2019 Community Health Needs Assessment

Winner Regional Health

Winner, South Dakota

Winner Regional Health

Community Health Needs Assessment
2019

Dear Community Members,

Winner Regional Health is pleased to present the 2019 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 December 2017 and January 2018 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. Winner Regional in partnership with Sanford Health, further analyzed the data, identified unmet needs, and collaborated 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 were 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.

WRH has set strategy to address the following community health needs:
- Children and Youth
- Healthcare and Wellness

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 planned to address each identified need.

At Winner Regional Health, 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,

Kevin Coffey
Chief Executive Officer
Winner Regional Health

Winner Regional Health

Community Health Needs Assessment 2019

EXECUTIVE SUMMARY

Community Health Needs Assessment
2019

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 not-for-profit status and create opportunity to identify and address public health issues from a broad perspective.

Study Design and Methodology

The following report includes non-generalizable survey results from an online survey of community leaders and key stakeholders identified by Winner Regional Health. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. Therefore, it is important to note that the data in this report are not generalizable to the community.

1. Primary Research

Stakeholder Survey: an online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholder's concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health, and the Center for Social Research

(CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health distributed the survey link via email to stakeholders and key leaders in Tripp County. Data collection occurred during December 2017 and January 2018. A total of 7 community stakeholders participated in the survey.

Resident Survey: the resident survey tool includes questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a link to the survey was published in the local newspaper. A total of 35 community residents participated in the survey.

Community Asset Mapping: asset mapping was conducted to find the community resources available to address the assessed needs. Each unmet need was researched to determine what resources were available to address the needs. Once gaps were determined, the prioritization exercise followed with key stakeholder groups determining the top needs.

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

Prioritization Process: the primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to complete the multi-voting exercise.

2. Secondary Research

   A. The 2018 County Health Rankings were reviewed and included in the report and in the asset mapping process.
   B. The U.S. Census Bureau estimates were reviewed.
   C. Community Commons were reviewed and specific data sets were considered.

Key Findings – Primary Research

Key findings are based on the non-generalizable survey data, with indicators ranked on a 1-5
Likert scale, with 5 being of highest concern. Survey results ranking 3.5 or higher are considered to high-ranking concerns.

1. **Economics:** Cost of affordable housing was the highest ranked economic concern at 4.00. Skilled labor workforce and employment options were also top concerns at 3.29 and 3.0 respectively.

2. **Children and Youth:** Childhood obesity ranks highest of the concerns for children and youth with a ranking of 2.86. Other top concerns were availability of education about birth control (2.8) and teen pregnancy (2.8).

3. **Health Care and Wellness:** Access to affordable prescription drugs was of highest concern to survey respondents at 3.33. Access to affordable health insurance coverage and access to affordable health care were other key concerns ranking at 3.29 each.

4. **Aging Population:** At 2.80, the cost of in-home services was the top aging concern among survey respondents. Additionally, cost of long-term care and the cost of memory care at 2.80 each were also mentioned as community needs.

5. **Mental Health/Behavioral Health**: Survey respondents indicated that depression was the top mental health concern at a rating of 2.86. Alcohol (2.71) and drug (2.86) use and abuse were also mentioned as concerns.

Key Findings – Secondary Research Based on the 2019 County Health Rankings

Health Outcomes

	Tripp County	National	South Dakota
Premature Death (years of life lost before age 75 per 100,000 population)	7,500	5,400	7,300
Poor or Fair Health	14%	12%	12%
# unhealthy mental health days in the last 30 days	3.2	3.1	2.9
% live births with low birth weight (<2500g)	8%	6%	6%

Health Factors

	Tripp County	National	South Dakota
% adults currently smoking	17%	14%	18%
% adults considered obese (BMI > 30)	34%	26%	31%
% adults reporting excessive or binge drinking	17%	13%	20%
# alcohol-impaired driving deaths	50%	13%	36%
# sexually transmitted infections	184.0	152.8	504
Teen birth rate (# of births per 1,000 female pop. 15-19)	35	14	28
% uninsured adults	15%	6%	10%
Ratio of population to primary care Physicians	1,100:1	1,050:1	1,320:1
Ratio of population to mental health providers	290:1	310:1	590:1
Ratio of population to dentists	1,090:1	1,260:1	1,690:1
Preventable hospital stays (per 100,000 Medicare enrollees)	6,018	2,765	4,724
Mammography screening	37%	49%	49%
High school graduation rate	88%	96%	84%
College (at least some post-secondary education)	52%	73%	68%
Unemployment rate	2.9%	2.9%	3.3%
% child poverty	27%	11%	16%
Social associations (# membership associations per 10,000 people)	21.8	21.9	16.4
% children in single-parent households	25%	20%	31%
Violent crime	147	63	373

Food insecurity	14%	9%	12%
Home ownership	69%	80%	68%
% children eligible for free/reduced lunch	47%	32%	38%
Annual median household income	$42,700	$67,100	$56,900

The following needs were brought forward for prioritization:
- Economics
- Children and Youth
- Health Care and Wellness
- Aging Population
- Mental Health/Behavioral Health

Winner Regional Health has determined the 2020-2022 implementation strategies for the following needs:
- Health Care and Wellness
- Children and Youth

Implementation Strategies
Implementation Strategy for Winner Regional Health (WRH)

2020-2022 Action Plan

Priority 1: Children and Youth

Projected Impact: Fit Youth for a Healthy Future

Goal 1: Assisting area youth with establishing healthy habits based on smart food choices and active lifestyles.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships / collaborations (if applicable)
Promoting health and well being by educating local students on 1) Healthy food choices, and 2) The benefits of living an active lifestyle.	Education will be done with students periodically throughout the year.		WRH Leadership	Winner School District

Priority 2: Healthcare and Wellness

Projected Impact: Bring an awareness to employees and community regarding the importance of being healthy and keeping active.

Goal 1:

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships / collaborations (if applicable)
WRH Wellness Committee will incorporate up to a 15 minutes 'recess' for employees to help reduce stress.	• # of participants at start of program • # of participants at the end of the program • Pre survey followed up with a post survey to evaluate physical (i.e. blood pressure) and mental stress levels.		WRH Leadership	

Community Health Needs Assessment 2019

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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 not-for-profit status and create opportunity to identify and address public health issues from a broad perspective.

At Winner Regional Healthcare, ongoing commitment to quality and integrity is reflected in our mission statement: *Professional Care with a Personal Touch.* Thank you for entrusting your health care to Winner Regional Health. We are proud to be a part of the community and we look forward to providing a continuum of care for many years to come.

Regulatory Requirements

Federal regulations stipulate that non-profit medical centers conduct a community health needs assessment at least once every three years and prioritize the needs for the purpose of implementation strategy development and submission in accordance with the Internal Revenue Code 501(r). IRS Code 501(r) requires that each hospital must have: (1) conducted a community health needs assessment in the applicable taxable year; (2) adopted an implementation strategy for meeting the community health needs identified in the assessment; and (3) created transparency by making the information widely available.

The regulations stipulate that each medical center take into account input from persons who represent the broad interests of the community. We are required to seek at least one state, local, tribal or regional government public health department or state Office of Rural Health with knowledge, information or expertise relevant to the health needs of the community.

Non-profit hospitals are required to seek input from members of medically underserved, low income, and minority populations in the community, or organizations serving or representing the interest of such populations, and underserved populations experiencing disparities or at risk of not receiving adequate care as a result of being uninsured or due to geographic, language or financial or other barriers.

The community health needs assessment includes a process to identify community resources available to address the assessed needs and to prioritize the needs. Hospitals are to address each assessed need or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on the IRS 990 and a status report must be provided each year on IRS form 990 Schedule H.

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for the report. Sanford places the CHNA reports and the implementation strategies on the Sanford website. Hospitals are required to keep three cycles of assessments on the web site.

Acknowledgements

Winner Regional Health would like to thank the Center for Social Research at North Dakota State University for their assistance and expertise while performing the assessment and analysis of the community health data.

Winner Regional Health Leadership:
- Kevin Coffey – CEO, Winner Regional Health
- Deb Davis – DOO, Winner Regional Health
- Kristine Schmidt – Interim DON, LTC, Winner Regional Health
- Julie Hennebold – CNO, Winner Regional Health
- Earl "Skip" Pierce – CFO, Winner Regional Health
- Nicole Olson – Clinic Director, Winner Regional Health
- Betty Tideman – Administrative Assistant, Winner Regional Health

We express our gratitude to the following community collaborative members for their expertise with the CHNA process. From planning, development and analysis of the community health needs assessment to completing the survey, numerous community members contributed to this project for which we are grateful.

- Kevin Coffey – CEO, Winner Regional Health
- Deb Davis – DOO, Winner Regional Health
- Sara Chytka, Rural Advocate / Outreach Specialist, Winner Resource Center
- Betty Tideman, Winner Regional Health
- Nicole Olson, Winner Regional Health
- Julie Hennebold, CNO, Winner Regional Health
- Earl "Skip" Pierce, CFO, Winner Regional Health
- Lana Stickland, Insurance Agent, Winner
- Keven Morehart, School Superintendent, Winner School District

We extend special thanks to *physicians, nurses, school leadership and school board members, representatives from the Native American community, representatives for the mentally and physically disabled, social services, the county sheriff, non-profit organizations, and public health officers for their participation in this work.*

Description of Winner Regional Health

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

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

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

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

Winner Regional Health is a 25-bed Critical Access Hospital and 80-bed long-term care facility that caters to the health needs of south central South Dakota and north central Nebraska.

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

- Audiology
- Cardiology
- Dermatology
- Diabetic Education
- Dietician
- Lactation Consultant
- Neurology
- Nephrology
- OB/GYN
- Ophthalmology
- Oral Sedation
- Orthopedics
- Outpatient chemotherapy
- Pain Clinic
- Podiatry
- Pulmonology

- Retail Pharmacy (Winner Regional Health Pharmacy)
- Speech Therapy
- Urology
- Vascular

Description of the Community Served

Winner, South Dakota is located in south central South Dakota along Highways 18, 183 and 44 and is the county seat of Tripp County. The population of Winner is 3,137 and the city covers approximately 922.5 acres of land. Winner was part of the famous Louisiana Purchase of 1803 and later part of the Dakota Territory, established by an act of Congress and a proclamation by President Abraham Lincoln in 1861.

Winner was so named because it was the "winner" in the struggle to establish a town along the railroad right-of-way when the Chicago North Western began moving west from Dallas, SD in 1909.

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

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

Limitations of the Study

The findings in this study provide a limited snapshot of behaviors, attitudes, and perceptions of residents living in the Winner, SD area. Invitations were extended to a wide base of county and city leadership, local organizations and agencies representing diverse populations and disparities. However, when comparing certain demographic characteristics (i.e., age, income, minority status) with the current population estimates from the U.S. Census Bureau, it was evident that older, white, more highly educated, and higher income earners were overrepresented. Overrepresentation of this nature is typical in health needs assessments.

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

A good faith effort was made to secure input from a broad base of the community. Invitations were extended to county and community leaders, 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.

Winner Regional Health 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 to develop the survey tool and throughout the assessment process.

Public comments and response to the community health needs assessment and the implementations strategies are welcome on the Winner Regional Health web at http://winnerregional.org

Key Findings

Community Health Concerns

Economics
The availability of affordable housing is of high concern for the respondents of the survey. Other concerns included skilled labor workforce and employment options.

Level of concern with statements about the community regarding ECONOMIC WELL-BEING
(1=no attention needed; 5=critical attention needed)

|	
Availability of affordable housing (N=7)	4.00
Skilled labor workforce (N=7)	3.29
Employment options (N=7)	3.00

Aging Population
The greatest areas of concern among survey respondents for the aging population includes the cost of in-home services and the cost of long-term care and memory care. Respondents are also concerned about the availability of resources to help the caregiver.

Level of concern with statements about the community regarding the AGING POPULATION
(1=no attention needed; 5=critical attention needed)

|	
Cost of in-home services (N=5)	2.80
Cost of long-term care (N=5)	2.80
Cost of memory care (N=5)	2.80
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=7)	2.71
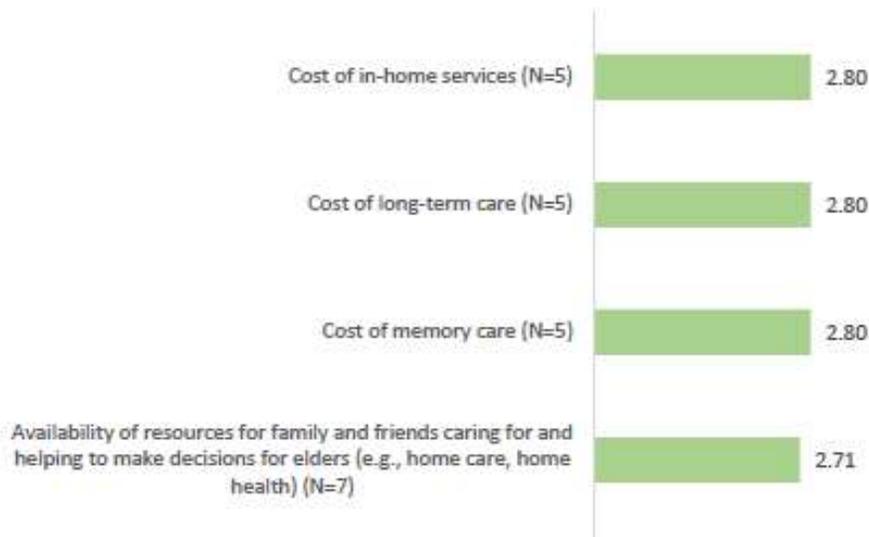
Children and Youth
The highest concerns regarding children and youth are childhood obesity, availability of education about birth control, teen pregnancy, and availability of quality childcare.

Level of concern with statements about the community regarding CHILDREN AND YOUTH
(1=no attention needed; 5=critical attention needed)

|	
Childhood obesity (N=7)	2.86
Availability of education about birth control (N=5)	2.80
Teen pregnancy (N=5)	2.80
Availability of quality child care (N=6)	2.67
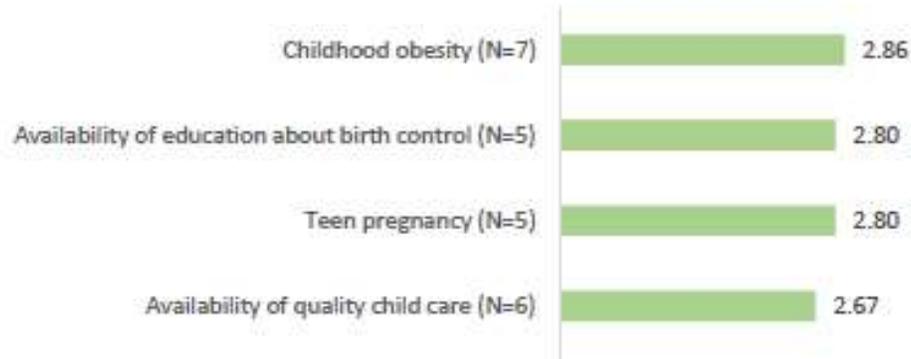
Safety
Respondents have concerns with respect to safety issues concerning the abuse of prescription drugs, child abuse and neglect, criminal activity, and domestic violence.

Level of concern with statements about the community regarding SAFETY
(1=no attention needed; 5=critical attention needed)

Abuse of prescription drugs (N=6)	2.67
Child abuse and neglect (N=6)	2.50
Criminal activity (N=6)	2.50
Domestic violence (N=6)	2.50
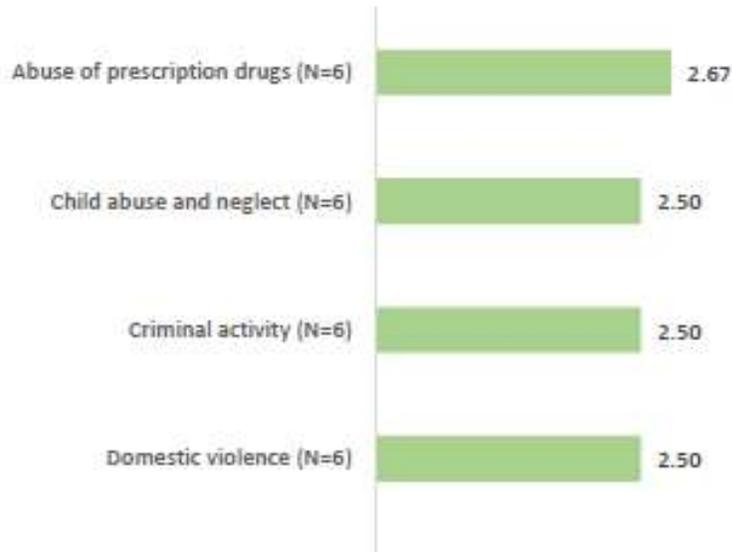
Health Care and Wellness

The top concern among survey respondents is access to affordable prescription drugs. Access to affordable health care and vision insurance coverage, affordable health care, and availability of providers are also areas of concern in the community.

Level of concern with statements about the community regarding HEALTH CARE AND WELLNESS
(1=no attention needed; 5=critical attention needed)

| Statement	Score
Access to affordable prescription drugs (N=6)	3.33
Access to affordable health insurance coverage (N=7)	3.29
Access to affordable healthcare (N=7)	3.29
Access to affordable vision insurance coverage (N=7)	2.71
Availability of doctors, physician assistants, or nurse practitioners (N=7)	2.71
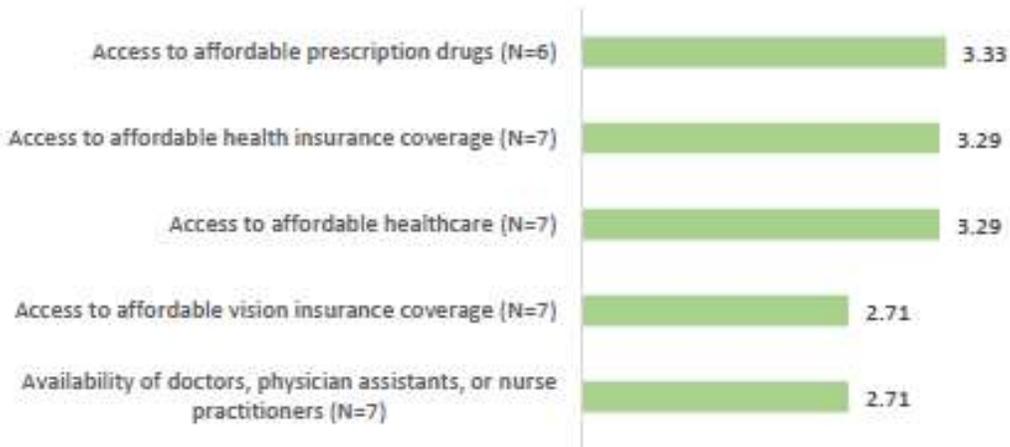
Mental Health and Substance Abuse

Survey respondents were concerned a variety of mental health and substance abuse issues including depression, drug use and abuse, alcohol use and abuse, and dementia and Alzheimer's disease.

Level of concern with statements about the community regarding MENTAL HEALTH AND SUBSTANCE ABUSE
(1=no attention needed; 5=critical attention needed)

Statement	Score
Depression (N=7)	2.86
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=7)	2.86
Alcohol use and abuse (N=7)	2.71
Dementia and Alzheimer's disease (N=7)	2.57
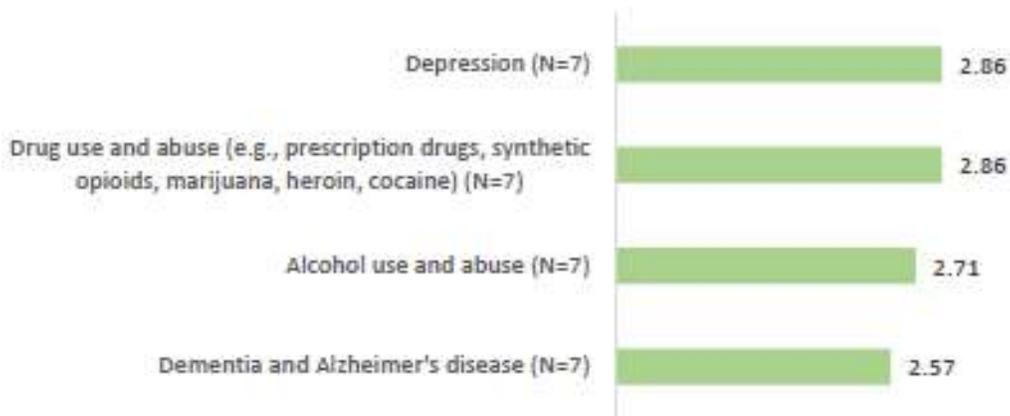
Personal Health Concerns

Respondents' Personal Health Status
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI), which calculates weight status using an individual's weight and height, the majority (63%) of respondents reported themselves as overweight or obese. However, the vast majority (95%) of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, 69% visited a doctor or health care provider for a routine physical and 77% visited a dentist or dental clinic.

Respondents' rating of their health in general

Excellent — 26%
Very Good — 46%
Good — 23%
Fair — 6%
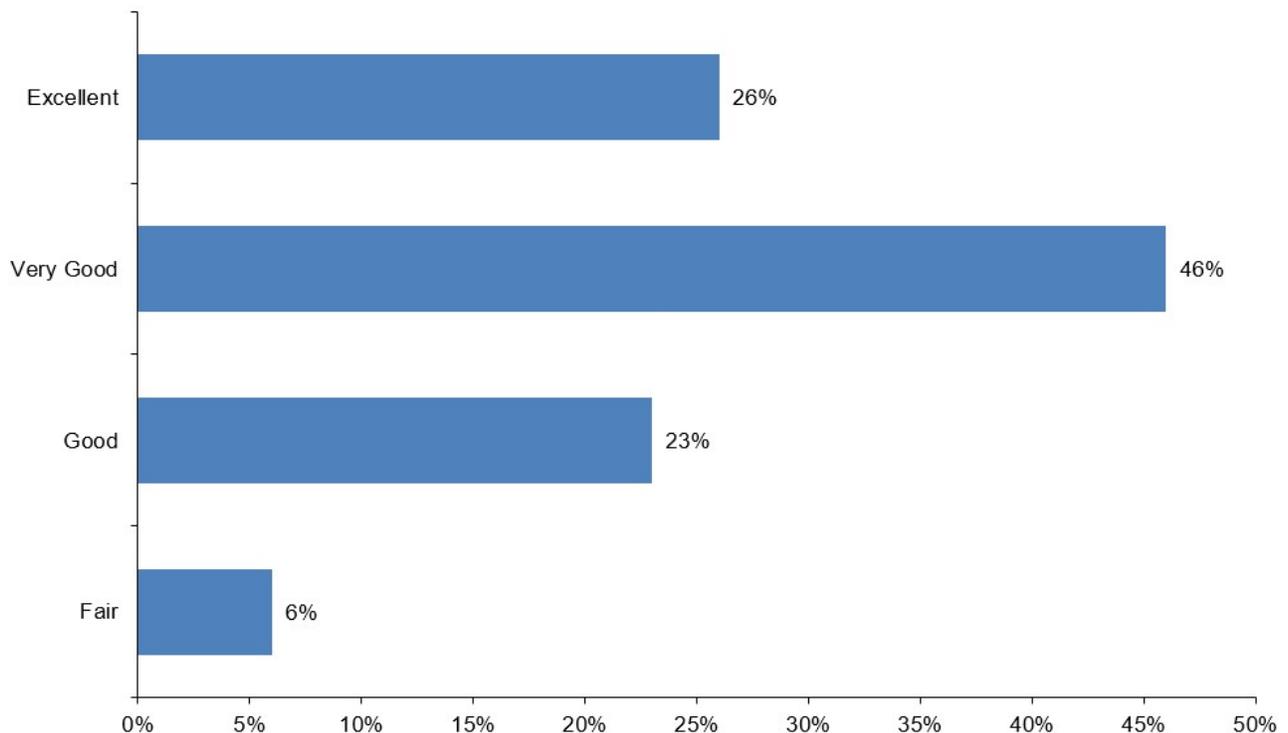
Base: Fair (n=2), Good (n=8), Very Good (n=16), Excellent (n=9), Sample Size = 35

Obesity is a common, but serious disease. Obesity can have adverse effects on health and lead to a reduced life expectancy. Adults with a BMI over 25 are considered overweight and adults with a BMI over 30 are considered obese. According to the CDC, obesity and overweight are the second leading cause of preventable deaths, tagging close behind tobacco use.

Health conditions related to obesity:
- Coronary heart disease
- Type 2 diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension
- Dyslipidemia
- Stroke

- Liver and gallbladder disease
- Sleep apnea and respiratory problems
- Osteoarthritis
- Gynecological problems

Nationally, more than 30% of adults, 17% of youth age 6-19 years, and more than 8% of children 2 to 5 years of age are obese.

For information about the BMI, visit the Center for Diseases Control and Prevention, *About BMI for Adults*, www.cdc.gov/healthyweight/assessing/bmi/

Respondents' weight status based on the Body Mass Index (BMI) scale
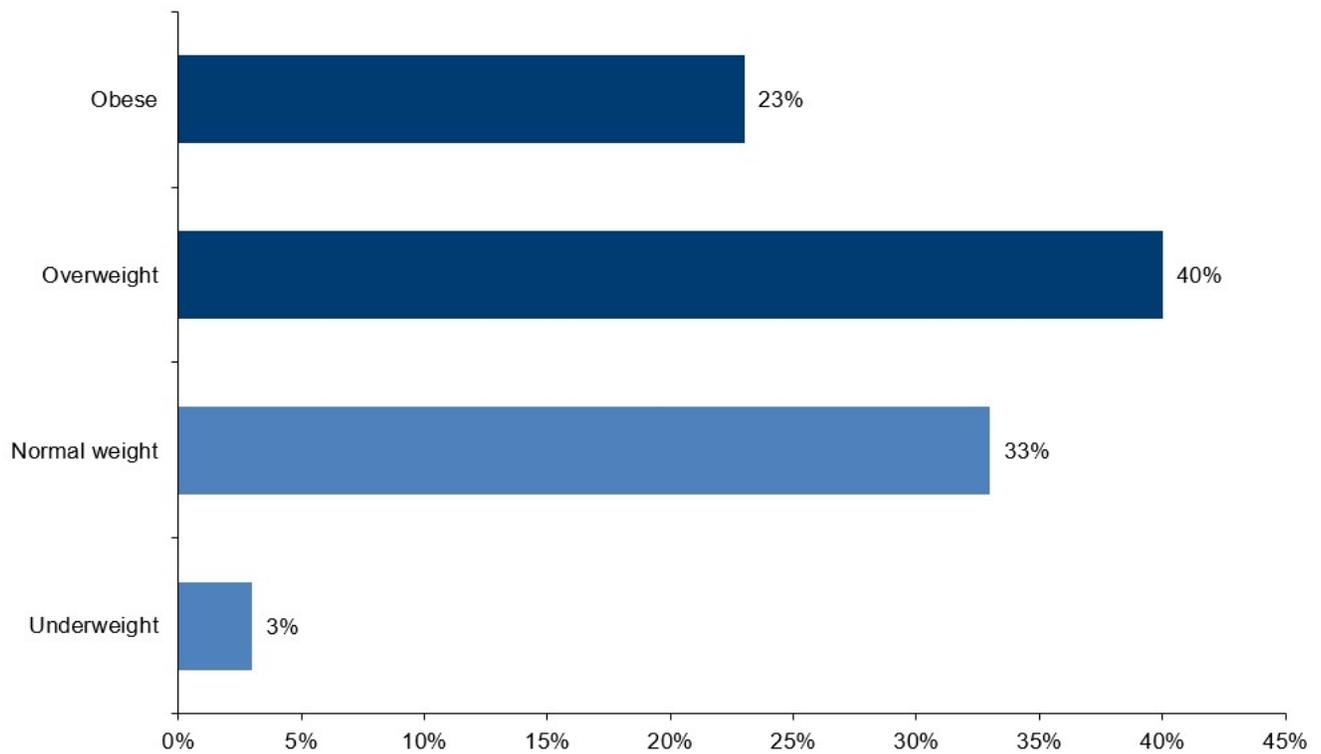
Base: Underweight (n=1), Normal weight (n=10), Overweight (n=12), Obese (n=7), Sample Size = 30

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.
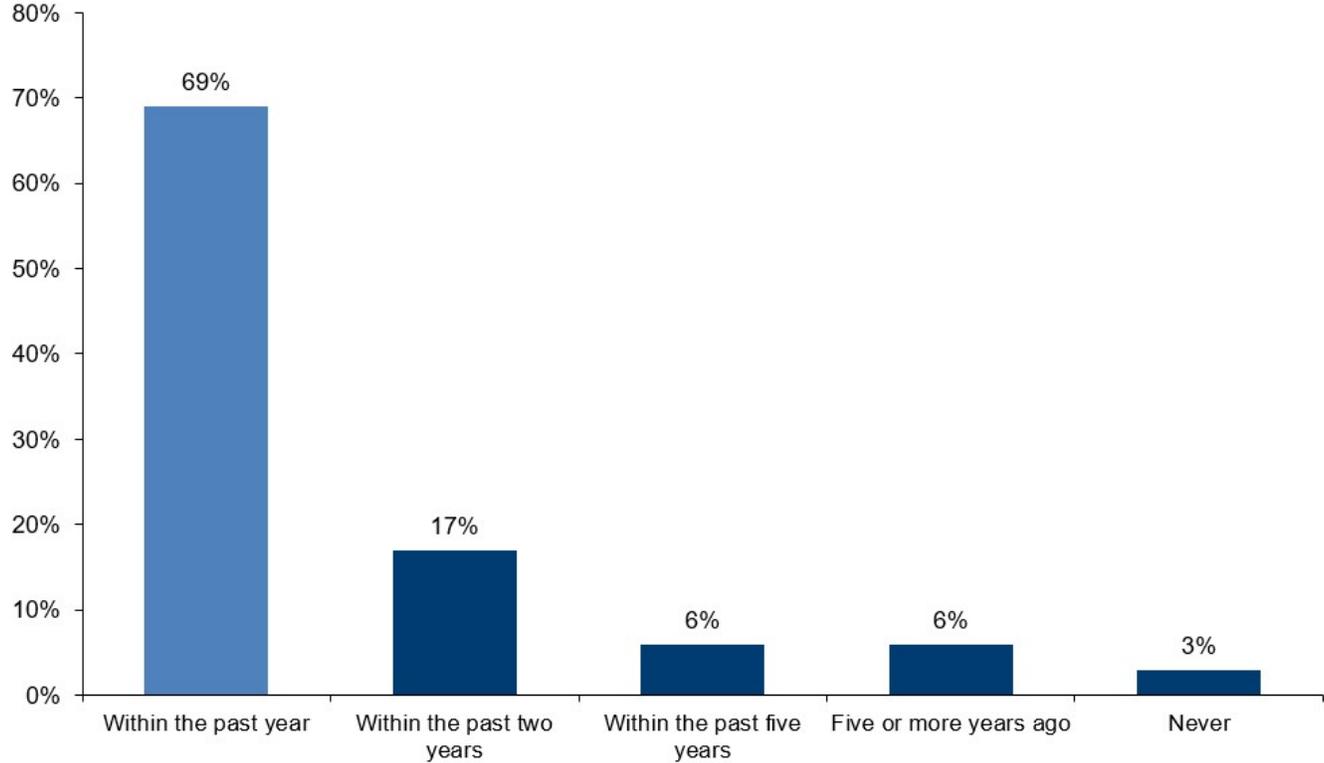

Base: Within the past year (n=24), Within the past two years (n=6), Within the past five years (n=2), Five or more years ago (n=2), Never (n=1), Sample Size = 35

Preventive Health

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

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

Whether or not respondents have had preventive screenings in the past year, by type of screening
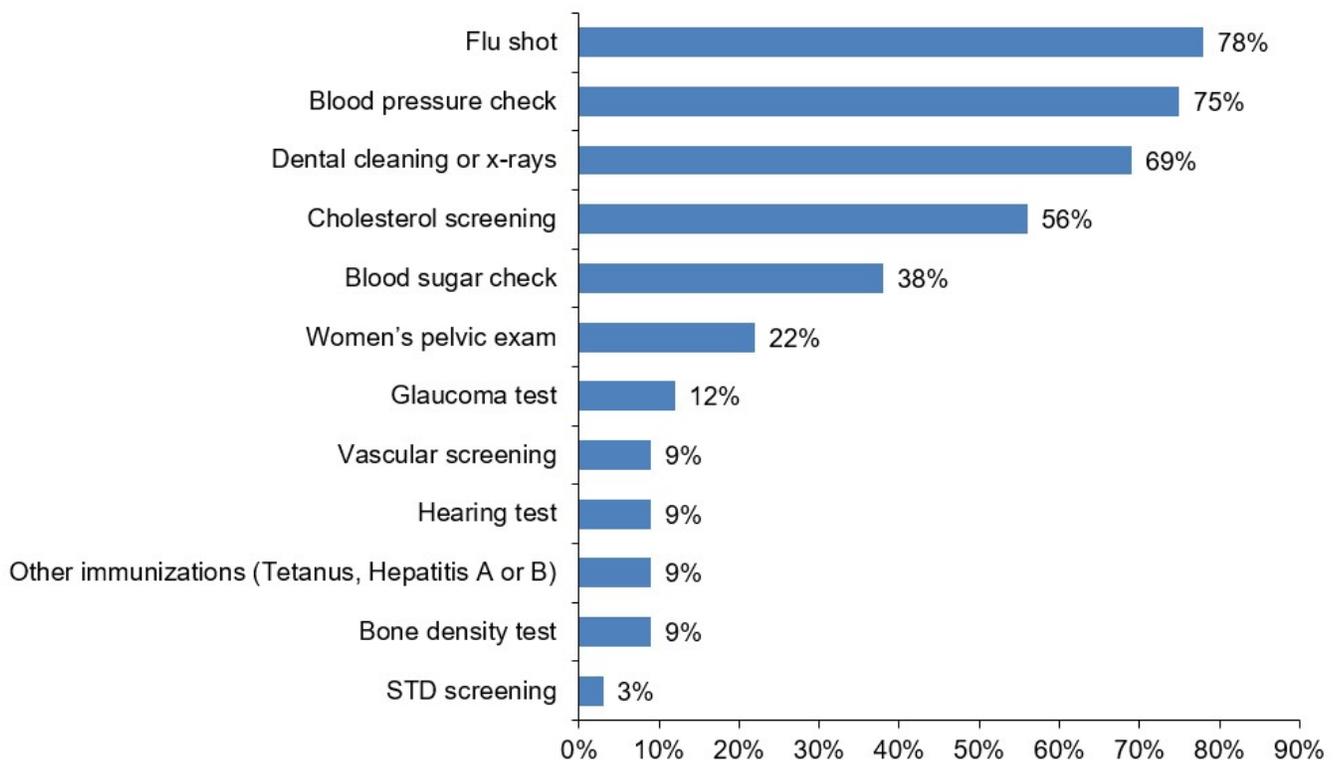
Flu shot — 78%
Blood pressure check — 75%
Dental cleaning or x-rays — 69%
Cholesterol screening — 56%
Blood sugar check — 38%
Women's pelvic exam — 22%
Glaucoma test — 12%
Vascular screening — 9%
Hearing test — 9%
Other immunizations (Tetanus, Hepatitis A or B) — 9%
Bone density test — 9%
STD screening — 3%

Base: Blood pressure check (n=24), Blood sugar check (n=12), Bone density test (n=3), Cholesterol screening (n=18), Dental cleaning or x-rays (n=22), Flu shot (n=25), Other immunizations (Tetanus, Hepatitis A or B) (n=3), Glaucoma test (n=4), Hearing test (n=3), Women's pelvic exam (n=7), STD screening (n=1), Vascular screening (n=3), Sample Size = 32

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 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.
  - The HPV test looks for the virus that can cause these cell changes (human papillomavirus) (http://www.cdc.gov/cancer/hpv/basic_info/)

- *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: 1) 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; 2) 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 survey indicate that 26% 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 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 31% of respondents reported having 3 or more servings of vegetables the prior day, and only 12% respondents reported having 3 or more servings of fruits the prior day.

