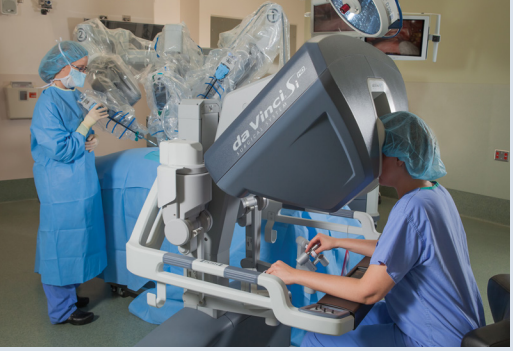

















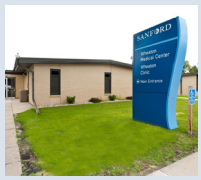

SANFORD®
HEALTH

Sanford Health Network

2018 Community Health Needs Assessment

dba Sanford Luverne Medical Center EIN# 46-0388596

Dear Community Members,

Sanford Medical Center Luverne is pleased to present the 2018 Community Health Needs Assessment (CHNA).

Sanford completes a community health needs assessment every three years. It is through this work that we identify the unmet needs in the community and strategically plan how we can best address those needs. The CHNA process aligns with Sanford's mission - *Dedicated to the work of health and healing.*

During 2017 and 2018, members of the community were invited to complete a survey to help identify the unmet needs. Key stakeholders completed a survey to identify concerns for the community related to economic well-being, transportation, children and youth, the aging population, safety, access to services, and mental and behavioral health. Sanford analyzed the data from the primary research and met with key stakeholders to prioritize the identified needs. Our strategies to address the needs are included in this report.

Sanford will address the following health needs in a formalized implementation strategy for the 2019-2021 fiscal years:

- Health Care Access
- Mental Health/Behavioral Health and Substance Abuse

The CHNA also focused on the strengths of our community and includes the many community assets that are available to address the community health needs. We have also included an impact report from our 2016 implementation strategies.

Sanford Luverne is committed to extending care beyond our bricks and mortar. We are committed to meeting the health care needs of the broader community. Together, we can fulfill our mission.

Sincerely,

Tammy Loosbrock
Senior Director
Sanford Luverne Medical Center

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Sanford Luverne Medical Center

Community Health Needs Assessment

2018

Executive Summary

Purpose

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

Our Guiding Principles

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

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 implementations strategy development and submission in accordance with the Internal Revenue Code 501(r).

Internal Revenue 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, financial or other barriers.

The community health needs assessment includes a process to identify community resources that are available to address the assessed needs and a prioritization of the needs.

Hospitals are to address each and every assessed needs 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 IRS Form 990 and a status report must be provided each year on IRS 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. The 2018 report will be Sanford's third report cycle since the requirements were enacted in 2010.

Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholders' 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 located within the community and Rock County. Data collection occurred during November 2017. A total of 21 community stakeholders participated in the survey.

   B. *Resident Survey*
   The resident survey tool included 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 Statewide Health Improvement Partnership (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 notice was posted in the local newspaper to invite residents to take the survey. The newspaper post included a URL for the survey. A total of 92 community residents participated in the survey.

   C. *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.

   D. *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.

E. *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. The Community Commons link is https://www.communitycommons.org/maps-data/
   D. Key Data from SWHHS Community Health Assessment Analysis for Rock County was also reviewed.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Luverne and Rock County, Minnesota. A good faith effort was made to secure input from a broad base of the community. However, when comparing certain demographic characteristics (i.e., age, gender, income, minority status) with the current population estimates from the U.S. Census Bureau, there was improvement over the last several CHNAs but there is still a need to capture demographic that better represents the community. This is part of our CHNA continuous improvement process.

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; and leaders, representatives, or members of medically underserved, low income, and minority populations.

Sanford extended a good faith effort to engage all of the aforementioned community representatives in the survey process. We worked closely with public health experts throughout the assessment process.

Public comments and responses to the community health needs assessment and the implementations strategies are welcome on the Sanford website or contact can be made at https://www.sanfordhealth.org/contact-us/form.

Key Findings

Community Health Concerns

The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.5 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.5; however, the high ranking needs of 3.5 or above are considered for the prioritization process. The resident survey addresses personal health needs and concern. The secondary research provides further understanding of the health of the community and in some cases the indicators are aligned and validate our findings.

Economic Well-Being
Community stakeholders are most concerned that there is a need for a skilled labor force (ranking 3.90), affordable housing (3.76), and employment options (3.57).

Children and Youth
Community stakeholders are most concerned about the availability and cost of quality childcare (4.42), the availability and cost of services for at-risk youth (3.68), substance abuse by youth (3.63), bullying (3.58), and teen suicide (3.53).

Aging Population
Community stakeholders are most concerned about the cost of long-term care (3.79), the availability of memory care (3.74), and the cost of in-home services (3.53).

Health Care Access
Community stakeholders are most concerned about access to affordable health insurance coverage (4.00), access to affordable dental insurance (3.79), access to affordable health care (3.79), the availability non-traditional hours (3.68), the availability of mental health providers (3.58), and access to affordable prescription drugs (3.53).

Mental Health and Substance Abuse
Community stakeholders are most concerned about depression (3.74), drug use and abuse (3.74), and alcohol use and abuse (3.58).

Resident survey participants are facing the following issues:

- 66% report that they are overweight or obese
- 40% are diagnosed with anxiety
- 38% self-report binge drinking at least 1X/month
- 27% have not visited a dentist in more than a year
- 9% report running out of food before having money to buy more
- 21% are diagnosed with depression
- 21% self-report that they have drugs in their home they are not using
- 29% have a diagnosis of hypertension and/or high cholesterol
- 11% currently smoke cigarettes

Community stakeholders worked through a multi-voting prioritization process to determine the top priorities and needs of the community.

Sanford Luverne will address the following health needs in a formalized implementation strategy for the 2019-2021 fiscal years:

- *Health Care Access*
- *Mental Health/Behavioral Health and Substance Abuse*

Implementation Strategies

Priority 1: Health Care Access

According to the County Health Rankings for Clinical Care, access to affordable health care is important to physical, social, and mental health. Health insurance, local care options, and a usual source of care help to ensure access to health care. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met.

Sanford has made health care access a significant priority and has developed strategies to promote and improve access to services. It is Sanford's goal that all patients requiring access to healthcare are successful in securing timely appointments

Priority 2: Mental Health/Behavioral Health and Substance Abuse

Mental health is important at every stage of life and affects how people think, feel, and act. According to the National Institute of Mental Health, depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors. Depression is among the most treatable of mental disorders.

Sanford has made mental health a significant priority and has developed strategies to reduce mortality and morbidity from mental health and behavioral health and substance abuse. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by addiction and mental illness.

Sanford Luverne Medical Center

Community Health Needs Assessment

2018

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Acknowledgements

Sanford Health would like to thank and acknowledge the Steering Committees for their assistance and expertise while conducting the assessment and analysis of the community needs.

Sanford Steering Group:

- Sara Ballhagen, Administrative Assistant, Sanford Wheaton
- Stacy Barstad, Senior Director, Sanford Tracy and Sanford Westbrook
- Rob Belanger, Clinic Director, Sanford Bagley
- Catherine Bernard, Tax Manager, Corporate Accounting, Sanford Health
- Michelle Bruhn, Senior Vice President, Finance, Health Services Division, Sanford Health
- Randy Bury, Chief Administrative Officer, Sanford Health
- Brian Carlson, Executive Director, Sanford Thief River Falls
- Denise Clouse, Marketing Coordinator, Sanford Tracy
- Ashley Erickson, Senior Director, Sanford Aberdeen
- JoAnn Foltz, Senior Director, Sanford Wheaton
- Isaac Gerdes, Senior Director, Sanford Webster
- Paul Gerhart, Director of Fiscal Services, Sanford Canton
- Julie Girard, Improvement Advisor, Sanford Vermillion
- Paul Hanson, President, Sanford Sioux Falls

- Joy Johnson, VP, Operations, Sanford Bemidji
- JoAnn Kunkel, Chief Financial Officer, Sanford Health
- Mary Lake, Executive Assistant, Sanford Health Network Fargo Region
- Amber Langner, Senior Director of Finance, Corporate Accounting, Sanford Health
- Scott Larson, Senior Director, Sanford Canton
- Tiffany Lawrence, VP, Finance, Sanford Fargo
- Martha Leclerc, VP, Corporate Contracting, Sanford Health
- Tammy Loosbrock, Senior Director, Sanford Luverne and Sanford Rock Rapids
- Carrie McLeod, Director, Sanford Community Health Improvement/Community Benefit
- Jac McTaggart, Senior Director, Sanford Hillsboro and Sanford Mayville
- Rick Nordahl, Senior Director, Sanford Sheldon
- Erica Peterson, Senior Director, Sanford Chamberlain
- Gwen Post, Director of Nursing and Clinical Services, Sanford Worthington
- Dawn Schnell, Senior Director, Sanford Jackson
- Lori Sisk, Senior Director, Sanford Canby and Sanford Clear Lake
- Jennifer Tewes, Clinic Supervisor, Sanford Jackson
- Tim Tracy, Senior Director, Sanford Vermillion
- Ruth Twedt, Manager of Ancillary Services, Sanford Clear Lake
- Marnie Walth, Senior Legislative Affairs Specialist, Sanford Bismarck
- Jennifer Weg, Executive Director, Sanford Worthington

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

- Clinton Alexander, Fargo Moorhead Native American Center
- Kristin Bausman, Becker County Public Health
- Justin Bohrer, Fargo Cass Public Health
- Cynthia Borgen, Beltrami Public Health
- Jackie Buboltz, Essentia Health
- Anita Cardinal, Pennington County Public Health
- Leah Deyo, Essentia Health
- Peter Ekadu, Nobles County Public Health
- Stacie Golombiecki, Nobles County Public Health
- Christian Harris, New American Consortium
- Caitlyn Hurley, Avera Health
- Deb Jacobs, Wilkin County Public Health
- Joy Johnson, Sanford Health
- Ann Kinney, Minnesota Department of Health
- Krista Kopperud, Southwest Health and Human Services
- Ann Malmberg, Dakota Medical Foundation Mayors' Blue Ribbon Commission on Addiction
- Kathy McKay, Clay County Public Health
- Jac McTaggert, Sanford Health
- Mary Michaels, Sioux Falls Department of Health
- Teresa Miler, Avera Health
- Renae Moch, Burleigh County Public Health
- Brittany Ness, Steel County Public Health
- Ruth Roman, Fargo Cass Public Health
- Kay Schwartzwalter, Center for Social Research, NDSU
- Becky Secore, Beltrami Public Health

- Julie Sorby, Family HealthCare Center
- Brenda Stallman, Traill County Public Health
- Diane Thorson, Ottertail County Public Health
- Juli Ward, Avera Health
- MayLynn Warne, North Dakota Public Health Association

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

The following Luverne community stakeholders participated in community discussions and helped to formulate the priorities for our implementation strategies:

- Cindy Arends, Luverne Community Education
- Carol Biren, Southwest Health & Human Services
- Everette Brandenberg, Sanford Luverne Advisory Board
- Norma Brands, ACE of SW Minnesota
- Lisa Dinger, Luverne Public Schools
- Tami Dorenkamper, MNRAA
- Mary Gehrke, Southwest Health & Human Services
- Wanda Jarchow, Rock County Oral Health Task Force
- Krista Kopperud, Southwest Health & Human Services
- Tammy Loosbrock, Sanford Health
- Michelle Miranowski, Community Transit
- Jennifer Nelson, Southwest Health & Human Services
- Michelle Redinger, Edgebrook Administration
- Nadine Schoep, Sanford Luverne Advisory Board
- Carrie Soto, Good Samaritan Society
- Jennifer Stratton, Rock County
- Evan Verbrugge, Rock County Sheriff

Description of Sanford Luverne Medical Center

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

Services at Sanford Luverne include emergency services/ambulance, home care, hospice, infusion, radiology, respiratory care and surgery.

