Sanford Health Network
Community Health Needs Assessment
2012-2013

Winner Regional
Healthcare Center
SANFORD

Winner Regional Healthcare Center

Community Health Needs Assessment 2013

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Winner Regional Healthcare Center
Community Health Needs Assessment
2013

Purpose

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

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

The 2010 PPACA enactment requires that each hospital must have: (1) conducted a community health needs assessment in the applicable taxable year; (2) adopted an implementation strategy for meeting the community health needs identified in the assessment; and (3) created transparency by making the information widely available. For tax-exempt hospital organizations that own and operate more than one hospital facility, as within Sanford Health, the new tax-exemption requirements apply to each individual hospital. The first required needs assessment falls within the fiscal year July 1, 2012 through June 30, 2013.

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

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

Acknowledgements

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

Sanford Enterprise Steering Group:
- *Enterprise Lead:* Carrie McLeod, MBA, MM, LRD,CDE; Office of Health Care Reform, Community Benefit/Community Health Improvement
- *Sioux Falls Region Co-Lead:* Bruce Viessman, CFO, Sanford Health Network Sioux Falls
- Mike Begeman, Chief of Staff/Vice President of Public Affairs
- Maxine Brinkman, CPA; Director of Financial Decisions and Operations Support
- Michelle Bruhn, CPA; CFO, Health Services Division
- Randy Bury, COO, Sanford Medical Center USD
- Jane Heilman, BA; Senior Corporate Communication Strategist
- Kristie Invie, BS, MBA; Vice President for Clinical Performance
- Joy Johnson, Bemidji Region Co-Lead, VP, Business Development and Marketing, Bemidji
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- JoAnn Kunkel, CFO, Sanford Health
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Sanford Fargo Region Steering Group:
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- Angela Novak, MBA; VP, Sanford Health Marketing
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- Les Wietstock, MSA; CFO Sanford Health Network Fargo

Winner Community Health Needs Assessment Steering Group:
- Kevin Coffey, CEO, WRHC
- Phil Husher, CFO, WRHC
- Karey Thieman, CNO, WRHC
- Deb Davis, DOO, WRHC
- Kathy Krogman, DON, WRHC
- Amber McPhee, Clinic Manager, WRHC

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

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

The following key community stakeholders participated in this assessment work:
- Maureen Baker, Volunteer, Thrift Store/Food Bank/Winner Transit, Winner, SD
- Casey Berndt, Financial Advisor, Edward Jones, Winner, SD
- Donna Brown, Executive Director, Southern Plains Behavioral Health Services, Winner, SD
- Kim DeMers, Curriculum Director, Winner School District, Winner, SD
- Irene Giessinger, Owner, Sodak Printers, Winner, SD
- Sandra Hausmann, Teacher, Todd Co. School District, Mission, SD
- Lisa Jankauskas, Teller, Wells Fargo, Winner, SD
- Darrel Kaiser, Owner, Frontier Motors, Winner, SD
- Chuck Keiser, VP and Agency Manager, First Fidelity Bank, Winner, SD
- Diane Kludt, School Counselor, Winner School District, Winner, SD
- Nancy Lewis, Owner, Hometown Automotive, Winner, SD
- Teresa Marts, Physician, Winner Regional Healthcare Center, Winner, SD
- Brad Mellang, Manager, Shopko, Winner, SD
- John Meyer, Owner, Office Products Center, Winner, SD
- Rita Neyens, Loan Secretary, First Fidelity Bank, Winner, SD
- Coleen Patmore, Retail Business Owner, Winner, SD
- Mardi Pederson, Manager, K's Signs and Graphics, Winner, SD
- Ashley Robbins, Photographer, Ashley Robbins Photography, Winner, SD
- Betsy Rohde, Office Manager, Winner Regional Healthcare Center, Winner, SD
- Ellen Storms, Nurse, Winner Regional Healthcare Center, Winner, SD
- Lana Stickland, Insurance Agent, The Insurance Center, Winner, SD
- Betty Tideman, Clerical Worker, Winner, SD
- Eva Watzel, Retired, Winner, SD
- Name Withheld (5)

![Winner Regional Healthcare Center - Sanford logo]

Winner Regional Healthcare Center
Community Health Needs Assessment
2013

Executive Summary

Purpose

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

Study Design and Methodology

Sanford Health Fargo convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Greater Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across the enterprise. After much discussion, it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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

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

The following qualitative data sets were studied:
- Community Health Needs Assessment of Community Leaders
- Focus Group Surveys of Key Stakeholders in Community

The following quantitative data sets were studied:
- 2011 County Health Profile for Tripp County
- Aging Profiles for Tripp County
- Diversity Profiles for Tripp County

The following primary research was conducted within the Sanford Quality and Decision Support teams and the data sets will be discussed in this report:
- Quality data
- Top diagnoses for all inpatients by diagnosis

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

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

Key Findings – Primary Research

Winner Regional Healthcare Center provided electronic copies as well as paper copies of the Community Health Needs Assessment Survey tool that was developed by the Greater Fargo Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the community.

The findings discussed in this section are a result of the analysis of the qualitative survey data.

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.

Winner Regional Healthcare Center extended a good faith effort to engage all of the aforementioned community representatives in the survey process. The list of individuals who agreed to take the survey and also submit their names are included in the acknowledgement section of this report. In some cases there were surveys that were submitted without names or without a specified area of expertise or affiliation. Sanford 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 Winner Regional Healthcare Center website.

Respondents had very high levels of agreement that the people in their community are friendly, helpful and supportive, there is quality health care, the community is a good place to raise kids, and is a safe and healthy place to live with quality school systems and programs for youth. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness, higher education opportunities, effective transportation and cultural richness in their community.

Respondents were most concerned about the cost of health care and/or insurance, low wages, false sense of entitlement, substance abuse, bullying, and child abuse and neglect. Respondents were also concerned with issues regarding children and youth, domestic violence and issues regarding the aging population (e.g. availability and cost of long-term care, and availability of resources to help the elderly stay in their homes), and issues with health care systems/policy unrelated to cost. Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, adequacy of insurance, access to insurance coverage (e.g., preexisting conditions) prescription drugs, the availability of dental and vision insurance, and the availability of medical providers. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. Cancer, chronic disease (e.g. diabetes, health disease, multiple sclerosis), stress, the availability of qualified mental health providers, and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about the availability of bilingual providers and/or translators, and the provider not taking new patients.

Respondents were concerned with respect to the availability of employment opportunities and low wages, poverty, affordable housing, and the economic disparities between higher and lower classes. Respondents were moderately concerned with the availability of public transportation, road conditions. Respondents were least concerned with traffic congestion.

Respondents were not very concerned with environmental issues in their community. There is high agreement that the community has a general cleanness.

<u>Safety Concerns</u>

The levels of concern among respondents regarding substance use and abuse issues in their community were fairly high. Respondents were most concerned about drug and alcohol use and abuse and smoking. Although still moderately high, respondents were least concerned about the presence of drug dealers in the community.

Delivery of Health Care in the Community

<u>Respondent's Choice for Primary Health Care Provider</u>

The top reasons respondents gave for their choice of primary health care provider were location, quality of services, availability of services, and the sense of being valued as a patient. Influence by health insurance ranked the lowest reason for primary care provider choice.

More than 50% (56.5%) said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because they thought that it was not necessary. Fear, unfamiliarity with recommendations, and not knowing who to see were not reasons that the majority of respondents gave.
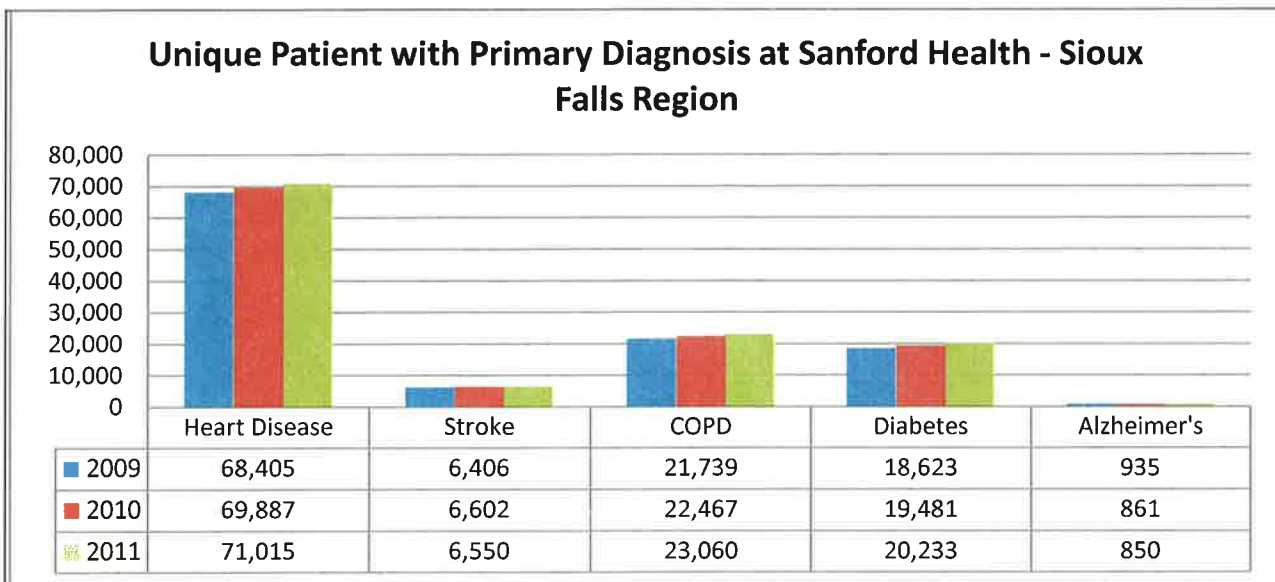
<u>Health Care Coverage</u>

A majority of respondents (73.2%) said they had paid for health care costs over the last 12 months by health insurance through an employer. Medicare, personal income and private health insurance benefits were also used.

<u>Primary Care Provider</u>

Respondents were asked which provider they used for their primary health care. Ninety-three percent (93%) of respondents said they use Sanford Winner as their primary health care provider.

Quality Data

The Center for Disease Control has determined the leading causes of death in South Dakota to be heart disease, chronic lower respiratory disease, stroke, Alzheimer's disease, and diabetes. Chronic disease is among the most common and most costly health problems. The unique patient population within Sanford Health Sioux Falls Region with a primary diagnosis for these leading causes of death includes 71,015 patients with heart disease, 20,233 patients with diabetes, 23,060 patients with COPD, 850 patients with Alzheimer's, and 6,550 stroke patients.

Unique Patient with Primary Diagnosis at Sanford Health - Sioux Falls Region

	Heart Disease	Stroke	COPD	Diabetes	Alzheimer's
2009	68,405	6,406	21,739	18,623	935
2010	69,887	6,602	22,467	19,481	861
2011	71,015	6,550	23,060	20,233	850

Inpatient Diagnosis by Volume

The top Diagnosis Related Groups within the Winner Regional Healthcare Center inpatient setting were analyzed to determine the highest utilization by volume.

Table 1. Top Diagnosis Related Group by volume

FY 2009	FY 2010	FY 2011
Esophagitis Digestive Disorder w/o MCC	Esophagitis Digest Disorder w/o MCC	Esophagitis Digest Disorder w/o MCC
Pneumonia w CC	Heart Failure & Shock w/o CC/MCC	Pneumonia w/o CC MCC
Pneumonia w/o CC/MCC	Cellulitis w/o MCC	Pneumonia w/CC
Heart Failure & Shock w CC	Pneumonia w/o CC/MCC	Cellulitis w/o MCC
Kidney & UTI w/o MCC	Kidney & UTI w/o MCC	Heart failure & Shock w/o CC/MCC

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Winner Regional Healthcare Center is a Critical Access Hospital. As such, their Medicare reimbursement is based on a cost per day calculation and not on the basis of a DRG.

Key Findings – Secondary Research

Health Outcomes

The mortality health outcomes indicate that South Dakota as a state has more premature deaths than the national benchmark. While the state of South Dakota (6,815) and Tripp County (5,782) have more premature deaths than the national benchmark (5,564), Tripp County, South Dakota has a lower rate than the state benchmark.

The morbidity health outcomes indicate that South Dakota citizens report more days of poor health (12%) than the national benchmark (10%), and Tripp County (14%) reports a much higher rate than the national benchmark. South Dakota (2.8) and Tripp County (2.7) report more physically unhealthy days than the national benchmark (2.6).

The state of South Dakota (2.6) reports more mentally unhealthy days than the national benchmark (2.3), while Tripp County (2.2) reports better mental health days.

South Dakota (6.8%) has a higher percentage of low birth weight than the national benchmark (6.0%). This data is not available for Tripp County.

Health Factors

The health behavior outcomes indicate that South Dakota (20%) has a higher percentage of adult smokers than the national average (14%); however, Tripp County (14%) has a lower average. Adult obesity is also higher in the state of South Dakota (29%) and Tripp County (32%), than the national average (25%). South Dakota (2.8) and Tripp County (2.7) have higher percentages of physical inactivity than the national benchmark (2.6). South Dakota (2.6) has a higher rate of self-reported poor mental health days than the national benchmark (2.3) and Tripp County (2.2) is ranked slightly more positive than the national benchmark. South Dakota has a higher percentage (6.8%) of lower birth weight than the national benchmark (6.0%). The data is not available for this indicator for Tripp County.

South Dakota (19%) and Tripp County (15%) have higher percentages of binge drinking reports than the national benchmark (8%). Motor vehicle crash death rates are nearly double the national benchmark (12) in South Dakota (23.7). The data is not available for this indicator for Tripp County.

Sexually transmitted infections rank substantially higher than the national average for South Dakota (371.3 vs. national benchmark of 83.0), and Tripp County (140.8). The teen birth rate is higher in South Dakota (38.7) and Tripp County (41.1) than the national benchmark (22).

The clinical care outcomes indicate that South Dakota has a higher percentage of uninsured adults (16%) than the national benchmark (13%), while Tripp County (19%) is substantially higher than both state and national benchmarks. The percentage of uninsured youth in Tripp County is higher (9%) than the national benchmark (7%), but is the same as South Dakota (9%) as a whole.

The ratio of population to primary care physicians is higher in South Dakota (769:1) than the national benchmark (631:1), but the ratio is more positive in Tripp County (560:1).

The ratio of population to mental health providers is much worse in South Dakota (3,544:1) and Tripp County (5,603:1) than the national benchmark (2,242:1).The number of professionally active dentists is lower than the

national benchmark (69) in South Dakota (50) and Tripp County (35.2). Preventable hospital stays are higher than the national benchmark (52) in South Dakota (68.6) and in Tripp County (89.1).

Diabetic screening in South Dakota (83%) is lower than the national benchmark (89%), but is slightly higher than the national benchmark in Tripp County (92%). Mammography screening is lower in South Dakota (68%) and Tripp County (69%) than the national benchmark (74%).

The social and economic factor outcomes indicate that South Dakota (83%) and Tripp County (85%) have a lower high school average than the national benchmark (92%), and both South Dakota (64%) and Tripp County (58%) have a lower percentage of post secondary education than the national benchmark (68%).The unemployment rate was lower in South Dakota (4.8%) and in Tripp County (3.5%) than the national benchmark (5.3%). The percentage of child poverty is substantially higher in South Dakota (18%) than the national benchmark (11%); however, Tripp County (27%) is substantially higher than the national benchmark for child poverty. Inadequate social support is higher in South Dakota and Tripp County (both at 17%) than the national benchmark (14%).

The percentage of children in single parent households is higher than the national benchmark (20%) in South Dakota (29%) and Tripp County (31%).The number of homicide deaths in South Dakota (2.5/100,000) is higher than the national benchmark (1.0/100,000). The data is not available for this indicator for Tripp County.

The physical environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked far below the national benchmark (92%) in Tripp County (40%) and in South Dakota (42%). In this rural area there can be far distances to travel to grocery stores, and there are food deserts in some communities where only a gas station convenience store is close to home. Access to recreational facilities ranks lower than the national benchmark (17/100,000) for South Dakota (13/100,000) but is substantially higher for Tripp County (71/100,000).

Youth account for 25% of the population in Tripp County. The elderly account for 21% of the population in Tripp County. Fifty-one percent (51%) of Tripp County is rural compared to 48% of South Dakota and 21% as the national benchmark.

Only 2% of South Dakotans are not proficient in English compared to the national benchmark of 9%. The data is not available for this indicator for Tripp County. South Dakota's illiteracy rate is 7%, Tripp County is at 9%, compared to the national benchmark of 15%.

The population for this area is 21% older than 65 years of age and 4% older than 85 years of age. Fourteen percent (14%) of South Dakotans are older than 65 years of age and only 2% are older than 85 years of age.

The gender distribution is 49% male and 51% female. The gender mix is 50-50 for the state of South Dakota.

The majority of individuals (71%) in Tripp County own their homes. Sixty-eight percent (68%) of South Dakotans own their own home.

According to the 2010 Census Data, the population of working age in the labor force is 69% in Tripp County. The percentage of those who are living at less than 100% of the poverty level is 14% in South Dakota and 16 % in Tripp County. In South Dakota, 33% and in Tripp County 41% are at less than 200% of the poverty level. The median annual household income in South Dakota is $46,369 while Tripp County is at $40,221.

The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian alone, then Hispanic origin of any race, and Black alone. The Asian population ranks fifth in South Dakota.

In Tripp County the ranking is White (83%), American Indian (14%), Hispanic (1%) and Asian (.002%).

Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resources/asset mapping and multi-voting prioritization process:

Priority 1: Physician Recruitment

Goal: **Increase the number of physicians in the community.**

> **Measurable Outcome:**
> - Number and specialties of physicians
> - Number of patients seen per provider
>
> **Sanford Resources:**
> - CEO

Priority 2: Employee-Based Wellness Programs

Goal: **Promote employee-based wellness programs to WRHC employees (this group is the largest employer in the community).**

> **Measurable Outcomes:**
> - An educational session is conducted for staff on the benefits of wellness and opportunities are identified for outreach services.
> - Fitness activities are provided for staff and staff is encouraged to participate.
> - Possible specials for WRHC employees are explored with other local wellness facilities.
> - Evidence-based programs to educate/activate a healthier lifestyle (i.e. cooking classes, etc.) are offered.
> - The potential of offering a children's health fair is explored.
>
> **Sanford Resources:**
> - CFO
> - HR Director

Priority 3: Evaluate Chronic Health Issues in the Community

Goal: **Evaluate chronic health issues in the community. Based on those findings, take the top one or two issues and determine the best way to address the population that is impacted.**

> **Measurable Outcomes:**
> - The top two chronic health issues are in the community are identified.
> - The best ways to address the impacted population are determined.
> - Groups to assist with the top two chronic health issues are formed.
>
> **Sanford Resources:**
> - CNO
> - DNO
> - Clinic Manager

Winner Regional Healthcare Center

Community Health Needs Assessment
2013

Winner Regional Healthcare Center has had a management agreement with Sanford Health since 1996. Sanford Health aids the hospital and long term care facility with purchasing, training, technology and administration. Winner Regional is dedicated to providing the best care possible for the benefit of patients and residents who utilize our services in a rural populated area in south central South Dakota.

Mission: The spiritual physical and mental well being of our patients and residents is our primary concern. Excellence in healthcare is our tradition. *Professional Care with a Personal Touch.*

Our Values: We believe that if our values will come from the heart, then our daily behavior will reflect our commitment to our coworkers and the people we serve.

- Attitude
- Respect
- Privacy and Confidentiality
- Communication
- Ownership and accountability
- Teamwork and Accountability
- Appearance
- Safety and Security

Description of Winner Regional Healthcare Center

Winner Regional Healthcare Center is a not-for-profit facility that operates for the benefit of patients and residents in our service area.

The nine-person volunteer Board of Directors manages the operation of our institution. The board chooses three candidates from our local communities each year to serve three-year terms on the board.

Our management agreement with Sanford Health aids the hospital and long-term care facility with purchasing, training, technology and administration.

Winner Regional is dedicated to providing quality employment opportunities and purchasing local goods whenever possible.

Our dedicated staff is comprised of local residents from our communities, making a large contribution to our local economy. Ongoing commitment to quality and integrity is reflected in our mission statement: *Professional Care with a Personal Touch.*

Winner Regional Healthcare Center is a 25-bed Critical Access Hospital and 81-bed long-term care facility that caters to the health needs of south central South Dakota and north central Nebraska.

Physicians in the following specialties provide consultation and treatment at Winner Regional Healthcare Center's Outreach Clinic. Specialty care includes:

- Audiology
- OB/GYN
- Ophthalmology
- Podiatry
- Cardiology
- Cardiology
- Dietician
- Allergist
- Orthopedics
- Urology
- Pediatric Cardiology
- Outpatient chemotherapy

Description of the Community Served

Winner, South Dakota is located in south central South Dakota along Highways 18, 183 and 44 and is the county seat of Tripp County. The population of Winner is 3,137, and the city covers approximately 922.5 acres of land. Winner was part of the famous Louisiana Purchase of 1803 and later part of the Dakota Territory, which was established by an act of Congress and a proclamation by President Abraham Lincoln in 1861. Winner was so named because it was the "winner" in the struggle to establish a town along the railroad right-of-way when the Chicago North Western began moving west from Dallas, SD in 1909.

Over 300 businesses are active in Winner and the Winner School District is rated level 1 by the South Dakota Division of Education with the high school accredited by the North Central Association of Colleges and High Schools.

Winner is home to a regional health care center and two modern assisted living centers. Recent capital improvements in the city include a new main street, new runway at the airport, and a new fire hall/ambulance facility with a new training room.

Study Design and Methodology

In May 2011 Sanford Health Fargo convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative is to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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

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

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

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

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

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

The following qualitative data set was studied:
- Community Health Needs Assessment of Community Leaders

The following quantitative data sets were studied:
- 2011 County Health Profiles for Tripp County
- Aging Profiles for Tripp County
- Diversity Profiles for Tripp County

The following primary research was conducted within the Sanford Quality and Decision Support teams and the data sets will be discussed in this report:
- Quality data
- Top diagnosis for all inpatients by diagnosis

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.

Resource Identification

Each unmet need was researched to determine what resources were available in the community to address the needs. The steering committee performed the asset mapping and reviewed the findings. The group conducted an informal gap analysis to determine what need 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.

Community Health Needs Assessment of Community Leaders

The purpose of the community leader survey was to explore the views of key leaders in the Winner community area (e.g. health professionals, social workers, educators, elected leadership, and nonprofit leaders) regarding the resident population's health and the prevalence of disease and health issues within the community.

The Winner Community Health Needs Assessment Committee identified the key community leaders for Winner and the surrounding area. The key stakeholder survey was loaded onto Survey Monkey and the link to the survey was sent by email to all identified community stakeholders with computer access. Paper surveys were handed out at meetings for those stakeholders who did not have access to a computer, and the completed survey data was entered into the data base by hospital staff.

The community leaders' survey included a set of questions at the end relating to the respondent's name, title, affiliation, area of expertise, city/town, and state. These questions were included to fulfill the current interpretation of IRS requirements for non-profit hospitals conducting community health needs assessments as part of the new compliance requirements imposed by the PPACA law on March 23, 2010.

2011 County Health Profiles

The County Health Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. State and national benchmarking required additional data sources, including the U.S. Census Bureau, Small Area Health Insurance Estimates, and the Centers for Disease Control and Prevention's National Center for Health Statistics – the Health Indicators Warehouse.

Aging Profiles

The Aging Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available.

Diversity Profiles

The Diversity Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

The Center for Disease Control National Center for Health Statistics determines the leading causes of death by state. Based on this data, the leading causes of death in South Dakota include heart disease, chronic lower respiratory disease, stroke, Alzheimer's disease, and diabetes. The data analyzed for Sanford Health is determined by unique patients with primary diagnosis. The data is provided at a regional level to prevent double reporting.

Top Diagnosis

Primary research was conducted to determine the top DRGs among patients who received care at Winner Healthcare Center. The inpatient data was further studied to determine the top volume by DRG, the top DRG by the average direct cost, and the top DRG for Community Care delivered by volume and cost.

Limitations

The Winner Community Health Needs Assessment leadership group attempted to reach many more key community and county stakeholders for the purpose of determining the needs of the community. There were 59 members of this key stakeholder group who completed the survey or part of the survey.

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

Primary Research

Summary of the Survey Results

Winner Healthcare Center distributed the community health needs assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the community. Findings discussed in this section are a result of the analysis of the survey qualitative data.

Respondents had very high levels of agreement that people in their community are friendly, helpful and supportive and that there is a sense of community connection. Respondents also thought that the community is a good place to raise kids, there is a quality school system, programs for youth, and that there is quality health care in Winner.

However, respondents agreed the least that there is quality higher education opportunities, a sense of cultural richness, tolerance, inclusion, and open-mindedness in their community. Respondents also had concern that there is a lack of effective transportation.

Respondents were most concerned about substance abuse, child abuse and neglect, a false sense of entitlement, problems related to health care systems/policies (not related to cost) and issues regarding the aging population (e.g. availability and cost of long-term care and availability of resources to help the elderly stay in their homes).

Respondents were also concerned with issues regarding children and youth and specifically bullying. Environmental issues regarding garbage and litter, water quality, air quality, and noise levels were not a large concern.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance, health care, and prescription drugs. Respondents were also concerned about physical health issues, particularly obesity, poor nutrition and eating habits, and inactivity or lack of exercise. The adequacy of health

insurance (i.e., amount of co-pays and deductibles) and access to health insurance coverage (i.e., pre-existing conditions), as well as chronic disease (e.g. diabetes, health disease, cancer) stress, the availability of qualified mental health providers, and depression were also among the top health and wellness concerns among respondents. Respondents were least concerned about the availability of bilingual providers, providers not taking new patients and access to transportation.

Community Assets/Best Things 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 agreement with various statements about their community regarding people, services and resources, and quality of life.

Respondents were asked to rate their level of agreement with various statements regarding PEOPLE, SERVICES AND RESOURCES, QUALITY OF LIFE, GEOGRAPHIC SETTING, and ACTIVITIES in their community.