According to the U.S. Department of Health and Human Services, U.S. Department of Agriculture Dietary Guidelines for Americans, it is recommended that individuals consume 3 to 5 servings of vegetables per day and 2 to 4 servings of fruit per day depending on age. A 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
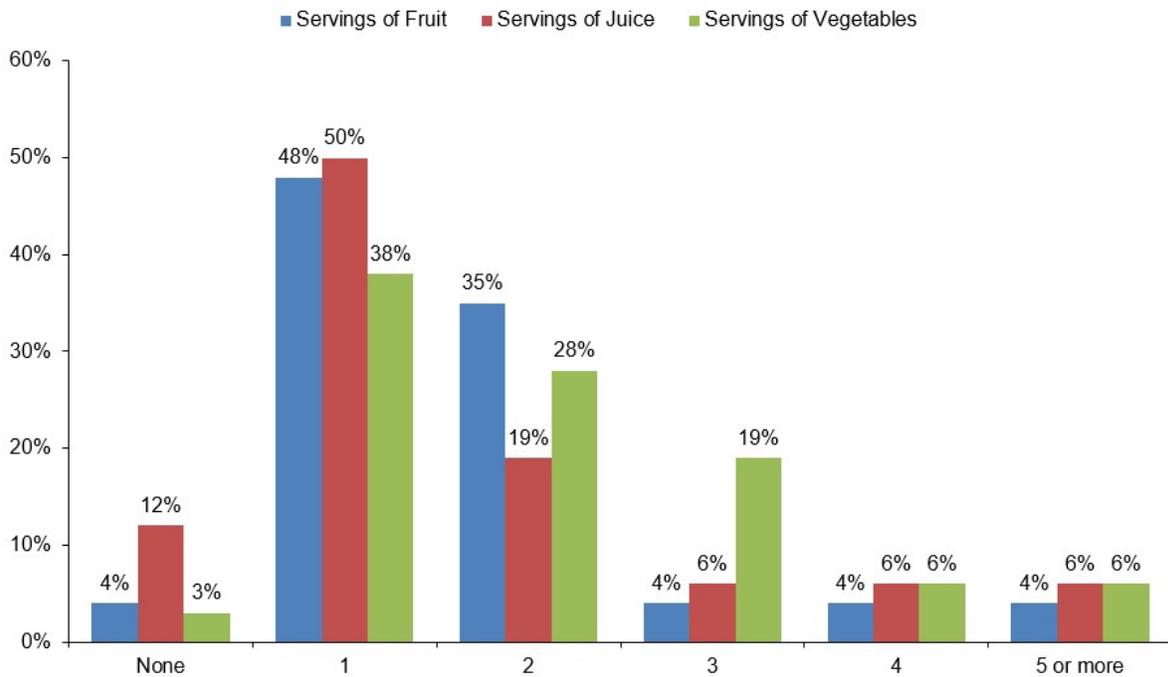
Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines. 54% of survey respondents engage in moderate activity 3 or more times per week and 21% 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
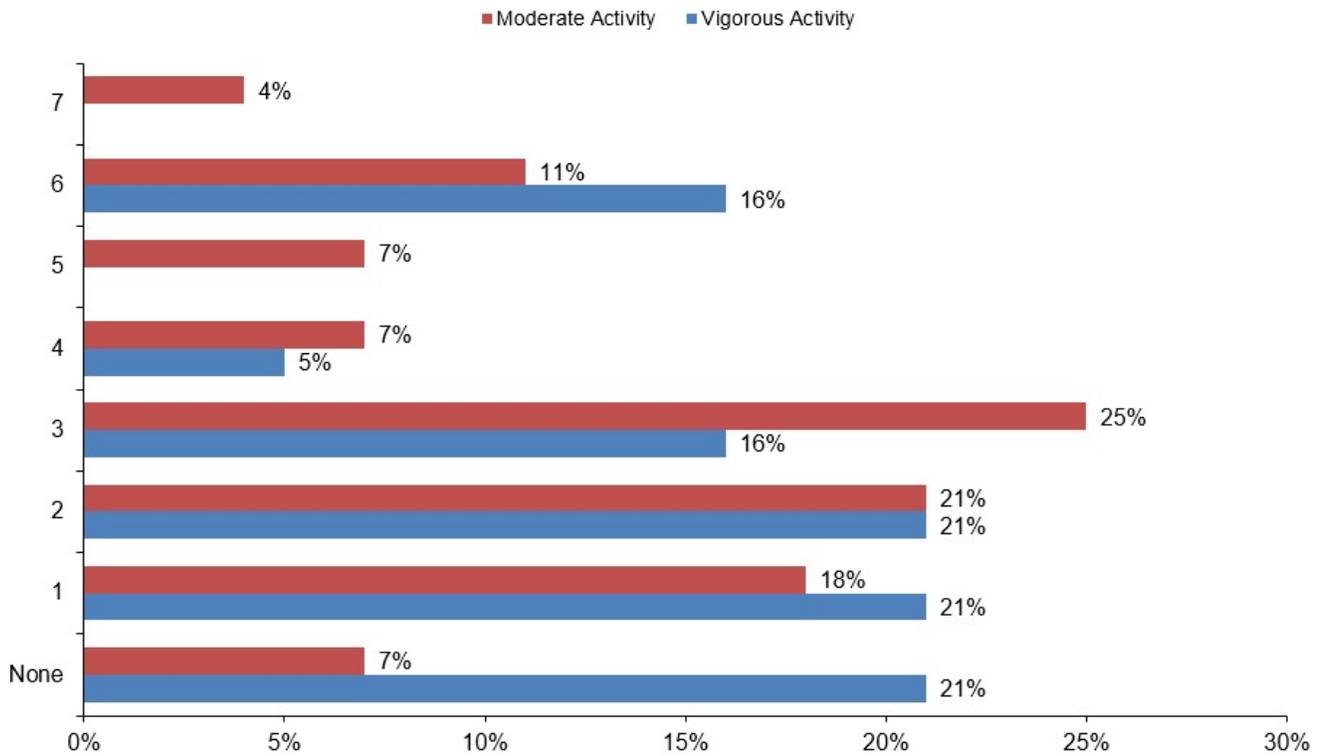
Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users with only 3% of respondents indicating they use tobacco on a daily basis. Secondary research through the 2019 *County Health Rankings* finds that 17% of Tripp County residents are current smokers.

**How often respondents currently use tobacco**
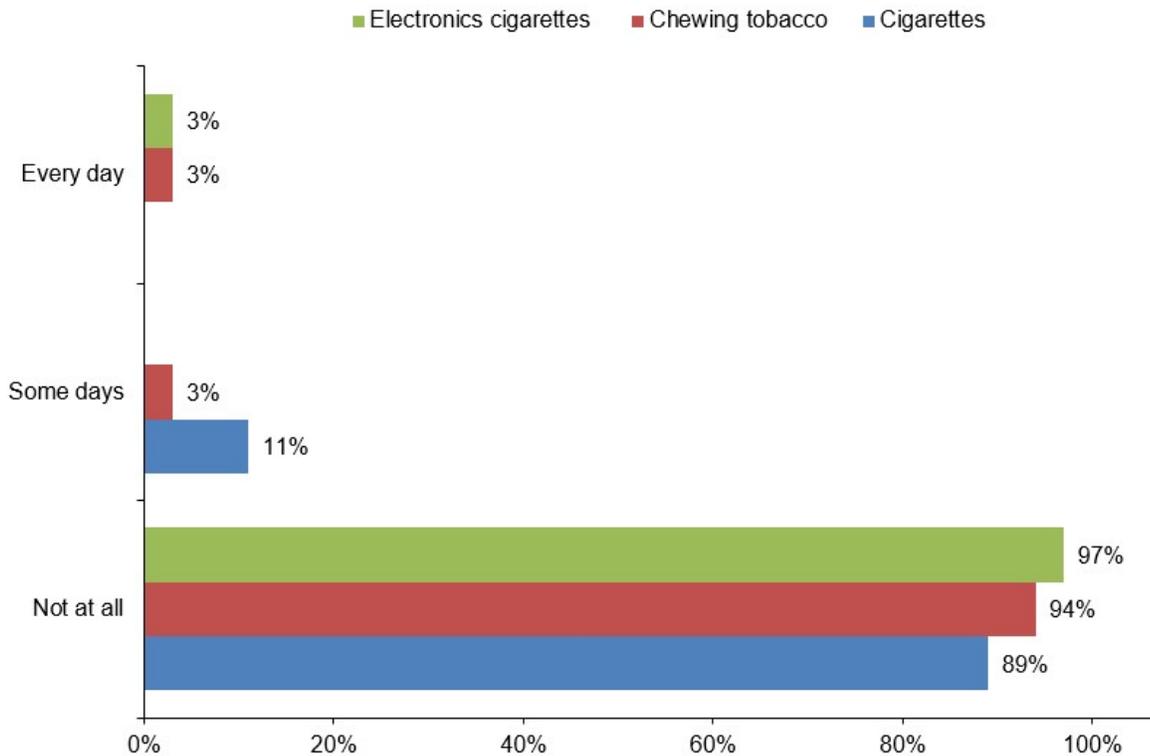
Mental Health

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 survey respondents, mental health is a moderately high area of concern. 23% of respondents report that they had little interest or pleasure in doing things several days per week or more, and 26% report that they feel down, depressed, or hopeless several days per week or more.

Percentage of respondents who have been bothered by these issues over the past two weeks

Legend: ■ Feeling down, depressed or hopeless ■ Little interest or pleasure in doing things

| Category	Feeling down, depressed or hopeless	Little interest or pleasure in doing things
Nearly every day	3%	3%
More than half the days	6%	6%
Several days	17%	14%
Not at all	74%	77%
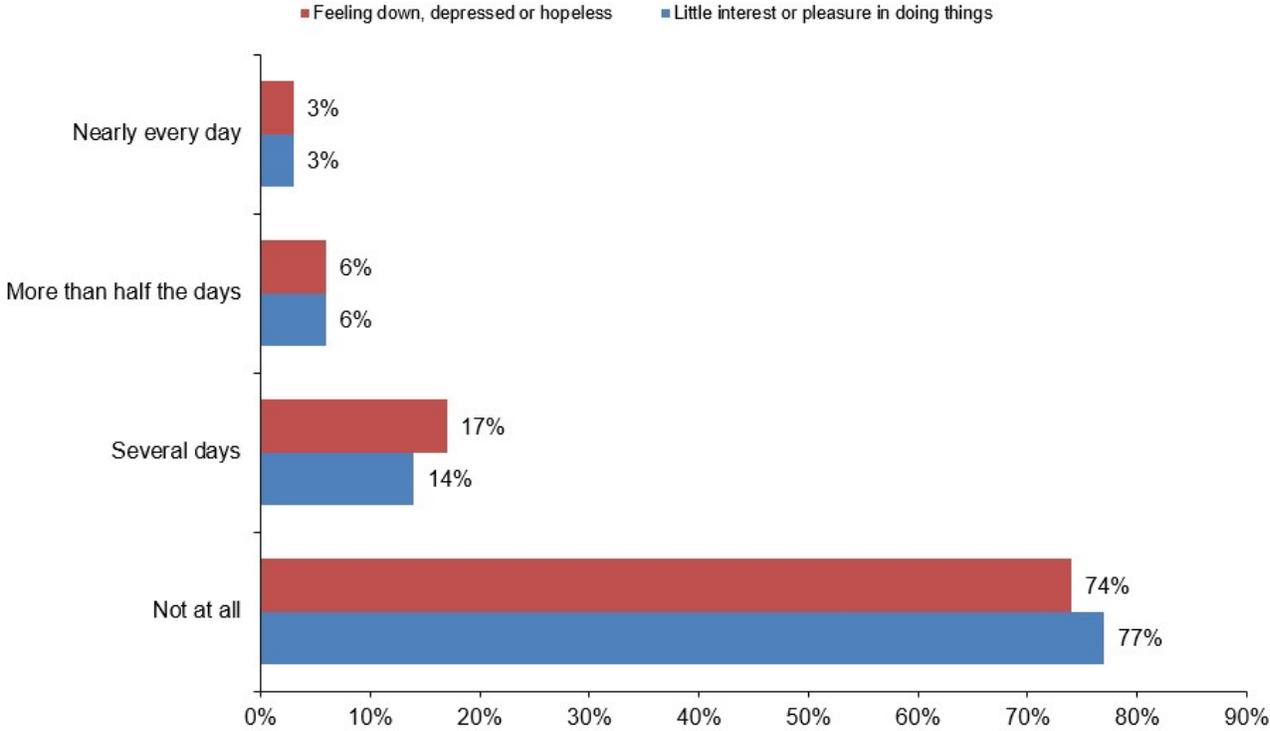
Substance Abuse Responses

Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In the Winner community, 29% of respondents report binge drinking at least once per month and 17% report binge drinking two to three times per week. Secondary research through the 2019 *County Health Rankings* indicates that 17% of Tripp County residents report excessive drinking. 9% of respondents indicated that alcohol has had a harmful effect on themselves or on a family member in the past two years.

Number of times with at least 1 drink in the past 30 days

Base: None (n=2), 1 to 7 days (n=13), 8 to 14 days (n=5), 15 to 21 days (n=4), 22 to 30 days (n=2), Sample Size = 26

Average number of drinks per day when you drink by gender

Base: 1 drink (n=11), 2 drinks (n=5), 3 drinks (n=3), 4 drinks (n=1), 5 or more drinks (n=2), Sample Size = 22
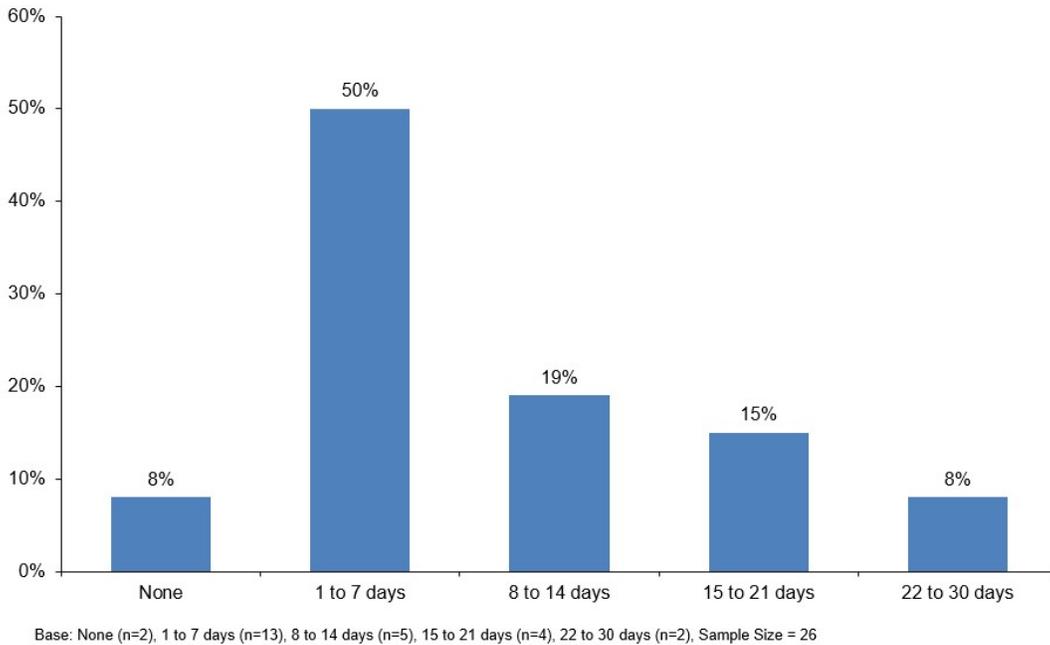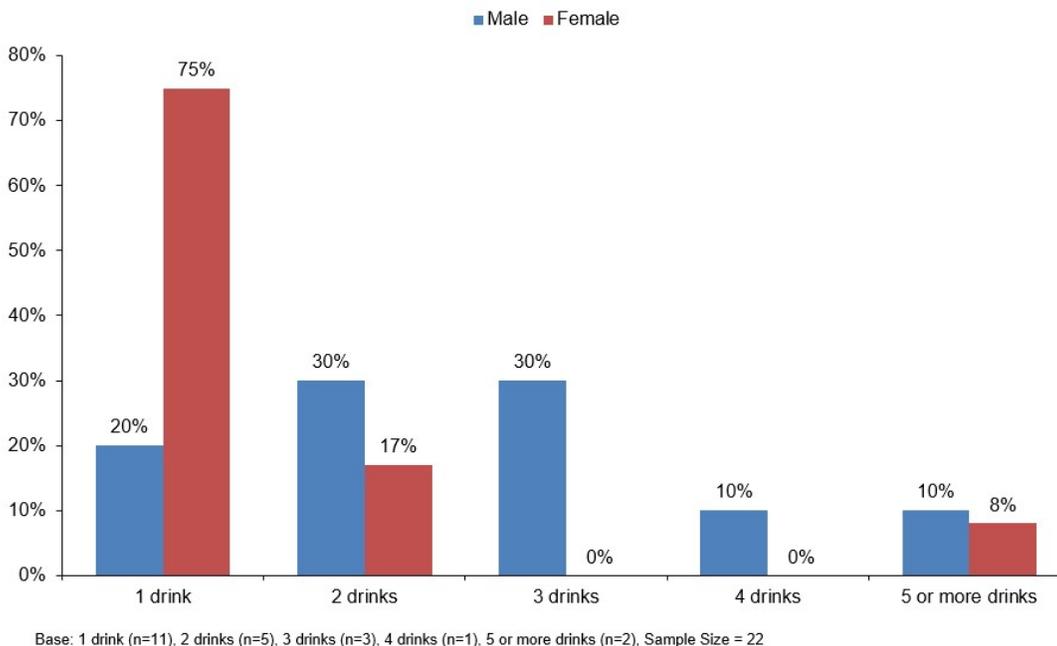
Demographics

General Population Data – Tripp County, South Dakota

	Tripp County
Total population	5,460
Median age	46.5
Median household income	$48,409
% living below poverty level	19.7%
Unemployment rate	2.9%
% high school graduate or higher	89.4%

Source: 2017 United States Census Bureau – www.census.gov

Survey Respondents

Of the respondents, 57% were female and 43% were male. 83% of respondents owned their own homes, 71% were employed with 29% self-employed, and 71% had completed at least some post-secondary education. 29% of those surveyed are military veterans.

Zip code of respondents

Zip code	**# of respondents**
57580	6

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. Top priorities, for further development into implementation strategies, were determined via the multi-voting methodology.

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

The asset map includes identified needs from the following:
- Identified needs from the non-generalizable survey
- Community stakeholders review and further development
- Secondary research data
- Community resources that are available to address the need(s)

The Asset Map can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:
- Economics – availability of affordable housing and skilled labor workforce
- Children and Youth – childhood obesity, availability of information about birth control, teen pregnancy
- Health Care and Wellness – access to affordable prescription drugs, access to affordable health insurance coverage health care
- Aging Population – cost of in-home services, cost of long-term care and memory care
- Mental Health – depression and drug use and abuse

WRH 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, WRH leaders will communicate the findings to community leaders and experts who can best focus on a solution to the concern.

A document that shares what Winner Regional Health is doing to address the need or defends why WRH is not addressing the need can be found in the Appendix.

Members of the community stakeholder group determined that children and youth and healthcare and wellness are the top unmet needs. Winner Regional Health has determined the 2020-2022 implementation strategies for the following needs:
- Children and Youth
- Healthcare and Wellness

Addressing the Needs

Identified Concerns	How Winner Regional Health is addressing the needs
Economics • Cost of affordable housing 4.00 • Skilled labor workforce 3.29 • Employment options 3.00	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders.
Children and Youth • Childhood obesity 2.86 • Availability of education about birth control 2.8 • Teen pregnancy 2.80	The focus will be on educating our youth in the community on the importance of establishing healthy habits based on smart food choices and active lifestyles. Page 36 provides further detail.
Healthcare and Wellness • Access to affordable prescription drugs 3.33 • Access to affordable health insurance coverage 3.29 • Access to affordable health care 3.29	The focus areas starting in 2020 and going through to 2022 that the Wellness Committee will spearhead will be the focus on employees at WRH and providing stress release activities. The Action Plan on page 36 provides the detail.
Aging • Cost of in-home services 2.80 • Cost of long-term care 2.80 • Cost of memory care 2.80	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders.
Mental Health / Behavioral Health • Depression 2.86 • Drug use and abuse 2.86 • Alcohol use and abuse 2.71 • Dementia and Alzheimer's Disease 2.57	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders.

2020-2022 Implementation Strategies

Implementation Strategy for Winner Regional Health (WRH)

2020-2022 Action Plan

Priority 1: Children and Youth

Projected Impact: Fit Youth for a Healthy Future

Goal 1: Assisting area youth with establishing healthy habits based on smart food choices and active lifestyles.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships / collaborations (if applicable)
Promoting health and well being by educating local students on 1) Healthy food choices, and 2) The benefits of living an active lifestyle.	Education will be done with students periodically throughout the year.		WRH Leadership	Winner School District

Priority 2: Healthcare and Wellness

Projected Impact: Bring an awareness to employees and community regarding the importance of being healthy and keeping active.

Goal 1:

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships / collaborations (if applicable)
WRH Wellness Committee will incorporate up to a 15 minutes 'recess'	• # of participants at start of program • # of participants at the end of the program		WRH Leadership	

for employees to help reduce stress.	• Pre survey followed up with a post survey to evaluate physical (i.e. blood pressure) and mental stress levels.				

2016 Implementation Strategy Impact

The 2016 Community Health Needs Assessment served as a catalyst to lift up physical health, mental health, and behavioral health as implementation strategies for the 2017-2019 timespan. The following strategies were implemented.

Concerns Identified	2017-2019 Implementation Strategies
Health Care Access	• Conduct community focus groups to develop a strategic plan based on the outcome • Evaluate the usage of the emergency room to determine how many visits are Level 1 • Determine how many ill patients are seen the same day as they call the clinic
Physical Health	• Improve the overall physical health of the community • Offer Better Choices, Better Health support group meetings • Encourage healthier eating

These 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.

1. **Impact of the Strategy to Improve Health Care Access**

   The first concern identified was Health Care Access. The actions that were conducted with the first Goal were to Conduct Community Focus Groups, prioritize the results and develop a plan to address the needs. Throughout the three-year period, the focus groups were conducted, the feedback was prioritized and the plan was implemented. During this same period, a building project was underway and many of the issues from the concerns addressed in the focus groups were resolved. Other items that were not a result of the physical building layout were addressed throughout the CHNA timeframe.

   The second goal was to evaluate the usage of the emergency room. There appeared to be less than 1% of emergency room visits that were classified as a level 1, or clinic type needs.

   The third goal was to determine if patients that call the clinic and needed to see a clinician due to being ill, could be seen the same day. A process has been developed where a provider is available to handle walk-in patients. The impact of the three goals has been overall successful. The community now knows we listen to their concerns, the emergency room is rarely being used as a clinic visit and patients can get access to a provider for illness the same day they call.

2. **Impact of the Strategy to Enhance the Physical Health of the Winner Community**

   The Physical Health of the Community was the second key concern addressed during the 2017 – 2019 CHNA. WRH is fortunate to have medical students that complete a rotation in rural areas. The program is called FARM (Frontier and Rural Medicine). One of the requirements of the program is to do community projects to bring health related awareness to community members.

   The second strategy was to offer the program Better Choices, Better Health support group meetings in and around the Winner area. This program helps people with chronic conditions (i.e. diabetes, pain, and any disease that has affected one's life) by providing coping skills to enhance the person's daily life. The program is gaining popularity throughout the entire state and those that have taken the six-week workshop feel the course was valuable to them.
   The third task was to encourage healthier eating. Physical Health must start with awareness and knowledge. The three tactics WRH chose to focus did just that.

Community Feedback

Winner Regional Health leadership is prepared to accept feedback on our 2016 Community Health Needs Assessment and has provided online comment fields for ease of access on our website.

Please address your concerns or questions at: http://winnerregional.org

APPENDIX

Primary Research

Winner Regional Health - Asset Mapping

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings or Focus on SD Report	Community resources that are available to address the need
Economics • Cost of affordable housing 4.00 • Skilled labor workforce 3.29 • Employment options 3.00	16.7% of respondents rent versus owning a home	11% of county residents have housing problems (overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities) Median household income $42,700 lower than SD Avg. $56,900	Apartments in Winner: • Frontier Apts. 605-347-3077 • Presidential Square 605-842-1012 • Lamro Apts. 605-842-3615 • Homestead Townhomes 605-224-8231 Low Income Housing in Winner: • Lamro Apts. 605-271-4663 • Homestead Apts. 952-949-2200 Realtors and/or Housing contacts in Winner: • Shippy Realty 605-609-7599 • Dan Clark Realty 605-842-3300 • Whetham Realty 605-842-3020 • Burns Rentals 605-842-1930 • Mathis Rentals 605-842-0254 Burke Housing & Redevelopment Commission – 605-775-2676 Labor/employment resources: • Winner Department of Labor and Regulation Office – 605-842-0474 • SD Works - link • DLR On-the-Job Training Program – 605-773-4133

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings or Focus on SD Report	Community resources that are available to address the need
			• Start Today SD Apprenticeship Program - link • Veterans Employment Info – link
Children and Youth • Childhood obesity 2.86 • Availability of education about birth control 2.8 • Teen pregnancy 2.80	27% of children have not had a medical check-up in the last year 42% of respondents reported 1 or fewer days of physical activity per week 1 in 10 respondents reported that having money for food has been an issue	26% of children live in poverty 47% of children are eligible for free or reduced price lunches higher than SD Avg. 38% Teen birth rate of Tripp County (40 per 1000) is higher than SD Avg. 34 per 1000 8% of babies are classified as low birthweight versus 6% statewide	Childhood obesity resources: • AWANA - 605-842-2020 • School District - 605-842-0894 • 4-H Club - 605-842-1155 • Boy Scouts Troop 100 - 605-361-2697 • Girl Scouts - 605-336-2978 • Performance Fitness – 605-840-4492 • Winner City Pool – 605-842-9003 • Winner Parks Department – 605-842-2606 • Winner Regional Clinic dietician 605-842-2626 • Avera Clinic dietitian - 605-842-2443 Birth control and pregnancy resources: • Winner hospital 605-842-7100 • Winner Regional Clinic 605-842-2626 • Avera Clinic in Winner 605-842-2443 • Burke Clinic – 605-775-2631 • Tripp County Public Health Services – 605-842-7166 • Planned Parenthood Direct App (on the AppStore or GooglePlay)
Healthcare and Wellness • Access to affordable prescription drugs 3.33 • Access to affordable health insurance coverage 3.29 • Access to affordable health care 3.29	9% of respondents have not seen a health care provider for five or more years 38% of respondents do not have any dental insurance coverage	10% of children living in Tripp County are uninsured and 26% of children live in poverty (SD Average – 18%)	Health insurance in Winner: • American Family - 605-842-8300 • Dakota Care - 605-842-3260 • Bank West – 605-842-3004 • First Fidelity – 605-842-3811 • State Farm – 605-842-0470 • The Insurance Center – 605-842-3260 Health care providers: • Winner hospital - 605-842-7100 • Winner Regional Clinic - 605-842-2626 • Avera Clinic in Winner - 605-842-2443 • Burke Clinic – 605-775-2631

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings or Focus on SD Report	Community resources that are available to address the need
			• Atlas Chiropractic - 605-842-1588 • Hearing Health Center - 605-842-1209 • Daniel Peters, OD - 605-842-1974 • Winner Dental Clinic - 605-842-1793 • Winner Family Dentistry - 605-842-2101 • Winner Physical Therapy - 605-842-7188 SD Medicaid / DSS – 800-305-3064 Community Connections - 605-842-1708 SD DHS Prescription Assistance Program - 605-773-3656 Southern Dakota Insurance Agency - 605-775-2097
Mental Health/ Behavioral Health • Depression 2.86 • Drug use and abuse 2.86 • Alcohol use and abuse 2.71 • Dementia and Alzheimer's Disease 2.57 • Smoking and tobacco use 2.50 • Stress 2.50	10% of respondents have been diagnosed with depression 25% of respondents have felt down, depressed, or hopeless in the two weeks prior to the survey	• 10% smoke • 17% binge drink two to three times per week • 21% abuse alcohol •	Addiction resources: • Winner Regional Clinic 605-842-2626 • Avera Clinic, Winner 605-842-2443 • Southern Plains Behavioral Health Clinic, Winner, SD 605-842-1465 • Main Gate Counseling Services / Drug Addiction Counseling - 605-842-0312 • SD QuitLine – 866-737-8487 • Alcoholics Anonymous – Winner Westside Group – Trinity Episcopal Church – 605-842-2211 Depression / stress resources: • Winner Regional Clinic 605-842-2626 • Avera Clinic, Winner 605-842-2443 • Southern Plains Behavioral Health Clinic, Winner, SD 605-842-1465 • Main Gate Counseling Services - 605-842-0312 • SD Division of Behavioral Health – 605-367-5236

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings or Focus on SD Report	Community resources that are available to address the need
			• National Suicide Prevention Hotline – 1-800-273-8255 • NAMI of South Dakota – 605-271-1871 Elder care resources: • Winner Regional LTC 605-842-7200 • SD Long Term Services and Supports - 866-854-5465 • DSS Winner Office – 605-842-0400

Winner Regional Health

2019 Community Health Needs Assessment Prioritization Worksheet

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

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote
Economics • Cost of affordable housing 4.00 • Skilled labor workforce 3.29 • Employment options 3.00		
Children and Youth • Childhood obesity 2.86 • Availability of education about birth control 2.8 • Teen pregnancy 2.80	Voted #1 Priority	
Healthcare and Wellness • Access to affordable prescription drugs 3.33 • Access to affordable health insurance coverage 3.29 • Access to affordable health care 3.29	Voted #2 Priority	
Mental Health / Behavioral Health • Depression 2.86 • Drug use and abuse 2.86 • Alcohol use and abuse 2.71 • Dementia and Alzheimer's Disease 2.57 • Smoking and tobacco use 2.50 • Stress 2.50		

Winner Regional Health

Community Health Needs Assessment

Results from a Non-Generalizable Online Survey

December 2017 and January 2018

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a December 2017 and January 2018 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.** A total of 42 respondents participated in the online survey.

