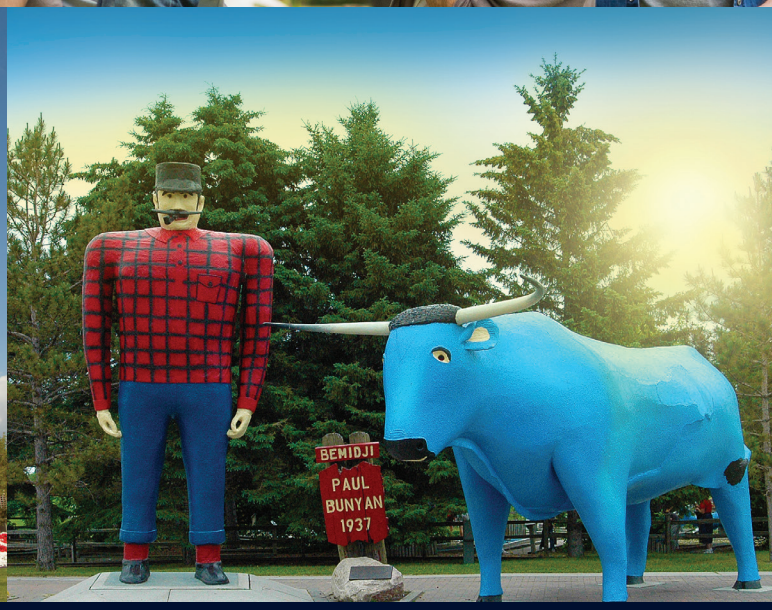


Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

cba Sanford Clear Lake Medical Center EIN # 46-0388596

SANFORD HEALTH

Sanford Clear Lake Medical Center

Community Health Needs Assessment

2016

Dear Community Members,

Sanford Clear Lake is pleased to present the 2016 Community Health Needs Assessment.

Part of the comprehensive assessment work is to formally identify unmet health needs in the community. Community stakeholders helped to prioritize the unmet needs for further implementation strategy development. We are grateful to all the community members who joined us in this important work.

During 2015 members of the community were asked to complete a survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. Sanford further analyzed the data, identified unmet needs, and partnered with key community stakeholders to develop a list of resources and assets that were available to address each need. A gap analysis and prioritization exercise was also conducted to identify the most significant health needs, and to further address these needs through the implementation strategies that are included in this document.

Sanford Clear Lake has set strategy to address the following community health needs:

- Mental Health
- Physical Health

The report focuses on community assets as well as community health needs. The asset map/resource list is included in this document along with the actions that will be taken to address each identified need.

At Sanford Clear Lake, patient care extends beyond our bricks and mortar. As a not-for-profit organization, ensuring that the benefits of health care reach the broad needs of our communities is at the core of who we are. Through our work, we can bring health and healing to the people who live and work in our communities. Together, we can fulfill this mission.

Sincerely,

Lori Sisk
Chief Executive Officer
Sanford Clear Lake Medical Center

Sanford Clear Lake Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

SANFORD HEALTH

Sanford Clear Lake Medical Center

Community Health Needs Assessment
2016

Purpose

A community health needs assessment is critical to a vital community benefit program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment helps the community build capacity to support policy, systems, environmental changes and community health improvement. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining not-for-profit status.

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

Study Design and Methodology

1. Non-Generalizable Survey

   A non-generalizable survey was conducted as an on-line survey through a partnership between Sanford and the Center for Social Research (CSR) at North Dakota State University. CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various community stakeholders and agencies, at times using a snowball approach. Data collection occurred throughout the month of March 2015 and a total of 35 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community leaders in the greater Clear Lake area was to learn about the perceptions of area community leaders regarding community health, their personal health, preventive health, and the prevalence of disease. This group included community leaders, and agency leaders representing chronic disease and disparity.

   A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.0 and above were included in the needs to be

addressed and prioritized. Many of the identified needs that ranked below 3.0 are being addressed by Sanford and community partners. However, 3.0 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

   Community stakeholders were invited to a meeting to review the findings from assessment research and to discuss the top health issues facing the community. Community stakeholders discussed the findings and helped to determine key priorities for the community. Those priorities will be addressed in the implementation strategies for 2017-2019.

3. Community Asset Mapping

   Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources were available in the community to address the needs. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes the 2015 County Health Rankings for Deuel County.

Key Findings – Primary Research

The key findings are based on the non-generalizable survey data and secondary research. Key indicators were ranked on a 1-5 Likert scale, with 5 being the highest concern ranking. Survey results ranking 3.0 or higher are considered to be high-ranking concerns for the key stakeholder non-generalizable survey. While Sanford is addressing many of the concerns that ranked less than 3.0, the top priorities for prioritization are those that rank 3.0 and above.

Aging: The top ranking concern about the aging population among respondents is the cost of long term care (3.63). The availability of resources for caregivers (3.29) and the availability of memory care (3.23) are also high concerns.

Children and Youth: Bullying (3.61) ranked the highest of concerns for children and youth among survey respondents. The availability of activities for children and youth (3.56) and the cost of these activities (3.29) are moderately high concerns among survey respondents.

Health Care: The health care indicator addressed access to health care and the cost concerns. The access to affordable health insurance (3.48), the cost of affordable vision insurance (3.45), the cost of affordable dental insurance coverage (3.45) and access to affordable health care (3.27) are the highest concerns among the respondents in the health care access category.

Safety: The presence of street drugs and alcohol in the community (3.25) are high concerns among survey respondents.

Physical Health: Chronic disease (3.55), cancer (3.50), obesity (3.48), inactivity and lack of exercise (3.48), and poor nutrition and eating habits (3.48) are the highest physical health concerns.

Mental Health/Behavioral Health: Stress (3.58), depression (3.36), dementia and Alzheimer's (3.15), underage drinking (3.52), underage drug use and abuse (3.45), smoking and tobacco use (3.39), and alcohol use and abuse (3.30) are the highest concerns for mental health/behavioral health.

Preventive Health: Flu vaccinations, immunizations and STDs are preventive health concerns based on primary and secondary research.

Key Findings – Secondary Research based on the 2015 County Health Rankings

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcome for the state of South Dakota is 6,738 per 100,000. Deuel County has a lower rate at 5,856 per 100,000.

Poor or fair health: 13% of adults in Deuel County report poor or fair health compared to 10% nationally and 11% in South Dakota.

The average number of days reported in the last 30 as unhealthy mental health days is 2.4 in Deuel County. South Dakota as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 5.7% in Deuel County. The state of South Dakota is at 6.5%.

Health Factors

The percent of adults who are currently smoking is 19% in Deuel County. 18% of adults are current smokers in South Dakota.

43% of the adult populations in Deuel County are considered to be obese with a BMI over 30. In the state of South Dakota, 29% of the population is obese.

The percent of adults reporting excessive or binge drinking is 22% in Deuel County. South Dakota reports 19% are binge drinkers statewide. Driving deaths that have alcohol involvement is at 0% in Deuel County. Alcohol involvement in driving deaths is at 37% in South Dakota.

Sexually transmitted infections rank substantially higher than the national benchmark (138) for South Dakota (471) and Deuel County (183). The teen birth rate is higher in South Dakota (37) than the national benchmark (20). The teen birth rate is 27 in Deuel County.

The clinical care outcomes indicate that the percentage of uninsured adults is 14% in South Dakota and 14% in Deuel County.

The ratio of population to primary care physicians is 1,302:1 in South Dakota. Deuel County's ratio is 4,380:1.

The ratio of population to mental health providers is 664:1 in South Dakota. Deuel County's ratio is not available in the County Health Rankings data.

The number of professionally active dentists in South Dakota is 1,813:1 and in Deuel County the ratio is 4,320:1.

Preventable hospital stays are 63 in Deuel County, 57 in South Dakota, and 41 nationally.

Diabetic screening is at 92% in Deuel County and 84% in South Dakota as a whole. Mammography screening is at 75% in Deuel County and 66.5% in South Dakota.

The social and economic factor outcomes indicate that South Dakota is at 78% for high school graduation. Deuel County does not have data reported in the County Health Rankings for graduation rate. Post-secondary education (some post-secondary education) is at 58% in Deuel County and 66.7% in South Dakota.

The unemployment rate is 5.1% in Deuel County and 3.8% in South Dakota. The percentage of child poverty is 13% in Deuel County. The child poverty rate is 19% in South Dakota.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is in Deuel County is 22.8. The state of South Dakota ranks at 17.4.

The percentage of children in single parent households is 15% in Deuel County and 31% in South Dakota.

Violent crime is lower in Deuel County at 30 per 100,000 populations than South Dakota, which has 282 cases per 100,000 populations.

The following needs were brought forward for prioritization:

- Aging
- Children and Youth
- Safety
- Health Care Access
- Physical Health
- Mental Health/Behavioral Health Substance Abuse
- Preventive Health

Members of the community stakeholders determined that mental health and physical health are the top unmet needs.

- Mental Health
- Physical Health

Sanford has determined the 2017-2019 implementation strategies for the following needs:

- Priority 1: Mental Health
- Priority 2: Physical Health

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

Mental health includes emotional, psychological, and social well-being. It affects how people think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health problems are common but people with mental health problems can get better and many recover completely.

Sanford has prioritized mental/behavioral health as a top priority and has formalized strategy to help with access to increase utilization of resources for those in need of mental health services, and to establish telehealth outreach services.

Sanford will develop a directory of mental health services that are available to community members. The directory will be distributed to groups and organizations in the community.

Priority 2: Physical Health

Physical health consists of many components, including rest and sleep, nutrition, physical activity, and self- care. Primary prevention is a way to remain physically healthy.

Sanford has formalized strategy to increase compliance of preventive screenings and services. The focus will be on colorectal screenings, mammography, diabetic foot care and vaccinations.

Sanford Clear Lake Medical Center

Community Health Needs Assessment 2016

Table of Contents

Purpose

A community health needs assessment is critical to a vital community benefit program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment helps the community build capacity to support policy, systems, environmental changes and community health improvement. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining not-for-profit status.

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

Our Guiding Principles:

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

Acknowledgements

Sanford Health would like to acknowledge and thank the Steering Committees for their assistance and expertise while performing the assessment and analysis of the community health data. The assessment provides support for the future direction of our work.

Sanford Enterprise Steering Group:

- JoAnn Kunkel, CFO, Sanford Enterprise
- Michelle Bruhn, CFO, Health Services Division
- Tiffany Lawrence, CPA, Fargo Region Co-Lead, CFO, Sanford Medical Center Fargo
- Bruce Viessman, Sioux Falls Region Co-Lead, CFO, Sanford Health Network
- Martha Leclerc, MS, Vice President, Revenue Management
- Randy Bury, CAO, Health Services Division
- Steve Goetsch, CFO, Sioux Falls Region
- Jane Heilmann, Senior Corporate Communications Strategist
- Joy Johnson, COO Bemidji Region
- Kirk Christy, CFO, Bismarck Region

- Carrie McLeod, MBA, MS, LRD,CDE, Enterprise Lead, Enterprise Community Health/Community Benefit

Sanford Clear Lake Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health /Community Benefit
- Stephanie Dobbs, Chief Nursing Officer, Sanford Clear Lake Medical Center
- Renee Axtell, Outreach Coordinator, Sanford Clear Lake Medical Center

We express our gratitude to the following community collaborative members for their expertise with the planning, development and analysis of the community health needs assessment.

- Alicia Collura, Sioux Falls Public Health
- Anita Cardinal, Pennington County Public Health
- Ann Malmberg, Essentia Health
- Becky Secore, Beltrami County Public Health Unit
- Brenda Stallman, Traill County Public Health
- Brie Taralson, Essentia Health
- Brittany Ness, Steele County Public Health
- Caitlin Hurley, Avera Health
- Carrie McLeod, Sanford Health
- Dan Heinemann, MD, CMO, Sanford Health Network, Sioux Falls Region
- Jac McTaggart, Sanford Health
- Jessica Spaeth, City of Halstad
- Joy Johnson, Sanford Health
- Julie Jeske, CHI-St. Alexius Health
- Julie Miller, South Dakota Department of Health
- Julie Ward, Avera Health
- Katie Olson, South Dakota State University
- Kay Schwarzwalter, Center for Social Research, North Dakota State University
- Kim Jacobson, Traill County Public Health
- Kip Littau, South Dakota State University
- Marnie Walth, Sanford Health
- Mary Michaels, Sioux Falls Public Health
- Nancy Fahrenwald, South Dakota State University
- Renae Moch, Burleigh County Public Health
- Roger Baier, Sanford Health
- Ruth Bachmeier, Fargo Cass Public Health
- Sandra Melstad, Public Health Consultant, South Dakota Department of Health
- Stan Kogan, Sioux Falls Public Health
- Stephen Pickard, PhD., North Dakota Department of Health
- Susan Kahler, Burleigh County Public Health
- Teresa Miller, Avera Health

We extend special thanks to the community and county leaders, public health administration, physicians, nurses, representatives from the community and diverse populations for their participation

in this work. Together we are reaching our vision “to improve the human condition through exceptional care, innovation and discovery”.

The following Deuel County community stakeholders participated in community discussions and helped to formulate the priorities for future work:

- Marlin Bjerke, Hospital Board Member
- Mark Law, Ambulance Director
- Bob Atyeo, Hospital Board Member, Ambulance Service
- Dean Christensen, School Superintendent, Hospital Board Member
- Darla Tobin, Business Office Manager/Quality Manager
- Marcile Djonne, Community Member
- Lori Hlavacek, RN, Clinic Nurse Supervisor
- Stephanie Dobbs, RN, Chief Nursing Officer
- Tammy Baer, RN, Community Health Nurse
- Paul Brandt, Board Member
- Tamara Pommer, RN, Health Coach
- Renee Axtell, RN, Outreach Coordinator
- Lori Sisk, CEO

Description of Sanford Clear Lake Medical Center, Clear Lake, SD

Sanford Clear Lake Medical Center is a community-based, 20-bed acute care Critical Access Hospital serving over 4,500 people in Deuel County in southeastern South Dakota. The nearest tertiary center is in Sioux Falls, SD, approximately 100 miles to the south. The medical center is located in a medically underserved area with high infant mortality, poverty and an elderly population.

Sanford Clear Lake Medical Center offers 24-hour emergency room services, and has an attached rural health clinic with 1 full-time provider and 1 full-time nurse practitioner. Other services include home health care, community health and an off-site wellness center. Sanford Clear Lake has an active outreach program to provide same day outpatient surgery, cardiac rehab and other cardiology services, therapies, podiatry, nephrology, psychology, radiology and lab.

Description of the Community Served - Clear Lake, SD

Clear Lake is located in Deuel County in southeastern South Dakota. It has a population of 1,200 and was named after the local Clear Lake. It is home to two community parks, a pool, athletic complex, six churches and the Deuel County Courthouse.

Clear Lake hosts one of the largest rodeos in the area, drawing thousands of people to the town. It is held in the nation's most natural rodeo bowl in the Coteau Hills, a native grassland prairie formed by glaciers. During the rodeo, visitors and residents alike enjoy camping, community garage and yard sales, and a parade.

Study Design and Methodology

1. Non-Generalizable Survey

   An on-line non-generalizable survey was conducted of residents in Clear Lake and Deuel County, South Dakota. The survey instrument was developed in partnership with public health leaders from across the enterprise, and researchers at the Center for Social Research (CSR) at North Dakota State University (NDSU). The CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various community stakeholders and community agencies, at times using a snowball approach**.** Data collection occurred throughout the month of March 2015 and a total of 35 respondents participated in the on-line survey.

   The purpose of the non-generalizable survey of residents in the greater Clear Lake area was to learn about the perceptions of area community leaders regarding community health, their personal health, preventive health, and the prevalence of disease. This group included community leaders and agency leaders representing public health, city government, chronic disease and disparity.

   A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.0 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.0 are being addressed by Sanford and community partners. However, 3.0 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

   Community stakeholders were invited to a meeting to review the early findings from the generalizable survey and to discuss the top health issues or health-related issues facing the community. The community stakeholders helped to determine key priorities for the community.

3. Community Asset Mapping

   Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. The process implemented in this work was based on the McKnight Foundation model - Mapping Community Capacity by John L. McKnight and John P. Kretzmann, Institute for Policy Research at Northwestern University.
   Each unmet need was researched to determine what resources were available in the community to address the needs. The community stakeholder group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes County Health Rankings for Deuel County.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Deuel County, South Dakota. However, when comparing certain demographic characteristics (i.e., age, income, minority status) with the current population estimates from the U.S. Census Bureau, it was evident that older, white, more highly educated, and higher income earners were overrepresented. Overrepresentation of this nature is typical in health needs assessments.

A good faith effort was made to secure input from a broad base of the community. The generalizable survey was mailed to a representative group of the area to assure input from all demographics. Additionally, invitations were extended to county and community leaders, organizations and agencies representing diverse populations and disparities.

Additional data was reviewed through secondary research. The data for the secondary research was secured from the County Health Rankings.

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

Sanford extended a good faith effort to engage all of the aforementioned community representatives in the survey process. In some cases there were surveys that were submitted without names or without a specified area of expertise or affiliation. We worked closely with public health experts throughout the assessment process.

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

Key Findings

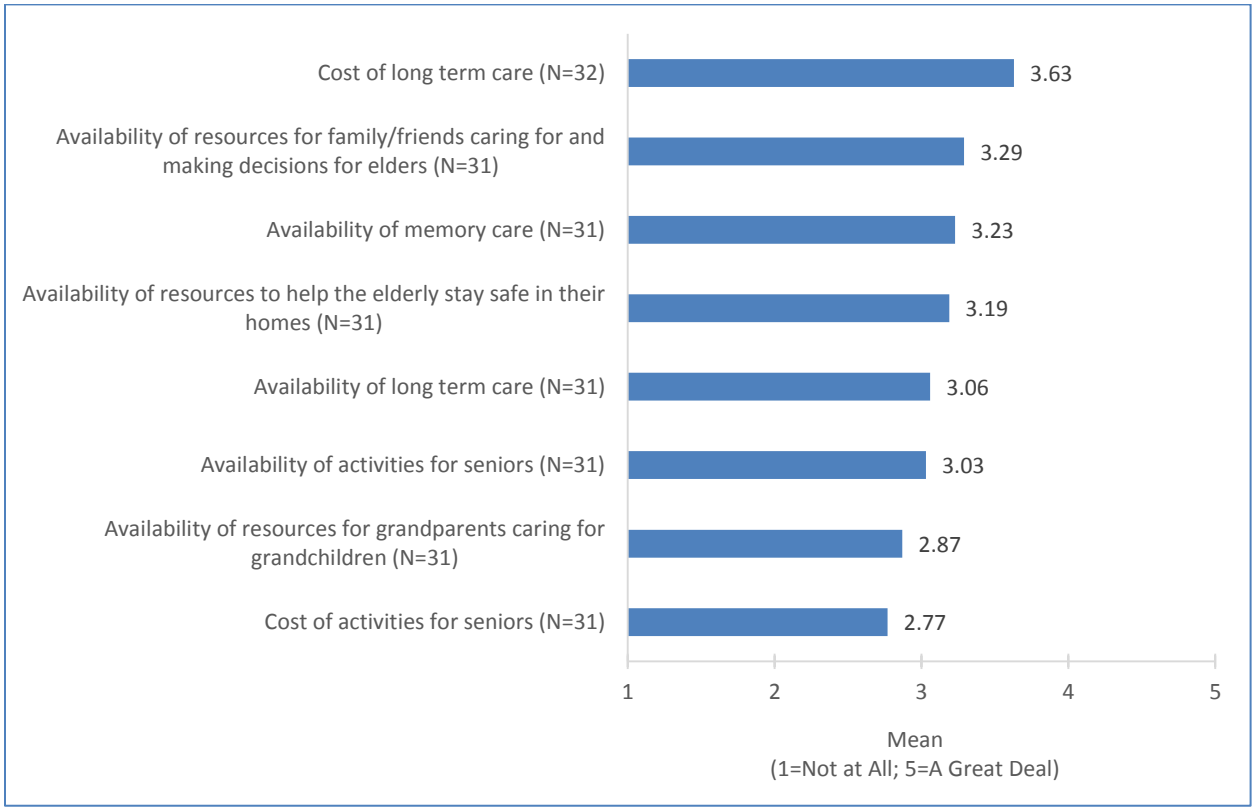
Primary Research

Community Health Concerns

The following concerns ranked highest of all the indicators on the non-generalizable (community stakeholders) surveys.

Aging Population: The cost of long term care is the highest concern for the community stakeholder survey respondents.

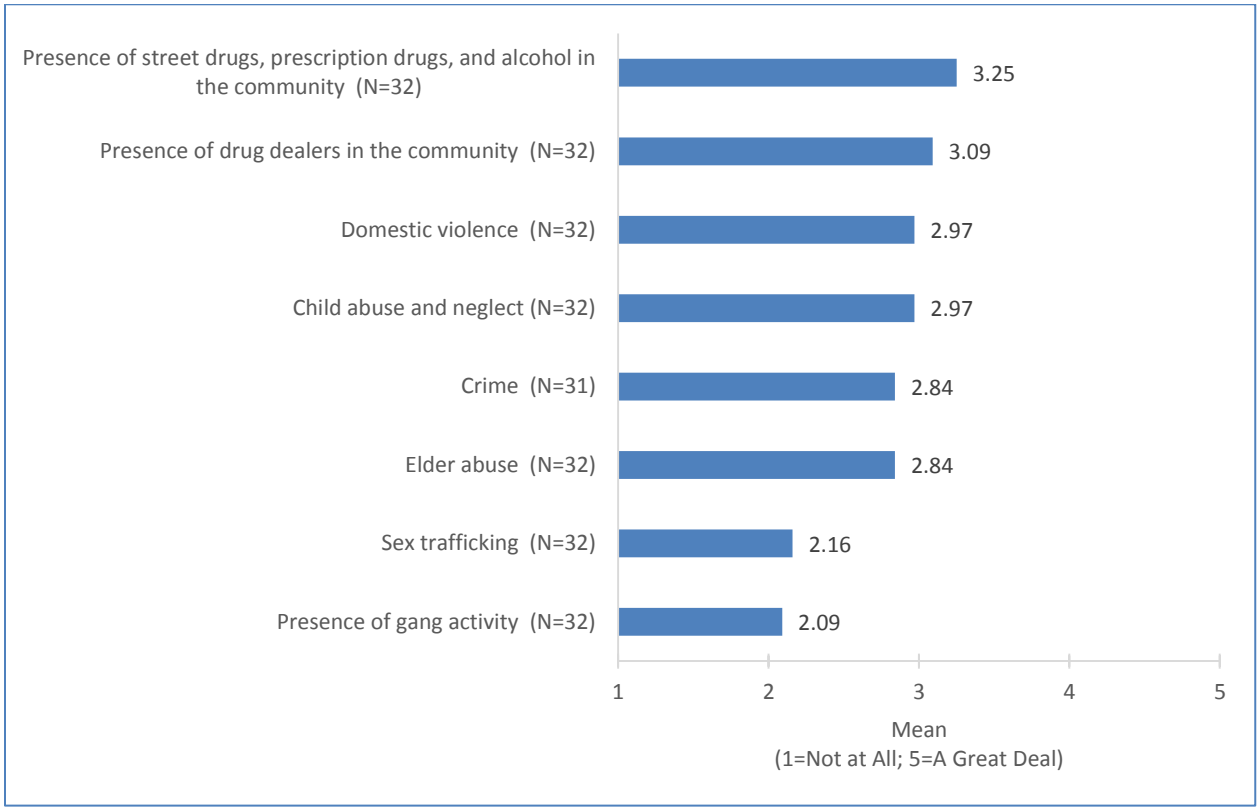
Level of concern with statements about the community regarding the AGING POPULATION



Sanford is working collaboratively with the area aging service providers to coordinate care for the aging population. Social workers, case managers, and discharge planners are working collaboratively with area service providers to assure safe discharge, and when appropriate, to assist in transitions from levels of care.

Safety: Safety is a high concerns for the respondents of the non-generalizable survey regarding the presence of street drugs and alcohol in the community, and drug dealers in the community.

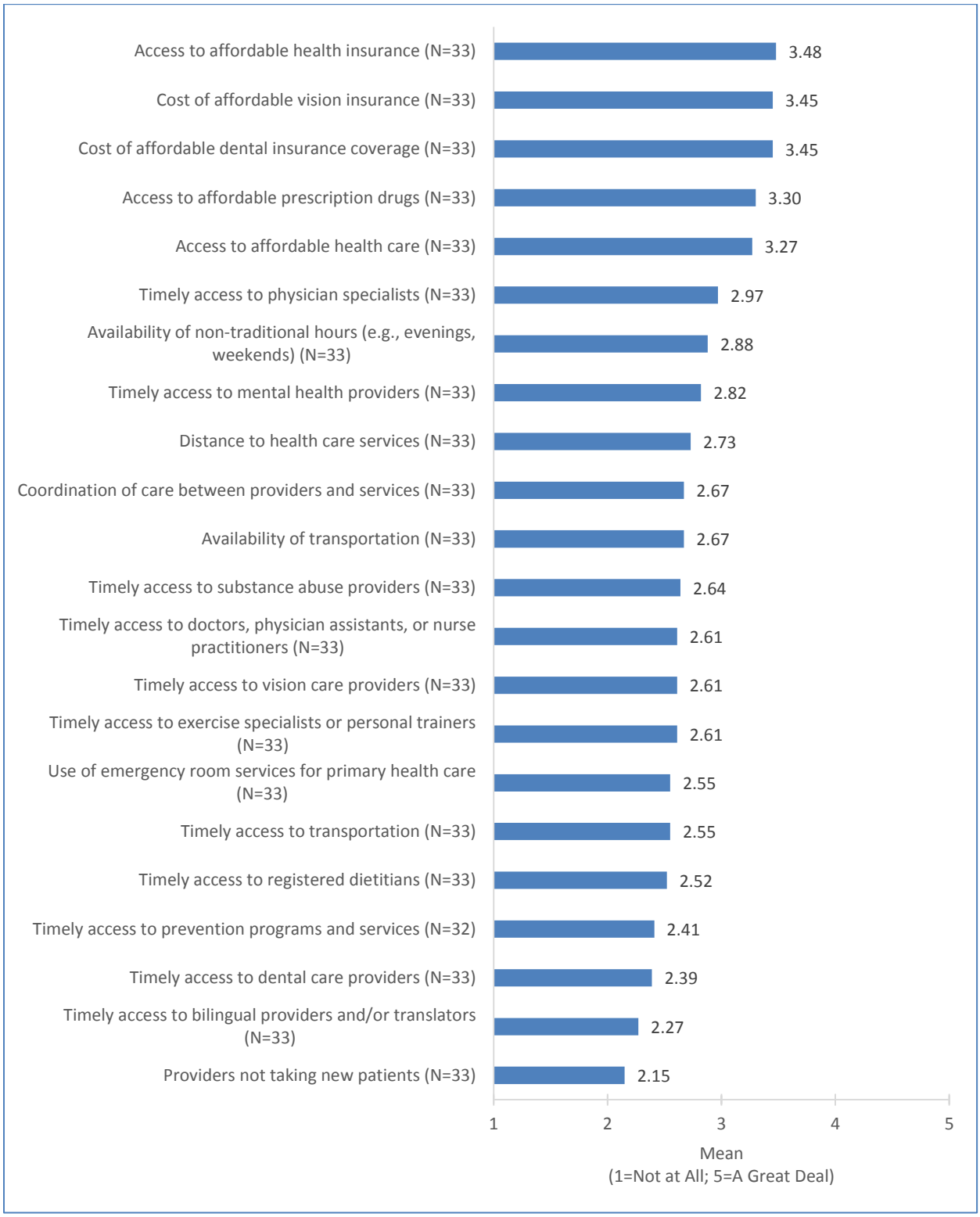
Level of concern with statements about the community regarding SAFETY



The Clear Lake area law enforcement agency is actively involved in monitoring drugs and alcohol in the community. Numerous prevention programs are available.

Health Care Access: Community stakeholders ranked the access to affordable health insurance, the cost of affordable vision and dental insurance, access to affordable prescription drugs, and access to affordable health care as top concerns for healthcare access.

