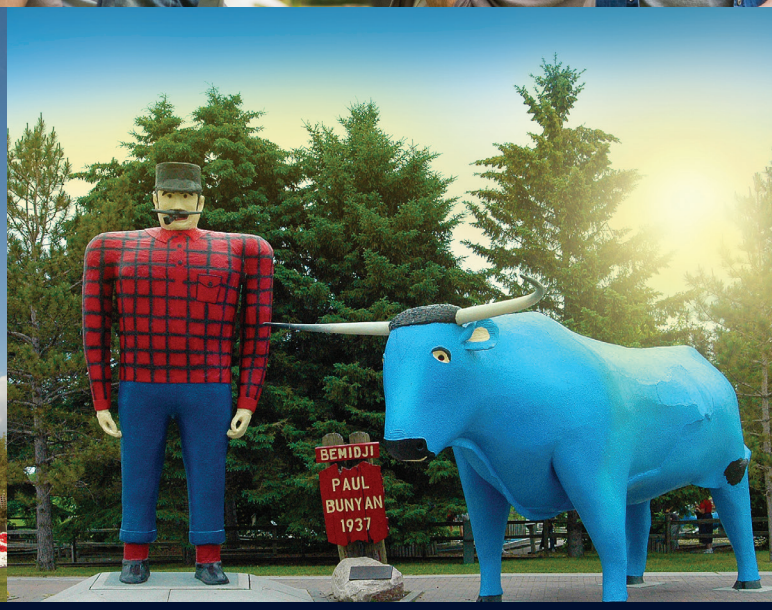


Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

dba Sanford Vermillion Medical Center EIN # 46-0388596

SANFORD HEALTH

Sanford Vermillion Medical Center

Community Health Needs Assessment 2016

Dear Community Members,

Sanford Vermillion 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 Vermillion 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 action steps that will be taken to address each identified need.

At Sanford Vermillion, 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 communities is at the core of who we are. Through our work with communities, we can bring health and healing to the people who live and work across our communities. Together, we can fulfill this mission.

Sincerely,

Timothy J. Tracy
Chief Executive Officer
Sanford Vermillion Medical Center

Sanford Vermillion Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

SANFORD HEALTH

Sanford Vermillion 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 on-line during 2015. The Center for Social Research at North Dakota State University developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various key community stakeholders and agencies, at times using a snowball approach**.** Data collection occurred throughout the month of May 2015 and a total of 237 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community stakeholders in the area is to learn about the perceptions of area community leaders regarding community health, their personal health, preventive health, and the prevalence of disease.

   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. 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. 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 South Dakota Health Study for Clay County and Union County.

Key Findings – Primary Research

The key findings are based on non-generalizable survey data. Key indicators were ranked on a 1-5 Likert scale, with 5 being the highest concern ranking. The survey results that rank 3.5 or higher are considered to be high ranking and are included in the prioritization process.

1. **Economics:** The respondents scored this area 3.59 so is identified as an area of concern specifically mentioning availability of affordability of housing in the Vermillion community as an area of concern.

2. **Aging:** Cost of long term care for the aging had the highest score on the survey with 3.99 and availability of memory care also was identified as an area of concern with a score of 3.55.

3. **Children and Youth:** Bullying was identified as a concern for the Vermillion community with a score of 3.69.

4. **Safety:** Presence of street drugs and alcohol in the community was shown to be a concern with a score of 3.64 as well as child abuse and neglect with a score of 3.50.

5. **Health Care:** There were four areas of concern related to healthcare identified including: access to affordable health insurance which scored 3.87; cost of affordable vision insurance which scored 3.65; access to affordable healthcare with a score of 3.61 and cost of affordable dental insurance coverage which scored 3.61.

6. **Physical Health:** There were 3 areas of concern related to physical health including: poor nutritional and eating habits which scored 3.68; inactivity and lack of exercise with a score of 3.65 and obesity which scored 3.59.

7. **Mental Health/Behavioral Health:** The survey showed five areas of concern related to mental health including: underage drug use and abuse 3.89; underage drinking 3.86; stress 3.54; alcohol use and abuse 3.71; and drug use and abuse with 3.61.

Key Findings – Secondary Research Based on the South Dakota Health Study & US Census Study 2010-2014

The South Dakota Health Survey was a statewide health assessment designed to provide a picture of county and statewide health needs. The survey included a representation of rural and American Indian subpopulations. Additionally, homeless, immigrant and refugee, and housing insecure populations were included in this study.

1. **Economics:** The owner occupied housing rate in Clay County is 39% and 74.7% in Union County. Median gross rent in Clay County was $679 and $764 in Union County. There are 37% of the population in Clay County who live at or below the poverty level and 6.3% in Union County.

2. **Aging:** Clay County has 8.4% of its population age 65 and older. Union County has 14% of its population age 65 and older.

3. **Children/Youth:** Clay County has 15.3% of its population under age 18 including 4.9% under age 5. Union County has 26.2% under age 18 with 6.8% of those under age 5.

4. **Safety:** Clay County's crime index rate is 2,499 crimes per 100,000 people and Union County's is 501 per 100,000 people with mostly property vs. violent crimes.

5. **Health Care:** 87.9% in Clay County have a usual place to go for healthcare; 77% have a personal provider; 5.5% have unmet needs; 1.4% have unmet prescription needs; 42% have unmet mental health needs; 71% need healthcare; 77% have prescription needs

6. **Physical Health:** 10.1% Clay County has diabetes; 21.1% has asthma; 14.3% has high blood pressure; 3.7% heart disease; 19% high cholesterol; 3.5% cancer

7. **Mental Health/Behavioral Health:** 11% of Clay County have fair or poor mental health; 8% have depression and 4.7% have anxiety

The following needs were brought forward for prioritization:

- Economics
- Aging
- Children and Youth
- Safety
- Health Care
- Physical Health
- Mental Health

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

- Mental Health
- Physical Health

Implementation Strategies

Priority 1: Mental Health
Depression is a common but serious illness that can interfere with daily life. Many people with a depressive illness never seek treatment. But the majority, even those with the most severe depression, can get better with treatment. County Health Rankings for Clay County indicate that 11% of the residents have fair or poor mental health.

Sanford has prioritized depression as a top priority and has set strategy to perform assessments for depression and to improve PHQ-9 scores for patients who are a diagnosed with depression. The goal is to improve PHQ-9 scores for patients with depression. The measurable outcome is the percentage of patients with major depression or dysthymia and an initial PHQ-9 score greater than nine whose six-month PHQ-9 score is less than five.

Priority 2: Physical Health
Poor nutrition and eating habits can lead to obesity and many physical health problems for the community such as diabetes, high cholesterol and hypertension. Sanford Vermillion through its health coach program, providers, dietitian and Wellness programs will be implementing several programs and community education sessions with the goal of improving the physical health of the Vermillion community.

Sanford Vermillion Medical Center

Community Health Needs Assessment 2016

Table of Contents

Purpose of the Community Health Needs Assessment

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

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

Our Guiding Principles:

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

Acknowledgements

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

Sanford Enterprise Steering Group:

- JoAnn Kunkel, CFO, Sanford Enterprise
- Michelle Bruhn, CFO, Health Services Division
- Tiffany Lawrence, CPA, Fargo Region Co-Lead, CFO, Sanford Medical Center Fargo
- Bruce Viessman, Sioux Falls Region Co-Lead, CFO, Sanford Health Network
- Martha Leclerc, MS, Vice President, Revenue Management
- Randy Bury, CAO, Health Services Division

- Steve Goetsch, CFO, Sioux Falls Region
- Jane Heilmann, Senior Corporate Communications Strategist
- Joy Johnson, COO Bemidji Region
- Kirk Christy, CFO, Bismarck Region
- Carrie McLeod, MBA, MM, LRD,CDE, Enterprise Lead, Enterprise Community Health/Community Benefit

Sanford Vermillion Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE, Enterprise Lead, Office of Health Care Reform, Community Benefit/Community Health Improvement
- Julie Girard, Quality Coordinator, Administration

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

We extend special thanks to the state legislators, mayors, city council/commission members, physicians, nurses, university presidents and leaders, school superintendents and school board members, representatives from the Native American community, representatives for the mentally and physically disabled, social services, non-profit and service organizations, city, government and public health officers 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 Vermillion and surrounding area Key Community Stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Timothy J. Tracy, Sanford Vermillion CEO
- Jeffrey Berens, Sanford Vermillion CNO
- Mary Merrigan, Sanford Vermillion Public Relations
- Julie Girard, Sanford Vermillion Quality/Risk
- Cindy Benzel, Sanford Vermillion HR/Payroll
- Rachel Olson, Sanford Vermillion Ancillary Services
- Elizabeth Fox, Community Member/Patient Advisory Board Member
- Kevin Mills, Community Member/Patient Advisory Board Member
- Carrie McLeod, SH Community Health

Description of Sanford Vermillion Medical Center

Sanford Vermillion Medical Center is a 25-bed, acute care Critical Access Hospital serving 25,000 people in Clay and Union counties in southeast South Dakota and a few counties across the Missouri river in Nebraska. Services provided include trauma/emergency medicine, therapies, mammography and radiology.

Sanford Health partnered with Dakota Hospital Foundation in Vermillion on a $12 million remodeling and expansion of Sanford Vermillion Medical Center. Plans include remodeling several areas, removing a 1935 building and replacing it with an expanded outpatient service center with enhanced technology. The five-year-project was announced in 2014 and is in progress. Sanford Health will assume ownership for the infrastructure, including building projects and technology, at the conclusion of the project.

Sanford Vermillion also includes an outpatient clinic, a 66-bed nursing home, and 23-unit senior living apartment complex. The clinic provides over 24,000 patient visits annually to include the USD student health contract population.

Sanford Vermillion employs 7 clinicians, including physicians and advanced practice providers and 250 employees.

Description of the Community Served

Vermillion lies atop a bluff on the Missouri River. It has a population of 10,600 and is home to a variety of farmers, manufacturers, professionals, students and scholars. The University of South Dakota was founded in Vermillion in 1862 and currently enrolls over 10,000 students. Vermillion boasts small town charm and big town cultural amenities, including museums and art galleries, theater, art, music and dance productions.

Study Design and Methodology

1. **Non-Generalizable Survey**
   A non-generalizable on-line survey was conducted by Sanford health with the assistance of public health leadership and the Center for Social Research (CSR) at North Dakota State University. 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 community stakeholders and various agencies, at times using a snowball approach**.** Data collection occurred throughout the month of March 2015 and a total of 253 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community members and key stakeholders in the greater Vermillion 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. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized. As stated in the generalizable survey methodology, many of the identified needs that ranked below 3.5 are being

addressed by Sanford. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. **Community Stakeholder Meeting**
   Community stakeholders were invited to a meeting to review the early findings from the generalizable survey and to discuss the top health issues or health-related issues facing the community. Community stakeholders discussed the community needs and 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. Sanford and community stakeholders performed the asset mapping review. 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.

4. **Secondary Research**
   The secondary data includes the South Dakota Health Study for Clay and Union counties.

Limitations of the Study

The findings in this study provide a limited snapshot of behaviors, attitudes, and perceptions of residents living in the Vermillion primary service area. A good faith effort was made to secure input from a broad base of the community. Invitations were extended to county and city leadership, local legislators, organizations and agencies representing diverse populations and disparities.

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.

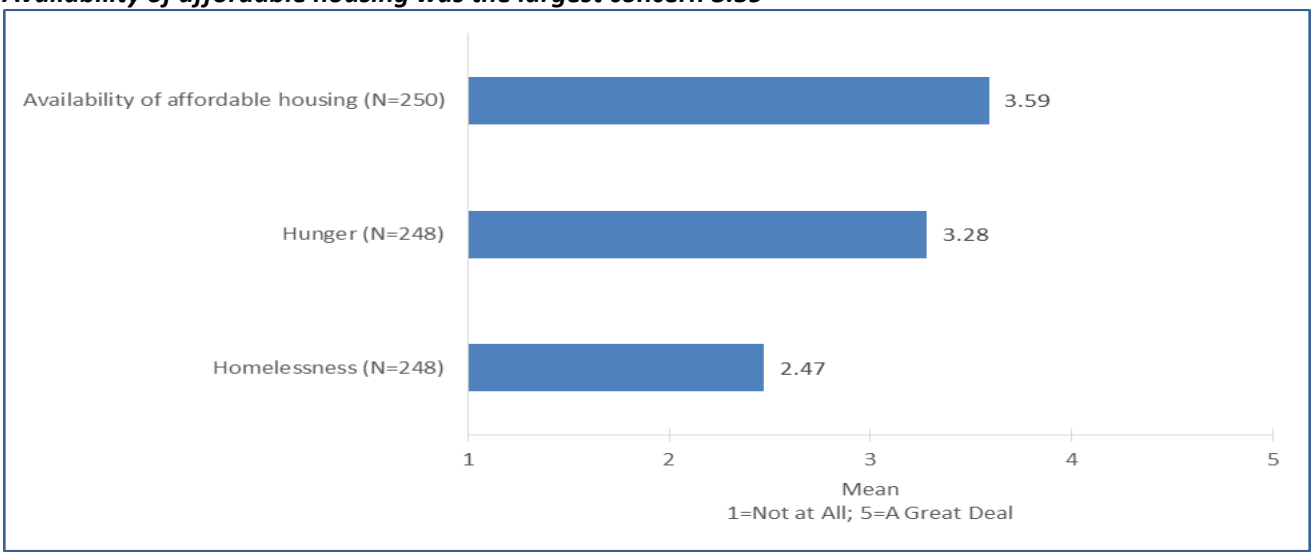
Key Findings

Community Health Concerns

Economics

Using a scale of 1 to 5 with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with statements about the community regarding housing, hunger and homelessness.

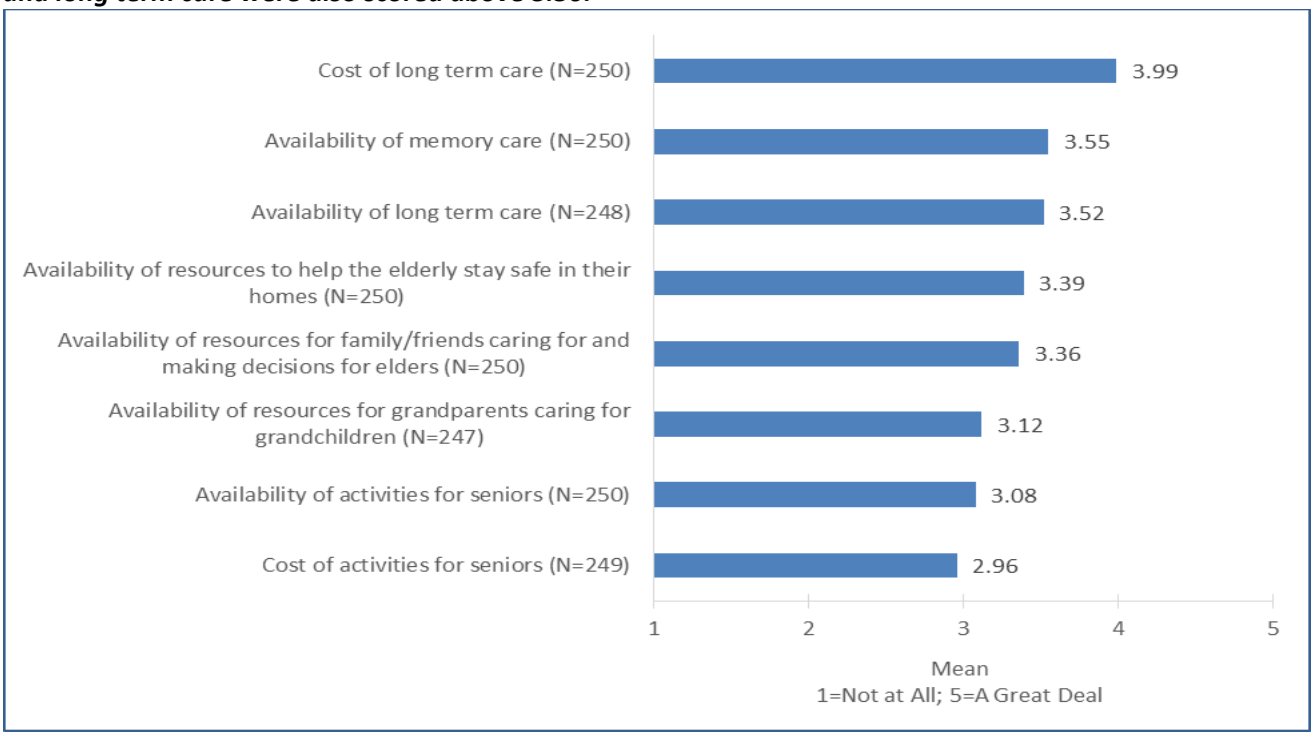
Availability of affordable housing was the largest concern 3.59



Aging Population

Using a scale of 1 to 5 respondents were asked to rate their level of concern with statements about the community regarding the Aging Population.

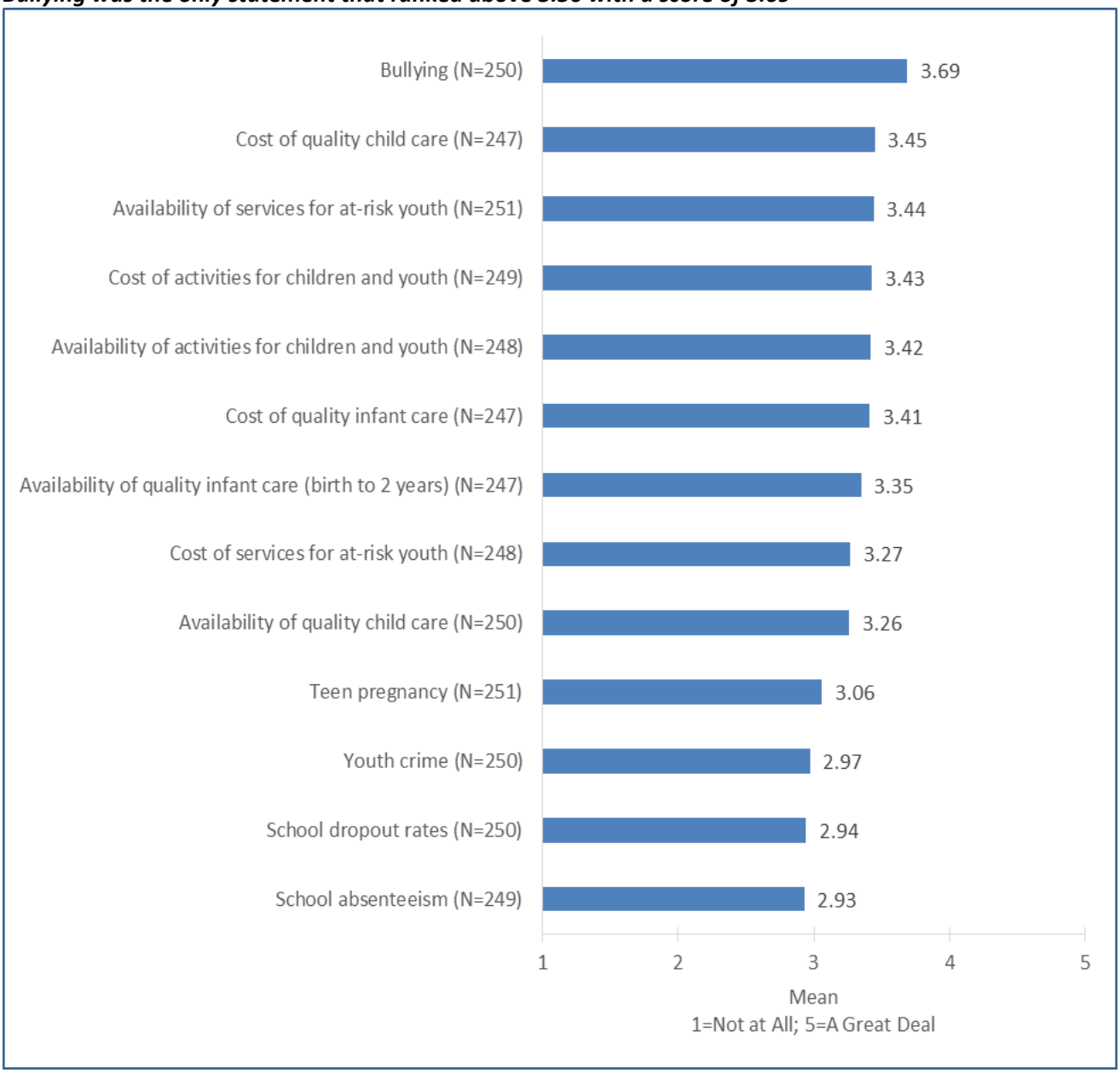
Cost of long term care was the highest rated concern on the entire survey. Availability of memory care and long term care were also scored above 3.50.



Children and Youth

Respondents were asked to rate from 1 to 5 their levels of concern with statements about the community regarding Children and Youth.

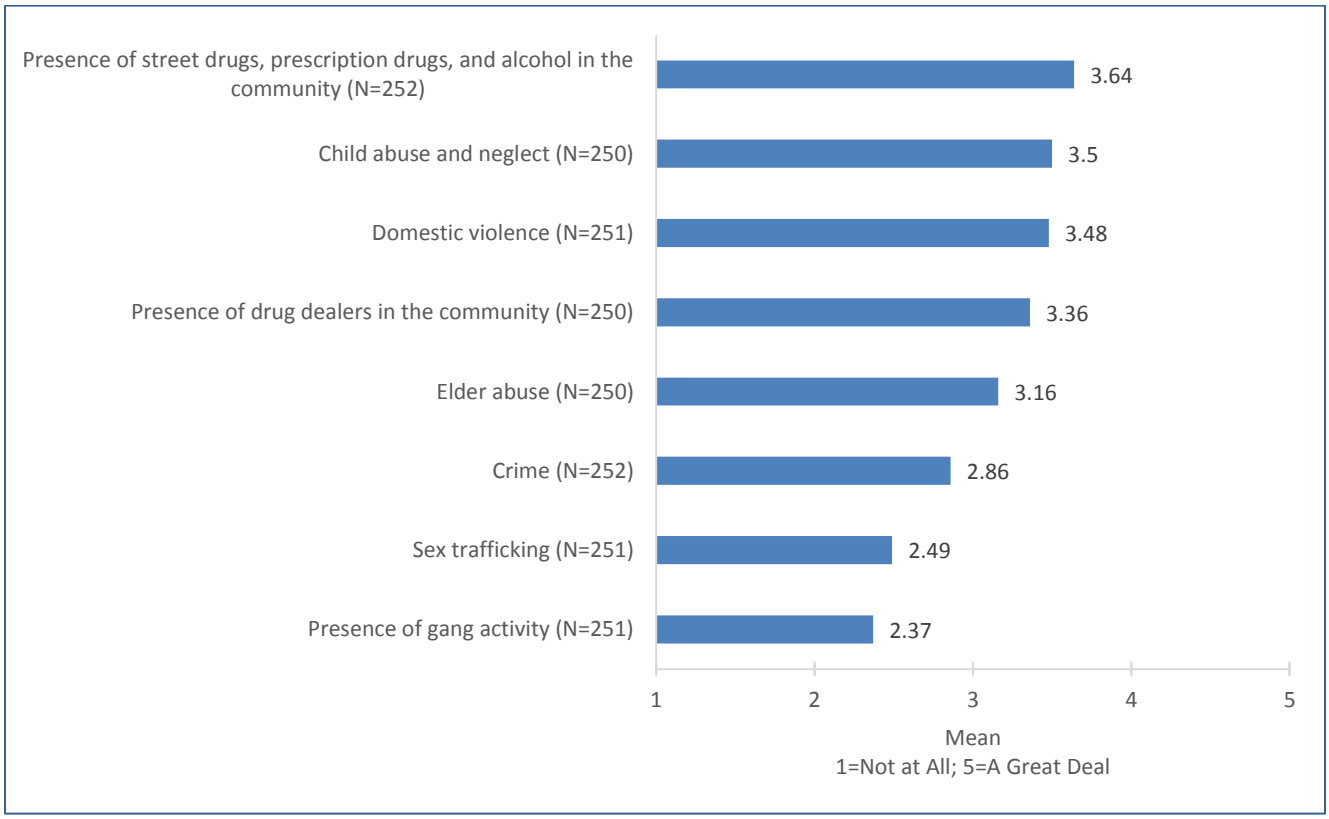
Bullying was the only statement that ranked above 3.50 with a score of 3.69



Safety

Respondents were asked to rate their levels of concern from 1 to 5 for statements about the SAFETY of the community.

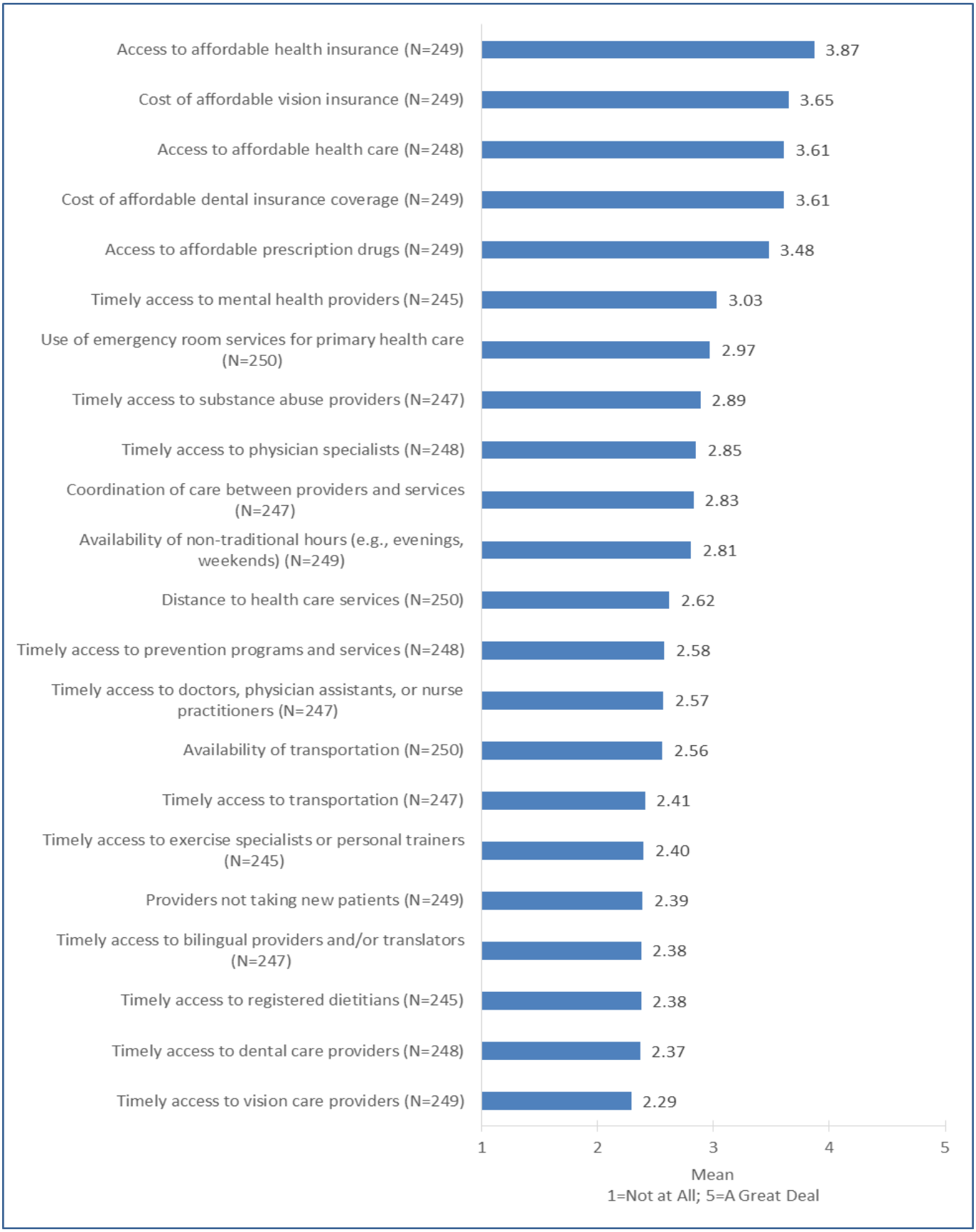
Street Drugs and Alcohol in the Community as well as Child Abuse and Neglect were identified as concerns by respondents with 3.64 and 3.50



Health Care Access and Cost

Respondents were asked to rate their level of concern from 1 to 5 for statements about the community for Health Care Access and Cost.

