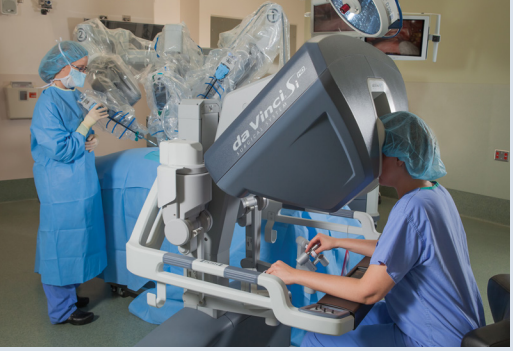


















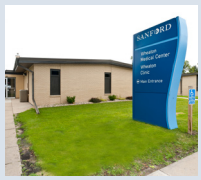




SANFORD HEALTH

Sanford Health Network

2018 Community Health Needs Assessment

dba Sanford Canby Medical Center EIN# 46-0388596

Dear Community Members,

Sanford Medical Center Canby 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:

- *Physical Health*
- *Behavioral Health and Mental Health Access*

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 Canby 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,

Lori Sisk

Lori Sisk, RN, MHA
Senior Director
Sanford Medical Center Canby

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Sanford Medical Center Canby

Community Health Needs Assessment

2018

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. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholder's concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health distributed the survey link via email to stakeholders and key leaders located within Yellow Medicine County. Data collection occurred during November 2017. A total of 20 community stakeholders participated in the survey.

   B. *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 52 community residents participated in the survey.

   C. *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.

   D. *Community Stakeholder Discussions*
   Community stakeholders were invited to attend a presentation of the findings of the CHNA research. Facilitated discussion commenced and each participant was asked to consider his or her top two or three priorities that should be further developed into implementation strategies. The meeting served to inform the group of the findings but also served as a catalyst to drive collaboration.

E. *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. Key community stakeholders met with medical center leaders to complete the multi-voting exercise.

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 Yellow Medicine 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 https://www.sanfordhealth.org/contact-us/form.

Key Findings

Community Health Concerns
The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.0 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.0; however, the high ranking needs of 3.0 or above are considered for the prioritization process. The resident survey addresses personal health needs and concern. The secondary research provides further understanding of the health of the community and in many cases the indicators are aligned and validate our findings.

Economic Well-Being
Community stakeholders are most concerned about employment options (ranking 3.40) and a skilled labor force (3.20).

Children and Youth
Community stakeholders are most concerned about childhood obesity (3.38), the availability of quality childcare (3.13), and bullying (3.06).

Aging Population
Community stakeholders are most concerned about the cost of long term care (3.67) and memory care (3.50) and the cost of in-home services (3.13).

Health Care Access
Community stakeholders are most concerned about access to affordable health insurance coverage (3.43), access to affordable health care (3.36), access to affordable prescription drugs (3.29), the availability of mental health providers (3.29), the availability of behavioral health providers (3.23), access to affordable vision insurance (3.21), and access to affordable dental insurance (3.07).

Mental Health and Substance Abuse
Community stakeholders are most concerned about dementia and Alzheimer's disease (3.54), depression (3.36), stress (3.21), drug use and abuse (3.08), alcohol use and abuse (3.00), and tobacco use (3.00).

Resident survey participants are facing the following issues:

- 70% report that they are overweight or obese
- 53% self-report binge drinking at least 1X/month
- 31% have been diagnosed with depression
- 28% have a diagnosis of hypertension
- 23% have been diagnosed with high cholesterol
- 20% currently smoke cigarettes
- 16% report running out of food before having money to buy more

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

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

- Physical Health
- Behavioral Health and Mental Access

Implementation Strategies

Priority 1: Physical Health

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 Canby has made physical health specific to obesity a significant priority and has developed strategy to improve physical health and reduce the negative health effects of obesity.

Priority 2: Behavioral Health and Mental Access

Mental health is important at every stage of life and affects how people think, feel and act. According to the National Institute of Mental Health, depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental and psychological factors. Depression is among the most treatable of mental disorders.

Sanford has made mental health a significant priority and has developed strategies to reduce mortality and morbidity from mental health and behavioral health and substance abuse. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by addiction and mental illness.

Sanford Canby Medical Center

Community Health Needs Assessment

2018

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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 Tvedt, 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.”

The following Sioux Falls community stakeholders participated in community discussions and helped to formulate the priorities for our implementation strategies:

- Jason Anderson, Long Term Care Director, Sanford Health
- Morgan Engelkes, Intern
- Cheryl Ferguson, Clinic Director, Sanford Health
- Diana Fliss, Canby Hospital District Board Chair
- Brenda Knutson, Director of Nursing, Sanford Health
- Allison Nelson, Finance Director, Sanford Health
- Dawn Regnier, Minnesota West Director of Customized Training
- Lori Sisk, Senior Director, Sanford Health
- Ruth Tvedt, Ancillary Services Manager, Sanford Health

Description of the Medical Center

Sanford Canby Medical Center (SCMC) is a community-based, 25-bed acute care Critical Access Hospital serving over 6,000 people. The medical center complex includes an attached Rural Health Clinic, skilled nursing facility, senior housing/assisted living facility, dental clinic, home health care service, dialysis unit and wellness center. Sanford Canby also has beds designated for swing bed services and owns its own ambulance service.

The medical center is located in a medically underserved area, as designated by the Federal Health Resources and Services Administration (HRSA). It serves an increasingly elderly population who are unable to travel distances for routine health care services.

Sanford Canby employs 2 family medicine physicians, 1 internal medicine physician, 1 surgeon, 3 advance practice providers, and 285 employees. Outreach services are provided for cardiology, orthopedics, nephrology, OB/GYN, ENT, urology, ophthalmology, vascular and GI.

Description of the Community Served

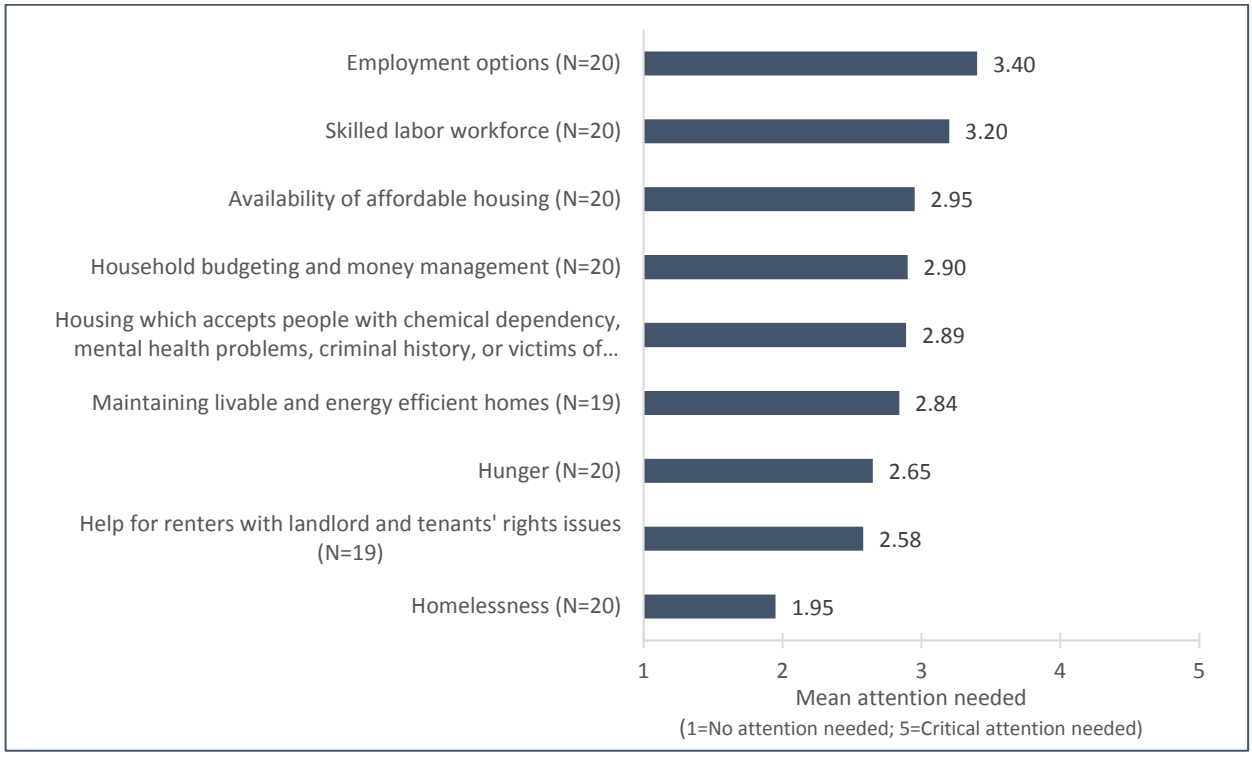
Canby, known as the Gateway to the Prairie, has a population of 1,800 people, and is located in southwestern Minnesota in Yellow Medicine County. The community is home to Del Clark Lake, which provides an abundance of recreational and leisure activities including hunting, fishing, golf and walking/biking trails. Canby has excellent schools, including an independent school district, St. Peter's Catholic School, and Minnesota West Community College. Sanford Canby is very active in the local chamber of commerce and works with the community to strengthen its assets.

Key Findings

Community Health Concerns

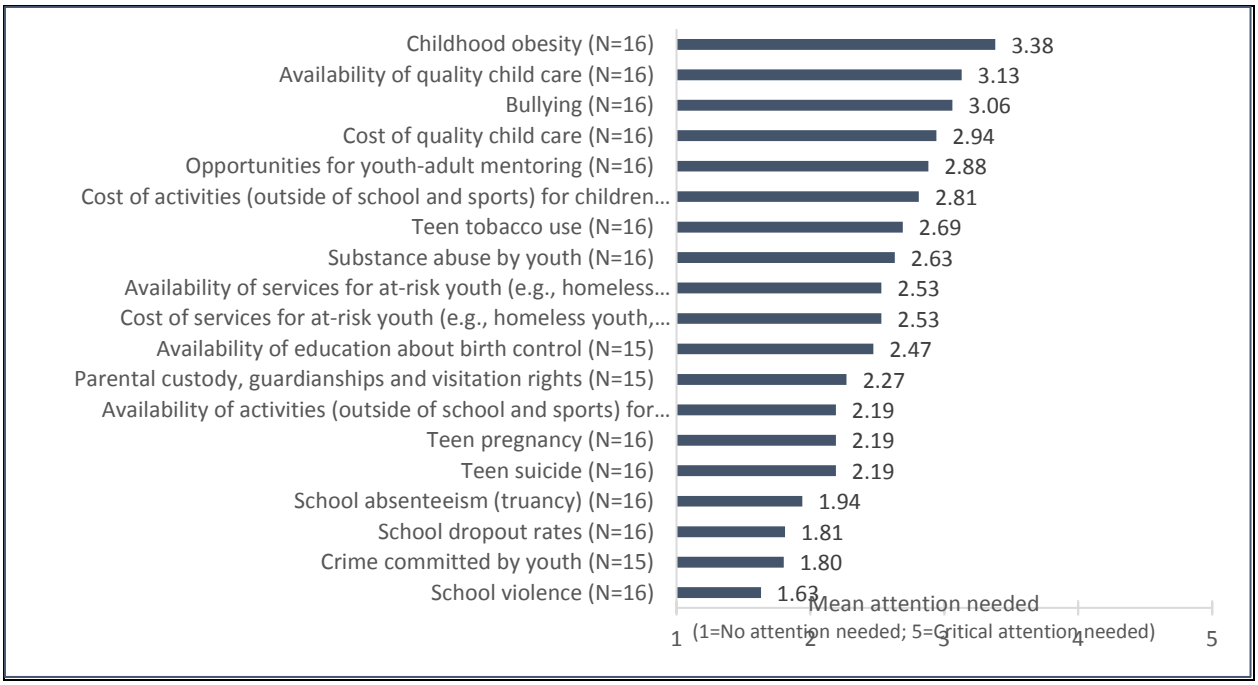
The key findings are based on the key stakeholder survey, the resident survey, and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.0 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.0; however, the high ranking needs of 3.0 or above are considered for the prioritization process. The resident survey addresses personal health needs and concerns. The secondary research provides further understanding of the health of the community, and in some cases, the indicators align with and validate our findings.

Economic Well-Being: The concern for the community's economic well-being is focused on the need for employment options, and a skilled workforce.



Healthy People 2020 has defined the social determinants of health. "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." The patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

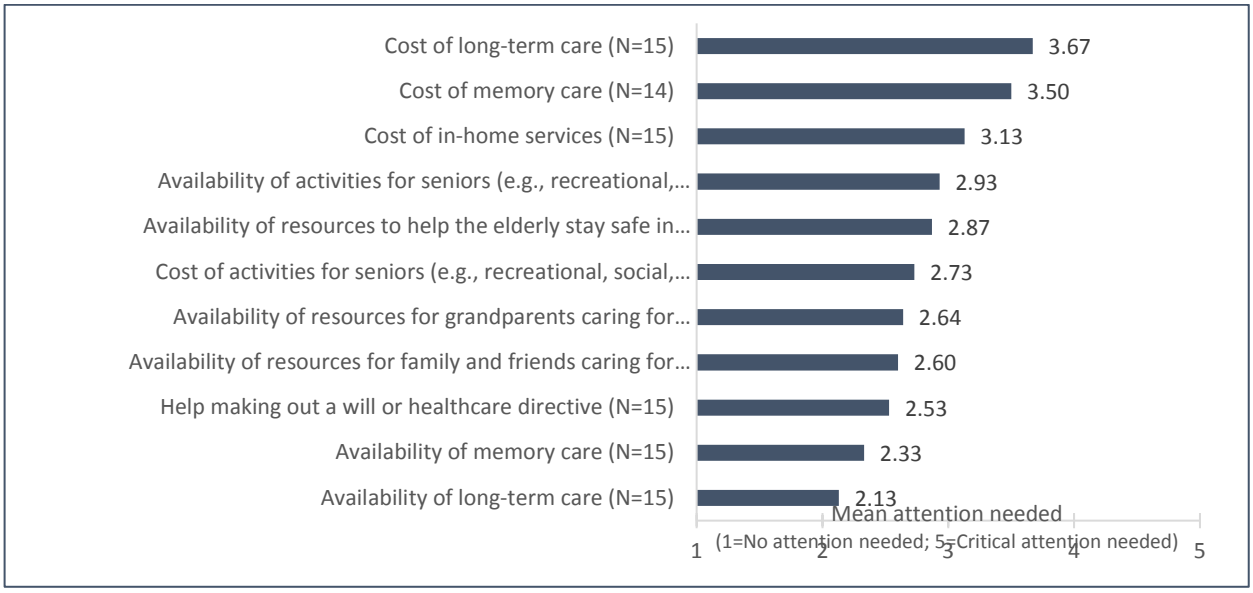
Children and Youth: The highest concerns for children and youth are childhood obesity, the availability of quality childcare, and bullying.



Obesity 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.

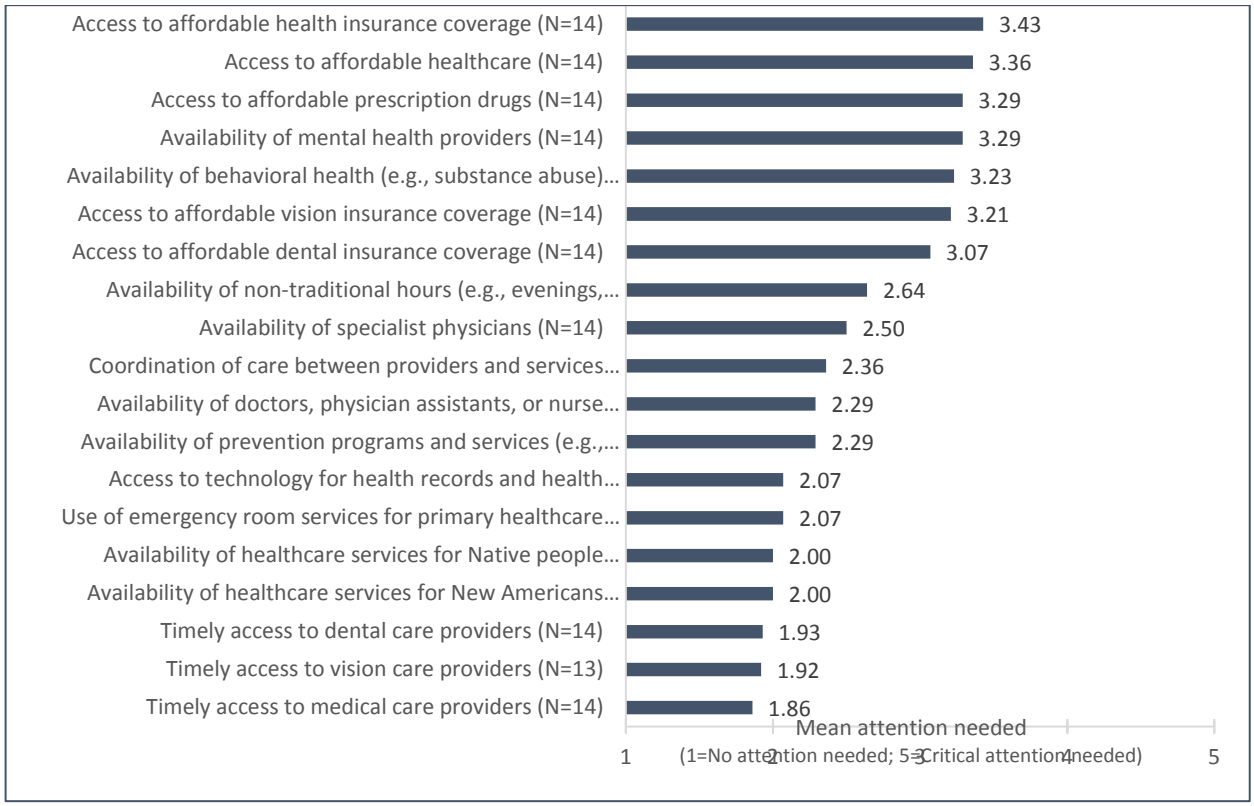
Aging Population: The cost of long term care and memory care are top concerns once again and were top concerns during the 2016 CHNA cycle. The cost of in-home services is also a top concern.

Current state of community issues regarding the AGING POPULATION



Acording to the U.S. Health and Human Services Administration on Aging, the cost of long term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford providers work to help seniors live healthy independent lives. Sanford social workers, case managers, and discharge planners refer patients to area service providers to make certain that patients receive a safe discharge and transition to the appropriate levels of care.

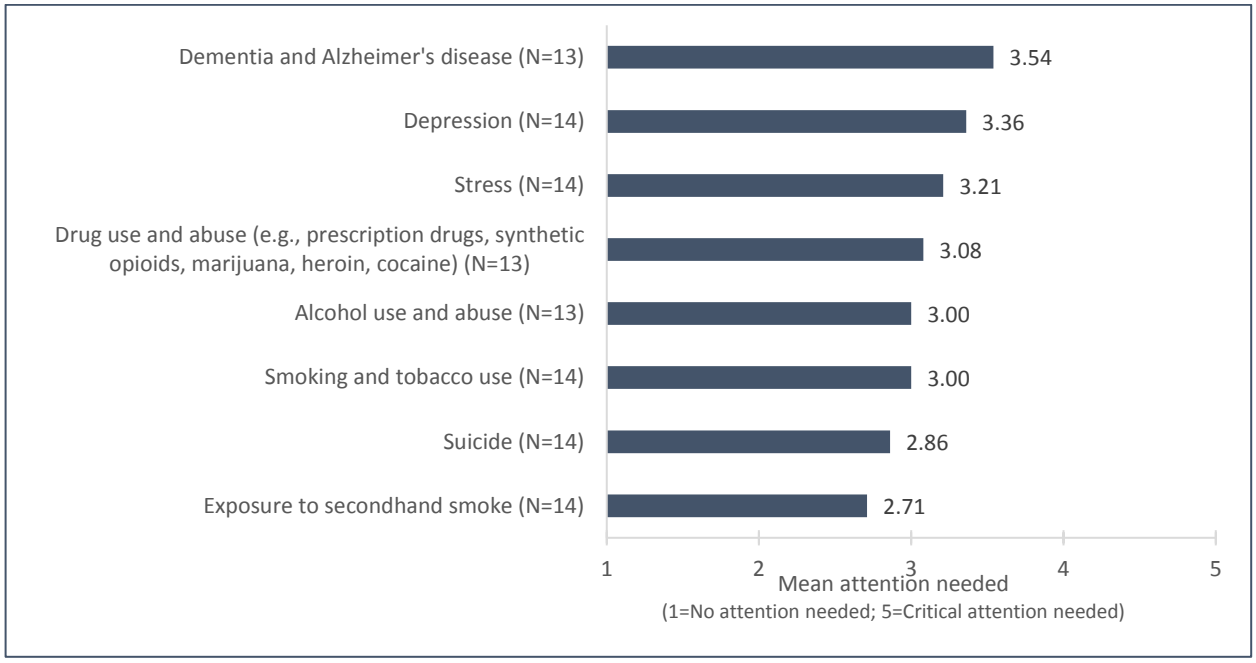
Health Care and Wellness: Access to affordable health insurance, access to affordable health care, and access to affordable prescription drugs are all high concerns for community stakeholders. The availability of behavioral health and mental health providers, access to affordable vision and dental insurance are ranked very high among the top concerns for the community.



According to the Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. The 2016 HRSA report projected that the supply of workers in selected behavioral health professions would be approximately 250,000 workers short of the projected demand by 2025.

Mental Health and Substance Abuse: Dementia and Alzheimer's disease, depression, stress, drug use and abuse, alcohol use and abuse, and tobacco use are top concerns for the community.

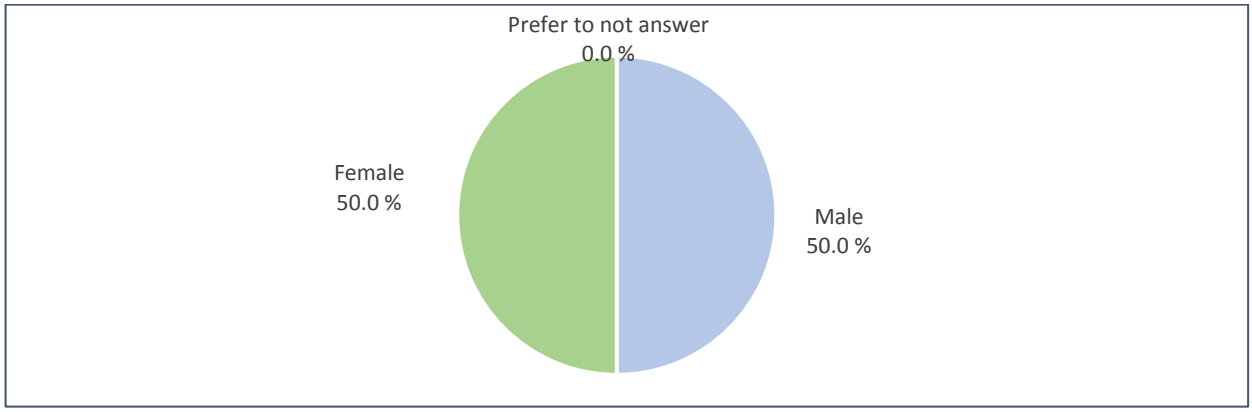
Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



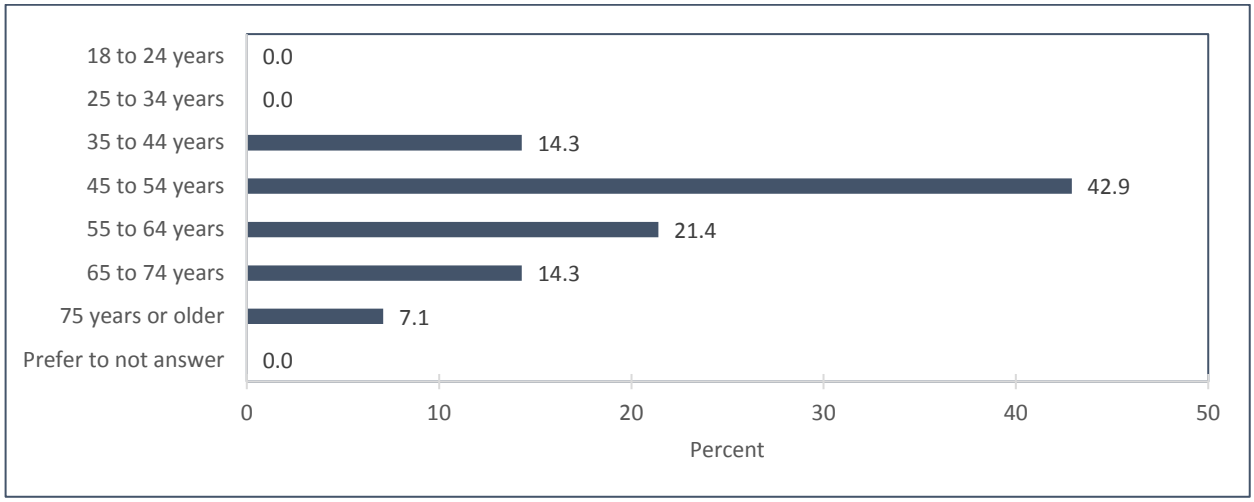
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental illness, 1.7 million of whom were age 18 to 25. Additionally, 15.7 million adults (age 18 or older) and 2.8 million youth (age 12 to 17) had a major depressive episode during the past year. In 2014, an estimated 22.5 million Americans age 12 and older self-reported needing treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing mental health treatment or counseling in the past year. These disorders are among the top conditions that cause disability and carry a high burden of disease in the United States, resulting in significant costs to families, employers, and publicly funded health systems. By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide."

Demographic Information for Key Stakeholder Participants

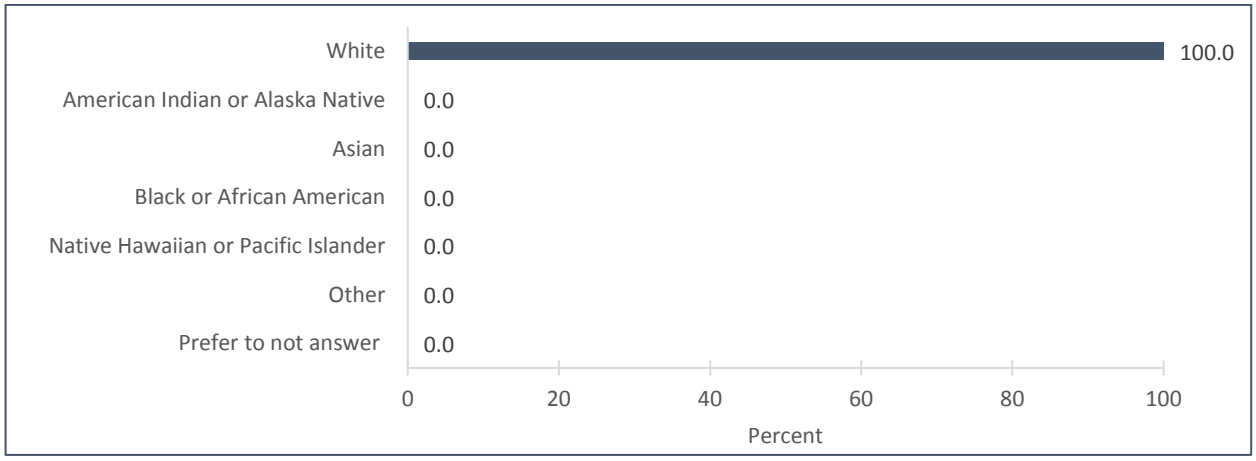
Biological Gender



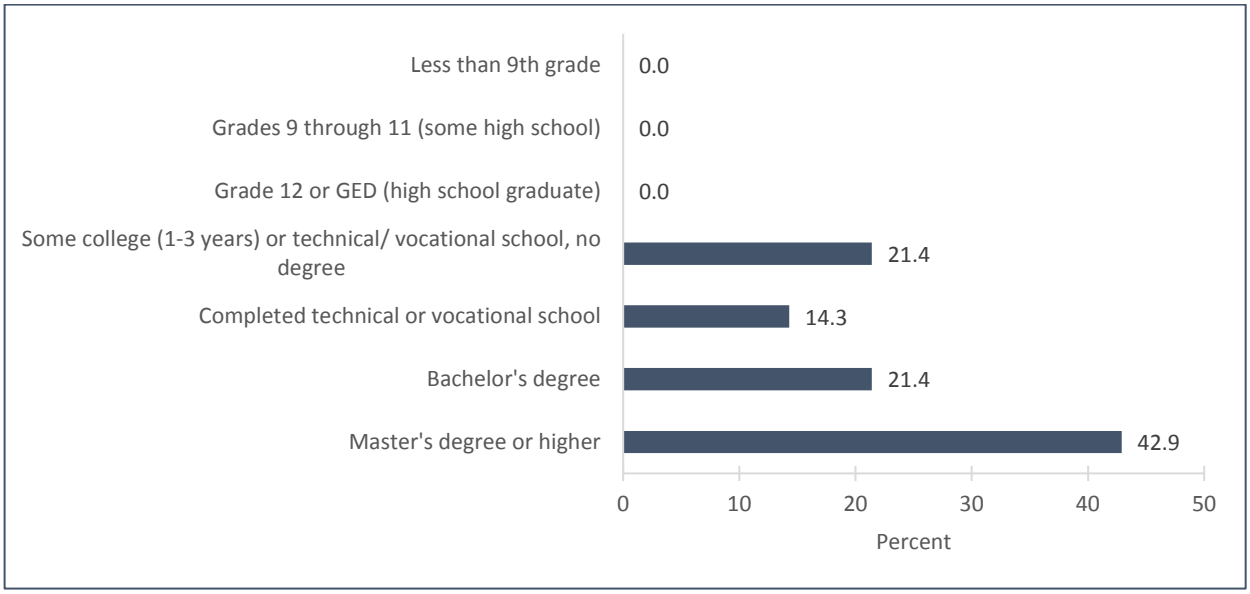
Age of Respondents



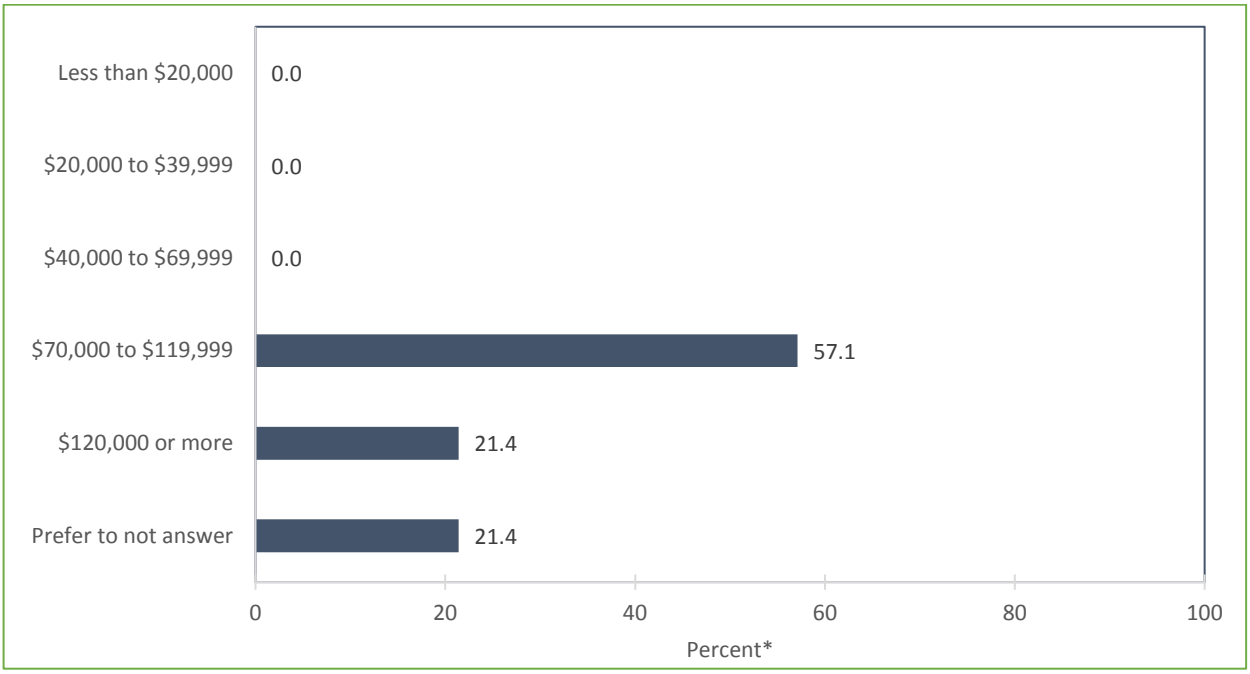
Race of Participants



Highest Level of Education Completed



Annual Household Income of Respondents, From All Sources, Before Taxes



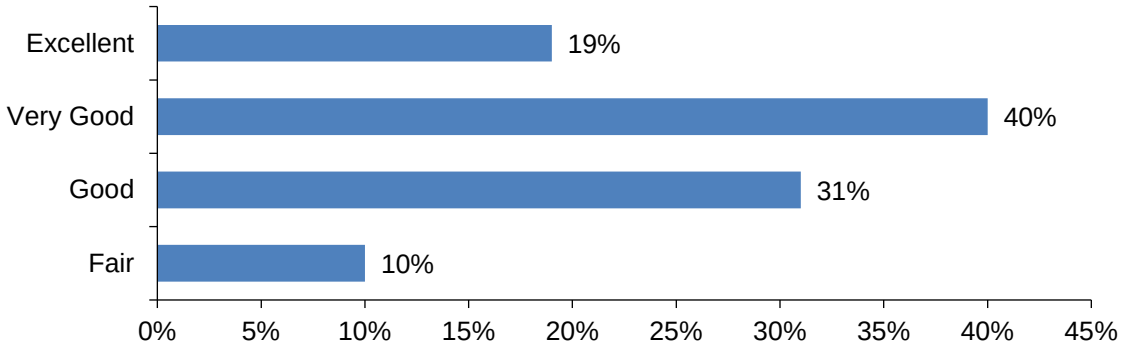
Residents' Health Concerns

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.

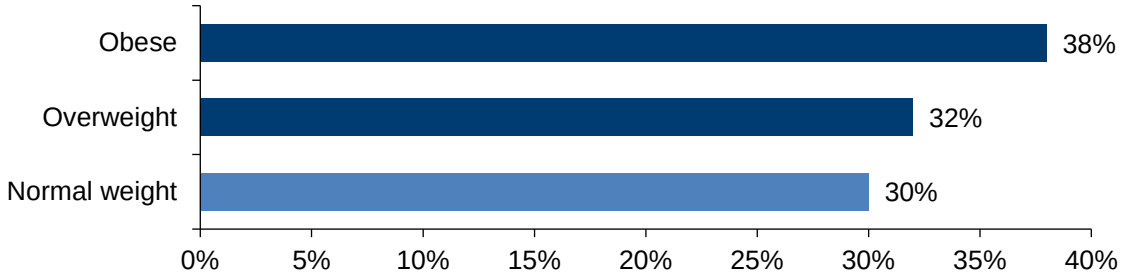
How would you rate your health?

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



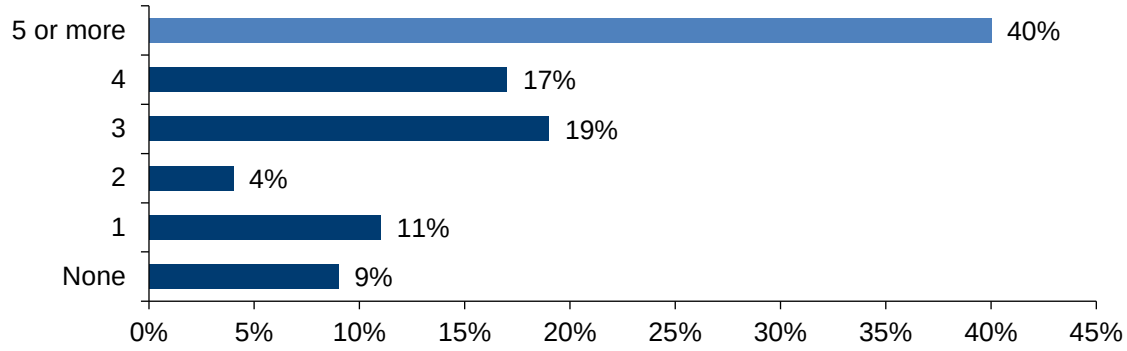
Body Mass Index (BMI)

Seventy percent of survey participants are overweight or obese.



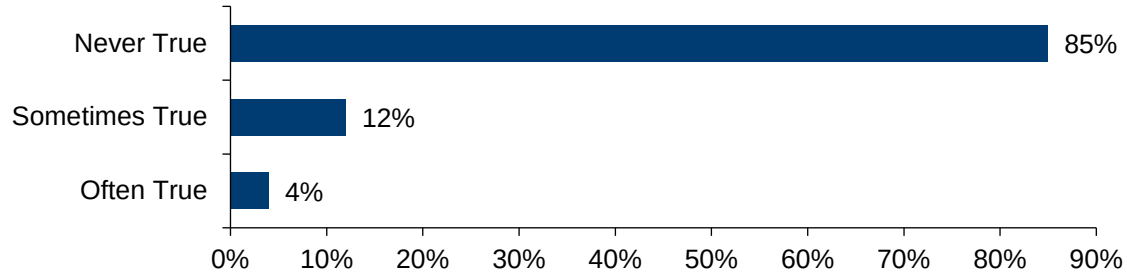
Total Servings of Fruits, Vegetables and Juice

Only 40% are consuming the recommended 5 or more daily servings of fruit and vegetables.



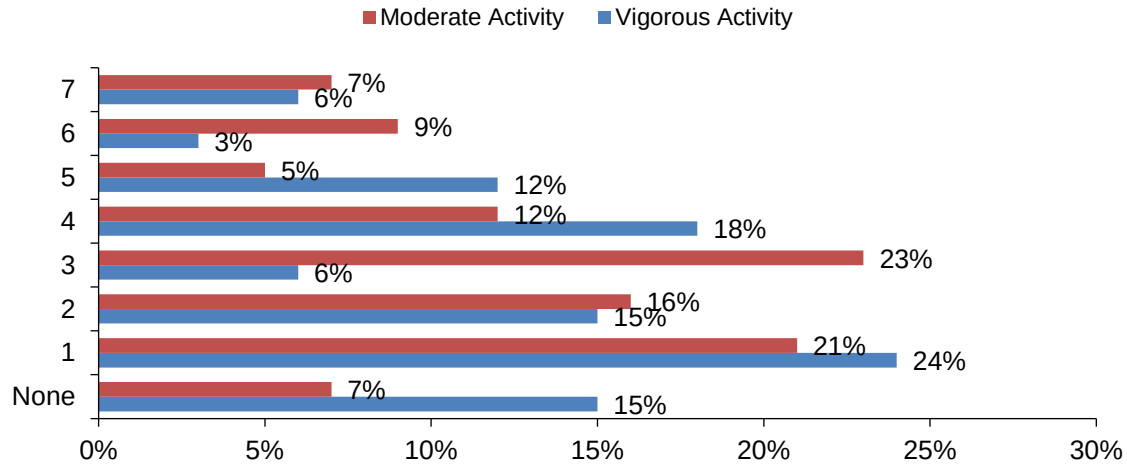
Food Insecurity

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



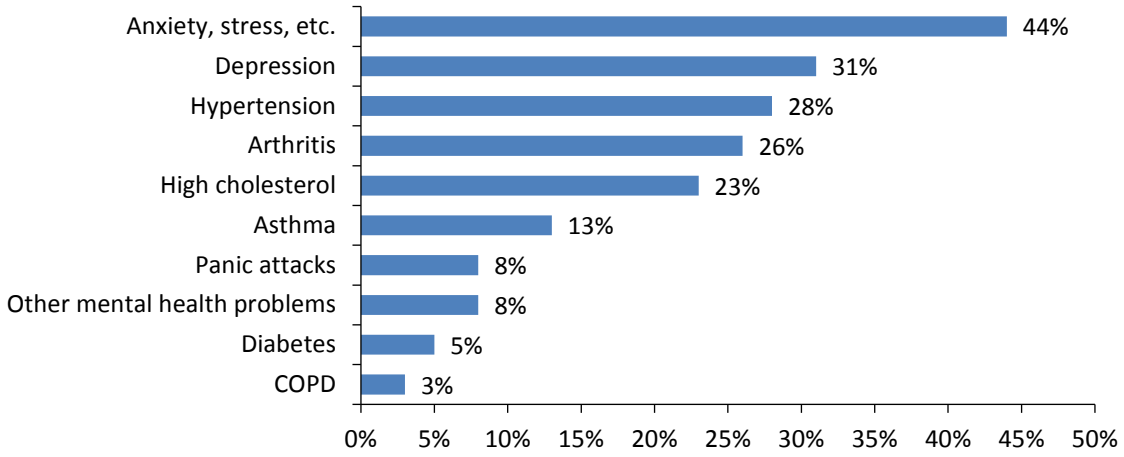
Days per Week of Physical Activity

Fifty-six percent have moderate exercise three or more times each week.



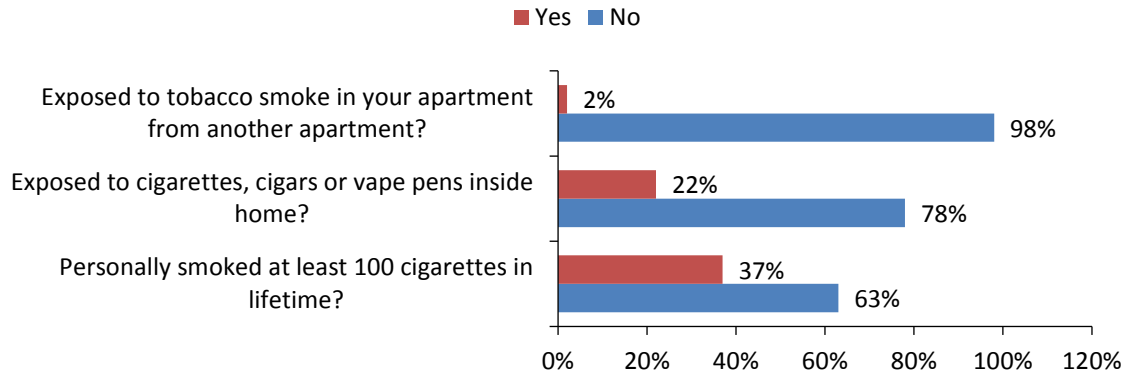
Past Diagnosis

Depression, anxiety, high cholesterol, hypertension and arthritis are the top diagnoses for the survey participants**.**



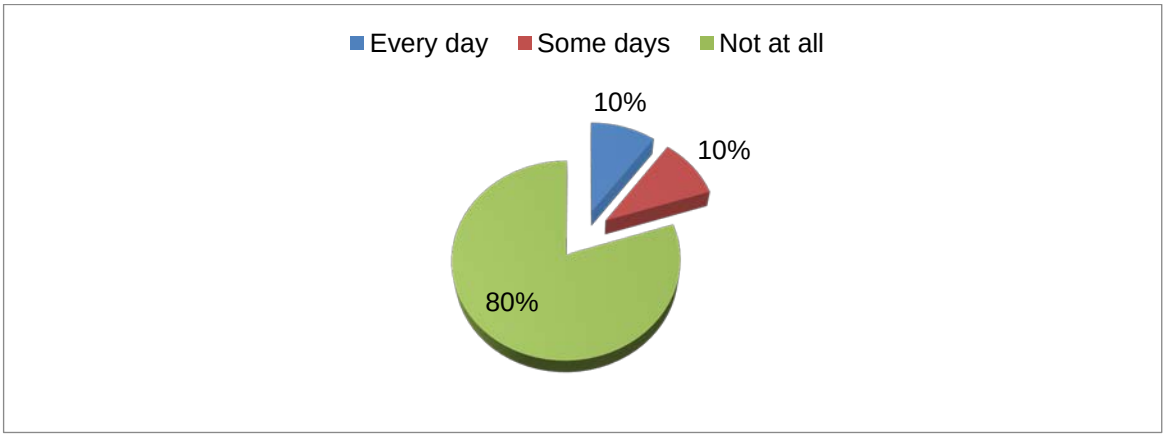
Exposure to Tobacco Smoke

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



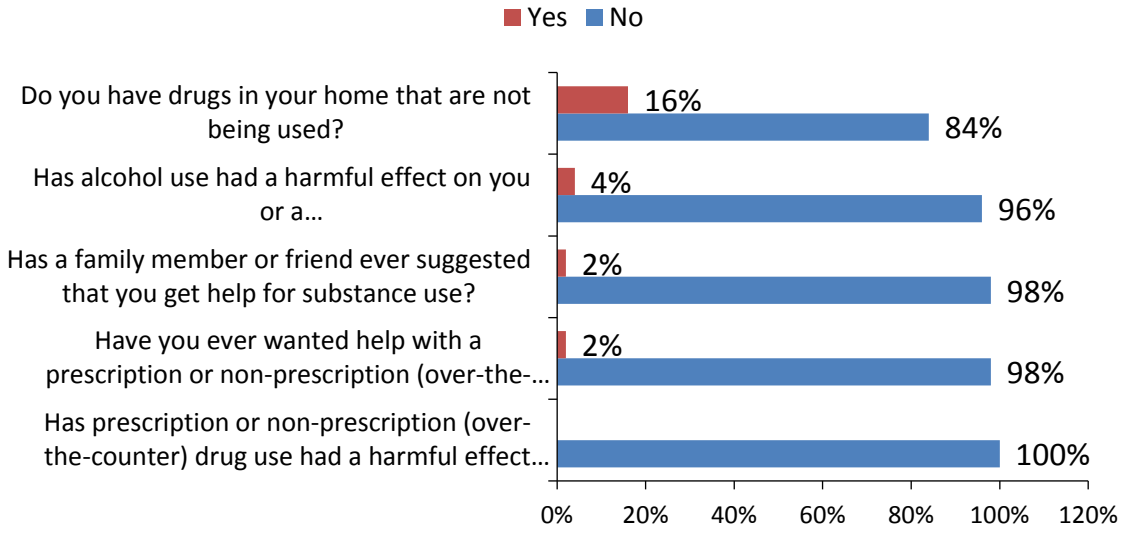
Do you currently smoke cigarettes?