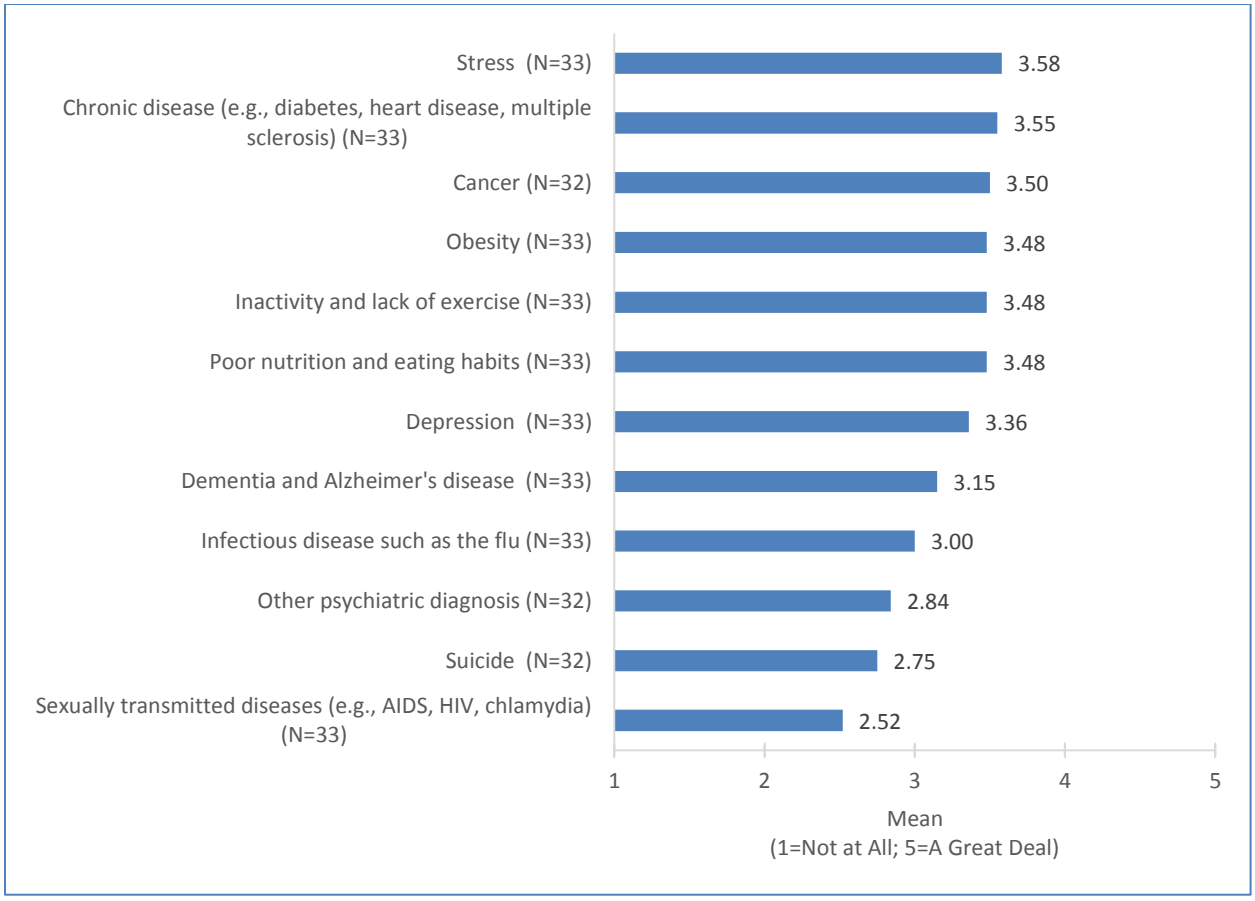
Level of concern with statements about the community regarding HEALTH CARE



Sanford Clear Lake offers charity care to patients unable to pay for medical treatment. Sanford's community care policy defines qualifications and financial counselors are available to assist patients who qualify for free or subsidized care. Financial counselors also assist with enrollment for patients who qualify for public programs. Prescription drugs are made available at a free or reduced rate for patients who are unable to pay. The Sanford Health Plan is also available to community members.

Physical Health: The top physical health concern among the community stakeholders is chronic disease. Cancer, obesity, inactivity, and poor nutrition and eating habits are also ranked as high concerns. The mental health concerns in this graph are discussed in the next section.

Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH



Sanford is adding telemedicine services for diabetes and cardiology patients. A registered dietitian is available to provide medical nutrition therapy and education sessions.

The chronic disease self-management Better Choices, Better Health Program at Sanford is offered free of charge to community members. Better Choices, Better Health is modeled after Stanford University's chronic disease self-management program. The workshops are 2 ½ hours

long and meet weekly for 6 weeks. The program is facilitated by two trained lay leaders, and one or both of them have a chronic condition themselves. Research has found that after participating in the program, individuals are better able to manage their symptoms, communicate more easily with their doctors, are less limited by the disease, and generally feel better.

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* Initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents benefit from their own set of resources where they can find tips and tools on becoming healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites, including videos, slideshows, games, articles, and even *fit* songs.

- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.

- *fit*4Schools – *fit*4Schools includes unique *fit*-based lessons integrated into daily classroom activities. *fit*4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:
    - Reached 50,000 schools
    - 180,000 page views from educators across the country
    - 12,000 lesson plan downloads, representing 600,000+ students

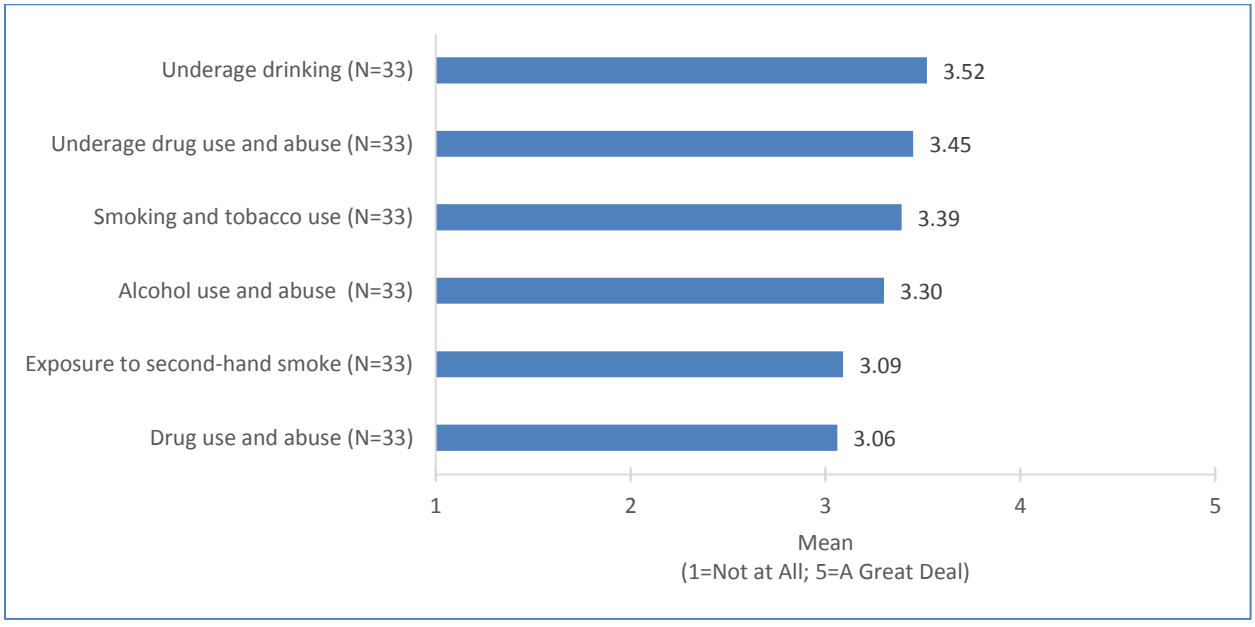
- Community
    - The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint. *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
    - Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
    - MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.

- eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward
  - *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:
    - Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between health care providers and families.
    - Health Coaches – Exploring meaningful ways for health coaches to promote healthy choices with children and adults.
    - Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach efforts.
    - *fit*Club 4 Boys – 10-week after school program for boys, ages 8-12, to develop knowledge of *fit* principles and healthy behavior choices.
    - *fit* Parent/child – Class for parents and children to understand healthy choices and the benefits of living a healthy lifestyle.

Mental Health /Behavioral Health: The top behavioral health concerns are stress, depression, and dementia and Alzheimer's disease. Underage drinking, underage drug use and abuse, drug use and abuse, smoking and tobacco use, exposure to second hand smoke, and alcohol use and abuse are all high concerns for behavioral health among survey respondents.

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

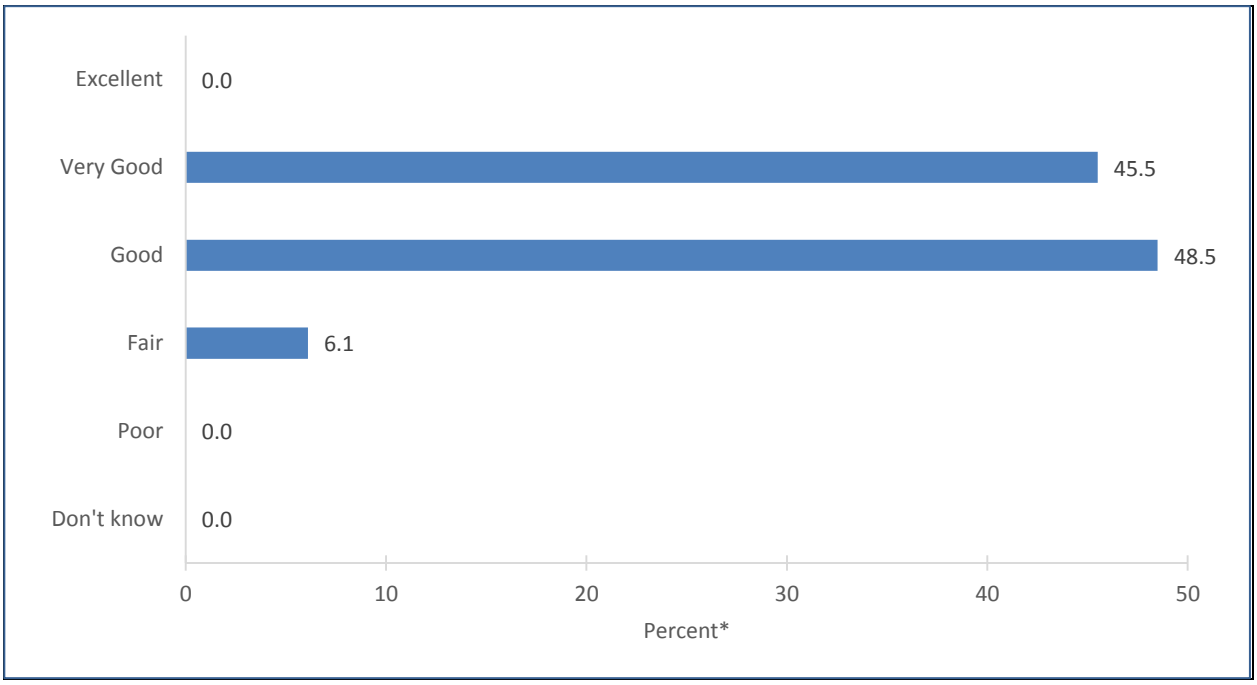


Personal Health Concerns

Respondents' Personal Health Status

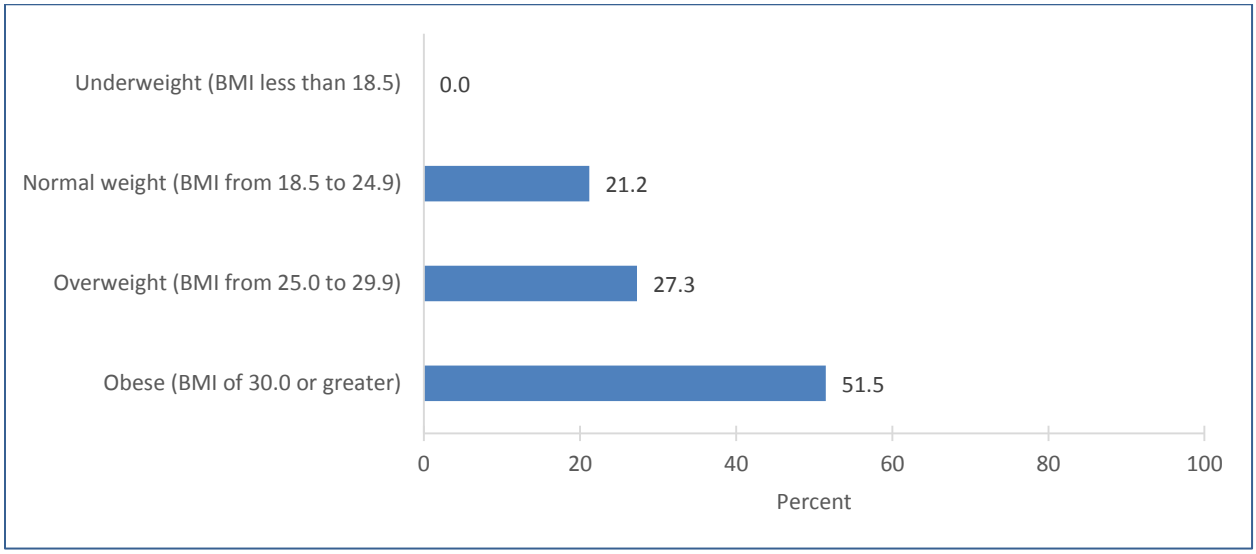
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area (76.5%) are overweight or obese. However, the vast majority (94%) of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, over 78% of respondents visited a doctor or health care provider for a routine physical and over 75% visited a dentist or dental clinic.

Respondents' rating of their health in general



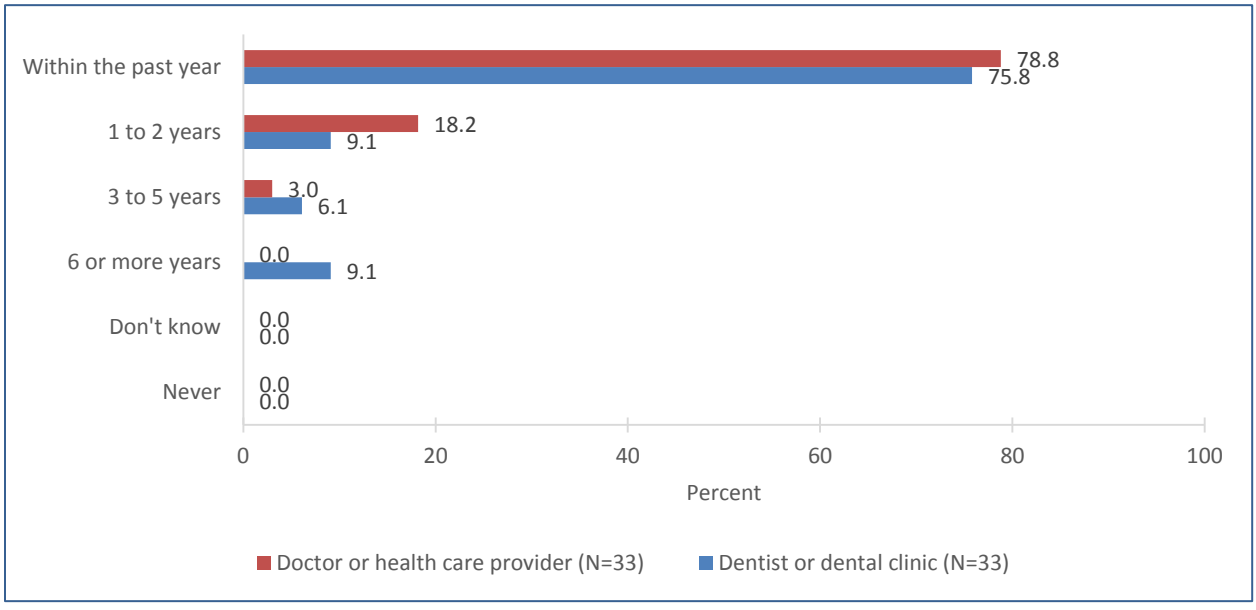
94% of the community stakeholders (non-generalizable) rate their health as good or better.

Respondents' weight status based on the Body Mass Index (BMI) scale



76.5% of the key stakeholders report a BMI that is overweight or obese.

Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason



Preventive Health

Preventive health care promotes the detection and prevention of illness and disease and is another important component of good health and well-being. Community results indicate that within the past year, the majority of respondents had a blood pressure screening, blood sugar screening, cholesterol screening, and dental screening.

There are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, cardio screening, glaucoma test, hearing screening, immunizations, STD test, vascular screening, colorectal cancer screening, and skin cancer screening) in the past year. Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate.

Whether or not respondents have had preventive screenings in the past year, by type of screening

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=33)	90.9	9.1	100.0
Blood sugar screening (N=33)	75.8	24.2	100.0
Bone density test (N=33)	12.1	87.9	100.0
Cardiovascular screening (N=33)	21.2	78.8	100.0
Cholesterol screening (N=33)	66.7	33.3	100.0
Dental screening and X-rays (N=32)	78.1	21.9	100.0
Flu shot (N=32)	78.1	21.9	100.0
Glaucoma test (N=32)	46.9	53.1	100.0
Hearing screening (N=31)	9.7	90.3	100.0
Immunizations (N=30)	40.0	60.0	100.0
Pelvic exam (N=27 Females)	66.7	33.3	100.0
STD (N=32)	12.5	87.5	100.0
Vascular screening (N=32)	9.4	90.6	100.0
CANCER SCREENINGS			
Breast cancer screening (N=27 Females)	66.7	33.3	100.0
Cervical cancer screening (N=28 Females)	60.7	39.3	100.0
Colorectal cancer screening (N=32)	28.1	71.9	100.0
Prostate cancer screening (N=5 Males)	60.0	40.0	100.0
Skin cancer screening (N=33)	24.2	75.8	100.0

Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=3)	66.7	0.0	33.3	0.0	0.0	0.0	0.0
Blood sugar screening (N=8)	50.0	37.5	12.5	0.0	0.0	0.0	0.0
Bone density test (N=29)	31.0	58.6	3.4	3.4	0.0	0.0	3.4
Cardiovascular screening (N=26)	34.6	46.2	3.8	0.0	0.0	0.0	0.0
Cholesterol screening (N=11)	45.5	27.3	9.1	0.0	0.0	0.0	9.1
Dental screening and X-rays (N=7)	42.9	14.3	42.9	0.0	0.0	0.0	0.0
Flu shot (N=7)	71.4	14.3	0.0	0.0	0.0	0.0	28.6
Glaucoma test (N=17)	64.7	17.6	5.9	0.0	0.0	0.0	0.0
Hearing screening (N=28)	50.0	28.6	7.1	0.0	0.0	0.0	3.6
Immunizations (N=18)	50.0	33.3	5.6	0.0	0.0	0.0	11.1
Pelvic exam (N=9 Females)	22.2	66.7	11.1	0.0	0.0	0.0	0.0
STD (N=28)	60.7	28.6	3.6	0.0	0.0	0.0	3.6
Vascular screening (N=29)	31.0	65.5	3.4	0.0	0.0	0.0	0.0
CANCER SCREENINGS							
Breast cancer screening (N=9 Females)	44.4	22.2	11.1	0.0	0.0	0.0	22.2
Cervical cancer screening (N=11 Females)	18.2	54.5	9.1	0.0	0.0	0.0	18.2
Colorectal cancer screening (N=23)	52.2	30.4	4.3	4.3	0.0	0.0	8.7
Prostate cancer screening (N=2 Males)	50.0	50.0	0.0	0.0	0.0	0.0	0.0
Skin cancer screening (N=25)	32.0	52.0	4.0	0.0	0.0	0.0	12.0

*Percentages do not total 100.0 due to multiple responses.

- *For most types of screenings, the most common reasons for not getting the test or procedure are that it is not necessary and the doctor has not suggested one.*
- *For the flu shot screening, most respondents cite that it was not necessary or other reasons for not getting the shot.*
  45.5% of the respondents were under 45 years of age.

Breast cancer screening: According to the Center for Disease Control (CDC), a mammogram is an x-ray of the breast. Mammograms are the best way to find breast cancer early, when it is easier to treat and before it is big enough to feel or cause symptoms. Having regular mammograms can lower the risk of dying from breast cancer. The U.S. Preventive Services Task Force recommends that if you are 50 to 74 years old, be sure to have a screening mammogram every two years. If you are 40 to 49 years old, talk to your doctor about when to start and how often to get a screening mammogram.

Cervical cancer screening: Cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up. Two screening tests can help prevent cervical cancer or find it early:

- The Pap test (or Pap smear) looks for *pre-cancers*, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- The HPV test looks for the virus (human papillomavirus(http://www.cdc.gov/cancer/hpv/basic_info/)) that can cause these cell changes.

The Pap test is recommended for all women between the ages of 21 and 65 years old, and can be done in a doctor's office or clinic.

Colorectal cancer screening: Colorectal cancer almost always develops from *precancerous polyps* (abnormal growths) in the colon or rectum. Screening tests can also find colorectal cancer early, when treatment works best. Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 years and continuing until age 75 years.

Prostate cancer screening: The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:

- Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.
- Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65).
- Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).

After this discussion, those men who want to be screened should be tested with the prostate-specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as a part of screening.

If, after this discussion, a man is unable to decide if testing is right for him, the screening decision can be made by the health care provider, who should take into account the patient’s general health preferences and values.

Assuming no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test:

- Men who choose to be tested who have a PSA of less than 2.5ng/mL may only need to be retested every 2 years.
- Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.

Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone is important when making decisions about screening.

Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing becomes available. Further discussions are also needed to take into account changes in the patient's health, values and preferences.

Skin cancer screening: The U.S. Preventive Services Task Force (USPSTF) has concluded there is not enough evidence to recommend for or against routine screening (total body examination by a doctor) to find skin cancers early. The USPSTF recommends that doctors:

- Be aware that fair-skinned men and women aged 65 and older, and people with atypical moles or more than 50 moles, are at greater risk for melanoma.
- Look for skin abnormalities when performing physical examinations for other reasons.

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the generalizable survey indicate that 37% of respondents did not have a flu shot last year.

The Center for Disease Control states that influenza is a serious disease that can lead to hospitalization and sometimes even death. Even healthy people can get sick from the flu and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies provide protection against infection with the viruses that are in the vaccine.

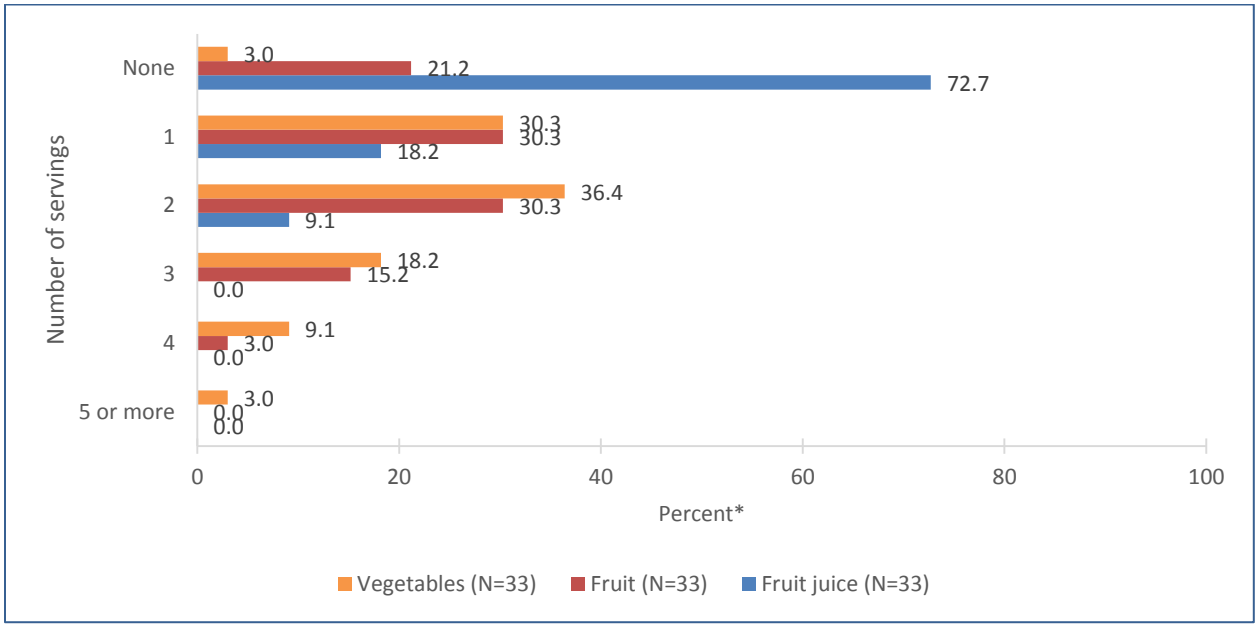
Sanford Health employees are required to have an annual flu vaccine as a protective measure for our patients as well as our staff.

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 37.8% of respondents reported having 3 or more servings of vegetables the prior day. Only 23% reported having 3 or more servings of fruits the prior day.

According to the U.S. Department of Health and Human Services, U.S. Department of Agriculture - Dietary Guidelines for Americans, it is recommended that individuals consume 3 to 5 servings of vegetables per day and 2 to 4 servings of fruit per day depending on age. A meal plan high in fruits and vegetables is associated with decreased risk for chronic diseases. In addition, because fruits and vegetables have low energy density (i.e., few calories relative to volume), eating them as part of a reduced-calorie meal plan can be beneficial for weight management.

Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday

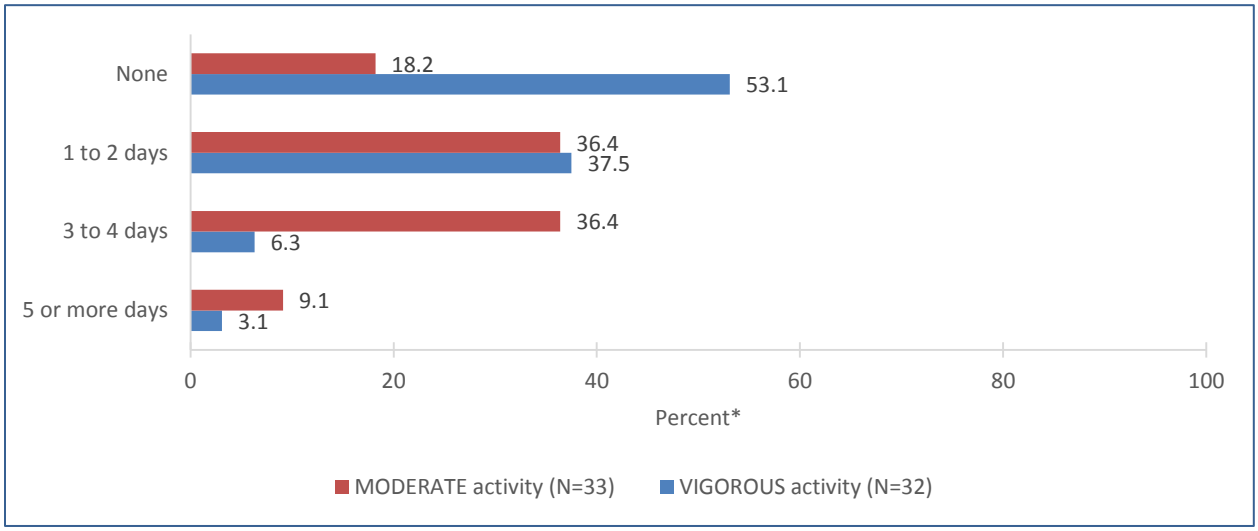


Physical Activity Levels

Study results suggest that 50% of respondents do meet physical activity guidelines. 23% of respondents have 3 or more days per week with moderate activity.

Guidelines from the Centers for Disease Control and Prevention recommend that individuals participate in 150 minutes of moderate physical activity per week or 75 minutes of vigorous physical activity per week to help sustain and improve health.

