



Sanford Health Network  
Community Health Needs Assessment  
2012-2013

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**Sanford Chamberlain Medical Center**

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**2012-2013**

**6/10/13**

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## Sanford Chamberlain Medical Center Community Health Needs Assessment 2012-2013

### **Purpose**

Sanford Chamberlain Medical Center is part of Sanford Health, an integrated health system headquartered in the Dakotas and the largest rural not-for-profit health care system in the nation with locations in 126 communities in eight states.

Sanford Chamberlain Medical Center has undertaken a community health needs assessment as required by the Patient Protection and Affordable Care Act, and as part of the IRS 990 requirement for a not-for-profit health system to address issues that have been assessed as unmet needs in the community.

PPACA requires that each hospital must have: (1) conducted a community health needs assessment in the applicable taxable year; (2) adopted an implementation strategy for meeting the community health needs identified in the assessment; and (3) created transparency by making the information widely available. For tax exempt hospital organizations that own and operate more than one hospital facility, as within Sanford Health, the new tax exemption requirements will apply to each individual hospital. The first required needs assessment falls within the fiscal year July 1, 2012 through June 30, 2013.

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

A community health needs assessment is critical to a vital Community Investment/Community Benefit Program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining not-for-profit status.

## Acknowledgements

Sanford Health would like to acknowledge and thank the Steering Committees and the Greater Fargo Moorhead Community Health Needs Assessment Collaborative for their expertise while performing the assessment and analysis of the community health data. The assessment provides support for the future directions of our work as the region's leading health care system.

### Sanford Enterprise Steering Group:

- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD,CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Sioux Falls Region Co-Lead:* Bruce Viessman, CFO, Sanford Health Network Sioux Falls
- Mike Begeman, Chief of Staff/Vice President of Public Affairs
- Maxine Brinkman, CPA; Director of Financial Decisions and Operations Support
- Michelle Bruhn, CPA; CFO, Health Services Division
- Randy Bury, COO, Sanford Medical Center USD
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- JoAnn Kunkel, CFO, Sanford Health
- Tiffany Lawrence, CPA; Fargo Region Co-Lead, CFO, Sanford Medical Center Fargo
- Martha Leclerc, MS; Vice President, Office of Health Reform and Strategic Payment
- Doug Nowak, MBA; Executive Director, Decision Support
- Heather Vanmeveren, CPA; Director of Accounting

### Sanford Sioux Falls Network Steering Group:

- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD,CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Sioux Falls Region Co-Lead:* Bruce Viessman, CFO, Sanford Health Network Sioux Falls
- Michelle Bruhn, CPA; CFO, Health Services Division
- Mike Daly, Director, Public Affairs
- Doug Nowak, Executive Director, Decision Support
- Jeff Rotert, COO/CFO, Sanford Worthington Medical Center
- Cindy Schuck, Manager, Accreditation Standards Program
- Dan Staebell, Communications Department
- Justin Tiffany, Project Specialist, Health Network, Sanford Medical Center

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

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

Our Guiding Principles:

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

The following key community stakeholders participated in this assessment work:

- Mary Jane Alexander, Outreach/PQI Director, St. Joseph's Indian School, Chamberlain, SD
- Jesse Baller, City Commissioner, Kimball, SD
- Mark Benton, General Manager/CEO, Midstate Communication, Chamberlain, SD
- Joel Bergeson, Elementary Principal, Chamberlain School District, Mitchell, SD
- Erin Bergeleen, Ag Loan Officer, First Dakota National Bank, Kimball, SD
- Allan Bertram, Principal, Chamberlain High School, Chamberlain, SD
- Amy Blum, Strategic Projects Director, St. Joseph's Indian School, Chamberlain, SD
- Pat Blum, RN, Dakota Milestones, Chamberlain, SD
- Rod Boward, President/Manager, Kennebec Telephone Co., Inc., Kennebec, SD
- Destiny Brennan, Board Member, The Children's Ark, Inc., Chamberlain, SD
- Robert Burke, Retail, Chamberlain, SD
- Brad Carson, President, Wells Fargo Bank, Chamberlain, SD
- Sharon Casey, VP, Casey Corporation, Chamberlain, SD
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- Leroy Choal, Choal Construction, Reliance, SD
- Shirley Crane, CHR Director, Lower Brule Sioux Tribe, Lower Brule, SD
- Kory Christianson, Executive Director of Development, St. Joseph's Indian School, Chamberlain, SD
- Cathy Dale, Director of Finance, St. Joseph's Indian School, Chamberlain, SD
- Donna Dean, HR Director, St. Joseph's Indian School, Chamberlain, SD
- Kathleen Donohue, Educator, St. Joseph's Indian School, Chamberlain, SD
- Mindy Donovan, Board Member, Tree House Preschool, Chamberlain, SD
- Ellen Durkin, Clinical Social Worker, Lower Brule Sioux Tribe, Lower Brule, SD
- Gary Dozark, Brule County Commissioner, Pukwana, SD
- Tolly Estes, Housing Director, Crow Creek Sioux Tribe, Fort Thompson, SD
- Doug Feltman, Lions Club Member, Chamberlain, SD
- Kathy Feltman, Retired Medical Clinic Manager, Chamberlain, SD
- LeToy Fleury, Counselor, Crow Creek Tribal Scholls, Fort Thompson, SD
- Gail Griner, Director of Finance & Administration, Diamond Willow Ministries, Fort Thompson, SD
- Sheri Hardman, Superintendent, Kimball School District, Kimball, SD
- Neoma Harris, Marketing Director, St. Joseph's Indian School, Chamberlain, SD
- Mary Hendricks, Gann Valley, SD
- Cheryl Hickey, Personal Banking Representative, First Dakota National Bank, Chamberlain, SD
- Tanya Houska, Business Office, St. Joseph's Indian School, Chamberlain, SD
- Sanford Hrabec, Lions Club Member, Chamberlain, SD
- Father Stephen Huffstetter, Director, St. Joseph's Indian School, Chamberlain, SD
- Melissa Hutmacher, Director, Cozard Memorial Library, Chamberlain, SD
- Denise Hyland, Planned Giving Manager, St. Joseph's Indian School, Chamberlain, SD
- Chad Johnson, Town & Country Club, Kennebec, SD
- Chantelle Jones, Manager, Chamber of Commerce, Chamberlain, SD



- John Jones, Family Practice Physician, Sanford Chamberlain, Chamberlain, SD
- Randy Jordan, Administrator, Indian Health Service, Lower Brule, SD
- Larry Jurgensen, Power Company Employee, Chamberlain, SD
- Wilfred Keebel, Ex-Chairman, Crow Creek Sioux Tribe, Fort Thompson, SD
- Father Anthony Kluckman, Chaplain, St. Joseph's Indian School, Chamberlain, SD
- Robyn Knech, President, Daycare Parent Board, Chamberlain, SD
- Nikki Knippling, Office Manager, Cedar Shore Resort, Chamberlain, SD
- Maynard J. Konechne, Owner, Konechne Digging, Kimball, SD
- Cal Kroeker, Pastor, Central Plains Evangelical Church, Chamberlain, SD
- Michelle Langenbau, Bookkeeper, South Dakota Wheat Growers, Kennebec, SD
- Leanne Larson, School Board Member, Chamberlain, SD
- Cassi Leiferman, Pharmacist, Sanford Chamberlain, Chamberlain, SD
- Brent Leiferman, School Board Member, Kimball, SD
- Janice A. Lien, Retired Teacher, Kennebec, SD
- Amanda Longhenry, Science Teacher, Lyman School District, Chamberlain, SD
- Todd Longville, Grain Elevator Manager, Kennebec, SD
- Theresa Long Turkey, Administrative Asst./Office Manager, Hunkpati Investments, Lower Brule, SD
- LaDonna McManus, PBR, First Dakota Bank, Chamberlain, SD
- Larry J. McManus, Manager, Tri County Landfill Association, Inc., Pukwana, SD
- Darlene Medicine Crow, Counselor, Project Safe, Fort Thompson, SD
- Eugene Mertens, Town Board Chairman, Kennebec, SD
- Gailen Meyerink, President, First Dakota National Bank, Chamberlain, SD
- Chad Mutziger, City Council Member, Chamberlain, SD
- James Nesladek, Brule County Commissioner, Chamberlain, SD
- Duane Neugebauer, Pastor, Trinity Lutheran Church, Chamberlain, SD
- Corrine Overweg, Secretary, Chamber of Commerce, Kimball, SD
- Steve Perry, Lyman County Commissioner, Presho, SD
- Chisum Peterson, Owner, Peterson Land & Auction, Chamberlain, SD
- Greg Powell, City Engineer, Chamberlain, SD
- Jeff Priebe, Senior VP, First Dakota Bank, Chamberlain, SD
- Don Reinesch, Bruce County Commissioner, Kimball, SD
- Marlene Reuman, School Board President, Lyman High School, Presho, SD
- Ed Schaub, Retired, Kimball, SD
- Clint Soulek, Business Owner/Manager, Chamberlain, SD
- John Soulek, Customer Service Rep, Noteboom Implement, Kimball, SD
- Julie Soulek, Residential Director, St. Joseph's Indian School, Chamberlain, SD
- Clifton Stone, Regional Supervisor, SD Game, Fish & Parks Dept., Chamberlain, SD
- Tim Thomas, Dialysis Technician, Sanford Chamberlain, Chamberlain, SD
- Dixie Thompson, Museum Director, St. Joseph's Indian School, Chamberlain, SD
- Anonymous, Chamber, SD

## Sanford Chamberlain Medical Center Community Health Needs Assessment 2012-2013

### Executive Summary

#### Purpose

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

#### Study Design and Methodology

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Brule, Buffalo and Lyman counties
- Aging Profiles for Brule, Buffalo and Lyman counties
- Diversity Profiles for Brule, Buffalo and Lyman counties

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

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

## Summary of Key Findings

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

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

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

### *Community - People, Economic Issues and Youth Concerns*

Primary research showed that among 91 respondents surveyed, respondents had very high levels of agreement that their communities were generally populated with friendly, helpful and supportive people who felt connected with their communities. Respondents did indicate that the communities were family friendly and located in a peaceful and calm environment, indicative of the rural nature of the service area. Survey respondents did indicate concerns about cultural richness, tolerance and inclusion and quality higher education opportunities, again most likely due to the rural nature and sparse population of the area served. Respondents were also most concerned with substance abuse and bullying and were also concerned with issues regarding cost of health care and/or insurance, cost and/or availability of elder care, and changes in family composition (e.g. divorces, single parenting).

### *Health/Wellness Concerns*

Among health and wellness concerns, respondents were most concerned about the cost of health insurance, cancer, cost of health care, and drug use and abuse. Respondents were also concerned with cost of prescription drugs, chronic disease, alcohol use and abuse, obesity, availability of doctors, nurses and/or specialists, and adequacy of health insurance (e.g. amount of copays and deductibles, consistency of coverage). Availability of bilingual providers and/or translators and availability of good walking or biking options were not major concerns.

### *Delivery of Health Care*

Respondents mentioned the strong partnerships and collaborations that are working to create healthier communities, such as the Suicide Task Force and the Prairie Futures Nursing Program. Faith and religious organizations that are addressing social concerns, such as the Chamberlain Ministerial Society, were also mentioned. Respondents also said that affordable housing was another issue within the community. Respondents had moderate agreement that there is an engaged government and socially and culturally diverse community. There was also moderate agreement that the people who live in the communities are aware of/engaged in social, civic, or political issues and that there is a sense that people can make a difference.

### ***Primary Health Care***

Respondents indicated that the biggest driver in influencing their choice of primary health care provider was location. Availability of the service and quality of services also were factors, but not to the extent of location. Over half the respondents drive less than 20 miles for health care services.

Over half of the respondents had not had a cancer screening or cancer care in the last 12 months, indicating that it had not been necessary or the doctor had not suggested it.

### ***Health Care Coverage***

Respondents indicated that they had paid for health care costs, for themselves or family members, mostly through health insurance through an employer. Personal income and private health insurance were also used.

### ***Chronic Disease***

Weight control has the highest level of response for personal general health conditions/diseases among the respondents. Other chronic diseases found among respondents included arthritis, asthma, cancer, heart disease, diabetes, Alzheimer's, hypertension, hypercholesterolemia and depression.

### ***Demographics***

The majority of respondents were between the ages of 35 and 59. Over half of the respondents were female and just over half had a Bachelor's degree or higher.

## **Key Findings – Secondary Research**

### ***Health Outcomes***

The state of South Dakota has more premature deaths than the national benchmark, and Brule, Buffalo and Lyman counties have higher rates than the national benchmark and South Dakota as a whole. The Morbidity health outcomes indicate that Brule and Buffalo county citizens report more days of poor health (self-reported) than the national or South Dakota benchmark.

South Dakota and Brule and Buffalo counties report more mentally unhealthy days than the state or national benchmarks, while Lyman County is below both benchmarks.

Brule County has a lower percentage of low birth weight than either the state or national benchmarks, while Lyman and Buffalo counties are above both benchmarks.

### ***Health Behaviors***

The Health Behavior outcomes indicate that South Dakota and Brule, Buffalo and Lyman counties have higher percentages of adult smokers (equal to or greater than 100 cigarettes) than the national benchmark. Of the three counties, Buffalo County has nearly half of its population (46%) as adult smokers. All three counties are above the state and national benchmarks for adult obesity (greater than or equal to 30 BMI), and South Dakota and Brule, Buffalo and Lyman counties have a greater percentage of physical inactivity than the national benchmark.

South Dakota (19%), Brule (13%), Buffalo (35%) and Lyman (21%) counties have much higher percentages of excessive drinking than the national benchmark (8%).

The teen birth rate in South Dakota, Buffalo and Lyman counties is higher than the national benchmark. Buffalo and Lyman are significantly higher at 135 and 77. Brule County is below the national and state benchmarks.

## *Health Factors*

### Clinical Care

The Clinical Care outcomes indicate that South Dakota and Brule, Buffalo and Lyman counties have higher percentages of uninsured adults than the national benchmark.

There are more patients per physician in South Dakota and Buffalo County than the national benchmark, with Buffalo County nearly double the South Dakota ratio. Brule and Lyman counties are below the state and national benchmarks.

The ratio of population to mental health providers is less positive in South Dakota and Brule, Buffalo and Lyman counties than the national benchmark.

Limited reportable data for preventable hospital stays was available for the all counties served. Diabetes screening in South Dakota is lower than the national benchmark. Brule and Buffalo County diabetes screening is below the national benchmark but about the same as the South Dakota percentage. Lyman County screening is below the state and national benchmarks.

### Social and Economic Factors

The Social and Economic Factors outcomes indicate that South Dakota and Brule, Buffalo and Lyman counties have lower high school graduation rates than the national benchmark. Like South Dakota, Brule, Buffalo and Lyman counties have lower percentages of post-secondary education than the national benchmark.

The unemployment rate was lower in South Dakota and Brule County than the national benchmark, but Lyman and Buffalo counties exceeded both the state and national benchmarks.

The percentage of child poverty is higher in South Dakota and Brule, Buffalo and Lyman counties than the national benchmark.

### Physical Environment

Because of the rural geography, the Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food in Lyman and Brule counties is below the national and state benchmark, while Buffalo County is below the benchmarks.

Access to recreational facilities ranks lower in South Dakota and Brule, Buffalo and Lyman counties than the national percentage.

### Demographics

Youth account for 28.5-40.5% of the population in Buffalo and Lyman counties, which is above the national and state benchmark, while Brule County is near the national benchmark.

South Dakota and all three counties in the service area population are more proficient in the English language than the national benchmark. Additionally, South Dakota and Brule, Buffalo and Lyman counties have a higher rate of literacy than the national threshold.

### Diversity Profile

The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian, Hispanic, Asian and Black.

### **Limitations**

The Sanford Chamberlain Community Needs Health Assessment Steering Group attempted to survey key community leaders and stakeholders for the purpose of determining the needs of the community. While 91 surveys were returned, there were still some key stakeholders who did not complete the survey.

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

### **Implementation Strategy**

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

- Urgent Care/Access to Providers
- Mental Health /Substance Abuse

Strategies to address the identified needs include:

- Priority 1: Urgent Care/Access to providers
  - Extended hours of clinic two days per week (until 6 p.m.)
  - Walk in clinic two days/week from 4:00-6:30 p.m.
  - Create advertising to educate customers on walk-in clinic (e.g. not to be used for annual physicals)
- Priority 2: Mental Health/Substance Abuse
  - Fully implement HC program – including psychiatrist and Behavioral Health support professionals
  - Utilize internal resources already available through on staff MSW

## Sanford Chamberlain Medical Center Community Health Needs Assessment 2012-2013

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

**Our Mission:** *Dedicated to the Work of Health and Healing*

We provide the best care possible for patients at every stage of life, and support healing and wholeness in body, mind and spirit.

**Our Vision:** *To improve the Human Condition through Exceptional Care, Innovation and Discovery*

We strive to provide exceptional care that exceeds our patients' expectations. We encourage diversity in thought and ideas that lead to better care, service and advanced expertise.

**Our Values:**

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

**Our Promise:** *Deliver a flawless experience that inspires*

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

**Guiding Principles:**

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

## **Description of the Hospital**

Sanford Chamberlain Medical Center, Sanford Chamberlain Clinic and the Sanford Chamberlain Care Center are proud to be members of the Sanford Health Network.

Sanford Chamberlain Medical Center is a 25-bed private room facility that provides a variety of inpatient and outpatient care services. We offer physical, occupational and speech therapies in our Physical Medicine Department. Our Radiology Department and Laboratory offer some of the finest equipment and trained staff in the area. Through our partnership with Sanford Health, other services are also available including: Dialysis, Home Health, and Durable Medical Equipment.

We offer services at two clinic sites in Chamberlain and Kimball.

Sanford Chamberlain Care Center provides loving care for older adults from the tri-county area. We offer:

- 24-hour nursing care
- Rehabilitation services
- Daily activities program and therapeutic recreation
- Pharmacy services
- Spiritual care
- Resident Council
- Registered dietitian
- Social Services
- Hospice program
- Smoke-free environment
- South Dakota State Health Department Licensure
- Medicaid-certified

We are dedicated to providing the best health care services to the people in the tri-county area of Brule, Buffalo, and Lyman counties through a holistic, integrated care continuum. Since our partnership with Sanford Health, we have expanded our outreach services, training programs and education resources to provide the people of the tri-county area with comprehensive, high quality, accessible health care services.

## **Description of the Community Served**

Brule, Buffalo and Lyman counties are situated in central South Dakota along the banks of the Missouri River. Sanford Chamberlain Medical Center serves all three counties. Major towns in each of the counties include Chamberlain, Kimball, Fort Thompson, Gann Valley, Kennebec and Lower Brule. All three counties are primarily rural in nature, with Buffalo County being the least densely populated. The agriculture industry is the primary industry within the tri-county area. Chamberlain is the largest community served, with a population of approximately 2,600. Primary employers within the Chamberlain community include the public school system, St. Joseph's Indian School, and Sanford Health.

## **Study Design and Methodology**

In May 2011 Sanford Health convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across



the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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

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

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

A subgroup of this collaborative met with researchers from the North Dakota State University Center for Social Research to develop a survey tool for our key stakeholder groups. The survey tool incorporated the University of North Dakota's Center for Rural Health community health needs assessment tool and the Fletcher Allen community health needs assessment tool. North Dakota State University and the University of North Dakota Center for Rural Health worked together to develop additional questions and to ensure that scientific methodology was incorporated in the design.

Finally, it was the desire of the collaborative that the data would be shared broadly with others and that if possible it would be hosted on a web site where there could be access for a broad base of community, state and regional individuals and groups.

This community health needs assessment was conducted during FY 2012 and FY 2013. The main model for our work is the Association for Community Health Improvement's (ACHI) Community Health Needs Assessment Toolkit.

The following qualitative data sets were studied:

- Survey of Key Stakeholders

The following quantitative data sets were studied:

- 2011 County Health Profiles for Brule, Buffalo and Lyman counties
- Aging Profiles for Brule, Buffalo and Lyman counties
- Diversity Profiles for Brule, Buffalo and Lyman counties

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

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

## Primary Research

### Key Findings – Primary Research

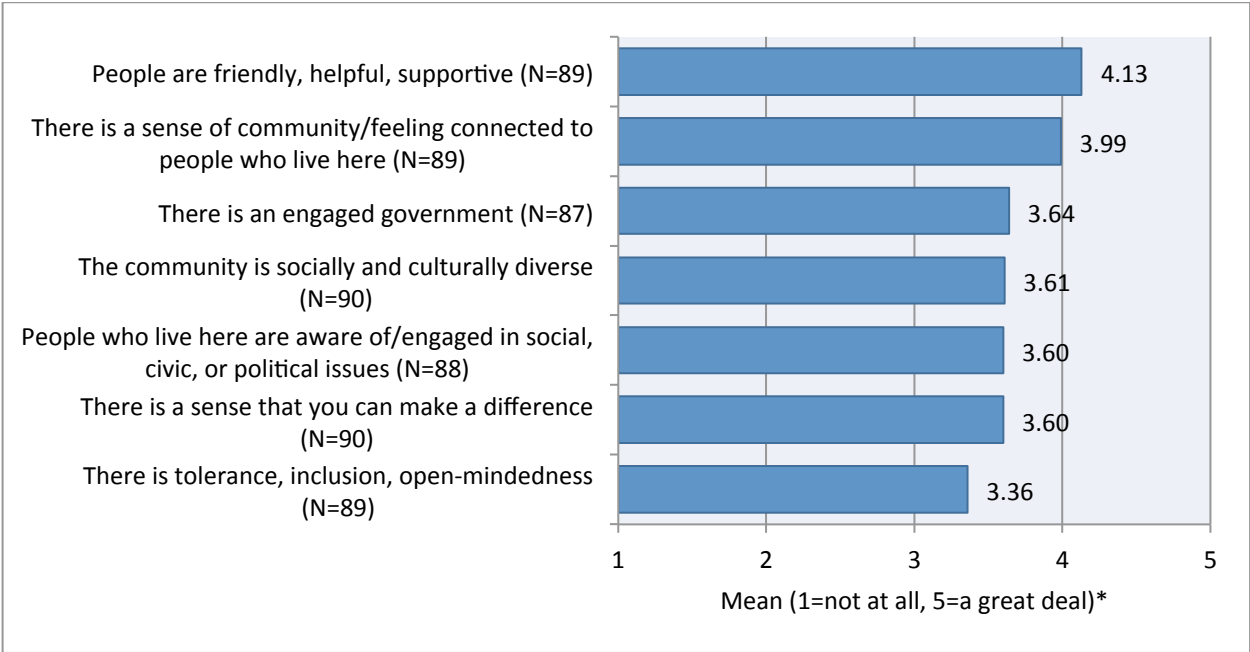
Sanford Chamberlain distributed the community health needs assessment survey tool that was developed by the Brule-Buffalo-Lyman Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of Chamberlain and area communities. The findings discussed in this section are a result of the analysis of the survey qualitative data.

#### Community Assets/Best Things about the Community

Respondents had very high levels of agreement that their communities were generally populated with friendly, helpful and supportive people who felt connected with the communities. The respondents also felt the communities were family-friendly and located in a peaceful and calm environment. However, respondents agreed the least that there is cultural richness, tolerance and inclusion, and that quality higher education opportunities are available.

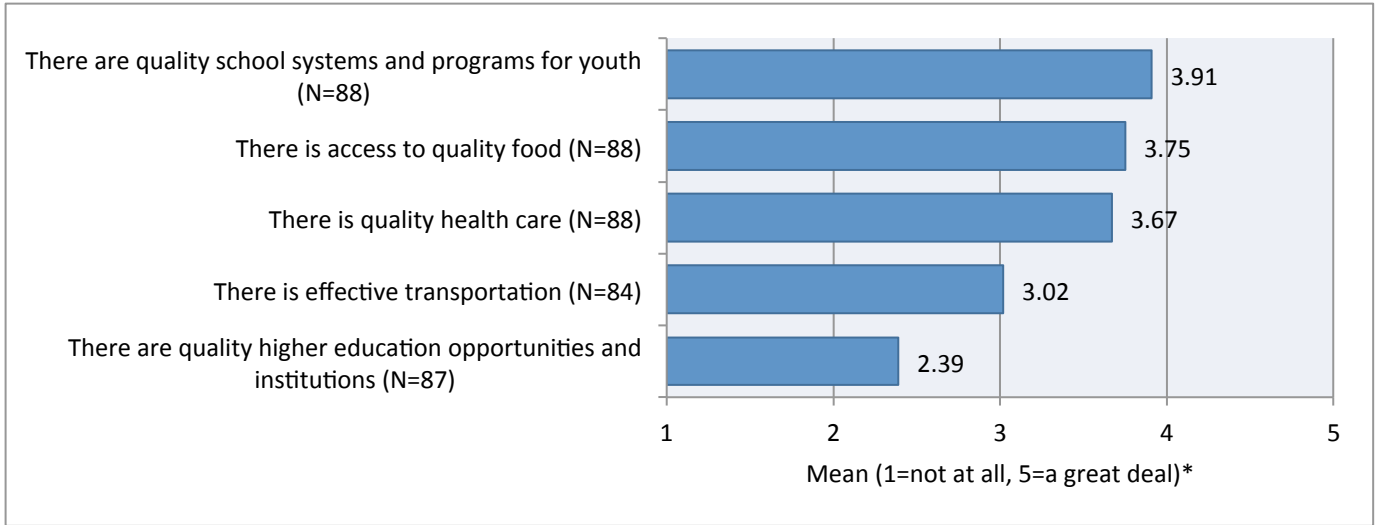
#### People

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



Services and Resources

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

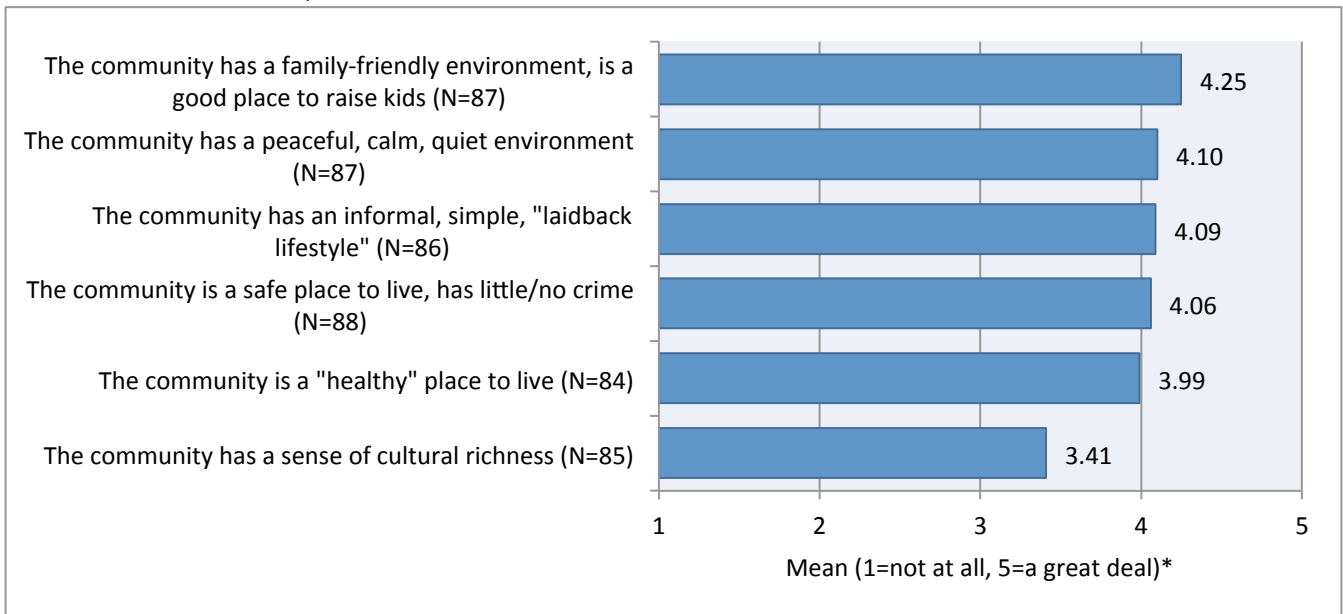


\*Means exclude "do not know" responses.

Quality of Life

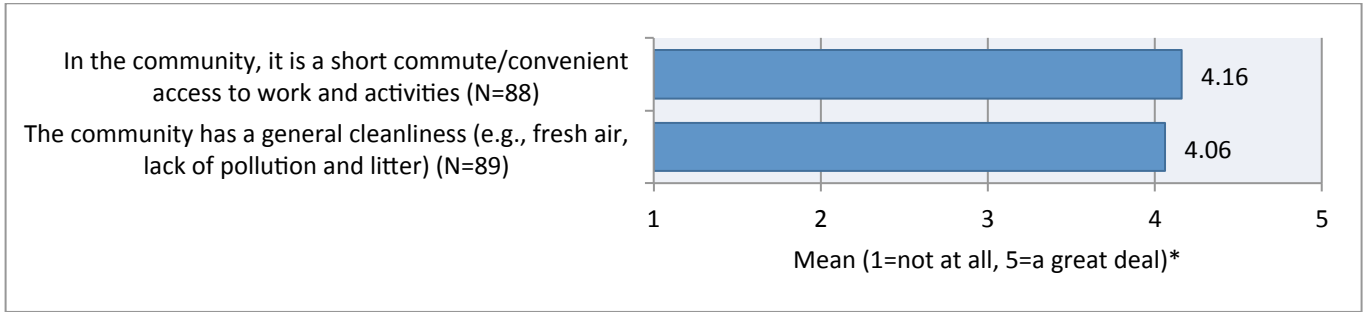
Figure 3. Level of agreement with statements about the community regarding QUALITY OF LIFE

\*Means exclude "do not know" responses.



