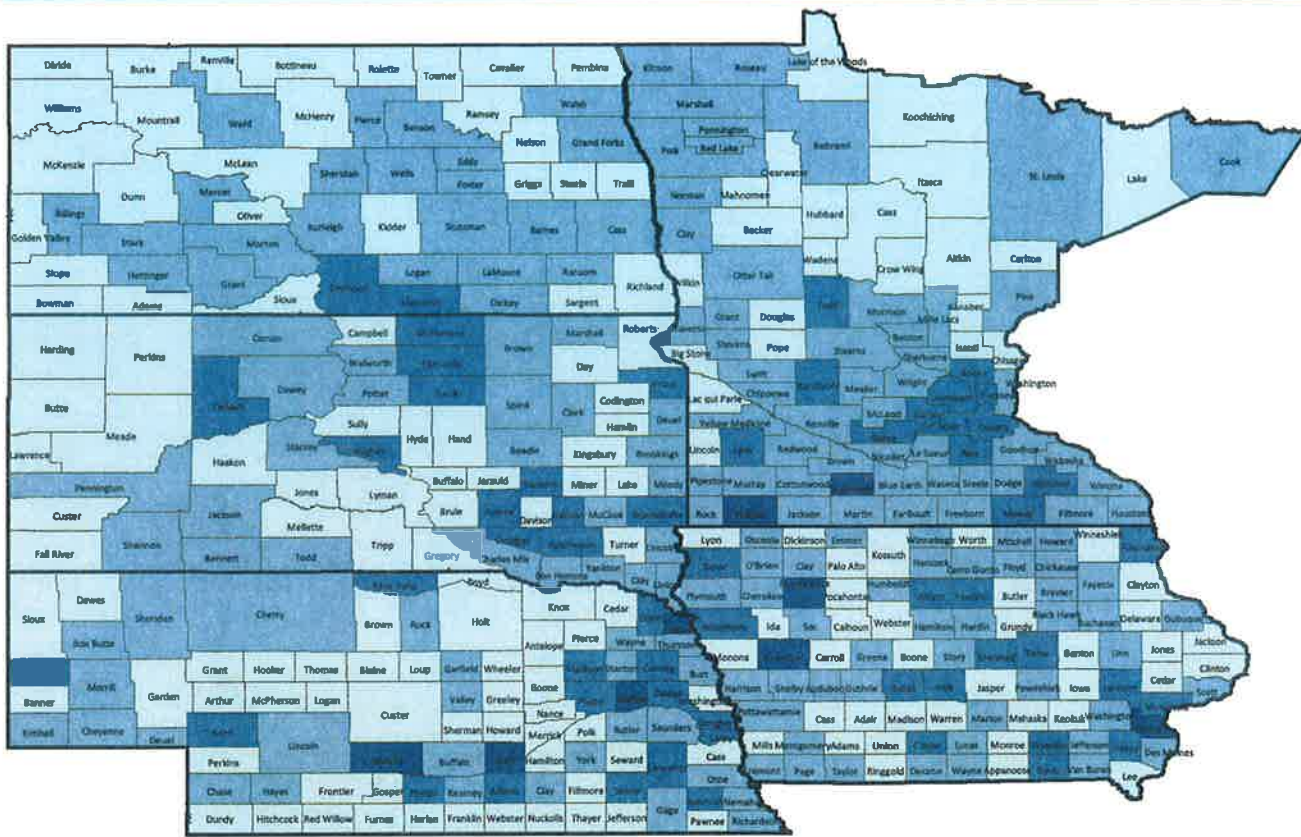
Where It Comes From: This measure is calculated by the U.S. Census Bureau using data from 2000.

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

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Map 35

Not English Proficient - A demographic measure

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

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

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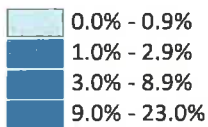
CONTEXT

