

## Executive Report

# 2019 Community Health Needs Assessment

## Aitkin County, Minnesota

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*Prepared for:*  
Riverwood Healthcare Center

*By:*  
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2018-1771-02  
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# Introduction



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## Project Overview

### Project Goals

This Community Health Needs Assessment is a systematic approach to determining the health status, behaviors, and needs of residents in Aitkin County, Minnesota, the primary service area of Riverwood Healthcare Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Riverwood Healthcare Center by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

### Methodology

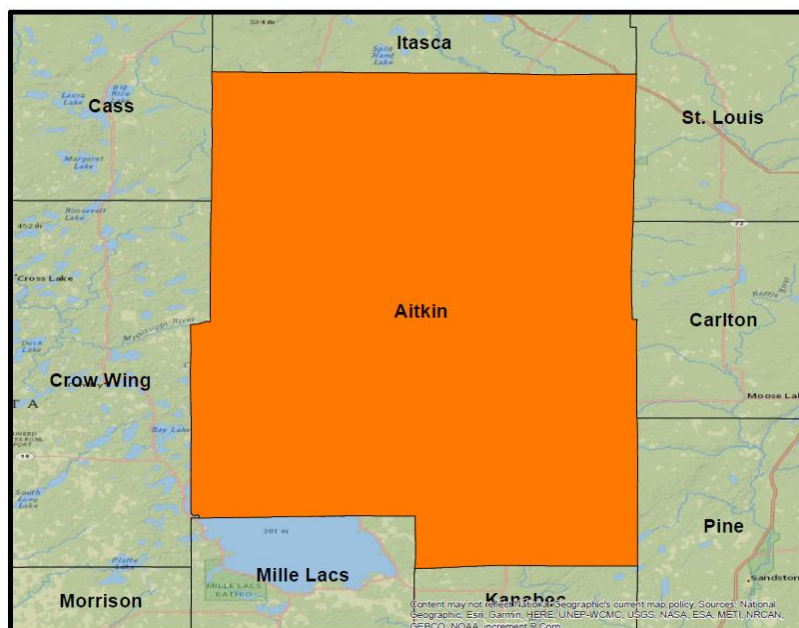
This assessment incorporates data from both quantitative and qualitative sources.

Quantitative data input includes secondary research (vital statistics and other existing health-related data) that allows for comparison to benchmark data at the state and national levels.

Qualitative data input includes primary research gathered through the Online Key Informant Survey.

### Community Defined for This Assessment

Aitkin County, Minnesota (where over 75% of Riverwood Healthcare Center's patients reside), represents the primary service area for the hospital and the study area for this assessment.



### Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was implemented as part of this process. A list of recommended participants was provided by Riverwood Healthcare Center; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 92 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physicians	8	3
Public Health Representatives	5	3
Other Health Providers	22	12
Social Services Providers	18	7
Other Community Leaders	147	67

Final participation included representatives of the organizations outlined below.

- Access North Center for Independent Living of Northeastern Minnesota
- Aitkin Acupuncture
- Aitkin County
- Aitkin County CARE, Inc.
- Aitkin County Commissioners Office
- Aitkin County Developmental Achievement Center (DAC)
- Aitkin County Extension Committee
- Aitkin County Fair Board
- Aitkin County Health & Human Services
- Aitkin County Sheriff's Office
- Aitkin County Veterans Services
- Aitkin High School
- Aitkin Police
- Aitkin Public Schools
- Aitkin Public Utilities
- Aitkin Township
- Aitkin United Methodist Church
- Aitkin-Itasca-Koochiching Community Health Board
- Central MN Cattlemen's Assoc.
- City of Aitkin
- City of Tamarack
- Community Meal
- EyeCare Centers of Aitkin and McGregor
- Floe International, Inc.
- Hill City School

- HOPE (Healing Opportunity Provided Equally)
- Housing and Redevelopment Authority
- Lakes and Pines
- Larson Law Office
- Loren Larson
- Lundberg Plumbing & Heating
- McGregor Carefree Living
- McGregor Dental
- McGregor Insurance Agency
- McGregor Independent School District #4
- Minnesota Department of Health
- Paulbeck's County Market
- Riverwood Healthcare Center
- The Office Shop, Inc.

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

*NOTE: The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area. Thus, these findings are based on perceptions, not facts.*

### Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was also consulted to complement the research quality of this Community Health Needs Assessment. Data for the county were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns



- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

### Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

### Public Comment

Riverwood Healthcare Center made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Riverwood Healthcare Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Riverwood Healthcare Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

## IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H (2017)		See Report Page(s)
<b>Part V Section B Line 3a</b> <i>A definition of the community served by the hospital facility</i>		6
<b>Part V Section B Line 3b</b> <i>Demographics of the community</i>		20
<b>Part V Section B Line 3c</b> <i>Existing health care facilities and resources within the community that are available to respond to the health needs of the community</i>		106
<b>Part V Section B Line 3d</b> <i>How data was obtained</i>		6
<b>Part V Section B Line 3e</b> <i>The significant health needs of the community</i>		11
<b>Part V Section B Line 3f</b> <i>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</i>		Addressed Throughout
<b>Part V Section B Line 3g</b> <i>The process for identifying and prioritizing community health needs and services to meet the community health needs</i>		12
<b>Part V Section B Line 3h</b> <i>The process for consulting with persons representing the community's interests</i>		7
<b>Part V Section B Line 3i</b> <i>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)</i>		110

## Summary of Findings

### Identified Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

Areas of Opportunity Identified Through This Assessment	
<b>Access to Health Services</b>	<ul style="list-style-type: none"> <li>• Lack of Health Insurance</li> <li>• Access to Primary Care Physicians</li> </ul>
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• Cancer Deaths</li> <li>• Colon Cancer Screening [Age 50+]</li> </ul>
<b>Diabetes</b>	<ul style="list-style-type: none"> <li>• Diabetes Prevalence</li> </ul>
<b>Family Planning</b>	<ul style="list-style-type: none"> <li>• Teen Births</li> </ul>
<b>Injury &amp; Violence</b>	<ul style="list-style-type: none"> <li>• Unintentional Injury Deaths</li> </ul>
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>• <i>Key Informants: Mental health ranked as a top concern.</i></li> </ul>
<b>Nutrition, Physical Activity, &amp; Weight</b>	<ul style="list-style-type: none"> <li>• Fruit/Vegetable Consumption</li> <li>• Low Food Access</li> <li>• Obesity [Adults]</li> <li>• Leisure-Time Physical Activity</li> <li>• <i>Key Informants: Nutrition, physical activity &amp; weight ranked as a top concern.</i></li> </ul>
<b>Substance Abuse</b>	<ul style="list-style-type: none"> <li>• <i>Key Informants: Substance abuse ranked as a top concern.</i></li> </ul>

### Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment (see “Areas of Opportunity” above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. **Mental Health**
2. **Substance Abuse**
3. **Nutrition, Physical Activity, and Weight**
4. **Diabetes**
5. **Cancer**
6. **Access to Health Services**
7. **Injury and Violence**
8. **Family Planning**

### Hospital Implementation Strategy

Riverwood Healthcare Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

*Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.*

## Secondary Data Tables: Comparisons With Benchmark Data
















The following tables provide an overview of secondary data indicators in Aitkin County. These data are grouped to correspond with the Topic Areas presented in Healthy People 2020 and the areas addressed in the Online Key Informant Survey.






### Reading the Summary Tables












■ In the following tables, Aitkin County results are shown in the larger, blue column.















■ The columns to the right of the Aitkin County column provide comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether Aitkin County compares favorably (👍), unfavorably (👎), or comparably (👉) to these external data.






Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.






Social Determinants	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Linguistically Isolated Population (Percent)	0.1	 2.6	 4.5	
Population in Poverty (Percent)	12.8	 10.8	 15.1	
Population Below 200% FPL (Percent)	36.3	 25.9	 33.6	
Children Below 200% FPL (Percent)	49.5	 32.5	 43.3	
No High School Diploma (Age 25+, Percent)	8.7	 7.4	 13.0	
Unemployment Rate (Age 16+, Percent)	3.5	 2.5	 4.0	
		 better	 similar	 worse
















Overall Health	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Fair/Poor Overall Health (Percent)	16.9	 10.5	 15.7	
		 better	 similar	 worse









Access to Health Services	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Uninsured (% Adults 18-64)	7.5	 5.4	 12.1	 0.0
Uninsured (% Children 0-17)	5.1	 3.2	 4.7	 0.0
Primary Care Doctors per 100,000	76.1	 102.1	 87.8	
		 better	 similar	 worse










Cancer	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)	180.8	 153.1	 160.9	 161.4
Mammogram in Past 2 Years (Medicare Women 67-69, Percent)	72.0	 64.5	 63.1	 81.1
Pap Test in Past 3 Years (Women 18+, Percent)	81.2	 79.2	 77.6	 93.0
Ever Sigmoidoscopy/Colonoscopy (Age 50+, Percent)	64.7	 68.5	 61.3	
		 better	 similar	 worse

Diabetes	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Prevalence of Diabetes (Percent)	7.6	 7.2	 9.2	
		 better	 similar	 worse














Family Planning	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Teen Births per 1,000 (Age 15-19)	26.9	 23.8	 36.6	
		 better	 similar	 worse







Heart Disease & Stroke	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Diseases of the Heart (Age-Adjusted Death Rate)	123.2	 117.3	 168.2	 156.9
Stroke (Age-Adjusted Death Rate)	34.2	 33.0	 36.9	 33.8
Told Have High Cholesterol (Percent)	29.0	 35.5	 38.5	 13.5
Told Have High Blood Pressure (Percent)	20.6	 21.9	 28.2	 26.9
		 better	 similar	 worse








Injury & Violence Prevention	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)	64.7	 40.9	 41.9	 36.0
Violent Crime per 100,000	169.2	 233.6	 379.7	
		 better	 similar	 worse








Maternal, Infant & Child Health	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Low Birthweight Births (Percent)	5.9	 6.5	 8.2	 7.8
Infant Death Rate	1.4	 5.2	 6.5	 6.0
		 better	 similar	 worse















Nutrition, Physical Activity & Weight	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
<5 Fruits/Vegetables Per Day (Percent)	91.4	 78.1	 75.7	
Population With Low Food Access (Percent)	32.4	 28.1	 22.4	
Prevalence of Obesity (BMI 30+, Percent)	29.2	 26.7	 27.5	 30.5
No Leisure-Time Physical Activity (Percent)	22.4	 18.2	 21.8	 32.6
		 better	 similar	 worse

Oral Health	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Dental Visit in Past Year (Percent)	77.2	 77.6	 69.8	 49.0
		 better	 similar	 worse

Respiratory Diseases	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)	37.2	 36.1	 41.3	
Asthma Prevalence (Percent)	2.3	 11.1	 13.4	
		 better	 similar	 worse

Sexually Transmitted Diseases	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000	31.8	 75.1	 110.7	
Chlamydia Incidence per 100,000	127.1	 367.1	 456.1	
		 better	 similar	 worse

Substance Abuse	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Excessive Drinking (Percent)	15.1	 19.3	 16.4	 25.4
		 better	 similar	 worse

Tobacco Use	Aitkin County	Aitkin County vs. Benchmarks		
		vs. MN	vs. US	vs. HP2020
Current Smoker (Percent)	13.0	 16.3	 18.1	 12.0
		 better	 similar	 worse

## Community Description



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## Population Characteristics

### Total Population

Aitkin County, the focus of this Community Health Needs Assessment, encompasses 1,821.73 square miles and houses a total population of 15,722 residents, according to latest census estimates.

**Total Population**  
(Estimated Population, 2012-2016)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Aitkin County	15,722	1,821.73	8.63
Minnesota	5,450,868	79,626.72	68.46
United States	318,558,162	3,532,068.58	90.19

Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

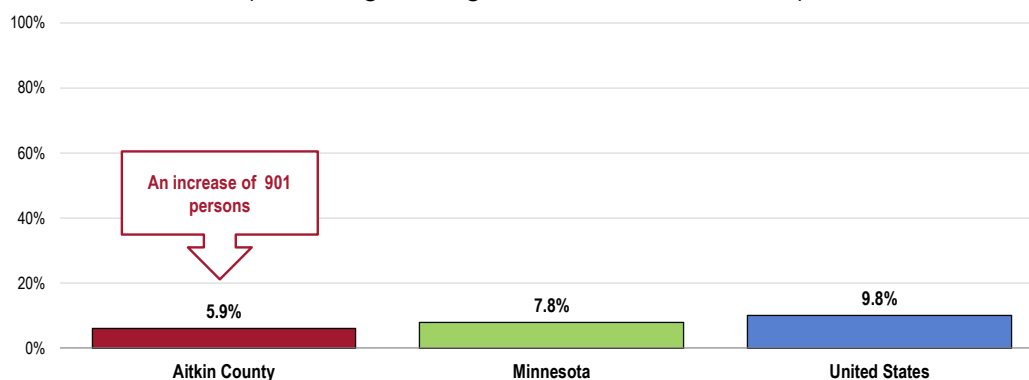
### Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

**Between the 2000 and 2010 US Censuses, the population of Aitkin County increased by 901 persons, or 5.9%.**

- Both the Minnesota and US populations also increased during this time.

**Change in Total Population**  
(Percentage Change Between 2000 and 2010)



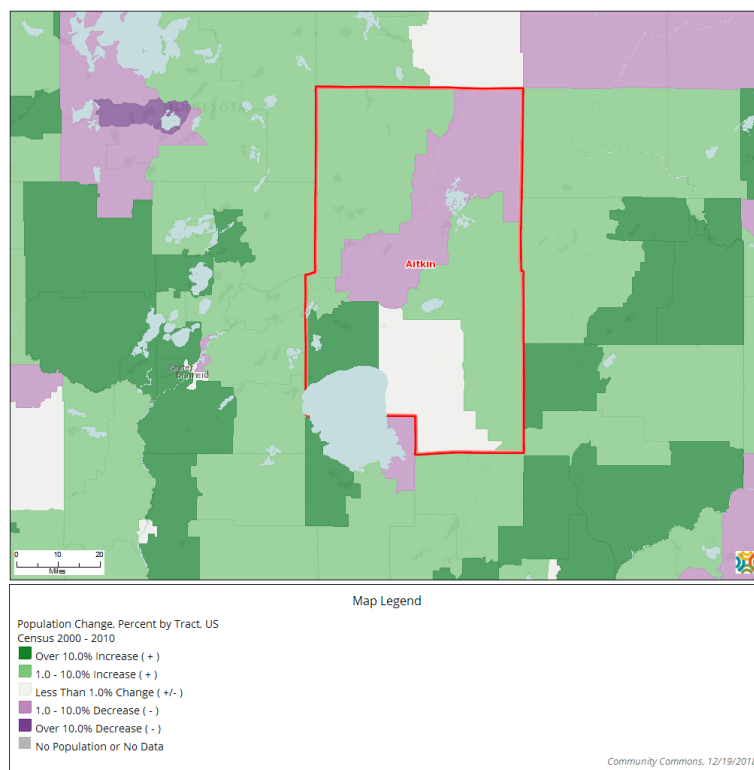
Sources:

- Retrieved January 2019 from Community Commons at <http://www.chna.org>.
- US Census Bureau Decennial Census (2000-2010).

Notes:

- A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

- Note that the greatest proportional increase in population occurred in the southwestern parts of the county.



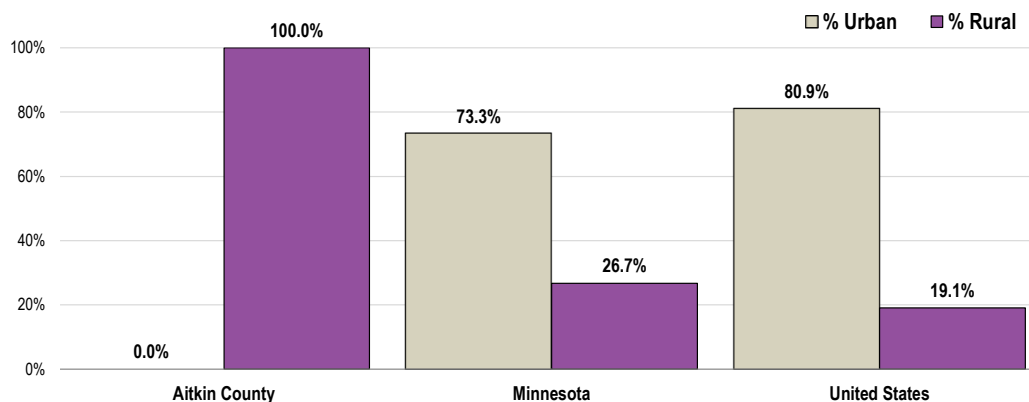
## Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

**Aitkin County is wholly rural, with 100% of the population living in communities designated as rural.**

- In contrast, over 73% of the state and national populations live in urban areas.

## Urban and Rural Population (2010)



Sources: • US Census Bureau Decennial Census.

• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

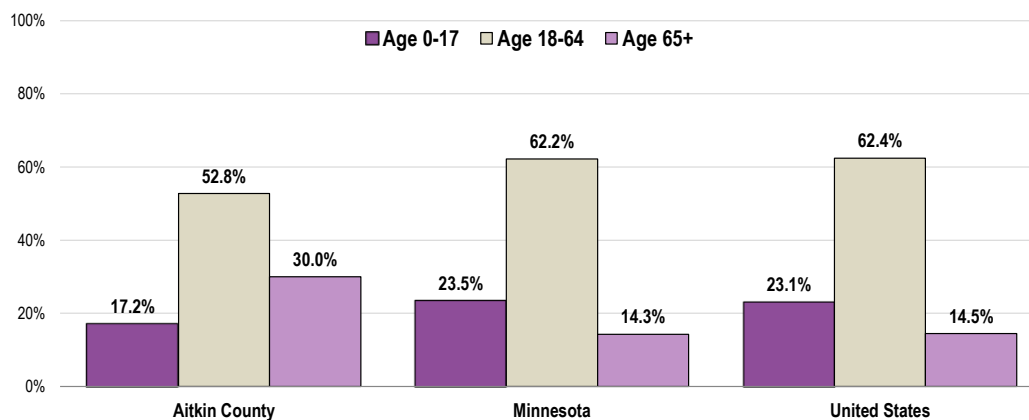
## Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

**In Aitkin County, 17.2% of the population are infants, children, or adolescents (age 0-17); another 52.8% are age 18 to 64, while 30.0% are age 65 and older.**

- The percentage of older adults (65+) is notably higher than found statewide or nationally.

## Total Population by Age Groups, Percent (2012-2016)



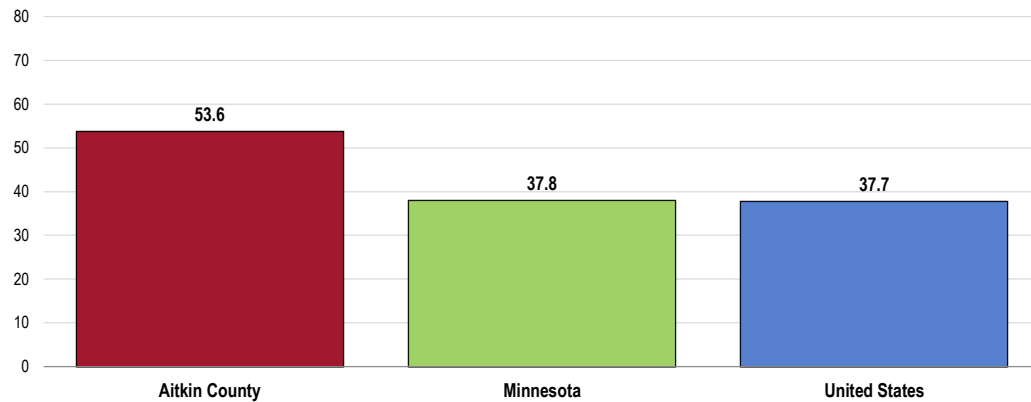
Sources: • US Census Bureau American Community Survey 5-year estimates.

• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

## Median Age

Aitkin County is “older” than the state and the nation in that its median age is higher.

