



Dear Community Members,

Sanford Medical Center Rock Rapids is pleased to present the 2018 Community Health Needs Assessment (CHNA).

Sanford completes a community health needs assessment every three years. It is through this work that we identify the unmet needs in the community and strategically plan how we can best address those needs. The CHNA process aligns with Sanford's mission - *Dedicated to the work of health and healing.* 

During 2017 and 2018, members of the community were invited to complete a survey to help identify the unmet needs. Key stakeholders completed a survey to identify concerns for the community related to economic well-being, transportation, children and youth, the aging population, safety, access to services, and mental and behavioral health. Sanford analyzed the data from the primary research and met with key stakeholders to prioritize the identified needs. Our strategies to address the needs are included in this report.

Sanford will address the following health needs in a formalized implementation strategy for the 2019-2021 fiscal years:

- Obesity
- Chronic Disease

The CHNA also focused on the strengths of our community and includes the many community assets that are available to address the community health needs. We have also included an impact report from our 2016 implementation strategies.

Sanford Rock Rapids is committed to extending care beyond our bricks and mortar. We are committed to meeting the health care needs of the broader community. Together, we can fulfill our mission.

Sincerely,

Jammy Roshmer

Tammy Loosbrock Senior Director Sanford Rock Rapids Medical Center

# **Table of Contents**

	Page
Executive Summary	4
Community Health Needs Assessment	8
Purpose	9
Our Guiding Principles	9
Regulatory Requirements	9
Study Design and Methodology	10
Limitations of the Study	11
Acknowledgements	11
Description of Medical Center	14
Description of Community Served	15
Key Findings	16
Demographic Information for Community Resident Participants	24
Secondary Research Findings	26
Health Needs and Community Resources Identified	27
Prioritization Worksheet	28
How Sanford Rock Rapids is Addressing the Needs	29
Implementation Strategies	33
<ul> <li>Implementation Strategies – 2019-2021</li> </ul>	
<ul> <li>Implementation Strategy Action Plan – 2019-2021</li> </ul>	
<ul> <li>Demonstrating Impact – 2017-2019 Strategies</li> </ul>	
<ul> <li>Demonstrating Impact through Outcomes - 2017-2019 Strategies</li> </ul>	
Community Feedback from the 2016 Community Health Needs Assessment	39
Appendix	40
Primary Research	
o Asset Map	
o Resident Survey	
<ul> <li>Prioritization Worksheet</li> </ul>	
Secondary Data	

- o Definitions of Key Indicators
- County Health Rankings

# Sanford Rock Rapids Medical Center

# 2018 Community Health Needs Assessment

## **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 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 the not-for-profit status and create opportunity to identify and address public health issues from a broad perspective. A community health needs assessment identifies the community's strengths and areas for improvement. 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.

#### **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 are essential to success
- Sanford Health is invited into the communities we serve

#### **Regulatory Requirements**

Federal regulations stipulate that non-profit medical centers conduct a community health needs assessment at least once every three years and prioritize the needs for the purpose of implementation strategy development and submission in accordance with the Internal Revenue Code 501(r).

The Internal Revenue Code 501(r) 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.

The regulations stipulate that each medical center take into account input from persons who represent the broad interests of the community. We are required to seek at least one state, local, tribal or regional government public health department or state Office of Rural Health with knowledge, information or expertise relevant to the health needs of the community.

Non-profit hospitals are required to seek input from members of medically underserved, low income, and minority populations in the community, or organizations serving or representing the interest of such

populations, and underserved populations experiencing disparities or at risk of not receiving adequate care as a result of being uninsured or due to geographic, language, financial or other barriers.

The community health needs assessment includes a process to identify community resources that are available to address the assessed needs and to prioritize the needs.

Hospitals are to address each and every assessed need or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on the IRS 990 and a status report must be provided each year on IRS 990 Schedule H.

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for it. Sanford places the CHNA reports and the implementation strategies on the Sanford website. Hospitals are required to keep three cycles of assessments on the web site. The 2018 report will be Sanford's third report cycle since the requirements were enacted in 2010.

#### **Study Design and Methodology**

- 1. Primary Research
  - A. Resident Survey

The resident survey tool includes questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a link to the survey was sent by email to members of the community. A total of 45 community residents participated in the survey.

B. Community Asset Mapping

Asset mapping was conducted to find the community resources available to address the assessed needs. Each unmet need was researched to determine what resources were available to address the needs. Once gaps were determined, the prioritization exercise followed with key stakeholder groups determining the top needs.

C. Prioritization Process

The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies.

#### 2. Secondary Research

- A. The 2018 County Health Rankings were reviewed and included in the report and in the asset mapping process.
- B. The U.S. Census Bureau estimates were reviewed.
- C. Community Commons were reviewed and specific data sets were considered. The Community Commons link is https://www.communitycommons.org/maps-data/.

#### **Limitations of the Study**

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Lyon County. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs but there is still a need to capture demographics that better represent the community. This is part of our CHNA continuous improvement process.

Internal Revenue Code 501(r) 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; and 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. We worked closely with public health experts throughout the assessment process.

Public comments and responses to the community health needs assessment and the implementation strategies are welcome on the Sanford website or contact can be made at <a href="https://www.sanfordhealth.org/contact-us/form">https://www.sanfordhealth.org/contact-us/form</a>.

## **Key Findings**

#### **Community Health Concerns**

The resident survey addresses personal health needs and concerns. The secondary research provides further understanding of the health of the community and in many cases the indicators are aligned and validate our findings.

#### **General Health**

- Ninety-eight percent of survey participants ranked their health as good or better.
- Body mass index indicates that 68% are overweight or obese.
- Only 35% are getting the recommended amount of fruits and vegetable each day.
- Fifty-two percent are getting moderate exercise at least three times each week.
- Thirty-three percent have a past diagnosis of arthritis.
- Twenty-nine percent have a past diagnosis of hypertension.

#### **Food Insecurity**

• Nine percent of survey participants ran out of food before having money to buy more.

#### **Children and Youth**

• Twenty-four percent of survey participants do not always use seat belts for their children, and twenty percent do not always use car seats.

#### Health Care Access

- Twenty-five percent have not had a routine check-up in more than a year.
- Over twelve percent have not visited a dentist in more than a year.

#### Mental Health and Substance Abuse

- Forty-nine percent have a past diagnosis of anxiety.
- Thirty-eight percent have a past diagnosis of depression.
- Thirty-one percent report binge drinking at least once a month.

Community stakeholders worked through a multi-voting prioritization process to determine the top priorities and needs of the community.

Sanford Rock Rapids will address the following health needs in a formalized implementation strategy for the 2019-2021 fiscal years:

- Obesity
- Chronic Disease

### **Implementation Strategies**

#### Priority 1: Obesity

According the Center for Disease Control, Obesity is a complex health issue to address. Obesity can be caused from a combination of contributing factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors in our society include the food and physical activity environment, education and skills, and food marketing and promotion.

Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and is associated with morbidity and illnesses including diabetes, heart disease, stroke, and some types of cancer.

Sanford has made obesity reduction a significant priority and has developed strategies to offer support programs that can reduce obesity rates and improve overall health.

#### Priority 2: Chronic Disease

Sanford has made chronic disease a significant priority and has developed strategies to reduce mortality and morbidity from chronic disease. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by chronic diseases.

# Sanford Rock Rapids Medical Center Community Health Needs Assessment 2018

# Sanford Rock Rapids Medical Center

# Community Health Needs Assessment 2018

#### 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 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 the not-for-profit status and create opportunity to identify and address public health issues from a broad perspective. A community health needs assessment identifies the community's strengths and areas for improvement. 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.

#### **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 are essential to success
- Sanford Health is invited into the communities we serve

#### **Regulatory Requirements**

Federal regulations stipulate that non-profit medical centers conduct a community health needs assessment at least once every three years and prioritize the needs for the purpose of implementation strategy development and submission in accordance with the Internal Revenue Code 501(r).

The Internal Revenue Code 501(r) 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.

The regulations stipulate that each medical center take into account input from persons who represent the broad interests of the community. We are required to seek at least one state, local, tribal or regional government public health department or state Office of Rural Health with knowledge, information or expertise relevant to the health needs of the community.

Non-profit hospitals are required to seek input from members of medically underserved, low income, and minority populations in the community, or organizations serving or representing the interest of such

populations, and underserved populations experiencing disparities or at risk of not receiving adequate care as a result of being uninsured or due to geographic, language, financial or other barriers.

The community health needs assessment includes a process to identify community resources that are available to address the assessed needs and to prioritize the needs.

Hospitals are to address each and every assessed need or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on the IRS 990 and a status report must be provided each year on IRS 990 Schedule H.

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for it. Sanford places the CHNA reports and the implementation strategies on the Sanford website. Hospitals are required to keep three cycles of assessments on the web site. The 2018 report will be Sanford's third report cycle since the requirements were enacted in 2010.

#### **Study Design and Methodology**

- 1. Primary Research
  - A. Resident Survey

The resident survey tool includes questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a link to the survey was sent by email to members of the community. A total of 45 community residents participated in the survey.

B. Community Asset Mapping

Asset mapping was conducted to find the community resources available to address the assessed needs. Each unmet need was researched to determine what resources were available to address the needs. Once gaps were determined, the prioritization exercise followed with key stakeholder groups determining the top needs.

C. Prioritization Process

The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies.

#### 2. Secondary Research

- A. The 2018 County Health Rankings were reviewed and included in the report and in the asset mapping process.
- B. The U.S. Census Bureau estimates were reviewed.
- C. Community Commons were reviewed and specific data sets were considered. The Community Commons link is https://www.communitycommons.org/maps-data/.

#### **Limitations of the Study**

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Lyon County. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs but there is still a need to capture demographics that better represent the community. This is part of our CHNA continuous improvement process.

Internal Revenue Code 501(r) 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; and 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. We worked closely with public health experts throughout the assessment process.

Public comments and responses to the community health needs assessment and the implementation strategies are welcome on the Sanford website or contact can be made at <a href="https://www.sanfordhealth.org/contact-us/form">https://www.sanfordhealth.org/contact-us/form</a>.

#### Acknowledgements

Sanford Health would like to thank and acknowledge the Steering Committees for their assistance and expertise while conducting the assessment and analysis of the community needs.

Sanford Steering Group:

- Sara Ballhagen, Administrative Assistant, Sanford Wheaton
- Stacy Barstad, Senior Director, Sanford Tracy and Sanford Westbrook
- Rob Belanger, Clinic Director, Sanford Bagley
- Catherine Bernard, Tax Manager, Corporate Accounting, Sanford Health
- Michelle Bruhn, Senior Vice President, Finance, Health Services Division, Sanford Health
- Randy Bury, Chief Administrative Officer, Sanford Health
- Brian Carlson, Executive Director, Sanford Thief River Falls
- Denise Clouse, Marketing Coordinator, Sanford Tracy
- Ashley Erickson, Senior Director, Sanford Aberdeen
- JoAnn Foltz, Senior Director, Sanford Wheaton
- Isaac Gerdes, Senior Director, Sanford Webster
- Paul Gerhart, Director of Fiscal Services, Sanford Canton
- Julie Girard, Improvement Advisor, Sanford Vermillion
- Paul Hanson, President, Sanford Sioux Falls
- Joy Johnson, VP of Operations, Sanford Bemidji
- JoAnn Kunkel, Chief Financial Officer, Sanford Health
- Mary Lake, Executive Assistant, Sanford Health Network Fargo Region
- Amber Langner, Senior Director of Finance, Corporate Accounting, Sanford Health
- Scott Larson, Senior Director, Sanford Canton

- Tiffany Lawrence, VP, Finance, Sanford Fargo
- Martha Leclerc, VP, Corporate Contracting, Sanford Health
- Tammy Loosbrock, Senior Director, Sanford Luverne and Sanford Rock Rapids
- Carrie McLeod, Sanford Community Health Improvement/Community Benefit Director
- Jac McTaggart, Senior Director, Sanford Hillsboro and Sanford Mayville
- Rick Nordahl, Senior Director, Sanford Sheldon
- Erica Peterson, Senior Director, Sanford Chamberlain
- Gwen Post, Director of Nursing and Clinical Services, Sanford Worthington
- Dawn Schnell, Senior Director, Sanford Jackson
- Lori Sisk, Senior Director, Sanford Canby and Sanford Clear Lake
- Jennifer Tewes, Clinic Supervisor, Sanford Jackson
- Tim Tracy, Senior Director, Sanford Vermillion
- Ruth Twedt, Manager of Ancillary Services, Sanford Clear Lake
- Marnie Walth, Senior Legislative Affairs Specialist, Sanford Bismarck
- Jennifer Weg, Executive Director, Sanford Worthington

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

- Clinton Alexander, Fargo Moorhead Native American Center
- Kristin Bausman, Becker County Public Health
- Justin Bohrer, Fargo Cass Public Health
- Pam Bonrud, Northwestern Energy
- Cynthia Borgen, Beltrami Public Health
- Jackie Buboltz, Essentia Health
- Anita Cardinal, Pennington County Public Health
- Leah Deyo, Essentia Health
- Peter Ekadu, Nobles County Public Health
- Stacie Golombiecki, Nobles County Public Health
- Christian Harris, New American Consortium
- Caitlyn Hurley, Avera Health
- Deb Jacobs, Wilkin County Public Health
- Joy Johnson, Sanford Health
- Ann Kinney, PhD, Minnesota Department of Health
- Krista Kopperud, Southwest Health and Human Services
- Ann Malmberg, Dakota Medical Foundation Mayors' Blue Ribbon Commission on Addiction
- Kathy McKay, Clay County Public Health
- Jac McTaggert, Sanford Health
- Mary Michaels, Sioux Falls Department of Health
- Teresa Miler, Avera Health
- Renae Moch, Burleigh County Public Health
- Brittany Ness, Steele County Public Health
- Ruth Roman, Fargo Cass Public Health
- Kay Schwartzwalter, Center for Social Research, NDSU
- Becky Secore, Beltrami Public Health
- Julie Sorby, Family HealthCare Center
- Brenda Stallman, Traill County Public Health

- Diane Thorson, Ottertail County Public Health
- Juli Ward, Avera Health
- MayLynn Warne, North Dakota Public Health Association

We extend our special thanks to the community and county leaders, public health administration, physicians, nurses, legislators and community representatives for diverse populations for their participation in this work. Together we are reaching our vision "to improve the human condition through exceptional care, innovation and discovery."

# Description of the Medical Center Sanford Rock Rapids Medical Center – Rock Rapids, Iowa



Sanford Rock Rapids Medical Center is a 16-bed Critical Access Hospital serving Lyon County, Iowa with its primary service area including Rock Rapids, George, Little Rock, Lester, Alvord and Doon, and its secondary service area including Larchwood, Steen (MN) and Ellsworth (MN).

Sanford Rock Rapids includes the medical center, Sanford Rock Rapids Clinic, Sanford George Clinic, and Sanford Rock Rapids Fitness Center. Services provided include emergency/trauma, cardiology and surgery.

Sanford Rock Rapids employs 5 clinicians, including physicians and advanced practice providers and over 100 employees. Sanford Rock Rapids Clinic and Sanford George Clinic provide family medicine services. Sanford Rock Rapids Fitness Center offers members 24-hour access to meet their various wellness needs.