Geographic Setting

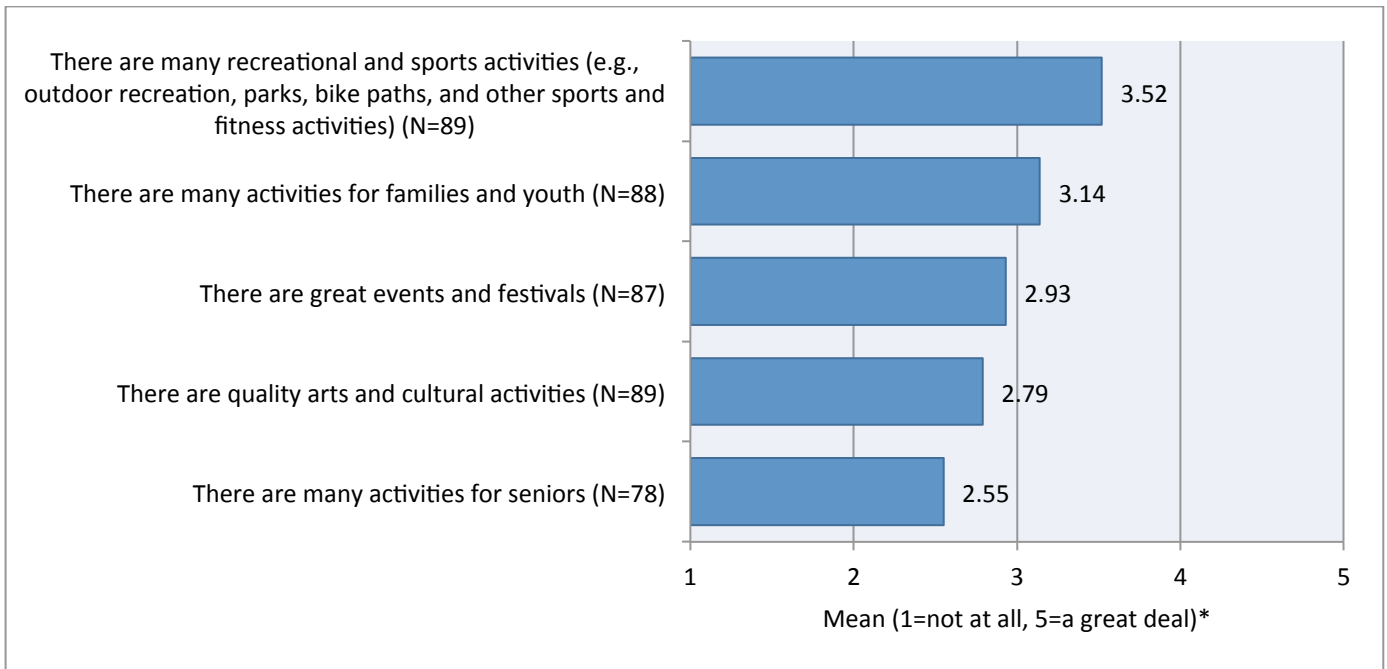
Figure 4. Level of agreement with statements about the community regarding the GEOGRAPHIC SETTING



\*Means exclude "do not know" responses.

Activities

Figure 5. Level of agreement with statements about the community regarding ACTIVITIES



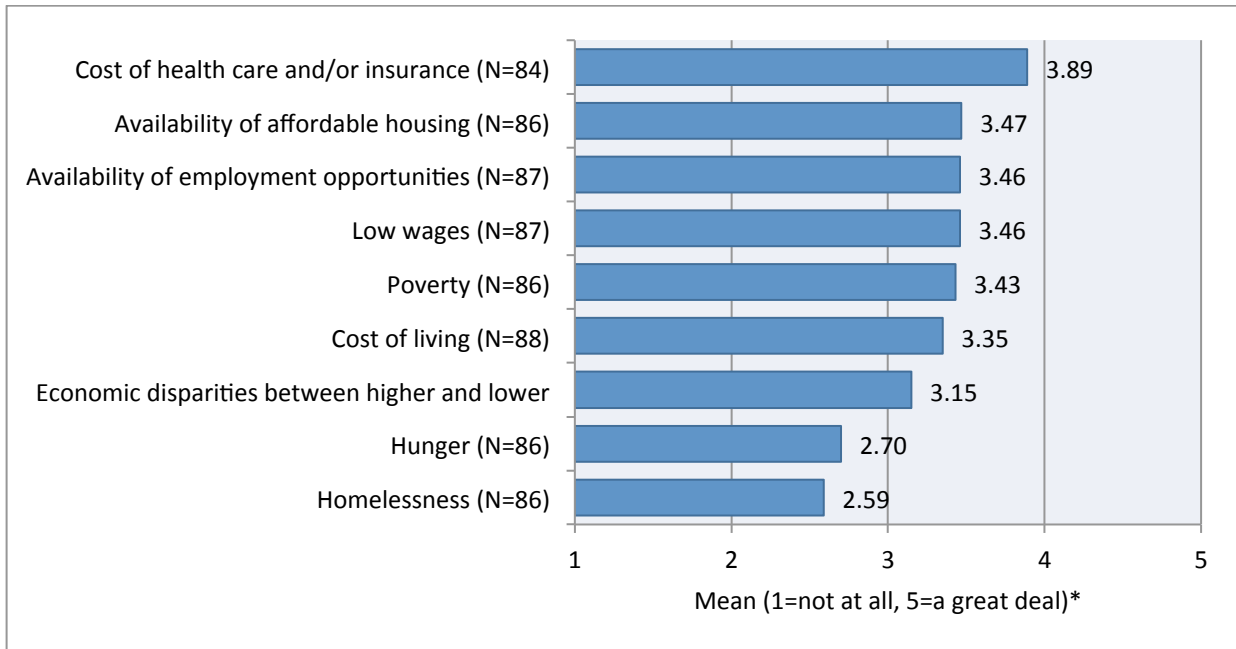
\*Means exclude "do not know" responses.

## General Concerns about the Community

### Economic Issues

Respondents were most concerned about substance abuse and bullying; and were also concerned with issues regarding cost of health care and/or insurance, cost and/or availability of elder care, and changes in family composition (e.g. divorces, single parenting).

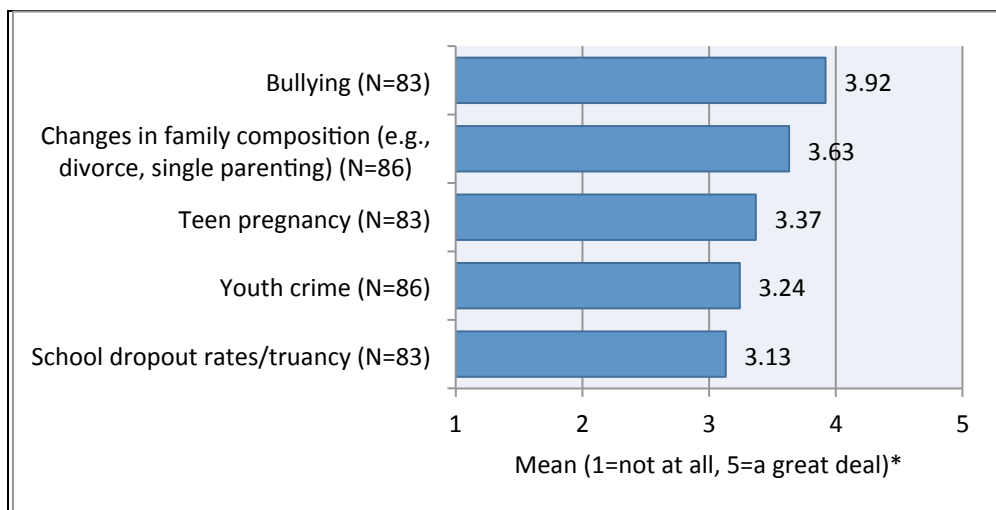
Figure 6. Level of concern with statements about the community regarding ECONOMIC ISSUES



\*Means exclude "do not know" responses.

### Youth Concerns

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



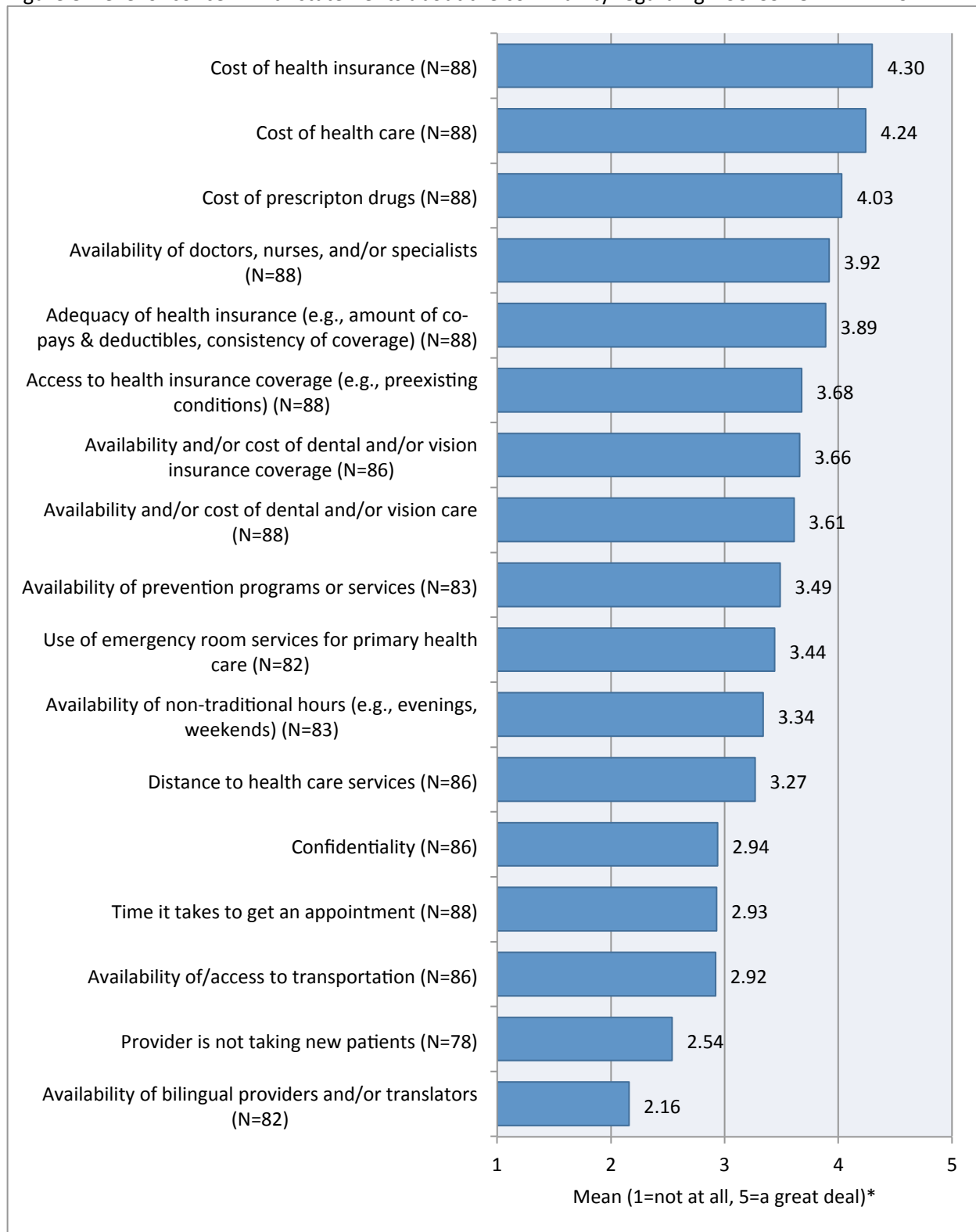
\*Means exclude "do not know" responses.

### *Community Health and Wellness Concerns*

Among health and wellness concerns, respondents were most concerned about the cost of health insurance, cancer, cost of health care, and drug use and abuse. Respondents were also concerned with cost of prescription drugs, chronic disease, alcohol use and abuse, obesity, availability of doctors, nurses and/or specialists, and adequacy of health insurance (e.g. amount of copays and deductibles, consistency of coverage). Availability of bilingual providers and/or translators and availability of good walking or biking options were not large concerns.

Access to Health Care

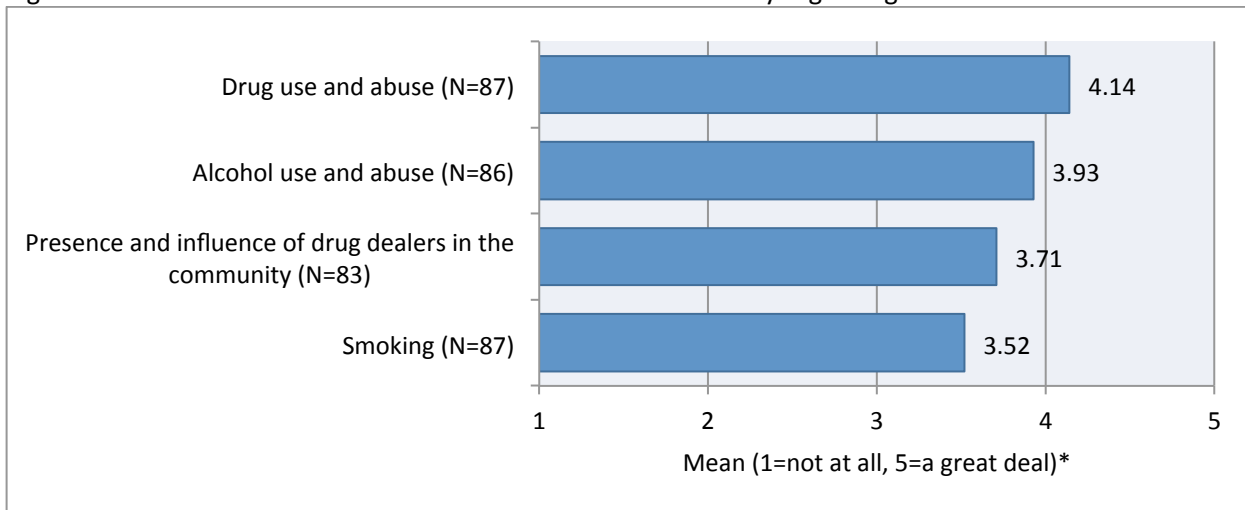
Figure 8. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE



\*Means exclude "do not know" responses.

## Substance Use and Abuse

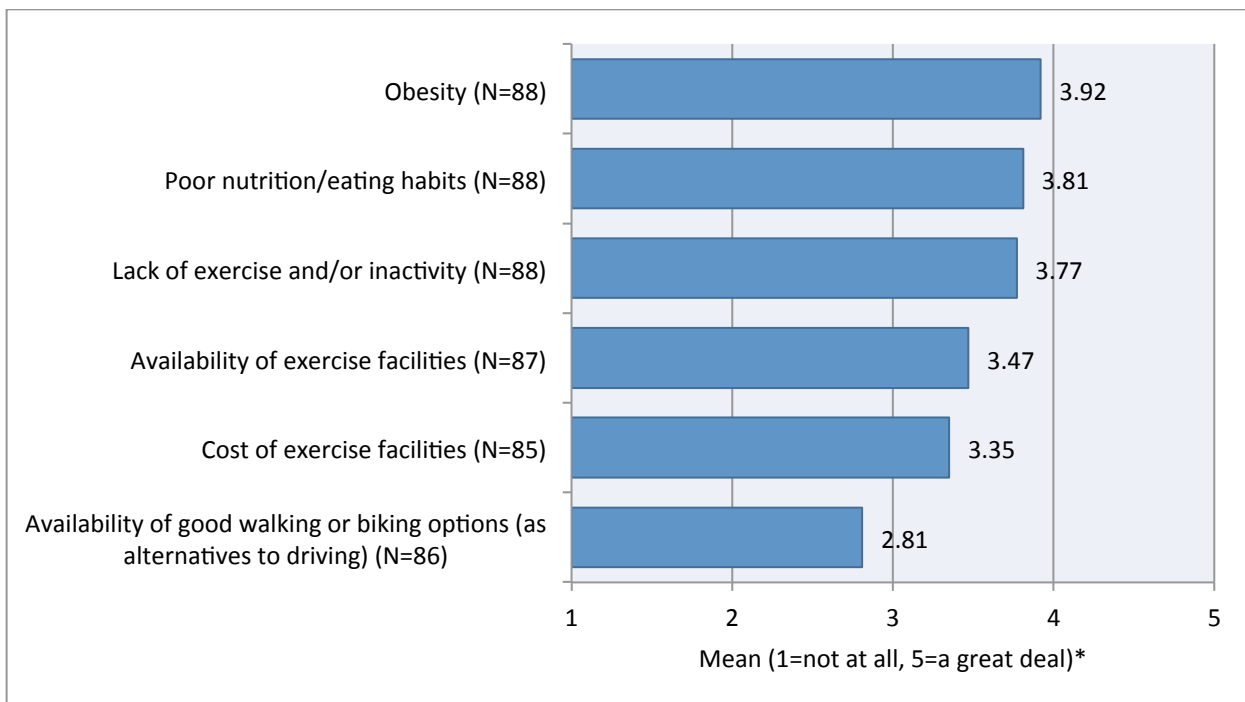
Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



\*Means exclude "do not know" responses.

## Physical Health

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

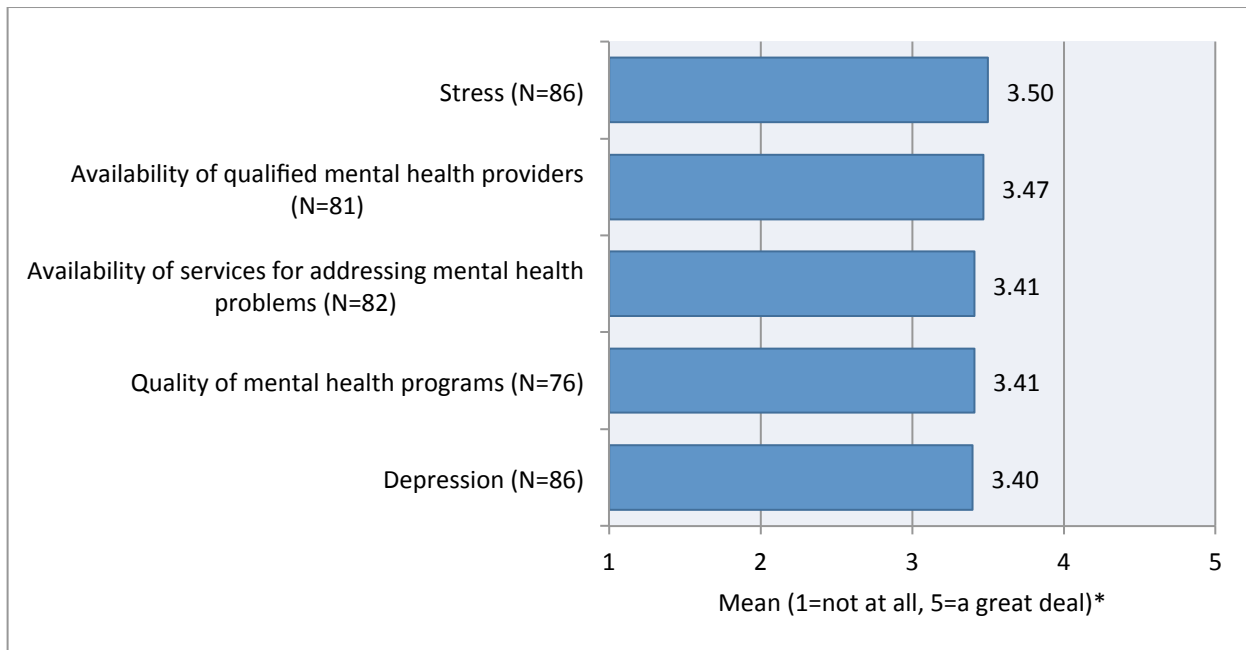


\*Means exclude "do not know" responses.



## Mental Health

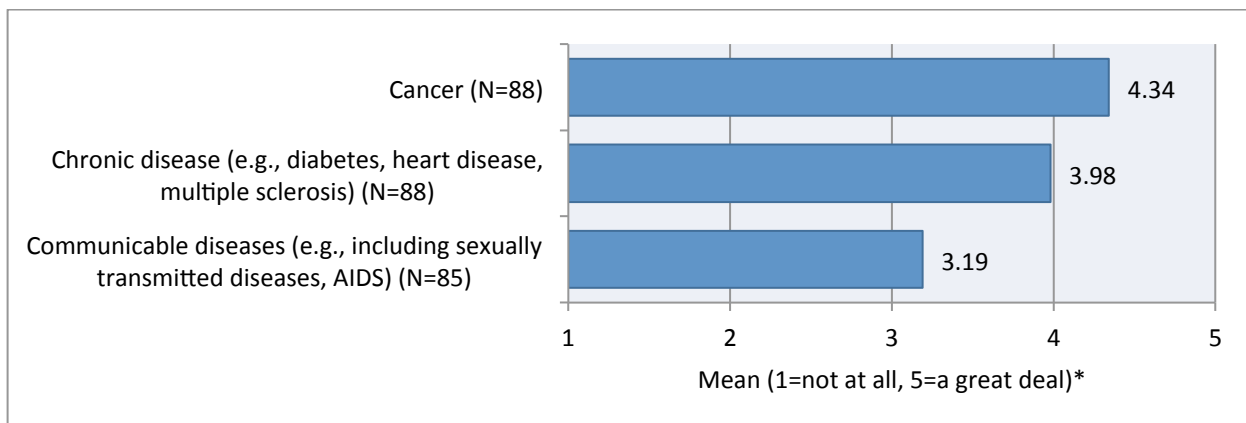
Figure 11. Level of concern with statements about the community regarding MENTAL HEALTH



\*Means exclude "do not know" responses.

## Illness

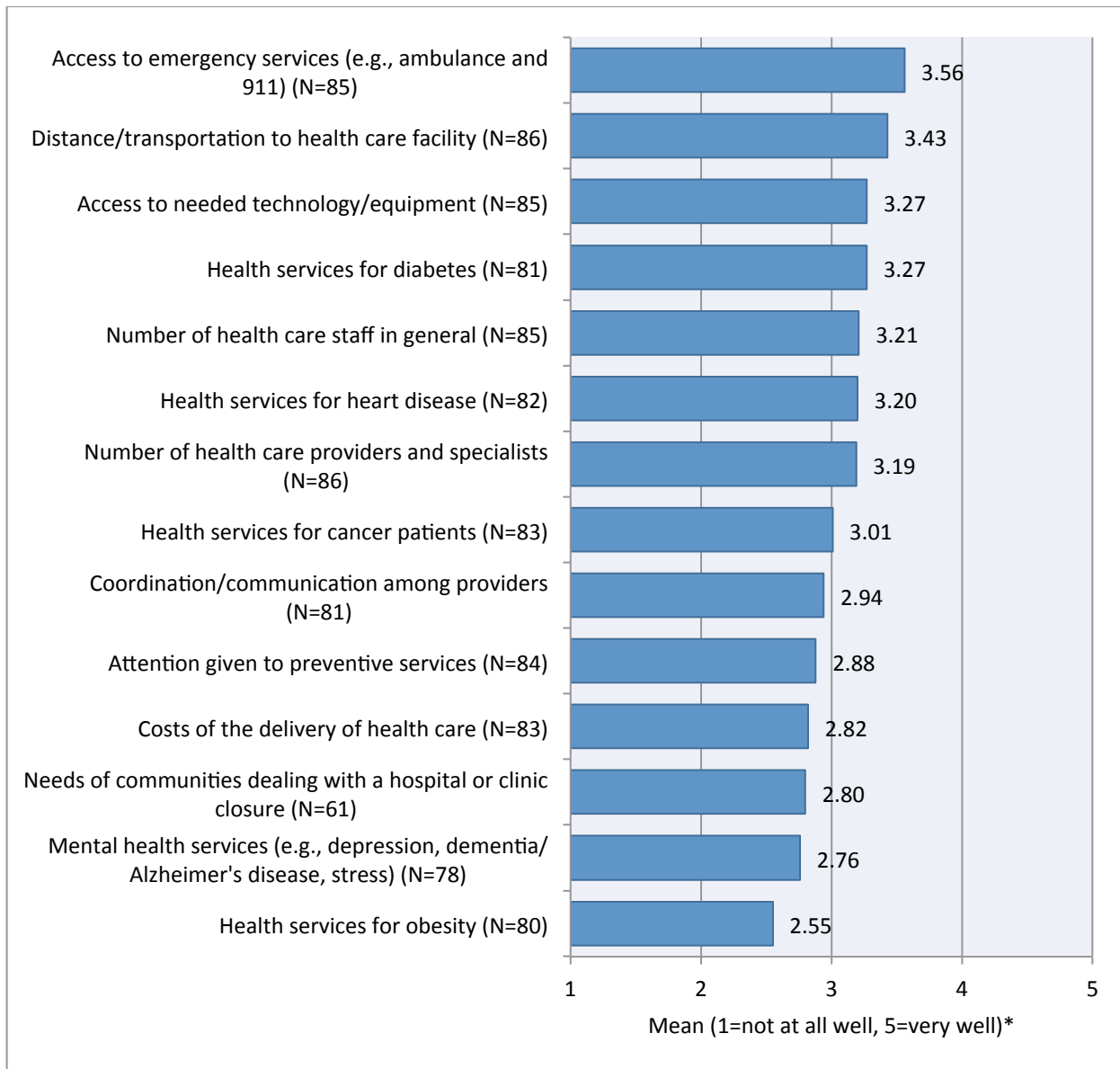
Figure 12. Level of concern with statements about the community regarding ILLNESS



\*Means exclude "do not know" responses.

*Delivery of Health Care in the Community*

Figure 13. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed



\*Means exclude "do not know" responses.

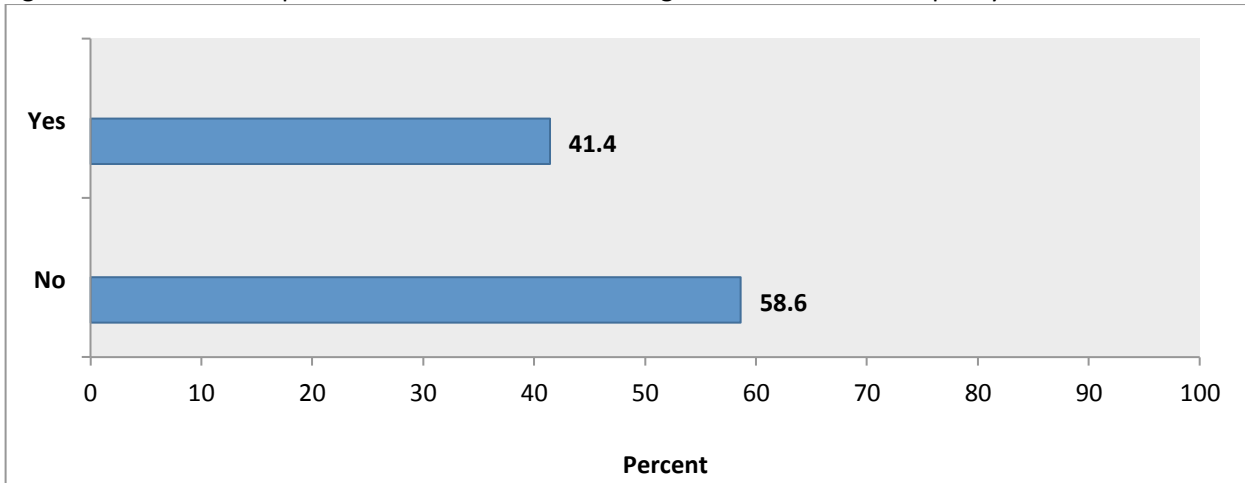
Respondents mentioned the strong partnerships and collaborations that are working to create healthier communities. Faith and religious organizations that are addressing social concerns and supporting the community were also mentioned. Respondents also said that affordable housing was another issue within the community.

Respondents had moderate agreement that there an engaged government and a socially and culturally diverse community. There was also moderate agreement that the people who live in the communities are aware of/engaged in social, civic, or political issues and that there is a sense people can make a difference.

### Personal Health Care Information

Respondents were asked whether they had a cancer screening or cancer care in the past year, and if they had not, reasons for not having done so. Over 50% said that they did have a cancer screening or cancer care in the past year.

Figure 18. Whether respondents had a cancer screening or cancer care in the past year

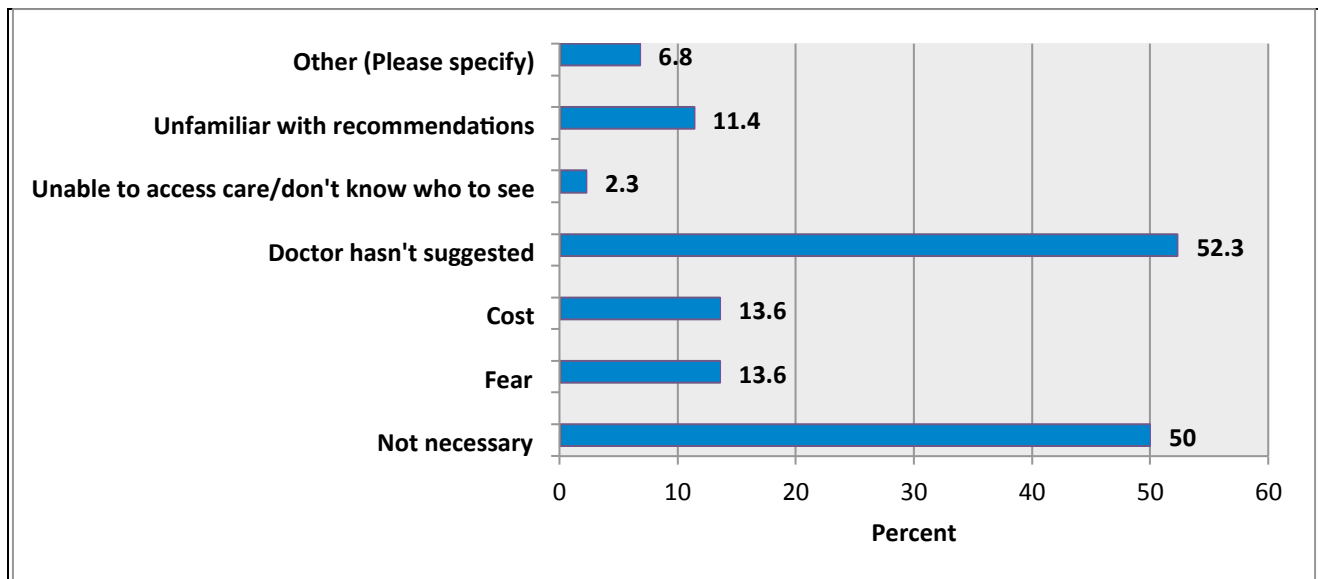


### Cancer Screening

Among respondents who had not had a cancer screening or cancer care in the past year, 52% said they had not done so because their doctor had not suggested it.

