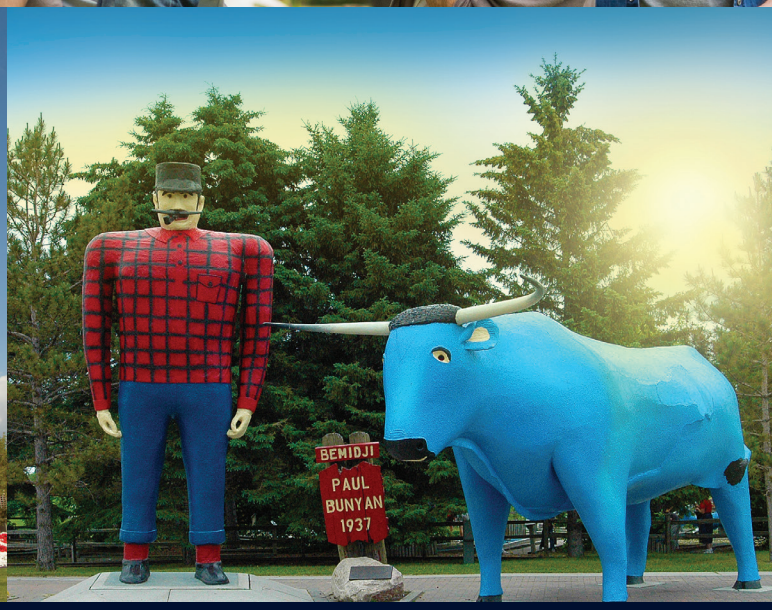

Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

dba Sanford Tracy Medical Center EIN # 46-0388596

SANFORD HEALTH

Sanford Tracy Medical Center

Community Health Needs Assessment

2016

Dear Community Members,

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

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

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

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

- Mental Health
- Physical Health

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

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

Sincerely,

Stacy Barstad

Stacy Barstad
Chief Executive Officer
Sanford Tracy Medical Center

Sanford Tracy Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

Sanford Tracy Medical Center

Community Health Needs Assessment
2016

Purpose

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

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

Study Design and Methodology

1. Non-Generalizable Survey

   A non-generalizable survey was conducted as an on-line survey through a partnership between Sanford and the Center for Social Research (CSR) at North Dakota State University. CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various community stakeholders and agencies, at times using a snowball approach. Data collection occurred throughout the month of April 2015 and a total of 20 respondents participated in the on-line survey.

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

   A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by Sanford and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

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

3. Community Asset Mapping

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

4. Secondary Research

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

Key Findings – Primary Research

The key findings are based on the non-generalizable survey data and secondary research. Key indicators were ranked on a 1-5 Likert scale, with 5 being the highest concern ranking. Survey results ranking 3.5 or higher are considered to be high-ranking concerns for the key stakeholder non-generalizable survey. While Sanford is addressing many of the concerns that ranked less than 3.5, the top priorities for prioritization are those that rank 3.5 and above.

Aging: The top ranking concern about the aging population among respondents overall is the cost of long term care (3.80).

Safety: The presence of street drugs and alcohol in the community (3.60) and the presence of drug dealers in the community (3.60) are the highest safety concerns of the respondents.

Health Care: The health care indicator addressed access to health care and the cost concerns. The cost of affordable dental insurance coverage (3.55) and access to affordable health insurance (3.55) are the highest concerns among the respondents in the health care access category.

Physical Health: Chronic disease (3.58), inactivity and lack of exercise (3.58), cancer (3.53), and obesity (3.53) are the highest physical health concerns.

Mental Health/Behavioral Health: Dementia and Alzheimer's (3.84), underage drinking (3.80), underage drug use and abuse, (3.80), depression (3.63), drug use and abuse (3.55), smoking and tobacco use (3.55), and alcohol use and abuse (3.50) are the highest concerns for mental health/behavioral health.

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

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

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcome for the state of Minnesota is 5,038 per 100,000. Lyon County has a higher rate at 5,147 per 100,000.

Poor or fair health: 12% of adults in Lyon County report poor or fair health compared to 10% nationally and 11% in Minnesota.

The average number of days reported in the last 30 as unhealthy mental health days is 2.6 in Lyon County. Minnesota as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 6.2% in Lyon County. The state of Minnesota is at 6.5%.

Health Factors

The percent of adults who are currently smoking is 18% in Lyon County. 16% of adults are current smokers in Minnesota.

29% of the adult population in Lyon County is considered to be obese with a BMI over 30. 26% of the population in Minnesota is obese.

The percent of adults reporting excessive or binge drinking is 26% in Lyon County. Minnesota reports 19% are binge drinkers statewide. Driving deaths that have alcohol involvement is at 44% in Lyon County. Alcohol involvement in driving deaths is at 31% in Minnesota.

Sexually transmitted infections rank substantially higher than the national benchmark (138) for Minnesota (336) and Lyon County (196). The teen birth rate is higher in Minnesota (24) than the national benchmark (20). The teen birth rate is 22 in Lyon County.

The clinical care outcomes indicate that the percentage of uninsured adults is 9% in Minnesota and 9% in Lyon County.

The ratio of population to primary care physicians is 1,113:1 in Minnesota. Lyon County's ratio is 1,419:1.

The ratio of population to mental health providers is 529:1 in Minnesota. Lyon County's ratio is 689:1.

The number of professionally active dentists in Minnesota is 1,404:1 and in Lyon County the ratio is 2,317:1.

Preventable hospital stays are 54 in Lyon County, 45 in Minnesota, and 41 nationally.

Diabetic screening is at 92% in Lyon County and 88% in Minnesota as a whole. Mammography screening is at 77.3% in Lyon County and 66.7% in Minnesota.

The social and economic factor outcomes indicate that Minnesota is at 78% for high school graduation. Lyon County has a graduation rate of 84%. Post-secondary education (some post-secondary education) is at 68.2% in Lyon County and 73.3% in Minnesota.

The unemployment rate is 4.2% in Lyon County and 5.1% in Minnesota. The percentage of child poverty is 15% in Lyon County. The child poverty rate is 14% in Minnesota.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is lower in Lyon County at 19.2. The state of Minnesota ranks at 13.2.

The percentage of children in single parent households is 25% in Lyon County and 28% in Minnesota.

Violent crime is lower in Lyon County at 153 per 100,000 populations than Minnesota, which has 229 cases per 100,000 populations.

The following needs were brought forward for prioritization:

- Aging – cost of long term care
- Safety – presence of street drugs and alcohol in the community and the presence of drug dealers in the community
- Health Care Access – the cost of affordable dental insurance and access to affordable health insurance
- Physical Health – chronic disease, inactivity, cancer and obesity
- Mental Health – dementia and Alzheimer's, underage drinking, underage drug use and abuse, depression, substance use and abuse (drugs, alcohol and tobacco)
- Preventive Health – flu vaccines, immunizations and STDs

Members of the collaborative determined that children and youth are a top unmet need. Community stakeholders also rated mental illness a top priority.

- Mental Health
- Physical Health

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

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

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

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

Many factors contribute to mental health problems, including:

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

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

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to help with access and to reduce the time that patients with mental health needs are placed for services. Sanford is working with community partners to create new recovery program options for community members.

Sanford has set strategy to work with the MN Department of Health on a pilot for integrating behavioral health into critical access hospitals.

Priority 2: Physical Health

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

Sanford has set strategy to help the community improve their physical health and chronic health conditions. A goal of this strategy is to increase the awareness of Medical Home and Health Coach.

Additionally, Sanford *fit* is an on-line community health activation initiative created by Sanford Health that provides engaging programs and resources to kids, families, leaders and role models across numerous settings to promote and activate healthy choices. The four key factors of healthy choices, a healthy body and healthy life included in *fit* are, MOOD – Emotions and Attitudes, RECHARGE – Sleep and Relaxation, FOOD – Mindful Nutrition Choices, and MOVE – Physical Activity Levels.

SANFORD HEALTH

Sanford Tracy Medical Center

Community Health Needs Assessment 2016

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Purpose

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

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

Our Guiding Principles:

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

Acknowledgements

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

Sanford Enterprise Steering Group:

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

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

Sanford Tracy Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health/ Community Benefit
- Stacy Barstad, Chief Executive Officer, Sanford Tracy Medical Center

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

- Alicia Collura, Sioux Falls Public Health
- Anita Cardinal, Pennington County Public Health
- Ann Malmberg, Essentia Health
- Becky Secore, Lyon Public Health
- Brenda Stallman, Traill County Public Health
- Brie Taralson, Essentia Health
- Brittany Ness, Steele County Public Health
- Caitlin Hurley, Avera Health
- Carrie McLeod, Sanford Health
- Dan Heinemann, MD, CMO, Sanford Health Network, Sioux Falls Region
- Gina Nolte, Partnership4Health, Clay County
- Jac McTaggart, Sanford Health
- Jessica Spaeth, City of Halstad
- Joy Johnson, Sanford Health
- Julie Jeske, CHI-St. Alexius Health
- Julie Miller, South Dakota Department of Health
- Julie Ward, Avera Health
- Kathy McKay, Clay County Public Health
- Katie Olson, South Dakota State University
- Kay Schwarzwalter, Center for Social Research, North Dakota State University
- Kim Jacobson, Traill County Public Health
- Kip Littau, South Dakota State University
- Marnie Walth, Sanford Health
- Mary Michaels, Sioux Falls Public Health
- Nancy Fahrenwald, South Dakota State University
- Renae Moch, Burleigh County Public Health
- Roger Baier, Sanford Health
- Ruth Bachmeier, Fargo Cass Public Health
- Sandra Melstad, Public Health Consultant, South Dakota Department of Health
- Stan Kogan, Sioux Falls Public Health
- Stephen Pickard, PhD., North Dakota Department of Health
- Susan Kahler, Burleigh County Public Health
- Teresa Miller, Avera Health

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

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

The following Tracy and Lyon County community stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Denise Clouse, Marketing Manager, Administrative Team
- Steve Ferrazano, Board Member
- Brenda Mentjes, Board Member
- Gayle Kaup, Board Member
- Mike Votka, Board Member, City Administrator
- Chad Anderson, School Superintendent
- Jane Sabinske, Director of Nursing, Westbrook Administrative Team
- Becky Luft, PI/Risk Manager, Administrative Team
- Meghan Westover, Administrative Assistant, Administrative Team
- Becky Foster, Human Resource Manager, Administrative Team
- Josh Sammons, Clinic Director, Administrative Team
- Matt Knackmuhs, Community Member
- Gordon Kopperud, Director of Operations, Administrative Team
- Claire Hannish, Hospital Board Member
- Jeri Schon, Chief Nursing Officer, Sanford Tracy
- Loretta Gervais, Board Member
- Stacy Barstad, CEO, Sanford Tracy
- Jason Swanson, Administrator, Prairieview Nursing Home

Description of Sanford Tracy Medical Center

Sanford Tracy Medical Center is a 25-bed critical access hospital located in Lyon County in southwest Minnesota. Since 2001 Sanford Tracy has enjoyed a collaborative relationship with Sanford Westbrook Medical Center. As neighboring communities, these two health care facilities share executive leadership and managerial staffing in the areas of radiology, laboratory, human resources and marketing/ community relations. The efficiency and cost effectiveness of these shared resources allows each facility to redirect valuable time, energy and financial assets into direct patient care. The two critical access hospitals provide services for approximately 9,400 people.

Built by the City of Tracy in 1960 as a municipal hospital, the hospital became a leased member Sanford Health Network in 1998 and is a designated Level 4 Trauma facility. Additional renovation and expansion was completed in 2010, which increased space in the clinic to accommodate additional primary care providers and provide space for visiting medical specialists.

The hospital campus consists of a primary care clinic, medical specialty outpatient clinic, and a 30-apartment senior living facility. In addition, two satellite medical clinics are located in the neighboring communities of Balaton (12 miles to the west) and Walnut Grove (7 miles to the east. The service area of Sanford Tracy includes the communities of Tracy, Currie, Balaton, Amiret, Walnut Grove, Milroy and

Revere. The population of this area is approximately 5,740. Sanford Tracy employs 1.5 clinicians and 103 employees.

Description of the Community Served

Tracy is a city of 2,300 people located in Lyon County, Minnesota. It is situated in a thriving agriculture area with an active retail environment. It is home to Tracy-Milroy-Balaton High School and Elementary School, Tracy Food Pride, a public day care facility, retail shops, and a public library. In addition, numerous churches, city and county parks, an aquatic center, and recreation amenities are available. Seniors are well served with a choice of affordable housing options. Tracy has everything to satisfy families that work in the city or commute from nearby communities.

Study Design and Methodology

1. Non-Generalizable Survey

   An on-line non-generalizable survey was conducted of residents in Tracy and Lyon County, Minnesota. The survey instrument was developed in partnership with members of the Greater Fargo-Moorhead Community Health Needs Assessment collaborative, Sioux Falls community collaborative, Bismarck community collaborative, public health leaders from across the enterprise, and researchers at the Center for Social Research (CSR) at North Dakota State University (NDSU). The CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various community stakeholders and community agencies, at times using a snowball approach**.** Data collection occurred throughout the month of April 2015 and a total of 20 respondents participated in the on-line survey.

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

   A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by Sanford and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

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

3. Community Asset Mapping

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

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

4. Secondary Research

   The secondary data includes County Health Rankings for Lyon County.

Limitations of the Study

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

Literature reviews indicate that there are non-response rate issues among younger respondents. In particular, response rates to health care and community health needs assessment surveys have often been found to be higher for older respondents. Studies have also shown lower response rates for socially disadvantaged groups (i.e., socially, culturally, or financially).

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

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

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

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

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

Key Findings

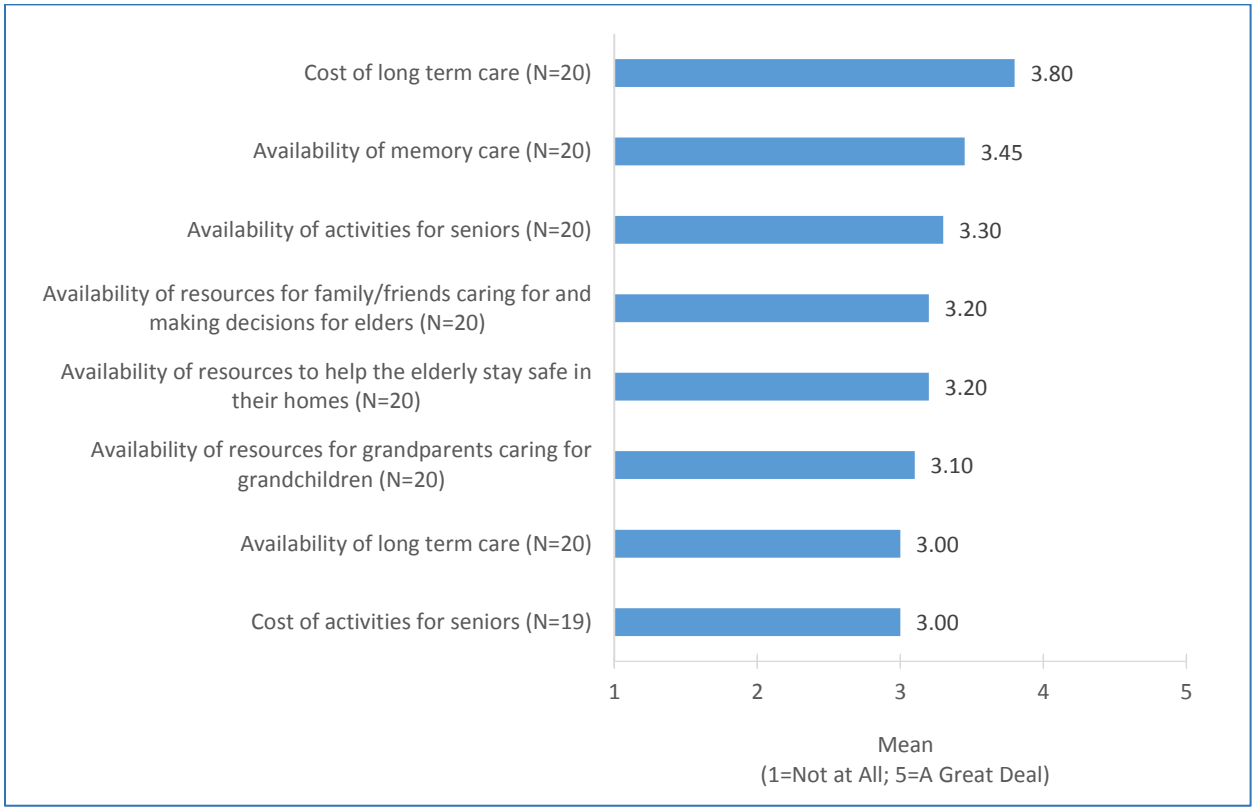
Primary Research

Community Health Concerns

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

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

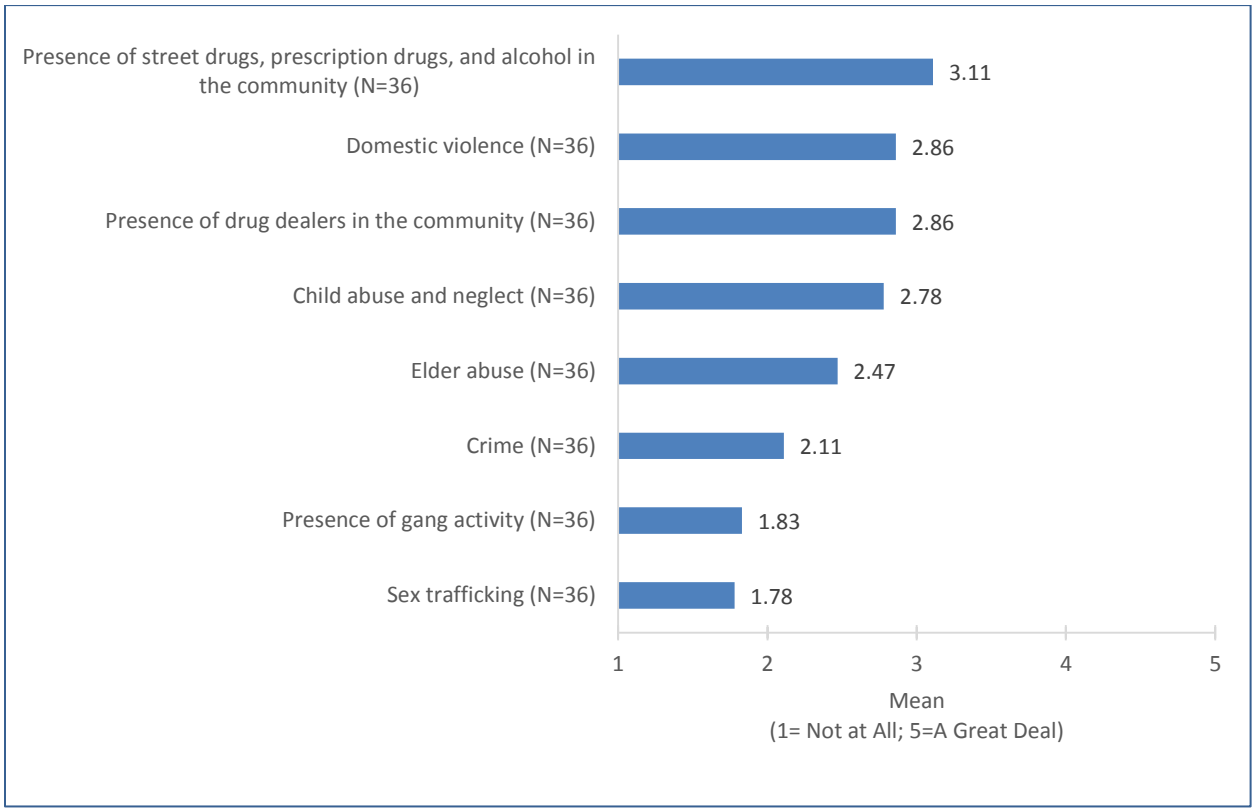
Level of concern with statements about the community regarding the AGING POPULATION



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

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

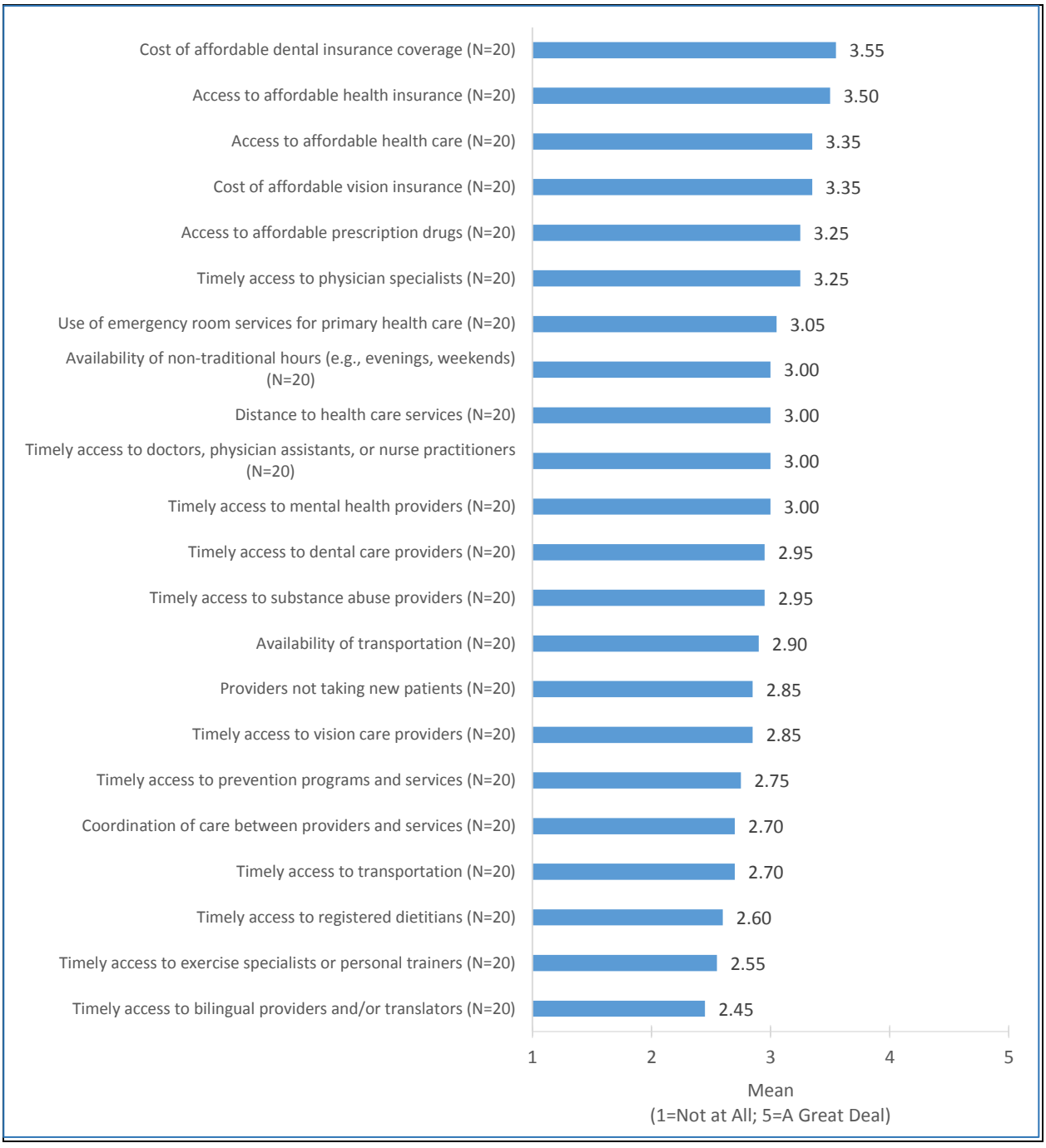
Level of concern with statements about the community regarding SAFETY



Sanford screens patients for substance abuse on admission to the emergency department.