People

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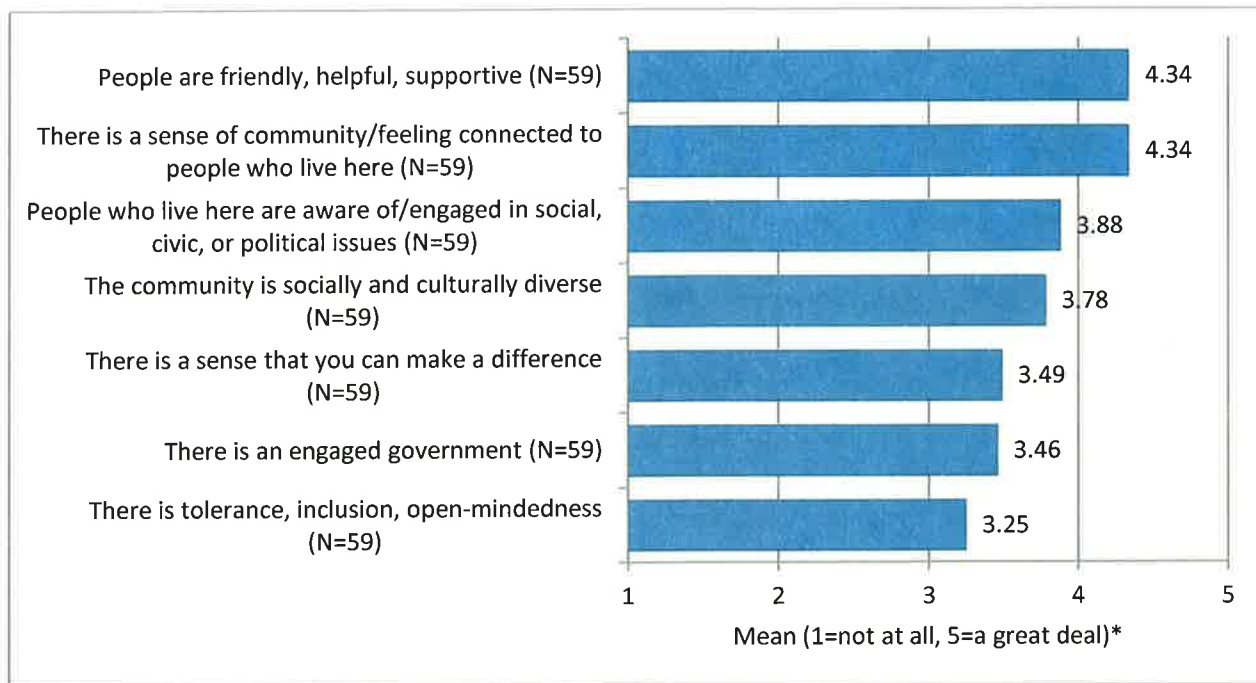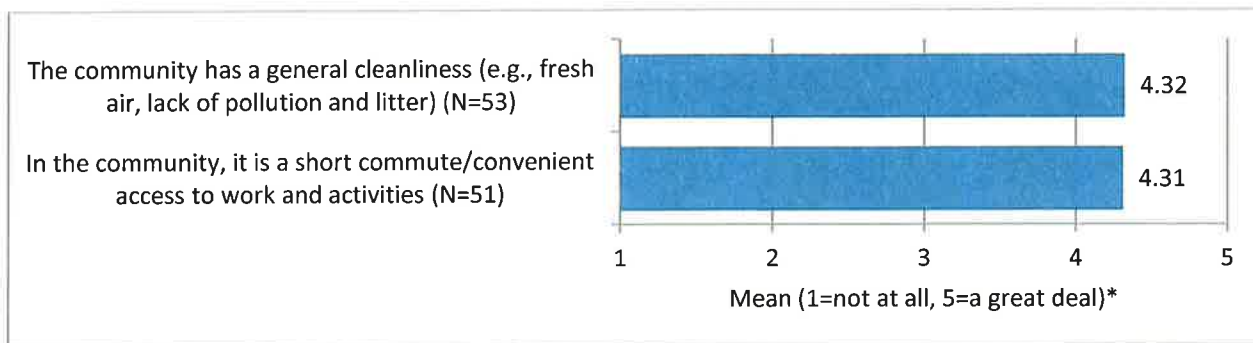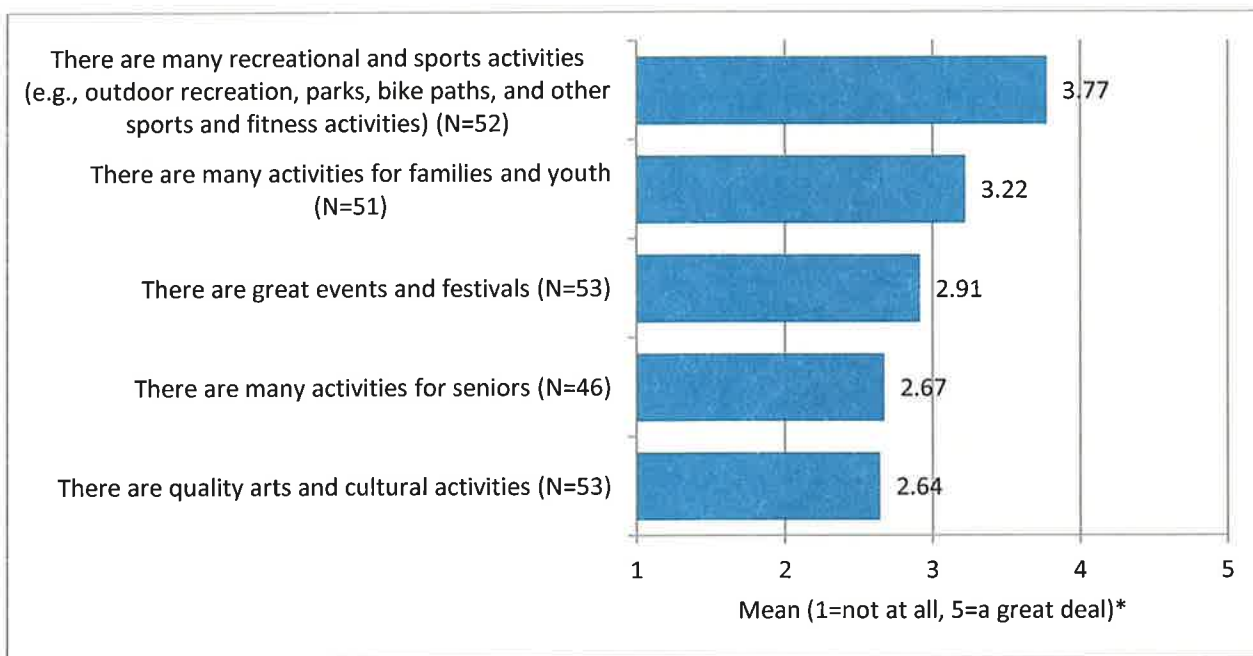

*Means exclude "do not know" responses.

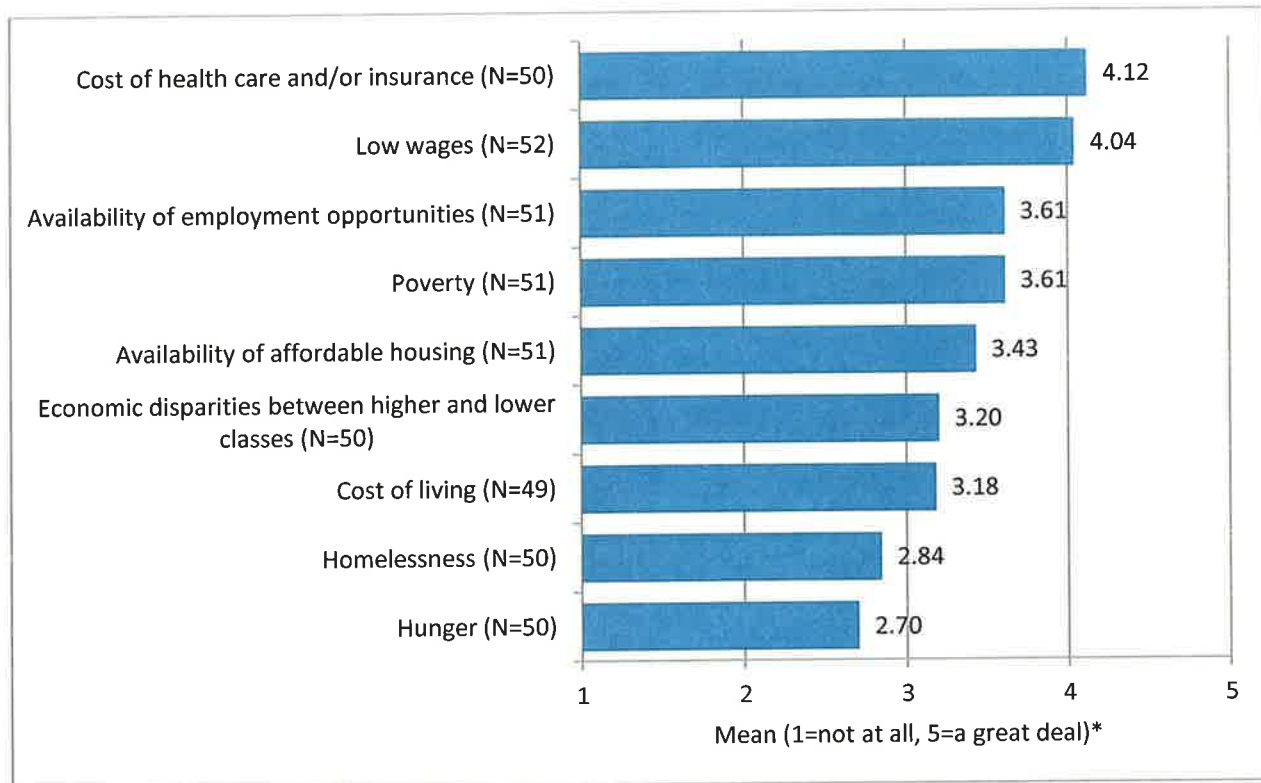## Services and Resources

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

Statement	Mean
There is quality health care (N=54)	4.06
There are quality school systems and programs for youth (N=54)	4.04
There is access to quality food (N=54)	3.81
There is effective transportation (N=54)	3.76
There are quality higher education opportunities and institutions (N=52)	2.38

Mean (1=not at all, 5=a great deal)*
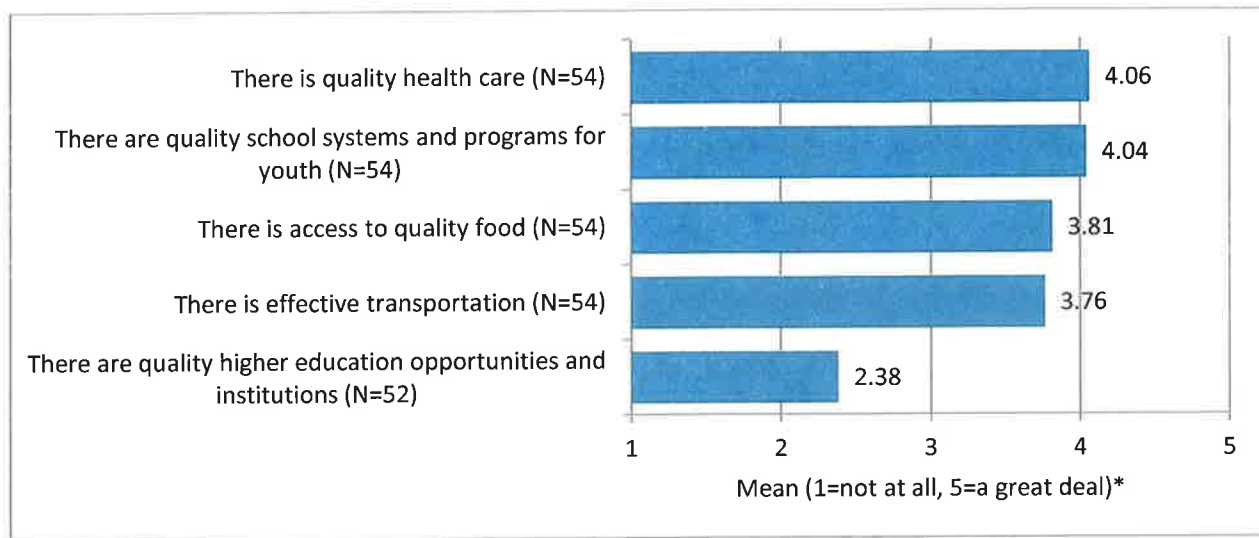
*Means exclude "do not know" responses.

Quality of Life

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

Statement	Mean
The community has a family-friendly environment, is a good place to raise kids (N=52)	4.27
The community has an informal, simple, "laidback lifestyle" (N=53)	4.23
The community has a peaceful, calm, quiet environment (N=54)	4.19
The community is a "healthy" place to live (N=54)	4.04
The community is a safe place to live, has little/no crime (N=54)	4.02
The community has a sense of cultural richness (N=52)	3.15

Mean (1=not at all, 5=a great deal)*

Means

*Means exclude "do not know" responses.

<u>Geographic Setting</u>

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

*Means exclude "do not know" responses.

<u>Activities</u>

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

*Means exclude "do not know" responses.

General Concerns about the Community

Respondents were asked to rate their level of concern with various statements regarding ECONOMIC ISSUES, SERVICES AND RESOURCES, TRANSPORTATION, ENVIRONMENTAL POLLUTION, YOUTH CONCERNS, and SAFETY CONCERNS in their community.

Economic Issues

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

*Means exclude "do not know" responses.

Services and Resources

Figure 7. Level of concern with statements about the community regarding SERVICES AND RESOURCES
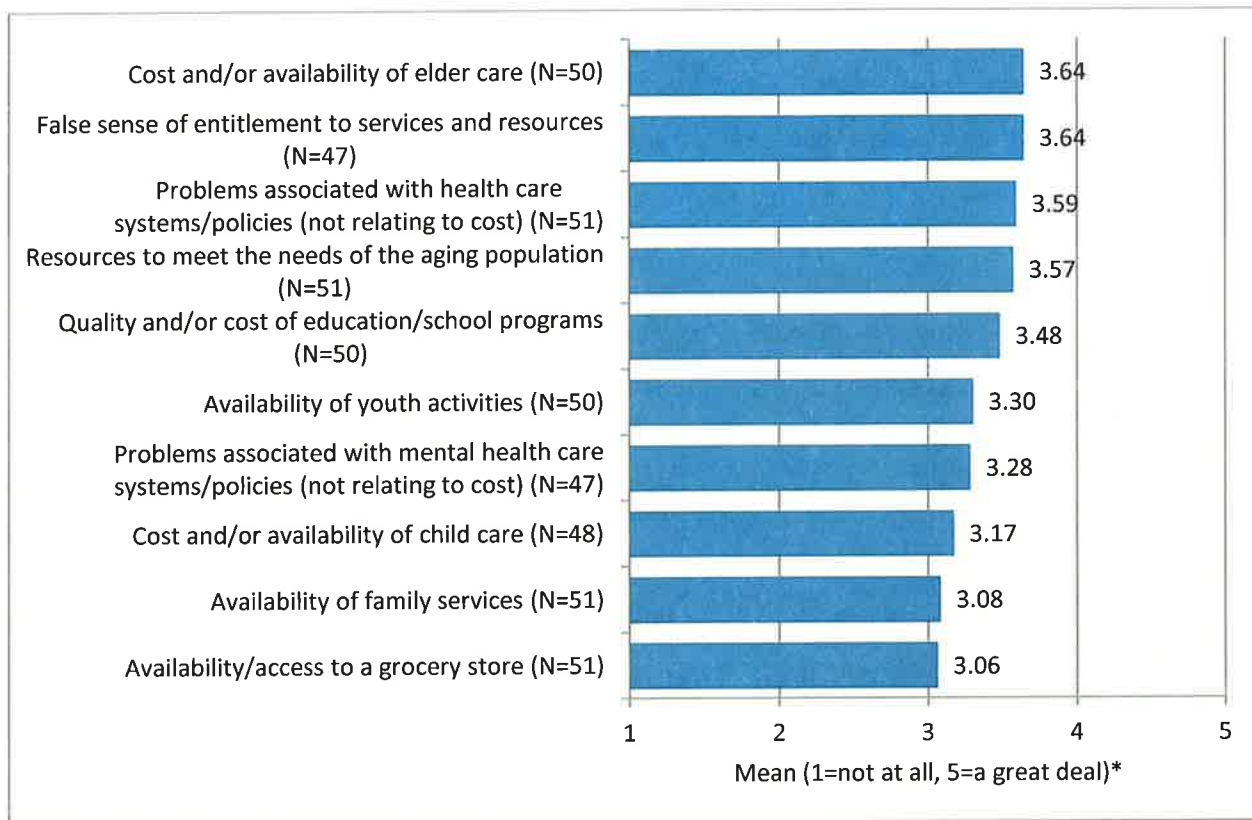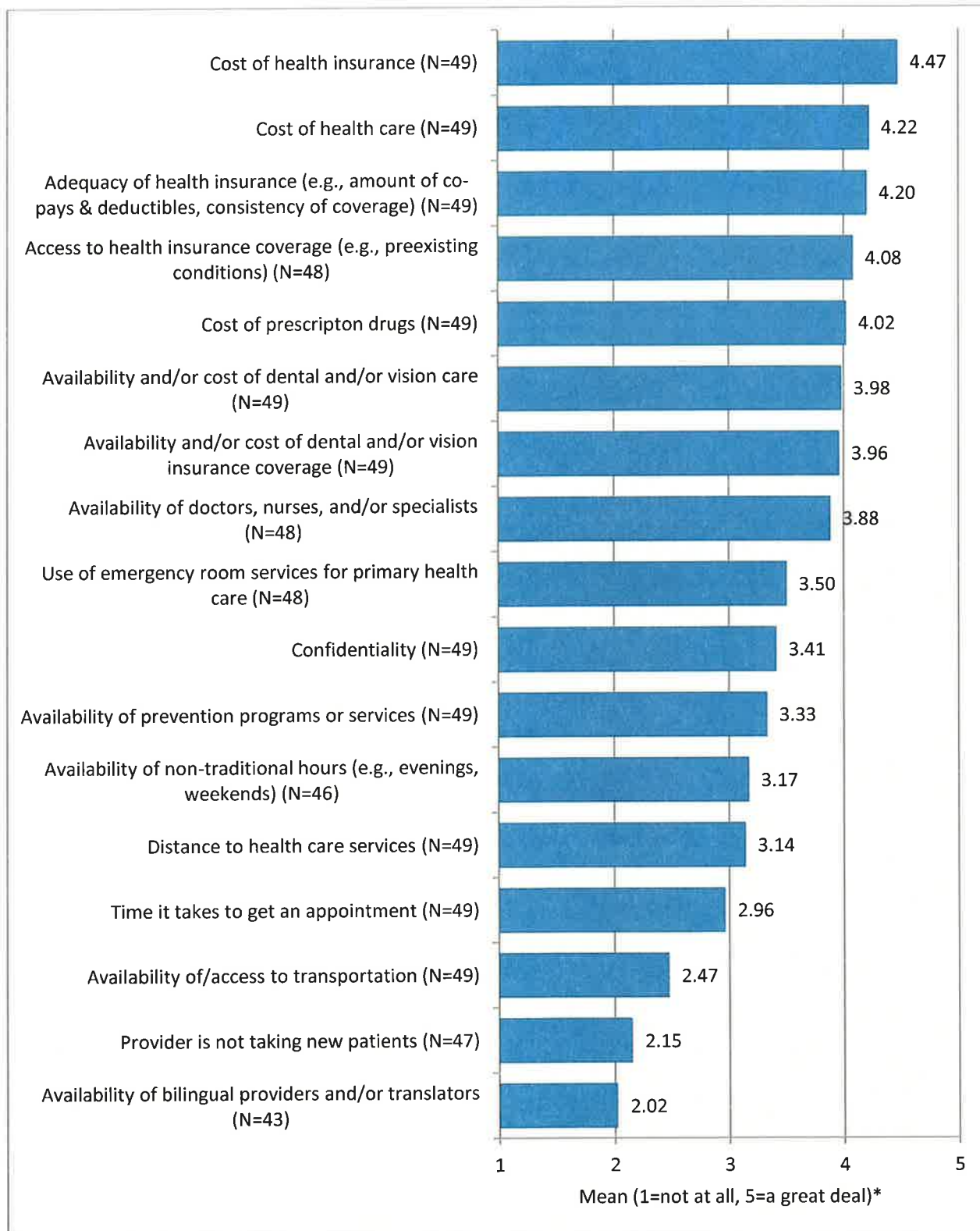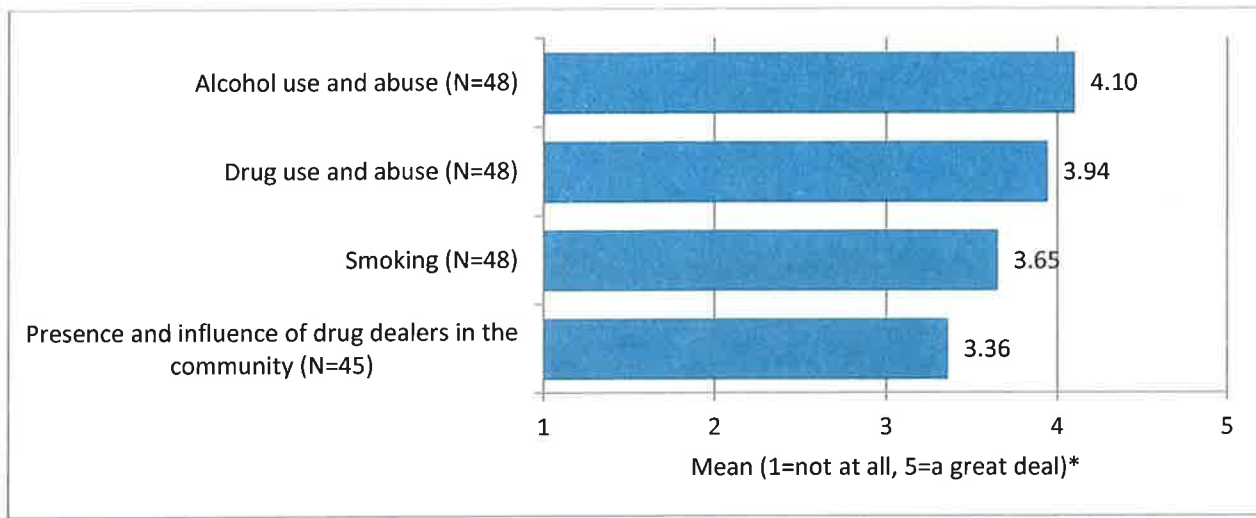

*Means exclude "do not know" responses.

Transportation
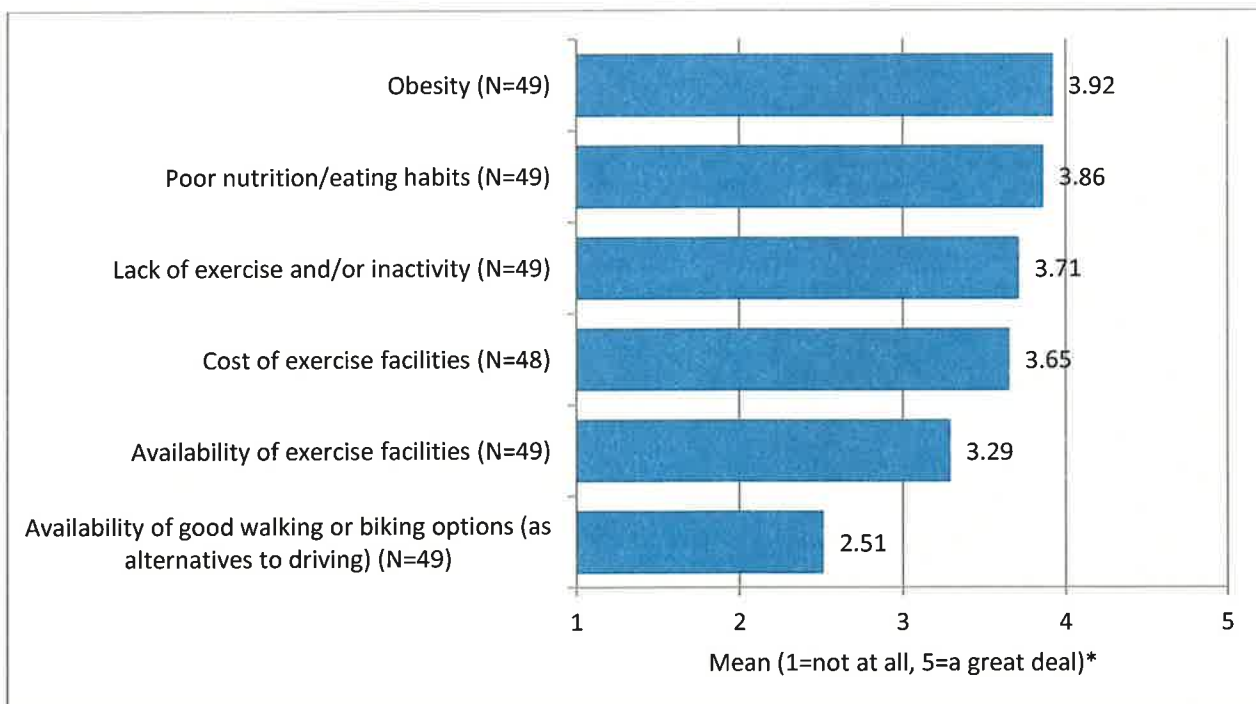
Figure 8. Level of concern with statements about the community regarding TRANSPORTATION
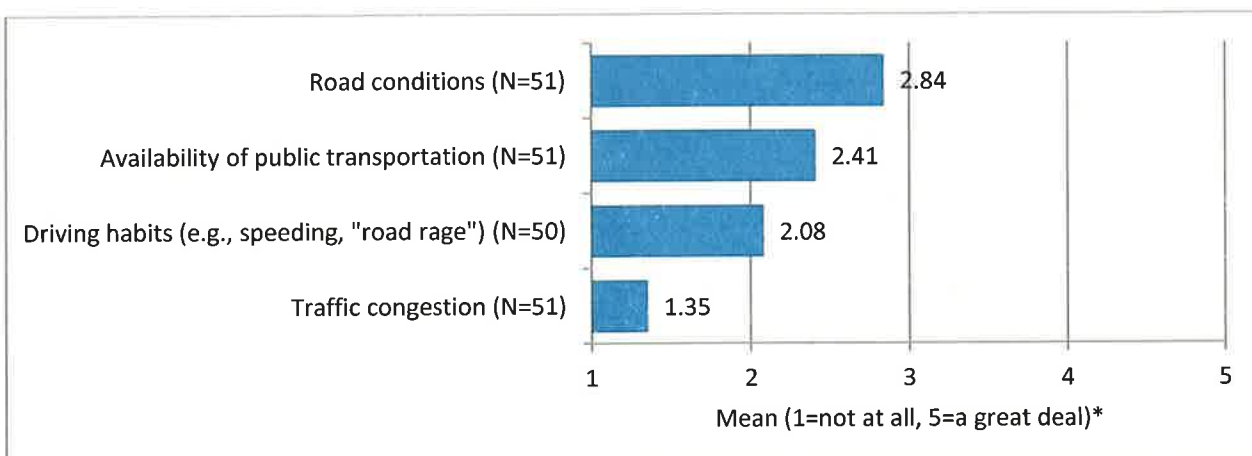
*Means exclude "do not know" responses.

Environmental Pollution

Figure 9. Level of concern with statements about the community regarding ENVIRONMENTAL POLLUTION

	Mean
Water pollution (N=51)	1.92
Air pollution (N=51)	1.67
Noise pollution (N=51)	1.63

Mean (1=not at all, 5=a great deal)*
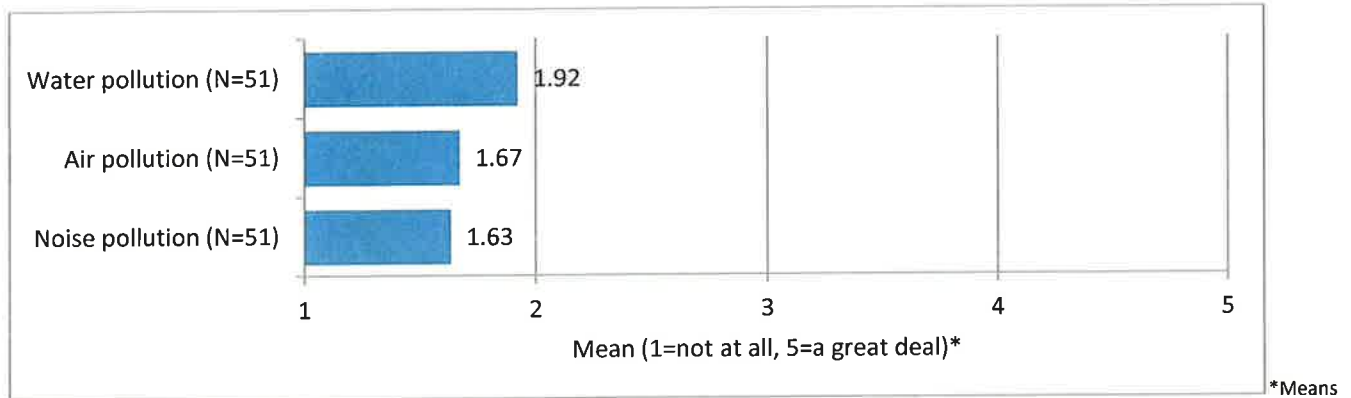
*Means exclude "do not know" responses.

Youth Concerns

Figure 10. Level of concern with statements about the community regarding YOUTH CONCERNS

	Mean
Bullying (N=47)	3.81
Changes in family composition (e.g., divorce, single...	3.52
Teen pregnancy (N=51)	3.22
School dropout rates/truancy (N=50)	3.14
Youth crime (N=50)	3.04

Mean (1=not at all, 5=a great deal)*
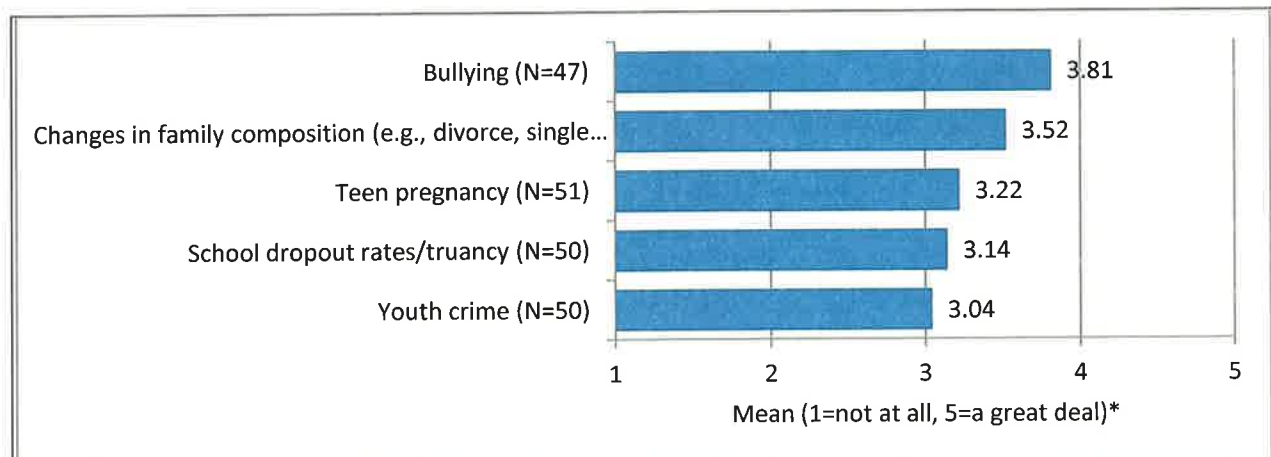
*Means exclude "do not know" responses.