- Over 13% stated that cost was a factor.
- 50% of respondents stated that they thought the cancer screening was not necessary.
- Fear and cost was a reason for over 13% of respondents to not have the screening. (Figure 19)

Figure 19. Reasons among respondents who have not had a cancer screening or cancer care in the past year

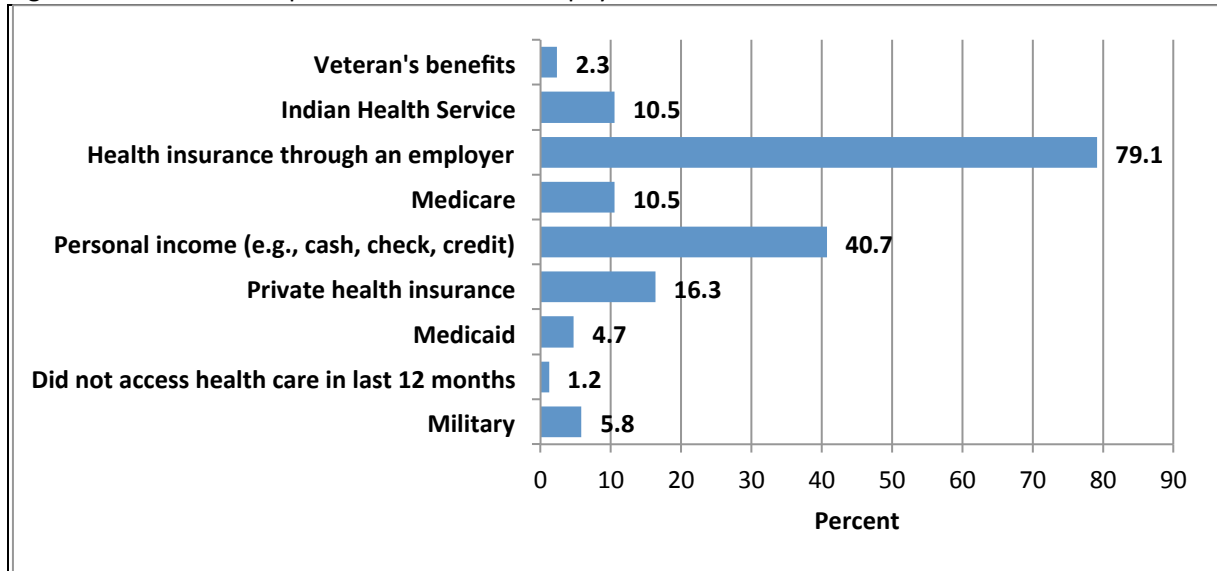


Percentages do not equal 100.0 due to multiple responses.

### Health Care Coverage

Respondents were asked how they had paid for health care costs, for themselves or family members, over the last 12 months. A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income and private health insurance were also used. Medicare was used by 10% of respondents and Medicaid by over 4%. Indian Health Services was utilized by over 10% of respondents. Military and veteran’s benefits are also a part of the mix.

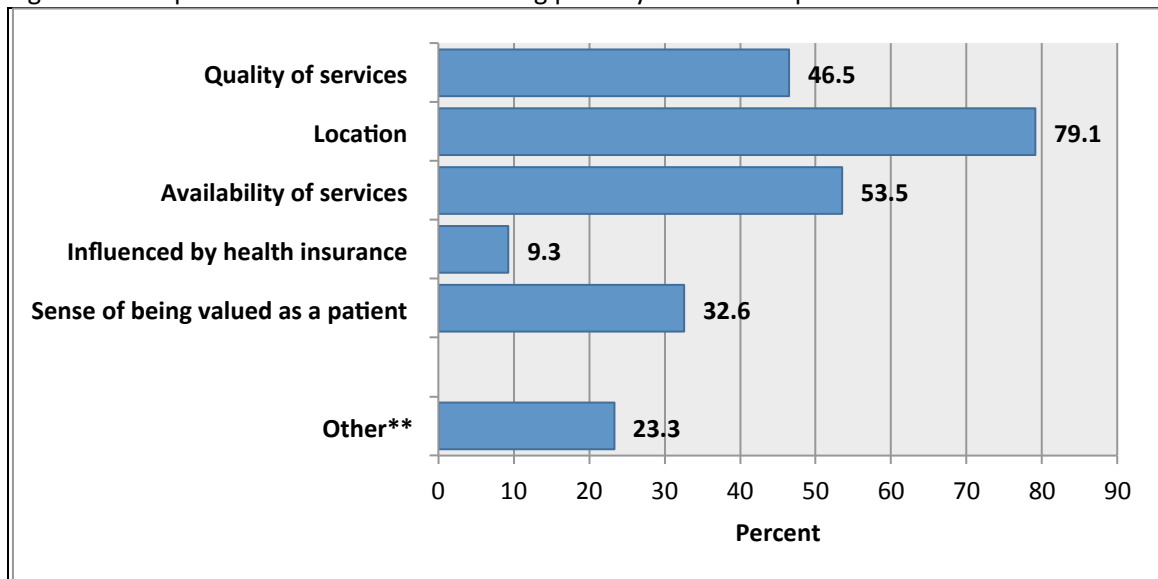
Figure 20. Methods respondents have used to pay for health care costs over the last 12 months



### Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and the availability of services. (Figure 21)

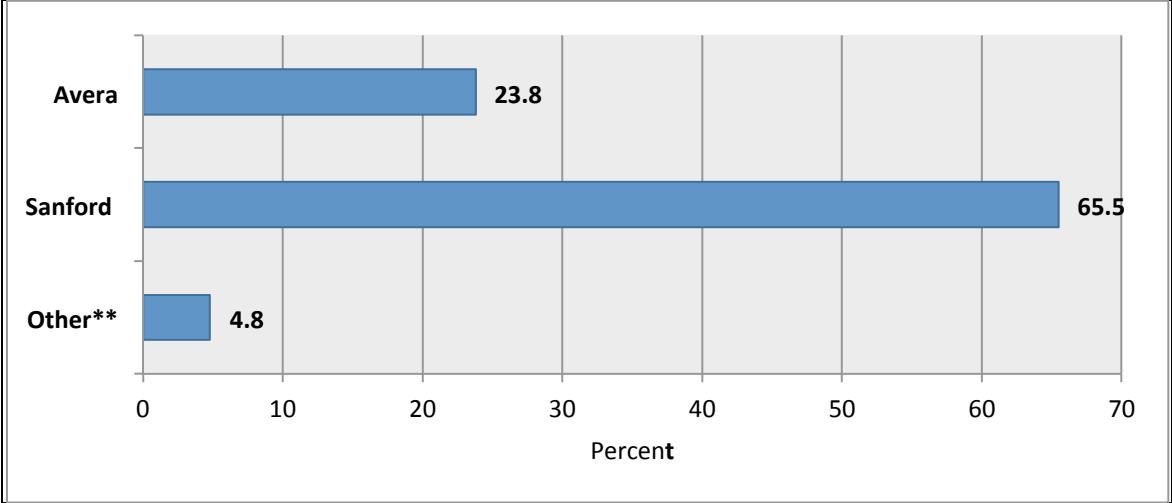
Figure 21. Respondents’ reasons for choosing primary health care provider



Respondents' Primary Health Care Provider

Respondents were asked which provider they used for their primary health care. Sixty five percent (65%) of respondents said they use Sanford Health as their primary health care provider. (Figure 22)

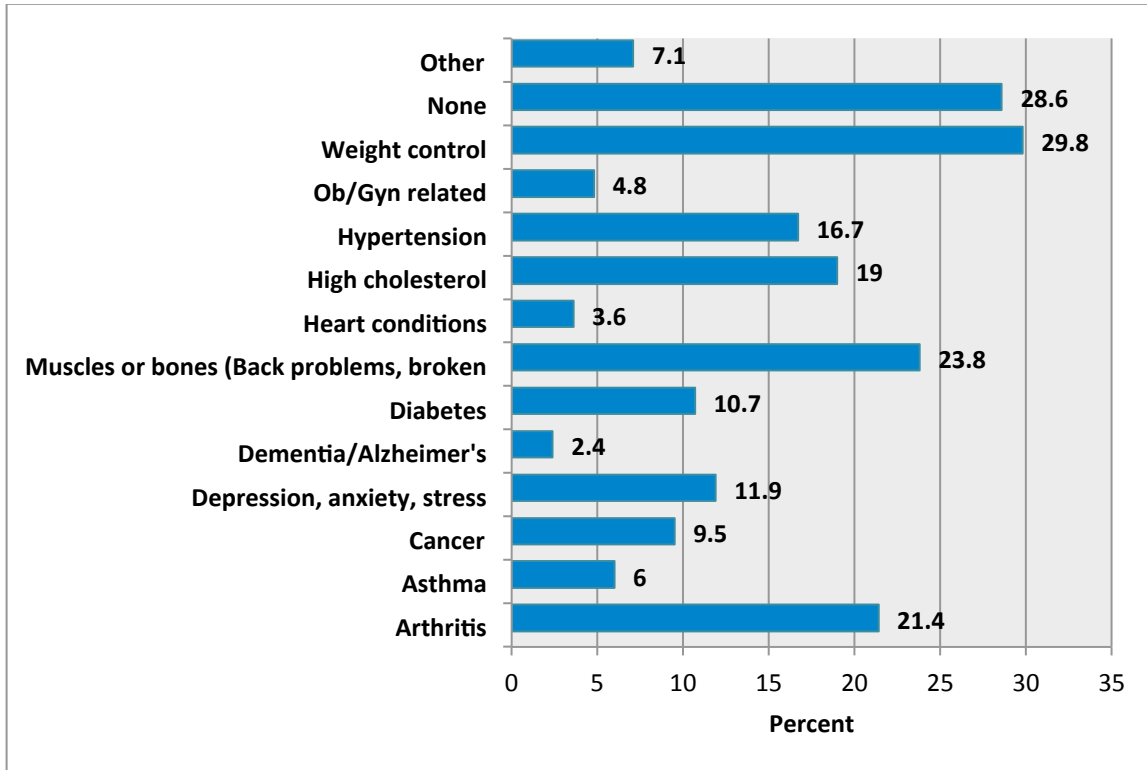
Figure 22. Respondents' primary health care provider



### Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. Weight control received the most responses with 29.8% of participants selecting this condition. The chronic diseases found among respondents include arthritis, asthma, cancer, heart disease, diabetes, Alzheimer's, high cholesterol, hypertension and depression. (Figure 26)

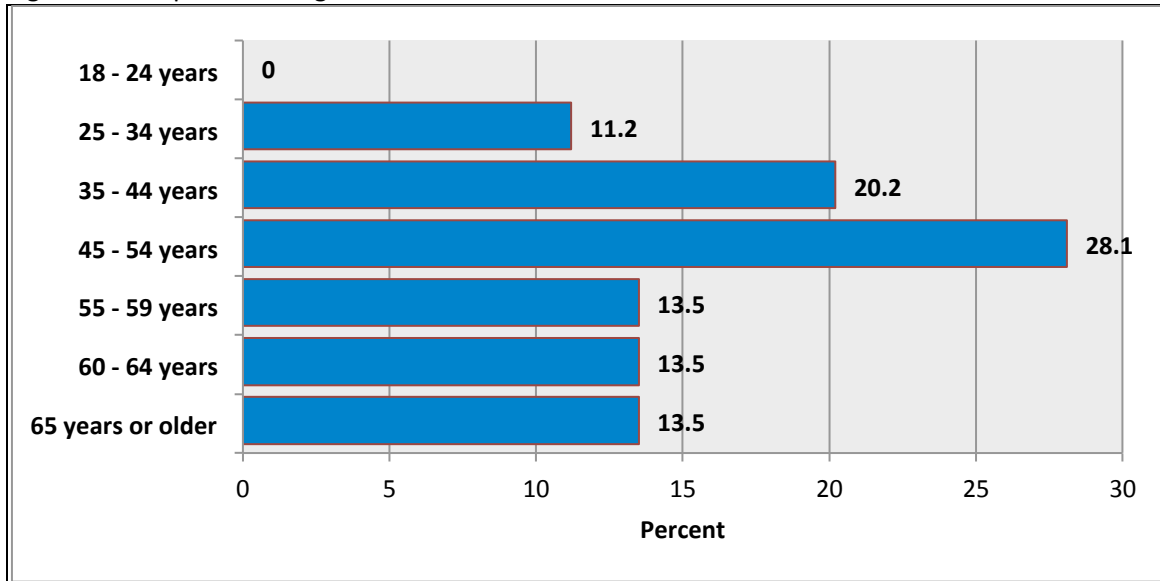
Figure 26. Respondent's health/chronic diseases



### Demographic Information

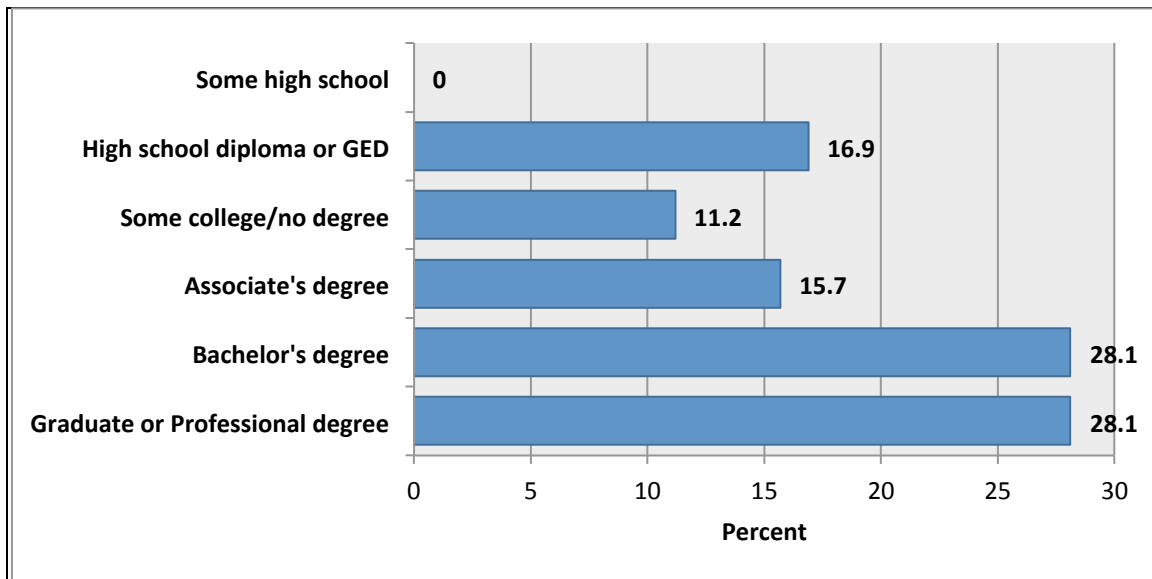
The majority (48.3%) of respondents are 35 to 54 years old.

Figure 23. Respondents' age distribution



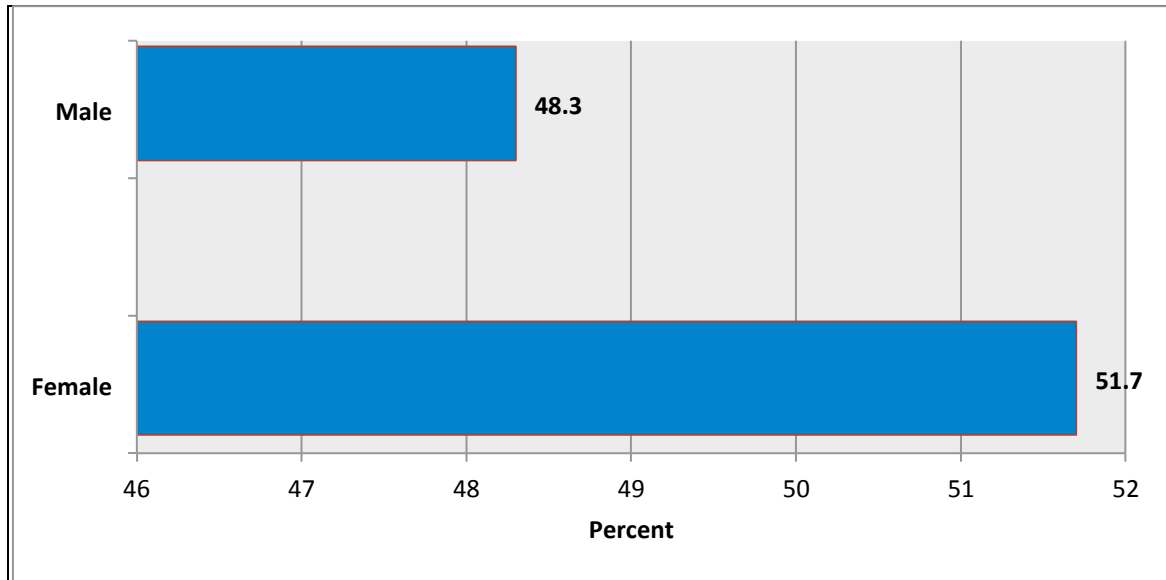
Over 25% respondents have a Bachelor's degree or higher, including 28% who have a graduate or professional degree.

Figure 24. Respondents' education



Over 51% of respondents are female.

Figure 25. Respondents' gender distribution



## Secondary Research

### Health Outcomes – Mortality and Morbidity

The state of South Dakota has more premature deaths than the national benchmark, and Brule, Buffalo and Lyman counties have higher rates than the national benchmark and South Dakota as a whole. The Morbidity health outcomes indicate that Brule and Buffalo county citizens report more days of poor health (self-reported) than the national or South Dakota benchmark.

South Dakota and Brule and Buffalo counties report more mentally unhealthy days than the state or national benchmarks, while Lyman County is below both benchmarks.

Brule County has a lower percentage of low birth weight than either the state or national benchmarks, while Lyman and Buffalo counties are above both benchmarks.

### Health Outcomes – Brule County

HEALTH OUTCOMES		Brule	*National Benchmark	South Dakota
<i>Mortality</i>				
<b>Premature death</b>	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	7,911	5,564	6,815
<i>Morbidity</i>				
<b>Poor or fair health</b>	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	13%	10%	12%
<b>Poor physical health days</b>	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.1	2.6	2.8
<b>Poor mental health days</b>	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	2.3	2.6
<b>Low birthweight</b>	Percent of live births with low birthweight (<2,500 grams), 2001-2007	-	6.0%	6.8%



## Health Outcomes – Buffalo County

HEALTH OUTCOMES		Buffalo	*National Benchmark	South Dakota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	18,997	5,564	6,815
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	22%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.8	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.3	2.3	2.6
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	-	6.0%	6.8%

## Health Outcomes – Lyman County

HEALTH OUTCOMES		Lyman	*National Benchmark	South Dakota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	11,358	5,564	6,815
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	13%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.8	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	3.1	2.3	2.6
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	-	6.0%	6.8%

## Health Factors

The Health Behavior outcomes indicate that South Dakota and Brule, Buffalo and Lyman counties have higher percentages of adult smokers (equal to or greater than 100 cigarettes) than the national benchmark. Of the three counties, Buffalo County has nearly half of its population (46%) as adult smokers. All three counties are above the state and national benchmarks for adult obesity (greater than or equal to 30 BMI) and South Dakota and Brule, Buffalo and Lyman counties have a greater percentage of physical inactivity than the national benchmark.

## Health Behaviors Brule County

HEALTH FACTORS		Brule	*National Benchmark	South Dakota
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m <sup>2</sup> , 2008	29%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	29%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	13%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	153.7	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	23.2	22.0	38.7

South Dakota (19%), Brule (13%), Buffalo (35%) and Lyman (21%) counties have much higher percentages of excessive drinking than the national benchmark (8%).

### Health Behaviors Buffalo County

HEALTH FACTORS		Buffalo	*National Benchmark	South Dakota
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	49%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m <sup>2</sup> , 2008	39%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	29%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	36%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	1353.9	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	137.8	22.0	38.7

The teen birth rate in South Dakota, Buffalo and Lyman counties is higher than the national benchmark. Buffalo and Lyman counties are significantly higher at 135 and 77. Brule County is below the national and state benchmarks.

### Health Behaviors Lyman County

HEALTH FACTORS		Lyman	*National Benchmark	South Dakota
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	28%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m <sup>2</sup> , 2008	33%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	32%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	25%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	997.1	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	83.8	22.0	38.7

### Clinical Care

The Clinical Care outcomes indicate that South Dakota and Brule, Buffalo and Lyman counties have higher percentages of uninsured adults than the national benchmark.

Clinical Care		Brule	*National Benchmark	South Dakota
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007			
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	14%	7%	9%
Primary care physicians	Ratio of total population to primary care physicians, 2008	372:1	631:1	769:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,204:1	2,242:1	3,544:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	19.2	69.0	50.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	79.5	52.0	68.6
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	94%	89%	83%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	73%	74%	68%

*Clinical Care*

		Buffalo	*National Benchmark	South Dakota
<b>Uninsured adults</b>	Percent of adult population ages 18-64 without health insurance, 20			
<b>Uninsured youth</b>	Percent of youth ages 0-18 without health insurance, 2007	5%	7%	9%
<b>Primary care physicians</b>	Ratio of total population to primary care physicians, 2008	2,136:1	631:1	769:1
<b>Mental health providers</b>	Ratio of total population to mental health providers, 2008	2,136:0	2,242:1	3,544:1
<b>Dentist rate</b>	Number of professionally active dentists per 100,000 population, 2007	-	69.0	50.0
<b>Preventable hospital stays</b>	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	203.5	52.0	68.6
<b>Diabetic screening</b>	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	-	89%	83%
<b>Mammography screening</b>	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	-	74%	68%

		Lyman	*National Benchmark	South Dakota
<i>Clinical Care</i>				
<b>Uninsured adults</b>	Percent of adult population ages 18-64 without health insurance, 2007	25%	13%	16%
<b>Uninsured youth</b>	Percent of youth ages 0-18 without health insurance, 2007	12%	7%	9%
<b>Primary care physicians</b>	Ratio of total population to primary care physicians, 2008	-	631:1	769:1
<b>Mental health providers</b>	Ratio of total population to mental health providers, 2008	3,809:0	2,242:1	3,544:1
<b>Dentist rate</b>	Number of professionally active dentists per 100,000 population, 2007	0.0	69.0	50.0
<b>Preventable hospital stays</b>	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	83.9	52.0	68.6
<b>Diabetic screening</b>	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	70%	89%	83%
<b>Mammography screening</b>	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	69%	74%	68%

There are more patients per physician in South Dakota and Buffalo County than the national benchmark, with Buffalo County nearly double the South Dakota ratio. Brule and Lyman counties are below the state and national benchmarks.

The ratio of population to mental health providers is less positive in South Dakota and Brule, Buffalo and Lyman counties than the national benchmark.

Limited reportable data for preventable hospital stays was available for the all counties served. Diabetes screening in South Dakota is lower than the national benchmark. Brule and Buffalo County diabetes screening is below the national benchmark but about the same as the South Dakota percentage. Lyman County screening is below the state and national benchmarks.

Social and Economic Factors

The Social and Economic Factors outcomes indicate that South Dakota and Brule, Buffalo and Lyman counties have lower high school graduation rates than the national benchmark. Like South Dakota, Brule, Buffalo and Lyman counties have lower percentages of post-secondary education than the national benchmark.

South Dakota unemployment rate was lower in South Dakota and Brule County than the national benchmark, but Lyman and Buffalo counties exceeded both the state and national benchmarks.

The percentage of child poverty is higher in South Dakota and Brule, Buffalo and Lyman counties than the national benchmark.

		Brule	*National Benchmark	South Dakota
<i>Social and Economic Factors</i>				
<b>High school graduation</b>	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	80%	92%	83%
<b>Some college</b>	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	57%	68%	64%
<b>Unemployment</b>	Percent of population ages 16 and older that is unemployed but seeking work, 2009	3.4%	5.3%	4.8%
<b>Child poverty</b>	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	20%	11%	18%
<b>Inadequate social support</b>	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	21%	14%	17%
<b>Children in single-parent households</b>	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	21%	20%	29%
<b>Homicide rate</b>	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5

<i>Physical Environment</i>				
<b>Air pollution-particulate matter</b>	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
<b>Air pollution-ozone</b>	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
<b>Access to healthy foods</b>	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	67%	92%	42%
<b>Access to recreational facilities</b>	Number of recreational facilities per 100,000 population, 2008	38.0	17.0	13.0

		Buffalo	*National Benchmark	South Dakota
<i>Social and Economic Factors</i>				
<b>High school graduation</b>	Percent of ninth-grade cohort in public schools that graduates from h school in four years, 2006-2007			
<b>Some college</b>	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	25%	68%	64%
<b>Unemployment</b>	Percent of population ages 16 and older that is unemployed but seeking work, 2009	14.8%	5.3%	4.8%
<b>Child poverty</b>	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	48%	11%	18%
<b>Inadequate social support</b>	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	-	14%	17%
<b>Children in single-parent households</b>	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	72%	20%	29%
<b>Homicide rate</b>	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5

<i>Physical Environment</i>				
<b>Air pollution-particulate matter</b>	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
<b>Air pollution-ozone</b>	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
<b>Access to healthy foods</b>	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	0%	92%	42%
<b>Access to recreational facilities</b>	Number of recreational facilities per 100,000 population, 2008	0.0	17.0	13.0

<b>HEALTH FACTORS (continued)</b>		Lyman	*National Benchmark	South Dakota
<i>Social and Economic Factors</i>				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	95%	92%	83%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	40%	68%	64%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	5.9%	5.3%	4.8%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	34%	11%	18%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	23%	14%	17%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	59%	20%	29%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5
<i>Physical Environment</i>				
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	67%	92%	42%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	0.0	17.0	13.0

### Physical Environment

Because of the rural geography, the Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food in Lyman and Brule counties is below the national and state benchmark, while Buffalo County is below the benchmarks.

Access to recreational facilities ranks lower in South Dakota and Brule, Buffalo and Lyman counties than the national percentage.

### Demographics

Youth account for 28.5-40.5% of the population in Buffalo and Lyman counties, which is above the national and state benchmark, while Brule County is near the national benchmark.

South Dakota and all three counties in the service area population are more proficient in the English language than the national benchmark. Additionally, South Dakota and Brule, Buffalo and Lyman counties have higher rates of literacy than the national threshold.

<i>Demographics</i>		Brule	United States	South Dakota
Youth	Percent of total population ages 0-17, 2009	28%	24%	25%
Elderly	Percent of total population ages 65 and older, 2009	17%	13%	14%
Rural	Percent of total population living in a rural area, 2000	100%	21%	48%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	0%	9%	2%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	7%	15%	7%

<i>Demographics</i>		Buffalo	United States	South Dakota
<b>Youth</b>	Percent of total population ages 0-17, 2009	39%	24%	25%
<b>Elderly</b>	Percent of total population ages 65 and older, 2009	7%	13%	14%
<b>Rural</b>	Percent of total population living in a rural area, 2000	100%	21%	48%
<b>Not English proficient</b>	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	2%
<b>Illiteracy</b>	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	14%	15%	7%

<i>Demographics</i>		Lyman	United States	South Dakota
<b>Youth</b>	Percent of total population ages 0-17, 2009	30%	24%	25%
<b>Elderly</b>	Percent of total population ages 65 and older, 2009	14%	13%	14%
<b>Rural</b>	Percent of total population living in a rural area, 2000	100%	21%	48%
<b>Not English proficient</b>	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	2%
<b>Illiteracy</b>	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	9%	15%	7%

## Diversity Profile

The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian, Hispanic, Asian and Black.

## Diversity Profile

South Dakota

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

CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
<i>Population</i> <sup>1</sup>						
<b>Total population</b>	814,180	699,392	10,207	71,817	7,610	22,119
<b>Percent ages 0 to 17</b>	25%	22%	36%	40%	27%	42%
<b>Percent ages 18 to 44</b>	34%	34%	48%	38%	50%	43%
<b>Percent ages 45 to 64</b>	26%	28%	14%	17%	18%	12%
<b>Percent ages 65 and older</b>	14%	16%	2%	5%	4%	3%
<b>Median age (in years)</b>	36.9	39.9	25.0	23.6	28.8	22.3

# Diversity Profile

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

**Brule County**

South Dakota

CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
<i>Population<sup>1</sup></i>						
Total population	5,255	4,646	12	445	9	75
Percent ages 0 to 17	26%	23%	50%	45%	33%	49%
Percent ages 18 to 44	29%	28%	25%	36%	33%	40%
Percent ages 45 to 64	28%	30%	25%	12%	33%	8%
Percent ages 65 and older	17%	19%	0%	7%	0%	3%
Median age (in years)	41.3	44.3	17.5	20.8	22.5	18.2

## Health Needs Identified

### *Community Assets/Prioritization Process*

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

Table 1 in the Appendix displays the concerns and assessed needs that were determined by the assessment:

- Urgent care/after-hours clinic/availability of providers
- Housing
- Diabetes services locally
- Outreach doctors (specialties) to community
- Keep young people in the community
- Cancer – travel out of town to get treatment
- Mental Health shortage/suicide incidence
- Substance abuse
- Dental care shortage
- Obesity
- Higher incidence of premature death
- Community wellness program
- Transportation issues
- Bullying

After asset mapping to identify the community resources that are available to address the needs, the priorities that remain include:

- Behavioral Health
- Access to Care

The Sanford Chamberlain Community Needs Assessment Steering Committee then utilized the multi-voting technique to establish priority needs.