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

Level of concern with statements about the community regarding HEALTH CARE

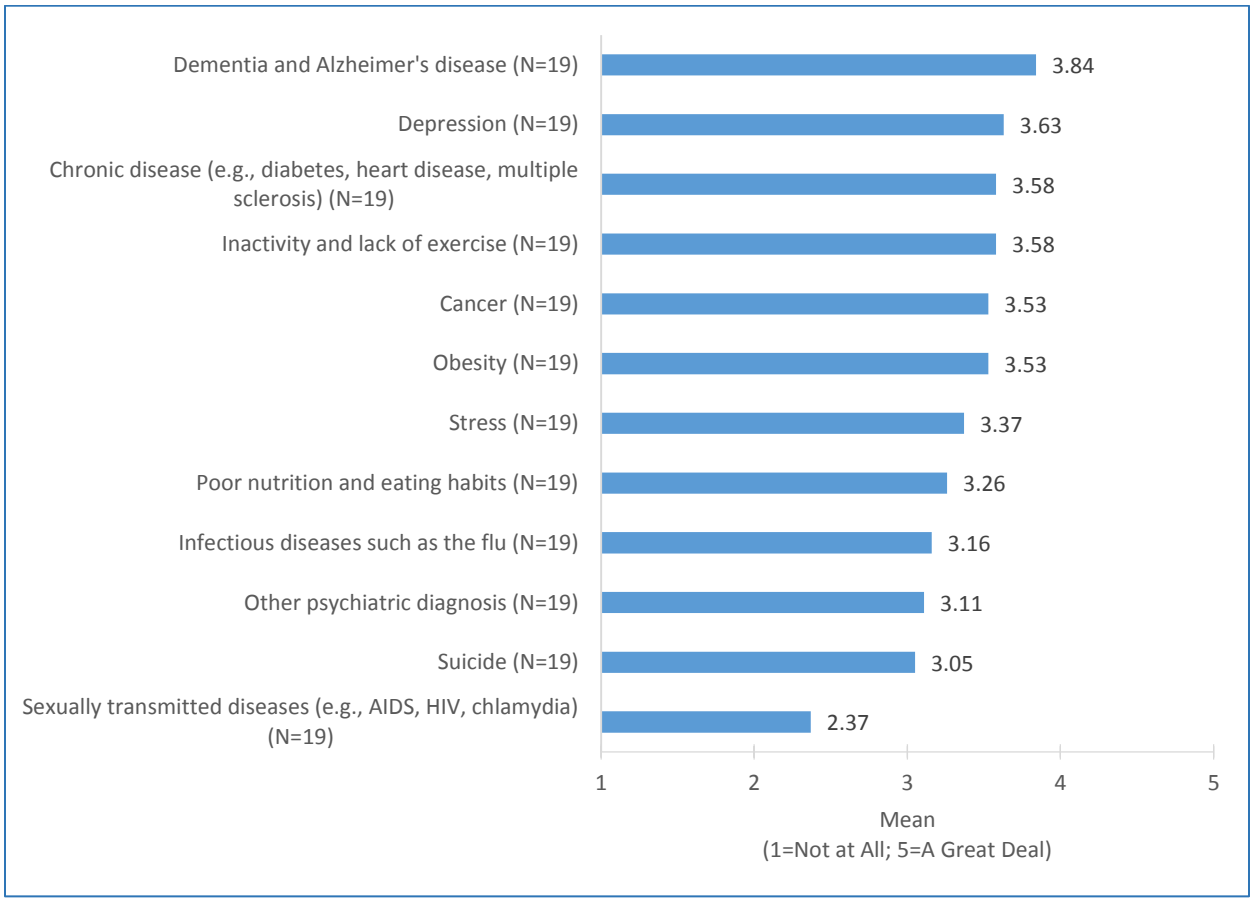


Sanford Tracy offers charity care to patients unable to pay for medical treatment. Sanford's community care policy defines qualifications and financial counselors are available to assist patients who qualify for free or subsidized care. Financial counselors also assist with enrollment for patients who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

reduced rate for patients who are unable to pay. The Sanford Health Plan is also available to community members.

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

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



Chronic disease is supported by the Health Care Home and Health Coach Clinic and Medical Home, preventative services and screenings offered at Sanford. An exercise boot camp is available for community members.

The chronic disease self-management Better Choices, Better Health Program at Sanford is offered free of charge to community members. Better Choices, Better Health is modeled after Stanford University's chronic disease self-management program. The workshops are 2 ½ hours long and meet weekly for 6 weeks. The program is facilitated by two trained lay leaders, and one or both of them have chronic condition themselves. Research has found that after participating in the program individuals are better able to manage their symptoms, communicate more easily with their doctors, are less limited by the disease, and generally feel better.

Sanford has added an oncologist as outreach specialty care and an expanded chemotherapy program.

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

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

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

- fit4Schools – fit4Schools includes unique fit-based lessons integrated into daily classroom activities. fit4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:
    - Reached 50,000 schools
    - 180,000 page views from educators across the country
    - 12,000 lesson plan downloads, representing 600,000+ students

  We are also reaching thousands of students through several pilot school programs.
    - *fit*4Schools – *fit*4Schools, which includes unique *fit*-based lessons integrated into daily classroom activities, is in its final phase of development. It is being piloted in seven elementary schools in the Sanford region.

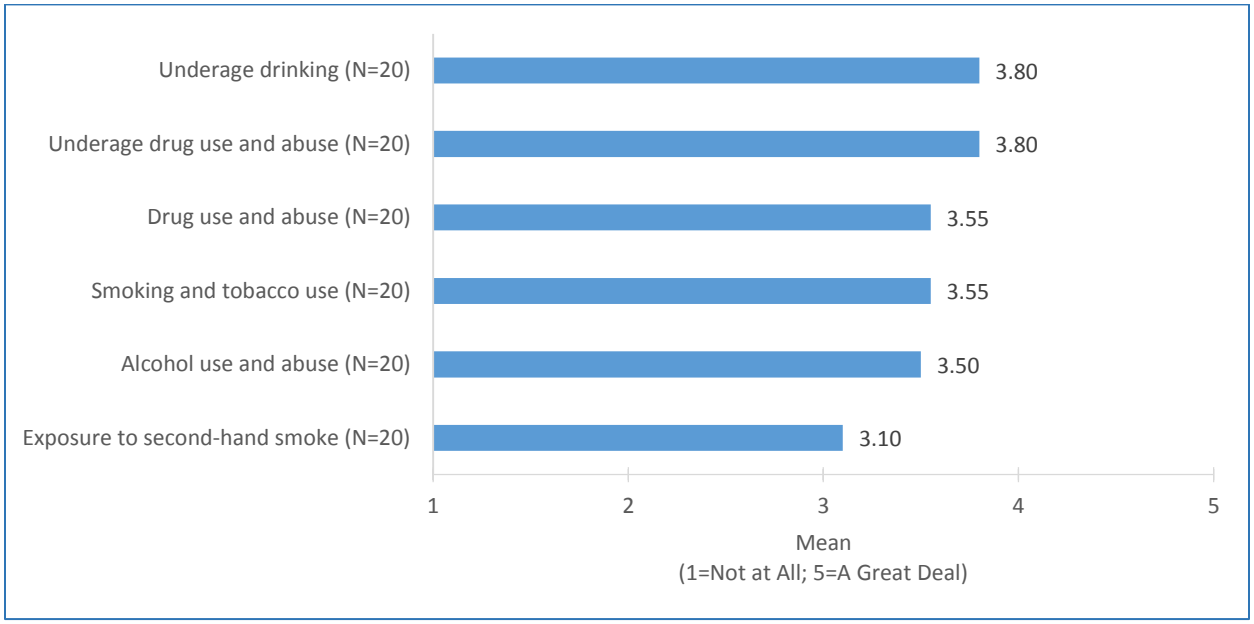
- Community
    - The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint. *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.

- Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
- MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.
- eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

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

Mental Health /Behavioral Health: The top behavioral health concerns are dementia and Alzheimer's, underage drinking, underage drug use and abuse, depression, drug use and abuse, smoking and tobacco use, and alcohol use and abuse.

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



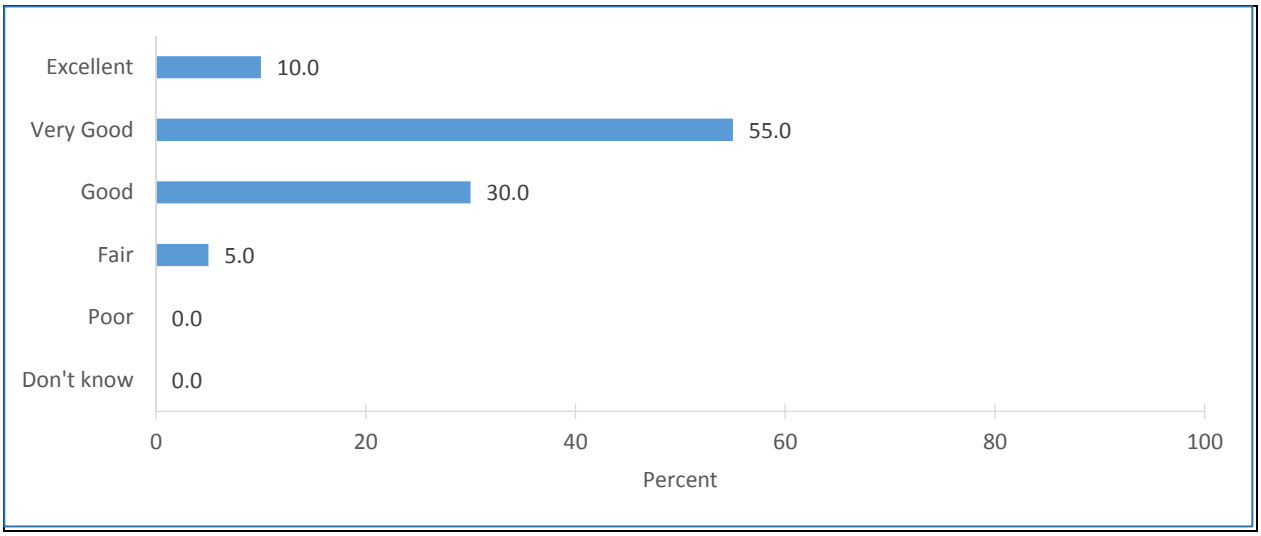
Sanford screens patients for depression on admission to the emergency department. Behavioral health services are embedded in the clinic. Primary care providers refer to mental health providers and there are two Masters Social Workers on staff to assist with resources and identify abuse issues.

Personal Health Concerns

Respondents' Personal Health Status

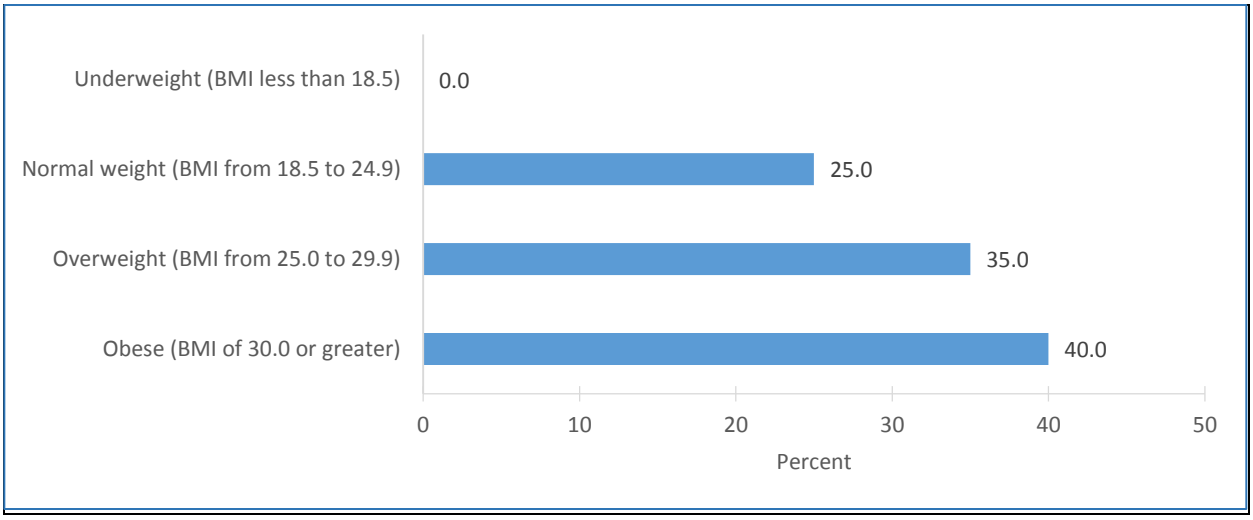
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area (75%) are overweight or obese. However, the vast majority (95%) of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, over 89% of respondents visited a doctor or health care provider for a routine physical and over 94% visited a dentist or dental clinic.

Respondents' rating of their health in general



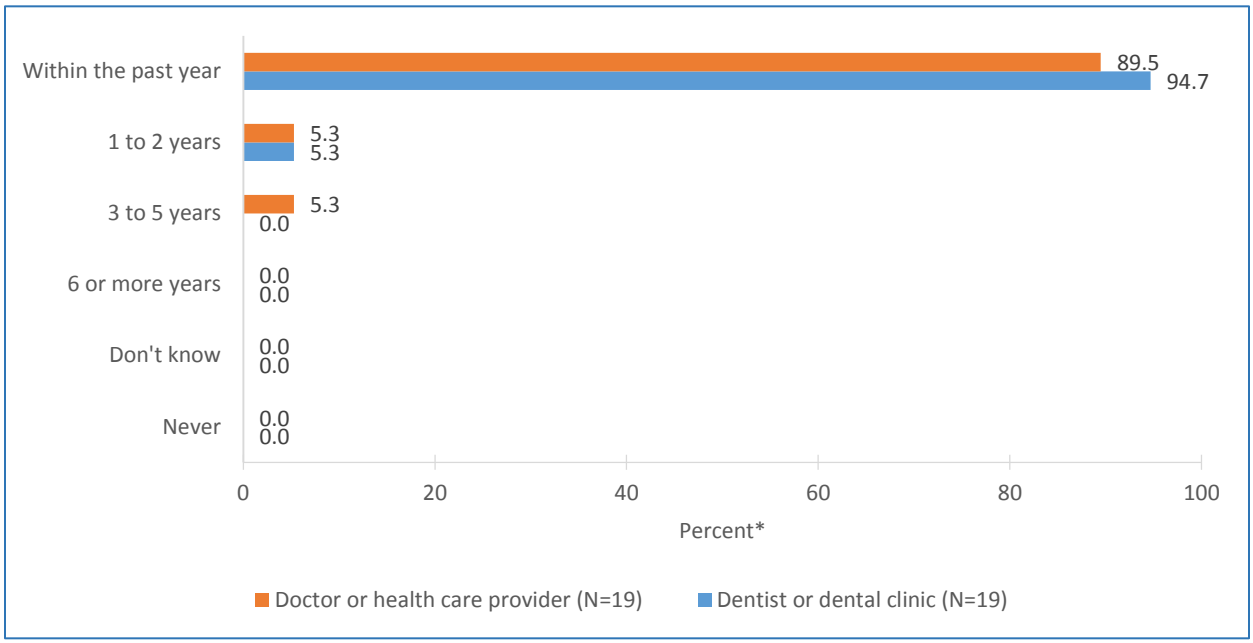
95% of the community stakeholders (non-generalizable) rate their health as good or better.

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



75% of the key stakeholders report a BMI that is overweight or obese.

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



Preventive Health

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

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

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=19)	89.5	10.5	100.0
Blood sugar screening (N=19)	68.4	31.6	100.0
Bone density test (N=18)	11.1	88.9	100.0
Cardiovascular screening (N=19)	36.8	63.2	100.0
Cholesterol screening (N=19)	68.4	31.6	100.0
Dental screening and X-rays (N=18)	94.4	5.6	100.0
Flu shot (N=19)	78.9	21.1	100.0
Glaucoma test (N=18)	44.4	55.6	100.0
Hearing screening (N=19)	15.8	84.2	100.0
Immunizations (N=18)	38.9	61.1	100.0
Pelvic exam (N=11 Females)	72.7	27.3	100.0
STD (N=18)	16.7	83.3	100.0
Vascular screening (N=18)	5.6	94.4	100.0
CANCER SCREENINGS			
Breast cancer screening (N=12 Females)	75.0	25.0	100.0
Cervical cancer screening (N=12 Females)	75.0	25.0	100.0
Colorectal cancer screening (N=19)	31.6	68.4	100.0
Prostate cancer screening (N=7 Males)	28.6	71.4	100.0
Skin cancer screening (N=18)	27.8	72.2	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=2)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Blood sugar screening (N=6)	33.3	50.0	16.7	0.0	0.0	0.0	0.0
Bone density test (N=16)	31.3	56.3	0.0	0.0	6.3	0.0	6.3
Cardiovascular screening (N=12)	41.7	50.0	0.0	0.0	0.0	0.0	8.3
Cholesterol screening (N=6)	50.0	50.0	16.7	0.0	0.0	0.0	0.0
Dental screening and X-rays (N=1)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Flu shot (N=4)	25.0	0.0	0.0	0.0	0.0	0.0	50.0

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Glaucoma test (N=10)	20.0	50.0	0.0	0.0	0.0	0.0	0.0
Hearing screening (N=16)	31.3	43.8	0.0	0.0	0.0	0.0	6.3
Immunizations (N=11)	63.6	27.3	0.0	0.0	0.0	0.0	0.0
Pelvic exam (N=3 Females)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
STD (N=15)	53.3	20.0	0.0	0.0	0.0	0.0	6.7
Vascular screening (N=17)	41.2	41.2	0.0	0.0	0.0	0.0	5.9

- *For most types of screenings, the most common reasons for not getting the test or procedure are that it is not necessary and the doctor has not suggested one.*
- *For the flu shot screening, most respondents cite that it was not necessary or other reasons for not getting the shot.*
  31.6% of the non-generalizable respondents were under 45 years of age. Over 52% were in the 55 years or above category.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Flu Vaccines

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

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

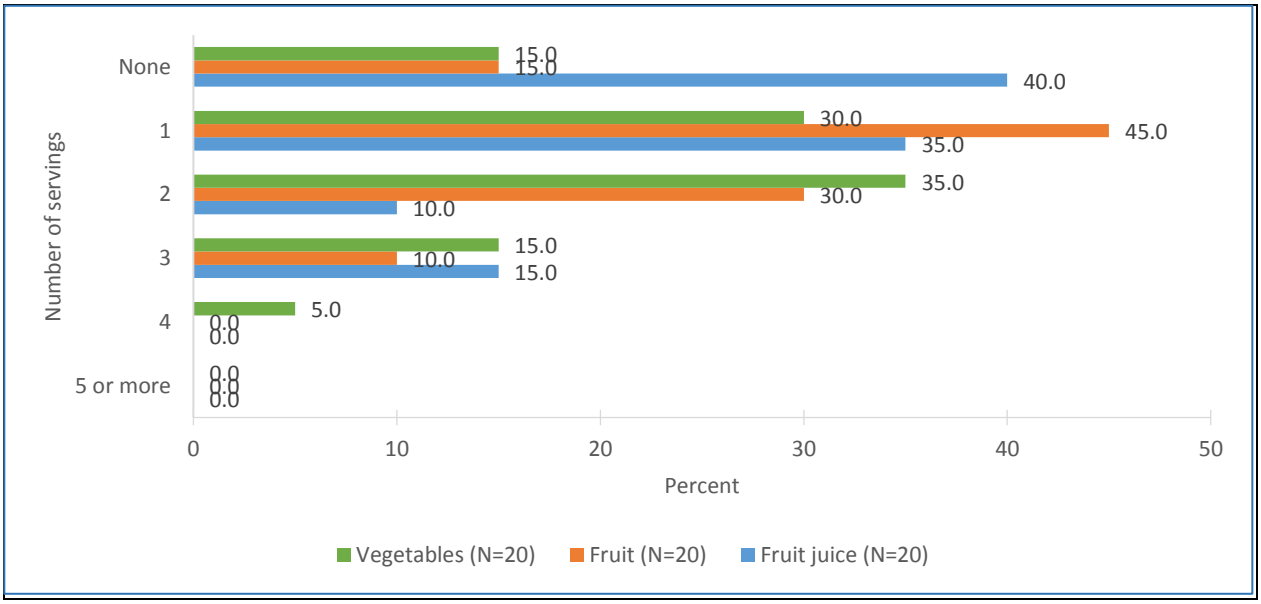
Sanford Health employees are required to have an annual flu vaccine as a protective measure for our patients as well as our staff. Sanford holds annual flu blitz events to increase the number of community members both pediatric and adult who receive the flu vaccine.

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 20% of respondents reported having 3 or more servings of vegetables the prior day. Only 10% reported having 3 or more servings of fruits the prior day.

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

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

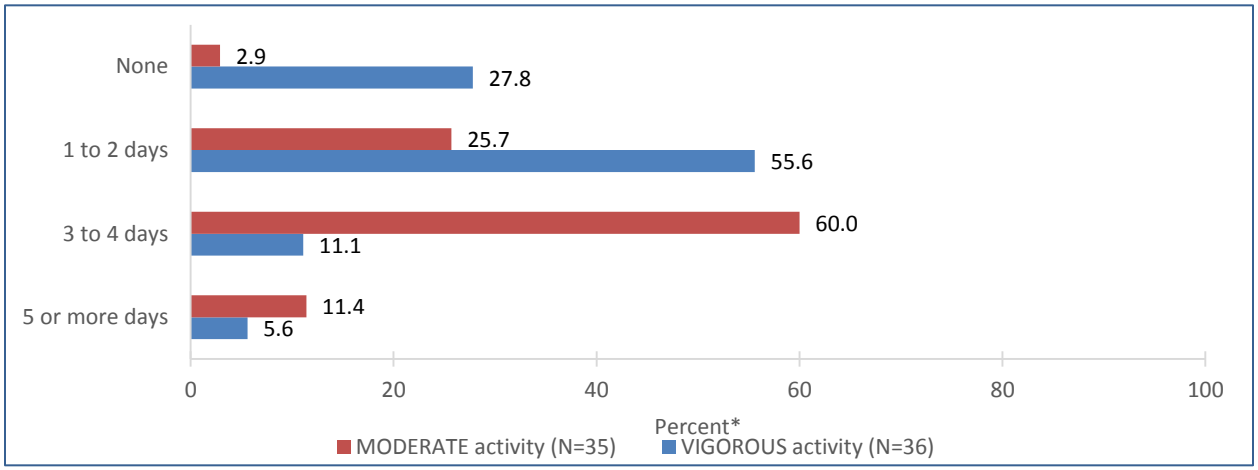


Physical Activity Levels

Study results suggest that 40% of respondents do meet physical activity guidelines. 60% of respondents have 3 or more days per week with moderate activity.

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

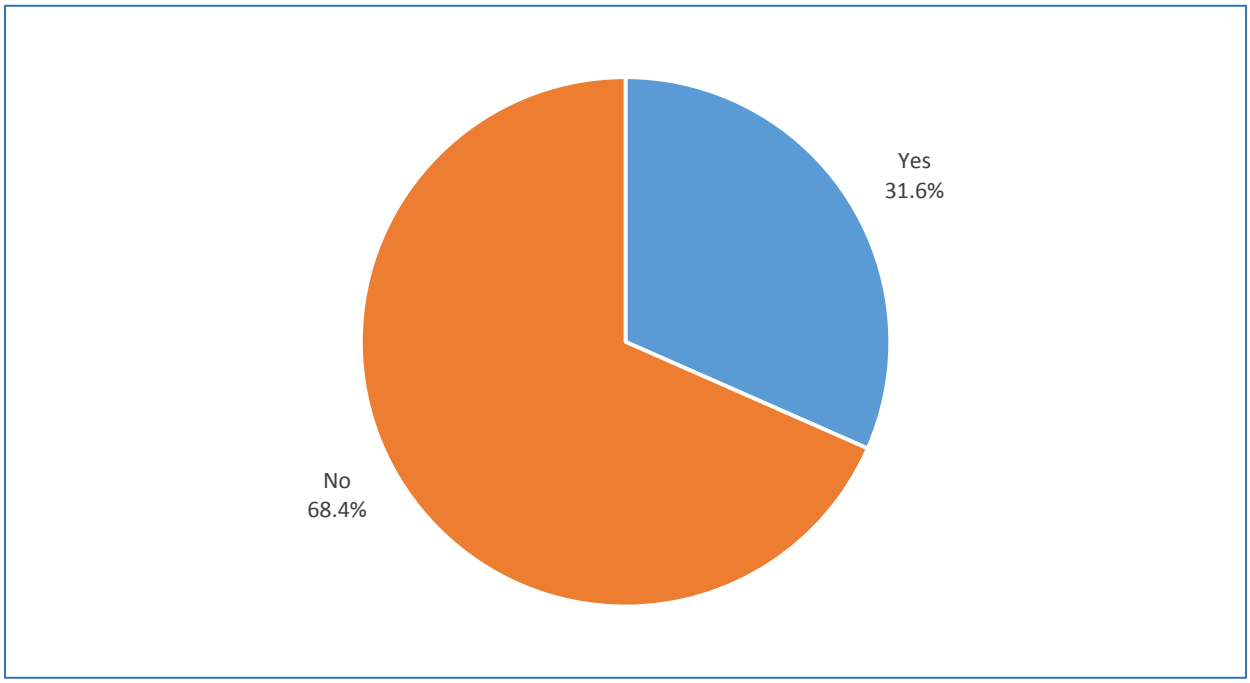
Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



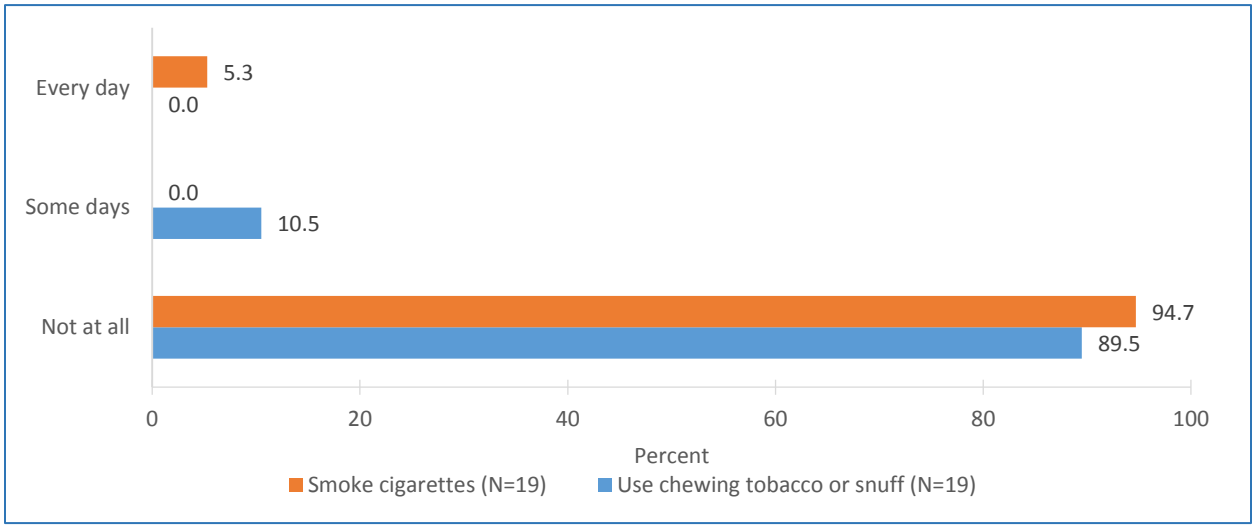
Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 31.6% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates a former smoker status according to the Centers for Disease Control and Prevention.