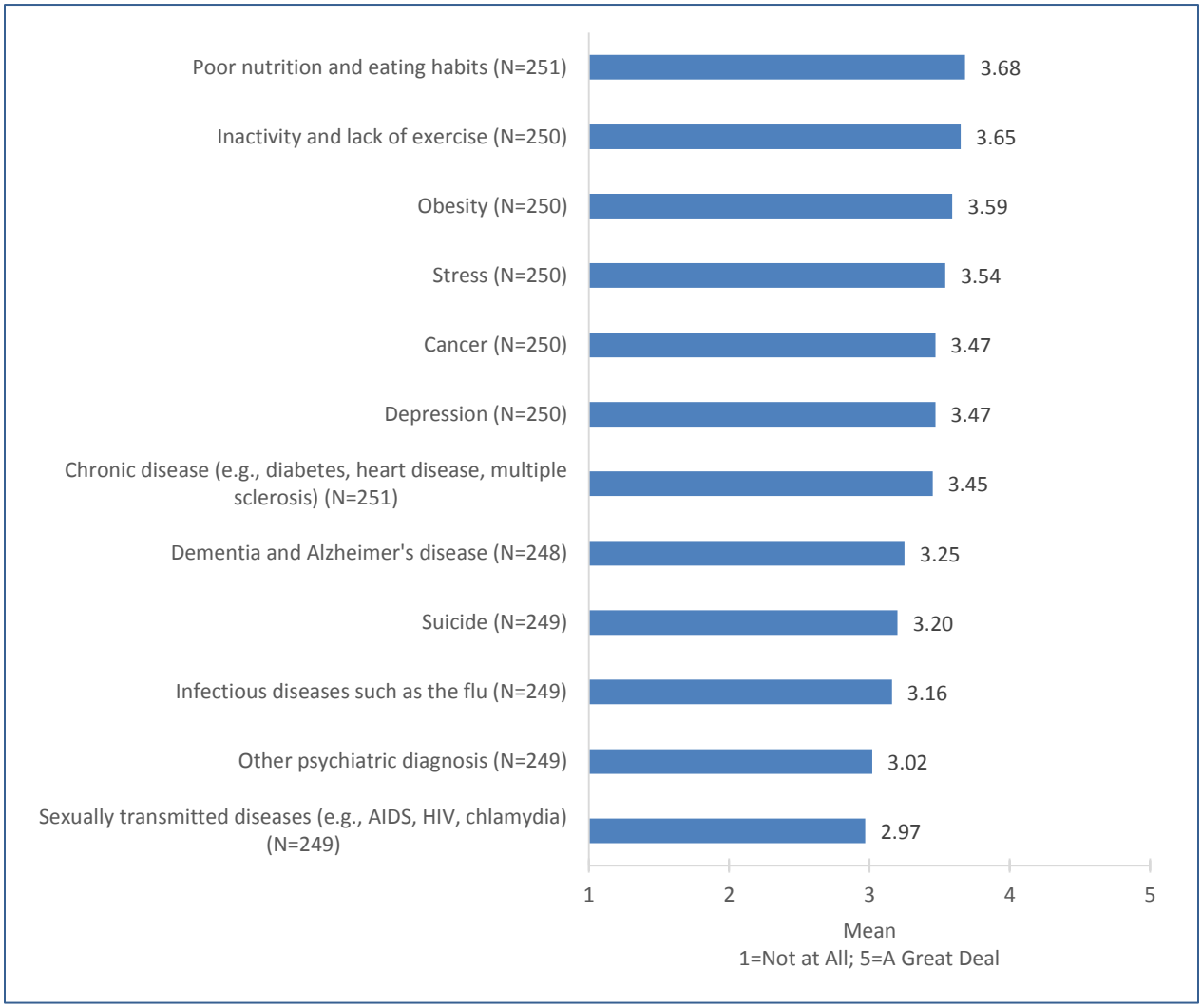
There were 4 areas that scored above 3.5 or were identified as areas of concern including access to affordable health insurance, cost of affordable vision insurance, access to affordable healthcare, and cost of affordable dental insurance coverage.


Access to affordable health insurance (N=249) 3.87
Cost of affordable vision insurance (N=249) 3.65
Access to affordable health care (N=248) 3.61
Cost of affordable dental insurance coverage (N=249) 3.61
Access to affordable prescription drugs (N=249) 3.48
Timely access to mental health providers (N=245) 3.03
Use of emergency room services for primary health care (N=250) 2.97
Timely access to substance abuse providers (N=247) 2.89
Timely access to physician specialists (N=248) 2.85
Coordination of care between providers and services (N=247) 2.83
Availability of non-traditional hours (e.g., evenings, weekends) (N=249) 2.81
Distance to health care services (N=250) 2.62
Timely access to prevention programs and services (N=248) 2.58
Timely access to doctors, physician assistants, or nurse practitioners (N=247) 2.57
Availability of transportation (N=250) 2.56
Timely access to transportation (N=247) 2.41
Timely access to exercise specialists or personal trainers (N=245) 2.40
Providers not taking new patients (N=249) 2.39
Timely access to bilingual providers and/or translators (N=247) 2.38
Timely access to registered dietitians (N=245) 2.38
Timely access to dental care providers (N=248) 2.37
Timely access to vision care providers (N=249) 2.29
1
2
3
4
5
Mean
1=Not at All; 5=A Great Deal

Physical & Mental Health

Respondents were asked to rate their level of concern from 1 to 5 with statements about their community regarding Physical Health.

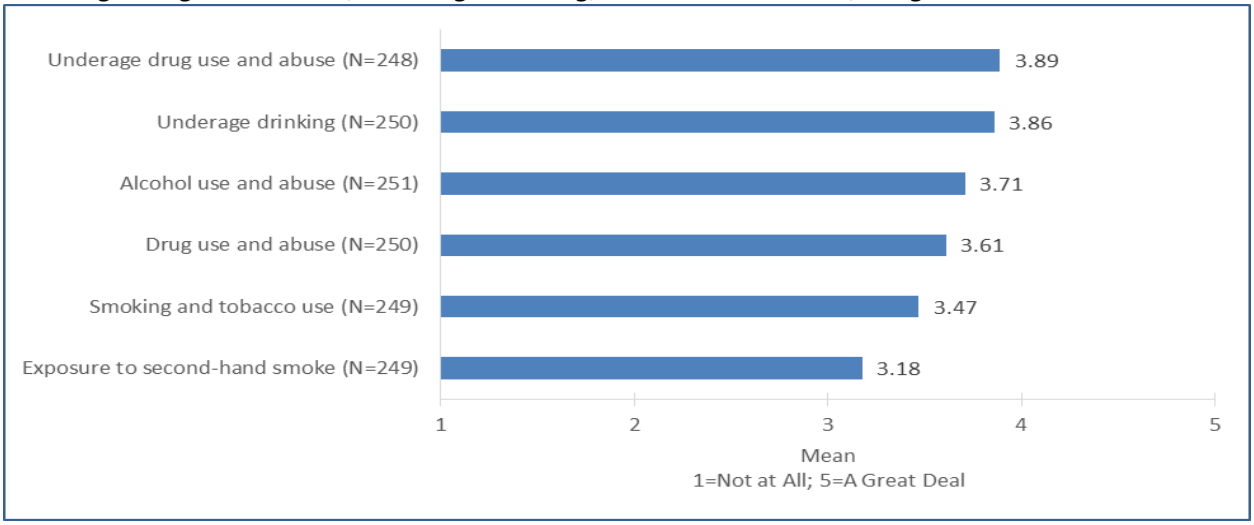
There were 4 statements identified as areas of concern for Physical& Mental Health: Poor Nutrition & Eating Habits; Inactivity & Lack of Exercise; Obesity; and Stress.



Substance Use and Abuse

Respondents were asked to rate their levels of concern from 1 to 5 with statements about the community regarding Substance Use and Abuse.

There were 4 Substance Use and Abuse statements identified by the respondents as areas of concern including: Drug use & abuse; Underage drinking; Alcohol use & abuse; Drug use & abuse.

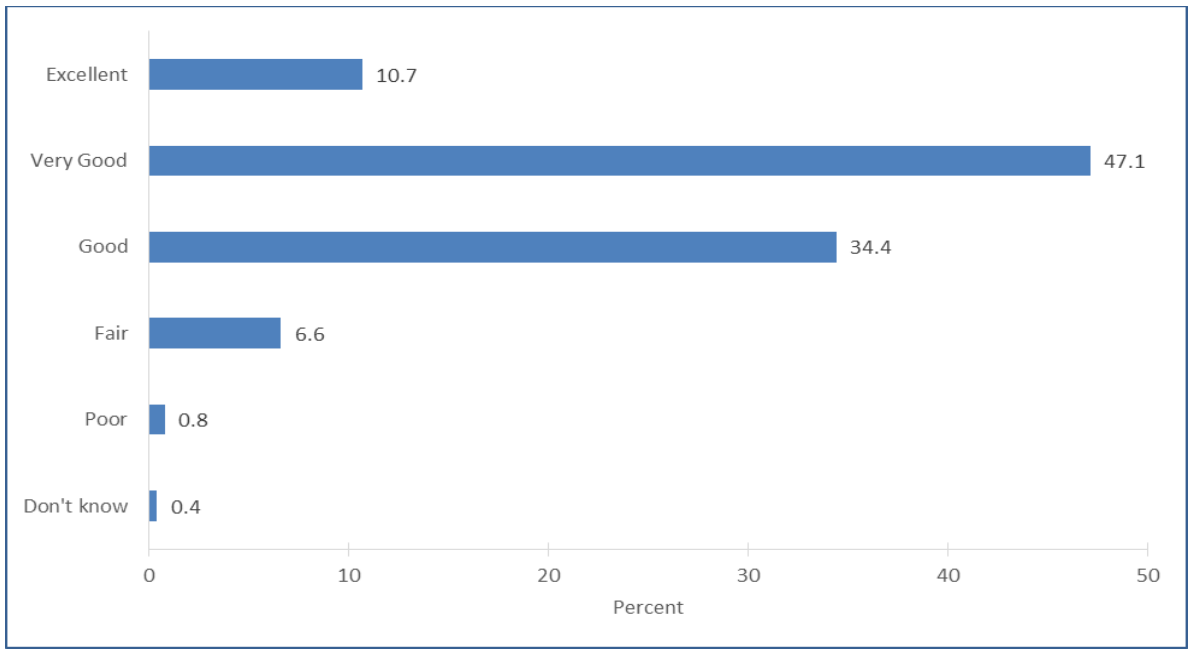


Personal Health Concerns

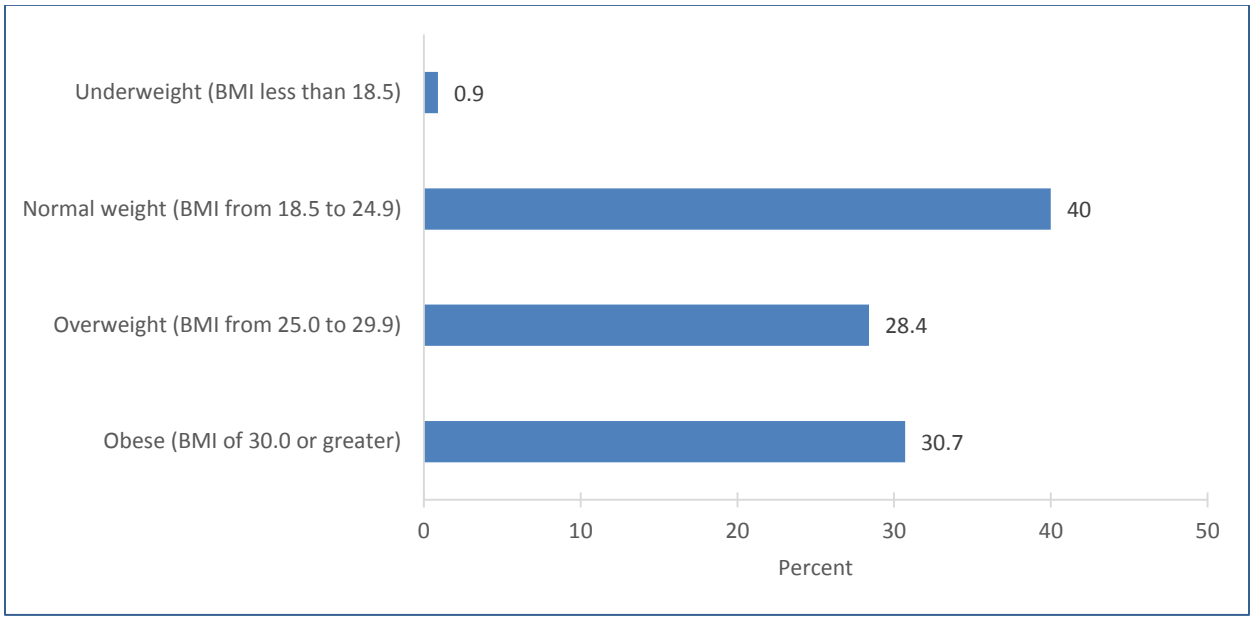
Respondents' Personal Health Status

Survey respondents were asked to rate their health in general from poor to excellent or they could answer "don't know."

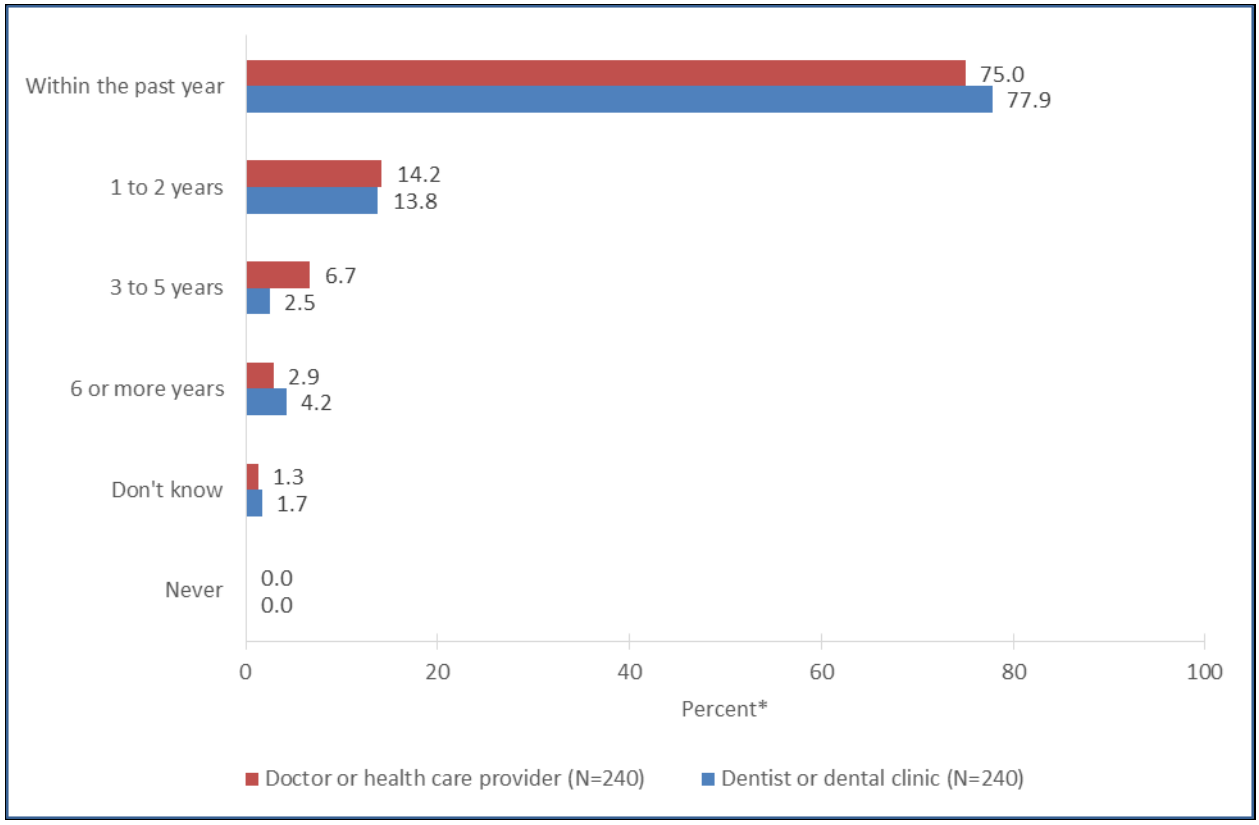
Respondents' rating of their health in general



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



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



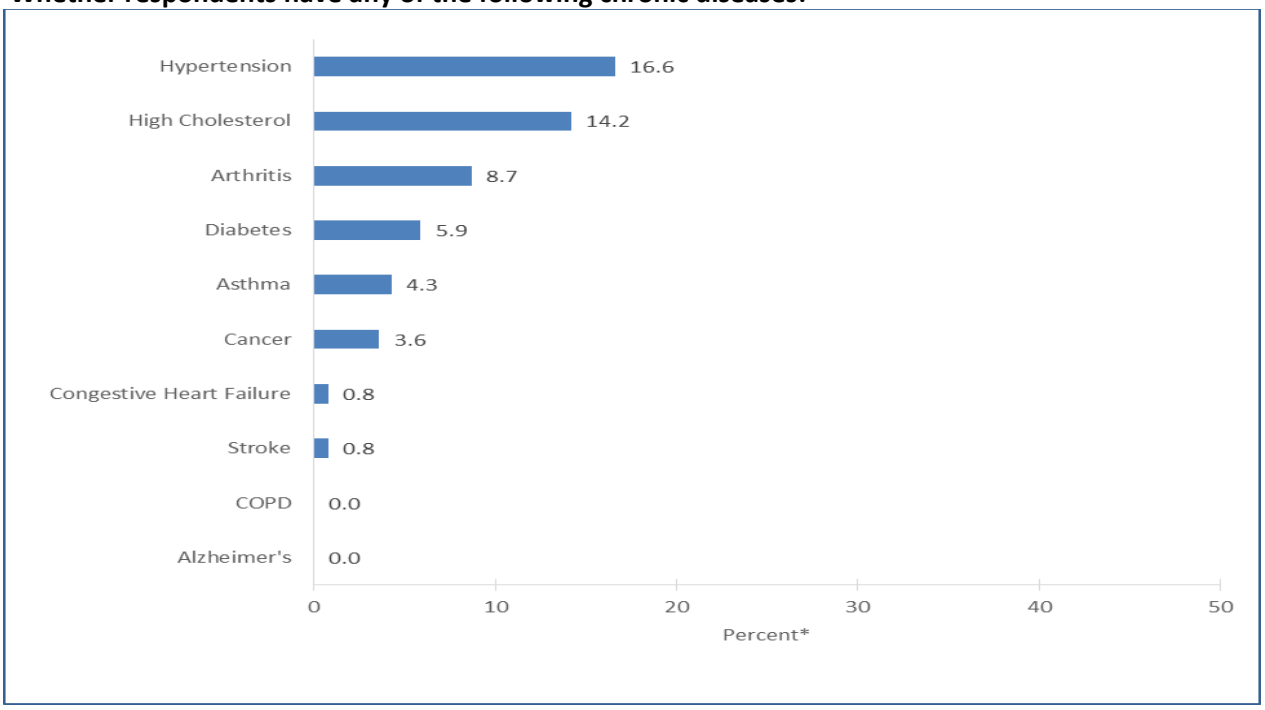
Preventive Health

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 are shown in the table below.

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=240)	90.0	10.0	100.0
Blood sugar screening (N=238)	72.7	27.3	100.0
Bone density test (N=232)	9.5	90.5	100.0
Cardiovascular screening (N=233)	20.2	79.8	100.0
Cholesterol screening (N=238)	73.9	26.1	100.0
Dental screening and X-rays (N=236)	78.4	21.6	100.0
Flu shot (N=240)	87.9	12.1	100.0
Glaucoma test (N=235)	51.9	48.1	100.0
Hearing screening (N=232)	14.2	85.8	100.0
Immunizations (N=231)	27.3	72.7	100.0
Pelvic exam (N=175 Females)	68.0	32.0	100.0
STD (N=228)	11.0	89.0	100.0
Vascular screening (N=228)	9.6	90.4	100.0
CANCER SCREENINGS			
Breast cancer screening (N=172 Females)	59.9	40.1	100.0
Cervical cancer screening (N=174 Females)	64.4	35.6	100.0
Colorectal cancer screening (N=236)	19.9	80.1	100.0
Prostate cancer screening (N=64 Males)	39.1	60.9	100.0
Skin cancer screening (N=236)	25.8	74.2	100.0

Whether respondents have any of the following chronic diseases:



N=253 Percentages do not total 100 due to multiple responses

Screenings

- 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 that can cause these cell changes (human papillomavirus) (http://www.cdc.gov/cancer/hpv/basic_info/)
  - 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 and continuing until age 75.

- 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 2.5 ng/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 12% of respondents did not have a flu shot last year.

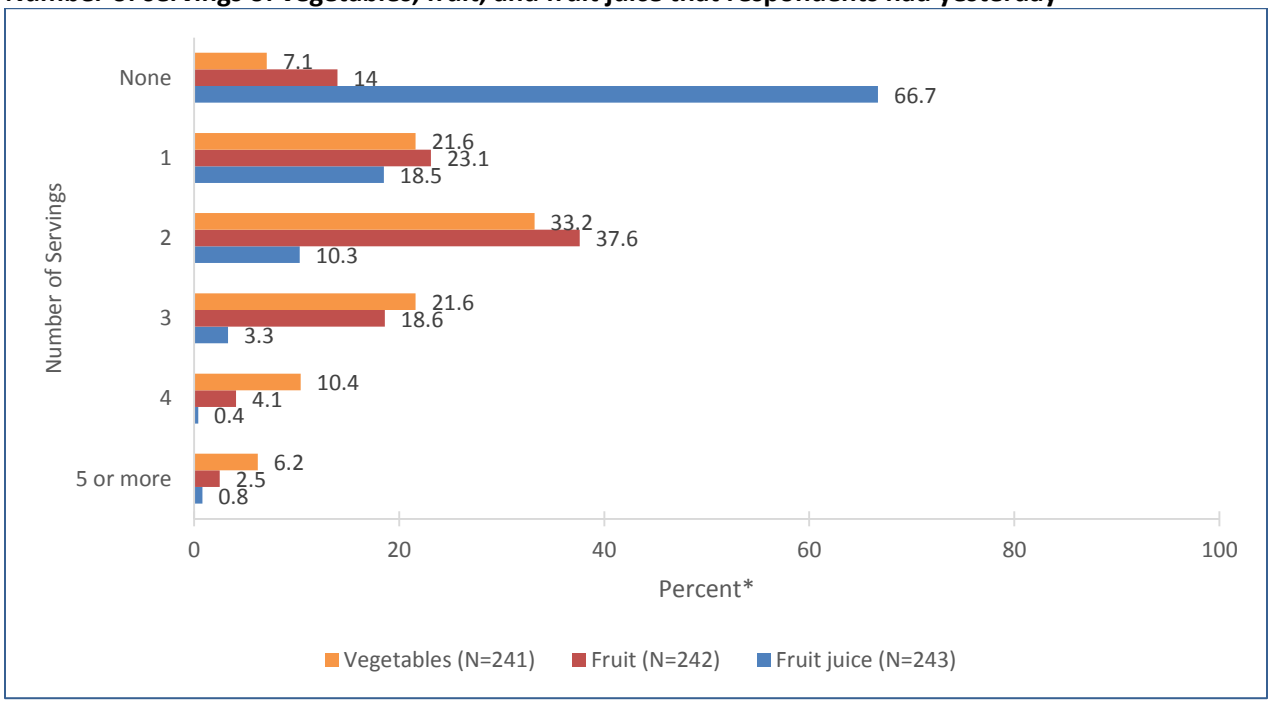
The Center for Disease Control states that influenza is a serious disease that can lead to hospitalization and sometimes even death. Even healthy people can get sick from the flu and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies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

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 38.2% of respondents reported having 3 or more servings of vegetables the prior day and 25.2% 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 AgricultureDietary 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 diet 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 diet can be beneficial for weight management.

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

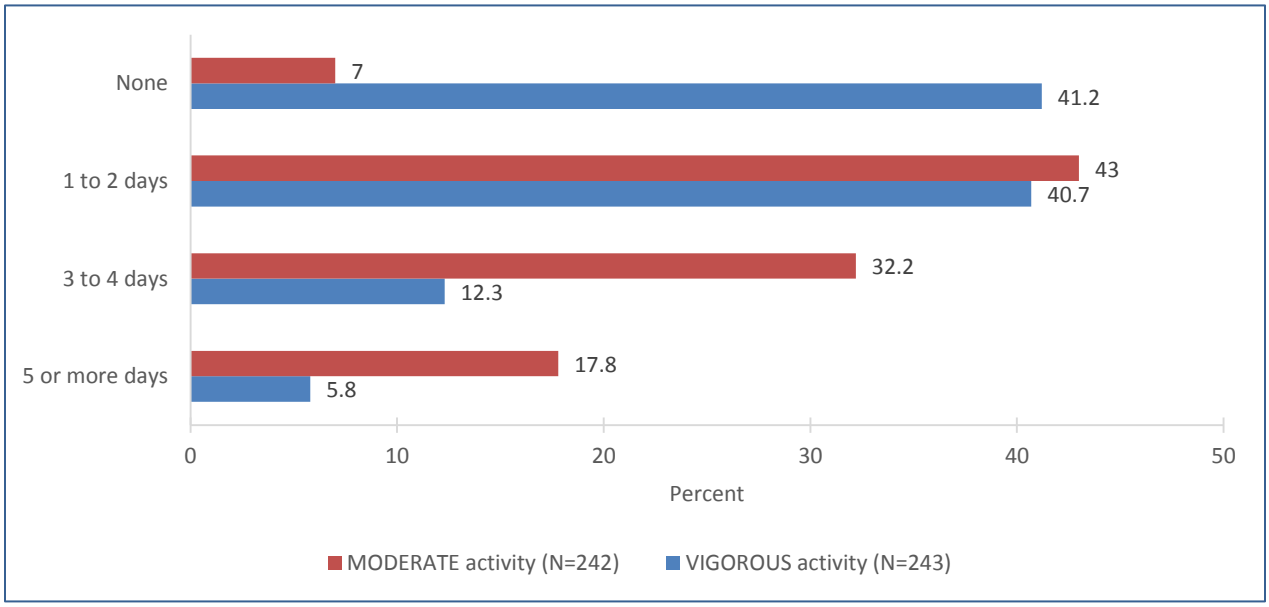


Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines; 50% of respondents engage in moderate activity 3 or more times per week and 18.1% engage in vigorous activity 3 or more times per week.

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

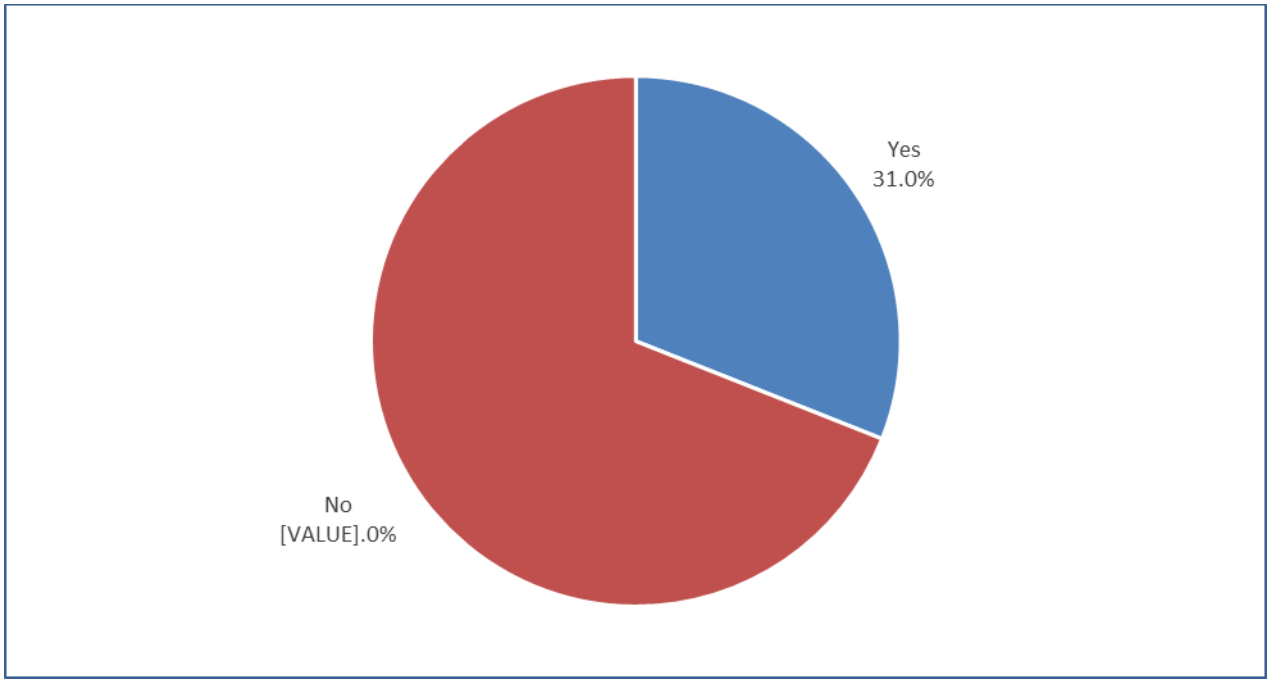


Tobacco Use

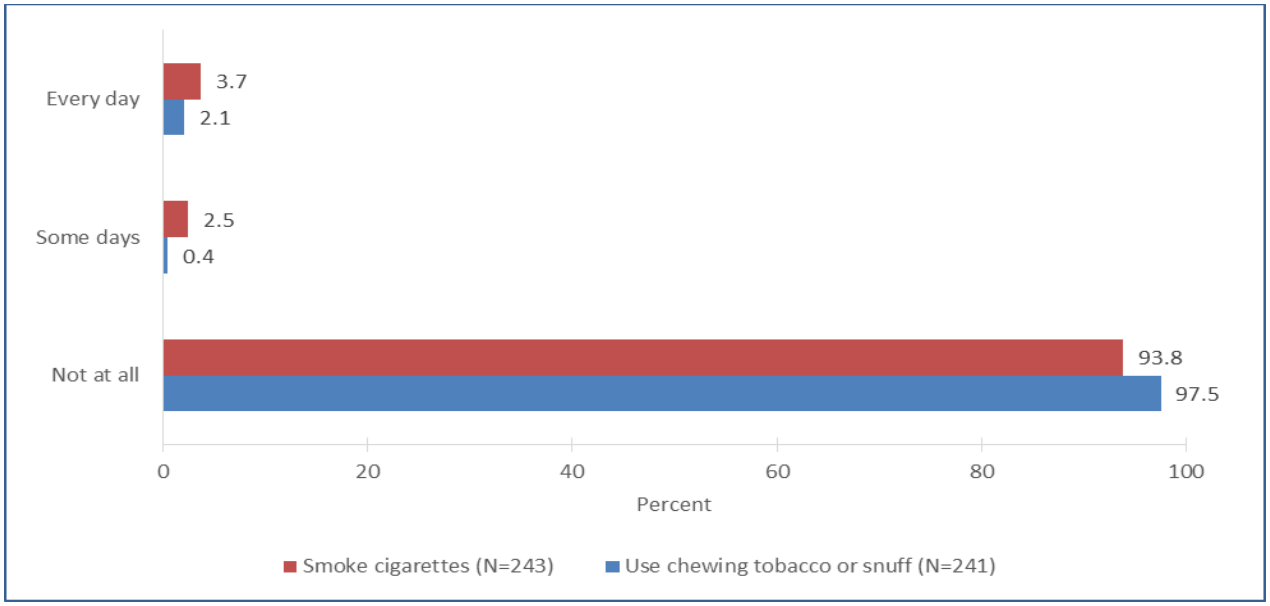
Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 69% of respondents has smoked at least 100 cigarettes in their lifetime, which indicates former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the South Dakota Focus on Health Study finds that 16% percent of Clay County and 8% of Union County residents are current smokers.