# IMPLEMENTATION STRATEGY

## 2013 Community Health Needs Assessment Sanford Chamberlain Implementation Strategy

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

- Urgent Care/Access to Providers
- Mental Health /Substance Abuse

Strategies to address the identified needs include:

- **Priority 1: Urgent Care/Access to providers**
  - Extended hours of clinic two days per week (until 6 p.m.)
  - Walk in clinic two days/week from 4:00-6:30 p.m.
  - Create advertising to educate customers on walk-in clinic (e.g. not to be used for annual physicals)
- **Priority 2: Mental Health/Substance Abuse**
  - Fully implement HC program – including psychiatrist and Behavioral Health support professionals
  - Utilize internal resources already available through on staff MSW

## 2013 Community Health Needs Assessment Enterprise Implementation Strategy

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

- Mental Health Services
- Obesity

### Implementation Strategy: Mental Health Services - Sanford One Mind

- Completion (to the extent resources allow) of full integration of Behavioral Health services in all primary care clinics in Fargo and Sioux Falls
- Completion (to the extent resources allow) of full integration of Behavioral Health services or access to Behavioral Health outreach in all regional clinic sites in the North, South and Bemidji regions
- Complete presentation of outcomes of first three years of integrated Behavioral Health services
- Implementation of integrated Behavioral Health into clinics in new regions
- Design Team for Inpatient Psychiatric Unit, Partial Hospitalization and Clinic Space for Fargo presents recommendations for design of new spaces
- Design Team for Sioux Falls Inpatient Psychiatric Units and Partial Hospitalization

### Implementation Strategy: Obesity

- Medical Management for Obesity
  - Develop CME curriculum for providers and interdisciplinary teams across the enterprise inclusive of medical, nutrition, nursing, and Behavioral Health professionals
- Develop community education programming
  - Include the following program options in the curriculum to create awareness of existing resources:
    - Family Wellness Center
    - Honor Your Health Program
    - WebMD Fit Program
    - Bariatric Services
    - Eating Disorder Institute
    - Mental Health/Behavioral Health
    - Profile
- Actively participate in community initiatives to address wellness, fitness and healthy living

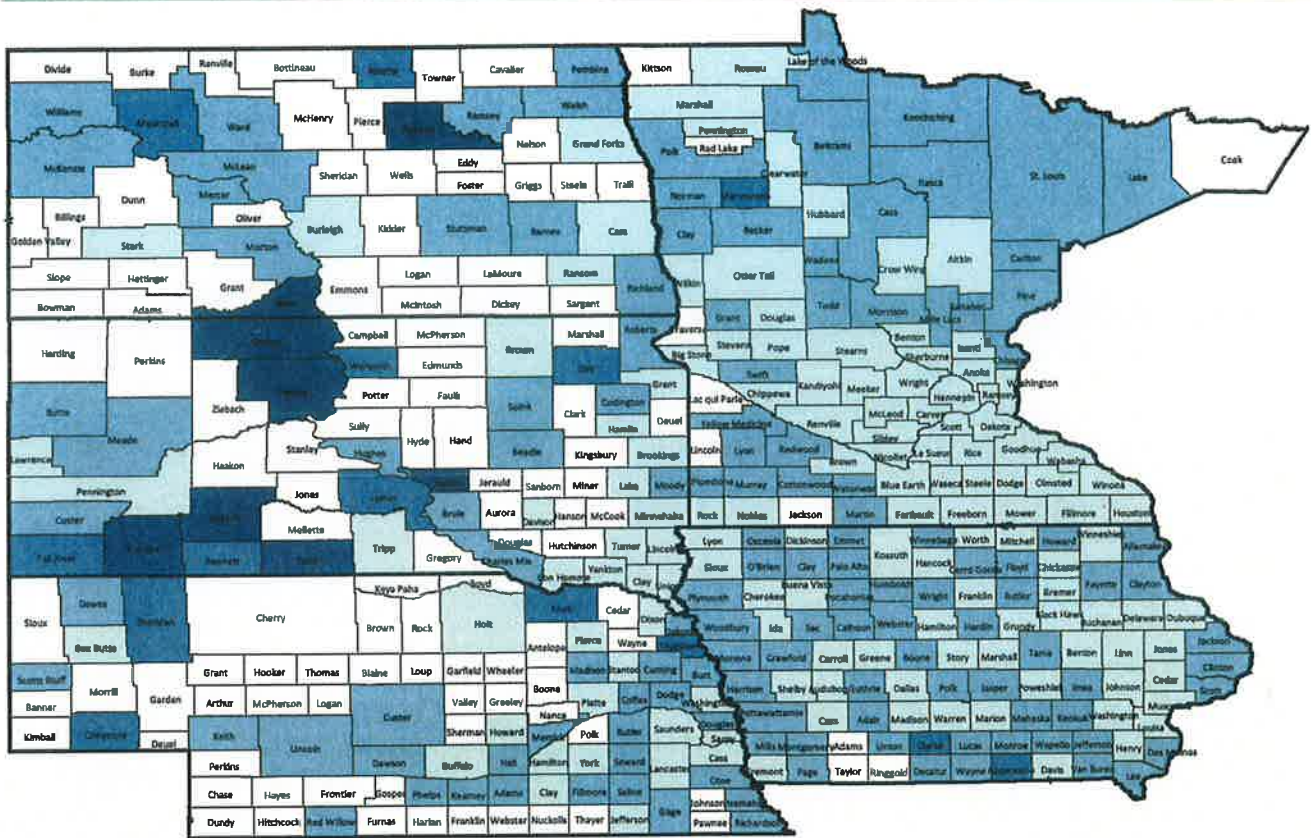
# APPENDIX

## Definitions of Health Variables

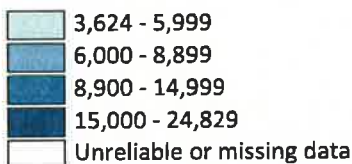
Definitions of Health Variables from the <i>County Health Rankings 2011 Report</i> Variable	Definition
<b>Poor or Fair Health</b>	Self-reported health status based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"
<b>Poor Physical Health Days (in past 30 days)</b>	Estimate based on responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"
<b>Poor Mental Health Days (in past 30 days)</b>	Estimate based on responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
<b>Adult Smoking</b>	Percent of adults that report smoking equal to, or greater than, 100 cigarettes and are currently a smoker
<b>Adult Obesity</b>	Percent of adults that report a BMI greater than, or equal to, 30
<b>Excessive Drinking</b>	Percent of as individuals that report binge drinking in the past 30 days (more than 4 drinks on one occasion for women, more than 5 for men) or heavy drinking (defined as more than 1 (women) or 2 (men) drinks per day on average
<b>Sexually Transmitted Infections</b>	Chlamydia rate per 100,000 population
<b>Teen Birth Rate</b>	Birth rate per 1,000 female population, ages 15-19
<b>Uninsured Adults</b>	Percent of population under age 65 without health insurance
<b>Preventable Hospital Stays</b>	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
<b>Mammography Screening</b>	Percent of female Medicare enrollees that receive mammography screening
<b>Access to Healthy Foods</b>	Healthy food outlets include grocery stores and produce stands/farmers' markets
<b>Access to Recreational Facilities</b>	Rate of recreational facilities per 100,000 population
<b>Physical Inactivity</b>	Percent of adults aged 20 and over that report no leisure time physical activity
<b>Primary Care Provider Ratio</b>	Ratio of population to primary care providers
<b>Mental Health Care Provider Ratio</b>	Ratio of population to mental health care providers
<b>Diabetes Screening</b>	Percent of Medicare enrollees with diabetes that receive HbA1c screening
<b>Binge Drinking</b>	Percent of adults that report binge drinking in the last 30 days. Binge drinking is consuming more than 4 (women) or 5 (men) alcoholic drinks on one occasion.

# Premature Death - A health outcome measure focusing on mortality

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



Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007



## CONTEXT

**What It Is:** Premature death is represented by the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person who dies at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL. The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 U.S. population.

**Where It Comes From:** Data on deaths, including age at death, are based on death certificates and are routinely reported to the National Vital Statistics System (NVSS) at the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC). NVSS calculates age-adjusted YPLL rates based on three-year averages to create more robust estimates of mortality, particularly for counties with smaller populations.

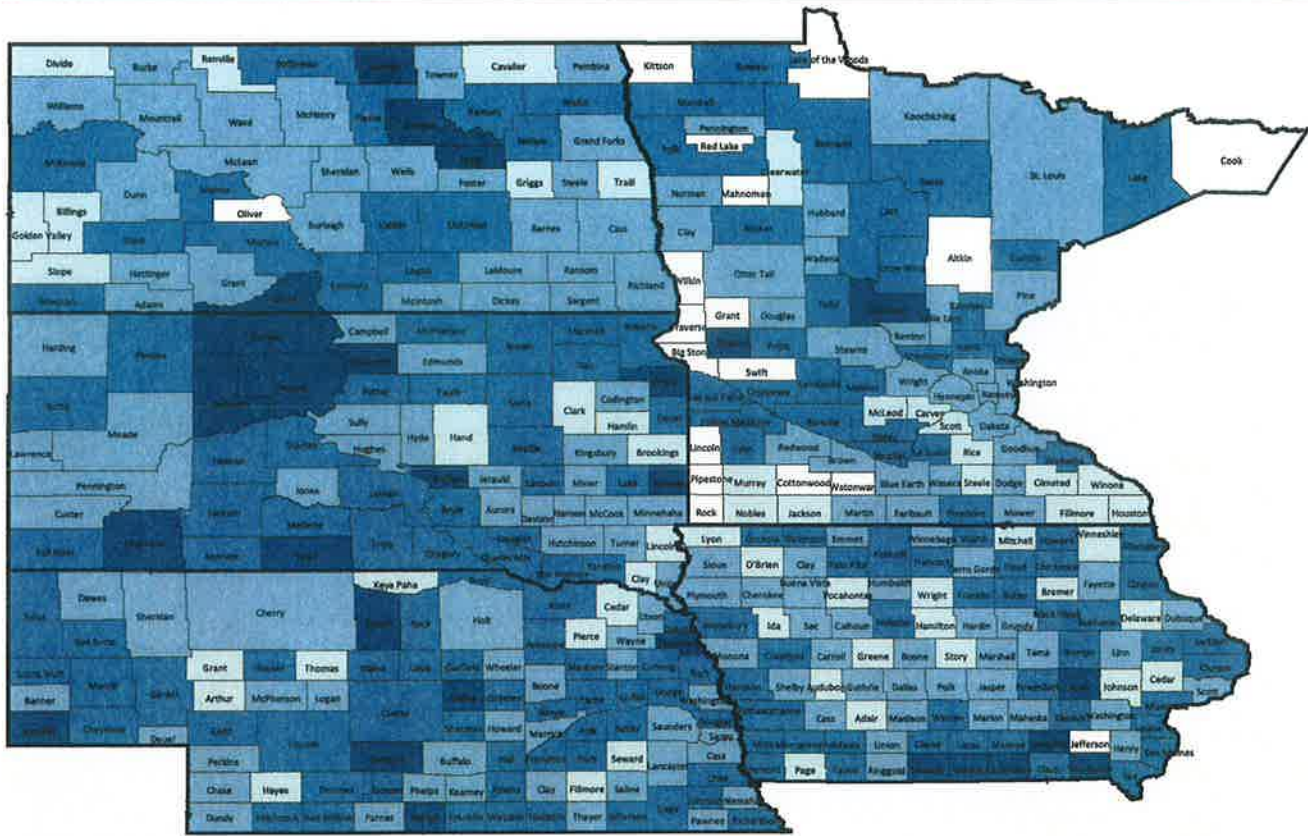
**Importance:** Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

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

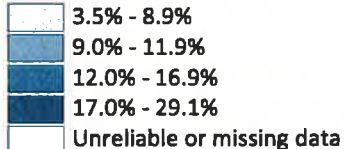
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Poor or Fair Health - A health outcome measure focusing on morbidity

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



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



CONTEXT

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

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

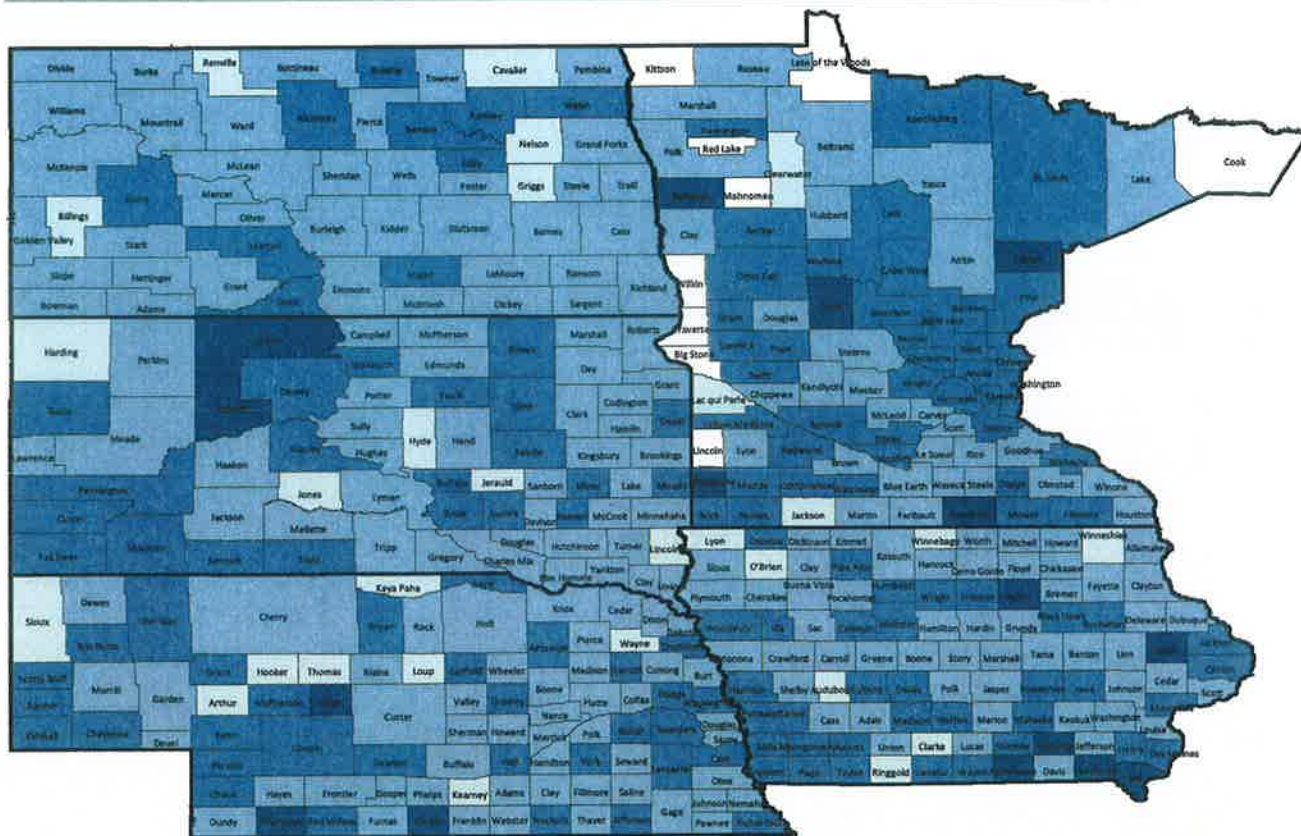
**Importance:** Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable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

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

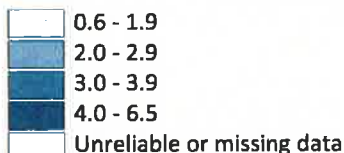
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Poor Physical Health Days - A health outcome measure focusing on morbidity

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



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



CONTEXT

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

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

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

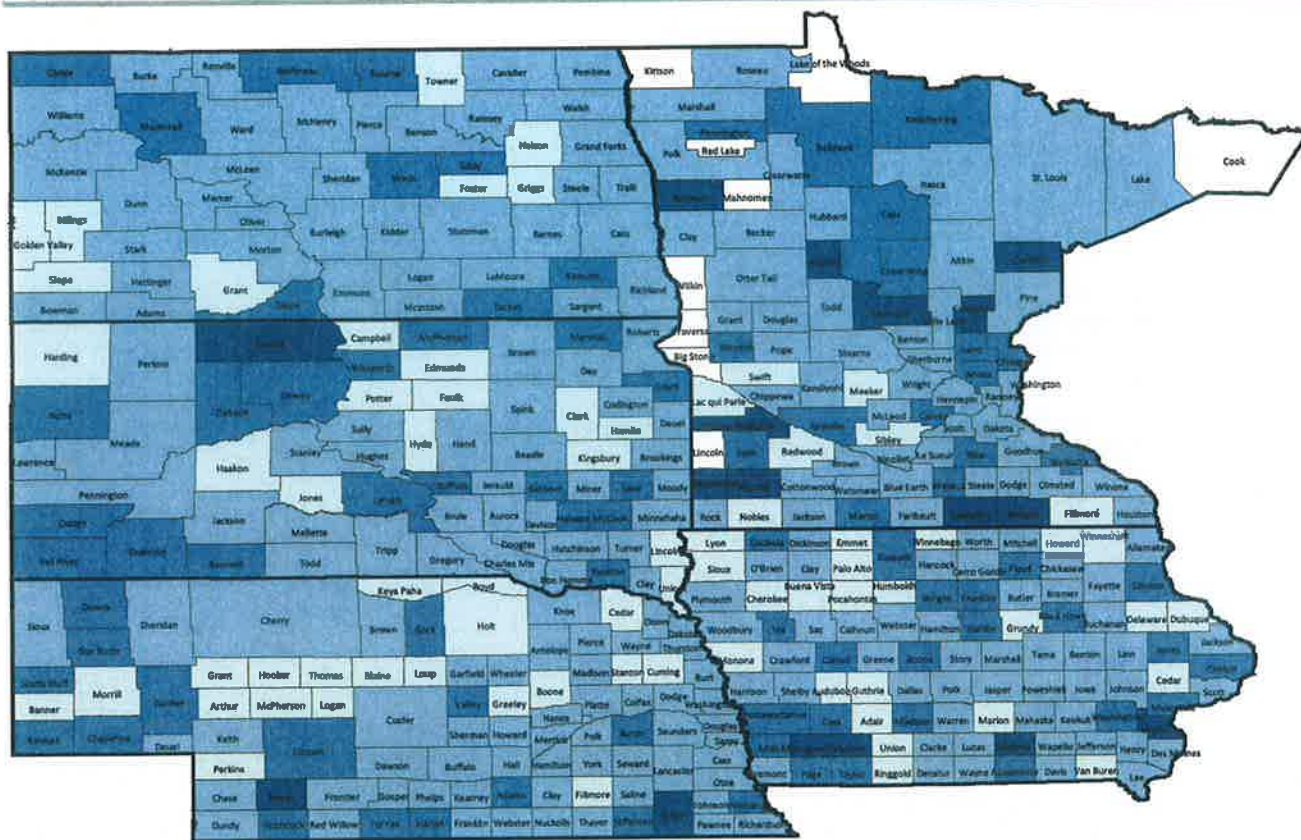
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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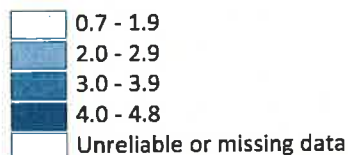


# Poor Mental Health Days - A health outcome measure focusing on morbidity

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



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



## CONTEXT

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

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

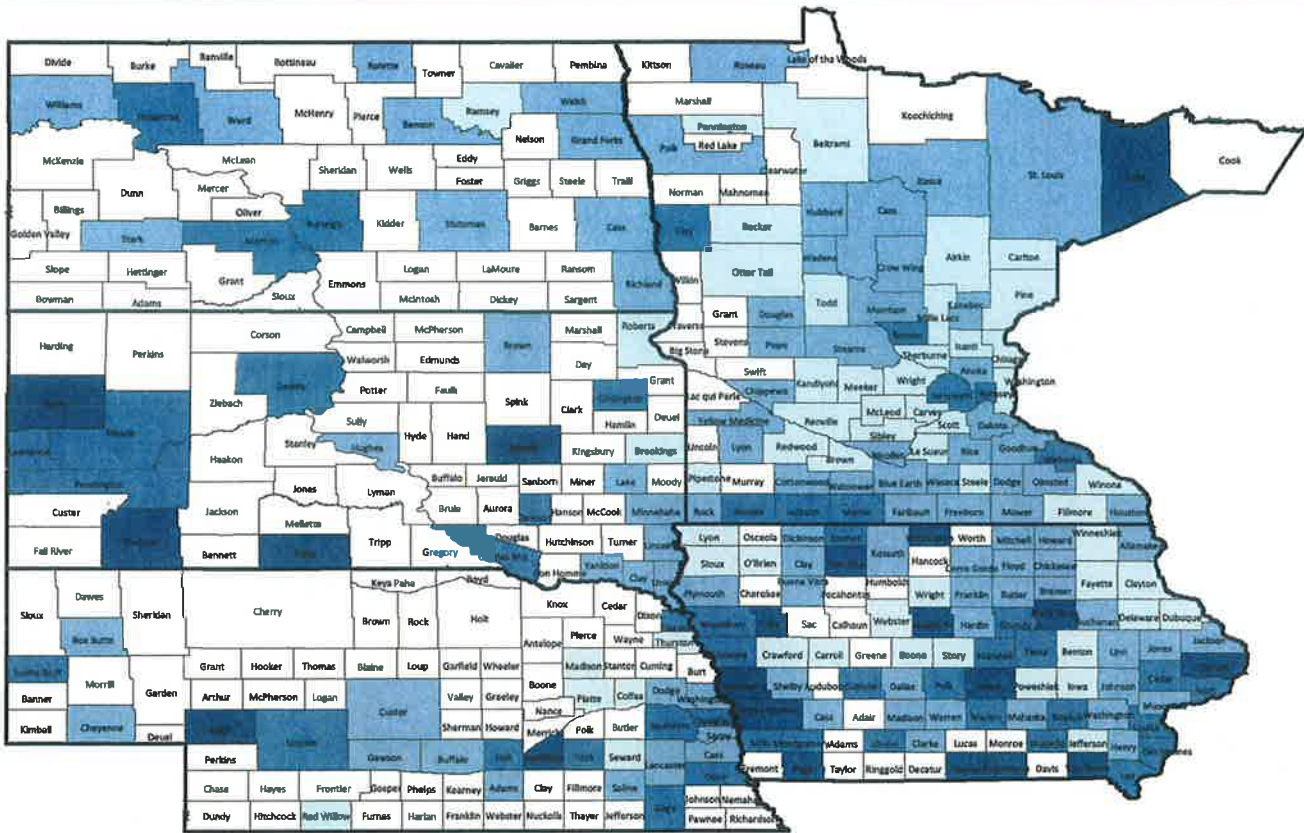
**Importance:** Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represent an important facet of health-related quality of life. The County Health Rankings considers health-related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

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

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# Low Birthweight - A health outcome measure focusing on morbidity

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



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



## CONTEXT

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

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

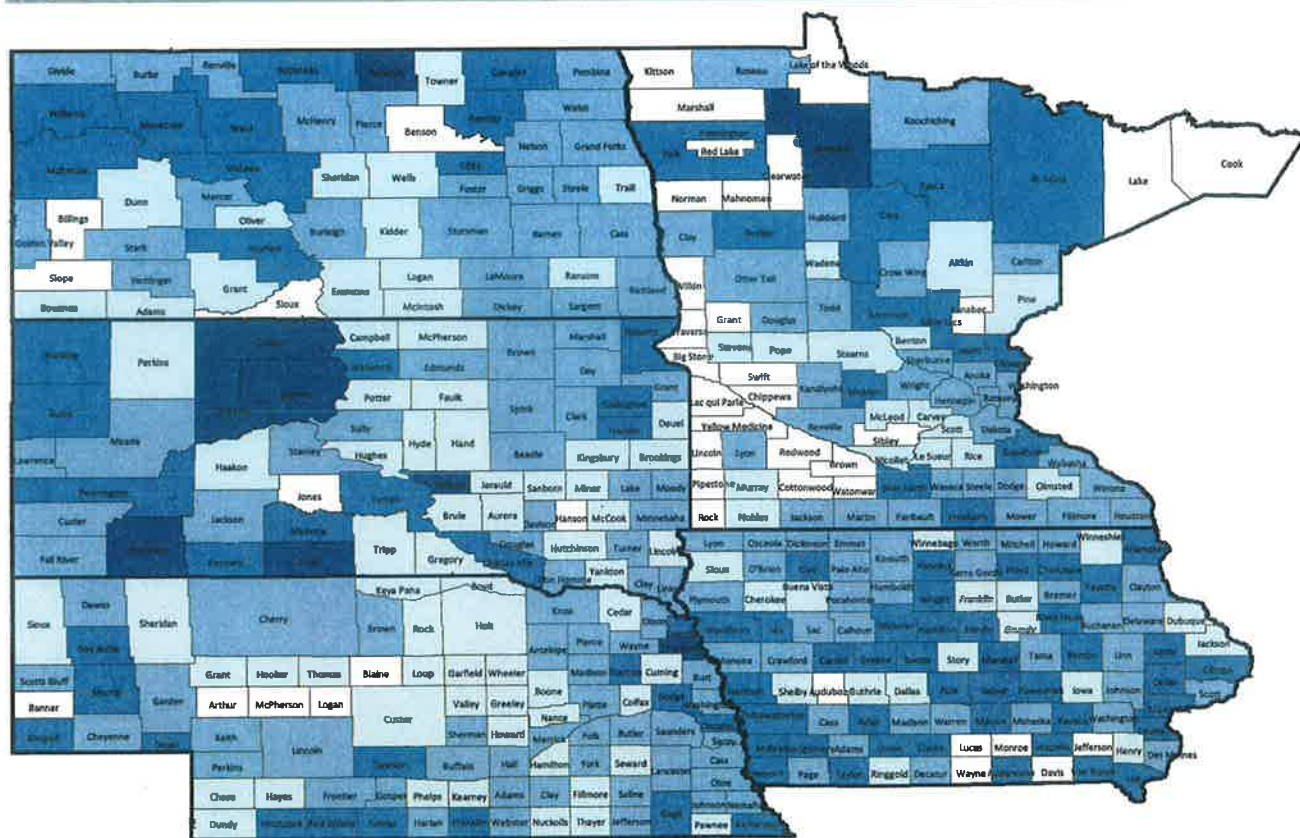
**Importance:** Low birthweight represents two factors: maternal exposure to health risks and an infant’s current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

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

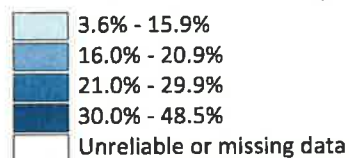
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# Adult Smoking - A health factor measure focusing on health behaviors

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



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



## CONTEXT

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

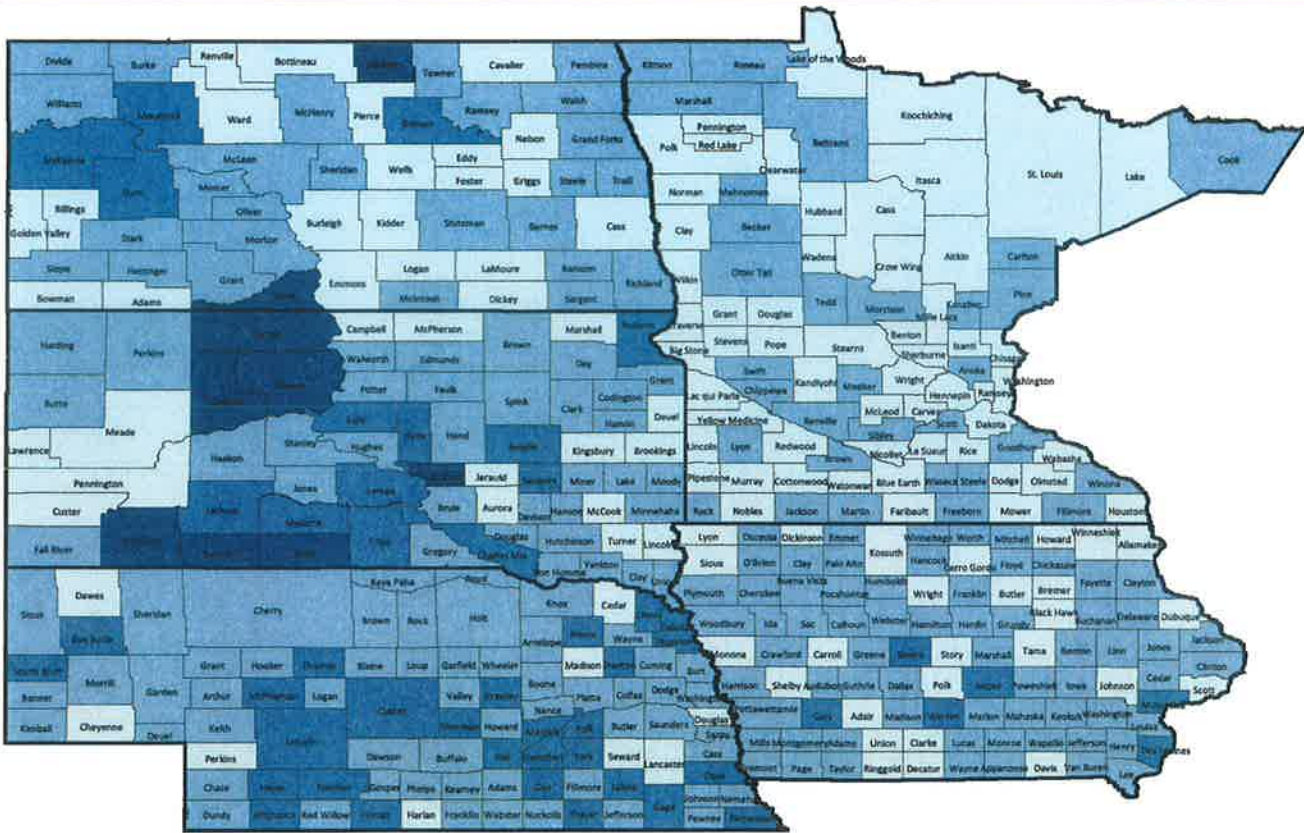
**Where It Comes From:** This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized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