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



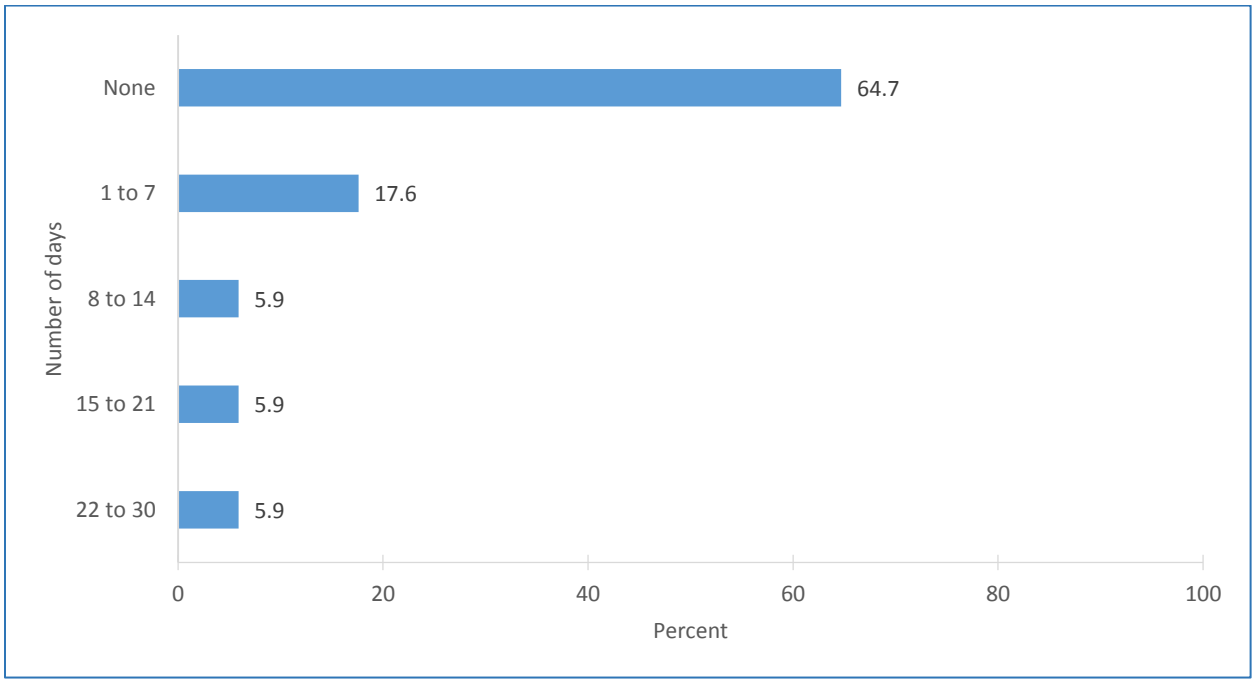
How often respondents currently smoke cigarettes and use chewing tobacco or snuff



Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others. Among Tracy and Lyon County respondents, mental health is a moderately high area of concern, particularly depression, and stress. 25% of respondents have been told or diagnosed by a doctor or health professional that they have anxiety or stress and 20% have been told they have depression. In addition, 23.6% of respondents self-report that in the last month, there were days when their mental health was not good.

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

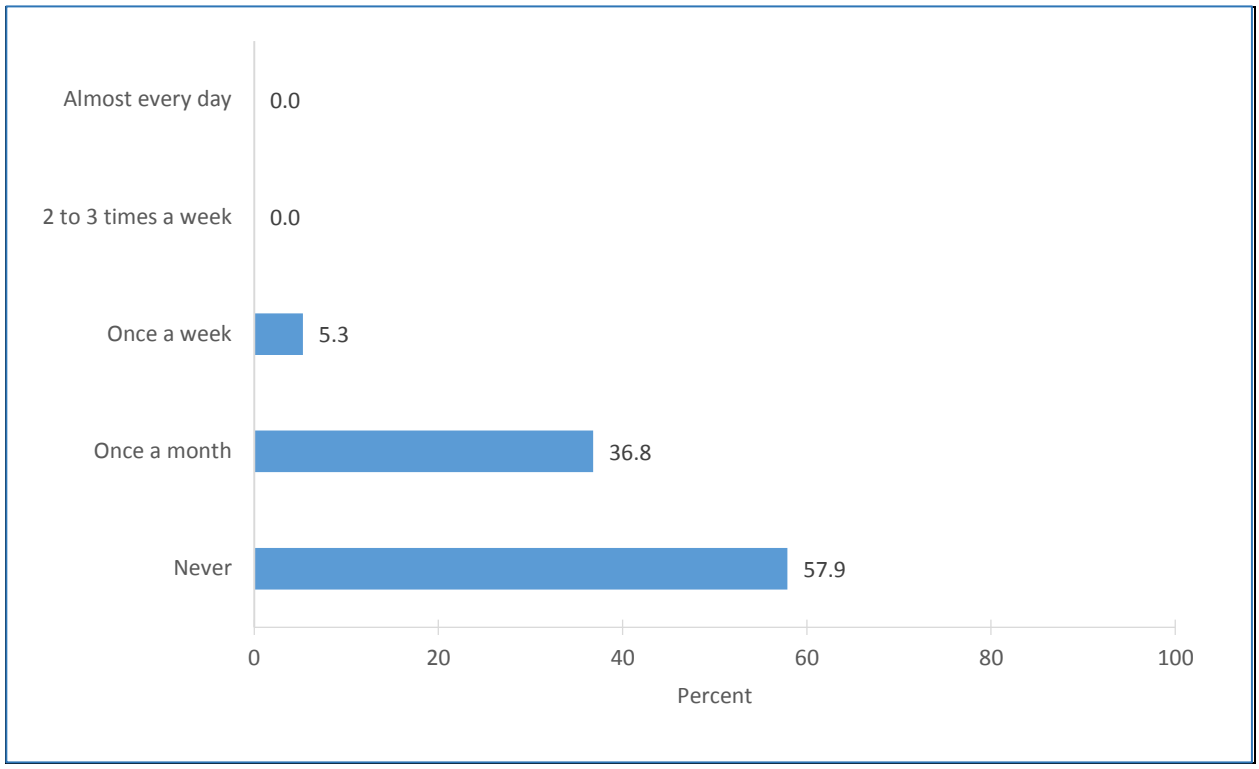


Substance Abuse Responses

Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In Tracy and Lyon County, 73.7% of the community stakeholder's respondents drank alcoholic beverages on at least one of the days in the last month. On days they drank, 14% of respondents drank an average of 3 or more drinks per day. In regards to binge drinking, 42.1% of community stakeholder's respondents report binge drinking at least once per month,

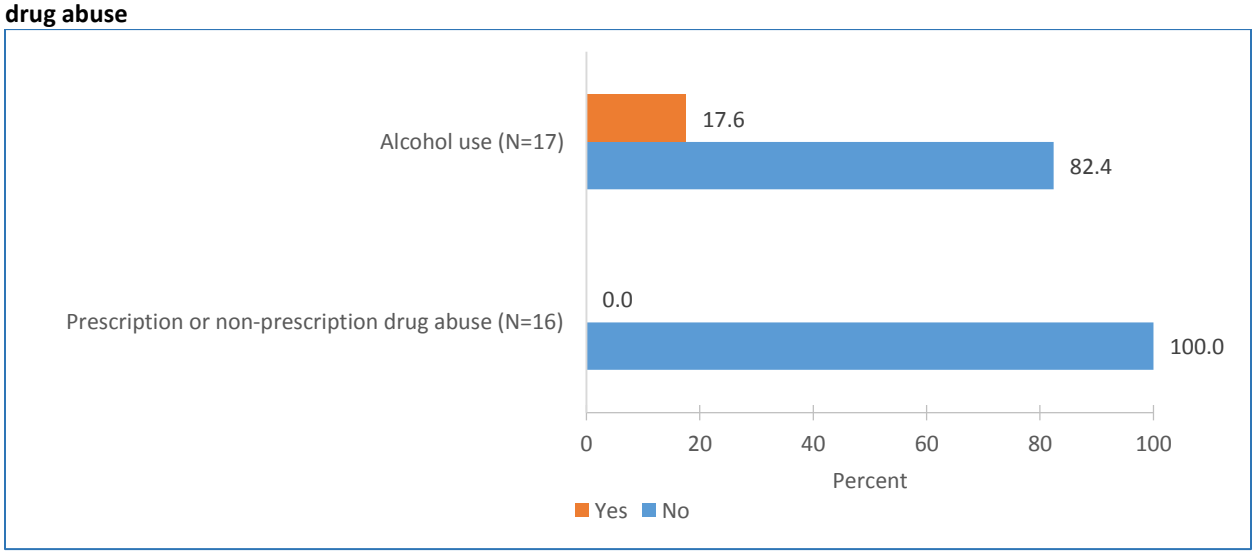
Secondary research through the 2015 County Health Rankings found that 26% of residents in Lyon County report excessive drinking, and 44% of the driving deaths indicated alcohol involvement. (See Appendix)

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



N=19

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



17.6% percent of respondents from the community stakeholder group reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking (42%).

Other forms of substance abuse include the use of prescription or non-prescription drugs. 0% of the community stakeholder's respondents reported having had a problem with prescription or non-prescription drug abuse.

Demographics

Total Population – 2010 U.S. Census Bureau

- Lyon County: 25,857

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	1,872	7.2	985	3.8	887	3.4
5-9	1,686	6.5	843	3.3	843	3.3
10-14	1,667	6.4	851	3.3	816	3.2
15-19	2,045	7.9	993	3.8	1,052	4.1
20-24	2,465	9.5	1,230	4.8	1,235	4.8
25-29	1,868	7.2	981	3.8	887	3.4
30-34	1,547	6.0	835	3.2	712	2.8
35-39	1,415	5.5	731	2.8	684	2.6
40-44	1,425	5.5	716	2.8	709	2.7
45-49	1,753	6.8	889	3.4	864	3.3
50-54	1,838	7.1	873	3.4	965	3.7
55-59	1,591	6.2	828	3.2	763	3.0
60-64	1,166	4.5	598	2.3	568	2.2
65-69	907	3.5	445	1.7	462	1.8
70-74	698	2.7	344	1.3	354	1.4
75-79	636	2.5	255	1.0	381	1.5
80-84	588	2.3	231	0.9	357	1.4
85 and over	690	2.7	217	0.8	473	1.8
Median age	34.1		33		35.5	

Population by Race

	Lyon	Percent
White	23,360	90.3
Black or African American	587	2.3
American Indian or Alaska Native	114	0.4
Asian	679	2.6
Native Hawaiian or other Pacific Islander	7	0.0
Hispanic or Latino	1,541	6.0

The per capita personal income in Lyon County, Minnesota is $18,013. 24.6% of individuals 15 years and older in Lyon County are living below the poverty level. The unemployment rate in Lyon County, Minnesota is 4.2%.

Health Needs and Community Resources Identified

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

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

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

The asset map process includes identified needs from the following:

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

See Asset Map in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Aging – cost of long term care
- Safety – presence of street drugs and alcohol in the community and the presence of drug dealers in the community
- Health Care Access – the cost of affordable dental insurance and access to affordable health insurance
- Physical Health – chronic disease, inactivity, cancer and obesity
- Mental Health – dementia and Alzheimer's, underage drinking, underage drug use and abuse, depression, substance use and abuse (drugs, alcohol and tobacco)
- Preventive Health – flu vaccines, immunizations and STDs

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

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

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

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

- Mental Health
- Physical Health

Addressing the Needs

Identified Concerns	How Sanford Tracy Medical Center is Addressing the Needs
Aging • Cost of long term care	• Resources to help with patients who leave Sanford Tracy facility to long term care. • Social Worker and discharge planning to help with decisions and resources.
Safety • Presence of drug dealers in the community • Presence of street drugs and alcohol in the community	Assessment in ER upon admission.
Health Care • Cost of affordable dental insurance coverage • Access to affordable health insurance	Sanford Health Plan advertised and marketed in area.
Physical Health • Chronic disease • Inactivity and lack of exercise • Cancer • Obesity ○ County rate is obese 29%	• Implementation of Health Coach and Medical Home to monitor and help patients with compliance of their health care. Preventative services, screenings and wellness services are offered. • Promoting Sanford Profile and *fit* Kids programs through Sanford. • Offering public education on different chronic diseases. Wellness Director has offered exercise "boot camps" for the public. • Oncologist added to outreach providers and expanded chemo therapy program. • Education and screening during *Hospital Week* and also at community events.
Mental Health • Dementia and Alzheimer's • Underage drinking • Underage drug abuse • Depression • Drug use and abuse • Smoking and tobacco use • Alcohol use and abuse	• Behavioral health providers embedded in clinic to help with various mental health issues. • Primary care providers working with the mental health providers for referrals and proper placement. • Two MSWs on staff to help with resources and identifying abuse issues.
Preventive Health • Flu shots • Immunizations • STDs	• Offering flu shot clinics for the public. • Address and encourage keeping updated immunizations with clinic patients.

SANFORD HEALTH

2016 Implementation Strategy

Community Health Needs Assessment

Implementation Strategy for Sanford Tracy Medical Center

FY 2017-2020 Action Plan

Priority 1: Mental Health

Projected Impact: To help with access and overall awareness of community of resources for mental health services

Goal 1: To show a decrease of time for mental health patients to be in the ER and go to placement

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Continue discussion on holding patients and resources to help with placing patients quickly	Track and evaluate Turnaround time for patients that come into ER and placement availability	State of MN, State Bed Tracker, Providers and Nursing Staff	Barstad/ Schons/ Deadrick-Nelson Wee	Local police and ambulance departments for transportation

Goal 2: Awareness of treatment of drug programs to community members

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Work with community partners to create new recovery program options for community members	Alcohol and Drug Treatment program(s) Awareness is marketed to community providers	Public Health, Community and City leaders	Behavioral Health team/ Barstad/ Sammons	City of Tracy leaders/Lyon County Public Health

Goal 3: Work with MN Dept. of Health on pilot project for integrating behavioral health into critical access hospitals

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
The National Rural Health Resource Center's Rural Health Innovations has received a Flex grant from our office to provide technical assistance for improving the health of rural communities by increasing communication, partnership and collaboration among critical access hospitals, behavioral and mental health providers and other community partners	Successfully having more of a presence of behavioral health resources and providers into our critical access hospital at Sanford Tracy	MN Dept of Health, Community Partners	Barstad/ Schons/ Sammons/ Luft	Lyon County Public Health

Priority 2: Physical Health

Projected Impact: To help community improve their physical health and overall chronic health conditions

Goal 1: Medical Home and Health Coach utilization

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Increase awareness and utilization of Medical Home and Health Coach to reach obese patients	Track through running patient registry and follow up on eligible patients	Medical Staff/Health Coach	Sammon/ Kolar/ Morman	N/A

Goal 2: Sanford Fit Kids Utilization

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Work with Sanford *fit* Kids and work with community to bring this service more visibility	Presentations at school and at various community groups	Medical Staff/Schools/ Athletic Trainer/ Marketing	Clouse/ Radke/ Barstad	Tracy Public Schools

Goal 3: **Utilizing Sanford Profile services**

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Exploring utilization of new Sanford Profile weight management service for the community	Enrollment of at least 3 new patients over the next 1 year	Sanford Profile tools/Provider and community awareness	Radke/ Clouse/ Barstad	N/A

SANFORD HEALTH

2013 Implementation Strategy Impact

Demonstrating Impact

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

2013 Community Health Needs Assessment
Sanford Tracy Implementation Strategy

1. **Implementation Strategy: Urgent Care After Hours**

   Three-Year Plan (January 2012 - January 2015)

   - To have full medical staff to be able to coordinate expanded hours
   - Nursing staff coordination
   - Receptionist staff coordination
   - Marketing
   - Ancillary staff coordination-Lab/X-Ray, etc.

2. **Implementation Strategy: Mental Health Services**

   Three-Year Plan (January 2012 - January 2015)

   - To increase providers available
   - Obtain certification of Medical Home and implement Health Coach to help with resources and guidance for patients
   - Continued discussion on holding patients and resources to help with placing patients quickly to an appropriate facility
   - Work with community partners to create new recovery program options for community members

The 2013 strategies have served as a base for reaching out and utilizing resources and implementing resources in the Tracy community. The impact has been positive and the work will continue into the future through new or continued programming and services on the strategies.

Impact of the Strategy of Urgent Care After Hours

The strategy of adding Urgent Care after hours is a work in process. Provider turnover has been a key in not being able to add this program. Turnover of APPs and MDs over the last three years has been a roadblock in order to have enough providers to sustain after hours services. With the continued recruitment of medical staff, the goal is to implement this program at full staffing levels. Due to the difficulty of recruiting to a rural community, this goal has not been able to be accomplished in the last three to four years.

Impact of the Strategy to Address Mental Health

In the spring of 2013, Sanford Tracy was successful in adding a nurse practitioner specializing in behavioral health. In addition, Medical Home certification and the addition of a Health Coach were realized in the fall of 2013. This has helped with patients being able to use specialized services and identifying needs that can be referred to the nurse practitioner by the primary care providers. Due to the shortage of inpatient beds in the state of Minnesota, ongoing communication and working with resources within the state for ER placement of behavioral health patients has been a work in process. The two social workers who have been employed have been able to help Sanford Tracy identify programs for addiction and recovery programs around the community area for access to patients.

Community Feedback from the 2013 Community Health Needs Assessment

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

APPENDIX

Primary Research

Tracy 2016 CHNA Asset Map

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Aging population		Cost of long term care 3.80		X
Safety		Presence of drug dealers in the community 3.60 Presence of street drugs, and alcohol in the community 3.60		
Health Care		Cost of affordable dental insurance coverage 3.55 Access to affordable health insurance 3.55		X
Physical Health	12% of adults report poor physical health in the last month, compared to 2.5% nationally and 2.8% statewide. 6.2% of live births are of low birth weight (less than 2500 grams) 29% of adults are obese 18% of adults are current smokers 19% of adults have no leisure time physical activity Teen births are at 22 per 1000 female population – national rate is 20	Chronic disease 3.58 • 20.% of respondents reported hypertension • 20% reported high cholesterol • 10.% reported diabetes • Inactivity and lack of exercise 3.58 Cancer 3.53 • 20% reported cancer Obesity 3.53 • BMI – overweight or obese 75% • Only 20% of respondents have 3 or more vegetables/day and 10 % have 3 or more fruits/day • 60% have 3 or more days each week of moderate activity and 20 % report 3 or more days of vigorous activity each week	Sanford Cancer Biology Research Center Sanford Dietitians MN Extension Service Sanford Medical Home The Sanford Project – to cure Type 1 DB in Denny Sanford's lifetime Sanford WebMD Fit Kids Sanford's Better Choices/Better Health Program(chronic illnesses program) Sanford Tracy Medical Center	X

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Mental Health/Behavioral Health	Number of poor mental health days in the past month is 2.6 compared to 2.3 nationally and 2.6 across the state 26% of adults report binge or excessive drinking 44% of driving deaths are with alcohol involvement 18% of adults smoke	Dementia and Alzheimer's 3.84 Underage drinking 3.80 Underage drug use and abuse 3.80 Depression 3.63 • 25% of respondents report that they have been told by a doctor that they have anxiety or stress, and 20% report being told that they have depression 23.6% reported 1 or more days in the last month when their mental health was not good. Drug use and abuse 3.55 Smoking and tobacco 3.55 Alcohol use and abuse 3.50 • 14% of respondents reported 3 or more drinks /d on average • 42.1% reported 4 or 5 drinks (binge) on the same occasion over the past month • 17.6% reported having a problem with alcohol use or drug use, however 10.5 % reported that alcohol use had harmful effects on the respondent or a family member	Sanford One Care	X

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Preventive Health	77.3% of female Medicare enrollees age 67-69 receive mammography screenings STDs are at 196 compared to 138 nationally and 336 across the state	21.1% did not receive a flu shot in the past year 61.1% have not had an immunization in the past year 10.6% of respondents report that it has been over a year since they have seen their health care provider and 5.3 % have not seen their dentist over the last year.	Sanford Tracy Public Health Department	X

Sanford Tracy 2016 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Aging • Cost of long term care 3.80 (2)	XXX		
Safety • Presence of drug dealers in the community 3.60 (4) • Presence of street drugs and alcohol in the community 3.60 (4)	X		
Health Care • Cost of affordable dental insurance coverage 3.55 (6) • Access to affordable health insurance 3.55 (6)	XX		
Physical Health • Chronic disease 3.58 (5) • Inactivity and lack of exercise 3.58 (5) • Cancer 3.53 (7) • Obesity 3.53 (7) ○ County rate is obese 29%	XXXXX XXXXX X #2 priority		
Mental Health • Dementia and Alzheimer's 3.84 (1) • Underage drinking 3.80 (2) • Underage drug abuse 3.80 (2) Depression 3.63 (3) • Drug use and abuse 3.55 (6) • Smoking and tobacco use 3.55 (6) • Alcohol use and abuse 3.50 (8)	XXXXX XXXXX XXXX #1 priority		
Preventive Health • Flu shots • Immunizations • STDs			

Participants: Denise Clouse-Marketing Manager, Administrative Team, Steve Ferrazano-Board Member, Brenda Mentjes-Board Member, Gayle Kaup-Board Member, Mike Votka-Board Member-City Administrator, Chad Anderson-School Superintendent, Jane Sabinske-Director of Nursing, Westbrook-Administrative Team, Becky Luft-PI/Risk Manager-Administrative Team, Meghan Westover, Admin. Assistant-Administrative Team, Becky Foster, Human Resource Manager-Administrative Team, Josh Sammons-Clinic Director-Administrative Team, Matt Knackmuhs-community member, Gordon Kopperud-Director of Operations-Administrative Team, Claire Hannish-Hospital board member, Jeri Schons-Chief Nursing Officier-Tracy, Loretta Gervais, Board Member., Stacy Barstad, CEO, Jason Swanson, Prairieview Nursing Home Administrator

Sanford Tracy Medical Center

Community Health Needs Assessment

Results from an April 2015 Non-generalizable

Online Survey

September 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an April 2015 online survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative invited viewers to access the online survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach**. Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred throughout the month of April 2015 and a total of 20 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