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

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

Issue	Mean attention needed
Availability of affordable housing (N=7)	4.00
Skilled labor workforce (N=7)	3.29
Employment options (N=7)	3.00
Hunger (N=7)	2.86
Maintaining livable and energy efficient homes (N=7)	2.86
Help for renters with landlord and tenants' rights issues (N=6)	2.67
Homelessness (N=6)	2.67
Household budgeting and money management (N=6)	2.67
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=6)	2.67

Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Figure 2. Current state of community issues regarding TRANSPORTATION

48

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

Issue	Mean attention needed
Childhood obesity (N=7)	2.86
Availability of education about birth control (N=5)	2.80
Teen pregnancy (N=5)	2.80
Availability of quality child care (N=6)	2.67
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=6)	2.67
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=6)	2.67
Substance abuse by youth (N=6)	2.67
Teen tobacco use (N=6)	2.67
Cost of activities (outside of school and sports) for children and youth (N=5)	2.60
Cost of quality child care (N=5)	2.60
Bullying (N=6)	2.50
Crime committed by youth (N=6)	2.50
Parental custody, guardianships and visitation rights (N=6)	2.50
School absenteeism (truancy) (N=6)	2.50
School dropout rates (N=6)	2.50
Opportunities for youth-adult mentoring (N=6)	2.33
School violence (N=6)	2.33
Teen suicide (N=6)	2.33
Availability of activities (outside of school and sports) for children and youth (N=7)	2.29

Mean attention needed
(1=No attention needed; 5=Critical attention needed)

49

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

Cost of in-home services (N=5) — 2.80

Cost of long-term care (N=5) — 2.80

Cost of memory care (N=5) — 2.80

Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=7) — 2.71

Availability of activities for seniors (e.g., recreational, social, cultural) (N=7) — 2.57

Availability of memory care (N=7) — 2.57

Availability of resources for grandparents caring for grandchildren (N=7) — 2.57

Availability of resources to help the elderly stay safe in their homes (N=7) — 2.57

Help making out a will or healthcare directive (N=6) — 2.50

Cost of activities for seniors (e.g., recreational, social, cultural) (N=7) — 2.43

Availability of long-term care (N=7) — 2.29

Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Figure 5. Current state of community issues regarding SAFETY

	Mean attention needed
Abuse of prescription drugs (N=6)	2.67
Child abuse and neglect (N=6)	2.50
Criminal activity (N=6)	2.50
Domestic violence (N=6)	2.50
Culture of excessive and binge drinking (N=6)	2.33
Presence of street drugs (N=5)	2.20
Elder abuse (N=6)	2.00
Presence of drug dealers (N=5)	2.00
Presence of gang activity (N=5)	2.00
Availability of emergency medical services (N=7)	1.86
Lack of police or delayed response of police (N=6)	1.83
Sex trafficking (N=5)	1.80

Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

Issue	Mean
Access to affordable prescription drugs (N=6)	3.33
Access to affordable health insurance coverage (N=7)	3.29
Access to affordable healthcare (N=7)	3.29
Access to affordable vision insurance coverage (N=7)	2.71
Availability of doctors, physician assistants, or nurse practitioners (N=7)	2.71
Access to affordable dental insurance coverage (N=7)	2.57
Timely access to medical care providers (N=7)	2.57
Availability of mental health providers (N=6)	2.50
Availability of non-traditional hours (e.g., evenings, weekends) (N=6)	2.50
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=6)	2.50
Timely access to dental care providers (N=7)	2.43
Availability of behavioral health (e.g., substance abuse) providers (N=6)	2.33
Coordination of care between providers and services (N=7)	2.29
Availability of specialist physicians (N=5)	2.20
Access to technology for health records and health education (N=6)	2.17
Timely access to vision care providers (N=7)	2.14
Use of emergency room services for primary healthcare (N=7)	2.14
Availability of healthcare services for Native people (N=6)	2.00
Availability of healthcare services for New Americans (N=4)	1.75

Mean attention needed
(1=No attention needed; 5=Critical attention needed)

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

	Mean attention needed
Depression (N=7)	2.86
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=7)	2.86
Alcohol use and abuse (N=7)	2.71
Dementia and Alzheimer's disease (N=7)	2.57
Smoking and tobacco use (N=6)	2.50
Stress (N=6)	2.50
Exposure to secondhand smoke (N=6)	2.33
Suicide (N=6)	2.33

Mean attention needed
(1=No attention needed; 5=Critical attention needed)

Demographic Information

Figure 8. Age of respondents

Age	Percent*
18 to 24 years	0.0
25 to 34 years	0.0
35 to 44 years	0.0
45 to 54 years	42.9
55 to 64 years	28.6
65 to 74 years	28.6
75 years or older	0.0
Prefer to not answer	0.0

Percent*

N=7

*Percentages do not total 100.0 due to rounding.

53

Figure 9. Biological sex of respondents

Prefer to not answer
0.0 %

Male
42.9 %

Female
57.1 %

N=7

Figure 10. Race of respondents

	Percent
White	100.0
Black or African American	0.0
American Indian or Alaska Native	0.0
Asian	0.0
Native Hawaiian or Pacific Islander	0.0
Other	0.0
Prefer to not answer	0.0

N=7

Figure 11. Whether respondents are of Hispanic or Latino origin

Prefer to not answer, 0.0%

Yes, 0.0%

No, 100.0%
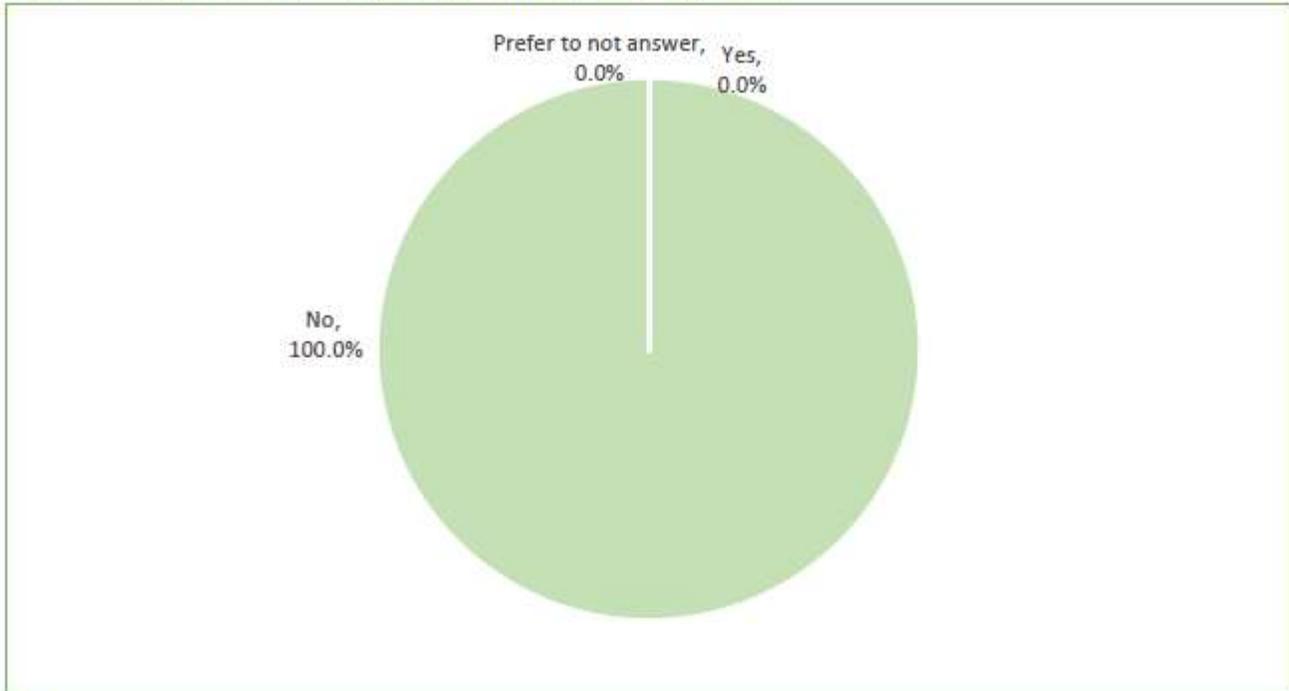
N=6

Figure 12. Marital status of respondents

	Percent
Married	85.7
Widowed	0.0
Divorced	0.0
Separated	0.0
Never married	14.3
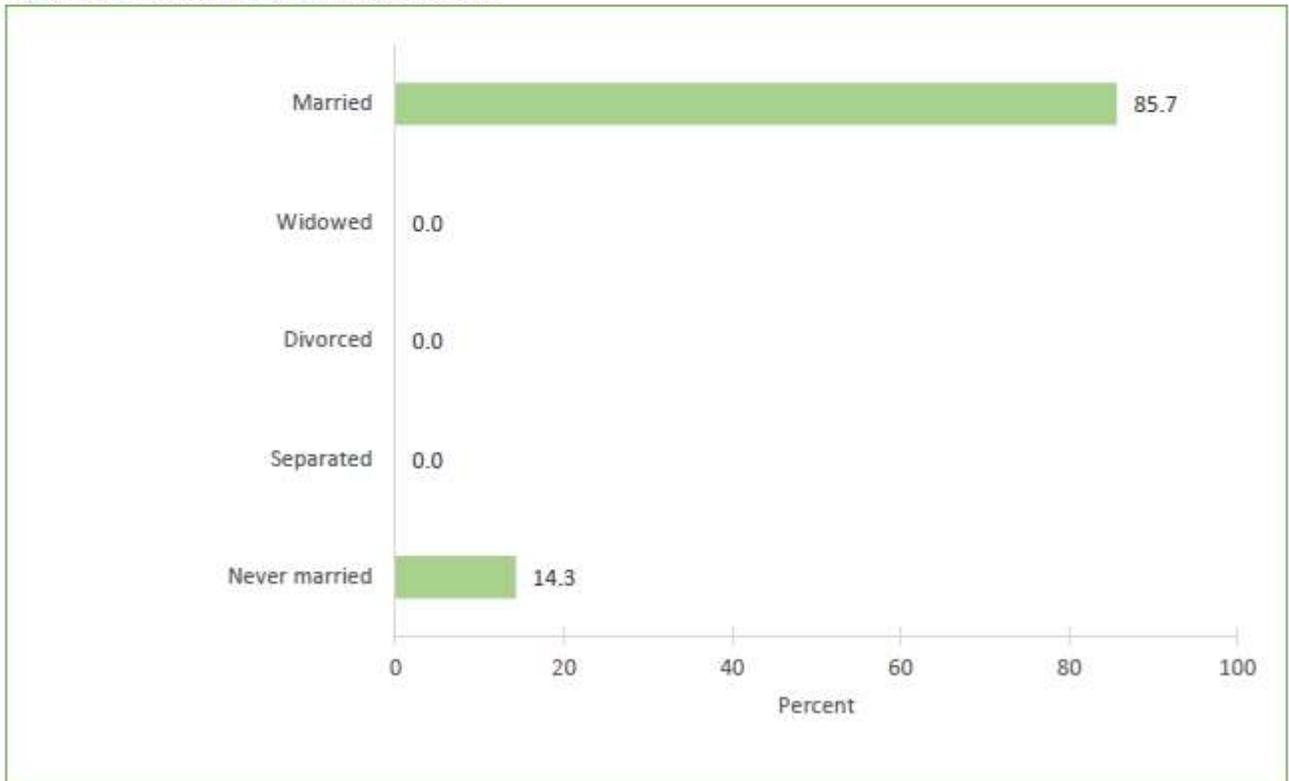
N=7

Figure 13. Living situation of respondents
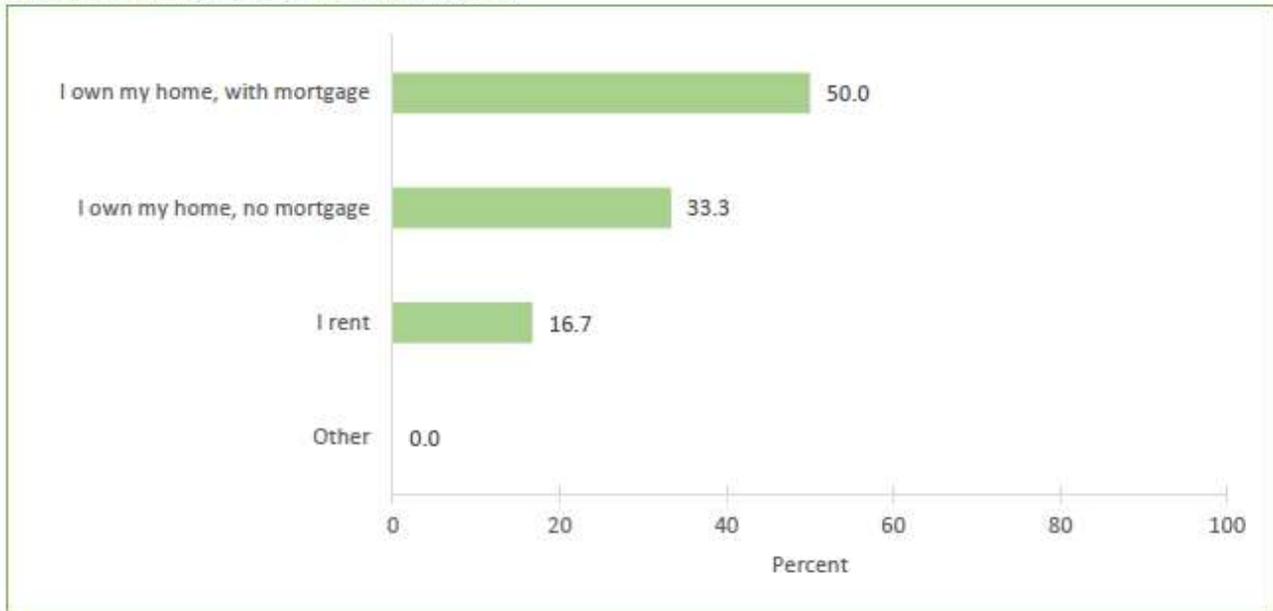
N=6

Figure 14. Highest level of education completed by respondents

N=7
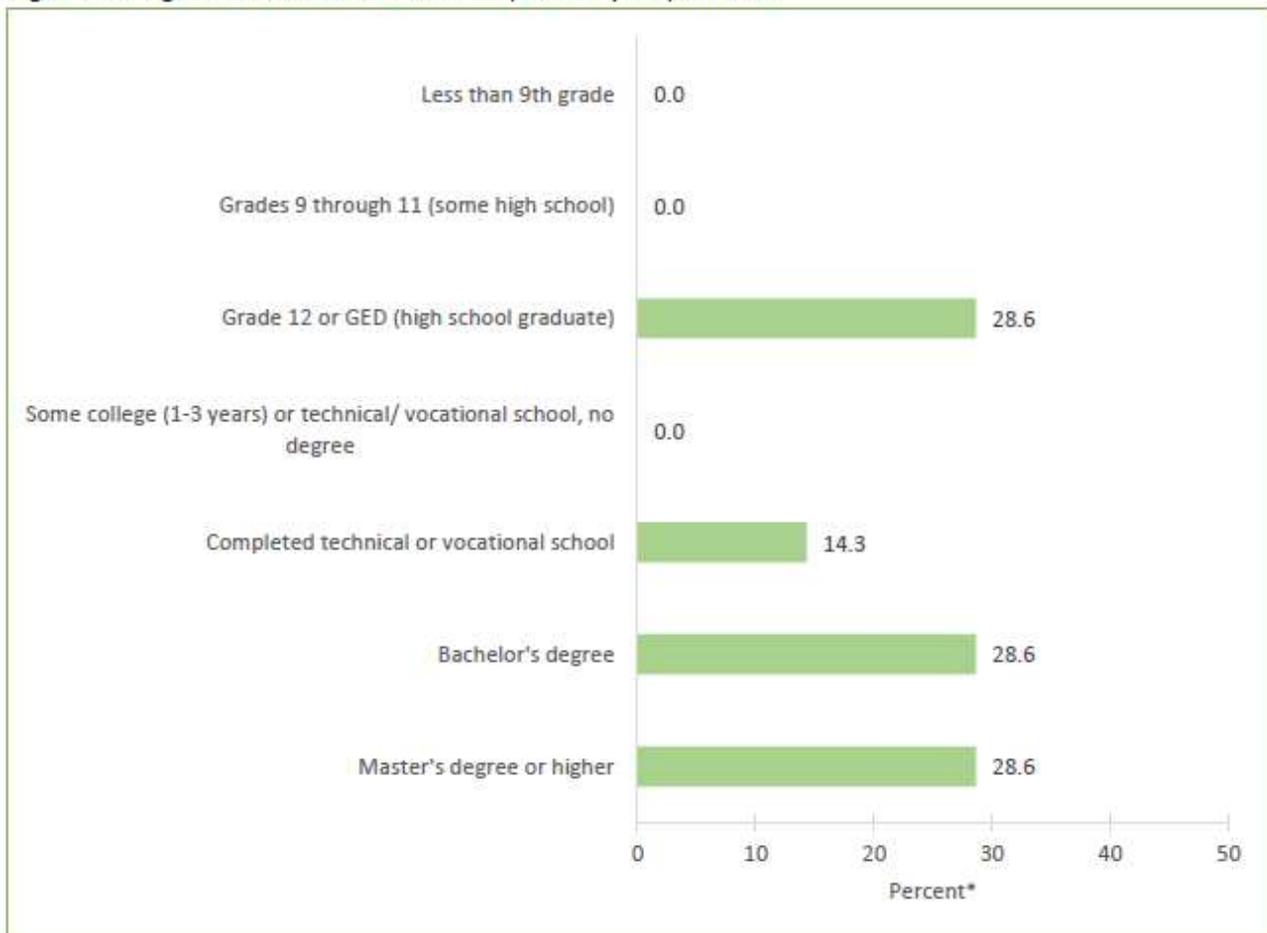
*Percentages do not total 100.0 due to rounding.

Figure 15. Employment status of respondents
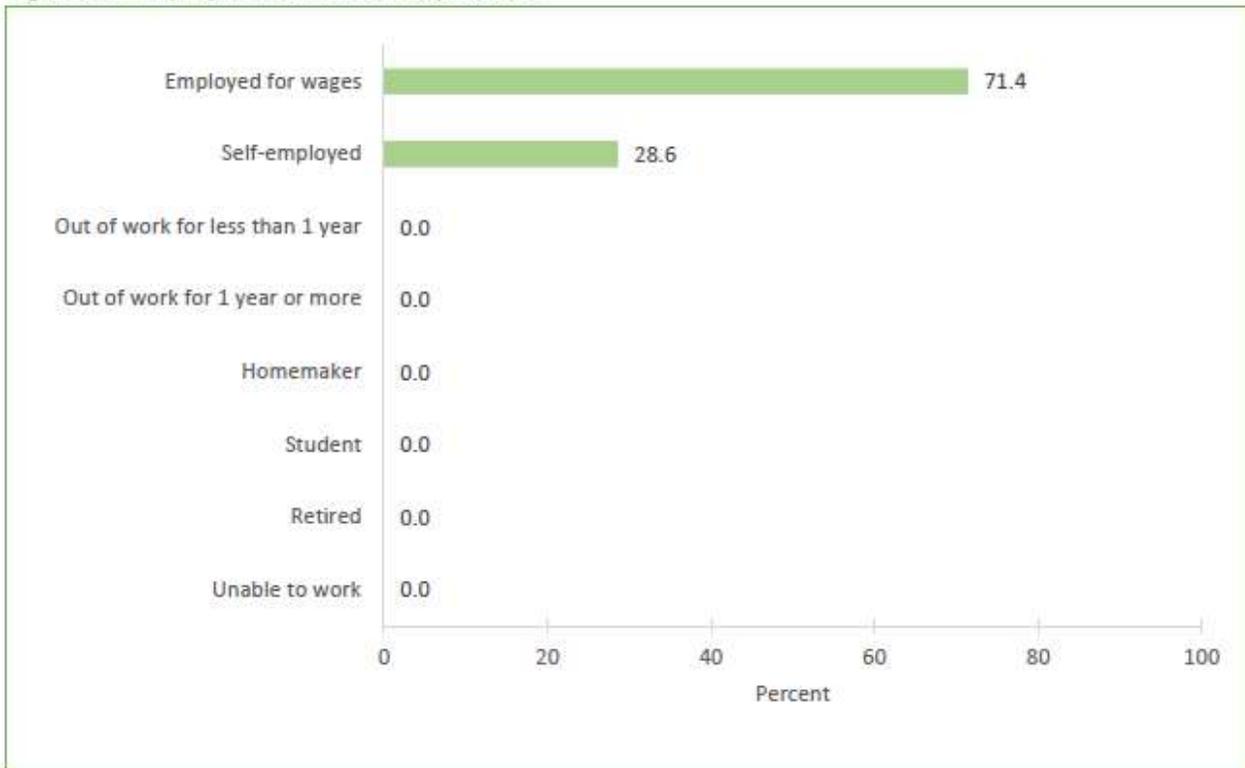
N=7

Figure 16. Whether respondents are military veterans
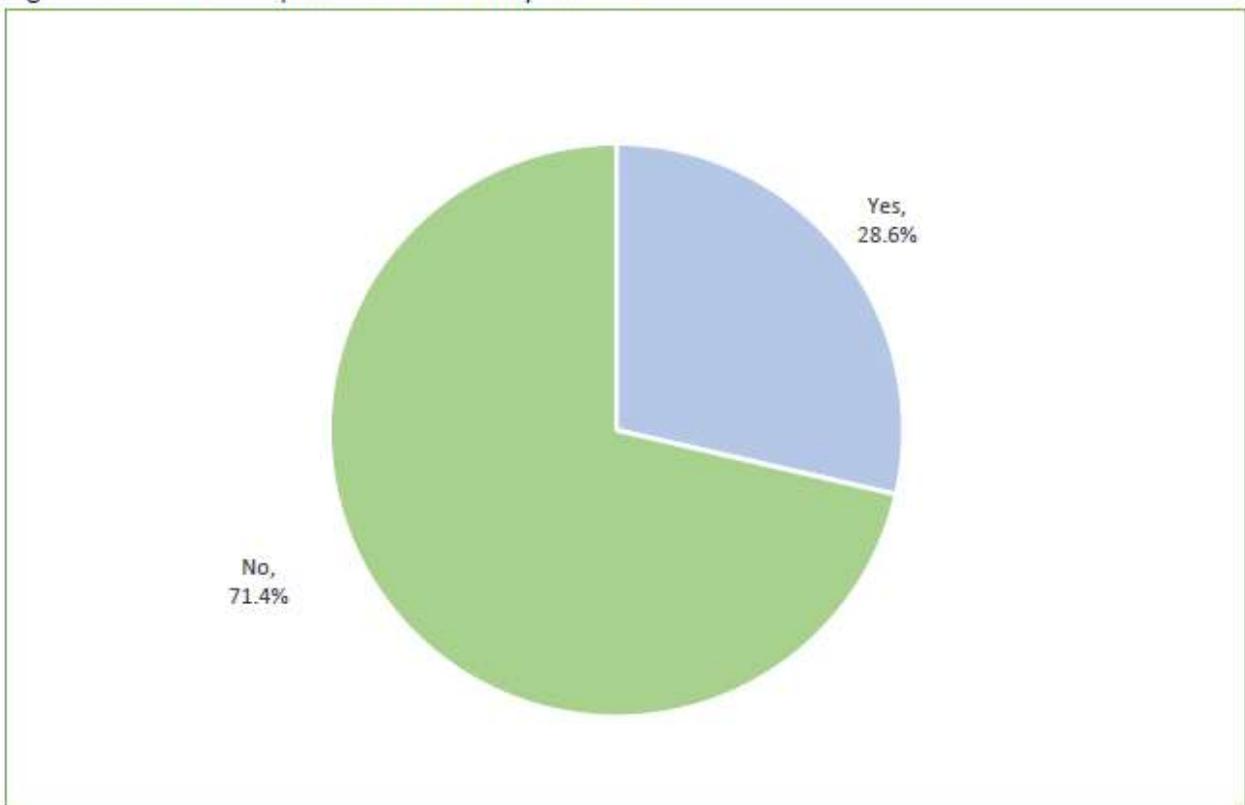
N=7

Figure 17. Annual household income of respondents, from all sources, before taxes
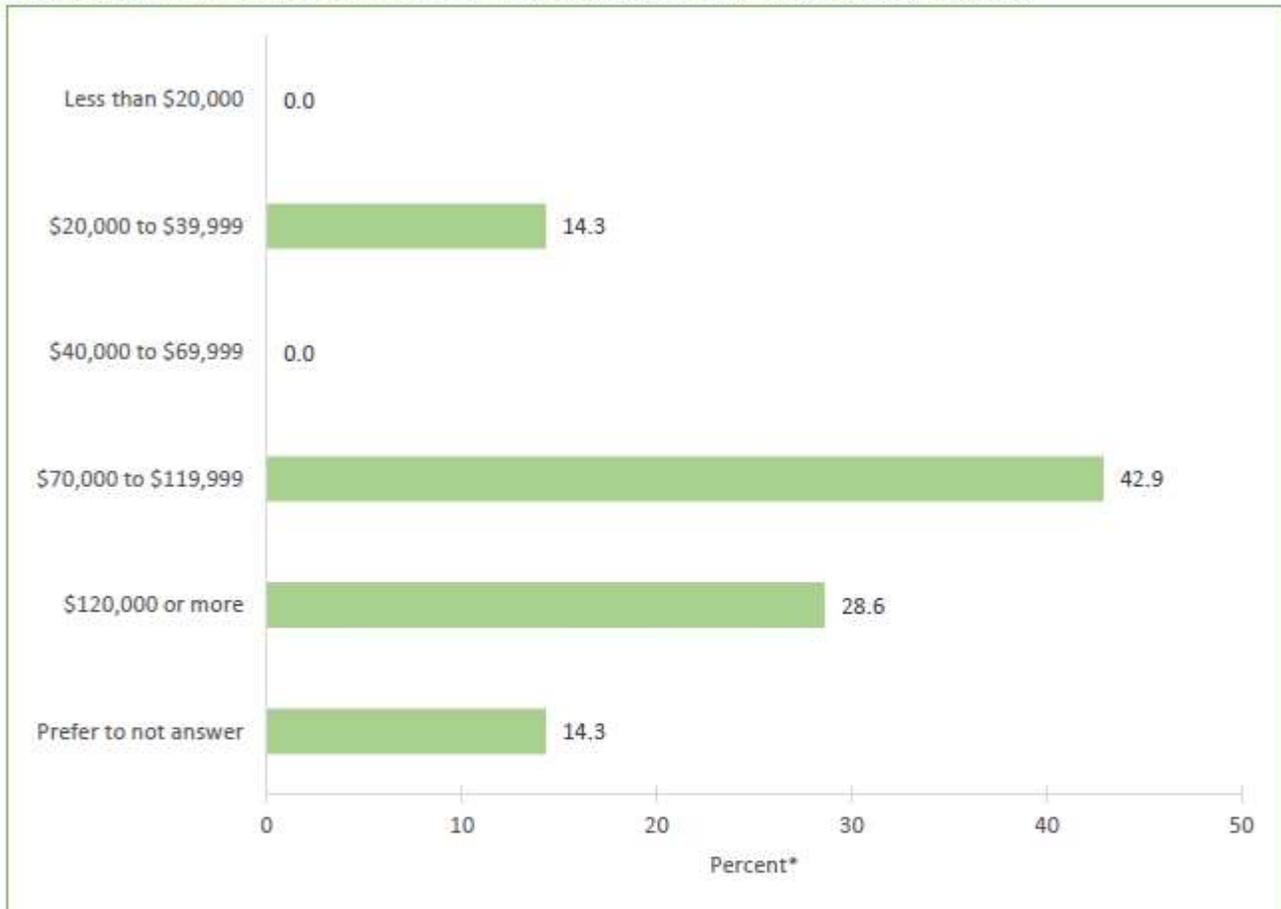
N=7
*Percentages do not total 100.0 due to rounding.

Table 1. Zip code of respondents

Zip code	Number of respondents
57580	6

APPENDIX TABLE

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

Statements	Mean**	Percent of respondents*						
		Level of attention needed					NA	Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical		
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=7)	4.00	0.0	14.3	14.3	28.6	42.9	0.0	100.1
Employment options (N=7)	3.00	0.0	28.6	42.9	28.6	0.0	0.0	100.1
Help for renters with landlord and tenants' rights issues (N=6)	2.67	0.0	50.0	33.3	16.7	0.0	0.0	100.0
Homelessness (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
Household budgeting and money management (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
Hunger (N=7)	2.86	0.0	28.6	57.1	14.3	0.0	0.0	100.0
Maintaining livable and energy efficient homes (N=7)	2.86	0.0	14.3	85.7	0.0	0.0	0.0	100.0
Skilled labor workforce (N=7)	3.29	0.0	0.0	71.4	28.6	0.0	0.0	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=7)	2.29	0.0	71.4	28.6	0.0	0.0	0.0	100.0
Availability of public transportation (N=7)	2.00	14.3	57.1	14.3	0.0	0.0	14.3	100.0
Availability of walking and biking options (N=7)	2.00	14.3	71.4	14.3	0.0	0.0	0.0	100.0
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=7)	2.14	0.0	85.7	14.3	0.0	0.0	0.0	100.0
Cost of public transportation (N=7)	2.00	14.3	57.1	14.3	0.0	0.0	14.3	100.0
Driving habits (e.g., speeding, road rage) (N=6)	2.25	0.0	50.0	16.7	0.0	0.0	33.3	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=7)	2.29	14.3	42.9	42.9	0.0	0.0	0.0	100.1
Availability of education about birth control (N=5)	2.80	0.0	40.0	40.0	20.0	0.0	0.0	100.0
Availability of quality child care (N=7)	2.67	0.0	28.6	57.1	0.0	0.0	14.3	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
Bullying (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
Childhood obesity (N=7)	2.86	0.0	14.3	85.7	0.0	0.0	0.0	100.0

| Statements | Mean** | Percent of respondents* | | | | | | Total |
| | | Level of attention needed | | | | | | |
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Cost of activities (outside of school and sports) for children and youth (N=5)	2.60	0.0	40.0	60.0	0.0	0.0	0.0	100.0
Cost of quality child care (N=6)	2.60	0.0	33.3	50.0	0.0	0.0	16.7	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
Crime committed by youth (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
Opportunities for youth-adult mentoring (N=6)	2.33	0.0	66.7	33.3	0.0	0.0	0.0	100.0
Parental custody, guardianships and visitation rights (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
School absenteeism (truancy) (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
School dropout rates (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
School violence (N=6)	2.33	0.0	66.7	33.3	0.0	0.0	0.0	100.0
Substance abuse by youth (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
Teen pregnancy (N=5)	2.80	0.0	40.0	40.0	20.0	0.0	0.0	100.0
Teen suicide (N=6)	2.33	0.0	66.7	33.3	0.0	0.0	0.0	100.0
Teen tobacco use (N=6)	2.67	0.0	33.3	66.7	0.0	0.0	0.0	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=7)	2.57	0.0	57.1	28.6	14.3	0.0	0.0	100.0
Availability of long-term care (N=7)	2.29	14.3	42.9	42.9	0.0	0.0	0.0	100.1
Availability of memory care (N=7)	2.57	0.0	42.9	57.1	0.0	0.0	0.0	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=7)	2.71	0.0	42.9	42.9	14.3	0.0	0.0	100.1
Availability of resources for grandparents caring for grandchildren (N=7)	2.57	0.0	42.9	57.1	0.0	0.0	0.0	100.0
Availability of resources to help the elderly stay safe in their homes (N=7)	2.57	0.0	57.1	28.6	14.3	0.0	0.0	100.0
Cost of activities for seniors (e.g., recreational, social, cultural) (N=7)	2.43	0.0	71.4	14.3	14.3	0.0	0.0	100.0
Cost of in-home services (N=5)	2.80	0.0	40.0	40.0	20.0	0.0	0.0	100.0
Cost of long-term care (N=5)	2.80	0.0	40.0	40.0	20.0	0.0	0.0	100.0
Cost of memory care (N=5)	2.80	0.0	40.0	40.0	20.0	0.0	0.0	100.0
Help making out a will or healthcare directive (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
SAFETY								
Abuse of prescription drugs (N=7)	2.67	0.0	28.6	57.1	0.0	0.0	14.3	100.0
Availability of emergency medical services (N=7)	1.86	28.6	57.1	14.3	0.0	0.0	0.0	100.0
Child abuse and neglect (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
Criminal activity (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
Culture of excessive and binge drinking (N=6)	2.33	0.0	66.7	33.3	0.0	0.0	0.0	100.0
Domestic violence (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
Elder abuse (N=6)	2.00	16.7	66.7	16.7	0.0	0.0	0.0	100.1

| Statements | Mean** | Percent of respondents* | | | | | | |
| | | Level of attention needed | | | | | | |
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Lack of police or delayed response of police (N=6)	1.83	16.7	83.3	0.0	0.0	0.0	0.0	100.0
Presence of drug dealers (N=5)	2.00	0.0	100.0	0.0	0.0	0.0	0.0	100.0
Presence of gang activity (N=5)	2.00	0.0	100.0	0.0	0.0	0.0	0.0	100.0
Presence of street drugs (N=5)	2.20	0.0	80.0	20.0	0.0	0.0	0.0	100.0
Sex trafficking (N=5)	1.80	20.0	80.0	0.0	0.0	0.0	0.0	100.0
HEALTHCARE AND WELLNESS								
Access to affordable dental insurance coverage (N=7)	2.57	14.3	42.9	28.6	0.0	14.3	0.0	100.1
Access to affordable health insurance coverage (N=7)	3.29	14.3	14.3	28.6	14.3	28.6	0.0	100.1
Access to affordable healthcare (N=7)	3.29	14.3	0.0	57.1	0.0	28.6	0.0	100.0
Access to affordable prescription drugs (N=6)	3.33	16.7	0.0	50.0	0.0	33.3	0.0	100.0
Access to affordable vision insurance coverage (N=7)	2.71	14.3	14.3	57.1	14.3	0.0	0.0	100.0
Access to technology for health records and health education (N=6)	2.17	16.7	50.0	33.3	0.0	0.0	0.0	100.0
Availability of behavioral health (e.g., substance abuse) providers (N=6)	2.33	16.7	33.3	50.0	0.0	0.0	0.0	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=7)	2.71	14.3	14.3	57.1	14.3	0.0	0.0	100.0
Availability of healthcare services for Native people (N=6)	2.00	16.7	66.7	16.7	0.0	0.0	0.0	100.1
Availability of healthcare services for New Americans (N=6)	1.75	16.7	50.0	0.0	0.0	0.0	33.3	100.0
Availability of mental health providers (N=6)	2.50	16.7	33.3	33.3	16.7	0.0	0.0	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=6)	2.50	0.0	66.7	16.7	16.7	0.0	0.0	100.1
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=6)	2.50	0.0	50.0	50.0	0.0	0.0	0.0	100.0
Availability of specialist physicians (N=5)	2.20	20.0	40.0	40.0	0.0	0.0	0.0	100.0
Coordination of care between providers and services (N=7)	2.29	14.3	57.1	14.3	14.3	0.0	0.0	100.0
Timely access to medical care providers (N=7)	2.57	14.3	28.6	42.9	14.3	0.0	0.0	100.1
Timely access to dental care providers (N=7)	2.43	14.3	42.9	28.6	14.3	0.0	0.0	100.1
Timely access to vision care providers (N=7)	2.14	14.3	57.1	28.6	0.0	0.0	0.0	100.0
Use of emergency room services for primary healthcare (N=7)	2.14	14.3	57.1	28.6	0.0	0.0	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=7)	2.71	0.0	28.6	71.4	0.0	0.0	0.0	100.0

