2026-2028 COMMUNITY HEALTH NEEDS ASSESSMENT

Kanabec & Pine Counties, Minnesota

Sponsored by

welia HEALTH

2025-0446-02

Prepared by
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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in service area of Welia Health. 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.

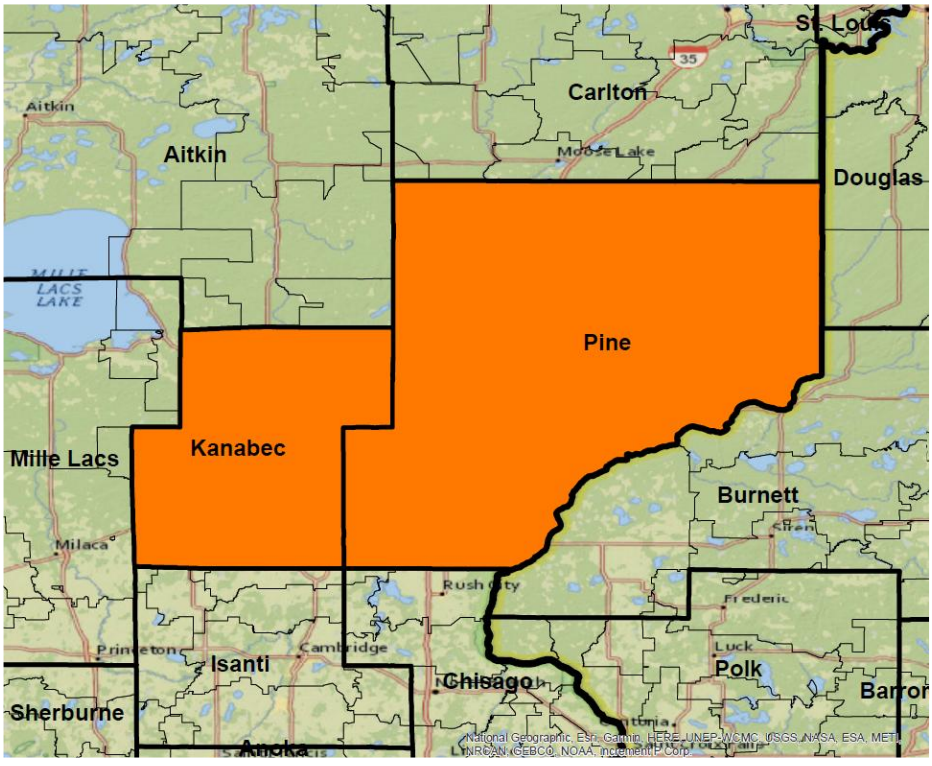
This assessment was conducted on behalf of Welia Health by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

Quantitative data input for this assessment 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 among community leaders gathered through an Online Key Informant Survey.

Community Defined for This Assessment

The study area for this effort (referred to as “Service Area” in this report) includes Kanabec and Pine counties in Minnesota. This community definition, determined based on the residence of most recent patients of Welia Health, is illustrated in the following map.



Online Key Informant Survey

To solicit input from community key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Welia Health; 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, 37 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	2
Public Health Representatives	7
Other Health Providers	13
Social Services Providers	3
Other Community Leaders	12

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Family Pathways
- First Citizen's Bank
- Kanabec County Community Health
- Kanabec County Veteran's Services
- Lake Street Family Dental
- Lakes and Pines, CAC
- Mora Public Schools
- Ogilvie Public Schools
- Pine City Area Chamber of Commerce
- Pine City Public Schools
- Pine County Public Health
- Seven County Senior Federation
- St. Clare Living Community of Mora
- Welia Health

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.

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- 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, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- 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

Note that data are not available for both counties for all measures (see footnotes in the charts throughout this report).

Benchmark Data

Minnesota and National Data

Where possible, state and national data are provided as an additional benchmark against which to compare local findings.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

For the purpose of this report, “significance” of secondary data indicators (which might be subject to reporting error) is determined by a 15% variation from the comparative measure.

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 medical conditions that are not specifically addressed.

Public Comment

Welia Health 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, Welia Health 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. Welia Health 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 nonprofit 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 Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	21
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	81
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	11
Part V Section B Line 3h The process for consulting with persons representing the community's interests	7
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	86

SUMMARY OF FINDINGS

Significant 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. From these data, opportunities for health improvement exist in the service 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 key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Access to Primary Care Physicians
CANCER	▪ Cancer Deaths ▪ Lung Cancer Incidence
DISABLING CONDITIONS	▪ Disability Prevalence
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ○ Motor Vehicle Crash Deaths
MENTAL HEALTH	▪ Suicide Deaths ▪ Mental Health Provider Ratio ▪ Key Informants: *Mental Health* ranked as a top concern.
ORAL HEALTH	▪ Access to Dentists
RESPIRATORY DISEASE	▪ Lung Disease Deaths
SUBSTANCE USE	▪ Excessive Drinking ▪ Key Informants: Substance Use ranked as a top concern.
TOBACCO USE	▪ Cigarette Smoking

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part 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 Use
3. Tobacco Use
4. Oral Health
5. Cancer
6. Disabling Conditions
7. Injury & Violence
8. Access to Health Care Services
9. Respiratory Diseases

Hospital Implementation Strategy

Welia Health 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 the prior CHNA can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

The following tables provide an overview of indicators in the service area, grouped by health topic.

Reading the Summary Tables

- In the following tables, service area results are shown in the larger, gray column.
- The columns to the left of the Service Area column provide comparisons among the two counties, identifying differences for each as “better than” (☀), “worse than” (☁), or “similar to” (⛅) the opposing area.
- The columns to the right of the Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the service area compares favorably (☀), unfavorably (☁), or comparably (⛅) to these external data.

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

SOCIAL DETERMINANTS	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	0.2	0.1	0.1	2.2	3.9	
Population in Poverty (Percent)	9.8	10.5	10.2	9.2	12.4	8.0
Children in Poverty (Percent)	9.2	11.8	10.8	10.6	16.3	8.0
No High School Diploma (Age 25+, Percent)	8.8	8.6	8.7	6.2	10.6	
Unemployment Rate (Age 16+, Percent)	9.5	9.1	9.3	3.9	4.3	
Housing Exceeds 30% of Income (Percent)	24.6	23.4	23.8	24.4	29.3	25.5
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

OVERALL HEALTH	DISPARITY BETWEEN COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
"Fair/Poor" Overall Health (Percent)	17.6	16.8	17.1	14.4	17.9	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

ACCESS TO HEALTH CARE	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Uninsured (Adults 18-64, Percent)	7.7	7.9	7.8	6.2	11.2	7.6
Uninsured (Children 0-18, Percent)	4.9	3.9	4.3	3.3	5.1	7.6
Routine Checkup in Past Year (Percent)	71.7	73.4	72.8	71.9	76.1	

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Primary Care Doctors per 100,000	99.8	31.2	55.7	138.0	116.6	

Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.

better similar worse

CANCER	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Cancer Deaths per 100,000	248.8	269.1	261.9	178.5	182.7	
Cancer Incidence per 100,000	469.6	502.0	490.2	480.0	444.4	
Female Breast Cancer Incidence per 100,000	92.2	133.1	117.6	140.4	129.8	
Prostate Cancer Incidence per 100,000	101.6	108.9	106.4	117.0	113.2	
Colorectal Cancer Incidence per 100,000	38.2	36.9	37.4	36.1	36.4	
Lung Cancer Incidence per 100,000	85.3	74.0	78.0	54.4	53.1	
Breast Cancer Screening in Past 2 Years (Women 50-74, Percent)	76.9	75.0	75.7	78.5	76.5	80.5
Cervical Cancer Screening in Past 3 Years (Women 21-65, Percent)	80.6	81.8	81.4	82.2	82.8	84.3
Colorectal Cancer Screening (Age 45-75, Percent)	67.1	66.1	66.5	68.7	66.3	74.4

Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.

better similar worse

	DISPARITY AMONG COUNTIES			SERVICE AREA vs. BENCHMARKS		
DIABETES	**Kanabec County**	**Pine County**	**Service Area**	**vs. MN**	**vs. US**	**vs. HP2030**
Diabetes Prevalence (Percent)	12.0	12.7	**12.4**	10.0	12.0	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

	DISPARITY AMONG COUNTIES			SERVICE AREA vs. BENCHMARKS		
DISABLING CONDITIONS	**Kanabec County**	**Pine County**	**Service Area**	**vs. MN**	**vs. US**	**vs. HP2030**
Disability Prevalence (Percent)	16.0	17.7	**17.1**	11.4	13.0	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

	DISPARITY AMONG COUNTIES			SERVICE AREA vs. BENCHMARKS		
HEART DISEASE & STROKE	**Kanabec County**	**Pine County**	**Service Area**	**vs. MN**	**vs. US**	**vs. HP2030**
Heart Disease Deaths per 100,000	198.8	235.3	**222.3**	153.0	207.2	
Stroke Deaths per 100,000	53.7	51.4	**52.2**	41.4	48.3	
High Blood Pressure Prevalence (Percent)	35.4	38.1	**37.1**	29.8	32.7	42.6
High Blood Cholesterol Prevalence (Percent)	34.0	35.3	**34.8**	30.9	35.5	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Low Birthweight (Percent of Births)	5.8	7.1	6.6	7.0	8.4	
Teen Births per 1,000 Females 15-19	16.4	14.8	15.4	9.4	15.5	

Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000	75.6	93.3	87.0	61.6	63.3	
Motor Vehicle Crash Deaths per 100,000	24.4	18.3	20.4	8.4	12.8	

Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.

better similar worse

MENTAL HEALTH	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Suicide Deaths per 100,000	24.4	19.6	21.3	14.3	14.5	
Mental Health Providers per 100,000	237.0	193.9	209.3	315.7	319.4	

Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Fast Food Restaurants per 100,000	31.2	52.0	44.5	68.0	80.0	
Population With Low Food Access (Percent)	11.9	12.0	12.0	27.4	22.2	
No Leisure-Time Physical Activity (Percent)	17.0	19.2	18.4	17.2	19.5	21.8
Obese (Percent)	37.8	39.4	38.8	33.9	33.3	36.0
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

ORAL HEALTH	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Dental Visit in Past Year (Percent)	62.2	64.4	63.6	67.5	63.9	45.0
Dentists per 100,000	56.1	38.1	44.5	69.5	66.7	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

RESPIRATORY DISEASE	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
	Kanabec County	Pine County		vs. MN	vs. US	vs. HP2030
Lung Disease Deaths per 100,000	72.0	69.7	70.5	38.2	44.9	
Asthma Prevalence (Percent)	10.3	10.2	10.2	10.0	9.9	
COPD Prevalence (Percent)	7.8	7.5	7.6	5.6	6.8	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
SEXUAL HEALTH	**Kanabec County**	**Pine County**		**vs. MN**	**vs. US**	**vs. HP2030**
HIV Prevalence per 100,000	64.3	105.5	**90.9**	196.9	386.6	
Chlamydia Incidence per 100,000	198.8	228.5	**218.0**	379.5	492.2	
Gonorrhea Incidence per 100,000	24.1	79.5	**59.8**	134.5	179.0	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
SUBSTANCE USE	**Kanabec County**	**Pine County**		**vs. MN**	**vs. US**	**vs. HP2030**
Excessive Drinking (Percent)	24.7	22.5	**23.2**	22.6	19.4	
Drug Overdose Deaths per 100,000			**27.4**	20.8	29.1	
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

	DISPARITY AMONG COUNTIES		Service Area	SERVICE AREA vs. BENCHMARKS		
TOBACCO USE	**Kanabec County**	**Pine County**		**vs. MN**	**vs. US**	**vs. HP2030**
Cigarette Smoking (Percent)	18.3	16.7	**17.3**	13.6	12.9	6.1
	Note: In the section above, the two counties are compared against each other. Throughout these tables, a blank or empty cell indicates that data are not available or not reliable for this indicator.			better	similar	worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2019-2023)

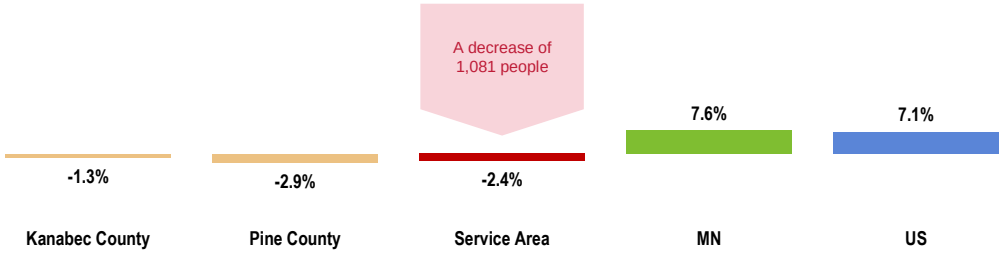
	TOTAL POPULATION	TOTAL LAND AREA (SQUARE MILES)	POPULATION DENSITY (PER SQUARE MILE)
Kanabec County	16,261	521.61	31
Pine County	29,411	1,411.34	21
Service Area	45,672	1,932.95	24
Minnesota	5,713,716	79,631.47	72
United States	332,387,540	3,533,298.58	94

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

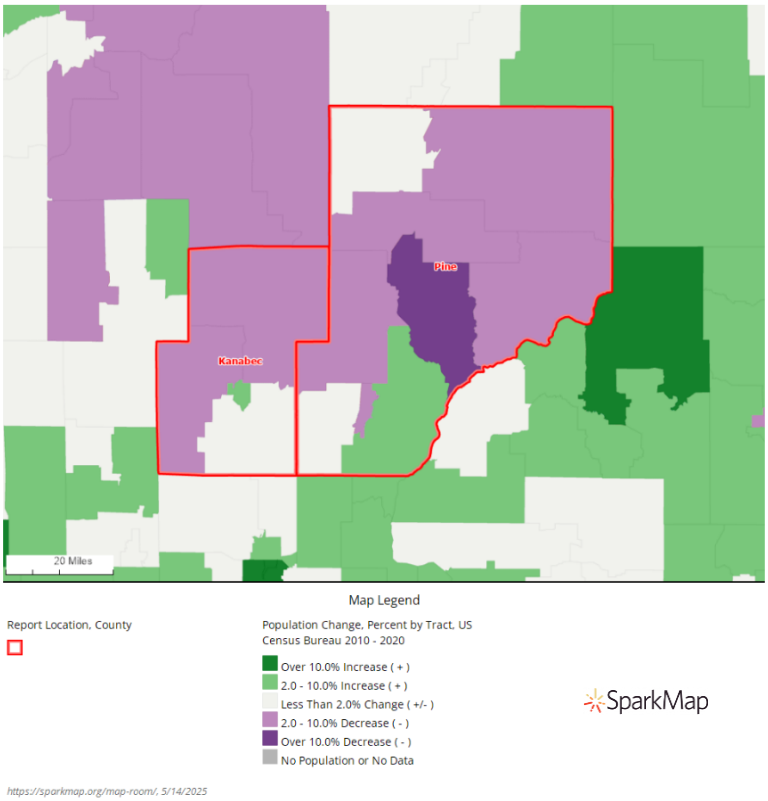
Population Change

A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources. The following chart and map illustrate the changes that have occurred in the service area between the 2010 and 2020 US Censuses.

Change in Total Population
(Percentage Change Between 2010 and 2020)

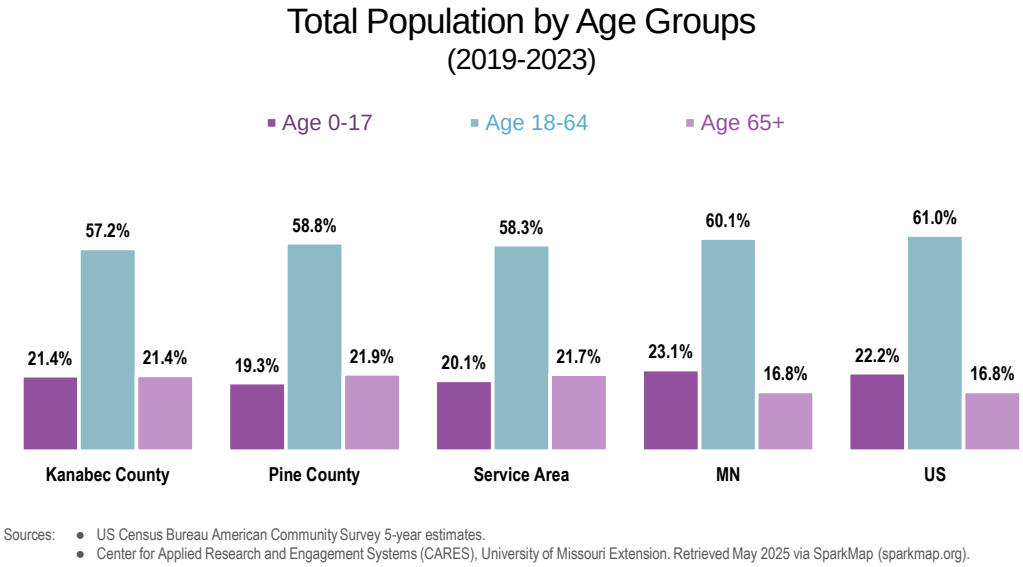


Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).