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

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

Description of the Community Served

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

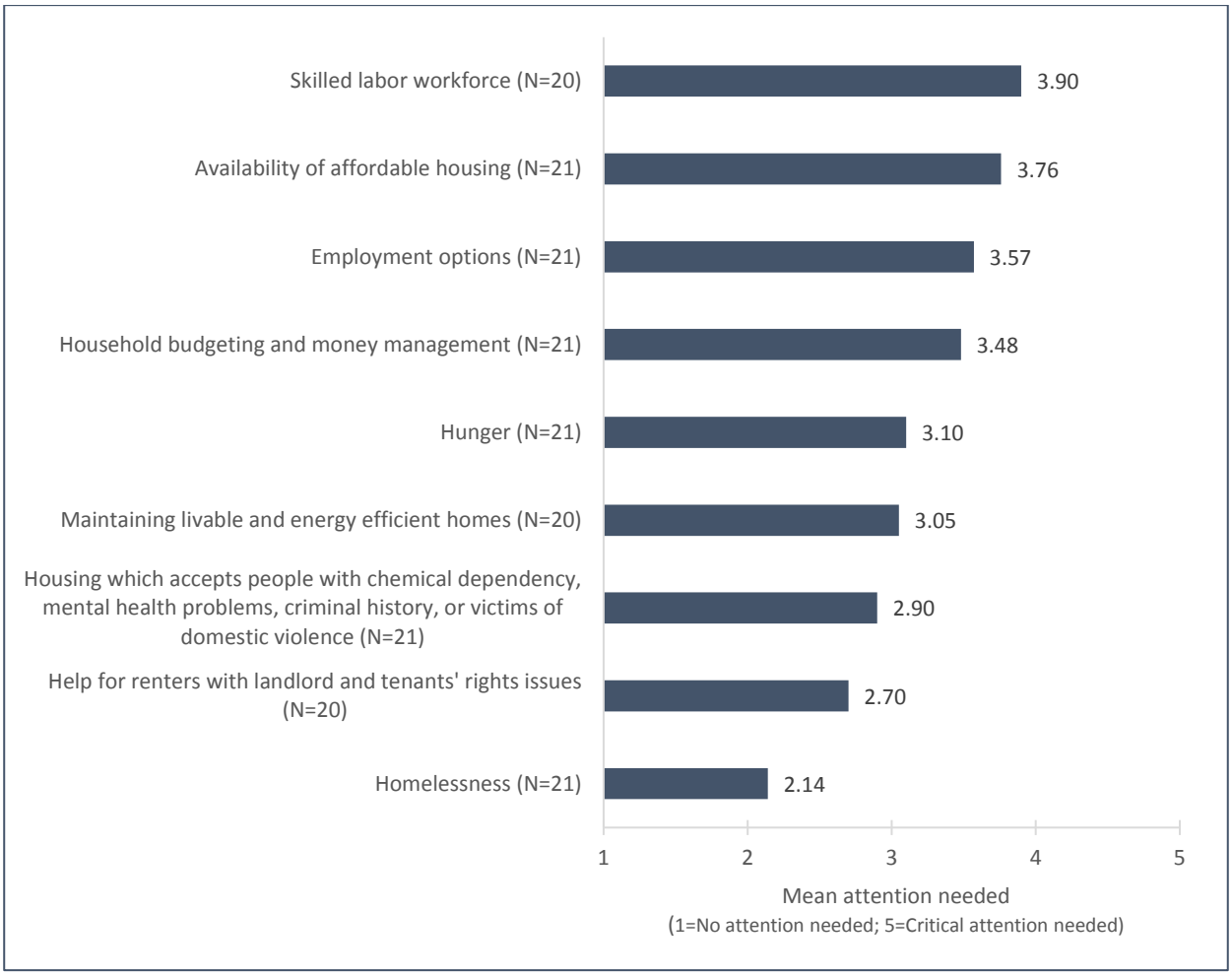
A historic landmark in the city is the Rock County Courthouse, which was built in 1888 in the Romanesque style of architecture.

Key Findings

Community Health Concerns

The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.5 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.5; however, the high ranking needs of 3.5 or above are considered for the prioritization process. The resident survey addresses personal health needs and concerns. The secondary research provides further understanding of the health of the community, and in some cases the indicators align with and validate our findings.

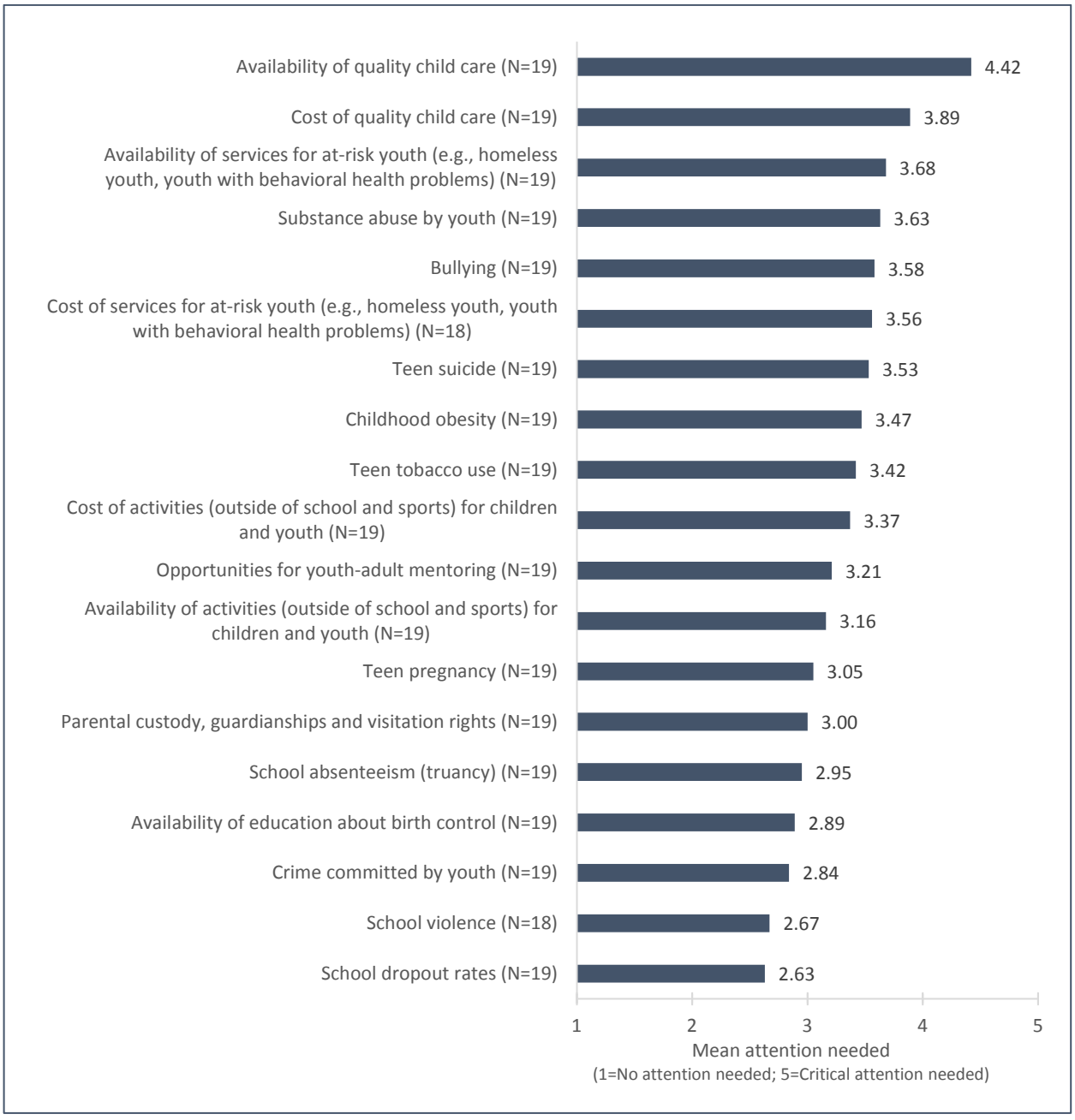
Economic Well-Being: The concern for the community's economic well-being is focused on the need a skilled labor force, affordable housing, and employment options.



Healthy People 2020 has defined the social determinants of health. "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." The patterns of social engagement and sense of security and well-being are

also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

Children and Youth: The concern for children and youth is highest for the availability and cost of quality childcare, the availability and cost of services for at-risk youth, substance abuse, bullying, and teen suicide.



According the U.S. Department of Drug Enforcement Administration (DEA), nationally almost 20 percent of students surveyed admit to using marijuana at least once during the last 30 days, and 13 percent of students surveyed admitted driving when they used marijuana within the last 30 days.

Researchers have identified *risk factors* that can increase a person's chances for misuse, and *protective factors* that can reduce the risk. However, many people with risk factors do not abuse substances. The risk factors for substance abuse among youth include boredom, stress, curiosity, the desire to feel grown up, or to lessen peer pressure.

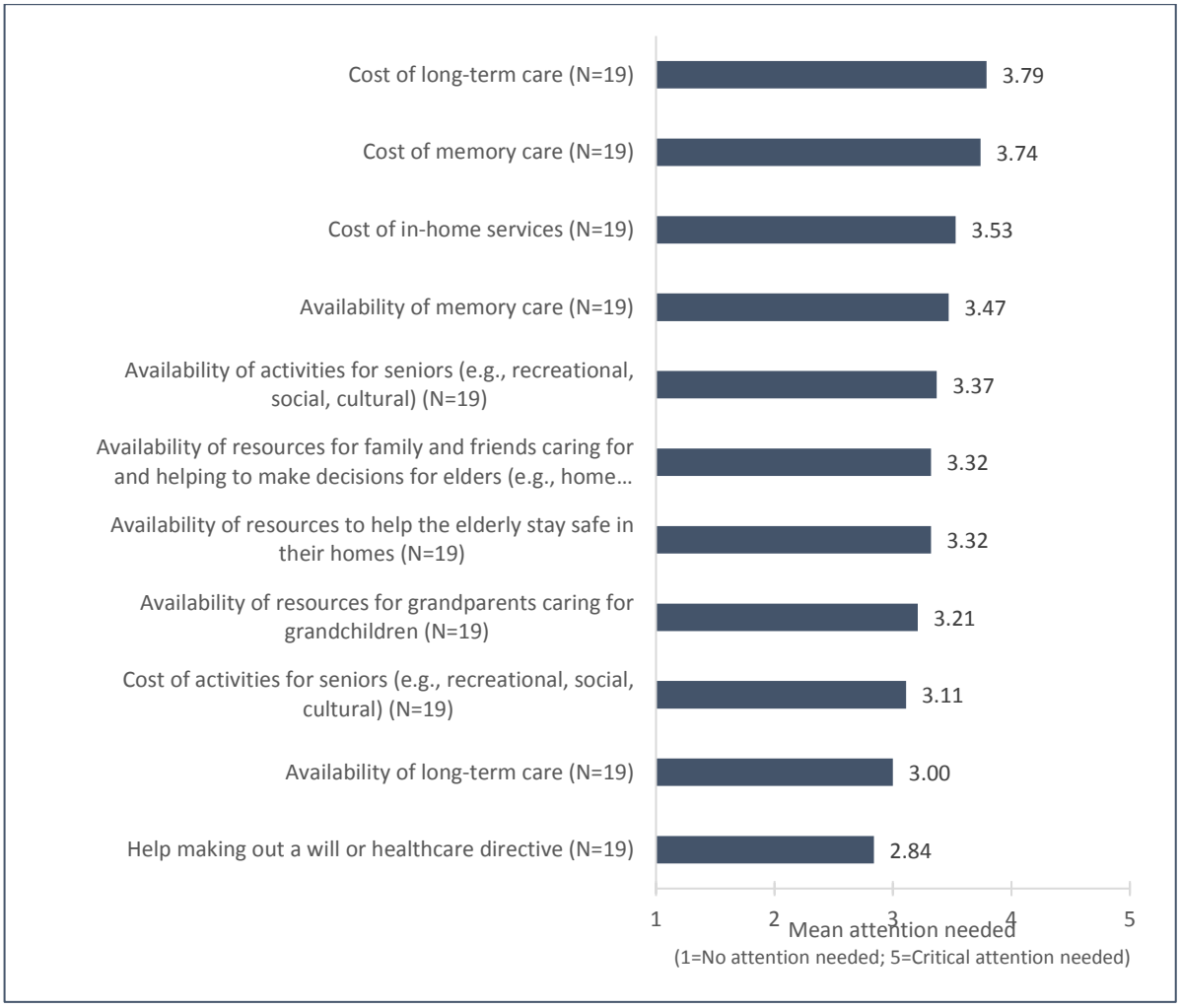
Youth may also be more likely to try drugs because of circumstances or events called risk factors. Examples of risk factors include:

- Poor grades in school
- Engaging in alcohol or drug use at a young age
- Friends and peers who engage in alcohol or drug use
- Persistent, progressive, and generalized substance use, misuse, and use disorders by family members
- Conflict between parents or between parents and children, including abuse or neglect
- Bullying

Protective factors include:

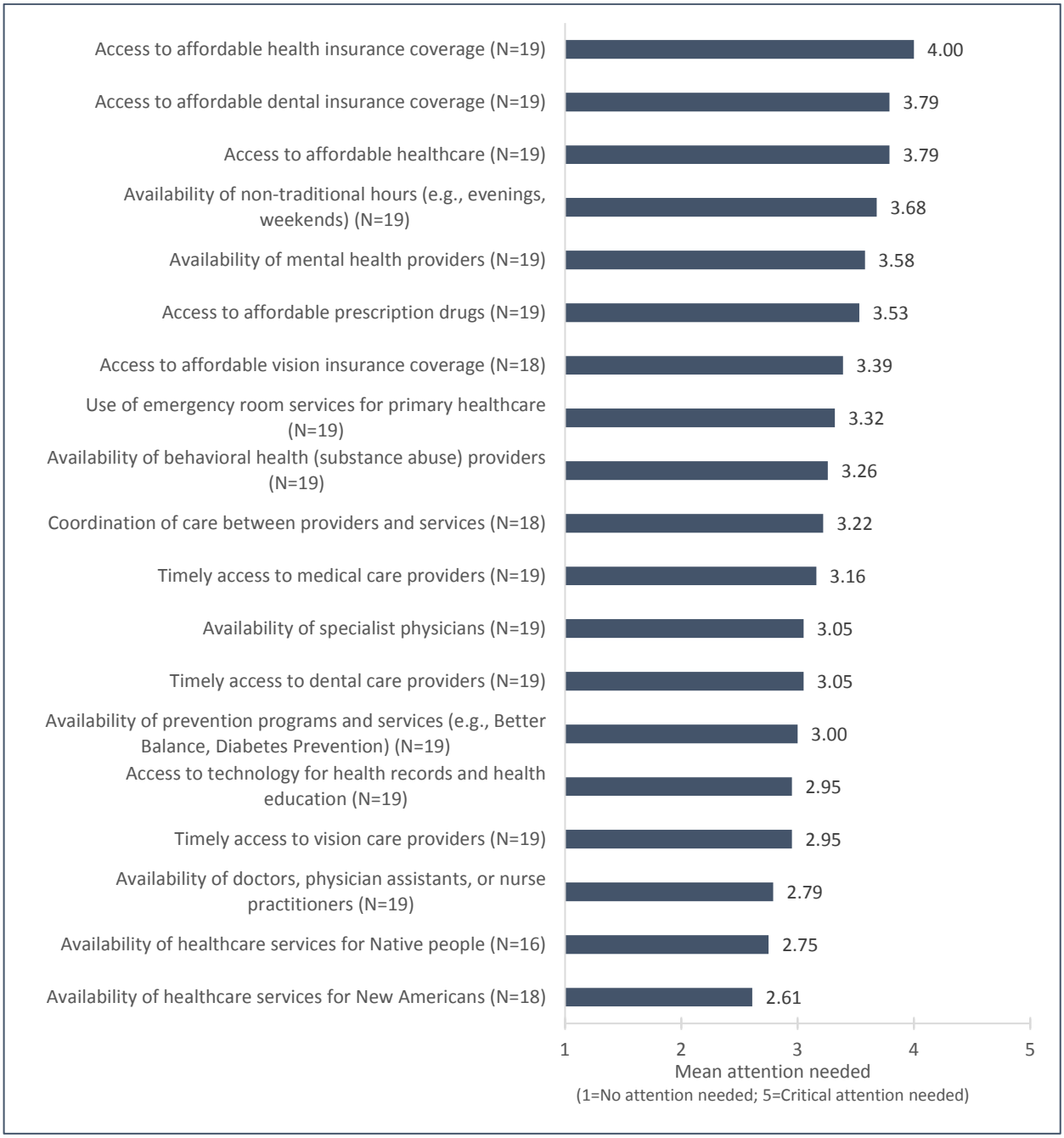
- Having high self-esteem
- Attending a school with policies against using alcohol and drugs
- Having an adult role model who doesn't use tobacco or drugs or misuse alcohol
- Participating in athletic, community, or faith-based groups
- Living in a community with youth activities that prohibit drugs and alcohol

Aging Population: The cost of long-term care and memory care are top concerns again and were top concerns during the 2016 CHNA cycle.