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

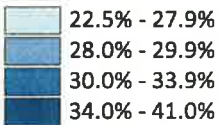
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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**Adult Obesity - A health factor measure focusing on health behaviors**  
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults that report a body mass index (BMI) of at least 30 kg/m<sup>2</sup>, 2008



CONTEXT

**What It Is:** The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m<sup>2</sup>.

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

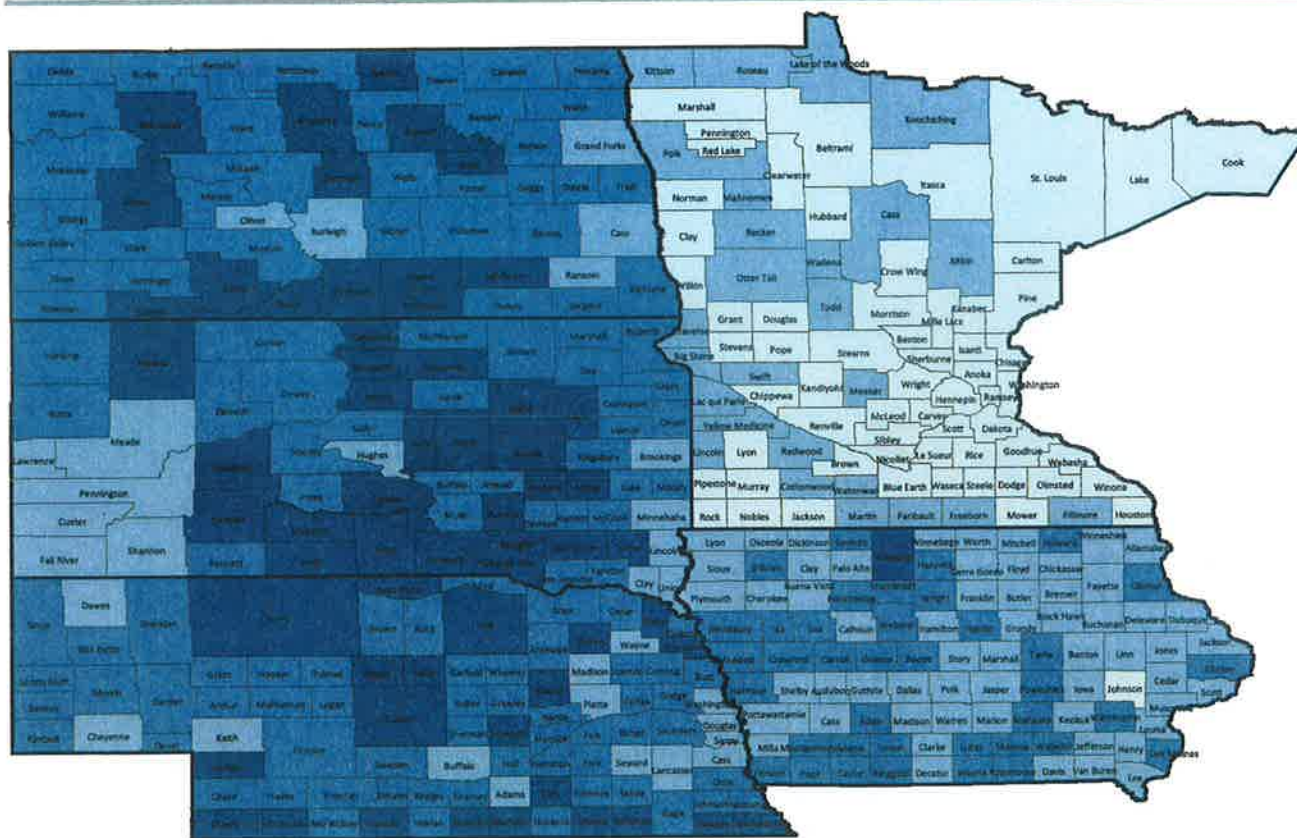
**Importance:** Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep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

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

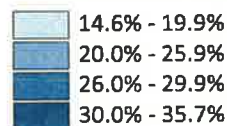
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# Physical Inactivity - A health factor measure focusing on health behaviors

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



Percent of adults reporting no leisure time physical activity, 2008



## CONTEXT

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

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

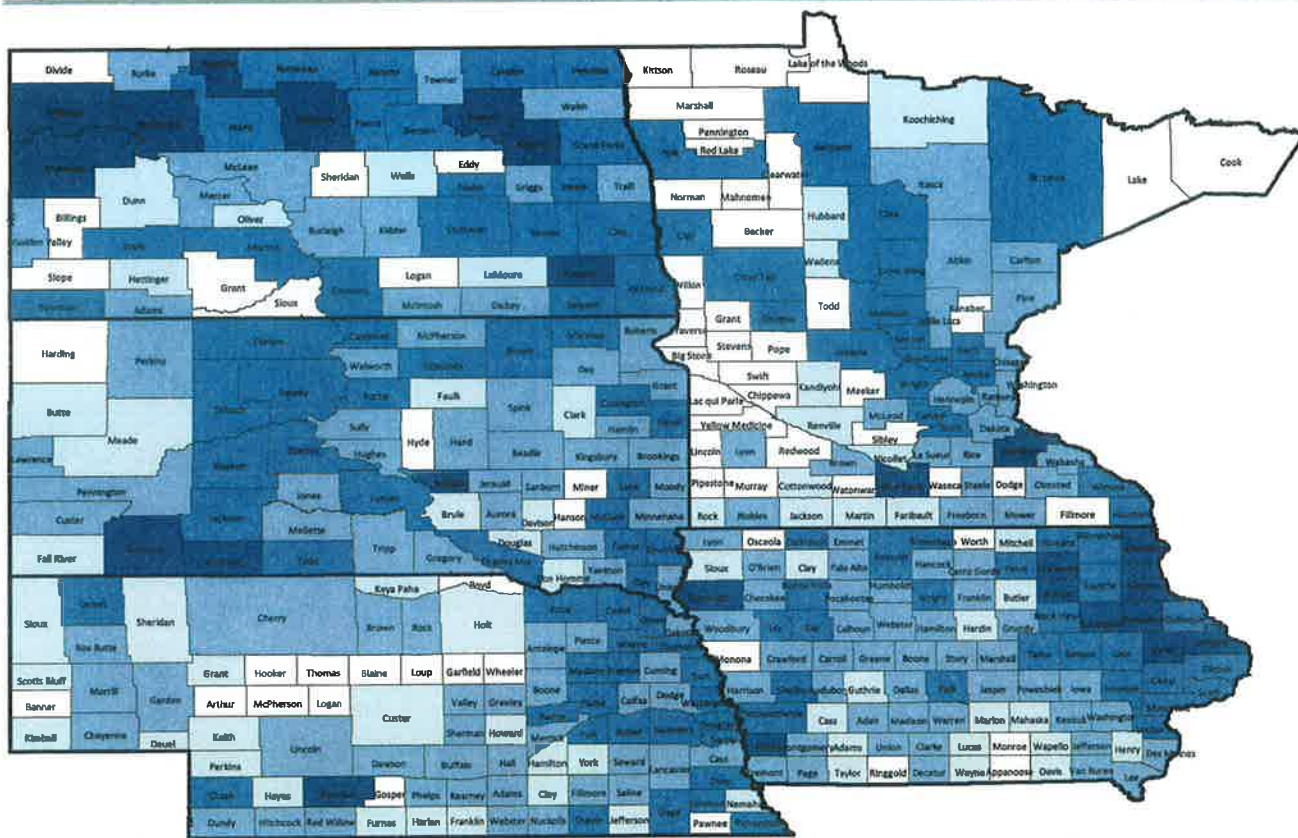
**Importance:** Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental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

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

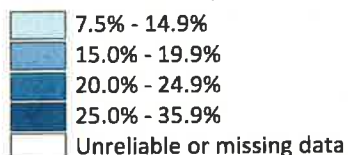
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# Excessive Drinking - A health factor measure focusing on health behaviors

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



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



## CONTEXT

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

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

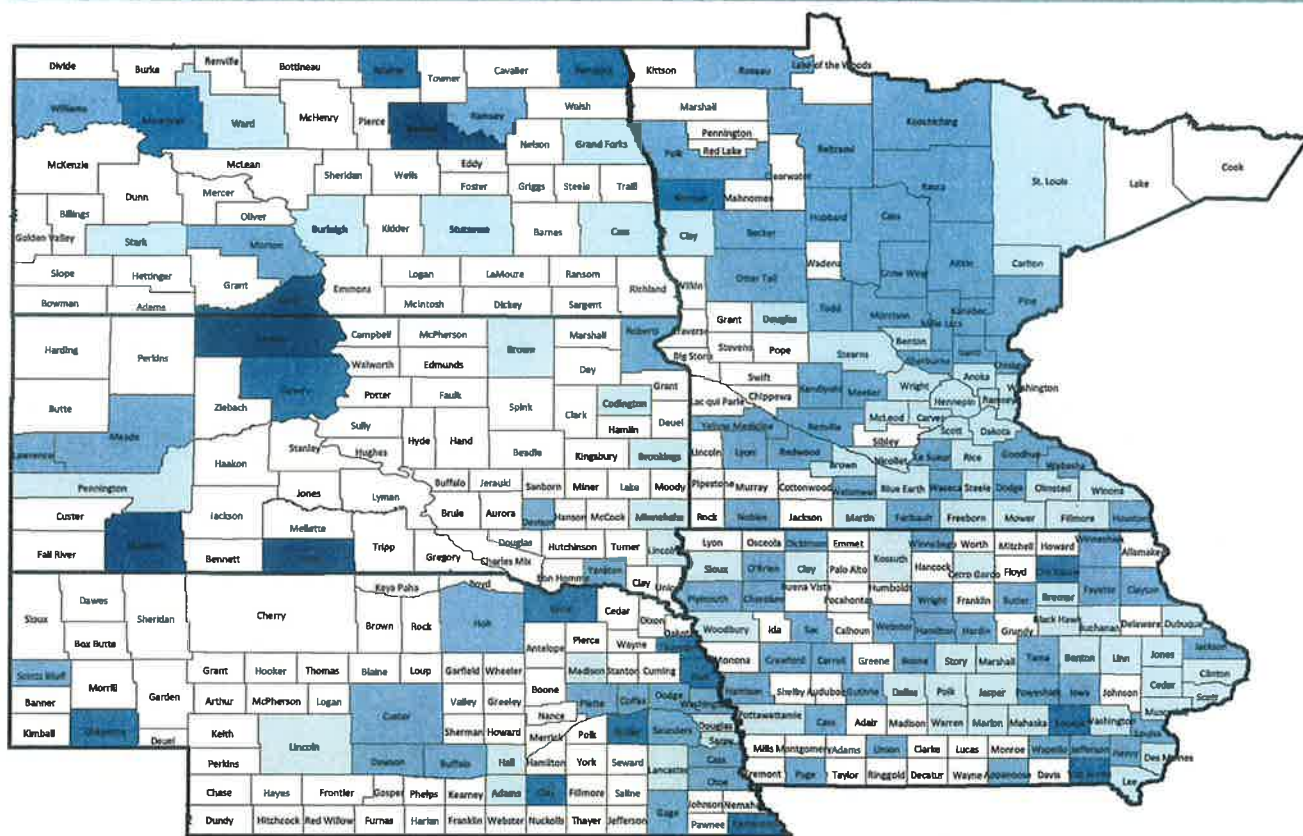
**Importance:** Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence,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

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

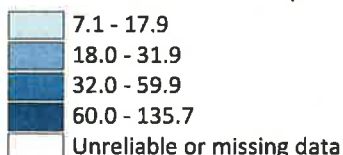
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# Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

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



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



## CONTEXT

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

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

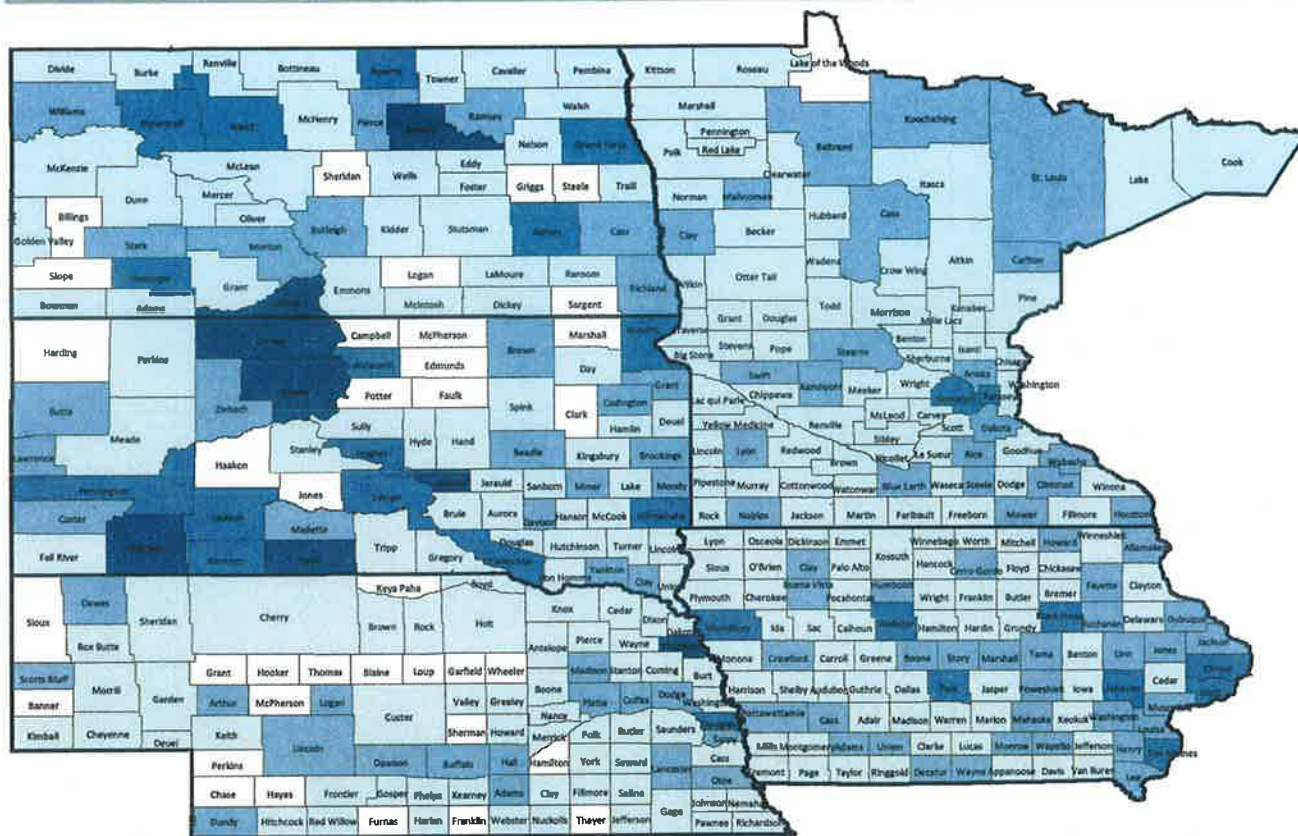
**Importance:** A strong association has been demonstrated between excessive drinking and alcohol-impaired driving, with approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.

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

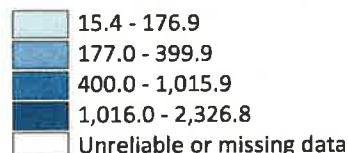
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# Sexually Transmitted Infections - A health factor measure focusing on health behaviors

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



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



## CONTEXT

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

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

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

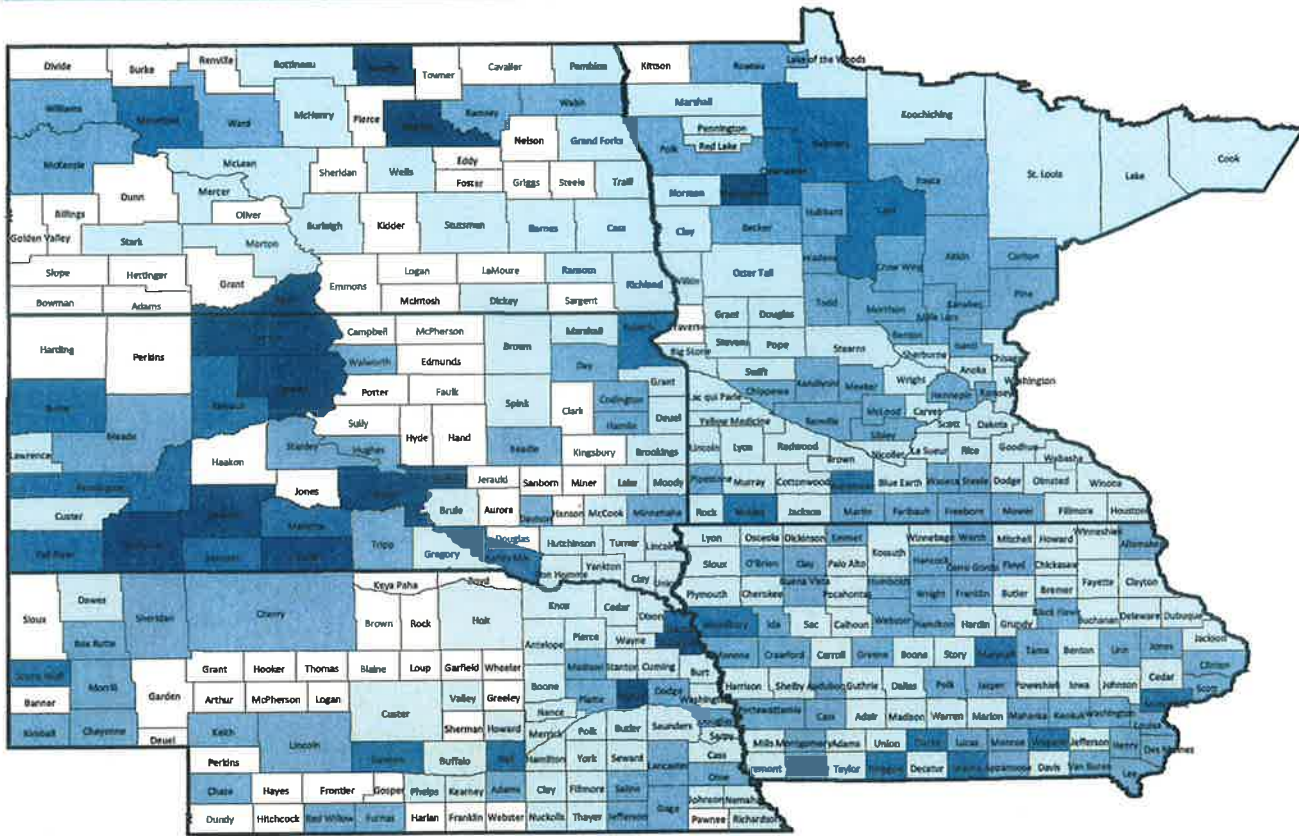
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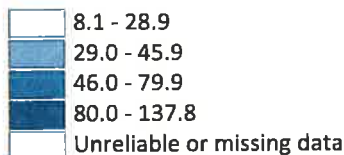


# Teen Birth Rate - A health factor measure focusing on health behaviors

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



Number of teen births per 1,000 females ages 15 through 19, 2001-2007



## CONTEXT

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

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

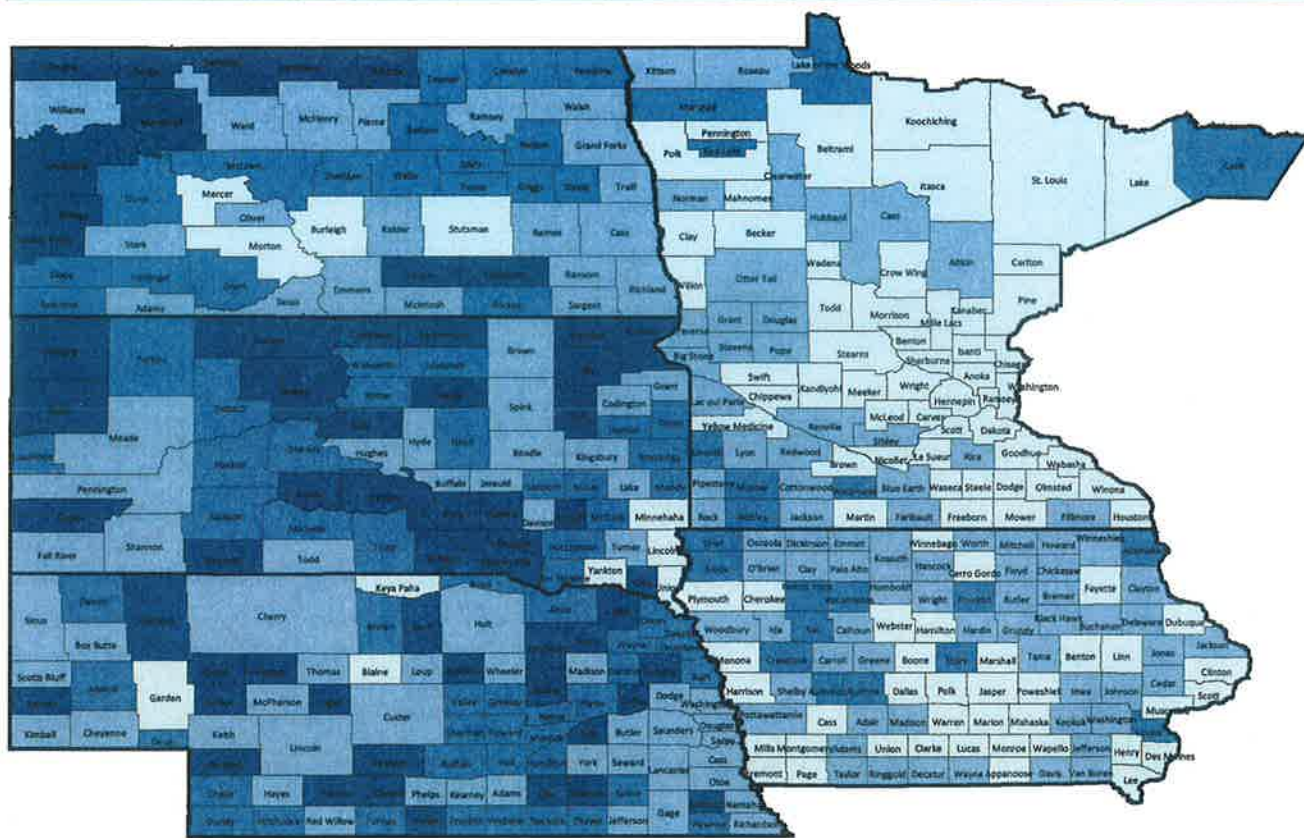
**Importance:** Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term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

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

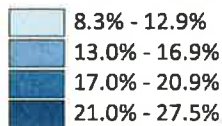
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# Uninsured Adults - A health factor measure focusing on clinical care

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



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



## CONTEXT

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

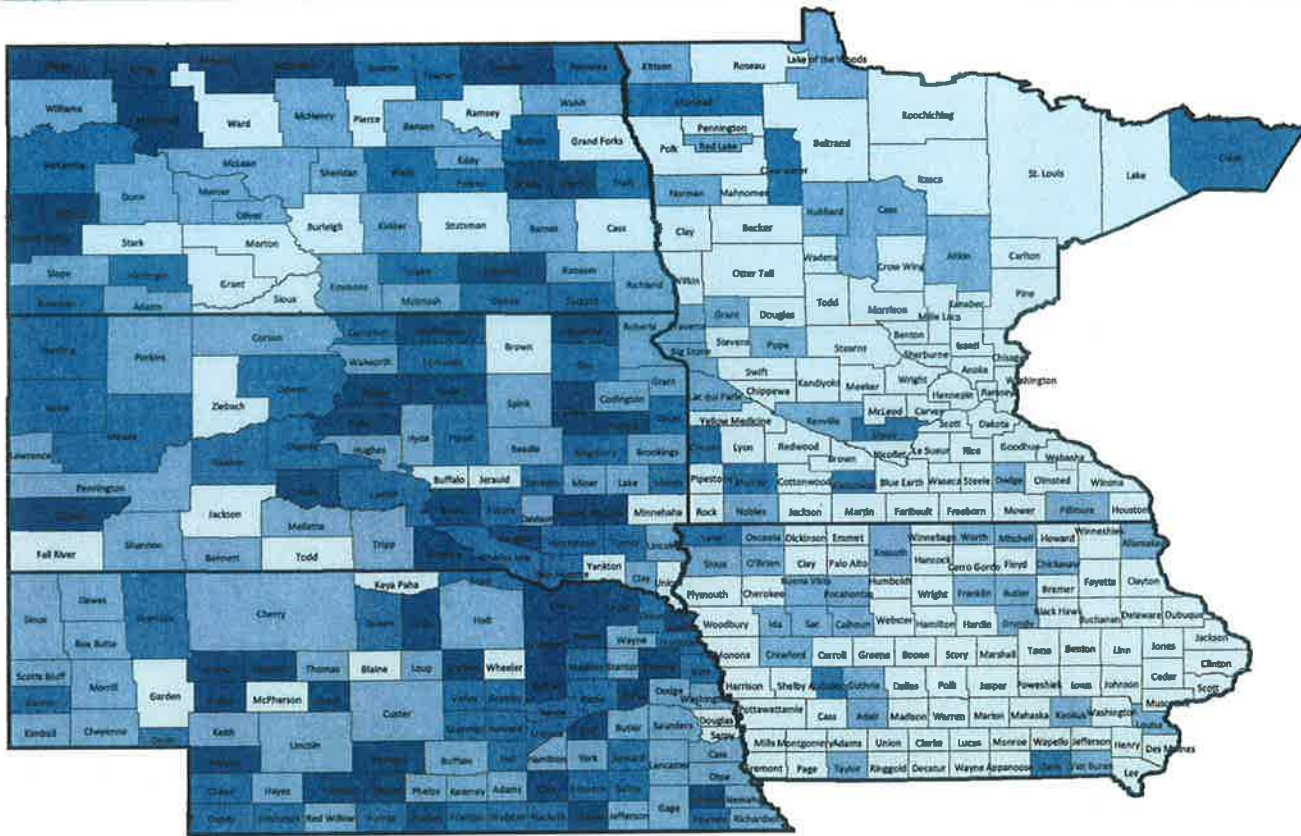
**Where It Comes From:** The Small Area Health Insurance Estimates from the U.S. Census Bureau provide annual estimates of the population without health insurance coverage for all U.S. states and their counties. The estimates used are for the most recent year for which reliable county-level estimates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

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

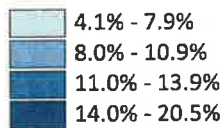
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**Uninsured Youth** - A health factor measure focusing on clinical care  
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



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



**CONTEXT**

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

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

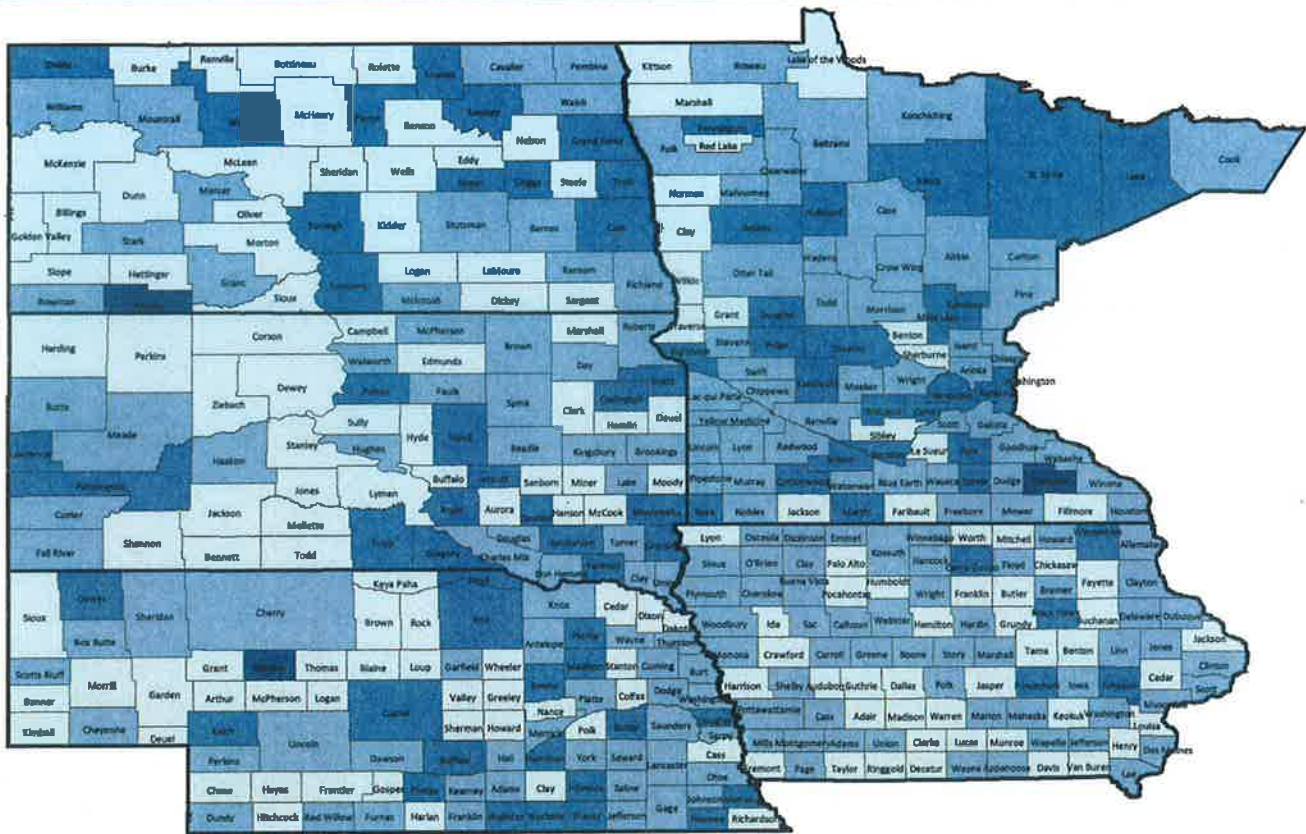
**Importance:** Children without health insurance are more likely than others to receive late or no care for health problems, putting them at greater risk for hospitalization. In addition to resulting in reduced access to health care, a lack of health insurance can also negatively influence children’s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