Age

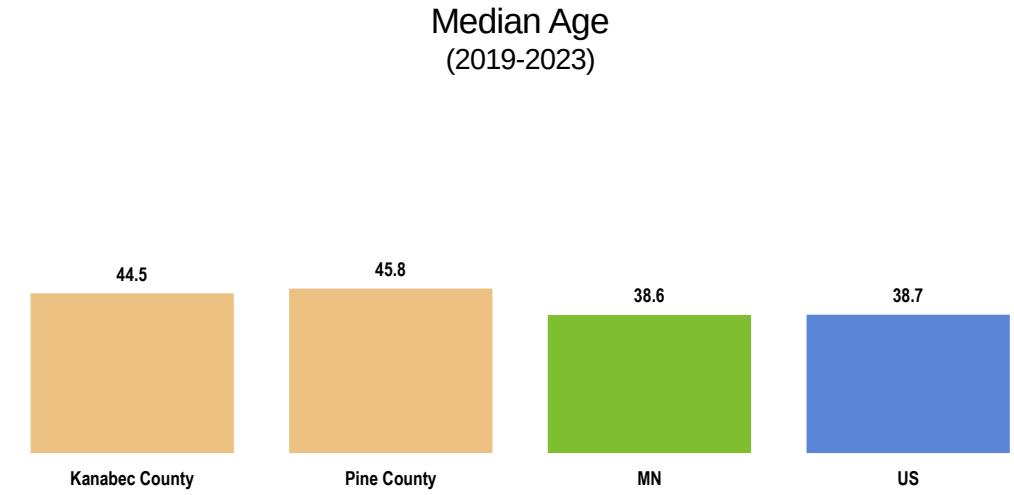
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

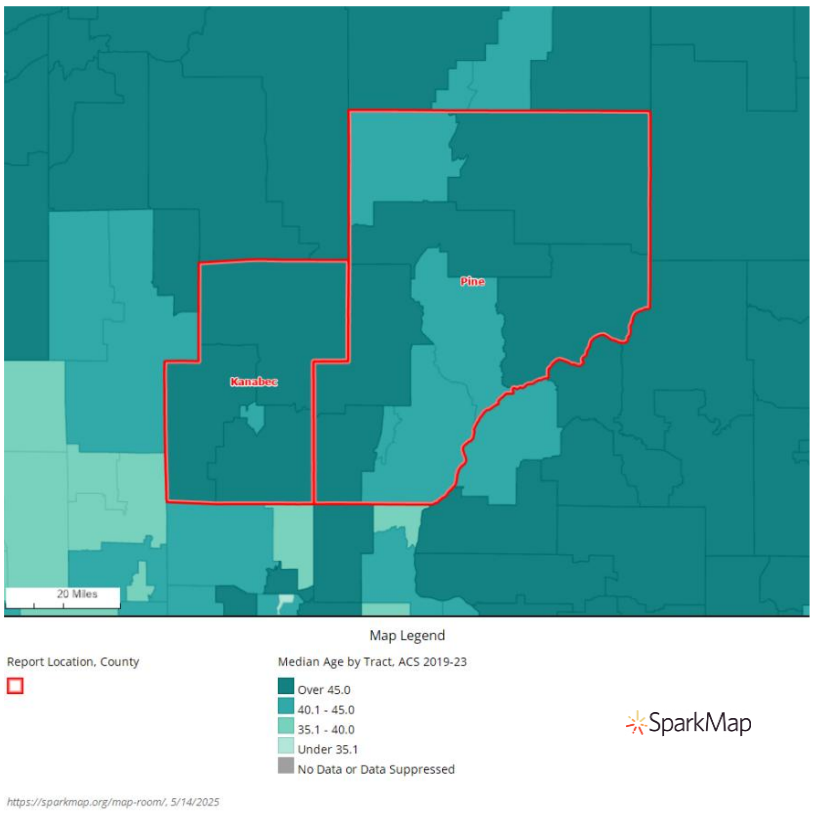
Median Age

Note the median age of our population, relative to state and national medians.



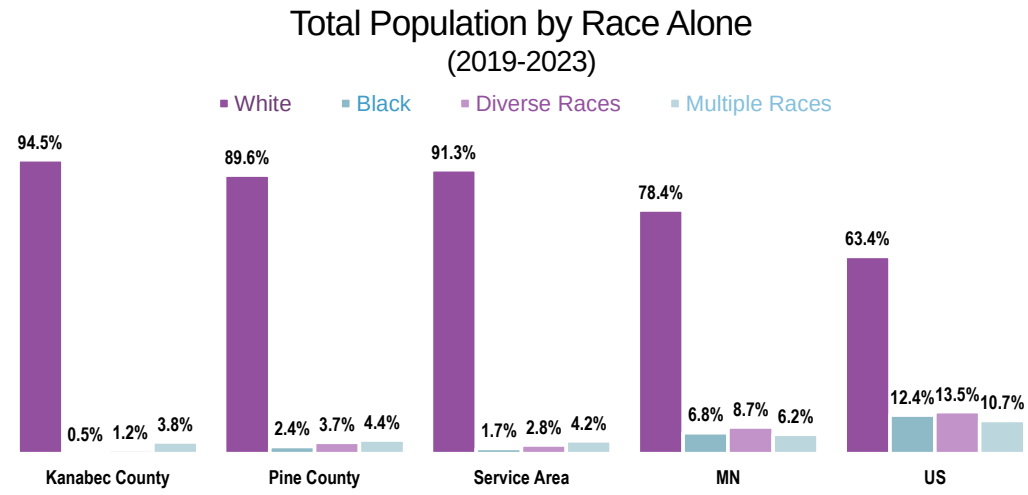
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Note:
- A composite median is not available for the Service Area as a whole.



Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. “Race Alone” reflects those who identify with a single race category — people who identify their origin as Hispanic, Latino, or Spanish may be of any race.



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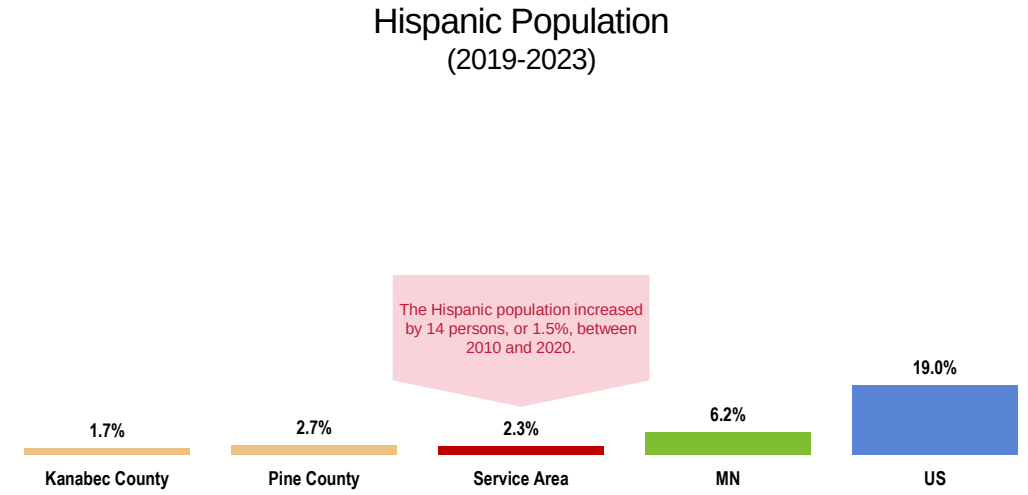


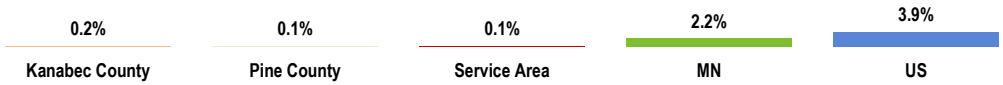
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Linguistic Isolation

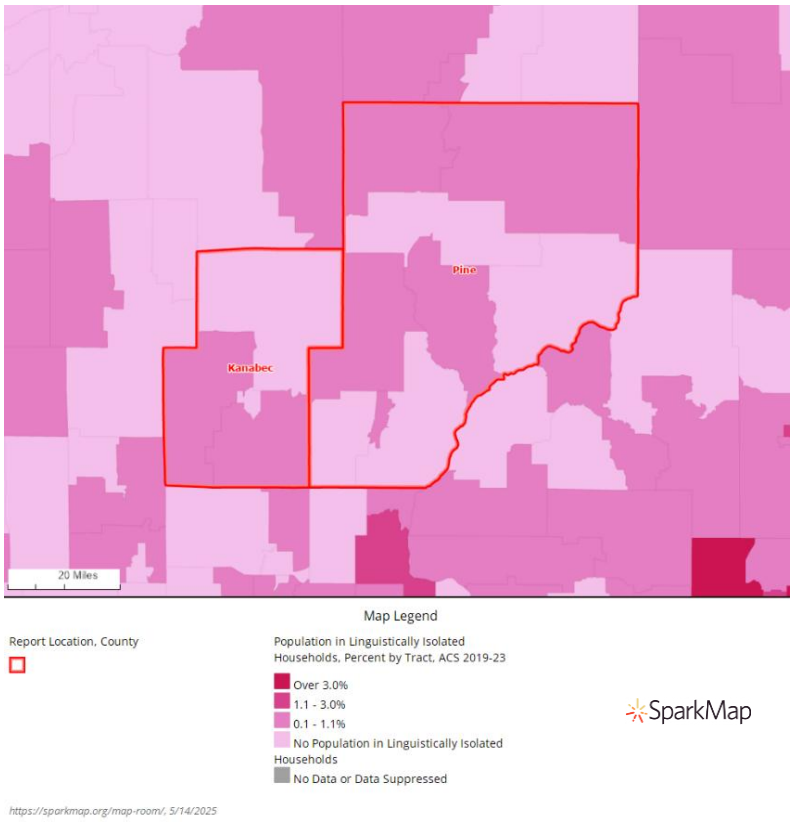
This indicator reports the percentage of the population age 5 years and older who live in a home in which: 1) no person age 14 years or older speaks only English; or 2) no person age 14 years or older speaks a non-English language but also speaks English “very well.”

Linguistically Isolated Population
(2019-2023)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.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."



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

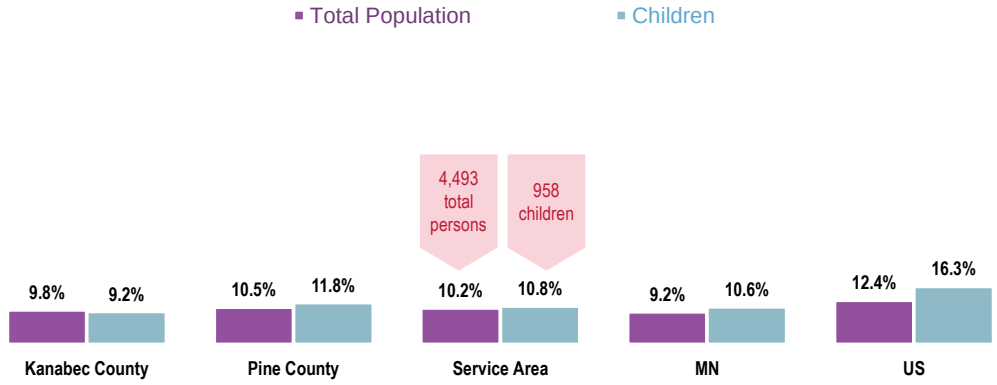
Poverty

Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to accessing health services, healthy food, and other necessities that contribute to health status. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well as the percentage of children in the service area living in poverty, in comparison to state and national proportions.

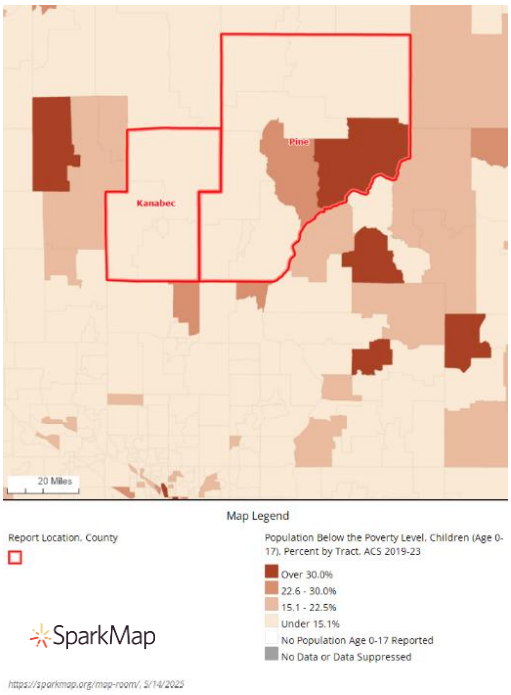
Percent of Population in Poverty

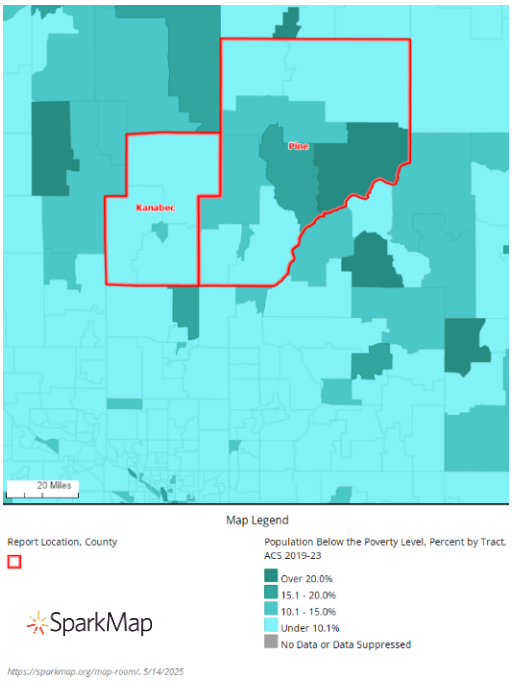
(2019-2023)

Healthy People 2030 = 8.0% or Lower



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

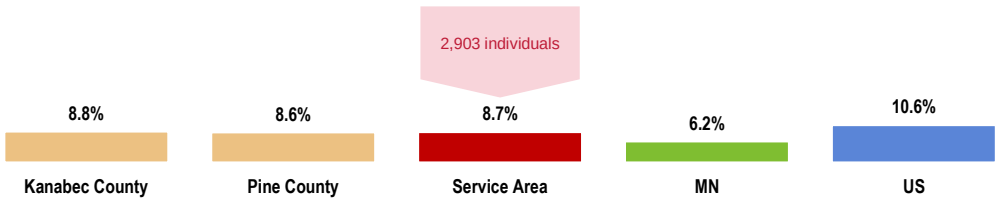




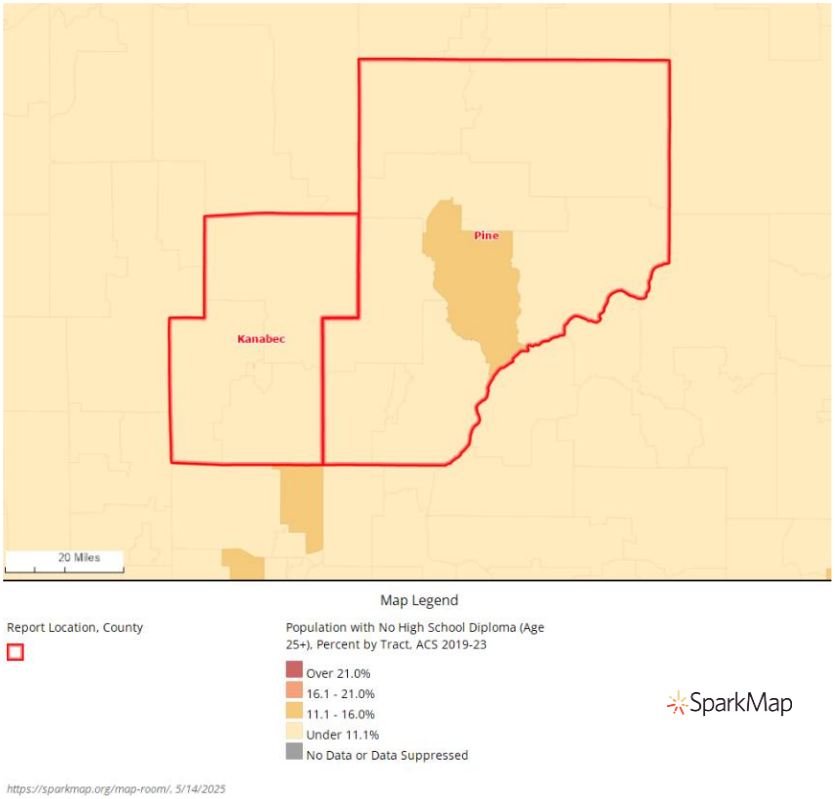
Education

Education levels are reflected in the proportion of our population age 25 and older without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes.

Population With No High School Diploma
(Adults Age 25 and Older, 2019-2023)



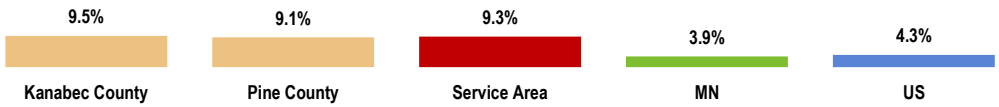
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).