# **Description of the Community Served**

Rock Rapids, with a population of 2,500, is the county seat of Lyon County, located in extreme northwest lowa, only 15 miles south of Interstate 90. It is known as the "City of Murals." The Rock Rapids Mural Society was formed in 2002 to re-beautify the town and restore its historic past in artistic form. The first mural was completed in 2002, and the 21<sup>st</sup> mural was completed in 2008.

Rock Rapids is predominately an agricultural community. Larger employers with the community are Sanford Rock Rapids, GlyLyon, and Central Lyon School.

There are many recreational opportunities in the area including fishing, swimming, soccer, baseball, skate park, softball, museums, snowmobiling, ice skating and more.

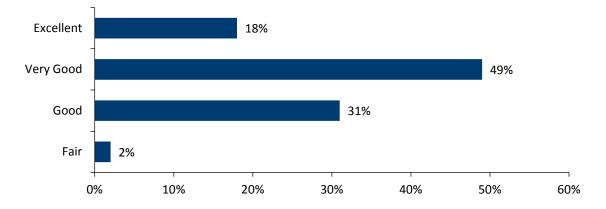
# **Key Findings**

#### **Residents' Health Concerns**

Health is personal and it starts in our homes, schools, workplaces, neighborhoods and communities. Eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor for routine check-ups can positively influence our health.

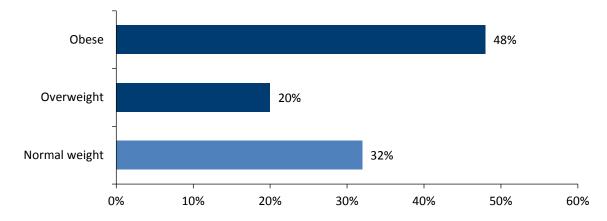
The resident survey asks questions specific to the participant's personal health and health behaviors.

#### How would you rate your health?



Ninety eight percent of survey participants rated their health as good or better.

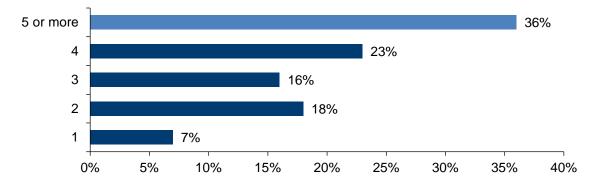
#### Body Mass Index (BMI)



Sixty-eight percent of survey participants are overweight or obese.

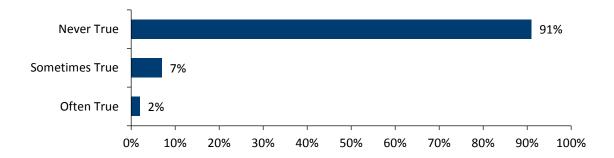
#### **Total Servings of Fruits, Vegetables and Juice**

Only 36% are consuming the recommended 5 or more daily servings of fruit and vegetables.



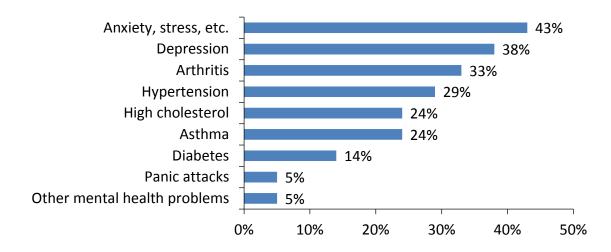
#### **Food insecurity**

Nine percent report running out of food before having money to buy more.



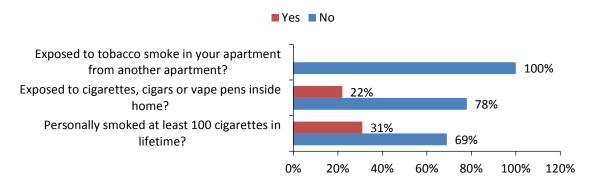
#### **Past Diagnosis**

Anxiety, depression, arthritis, hypertension and high cholesterol are the top diagnoses for the survey participants.



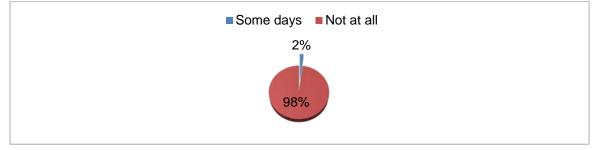
#### **Exposure to Tobacco Smoke**

Twenty-two percent are exposed to cigarettes, cigars or vape pens and thirty-one percent have smoked in their lifetime.



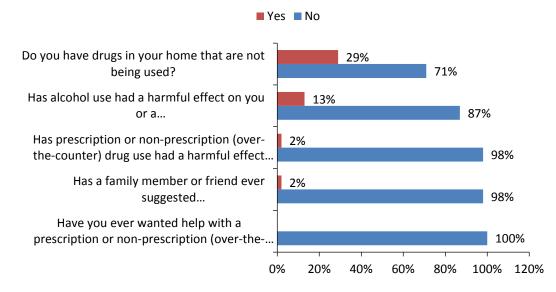
#### Do you currently smoke cigarettes?

Only 2% percent currently smoke cigarettes.



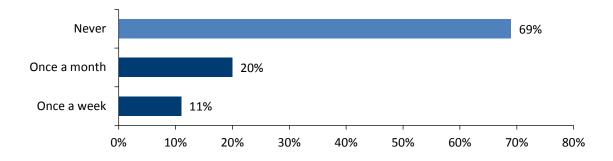
#### **Drug and Alcohol Issues**

Twenty-three percent have drugs in their home that they are no longer using. Fifteen percent report that alcohol has had a harmful effect on them or a member of their family.

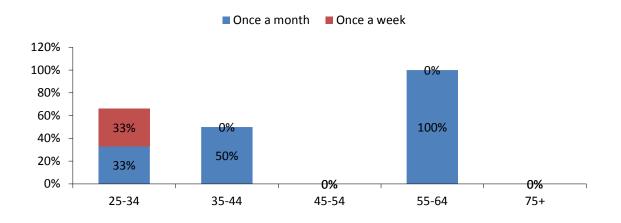


#### **Binge Drinking**

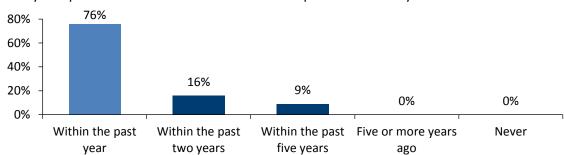
Thirty-one percent binge drink at least once per month.



Binge Drinking Past 30 days by Age



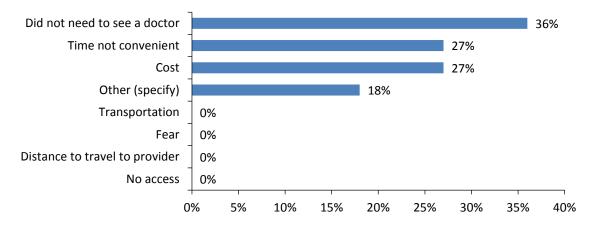
#### How long has it been since you last visited a doctor or health care provider for a routine check-up?



Twenty-five percent have not had a routine check-up in more than a year.

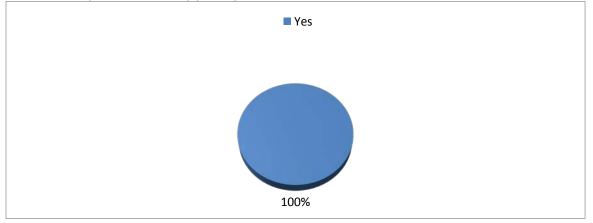
#### **Barriers to Routine Check-up**

Thirty-two percent of survey respondents report not needing a routine check-up and twenty-seven percent report that time is not convenient.



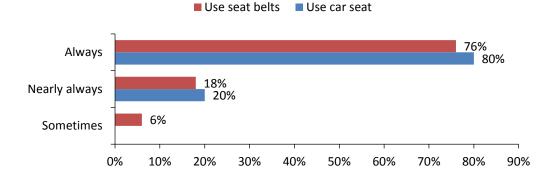
#### Do you have health care coverage for your children or dependents?

One hundred percent of survey participants have health insurance for their children.

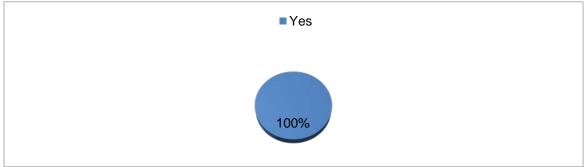


#### **Children's Car Safety**

Twenty-four percent of survey participants do not always use seat belts for their children and twenty percent do not always use car seats.



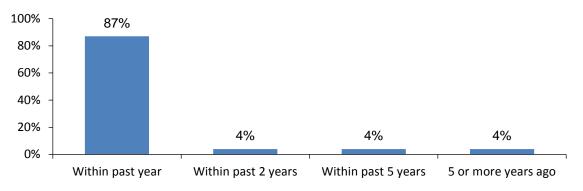
#### Do you currently have any kind of health insurance?



Two percent do not have health care insurance for themselves.

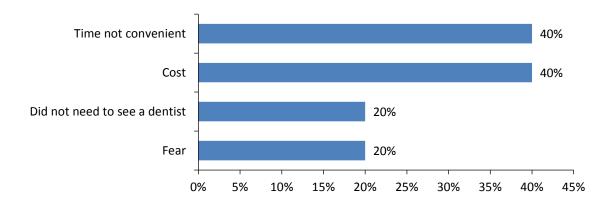
#### How long has it been since you last visited a dentist?

Twelve percent have not visited a dentist in more than a year.

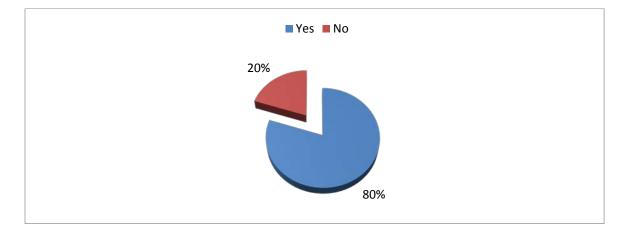


#### **Barriers to Visiting the Dentist**

Forty percent state that cost and convenient time are barriers to receiving dental care.



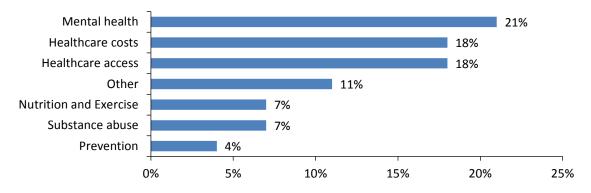
#### Do you have any kind of dental care or oral health insurance coverage?



Twenty percent of survey respondents do not have dental insurance.

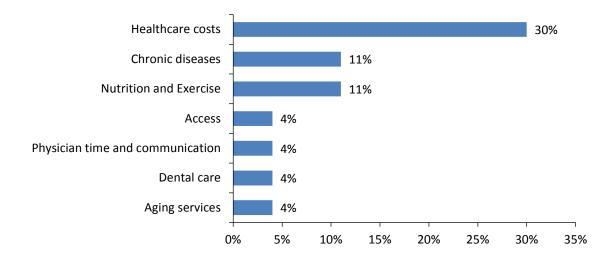
#### **Most Important Community Issues**

Mental health, health care costs, and health care access are the top concerns of respondents for their community.



#### Most Important Issue for Family

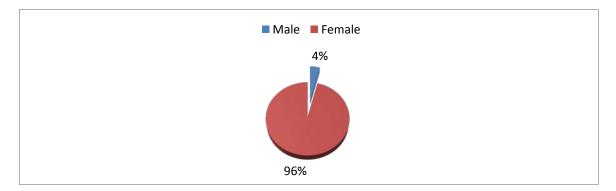
Health care costs, chronic disease, and nutrition and exercise are the top concerns of survey respondents for their family.



# **Demographic Information for Community Resident Participants**

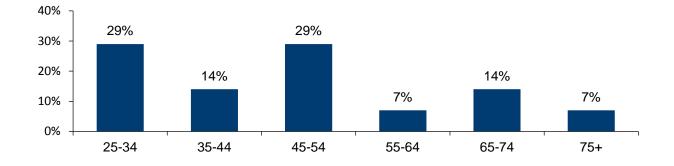
#### **Biological Gender**

Only 4% of the survey participants were male.

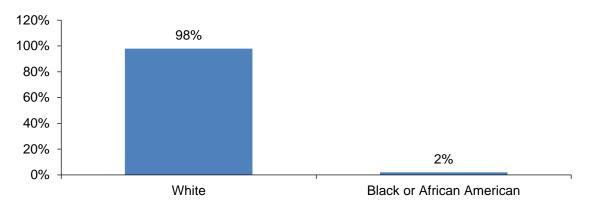


#### Age

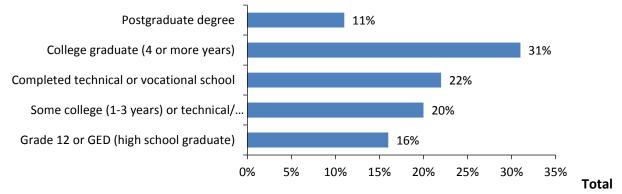
Every age group was represented among the survey participants.





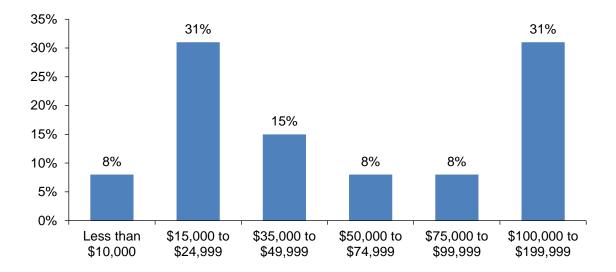


#### **Education Level**



#### **Annual Household Income**

Thirty-nine percent of survey participants have an annual household income at or below the Federal Poverty Level for a family of four.



# Secondary Research Findings

## <u>Census Data</u>

	Lyon County
Population	11,754
% below 18 years of age	28.4
% 65 and older	17.3
% White – non-Hispanic	95.8
American Indian	0.4
Hispanic	2.6
African American	0.2
Asian	0.3
% Female	49.2
% Rural	100

## **County Health Rankings**

	Lyon County	State of Iowa	U.S. Top Performers
Adult smoking	13%	17%	14%
Adult obesity	34%	32%	26%
Physical inactivity	33%	25%	20%
Excessive drinking	22%	22%	13%
Alcohol-related driving deaths	22%	27%	13%
Food insecurity	9%	12%	10%
Uninsured adults	6%	7%	7%
Uninsured children	5%	4%	3%
Children in poverty	9%	15%	12%
Children eligible for free or reduced lunch	26%	41%	33%
Diabetes monitoring	93%	90%	91%
Mammography screening	71%	69%	71%
Median household income	\$62,500	\$56,400	\$65,600

# **Health Needs and Community Resources Identified**

The Internal Revenue Service requires that a community health needs assessment include an inventory of resources that are available to address the unmet needs. This document is referred to as an asset map. Sanford Health conducted asset mapping by reviewing the primary and secondary research and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources are available in the community and county to address the needs. The asset map was reviewed by Sanford leadership and by community key stakeholders to validate the assets. The asset map helped to identify gaps in services. Once gaps were determined the key stakeholder group proceeded to the prioritization discussion and multi-voting exercise. The group was asked to prioritize the top two concerns that would be further developed into implementation strategies.

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

The asset mapping process identified needs from the following:

- Key stakeholder survey
- Resident survey
- Facilitated discussion by the key stakeholders
- Secondary research
- Community resources that are available to address the needs

Please see the asset map in the Appendix.