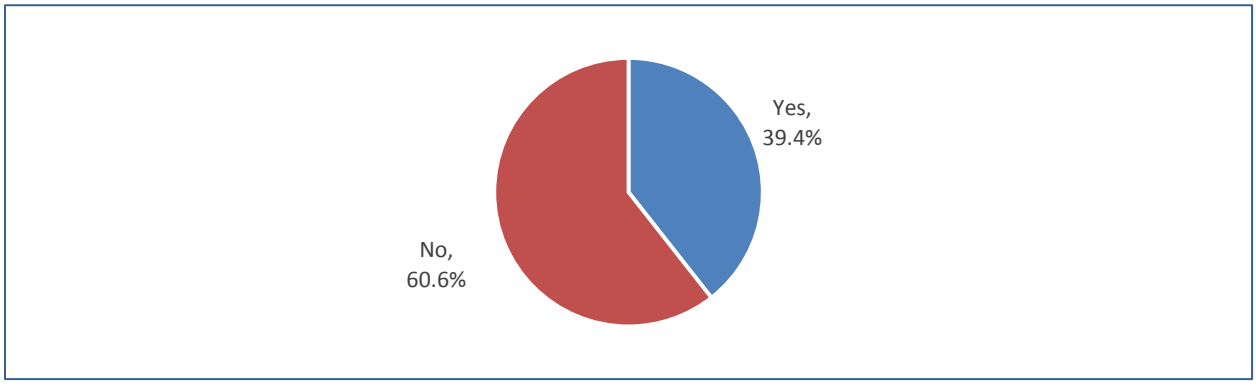
Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



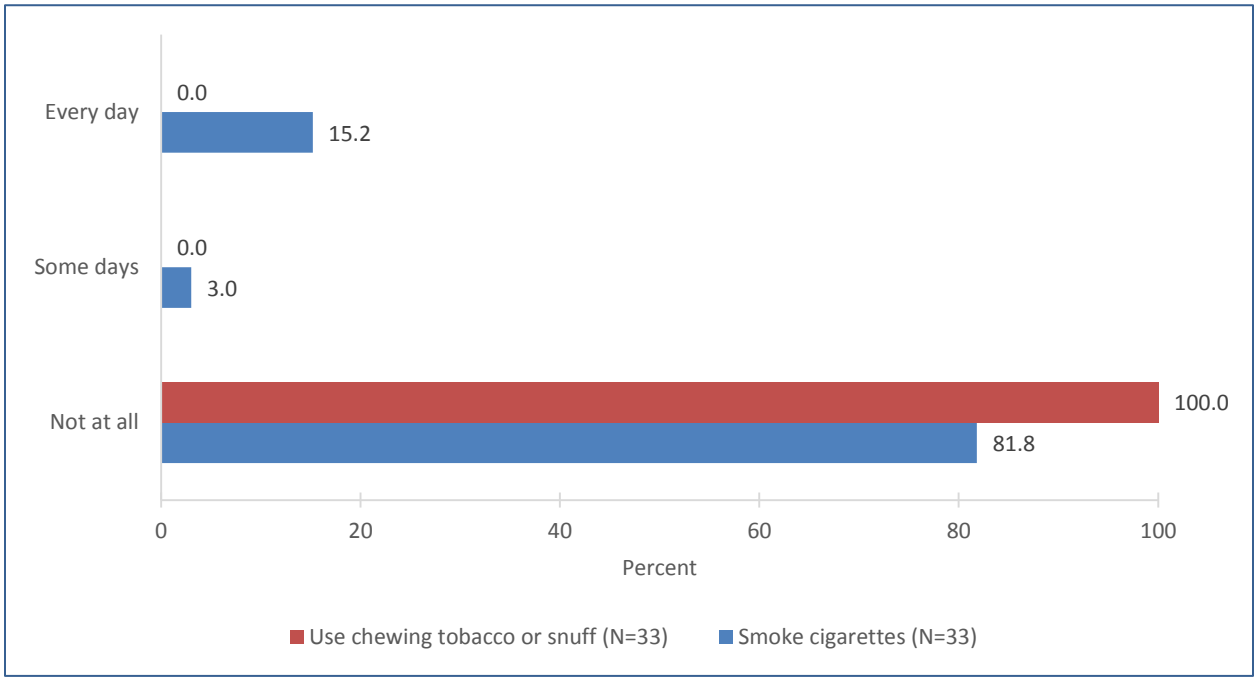
Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 39.4% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates a former smoker status according to the Centers for Disease Control and Prevention.

Whether respondents have smoked at least 100 cigarettes in their entire life



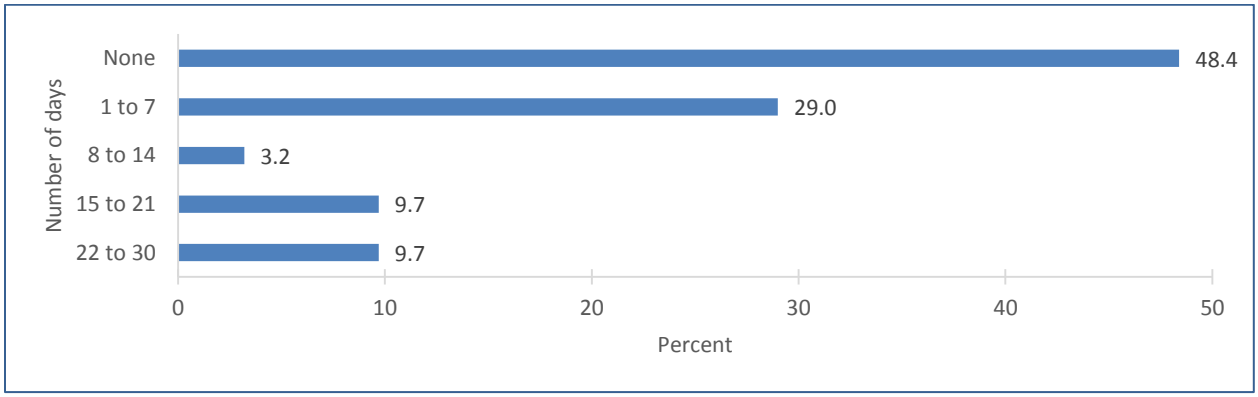
How often respondents currently smoke cigarettes and use chewing tobacco or snuff



Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others. Among Clear Lake respondents, mental health is a moderately high area of concern, particularly depression, and stress. 22.9% of respondents have been told or diagnosed by a doctor or health professional that they have anxiety or stress and 22.9% have been told they have depression. In addition, 44.3% of respondents self-report that in the last month, there were days when their mental health was not good.

Number of days in the last month that respondents' mental health was not good

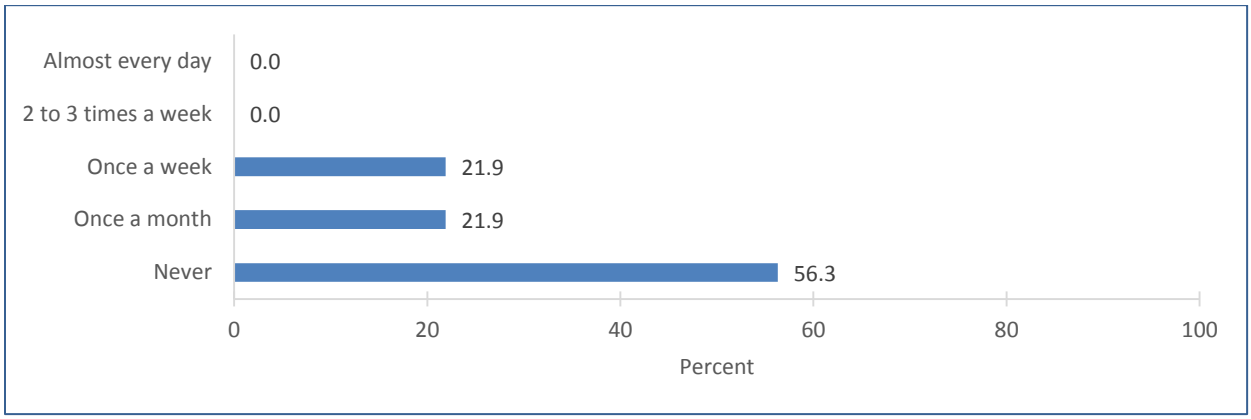


Substance Abuse Responses

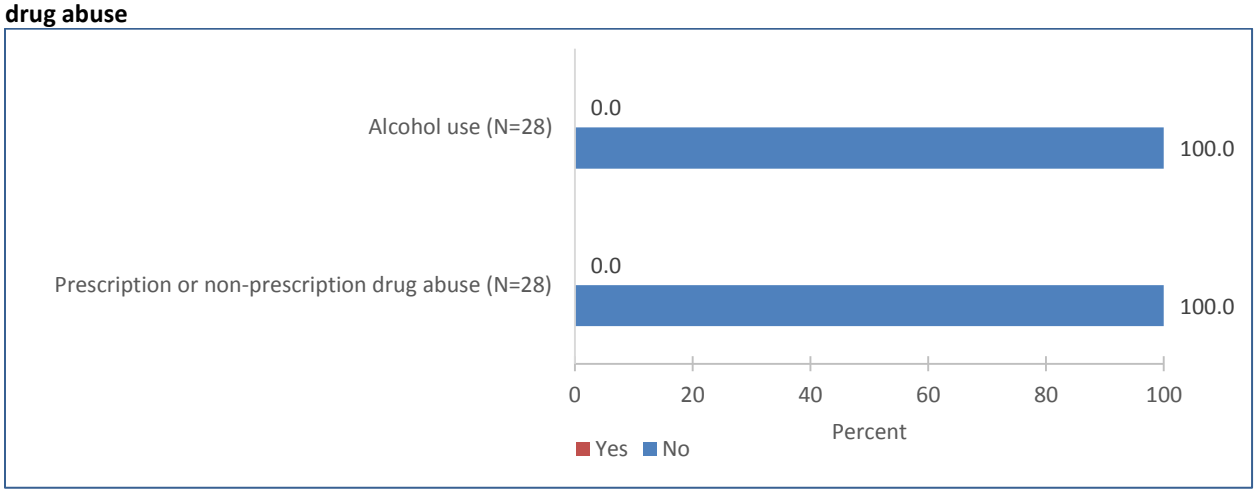
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In Deuel County, 76.7% of the community stakeholder's respondents drank alcoholic beverages on at least one of the days in the last month. On days they drank, 26.3% of respondents drank an average of 3 or more drinks per day. In regards to binge drinking, 36% of community stakeholder's respondents report binge drinking at least once per month,

Secondary research through the 2015 County Health Rankings found that 22% of residents in Deuel County report excessive drinking. (See Appendix)

Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (binge drinking is defined by the CDC as 4 drinks for females, 5 drinks for males) on the same occasion



Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse



No respondents reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking (36%). Other forms of substance abuse include the use of prescription or non-prescription drugs. No respondents reported having had a problem with prescription or non-prescription drug abuse.

Demographics

Total Population – 2010 U.S. Census Bureau

- Deuel County: 4,364

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	270	6.2	144	3.3	126	2.9
5-9	272	6.2	153	3.5	119	2.7
10-14	294	6.7	158	3.6	136	3.1
15-19	290	6.6	139	3.2	151	3.5
20-24	168	3.8	96	2.2	72	1.6
25-29	221	5.1	120	2.7	101	2.3
30-34	229	5.2	120	2.7	109	2.5
35-39	226	5.2	112	2.6	114	2.6
40-44	268	6.1	128	2.9	140	3.2
45-49	342	7.8	180	4.1	162	3.7
50-54	360	8.2	197	4.5	163	3.7
55-59	301	6.9	157	3.6	144	3.3
60-64	284	6.5	148	3.4	136	3.1
65-69	223	5.1	106	2.4	117	2.7
70-74	190	4.4	97	2.2	93	2.1
75-79	169	3.9	83	1.9	88	2.0
80-84	133	3.0	63	1.4	70	1.6
85 and over	124	2.8	49	1.1	75	1.7
Median age	43.9		42.9		44.6	

Population by Race

	Deuel	Percent
White	4,253	97.5
Black or African American	13	0.3
American Indian or Alaska Native	12	0.3
Asian	4	0.1
Native Hawaiian or other Pacific Islander	0	0.0
Hispanic or Latino	86	2.0

The per capita personal income in Deuel County, South Dakota is $28,810. The poverty level is at 10.1% and consists of individuals 15 years and older in Deuel County who are living below the poverty level. The unemployment rate in Deuel County, South Dakota is 5.1%.

Health Needs and Community Resources Identified

One of the Internal Revenue Service requirements for a community health needs assessment is to identify the resources that are available in the community to address unmet needs. Sanford Health conducted asset mapping by reviewing the primary and secondary research and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources are available in the community to address the needs.

Sanford Health and community partners developed the asset map. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

The process implemented in this work was based on the McKnight Foundation model - Mapping Community Capacity by John L. McKnight and John P. Kretzmann, Institute for Policy Research at Northwestern University.

The asset map process includes identified needs from the following:

- The non-generalizable survey
- Concerns expressed by the key stakeholder group
- Secondary research data
- Community resources that are available to address the need(s)

The Asset Map is included in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Aging - cost of long term care, availability of resources for family /friends caring for and making decisions for elders
- Children and Youth – bullying, availability and cost of activities
- Safety – presence of street drugs and alcohol in the community
- Health Care Access – affordable insurance (health, vision, dental), affordable prescription drugs, affordable health care
- Physical Health – chronic disease, cancer, obesity, inactivity, poor nutrition
- Mental Health/Behavioral Health - substance abuse, stress, depression, dementia and Alzheimer's
- Preventive Health - underage drinking and drug abuse, smoking and tobacco, alcohol use and abuse

Sanford is addressing all of the assessed needs that fall within our scope of work. In some cases the need is one where we do not have the expertise to adequately address the need. However, Sanford leaders will communicate these findings to community leaders and experts who can best focus on a solution to the concern.

A document that shares what Sanford is doing to address the need or defends why Sanford is not addressing the need can be found in the next section.

Members of the collaborative determined that mental health and physical health are top unmet needs for further implementation strategy development.

Sanford has determined the 2016-2019 implementation strategies for the following needs:

- Mental Health
- Physical Health

2016 Community Health Needs Assessment
Sanford Clear Lake Medical Center

Addressing the Needs

Identified Concerns	How Sanford Clear Lake is Addressing the Needs
Aging • Cost of long-term care • Availability of resources for family /friends caring for and making decisions for elders • Availability of memory care	• Although we cannot modify the rates of the long term care facility, the social worker will be available to assist residents and patients with applying for assistance to help with the cost once personal resources have been exhausted. • Early education on long term care insurance would also be helpful. • Family/friends acting as caregivers have access to the Department of Social Services, Adult Services and Aging in Watertown, SD for inquiry. • Local nursing home and assisted living are equipped with Wander Guard system to allow safe environment for someone needing memory care. A secure memory unit, separate from general population, can be found in Watertown, SD.
Children and Youth • Bullying • Availability of activities for children and youth • Cost of activities for children and youth • Children living in poverty 13% • Children in single parent households 15%	• The school counselor at the Clear Lake School offers various programs such as the *Rachel's Challenge* to educate students and families about bullying. • Various activities are offered both at a school level as well as a community level such as: basketball, volleyball, football, cheerleading, track, wrestling, gymnastics, 4-H, rodeo, etc. All activities are offered free of charge through the school except for the cost of personal gear (shoes, practice shorts, etc.).
Health Care • Access to affordable health insurance • Cost of affordable vision insurance • Cost of affordable dental insurance coverage • Access to affordable prescription drugs • Access to affordable health care • Unmet medical needs • Unmet mental health needs • Need prescription medications	• Reviewing health maintenance on all inpatients in order to identify testing that needs to be completed. • Adding telemed services to include ENT, Diabetes/Endocrinology. Cardiology is also being provided opportunities to complete telemed with unforeseen weather permitting travel so appointments are not cancelled last minute. • We work closely with our pharmacists here at Sanford Clear Lake to ensure all options for discount medication education are provided.

Identified Concerns	How Sanford Clear Lake is Addressing the Needs

Safety
• Presence of street drugs and alcohol in the community
	Law enforcement is actively involved in monitoring drugs and alcohol in the community.
	
	Ideas for preventive programs include:
	• Preventive programs should enhance protective factors and reverse or reduce risk factors
	• Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol)
	• Prevention programs should address the type of drug abuse problem in the local community
	• Prevention programs can start as early as elementary school children to work on self-control; emotional awareness; communication; social problem-solving; and academic support, especially in reading
	• Prevention programs for middle or junior high student should focus on
	  ○ Study habits and academic support
	  ○ Communication
	  ○ Peer relationships
	  ○ Self-efficacy and assertiveness
	  ○ Drug resistance skills
	  ○ Reinforcement of anti-drug attitudes
	  ○ Strengthening of personal commitments again drug abuse

Physical Health
• Chronic disease
• Cancer
• Obesity
  ○ Respondents reporting overweight or obese
• Inactivity and lack of exercise
  ○ 45.5% report having moderate activity 1 or more days per week and 9.4% report having 1 or more days of vigorous activity per week
• Poor nutrition and eating habits
  ○ 30.3 % of respondents have 3 or more servings of vegetables daily and 18.2% have 3 or more servings of fruit daily
• Hypertension
• Diabetes
• High cholesterol
• Low birth weight
• High blood pressure
• Preventive health – flu shots and immunizations, mammograms
	• Local nursing home and assisted living utilize a registered dietitian who oversees all residents with identified nutrition concerns. Nutrition concerns are identified by the facility's certified dietary manager and/or charge nurse. The registered dietician, certified dietary manager, and charge nurse provide education on these topics if they pertain to that person.
	• We have completed cardiovascular screening in youth in previous years
	• Heart and vascular screenings for adults multiple times throughout the year
	• Promoting our local wellness center
	• Offer free blood pressure checks through our Community Health Department
	• Educate and offer WebMD Fit Program

Identified Concerns	How Sanford Clear Lake is Addressing the Needs

Mental Health
• Stress, depression, anxiety, PTSD
  ○ 22.9% of respondents have been told by their health care provider that they have depression, 22.9% anxiety/stress, and 11.4 panic attacks
• Dementia and Alzheimer's
• Poor mental health days
  ○ 51.6% of respondents reported that their mental health was not good on 1 or more days during the last month. Of those reporting 9.7% reported for 15 or more days and 9.7 reported for 22 to days.
	• Local nursing home and assisted living contract with psychologists from Bridgeway Counseling out of Watertown, SD to provide evaluations and treatment for mental health concerns which are identified by facility staff.
	• Telemed services may be an option by the end of January 2016 with a new provider coming onboard at SMC.
	• Local law enforcement has a workflow to ensure proper placement of elderly patients who are on antipsychotic medications to prevent inappropriate placement in such places as Yankton. The push for outlying referring facilities is to ensure that patients have been properly medicated prior to sending for psychiatric treatment otherwise a large percentage of patients are being denied until these baseline steps are taken.

Substance Use and Abuse
• Underage drinking
• Underage drug use and abuse
• Smoking and tobacco
  ○ 39.4% of respondents reported that they have smoked at least 100 cigarettes in their life and 15.2 report smoking every day
• Alcohol use and abuse
  ○ 30.4% of respondents report drinking 3 or more drinks per day
  ○ 43.8% report consuming 4-5 (binge) alcoholic drinks on one accession in the past month
  ○ No respondents reported having a problem with alcohol
  ○ 9.4% report that alcohol has had a harmful effect on respondent or a family member
	• In Deuel County, based on January 2016 statistics from the Sheriff, Deuel County sees less than 3 minors charged with underage drinking per month. When charged with underage drinking, the minor must go through the court appointment treatment such as AA or education of that sort. If of legal age, they are charged for reasons identified and adhere to the same rules as deemed necessary by the court.
	• DARE is taught on 3 different levels in elementary, middle school and high school level. In Clear Lake the only level taught is elementary at this time.
	• SD Quit Line is offered to patients on every level along with smoking cessation education.

Preventive Health • 21.9% of respondents have not has a flu shot in the past year • 60% of respondents have not had immunizations in the past year - 50% stated that it was not necessary • 21.2% had not seen a doctor in the past year • 24.3 % had not seen a dentist in the past year	• Local nursing home and assisted living residents are automatically offered the flu shot every year. They must be seen by their physician at regular intervals to remain in compliance with regulations. Nurses are available 24 hours a day if residents have oral concerns. • All inpatients as well as clinic visit patients have their health maintenance reviewed on all appointments or inpatient hospitalizations. Appointments or immunizations are provided at that time to follow up with any needs that are unmet to ensure health maintenance is achieved. If patient declines services, education is provided so they fully understand the importance of preventive medicine.

SANFORD HEALTH

2016 Implementation Strategy

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

Mental health includes emotional, psychological, and social well-being. It affects how people think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health problems are common but people with mental health problems can get better and many recover completely.

Sanford has prioritized mental/behavioral health as a top priority and has formalized strategy to help with access to increase utilization of resources for those in need of mental health services, and to establish telehealth outreach services.

Sanford will develop a directory of mental health services that are available to community members. The directory will be distributed to groups and organizations in the community.

Priority 2: Physical Health

Physical health consists of many components, including rest and sleep, nutrition, physical activity, and self- care. Primary prevention is a way to remain physically healthy.

Sanford has formalized strategy to increase compliance of preventive screenings and services. The focus will be on colorectal screenings, mammography, diabetic foot care and vaccinations.

Implementation Strategy for Sanford Clear Lake Medical Center

FY 2017-2019 Action Plan

Priority 1: Mental Health

Projected Impact: Offer various resources for those in need of mental health services

Goal 1: Establish Mental Health Telemedicine Services

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Involve Health Coach in assisting with gathering an estimate of how many patients would benefit from mental health services	100% of all Medical Home patients will be evaluated for need	Tamara Pommer, Health Coach	Darla Toben, Business Office Mgr; Stephanie Dobbs, CNO	
Involve providers and clinic staff in assisting with gathering an estimate of how many patients would benefit from mental health services	100% of all scheduled patients will be evaluated for need	Clinic Nurses Clinic Providers	Stephanie Dobbs, CNO; Renee Axtell, Outreach Coordinator	
Provide a system for patients to get in touch with designated staff if mental health services are needed	Finalize a system by May 1, 2016 to help reach patients who do not have a PCP in the community but still need assistance	Darla Toben, Business Office Manager; Kayla Fieber, Marketing Manager; Renee Axtell, Outreach Coordinator	Stephanie Dobbs, CNO	Marketing to get info to public

Goal 2: Develop and distribute a directory of mental health services to various groups/organizations in the community

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Research various resources available to assist with mental health issues	Resources in a 50-mile radius of Clear Lake will be researched	Mary Buck, RN	Stephanie Dobbs, CNO	
Identify programs already in place and determine program eligibility	Programs in a 50-mile radius of Clear Lake will be identified	Mary Buck, RN	Stephanie Dobbs, CNO	
Develop and distribute a directory of mental health services to those groups identified as high risk	Develop a directory that is ready for distribution by July 1, 2016	Renee Axtell, Outreach Coord.; Kayla Fieber, Marketing Manager	Stephanie Dobbs, CNO	Marketing (flyers, ad in paper, DADI website, churches, service organ., police, SART education, schools)

<u>Priority 2</u>: Physical Health

<u>Projected Impact</u>: Increase compliance with preventive screenings recommendations

<u>Goal 1</u>: Educate on preventative health services that are available at SCLMC

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Describe various services available to patients	100% of patients in the service area will be informed of the preventive health services available at SCLMC	Tamara Pommer, Health Coach; Renee Axtell, Outreach Coordinator	Stephanie Dobbs, CNO	Marketing, Nursing
Continue to offer current preventive services and better educate on the importance of these screenings • Colorectal screening • Mammograms • Vaccinations • Diabetic foot care	90% of patients will have a preventive health service offered each year • ages 51-75 • ages 40-75 • ages 0-18 in Community Health • any diabetic patient	Tamara Pommer, Health coach; Renee Axtell, Outreach Coordinator; Tammy Baer, Community Health RN	Stephanie Dobbs, RN	

SANFORD HEALTH

2013 Implementation Strategy Impact

Demonstrating Impact

The 2013 Community Health Needs Assessment served as a catalyst to lift up obesity and mental health services as implementation strategies for the 2013-2016 timespan. The following strategies were implemented.

Implementation Strategy: Youth/Athletic Cardiovascular Screenings

Three Year Plan (January 2012 - January 2015)

- Complete community education presentations on youth heart screenings.
- Arrange for all students in grades 6-12 at Deuel School in Clear Lake to have a heart screening completed.
- Arrange for the incoming 6th grade class to have heart screening done with school sign-up starting with the August 2013 year.
- Complete fundraising efforts to cover the costs of all youth heart screenings.
- Newspaper articles and flyers published for community awareness.

Implementation Strategy: Obesity

Three Year Plan (January 2012 - January 2015)

- Complete BMI on all students in grade 6-12 in Deuel School in Clear Lake.
- Identify all students with BMI higher than "normal" range and do 1-1 counseling with nurse educator on healthy food/meal choices.
- Advertise hospital-owned wellness center open to public 7 days a week/24 hrs. a day at a small monthly fee.
- Complete youth obesity project in community in summer of 2013. Project will be published for professional degree.

Impact of the Strategy to Address Youth/Athletic Cardiovascular Screenings

Athletic cardiovascular screenings were offered to all students in grade 6-12. (Students did not have to be athletes to participate.) They were offered to approximately 240 students. Of these 240 students, 138 completed the free cardiovascular screenings.

The screenings included an EKG and echocardiogram (test for heart abnormalities that can be life threatening but often correctable with early detection); fasting lipid panel (cholesterol and triglyceride levels) which can contribute to heart disease; and BMI or Body Mass Index which takes the student's height and weight into account.

Of the 138 screenings that were completed, 22 students were referred to their primary health care provider due to increased cholesterol levels, 34 were referred for elevated BMI, and 22 for high blood pressure.

Sanford provided quarterly newspaper articles in local publications and provided reports to various community clubs throughout the year. Education about the wellness center, mammography, rehab services, and clinic services was provided at the health fair.

Community Health nurses provided education to schools and at various community events; on a variety of health and wellness topics throughout the year. Sanford Clear Lake continues to offer these education sessions to the community.

Impact of the Strategy to Address Obesity

Sanford Clear Lake worked with the local school system to see if we could obtain BMI measurements on all students in grade 6-12. Sanford Health also acquired BMI's from the athletic heart screening results.

A survey was sent out to all students in grades 6-12 and there were 172 students respondents. The survey focused on nutrition and exercise. The results were analyzed to determine the education needs.

Sanford Health provided education to all students regarding normal BMI ranges, along with dietary and exercise tips. Information was shared regarding Sanford's *fit* kids website and myplate.gov which offer a variety of exercise advice, diet tips, and healthy activities for youth.

The 2013 strategies have served as a starting point to reach a broader community base and to meet the needs of the top health priorities for the community. The impact has been positive and the work will continue into the future through new or continued programming and services specific to these strategies.

Community Feedback from the 2013 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on the 2013 Community Health Needs Assessment and has provided on-line comment fields for ease of access on our website. There have been no comments to date.

