Sanford Health Network

Community Health Needs Assessment

2012-2013

dba Sanford Sheldon Medical Center EIN# 46-0388596

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Purpose

Sanford Sheldon 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 Sheldon 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 key community stakeholders* participated in this assessment work:

- Educators of the Sheldon Community School District, Sheldon, IA
- Volunteers of Sanford Sheldon Medical Center, Sheldon, IA
- High School Seniors of the Sheldon Community School District, Sheldon, IA
- Administration of Northwest Iowa Community College, Sheldon, IA
- Consumer Council Group of Sheldon, IA
- Sanford Sheldon Medical Center Staff, Sheldon, IA
- Professional Staff of Peoples Bank, Sheldon, IA
- Lions Club Service Organization Group, Sheldon, IA
- O'Brien County Public Health Employees
- City of Sheldon Employees and Council Members, Sheldon, IA
- Cabinet Members of Village Northwest Unlimited, Sheldon, IA
- Sheldon Ambulance Team Members, Sheldon, IA
- Prairie Queen Kiwanis Members, Sheldon, IA
- Sheldon Noon Kiwanis Members, Sheldon, IA

*Specific names available upon request**.**

Sanford Sheldon Medical Center
Community Health Needs Assessment
2012-2013

Executive Summary

Purpose

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

Study Design and Methodology

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for O'Brien County
- Aging Profiles for O'Brien County
- Diversity Profiles for O'Brien 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

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

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

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

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

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

Respondents had very high levels of agreement that their community has a quality school system and programs for youth, there are quality higher education opportunities and institutions, and there is quality health care. However, respondents agreed the least that there the community is socially and culturally diverse and there is tolerance, inclusion, and open-mindedness in their community.

Respondents were most concerned healthcare cost/insurance cost, low wages, and availability of employment opportunities were high general levels of concerns within the community. Respondents were also concerned with issues regarding housing or the lack of rental houses and apartments, as well as run down houses and sidewalks not maintained. Environmental issues of water quality, air quality, and noise levels were not a large concern. Prostitution and violent crimes were also not large concerns.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care and physicians. Respondents were also concerned about access issues, particularly unacceptable delays for care, the need for urgent care or walk-in clinics, as well as the need for more specialty physicians. The need for additional medical physicians was also a concern of the respondents. The healthcare uninsured community members were also among the top health and wellness concerns among respondents. Respondents were least concerned about distance to health care services and availability of bilingual providers and/or translators.

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

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

Respondents were moderately concerned about obesity and had a low level of concern with the availability of good walking or biking options. Respondents were least concerned with traffic congestion.

Respondents were not very concerned with environmental issues in their community. Garbage and litter concerns were more of a concern than water, noise and air quality.

The levels of concern among respondents regarding substance use and abuse issues in their community were fairly high with equal amount of concern about alcohol use and abuse. Although still moderately high, respondents were least concerned about exposure to second-hand smoke.

The top three reasons respondents gave for their choice of primary health care provider were quality of services, being influenced by their health insurance, and availability of doctors, nurses and/or specialists.

About 23% of respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because it was not necessary. "The doctor hasn't suggested it" was also a reason behind not having a screening performed.

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

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

One in five respondents said choosing their primary health care provider was influenced by their health insurance as well as being valued as a patient. Cost was not an issue in choosing a provider for most respondents.

Respondents were asked which provider they used for their primary health care. Eighty-three percent (83%) of respondents said they use Sanford Health/Sanford Sheldon as their primary health care provider.

Key Findings – Secondary Research

Health Outcomes

The mortality health outcomes indicate that Iowa as a state and O'Brien County have more premature deaths than the national benchmark.

The morbidity health outcomes indicate that Iowa citizens and O'Brien County report less days of poor health than the national benchmark.

O'Brien County reports less than the national benchmark for mentally unhealthy days while Iowa as a state reports more than the national benchmark.

O'Brien County has a lower percentage of low birth weight than the national benchmark while the state of Iowa has a higher percentage of low birth weight.

Health Factors

The health behavior outcomes indicate that the state of Iowa and O'Brien County have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in the state of Iowa and O'Brien County. The state of Iowa and O'Brien County have a higher percentage of physical inactivity than the national benchmark.

The state of Iowa and O'Brien County have a higher percentage of binge drinking reports than the national benchmark. Motor vehicle crash death rates are also higher than the national benchmark in the state of Iowa and O'Brien County.

Sexually transmitted infections rank lower than the national benchmark for O'Brien County, while the state of Iowa is substantially higher than the national benchmark. The teen birth rate is higher in O'Brien County and the state of Iowa than the national benchmark.

The clinical care outcomes indicate that O'Brien County has a higher percentage of uninsured adults than the national benchmark, while Iowa as a state meets the national benchmark. The percentage of uninsured youth is the higher in O'Brien County than the national benchmark, but is slightly lower in Iowa as a whole.
The ratio of population to primary care physicians is substantially higher in Iowa and O'Brien County than the national benchmark. The ratio of population to mental health providers is also much higher in Iowa and O'Brien County than the national benchmark. The number of professionally active dentists is lower than the national benchmark in Iowa and O'Brien County. Preventable hospital stays are higher than the national benchmark in Iowa and O'Brien County.

Diabetes screening in Iowa and O'Brien County is slightly lower than the national benchmark. Iowa and O'Brien County rank slightly lower than the national benchmark for mammography screenings.

The social and economic factor outcomes indicate that Iowa and O'Brien County both have a lower high school graduation rate than the national benchmark. The unemployment rate was slightly lower in O'Brien County during 2009 while Iowa is slightly higher than the national benchmark during 2009. The percentage of child poverty is higher in Iowa than the national benchmark. The percentage in O'Brien County is the same as the national benchmark.

The percentage of children in single parent households is lower in O'Brien County than the national benchmark, while the state of Iowa percentage is higher. The number of homicide deaths in Iowa is higher than the national benchmark but in O'Brien County is lower than the national benchmark.

The physical environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked below the national benchmark for O'Brien County; however, for Iowa as a whole this is ranked far below the national benchmark. In this rural area there can be a far distance to travel to grocery stores, and there are food deserts in some communities where only a gas station convenience store is close to home. Access to recreational facilities ranks higher than the national benchmark for O'Brien County and lower than the national benchmark for the state.

Youth account for 23% of the population in O'Brien County. Elderly account for 21% of the population in O'Brien County and for 15% of the population in the state as a whole. Seventy percent (70%) of O'Brien County is rural compared to 39% for the state of Iowa and 21% as the national benchmark.

Only 2% of O'Brien County residents and 3% of Iowans are not proficient in English compared to the national benchmark which is 9%.

The population for this area is relatively young with only 4% older than 85 years of age; however, 20% of the population is older than 65 years of age. The median age for O'Brien County is 43.6 and for Iowa it is 38.1.

The gender distribution is 50-50 across the state of Iowa and in O'Brien County.

The majority (72%) of individuals in Iowa own their homes, while the ownership rate for O'Brien County is 76%.

According to the 2010 Census Data, the population of working age in the labor force ranges from 67-69% in Iowa and in O'Brien County. The percentage of those who are living at less than 100% of the poverty level range between 11-12 % in Iowa and O'Brien County, and 29-42% at the less than 200% of the poverty level.

The median household income in the state of Iowa as a whole is $48,872, with a median income of $44,018 in O'Brien County.

The population distribution from the 2010 U.S. Census Summary by race demonstrates that Iowa and O'Brien County are predominantly white. In Iowa, the white population totals 2,781,561 of the 3,046,355 total state population, and in O'Brien County it totals 13,829 while the total population in O'Brien County is 14,398.

Hispanic origin of any race ranks second in both the state of Iowa and O'Brien County. For Iowa the Hispanic origin is 151,544 and O'Brien County is 545.

Implementation Strategy

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

- Access
- Physician Recruitment
- Preventative Services

Implementation Strategy – Access

- Devise and implement a plan to create optimal coverage of the emergency department utilizing APPs.
- Recruit additional physicians to meet the needs of the patient base and growth.
- Utilize Health Care Coach to manage/reduce repeat visits.
- Offer a physician assistant in the Sheldon clinic for acute care appointments open with daily access.

Implementation Strategy – Recruitment

- Continue to work to recruit at a minimum of two additional physicians.
- Work closely with Sanford Physician Recruitment department to ensure opportunities in Sheldon are actively promoted.

Implementation Strategy – Preventative Services

- Continue to offer the current preventative services and better educate the community on the importance and value of these screenings.
- Work with Sanford Health and the Outreach providers to determine the preventative services opportunities that are needed in the communities.

Sanford Sheldon Medical Center

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

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

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

Our Values:

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

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

Guiding Principles:

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

Description of Sanford Sheldon Medical Center

Sanford Sheldon Medical Center (Sanford Sheldon) is a 25-bed Critical Access Hospital that provides inpatient, acute and long-term care. In addition, Sanford Sheldon offers a broad range of outpatient services which includes Sanford Sheldon Clinic, Sanford Health Boyden Clinic, Sanford Health Sanborn Clinic and Sanford Hartley Clinic operating as hospital departments. Sanford Sheldon provides health care services to over 10,000 residents of O'Brien County and portions of Sioux, Osceola and Lyon counties in northwest Iowa. The nearest tertiary care centers are Mercy Medical in Sioux City, Iowa and Sanford USD Medical Center, which is approximately 70 miles west in Sioux Falls, South Dakota. The total number of admissions for last fiscal year was 825 at Sanford Sheldon with outpatient encounters totaling 43,144 and 37,756 medical clinic visits. Sanford Sheldon currently employs approximately 317 employees. Four family physicians, three physician assistants and two nurse practitioners with Sanford Sheldon Clinic provide health care to individuals of all ages. Several specialty physicians provide outreach clinics at Sanford Sheldon on a weekly, twice monthly or monthly basis. As a member of the Sanford Health Network, Sanford Sheldon offers consulting specialists who provide services in Sheldon that include general and specialized surgery, cardiology, otolaryngology, urology, obstetrics/gynecology, orthopedics, vascular and podiatry.

Description of the Community Served

The 2010 US Census reports a city population of 5,188 for Sheldon. Sanford Sheldon is located in O'Brien County, which has a total population 14,398. The population over the age of 65 is 20% as compared to the 2010 Iowa state rate of 15%. This is important because residents generally begin to require more care as they age, meaning Sanford Sheldon is responding to a higher level of medical needs for this population. Sanford Sheldon provides service to additional residents from portions of Sioux, Osceola and Lyon counties in northwest Iowa, which equates to health services provided for over 10,000 people in northwest Iowa. Sheldon is largest community in O'Brien County. Sheldon is predominantly a farming community with other larger employers in finance, manufacturing, health care and education.

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 Profiles for O'Brien County
- Aging Profiles for O'Brien County
- Diversity Profiles for O'Brien County

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

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

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 Sheldon Community Health Needs Assessment Collaborative attempted to convene nearly 300 key community and county stakeholders for the purpose of determining the needs of the community. There were 298 respondents completed the survey and focus group questions. The generalizable survey was completed by 298 community members through random selection and provided a high confidence level.

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

Primary Research

Summary of the Survey Results

Respondents had very high levels of agreement that their community has educational opportunities and programs, the community is a good place to raise kids, and there is quality health care. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community.

Respondents were most concerned about economic issues regarding cost of health care and/or insurance and low wages as well as substance abuse. Respondents were also concerned with issues regarding children and youth (e.g. availability and cost of quality child care, bullying, availability and child abuse and neglect). Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health insurance (e.g. amount of co-pays and deductibles) and access to health insurance coverage (e.g. pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, multiple sclerosis) and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about patient confidentiality and distance to health care services.

Community Assets/Best Things about the Community

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

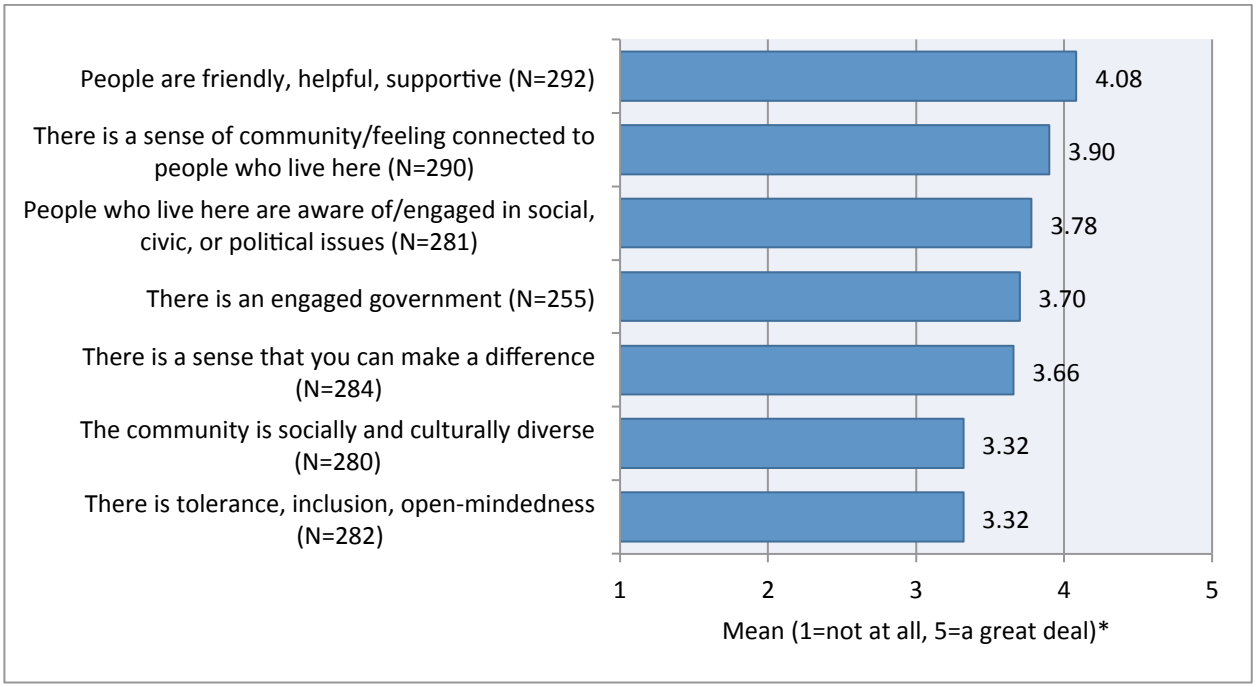
Respondents indicated the top five community assets or best things about the community were: there are quality higher education opportunities and institutions, the community is a good place to raise kids, there are quality school systems and programs for youth, there is quality health care, and people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

People

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

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

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

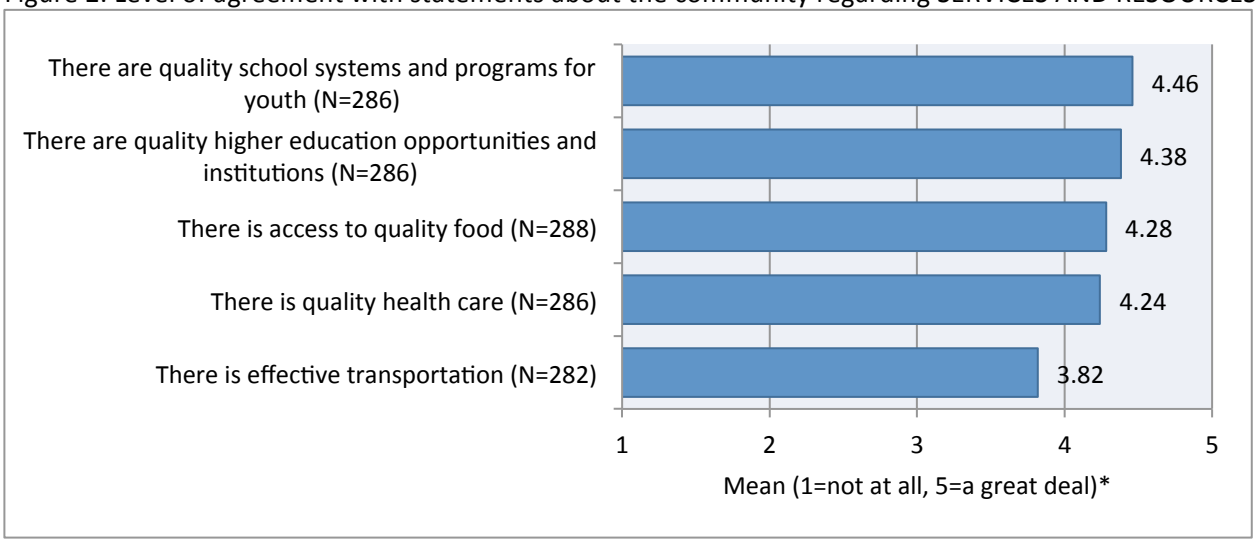


Services and Resources

Respondents had high levels of agreement that there are quality higher education opportunities and institutions as well as quality school systems and programs for youth in their community.

Although still a moderate level of agreement, respondents agreed the least that there is effective transportation in their community. Overall, respondents had a high level of agreement with positive statements regarding services and resources issues in their community.

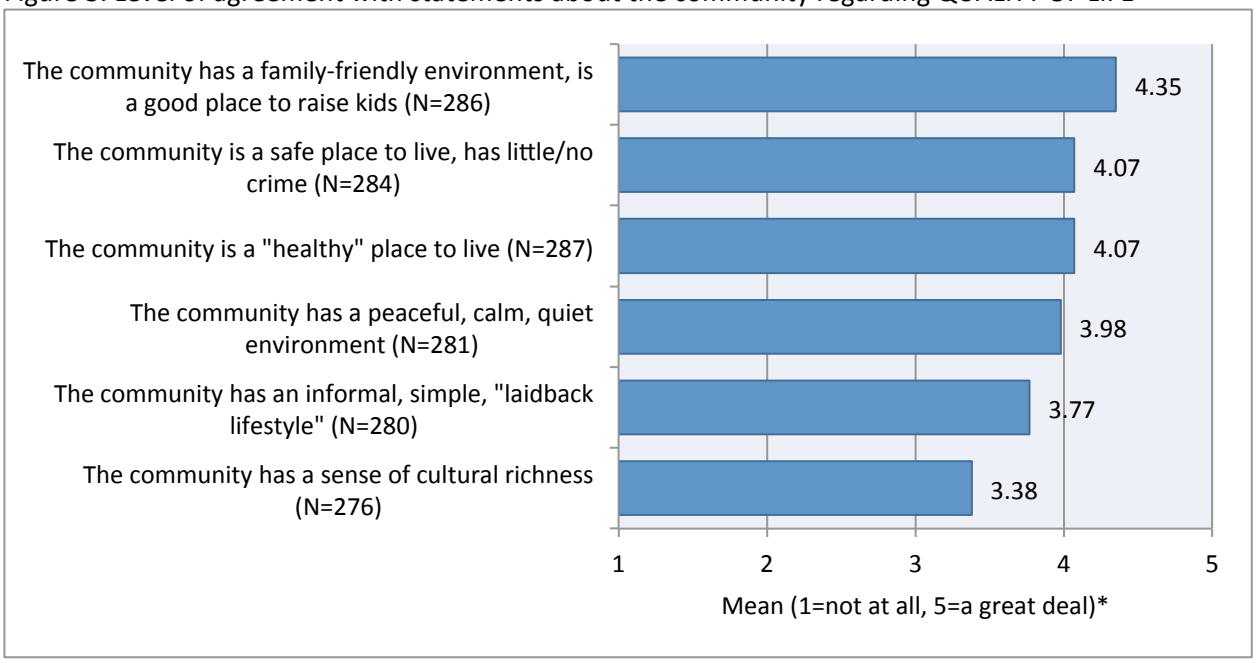
Figure 2. Level of agreement with statements about the community regarding SERVICES AND RESOURCES



Quality of Life

Respondents had a very high level of agreement that their community is a good place to raise kids. Respondents had high levels of agreement with the remaining components of quality of life issues in their community.

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



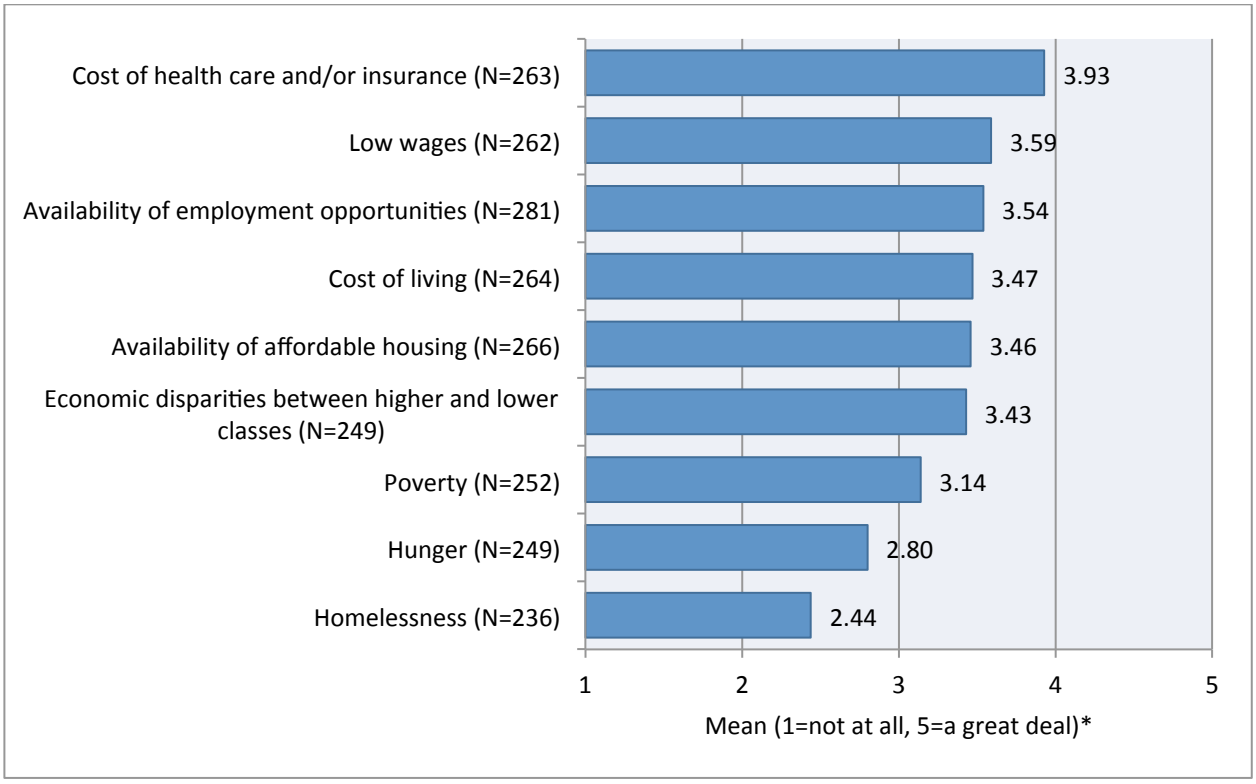
General Concerns about the Community

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

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

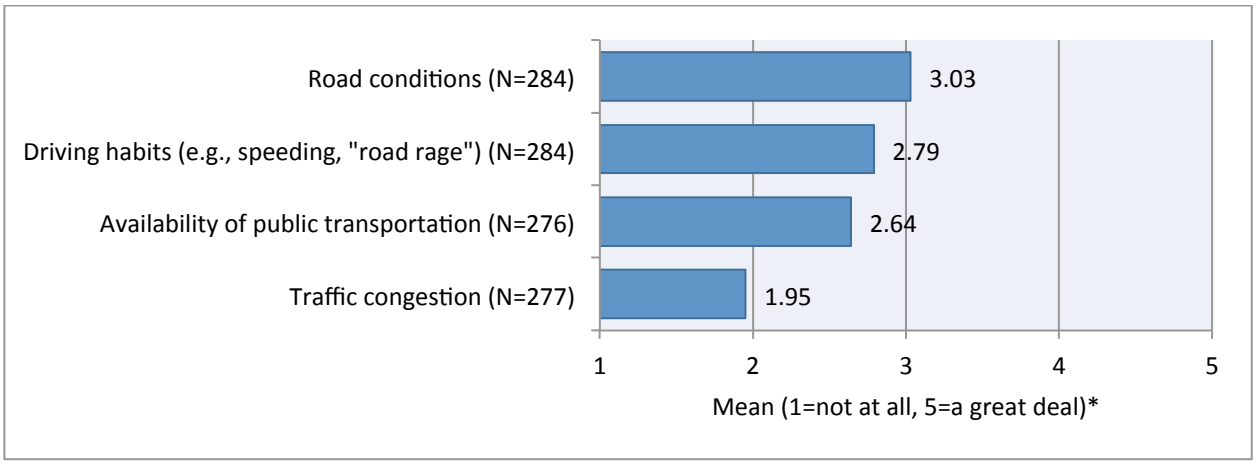
Economic Issues
Respondents had high levels of concern with respect to the cost of health care and/or insurance, low wages and availability of employment opportunities. Respondents were least concerned with the homelessness.

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



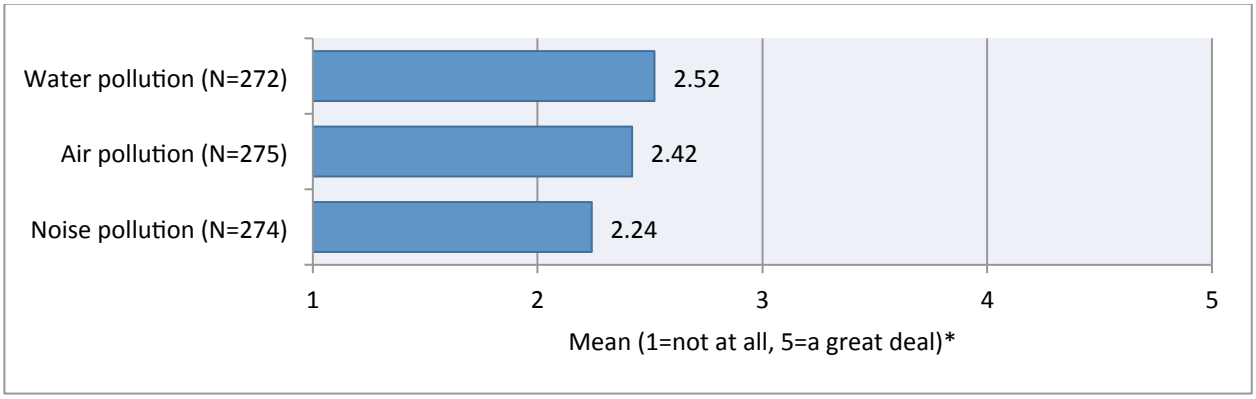
Transportation
Respondents were most concerned with road conditions. Respondents were least concerned with traffic congestion.