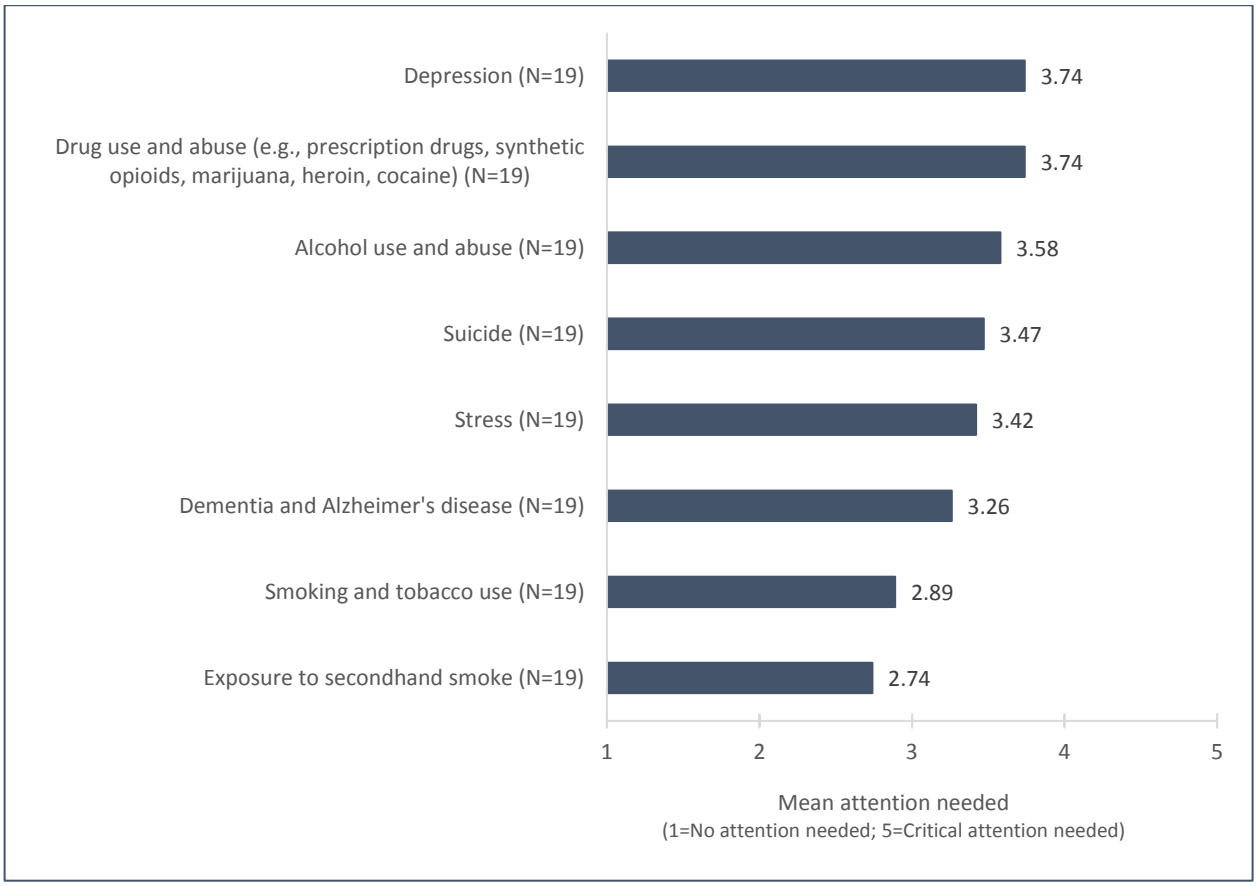
According to the U.S. Health and Human Services Administration on Aging, the cost of long-term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford providers work to help seniors live healthy independent lives. Sanford social workers, case managers, and discharge planners refer patients to area service providers to make certain that patients receive a safe discharge and transition to the appropriate levels of care.

Health Care and Wellness: Access to affordable health and dental insurance, access to affordable health care, the availability of non-traditional hours, the availability of mental health providers, and access to affordable prescription drugs, are ranked very high among the top concerns for the community.



According to the Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. The 2016 HRSA report projected that the supply of workers in selected behavioral health professions would be approximately 250,000 workers short of the projected demand by 2025.

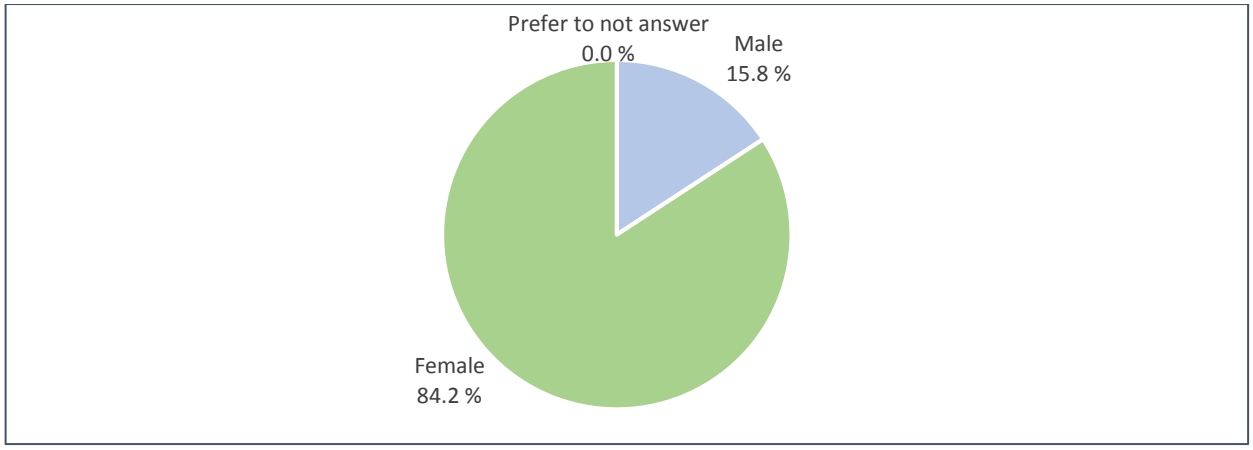
Mental Health and Substance Abuse: Depression, drug use and abuse, and alcohol use and abuse are top concerns for the community.



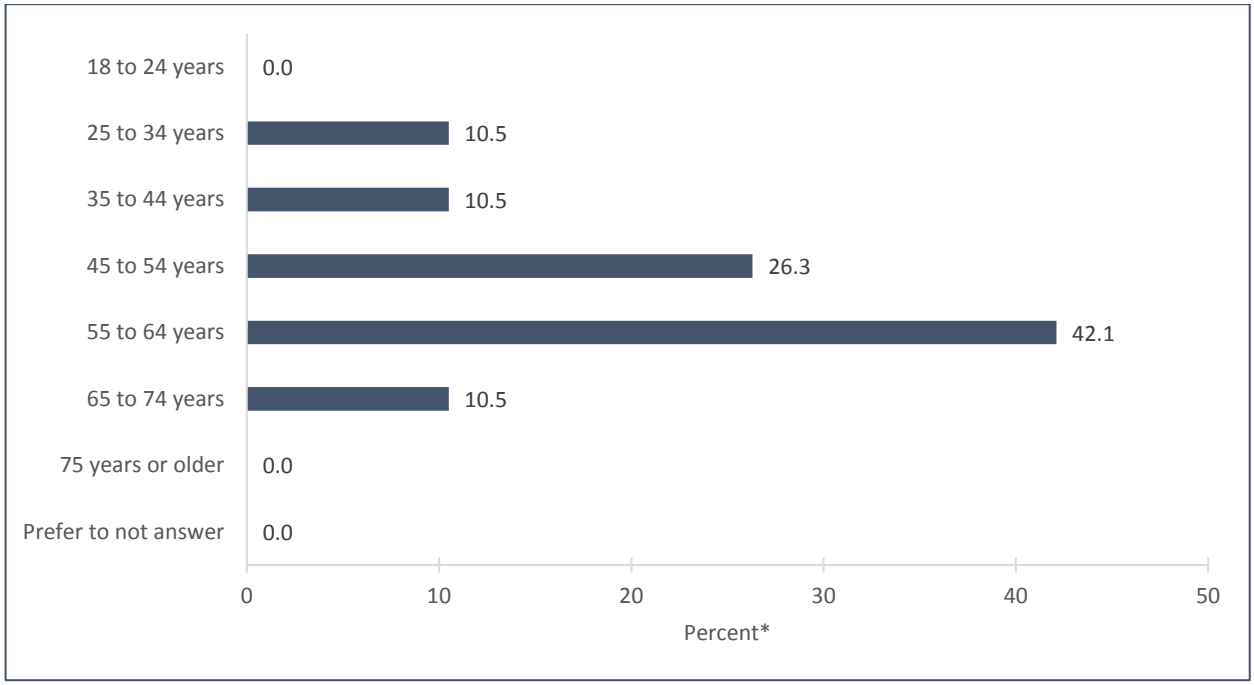
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental illness, and 1.7 million of whom were age 18 to 25. Also, 15.7 million adults (age 18 or older) and 2.8 million youth (age 12 to 17) had a major depressive episode during the past year. In 2014, an estimated 22.5 million Americans age 12 and older self-reported needing treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing mental health treatment or counseling in the past year. These disorders are among the top conditions that cause disability and carry a high burden of disease in the United States, resulting in significant costs to families, employers, and publicly funded health systems. By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide."