Twenty percent currently smoke cigarettes.



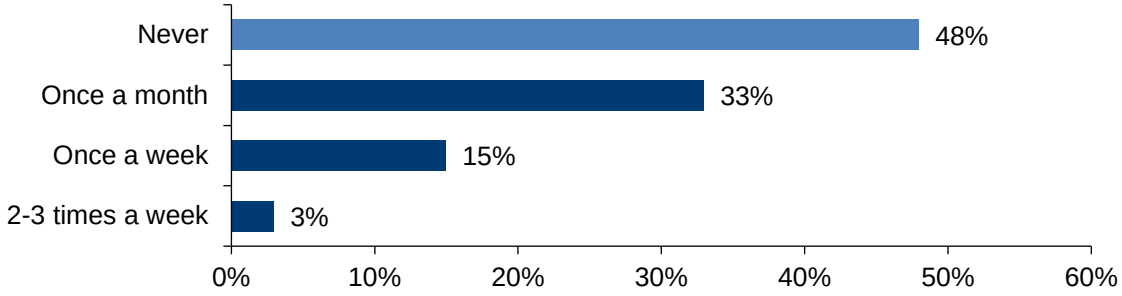
Drug and Alcohol Issues

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

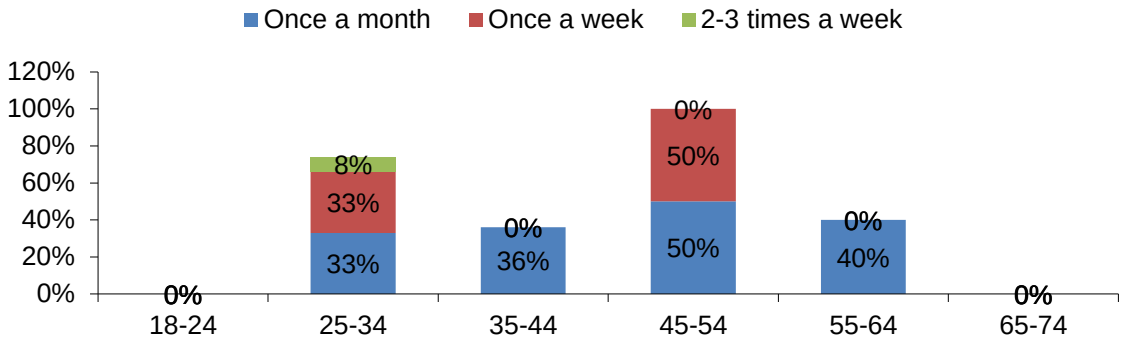


Binge Drinking

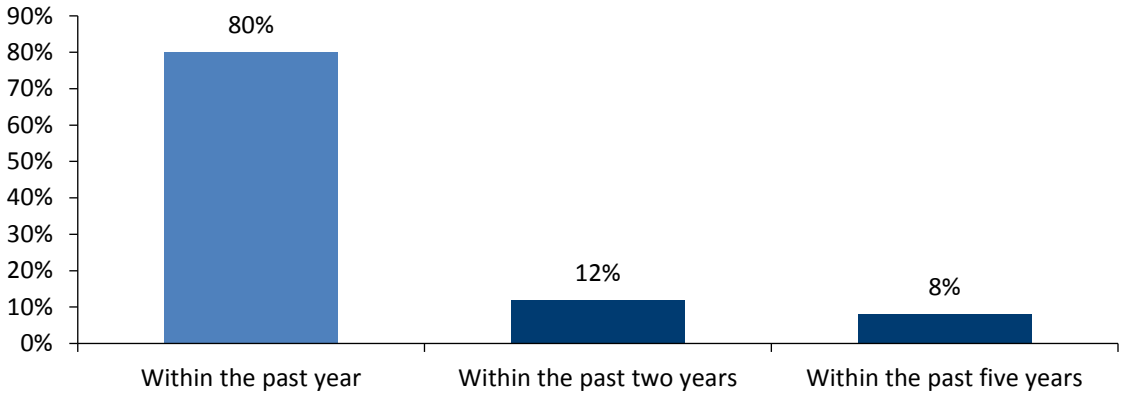
Fifty-two percent binge drink at least once per month.



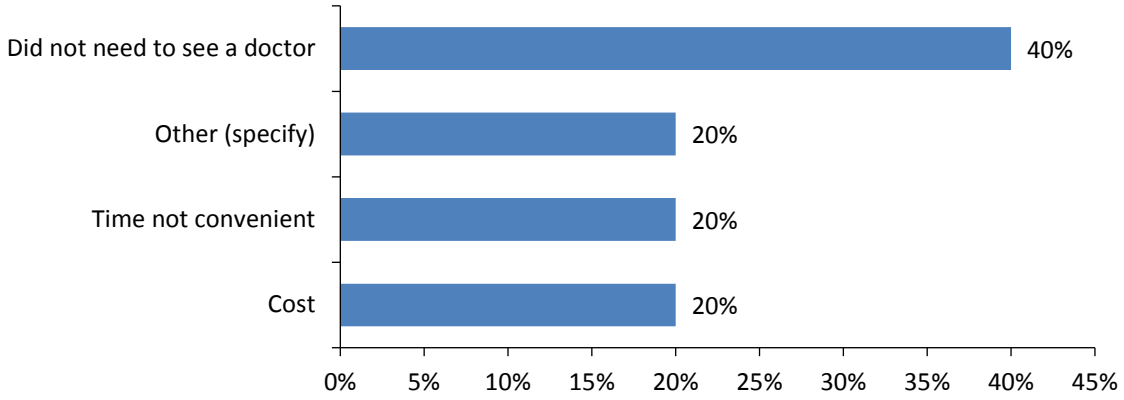
Binge Drinking Past 30 days by Age



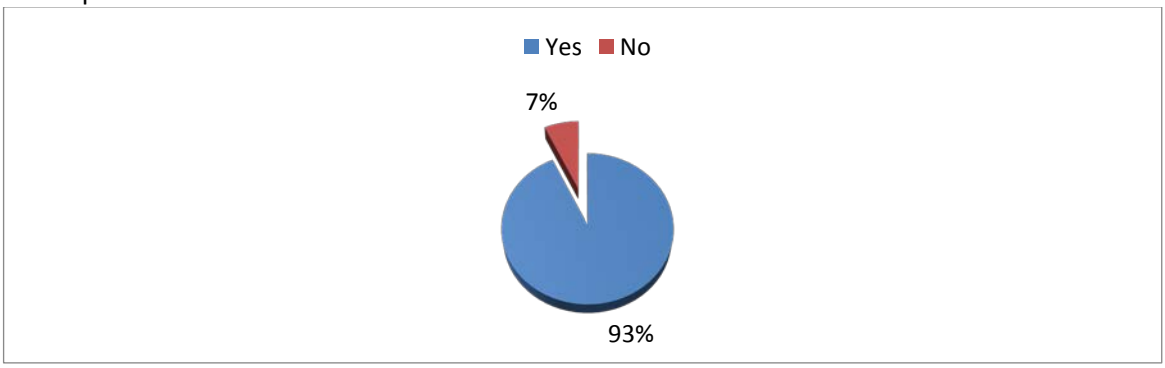
How long has it been since you last visited a doctor or health care provider for a routine check-up?
Twenty percent have not had a routine check-up in more than a year.



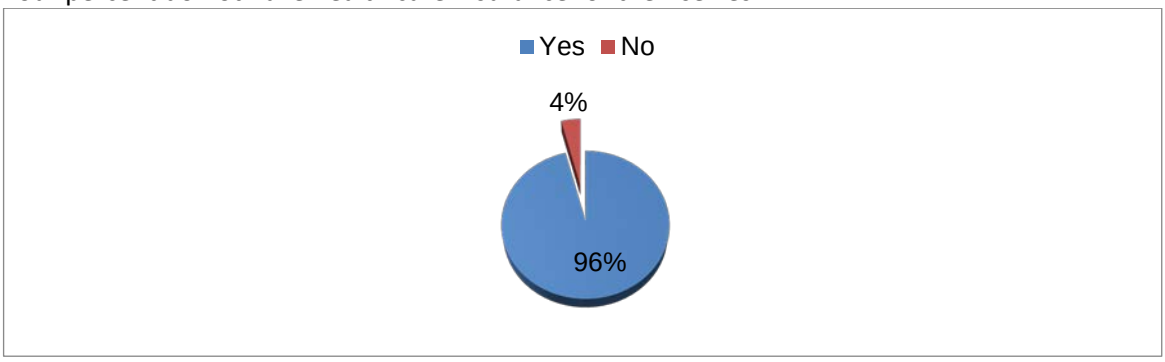
Barriers to Routine Check-up
Forty percent of survey respondents report not needing a routine check-up.



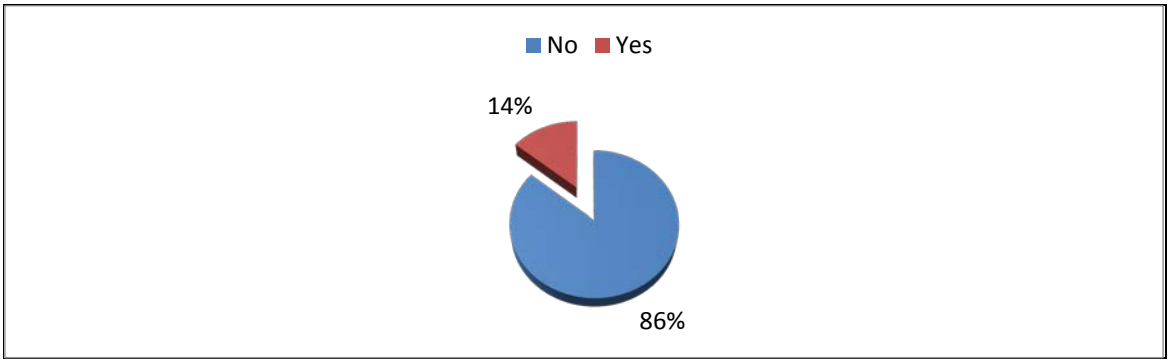
Do you have health care coverage for your children or dependents?
Seven percent do not have health care insurance for their children.



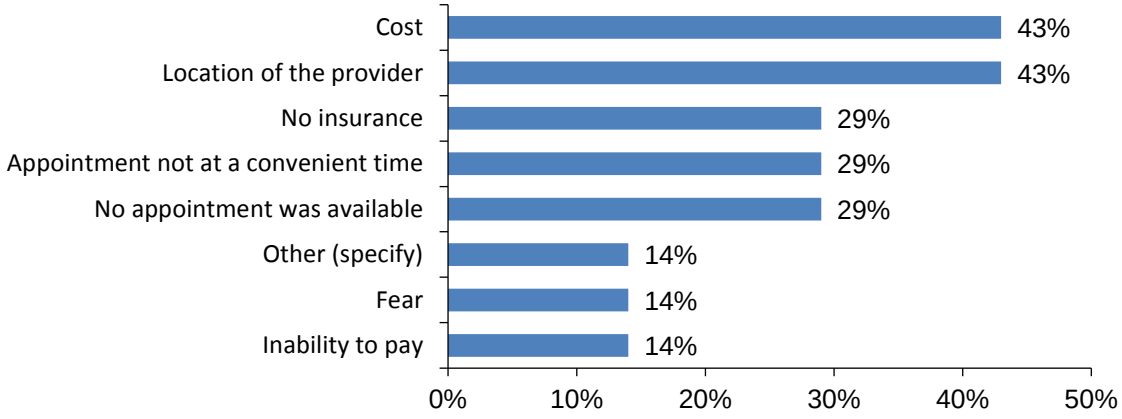
Do you currently have any kind of health insurance?
Four percent do not have health care insurance for themselves.



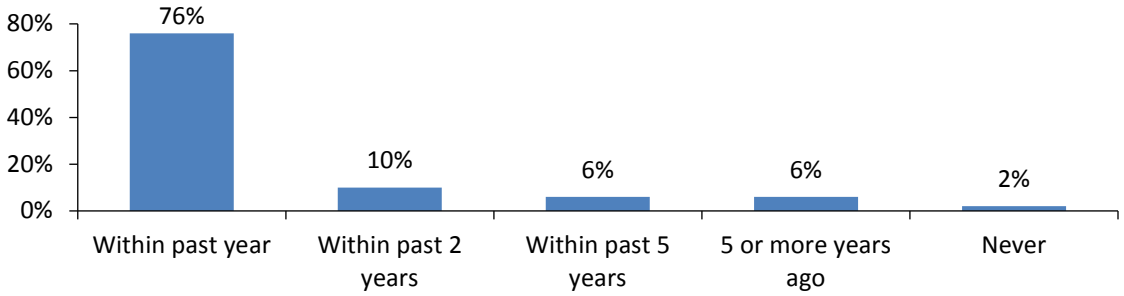
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?
Fourteen percent report not receiving the care that they needed.



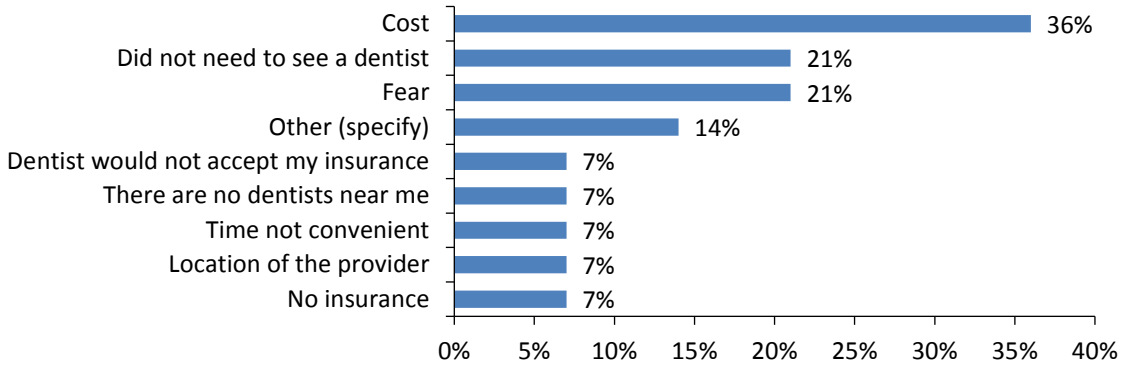
Barriers to receiving medical care



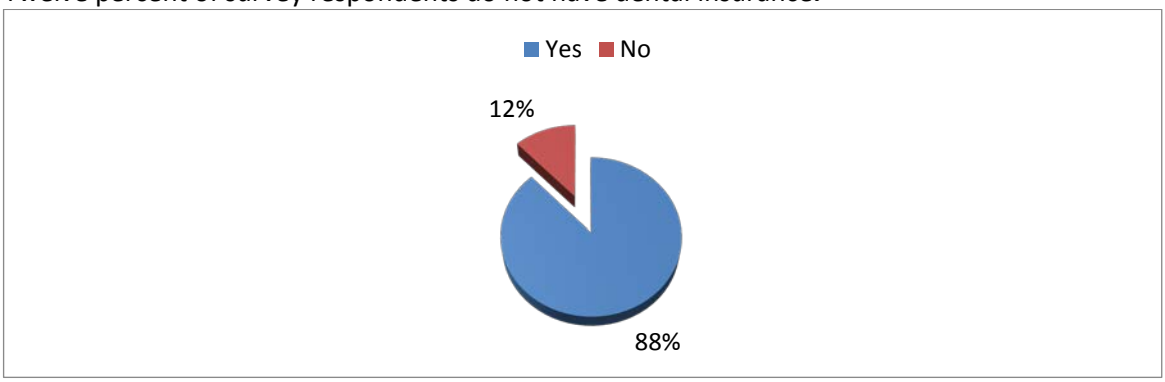
How long has it been since you last visited a dentist?
Twenty-four percent have not visited a dentist in more than a year.



Barriers to visiting the dentist

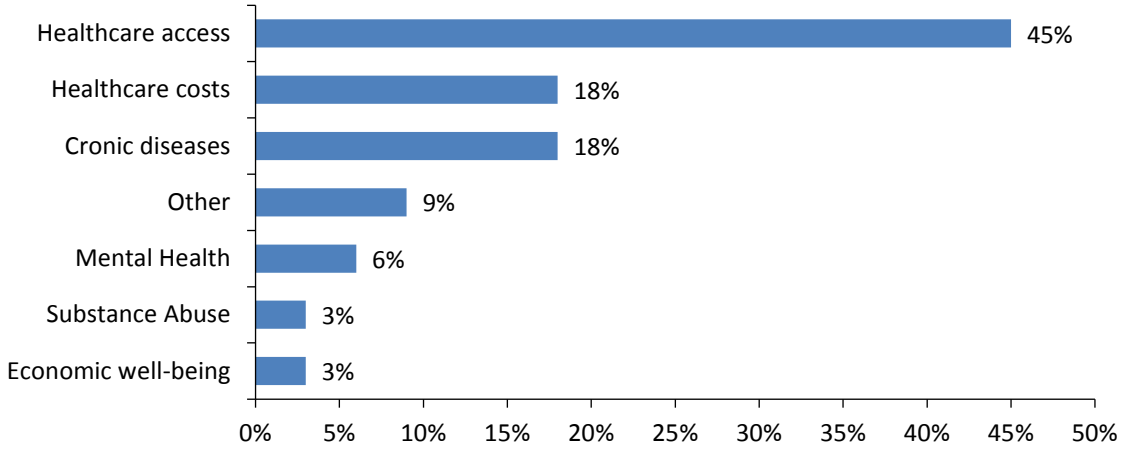


Do you have any kind of dental care or oral health insurance coverage?
Twelve percent of survey respondents do not have dental insurance**.**



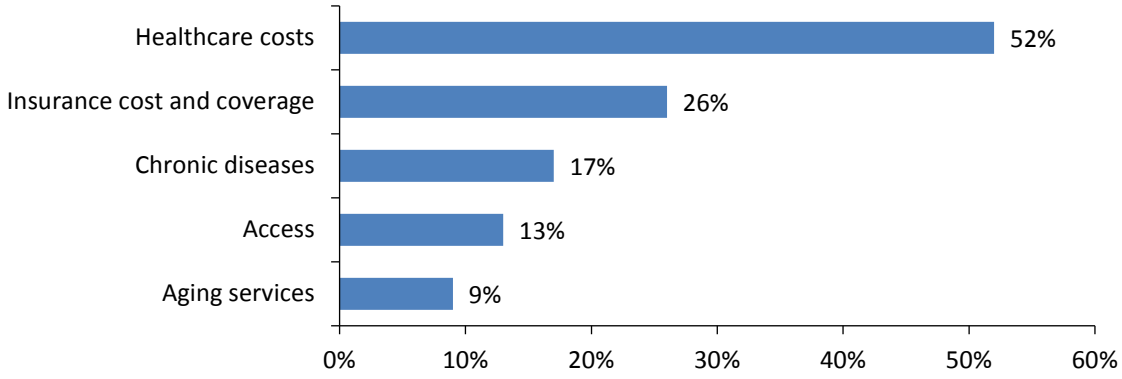
Most Important Community Issues

Health care access and health care costs and chronic disease are the top concerns of respondents for their community.



Most Important Issue for Family

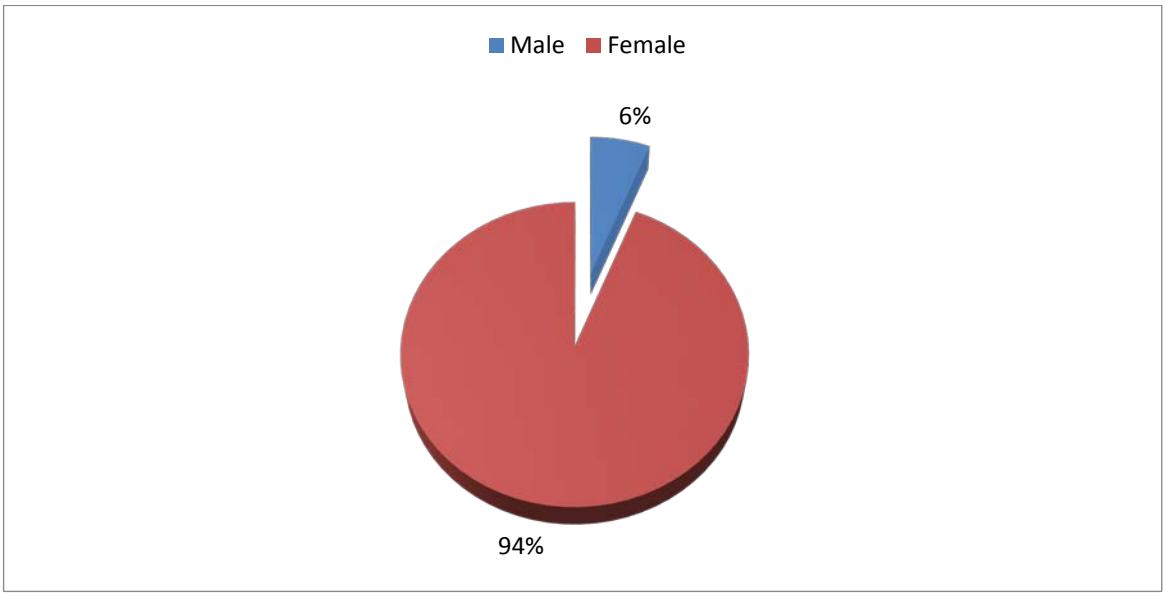
Health care costs and insurance cost and coverage are the top concerns of survey respondents for their family.



Demographic Information for Community Resident Participants

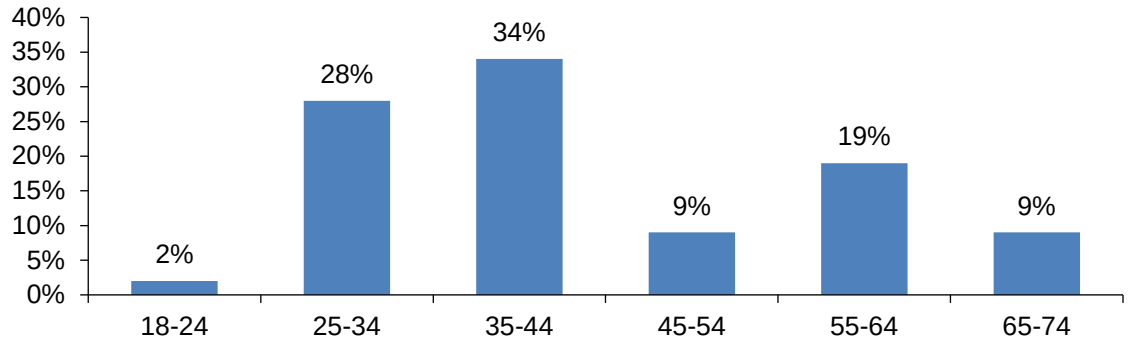
Biological Gender

Only 6% of the survey participants were male.

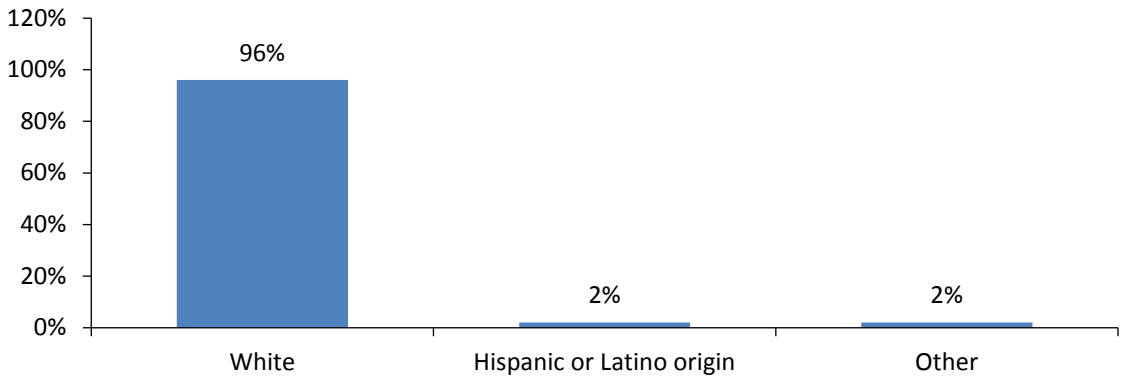


Age

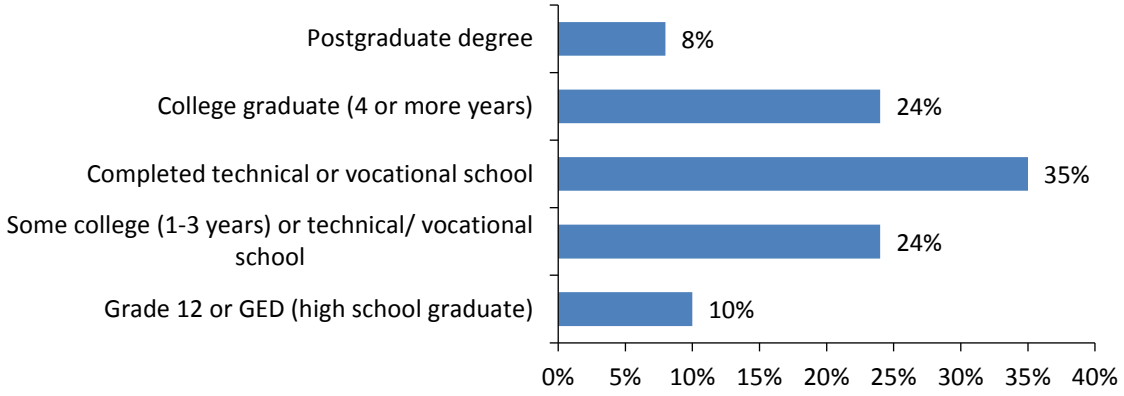
Every age group was represented among the survey participants; however, only 2% fell into the 18-24 age group.



Ethnicity

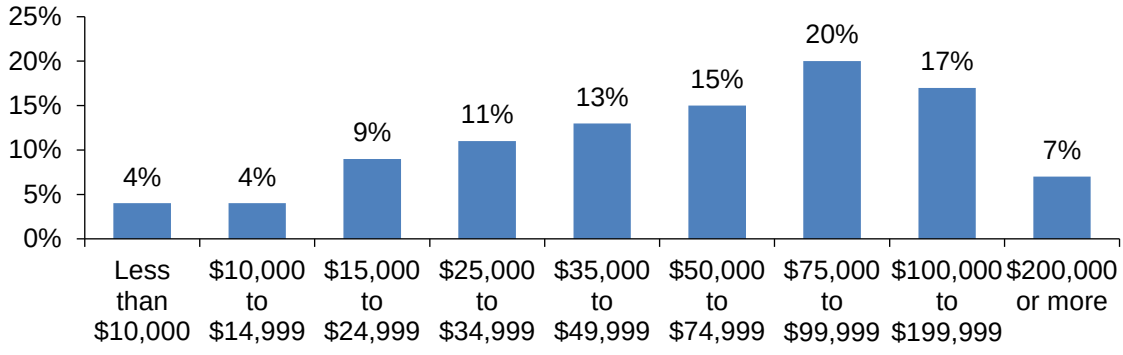


Education Level



Total Annual Household Income

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



Secondary Research Findings

Census Data

9,935 - Total population for Yellow Medicine County in Minnesota

	Yellow Medicine County
% below 18 years of age	23.0
% 65 and older	20.3
% White – non-Hispanic	90.2
American Indian	3.9
Hispanic	4.1
African American	0.4
Asian	0.6
% Female	49.5
% Rural	80.8

County Health Rankings

	Yellow Medicine County	State of Minnesota	U.S. Top Performers
Adult smoking	15%	15%	14%
Adult obesity	29%	27%	26%
Physical inactivity	26%	20%	20%
Excessive drinking	22%	23%	13%
Alcohol related driving deaths	22%	30%	13%
Food insecurity	9%	10%	10%
Uninsured adults	7%	6%	7%
Uninsured children	4%	3%	3%
Children in poverty	14%	13%	12%
Children eligible for free or reduced lunch	42%	38%	33%
Diabetes monitoring	84%	88%	91%
Mammography screening	66%	65%	71%
Median household income	$55,700	$65,100	$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.

Canby 2019 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
Economic Well-Being • Employment options 3.40 • Skilled labor force 3.20
Children and Youth • Childhood obesity 3.38 • Availability of quality childcare 3.13 • Bullying 3.06 • Children living in poverty 15% (County Health Rankings) • Teen pregnancy (County Health Rankings)
Aging Population • Cost of long term care 3.67 • Cost of memory care 3.50 • Cost of in-home services 3.13
Healthcare Access • Access to affordable health insurance coverage 3.43 • Access to affordable health care 3.36 • Access to affordable prescription drugs 3.29 • Availability of mental health providers 3.29 • Availability of behavioral health 3.23 • Access to affordable vision insurance coverage 3.21 • Access to affordable dental insurance coverage 3.07
Mental Health and Substance Abuse • Dementia and Alzheimer's disease 3.54 • Depression 3.36 • Anxiety 44% self-report • Stress 3.21 • Drug use and abuse 3.08 • Alcohol use and abuse 3.00 • 52% binge drink • Smoking and tobacco use 3.00
Wellness • Adult obesity • Hypertension • Arthritis • High cholesterol • Dental care • Healthy nutrition

2018 Community Health Needs Assessment

How Sanford Canby is Addressing the Community Needs

Identified Concerns	How Sanford Canby is Addressing the Community Needs
ECONOMIC WELL BEING	
Employment options	Sanford Canby hosted two hiring fairs in the past year. SCMC maintains an active list of vacant positions ranging from entry level positions to professional positions on the Sanford Careers website.
Skilled labor force	Sanford has many programs in place to address workforce development, including the Sons and Daughters scholarship program, the Heart of Tomorrow Program, internships for college students who are interested in health care careers, and health career programs for high school students. Sanford Canby has offered classes at SCMC for certified nursing assistants. Additionally, tuition reimbursement programs are available for current staff interested in educational opportunities that are advantageous for both the staff and the operation.
CHILDREN AND YOUTH	
Childhood obesity	SCMC implemented Sanford *fit* Kids in the Canby Public School and St. Peter's Catholic School in grades K-6. We support area athletic events through sponsorships. The Sanford POWER program is offered to middle and high school students. Sanford Canby warehouse space is available for use by non-profits for events and high school sporting groups for practice.
Availability of quality childcare	CPR training/first aid is offered periodically and is open to the public.
Bullying	The implementation of the Sanford *fit*Kids program addresses mood and stress management strategies.
AGING POPULATION	
Cost of long term care	Sanford Sylvan Court has made application to become a community- based nursing home provider. LTC staff work directly with the County to support waiver services. 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 memory care	Assisted living services are offered through Sanford Sylvan Place. Home health services are offered in the community by the Sanford Canby Home Health Agency.
Cost of in-home services	Home Health staff work directly with the county to support waiver services.
HEALTH CARE ACCESS	
Access to affordable health insurance coverage	SCMS has a small team of staff members conducting presumptive eligibility for patients possibly needing financial assistance. Health insurance is offered to Sanford Canby staff. Charity care is offered at Sanford Canby via the Sanford Health Charity Care policy. Sanford contributed nearly $300 million system-wide in charity care during FY 2017. Financial counselors are available to help patients who need free or discounted care.
Access to affordable health care	SCMS has a small team of staff members conducting presumptive eligibility for patients possibly needing financial assistance. Charity care is offered at Sanford Canby via the Sanford Health Charity Care policy. Sanford contributed nearly $300 million system-wide in charity care during FY 2017. Financial counselors are available to help patients who need free or discounted care.
Access to affordable prescription drugs	The RN Health Coach and pharmacy staff work with Project Hope to assist with providing affordable prescription drugs.

Identified Concerns	How Sanford Canby is Addressing the Community Needs
Availability of mental health providers	Health care team speaks to sophomore class about health care careers.
Availability of behavioral health	SCMC supports behavioral health presence on Sanford Canby campus through leased space.
Access to affordable vision insurance coverage	Vision insurance is offered to Sanford Canby staff. The local eye care clinic in Canby participates in the Care Credit Program, accepts MN Medicaid and offers discount eye exams for cash paying, low income residents.
Access to affordable dental insurance coverage	Sanford Canby Dental Clinic accepts MN Medicaid patients. Sanford dental insurance is offered to SCMC staff. They participate in the Care Credit program.
MENTAL HEALTH & SUBSTANCE ABUSE	
Dementia & Alzheimer's Disease	Pathways support group is available to the public. Adult day care is offered in the long term care center.
Depression	Sanford offers sponsorship support for over 20 local community events. RN Health Coach is available to assist with consult and resource education.
Stress	SCMC allows local card playing group to utilize space to meet, socialize and play bridge. SCMC allows local Bible study group to meet in the long term care center. Yellow Medicine County mental health services are offered through leased space. Sanford Canby warehouse space is available for use by non-profits for events and high school sporting groups for practice.
Drug use and abuse	The Sanford Quality Cabinet has implemented a program to reduce opioid prescriptions. The RN Health Coach is available to assist drug and alcohol abuse.
Alcohol use and abuse	Host site for AA meetings. RN Health Coach is available to assist drug and alcohol abuse.
Smoking and tobacco use	Smoking and tobacco cessation is offered through clinic. RN Health Coach is available to assist with cessation.

Implementation Strategies

Implementation Strategies - 2018

Priority 1: Physical Health

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 Canby has made physical health specific to obesity a significant priority and has developed strategy to improve physical health and reduce the negative health effects of obesity.

Priority 2: Mental Health

Mental health is important at every stage of life and affects how people think, feel and act. According to the National Institute of Mental Health, depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental and psychological factors. Depression is among the most treatable of mental disorders.

Sanford has made mental health a significant priority and has developed strategies to reduce mortality and morbidity from mental health and behavioral health and substance abuse. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by addiction and mental illness.

Sanford Canby Community Health Needs Assessment
Implementation Strategy Action Plan for 2019-2021

<u>Priority 1</u>: Physical Health

Projected Impact: Improved physical health of the greater Canby, Minnesota community

Goal 1: Reduce the negative health effects of obesity

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
The CHNA planning committee will routinely review events in the community that promote physical activity and review the need to provide sponsorship support to the various events and activities.	Meet monthly in years 2019, 2020, and 2021 # of sponsorships	Administrative Team	Administrative Team	Various community organizations
Sustain Sanford *fit*Kids program with school-age youth.	Complete bi-annual *fit*Kids education to students in the school # of participating students	Administrative Team	Administrative Team and WC coordinator	Canby Public School and Parochial School
Continue employee health and wellness initiatives at Sanford Canby Medical Center.	Provide information to staff regarding opportunities for wellness activities at Sanford Canby # of initiatives held annually and # of participants	Administrative Team	Administrative Team and WC coordinator	

<u>Priority 2</u>: Behavioral Health and Mental Health Access

Projected Impact: Increased awareness of resources available for those in need of mental health services

Goal 1: Provide a platform for members of the community to address mental health

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Routinely offer support group for members of the community that are either directly or indirectly affected by chronic illness.	Sustain quarterly meetings of the Pathways support group # of participants	Administrative Team	Administrative Team, Department Head team	

Goal 2: Increase identification of patients in need of mental health services

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Identify patient needs with the use of the PHQ-9 screening tool within the electronic medical record.	Ensure all Medical Home patients are evaluated for mental health needs # of patients who show improvement in PHQ-9 score	Administrative Team	Clinic staff including RN Health Coach	

Impact from the FY 2017-2019 Action Plan
Community Health Needs Assessment

Priority 1: Physical Health

Projected Impact: Improve the physical health of the greater Canby, Minnesota community

Goal 1: Reduce the negative health effects of obesity

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations (if applicable)
Reorganize planning committee	Meet quarterly during the timeframe of 2017-2020	Existing	CEO, Directors and Nursing Leadership	Citizens of Canby
Implement Together.Canby.Can (an initiative to promote healthy lifestyle within the community and promotion of resources)	Complete biannual to quarterly community education events	Existing/Grant Funds	Directors and Community Health Needs Committee	Community Organizations (i.e. Chamber of Commerce)
Continue implementation of the *fit* kids program to school age youth	Complete quarterly or biannual implementation to students in elementary and/or secondary education during the 2017-2020 school years	Existing	Directors and Community Health Needs Committee	Canby Public and Parochial Schools
Establish employee education to promote healthy lifestyles	Complete biannual employee wellness and education programs	Existing	Directors and Community Health Needs Committee	

Goal 2: Controlling hypertension in the community of Canby, Minnesota

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Implementation of the MN Community Measurement – Application of Blood Pressure screening and follow-up for	Improved blood pressure and decrease in consequences of high blood pressure which include: stroke, heart failure, vision loss, heart attack, kidney disease/ failure	Existing	Directors and Rural Health Clinic Providers/Staff	

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
those with readings greater than 140/90				
Complete blood pressure screenings during community events	Complete one screening clinic in the community per year	Existing	Directors and Community Health Needs Committee	
Continue implementation of the *fit* kids program to school age youth	Complete quarterly or bi-annual implementation to students in elementary and/or secondary education during the 2017-2020 school years	Existing	Directors and Community Health Needs Committee	Canby Public and Parochial Schools

Priority 2: Mental Health

Projected Impact: Awareness of resources available for people and family members of those with mental health conditions

Goal 1: Reduce the negative effects of stress on all and at risk populations

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Reorganize planning committee	Meet quarterly during the timeframe of 20172020	Existing	CEO, Directors and Nursing Leadership	Citizens of Canby
Implement Together.Canby.Can (an initiative to promote healthy lifestyle within the community and promotion of resources)	Complete biannual to quarterly community education events	Existing	Directors and Community Health Needs Committee	Community Organizations (i.e. Chamber of Commerce)
Continue implementation of the *fit* kids program to school age youth	Complete quarterly or biannual implementation to students in elementary and/or secondary education during the 2017-2020 school years	Existing	Directors and Community Health Needs Committee	

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Establish employee education to promote healthy lifestyles	Complete biannual employee wellness and education programs	Existing	Directors, Community Health Needs Committee, and employees of Sanford Canby Medical Center	

<u>Goal 2</u>: Increase education to improve the awareness of mental health conditions and resources to our community members

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Implement education for awareness and prevention	Complete annual to quarterly community education events	Existing	Directors and Community Health Needs Committee	
Determine availability of resources within our geographical location for mental health conditions	Complete a meeting with public health in the 2017-2019 timeframe to establish a relationship to maximize resources	Existing	CEO, Directors and Nursing Leadership	Yellow Medicine Public Health

Demonstrating Impact – 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 Canby Medical Center, the top priorities addressed through an implementation strategy process include:

- Physical Health
- Mental Health

With a projected impact of improving the physical and mental health of the greater Canby, Minnesota community and the goal of reducing the negative health effects of obesity and controlling hypertension, the BMI reduction initiative was started in the Sanford Canby Clinic. The aim of the BMI reduction initiative was to identify patients who could benefit from weight loss, as well as commit to a 12-week weight loss program. Sessions were established in February 2017 with new sessions starting every six weeks. The last session concluded in August 2017.

The Sanford RN Health Coach performed readiness assessments on each participant. The assessment involved data collection to record initial weight, BMI, and blood pressure. Together with the RN Health coach, each participant set individual smart goals. Throughout the course of the program, participants completed a weekly one-on-one check-in with the purpose of reassessing goals and reporting weights. Monthly, a re-charge session was conducted. During this session, participants could discuss activity, diet, mood, and share personal stories. The session also provided a platform for sharing healthy recipes and sampling of healthy food choices.

Four groups (26 participants in total) completed the sessions. The first group, consisting of 8 participants, lost a total of 63 pounds. Each of the participants lost weight, decreased their BMI, and reduced their blood pressure. The second group had 10 participants and recorded a total loss of 26 pounds. Again, each of the patients reduced their blood pressure and all but two patients lost weight. These two patients stayed the same weight. Five of the patients also saw a reduction in their BMI. The third group had three participants. Each participant lost weight and reduced their BMI. The total weight loss for group 3 was 20 pounds. Two of the three participants also recorded a reduction in blood pressure. The fourth group consisted of five participants. One participant maintained their initial weight and another participant gained three pounds. All other participants recorded a reduction in BMI. In total, 31 pounds were lost in this group. Two participants saw reduction in blood pressure and two elevated slightly, with the remaining participants maintaining blood pressure, which was within normal limits. Participants noted that one-on-one sessions offered accountability to the program.

The electronic medical record (EMR) has been upgraded with added capability of addressing BMI. Now, when a patient's height and weight are entered at the visit, an automatic BMI calculation occurs. If the calculation meets or exceeds a BMI of 30 (defined as obese by CDC definition), providers are alerted within the EMR allowing them to specifically address lifestyle, exercise, etc. In addition, the EMR allows providers to refer patients to weight loss programs, a dietician, bariatric surgery, an RN Health Coach, behavioral health, and/or pulmonology. With the added functionality in the EMR, BMI can be addressed at every patient visit.

Together.Canby.Can, an initiative to promote healthy lifestyles within the community and promote resources, began in 2015 and continued on into 2016. The strategy of this initiative was to address both mental and physical health. Through this initiative, we were able to offer monthly wellness education classes to the general public that focused on topics including nutrition, healthy routines, mental health, better balance, etc. Attendance exceeded 75 individuals.

A Lunch and Learn series launched and made available to Sanford Canby staff, as well as members of the community. Attendees were invited to bring their lunch and listen to various topics that addressed both physical and mental health. Various topics included, but were not limited to, recognizing stroke signs, mindfulness, and coping with change. The Lunch and Learn educational sessions are still offered monthly. Ten to fifteen community members are in attendance at each session.

The Sanford *fit* Kids program focuses on four areas of a fit lifestyle - Food, Move, Recharge, and Mood. The CHNA team brought this program to both Canby Public School and St. Peter's Catholic School in the fall and spring of 2016-2017. Grades kindergarten through sixth were able to take part in the program. Approximately 350 students were impacted.

Sanford Canby supports various health-related events throughout the Canby community. A dive-in movie was held at the Canby swimming pool in August 2017. Patrons at the pool could swim and enjoy a movie all at the same time. Sanford Canby supports Canby 4 Kids, a non-profit organization that focuses on providing fun activities and opportunities to Canby area youth. In August 2018, Canby 4 Kids held a *National Night Out* at the Canby swimming pool park.

A support group was developed and implemented to combine multiple support groups together under one umbrella. This group supports those who may be personally living with a chronic illness or may be living with someone or supporting someone with a chronic illness. On average, five to ten people attend this group.

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 Canby Medical Center's CHNA.