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



Environment
Respondents were not very concerned with environmental issues in their community.

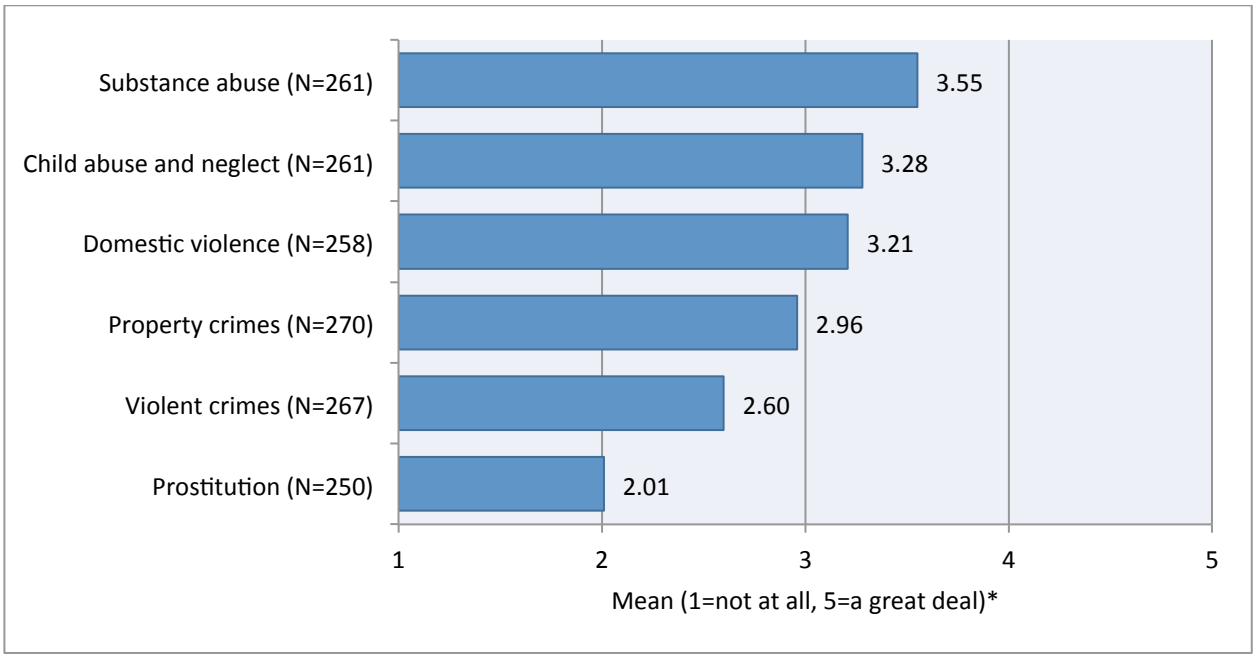
Figure 6. Level of concern with statements about the community regarding ENVIRONMENTAL POLLUTION



Safety

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

Figure 7. Level of concern with statements about the community regarding SAFETY CONCERNS

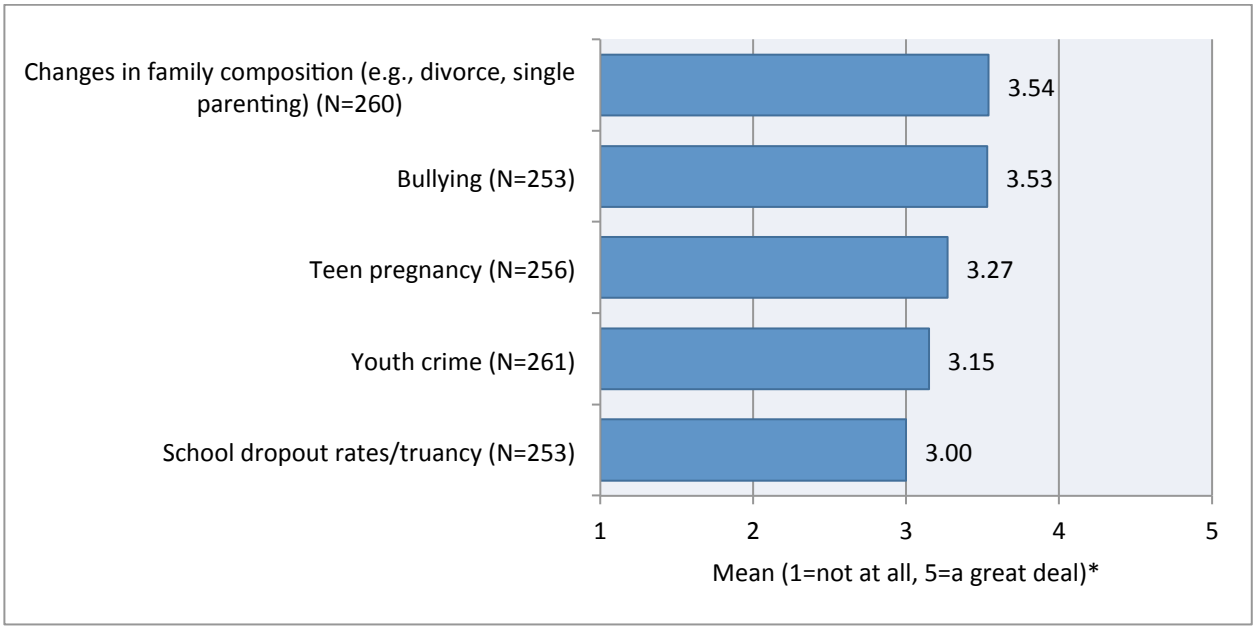


Children and Youth

Regarding children and youth, respondents were most concerned with the availability and cost of quality child care in their community, bullying, and the availability and cost of services for at-risk youth. Respondents were least concerned with youth crime.

Overall, respondents had a moderate level of concern regarding changes in family composition and bullying.

Figure 8. Level of concern with statements about the community regarding YOUTH CONCERNS



Community Health and Wellness Concerns

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

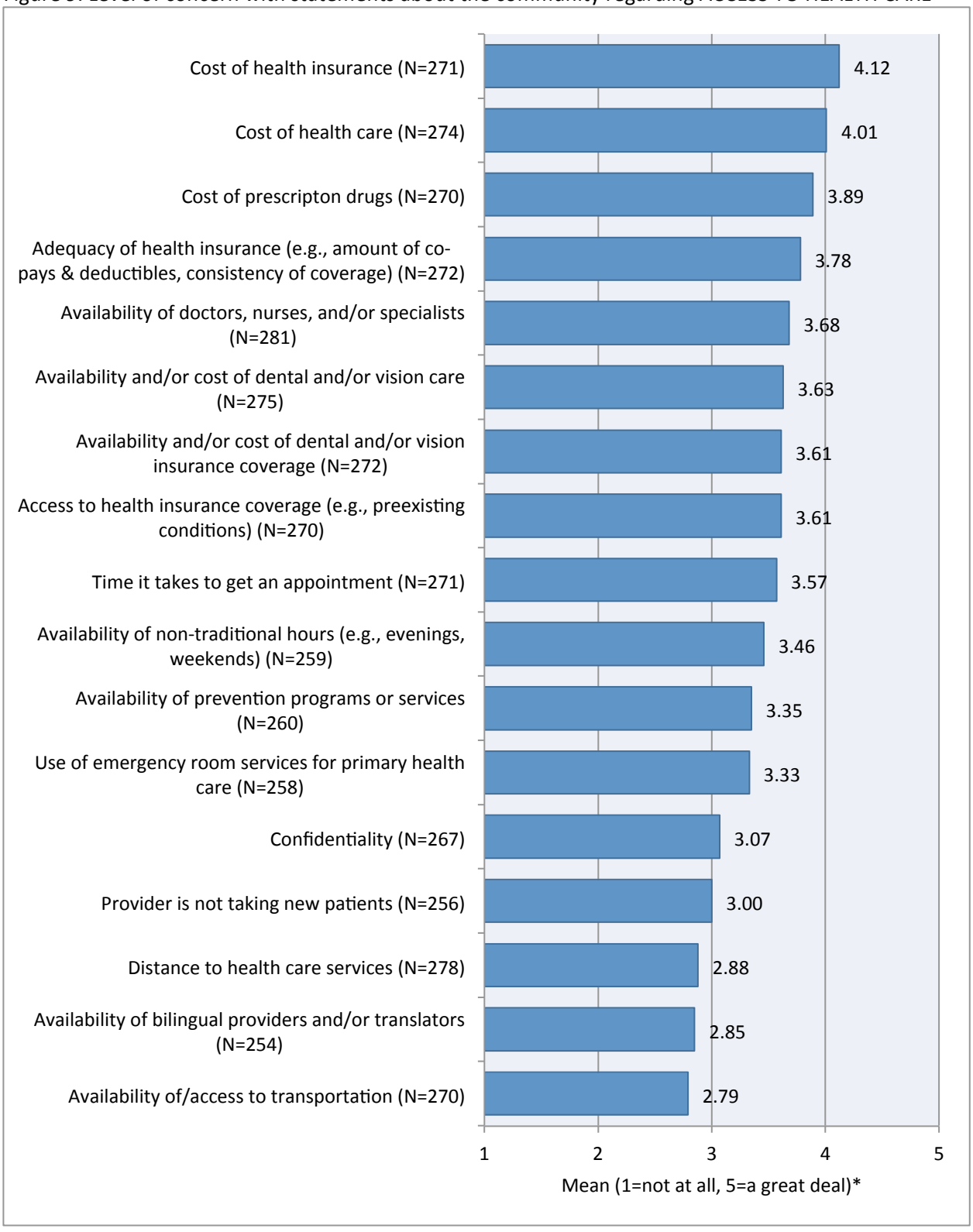
The top six health and wellness concerns among community leaders were:

- Cost of health insurance
- Cost of health care
- Cost of prescription drugs
- Adequacy of health insurance
- Availability of doctors, nurses and/or specialists
- Availability of cost of dental and/or vision care

Access to Health Care

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

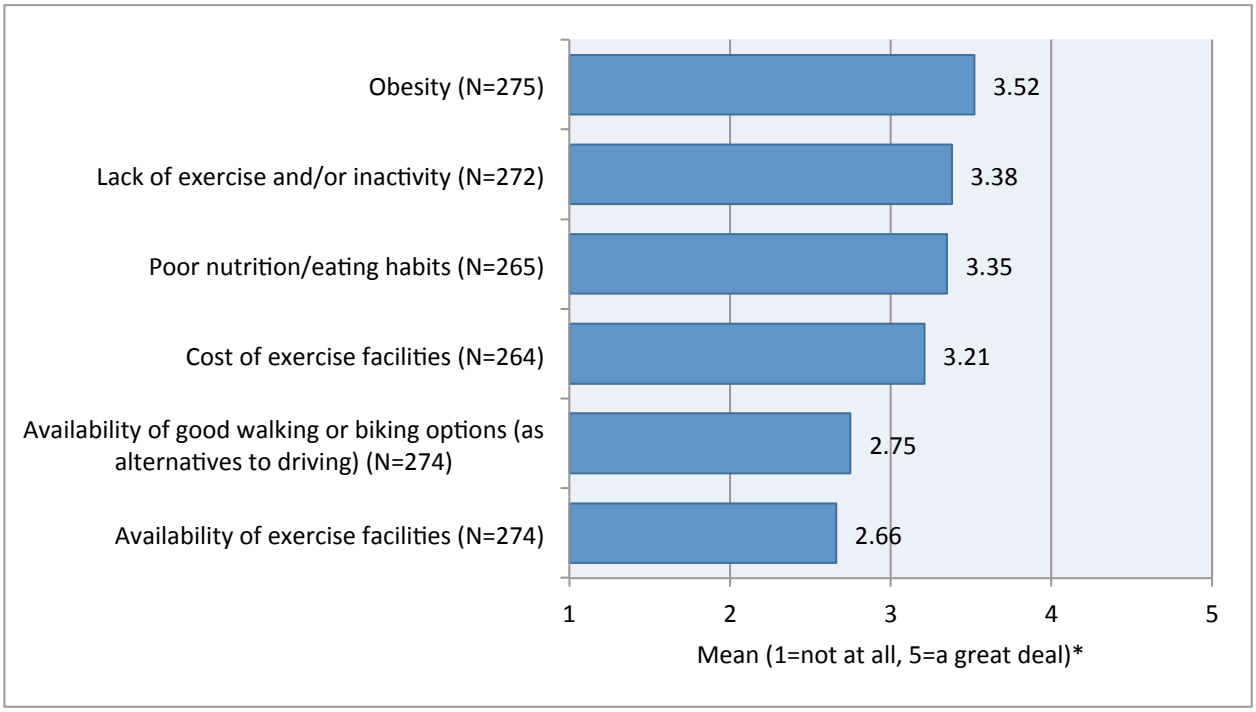
Figure 9. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE



Physical and Mental Health

Regarding physical and mental health issues, respondents had the highest levels of concern with respect to obesity, poor nutrition and eating habits, inactivity and lack of exercise, and cost of exercise facilities. Respondents were least concerned with the availability of exercise facilities.

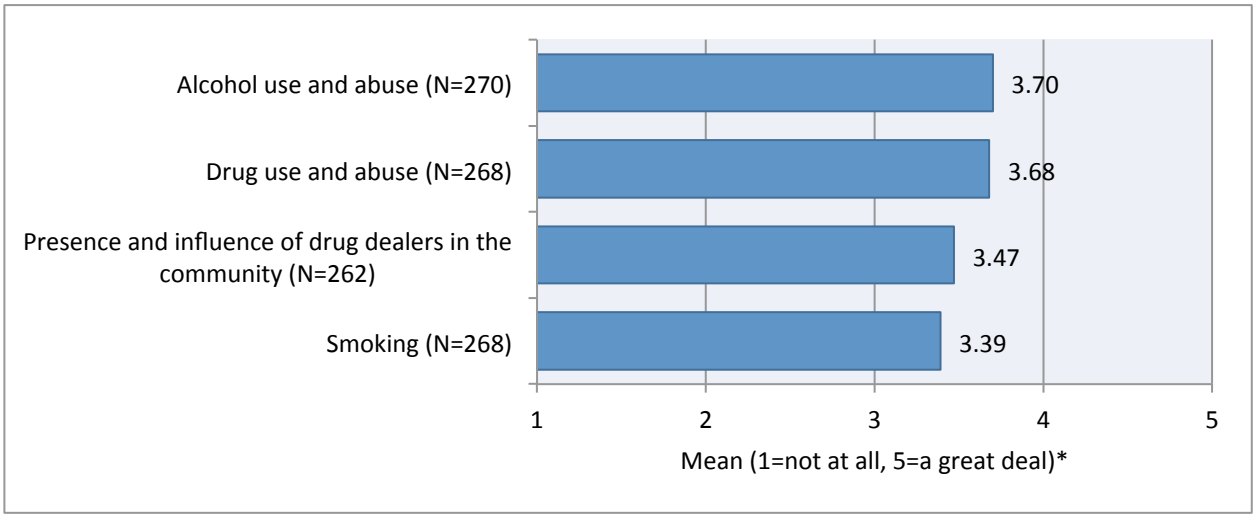
Figure 10. Level of concern with statements about the community regarding PHYSICAL HEALTH



Substance Use and Abuse

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

Figure 11. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



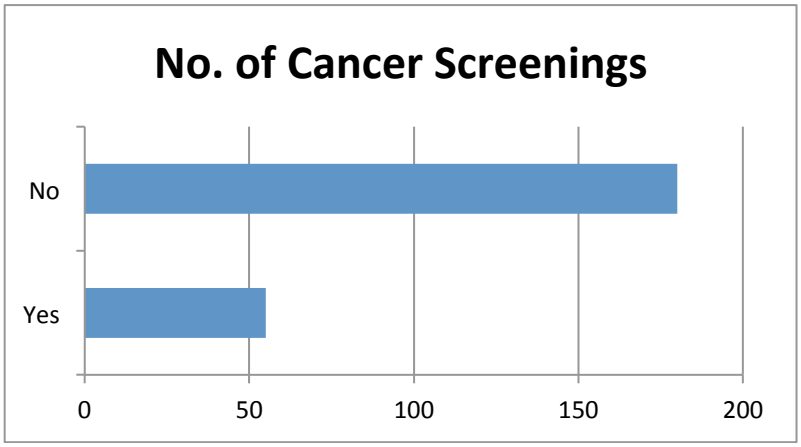
Personal Heath Care Information

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

Cancer Screening

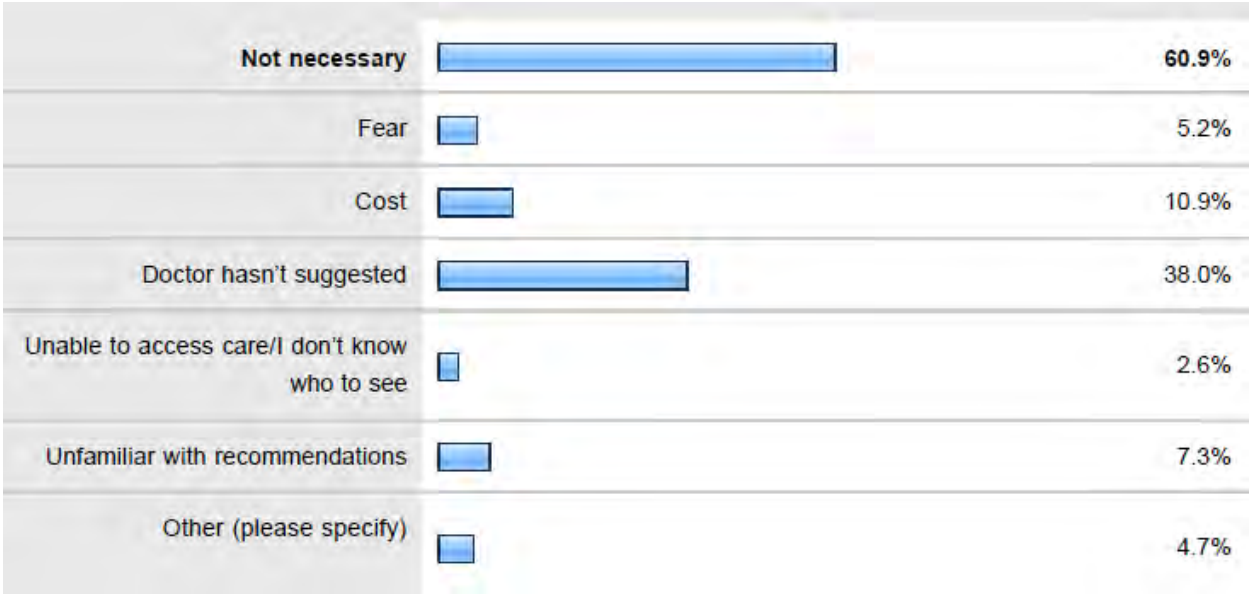
Approximately 77% of respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because it was not necessary. Doctor hasn't suggested it and cost were also reasons respondents gave.

Figure 12. Whether respondents had a cancer screening or cancer care in the past year



Among respondents who had not had a cancer screening or cancer care in the past year, 77% said they had not done so because it was not necessary or their doctor had not suggested it. Cost was also a reason for some respondents.

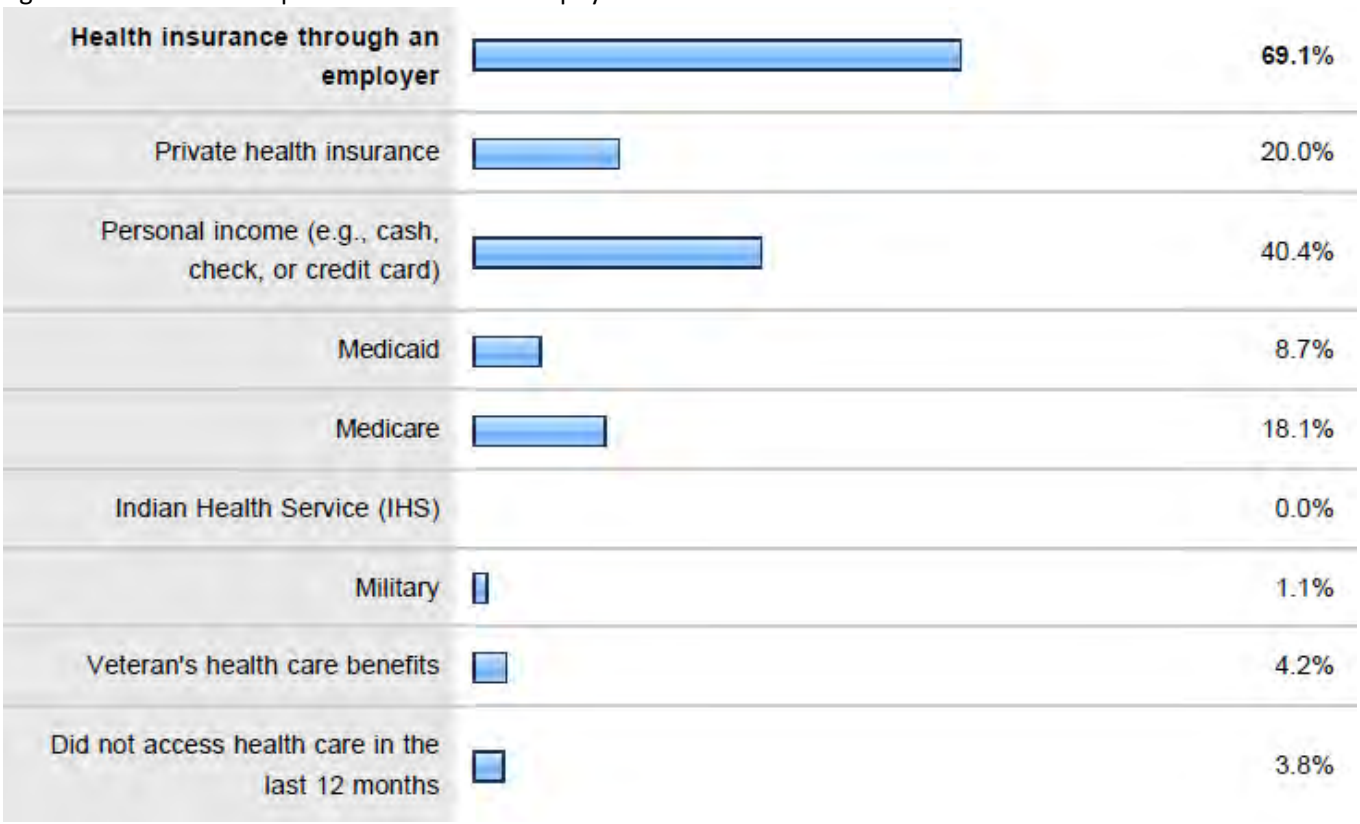
Figure 13. Among respondents who have not had a cancer screening or cancer care in the past year, reasons for not having done so



Health Care Coverage

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

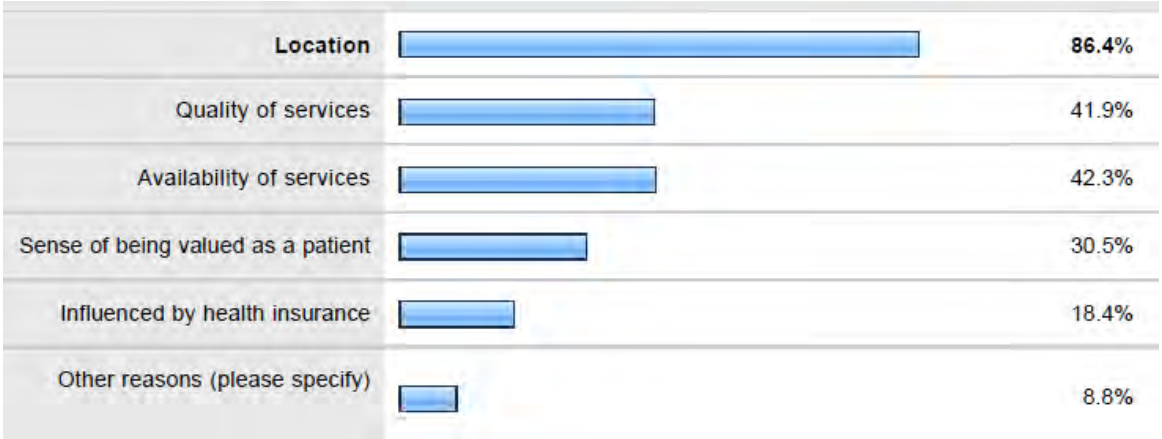
Figure 14. Methods respondents have used to pay for health care costs over the last 12 months



Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, location, and availability of services (*Figure 15)*.