Demographic Information for Key Stakeholder Participants

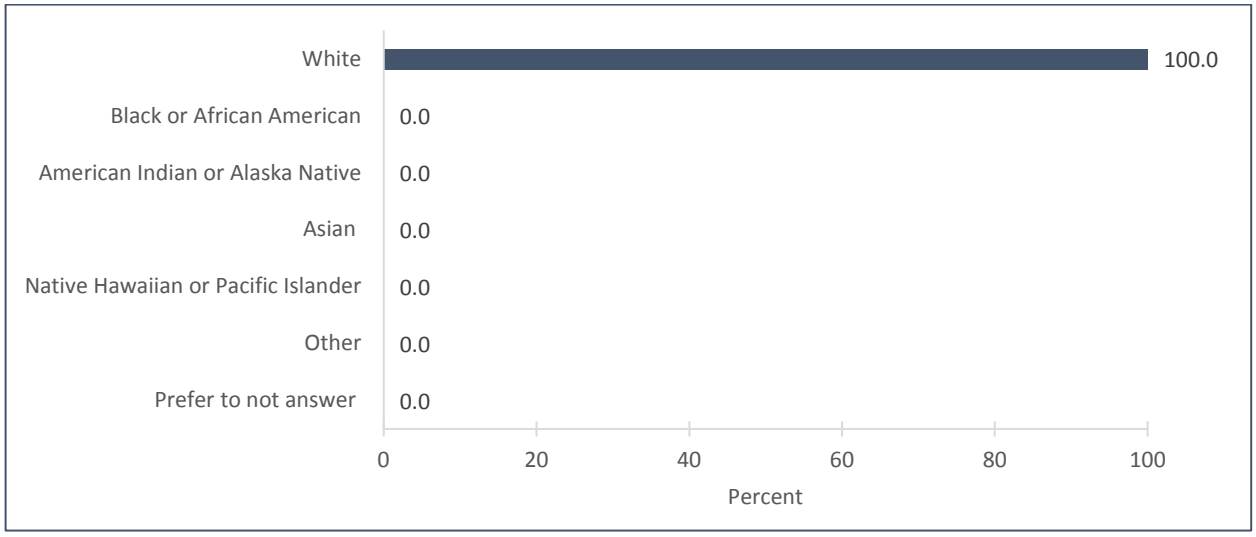
Biological Gender



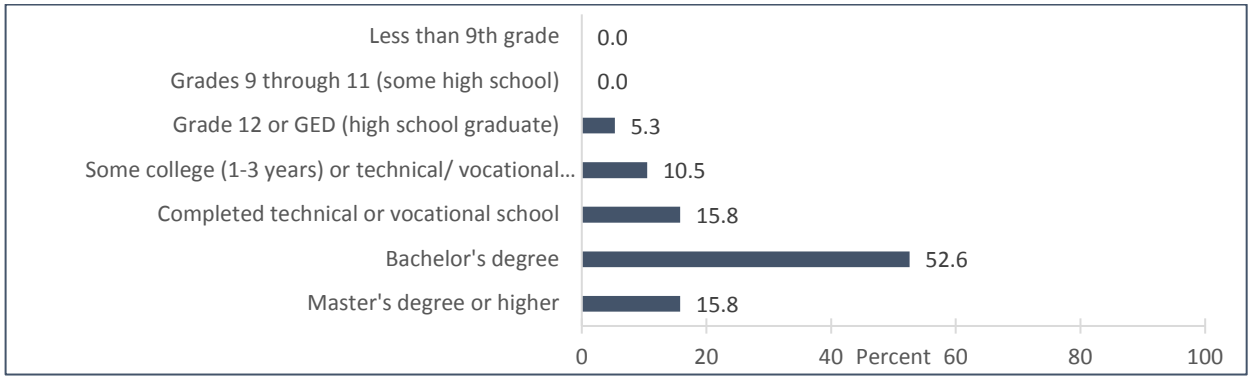
Age of Participants



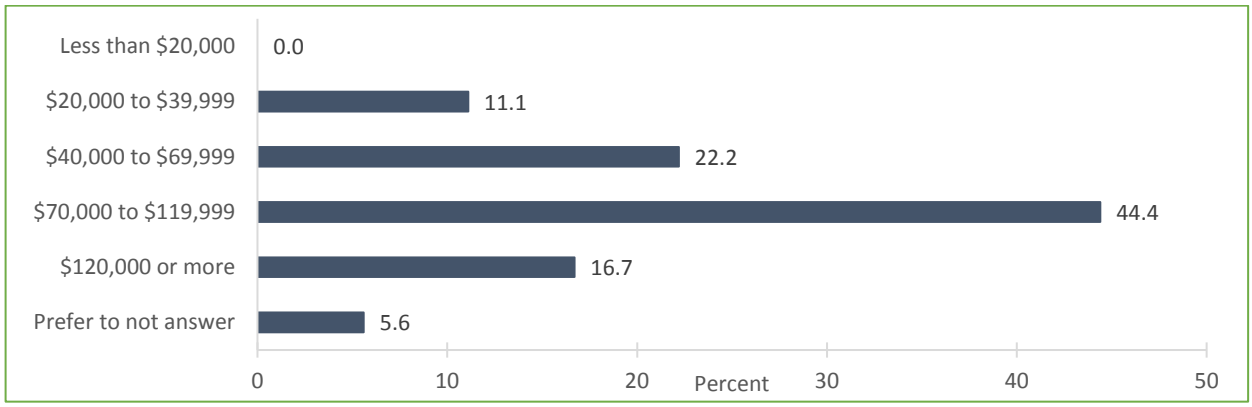
Race of Participants



Highest Level of Education Completed



Annual Household Income of Respondents, from all sources, before taxes



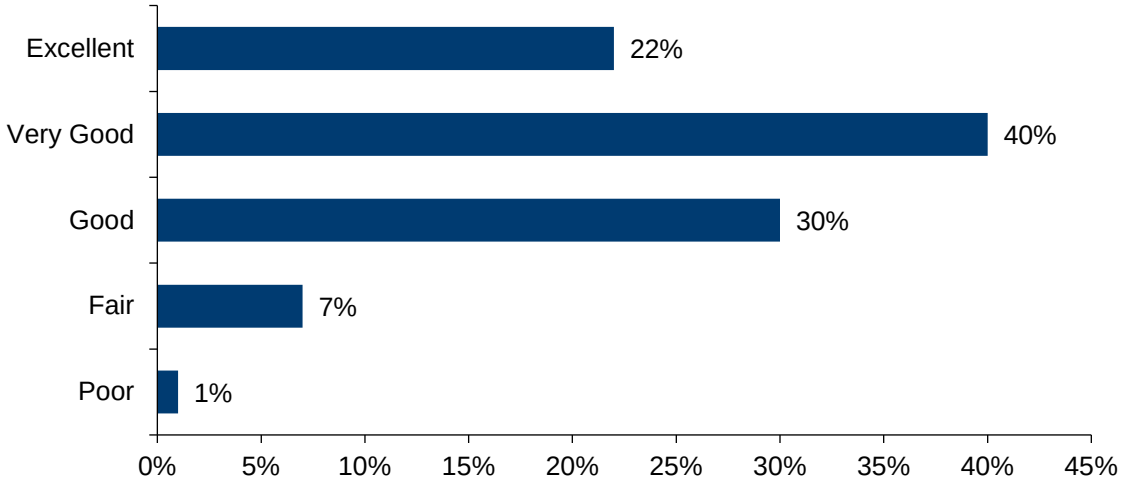
Residents' Health Concerns

Health is personal and it starts in our homes, schools, workplaces, neighborhoods, and communities. Eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor for routine check-ups can positively influence our health.

The resident survey asks questions specific to the participants' personal health and health behaviors.

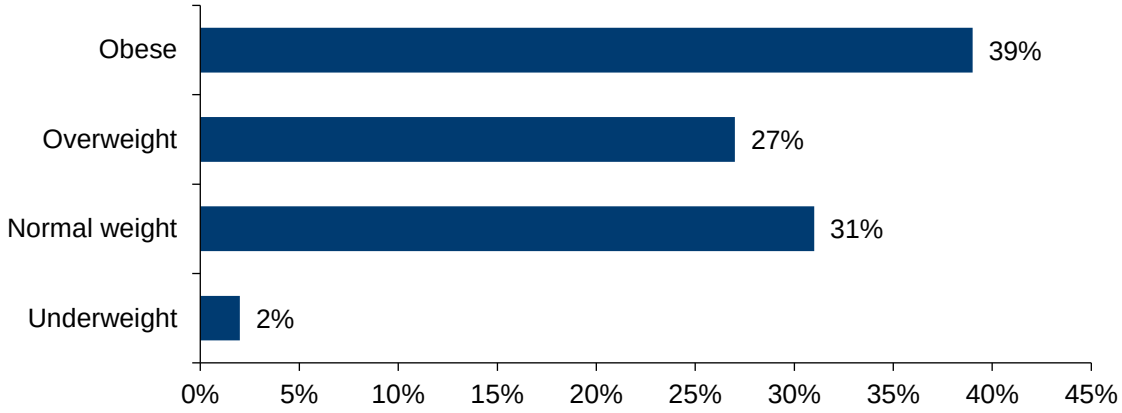
How would you rate your health?

Ninety-two percent of survey participants rated their health as good or better.



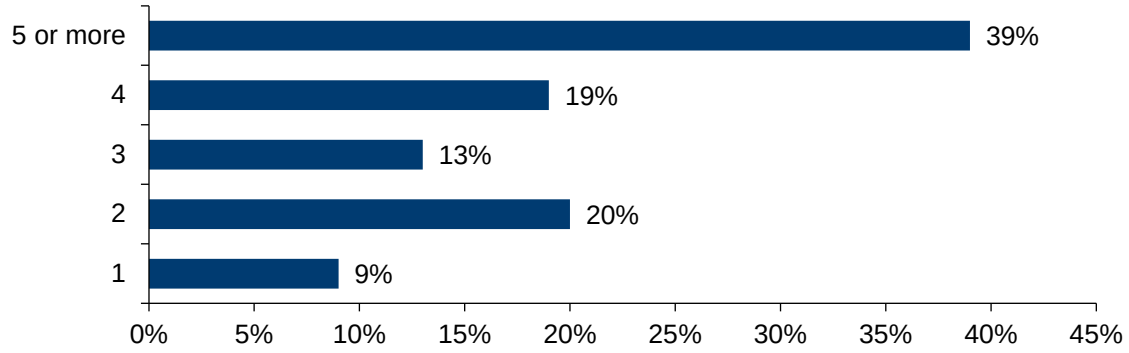
Body Mass Index

Sixty-seven percent of participants are overweight or obese.



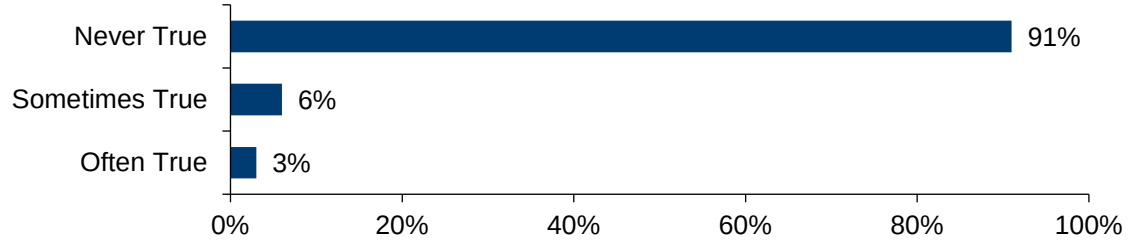
Total daily servings of fruits and vegetables

Only 39% are getting their recommended five or more a day servings of fruits and vegetables.



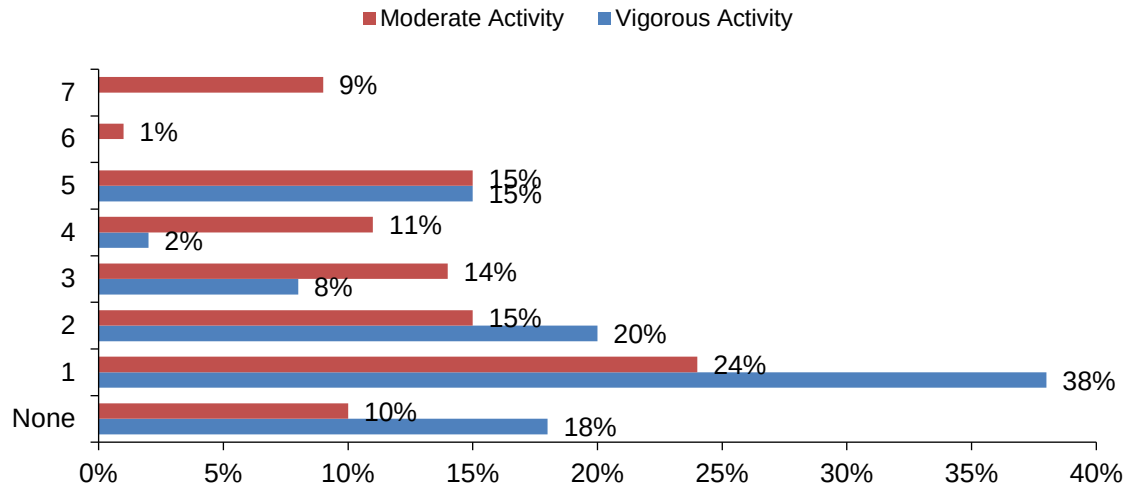
Food did not last until there was money to buy more

Nine percent of survey participants run out of food before they have money to purchase more.



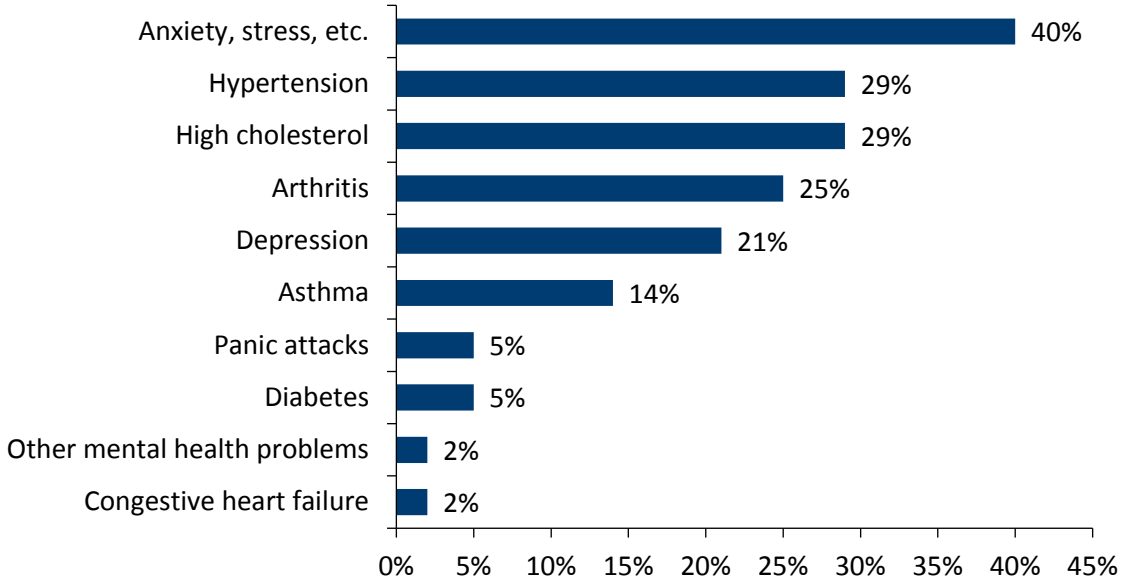
Days per week of physical activity

Forty-nine percent of survey participants have moderate physical activity three or more times each week.