Figure 11. Level of concern with statements about the community regarding SAFETY CONCERNS
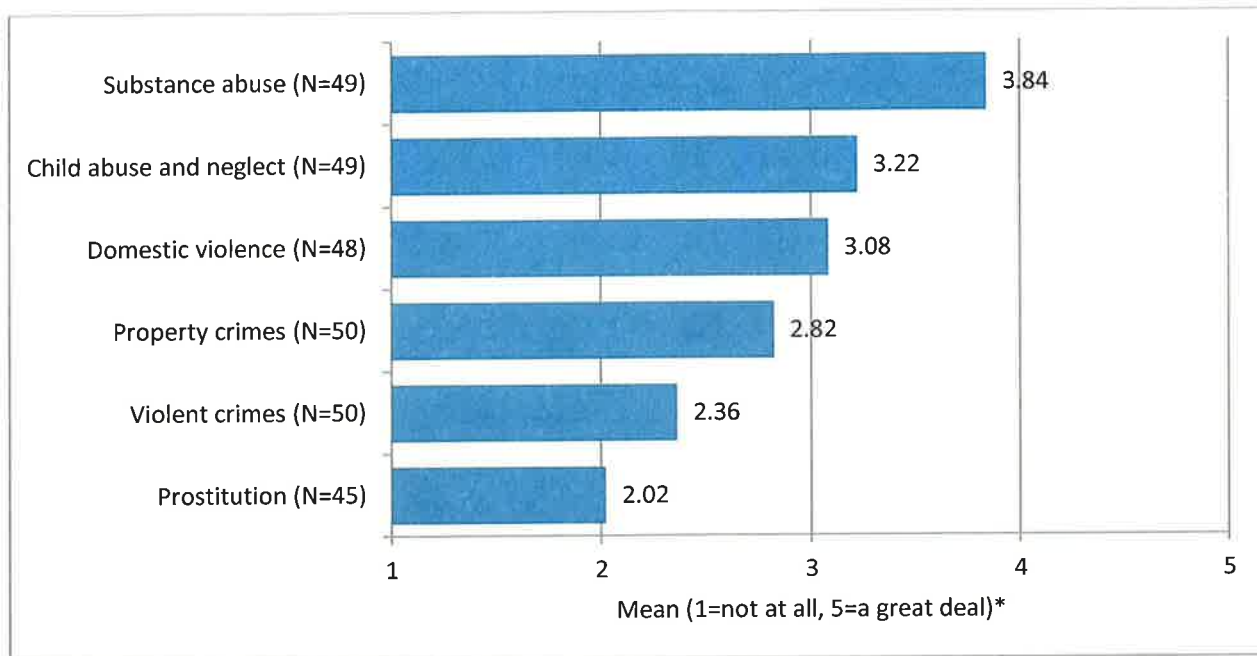
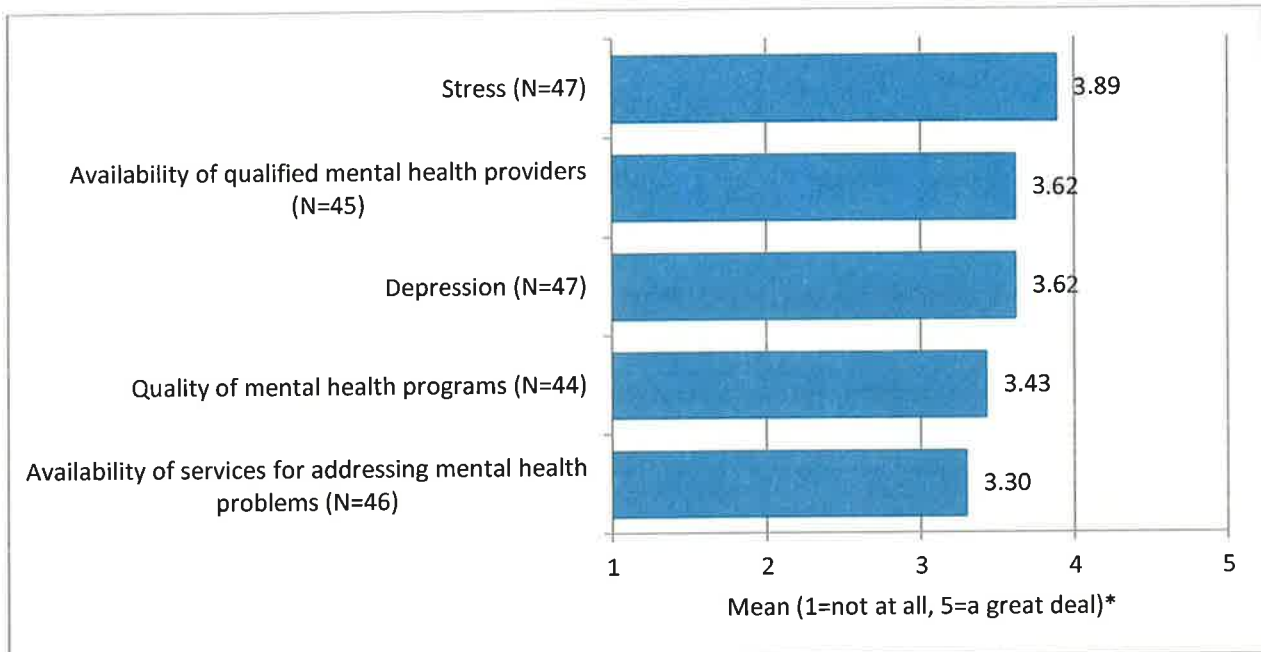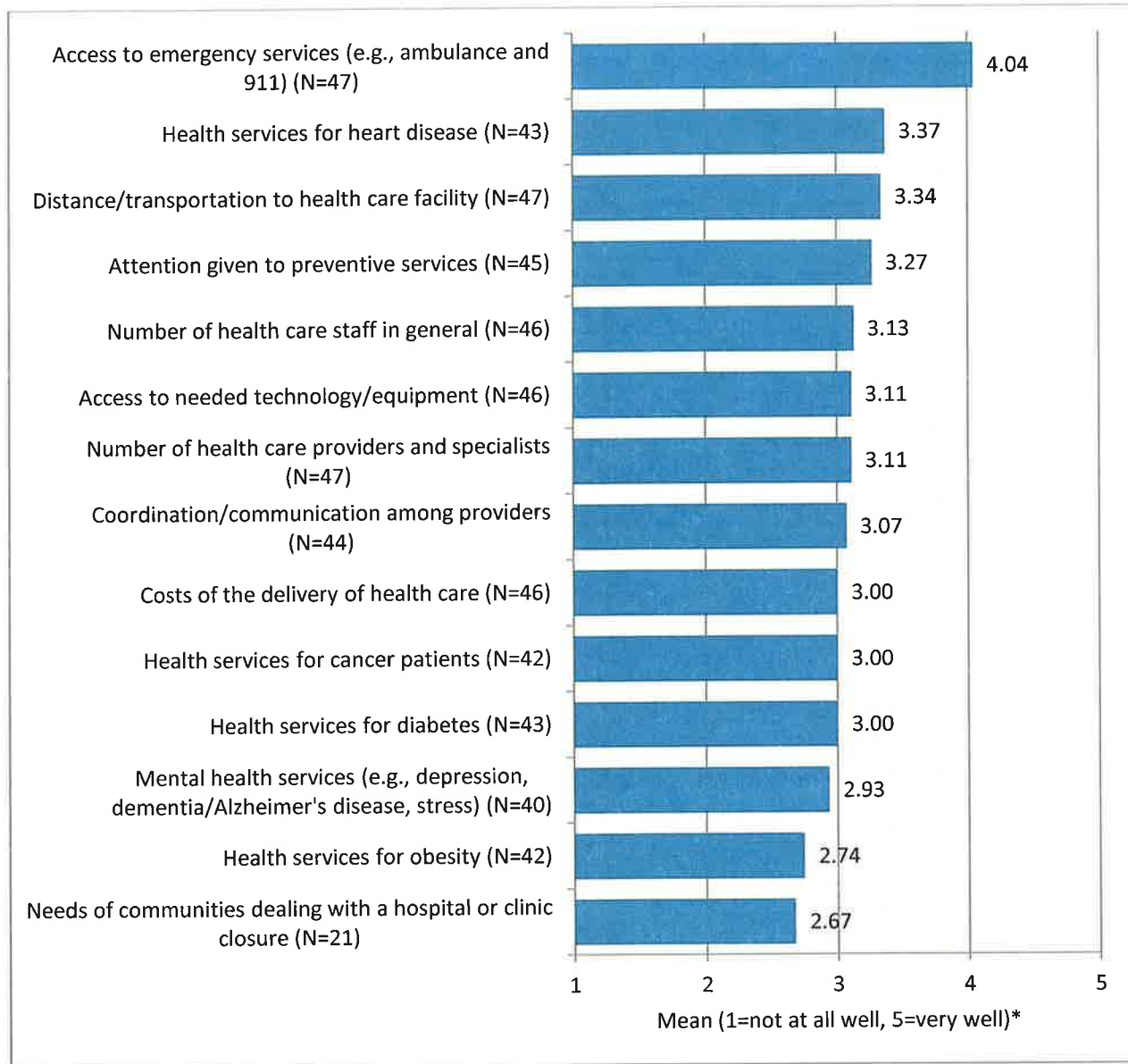*Means exclude "do not know" responses.

Community Health and Wellness Concerns

Respondents were asked to rate their level of concern about health and wellness issues in their community regarding ACCESS TO HEALTH CARE, SUBSTANCE USE AND ABUSE, PHYSICAL HEALTH, MENTAL HEALTH, and ILLNESS.

Access to Health Care

Figure 12. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE

Statement	Mean
Cost of health insurance (N=49)	4.47
Cost of health care (N=49)	4.22
Adequacy of health insurance (e.g., amount of co-pays & deductibles, consistency of coverage) (N=49)	4.20
Access to health insurance coverage (e.g., preexisting conditions) (N=48)	4.08
Cost of prescripton drugs (N=49)	4.02
Availability and/or cost of dental and/or vision care (N=49)	3.98
Availability and/or cost of dental and/or vision insurance coverage (N=49)	3.96
Availability of doctors, nurses, and/or specialists (N=48)	3.88
Use of emergency room services for primary health care (N=48)	3.50
Confidentiality (N=49)	3.41
Availability of prevention programs or services (N=49)	3.33
Availability of non-traditional hours (e.g., evenings, weekends) (N=46)	3.17
Distance to health care services (N=49)	3.14
Time it takes to get an appointment (N=49)	2.96
Availability of/access to transportation (N=49)	2.47
Provider is not taking new patients (N=47)	2.15
Availability of bilingual providers and/or translators (N=43)	2.02

Mean (1=not at all, 5=a great deal)*

*Means exclude "do not know" responses

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Substance Use and Abuse

Figure 13. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

*Means exclude "do not know" responses

Physical Health

Figure 14. Level of concern with statements about the community regarding PHYSICAL HEALTH

*Means exclude "do not know" responses

Mental Health

Figure 15. Level of concern with statements about the community regarding MENTAL HEALTH

Stress (N=47) 3.89
Availability of qualified mental health providers (N=45) 3.62
Depression (N=47) 3.62
Quality of mental health programs (N=44) 3.43
Availability of services for addressing mental health problems (N=46) 3.30

Mean (1=not at all, 5=a great deal)*

*Means exclude "do not know" responses

Illness

Figure 16. Level of concern with statements about the community regarding ILLNESS

Cancer (N=47) 4.51
Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (N=48) 4.19
Communicable diseases (e.g., including sexually transmitted diseases, AIDS) (N=45) 3.29

Mean (1=not at all, 5=a great deal)*
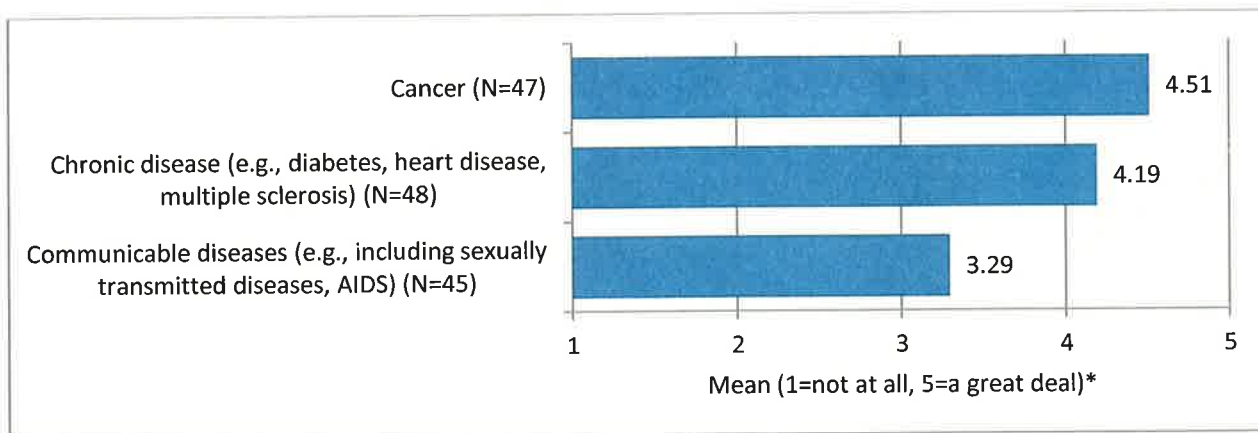
*Means exclude "do not know" responses

Delivery of Health Care in the Community

Respondents were asked to rate how well DELIVERY OF HEALTH CARE topics are being addressed in their community.

Delivery of Health Care

Figure 17. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed

*Means exclude "do not know" responses

Cancer Screening

More than 56% of respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because they did not feel that it was necessary or that the doctor had not recommended it. Fear and not knowing who to see were not considered to be the main reasons respondents gave.

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

Cancer Screening or Cancer Care within the Past Year

No	56.50%
Yes	43.50%
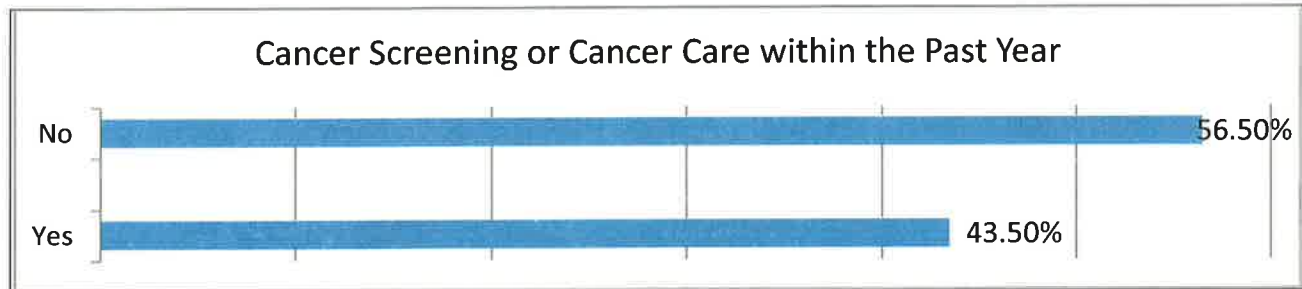
Figure 19. Reasons among respondents who have not had a cancer screening or cancer care in the past year

Reasons for Not Having a Cancer Screening

Other	0.00%
Unfamiliar with recommendations	19.00%
Don't know who to see/access care	9.50%
Doctor had not suggested it	33.30%
Cost	23.80%
Fear	0
Not necessary	47.60%
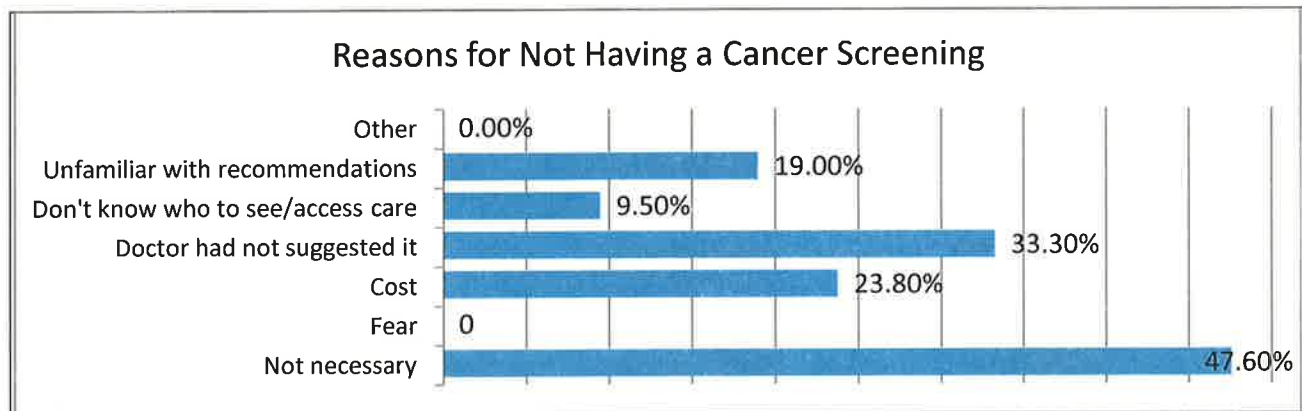
Health Care Coverage

Respondents were asked how they had paid for health care costs, for themselves or family members, over the last 12 months. A majority of respondents said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income and private health insurance were also used.

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

Health Coverage

Category	Percentage
Did not access	21.00%
Veteran's Benefits	0.00%
Military	0.00%
HIS	0.00%
Medicare	6.40%
Medicaid	0.00%
Personal Income	46.80%
Private health insurance	31.90%
Health Insurance through and employer	72.30%
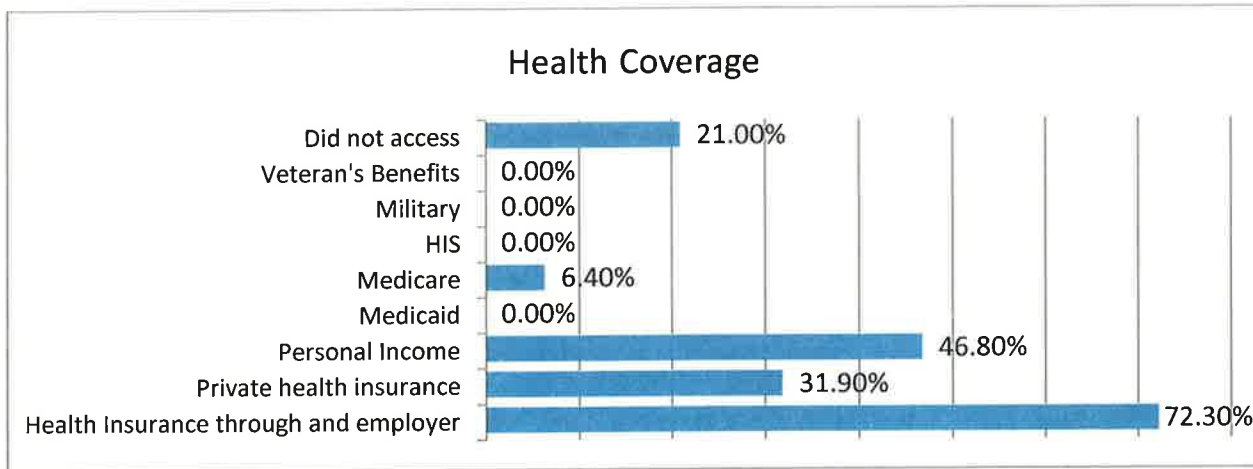
Primary Care Provider

The top three reasons respondents gave for their choice of primary health care provider were location, availability of services, and quality of services (Figure 21). Being valued as a patient was important to more than 29% of respondents.

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

Reasons for Choosing a Primary Care   Provider

Category	Percentage
Other	14.90%
Influenced by health insurance	12.80%
Sense of being values as a patient	29.80%
Availability of Services	51.10%
Quality of Services	44.70%
Location	87.20%

Respondents were asked which provider they used for their primary health care. Ninety-three percent (93%) of respondents said they use Sanford Winner as their primary health care provider.

Figure 22. Respondents' primary health care provider
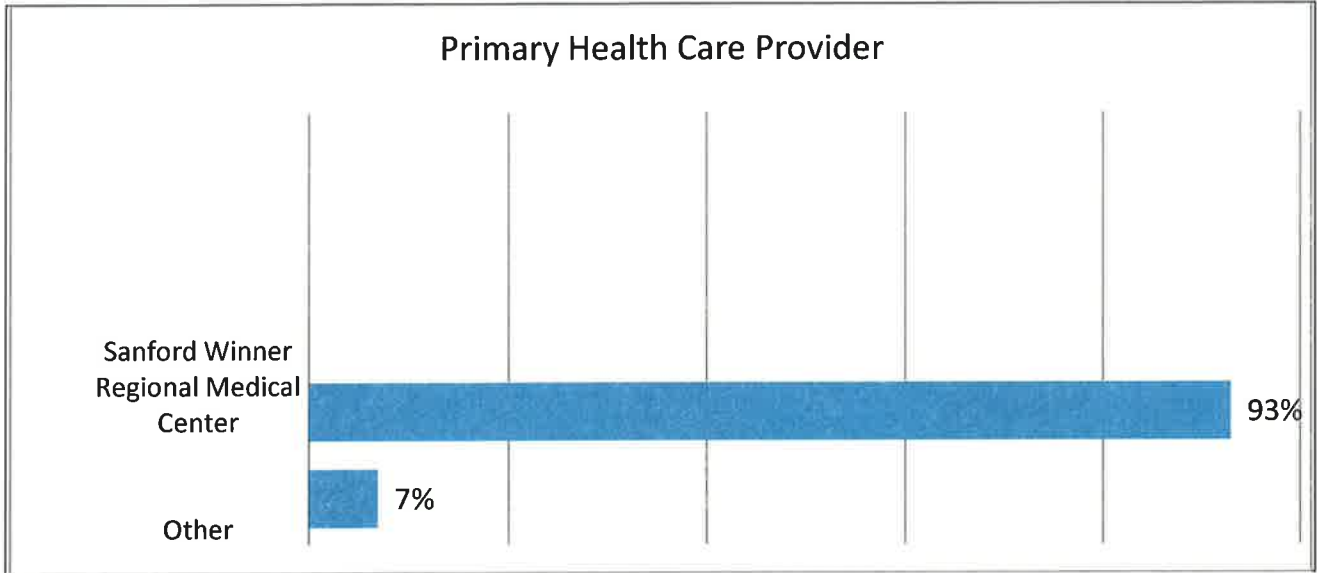
Respondents were asked to select their personal general health conditions/diseases. Weight control received the most responses with 37.8% of participants selecting this condition. The chronic diseases found among respondents include arthritis, asthma, cancer, heart disease, diabetes, Alzheimer's, muscle/bone conditions, high cholesterol, hypertension and depression (Figure 23).

Figure 23. Respondents' health/chronic diseases

Respondents' Health/Chronic Disease

Condition	Percentage
Other	4.40%
None	28.90%
Weight control	37.80%
OB/Gyn related	8.90%
Hypertension	15.60%
High Cholesterol	22.20%
Heart conditions - CHF	11.10%
Muscle or bone	11.10%
Diabetes	0.00%
Dementia/Alzheimer's	4.40%
Depression, anxiety, stress, etc.	31.10%
Cancer	6.70%
Asthma	6.70%
Arthritis	6.70%
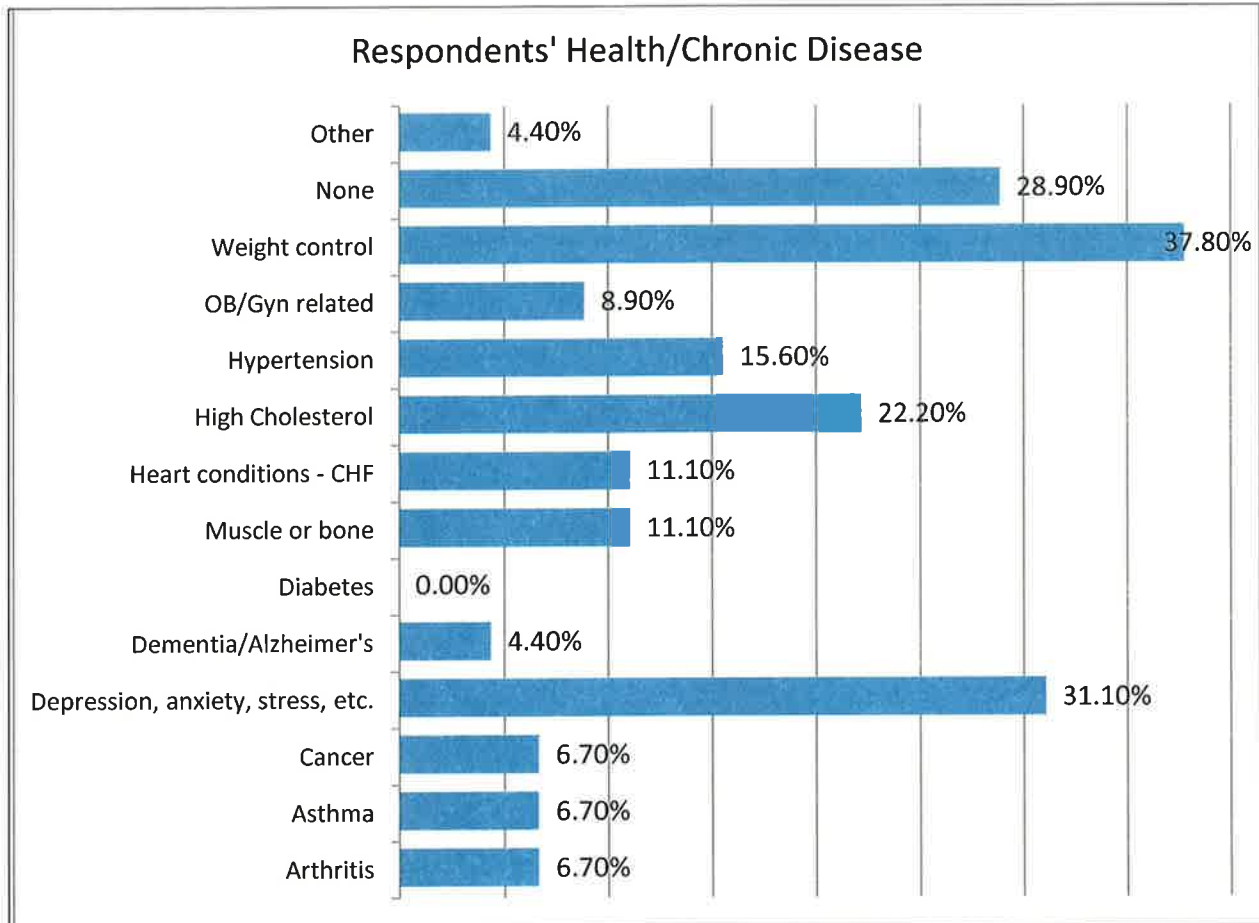
Demographic Information

The majority of respondents are 45 to 54 years old.