Appendix

Primary Research

Sanford Canby Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Economic Well Being	Employment options 3.40 Skilled labor force 3.20			Employment resources (major employers): • Sanford Canby, 112 St. Olaf Ave. S., Canby MN • MN West Community College, 1011 – 1st St. W., Canby MN • Canby Public School District, 307 – 1st St. W., Canby MN • St. Peter's Catholic School, 410 Ring Ave. N., Canby, MN • Helena Chemical Co., 120 – 1st St. W., Canby MN • Farmers Cooperative Assn. • REM Southwest Services Resources for a skilled labor force: • MN West Community College, 1011 – 1st St. W., Canby MN • Canby Community Education, 307 – 1st St. W., Canby MN • Canby Developmental Achievement Center, PO Box 154, Canby MN	
Children and Youth	Childhood obesity 3.38 Availability of quality child care 3.13 Bullying 3.06			Obesity resources: • Sanford Canby Medical Center • Sanford Wellness Center, 11 St. Olaf Ave. S., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • Fit N Glow, 203 St. Olaf Ave. N., Canby, MN • Sanford Profile • Sanford *fit*Kids Childhood obesity resources: • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • Prairie Five Community Action Partnership, 106 S. Olaf Ave., Canby MN • Summer Recreation Program – Canby Community – 307 1st St W, Canby, MN 56220 • Stonehill Regional Park, 1801 County Rd. 36, Canby MN • Sanford Canby Summer POWER Program – Therapy Department, 112 St Olaf Ave South, Canby MN 56220 • Canby Swimming Pool, Canby, MN	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Canby Golf Course, 1933 – 240th Ave., Canby MN • Disc Golf Course, Hwys. 75 and 68, Canby MN • Lake Sylvan, Hwys. 75 & 68, Canby MN • Triangle Park, 220th Ave., Canby MN • Central Park, Hwy 75, Canby MN • Lancer Lanes, 211 – 1st St W., Canby MN • Boy Scouts, 205 – 3rd St. E., Canby MN • Girl Scouts, 307 – 1st St. W., Canby MN • 4-H Clubs, 106 St. Olaf Ave. N., Canby MN • Canby 4 Kids, PO Box 51, Canby MN • The Connection, 209 St. Olaf Ave. N., Canby MN • Canby Public Library, 110 Oscar Avenue North, Canby MN • Community Center, 110 Oscar Ave. N., Canby MN Child care resources: • Jayne M. Sik, 2232 – 190th St., Canby MN • Bright Beginnings, 707 St. Olaf Ave. N., Canby MN • Nana's Daycare, 107 – 10th St. W., Canby MN • Suzanne M. Anseeuw, 1st St. E., Canby MN • Brenda Beiningen, Hwy. 75, Canby MN • Holly Drayna, 220th St., Canby MN • Ronda Duis, Orlando Ave., Canby MN • Janel Tol, 8th St. W., Canby MN • Jill Winters, 210th St., Canby MN • Kelly Gagnon, Pine Ave. N., Canby MN • Sarah Bednarek, Walnut Ave., Canby MN • Jo Ann Hansen, Haarfager Ave. S., Canby MN • Melissa Hulzebos, 8th St. W., Canby MN	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Sarah Traphagen, 5th St. W., Canby MN • Lynn Wollum, 7th St. E., Canby MN Child safety/bullying resources: • Police Dept., 110 Oscar Ave. N., Canby MN • Canby Public Schools, 307 – 1st St. W., Canby MN • St. Peter's Catholic School, 410 Ring Ave. N., Canby, MN • YAMS (Canby's Youth Against Misusing Substances), 307 -1st St. W., Canby MN • Sanford Canby Clinic Columbia Suicide Scale	
Aging Population	Cost of long term care 3.67 Cost of memory care 3.50 Cost of in-home services 3.13			Resources for aging adults: • Sanford Canby Medical Center, 112 St. Olaf Ave. S., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • Sanford Dental Clinic, 11 St. Olaf Ave. S., Canby MN • Sylvan Court, 112 St. Olaf Ave. S., Canby MN • Sylvan Place Assisted Living, 112 St. Olaf Ave. S., Canby MN • Canby Chiropractic Clinic, 109 St. Olaf Ave. S., Canby MN • Kaddatz Chiropractic Center, 106 – 8th St. W., Canby MN • Community Center, 110 Oscar Ave. N., Canby MN • Sanford Home Medical Eqmt., 131 St. Olaf Ave. N., Canby MN • Serenity House, 310 Haarfager Ave. S., Canby MN • Prairie Five Community Action Agency, 106 St. Olaf Ave. N., Canby MN • Sanford Hospice, 119 – 1st St. W., Canby MN • Sanford Canby Home Health Services • Yellow Medicine Family Service Center	
Health Care Access	Access to affordable health insurance coverage 3.43 Access to affordable health care 3.36			Health Care resources: • Sanford Canby Medical Center, 112 St. Olaf Ave. S., Canby MN	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	Access to affordable prescription drugs 3.29 Availability of mental health providers 3.29 Availability of behavioral health 3.23 Access to affordable vision insurance coverage 3.21 Access to affordable dental insurance coverage 3.07			• Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • Sanford Dental Clinic, 11 St. Olaf Ave. S., Canby MN • Sylvan Court, 112 St. Olaf Ave. S., Canby MN • Sylvan Place Assisted Living, 112 St. Olaf Ave. S., Canby MN • Canby Chiropractic Clinic, 109 St. Olaf Ave. S., Canby MN • Kaddatz Chiropractic Center, 106 – 8th St. W., Canby MN • Sanford Health Plan, 1749 – 28th St. S., Fargo ND • REM Eastview, 611 Haarfager Ave. N., Canby MN • REM Southwest Services, 125 – 1st St. E., Canby MN • Sanford Home Medical Eqmt., 131 St. Olaf Ave. N., Canby MN • Serenity House, 310 Haarfager Ave. S., Canby MN • Southview Assisted Living, 909 Ring Ave. N., Canby MN • MNSure, 1-855-366-7873 • Western Mental Health Center, 112 St. Olaf Ave. S., Canby MN • Sanford Hospice, 119 – 1st St. W., Canby MN Vision resources: • Heartland Eye Center, 107 – 1st Street E., Canby MN Dental resources: • Sanford Dental Clinic, 11 St. Olaf Ave. S., Canby MN - - hr. Dental - Dr Razi,, DDS, 112 St. Olaf Ave. S., Canby MN Prescription Assistance resources: • Canby Drug, 130 St. Olaf Ave. N., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • MN Drug Card, MNdrugcard.com Insurance options: • Nemitz Agency, 125 – 1st St. W., Canby MN Mental Health resources:	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Western Mental Health Center, 112 St. Olaf Ave. S., Canby MN • Sanford Canby Medical Center, 112 St. Olaf Ave. S., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • MN Mental Health Crisis Line, 112 St. Olaf Ave. S., Canby MN • Canby Developmental Achievement Center, PO Box 154, Canby MN	
Wellness				• Fit N Glow, 203 St. Olaf Ave. N., Canby, MN • Sanford Wellness Center, 11 St. Olaf Ave. S., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN	
Mental Health and Substance abuse	Dementia and Alzheimer's Disease 3.54 Depression 3.36 Stress 3.21 Drug use and abuse 3.08 Alcohol use and abuse 3.00 Smoking and tobacco use 3.00			Mental Health resources: • Western Mental Health Center, 112 St. Olaf Ave. S., Canby MN • Sanford Canby Medical Center, 112 St. Olaf Ave. S., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN • MN Mental Health Crisis Line, 112 St. Olaf Ave. S., Canby MN • Canby Developmental Achievement Center, PO Box 154, Canby MN Drug, alcohol, smoking resources: • Police Dept., 110 Oscar Ave. N., Canby MN • Canby Public Schools, 307 – 1st St. W., Canby MN • St. Peter's Catholic School, 410 Ring Ave. N., Canby, MN • YAMS (Canby's Youth Against Misusing Substances), 307 -1st St. W., Canby MN Alzheimer's Disease resources: • Sanford Canby Medical Center, 112 St. Olaf Ave. S., Canby MN • Sanford Clinic, 112 St. Olaf Ave. S., Canby MN	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Sylvan Court, 112 St. Olaf Ave. S., Canby MN • Sylvan Place Assisted Living, 112 St. Olaf Ave. S., Canby MN • Senior Haven Nursing Home, 112 St. Olaf Ave. S., Canby MN • Serenity House, 310 Haarfager Ave. S., Canby MN • Southview Assisted Living, 909 Ring Ave. N., Canby MN • Sanford Hospice, 119 – 1st St. W., Canby MN • REM Eastview, 611 Haarfager Ave. N., Canby MN • REM Southwest Services, 125 – 1st St. E., Canby MN	

Key Stakeholder Survey

Sanford Canby Medical Center

Community Health Needs Assessment
Results from an October 2017 Non-Generalizable

Online Survey of Community Stakeholders

November 2017

SANFORD

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an October 2017 online survey of community leaders and key stakeholders identified by Sanford Canby Medical Center. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. Therefore, it is important to note that the data in this report are not generalizable to the community. Data collection occurred during the month of October and the first week three weeks of November. A total of 20 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

Current State of Health and Wellness Issues within the Community

Using a 1 to 5 scale, with 1 being “no attention needed”; 2 being “little attention needed”; 3 being “moderate attention needed”; 4 being “serious attention needed”; and 5 being “critical attention needed,” respondents were asked to, based on their knowledge, select the option that best describes their understanding of the current state of each issue regarding ECONOMIC WELL-BEING, TRANSPORTATION, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTHCARE AND WELLNESS, and MENTAL HEALTH AND SUBSTANCE ABUSE.

Figure 1. Current state of community issues regarding ECONOMIC WELL-BEING

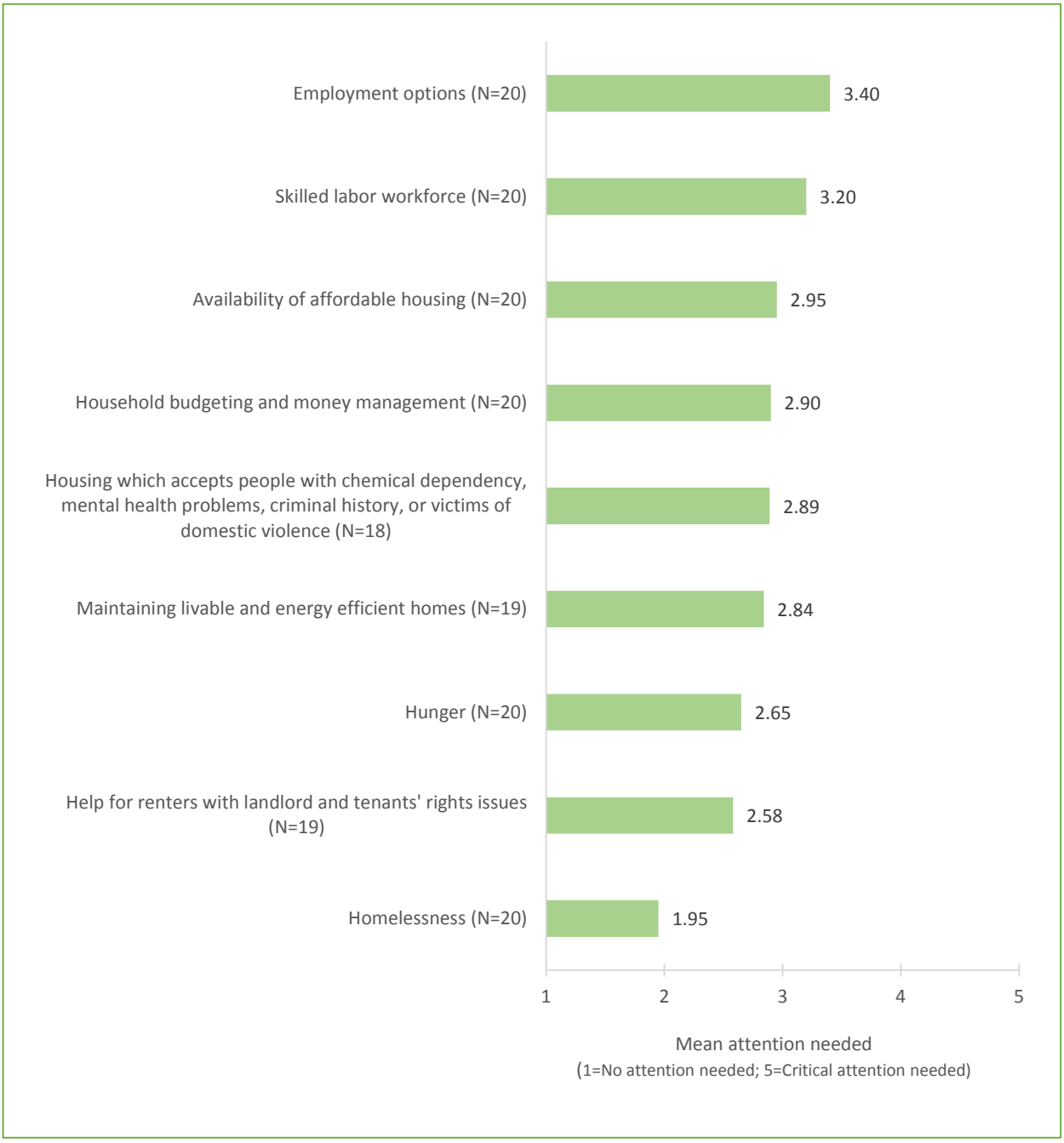


Figure 2. Current state of community issues regarding TRANSPORTATION

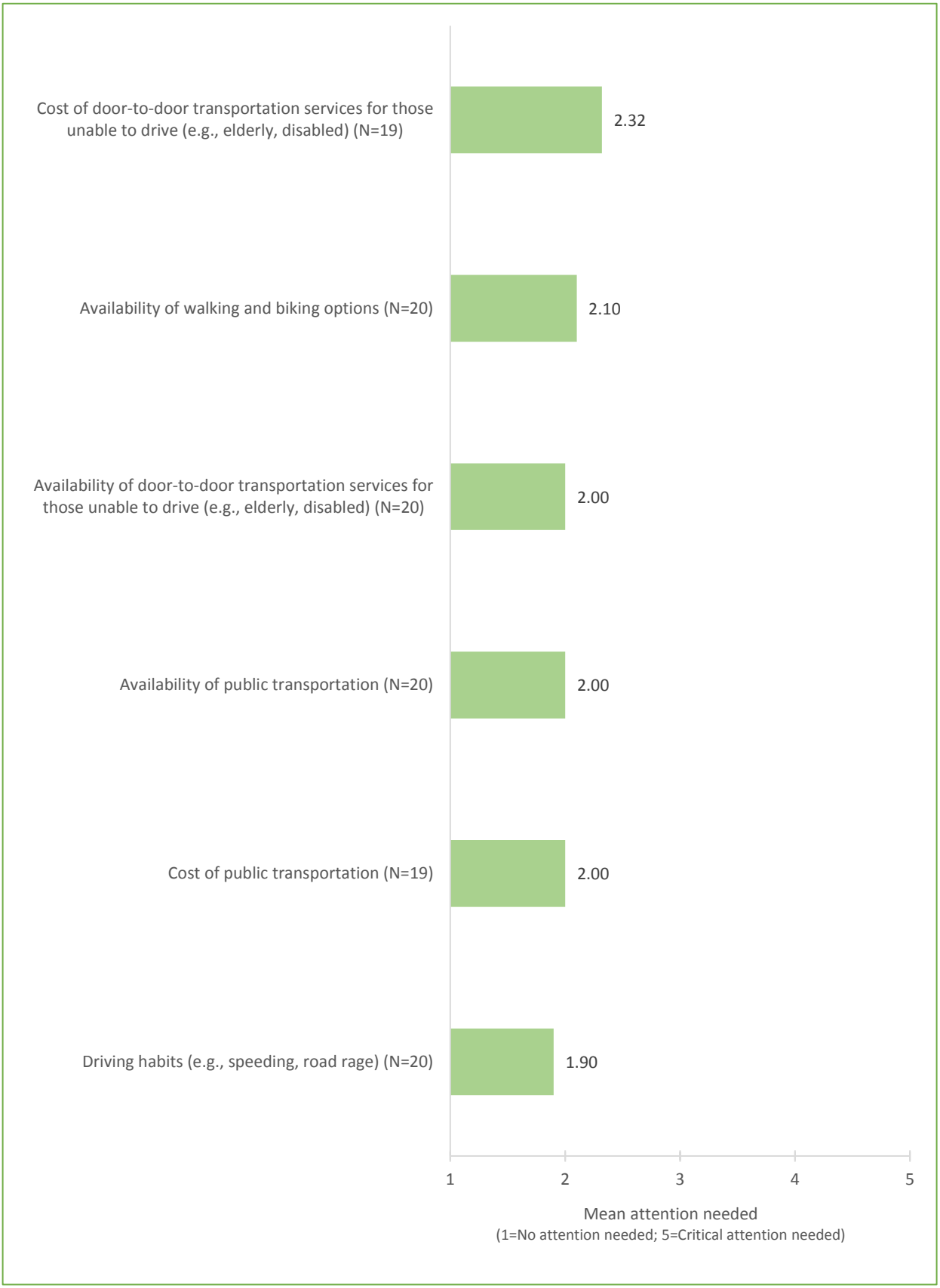


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

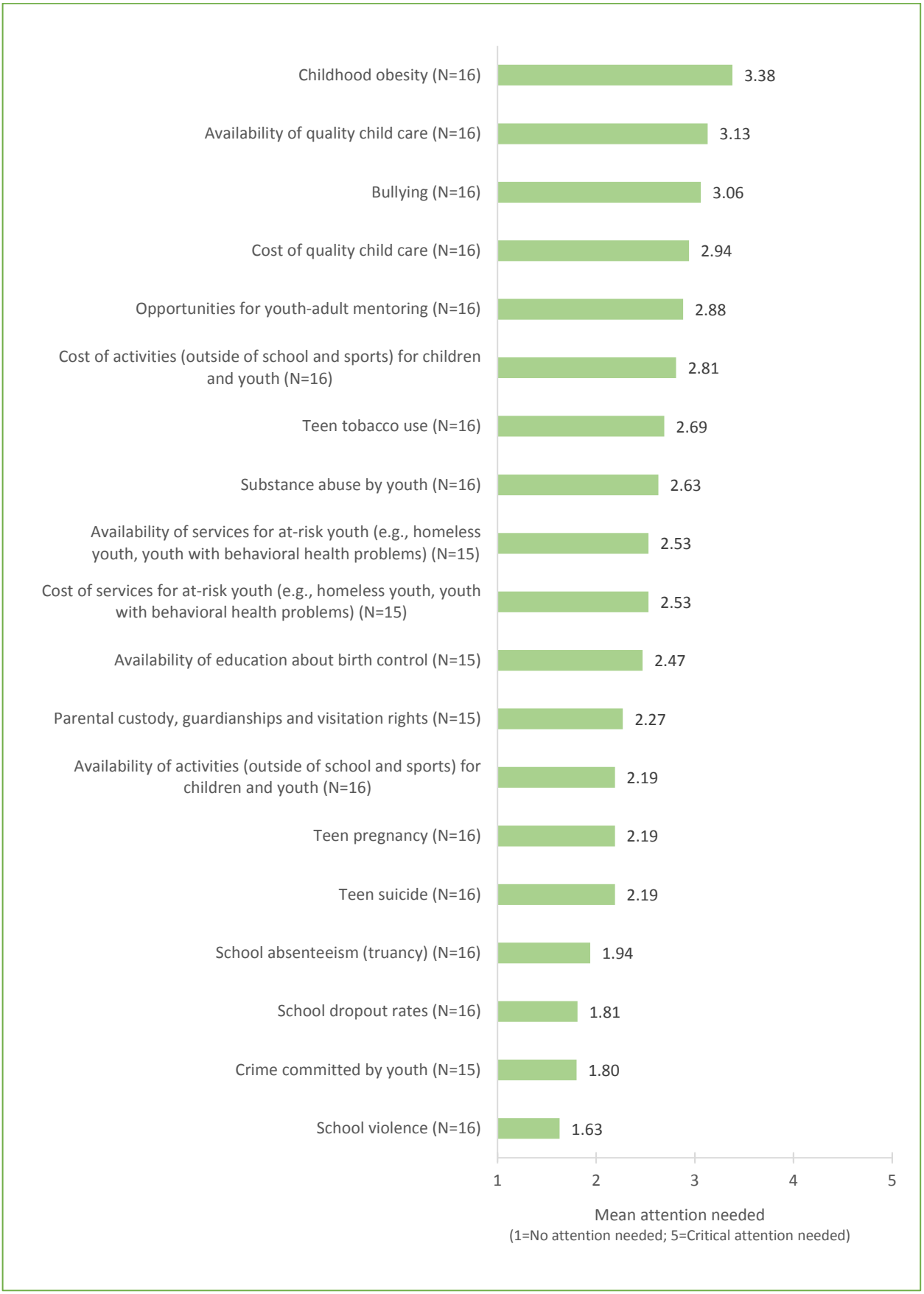

Childhood obesity (N=16)
3.38
Availability of quality child care (N=16)
3.13
Bullying (N=16)
3.06
Cost of quality child care (N=16)
2.94
Opportunities for youth-adult mentoring (N=16)
2.88
Cost of activities (outside of school and sports) for children and youth (N=16)
2.81
Teen tobacco use (N=16)
2.69
Substance abuse by youth (N=16)
2.63
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=15)
2.53
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=15)
2.53
Availability of education about birth control (N=15)
2.47
Parental custody, guardianships and visitation rights (N=15)
2.27
Availability of activities (outside of school and sports) for children and youth (N=16)
2.19
Teen pregnancy (N=16)
2.19
Teen suicide (N=16)
2.19
School absenteeism (truancy) (N=16)
1.94
School dropout rates (N=16)
1.81
Crime committed by youth (N=15)
1.80
School violence (N=16)
1.63
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Figure 4. Current state of community issues regarding the AGING POPULATION

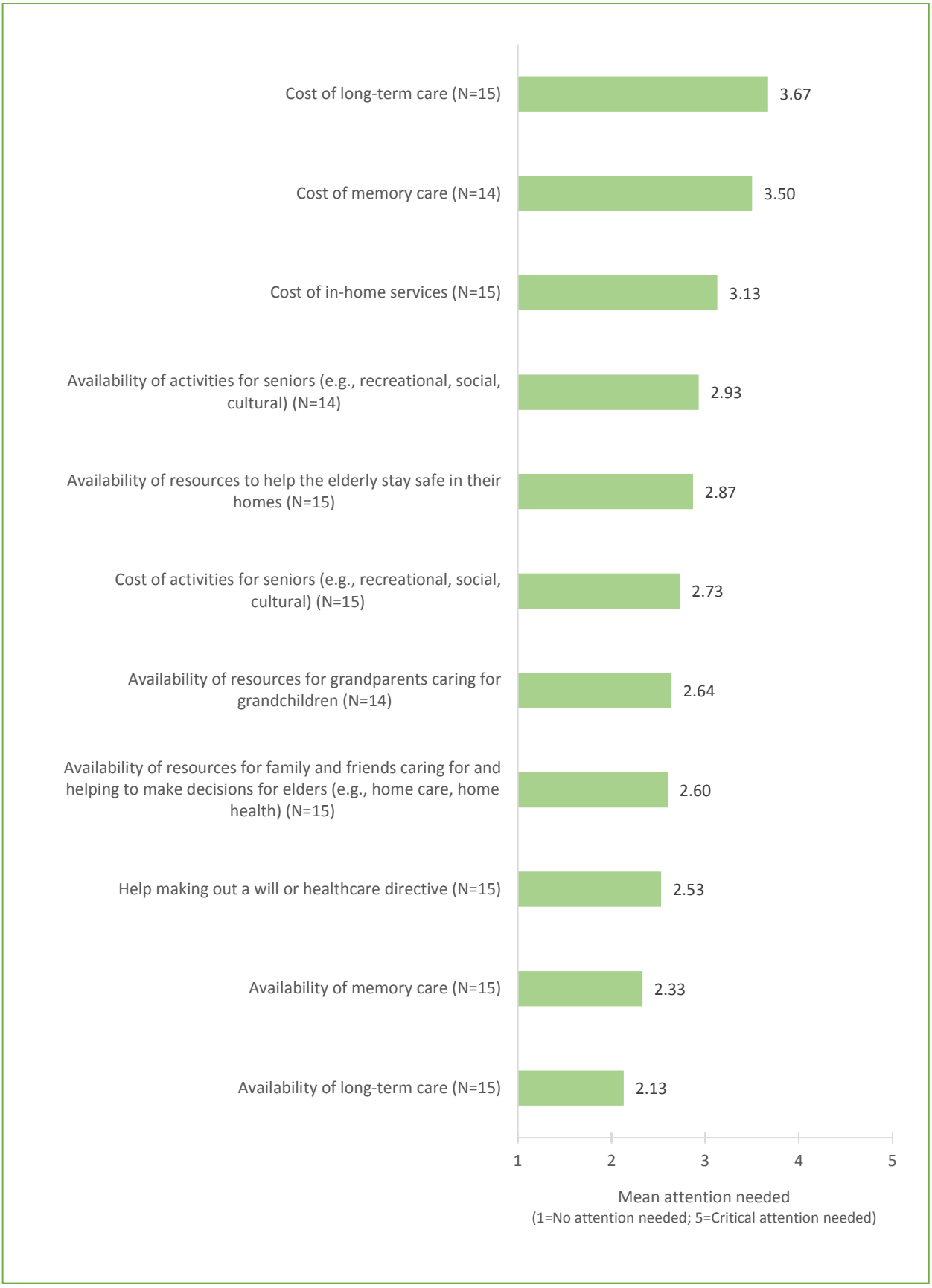

Cost of long-term care (N=15)
3.67
Cost of memory care (N=14)
3.50
Cost of in-home services (N=15)
3.13
Availability of activities for seniors (e.g., recreational, social, cultural) (N=14)
2.93
Availability of resources to help the elderly stay safe in their homes (N=15)
2.87
Cost of activities for seniors (e.g., recreational, social, cultural) (N=15)
2.73
Availability of resources for grandparents caring for grandchildren (N=14)
2.64
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=15)
2.60
Help making out a will or healthcare directive (N=15)
2.53
Availability of memory care (N=15)
2.33
Availability of long-term care (N=15)
2.13
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Figure 5. Current state of community issues regarding SAFETY

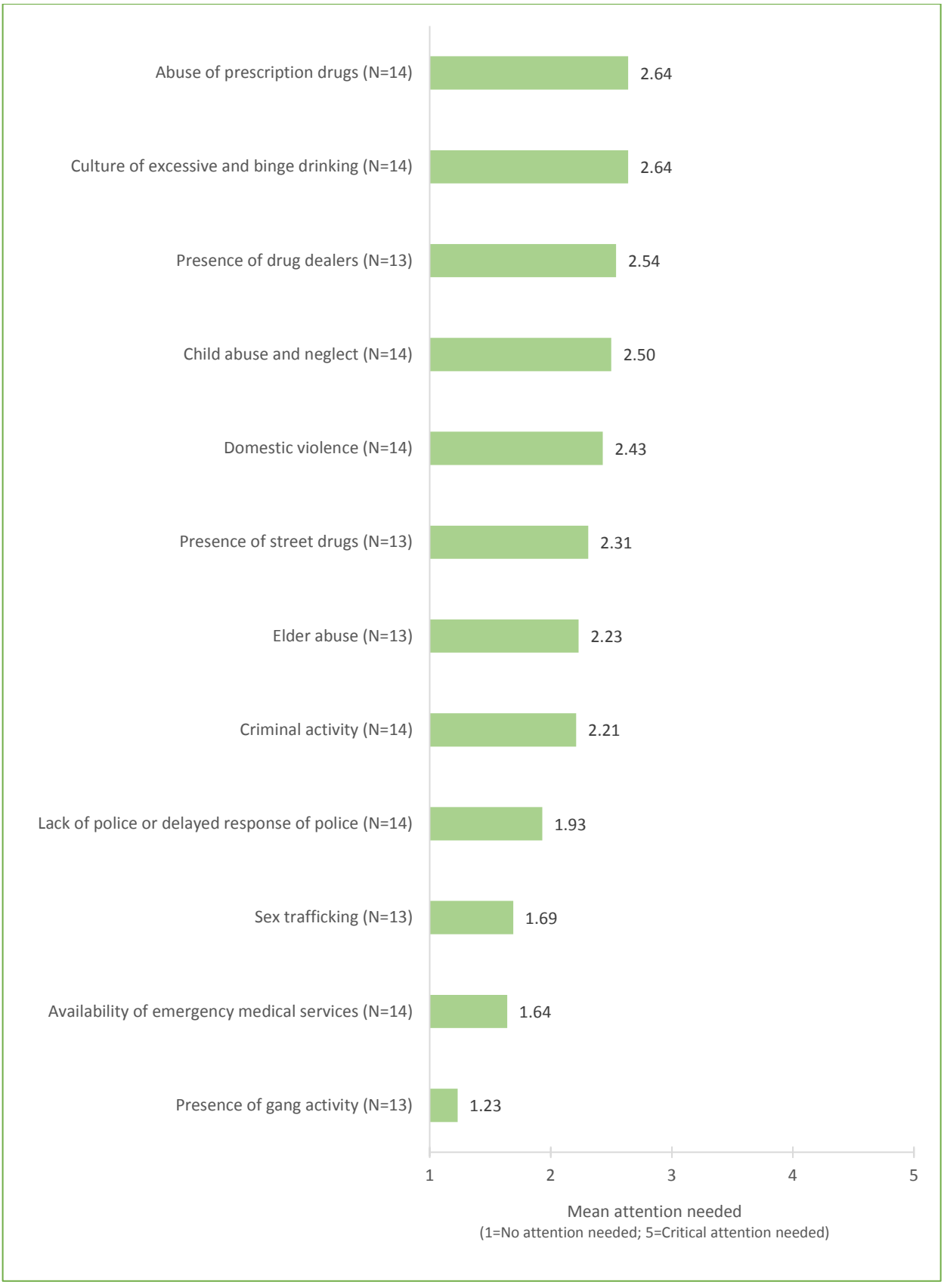
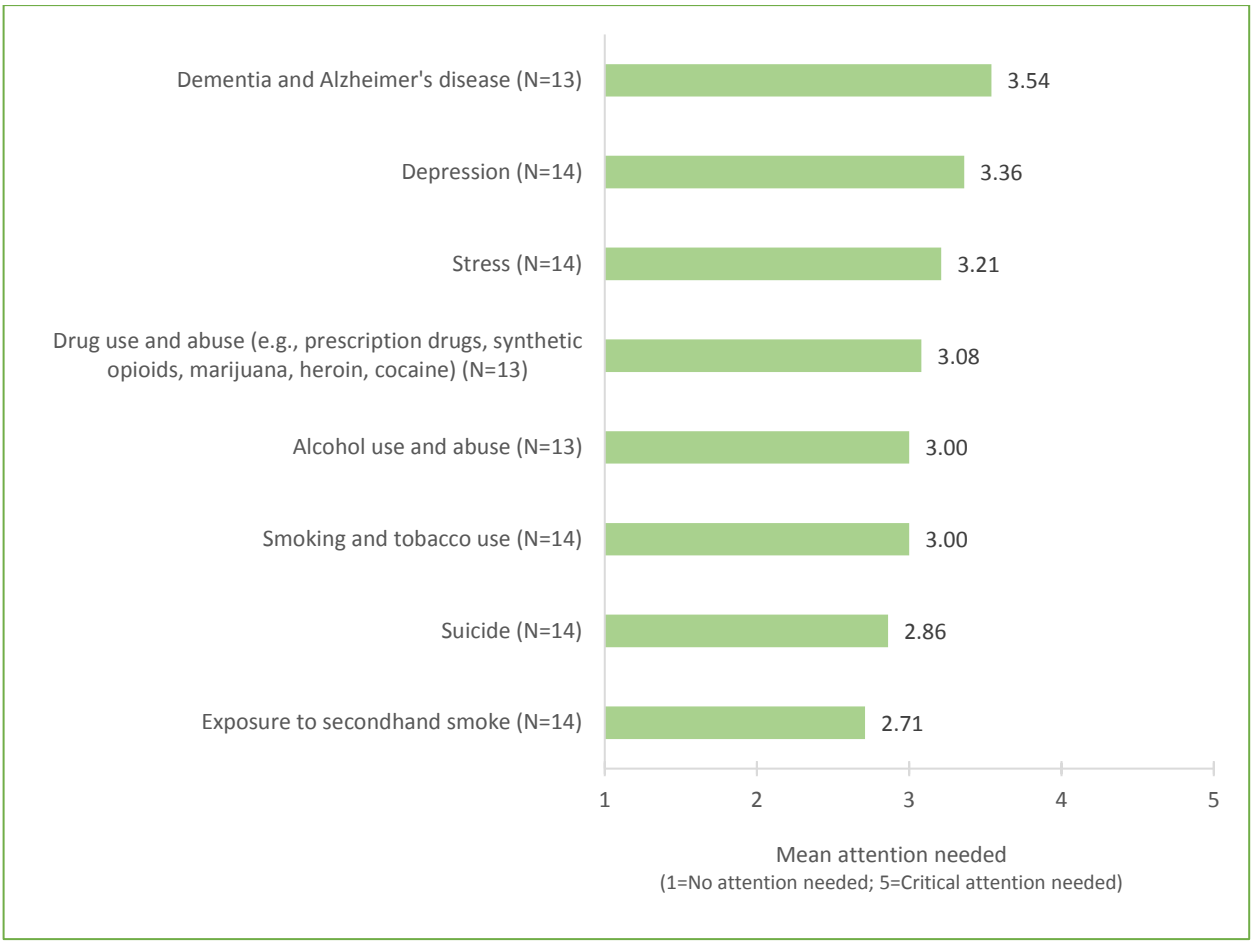


Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

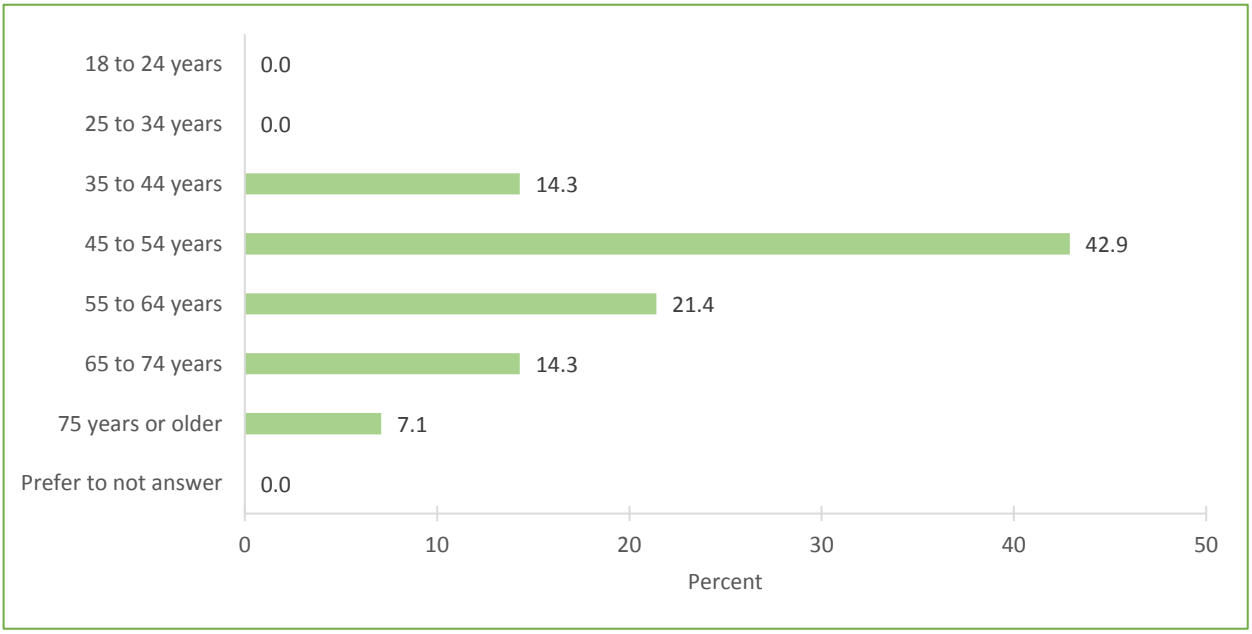

Access to affordable health insurance coverage (N=14)
3.43
Access to affordable healthcare (N=14)
3.36
Access to affordable prescription drugs (N=14)
3.29
Availability of mental health providers (N=14)
3.29
Availability of behavioral health (e.g., substance abuse) providers (N=13)
3.23
Access to affordable vision insurance coverage (N=14)
3.21
Access to affordable dental insurance coverage (N=14)
3.07
Availability of non-traditional hours (e.g., evenings, weekends) (N=14)
2.64
Availability of specialist physicians (N=14)
2.50
Coordination of care between providers and services (N=14)
2.36
Availability of doctors, physician assistants, or nurse practitioners (N=14)
2.29
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=14)
2.29
Access to technology for health records and health education (N=14)
2.07
Use of emergency room services for primary healthcare (N=14)
2.07
Availability of healthcare services for Native people (N=11)
2.00
Availability of healthcare services for New Americans (N=12)
2.00
Timely access to dental care providers (N=14)
1.93
Timely access to vision care providers (N=13)
1.92
Timely access to medical care providers (N=14)
1.86
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Figure 7. Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



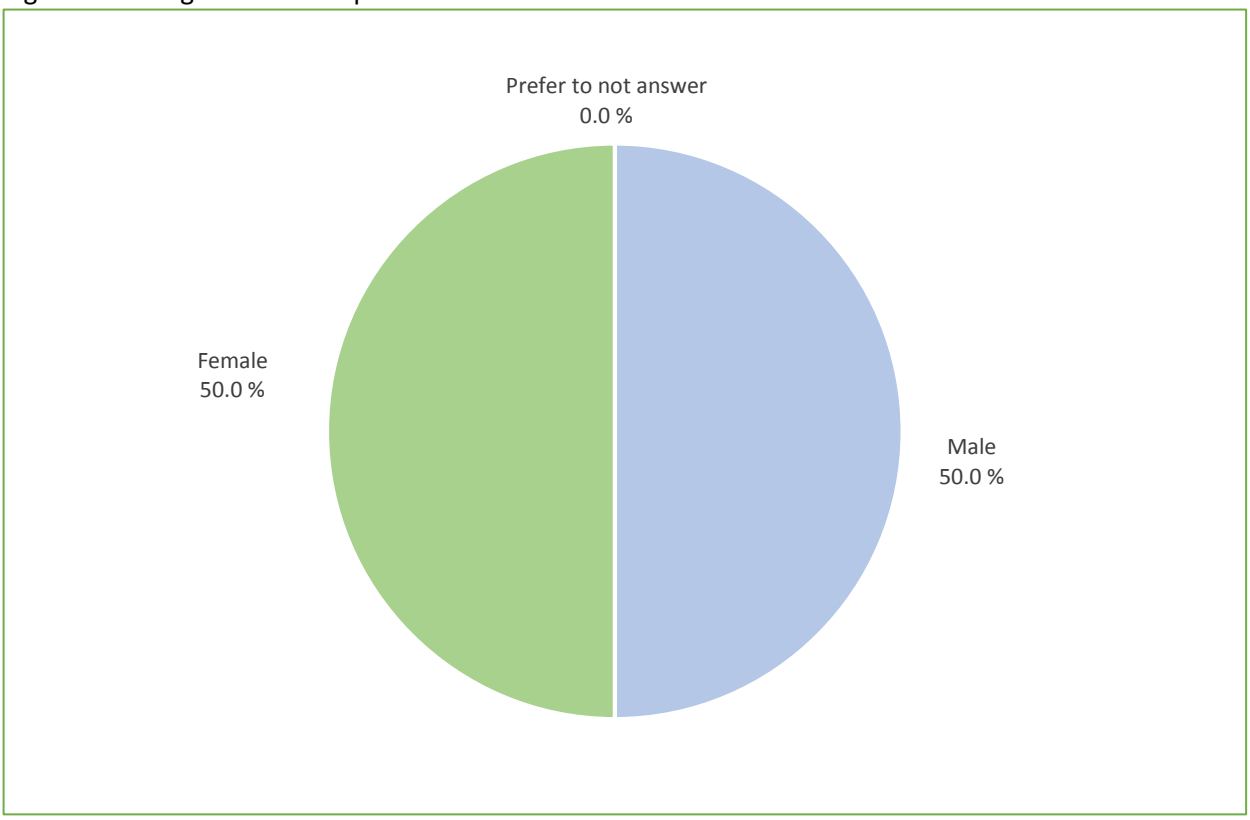
Demographic Information

Figure 8. Age of respondents



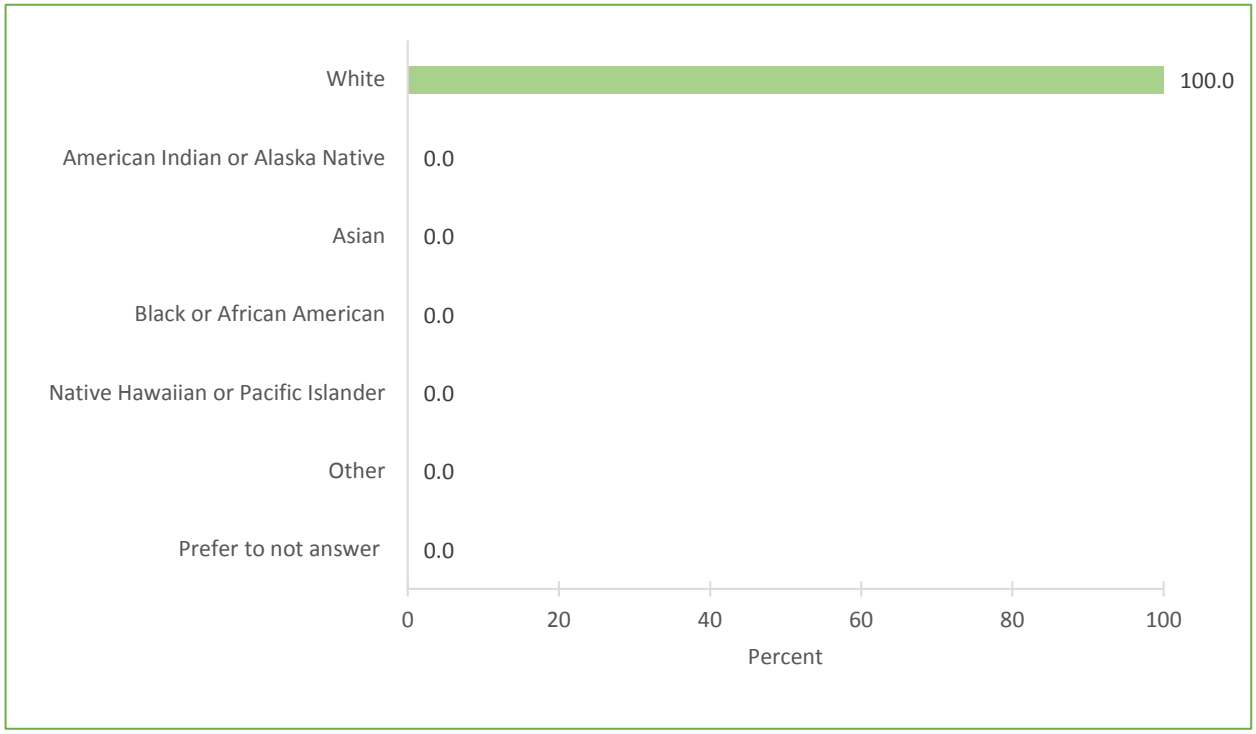
N=14

Figure 9. Biological sex of respondents



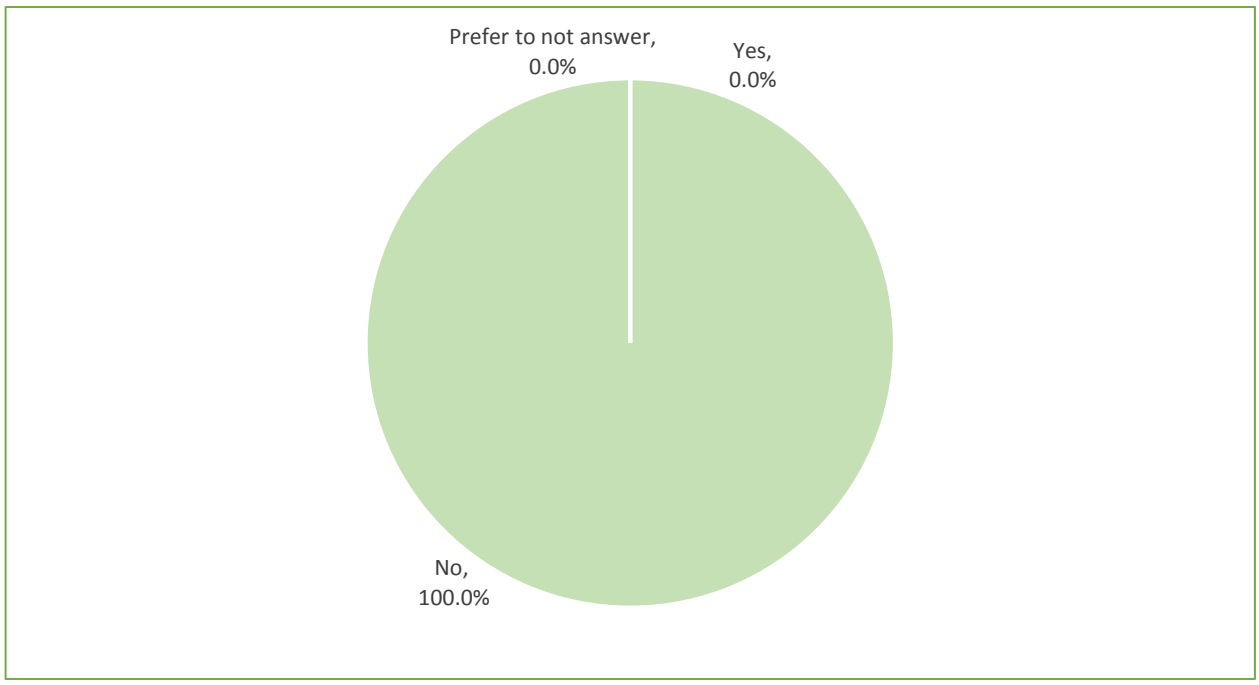
N=14

Figure 10. Race of respondents



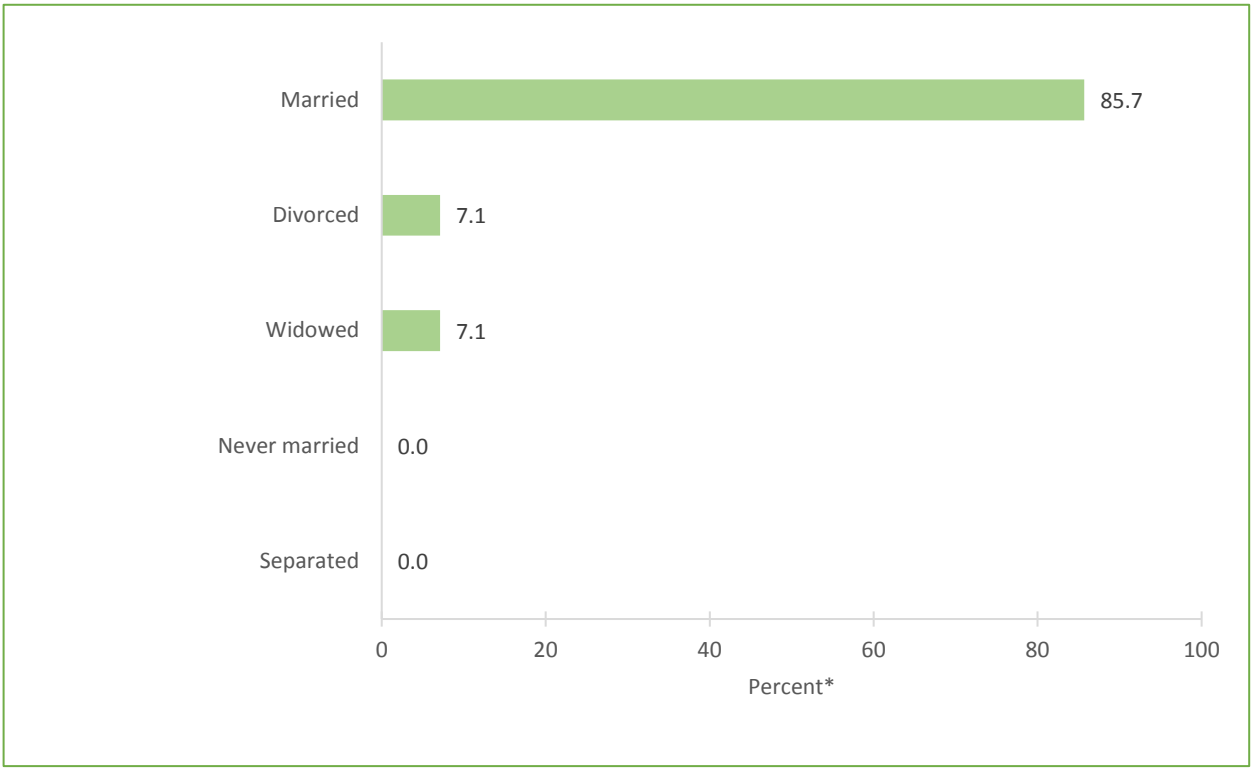
N=14

Figure 11. Whether respondents are of Hispanic or Latino origin



N=14

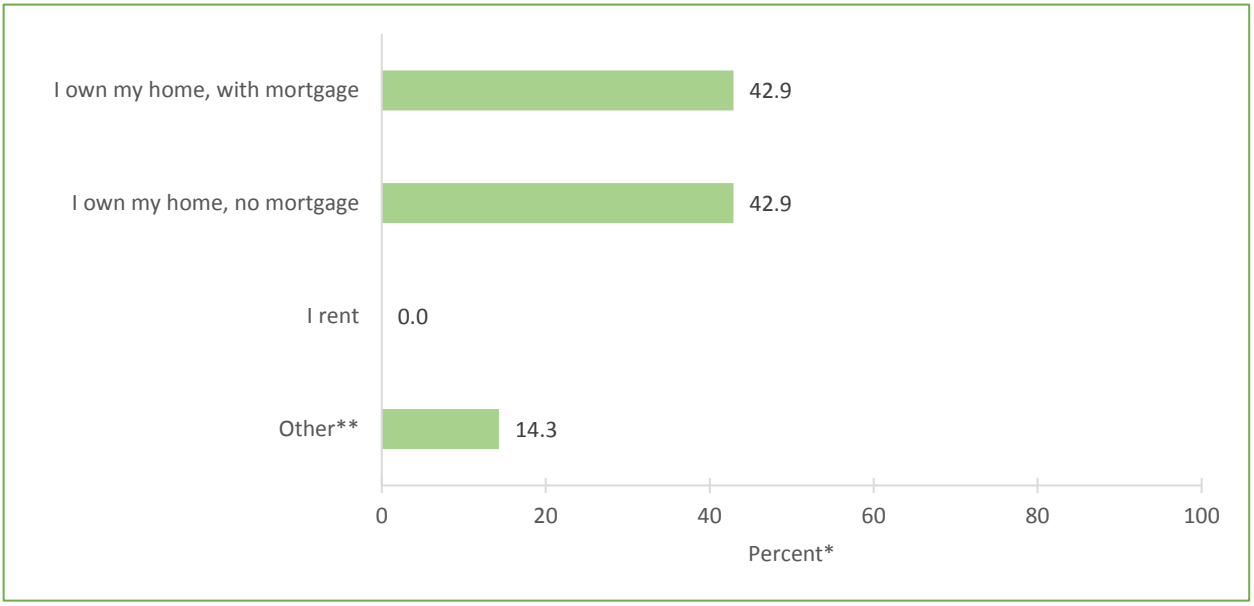
Figure 12. Marital status of respondents



N=14

*Percentages do not total 100.0 due to rounding.