APPENDIX

Primary Research

Clear Lake 2016 CHNA Asset Map

Identified concern	Specific areas of concern	Secondary data, County Rankings (CR), Helmsley Study (HS)		Community resources that are available to address the need	Gap?
Aging population	Cost of long-term care 3.63 Availability of resources for family /friends caring for and making decisions for elders 3.29 Availability of memory care 3.23	26.7% are over 65 years of age		Deuel Co. Good Samaritan Center 605-874-2159	X
Children and Youth	Bullying 3.61 Availability of activities for children and youth 3.56 Cost of activities for children and youth 3.29	Children in single parent home 15% (CR) Children in poverty 13% (CR)		Sanford WebMD Fit Kids Rachel's Challenge Clear Lake School District activities 605-874-2161 Teen Challenge in Brookings	X
Health Care	Access to affordable health insurance 3.48 Cost of affordable vision insurance 4.45 Cost of affordable dental insurance coverage 3.45 Access to affordable prescription drugs 3.30 Access to affordable health care 3.27	Unmet medical needs 67.9% (HS) Unmet mental Health needs 25.5% Need prescription medications 73.8% (HS)		Sanford Clear Lake Clinic 605-874-2141 Sanford Clear Lake Medical Center 605-874-2141	X

Identified concern	Specific areas of concern	Secondary data, County Rankings (CR), Helmsley Study (HS)		Community resources that are available to address the need	Gap?
Safety	Presence of street drugs, and alcohol in the community 3.25			Teen Challenge in Brookings	X
Physical Health	Chronic disease 3.55 Cancer 3.50 Obesity 3.48 Inactivity and lack of exercise 3.48 Poor nutrition and eating habits 3.48 Hypertension 22.9% Diabetes 14.3% High Cholesterol 8.6% Respondents reporting overweight or obese – 78.8% 30.3 % of respondents have 3 or more servings of vegetables daily and 18.2% have 3 or more servings of fruit daily 45.5% report having moderate activity 1 or more days per week and 9.4% report having 1 or more days of vigorous activity per week	3 = average poor physical health days in the past month (national benchmark is 2.3) Obesity – 34% (25% nationally) 30% of adults report no leisure time physical activity (national benchmark is 20%) 138 newly reported sexually transmitted infections (chlamydia cases per 100,000 populations) compared to 128 nationally 27 teen births per 1,000 population ages 15-19, compared to 20 as the national benchmark Low birth weight 5.7 (CR) ↑ BP 40.9% (HS) ↑Chol 31.8% (HS)		Sanford Cancer Biology Research Center Sanford Dietitians Sanford certified diabetes educators Sanford Medical Home Sanford health coaches Sanford WebMD Fit Kids Sanford Clear Lake Wellness Center 605-874-3552	X

Identified concern	Specific areas of concern	Secondary data, County Rankings (CR), Helmsley Study (HS)		Community resources that are available to address the need	Gap?
Mental Health	Stress 3.58 Depression 3.36 Dementia and Alzheimer's 3.15 22.9% of respondents have been told by their health care provider that they have depression, 22.9% anxiety/ stress, and 11.4 panic	2.4 = average poor mental health days in the past month (national benchmark = 2.3) Depression 12.3% (HS) Anxiety 14% (HS) PTSD 5% (HS)	51.6% of respondents reported that their mental health was not good on 1 or more days during the last month. Of those reporting 9.7% reported for 15 or more days and 9.7 reported for 22 to days.	Sanford One Care 211 – call line Human Services in Watertown	X
Substance Use and Abuse	Underage drinking 3.52 Underage drug use and abuse 3.45 Smoking and tobacco 3,39 Alcohol use and abuse 3.30 39.4% of respondents reported that they have smoked at least 100 cigarettes in their life and 15.2 report smoking every day 30.4% of respondents report drinking 3 or more drinks per day 43.8% report consuming 4-5 (binge) alcoholic drinks on one	Adult smoking = 19% (14% nationally) 15% (HS) 22% of adults report excessive or binge drinking 40.9% (HS)		Sanford One Care Teen Challenge in Brookings	X

Identified concern	Specific areas of concern	Secondary data, County Rankings (CR), Helmsley Study (HS)		Community resources that are available to address the need	Gap?
	accession in the past month No one reported having a problem with alcohol 9.4% report that alcohol has had a harmful effect on respondent or a family member				
Preventive Health	21.9% of respondents have not has a flu shot in the past year 60% of respondents have not had immunizations in the past year - 50% stated that it was not necessary 21.2% had not seen a doctor in the past year 24.3 % had not seen a dentist in the past year			Sanford Clear Lake Clinic 605-874-2141	X

Clear Lake 2016 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

- Cost and/or return on investment
- Availability of solutions
- Impact of problem
- Availability of resources (staff, time, money, equipment) to solve problem
- Urgency of solving problem (H1N1 or air pollution)
- Size of problem (e.g. # of individuals affected)

Criteria to Identify Intervention for Problem

- Expertise to implement solution
- Return on investment
- Effectiveness of solution
- Ease of implementation/maintenance
- Potential negative consequences
- Legal considerations
- Impact on systems or health
- Feasibility of intervention

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Aging • Cost of long-term care 3.63 • Availability of resources for family /friends caring for and making decisions for elders 3.29 • Availability of memory care 3.23	X X Availability of resources for family/friends was specifically mentioned		
Children and Youth • Bullying 3.61 • Availability of activities for children and youth 3.56 • Cost of activities for children and youth 3.29 Children living in poverty 13% (CR) Children in single parent households 15% (CR)	X X X Availability of activities for children and youth specifically mentioned	X X X	
Health Care • Access to affordable health insurance 3.48 • Cost of affordable vision insurance 4.45 • Cost of affordable dental insurance coverage 3.45 • Access to affordable prescription drugs 3.30 • Access to affordable health care 3.27 Unmet medical needs 67.8% (HS) Unmet mental health needs 25.5% (HS) Need prescription medications 73.8% (HS)	X Access to affordable drugs was specifically mentioned	X X	

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Safety • Presence of street drugs, and alcohol in the community 3.25	X X		
Physical Health • Chronic disease 3.55 • Cancer 3.50 • Obesity 3.48 • Inactivity and lack of exercise 3.48 • Poor nutrition and eating habits 3.48 • Hypertension 22.9% • Diabetes 14.3% • High Cholesterol 8.6% • Respondents reporting overweight or obese – 78.8% • 30.3 % of respondents have 3 or more servings of vegetables daily and 18.2% have 3 or more servings of fruit daily • 45.5% report having moderate activity 1 or more days per week and 9.4% report having 1 or more days of vigorous activity per week Low birth weight 5.7 (CR) High Blood Pressure 40.9% (HS) High cholesterol 31.8% (HS) Preventive Health – Flu shots and immunizations Mammograms	X X X **Cancer & obesity were specifically mentioned**	**X** **X** **X** **X** **X**	
Mental Health • Stress 3.58 • Depression 3.36 • Dementia and Alzheimer's 3.15 • 22.9% of respondents have been told by their health care provider that they have depression, 22.9% anxiety/stress, and 11.4 panic attacks • 51.6% of respondents reported that their mental health was not good on 1 or more days during the last month. Of those reporting 9,7% reported for 15 or more days and 9.7 reported for 22 to days. Poor mental health days (CR) Depression 12.3% (HS) Anxiety 14% (HS) PTSD 5% (HS)	X X X Stress was specifically mentioned	X X X X X X	

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Substance Use and Abuse • Underage drinking 3.52 • Underage drug use and abuse 3.45 • Smoking and tobacco 3.39 15% (HS) • Alcohol use and abuse 3.30 • 39.4% of respondents reported that they have smoked at least 100 cigarettes in their life and 15.2 report smoking every day • 30.4% of respondents report drinking 3 or more drinks per day • 43.8% report consuming 4-5 (binge) alcoholic drinks on one accession in the past month 40.9% (HS) • No one reported having a problem with alcohol • 9.4% report that alcohol has had a harmful effect on respondent or a family member	X	X	
Preventive Health • 21.9% of respondents have not has a flu shot in the past year • 60% of respondents have not had immunizations in the past year - 50% stated that it was not necessary • 21.2% had not seen a doctor in the past year • 24.3 % had not seen a dentist in the past year.	X X Flu shots was specifically mentioned		

County Health Rankings (CR) Helmsley Study (HS)

Top Priorities:

- Physical Health – 5 votes
- Mental Health – 6 votes

Present: Marlin Bjerke, Mark Law, Bob Atyeo, Dean Christensen, Darla Tobin, Marcia Djonne, Lori Hlavacek, Stephanie Dobbs, Tammy Baer, Paula Brandt, Tamara Pommer, Renee Axtell, Lori Sisk

Sanford Clear Lake Medical Center

Community Health Needs Assessment

Results from a March 2015 Non-Generalizable

Online Survey

August 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a March 2015 on-line survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative invited viewers to access the online survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach**. Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred throughout the month of March 2015 and a total of 35 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

General Health and Wellness Concerns about the Community

Using a 1 to 5 scale, with 1 being “not at all” and 5 being “a great deal,” respondents were asked to rate their level of concern with various statements regarding ECONOMICS, TRANSPORTATION, the ENVIRONMENT, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTH CARE, PHYSICAL AND MENTAL HEALTH, and SUBSTANCE USE AND ABUSE.

Figure 1. Level of concern with statements about the community regarding ECONOMICS

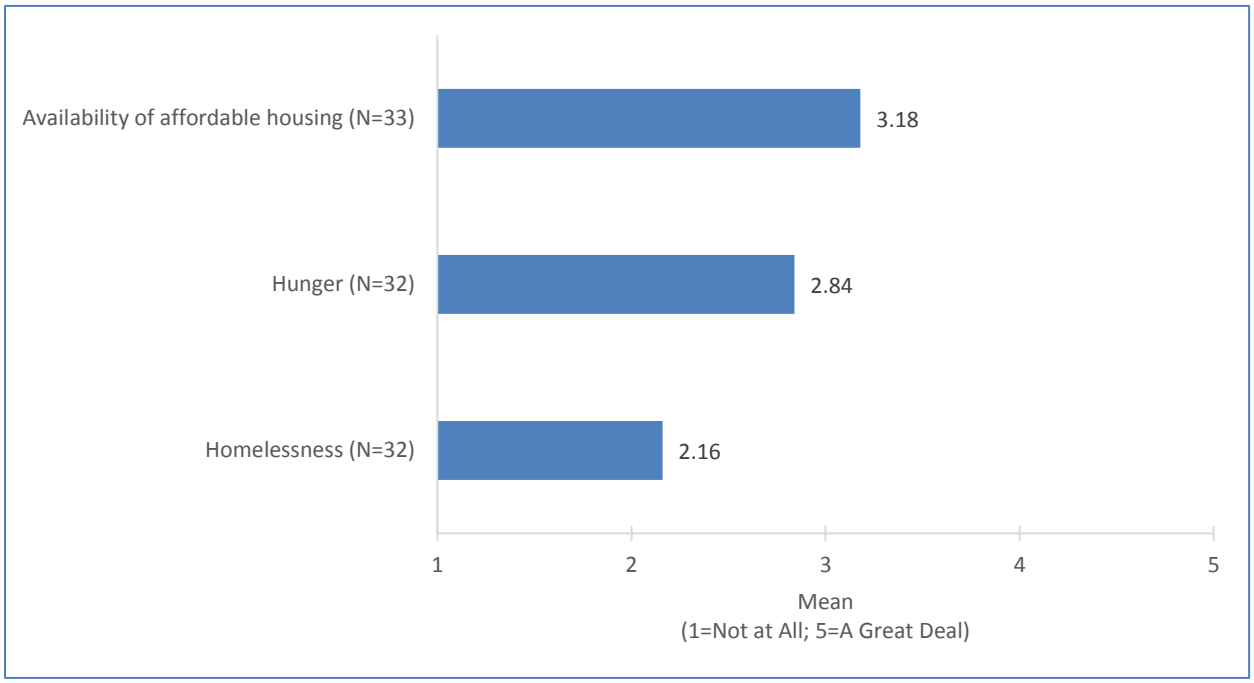


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

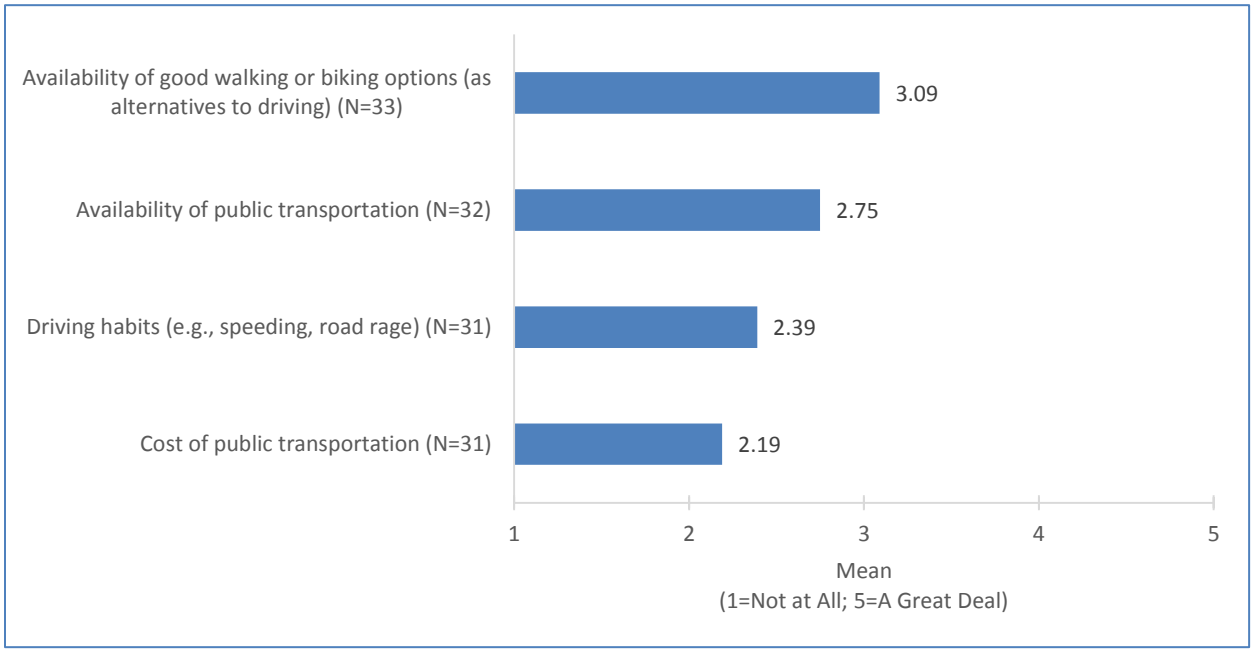


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

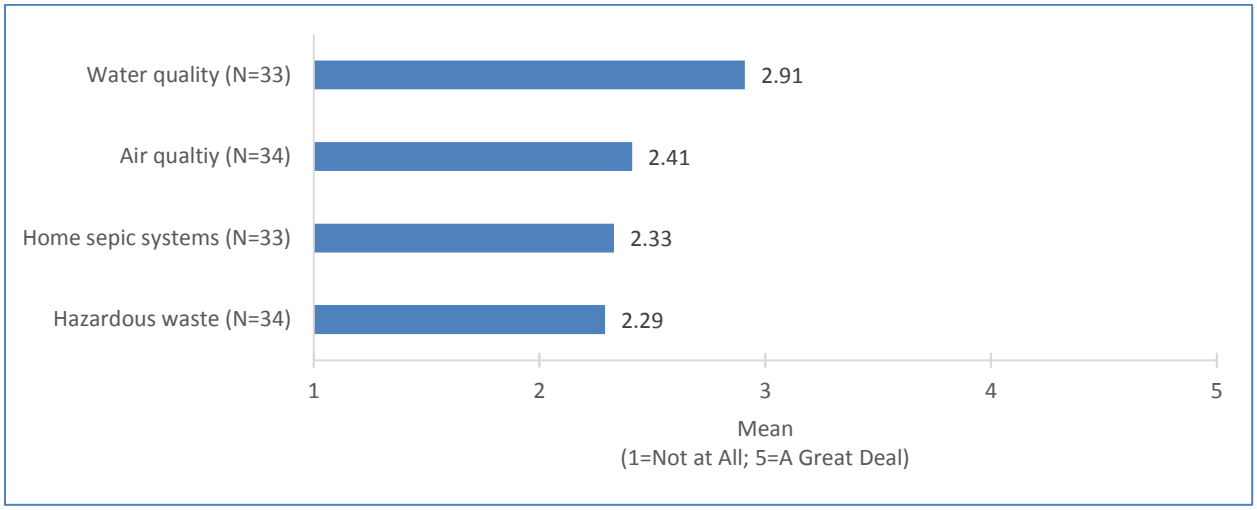


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

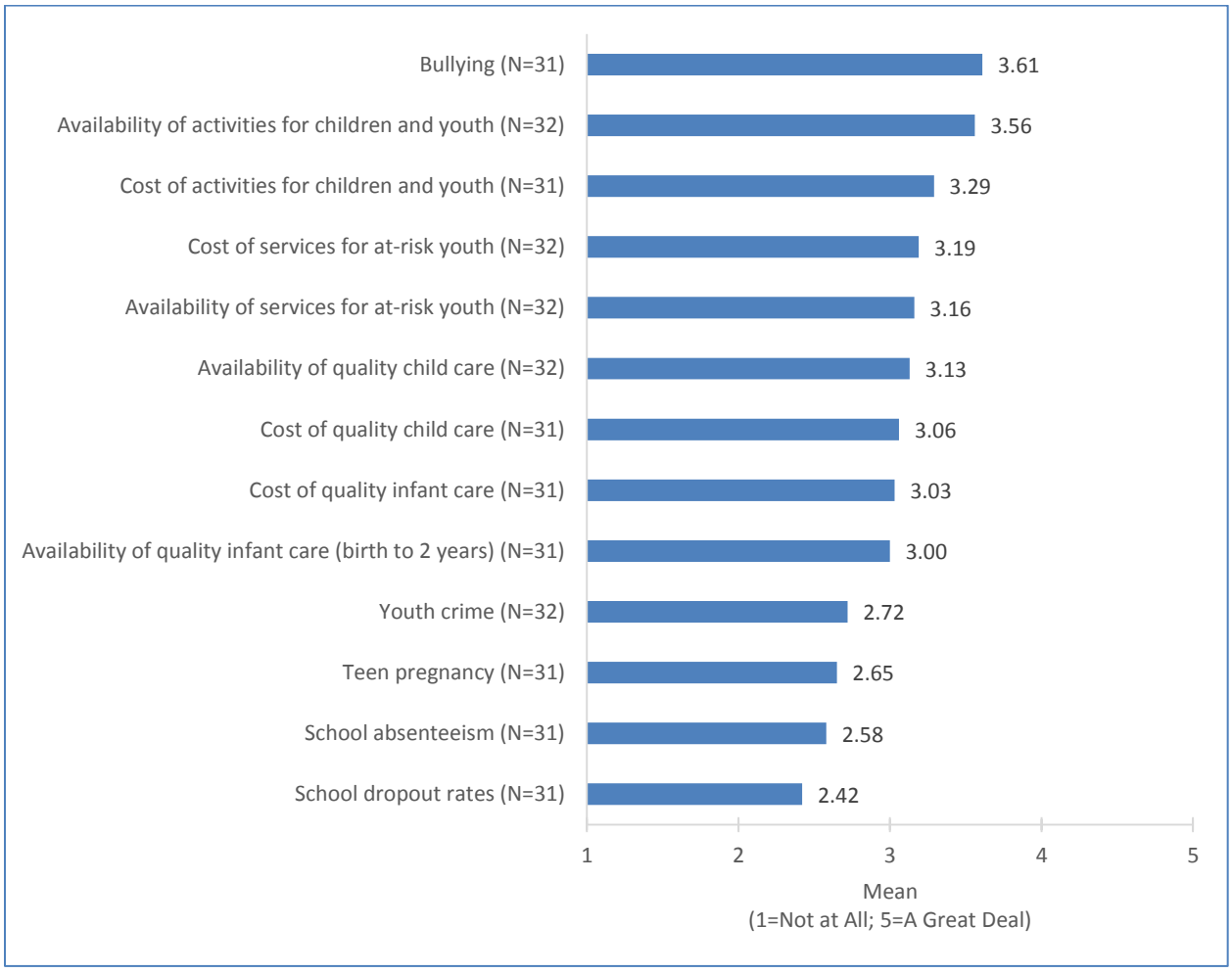


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

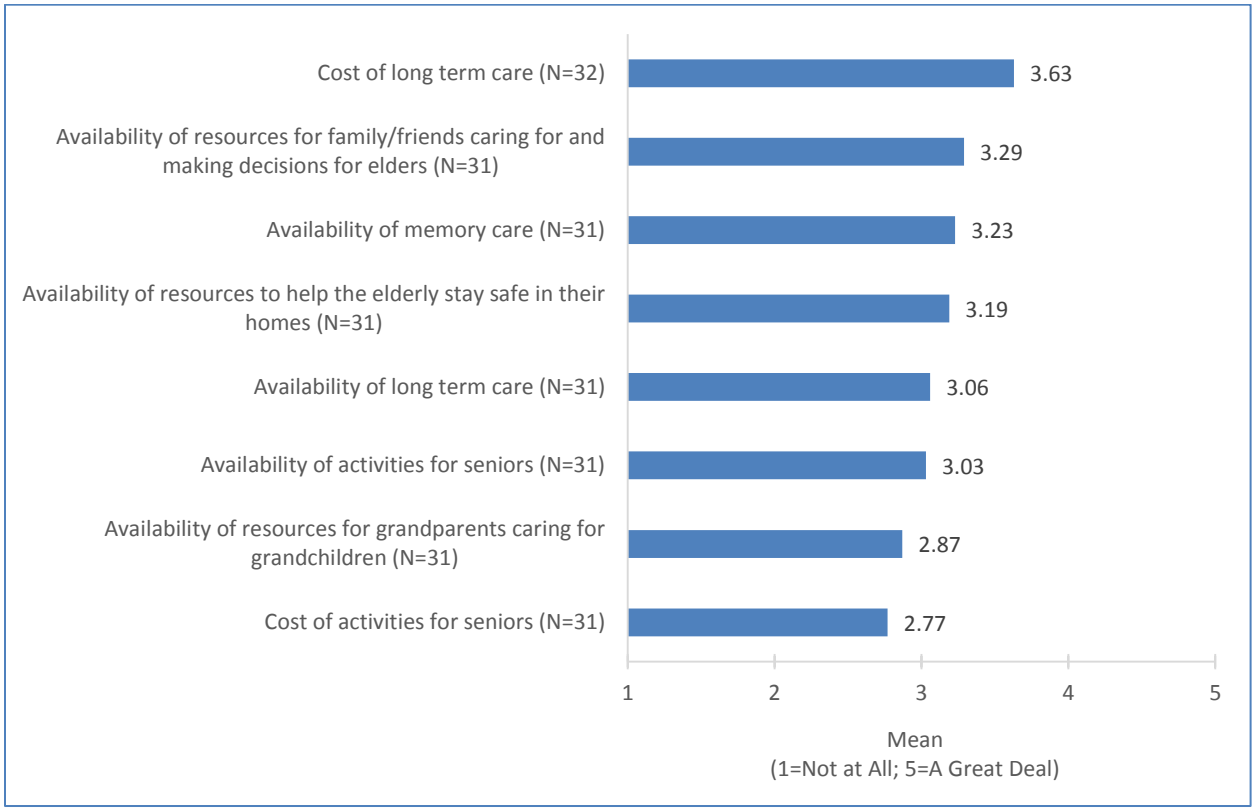


Figure 6. Level of concern with statements about the community regarding SAFETY

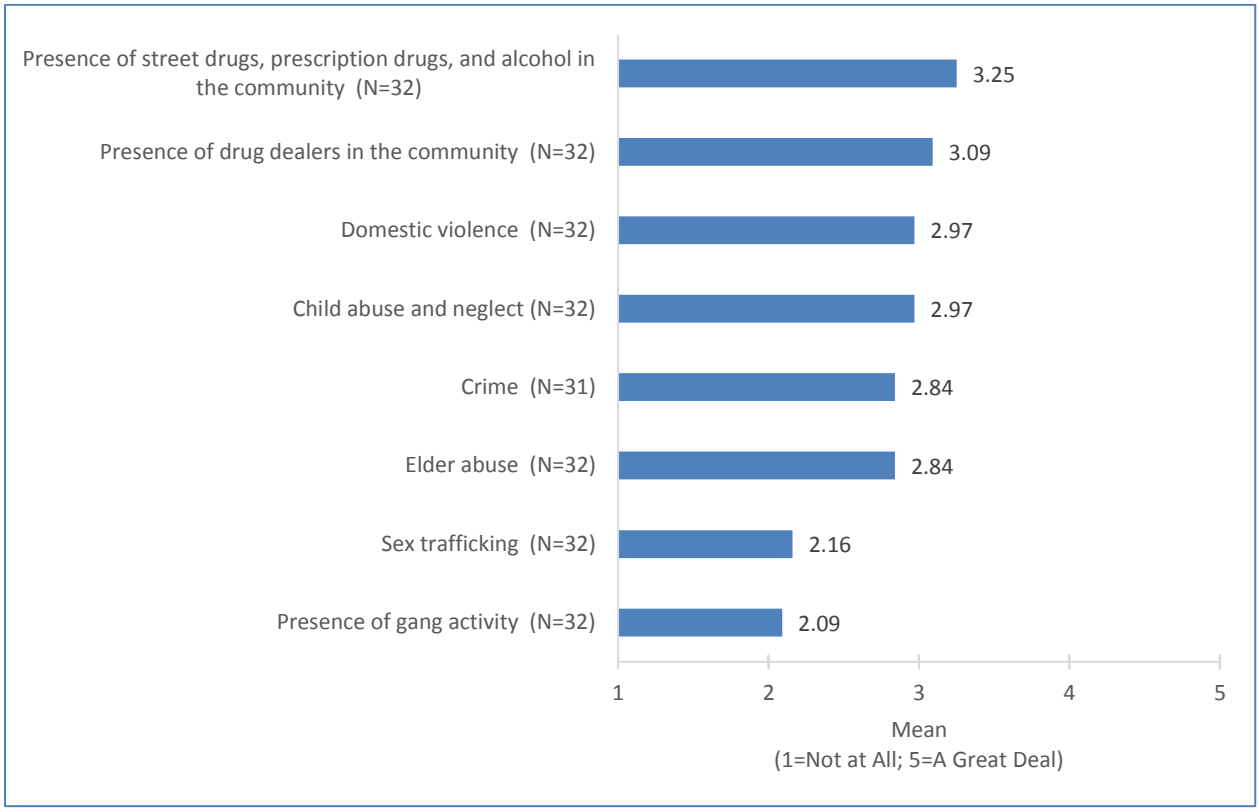


Figure 7. Level of concern with statements about community regarding HEALTH CARE

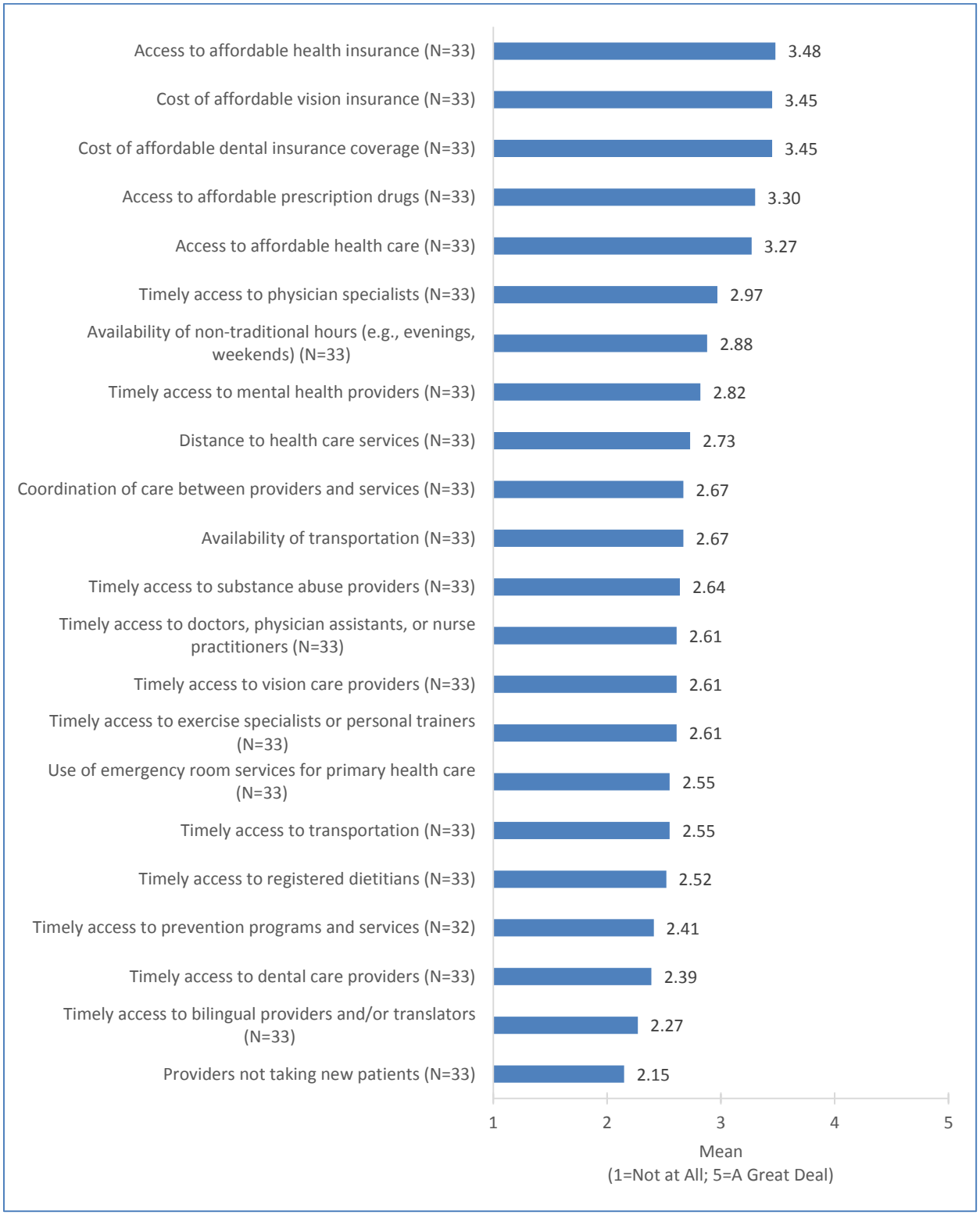


Figure 8. Level of concern with statements about community regarding PHYSICAL AND MENTAL HEALTH