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

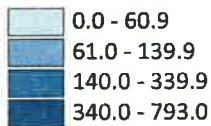
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# Primary Care Physicians - A health factor measure focusing on clinical care

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



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



## CONTEXT

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

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

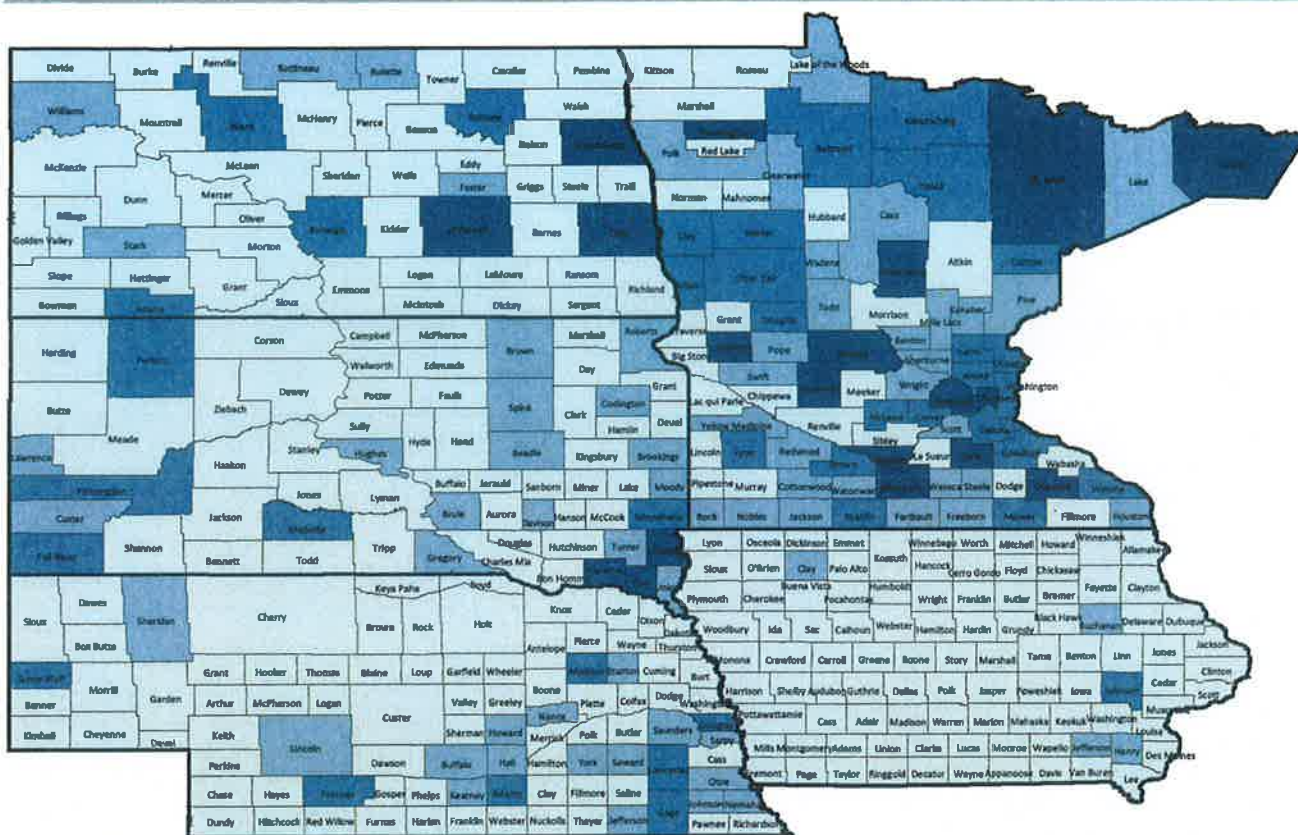
**Importance:** Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential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

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

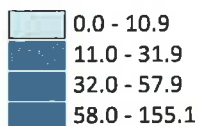
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# Mental Health Providers - A health factor measure focusing on clinical care

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



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



## CONTEXT

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

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

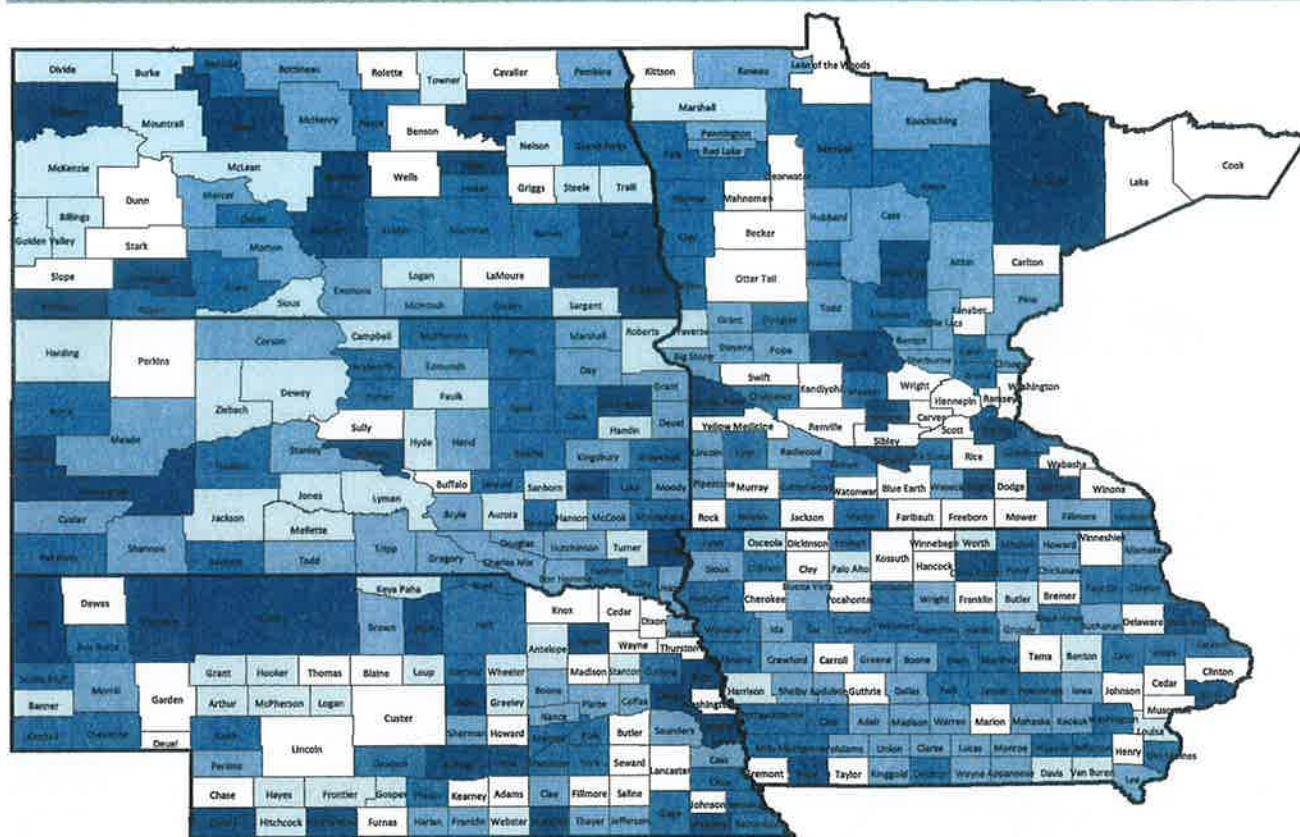
**Importance:** Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges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

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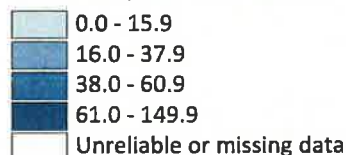
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# Dentist Rate - A health factor measure focusing on clinical care

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



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



## CONTEXT

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

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

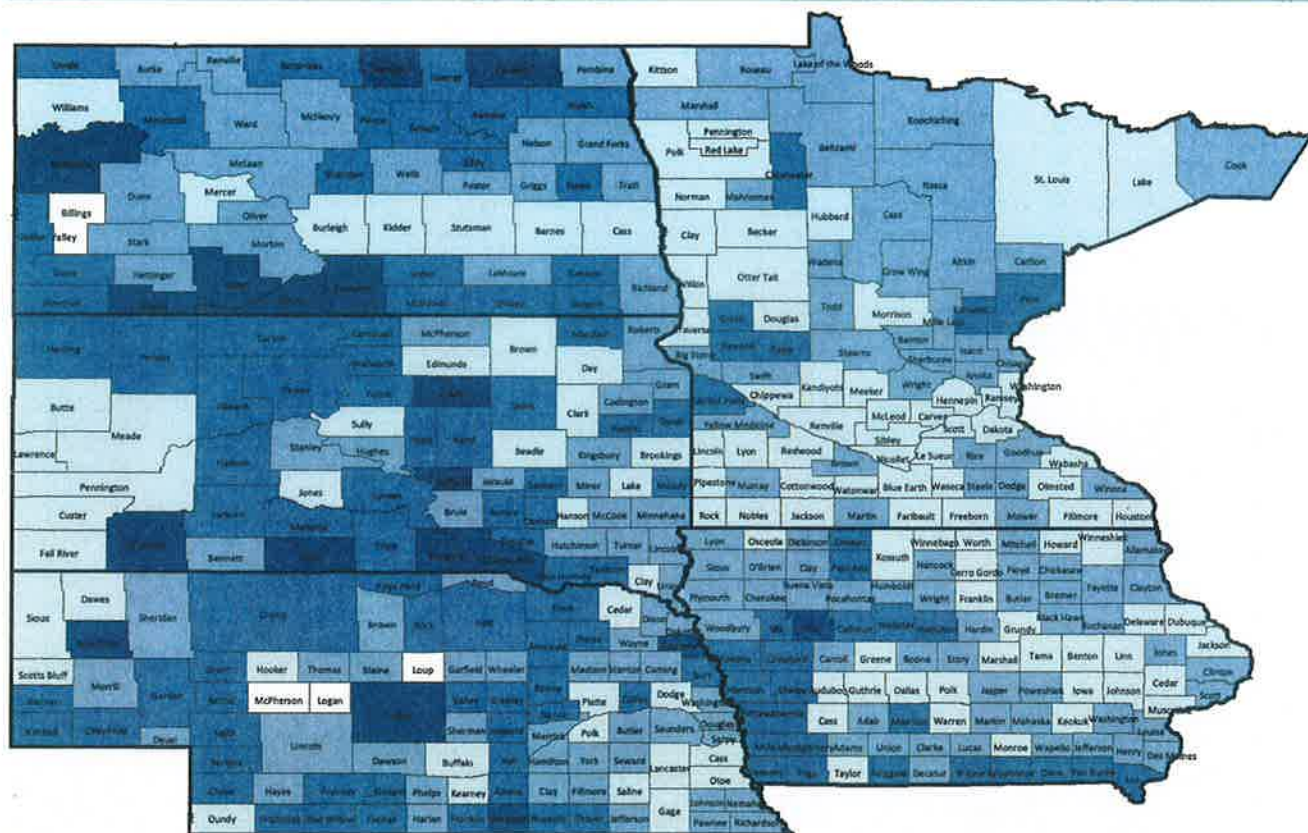
**Importance:** Today, thanks to fluoride, healthier lifestyles and quality dental care, more people than ever before are keeping their natural teeth throughout their lifetime. Yet for those who live in areas where a dentist is not available or those who cannot afford treatment, getting dental care can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

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

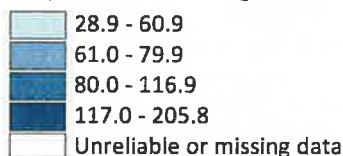
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# Preventable Hospital Stays - A health factor measure focusing on clinical care

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



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



## CONTEXT

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

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

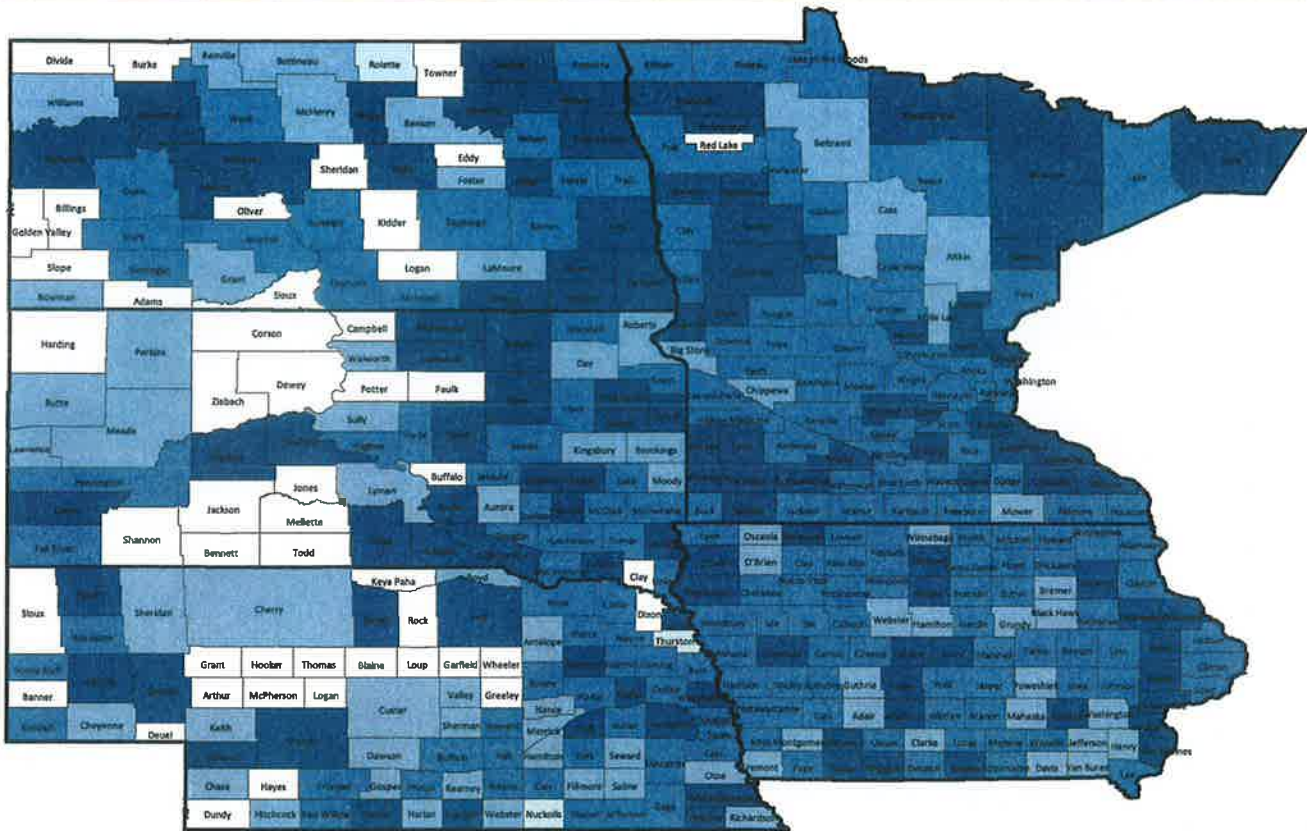
**Importance:** Hospitalization for diagnoses amenable to outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent the population's tendency to overuse the hospital as a main source of care.

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

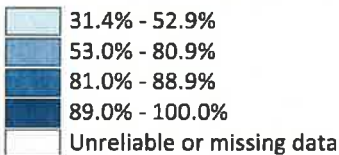
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Diabetic Screening - A health factor measure focusing on clinical care

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



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



CONTEXT

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

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

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

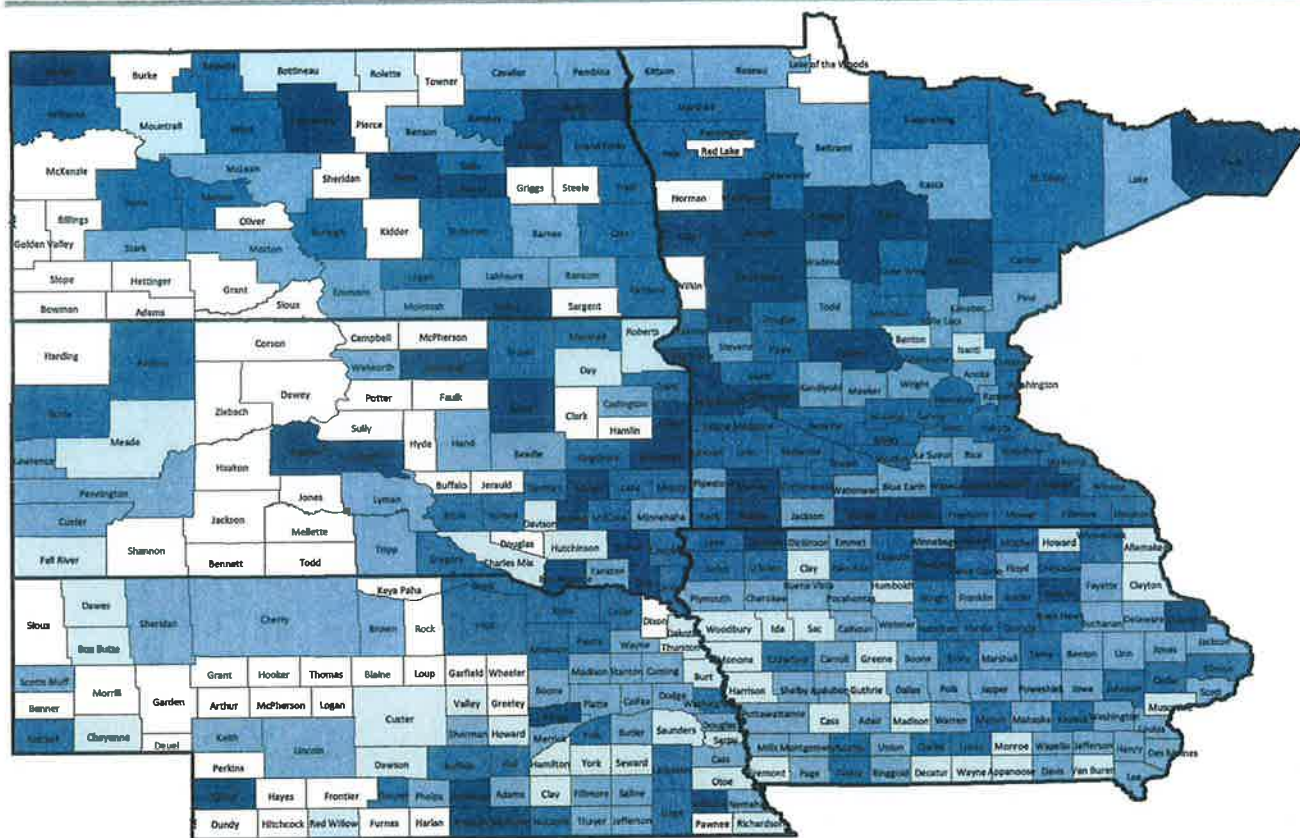
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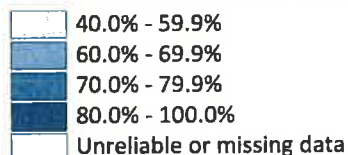


# Mammography Screening - A health factor measure focusing on clinical care

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



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



## CONTEXT

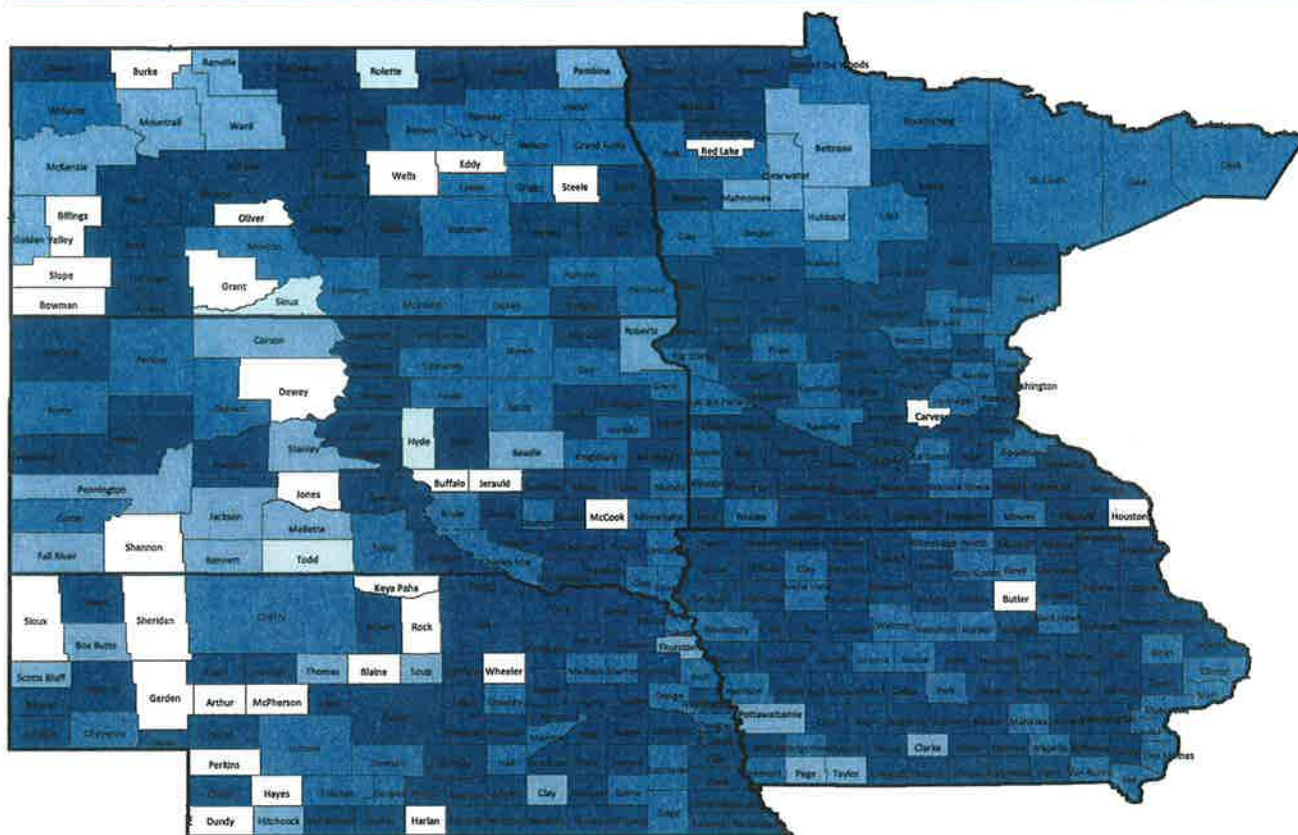
**What It Is:** This measure represents the percent of female Medicare enrollees ages 40 through 69 that had at least one mammogram over a two-year period.

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

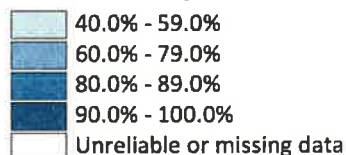
**Importance:** Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician's recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages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

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

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



CONTEXT

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

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

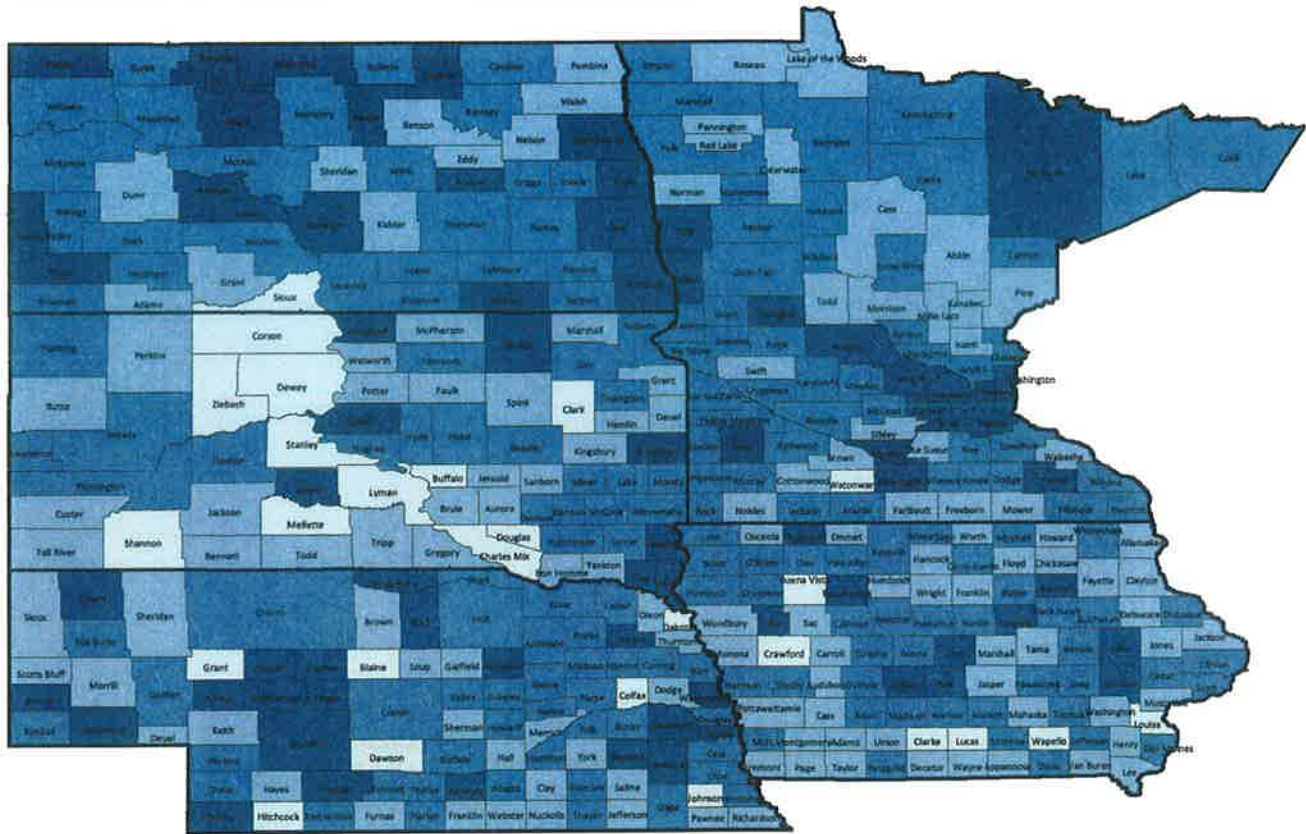
**Importance:** The relationship between more education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

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

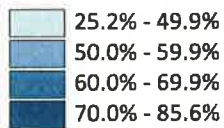
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**Some College** - A health factor measure focusing on education

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



Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009



CONTEXT

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

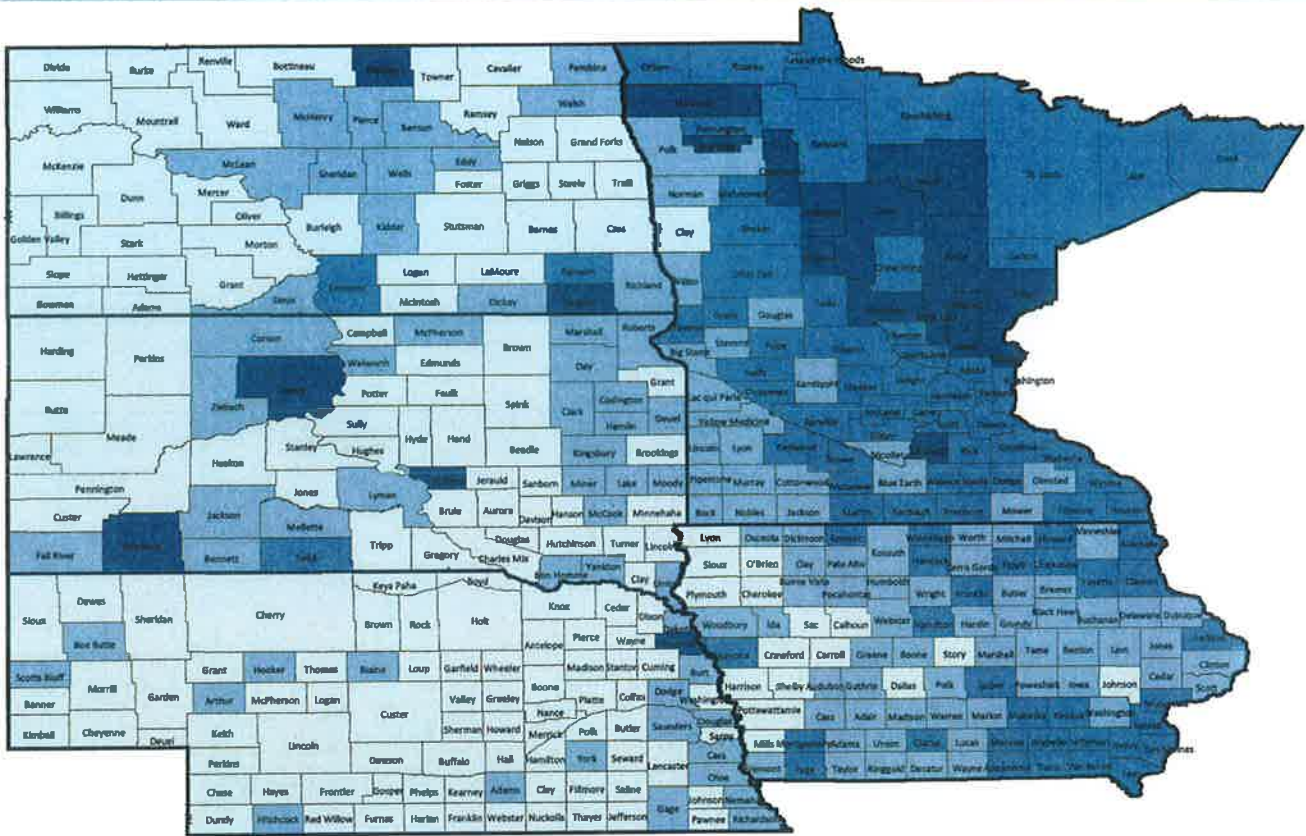
**Where It Comes From:** Estimates of the population ages 25 through 44 with some post-secondary education were calculated using the 5-year estimates from the U.S. Census Bureau’s American Community Survey (ACS).