### Rock Rapids 2018 Community Health Needs Assessment Prioritization Worksheet

#### **Criteria to Identify Priority Problem**

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

#### Criteria to Identify Intervention for Problem

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

#### Health Indicator/Concern

- 68% are overweight or obese
- 64% are not getting their 5 servings/day of fruits and vegetables
- 9% run out of food
- 43% have an anxiety diagnosis
- 38% have a depression diagnosis
- 33% have arthritis
- 29% have hypertension
- 24% have high cholesterol
- 24% have asthma
- 31% binge drink
- 29% have drugs they are not using in their homes
- 32% did not get a flu shot last year
- 24% do not always use seat belts for their children
- 20% do not always use car seats for their children
- 20% do not have dental insurance

# How Sanford Rock Rapids is Addressing the Needs

Identified Concerns	How Sanford Rock Rapids is Addressing the Community Needs			
ECONOMIC WELL BEING				
Skilled labor workforce	<ul> <li>Student internships in many different departments.</li> <li>Contribution to school simulation table for ag- and health-related education.</li> <li>Supporting NCC with tax dollars for radiology and nursing programs a letters of support for referendum.</li> </ul>			
Availability of affordable housing	<ul> <li>Information/need shared with community partners.</li> <li>Participated in community strategic planning reviewing need for affordable housing at all levels.</li> </ul>			
Employment options	Sanford Rock Rapids provides employment opportunities to all educational levels.			
Run out of food before they have money to buy more	<ul> <li>Sanford Rock Rapids RN Health Coach helps link patients to community resources.</li> <li>Sanford Rock Rapids supports local food shelves through staff donations of food as well as through dollars through fundraising.</li> </ul>			
CHILDREN & YOUTH				
Availability of quality childcare	Sanford Rock Rapids provided a donation to Kids Club daycare for outside play equipment.			
Cost of quality childcare	Sanford Rock Rapids will share information with city and community partners.			
Availability of services for at- risk youth	Sanford supports <i>Face it Together</i> , a behavioral health approach to recovery. The BHTT serves as an integral core team member within the patient- centered Medical Home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management.			
	<ul> <li>BHTT key points:</li> <li>BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease.</li> <li>BHTT works to ensure seamless interface between primary care and specialty and/or community based resources.</li> <li>They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.</li> </ul>			
Substance abuse by youth	Sanford supports <i>Face it Together</i> , a behavioral health approach to recovery. The BHTT serves as an integral core team member within the patient- centered Medical Home. The BHTT works with the physician, advanced			

Identified Concerns	How Sanford Rock Rapids is Addressing the Community Needs			
	practice provider, RN Health Coach, nurses, care coordinator assistant, peer			
	support advocate and community partners, all of whom work collaboratively			
	to provide the best care to patients. The BHTT is an important resource for			
	patients and team members for issues related to mental and behavioral			
	health, chemical health, and psychosocial aspects of health and disease, and			
	lifestyle management to support optimal patient functioning. The BHTT is			
	integral in the adult and teen screening performed in the primary care			
	clinics. They provide diagnostic assessments and determine disposition			
	triaged according to level of clinical acuity and medical and psychosocial			
	complexity, on-site crisis assessment and crisis intervention, brief counseling,			
	referrals, and education services across the continuum of care. They also			
	provide follow-up to ensure continuity of care and those patients are			
	receiving appropriate behavioral health management.			
	BHTT key points:			
	• BHTT role is patient-centered and focuses on assisting the primary care			
	medical team in identifying, triaging and effectively helping patients			
	manage behavioral health problems or psychosocial comorbidities of			
	their chronic medical disease.			
	BHTT works to ensure seamless interface between primary care and			
	specialty and/or community based resources.			
	They are able to assist in mental health crisis management and intervention			
	within the clinic setting helping ensure patient safety.			
Bullying	Sanford Rock Rapids will share findings with school.			
Cost of services for at-risk	Sanford's <i>Child's Voice</i> is a nationally accredited Child Advocacy Center in			
youth	nearby Sioux Falls that provides medical evaluations for children who may be			
Teen suicide	victims of abuse and neglect.			
	Sanford supports <i>Face it Together</i> , a behavioral health approach to recovery. The BHTT serves as an integral core team member within the patient-			
	centered Medical Home. The BHTT works with the physician, advanced			
	practice provider, RN Health Coach, nurses, care coordinator assistant, peer			
	support advocate and community partners, all of whom work collaboratively			
	to provide the best care to patients. The BHTT is an important resource for			
	patients and team members for issues related to mental and behavioral			
	health, chemical health, and psychosocial aspects of health and disease, and			
	lifestyle management to support optimal patient functioning. The BHTT is			
	integral in the adult and teen screening performed in the primary care			
	clinics. They provide diagnostic assessments and determine disposition			
	triaged according to level of clinical acuity and medical and psychosocial			
	complexity, on-site crisis assessment and crisis intervention, brief counseling,			
	referrals, and education services across the continuum of care. They also			
	provide follow-up to ensure continuity of care and those patients are			
	receiving appropriate behavioral health management.			
	BHTT key points:			
	BHTT role is patient-centered and focuses on assisting the primary care			
	• DEFITIONE IS Patient-Centered and focuses on assisting the printary care			
	medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of			
	medical team in identifying, triaging and effectively helping patients			
	medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of			

Identified Concerns	How Sanford Rock Rapids is Addressing the Community Needs			
	They are able to assist in mental health crisis management and			
	intervention within the clinic setting helping ensure patient safety.			
AGING POPULATION				
Cost of long-term care	<ul> <li>Sanford providers work to keep seniors healthy and living independently as long as possible. The recent Good Samaritan affiliation will provide the organization with expertise in the area of long-term care and assisted living services and help to create efficiencies for members in the communities that we serve.</li> <li>Sanford Rock Rapids will share with area long-term care providers</li> </ul>			
Cost of memory care	Sanford Rock Rapids will share with area long-term care providers The recent Good Samaritan affiliation will provide the organization with expertise in the area of long-term care and assisted living services and help to create efficiencies for members in the communities that we serve.			
Cost of in-home services	Sanford Rock Rapids will share with area in-home providers The recent Good Samaritan affiliation will provide the organization with expertise in the area of long-term care and assisted living services and help to create efficiencies for members in the communities that we serve.			
SAFETY				
Have drugs in their home that are not being used – 21% HEALTH CARE ACCESS	Sanford Rock Rapids provides education to patients to dispose of medications at the Sheriff's office, Rexall Corner Drug, or Lewis Family Drug.			
Access to affordable health	Sanford Health Plan			
insurance coverage	Sanford Community Care program			
Access to affordable dental insurance coverage	Sanford Rock Rapids will share information with area dentists.			
Availability of non-traditional hours	Sanford Rock Rapids will have longer hours implemented for clinic services in upcoming year.			
Availability of mental health providers	<ul><li>Sanford Rock Rapids will share with community partners.</li><li>Sanford Rock Rapids will implement telehealth psych visits this next year.</li></ul>			
Access to affordable prescription drugs	Sanford Rock Rapids RN Health Coach assists with enrollment into services that help to provide medications at a reduced cost.			
MENTAL HEALTH & SUBSTANCE ABUSE				
Depression	Sanford Rock Rapids RN Health Coach and clinic team continue to focus on depression screening and treatment.			
Drug use & abuse	Sanford Rock Rapids works with area providers in the treatment of substance use.			
Alcohol use & abuse	Sanford Rock Rapids works with area providers in the treatment of substance use.			
Diagnosis of depression – 21%	Sanford Rock Rapids RN Health Coach and clinic team continue to focus on depression screening and treatment.			
Diagnosis of anxiety/stress – 40%	Sanford Rock Rapids RN Health Coach and clinic team continue to focus on anxiety screening and treatment.			
Currently smoke cigarettes – 11%	Sanford Rock Rapids assesses for smoking use, provides education, and the RN Health Coach works with patients who are looking for resources to quit.			
Binge drink at least 1 x / month - 38%	Sanford Rock Rapids clinic and staff encourage healthy lifestyles during preventive visits.			
WELLNESS				
Diagnosis of high cholesterol & hypertension – 29%	Sanford Rock Rapids clinic uses metrics to monitor as part of Medical Home and continues to improve metrics.			

Identified Concerns	How Sanford Rock Rapids is Addressing the Community Needs		
Diagnosed with arthritis – 25%	Sanford Rock Rapids works to assist patients with arthritis diagnosis to maintain independent functioning through education and therapy.		
Obese – 39%	Sanford Rock Rapids is focusing on obesity and overweight as part of quality metrics.		
Overweight – 27%	Sanford Rock Rapids is focusing on obesity and overweight as part of quality metrics.		
Do not eat 5+ fruits/vegetables each day – 61%	Sanford Rock Rapids dietitian, RN Health Coach, and nursing staff encourage healthy lifestyles during visits with patients.		
Do not get moderate exercise at least 3 x / week – 50%	Sanford Rock Rapids dietitian, RN Health Coach, and nursing staff encourage healthy lifestyles during visits with patients.		
Have not had a routine check- up in more than 1 year – 14%	Sanford Rock Rapids will continue to stress the important of routine provider visits at health fairs.		
Did not have a flu shot this past year – 28%	<ul> <li>Sanford Rock Rapids will continue to offer community flu shot walk-in times.</li> <li>Sanford Rock Rapids will partner with community partners who would like to offer flu shots to employees.</li> </ul>		
Have not seen their dentist in more than 1 year – 27%	Sanford Rock Rapids will share findings with area dentist.		

**Implementation Strategies** 

## Implementation Strategies – 2019-2021

#### Priority 1: Obesity

According the Center for Disease Control, Obesity is a complex health issue to address. Obesity can be caused from a combination of contributing factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors in our society include the food and physical activity environment, education and skills, and food marketing and promotion.

Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and is associated with morbidity and illnesses including diabetes, heart disease, stroke, and some types of cancer.

Sanford has made obesity reduction a significant priority and has developed strategies to offer support programs that can reduce obesity rates and improve overall health.

#### Priority 2: Chronic Disease

Sanford has made chronic disease a significant priority and has developed strategies to reduce mortality and morbidity from chronic disease. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by chronic diseases.

# Implementation Strategy Action Plan – 2019-2021

#### <u>Priority 1</u>: Obesity Projected Impact: Decrease obesity rates Goal 1: Provide services and fitness center upgrades to promote healthy lifestyles

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources	Leadership	Note any community partnerships and collaborations-if applicable
Pursue funding to update fitness center, thus drawing people there to work out	Dollars received, equipment updated, memberships increased	Sanford grant office, Sanford Rock Rapids fitness staff and supervisor staff time	Senior Director	City and school partnership, Health Services of Lyon County
Implement programs focusing on chronic diseases and decreasing obesity	Decrease metrics measured for obesity and other chronic conditions	Staff time for: RN Health Coach Diabetic Educator Fitness Center staff	Clinic director Rehab/Fitness supervisor Senior director	Health Services of Lyon County, Area grocery stores

#### Priority 2: Chronic Disease

#### Projected Impact: Improve community health to decrease amount of chronic health conditions Goal 1: Promote healthy nutrition and physical exercise

Actions/Tactics	Measurable	Dedicated	Leadership	Note any community
	outcomes	resources		partnerships and
	& timeline			collaborations-if
				applicable
Support activities focusing	Number of	Sanford Rock	Senior director	Luverne chamber
on healthy eating	activities	Rapids sponsorship		Luverne school
	sponsored and	dollars		Health Services of
	participant			Lyon County
	numbers			Area grocery stores
Utilize Healthy Planet	Medical Home	RN Health Coach	Clinic director,	
registry to identify pre	metric scores	and care	Senior director	
conditions to implement		coordinator		
prevention strategies		assistant staff		
		time, diabetic		
		educator, dietitian		
Increase physical activity	Number of	Fitness center	Senior director,	Area fitness centers,
	memberships	Fitness center staff	Fitness center	Health Services of
	to fitness	RN Health Coach	supervisor	Lyon County
	center, number	Diabetic educator		
	of people			
	reporting			
	increased			
	activity			

# **Demonstrating Impact – FY 2017-2019 Strategies**

## Priority 1: Improving the mental health and aging services of the community

#### **Projected Impact: Improved access and coordination of care**

#### <u>Goal 1:</u> Enhanced access to mental health and substance abuse resources

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Expanded access to behavioral health triage therapist (BHTT) and mental health providers within our service area	Successful referrals to behavioral health	CNO, RN Health Coach	CNO, Clinic director, CEO	Local Mental Health providers, Sanford and Avera mental health practitioners
RN Health Coach partnership with local and Sanford mental health resources to triage patients into appropriate providers	Behavioral Health referrals, decreased PHQ9 scores, improved mental health scores	RN Health Coach	Clinic director, CNO	Local Mental Health providers, Sanford and Avera Mental Health Resources
Leadership to engage in the community collaborative efforts to improve access to mental health providers	Decreased PHQ9 scores, improved mental health scores, Fewer ER visits for mental health diagnosis	CNO, clinic director	CEO	Local Mental Health providers, county agencies, law enforcement
Partnership with Health Services of Lyon County and local mental health providers in providing education to school or other agencies on improving mental health and decreasing substance abuse	Decreased incidence of underage drug and alcohol use	RN Health Coach, Outreach coordinator	CEO, Clinic director	Health Services of Lyon County, Law enforcement, Local mental health providers, School
Provide community education through various avenues such as health fairs or speakers at events on topic of stress management tips/mental health strategies	Decreased mental health scores	Outreach coordinator, RN Health Coach, Marketing	CNO, Clinic director, CEO	

Goal 2: Enhanced availability and access to resources to allow the elderly to stay safe in their homes

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Work with local facilities (LTC and hospital) on discharge to home and home options available for patients to ensure independence and safety at home	Referrals for home care, readmissions	Discharge planner, RN Health Coach	CNO, Clinic director	Health Services of Lyon County, Sanford Sheldon Home Care and Hospice, other area hospice providers
Pharmacist involved in medication instruction to ensure proper usage at home	Readmissions	Pharmacist, discharge planner	CNO	Area pharmacies

#### **<u>Priority 2</u>**: Improving the physical health of the community <u>Projected Impact</u>: Improved chronic disease management

#### <u>Goal 1</u>: Improved Minnesota Community Measure scores for identified chronic conditions

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Key clinic staff will continue to focus on the disease registry and expand beyond diabetes as targets are met and evolving needs/gaps are identified	MN Community Measure scores	RN Health Coach, Clinical supervisor	Clinic director, CEO, physicians	
Pharmacist involvement in educational opportunities 1:1 or group to impact medication management	MN Community Measure scores, readmissions	Pharmacist	CNO, Clinic director	RN Health Coach, Diabetic educators, Cardiac rehab RNs, local providers
Educational opportunities will be provided to the community to encourage healthy eating	County obesity rates, MN Community Measure scores	Dietician, Diabetic educators, Outreach coordinator	CEO, clinic director, physicians	Chamber, School, Dinner date
Explore options to increase availability of dental services that accept Medicaid	Access to dental care for Medicaid patients	CEO, Clinic director	CEO, clinic director	Local dentists, mobile dental services, Health Services of Lyon County
Engage as a community leader in activities that promote physical health in the community	County obesity rates, expanded use of trails/fitness centers, number of activities to promote health/wellness	Wellness staff, rehab manager	CEO, rehab manager	City, school, Chamber

# Demonstrating Impact through Outcomes 2017-2019 Strategies

During the 2016 Community Health Needs Assessment research cycle community members were invited to discuss community needs, provide recommendations and vote on the top priorities to address over the following three years. At Sanford Rock Rapids Medical Center, the top priorities addressed through an implementation strategy process include:

- 1) Improving the mental health of the community
- 2) Improving the aging services of the community
- 3) Improving the physical health of the community

#### **MENTAL HEALTH**

<u>Enhanced access to mental health and substance abuse resources</u> - Sanford Rock Rapids has
partnered with area mental health services to refer patients to outpatient services. In addition,
Sanford is now partnering with area providers to bring consulting services to patients in a
mental health crisis in the emergency room. Sanford Rock Rapids is also in the process of
moving forward with telehealth mental health services.