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



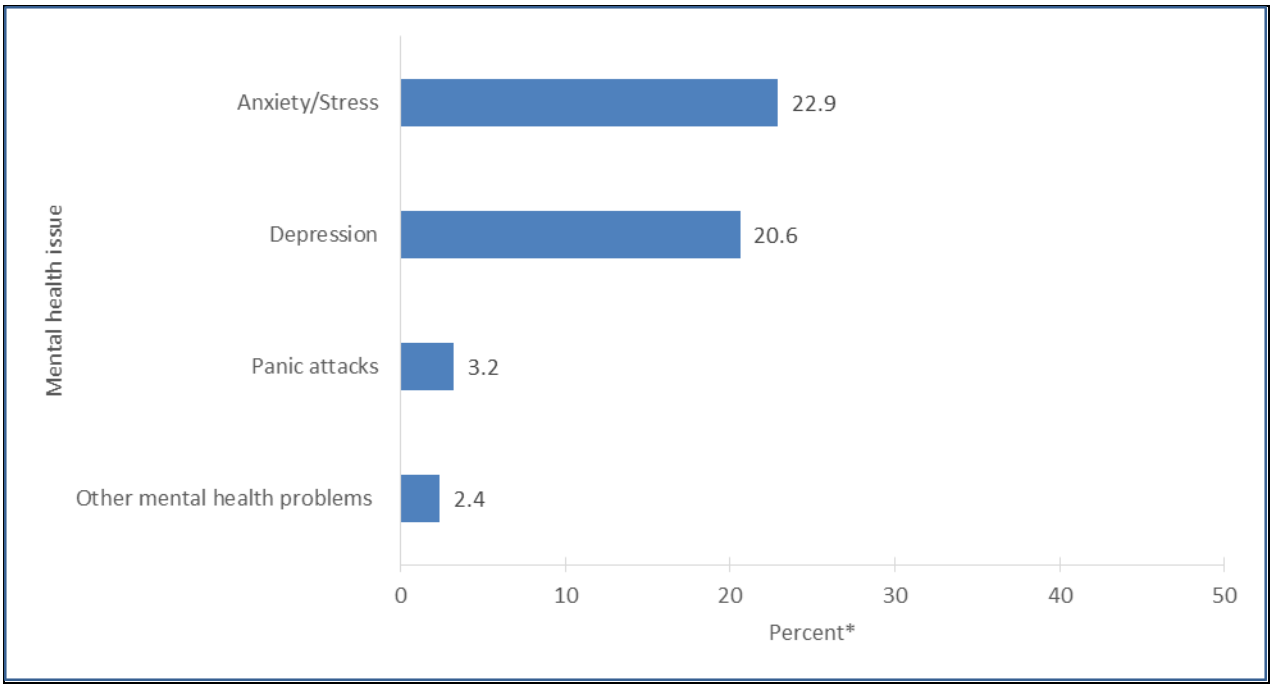
How often respondents currently smoke cigarettes and use chewing tobacco or snuff



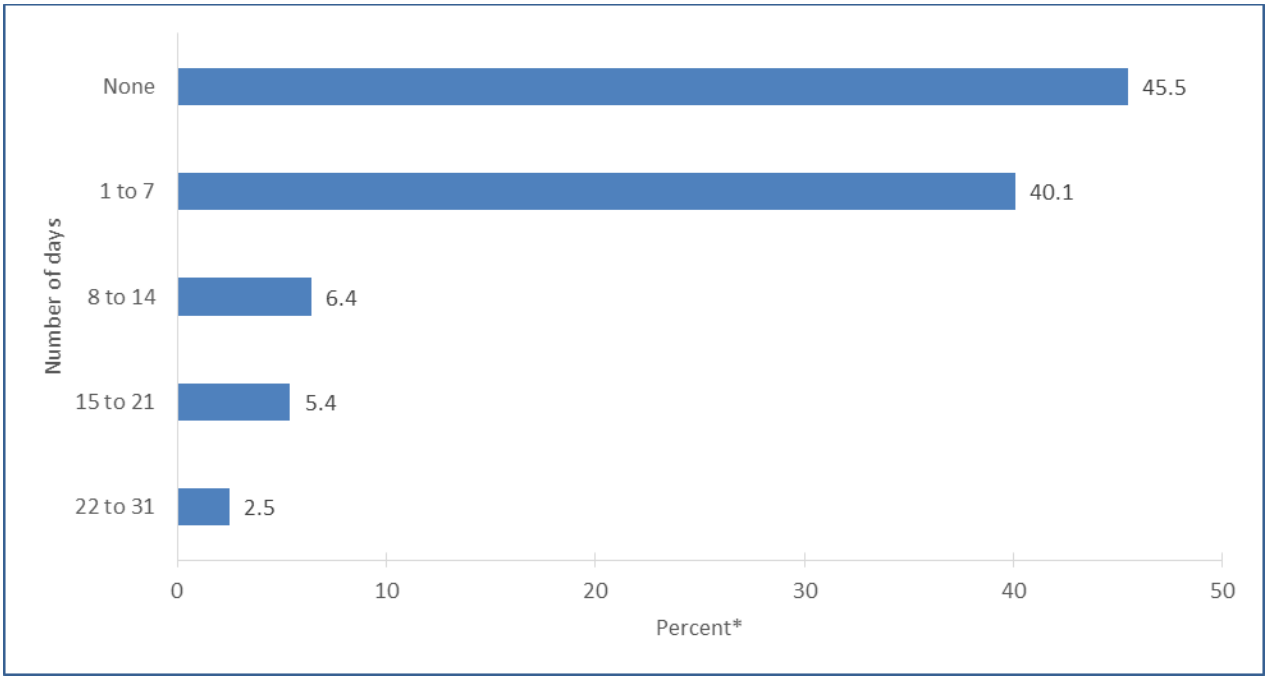
Mental Health

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 237 respondents, mental health is a moderately high concern.

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



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

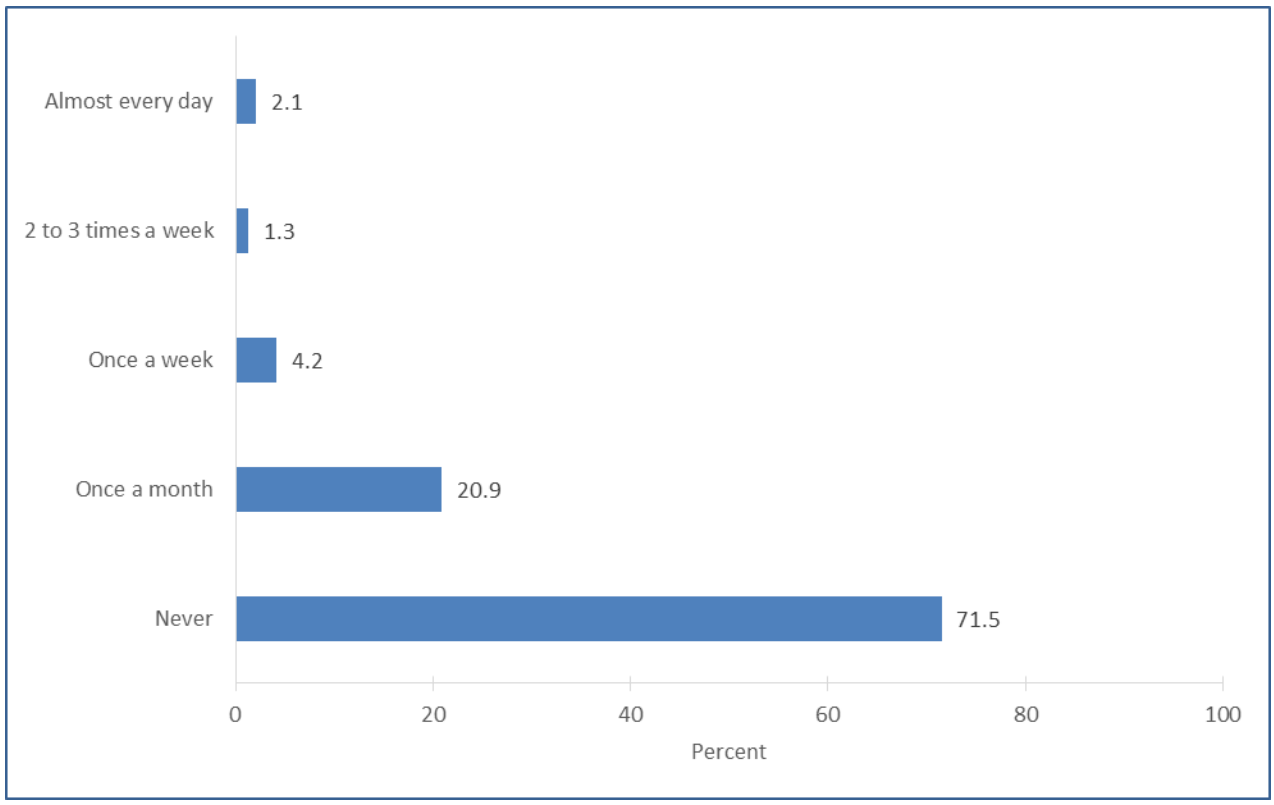


Substance Abuse Responses

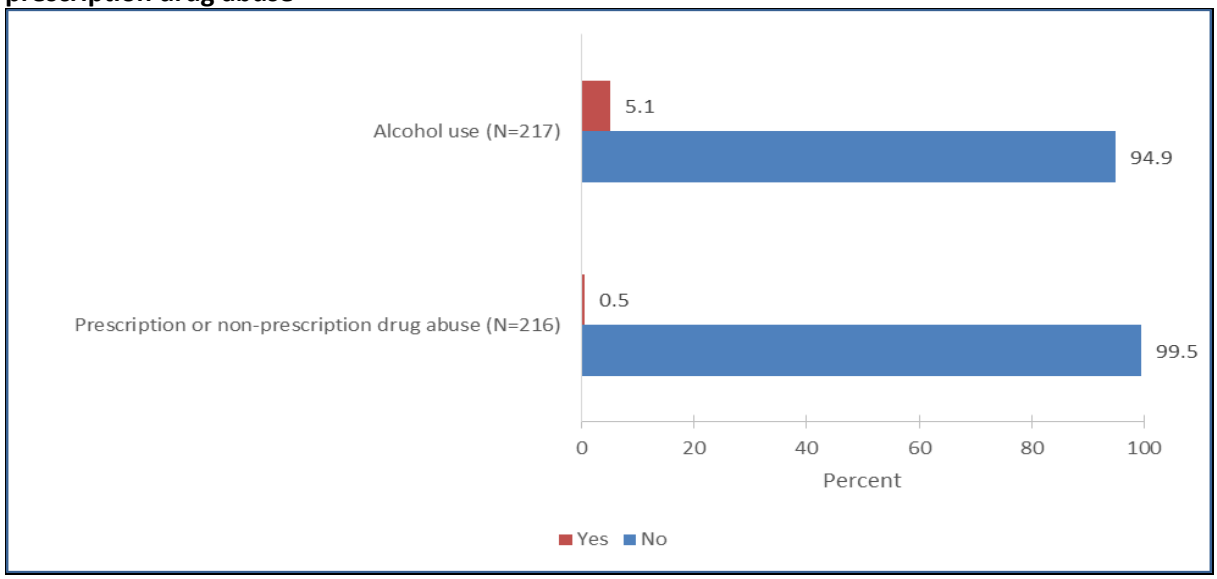
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns.

Secondary research through the South Dakota Focus on Health Study indicates that 20% of Clay County residents and 18% of Union County residents report binge drinking.

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



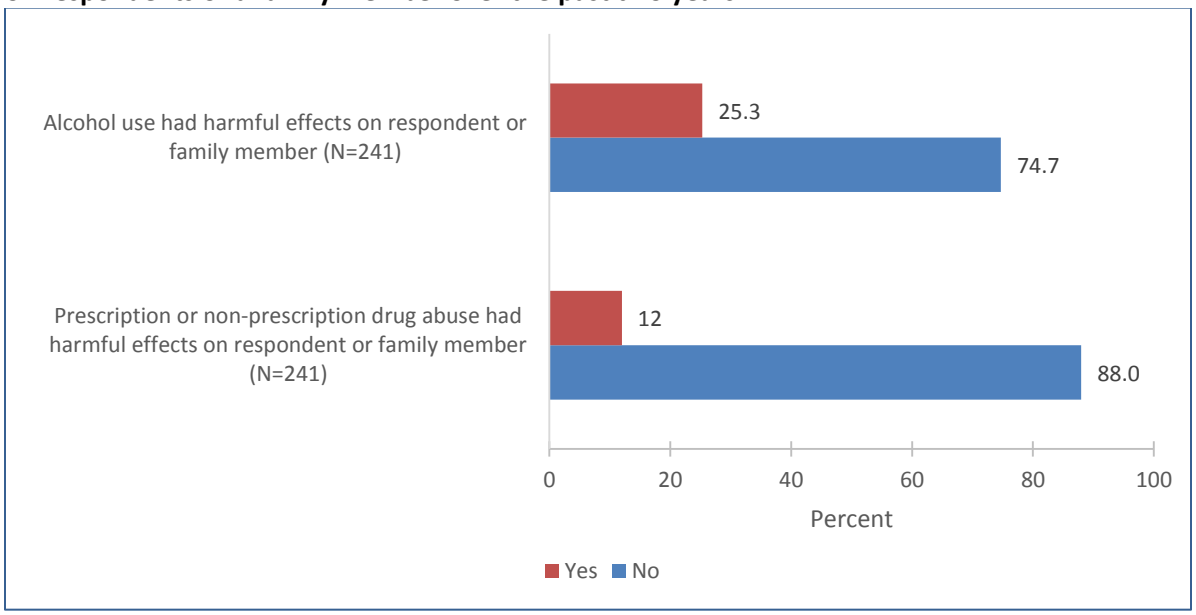
Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse



Only 5.1% of respondents reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking. Overall, 25.3% of respondents report alcohol use has had harmful effects on themselves or a family member over the past two years.

Other forms of substance abuse include the use of prescription or non-prescription drugs. Less than 1% of respondents in the area reported having had a problem with prescription or non-prescription drug abuse. However, 12% of respondents said prescription or non-prescription drug abuse has had harmful effects on themselves or a family member over the last two years.

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



Demographics

<u>Total Population</u> – 2010 U.S. Census Bureau

- **Clay County: 13,864**
- **Union County: 14,399**

	Number	Percent	Males #	Male Percent	Females #	Female Percent
<5 years	**Clay:** 725 **Union:** 978	**Clay:** 5.2 **Union:** 6.8	**Clay:** 372 **Union:** 505	**Clay:** 2.7 **Union:** 3.5	**Clay:** 353 **Union:** 473	**Clay:** 2.5 **Union:** 3.3
5-9	**Clay:** 693 **Union:** 1051	**Clay:** 5.0 **Union:** 7.3	**Clay:** 352 **Union:** 509	**Clay:** 2.5 **Union:** 3.5	**Clay:** 341 **Union:** 542	**Clay:** 2.5 **Union:** 3.8
10-14	**Clay:** 624 **Union:** 1088	**Clay:** 4.5 **Union:** 7.6	**Clay:** 301 **Union:** 581	**Clay:** 2.2 **Union:** 4.0	**Clay:** 323 **Union:** 507	**Clay:** 2.3 **Union:** 3.5
15-19	**Clay:** 1633 **Union:** 940	**Clay:** 11.8 **Union:** 6.5	**Clay:** 738 **Union:** 509	**Clay:** 5.3 **Union:** 3.5	**Clay:** 895 **Union:** 431	**Clay:** 6.5 **Union:** 3.0
20-24	**Clay:** 3264 **Union:** 553	**Clay:** 23.5 **Union:** 3.8	**Clay:** 1535 **Union:** 271	**Clay:** 11.1 **Union:** 1.9	**Clay:** 1729 **Union:** 282	**Clay:** 12.5 **Union:** 2.0
25-29	**Clay:** 1064 **Union:** 809	**Clay:** 7.7 **Union:** 5.6	**Clay:** 570 **Union:** 396	**Clay:** 4.1 **Union:** 2.8	**Clay:** 494 **Union:** 413	**Clay:** 3.6 **Union:** 2.9
30-34	**Clay:** 684 **Union:** 840	**Clay:** 4.9 **Union:** 5.8	**Clay:** 355 **Union:** 398	**Clay:** 2.6 **Union:** 2.8	**Clay:** 329 **Union:** 442	**Clay:** 2.4 **Union:** 3.1
35-39	**Clay:** 547 **Union:** 890	**Clay:** 3.9 **Union:** 6.2	**Clay:** 286 **Union:** 442	**Clay:** 2.1 **Union:** 3.1	**Clay:** 261 **Union:** 448	**Clay:** 1.9 **Union:** 3.1
40-44	**Clay:** 610 **Union**: 1012	**Clay:** 4.4 **Union:** 7.0	**Clay:** 299 **Union:** 523	**Clay:** 2.2 **Union:** 3.6	**Clay:** 311 **Union:** 489	**Clay:** 2.2 **Union:** 3.4
45-49	**Clay:** 668 **Union:** 1107	**Clay:** 4.8 **Union:** 7.7	**Clay:** 316 **Union:** 566	**Clay:** 2.3 **Union:** 3.9	**Clay:** 352 **Union:** 541	**Clay:** 2.5 **Union:** 3.8
50-54	**Clay:** 676 **Union:** 1107	**Clay:** 4.9 **Union:** 7.7	**Clay:** 339 **Union:** 559	**Clay:** 2.4 **Union:** 3.9	**Clay:** 337 **Union:** 548	**Clay:** 2.4 **Union:** 3.8
55-59	**Clay**: 675 **Union:** 1104	**Clay:** 4.9 **Union:** 7.7	**Clay:** 350 **Union:** 580	**Clay:** 2.5 **Union:** 4.0	**Clay:** 325 **Union:** 524	**Clay:** 2.3 **Union:** 3.6
60-64	**Clay:** 580 **Union:** 898	**Clay:** 4.2 **Union:** 6.2	**Clay:** 309 **Union:** 453	**Clay:** 2.2 **Union:** 3.1	**Clay:** 271 **Union:** 445	**Clay:** 2.0 **Union:** 3.1
65-69	**Clay:** 410 **Union:** 606	**Clay:** 3.0 **Union:** 4.2	**Clay:** 215 **Union:** 303	**Clay:** 1.6 **Union:** 2.1	**Clay:** 195 **Union:** 303	**Clay:** 1.4 **Union:** 2.1
70-74	**Clay:** 302 **Union:** 424	**Clay:** 2.2 **Union:** 2.9	**Clay:** 136 **Union:** 201	**Clay:** 1.0 **Union:** 1.4	**Clay:** 166 **Union:** 223	**Clay:** 1.2 **Union:** 1.5
75-79	**Clay:** 251 **Union:** 374	**Clay:** 1.8 **Union:** 2.6	**Clay:** 103 **Union:** 166	**Clay:** 0.7 **Union:** 1.2	**Clay:** 148 **Union:** 208	**Clay:** 1.1 **Union:** 1.4
80-84	**Clay:** 194 **Union:** 343	**Clay:** 1.4 **Union:** 2.4	**Clay:** 82 **Union:** 145	**Clay:** 0.6 **Union:** 1.0	**Clay:** 112 **Union:** 198	**Clay:** 0.8 **Union:** 1.4
85 and over	**Clay:** 264 **Union:** 275	**Clay:** 1.9 **Union:** 1.9	**Clay:** 82 **Union:** 111	**Clay:** 0.6 **Union:** 0.8	**Clay:** 182 **Union:** 164	**Clay:** 1.3 **Union:** 1.1
Females	**Clay:** 7237 **Union:** 7185	**Clay:** 52.2 **Union:** 49.9	**Males**	**Clay:** 47.8 **Union:** 50.1	**Clay:** 6627 **Union:**7218	
Median age	**Clay:** 25 **Union:** 40.2	**SD:** 36				

Population by Race

	Clay	Percent	Union	Percent
White	12,422	89.6	13,751	95.5
Black or African American	235	1.7	101	0.7
American Indian or Alaska Native	499	3.6	86	0.6
Asian	291	2.1	129	0.9
Native Hawaiian or other Pacific Islander	0	0	14	0.1
Hispanic or Latino	333	2.4	302	2.1

The per capita personal income in Clay County, SD is $17,454, and in Union County is $37,326. Those living below the poverty level are 37% in Clay County, 6.3% in Union County, and the unemployment rate in Clay County is 3.3% and in Union County is 3.4%.

Health Needs and Community Resources Identified

One of the requirements for a community health needs assessment is to identify the resources that are available in the community to address unmet needs. Asset mapping was conducted 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 were available in the community to address the needs.

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

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 includes identified needs from the following:

- Identified needs from 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 is shown in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Economics
- Aging Population
- Children and Youth
- Safety
- Mental Health
- 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 with 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 Appendix.

Members of the collaborative determined that Mental Health and Physical Health are the top unmet needs in the community.

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

- Mental Health
- Physical Health

Addressing the Needs
Sanford Vermillion Medical Center

Identified Concerns	How Sanford Vermillion is Addressing the Needs
Economics • Availability of affordable housing	• Bliss point addition of lots/new homes; Mickelson Avenue lots available • New apartment developments throughout Vermillion • Referral to Vermillion Housing & Development Commission (HUD) • Congregate Care/Senior Living apartments at Dakota Gardens • Sanford Vermillion Care Center – nursing home
Aging • Cost of long term care • Availability of memory care	• Referral to state legislatures • 12-bed dementia locked unit at Sanford Vermillion Care Center (SVCC) & 54 general 54 LTC beds • Sanford Arts & Music/Memory Program at SVCC • Alzheimer's Support Group • Requested Assisted Living Feasibility Study & Community Forum
Children and Youth • Bullying	• Referral to Vermillion School Boards • SVMC staff volunteer at schools through Junior Achievement • Sanford *fit* program for kids at schools
Safety • Presence of street drugs and alcohol in the community • Child abuse and neglect	• DARE program in Vermillion schools • SE CASA • Community education/involvement – seeking resources/referrals • Law enforcement
Health Care • Access to affordable health insurance • Cost of affordable vision insurance • Access to affordable health care • Cost of affordable dental insurance coverage	• Referral to state legislatures • Sanford Health Plan • Sanford Vermillion supports SD expansion of Medicaid program to under- and uninsured • SVMC/SVC accepts most insurance plans & participates in Medicaid/Medicare program • SVMC/SVC financial assistance program for self-pay and under insured • SVMC provides 250+ employees with competitive benefit package - health/vision/dental coverage • SVMC free/reduced cost screenings at health fairs, etc. • Direct Cost Labs
Physical Health, Poor Nutrition and Eating Habits • Inactivity and lack of exercise • Obesity ○ 59.1% of respondents report they are overweight or obese Only 38.4% report	• Welcome Table • Vermillion Food Pantry • Sanford *fit* program for kids • Sanford *Profile* outreach weight loss program at SVMC • City expanded bike path • USD Wellness Center; Anytime Fitness • Sanford Great Strides Program •

Identified Concerns	How Sanford Vermillion is Addressing the Needs
having 3 or more vegetables/day ○ Only 25.2% report having 3 or more fruits/day ○ 50% report moderate exercise at least 3x/week ○ High Cholesterol ○ Hypertension	• Sanford weight lifting/exercise equipment donation to school district • SCV Health Coaching – diabetes, hypertension, asthma • SVMC & HyVee dietitians services • Vermillion backpack program • Healthy Cooking classes by dietitian • Partnering with community for brown bag lunches on nutritional topics • Partner with Vermillion Recreation on sponsoring community activities • Sanford Vermillion annual Health Fair • Sanford free blood pressure screenings • Relay for Life participation/Sanford Vermillion team
Mental Health • Underage drug use and abuse • Underage drinking • Stress • Alcohol use and abuse / binge drinking • Drug use and abuse	• SVMC Psychiatry Outreach program with CNP on-site once per month • SVMC Psychiatry telemedicine program • SVMC part time Mental Health counselor • SE CASA • Community MH Counselors – Deb Gapp; Lewis & Clark Behavioral Health • USD Counseling Department & Education department programs • DARE program in schools • AA programs/meetings in community • SVMC representative on USD Alcohol & Suicide Prevention Committee

2016-2019 Implementation Strategies

Implementation Strategies

Priority 1: Mental Health

Depression is a common but serious illness that can interferes with daily life. Many people with a depressive illness never seek treatment. But the majority, even those with the most severe depression, can get better with treatment. County Health Rankings for Clay County indicates that 11% of the residents have fair or poor mental health.

Sanford has prioritized depression as a top priority and has set strategy to perform assessments for depression and to improve PHQ-9 scores for patients who are a diagnosed with depression. The goal is to improve PHQ-9 scores for patients with depression. The measurable outcome is the percentage of patients with major depression or dysthymia and an initial PHQ-9 score greater than nine whose six-month PHQ-9 score is less than five.

Sanford Vermillion is also evaluating several opportunities to increase the availability of mental health services in the Vermillion community.

Priority 2: Physical Health

Poor nutrition and eating habits can lead to obesity and many physical health problems for the community such as diabetes, high cholesterol and hypertension. Sanford Vermillion through its health coach program, providers, dietitian and Wellness programs will be implementing several programs and community education sessions with the goal of improving the physical health of the Vermillion community.

Community Health Needs Assessment

Implementation Strategy for Vermillion Medical Center

FY 2017-2019 Action Plan

Priority 1: Mental Health

Projected Impact: Increased opportunities for adults and pediatrics to obtain mental health services in the Vermillion community

Goal 1: Increase Mental Health Services in the Vermillion community

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Increase SVMC mental health counselor status to 1 FTE	Number of patients seen	Mental Health Counselor	SVMC	
Partner with USD on paying for a prevention counselor position	Number of patients seen		SVMC	University of South Dakota
Education sessions held at the high school level; i.e. DARE	Reduction in underage citations		SVMC	Vermillion School District Resource Officer- Sheriff
Add CNP to psychiatry outreach services at Sanford Vermillion at least once per month	Increase number of psychiatry outpatient visits	SC Psychiatry	SVMC	
Offer psychiatry telemedicine services at Sanford Vermillion	Increase the number of psychiatry outpatient visits and consults	SC Psychiatry	SVMC	

Priority 2: Physical Health

Projected Impact: Reduction in obesity, hypertension and high cholesterol and overall improvement in physical health condition

Goal 1: Improve community's nutrition, physical health and reduce obesity in community

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Note any community partnerships and collaborations (if applicable)
Provide monthly cooking classes to our diabetic registry patients	Number of attendees; healthy lifestyle changes	Dietician	SVMC	Aramark
Safe bike to work/school program	Number of children biking to work; number of employees	Athletic Trainer	SVMC	Vermillion School District; Vermillion Parks & Rec
Fund Sanford *fit* kids program with local schools	Increased activities for youth and reduction in pediatric obesity	Fund *fit* kids Program Coordinator	SVMC	Vermillion School District
Increase fruits & veggies through Bountiful Basket or co-ops	Number of members in co-ops	Dietitian	SVMC	Vermillion Chamber; Farmers Market
Walk to work program for Sanford Vermillion employees	Number of in-town employees walking to work	Wellness Committee	SVMC	
Children's healthy cooking classes with parents	Number of attendees	Wellness Committee	SVMC	HyVee United Way
Provide Sanford Health Fair with free and reduced screenings; healthy education	Number of attendees	Wellness Committee	SVMC	USD Medical School
Add Sanford *Profile* outreach services at least monthly at Sanford Vermillion	Number of Sanford *Profile* clients in the Vermillion community	SC staff	SVMC	Sanford *Profile*

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 for two priority areas:

- Mental Health
- Specialty Outreach Services

2013 Community Health Needs Assessment
Sanford Vermillion Implementation Strategy

Implementation Strategy: Mental Health

- Sanford One Mind/One Care
- Utilize internal resources available through SVMC Mental Health Counselor
- Look at expansion of Employee Assistance Programs already available in community
- Collaborate with other mental health providers in community to look at expansion options
- Utilize current clinic Health Coach and expansion of telehealth Psychiatry/Psychologist services to expand mental health services to patients

Implementation Strategy: Specialty Outreach Services

- Continue to work with Sanford Health and other outreach providers to determine the viability of additional outreach services for Sanford Vermillion
- Continue development of telehealth services and capabilities to provide outreach services to patients at Sanford Vermillion
- The 2013 strategies have served a broad reach across our community and region. The impact has been positive and the work will continue into the future through new or continued programming and services.

Impact of the Strategy to Address Mental Health

SVMC mental health counselor is scheduled with patients to capacity.

We were able to add a Psychiatry clinic outreach monthly service provided by a CNP who sees patients of all ages at Sanford Clinic Vermillion.

We are set up to provide Psychiatrist telehealth visits at Sanford Vermillion.

Through these strategies we have significantly increased the number of mental health patients seen at Sanford Vermillion.