Resident Survey

Winner CHNA Survey Report

March 08, 2018

Charts Exported by MarketSight®

How would you rate your health?
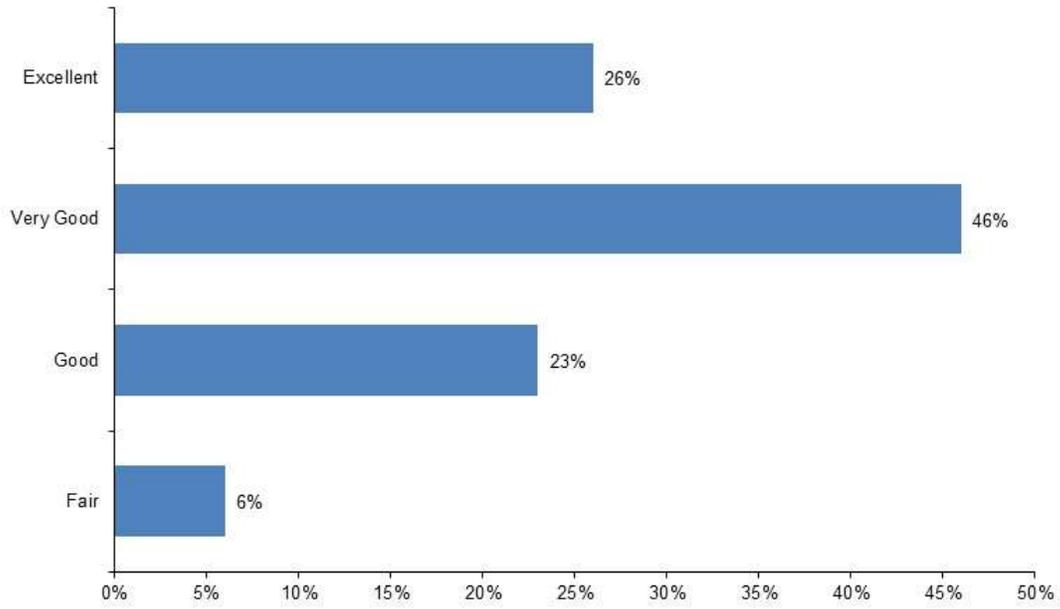
Base: Fair (n=2), Good (n=8), Very Good (n=16), Excellent (n=9), Sample Size = 35

(Community 2 = Tripp)

BMI
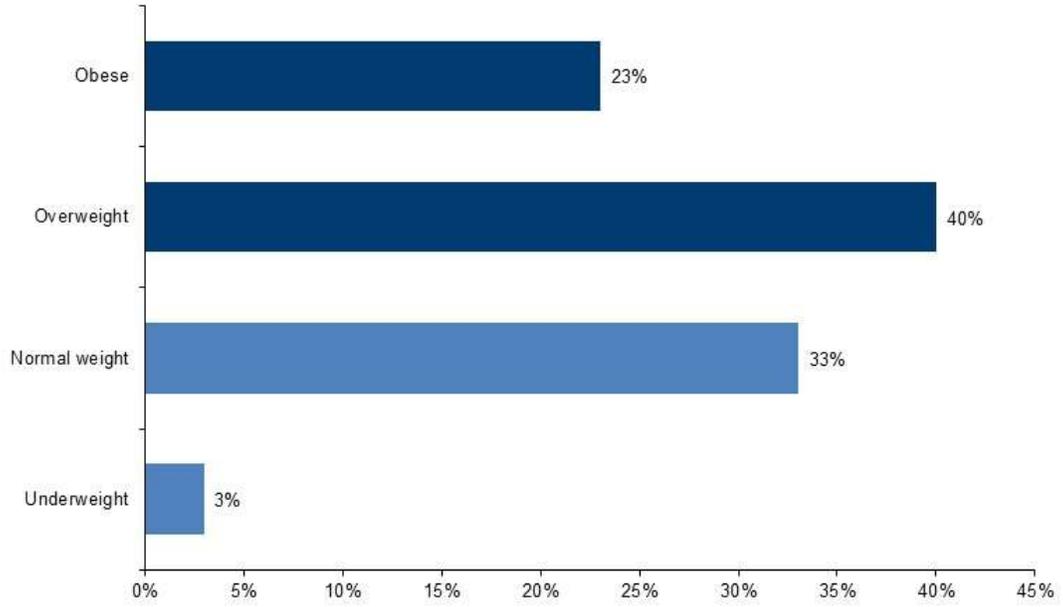
Base: Underweight (n=1), Normal weight (n=10), Overweight (n=12), Obese (n=7), Sample Size = 30

(Community 2 = Tripp)

Servings of Vegetables
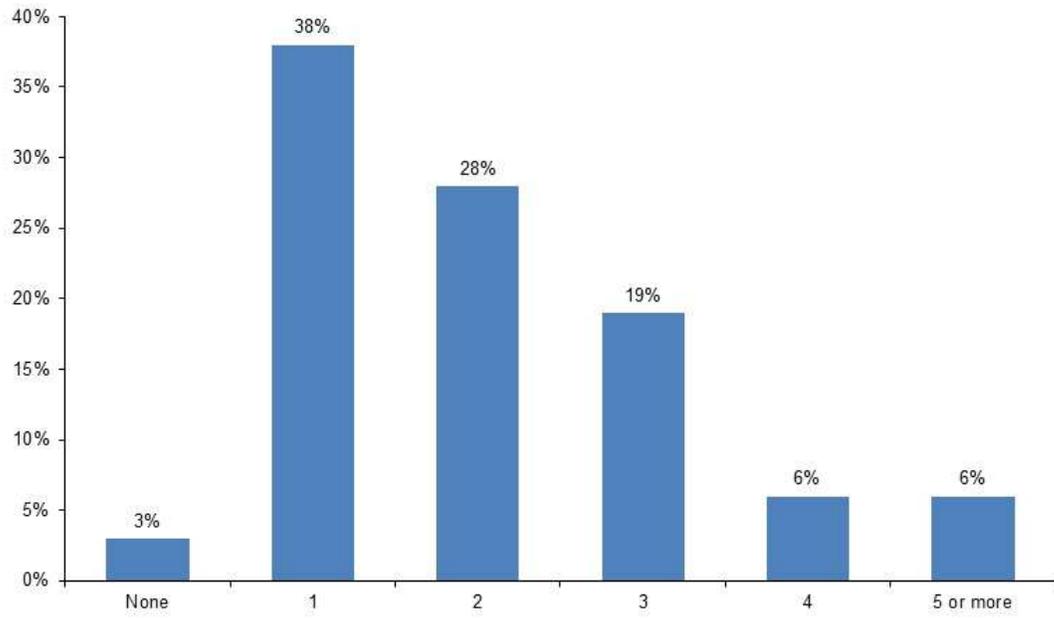
Base: None (n=1), 1 (n=12), 2 (n=9), 3 (n=6), 4 (n=2), 5 or more (n=2), Sample Size = 32

(Community 2 = Tripp)

Servings of Juice
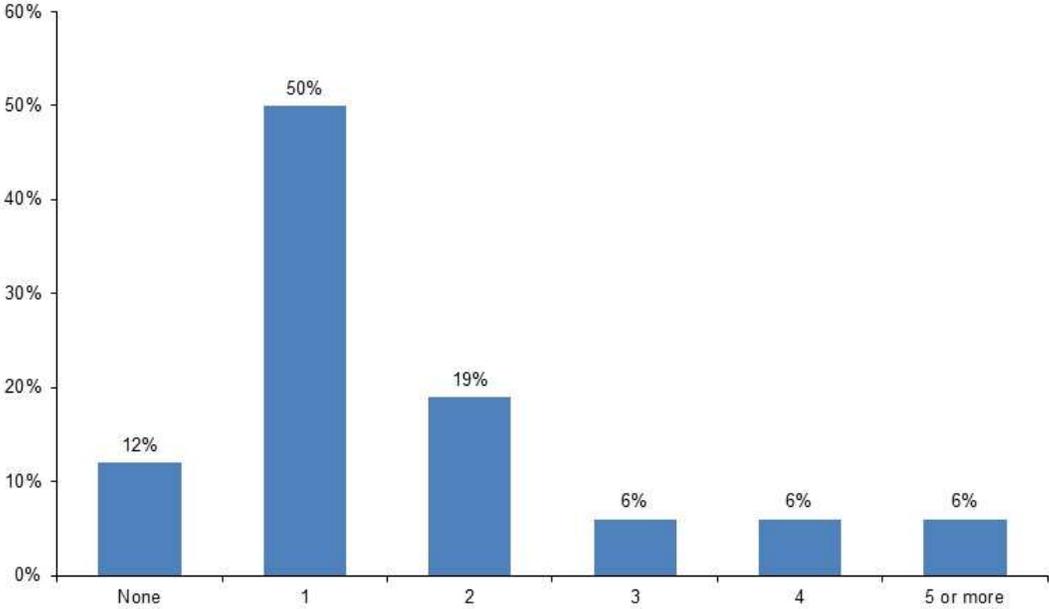
Base: None (n=2), 1 (n=8), 2 (n=3), 3 (n=1), 4 (n=1), 5 or more (n=1), Sample Size = 16

(Community 2 = Tripp)
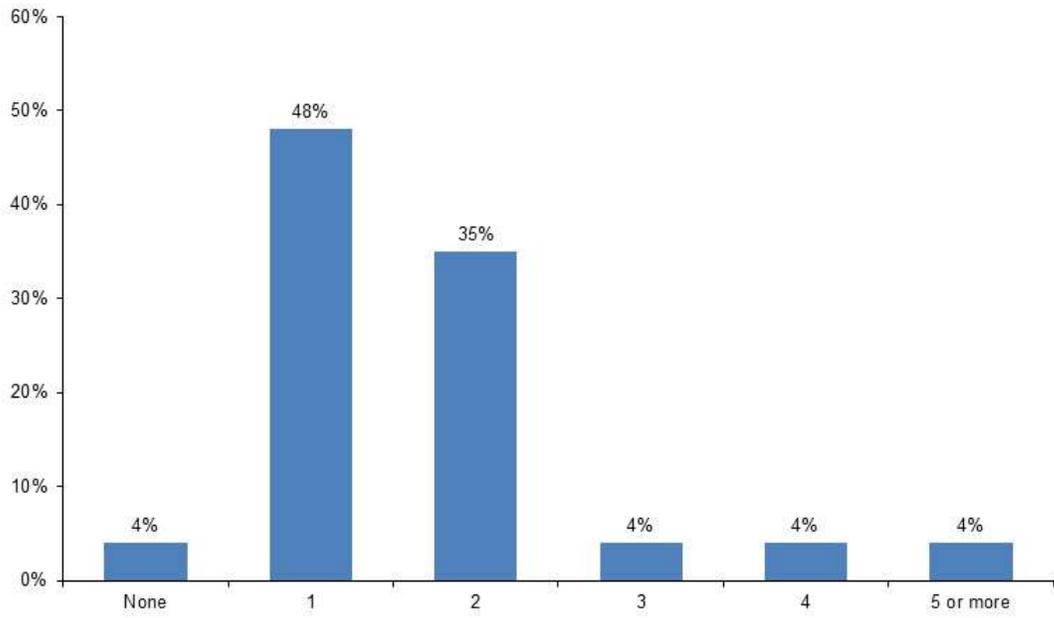
Servings of Fruit

Base: None (n=1), 1 (n=11), 2 (n=8), 3 (n=1), 4 (n=1), 5 or more (n=1), Sample Size = 23

(Community 2 = Tripp)

Servings of Fruit, Vegetables and Juice

Legend: ■ Servings of Fruit ■ Servings of Juice ■ Servings of Vegetables

Category	Servings of Fruit	Servings of Juice	Servings of Vegetables
None	4%	12%	3%
1	48%	50%	38%
2	35%	19%	28%
3	4%	6%	19%
4	4%	6%	6%
5 or more	4%	6%	6%
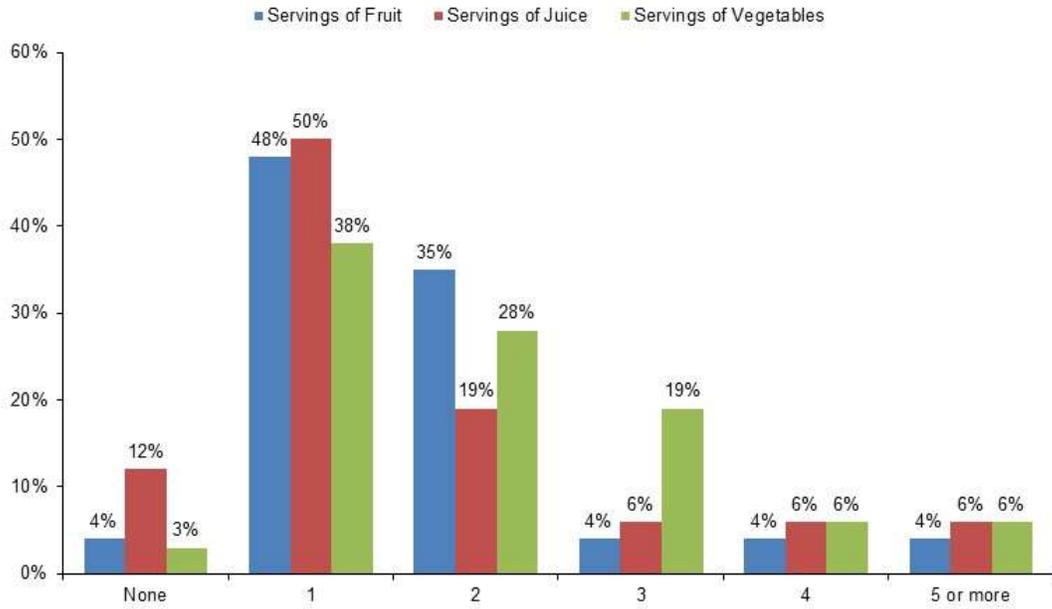
Sample Size = Variable

(Community 2 = Tripp)

Total Servings of Fruits, Vegetables and Juice
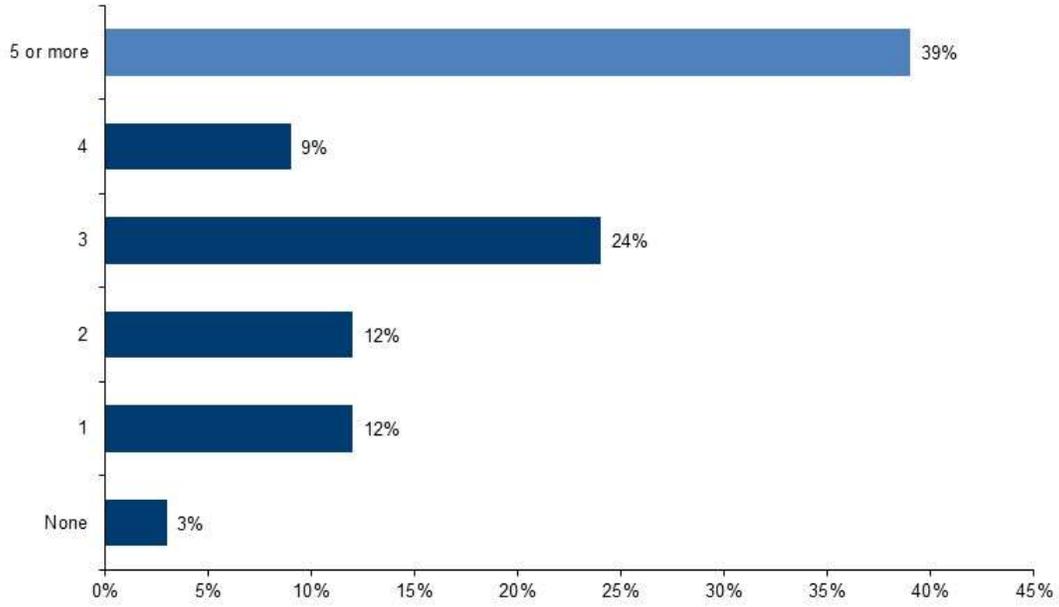
Base: None (n=1), 1 (n=4), 2 (n=4), 3 (n=8), 4 (n=3), 5 or more (n=13), Sample Size = 33

(Community 2 = Tripp)

Snapple, Flavored Teas, Capri Sun, etc.
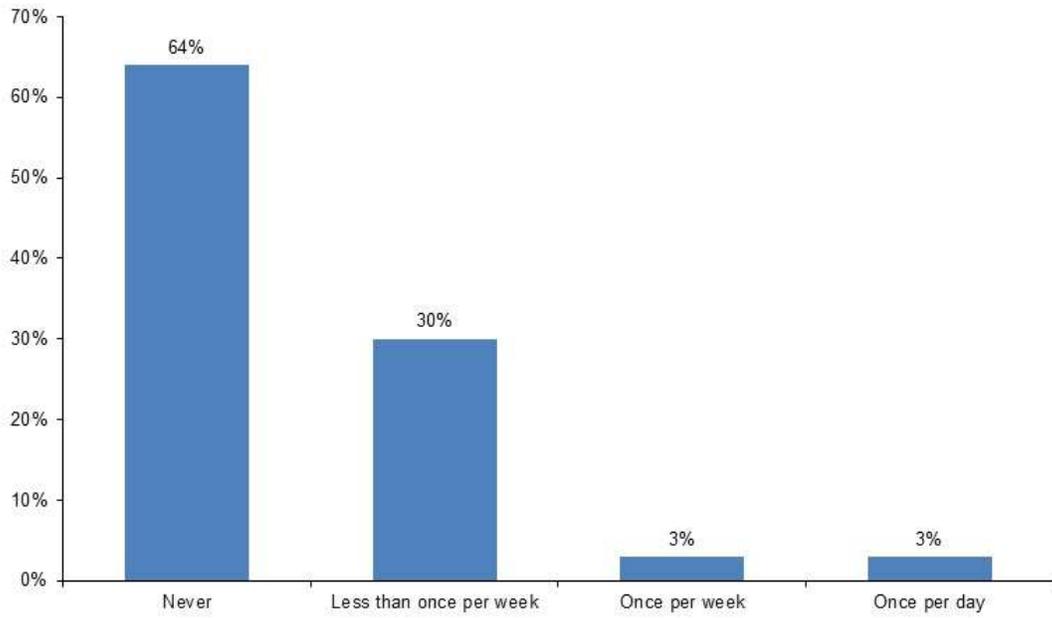
Base: Never (n=21), Less than once per week (n=10), Once per week (n=1), Once per day (n=1), Sample Size = 33

(Community 2 = Tripp)

Gatorade, Powerade, etc.
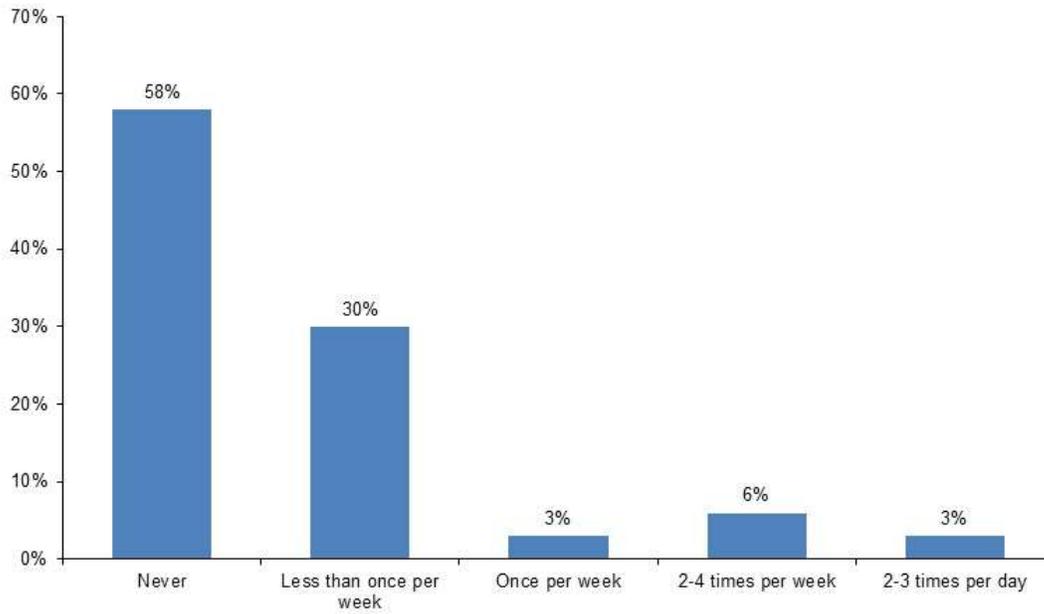
Base: Never (n=19), Less than once per week (n=10), Once per week (n=1), 2-4 times per week (n=2), 2-3 times per day (n=1), Sample Size = 33

(Community 2 = Tripp)

Soda or Pop

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

40%

20%

11%   11%

6%   6%

3%   3%

Never | Less than once per week | Once per week | 2-4 times per week | 5-6 times per week | Once per day | 2-3 times per day | 4+ times per day
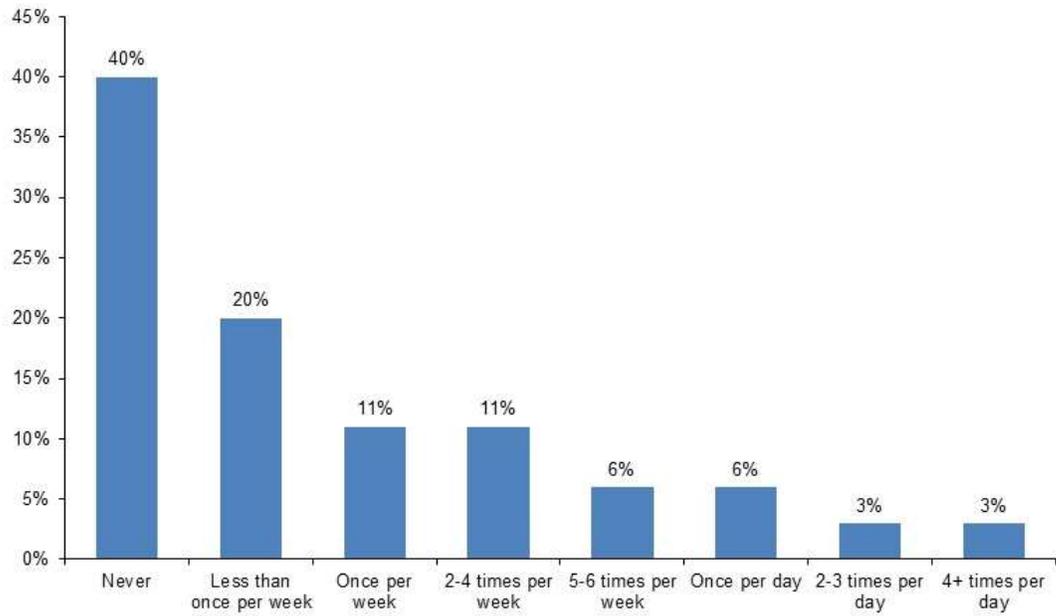
Base: Never (n=14), Less than once per week (n=7), Once per week (n=4), 2-4 times per week (n=4), 5-6 times per week (n=2), Once per day (n=2), 2-3 times per day (n=1), 4+ times per day (n=1), Sample Size = 35
(Community 2 = Tripp)

Energy Drinks
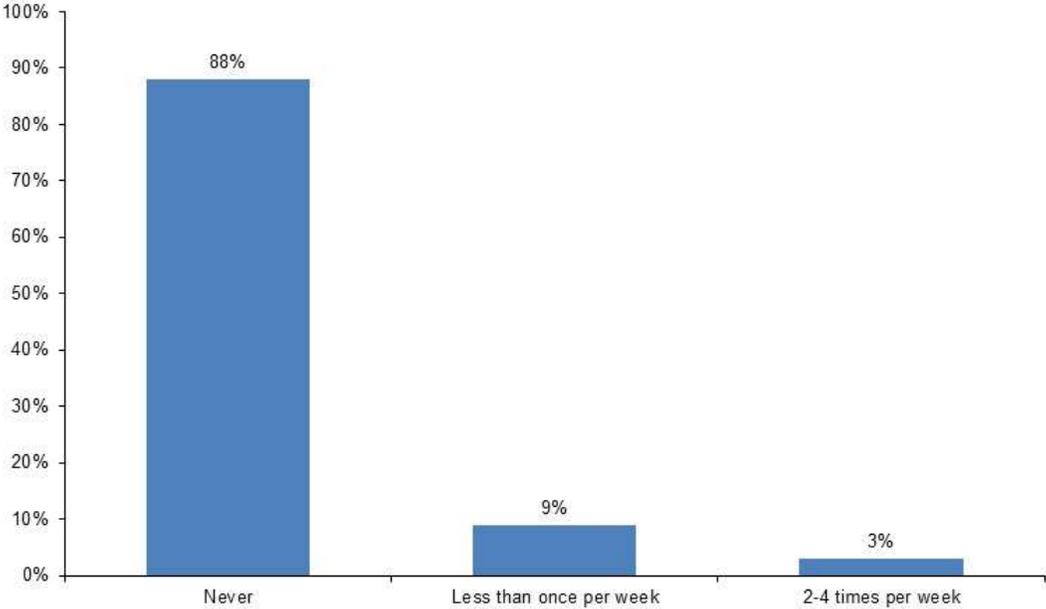
Base: Never (n=30), Less than once per week (n=3), 2-4 times per week (n=1), Sample Size = 34

(Community 2 = Tripp)

Sugar Sweetened Drinks

Legend: ■ Snapple, Flavored Teas, Capri Sun, etc. ■ Gatorade, Powerade, etc. ■ Soda or Pop ■ Energy Drinks

	Never	Less than once per week	Once per week	2-4 times per week	5-6 times per week	Once per day	2-3 times per day	4+ times per day
Snapple, Flavored Teas, Capri Sun, etc.	64%	30%	3%			3%		
Gatorade, Powerade, etc.	58%	30%	3%	6%			3%	
Soda or Pop	40%	20%	11%	11%	6%	6%	3%	3%
Energy Drinks	88%	9%		3%				
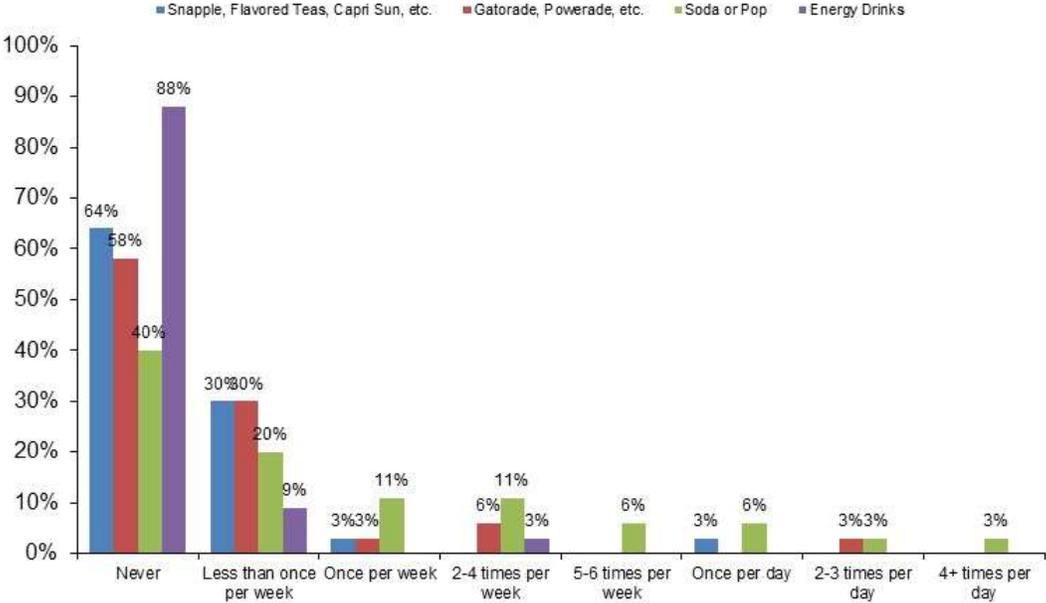
Sample Size = Variable

(Community 2 = Tripp)

Worried whether our food would run out before we got money to buy more.
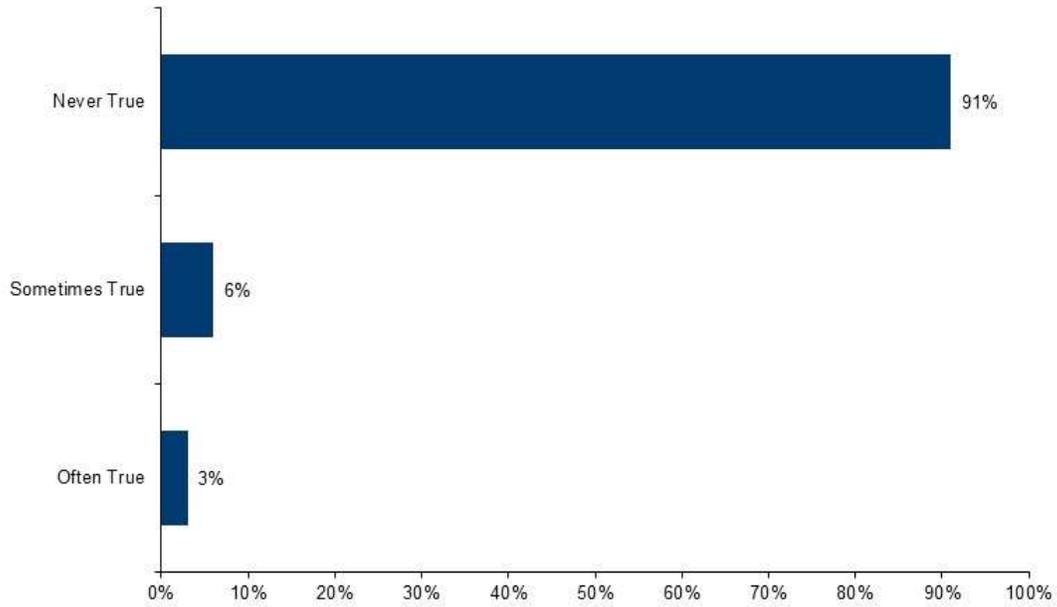
Base: Often True (n=1), Sometimes True (n=2), Never True (n=32), Sample Size = 35

(Community 2 = Tripp)

The food that we bought just didn't last, and we didn't have money to get more.
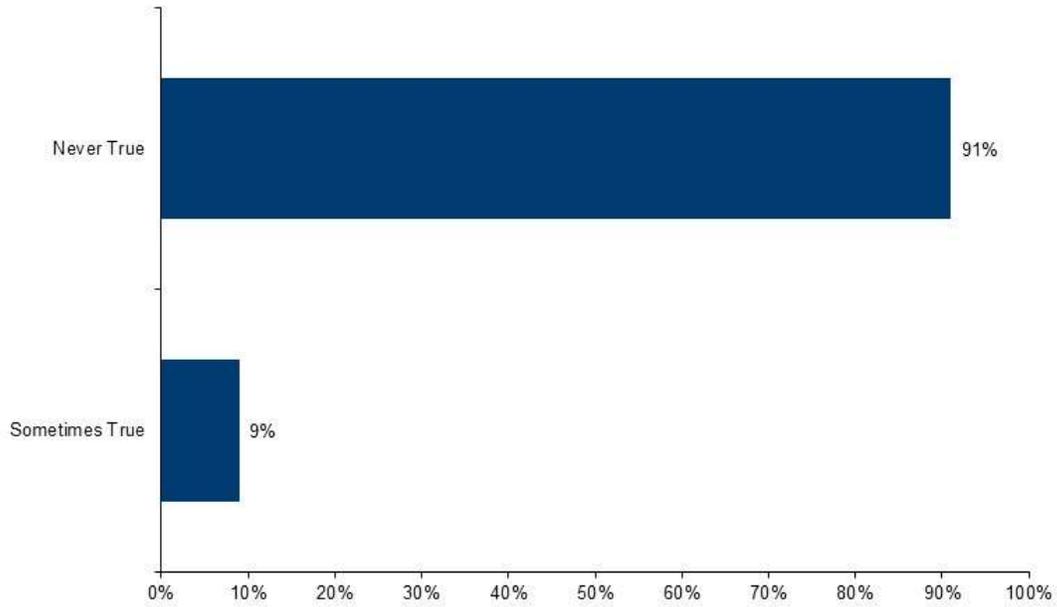
Base: Sometimes True (n=3), Never True (n=32), Sample Size = 35