#### AGING SERVICES

• Enhanced availability and access to resources to allow the elderly to stay safe in their homes -Sanford Rock Rapids has partnered with area nursing homes and home health services to refer patients who need additional care after discharge. In addition, Sanford Rock Rapids provides follow up phone calls on patients after discharge. Depending on diagnosis, patients are scheduled with follow-up provider visits prior to discharge, either within 7 days or within 14 days, depending on readmission potential. Readmission scores to any Sanford facility are currently 7.7%, with a goal of under 7%. This number has trended down over the past three years as we have worked to prevent readmissions and partner with our area home care providers. The Sanford Rock Rapids pharmacist is active in medication management and partnering with the RN Health Coach and dietician to look at high-risk patients and implement the best management to prevent a hospital admission.

#### PHYSICAL HEALTH

 Improvement in Minnesota Community Measure Scores for identified chronic conditions -Sanford Rock Rapids has worked hard to improve quality metrics for chronic conditions over the past three years. In January 2015, 32.5% of diabetic patients had optimal management, and June 2018, we were at 50.6%. Optimal vascular was at 53% in January 2015, and is now up to 57.1%. 84.5% of hypertension patients had optimal management in 2015; today it is up to 90.5%. Breast cancer screening was completed on 70.4% of eligible women in January 2015, and today it is at 73.3%. Colorectal screening has also increased from 65.4% to 71.8% of patients being screened. Sanford Rock Rapids will continue to focus on obesity and will continue to be a community partner in ways to promote individual and community health.

#### **Community Feedback from the 2016 Community Health Needs Assessment**

Sanford Health is prepared to accept feedback on the 2016 Community Health Needs Assessment and has provided online comment fields on our website for ease of access. There have been no comments or questions about the Sanford Rock Rapids Medical Center's CHNA.

## Appendix

**Primary Research** 

### Rock Rapids Asset Map

Identified concern	Resident survey	Secondary data	Community resources available to address the need	Gap ?
Economic Well Being	9% run out of food before they have money to buy more	10% of population has food insecurity	<ul> <li>Hunger resources:</li> <li>Sunshine Foods, 106 N. Boone St., Rock Rapids IA</li> <li>R &amp; L Foods, 213 Main St., Doon IA</li> <li>Larchwood Food Ctr., 425 Fell St., Larchwood IA</li> <li>Total Stop, 113 N. Main, George IA</li> <li>Little Rock Community Foods, Little Rock IA</li> <li>Meals on Wheels, 409 Main, Little Rock IA</li> <li>Meals on Wheels, 315 Main, Rock Rapids IA</li> <li>Meals on Wheels, 324 – 1<sup>st</sup> Ave. N., George IA</li> <li>WIC, 302 S. Lincoln, Rock Rapids IA</li> <li>SNAP, 315–1<sup>st</sup> Ave., Rock Rapids IA</li> <li>Mid-Sioux Opportunity Outreach food pantry, 302 S. Lincoln, Rock Rapids IA</li> <li>Rock Rapids Methodist Church food pantry, 302 S. Carroll St., Rock Rapids IA</li> <li>Atlas food pantry, 112 – 1<sup>st</sup> Ave., Rock Rapids IA</li> <li>United Church of Christ food pantry, 935 Edwards St., Larchwood IA</li> <li>Rock Rapids Farmers Market</li> </ul>	
Children and Youth	24% do not always use seat belts for their children 20% do not always use car seats for their children	9% of children live in poverty 27% of children are eligible for free or reduced lunch	<ul> <li>Car Seat programs:</li> <li>Everyday Miracles (car seat giveaway program), 1121 Jackson St. NE, Minneapolis</li> <li>Lyon Co. Motor Vehicle office (education about importance of &amp; how to use a car seat), 206 S. 2<sup>nd</sup> Ave., Rock Rapids IA</li> <li>Lyon County extension office (education about child safety &amp; car seats), 301-1/2 – 1<sup>st</sup> Ave., Rock Rapids IA</li> </ul>	
Safety	29% have drugs they are not using in their homes		<ul> <li>Drug Take-Back Programs:</li> <li>Lyon County Sherriff Office</li> <li>Lewis Drug, 106 N. Boone St., Rock Rapids IA</li> <li>Corner Rexall Drug, 220 Main, Rock Rapids IA</li> </ul>	
Health Care Access	20% do not have dental insurance		<ul> <li>Dental Insurance resources:</li> <li>State Farm Insurance, 210 – 1<sup>st</sup> Ave. E., Rock Rapids IA</li> <li>Modern Woodmen, 938 Broadway, Larchwood IA</li> <li>Modern Woodmen, 407 S. Main, Inwood IA</li> </ul>	
Wellness	68% are overweight / obese 64% are not getting 5 servings/ day of fruits and vegetables 33% have arthritis	Adult obesity is 32% for Lyon County	<ul> <li>Obesity resources:</li> <li>Health Services of Lyon Co., 315 Main, Rock Rapids IA</li> <li>Sanford Rock Rapids Clinic dietitian and diabetic education classes, 803 S. Greene St., Rock Rapids IA</li> <li>Sanford Inwood Clinic dietician, 303 E. Jefferson St., Inwood IA</li> <li>Sanford Fitness Center, 400 S. 7<sup>th</sup> Ave., Rock Rapids IA</li> <li>Get Energized, 213 – 1<sup>st</sup> Ave. E., Rock Rapids IA</li> </ul>	

Identified Resident survey Secondary data	Community resources available to address the need	Gap ?
concern       29% have hypertension       24% have high cholesterol         24% have asthma       32% did not get a flu shot last year         32% did not get a flu       1	<ul> <li>Larchwood Recreational Center, 1138 Broadway, Larchwood IA</li> <li>Community Center, Lester IA</li> <li>Bixler Boot Camp, 104 N. Main, Inwood IA</li> <li>Zone Fitness, 1806 – 240<sup>th</sup> St., Inwood IA</li> <li>Island Park, Rock Rapids IA</li> <li>Kiwanis Park/Skateboard park, Rock Rapids IA</li> <li>Swimming Pool, 401 N. Story St., Rock Rapids IA</li> <li>Swimming Pool, Inwood IA</li> <li>George walking trails</li> <li>Rock Rapids Golf, 1344 N. Union St., Rock Rapids IA</li> <li>Otter Valley Golf, 2669 Kennedy Ave., George IA</li> <li>Healthy Food resources:</li> <li>Sunshine foods, 106 N Boone St., Rock Rapids IA</li> <li>Larchwood Food Center, 425 Fell St., Larchwood IA</li> <li>Total Stop, 113 N. Main, George IA</li> <li>Little Rock Community Foods, Little Rock IA</li> <li>Rock Rapids Farmers Market</li> </ul> Chronic Disease resources: <ul> <li>Sanford's Better Choices, Better Health, c/o Sanford Clinic, 803 S. Greene St., Rock Rapids IA</li> <li>Health Services of Lyon Co., 315 Main, Rock Rapids IA</li> <li>Sanford Rock Rapids IA<!--</td--><td>?</td></li></ul>	?

Identified concern	Resident survey	Secondary data	Community resources available to address the need	Gap ?
Mental Health and Substance abuse	<ul> <li>43% have an anxiety diagnosis</li> <li>38% have a depression diagnosis</li> <li>31% binge drink</li> </ul>	33% of accident deaths are alcohol induced	<ul> <li>Mental Health resources:</li> <li>Sanford Rock Rapids clinic, tele behavioral health resources, 803 S Greene St, Rock Rapids IA 51246</li> <li>Lyon Co. Mental Health Services, 315 Main, Rock Rapids IA</li> <li>Seasons Center for Behavioral Health, 315 Main, Rock Rapids IA</li> <li>Hope Haven, 1202 S. 3<sup>rd</sup> Ave., Rock Rapids IA</li> </ul>	
			<ul> <li>Substance Abuse resources:</li> <li>Lyon Co. Mental Health Services, 315 Main, Rock Rapids IA</li> <li>Compass Pointe, 315 Main, Rock Rapids IA</li> <li>NW Iowa Alcoholism &amp; Drug Treatment Unit, 315 – 1<sup>st</sup> Ave., Rock Rapids IA</li> </ul>	

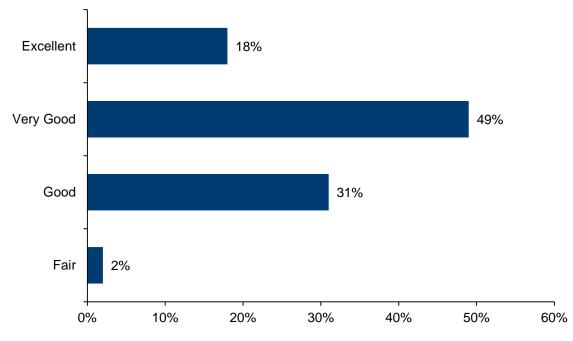
**Resident Survey** 

### Lyon County IA

July 05, 2018

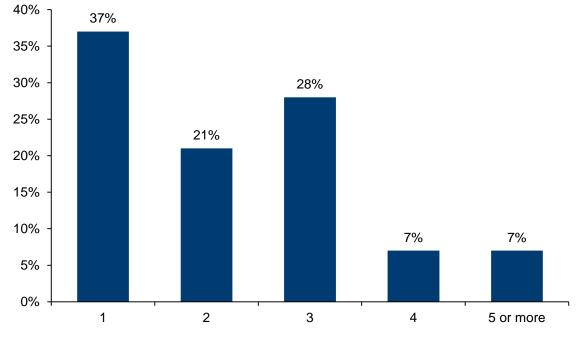
Sanford Health

#### How would you rate your health?



Base: Fair (n=1), Good (n=14), Very Good (n=22), Excellent (n=8), Sample Size = 45

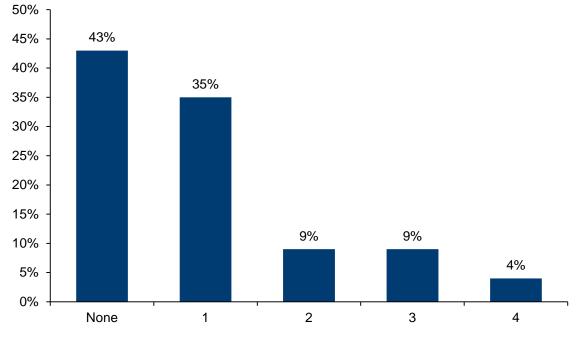
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### Servings of Vegetables

Base: 1 (n=16), 2 (n=9), 3 (n=12), 4 (n=3), 5 or more (n=3), Sample Size = 43

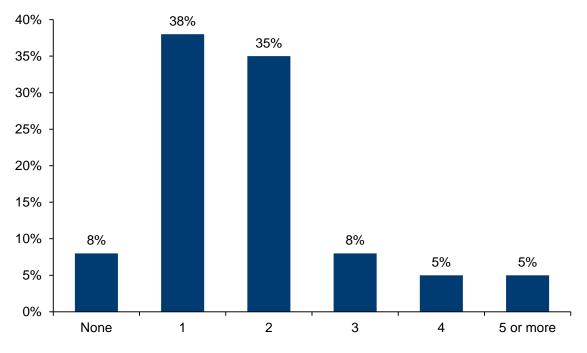
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Servings of Juice

Base: None (n=10), 1 (n=8), 2 (n=2), 3 (n=2), 4 (n=1), Sample Size = 23

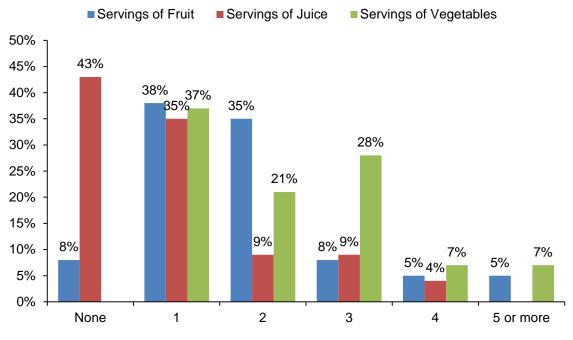
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Servings of Fruit

Base: None (n=3), 1 (n=14), 2 (n=13), 3 (n=3), 4 (n=2), 5 or more (n=2), Sample Size = 37

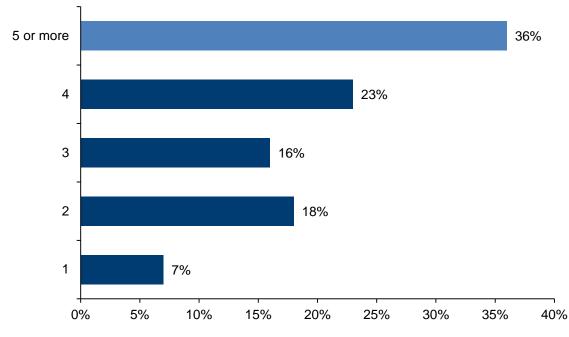
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### Servings of Fruit, Vegetables and Juice

Sample Size = Variable

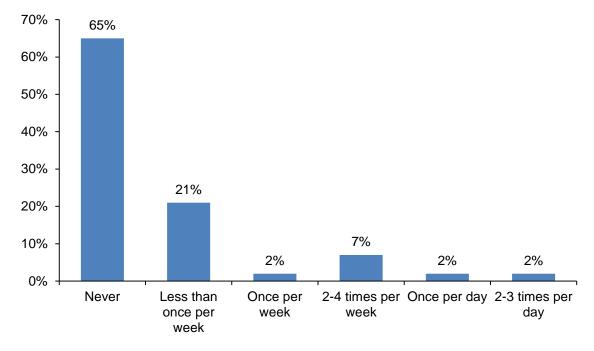
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### Total Servings of Fruits, Vegetables and Juice

Base: 1 (n=3), 2 (n=8), 3 (n=7), 4 (n=10), 5 or more (n=16), Sample Size = 44

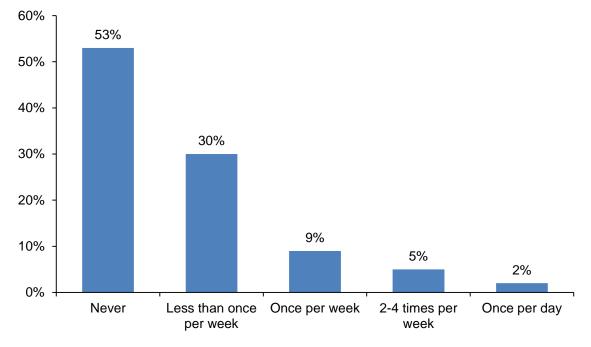
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Snapple, Flavored Teas, Capri Sun, etc.