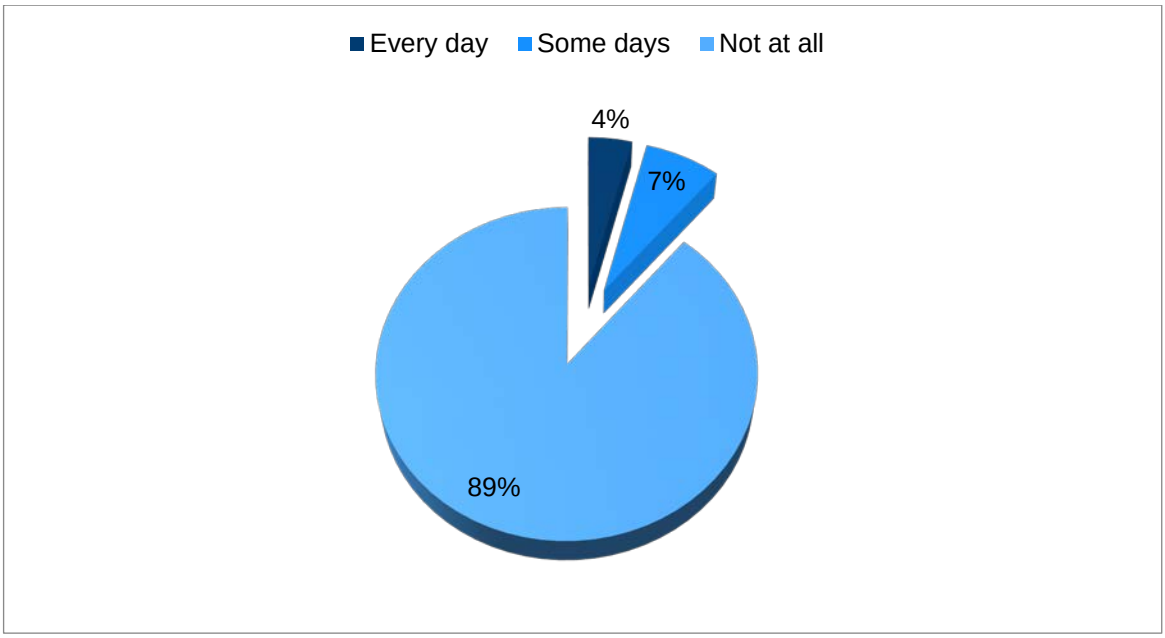
Past diagnosis

Anxiety ranks very high among survey participants. High cholesterol, hypertension, arthritis and depression are the top chronic disease issues among survey participants.



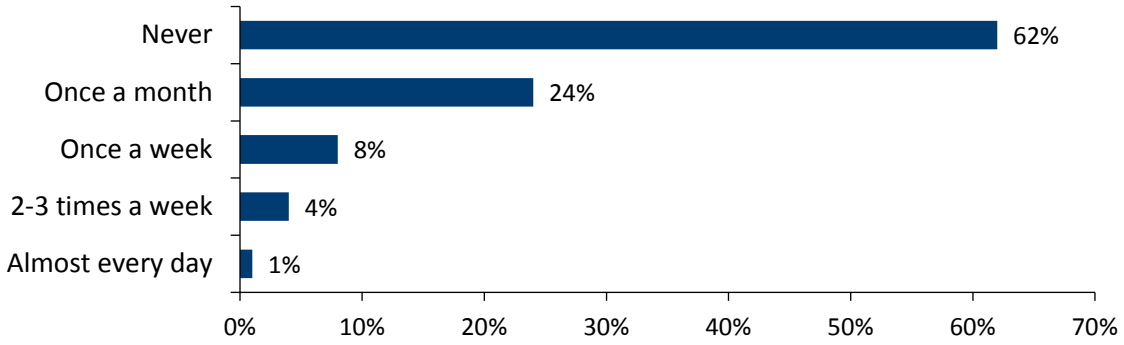
Tobacco use

Eleven percent of survey participants currently smoke cigarettes. Sixteen percent smoke cigarettes every day.

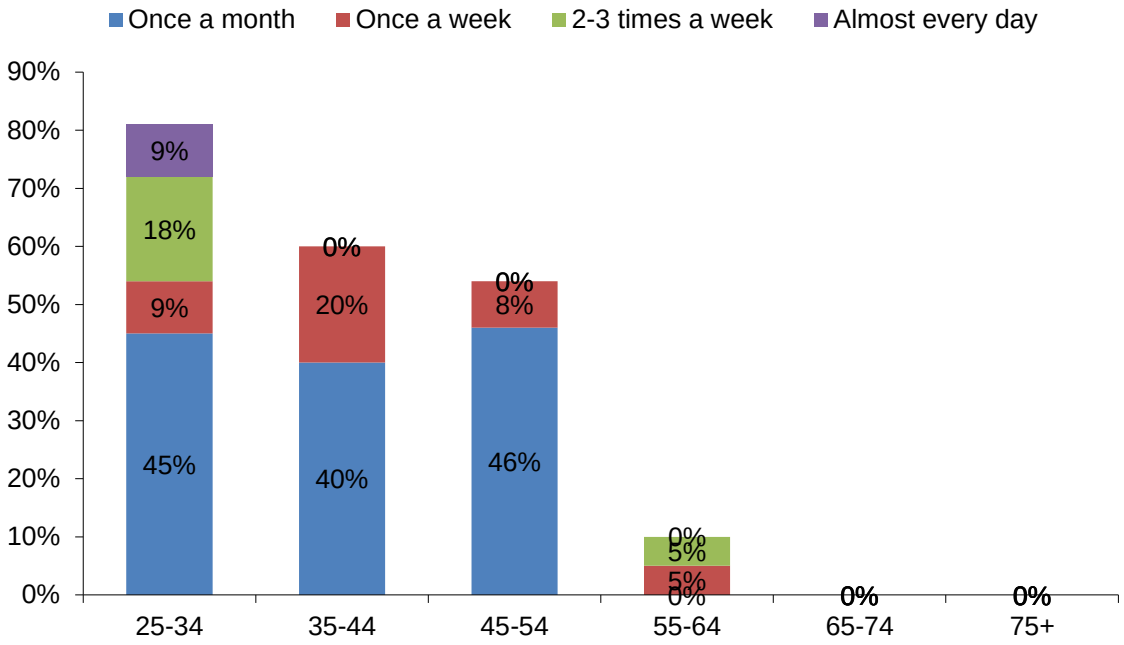


Binge drinking

Thirty-eight percent of survey participants self-report that they binge drink at least once per month and twenty percent binge at least weekly.

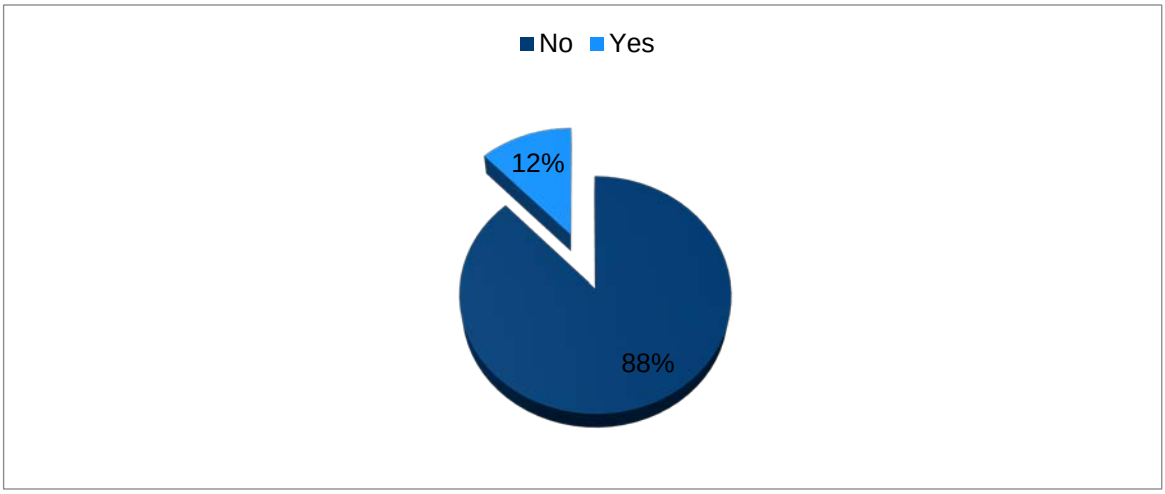


Binge drinking by age



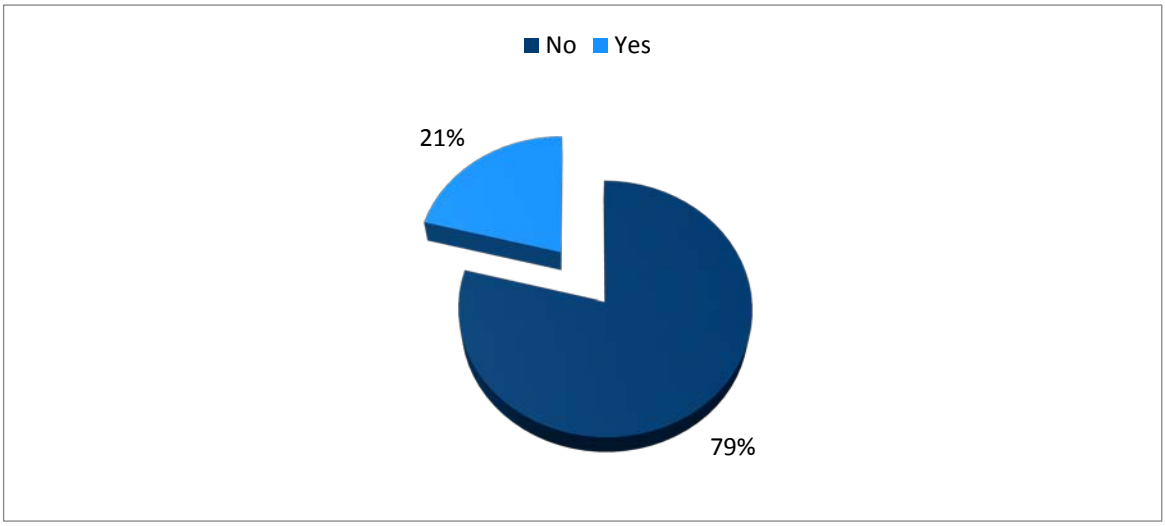
Has alcohol had a harmful effect on you or a family member in the past two years?

Twelve percent of survey participants report that alcohol has had a harmful effect on themselves or a family member within the past two years.



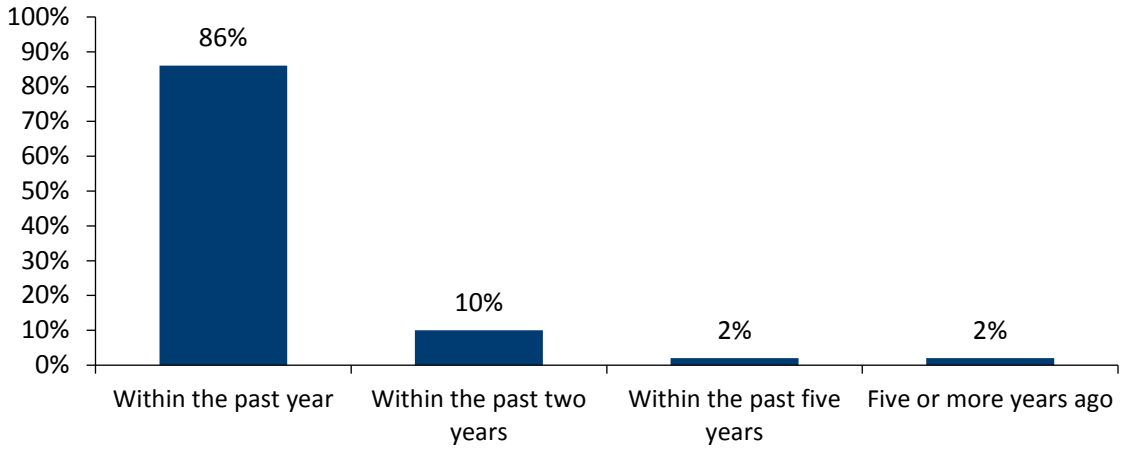
Do you have drugs in your home that are not being used?

Twenty-one percent have drugs in their home that they are no longer using.



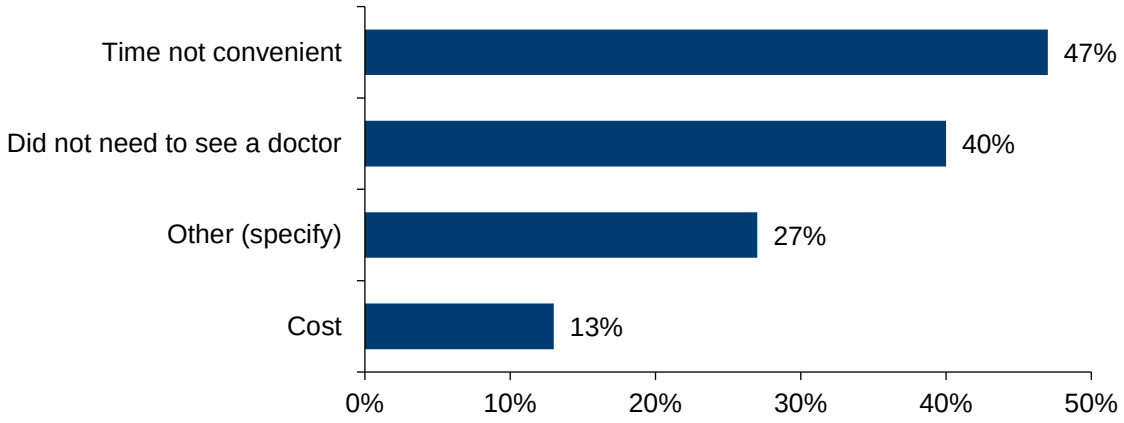
How long has it been since you visited a doctor or health care provider for a routine check-up?

Fourteen percent of survey participants have not had a routine check-up in more than a year.



