



Sanford Health Network  
2016 Community Health  
Needs Assessment

**SANFORD**<sup>®</sup>  
HEALTH



**Sanford Laverne Medical Center**  
**Community Health Needs Assessment**  
**2016**

Dear Community Members,

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

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

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

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

- Mental Health
- Physical Health

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

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

Sincerely,



Tammy Loosbrock  
Chief Executive Officer  
Sanford Luverne Medical Center

**Sanford Laverne Medical Center**

**Community Health Needs Assessment**  
**2016**

**EXECUTIVE SUMMARY**

## Sanford Laverne Medical Center

### Community Health Needs Assessment 2016

#### Purpose

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

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

#### Study Design and Methodology

##### 1. Non-Generalizable Survey

A non-generalizable survey was conducted as an on-line survey through a partnership between Sanford and the Center for Social Research (CSR) at North Dakota State University. CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various community stakeholders and agencies, at times using a snowball approach. Data collection occurred throughout the month of March 2015 and a total of 58 respondents participated in the on-line survey.

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

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

## 2. Community Stakeholder Meeting

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

## 3. Community Asset Mapping

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

## 4. Secondary Research

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

## Key Findings – Primary Research

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

Aging: The top ranking concern about the aging population among respondents overall is the cost of long term care (3.81). The availability of memory care is also ranked as a high concern.

Children and Youth: The availability of quality infant care (3.95) and quality child care (3.84) are the top concerns regarding children and youth in the community.

Safety: The presence of street drugs and alcohol in the community (3.61) is the highest safety concern of the respondents.

Health Care: The health care indicator addressed access to health care and the cost concerns. Access to affordable health insurance (3.55) is the highest concern among the respondents in the health care access category.

Physical Health: Cancer (3.67), inactivity and lack of exercise (3.62), obesity (3.60), poor nutrition and eating habits (3.59), and chronic disease (3.53) are the highest physical health concerns.

Mental Health/Behavioral Health: Underage drug use and abuse (3.69), underage drinking (3.59), stress (3.52), smoking (3.52), and tobacco use (3.55) are the highest concerns for mental health/behavioral health.

Preventive Health: Flu vaccinations and Immunizations are preventive health concerns based on research.

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

### Health Outcomes

Premature Death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcome for the state of Minnesota is 5,038 per 100,000. Rock County has a higher rate at 5,223 per 100,000.

Poor or Fair Health: Rock County data for poor or fair health is not available. This ranking indicates 10% nationally and 11% in Minnesota.

The average number of days reported in the last 30 as unhealthy mental health days is not available for Rock County. Minnesota as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 5.5% in Rock County. The state of Minnesota is at 6.5%.

### Health Factors

The percent of adults who are currently smoking is not available for Rock County. 16% of adults are current smokers in Minnesota.

27% of the adult population in Rock County is considered to be obese with a BMI over 30. 26% of the population in Minnesota is obese.

The percent of adults reporting excessive or binge drinking is 17% in Rock County. Minnesota reports 19% are binge drinkers statewide. Driving deaths that have alcohol involvement is at 0% in Rock County. Alcohol involvement in driving deaths is at 31% in Minnesota.

Sexually transmitted infections rank lower and more positive in Luverne than the national benchmark (138). Minnesota is at 336 and Rock County is at 126. The teen birth rate is higher in Minnesota (24) than the national benchmark (20). The teen birth rate is 22 in Rock County.

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

The ratio of population to primary care physicians is 1,113:1 in Minnesota. Rock County's ratio is 1,061:1.

The ratio of population to mental health providers is 529:1 in Minnesota. Rock County's ratio is 1,360:1.

The number of professionally active dentists in Minnesota is 1,404:1; in Rock County the ratio is 2,380:1.

Preventable hospital stays are 40 in Rock County, 45 in Minnesota, and 41 nationally.

Diabetic screening is at 95% in Rock County, and 88% in Minnesota as a whole. Mammography screening is at 77.3% in Rock County, and 66.7% in Minnesota.

The social and economic factor outcomes indicate that Minnesota is at 78% for high school graduation. Rock County has a graduation rate of 81%. Post-secondary education (some post-secondary education) is at 68.4% in Rock County and 73.3% in Minnesota.

The unemployment rate is 3.3% in Rock County, and 5.1% in Minnesota. The percentage of child poverty is 14% in Rock County. The child poverty rate is 14% in Minnesota.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is higher in Rock County at 26.2. The state of Minnesota ranks at 13.2.

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

Violent crime is higher in Rock County at 787 per 100,000 than Minnesota, which has 229 cases per 100,000.

The following needs were brought forward for prioritization:

- Aging – cost of long term care, availability of memory care
- Children and Youth – availability of quality infant care and quality child care
- Safety – presence of street drugs and alcohol in the community
- Health Care Access – access to affordable health insurance
- Physical Health – cancer, chronic disease, inactivity, poor nutrition and obesity
- Mental Health – underage drinking, underage drug use and abuse, stress and tobacco use
- Preventive Health – flu vaccines, immunizations

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

- Mental Health
- Physical Health

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

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



## Implementation Strategies

### Priority 1: Physical Health

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

Sanford has set strategy to help the community improve their physical health and chronic health conditions. The goal of this strategy is to improve the Minnesota Community Measures scores for identified chronic disease.

### Priority 2: Mental Health/Behavioral Health

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

Many factors contribute to mental health problems, including:

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

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

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to improve access and coordination of care. Sanford is working with community partners to create program and referral options for community members.

**Sanford Laverne Medical Center**

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## Purpose

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

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

### Our Guiding Principles:

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

## Acknowledgements

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

### Sanford Enterprise Steering Group:

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

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

**Sanford Laverne Steering Group:**

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health /Community Benefit
- Tammy Loosbrock, Chief Executive Officer, Sanford Laverne Medical Center

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

- Alicia Collura, Sioux Falls Public Health
- Anita Cardinal, Pennington County Public Health
- Ann Malmberg, Essentia Health
- Becky Secore, Beltrami County Public Health Unit
- Brenda Stallman, Traill County Public Health
- Brie Taralson, Essentia Health
- Brittany Ness, Steele County Public Health
- Caitlin Hurley, Avera Health
- Carrie McLeod, Sanford Health
- Dan Heinemann, MD, CMO, Sanford Health Network, Sioux Falls Region
- Jac McTaggart, Sanford Health
- Jessica Spaeth, City of Halstad
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- Julie Jeske, CHI-St. Alexius Health
- Julie Miller, South Dakota Department of Health
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- Kim Jacobson, Traill County Public Health
- Kip Littau, South Dakota State University
- Marnie Walth, Sanford Health
- Mary Michaels, Sioux Falls Public Health
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- Roger Baier, Sanford Health
- Ruth Bachmeier, Fargo Cass Public Health
- Sandra Melstad, Public Health Consultant, South Dakota Department of Health
- Stan Kogan, Sioux Falls Public Health
- Stephen Pickard, PhD., North Dakota Department of Health
- Susan Kahler, Burleigh County Public Health
- Teresa Miller, Avera Health

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



**The following Luverne and Rock County community stakeholders participated in community discussions and helped to formulate the priorities for future work.**

- Jennifer Stratton, Southwest Minnesota Health and Human Services
- Mike Werner, Administrator, Parkview Manor Nursing Home
- Greta VanDerBrink, Coordinator Ace of Rock County, Southwest Minnesota
- Tammy Loosbroock, Chief Executive Officer, Sanford Luverne Medical Center
- Carrie McLeod, Community Health, Sanford Health

## Description of Sanford Luverne Medical Center



Sanford Luverne Medical Center (SLMC) is a 25-bed Critical Access Hospital that provides inpatient, acute and long-term care to over 10,000 residents of Rock County and portions of Murray, Nobles and Pipestone counties in southwest Minnesota. The nearest tertiary care center, Sanford USD Medical Center, is approximately 35 miles west in Sioux Falls, SD.

In addition, SLMC offers a broad range of outpatient services at Sanford Luverne Clinic, a medical clinic operating as a hospital department. Specialty physicians provide outreach services on a twice-monthly or monthly basis in areas such as general and specialized surgery, allergy/asthma, cardiology, oncology, ophthalmology, otolaryngology, radiology, urology, obstetrics/ gynecology, pathology, orthopedics, vascular and pulmonology.

Sanford Luverne employs 10 clinicians, including physicians and advanced practice providers and over 250 employees.

## Description of the Community Served



Luverne is the county seat of Rock County and has a population of 4,700. It is predominantly a farming community with other larger employers in finance, processing plants, health care and education.

A historic landmark in the city is the Rock County Courthouse which was built in 1888 in the Romanesque style of architecture.

## Study Design and Methodology

### 1. Non-Generalizable Survey

An on-line non-generalizable survey was conducted of residents in Luverne and Rock County, Minnesota. The survey instrument was developed in partnership with members of the Greater Fargo-Moorhead Community Health Needs Assessment collaborative, Sioux Falls community collaborative, Bismarck community collaborative, public health leaders from across the enterprise, and researchers at the Center for Social Research (CSR) at North Dakota State University (NDSU). The CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various community stakeholders and community agencies, at times using a snowball approach. Data collection occurred throughout the month of March 2015 and a total of 58 respondents participated in the on-line survey.

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

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

### 2. Community Stakeholder Meeting

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

### 3. Community Asset Mapping

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

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

#### 4. Secondary Research

The secondary data includes County Health Rankings for Rock County.

### Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Luverne and Rock County, Minnesota. A good faith effort was made to secure input from a broad base of the community. The generalizable survey was mailed to a representative group of the area to assure input from all demographics. Additionally, invitations were extended to county and community leaders, organizations and agencies representing diverse populations and disparities.

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

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

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

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

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

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



# Key Findings

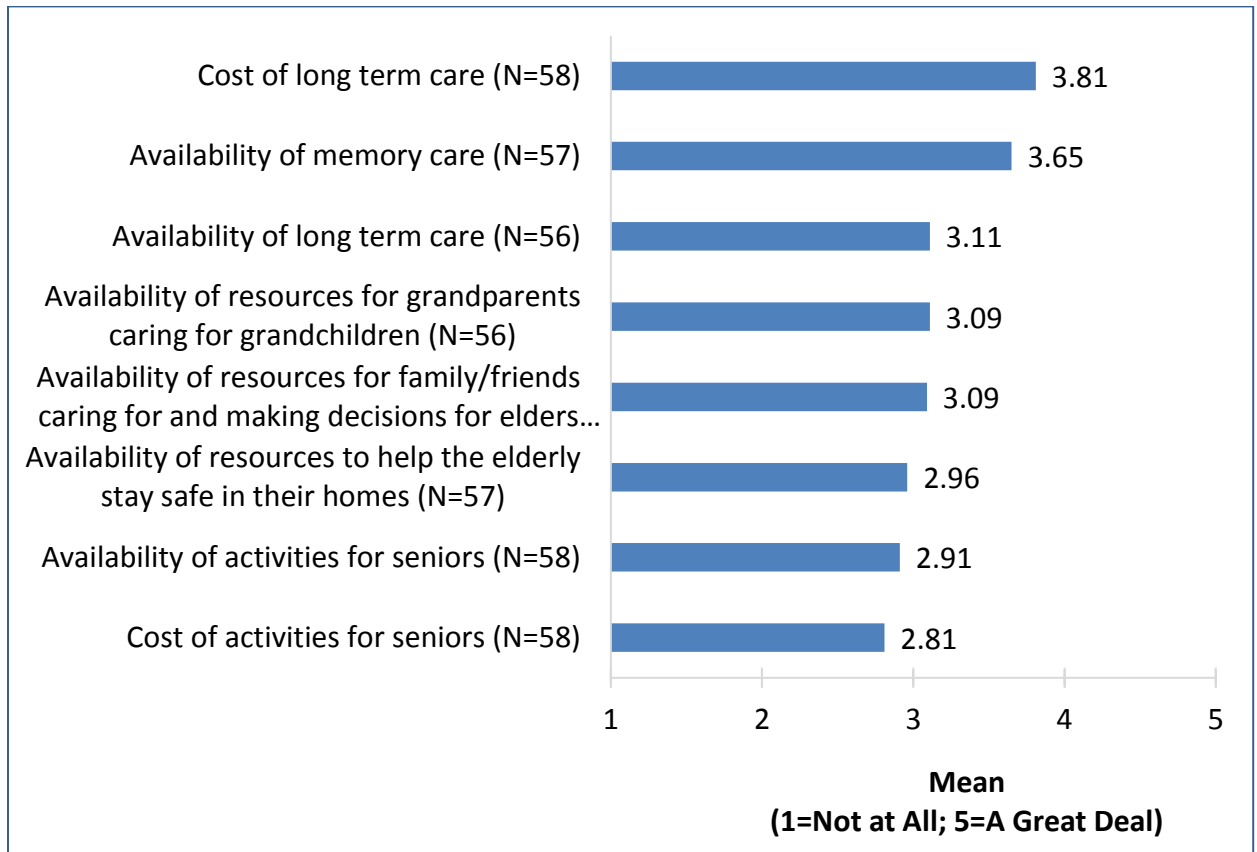
## Primary Research

### Community Health Concerns

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

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

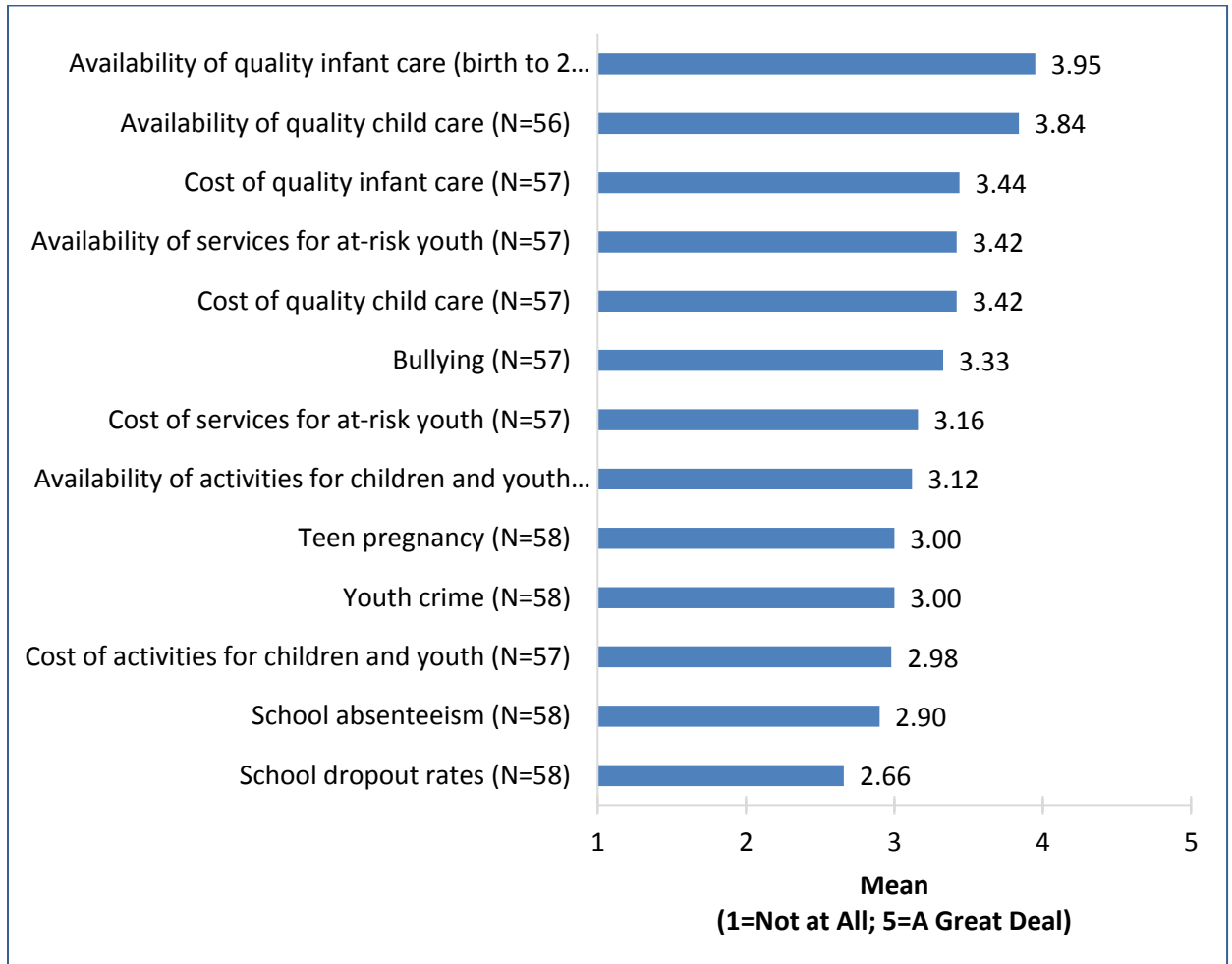
#### **Level of concern with statements about the community regarding the AGING POPULATION**



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

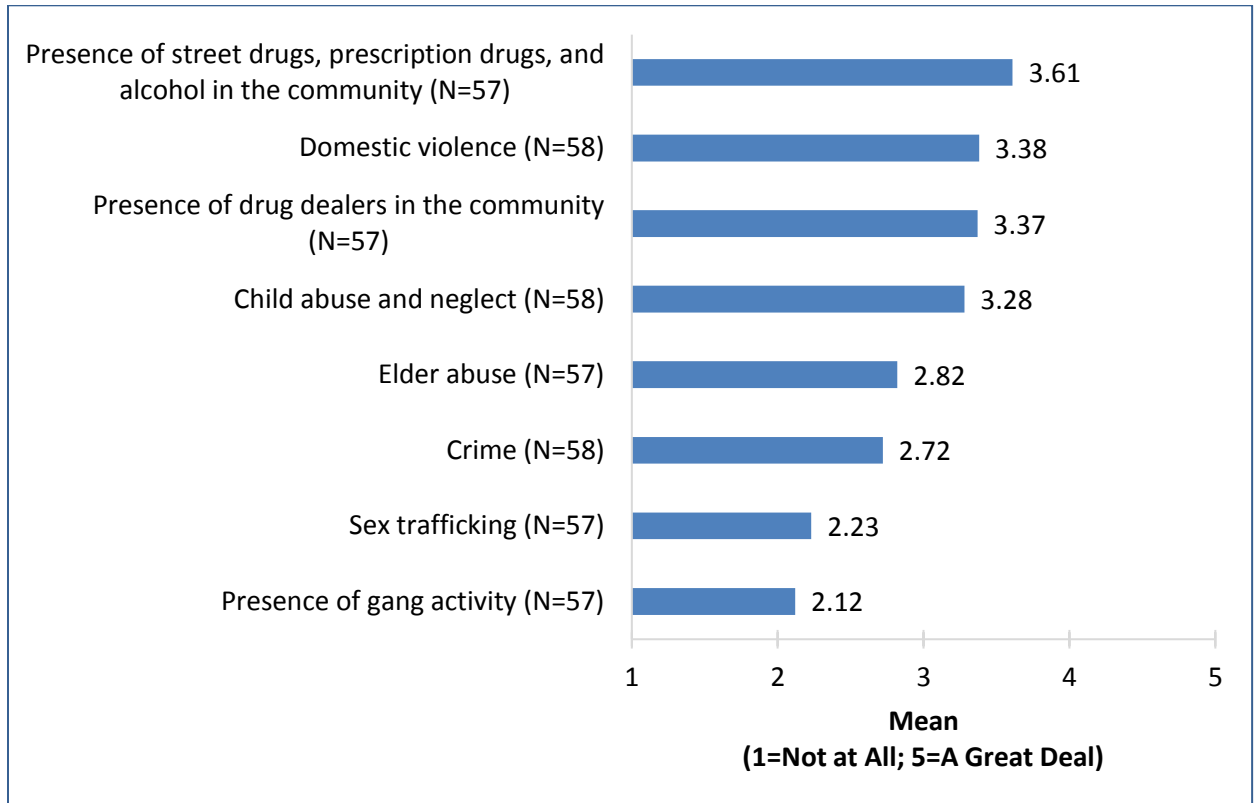
**Children and Youth:**

**Level of concern with statements about the community regarding CHILDREN AND YOUTH**



**Safety:** Safety regarding the presence of street drugs and alcohol in the community is a high concern for the respondents of the non-generalizable survey.

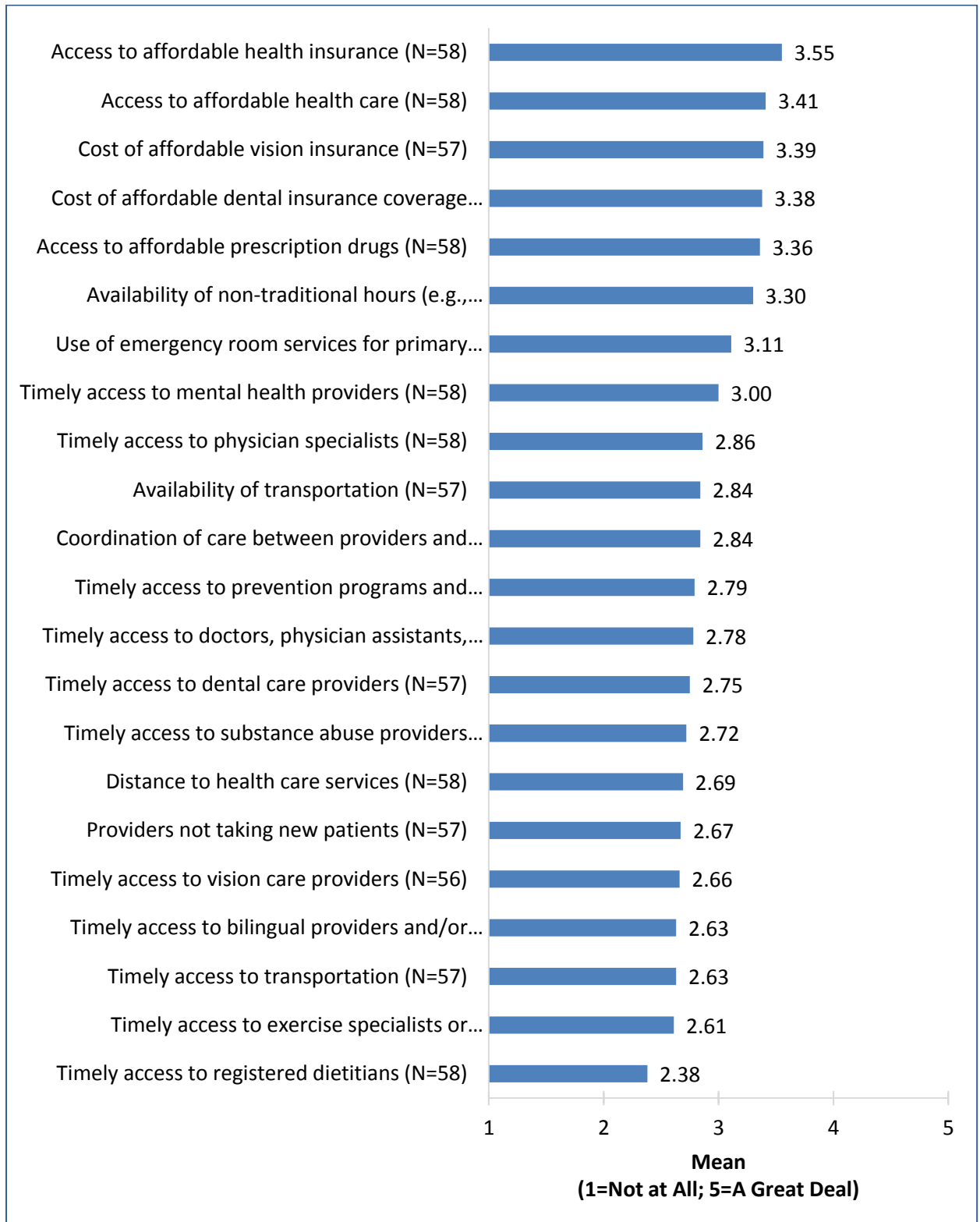
**Level of concern with statements about the community regarding SAFETY**



Sanford screens patients for substance abuse on admission to the emergency department. Sanford also partners with the local law enforcement agencies and in the drug court process.

**Health Care Access:** Community stakeholders ranked the cost of affordable health insurance as the top concern for health care access.