General Health and Wellness Concerns about the Community

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

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

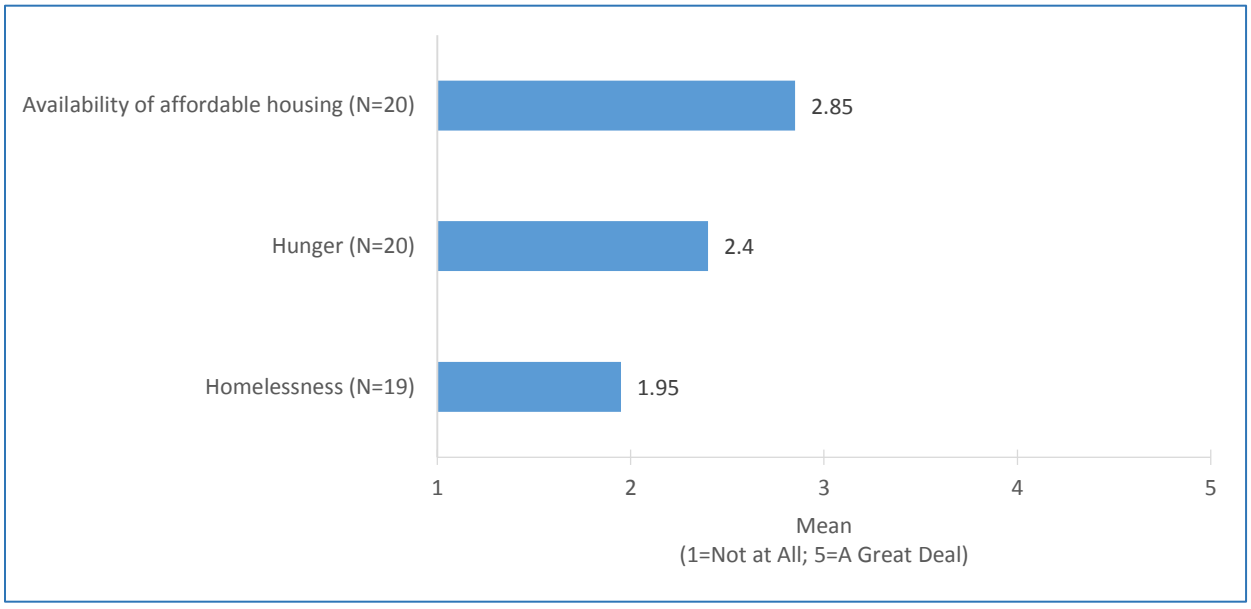


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

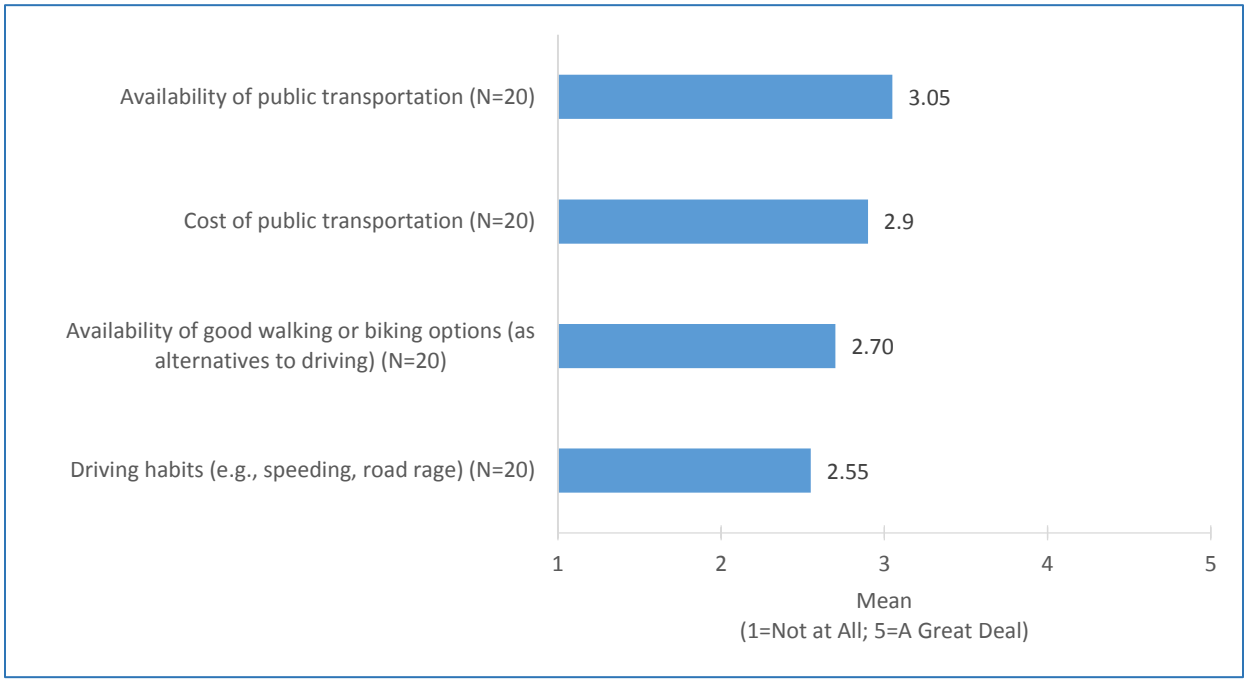


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

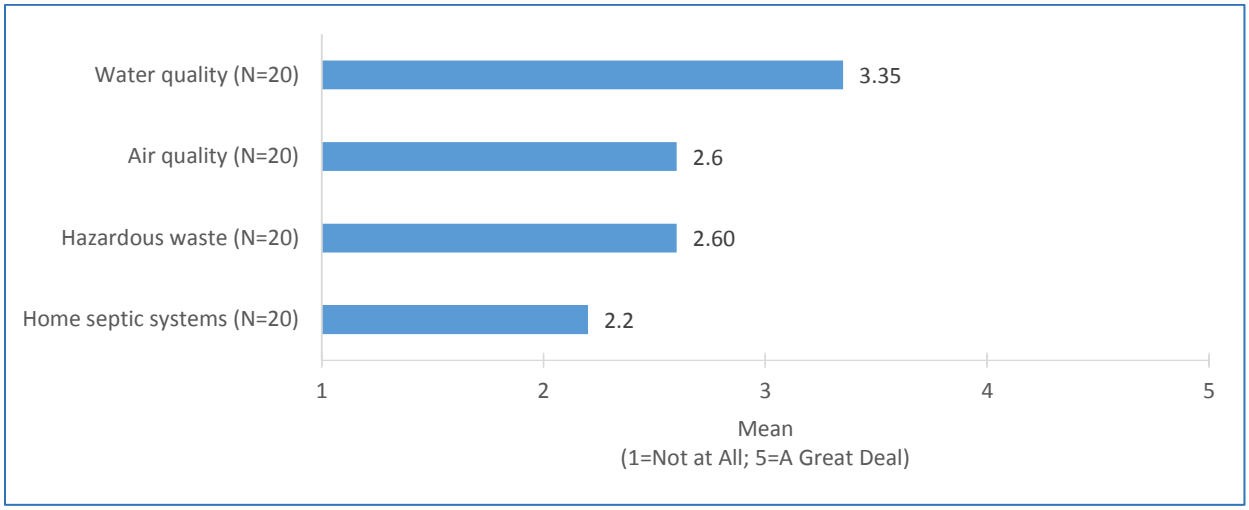


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

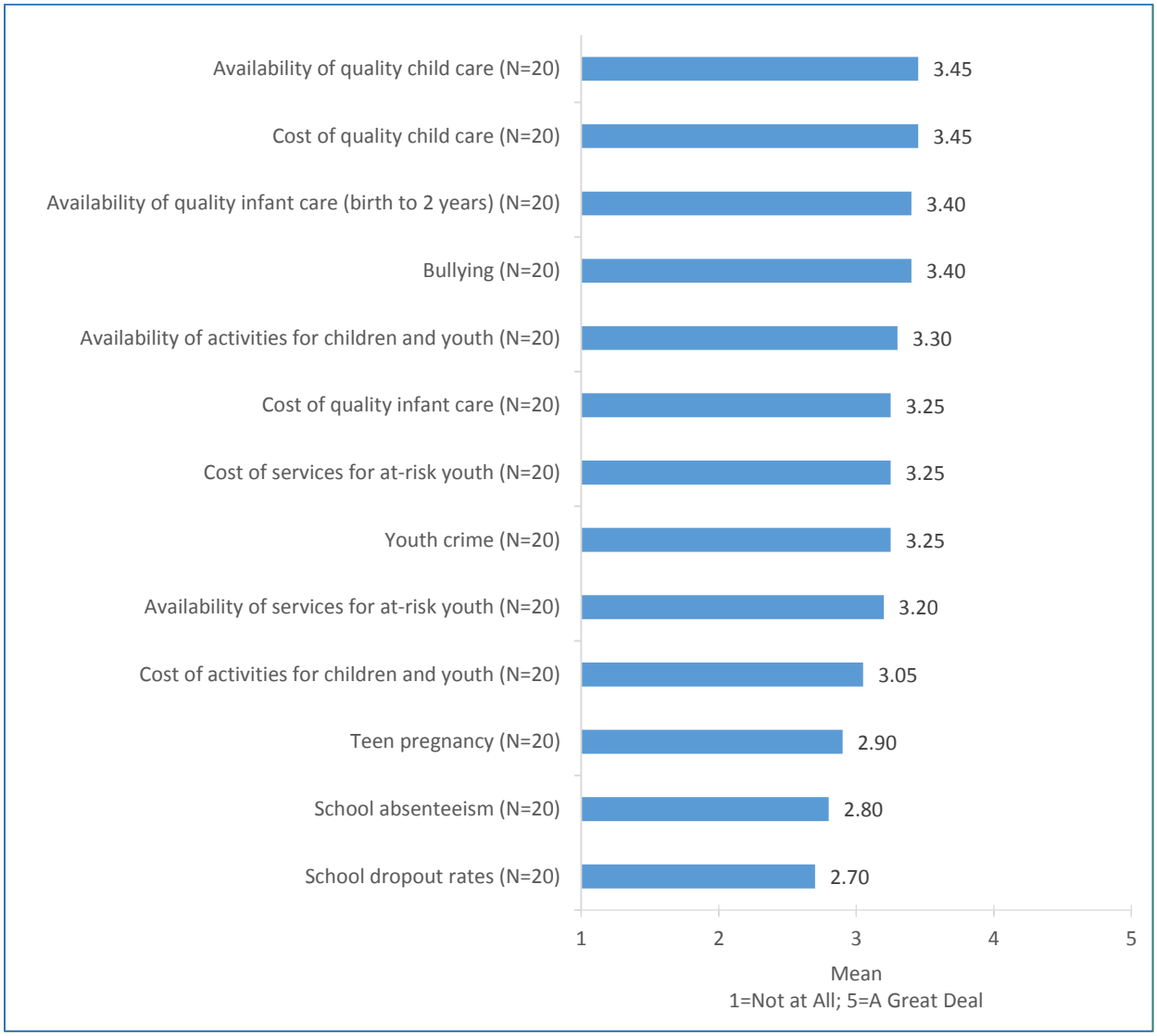


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

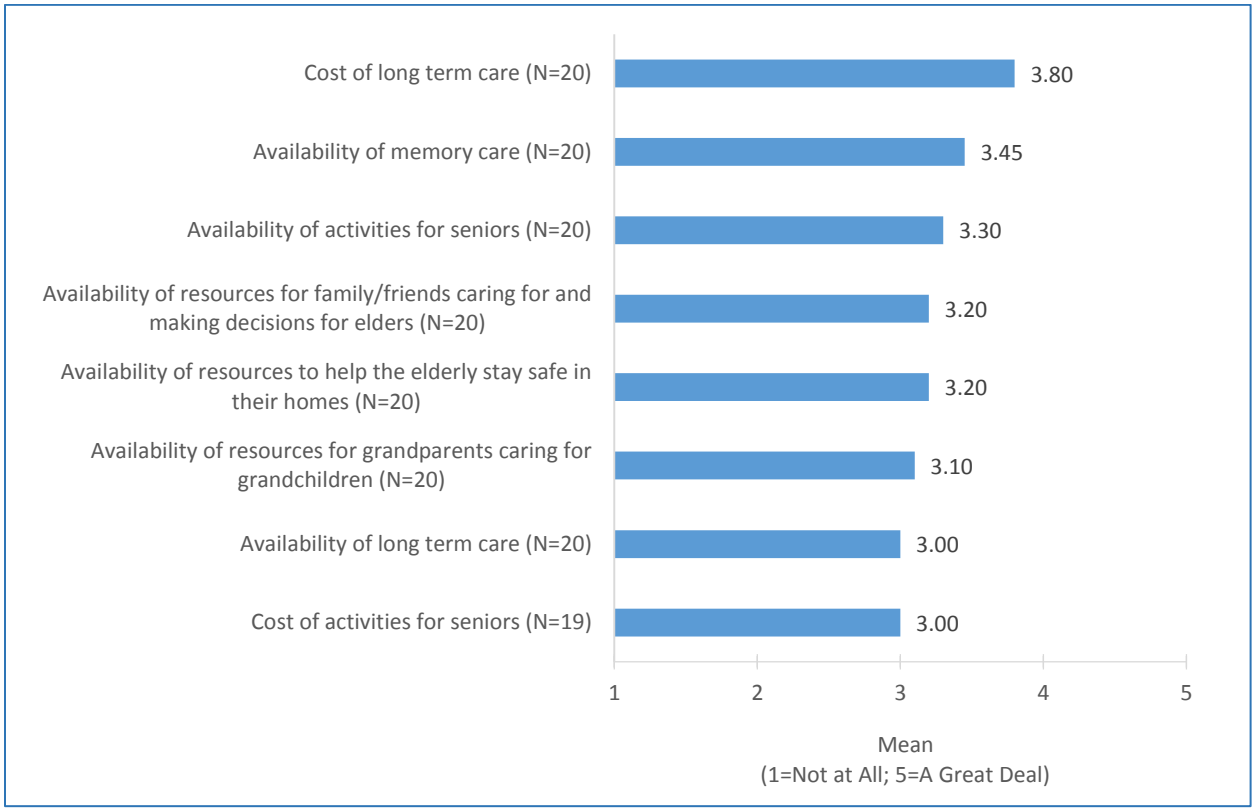


Figure 6. Level of concern with statements about the community regarding SAFETY

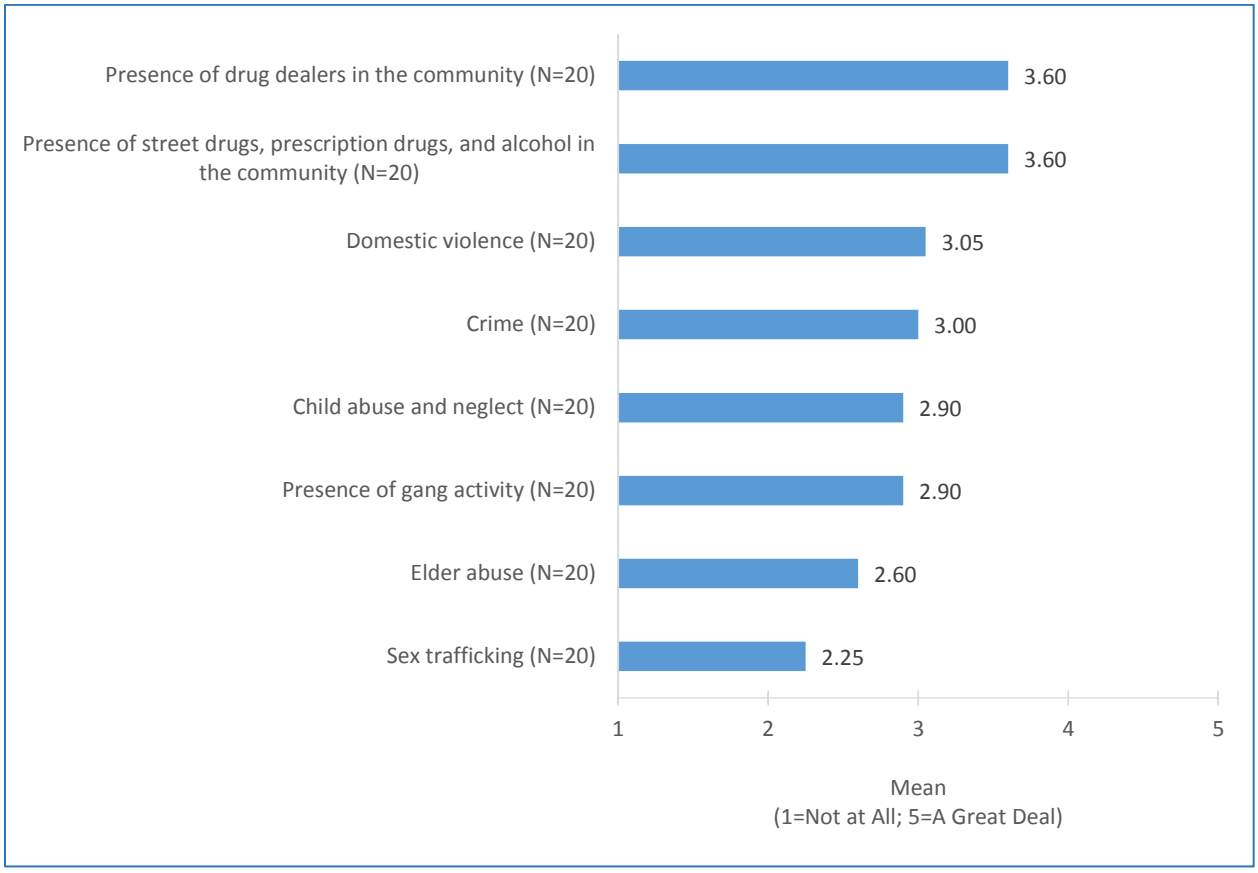


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

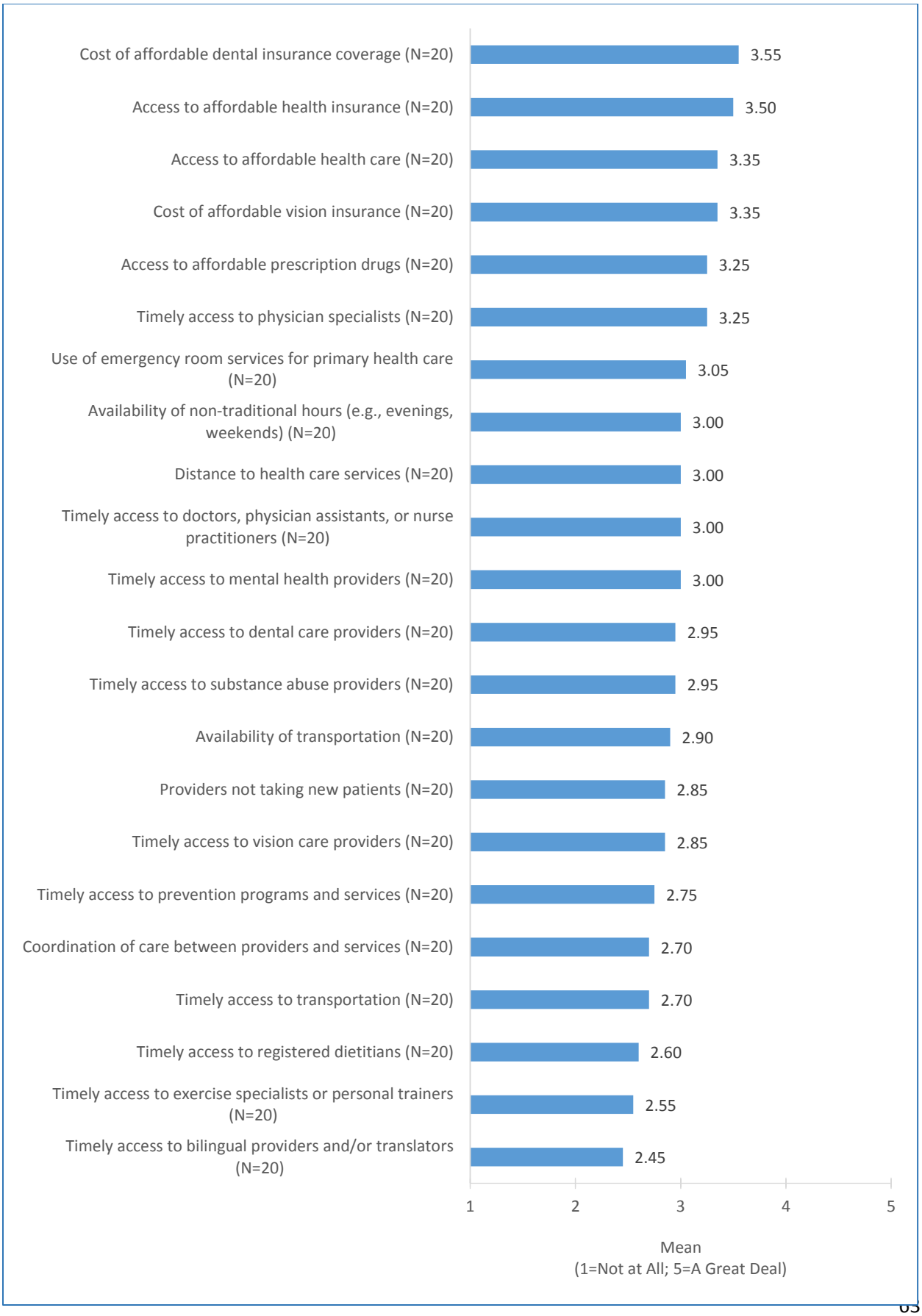

Cost of affordable dental insurance coverage (N=20)
3.55
Access to affordable health insurance (N=20)
3.50
Access to affordable health care (N=20)
3.35
Cost of affordable vision insurance (N=20)
3.35
Access to affordable prescription drugs (N=20)
3.25
Timely access to physician specialists (N=20)
3.25
Use of emergency room services for primary health care (N=20)
3.05
Availability of non-traditional hours (e.g., evenings, weekends) (N=20)
3.00
Distance to health care services (N=20)
3.00
Timely access to doctors, physician assistants, or nurse practitioners (N=20)
3.00
Timely access to mental health providers (N=20)
3.00
Timely access to dental care providers (N=20)
2.95
Timely access to substance abuse providers (N=20)
2.95
Availability of transportation (N=20)
2.90
Providers not taking new patients (N=20)
2.85
Timely access to vision care providers (N=20)
2.85
Timely access to prevention programs and services (N=20)
2.75
Coordination of care between providers and services (N=20)
2.70
Timely access to transportation (N=20)
2.70
Timely access to registered dietitians (N=20)
2.60
Timely access to exercise specialists or personal trainers (N=20)
2.55
Timely access to bilingual providers and/or translators (N=20)
2.45
1
2
3
4
5
Mean
(1=Not at All; 5=A Great Deal)

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

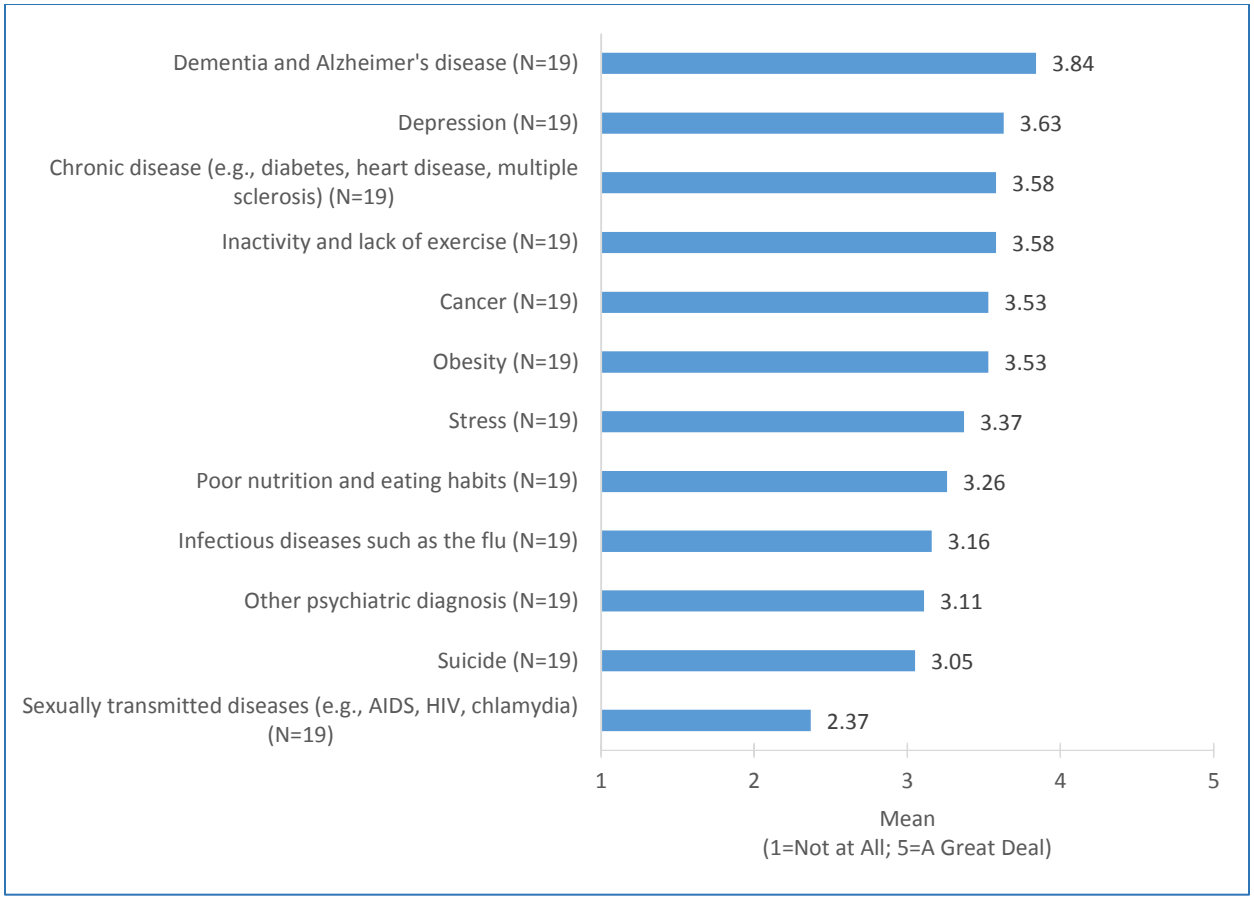
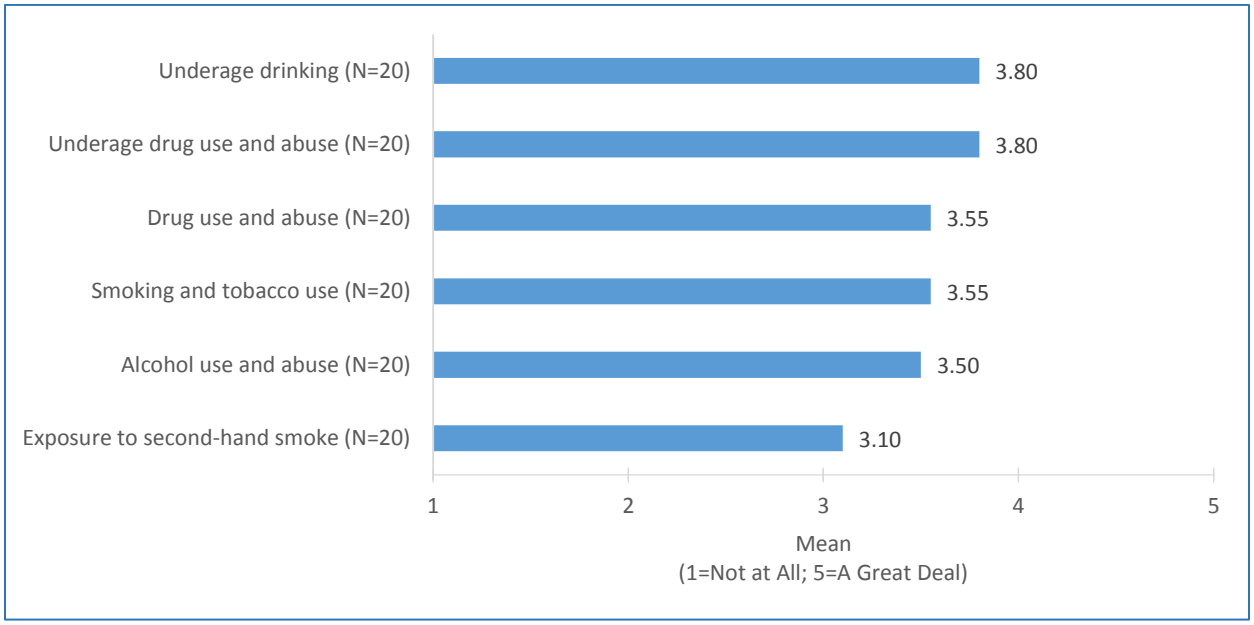
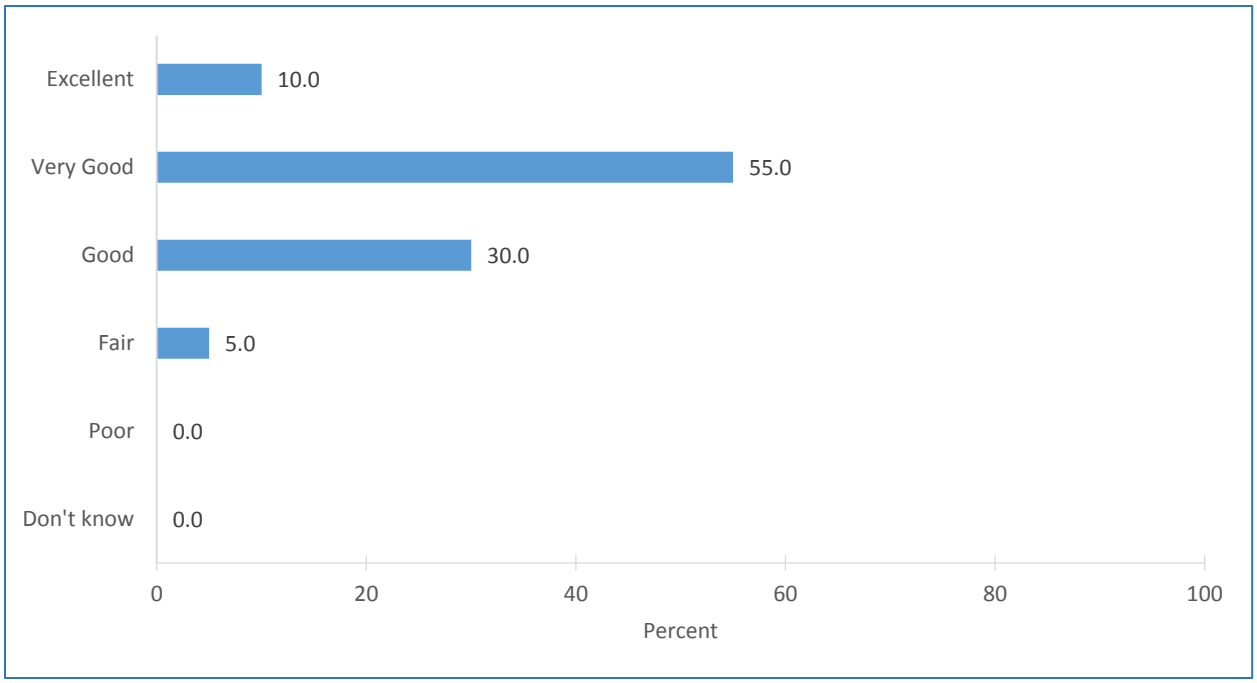