Impact of the Strategy to Address Specialty Outreach Services

By working with Sanford Health and the surrounding communities of Vermillion, Sanford Vermillion has been able to provide the following additional specialty outreach services to the Vermillion community:

- Urology
- Psychiatry
- Nephrology
- Dermatology
- ENT
- Vascular Screens
- Pediatric Rehab Medicine

Community Feedback from the 2013 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on our 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

Vermillion Asset Mapping

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
Economics	• Availability of housing 3.59	An area of concern		Vermillion Housing Authority 605-677-7192 / 605-677-7191 CCCS of LSS – SD (housing counseling agency) - 605-330-2700 Low income apartments: • Applewood Court Apts. 605-352-8536 • Cressman Court Apts. – 605-348-5656 • Oakwood Apts. 605-624-9557 • Walnut St. Apts. – 605-624-4419 Apartments: • University Rentals 605-624-8001 • Clark's Landing 605-209-7122 • Dakota View 605-624-5642 Mobile homes: • Mobile Home Renting 605-610-0006 • Westgate Mobile Homes • 605-624-3625 Real estate agencies: • Premier Real Estate 605-624-2646 • Dakota Realty 605-624-4476 • Maloney Real Estate 605-624-3333	X

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
Aging population	• Cost of LTC 3.99 • Availability of memory care 3.55 • Availability of LTC 3.52			SD Department of Social Services 605-367-5444 Sanford Dakota Gardens 605-677-3500 SESDAC (group home) 605-624-2952 / 605-624-0061 (2 locations) Home Care: • Heartland Home Care 605-624-5900 • Sanford Visiting Nurses Assn. 605-624-1912 Sanford HME – 605-624-4955	X
Children and Youth	• Bullying 3.69		• 16% have 3 or more ACEs • 11.8% have 5 or more ACEs	Mental Health Counselors: • Michelle Hinseth 605-677-3500 • Gapp Counseling Service 605-677-9052 • Lewis & Clark Behavioral Health 605-624-9148 • Alcohol & Drug Counseling Service 605-624-9148 • Dakota Oak Counseling 605-759-8359 • Sioux Falls Psychological Services 605-334-2696 • Great Plains Psychological Services 605-323-2345	X
Crime/Safety	• Presence of street drugs, prescription drugs and alcohol 3.64 • Child abuse and neglect 3.50			Vermillion Police – 605-677-7070 Sheriff's office – 605-677-7100 SVMC ER – 605-677-3500	X

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
				Children's Inn (services for family violence, child abuse) - 605-338-0116 SE CASA Substance Abuse resources: • Gapp Counseling Service 605-677-9052 • Michelle Hinseth 605-677-3500 • Lewis & Clark Behavioral Health 605-624-9148 • Alcohol & Drug Counseling Service 605-624-9148 • Glory Home 605-332-3273 • Keystone Outreach 605-413-1493 • Sioux Falls VAMC 605-336-3230 • Tallgrass Recovery 605-368-5559 • Bartels Counseling 605-310-0032 • Choices Recovery 605-334-1822 • Counseling Resources 605-331-2419 • Dakota Drug & Alcohol Prevention 605-331-5724 • First Step 605-361-1505 • Carroll Institute 605-336-2556 • Sioux Falls Urban Indian Health 605-339-0420 • Transitional Living Corporation 605-368-5559 • Sioux Falls Treatment Center 605-332-3236 • Arch Halfway House 605-332-6730 • Changes & Choices Recovery Center 605-332-9257 • Face it Together 605-271-9044	

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
Access to Healthcare Cost of Healthcare /	• Access to affordable health insurance 3.87 • Cost of affordable vision insurance 3.65 • Access to affordable health care 3.61 • Cost of affordable dental insurance coverage 3.61	This is an area of concern	• 87.9% have a place to go for healthcare • 77.2% have a personal doctor • 5.5% have unmet medical needs • 1.4% have unmet prescription drug needs • 42.1% have unmet mental health needs	Sanford Health Community Care Programs Medical Home Program Sanford Health Case Managers Sanford Health Parish Nurses Sanford Health Social Workers Clinics: • Sanford Vermillion – 605-677-3700 • Vermillion Medical Clinic 605-624-8643 • Olson Medical Clinic 605-624-5666 • Public Health – 605-677-6767 Summit Dental Health (has a discount dental plan) - 605-624-0070 Prescription Assistance programs: • CancerCare co-payment Assistance Foundation 866-552-6729 • Freedrugcard.us • Rxfreecard.com • Medsavercard.com • Yourrxcard.com • Medicationdiscountcard.com • Needymeds.org/ drugcard • Caprxprogram.org • Southdakotarxcard.com • Gooddaysfromcdf.org 877-968-7233	X

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
				• NORD Patient Assistance Programs 800-999-6673 • SD Partnership for Prescription Assistance 888-477-2669 • Patient Access Network (PAN) Foundation 866-316-7263 • Pfizer RX Pathways 866-776-3700 • RXhope.com **Home Care resources:** • Sanford Home Care **Mental Health resources:** • Michelle Hinseth 605-677-3500 • Southeastern Behavioral HealthCare 605-336-0503 / 605-336-0510 • Gapp Counseling Service 605-677-9052 • Lewis & Clark Behavioral Health 605-624-9148 • Alcohol & Drug Counseling Service 605-624-9148 • Dakota Oak Counseling 605-759-8359 • Sioux Falls Psychological Services 605-334-2696 • Great Plains Psychological Services 605-323-2345 **Respite Care facilities:** • SD Dept. of Human Services Respite Care Program 800-265-9684	

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?

Physical Health	• Poor nutrition and eating habits 3.68
	• Inactivity and lack of exercise 3.65
	• Obesity 3.59
	  • 59.1% of respondents report they are overweight or obese
	  • Only 38.4% report having 3 or more vegetables/day
	  • Only 25.2% report having 3 or more fruits/day
	  • 50% report moderate exercise at least 3x/week
	  • High Cholesterol
	  • Hypertension
			• 7.8% have diabetes
			• 9% have asthma
			• 28.2% have hypertension
			• 7.4% have heart disease
			• 27.6% have high cholesterol
			• 2.7% have COPD
			• 7.2% have cancer
			• 81.5% rate their health status as good or better
				Sanford Dietitian
				HyVee Dietitian
				
				Farmers Markets:
				• Vermillion Area Farmers Market 605-624-5369
				• Morse Farmers Market 605-624-2272
				• Heikes Family Farm (CSA) 605-222-3949
				
				Exercise Facilities:
				• Vermillion School System Athletic Department 605-677-7000
				• Vermillion Parks & Recreation Dept. – 605-677-7050
				• Anytime Fitness 605-624-9250
				• USD Wellness Center 605-677-8803
				
				Clinics:
				• Sanford Vermillion – 605-677-3700 Better Choices, Better Health program for chronic disease patients - offered by Sanford free of charge
				• Vermillion Medical Clinic 605-624-8643
				• Olson Medical Clinic 605-624-5666
				• Public Health – 605-677-6767
				Sanford Profile Outreach Clinic
					X

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
Mental Health/ Behavioral Health	• Underage drug use and abuse 3.89 • Underage drinking 3.86 • Stress 3.54 • Alcohol use and abuse 3.71 ○ 29.1% of respondents report binge drinking • Drug use and abuse 3.61		• 6.4% need mental health care • 2.8% have depression • 3.4%% have anxiety • 2.3% deal with PTSD • 1.4% are bipolar • 2.1% report addiction issues • 13.4% are current smokers • 35.8% abuse alcohol • 6.8% used marijuana in the past year	Mental Health resources: • Michelle Hinseth 605-677-3500 • Gapp Counseling Service 605-677-9052 • Heuermann Counseling Clinic 605-336-1974 • Catholic Family Services 605-988-3775 • LifeMarks Behavioral Health 605-334-1414 • Southeastern Behavioral HealthCare 605-336-0503 / 605-336-0510 • Lewis & Clark Behavioral Health 605-624-9148 • Alcohol & Drug Counseling Service 605-624-9148 • Dakota Oak Counseling 605-759-8359 • Sioux Falls Psychological Services 605-334-2696 • Great Plains Psychological Services 605-323-2345 PTSD resources: • VA / Vet Center 605-330-4552 • Avera Health 605-322 8000 Substance Abuse resources: • Glory Home 605-332-3273 • Keystone Outreach 605-413-1493 • Sioux Falls VAMC 605-336-3230 • Tallgrass Recovery 605-368-5559 • Bartels Counseling 605-310-0032 • Choices Recovery 605-334-1822 • Counseling Resources 605-331-2419	X

Identified concern	Non-Generalizable Survey Specific areas of concern	Community stakeholders Specific areas of concern	Secondary Data Focus on South Dakota Report	Community resources that are available to address the need	Gap ?
				• Dakota Drug & Alcohol Prevention 605-331-5724 • First Step 605-361-1505 • Carroll Institute 605-336-2556 • Sioux Falls Urban Indian Health 605-339-0420 • Transitional Living Corporation 6005-368-5559 • Sioux Falls Treatment Center 605-332-3236 • Arch Halfway House 605-332-6730 • Changes & Choices Recovery Center 605-332-9257 • Face it Together 605-271-9044 • Minnehaha Co. Detox Center 605-367-5297	

Vermillion 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 (Ebola or air pollution)
- Size of problem (e.g. # of individuals affected)

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economics • Availability of affordable housing 3.59	X		
Aging • Cost of long term care 3.99 (1) • Availability of memory care 3.55	XX	X	
Children and Youth • Bullying 3.69 (6)			
Safety • Presence of street drugs and alcohol in the community 3.64 **(9)** • Child abuse and neglect 3.50			
Health Care • Access to affordable health insurance 3.87 (3) • Cost of affordable vision insurance 3.65 (8) • Access to affordable health care 3.61 (10) • Cost of affordable dental insurance coverage 3.61 (10)	XX	XXX	XXX

Physical Health, Poor Nutrition and Eating Habits 3.68
• Inactivity and lack of exercise 3.65
• Obesity 3.59
  • 59.1% of respondents report they are overweight or obese Only 38.4% report having 3 or more vegetables/day
  • Only 25.2% report having 3 or more fruits/day
  • 50% report moderate exercise at least 3x/week
  • High Cholesterol
  • Hypertension
	XXX	XXXX	XXXXX
			#2 priority

Mental Health • Underage drug use and abuse 3.89 • Underage drinking 3.86 • Stress 3.54 • Alcohol use and abuse 3.71 • 29.1% of respondents report binge drinking • Drug use and abuse 3.61	XXXXXXXX #1 priority		

Present: Timothy J. Tracy, Sanford Vermillion CEO; Jeffrey Berens, Sanford Vermillion CNO; Mary Merrigan, Sanford Vermillion Public Relations, Julie Girard, Sanford Vermillion Quality/Risk; Cindy Benzel, Sanford Vermillion HR/Payroll, Rachel Olson, Sanford Vermillion Ancillary Services; Elizabeth Fox, Community Member/Patient Advisory Board Member; Kevin Mills, Community Member/Patient Advisory Board Member; Carrie McLeod, SH Community Health Improvement

Sanford Vermillion 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 253 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