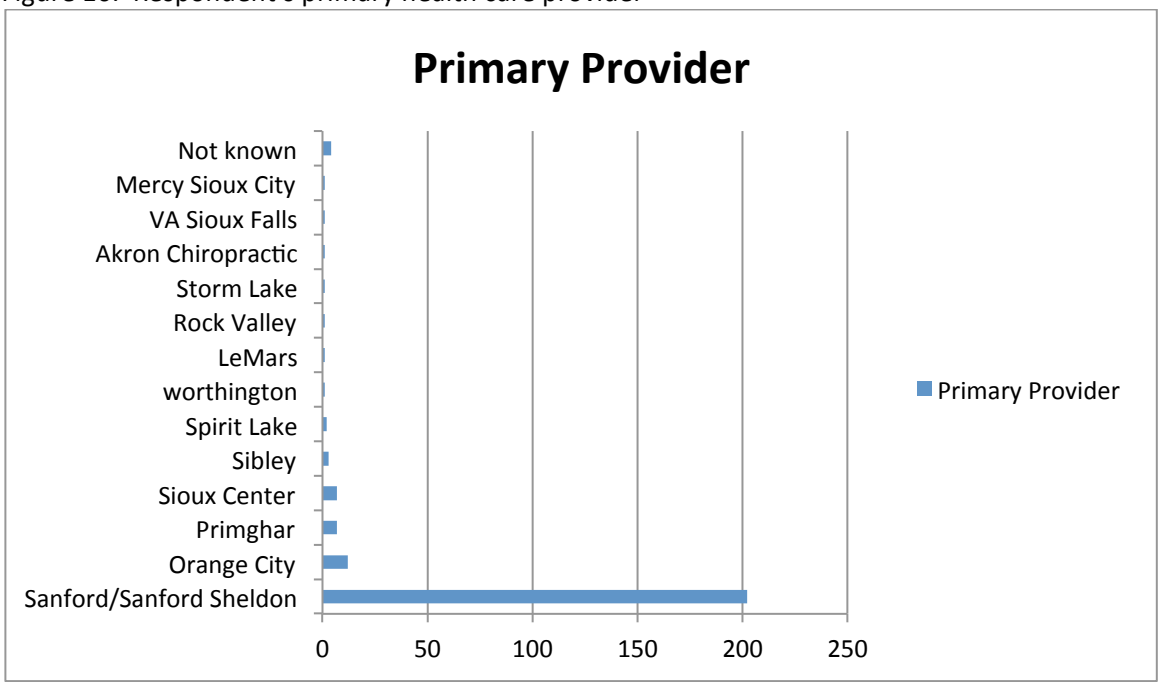
Figure 15. Respondents' reasons for choosing primary health care provider



Respondent's Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. 83% said they use Sanford/Sanford Sheldon as their primary health care provider.

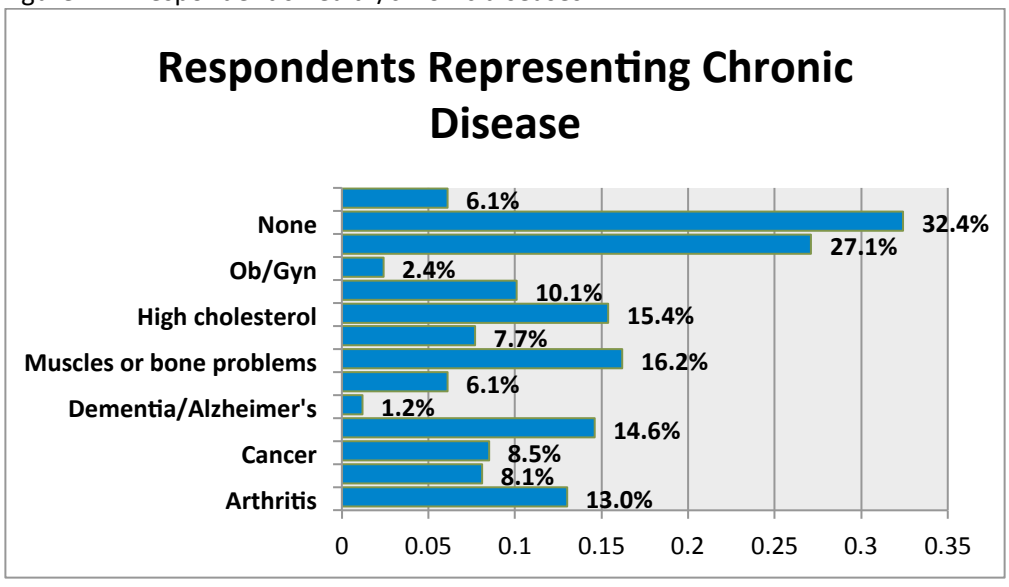
Figure 16. Respondent's primary health care provider



Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight control received the most responses with 27.1 % of participants selecting this condition. The chronic diseases found in the highest percentage among respondents include depression, anxiety and stress, and hypercholesterolemia. (Figure 17)

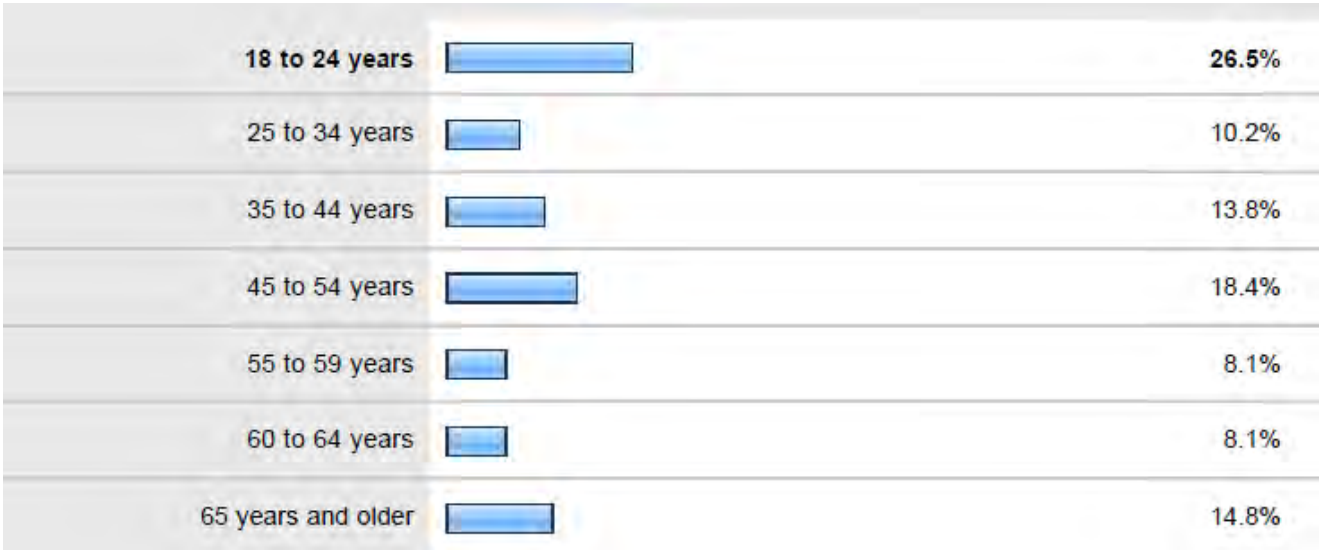
Figure 17. Respondent's health/chronic diseases.



Demographic Information

The majority of respondents are 18 to 24 years old.

Figure 18. Respondents' age distribution



Most respondents have a high school diploma or Bachelor's degree or higher, including a high percent who have a Graduate or Professional degree.

Figure 19. Respondents' education

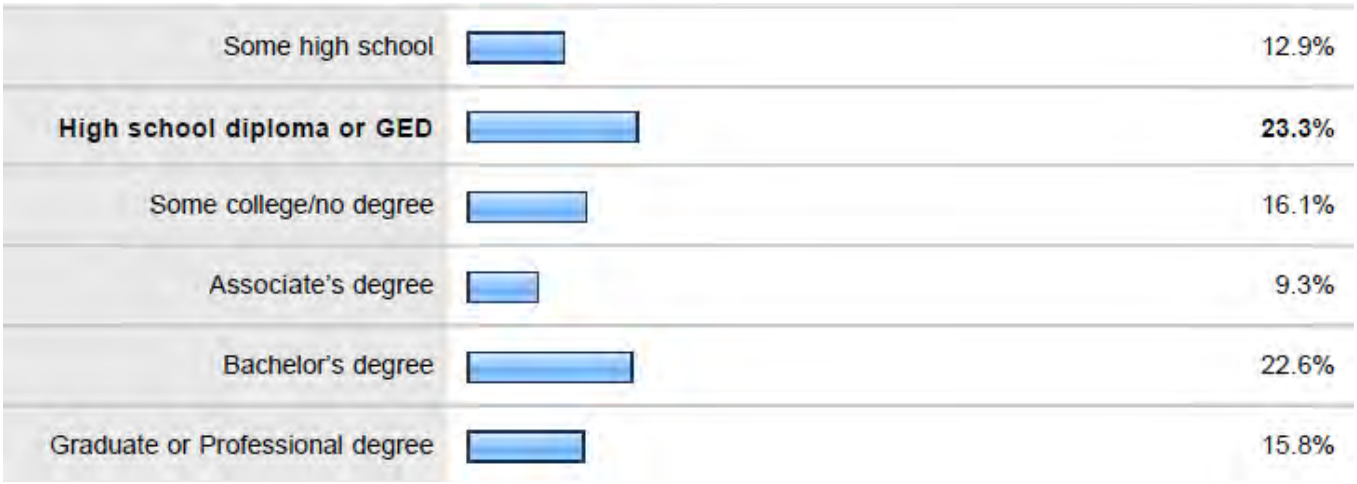
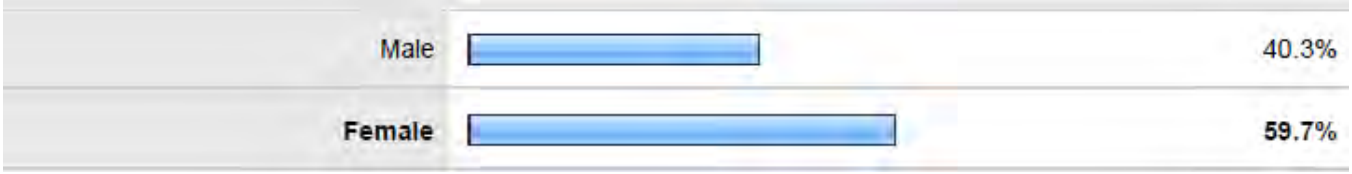


Figure 20. Respondents' gender distribution



Secondary Research

Health Outcomes

Mortality

		O'Brien County	National Benchmark	Iowa
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	6,953	5,564	5,976

Morbidity

		O'Brien County	National Benchmark	Iowa
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	6%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.4	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.0	2.3	2.7
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	4.7%	6.0%	6.8%

Health Factors

Health Behaviors

		O'Brien County	National Benchmark	Iowa
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	21%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	29%	25%	28%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	27%	20%	25%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	18%	8%	20%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	21.8	12.0	15.2
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	78.8	83.0	313.6
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	34.2	22.0	32.0

Clinical Care

		O'Brien County	National Benchmark	Iowa
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	16%	13%	13%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	8%	7%	6%
Primary care physicians	Ratio of total population to primary care physicians, 2008	1,263:1	631:1	984:1
Mental health providers	Ratio of total population to mental health providers, 2008	13,898:0	2,242:1	14,190:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	43.0	69.0	54.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	71.3	52.0	67.5
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	80%	89%	86%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	72%	74%	67%

Social and Economic Factors

		O'Brien County	National Benchmark	Iowa
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	90%	92%	87%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	62%	68%	66%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	4.9%	5.3%	6.0%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	11%	14%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	14%	16%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	15%	20%	26%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	1.9

Physical Environment

		O'Brien County	National Benchmark	Iowa
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	1
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	86%	92%	39%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	29.0	17.0	12.0

Demographics

		O'Brien County	National Benchmark	Iowa
Youth	Percent of total population ages 0-17, 2009	23%	24%	24%
Elderly	Percent of total population ages 65 and older, 2009	21%	13%	15%
Rural	Percent of total population living in a rural area, 2000	70%	21%	39%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	2%	9%	3%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	8%	15%	8%

Population by Age

For O'Brien County

CHARACTERISTICS	Total	Less than 65 Years	Ages 65 and Older
Population[1]			
Total population	14,398	11,461	2,937
Percent ages 65 and older	20%	-	100%
Percent ages 85 and older	4%	-	20%

For Iowa

CHARACTERISTICS	Total	Less than 65 Years	Ages 65 and Older
Population[1]			
Total population	3,046,355	2,593,467	452,888
Percent ages 65 and older	15%	-	100%
Percent ages 85 and older	3%	-	16%

Housing

For O'Brien County

Housing	Total	Less than 65 Years	Age 65 & Older
Percent of occupied housing that is owner-occupied	76%	74%	79%
Percent of occupied housing that is renter-occupied	24%	26%	21%

For Iowa

Housing	Total	Less than 65 Years	Age 65 & Older
Percent of occupied housing that is owner-occupied	72%	70%	80%
Percent of occupied housing that is renter-occupied	28%	30%	20%

Economic Security

For O'Brien County

Economic Security	Total	Less than 65 Years	Age 65 & Older
Percent of working-age population in labor force	67%	85%	17%
Percent of total population with income less than 100% of poverty	11%	12%	8%
Percent of total population with income less than 200% of poverty	31%	29%	42%
Median household income (by age of householder)	$44,018	$46,974	$25,000
Owner-occupied housing units (by age of householder)	4,633	3,120	1,513
Percent spending 30% or more of income toward housing costs	14%	12%	17%
Renter-occupied housing units (by age of householder)	1,389	992	397
Percent spending 30% or more of income toward housing costs	46%	40%	60%

	Total	Less than 65 Years	Age 65 & Older

Economic Security[1] For Iowa

Percent of working-age population in labor force	69%	81%	17%
Percent of total population with income less than 100% of poverty	12%	12%	7%
Percent of total population with income less than 200% of poverty	29%	29%	32%
Median household income (by age of householder)	$48,872	$47,724	$31,591
Owner-occupied housing units (by age of householder)	889,912	659,513	230,399
Percent spending 30% or more of income toward housing costs	20%	20%	21%
Renter-occupied housing units (by age of householder)	326,042	272,028	54,014
Percent spending 30% or more of income toward housing costs	40%	39%	45%

Diversity Profile

		RACE				ETHNICITY
CHARACTERISTICS For O'Brien County	Total	White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
Population[1]						
Total population	14,398	13,829	67	18	82	545
Percent ages 0 to 17	24%	23%	39%	17%	41%	44%
Percent ages 18 to 44	28%	27%	51%	56%	40%	47%
Percent ages 45 to 64	28%	29%	8%	28%	17%	8%
Percent ages 65 and older	20%	21%	3%	0%	1%	2%
Median age (in years)	43.6	45.1	20.8	36.5	23.0	21.9

CHARACTERISTICS For Iowa	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
Population [1]						
Total population	3,046,355	2,781,561	89,148	11,084	53,094	151,544
Percent ages 0 to 17	24%	23%	35%	33%	25%	42%
Percent ages 18 to 44	35%	34%	42%	41%	53%	43%
Percent ages 45 to 64	27%	28%	18%	21%	17%	12%
Percent ages 65 and older	15%	16%	5%	5%	5%	3%
Median age (in years)	38.1	39.9	25.5	28.1	28.7	22.2

Health Needs Identified

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

- Healthcare Cost/Insurance cost
- Housing
- Access
- Economic Situations/Business Community
- Physicians
- Parenting
- Youth
- Elderly

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
- Physician Recruitment
- Preventative Services

The Sanford Sheldon Medical Center Health Needs Assessment Collaborative is establishing key initiative strategies to address all three of the above listed concerns. Leadership from Sanford Health will serve on all three key initiative groups.

Sanford Sheldon Medical Center will specifically address access, physician recruitment, and preventative services and execute the implementation strategy.

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

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Sanford Sheldon Medical Center Implementation Strategy

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

- Access
- Physician Recruitment
- Preventative Services

Implementation Strategy – Access

- Devise and implement a plan to create optimal coverage of the emergency department utilizing APPs.
- Recruit additional physicians to meet the needs of the patient base and growth.
- Utilize Health Care Coach to manage/reduce repeat visits.
- Offer a physician assistant in the Sheldon clinic for acute care appointments open with daily access.

Implementation Strategy – Recruitment

- Continue to work to recruit at a minimum of two additional physicians.
- Work closely with Sanford Physician Recruitment department to ensure opportunities in Sheldon are actively promoted.

Implementation Strategy – Preventative Services

- Continue to offer the current preventative services and better educate the community on the importance and value of these screenings.
- Work with Sanford Health and the Outreach providers to determine the preventative services opportunities that are needed in the communities.

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

Aging Profile

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

O'Brien County
Iowa

CHARACTERISTICS	Total	AGE	
		Less than 65 Years	Ages 65 and Older
Population[1]			
Total population	14,398	11,461	2,937
Percent ages 65 and older	20%	-	100%
Percent ages 85 and older	4%	-	20%
Percent male	50%	52%	41%
Percent female	50%	48%	59%
Living Arrangements			
Total households (by age of householder)[1]	6,069	4,110	1,959
Percent with family households (i.e., at least two people who are related)	65%	73%	48%
Percent with householder living alone	31%	22%	51%
Grandparents living with their grandchildren*[2]	107	87	20
Percent who are responsible for their grandchildren	47%	38%	85%
Housing[1]			
Percent of occupied housing that is owner-occupied	76%	74%	79%
Percent of occupied housing that is renter-occupied	24%	26%	21%
Economic Security[2]			
Percent of working-age population in labor force	67%	85%	17%
Percent of total population with income less than 100% of poverty	11%	12%	8%
Percent of total population with income less than 200% of poverty	31%	29%	42%
Median household income (by age of householder)	$44,018	$46,974	$25,000
Owner-occupied housing units (by age of householder)	4,633	3,120	1,513
Percent spending 30% or more of income toward housing costs	14%	12%	17%
Renter-occupied housing units (by age of householder)	1,389	992	397
Percent spending 30% or more of income toward housing costs	46%	40%	60%

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.

 The Aging Profile was prepared by researchers at North Dakota State University in Fargo for Sanford Health. May 2012

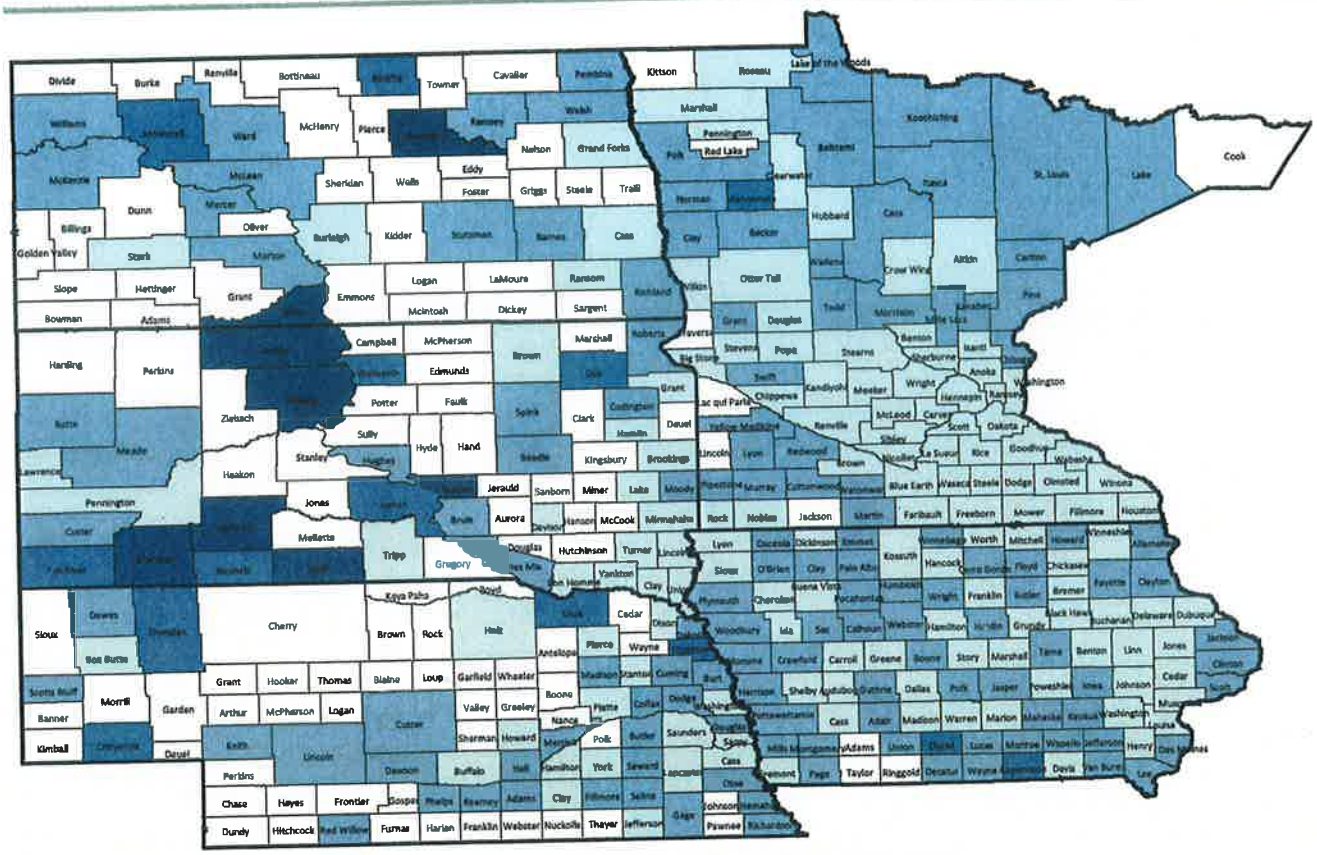
Definitions of Health Variables

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.

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.

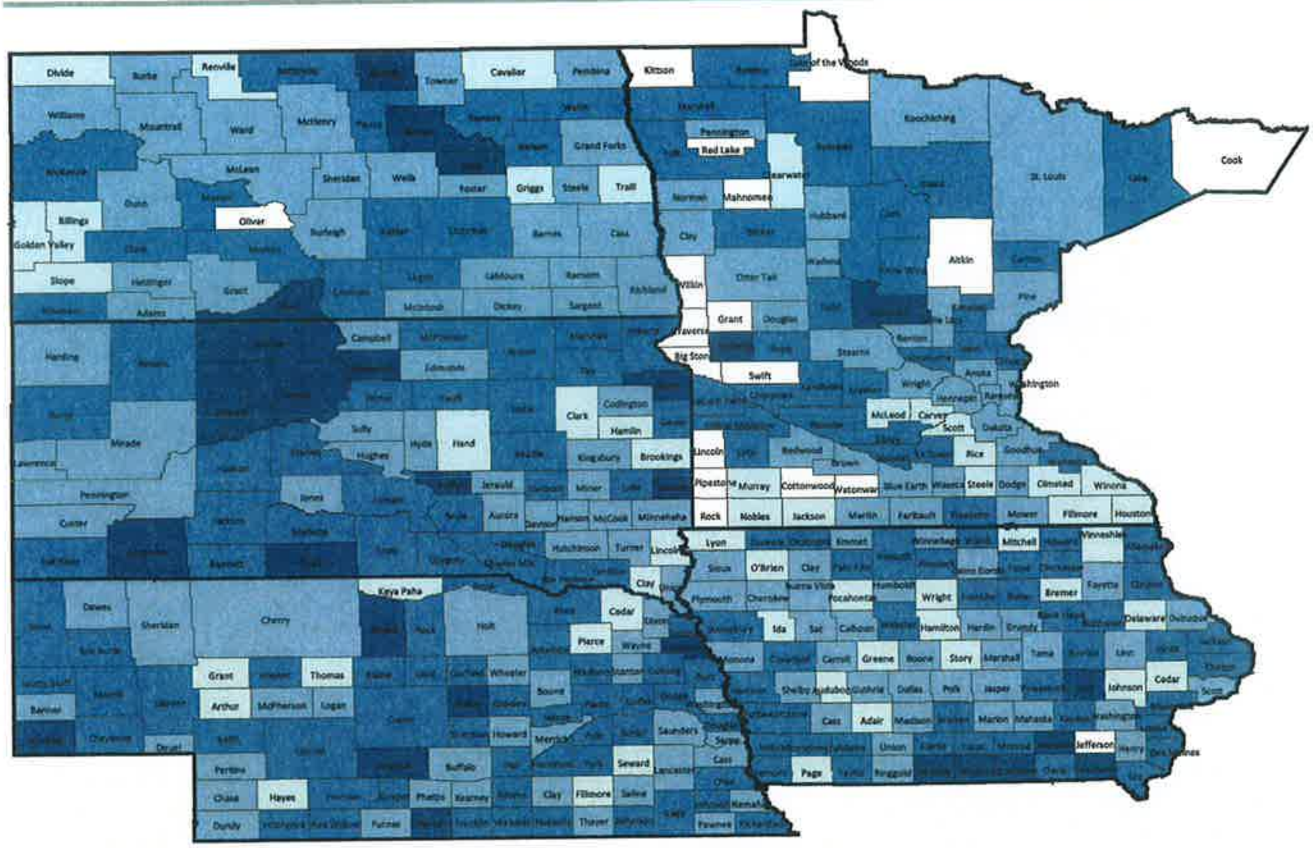
Importance: Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

- 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/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

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

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



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

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

CONTEXT

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

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

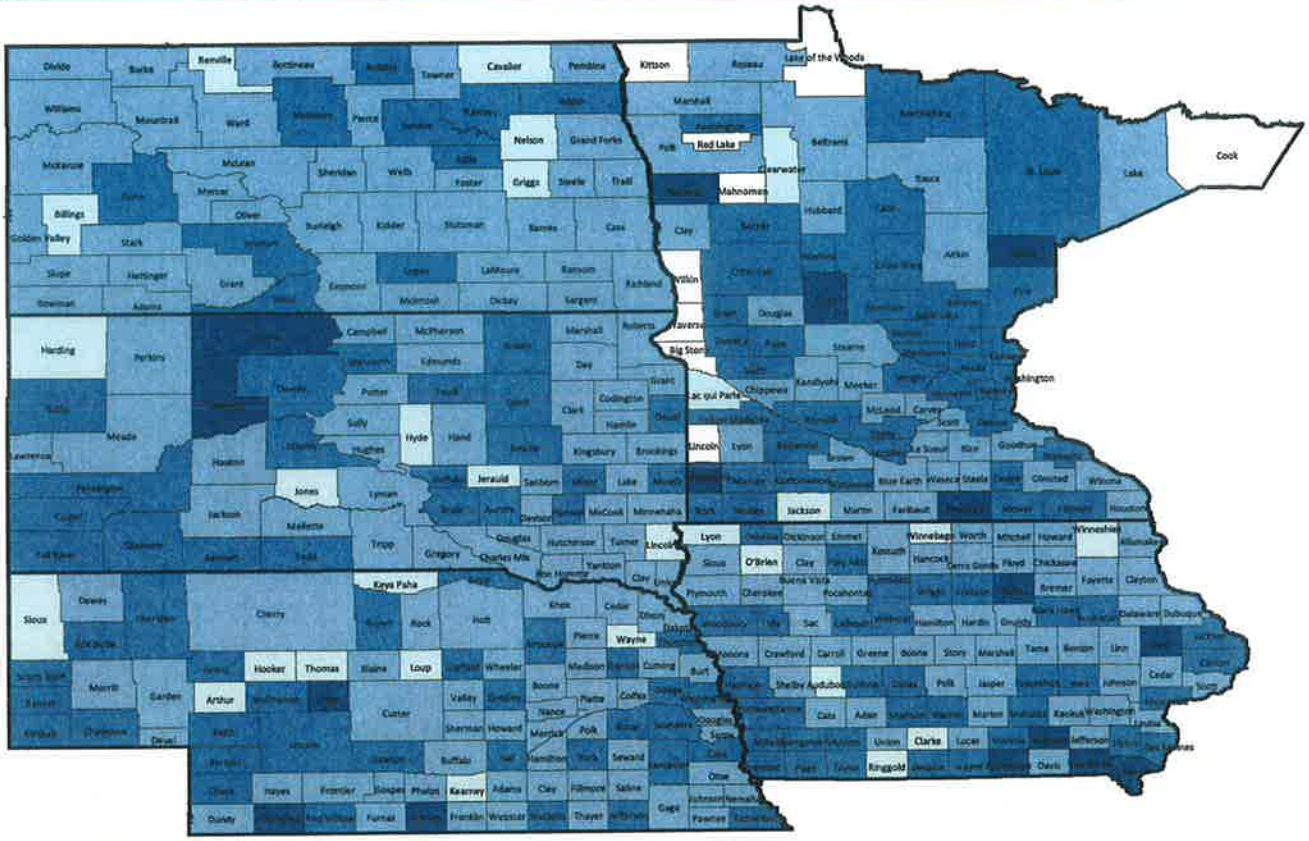
Importance: Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable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