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



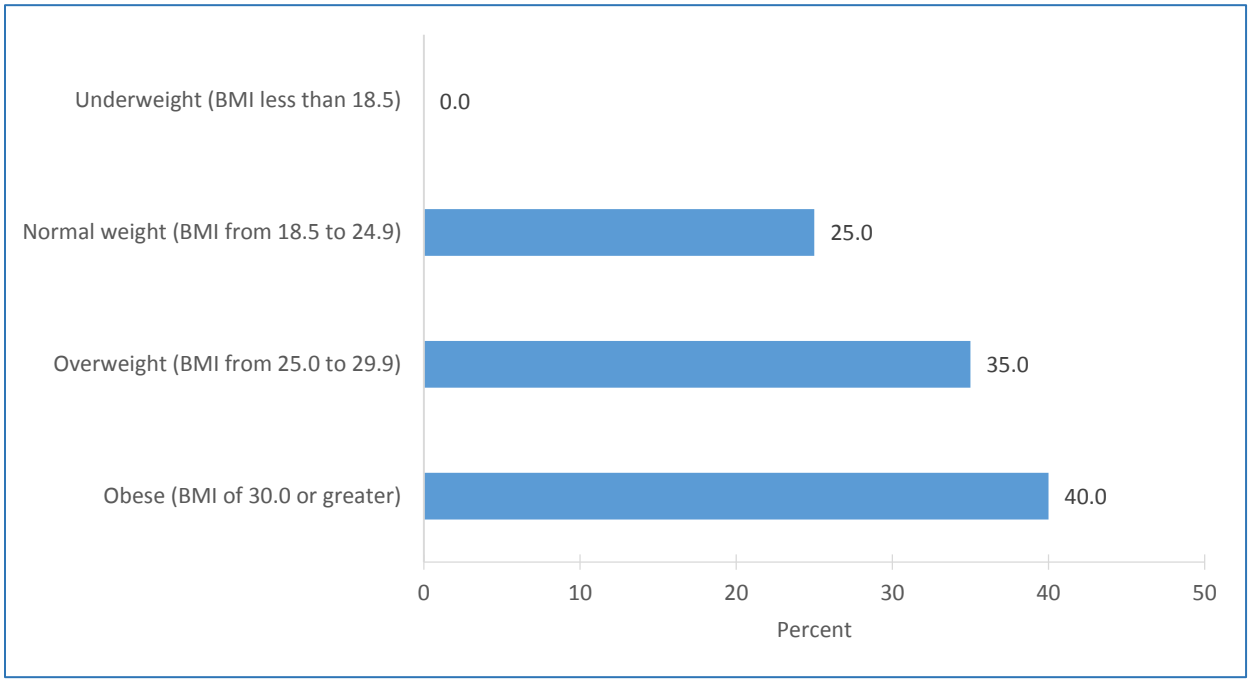
General Health

Figure 10. Respondents' rating of their health in general



N=20

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



N=20

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

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

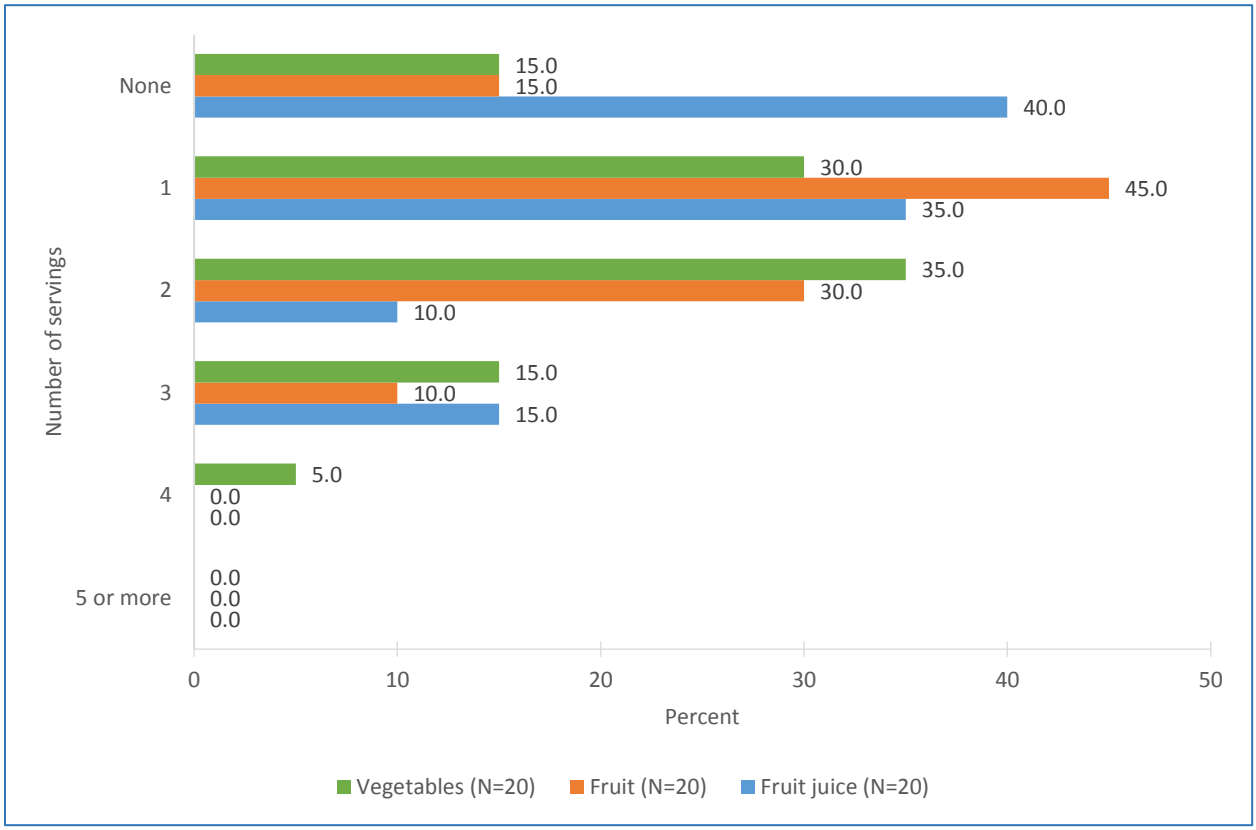
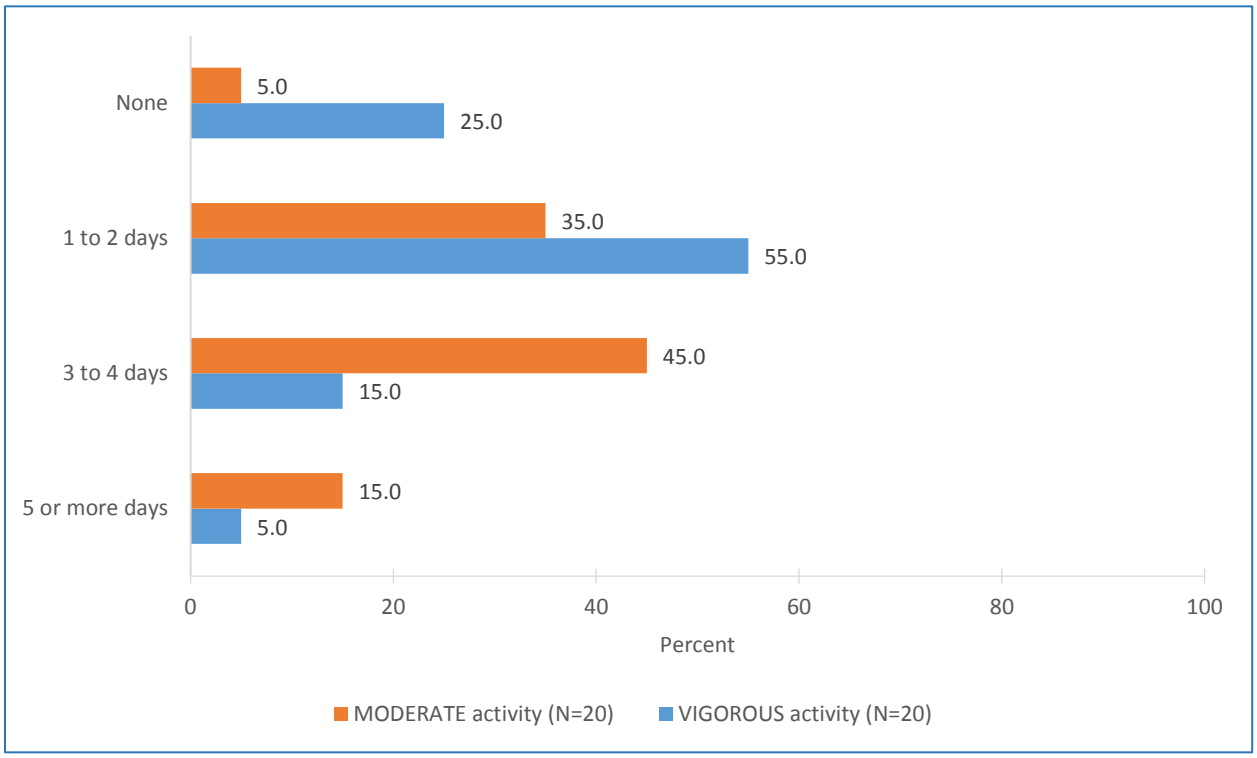
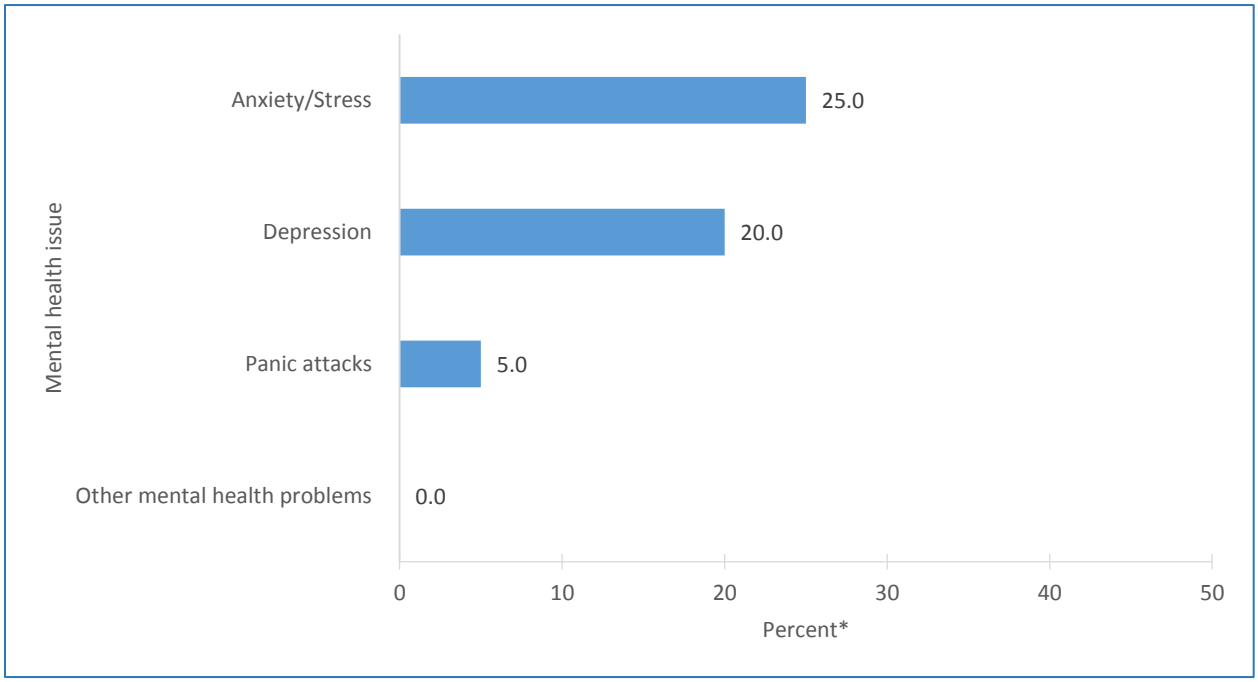


Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



Mental Health

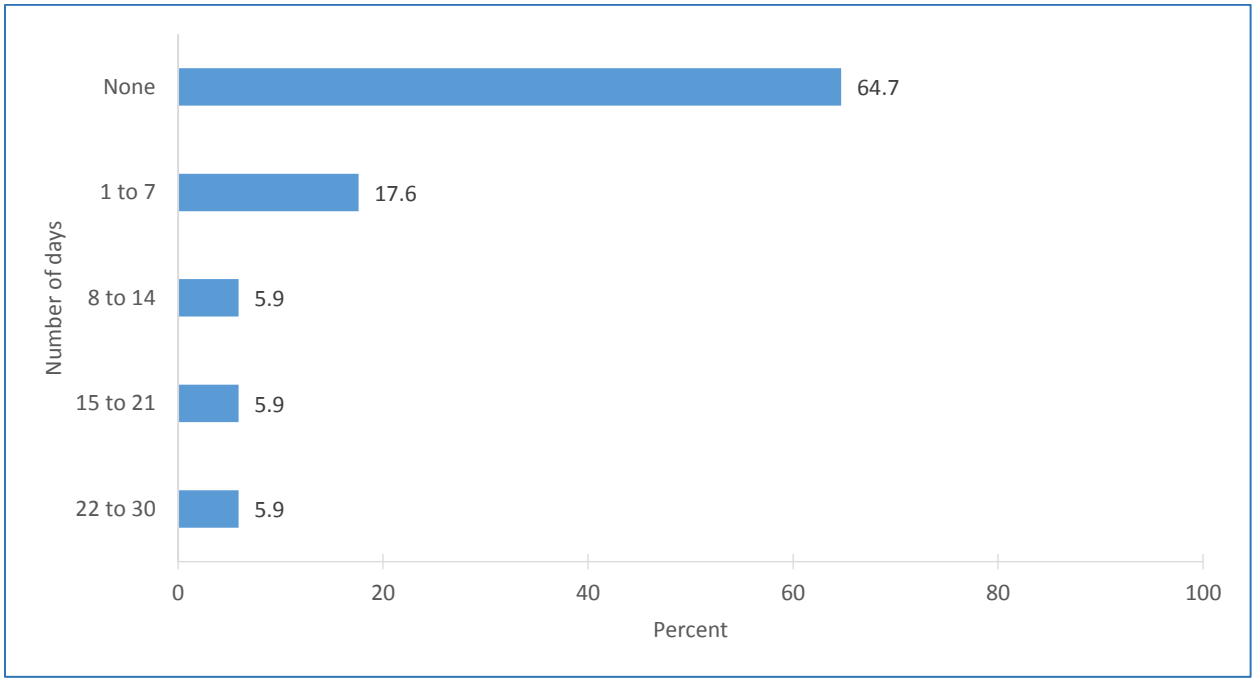
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=20

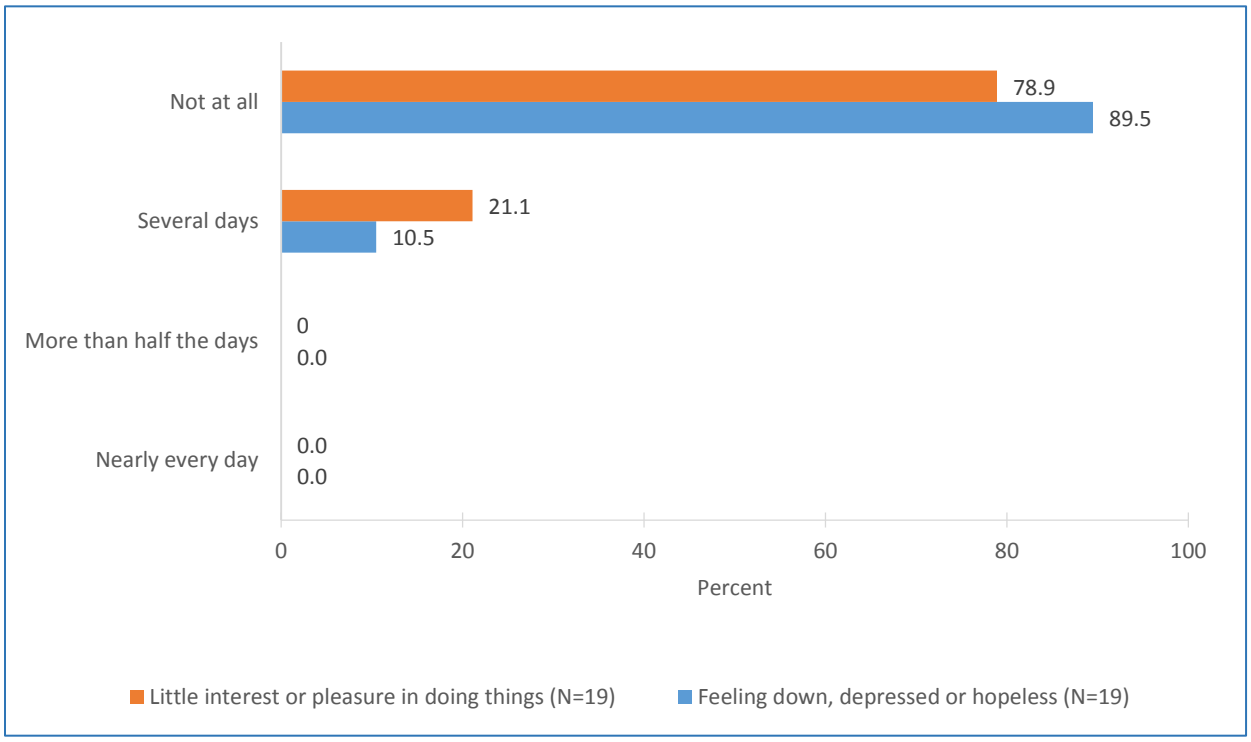
*Percentages do not total 100.0 due to multiple responses.

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



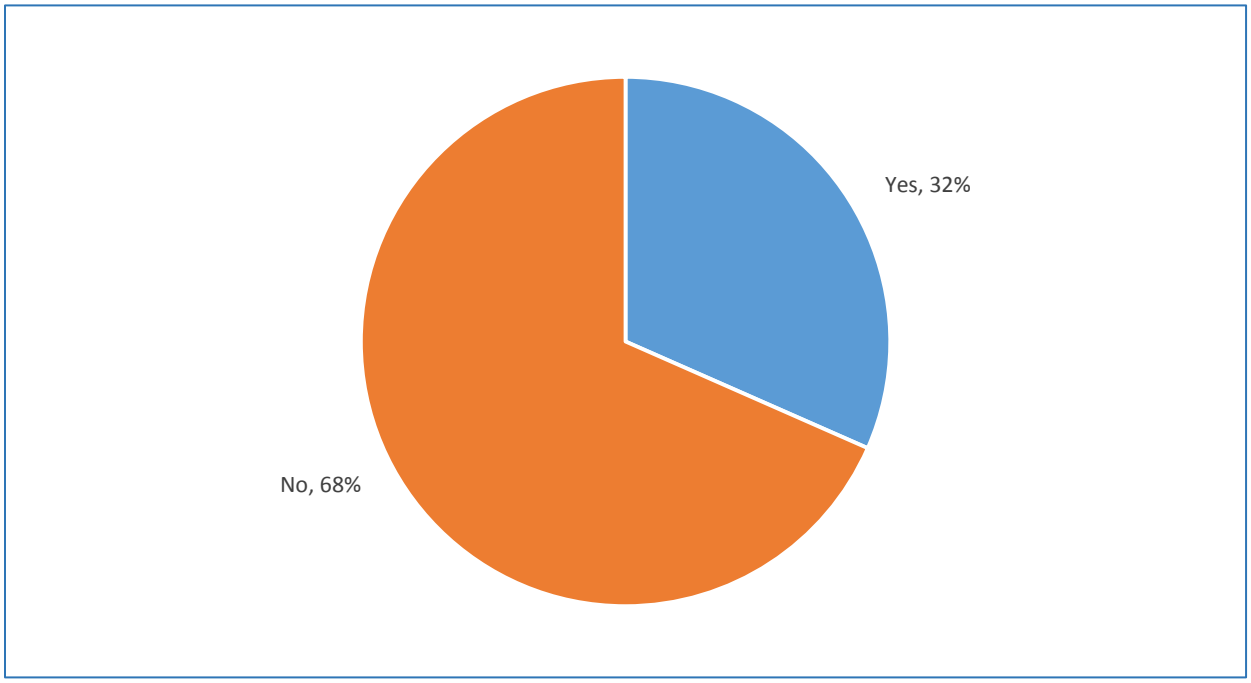
N=17

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



Tobacco Use

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



N=19

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

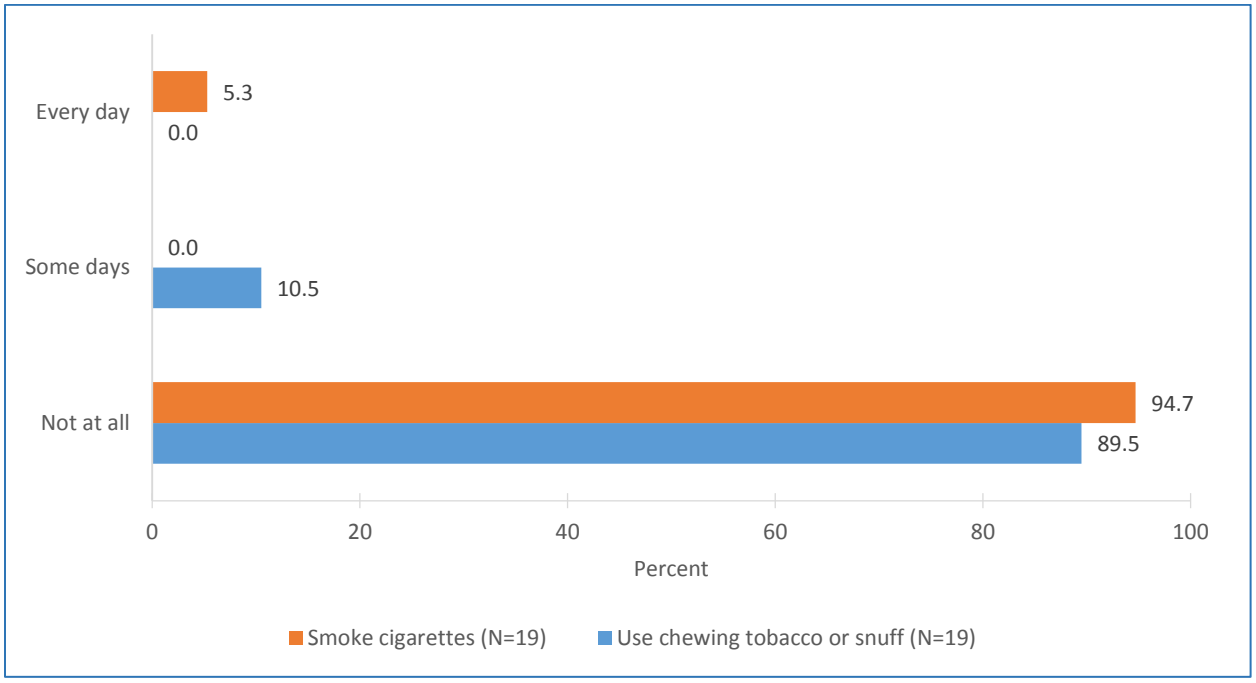
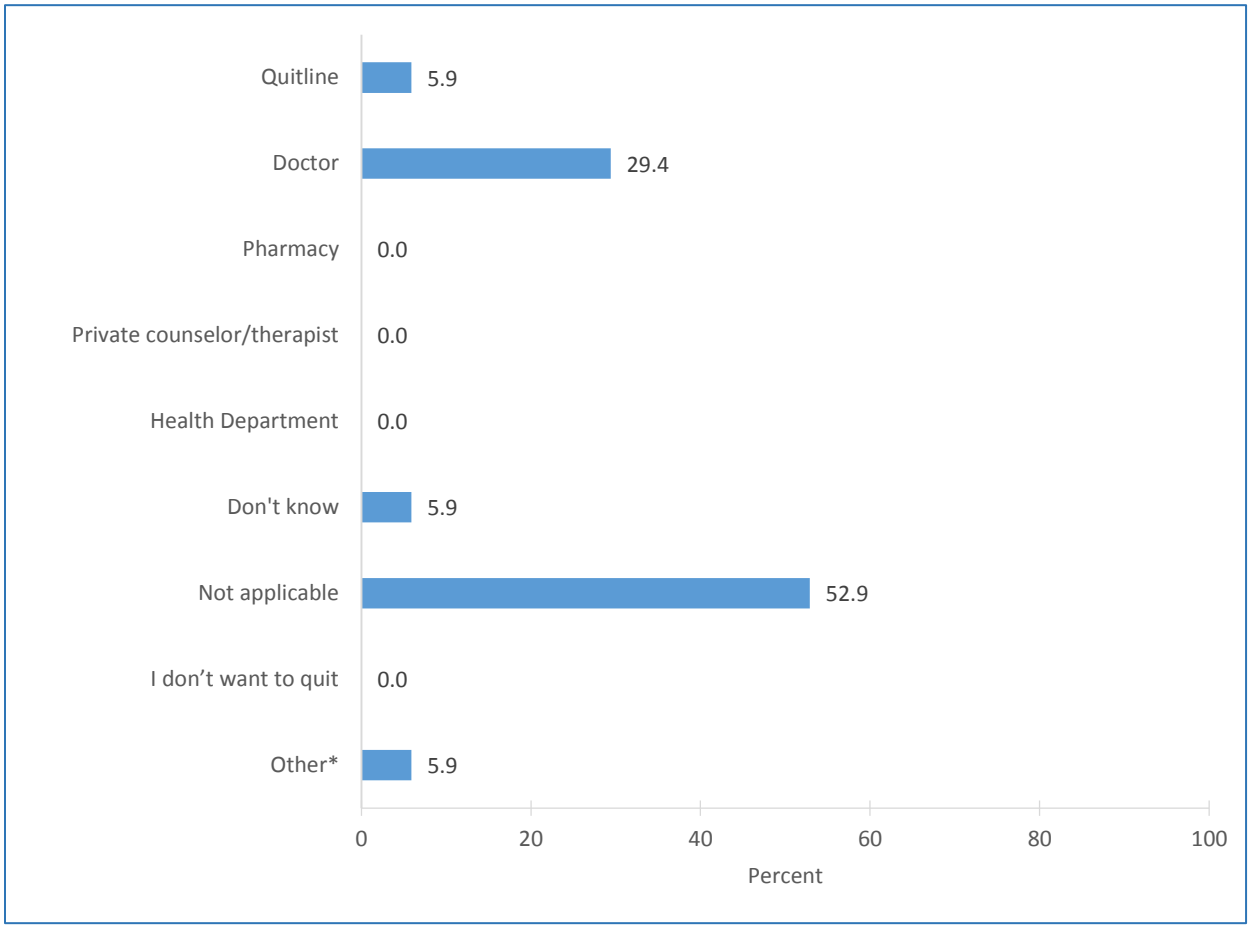