General Health and Wellness Concerns about the Community

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

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

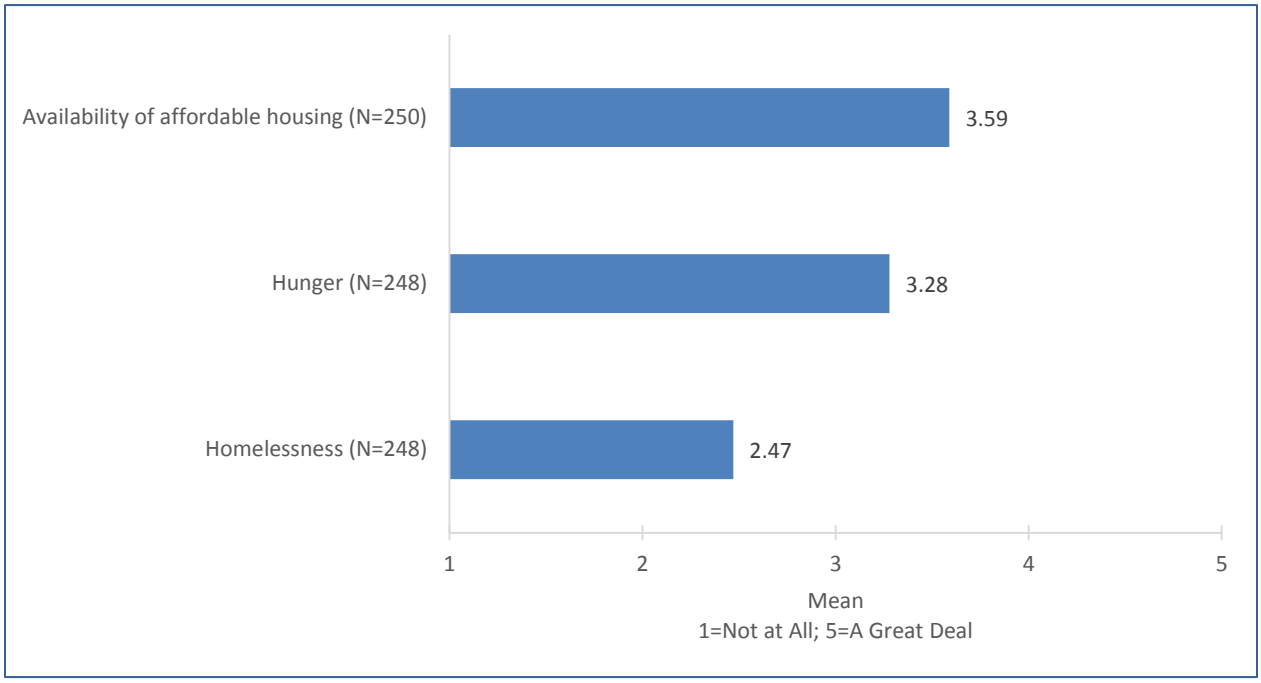


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

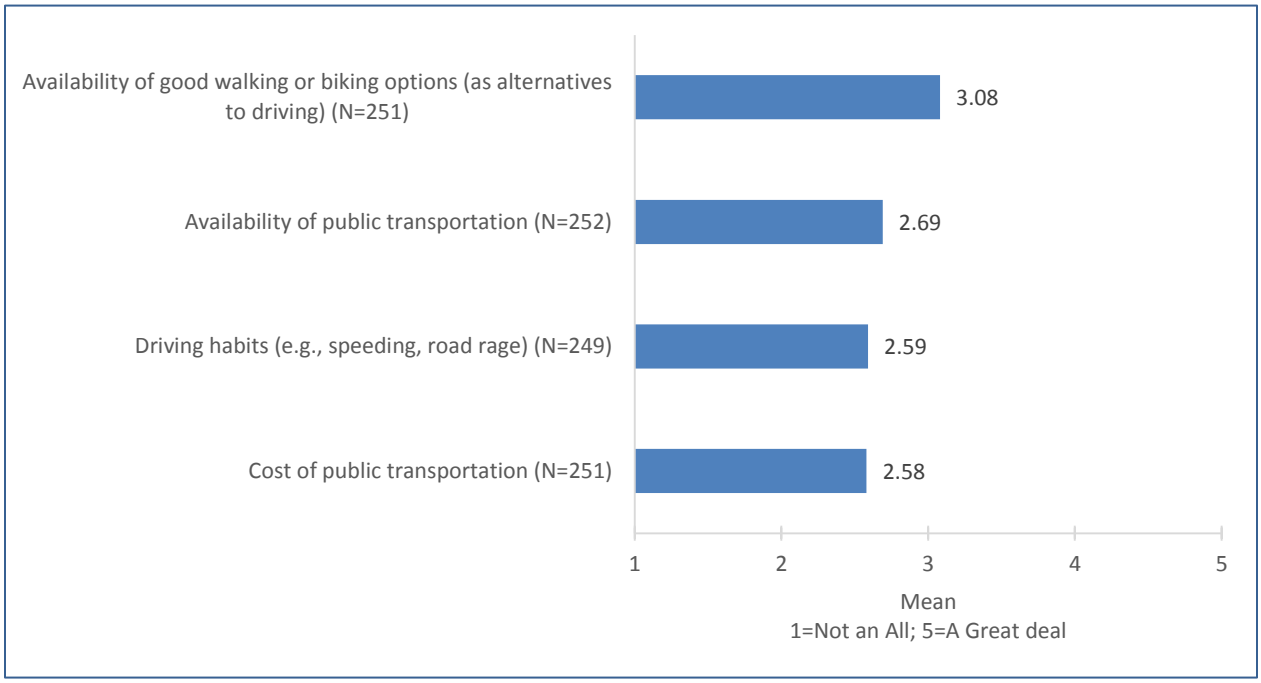


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

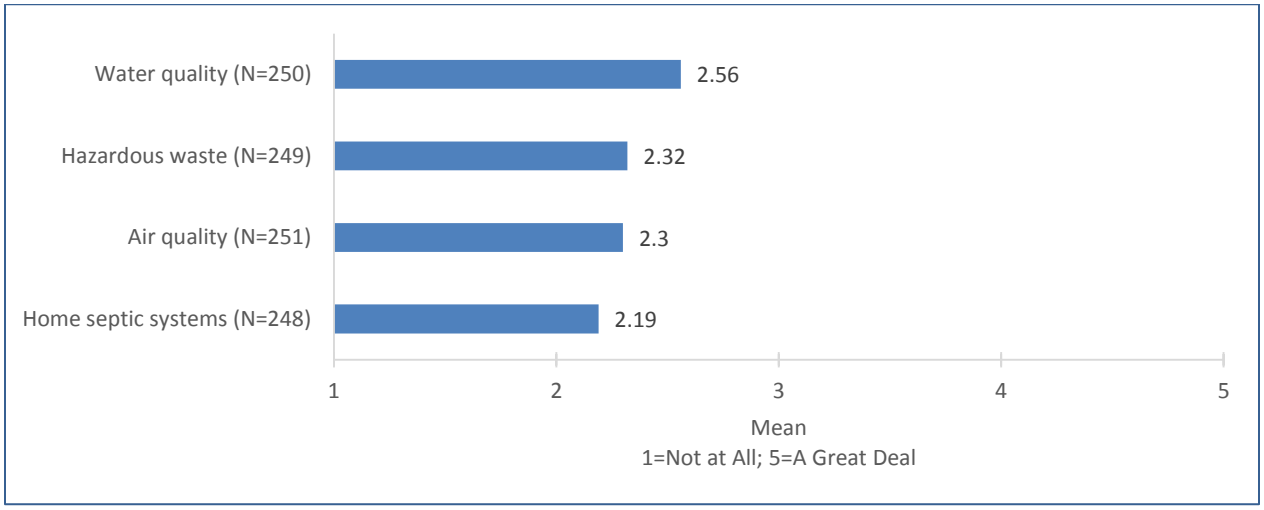


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

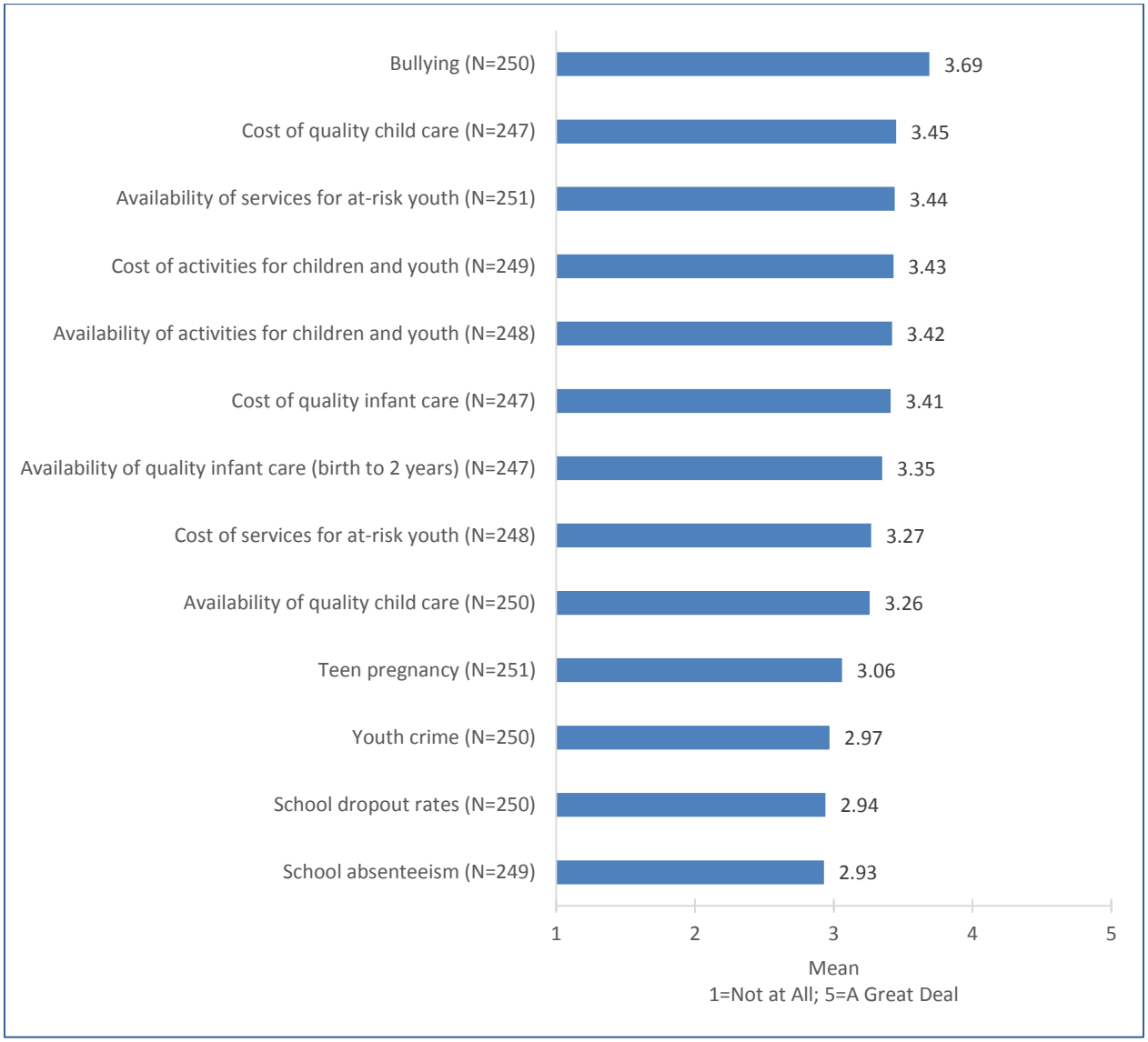


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

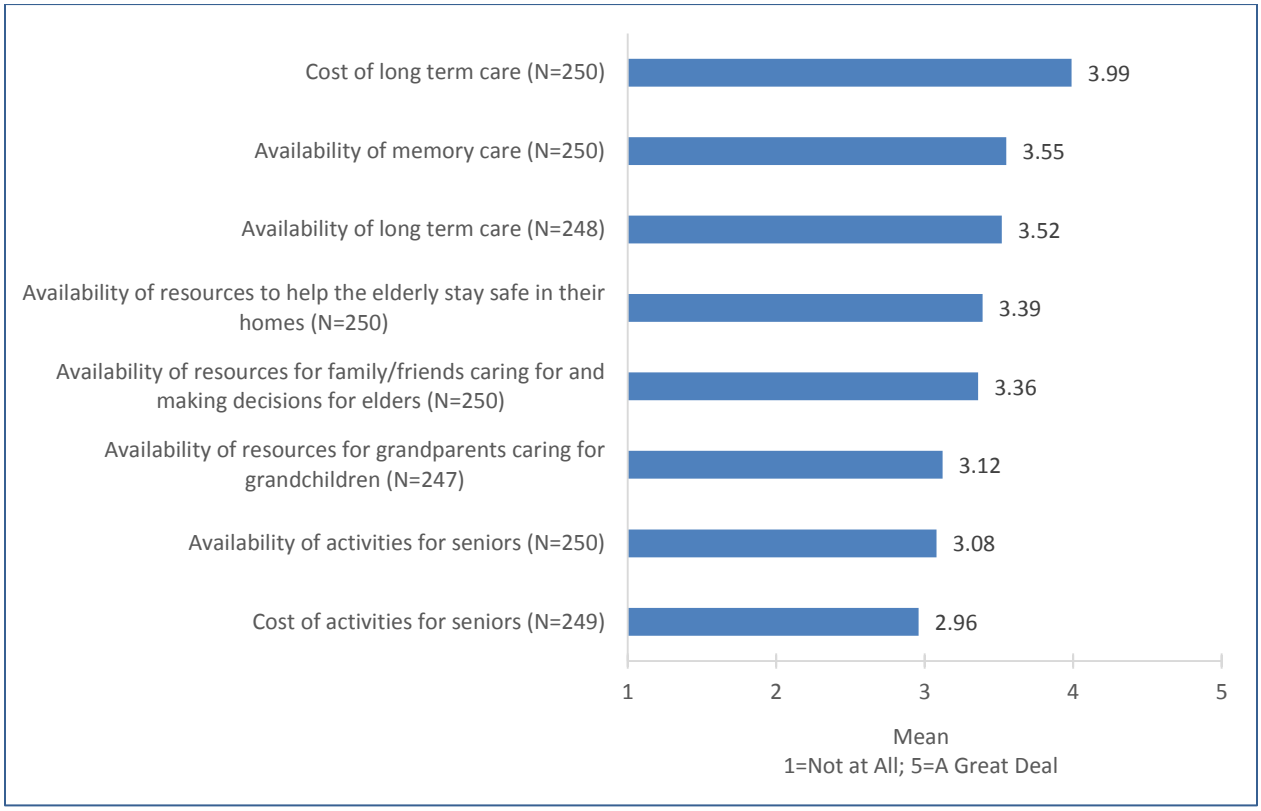


Figure 6. Level of concern with statements about the community regarding SAFETY

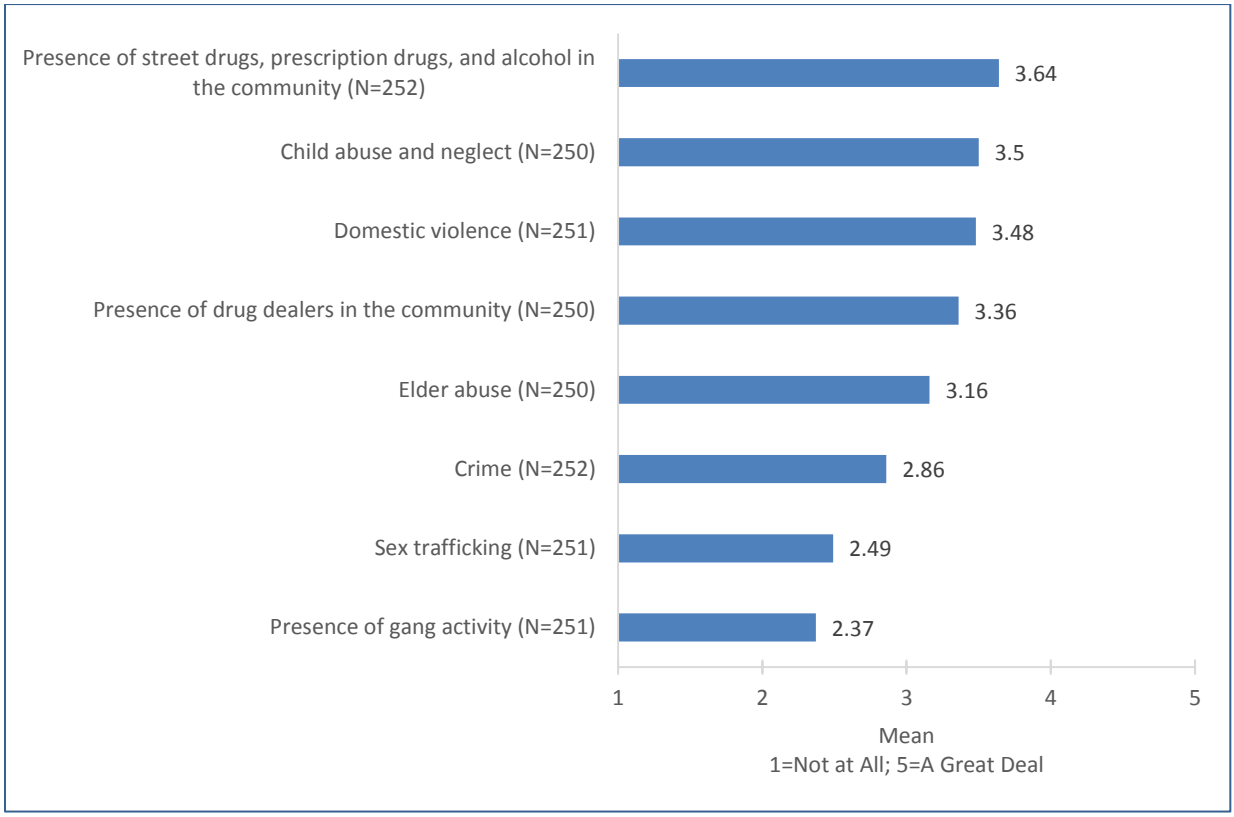


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

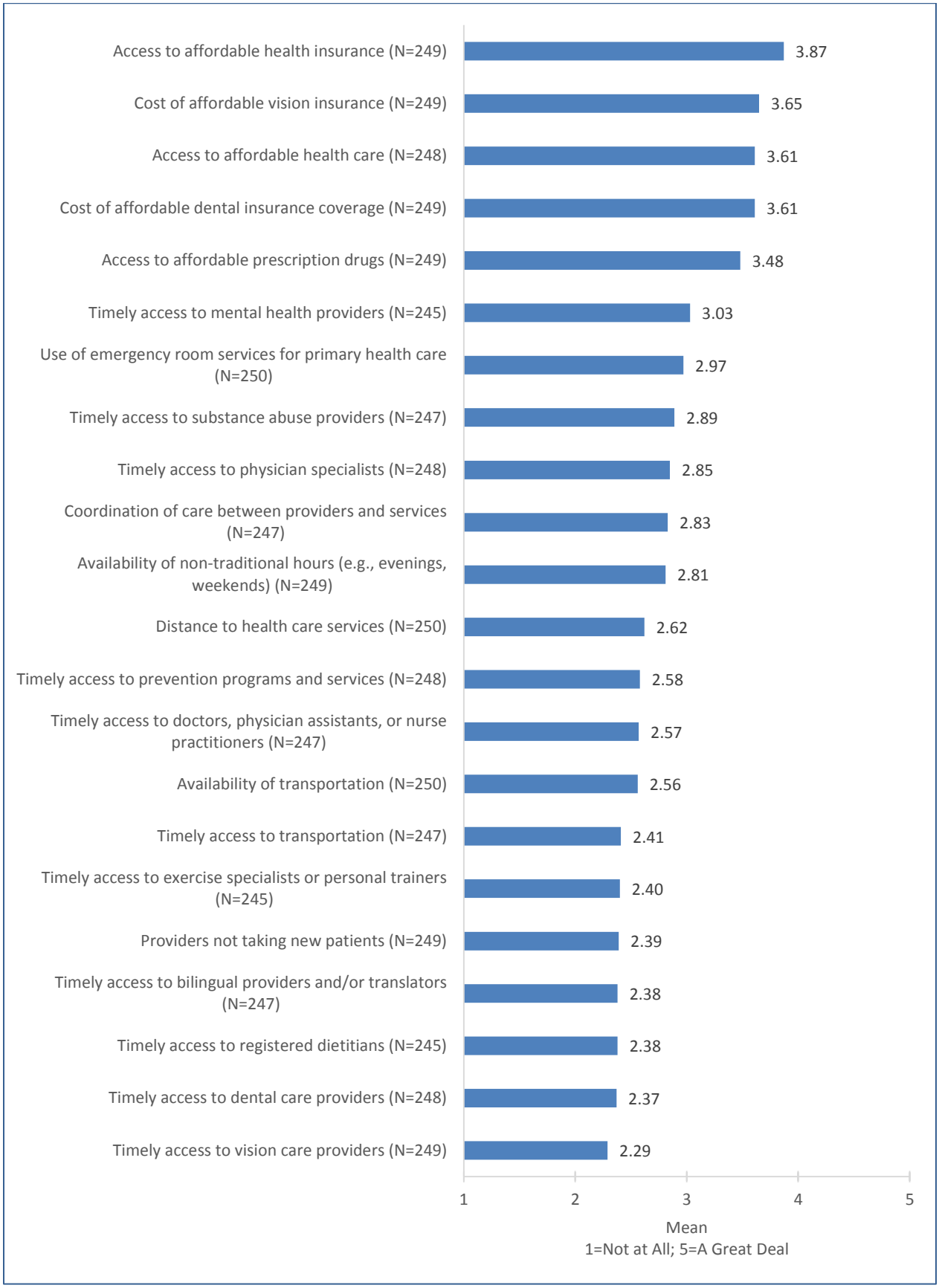


Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

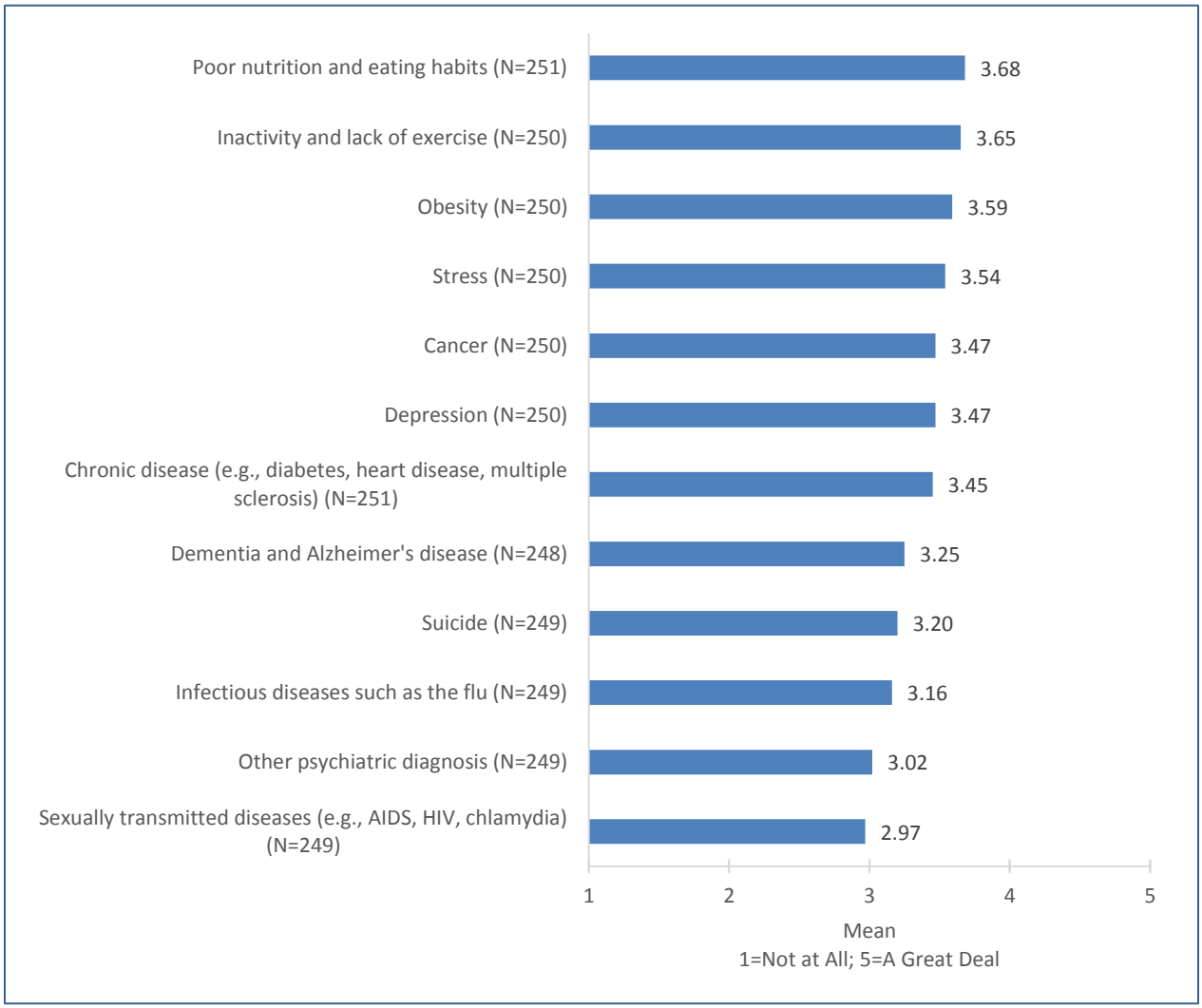
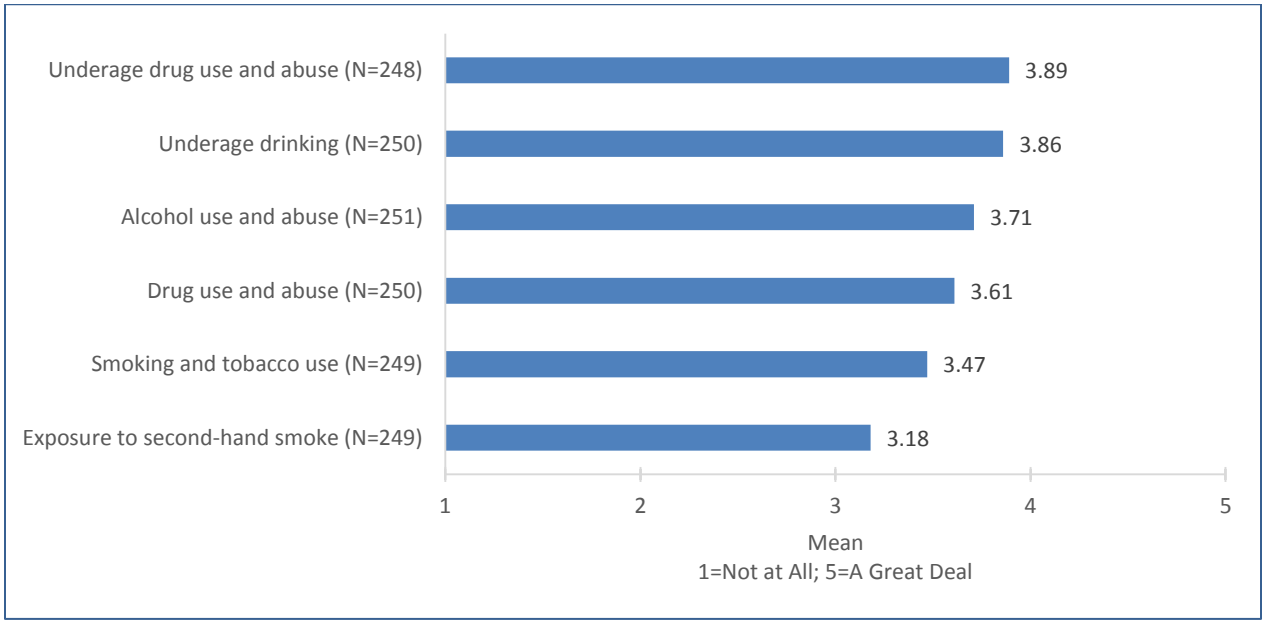
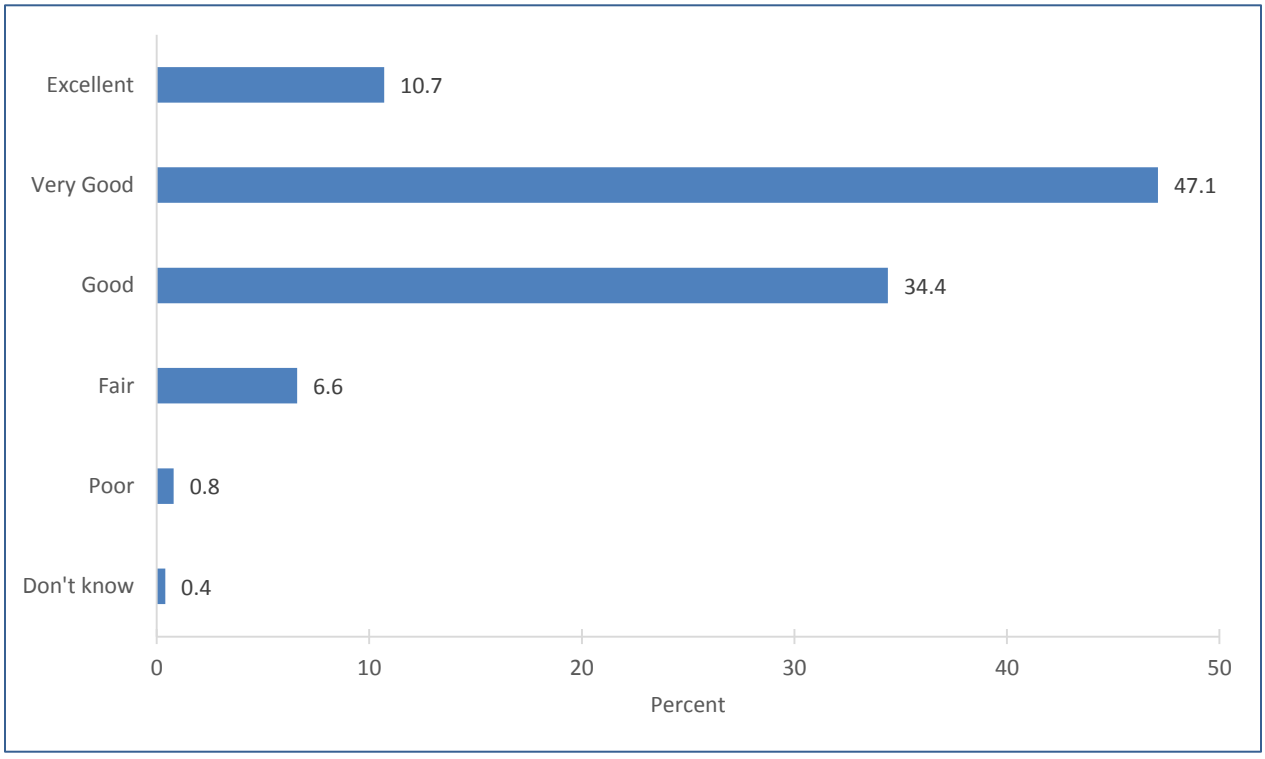


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



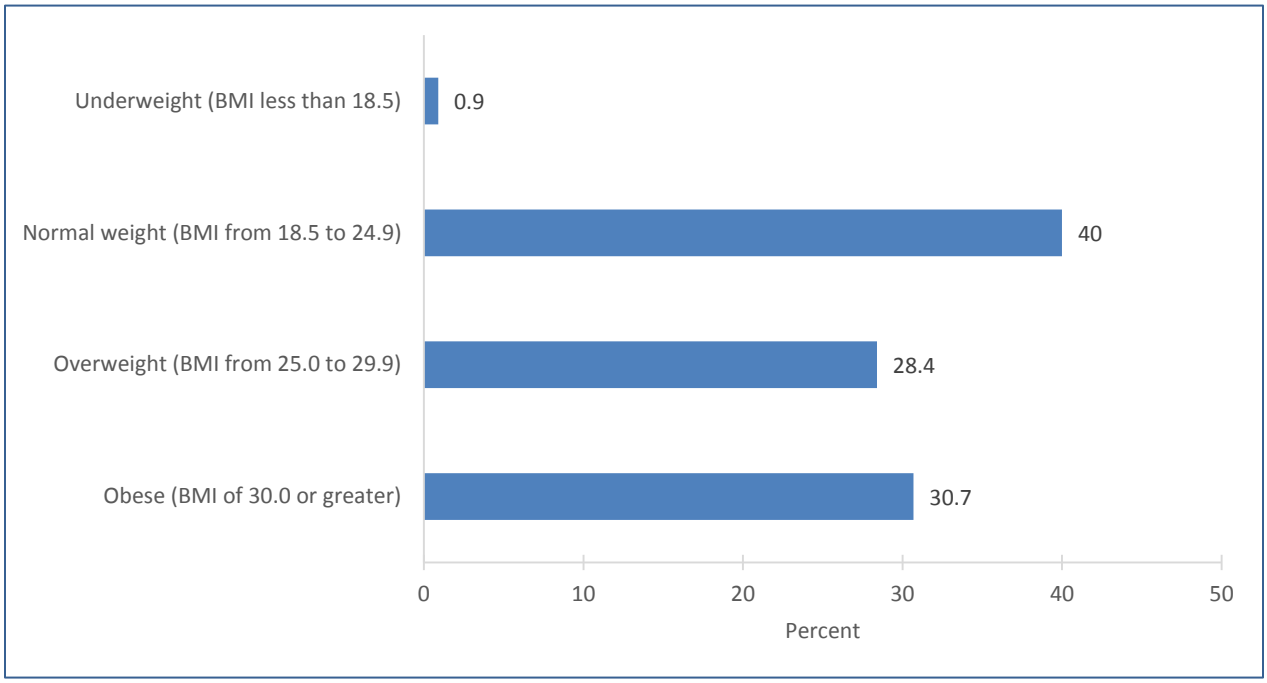
General Health

Figure 10. Respondents' rating of their health in general



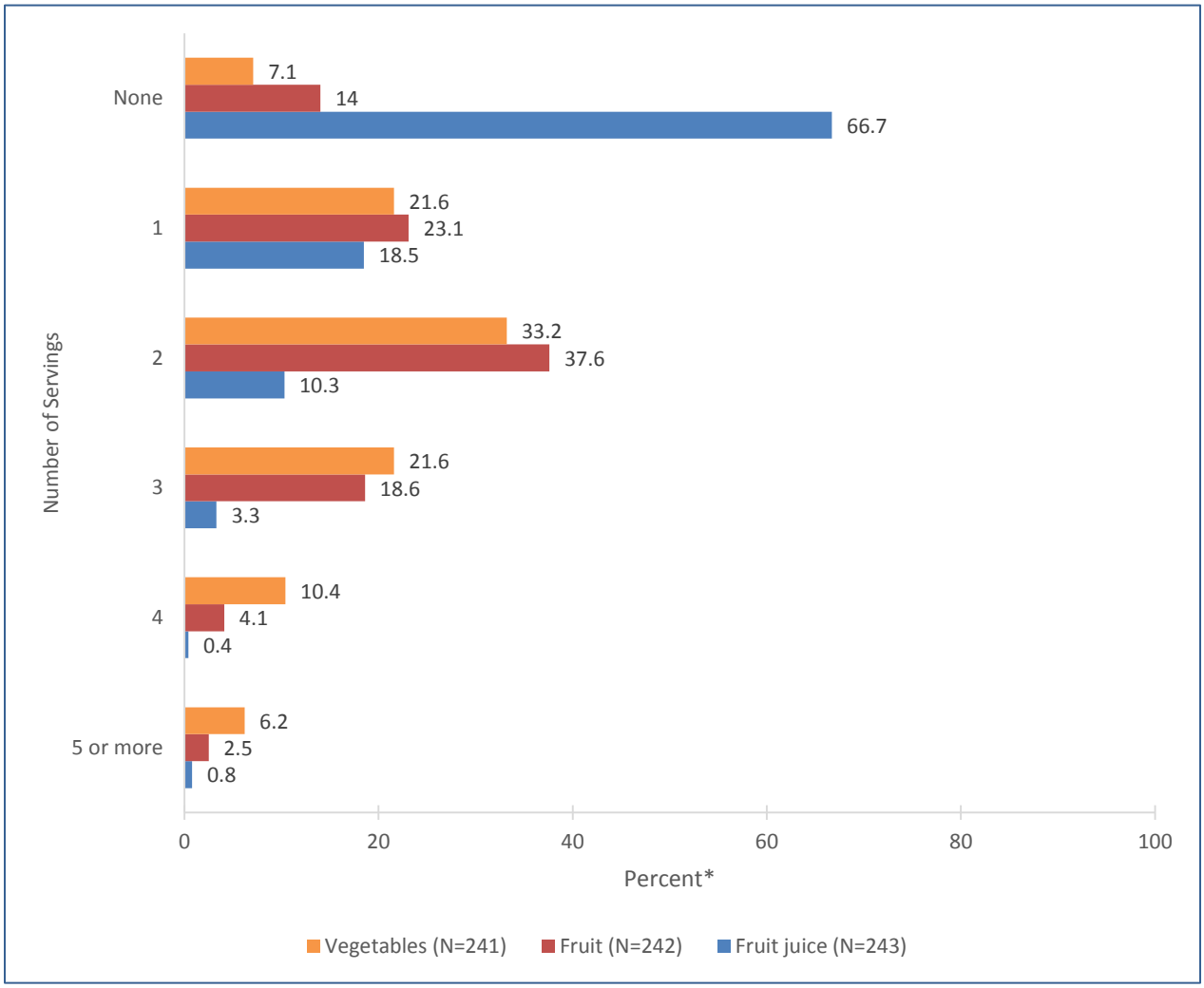
N=244

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



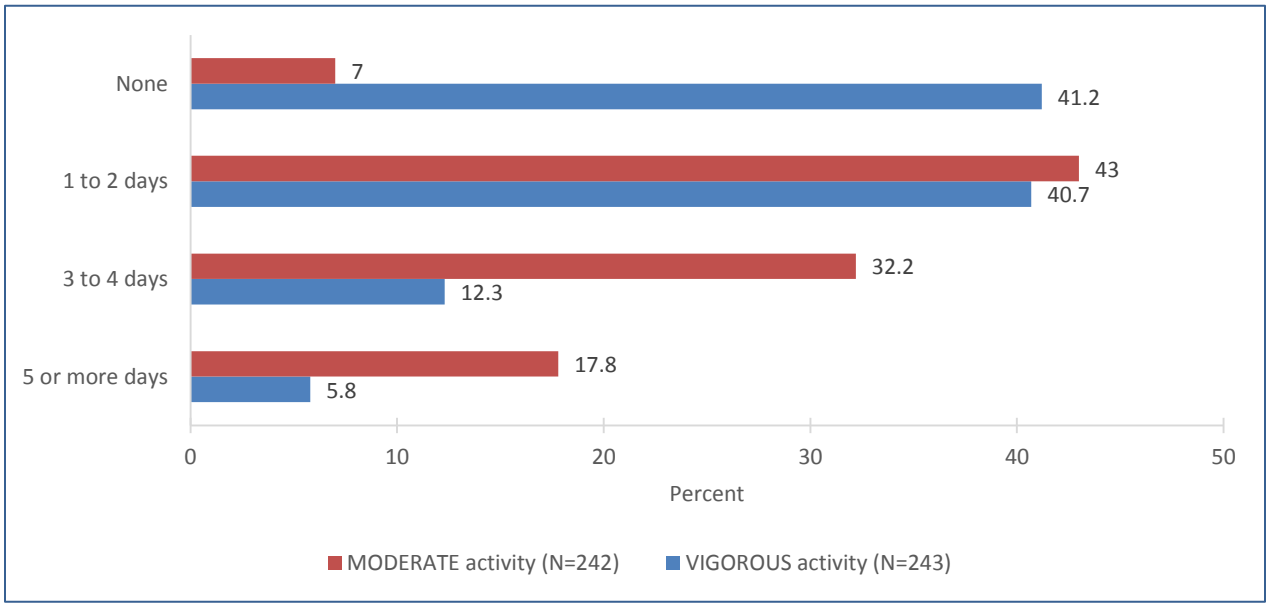
N=225 *For information about the BMI, visit the Centers for Disease Control and Prevention, *About BMI for Adults*, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/.

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



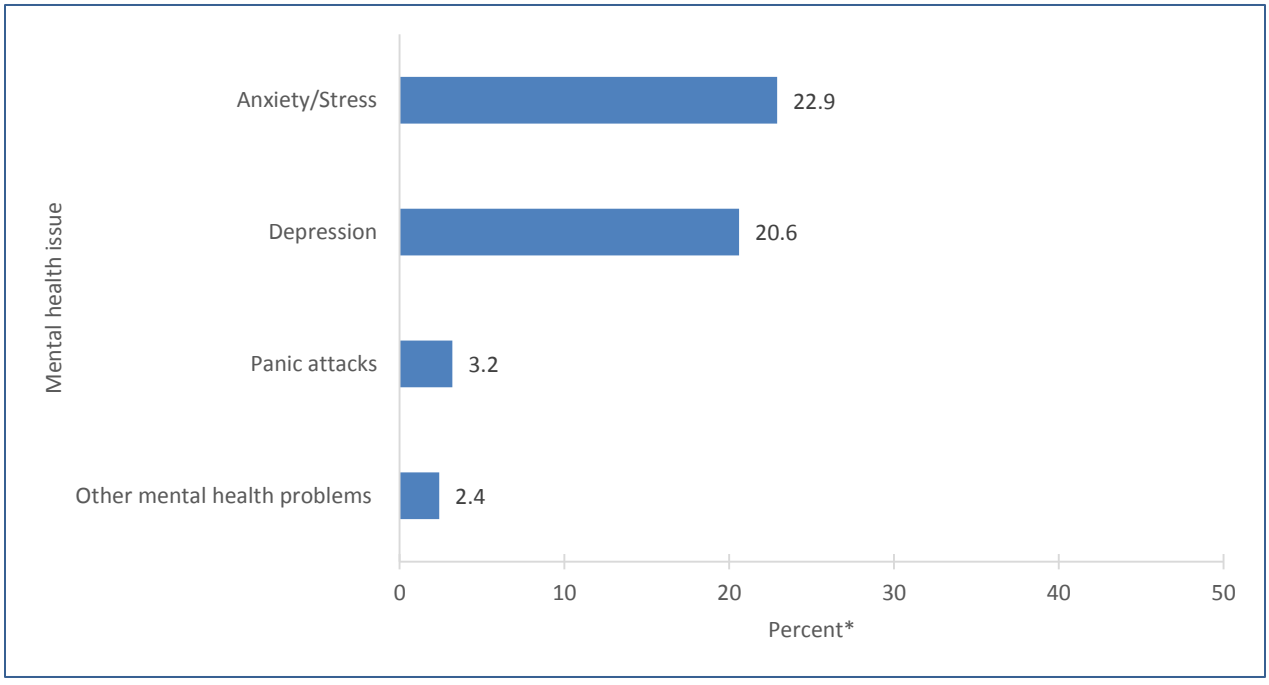
*Percentages may not total 100.0 due to rounding.

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



Mental Health

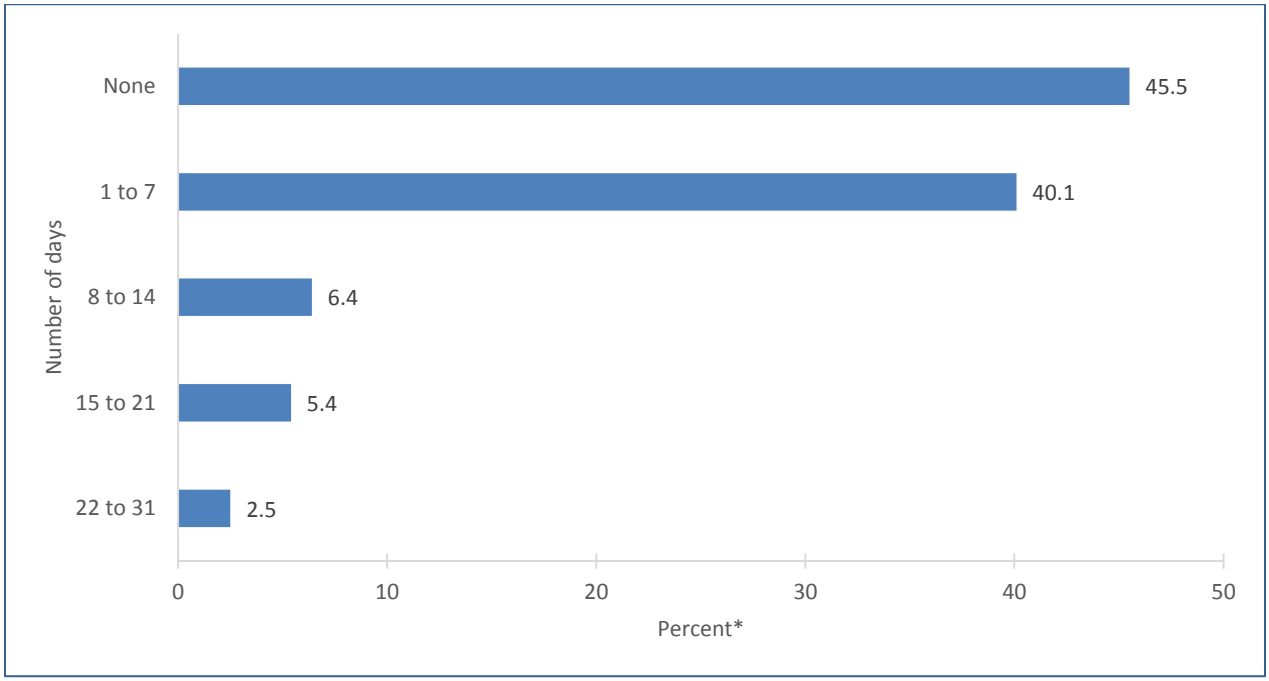
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=253

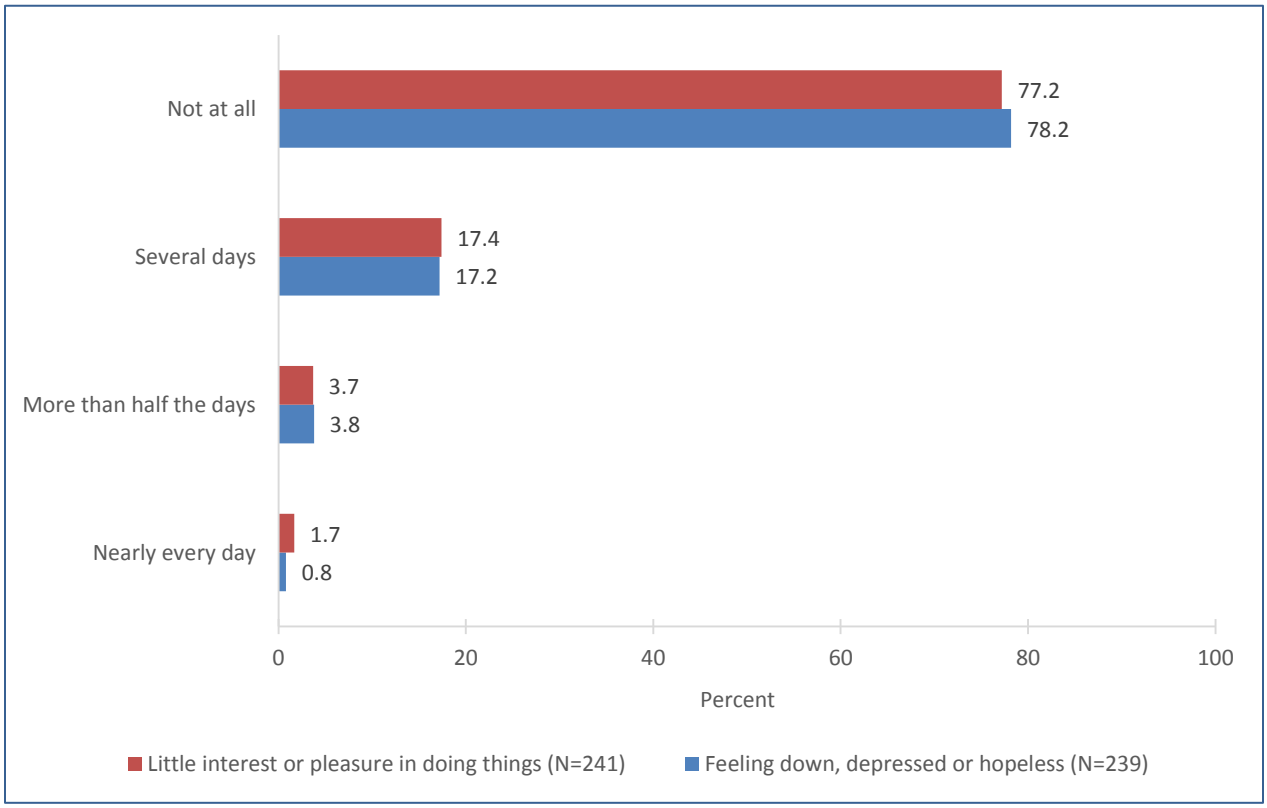
*Percentages do not total 100.0 due to multiple responses.

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



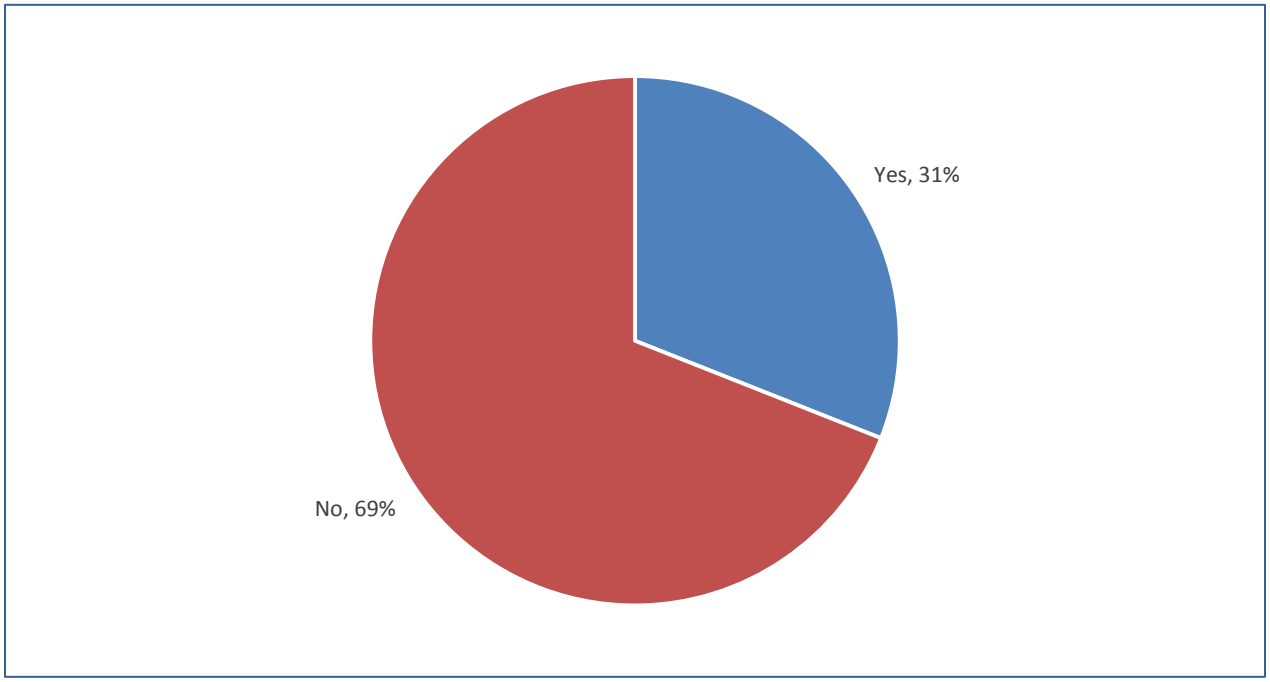
*Percentages do not total 100.0 due to rounding.