**Level of concern with statements about the community regarding HEALTH CARE**

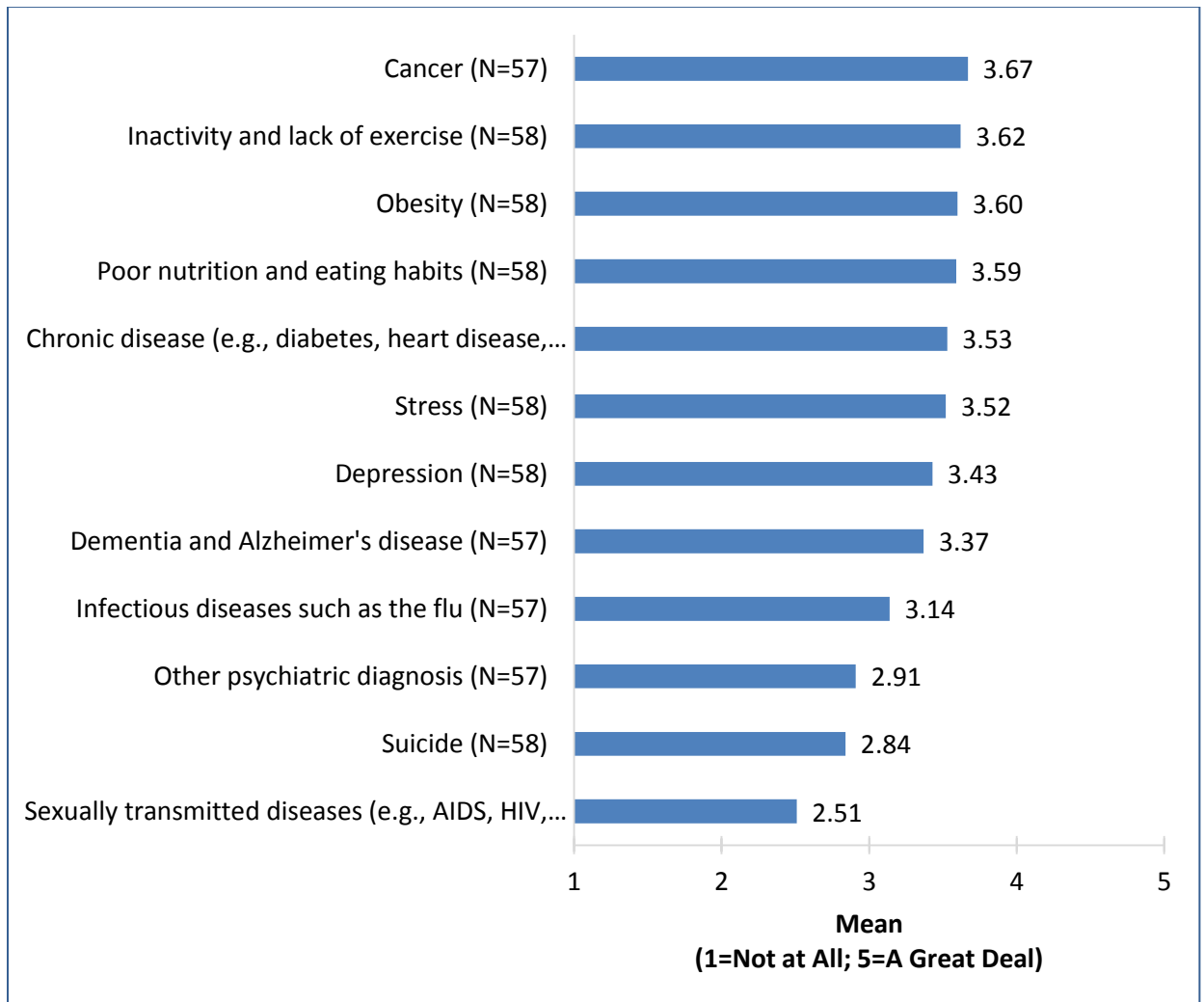




Sanford Laverne offers charity care to patients unable to pay for medical treatment. Sanford's community care policy defines qualifications and financial counselors are available to assist patients who qualify for free or subsidized care. Financial counselors also assist with enrollment for patients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

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

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



Sanford Health is focusing on enhancing the percentage of patients receiving preventive screenings including colonoscopies and mammograms. Additionally, Sanford is focusing on improving wellness and the health of the community through internal expertise and community partnerships.

Chronic disease is supported by the clinical dietitian, the Health Coach Clinic, and Medical Home. Preventive services and screenings are offered at Sanford. A wellness coordinator is available for community members.

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

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

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

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents benefit from their own set of resources where they can find tips and tools on becoming healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites, including videos, slideshows, games, articles, and even *fit* songs.
- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.
- *fit4Schools* – *fit4Schools* includes unique *fit*-based lessons integrated into daily classroom activities. [fit4schools.sanfordfit.org](http://fit4schools.sanfordfit.org) is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science,

technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:

- Reached 50,000 schools
- 180,000 page views from educators across the country
- 12,000 lesson plan downloads, representing 600,000+ students

We are also reaching thousands of students through several pilot school programs.

- *fit4Schools* – *fit4Schools*, which includes unique *fit*-based lessons integrated into daily classroom activities, is in its final phase of development. It is being piloted in seven elementary schools in the Sanford region.

- Community

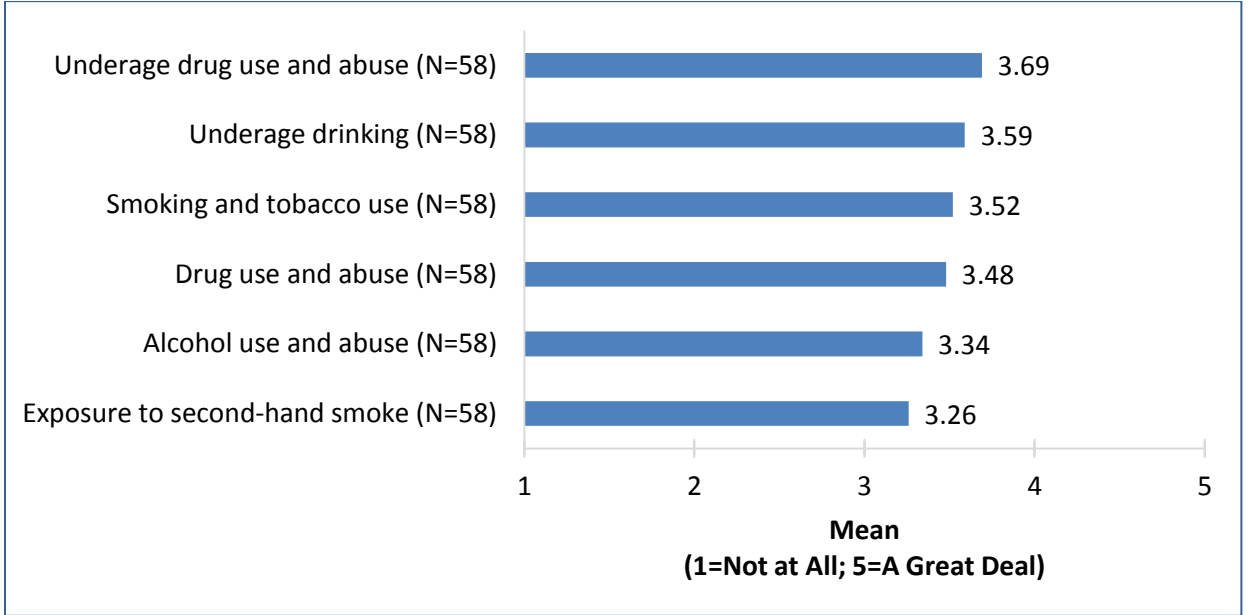
- The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint. *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
- Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
- MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.
- eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward

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

**Mental Health /Behavioral Health:** The top behavioral health concerns are underage drug use and abuse, underage drinking and tobacco use.

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



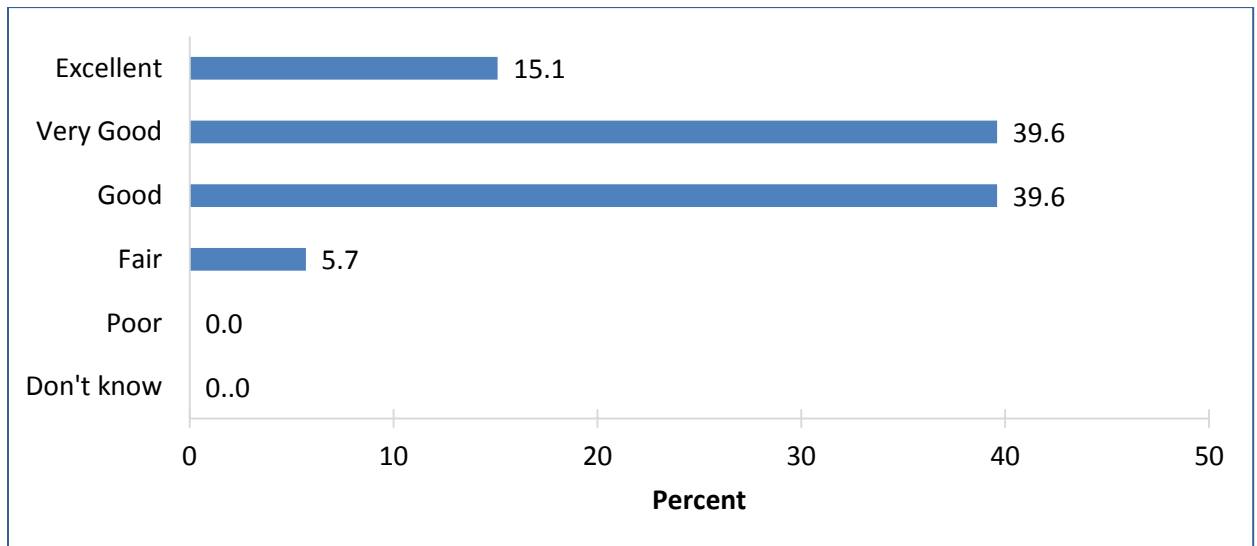
Sanford screens patients for depression on admission to the emergency department. Behavioral health services are embedded into the clinic. Primary care providers refer to mental health providers and there is a behavioral health triage therapist to access and refer for services.

## Personal Health Concerns

### **Respondents' Personal Health Status**

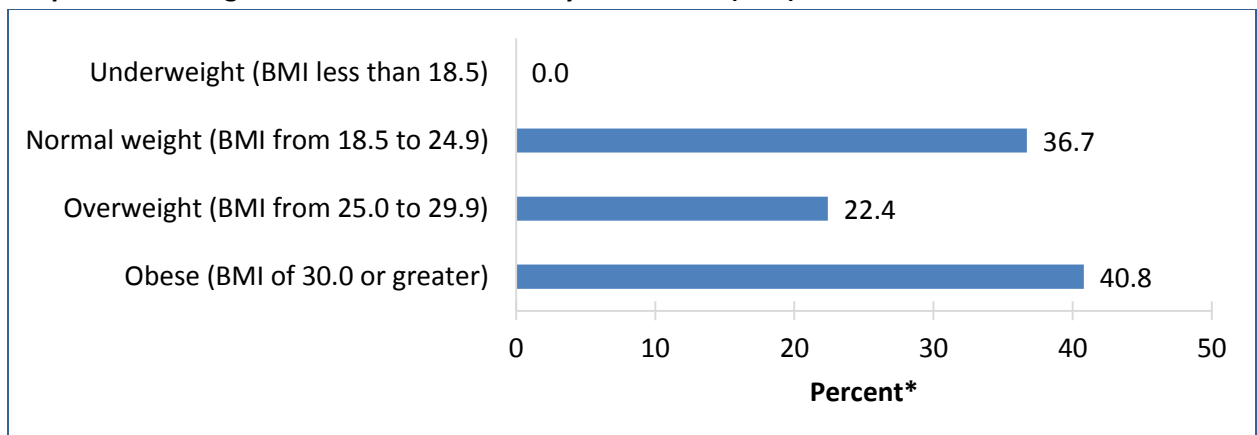
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area (63.2%) are overweight or obese. However, the vast majority (94.3%) of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, over 82% of respondents visited a doctor or health care provider for a routine physical and over 82% visited a dentist or dental clinic.

### **Respondents' rating of their health in general**



94.3% of the community stakeholders (non-generalizable) rate their health as good or better

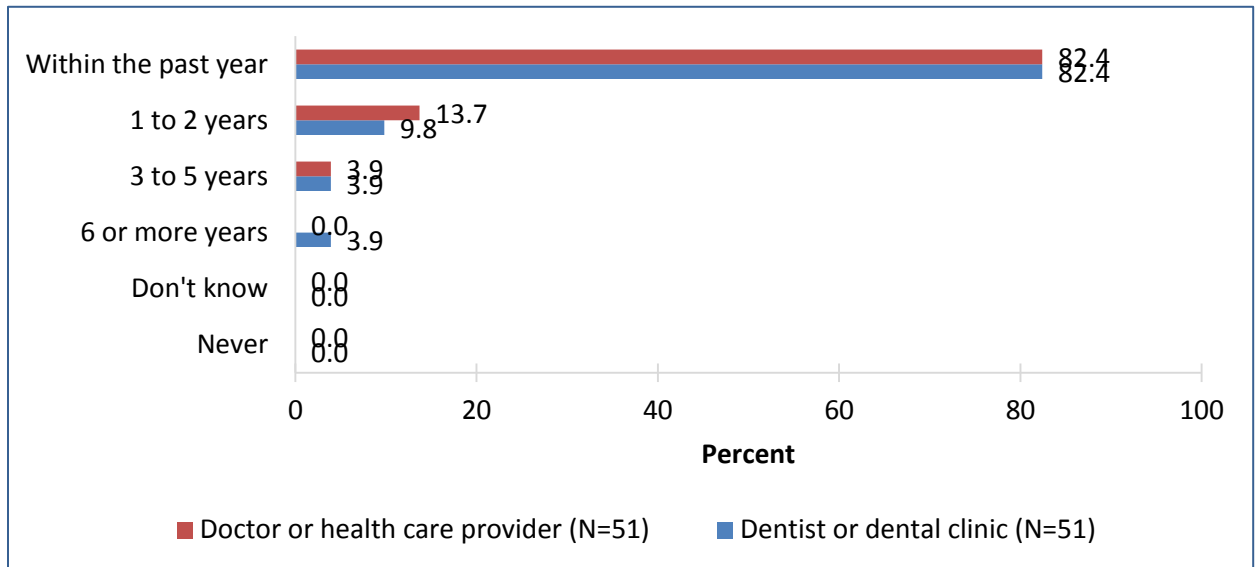
### **Respondents' weight status based on the Body Mass Index (BMI) scale**



63.2% of the key stakeholders report a BMI that is overweight or obese.



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



**Preventive Health**

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

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

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

Type of screening	Percent of respondents		
	Yes	No	Total
<b>GENERAL SCREENINGS</b>			
Blood pressure screening (N=51)	88.2	11.8	100.0
Blood sugar screening (N=51)	62.7	37.3	100.0
Bone density test (N=51)	5.9	94.1	100.0
Cardiovascular screening (N=51)	21.6	78.4	100.0
Cholesterol screening (N=51)	60.8	39.2	100.0
Dental screening and X-rays (N=51)	82.4	17.6	100.0
Flu shot (N=51)	82.4	17.6	100.0
Glaucoma test (N=51)	49.0	51.0	100.0
Hearing screening (N=51)	9.8	90.2	100.0
Immunizations (N=51)	33.3	66.7	100.0
Pelvic exam (N=30 Females)	50.0	50.0	100.0
STD (N=51)	3.9	96.1	100.0
Vascular screening (N=51)	9.8	90.2	100.0
<b>CANCER SCREENINGS</b>			
Breast cancer screening (N=30 Females)	73.3	26.7	100.0
Cervical cancer screening (N=30 Females)	43.3	56.7	100.0
Colorectal cancer screening (N=49)	28.6	71.4	100.0
Prostate cancer screening (N=17 Males)	35.3	64.7	100.0
Skin cancer screening (N=50)	38.0	62.0	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
<b>GENERAL SCREENINGS</b>							
Blood pressure screening (N=6)	66.7	50.0	0.0	0.0	0.0	0.0	0.0
Blood sugar screening (N=19)	36.8	52.6	0.0	0.0	0.0	0.0	10.5
Bone density test (N=48)	29.2	58.3	0.0	0.0	0.0	0.0	4.2
Cardiovascular screening (N=40)	25.0	72.5	0.0	0.0	0.0	0.0	2.5
Cholesterol screening (N=20)	40.0	55.0	5.0	0.0	0.0	0.0	5.0
Dental screening and X-rays (N=9)	22.2	22.2	22.2	22.2	11.1	0.0	0.0
Flu shot (N=9)	11.1	0.0	0.0	0.0	11.1	0.0	66.7
Glaucoma test (N=26)	50.0	42.3	0.0	0.0	0.0	0.0	11.5
Hearing screening (N=46)	47.8	43.5	2.2	0.0	0.0	0.0	4.3

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Immunizations (N=34)	52.9	44.1	0.0	0.0	0.0	0.0	5.9
Pelvic exam (N=15 Females)	60.0	46.7	0.0	0.0	0.0	0.0	6.7
STD (N=49)	65.3	30.6	0.0	0.0	0.0	0.0	2.0
Vascular screening (N=46)	37.0	56.5	0.0	0.0	0.0	0.0	6.5
<b>CANCER SCREENINGS</b>							
Breast cancer screening (N=8 Females)	25.0	12.5	0.0	0.0	0.0	0.0	50.0
Cervical cancer screening (N=17 Females)	64.7	23.5	0.0	0.0	0.0	0.0	17.6
Colorectal cancer screening (N=35)	54.3	28.6	2.9	0.0	0.0	0.0	17.1
Prostate cancer screening (N=11 Males)	27.3	54.5	9.1	0.0	0.0	0.0	18.2
Skin cancer screening (N=31)	19.4	64.5	3.2	0.0	0.0	0.0	12.9

- For most types of screenings, the most common reasons for not getting the test or procedure are that it is not necessary and the doctor has not suggested one.
- For the flu shot screening, most respondents cite that it was not necessary or other reasons for not getting the shot. 0% of the non-generalizable respondents were under 45 years of age. Over 47% were in the 55 years or above category.

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

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

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

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

Colorectal cancer screening: Colorectal cancer almost always develops from *precancerous polyps* (abnormal growths) in the colon or rectum. Screening tests can also find colorectal cancer early, when treatment works best. Regular screening, beginning at age 50, is the key to preventing

colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 years and continuing until age 75 years.

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

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

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

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

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

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

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

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

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

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

## **Flu Vaccines**

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

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

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

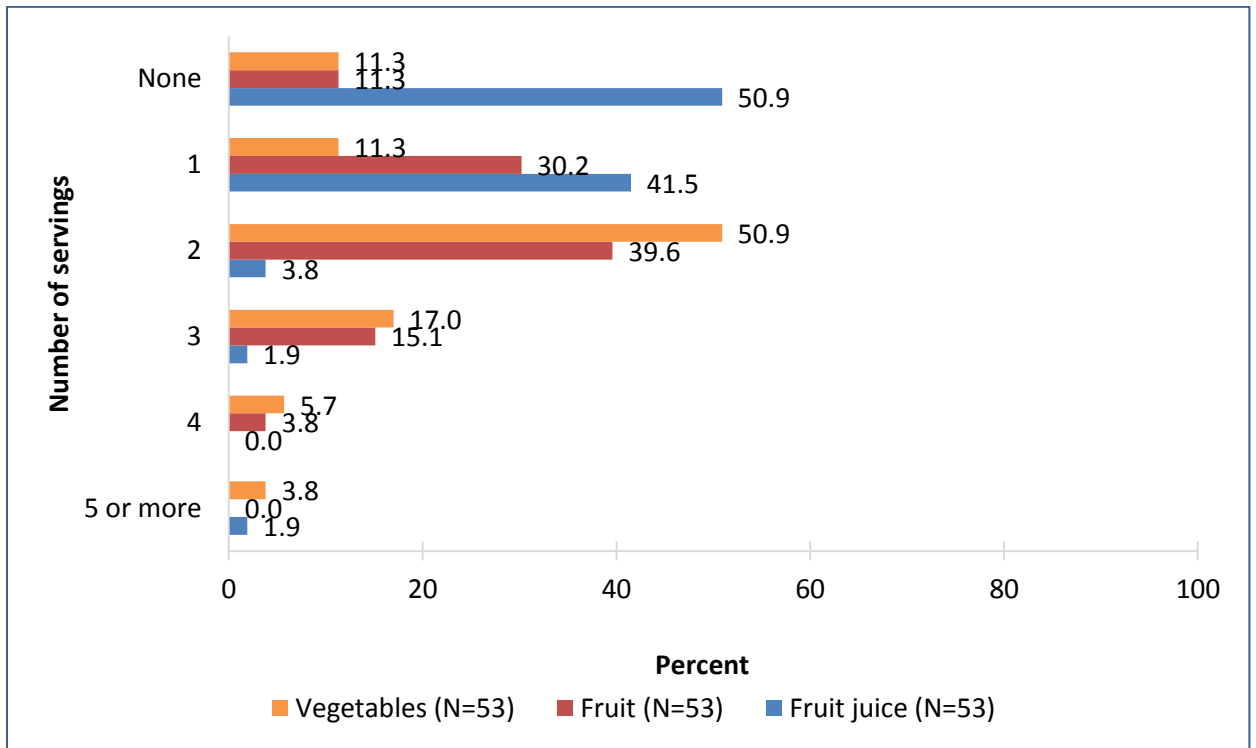
Sanford Luverne also partners with the Hills Beaver Creek and Luverne schools to offer in-school flu shot clinics.

## **Fruit and Vegetable Intake**

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 26.5% of respondents reported having 3 or more servings of vegetables the prior day. Only 18.9% reported having 3 or more servings of fruits the prior day.

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

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

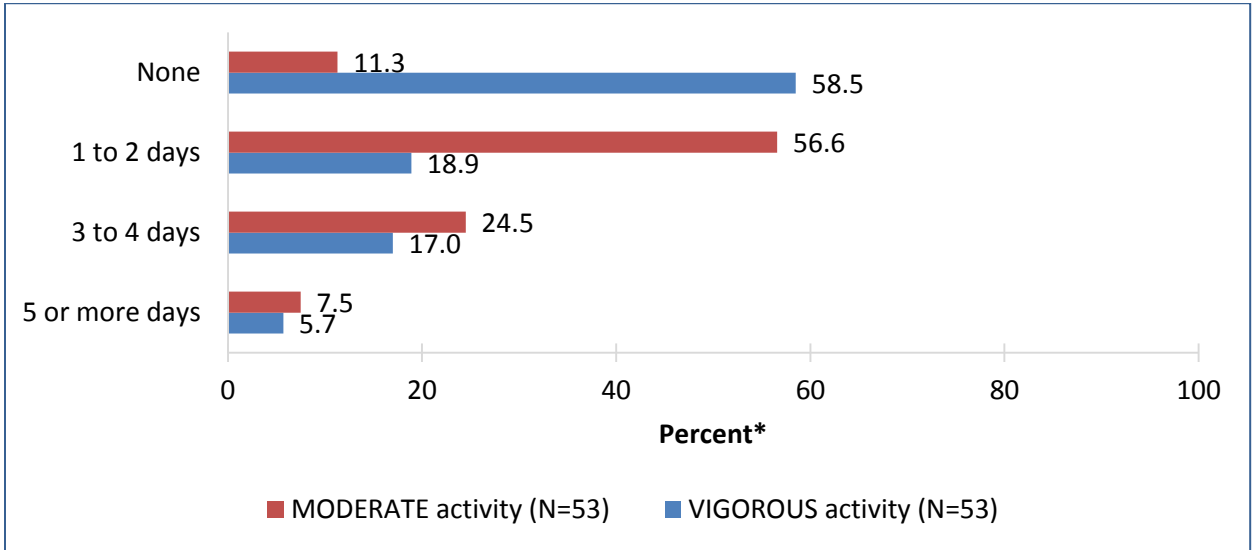


### Physical Activity Levels

Study results suggest that respondents do not meet physical activity guidelines. 32% of respondents have 3 or more days per week with moderate activity.

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

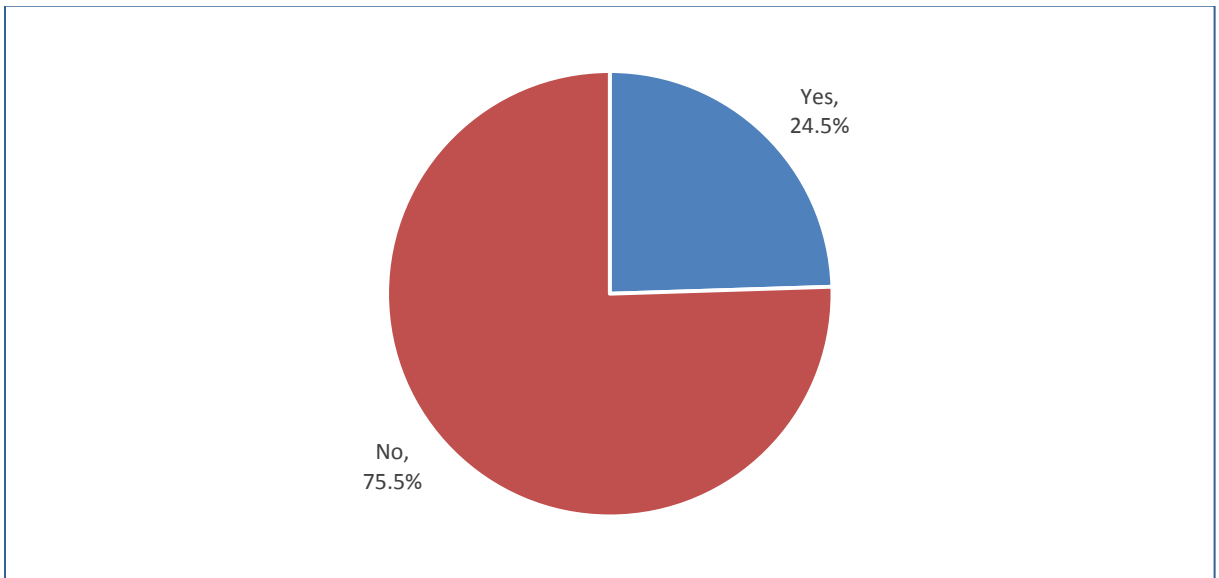
**Number of days in an average week respondents engage in MODERATE and VIGOROUS activity**



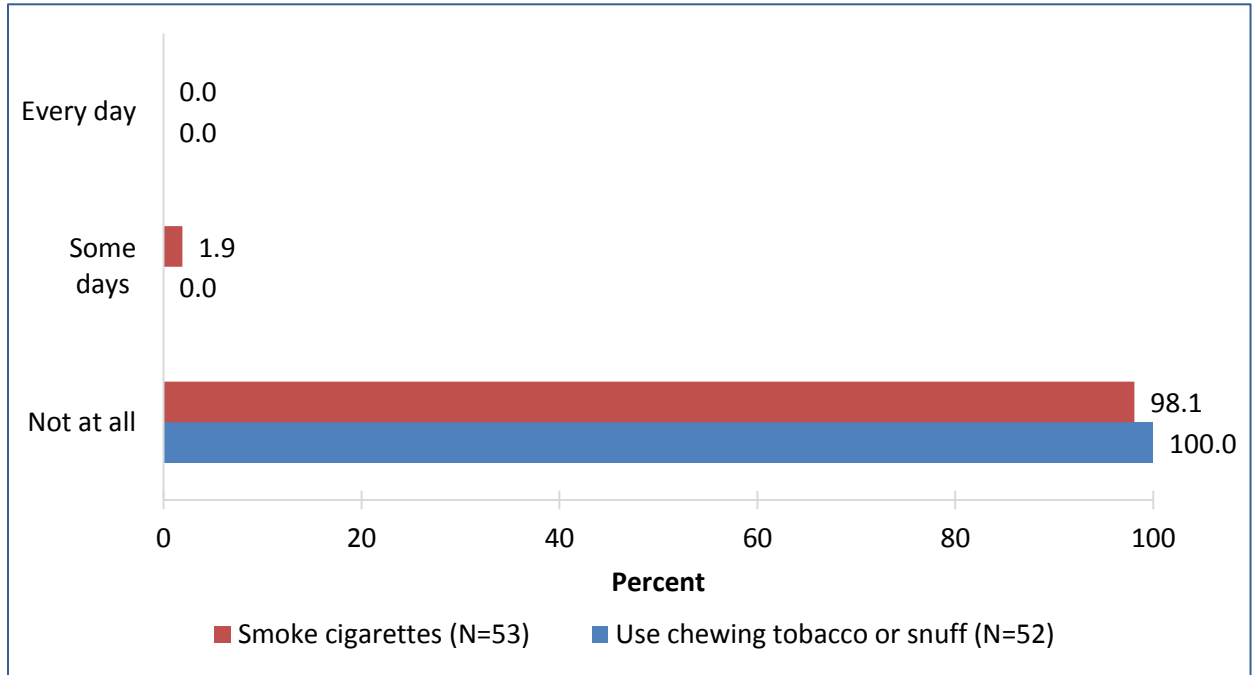
**Tobacco Use**

Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 24.5% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates a former smoker status according to the Centers for Disease Control and Prevention.