Employment

Changes in unemployment rates in the service area over the past several years are outlined in the following chart. This indicator is relevant because unemployment creates financial instability and barriers to accessing insurance coverage, health services, healthy food, and other necessities that contribute to health status.

Unemployment Rate
(March 2025)



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

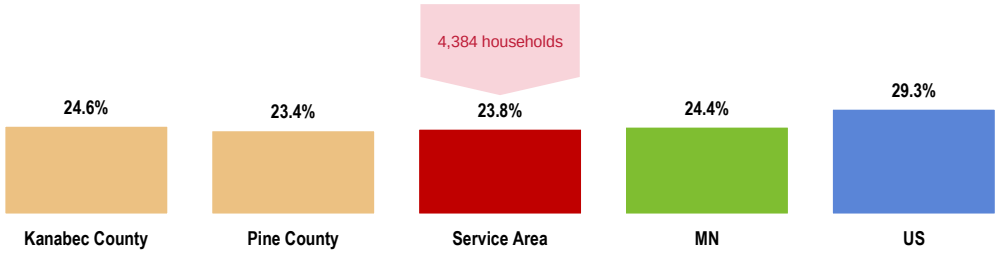
Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Housing Burden

"Housing burden" reports the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income.

The following chart shows the housing burden in the service area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.

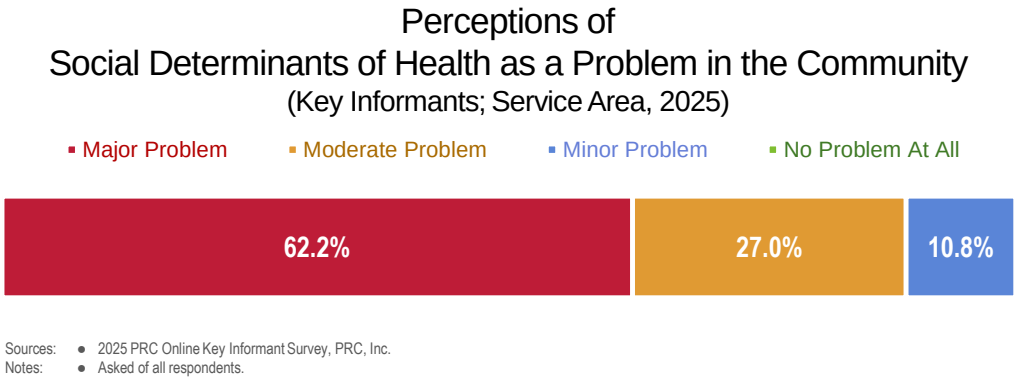
Housing Costs Exceed 30 Percent of Household Income
(Percent of Households; 2019-2023)
Healthy People 2030 = 25.5% or Lower



Sources:
- US Census Bureau, American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Social Determinants of Health

Key informants' ratings of the severity of *Social Determinants of Health* as a concern in the service area are outlined below.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Housing

> Lack of resources such as housing, transportation, specialty. — Social Services Provider
>
> When a person or family has housing issues they will likely not establish health care with a physician. They may only be seen for emergent/urgent medical needs and their medical records vary across other communities. When a family has affordable housing in a community with a healthcare system, they are more likely to establish routine care. Routine care can help prevent crisis and emergency needs. Income of course directly impacts affordable housing. Education is disrupted when families can not afford to live in an area, children are taken from one school district to the next. Some children can be placed in several schools over one school year, which can be devastating to their development. — Community Leader
>
> Housing is virtually unaffordable for those who do not have a two-income household or do not make upwards of $65k per year. Housing availability is also limited. Those that need income-based housing are waiting years for an opportunity to have their own space. Income/education. The ability of many of our residents to procure jobs that pay $65+ a year is limited. Many travel 30+ miles to find work that pay a wage that is livable. Those that do work in the community are government employees — county, city, school or work for healthcare (Welia, Essentia, Fairview). Environment. In Mora the walking paths are not updated, limited in distance and availability. While Pine City proper offers more walking and paths, the counties as a whole are not easy to travel without a vehicle. Discrimination. There is a stigma in rural communities that runs deep - race, ethnicity, education, mental/physical health. — Public Health Representative
>
> Lack of affordable housing for all income levels. This detrimentally affects the health of lower and moderate-income households that either have to commute long distances for their job or are unsheltered because no housing is available. — Community Leader
>
> Lack of affordable housing, lack of businesses hiring, lack of places willing to hire youth, age discrimination. — Public Health Representative
>
> We have very limited access to funds for housing. Along with that, we have limited jobs, limited resources and limited funding to provide assistance to those in need. — Public Health Representative
>
> We definitely have an affordable housing problem in our two counties that affects the "great middle". Economic stress and uncertainty can lead to challenges to mental health, substance abuse, addictive behaviors, lack of access to healthy foods, exercise and social supports. Among working residents without good health insurance, I see a tradition of NOT going to see health professionals on a regular basis due to cost. I would rather see across-the-board access to preventative care; not dependent on insurance status. On the bright side, our lowest income community members are likely to qualify for Medical Assistance or MinnesotaCare, and are perhaps likelier to see professionals and receive care. Ideally such public programs that leave those families and individuals with more income to spend on healthier behaviors. Students now have healthy free meals at school, which is a great thing. Our higher income/higher education residents may not perceive the barriers others face. — Community Leader

> Affordable housing is at a premium. And some homes that are rentals are in poor condition. People pay too much for heat then. We need more employment opportunities that pay more than a minimum wage. — Community Leader
>
> Lack of housing, cost of housing, cost of living, schools not supporting children, lack of commitment to support schools from community members. — Community Leader
>
> Housing is growing harder to find at a reasonable price with inflation rising and pay staying steady. Along with availability, specifically to those who make less and/or are younger in age and cannot afford mortgage or rental costs even when working full time. I think many people travel to the metro or St. Cloud to find higher paying work, it is hard for rural counties/communities to compete with other's pay. Education I feel the same, people travel. Luckily Pine Technical College and Anoka Ramsey - Cambridge are a close, and very affordable option for post-high school education. I think many of these things tie back to funding. — Community Leader

Income/Poverty

> Kanabec and Pine are two of the poorest counties in the state. We frequently have patients in the healthcare system who struggle with housing, income, food supply, lack of education, etc.. — Health Provider
>
> Many of our patients we serve at Welia report difficulty meeting basic needs for food, clothing, shelter, transportation, which negatively impacts their mental health. — Health Provider
>
> Kanabec County is a low-income community. This can be a barrier when it comes to finding a place to live, getting a good job, continuing one's education, and being able to purchase a vehicle to get to work. — Community Leader
>
> Poor, isolation, lack of transportation, elderly, lack of support. — Health Provider
>
> Income and housing — Social Services Provider
>
> Lower median income. Lower educational status. Very limited homeless resources. Housing is limited, especially low income housing. Higher rates of substance use including tobacco. Will be interesting to see what happens with marijuana legalization. This will undoubtedly contribute negatively in this regard. Higher rates of methamphetamine use. There are resources for opioid use disorder, but less for alcohol, tobacco, and drug use disorders. — Physician
>
> One of the poorest counties in the state, trouble getting rides and medicine. — Physician
>
> Low wage jobs in community. Lack of childcare options make it difficult to work. People live in homes that are aging and need repair, may have mold or other issues that lead to health issues. Aging community - lack of housing. — Public Health Representative
>
> This is a low-income area that faces the typical bouquet of health and health care related issues associated with socio-economic determinates of health. — Health Provider

Transportation

> We live in a poor community that has poor access via affordable transportation options. Housing is not available or affordable options for individuals and families. Wages are poor in the local area and require people to drive distances for a living wage. — Health Provider
>
> We have limited transportation resources, limited income for our local population, lack of food support, local food shelves are gross with rotten food per patients. Stigma that comes along with getting "labeled" is also a concern for patients. Insurance issues since COVID-19 insurance have lapsed causing a large gap of services that were provided during the pandemic and since stopped. — Social Services Provider

Unhoused Population

> Homeless teens due to family issues. This places them at serious risk. — Community Leader
>
> I am not sure if homelessness is a health issue, but it may have resulted in them due to a lack of resources or opportunities available to them in the community. There is a growing population of homeless in the area and seems to be continuing to grow. — Health Provider

Childcare

> Childcare. There is not enough to go around at an affordable cost for working class adults to afford. — Community Leader

HEALTH STATUS

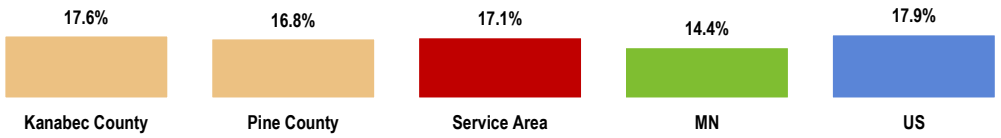
OVERALL HEALTH STATUS

The following indicator provides a relevant measure of overall health status in the service area, noting the prevalence of residents' "fair" or "poor" health evaluations. While this measure is self-reported and a subjective evaluation, it is an indicator which has proven to be highly predictive of health needs.

The CDC's Behavioral Risk Factor Survey, from which these data are derived, asked respondents:

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"

Adults With "Fair" or "Poor" Overall Health
(2022)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

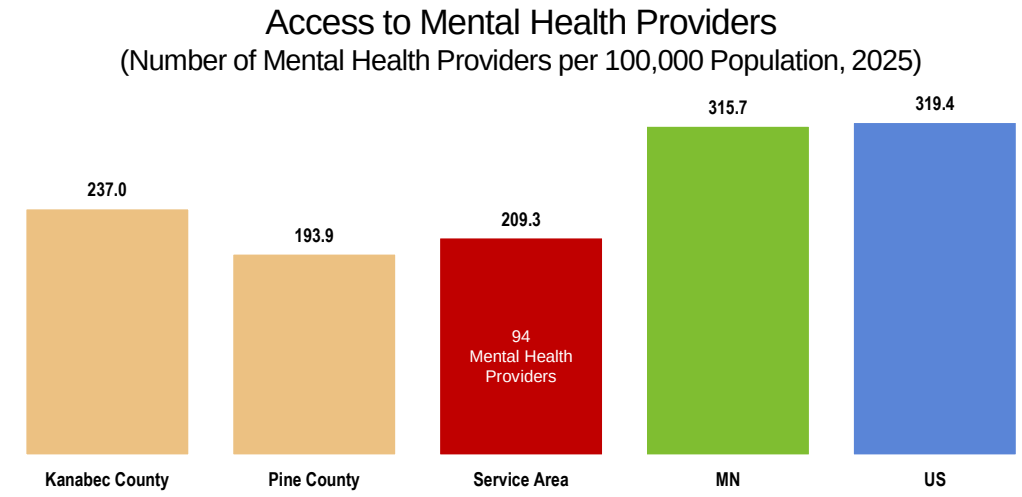
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care.

Note that this indicator only reflects providers practicing in the service area and residents in the service area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

The data below show the number of mental health care providers in the service area relative to the service area population size (per 100,000 residents). This is compared to the rates found statewide and nationally.

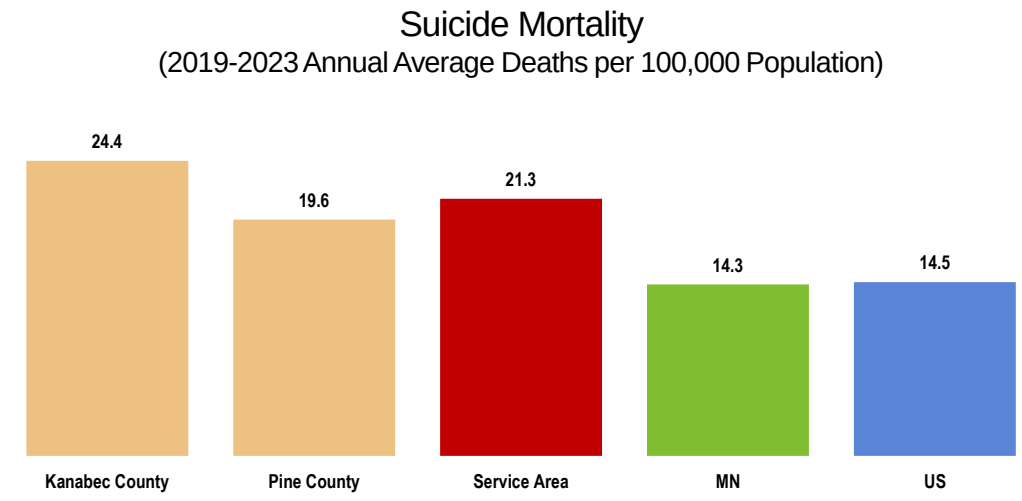


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Suicide

The following reports the rate of death in the service area due to intentional self-harm (suicide) in comparison to statewide and national rates. This measure is relevant as an indicator of poor mental health.

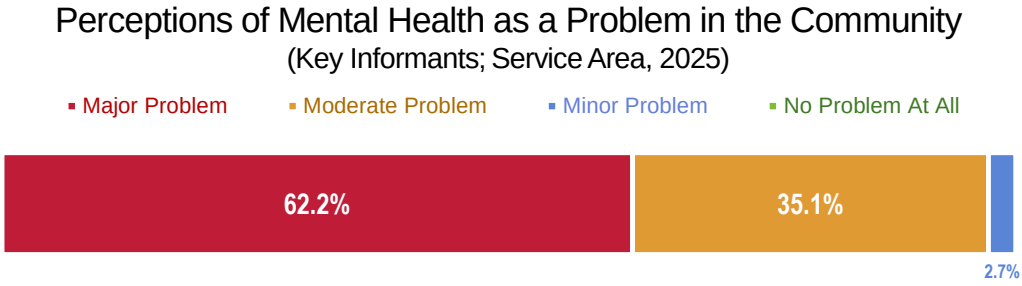


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

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.

Key Informant Input: Mental Health

Key informants' ratings of the severity of *Mental Health* as a concern in the service area are outlined below.



Sources:
- 2025 PRC Online Key Informant Survey, PRC, 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

> Lack of resources, wanting to be free of judgment or bias, and low health literacy. — Health Provider
>
> Lack of access to mental health management, medications, and services, especially for those experiencing severe mental health needs. — Community Leader
>
> Access to mental health resources. — Community Leader
>
> Lack of resources. — Health Provider
>
> Getting in to see a mental health professional in a timely manner can be very challenging, which can only cause more issues. Many people do not have insurance coverage for mental health appointments and cannot afford to go. — Community Leader

> Lack of resources. — Health Provider
>
> I believe the biggest issue with Mental Health is access to care in a timely manner. If a person is in crisis and is admitted to the ER for observation and then transferred, follow-up care and recovery services fall the way side. I believe a NAVIGATOR would be very beneficial to those who have mental health issues. For example the NAVIGATOR can assist the person in recovery by finding a counselor/therapist/etc. The NAVIGATOR can assist with med management, many persons who have new diagnosis or have been in crisis can be overwhelmed with new medications, therapies, etc. Besides dealing with the aftermath of a crisis, they also have a life which may include children, work, etc. If our community had at least one (I believe more would be very helpful) to help persons navigate mental health it would be very beneficial to our community. The NAVIGATOR could assist the hospital, social services, veteran services, elderly services as it relates to mental health. — Community Leader
>
> Access to mental health services is limited. There is only one Medicare therapist for Kanabec County. Additionally, there are very limited services for pediatric mental health. — Health Provider
>
> There is a lack of mental health support in the area, and there is still a stigma with mental health that is causing a barrier to receiving care. We need to normalize mental health care and make it a priority. — Health Provider
>
> Timely access. — Public Health Representative
>
> Lack of resources and quality care options - especially for the youth. There may be one or two providers in the Mora area that see youth through teenagers. Pine City has slightly more options but those resources/providers see people from a large swath. Juvenile justice has a difficult time finding places that can take those that have more serious mental health needs. It's no secret that mental health beds are virtually unavailable or the wait time is too long and the process too cumbersome. There are other barriers - stigma, financial, and access (due to transportation). — Public Health Representative
>
> Access to services and support. — Public Health Representative
>
> Currently when referrals are being placed patients will have anywhere from a couple weeks to months for counseling support. Psychiatry medication management has become easier to access. Group home level of care is also increasing those patients are high needs and complex. In our area we do not have the ability to meet their needs. We need more complex case management/psychiatry resources. — Social Services Provider
>
> Challenging group homes that are unable to care for these patients. Lack of close available beds. Many times, patients are sent to North Dakota for placement. — Social Services Provider
>
> Access to mental health services. — Health Provider

Follow-Up/Support

> People with mental health issues have hardly any assistance for anything beyond a diagnosis or emergency threat. They may get immediate help when needed, but aftercare is completely lacking. — Public Health Representative
>
> Mental health support groups and crisis services statewide, other than the Emergency Room, seem to be lacking. — Community Leader

Access for Medical Assistance (MA) Patients

> Access to a variety of mental health providers who bill their insurance i.e. Medicare. Many people are not eligible for MA but cannot afford co-pays or deductibles. Mental health services are ongoing and often need to be routine. — Health Provider

Lack of Providers

> There aren't enough providers, especially for lower-income households seeking mental health appointments. There is also ongoing stigma felt by some that keeps them from seeking a diagnosis and/or treatment. — Community Leader