Figure 24. Respondents' age distribution

Age Distribution

- 65 and older: 8.70%
- 60 - 64 years: 6.50%
- 55 - 59 years: 8.70%
- 45 - 54 years: 41.30%
- 35 - 44 years: 21.70%
- 25 - 34 years: 13%
- 18 - 24 years: 0
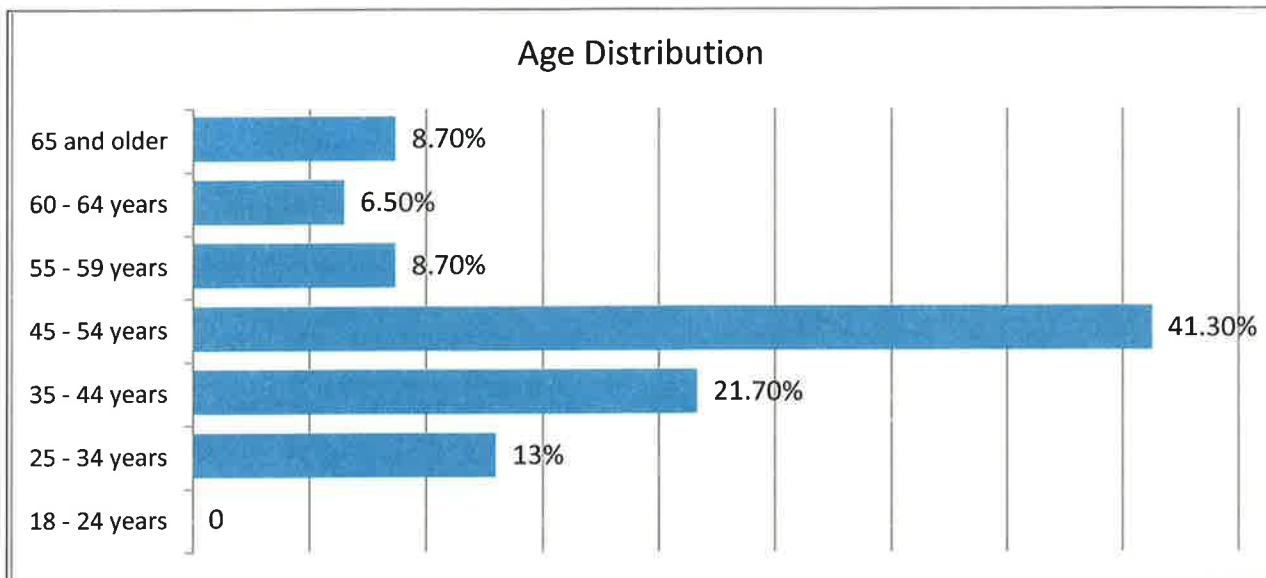
Most respondents have a bachelor's degree or higher. Over 17% have a graduate or professional degree.

Figure 25. Respondents' education

Respondents' Education

- Graduate or Professional degree: 17.80%
- Bachelor's degree: 35.60%
- Associate's degree: 15.60%
- Some college/no degree: 15.60%
- High School or GED: 15.60%
- Some high school: 0
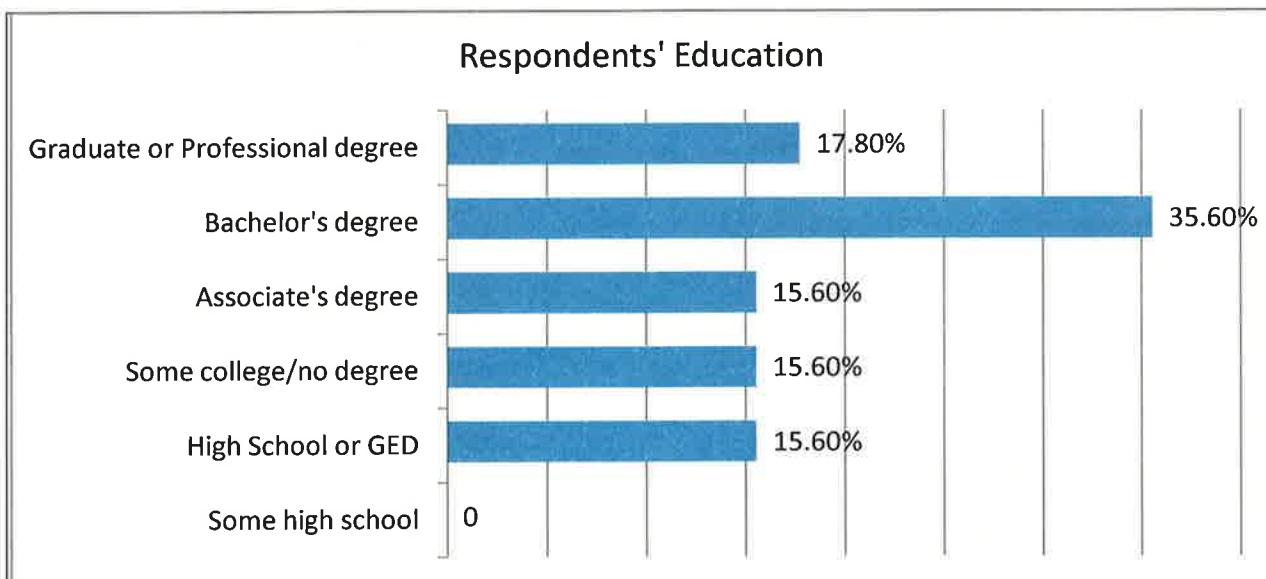
Figure 26. Respondents' gender distribution

Gender

Female ████████████████████████████████████ 80%

Male ████ 20%
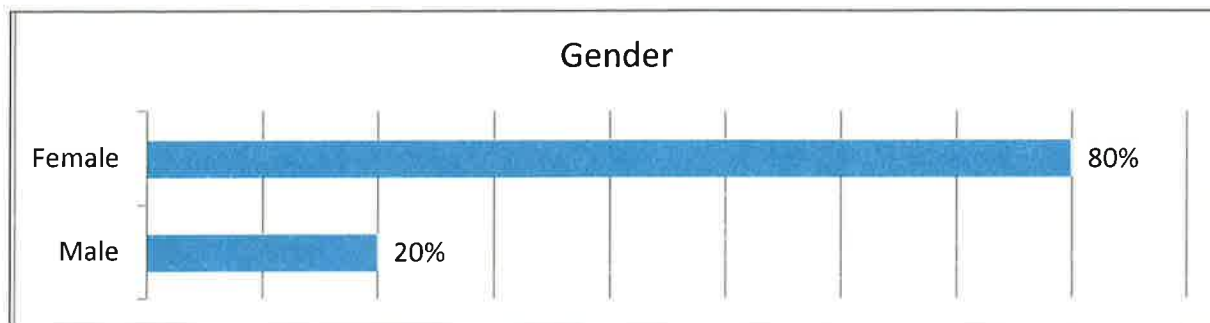
Quality Data

Center for Disease Control – Measures of Health and Leading Causes of Death by State

The Center for Disease Control has determined the leading causes of death in South Dakota to be heart disease, chronic lower respiratory disease, stroke, Alzheimer's disease, and diabetes.

Inpatient Diagnosis by Volume

The top Diagnosis Related Groups within the Winner Regional Healthcare Center inpatient setting were analyzed to determine the highest utilization by volume and the highest direct cost by diagnosis.

Table 1. Top Diagnosis Related Group by Volume

FY 2009	FY 2010	FY 2011
Esophagitis Digestive Disorder w/o MCC	Esophagitis Digest Disorder w/o MCC	Esophagitis Digest Disorder w/o MCC
Pneumonia w CC	Heart Failure & Shock w/o CC/MCC	Pneumonia w/o CC MCC
Pneumonia w/o CC/MCC	Cellulitis w/o MCC	Pneumonia w/CC
Heart Failure & Shock w CC	Pneumonia w/o CC/MCC	Cellulitis w/o MCC
Kidney & UTI w/o MCC	Kidney & UTI w/o MCC	Heart failure & Shock w/o CC/MCC

WRHC is a Critical Access Hospital. As such, their Medicare reimbursement is based on a cost per day calculation and not on the basis of a DRG.

Secondary Research

The 2011 County Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. State and national benchmarking required additional data sources, including the U.S. Census Bureau, Small Area Health Insurance Estimates, and the Centers for Disease Control and Prevention's National Center for Health Statistics – the Health Indicators Warehouse. The County Profile Data is included in the Appendix.

Health Outcomes

The mortality health outcomes indicate that South Dakota as a state has more premature deaths than the national benchmark. While the state of South Dakota (6,815) and Tripp County (5,782) have more premature deaths than the national benchmark (5,564), Tripp County has a lower rate than the state benchmark.

The morbidity health outcomes indicate that South Dakota citizens report more days of poor health (12%) than the national benchmark (10%), and Tripp County (14%) reports a much higher rate than the national benchmark. South Dakota (2.8) and Tripp County (2.7) report more physically unhealthy days than the national benchmark (2.6)

The state of South Dakota (2.6) reports more mentally unhealthy days than the national benchmark (2.3), while Tripp County (2.2) reports better mental health days.

South Dakota (6.8%) has a higher percentage of low birth weight than the national benchmark (6.0%). The data is not available for this indicator for Tripp County.

Mortality

		National Benchmark	SD	Tripp County SD
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,564	6,815	5,782

Morbidity

		National Benchmark	SD	Tripp County SD
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	10%	12%	14%
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.8	2.7
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-09	2.3	2.6	2.2
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.0%	6.80%	NA

Health Factors

The health behavior outcomes indicate that South Dakota (20%) has a higher percentage of adult smokers than the national average (14%); however, Tripp County (14%) has a lower average. Adult obesity is also higher in the state of South Dakota (29%) and Tripp County (32%), than the national average (25%). South Dakota (2.8) and Tripp County (2.7) have a higher percentage of physical inactivity than the national benchmark (2.6). South Dakota (2.6) has a higher rate of self-reported poor mental health days than the national benchmark (2.3) and Tripp County (2.2) is ranked slightly more positive than the national benchmark. South Dakota has a higher percentage (6.8%) of lower birth weight than the national benchmark (6.0%). The data is not available for this indicator for Tripp County.

South Dakota (19%) and Tripp County (15%) have higher percentages of binge drinking reports than the national benchmark (8%). Motor vehicle crash death rates are nearly double the national benchmark (12) in South Dakota (23.7). The data is not available for this indicator for Tripp County.

Sexually transmitted infections rank substantially higher than the national average for South Dakota (371.3 vs. national benchmark of 83.0) and Tripp County (140.8). The teen birth rate is higher in South Dakota (38.7) and Tripp County (41.1) than the national benchmark (22).

Health Behaviors

		National Benchmark	SD	Tripp County SD
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	20%	14%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	25%	29%	32%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	26%	32%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, (consuming >4 for women and >5 for men on a single occasion) 2003-2009	8%	19%	15%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	12.0	23.7	NA
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	83.0	371.3	140.8
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	22.0	38.7	41.1

Clinical Care

The clinical care outcomes indicate that South Dakota has a higher percentage of uninsured adults (16%) than the national benchmark (13%), while Tripp County (19%) is substantially higher than both state and national benchmarks. The percentage of uninsured youth in Tripp County is higher (9%) than the national benchmark (7%), but is the same as South Dakota (9%) as a whole.

The ratio of population to primary care physicians is higher in South Dakota (769:1) than the national benchmark (631:1), but the ratio is more positive in Tripp County (560:1).

The ratio of population to mental health providers is much worse in South Dakota (3,544:1) and Tripp County (5,603:0) than the national benchmark (2,242:1).The number of professionally active dentists is lower than the national benchmark (69) in South Dakota (50) and Tripp County (35.2). Preventable hospital stays are higher than the national benchmark (52) in South Dakota (68.6) and in Tripp County (89.1).

Diabetic screening in South Dakota (83%) is lower than the national benchmark (89%), but is slightly higher than the national benchmark in Tripp County (92%). Mammography screening is lower in South Dakota (68%) and Tripp County (69%) than the national benchmark (74%).

		National Benchmark	SD	Tripp County SD
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	16%	19%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	7%	9%	9%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	631:1	769:1	560:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	2242:1	3544:1	5,603:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	69:0	50.0	35.2
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.0	68.6	89.1
Diabetes screening	Percent of Medicare enrollees with diabetes who receive HbA1c screening, 2006-2007	89%	83%	92%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	68%	69%

Social and Economic Factors

The social and economic factor outcomes indicate that South Dakota (83%) and Tripp County (85%) have a lower high school average than the national benchmark (92%), and both South Dakota (64%) and Tripp County (58%) have a lower percentage of post secondary education than the national benchmark (68%).The unemployment rate was lower in South Dakota (4.8%) and in Tripp County (3.5%) than the national benchmark (5.3%). The percentage of child poverty is substantially higher in South Dakota (18%) than the national benchmark (11%); however, Tripp County (27%) is substantially higher than the national benchmark for child poverty. Inadequate social support is higher in South Dakota and Tripp County (both at 17%) than the national benchmark (14%).

The percentage of children in single parent households is higher than the national benchmark (20%) in South Dakota (29%) and Tripp County (31%).The number of homicide deaths in South Dakota (2.5/100,000) is higher than the national benchmark (1.0/100,000). The data is not available for this indicator for Tripp County.

		National Benchmark	SD	Tripp County SD
High school graduation	Percent of 9th gr. cohort in public schools that graduates from high school in 4 years 2006-2007	92%	83.0%	85%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	64.0%	58%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009	5.3%	4.8%	3.5%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	18.0%	27%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	17.0%	17%
Children in single parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	20%	29.0%	31%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	1.0	2.5	NA

Physical Environment

The physical environment outcomes indicate that there is no air pollution or ozone pollution in this area. Access to healthy food is ranked far below the national benchmark (92%) in Tripp County (40%) and in South Dakota (42%). In this rural area there can be far distances to travel to grocery stores, and there are food deserts in some communities where only a gas station convenience store is close to home. Access to recreational facilities ranks lower than the national benchmark (17/100,000) for South Dakota (13/100,000) but is substantially higher for Tripp County (71/100,000).

		National Benchmark	SD	Tripp County SD
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e. grocery store or produce stand/farmers market), 2008	92%	42.0%	40%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	17.0	13	71.1

Demographics

Youth account for 25% of the population in Tripp County. The elderly account for 21% of the population in Tripp County. Fifty-one percent (51%) of Tripp County is rural compared to 48% of South Dakota and 21% as the national benchmark.

Only 2% of South Dakotans are not proficient in English compared to the national benchmark of 9%. The data is not available for this indicator for Tripp County. South Dakota's illiteracy rate is 7% and Tripp County is at 9%, compared to the national benchmark of 15%.

		National Benchmark	SD	Tripp County SD
Youth	Percent of total population ages 0-17, 2009	24%	25%	25%
Elderly	Percent of total population ages 65 and older, 2009	13%	14%	21%
Rural	Percent of total population living in rural area, 2000	21%	48%	51%
Not English Proficient	Percent of total population that speaks English less than "very well". 2005-2009	9%	2%	0%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	7%	9%

Population Age

The population for this area is 21% older than 65 years of age and 4% older than 85 years of age. Fourteen percent (14%) of South Dakotans are older than 65 years of age and only 2% are older than 85 years of age.

The gender distribution is 49% male and 51% female. The gender mix is 50-50 for the state of South Dakota.

	National Benchmark	South Dakota	Tripp County South Dakota
Total population	307,745,538	814,180	5,644
Percent ages 65 and older	13%	14%	21%
Percent 85 and older	2%	2%	4%
Percent male	49%	50%	49%
Percent female	51%	50%	51%

Based on 2010 Census data

Housing

The majority of individuals (71%) in Tripp County own their homes. Sixty-eight percent (68%) of South Dakotans own their own home.

	National Benchmark	South Dakota	Tripp County South Dakota
Percent of occupied housing that is owner-occupied	65%	68%	71%
Percent of occupied housing that is renter-occupied	35%	32%	29%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 69% in Tripp County. The percentage of those who are living at less than 100% of the poverty level is 14% in South Dakota, and 16 % in Tripp County. In South Dakota, 33%, and in Tripp County, 41%, are at less than 200% of the poverty level. The median annual household income in South Dakota is $46,369 while Tripp County is at $40,221.

	National Benchmark	South Dakota	Tripp County South Dakota
Percent of working age population in the labor force	65%	69%	69%
Percent of total population with income less than 100% of poverty	14%	14%	16%
Percent of total population with income less than 200% of poverty	32%	33%	41%
Median household income	$51,914	$46,369	$40221
Owner occupied housing units	76,089,650	217,250	1,870
Percent spending 30% or more income toward housing costs	30%	20%	15%
Renter occupied housing units	38,146,346	98,218	672
Percent renters spending 30% or more of income toward housing costs	47%	35%	42%

Diversity Profile

The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian alone, then Hispanic origin of any race, and Black alone. The Asian population ranks fifth in South Dakota.

In Tripp County the ranking is White (83%), American Indian (14%), Hispanic (1%) and Asian (.002%).

	National Benchmark	South Dakota	Tripp County South Dakota
Total population	308,745,538	814,180	5,644
White alone	223,553,265	699,392	4,689
Asian alone	14,674,252	7,610	12
Black alone	38,929,319	10,207	6
Hispanic origin – of any race	50,477,594	22,119	60
American Indian	2,932,248	71,817	788

Health Needs Identified

The identified needs from the surveys and analysis of secondary data indicated the following needs:
- Adult obesity
- Teen birth rate
- Lack of mental health providers
- Access to healthy foods
- Preventable hospital stays
- Child poverty
- Children in single parent homes
- Lack of post-secondary education
- Living greater than 200% of poverty level
- Median annual household income
- Uninsured adults
- Cancer
- Wellness

Community Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. Community experts were asked to complete the asset mapping exercise. Individuals who contributed to this work include the health department, social services, education, community members and leaders from the health care facilities within the county.

Table 1 in the Appendix displays the concerns and assessed needs that were determined by the assessment and includes the assets in the community that address the needs.

An informal gap analysis was conducted at the conclusion of the asset mapping work. The gap analysis determined that there were three main areas on which to focus attention. A multi-voting prioritization process determined the priority of the remaining needs.

The priorities that remain include:
- Physician Recruitment
- Employee-Based Wellness Program
- Chronic Health Issues in the Community

The Winner Community Health Needs Assessment Collaborative is establishing key initiative strategies to address all of the above listed concerns. Leadership from Winner Regional Healthcare Center will serve on all local groups.

Table 2 in the Appendix displays the unmet needs that were determined after the asset mapping exercise and the prioritized list of remaining needs.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment
Winner Regional Healthcare Center Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resources/asset mapping and multi-voting prioritization process:

Priority 1: Physician Recruitment

Goal: Increase the number of physicians in the community.

Measurable Outcome:
- Number and specialties of physicians
- Number of patients seen per provider

Sanford Resources:
- CEO

Priority 2: Employee-Based Wellness Programs

Goal: Promote employee-based wellness programs to WRHC employees (this group is the largest employer in the community).

Measurable Outcomes:
- An educational session is conducted for staff on the benefits of wellness and opportunities are identified for outreach services.
- Fitness activities are provided for staff and staff is encouraged to participate.
- Possible specials for WRHC employees are explored with other local wellness facilities.
- Evidence-based programs to educate/activate a healthier lifestyle (i.e. cooking classes, etc.) are offered.
- The potential of offering a children's health fair is explored.

Sanford Resources:
- CFO
- HR Director

<u>Priority 3: Evaluate Chronic Health Issues in the Community</u>

<u>Goal:</u> Evaluate chronic health issues in the community. Based on those findings, take the top one or two issues and determine the best way to address the population that is impacted.

    Measurable Outcomes:
- The top two chronic health issues are in the community are identified.
- The best ways to address the impacted population are determined.
- Groups to assist with the top two chronic health issues are formed.

    Sanford Resources:
- CNO
- DNO
- Clinic Manager

APPENDIX

2011 County Health Profile

An adaptation of the County Health Rankings Project for the Fargo-Moorhead
Community Health Needs Assessment Collaborative

Tripp County
South Dakota

HEALTH OUTCOMES		Tripp	*National Benchmark	South Dakota
Mortality				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,782	5,564	6,815
Morbidity				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	14%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.7	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.2	2.3	2.6
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	-	6.0%	6.8%

HEALTH FACTORS

		Tripp	*National Benchmark	South Dakota
Health Behaviors				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	14%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	32%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	32%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	15%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	140.8	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	41.1	22.0	38.7
Clinical Care				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	19%	13%	16%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	9%	7%	9%
Primary care physicians	Ratio of total population to primary care physicians, 2008	560:1	631:1	769:1
Mental health providers	Ratio of total population to mental health providers, 2008	5,603:0	2,242:1	3,544:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	35.2	69.0	50.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	89.1	52.0	68.6
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	92%	89%	83%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	69%	74%	68%

HEALTH FACTORS (continued)		Tripp	*National Benchmark	South Dakota
Social and Economic Factors				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	85%	92%	83%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	58%	68%	64%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	3.5%	5.3%	4.8%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	27%	11%	18%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	17%	14%	17%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	31%	20%	29%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5
Physical Environment				
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	40%	92%	42%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	71.0	17.0	13.0

Demographics		Tripp	United States	South Dakota
Youth	Percent of total population ages 0-17, 2009	25%	24%	25%
Elderly	Percent of total population ages 65 and older, 2009	21%	13%	14%
Rural	Percent of total population living in a rural area, 2000	51%	21%	48%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	0%	9%	2%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	9%	15%	7%

*The national benchmark is the 90th percentile (i.e., 10% of counties nationwide ranked better). **Binge drinking is defined as consuming more than 4 (for women) or 5 (for men) alcoholic beverages on a single occasion in the past 30 days. Heavy drinking is defined as drinking more than 1 (for women) or 2 (for men) alcoholic beverages per day on average. - Blank values reflect unreliable or missing data.

Source: The overall format and content of the County Health Profiles is based largely on County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/. Additional data sources include the U.S. Census Bureau, Small Area Health Insurance Estimates, http://www.census.gov/sahie/ and the Centers for Disease Control and Prevention's National Center for Health Statistics - the Health Indicators Warehouse, http://healthindicators.gov and "Health, United States, 2010," Table 109, http://www.cdc.gov/nchs/hus.htm.

Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. The 2011 County Health Profile was prepared by researchers at North Dakota State University in Fargo for the 2011-2013 Fargo-Moorhead Community Health Needs Assessment Collaborative. December 2011

Definitions of Health Variables

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

Aging Profile

2010 Demographic and Socio-Economic Profile
for the Aging Population Ages 65 and Older

Tripp County

South Dakota

CHARACTERISTICS	Total	AGE	
		Less than 65 Years	Ages 65 and Older
Population [1]			
Total population	5,644	4,457	1,187
Percent ages 65 and older	21%	-	100%
Percent ages 85 and older	4%	-	20%
Percent male	49%	51%	43%
Percent female	51%	49%	57%
Living Arrangements			
Total households (by age of householder) [1]	2,419	1,605	814
Percent with family households (i.e., at least two people who are related)	62%	71%	45%
Percent with householder living alone	35%	25%	54%
Grandparents living with their grandchildren* [2]	19	12	7
Percent who are responsible for their grandchildren	100%	100%	100%
Housing [1]			
Percent of occupied housing that is owner-occupied	71%	70%	74%
Percent of occupied housing that is renter-occupied	29%	30%	26%
Economic Security [2]			
Percent of working-age population in labor force	69%	84%	25%
Percent of total population with income less than 100% of poverty	16%	18%	9%
Percent of total population with income less than 200% of poverty	41%	44%	29%
Median household income (by age of householder)	$40,221	$36,916	$33,835
Owner-occupied housing units (by age of householder)	1,870	1,242	628
Percent spending 30% or more of income toward housing costs	15%	15%	16%
Renter-occupied housing units (by age of householder)	672	589	83
Percent spending 30% or more of income toward housing costs	42%	40%	57%

Note: *The age categories for this indicator are grandparents ages 35 to 59 and grandparents ages 60 and older.

Source: U.S. Census Bureau, [1] 2010 Census Summary File 1 and [2] 2006-2010 American Community Survey 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable.

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Diversity Profile

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

Tripp County

South Dakota

| CHARACTERISTICS | Total | RACE | | | | ETHNICITY |
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
Population [1]						
Total population	5,644	4,689	6	788	12	60
Percent ages 0 to 17	23%	20%	33%	40%	25%	53%
Percent ages 18 to 44	26%	24%	33%	40%	25%	33%
Percent ages 45 to 64	29%	32%	17%	15%	25%	12%
Percent ages 65 and older	21%	24%	17%	5%	25%	2%
Median age (in years)	45.3	48.8	36.5	23.3	44.5	17.0
Living Arrangements						
Total households [1]	2,419	2,164	2	203	5	13
Percent with householder living alone	35%	35%	50%	25%	80%	62%
Percent with families with children ages 0 to 17	25%	23%	50%	46%	20%	23%
Grandparents living with their grandchildren [2]	19	7	0	12	0	0
Percent who are responsible for grandchildren	100%	100%	-	100%	-	-
Housing [1]						
Percent occupied housing that is owner-occupied	71%	76%	0%	29%	40%	31%
Percent occupied housing that is renter-occupied	29%	24%	100%	71%	60%	69%
Educational Attainment [2]						
Percent of persons ages 25 and older with high school degree or higher	88%	89%	-	75%	100%	-
Percent of persons ages 25 and older with Bachelor's degree or higher	16%	15%	-	41%	0%	-
Economic Security [2]						
Unemployment rate	5%	1%	0%	18%	0%	0%
Median household income	$40,221	$42,029	-	$34,076	-	-
Percent of households with income <$25,000	30%	26%	100%	43%	-	100%
Percent of persons with income <100% poverty	16%	11%	100%	27%	0%	0%
Percent of children ages 0 to 17 in families with income <100% poverty	27%	21%	-	29%	-	-
Percent of elderly ages 65 and older with income <100% poverty	10%	9%	-	0%	-	-

Source: U.S. Census Bureau, [1] 2010 Census Summary File 1 and [2] 2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.
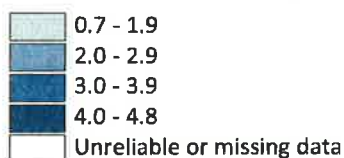
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Map 1

Premature Death - A health outcome measure focusing on mortality

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
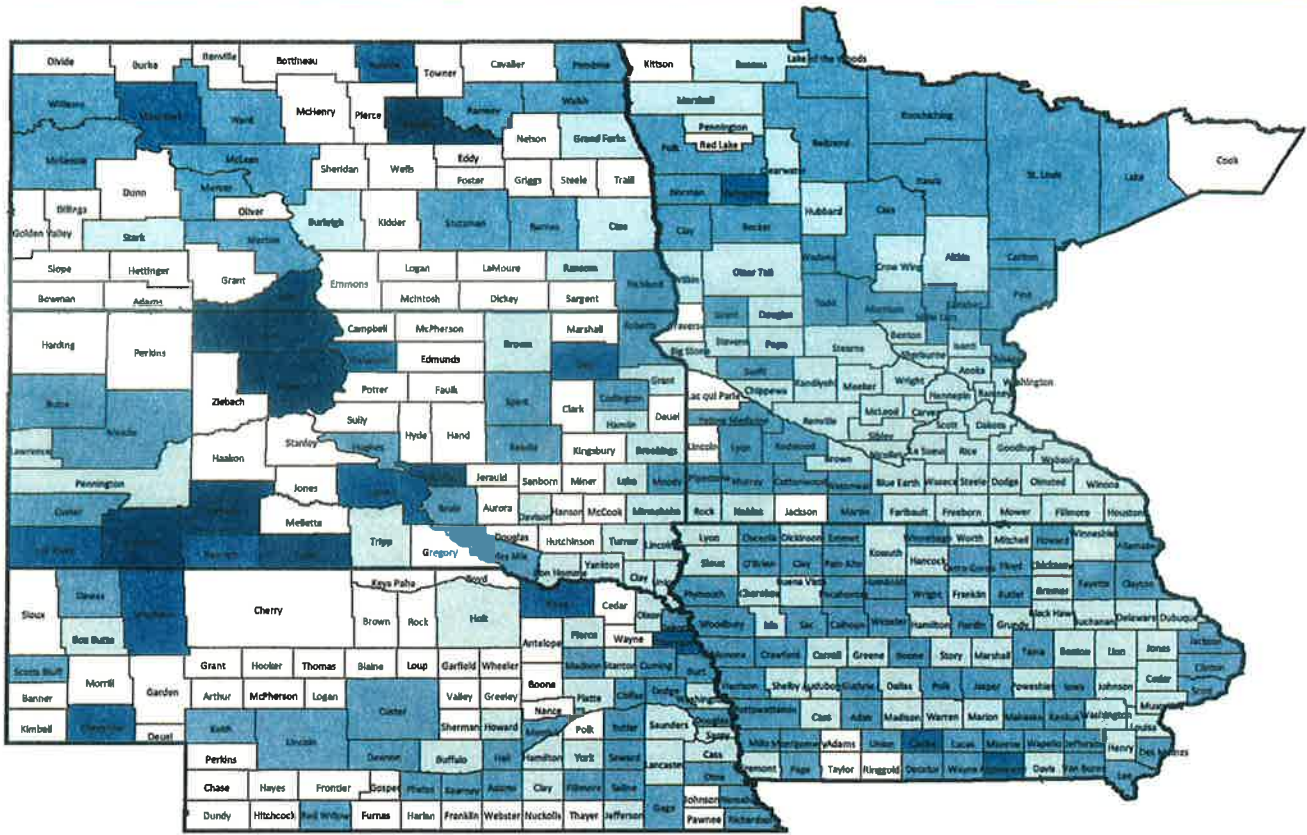
Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007