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



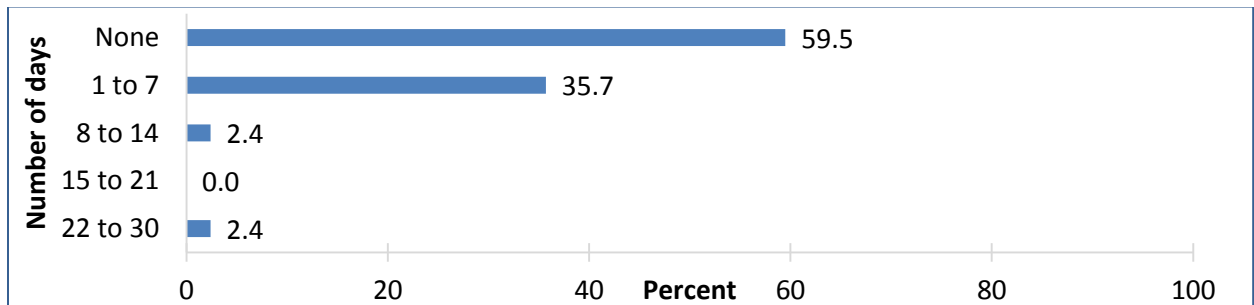
**How often respondents currently smoke cigarettes and use chewing tobacco or snuff**



**Mental Health**

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others. Among Luverne and Rock County respondents, mental health is a moderately high area of concern, particularly depression, and stress. 31.5% of respondents have been told or diagnosed by a doctor or health professional that they have anxiety or stress and 33.3% have been told they have depression. In addition, 40.5% of respondents self-report that in the last month, there were days when their mental health was not good.

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



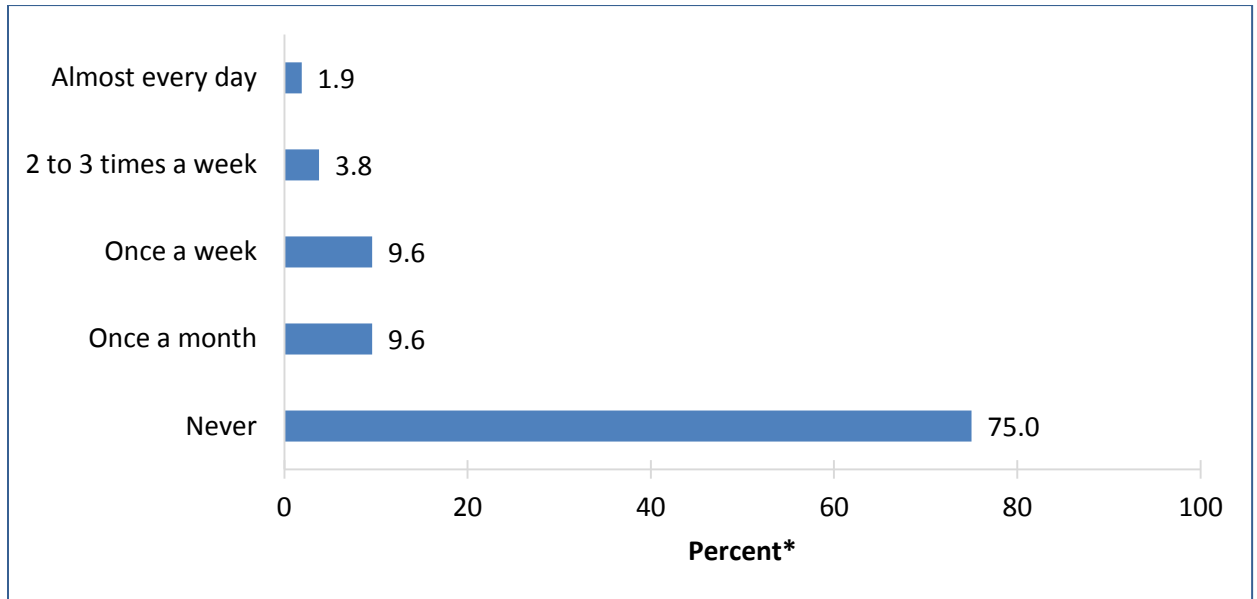


**Substance Abuse Responses**

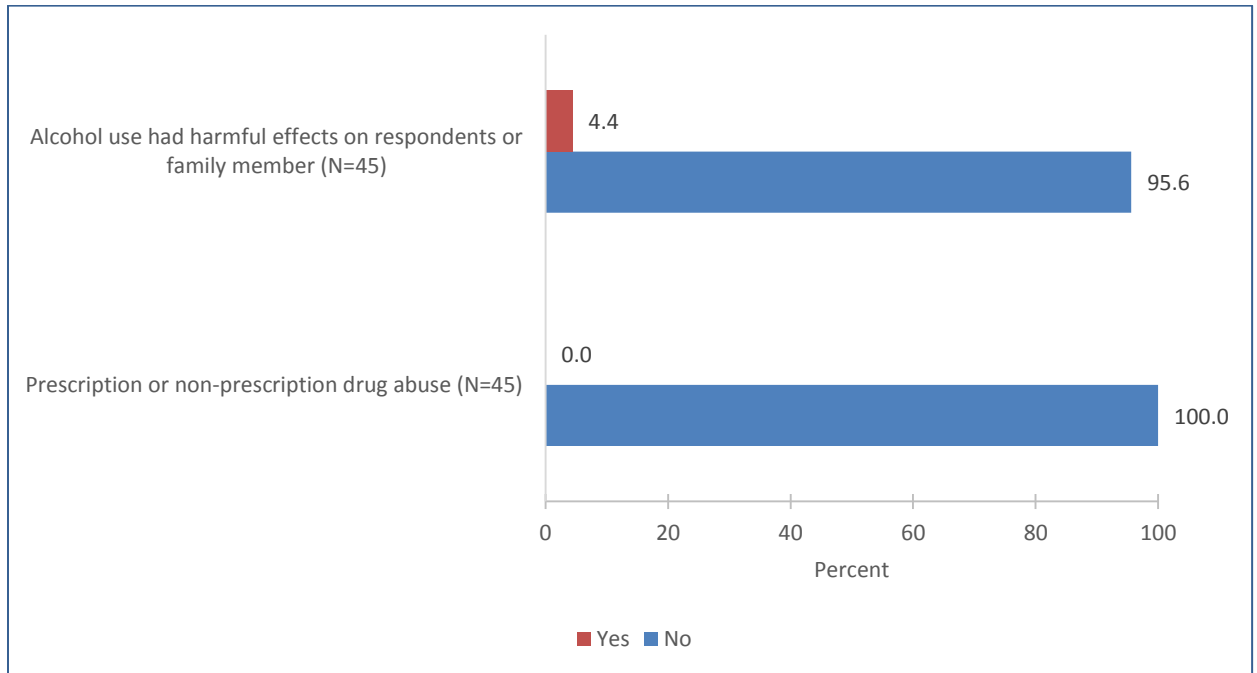
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In Luverne and Rock County, 82.2% of the community stakeholder’s respondents drank alcoholic beverages on at least one of the days in the last month. On days they drank, 13.3% of respondents drank an average of 3 or more drinks per day. In regards to binge drinking, 24.9% of community stakeholder’s respondents report binge drinking at least once per month,

Secondary research through the 2015 County Health Rankings found that 17% of residents in Rock County report excessive drinking, and 0% of the driving deaths indicated alcohol involvement. (See Appendix)

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



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



4.4% percent of respondents from the community stakeholder group reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking (24.9%).

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

## Demographics

### Total Population – 2010 U.S. Census Bureau

- Rock County: 9,687

### Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	683	7.1	354	3.7	329	3.4
5-9	713	7.4	357	3.7	356	3.7
10-14	673	6.9	354	3.7	319	3.3
15-19	641	6.6	338	3.5	303	3.1
20-24	389	4.0	206	2.1	183	1.9
25-29	504	5.2	241	2.5	263	2.7
30-34	549	5.7	278	2.9	271	2.8
35-39	558	5.8	282	2.9	276	2.8
40-44	505	5.2	260	2.7	245	2.5
45-49	673	6.9	324	3.3	349	3.6
50-54	713	7.4	357	3.7	356	3.7
55-59	658	6.8	331	3.4	327	3.4
60-64	593	6.1	311	3.2	282	2.9
65-69	448	4.6	234	2.4	214	2.2
70-74	349	3.6	156	1.6	193	2.0
75-79	329	3.4	145	1.5	184	1.9
80-84	327	3.4	131	1.4	196	2.0
85 and over	382	3.9	129	1.3	253	2.6
Median age	41.4		39.8		43.2	

### Population by Race

	Rock County	Percent
White	9,365	96.7
Black or African American	59	0.6
American Indian or Alaska Native	34	0.4
Asian	53	0.5
Native Hawaiian or other Pacific Islander	1	0.0
Hispanic or Latino	197	2.0

The per capita personal income in Rock County, Minnesota is \$25,586. 11.6% of individuals 18 years and older in Rock County are living below the poverty level. The unemployment rate in Rock County, Minnesota is 3.3%.

## *Health Needs and Community Resources Identified*

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

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

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

The asset map process includes identified needs from the following:

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

The asset map can be found in the Appendix.

## *Prioritization*

The following needs were brought forward for prioritization:

- Aging – cost of long term care, availability of memory care
- Children and Youth – availability of quality infant care and quality child care
- Safety – presence of street drugs and alcohol in the community
- Health Care Access – access to affordable health insurance
- Physical Health – cancer, chronic disease, inactivity, poor nutrition and obesity
- Mental Health – underage drinking, underage drug use and abuse, stress and tobacco use
- Preventive Health – flu vaccines, immunizations

Members of the community stakeholders group determined that mental health and physical health are the top unmet needs.

- Mental Health
- Physical Health

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

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

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

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

**Sanford Laverne Medical Center**  
*Addressing the Needs*

Identified Concerns	How Sanford Laverne is Addressing the Needs
<b>Aging</b> <ul style="list-style-type: none"> <li>• Cost of long term care</li> <li>• Availability of memory care</li> </ul>	Sharing information on need for memory care with area senior housing partners.
<b>Children and Youth</b> <ul style="list-style-type: none"> <li>• Availability of quality infant care</li> <li>• Availability of quality childcare</li> </ul>	Sharing need with city for conducting a needs assessment.
<b>Safety</b> <ul style="list-style-type: none"> <li>• Presence of street drugs and alcohol in the community</li> </ul>	Partnering with local law enforcement in the county drug court process .
<b>Health Care</b> <ul style="list-style-type: none"> <li>• Access to affordable health insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Sanford Health Plan</li> <li>• Sanford Community Care program</li> </ul>
<b>Physical Health</b> <ul style="list-style-type: none"> <li>• Cancer</li> <li>• Inactivity and lack of exercise; Obesity               <ul style="list-style-type: none"> <li>○ County rate is obese 27%</li> </ul> </li> <li>• Poor nutrition and eating habits</li> <li>• Chronic disease</li> </ul>	<ul style="list-style-type: none"> <li>• Sanford Laverne dietician conducting programs for intensive behavioral therapy for obese patients and providing education monthly at senior center.</li> <li>• Sanford Laverne Medical Home model within the clinic impacting chronic disease and care coordination through Health Coach and care coordinator assistant.</li> <li>• Sanford Laverne wellness coordinator hosting community wellness challenges.</li> <li>• Sanford Laverne partnered with master gardeners on grant writing to expand community gardens for greater access to fresh produce.</li> <li>• Sanford Laverne rep on the Food Shelf to impact food choices/more healthy options.</li> <li>• Sanford Laverne submitting grant letters of support for expanded walking/biking path access.</li> </ul>
<b>Mental Health</b> <ul style="list-style-type: none"> <li>• Underage drug abuse</li> <li>• Underage drinking</li> <li>• Stress</li> <li>• Smoking and tobacco use</li> </ul>	<ul style="list-style-type: none"> <li>• Sanford Laverne has recruited and recently hired a behavioral health triage therapist who is completing orientation. Plans to ramp up to part-time by mid-2016. She has met with SW Mental Health resources to begin collaboration.</li> <li>• Sanford Laverne has an outpatient chemical dependency program that is involved with county and surrounding county drug courts as well as actively involved with community groups working to impact drug/alcohol use.</li> <li>• Sanford Laverne has access to telehealth psych providers for adults and pediatric needs.</li> </ul>
<b>Preventive Health</b> <ul style="list-style-type: none"> <li>• 17.6% did not receive a flu shot last year</li> <li>• 66.7% did not have an immunization last year</li> </ul>	<ul style="list-style-type: none"> <li>• Sanford Laverne conducts school flu shot clinics at area schools to ensure kids are vaccinated.</li> <li>• Sanford Laverne staff are reviewing snapshot in EMR to ensure immunizations are given at appropriate times.</li> </ul>

# 2016 Implementation Strategy

## Implementation Strategies

### **Priority 1: Physical Health**

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

Sanford has set strategy to help the community improve their physical health and chronic health conditions. The goal of this strategy is to improve the Minnesota Community Measures scores for identified chronic disease.

### **Priority 2: Mental Health/Behavioral Health**

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

Many factors contribute to mental health problems, including:

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

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

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to improve access and coordination of care. Sanford is working with community partners to create program and referral options for community members.



**Community Health Needs Assessment  
Implementation Strategy for Sanford Laverne Medical Center  
FY 2017-2020 Action Plan**

**Priority 1: Improving the physical health of the community**

**Projected Impact: Improved chronic disease management**

**Goal 1: Improved MN Community Measure Scores for identified chronic disease management**

<b>Actions/Tactics</b>	<b>Measureable Outcomes</b>	<b>Dedicated Resources</b>	<b>Leadership</b>	<b>Community partnerships and collaborations (if applicable)</b>
Key clinic staff will continue to monitor the disease registry & expand beyond the asthma, diabetes and mental health focus to new evolving needs as gaps are identified	MN Community Measure Scores	RN Health Coach, Clinical Supervisor, Care Coordinator	Clinic Director, CEO, Physicians	
Educational opportunities will be provided to the community to encourage healthy eating	County obesity rates, MN Community Measure Scores	Dietitian, RN Health Coach, Wellness Coord., Diabetic educators, Sanford Wellness Committee	CEO, clinic director, physicians	Chamber, School, Food shelf, farmers market
Explore options to increase availability of dental services that accept MA	Access to dental care for MA patients	CEO, Clinic director	CEO, clinic director	Local dentists, Mobile dental services, SW Health and Human Services
Engage community around wellness and become a leader in activities that promote physical health in the community	County obesity rates, expanded use of walking/biking trails, number of activities to promote health/wellness in the community, designated healthy community (ex: Blue Zone)	Wellness Coord., CEO, RN Health Coach, Employee Health RN	CEO, rehab manager	City, school, Chamber

**Priority 2: Improving the mental health of the community**

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

**Goal 1: Enhanced access to mental health and substance abuse resources**

<b>Actions/Tactics</b>	<b>Measureable Outcomes</b>	<b>Resources</b>	<b>Leadership</b>	<b>Community partnerships and collaborations - if applicable</b>
Expanded access to behavioral health triage therapist (BHTT)	Referrals to behavioral health	Behavioral Health Triage Therapist	Clinic director	Sanford Behavioral Health Team
BHTT partnership with local and Sanford mental health resources to triage patients into appropriate providers	Behavioral health referrals, decreased PHQ9 scores, improved mental health scores	Behavioral Health Triage Therapist, Care Coordinator Assistant	Clinic director	SW Mental Health, Sanford Mental Health Resources
BHTT to engage in the community to provide education on improving mental health	Decreased PHQ9 scores, improved mental health scores	Behavioral Health Triage Therapist, RN Health Coach and Care Coordinator Assistant	Clinic director	SW Mental Health
Chemical dependency program actively involved with county drug court programs	Enhanced access to substance abuse services	Chemical dependency staff	CEO	Rock County & surrounding counties' drug courts, school, law enforcement
Chemical dependency and BHTT partnership in providing education to school or other agencies on improving mental health and decreasing substance abuse	Decreased incidence of underage drug and alcohol use	Chemical dependency staff, behavioral health triage therapist	CEO, Clinic director	SW Mental Health, School, County/Drug court

# 2013 Implementation Strategy Impact

# Demonstrating Impact

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

## 2013 Community Health Needs Assessment Sanford Luverne Implementation Strategy

### After Hours Access/Walk In Clinic

#### **Three-Year Plan (January 2013 - January 2015)**

- Complete after hours volume analysis by September 30, 2013
- Complete proforma and business plan by December 31, 2013
- Sanford Health Network level review of proforma and business plan: Decline/Approve by February 15, 2014
- FY 14 budget developed to include initiative by February 28, 2014
- Implementation by September 30, 2014

### Lack of Knowledge on Services Available in the Community

#### **Three-Year Plan (January 2013 - January 2015)**

- Develop Rock County Collaborative of key stakeholders by July 31, 2013
- Develop tool of available resources by December 31, 2013
- Design/print resource materials with Sanford marketing by February 28, 2014
- Share resource tool with key community stakeholders/access points to care by April 30, 2014 and at various events throughout FY 16

### Impact of the Strategy to Address After Hours Access

Sanford Luverne analyzed volume data and completed a financial analysis for a potential after hours clinic. The addition of a new provider in the clinic as well as E-visits through MyChart, impacted the demand for an extended hours clinic.

Patients are currently able to access a video visit or E-visit with their provider through MyChart for after hours access without having to leave the community for urgent care needs. The new E-visits and MyChart access has addressed the need for additional options and access.

### Impact of the Strategy to Address Awareness of Available Services

The 2013 CHNA found that community members were not always aware of resources and services available to them. Sanford convened a Community Safe Transitions collaborative that meets on a quarterly basis at Sanford Luverne. Team members include: Sanford Luverne Medical Center representatives, retail pharmacy, behavior health, nursing home, home care, services for the retired and aging, group homes, social workers, and transportation providers.

The collaborative updated brochures and distributed them among group members. Group members will distribute the information as needed throughout community and area. Updated information was also uploaded to the “resource tab” of Sanford OneChart and the Sanford Health Coach will continue to update information on the chart as new information becomes available.

The impact from the 2013 Implementation strategies has been positive and the work will extend into the future through new or continued focus on the strategies.

### **Community Feedback from the 2013 Community Health Needs Assessment**

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

# APPENDIX

# Primary Research

## Sanford Luverne 2016 CHNA Asset Map

Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Aging population		<p>Cost of long term care 3.81</p> <p>Availability of memory care 3.65</p>	Area Long Term Care & Assisted Living facilities – Luverne, Edgerton, Hills, Ellsworth, Adrian	X
Children and Youth Health Care		<p>Availability of quality infant care 3.95</p> <p>Availability of quality child Care 3.84</p>	Sanford WebMD Fit Kids Rock County day care providers	X
Safety		Presence of street drugs, and alcohol in the community 3.61	Sanford Luverne Chemical Dependency Program Rock Nobles Drug court Rock County Law Enforcement	X
Health Care		Access to affordable health insurance 3.55	Sanford Luverne Medical Ctr. Sanford Video and E-visits Sanford Community Care Program Sanford Financial Counselors	X
Physical Health	<p>5.5% of live births are of low birth weight (less than 2500 grams)</p> <p>95% of diabetic Medicare enrollees ages 65-75 receive HgnA1C</p> <p>27% of adults are obese</p> <p>23% of adults have no leisure time physical activity</p> <p>Teen births are at 22 per 1000 female population – national rate is 20.</p>	<p>Cancer 3.67</p> <p>Inactivity and lack of exercise 3.62</p> <ul style="list-style-type: none"> <li>Only 45.5% have 3 or more days each week of moderate activity and 20 % report 3 or more days of vigorous activity each week</li> </ul> <p>Obesity 3.60</p> <ul style="list-style-type: none"> <li>63.2% report that they are overweight or obese</li> </ul> <p>Poor nutrition and eating habits 3.59</p> <ul style="list-style-type: none"> <li>Only 26.5% report eating 3 or more vegetables daily and 18.9 % report 3 or more fruits daily</li> </ul> <p>Chronic disease 3.53</p> <ul style="list-style-type: none"> <li>22.4% of respondents reported hypertension</li> </ul>	<p>Sanford Cancer Biology Research Center</p> <p>Sanford Luverne dietitians</p> <p>Biking and walking paths</p> <p>Area fitness centers</p> <p>Open walking at school</p> <p>Community gardens/Farmers market</p> <p>Sanford Luverne Intensive Behavioral Therapy program</p> <p>MN Extension service</p> <p>Sanford Medical Home</p> <p>The Sanford Project – to cure Type 1 DB in Denny Sanford’s lifetime</p> <p>Sanford WebMD Fit Kids</p> <p>Sanford’s Better Choices/Bette Health Program to address chronic illnesses</p> <p>Sanford Luverne Health Coach</p> <p>Sanford Luverne Medical Center</p>	X



Identified concern	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
		<ul style="list-style-type: none"> <li>15.5% reported high cholesterol</li> <li>13.8% reported arthritis</li> </ul>		
Mental Health	17% of adults report binge or excessive drinking	<p>Underage drug use and abuse 3.69</p> <p>Underage drinking 3.59</p> <p>Stress 3.52</p> <p>Smoking and tobacco use 3.52</p> <p>25.9% of respondents report that they have been told by a doctor that they have anxiety or stress, and 8.6% report being told that they have depression</p> <p>40.5% reported 1 or more days in the last month when their mental health was not good</p> <p>13.3% of respondents reported 3 or more drinks /d on average</p> <p>24.9% reported 4 or 5 drinks ( binge) on the same occasion over the past month</p> <p>Only 4.4% reported having a problem with alcohol use or drug use, however 15.4% reported that alcohol use had harmful effects on the respondent or a family member</p>	<p>Sanford One Care</p> <p>Sanford Luverne Chemical Dependency Program</p> <p>Sanford Luverne Behavioral Health Therapist</p> <p>Sanford tele-psych services</p> <p>Southwest Mental Health Services</p>	X
Preventive Health	55.4% of female Medicare enrollees age 67-69 receive mammography screenings	<p>17.6% did not receive a flu shot in the past year</p> <p>66.7% have not had an immunization in the past year</p> <p>17.6% of respondents report that it has been over a year since they have seen their health care provider and 14.6 % have not seen their dentist over the last year</p>	<p>Public Health office</p> <p>Area pharmacies that offer flu shots</p> <p>Sanford Luverne Medical Ctr.</p> <p>Medical Home Services</p> <p>Luverne and Rock County dentists</p>	X

## Sanford Luverne 2016 Community Health Needs Assessment Prioritization Worksheet

**Criteria to Identify Priority Problem**

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

**Criteria to Identify Intervention for Problem**

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
<b>Aging</b> <ul style="list-style-type: none"> <li>• Cost of long term care 3.81</li> <li>• Availability of memory care 3.65</li> </ul>			
<b>Children and Youth</b> <ul style="list-style-type: none"> <li>• Availability of quality infant care 3.95</li> <li>• Availability of quality childcare 3.84</li> </ul>			
<b>Safety</b> <ul style="list-style-type: none"> <li>• Presence of street drugs and alcohol in the community 3.61</li> </ul>			
<b>Health Care</b> <ul style="list-style-type: none"> <li>• Access to affordable health insurance 3.55</li> </ul>	X		
<b>Physical Health</b> <ul style="list-style-type: none"> <li>• Cancer 3.67</li> <li>• Inactivity and lack of exercise 3.62</li> <li>• Obesity 3.60               <ul style="list-style-type: none"> <li>○ County rate is obese 27%</li> </ul> </li> <li>• Poor nutrition and eating habits 3.59</li> <li>• Chronic disease 3.53</li> </ul>	XXX		
<b>Mental Health</b> <ul style="list-style-type: none"> <li>• Underage drug abuse 3.69</li> <li>• Underage drinking 3.59</li> <li>• Stress 3.52</li> <li>• Smoking and tobacco use 3.52</li> </ul>	XXXX		
<b>Preventive Health</b> <ul style="list-style-type: none"> <li>• 17.6% did not receive a flu shot last year</li> <li>• 66.7% did not have an immunization last year</li> </ul>			

**Present:** Jennifer Stratton, Mike Werner, Greta VanDerBrink, Tammy Loosbrock

**Sanford Luverne Medical Center**  
Community Health Needs Assessment  
Results from a March 2015 Non-generalizable  
Online Survey  
  
August 2015

## STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a March 2015 online survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative invited viewers to access the online survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach. **Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred throughout the month of March 2015 and a total of 58 respondents participated in the online survey.