Affordable Care/Services

> Not being able to afford mental health care. I feel like there needs to be more crisis/first response units for mental health concerns. — Social Services Provider

Denial/Stigma

> Stigma. People do not seek help. Inability to access services because of insurance restrictions or inability to pay. — Public Health Representative

Incidence/Prevalence

> Mental health situations are prevalent in Kanabec County. — Community Leader

Parental Influence

> Parent mental health is interfering with student education. — Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

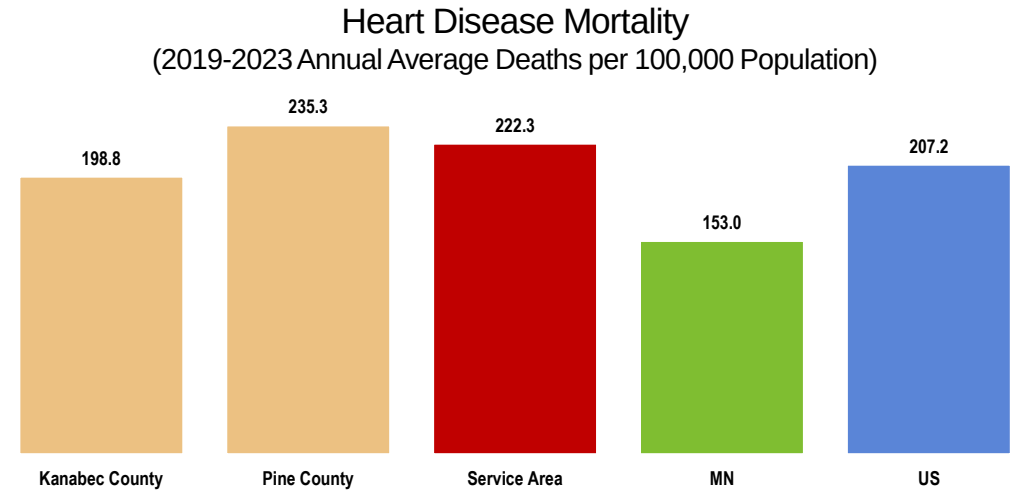
Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Heart Disease Deaths

Heart disease is a leading cause of death in the service area and throughout the United States. The chart that follows illustrates how our mortality rate compares to rates in Minnesota and the US.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
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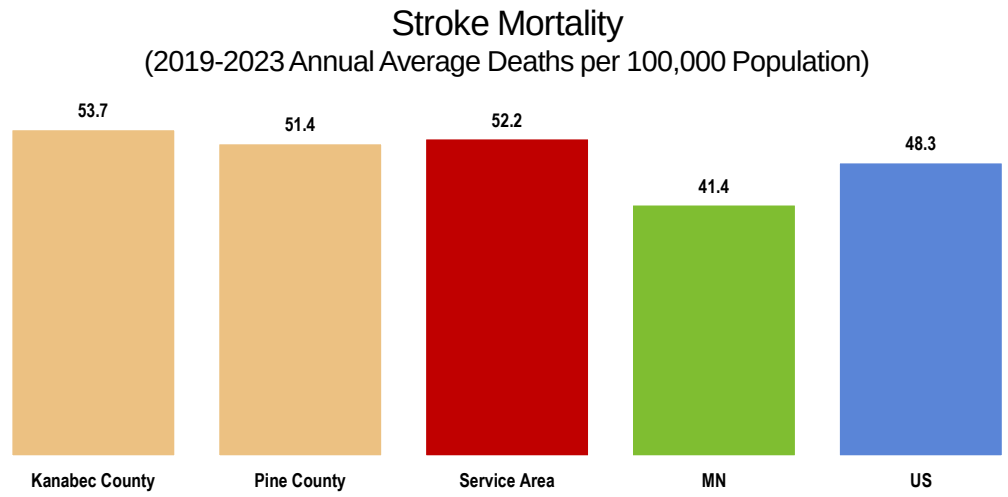
- Rates are per 100,000 population.

Stroke Deaths

Stroke, a leading cause of death in the service area and throughout the nation, shares many of the same risk factors as heart disease. Outlined in the following chart is a comparison of stroke mortality locally, statewide, and nationally.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
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- Rates are per 100,000 population.

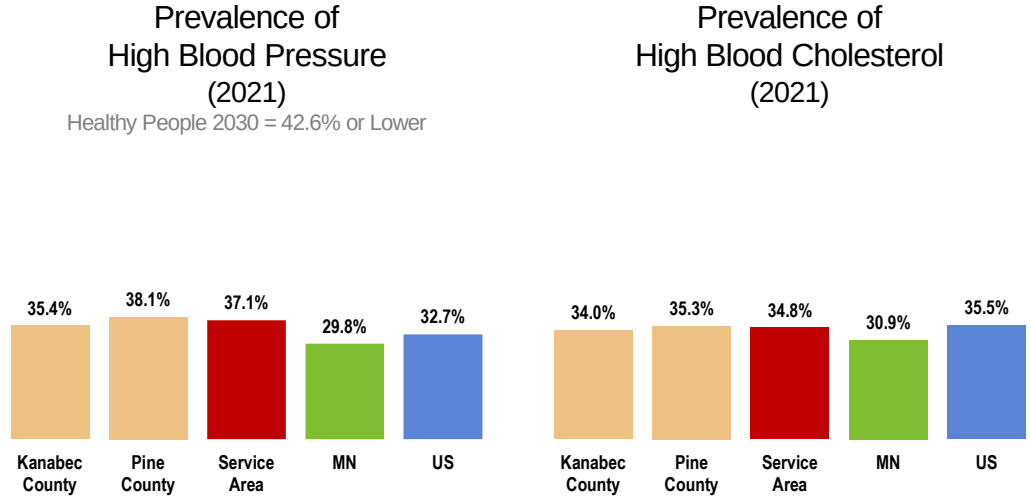
Blood Pressure & Cholesterol

The following chart illustrates the percentages of service area adults who have been told that they have high blood pressure or high cholesterol, known risk factors for cardiovascular disease.

The CDC's Behavioral Risk Factor Survey asked:

"Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?"

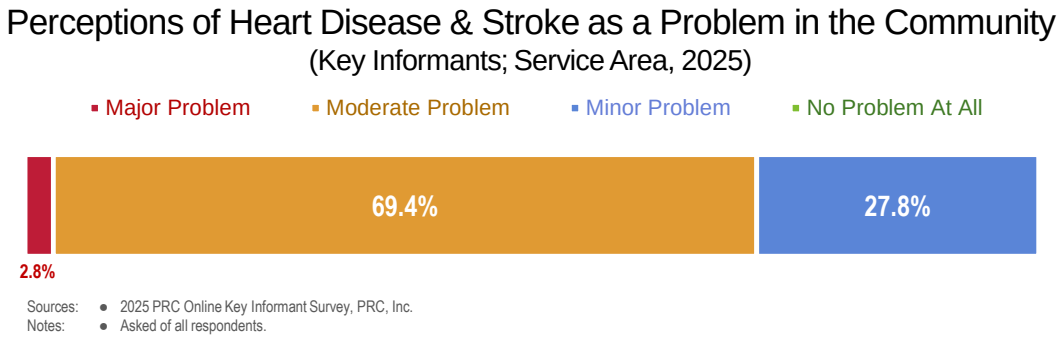
"Have you ever been told by a doctor, nurse, or other health professional that your cholesterol is high?"



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Heart Disease & Stroke

Outlined below are key informants' levels of concern for *Heart Disease & Stroke* as an issue in the service area.



Top Concerns

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

Affordable Medications/Supplies

> These diseases are complex and often result in multiple medications, with high health care high costs, and require frequent education from health care professionals. We do not have regular access to cardiology or neurology locally and often patients need to wait to be seen or are asked to follow-up in the cities. — Health Provider

CANCER

ABOUT CANCER

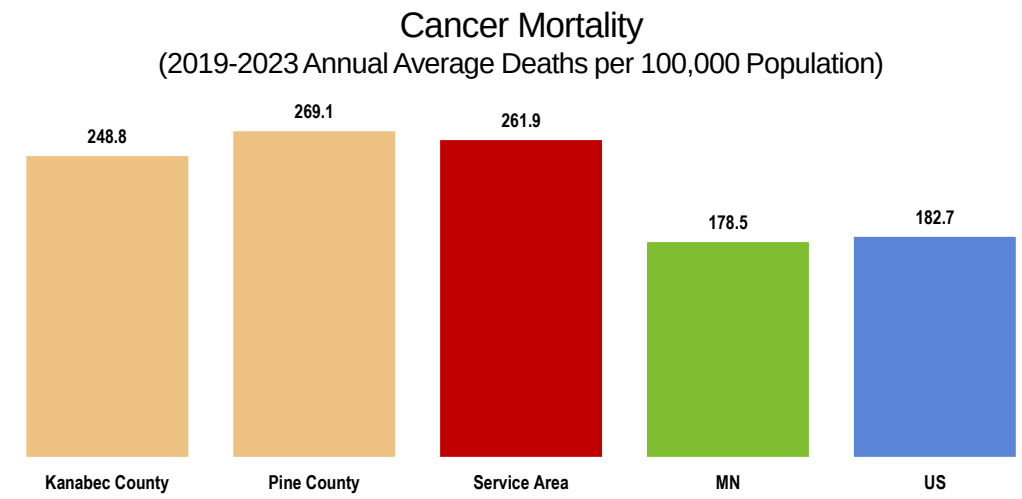
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Cancer Deaths

Cancer is a leading cause of death in the service area and throughout the United States. Cancer mortality rates are outlined below.



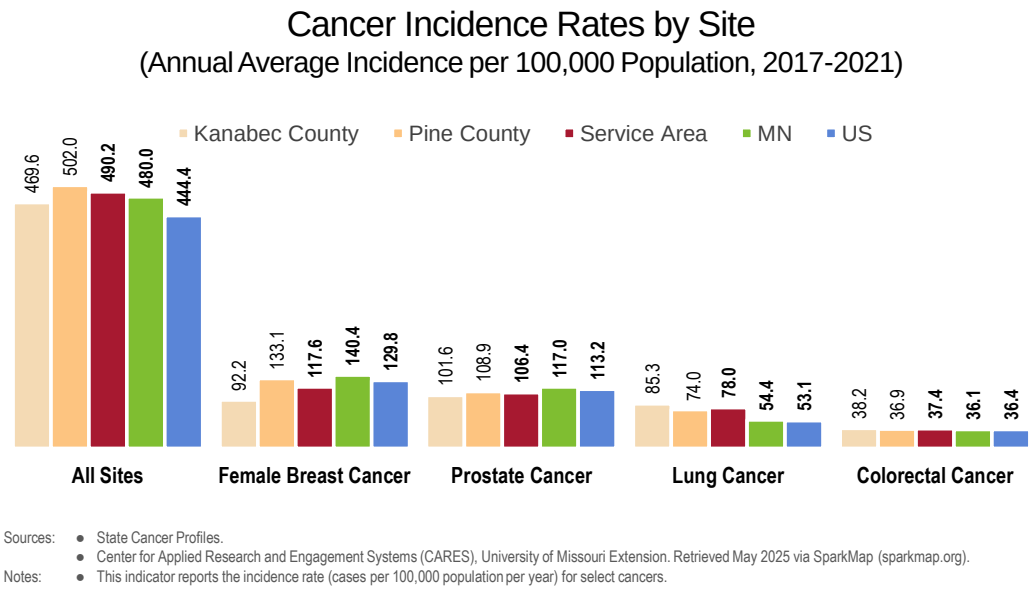
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

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.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

It is important to identify leading cancers by site in order to better address them through targeted intervention. The following chart illustrates the service area incidence rates for leading cancer sites.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

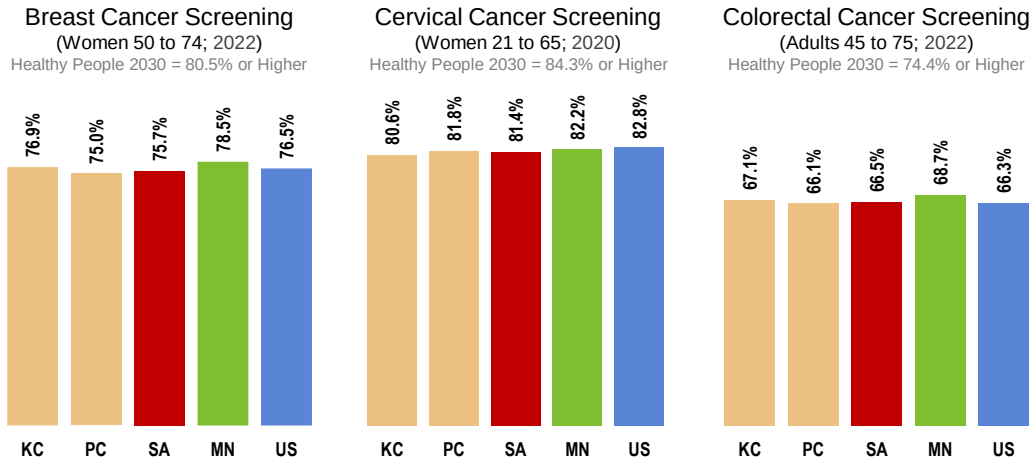
COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

The following outlines the percentages of residents receiving these age-appropriate cancer screenings. These are important preventive behaviors for early detection and treatment of health problems. Low screening levels can highlight a lack of access to preventive care, a lack of health knowledge, or other barriers.

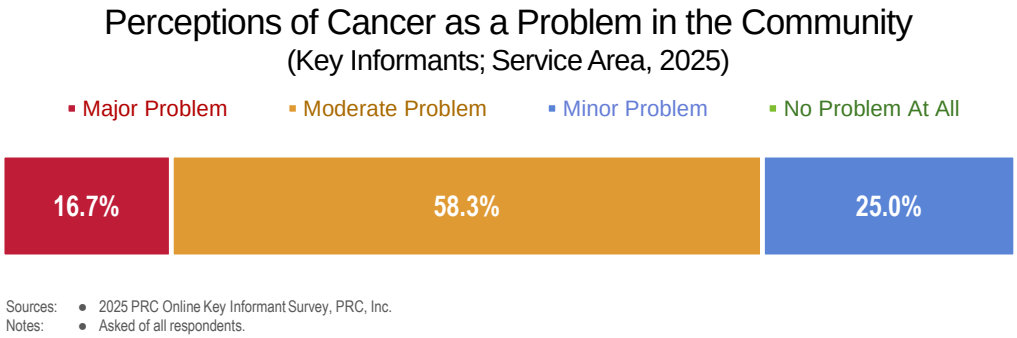


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 45-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.

Key Informant Input: Cancer

Key informants' perceptions of *Cancer* as a local health concern are outlined below.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

> We are hearing about more and more people being diagnosed at younger ages. — Health Provider
>
> I am becoming more and more aware of individuals diagnosed with leukemia and esophageal cancer. Is it connected to our environment, the result of our growing solid waste center. — Community Leader
>
> So many people recently have been diagnosed or passed away as a result of cancer in our area. — Community Leader

Access to Local Care/Services

> Many major treatments that may be needed are located in the cities. There is a lack of transportation and financial resources to assist people with cancer, causing some difficulty to receive the proper treatment. — Social Services Provider

Access to Specialists

> I believe that cancer care also has limited accessibility. Yes, we do have a local oncology provider, but we do not have a good number of choices. — Public Health Representative

Follow-Up/Support

> Lack of support groups locally. No facility locally that offers radiation, so transportation becomes an issue for many. — Social Services Provider

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

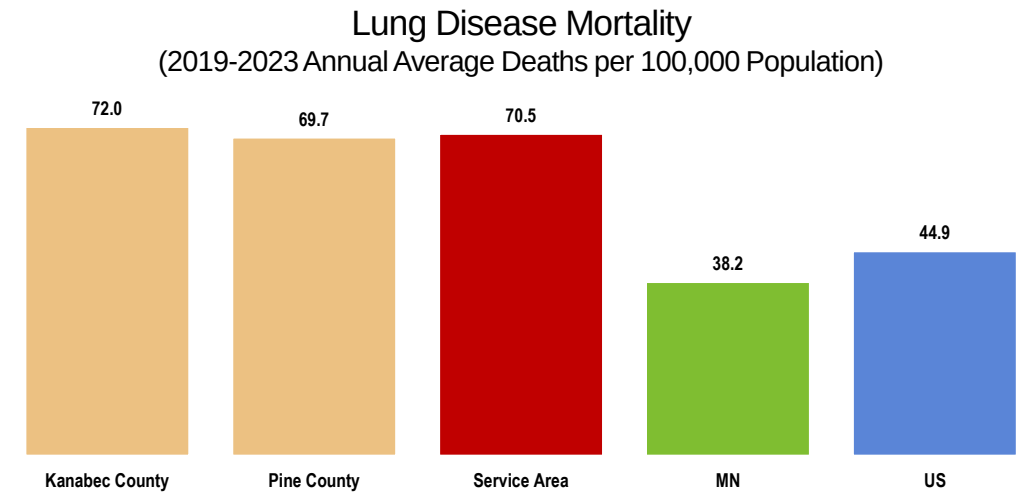
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Lung Disease Deaths

Note: Here, lung disease reflects chronic lower respiratory disease deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.