(Community 2 = Tripp)

Days Per Week of Moderate Physical Activity
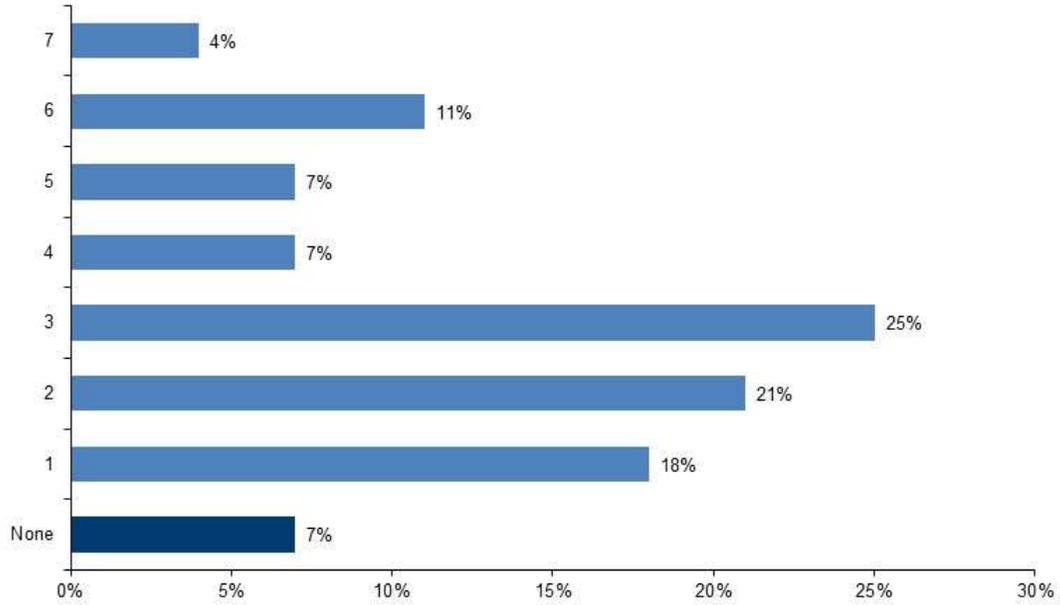
Base: None (n=2), 1 (n=5), 2 (n=6), 3 (n=7), 4 (n=2), 5 (n=2), 6 (n=3), 7 (n=1), Sample Size = 28

(Community 2 = Tripp)

Days Per Week of Vigorous Physical Activity
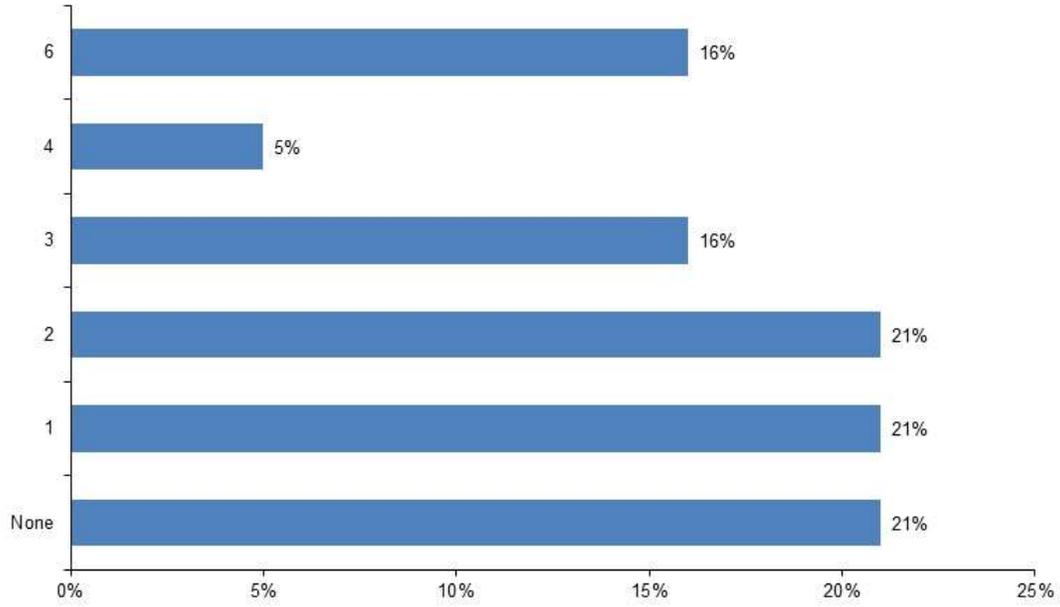
Base: None (n=4), 1 (n=4), 2 (n=4), 3 (n=3), 4 (n=1), 6 (n=3), Sample Size = 19

(Community 2 = Tripp)

Days Per Week of Physical Activity

■ Moderate Activity ■ Vigorous Activity

Days	Moderate	Vigorous
7	4%	
6	11%	16%
5	7%	
4	7%	5%
3	25%	16%
2	21%	21%
1	18%	21%
None	7%	21%

0%   5%   10%   15%   20%   25%   30%
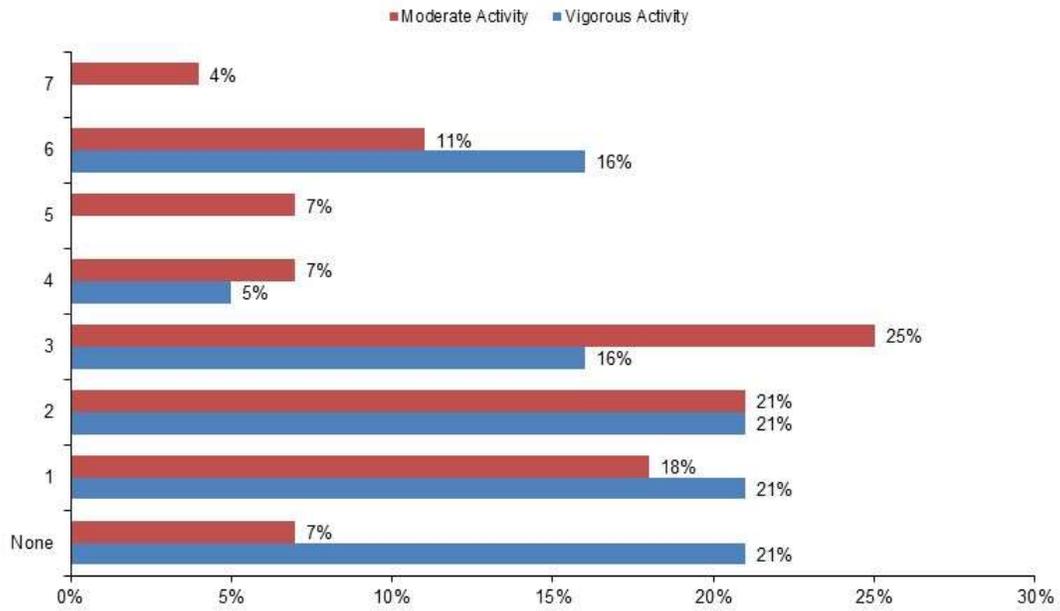
Sample Size = Variable

(Community 2 = Tripp)

Past Diagnosis by Total Household Income

Legend: ■ Anxiety, stress, etc. ■ Arthritis ■ Asthma ■ Depression ■ Diabetes ■ High cholesterol ■ Hypertension

Income	Values
$100,000 to $199,999	0% 33% 0% 67% 0%
$75,000 to $99,999	17% 67% 0% 17% 0% 67% 17%
$50,000 to $74,999	20% 60% 20% 0% 20% 0% 20%
$35,000 to $49,999	33% 33% 0% 33% 0% 67% 33%

X-axis: 0% 50% 100% 150% 200% 250%
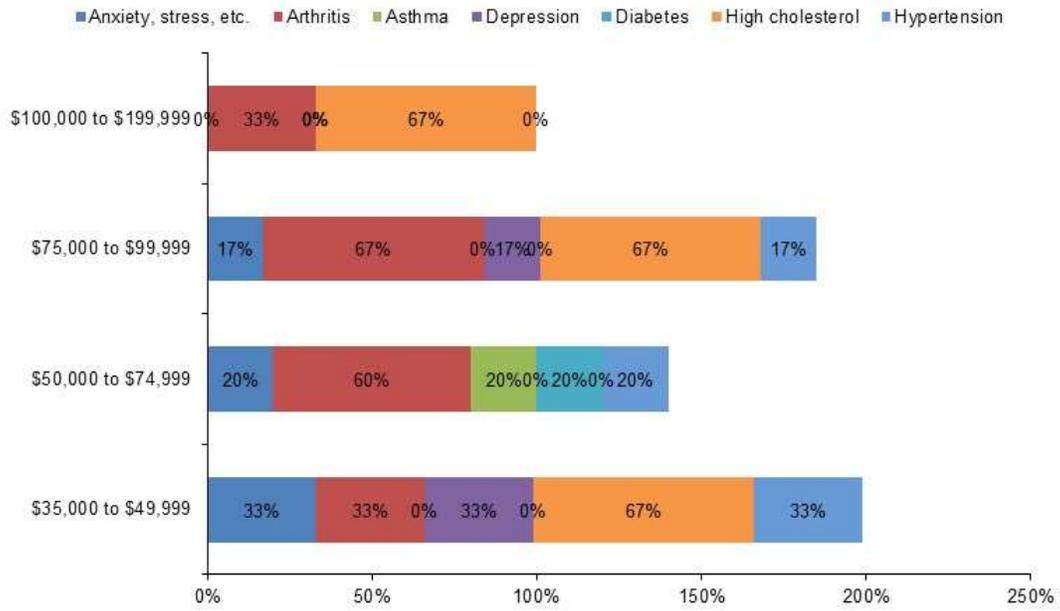
Base: $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=5), $75,000 to $99,999 (n=6), $100,000 to $199,999 (n=3), Sample Size = 17

(Community 2 = Tripp)

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Past Diagnosis

Diagnosis	Percentage
High cholesterol	45%
Arthritis	45%
Anxiety, stress, etc.	25%
Hypertension	20%
Depression	10%
Diabetes	5%
COPD	5%
Asthma	5%

Base: Anxiety, stress, etc. (n=5), Arthritis (n=9), Asthma (n=1), COPD (n=1), Depression (n=2), Diabetes (n=1), High cholesterol (n=9), Hypertension (n=4), Sample Size = 20
(Community 2 = Tripp)

Little Interest or Pleasure in Doing Things
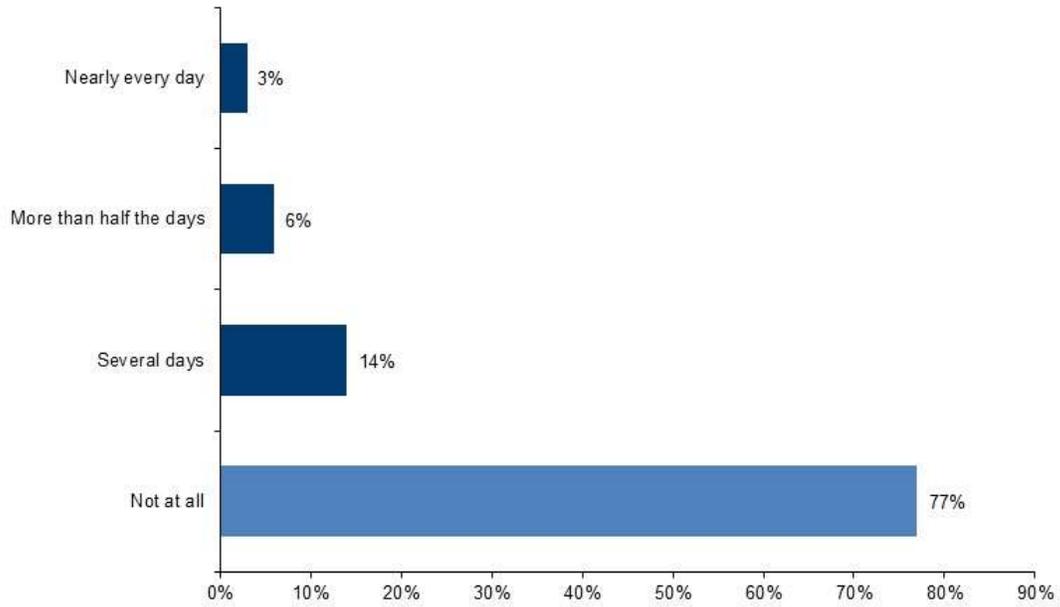
Base: Not at all (n=27), Several days (n=5), More than half the days (n=2), Nearly every day (n=1), Sample Size = 35

(Community 2 = Tripp)

83

Feeling Down, Depressed or Hopeless
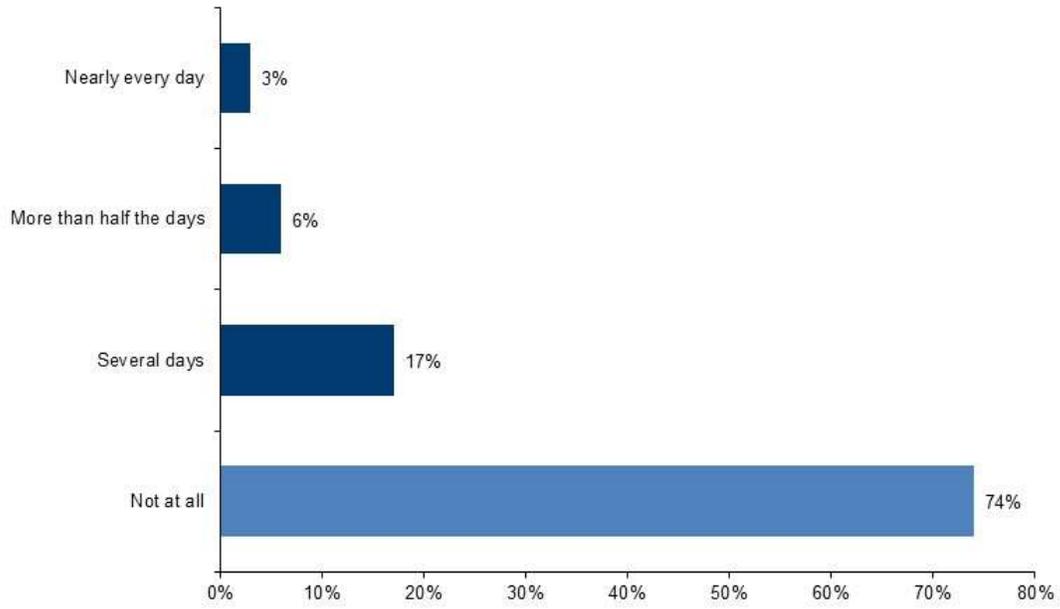
Base: Not at all (n=26), Several days (n=6), More than half the days (n=2), Nearly every day (n=1), Sample Size = 35

(Community 2 = Tripp)

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

■ Feeling down, depressed or hopeless   ■ Little interest or pleasure in doing things

Nearly every day
- 3%
- 3%

More than half the days
- 6%
- 6%

Several days
- 17%
- 14%

Not at all
- 74%
- 77%

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%
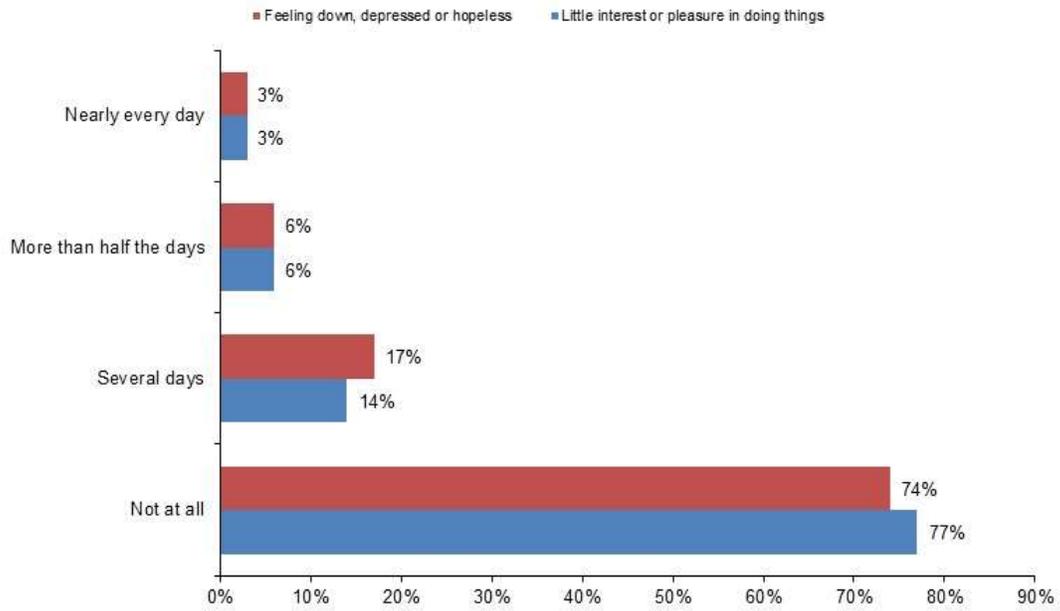
Sample Size = 35

(Community 2 = Tripp)

Have you smoked at least 100 cigarettes in your entire life?

■No ■Yes

26%

74%
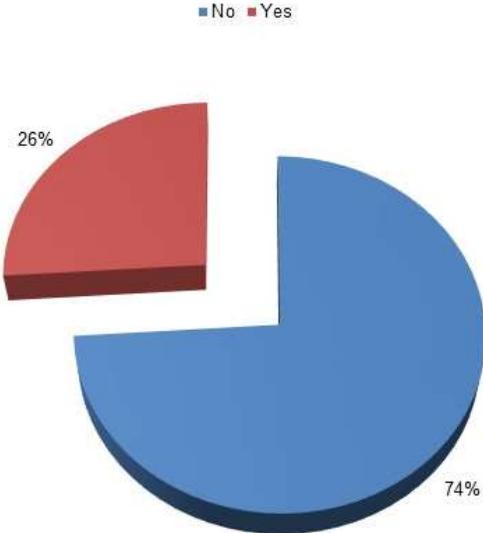
Base: Yes (n=9), No (n=26), Sample Size = 35

(Community 2 = Tripp)

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

■No ■Yes

17%

83%
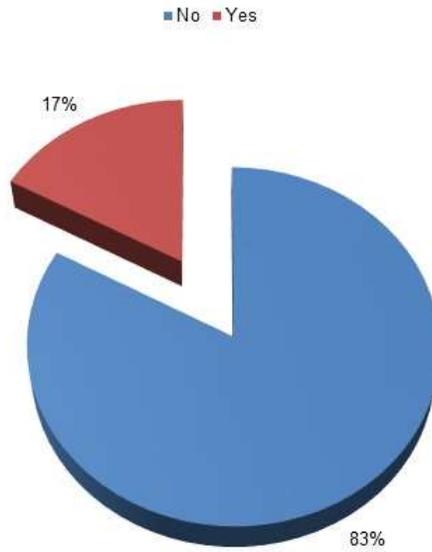
Base: Yes (n=6), No (n=29), Sample Size = 35

(Community 2 = Tripp)

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

■ No ■ Yes

3%

97%
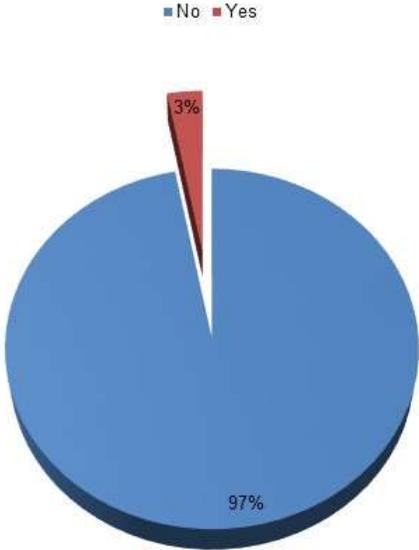
Base: Yes (n=1), No (n=34), Sample Size = 35

(Community 2 = Tripp)

Exposure to Tobacco Smoke

■Yes ■No

Exposed to tobacco smoke in your apartment from another apartment?
- Yes: 3%
- No: 97%

Exposed to cigarettes, cigars or vape pens inside home?
- Yes: 17%
- No: 83%

Personally smoked at least 100 cigarettes in lifetime?
- Yes: 26%
- No: 74%
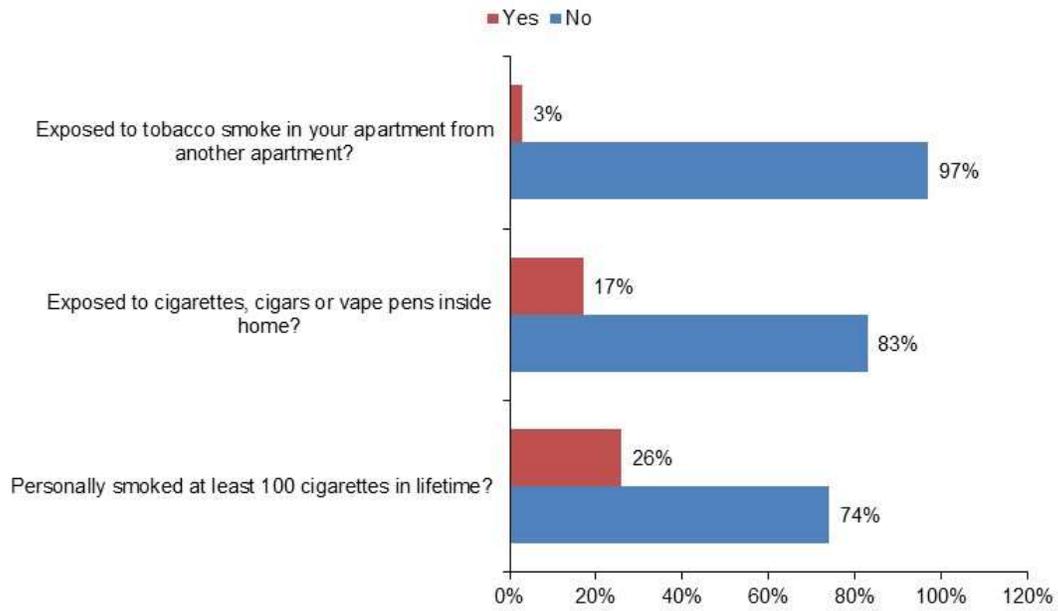
Base: Personally smoked at least 100 cigarettes in lifetime? (n=35), Exposed to cigarettes, cigars or vape pens inside home? (n=35), Exposed to tobacco smoke in your apartment from another apartment? (n=35), Sample Size = 35
(Community 2 = Tripp)

Do you currently smoke cigarettes?

■ Some days   ■ Not at all

11%

89%
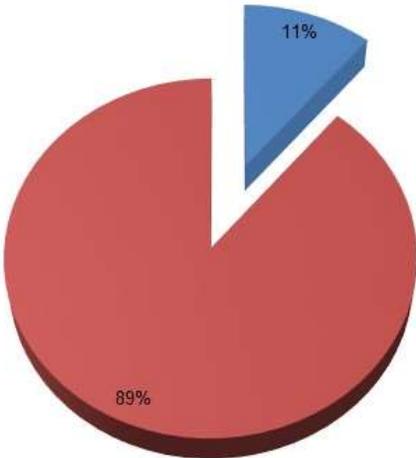
Base: Not at all (n=31), Some days (n=4), Sample Size = 35

(Community 2 = Tripp)

Do you currently use chewing tobacco?

■ Not at all   ■ Some days   ■ Every day

3%

3%

94%
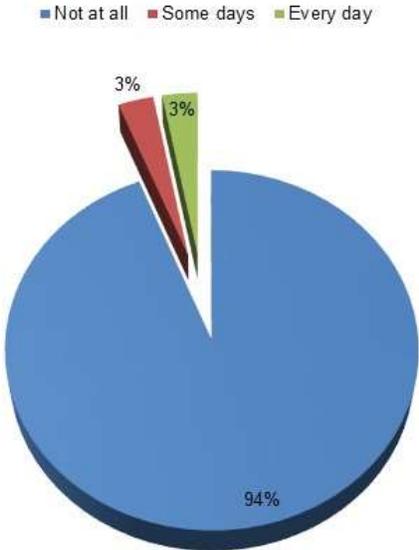
Base: Not at all (n=31), Some days (n=1), Every day (n=1), Sample Size = 33

(Community 2 = Tripp)

Do you currently use electronics cigarettes or vape?

■ Every day ■ Not at all

3%

97%

Base: Not at all (n=32), Every day (n=1), Sample Size = 33

(Community 2 = Tripp)

Current Tobacco Use

Legend: Electronics cigarettes ■ Chewing tobacco ■ Cigarettes

- Every day: Electronics cigarettes 3%, Chewing tobacco 3%
- Some days: Chewing tobacco 3%, Cigarettes 11%
- Not at all: Electronics cigarettes 97%, Chewing tobacco 94%, Cigarettes 89%
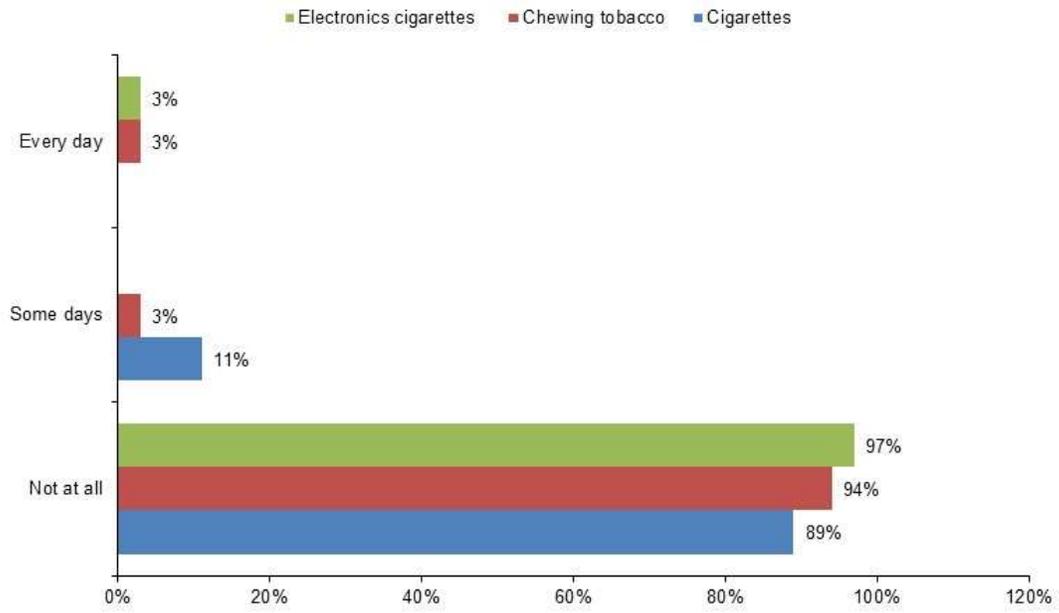
Sample Size = Variable

(Community 2 = Tripp)

Where would you go for help if you wanted to quit using tobacco products?
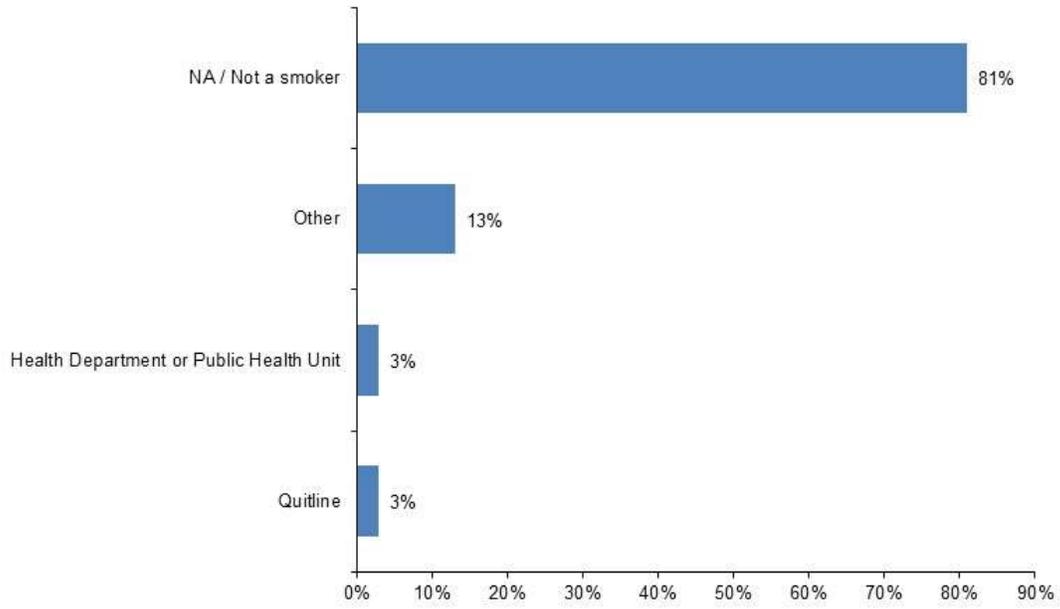
Base: NA / Not a smoker (n=25), Quitline (n=1), Health Department or Public Health Unit (n=1), Other (n=4), Sample Size = 31

(Community 2 = Tripp)

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

■ Yes ■ No

40%

60%
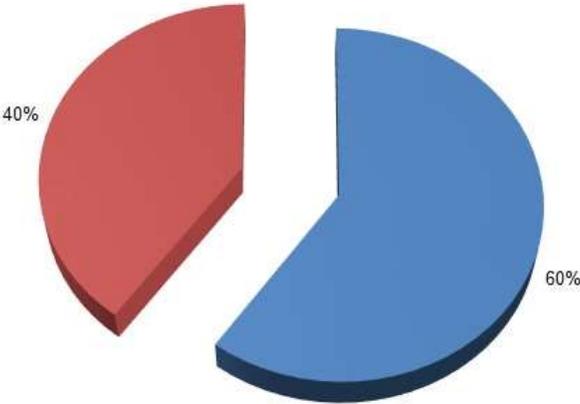
Base: Yes (n=3), No (n=2), Sample Size = 5

(Community 2 = Tripp)

Number of days with at least 1 drink in the past 30 days
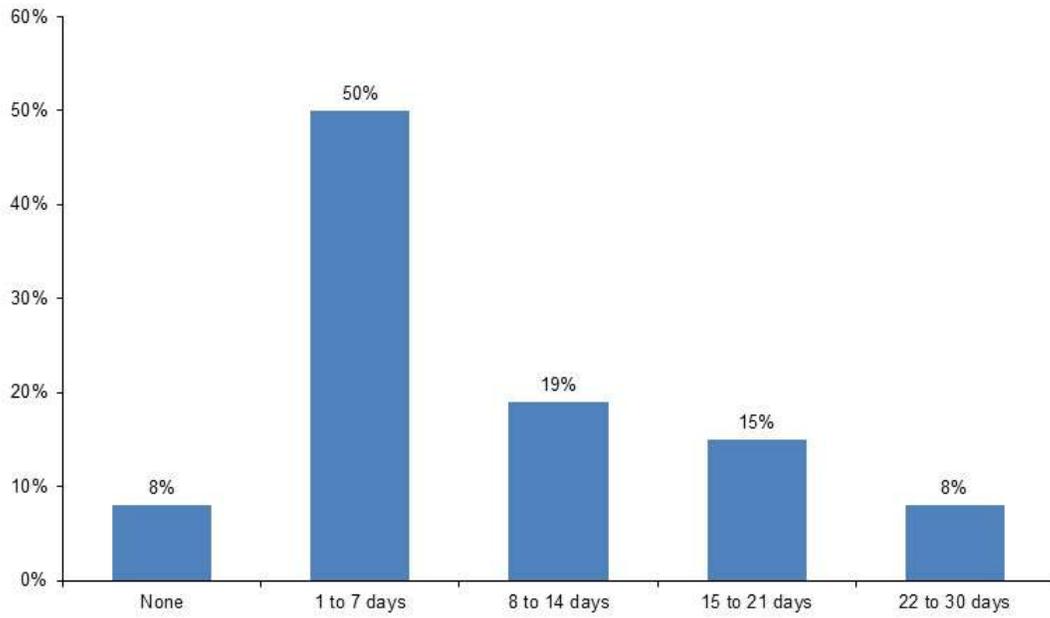
Base: None (n=2), 1 to 7 days (n=13), 8 to 14 days (n=5), 15 to 21 days (n=4), 22 to 30 days (n=2), Sample Size = 26