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Table 3. Zip code of respondents

## SURVEY RESULTS

### General Health and Wellness Concerns about the Community

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

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

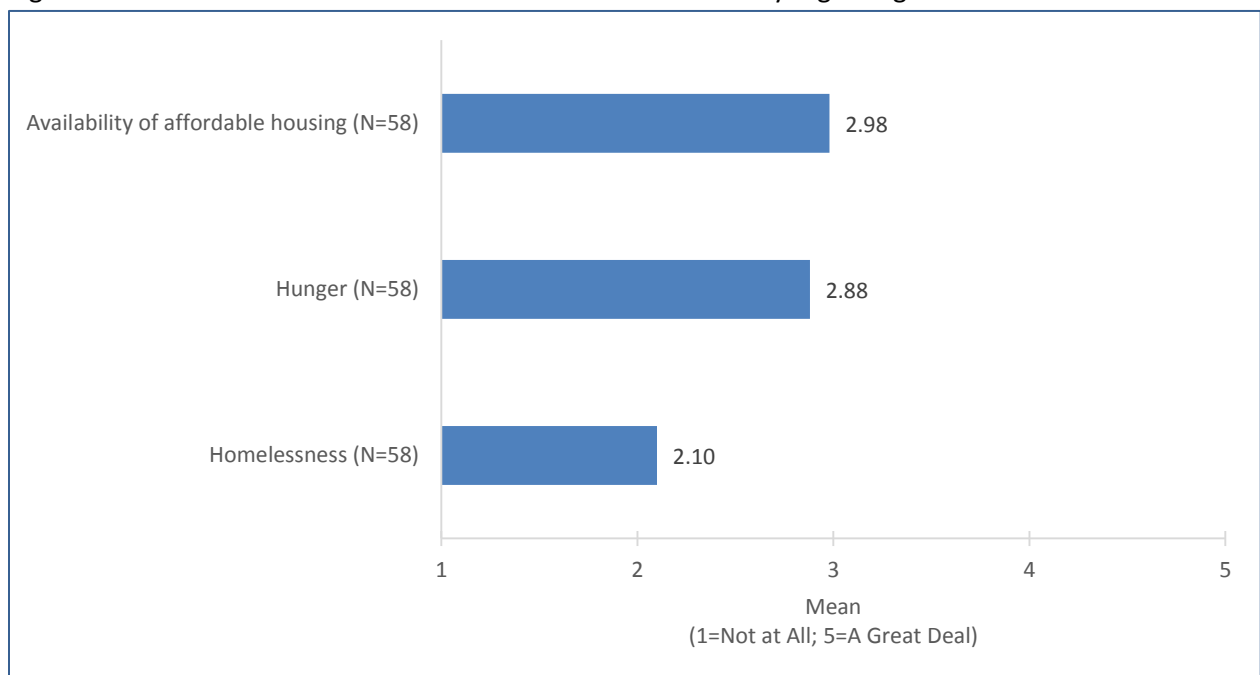




Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

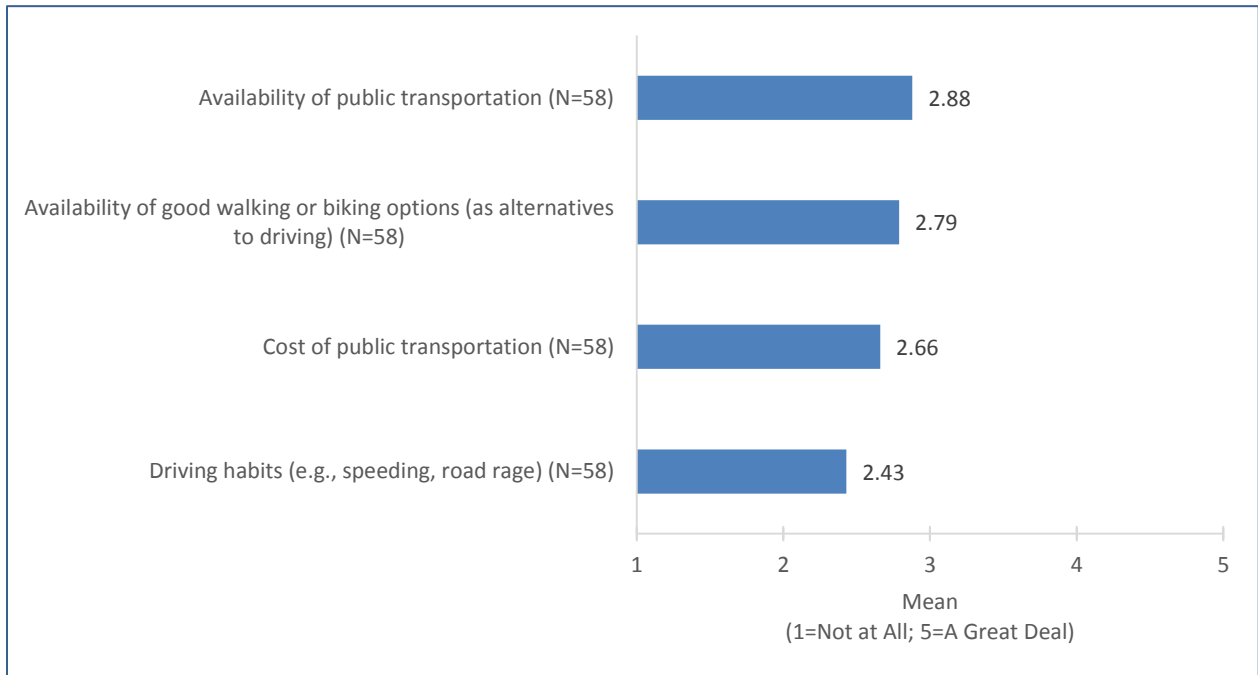


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

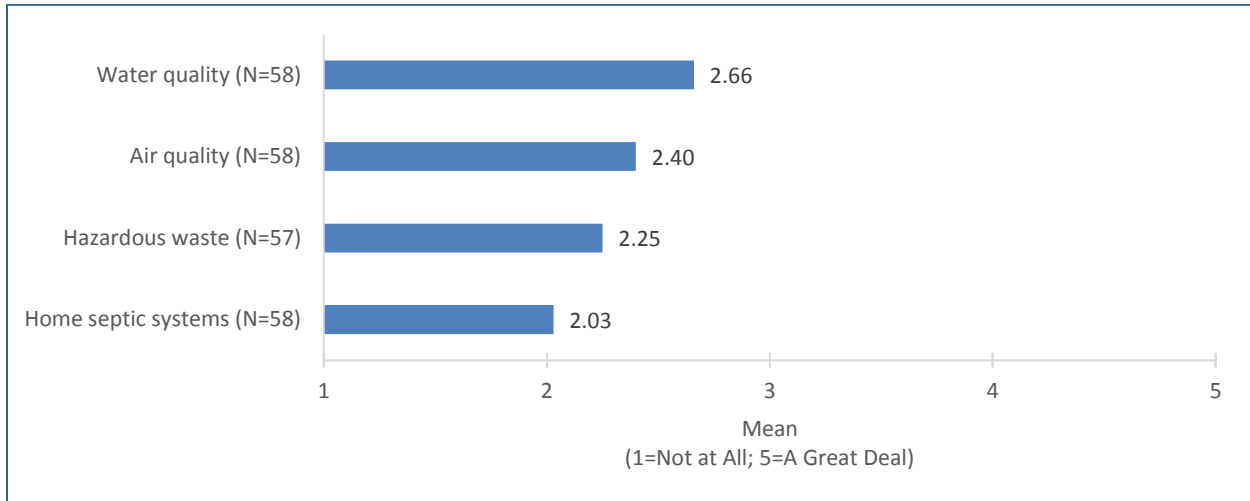


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

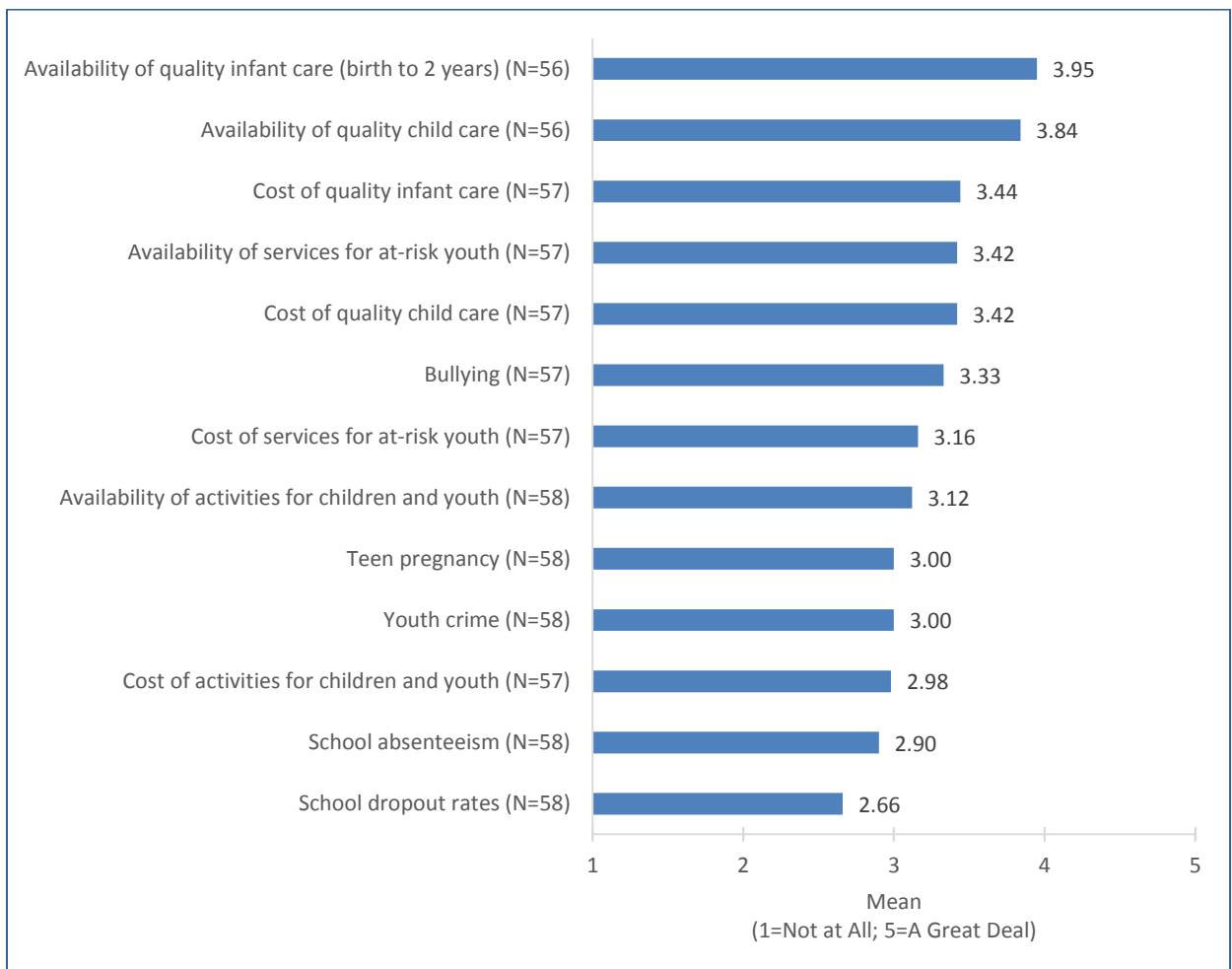


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

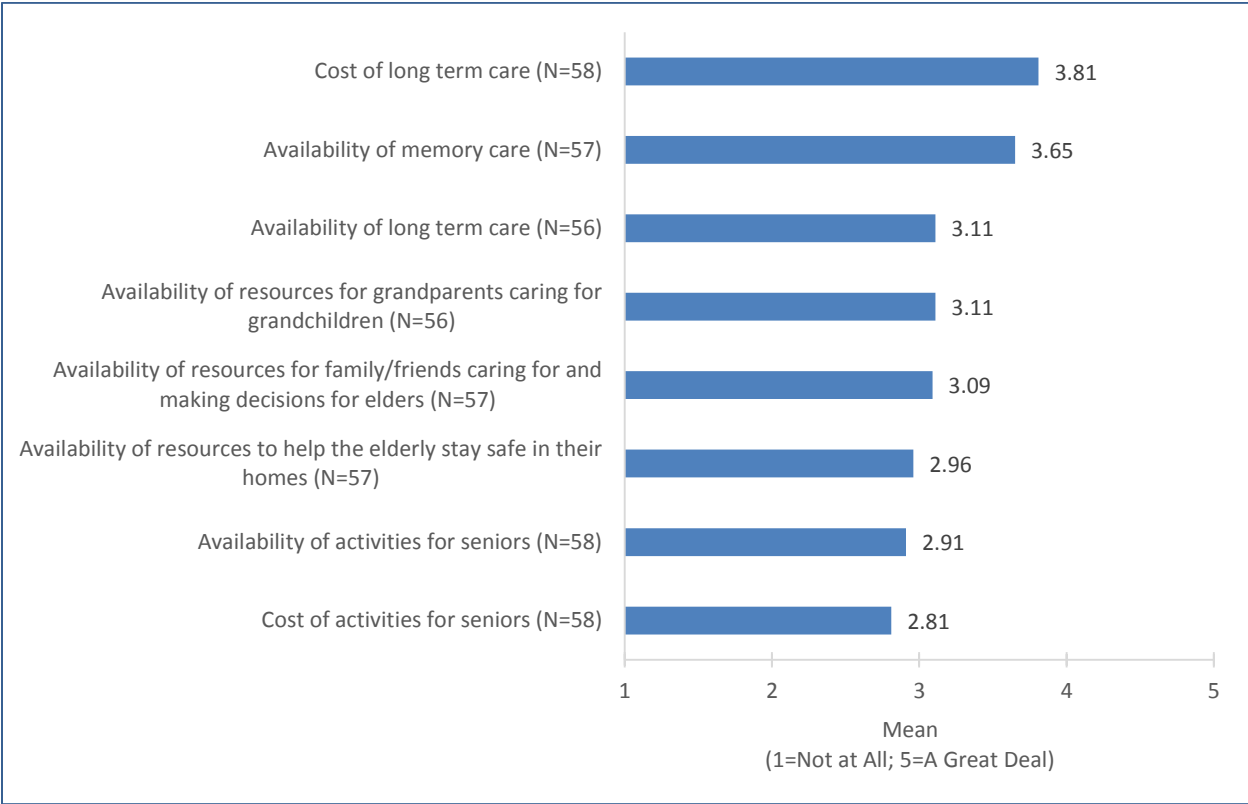


Figure 6. Level of concern with statements about the community regarding SAFETY

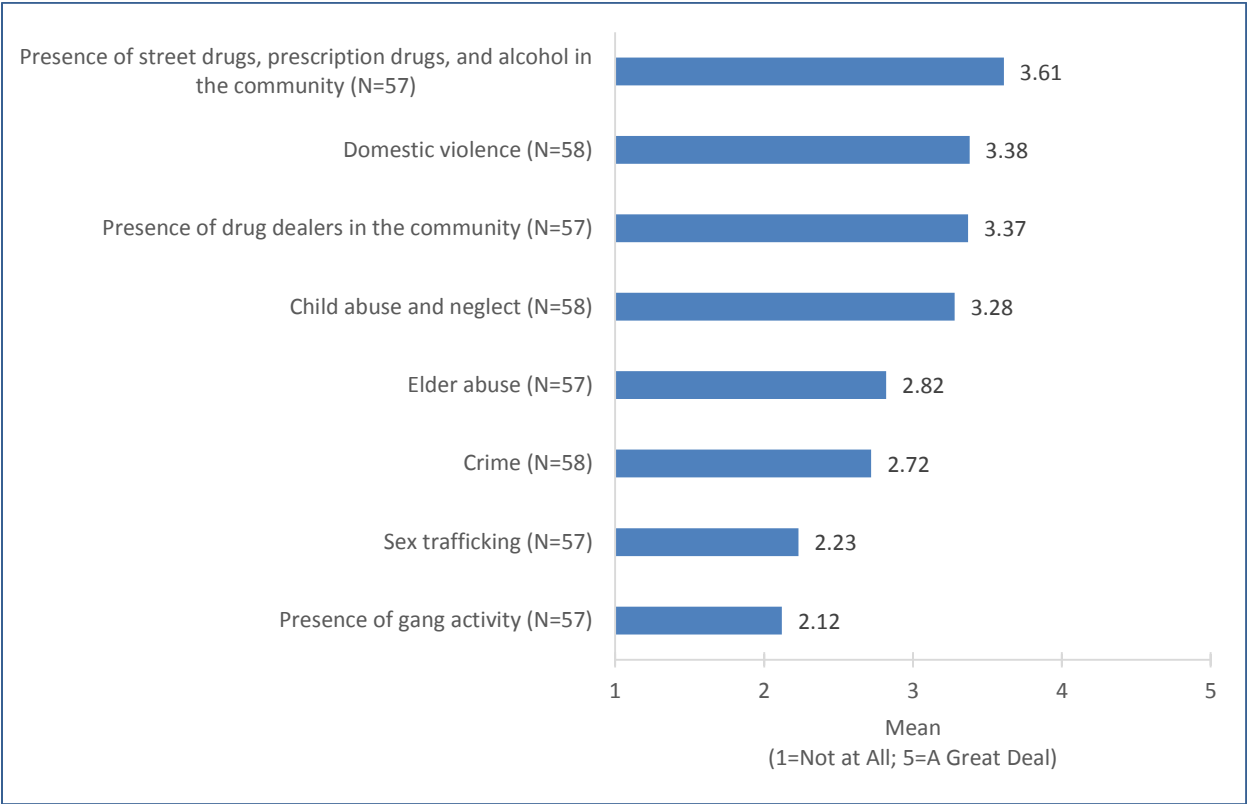


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

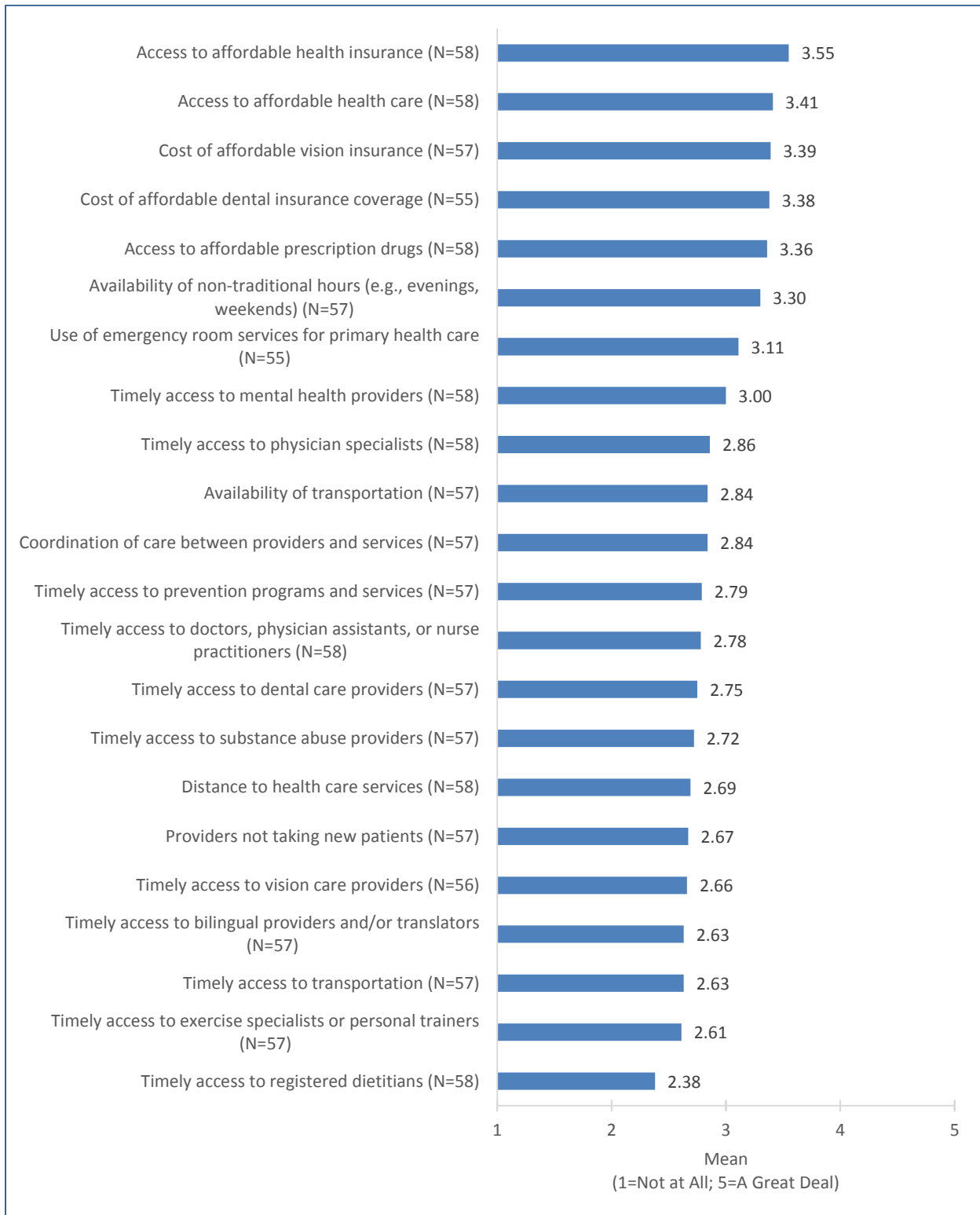


Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

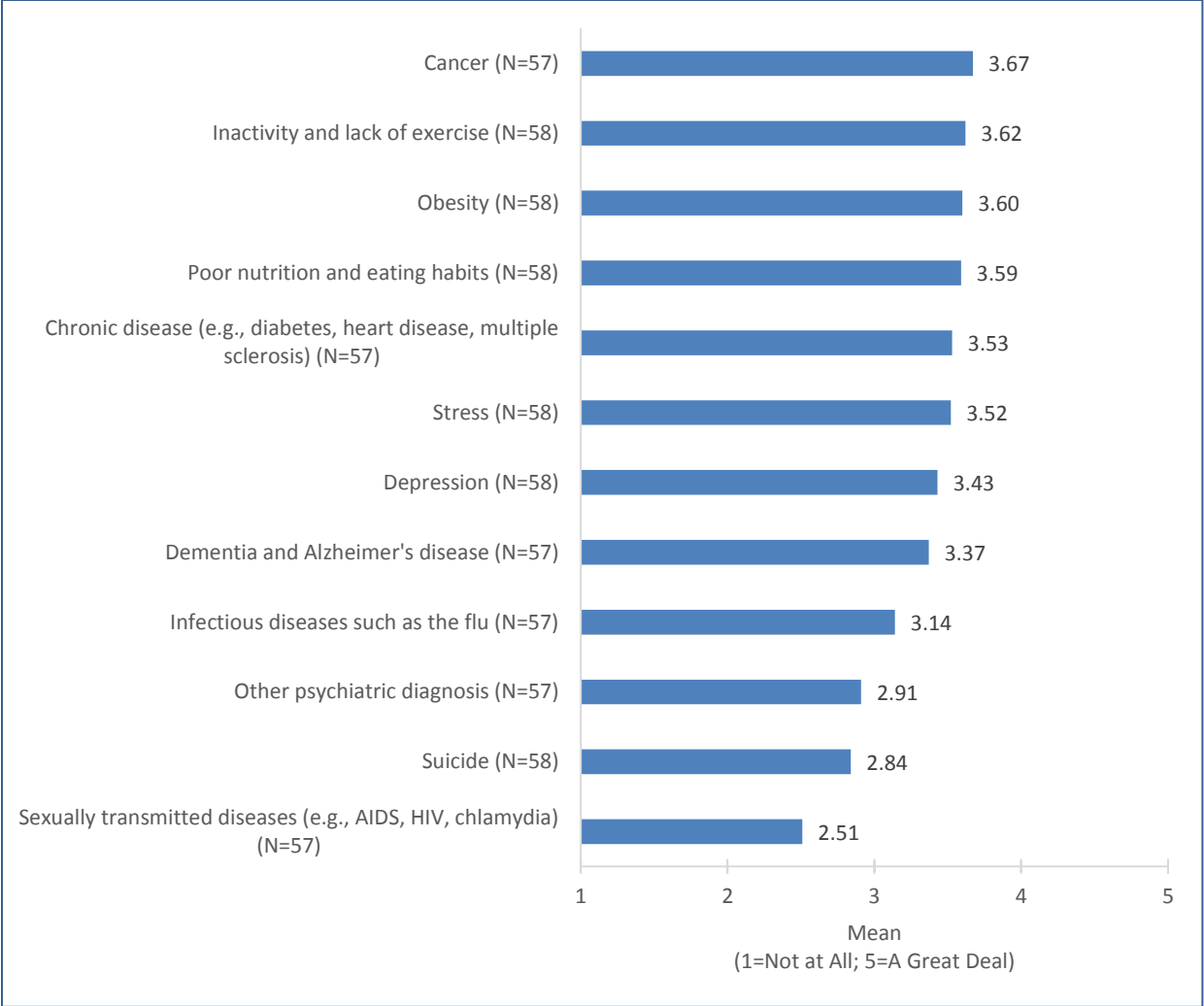
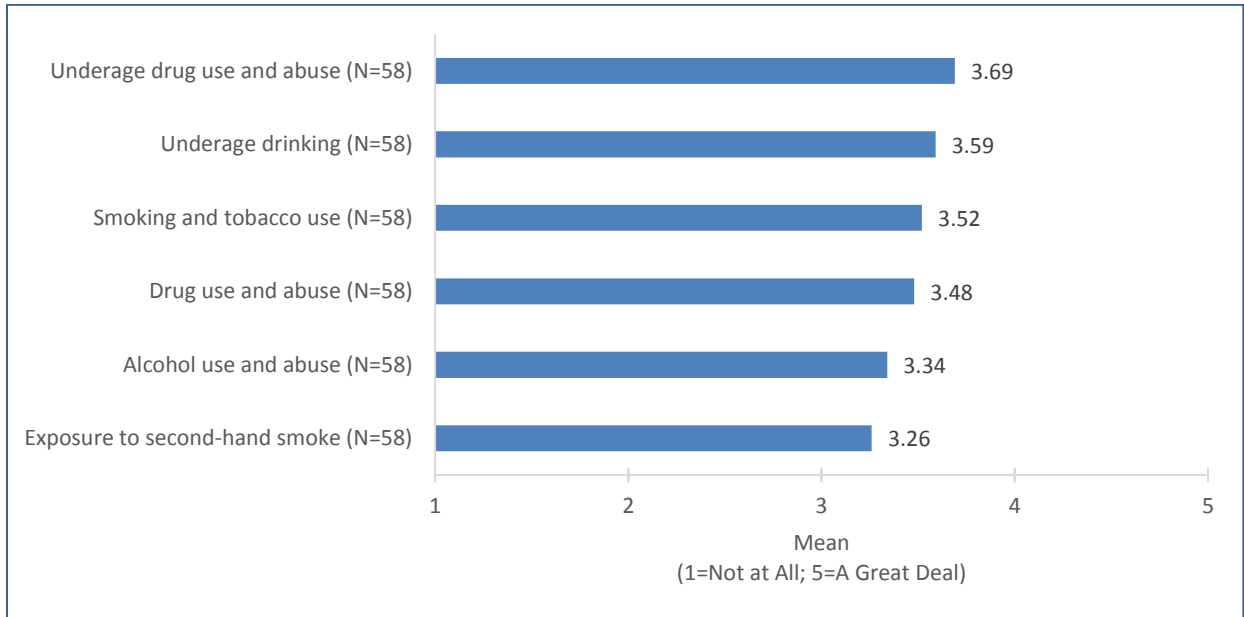
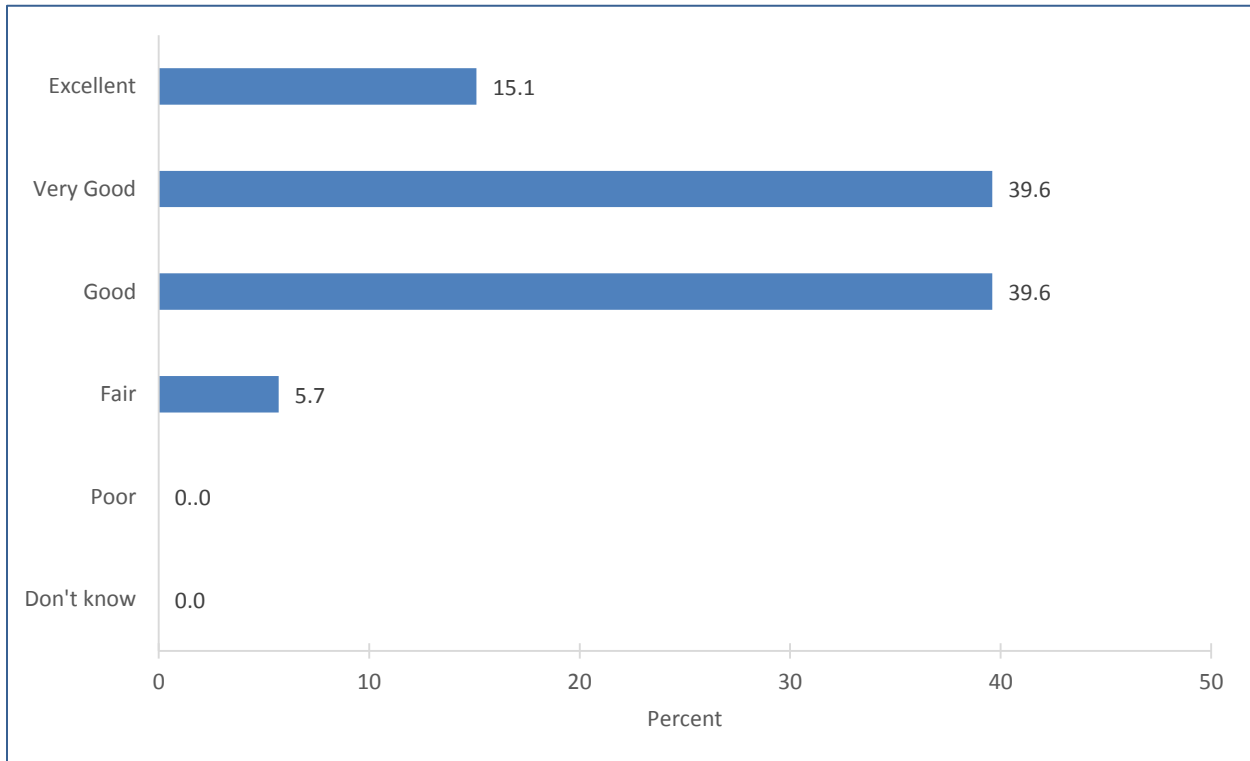