Figure 13. Living situation of respondents

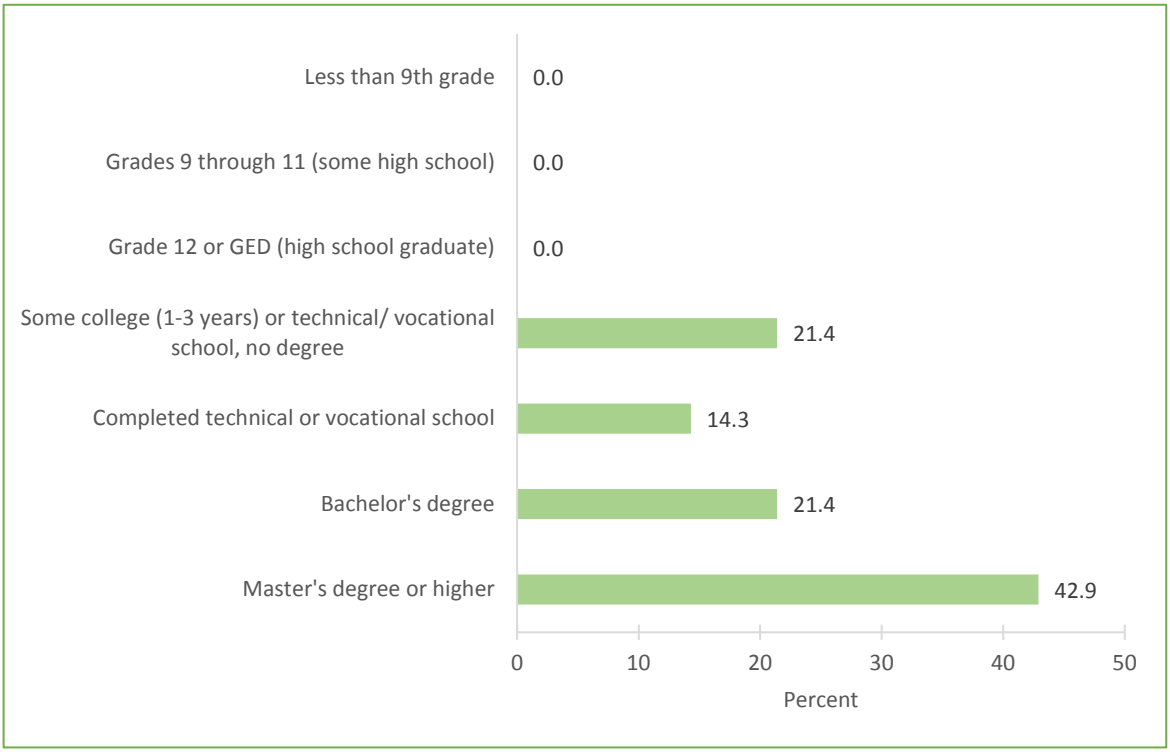


N=14

*Percentages do not total 100.0 due to rounding.

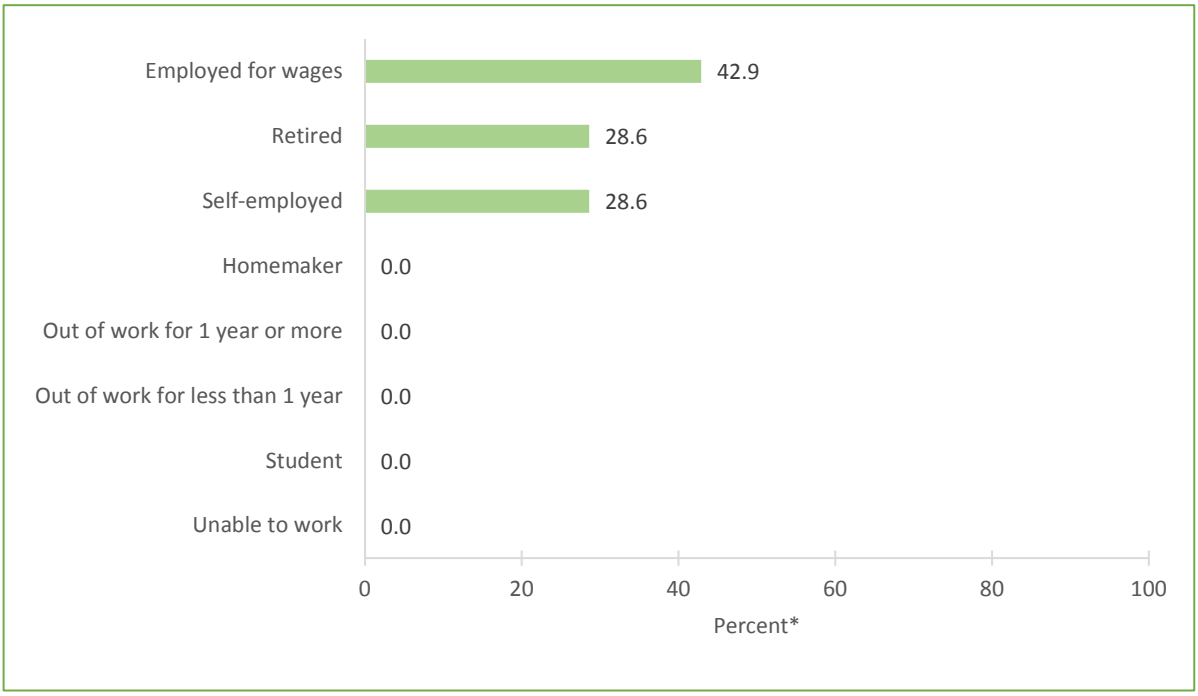
**There were no written responses to “other”.

Figure 14. Highest level of education completed by respondents



N=14

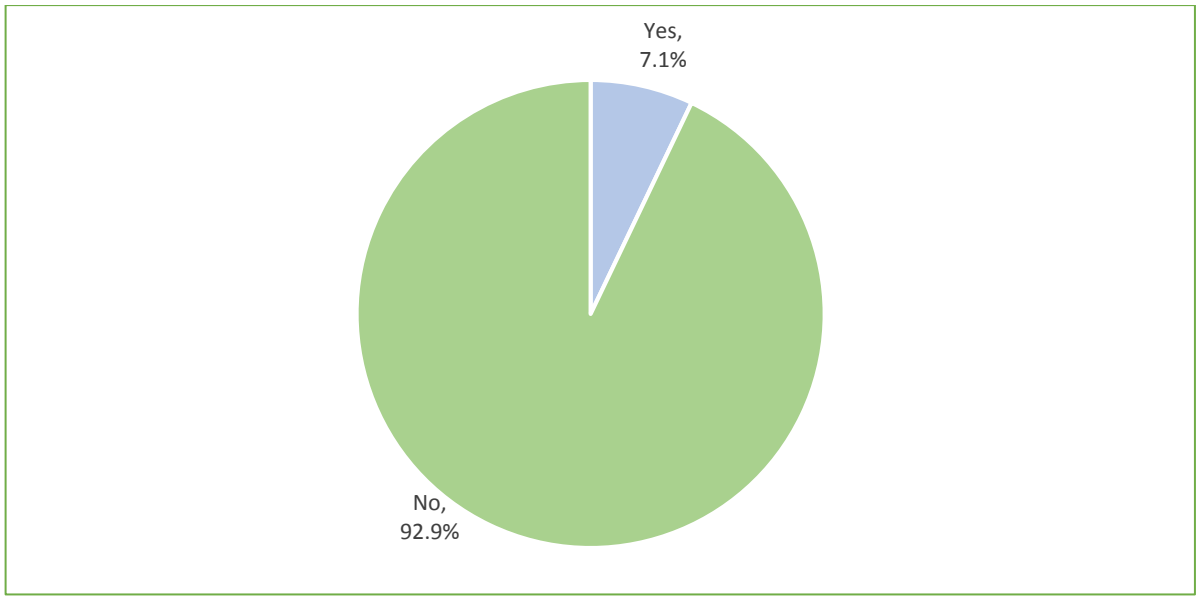
Figure 15. Employment status of respondents



N=14

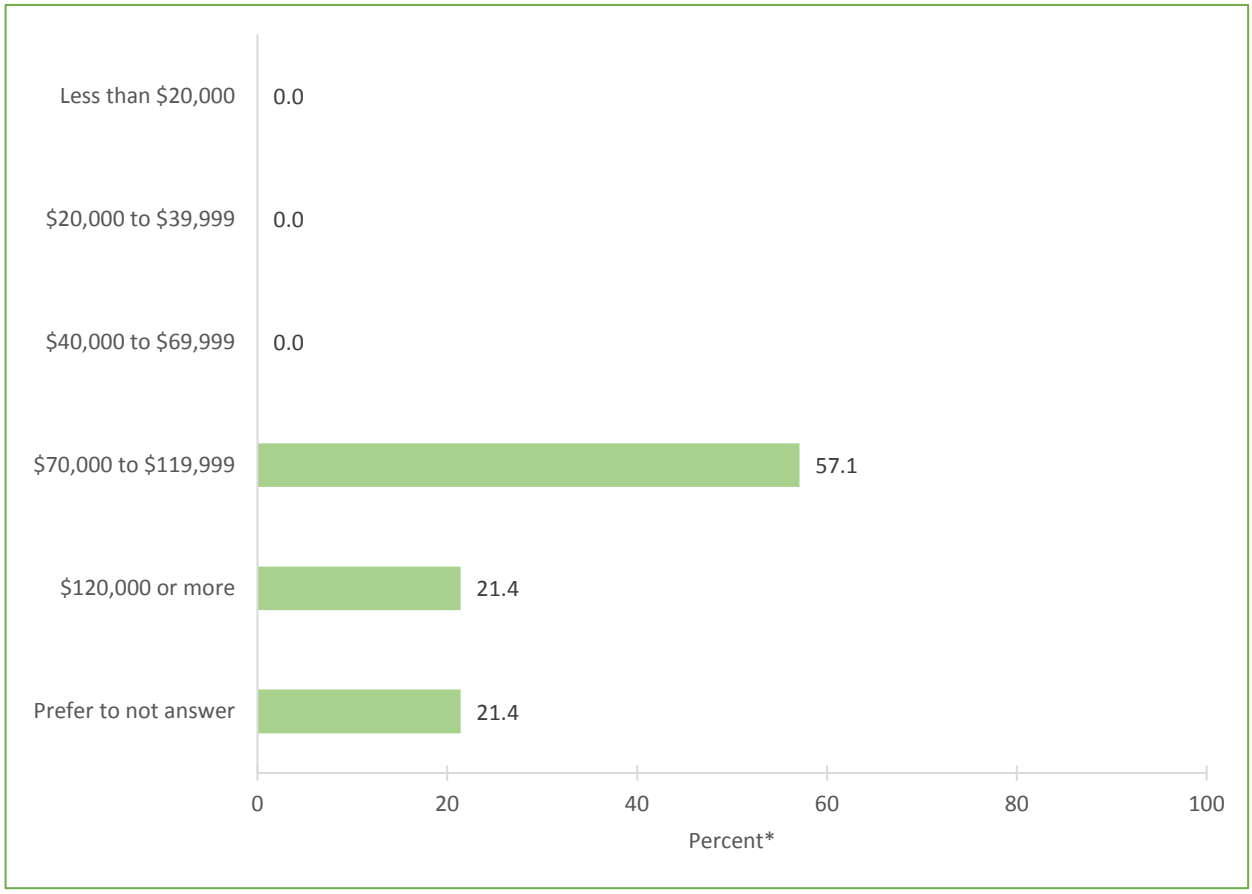
*Percentages do not total 100.0 due to rounding.

Figure 16. Whether respondents are military veterans



N=14

Figure 17. Annual household income of respondents, from all sources, before taxes



N=14
*Percentages do not total 100.0 due to rounding.

Table 1. Zip code of respondents

Zip code	Number of respondents
56220	14

Table 2. Comments from respondents

Comments
Access to the internet in our rural areas is a critical need. Jobs that pay a good living wage is also a critical need.
I believe all areas can be improved on, nothing is perfect. I also believe that for our small town, there is access to different types of services, including care & public transportation.
Need a column titled "unknown" or "no knowledge of issue".

APPENDIX TABLE

Appendix Table 1. Current state of health and wellness issues within the community

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=20)	2.95	0.0	20.0	65.0	15.0	0.0	0.0	100.0
Employment options (N=20)	3.40	5.0	10.0	35.0	40.0	10.0	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=20)	2.58	5.0	35.0	50.0	5.0	0.0	5.0	100.0
Homelessness (N=20)	1.95	30.0	50.0	15.0	5.0	0.0	0.0	100.0
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=20)	2.89	10.0	20.0	35.0	20.0	5.0	10.0	100.0
Household budgeting and money management (N=20)	2.90	5.0	20.0	60.0	10.0	5.0	0.0	100.0
Hunger (N=20)	2.65	10.0	35.0	35.0	20.0	0.0	0.0	100.0
Maintaining livable and energy efficient homes (N=19)	2.84	10.5	26.3	36.8	21.1	5.3	0.0	100.0
Skilled labor workforce (N=20)	3.20	0.0	20.0	50.0	20.0	10.0	0.0	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=20)	2.00	30.0	45.0	20.0	5.0	0.0	0.0	100.0
Availability of public transportation (N=20)	2.00	30.0	45.0	20.0	5.0	0.0	0.0	100.0
Availability of walking and biking options (N=20)	2.10	30.0	40.0	20.0	10.0	0.0	0.0	100.0
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=20)	2.32	15.0	40.0	35.0	5.0	0.0	5.0	100.0
Cost of public transportation (N=20)	2.00	35.0	30.0	25.0	5.0	0.0	5.0	100.0
Driving habits (e.g., speeding, road rage) (N=20)	1.90	40.0	30.0	30.0	0.0	0.0	0.0	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=16)	2.19	18.8	50.0	25.0	6.3	0.0	0.0	100.1
Availability of education about birth control (N=15)	2.47	13.3	40.0	33.3	13.3	0.0	0.0	99.9
Availability of quality child care (N=16)	3.13	0.0	12.5	62.5	25.0	0.0	0.0	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth	2.53	12.5	31.3	37.5	12.5	0.0	6.3	100.1

Statements	Mean**	Percent of respondents* Level of attention needed 1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
with behavioral health problems) (N=16)								
Bullying (N=16)	3.06	0.0	18.8	62.5	12.5	6.3	0.0	100.1
Childhood obesity (N=16)	3.38	0.0	25.0	37.5	12.5	25.0	0.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=16)	2.81	18.8	18.8	25.0	37.5	0.0	0.0	100.1
Cost of quality child care (N=16)	2.94	12.5	6.3	62.5	12.5	6.3	0.0	100.1
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=16)	2.53	25.0	18.8	25.0	25.0	0.0	6.3	100.1
Crime committed by youth (N=16)	1.80	31.3	50.0	12.5	0.0	0.0	6.3	100.1
Opportunities for youth-adult mentoring (N=16)	2.88	12.5	25.0	31.3	25.0	6.3	0.0	100.1
Parental custody, guardianships and visitation rights (N=15)	2.27	13.3	46.7	40.0	0.0	0.0	0.0	100.0
School absenteeism (truancy) (N=16)	1.94	18.8	68.8	12.5	0.0	0.0	0.0	100.1
School dropout rates (N=16)	1.81	37.5	50.0	6.3	6.3	0.0	0.0	100.1
School violence (N=16)	1.63	37.5	62.5	0.0	0.0	0.0	0.0	100.0
Substance abuse by youth (N=16)	2.63	6.3	37.5	43.8	12.5	0.0	0.0	100.1
Teen pregnancy (N=16)	2.19	25.0	43.8	25.0	0.0	6.3	0.0	100.1
Teen suicide (N=16)	2.19	31.3	25.0	37.5	6.3	0.0	0.0	100.1
Teen tobacco use (N=16)	2.69	6.3	43.8	31.3	12.5	6.3	0.0	100.2
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=15)	2.93	13.3	0.0	60.0	20.0	0.0	6.7	100.0
Availability of long-term care (N=16)	2.13	37.5	18.8	25.0	12.5	0.0	6.3	100.1
Availability of memory care (N=16)	2.33	25.0	25.0	31.3	12.5	0.0	6.3	100.1
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=16)	2.60	12.5	31.3	31.3	18.8	0.0	6.3	100.2
Availability of resources for grandparents caring for grandchildren (N=16)	2.64	12.5	25.0	31.3	18.8	0.0	12.5	100.1
Availability of resources to help the elderly stay safe in their homes (N=16)	2.87	0.0	31.3	43.8	18.8	0.0	6.3	100.2
Cost of activities for seniors (e.g., recreational, social, cultural) (N=16)	2.73	6.3	25.0	56.3	0.0	6.3	6.3	100.2
Cost of in-home services (N=16)	3.13	0.0	18.8	43.8	31.3	0.0	6.3	100.2
Cost of long-term care (N=16)	3.67	0.0	12.5	25.0	37.5	18.8	6.3	100.1
Cost of memory care (N=16)	3.50	0.0	12.5	25.0	43.8	6.3	12.5	100.1
Help making out a will or healthcare directive (N=16)	2.53	6.3	37.5	43.8	6.3	0.0	6.3	100.2

Statements	Mean**	Percent of respondents* Level of attention needed 1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
SAFETY								
Abuse of prescription drugs (N=14)	2.64	7.1	35.7	42.9	14.3	0.0	0.0	100.0
Availability of emergency medical services (N=14)	1.64	42.9	50.0	7.1	0.0	0.0	0.0	100.0
Child abuse and neglect (N=14)	2.50	7.1	50.0	28.6	14.3	0.0	0.0	100.0
Criminal activity (N=14)	2.21	7.1	64.3	28.6	0.0	0.0	0.0	100.0
Culture of excessive and binge drinking (N=14)	2.64	7.1	28.6	57.1	7.1	0.0	0.0	99.9
Domestic violence (N=14)	2.43	7.1	50.0	35.7	7.1	0.0	0.0	99.9
Elder abuse (N=14)	2.23	14.3	50.0	21.4	7.1	0.0	7.1	99.9
Lack of police or delayed response of police (N=14)	1.93	35.7	50.0	7.1	0.0	7.1	0.0	99.9
Presence of drug dealers (N=14)	2.54	21.4	21.4	28.6	21.4	0.0	7.1	99.9
Presence of gang activity (N=14)	1.23	71.4	21.4	0.0	0.0	0.0	7.1	99.9
Presence of street drugs (N=14)	2.31	14.3	42.9	28.6	7.1	0.0	7.1	100.0
Sex trafficking (N=14)	1.69	50.0	28.6	7.1	7.1	0.0	7.1	99.9
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=14)	3.07	0.0	42.9	14.3	35.7	7.1	0.0	100.0
Access to affordable health insurance coverage (N=14)	3.43	0.0	21.4	28.6	35.7	14.3	0.0	100.0
Access to affordable healthcare (N=14)	3.36	0.0	21.4	42.9	14.3	21.4	0.0	100.0
Access to affordable prescription drugs (N=14)	3.29	0.0	21.4	42.9	21.4	14.3	0.0	100.0
Access to affordable vision insurance coverage (N=14)	3.21	0.0	28.6	28.6	35.7	7.1	0.0	100.0
Access to technology for health records and health education (N=14)	2.07	28.6	35.7	35.7	0.0	0.0	0.0	100.0
Availability of behavioral health (e.g., substance abuse) providers (N=14)	3.23	0.0	21.4	42.9	14.3	14.3	7.1	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=14)	2.29	35.7	14.3	35.7	14.3	0.0	0.0	100.0
Availability of healthcare services for Native people (N=14)	2.00	35.7	21.4	14.3	0.0	7.1	21.4	99.9
Availability of healthcare services for New Americans (N=14)	2.00	35.7	28.6	14.3	0.0	7.1	14.3	100.0
Availability of mental health providers (N=14)	3.29	14.3	14.3	21.4	28.6	21.4	0.0	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=14)	2.64	7.1	42.9	35.7	7.1	7.1	0.0	99.9
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=14)	2.29	21.4	28.6	50.0	0.0	0.0	0.0	100.0
Availability of specialist physicians (N=14)	2.50	14.3	50.0	14.3	14.3	7.1	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Coordination of care between providers and services (N=14)	2.36	21.4	42.9	21.4	7.1	7.1	0.0	99.9
Timely access to medical care providers (N=14)	1.86	35.7	42.9	21.4	0.0	0.0	0.0	100.0
Timely access to dental care providers (N=14)	1.93	28.6	50.0	21.4	0.0	0.0	0.0	100.0
Timely access to vision care providers (N=13)	1.92	30.8	46.2	23.1	0.0	0.0	0.0	100.1
Use of emergency room services for primary healthcare (N=14)	2.07	35.7	35.7	21.4	0.0	7.1	0.0	99.9
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=14)	3.00	7.1	14.3	42.9	28.6	0.0	7.1	100.0
Dementia and Alzheimer's disease (N=14)	3.54	7.1	0.0	35.7	35.7	14.3	7.1	99.9
Depression (N=14)	3.36	7.1	7.1	35.7	42.9	7.1	0.0	99.9
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=14)	3.08	7.1	7.1	50.0	28.6	0.0	7.1	99.9
Exposure to secondhand smoke (N=14)	2.71	21.4	35.7	14.3	7.1	21.4	0.0	99.9
Smoking and tobacco use (N=14)	3.00	7.1	35.7	28.6	7.1	21.4	0.0	99.9
Stress (N=14)	3.21	14.3	7.1	35.7	28.6	14.3	0.0	100.0
Suicide (N=14)	2.86	21.4	14.3	28.6	28.6	7.1	0.0	100.0

*Percentages may not total 100.0 due to rounding.

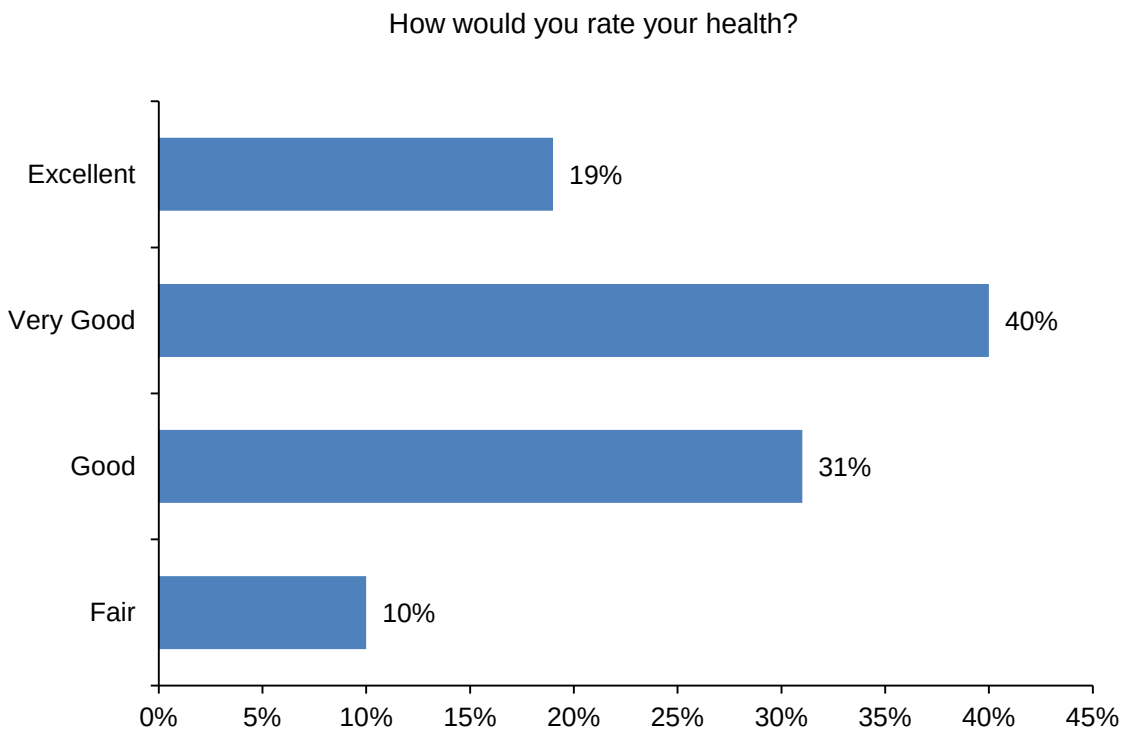
**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflect total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

Resident Survey

Canby CHNA Survey Report

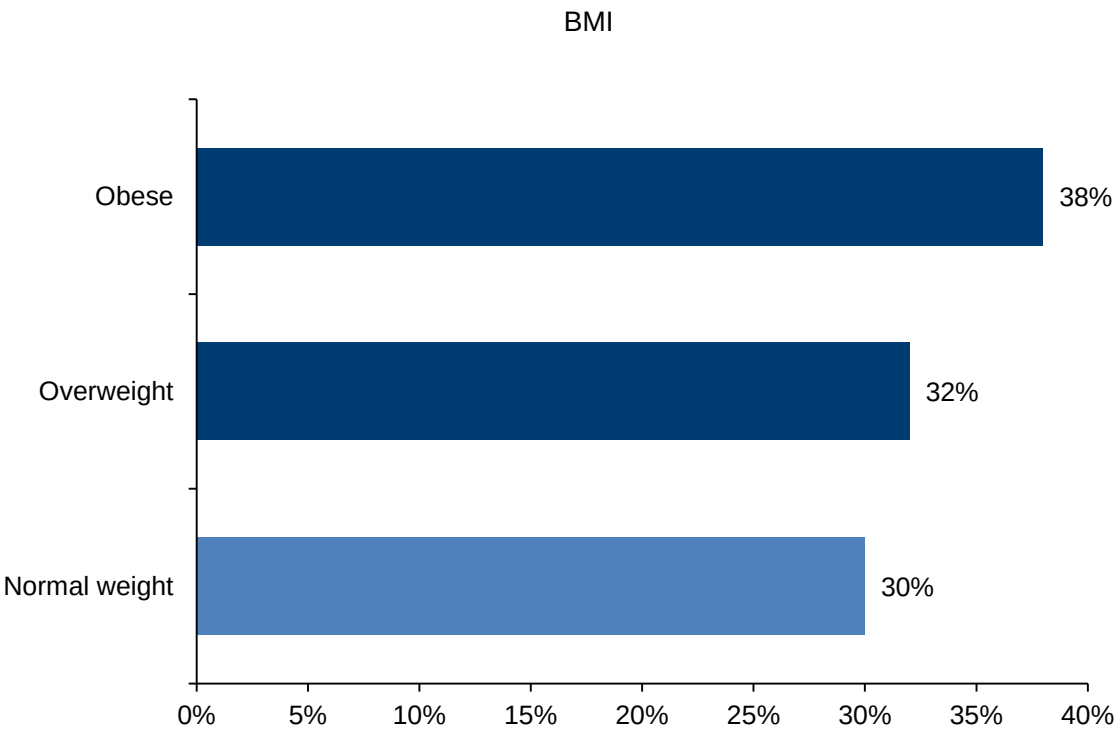
February 27, 2018

Charts Exported by MarketSight®



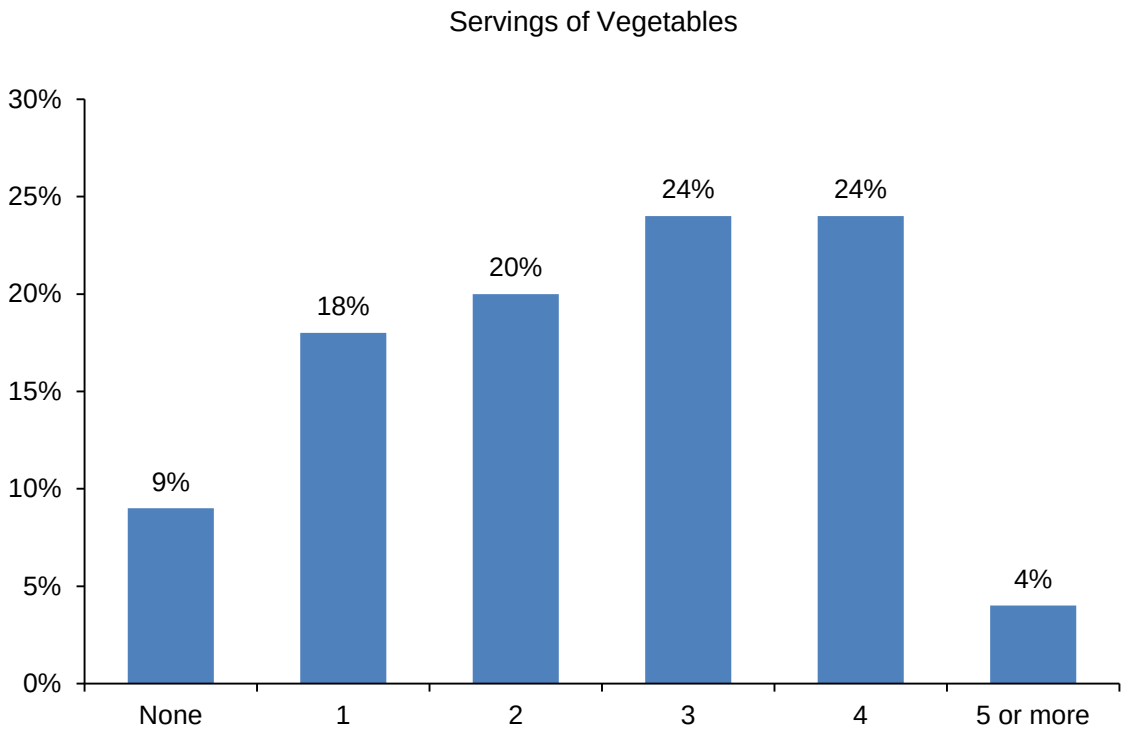
Base: Fair (n=5), Good (n=16), Very Good (n=21), Excellent (n=10), Sample Size = 52

(Community = Yellow Medicine)



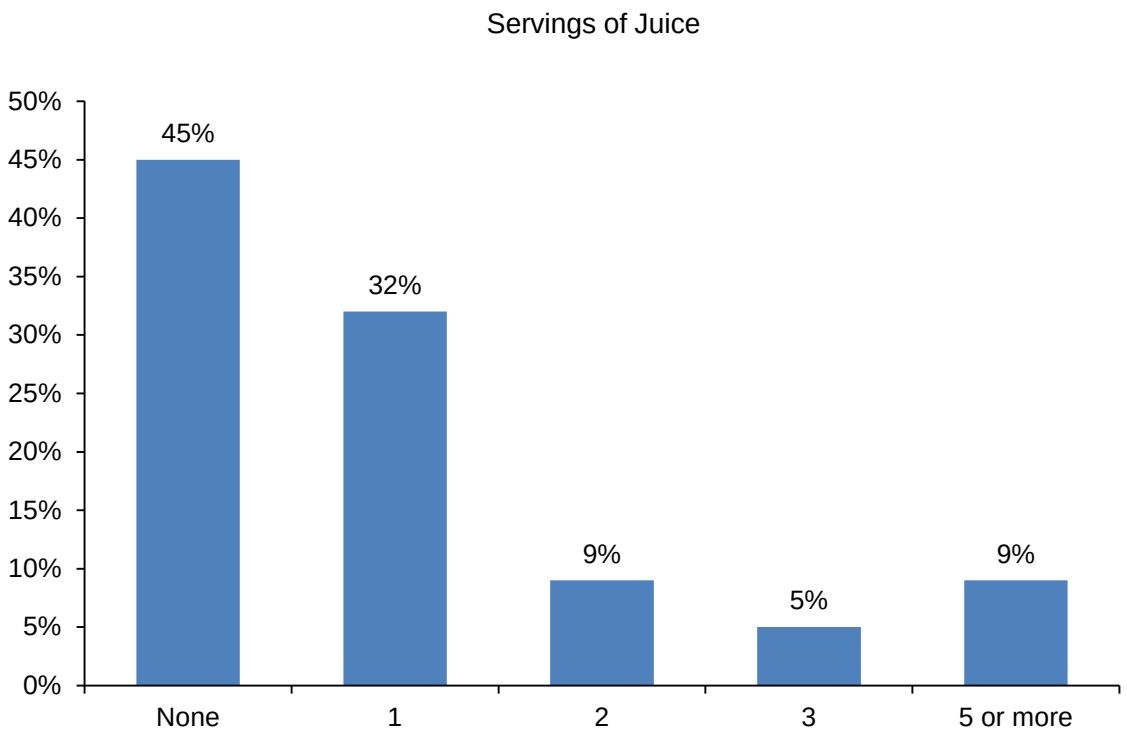
Base: Normal weight (n=15), Overweight (n=16), Obese (n=19), Sample Size = 50

(Community = Yellow Medicine)



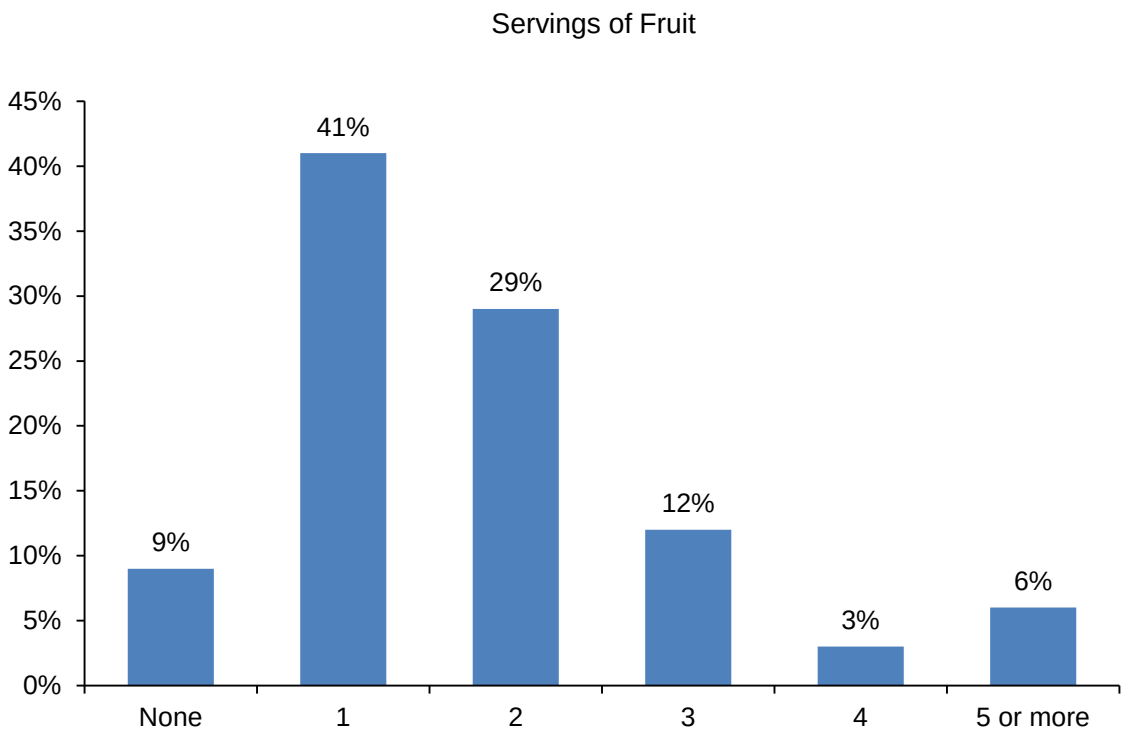
Base: None (n=4), 1 (n=8), 2 (n=9), 3 (n=11), 4 (n=11), 5 or more (n=2), Sample Size = 45

(Community = Yellow Medicine)



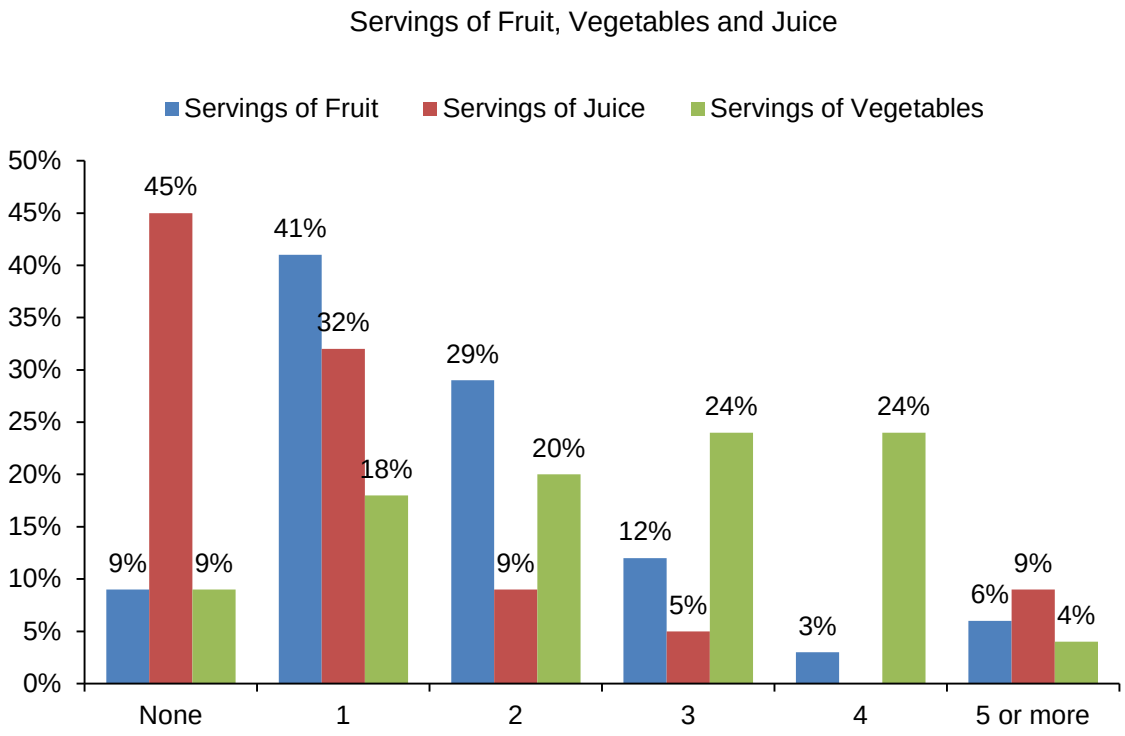
Base: None (n=10), 1 (n=7), 2 (n=2), 3 (n=1), 5 or more (n=2), Sample Size = 22

(Community = Yellow Medicine)