- 3,624 - 5,999
- 6,000 - 8,899
- 8,900 - 14,999
- 15,000 - 24,829
- Unreliable or missing data
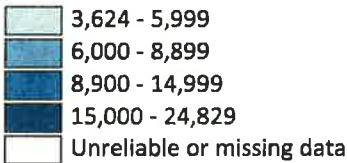
CONTEXT

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

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

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

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

Map 2

Poor or Fair Health - A health outcome measure focusing on morbidity
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

- 3.5% - 8.9%
- 9.0% - 11.9%
- 12.0% - 16.9%
- 17.0% - 29.1%
- Unreliable or missing data
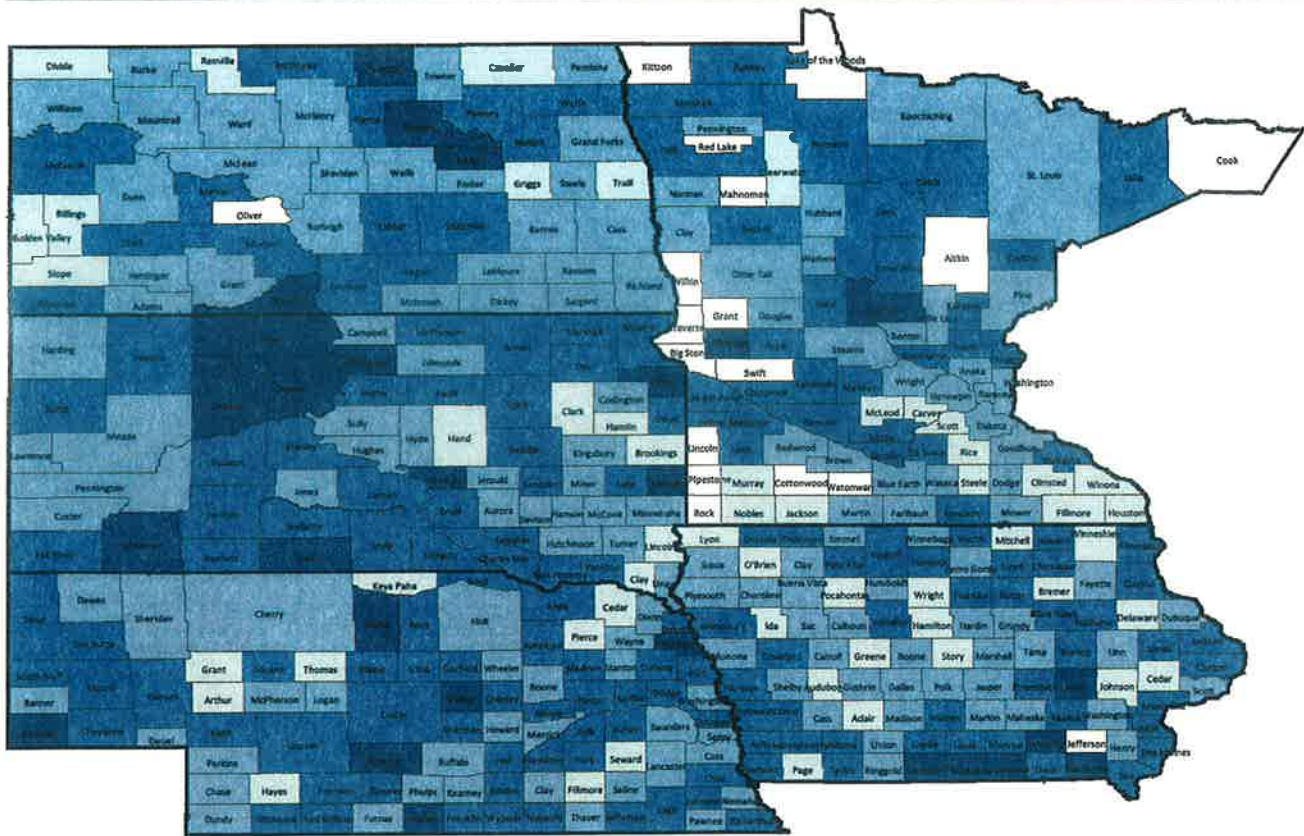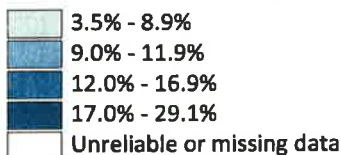
CONTEXT

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

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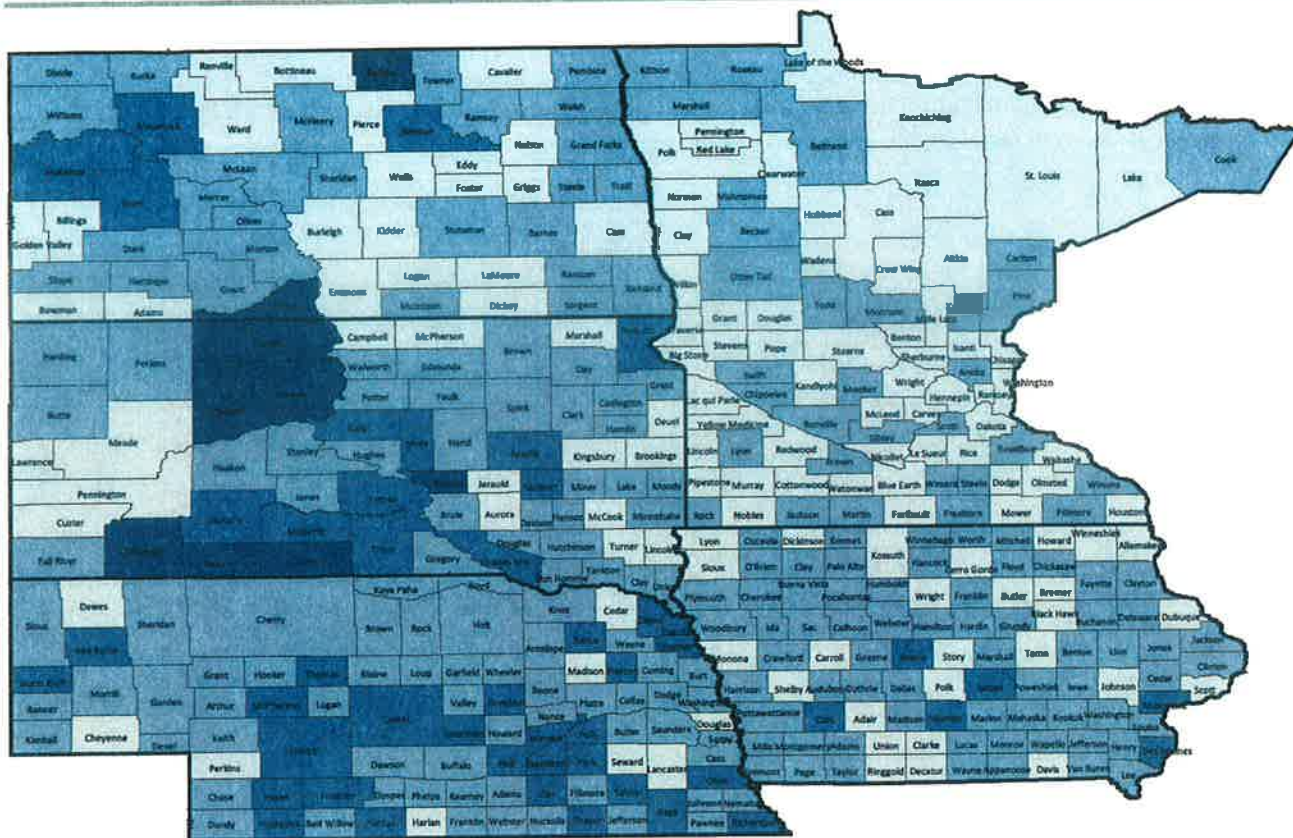n households with a land-line telephone. Seven years of data are used to generate more stable estimates of self-reported health status.

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

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

Map 3

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

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

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

- 0.6 - 1.9
- 2.0 - 2.9
- 3.0 - 3.9
- 4.0 - 6.5
- Unreliable or missing data

CONTEXT

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

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 1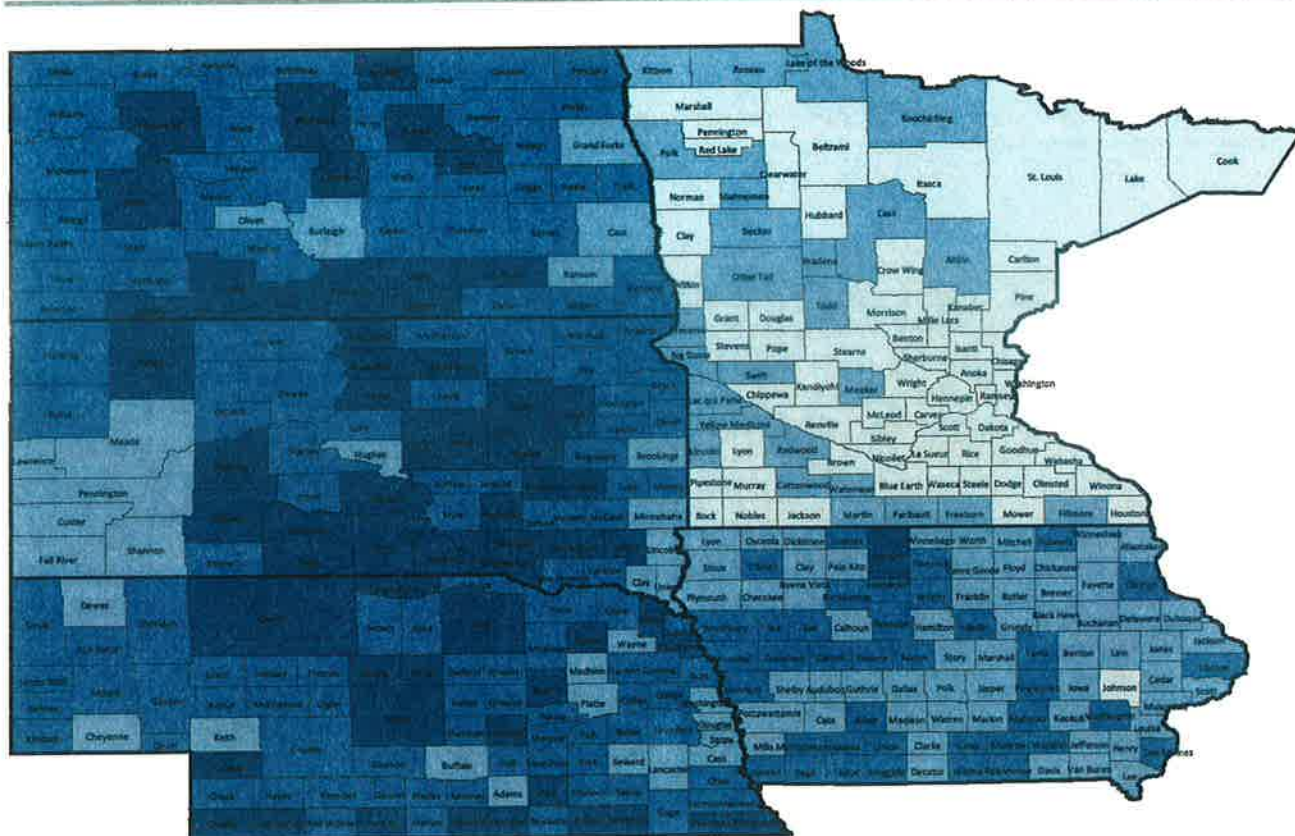8 and older living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of poor physical health days.

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

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

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Map 4

Poor Mental Health Days - A health outcome measure focusing on morbidity
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

- 0.7 - 1.9
- 2.0 - 2.9
- 3.0 - 3.9
- 4.0 - 4.8
- Unreliable or missing data

CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
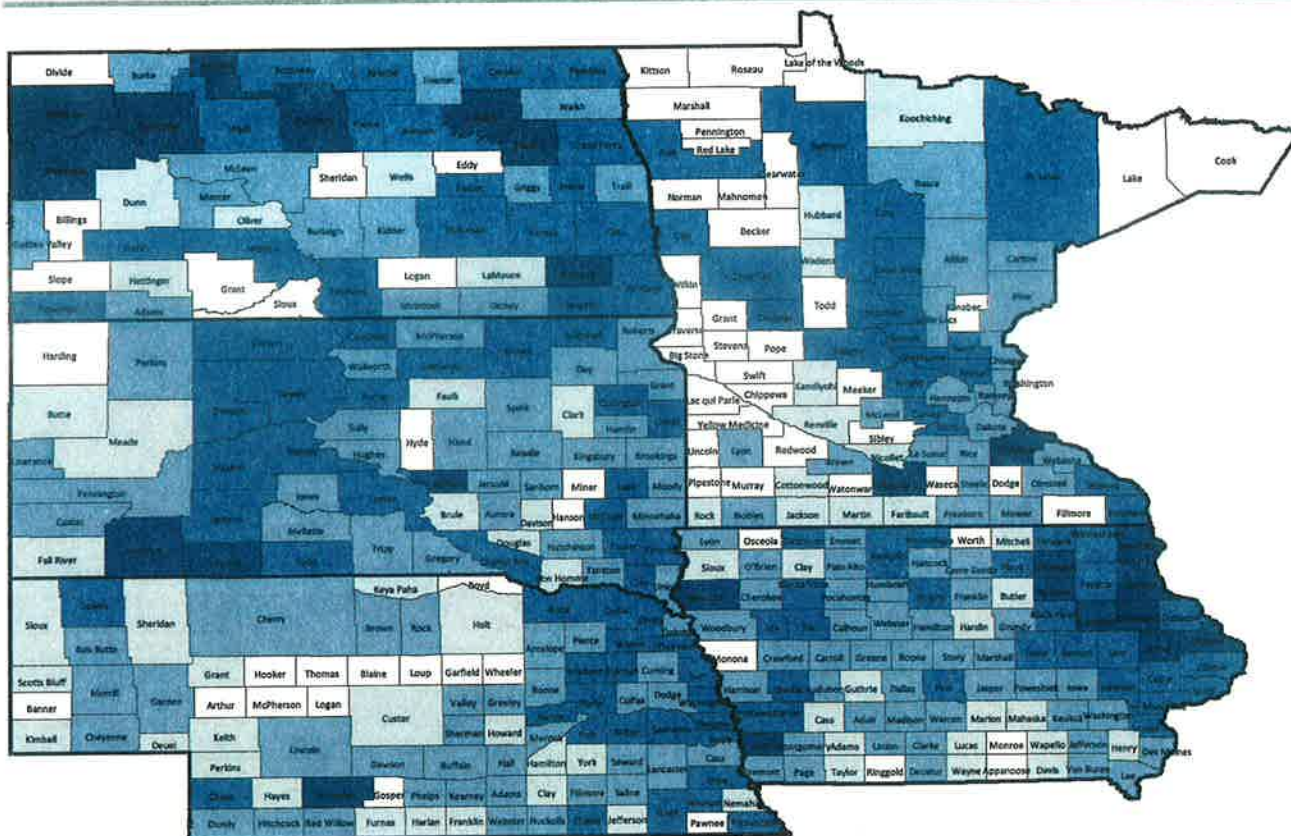
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Map 5

Low Birthweight - A health outcome measure focusing on morbidity

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

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

- 4.7% - 5.9%
- 6.0% - 6.9%
- 7.0% - 7.9%
- 8.0% - 9.1%
- Unreliable or missing data
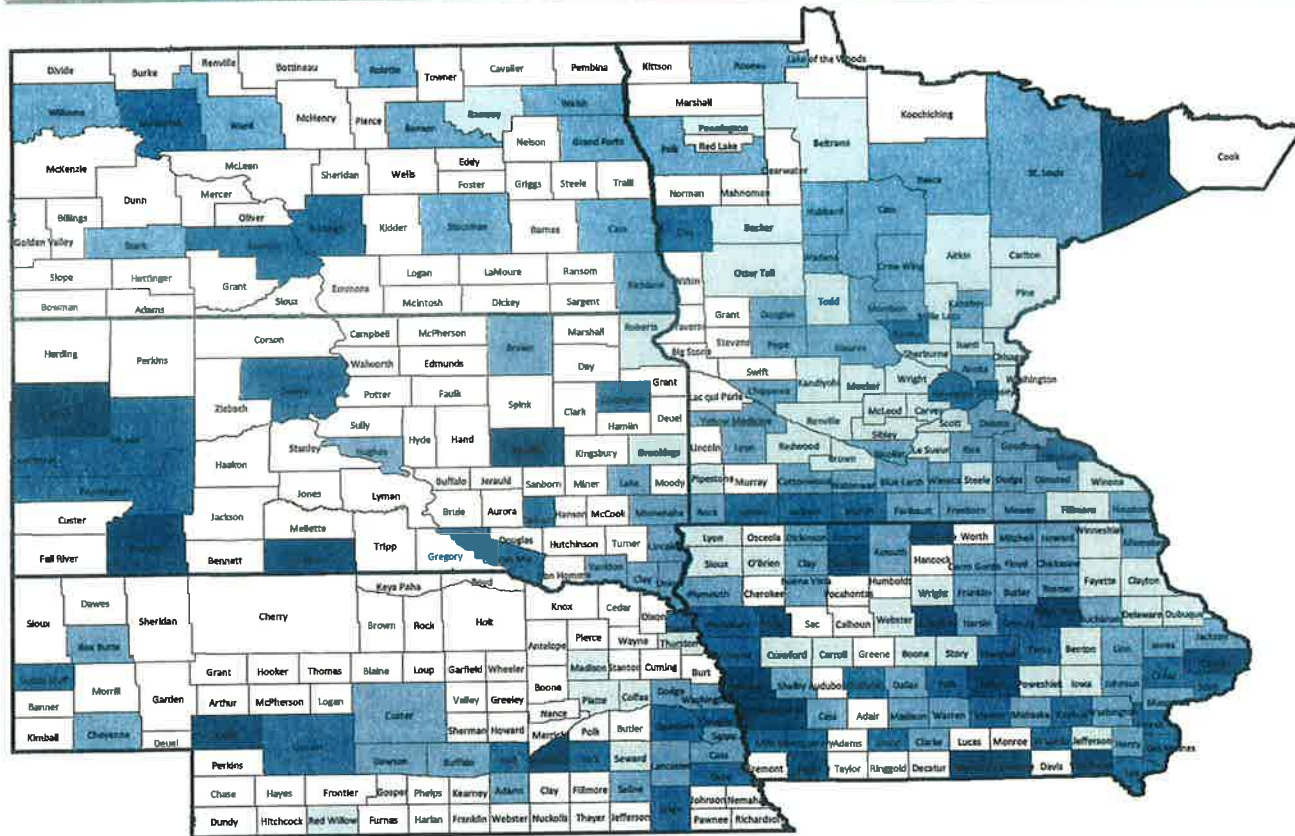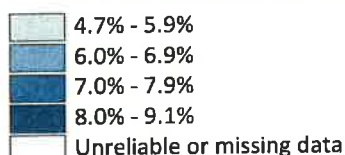
CONTEXT

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

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

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

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

Map 6

Adult Smoking - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
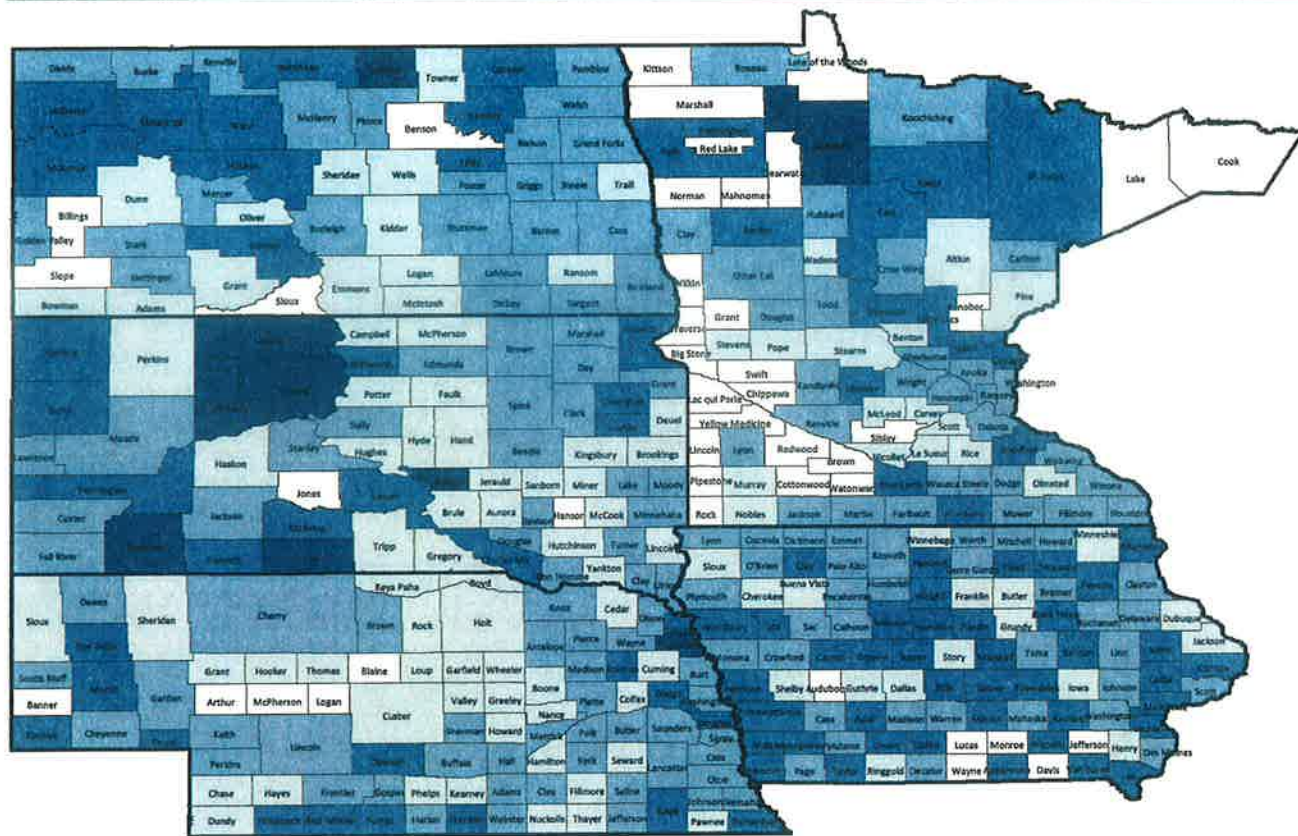
Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009

- 3.6% - 15.9%
- 16.0% - 20.9%
- 21.0% - 29.9%
- 30.0% - 48.5%
- Unreliable or missing data
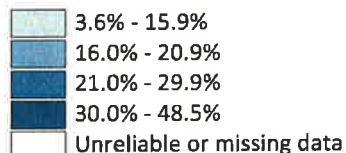
CONTEXT

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

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

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

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

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Map 7

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

Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008

- 22.5% - 27.9%
- 28.0% - 29.9%
- 30.0% - 33.9%
- 34.0% - 41.0%

CONTEXT

What It Is: The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2.

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

Importance: Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis.
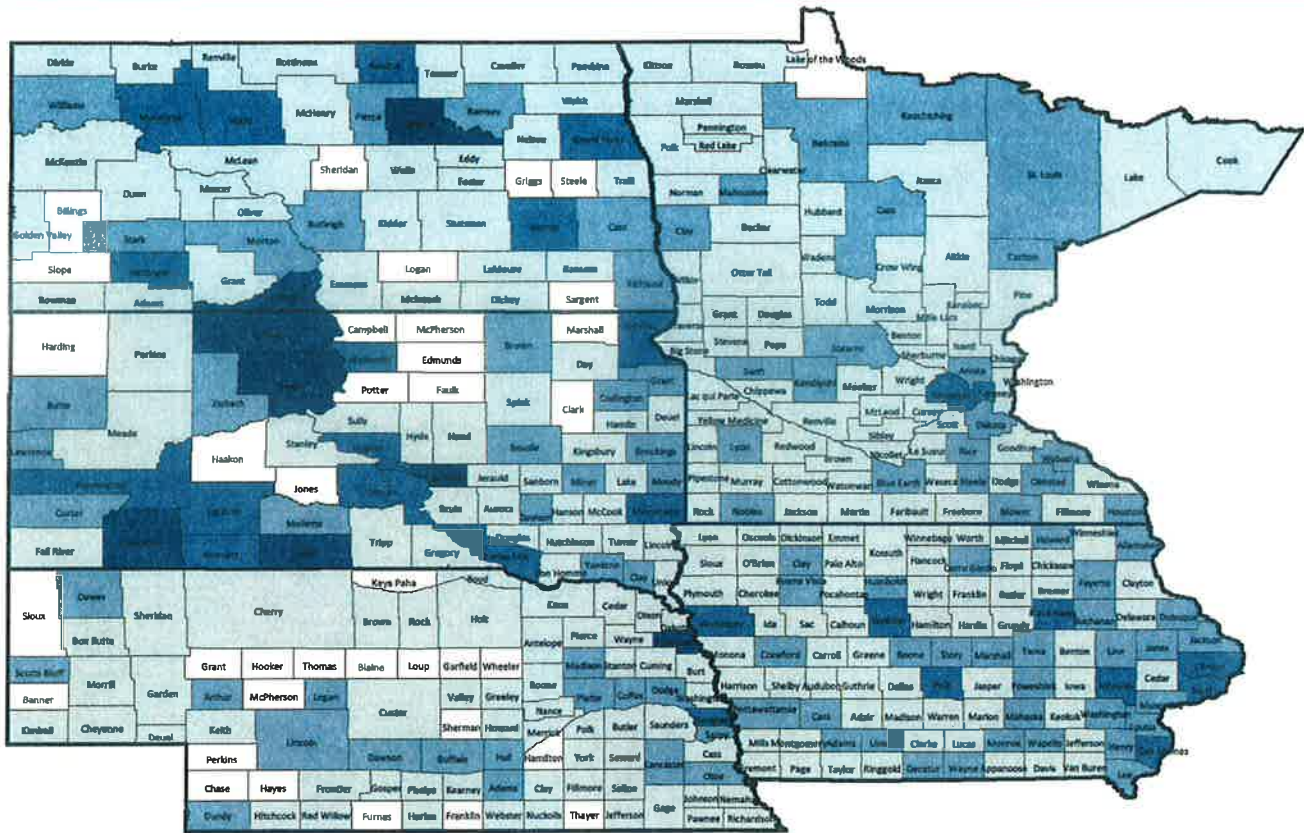
- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.