The mortality rate for lung disease in the service area is summarized below, in comparison with Minnesota and national rates.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.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.

Asthma Prevalence

The following chart shows the prevalence of asthma among service area adults.

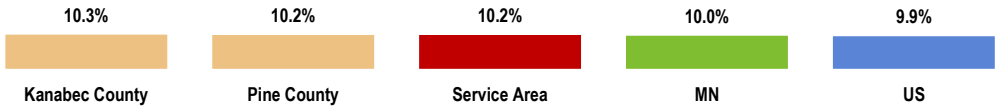
The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had asthma?"

"Do you still have asthma?"

Prevalence includes those responding "yes" to both.

Prevalence of Asthma
(2022)



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

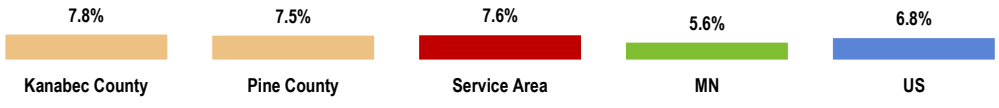
COPD Prevalence

The following chart shows the prevalence of chronic obstructive pulmonary disease (COPD) among service area adults.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)
(2022)

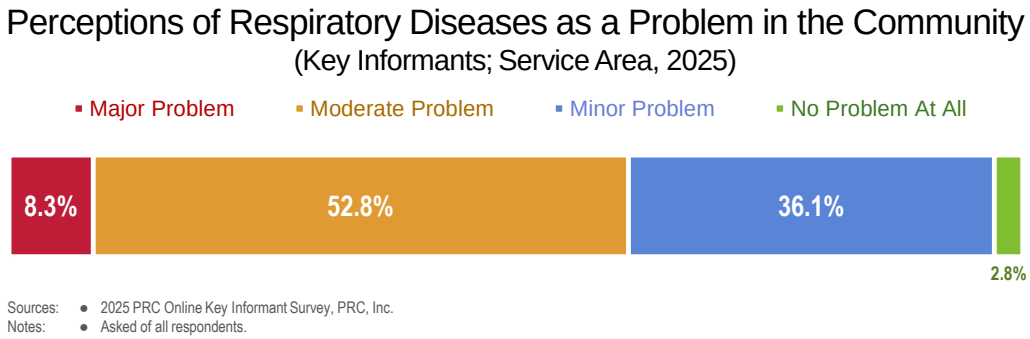


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Key Informant Input: Respiratory Disease

The following outlines key informants' perceptions of *Respiratory Disease* in our community.



Top Concerns

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

Incidence/Prevalence

> High incidence of COPD. — Health Provider

Tobacco Use

> High smoking population. Any respiratory illness causes more serious illness. — Physician

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

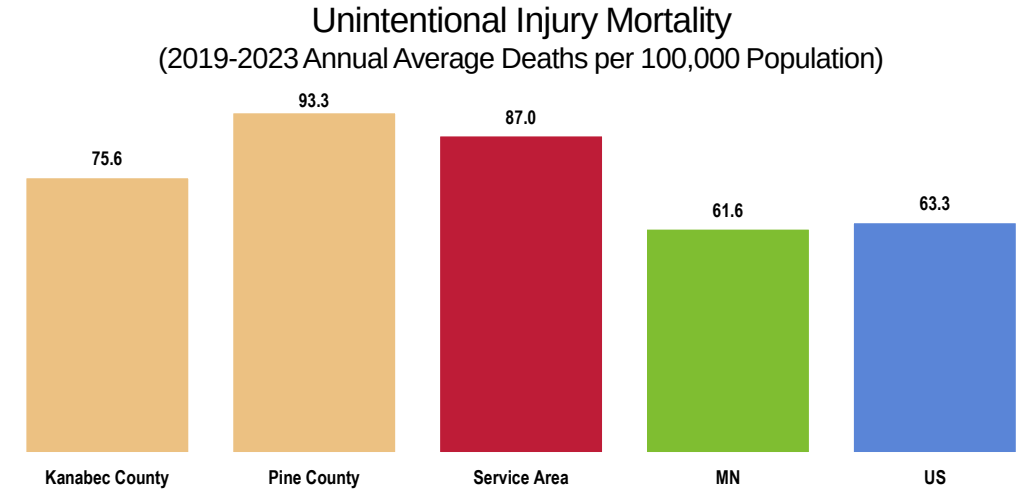
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

Unintentional injury is a leading cause of death. The chart that follows illustrates unintentional injury death rates for the service area, Minnesota, and the US.

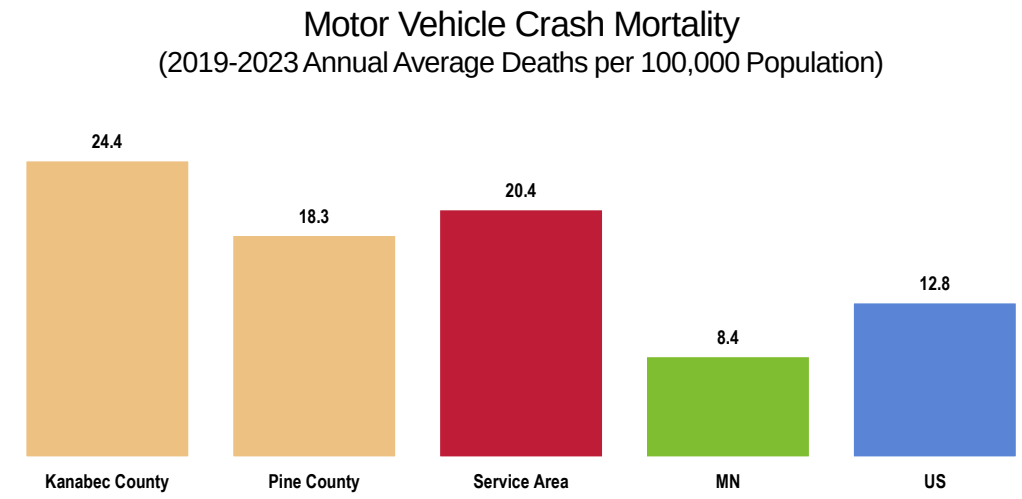


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

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.

Motor Vehicle Crash Deaths

Motor vehicle crash deaths are preventable and are a cause of premature death. Mortality rates for motor vehicle crash deaths are outlined below.

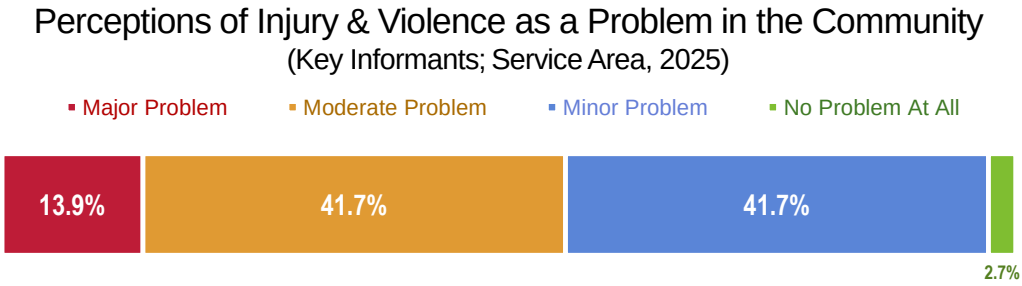


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

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.

Key Informant Input: Injury & Violence

Key informants' perceptions of *Injury & Violence* in our community:



Sources:
- 2025 PRC Online Key Informant Survey, PRC, 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

> As a health care provider, I have come across many patients who have struggled with violence at home. We also have a public jail roster, which shows that violence is a problem in our counties. — Health Provider
>
> I look at the court records in our weekly local paper. Domestic violence is among the cases every week. When I worked at our church as a pastoral associate, I talked with victims frequently. — Community Leader
>
> I work with children and families daily. Too many children are not protected from seeing or experiencing violence. — Community Leader
>
> There is an increase in the court reports of domestic situations in Kanabec County. — Community Leader

Access to Care/Services

> I believe that resources for violence, physical abuse, and emotional abuse are very limited in our area. We do not discuss domestic abuse enough in our area, and that is concerning. — Public Health Representative

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

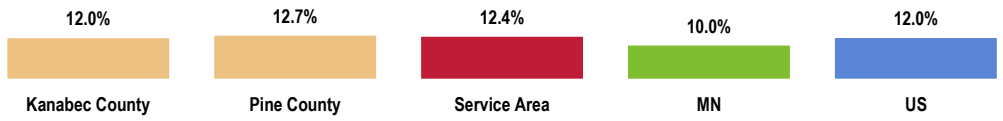
Prevalence of Diabetes

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had diabetes?"

Diabetes is a prevalent and long-lasting (chronic) health condition with a number of adverse health effects, and it may indicate an unhealthy lifestyle. The prevalence of diabetes among service area adults age 20 and older is outlined below, compared to state and national prevalence levels.

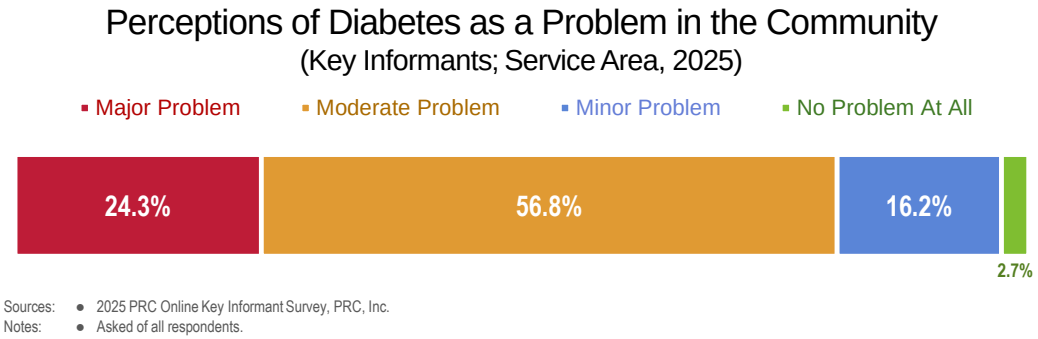
Prevalence of Diabetes
(Adults Age 20 and Older; 2022)



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Key Informant Input: Diabetes

The following are key informants' ratings of *Diabetes* as a health concern in the service area.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Access to Affordable Healthy Food

> Access to healthy foods, education, follow up, and a lack of health literacy. — Public Health Representative
>
> Access to affordable healthy food choices, the inability to prepare healthy meals, and the difficultly of getting in to see a physician. In very rural areas, the inability to exercise safely. Roads with no shoulders. Access to diabetic supplies for some. — Public Health Representative
>
> Access to good quality foods. The cost of eating and maintaining a healthy lifestyle. Pine City is lacking a wellness center for people living with diabetes to utilize. — Health Provider
>
> Access to affordable healthy foods in an area of low income. — Health Provider

Disease Management

> I feel that just people knowing how to manage it properly. They do not take it seriously enough. — Health Provider
>
> Understanding the diagnosis and how to regulate it. — Community Leader

Prevention/Screenings

> Prevention of diabetes. Proper education about root causes, ways to prevent diabetes. As is commonly the case, many ignore risk factors and want treatment or drugs to correct the problem. As our population ages there will be more and more people who are diabetic and need services. Also, a contributing factor is access to healthy food at a price that is affordable. With one grocery store in Mora, access isn't ideal. Pine City has more options and continues to find ways to bring in more businesses that offer quality, nutritious foods where more people are able to have access. — Public Health Representative

Access to Care/Services

> Lack of insurance, lack of transportation, and lack of follow-through. — Social Services Provider

DISABLING CONDITIONS

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

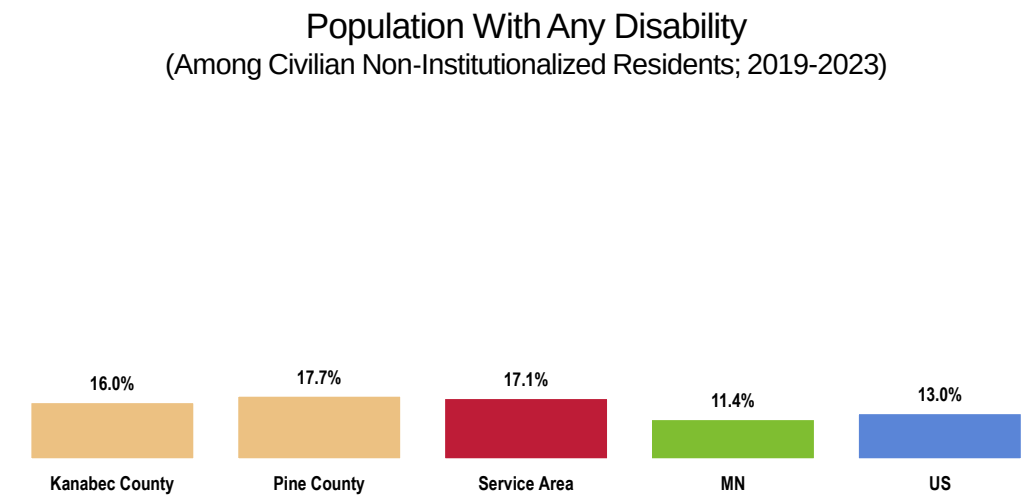
– Healthy People 2030 (https://health.gov/healthypeople)

Disability

The following represents the percentage of the total civilian, non-institutionalized population in the service area with a disability. This indicator is relevant because disabled individuals may comprise a vulnerable population that requires targeted services and outreach.

Disability data come from the US Census Bureau's American Community Survey (ACS), Survey of Income and Program Participation (SIPP), and Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent-living difficulty.

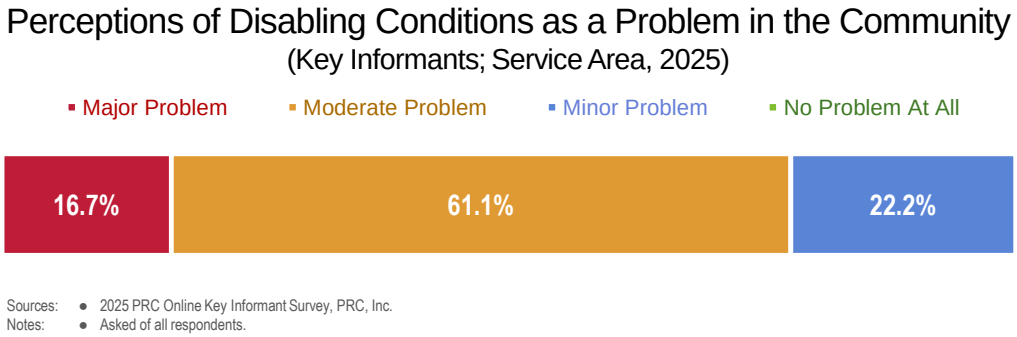
Respondents who report any one of the six disability types are considered to have a disability.



Sources:
- US Census Bureau, American Community Survey.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Key Informant Input: Disabling Conditions

Key informants' perceptions of *Disabling Conditions* are outlined below.



Sources: • 2025 PRC Online Key Informant Survey, PRC, 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

> We have limited specialty areas. — Social Services Provider
>
> Lack of resources. — Health Provider
>
> The rural counties limit access and support for these patients. Access to health care such as pain clinics are not local. Neurology services are very limited as are hearing options. — Health Provider

Aging Population

> My perception is that a growing segment of the local community is prematurely aging. Such individuals of any age may require caregiver support from family and friends to function and participate in society. Those without such support can become quite isolated and withdraw from the community. I am more familiar with the programs for older adults, my clientele. — Community Leader

Incidence/Prevalence

> I believe the Alzheimer's and dementia populations are going to increase in the coming years. — Community Leader

Transportation

> I just feel there are a lot of people with these conditions who do not have help or transportation availably. — Health Provider

BIRTHS

BIRTH OUTCOMES & RISKS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

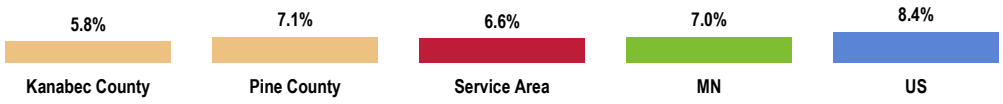
– Healthy People 2030 (https://health.gov/healthypeople)

Low-Weight Births

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. The following chart illustrates the percent of total births that are low birth weight.