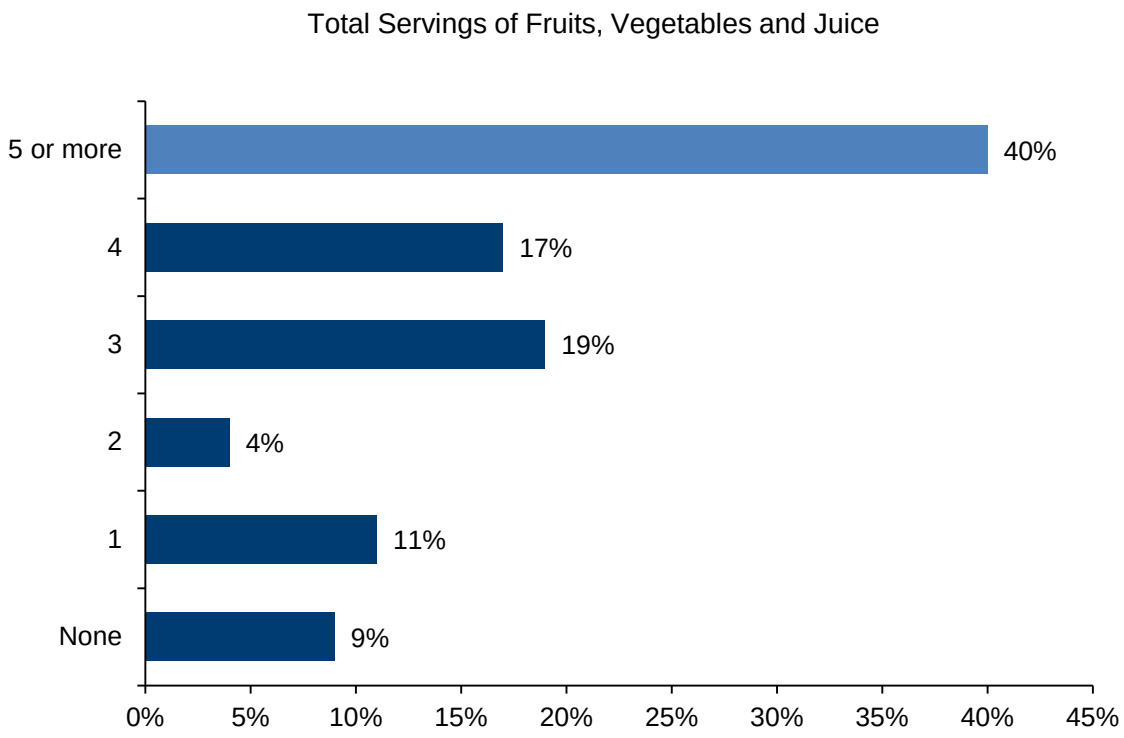
Base: None (n=3), 1 (n=14), 2 (n=10), 3 (n=4), 4 (n=1), 5 or more (n=2), Sample Size = 34

(Community = Yellow Medicine)



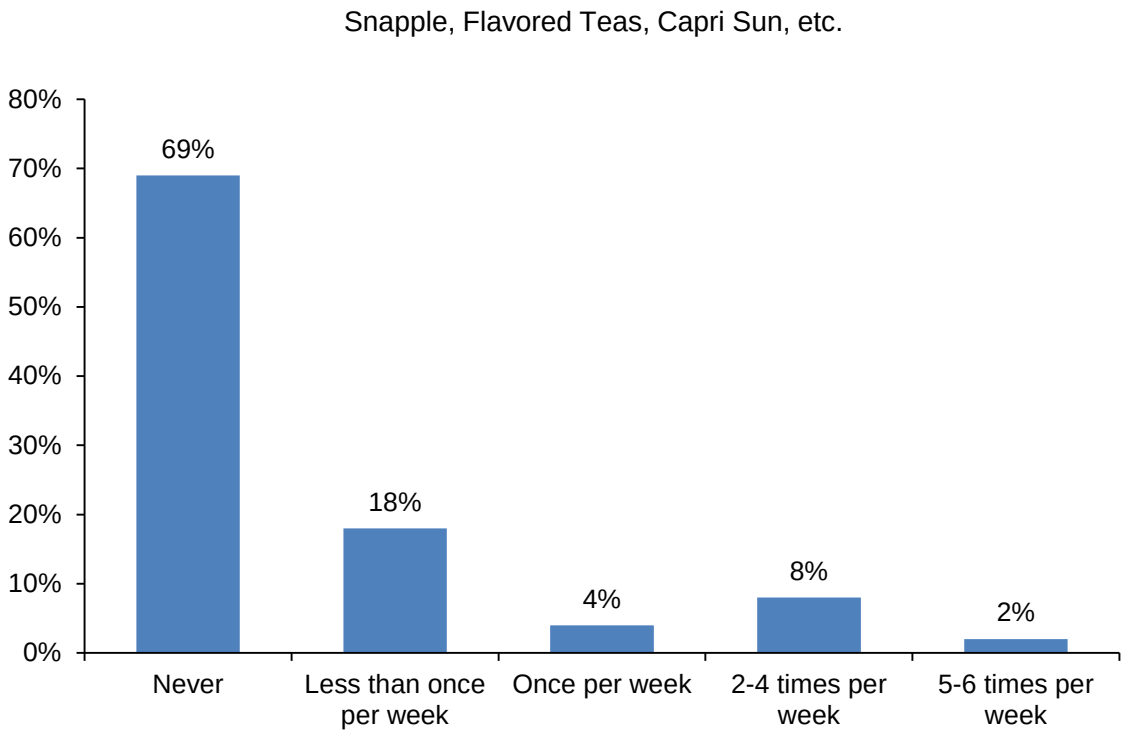
Sample Size = Variable

(Community = Yellow Medicine)



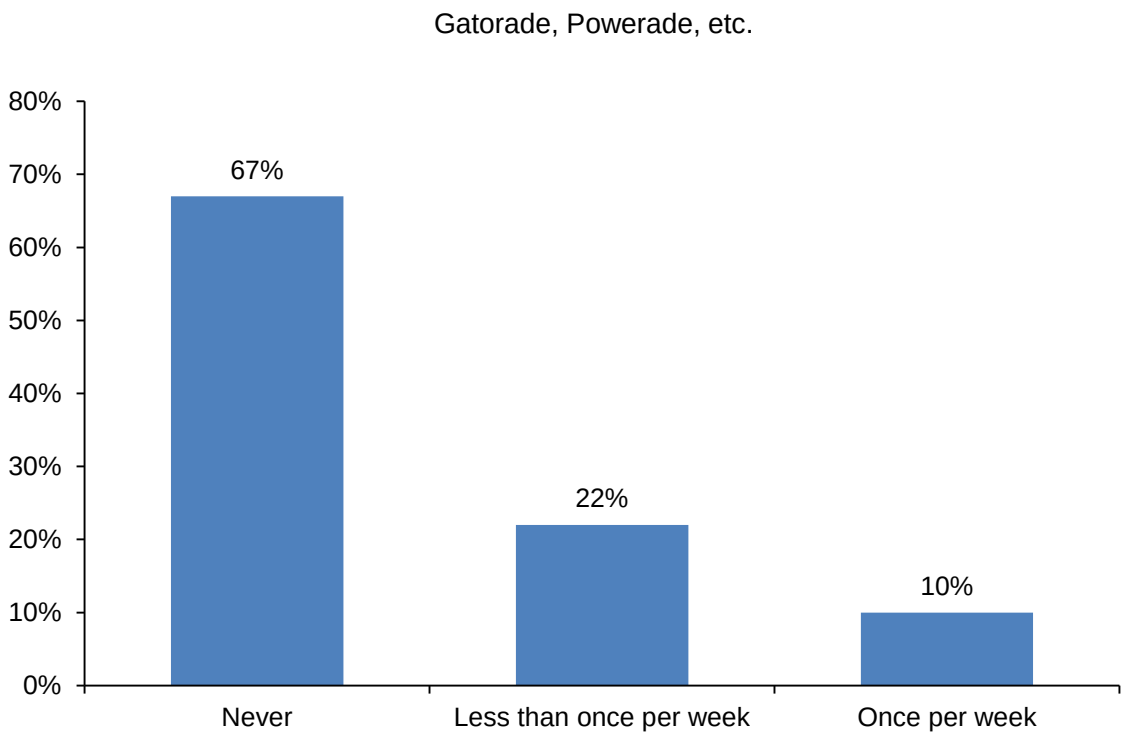
Base: None (n=4), 1 (n=5), 2 (n=2), 3 (n=9), 4 (n=8), 5 or more (n=19), Sample Size = 47

(Community = Yellow Medicine)



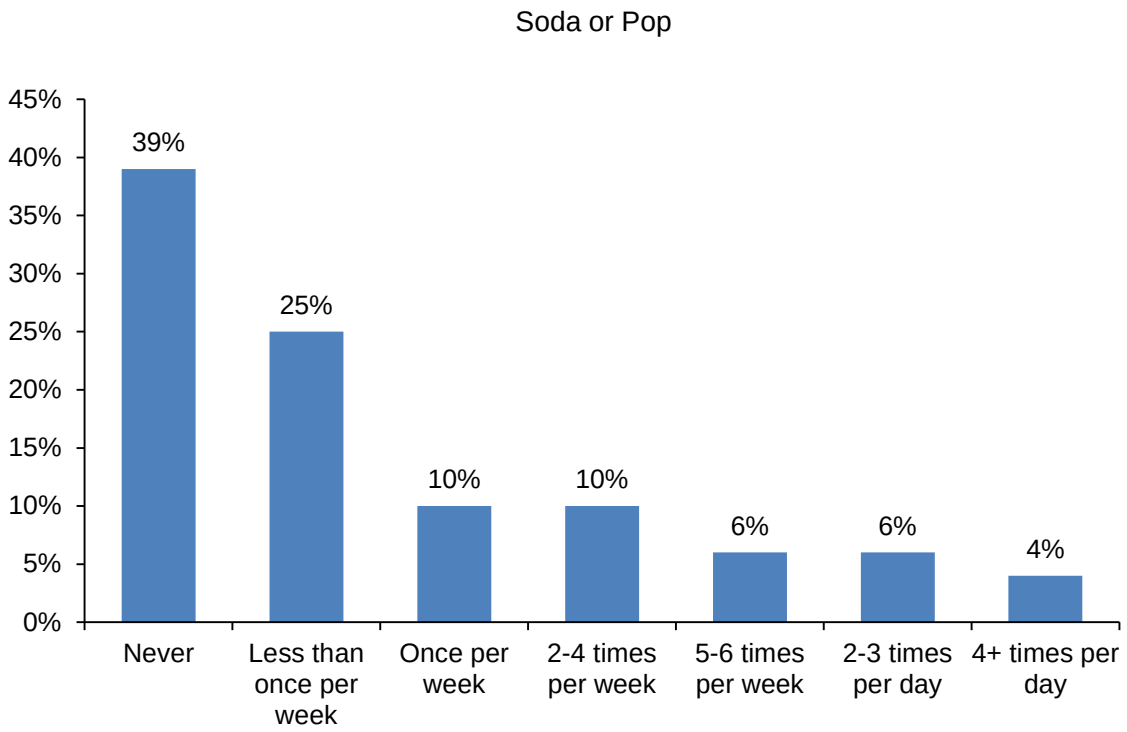
Base: Never (n=35), Less than once per week (n=9), Once per week (n=2), 2-4 times per week (n=4), 5-6 times per week (n=1), Sample Size = 51

(Community = Yellow Medicine)



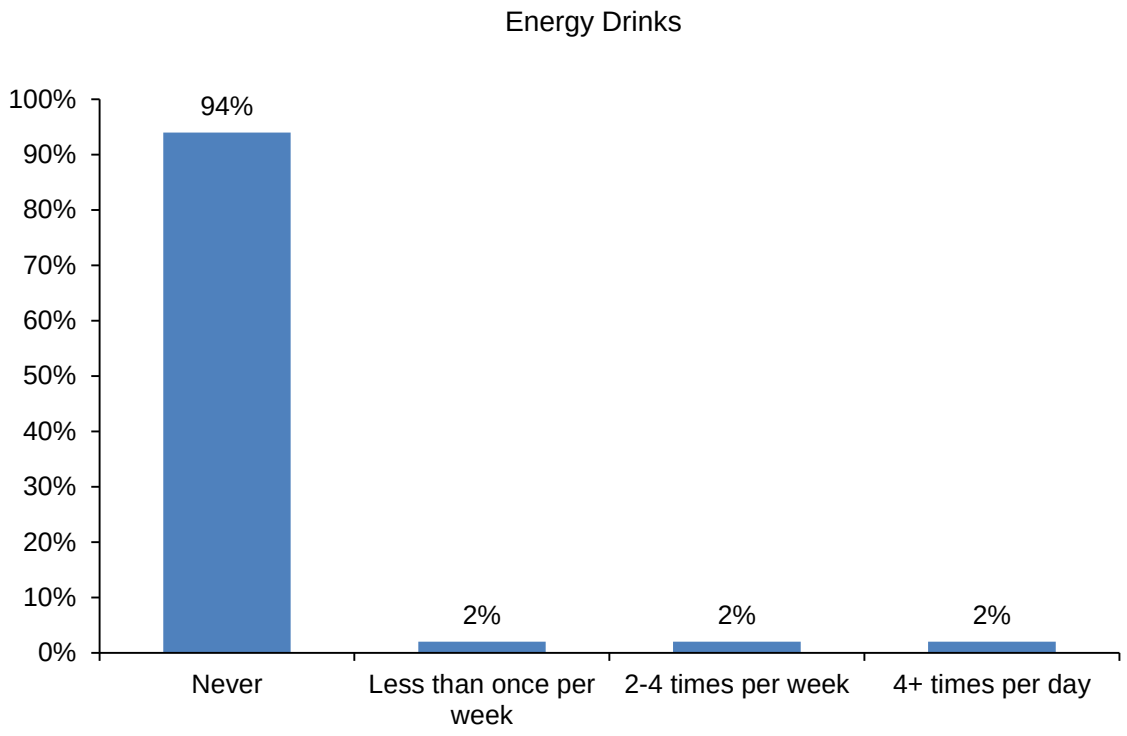
Base: Never (n=33), Less than once per week (n=11), Once per week (n=5), Sample Size = 49

(Community = Yellow Medicine)



Base: Never (n=20), Less than once per week (n=13), Once per week (n=5), 2-4 times per week (n=5), 5-6 times per week (n=3), 2-3 times per day (n=3), 4+ times per day (n=2), Sample Size = 51

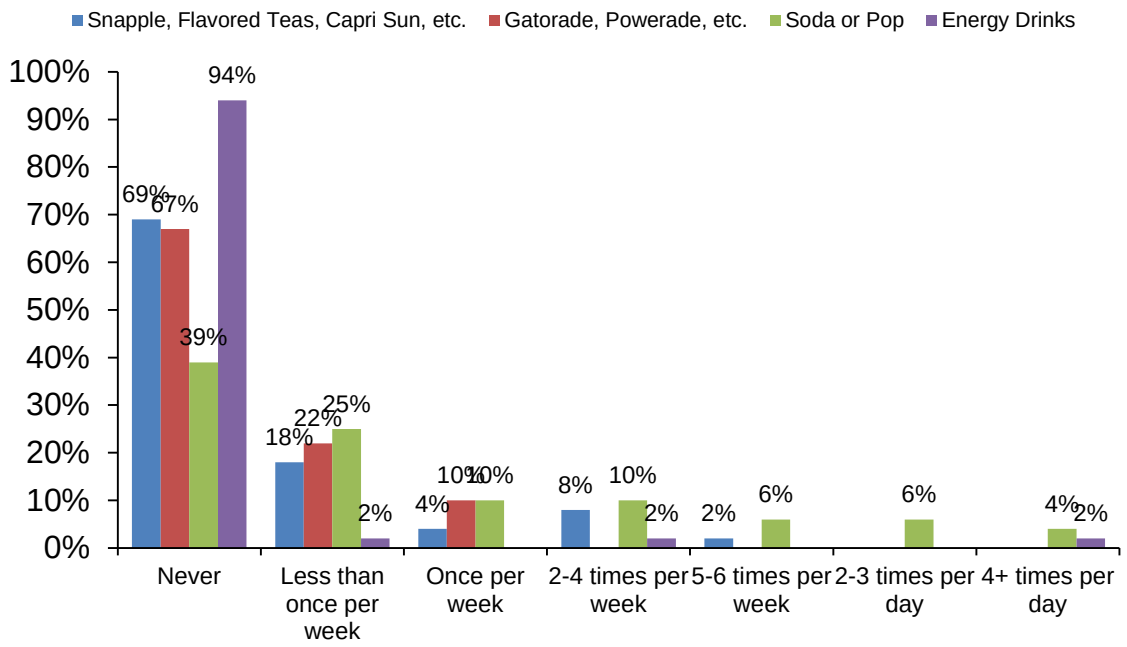
(Community = Yellow Medicine)



Base: Never (n=47), Less than once per week (n=1), 2-4 times per week (n=1), 4+ times per day (n=1), Sample Size = 50

(Community = Yellow Medicine)

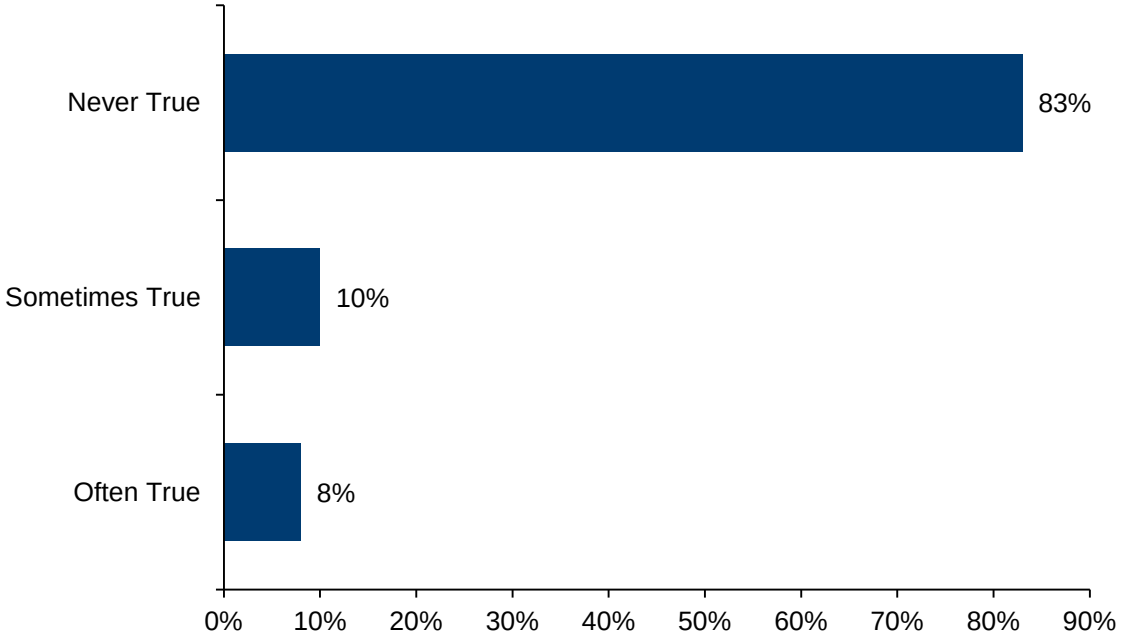
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Yellow Medicine)

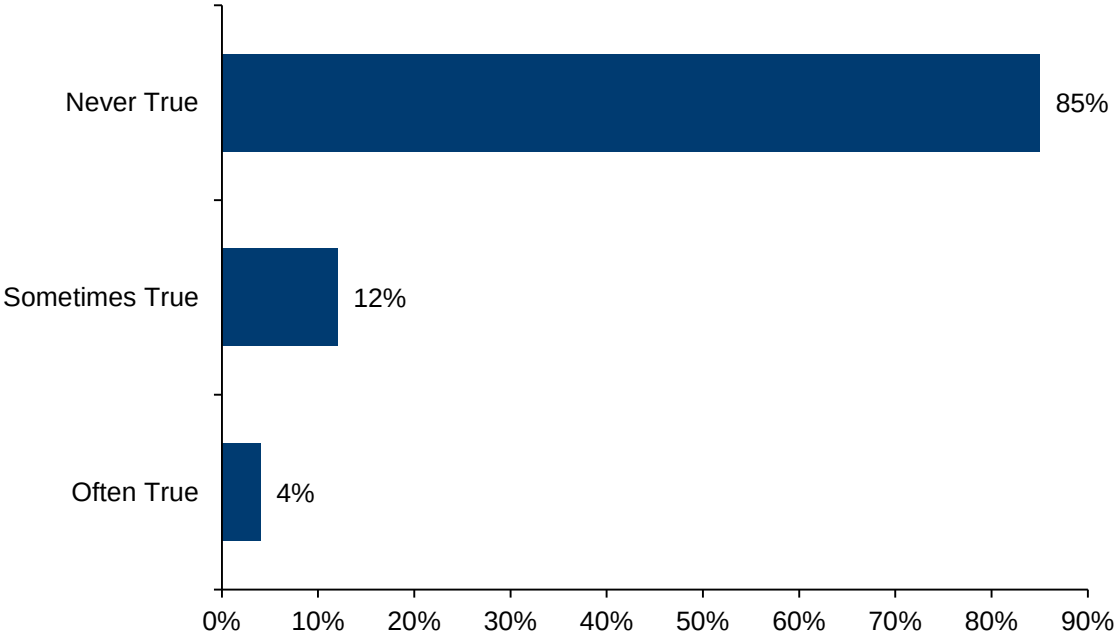
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=4), Sometimes True (n=5), Never True (n=43), Sample Size = 52

(Community = Yellow Medicine)

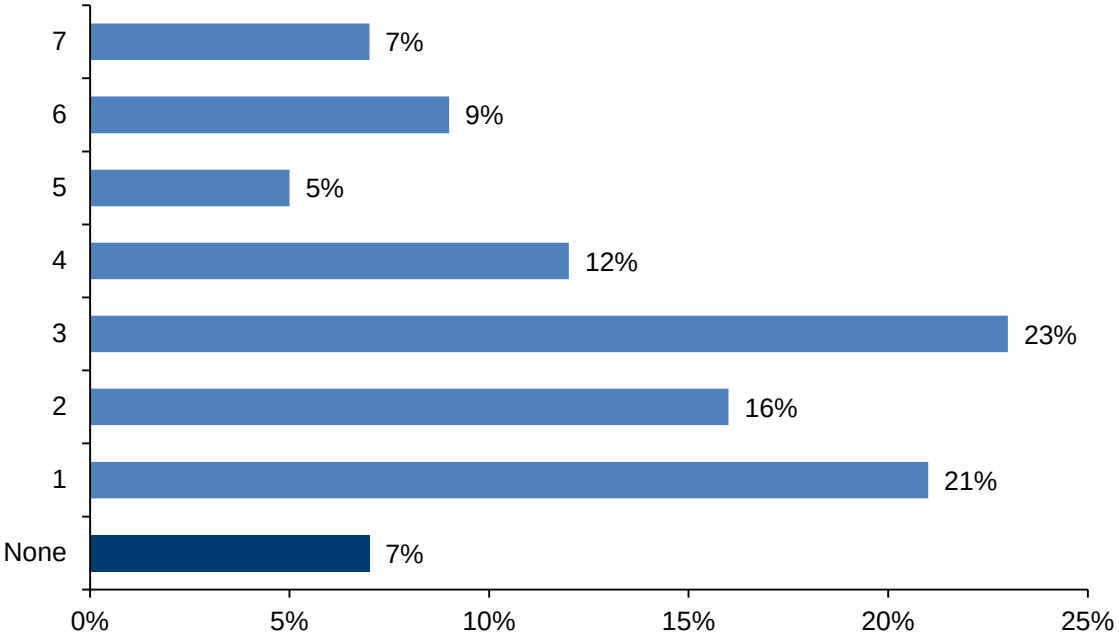
The food that we bought just didn’t last, and we didn’t have money to get more.



Base: Often True (n=2), Sometimes True (n=6), Never True (n=44), Sample Size = 52

(Community = Yellow Medicine)

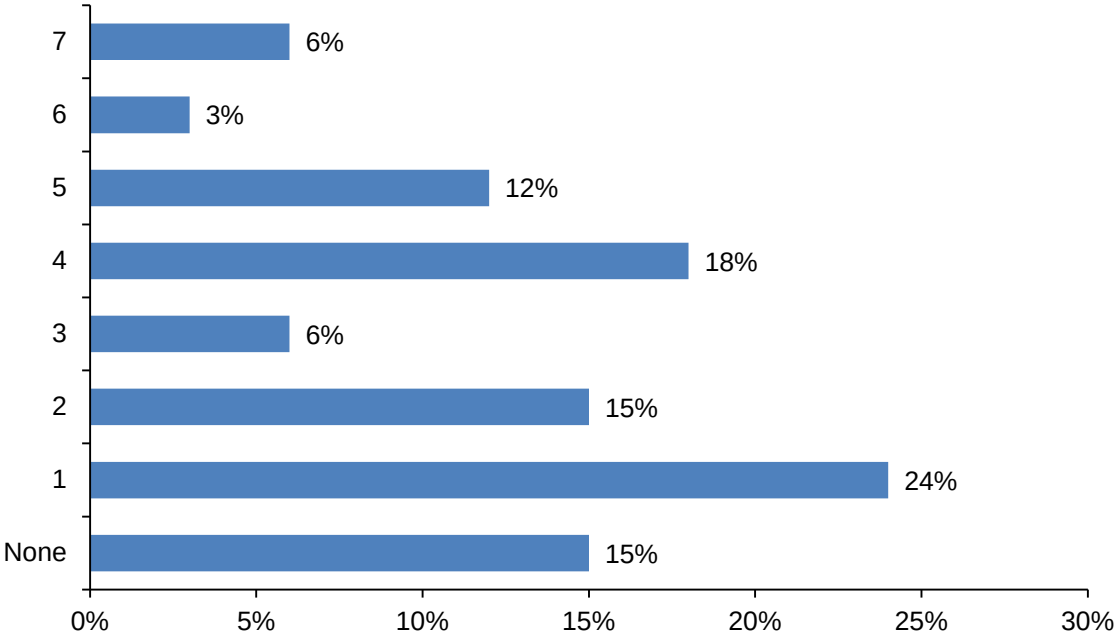
Days Per Week of Moderate Physical Activity



Base: None (n=3), 1 (n=9), 2 (n=7), 3 (n=10), 4 (n=5), 5 (n=2), 6 (n=4), 7 (n=3), Sample Size = 43

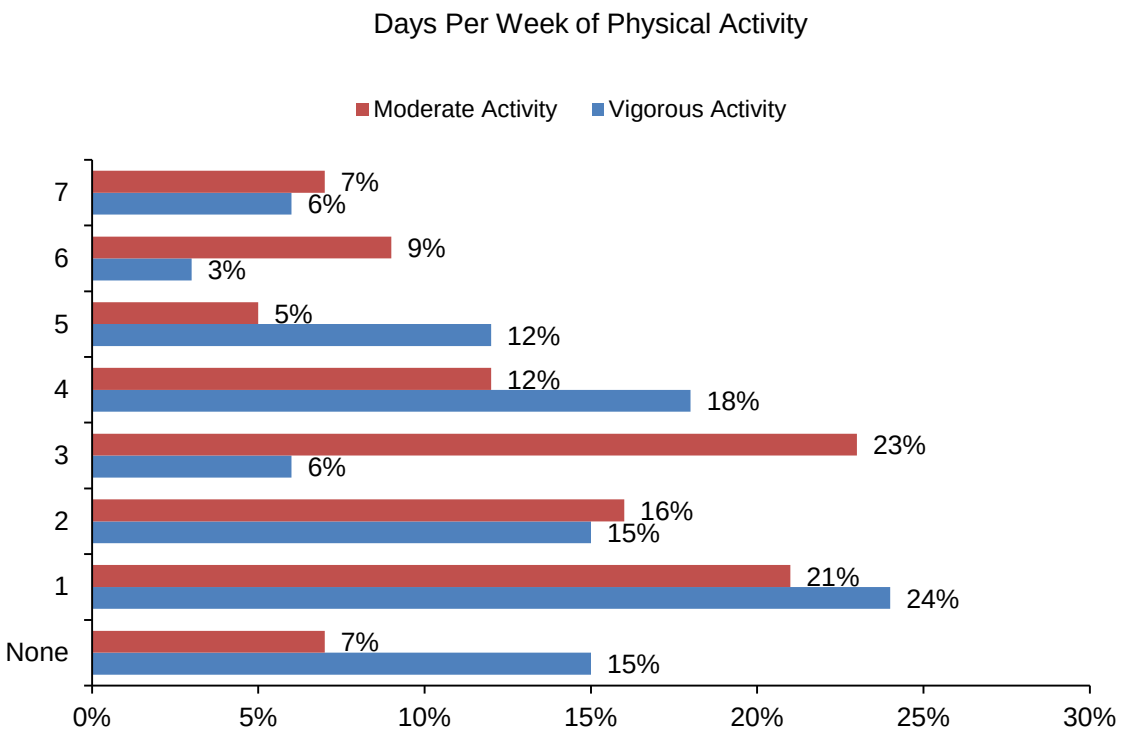
(Community = Yellow Medicine)

Days Per Week of Vigorous Physical Activity



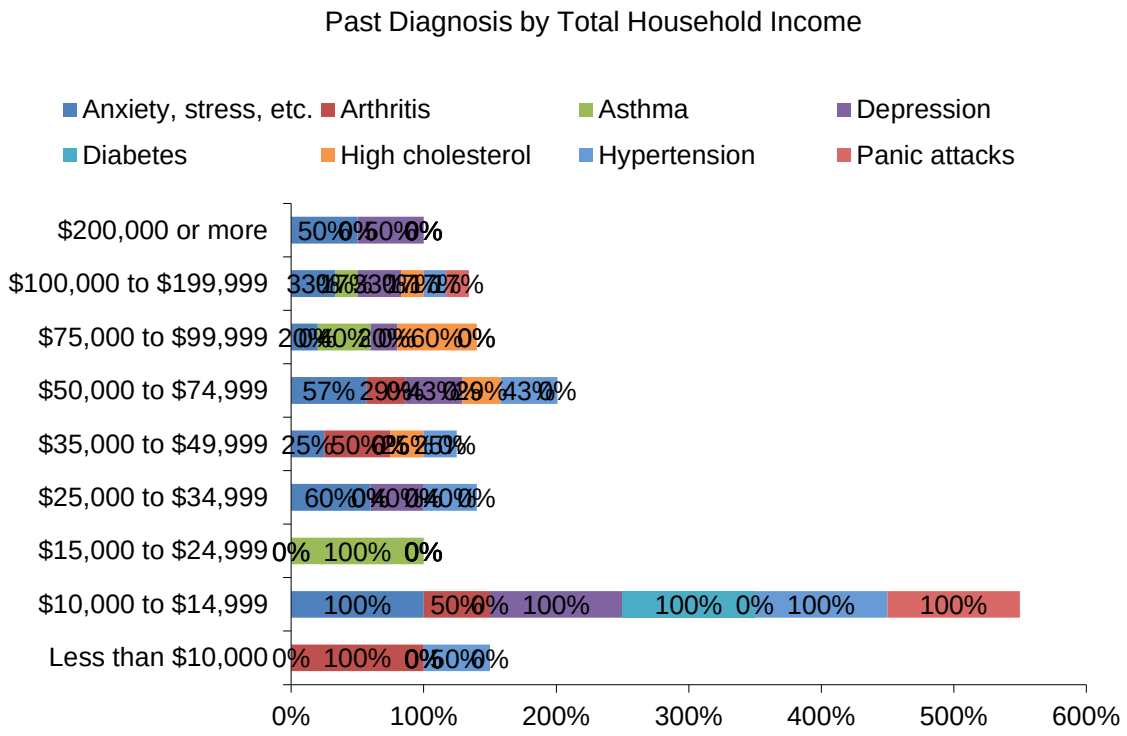
Base: None (n=5), 1 (n=8), 2 (n=5), 3 (n=2), 4 (n=6), 5 (n=4), 6 (n=1), 7 (n=2), Sample Size = 33

(Community = Yellow Medicine)



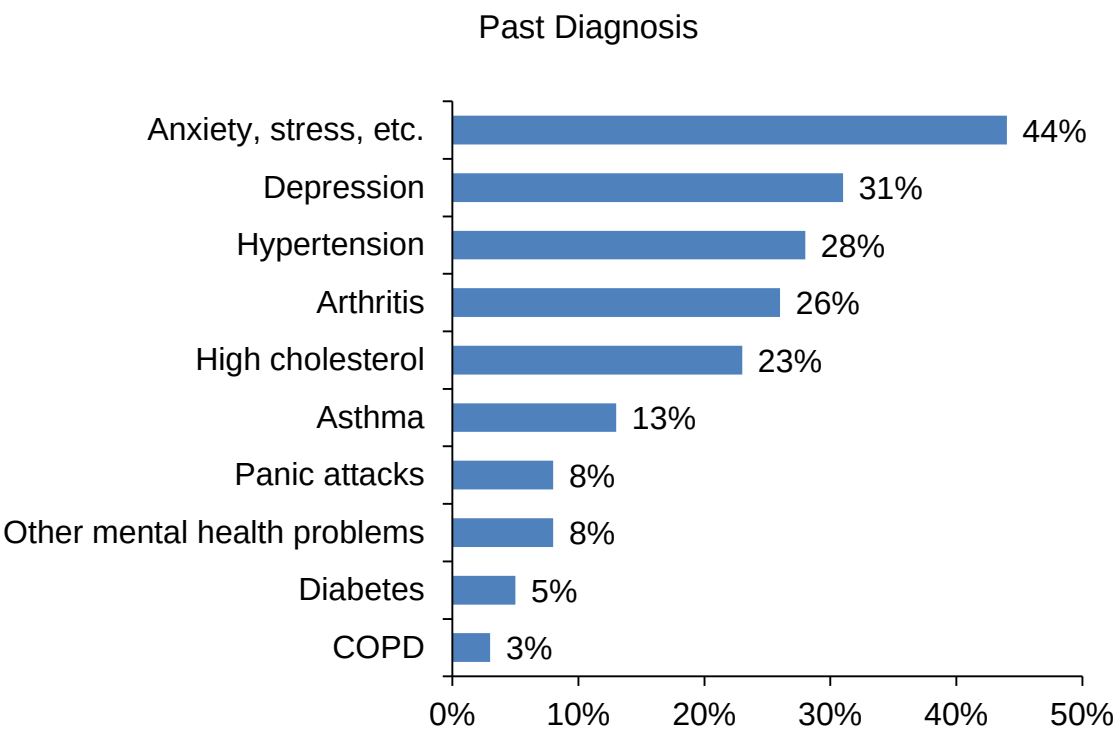
Sample Size = Variable

(Community = Yellow Medicine)



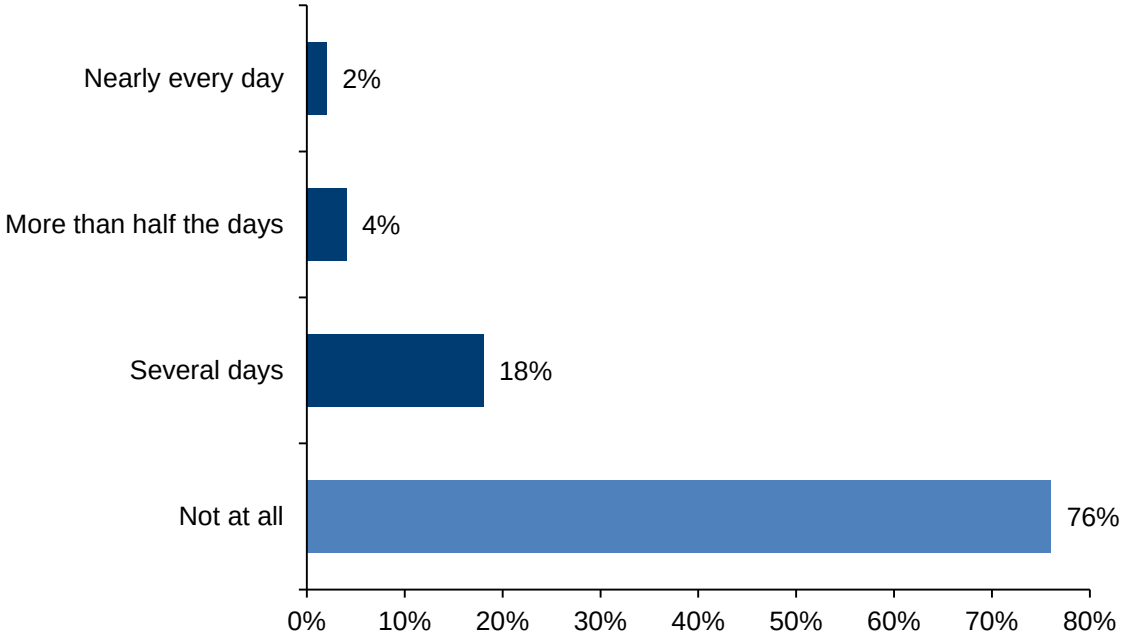
Base: Less than $10,000 (n=2), $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=1), $25,000 to $34,999 (n=5), $35,000 to $49,999 (n=4), $50,000 to $74,999 (n=7), $75,000 to $99,999 (n=5), $100,000 to $199,999 (n=6), $200,000 or more (n=2), Sample Size = 34

(Community = Yellow Medicine)



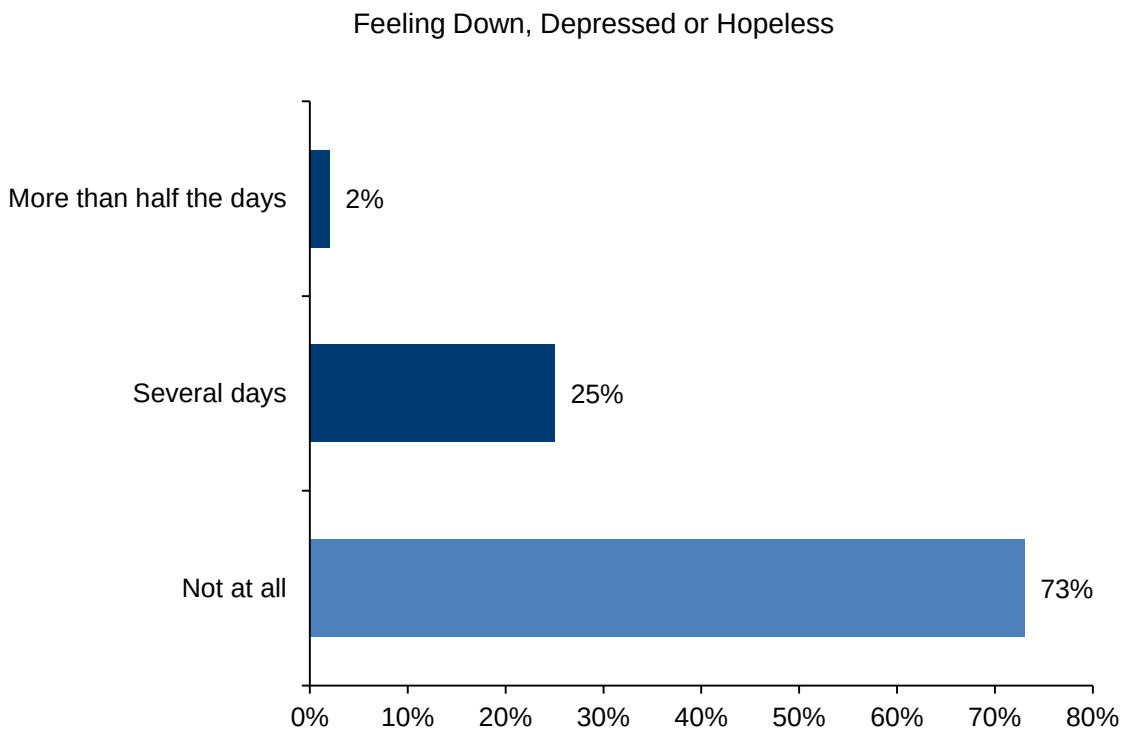
Base: Anxiety, stress, etc. (n=17), Arthritis (n=10), Asthma (n=5), COPD (n=1), Depression (n=12), Diabetes (n=2), High cholesterol (n=9), Hypertension (n=11), Other mental health problems (n=3), Panic attacks (n=3), Sample Size = 39 (Community = Yellow Medicine)

Little Interest or Pleasure in Doing Things



Base: Not at all (n=39), Several days (n=9), More than half the days (n=2), Nearly every day (n=1), Sample Size = 51

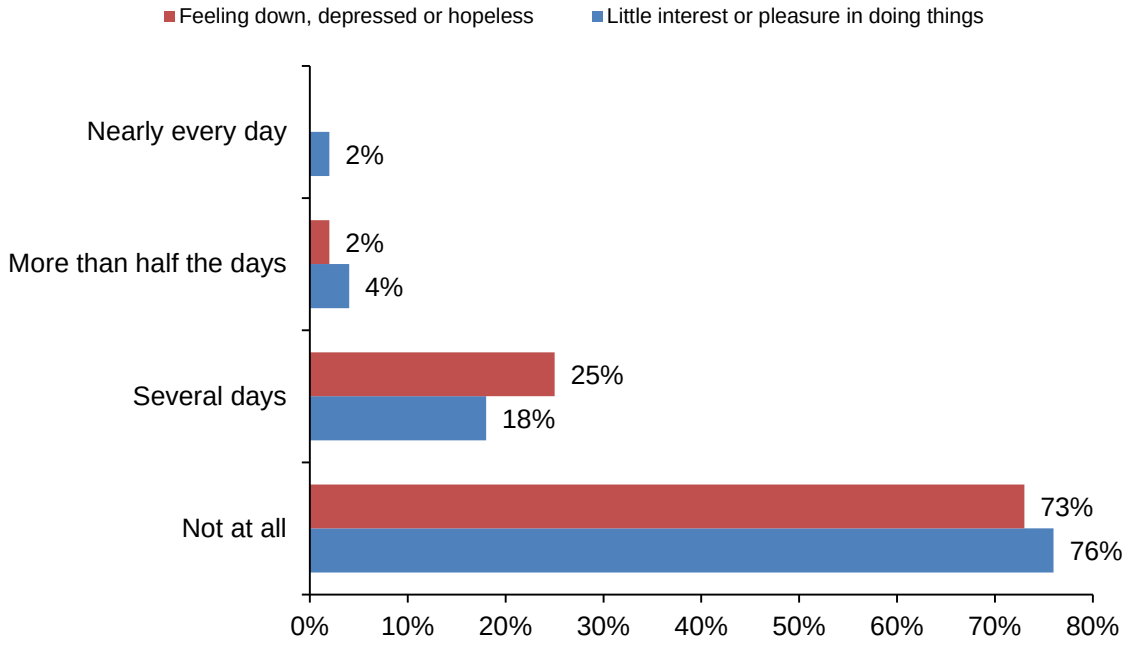
(Community = Yellow Medicine)



Base: Not at all (n=37), Several days (n=13), More than half the days (n=1), Sample Size = 51

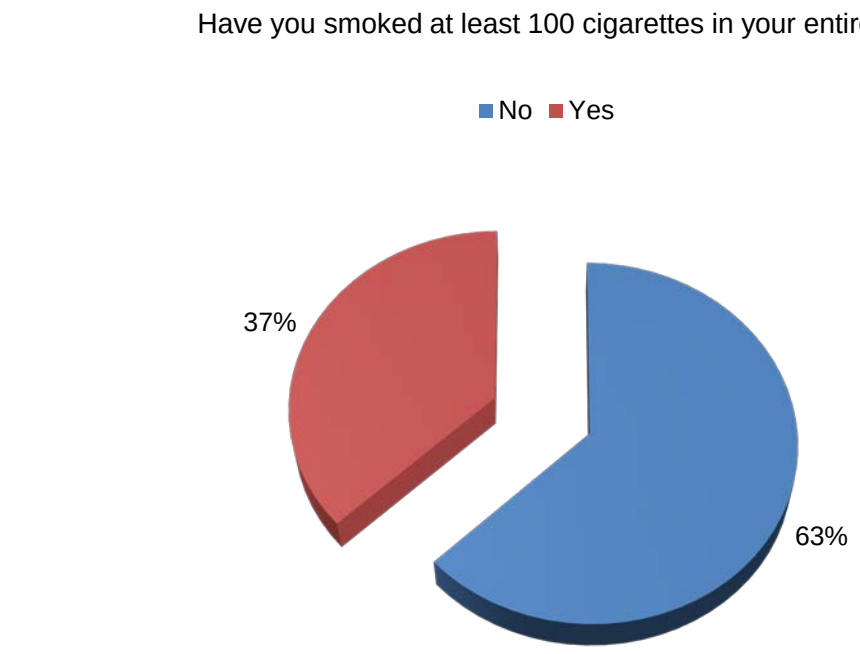
(Community = Yellow Medicine)

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



Sample Size = 51

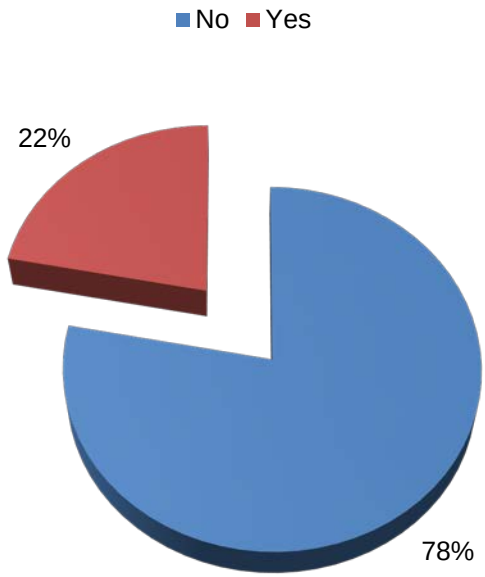
(Community = Yellow Medicine)



Base: Yes (n=19), No (n=32), Sample Size = 51

(Community = Yellow Medicine)