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Map 8

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

Percent of adults reporting no leisure time physical activity, 2008

- 14.6% - 19.9%
- 20.0% - 25.9%
- 26.0% - 29.9%
- 30.0% - 35.7%
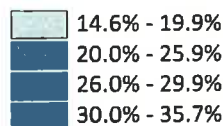
CONTEXT

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

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

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

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

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Map 9

Excessive Drinking - A health factor measure focusing on health behaviors

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

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

- 7.5% - 14.9%
- 15.0% - 19.9%
- 20.0% - 24.9%
- 25.0% - 35.9%
- Unreliable or missing data

CONTEXT

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

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

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

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

Map 10

Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

- 7.1 - 17.9
- 18.0 - 31.9
- 32.0 - 59.9
- 60.0 - 135.7
- Unreliable or missing data
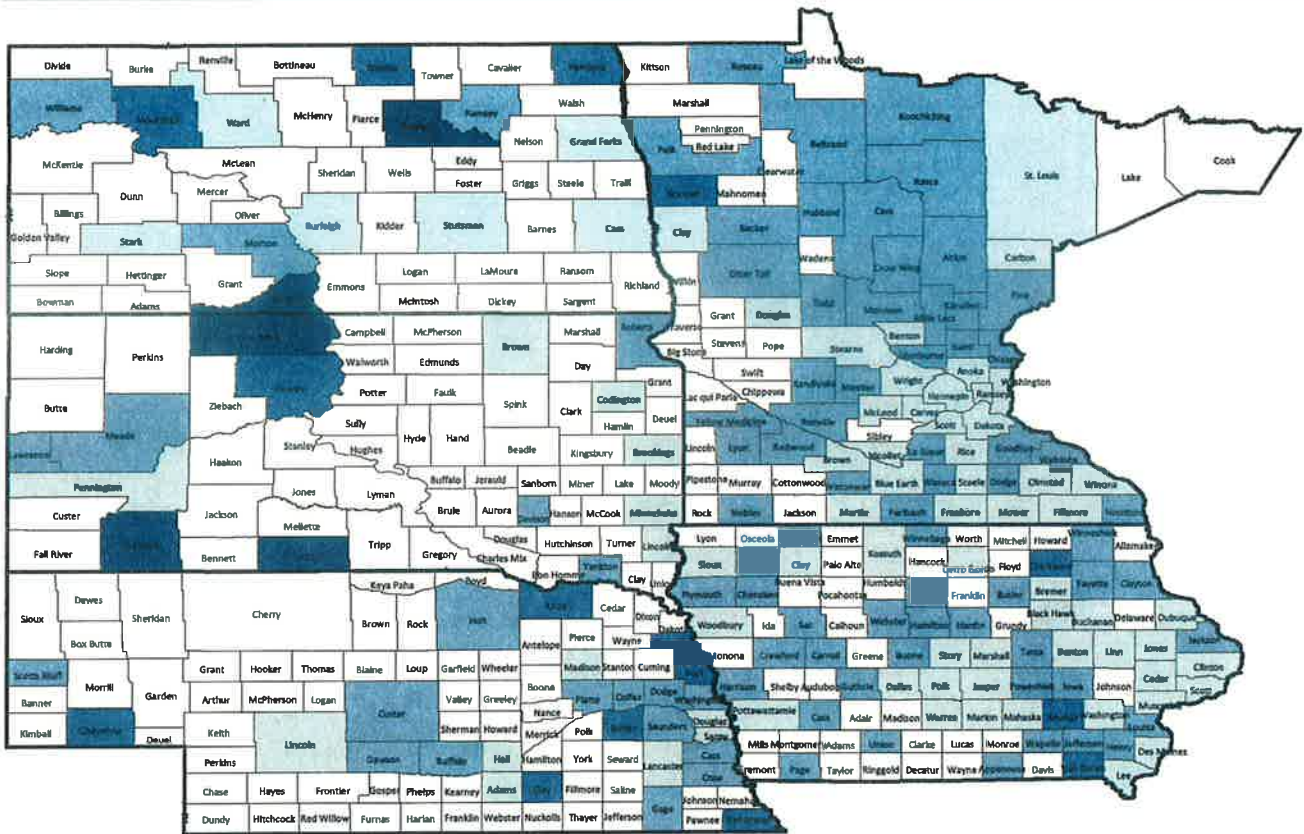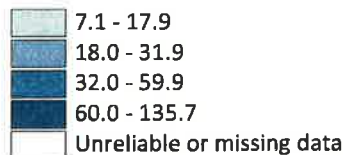
CONTEXT

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

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

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

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

Map 11

Sexually Transmitted Infections - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

	15.4 - 176.9
	177.0 - 399.9
	400.0 - 1,015.9
	1,016.0 - 2,326.8
	Unreliable or missing data
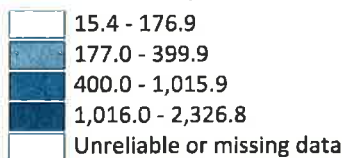
CONTEXT

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

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

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

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

Map 12

Teen Birth Rate - A health factor measure focusing on health behaviors
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
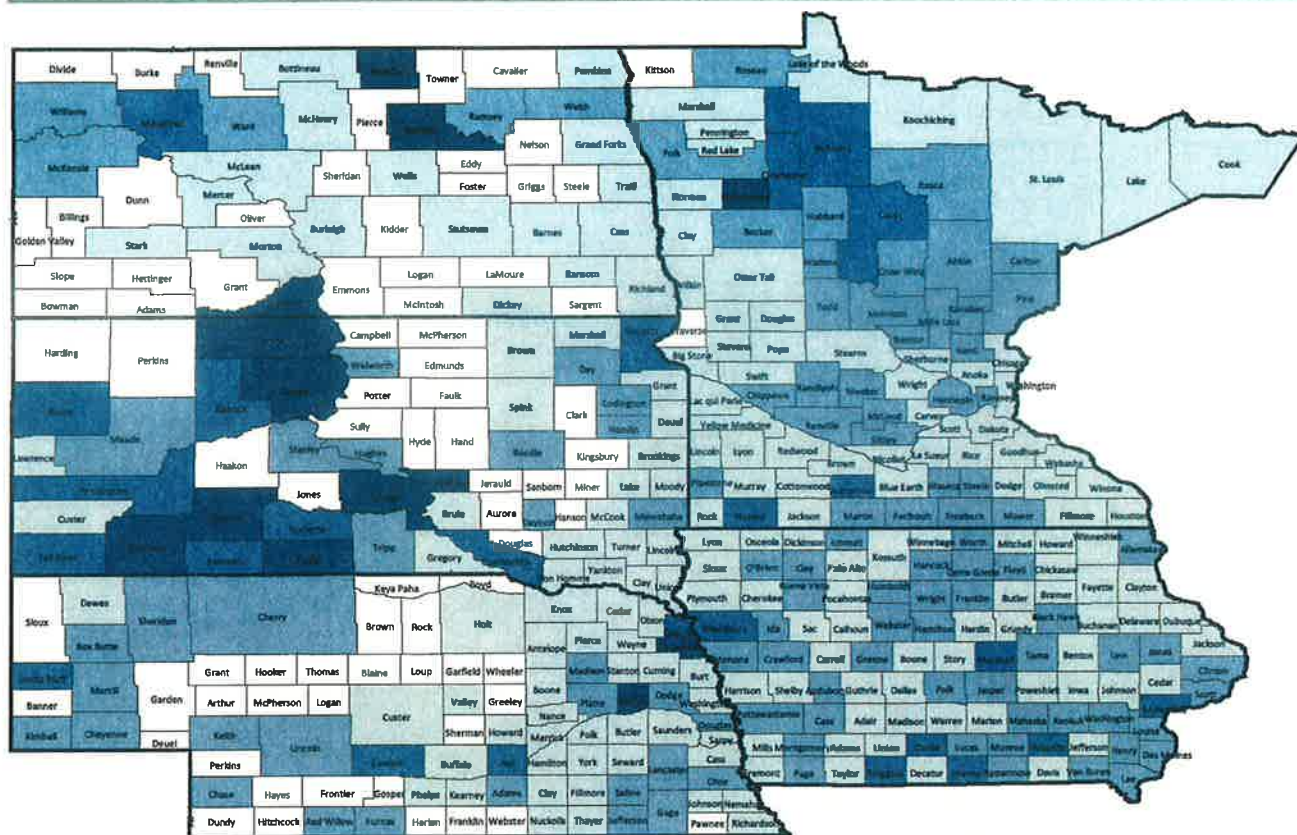
Number of teen births per 1,000 females ages 15 through 19, 2001-1007

- 8.1 - 28.9
- 29.0 - 45.9
- 46.0 - 79.9
- 80.0 - 137.8
- Unreliable or missing data
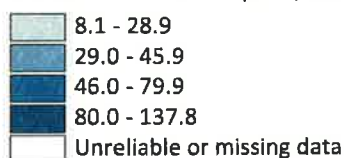
CONTEXT

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

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

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

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

Map 13

Uninsured Adults - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
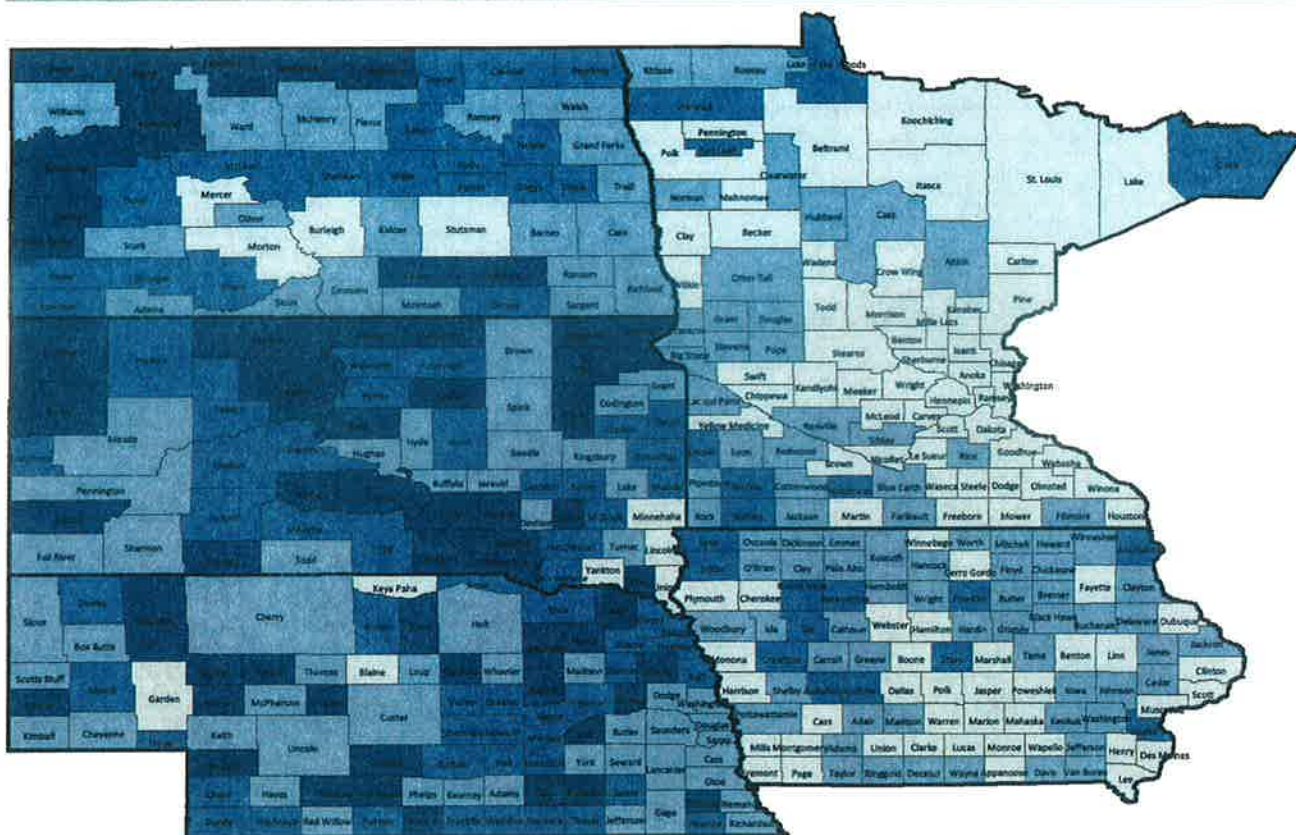
Percent of adult population ages 18 through 64 without health insurance, 2007

- 8.3% - 12.9%
- 13.0% - 16.9%
- 17.0% - 20.9%
- 21.0% - 27.5%
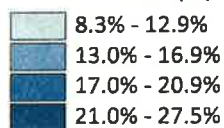
CONTEXT

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

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

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

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

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

Map 14
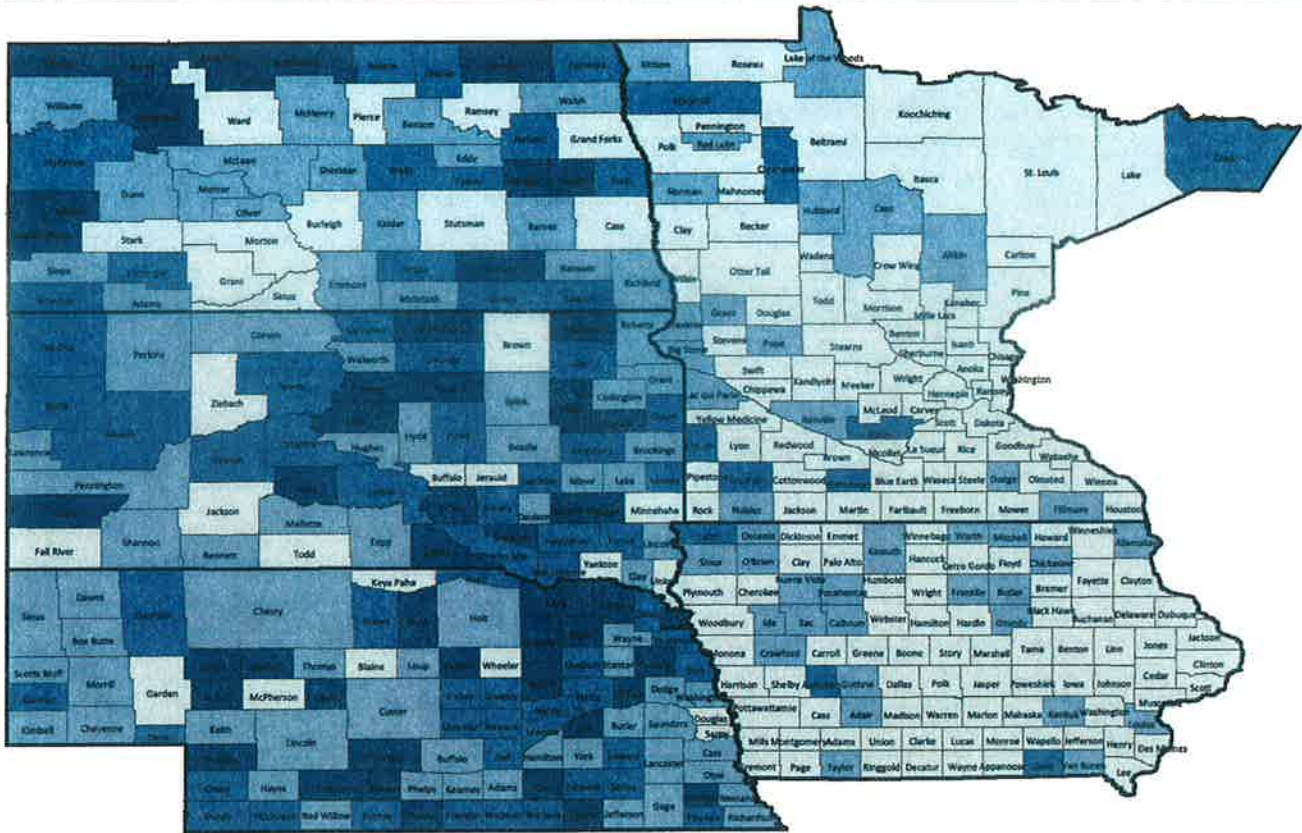
Percent of youth ages 0 through 18 without health insurance, 2007

	4.1% - 7.9%
	8.0% - 10.9%
	11.0% - 13.9%
	14.0% - 20.5%

CONTEXT

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

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

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

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

Map 15

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
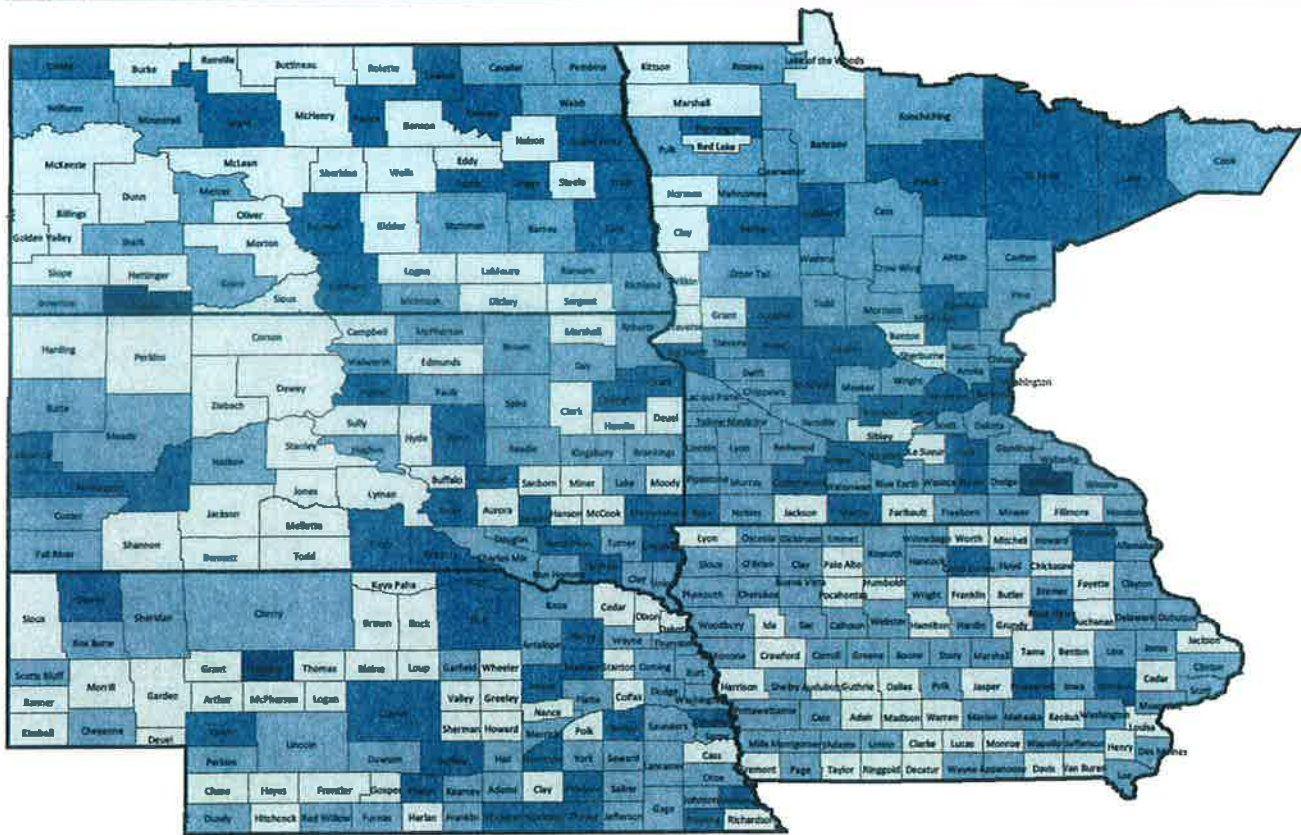
Number of primary care physicians per 100,000 population, 2008

- 0.0 - 60.9
- 61.0 - 139.9
- 140.0 - 339.9
- 340.0 - 793.0
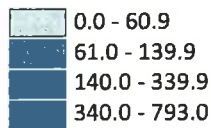
CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
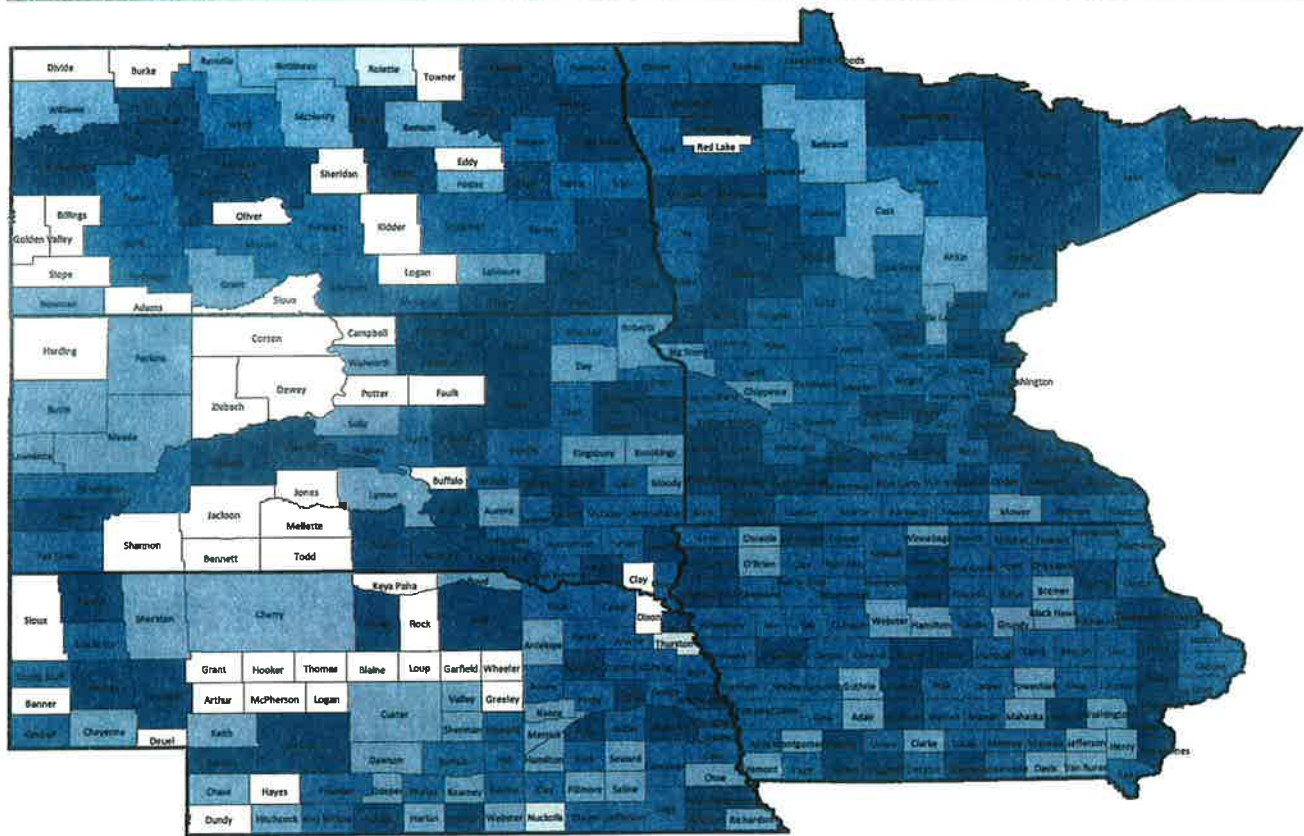
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Map 16

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

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

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

- 0.0 - 10.9
- 11.0 - 31.9
- 32.0 - 57.9
- 58.0 - 155.1
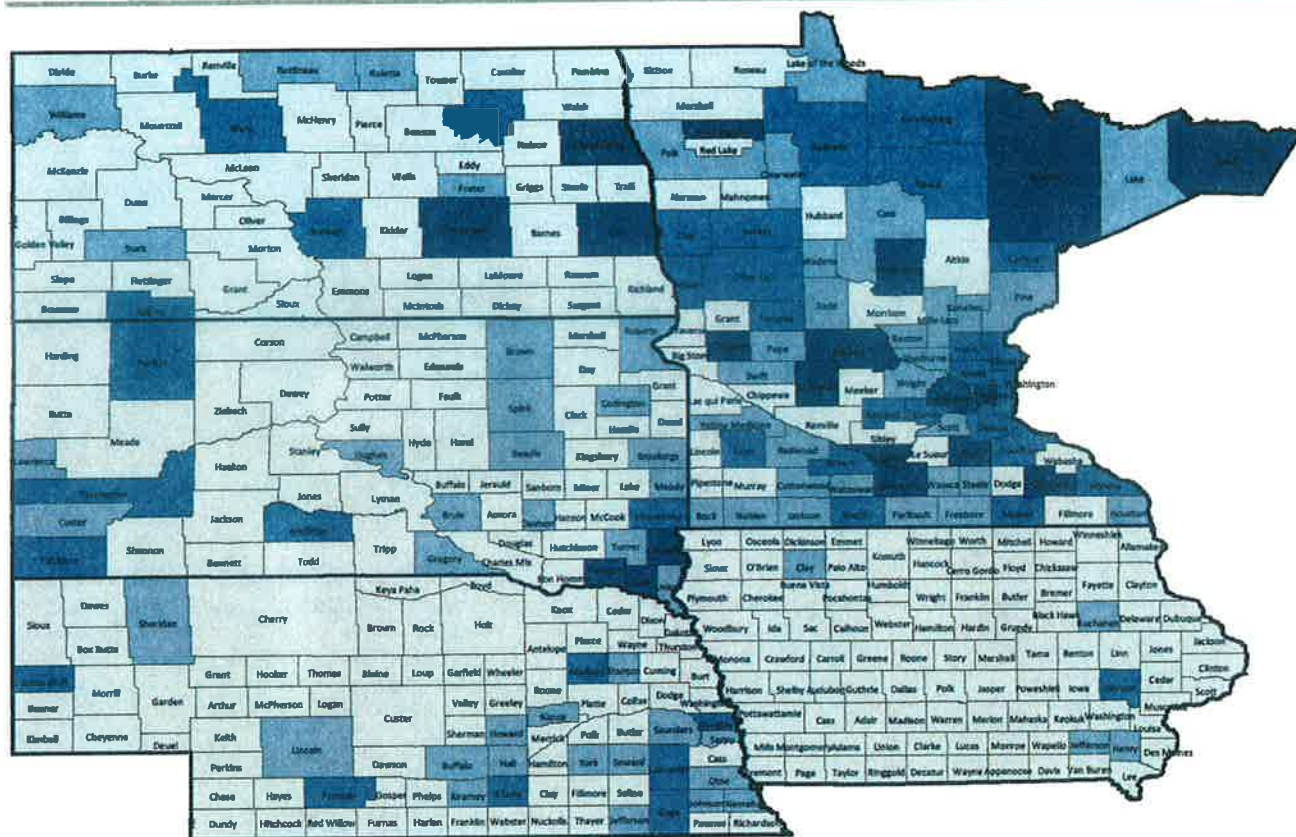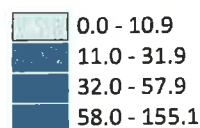
CONTEXT

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

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

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

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

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Map 17

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

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

- 0.0 - 15.9
- 16.0 - 37.9
- 38.0 - 60.9
- 61.0 - 149.9
- Unreliable or missing data
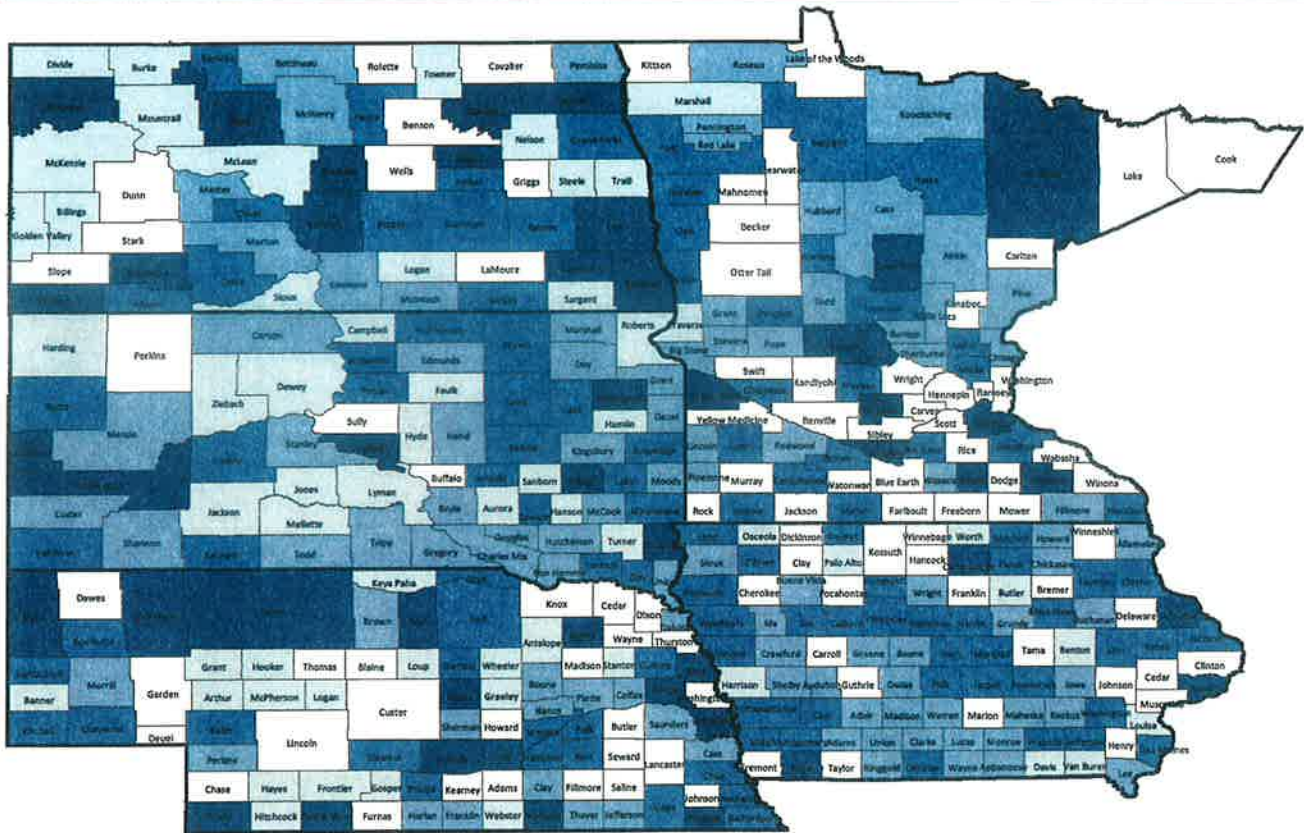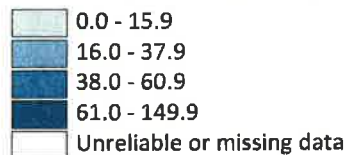
CONTEXT

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

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

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

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

Map 18

Preventable Hospital Stays - A health factor measure focusing on clinical care
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