Figure 19. Location respondents would first go if they wanted help to quit using tobacco

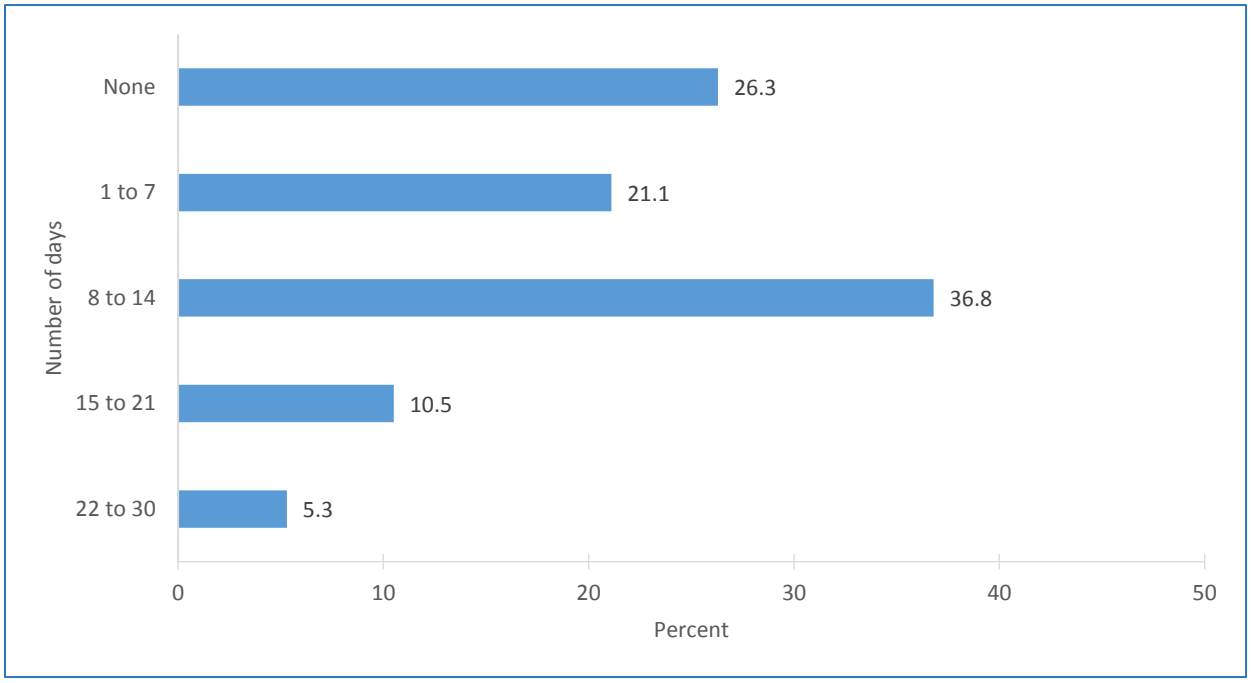


N=17

*Other response is “Department store for nicotine gum”.

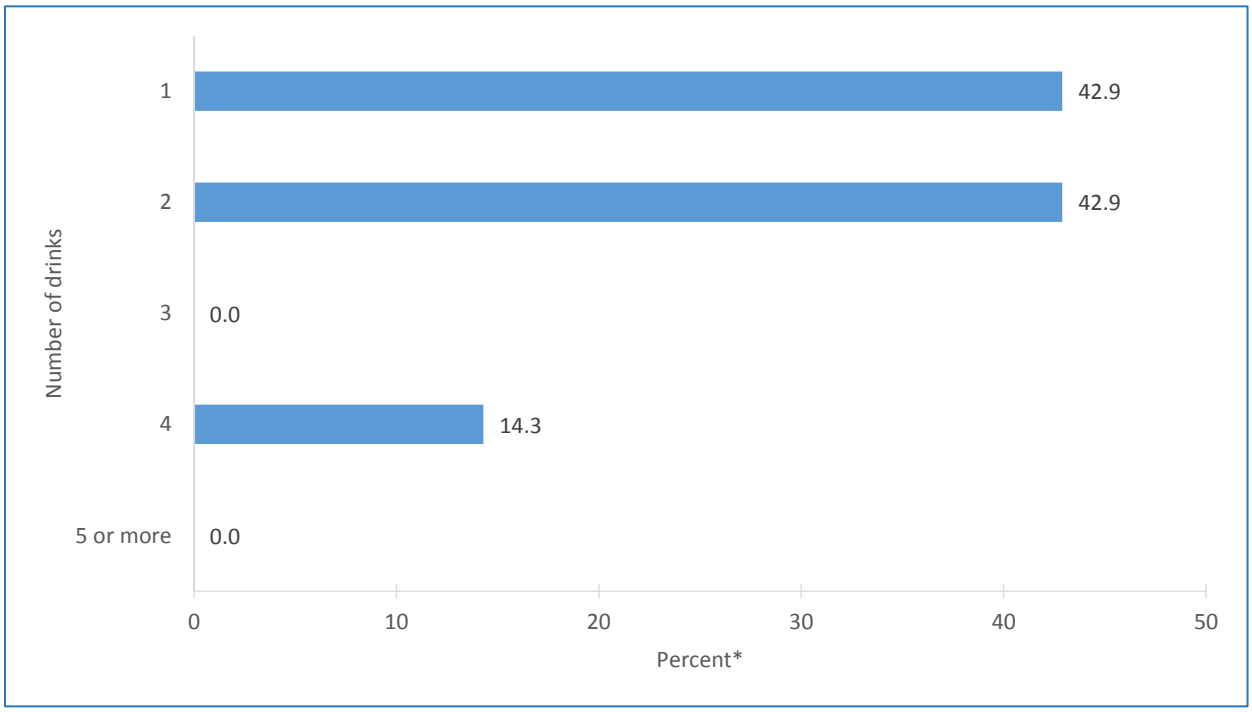
Alcohol Use and Prescription Drug/Non-Prescription Drug Abuse

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



N=19

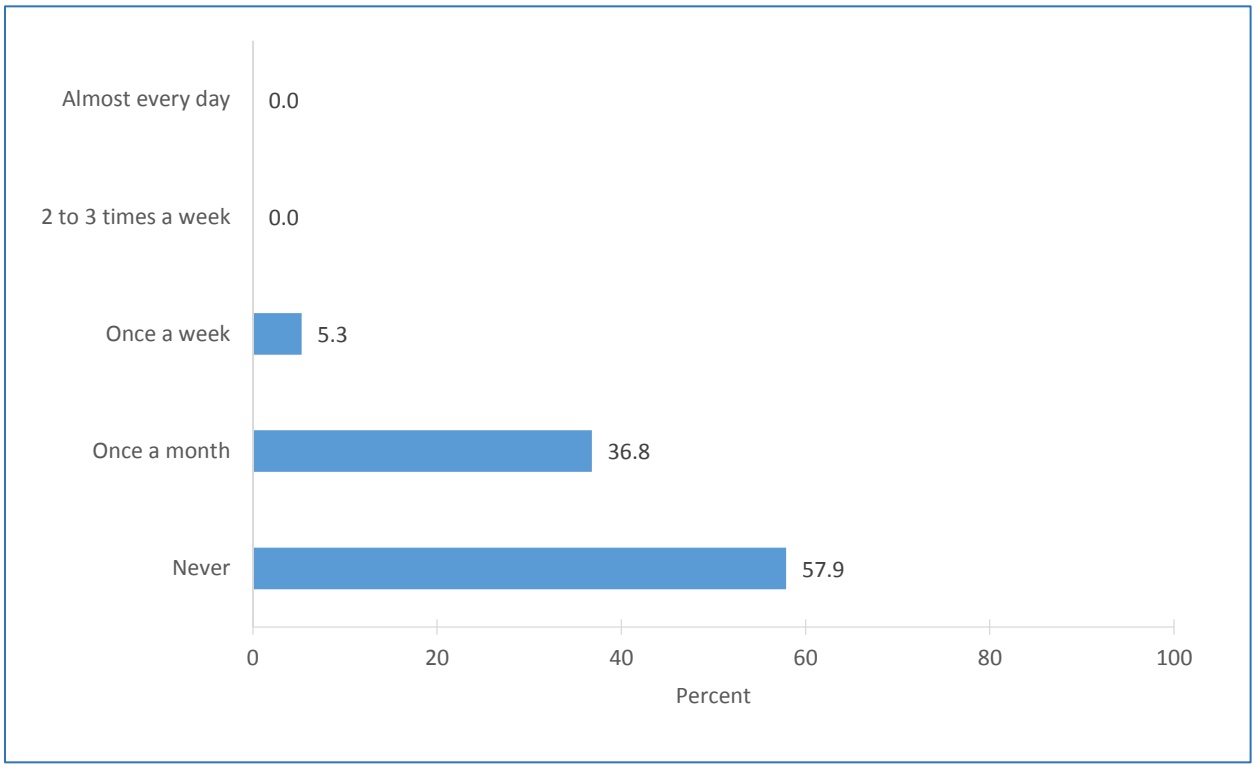
Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=14

*Percentages do not total 100.0 due to rounding.

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



N=19

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

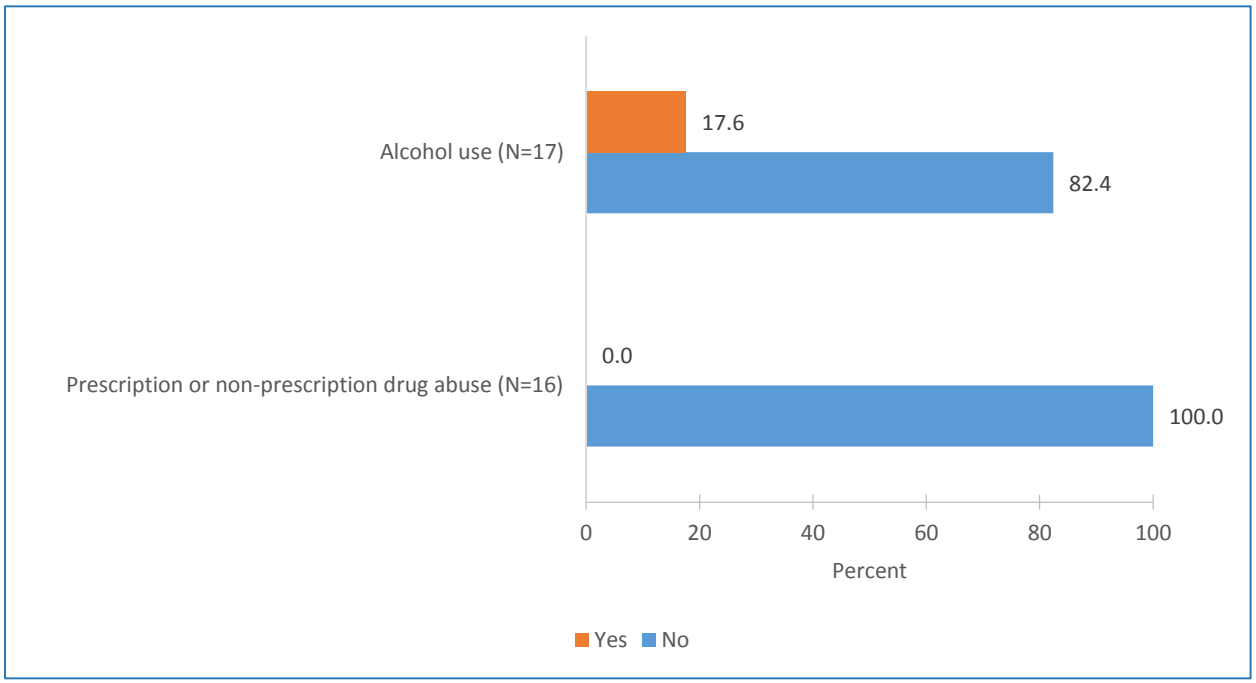


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

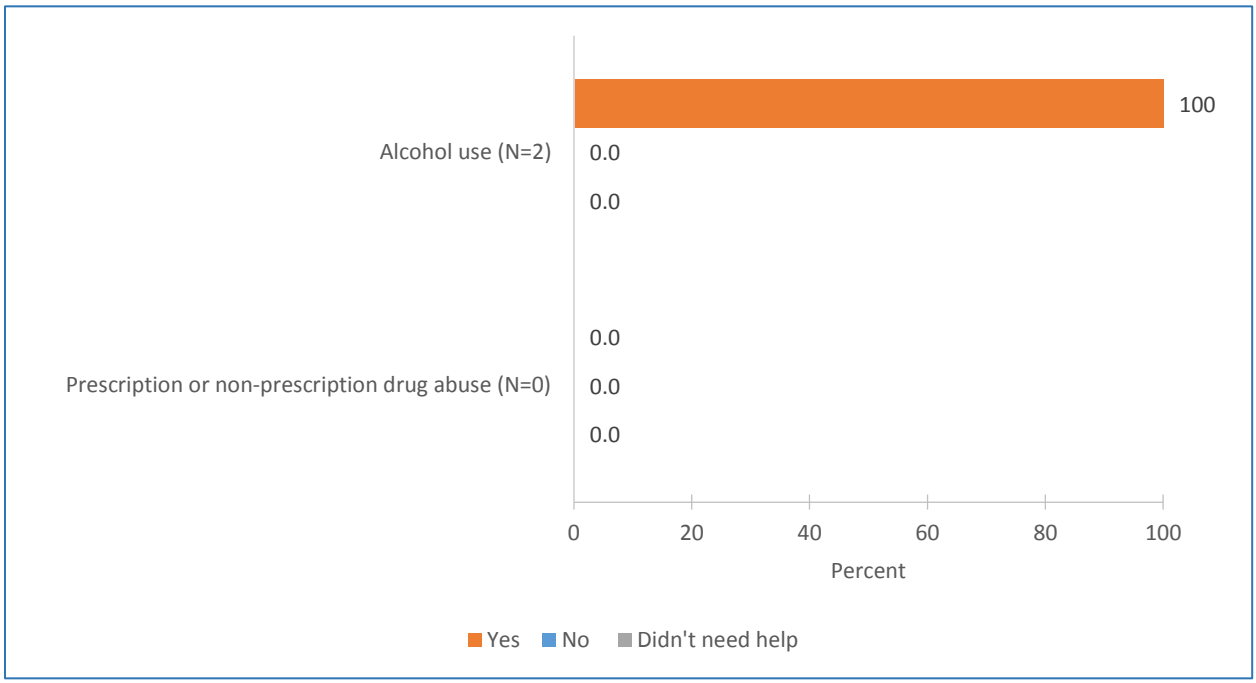
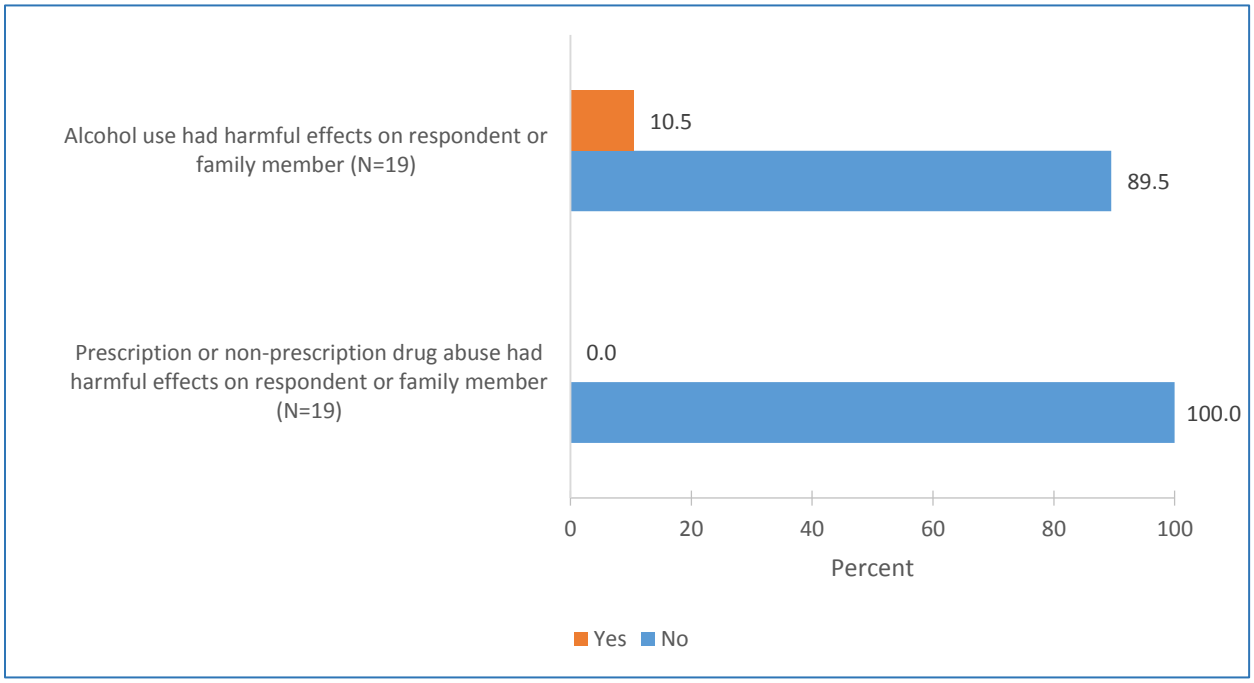


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=19)	89.5	10.5	100.0
Blood sugar screening (N=19)	68.4	31.6	100.0
Bone density test (N=18)	11.1	88.9	100.0
Cardiovascular screening (N=19)	36.8	63.2	100.0
Cholesterol screening (N=19)	68.4	31.6	100.0
Dental screening and X-rays (N=18)	94.4	5.6	100.0
Flu shot (N=19)	78.9	21.1	100.0
Glaucoma test (N=18)	44.4	55.6	100.0
Hearing screening (N=19)	15.8	84.2	100.0
Immunizations (N=18)	38.9	61.1	100.0
Pelvic exam (N=11 Females)	72.7	27.3	100.0
STD (N=18)	16.7	83.3	100.0
Vascular screening (N=18)	5.6	94.4	100.0
CANCER SCREENINGS			
Breast cancer screening (N=12 Females)	75.0	25.0	100.0
Cervical cancer screening (N=12 Females)	75.0	25.0	100.0
Colorectal cancer screening (N=19)	31.6	68.4	100.0
Prostate cancer screening (N=7 Males)	28.6	71.4	100.0
Skin cancer screening (N=18)	27.8	72.2	100.0

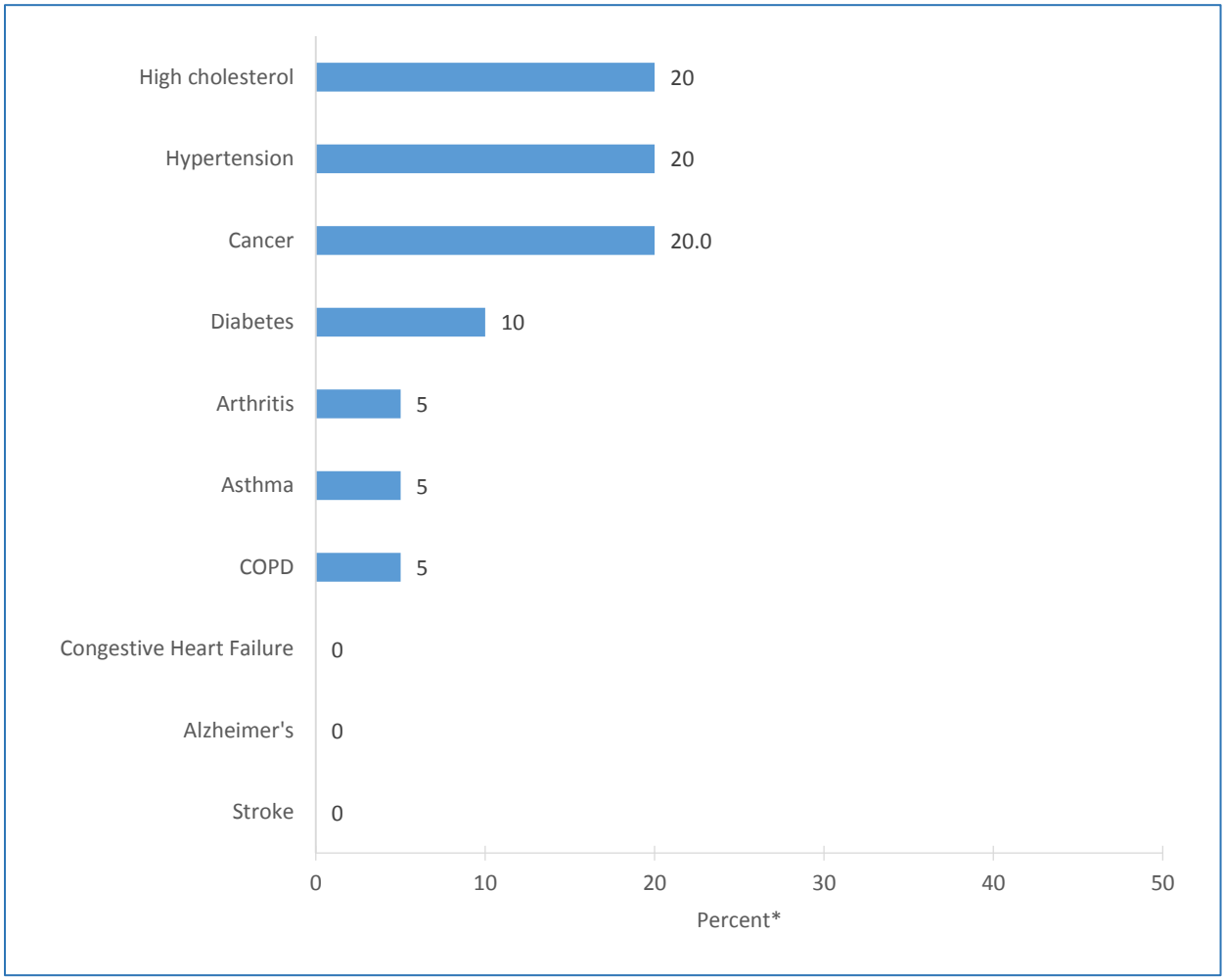
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=2)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Blood sugar screening (N=6)	33.3	50.0	16.7	0.0	0.0	0.0	0.0
Bone density test (N=16)	31.3	56.3	0.0	0.0	6.3	0.0	6.3
Cardiovascular screening (N=12)	41.7	50.0	0.0	0.0	0.0	0.0	8.3
Cholesterol screening (N=6)	50.0	50.0	16.7	0.0	0.0	0.0	0.0

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Dental screening and X-rays (N=1)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Flu shot (N=4)	25.0	0.0	0.0	0.0	0.0	0.0	50.0
Glaucoma test (N=10)	20.0	50.0	0.0	0.0	0.0	0.0	0.0
Hearing screening (N=16)	31.3	43.8	0.0	0.0	0.0	0.0	6.3
Immunizations (N=11)	63.6	27.3	0.0	0.0	0.0	0.0	0.0
Pelvic exam (N=3 Females)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
STD (N=15)	53.3	20.0	0.0	0.0	0.0	0.0	6.7
Vascular screening (N=17)	41.2	41.2	0.0	0.0	0.0	0.0	5.9
CANCER SCREENINGS							
Breast cancer screening (N=3 Females)	33.3	33.3	0.0	0.0	0.0	33.3	0.0
Cervical cancer screening (N=3 Females)	66.7	0.0	0.0	0.0	0.0	33.3	0.0
Colorectal cancer screening (N=13)	46.2	23.1	0.0	0.0	0.0	0.0	0.0
Prostate cancer screening (N=5 Males)	20.0	60.0	0.0	0.0	0.0	0.0	0.0
Skin cancer screening (N=13)	23.1	69.2	0.0	0.0	0.0	7.7	7.7

*Percentages may not total 100.0 due to multiple responses.