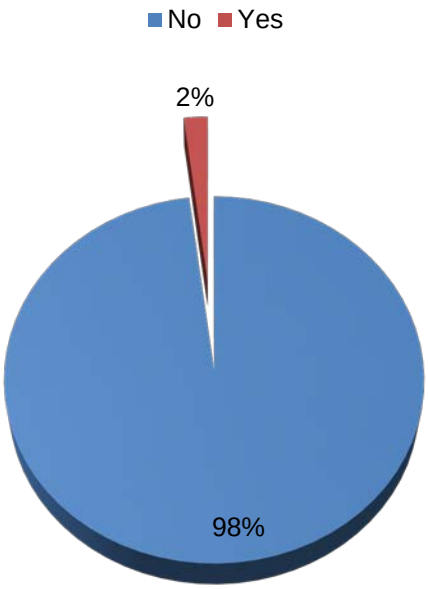
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=11), No (n=40), Sample Size = 51

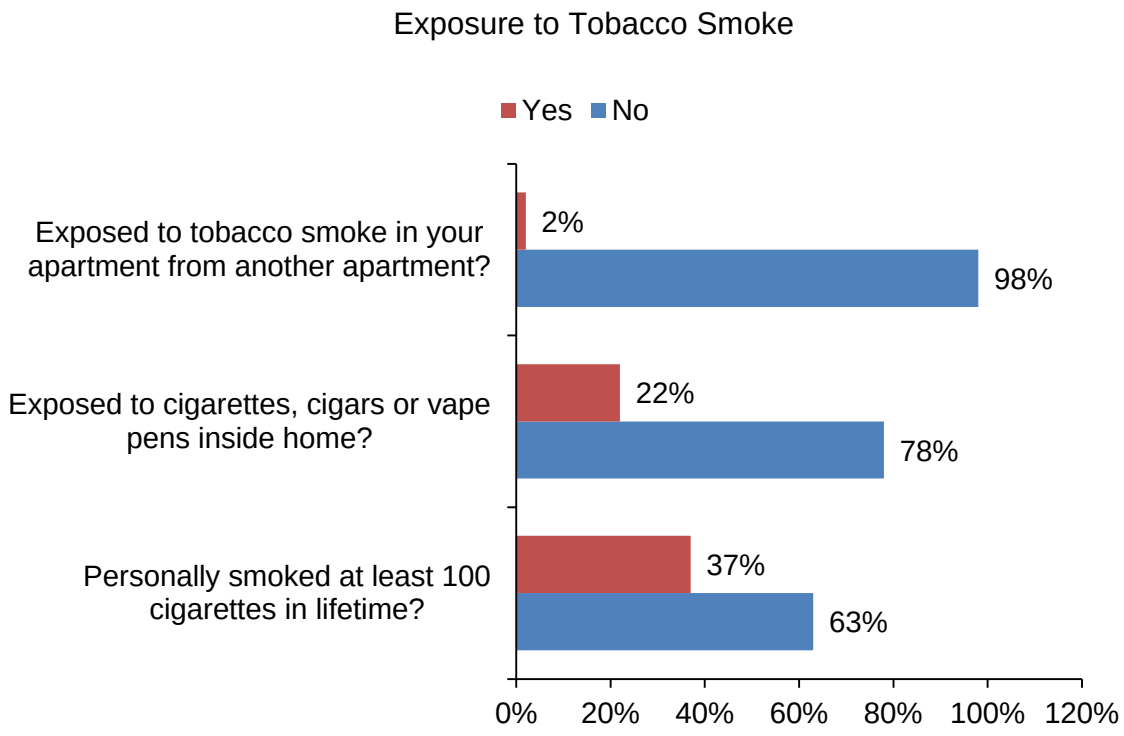
(Community = Yellow Medicine)

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



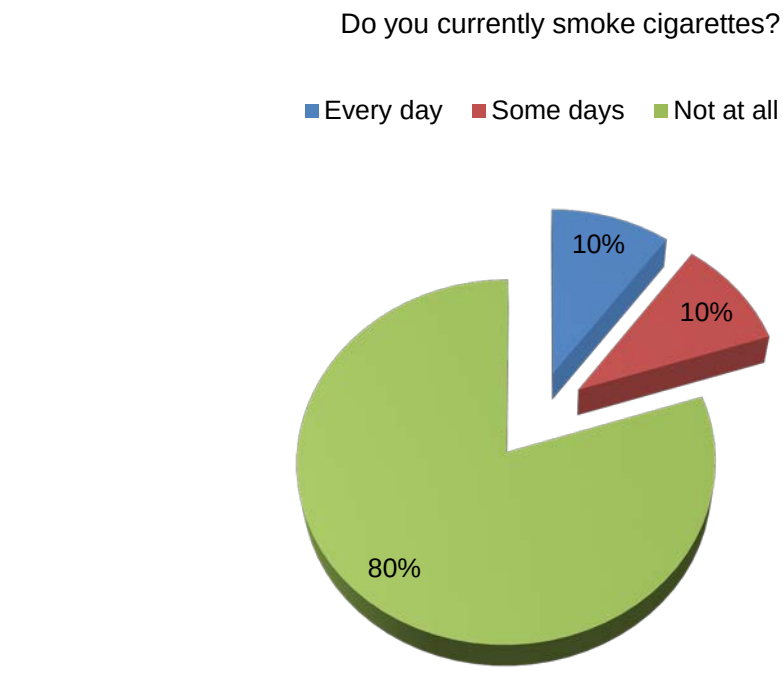
Base: Yes (n=1), No (n=50), Sample Size = 51

(Community = Yellow Medicine)



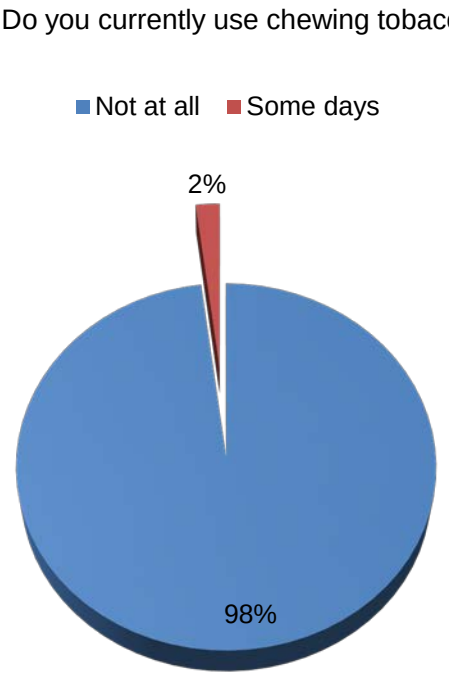
Base: Personally smoked at least 100 cigarettes in lifetime? (n=51), Exposed to cigarettes, cigars or vape pens inside home? (n=51), Exposed to tobacco smoke in your apartment from another apartment? (n=51), Sample Size = 51

(Community = Yellow Medicine)



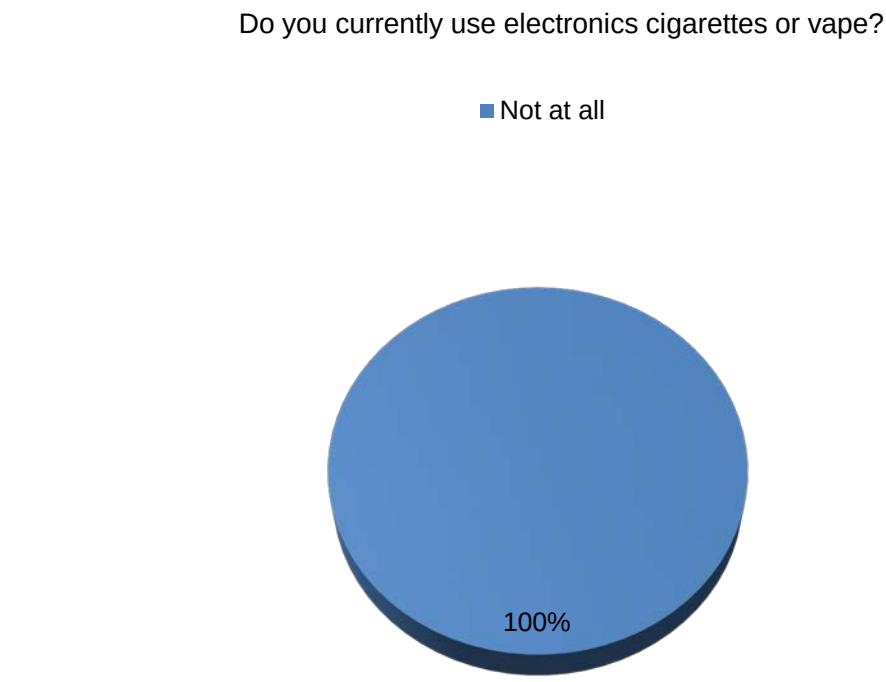
Base: Not at all (n=41), Some days (n=5), Every day (n=5), Sample Size = 51

(Community = Yellow Medicine)



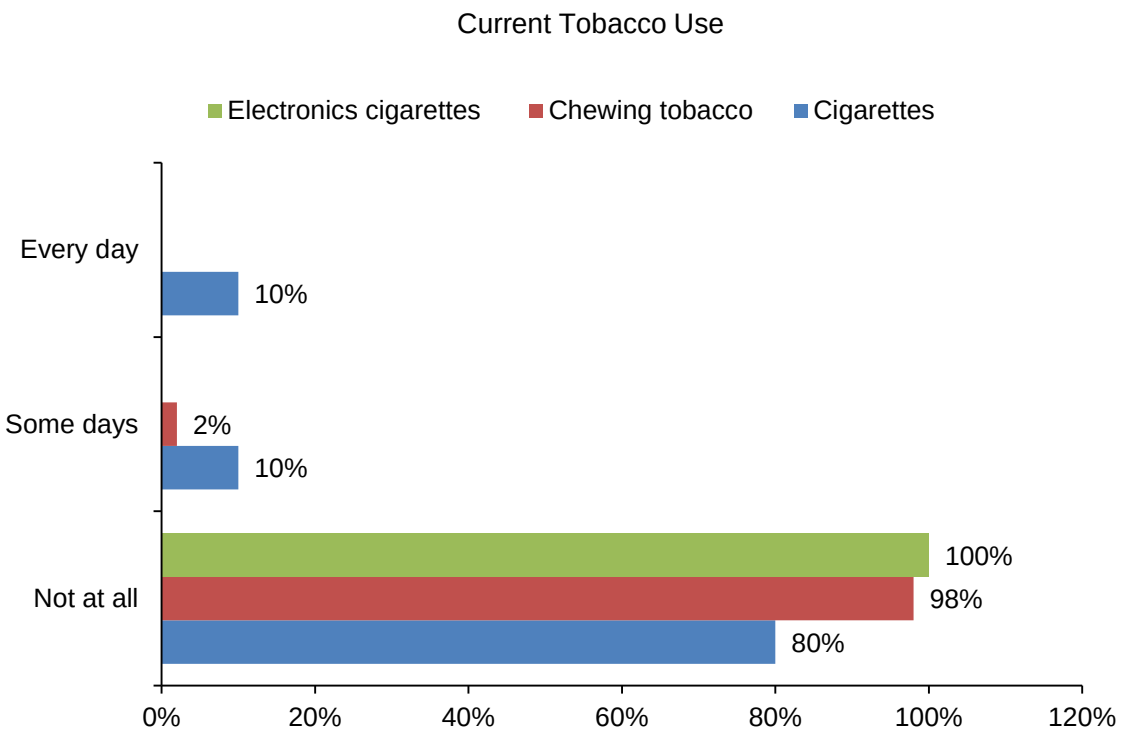
Base: Not at all (n=50), Some days (n=1), Sample Size = 51

(Community = Yellow Medicine)



Base: Not at all (n=51), Sample Size = 51

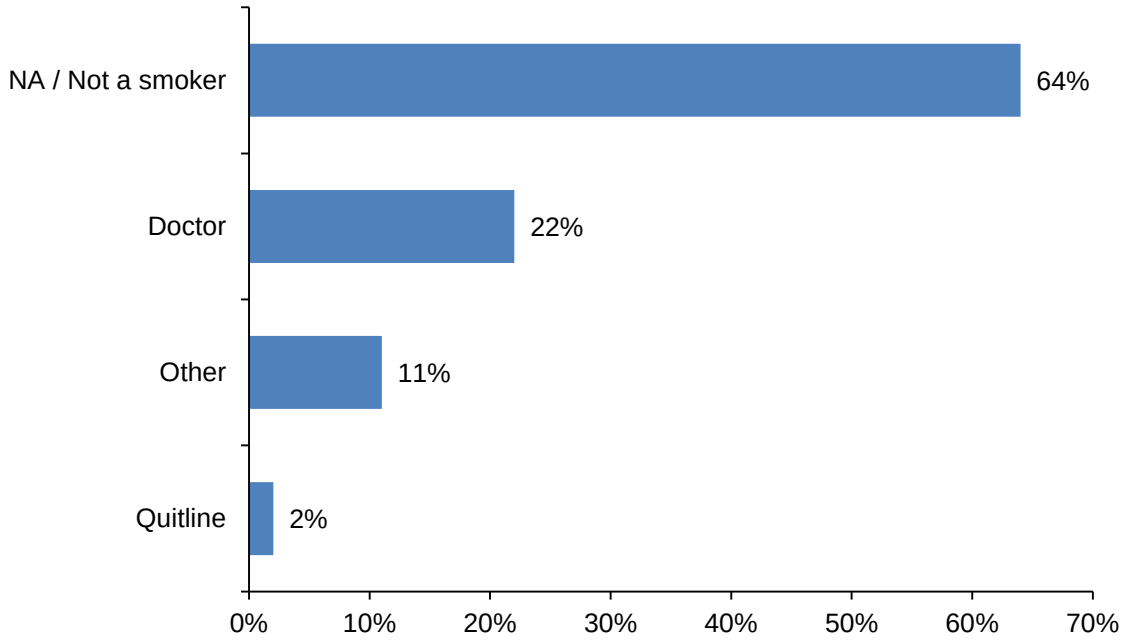
(Community = Yellow Medicine)



Sample Size = 51

(Community = Yellow Medicine)

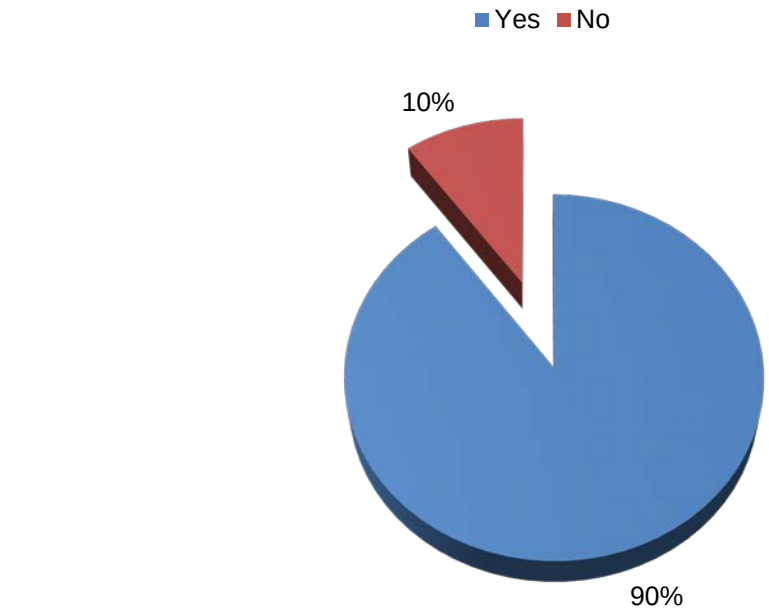
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=29), Quitline (n=1), Doctor (n=10), Other (n=5), Sample Size = 45

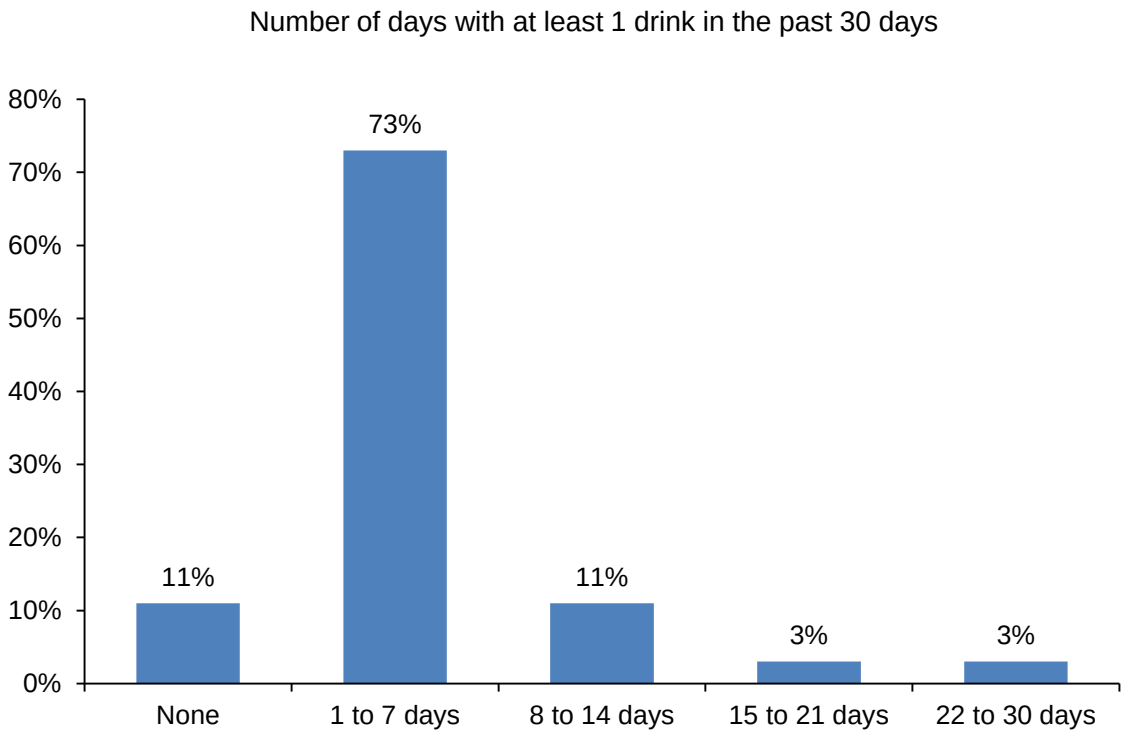
(Community = Yellow Medicine)

During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit? (Smokers only)



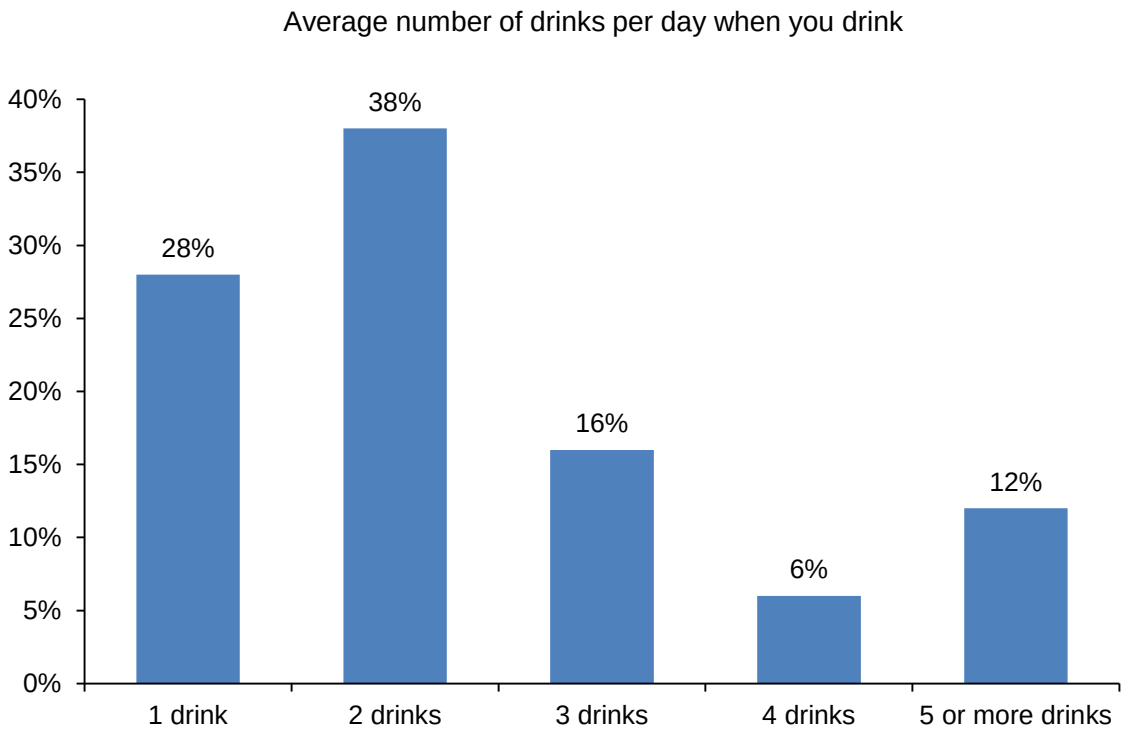
Base: Yes (n=9), No (n=1), Sample Size = 10

(Community = Yellow Medicine)



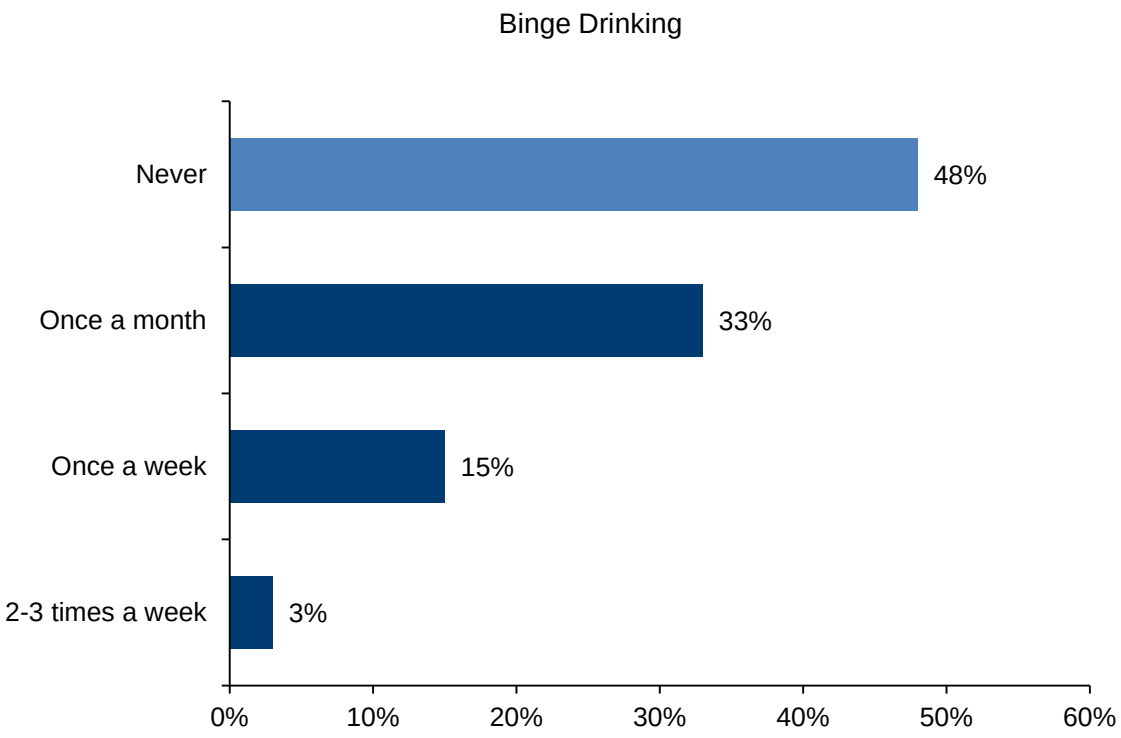
Base: None (n=4), 1 to 7 days (n=27), 8 to 14 days (n=4), 15 to 21 days (n=1), 22 to 30 days (n=1), Sample Size = 37

(Community = Yellow Medicine)



Base: 1 drink (n=9), 2 drinks (n=12), 3 drinks (n=5), 4 drinks (n=2), 5 or more drinks (n=4), Sample Size = 32

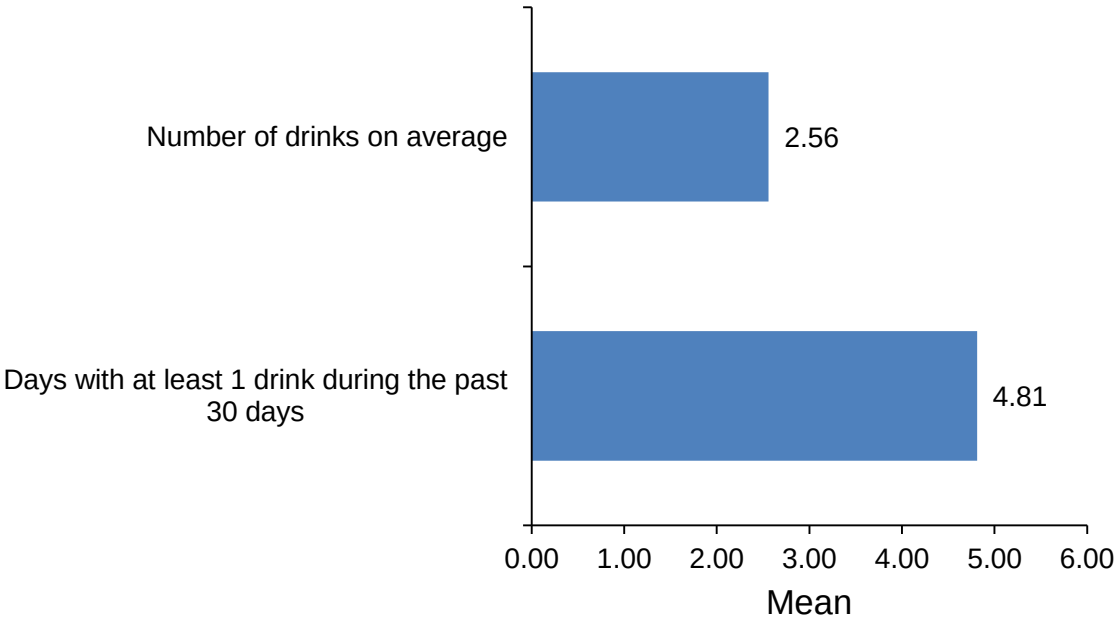
(Community = Yellow Medicine)



Base: 2-3 times a week (n=1), Once a week (n=5), Once a month (n=11), Never (n=16), Sample Size = 33

(Community = Yellow Medicine)

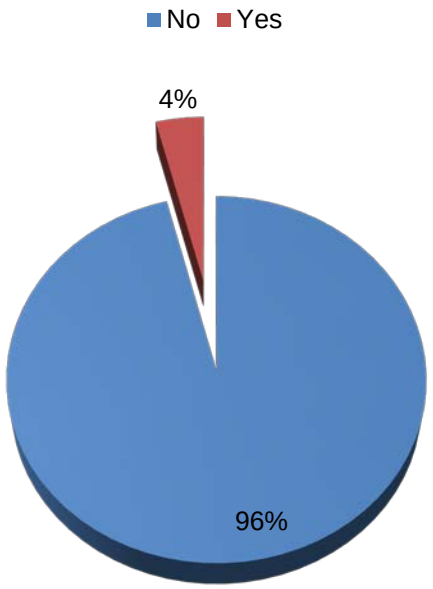
Average Alcohol Use During the Past 30 Days



Base: Days with at least 1 drink during the past 30 days (n=37), Number of drinks on average (n=32), Sample Size = Variable

(Community = Yellow Medicine)

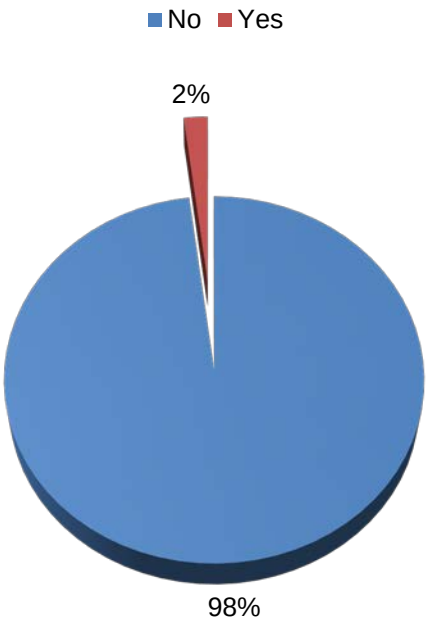
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=2), No (n=49), Sample Size = 51

(Community = Yellow Medicine)

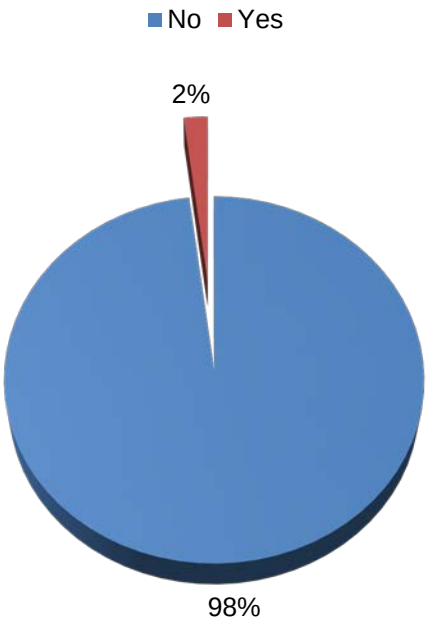
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=1), No (n=50), Sample Size = 51

(Community = Yellow Medicine)

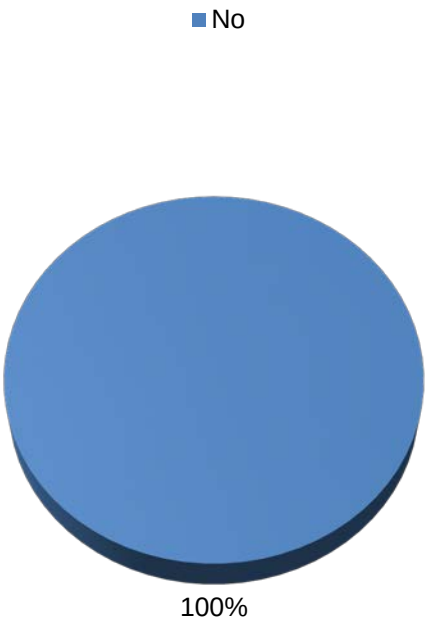
Has a family member or friend ever suggested that you get help for substance use?



Base: Yes (n=1), No (n=50), Sample Size = 51

(Community = Yellow Medicine)

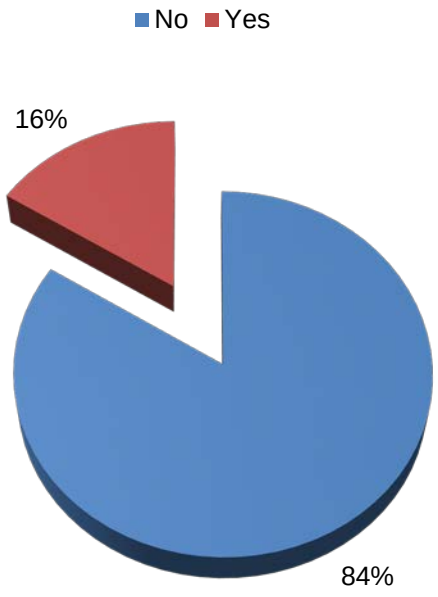
Has prescription or non-prescription drug use had a harmful effect on you or a family member in the past two years?



Base: No (n=51), Sample Size = 51

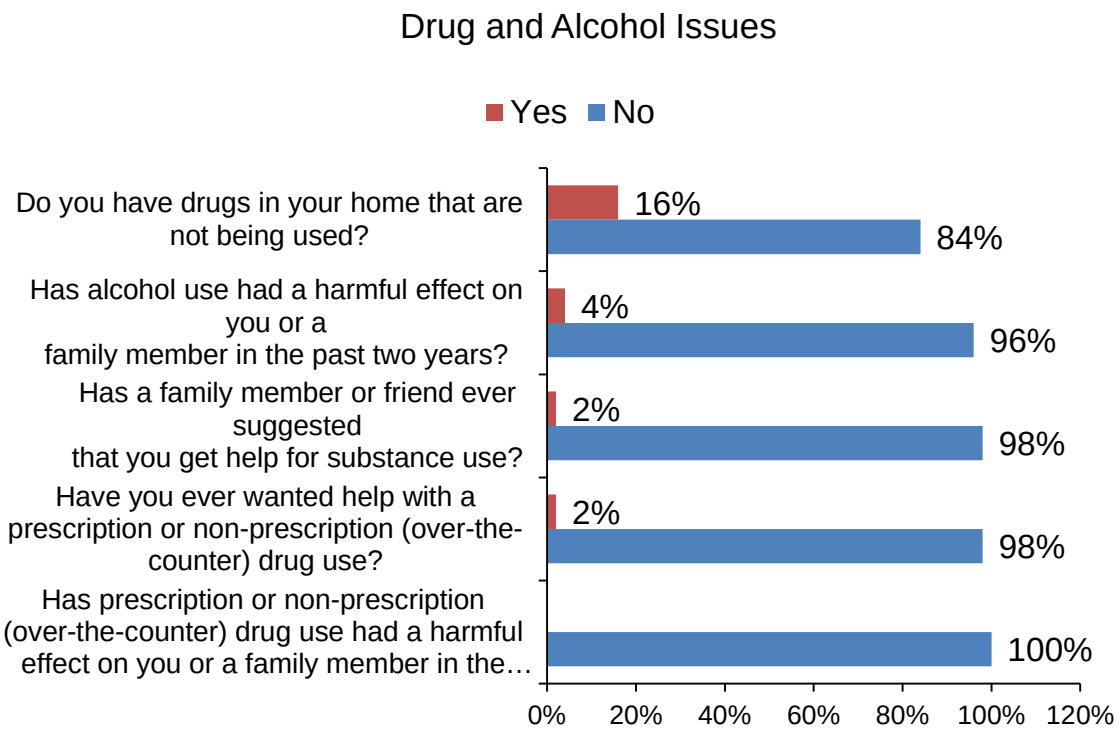
(Community = Yellow Medicine)

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



Base: Yes (n=8), No (n=43), Sample Size = 51

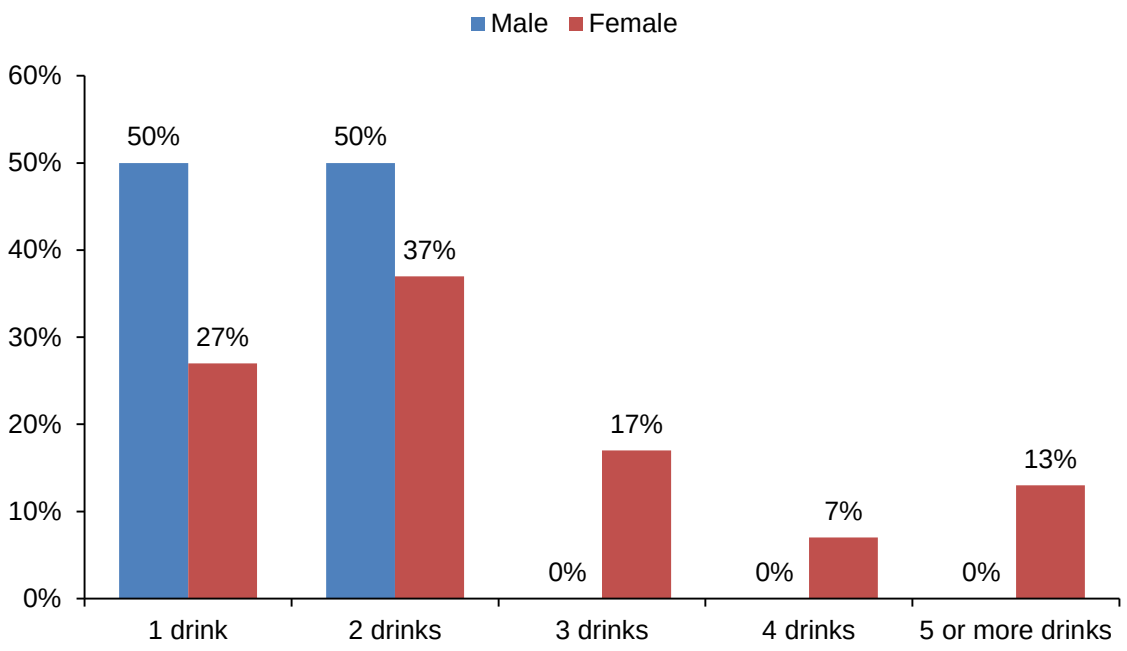
(Community = Yellow Medicine)



Sample Size = 51

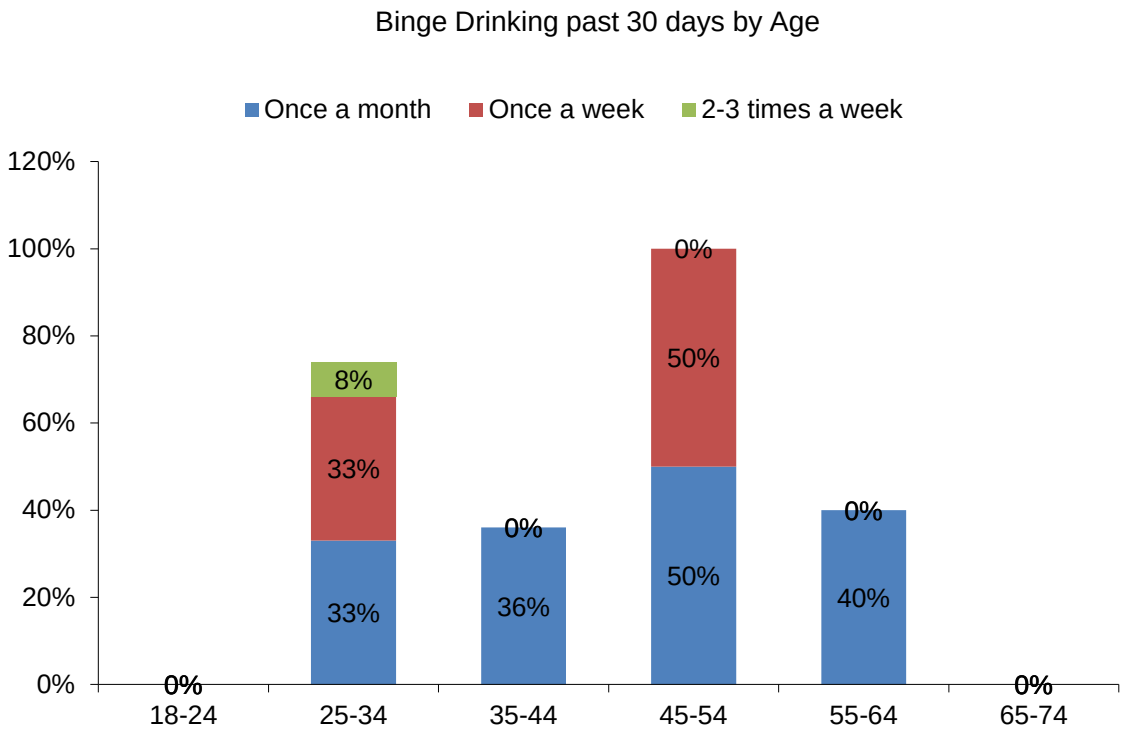
(Community = Yellow Medicine)

Average number of drinks per day when you drink by gender



Base: 1 drink (n=9), 2 drinks (n=12), 3 drinks (n=5), 4 drinks (n=2), 5 or more drinks (n=4), Sample Size = 32

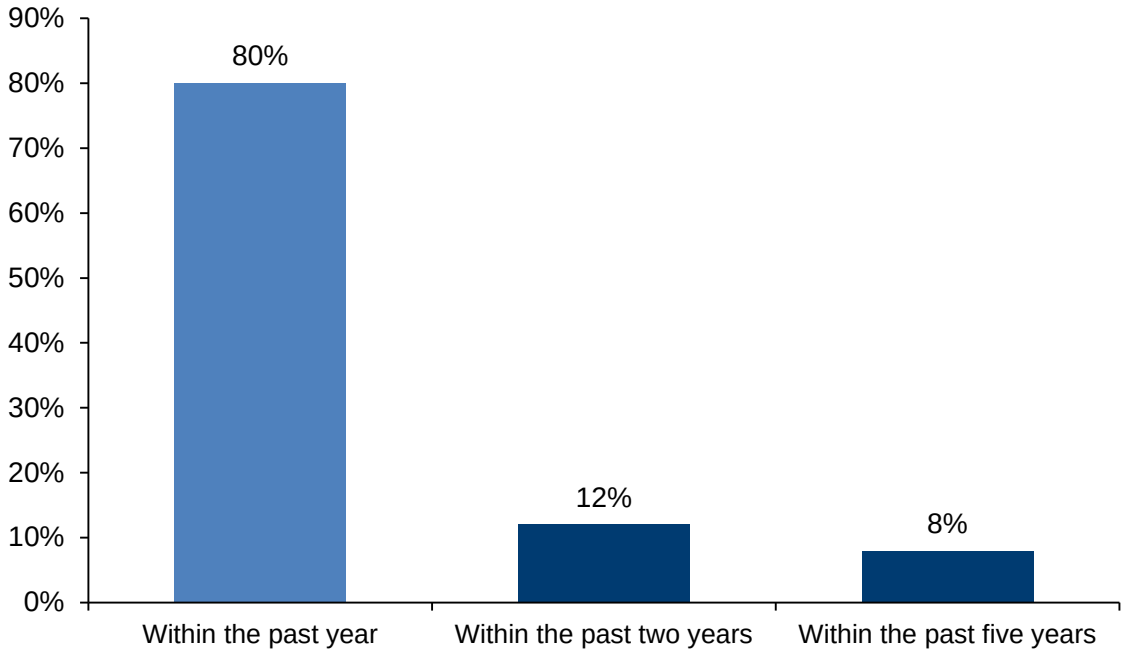
(Community = Yellow Medicine)



Base: 18-24 (n=1), 25-34 (n=12), 35-44 (n=11), 45-54 (n=2), 55-64 (n=5), 65-74 (n=2), Sample Size = 33

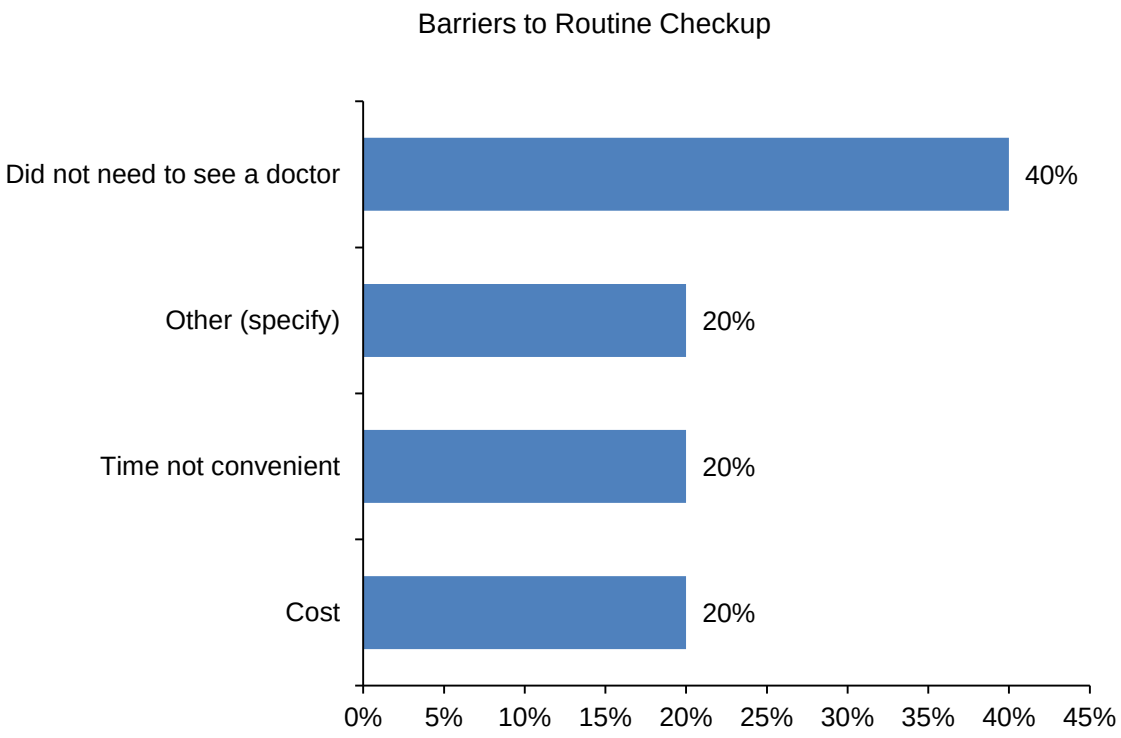
(Community = Yellow Medicine)

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=41), Within the past two years (n=6), Within the past five years (n=4), Sample Size = 51

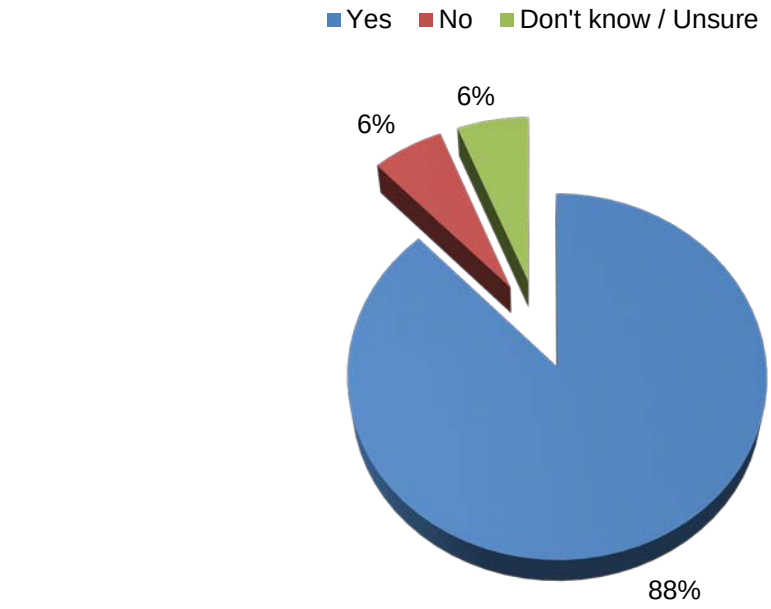
(Community = Yellow Medicine)



Base: Cost (n=2), Time not convenient (n=2), Did not need to see a doctor (n=4), Other (specify) (n=2), Sample Size = 10

(Community = Yellow Medicine)

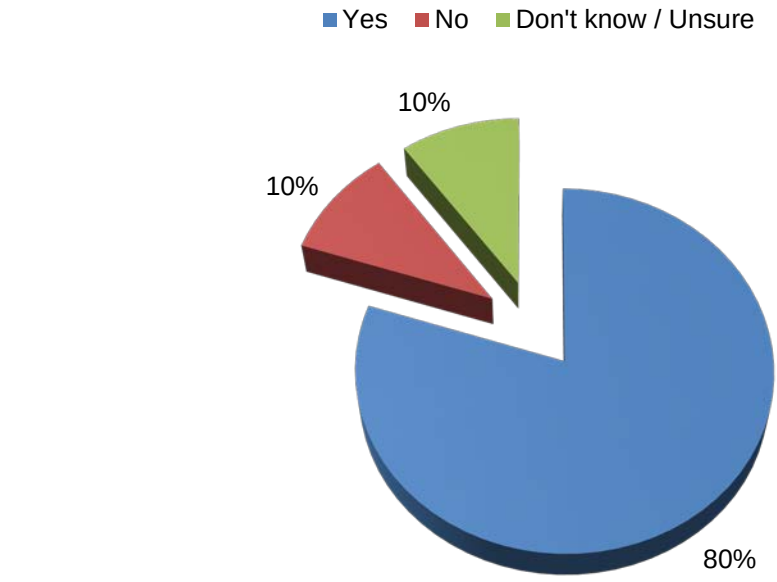
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=45), No (n=3), Don't know / Unsure (n=3), Sample Size = 51

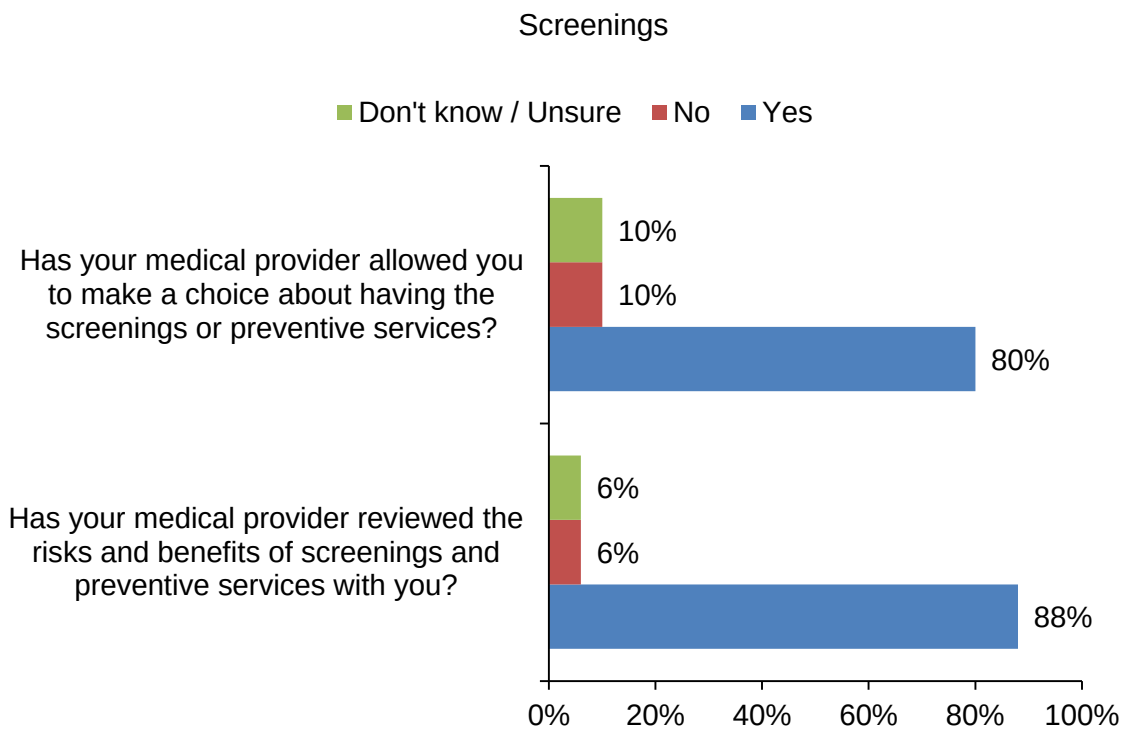
(Community = Yellow Medicine)

Has your medical provider allowed you to make a choice about having screenings or preventive services?