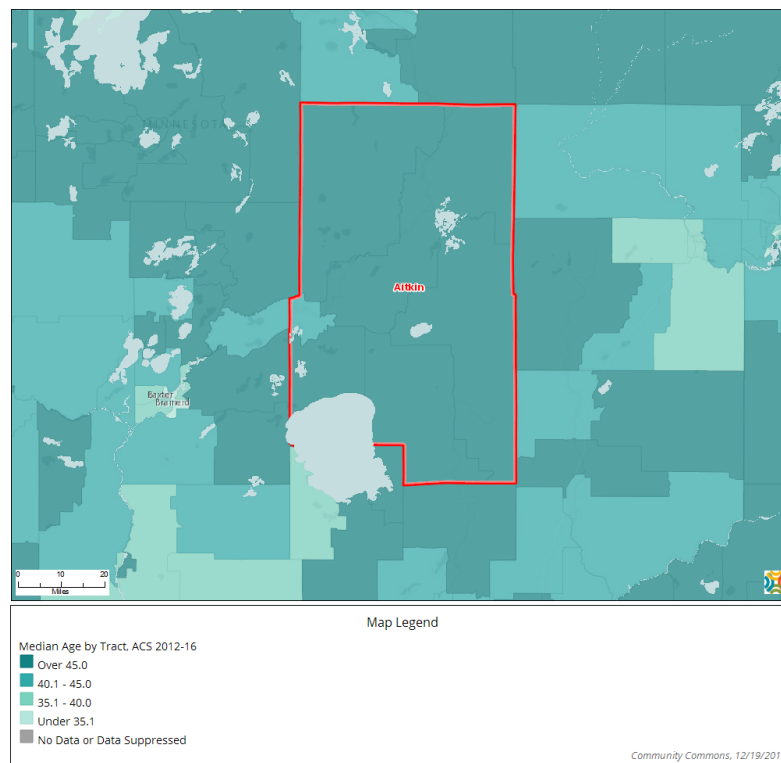
### Median Age (2012-2016)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.
- Median age not available for the Total Service Area.

- The following map provides an illustration of the median age in Aitkin County by census tract.



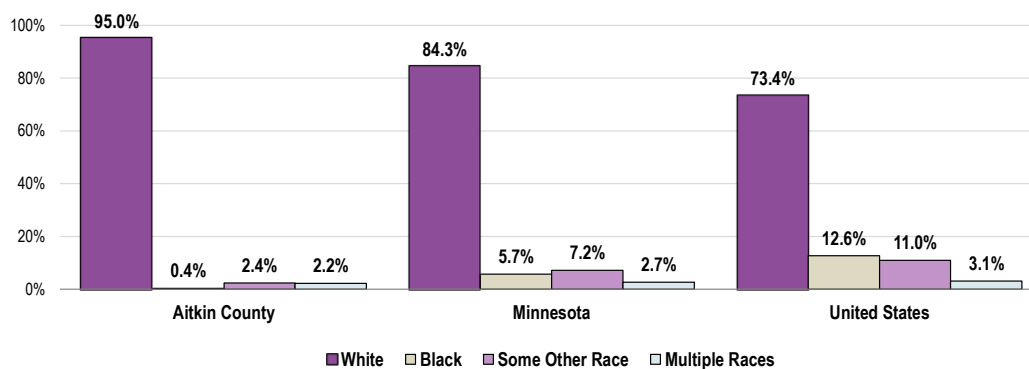
## Race & Ethnicity

### Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 95.0% of residents of Aitkin County are White, and 0.4% are Black.

- The distribution across the state and nation is considerably more diverse.

### Total Population by Race Alone, Percent (2012-2016)



Sources:

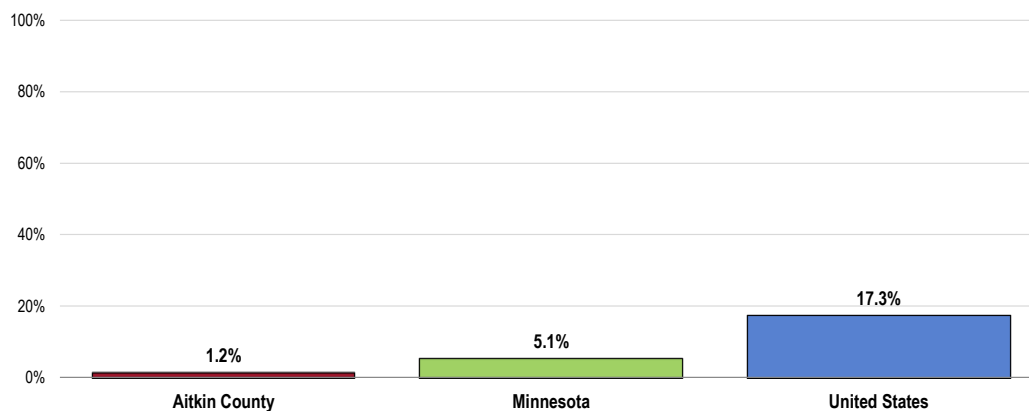
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

### Ethnicity

A total of 1.2% of county residents are Hispanic or Latino.

- Much lower than found statewide or (especially) nationally.

### Hispanic Population (2012-2016)



Sources:

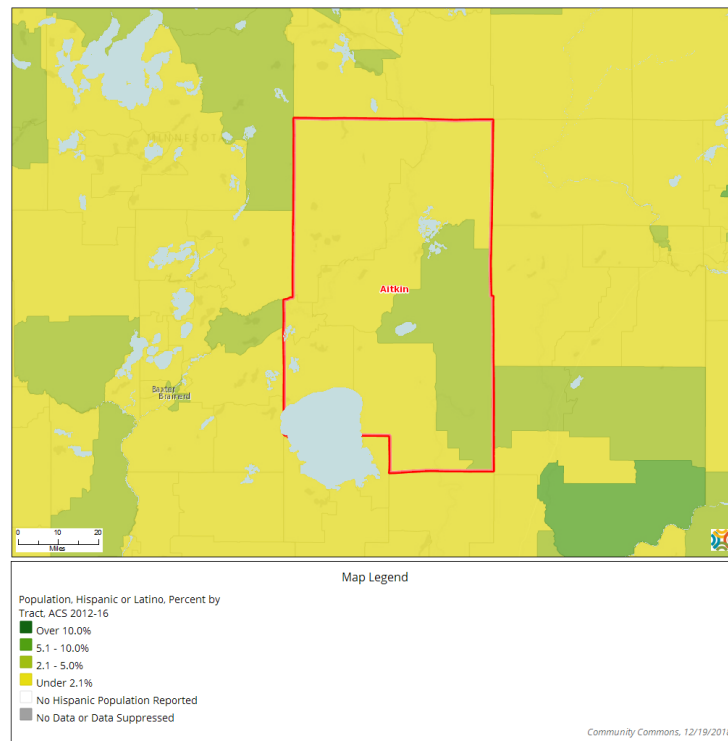
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes:

- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

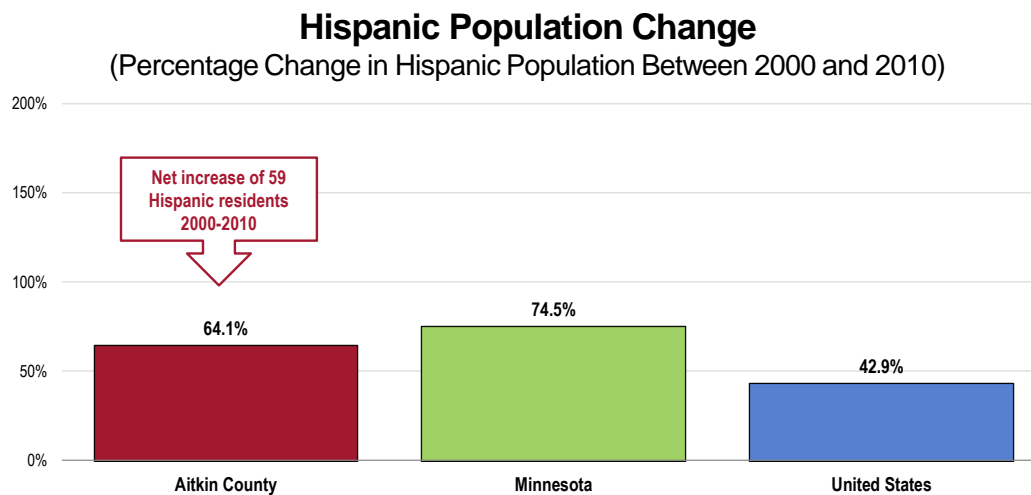


- The Hispanic population appears to be most concentrated in southeastern Aitkin County.



**Between 2000 and 2010, the Hispanic population in Aitkin County increased by 59 residents, or 64.1%.**

- Lower (in terms of percentage growth) than found statewide.
- Higher than found nationally.



Sources:

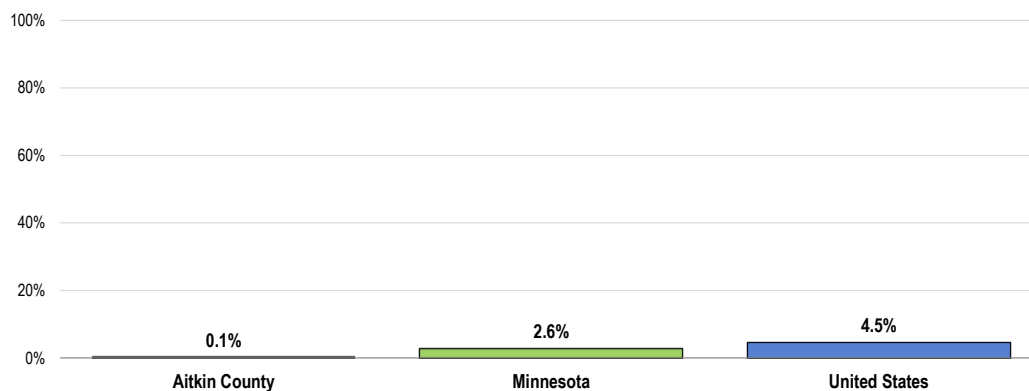
- US Census Bureau Decennial Census (2000-2010).
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

## Linguistic Isolation

Just 0.1% of the Aitkin County population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English, or speaking English “very well”).

- Much lower than that found statewide and nationally.

### Linguistically Isolated Population (2012-2016)

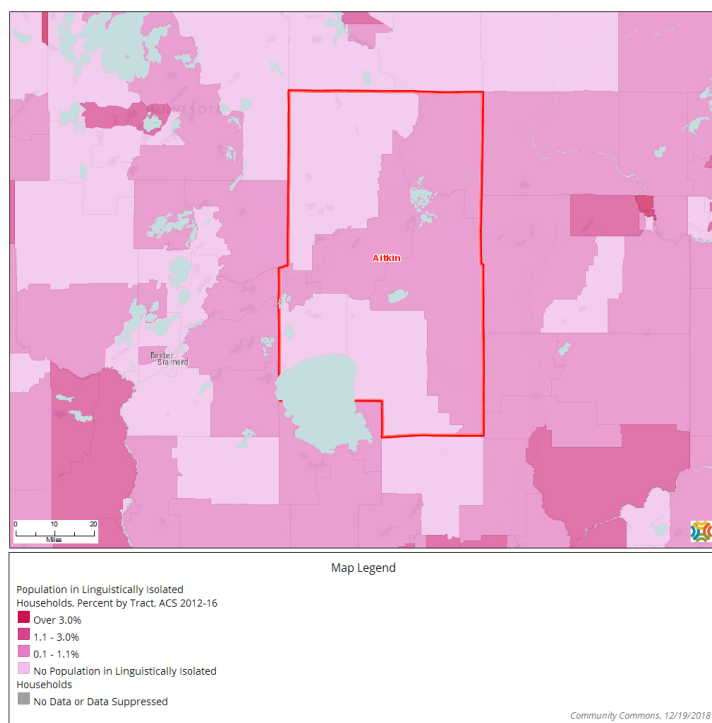


Sources: • US Census Bureau American Community Survey 5-year estimates.

• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English “very well.”

- Note the following map illustrating linguistic isolation by census tract.



## Social Determinants of Health

### About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Poverty

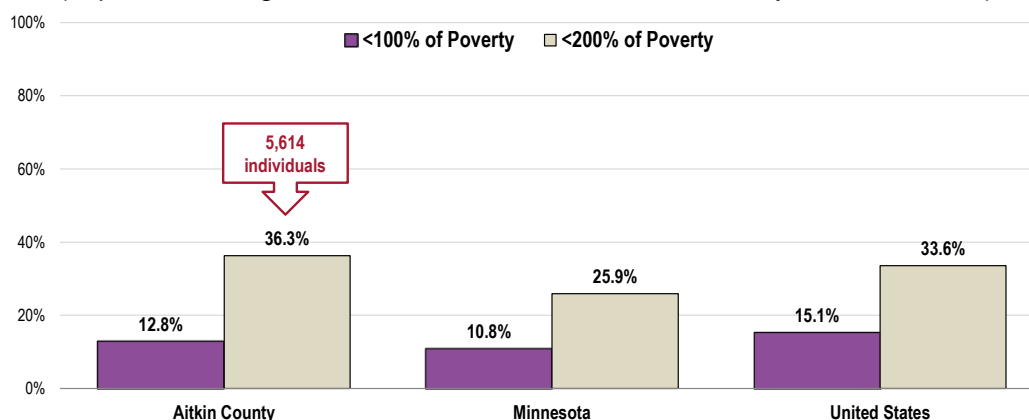
The latest census estimate shows **12.8% of the Aitkin County population living below the federal poverty level.**

**In all, 36.3% of county residents (an estimated 5,614 individuals) live below 200% of the federal poverty level.**

- The proportion of those living below 200% of poverty is higher than reported both statewide and nationally.

### Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2012-2016)

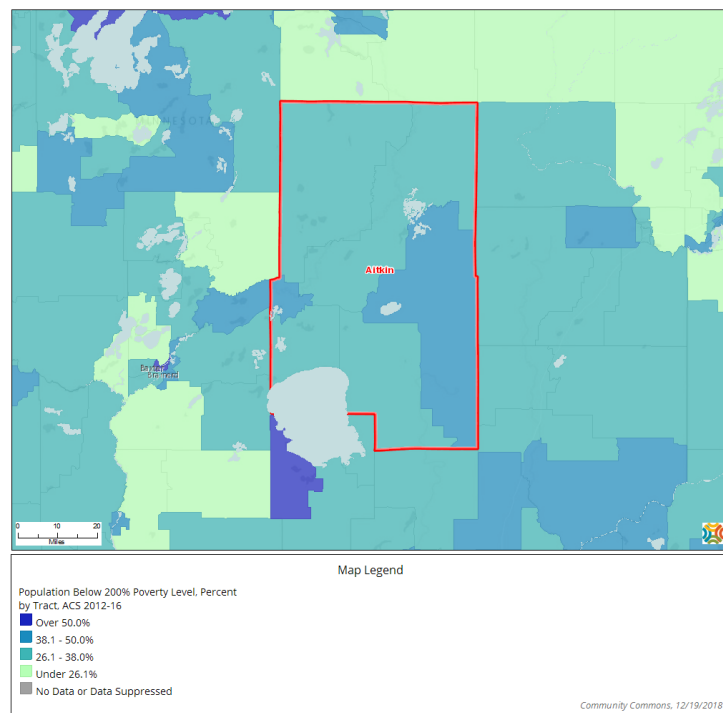
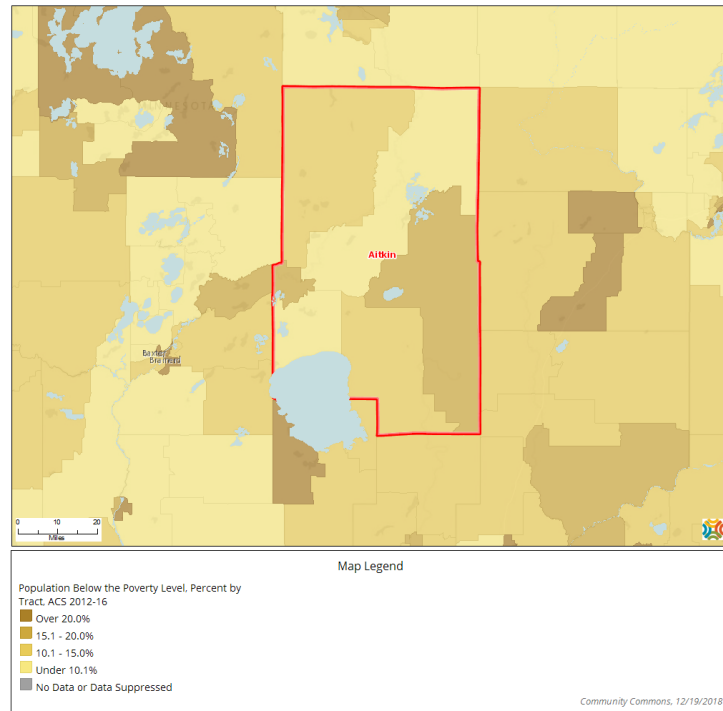


Sources: • US Census Bureau American Community Survey 5-year estimates.

• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes: • Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- Census tracts in southeastern Aitkin County exhibit the highest concentration of poverty, as well as higher concentrations of persons living below the 200% poverty threshold.

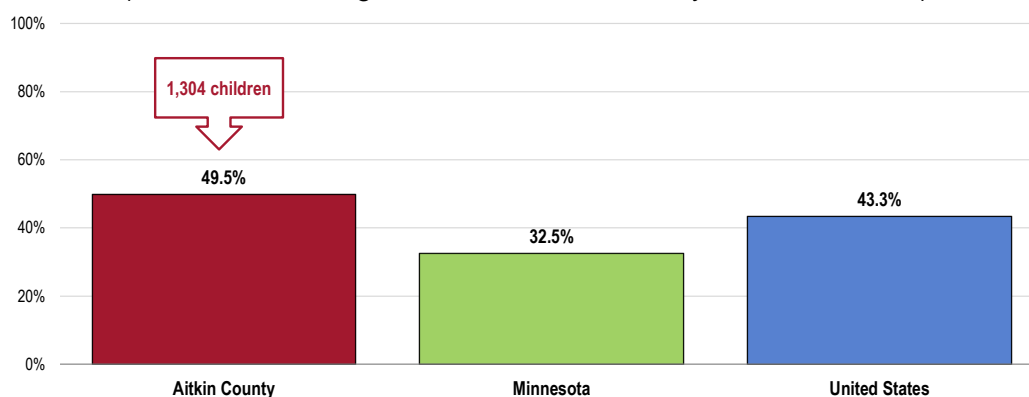


### Children in Low-Income Households

Additionally, just under half (49.5%) of Aitkin County children age 0-17 (representing an estimated 1,304 children) live below the 200% poverty threshold.

- Less favorable than the proportions found statewide and nationally.

#### Percent of Children in Low-Income Households (Children 0-17 Living Below 200% of the Poverty Level, 2012-2016)

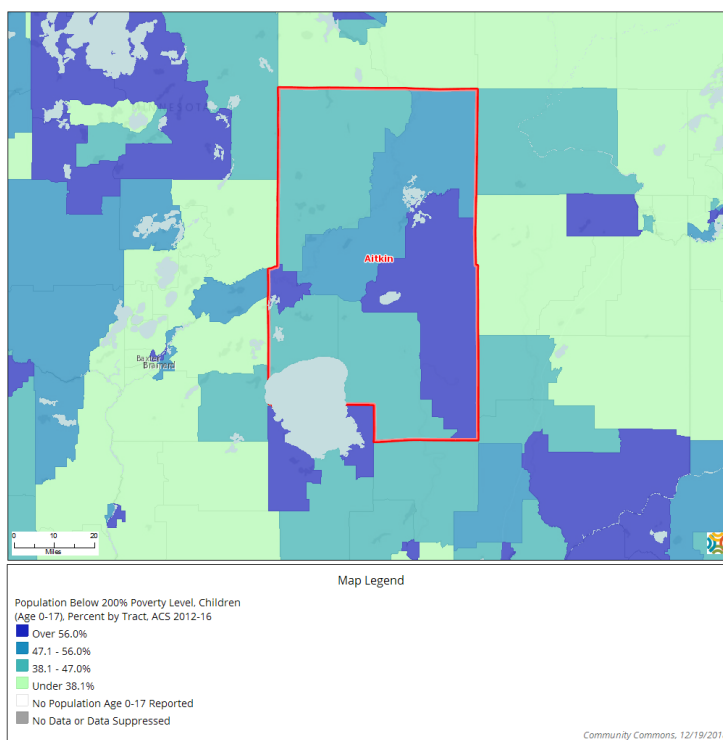


Sources: • US Census Bureau American Community Survey 5-year estimates.

• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of children aged 0-17 living in households with income below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

- In the following map showing Aitkin County census tracts, note the dark blue areas that represent the concentration of children in lower-income households.