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

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

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**Unemployment** - A health factor measure focusing on labor  
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of population ages 16 and older that is unemployed but seeking work, 2009



CONTEXT

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

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

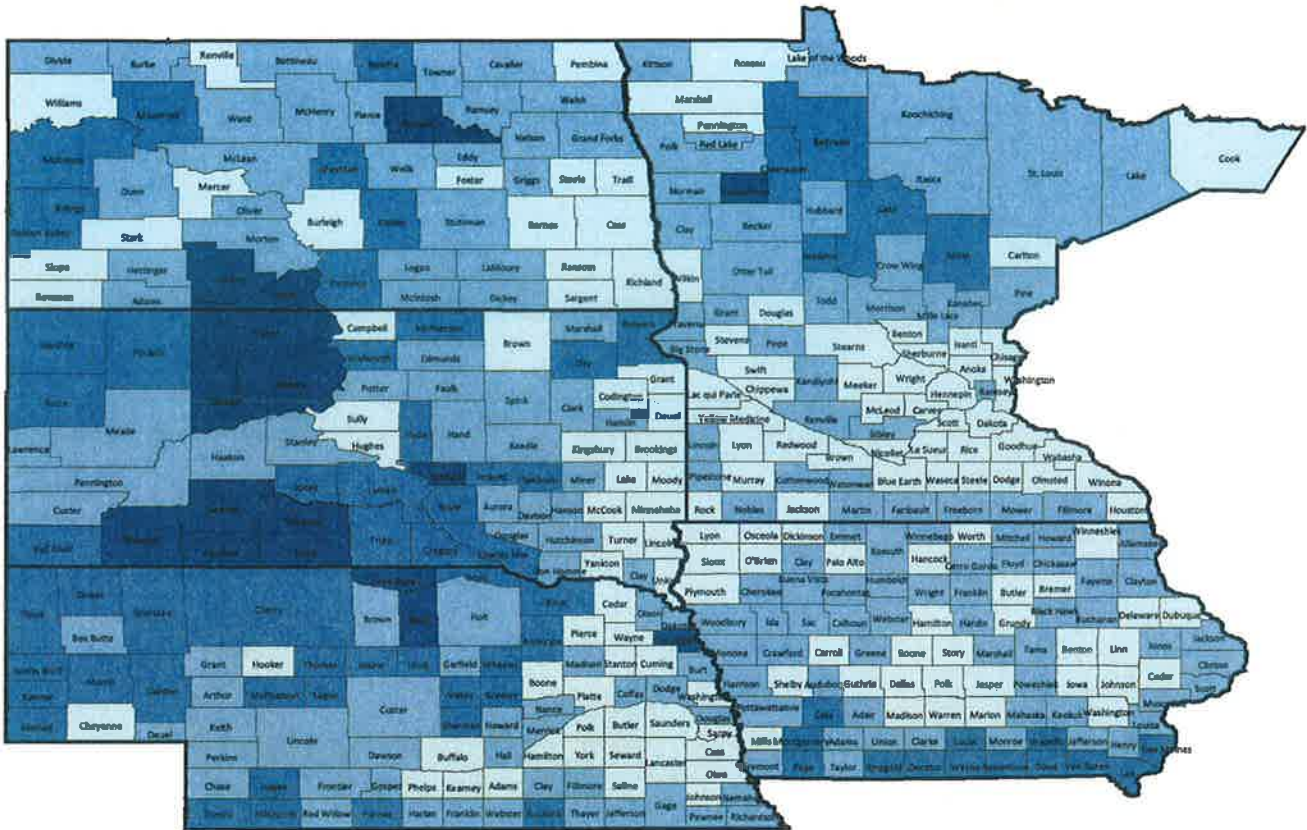
**Importance:** Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors,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

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

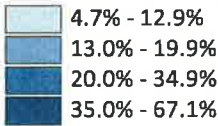
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# Children in Poverty - A health factor measure focusing on income and poverty

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



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



## CONTEXT

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

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

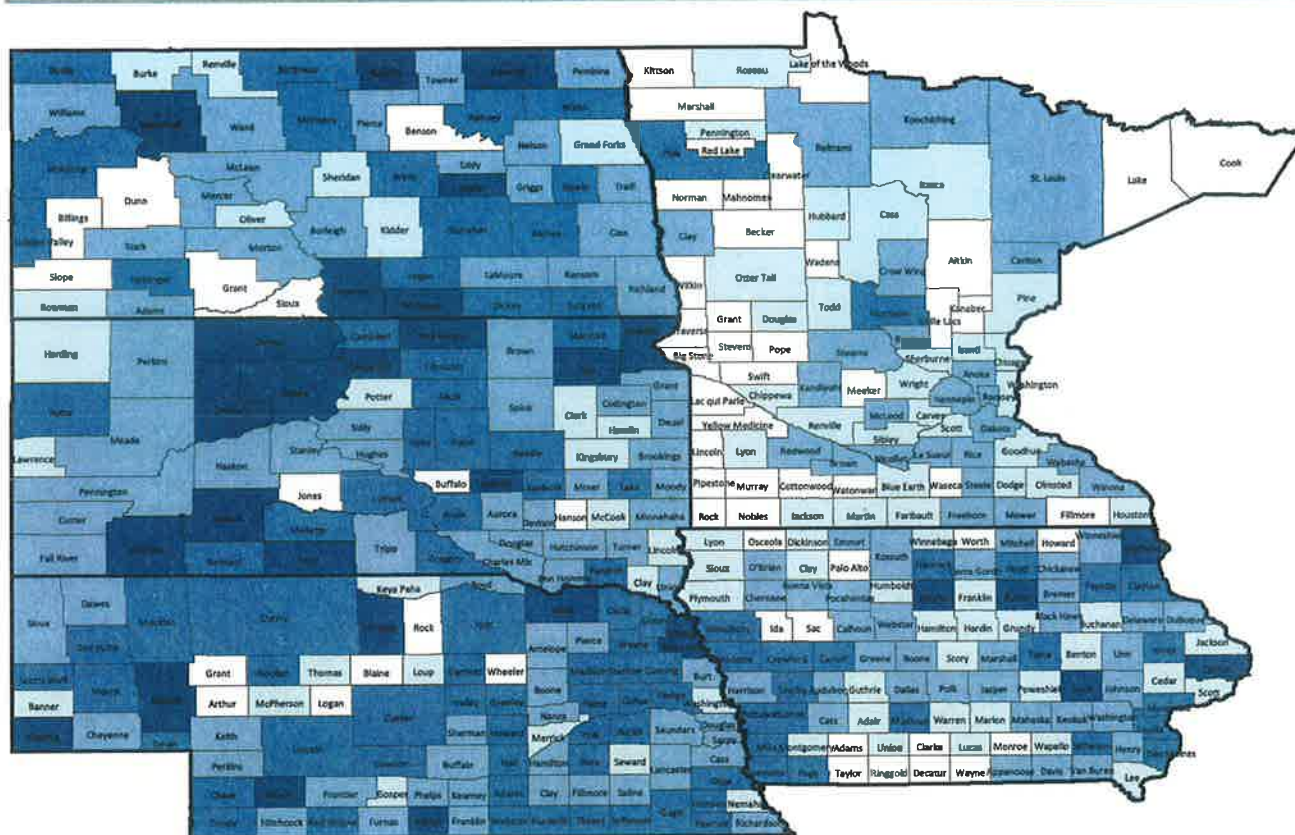
**Importance:** Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. While negative health effects resulting from poverty are present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

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

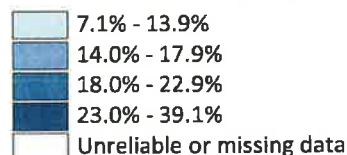
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# Inadequate Social Support - A health factor measure focusing on social networks

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



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



## CONTEXT

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

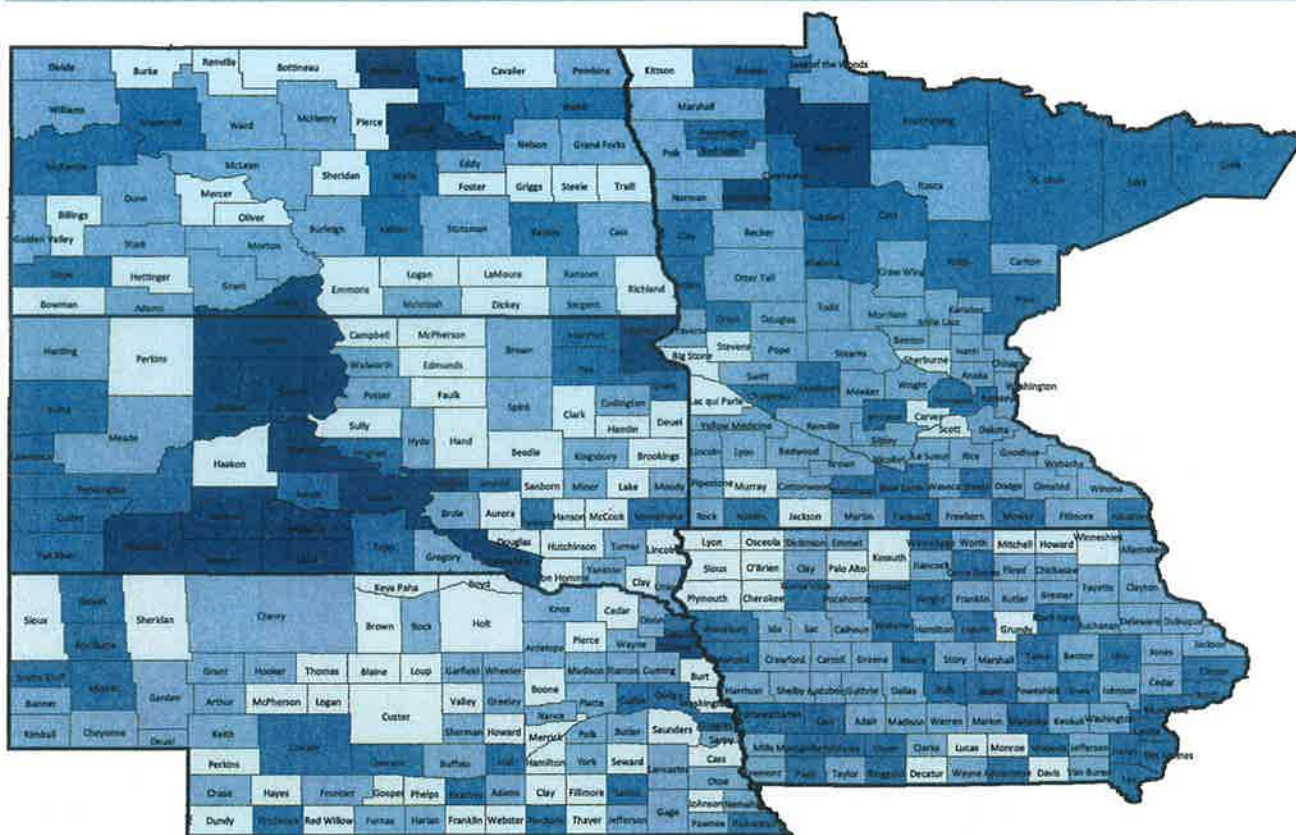
**Where It Comes From:** This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized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

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

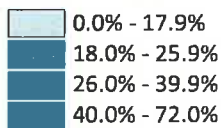
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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**Children in Single-Parent Households - A health factor measure focusing on families**  
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009



**CONTEXT**

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

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

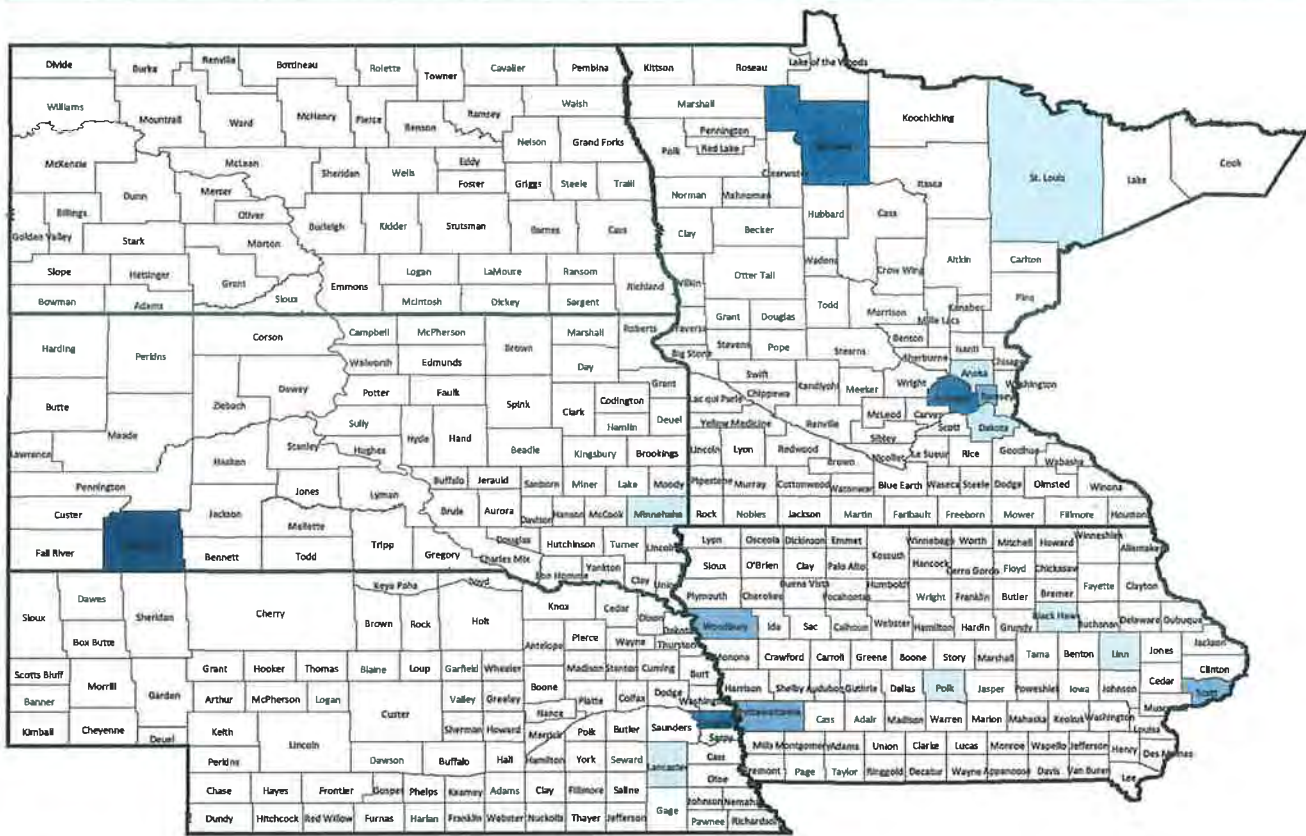
**Importance:** Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

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

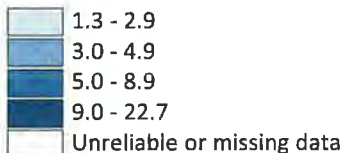
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# Homicide Rate - A health factor measure focusing on violent crime

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



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



## CONTEXT

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

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

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

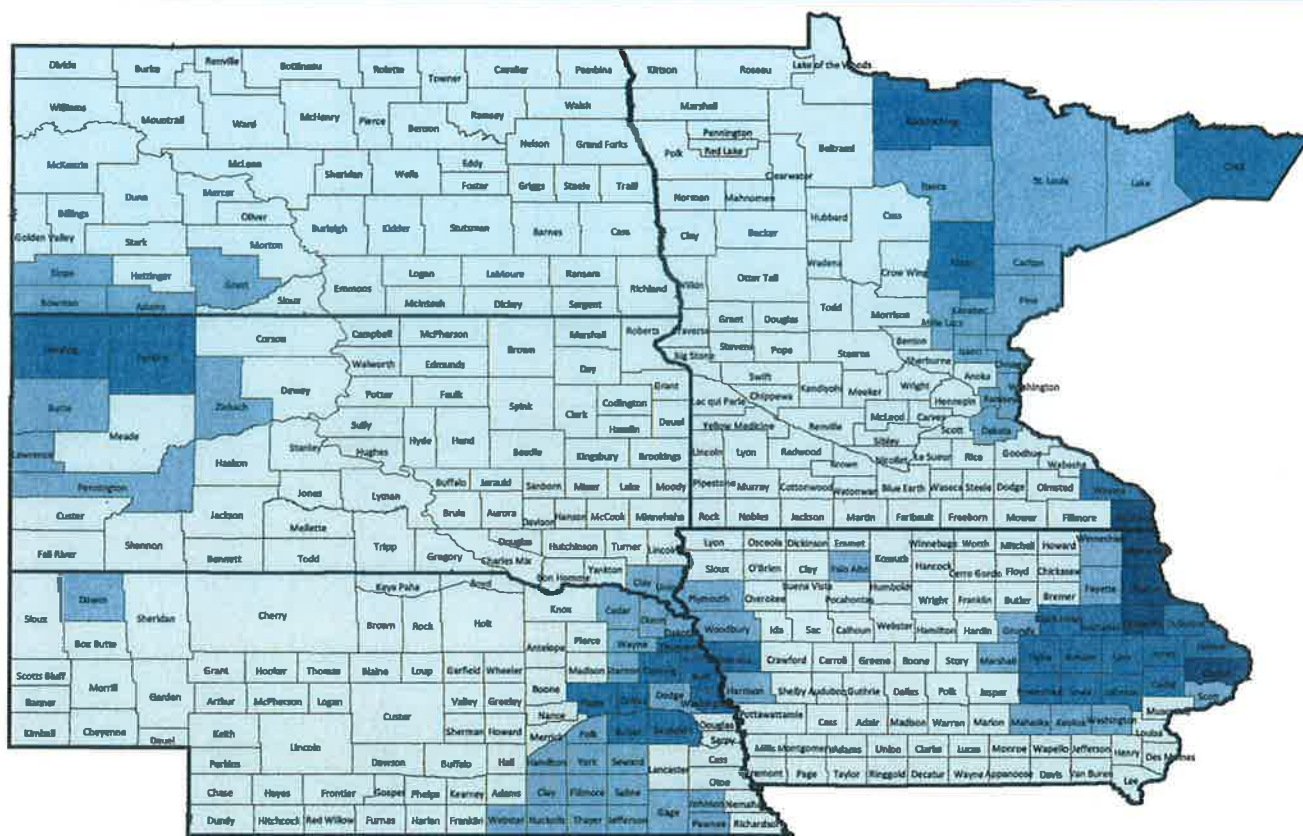
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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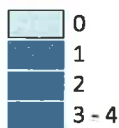


# Air Pollution-Particulate Matter Days - A health factor measure focusing on physical environment

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



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



## CONTEXT

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

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

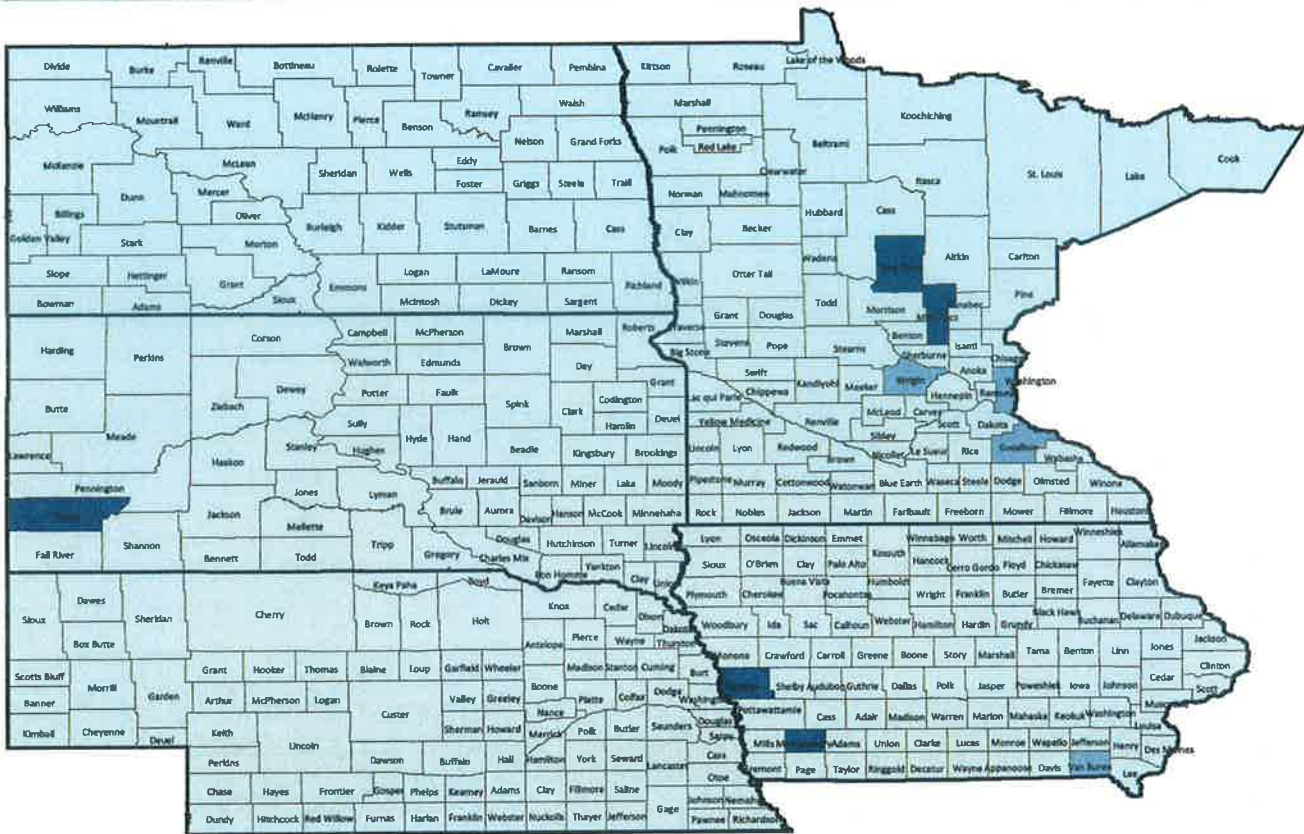
**Importance:** The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

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

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

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



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



## CONTEXT

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

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

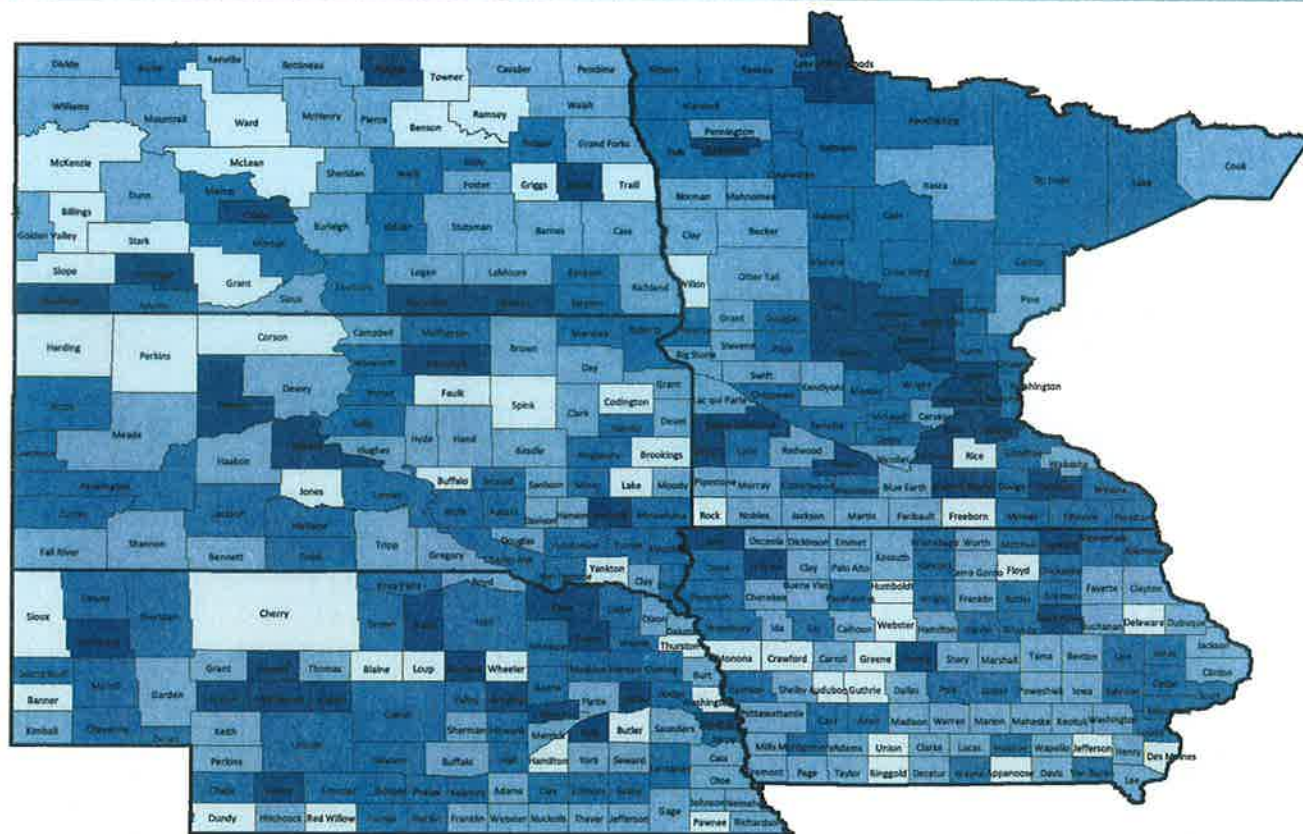
**Importance:** The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

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

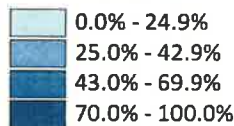
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# Access to Healthy Foods - A health factor measure focusing on physical environment

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



Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008



## CONTEXT

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

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

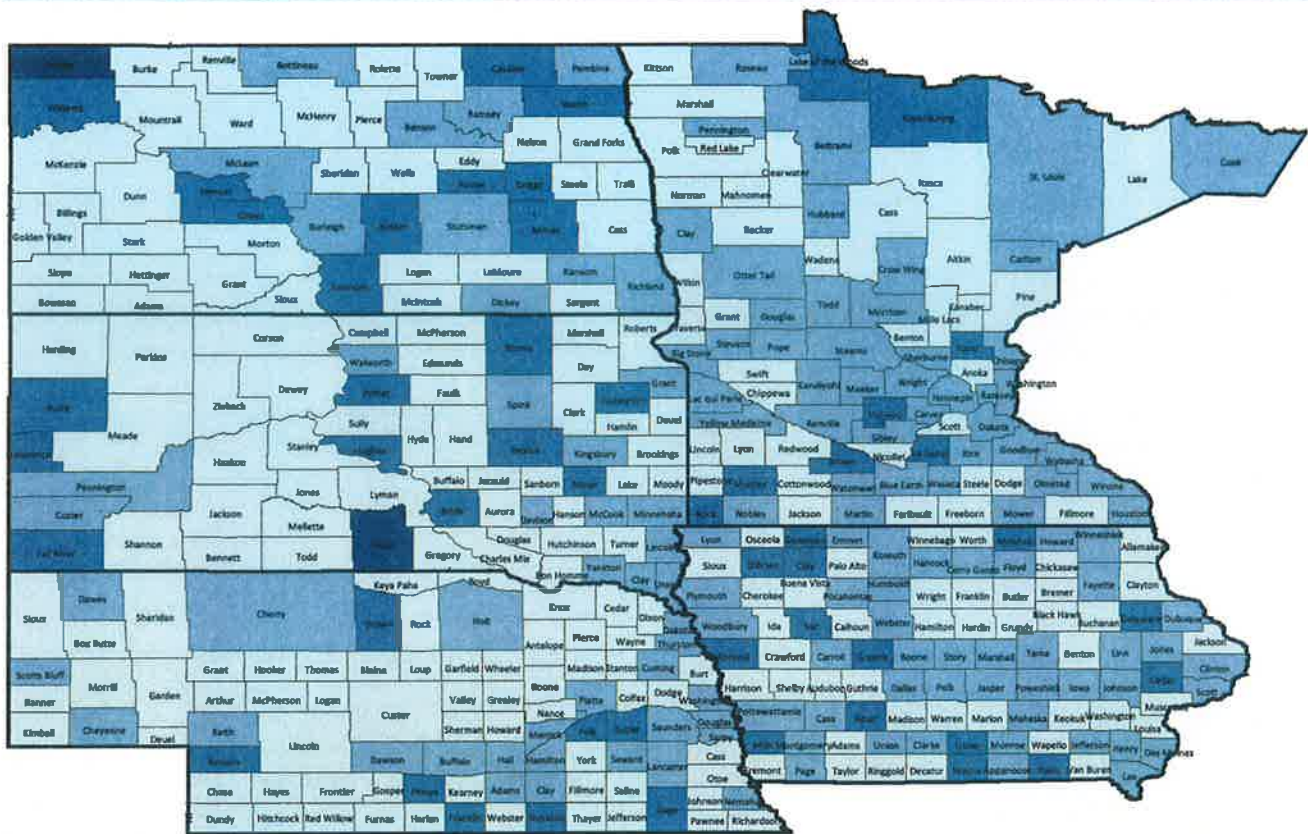
**Importance:** Studies have linked the food environment to consumption of healthy food and overall health outcomes.