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



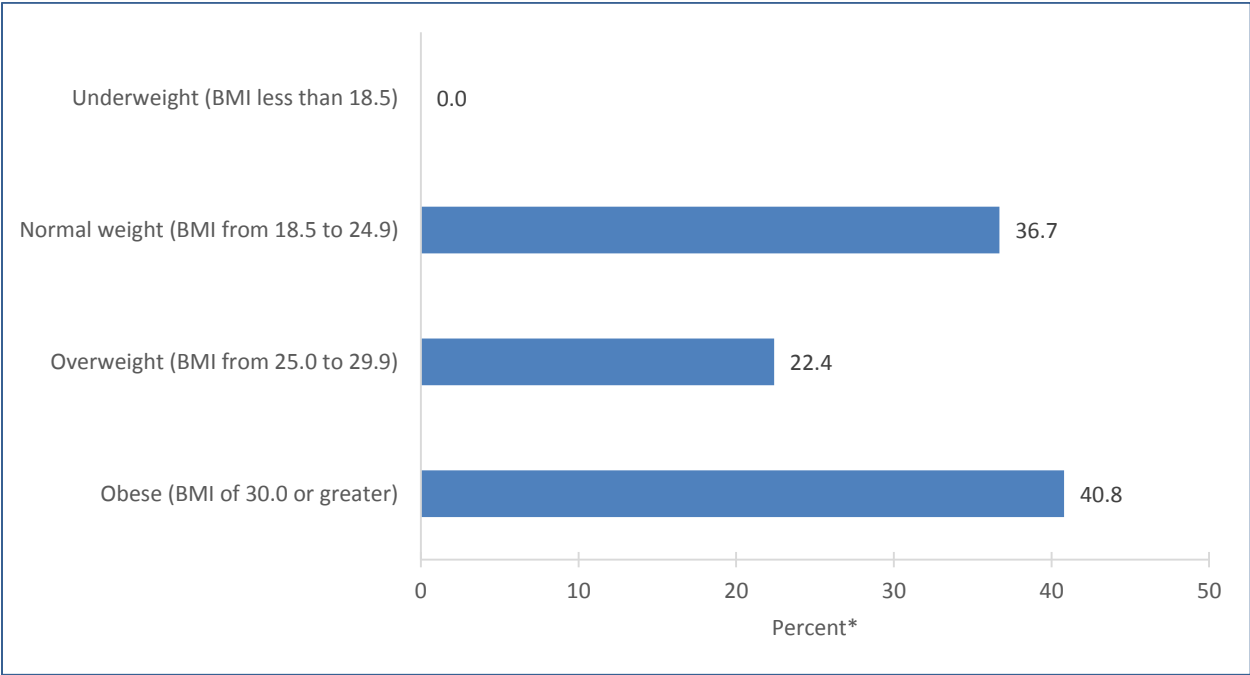
### General Health

Figure 10. Respondents' rating of their health in general



N=53

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



N=49

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

\*\* Percentages do not total 100.0 due to rounding.



Figure 12. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday

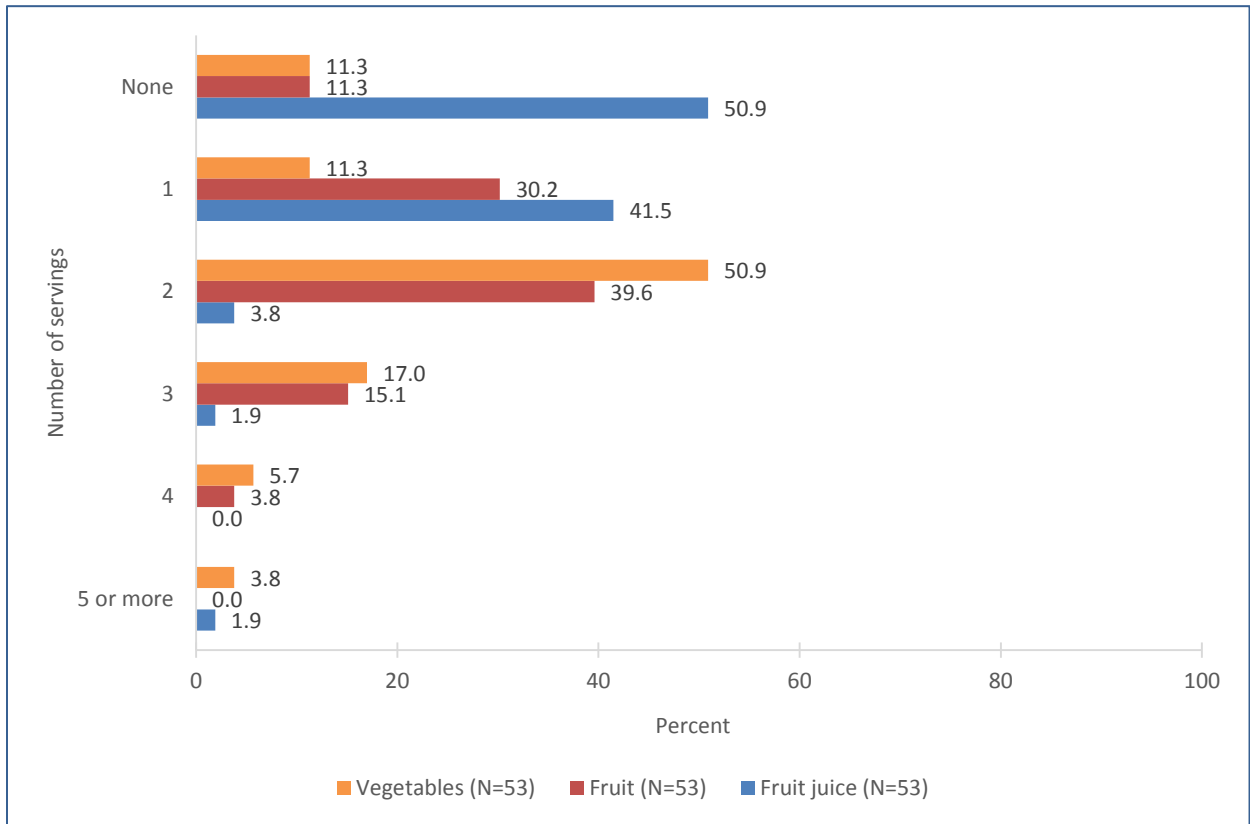
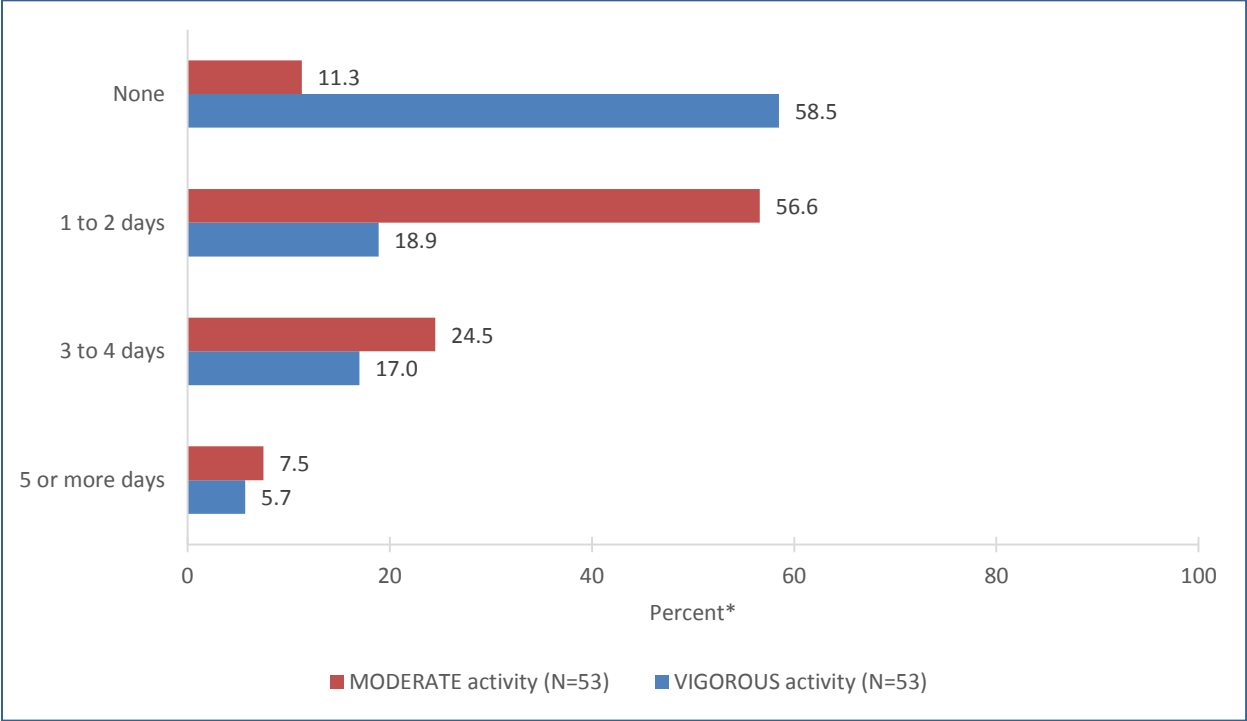


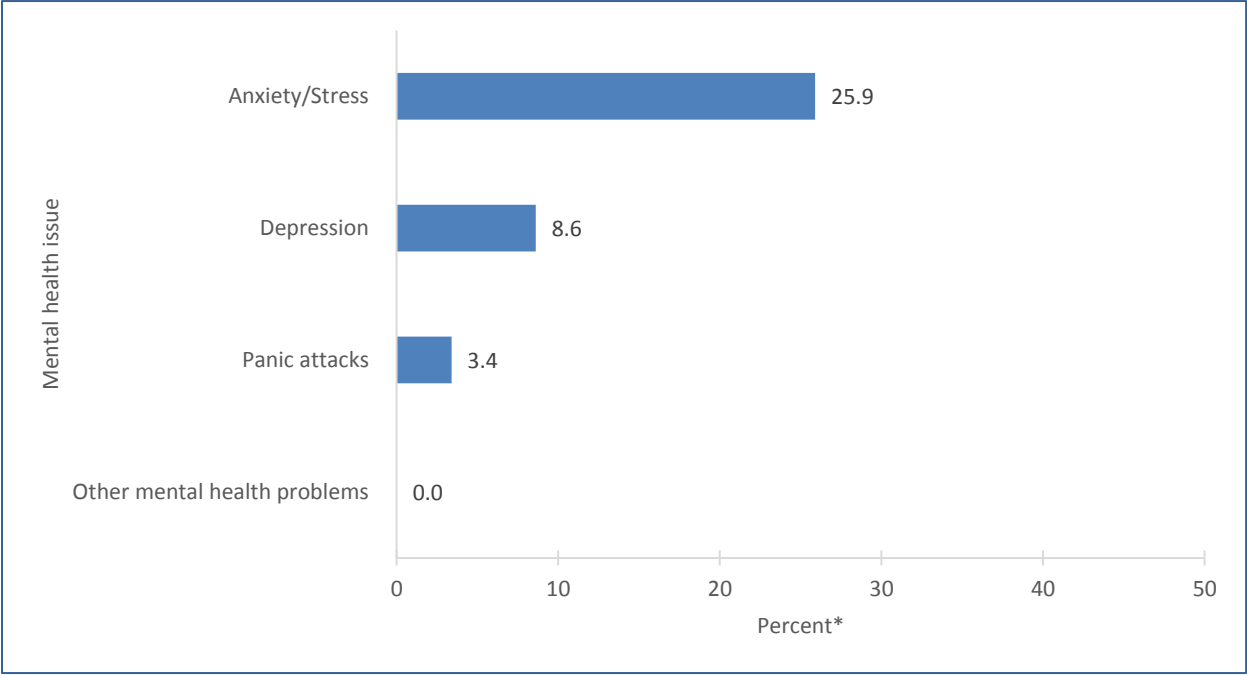
Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



\*Percentages do not total 100.0 due to rounding.

**Mental Health**

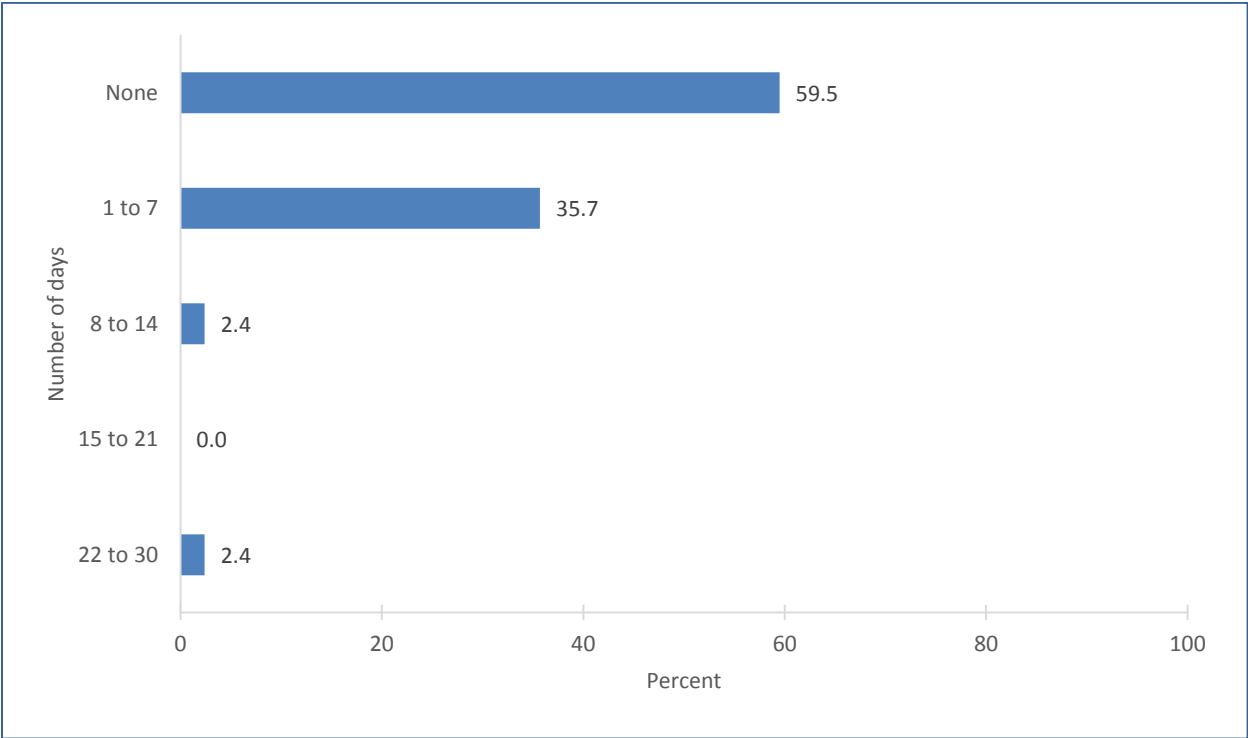
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=58

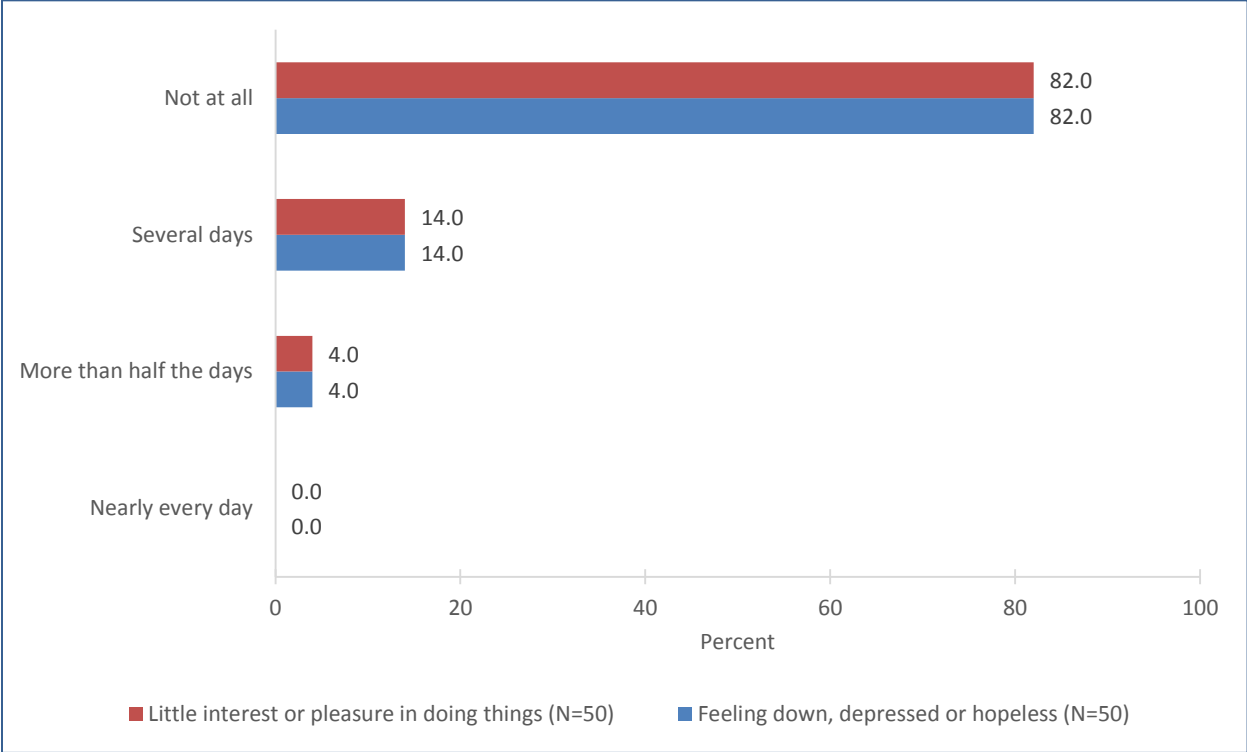
\*Percentages do not total 100.0 due to multiple responses.