- 28.9 - 60.9
- 61.0 - 79.9
- 80.0 - 116.9
- 117.0 - 205.8
- Unreliable or missing data
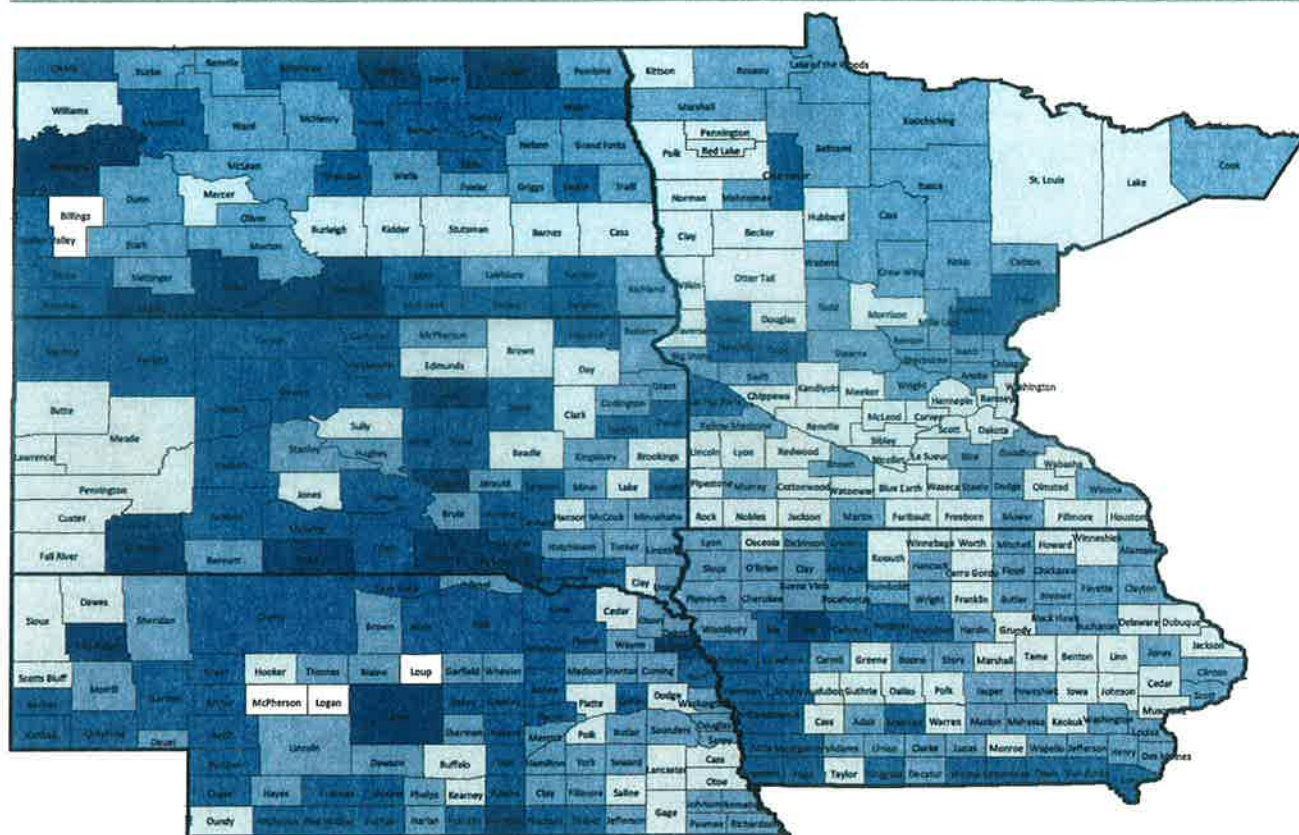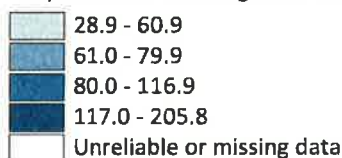
CONTEXT

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

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

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

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

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Map 19

Diabetic Screening - A health factor measure focusing on clinical care

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

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

- 31.4% - 52.9%
- 53.0% - 80.9%
- 81.0% - 88.9%
- 89.0% - 100.0%
- Unreliable or missing data
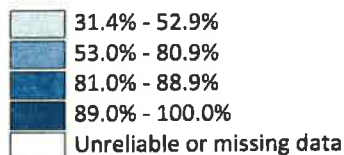
CONTEXT

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

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

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

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

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Map 20

Mammography Screening - A health factor measure focusing on clinical care

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

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

- 40.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 79.9%
- 80.0% - 100.0%
- Unreliable or missing data
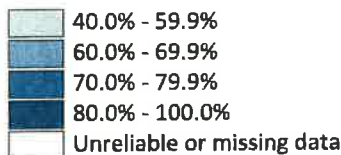
CONTEXT

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

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

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

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

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

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

- 40.0% - 59.0%
- 60.0% - 79.0%
- 80.0% - 89.0%
- 90.0% - 100.0%
- Unreliable or missing data

CONTEXT

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

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

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

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

Map 22

Some College - A health factor measure focusing on education

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
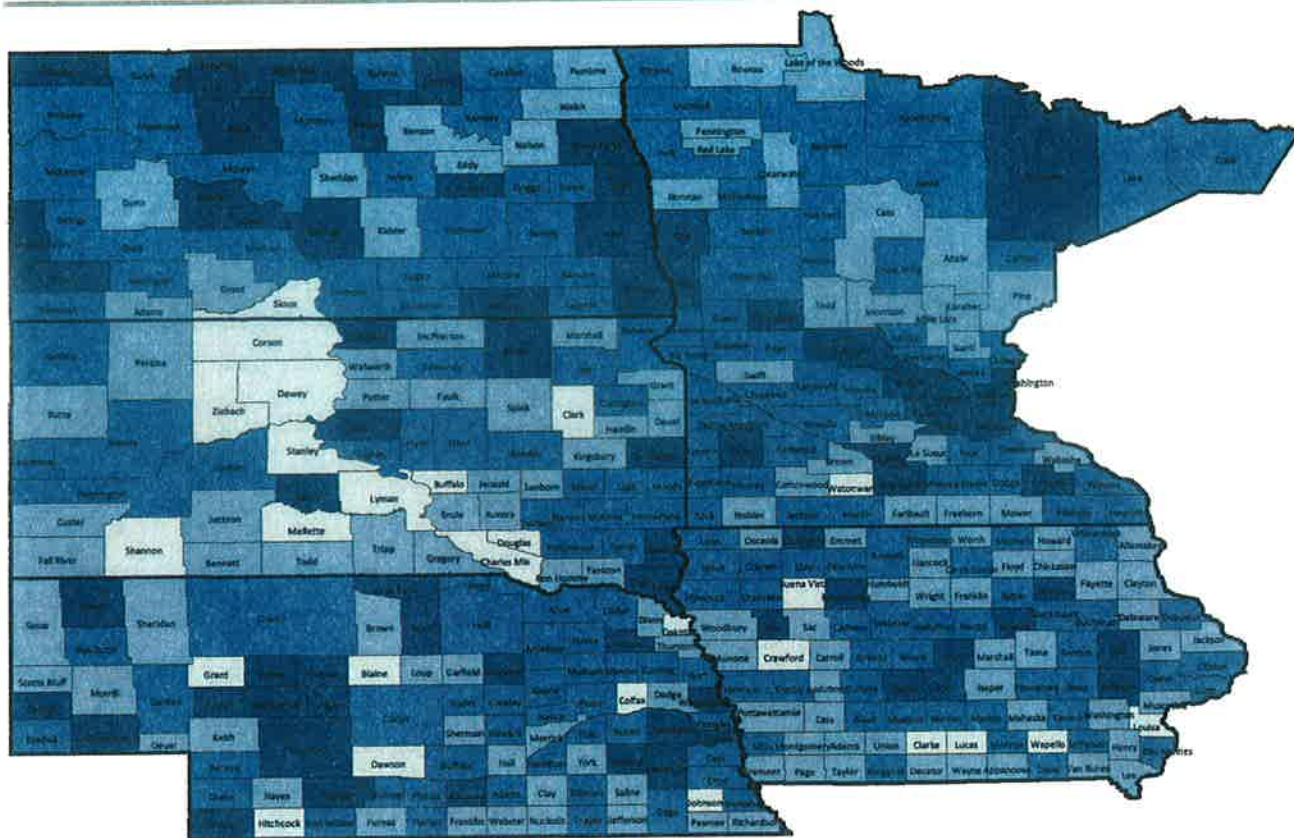
Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009
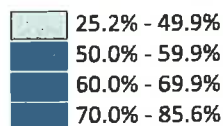
- 25.2% - 49.9%
- 50.0% - 59.9%
- 60.0% - 69.9%
- 70.0% - 85.6%

CONTEXT

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

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

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

Map 23

Unemployment - A health factor measure focusing on labor

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
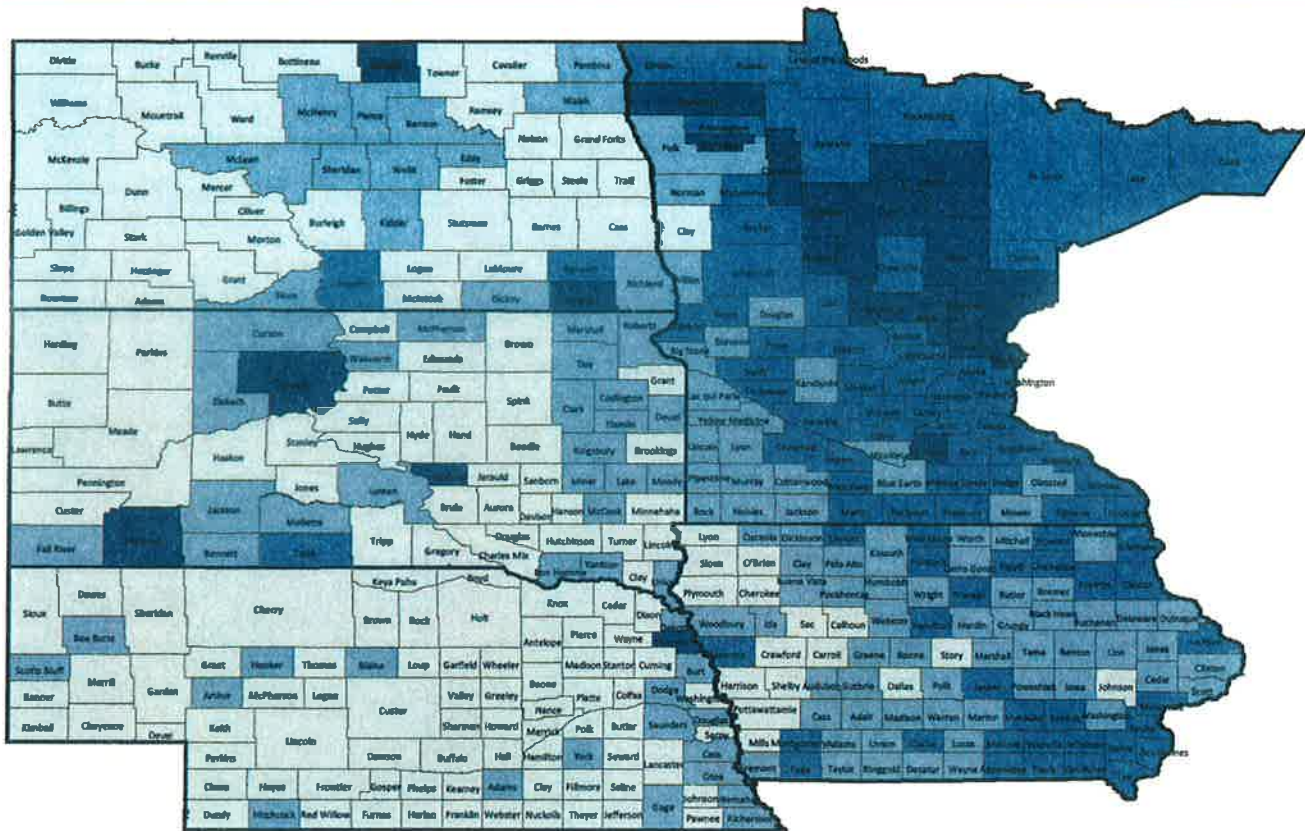
Percent of population ages 16 and older that is unemployed but seeking work, 2009

- 2.4% - 4.9%
- 5.0% - 6.9%
- 7.0% - 9.9%
- 10.0% - 15.1%
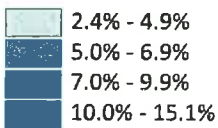
CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
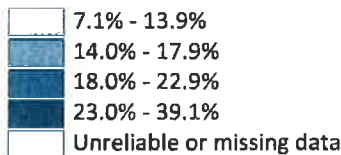
Map 24

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
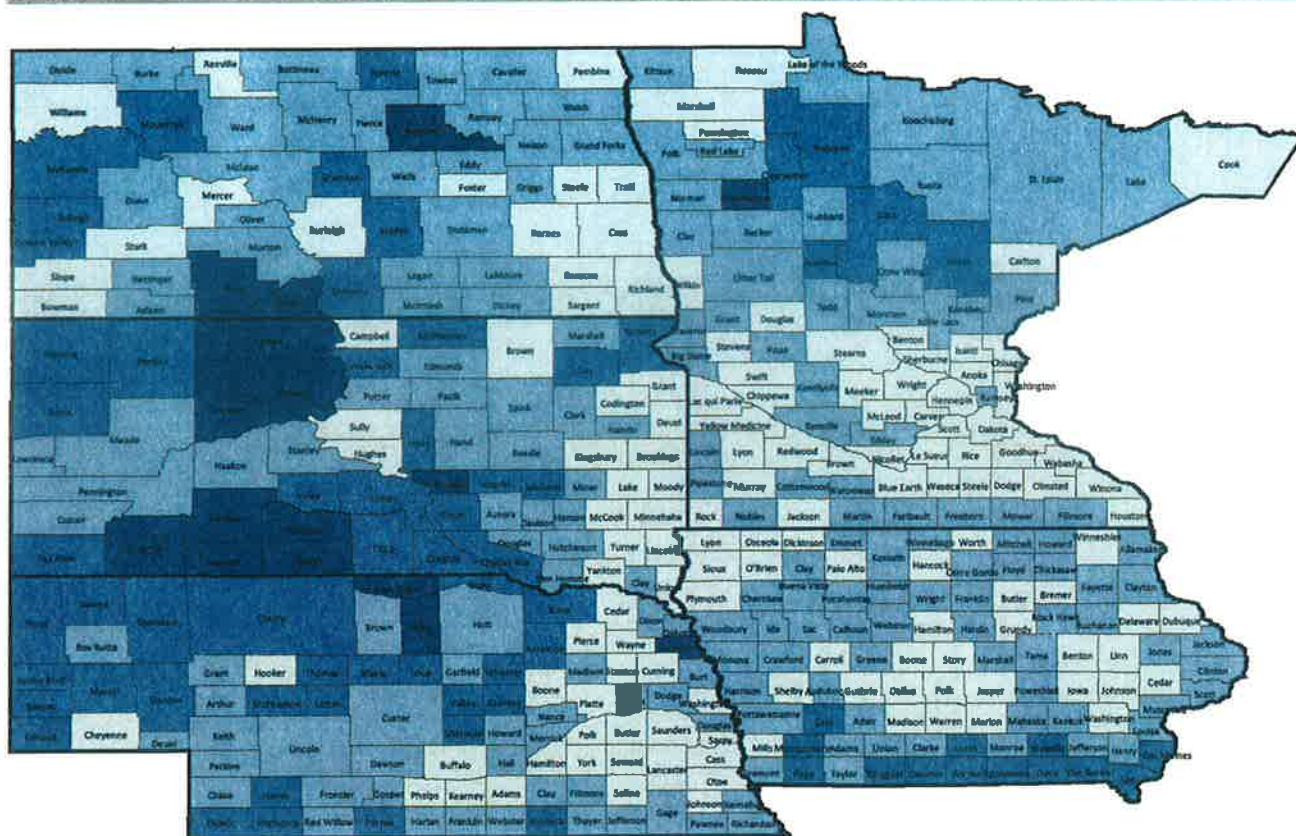
Percent of children ages 0 through 17 living below the Federal Poverty Line, 2008

- 4.7% - 12.9%
- 13.0% - 19.9%
- 20.0% - 34.9%
- 35.0% - 67.1%
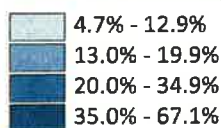
CONTEXT

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

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

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

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

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

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

- 7.1% - 13.9%
- 14.0% - 17.9%
- 18.0% - 22.9%
- 23.0% - 39.1%
- Unreliable or missing data

CONTEXT

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

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

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

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

Map 26

Children in Single-Parent Households - A health factor measure focusing on families

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
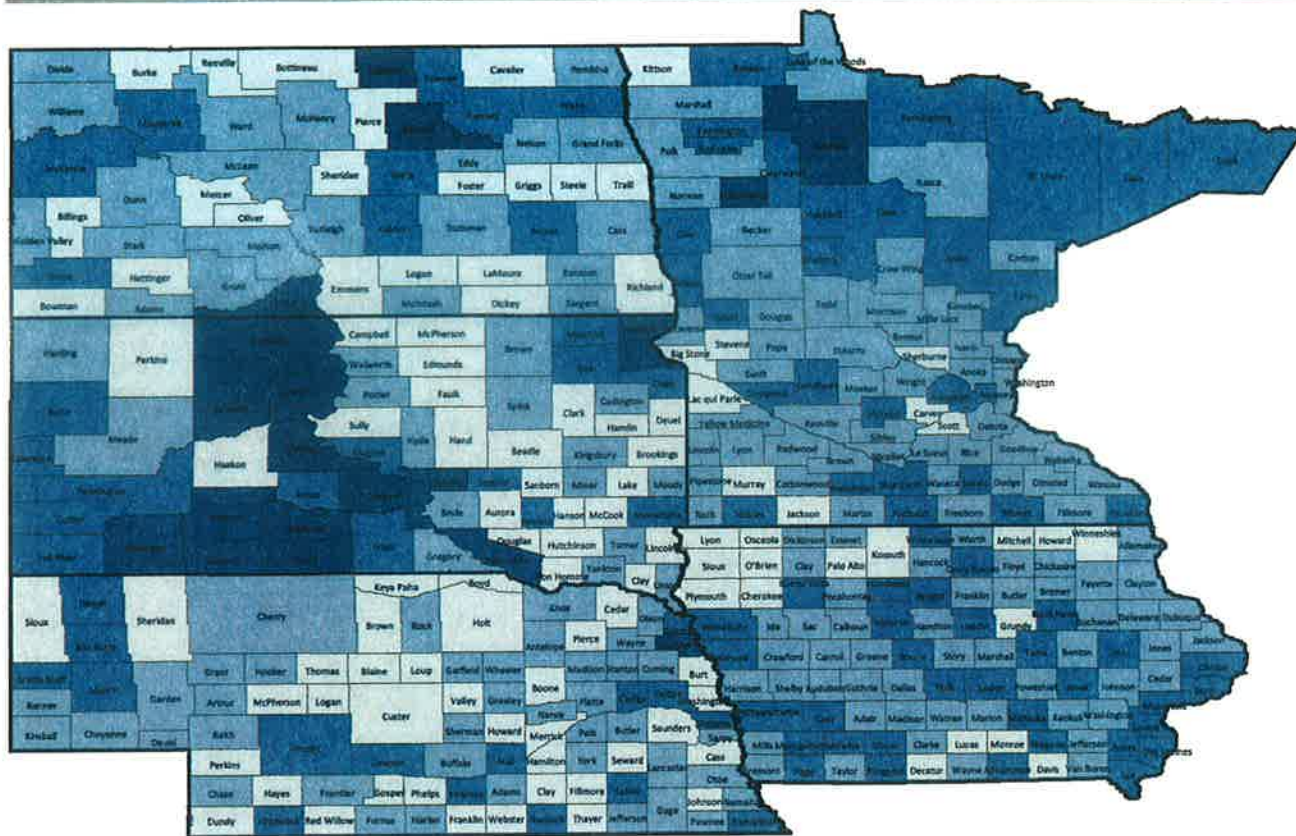
Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009

	0.0% - 17.9%
	18.0% - 25.9%
	26.0% - 39.9%
	40.0% - 72.0%

CONTEXT

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

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

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

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

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Map 27

Homicide Rate - A health factor measure focusing on violent crime
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
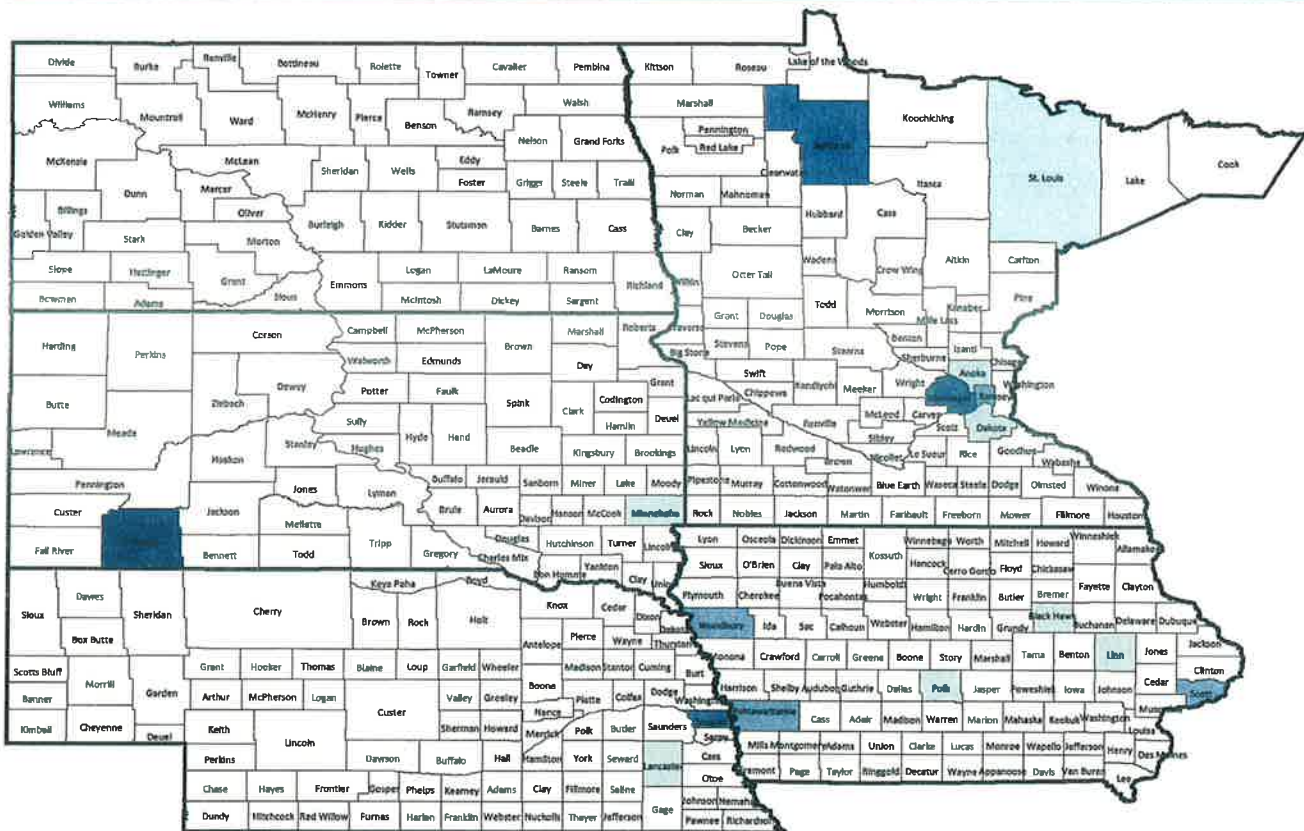
Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007

- 1.3 - 2.9
- 3.0 - 4.9
- 5.0 - 8.9
- 9.0 - 22.7
- Unreliable or missing data
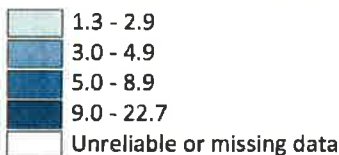
CONTEXT

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

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

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

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

Map 28

Air Pollution-Particulate Matter Days - A health factor measure focusing on physical environment
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

- 0
- 1
- 2
- 3 - 4
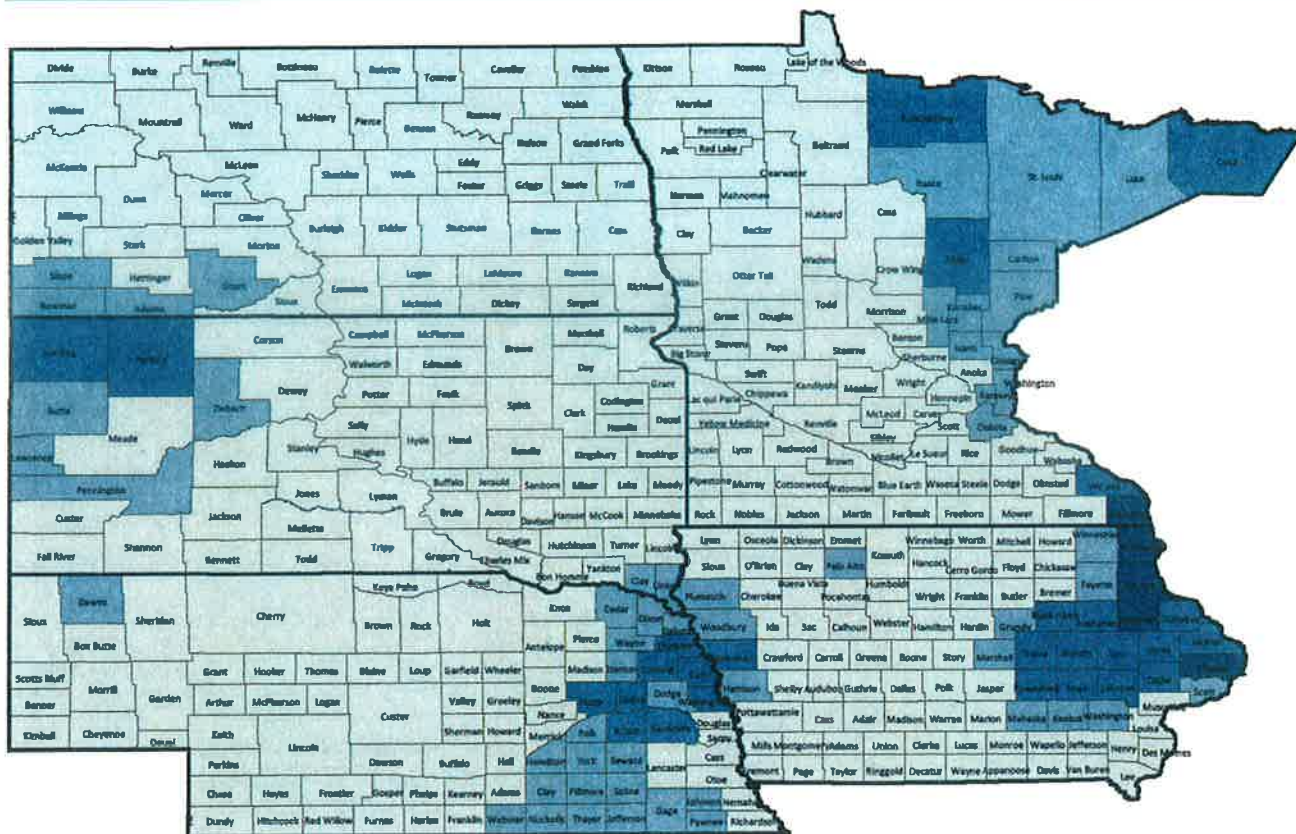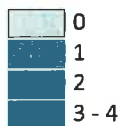
CONTEXT