Low-Weight Births
(Percent of Live Births, 2017-2023)



Sources: University of Wisconsin Population Health Institute, County Health Rankings.
Note: This indicator reports the percentage of total births that are low birth weight (Under 2500g).
Low-Weight Birth Rate is not available for the Service Area as a whole.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

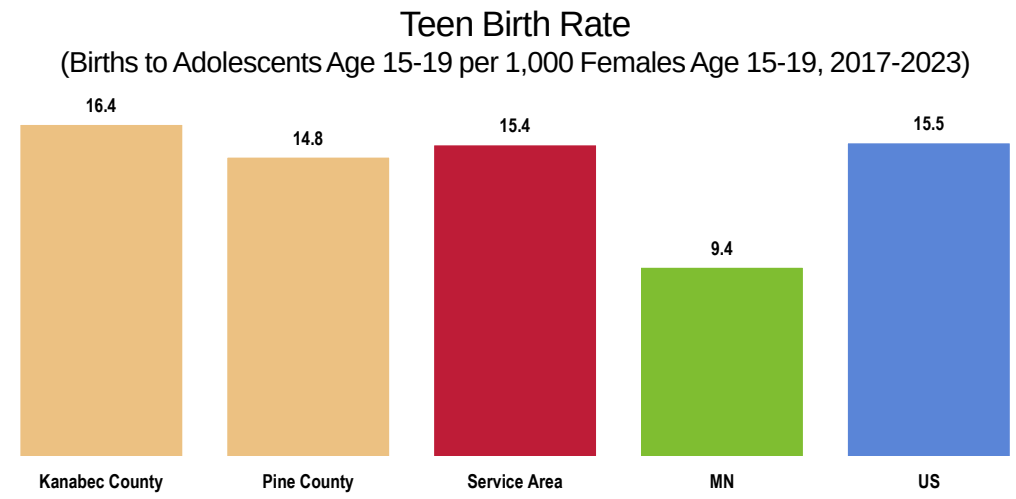
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Here, teen births include births to women ages 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

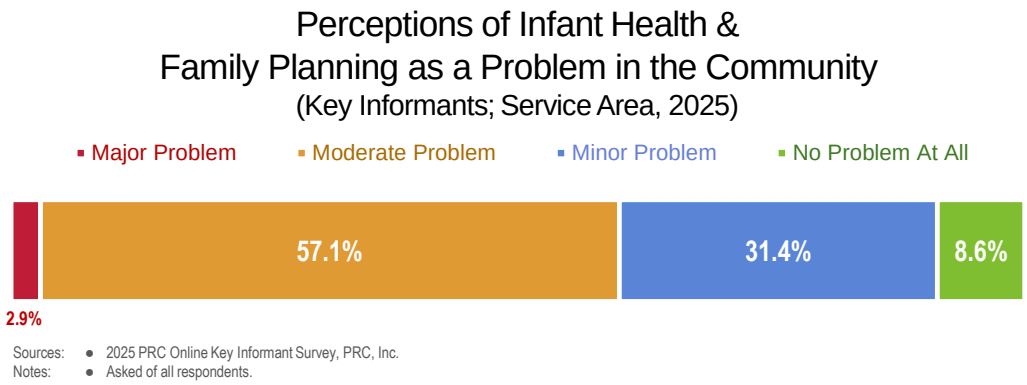
The following chart outlines the teen birth rate in the service area, compared to rates statewide and nationally. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Key Informant Input: Infant Health & Family Planning

Key informants' perceptions of *Infant Health & Family Planning* as a community health issue are outlined below.



Top Concerns

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

Awareness/Education

> We need to be more open with conversations about family planning. Access is limited in schools and even at clinics for information. — Health Provider

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

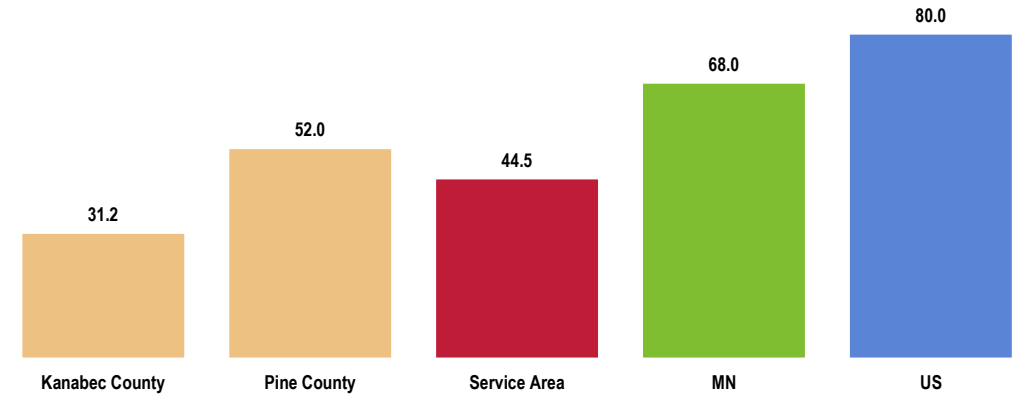
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Food Environment: Fast Food

The following shows the number of fast food restaurants in the service area, expressed as a rate per 100,000 residents. This indicator provides a measure of healthy food access and environmental influences on dietary behavior.

Here, fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.



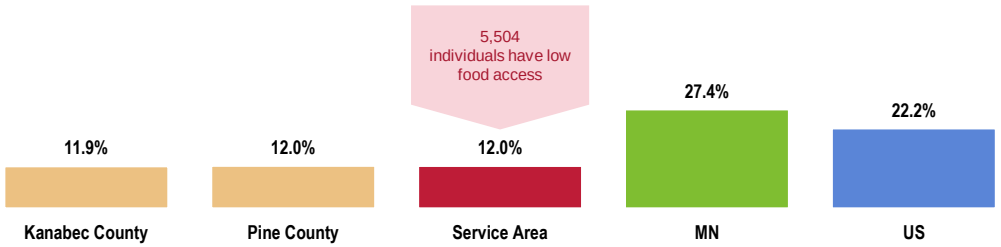
Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Low Food Access

Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store (or 10 miles in rural areas).

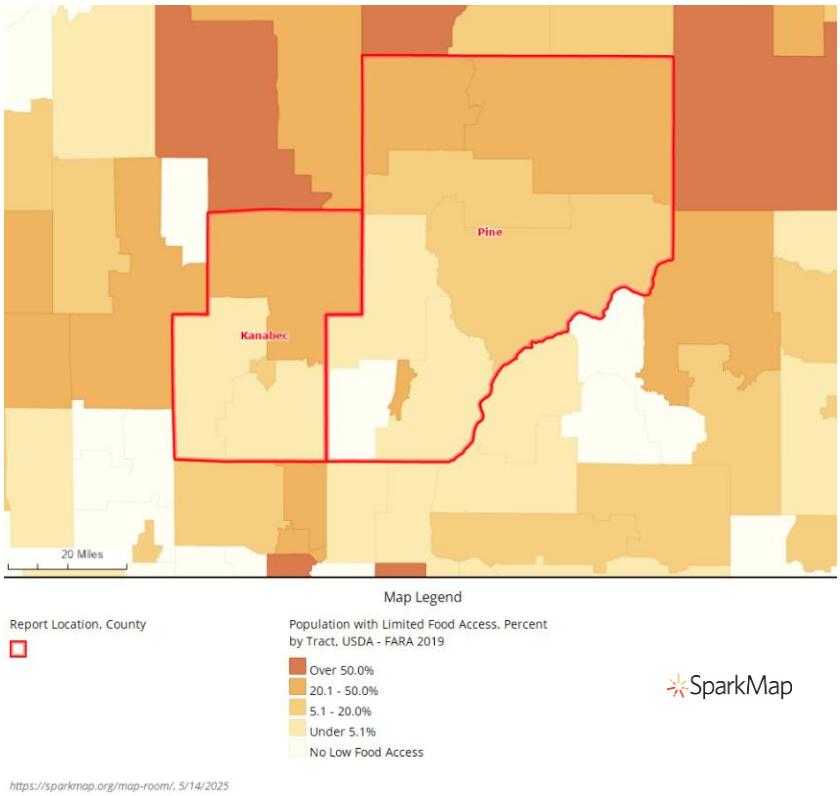
The following chart shows US Department of Agriculture data determining the percentage of service area residents found to have low food access, meaning that they do not live near a supermarket or large grocery store.

Population With Low Food Access
(Percent of Population Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.



PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

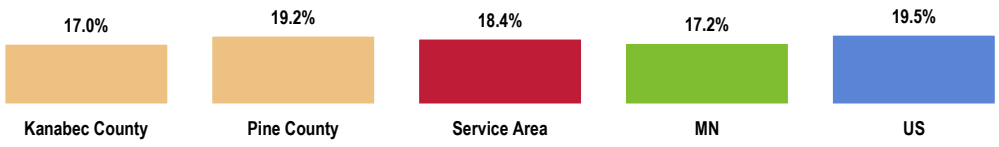
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

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.

Below is the percentage of service area adults age 20 and older who report no leisure-time physical activity in the past month. This measure is important as an indicator of risk for significant health issues such as obesity or poor cardiovascular health.

No Leisure-Time Physical Activity in the Past Month
(Among Adults Age 20 and Older, 2021)
Healthy People 2030 = 21.8% or Lower



Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

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 ≥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 ≥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
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥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

"Obese" includes respondents with a BMI value ≥30.0.

Outlined below is the percentage of service area adults age 20 and older who are obese, indicating that they might lead an unhealthy lifestyle and be at risk for adverse health issues.

Prevalence of Obesity
(Adults Age 20 and Older With a Body Mass Index ≥ 30.0, 2022)
Healthy People 2030 = 36.0% or Lower

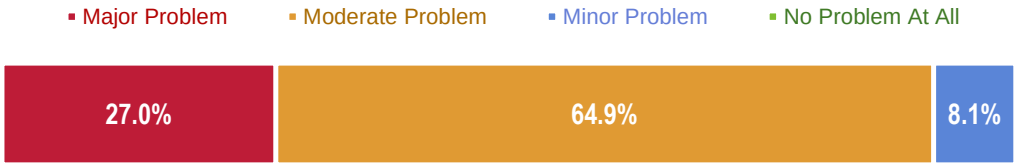
Sources:
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants' ratings of *Nutrition, Physical Activity & Weight* as a community health issue are illustrated below.

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Key Informants; Service Area, 2025)



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access to Affordable Healthy Food

> Eating healthy is very expensive. People do not know or maybe do not have time to prepare meals from scratch and are eating more processed foods which are less healthy. Lack of access to physical activity. People are too busy (or at least think they are) too busy to exercise. For some, like me, lack of motivation. — Public Health Representative
>
> We have limited options for healthy food choices that are affordable and activity options that provide ways for people to stay active. — Health Provider
>
> Healthy food can be expensive and time-consuming to prepare. Obesity is impacting participation in activities. — Community Leader

Lifestyle

> One grocery store with 15 Dollar General Stores within a 25 mile radius of Mora. The Dollar General stores typically have very poor quality foods. "Junk food" is everywhere (hardware stores, grocery store, Dollar General, etc.). Many don't understand what a "healthy" diet entails. Physical activity options are limited (especially in the winter) and many are not active. For those less active, starting some physical activity can be challenging (where to go, what to do, etc.). Obesity is a problem as well. — Physician
>
> Price of nutrition and physical activity centers like gyms. Poor food quality. — Community Leader

Awareness/Education

> Lack of education, lack of affordable gyms and/or daycare for gyms to attend different classes, and lack of affordable food. — Public Health Representative

Access to Care/Services

> Lack of resources. Pine City does not have a wellness center for people to use to better their health. — Health Provider

Income/Poverty

> Poor population, social concerns, and limited resources. — Health Provider

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

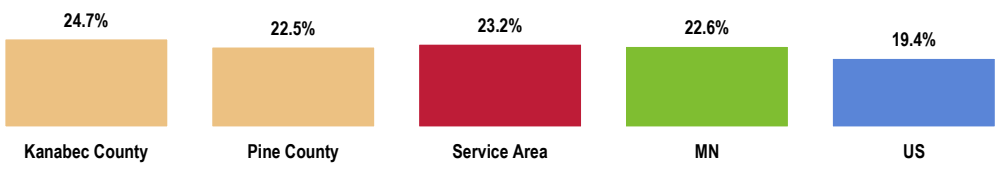
Excessive Alcohol Use

The following illustrates the prevalence of excessive drinking in the service area, as well as statewide and nationally. Excessive drinking is linked to significant health issues, such as cirrhosis, certain cancers, and untreated mental/behavioral health issues.

Excessive drinking includes heavy and/or binge drinking:

- HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking
(2022)

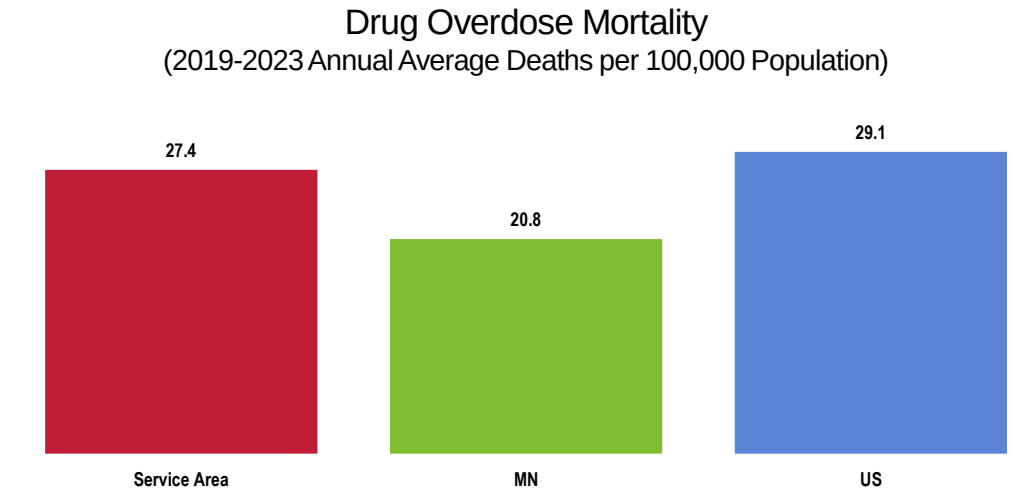


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

Drug Overdose Deaths

The chart that follows illustrates death rates attributed to drug overdoses (all substances, excluding alcohol) for the service area, Minnesota, and the US.

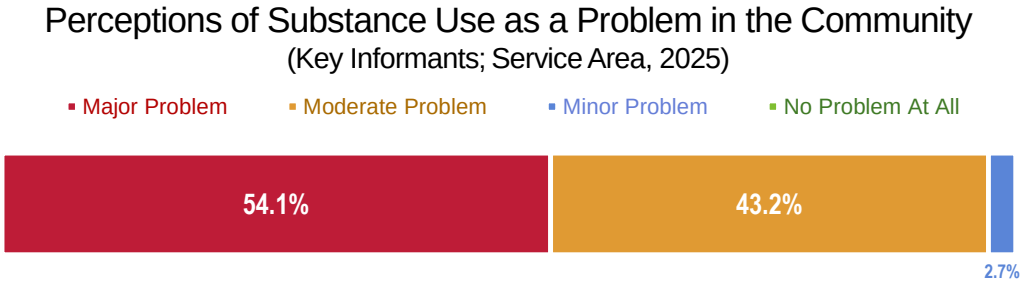


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

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.
- Drug Overdose Mortality Rate is not available for Kanabec County.

Key Informant Input: Substance Use

Note the following perceptions regarding *Substance Use* in the community among key informants taking part in an online survey.



Sources:
- 2025 PRC Online Key Informant Survey, PRC, 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

> People don't have resources or the drive to obtain assistance. — Public Health Representative
>
> Lack of treatment facilities. We do have a large facility that is geared towards women. This is helpful, but I do feel as if we could use more. — Public Health Representative
>
> Availability. Options should include non-traditional working hours so people who are encouraged to work do not have to take time off for what they need. — Health Provider

> This goes along with mental health. There is a lack of resources for sobriety and living expenses. People who are using substances tend to have a hard time with employment and do not have insurance. — Health Provider
>
> Ability to get to treatment as well as transportation for it. Cost, work, the environment, and those around you. — Community Leader
>
> Lack of facilities and outpatient care. — Social Services Provider

Denial/Stigma

> Stigma. — Health Provider
>
> Stigma. I don't think services for help are simply talked about enough with no judgement. — Community Leader
>
> Willingness to admit there is a problem, funding issues, and insurance gaps. Some patients require inpatient stabilization first for mental health such as hospitalization and detox centers. — Health Provider
>
> The person who needs it doesn't typically think they have a problem. — Community Leader
>
> Stigma. Youth starting to smoke, drink, use substances because they have a low perception of harm from using these substances. Community does not necessarily support some of the policies that are proven to prevent youth access and use of substances (it is looked at as squashing commerce). It would be very helpful for more of the medical community to speak out. — Public Health Representative

Awareness/Education

> Not knowing what resources are available and the embarrassment of admitting you have a problem. — Community Leader
>
> A lack of understanding and fear of bias. — Health Provider

Incidence/Prevalence

> So much meth use in Kanabec and Pine County. Care for a lot of patients from two different residential chemical-dependency treatment facilities. — Physician
>
> More moderate. — Social Services Provider

Most Problematic Substances

Note below which substances key informants (who rated this as a “major problem”) identified as causing the most problems in the service area.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a “Major Problem”)	
ALCOHOL	50.0%
METHAMPHETAMINE OR OTHER AMPHETAMINES	38.9%
PRESCRIPTION MEDICATIONS	11.1%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking Prevalence

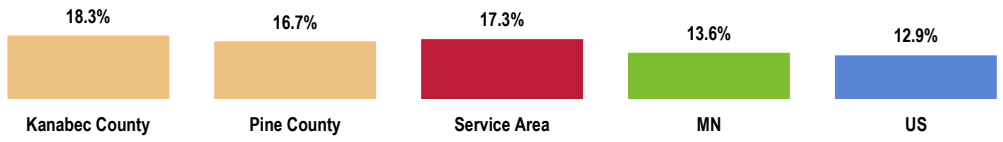
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note below the prevalence of cigarette smoking in our community.