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



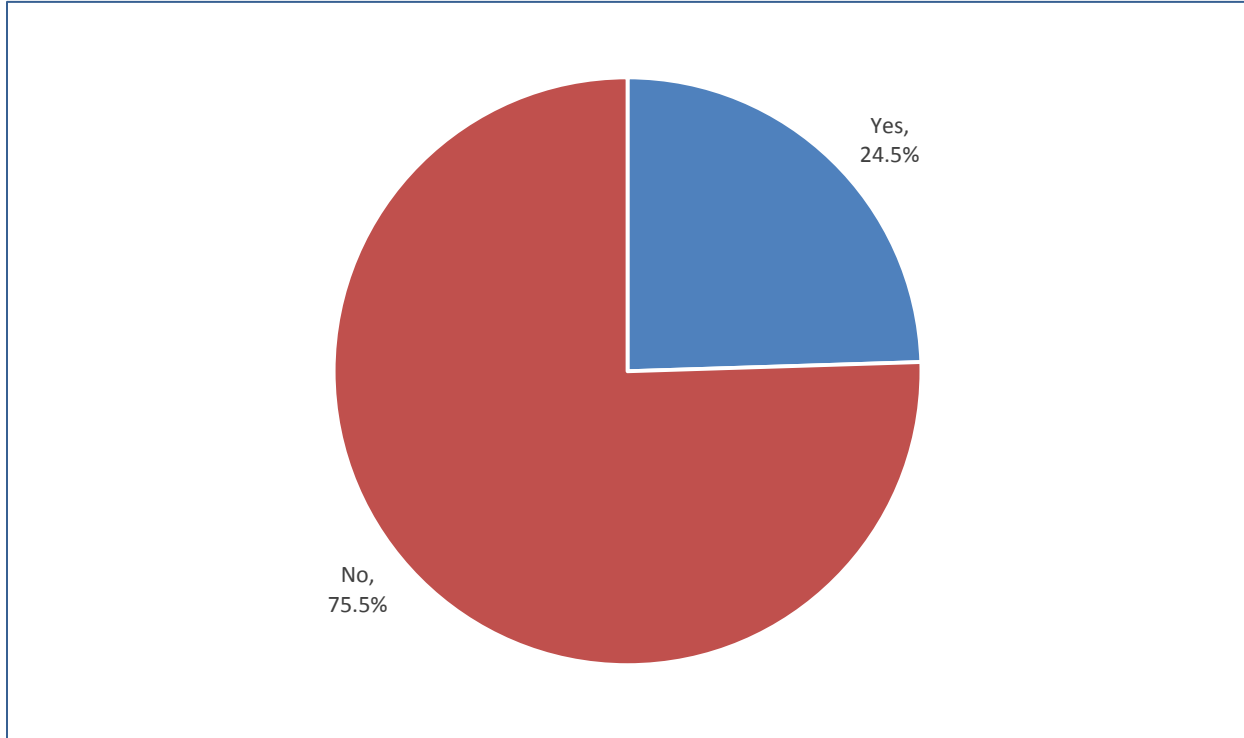
N=42

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



## Tobacco Use

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



N=53

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

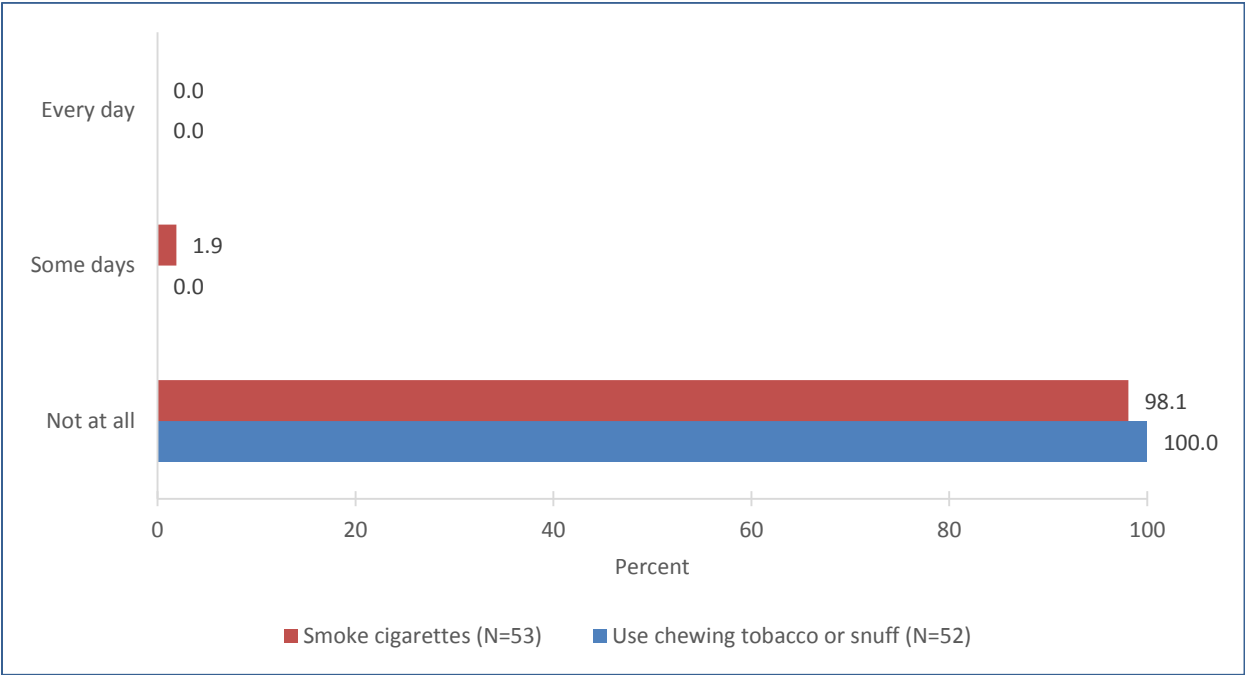
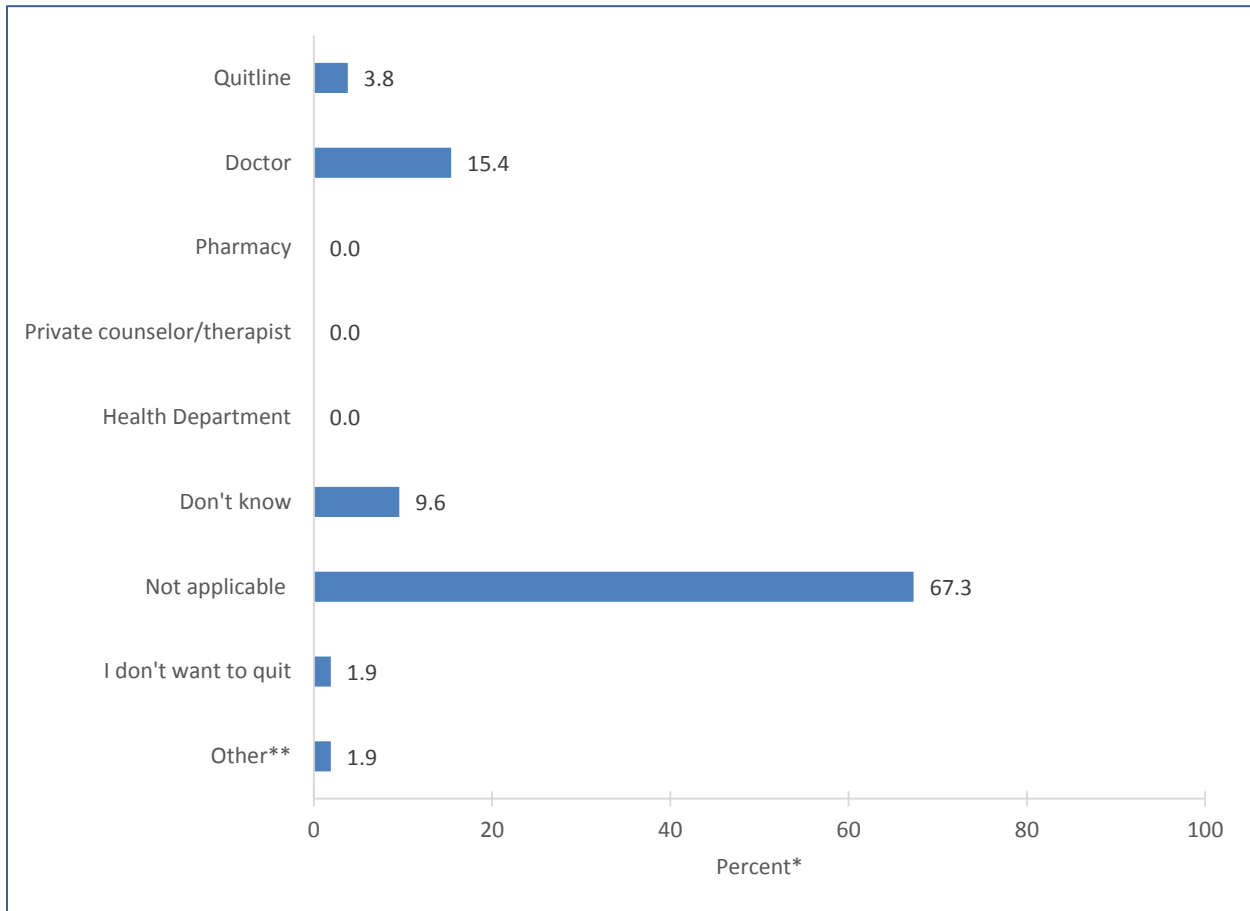


Figure 19. Location respondents would first go if they wanted help to quit using tobacco



N=52

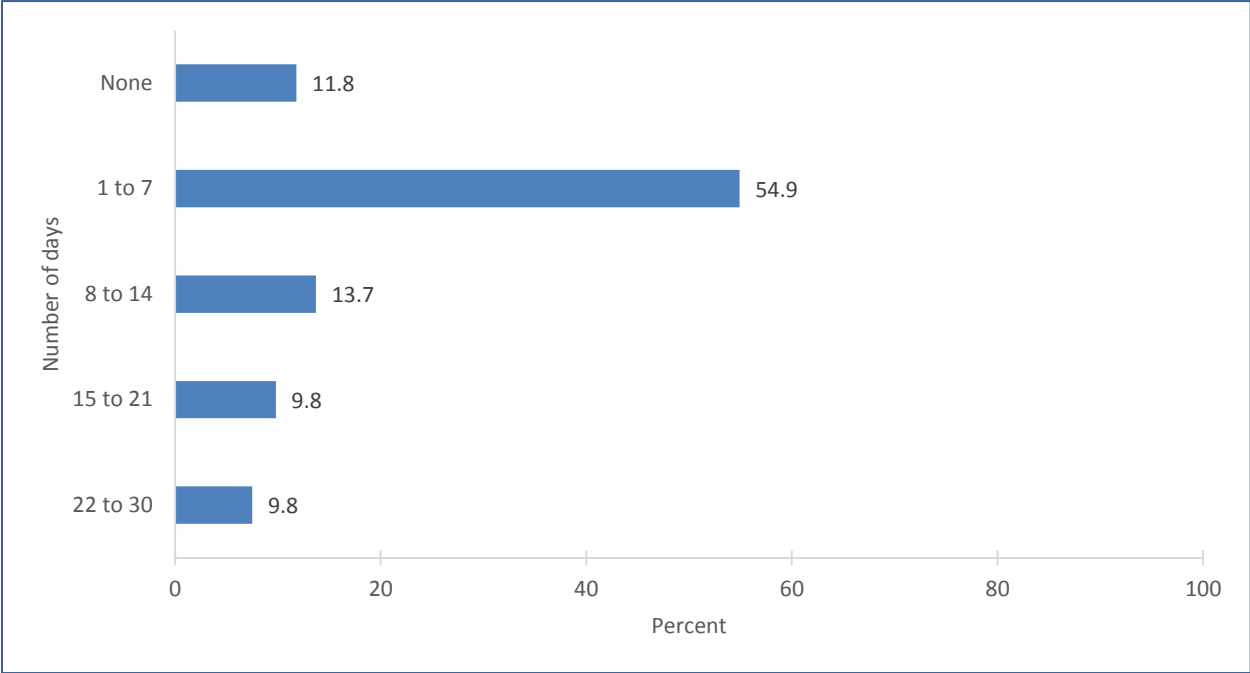
\*Percentages do not total 100.0 due to rounding.

\*\*Other response is "Independent/self".



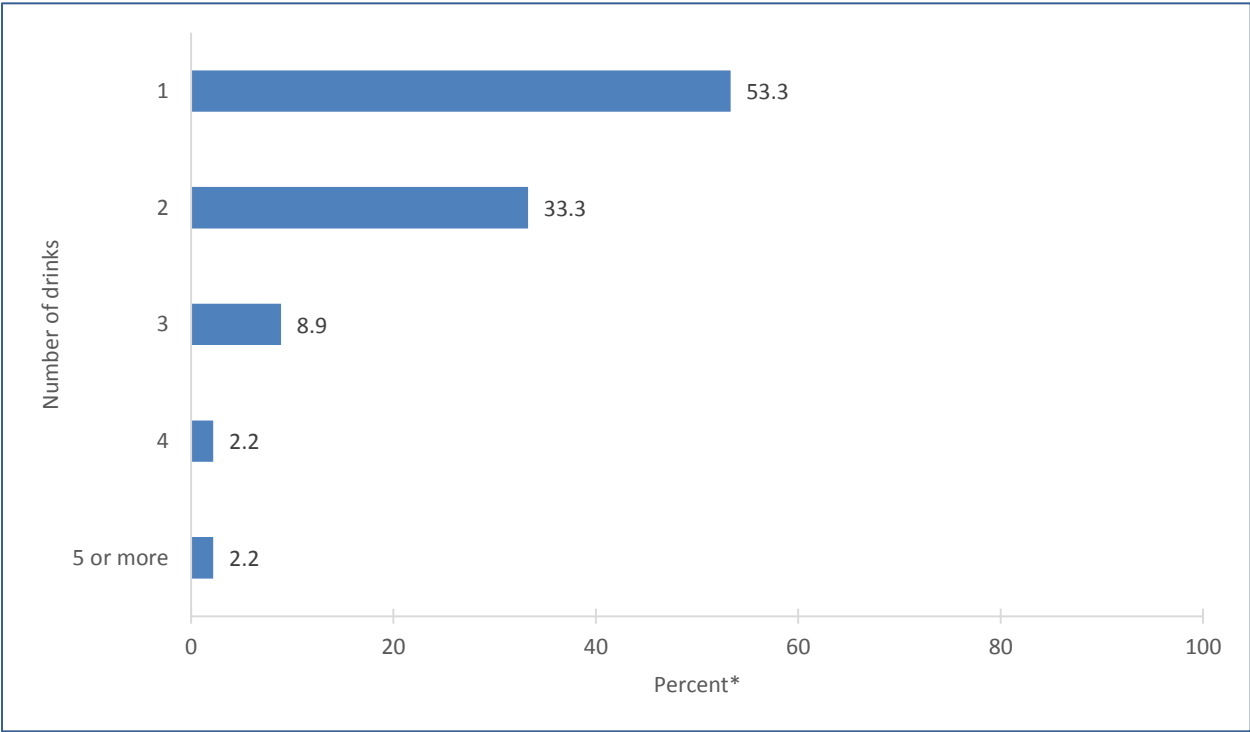
**Alcohol Use and Prescription Drug/Non-prescription Drug Abuse**

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



N=51

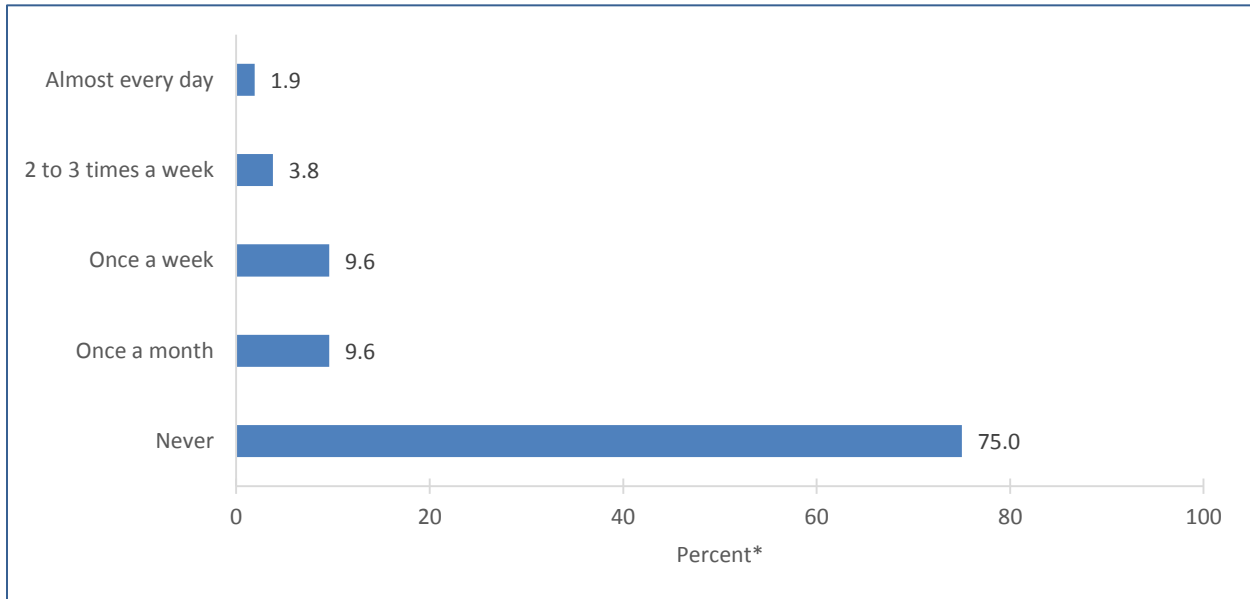
Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=45

\*Percentage do not total 100.0 due to rounding.

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



N=52

\*Percentages do not total 100.0 due to rounding.

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

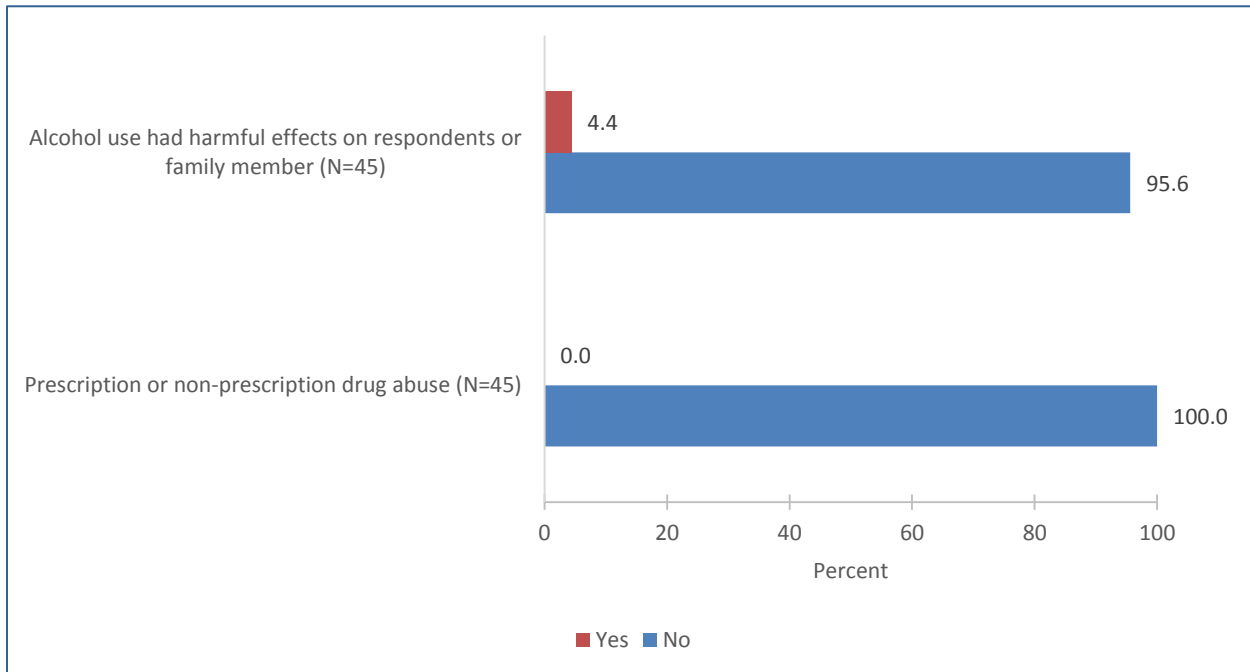


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

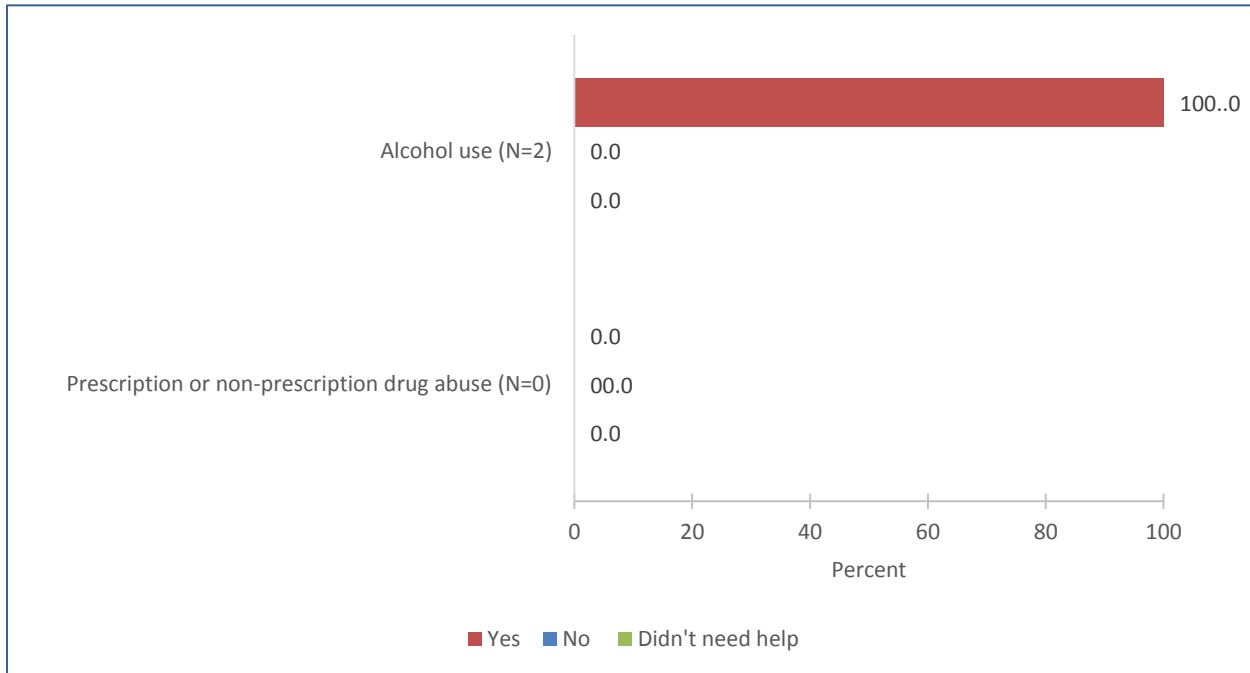
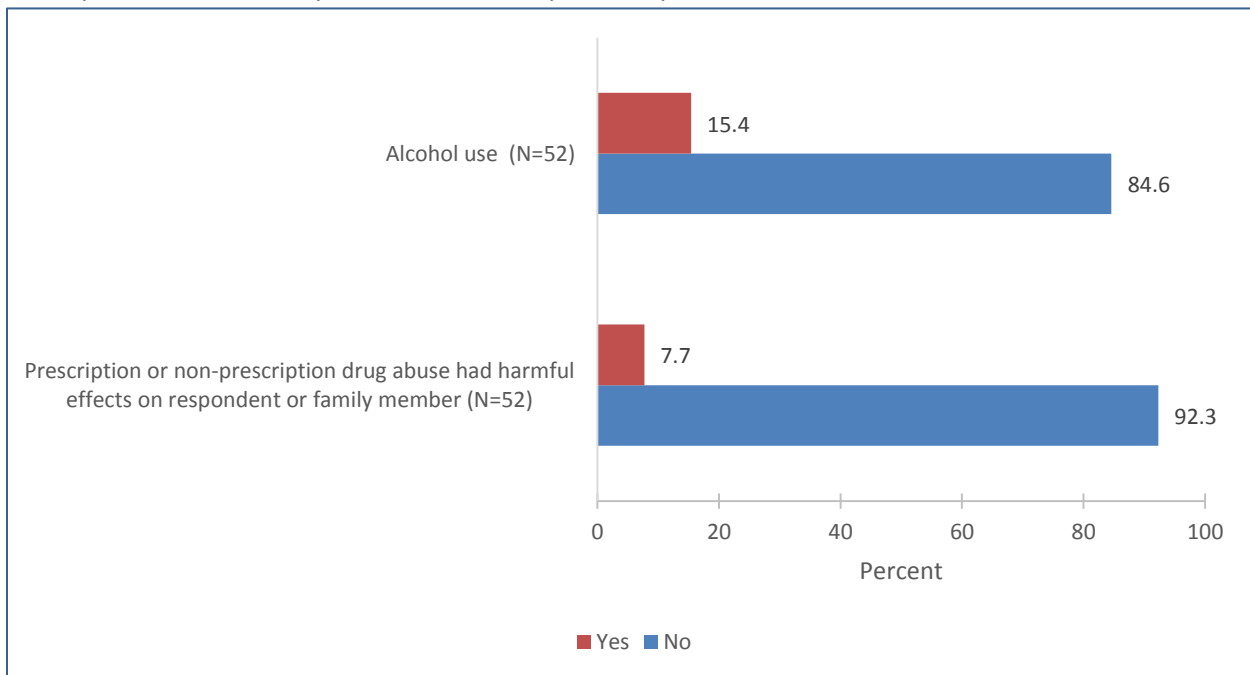


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



## Preventive Health

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

Type of screening	Percent of respondents		
	Yes	No	Total
<b>GENERAL SCREENINGS</b>			
Blood pressure screening (N=51)	88.2	11.8	100.0
Blood sugar screening (N=51)	62.7	37.3	100.0
Bone density test (N=51)	5.9	94.1	100.0
Cardiovascular screening (N=51)	21.6	78.4	100.0
Cholesterol screening (N=51)	60.8	39.2	100.0
Dental screening and X-rays (N=51)	82.4	17.6	100.0
Flu shot (N=51)	82.4	17.6	100.0
Glaucoma test (N=51)	49.0	51.0	100.0
Hearing screening (N=51)	9.8	90.2	100.0
Immunizations (N=51)	33.3	66.7	100.0
Pelvic exam (N=30 Females)	50.0	50.0	100.0
STD (N=51)	3.9	96.1	100.0
Vascular screening (N=51)	9.8	90.2	100.0
<b>CANCER SCREENINGS</b>			
Breast cancer screening (N=30 Females)	73.3	26.7	100.0
Cervical cancer screening (N=30 Females)	43.3	56.7	100.0
Colorectal cancer screening (N=49)	28.6	71.4	100.0
Prostate cancer screening (N=17 Males)	35.3	64.7	100.0
Skin cancer screening (N=50)	38.0	62.0	100.0

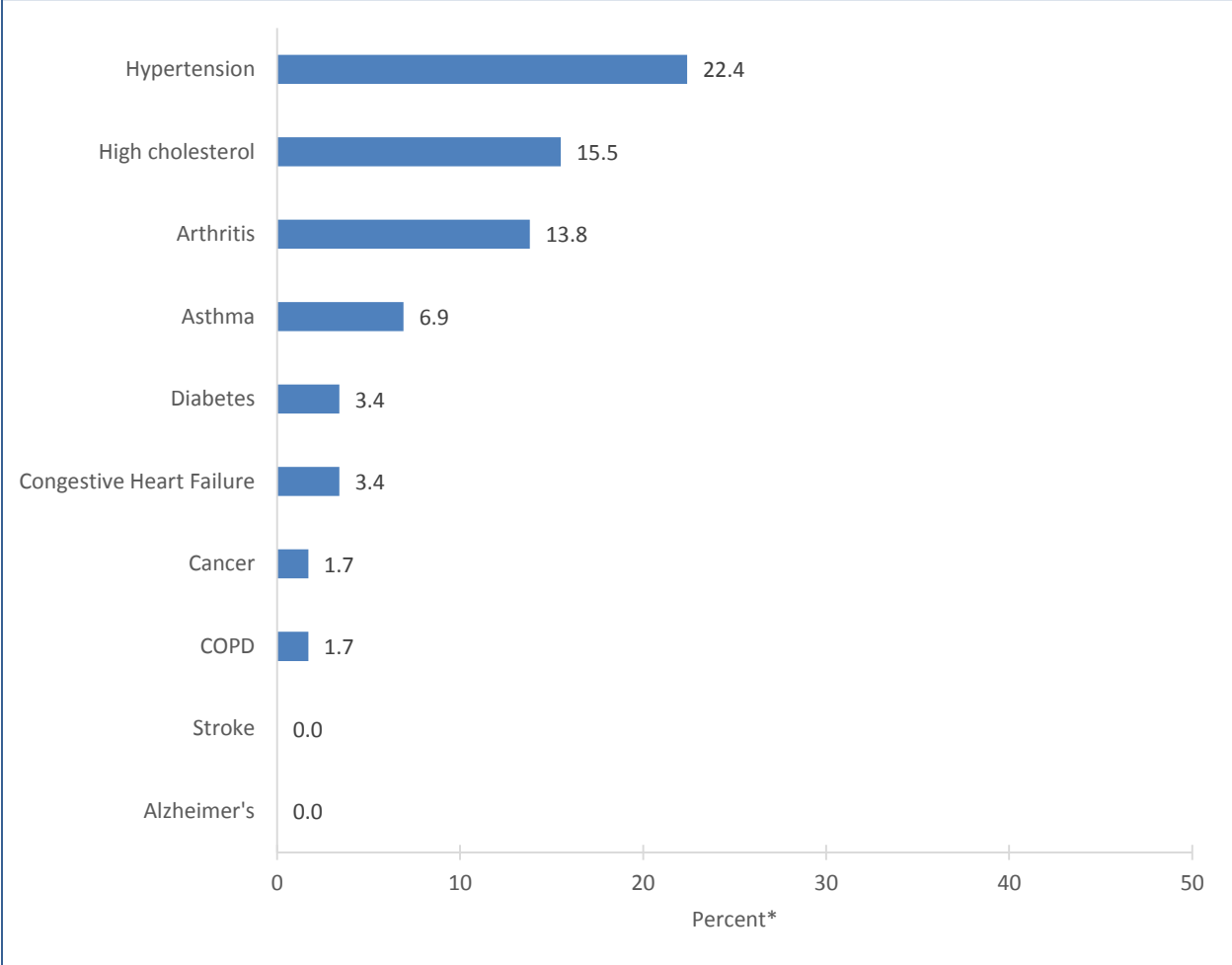
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
<b>GENERAL SCREENINGS</b>							
Blood pressure screening (N=6)	66.7	50.0	0.0	0.0	0.0	0.0	0.0
Blood sugar screening (N=19)	36.8	52.6	0.0	0.0	0.0	0.0	10.5
Bone density test (N=48)	29.2	58.3	0.0	0.0	0.0	0.0	4.2
Cardiovascular screening (N=40)	25.0	72.5	0.0	0.0	0.0	0.0	2.5
Cholesterol screening (N=20)	40.0	55.0	5.0	0.0	0.0	0.0	5.0
Dental screening and X-rays (N=9)	22.2	22.2	22.2	22.2	11.1	0.0	0.0

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Flu shot (N=9)	11.1	0.0	0.0	0.0	11.1	0.0	66.7
Glaucoma test (N=26)	50.0	42.3	0.0	0.0	0.0	0.0	11.5
Hearing screening (N=46)	47.8	43.5	2.2	0.0	0.0	0.0	4.3
Immunizations (N=34)	52.9	44.1	0.0	0.0	0.0	0.0	5.9
Pelvic exam (N=15 Females)	60.0	46.7	0.0	0.0	0.0	0.0	6.7
STD (N=49)	65.3	30.6	0.0	0.0	0.0	0.0	2.0
Vascular screening (N=46)	37.0	56.5	0.0	0.0	0.0	0.0	6.5
<b>CANCER SCREENINGS</b>							
Breast cancer screening (N=8 Females)	25.0	12.5	0.0	0.0	0.0	0.0	50.0
Cervical cancer screening (N=17 Females)	64.7	23.5	0.0	0.0	0.0	0.0	17.6
Colorectal cancer screening (N=35)	54.3	28.6	2.9	0.0	0.0	0.0	17.1
Prostate cancer screening (N=11 Males)	27.3	54.5	9.1	0.0	0.0	0.0	18.2
Skin cancer screening (N=31)	19.4	64.5	3.2	0.0	0.0	0.0	12.9

\*Percentages may not total 100.0 due to multiple responses.