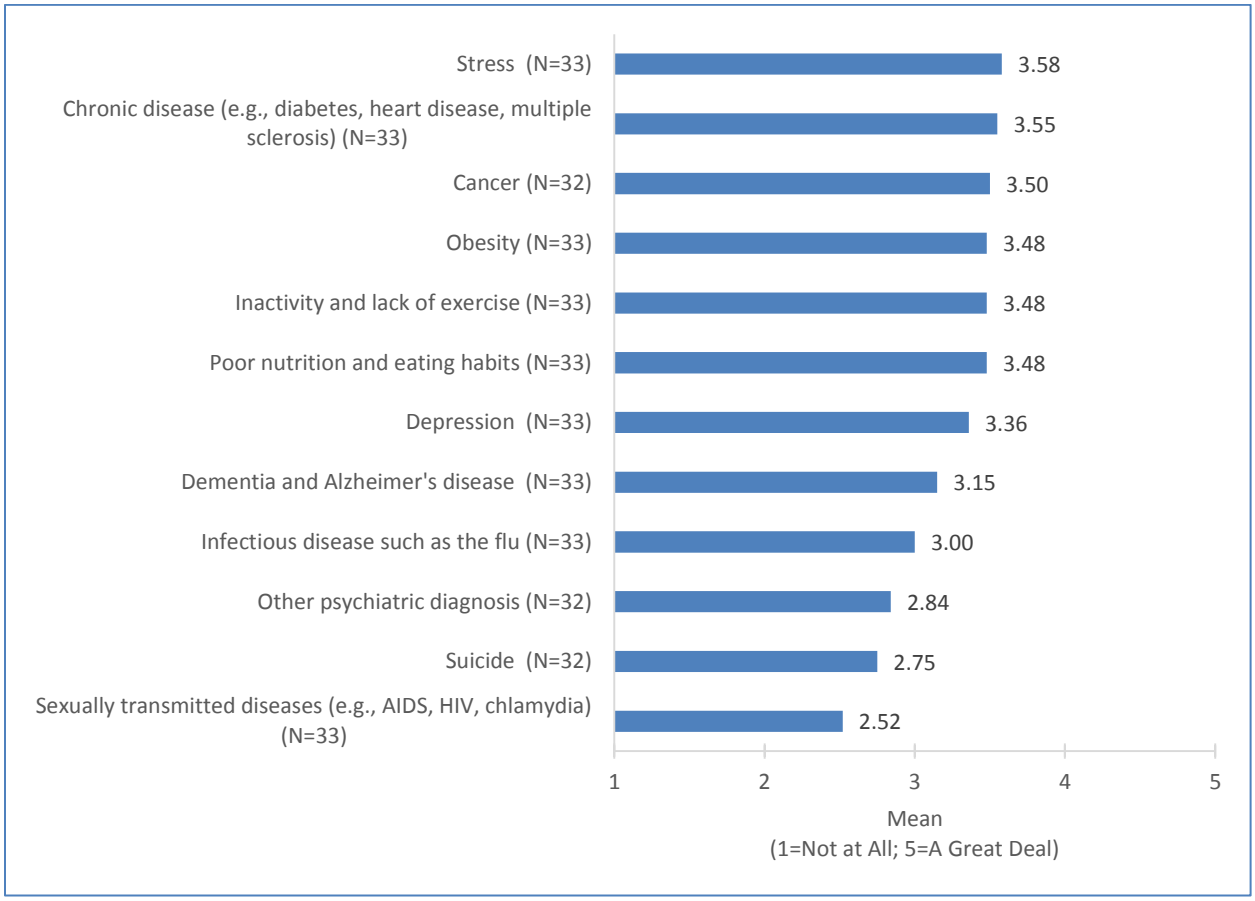
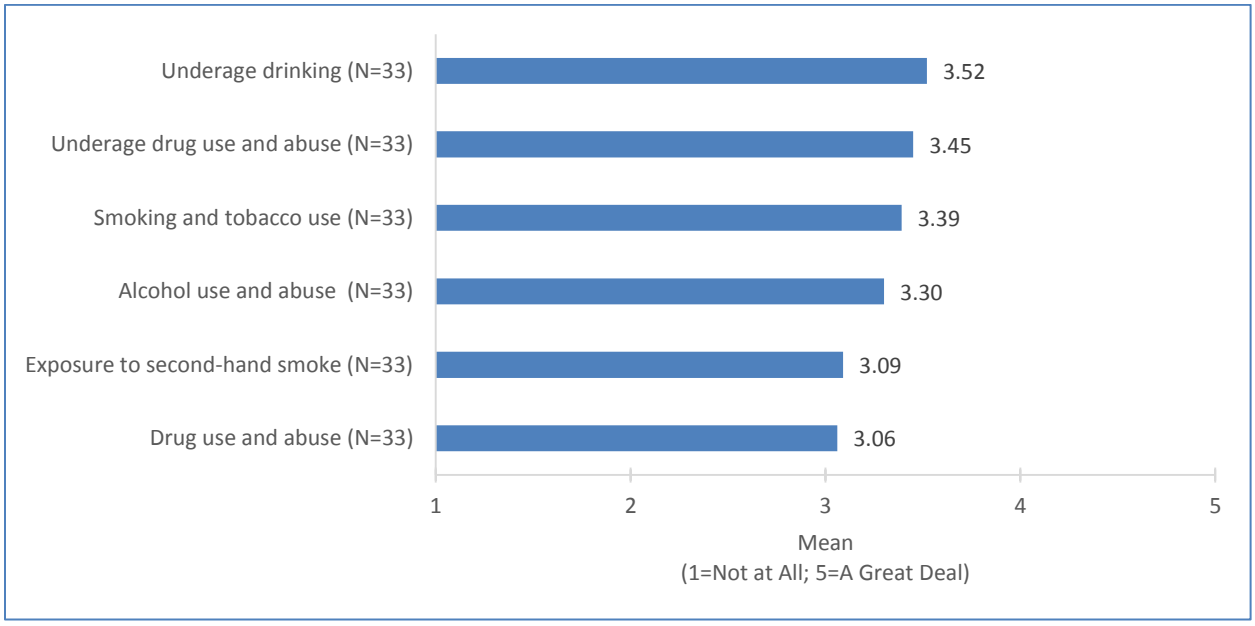
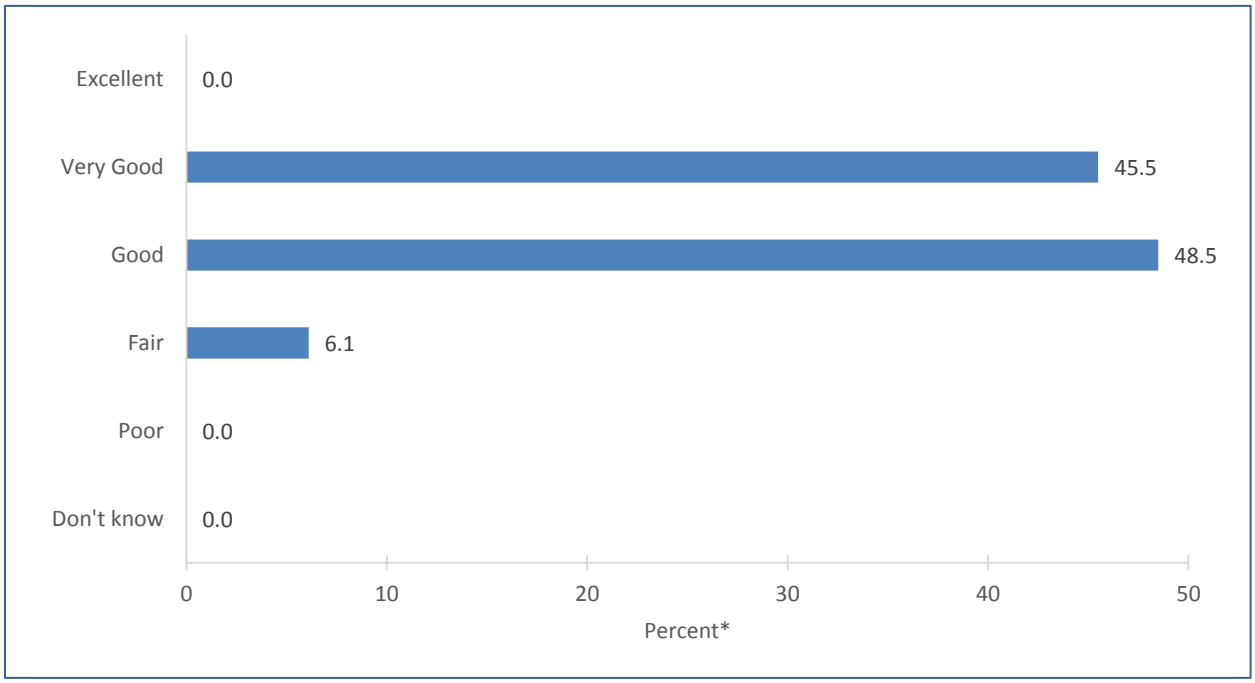


Figure 9. Level of concern with statements about community regarding SUBSTANCE USE AND ABUSE



General Health

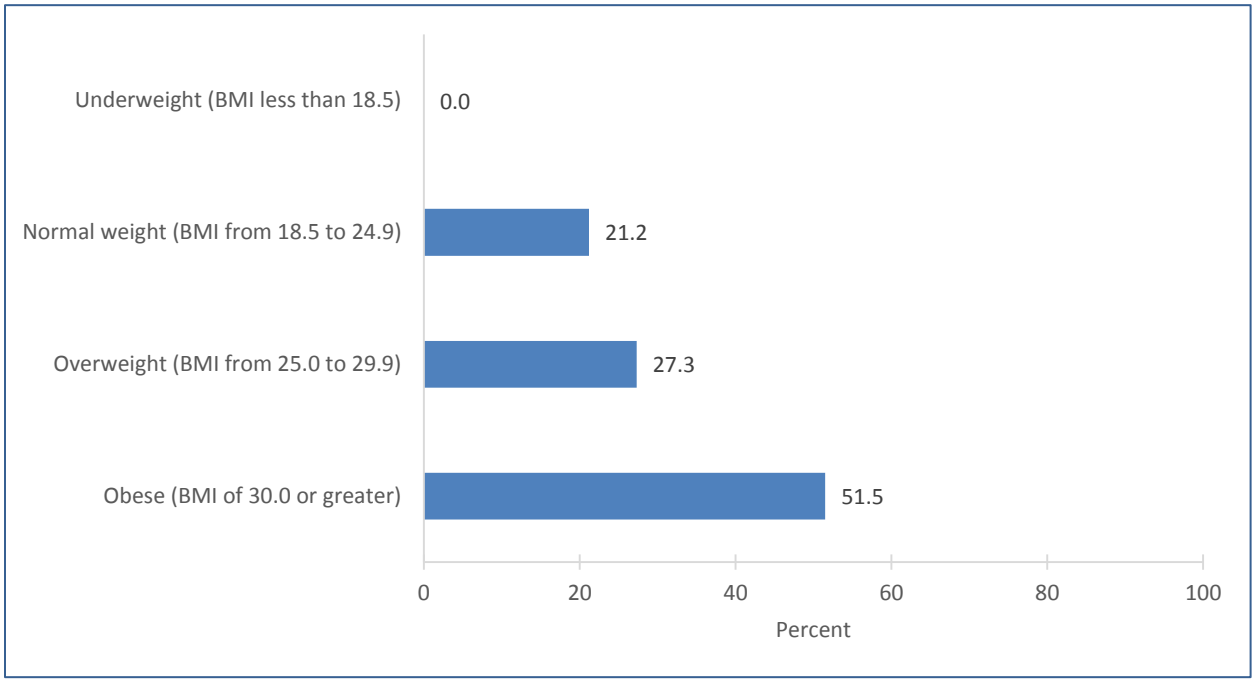
Figure 10. Respondents' rating of health in general



N=33

*Percentages do not total 100.0 due to rounding.

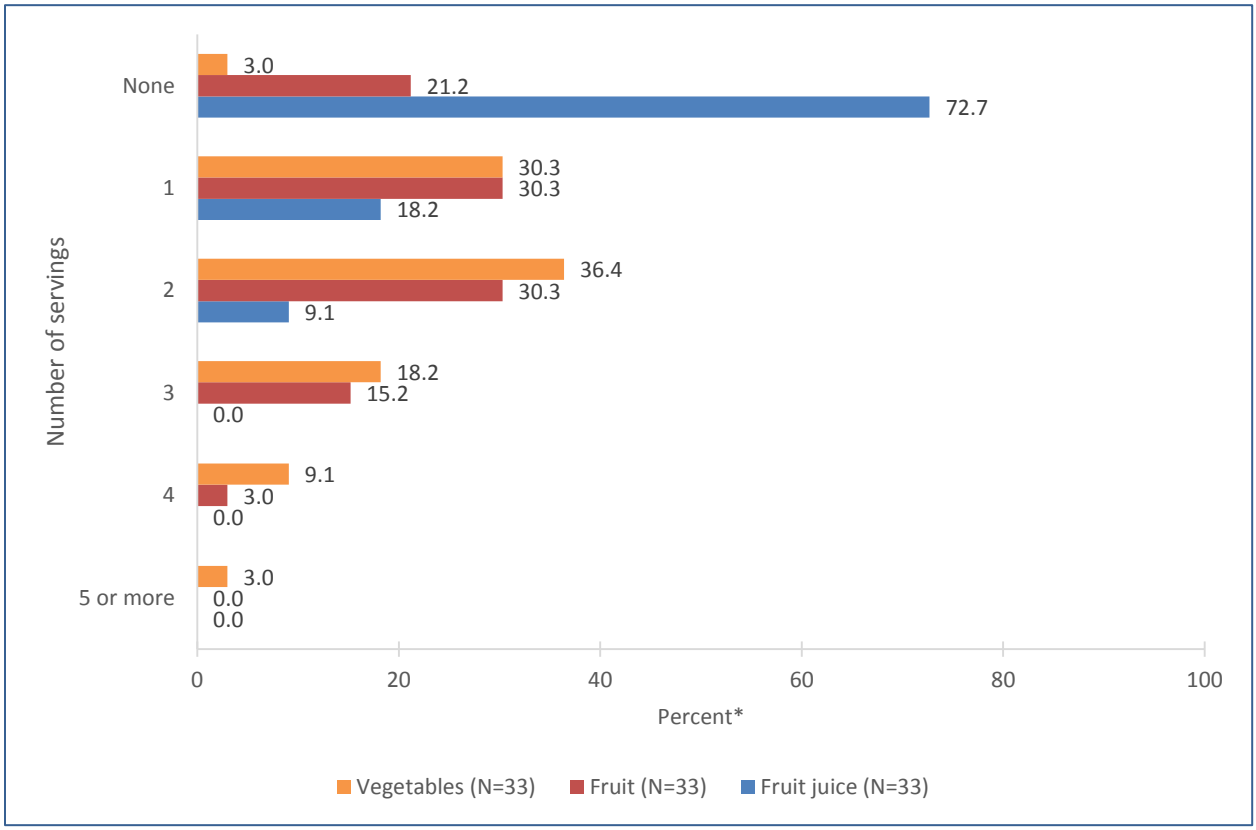
Figure 11. Respondents' weight status based on the Body-Mass Index (BMI) scale



N=33

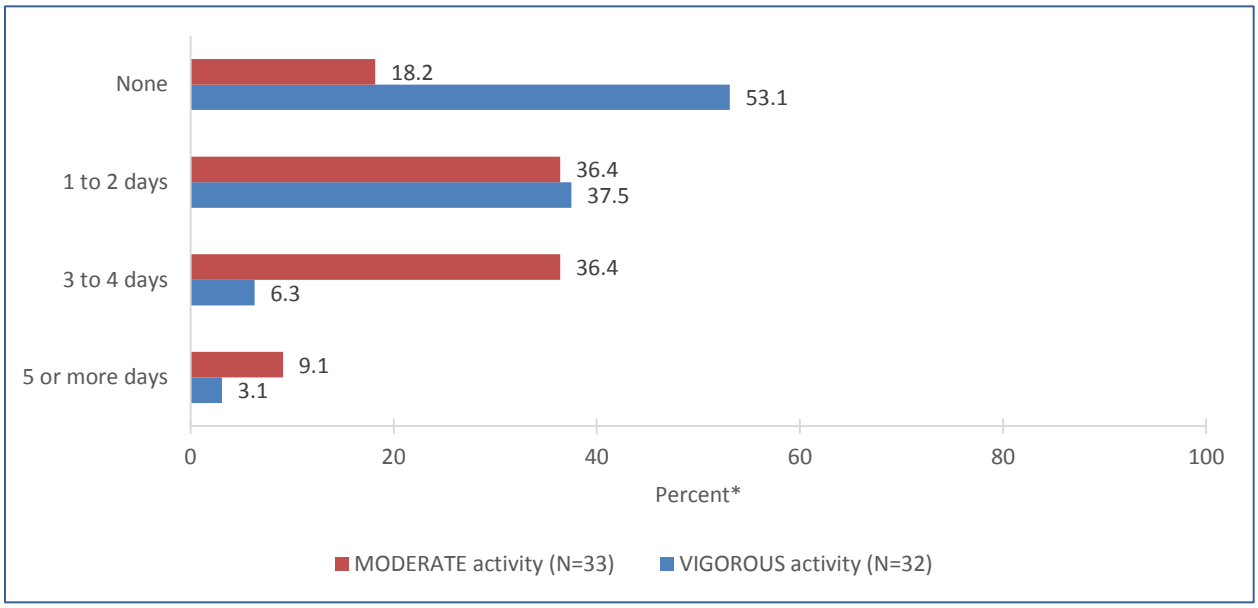
*For information about the BMI, visit the Centers for Disease Control and Prevention, *About BMI for Adults*, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/.

Figure12. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday



*Percentages may not total 100.0 due to rounding.

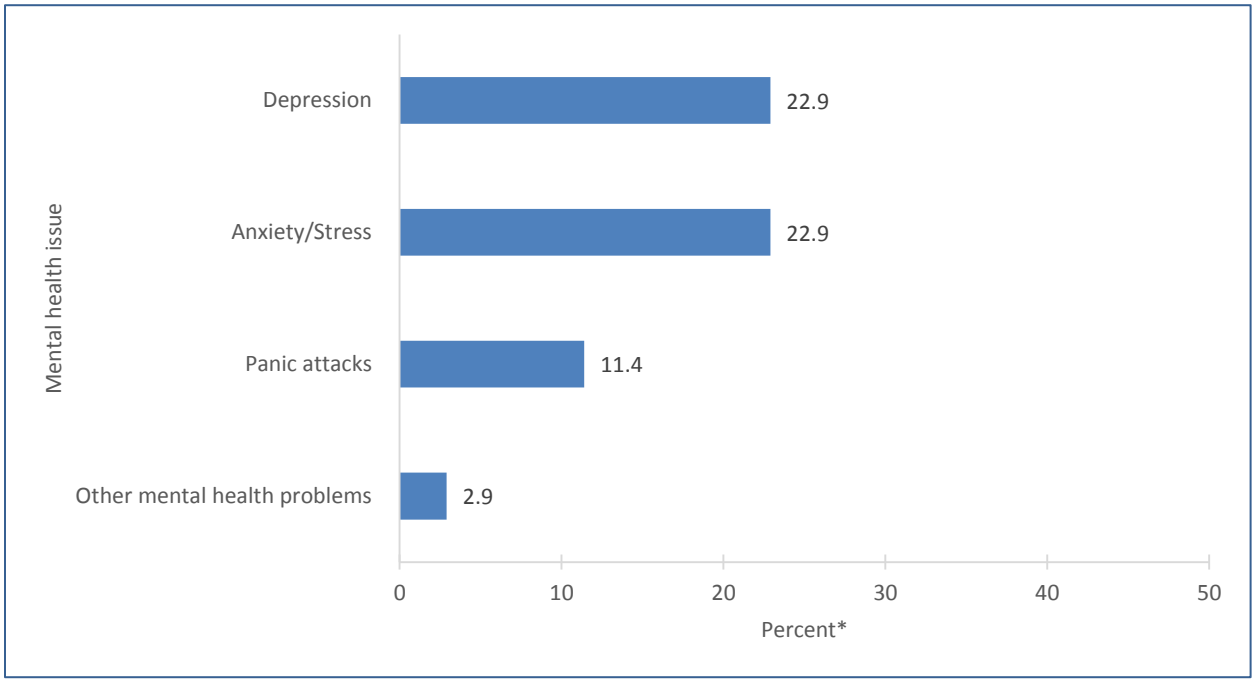
Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



*Percentages may not total 100.0 due to rounding.

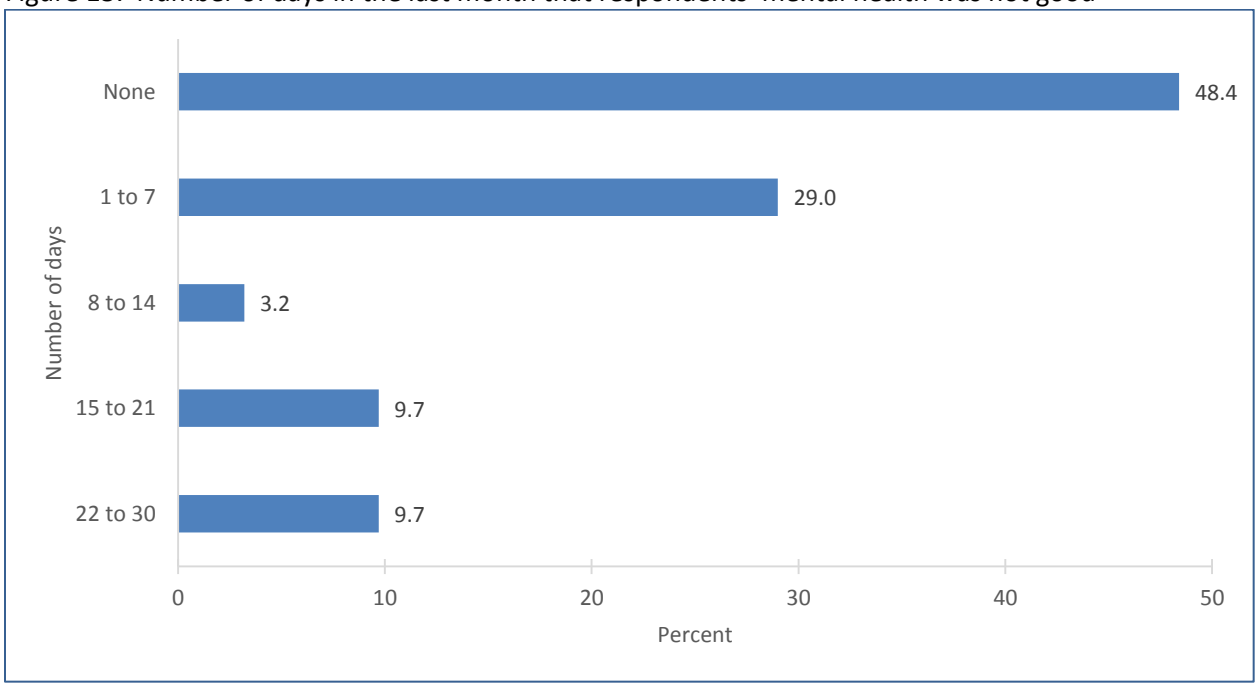
Mental Health

Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



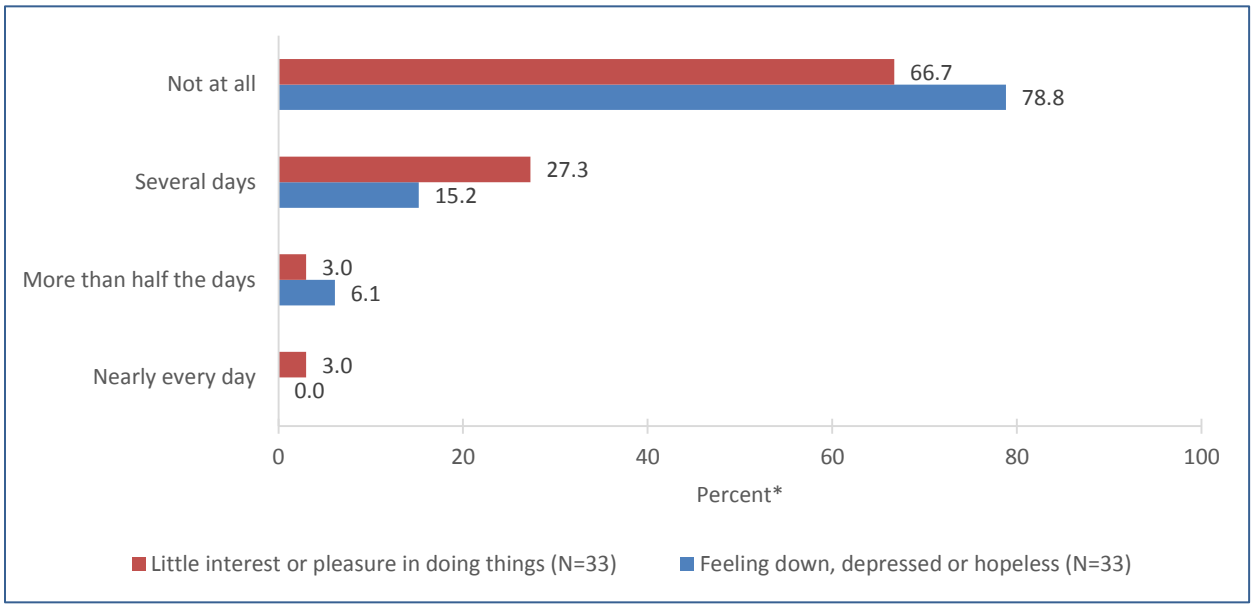
N=35 *Percentages do not total 100.0 due to multiple responses.

Figure 15. Number of days in the last month that respondents' mental health was not good



N=31

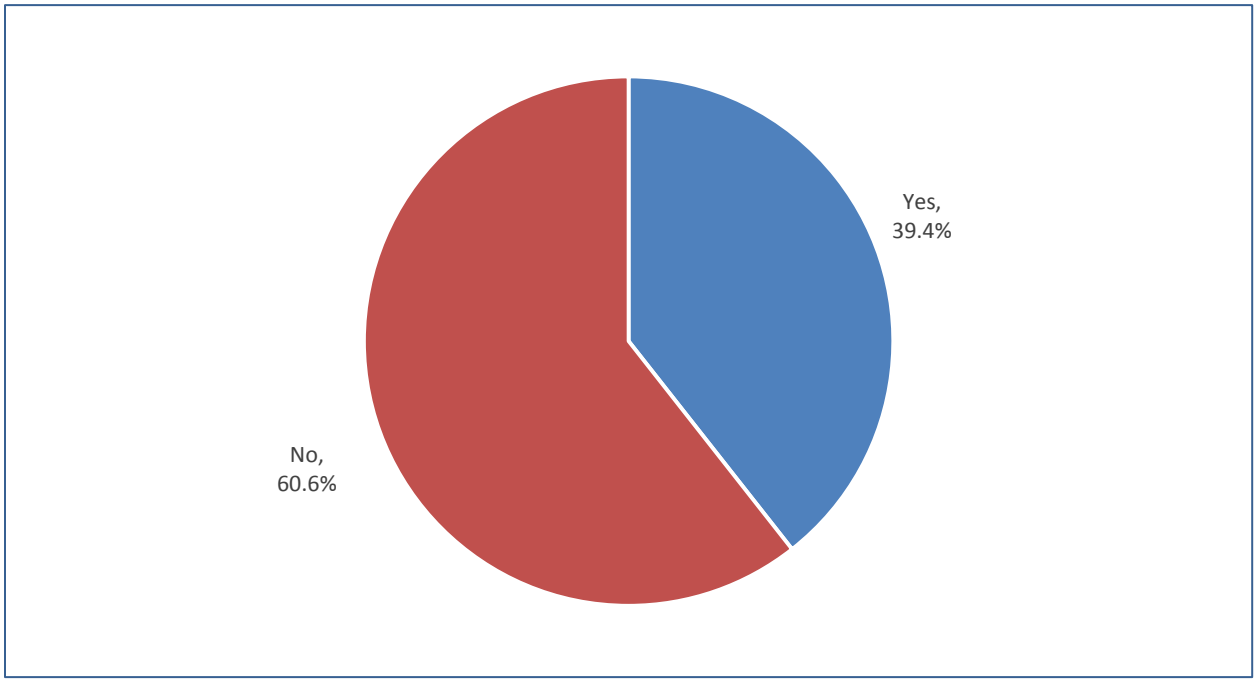
Figure 16. How often, over the past two weeks, respondents have been bothered by mental health issues



*Percentages may not total 100.0 due to rounding.