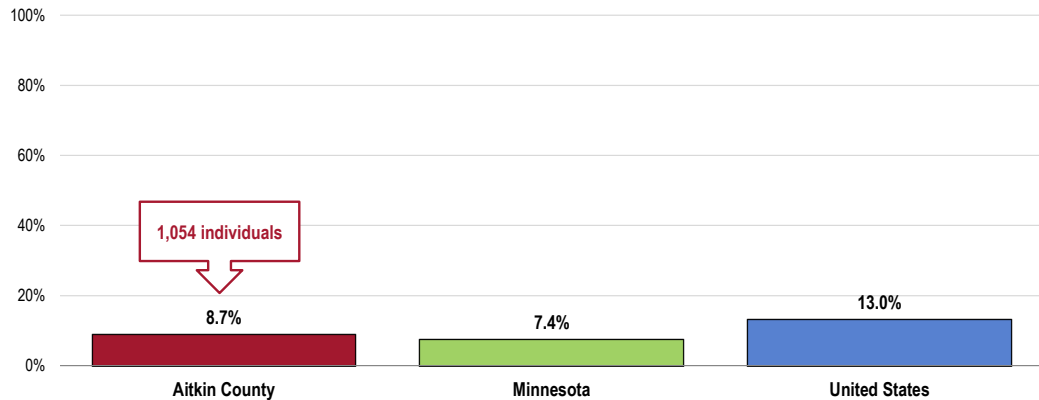
## Education

Among the Aitkin County population age 25 and older, an estimated 8.7% (over 1,000 individuals) do not have a high school diploma.

- Less favorable than found statewide.
- More favorable than found nationally.

### Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2012-2016)



Sources: • US Census Bureau American Community Survey 5-year estimates.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because educational attainment is linked to positive health outcomes.

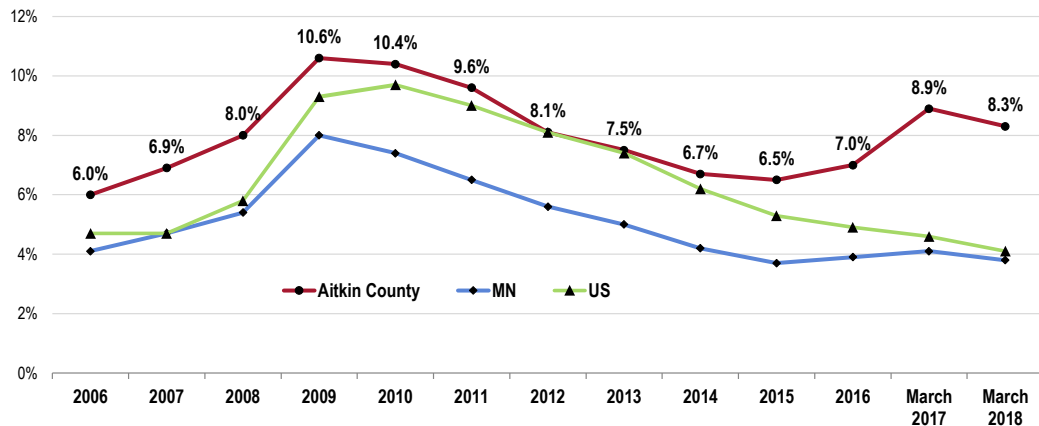
## Employment

According to data derived from the US Department of Labor, the unemployment rate in Aitkin County in March 2018 was 8.3%.

- Notably higher than the Minnesota and US unemployment rates.

### Unemployment Rate

(Percent of Non-Institutionalized Population Age 16+ Unemployed, Not Seasonally Adjusted)



Sources: • US Department of Labor, Bureau of Labor Statistics.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because unemployment creates financial instability and barriers to access including insurance coverage, health services, healthy food, and other necessities that contribute to poor health status.

## General Health Status



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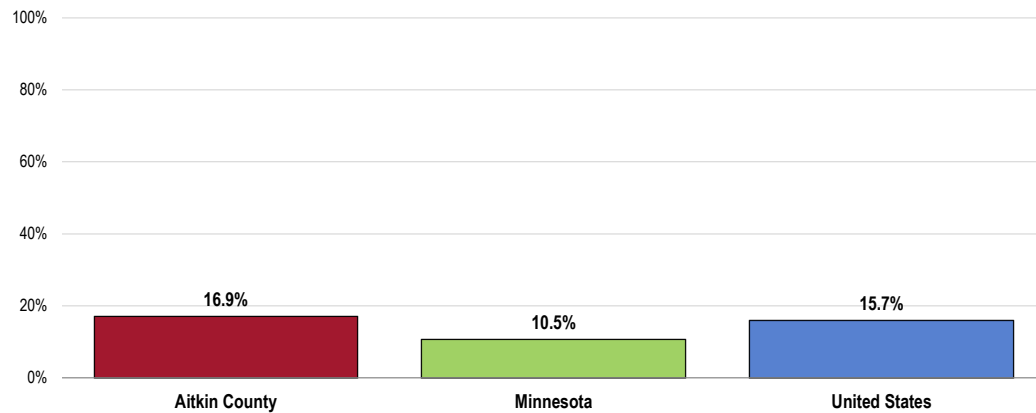
## Overall Health Status

### Self-Reported Health Status

A total of 16.9% of Aitkin County adults rate their overall health as “fair” or “poor.”

- Less favorable than statewide and national findings.

### Adults With Fair or Poor Health (Age-Adjusted) (2006-2012)



Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because it is a measure of general poor health status.



## Mental Health

### RELATED ISSUE:

See also  
*Potentially Disabling  
Conditions in the Death,  
Disease & Chronic  
Conditions* section of this  
report.

### About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Key Informant Input: Mental Health

Over half of key informants taking part in an online survey characterized *Mental Health* as a “major problem” in the community.

### Perceptions of Mental Health as a Problem in the Community (Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Challenges

Among those rating this issue as a “major problem,” the following represent what key informants see as the main challenges for persons with mental illness:

### Access to Care/Services

*Very limited access to beds for those requiring inpatient mental health treatment. Patients are required to receive inpatient care a great distance from their homes. For children, this is a major concern that adds to the emotional issues they already have. Also, there is limited understanding of the needs of the mentally ill. There is a stigma that is applied due to the lack of understanding. — Social Services Provider*

*Access to care/in-patient treatment is not available in our community. The closest in-patient facilities are many miles away and not easily accessible for families to visit patients. There are long waiting lists for these facilities, which means that patients then must go to community behavioral health hospitals that are even further away from family within the state. — Community Leader*

*Access to mental health services. Counseling is booked, and it takes months to receive service. Services for crisis mental health is very limited and leads to long wait times and creates backlog in other areas. — Community Leader*

*I have been made aware through friends that there are no resources for mental health care in the county, causing people to have to travel at great expense buying gas and food. This is something that has just been brought to my attention over the past week. — Community Leader*

*Aitkin County Public Health conducted their Community Health Assessment during Spring-Summer of 2018 in which the community has identified mental health as a top priority in which more resources and funds should be looked into to address this problem identified by citizens in Aitkin County. Other challenges facing Aitkin County include breaking down the stigma. — Public Health Representative*

*There is no local facility to provide a 72-hour hold. At times, there is no facility at all to send someone for a 72-hour hold. Too many times, people with mental issues have a severe problem, but when taken to the hospital for evaluation, they know what to say so they can be released. But the issue is still ongoing. Our society is so concerned with interfering with someone's right to make their own choices, that we are not providing enough assistance to those who needed. Often, I see this with people with mental health issues who cannot handle their own finances and end up homeless or constantly moving. We need to draw a line between someone's rights and what is best for that person. — Social Services Provider*

*Lack of resources and the requirement to go to a different facility for this type of treatment rather than being able to go to the "doctor". This creates the stigma, and this is exactly what individuals who struggle with this do not need. Transportation to mental health treatment is also an issue. — Social Services Provider*

*Extreme prevalence. More services are becoming available, but long wait times for assessments and/or appointments and still limited resources for the need. Consumers often need to travel. Lack of resources for children. — Public Health Representative*

*They either don't have insurance or can't find a counseling center, therapist, etc. We have very limited resources for people with mental illnesses. — Community Leader*

*Mental health is rising, and we do not have the facilities for inpatient placement or treatment in a timely manner without driving a minimum of 40 miles. — Community Leader*

*Multiple individuals have mental illness in the area and are not able to receive assistance. There are not enough resources in the area for the growing mental illness population. — Other Health Provider*

*Services in the community may not be known or may be inaccessible for community members; many with mental health go undiagnosed. — Community Leader*

*Getting an appointment when needed. Also having an inpatient bed available that is close to home. — Community Leader*

*Finding a safe place to be if a crisis occurs. — Community Leader*

*Ability to get into appointments and transportation to appropriate facilities. — Other Health Provider*

*Access to services locally, especially for family counseling. — Other Health Provider*

*Limited service and availability. — Social Services Provider*

*Not enough resources or services to address this high need. — Other Health Provider*

*Getting access to services. Especially children. — Community Leader*

*Lack of care available in our area. — Community Leader*

*Not a lot of resources in our community. — Other Health Provider*

*Not having services and nowhere to go. — Community Leader*

### Access to Providers

*Access to a mental health provider that can perform a comprehensive assessment and manage medications is limited which leads to a wait for appointments. If someone requires an inpatient stay, they may need to travel far from home and may also be placed on a waiting list. I believe that there is still a stigma related to mental health conditions limiting a patient's feelings of acceptance. Special Employment opportunities for patients with mental illness is not readily available. — Other Health Provider*

*We need more access to highly trained professionals in our community. We need options for [ages] 0-5 mental health. We need services and providers for people on Medicare. We need support groups for those people experiencing mental health issues and more comprehensive crisis services. We also need better access to more expedient psychiatric care and med providers. — Community Leader*

*Access to counseling services or support for mental health. Support services not only countywide, but within the school districts as well. Schools are seeing mental health issues with younger children more than ever. — Community Leader*

*Access to mental health care providers (psychiatrists/psychologists) for both ongoing/long-term services and emergency services is very limited. Insurance coverage for mental health services is seriously lacking. Families and individuals are under-served for financial reasons. No in-patient mental health facilities in the community for crisis intervention care. — Other Health Provider*

*Not enough specialized providers and lack of counseling services. — Other Health Provider*

### Denial/Stigma

*I see it not being addressed/ acknowledged by people. People don't know where help is or if they even need help. There are not enough professionals to sufficiently help the youth in Aitkin County. — Community Leader*

*Community support. — Community Leader*

*Accepting that they need assistance and paying for it. — Community Leader*

*Not wanting to get help. — Community Leader*

*Stigma, lack of insurance. — Community Leader*

### Affordable Care/Services

*Cost is always an issue but also having enough mental health workers available is important also. Resources are limited. — Community Leader*

*Money, transportation, lack of support groups. — Other Health Provider*

### Prevalence/Incidence

*I deal with many people in the area that have mental health issues. While they may be able to get medications at Riverwood, there really are not many counseling centers or therapists in this area. Those that are available are very booked up. — Community Leader*

*So many people struggling with mental health concerns, yet access to providers and socially acceptable solutions is limited. — Community Leader*

### Suicide Rates

*Suicide attempts are reported high by the Aitkin school nurse. Students report high rates of anxiety, depression. Adults in the Bridge to Health Survey (2015), 21% reported having anxiety or panic attacks, 22% depression. Residents who live in poverty were more likely to report stress, depression or problems with emotions for 14 or more days during the past month, compared to residents who are not in poverty. Residents who live in poverty were more likely to delay seeking mental health care compared to residents who are not in poverty. — Community Leader*

*We have more suicides and young people with issues like anxiety and depression. — Community Leader*

### Access to Medication/Supplies

*Access to health care and prescription drug coverage. Access to a pharmacy that is open 7 days a week and can fill prescriptions for meds any day for any provider if needed. There are not many advertised support groups for mental health and transportation can be difficult. These people need to work and care for children and sometimes they don't have the skills and access to help needed. — Community Leader*

### ACEs

*When parents register their child with early childhood in Hill City, there is a section on risk factors. Family with mental health issues and incarceration of a family member are 2 areas that checked often. In adult classes, we have many parents discuss the mental health needs of themselves or a family member, or child. The number of referrals to Children's Mental Health services have more than tripled in the past years. We currently have CMH (Children's Mental Health) working with children 2 full days a week, and we could easily have them a third. Currently we have 34% of our early childhood children receiving CMH services. The parents of most of the 34% are also in need of services (some are receiving them, and some are not). If we could get someone good in town, for people not to travel, it would be awesome! Challenges: no insurance, no way to get to services, don't trust people (afraid county will take kids away), don't see a need to receive services for themselves. — Community Leader*

### Alcohol/Drug Use

*Opioid addiction. — Community Leader*

### Awareness/Education

*I believe that awareness of mental health resources is a problem. I think that most people do not want to admit that they may have a mental illness and do not want to talk to anyone about it. — Community Leader*

### Children/Youth

*Anxiety, eating disorders, depression are serious issues among our youth. The biggest challenge is finding professionals who can help them with their problems. I can't imagine how difficult it must be to find mental health professionals who are willing to work in a rural community. — Community Leader*

# **Death, Disease & Chronic Conditions**



**Professional Research Consultants, Inc.**

## Cardiovascular Disease

### About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Age-Adjusted Heart Disease & Stroke Deaths

### Age-Adjusted Death Rates

In order to compare mortality in the region with other localities (in this case, Minnesota and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

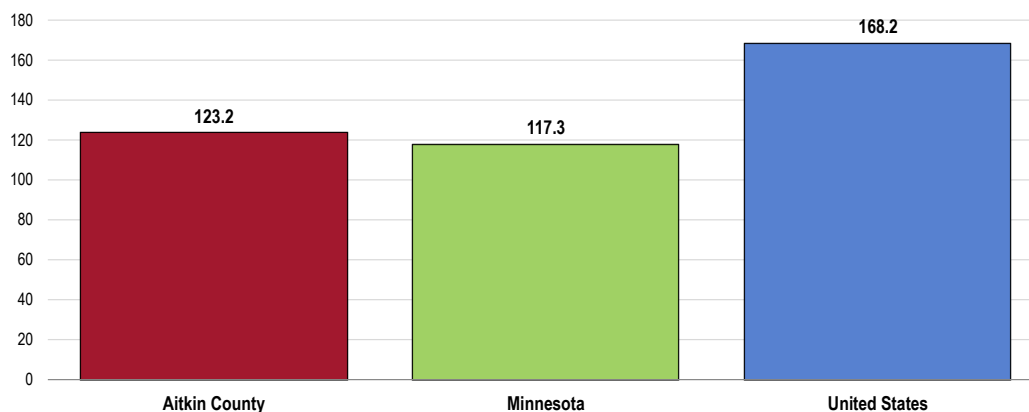
Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

### Heart Disease Deaths

Between 2012 and 2016, there was an annual average age-adjusted heart disease mortality rate of 123.2 deaths per 100,000 population in Aitkin County.

- Statistically similar to the statewide rate.
- Notably more favorable than the national rate.
- Satisfies the Healthy People 2020 objective of 156.9 or lower.

**Heart Disease: Age-Adjusted Mortality**  
(2012-2016 Annual Average Deaths per 100,000 Population)  
**Healthy People 2020 Target = 156.9 or Lower (Adjusted)**



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.  
• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

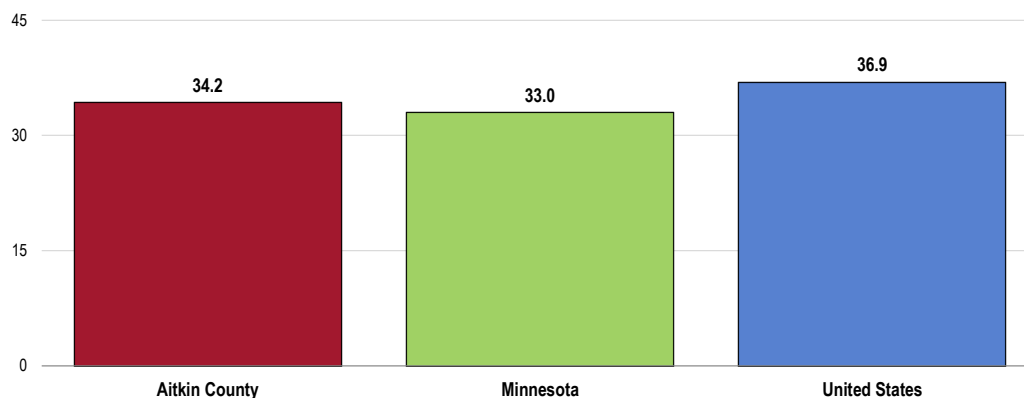
Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]  
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Stroke Deaths

Between 2012 and 2016, there was an annual average age-adjusted stroke mortality rate of 34.2 deaths per 100,000 population in Aitkin County.

- Comparable to the Minnesota rate.
- More favorable than the national rate.
- Comparable to the Healthy People 2020 target of 33.8 or lower.

### Stroke: Age-Adjusted Mortality (2012-2016 Annual Average Deaths per 100,000 Population) Healthy People 2020 Target = 33.8 or Lower (Adjusted)



- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2016-2016. Accessed using CDC WONDER.
  - Retrieved January 2019 from Community Commons at <http://www.chna.org>.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
  - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.



## Prevalence of High Blood Pressure & High Blood Cholesterol

### About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

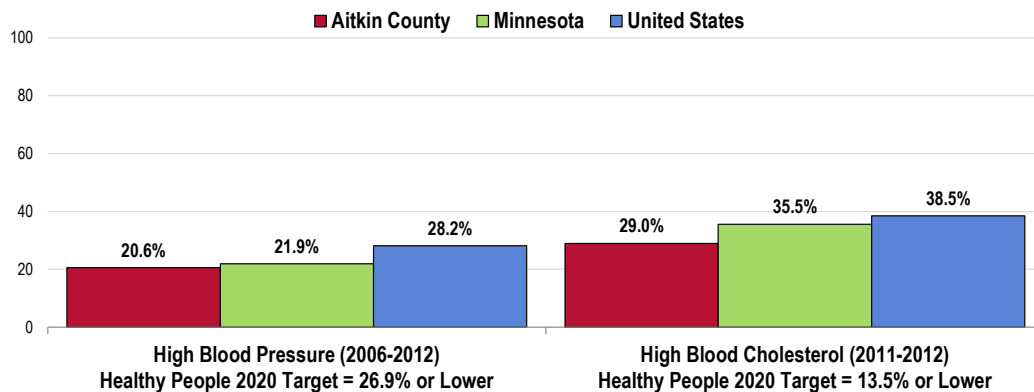
**A total of 20.6% of Aitkin County adults have been told at some point that their blood pressure was high.**

- More favorable than the Minnesota and US prevalence.
- Satisfies the Healthy People 2020 target (26.9% or lower).

**A total of 29.0% of adults have been told by a health professional that their cholesterol level was high.**

- Better than the state and national proportions.
- More than twice the Healthy People 2020 target (13.5% or lower).

## Prevalence of High Blood Pressure & High Blood Cholesterol



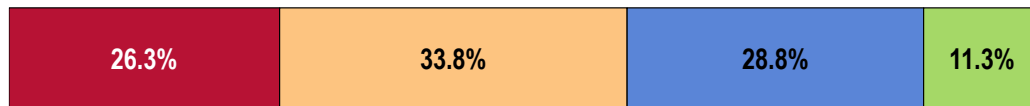
- Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
  - Retrieved January 2019 from Community Commons at <http://www.chna.org>.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-5.1 and HDS-7]
- Notes:
- This indicator is relevant because coronary heart disease is a leading cause of death in the US and is also related to high blood pressure, high cholesterol, and heart attacks.

## Key Informant Input: Heart Disease & Stroke

More than one-third of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a “moderate problem” in the community.

### Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2019)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Aging Population

*Aitkin County has a large aging population. Physical inactivity and obesity can be a problem for older folks. Eating an unhealthy diet also contributes to heart disease and stroke. Since there is high poverty in Aitkin County, getting people a healthy diet is a concern. Smoking is a problem also. Exercise needs to be a part of everyone's daily routine. Excessive alcohol use is prevalent. — Community Leader*

*We have the highest elderly population in the state of Minnesota, which brings along with it more chronic conditions- which includes heart disease and stroke. When a patient has a heart condition, it is costly, may cause missed work opportunities. Patients that experience a stroke may need to transfer to a different living arrangement or need more assistance in the home. These resources are not readily available, particularly in outlying areas of Aitkin County, and may be costly. This community is in need of additional opportunities to maintain a level of physical activity, especially in the winter months (ex. pool, walking track, and indoor gym spaces would be beneficial for all ages and activity levels). — Other Health Provider*

*Because of the age of the local population, there are a lot of people with heart disease and stroke issues. There are also many people with weight issues that add to the problem. — Community Leader*

*Again, we live in an aging community with a high volume of people with obesity and diabetes, which greatly impacts cardiovascular disease. Low socioeconomic status with few options for exercising and grocery shopping. High costs associated. — Other Health Provider*

*Because our community has a large aged population, heart disease and stroke are at an increase. — Community Leader*

*We have a lot of elderly; also, I know a lot of people with heart issues. — Community Leader*

*The aging population in Aitkin. — Community Leader*

*Elderly population, fitness. — Community Leader*

*Large elderly population. — Community Leader*

*Age of population. — Physician*

#### Access to Care/Services

*Access to weight-loss programs. — Community Leader*

*Major issues are treated in the cities or elsewhere. — Community Leader*

**Lifestyle**

*Weight, decreased activity, smoking, poor diet. — Other Health Provider*  
*Lack of exercise and obesity. — Community Leader*

**Prevalence/Incidence**

*Many people suffer heart attacks, some fatally, some recover but need major health care services. — Community Leader*  
*High prevalence. — Public Health Representative*

**Leading Cause of Death**

*In 2017, heart disease was the second leading cause of death in Aitkin County (according to the County Health Tables). — Community Leader*

## Cancer

### About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

• Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

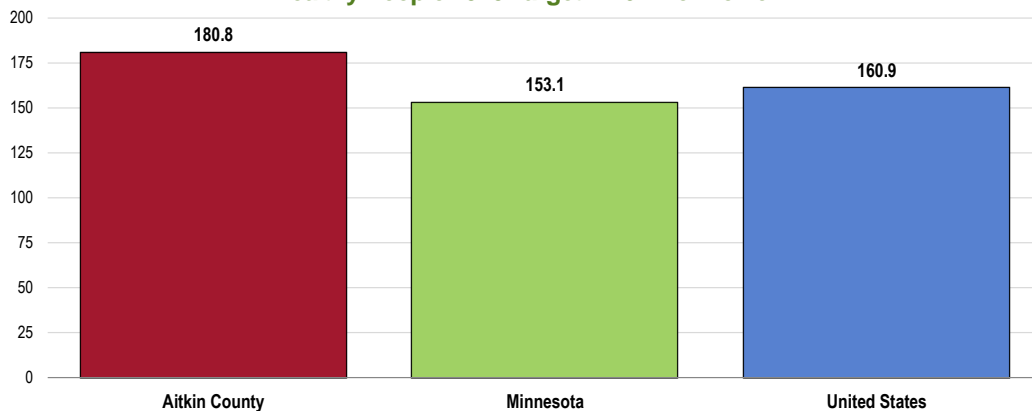
## Age-Adjusted Cancer Deaths

### All Cancer Deaths

Between 2012 and 2016, there was an annual average age-adjusted cancer mortality rate of 180.8 deaths per 100,000 population in Aitkin County.

- Worse than the statewide and national rates.
- Fails to satisfy the Healthy People 2020 target of 161.4 or lower.

**Cancer: Age-Adjusted Mortality**  
(2012-2016 Annual Average Deaths per 100,000 Population)  
**Healthy People 2020 Target = 161.4 or Lower**



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.  
• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]  
• Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).  
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

### About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

## Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

**Among county women age 67-69 enrolled in Medicare, nearly three-fourths (72.0%) had a mammogram within the past two years.**

- Better than statewide or national findings.
- Fails to satisfy the Healthy People 2020 target (81.1% or higher).

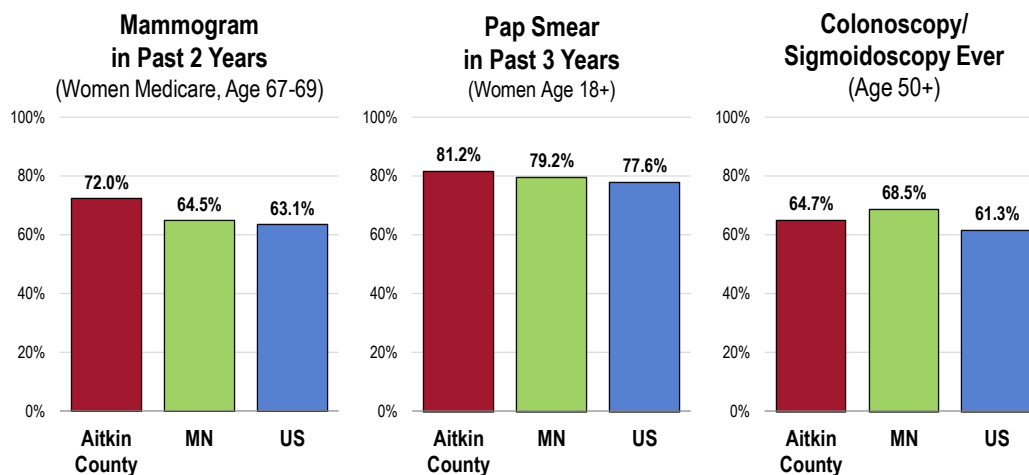
**Among all county women age 18+, 81.2 % had a Pap test within the past three years.**

- Similar to Minnesota and national findings.
- Fails to satisfy the Healthy People 2020 target (93.0% or higher).

**Among all county adults age 50+, 64.7% have ever had a sigmoidoscopy/ colonoscopy (lower endoscopy).**

- Worse than statewide findings
- Better than national findings.

## Cancer Screenings

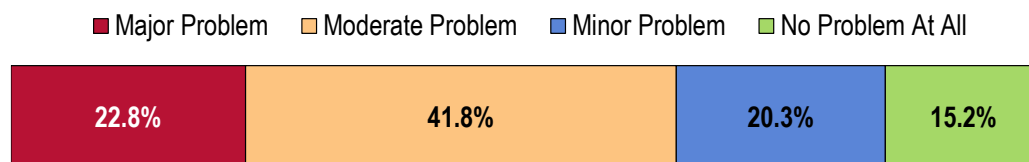


Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-12.  
• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

## Key Informant Input: Cancer

Key informants taking part in an online survey most often characterized **Cancer** as a “moderate problem” in the community.

## Perceptions of Cancer as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

### Prevalence/Incidence

*There seems to be a lot of people in our community that develop cancer. We are an older community, so that plays a part in it, but it seems like there are a lot of people being diagnosed. — Community Leader*

*Cancer is becoming more and more diagnosed every day and there is not enough cancer centers that specialize in cancer and its complexity. — Social Services Provider*

*High prevalence of multiple types. Ovarian is seemingly increasing with often late diagnosis. — Public Health Representative*

*I think we have a large population of people that have cancer. I do think that there is adequate treatment centers in the area for some types of cancers. — Community Leader*

*We have a very large amount of cancer patients in our community. Very few families are not affected*

*by cancer in some way. — Community Leader*

*I have seen too many women with breast cancer. It must be something in the food or water that people are eating. It also could be genetic. — Community Leader*

*So many of our friends and family have had some type of cancer. — Community Leader*

*Cancer is a major problem in all communities across the world. — Community Leader*

*Cancer is a problem everywhere, for everyone. — Community Leader*

*Cancer is a problem everywhere. — Community Leader*

### Quality of Providers

*Having top quality oncology is key to cancer. Transportation to and from treatment and more education. — Community Leader*

*Consistently having a well-qualified doctor available on a regular basis. — Community Leader*

### Access to Care/Services

*You have to travel a distance for good treatment, care and support. — Community Leader*

### Affordable Care/Services

*We have a lot of people with cancer issues and treatment is very expensive and extensive. Many have had to take a lot of time off work and travel for treatment. — Community Leader*

### Priorities

*While there is some education concerning cancer risks, I think people living in poverty have a hard time doing what needs to be done to conquer the risk of getting cancer and also can't afford to take necessary action (i.e., eating a healthy diet or getting to the doctor in time). Because there is an older population in Aitkin County, there are more chances of cancer diagnosis. — Community Leader*

## Respiratory Disease

### About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

**Asthma.** The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

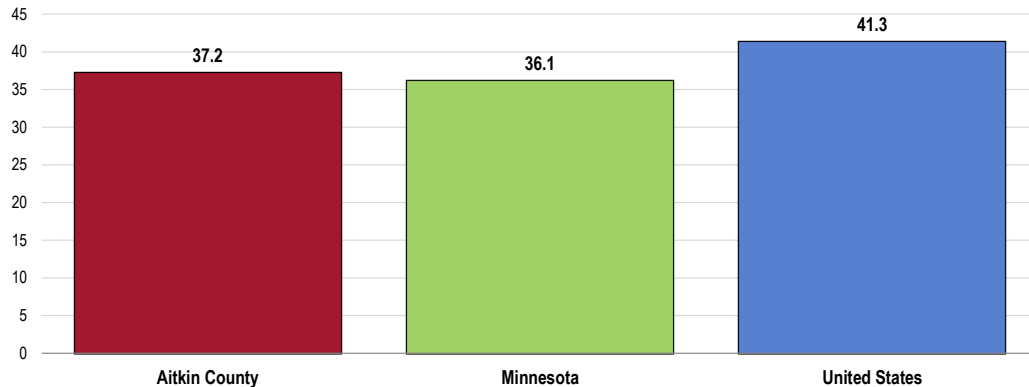


## Age-Adjusted Lung Disease Deaths

Between 2012 and 2016, there was an annual average age-adjusted lung disease mortality rate of 37.2 deaths per 100,000 population in Aitkin County.

- Similar to that found statewide.
- Lower than the national rate.

### CLRD: Age-Adjusted Mortality (2012-2016 Annual Average Deaths per 100,000 Population)



Sources: 

- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

  
Notes: 

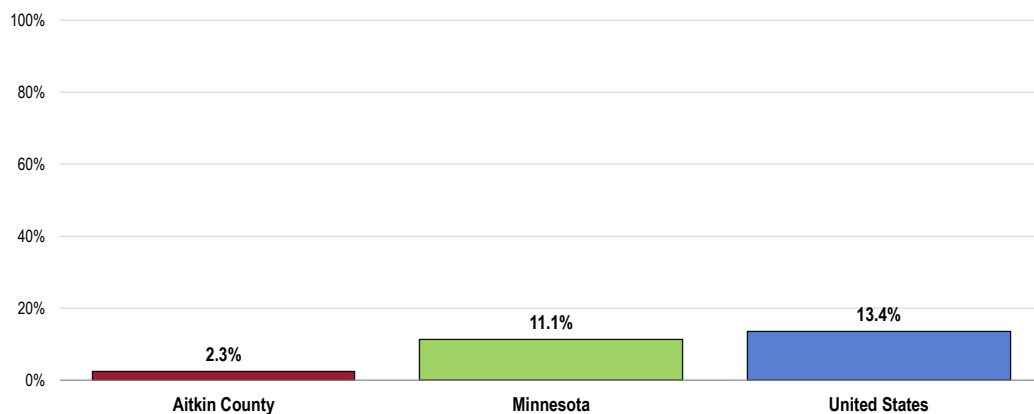
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Asthma Prevalence

A total of 2.3% of Aitkin County adults currently suffer from asthma.

- Notably lower than the statewide and national prevalence.

### Asthma Prevalence (2011-2012)



Sources: 

- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

  
Notes: 

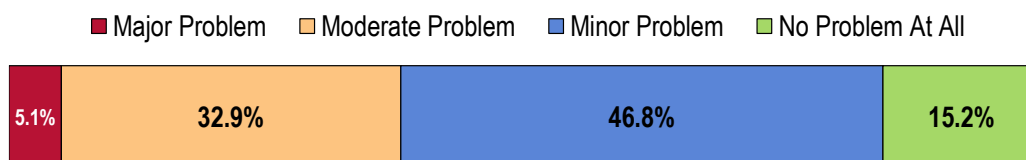
- This indicator is relevant because asthma is a prevalent problem in the US that is often exacerbated by poor environmental conditions.

## Key Informant Input: Respiratory Disease

Key informants taking part in an online survey generally characterized *Respiratory Disease* as a “minor problem” in the community.

### Perceptions of Respiratory Diseases as a Problem in the Community

(Key Informants, 2019)



Sources:   • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes:   • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Aging Population

*Aging population, and many have history of smoking. We do not have a local specialist to serve these individuals. — Other Health Provider*

*Age of population. — Physician*

#### Prevalence/Incidence

*Many people are on oxygen or suffer from asthma. — Community Leader*

#### Tobacco Use

*Elderly people who were smokers, or kids with allergies. — Community Leader*

## Injury & Violence

### About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

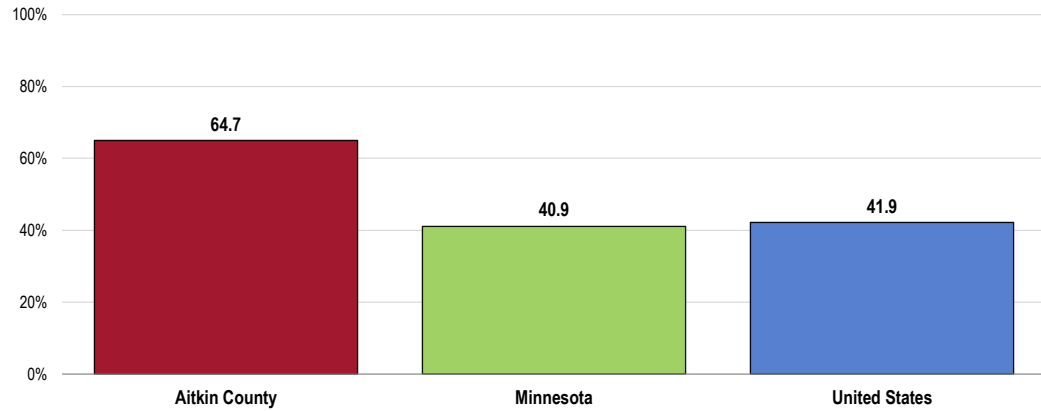
Between 2012 and 2016, there was an annual average age-adjusted unintentional injury mortality rate of 64.7 deaths per 100,000 population in Aitkin County.

- Much less favorable than the Minnesota and US rates.
- Far higher than the Healthy People 2020 target of 36.0 or lower.

## Unintentional Injuries: Age-Adjusted Mortality

(2012-2016 Annual Average Deaths per 100,000 Population)

**Healthy People 2020 Target = 36.0 or Lower**



Sources:

- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-2016. Accessed using CDC WONDER.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]

Notes:

- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

## Violent Crime

**Between 2012 and 2014, there were a reported 169.2 violent crimes per 100,000 population in Aitkin County.**

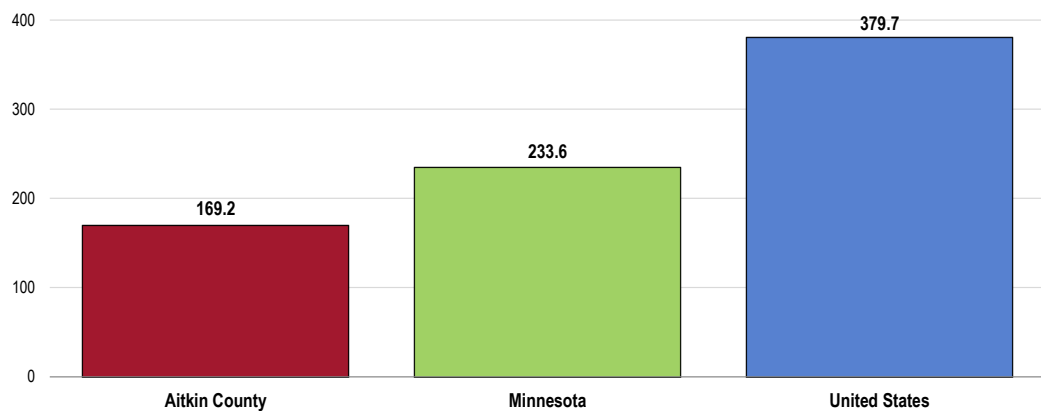
- Below the state and national rates for the same period.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

## Violent Crime

(Rate per 100,000 Population, 2012-2014)



Sources:

- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

## Key Informant Input: Injury & Violence

The greatest share of key informants taking part in an online survey characterized *Injury & Violence* as a “minor problem” in the community.

### Perceptions of Injury and Violence as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: ● Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Domestic/Family Violence

*Domestic violence isn't something that people like to talk about. Many have the mentality of “what happens behind closed doors” is none of their business. Very untrue! It takes a community to stand up for unacceptable behaviors. We need more support for healthier families. Prevention needs to start at younger ages, educating and modeling healthy relationships. — Community Leader*

#### Prevalence/Incidence

*I deal with it first-hand. — Other Health Provider*

#### Response Time

*The problem is the response time for accidents and violence. It can take law enforcement a long time to respond because of distance to travel. The ambulance in McGregor has a very large coverage area, as do the other communities. — Community Leader*

#### Work-Related Injuries

*We have an economy that is dangerous to work in; the trades aren't always safe. I know people who work in the Emergency Room, and they say it is a fairly busy place. I also think we have a domestic abuse issue here that often goes ignored. — Community Leader*

## Diabetes

### About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus: lowers life expectancy by up to 15 years; increases the risk of heart disease by 2 to 4 times; and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes. Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

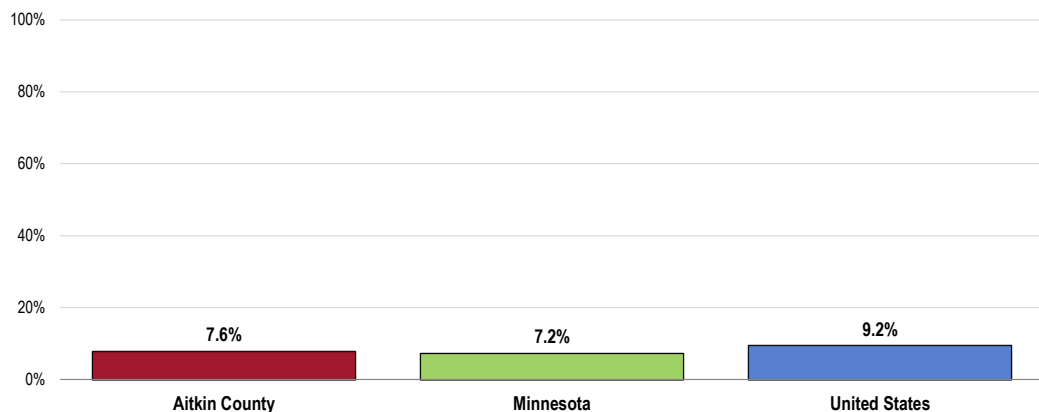
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Prevalence of Diabetes

Among Aitkin County adults age 20 and older, 7.6% have been diagnosed with diabetes.

- Statistically higher than the statewide prevalence.
- Lower than the national prevalence.

#### Adult Age 20+ Who Have Diabetes (2013)



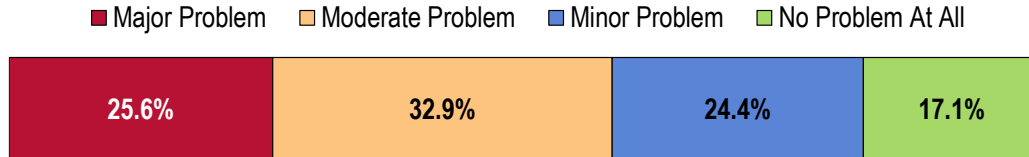
Sources: • Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the US; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

## Key Informant Input: Diabetes

The greatest share of key informants taking part in an online survey characterized *Diabetes* as a “moderate problem” in the community.

### Perceptions of Diabetes as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Challenges

Among those rating this issue as a “major problem,” the biggest challenges for people with diabetes are seen as:

### Awareness/Education

*Lack of support and lack of available ideas for eating better. Last year, we were able to offer a cooking class with healthy eating ideas through MN Extension Office in Grand Rapids. This year we have not had that opportunity. There can only be 10 people in a class, as well. It was an excellent class, and people have asked for it again. The staff that offered it previously has not had the time, and we (early childhood at Hill City) have not had the funds for a teacher to be present at the class and for childcare staffing. I think something like this would be great here. Another challenge is obesity and poverty. It is often cheaper for families to buy “easy” and processed foods than food that is good for you. Part of this issues is also generational poverty; it is a way of life, and people don’t like hearing they need to change. Another issue is school lunches. I know they face strict guidelines, but (at least in Hill City) there aren’t a lot of healthy options for all kids. — Community Leader*

*Lack of diabetes prevention efforts. Price of insulin and related supplies. — Public Health Representative*

*Not doing something until there’s a diagnosis and then using medication only. People need to be flagged at pre-diabetes and empowered to make lifestyle changes. — Community Leader*

*Being educated or wanting to be educated. Following through with medical advice. — Community Leader*

*Access to education and exercise. — Community Leader*

*Education and wanting to change diets. — Community Leader*

### Access to Healthy Food/Exercise Options

*Access to affordable healthy food choices. It is less expensive in Grand Rapids or Brainerd, but then there is a transportation barrier. Easy access to affordable diabetic supplies can be a problem. Pharmacies will mail some medications which is helpful; however, we only have one pharmacy in Aitkin at this time, and it does not take all types of insurances. We do not have an endocrinologist that comes to Aitkin. People need to travel for this specialty. — Other Health Provider*

*Exercise and healthy foods are the key to diabetes, and while we have SNAP Fitness and various outside activities, the access is quite limited, especially to those living in rural Aitkin County. Healthy (whole, fresh) are available, but are very expensive... cost prohibitive to much of the population. — Community Leader*

*They are unable to access the healthy foods that they need. There is also a lack of educational resources for people who have been diagnosed with diabetes. — Community Leader*

*Cost of food, adequate, non-judgmental support. — Other Health Provider*

#### **Cost of Medication/Care**

*Cost of medications and testing supplies. Affordable education that stresses the significance and heavy burden of diabetes not only on individuals but the entire health care system. — Other Health Provider*

*Affording the care they need to take care of the disease properly. — Community Leader*

*Access to affordable supplies and insulin. — Community Leader*

#### **Access to Care/Services**

*Access to consistent care with diet and exercise. — Community Leader*

#### **Aging Population**

*Age of population, fitness, mobility. — Community Leader*

#### **Disease Management**

*The biggest challenge with people with diabetes (pre-diabetes/Type 1 & 2) is management. For pre-diabetes, Riverwood Healthcare Center did offer "I prevent Type 2 Diabetes Prevention Program. This lifestyle change program is not a fad diet or exercise class, for it is not a quick fix. It is a year-long program focused on long-term changes and lasting results for those who are diagnosed as prediabetic. Many individuals need a program and guidance to show how their lifestyles have an influence on their health especially with nutrition and exercise. This program is no longer being offered at any location in the county. Need more programs and resources for preventing and managing diabetes. For Type 1 & Type 2 diabetes, the cost of insulin may be a barrier for individuals with financial stress. Cost for consultation for a Certified Diabetic Educator or Registered Dietitian may also be a factor related to insurance. — Public Health Representative*

*Weight and nutrition. We could really use a specialized weight management clinic to assist people with diabetes and prediabetes conditions. — Community Leader*

#### **Prevalence/Incidence**

*I am not familiar with diabetes, I am just aware that it is a condition that is discussed by community members. — Community Leader*



## Alzheimer's Disease

### About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

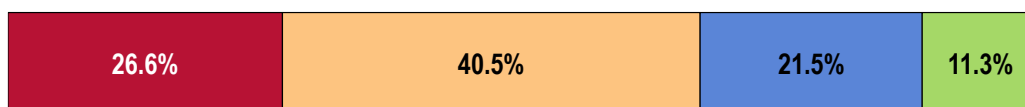
### Key Informant Input: Dementias, Including Alzheimer's Disease

The greatest share of Key informants taking part in an online survey characterized *Dementias, Including Alzheimer's Disease* as a “moderate problem” in the community.

### Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community

(Key Informants, 2019)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Aging Population

*We have a high population of elderly people who suffer from dementia. There are not enough caregivers or living centers that handle these types in this area. Often families are at a loss about what to do with family members in this condition. I think there needs to be more counseling available for family as well as more caregivers for the patients. — Community Leader*

*We are the oldest county in the state. We serve an older population, and the rates of dementia/Alzheimer's are increasing. There's more that needs to be done around prevention, delaying progressions, support for people living with dementia and their care-givers. — Community Leader*

*The aging population in Aitkin County is the highest in Minnesota. Population is very often isolated from family or so rural that neighbors are often unavailable, or the problem goes without diagnosis. — Community Leader*

*We are an older-than-average community, and our general population is aging. Dementia is a major health concern of the aged and is costly and complex to provide care for. We have limited facilities and resources with which to handle the coming surge in dementia cases as our population continues to age. Families are faced with difficult decisions and limited options, especially if they wish to stay in our community. — Other Health Provider*

*We have an aging population that requires specific care for this disease with limited facility space available. There is also little support for the families of those with this disease. — Community Leader*

*We have an aging population in our community therefore the number of people with dementia is high. — Other Health Provider*

*Increasing age of the population with an increase in memory disorders. — Public Health Representative*

*This disease effects mostly older people and we have a large population. — Community Leader*

*We have a large elderly population. — Other Health Provider*

*Elderly population. — Community Leader*

### **Prevalence/Incidence**

*I believe it is an issue in any community in today's world, first and foremost. Also, I have the opportunity to visit with parents in the area that are dealing with aging parents who are affected by dementia/Alzheimer's. There is currently no place that I am aware of to have help with this issue in Hill City. I do not know about Aitkin. Having a support group or a place to help with care for parents when needed may be of interest. A specific survey of people living in Hill City would be needed to know how many people would use the service. — Community Leader*

*The increase in people with dementia and Alzheimer's is an epidemic. — Community Leader*

*We have a high population of elderly suffering from either dementia or Alzheimer's. — Community Leader*

*This, too, affects many families in our community. — Community Leader*

### **Access to Care/Services**

*Individuals have increased behaviors and inappropriateness and have no place to go; there are no facilities around the Aitkin area that support individuals' behaviors. — Other Health Provider*

*Places for people suffering from dementia and Alzheimer's is limited in our community. — Community Leader*

*Limited resources available to families in our community. — Community Leader*

## Kidney Disease

### About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

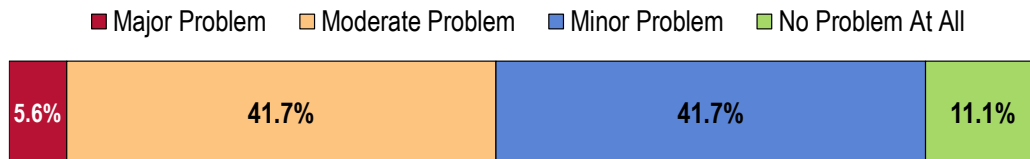
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Key Informant Input: Kidney Disease

Key informants taking part in an online survey characterized *Kidney Disease* as a “moderate problem” equally as often as a “minor problem” in the community.

### Perceptions of Kidney Disease as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

### Access to Care/Services

*When the dialysis center is open at Riverwood, this will help. Most people needing this service are required to travel long distances. — Social Services Provider*

*Those who have chronic kidney disease and require dialysis travel either to Grand Rapids, Brainerd or Mille Lacs for treatment; transportation becomes a barrier, for many have to go twice per week.*

*Riverwood is addressing this problem by adding on a dialysis center at the Aitkin location. — Public Health Representative*

*We have many local patients needing to travel for dialysis. — Community Leader*

### Prevalence/Incidence

*High prevalence with long distance travel for routine dialysis, although that is being remedied. — Public Health Representative*

## Potentially Disabling Conditions

### About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2<sup>nd</sup> leading cause of lost work time (after the common cold).
- 3<sup>rd</sup> most common reason to undergo a surgical procedure.
- 5<sup>th</sup> most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

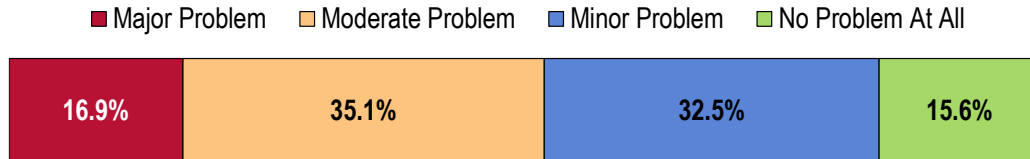
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

Key informants taking part in an online survey slightly more often characterized *Arthritis, Osteoporosis & Chronic Back Conditions* as a “moderate problem” than a “minor problem” in the community.

### Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community

(Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Aging Population

*I believe that arthritis/osteoporosis and back conditions are a major problem in our community due to the fact that a large percentage of our community members are elderly or aged. We live in a community that centers around retired individuals that have transplanted here from the cities. Our medical center does not offer an in-house arthritis specialist or specialists. People who want a variety of medical professionals to choose from will have to travel a great distance to see a RA specialist. — Community Leader*

*Aitkin County has a higher elderly population who experience arthritis/osteoporosis/back pain, in addition to the general population in the county who are seeking for relief/management and may be prescribed pain killers- which can lead to addiction if individual takes more than consulted to take. Opioid addiction is prevalent in Aitkin County. — Public Health Representative*

*We have an aging and elderly population in this county. This population tends to have more problems with joint pain and arthritis. It is sometimes difficult to see specialists in this area without waiting long periods of time or having to travel outside the area. There are many people in the area who suffer from back pain, and there does not seem to be anywhere for them to be treated without traveling to the metro area. — Community Leader*

*Our population is mainly over 55. Hip and knee replacements are prevalent in this community. — Community Leader*

*Aitkin is an older community. Many senior citizens struggle with mobility and pain. — Community Leader*

*Many older people with degenerative conditions and younger people that lift with poor mechanics. — Physician*

*We have an aging community, and a lot of people work labor jobs. — Community Leader*

*Those conditions often worsen with age and our population is older. — Community Leader*

*We have the most senior population with aging issues. — Community Leader*

*Age of population in Aitkin County. — Community Leader*

*Age of community. — Physician*

## Prevalence/Incidence

*Back and spine conditions are experienced by a large number of residents, even in very young ages. People must travel to be seen by specialists, and if a specialist is available locally, there is long wait time to get an appointment. — Public Health Representative*

*I hear many adults complain about back and knee pain at school functions and when they are picking up or dropping off kids. I do not know if these people are being treated by a physician or not. Some of this may or may not be related to obesity issues. — Community Leader*

## Vision & Hearing Impairment

### About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

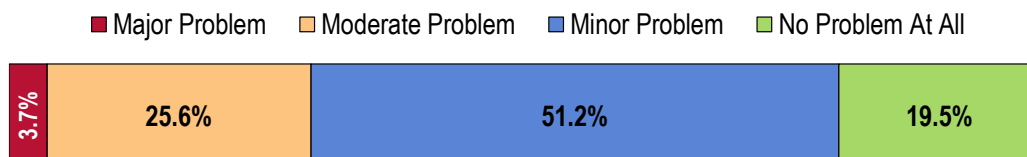
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Key Informant Input: Vision & Hearing

More than half of key informants taking part in an online survey characterized *Vision & Hearing* as a “minor problem” in the community.

### Perceptions of Vision and Hearing as a Problem in the Community

(Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Aging Population

*These are things that affect everyone, but elderly people seem to have a larger need, and we have a large elderly population. — Community Leader*

#### Insurance Issues

*Access to insurance. — Community Leader*



# Infectious Disease



**Professional Research Consultants, Inc.**

## HIV

### About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

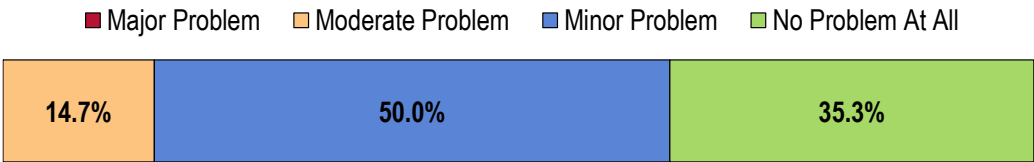
Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

Key Informant Input: HIV/AIDS

Half of key informants taking part in an online survey characterized *HIV/AIDS* as a “minor problem” in the community.

Perceptions of HIV/AIDS  
as a Problem in the Community  
(Key Informants, 2019)



Sources:   • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes:   • Asked of all respondents.

## Sexually Transmitted Diseases

### About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

**Biological Factors.** STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

**Social, Economic, and Behavioral Factors.** The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

• Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Chlamydia & Gonorrhea

In 2014, the chlamydia incidence rate in Aitkin County was 127.1 cases per 100,000 population.

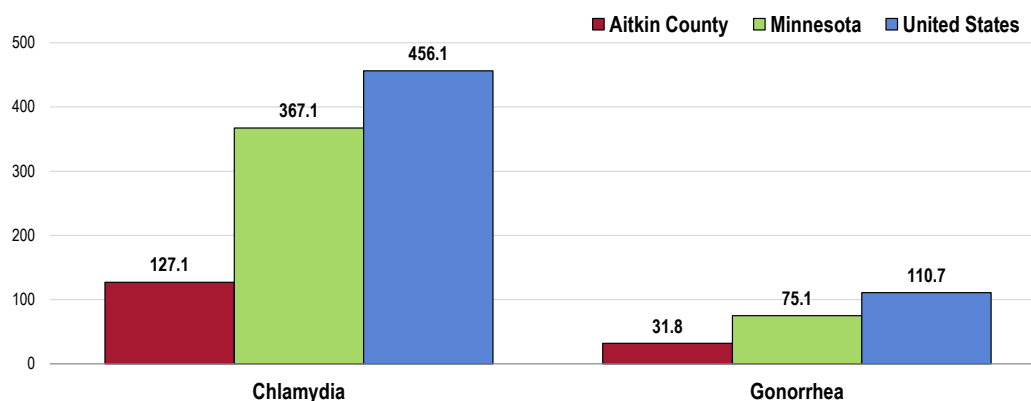
- Notably more favorable than the Minnesota and US incidence rates.

The gonorrhea incidence rate in the county was 31.8 cases per 100,000 population in 2014.

- Much more favorable than the statewide and (especially) national incidence rates.

## Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2014)



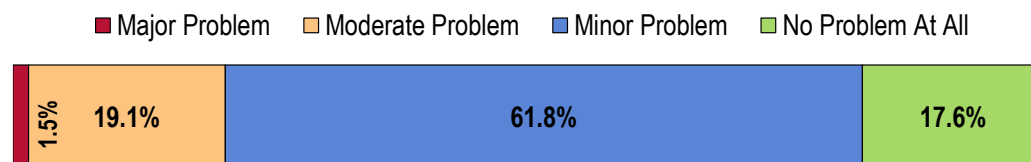
Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.  
 Notes: • This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

## Key Informant Input: Sexually Transmitted Diseases

Key informants taking part in an online survey most often characterized *Sexually Transmitted Diseases* as a “minor problem” in the community.

## Perceptions of Sexually Transmitted Diseases as a Problem in the Community

(Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” the following reason was given:

### Awareness/Education

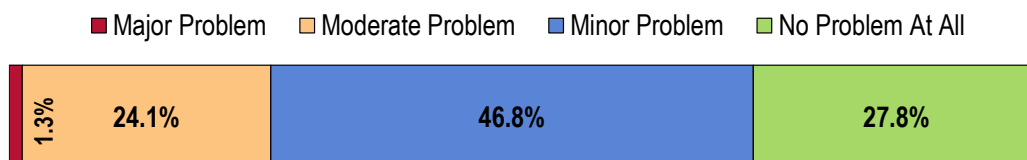
*Sexually transmitted diseases are a major problem because kids are not educated about safe sex at a young enough age, if at all. — Community Leader*

## Immunization & Infectious Diseases

### Key Informant Input: Immunization & Infectious Diseases

The greatest share of key informants taking part in an online survey characterized *Immunization & Infectious Diseases* as a “minor problem” in the community.

### Perceptions of Immunization and Infectious Diseases as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” the following reason was given:

#### Awareness/Education

Lack of knowledge and understanding of the importance of immunizations. — Other Health Provider

# Births



Professional Research Consultants, Inc.

## Birth Outcomes & Risks

### About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

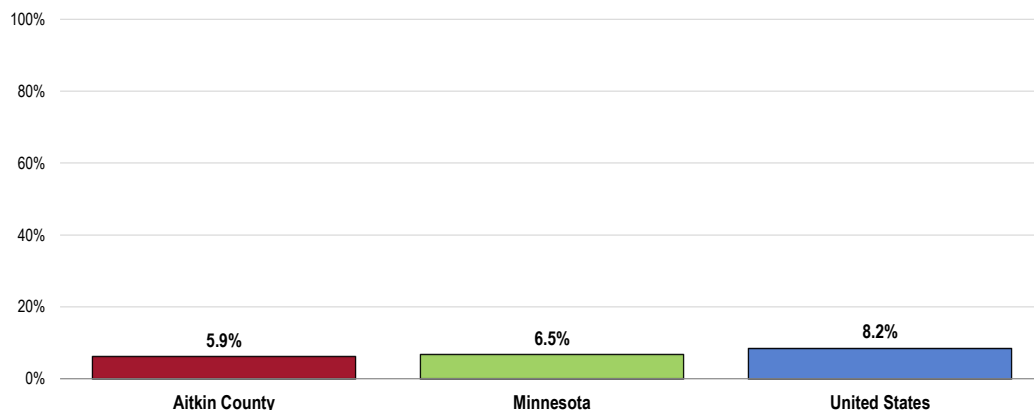
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Low-Weight Births

A total of 5.9% of 2006-2012 Aitkin County births were low-weight.

- Better than the Minnesota and US proportions.
- Satisfies the Healthy People 2020 target (7.8% or lower).

#### Low-Weight Births (Percent of Live Births, 2006-2012) Healthy People 2020 Target = 7.8% or Lower



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System: 2006-2012. Accessed using CDC WONDER.  
• Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Note: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]  
• This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.



Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

## Infant Mortality

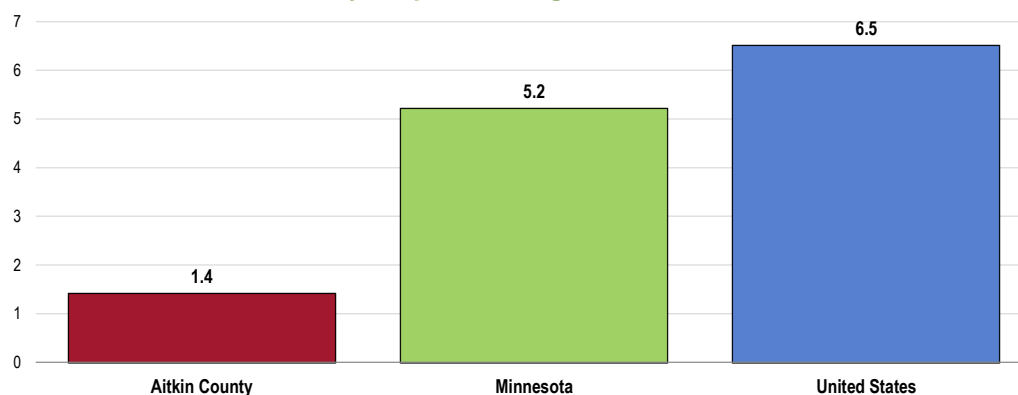
Between 2006 and 2010, there was an annual average of 1.4 infant deaths per 1,000 live births.

- Lower than the state and national rates.
- Satisfies the Healthy People 2020 target of 6.0 per 1,000 live births or lower.

### Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2006-2010)

Healthy People 2020 Target = 6.0 or Lower



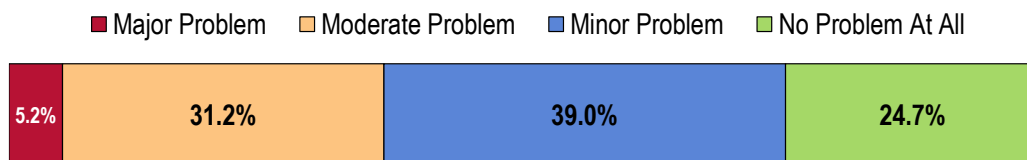
- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, *Area Health Resource File*. Data extracted January 2019.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
- Notes:
- Infant deaths include deaths of children under 1 year old.
  - This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

## Key Informant Input: Infant & Child Health

The greatest share of key informants taking part in an online survey characterized *Infant & Child Health* as a “minor problem” in the community.

### Perceptions of Infant and Child Health as a Problem in the Community

(Key Informants, 2019)



- Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.
- Notes:
- Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

### Childcare Options

*Access to childcare with emphasis on play/exercise. — Community Leader*

### Lack of Vaccinations

*It's a problem because so many parents do not follow-up with vaccinations; they don't take seriously advice from professionals to have kids treated for communicable diseases and continue to send them to day care and school, putting other kids at risk. — Community Leader*

### Unhealthy Living Conditions

*I feel that a large percentage of our children come from unhealthy living conditions. — Community Leader*

## Family Planning

### Births to Teen Mothers

#### About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents.

Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income.

Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

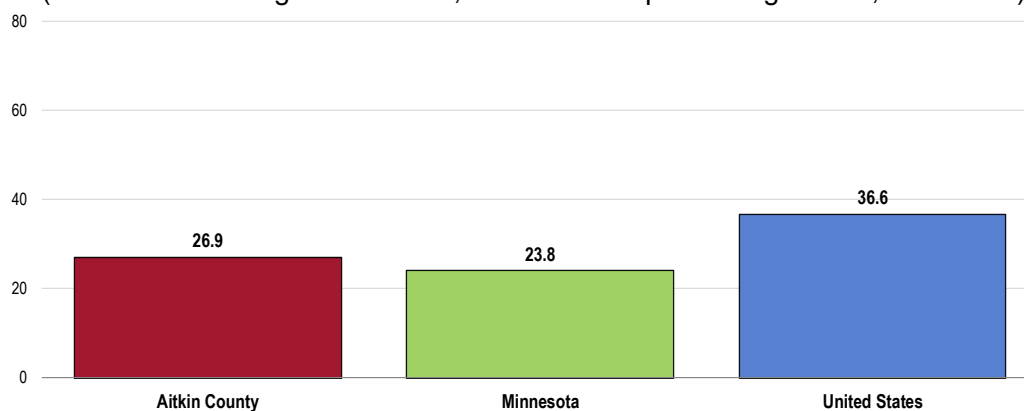
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Between 2006 and 2012, there were 26.9 births to women age 15 to 19 per 1,000 women in this age group in the Aitkin County.**

- Higher than the Minnesota rate.
- Lower than the national rate.

#### Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)



Sources: 

- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved from Community Commons at <http://www.chna.org>.

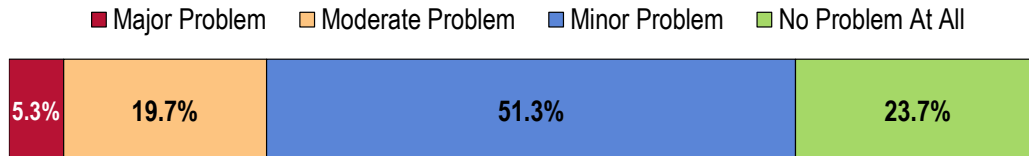
Notes: 

- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

## Key Informant Input: Family Planning

More than half of key informants taking part in an online survey characterized *Family Planning* as a “minor problem” in the community.

### Perceptions of Family Planning as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Social Norms

*I feel like our community's ultra conservative public stance on sex is detrimental to our youth. If a kid has access to transportation, they can buy condoms through self-checkout at Walmart in Brainerd. If they don't, they probably skip out on it all together. High school kids are having all kinds of sex, and I am very concerned with their use of contraceptives. There is not a discrete way to access family planning services here that I am aware of. — Community Leader*

*Because people in the community are unwilling to talk about it. — Community Leader*

# Modifiable Health Risks



**Professional Research Consultants, Inc.**

## Nutrition, Physical Activity & Weight

### Nutrition

#### About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

**Social Determinants of Diet.** Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

**Physical Determinants of Diet.** Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

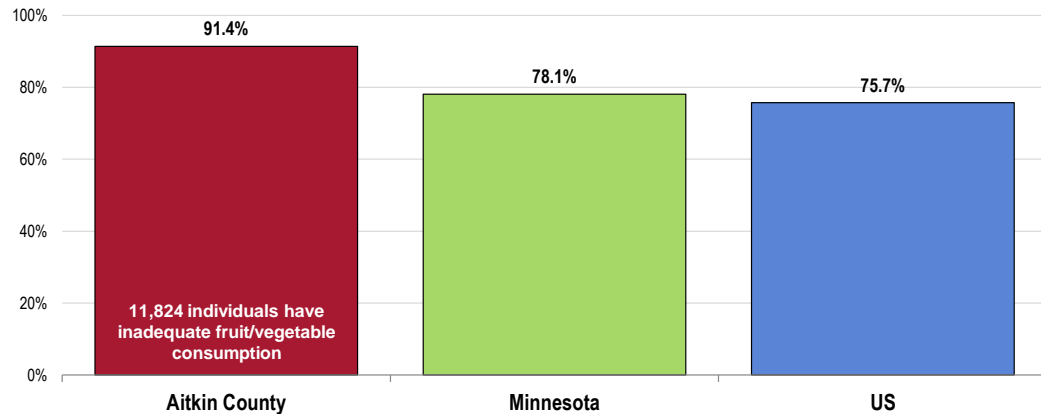
- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Fruits/Vegetable Consumption

A total of 91.4% of Aitkin County adults (representing 11,824 individuals) get fewer than the recommended five servings of fruits and/or vegetables per day.

- Less favorable than statewide and national findings.

#### Less Than 5 Servings of Fruits and Vegetables Each Day (2005-2009)



Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.

• Retrieved March 2019 from Community Commons at <http://www.chna.org>.

Notes: • This indicator reports the percent of adults age 18+ who are consuming less than 5 servings of fruits and vegetables each day. This indicator is relevant because current behaviors are determinants of future health, and because unhealthy eating habits may cause of significant health issues, such as obesity and diabetes.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas.

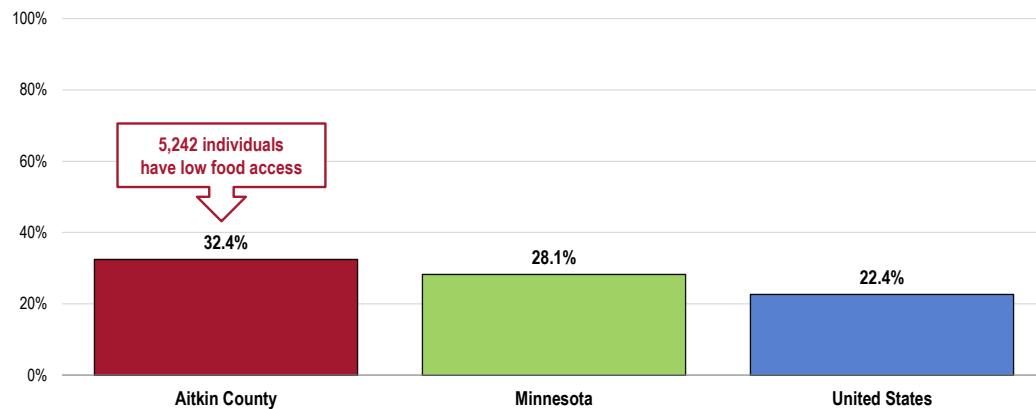
### Low Food Access (Food Deserts)

US Department of Agriculture data show that nearly one-third (32.4%) of the Aitkin County population (representing approximately 5,242 residents) have low food access or live in a "food desert," meaning that they do not live near a supermarket or large grocery store.

- Higher than statewide and national findings.

## Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



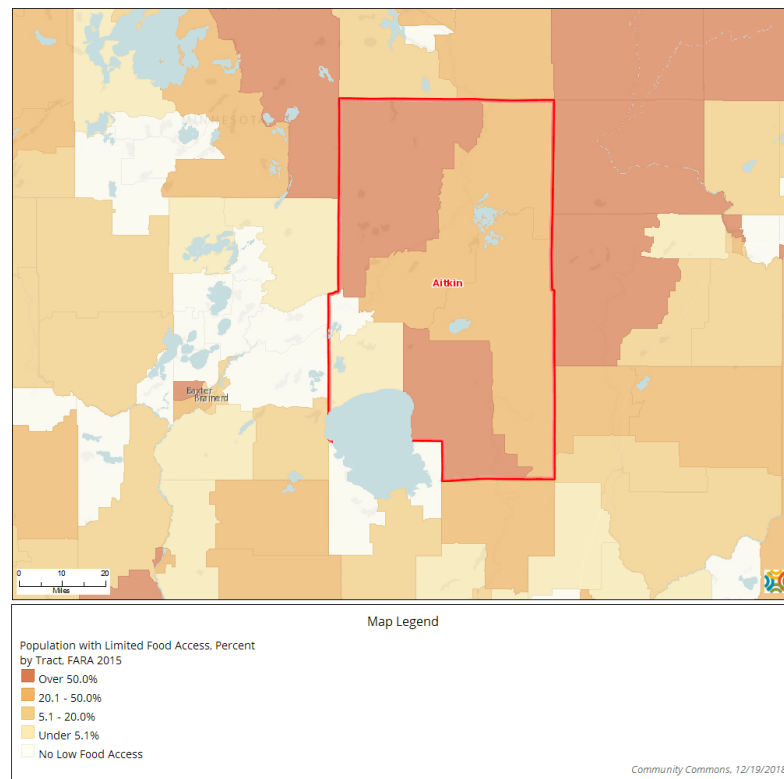
Sources:

- US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas (FARA).
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.

Notes:

- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

- The following map provides an illustration of food deserts by census tract.





## Physical Activity

### About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

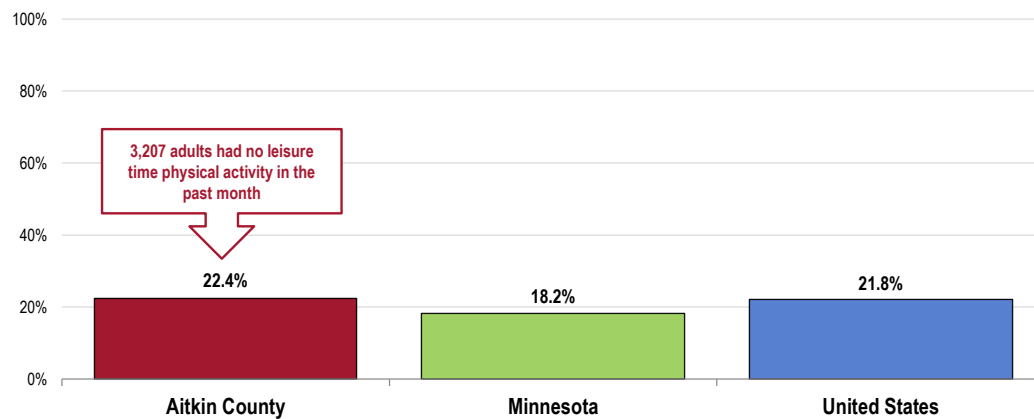
### Lack of Leisure-Time Physical Activity

A total of 22.4% of Aitkin County adults (representing 3,207 individuals) report no leisure-time physical activity in the past month.

- Less favorable than statewide findings.
- Similar to the national findings.
- Satisfies the Healthy People 2020 target (32.6% or lower).

### Adults Age 20+ Who Have No Leisure-Time Physical Activity in the Past Month (2013)

Healthy People 2020 Target = 32.6% or Lower



- Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
  - Retrieved January 2019 from Community Commons at <http://www.chna.org>.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1].
- Notes:
- This indicator reports the percent of adults aged 20+, who self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?". This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

## Weight Status

### About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared ( $m^2$ ). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ( $inches^2$ )] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9  $kg/m^2$  and obesity as a BMI  $\geq 30 kg/m^2$ . The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25  $kg/m^2$ . The increase in mortality, however, tends to be modest until a BMI of 30  $kg/m^2$  is reached. For persons with a BMI  $\geq 30 kg/m^2$ , mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25  $kg/m^2$ .

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI ( $kg/m^2$ )
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	$\geq 30.0$

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

## Obesity

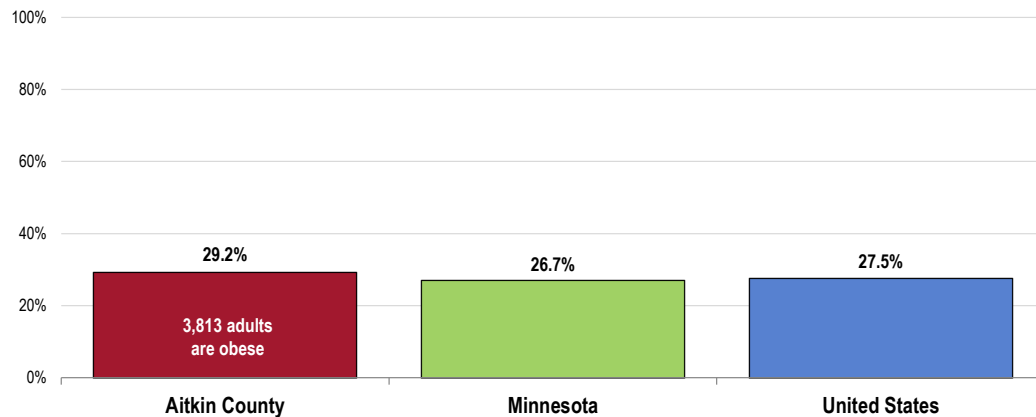
**A total of 29.2% of Aitkin County adults age 20 and older (representing 3,813 individuals) are obese.**

- Less favorable than Minnesota and US findings.
- Comparable to the Healthy People 2020 target (30.5% or lower).

### Adults Age 20 and Older Who Are Obese

(Body Mass Index  $\geq 30.0$ ; 2013)

**Healthy People 2020 Target = 30.5% or Lower**



Sources: • Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9].

Notes: • This indicator reports the percent of adults aged 20+ who self-report that they have a Body Mass Index (BMI) of 30.0 or greater (obese). This indicator is relevant because excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

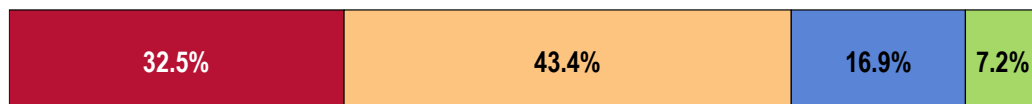
## Key Informant Input: Nutrition, Physical Activity & Weight

The greatest share of key informants taking part in an online survey characterized *Nutrition, Physical Activity & Weight* as a “moderate problem” in the community.

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

### Access to Healthy Food

*Even those of us who are knowledgeable about nutrition find it difficult to eat healthy in Aitkin. Produce is often expensive and of low quality. The variety is also limited. This is not a cut on the store owner; it is simple supply and demand. There isn't enough demand to keep things fresh and varied. We also have a limited space to exercise, especially in winter. The school is too packed with basketball players and dancers to be open to the public during the winter months. Even so, there isn't enough cardio or weight training spaces. Our outdoor activities are extremely limited for those who don't own their own property in any season. This then leads to weight issues that lead to any number of other health issues. — Community Leader*

*Nutrition/Healthy Weight: Barriers to healthy eating include lack of time and competing priorities; a cost of healthy food; adjusting habits to favor a better diet and geographic isolation. a) the time required to shop and prepare food is a challenge for people who already struggle with busy family and work schedules. Many individuals and families lack meal prepping and cooking skills. b) The cost of fresh food is the biggest challenge to eating healthy. Physical Activity: Barriers to physical activity include lack of time due to busy work schedules, competing priorities and competition with activities that promote sedentary time. Also, social norms and stigma is a barrier. For example, if one were to get a bicycle and start riding to work, there is a perception one lost their driver's license. Built environment barriers and geographic isolation is a challenge for our community members such as cycling and walking is not considered, due to poor street safety features and lack of trails. — Public Health Representative*

*Lack of nutritious offerings in downtown area, lack of support for physical activity opportunities (i.e. pickle ball court, bike/walk trail expansion, hockey rink, etc.) — Public Health Representative*

*Access to healthy food and education about how important good nutrition. Very little access to fitness programs/classes. — Other Health Provider*

*Inactivity, access to healthy foods for rural residents. — Community Leader*

*I think better access to healthier food options at an affordable price would be very good for our community. — Community Leader*

*People are unable to purchase quality healthy foods in the area. Many people live sedentary lifestyles. If you can not afford a gym membership to Snap Fitness you have limited resources to get some exercise. Although going to the gym is not the only way to get exercise. There is a lack of education around diet and exercise in the area. — Community Leader*

*So many challenges, access to affordable, healthy food, access to a 24 hour gym in McGregor. Group classes that are affordable or free. — Community Leader*

### Lifestyle

*Many of the chronic conditions we are seeing started with the precursor of poor nutrition, in activity, and weight mismanagement. Nutrition and physical activity can also help improve mental wellbeing. Community members complain of a lack of access to healthy foods, transportation and cost. Also, a lack of access to outdoor (and indoor) activities. — Community Leader*

*I believe basic nutrition is a major health issue in our community. I see the shopping carts of what people are buying at the County Market and, frankly, it is difficult to identify any real food present. Family Dollar is becoming a place that people buy 'groceries'. How can our community (and our nation) have decent health when people don't know the basics of self-care? As a medical community, I believe we are much too focused on diagnosing and treating disease (and we spend a lot of money doing that) rather than creating a foundation for good health. I believe more and more in the power of epigenetics, and that it is the environment we provide to our bodies that matters most to health-- environment being the food we eat, the thoughts we think, the water we drink, the air we breathe, the emotions we feel, our connection to people. We have enough research to support the importance of all of this. I would love to reorient around health care and not be focused on disease management. — Other Health Provider*

*Personal commitment of individuals to address these issues. — Community Leader*

*People caring about their general health. — Community Leader*

### Access to Care/Services

*Support and accountability for those desiring to make a change, access to facilities, training, education*

*and expertise to lead a healthy lifestyle. — Community Leader*

*Lack of facilities. — Community Leader*

### **Awareness/Education**

*Lack of knowledge/education, low socioeconomic status, few exercise facilities and only one grocery store, making food expensive. — Other Health Provider*

*Nutrition education, healthy eating options, places to exercise, lack of community fitness center, lack of gym space at the schools. — Community Leader*

### **Built Environment**

*Limited access to physical activity opportunities, especially in the winter time, and at a low cost. Our community is in need of a community center that could provide a pool, walking space, and indoor gym space. Aitkin county is large, and transportation is a barrier for many. Aitkin County has the largest elderly population in the state of Minnesota and outside exercise could pose safety issues. Our county has low socioeconomic status and purchasing fresh fruits and vegetables can be costly. We have many food deserts where people need to travel a long distance to find food especially fresh food. Food insecurities and lack of exercise lead to obesity. — Other Health Provider*

*Availability to facilities for exercise. Bad dietary habits by people. — Community Leader*

### **Insufficient Physical Activity**

*It would really be nice to have a center designed specifically for weight management and nutrition. Many health problems could be helped or even averted if people could maintain a healthy weight. We have people in this area who are very obese as well as those who are anorexic. We also need more outreach to schools to teach children about healthy weight management and nutrition. We have enough parks and activities for people to get exercise. — Community Leader*

*Lack of motivation. — Community Leader*

### **Affordable Care/Services**

*Finances. — Other Health Provider*

### **Obesity**

*Obesity, stress, inactive. Lack of fitness facilities in town, limited and no showers, etc. — Community Leader*

### **Social Determinants of Health**

*Generational poverty: lack knowledge of need and/or cannot afford to buy fresh fruits and vegetables. Obesity: an issue in Hill City. Poverty or low income: causes depression and defeatedness so they can't get beyond that to get up and get busy physically. Lack of desire to exercise: limited options for adults locally (maybe a lifeguard for summer beach; more outside and inside opportunities) — Community Leader*

### **Stress**

*Access to affordable, fresh/whole foods; but honestly, I think that stress/mental health is the most significant barrier to a healthy lifestyle. If we can manage mental health/stress more effectively, healthy lifestyles, for most, will follow. — Community Leader*

## Substance Abuse

### About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Excessive Drinking

A total of 15.1% of area adults drink alcohol excessively.

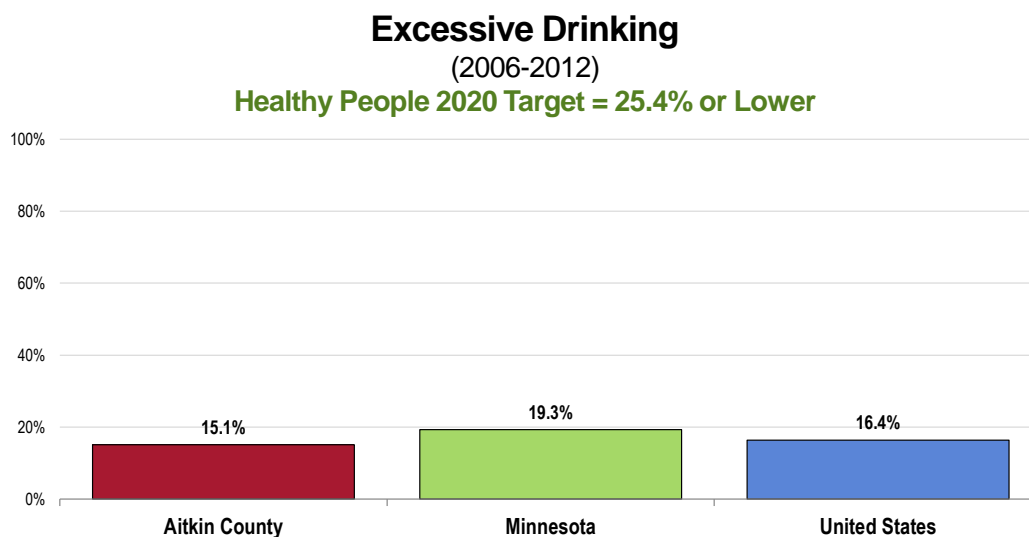
- Better than the statewide and national proportions.
- Satisfies the Healthy People 2020 target (25.4% or lower).

This indicator reports the percentage of adults aged 18 and older who self-report:

**heavy drinking** (defined as more than two drinks per day on average for men, and one drink per day on average for women)

or

**binge drinking** (5 or more drinks on a single occasion for men, 4 or more drinks on a single occasion for women).



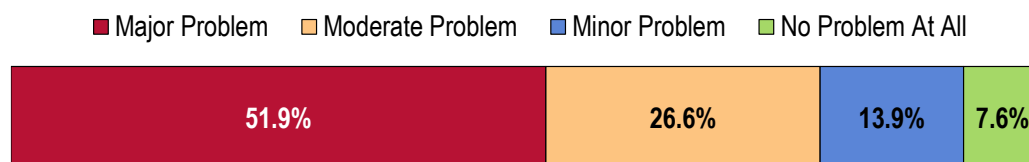
Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.  
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15].

Notes: • This indicator reports the percentage of adults aged 18 and older who self-report heavy drinking (defined as more than two drinks per day on average for men and one drink per day on average for women).

## Key Informant Input: Substance Abuse

More than half of key informants taking part in an online survey most often characterized *Substance Abuse* as a “major problem” in the community.