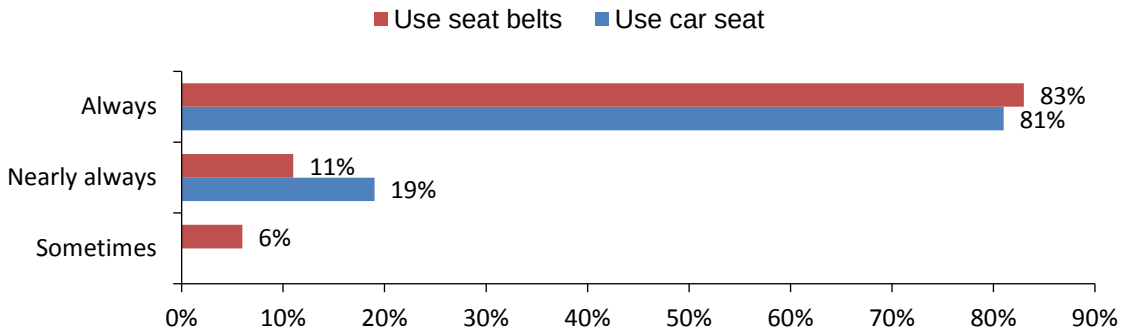
Barriers to routine check-up

Forty percent of survey participants stated that they did not need to see a doctor in the past year and thirteen percent stated that cost was a barrier.



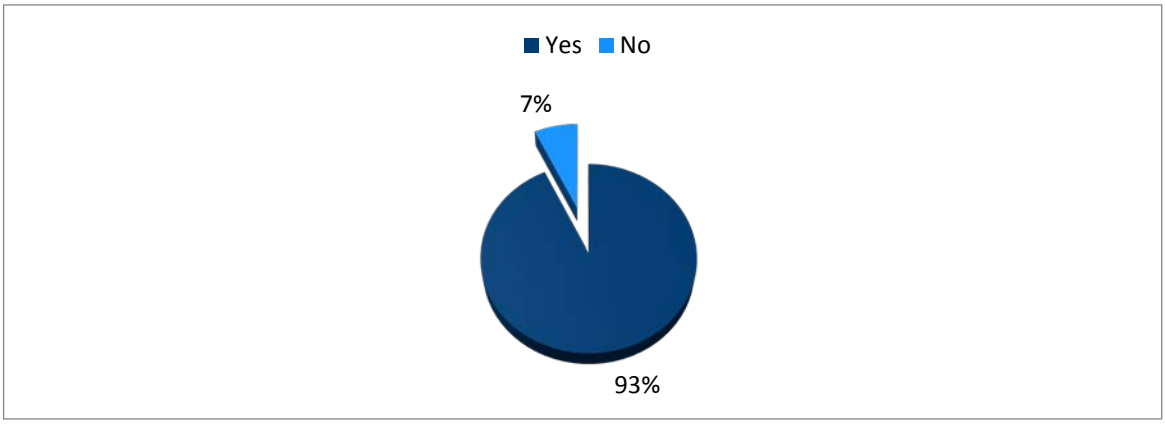
Child car safety

Seven percent do not always use seat belts for their children and nine percent do not always use car seats.



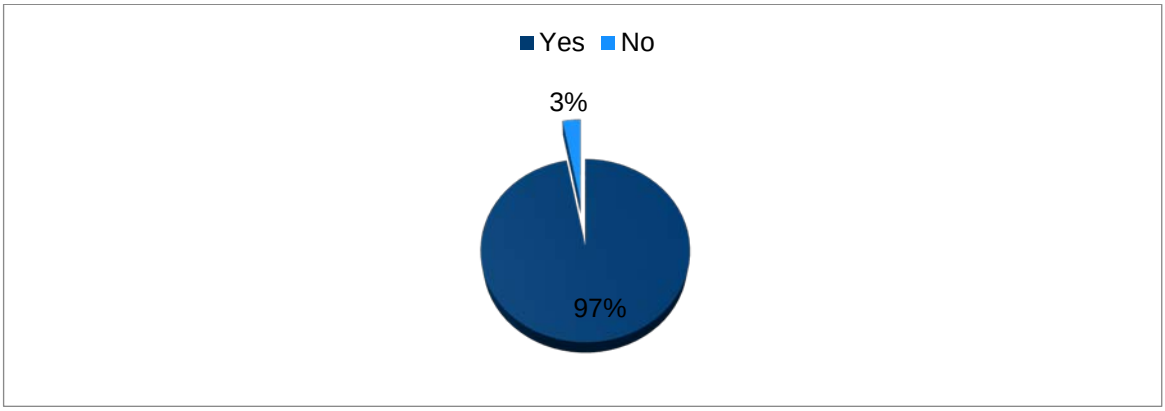
Do you have health care coverage for your children or dependents?

Only 7% of survey participants do not have health insurance for their children or dependents.



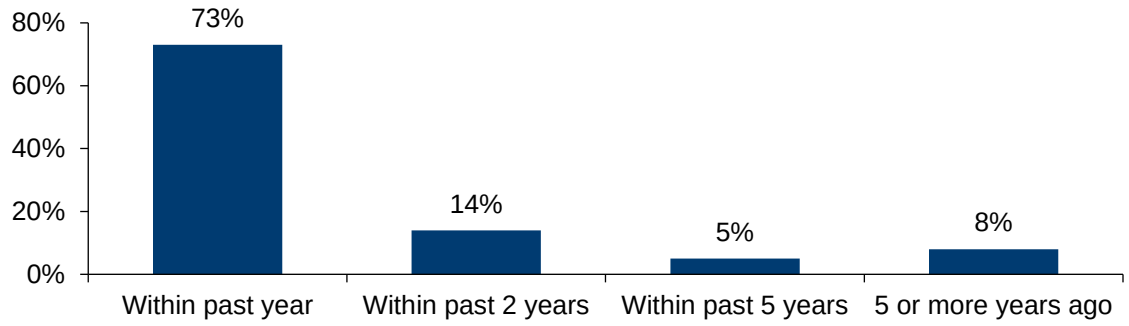
Do you currently have any kind of health insurance?

Only 3% of survey participants do not have health insurance.



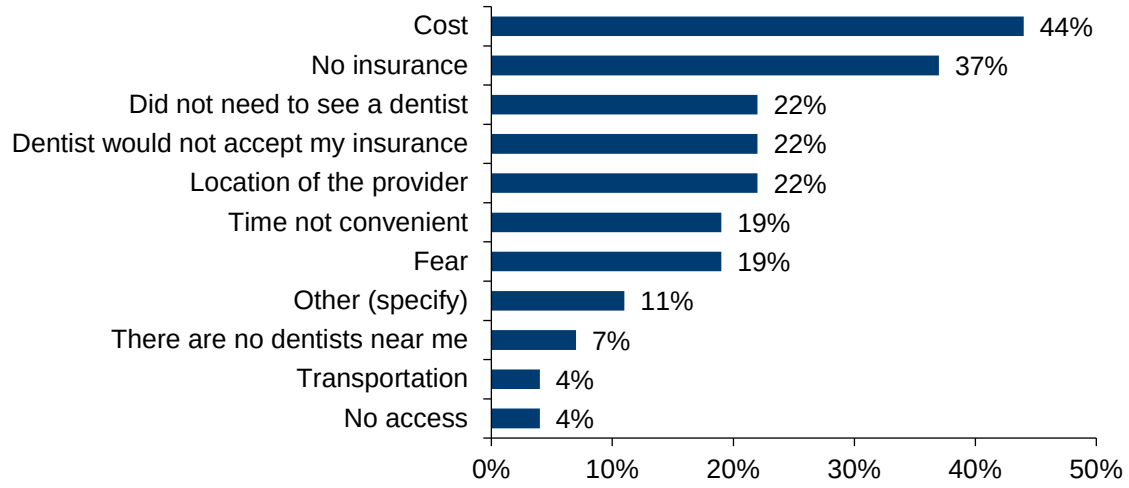
How long has it been since you visited a dentist?

Twenty-seven percent of survey participants have not visited a dentist in more than a year.



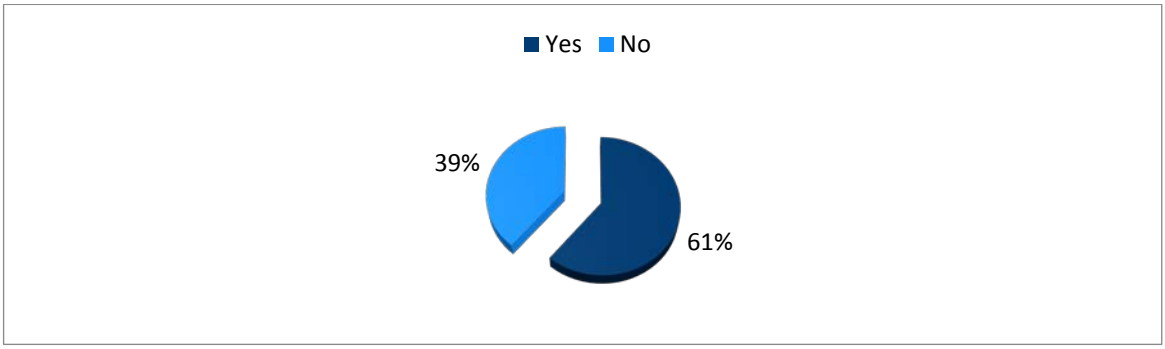
Barriers to visiting a dentist

Cost and no insurance are reported barriers to visiting a dentist.



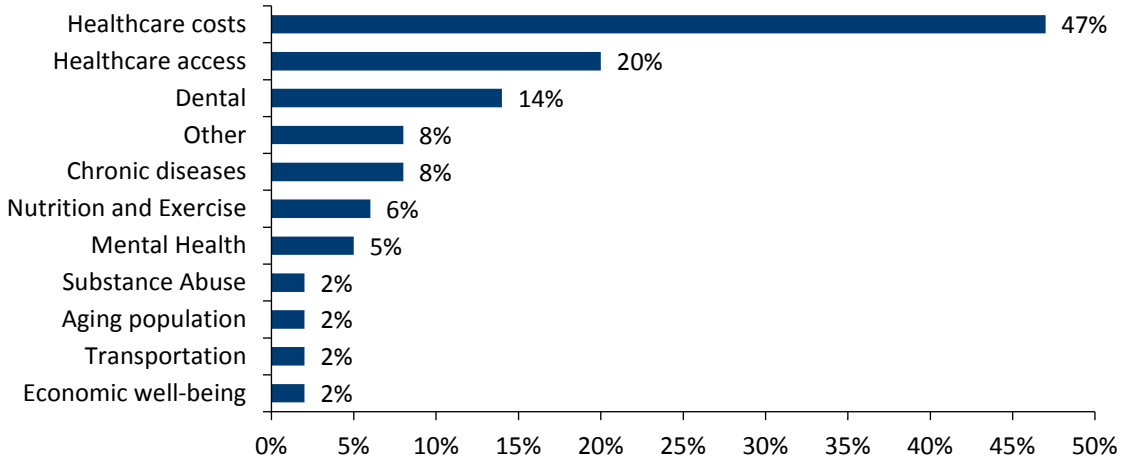
Do you have any type of dental insurance coverage?

Thirty-nine percent of survey participant do not have dental insurance.



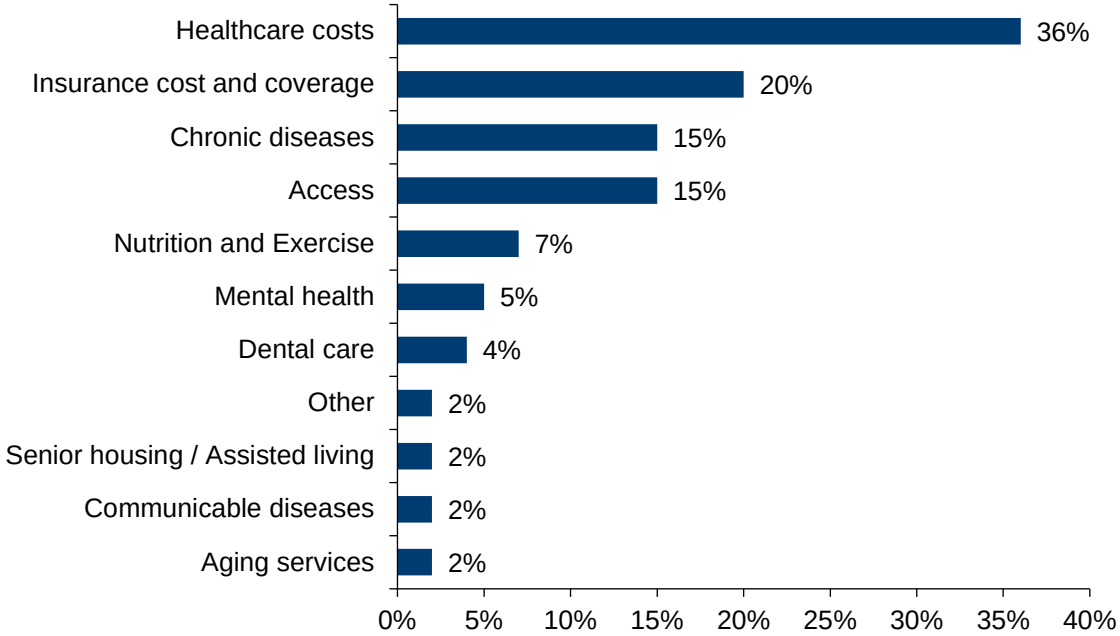
What are the most important community issues for you?

The cost of health care is a high concern for 47% of survey participants.



What are the most important community issues for your family?