Tobacco Use

Figure 17. Whether respondents have smoked at least 100 cigarettes in their entire life



N=33

Figure 18. How often respondents currently smoke cigarettes and use chewing tobacco or snuff

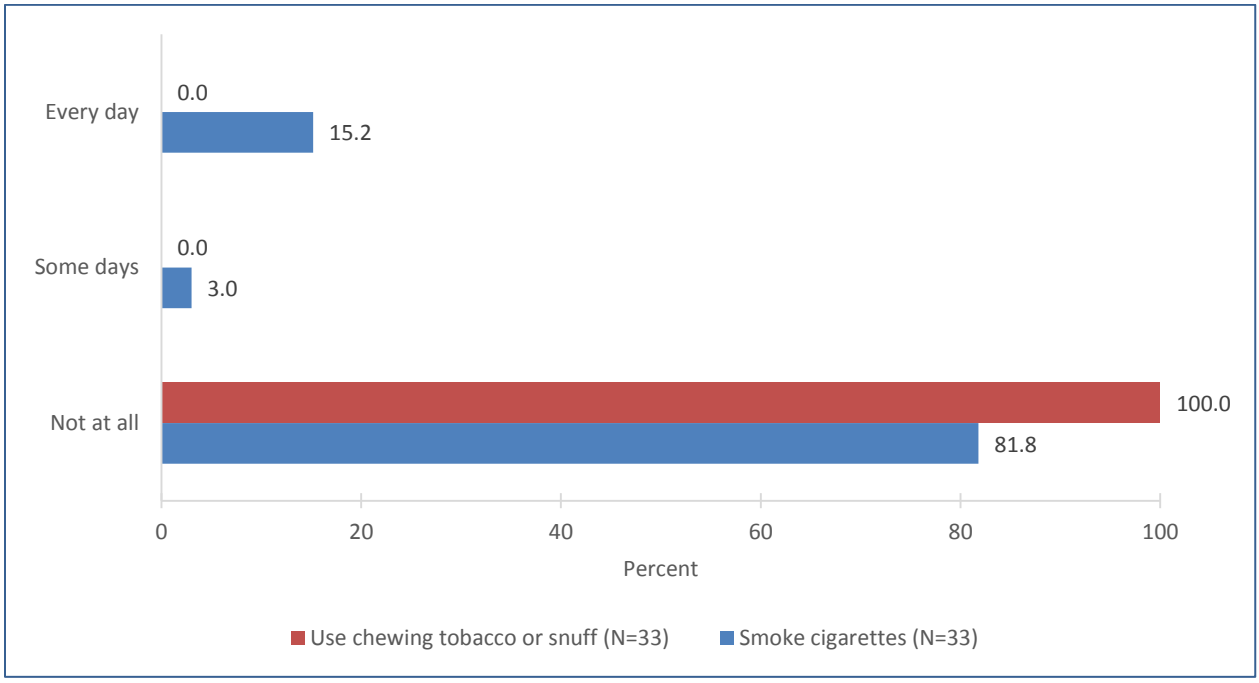
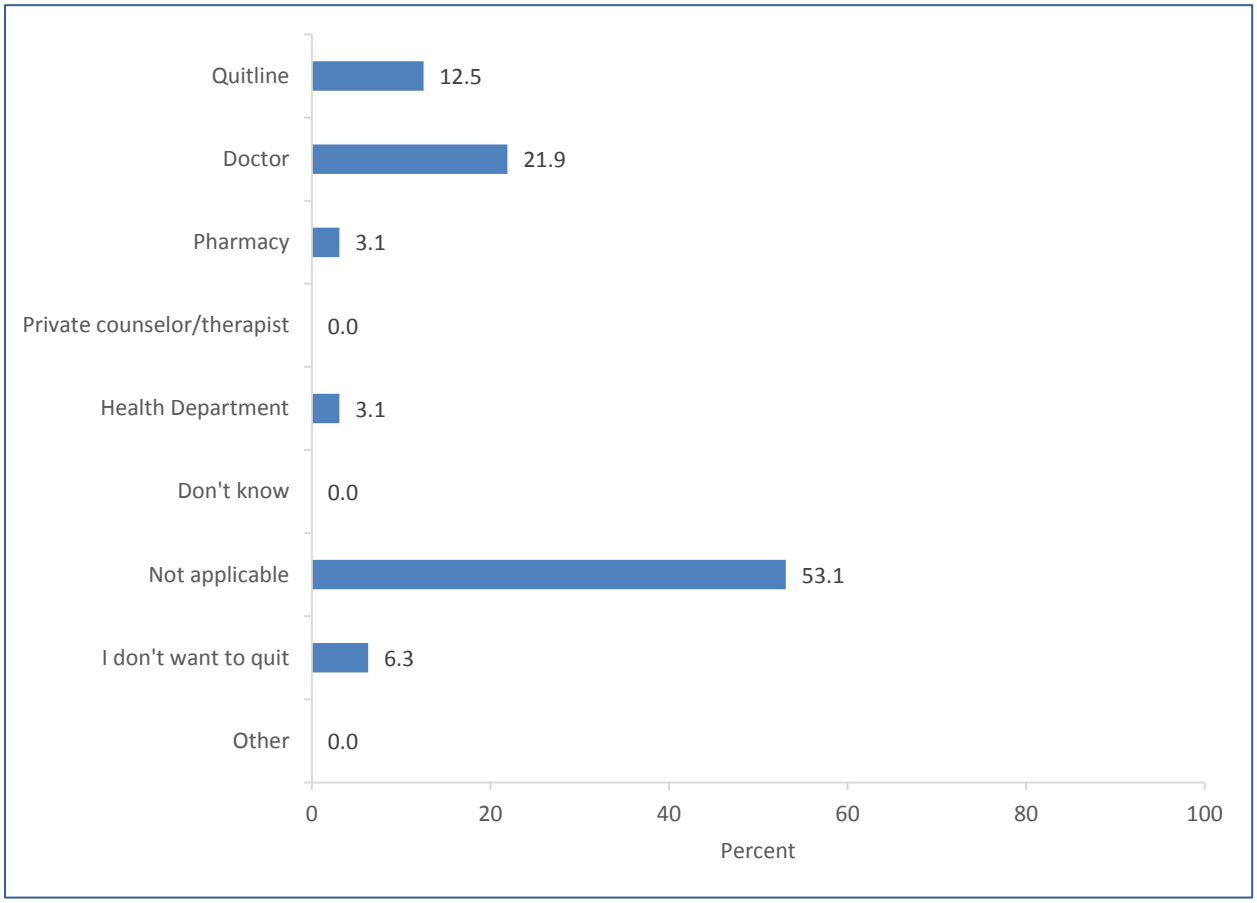


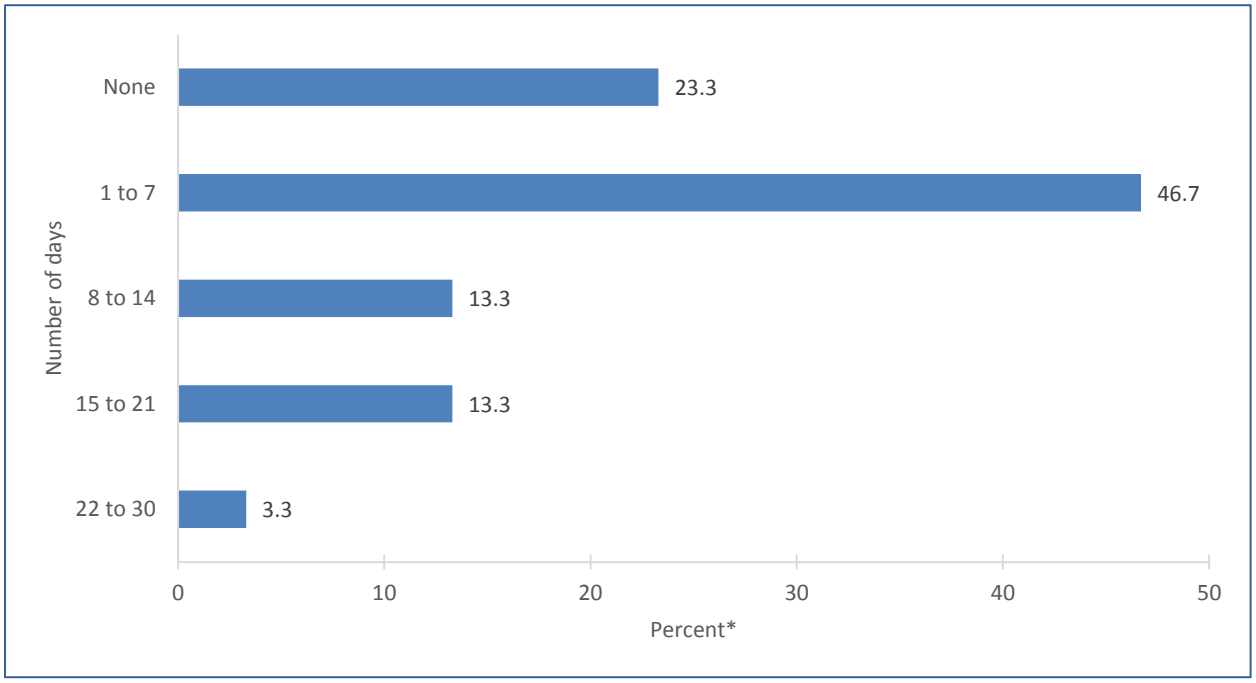
Figure 19. Location respondents would first go if they wanted help to quit using tobacco



N=32

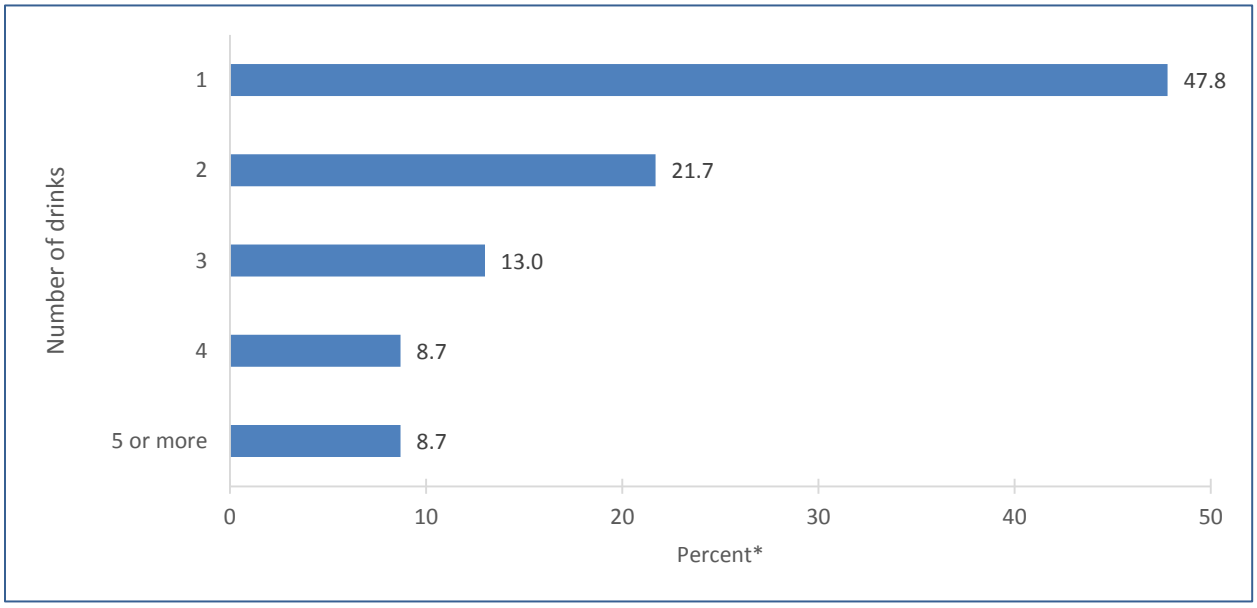
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

Figure 20. Number of days during the past month that respondents had at least one drink of any alcoholic beverage



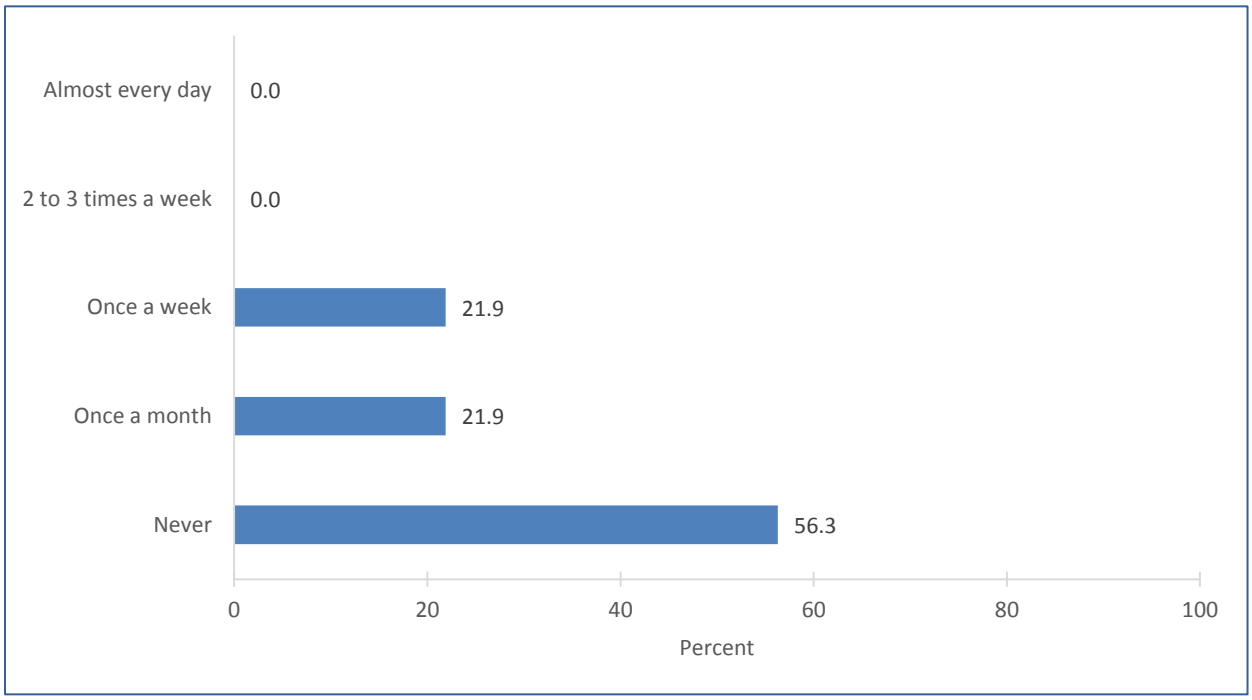
N=30 *Percentages do not total 100.0 due to rounding.

Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=23 *Percentages do not total 100.0 due to rounding.

Figure 22. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion



N=32

Figure 23. Whether respondents had a problem with alcohol use or prescription or non-prescription drug abuse

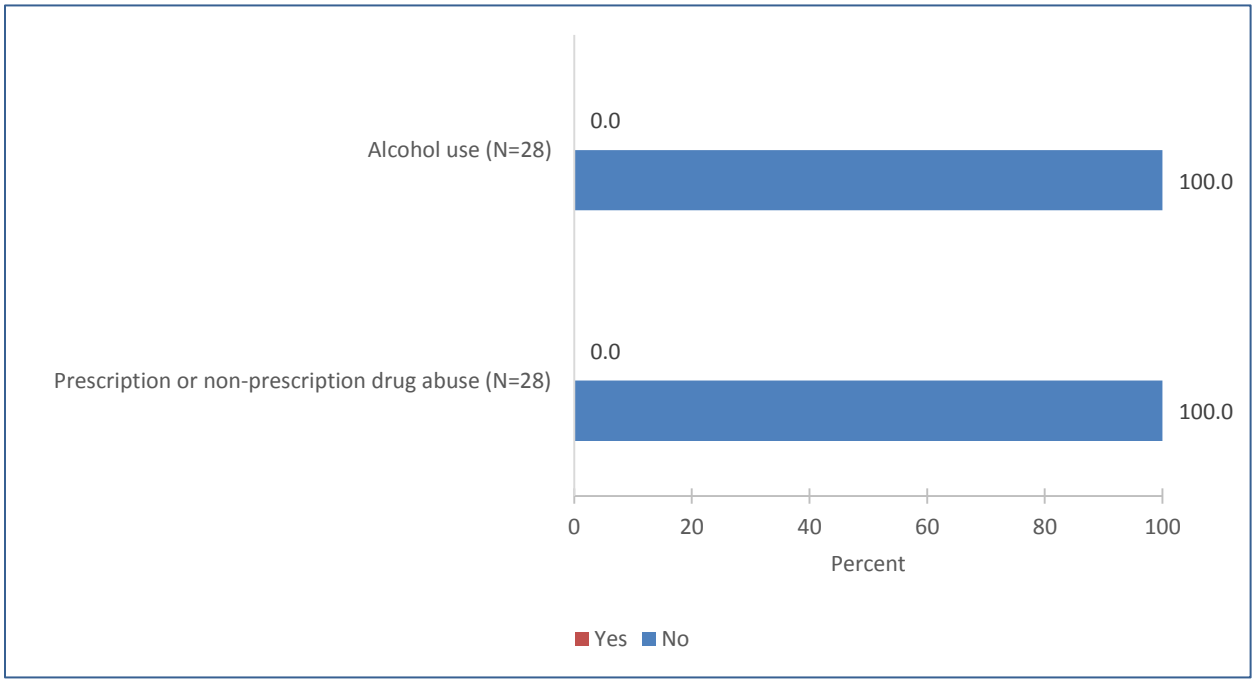
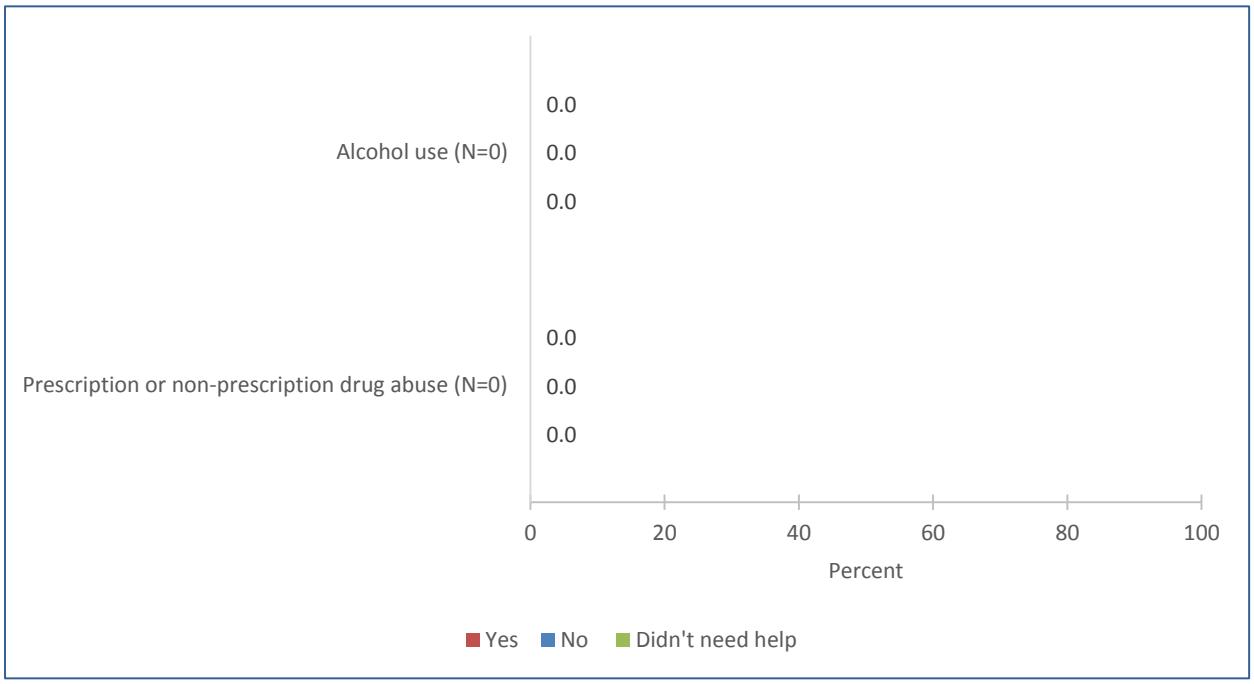
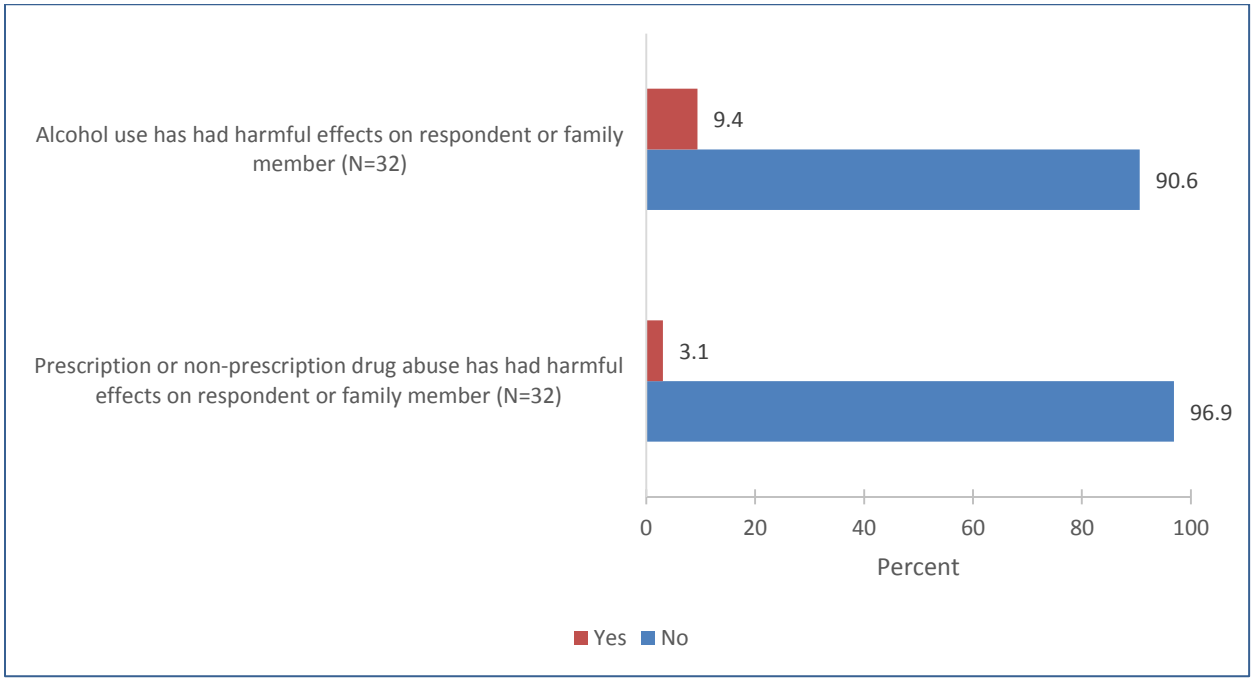


Figure 24. Of respondents who had ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed



Note: No respondents answered this question.

Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

Table 1. Whether or not respondents have had preventive screenings in the past year, by type of screening

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=33)	90.9	9.1	100.0
Blood sugar screening (N=33)	75.8	24.2	100.0
Bone density test (N=33)	12.1	87.9	100.0
Cardiovascular screening (N=33)	21.2	78.8	100.0
Cholesterol screening (N=33)	66.7	33.3	100.0
Dental screening and X-rays (N=32)	78.1	21.9	100.0
Flu shot (N=32)	78.1	21.9	100.0
Glaucoma test (N=32)	46.9	53.1	100.0
Hearing screening (N=31)	9.7	90.3	100.0
Immunizations (N=30)	40.0	60.0	100.0
Pelvic exam (N=27 Females)	66.7	33.3	100.0
STD (N=32)	12.5	87.5	100.0
Vascular screening (N=32)	9.4	90.6	100.0
CANCER SCREENINGS			
Breast cancer screening (N=27 Females)	66.7	33.3	100.0
Cervical cancer screening (N=28 Females)	60.7	39.3	100.0
Colorectal cancer screening (N=32)	28.1	71.9	100.0
Prostate cancer screening (N=5 Males)	60.0	40.0	100.0
Skin cancer screening (N=33)	24.2	75.8	100.0

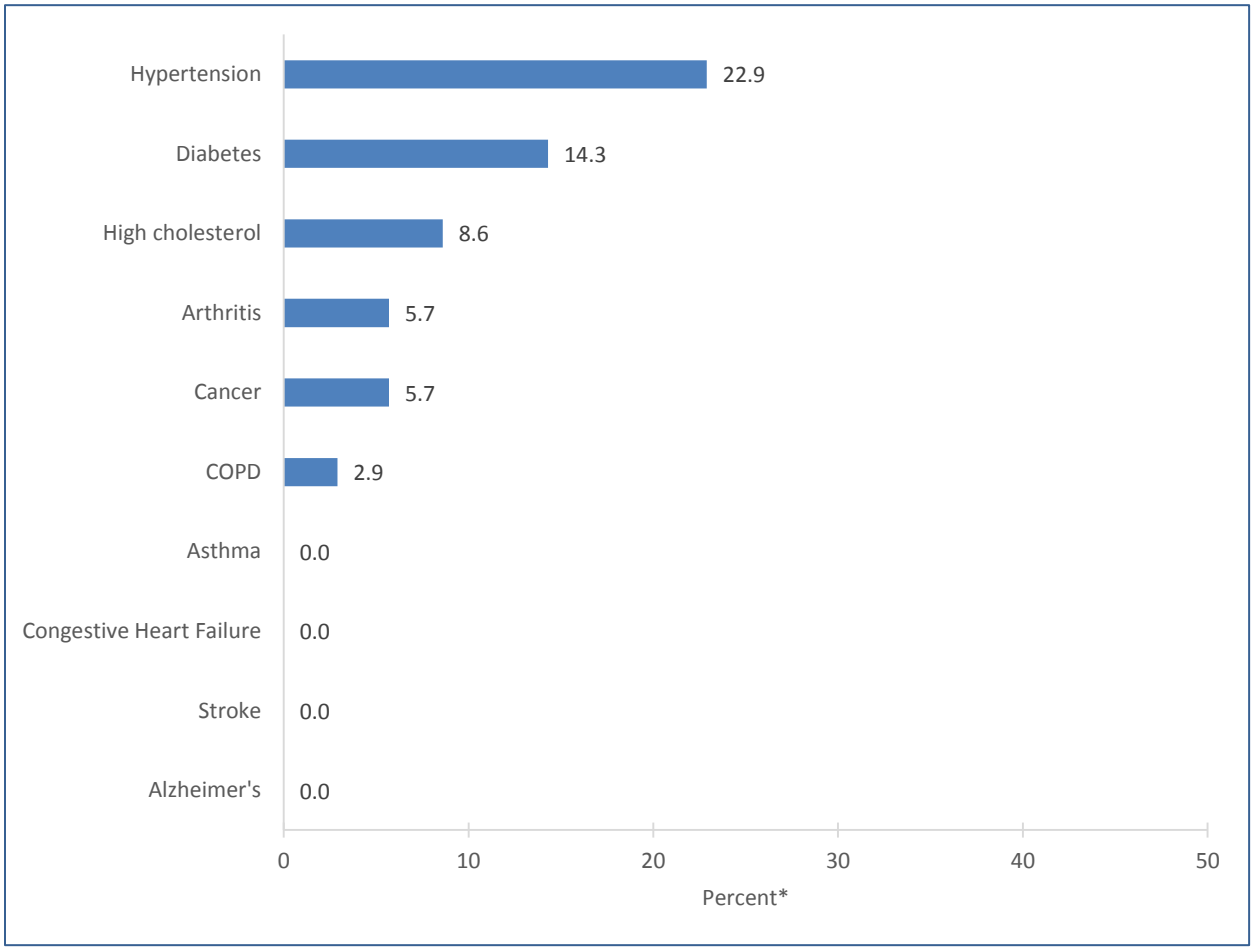
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=3)	66.7	0.0	33.3	0.0	0.0	0.0	0.0
Blood sugar screening (N=8)	50.0	37.5	12.5	0.0	0.0	0.0	0.0
Bone density test (N=29)	31.0	58.6	3.4	3.4	0.0	0.0	3.4
Cardiovascular screening (N=26)	34.6	46.2	3.8	0.0	0.0	0.0	0.0
Cholesterol screening (N=11)	45.5	27.3	9.1	0.0	0.0	0.0	9.1
Dental screening and	42.9	14.3	42.9				0.0

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
X-rays (N=7)				0.0	0.0	0.0	
Flu shot (N=7)	71.4	14.3	0.0	0.0	0.0	0.0	28.6
Glaucoma test (N=17)	64.7	17.6	5.9	0.0	0.0	0.0	0.0
Hearing screening (N=28)	50.0	28.6	7.1	0.0	0.0	0.0	3.6
Immunizations (N=18)	50.0	33.3	5.6	0.0	0.0	0.0	11.1
Pelvic exam (N=9 Females)	22.2	66.7	11.1	0.0	0.0	0.0	0.0
STD (N=28)	60.7	28.6	3.6	0.0	0.0	0.0	3.6
Vascular screening (N=29)	31.0	65.5	3.4	0.0	0.0	0.0	0.0
CANCER SCREENINGS							
Breast cancer screening (N=9 Females)	44.4	22.2	11.1	0.0	0.0	0.0	22.2
Cervical cancer screening (N=11 Females)	18.2	54.5	9.1	0.0	0.0	0.0	18.2
Colorectal cancer screening (N=23)	52.2	30.4	4.3	4.3	0.0	0.0	8.7
Prostate cancer screening (N=2 Males)	50.0	50.0	0.0	0.0	0.0	0.0	0.0
Skin cancer screening (N=25)	32.0	52.0	4.0	0.0	0.0	0.0	12.0

*Percentages do not total 100.0 due to multiple responses.