(Community 2 = Tripp)
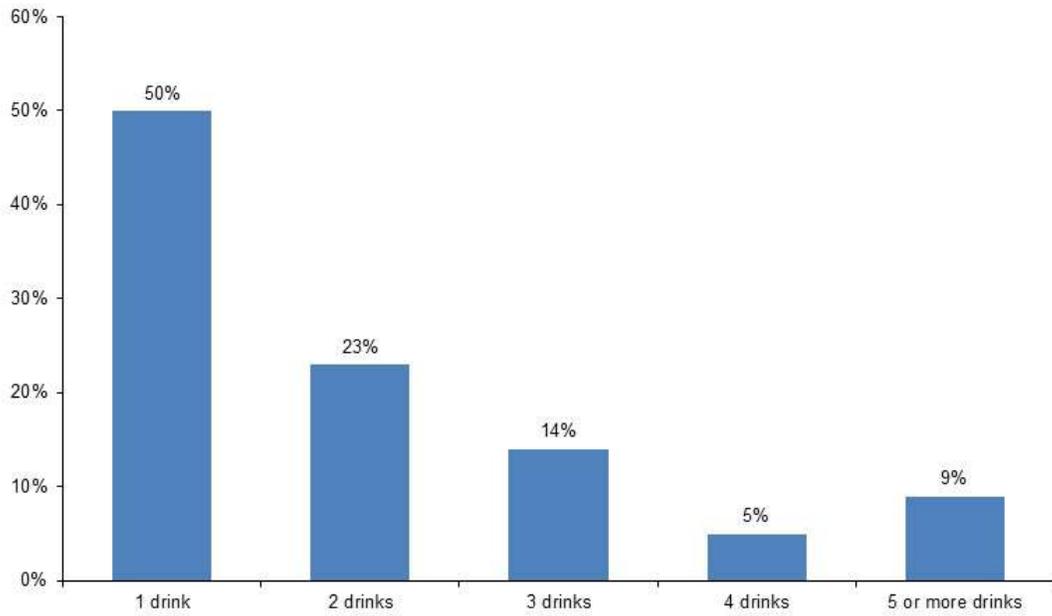
Average number of drinks per day when you drink

Base: 1 drink (n=11), 2 drinks (n=5), 3 drinks (n=3), 4 drinks (n=1), 5 or more drinks (n=2), Sample Size = 22

(Community 2 = Tripp)

Binge Drinking

Never	54%
Once a month	29%
2-3 times a week	17%
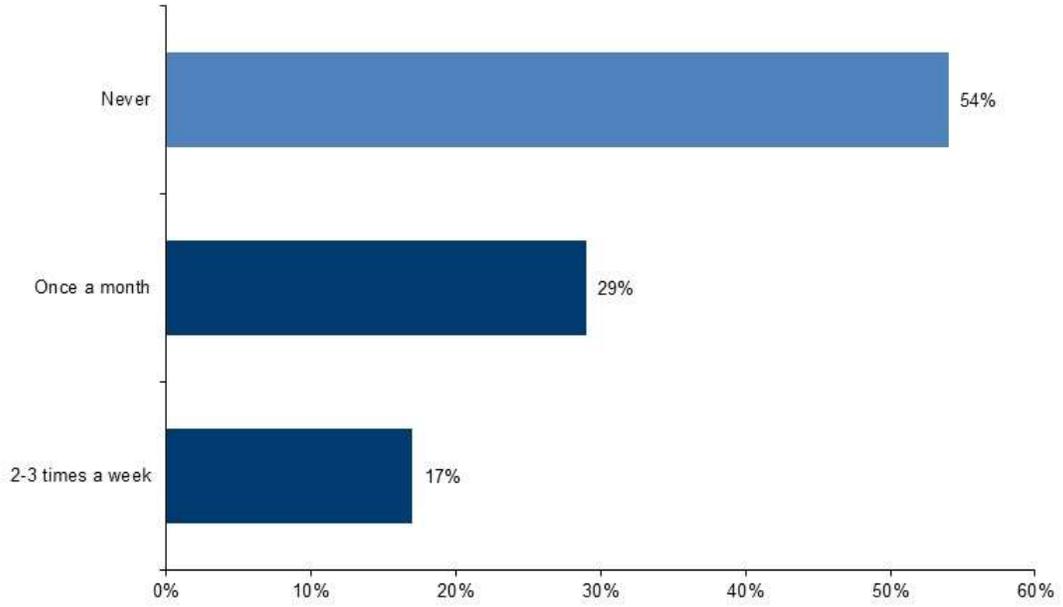
Base: 2-3 times a week (n=4), Once a month (n=7), Never (n=13), Sample Size = 24

(Community 2 = Tripp)

Average Alcohol Use During the Past 30 Days
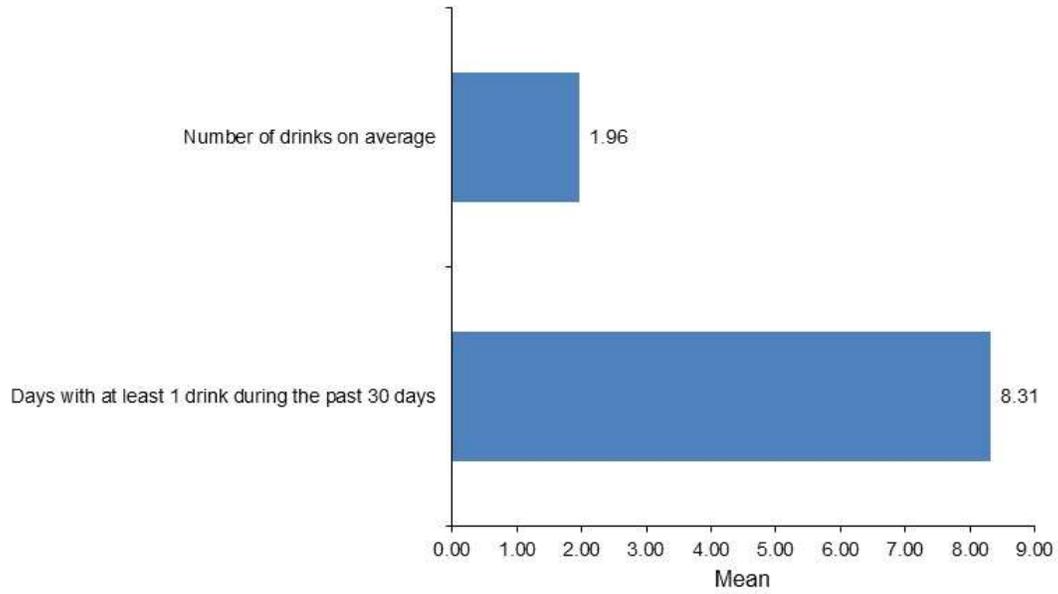
Base: Days with at least 1 drink during the past 30 days (n=26), Number of drinks on average (n=23), Sample Size = Variable

(Community 2 = Tripp)

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

■ No ■ Yes

9%

91%
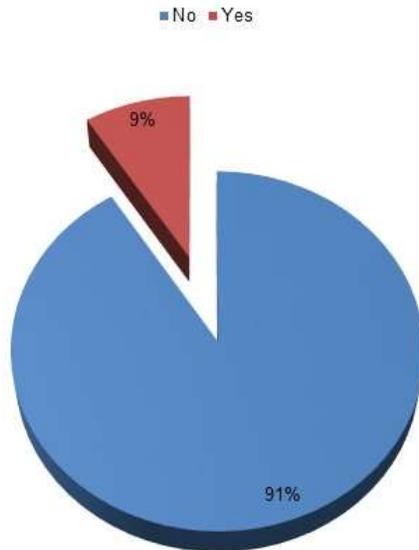
Base: Yes (n=3), No (n=32), Sample Size = 35

(Community 2 = Tripp)

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

■ No ■ Yes

3%

97%
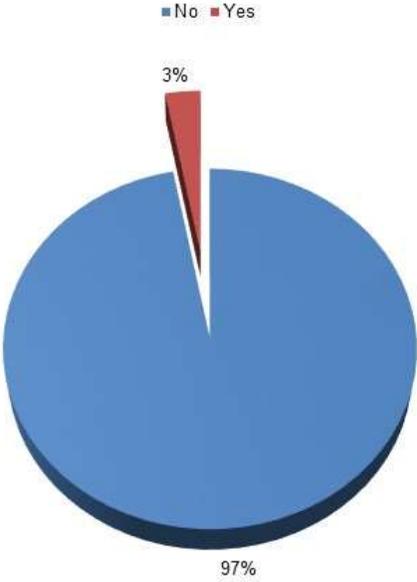
Base: Yes (n=1), No (n=34), Sample Size = 35

(Community 2 = Tripp)

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

■ No

100%
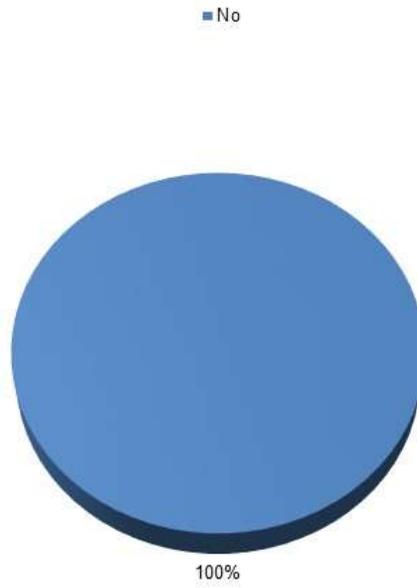
Base: No (n=35), Sample Size = 35

(Community 2 = Tripp)

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

■ No ■ Yes

3%

97%
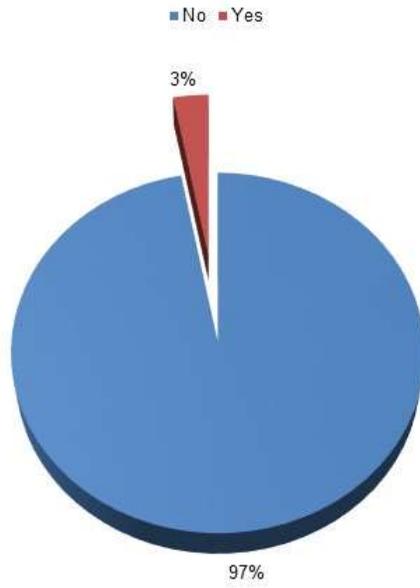
Base: Yes (n=1), No (n=34), Sample Size = 35

(Community 2 = Tripp)

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

■ No ■ Yes

34%

66%
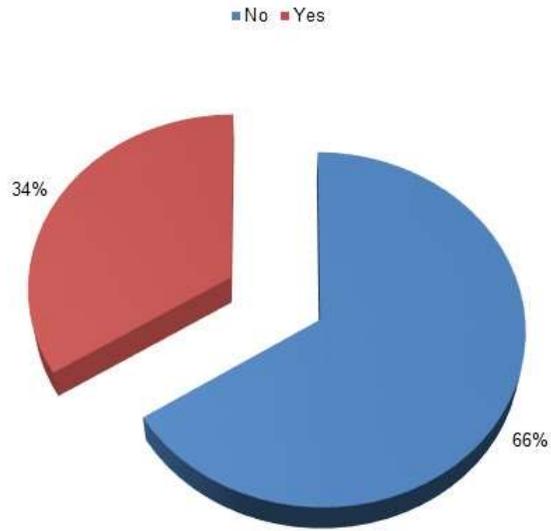
Base: Yes (n=12), No (n=23), Sample Size = 35

(Community 2 = Tripp)

Drug and Alcohol Issues
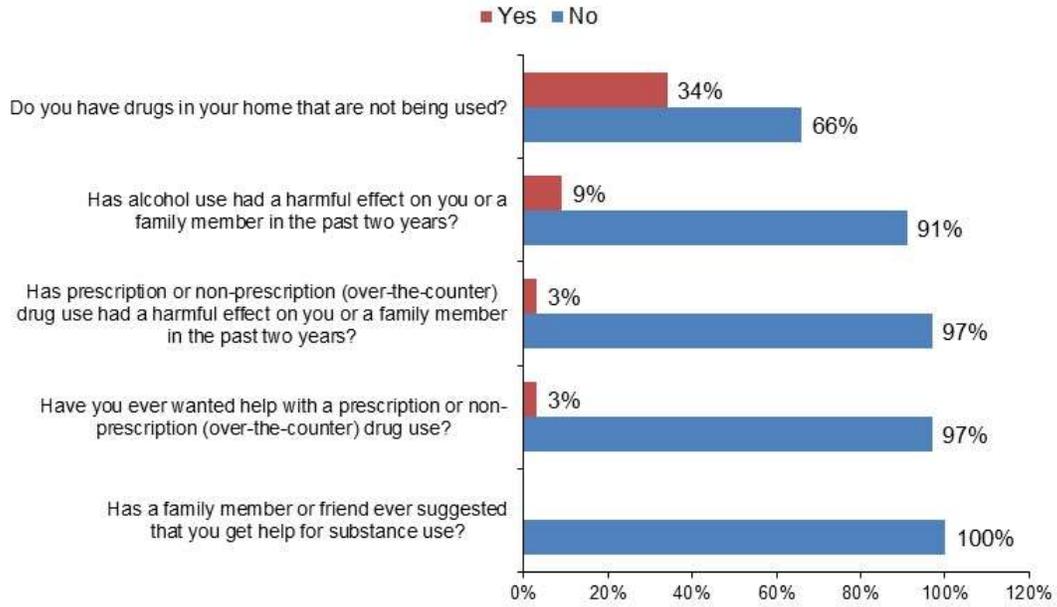
■ Yes ■ No

Do you have drugs in your home that are not being used?
- Yes: 34%
- No: 66%

Has alcohol use had a harmful effect on you or a family member in the past two years?
- Yes: 9%
- No: 91%

Has prescription or non-prescription (over-the-counter) drug use had a harmful effect on you or a family member in the past two years?
- Yes: 3%
- No: 97%

Have you ever wanted help with a prescription or non-prescription (over-the-counter) drug use?
- Yes: 3%
- No: 97%

Has a family member or friend ever suggested that you get help for substance use?
- No: 100%

Sample Size = 35

(Community 2 = Tripp)

Average number of drinks per day when you drink by gender

■Male ■Female
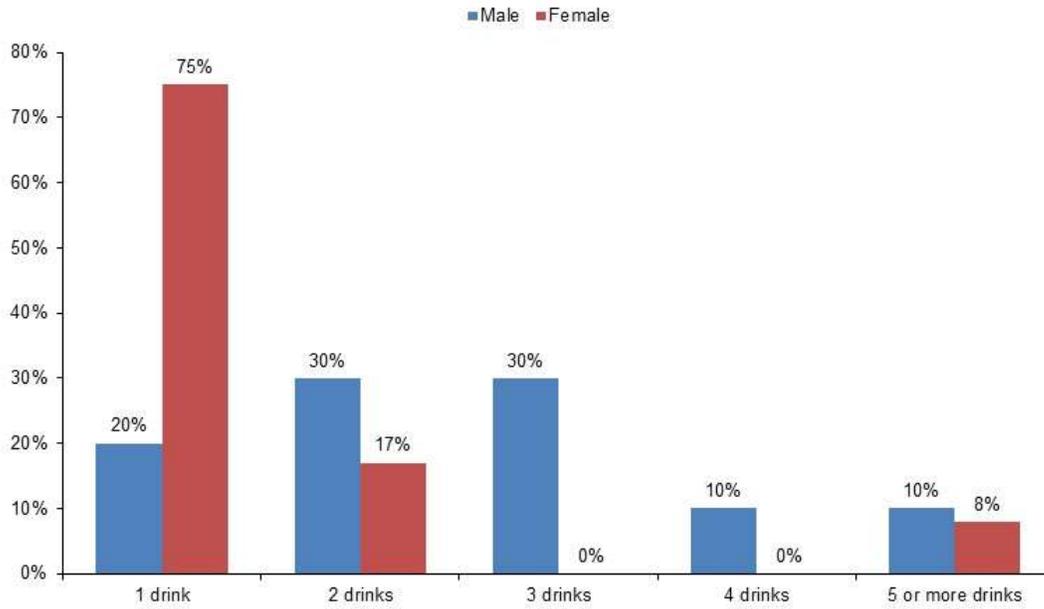
Base: 1 drink (n=11), 2 drinks (n=5), 3 drinks (n=3), 4 drinks (n=1), 5 or more drinks (n=2), Sample Size = 22

(Community 2 = Tripp)

Binge Drinking past 30 days by Age

■ Once a month ■ 2-3 times a week
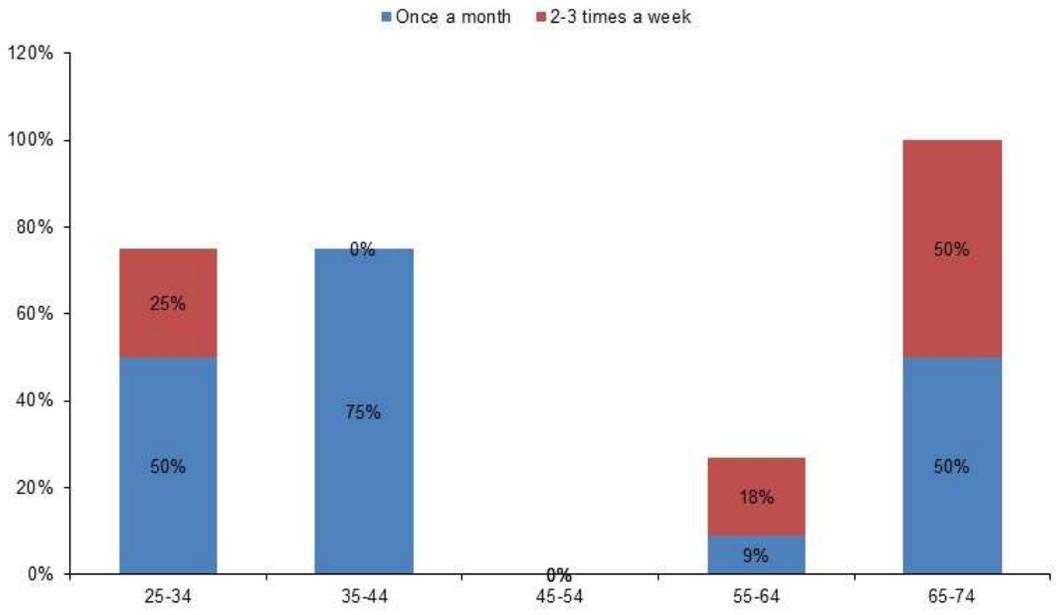
Base: 25-34 (n=4), 35-44 (n=4), 45-54 (n=3), 55-64 (n=11), 65-74 (n=2), Sample Size = 24

(Community 2 = Tripp)

How long has it been since you last visited a doctor or health care provider for a routine checkup?
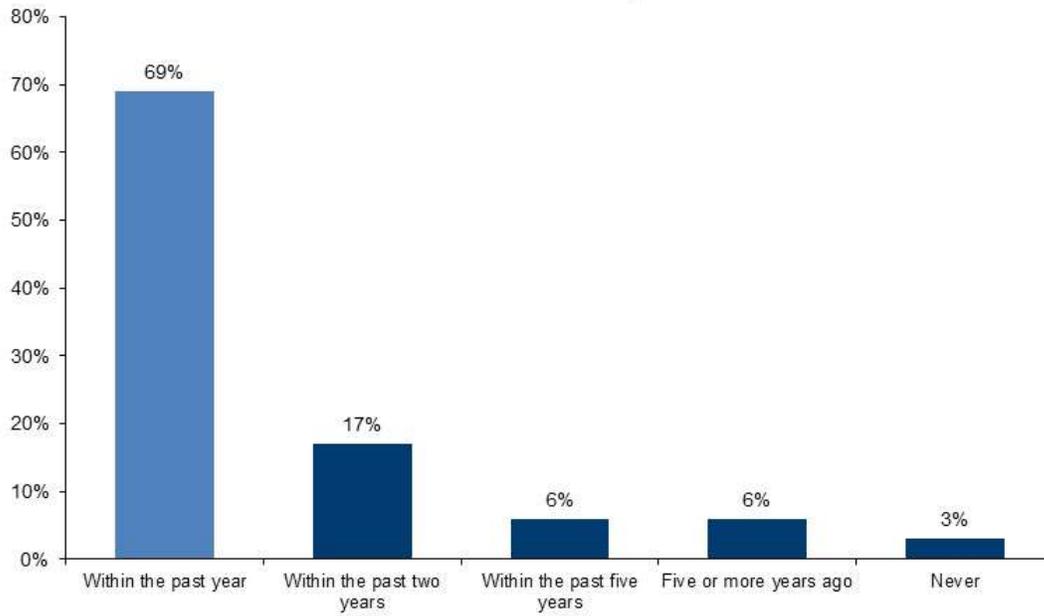
Base: Within the past year (n=24), Within the past two years (n=6), Within the past five years (n=2), Five or more years ago (n=2), Never (n=1), Sample Size = 35
(Community 2 = Tripp)

Barriers to Routine Checkup
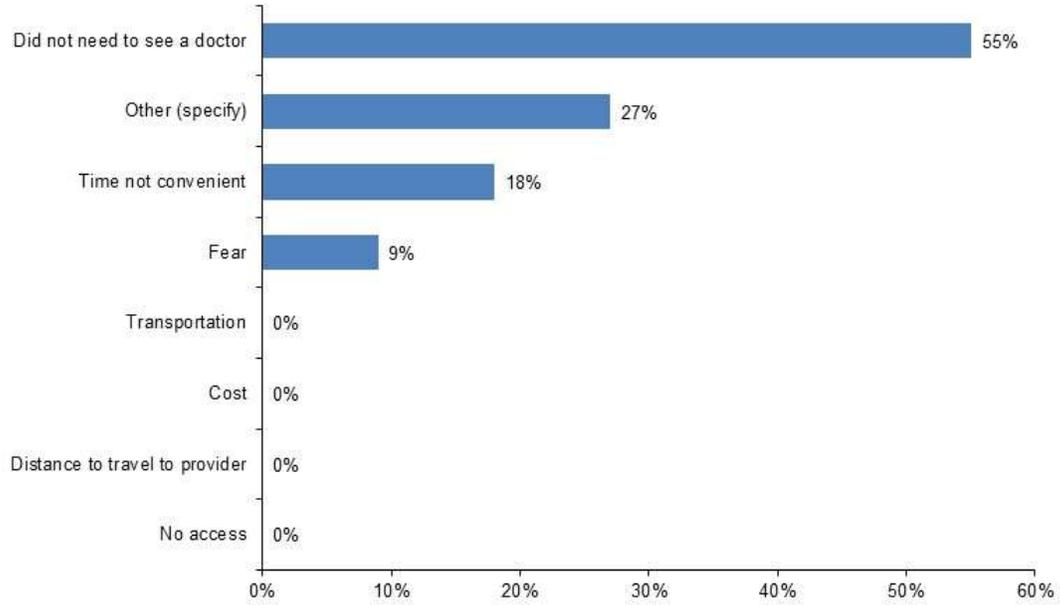
Base: No access (n=0), Distance to travel to provider (n=0), Cost (n=0), Fear (n=1), Transportation (n=0), Time not convenient (n=2), Did not need to see a doctor (n=6), Other (specify) (n=3), Sample Size = 11

(Community 2 = Tripp)

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

■ Yes ■ No ■ Don't know / Unsure

9%

21%

71%
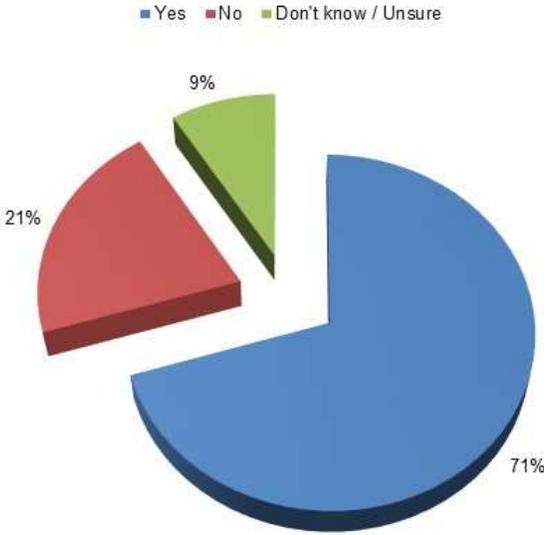
Base: Yes (n=24), No (n=7), Don't know / Unsure (n=3), Sample Size = 34

(Community 2 = Tripp)

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

■ Yes   ■ No   ■ Don't know / Unsure
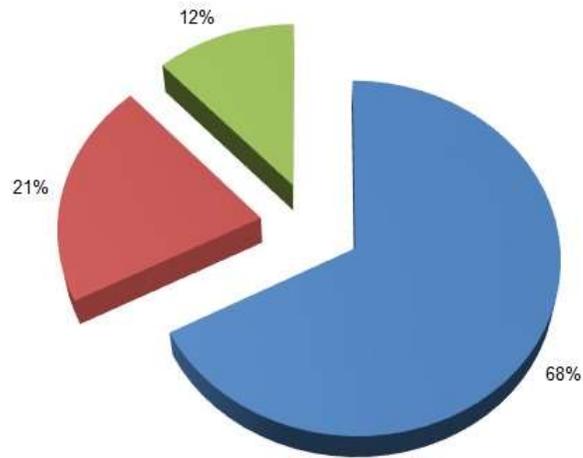
Base: Yes (n=23), No (n=7), Don't know / Unsure (n=4), Sample Size = 34

(Community 2 = Tripp)

Screenings

■ Don't know / Unsure ■ No ■ Yes

Has your medical provider allowed you to make a choice about having the screenings or preventive services?
- 12%
- 21%
- 68%

Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?
- 9%
- 21%
- 71%

0% 10% 20% 30% 40% 50% 60% 70% 80%
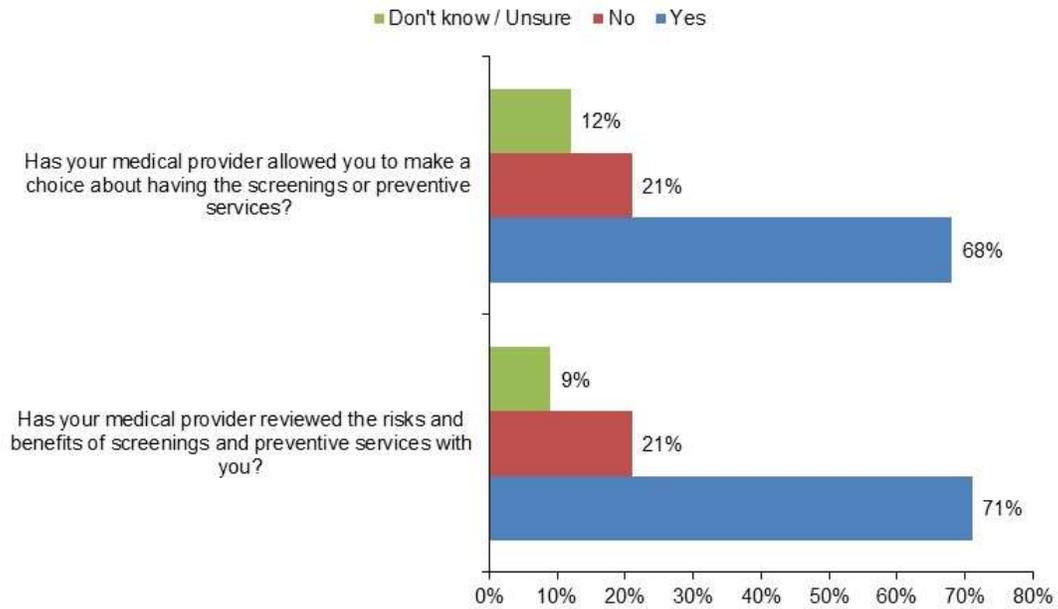
Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=34), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=34), Sample Size = 34

(Community 2 = Tripp)

Preventive Procedures Last Year
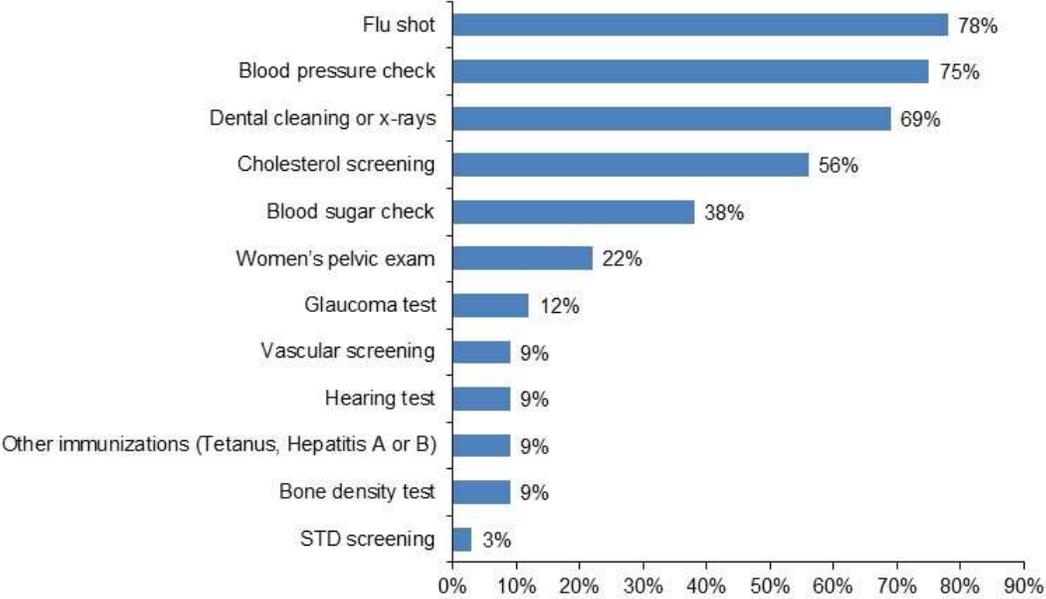
Procedure	Percentage
Flu shot	78%
Blood pressure check	75%
Dental cleaning or x-rays	69%
Cholesterol screening	56%
Blood sugar check	38%
Women's pelvic exam	22%
Glaucoma test	12%
Vascular screening	9%
Hearing test	9%
Other immunizations (Tetanus, Hepatitis A or B)	9%
Bone density test	9%
STD screening	3%

Base: Blood pressure check (n=24), Blood sugar check (n=12), Bone density test (n=3), Cholesterol screening (n=18), Dental cleaning or x-rays (n=22), Flu shot (n=25), Other immunizations (Tetanus, Hepatitis A or B) (n=3), Glaucoma test (n=4), Hearing test (n=3), Women's pelvic exam (n=7), STD screening (n=1), Vascular screening (n=3), Sample Size = 32
(Community 2 = Tripp)

Barriers for Preventive Procedures
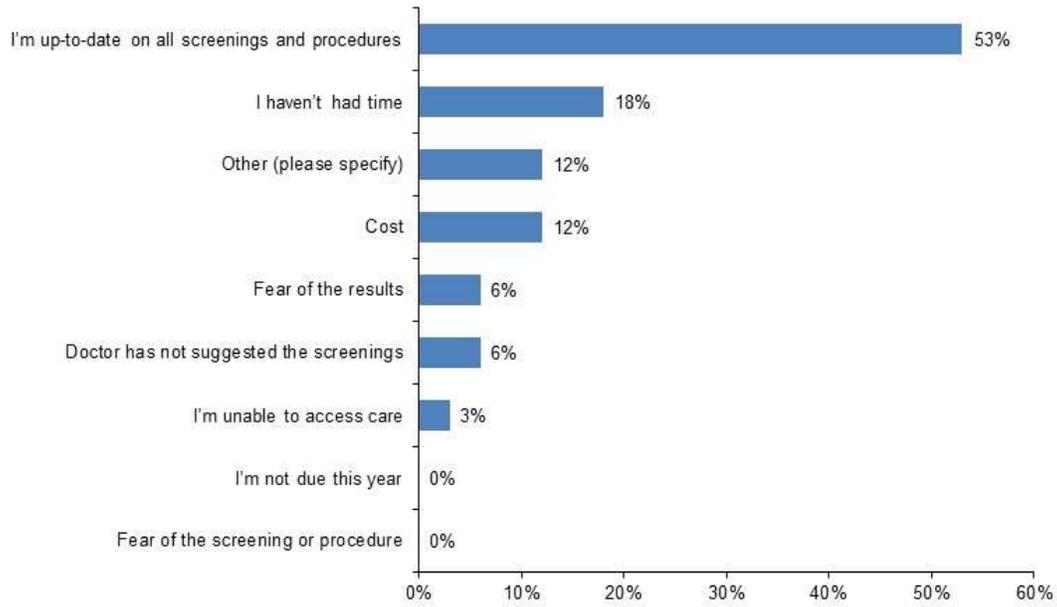
Base: I'm up-to-date on all screenings and procedures (n=18), Doctor has not suggested the screenings (n=2), Cost (n=4), I'm unable to access care (n=1), Fear of the screening or procedure (n=0), Fear of the results (n=2), I'm not due this year (n=0), I haven't had time (n=6), Other (please specify) (n=4), Sample Size = 34
(Community 2 = Tripp)

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

■ Yes ■ No

43%

57%
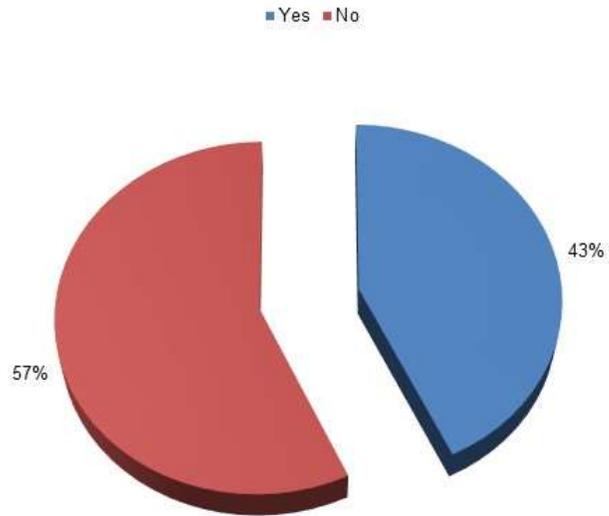
Base: Yes (n=15), No (n=20), Sample Size = 35

(Community 2 = Tripp)

Children's Car Safety

■ Use seat belts ■ Use car seat

Always
- Use seat belts: 64%
- Use car seat: 57%

Nearly always
- Use seat belts: 36%
- Use car seat: 29%

Seldom
- Use car seat: 14%
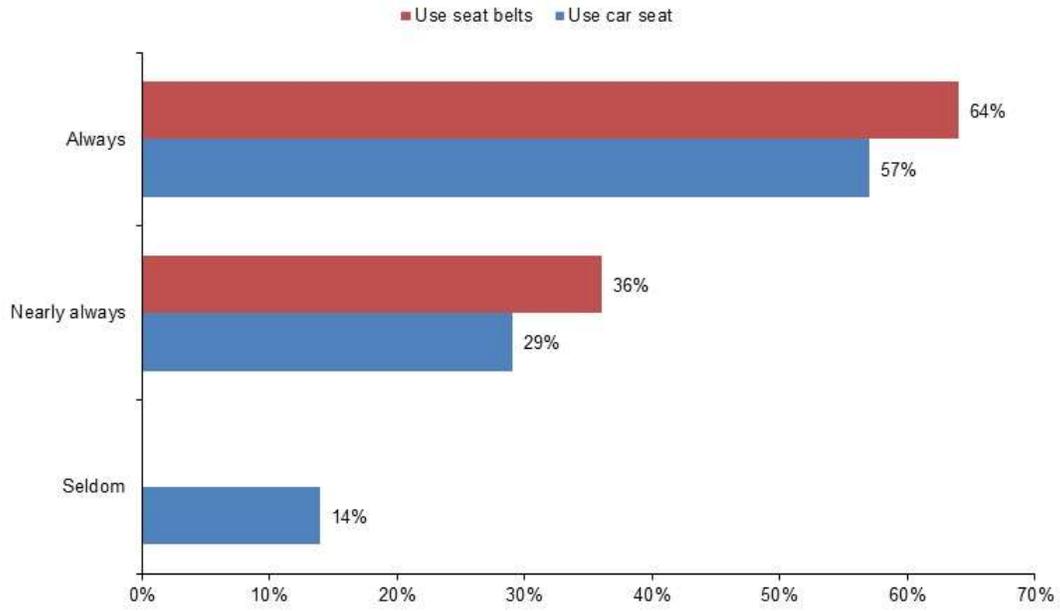
Sample Size = Variable

(Community 2 = Tripp)

Do you have healthcare coverage for your children or dependents?