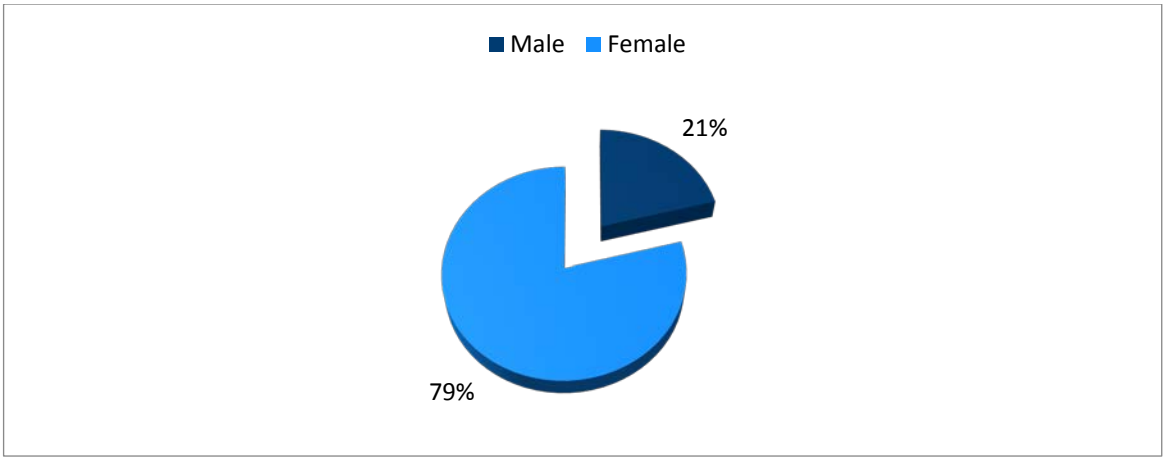
When asked what is the most important issue for the participant's family, health care cost and insurance cost and coverage were the top concerns.



Demographic Information for Community Resident Participants

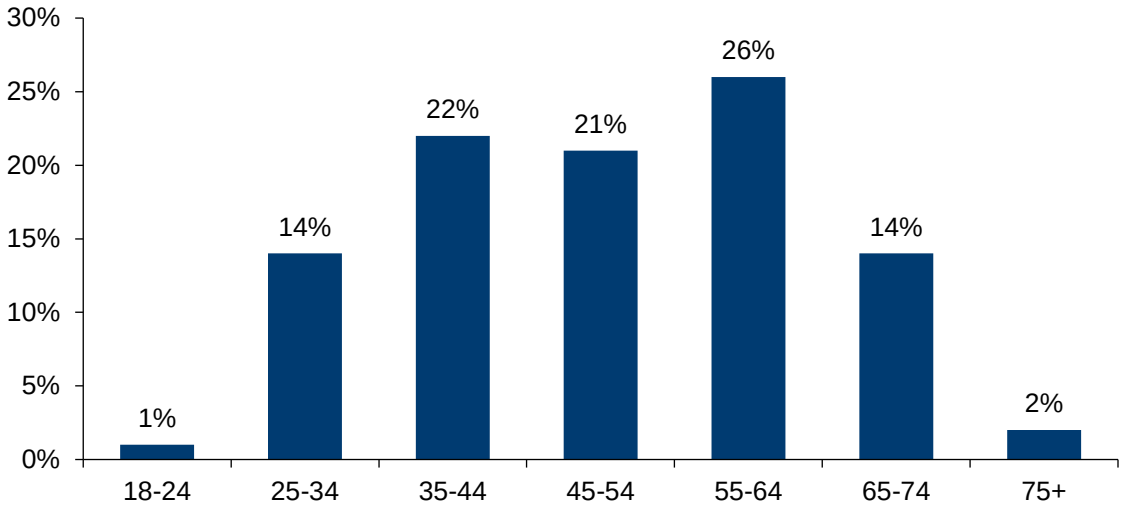
Biological Gender

Only 21% of the survey participants were male.

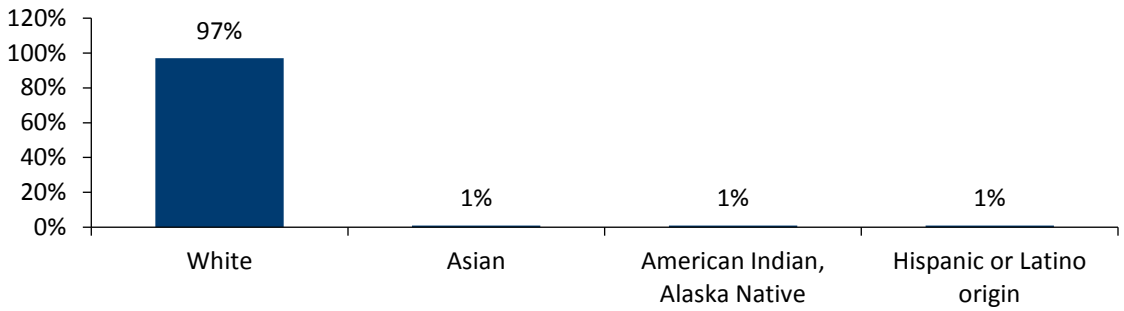


Age

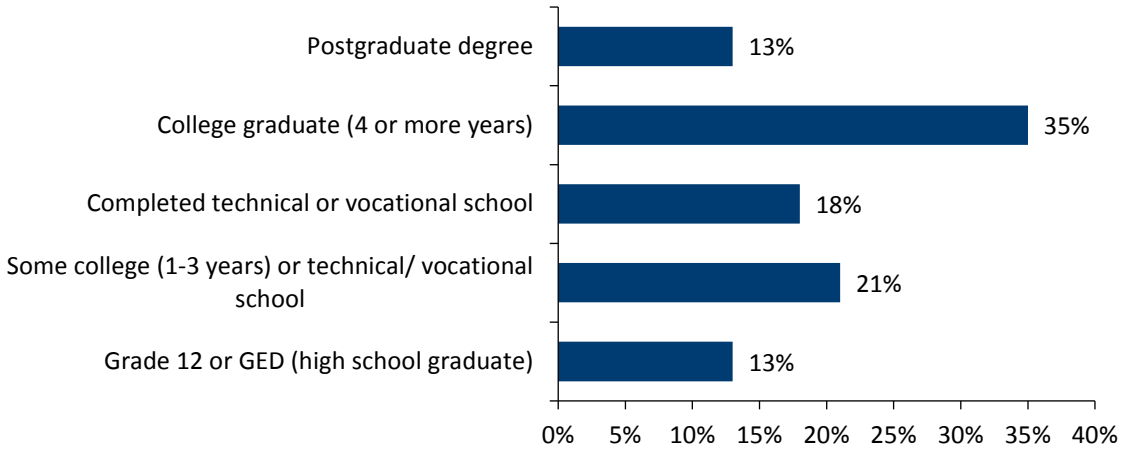
Every age group was represented among the survey participants; however, only 2% fell into the 75+ age group, and 1% in the 18-24 year group.



Ethnicity

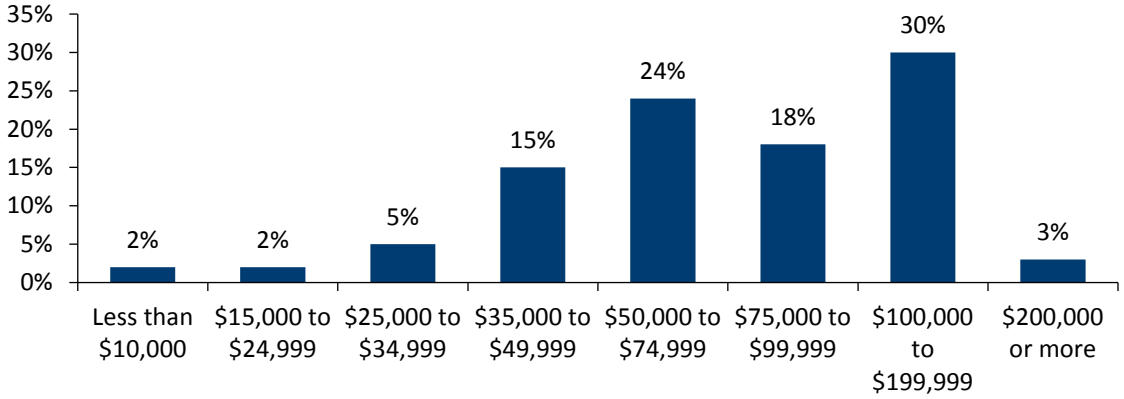


Education Level



Total Annual Household Income

Four percent of survey participants have an annual household income at or below the Federal Poverty Level (FPL) for a family of four.



Secondary Research Findings

Census Data

Population of Rock County, Minnesota	9,564
% below 18 years of age	25.3
% 65 and older	20.7
% White – non-Hispanic	94
American Indian	0,7
Hispanic	2.8
African American	0.9
Asian	0.8
% Female	50.8
% Rural	52.3%

County Health Rankings

	Rock County	State of Minnesota	U.S. Top Performers
Adult smoking	17%	15%	14%
Adult obesity	27%	27%	26%
Physical inactivity	24%	20%	20%
Excessive drinking	21%	23%	13%
Alcohol-related driving deaths	8%	30%	13%
Food insecurity	9%	10%	10%
Uninsured adults	6%	6%	7%
Uninsured children	3%	3%	3%
Children in poverty	11%	13%	12%
Children eligible for free or reduced lunch	30%	38%	33%
Diabetes monitoring	92%	88%	91%
Mammography screening	59%	65%	71%
Median household income	$57,500	$65,100	$65,600

Health Needs and Community Resources Identified

The Internal Revenue Service requires that a community health needs assessment include an inventory of resources that are available to address the unmet needs. This document is referred to as an asset map. Sanford Health conducted asset mapping by reviewing the primary and secondary research and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources are available in the community and county to address the needs. The asset map was reviewed by Sanford leadership and by community key stakeholders to validate the assets. The asset map helped to identify gaps in services. Once gaps were determined the key stakeholder group proceeded to the prioritization discussion and multi-voting exercise. The group was asked to prioritize the top two concerns that would be further developed into implementation strategies.

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

The asset mapping process identified needs from the following:

- Key stakeholder survey
- Resident survey
- Facilitated discussion by the key stakeholders
- Secondary research
- Community resources that are available to address the needs

Please see the asset map in the Appendix.

Prioritization Worksheet

A multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to discuss community needs and complete the multi-voting exercise.

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
Economic Well-Being • Skilled labor workforce 3.90 • Availability of affordable housing 3.76 • Employment options 3.57 • 9% report that they run out of food before they have money to buy more
Children and Youth • Availability of quality childcare 4.42 • Cost of quality childcare 3.89 • Availability of services for at-risk youth 3.68 • Substance abuse by youth 3.63 • Bullying 3.58 • Cost of services for at-risk youth 3.56 • Teen suicide 3.53
Aging Population • Cost of long-term care 3.79 • Most of memory care 3.74 • Cost of in-home services 3.53
Safety • 21% report having drugs in their home that they are not using
Health Care Access • Access to affordable health insurance coverage 4.00 • Access to affordable dental insurance coverage 3.79 • Access to affordable health care 3.79 • Availability of non-traditional hours 3.68 • Availability of mental health providers 3.58 • Access to affordable prescription drugs 3.53
Mental Health and Substance Abuse • Depression 3.74 • Drug use and abuse 3.74 • Alcohol use and abuse 3.58 • 21% report a diagnosis of depression • 40% report a diagnosis of anxiety/stress • 11% currently smoke cigarettes • 38% report binge drinking at least 1X/month
Wellness • 29% have been diagnosed with high cholesterol and hypertension • 25% have been diagnosed with arthritis • 39% report that they are obese • 27% report that they are overweight • 61% do not consume the recommended 5 or more fruit/ vegetables/d • 50% do not get moderate exercise at least 3X/week • 14% have not had a routine checkup in more than 1 year • 28% did not have a flu shot this past year • 27% report not seeing their dentist in more than 1 year

Please see the multi-voting prioritization worksheet in the Appendix.