Figure 26. Whether respondents have any of the following chronic diseases



N=35

*Percentages do not total 100.0 due to multiple responses.

Figure 27. Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since respondents last visited a dentist or dental clinic for any reason

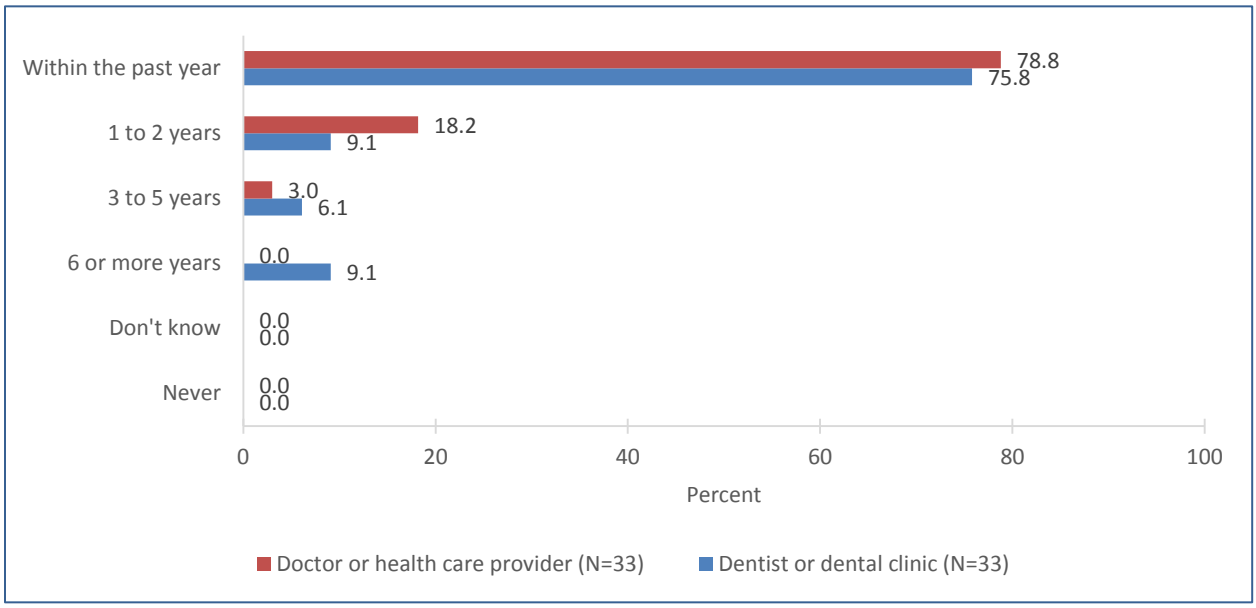
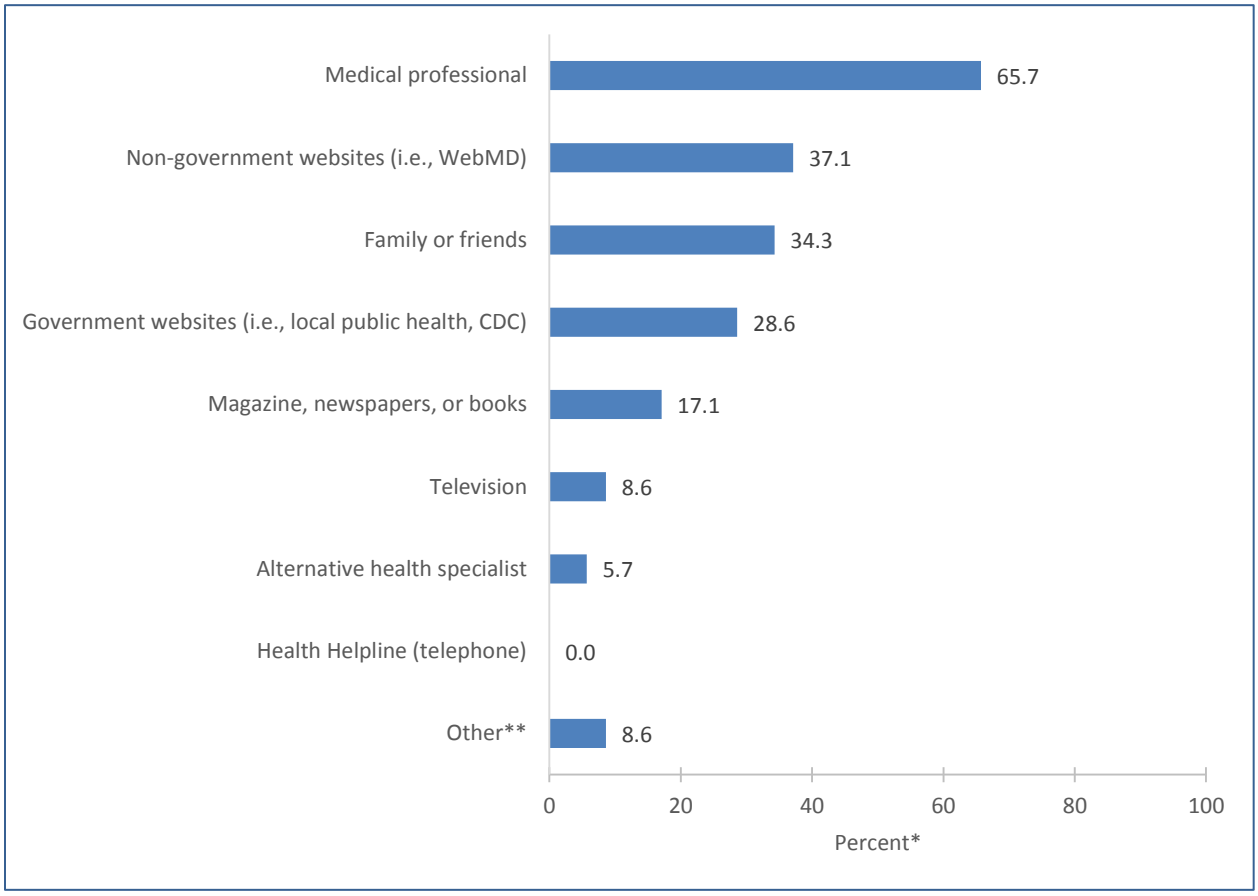


Figure 28. Where respondents get most of their health information

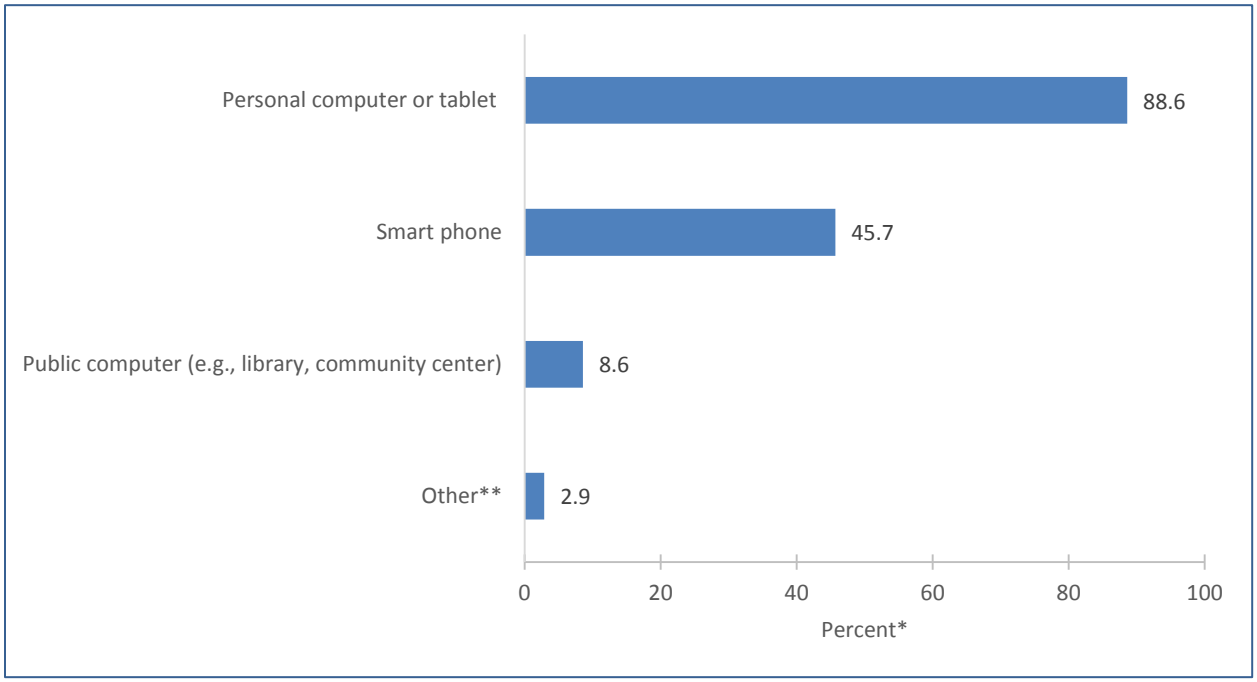


N=35

*Percentages do not total 100.0 due to multiple responses.

**Other responses include “our insurance” and “work”.

Figure 29. Best way for respondents to access technology for health information



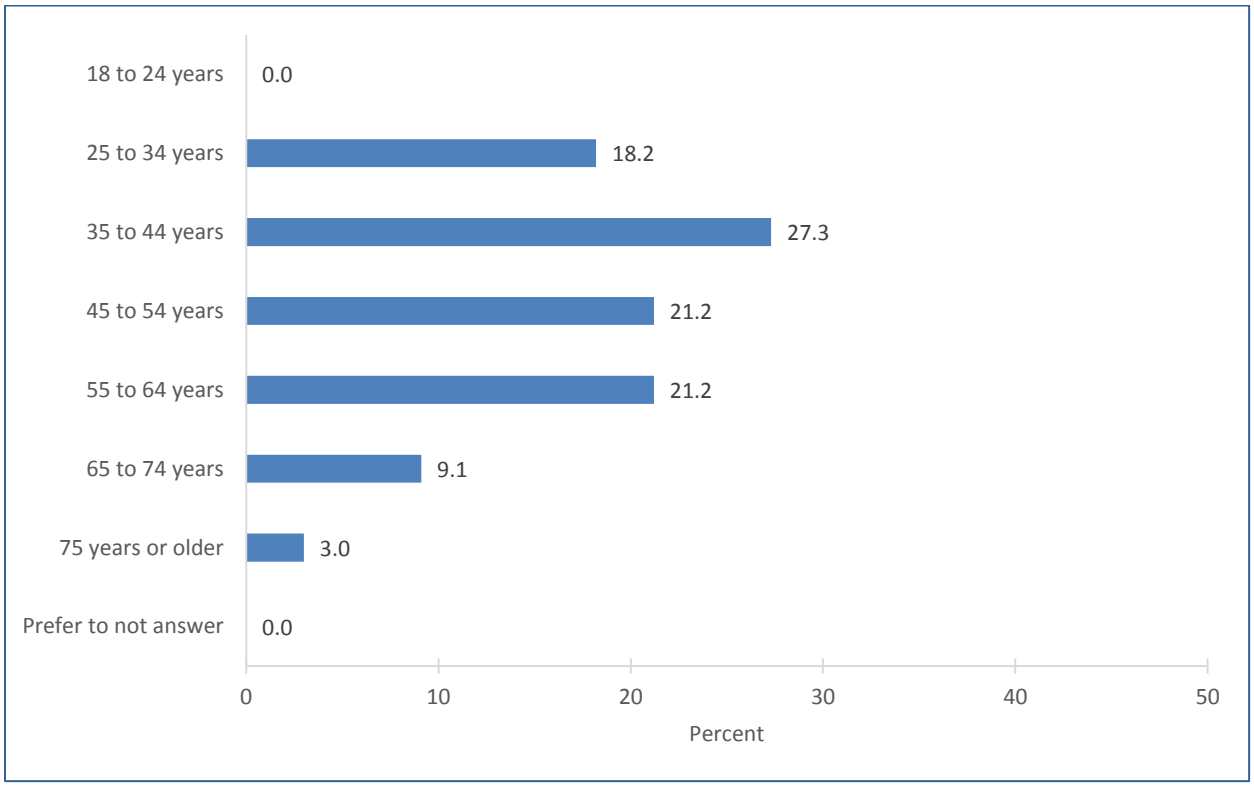
N=35

*Percentages do not total 100.0 due to multiple responses.

**Other response is “local clinic, staff”.

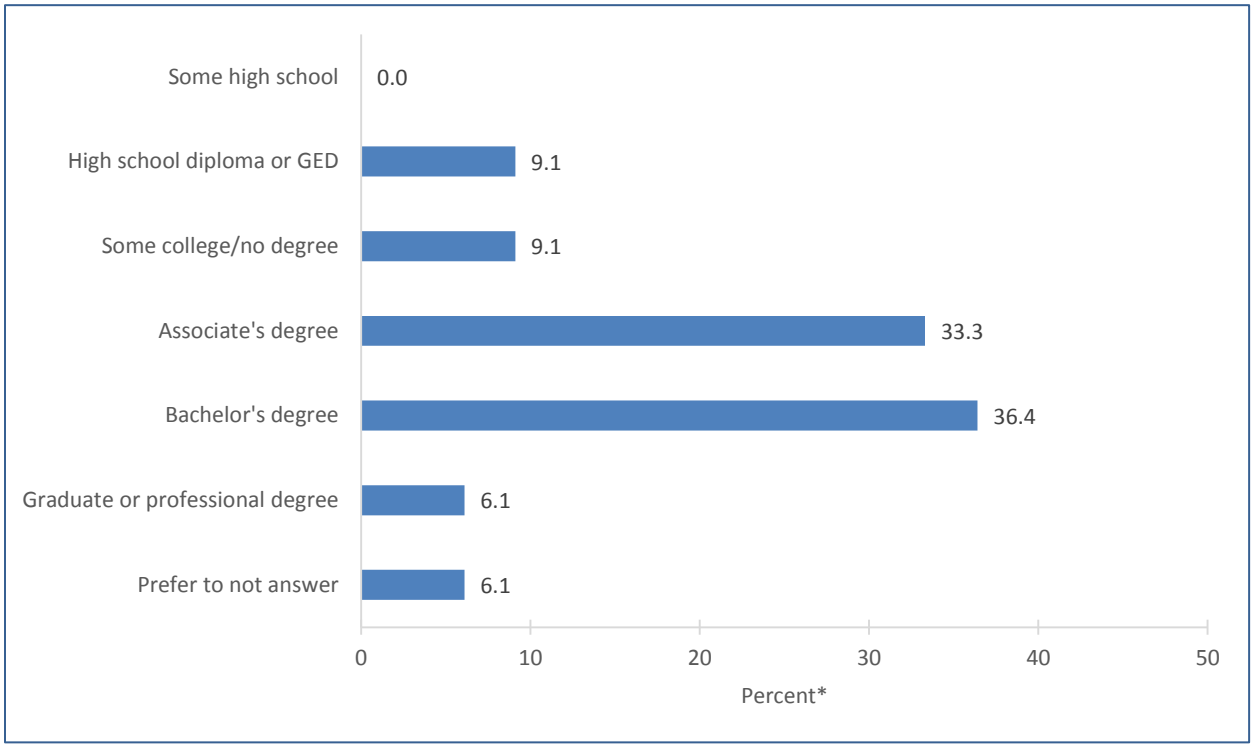
Demographic Information

Figure 30. Age of respondents



N=33

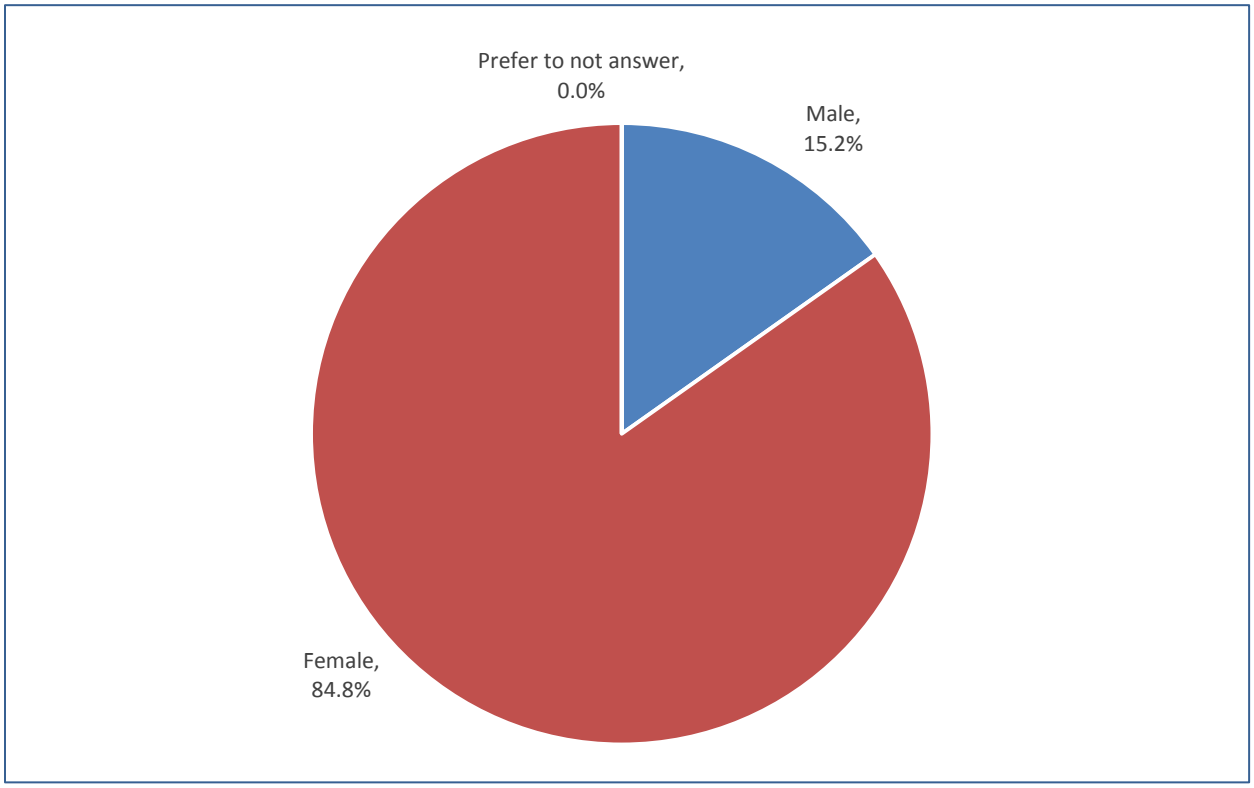
Figure 31. Highest level of education of respondents



N=33

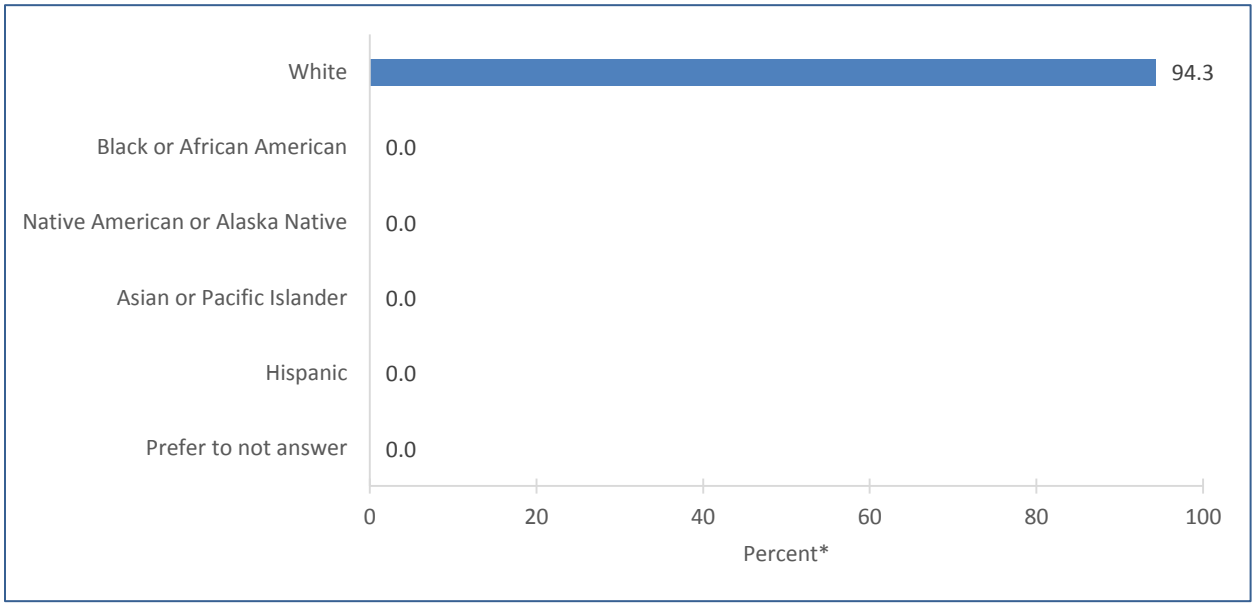
*Percentages do not total 100.0 due to rounding

Figure 32. Gender of respondents



N=33

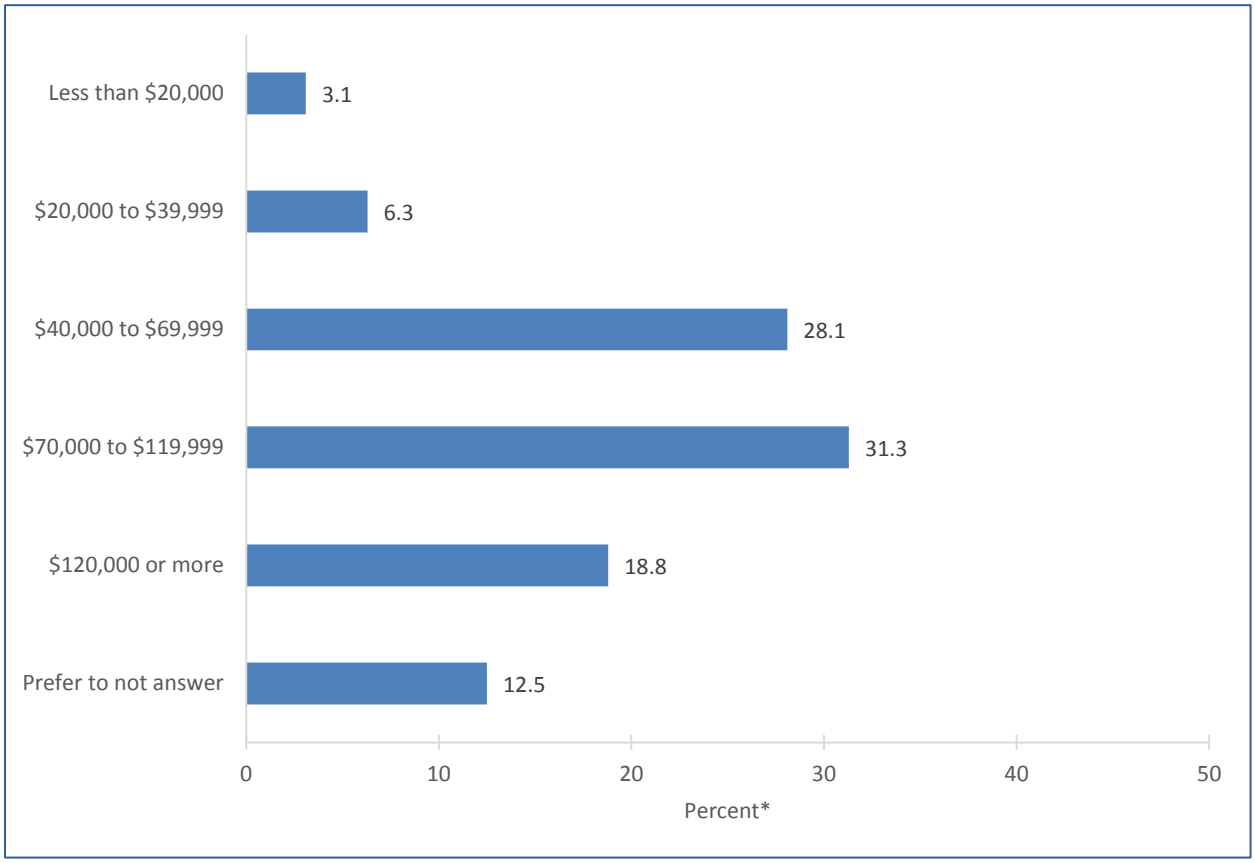
Figure 33. Race and ethnicity of respondents



N=35

*Percentages do not total 100.0 due to multiple responses.