### Perceptions of Substance Abuse as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
 Notes: • Asked of all respondents.



## Barriers to Treatment

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

### Access to Care/Services

*There are not many treatment centers available. None in our county that I am aware of. Also, sometimes I have had cases where both a husband and wife need treatment, and the center will say that they can only take one because of a conflict issue. This leaves the spouse with nowhere to go or having to wait or go a longer distance for treatment. — Community Leader*

*Limited access to beds for inpatient treatment. People may make the decision that they want to go to treatment, but they have to be proactive about it and wait for two to three weeks on a waiting list to get into a treatment program. — Social Services Provider*

*No close treatment facilities; you must travel over an hour to find a facility. — Community Leader*

*No detox services in the county or outpatient treatment programs that I am aware of. — Community Leader*

*There are no inpatient treatment facilities in our community. All facilities are many miles away and difficult for families to visit and provide support. — Community Leader*

*Lack of treatment in a location close to homes. Few addicts have driver's licenses or cars. Having a waiting list to get into treatment. — Community Leader*

*Treatment center that is close to home. — Community Leader*

*Accessibility and cost of treatment. — Community Leader*

*We need easy access to the professionals that offer treatment. — Other Health Provider*

*Lack of treatment centers close to Aitkin County. — Other Health Provider*

*Lack of in- and out-patient treatment in the area. Lack of supportive services when a person leaves treatment. Over-prescribing of medications. — Social Services Provider*

*Health insurance, access to health care. Having enough professionals to help people get the help they need. — Community Leader*

*Lack of trained professionals. — Community Leader*

*No designated inpatient or outpatient programs in the local area. — Other Health Provider*

*Available, but limited resources. Stigma. Supportive environments for recovery. — Public Health Representative*

*Is there a place to even get treatment in this community? — Community Leader*

*No inpatient treatment. Limited outpatient services. — Social Services Provider*

*Being a rural area with few other things to do and easy access. — Other Health Provider*

*No facility available. — Other Health Provider*

### Awareness/Education

*Again, I am not aware of any publicly advertised programs in this immediate area addressing substance abuse. — Other Health Provider*

*There are not well-advertised AA/NA meetings in our area. They are not diverse in their population, and, oftentimes, people feel very conspicuous when attending. There are no local treatment facilities that someone can go when they have hit rock bottom in any kind of expeditious manner. There aren't enough day treatment programs or co-occurring programs that address both mental health issues and chemical dependency issues. There are many people that are using and dealing, as well, that feeds the problem. — Community Leader*

*We have AA and NA groups that meet. However, they are not reaching people who need this type of support. We need to have more groups and individual care for people who are struggling to stay clean and sober. Not everyone resonates with a 12-step program. — Community Leader*

*Education in schools and home. — Community Leader*

### Denial/Stigma

*The realization that it is a problem. There are not enough professionals to serve or facilities to address the problem locally. — Community Leader*

*The unwillingness of people to quit. — Community Leader*

*People not wanting to seek assistance. — Community Leader*

*Peer/community acceptance. — Community Leader*

### Prevalence/Incidence

*Residents feel substance abuse is a major problem in Aitkin County. Meth, opioids, tobacco, marijuana, misuse of alcohol. — Community Leader*

*Substance abuse is a growing concern, more particularly in Aitkin County with the opioid epidemic, but not limited to drugs and alcohol. — Public Health Representative*

### Transportation

*Transportation. Difficulty to get a Rule 25 assessment done. Socioeconomic status. We are a large county and only have Riverwood as the chemical dependency resource in our county offering medication-assisted treatment. — Other Health Provider*

*Transportation. — Community Leader*

### Alcohol/Drug Use

*Addiction. — Community Leader*

### Social Norms

*Parents/families use, so kids think it is ok. Experimentation and then use / peer pressure, especially in such a small town. Lack of local opportunities (minimal academic or fun outlets, other than sports after school). Availability of substances, ease of concealment. It becomes a "way of life" for people who don't understand the detriments of it and don't see what they are doing as abusive. Some parents allow it. — Community Leader*

## Most Problematic Substances

Key informants (who rated this as a "major problem") identified **methamphetamine/other amphetamines** and **alcohol** as the most problematic substance abused in the community, followed by **heroin/other opioids**, **prescription medications**, and **marijuana**.

Problematic Substances				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Methamphetamines or Other Amphetamines	35.1%	13.5%	44.4%	<b>34</b>
Alcohol	35.1%	37.8%	8.3%	<b>30</b>
Heroin or Other Opioids	21.6%	18.9%	13.9%	<b>20</b>
Prescription Medications	5.4%	10.8%	19.4%	<b>13</b>
Marijuana	2.7%	13.5%	11.1%	<b>10</b>
Cocaine or Crack	0.0%	2.7%	0.0%	<b>1</b>
Inhalants	0.0%	0.0%	2.8%	<b>1</b>
Over-The-Counter Medications	0.0%	2.7%	0.0%	<b>1</b>

## Tobacco Use

### About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes: cancer; heart disease; lung diseases (including emphysema, bronchitis, and chronic airway obstruction); and premature birth, low birth weight, stillbirth, and infant death.

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Cigarette Smoking Prevalence

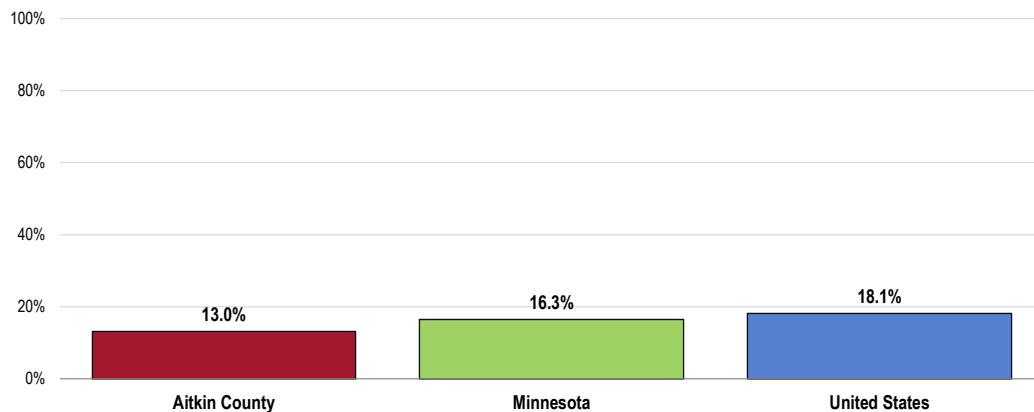
A total of 13.0% of Aitkin County adults currently smoke cigarettes, either regularly or occasionally.

- More favorable than Minnesota or US findings.
- Fails to satisfy the Healthy People 2020 target (12.0% or lower).

### Current Smokers

(2006-2012)

Healthy People 2020 Target = 12.0% or Lower



- Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse.
  - Retrieved January 2019 from Community Commons at <http://www.chna.org>.
  - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
- Notes:
- This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.
  - Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

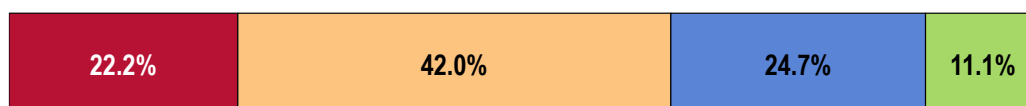
## Key Informant Input: Tobacco Use

Key informants taking part in an online survey most often characterized *Tobacco Use* as a “moderate problem” in the community.

### Perceptions of Tobacco Use as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

### Prevalence/Incidence

*Tobacco use is a major problem in most communities. Rural America still has a strong cultural tie to chewing tobacco and is now a hotspot for the vaping revolution. According to my teen, vaping is epidemic. — Community Leader*

*I see it daily. I smell it on the children's jackets and backpacks in preschool. Sometimes the whole jacket area reeks of tobacco smoke. I overhear older kids talking in the commons. Parents talk about it in parenting classes. Teen surveys. — Community Leader*

*Smoking behavior is visible throughout our community and is more prevalent in areas with individuals with mental health issues and low socioeconomic status, which is evident in our community. Aitkin has a vape shop. — Other Health Provider*

*The number of cases of lung cancer, COPD, etc. Seeing way too many smokers and hearing of younger people vaping. It may not be any worse than in the rest of the country but it's a major problem none the less. Unfortunately, people continue to choose to smoke. — Social Services Provider*

*It is almost an expectation that one smokes here. Vaping is not considered a problem so many of the high schoolers vape. — Other Health Provider*

*Many young adults still smoking or vaping. — Other Health Provider*

*High tobacco use rates. — Other Health Provider*

*Many people continue to smoke. — Other Health Provider*

*Ongoing problem. — Community Leader*

### E-Cigarettes and Vaping

*There is a vaping concern in our communities in Aitkin County, especially pertaining to our youth with the vaping epidemic. Consistent with national trends, e-cigarettes were the most commonly-used type of tobacco by MN students across all regions and is considered higher among rural students and at a high risk for nicotine dependence according to MDH's findings. MDH has also found that Greater Minnesota youth try smokeless tobacco younger and use more frequently. Minnesota and local communities need to work together to address this epidemic by strengthening their tobacco prevention efforts and create tobacco cessation programs tailored for specific age groups. — Public Health Representative*

*E-cigarettes are taking over the schools. — Community Leader*

*Youth access and vaping, specifically. — Public Health Representative*

**Socioeconomic Factors**

*Unfortunately, there are many people who are struggling to make ends meet who are also using tobacco products on a regular basis. — Community Leader*

*Low education levels and low socioeconomic status. — Other Health Provider*

**Easy Access**

*Tobacco is more readily available than fruits and veggies. Children should be taught the dangers of smoking at younger age. Tobacco users are often in the low-income classification, their kids may not have basic needs met but parents can always afford cigarettes. There aren't many support groups for those wanting help to quit smoking. — Community Leader*

**Priorities**

*People will choose smoking over paying their utility bills. It is also a health risk factor to others. — Community Leader*

# Access to Health Services



**Professional Research Consultants, Inc.**

## Lack of Health Insurance Coverage

**Among adults age 18 to 64 in Aitkin County, 7.5% report having no insurance coverage for healthcare expenses.**

- Worse than the state finding.
- Better than the national finding.
- The Healthy People 2020 target is universal coverage (0.0% uninsured).

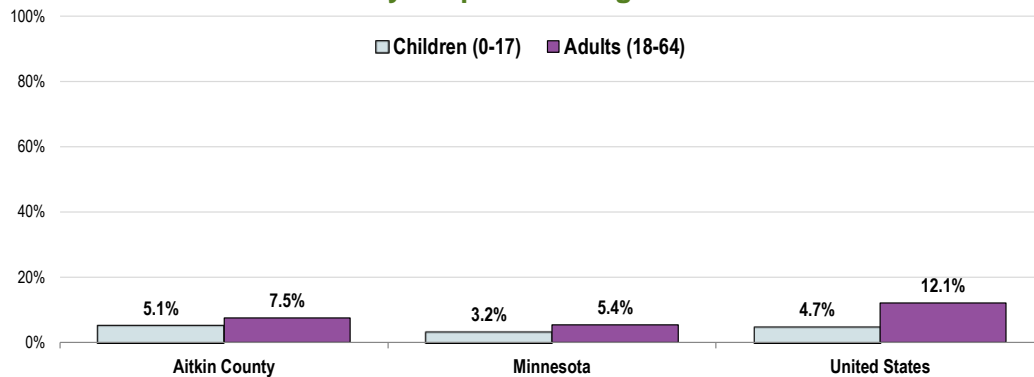
**Additionally, among children age 0 to 17 in Aitkin County, 5.1% have no insurance coverage for healthcare expenses.**

- Worse than both Minnesota and the US.
- The Healthy People 2020 target is universal coverage (0.0% uninsured).

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

### Uninsured Population (2016)

**Healthy People 2020 Target = 0.0%**



Sources:

- US Census Bureau, Small Area Health Insurance Estimates. & American Community Survey 5-year estimates.
- Retrieved January 2019 from Community Commons at <http://www.chna.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1.1].

Notes:

- The lack of health insurance is considered a *key driver* of health status. This indicator is relevant because lack of insurance is a primary barrier to healthcare access (including regular primary care, specialty care, and other health services) that contributes to poor health status.

## Difficulties Accessing Healthcare

### About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

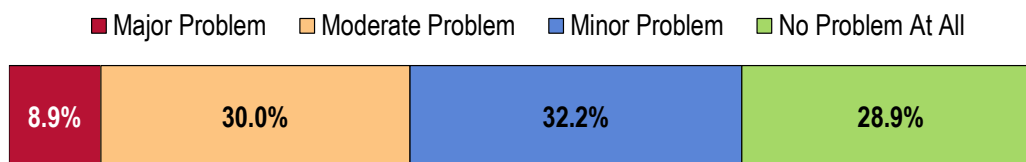
Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Key Informant Input: Access to Healthcare Services

The largest share of key informants taking part in an online survey characterized *Access to Healthcare Services* as a “minor problem” in the community.

### Perceptions of Access to Healthcare Services as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.  
Notes: • Asked of all respondents.

### Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

#### Affordable Care/Services

*Aitkin County Public Health conducted their Community Health Assessment in Spring-Summer of 2018 for the county, and access to health care was identified as one of the top three of priority issues by community members. Currently, public health leaders for the Aitkin-Itasca-Koochiching Community Health Board are meeting to identify strategies and objectives to address this priority issue. Rural residents often encounter barriers to healthcare that limit their ability to obtain the care they need, including the following: financial means to pay for services (health and dental), means to reach and use services such as transportation to services that may be located at a distance and the ability to take paid time off. Barriers that rural residents experience include: health insurance status, high deductible, transportation, health literacy and stigma associated with conditions such as mental health or substance abuse. — Public Health Representative*

*The cost of healthcare and healthcare insurance. — Community Leader*

*Affordable health care. Many of our residents are underinsured. High deductibles, low coverage. — Community Leader*



### Lack of Providers

*Ability of residents to get to appointments, availability of providers, low socioeconomic status, not seeing value in health care, and simply lack of knowledge/education of the importance of health care. — Other Health Provider*

*Availability of enough providers to meet demands. Long wait times for appointments. This has been a long-term issue that is articulated over and over by community. — Community Leader*

*It is difficult to see specialists at our local hospital. If you need to see a specialist you will need to drive to the Twin Cities, two-and-a-half hours or more away. — Community Leader*

### Insurance Issues

*Access to healthcare is the most important issue. If you do not have health insurance, people just don't/can't take care of themselves or their families. From general health to mental health to dental care. — Community Leader*

*Poor insurance coverage, no insurance, lack of transportation to appointments. — Community Leader*

### Lack of Specialists

*Lack of some specialty services. — Social Services Provider*

*Lack of specialists. Either there are none available for that health area, or those that are available are booked many months in advance. From personal experience, I can say that a patient does not want to wait 3 months to see a urologist when they are suffering from a kidney stone. This is just an example.*

*— Community Leader*

### Transportation

*Lack of transportation services in the area. Lack of volunteer drivers, adequate public transit, cab service, etc. — Social Services Provider*

*Transportation, livable wage jobs, early preventative education. — Community Leader*

### Stigma

*Stigma, lack affordable care — Community Leader*

### Wait Time

*The length of time to get a doctor appointment is very challenging. Many times, older residents in McGregor are waiting a couple of weeks for an appointment. The only option is to go to Aitkin to urgent care, which is difficult in distance and cost. — Community Leader*

### Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified **substance abuse treatment** and **mental health care** as the most difficult to access in the community.

Medical Care Difficult to Access Locally				
	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Substance Abuse Treatment	42.9%	14.3%	14.3%	<b>5</b>
Mental Health Care	28.6%	14.3%	28.6%	<b>5</b>
Dental Care	14.3%	14.3%	14.3%	<b>3</b>
Specialty Care	0.0%	14.3%	28.6%	<b>3</b>
Urgent Care	14.3%	14.3%	0.0%	<b>2</b>
Affordable Care	0.0%	14.3%	0.0%	<b>1</b>
Pain Management	0.0%	14.3%	0.0%	<b>1</b>
Chronic Disease Care	0.0%	0.0%	14.3%	<b>1</b>

## Primary Care Services

### About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

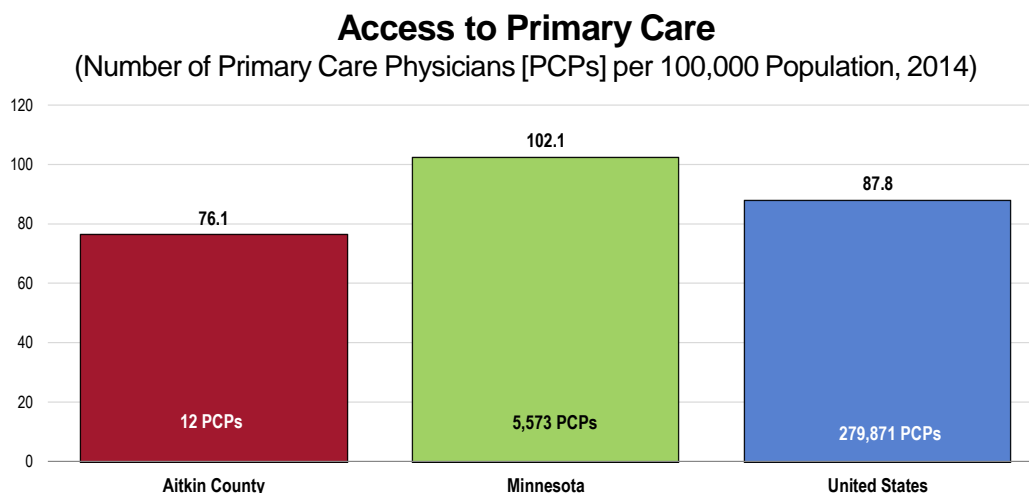
Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

### Access to Primary Care

In Aitkin County in 2014, there were 12 primary care physicians, translating to a rate of 76.1 primary care physicians per 100,000 population.

- Well below the rates found statewide and nationally.



- Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
  - Retrieved January 2019 from Community Commons at <http://www.chna.org>.
- Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

## Oral Health

### About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

## Dental Care

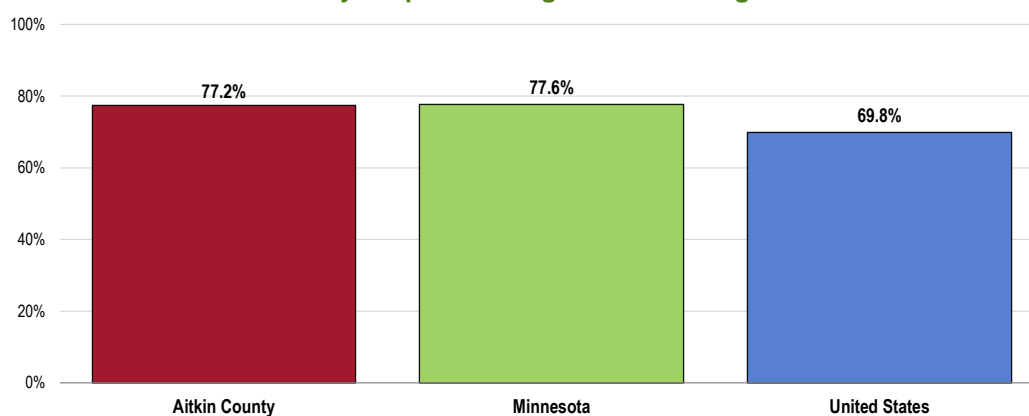
A total of 77.2% of Aitkin County adults have visited a dentist or dental clinic (for any reason) in the past year.

- Similar to statewide findings.
- More favorable than national findings.
- Satisfies the Healthy People 2020 target (49.0% or higher).

### Have Visited a Dentist or Dental Clinic Within the Past Year

(2006-2010)

Healthy People 2020 Target = 49.0% or Higher



Sources: • Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES.  
 • Retrieved January 2019 from Community Commons at <http://www.chna.org>.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

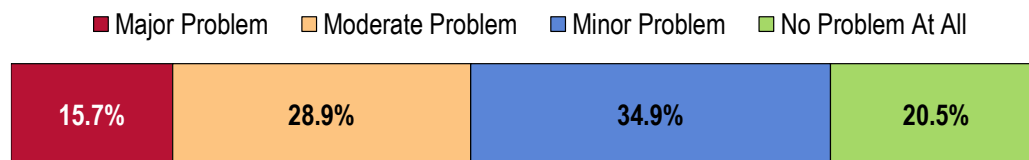
Notes: • This indicator is relevant because engaging in preventive behaviors decreases the likelihood of developing future health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

## Key Informant Input: Oral Health

Key informants taking part in an online survey generally characterized *Oral Health* as a “minor problem” in the community.

### Perceptions of Oral Health as a Problem in the Community

(Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes: • Asked of all respondents.

## Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

### Insurance Issues

*There are not enough dentists that take new patients with MN Care insurance. When they do the coverage from insurance is minimal for them and then the cost for services for the privately insured or cash paying clients is higher. If The dental office in McGregor closes many people will have to travel to Deerwood to see a dentist. That place provides subpar care and would rather pull a tooth than fix it — Community Leader*

*A large majority of residents on MA are not able to be seen in Aitkin County. Dentists claim to have their limit of MA patients, however many of these patients no longer use their services. The reimbursement rate for Dentists is too low that they loose money by taking these patients on. — Community Leader*

*The only dentist that will accept medical assistance is Northland Smiles in Deerwood and it is booked out for months. Our local dentists in Aitkin are booked out for quite a length of time, as well. — Community Leader*

*Lack of providers who will accept Medical Assistance (MA) as coverage. — Social Services Provider*

*Lack of insurance coverage, specially MA, for dental health in rural Minnesota to help the community not only with dental health but with lip/tongue ties in infants. — Public Health Representative*

*Access to those who do not have private insurance. Very few options for MA or Medicare patients — Other Health Provider*

*Dentists do not take MA. — Other Health Provider*

*Access to insurance. — Community Leader*

### Affordable Care/Services

*Dental care is very expensive, and a lot of people cannot afford it. — Community Leader*

### Lack of Providers

*Lack of providers, especially those who accept public insurance coverage. — Public Health Representative*

## Local Resources



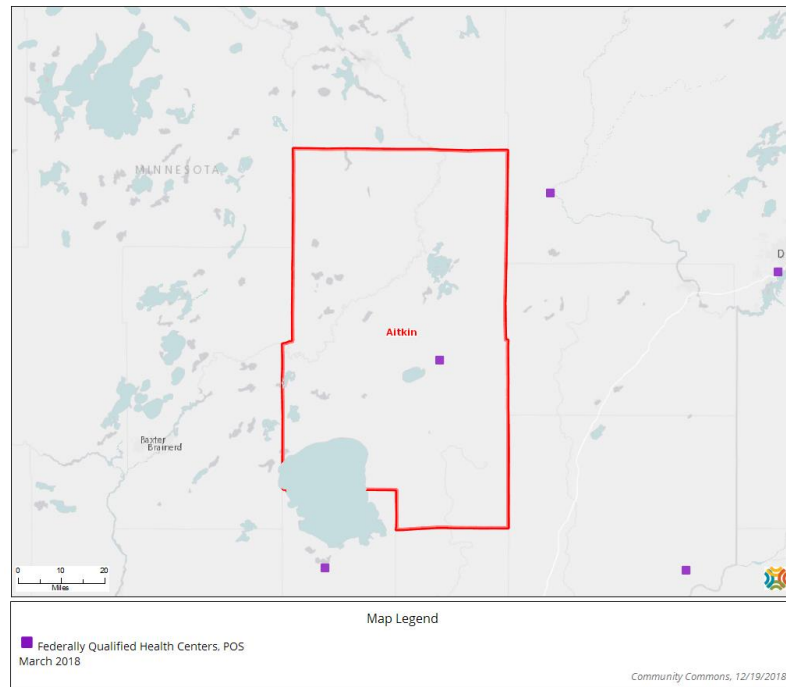
**Professional Research Consultants, Inc.**



## Healthcare Resources & Facilities

### Federally Qualified Health Centers (FQHCs)

As of March 2018, there was one Federally Qualified Health Center (FQHC) within Aitkin County.



## Resources Available to Address the Significant Health Needs

Incorporating input from community stakeholders taking part in the Online Key Informant Survey, the following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

### Access to Healthcare Services

211  
Aitkin County  
Aitkin County CARE (Coordinating Area Resources Effectively)  
Aitkin County Health and Human Services  
Aitkin County Public Health  
ANGELS of McGregor  
Arrowhead Transit  
Assisted Living Facilities  
Cuyuna Regional Medical Center  
Essentia Health  
Home Health Agencies  
Medical Assistance  
Northland Counseling  
Public Health  
Riverwood Clinics

### Arthritis, Osteoporosis & Chronic Back Conditions

Acupuncture Services  
Cuyuna Regional Medical Center  
Doctor's Offices  
Hospitals  
Local Healthcare System  
Riverwood Healthcare Center  
Senior Exercise Classes  
Silver Sneakers  
Snap Fitness  
St. Joseph's Medical Center

### Cancer

Aitkin Community Food Shelf  
Aitkin County CARE (Coordinating Area Resources Effectively)  
ANGELS of McGregor  
Cancer Services  
Churches

Cuyuna Regional Medical Center  
Doctor's Offices  
Essentia Health  
Financial/Healthcare Assistance Programs  
Hospitals  
Loaves and Fishes  
Public Health  
Riverwood Healthcare Center  
SAGE Program

### Dementias, Including Alzheimer's Disease

Adult Day Care Centers  
Adult Foster Care Providers  
Aicota Health Care Center  
Aitkin County CARE (Coordinating Area Resources Effectively)  
Aitkin Health Services  
Alzheimer's Association  
ARDC, Arrowhead Area Agency of Aging  
Assisted Living Facilities  
Caregiver Support Groups  
Cuyuna Regional Medical Center  
Doctor's Offices  
Educational Services  
Golden Horizons  
Home Health Agencies  
Hospice Care  
Medicare/Medicaid  
Memory Care Centers  
Respite Care  
Rivers Edge  
Riverwood Clinics  
Riverwood Healthcare Center

### Diabetes

Aicota Health Care Center  
Aitkin County CARE (Coordinating Area Resources Effectively)  
Aitkin Health Services

County Nurse  
 Cuyuna Regional Medical Center  
 Diabetes Education  
 Diabetes Prevention Program  
 Diabetes Support Group  
 Essentia Health  
 Farmer's Market  
 Golden Horizons  
 Grandma's Pantry and Market  
 Nutrition Services  
 Parks and Recreation  
 Riverwood Clinics  
 Riverwood Healthcare Center  
 School System  
 Snap Fitness

### **Family Planning**

Aitkin County Health and Human Services  
 Aitkin High School

### **Hearing & Vision**

Riverwood Healthcare Center

### **Heart Disease & Stroke**

Aitkin Community Food Shelf  
 Aitkin County CARE (Coordinating Area  
 Resources Effectively)  
 Aitkin County Health and Human Services  
 Bone Builders  
 Cardiac Rehab Services  
 Doctor's Offices  
 Farmer's Market  
 Heart Institute of Minnesota  
 Parks and Recreation  
 Paulbeck's County Market  
 Riverwood Clinics  
 Riverwood Healthcare Center  
 School System

### **Immunization/Infectious Disease**

Public Health  
 Riverwood Healthcare Center

### **Infant and Child Health**

ECEF Classes  
 Hospitals

### **Injury and Violence**

Advocates Against Domestic Abuse  
 Aitkin County  
 Hospitals

Law Enforcement  
 Rehab Services  
 Riverwood Healthcare Center

### **Kidney Disease**

Cuyuna Regional Medical Center  
 Dialysis Center  
 Doctor's Offices  
 Educational Services

### **Mental Health**

Access North  
 Aitkin County  
 Aitkin County Health and Human Services  
 Aitkin County Public Health  
 Aitkin High School  
 Children's Mental Health Services  
 Churches  
 Committee for Awareness and Prevention of  
 Suicide  
 Counseling Center  
 Crisis Line  
 Cuyuna Regional Medical Center  
 Doctor's Offices  
 Health and Human Services  
 Hospitals  
 Jail  
 Lakeside Counseling  
 Mental Health Advisory Committee  
 Mental Health Services  
 Northern Pines  
 Northland Counseling  
 Northwoods Behavioral Health Services  
 Nystrom and Associates  
 Outpatient Services  
 Range Mental Health  
 Riverwood Clinics  
 Riverwood Healthcare Center  
 School System

### **Nutrition, Physical Activity & Weight**

Aitkin County Public Health  
 Aitkin TOPS Program  
 Anytime Fitness  
 Bone Builders  
 Cuyuna Regional Medical Center  
 Diabetes Prevention Program  
 Educational Services  
 Essentia Health  
 Farm2School Program

Farmer's Market  
 Fitness Centers/Gyms  
 Gramma's Pantry and Market  
 Hallett Center of Crosby  
 Hill City School  
 Karmady Yoga and Fitness  
 McGregor Fitness Center  
 MN Statewide Health Improvement  
 Partnership Program  
 Nutrition Services  
 Overeaters Anonymous  
 Parks and Recreation  
 Paulbeck's County Market  
 Riverwood Healthcare Center  
 Ruby's Pantry  
 School System  
 Silver Sneakers  
 Snap Fitness  
 TOPS (Taking Off Pounds Sensibly)  
 University of Minnesota  
 Weight Watchers  
 WIC

#### Oral Health

Aitkin County Public Health  
 Children's Dental Services  
 Dentist's Offices  
 McGregor Dental Clinic  
 Mobile Dental Clinic  
 Northland Smiles  
 River Oaks  
 River Oaks Dental

#### Respiratory Diseases

Riverwood Healthcare Center

#### Substance Abuse

AA/NA  
 Aitkin Alano Club  
 Aitkin County  
 Aitkin County Health and Human Services  
 Aitkin County Public Health  
 Central MN Adult and Teen Challenge  
 Churches  
 County Services  
 Doctor's Offices  
 Drug Court  
 Jail  
 Law Enforcement  
 Licensed Independent Drug Counselors  
 Mental Health Services  
 Northern Pines  
 Northland Counseling  
 Public Health  
 Riverwood Healthcare Center  
 Sobriety Court

#### Tobacco Use

Aitkin County Public Health  
 American Lung Association  
 Clearway  
 Educational Services  
 Hill City School  
 Law Enforcement  
 Local Partnerships  
 Public Health Law Center  
 Riverwood Healthcare Center  
 School System  
 Smoking Cessation Programs

# Appendix



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## Evaluation of Past Activities

### Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that RHCC would focus on developing and/or supporting strategies and initiatives to improve:

#### 1. **MENTAL HEALTH:** Maintain existing mental health and behavioral health services while exploring the feasibility of expanded services.

**Strategy #1: Implement Patient Centered Healthcare Home in Riverwood's three primary care clinics.**

- In June 2017, Riverwood achieved Health Care Home (HCH) certification through the Minnesota Department of Health. The certification represents Riverwood's commitment to improve both value and quality of care delivery.

**Strategy #2: Continue offering Health & Wellness Coaching for patients ongoing.**

- Riverwood continues to offer Health and Wellness coaching, which is available to all patients and community members of all ages. In addition, Riverwood offered a series of Mindfulness Based Stress Reduction courses in Aitkin and McGregor in 2016. In 2017, Riverwood expanded its wellness offerings by partnering with Aitkin Acupuncture.

**Strategy #3: Develop a core group to explore the feasibility of expanded mental health services.**

- Riverwood is fortunate to have a dedicated mental health provider who provides care at all three clinic locations. Extended mental health hours are offered three days per week from 7:00 am – 7:00 pm. The mental health provider is also available one day per week for provider consultations and case reviews. A RN Care Manager was hired to support the mental health provider and patient care coordination.

#### 2. **NUTRITION, PHYSICAL ACTIVITY & WEIGHT:** To improve the health of community residents by encouraging healthy eating, physical activity and weight management.

**Strategy #1: Continue to provide comprehensive wellness programming, including wellness coaching and worksite wellness.**

- Riverwood's health coaching services are available to both patients and employees. Annually, Riverwood offers their employees the opportunity to participate in a comprehensive wellness screening, which includes preventive lab work and

biometrics. Riverwood has an onsite fitness center for employees and provides free tobacco cessation options for staff and direct family members. Riverwood continues to provide ongoing wellness education through their quarterly Riverwood newsletter sent to Aitkin County and area residents.

**Strategy #2: Promote healthy eating and offer nutritious meal options.**

- Riverwood continues to offer a full service salad bar in their cafeteria. Additionally, Riverwood has collaborated with local farmers to offer a “Farm2Riverwood” meal program which incorporates locally grown food into their menu. Riverwood also provides support and sponsors the Aitkin Farmers Market.

**Strategy #3: Encourage and support opportunities for physical activity.**

- Riverwood has a community resource guide that is available in clinic reception areas, internal SharePoint site and public website. The resource guide will list community resources from wellness to transportation.

**Strategy #4: Train Riverwood staff to support patients on their health and wellness goals.**

- In 2017, Riverwood offered Motivational Interviewing training for both clinical and non-clinical staff. Motivational Interviewing is a patient-centered counseling method for eliciting behavior change by helping individuals explore and resolve ambivalence. Over 15 participants completed the comprehensive multi-day training which included providers, nursing staff, patient access and physical therapists. In addition, all RN Care Managers completed the Clinical Health Coach training program which builds upon motivational interviewing and goal setting techniques to support self-care.

**3. HEART DISEASE & STROKE: To help prevent heart disease and stroke and offer access to treatment.**

**Strategy #1: Offer wellness coaching to help individuals reduce their risk factors such as obesity, hypertension, diabetes, etc. for heart disease.**

- In addition to a health and wellness coach, Riverwood has hired multiple RN Care Managers to support patients with chronic conditions and care coordination. All RN Care Managers completed the Clinical Health Coach training program. In addition, two RNs recently became certified Tobacco Treatment Specialists to better support patients with tobacco cessation.

**Strategy #2: Help RHCC patients monitor blood pressure.**

- Riverwood continues to offer the home blood pressure monitoring program throughout all three clinics. As needed, patients can lease a blood pressure monitor

to take home and use for a specified time frame to improve self-care and blood pressure awareness.

**Strategy #3: Partner with Minneapolis Heart Institute to provide a community education seminar with a cardiology specialist presenter.**

- In 2018, Riverwood partnered with the Minneapolis Heart Institute to offer two seminars in Aitkin on Atrial Fibrillation with cardiologist Dr. Eric Fenstad. The seminars were attended by 75 community members. Both programs included an educational display of materials on heart health risk factors and lifestyle activities.

**Strategy #4: Participate in Healthy Northland's multi-year Public Health Community Wellness Grant from the Minnesota Department of Health, and the Centers for Disease Control and Prevention to prevent obesity, diabetes, heart disease and stroke.**

- Riverwood was an active participant in the Community Wellness Grant. The grant brought awareness to preventive screening and allocating resources to areas of need. Riverwood collaborated with health systems across the state to improve clinical best practices. The grant helped implement the home blood pressure monitoring program at all three Riverwood clinics.

**Strategy #5: Riverwood cares for Congestive Heart Failure (CHF) patients via a comprehensive program.**

- Riverwood has continued their comprehensive CHF program. All newly diagnosed CHF patients receive a customized care plan. If a CHF patient does not have access to a home scale, Riverwood will provide a home scale to ensure they can accurately monitor their weight and check for fluid retention.

**4. DIABETES: To help prevent diabetes and help those with diabetes to better manage this disease for better health.**

**Strategy #1: Offer National Diabetes Prevention Program, a 16-week class series to promote healthy lifestyles and weight management.**

- Riverwood continued to offer the Diabetes Prevention Program through 2018. However, due to declining attendance and barriers to engagement, Riverwood has discontinued the Diabetic Prevention Program course however will work to replace it with alternative program options to better meet patient needs.

**Strategy #2: Offer diabetes education to patients who are newly diagnosed with diabetes and existing patients.**

- Riverwood is an ADA recognized Diabetes Center. We offer diabetic classes to newly diagnosed diabetes patients as well as those previously diagnosed that need



additional education. Diabetic education classes are offered multiple times per year in both Aitkin and McGregor.

**Strategy #3: Use Minnesota Community Measures (MNCM) as a trusted source of health data to improve health and the patient experience.**

- Riverwood actively participates in MNCM's statewide reporting program. Annually, Riverwood uses MNCM metrics for quality benchmarking to ensure high quality care is achieved. In 2016, Riverwood invested in a new electronic health record system, Epic. Epic allows for greater transparency of care and use of registries to better manage population health.

**Strategy #4: Participate in Healthy Northland's multi-year Public Health Community Wellness Grant from the Minnesota Department of Health, and the Centers for Disease Control and Prevention to prevent obesity, diabetes, heart disease and stroke.**

- Riverwood was an active participant in the Community Wellness Grant. The grant provided an opportunity to network with outside organizations while focusing on initiatives to enhance patient care and population health. The grant helped implement a home blood pressure monitoring program at all three clinic locations.

**5. ACCESS TO HEALTHCARE SERVICES:** To support enhanced access to primary and specialty care services.

**Strategy #1: Recruit physicians and advanced practice providers to provide primary care across Riverwood's clinics.**

- Since 2016, Riverwood has welcomed multiple new family physicians and advanced practice practitioners to enhance access. New family physicians include Dr. Erik Bostrom, MD and Dr. Melissa Herbranson, MD. New advance practice practitioners include physician assistants Emily Hendrickson and Faith Nyberg and certified family nurse practitioners Kathy Halbert, Jen Burgos, Tracy Matros and Karen Barton-Sundeen.

**Strategy #2: Strengthen and expand specialty care services in Aitkin to meet identified healthcare needs of local residents.**

- In July 2017, Riverwood launched a clinic expansion and remodel project in Aitkin to further support patient-centered care, enhance access and allow for growth of current and new service lines. With an anticipated completion date of summer 2019, the project will provide the infrastructure for team-based care in the primary care clinic while expanding the rehabilitation and orthopaedic departments. In addition, the expansion project will provide space for a new dialysis center to be operated by CentraCare.

**Strategy #3: Riverwood will explore the feasibility of developing a local kidney dialysis unit in Aitkin.**

- The new kidney care and dialysis unit, to be operated by CentraCare, in Aitkin is estimated to open in summer 2019. As part of the partnership with CentraCare, Dr. Benjamin Parker, who is board certified in both internal medicine and nephrology, is providing local nephrology outreach services on a routine basis at Riverwood Healthcare in Aitkin. Dr. Parker will oversee the clinical direction of the new dialysis facility.

**Strategy # 4: Riverwood offers Financial Counseling for those underinsured or uninsured patients having difficulty paying their medical bills.**

- Riverwood's Financial Counselor is available at our hospital in Aitkin to address individual needs. The financial counselor may answer questions about comparing health insurance policies side by side and how to choose a deductible. Riverwood's Community Care and Uninsured Policy can be found on their website. In 2018, Riverwood also launched an Online Bill Pay method, which is available for all patients, for easier payment options.

**6. INJURY & VIOLENCE: To help prevent harm to individuals from injuries and violence.**

**Strategy #1: Offer Level III Trauma Care for victims of accidents and other trauma incidents**

- Riverwood is a certified Level III Trauma Center with a 24/7 emergency department and airlift service. Riverwood offers a wide range of specialty services with more than 40 physicians, surgeons and clinicians.

**Strategy #2: Promote awareness of community classes and campaigns**

- Riverwood is an active participant in the Coordination of Care initiative with Stratis Health. This initiative allowed for collaboration with local health systems and home health agencies to decrease readmissions across our region. Quarterly meetings are scheduled where best practices are shared between health systems and workgroups are formed to decrease gaps in care. A Transition of Care Collaborative was also formed locally between Riverwood and stakeholders such as assisted living, long-term care and home health agencies for ongoing efforts to improvement communication. Riverwood has worked with Aitkin County CARE to promote Fall Prevention classes while also supporting the local Toward Zero Deaths (TZD) traffic safety campaign.

**7. SUBSTANCE ABUSE:** To help inform and educate community members about drug abuse prevention and treatment.

**Strategy #1: Evaluate the feasibility of developing a program to offer Vivitrol to Riverwood patients suffering from heroin and opioid withdrawal**

- In 2018, Riverwood received a two year Opioid Abuse Community Prevention Project grant through Minnesota Department of Health to reduce unnecessary opioid dispensing and overuse. Riverwood established a multidisciplinary controlled substance care team consisting of physicians, RN Opioid Care Manager, mental health provider and a pharmacist. The team works cohesively with patients to develop a personalized care plan to avoid dependence and addiction to opioids. Multiple Medication Assisted Treatment (MAT) options have been implemented including the use of Suboxone and Vivitrol. A key member of MAT is the RN Opioid Care Manager who will support patient engagement through motivational interviewing and goal setting to promote behavior and lifestyle change. Riverwood is on pace to exceed their goal to decrease opioid prescriptions by 35% by 2020.

**Strategy #2: Riverwood will offer community education on prescription drug dependence and how it can be prevented.**

- Riverwood is a part of a county-wide Opioid Task Force which involves local law enforcement and public entities to increase awareness and decrease opioid abuse.

**Strategy #3: Riverwood will collaborate with other health systems when possible to offer provider education on prescription opioid drug dependence and how it can be prevented.**

- Riverwood's multidisciplinary controlled substance care team attends weekly ECHO webinars which discuss opioid case reviews and best practices throughout the state. These webinars promote ongoing education, awareness and collaboration for participants. ECHO webinars are hosted by CHI St. Gabriel's Health.