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



N=58

\*Percentages do not total 100.0 due to multiple responses.

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

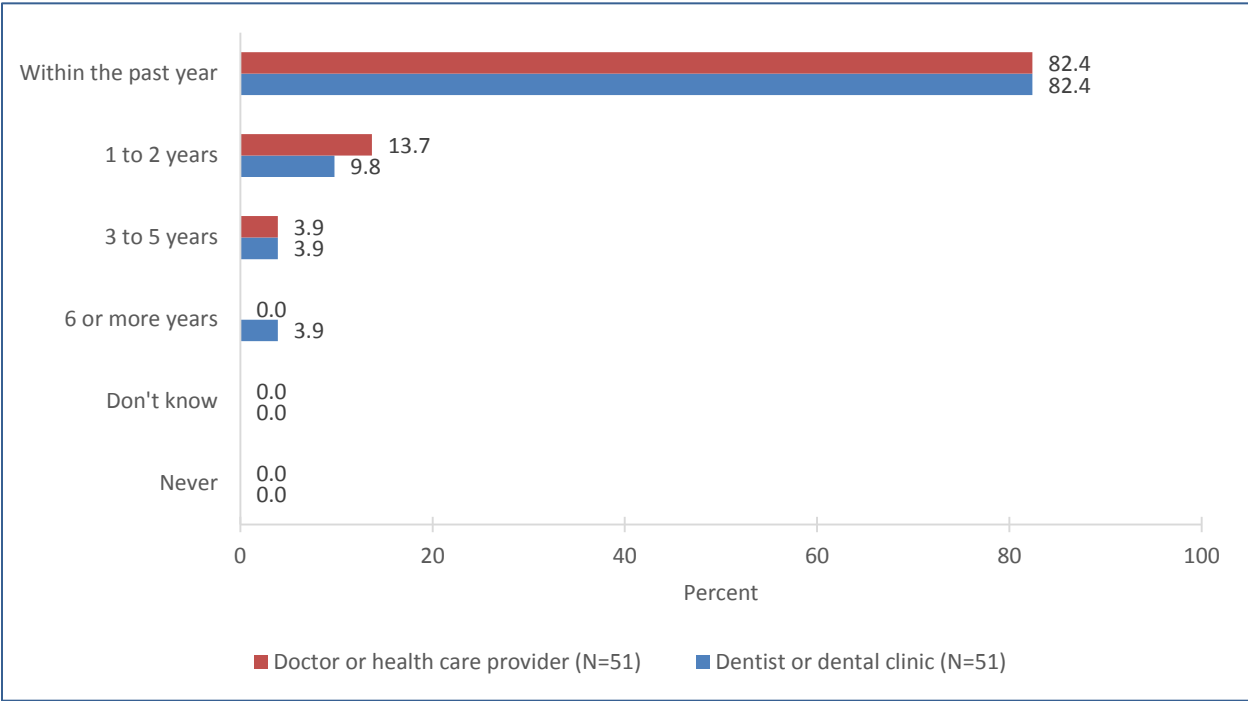
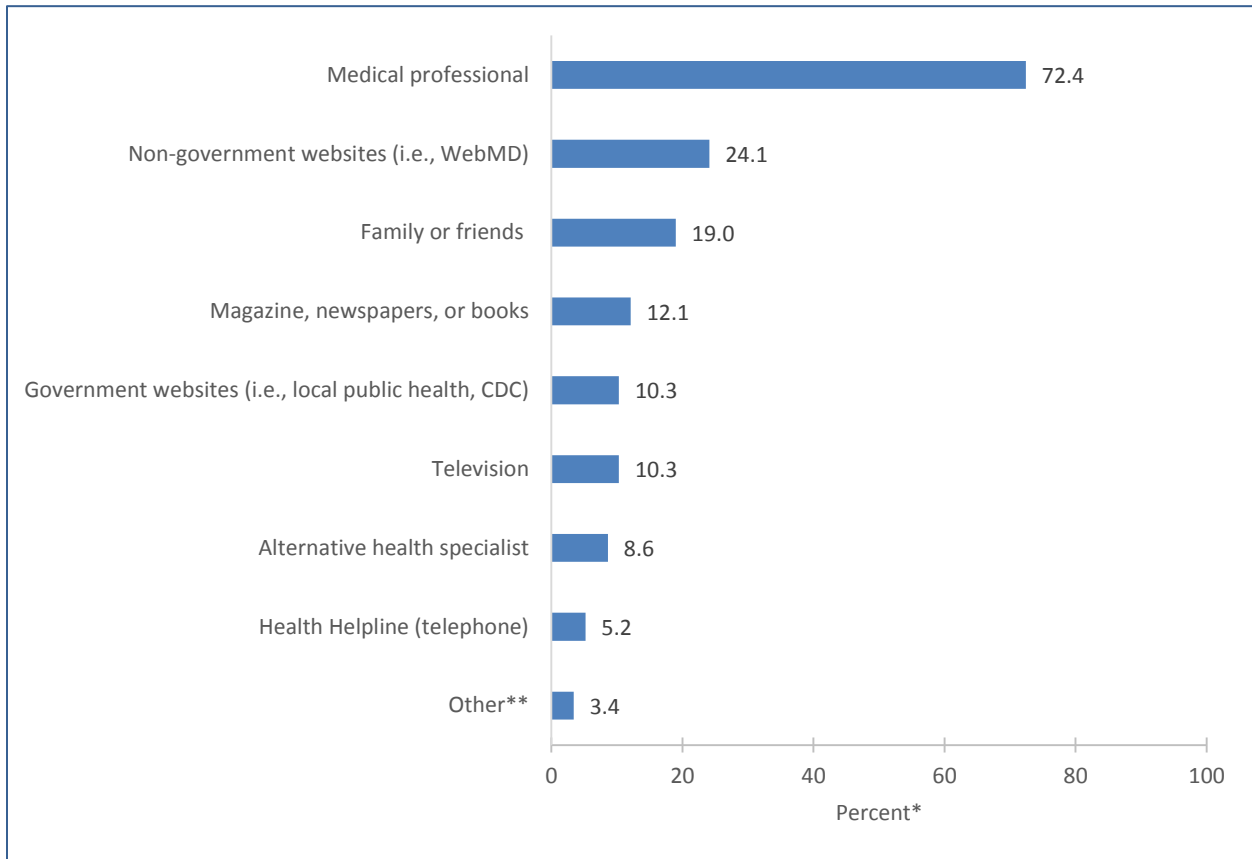




Figure 28. Where respondents get most of their health information

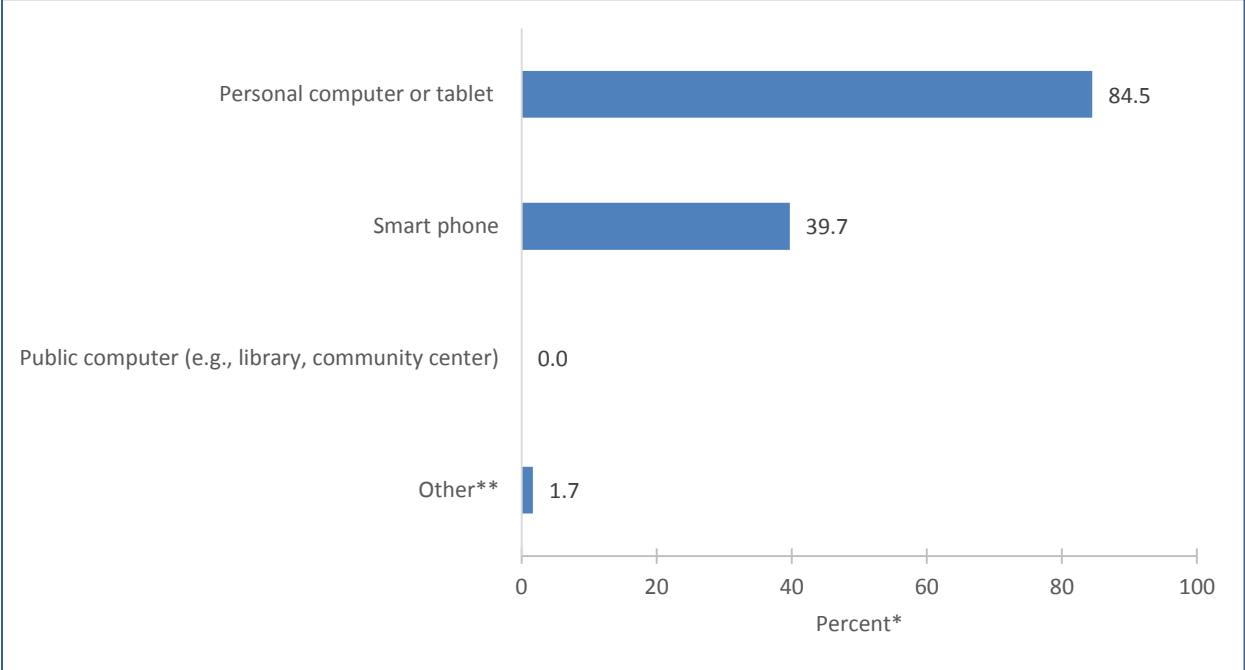


N=58

\*Percentages do not total 100.0 due to multiple responses.

\*\*Other responses include "Internet" (2).

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



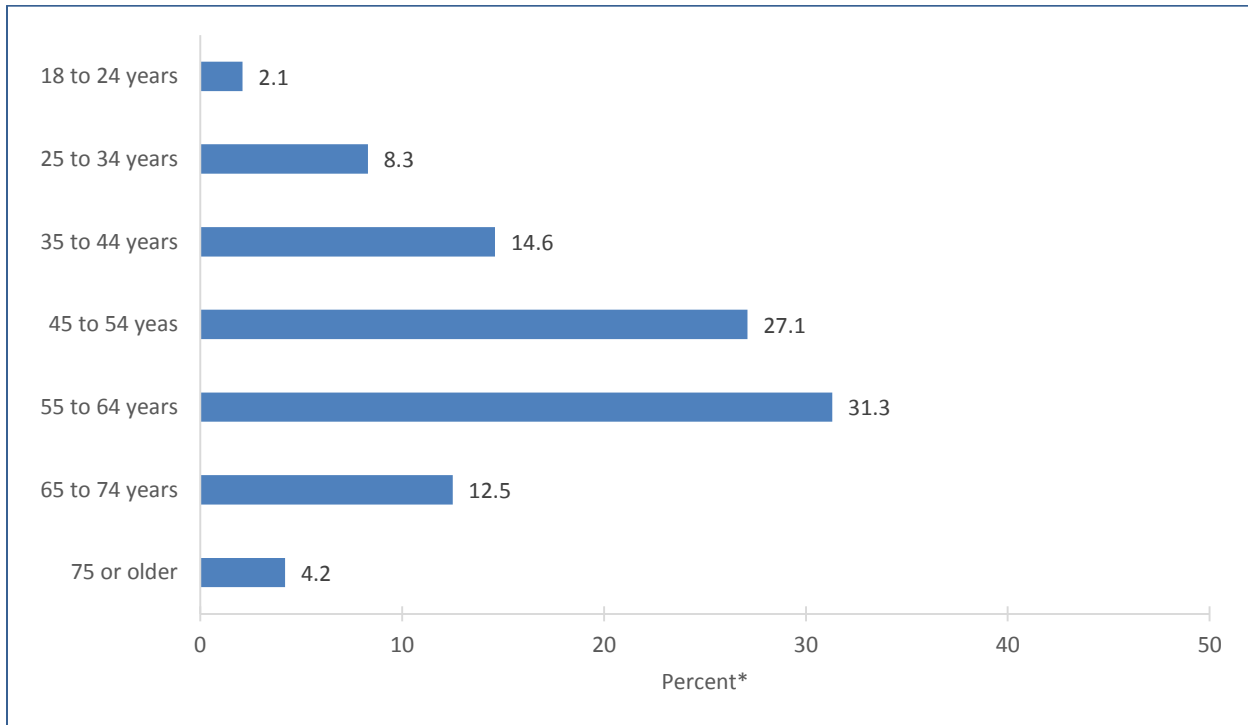
N=58

\*Percentages do not total 100.0 due to multiple responses.

\*\*Other response is “family member”.

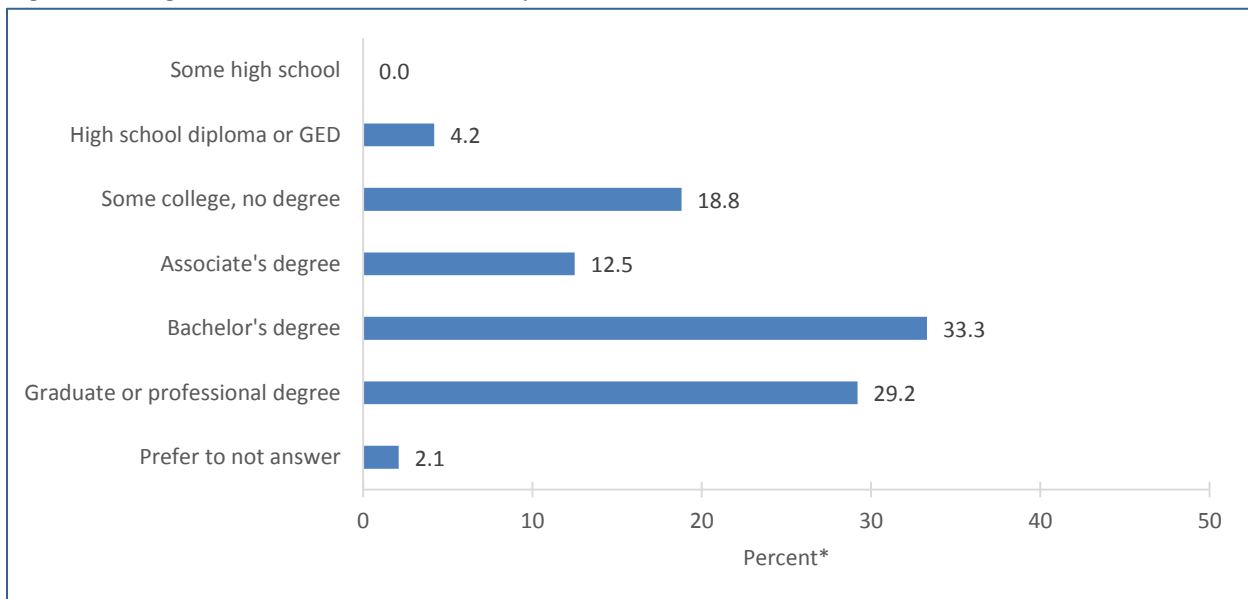
## Demographic Information

Figure 30. Age of respondents



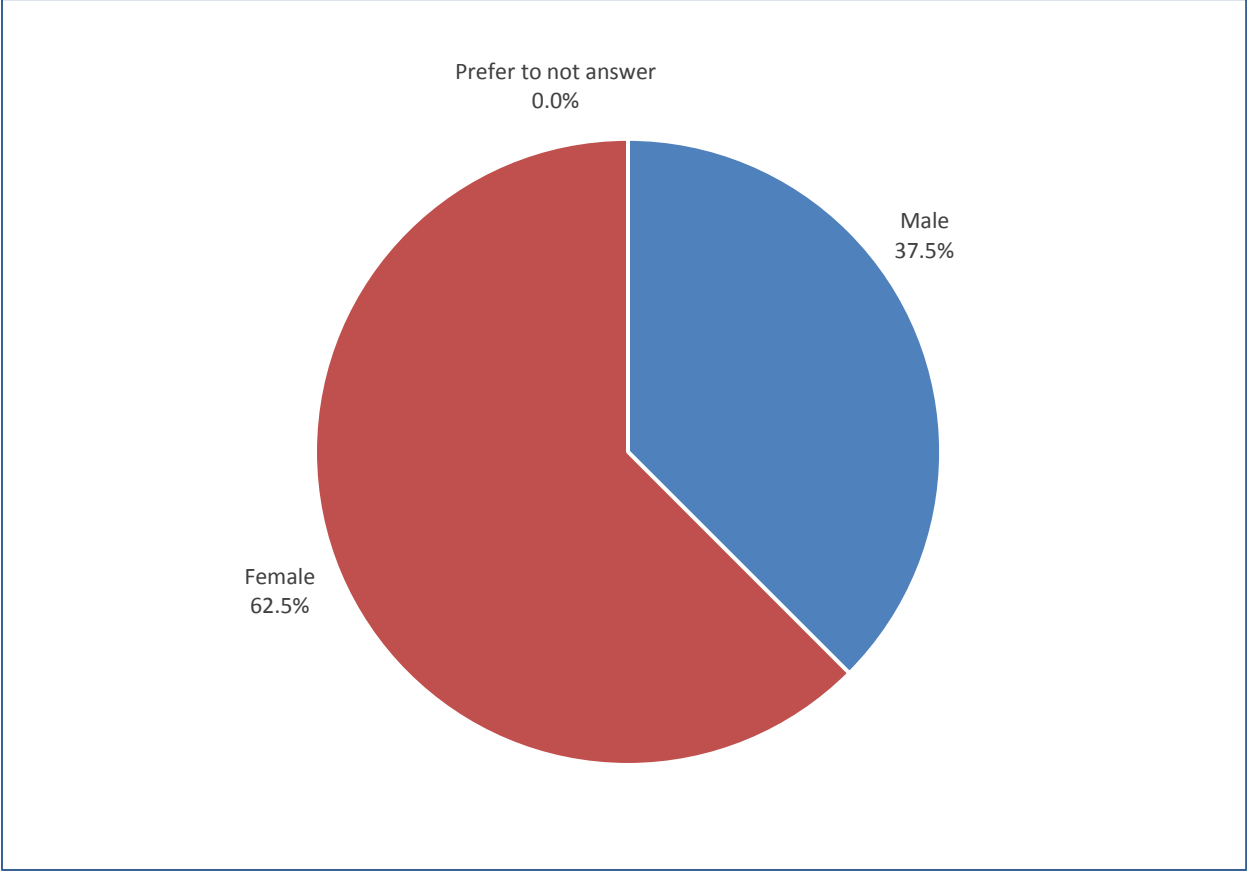
N=48 \*Percentages do not total 100.0 due to rounding.

Figure 31. Highest level of education of respondents



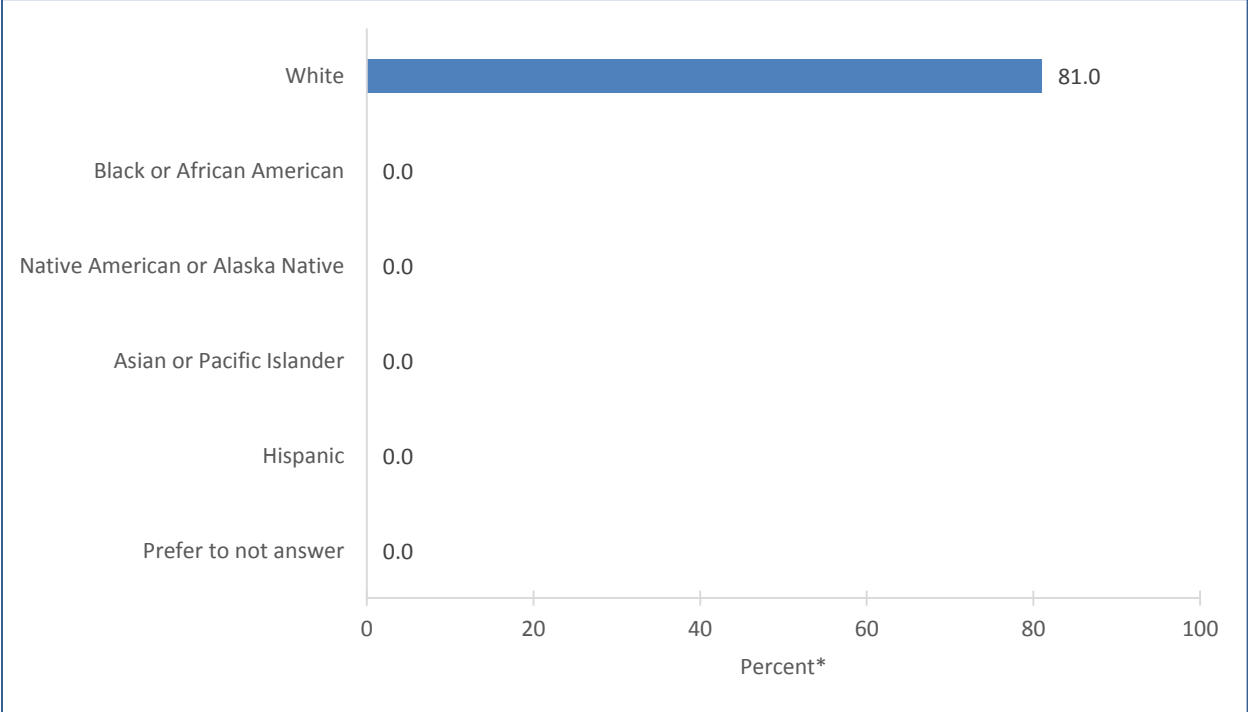
N=48 \*Percentages do not total 100.0 due to rounding.

Figure 32. Gender of respondents



N=48

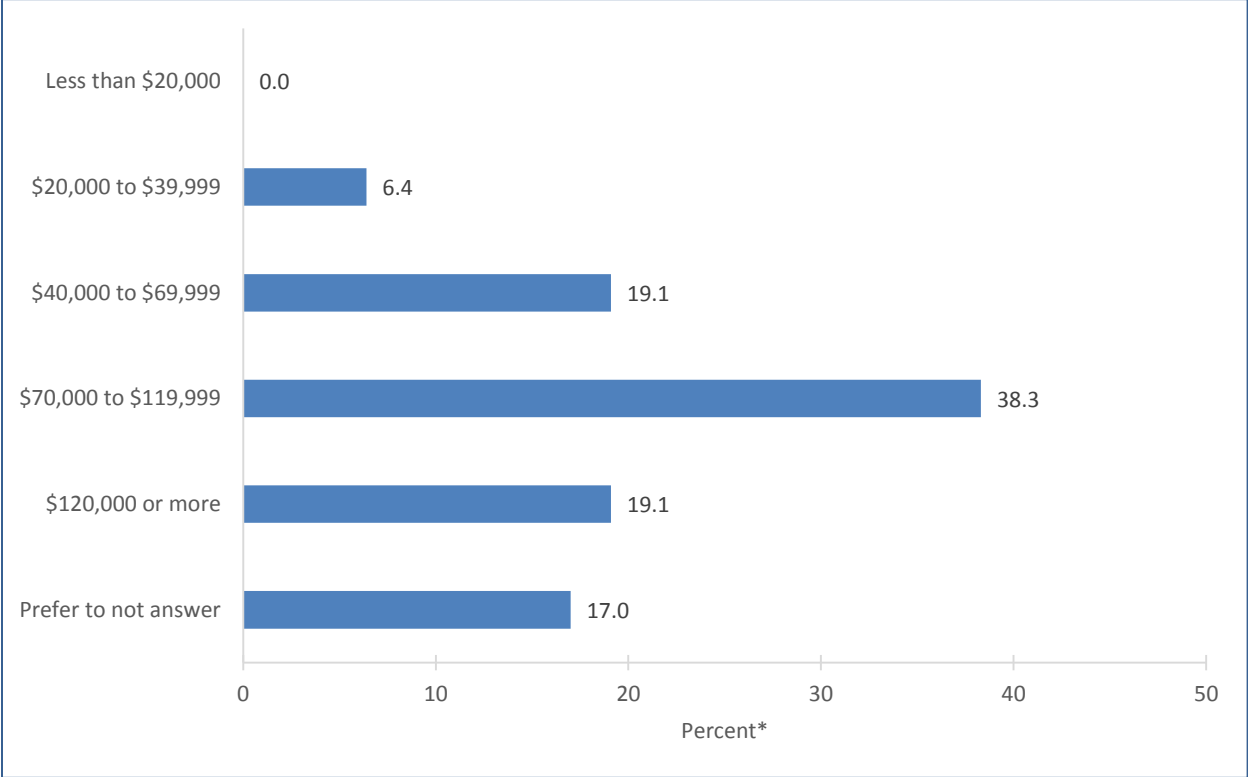
Figure 33. Race and ethnicity of respondents



N=58

\*Percentages do not total 100.0 due to multiple responses.