■ Yes

100%
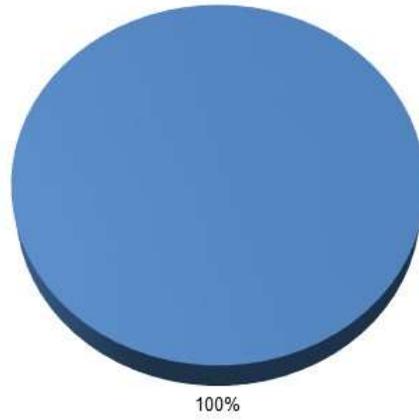
Base: Yes (n=15), Sample Size = 15

(Community 2 = Tripp)

Children's Preventative Services
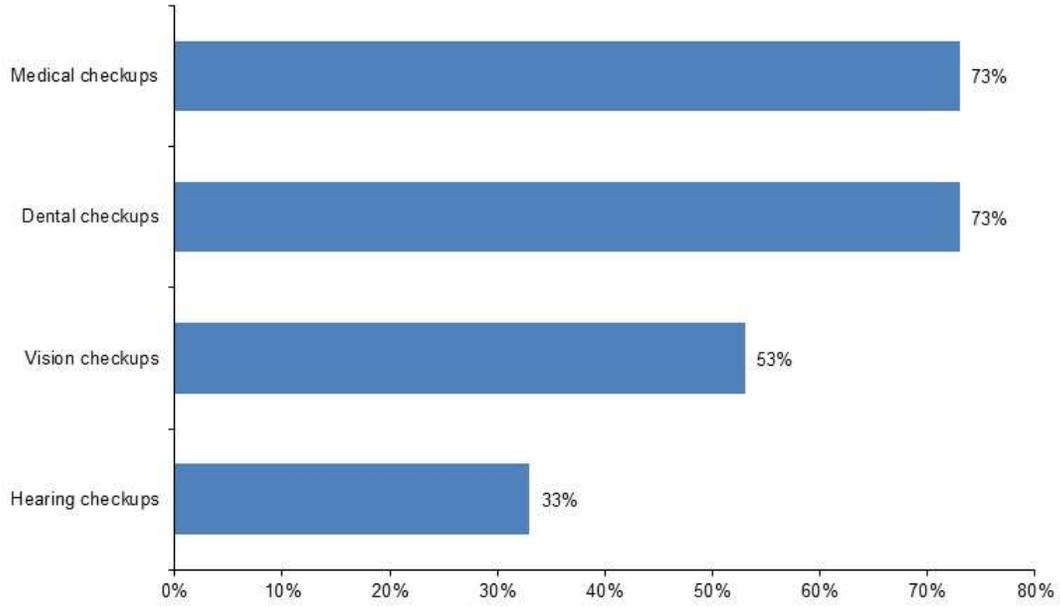
Base: Dental checkups (n=11), Vision checkups (n=8), Hearing checkups (n=5), Medical checkups (n=11), Sample Size = 15

(Community 2 = Tripp)

Where do you most often take your children when they are sick and need to see a health care provider?
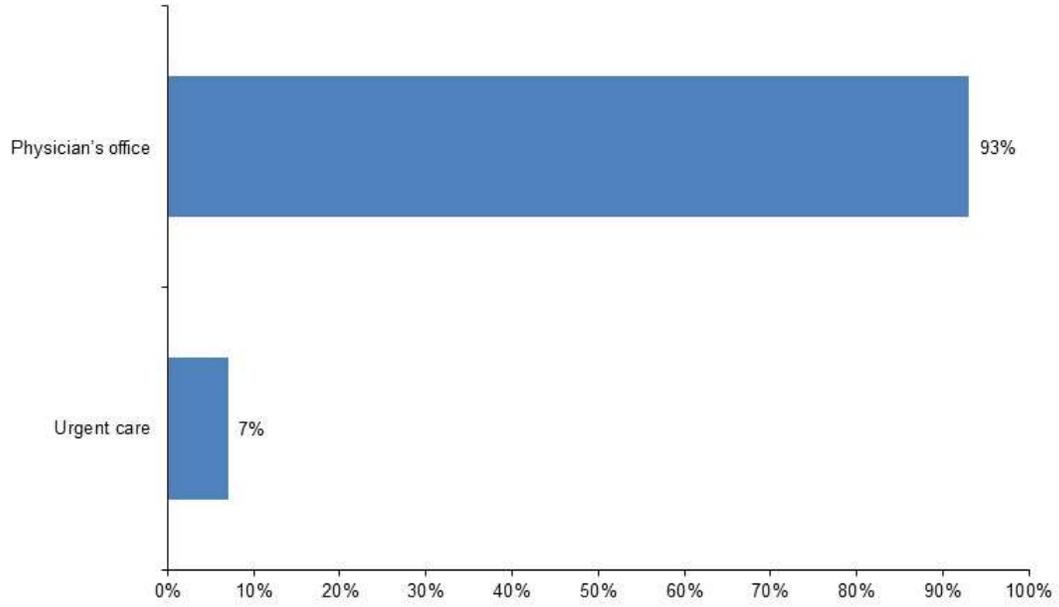
Base: Physician's office (n=14), Urgent care (n=1), Sample Size = 15

(Community 2 = Tripp)

Have you ever been diagnosed with cancer?

■ No ■ Yes

3%

97%
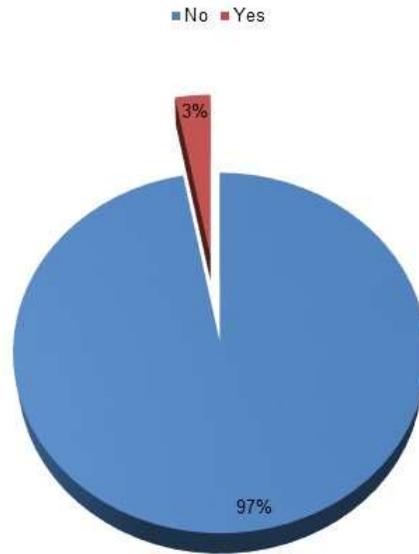
Base: Yes (n=1), No (n=34), Sample Size = 35

(Community 2 = Tripp)

Type of Cancer
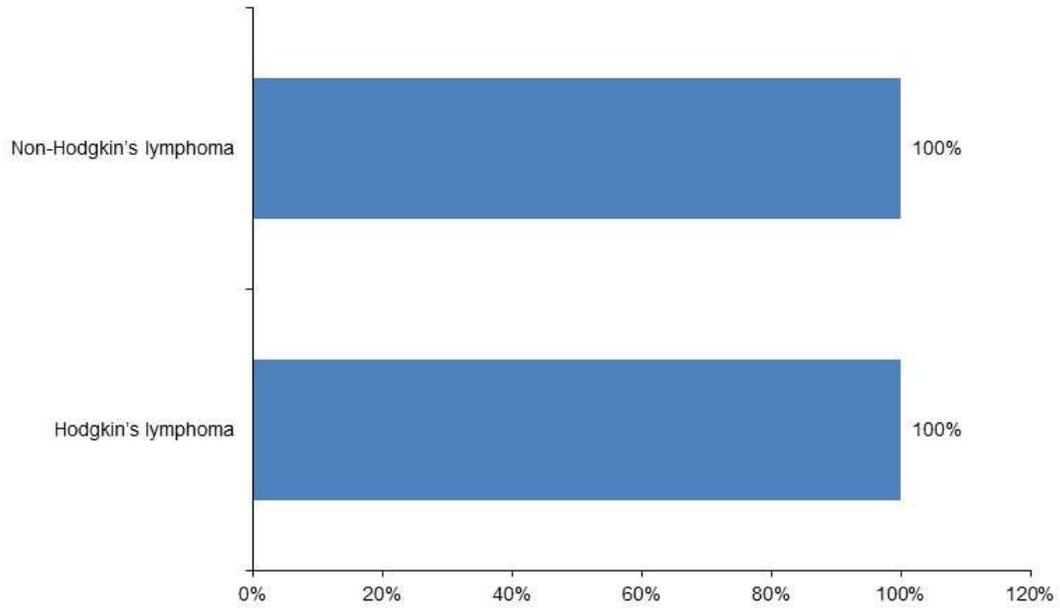
Base: Hodgkin's lymphoma (n=1), Non-Hodgkin's lymphoma (n=1), Sample Size = 1

(Community 2 = Tripp)

Do you currently have any kind of health insurance?

■ Yes ■ No


9%

91%
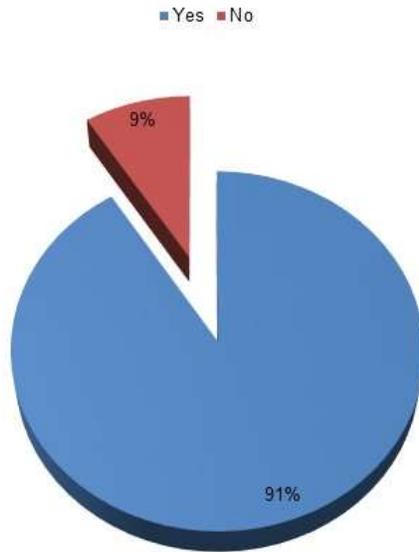
Base: Yes (n=32), No (n=3), Sample Size = 35

(Community 2 = Tripp)

Type of Insurance

Insurance Type	Percentage
Through an employer	69%
Individually purchased	28%
Medicare	9%
Medicare Part B (Medical insurance)	6%
Medicare Part A (Hospital insurance)	6%
Healthy Steps or CHIP	3%
Veteran Benefits (CHAMPUS, TRICARE)	3%
Medicaid / Medical Assistance	3%
Medicare Part D (Prescription insurance)	3%
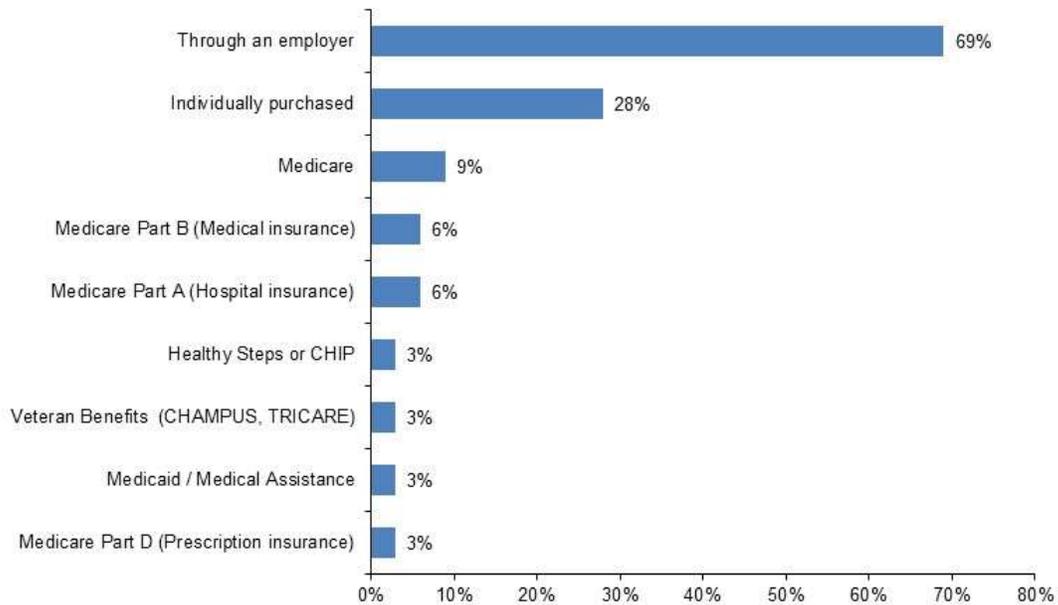
Base: Through an employer (n=22), Individually purchased (n=9), Medicare (n=3), Medicare Part A (Hospital insurance) (n=2), Medicare Part B (Medical insurance) (n=2), Medicare Part D (Prescription insurance) (n=1), Medicaid / Medical Assistance (n=1), Veteran Benefits (CHAMPUS, TRICARE) (n=1), Healthy Steps or CHIP (n=1), Sample Size = 32
(Community 2 = Tripp)

Do you have an established primary healthcare provider?

■ Yes ■ No

15%

85%
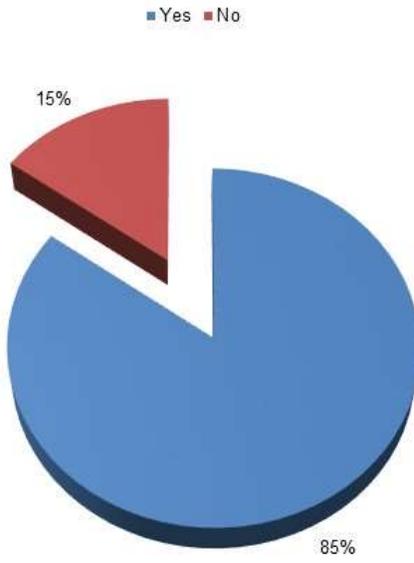
Base: Yes (n=29), No (n=5), Sample Size = 34

(Community 2 = Tripp)

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

■ No ■ Yes

3%

97%
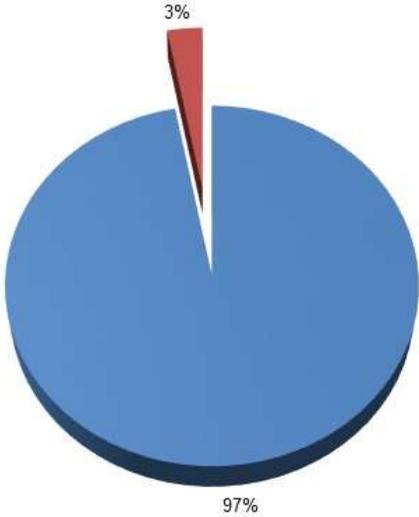
Base: Yes (n=1), No (n=34), Sample Size = 35

(Community 2 = Tripp)

Barriers to Receiving Care Needed

Appointment not at a convenient time — 100%

No appointment was available — 100%
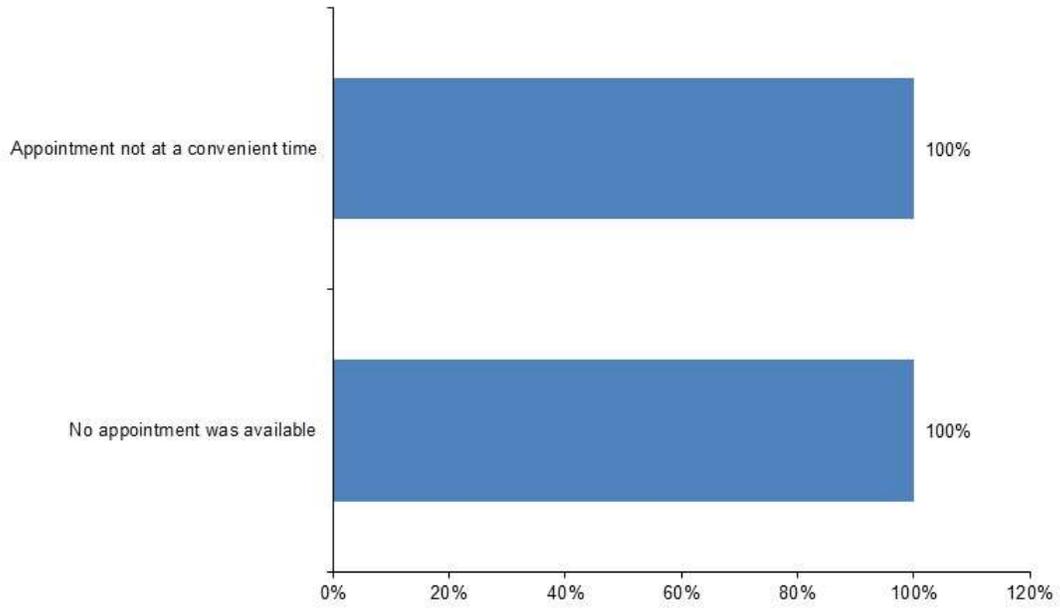
Base: No appointment was available (n=1), Appointment not at a convenient time (n=1)

(Community 2 = Tripp)

How long has it been since you last visited a dentist?
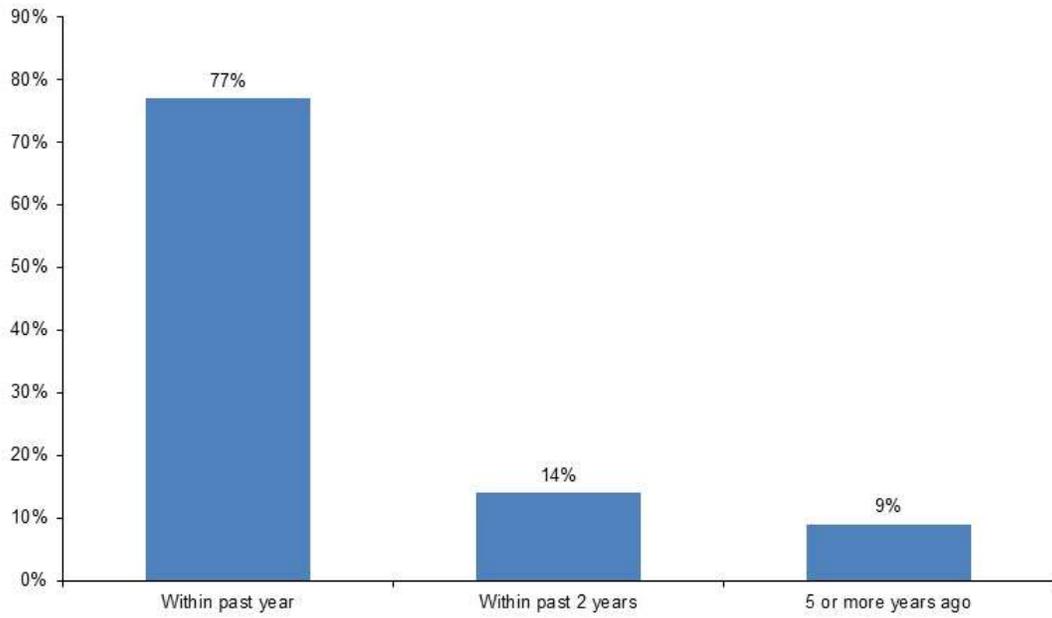
Base: Within past year (n=27), Within past 2 years (n=5), 5 or more years ago (n=3), Sample Size = 35

(Community 2 = Tripp)

Barriers to Visiting the Dentist
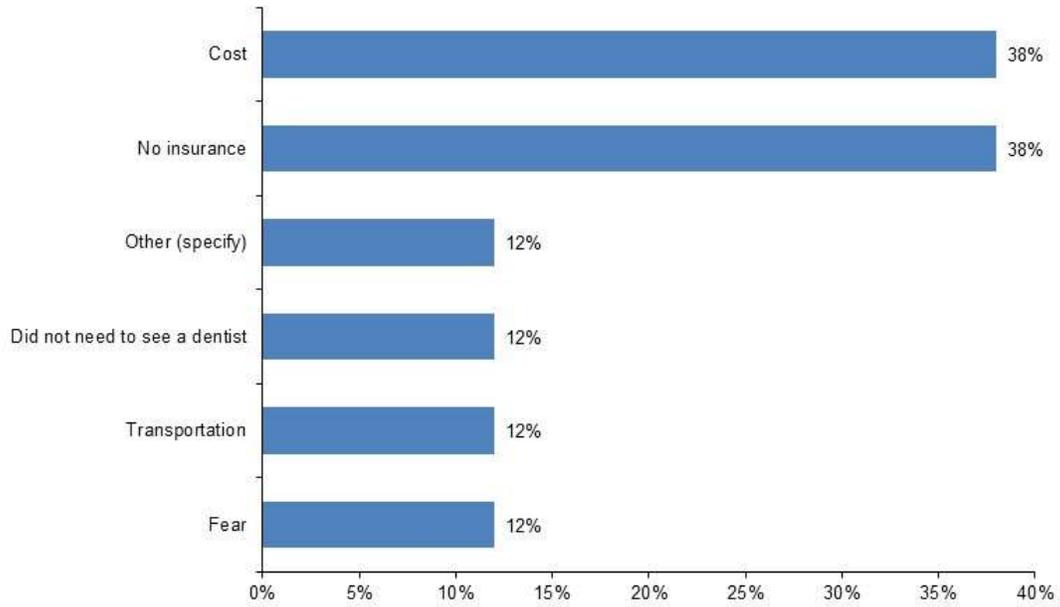
Base: No insurance (n=3), Cost (n=3), Fear (n=1), Transportation (n=1), Did not need to see a dentist (n=1), Other (specify) (n=1), Sample Size = 8

(Community 2 = Tripp)

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

■ Yes ■ No

31%

69%
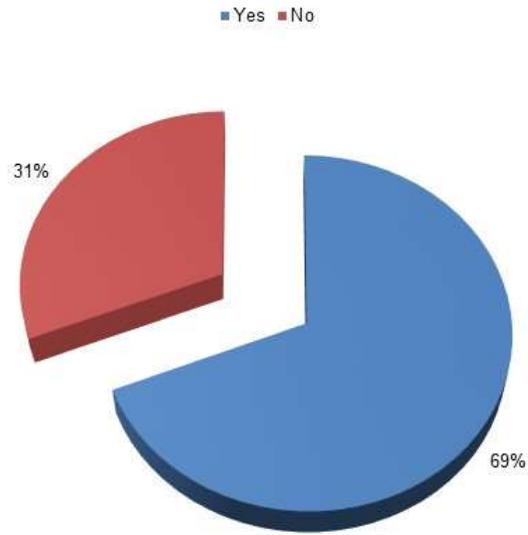
Base: Yes (n=24), No (n=11), Sample Size = 35

(Community 2 = Tripp)

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

■ Yes, only one   ■ Yes, more than one   ■ No

11%

11%

77%
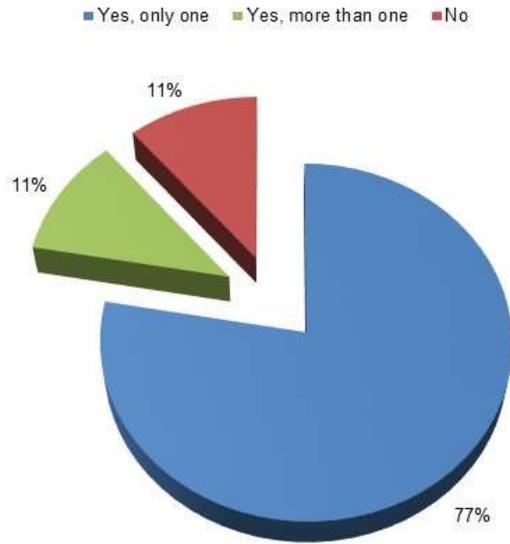
Base: Yes, only one (n=27), Yes, more than one (n=4), No (n=4), Sample Size = 35

(Community 2 = Tripp)

Most Important Community Issues
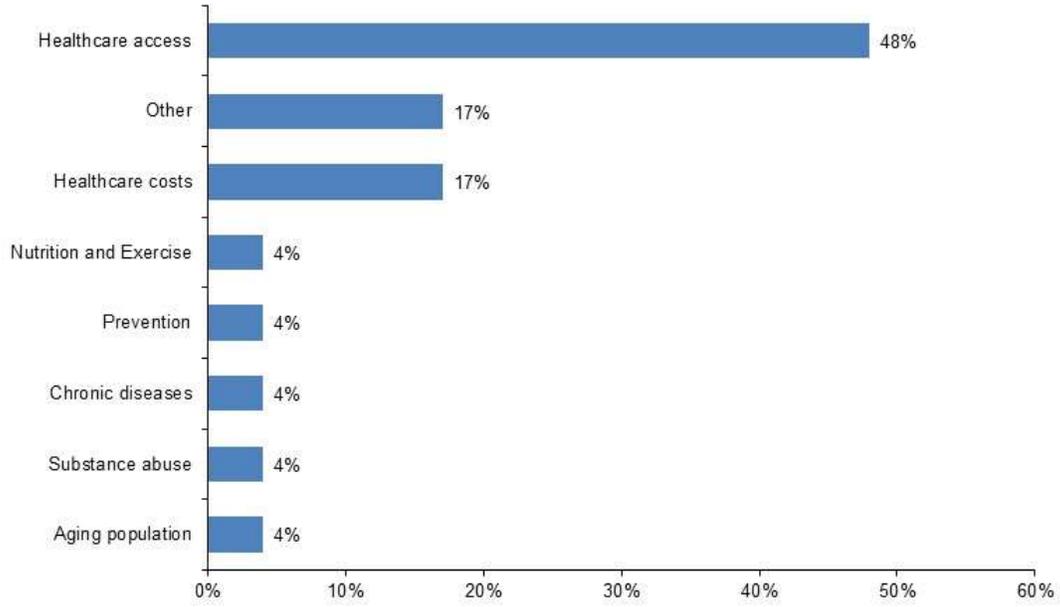
Base: Aging population (n=1), Healthcare access (n=11), Substance abuse (n=1), Chronic diseases (n=1), Healthcare costs (n=4), Prevention (n=1), Nutrition and Exercise (n=1), Other (n=4), Sample Size = 25

(Community 2 = Tripp)

## Most Important Issue for Family
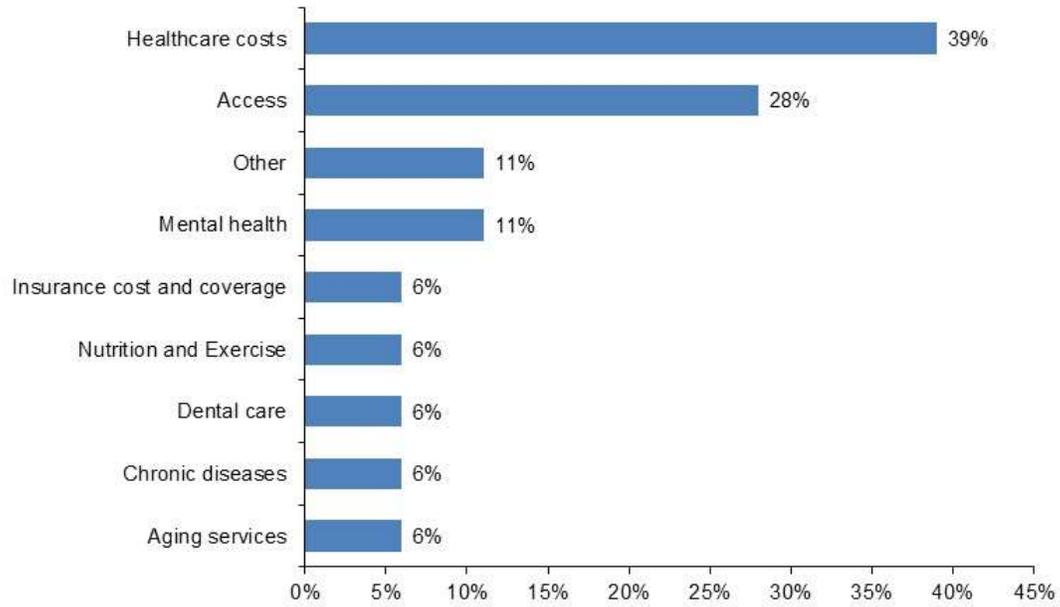
Base: Access (n=5), Aging services (n=1), Chronic diseases (n=1), Healthcare costs (n=7), Dental care (n=1), Nutrition and Exercise (n=1), Insurance cost and coverage (n=1), Mental health (n=2), Other (n=2), Sample Size = 23
(Community 2 = Tripp)

What is your biggest concern as you age? (Age 65+)

Concern	Percentage
Cost of long term care	22%
Cost of health care	17%
Other (specify)	11%
Financial problems	11%
Maintaining physical and mental health	11%
Transportation	6%
Access to long term care	6%
Feeling depressed, lonely, sad, isolated	6%
Affording your medications	6%
Access to health care	6%
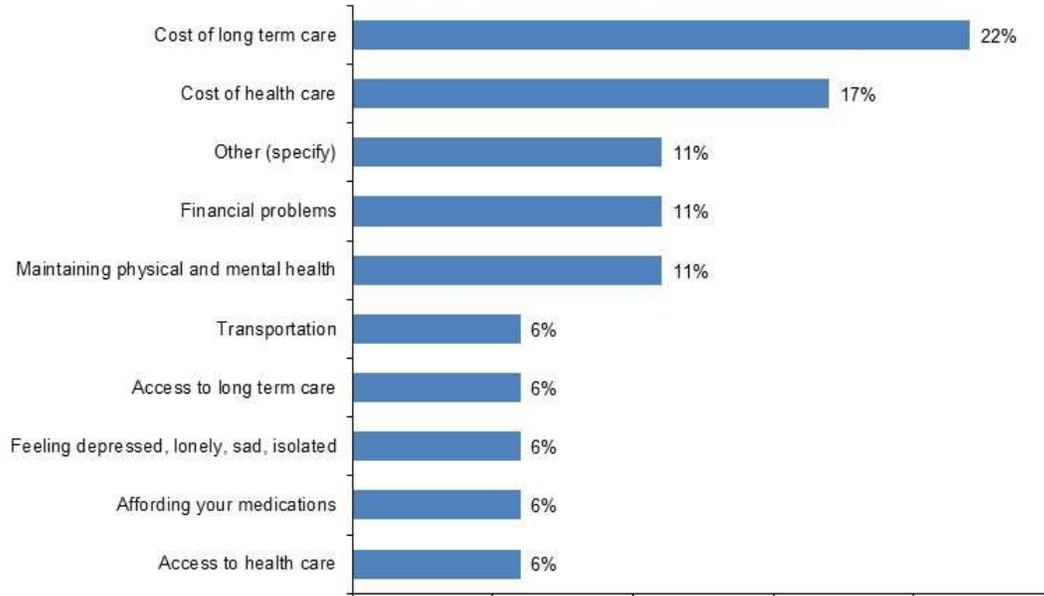
Base: Access to health care (n=1), Cost of health care (n=3), Affording your medications (n=1), Maintaining physical and mental health (n=2), Feeling depressed, lonely, sad, isolated (n=1), Access to long term care (n=1), Cost of long term care (n=4), Financial problems (n=2), Transportation (n=1), Other (specify) (n=2), Sample Size = 6
(Community 2 = 11pp)

Which of these tasks do you need assistance with? (Age 65+)
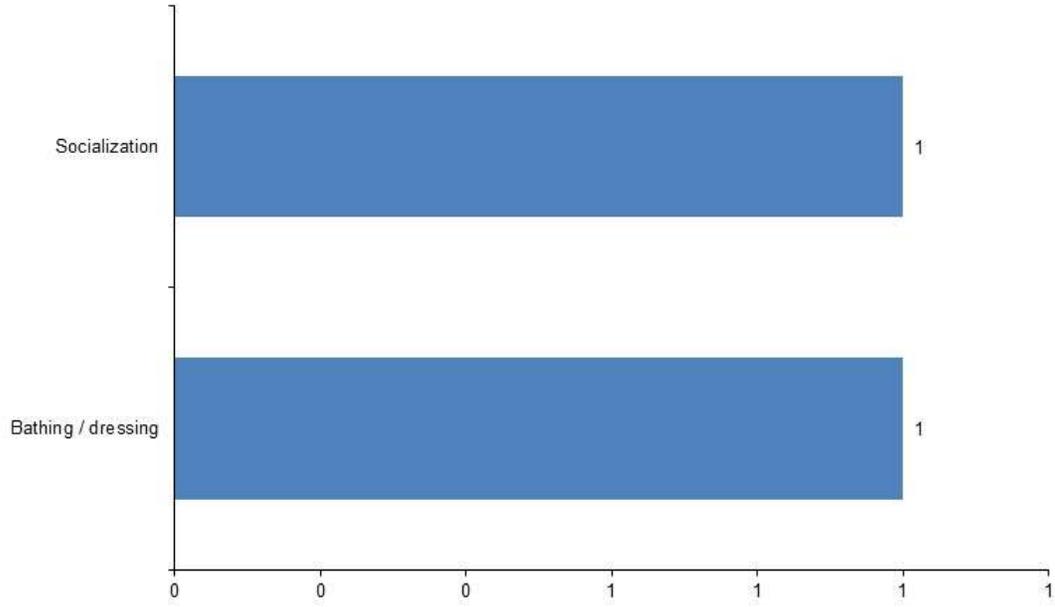