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

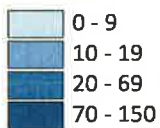
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# Access to Recreational Facilities - A health factor measure focusing on physical environment

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



Number of recreational facilities per 100,000 population, 2008



## CONTEXT

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

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

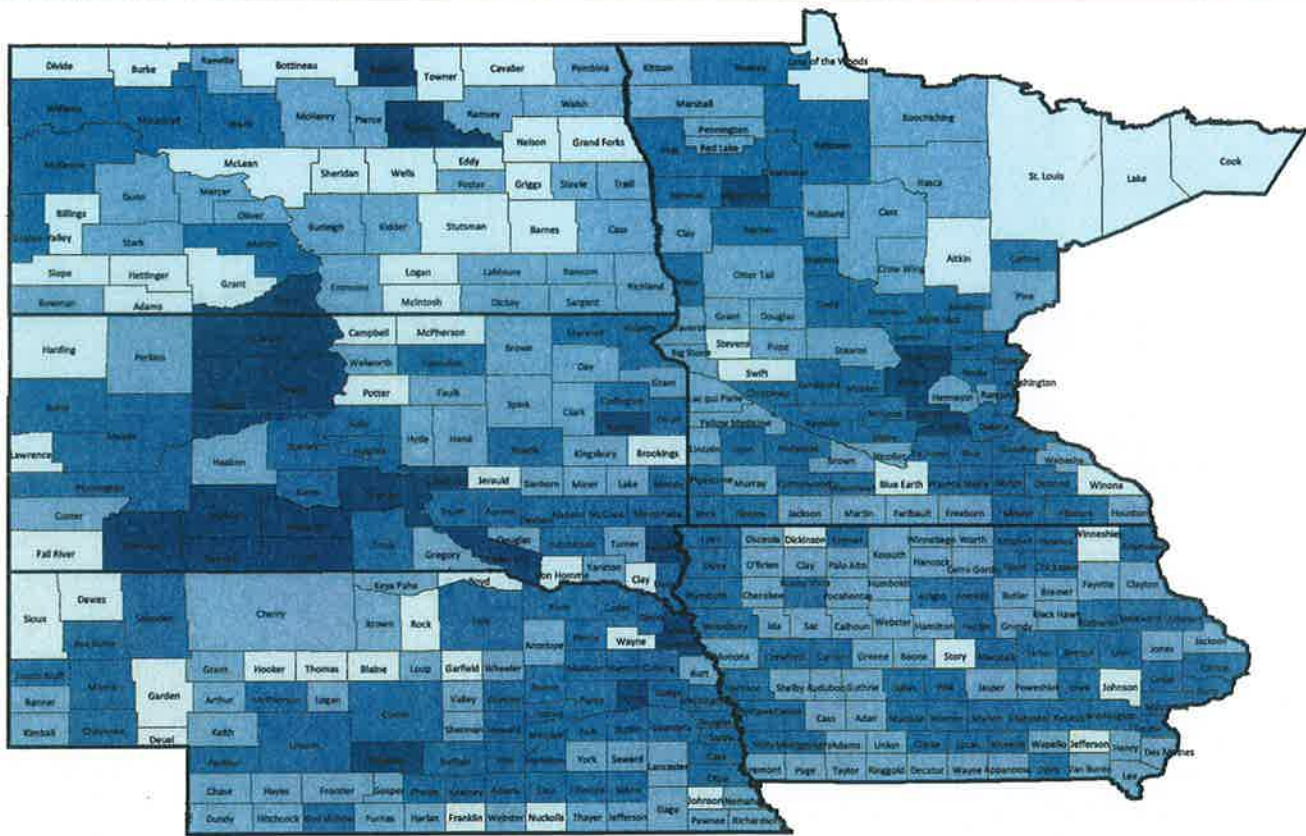
**Importance:** The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse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

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

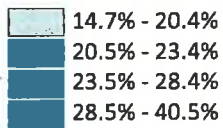
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Youth - A demographic measure

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



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



CONTEXT

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

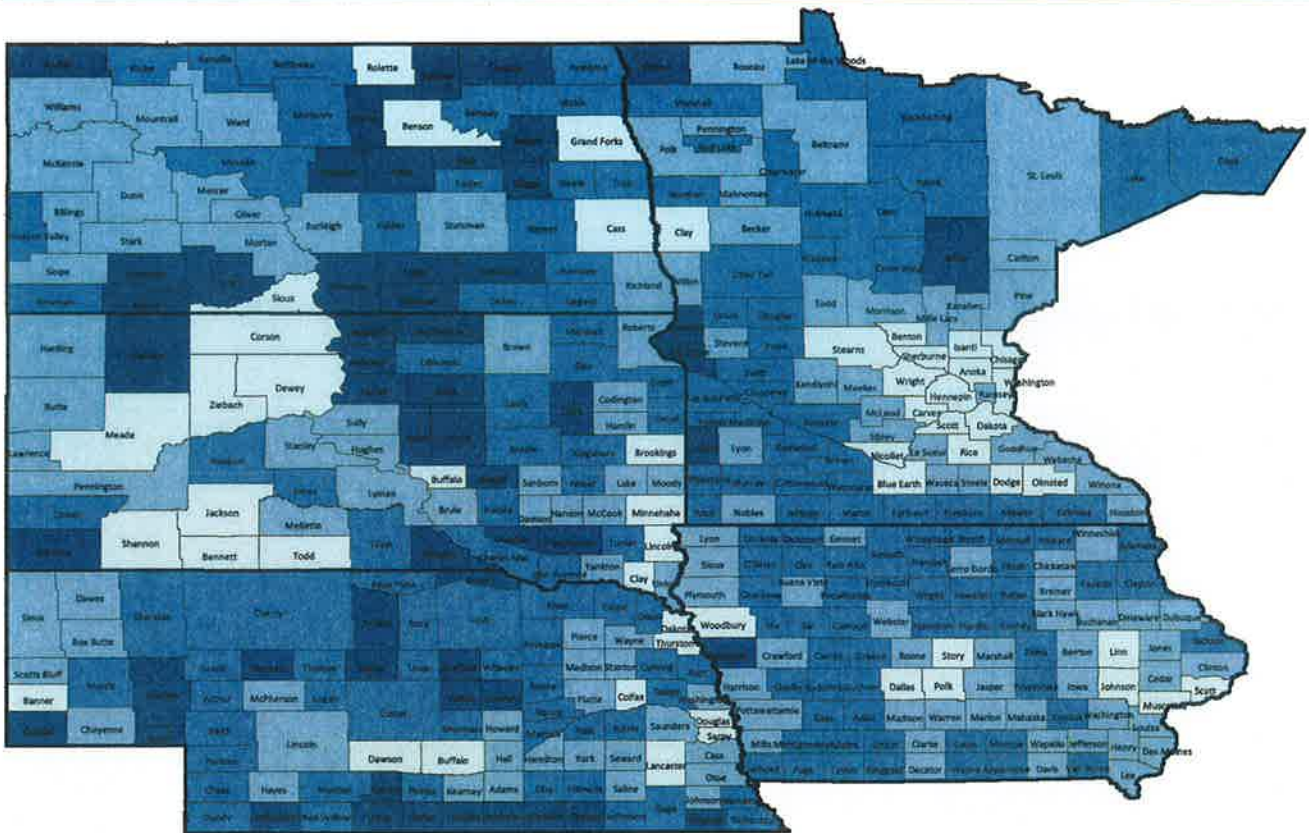
**Where It Comes From:** County demographic figures come from the U.S. Census Bureau's annual population estimates.

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

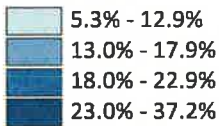
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# Elderly - A demographic measure

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



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



## CONTEXT

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

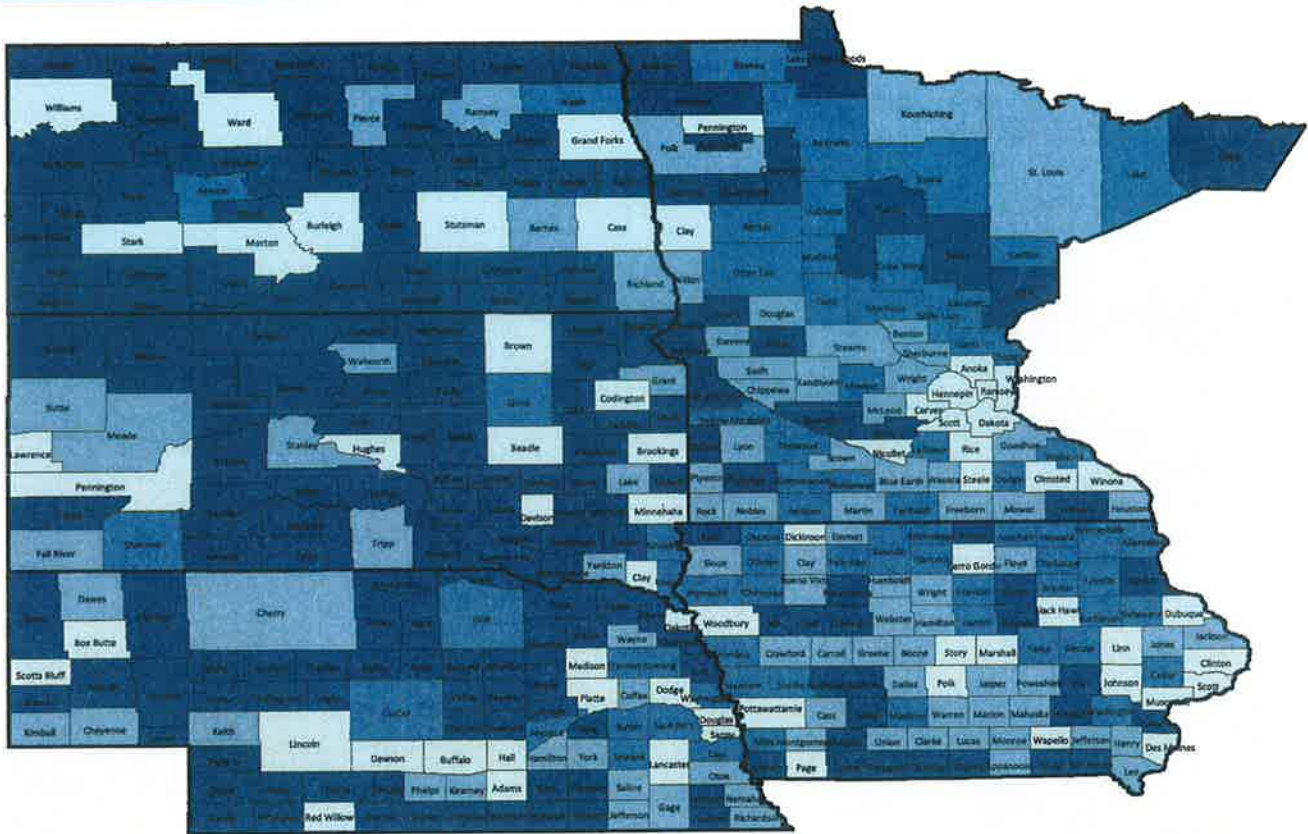
**Where It Comes From:** County demographic figures come from the U.S. Census Bureau's annual population estimates.

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

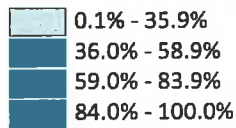
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Rural - A demographic measure

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



Percent of total population living in a rural area, 2000



CONTEXT

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

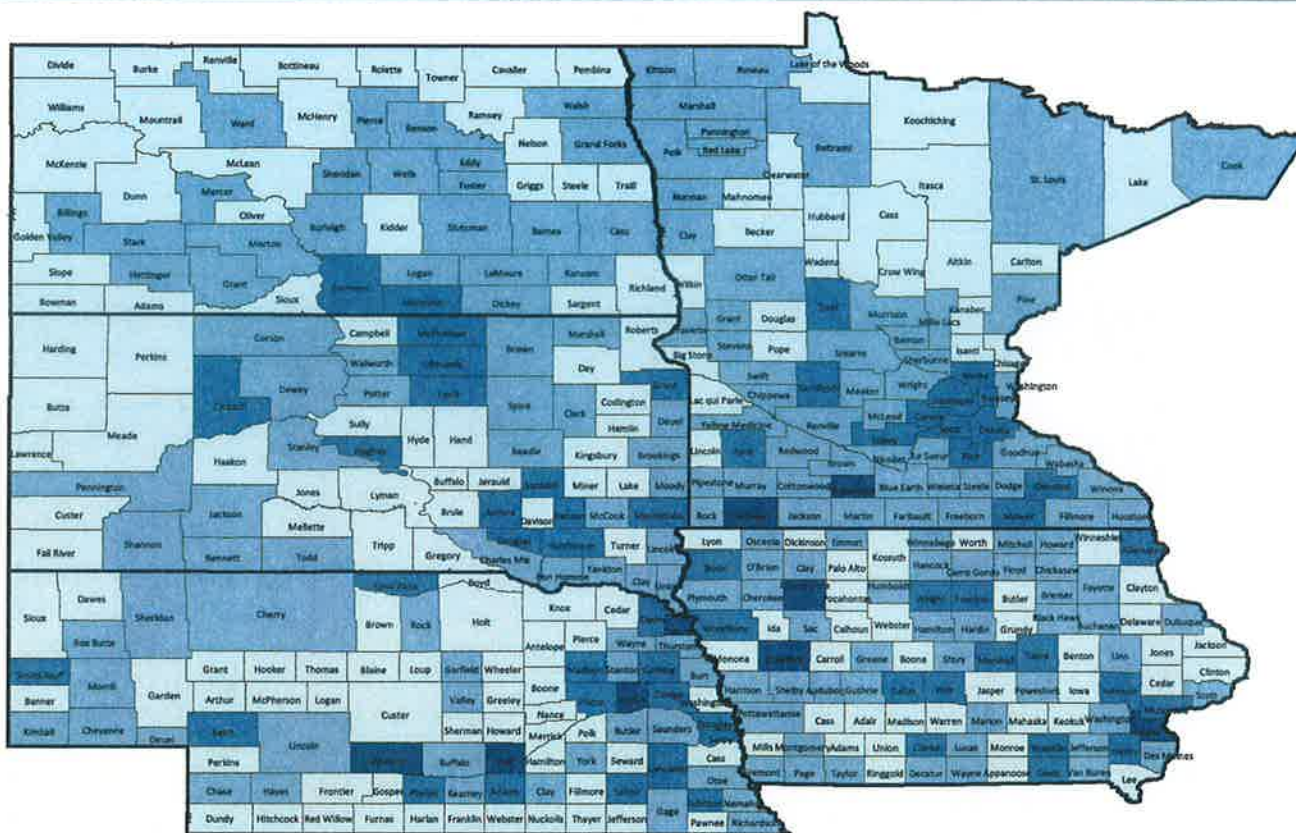
**Where It Comes From:** This measure is calculated by the U.S. Census Bureau using data from 2000.

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

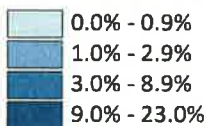
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# Not English Proficient - A demographic measure

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



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



### CONTEXT

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

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

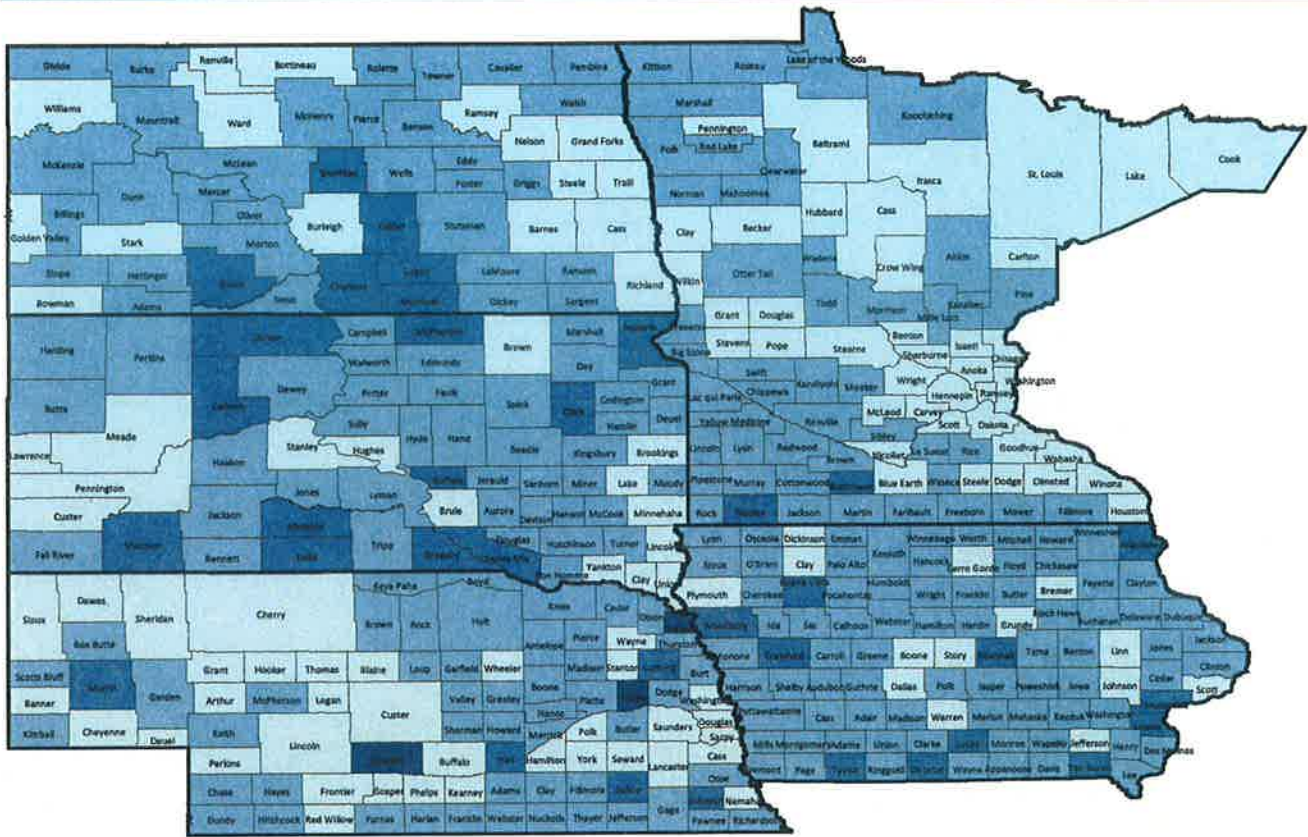
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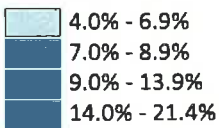


Illiteracy - A demographic measure

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



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



CONTEXT

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

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

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

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**Table 1**  
**Community Health Needs Assessment Asset Mapping**  
**Chamberlain Stakeholders**

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
<b>Access</b>	<ul style="list-style-type: none"> <li>• Need FT physicians &amp; PAs who live in the community rather than relying on visiting specialists</li> <li>• Need PAs who can prescribe medication in emergency situations</li> <li>• We have limited resources here (Kennebec &amp; Kimball)</li> <li>• There are many days when there is no doctor or PA in the clinic</li> <li>• Lack of outreach to our community</li> <li>• Need an urgent care or walk-in facility</li> <li>• Need evening hours at the clinic</li> <li>• Access to specialty physicians – pediatrician, neurologist, oncologist, stroke specialist, OB/Gyn</li> </ul>	<p>Telemedicine is available for dermatology and neurology</p> <p>Actively recruiting for 1 FP. Adding additional 1 FP beginning Oct 1.</p>	
<b>Cancer</b>	<ul style="list-style-type: none"> <li>• Concern with increasing rate of cancer &amp; needing to travel out of town to get cancer treatment</li> </ul>	<p>Sanford Cancer Biology Research Center</p> <p>Colon cancer screenings, fixed digital mammo</p>	
<b>Cardiac</b>	<ul style="list-style-type: none"> <li>• Concern with heart disease &amp; needing to travel out of town to get treatment</li> </ul>	<p>Dr. Stys from the Sanford Heart Hospital is here twice per month.</p>	
<b>Child Care</b>	<ul style="list-style-type: none"> <li>• Need an adequate number of day care providers</li> </ul>	<p>2 new daycares have opened, there have been conversations about expanding daycare hours</p>	
<b>Chronic Disease</b>	<ul style="list-style-type: none"> <li>• Concern about arthritis &amp; diabetes</li> <li>• Need diabetes services locally</li> </ul>	<p>Sanford WebMD Fit Kids,</p> <p>RN Health coach has been hired</p>	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
City Services County Services City Govt.	<ul style="list-style-type: none"> <li>Need strong, efficient, consistent, continuum healthcare for the chronically ill</li> <li>Lots of litter &amp; dirt along the curbs – especially on Main Street</li> </ul>	Plans for diabetic educator  Will share results with city leaders	
Competition Dental Care	<ul style="list-style-type: none"> <li>Need Sanford &amp; Avera to work better together</li> <li>Shortage of dentists</li> </ul>	Avera has access to our EMR Will share this information with county public health	
Economic Situation/ Business community	<ul style="list-style-type: none"> <li>Need to keep our young people in the community</li> <li>Concerned about lack of business development</li> <li>High percentage of child poverty</li> <li>High percent of adults with inadequate social support</li> </ul>	<ul style="list-style-type: none"> <li>Scholarships</li> <li>Prairie Futures</li> <li>Scrubs Camp/Camp Med</li> <li>GOOS committee (grow your own staff)</li> </ul>	
Education	<ul style="list-style-type: none"> <li>Need a community health fair</li> <li>Percentage of high school grads is low at 80% compared to 92% nation wide</li> <li>Lower percent of “some college” at 57% compared to 68% nation wide</li> </ul>	<ul style="list-style-type: none"> <li>HealthFair is October 27<sup>th</sup> (2<sup>nd</sup> Annual)</li> <li>Scrubs Camp for high school students</li> <li>Camp Med</li> </ul>	
Emergency Care	<ul style="list-style-type: none"> <li>Need faster, more efficient ER services at Chamberlain hospital</li> <li>Need access to emergency services</li> </ul>	<ul style="list-style-type: none"> <li>MS QMI committee reviews of patient surveys</li> <li>Med Staff QMI</li> <li>MS scripting committee</li> </ul>	
Health Factors	<ul style="list-style-type: none"> <li>High number of sexually transmitted diseases</li> <li>Low ratio of dentists per population</li> <li>High number of hospital readmissions</li> </ul>	Will share this information with the county public health officer	✓
Healthcare Cost/Insurance Cost	<ul style="list-style-type: none"> <li>Concern about the high cost of healthcare &amp; healthcare insurance</li> <li>High rate of uninsured adults and youth</li> </ul>	Sanford Community Care Program Financial Consultant is available	
Home Care	<ul style="list-style-type: none"> <li>Lack of home health care is a concern because of the aging population</li> </ul>	Sanford Home Health is available through local Chamberlain office. Visit with state leaders regarding limited reimbursement in Home Health arena.	✓

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
<b>Housing</b>	<ul style="list-style-type: none"> <li>Lack of nice rental homes</li> </ul>	<p>Will share this information with community leaders</p>	
<b>Healthy Nutrition</b>	<ul style="list-style-type: none"> <li>Groceries are expensive here</li> <li>67% have access to healthy foods compared to 92% nationwide</li> </ul>	<ul style="list-style-type: none"> <li>Dietician is on staff for consults</li> <li>Kids Camp is provided for education on health eating and exercise</li> <li>Sanford WebMD – Fit Kids</li> </ul>	
<b>Judicial / Police</b>	<ul style="list-style-type: none"> <li>Lack of law enforcement</li> </ul>		
<b>Mental Health</b>	<ul style="list-style-type: none"> <li>Shortage of mental health services &amp; qualified mental health staff</li> <li>No organized commitment process in extreme cases</li> <li>Concerned with suicide rate</li> <li>Concerned with depression</li> </ul>	<ul style="list-style-type: none"> <li>Sanford One Care</li> <li>Dr. Weimers psychiatrist</li> <li>Patty Juhnke, social worker, on staff</li> </ul>	
<b>Mortality and Morbidity</b>	<ul style="list-style-type: none"> <li>Higher incidence or premature death than state and nation</li> </ul>	<ul style="list-style-type: none"> <li>Free prenatal classes</li> <li>CPR education upon birthing discharge</li> </ul>	
<b>Native Americans</b>	<ul style="list-style-type: none"> <li>Stolen lands, treaty rights, abuse, Government not keeping promises</li> <li>Indian Health Service is slow to refer to a specialist – most services offered are “bandaids”</li> <li>Indian Health Service lacks confidentiality</li> <li>Would like IHS to provide services after hours</li> <li>Need more qualified personnel in the Tribal Mental Health Dept.</li> <li>We have tribal programs for wellness but need to motivate/publicize</li> <li>Lots of funding for the tribes but it never reaches the people – why? Clean it up &amp; get rid of 3<sup>rd</sup> parties.</li> </ul>	<ul style="list-style-type: none"> <li>Cultural Education</li> <li>Financial Consultant travels to Fort Thompson and Lower Brule IHS clinics</li> </ul>	
<b>Obesity</b>	<ul style="list-style-type: none"> <li>Concern over obesity &amp; how it is at the root of all other healthcare issues</li> </ul>	<ul style="list-style-type: none"> <li>Sanford WebMD Fit Kids</li> <li>Health Coach</li> <li>River City Fitness Gym</li> <li>Gym in PT open for employees</li> </ul>	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Physicians	<ul style="list-style-type: none"> <li>Lack of understanding by patients of what the doctor says</li> <li>Coordination &amp; communication among providers</li> </ul>	<ul style="list-style-type: none"> <li>Provider meeting monthly</li> <li>MS subcommittee scripting</li> </ul>	
Pollution	<ul style="list-style-type: none"> <li>Noise pollution from loud music (from one downtown bar especially)</li> <li>Concern about second-hand smoke</li> <li>River is polluted</li> <li>City water is not safe</li> <li>Substation &amp; electricity towers are causing sickness</li> </ul>	Will share this information with community leaders	
Poverty	<ul style="list-style-type: none"> <li>Widening gap because of poverty</li> </ul>	Sanford Community Care Financial counselors	
Prevention Services	<ul style="list-style-type: none"> <li>Concern about whooping cough</li> <li>Need more preventive services</li> </ul>	Sanford WebMD Fit Kids  Will share this information with public health officers	
Schools	<ul style="list-style-type: none"> <li>Need a knowledgeable school board</li> <li>Need some academic improvements</li> </ul>	Will share this information with school leadership	
Substance Abuse	<ul style="list-style-type: none"> <li>Concern about synthetic drug abuse, pain pill abuse</li> <li>Need education on substance abuse</li> <li>Concerned with addicts having children</li> <li>Higher incidence of excessive drinking</li> </ul>	<ul style="list-style-type: none"> <li>Sanford One Care</li> <li>Credentialed Psychiatrist, Dr. Weimers, available</li> <li>On Staff Social Worker (MSW)</li> </ul>	
Technology	<ul style="list-style-type: none"> <li>Would like to have telemedicine available to access specialists rather than driving 4-5 hours to Sioux Falls</li> <li>Concern about access to technology/equipment</li> </ul>	Telemedicine Grant	
Traffic/City Infrastructure	<ul style="list-style-type: none"> <li>Too many car accidents due to drunk driving &amp; underage driving</li> </ul>	Will share this information with community leaders	
Transportation	<ul style="list-style-type: none"> <li>Could use a taxi service</li> <li>Transportation issues</li> </ul>	<ul style="list-style-type: none"> <li>CHR</li> <li>Sanford Van is available</li> <li>Will share this information with community leaders</li> </ul>	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
<b>Wellness</b>	<ul style="list-style-type: none"> <li>• No workout facility</li> <li>• Need community wellness programs – something coordinated between Sanford &amp; the school system</li> </ul>	<ul style="list-style-type: none"> <li>• Sanford WebMD Fit Kids</li> <li>• River City Gym is available</li> </ul>	
<b>Youth</b>	<ul style="list-style-type: none"> <li>• Concern about loss of identity, culture, tradition as kids look to what they see on TV for culture</li> <li>• Teen dating violence</li> <li>• Drug &amp; alcohol use</li> <li>• Bullying issues</li> <li>• Obesity (especially in younger children)</li> <li>• Lack of good diet &amp; exercise</li> <li>• Concern with amount of screen time</li> <li>• Lack of parental involvement in lives of children – expecting the school to fulfill that role</li> </ul>	<p>Sanford WebMD Fit Kids Sanford One Care</p> <p>Will share this information with community leaders and public health</p>	
<b>Sanford Specific</b>	<ul style="list-style-type: none"> <li>• Lack of healthcare providers on Monday &amp; Fridays at the Sanford Clinic</li> <li>• Need faster, more efficient ER services at Chamberlain hospital</li> <li>• Rude staff at emergency room or clinic – no greeting, smile, hello</li> <li>• Concern about poor attitude toward Native Americans who come to the hospital</li> <li>• Concerned about the quality of care</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural Diversity Committee</li> <li>• Customer Service Training</li> <li>• Annual Quality Fair (local and network)</li> <li>• MS scripting</li> </ul>	

**Table 2**

**Prioritization Worksheet**

**Criteria to Identify Priority Problem**

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

**Criteria to Identify Intervention for Problem**

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

<b>Health Indicator/Concern</b> <i>(from asset mapping and gaps analysis worksheet)</i>	<b>Round 1 Vote</b>	<b>Round 2 Vote</b>	<b>Round 3 Vote</b>
Urgent care/after hours clinic/availability of providers	6	6	7
Housing	2		
Diabetes services locally	2		
Outreach doctors (specialties) to community	1		
Keep young people in community	3	2	
Cancer – travel out of town to get treatment	4	1	
Mental health shortage/suicide incidence	5	4	5
Substance abuse	4	2	
Dental care shortage	1		
Obesity	2		
Higher incidence of premature death	3	1	
Community wellness program	5	2	
Transportation issues	2		
Bullying	2		