Base: Never (n=28), Less than once per week (n=9), Once per week (n=1), 2-4 times per week (n=3), Once per day (n=1), 2-3 times per day (n=1), Sample Size = 43

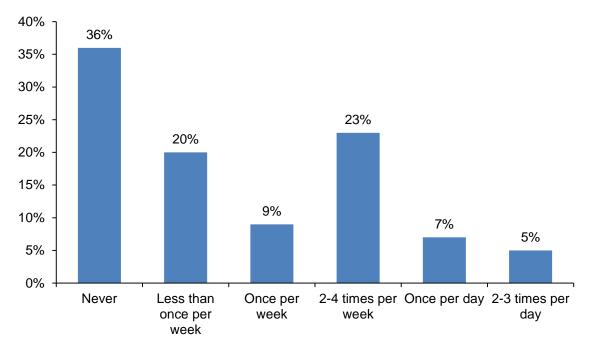
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Gatorade, Powerade, etc.

Base: Never (n=23), Less than once per week (n=13), Once per week (n=4), 2-4 times per week (n=2), Once per day (n=1), Sample Size = 43

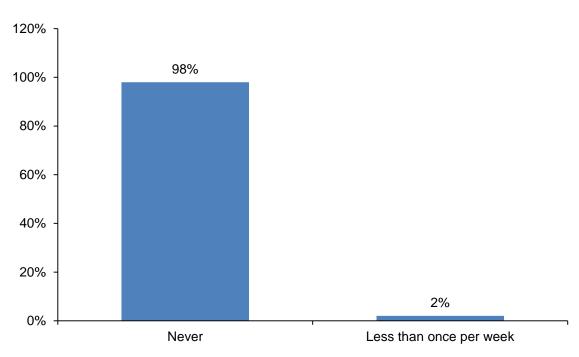
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Soda or Pop

Base: Never (n=16), Less than once per week (n=9), Once per week (n=4), 2-4 times per week (n=10), Once per day (n=3), 2-3 times per day (n=2), Sample Size = 44

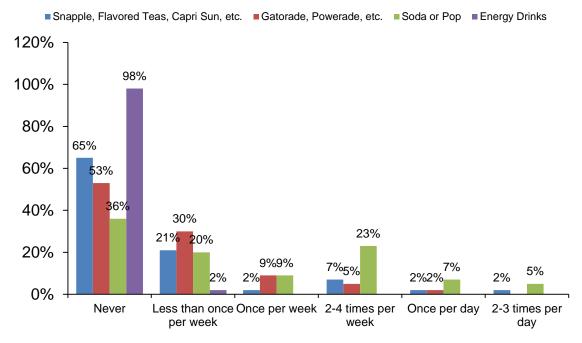
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Energy Drinks

Base: Never (n=42), Less than once per week (n=1), Sample Size = 43

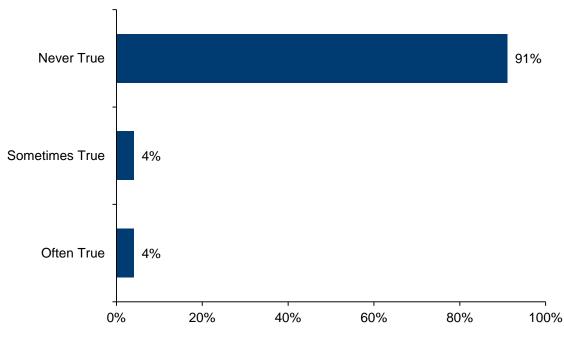
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### Sugar Sweetened Drinks

Sample Size = Variable

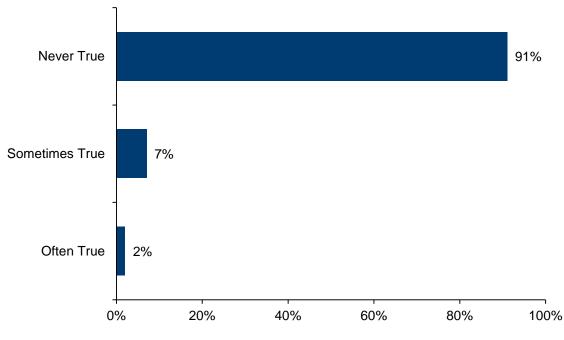
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Worried whether our food would run out before we got money to buy more.

Base: Often True (n=2), Sometimes True (n=2), Never True (n=41), Sample Size = 45

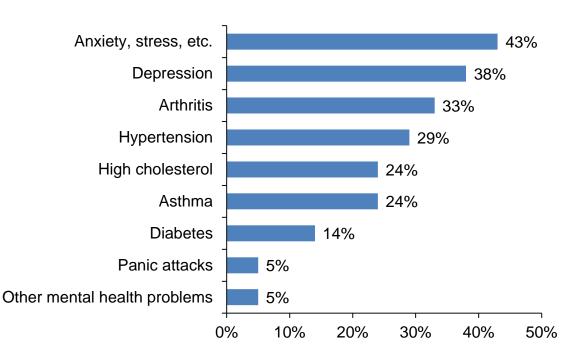
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



The food that we bought just didn't last, and we didn't have money to get more.

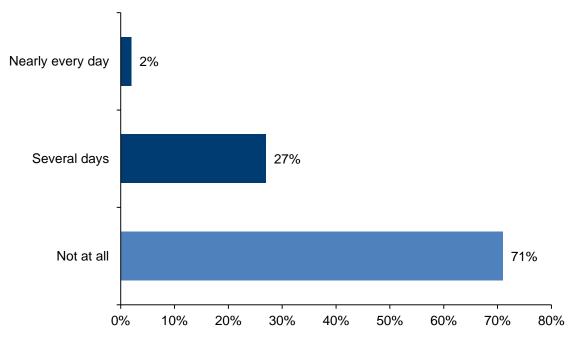
Base: Often True (n=1), Sometimes True (n=3), Never True (n=41), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Past Diagnosis

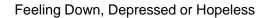
Base: Anxiety, stress, etc. (n=9), Arthritis (n=7), Asthma (n=5), Depression (n=8), Diabetes (n=3), High cholesterol (n=5), Hypertension (n=6), Other mental health problems (n=1), Panic attacks (n=1), Sample Size = 21 Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

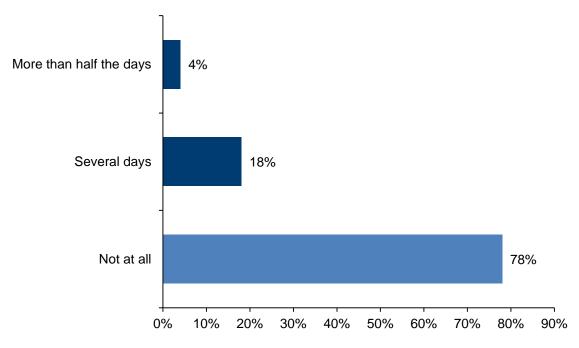


#### Little Interest or Pleasure in Doing Things

Base: Not at all (n=32), Several days (n=12), Nearly every day (n=1), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

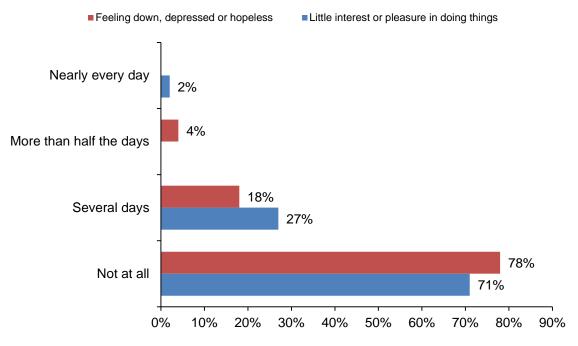




Base: Not at all (n=35), Several days (n=8), More than half the days (n=2), Sample Size = 45

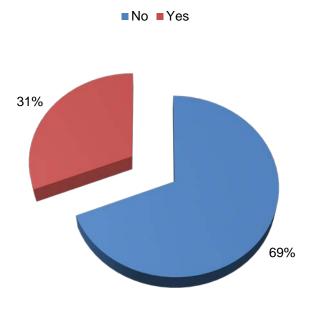
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

# Over the past two weeks, how often have you been bothered by either of the following issues?



Sample Size = 45

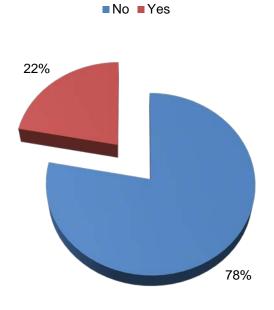
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



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

Base: Yes (n=14), No (n=31), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



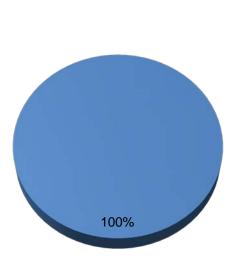
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?

Base: Yes (n=10), No (n=35), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

Have you smelled tobacco smoke in your apartment that comes from another apartment?

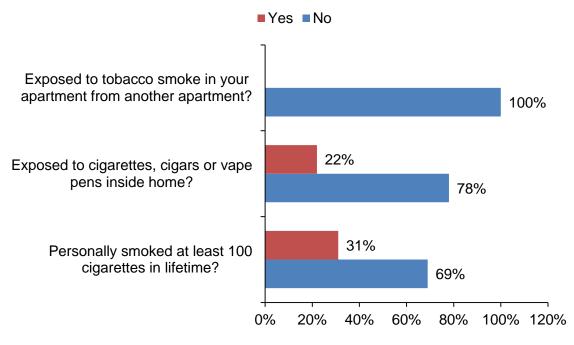
No



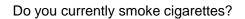
Base: No (n=45), Sample Size = 45

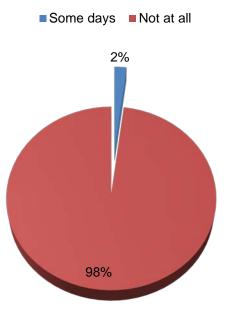
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

#### Exposure to Tobacco Smoke



Base: Personally smoked at least 100 cigarettes in lifetime? (n=45), Exposed to cigarettes, cigars or vape pens inside home? (n=45), Exposed to tobacco smoke in your apartment from another apartment? (n=45), Sample Size = 45 Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



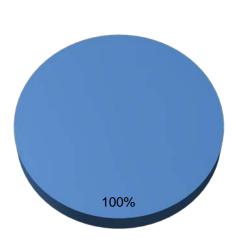


Base: Not at all (n=44), Some days (n=1), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

#### Do you currently use chewing tobacco?

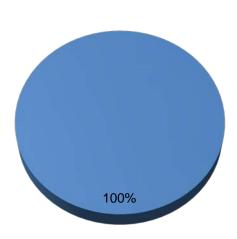
Not at all



Base: Not at all (n=45), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

#### Do you currently use electronics cigarettes or vape?

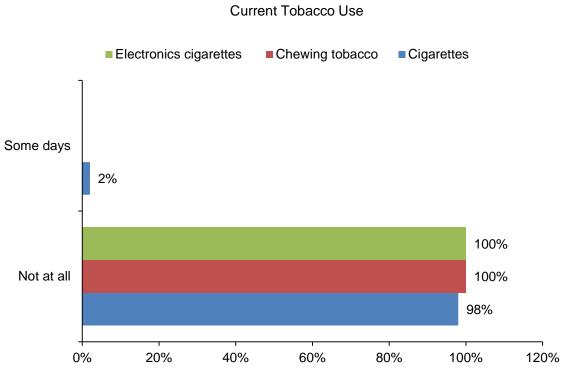


Base: Not at all (n=45), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

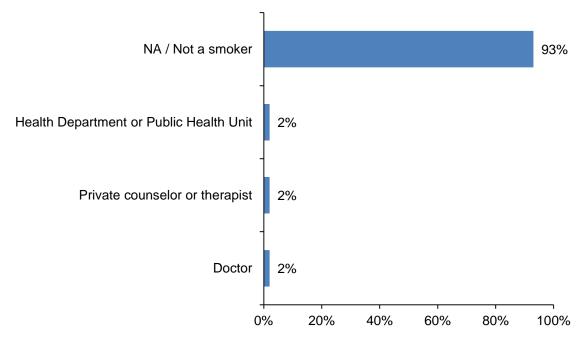
(listed in alphabetical order) = Lyon, IA)

#### Not at all



Sample Size = 45

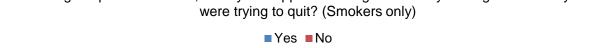
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



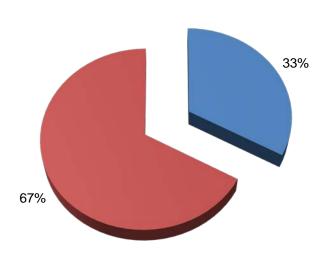
Where would you go for help if you wanted to quit using tobacco products?

Base: NA / Not a smoker (n=39), Doctor (n=1), Private counselor or therapist (n=1), Health Department or Public Health Unit (n=1), Sample Size = 42

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

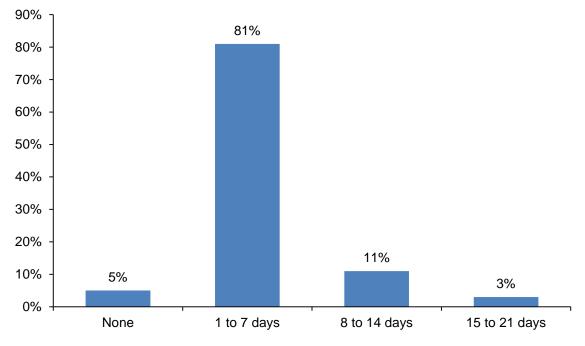


During the past 12 months, have you stopped smoking for one day or longer because you



Base: Yes (n=1), No (n=2), Sample Size = 3

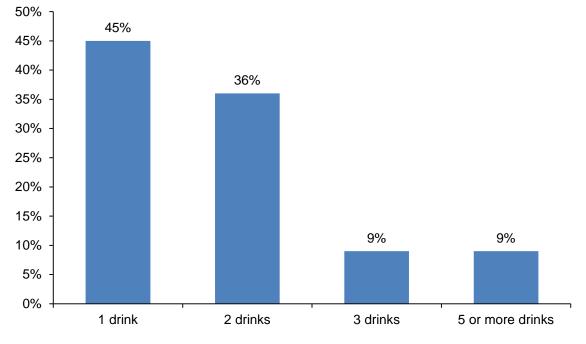
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



## Number of days with at least 1 drink in the past 30 days

Base: None (n=2), 1 to 7 days (n=30), 8 to 14 days (n=4), 15 to 21 days (n=1), Sample Size = 37

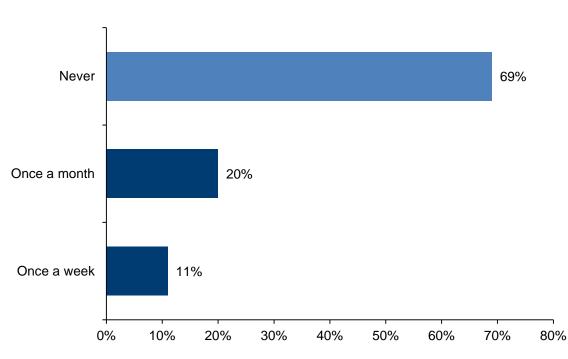
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



## Average number of drinks per day when you drink

Base: 1 drink (n=15), 2 drinks (n=12), 3 drinks (n=3), 5 or more drinks (n=3), Sample Size = 33

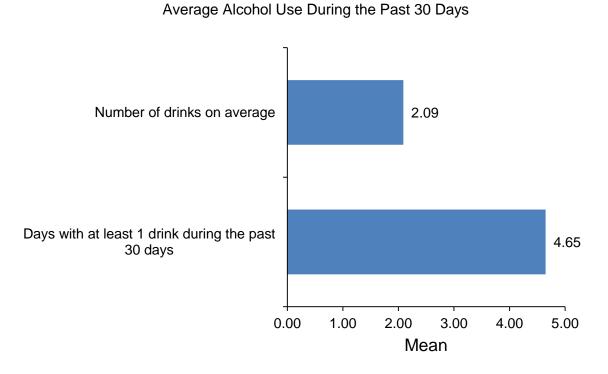
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



# **Binge Drinking**

Base: Once a week (n=4), Once a month (n=7), Never (n=24), Sample Size = 35

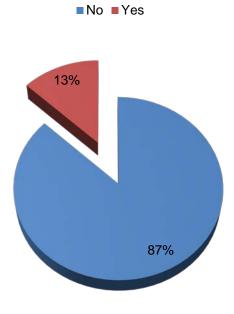
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Base: Days with at least 1 drink during the past 30 days (n=37), Number of drinks on average (n=34), Sample Size = Variable

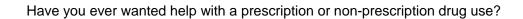
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

Has alcohol use had a harmful effect on you or a family member in the past two years?