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

Map 3

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

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



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

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

CONTEXT

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

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

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

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

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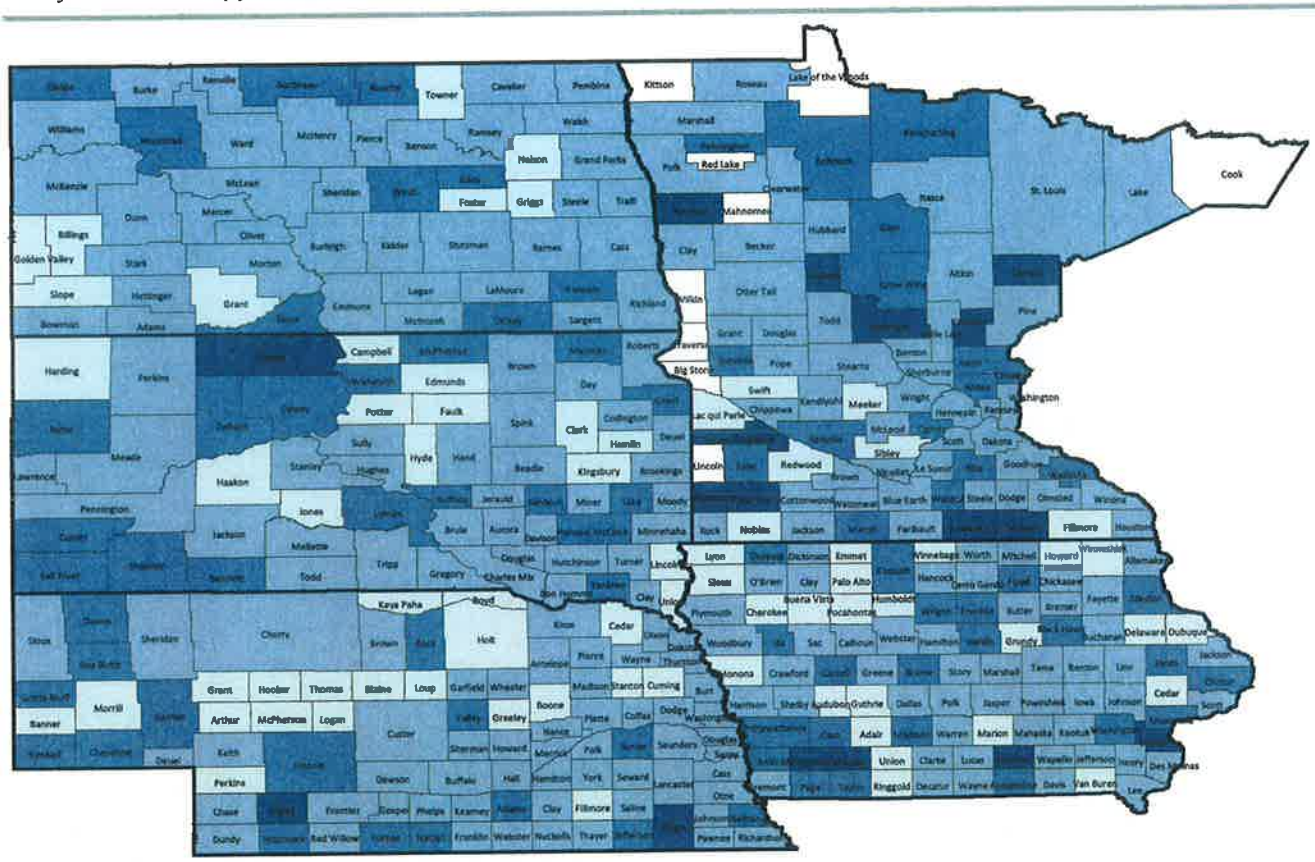
Map 4

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

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



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

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

CONTEXT

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

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

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

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

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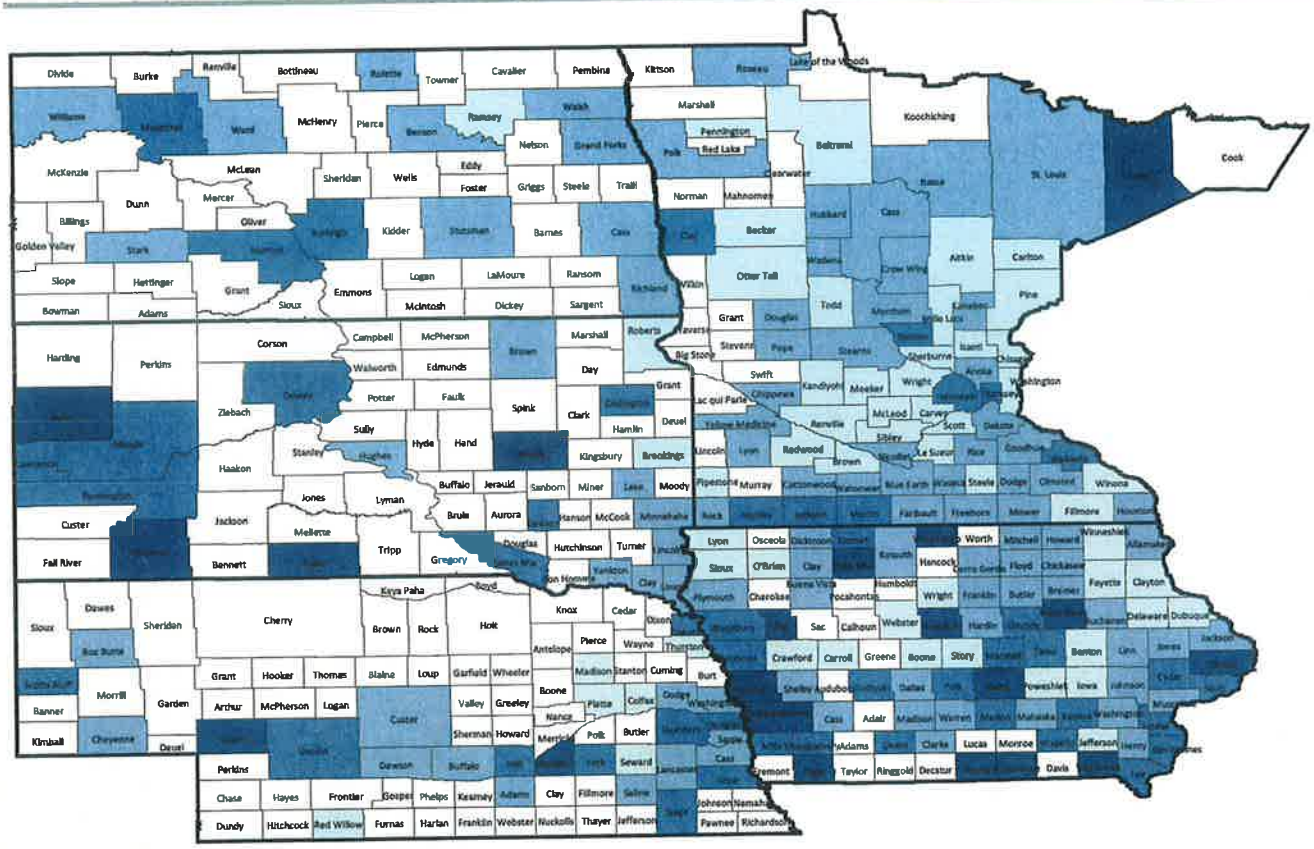
Map 5

Low Birthweight - A health outcome measure focusing on morbidity

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



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

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

CONTEXT

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

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

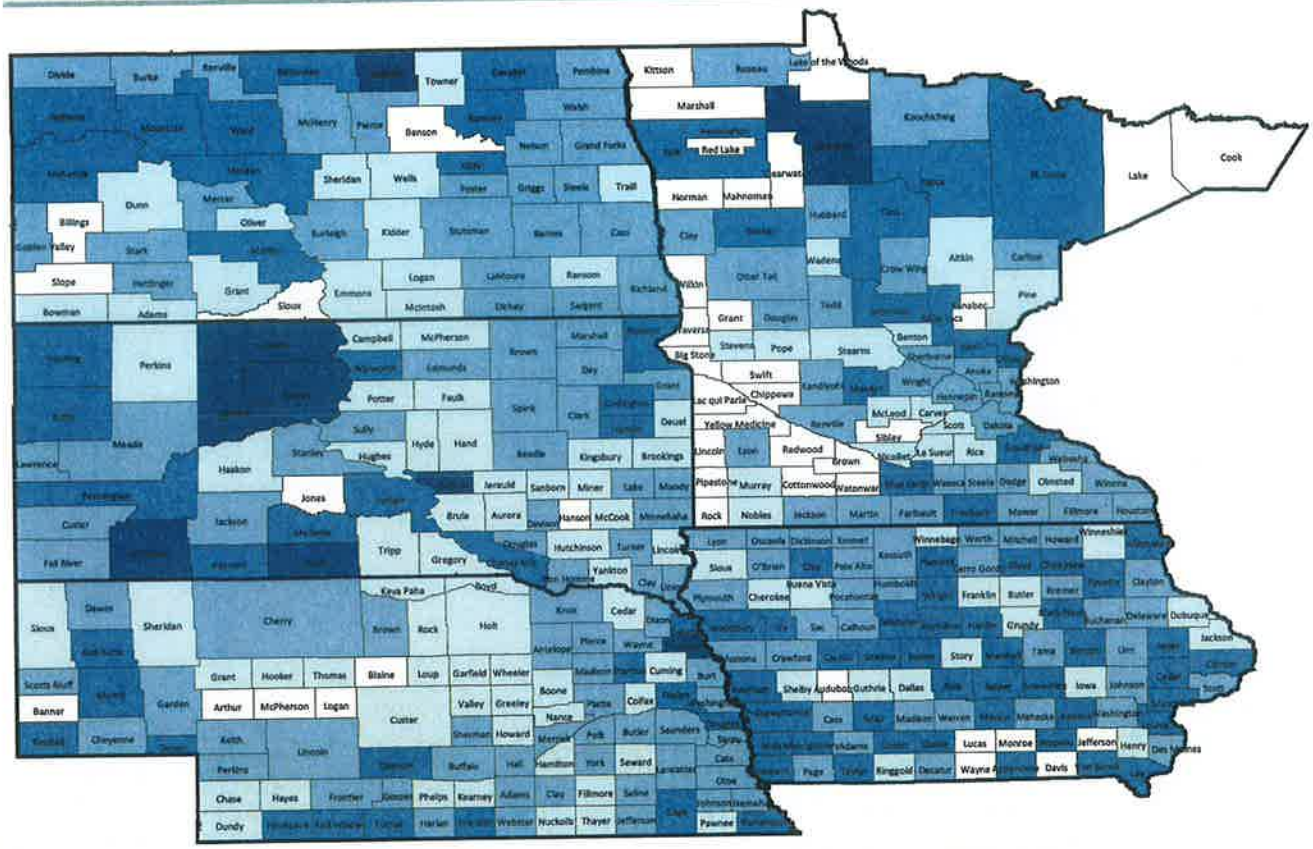
Importance: Low birthweight represents two factors: maternal exposure to health risks and an infant's current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

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

Map 6

Adult Smoking - A health factor measure focusing on health behaviors

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



Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

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

CONTEXT

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

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

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

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

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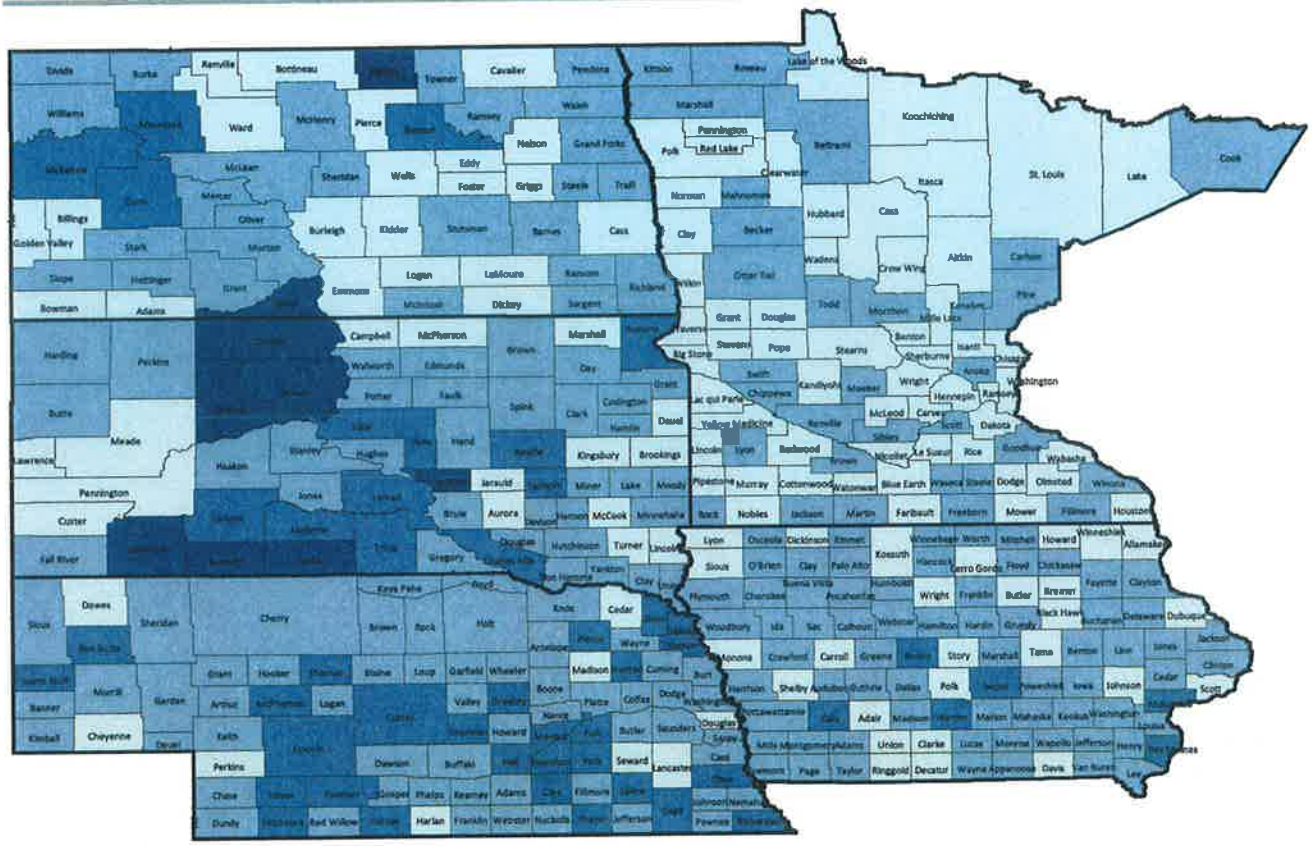
Map 7

Adult Obesity - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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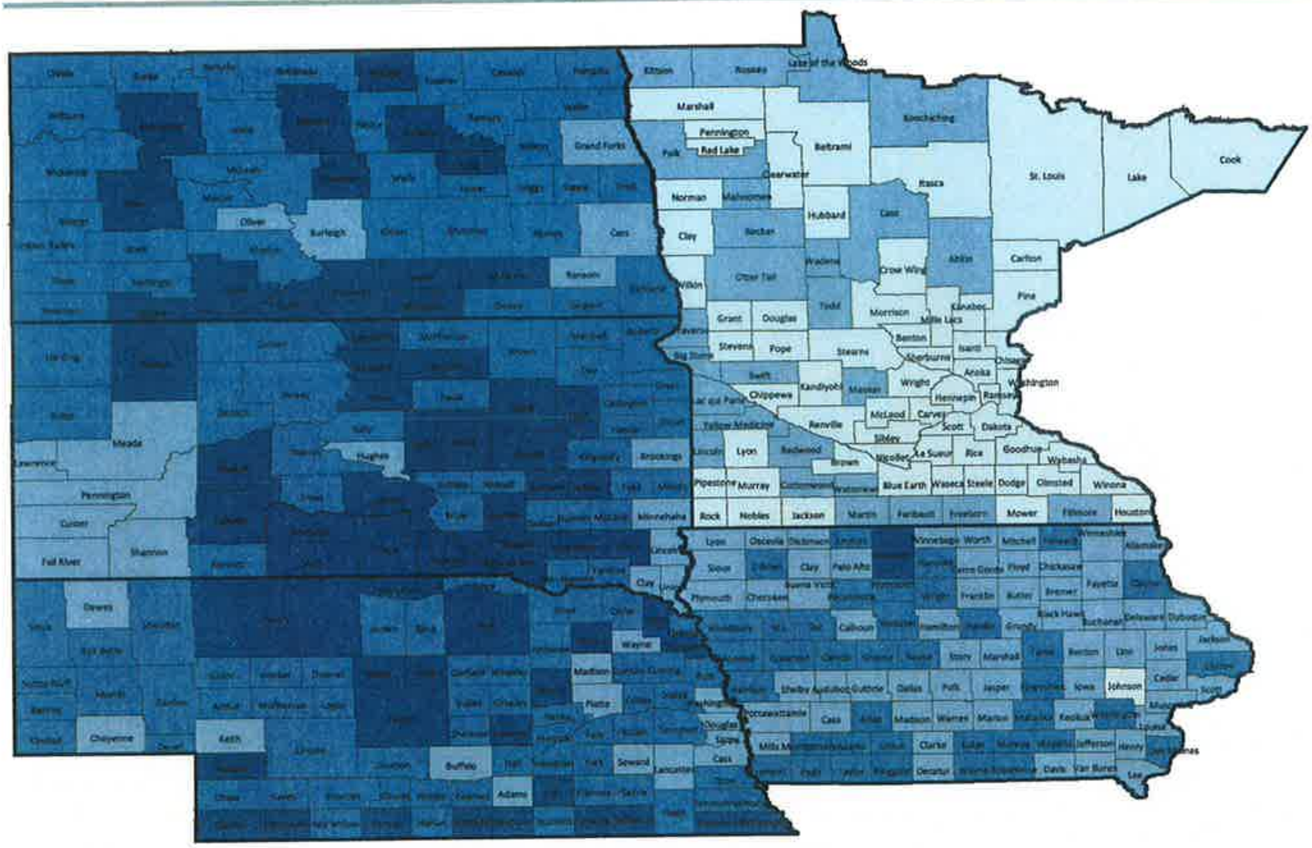
Physical Inactivity - A health factor measure focusing on health behaviors

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



Percent of adults reporting no leisure time physical activity, 2008

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

CONTEXT

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

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

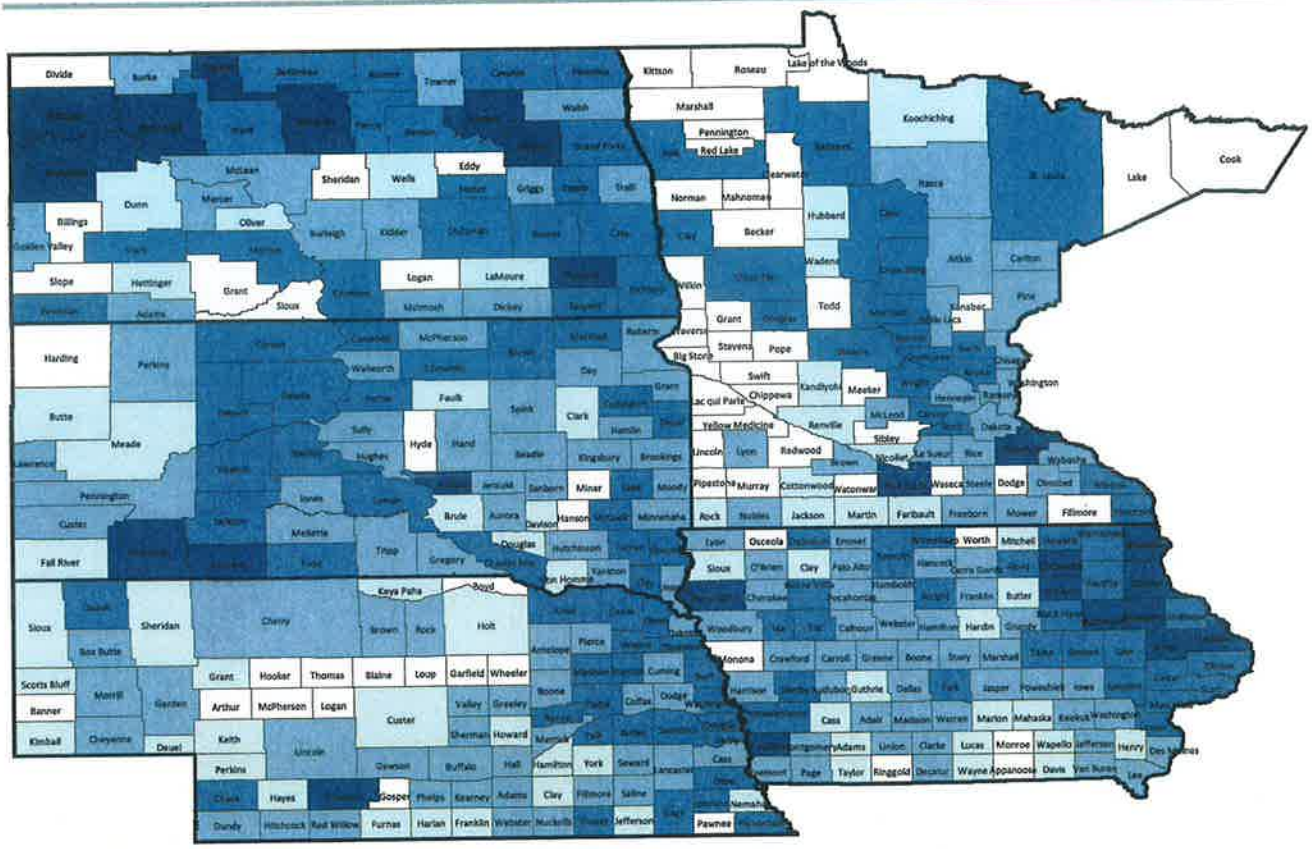
Importance: Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental health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

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

Map 9

Excessive Drinking - A health factor measure focusing on health behaviors

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



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

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

CONTEXT

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

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

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

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

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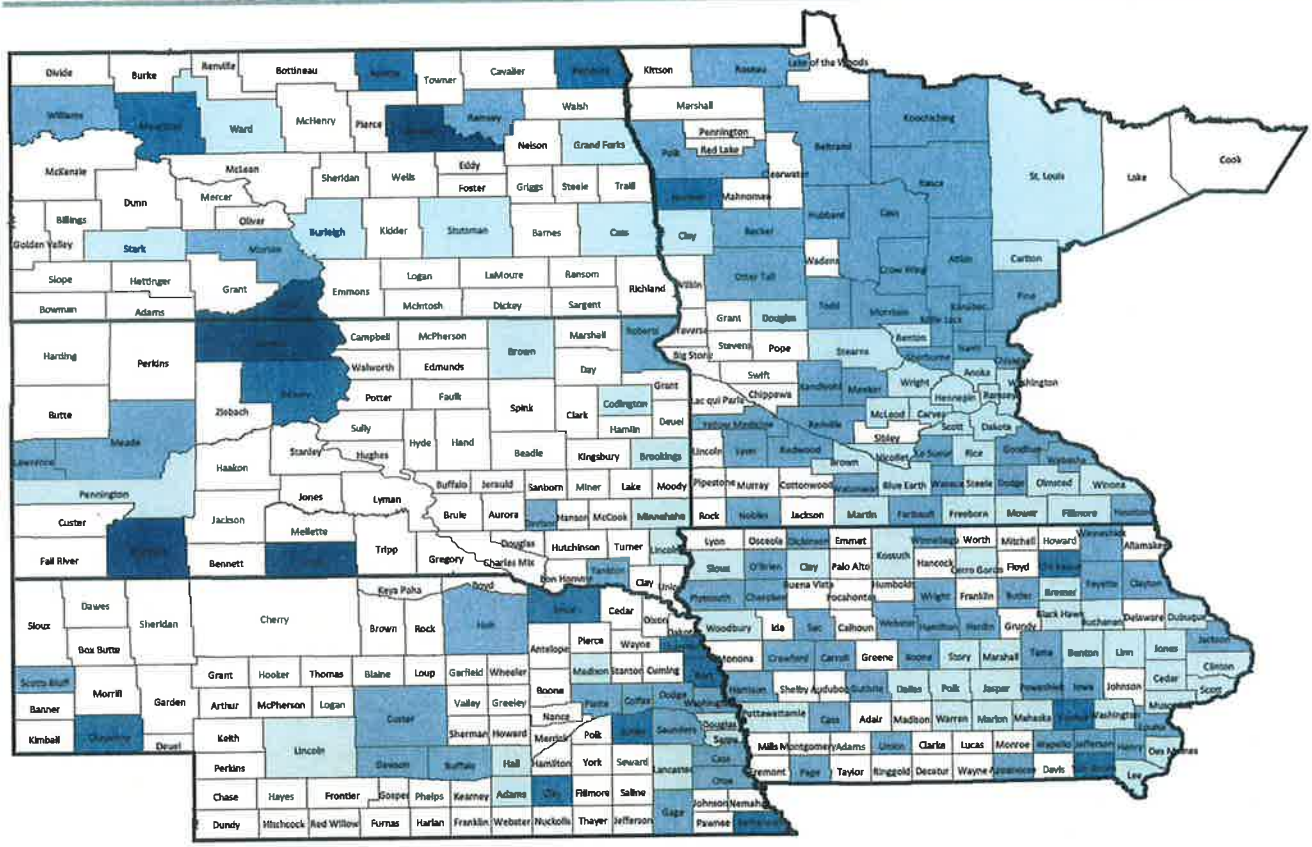
Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

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.