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=242

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

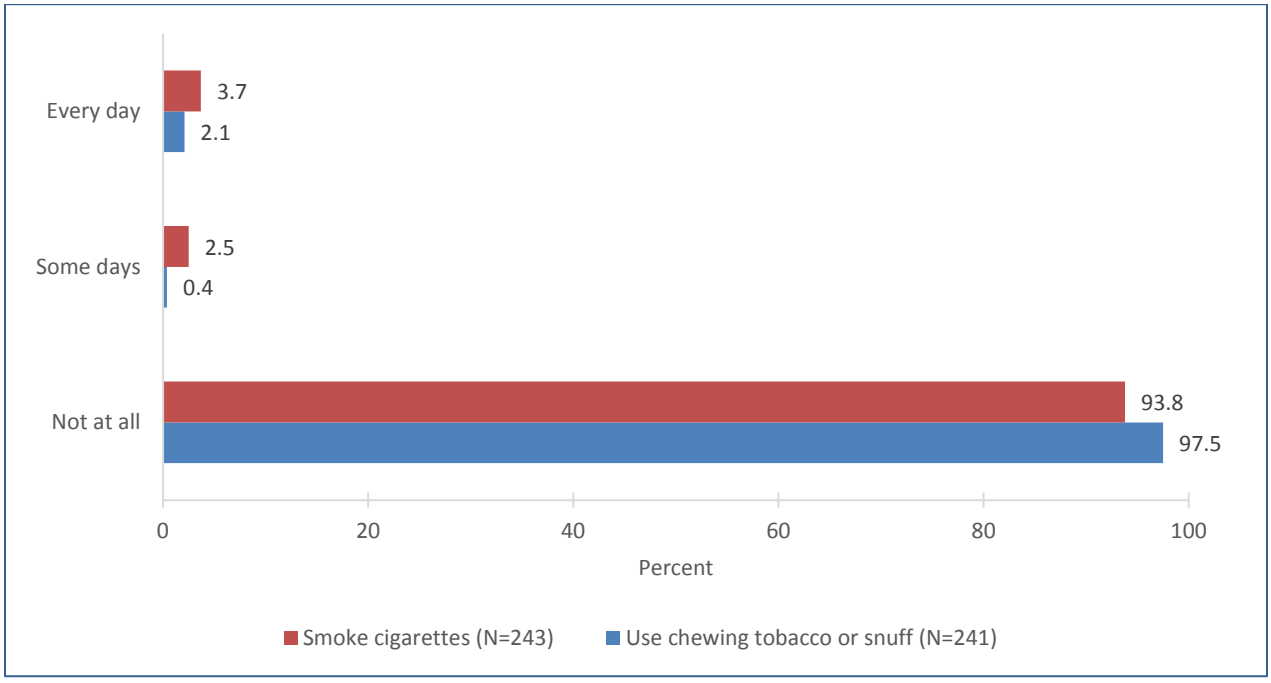
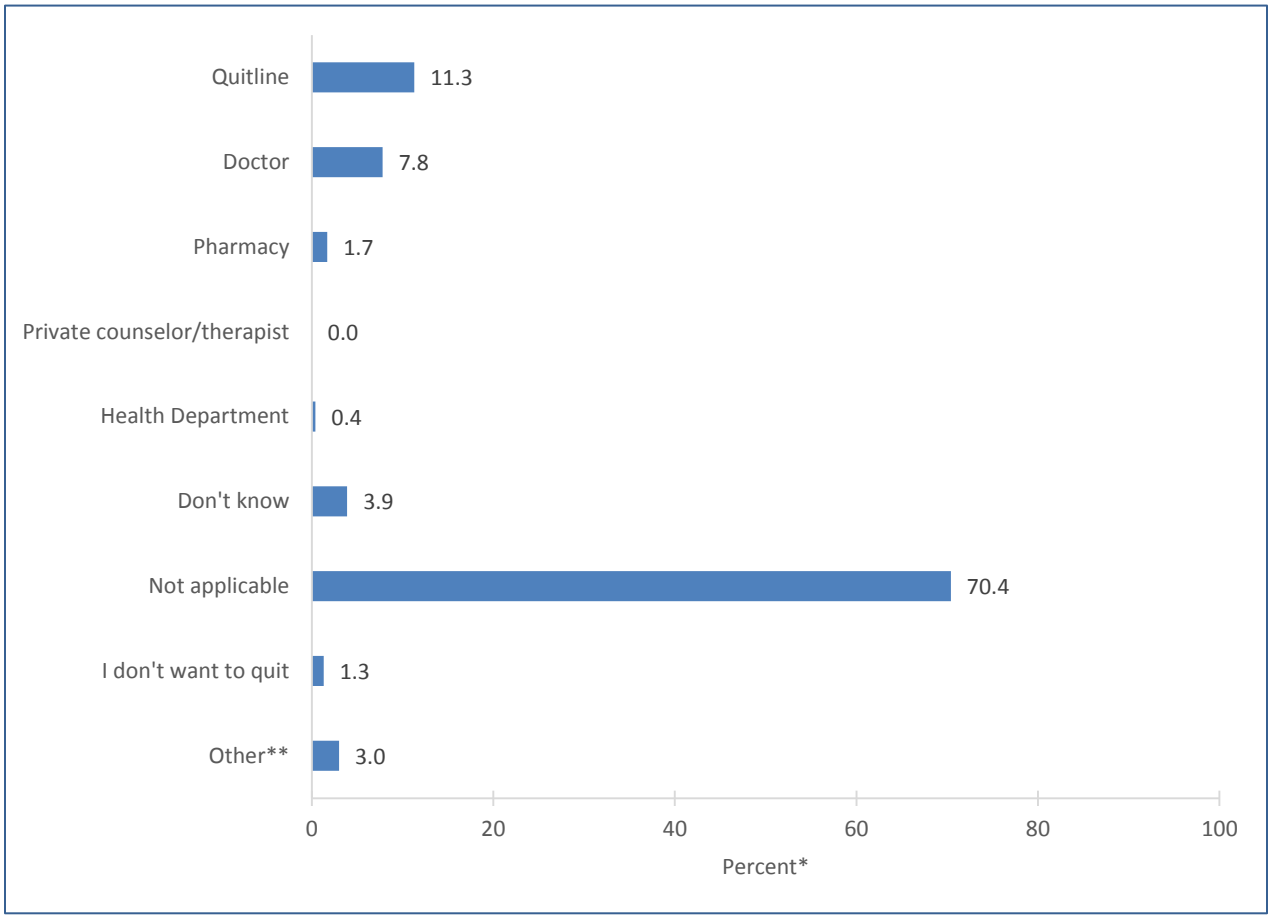


Figure 19. Location respondents would first go if they wanted help to quit using tobacco



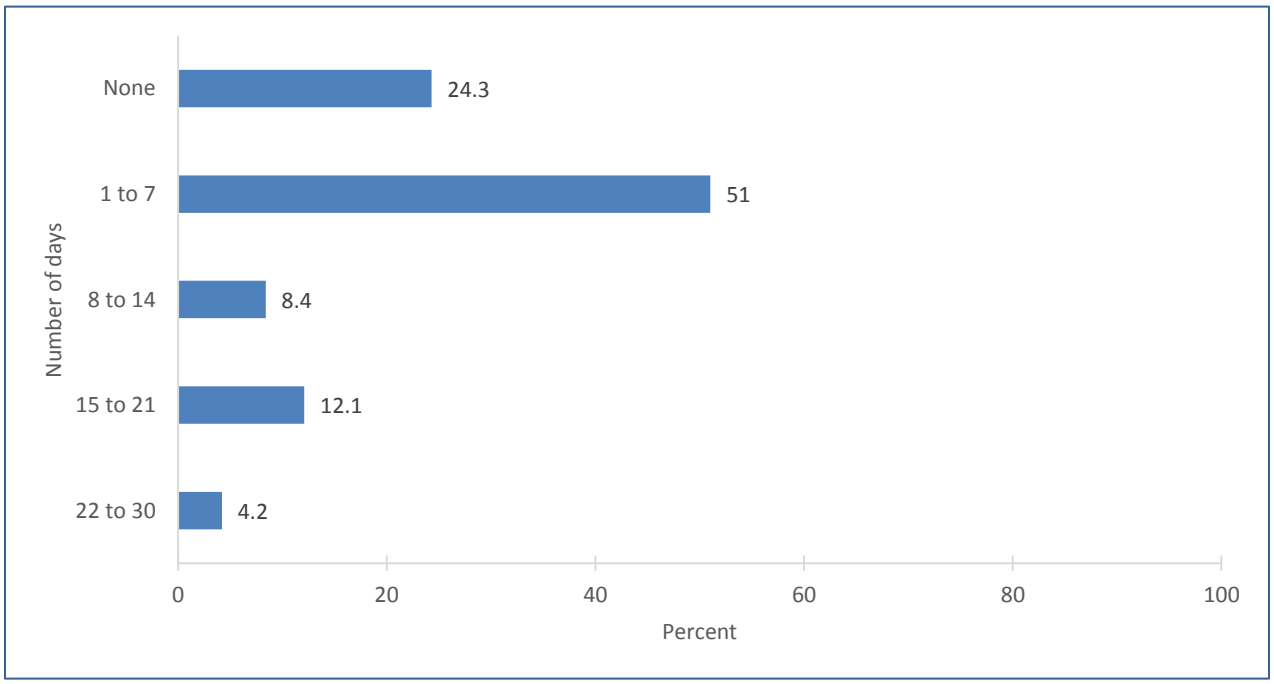
N=230

*Percentages do not total 100.0 due to rounding.

**Other responses include “Do it myself/cold turkey” (4), “Gym”, “Internet”, and “Nobody”.

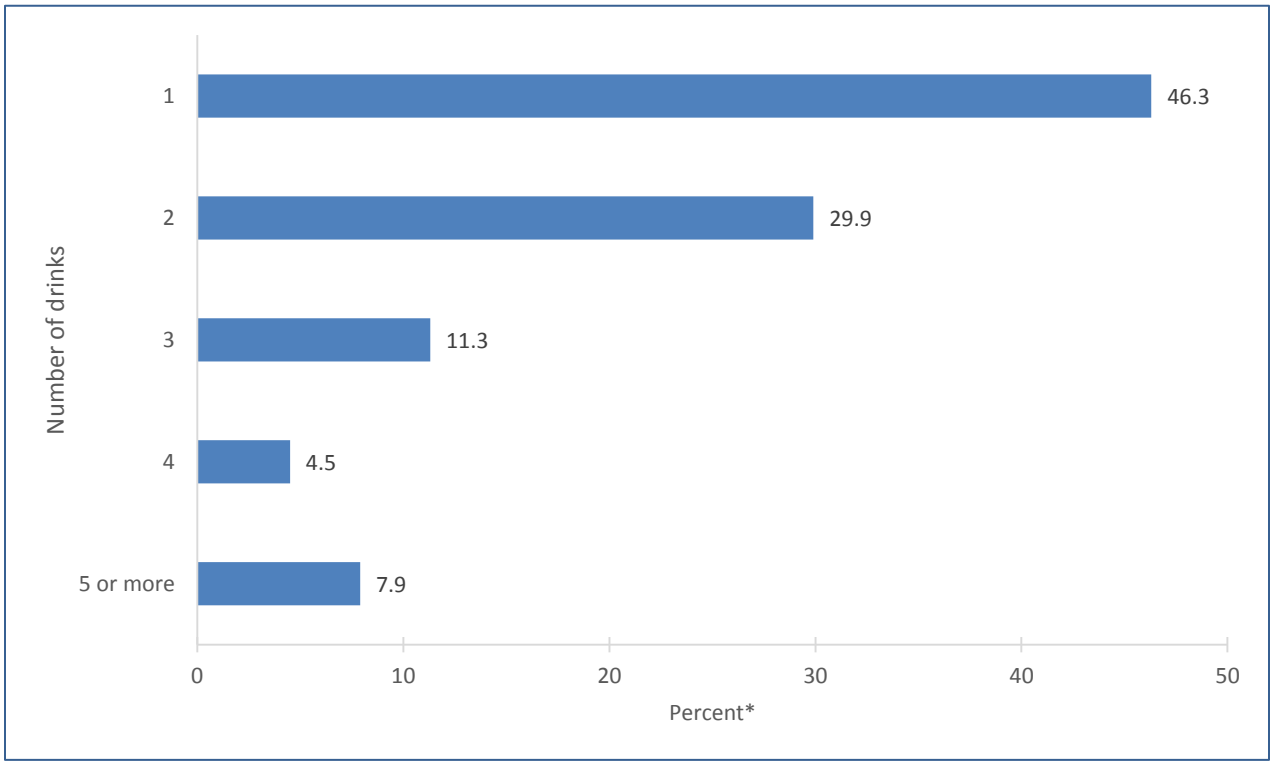
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

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



N=239

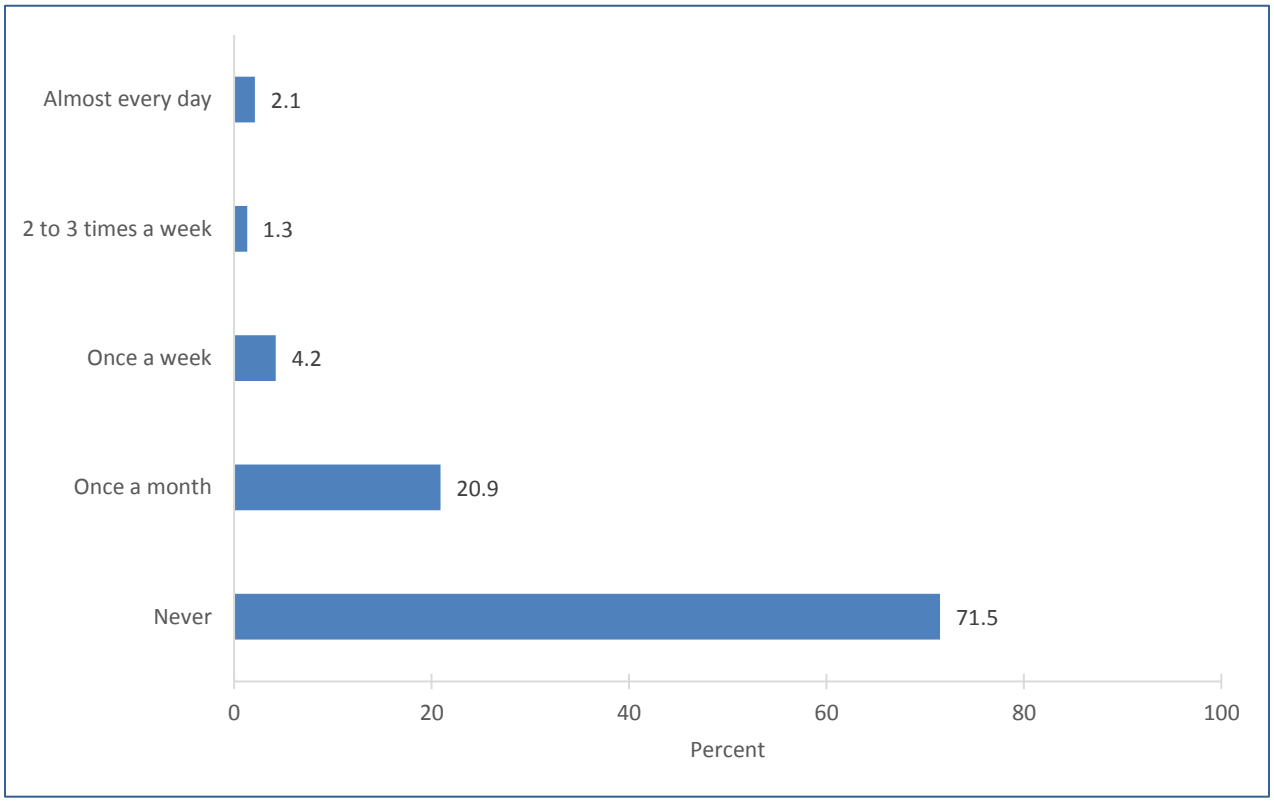
Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=177

*Percentages do not total 100.0 due to rounding.

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



N=239

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

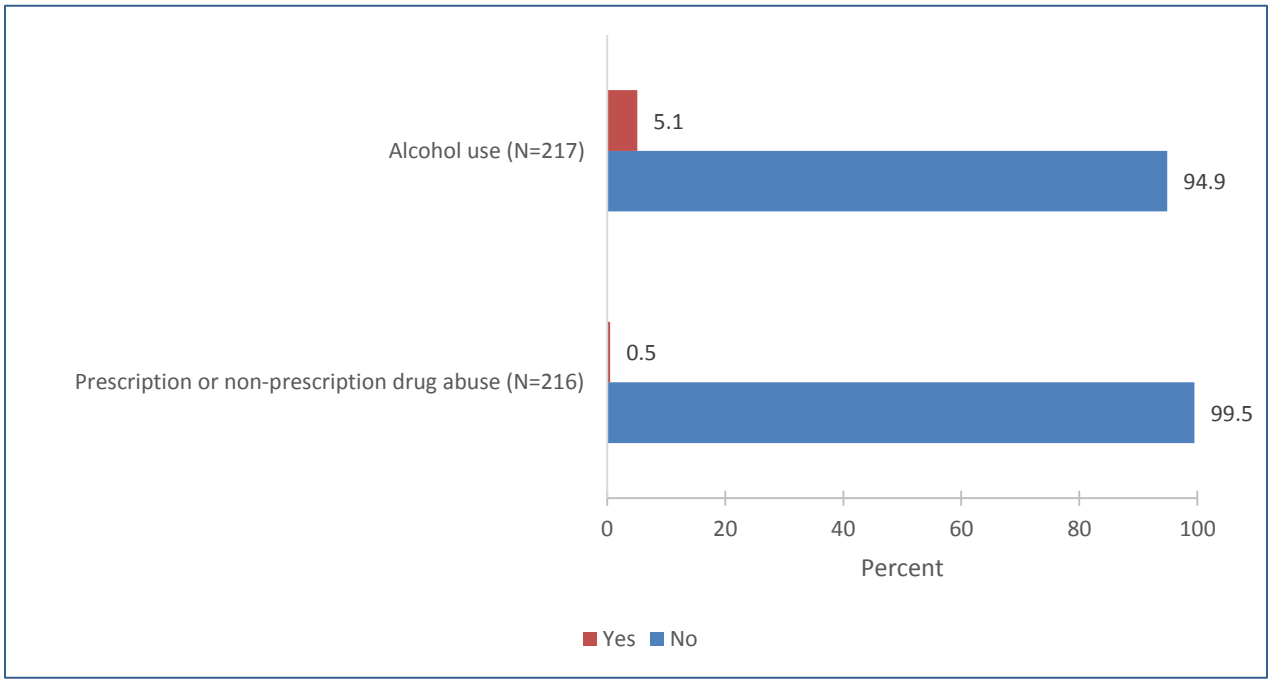
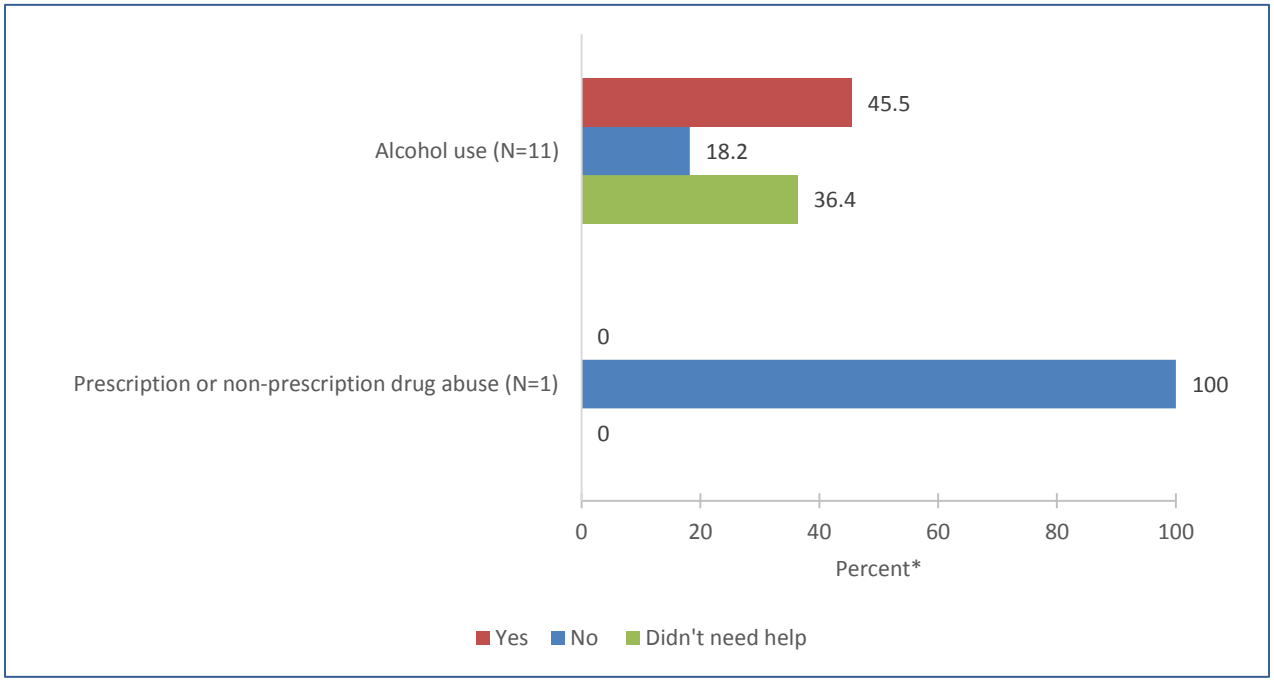
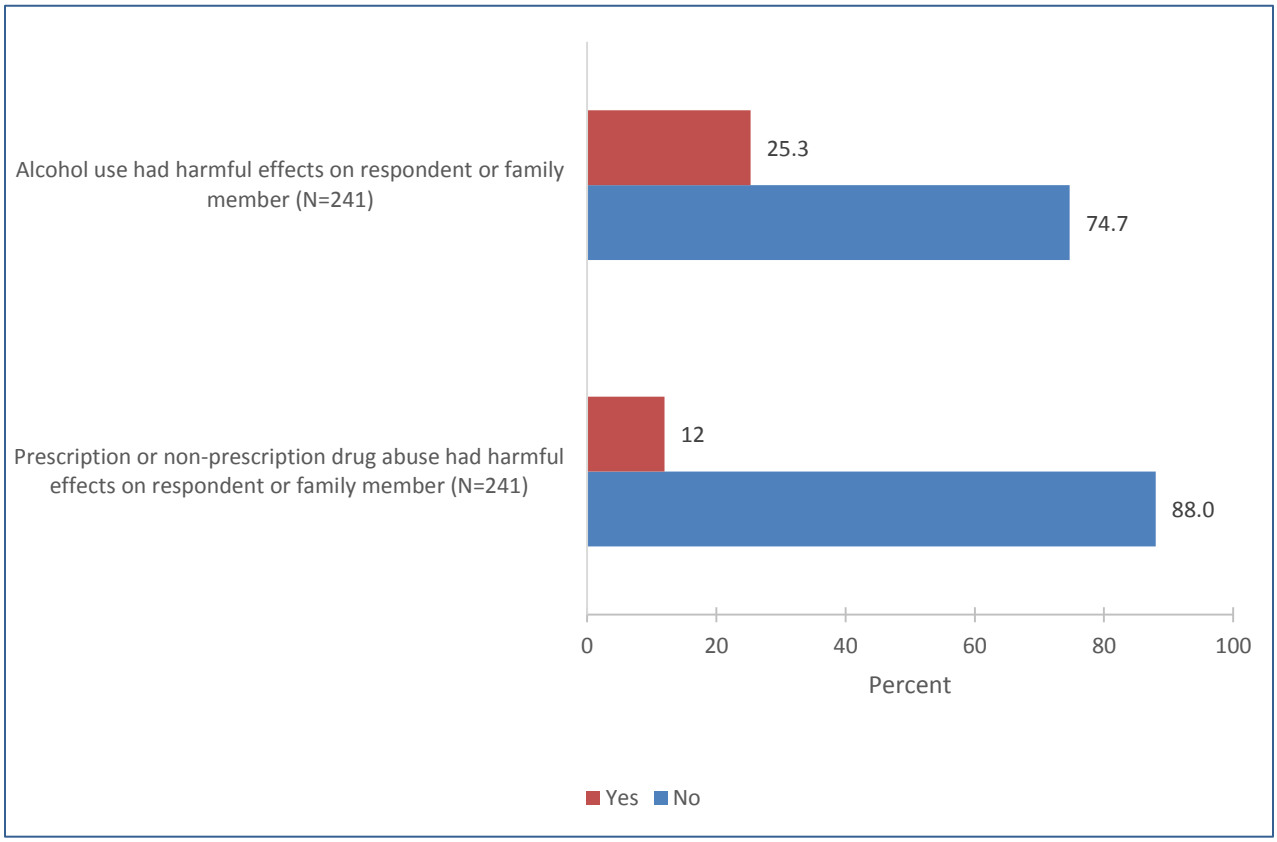


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed



*Percentages may not total 100.0 due to rounding.

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



Preventive Health

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=240)	90.0	10.0	100.0
Blood sugar screening (N=238)	72.7	27.3	100.0
Bone density test (N=232)	9.5	90.5	100.0
Cardiovascular screening (N=233)	20.2	79.8	100.0
Cholesterol screening (N=238)	73.9	26.1	100.0
Dental screening and X-rays (N=236)	78.4	21.6	100.0
Flu shot (N=240)	87.9	12.1	100.0
Glaucoma test (N=235)	51.9	48.1	100.0
Hearing screening (N=232)	14.2	85.8	100.0
Immunizations (N=231)	27.3	72.7	100.0
Pelvic exam (N=175 Females)	68.0	32.0	100.0
STD (N=228)	11.0	89.0	100.0
Vascular screening (N=228)	9.6	90.4	100.0
CANCER SCREENINGS			
Breast cancer screening (N=172 Females)	59.9	40.1	100.0
Cervical cancer screening (N=174 Females)	64.4	35.6	100.0
Colorectal cancer screening (N=236)	19.9	80.1	100.0
Prostate cancer screening (N=64 Males)	39.1	60.9	100.0
Skin cancer screening (N=236)	25.8	74.2	100.0

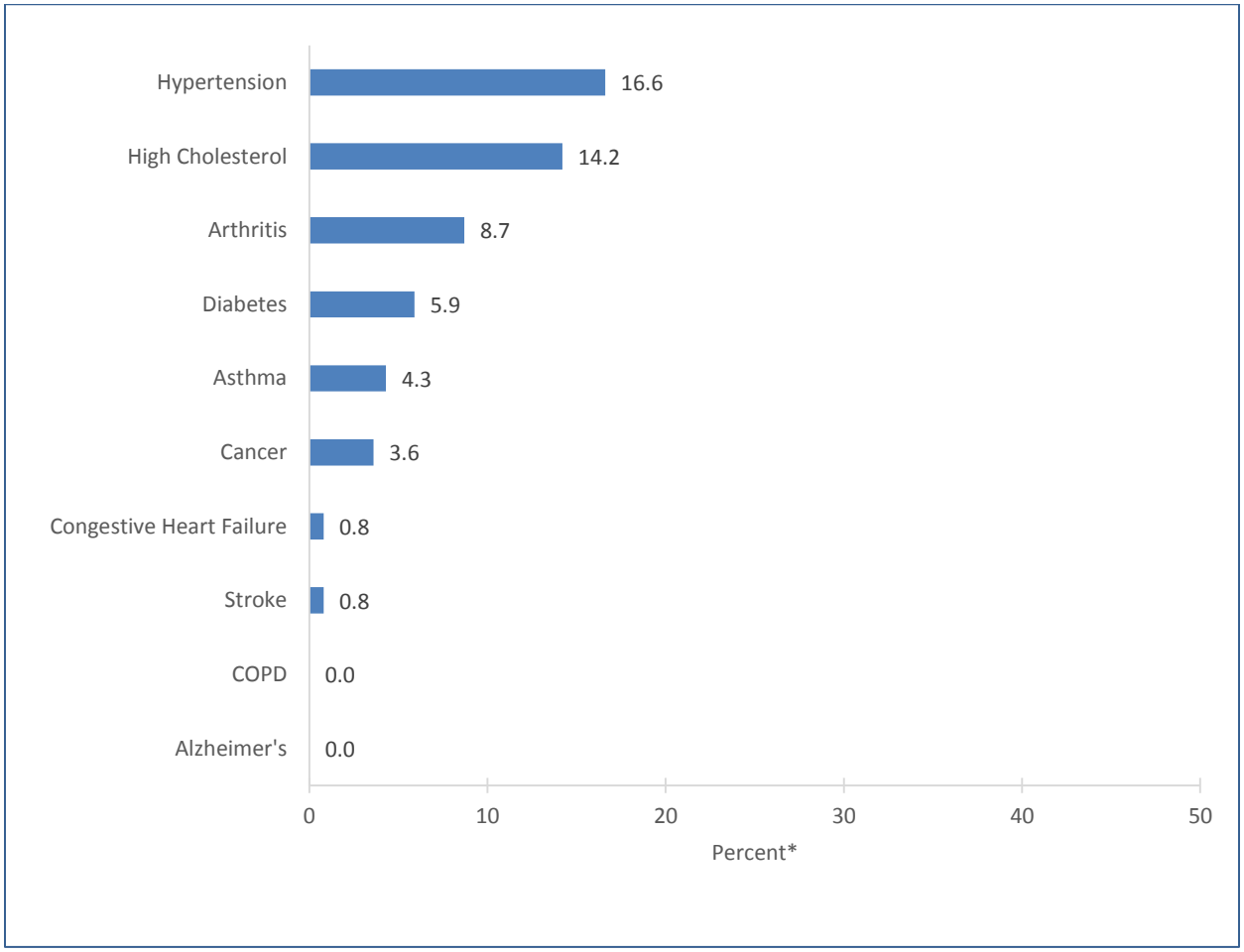
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=24)	50.0	25.0	8.3	4.2	4.2	0.0	4.2
Blood sugar screening (N=65)	40.0	33.8	7.7	0.0	0.0	0.0	7.7
Bone density test (N=210)	41.9	39.0	7.6	0.5	0.5	1.0	6.2
Cardiovascular screening (N=186)	40.9	44.1	7.5	0.0	0.0	0.5	4.8
Cholesterol screening (N=62)	37.1	32.3	8.1	0.0	1.6	1.6	11.3
Dental screening and X-rays (N=51)	15.7	5.9	33.3	17.6	13.7	0.0	25.5
Flu shot (N=29)	41.4	0.0	6.9	0.0	3.4	0.0	27.6
Glaucoma test (N=113)	48.7	27.4	8.0	0.0	0.0	0.0	6.2
Hearing screening (N=199)	51.8	28.6	6.5	0.0	0.5	1.0	5.5

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=168)	61.3	20.8	4.2	0.0	0.0	0.0	4.8
Pelvic exam (N=56 Female)	41.1	16.1	8.9	5.4	1.8	0.0	21.4
STD (N=203)	72.9	13.8	2.5	0.5	1.0	0.5	3.4
Vascular screening (N=206)	46.1	36.9	5.8	0.0	1.0	1.0	5.3
CANCER SCREENINGS							
Breast cancer screening (N=69 Females)	52.2	18.8	10.1	0.0	0.0	1.4	14.5
Cervical cancer screening (N=62 Females)	43.5	17.7	9.7	6.5	1.6	0.0	24.2
Colorectal cancer screening (N=189)	54.5	26.5	6.9	4.8	0.5	0.0	9.0
Prostate cancer screening (N=39 Males)	59.0	30.8	7.7	5.1	0.0	0.0	2.6
Skin cancer screening (N=175)	34.9	49.1	7.4	0.6	0.6	0.6	5.7

*Percentages do not total 100.0 due to multiple responses.