Base: Yes (n=40), No (n=5), Don't know / Unsure (n=5), Sample Size = 50

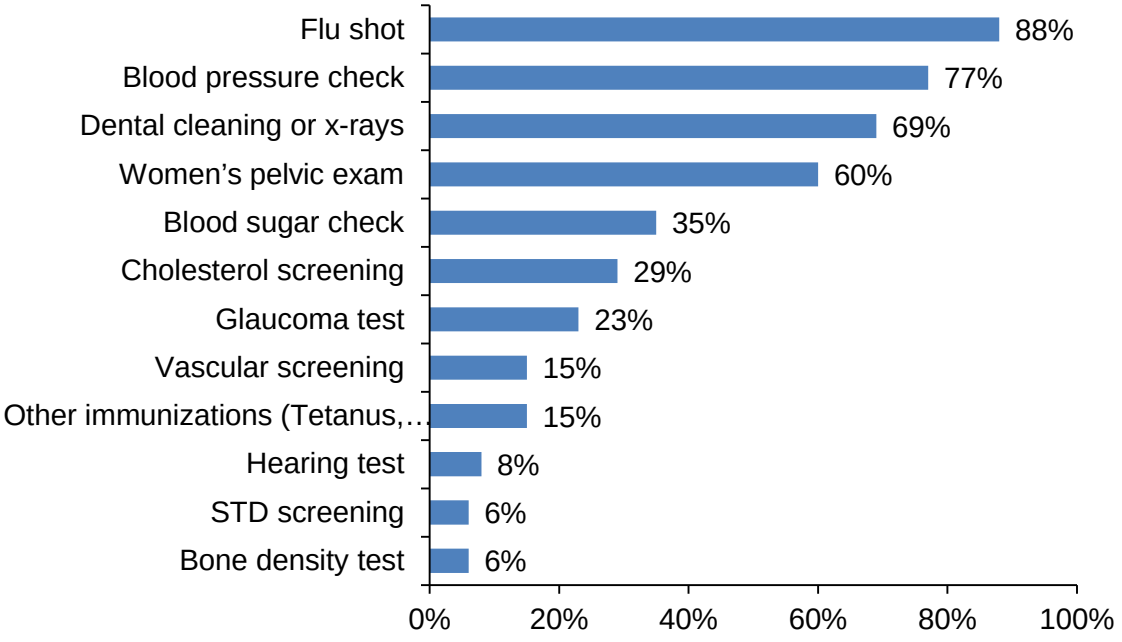
(Community = Yellow Medicine)



Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=50), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=51), Sample Size = Variable

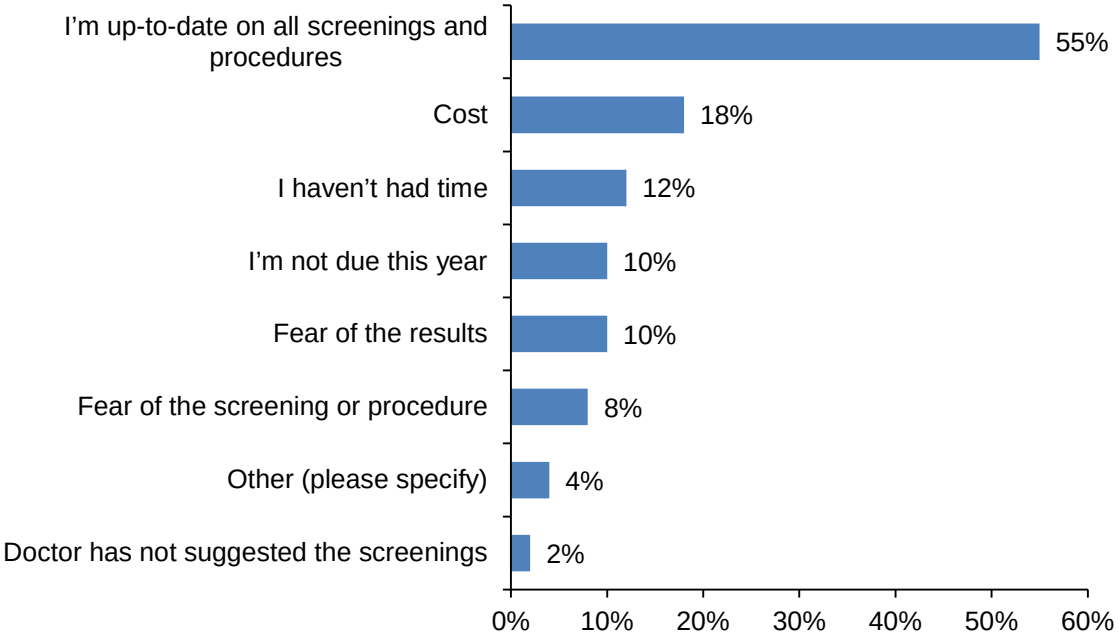
(Community = Yellow Medicine)

Preventive Procedures Last Year



Base: Blood pressure check (n=37), Blood sugar check (n=17), Bone density test (n=3), Cholesterol screening (n=14), Dental cleaning or x-rays (n=33), Flu shot (n=42), Other immunizations (Tetanus, Hepatitis A or B) (n=7), Glaucoma test (n=11), Hearing test (n=4), Women's pelvic exam (n=29), STD screening (n=3), Vascular screening (n=7), Sample Size = 48
(Community = Yellow Medicine)

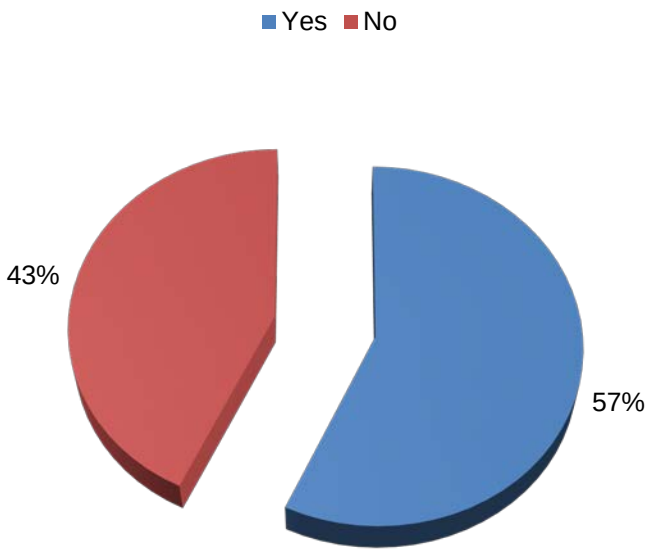
Barriers for Preventive Procedures



Base: I'm up-to-date on all screenings and procedures (n=28), Doctor has not suggested the screenings (n=1), Cost (n=9), Fear of the screening or procedure (n=4), Fear of the results (n=5), I'm not due this year (n=5), I haven't had time (n=6), Other (please specify) (n=2), Sample Size = 51

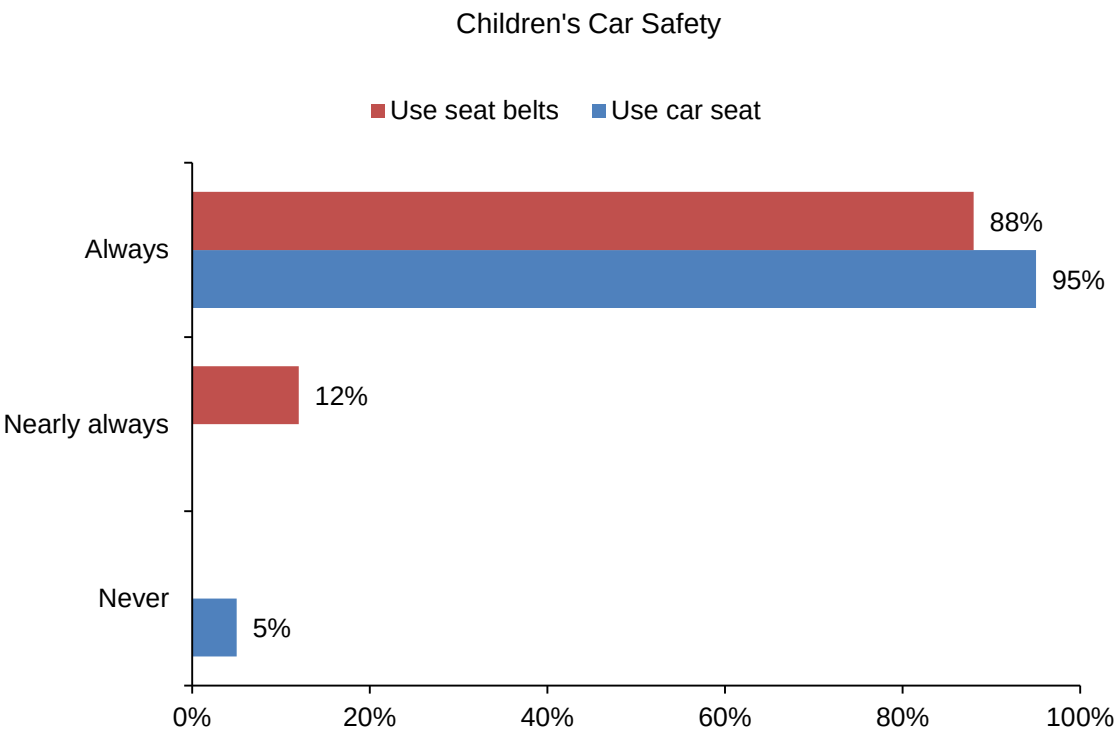
(Community = Yellow Medicine)

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



Base: Yes (n=29), No (n=22), Sample Size = 51

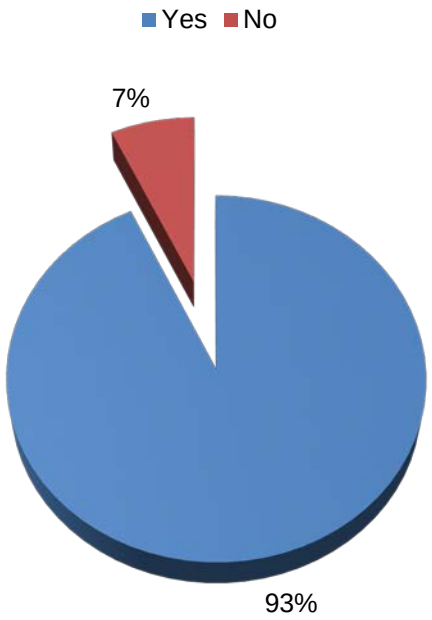
(Community = Yellow Medicine)



Sample Size = Variable

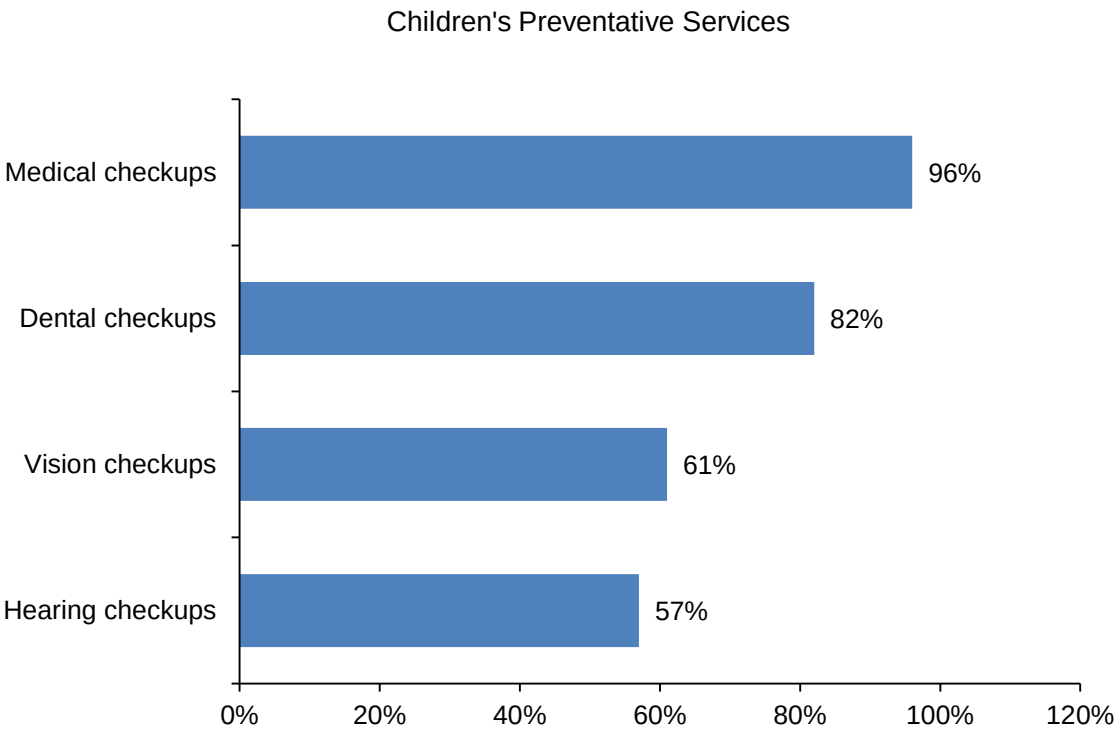
(Community = Yellow Medicine)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=27), No (n=2), Sample Size = 29

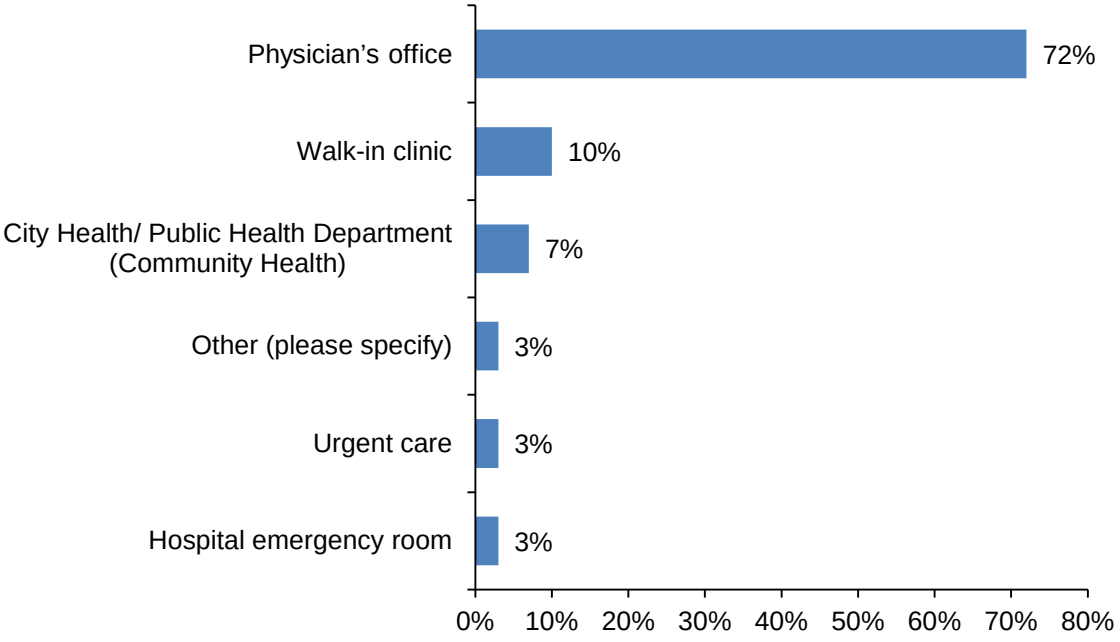
(Community = Yellow Medicine)



Base: Dental checkups (n=23), Vision checkups (n=17), Hearing checkups (n=16), Medical checkups (n=27), Sample Size = 28

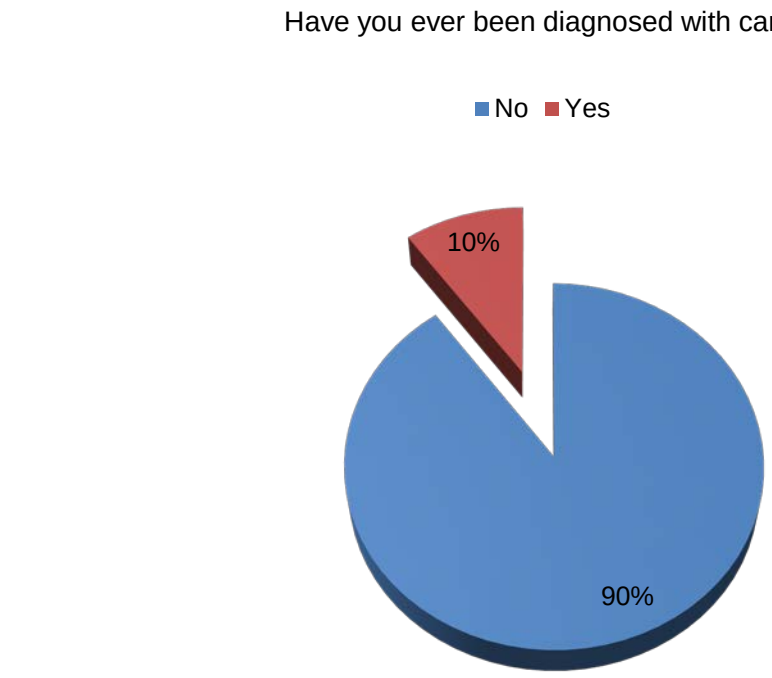
(Community = Yellow Medicine)

Where do you most often take your children when they are sick and need to see a health care provider?



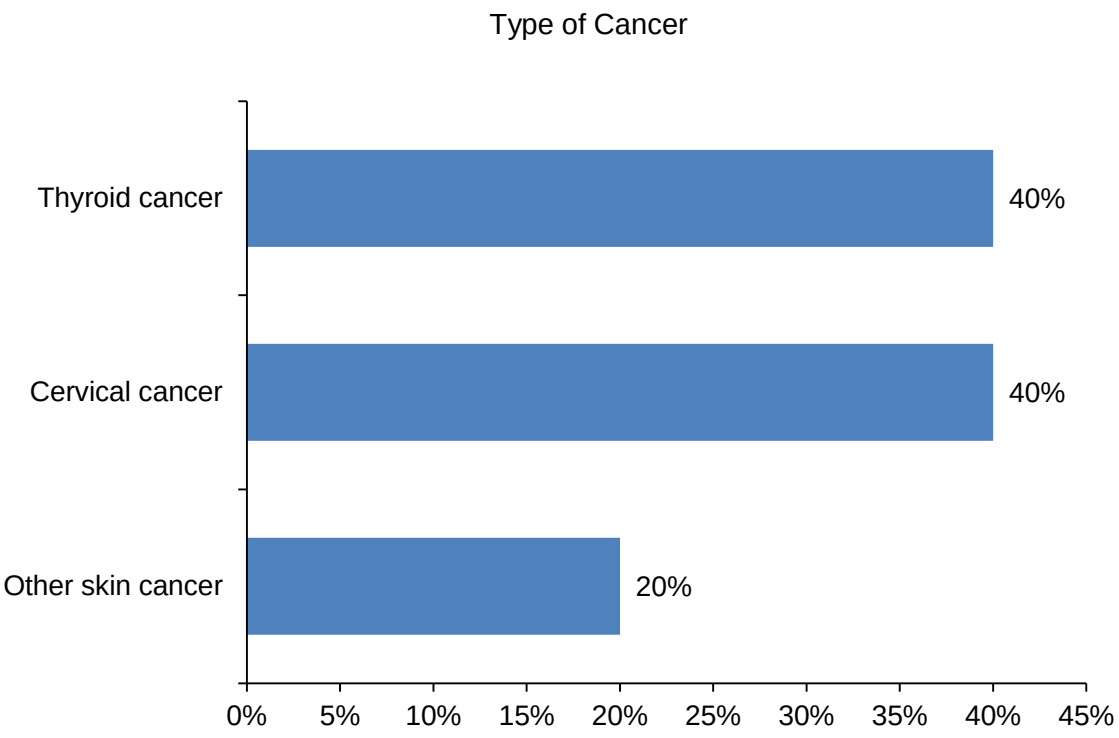
Base: Physician's office (n=21), Hospital emergency room (n=1), Urgent care (n=1), Walk-in clinic (n=3), City Health/ Public Health Department (Community Health) (n=2), Other (please specify) (n=1), Sample Size = 29

(Community = Yellow Medicine)



Base: Yes (n=5), No (n=46), Sample Size = 51

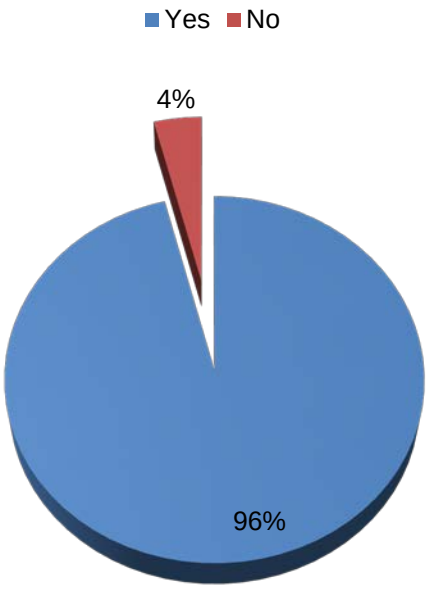
(Community = Yellow Medicine)



Base: Cervical cancer (n=2), Other skin cancer (n=1), Thyroid cancer (n=2), Sample Size = 5

(Community = Yellow Medicine)

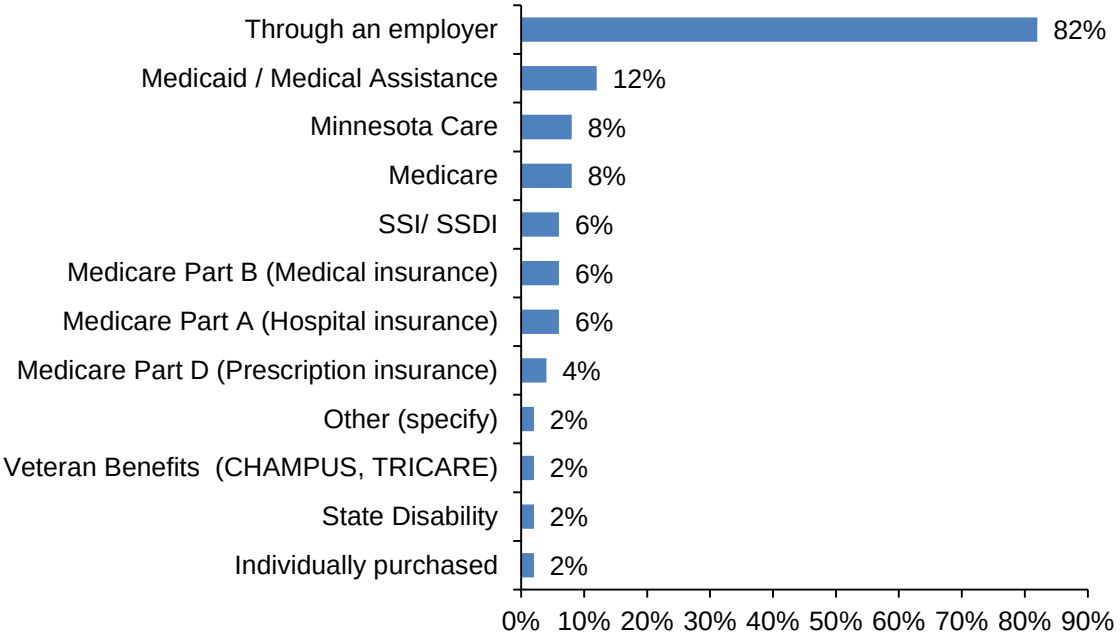
Do you currently have any kind of health insurance?



Base: Yes (n=49), No (n=2), Sample Size = 51

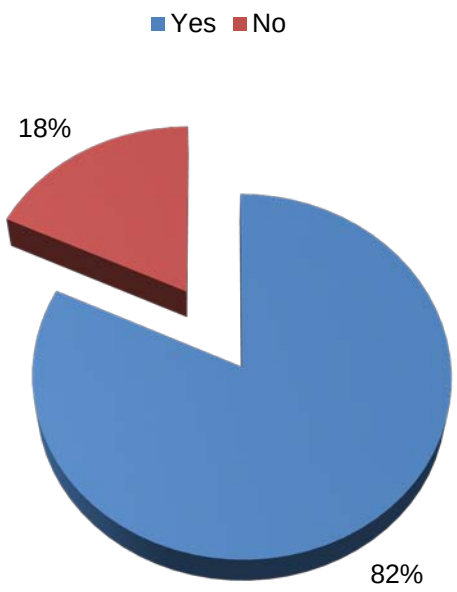
(Community = Yellow Medicine)

Type of Insurance



Base: Through an employer (n=40), Individually purchased (n=1), Medicare (n=4), Medicare Part A (Hospital insurance) (n=3), Medicare Part B (Medical insurance) (n=3), Medicare Part D (Prescription insurance) (n=2), State Disability (n=1), SSI/ SSDI (n=3), Medicaid / Medical Assistance (n=6), Minnesota Care (n=4), Veteran Benefits (CHAMPUS, TRICARE) (n=1), Other (specify) (n=1), Sample Size = 49
(Community = Yellow Medicine)

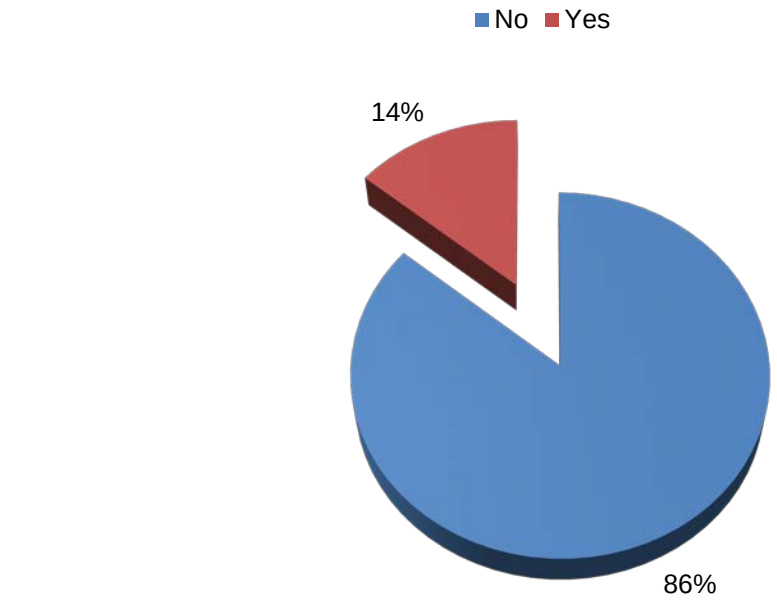
Do you have an established primary healthcare provider?



Base: Yes (n=42), No (n=9), Sample Size = 51

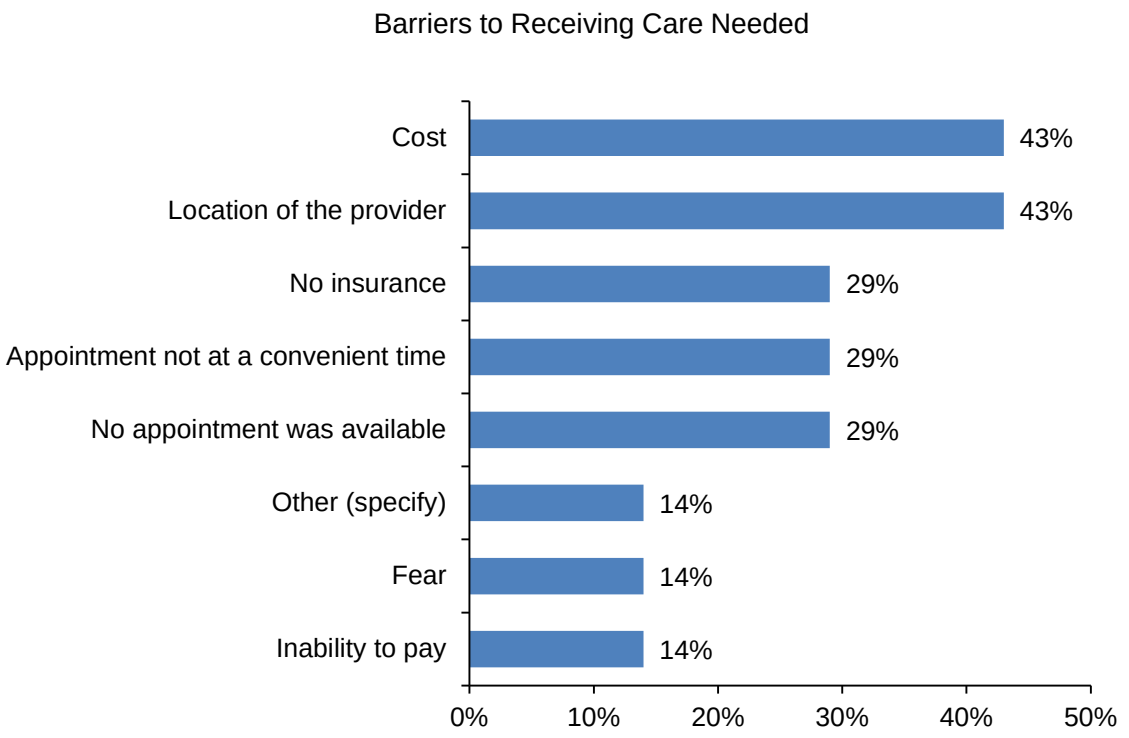
(Community = Yellow Medicine)

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



Base: Yes (n=7), No (n=43), Sample Size = 50

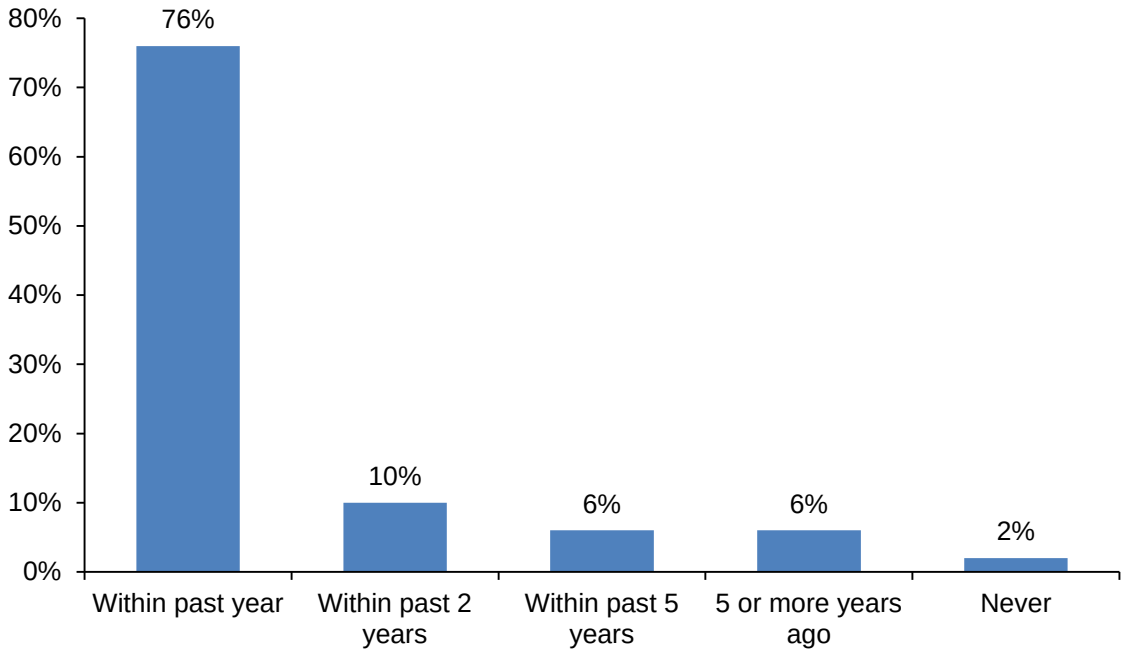
(Community = Yellow Medicine)



Base: Inability to pay (n=1), No appointment was available (n=2), Appointment not at a convenient time (n=2), No insurance (n=2), Location of the provider (n=3), Cost (n=3), Fear (n=1), Other (specify) (n=1)

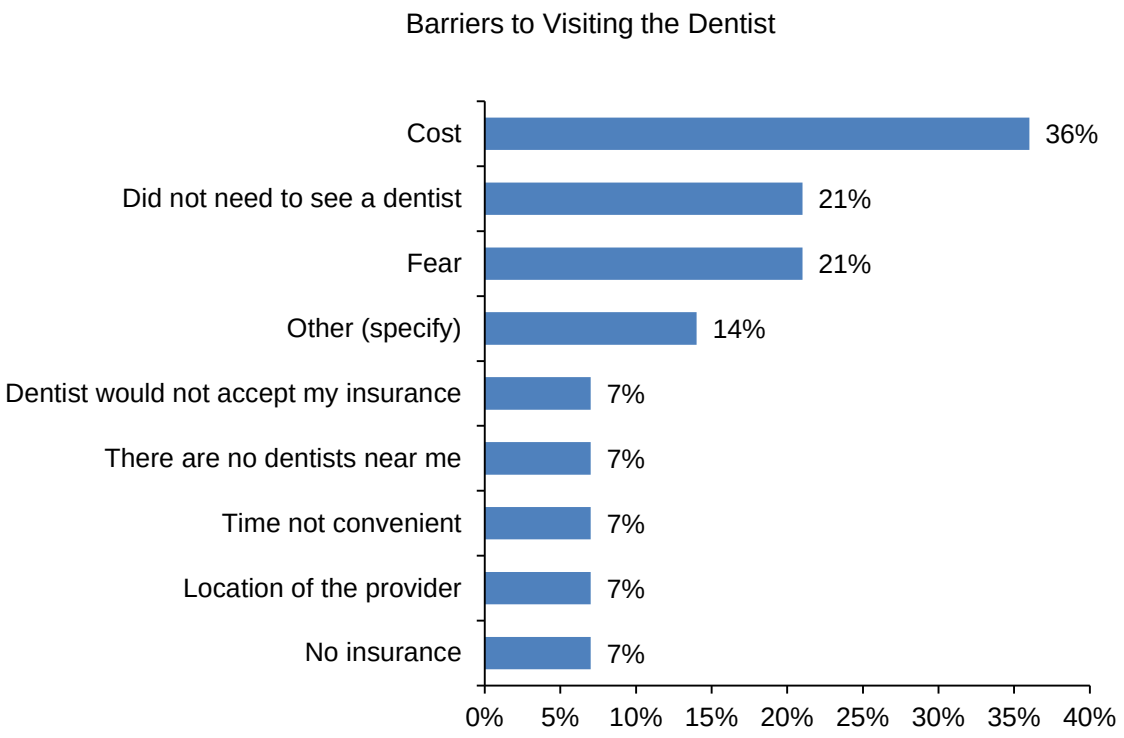
(Community = Yellow Medicine)

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



Base: Within past year (n=37), Within past 2 years (n=5), Within past 5 years (n=3), 5 or more years ago (n=3), Never (n=1), Sample Size = 49

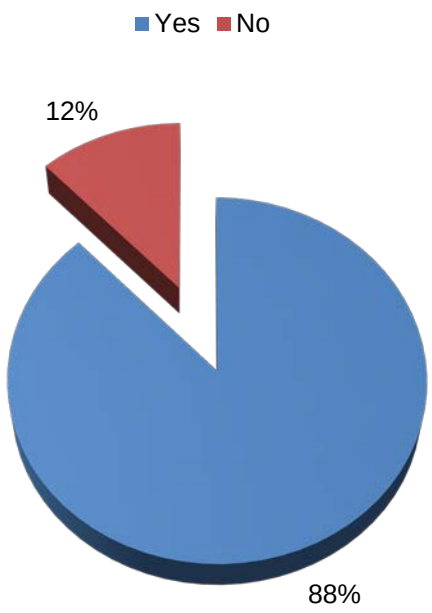
(Community = Yellow Medicine)



Base: No insurance (n=1), Location of the provider (n=1), Cost (n=5), Fear (n=3), Time not convenient (n=1), There are no dentists near me (n=1), Dentist would not accept my insurance (n=1), Did not need to see a dentist (n=3), Other (specify) (n=2), Sample Size = 14

(Community = Yellow Medicine)

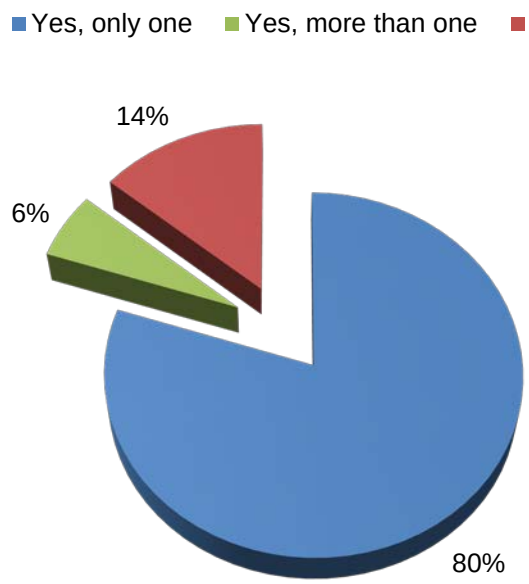
Do you have any kind of dental care or oral health insurance coverage?