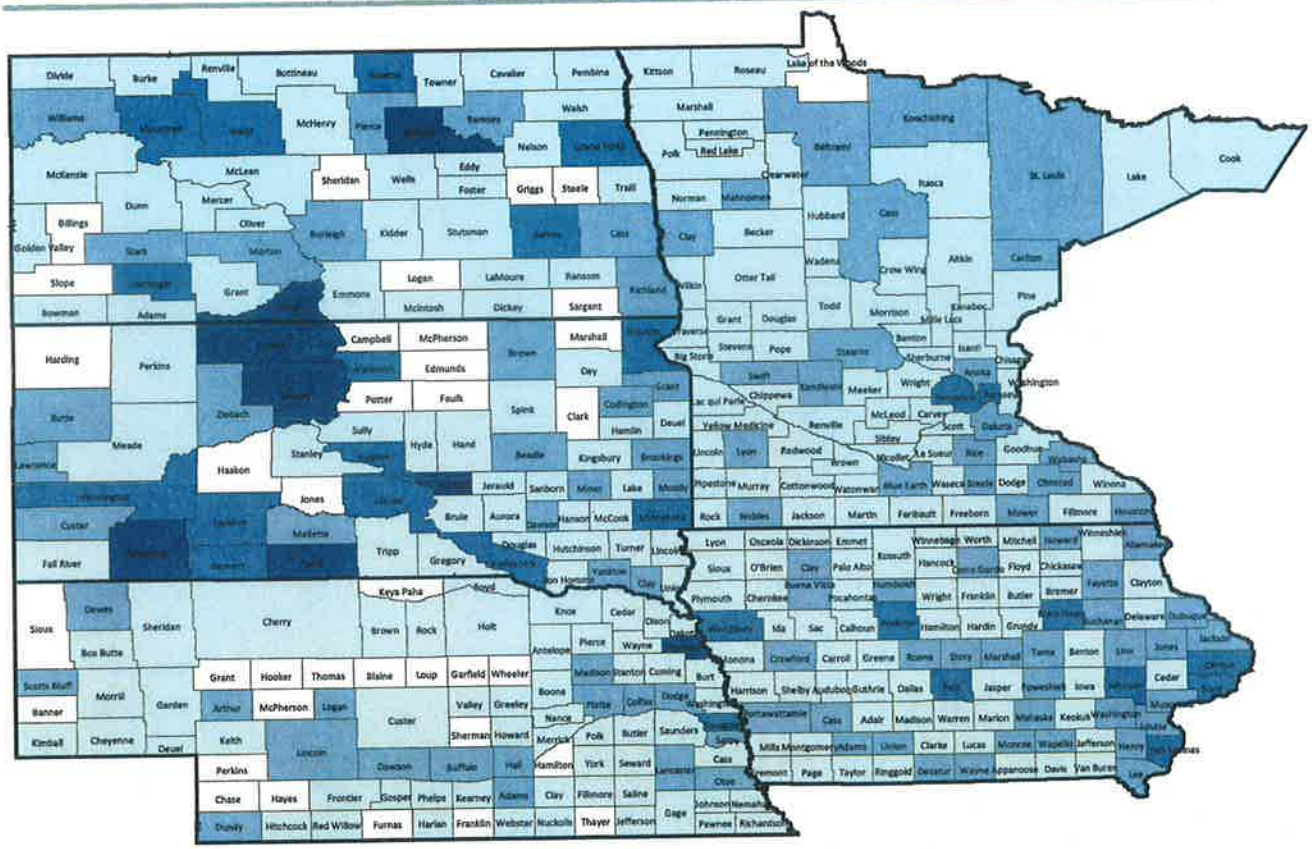
Where It Comes From: These data were calculated by National Center for Health Statistics (NCHS), part of the Centers for Disease Control and Prevention (CDC), based on data reported to the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates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

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.

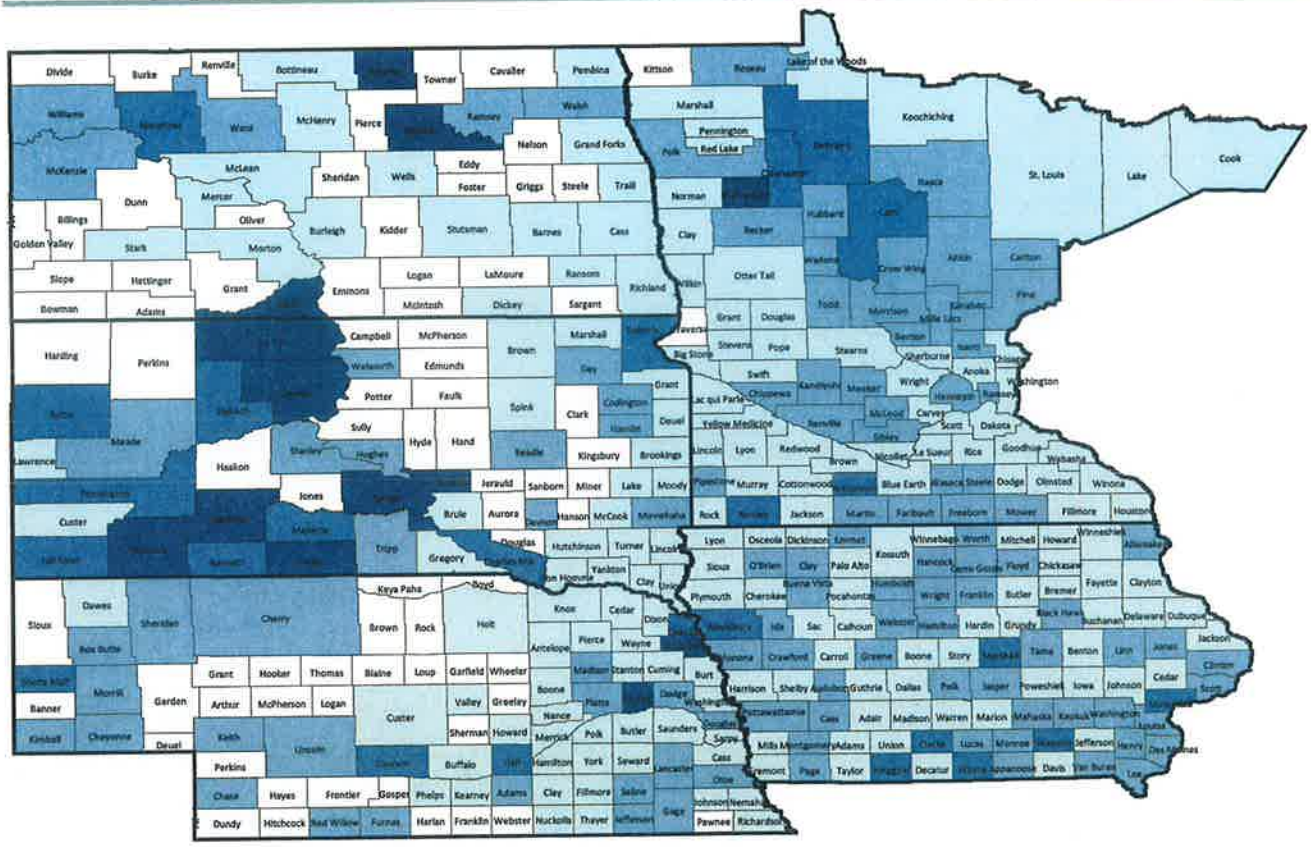
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 12

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

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



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

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

CONTEXT

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

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

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

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

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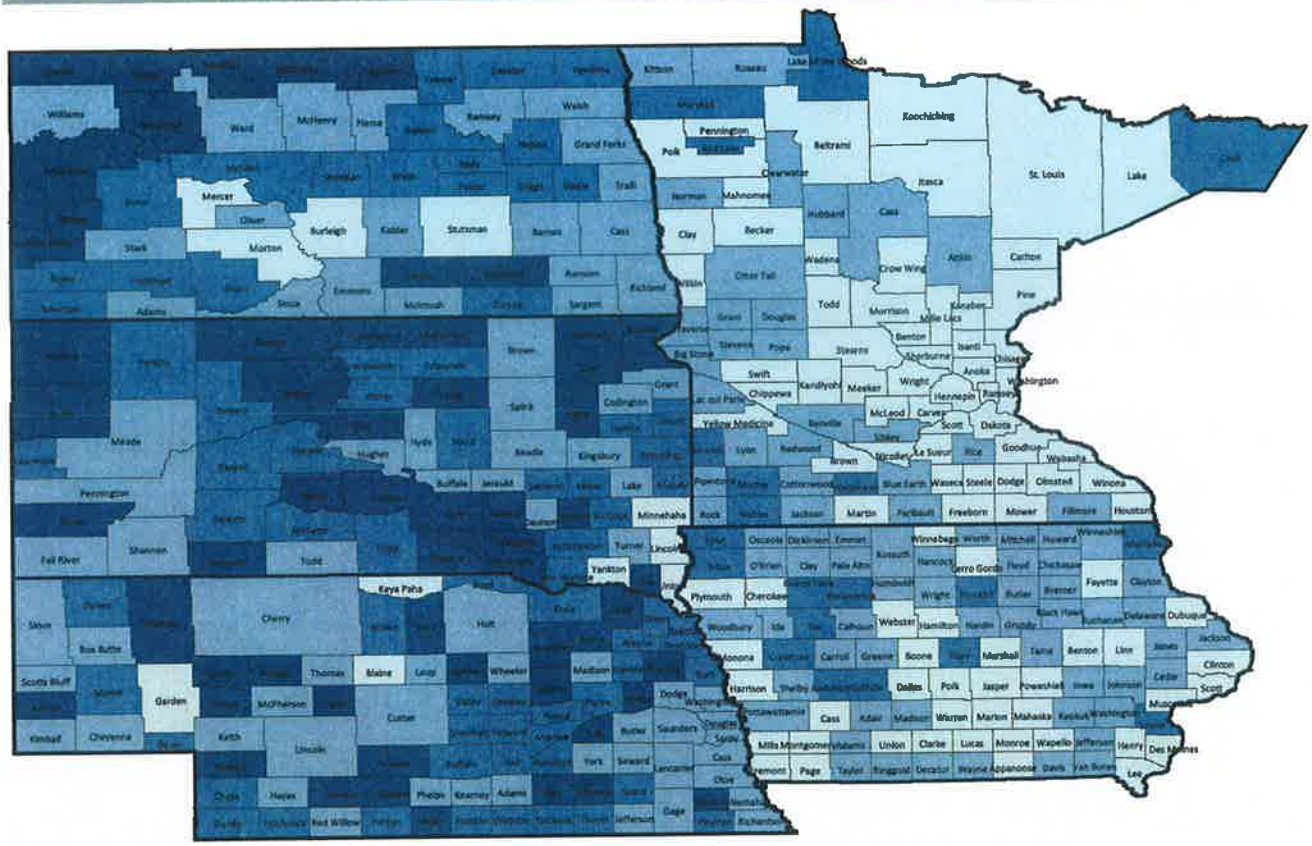
Uninsured Adults - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

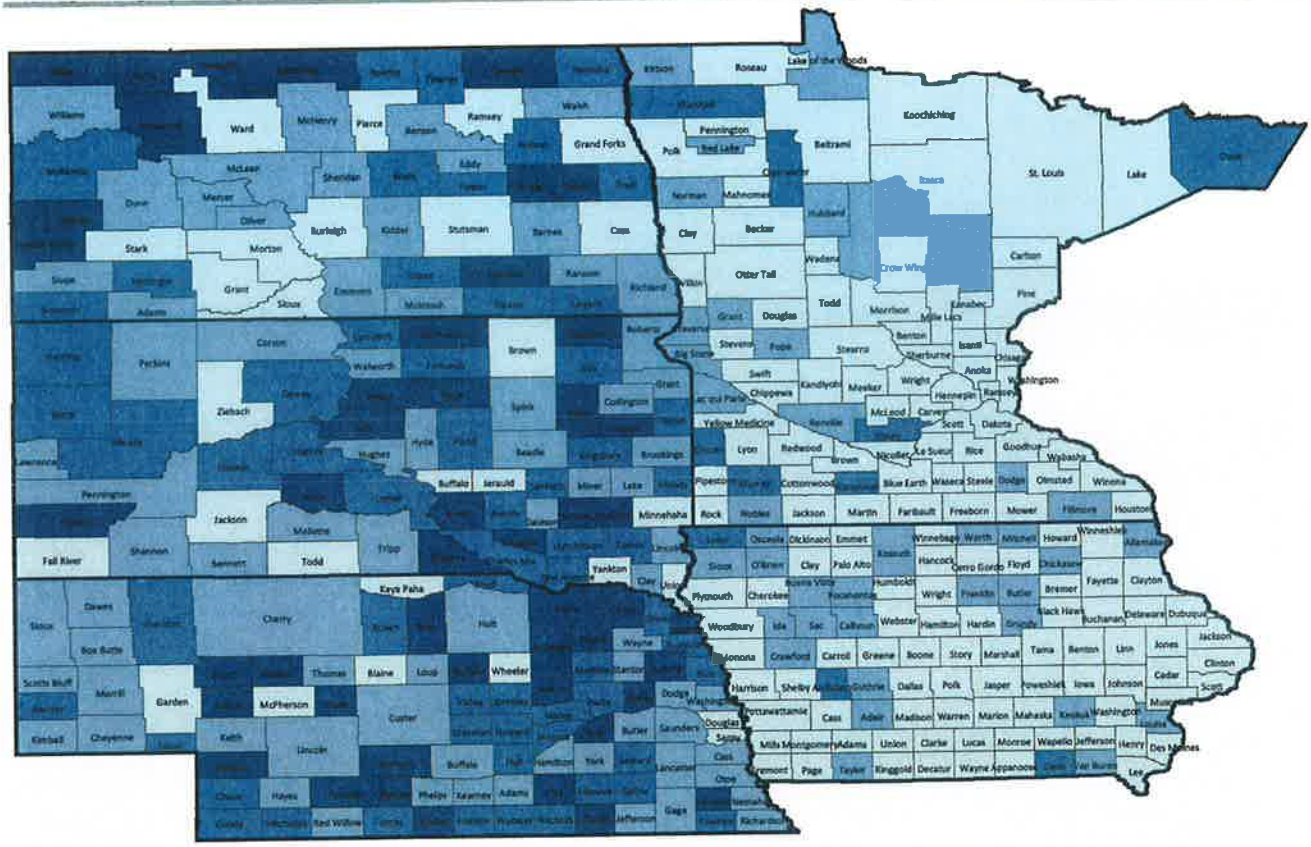
Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

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

Uninsured Youth - A health factor measure focusing on clinical care

Map 14

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



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

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

CONTEXT

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

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

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

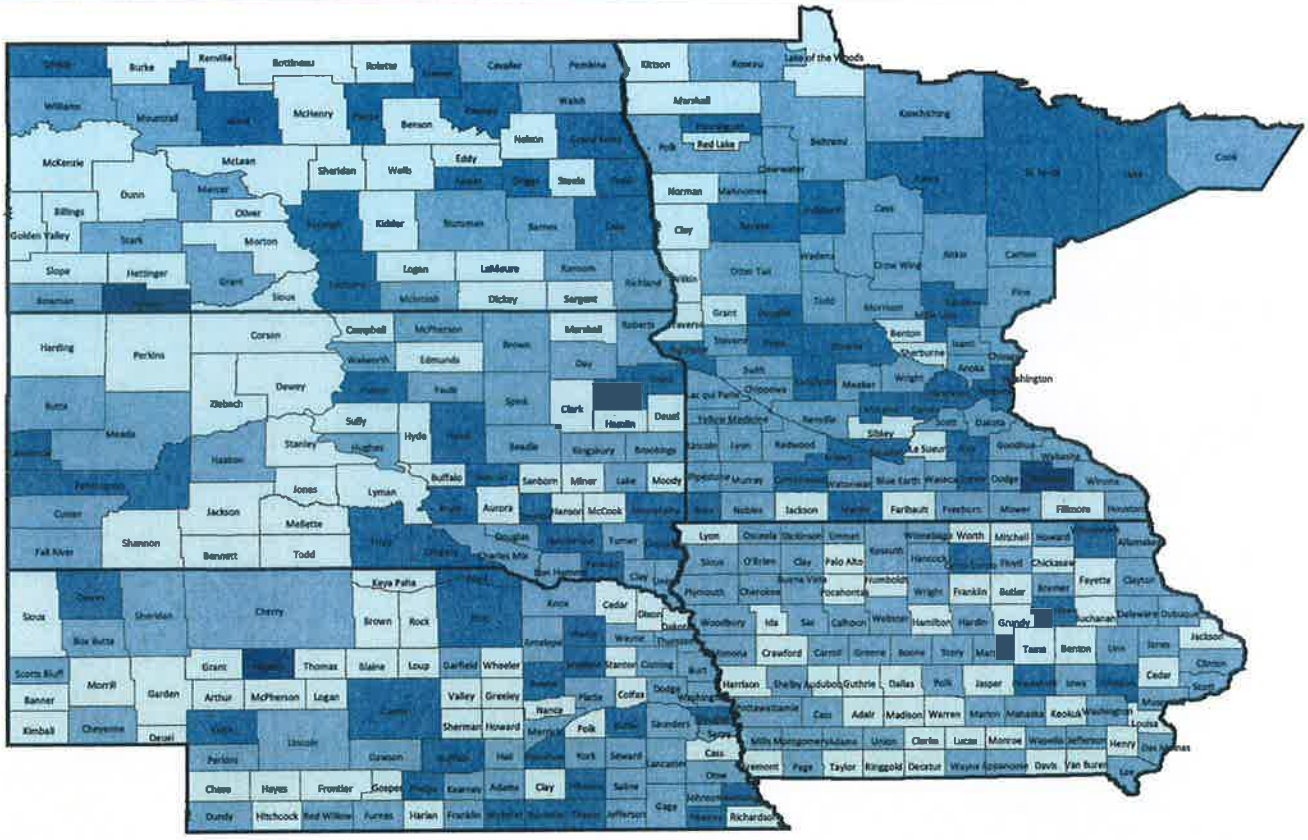
- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, http://www.census.gov/did/www/sahie/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

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

Map 15

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



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

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

CONTEXT

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

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

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

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

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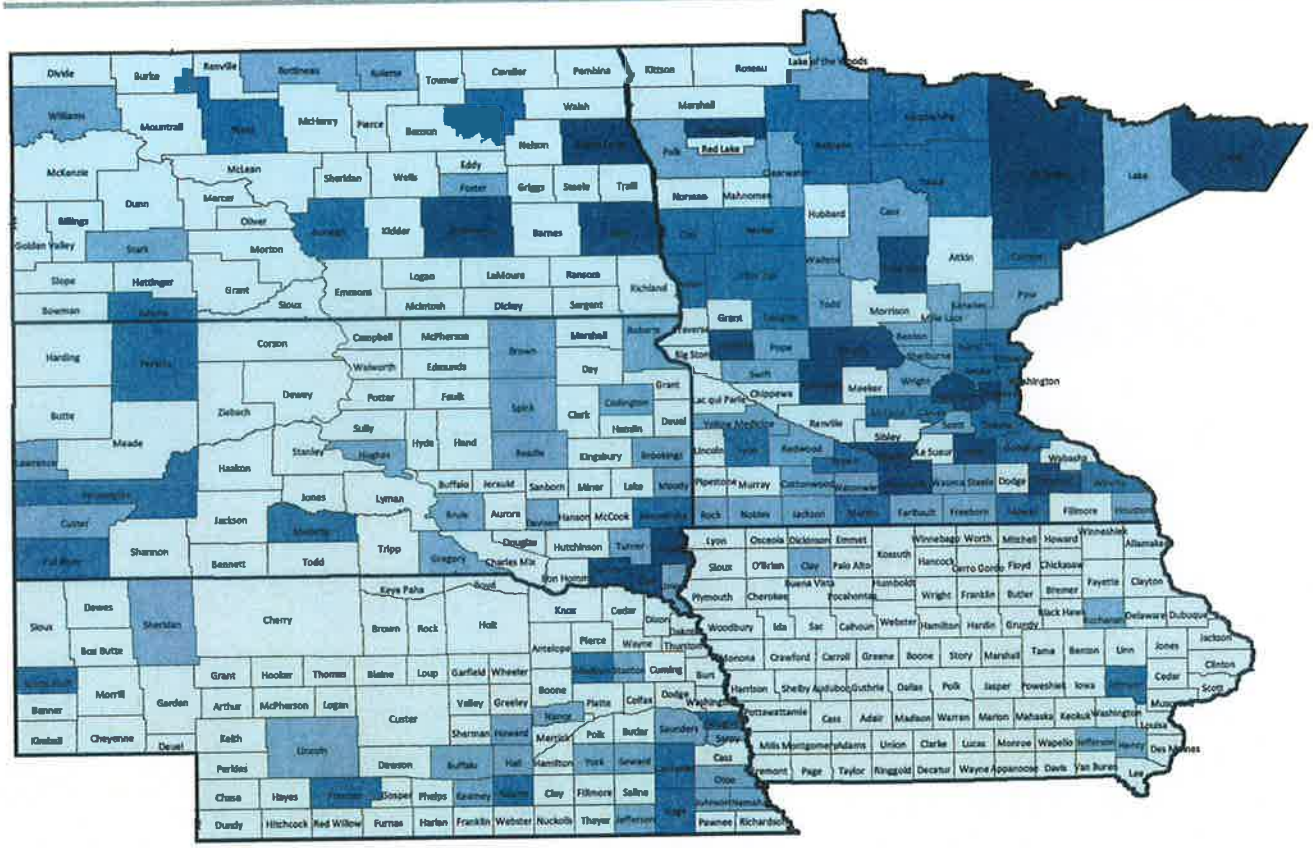
Map 16

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

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



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

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

CONTEXT

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

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

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

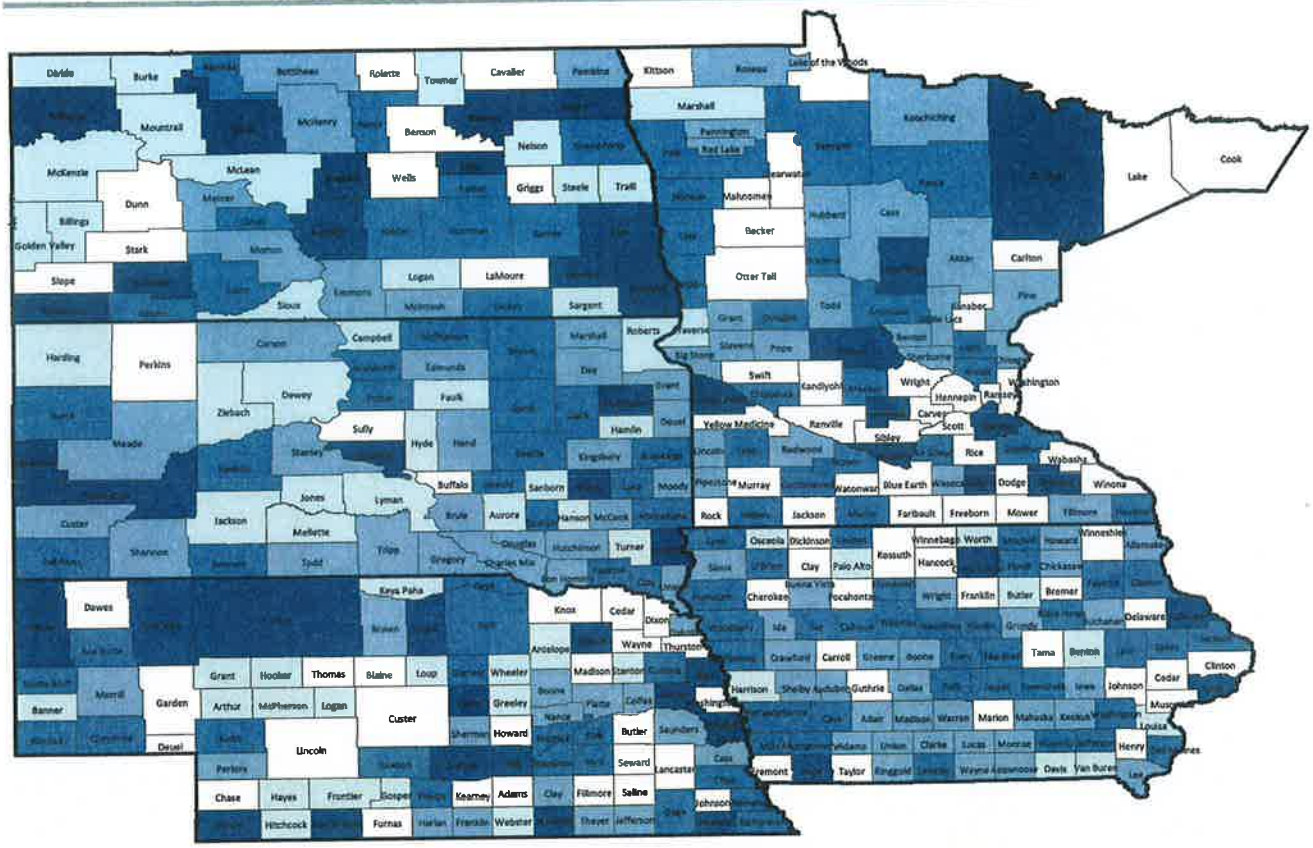
- Data were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 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).