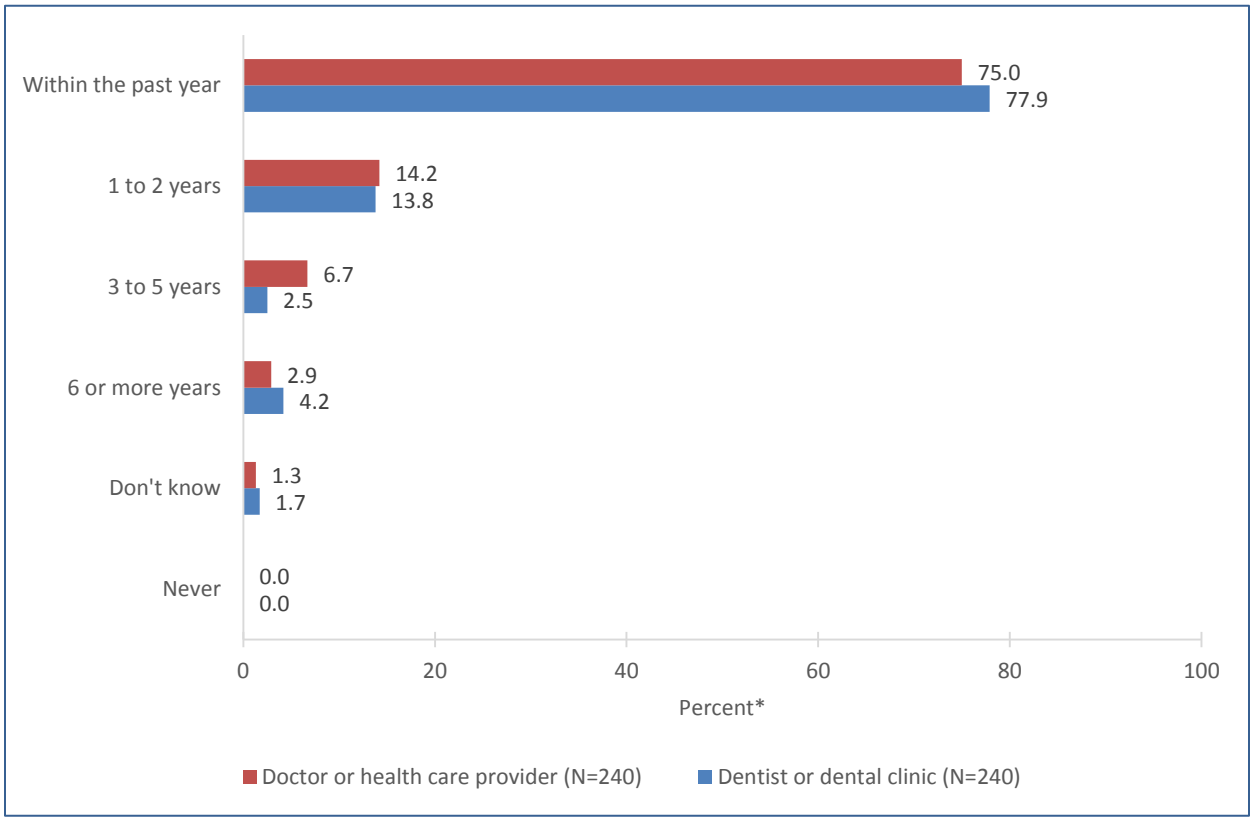
Figure 26. Whether respondents have any of the following chronic diseases



N=253

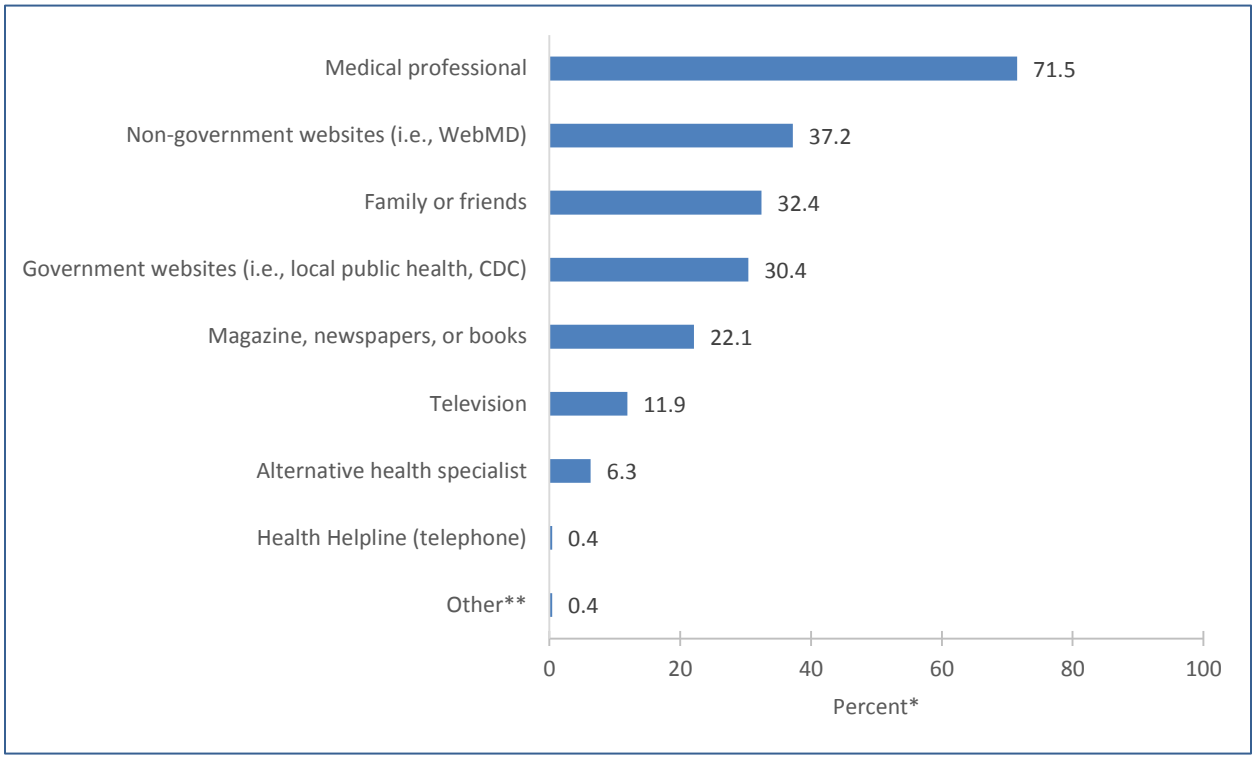
*Percentages do not total 100.0 due to multiple responses.

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



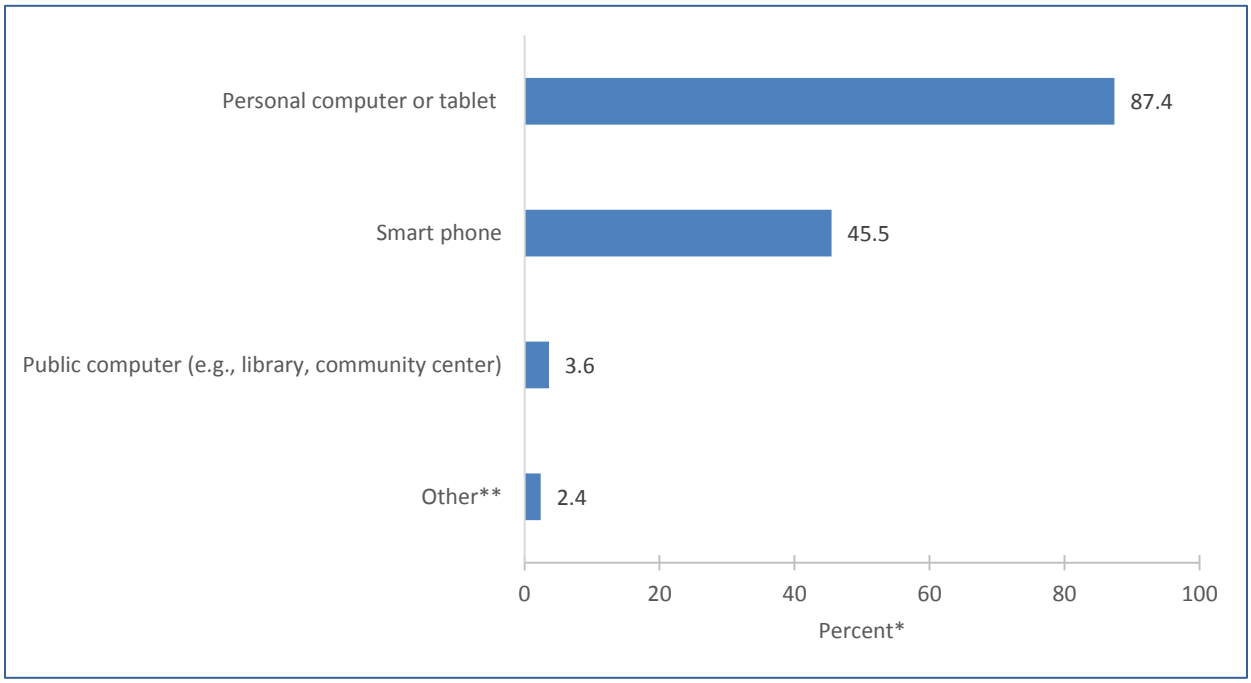
*Percentages do not total 100.0 due to rounding.

Figure 28. Where respondents get most of their health information



N=253 *Percentages do not total 100.0 due to multiple responses. **Other response is "I'm a health care nurse".

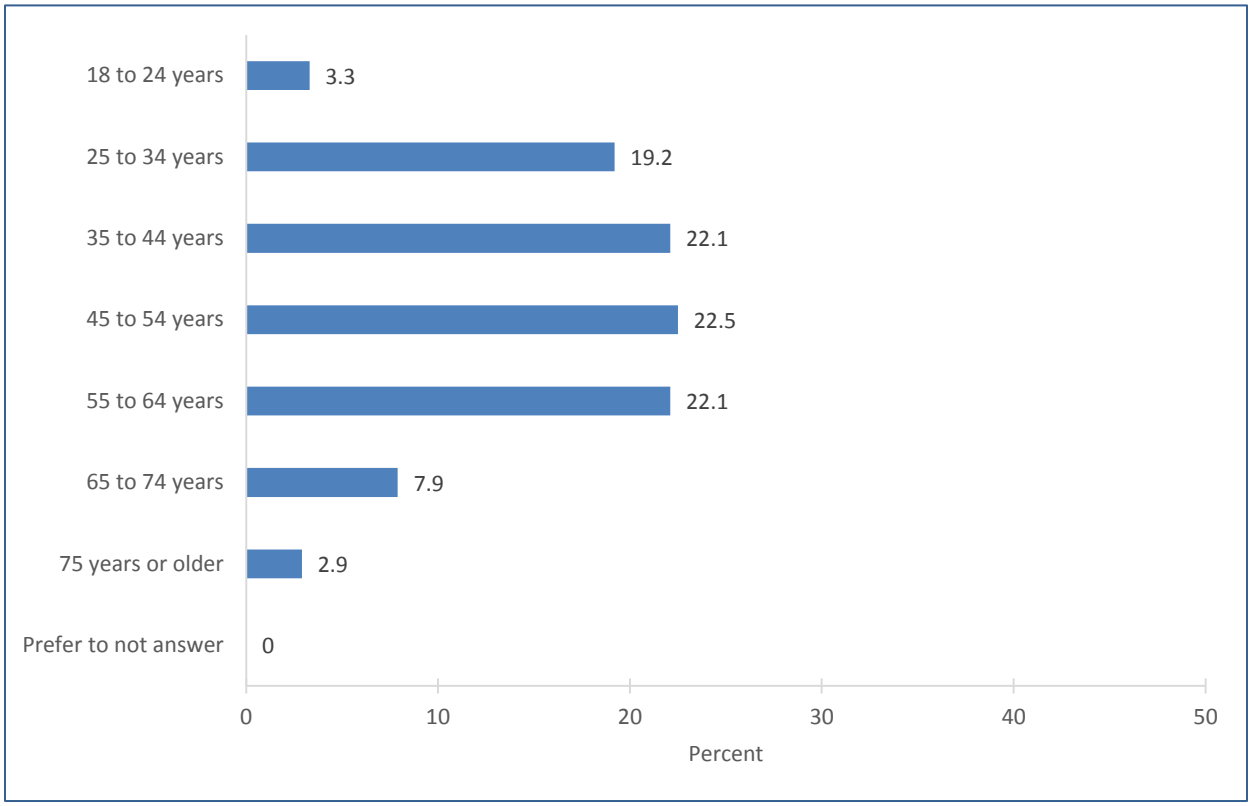
Figure 29. Best way for respondents to access technology for health information



N=253 *Percentages do not total 100.0 due to multiple responses. **Other responses include "I go to the doctor", "In person at the doctor's office or clinic", "Mail", "My nurse wife", "Pamphlets", and "Public seminars by health professionals".

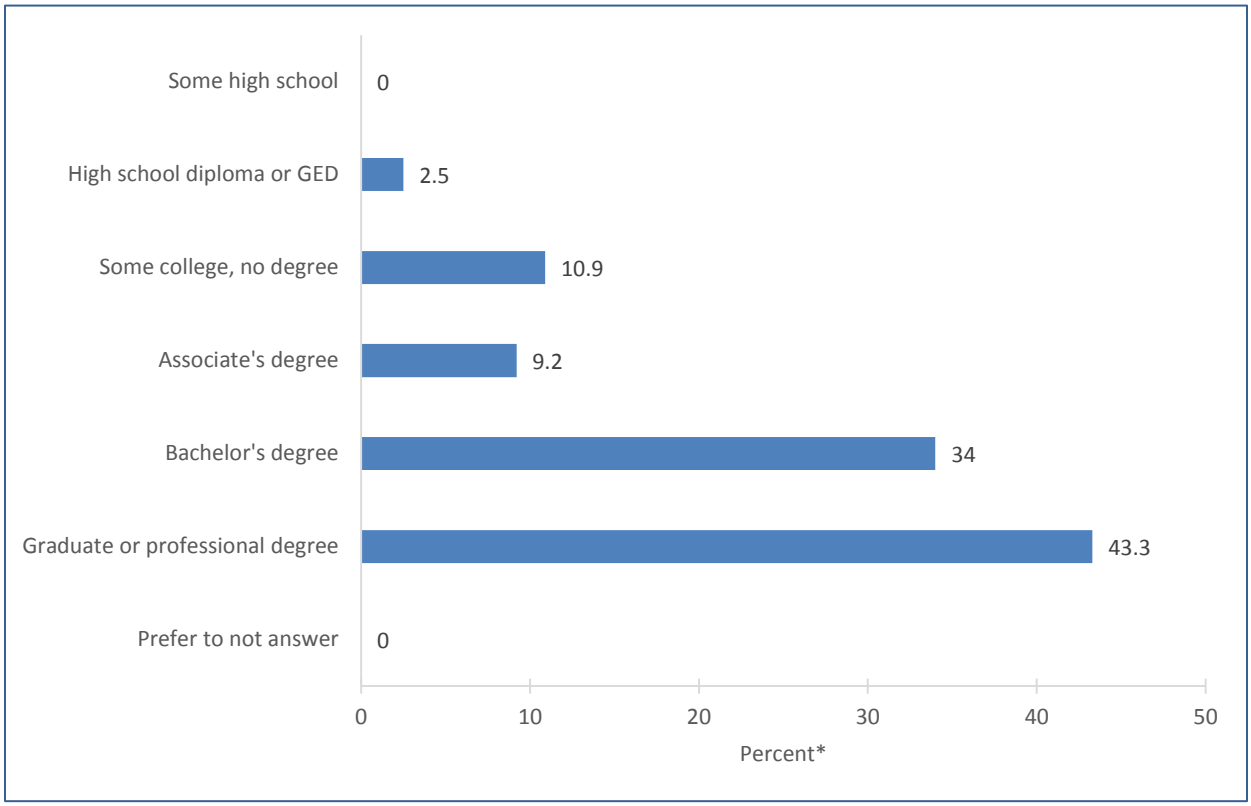
Demographic Information

Figure 30. Age of respondents



N=240

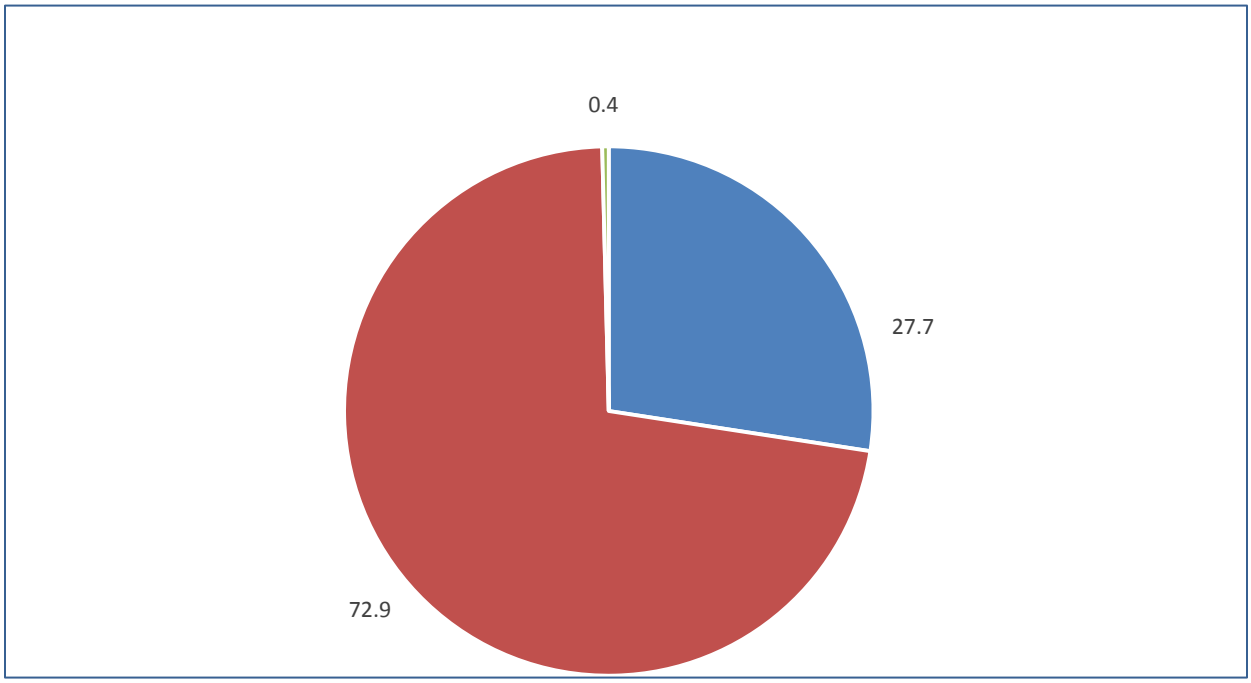
Figure 31. Highest level of education of respondents



N=238

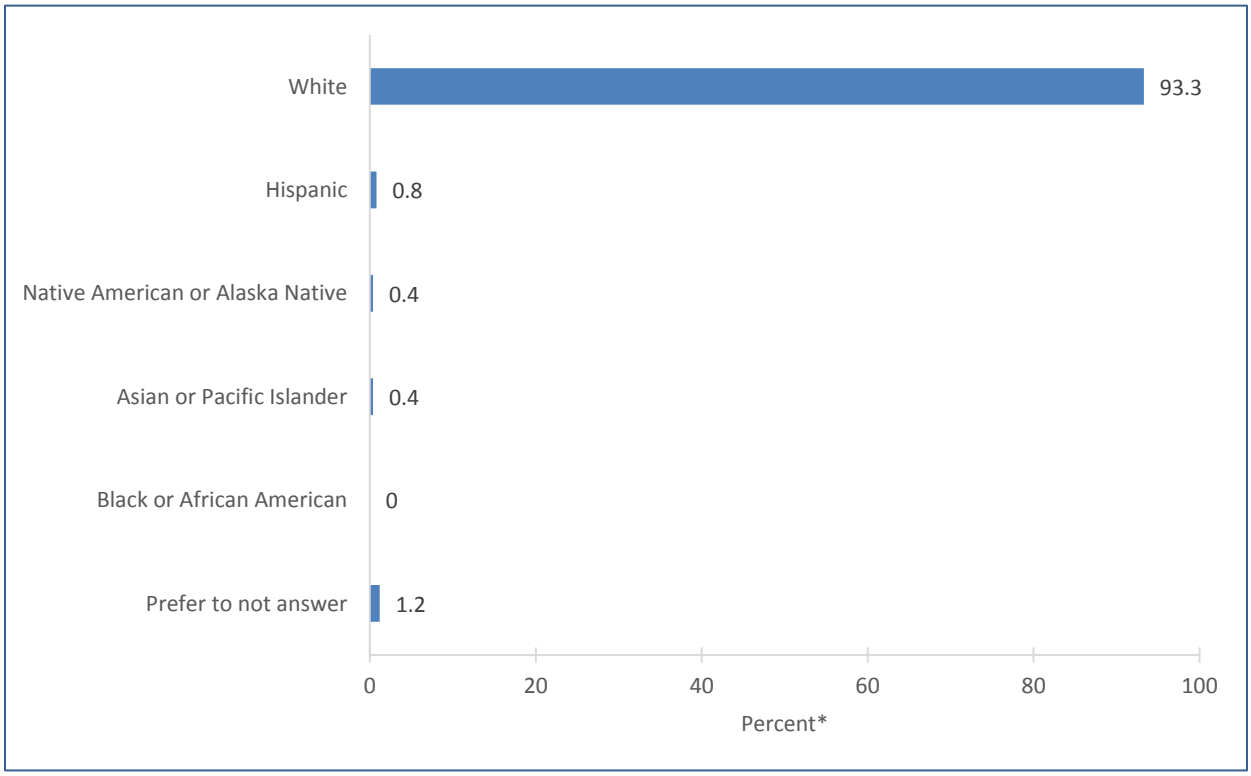
*Percentages do not total 100.0 due to rounding.

Figure 32. Gender of respondents



N=240

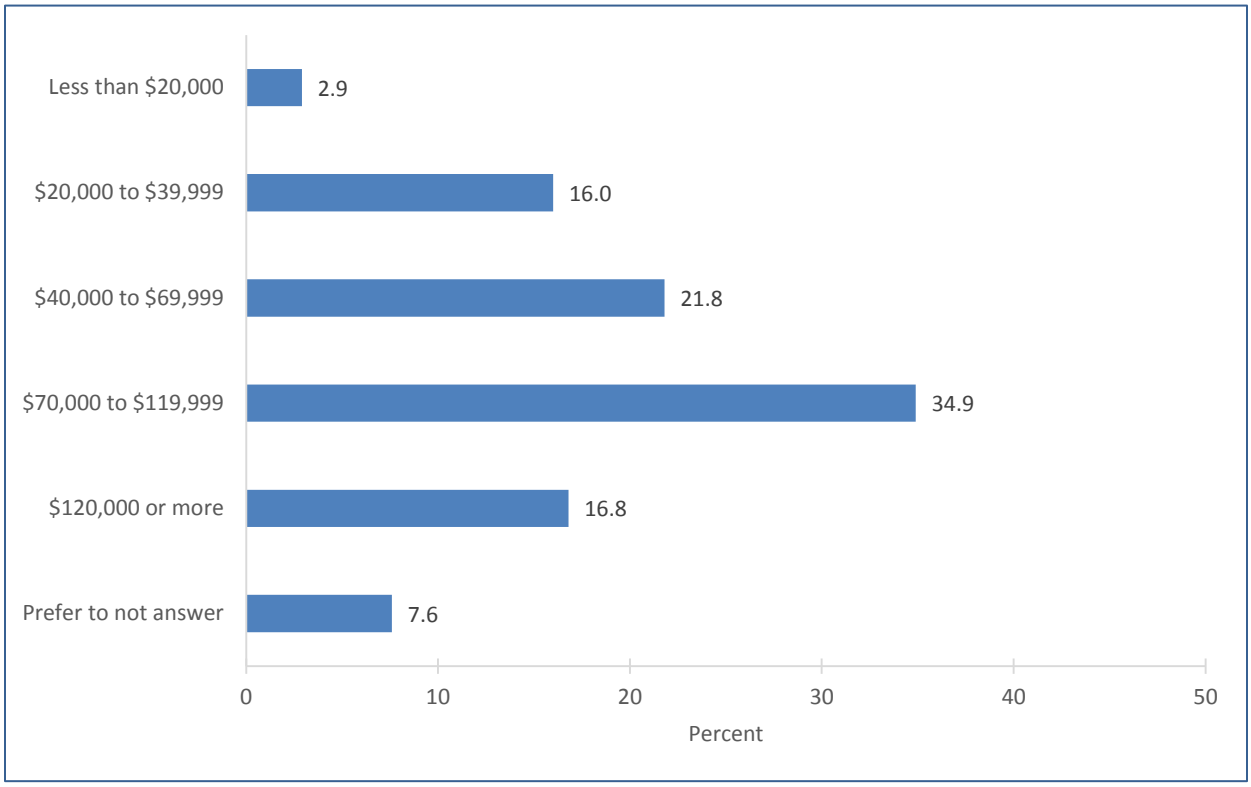
Figure 33. Race and ethnicity of respondents



N=253

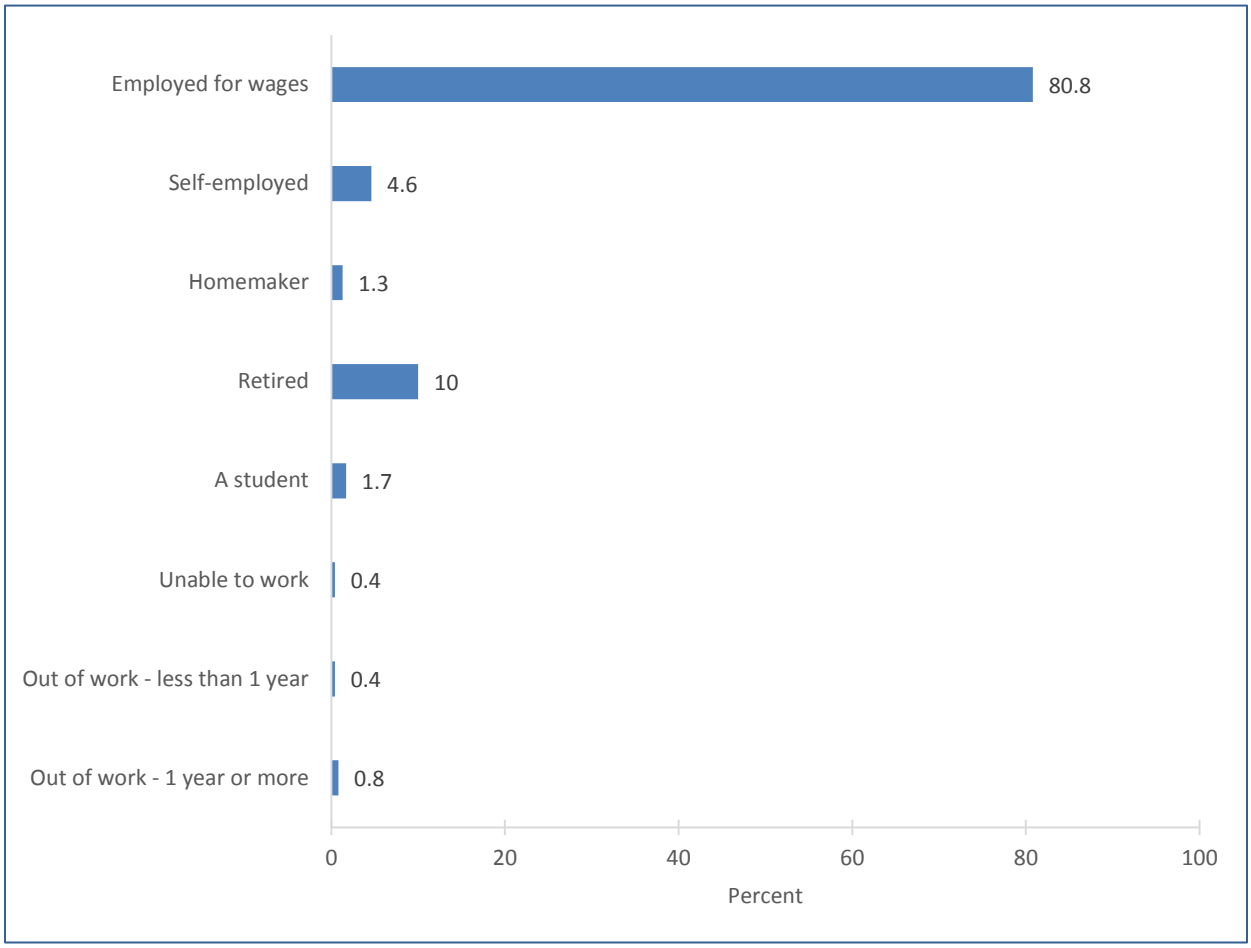
*Percentages do not total 100.0 due to multiple responses.