Base: Yes (n=44), No (n=6), Sample Size = 50

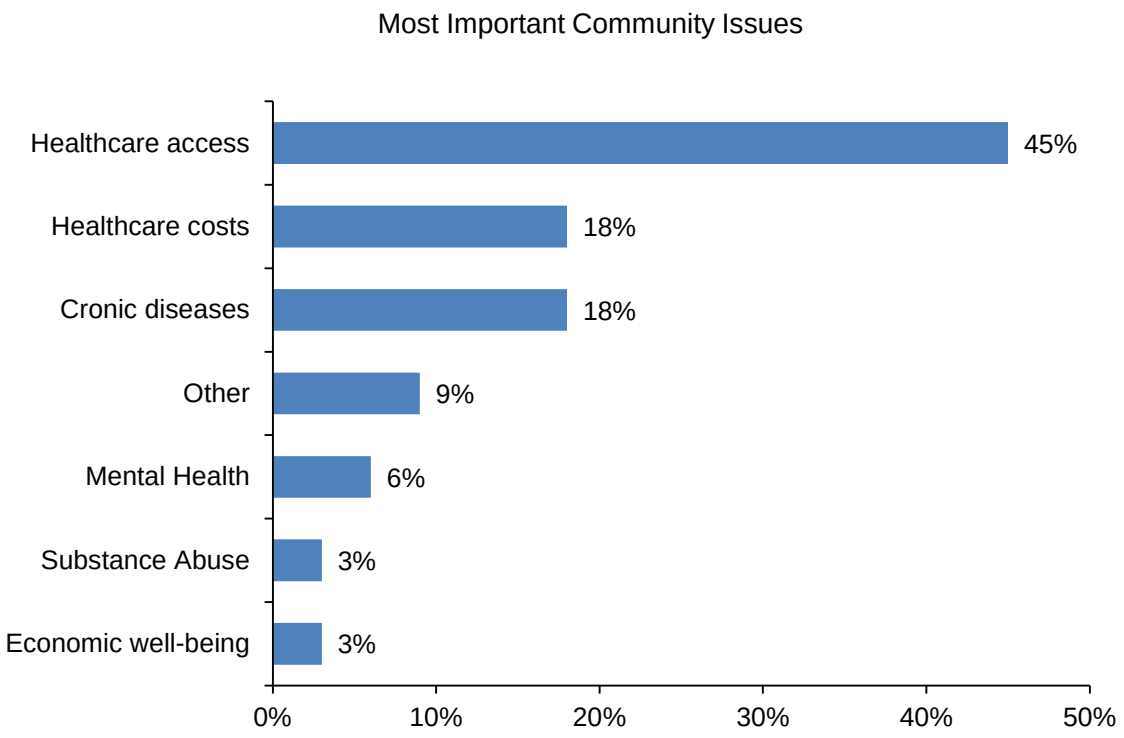
(Community = Yellow Medicine)

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



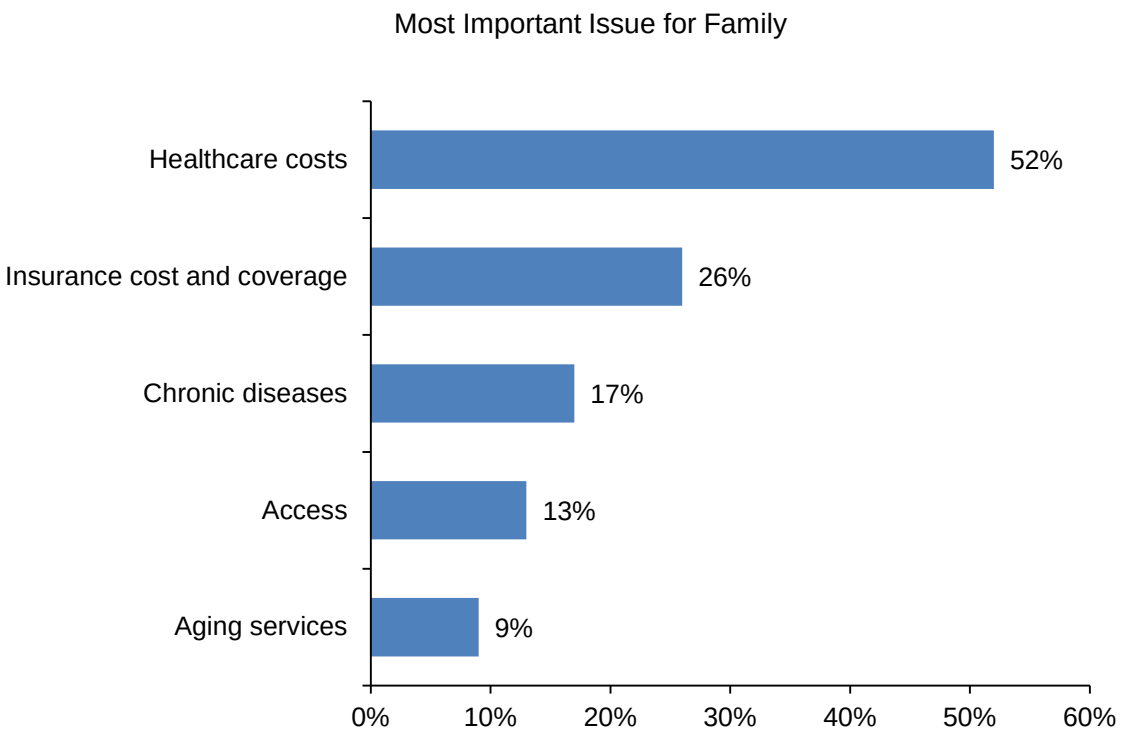
Base: Yes, only one (n=40), Yes, more than one (n=3), No (n=7), Sample Size = 50

(Community = Yellow Medicine)



Base: Economic well-being (n=1), Healthcare access (n=15), Mental Health (n=2), Substance Abuse (n=1), Chronic diseases (n=6), Healthcare costs (n=6), Other (n=3), Sample Size = 38

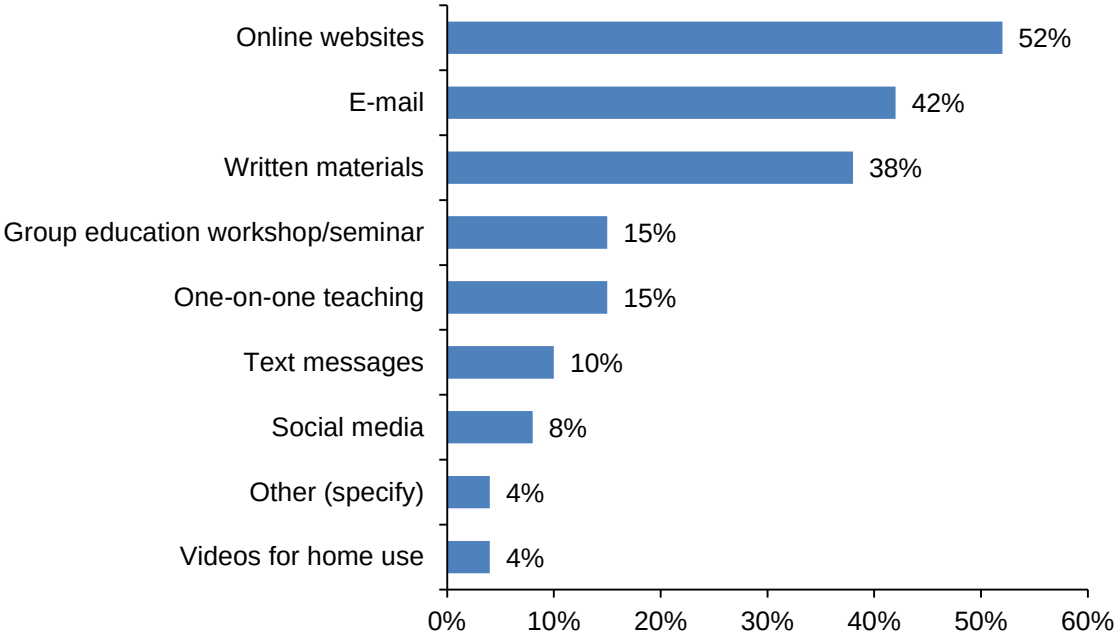
(Community = Yellow Medicine)



Base: Access (n=3), Aging services (n=2), Chronic diseases (n=4), Healthcare costs (n=12), Insurance cost and coverage (n=6), Sample Size = 35

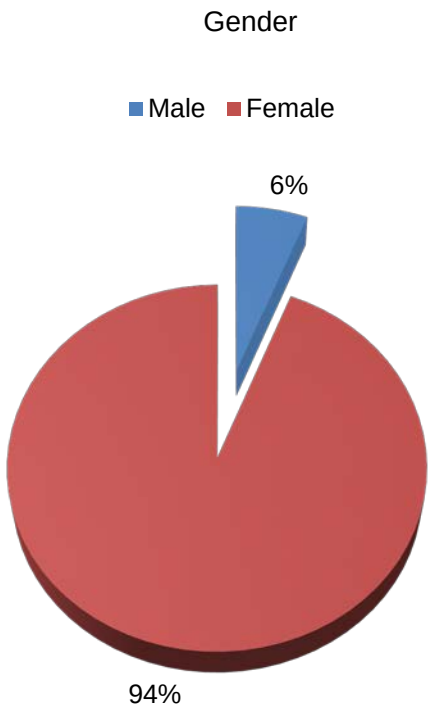
(Community = Yellow Medicine)

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



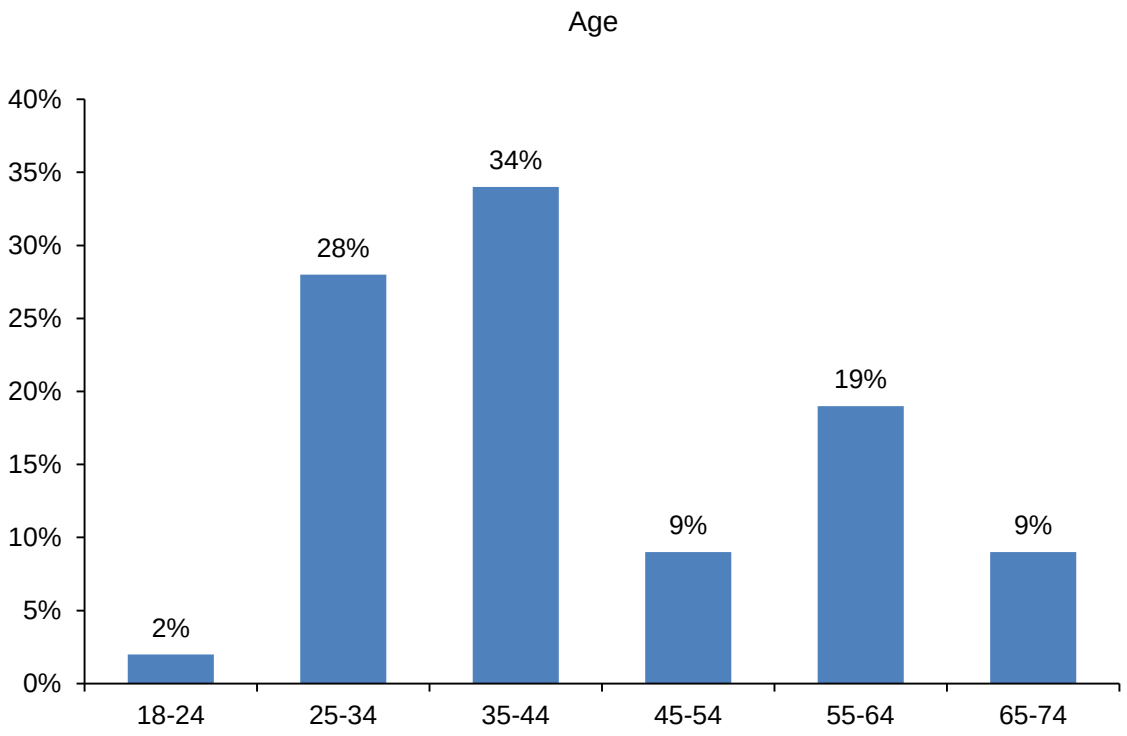
Base: Written materials (n=18), Videos for home use (n=2), Social media (n=4), Text messages (n=5), One-on-one teaching (n=7), E-mail (n=20), Group education workshop/seminar (n=7), Online websites (n=25), Other (specify) (n=2), Sample Size = 48

(Community = Yellow Medicine)



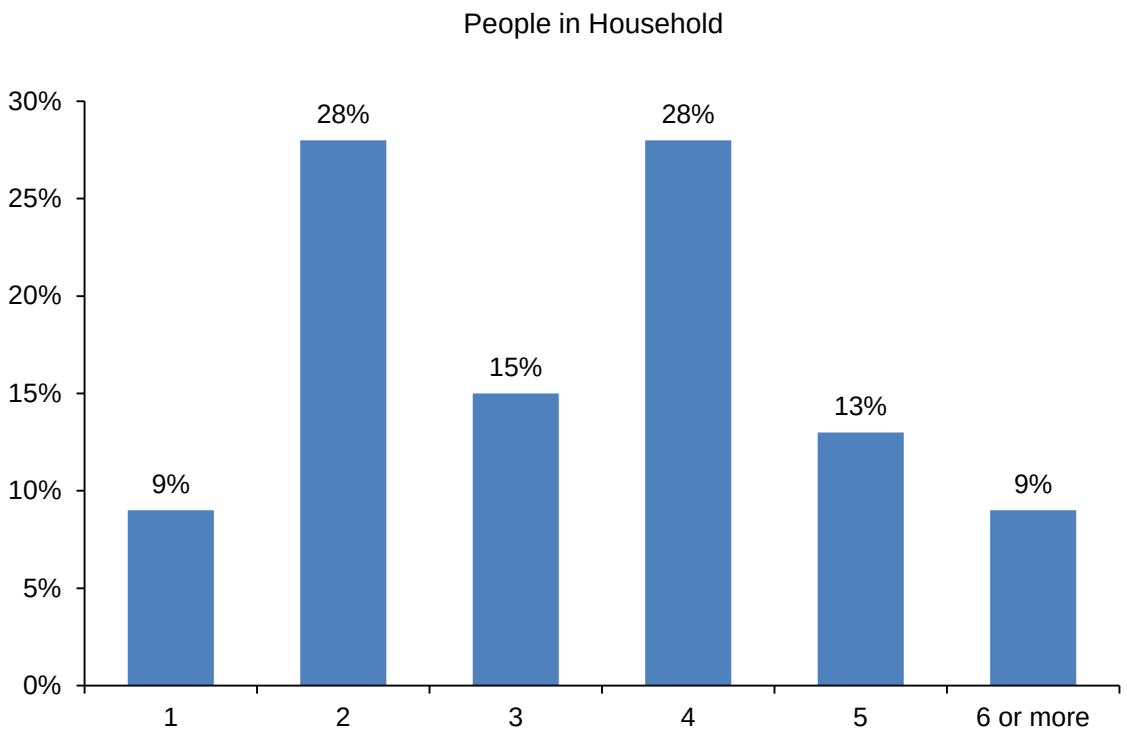
Base: Male (n=3), Female (n=48), Sample Size = 51

(Community = Yellow Medicine)



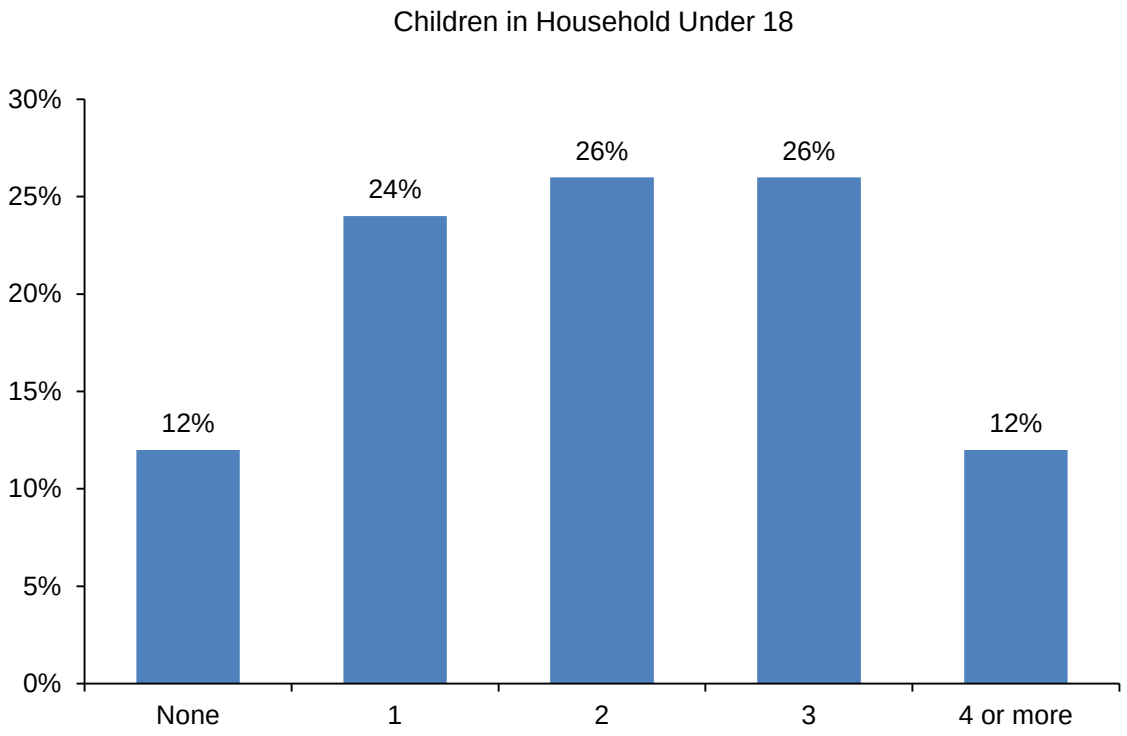
Base: 18-24 (n=1), 25-34 (n=13), 35-44 (n=16), 45-54 (n=4), 55-64 (n=9), 65-74 (n=4), Sample Size = 47

(Community = Yellow Medicine)



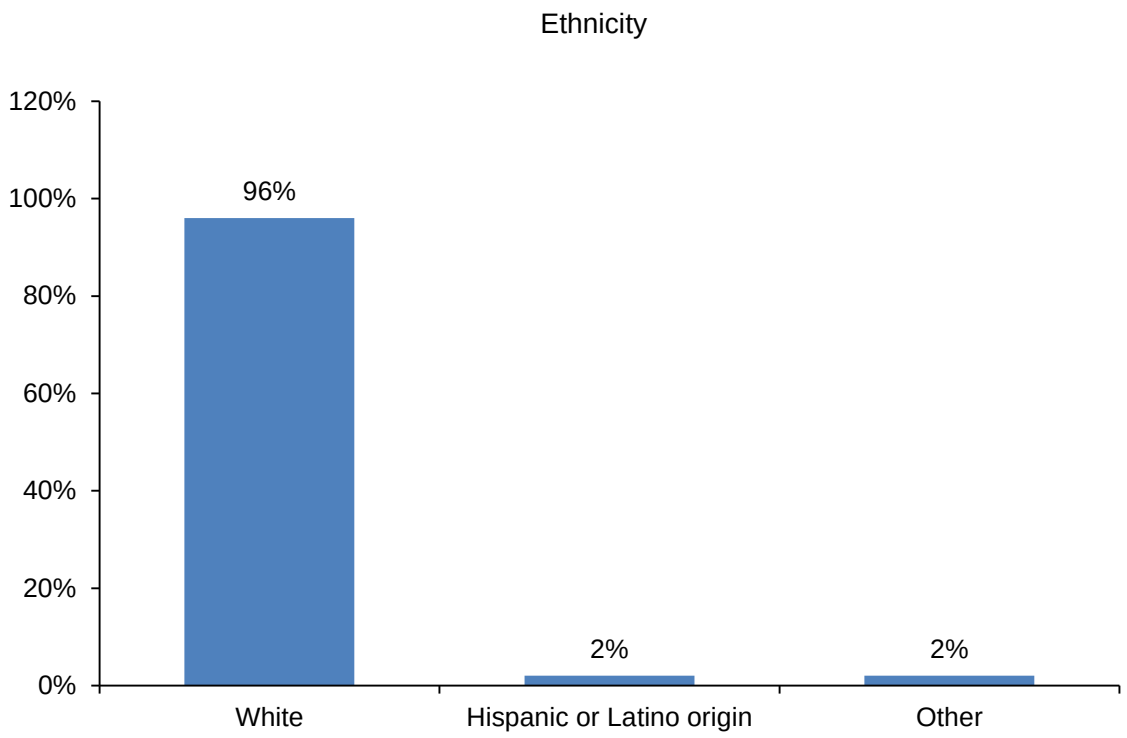
Base: 1 (n=4), 2 (n=13), 3 (n=7), 4 (n=13), 5 (n=6), 6 or more (n=4), Sample Size = 47

(Community = Yellow Medicine)



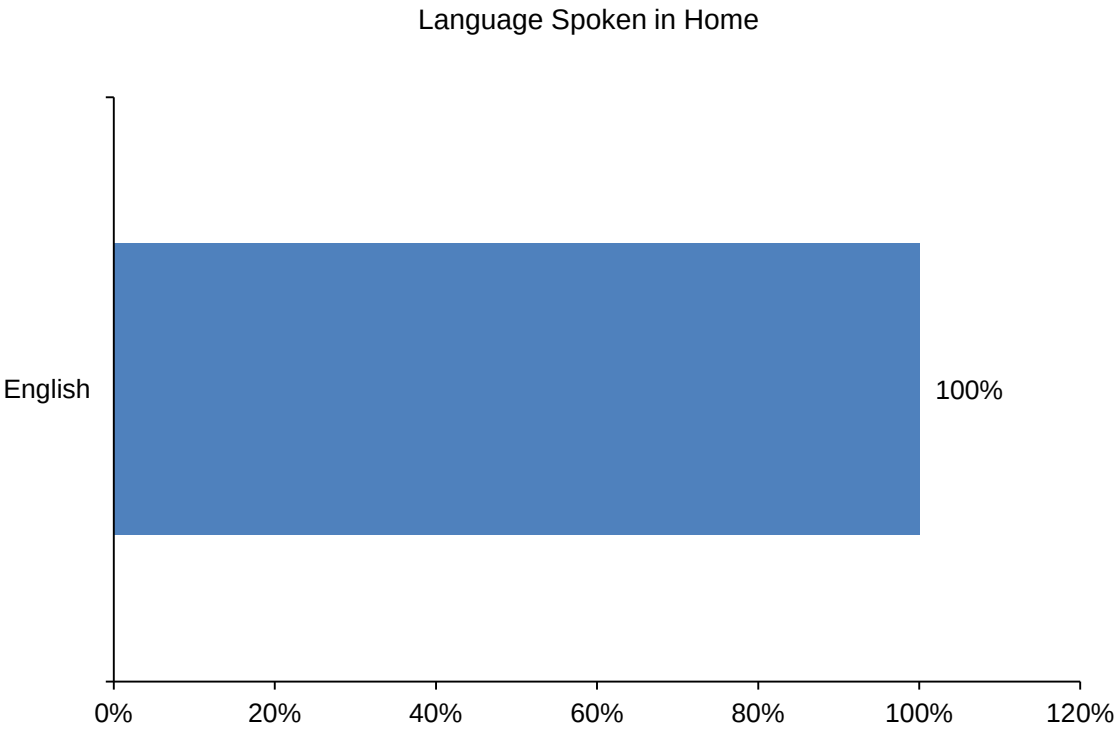
Base: None (n=4), 1 (n=8), 2 (n=9), 3 (n=9), 4 or more (n=4), Sample Size = 34

(Community = Yellow Medicine)



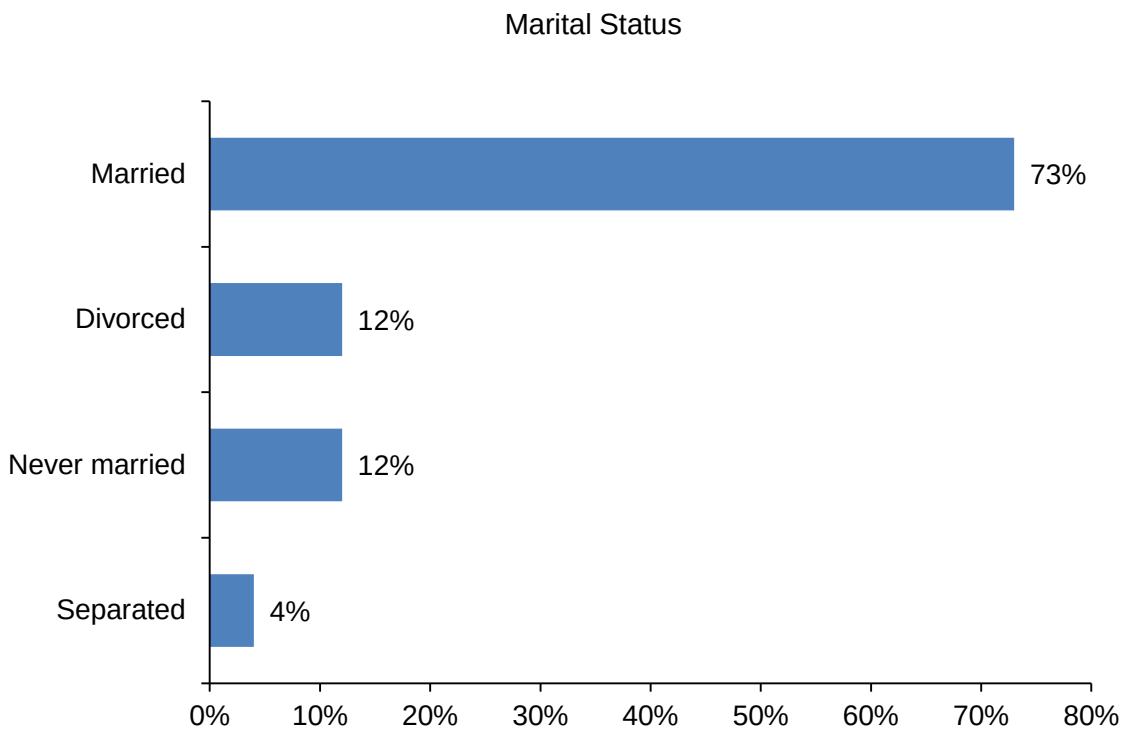
Base: White (n=49), Hispanic or Latino origin (n=1), Other (n=1), Sample Size = 51

(Community = Yellow Medicine)



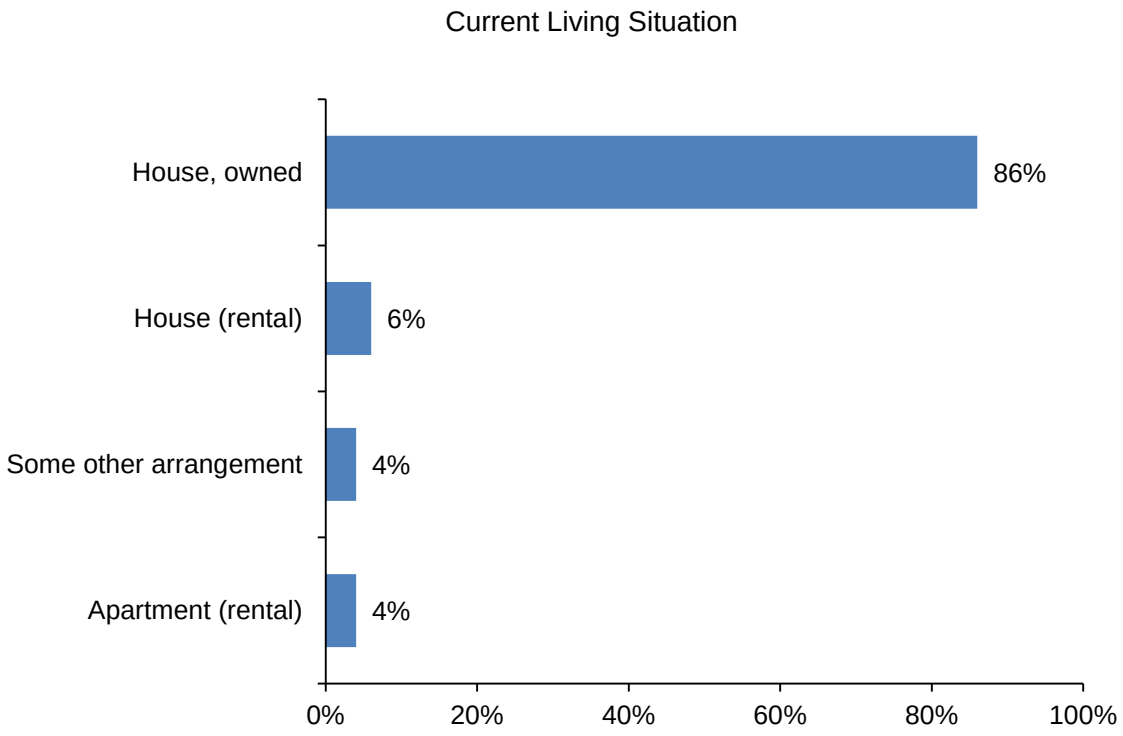
Base: English (n=51), Sample Size = 51

(Community = Yellow Medicine)



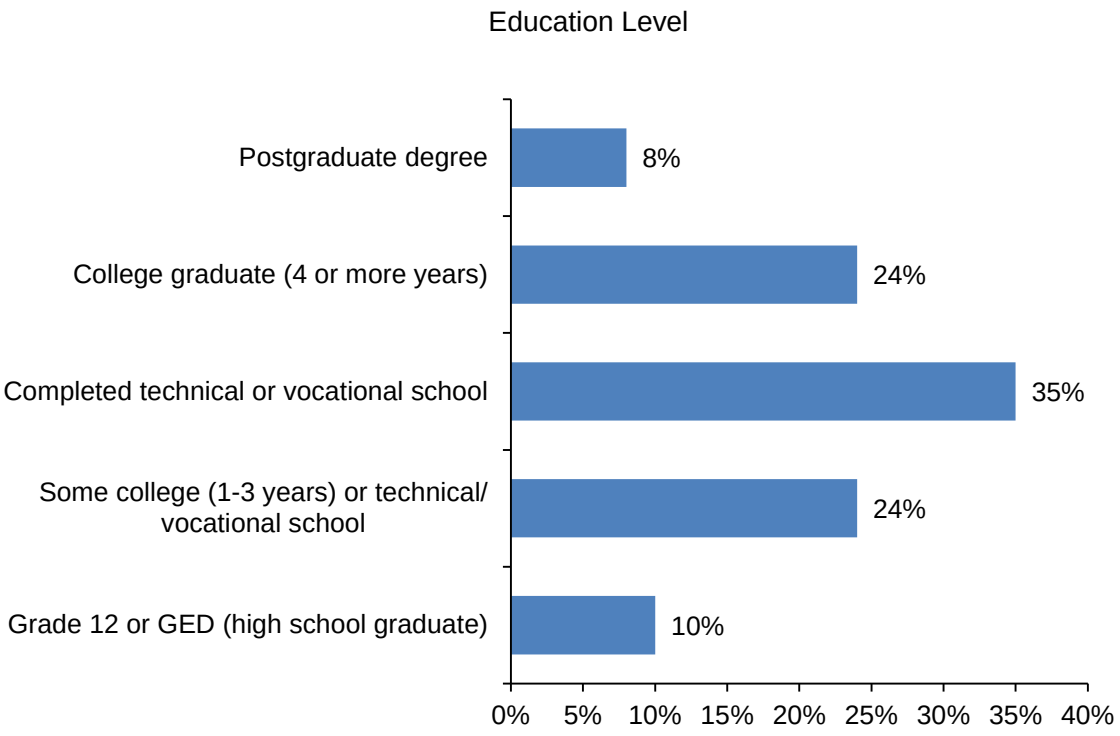
Base: Never married (n=6), Married (n=37), Divorced (n=6), Separated (n=2), Sample Size = 51

(Community = Yellow Medicine)



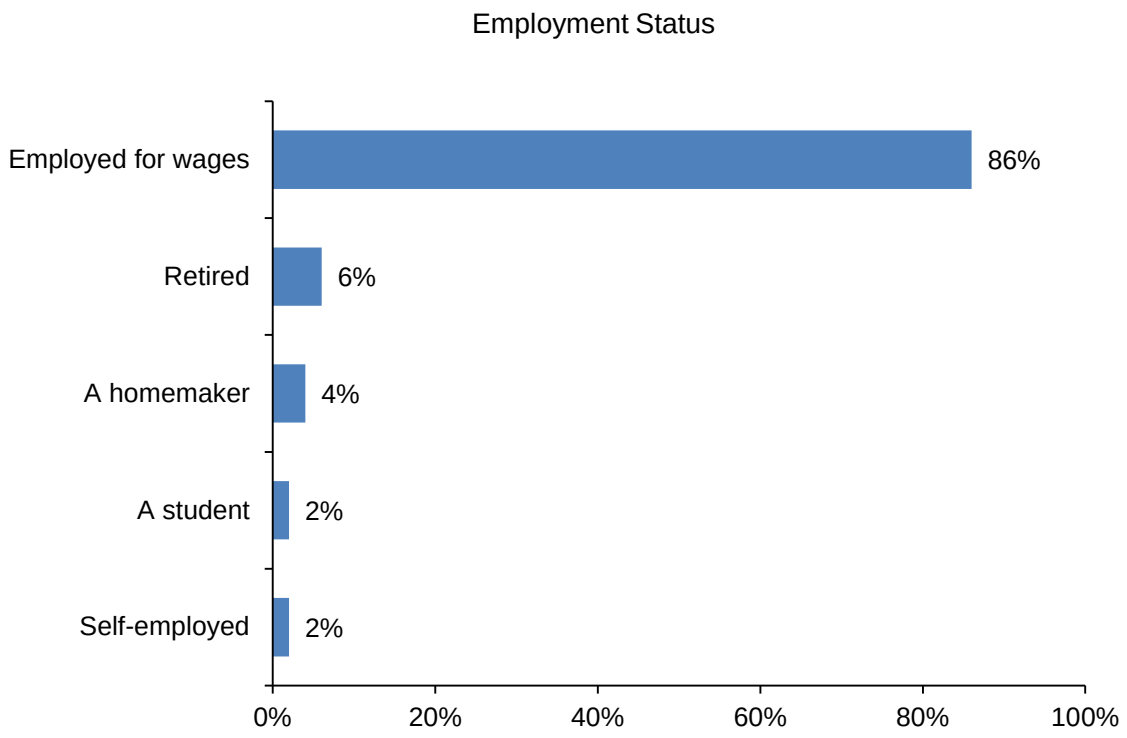
Base: House, owned (n=44), House (rental) (n=3), Apartment (rental) (n=2), Some other arrangement (n=2), Sample Size = 51

(Community = Yellow Medicine)



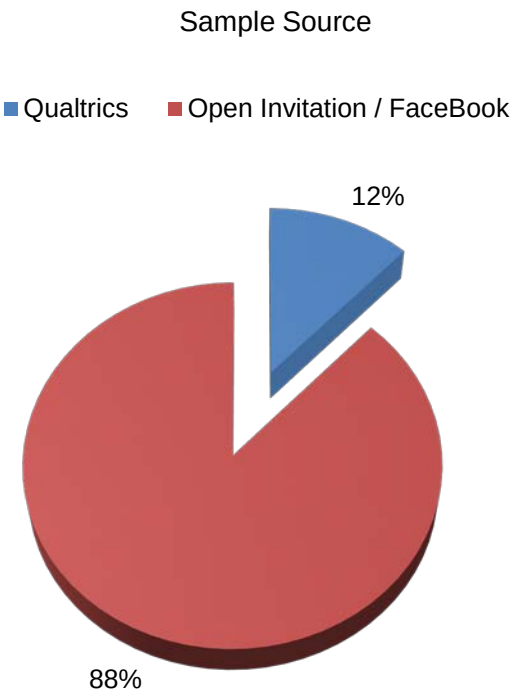
Base: Grade 12 or GED (high school graduate) (n=5), Some college (1-3 years) or technical/ vocational school (n=12), Completed technical or vocational school (n=18), College graduate (4 or more years) (n=12), Postgraduate degree (n=4), Sample Size = 51

(Community = Yellow Medicine)



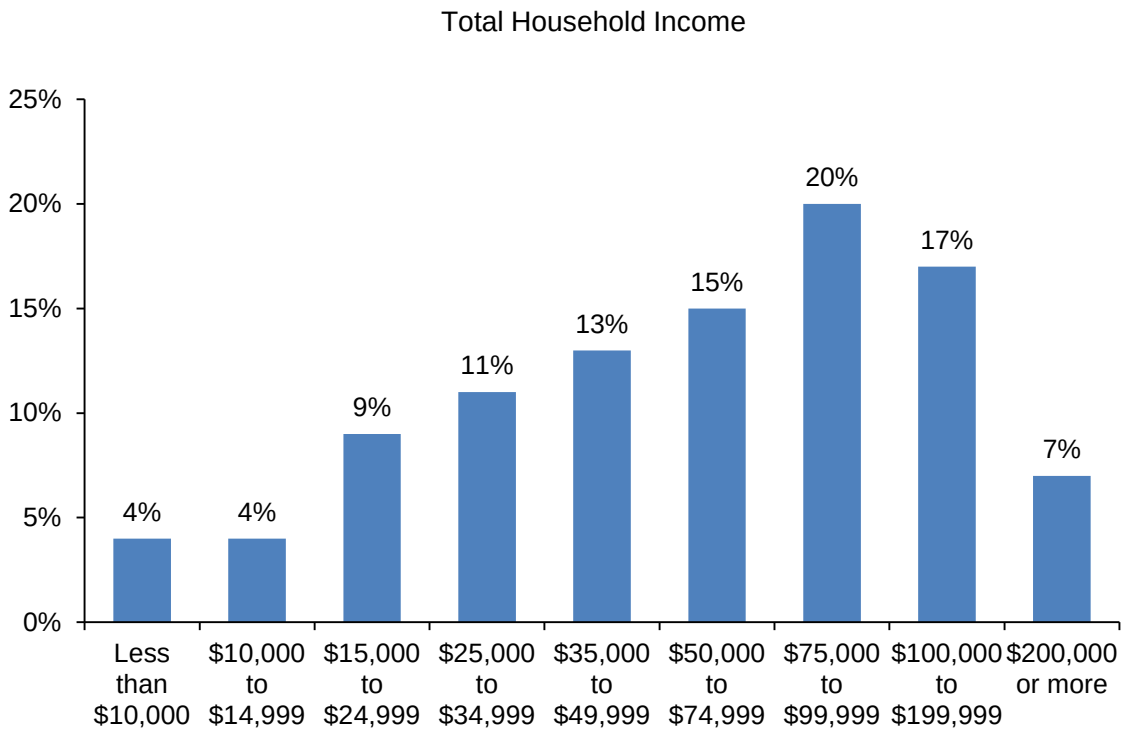
Base: Employed for wages (n=44), Self-employed (n=1), A homemaker (n=2), A student (n=1), Retired (n=3), Sample Size = 51

(Community = Yellow Medicine)



Base: Qualtrics (n=6), Open Invitation / Facebook (n=46), Sample Size = 52

(Community = Yellow Medicine)



Base: Less than $10,000 (n=2), $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=4), $25,000 to $34,999 (n=5), $35,000 to $49,999 (n=6), $50,000 to $74,999 (n=7), $75,000 to $99,999 (n=9), $100,000 to $199,999 (n=8), $200,000 or more (n=3), Sample Size = 46

(Community = Yellow Medicine)

Prioritization Worksheet

Canby 2019 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
Economic Well-Being • Employment options 3.40 • Skilled labor force 3.20			
Children and Youth • Childhood obesity 3.38 • Availability of quality childcare 3.13 • Bullying 3.06 • Children living in poverty 15% (County Health Rankings) • Teen pregnancy (County Health Rankings)	7 obesity	**9 obesity**	
Aging Population • Cost of long term care 3.67 • Cost of memory care 3.50 • Cost of in-home services 3.13	**3 cost of LTC**	**1 – aging population**	
Healthcare Access • Access to affordable health insurance coverage 3.43 • Access to affordable health care 3.36 • Access to affordable prescription drugs 3.29 • Availability of mental health providers 3.29 • Availability of behavioral health 3.23 • Access to affordable vision insurance coverage 3.21 • Access to affordable dental insurance coverage 3.07	2 access to affordable health care coverage 3 access to affordable health care 1 availability of mental health providers		
Mental Health and Substance Abuse • Dementia and Alzheimer's disease 3.54 • Depression 3.36 • Anxiety 44% self-report • Stress 3.21 • Drug use and abuse 3.08 • Alcohol use and abuse 3.00 • 52% binge drink • Smoking and tobacco use 3.00	2 dementia 3 depression 1 anxiety	**5 depression**	
Wellness • Adult obesity • Hypertension • Arthritis • High Cholesterol • Dental care • Healthy nutrition	4 adult obesity	**4 adult obesity**	

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:

* 95% confidence intervals are provided where applicable and available.
** Z-scores are "adjusted" z-scores (e.g., multiplied by -1 if a positively framed measure, set to zero for missing and unreliable
values for ranked counties, and truncated at -3 or +3 if county population is less than 20,000).

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

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

Measure	Data Elements	Description
		activity
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Excessive drinking	**% Excessive Drinking**	Percentage of adults that report excessive drinking
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Alcohol-impaired driving deaths	# Alcohol-Impaired Driving Deaths	Number of alcohol-impaired motor vehicle deaths
	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	95% CI - Low	95% confidence interval using Poisson distribution
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	**Teen Birth Rate**	Births per 1,000 females ages 15-19
	95% CI - Low	95% confidence interval
	95% CI - High	
	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
	95% CI - Low	95% confidence interval reported by SAHIE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	PCP Rate	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 providers	# Mental Health Providers	Number of mental health providers (MHP)
	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)
	# Medicare Enrollees	Number of Medicare enrollees

Measure	Data Elements	Description
Preventable hospital stays	**Preventable Hosp. Rate**	Discharges for Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetes monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	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 screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% 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 graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Measure	Data Elements	Description
Children in poverty	**% Children in Poverty**	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% 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 – f rom 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-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations 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 Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**Presence of violation**	County affected by a water violation: 1-Yes, 0-No
	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

Measure	Data Elements	Description
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	**% Drive Alone**	Percentage of workers who drive alone to work
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% 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
	% Drive Alone (White)	Percentage of non-Hispanic White workers who drive alone to work
Long commute - driving alone	# Workers who Drive Alone	Number of workers who commute in their car, truck or van alone
	% Long Commute - Drives Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

County Health Rankings for Yellow Medicine County

			County	**State**			
Population			9,935	5,519,952			
% below 18 years of age			23.0%	23.3%			
% 65 and older			20.3%	15.1%			
% Non-Hispanic African American			0.4%	6.0%			
% American Indian and Alaskan Native			3.9%	1.3%			
% Asian			0.6%	4.9%			
% Native Hawaiian/Other Pacific Islander			0.1%	0.1%			
% Hispanic			4.1%	5.2%			
% Non-Hispanic white			90.2%	80.6%			
% not proficient in English			1%	2%			
% Females			49.5%	50.2%			
% Rural			80.8%	26.7%			
		Yellow Medicine County	Trend (Click for info)	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
		Yellow Medicine County	Trend (Click for info)	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
Health Outcomes							60
Length of Life							52
Premature death	(Click for info)	5,800		4,700-7,100	5,300	5,100	
Quality of Life							63
Poor or fair health	(Click for info)	12%		12-13%	12%	12%	
Poor physical health days	(Click for info)	3.0		2.9-3.2	3.0	3.0	
Poor mental health days	(Click for info)	3.0		2.9-3.2	3.1	3.2	
Low birthweight		6%		5-8%	6%	6%	
Additional Health Outcomes (not included in overall ranking) –							
Premature age-adjusted mortality		300		240-360	270	260	
Child mortality					40	40	
Infant mortality					4	5	

			County	State			
Frequent physical distress		9%		9-10%	9%	9%	
Frequent mental distress		10%		9-10%	10%	10%	
Diabetes prevalence		10%		7-12%	8%	8%	
HIV prevalence					49	171	
Health Factors							39
Health Behaviors							41
Adult smoking	(Click for info)	15%		15-16%	14%	15%	
Adult obesity		29%		23-35%	26%	27%	
Food environment index		8.4			8.6	8.9	
Physical inactivity		26%		20-32%	20%	20%	
Access to exercise opportunities		61%			91%	88%	
Excessive drinking	(Click for info)	22%		21-23%	13%	23%	
Alcohol-impaired driving deaths		22%		6-42%	13%	30%	
Sexually transmitted infections		168.2			145.1	389.3	
Teen births		23		17-31	15	17	
Additional Health Behaviors (not included in overall ranking) –							
Food insecurity		9%			10%	10%	
Limited access to healthy foods		8%			2%	6%	
Drug overdose deaths					10	11	
Drug overdose deaths - modeled		8-11.9			8-11.9	12.5	
Motor vehicle crash deaths					9	8	
Insufficient sleep		29%		28-31%	27%	30%	
Clinical Care							74
Uninsured		6%		5-7%	6%	5%	
Primary care physicians		1,410:1			1,030:1	1,110:1	
Dentists		1,990:1			1,280:1	1,440:1	
Mental health providers		1,990:1			330:1	470:1	
Preventable hospital stays		59		47-71	35	37	
Diabetes monitoring		84%		64-100%	91%	88%	
Mammography screening		66%		45-86%	71%	65%	
Additional Clinical Care (not included in overall ranking) –							
Uninsured adults		7%		6-8%	7%	6%	
Uninsured children		4%		3-6%	3%	3%	
Health care costs		$9,922				$8,250	

			County	State			
Other primary care providers		1,419:1			782:1	1,020:1	
Social & Economic Factors							24
High school graduation		95%			95%	83%	
Some college		61%		55-67%	72%	74%	
Unemployment		3.9%			3.2%	3.9%	
Children in poverty		14%		10-18%	12%	13%	
% Children in Poverty % Children in Poverty (Hispanic) % Children in Poverty (White)		14% 39% 11%					
Income inequality		3.8		3.3-4.4	3.7	4.4	
Children in single-parent households		28%		22-34%	20%	28%	
Social associations		30.4			22.1	13.0	
Violent crime		72			62	231	
Injury deaths		80		57-109	55	62	
Additional Social & Economic Factors (not included in overall ranking) –							
Disconnected youth					10%	9%	
Median household income		$55,700		$49,700-61,600	$65,100	$65,600	
Household Income Household income (Hispanic) Household income (White)		$55,700 $41,300 $55,900					
Children eligible for free or reduced price lunch		42%			33%	38%	
Residential segregation - black/white					23	62	
Residential segregation - non-white/white		42			14	49	
Homicides					2	2	
Firearm fatalities					7	7	
Physical Environment							9
Air pollution - particulate matter	(	9.2			6.7	9.3	
Drinking water violations		No					
Severe housing problems		9%		7-11%	9%	14%	
Driving alone to work		74%		72-75%	72%	78%	
Long commute - driving alone		19%		16-22%	15%	30%	

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