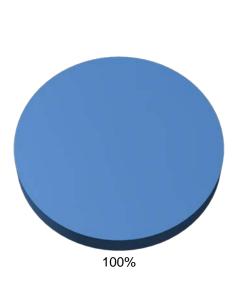


Base: Yes (n=6), No (n=39), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

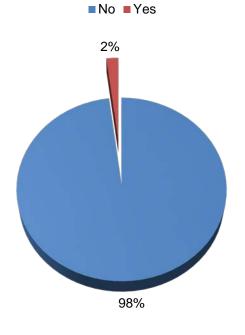


No



Base: No (n=45), Sample Size = 45

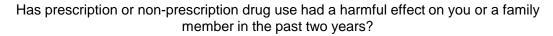
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

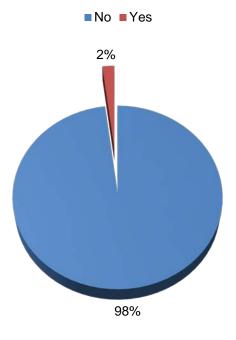


Has a family member or friend ever suggested that you get help for substance use?

Base: Yes (n=1), No (n=44), Sample Size = 45

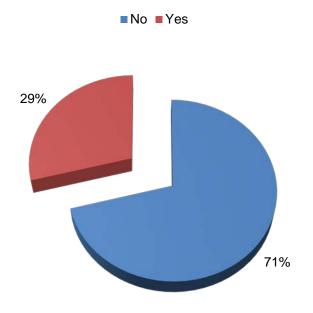
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.





Base: Yes (n=1), No (n=44), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

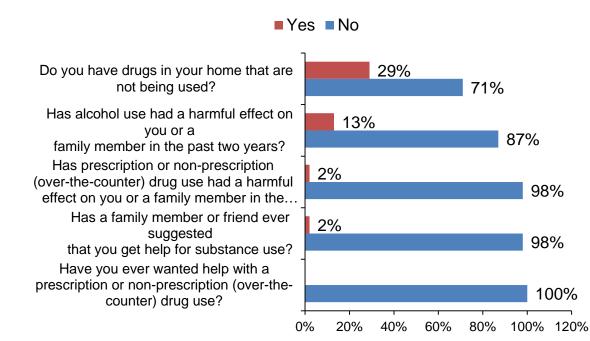


## Do you have drugs in your home that are not being used?

Base: Yes (n=13), No (n=32), Sample Size = 45

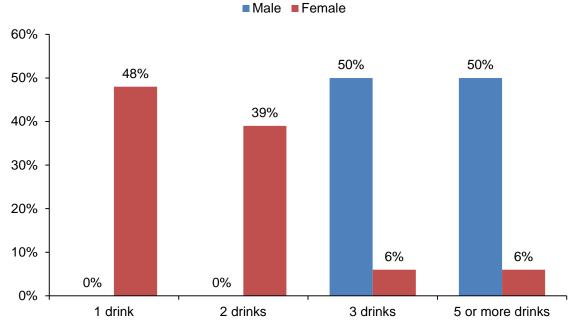
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

# **Drug and Alcohol Issues**



Sample Size = 45

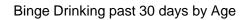
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

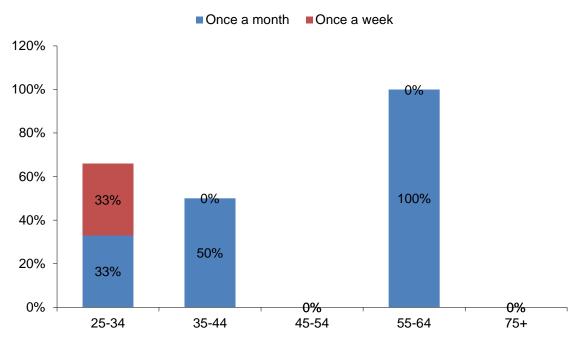


Average number of drinks per day when you drink by gender

Base: 1 drink (n=15), 2 drinks (n=12), 3 drinks (n=3), 5 or more drinks (n=3), Sample Size = 33

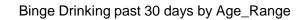
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

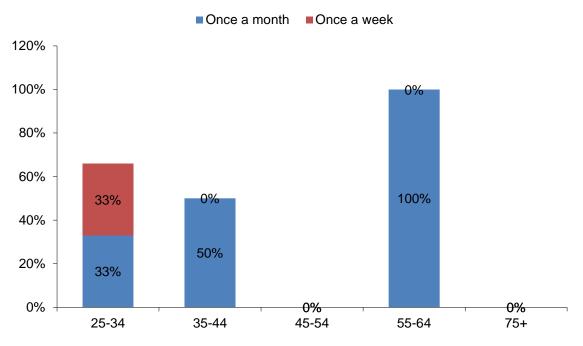




Base: 25-34 (n=3), 35-44 (n=2), 45-54 (n=4), 55-64 (n=1), 75+ (n=1), Sample Size = 11

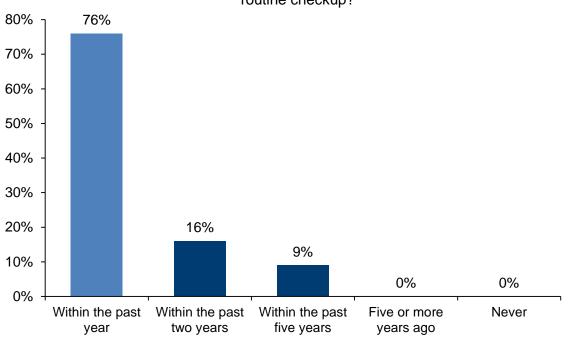
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.





Base: 25-34 (n=3), 35-44 (n=2), 45-54 (n=4), 55-64 (n=1), 75+ (n=1), Sample Size = 11

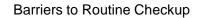
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

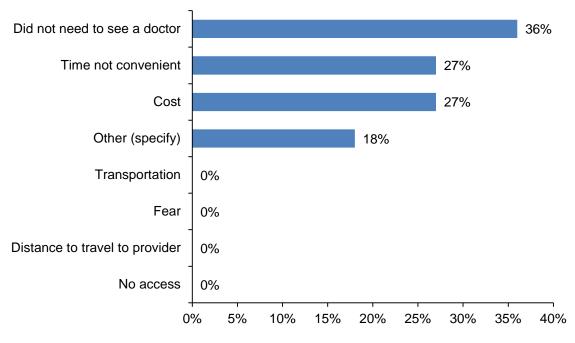


How long has it been since you last visited a doctor or health care provider for a routine checkup?

Base: Within the past year (n=34), Within the past two years (n=7), Within the past five years (n=4), Five or more years ago (n=0), Never (n=0), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

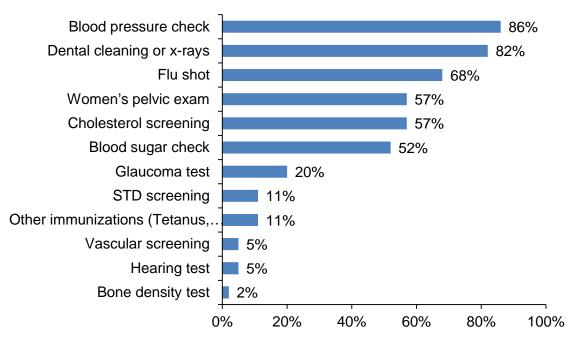




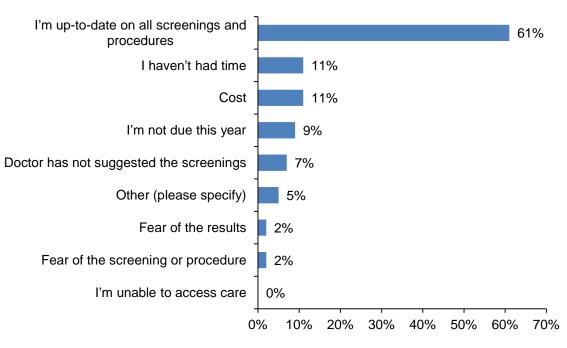
Base: No access (n=0), Distance to travel to provider (n=0), Cost (n=3), Fear (n=0), Transportation (n=0), Time not convenient (n=3), Did not need to see a doctor (n=4), Other (specify) (n=2), Sample Size = 11

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

#### Preventive Procedures Last Year

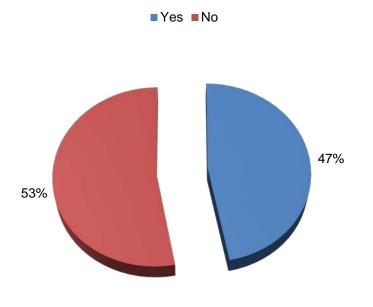


Base: Blood pressure check (n=38), Blood sugar check (n=23), Bone density test (n=1), Cholesterol screening (n=25), Dental cleaning or x-rays (n=36), Flu shot (n=30), Other immunizations (Tetanus, Hepatitis A or B) (n=5), Glaucoma test (n=9), Hearing test (n=2), Women's pelvic exam (n=25), STD screening (n=5), Vascular screening (n=2), Sample Size 44 Respondents Included = %, Fifter Applied, Telease select the county in which you live.



**Barriers for Preventive Procedures** 

Base: I'm up-to-date on all screenings and procedures (n=27), Doctor has not suggested the screenings (n=3), Cost (n=5), I'm unable to access care (n=0), Fear of the screening or procedure (n=1), Fear of the results (n=1), I'm not due this year (n=4), I haven't had time (n=5), Other (please specify) (n=2), Sample Size = 44 Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

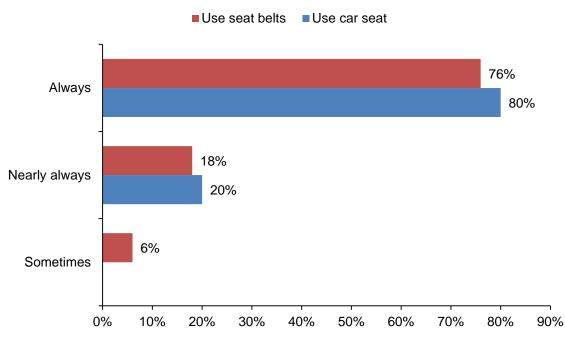


Do you have children under the age of 18 living in your household?

Base: Yes (n=21), No (n=24), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



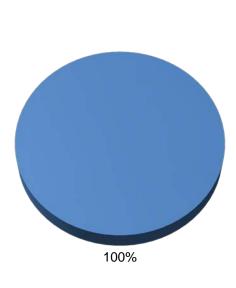


Sample Size = Variable

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

## Do you have healthcare coverage for your children or dependents?

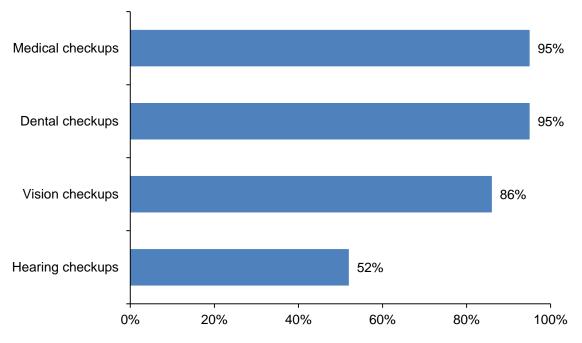
Yes



Base: Yes (n=21), Sample Size = 21

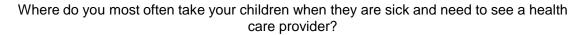
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

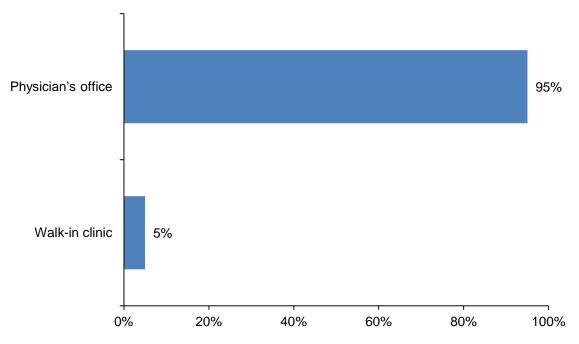
#### Children's Preventative Services



Base: Dental checkups (n=20), Vision checkups (n=18), Hearing checkups (n=11), Medical checkups (n=20), Sample Size = 21

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

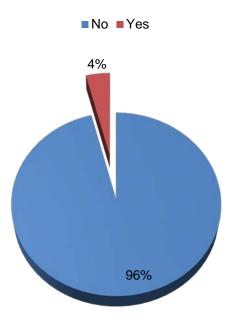




Base: Physician's office (n=20), Walk-in clinic (n=1), Sample Size = 21

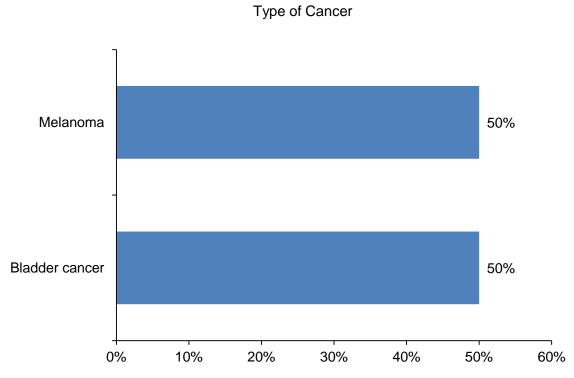
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

## Have you ever been diagnosed with cancer?



Base: Yes (n=2), No (n=43), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

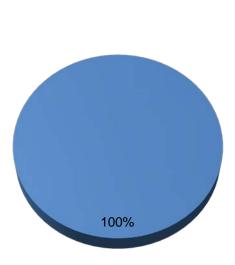


Base: Bladder cancer (n=1), Melanoma (n=1), Sample Size = 2

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

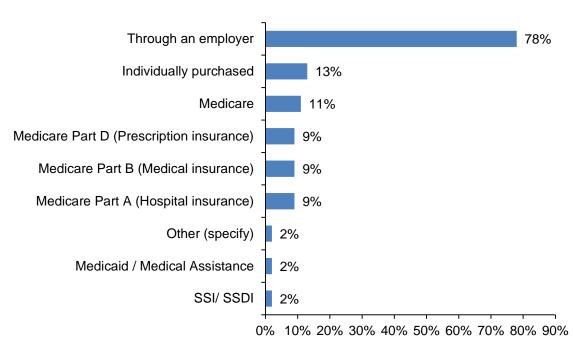
# Do you currently have any kind of health insurance?