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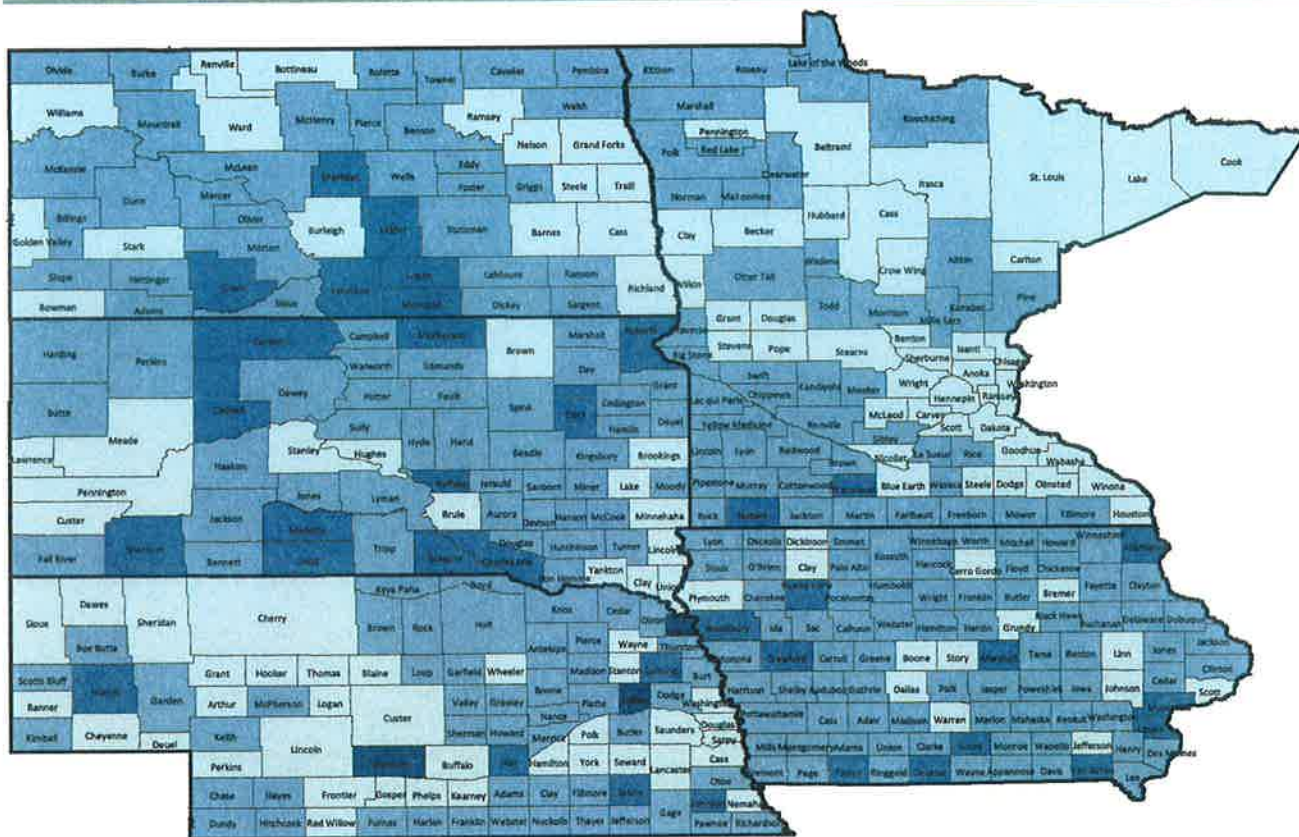
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

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

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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%
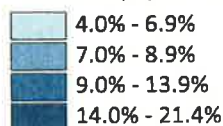
CONTEXT