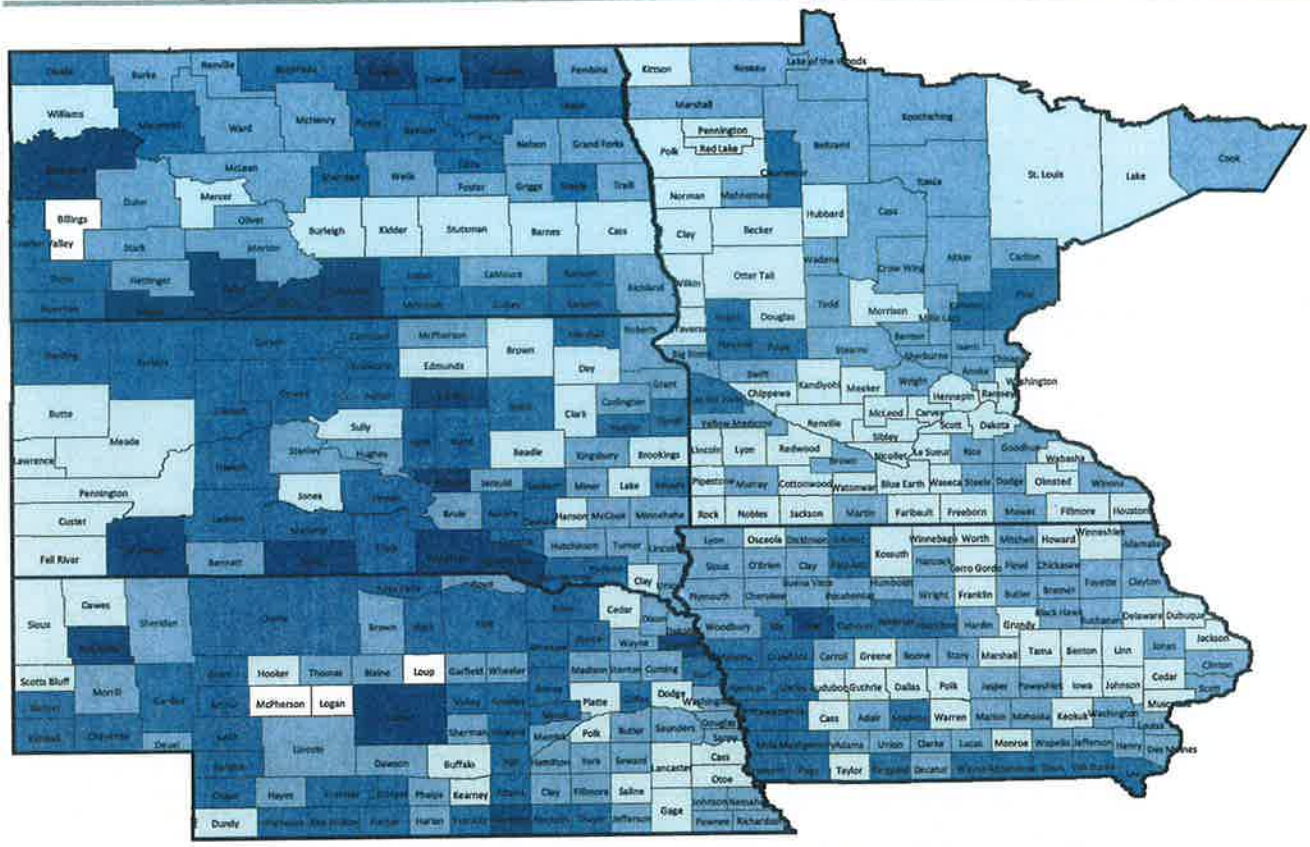
- Data were obtained from the Health Indicators Warehouse at http://healthindicators.gov/ which is maintained by the Centers for Disease Control and Prevention's National Center for Health Statistics.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 18

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

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



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

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

CONTEXT

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

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

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

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

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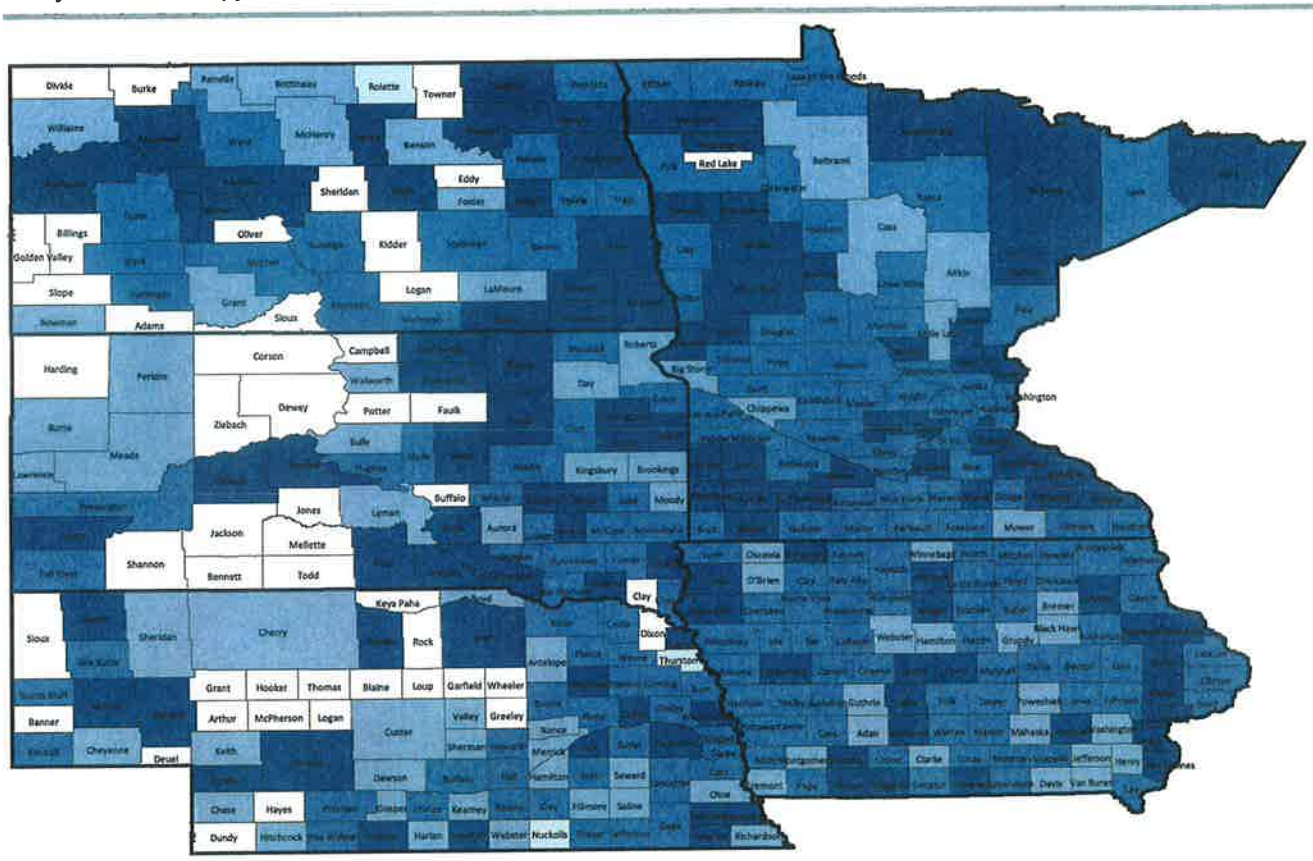
Map 19

Diabetic Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

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

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

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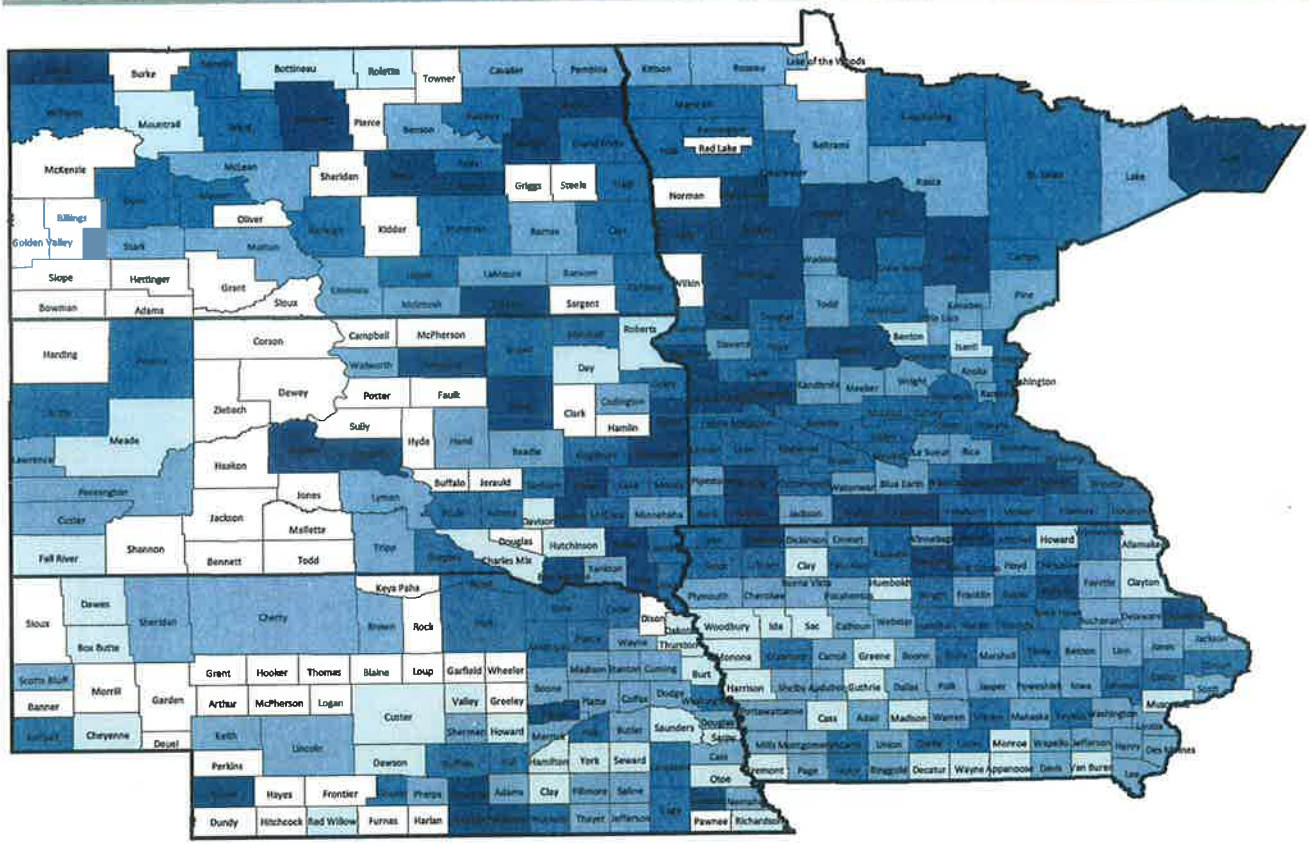
Mammography Screening - A health factor measure focusing on clinical care

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



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

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

CONTEXT

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

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

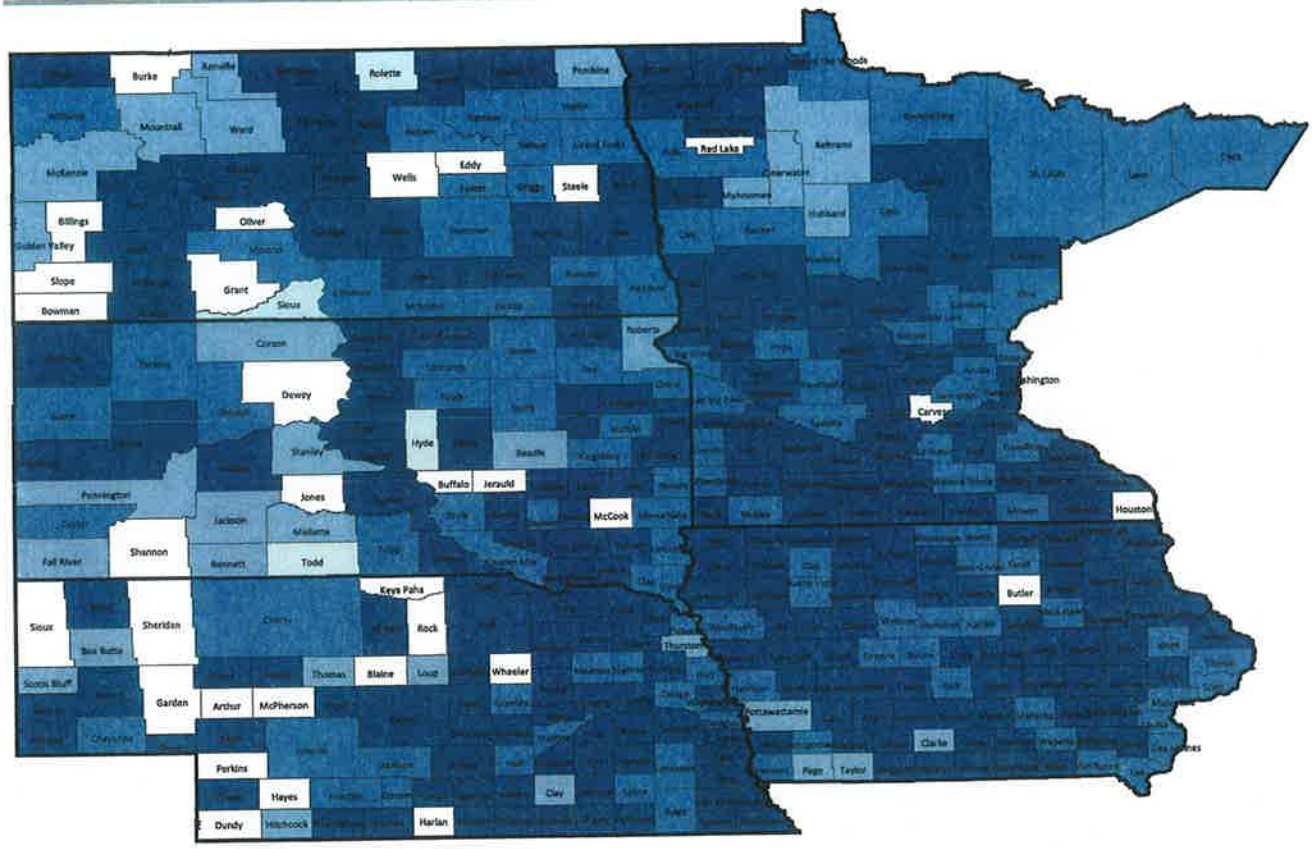
Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40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

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

High School Graduation - A health factor measure focusing on educaton

Map 21

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



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

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

CONTEXT

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

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

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

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

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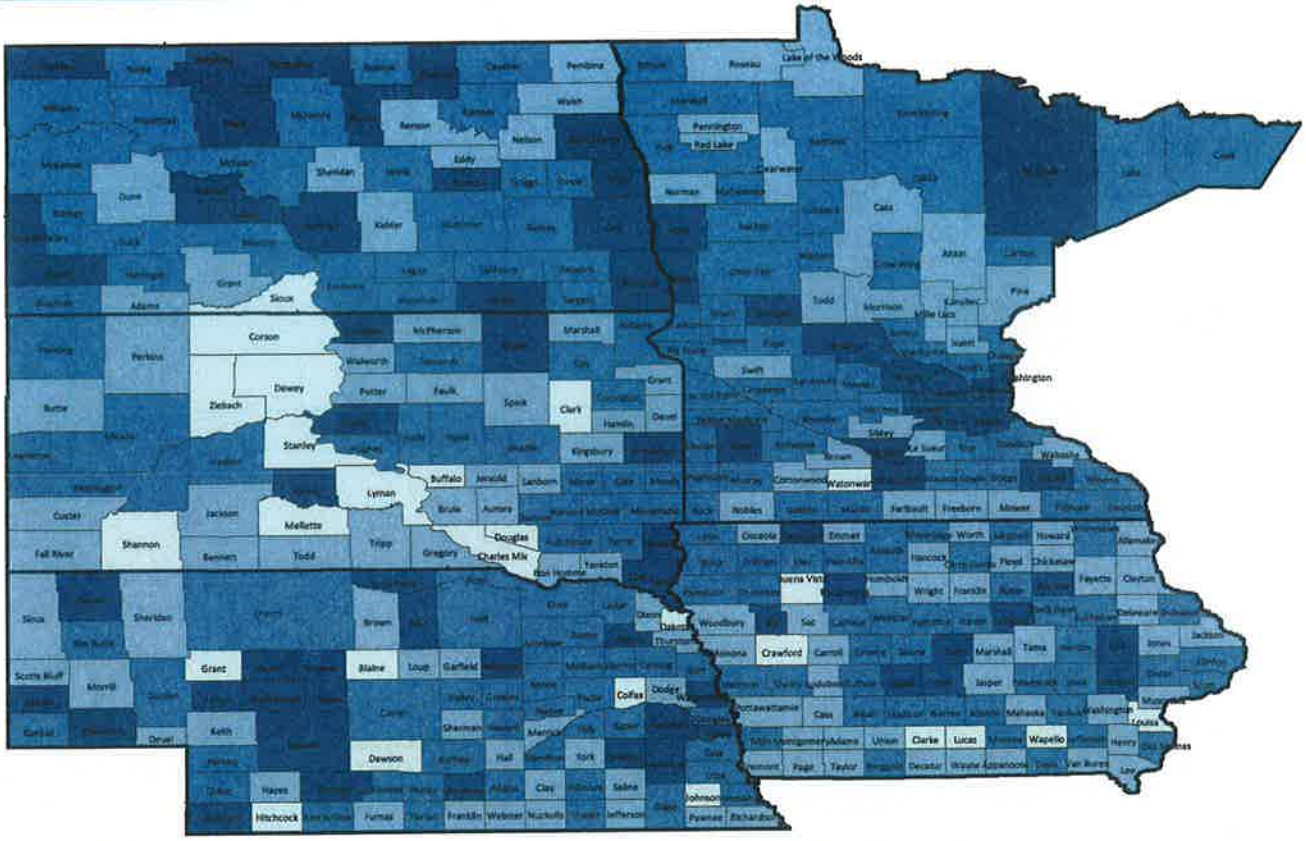
Map 22

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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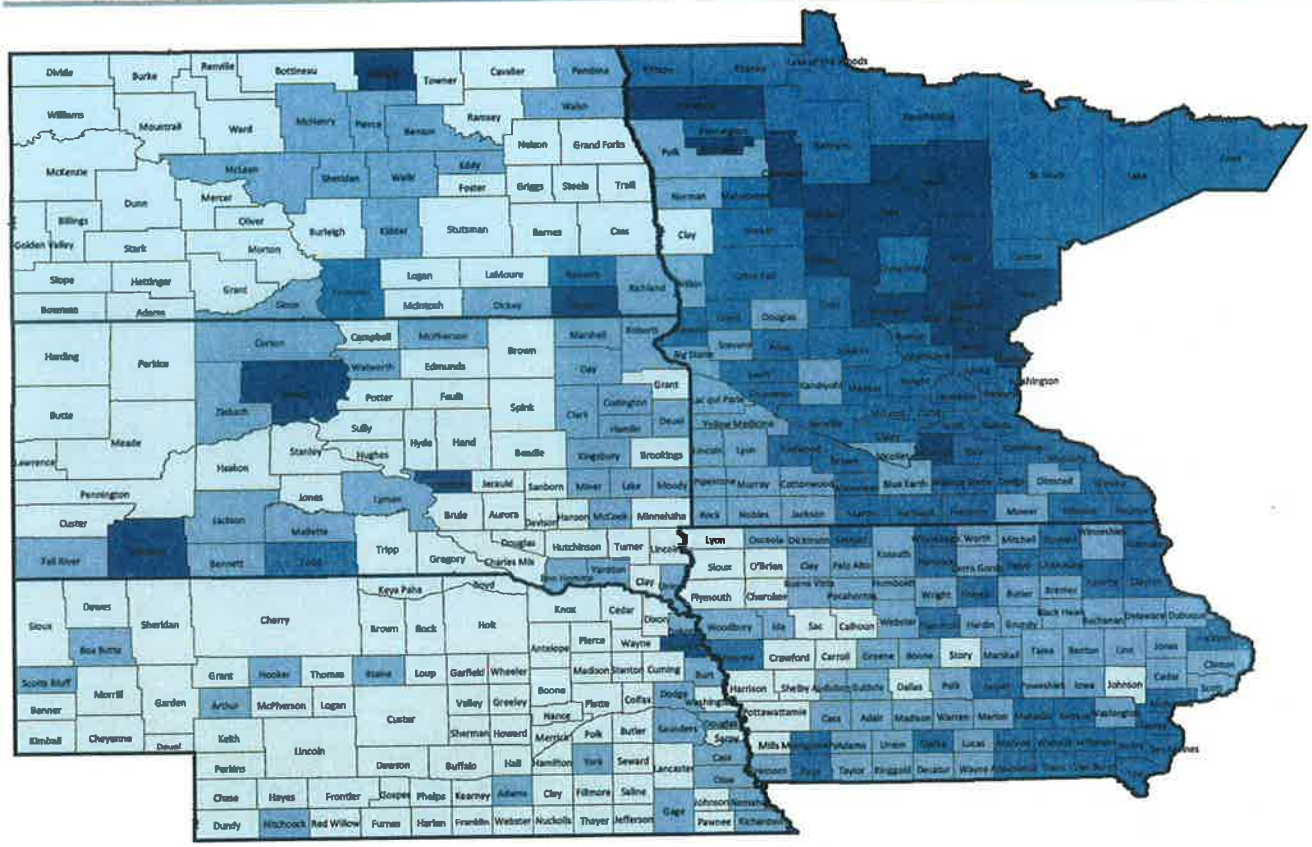
Map 23

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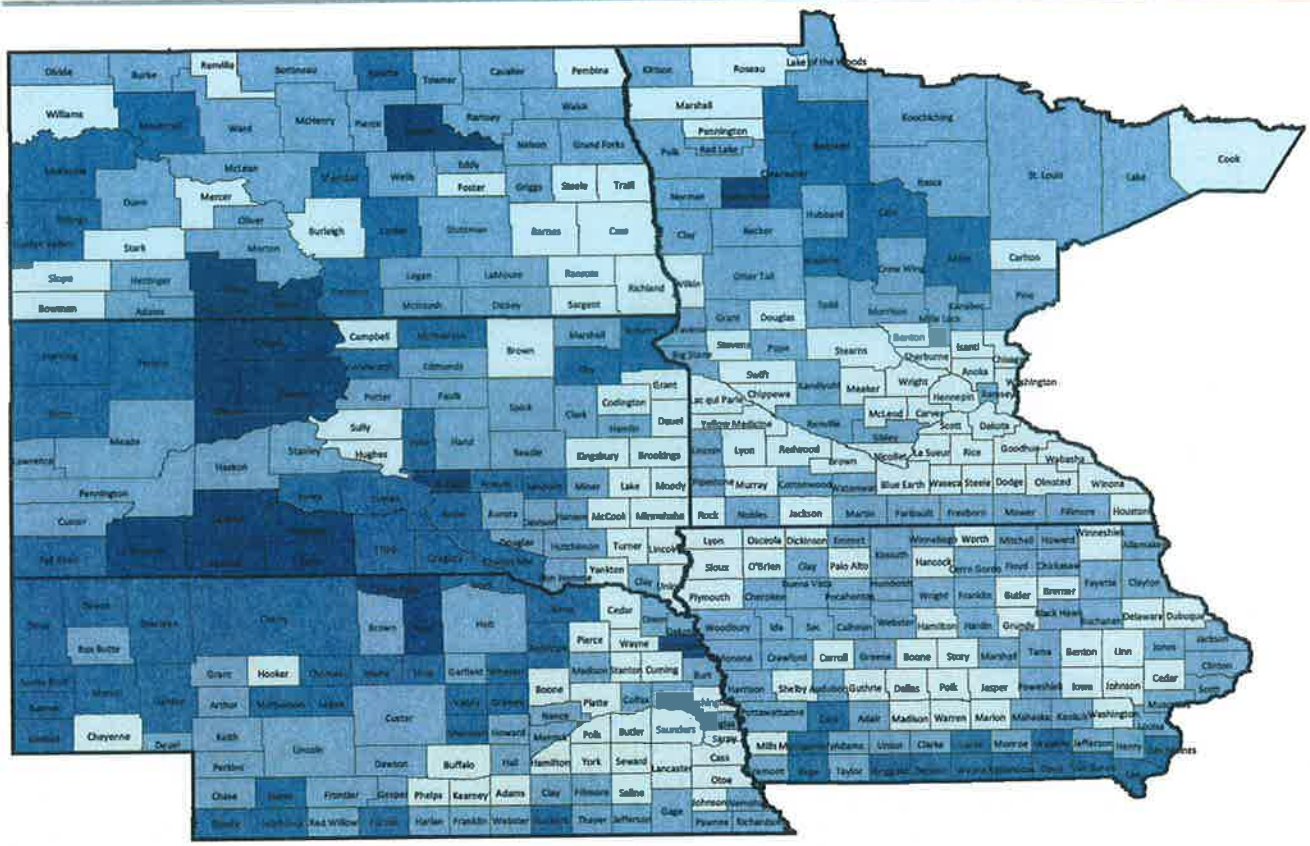
Children in Poverty - A health factor measure focusing on income and poverty