Figure 34. Annual household income of respondents



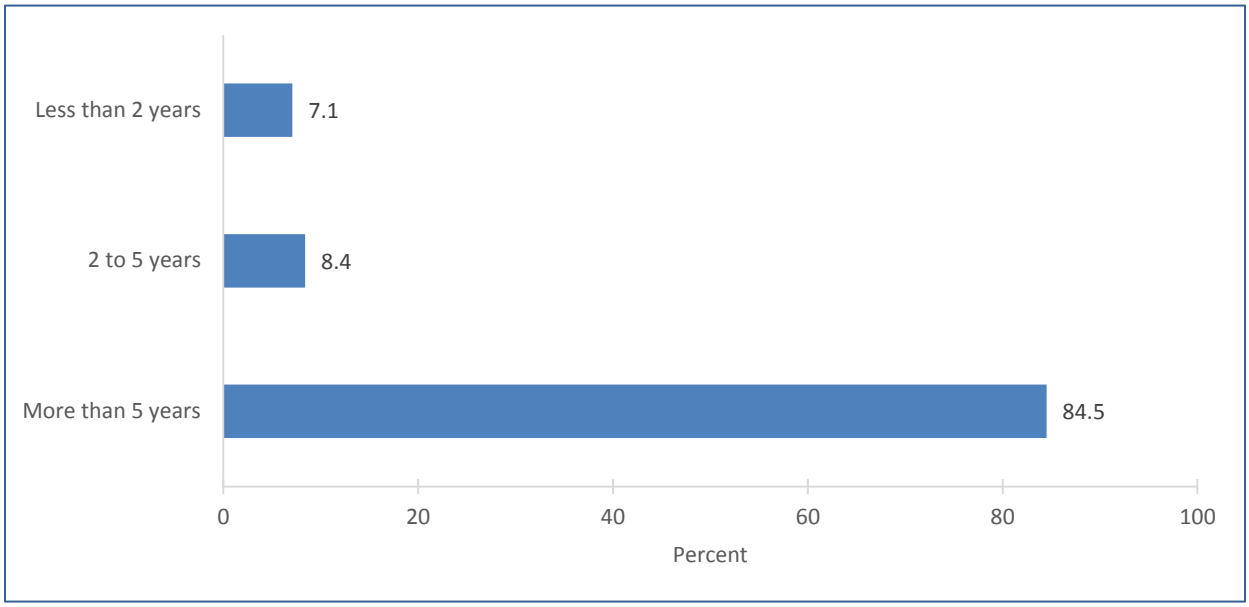
N=238

Figure 35. Employment status of respondents



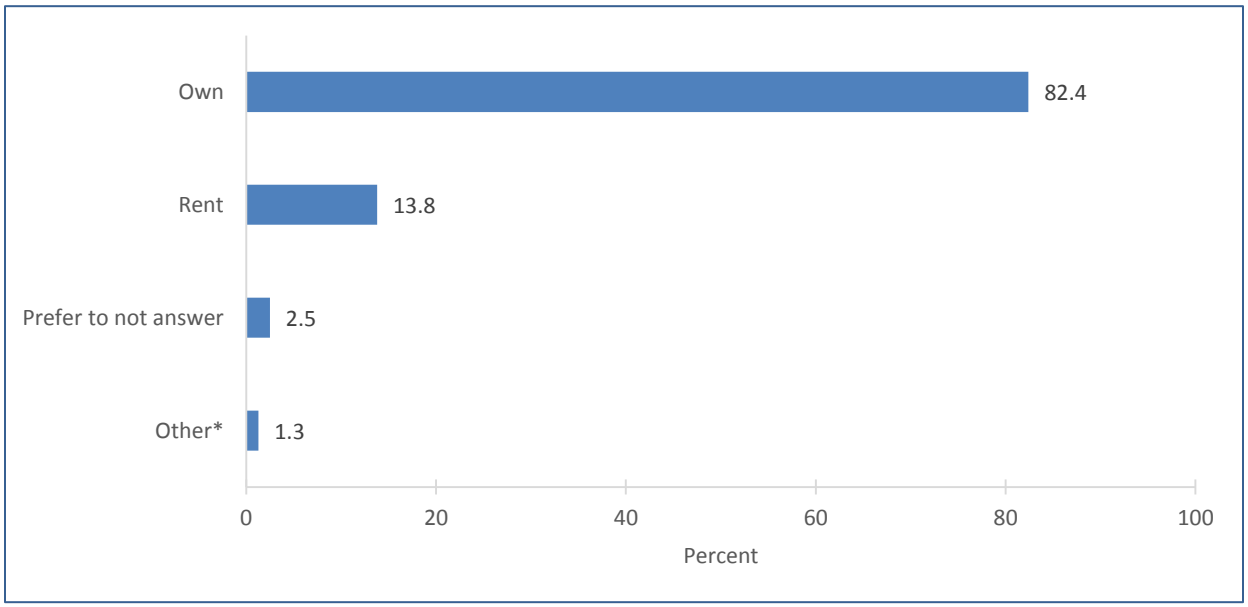
N=240

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



N=239

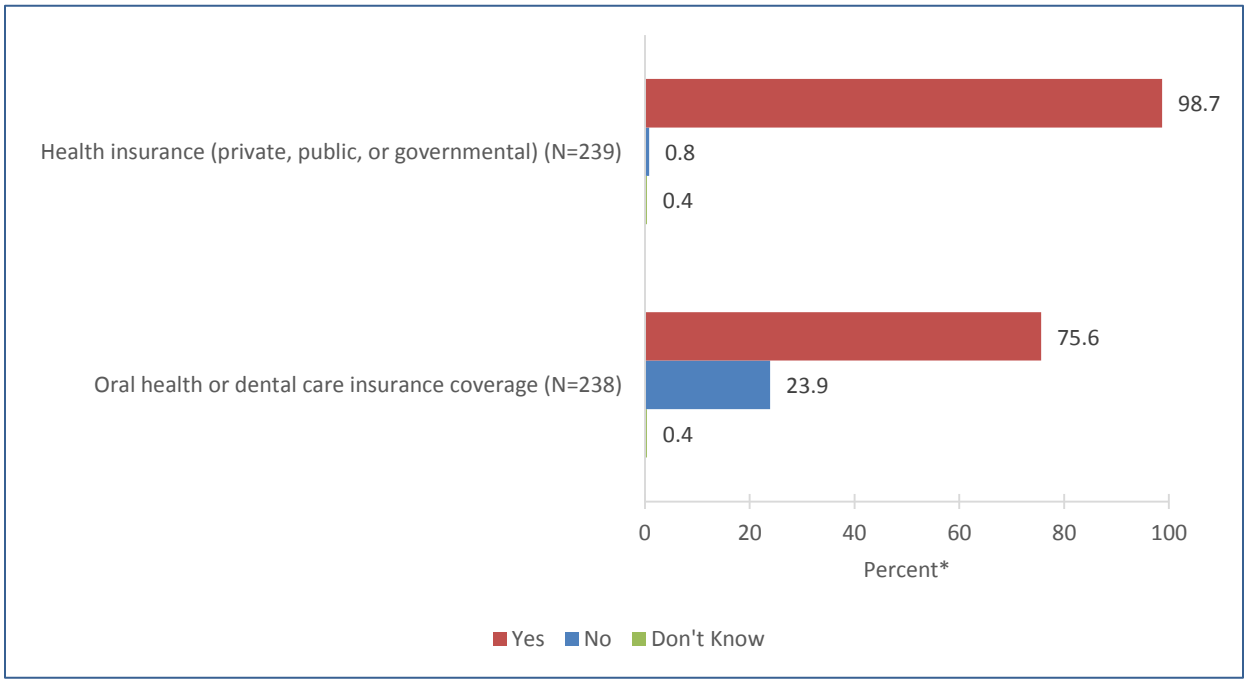
Figure 37. Whether respondents own or rent their home



N=239

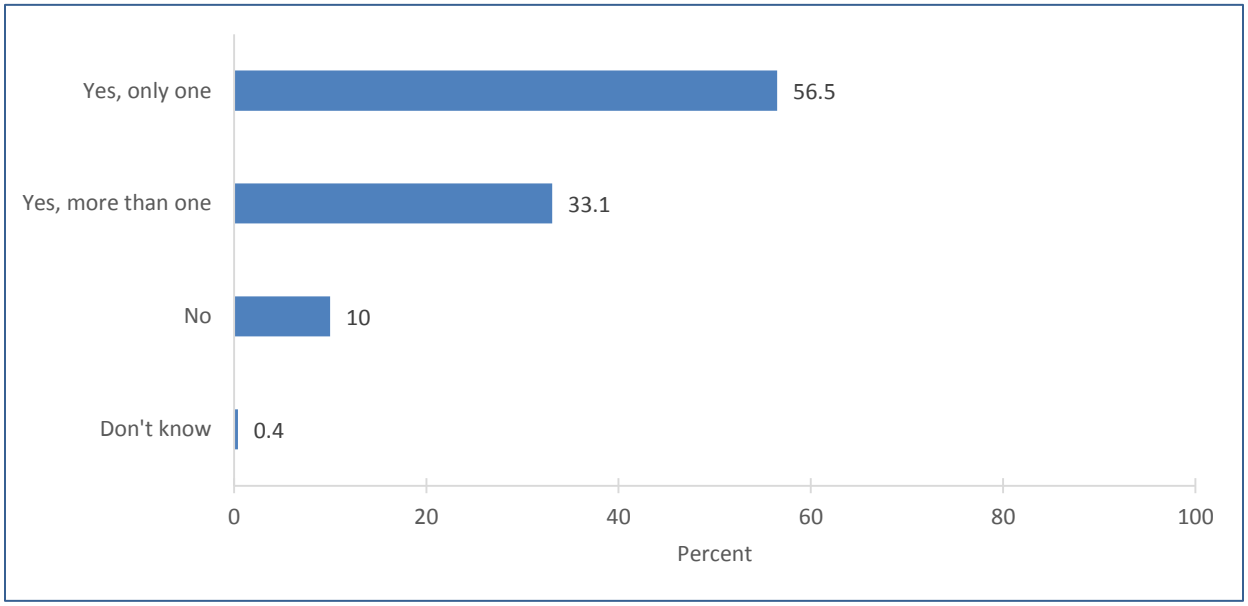
*Other responses include “A part of my job”, “Farm the land, but not pay rent”, “I live with my boyfriend in his home”.

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



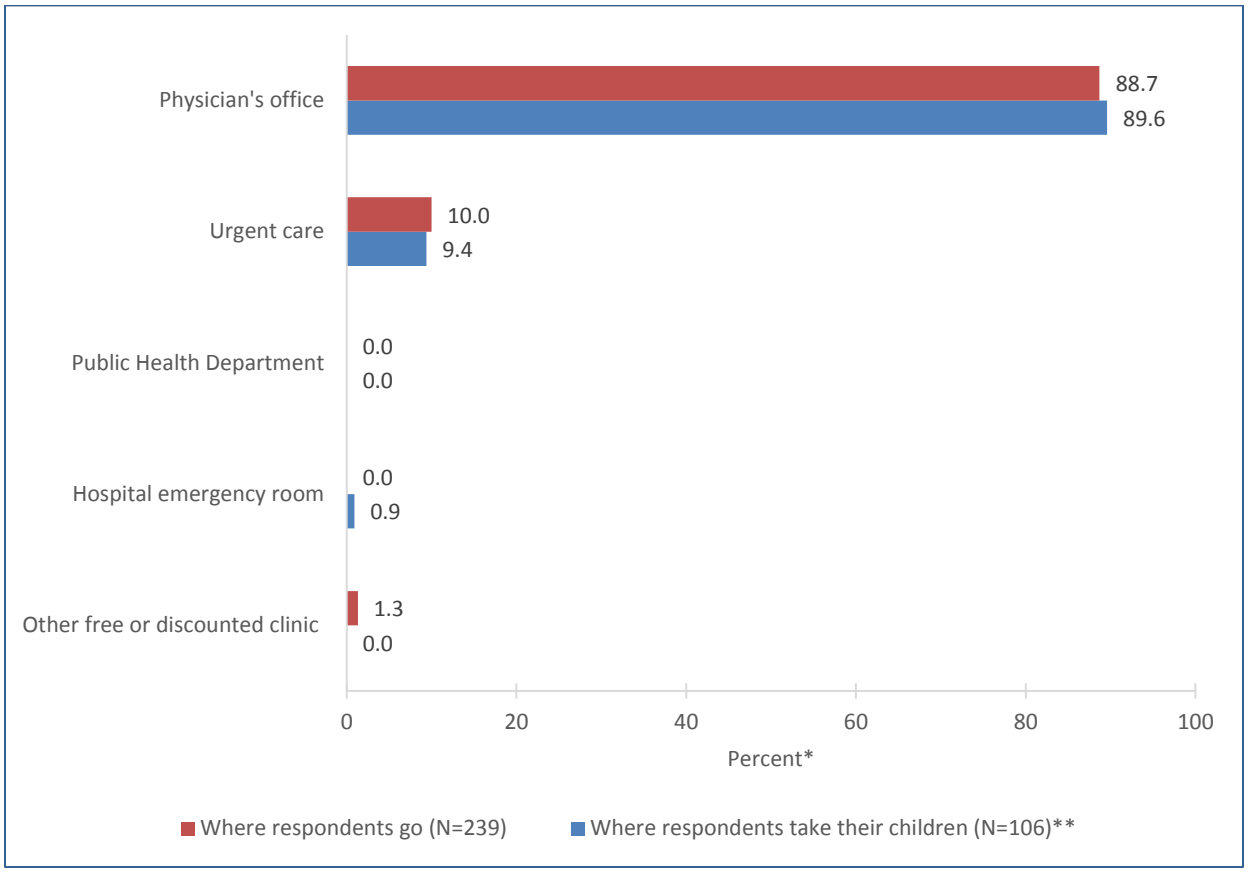
*Percentages do not total 100.0 due to rounding.

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



N=239

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



*Percentages may not total 100.0 due to rounding.

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

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

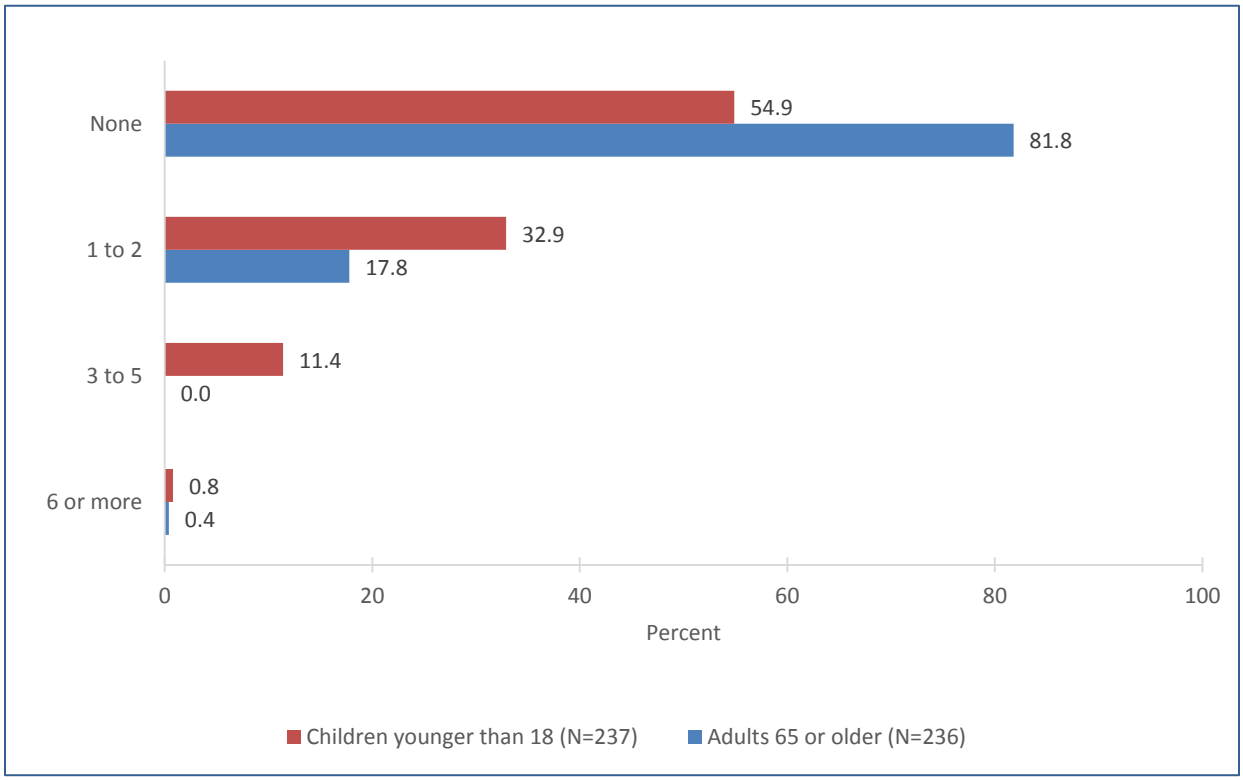
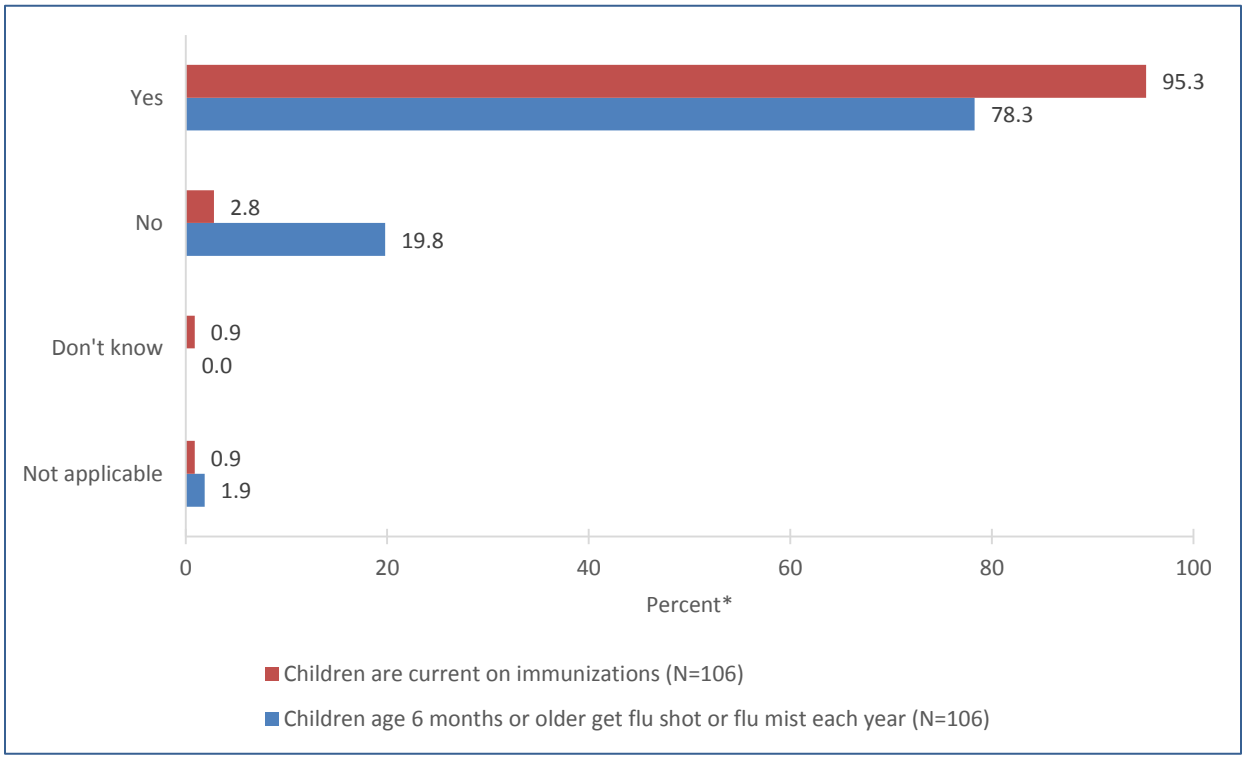


Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year**



*Percentages may not total 100.0 due to rounding.

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

Table 3. Zip code of respondents

Zip code	Number of respondents
57069	212
57010	6
57025	4
57073	3
57004	2
57031	2
57078	2
51001	1
57014	1
57038	1
57072	1
68757	1
68792	1

N=237

Definitions of Key Indicators

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

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

Contents:

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

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

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

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

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

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

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

Clay County

	Clay County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Health Outcomes					**16**
Length of Life					**26**
Premature death	6,555	4,851-8,259	5,200	6,738	
Quality of Life					**17**
Poor or fair health	5%	4-8%	10%	11%	
Poor physical health days	2.4	1.5-3.3	2.5	2.7	
Poor mental health days	2.3	1.4-3.2	2.3	2.6	
Low birth weight	6.5%	5.1-8.0%	5.9%	6.5%	
Additional Health Outcomes (not included in overall ranking) +					
Health Factors					**26**
Health Behaviors					**21**
Adult smoking	16%	11-22%	14%	18%	
Adult obesity	30%	24-36%	25%	29%	
Food environment index	7.2		8.4	7.4	
Physical inactivity	24%	19-29%	20%	25%	
Access to exercise opportunities	81%		92%	70%	
Excessive drinking	20%	14-28%	10%	19%	
Alcohol-impaired driving deaths	50%		14%	37%	
Sexually transmitted infections	333		138	471	

	Clay County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Teen births	9	7-12	20	37	
Additional Health Behaviors (not included in overall ranking) +					
Clinical Care					**33**
Uninsured	14%	12-16%	11%	14%	
Primary care physicians	1,570:1		1,045:1	1,302:1	
Dentists	1,742:1		1,377:1	1,813:1	
Mental health providers	2,323:1		386:1	664:1	
Preventable hospital stays	58	45-72	41	57	
Diabetic monitoring	77%	59-95%	90%	84%	
Mammography screening	68.8%	48.4-89.1%	70.7%	66.5%	
Additional Clinical Care (not included in overall ranking) +					
Social & Economic Factors					**17**
High school graduation	88%		93%	78%	
Some college	77.7%	67.2-88.3%	71.0%	66.7%	
Unemployment	3.7%		4.0%	3.8%	
Children in poverty	19%	14-25%	13%	19%	
Income inequality	6.2	5.2-7.1	3.7	4.2	
Children in single-parent households	15%	8-22%	20%	31%	
Social associations	14.2		22.0	17.4	
Violent crime	112		59	282	
Injury deaths	40	27-58	50	69	
Additional Social & Economic Factors (not included in overall ranking) +					

	Clay County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Physical Environment					**43**
Air pollution - particulate matter	11.7		9.5	10.8	
Drinking water violations	0%		0%	3%	
Severe housing problems	18%	12-24%	9%	12%	
Driving alone to work	71%	68-75%	71%	78%	
Long commute - driving alone	25%	19-31%	15%	14%	

2015
^ 10th/90th percentile, i.e., only 10% are better.

Union County

	Union County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Health Outcomes					**14**
Length of Life					**5**
Premature death	4,420	3,248-5,592	5,200	6,738	
Quality of Life					**29**
Poor or fair health	10%	8-14%	10%	11%	
Poor physical health days	2.0	1.5-2.6	2.5	2.7	
Poor mental health days	1.7	0.9-2.5	2.3	2.6	
Low birth weight	7.6%	6.1-9.0%	5.9%	6.5%	
Additional Health Outcomes (not included in overall ranking) +					
Health Factors					**2**
Health Behaviors					**6**
Adult smoking	15%	11-21%	14%	18%	
Adult obesity	29%	24-35%	25%	29%	
Food environment index	8.7		8.4	7.4	
Physical inactivity	26%	21-32%	20%	25%	
Access to exercise opportunities	70%		92%	70%	
Excessive drinking	18%	13-25%	10%	19%	
Alcohol-impaired driving deaths	21%		14%	37%	
Sexually transmitted infections	108		138	471	

	Union County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Teen births	19	14-24	20	37	
Additional Health Behaviors (not included in overall ranking) +					
Clinical Care					**6**
Uninsured	8%	7-10%	11%	14%	
Primary care physicians	1,061:1		1,045:1	1,302:1	
Dentists	2,118:1		1,377:1	1,813:1	
Mental health providers	7,415:1		386:1	664:1	
Preventable hospital stays	56	47-65	41	57	
Diabetic monitoring	89%	77-100%	90%	84%	
Mammography screening	63.3%	51.9-74.7%	70.7%	66.5%	
Additional Clinical Care (not included in overall ranking) +					
Social & Economic Factors					**2**
High school graduation	89%		93%	78%	
Some college	76.4%	68.5-84.3%	71.0%	66.7%	
Unemployment	4.2%		4.0%	3.8%	
Children in poverty	8%	6-10%	13%	19%	
Income inequality	3.7	3.3-4.2	3.7	4.2	
Children in single-parent households	19%	13-25%	20%	31%	
Social associations	16.8		22.0	17.4	
Violent crime	34		59	282	
Injury deaths	58	42-79	50	69	
Additional Social & Economic Factors (not included in overall ranking) +					

	Union County	Error Margin	Top U.S. Performers^	South Dakota	Rank (of 60)
Physical Environment					**39**
Air pollution - particulate matter	11.7		9.5	10.8	
Drinking water violations	2%		0%	3%	
Severe housing problems	6%	5-8%	9%	12%	
Driving alone to work	83%	81-86%	71%	78%	
Long commute - driving alone	20%	16-23%	15%	14%	

2015
^ 10th/90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

THE LEONA M. AND HARRY B.
HELMSLEY
CHARITABLE TRUST

SOUTH DAKOTA HEALTH STUDY: CLAY COUNTY RESULTS

Population, U.S. Census 2014 estimate: 13,932

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Clay County Responses: 120	Response Rate: 43%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		CLAY COUNTY (n = 120)
57.4%	Female	65.8%
11.3%	Non-White	13.6%
19.1%	Age 65 and older	11.0%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	24.9%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	16.0%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	11.8%

NEED FOR CARE

75.0%	Need Medical Care	71.4%
79.5%	Need Prescription Medications	77.5%
9.5%	Need Mental Health Care	6.4%
1.1%	Need Alcohol or Drug Treatment	0.0%

ACCESS TO CARE

94.2%	Have a usual place to go for care	87.9%
77.4%	Have a personal doctor/provider	77.2%
13.0%	Unmet medical needs	5.5%
6.4%	Unmet prescription needs	1.4%
35.8%	Unmet mental health needs	42.1%
45.6%	Unmet alcohol or drug abuse needs	N/A

HEALTH PROFILE

SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	CLAY COUNTY (n = 120)
11.4%	Diabetes	10.1%
10.9%	Asthma	21.1%
33.3%	High Blood Pressure	14.3%
8.9%	Heart Disease	3.7%
28.5%	High Cholesterol	19.0%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	0.9%
8.9%	Cancer	3.5%
54.7%	At least one of the above	40.2%
17.0%	Depression	7.9%
17.6%	Anxiety	4.7%
3.4%	PTSD (Post-Traumatic Stress Disorder)	1.6%
1.7%	Bipolar Disorder	1.4%
2.6%	Addiction Issues	2.1%
25.5%	At least one of the above	9.3%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	76.1%
5.5%	Depression	2.8%
7.5%	Anxiety	3.4%
6.0%	PTSD (Post-Traumatic Stress Disorder)	2.3%
17.0%	Current Smoker	13.4%
42.4%	Alcohol Abuse	35.8%
6.7%	Marijuana Use (past year)	6.8%

FOCUS ON SOUTH DAKOTA
A Picture of Health

SOUTH DAKOTA HEALTH STUDY: UNION COUNTY RESULTS

Population, U.S. Census 2014 estimate: 15,029

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Union County Responses: 84	Response Rate: 38%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		UNION COUNTY (n = 84)
57.4%	Female	53.4%
11.3%	Non-White	0.0%
19.1%	Age 65 and older	20.2%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	21.9%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	15.7%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	5.3%

NEED FOR CARE

75.0%	Need Medical Care	71.0%
79.5%	Need Prescription Medications	76.8%
9.5%	Need Mental Health Care	8.0%
1.1%	Need Alcohol or Drug Treatment	0.0%

ACCESS TO CARE

94.2%	Have a usual place to go for care	95.0%
77.4%	Have a personal doctor/provider	87.6%
13.0%	Unmet medical needs	6.9%
6.4%	Unmet prescription needs	1.5%
35.8%	Unmet mental health needs	8.5%
45.6%	Unmet alcohol or drug abuse needs	N/A

HEALTH PROFILE

SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	UNION COUNTY (n = 84)
11.4%	Diabetes	14.1%
10.9%	Asthma	7.1%
33.3%	High Blood Pressure	41.4%
8.9%	Heart Disease	10.5%
28.5%	High Cholesterol	38.6%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	5.1%
8.9%	Cancer	12.1%
54.7%	At least one of the above	59.3%
17.0%	Depression	14.9%
17.6%	Anxiety	15.7%
3.4%	PTSD (Post-Traumatic Stress Disorder)	0.0%
1.7%	Bipolar Disorder	1.4%
2.6%	Addiction Issues	0.0%
25.5%	At least one of the above	24.7%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	91.4%
5.5%	Depression	4.6%
7.5%	Anxiety	7.9%
6.0%	PTSD (Post-Traumatic Stress Disorder)	5.8%
17.0%	Current Smoker	16.6%
42.4%	Alcohol Abuse	55.1%
6.7%	Marijuana Use (past year)	3.4%

SANFORD HEALTH

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