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
Westbrook Stakeholders

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

Access	• Not enough healthcare providers
	   ○ Need more specialists
	   ○ Dental service
	   ○ Eye care
	   ○ General practitioners – limited number of MDs
	   ○ Mental Health Providers
		• Sanford Westbrook currently has outreach providers covering endoscopy, podiatry, OB/GYN, Cardiology, General Surgery, Orthopedics, and Nephrology-SVC; oncology is available through telemedicine.
		• Open Door of Mankato offers free dental screenings and travels to places for this resource. U Care also has a mobile dental van- U Care is more challenging to work with than Open Door. Sanford Westbrook had a grant through United Way, which helped coordinate low cost dental opportunities for patients with a local dentist- might be worth looking into.
		• Eye care is more challenging. Not known if there are local optometrists that would come to Westbrook to do eye care with patients.
		• Recruitment/Retention of providers is important and should be ongoing. The local committee has not met for some time and is a good reminder to focus on retention. The group would also like to see recruitment for an additional provider in Westbrook.
		• Sanford Tracy and Westbrook are now welcoming Dr. Zhao and Dr. Cochran, adult and child psychiatrists to the outreach schedule. We are also welcoming a NP specializing in mental health in January 2013. There is currently a child psychologist in the budget to be hired for the facilities.	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Cancer	• Cancer is a big problem in our community	• Sanford Cancer Biology Research. • Though there is a high cancer incidence rate in this area, there are limited resources for caregiver and families. • Sanford Westbrook can give chemotherapy to patients. • National organizations, such as the American Cancer Society, offer resources to cancer patients; need to be better about educating what is available and how to access them.	
Economic	• Need to provide more job opportunities • Property taxes are too high • We seem to be changing into a low income area • Concern about those who choose not to work & rely on welfare assistance instead • Poverty • High unemployment	• Though important for the community, Sanford Westbrook does not have the capacity to meet the needs of these concerns. • Will communicate these concerns with City Administration.	X
Emergency Services	• Time to hospital/EMT response	• The response rate to a call in Westbrook is around 4 minutes, but Sanford Westbrook does not have control as to how long it takes for the ambulance to get the patient to the hospital. • Sanford Westbrook currently has one employee on staff who is on the ambulance crew; it has been recommended to continue to encourage staff to become EMTs in order to keep the program a-float in Westbrook. • Though marked unmet, we would like to move this under access as a reminder to encourage staff to be a part of the Westbrook ambulance crew.	X
Healthcare & Insurance Cost	• Cost prohibits good healthcare choices	• Though important for the community, Sanford Westbrook does not have the capacity to meet the needs of these concerns. • Advocacy and education are important for the public. • Will communicate concerns to the Minnesota Hospital Association.	X
Health Factors	• Binge drinking	• There are a limited number of resources available in the area for those who are interested in recovery. • Westbrook does offer an AA class.	X
Morbidity and mortality	• High rate of premature death	• Higher premature death can be tied with higher incidence of chronic diseases and cancer. Sanford Westbrook can work to reduce these higher rates by focusing on the areas of chronic disease and cancer.	X

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Obesity	• Obesity is a big problem	• Sanford WebMD Fit Kids for children and parents • Diabetic education is available to patients through referral. • Dietician is available for those patients who request appt. • Westbrook has a wellness center for adults who would like to work out. There is a cost associated with it; those individuals with BCBS can receive a monthly discount. • Zumba was introduced to the community in June. There are two classes offered per week: Monday and Wednesday. • CHIP grant has received more than $50,000 to work with local school districts to improve their school lunches/nutritional program. • The Medical Home through Sanford should help patients who are obese as health coaching will be a part of the provider referral process.	
Snow Removal	• Sidewalks are not maintained in winter (too much snow & ice for winter walking or biking)	• Though important for the community, Sanford Westbrook does not have the capacity to meet the needs of these concerns. • Will communicate concerns to the City Administration.	X
Transportation	• Distance to more complex healthcare options (prenatal care, dental care)	• Sanford Westbrook offers outreach providers to meet the needs of OB/GYN services from Sanford Worthington. We are currently looking at dental care options. • Transportation services through Western Community Action (volunteer drivers) help transport families/individuals from the community who need help getting to and from medical appointments in farther away communities.	X
Youth	• Provide more opportunities for activities outside the home/school • Bullying • Child abuse and neglect	• Sanford WebMD Fit Kids • The Westbrook-Walnut Grove (WWG) school district does bullying education with students. • Providers in Westbrook work with our social worker to report suspicious child abuse/neglect cases. • Will communicate concerns to the WWG school district.	X

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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
Access	Not enough healthcare providers • Need more specialists • Dental service • Eye care • General practitioners • Mental Health Providers	• Need more specialists • Dental service • Eye care • General practitioners • Mental Health Providers	• Dental service • General practitioners • Mental Health Providers
Cancer	• Cancer is a big problem in our community	• Cancer is a big problem in our community	• Cancer is a big problem in our community
Emergency Services	• Time to hospital/ EMT response		
Health Factors	• Binge Drinking		
Morbidity and Mortality	• High rate of premature death		
Obesity	• Obesity is a big problem	• Obesity is a big problem	• Obesity is a big problem

In attendance: Pat Stewart, Lori Hebig, Laurie Stenke, Angela Nelson, Nate Knakmuhs, and Krista Kopperud