Map 24

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



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

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

CONTEXT

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

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

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

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

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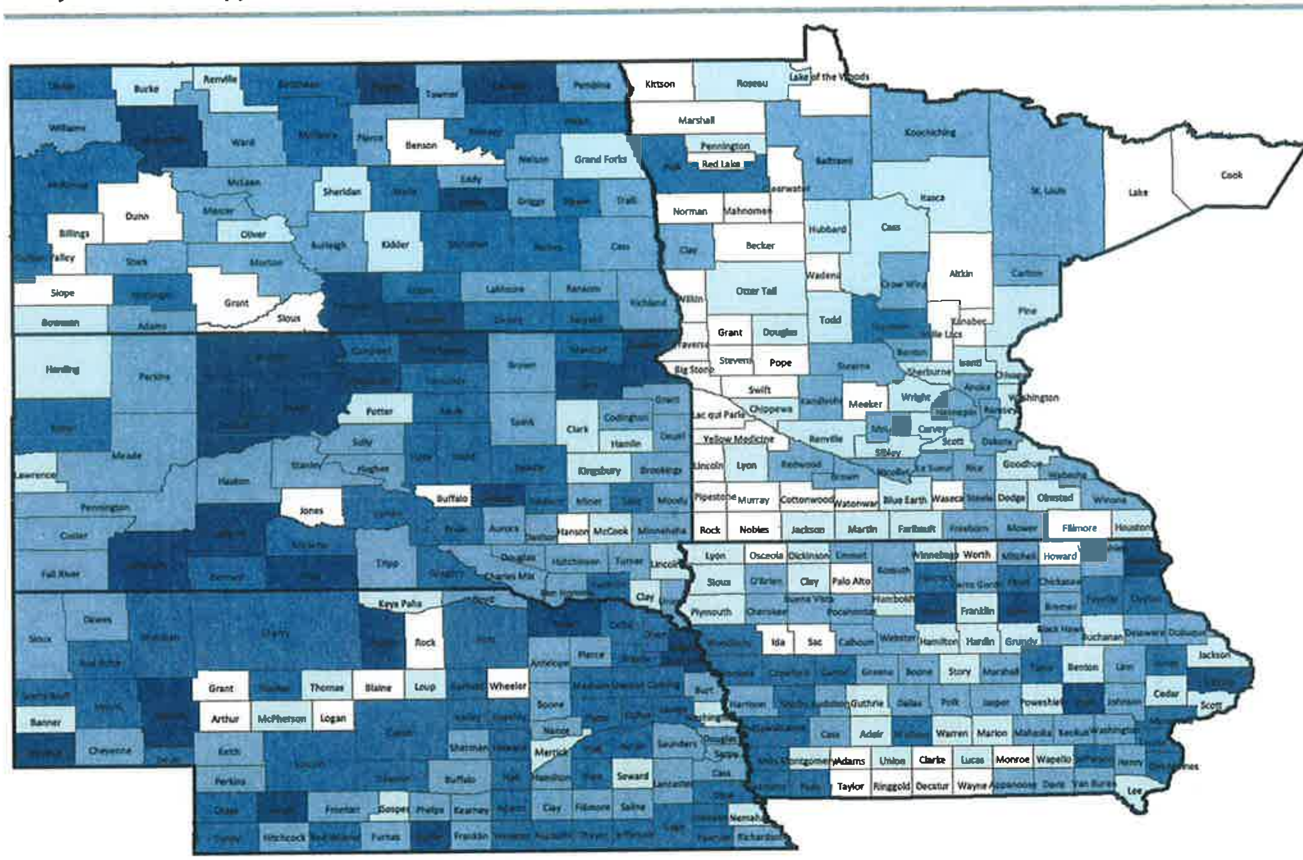
Inadequate Social Support - A health factor measure focusing on social networks

Map 25

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



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

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

CONTEXT

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

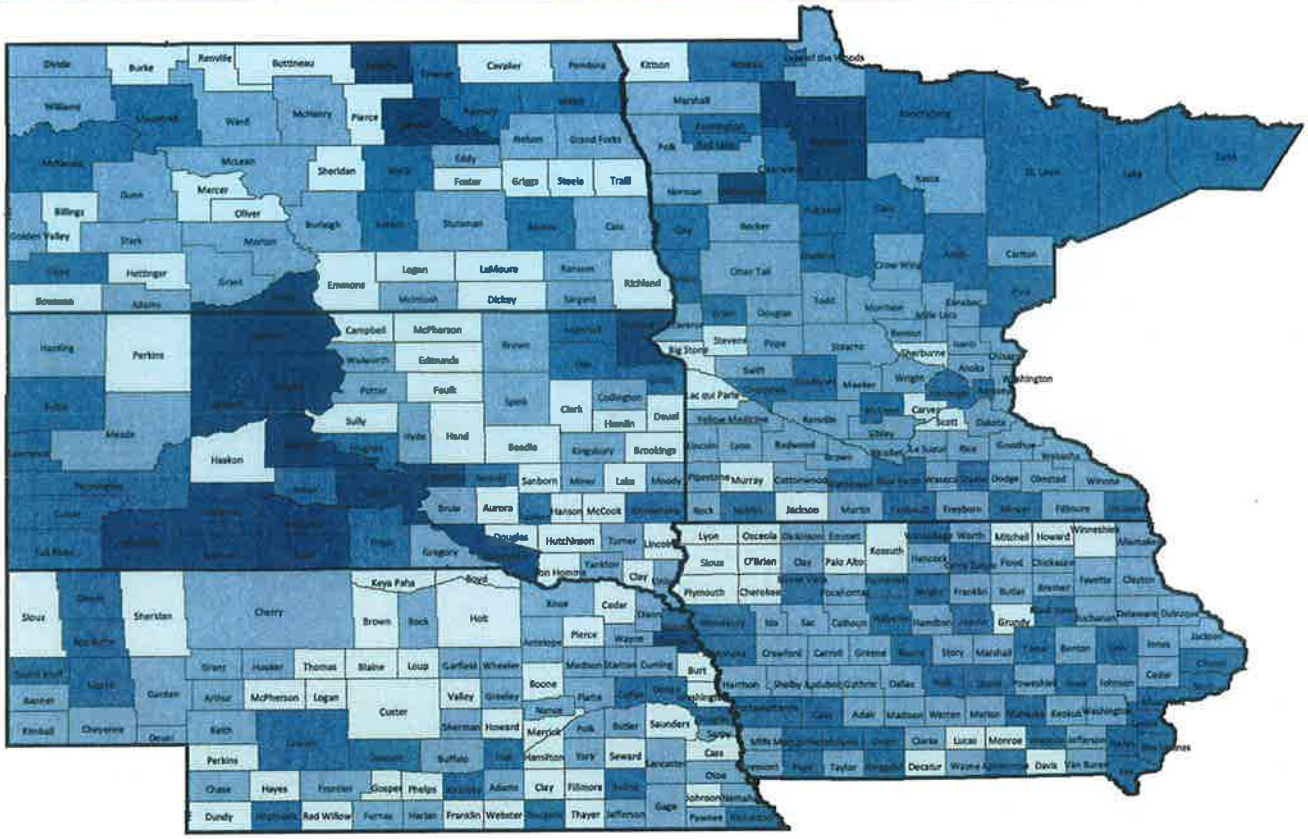
Where It Comes From: This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized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

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

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

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.

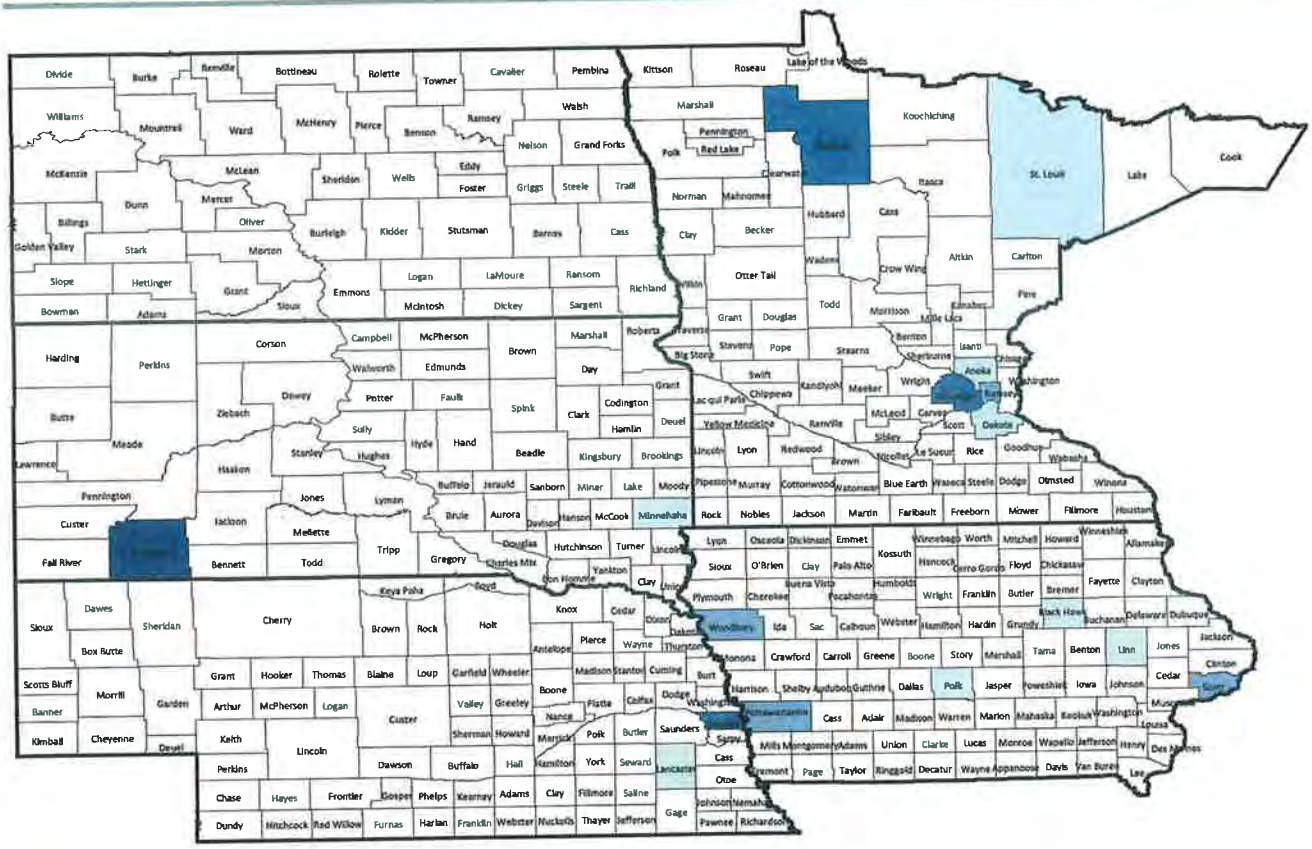
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 27

Homicide Rate - A health factor measure focusing on violent crime

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



Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

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

CONTEXT

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

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

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

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

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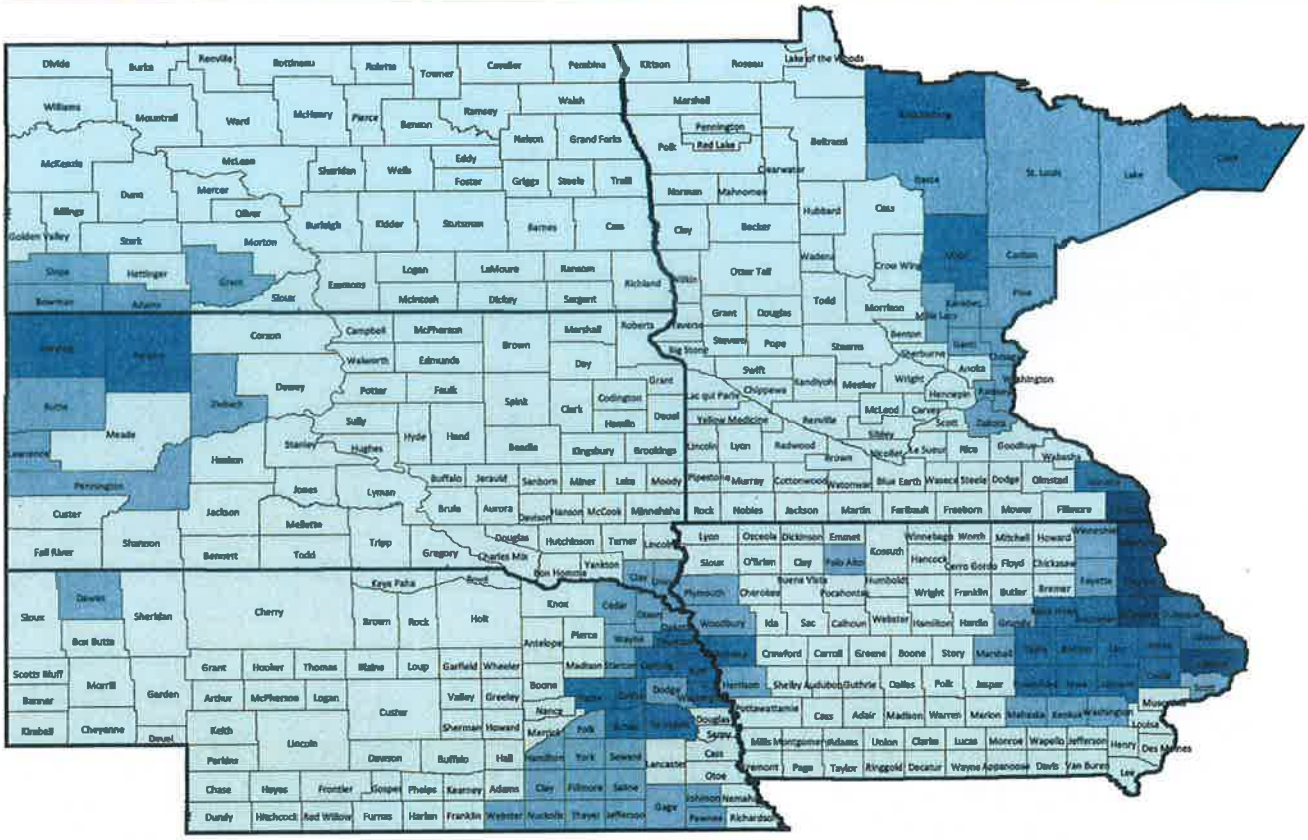
Map 28

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

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



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

- 0
- 1
- 2
- 3 - 4

CONTEXT

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

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

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

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

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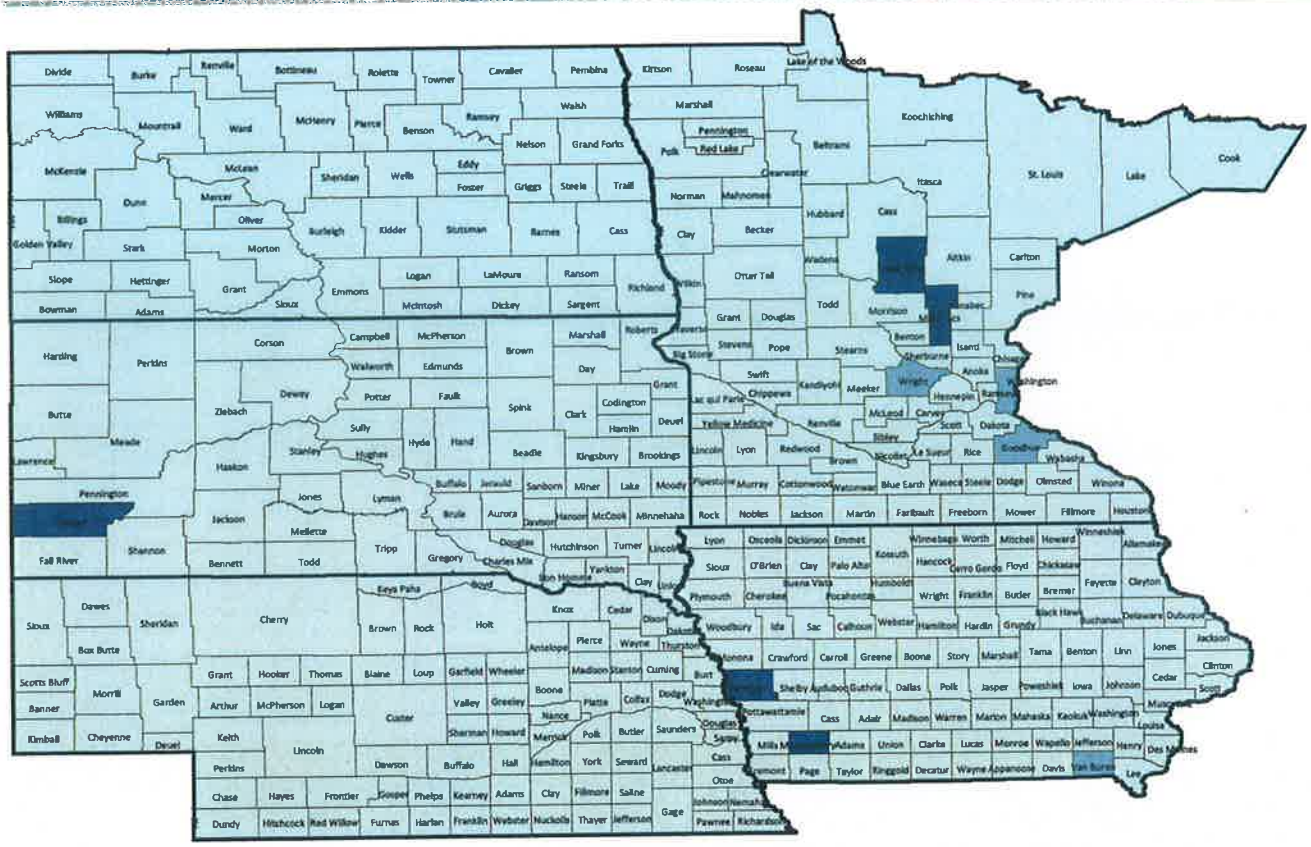
Air Pollution-OzoneDays - A health factor measure focusing on physical environment

Map 29

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



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

0
1
2

CONTEXT

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

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

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

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

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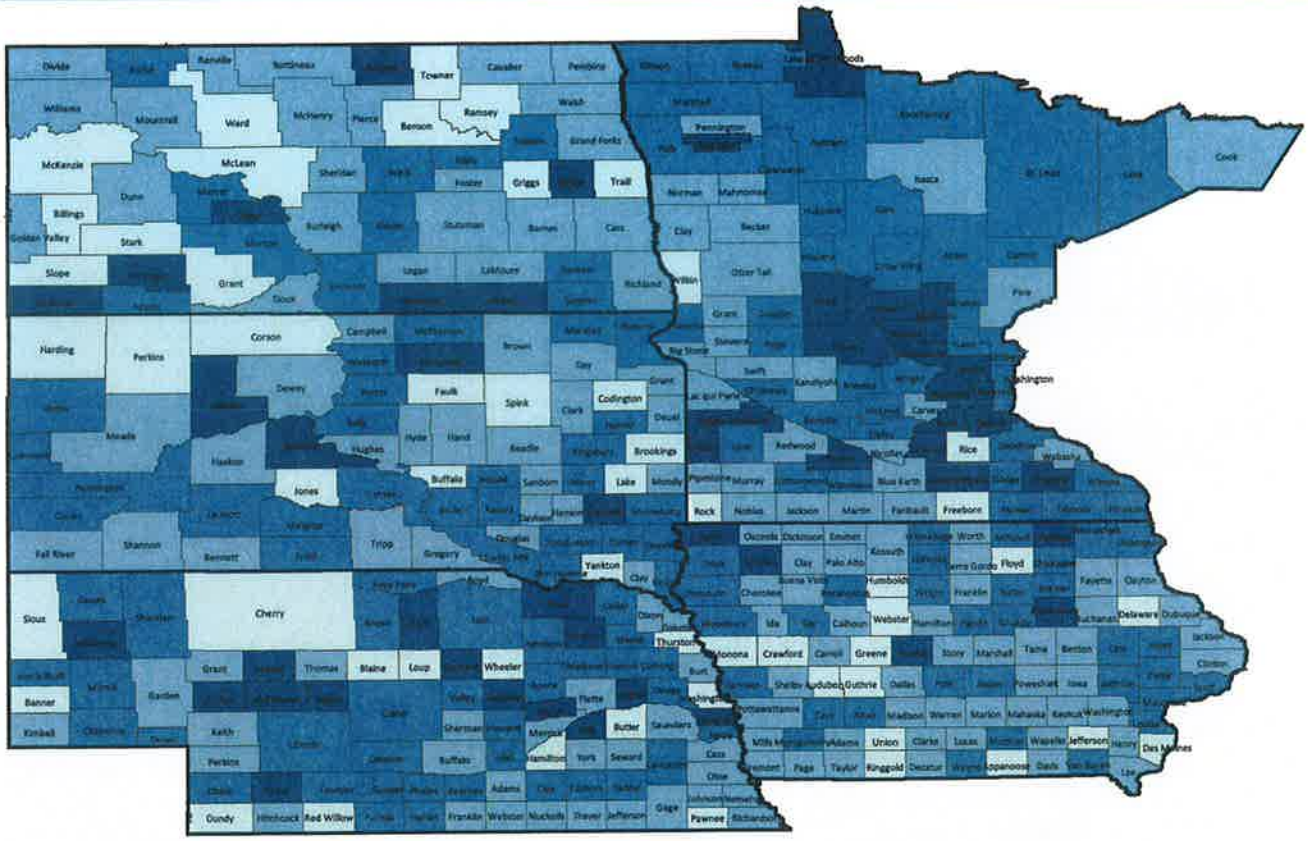
Map 30

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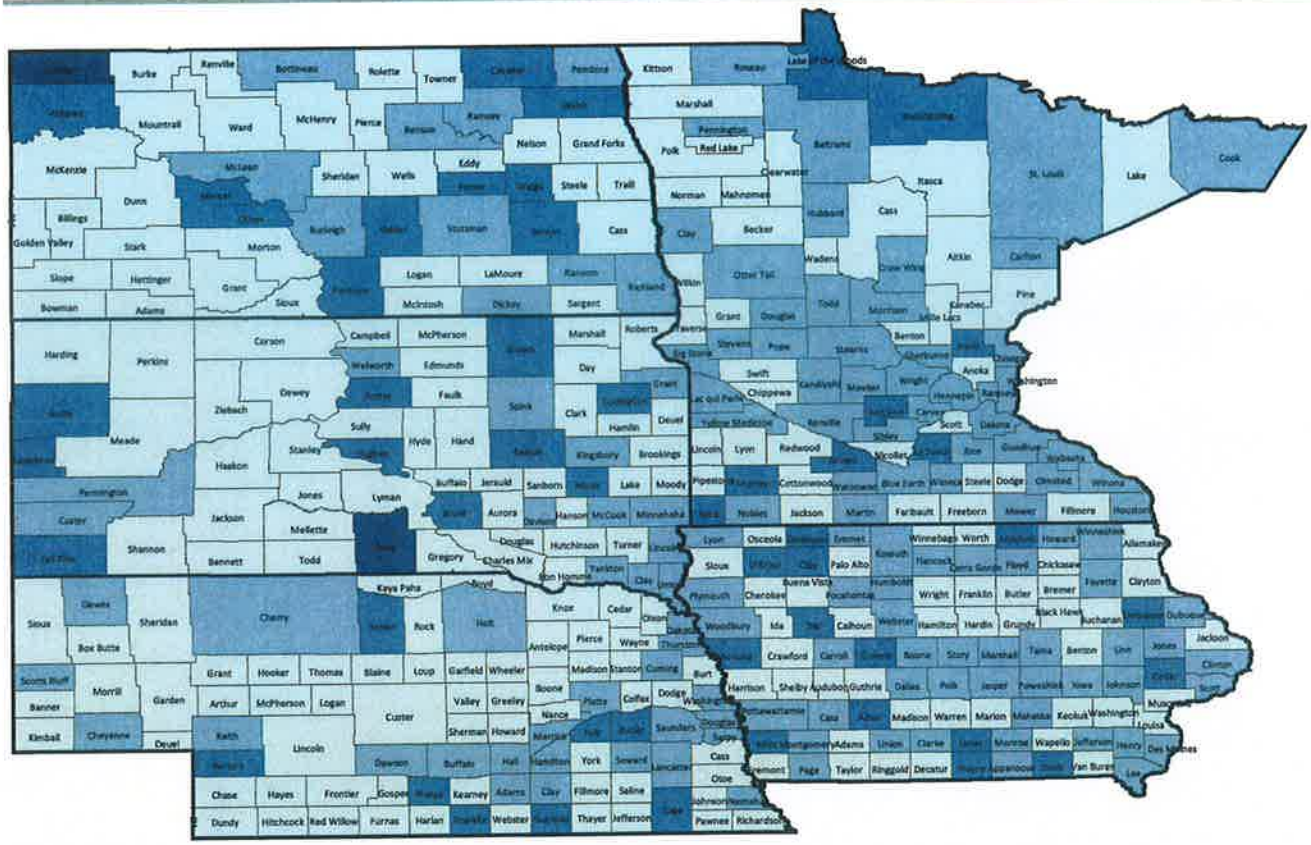
Access to Recreational Facilities - A health factor measure focusing on physical environment

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.