Yes



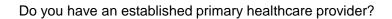
Base: Yes (n=45), Sample Size = 45

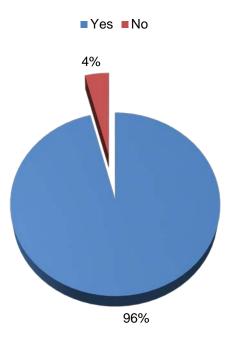
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Type of Insurance

Base: Through an employer (n=35), Individually purchased (n=6), Medicare (n=5), Medicare Part A (Hospital insurance) (n=4), Medicare Part B (Medical insurance) (n=4), Medicare Part D (Prescription insurance) (n=4), SSI/ SSDI (n=1), Medicaid / Medical Assistance (n=1), Other (specify) (n=1), Sample Size Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



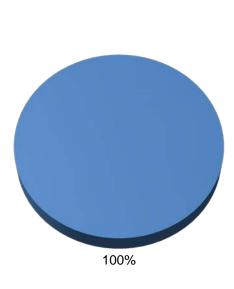


Base: Yes (n=43), No (n=2), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

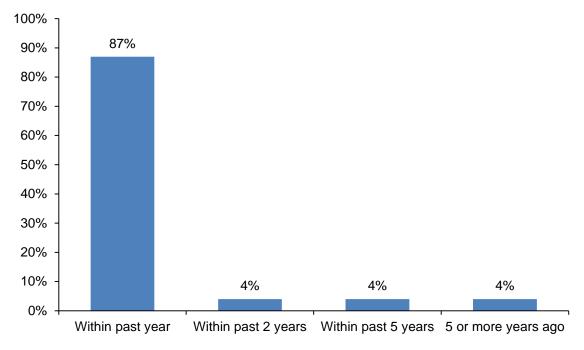
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?

No



Base: No (n=45), Sample Size = 45

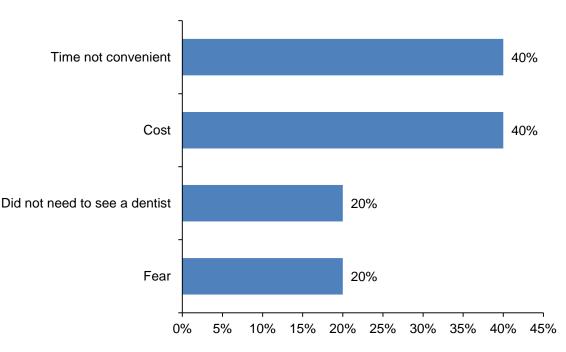
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



How long has it been since you last visited a dentist?

Base: Within past year (n=39), Within past 2 years (n=2), Within past 5 years (n=2), 5 or more years ago (n=2), Sample Size = 45

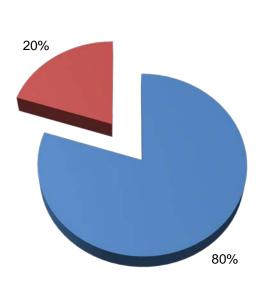
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### Barriers to Visiting the Dentist

Base: Cost (n=2), Fear (n=1), Time not convenient (n=2), Did not need to see a dentist (n=1), Sample Size = 5

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

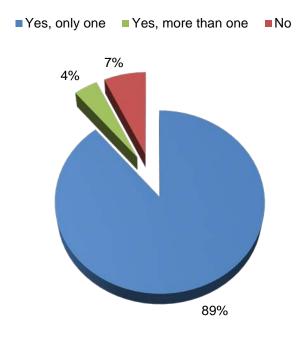


Do you have any kind of dental care or oral health insurance coverage?

■Yes ■No

Base: Yes (n=36), No (n=9), Sample Size = 45

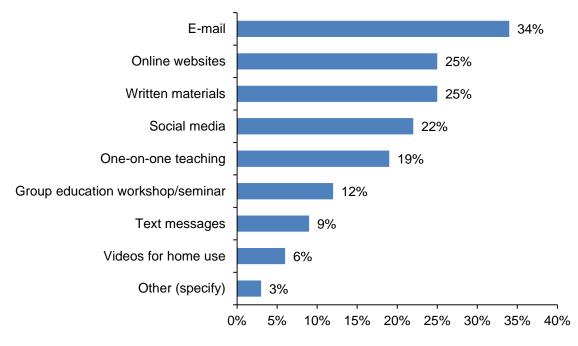
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



## Do you have a dentist that you see for routine care?

Base: Yes, only one (n=40), Yes, more than one (n=2), No (n=3), Sample Size = 45

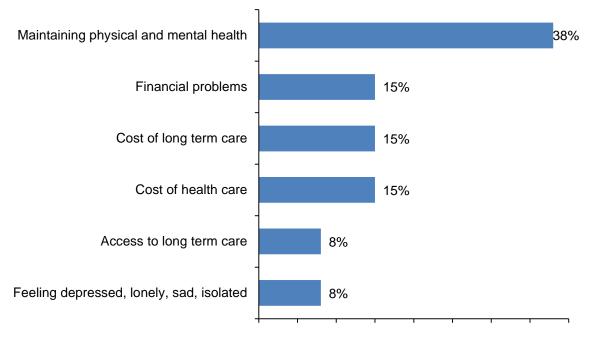
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### What method(s) would you prefer to get health information?

Base: Written materials (n=8), Videos for home use (n=2), Social media (n=7), Text messages (n=3), One-on-one teaching (n=6), E-mail (n=11), Group education workshop/seminar (n=4), Online websites (n=8), Other (specify) (n=1), Sample Size = 32

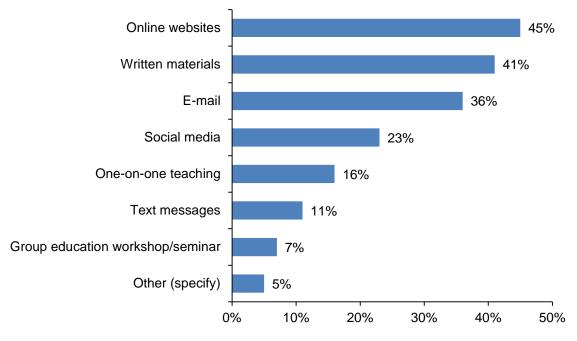
Respondents Included = 1%, Filter Applied, (Community 2 = Tripp)



#### What is your biggest concern as you age? (Age 65+)

Base: Cost of health care (n=2), Maintaining physical and mental health (n=5), Feeling depressed, lonely, sad, isolated (n=1), Access to long term care (n=1), Cost of long term care (n=2), Financial problems (n=2), Sample Size = 5

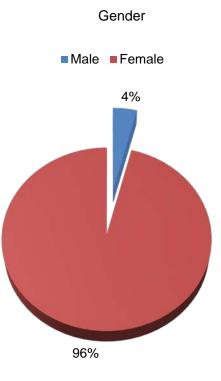
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



#### What method(s) would you prefer to get health information?

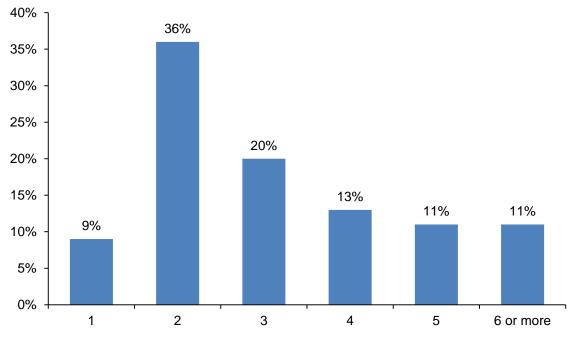
Base: Written materials (n=18), Social media (n=10), Text messages (n=5), One-on-one teaching (n=7), E-mail (n=16), Group education workshop/seminar (n=3), Online websites (n=20), Other (specify) (n=2), Sample Size = 44

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Base: Male (n=2), Female (n=43), Sample Size = 45

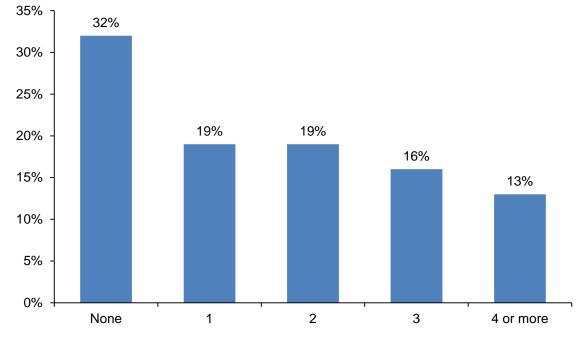
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



People in Household

Base: 1 (n=4), 2 (n=16), 3 (n=9), 4 (n=6), 5 (n=5), 6 or more (n=5), Sample Size = 45

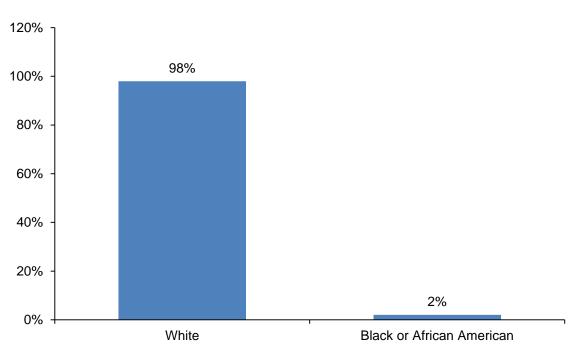
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



## Children in Household Under 18

Base: None (n=10), 1 (n=6), 2 (n=6), 3 (n=5), 4 or more (n=4), Sample Size = 31

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

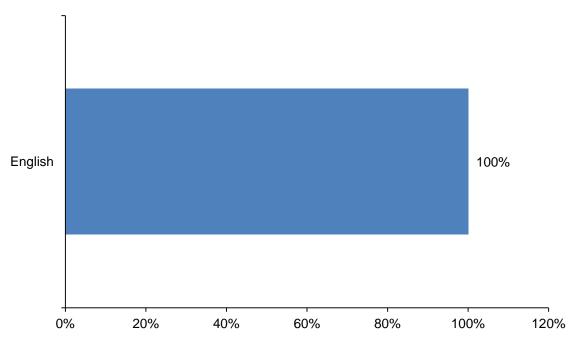


Ethnicity

Base: White (n=44), Black or African American (n=1), Sample Size = 45

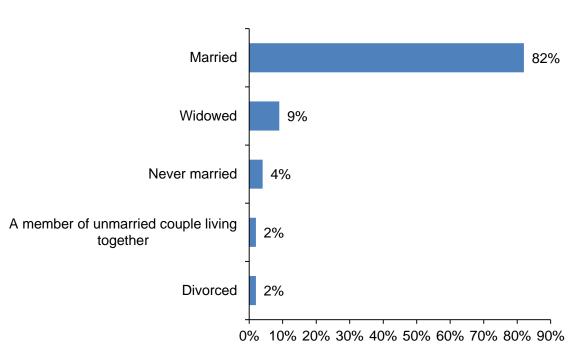
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.





Base: English (n=45), Sample Size = 45

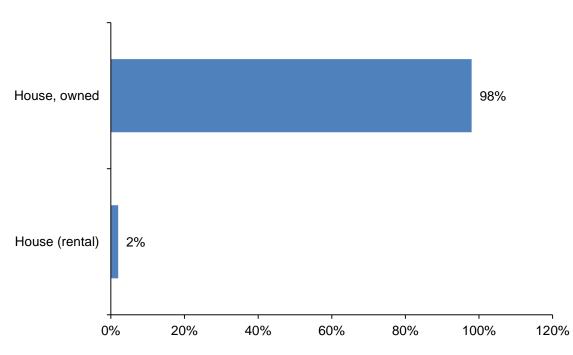
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Marital Status

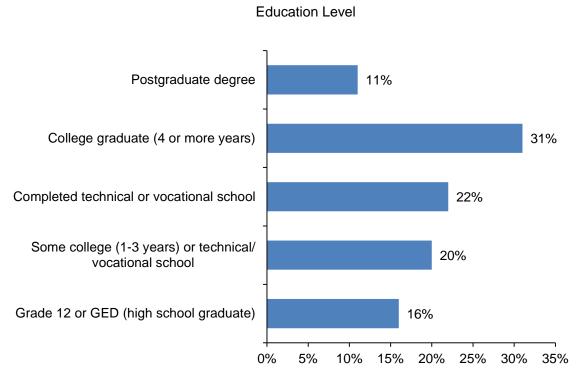
Base: Never married (n=2), Married (n=37), Divorced (n=1), Widowed (n=4), A member of unmarried couple living together (n=1), Sample Size = 45 Respondents Included = 1%, Filter Applied, (Please select the county in which you live.





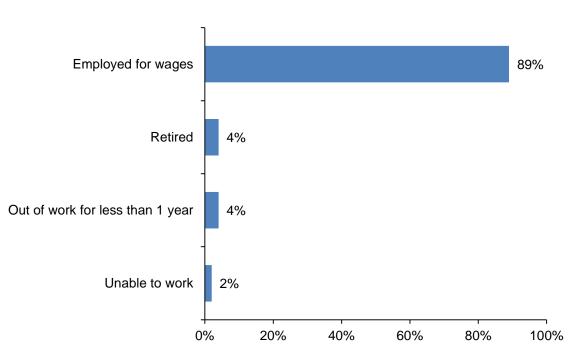
Base: House, owned (n=44), House (rental) (n=1), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



Base: Grade 12 or GED (high school graduate) (n=7), Some college (1-3 years) or technical/vocational school (n=9), Completed technical or vocational school (n=10), College graduate (4 or more years) (n=14), Postgraduate degree (n=5), Sample Size = 45

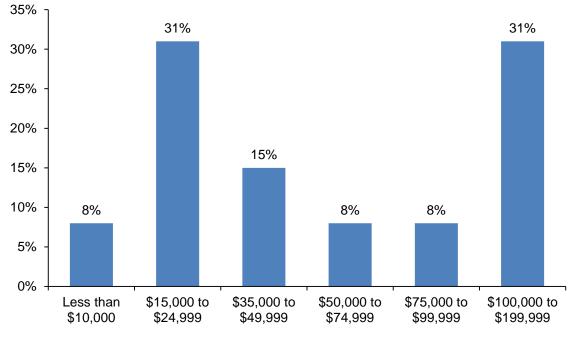
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.



**Employment Status** 

Base: Employed for wages (n=40), Out of work for less than 1 year (n=2), Retired (n=2), Unable to work (n=1), Sample Size = 45

Respondents Included = 1%, Filter Applied, (Please select the county in which you live.