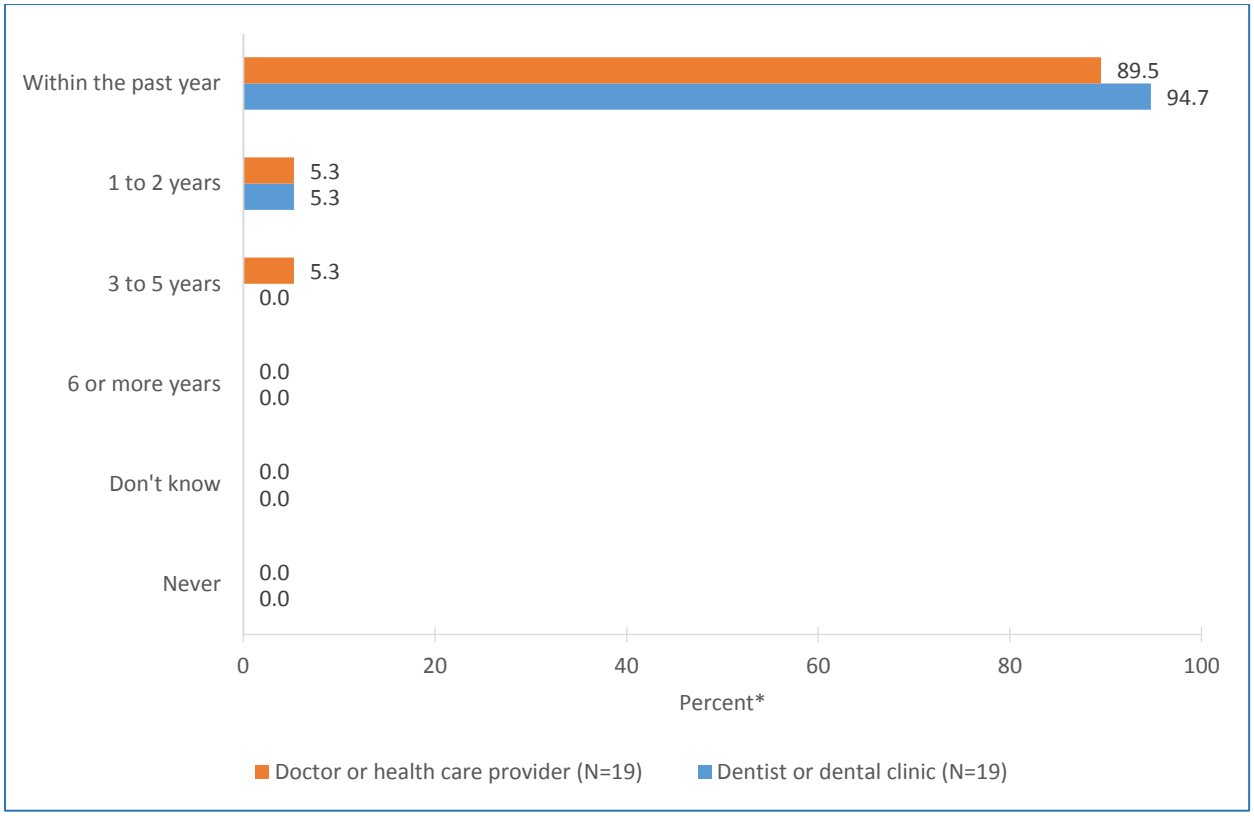
Figure 26. Whether respondents have any of the following chronic diseases



N=20

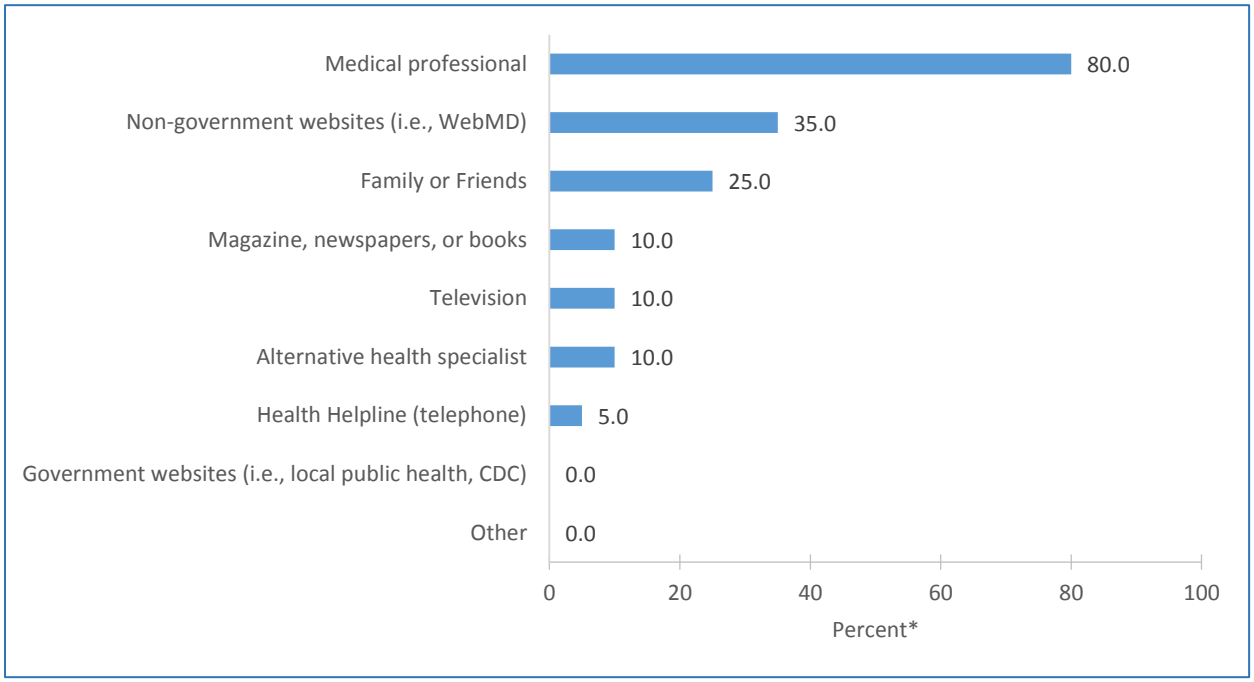
*Percentages do not total 100.0 due to multiple responses.

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



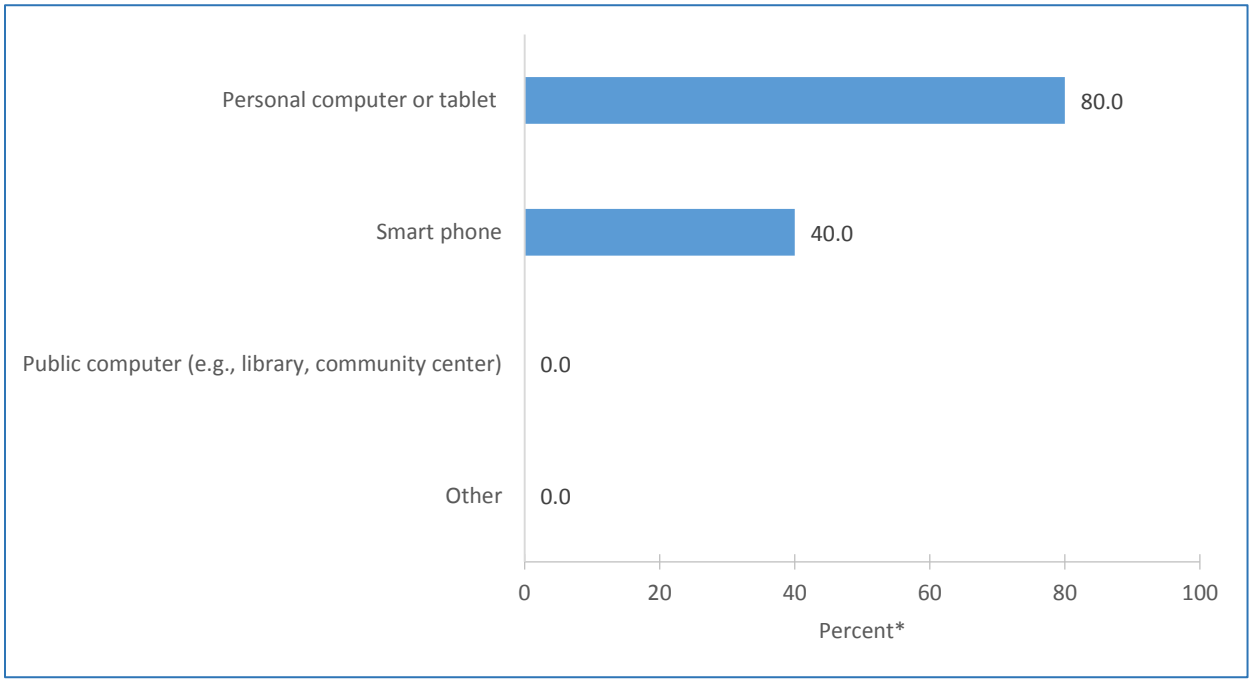
*Percentages may not total 100.0 due to rounding.

Figure 28. Where respondents get most of their health information



N=20 *Percentages do not total 100.0 due to multiple responses.

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

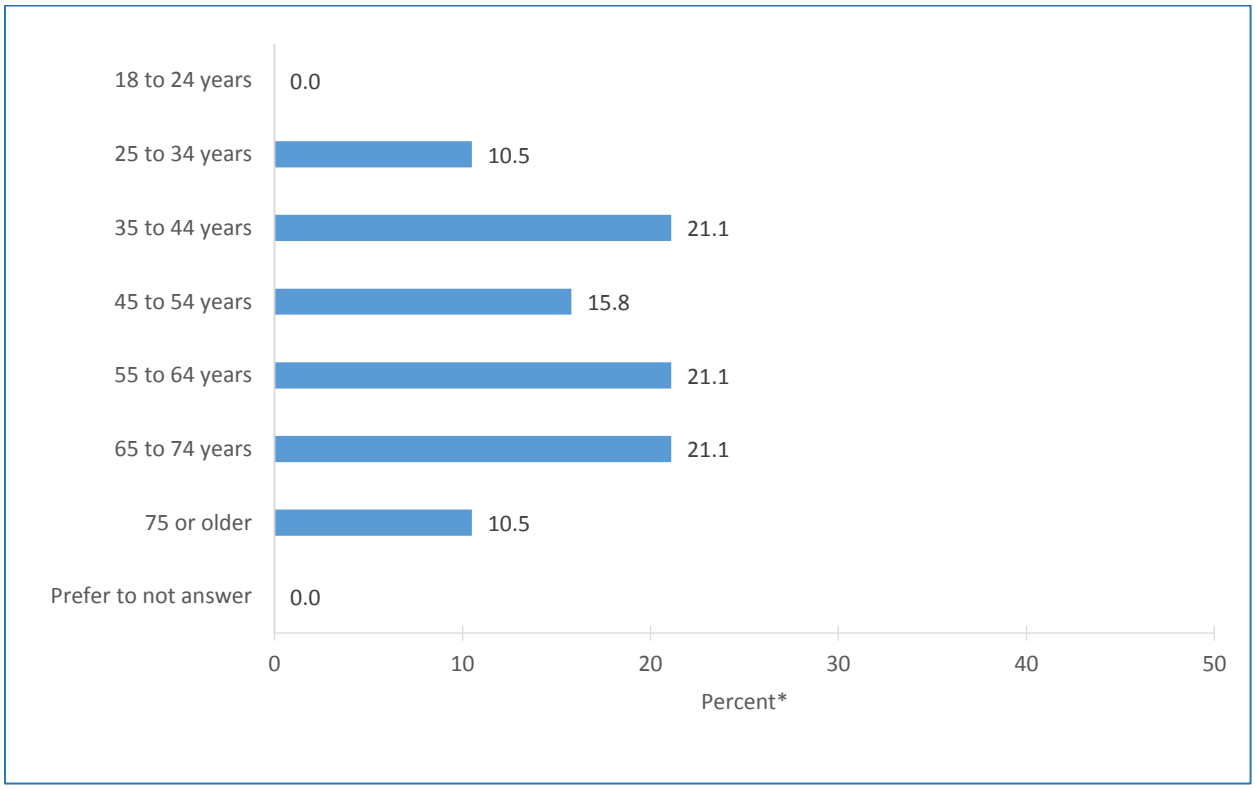


N=20

*Percentages do not total 100.0 due to multiple responses.

Demographic Information

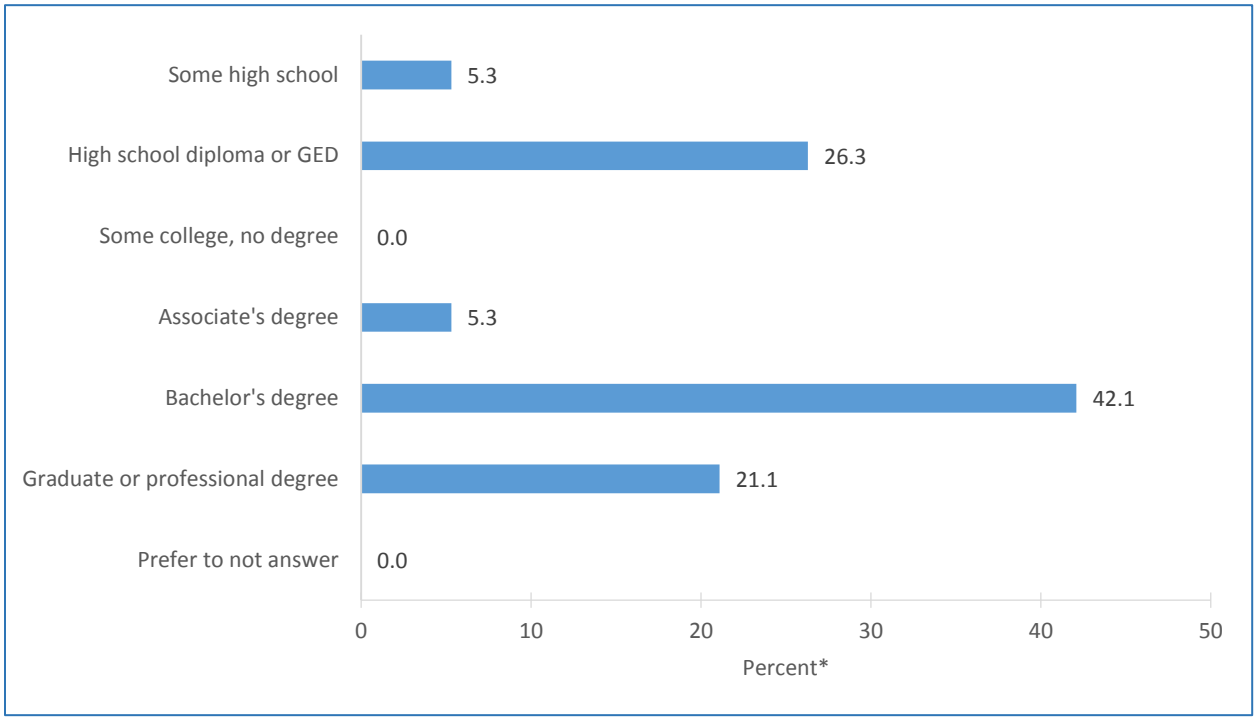
Figure 30. Age of respondents



N=19

*Percentages do not total 100.0 due to rounding.

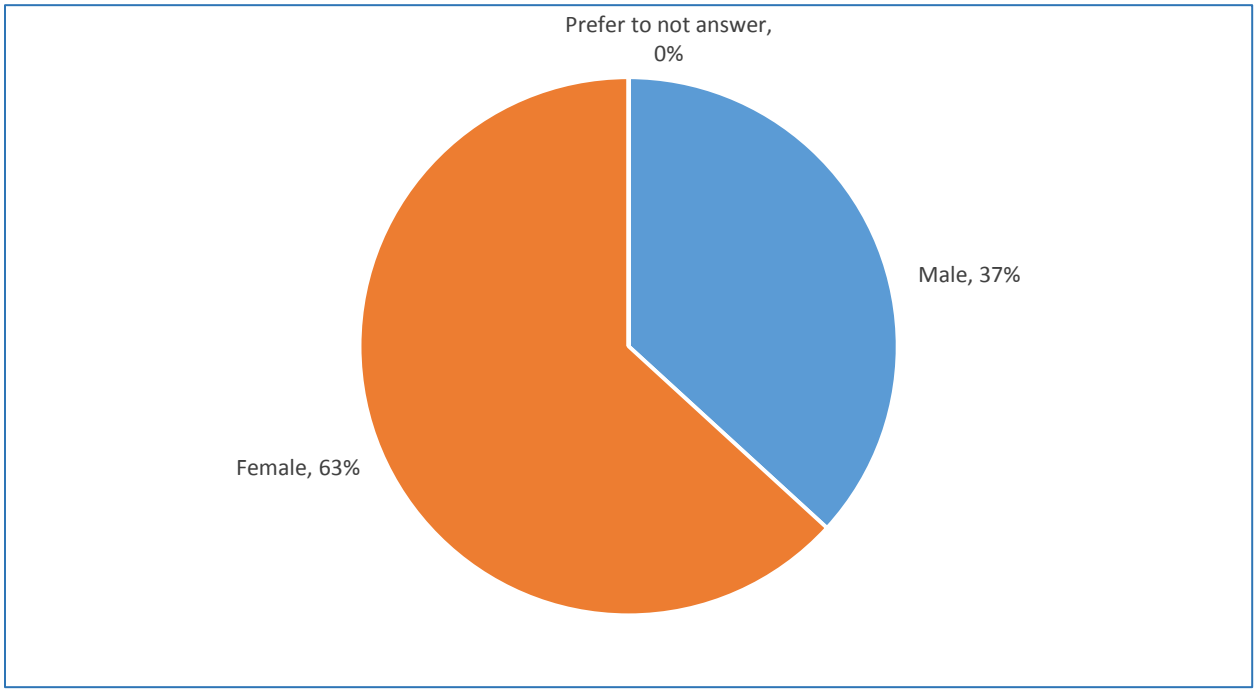
Figure 31. Highest level of education of respondents



N=19

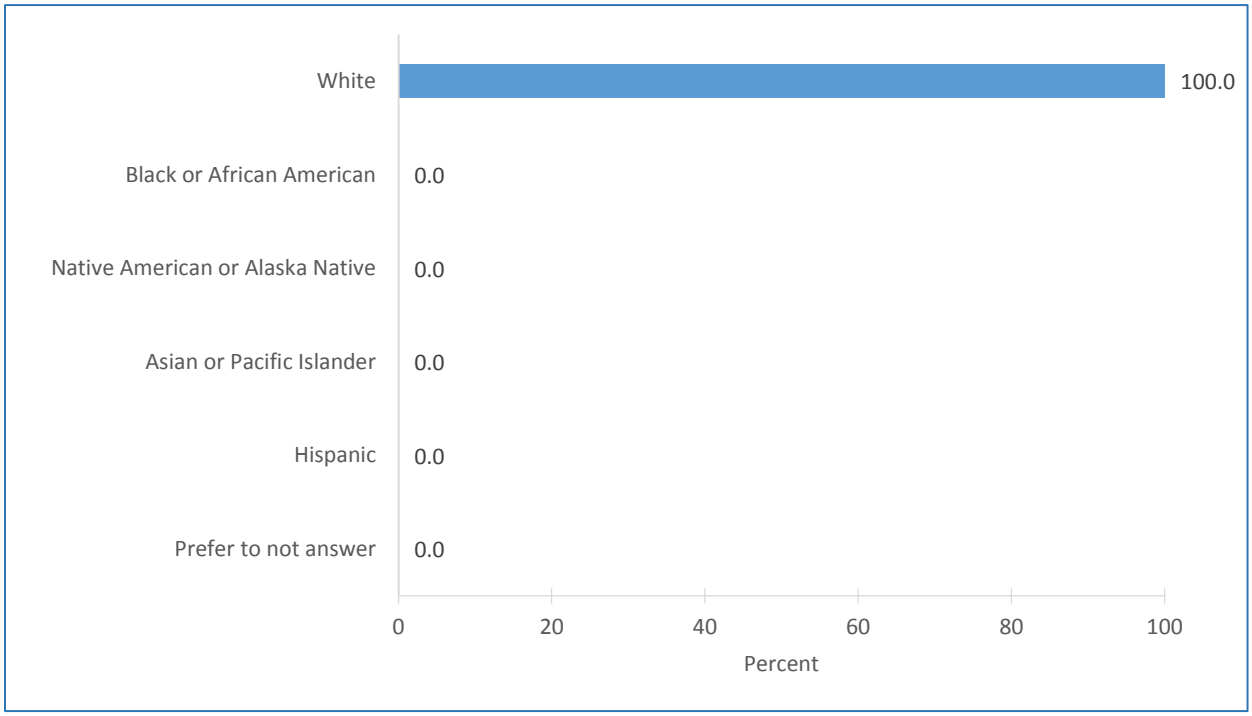
*Percentages do not total 100.0 due to rounding.