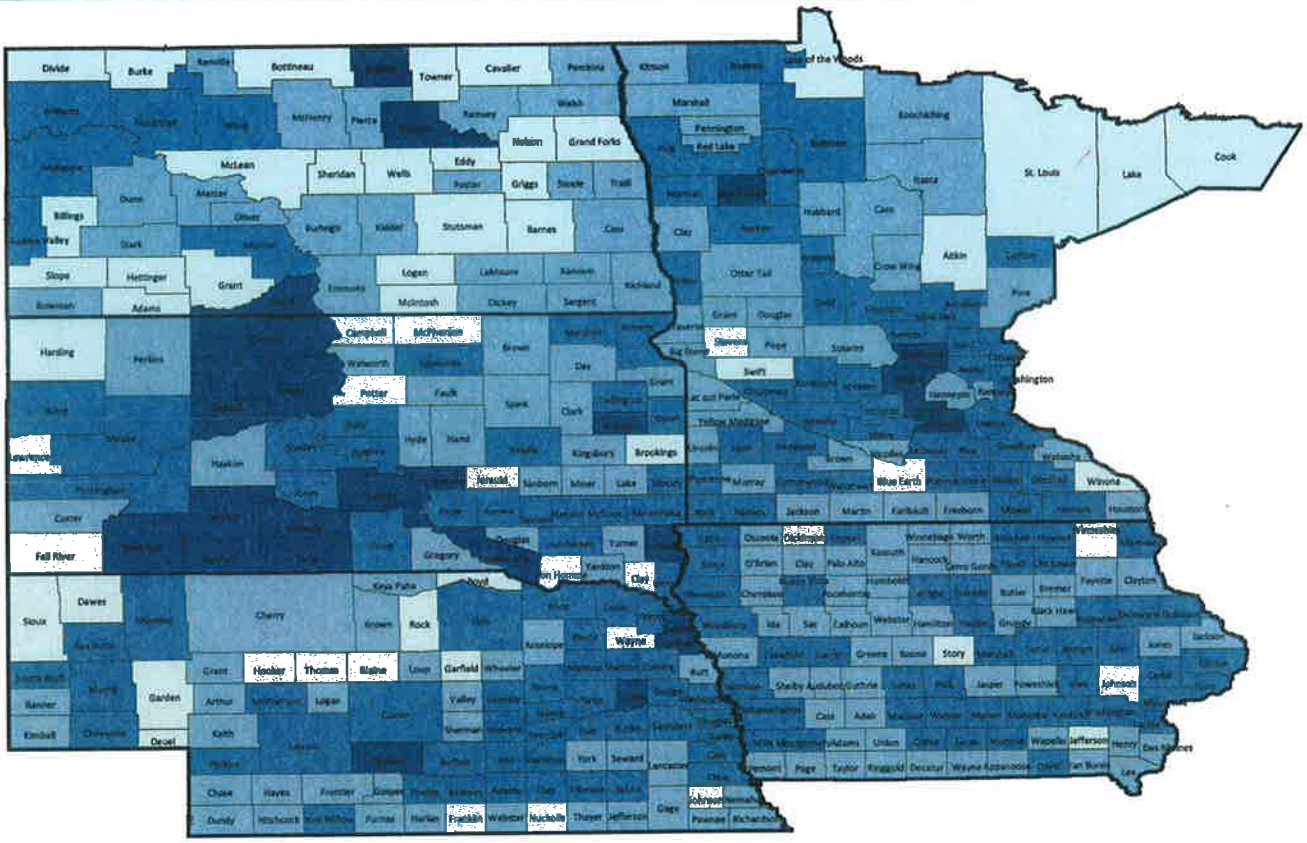
Importance: The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health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

Youth - A demographic measure

Map 32

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



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

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

CONTEXT

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

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

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

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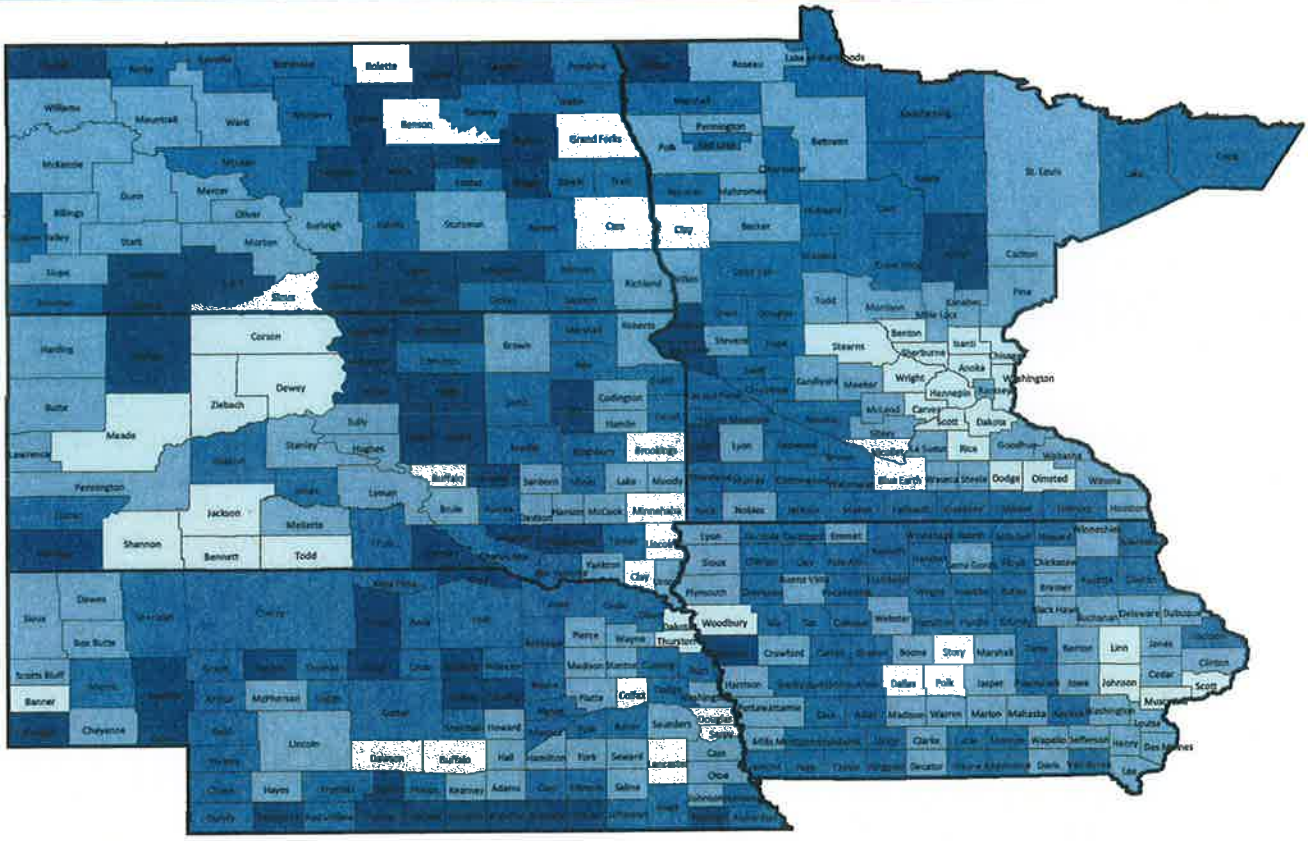
Elderly - A demographic measure

Map 33

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



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

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

CONTEXT

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

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

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

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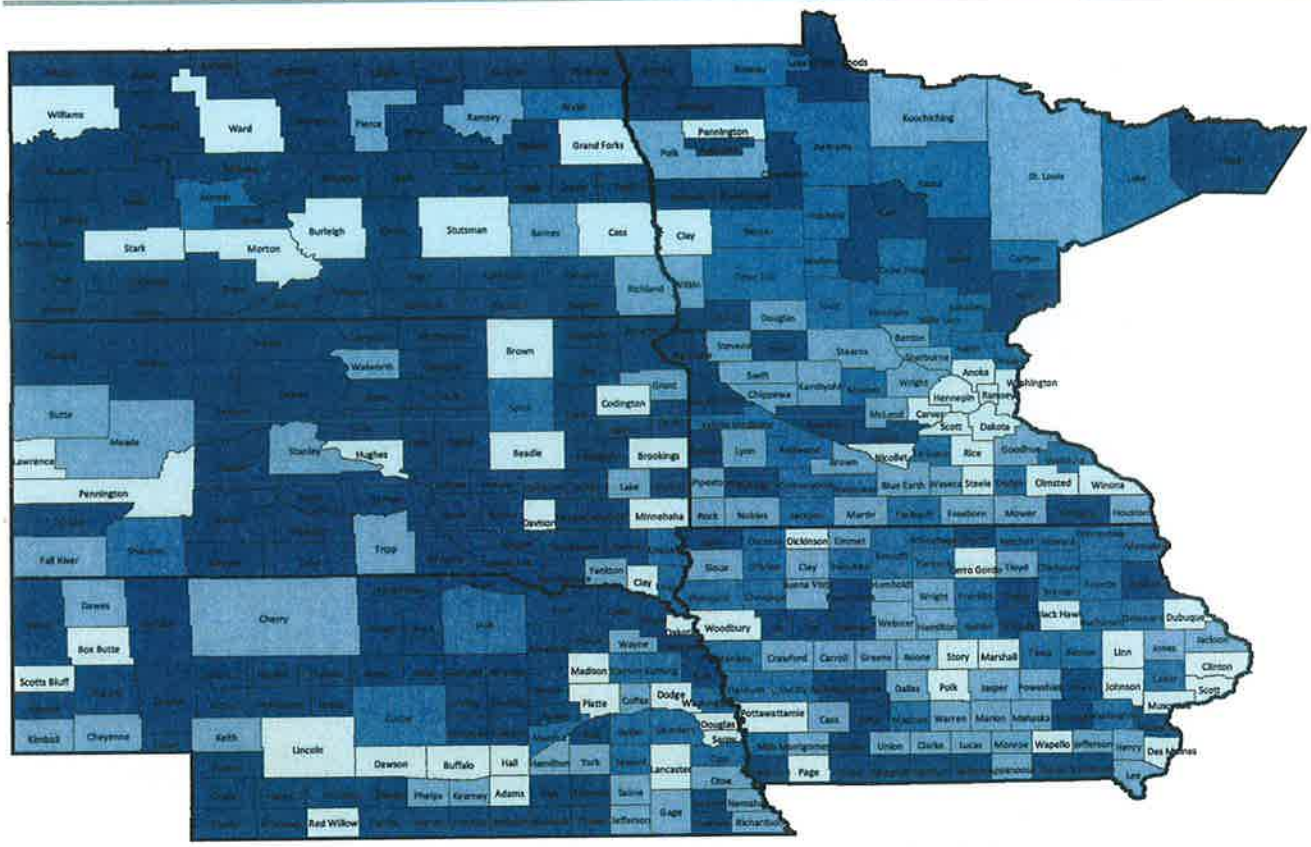
Rural - A demographic measure

Map 34

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



Percent of total population living in a rural area, 2000

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

CONTEXT

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

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

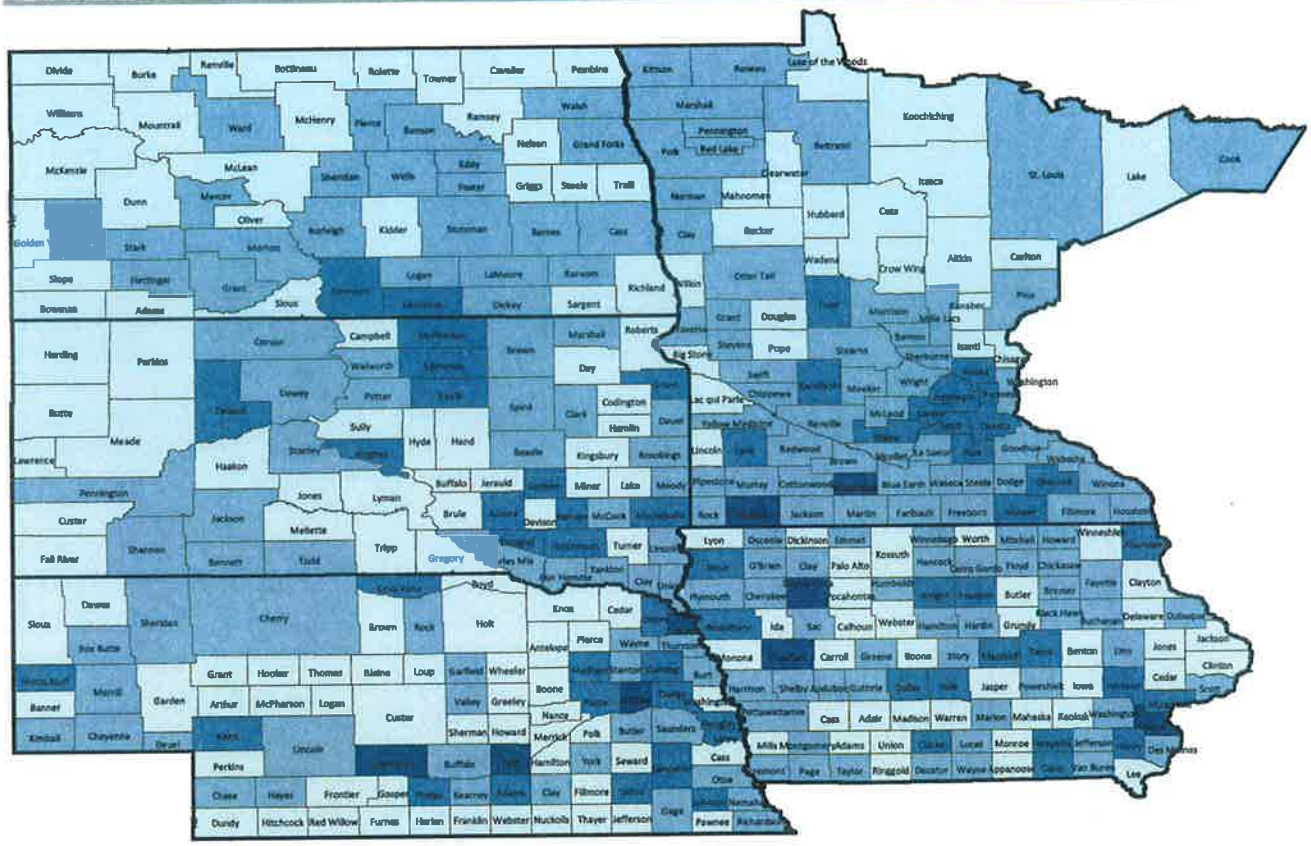
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Not English Proficient - A demographic measure

Map 35

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



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

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

CONTEXT

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

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

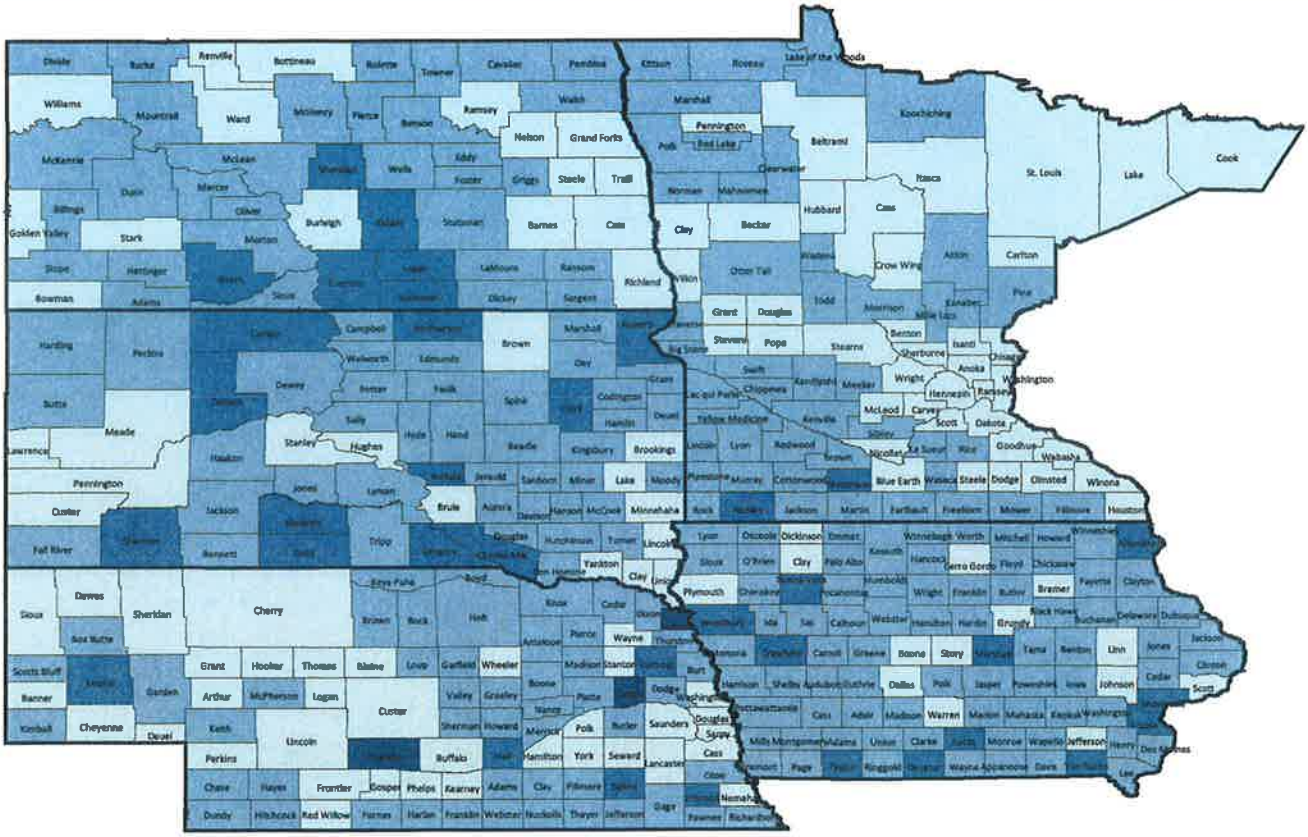
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

 This map was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Map 36

Illiteracy - A demographic measure

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



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

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

CONTEXT

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

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

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

SANFORD HEALTH

Table 1
Community Health Needs Assessment Asset Mapping
Sheldon Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Access	• Unacceptable delays for care because healthcare provider cannot meet the demands of the population due to employee turnover • Need an Urgent Care or Walk-in Clinic so that doctors are available evenings & on weekends (thereby decreasing unnecessary visits to the EC) • Need more physicians – can't get in for an appointment • Need more specialty physicians	Two physician slots are currently being recruited for in Sheldon. Also the emergency department is being staff separately during the day. Saturday 9 – 12 and Monday evening 6 – 9 the medical clinic is currently open and we added a provider to Monday evening. Two physician positions are being filled Oncology, pulmonology and additional neurology are on the requested list of specialties	
Cancer	• Concern with the rate of cancer in this area – is this caused by ag chemicals in NW Iowa? • Need cancer treatment in our own community so patients don't have to drive to Sioux Falls (chemo/ infusion center and radiation services)	Sanford Cancer Biology research Center We do some chemotherapy services and we do not have an oncologist. Radiation therapy is available in Worthington, Spencer, Sioux Falls and Sioux City.	
Cardiac	• Need cardiac services	We have a visiting cardiologist twice a month	
City & Co. Services; City Govt.; City Infrastr.	• Lack of foresight by City planners for residential development – no infrastructure in place • Cost of regulation because of so many laws • City government – too much spending • Cost of engineering • Our roads are bad	We will address the identified issues with City Leadership	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	• Too much money spent on roads • East 6th Street & Country Club Road should have curbs/gutters • Need more money spent on the other parts of town (not just the east side) • Fires • Noisey dogs – large dogs kept in small kennels – lots of barking • RFT- people bring with them drugs and crime		
Diabetes	• Concern over high number of diabetes patients • Need services & classes for diabetes patients • Low rat o Hgb A1C screenings	The Sanford Project to cure Type 1 Diabetes Sanford Medical Home Currently offer diabetes education for individual groups	

Economic Situation/ Business community	• Need more industry - to create jobs
	• Need higher paying jobs so that people would not have to work 2 jobs & have so little time to keep fit (exercise)
	• Grocery stores
	  ○ Hy-Vee & Fairway are hard for the elderly to get to
	  ○ RTA is too expensive for those who need it
	  ○ Grocery store has moved too far out (hard to walk to). Both stores are on the same side of town – it is a long walk for those on the other side of town.
		SCDC is currently working on new industry to come to towns.
		
		RIDES and Love Inc. available for transportation	

Elderly	• Transportation to the grocery store & clinic for the elderly who no longer drive • Need an elderly day care facility • Elderly abuse • Concern over Alzheimer's	The RIDES program is county operated. No plans for working on adult day care All hospital personnel are trained in Elder Abuse We have dementia unit in our long term care facility	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Emergency Care	• Concern about use of the EC as the primary physician • Concern about access to ER services • Need FT emergency services	Services are available 24/7 Emergency services personnel are volunteers at this point and serves us well	
Handicapped	• Need more money spent on those who are mentally or physically handicapped	Need this quantified as we have great access and services	
Healthcare Cost/Insurance Cost	• Health insurance cost (employees not paid enough to compensate for the cost of insurance) • Concern with those who do not have insurance – how do they pay for healthcare services? Entitlement mentality. • Concern about long-term care expenses • Need to offer discounts on insurance cost if leading a healthy lifestyle • Uninsured	There are different plans available in town. Community education Insurance company specific	
Health Factors	• Adult smoking • Death rate from motor vehicle crashes • Teen birth rate • Preventable hospital stays	Not out of the norm – Quitline Iowa available Not out of the norm Not out of the norm There are no preventable stays – better compliance from patients perspective	
Healthy Nutrition	• High cost of food • Concern about lack of healthy food options or poor quality • Need restaurants that offer healthy choices • Need classes that teach how to create healthy meals	Options are available Blue zone Currently partnering with Hy-Vee on this project	
Housing	• Need more rental houses & apartments • Lack of pride in neighborhood - run down houses, sidewalks not maintained well	Work with City Leadership to make more affordable housing available	
Judicial / Police	• Concern with drug users not being convicted	Judges following guidelines	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Mental Health	• Better trained doctors who can help with child/parent issues • Need more local mental health services	Sanford One Care Currently recruiting two positions and working with other agency	
Morbidity and mortality	• High rate of premature death	Not out of the norm	
Obesity	• Concern about high rates of obesity • Concern with those who eat at fast food places like McDonald's • Eating to relieve stress	Sanford WebMD Fit Kids Education to the community (Blue Zones)	
Parenting	• Parents are afraid to discipline their children because of the laws • Need family planning education • Lack of parenting guidance • Concern with parents who think it is OK for teens to drink because it's been accepted/tolerated in the past	Not aware of this issue Provided through the school Available services through the health center, Seasons Center, Love Inc and churches Community education opportunity	
Physical Activity	• Need hiking & biking trails • Need a cheaper wellness facility (or ability to buy just a one-day or weekly pass without a membership) • Need better adult recreation programs • Wellness centers need to work together to get funding, etc. • High incidence of inactivity	Sanford WebMD Fit Kids Our three facilities offer all of these requests and are very inexpensive.	
Physicians	• Concern with physicians who "guess" rather than making an accurate diagnosis • Concern with physicians who refer the patient to someone else when they can't come up with a diagnosis • Need more physicians – can't get in for an appointment • Need better/more communication between providers	Specialists are meant to do that Two more physicians being recruited Communication education with providers	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Pollution	• Concerns with the landfill • Concerns with lack of recycling • Concern with herbicides, pesticides • Concern that ag chemicals used in NW Iowa are contributing to a high cancer rate • Soy bean plant • Exposure to cell phone radiation • Overreaction of government re: issues of pollution & cost of mandates		
Poverty	• Need financial literacy for low income families	Love Inc/Churches	
Prevention Services	• Need more screenings (mammos, PSAs, heart, etc.) • Need more specific health & wellness programs for obesity, diabetes, heart disease, eating disorders • Access to a preventive dietician through community youth recreation & education programs • Flu	Sanford WebMD Fit Kids Currently	
Safety	• Concern about sex offenders in the community • Concern about high level of incest crimes & lack of reporting of those crimes		

Substance Abuse	• Need a local detox center
	• Concern with parents who think it is OK for teens to drink because it's been accepted/tolerated in the past
	• High incidence of binge drinking
	• Many drug concerns
	  ○ Marijuana use
	  ○ Meth use
	  ○ Prescription drug abuse
	  ○ Huffing
	  ○ Emerging use of synthetic cannabinoids & synthetic catthinones
		Sanford One Care
		Community education
		
		Education was given in July 2012 to social workers, healthcare professionals, educators and law enforcement by Sanford Sheldon	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Traffic Issues	• Need stop lights on Hwy. 18 • Need stop lights at Country Club Rd & Hwy 18 (25th and Hwy 18) • 9th and Washington needs a stop sign on 9th • Need more stop signs in the rural areas • How to best utilize or market access to a 4-lane highway	Will work with DOT, City and county on traffic issues	
Transportation	• Transportation to the grocery store or clinic for those who do not drive (or elderly) – such as buses • Concern over recent decision to allow unlicensed vehicles (4-wheelers, golf carts) to use city streets • Concern with bicyclists on the roads • Concern when turn signals are not used regularly • Concern with those who pass on the right by Fareway • Concern with those who don't use the turn lane by Hy Vee • Transportation costs – a monthly ticket in Ohio is $85 while a punch card ride is $6	Rides available and Love Inc. volunteers	
Workplace	• High turnover of doctors & nurses • Concern with pay levels for less skilled healthcare workers • Need incentives for senior workers to stay on the job	Compensation surveys conducted Incentives are in place in health care	
Youth	• Drugs, drinking • Concern with parents who think it is OK for teens to drink because it's been accepted/tolerated in the past • Truancy • Kids who need help but are not getting it • Teen pregnancy (& unwed mothers of all ages) • Lack of youth programs (swimming lessons, etc.) • Parents are afraid to discipline their children because of the laws	Sanford WebMD Fit Kids Sanford One Care Work with city and school on educational opportunities Power Program Sponsor athletic events/teams	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	• PE should be required for all students • Concern about obesity & body image • Concern about diabetes rate in children • Concern about constipation in children • Concern about potential undetected heart issues in children • Concern about cancer rates in children • Concern about "labeling" of children who have problems • Concern about birth defects		
Sanford Specific	• Perceived lack of compassion by clinic staff (schedulers, receptionists) • Perceived lack of confidentiality at clinic & pharmacy • Perceived lack of timeliness in answering of clinic phones / patients left on hold for 20 minutes • Concerned with hospital billing system – perceived to be very inefficient • Long visit time at the clinic (1-2 hours – lots of waiting) • Would like more time with the physician during a clinic visit • Need more education & explanation of the HIPAA law	Educate New telephone system upgrade should considerably cut down the hold time One Chart – everything comes on one bill now Emergency Department is now covered separately so the clinic wait time should improve This is done annually	

SANFORD HEALTH

Table 2
Sanford Sheldon Medical Center
Prioritization Worksheet

Health Indicator/Concern	Round 1 Vote N=20	Round 2 Vote N=11	Round 3 Vote
Access	3	1	1
Cancer			
Cardiac			
City & Co. Services; City Govt.; City Infrastructure	12	4	
Diabetes			
Economic Situation/ Business community	4	3	
Elderly	8		5
Emergency Care	11		
Handicapped			
Healthcare Cost/Insurance Cost	1		4
Health Factors			
Healthy Nutrition			
Housing	2		
Judicial / Police			
Mental Health			
Morbidity and mortality			
Obesity			
Parenting	6		
Physical Activity	10		
Physicians	5	2	2
Pollution			
Poverty			
Prevention Services	9	5	3
Safety			
Substance Abuse			
Traffic Issues			
Transportation			
Workplace			
Youth	7		
Sanford Specific			

*Round 1 voting took place at the Community Kiwanis Meeting which was a community group of 20 individuals. Top 12 highest priority items were identified (1 being the highest priority).

SANFORD HEALTH

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