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

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

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

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

Map 29

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

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

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

- 0
- 1
- 2

CONTEXT

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

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

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

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

Map 30

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

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota
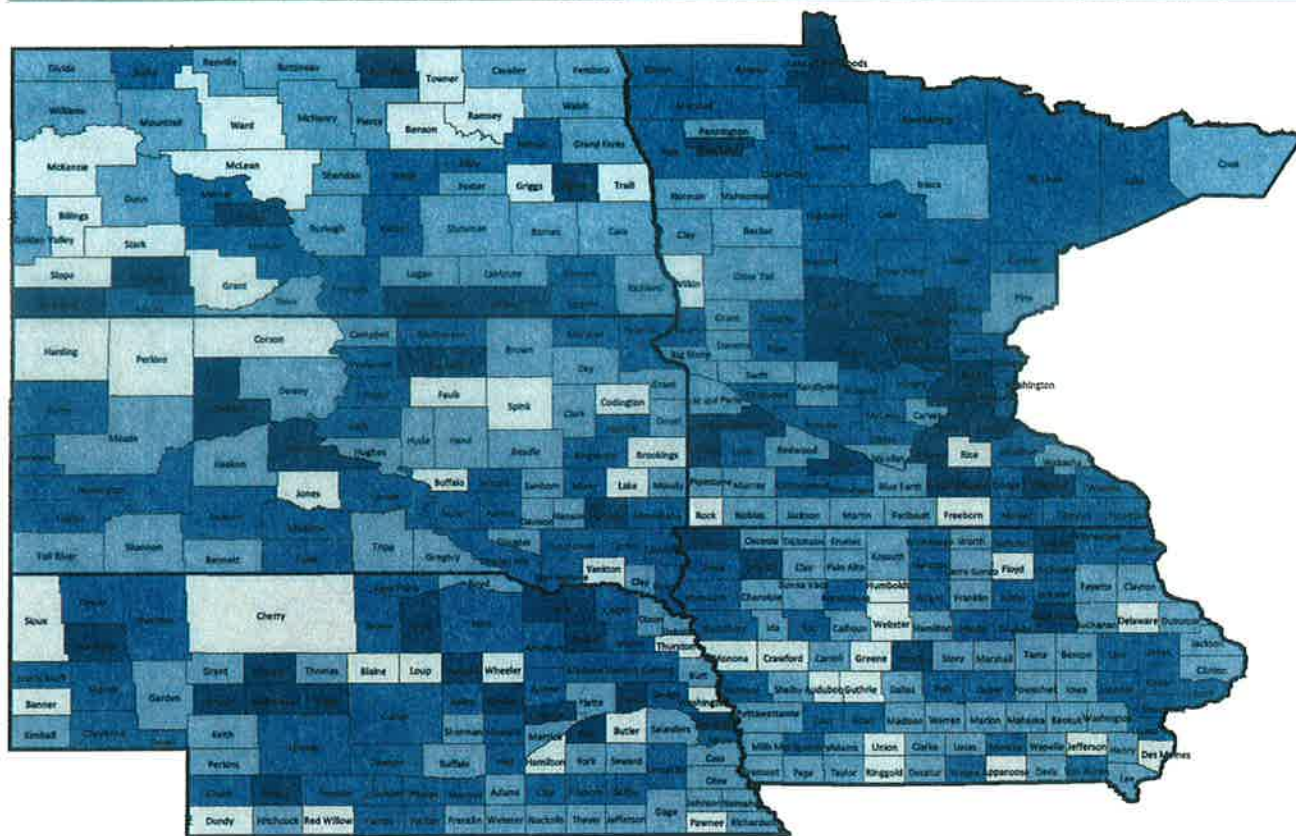
Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008

- 0.0% - 24.9%
- 25.0% - 42.9%
- 43.0% - 69.9%
- 70.0% - 100.0%
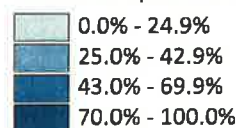
CONTEXT

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

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

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

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

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Map 31

Access to Recreational Facilities - A health factor measure focusing on physical environment
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Number of recreational facilities per 100,000 population, 2008

- 0 - 9
- 10 - 19
- 20 - 69
- 70 - 150
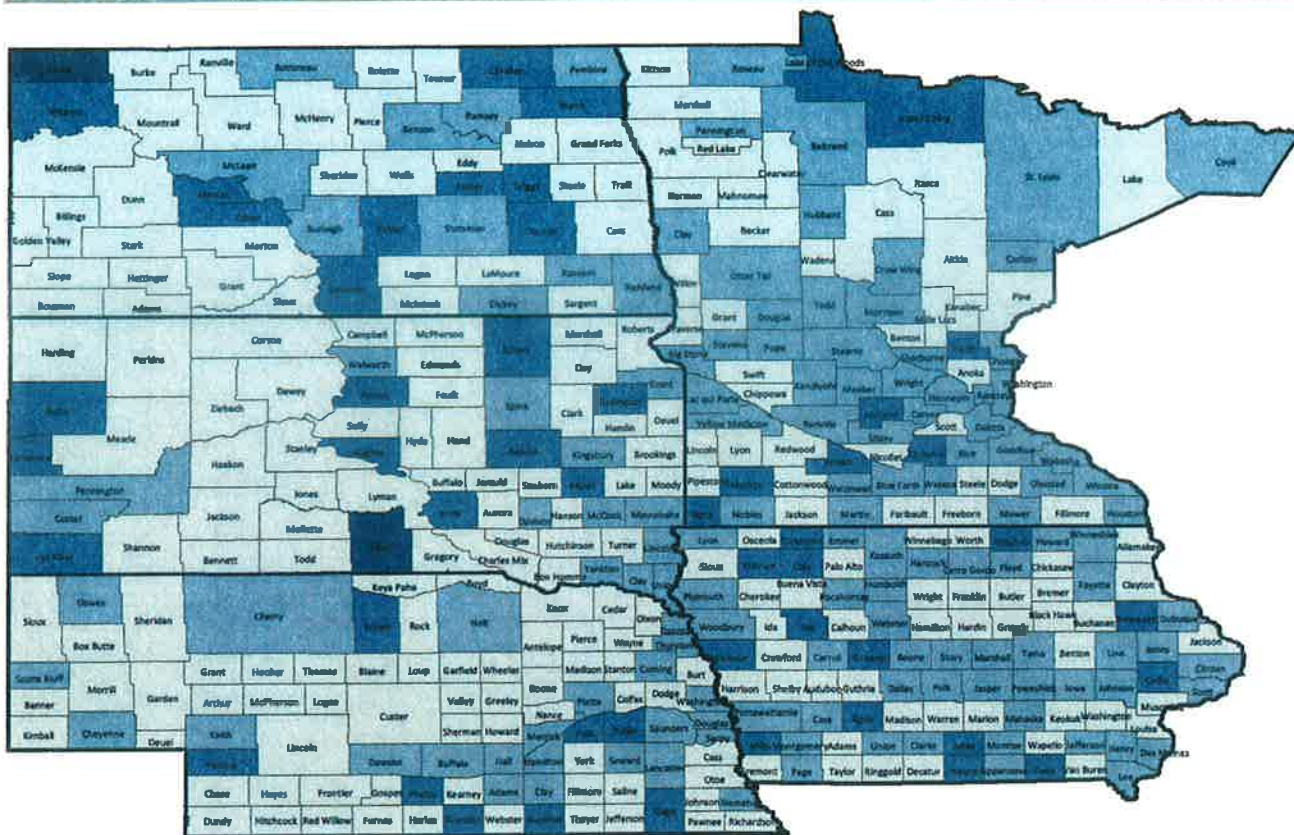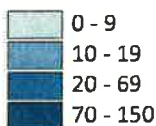
CONTEXT

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

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
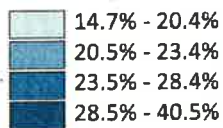
Map 32

Youth - A demographic measure

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

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

	14.7% - 20.4%
	20.5% - 23.4%
	23.5% - 28.4%
	28.5% - 40.5%

CONTEXT

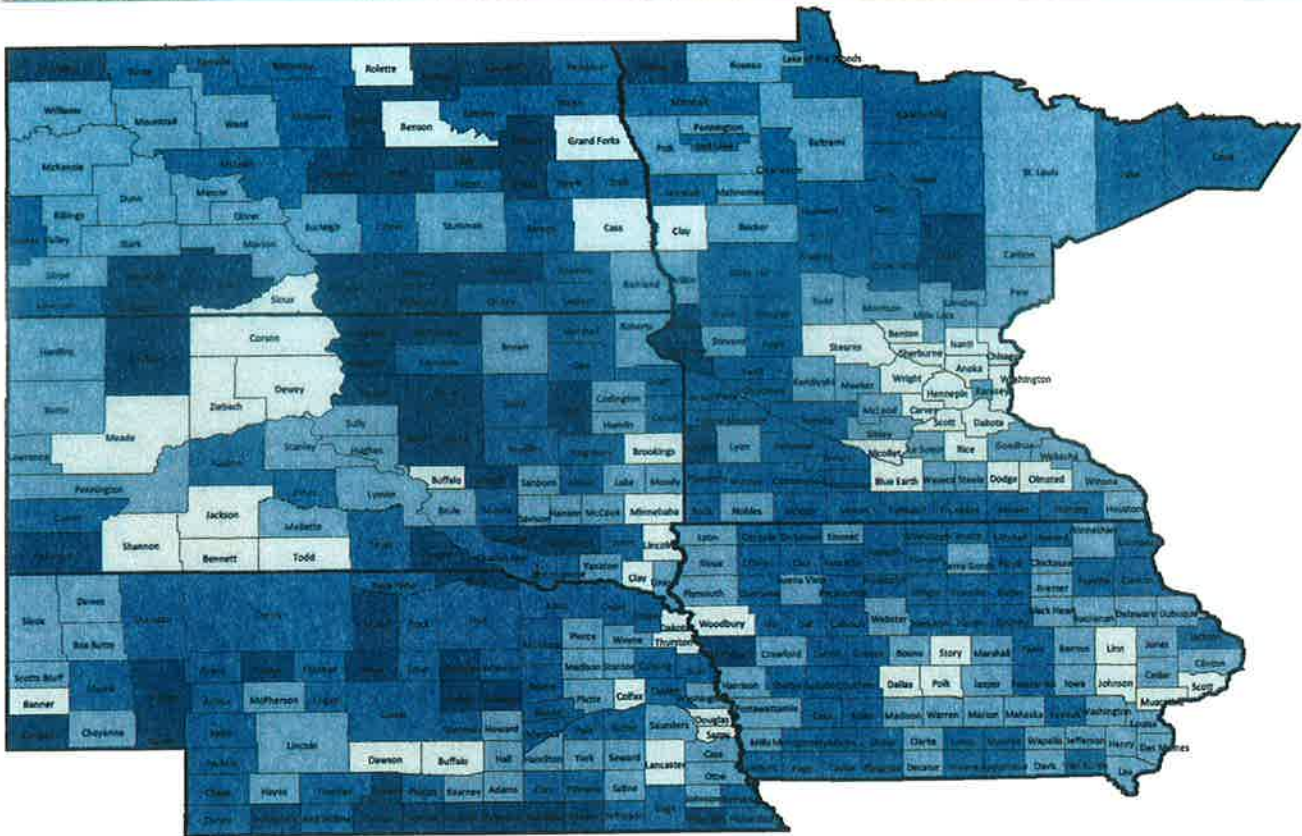**What It Is:** This measure represents the percent of a county's population that is less than 18 years of age.

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
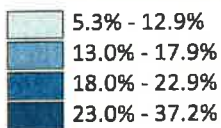
Map 33

Elderly - A demographic measure

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

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

- 5.3% - 12.9%
- 13.0% - 17.9%
- 18.0% - 22.9%
- 23.0% - 37.2%

CONTEXT

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

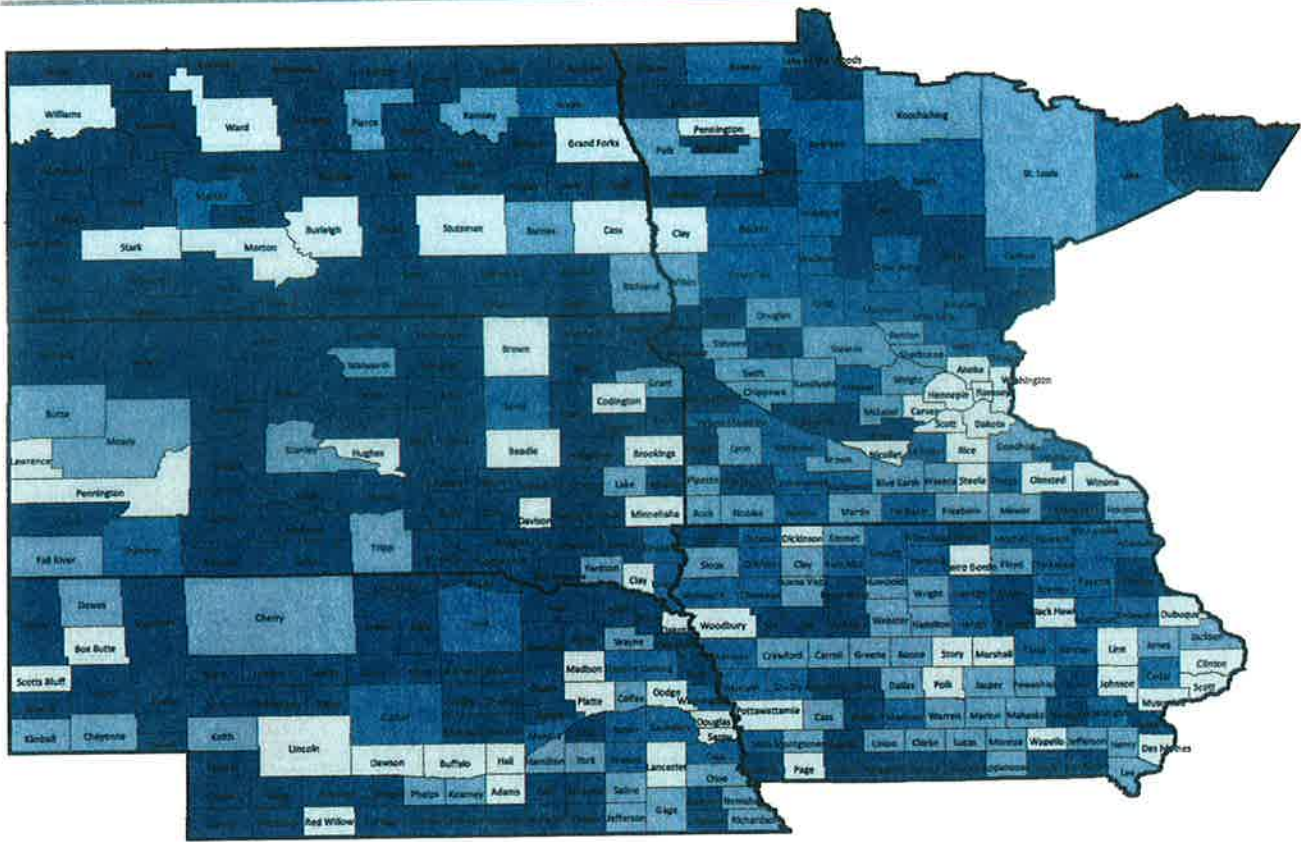**Where It Comes From:** County demographic figures come from the U.S. Census Bureau's annual population estimates.

Map 34

Rural - A demographic measure

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

Percent of total population living in a rural area, 2000

☐	0.1% - 35.9%
▨	36.0% - 58.9%
▨	59.0% - 83.9%
■	84.0% - 100.0%

CONTEXT

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

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

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/.
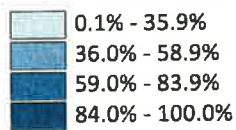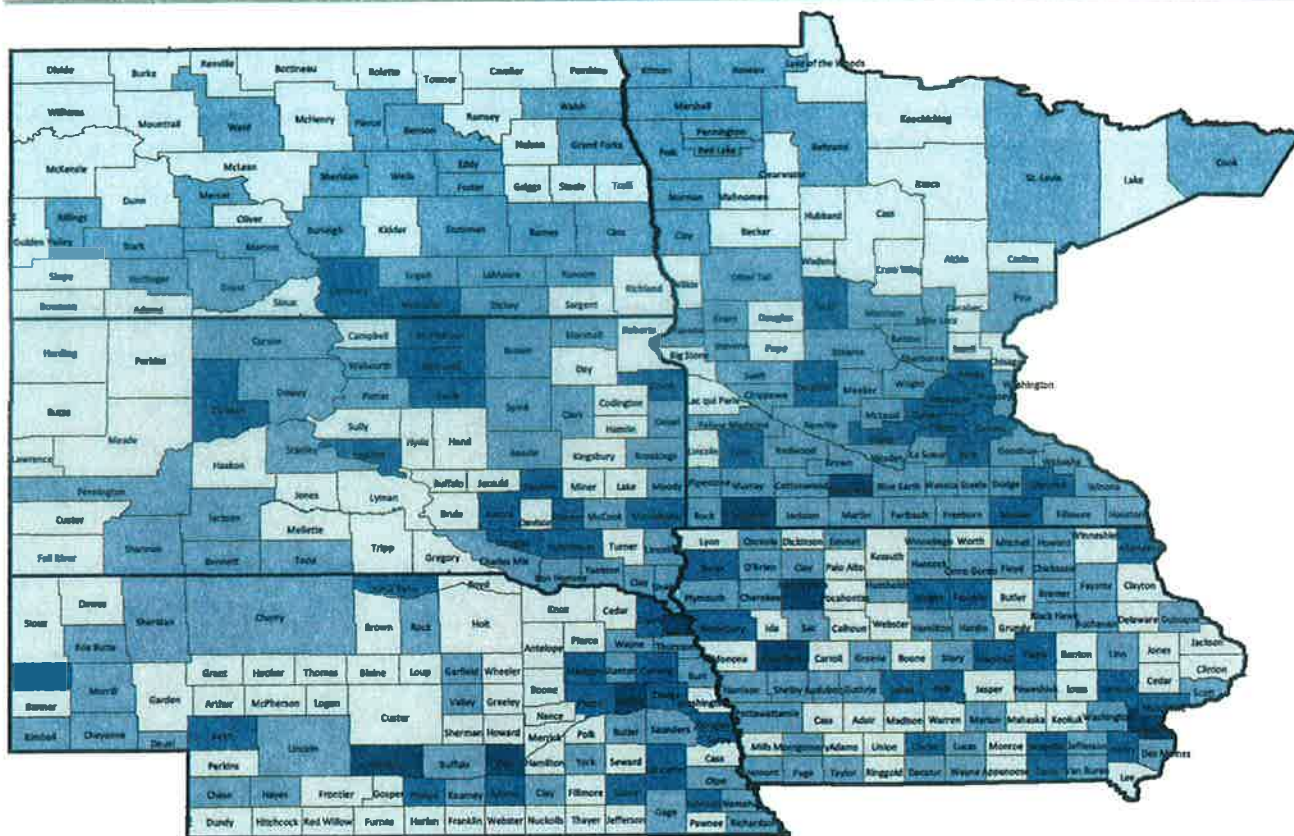
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Map 35

Not English Proficient - A demographic measure

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

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

- 0.0% - 0.9%
- 1.0% - 2.9%
- 3.0% - 8.9%
- 9.0% - 23.0%

CONTEXT

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

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

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

Map 36

Illiteracy - A demographic measure
County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

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

- 4.0% - 6.9%
- 7.0% - 8.9%
- 9.0% - 13.9%
- 14.0% - 21.4%
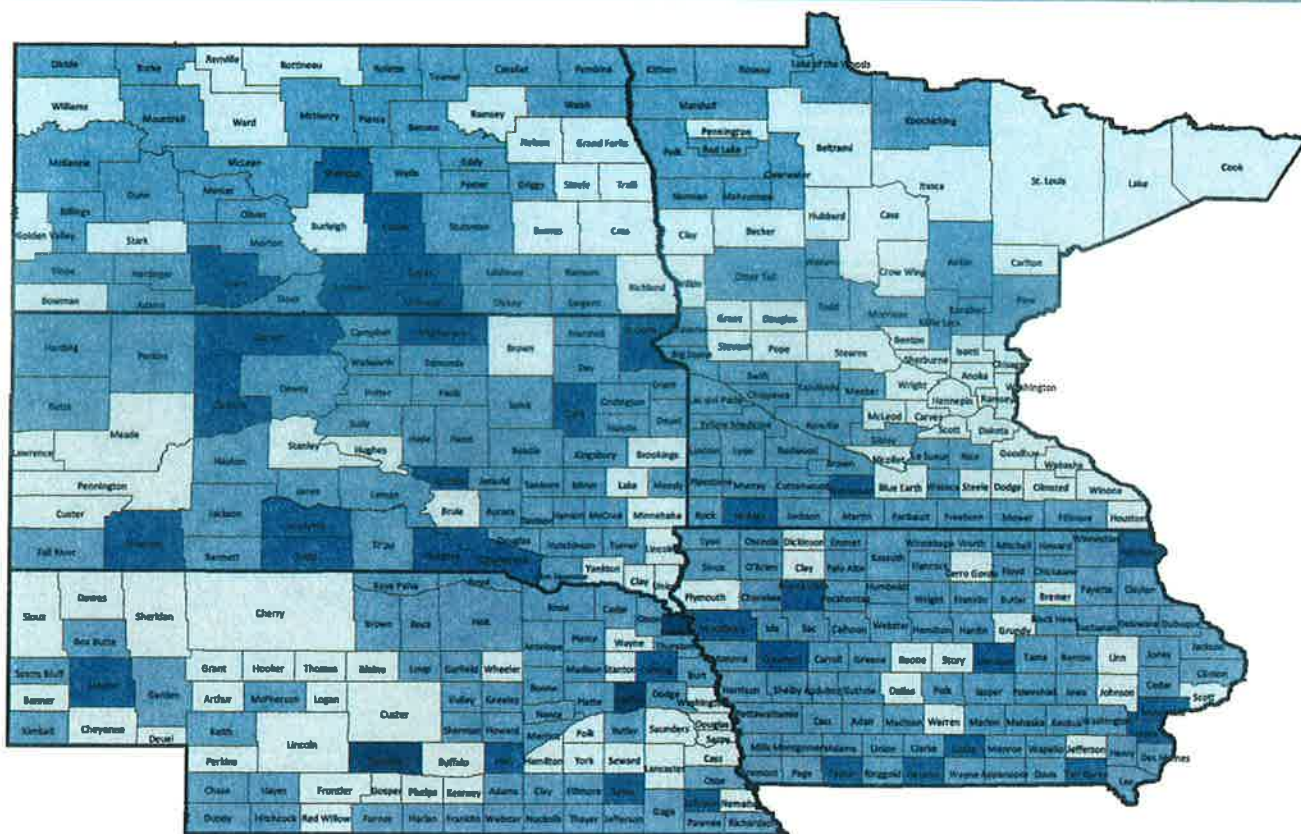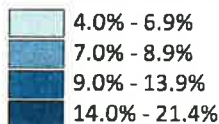
CONTEXT

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

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

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

Table 1

Community Health Needs Assessment Asset Mapping
Winner Regional Healthcare Center

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Addressing the need
Access	Availability of family services Availability /access to a grocery store	Social Services	Winner Regional Healthcare Center is addressing the need by providing information regarding the current charity care policy/ assistance. The facility recently donated over 250 pounds of food and a cash donation to the local food pantry. This donation is done on a yearly basis.
Cancer	High concern	Medical specialists	There is currently a search for another oncologist to fill the spot of the former oncologist from Rapid City Regional, who conducted an outreach clinic at Winner Regional Healthcare Center. This service is now being pursued by Sanford Health who is actively searching for an outreach oncologist to serve the Winner area.
Child Care	Cost and availability of child care	Child care providers Social Services	Winner Regional Healthcare Center is addressing some of the need by flexing staffing hours. Research is also being pursued for possible grant dollars that may facilitate assistance into the lack of availability.
Cost of Healthcare/ Insurance; Reimbursement	Cost of insurance Cost of health care Co-pays & deductibles Access to insurance Cost of prescription drugs Cost of vision insurance	Financial Counselors Financial assistance	Winner Regional Healthcare Center is addressing the need by evaluating ways to lessen staff's healthcare costs and by educating staff on ways to decrease healthcare needs. Clinic staff also informs patients that qualify of a sliding fee scale.
Dental Care	Cost and availability of dental care and insurance	Social Services	Winner Regional Healthcare Center is addressing the need by providing free dental insurance to all full-time employees at Winner Regional.
Diabetes	High concern for diabetes and other chronic diseases	Education Support Groups	Winner Regional Healthcare Center is addressing the need by providing diabetic education.
Elderly	Cost and availability of elder care Resources to meet the needs of the aging population		Winner Regional Healthcare Center is addressing the need by providing the best care possible to the resident in the current 80-bed long term care facility.

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Addressing the need
ER Services	Use of EC for primary care Access to EC	Education Extended clinic hours	Winner Regional Healthcare Center is addressing the need by providing level 3 trauma care as well as enhancing the clinic hours to divert "routine" care from the emergency room.
Financial Health	Low wages Availability of employment opportunities Poverty Affordable housing Economic disparities between higher and lower classes Cost of living	Job Service	Winner Regional Healthcare Center is addressing the need by sharing the results of the assessment with community leadership.
Legal Issues	Child abuse and neglect Domestic violence	Social Services	Winner Regional Healthcare Center is addressing the need by sharing the results of the assessment with local social service agencies.
Mental Health	Problems associated with care/systems unrelated to cost Bullying Stress Depression Availability of mental health providers Quality of mental health programs Availability of services	School Educators Mental Health Specialists	Winner Regional Healthcare Center is addressing the need by evaluating ways to enhance awareness as well as evaluating how telehealth could fill a much needed void.
Obesity	High concern Poor nutrition Lack of exercise and lack of facilities	Wellness education Classes with Dietitian	Winner Regional Healthcare Center is addressing the need by incentivizing employees (and community) to become more health conscious. As one of the chronic health issues in the community, Winner Regional will put this as a priority for FY 2014-2016.
Parenting	Availability of family services	Social Services	Winner Regional Healthcare Center is addressing the need by nurse practitioners at the clinic addressing "whole" health of the patient.
Physicians	Availability of physicians		Winner Regional Healthcare Center is addressing the need by recruiting additional physicians to fill the two open positions. This is a priority for FY 2014-2016.
Prevention/ Wellness	Availability of programs Communicable diseases/STDs	Education awareness by Healthcare	Winner Regional Healthcare Center is addressing the need by enhancing education/awareness via education/events. This focus is a priority for FY 2014-2016.

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Addressing the need
Substance abuse	High concern over substance abuse including: alcohol abuse; drug abuse; smoking; presence of drug dealers	School Educators Education from Physicians	Winner Regional Healthcare Center is addressing the need in the clinic by implementing "pain contracts" for patients that may be more likely to abuse prescription drugs.
Youth	Availability of youth activities Bullying Teen pregnancy Changes in family composition Truancy Crime	School Educators	Winner Regional Healthcare Center is currently involved with the Junior Achievement chapter with fourth grade students at the public school.
Winner Regional Health Center Specific	Confidentiality Availability of non-traditional hours	Staff Education Extended hours of clinic operations	Winner Regional Healthcare Center is addressing confidentiality by monitoring and handling any confidentiality breaches in the electronic medical record. Winner Regional is also trialing extended hours of the clinic, by holding open houses, providing promotional products with the new hours.

Table 2

Prioritization Worksheet

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

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

Health Indicator/Concern *(from asset mapping and gaps analysis worksheet)*	Round 1 Vote	Round 2 Vote	Round 3 Vote
~~Access~~ ~~Access to Healthy Foods~~			
Cancer Oncologist left community Patients must travel to receive cancer follow-up	XXXXXX	XXXXXX	XXXXXX
Child Care Child providers are not available for all shifts needed	XXX	XX	X
Cost of Healthcare/Insurance; Reimbursement Uninsured Adults Preventable Hospital Stays	XXXX	XXX	XX
Dental Care Cost and availability of dental care and insurance	XXXXX	XX	
Diabetes Lack of monitoring people with chronic health issues	XXXXXX	XXXXXX	XXXXXX
~~Education~~ ~~Lack of post-secondary education~~			
Elderly Cost of elder care Availability of elder care Resources to meet the needs of the aging population	XXXXXX	XXXXX	XXXXX

Health Indicator/Concern (from asset mapping and gaps analysis worksheet)	Round 1 Vote	Round 2 Vote	Round 3 Vote
ER Service Patient cannot see doctor so use ER for service	XXXXX	XXXXX	XXXX

Financial Health
    Median Annual Household Income
    # Living greater than 200% of poverty level
    Economic disparities
    Cost of living
	XXXX	XXX	XX

~~Legal Issues~~
    ~~Domestic violence~~
    ~~Child abuse/neglect~~			

Mental Health Lack of providers/service	XXXXXX	XXXXXX	XXXXX

Obesity
    Poor nutrition
    Lack of exercise
    High cost to belong to a wellness center
	XXXXXX	XXXXXX	XXXXXX

Parenting
    Child Poverty
    Children in Single Parent Homes
	XXXX	XXX	X

Physicians Physicians go to outreach sites, making availability within community untimely.	XXXXXX	XXXXXX	XXXXXX
Prevention/Wellness Lack of wellness related recreational facilities	XXXXX	XXXX	XXXX
Substance Abuse Alcohol/drug abuse	XXXXX	XXXX	XXXX

Youth
    Teen Birth Rate
    Bullying
	XXXX	XXX	XXX

WRHC Specific
    Confidentiality
    Availability of non-traditional hours
	XXXXXX	XXXXXX	XXXXX