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Have you smoked at least 100 cigarettes in your entire life?"

"Do you now smoke cigarettes every day, some days, or not at all?"

Cigarette smoking prevalence includes those who report having smoked at least 100 cigarettes in their lifetime and who currently smoke every day or on some days.

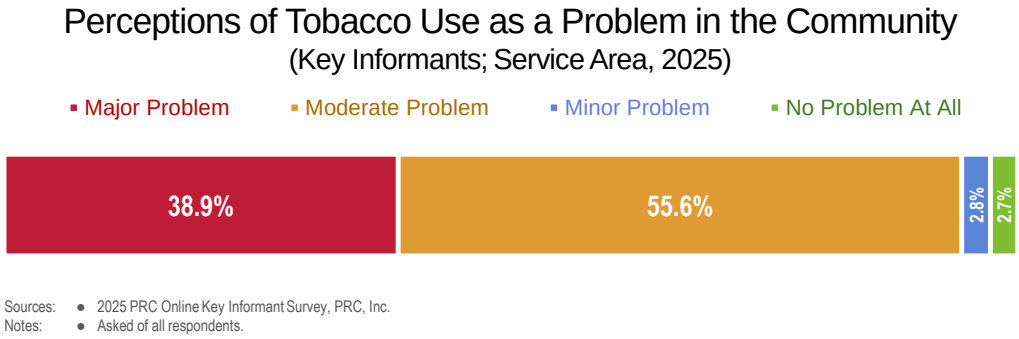


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.

Key Informant Input: Tobacco Use

Below are key informants' ratings of *Tobacco Use* as a community health concern.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

> Very high smoking rate in our population. — Physician
>
> Smoking is still prevalent in the area. — Health Provider
>
> It is common, not thought of as big of a deal as it is, and related to many long-term chronic health conditions. — Health Provider
>
> Many of the patients I treat report use of nicotine in various forms such as smoking, vaping, and chewing. Many report difficulty stopping due to severity of their addiction. — Health Provider
>
> Seeing a lot of people who smoke or chew. — Health Provider

E-Cigarettes

> I would say vaping is a concern. — Health Provider
>
> It is everywhere. Kids are vaping at such young ages. The way things are marketed as fun and normal creates a problem. Social media has not helped the tobacco issue. — Community Leader
>
> Vape detectors are alerting staff members that there are students using vapes and tobacco in the bathrooms. — Community Leader
>
> Vapes are prevalent in our schools which means kids are starting at early ages. — Community Leader

Awareness/Education

> The low perception of harm by youth. Flavored tobacco and vapes have made it less harsh but more addictive. The marketing by the big tobacco companies has been very effective. Access to products. Businesses who sell to people underage. People who buy for underage. The internet. — Public Health Representative

Generational

> Multigenerational use combined with cultural acceptance, especially within impoverished communities. — Health Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

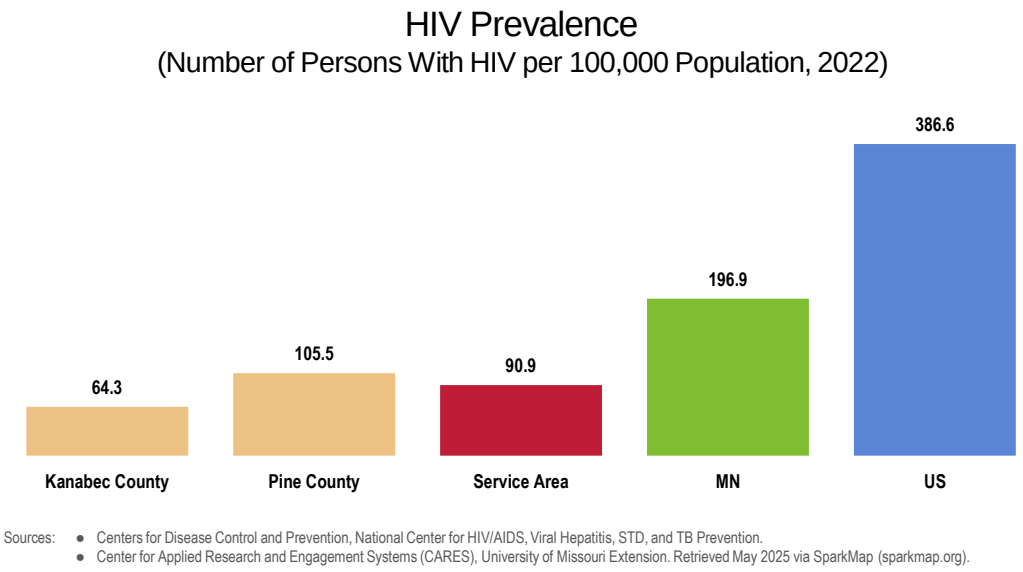
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

The following chart outlines the prevalence of HIV in our community, expressed as a rate per 100,000 population. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

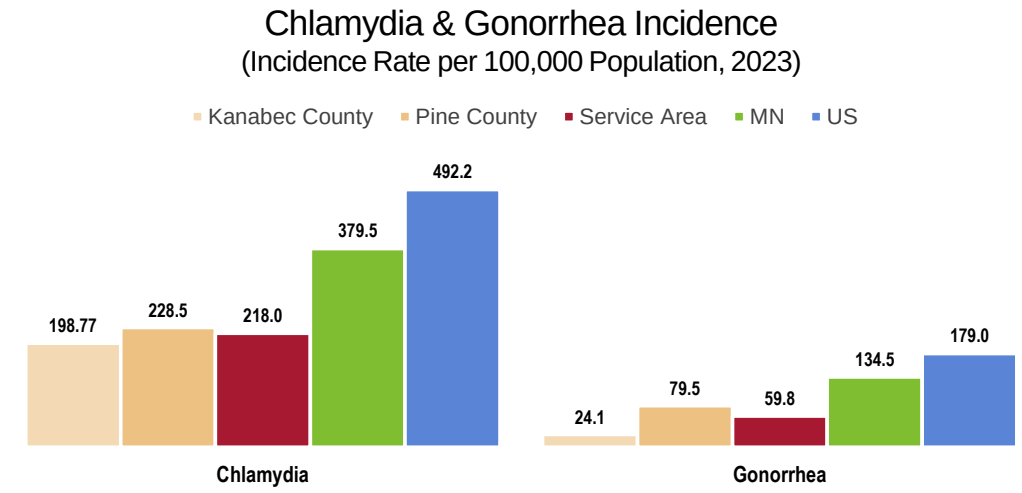


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

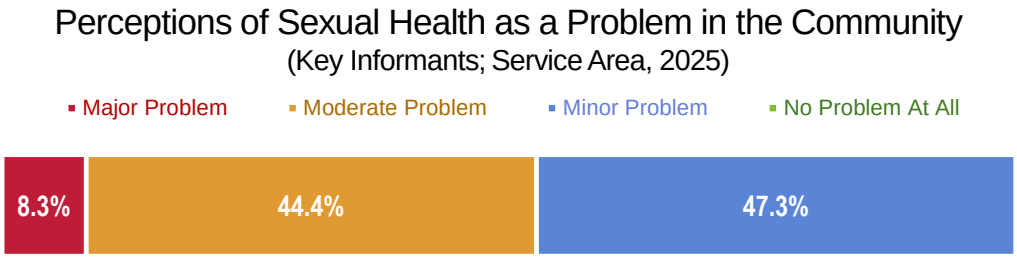
Chlamydia and gonorrhea are reportable health conditions that might indicate unsafe sexual practices in the community. Incidence rates for these sexually transmitted diseases are shown in the following chart.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

Key informants' ratings of *Sexual Health* as a community health concern are shown in the following chart.



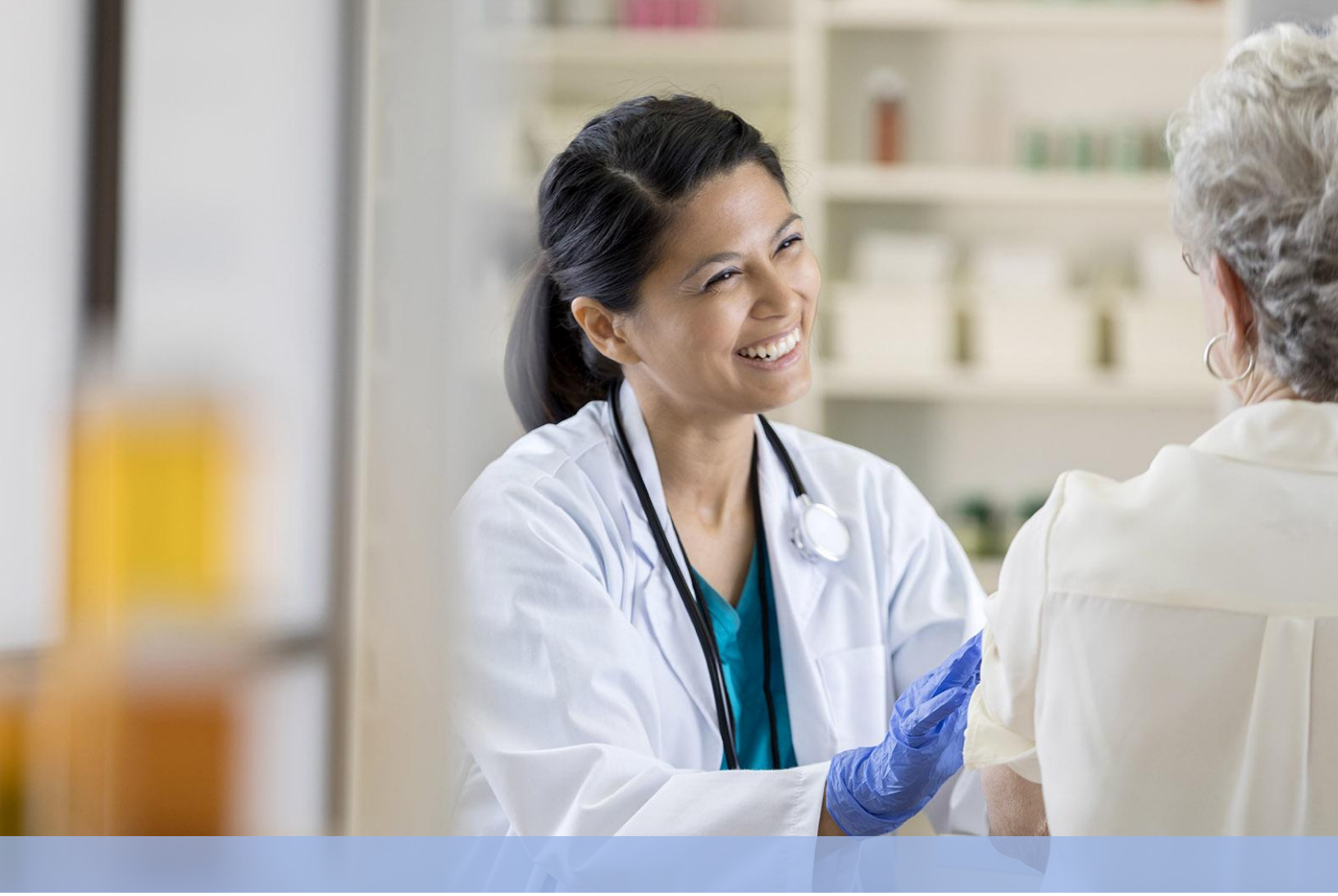
Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Stigma

> I do not believe that sexual health is talked about enough. There is such a stigma around sexual health, and it needs to be addressed. This is concerning to me, especially with the recent funding that was pulled from PEPFAR. — Public Health Representative



ACCESS TO HEALTH CARE

BARRIERS TO HEALTH CARE ACCESS

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

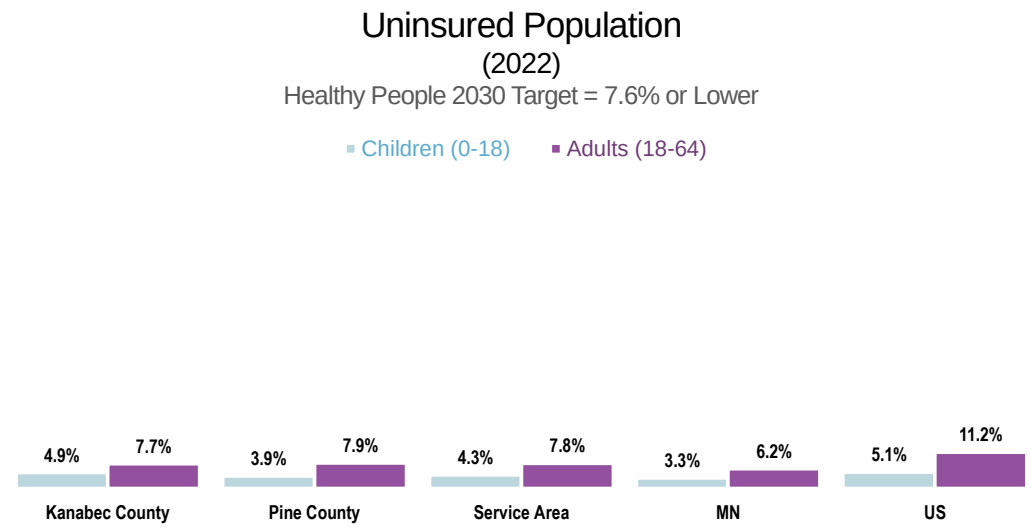
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects those younger than 65 (thus excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

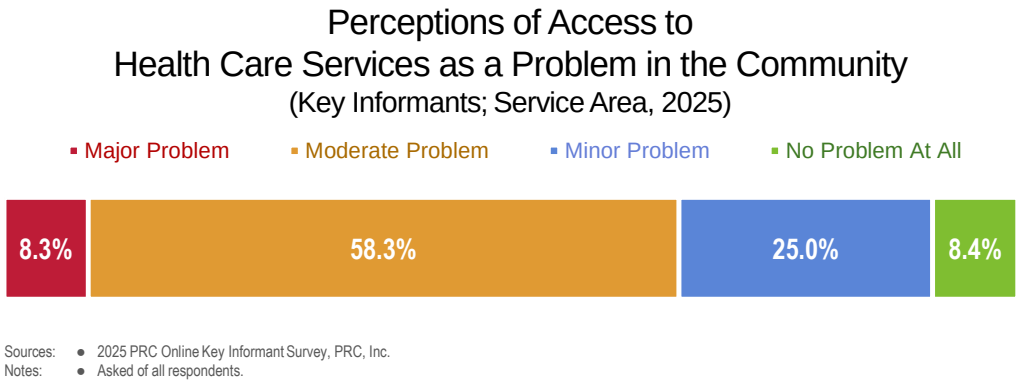
Health insurance coverage is a critical component of health care access and a key driver of health status. The following chart shows the latest figures for the prevalence of uninsured adults (age 18 to 64 years) and of uninsured children (under the age of 19) in the service area.



Sources:
- US Census Bureau, Small Area Health Insurance Estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Key Informant Input: Access to Health Care Services

Key informants' ratings of *Access to Health Care Services* as a problem in the service area is outlined below.



Sources: 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

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

Transportation

> Transportation. Unable to take care of health if you can't get there. — Community Leader
>
> The biggest challenge related to accessing health care services is transportation. We are lacking providers, drivers, and accessibility. — Public Health Representative

Access to Local Care/Services

> They are unable to deal with many serious issues and have to send people to the cities, and many people up here have issues with transportation and getting to a hospital or clinic that is further away. Also, it can be a challenge to get in to see a doctor in a timely manner. — Community Leader

Lack of Coordinated Care

> Coordinating care for those who can't do it for themselves. Great need for daycare providers in our community. Mental health advocacies. Dental care for those without insurance. — Community Leader

Insurance Concerns

> Insurance companies and some policies within the health systems. People do not bring up issues until they are acute because they get charged for even discussing a concern. — Public Health Representative

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

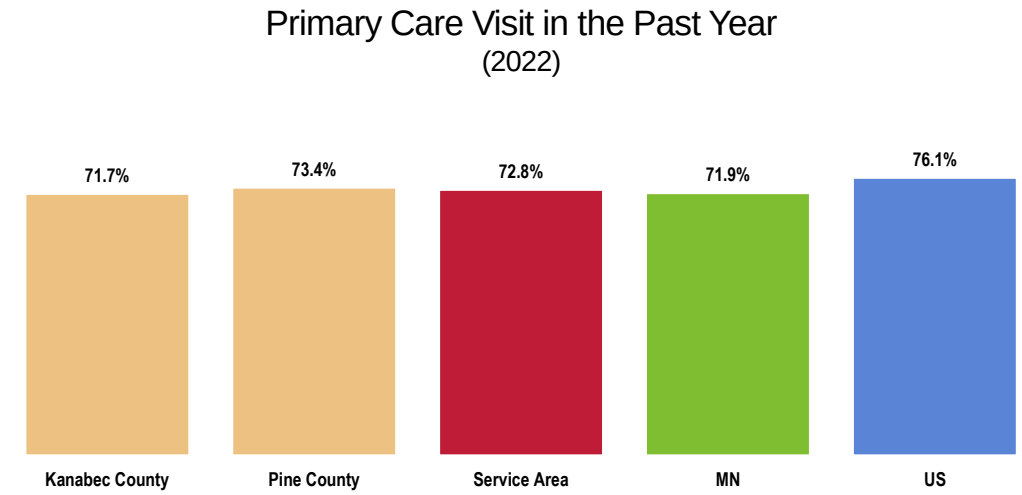
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Primary Care Visits

The following chart reports the percentage of service area adults who visited a doctor for a routine checkup in the past year.



Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

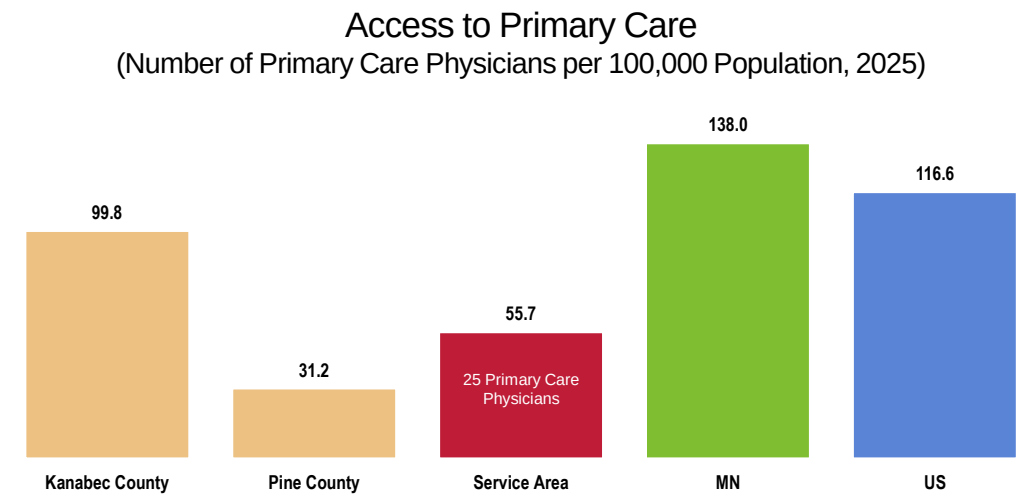
Notes:
- This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

Access to Primary Care

Doctors classified as “primary care physicians” by the AMA include: general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing subspecialties within the listed specialties are excluded.

Note that this indicator takes into account only primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following indicator outlines the number of primary care physicians per 100,000 population in the service area. Having adequate primary care practitioners contributes to access to preventive care.



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

ORAL HEALTH

ABOUT ORAL HEALTH

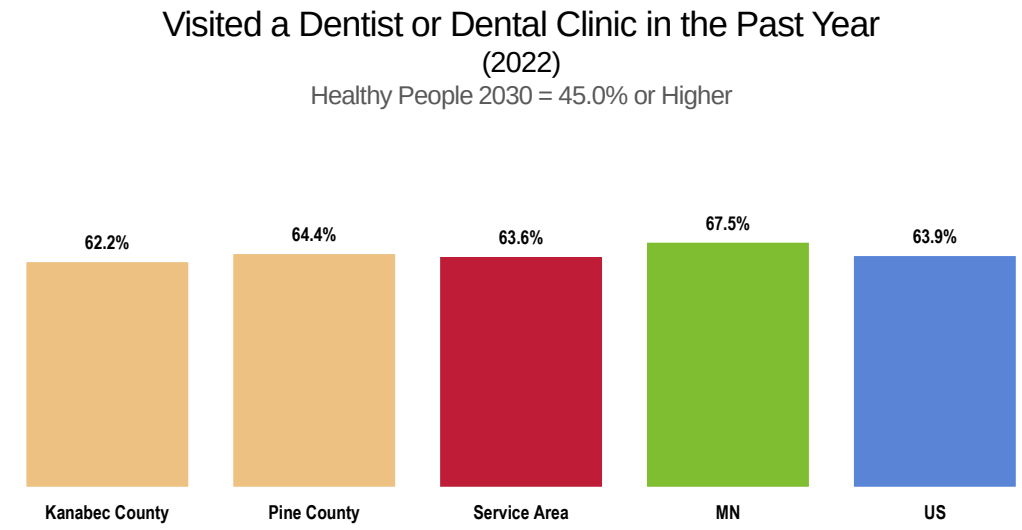
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Visits

The following chart shows the percentage of service area adults age 18 and older who have visited a dentist or dental clinic in the past year.

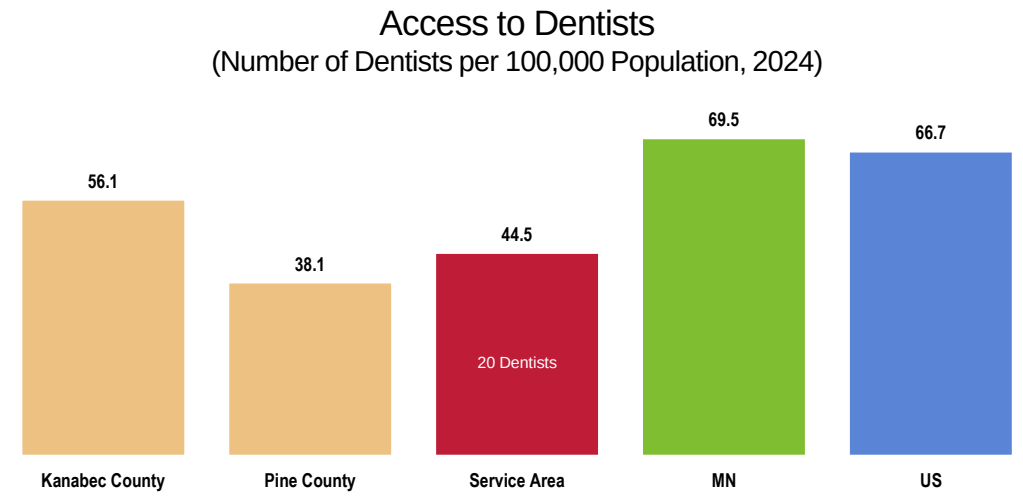


Sources:
- Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

The following chart outlines the number of dentists for every 100,000 residents in the service area.

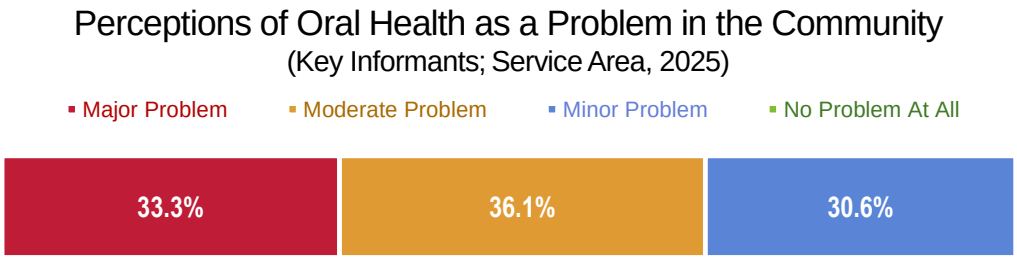


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved May 2025 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Key Informant Input: Oral Health

Key informants' perceptions of *Oral Health* are outlined below.



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Access for Medical Assistance (MA) Patients

> Severe lack of dentists who will accept medical assistance. Shortage of dentists in general. — Public Health Representative
>
> There are no Medicaid dental providers in the area. — Health Provider
>
> No local dentists take MA. — Health Provider
>
> Lack of access to dental services for those who require medical assistance. — Community Leader

Affordable Care/Services

> There a lot of people who cannot afford the dental care costs and insurances do not cover enough. — Health Provider
>
> The cost of dental insurance can be expensive, especially for those on fixed incomes and those who are no longer employed. — Community Leader

Prevention/Screenings

> The school district provides screening for littles. The number of littles with "bottle rot" or poor dental health is overwhelming. — Community Leader

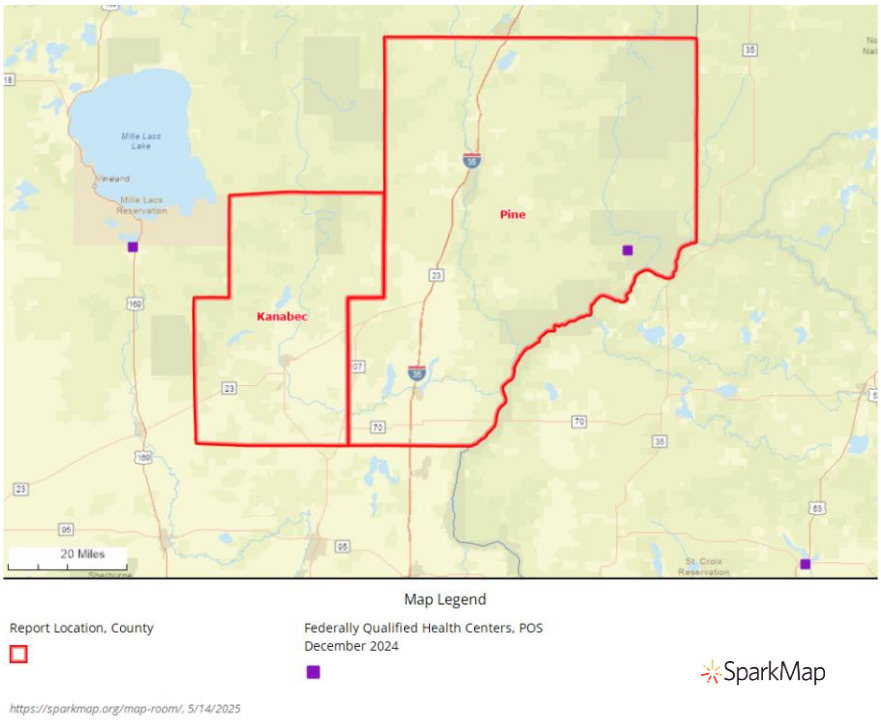
LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

FQHCs are community assets that provide health care to vulnerable populations; they receive federal funding to promote access to ambulatory care in areas designated as medically underserved.

The following map details Federally Qualified Health Centers (FQHCs) within the service area.



Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Insurance Company
- Kanabec County Public Health
- Mora Public Schools
- Recovering Hope
- Timber Trails
- Welia Health System

Cancer

- Abbott Northwestern
- Allina
- Bus Service
- Hospitals
- Kick Cancer to the Curb
- Public Health
- Telehealth
- Welia Health System

Diabetes

- Diabetes Educators
- Doctors' Offices
- Farmers' Markets
- Insurance Company
- Intensive Behavioral Therapy
- Kanabec County Community Health
- Lakes and Pines
- Parks and Recreation
- Public Health
- School Systems
- Welia Health System

Disabling Conditions

- AmeriCorps Seniors
- Congregate Dining
- Dial-A-Ride
- Kanabec County Public Health
- School Systems
- St. Clairs
- State Services for the Blind
- Support Groups
- Timber Trails
- Welia Health System

Heart Disease & Stroke

- Medication Therapy Management Pharmacists
- Telehealth
- Welia Health System

Infant Health & Family Planning

- Outlook Clinic

Injury & Violence

- AA/NA
- Family Pathways
- Kanabec County Public Health
- Kanabec County Sheriff's Department
- Law Enforcement
- Legacy Counseling Services
- Mille Lacs Band of Ojibwe Victim Services
- Minnesota Domestic Violence Crisis Line
- Mora Public Schools
- Public Health
- School Systems
- Therapy
- Welia Health System

Mental Health

- Ampersand
- Canvas Health
- Churches
- Counselors
- Doctors' Offices
- Empower Recovery Services
- Family Pathways
- Introspect
- Kanabec County
- Kanabec County Community Health

- Kanabec County Family Services
- Kanabec County Public Health
- Legacy Counseling Services
- Lighthouse
- Love the Journey
- Manes for Change
- Mental Health Clinics
- National Alliance on Mental Illness
- Nystrom
- Public Health
- Recovering Hope
- School Systems
- Selah Wellness
- Social Services
- Telehealth
- Therapeutic Services Agency
- Therapy
- Transportation Security Administration
- Welia Health System

Nutrition, Physical Activity & Weight

- Anytime Fitness
- Diabetes Educators
- Fitness Centers/Gyms
- Food Shelves
- Intensive Behavioral Therapy
- Parks and Recreation
- Selah Wellness
- Welia Health System
- Wellness Center
- Women, Infants and Children

Oral Health

- Affordable Dentures Franchise
- Dental Offices
- Doctors' Offices
- Haasken Dental
- Insurance Company
- Kanabec County Children's Dental Services
- Kanabec County Community Health
- Kanabec County Mobile Dental Services
- Lake Street Dental
- Lakes and Pines
- Minnesota Department of Veteran Affairs
- Mission of Mercy
- Parks and Recreation
- Pine Family Dental
- Public Health
- Seven County Senior Federation Membership
- Soft Dental

Respiratory Diseases

- County Benefits
- Doctors' Offices
- Pharmacies
- Pulmonary Rehab
- Respiratory Therapy
- Welia Health System

Sexual Health

- Kanabec County Community Health
- Kanabec County Public Health
- Outlook Clinic
- Welia Health System

Social Determinants of Health

- A Place for You
- AA/NA
- Arrowhead Transit
- Bus Service
- Churches
- City of Mora
- Compassionate Medicine Program
- DMV Job Center
- Family Pathways
- Family Services
- Food Bank
- Food Shelves
- Hospice
- Kanabec County Community Health
- Kanabec County Family Services
- Kanabec County Public Health
- Lakes and Pines
- Lions Club
- Low Income Housing
- Meals on Wheels
- Mission 61
- Mora Housing and Redevelopment Authority
- Municipalities
- Nursing Homes
- Postsecondary Enrollment Options
- Public Health
- Recovering Hope
- Section 8 Housing Programs
- Senior Linkage Line
- Social Services
- Supplemental Nutrition Assistance Program
- The County
- Timber Trails

Welia Health System
Women, Infants and Children

Substance Use

AA/NA
Celebrate Recovery
Changing Gaits
Dellwood Recovery
Doctors' Offices
Empower Recovery Services
Hospitals
Journey North
Kanabec County Health and Human Services
Kanabec County Public Health
Meadow Creek
Medical Community
Recovering Hope
Serenity Manor
Social Services
Suboxone Program
Welia Health System

Tobacco Use

Doctors' Offices
Insurance Company
Kanabec County Community Health
Kanabec County Public Health
Mora Public Schools
School Systems
Welia Health System

APPENDIX

EVALUATION OF PAST ACTIVITIES

Welia Health conducted its last CHNA in 2023-2025 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Welia Health would focus on developing and/or supporting strategies and initiatives to improve:

- Mental Health
- Substance Abuse
- Obesity & Healthy Living

Strategies for addressing these needs were outlined in Welia Health's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Welia Health to address these significant health needs in our community. The list below should not be considered a comprehensive list of all activities supporting the significant health needs of our community.

Mental Health

Welia Health's strategy to address mental health included improving access to mental health providers and services, identifying internal employee wellness programs, educating the public through support groups and eNewsletters, all while working towards decreasing stigma and increasing awareness of mental illness.

Welia Health consistently screened patients for depression during this time frame. In 2024, most patients, 77.5%, were identified as not at risk for depression. In 2024, there were 2,153 patient visits with mental health team providers. The provider team includes one mental health nurse practitioner and one licensed clinical social worker. Collaboration by our social work team and care coordinators with local community resources is part of our daily work.

Internal employee wellness activities included educational programs, access to external resources/benefits, and a commitment to employee engagement.

Externally, we publish regular blog posts and eNewsletters covering several topics on mental health to over 30,000 recipients. In person events are offered through support groups and learning events. Multiple patient/family resource guides are available in print at any Welia facility covering multiple health topics and community resources.

Substance Abuse

Welia Health's strategy to address substance abuse included offering medication assisted therapy, along with care coordination for the same. Similar resources to implement the mental health strategy are used. Additionally, providing best practice support for the provider team. At the end of 2024, there were 123 active patients enrolled in Medication Assisted Therapy. A full-time registered nurse is the care coordinator for these patients. Several physicians and advanced practice providers are providing this care with in-person and virtual care options. Welia Health is an active participant in the MDH Program-TOWN (Tackling Overdose with Networks). Welia Health is consistently requested to participate in community forums bringing awareness and knowledge of treatment programs for substance abuse.

Obesity and Healthy Living

Welia Health's strategy to address obesity and health living included providing healthy diet and physical activity education, improving access to community physical activity options, and improving access to primary care providers. Clinic visits are available with a Registered Dietician for Intensive Behavioral Therapy as well as Medical Nutrition Therapy. Welia Health maintains American Diabetes Association Recognition for their Diabetes Self-Management and Education program. The program has seen consistent growth over the years with an increasing focus on the use of technology tools to assist in diabetes management. Pre-Diabetes education events are held to promote awareness and prevention. We are certified as a Health

Care Home and routinely provide care coordination services. Improving access to primary care was shown through the completion rate of 54.5% of eligible Medicare beneficiaries receiving their annual wellness visit by the end of 2024. Welia is part of the Wellvana ACO and the Headwaters Network. Both focus on improving population health. Several primary care providers were added during 2023-2025 to allow for improved access to health care services. Other programs to support this health need included free sports physicals, employee wellness programs, employee fitness areas, the Diabetes Self-Management support group, community education through our eNewsletters and blogs, and our support of the Welia Center and the Hinckley/Finlayson Schools Walking Track and Fitness Center.