Figure 32. Gender of respondents



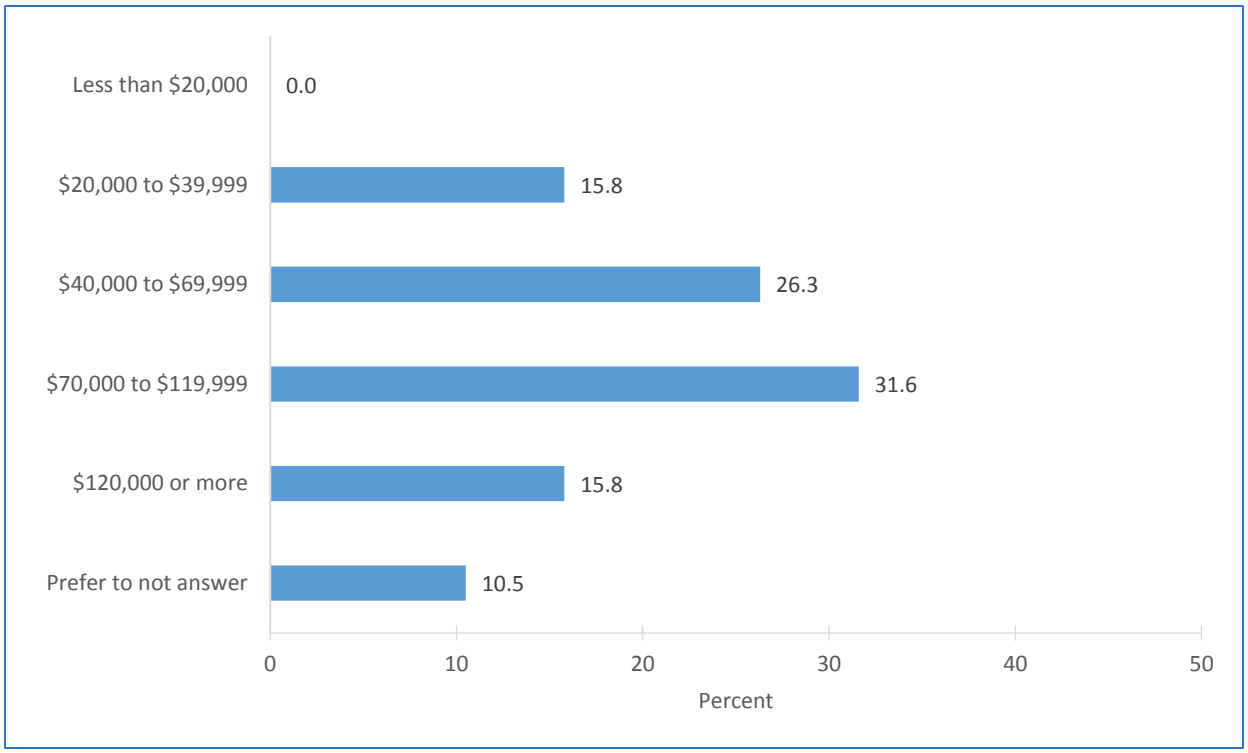
N=19

Figure 33. Race and ethnicity of respondents



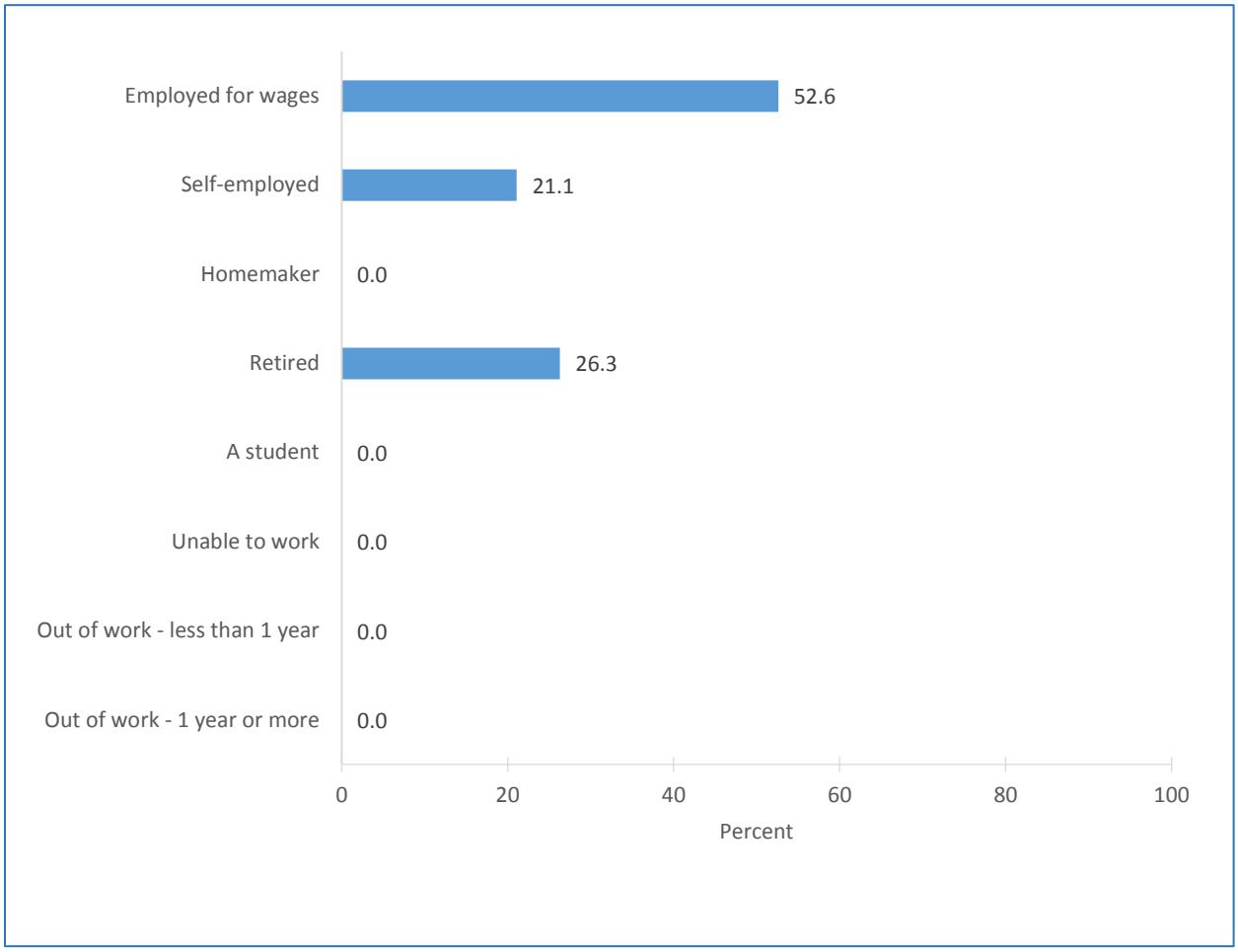
N=19

Figure 34. Annual household income of respondents



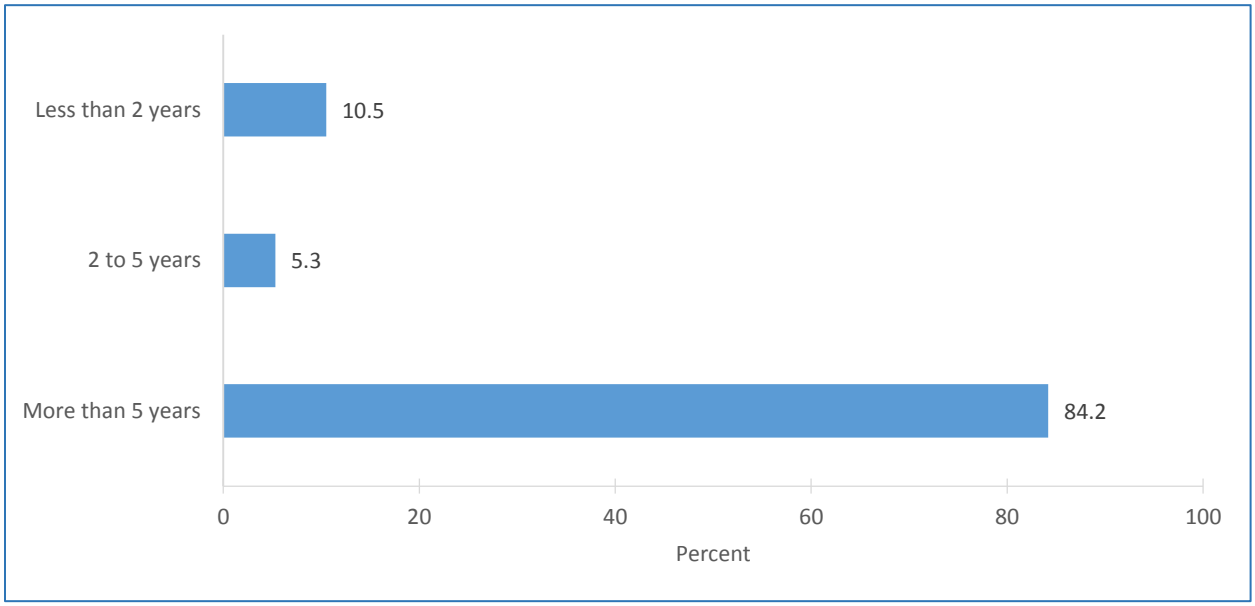
N=19

Figure 35. Employment status of respondents



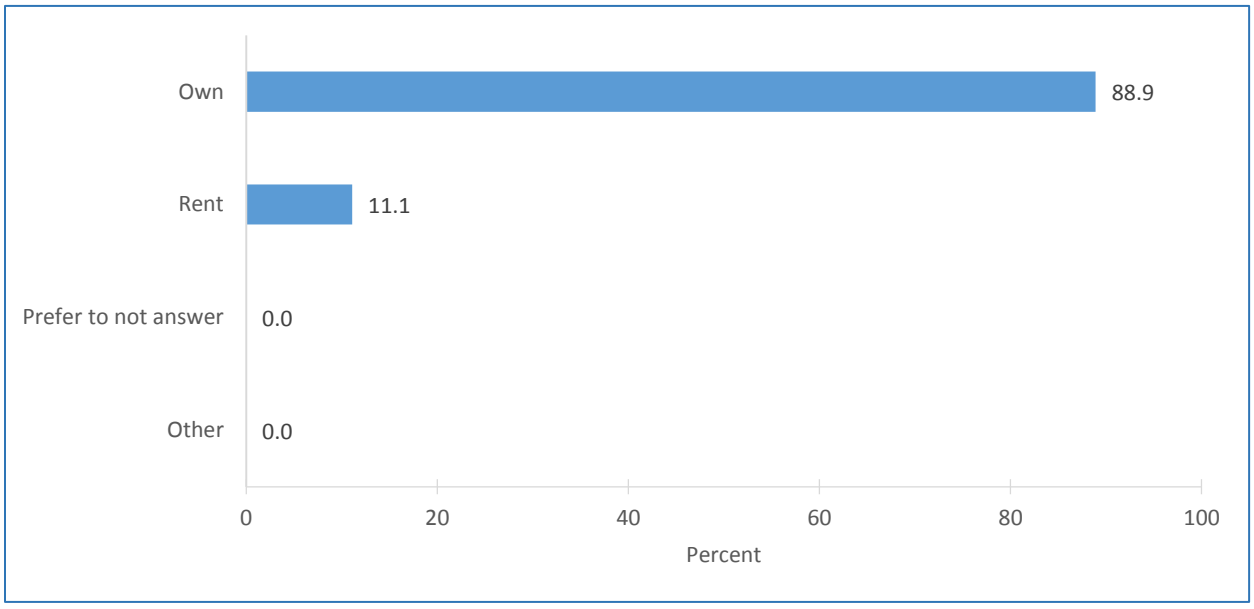
N=19

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



N=19

Figure 37. Whether respondents own or rent their home



N=18

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

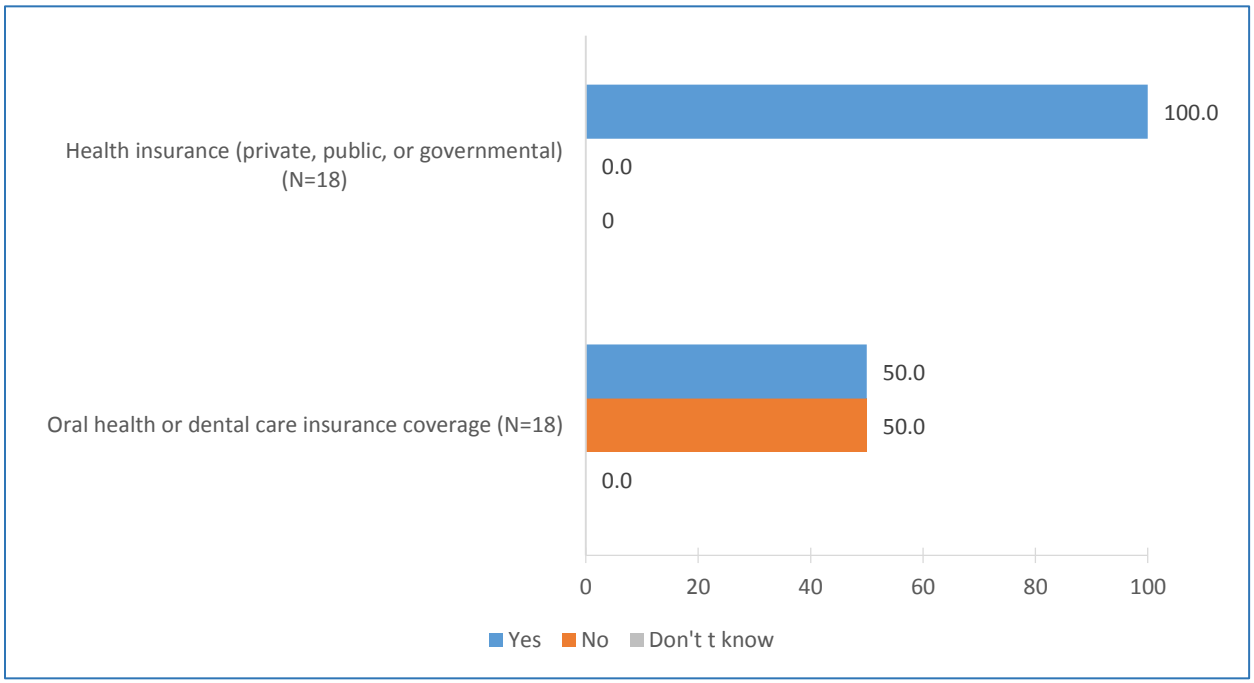
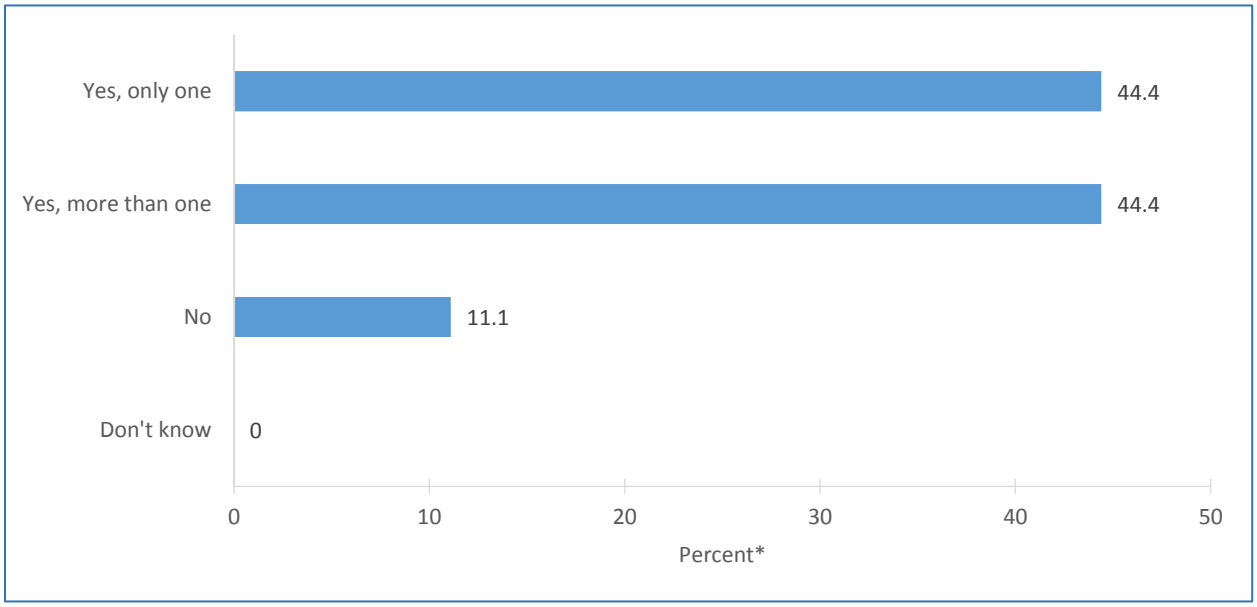
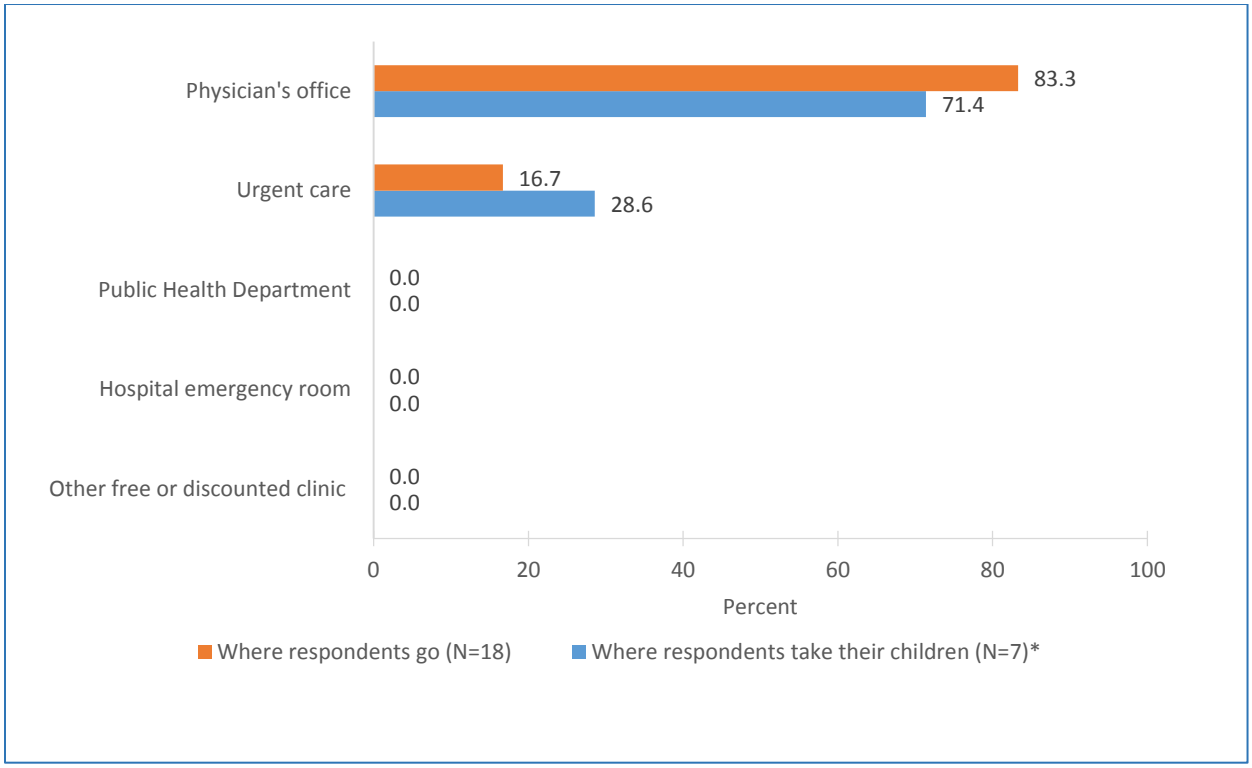


Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=18 *Percentages do not total 100.0 due to rounding.

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



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

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

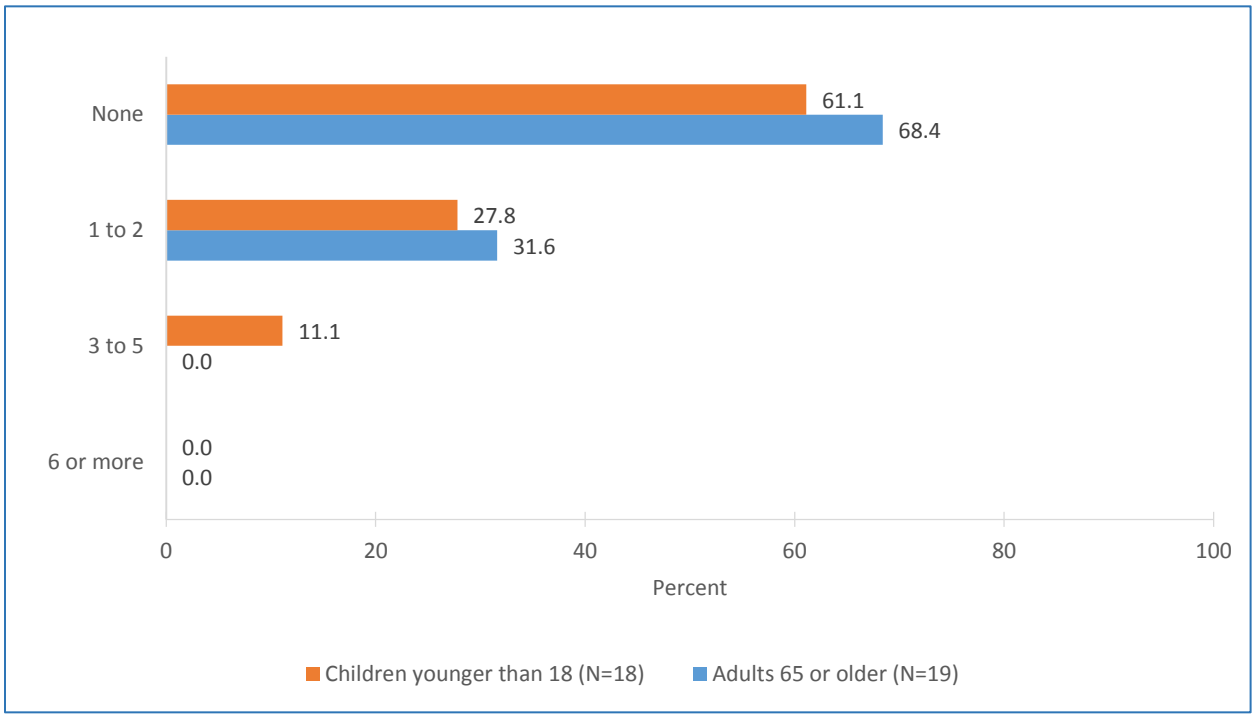
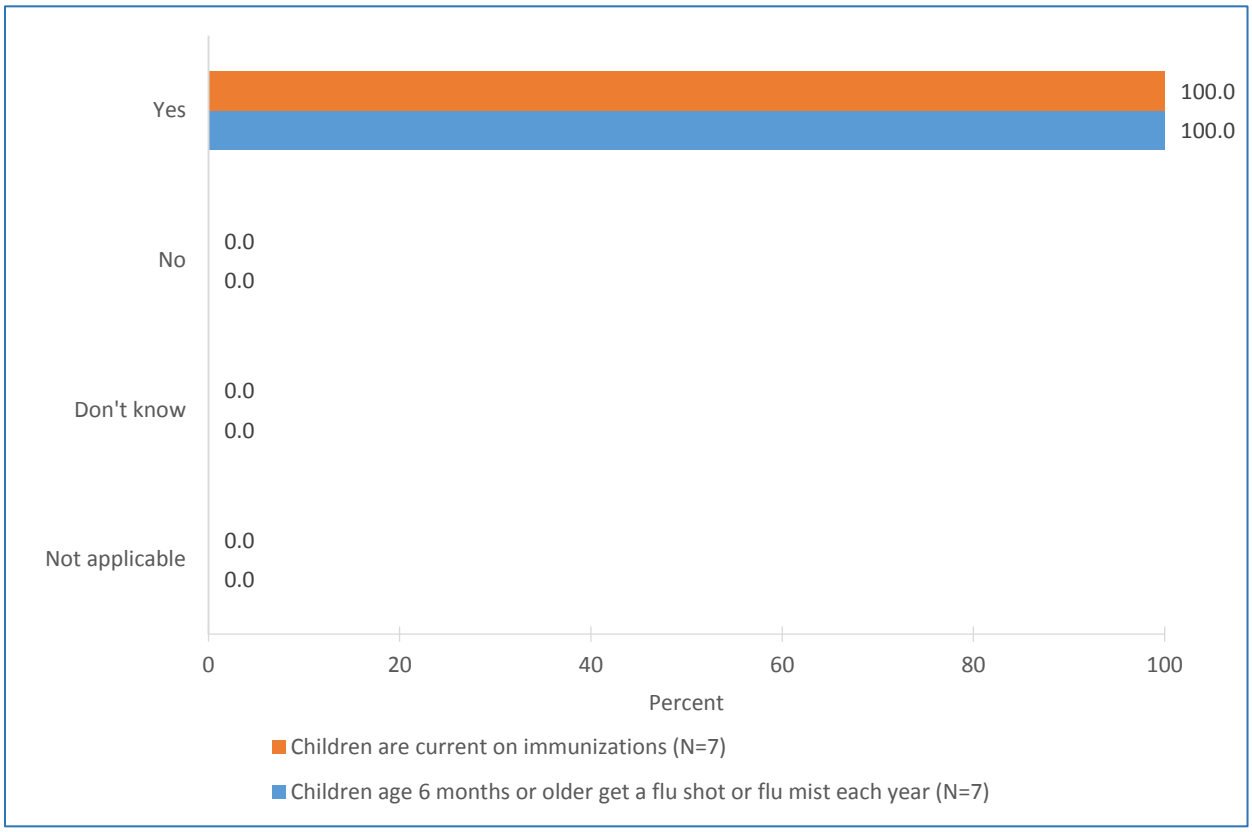


Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



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

Table 3. Zip code of respondents

Zip code	Number of respondents
56175	7
56180	3
56115	2
56172	2
56183	1
56258	1
56263	1

N=17

Secondary Research

Definitions of Key Indicators

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

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

Contents:

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

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

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

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

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

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

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

Lyon County

	Lyon County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Health Outcomes						**35**
Length of Life						**38**
Premature death	5,147		4,104-6,191	5,200	5,038	
Quality of Life						**38**
Poor or fair health	12%		8-19%	10%	11%	
Poor physical health days	1.6		1.0-2.2	2.5	2.8	
Poor mental health days	2.6		1.4-3.8	2.3	2.6	
Low birth weight	6.2%		5.2-7.1%	5.9%	6.5%	
Health Factors						**36**
Health Behaviors						**47**
Adult smoking	18%		12-27%	14%	16%	
Adult obesity	29%		24-35%	25%	26%	
Food environment index	8.1			8.4	8.3	
Physical inactivity	19%		15-23%	20%	19%	
Access to exercise opportunities	81%			92%	85%	
Excessive drinking	26%		19-35%	10%	19%	
Alcohol-impaired driving deaths	44%			14%	31%	
Sexually transmitted infections	196			138	336	
Teen births	22		18-25	20	24	
Clinical Care						**28**
Uninsured	9%		8-11%	11%	9%	
Primary care physicians	1,419:1			1,045:1	1,113:1	
Dentists	2,317:1			1,377:1	1,529:1	
Mental health providers	689:1			386:1	529:1	

	Lyon County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Preventable hospital stays	54		46-62	41	45	
Diabetic monitoring	92%		78-100%	90%	88%	
Mammography screening	77.3%		62.1-92.6%	70.7%	66.7%	
Social & Economic Factors						27
High school graduation	84%				78%	
Some college	68.2%		62.5-73.8%	71.0%	73.3%	
Unemployment	4.2%			4.0%	5.1%	
Children in poverty	15%		11-19%	13%	14%	
Income inequality	4.5		4.0-5.0	3.7	4.3	
Children in single-parent households	25%		20-31%	20%	28%	
Social associations	19.2			22.0	13.2	
Violent crime	153			59	229	
Injury deaths	51		39-64	50	56	
Physical Environment						49
Air pollution - particulate matter	12.9			9.5	12.0	
Drinking water violations	0%			0%	1%	
Severe housing problems	14%		12-17%	9%	15%	
Driving alone to work	75%		73-77%	71%	78%	
Long commute - driving alone	12%		10-14%	15%	29%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2015

SANFORD HEALTH

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