Base: Bathing / dressing (n=1), Socialization (n=1), Sample Size = 1

(Community 2 = Tripp)

Do you know where to go to get help with the tasks you need assistance with? (Age 65+)

■ Yes
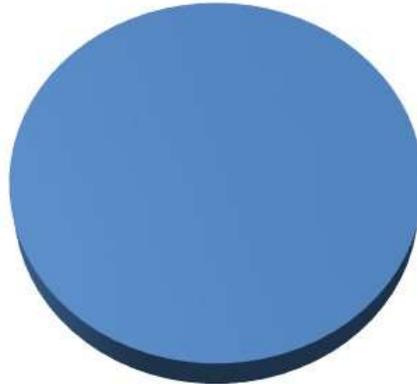
Base: Yes (n=1), Sample Size = 1

(Community 2 = Tripp)

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

Method	Percentage
E-mail	34%
Online websites	25%
Written materials	25%
Social media	22%
One-on-one teaching	19%
Group education workshop/seminar	12%
Text messages	9%
Videos for home use	6%
Other (specify)	3%
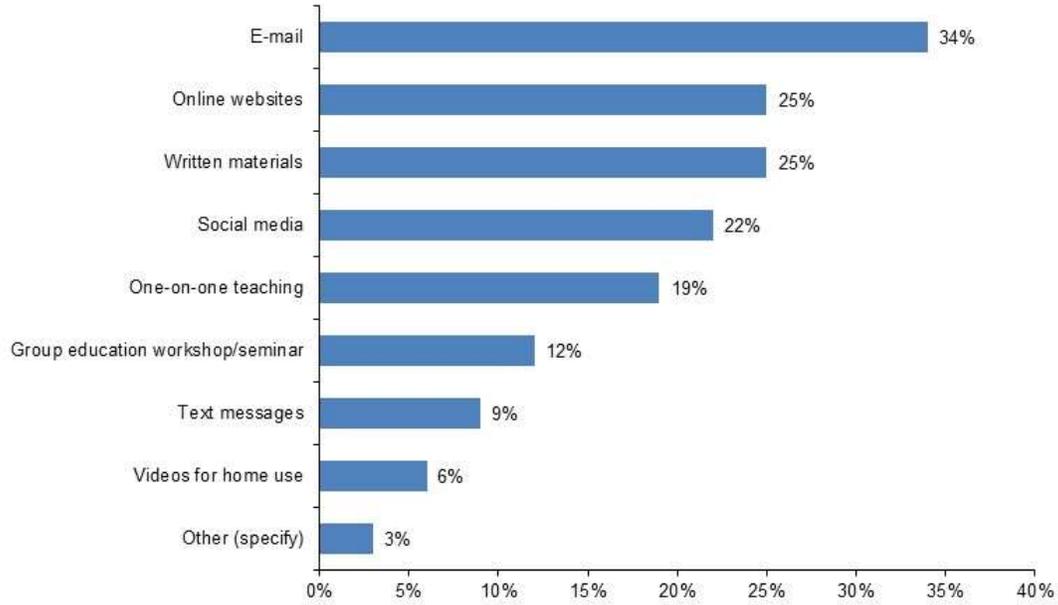
Base: Written materials (n=8), Videos for home use (n=2), Social media (n=7), Text messages (n=3), One-on-one teaching (n=6), E-mail (n=11), Group education workshop/seminar (n=4), Online websites (n=8), Other (specify) (n=1), Sample Size = 32

(Community 2 = Tripp)

Gender

■ Male ■ Female

43%

57%
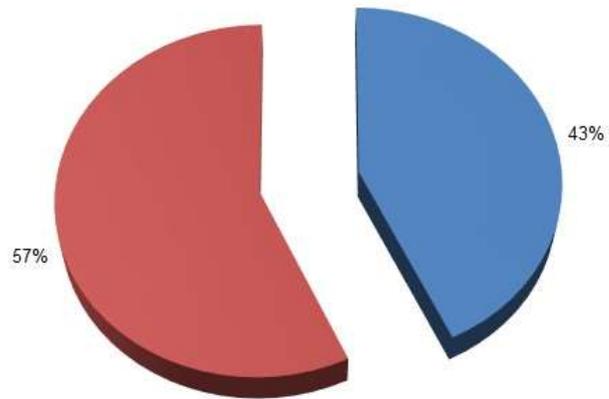
Base: Male (n=15), Female (n=20), Sample Size = 35

(Community 2 = Tripp)

Age
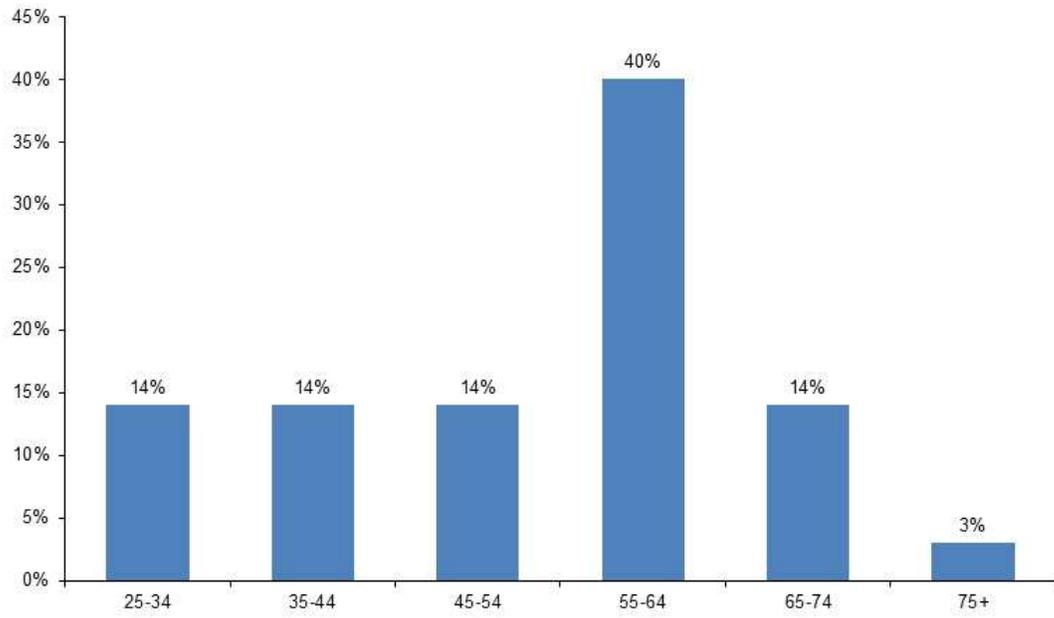
Base: 25-34 (n=5), 35-44 (n=5), 45-54 (n=5), 55-64 (n=14), 65-74 (n=5), 75+ (n=1), Sample Size = 35

(Community 2 = Tripp)

People in Household
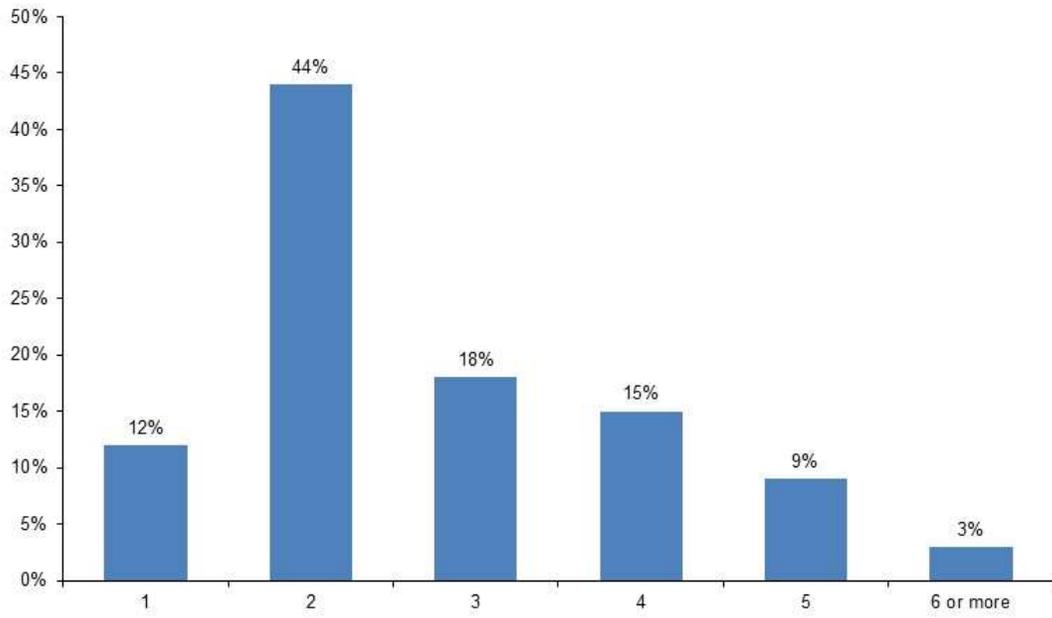
Base: 1 (n=4), 2 (n=15), 3 (n=6), 4 (n=5), 5 (n=3), 6 or more (n=1), Sample Size = 34

(Community 2 = Tripp)

Children in Household Under 18
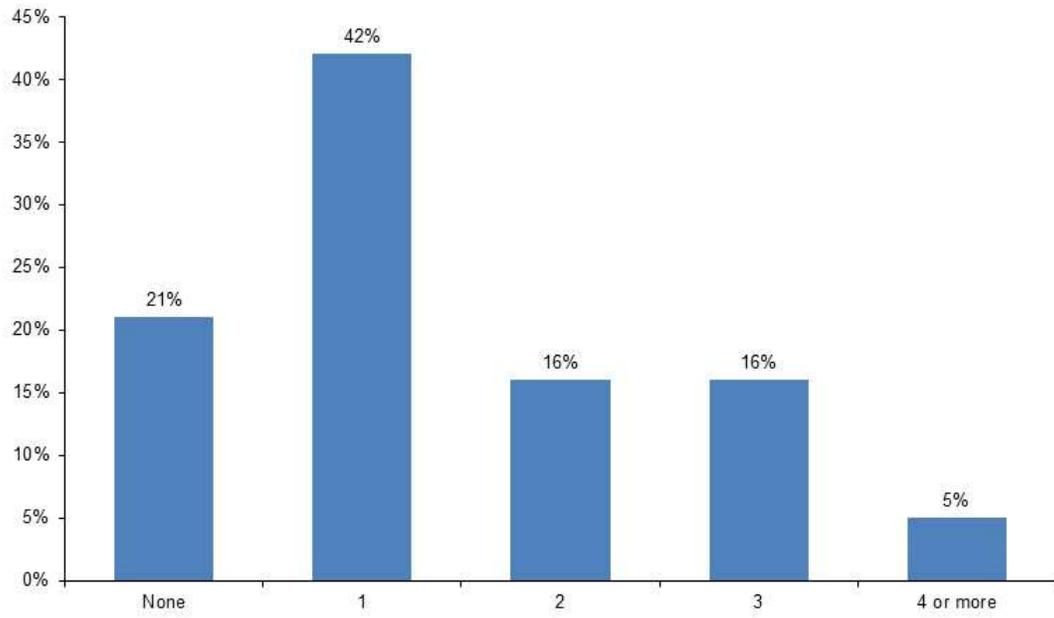
Base: None (n=4), 1 (n=8), 2 (n=3), 3 (n=3), 4 or more (n=1), Sample Size = 19

(Community 2 = Tripp)

Ethnicity
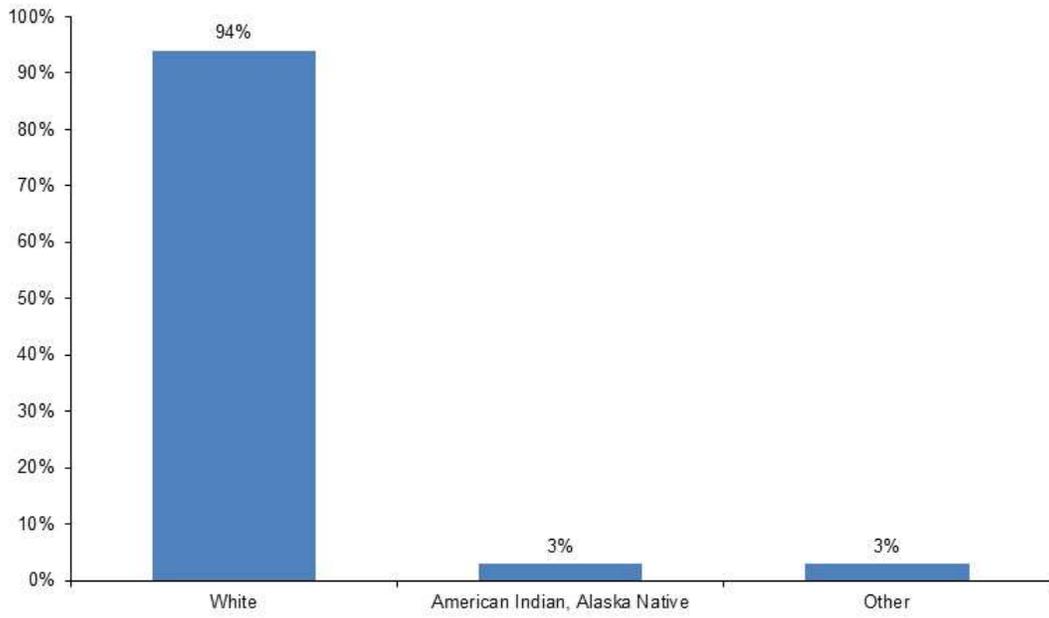
Base: White (n=33), American Indian, Alaska Native (n=1), Other (n=1), Sample Size = 35

(Community 2 = Tripp)

Language Spoken in Home

English   100%
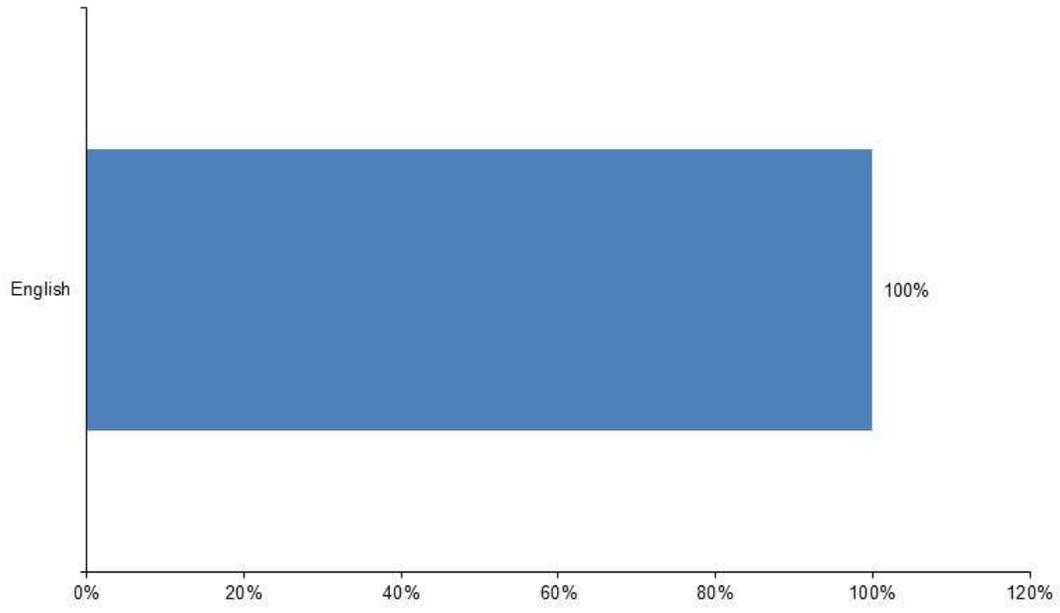
Base: English (n=35), Sample Size = 35

(Community 2 = Tripp)

Marital Status
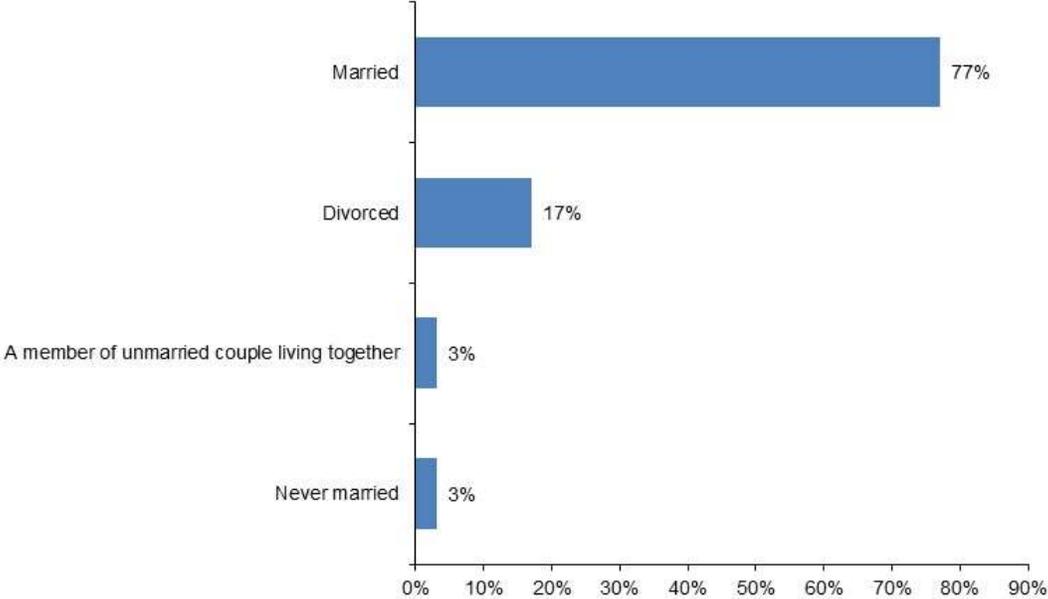
Base: Never married (n=1), Married (n=27), Divorced (n=6), A member of unmarried couple living together (n=1), Sample Size = 35

(Community 2 = Tripp)

Current Living Situation
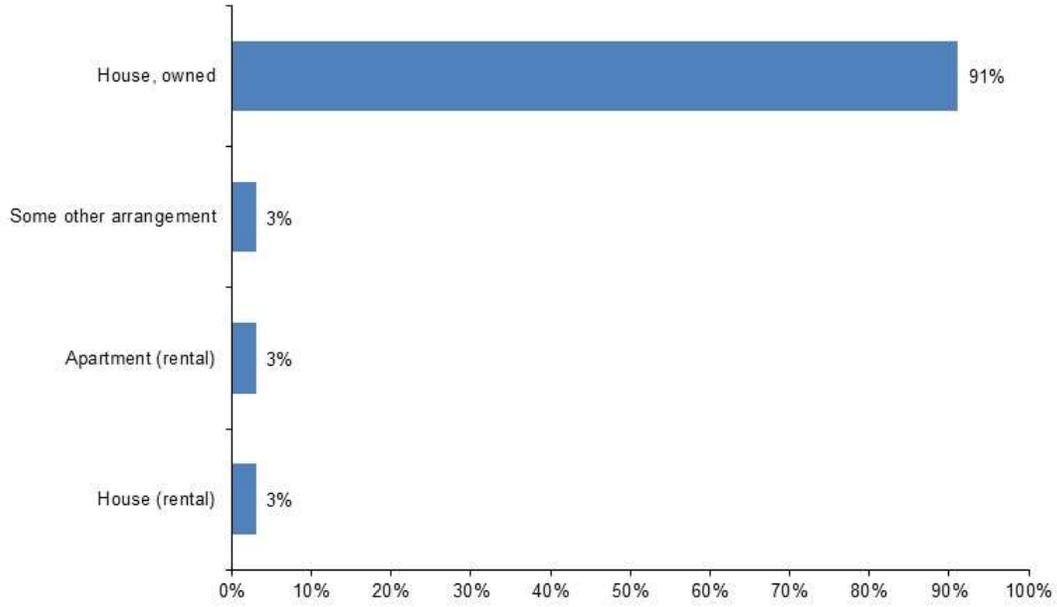
Base: House, owned (n=32), House (rental) (n=1), Apartment (rental) (n=1), Some other arrangement (n=1), Sample Size = 35

(Community 2 = Tripp)

Education Level
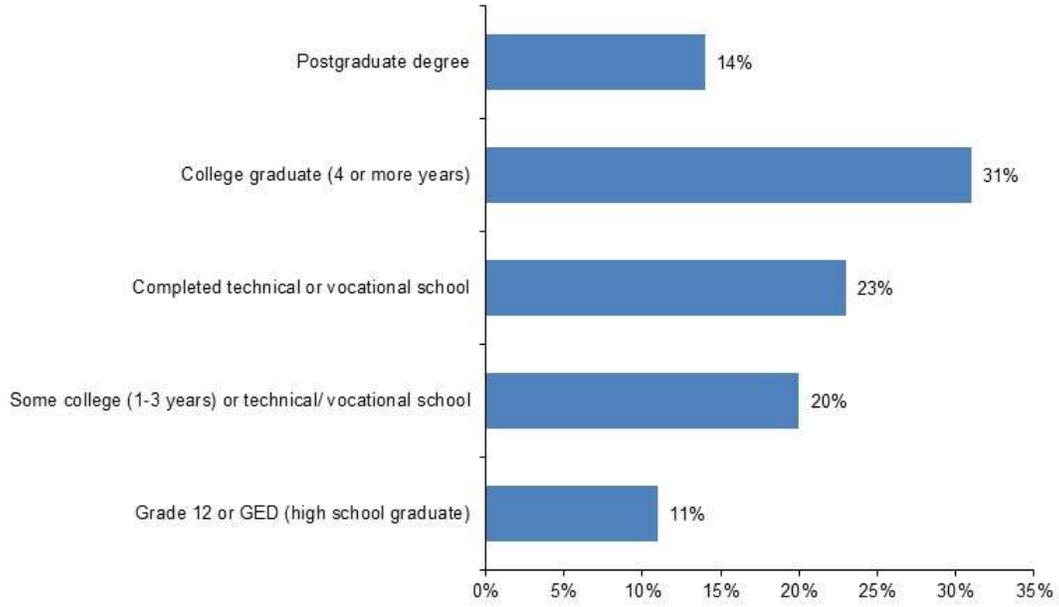
Base: Grade 12 or GED (high school graduate) (n=4), Some college (1-3 years) or technical/vocational school (n=7), Completed technical or vocational school (n=8), College graduate (4 or more years) (n=11), Postgraduate degree (n=5), Sample Size = 35

(Community 2 = Tripp)

Employment Status

Employed for wages — 69%

Self-employed — 20%

Retired — 11%

0%   10%   20%   30%   40%   50%   60%   70%   80%
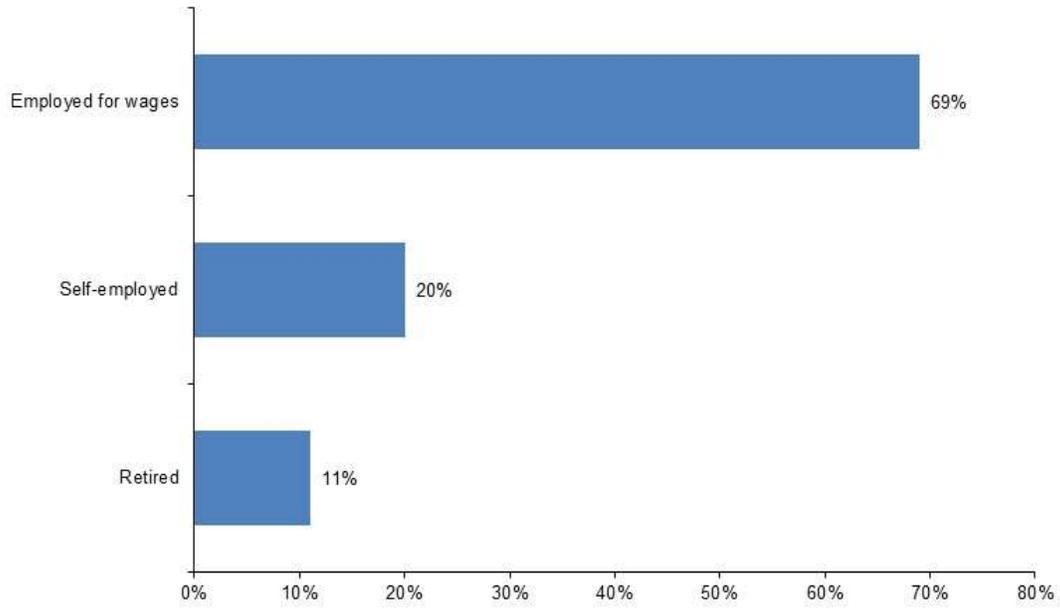
Base: Employed for wages (n=24), Self-employed (n=7), Retired (n=4), Sample Size = 35

(Community 2 = Tripp)

Sample Source

Qualtrics ▪ Open Invitation / FaceBook

9%

91%
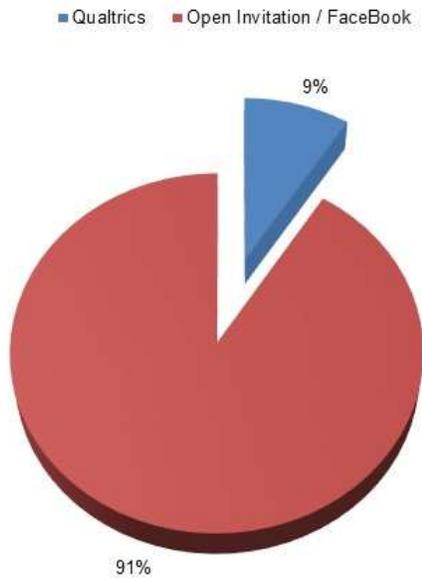
Base: Qualtrics (n=3), Open Invitation / FaceBook (n=32), Sample Size = 35

(Community 2 = Tripp)

Total Household Income
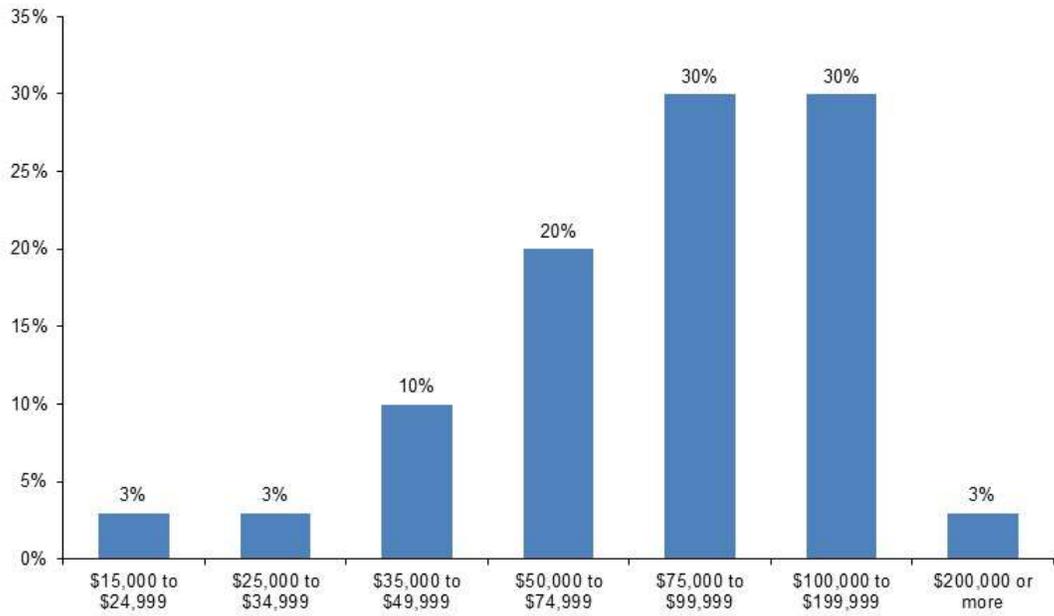
Base: $15,000 to $24,999 (n=1), $25,000 to $34,999 (n=1), $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=6), $75,000 to $99,999 (n=9), $100,000 to $199,999 (n=9), $200,000 or more (n=1), Sample Size = 30

(Community 2 = Tripp)

Secondary Research

DEFINITIONS OF KEY INDICATORS
A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in calculating the 2019 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:
- Outcomes & Factors Rankings
- Outcomes & Factors Sub Rankings
- Ranked Measures Data (including measure values, confidence intervals* and z-scores**)
- Additional Measures Data (including measure values and confidence intervals*)
- Ranked Measure Sources and Years
- Additional Measure Sources and Years

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

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

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

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Excessive drinking	**% Excessive Drinking**	Percentage of adults that report excessive drinking
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Alcohol-impaired driving deaths	# Alcohol-Impaired Driving Deaths	Number of alcohol-impaired motor vehicle deaths
	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	95% CI - Low	95% confidence interval using Poisson distribution
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	**Teen Birth Rate**	Births per 1,000 females ages 15-19
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Teen Birth Rate (Black)	Births per 1,000 females ages 15-19 for Black non-Hispanic mothers
	Teen Birth Rate (Hispanic)	Births per 1,000 females ages 15-19 for Hispanic mothers
	Teen Birth Rate (White)	Births per 1,000 females ages 15-19 for White non-Hispanic mothers
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance
	95% CI - Low	95% confidence interval reported by SAHIE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	PCP Rate	Primary Care Physicians per 100,000 population
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	Dentists per 100,000 population
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	Mental Health Providers per 100,000 population

Measure	Data Elements	Description
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	**Preventable Hosp. Rate**	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Preventable Hosp. Rate (Black)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Blacks
	Preventable Hosp. Rate (Hispanic)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Hispanics
	Preventable Hosp. Rate (White)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Whites
Mammography screening	**% Screened**	Percentage of female Medicare enrollees having an annual mammogram (age 65-74)
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Screened (Black)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Blacks
	% Screened (Hispanic)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Hispanics
	% Screened (White)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Whites
Flu vaccinations	**% Vaccinated**	Percentage of annual Medicare enrollees having an annual flu vaccination
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Vaccinated (Black)	Percentage of annual Medicare enrollees having an annual flu vaccination for Blacks
	% Vaccinated (Hispanic)	Percentage of annual Medicare enrollees having an annual flu vaccination for Hispanics
	% Vaccinated (White)	Percentage of annual Medicare enrollees having an annual flu vaccination for Whites
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Measure	Data Elements	Description
Children in poverty	**% Children in Poverty**	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Children in Poverty (Black)	Percentage of Black children (under age 18) living in poverty - from the 2013-2017 ACS
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty - from the 2013-2017 ACS
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2013-2017 ACS
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations per 10,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	Annual Average Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
	95% CI - Low	95% confidence interval as reported by CDC Wonder
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**Presence of violation**	County affected by a water violation: 1-Yes, 0-No
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	**% 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

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

Tripp County

County Demographics – Robert Wood Johnson Foundation County Health Rankings – 2019

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
HEALTH OUTCOMES					**47**
Length of Life					22
Premature Death	7,500	5,900-9,300	5,400	7,300	
Quality of Life					52
Poor or fair health	14%	13-14%	12%	12%	
Poor physical health days	3.5	3.3-3.6	3.0	3.1	
Poor mental health days	3.2	3.0-3.3	3.1	2.9	
Low birth weight	8%	5-10%	6%	6%	
HEALTH FACTORS					**45**
Health Behaviors					48
Adult smoking	17%	16-17%	14%	18%	
Adult obesity	34%	27-42%	26%	31%	
Food environment index	7.5		8.7	6.6	
Physical inactivity	24%	18-31%	19%	20%	
Access to exercise opportunities	58%		91%	72%	
Excessive drinking	17%	17-18%	13%	20%	
Alcohol-impaired driving deaths	50%	10-77%	13%	36%	
Sexually transmitted infections	184.0		152.8	504.5	
Teen births	35	25-47	14	28	
Clinical Care					44
Uninsured	15%	13-17%	6%	10%	
Primary care physicians	1,100:1		1,050:1	1,320:1	
Dentists	1,090:1		1,260:1	1,690:1	
Mental health providers	290:1		310:1	590:1	
Preventable hospital stays	6,018		2,765	4,724	
Mammography screening	37%		49%	49%	
Flu vaccinations	30%		52%	45%	
Social & Economic Factors					41
High school graduation	88%		96%	84%	
Some college	52%	39 - 64%	73%	68%	
Unemployment	2.9%		2.9%	3.3%	
Children in poverty	27%	18-35%	11%	16%	
Income inequality	4.8	3.0-6.6	3.7	4.2	
Children in single-parent households	25%	14-35%	20%	31%	
Social associations	21.8		21.9	16.4	
Violent crime	147		63	373	
Injury deaths	66	39-104	57	80	
Physical Environment					15
Air pollution – particulate matter	5.5		6.1	5.6	
Drinking water violations	No				
Severe housing problems	11%	7-15%	9%	12%	
Driving alone to work	77%	73-81%	72%	80%	
Long commute – driving alone	10%	6-13%	15%	15%	