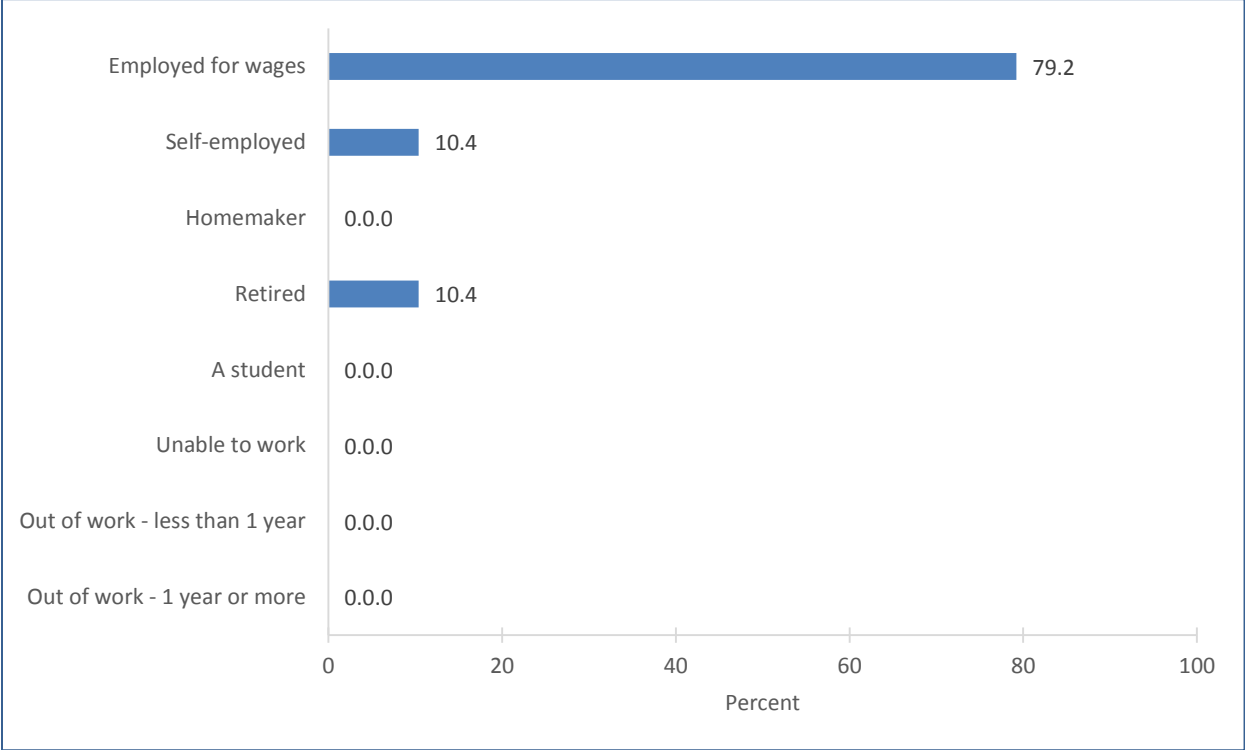
Figure 34. Annual household income of respondents



N=47

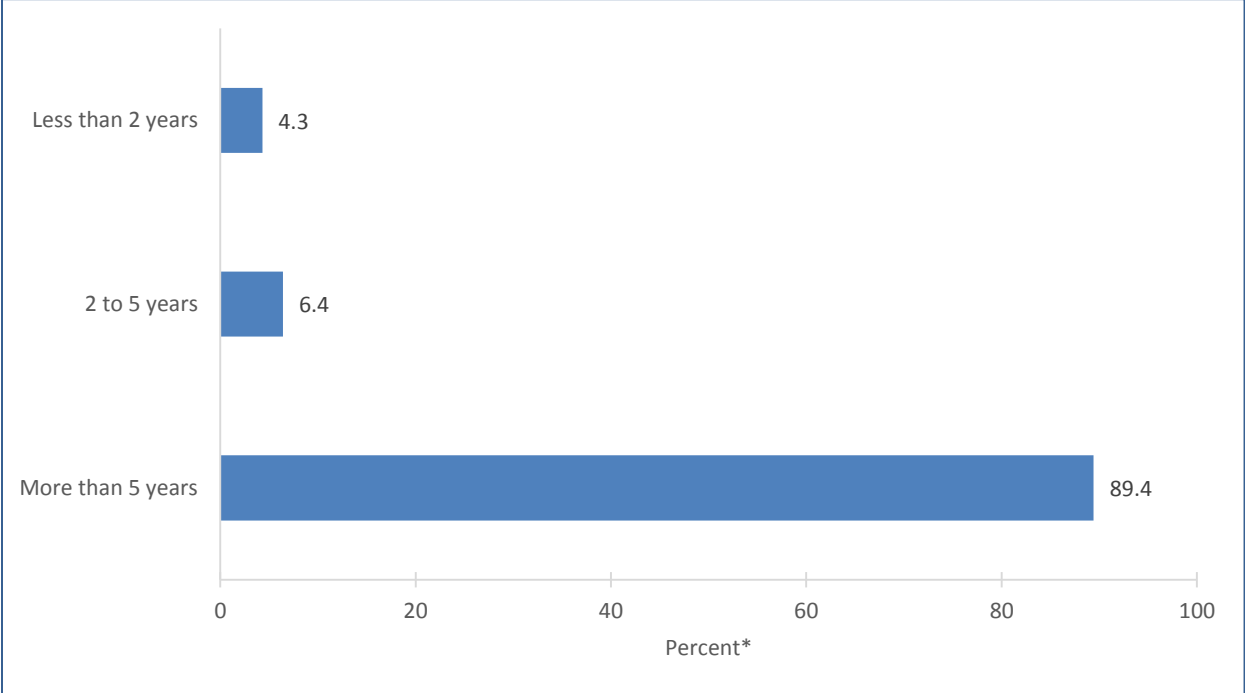
\*Percentages do not total 100.0 due to rounding.

Figure 35. Employment status of respondents



N=48

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

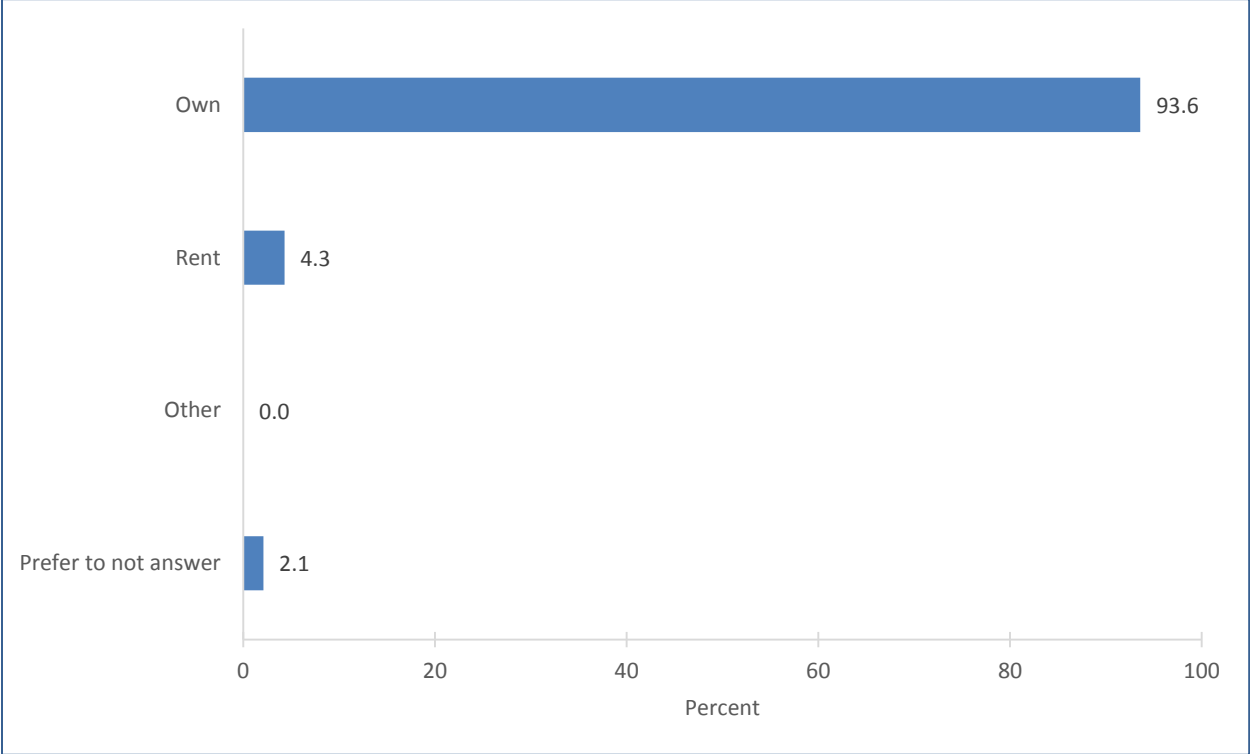


N=47

\*Percentages do not total 100.0 due to rounding.



Figure 37. Whether respondents own or rent their home



N=47

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

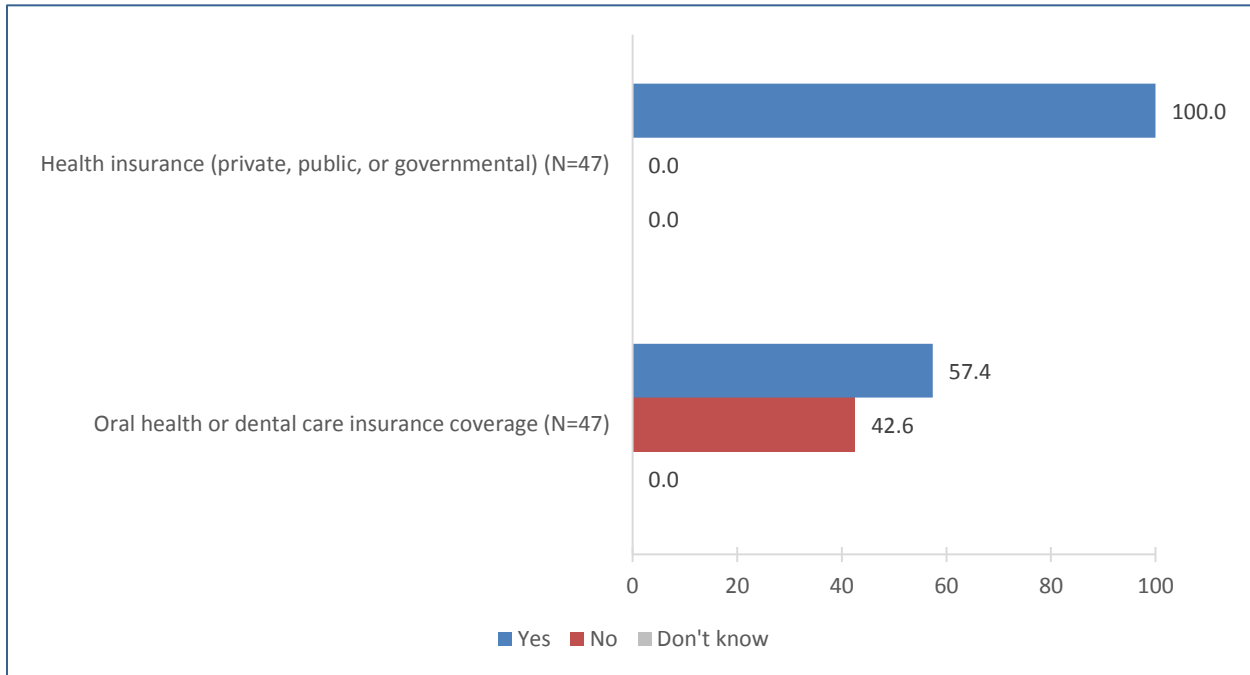
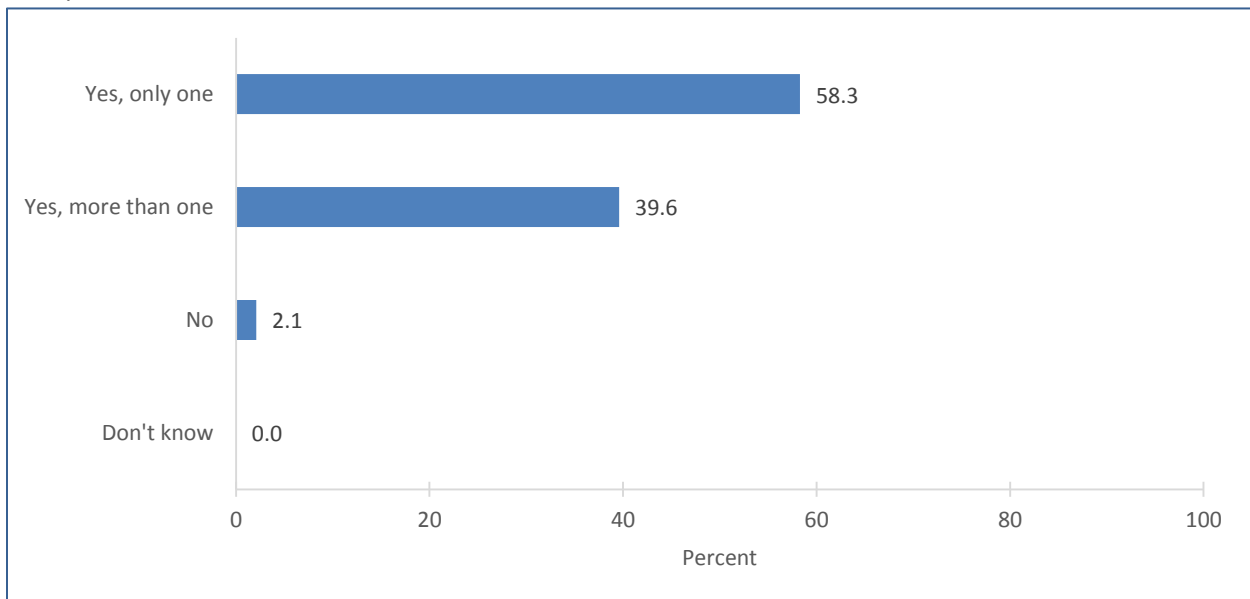
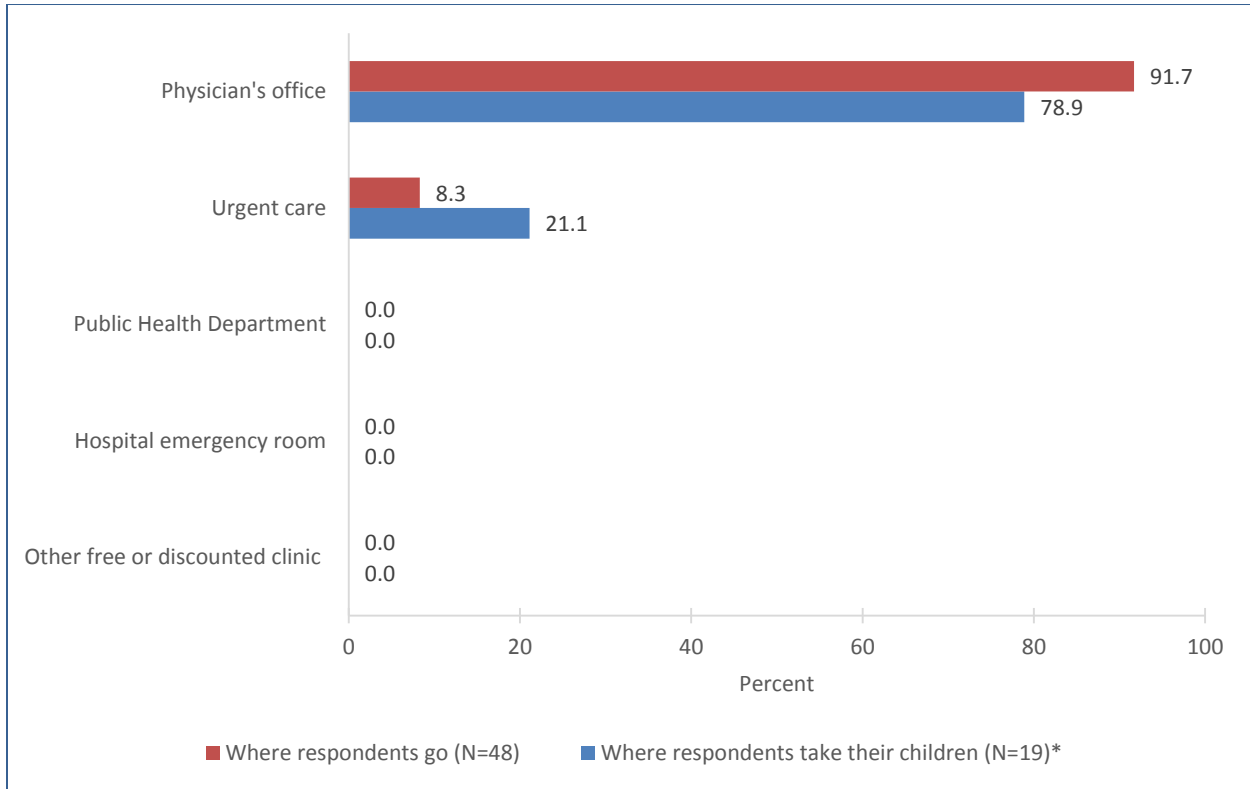


Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



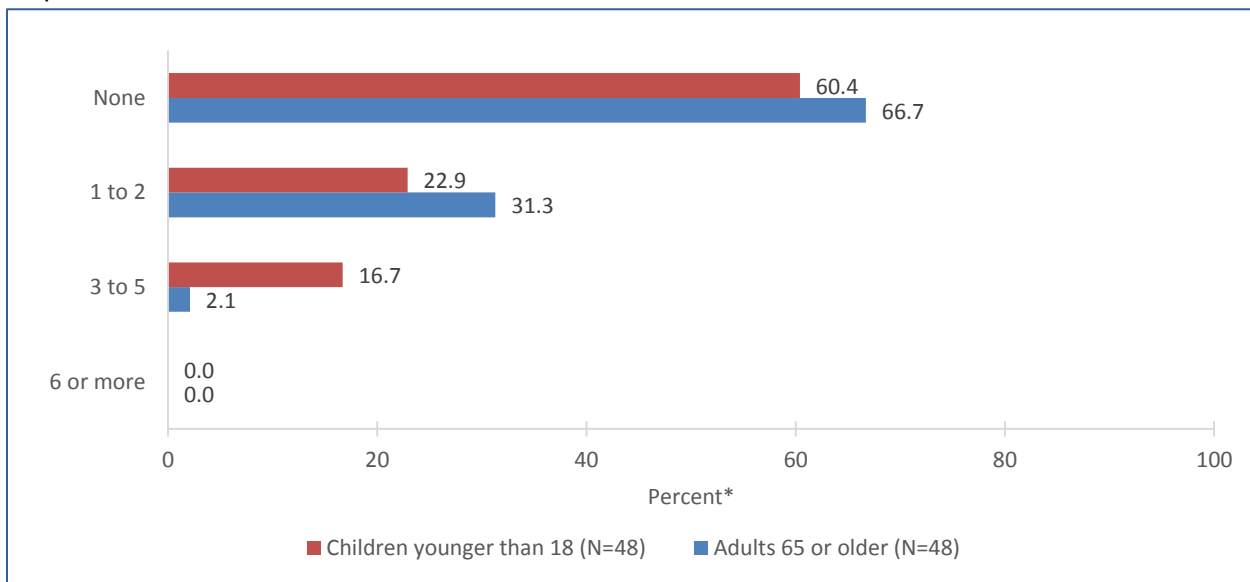
N=48

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



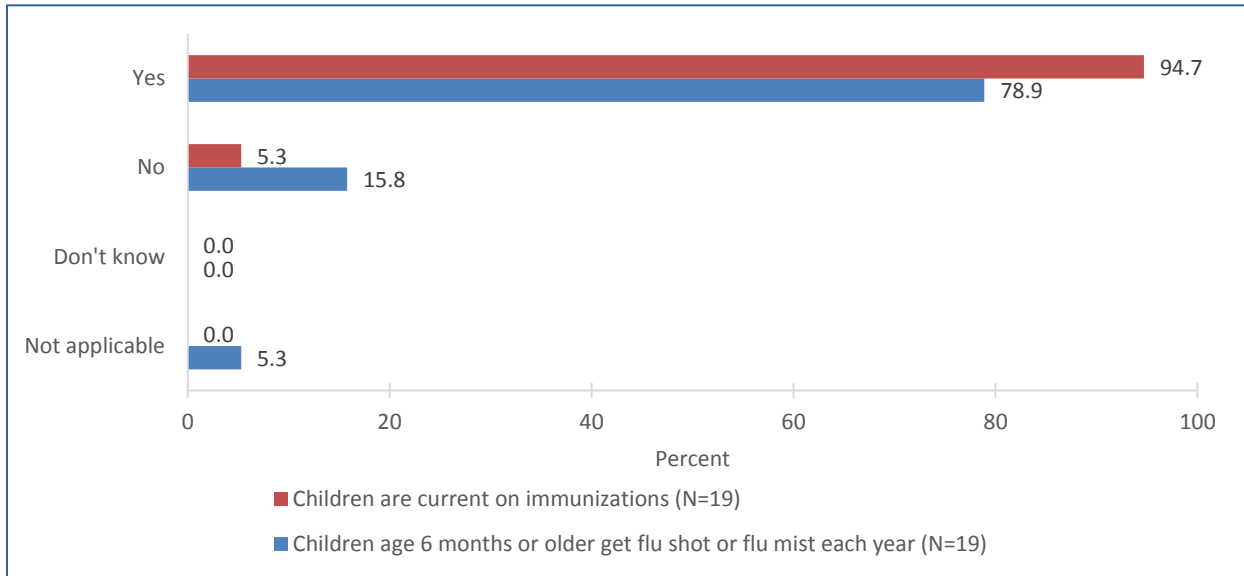
\*Of respondents who have children younger than age 18 living in their household.

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



\*Percentages may not total 100.0 due to rounding.

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



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

Table 3. Zip code of respondents

Zip code	Number of respondents
56156	29
56110	5
56116	2
51230	1
56122	1
56128	1
56129	1
56143	1
56147	1
56155	1
57030	1
57108	1
56129	1
56143	1
56147	1

# Secondary Research

# Definitions of Key Indicators

## County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

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

For additional information about how the *County Health Rankings* are calculated, please visit [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

### Contents:

Outcomes & Factors Rankings

Outcomes & Factors Sub Rankings

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

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

Ranked Measure Sources and Years

Additional Measure Sources and Years

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

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

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

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

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



Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Mammography screening</b>	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	<b>% Mammography</b>	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>High school graduation</b>	Cohort Size	Number of students expected to graduate
	<b>Graduation Rate</b>	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Some college</b>	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	<b>% Some College</b>	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Unemployment</b>	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	<b>% Unemployed</b>	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Children in poverty</b>	# Children in Poverty	Number of children (under age 18) living in poverty
	<b>% Children in Poverty</b>	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Income inequality</b>	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	<b>Income Ratio</b>	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Children in single-parent households</b>	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	<b>% Single-Parent Households</b>	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Social associations</b>	# Associations	Number of associations
	<b>Association Rate</b>	Associations / Population * 10,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
<b>Violent crime</b>	# Violent Crimes	Number of violent crimes
	<b>Violent Crime Rate</b>	Violent crimes/population * 100,000

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

# Rock County, Minnesota

## County Demographics

	Rock County	Error Margin	Top U.S. Performers <sup>^</sup>	Minnesota	Rank (of 87)
<b>Health Outcomes</b>					<b>38</b>
<b>Length of Life</b>					<b>41</b>
Premature death	5,223	4,189-6,435	5,200	5,038	
<b>Quality of Life</b>					<b>39</b>
Poor or fair health			10%	11%	
Poor physical health days			2.5	2.8	
Poor mental health days			2.3	2.6	
Low birth weight	5.5%	4.0-7.0%	5.9%	6.5%	
<b>Additional Health Outcomes (not included in overall ranking)</b>					
<b>Health Factors</b>					<b>19</b>
<b>Health Behaviors</b>					<b>18</b>
Adult smoking			14%	16%	
Adult obesity	27%	21-34%	25%	26%	
Food environment index	8.5		8.4	8.3	
Physical inactivity	23%	17-30%	20%	19%	
Access to exercise opportunities	65%		92%	85%	
Excessive drinking	17%	9-30%	10%	19%	
Alcohol-impaired driving deaths	0%		14%	31%	

	Rock County	Error Margin	Top U.S. Performers <sup>^</sup>	Minnesota	Rank (of 87)
<b>Sexually transmitted infections</b>	126		138	336	
<b>Teen births</b>	22	16-29	20	24	
<b>Additional Health Behaviors (not included in overall ranking)</b>					
<b>Clinical Care</b>					<b>24</b>
<b>Uninsured</b>	9%	8-10%	11%	9%	
<b>Primary care physicians</b>	1,061:1		1,045:1	1,113:1	
<b>Dentists</b>	2,380:1		1,377:1	1,529:1	
<b>Mental health providers</b>	1,360:1		386:1	529:1	
<b>Preventable hospital stays</b>	40	30-49	41	45	
<b>Diabetic monitoring</b>	95%	73-100%	90%	88%	
<b>Mammography screening</b>	55.4%	35.9-74.8%	70.7%	66.7%	
<b>Additional Clinical Care (not included in overall ranking)</b>					
<b>Social &amp; Economic Factors</b>					<b>35</b>
<b>High school graduation</b>	81%		93%	78%	
<b>Some college</b>	68.4%	60.4-76.4%	71.0%	73.3%	
<b>Unemployment</b>	3.3%		4.0%	5.1%	
<b>Children in poverty</b>	14%	10-17%	13%	14%	
<b>Income inequality</b>	4.1	3.6-4.6	3.7	4.3	
<b>Children in single-parent households</b>	28%	21-35%	20%	28%	
<b>Social associations</b>	26.2		22.0	13.2	
<b>Violent crime</b>	787		59	229	
<b>Injury deaths</b>	102	75-135	50	56	

	Rock County	Error Margin	Top U.S. Performers <sup>^</sup>	Minnesota	Rank (of 87)
<b>Additional Social &amp; Economic Factors (not included in overall ranking)</b>					
<b>Physical Environment</b>					<b>33</b>
Air pollution - particulate matter	12.5		9.5	12.0	
Drinking water violations	0%		0%	1%	
Severe housing problems	12%	9-14%	9%	15%	
Driving alone to work	75%	73-77%	71%	78%	
Long commute - driving alone	30%	25-34%	15%	29%	

2015

<sup>^</sup> 10th/90th percentile, i.e., only 10% are better.

Note: Blank values reflect unreliable or missing data



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