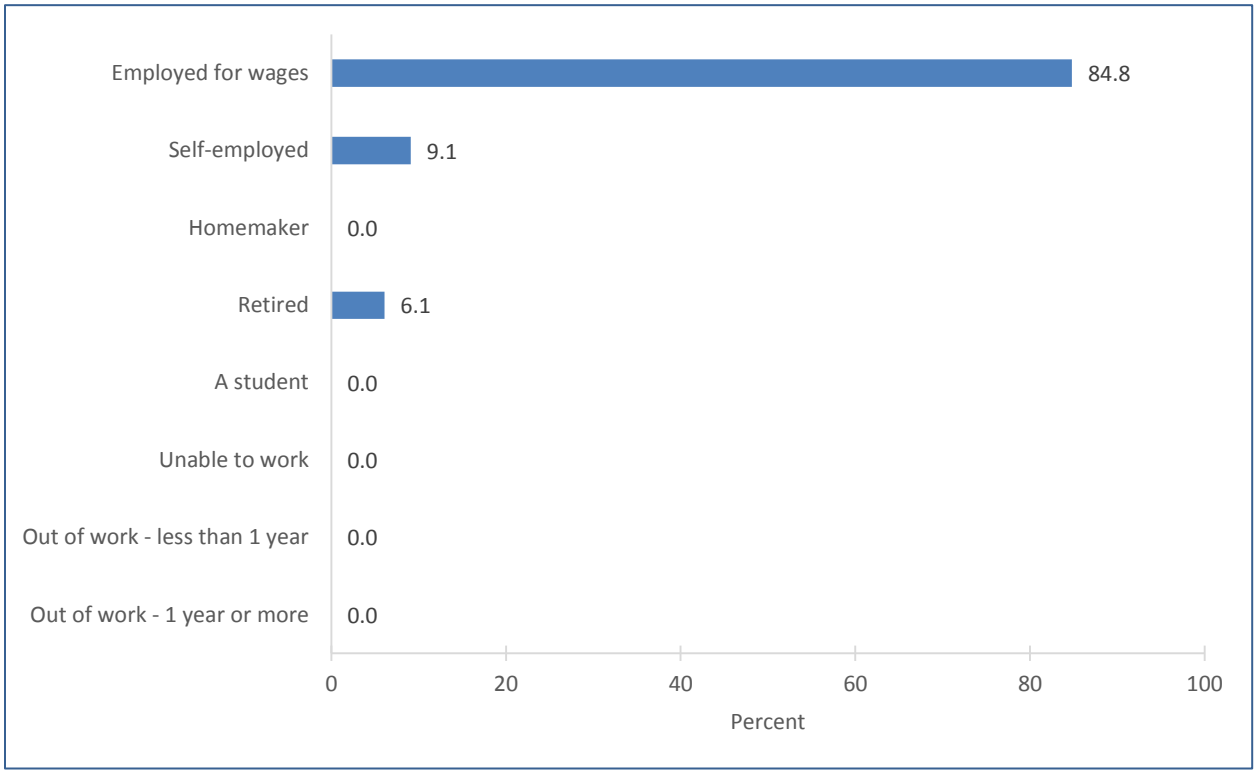
Figure 34. Annual household income of respondents



N=32

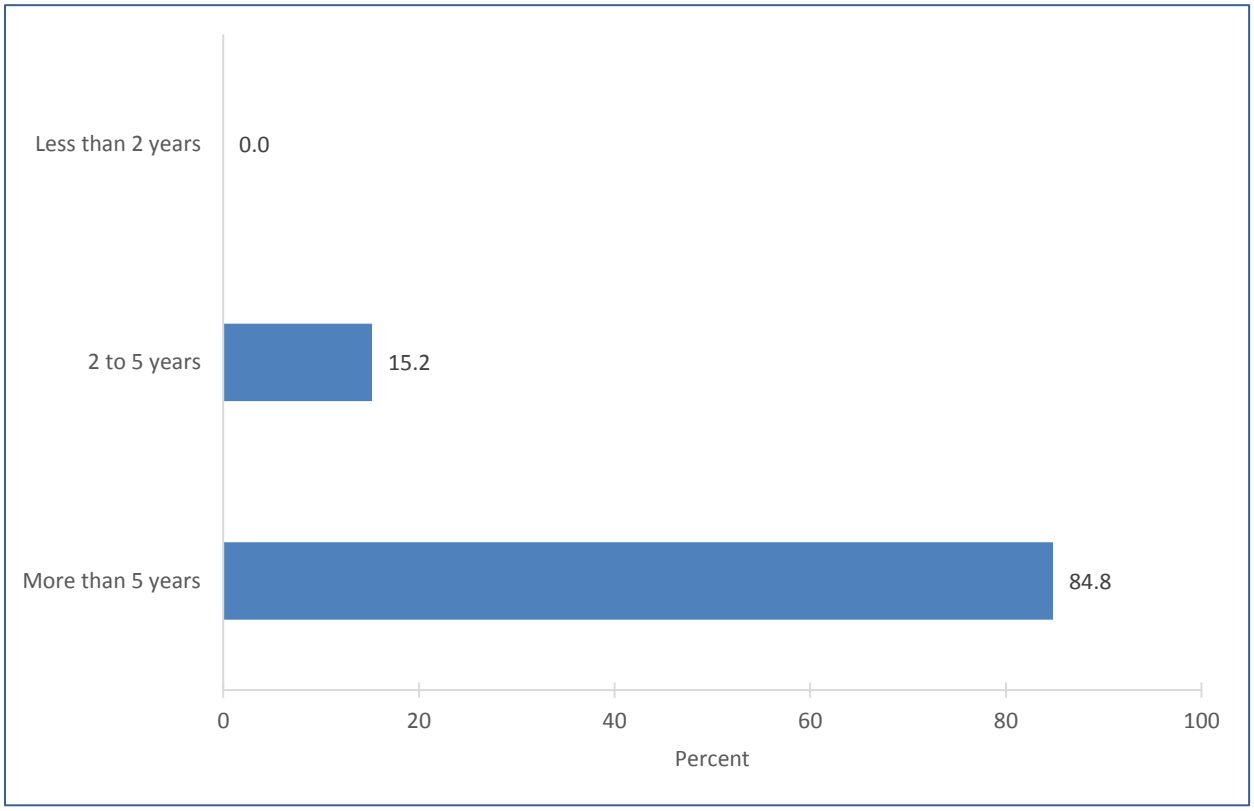
*Percentages do not total 100.0 due to rounding

Figure 35. Employment status of respondents



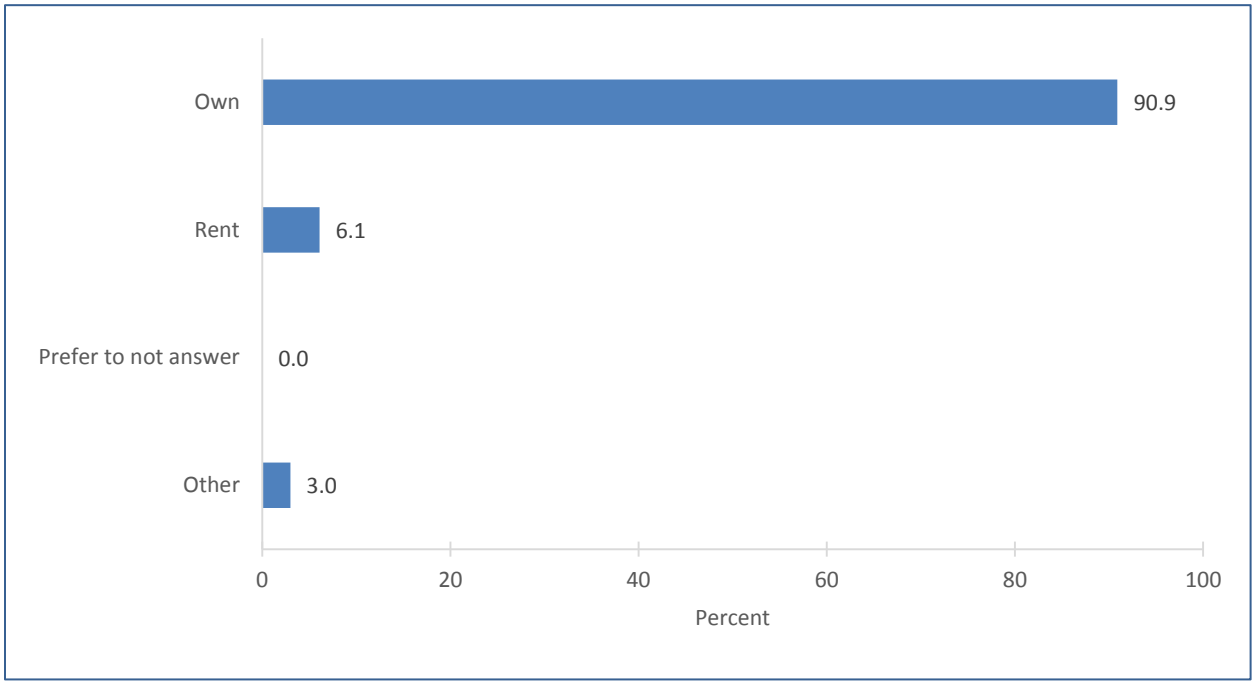
N=33

Figure 36. Length of time respondents have lived in their community



N=33

Figure 37. Whether respondents own or rent their home



N=33

Figure 38. Whether respondents have health insurance (private, public, or governmental) and oral health or dental care coverage

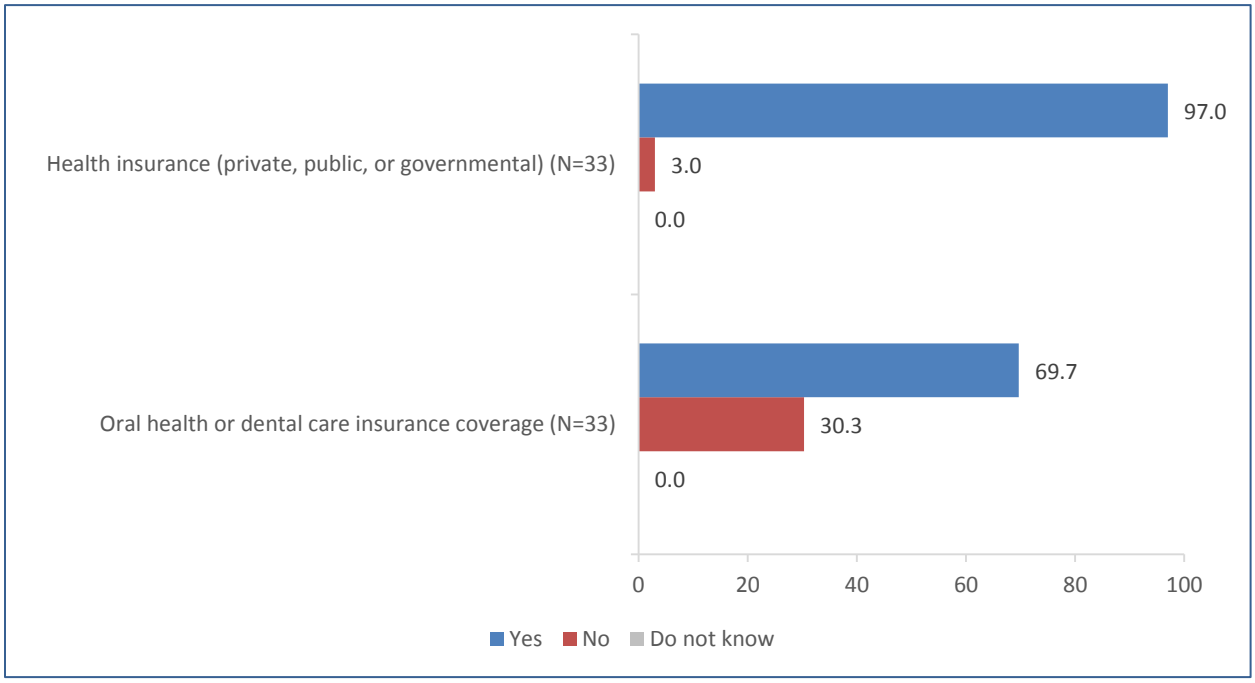
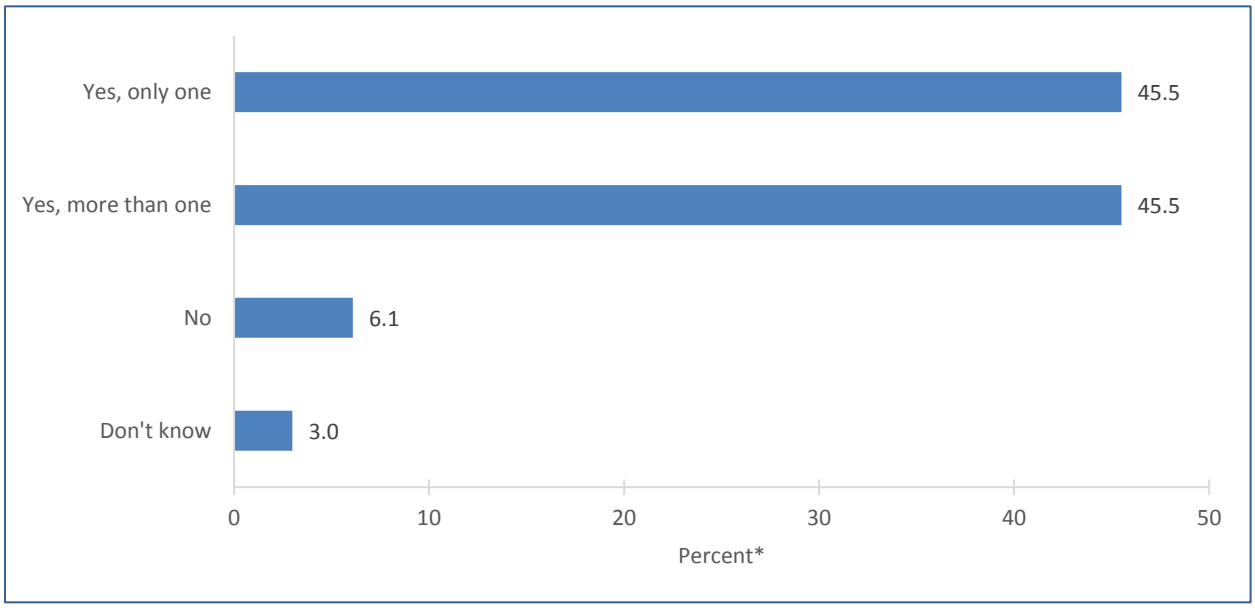


Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=33 *Percentages do not total 100.0 due to rounding.

Figure 40. Facilities that respondents go to most often when sick and take their children when they are sick

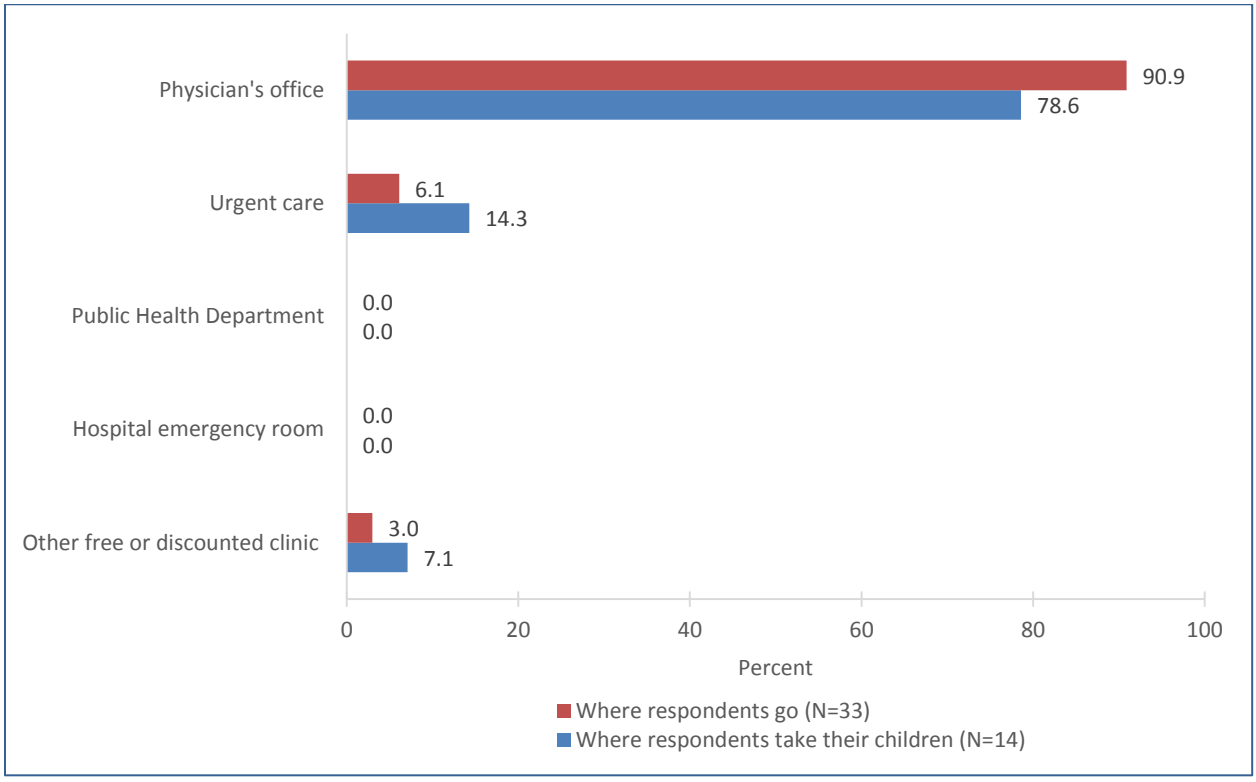
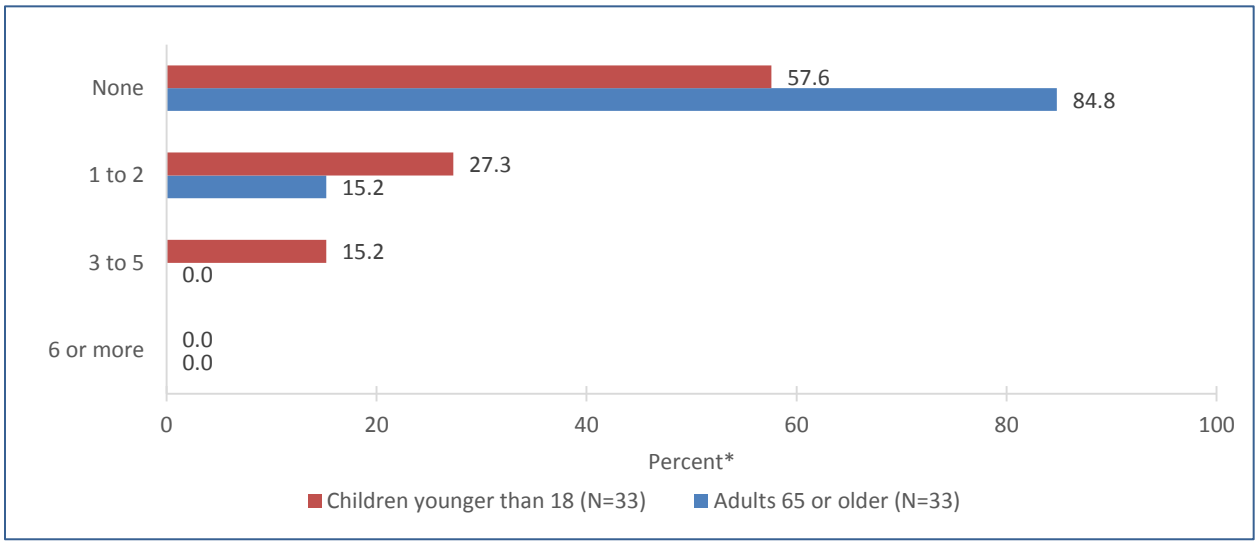
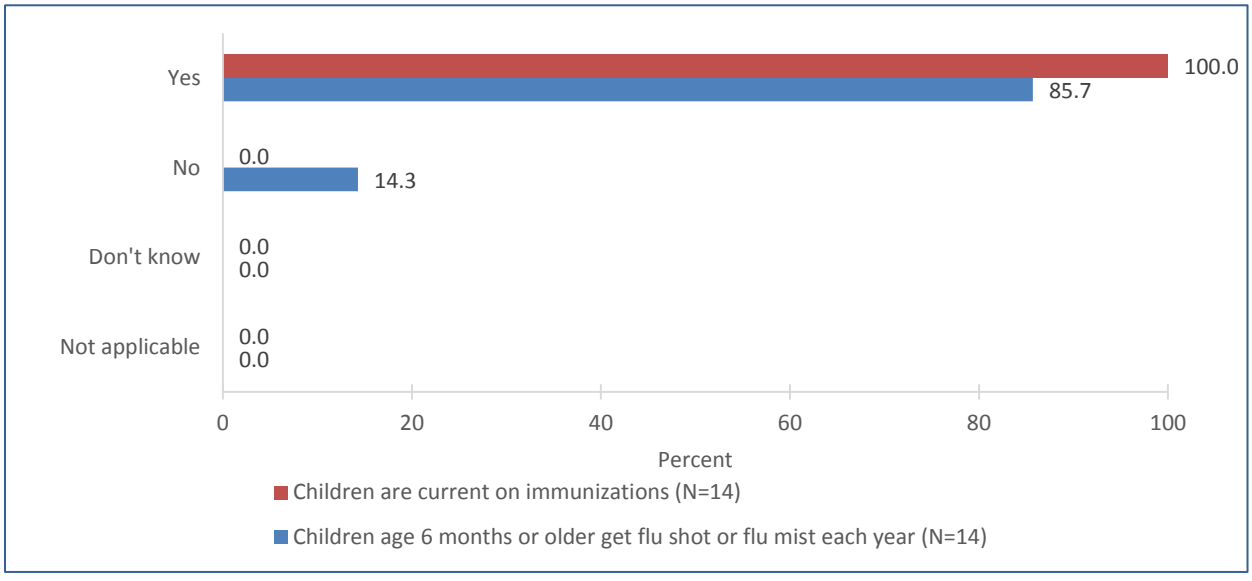


Figure 41. Number of children younger than 18 and number of adults age 65 or older living in respondents' household



*Percentages may not total 100.0 due to rounding.

Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



*Of respondents who have children younger than 18 years of age living in their household

Table 3. Zip code of respondents

Zip code	Number of respondents
57226	23
57237	2
57218	1
57223	1
57224	1
57238	1

N=29

SANFORD HEALTH

Secondary Research

Definitions of Key Indicators

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in calculating the 2015 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County Health Rankings* web site for your state.

For additional information about how the *County Health Rankings* are calculated, please visit www.countyhealthrankings.org

Contents:

* 95% confidence intervals are provided where applicable and available.

** Z-scores are "adjusted" z-scores (e.g., multiplied by -1 if a positively framed measure, set to zero for missing and unreliable values for ranked counties, and truncated at -3 or +3 if county population is less than 20,000).

Measure	Data Elements	Description
Geographic identifiers	**FIPS**	Federal Information Processing Standard
	State	
	County	
Premature death	# Deaths	Number of deaths under age 75
	Years of Potential Life Lost Rate	Age-adjusted YPLL rate per 100,000
	95% CI – Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor or fair health	Sample Size	Number of respondents
	% Fair/Poor	Percent of adults that report fair or poor health
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Measure	Data Elements	Description
Poor physical health days	Sample Size	Number of respondents
	Physically Unhealthy Days	Average number of reported physically unhealthy days per month
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor mental health days	Sample Size	Number of respondents
	Mentally Unhealthy Days	Average number of reported mentally unhealthy days per month
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Low birthweight	Unreliable	Value reported but considered unreliable since based on counts of twenty or less.
	# Low Birthweight Births	Number of low birthweight births
	# Live births	Number of live births
	% LBW	Percentage of births with low birth weight (<2500g)
	95% CI - Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Adult smoking	Sample Size	Number of respondents
	% Smokers	Percentage of adults that reported currently smoking
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Adult obesity	**% Obese**	Percentage of adults that report BMI >= 30
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Food environment index	**Food Environment Index**	Indicator of access to healthy foods - 0 is worst, 10 is best
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Physical inactivity	**% Physically Inactive**	Percentage of adults that report no leisure-time physical activity
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Access to exercise opportunities	# With Access	Number of people with access to exercise opportunities
	% With Access	Percentage of the population with access to places for physical activity
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Excessive drinking	Sample Size	Number of respondents
	% Excessive Drinking	Percentage of adults that report excessive drinking
	95% CI - Low	95% confidence interval reported by BRFSS

Measure	Data Elements	Description
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Alcohol-impaired driving deaths	# Alcohol-Impaired Driving Deaths	Number of alcohol-impaired motor vehicle deaths
	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases / Population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	Teen Births	Teen birth count, ages 15-19
	Teen Population	Female population, ages 15-19
	Teen Birth Rate	Teen births / females ages 15-19 * 1,000
	95% CI - Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance
	95% CI - Low	95% confidence interval reported by SAHIE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	PCP Rate	(Number of PCP/population)*100,000
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	(Number of dentists/population)*100,000
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	(Number of MHP/population)*100,000
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	# Medicare Enrollees	Number of Medicare enrollees
	Preventable Hosp. Rate	Discharges for Ambulatory Care Sensitive Conditions/Medicare Enrollees * 1,000
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetic monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c

Measure	Data Elements	Description
		test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in poverty	# Children in Poverty	Number of children (under age 18) living in poverty
	% Children in Poverty	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations / Population * 10,000

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes/population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
	95% CI - Low	95% confidence interval as reported by the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	Pop. In Viol	Average annual population affected by a water violation
	% Pop in Viol	Population affected by a water violation/Total population with public water
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	# Drive Alone	Number of people who drive alone to work
	# Workers	Number of workers in labor force
	% Drive Alone	Percentage of workers who drive alone to work
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Long commute - driving alone	# Workers who Drive Alone	Number of workers who commute in their car, truck or van alone
	% Long Commute - Drives Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Deuel County

County Demographics

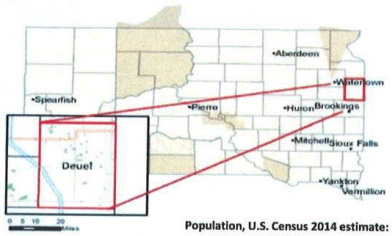
	Deuel County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Health Outcomes					20
Length of Life					22
Premature death	5,856	4,164-8,005	5,200	6,738	
Quality of Life					30
Poor or fair health	13%	8-22%	10%	11%	
Poor physical health days	3.0	1.8-4.2	2.5	2.7	
Poor mental health days	2.4	1.5-3.3	2.3	2.6	
Low birth weight	5.7%	3.3-8.1%	5.9%	6.5%	
Additional Health Outcomes (not included in overall ranking)					
Health Factors					42
Health Behaviors					42
Adult smoking	19%	12-29%	14%	18%	
Adult obesity	34%	28-40%	25%	29%	
Food environment index	6.4		8.4	7.4	
Physical inactivity	30%	23-37%	20%	25%	
Access to exercise opportunities	50%		92%	70%	
Excessive drinking	22%	15-31%	10%	19%	
Alcohol-impaired driving deaths	0%		14%	37%	

	Deuel County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Sexually transmitted infections	183		138	471	
Teen births	27	18-39	20	37	
Additional Health Behaviors (not included in overall ranking)					
Clinical Care					**35**
Uninsured	14%	13-16%	11%	14%	
Primary care physicians	4,380:1		1,045:1	1,302:1	
Dentists	4,320:1		1,377:1	1,813:1	
Mental health providers			386:1	664:1	
Preventable hospital stays	63	45-80	41	57	
Diabetic monitoring	92%	68-100%	90%	84%	
Mammography screening	75.0%	48.2-100.0%	70.7%	66.5%	
Additional Clinical Care (not included in overall ranking)					
Social & Economic Factors					**29**
High school graduation			93%	78%	
Some college	58.0%	47.9-68.2%	71.0%	66.7%	
Unemployment	5.1%		4.0%	3.8%	
Children in poverty	13%	9-17%	13%	19%	
Income inequality	3.2	2.7-3.6	3.7	4.2	
Children in single-parent households	15%	9-22%	20%	31%	
Social associations	22.8		22.0	17.4	
Violent crime	30		59	282	
Injury deaths	82	49-130	50	69	

	Deuel County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Additional Social & Economic Factors (not included in overall ranking)					
Physical Environment					**49**
Air pollution - particulate matter	12.2		9.5	10.8	
Drinking water violations	0%		0%	3%	
Severe housing problems	11%	7-14%	9%	12%	
Driving alone to work	74%	70-78%	71%	78%	
Long commute - driving alone	30%	24-37%	15%	14%	

FOCUS ON SOUTH DAKOTA
A Picture of Health

SOUTH DAKOTA HEALTH STUDY: DEUEL COUNTY RESULTS



Population, U.S. Census 2014 estimate: 4,312

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Deuel County Responses: 117	Response Rate: 60%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		DEUEL COUNTY (n = 117)
57.4%	Female	42.8%
11.3%	Non-White	4.5%
19.1%	Age 65 and older	26.7%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	14.8%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	12.6%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	4.4%

NEED FOR CARE

75.0%	Need Medical Care	67.9%
79.5%	Need Prescription Medications	73.8%
9.5%	Need Mental Health Care	5.8%
1.1%	Need Alcohol or Drug Treatment	0.8%

ACCESS TO CARE

94.2%	Have a usual place to go for care	91.4%
77.4%	Have a personal doctor/provider	76.8%
13.0%	Unmet medical needs	4.2%
6.4%	Unmet prescription needs	4.7%
35.8%	Unmet mental health needs	25.5%
45.6%	Unmet alcohol or drug abuse needs	0.0%

HEALTH PROFILE

SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	DEUEL COUNTY (n = 117)
11.4%	Diabetes	10.3%
10.9%	Asthma	4.6%
33.3%	High Blood Pressure	40.9%
8.9%	Heart Disease	11.0%
28.5%	High Cholesterol	31.8%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	4.7%
8.9%	Cancer	11.2%
54.7%	At least one of the above	56.0%
17.0%	Depression	12.3%
17.6%	Anxiety	14.0%
3.4%	PTSD (Post-Traumatic Stress Disorder)	0.7%
1.7%	Bipolar Disorder	0.7%
2.6%	Addiction Issues	4.8%
25.5%	At least one of the above	21.5%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	79.9%
5.5%	Depression	2.2%
7.5%	Anxiety	2.2%
6.0%	PTSD (Post-Traumatic Stress Disorder)	5.0%
17.0%	Current Smoker	15.0%
42.4%	Alcohol Abuse	40.9%
6.7%	Marijuana Use (past year)	2.5%

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