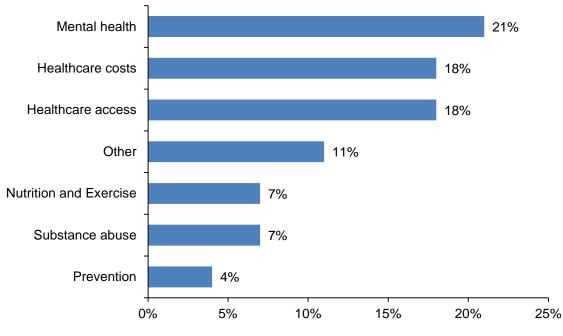


**Total Household Income** 

Base: Less than 10,000 (n=1), 15,000 to 24,999 (n=4), 35,000 to 49,999 (n=2), 550,000 to 74,999 (n=1), 75,000 to 99,999 (n=1), 100,000 to 199,999 (n=4), Sample Size = 13

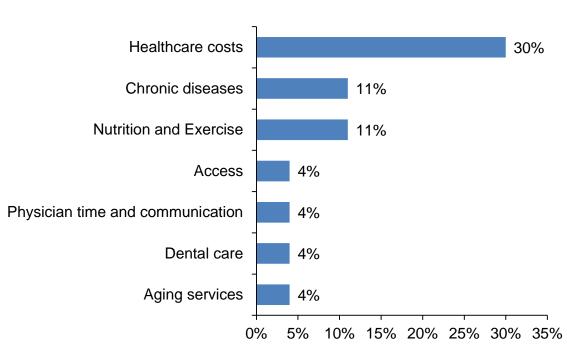
Respondents Included = 1%, Filter Applied, (Please select the county in which you live.





Sample Size = 28

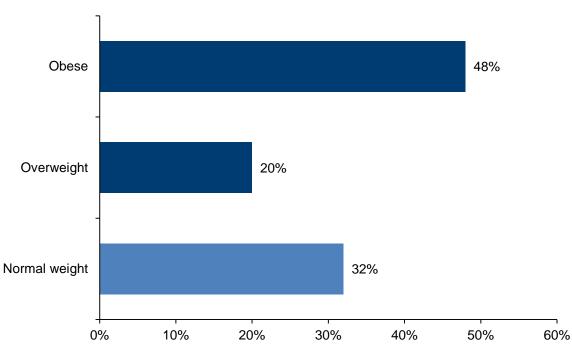
(Community = Nobles)



Most Important Issue for Family

Sample Size = 27

(Community = Lyon)



BMI

Base: Normal weight (n=14), Overweight (n=9), Obese (n=21), Sample Size = 44

(Community = Lyon)

### Rock Rapids 2018 Community Health Needs Assessment Prioritization Worksheet

#### **Criteria to Identify Priority Problem**

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

#### Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
68% are overweight or obese	#1 Obesity		
• 64% are not getting their 5 servings/day of fruits and vegetables			
• 9% run out of food	#2 Chronic		
• 43% have an anxiety diagnosis	Disease		
38% have a depression diagnosis			
• 33% have arthritis			
29% have hypertension			
24% have high cholesterol			
• 24% have asthma			
• 31% binge drink			
• 29% have drugs they are not using in their homes			
• 32% did not get a flu shot last year			
• 24% do not always use seat belts for their children			
• 20% do not always use car seats for their children			
20% do not have dental insurance			

**Secondary Research** 

# **Definitions of Key Indicators**



A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in

calculating the 2018 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County* 

Health Rankings web site for your state.

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

#### Contents:

**Outcomes & Factors Rankings** 

Outcomes & Factors Sub Rankings

Ranked Measures Data (including measure values, confidence intervals\* and z-scores\*\*)

Additional Measures Data (including measure values and confidence intervals\*)

Ranked Measure Sources and Years

Additional Measure Sources and Years

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

\*\* Z-scores are "adjusted" z-scores (e.g., multiplied by -1 if a positively framed measure, set to zero for missing and unreliable

values for ranked counties, and truncated at -3 or +3 if county population is less than 20,000).

Measure	Data Elements	Description
Geographic	FIPS	Federal Information Processing Standard
identifiers	State	
	County	
Premature death	Years of Potential Life Lost Rate	Age-adjusted YPLL rate per 100,000
	95% CI - Low	95% confidence interval reported by National Center for
	95% Cl - High	Health Statistics
	Z-Score	(Measure - Average of state counties)/(Standard
		Deviation)
	Years of Potential Life Lost Rate	Age-adjusted YPLL rate per 100,000 for non-Hispanic
	(Black)	Blacks

Measure	Data Elements	Description
	Years of Potential Life Lost Rate (Hispanic)	Age-adjusted YPLL rate per 100,000 for Hispanics
	Years of Potential Life Lost Rate (White)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Whites
Poor or fair health	% Fair/Poor	Percentage of adults that report fair or poor health
	95% CI - Low	
	95% Cl - High	95% confidence interval reported by BRFSS
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor physical health days	Physically Unhealthy Days	Average number of reported physically unhealthy days per month
·	95% CI - Low	
	95% Cl - High	95% confidence interval reported by BRFSS
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor mental health days	Mentally Unhealthy Days	Average number of reported mentally unhealthy days per month
	95% CI - Low	
	95% Cl - High	95% confidence interval reported by BRFSS
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Low birthweight	Unreliable	Value reported but considered unreliable since based on counts of twenty or less.
	% LBW	Percentage of births with low birth weight (<2500g)
	95% CI - Low	
	95% Cl - High	95% confidence interval
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% LBW (Black)	Percentage of births with low birth weight (<2500g) for non-Hispanic Blacks
	% LBW (Hispanic)	Percentage of births with low birth weight (<2500g) for Hispanics
	% LBW (White)	Percentage of births with low birth weight (<2500g) for non-Hispanic Whites
Adult smoking	% Smokers	Percentage of adults that reported currently smoking
	95% CI - Low	
	95% CI - High	95% confidence interval reported by BRFSS
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Adult obesity	% Obese	Percentage of adults that report BMI >= 30
	95% CI - Low	
	95% CI - High	95% confidence interval reported by BRFSS
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Measure	Data Elements	Description
Food environment	Food Environment Index	Indicator of access to healthy foods - 0 is worst, 10 is best
index	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Physical inactivity	% Physically Inactive	Percentage of adults that report no leisure-time physical activity
	95% CI - Low	
	95% CI - High	95% confidence interval
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Access to exercise opportunities	% With Access	Percentage of the population with access to places for physical activity
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Excessive drinking	% Excessive Drinking	Percentage of adults that report excessive drinking
	95% CI - Low	OE% confidence interval reported by DDESS
	95% Cl - High	95% confidence interval reported by BRFSS
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Alcohol-impaired	# Alcohol-Impaired Driving Deaths	Number of alcohol-impaired motor vehicle deaths
driving deaths	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	95% CI - Low	QE% confidence interval using Deisson distribution
	95% Cl - High	<ul> <li>95% confidence interval using Poisson distribution</li> </ul>
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually	# Chlamydia Cases	Number of chlamydia cases
transmitted infections	Chlamydia Rate	Chlamydia cases per 100,000 population
Infections	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	Teen Birth Rate	Births per 1,000 females ages 15-19
	95% Cl - Low	95% confidence interval
	95% Cl - High	95% confidence interval
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Teen Birth Rate (Black)	Births per 1,000 females ages 15-19 for Black non- Hispanic mothers
	Teen Birth Rate (Hispanic)	Births per 1,000 females ages 15-19 for Hispanic mothers
	Teen Birth Rate (White)	Births per 1,000 females ages 15-19 for White non- Hispanic mothers
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance

Measure	Data Elements	Description
	95% CI - Low	
	95% CI - High	95% confidence interval reported by SAHIE
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
physicians	PCP Rate	Primary Care Physicians per 100,000 population
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	Dentists per 100,000 population
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health	# Mental Health Providers	Number of mental health providers (MHP)
providers	MHP Rate	Mental Health Providers per 100,000 population
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable	# Medicare Enrollees	Number of Medicare enrollees
nospital stays	Preventable Hosp. Rate	Discharges for Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees
	95% CI - Low	
	95% CI - High	95% confidence interval reported by Dartmouth Institute
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetes	# Diabetics	Number of diabetic Medicare enrollees
monitoring	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c test
	95% CI - Low	
	95% CI - High	95% confidence interval reported by Dartmouth Institute
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Receiving HbA1c (Black)	Percentage of Black diabetic Medicare enrollees receiving HbA1c test
	% Receiving HbA1c (White)	Percentage of White diabetic Medicare enrollees receiving HbA1c test
Mammography	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
screening	% Mammography	Percentage of female Medicare enrollees having at least 1
		mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	

Measure	Data Elements	Description	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)	
	% Mammography (Black)	Percentage of Black female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)	
	% Mammography (White)	Percentage of White female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)	
High school	Cohort Size	Number of students expected to graduate	
graduation	Graduation Rate	Graduation rate	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)	
Some college	# Some College	Adults age 25-44 with some post-secondary education	
	Population	Adults age 25-44	
	% Some College	Percentage of adults age 25-44 with some post- secondary education	
	95% CI - Low		
	95% Cl - High	95% confidence interval	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)	
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking fo work	
	Labor Force	Size of the labor force	
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)	
Children in poverty	% Children in Poverty	Percentage of children (under age 18) living in poverty	
	95% CI - Low		
	95% Cl - High	95% confidence interval reported by SAIPE	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)	
	% Children in Poverty (Black)	Percentage of non-Hispanic Black children (under age 18) living in poverty - from the 2012-2016 ACS	
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty – from the 2012-2016 ACS	
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2012-2016 ACS	
Income inequality	80th Percentile Income	80th percentile of median household income	
	20th Percentile Income	20th percentile of median household income	
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)	
Children in single-	# Single-Parent Households	Number of children that live in single-parent households	
parent households	# Households	Number of children in households	

Measure	Data Elements	Description
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% Cl - Low	
	95% Cl - High	95% confidence interval
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations per 10,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000.
	95% CI - Low	95% confidence interval as reported by the National
	95% CI - High	Center for Health Statistics
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	Average Daily PM2.5	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water	Presence of violation	County affected by a water violation: 1-Yes, 0-No
violations	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	
	95% CI - High	95% confidence interval
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to	% Drive Alone	Percentage of workers who drive alone to work
work	95% CI - Low	05%
	95% CI - High	95% confidence interval
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Drive Alone (Black)	Percentage of non-Hispanic Black workers who drive alone to work
	% Drive Alone (Hispanic)	Percentage of Hispanic workers who drive alone to work

Measure	Data Elements	Description		
	% Drive Alone (White)	Percentage of non-Hispanic White workers who drive alone to work		
Long commute - driving alone	# Workers who Drive Alone			
% Long Commute - Drives Alone		Among workers who commute in their car alone, the percentage that commute more than 30 minutes		
	95% CI - Low			
	95% CI - High	95% confidence interval		
Z-Score		(Measure - Average of state counties)/(Standard Deviation)		

# County Health Rankings for Lyon County, Iowa

	County	State
Population	11,754	3,134,693
% below 18 years of age	28.4%	23.3%
% 65 and older	17.3%	16.4%
% Non-Hispanic African	0.2%	3.5%
American		
% American Indian and	0.4%	0.5%
Alaskan Native		
% Asian	0.3%	2.5%
% Native Hawaiian/Other	0.1%	0.1%
Pacific Islander		
% Hispanic	2.6%	5.8%
% Non-Hispanic white	95.8%	86.2%
% not proficient in	0%	2%
English		
% Females	49.2%	50.3%
% Rural	100.0%	36.0%

	Lyon	Error	Top U.S.	Iowa	Rank
	County	Margin	Performers		(of 99)
	Health Outcome	S			8
	Length of Life				10
Premature death	4,200	3,400-5,100	5,300	5,900	
Quality of Life				7	
Poor or fair health **	11%	10-12%	12%	13%	
Poor physical health days **	2.7	2.5-2.8	3.0	2.9	
Poor mental health days **	3.0	2.8-3.2	3.1	3.3	
Low birthweight	6%	5-7%	6%	7%	
Additional Health Outcomes (not included in o	verall ranking) +				
Premature age-adjusted mortality	260	210-310	270	310	
Child mortality			40	50	
Infant mortality			4	5	
Frequent physical distress	8%	8-9%	9%	9%	
Frequent mental distress	9%	9-10%	10%	10%	
Diabetes prevalence	11%	8-14%	8%	10%	
HIV prevalence			49	94	
Health Factors	•		•	•	7
Health Behaviors					16
Adult smoking **	13%	13-14%	14%	17%	
Adult obesity	34%	28-40%	26%	32%	
Food environment index	8.9		8.6	8.2	
Physical inactivity	33%	26-39%	20%	25%	

	Lyon	Error	Top U.S.	lowa	Rank
	County	Margin	Performers		(of 99)
Access to exercise opportunities	69%		91%	83%	
Excessive drinking **	22%	21-23%	13%	22%	
Alcohol-impaired driving deaths	22%	6-42%	13%	27%	
Sexually transmitted infections	119.8		145.1	388.9	
Teen births	16	11-22	15	22	
Additional Health Behaviors (not included in	n overall ranking) +				
Food insecurity	9%		10%	12%	
Limited access to healthy foods	3%		2%	6%	
Drug overdose deaths			10	9	
Drug overdose deaths - modeled	6-7.9		8-11.9	10.6	
Motor vehicle crash deaths	12	6-23	9	11	
Insufficient sleep	25%	24-26%	27%	28%	
Clinical Care				54	
Uninsured	6%	5-7%	6%	6%	
Primary care physicians	2,940:1	0.770	1,030:1	1,360:1	
Dentists	2,350:1		1,280:1	1,560:1	
Mental health providers	11,750:1		330:1	760:1	
Preventable hospital stays	63	50-75	35	49	
Diabetes monitoring	93%	76-100%	91%	90%	
Mammography screening	71%	58-85%	71%	69%	
Additional Clinical Care (not included in ove		50-0570	/1/0	0570	
Uninsured adults	6%	5-7%	7%	7%	
Uninsured children	5%	3-7%	3%	4%	
Health care costs	\$8,441	5-778	578	\$8,572	
Other primary care providers	2,351:1		782:1	1,185:1	
Social & Economic Factors	2,331.1		/02.1		
			05%	2	
High school graduation			95%	90%	
Some college	70%	63-78%	72%	70%	
Unemployment	2.1%		3.2%	3.7%	
Children in poverty	9%	7-12%	12%	15%	
% Children in Poverty	9%		x	1	I
% Children in Poverty (Hispanic)	10%		~		
% Children in Poverty (White)	7%				
Income inequality	3.5	3.1-3.9	3.7	4.2	
Children in single-parent households	11%	8-15%	20%	29%	
Social associations	28.9		22.1	15.2	
Violent crime	192		62	270	
Injury deaths	46	30-67	55	65	
Additional Social & Economic Factors (not in			I	1	I
Disconnected youth		<u> </u>	10%	9%	

	Lyon	Error	Top U.S.	Iowa	Rank
	County	Margin	Performers		(of 99)
Median household income	\$62,500	\$55,800-69,200	\$65,100	\$56,400	
Household Income	\$62,500		x		
Household income (Hispanic)	\$77,800				
Household income (White)	\$59,600				
Children eligible for free or reduced price	26%		33%	41%	
lunch					
Residential segregation - black/white			23	63	
Residential segregation - non-white/white	28		14	48	
Homicides			2	2	
Firearm fatalities			7	8	
Physical	Environment			20	
Air pollution - particulate matter **	9.4		6.7	9.6	
Drinking water violations	No				
Severe housing problems	8%	6-11%	9%	12%	
Driving alone to work	80%	78-83%	72%	81%	
Long commute - driving alone	24%	20-27%	15%	20%	

10th/90th percentile, i.e., only 10% are better. 2018

Note: Blank values reflect unreliable or missing data

\*\* Data should not be compared with prior years

12/18/18