Implementation Strategies

How Sanford Luverne is Addressing the Needs

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

Identified Concerns	How Sanford Luverne is Addressing the Community Needs
ECONOMIC WELL BEING	
Skilled labor workforce	• Sanford Luverne Senior Director assisted with teaching Introduction to Health Care Careers class • Sanford Luverne sponsoring CEO program for area students • Sanford Luverne supports area institutions by taking students for clinical rotations
Availability of affordable housing	Sanford Luverne has shared need with city leaders
Employment options	Sanford Luverne has a wide range of employment options available from entry level to highly educated
Run out of food before they have money to buy more – 9%	• Sanford Luverne has representation on Rock County food shelf board and home delivered meals board • Sanford Luverne contributes to food shelf and back pack programs • Sanford Luverne RN Health Coach assists patients with linking to resources
CHILDREN & YOUTH	
Availability of quality childcare	Sanford Luverne shares findings of the community health needs assessment with community partners. Advocates as requested through testimony at meetings or through grant letters of support.
Cost of quality childcare	Sanford Luverne shares findings of the community health needs assessment with community partners. Advocates as requested through testimony at meetings or through grant letters of support.
Availability of services for at-risk youth	• Sanford Luverne employs integrative health therapist • Sanford Luverne shares information with local school child guide program
Substance abuse by youth	• Sanford Luverne shares information with local school child guide program • Sanford Luverne substance abuse program shares information with local school and provides education
Bullying	Sanford Luverne shares information with local school child guide program
Cost of services for at-risk youth	Sanford Luverne shares information with local school child guide program
Teen suicide	• Sanford Luverne shares information with local school child guide program • Sanford Luverne providers share Text4life information with teens • Sanford Luverne providers use Teen Screen as part of preventive visits
AGING POPULATION	
Cost of long-term care	• Sharing information with area senior housing partners • Sanford Luverne hospice and home health assists with keeping seniors in their own homes functioning independently as long as possible
Cost of memory care	Sharing information on need for memory care with area senior housing partners
Cost of in-home services	• Sharing information with area senior housing partners

Identified Concerns	How Sanford Luverne is Addressing the Community Needs
	• Sanford Luverne hospice and home care reviews rates annually
SAFETY	
Have drugs in their home that are not being used – 21%	Sanford Luverne refers patients to county drug collection resource at Rock County law offices
HEALTH CARE ACCESS	
Access to affordable health insurance coverage	• Sanford Health Plan • Sanford Community Care program
Access to affordable dental insurance coverage	• Sanford Luverne shares information with Luv1Luvall initiative • Sanford Luverne providers assist with dental varnish for children at preventive visits • Sanford Luverne has offered outlet/plug-in ability for mobile dental services
Availability of non-traditional hours	Sanford Luverne continues to look at options for expanded hours. Sanford Health offers ability to have video visit or E visit after hours.
Availability of mental health providers	• Sanford Luverne employs integrative health therapist • Sanford Luverne integrative health therapist assists with referrals to area mental health providers • Sanford Luverne uses county mental health crisis response team in ER • Sanford Luverne has ability to access mental health providers through telehealth
Access to affordable prescription drugs	Sanford Luverne RN Health Coach assists patients with options to afford medications
MENTAL HEALTH & SUBSTANCE ABUSE	
Depression	Sanford Luverne providers screen for depression at clinic visits as well as in the ER and RN Health Coach actively manages patients with this diagnosis to bring depression screening measure within normal range
Drug use & abuse	Sanford Luverne substance use program provides assessments and outpatient treatment. Serves on area county drug courts.
Alcohol use & abuse	Sanford Luverne substance use program provides assessments and outpatient treatment. Serves on area county drug courts.
Diagnosis of depression – 21%	• Sanford Luverne providers screen for depression at clinic visits as well as in the ER and RN Health Coach actively manages patients with this diagnosis to bring depression screening measure within normal range • Sanford Luverne integrative health therapist assists providers with patients as needed
Diagnosis of anxiety/stress – 40%	• Sanford Luverne providers screen for diagnosis and treat as appropriate • Sanford Luverne integrative health therapist assists providers with patients as needed
Currently smoke cigarettes – 11%	• Sanford Luverne Respiratory Department has smoking cessation program • Sanford Luverne providers address smoking at clinic visits
Binge drink at least 1 x / month – 38%	• Sanford Luverne substance use program provides assessments and outpatient treatment. Serves on area county drug courts. • Sanford Luverne has shared information with Southwest Health and Human Services, county public health partner.
WELLNESS	
Diagnosis of high cholesterol & hypertension – 29%	• Sanford Luverne providers address at routine clinic visits • Sanford Luverne Medical Home model within the clinic impacts chronic disease and care coordination through RN Health Coach and care coordinator assistant

Identified Concerns	How Sanford Luverne is Addressing the Community Needs
Diagnosed with arthritis – 25%	Sanford Luverne Medical Home model within the clinic impacts chronic disease and care coordination through the RN Health Coach and care coordinator assistant
Obese – 39%	• Sanford Luverne dietician conducts programs for intensive behavioral therapy for obese patients and provides education monthly at senior center • Sanford Luverne providers address weight and weight management tips at routine preventive visits
Overweight – 27%	• Sanford Luverne dietician conducts programs on intensive behavioral therapy to assist with weight loss • Sanford Luverne wellness coordinator hosts community wellness challenges • Sanford Luverne has a rep on the food shelf to impact food choices/more healthy options
Do not eat 5+ fruits/vegetables each day – 61%	• Sanford Luverne partners with the farmers market and provides assistance to allow SNAP/EBT recipients ability to purchase fresh produce • Sanford Luverne physicians donate to provide certificates to food shelf recipients to purchase fresh produce at farmers market • Sanford Luverne partners with the farmers market to bring Power of Produce program o encourage healthy eating in children
Do not get moderate exercise at least 3 x / week – 50%	• Sanford Luverne submitted grant letters of support for expanded walking/biking path access • Sanford Luverne providers refer people to area fitness centers or walking at area school to ensure exercise
Have not had a routine check-up in more than 1 year – 14%	Sanford Luverne follows up with patients who need routine health care visits via letter and phone calls
Did not have a flu shot this past year – 28%	Sanford Luverne sponsors community flu shot clinic and hosts in-school vaccination events with Luverne and Hills-Beaver Creek schools
Have not seen their dentist in more than 1 year – 27%	• Sanford Luverne providers assist with dental varnish for children • Sanford Luverne providers have written grant letters of support to encourage more options for low income access to dentists

Implementation Strategies – 2019-2021

Priority 1: Health Care Access

According to the County Health Rankings for Clinical Care, access to affordable health care is important to physical, social, and mental health. Health insurance, local care options, and a usual source of care help to ensure access to health care. Having access to care allows individuals to enter the health care system, find care easily and locally, pay for care, and get their health needs met.

Sanford has made health care access a significant priority and has developed strategies to promote and improve access to services. It is Sanford's goal that all patients requiring access to health care are successful in securing timely appointments

Priority 2: Mental Health/Behavioral Health and Substance Abuse

Mental health is important at every stage of life and affects how people think, feel, and act. According to the National Institute of Mental Health, depression is one of the most common mental disorders in the U.S. Current research suggests that depression is caused by a combination of genetic, biological, environmental, and psychological factors. Depression is among the most treatable of mental disorders.

Sanford has made mental health a significant priority and has developed strategies to reduce mortality and morbidity from mental health, behavioral health and substance abuse. It is Sanford's goal to reduce the number of individuals whose overall well-being is negatively impacted by addiction and mental illness.

Sanford Luverne Community Health Needs Assessment

Implementation Strategy Action Plan – 2019-2021

Priority 1: Health Care Access

Projected Impact: Improve access to care and price transparency

Goal 1: Improve access to family medicine providers

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Recruit additional family medicine providers to support access to care	Providers recruited	Provider recruitment / Recruitment budget	Senior Director, Clinic Director Providers	
Implement video visit options with patients and area nursing homes	Number of video visits completed	Nursing support staff, Equipment	Clinic Director, Clinical Supervisor Providers	Area nursing homes
Ensure satellite clinics are staffed and hours are accessible for patients	Hours / Appointments	Providers, staff	Clinic director Providers	

Goal 2: Improve price transparency

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Implement price transparency	Number of requests completed; Clinic charges posted	Finance Team, Patient Access Department	Director of finance, All department supervisors	
Promote ability for patients to have pricing estimates for services	Number of requests completed	Finance Team, Patient Access Department	All dept supervisors	
Assist patients with options for finding affordable prescription drug coverage	Patients signed up for assistance; authorizations completed	RN Health Coach, Discharge Planner, Clinic Triage Nurses	Clinic director, hospital leadership Providers	Area pharmacies

Goal 3: Support access for dental health

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Provide dental varnish in the clinic	Number of patients	Nursing staff	Director of Clinic Operations Providers	School, county, Luv1Luvall poverty initiative
Assist with finding ways to bring access to more dental providers	Patients with dental care		Senior director	Luv1Luvall poverty initiative group

<u>Priority 2</u>: Mental Health and Substance Abuse

Projected Impact: (IRS mandatory)

Goal 1: Improve access to mental health services

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Partner with area mental health providers to ensure patients are seen timely and care is coordinated	Time until outpatient are seen	Integrated health therapist, Telepsych services	Clinic director, Senior director	SW Mental Health, School, Area mental health providers
Utilize crisis response team	Number of times used	Integrated health therapist, ER supervisor	Director of Nursing	Crisis response team
Ensure integrative health therapist access to all patients within the clinic setting	Visits completed	Integrated health therapist	Director of Clinic Operations	
Enhance community education on mental health	Educational sessions held	Integrated health therapist	Director of Clinic Operations	SW Mental health

Goal 2: Decrease depression and anxiety

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Assess for depression and anxiety with preventive medicine visits	PHQ9	RN Health Coach	Clinic director Providers	
Reassess high scores to ensure plan is optimal for care and adjust as needed/ reassess patient	PHQ9	RN Health Coach, care coordinator assistant	Clinic director Providers	

Goal 3: Decrease the amount of substance use within the community

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Support drug courts through active presence	Number of active drug court participants	Substance use staff	Senior Director	Area counties and law enforcement agencies
Education to key community groups on substance use and prevention tactics	Number of educational sessions	Substance use staff	Senior Director	Area schools

Demonstrating Impact – Addressing the Needs

Implementation Strategy for Sanford Luverne Medical Center
FY 2017-2019 Action Plan

Priority 1: Improving the physical health of the community

Projected Impact: Improved chronic disease management

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

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

<u>Priority 2</u>: Improving the mental health of the community

<u>Projected Impact</u>: Improved access and coordination of care

<u>Goal 1</u>: Enhanced access to mental health and substance abuse resources

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

Demonstrating Impact – 2017-2019 Strategies

During the 2016 Community Health Needs Assessment research cycle community members were invited to discuss community needs, provide recommendations, and vote on the top priorities to address over the following three years. At Sanford Luverne Medical Center, the top priorities addressed through an implementation strategy process include:

1) Physical health of the community
2) Mental health of the community

Improving the Physical Health of the Community

Sanford Luverne has a strong core team as part of the Medical Home model. The goal in this area focused on improving chronic disease management. Throughout the past three years, Sanford's core team has focused on using *Healthy Planet* population registries to ensure patients are receiving all recommended preventive care, focusing on asthma, diabetes and mental health/depression.

The quality scores in each of these areas have demonstrated improvements. Depression remission scores at 6 months measured 5.6% in July 2015, and as of July 2018, 18.1% patients noted they were in remission at 6 months and 25.1% at 12 months. Optimal diabetes management was 36% of patients in December 2014, and as of July 2018, was 53.6% of patients. In July 2015, 45.2% of patients had an asthma control test completed. In July 2018, 63.5% of patients have an asthma action plan in place – noting that the metrics for measurement changed during this time period.

In addition, Sanford Luverne's registered dietitian has utilized a variety of platforms to bring forward education on healthy eating options, including the local senior meal site. Sanford Luverne has supported the Luverne City efforts to expand the Luverne LOOP walking trail through grant writing, partnered with the City on a task force looking at wellness within the community, and sponsored several wellness challenges within the community. Despite this focus (and following national trends), Luverne continues to see higher obesity rates and will continue focusing on diet and exercise.

To attempt to meet the concerns about lack of dental services, the facility leadership reached out to bring dental services to the community through mobile services, but the request was denied. As part of the Blandin poverty initiative, a task force is now working to address dental access, such as bringing dental screenings into the school and bringing more access within the community. A letter of support from the physician group was sent to the local dentist to encourage taking more Medicaid patients and requesting a time to meet and discuss the need further.

Improving the Mental Health of the Community

Sanford Luverne now employs a part-ime therapist to assist with treatment and triage of mental health issues for patients. In addition, a second integrative health therapist has joined, providing additional access for Medicare beneficiaries. As part of Sanford's expanded mental health offerings, the therapist works very closely with local mental health providers. In addition, the facility sponsored mental health first aid training for the community and the Sanford therapist has completed the training to become a trainer. Sanford Luverne was awarded a grant to look at mental health services and care coordination and has developed a release of information form that allows for greater care coordination across all entities. This form was reviewed and approved by all agencies involved. Sanford Luverne has seen an improvement in depression remission scores over the past three years as well. Sanford Luverne is in the process of implementing telepsychiatry for access. The Sanford Luverne substance use program has actively been involved in Rock, Nobles, Pipestone, and Murray drug courts and is actively engaged in providing community education and serving on various community boards to decrease substance use issues within the county.

Community Feedback from the 2016 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on the 2016 Community Health Needs Assessment and has provided online comment fields on our website for ease of access. There have been no comments or questions about the Sanford Luverne Medical Center's CHNA.

Appendix

Primary Research

Luverne Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Economic Well Being	Skilled labor workforce 3.90 Availability of affordable housing 3.76 Employment options 3.57 9% report that they run out of food before they have money to buy more	9% report that they run out of food before they have money to buy more		Employment resources: • Economic Development Corp., 305 E. Luverne St., Luverne • Luverne Chamber Offices Major employers: • Sanford Luverne, 1600 N. Kniss Ave., Luverne • Luverne Public Schools, 709 N. Kniss, Luverne • MN Veterans Home, 1300 N. Kniss Ave., Luverne • Good Samaritan Society - Luverne, 110 S. Walnut Ave., Luverne • Continental Western, 10 Roundwind Rd., Luverne • Rock County offices, 204 E. Brown St., Luverne • City of Luverne, 305 E. Luverne St., Luverne • Total Card, Inc., 2 Roundwind Rd., Luverne • Papik Motors, 801 Commerce Rd., Luverne • Hills Stainless Steel, 505 W. Koehn Ave., Luverne Housing resources: • #Luv1LuvAll Housing Issue Team, Nicole Henrichs 401-500-3427 • #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 • Southwest Minnesota Housing Partnership, 2401 Broadway Ave, Slayton, MN – covers Rock County • SW MN Habitat for Humanity, 126 E. Main St., Luverne • Hsg. & Redevelopment Authority, 216 McKenzie St., Luverne • Cragoe Realty, 203 E. Main, Luverne • Real Estate Retrievers, 905 S. Kniss Ave., Luverne • Remax real estate, Kniss Ave, Luverne Low Income Apartments:	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Stone Creek Townhomes, 501 W. Hatting St., Luverne • Centennial Apts., 120 N. Spring St., Luverne • Blue Mound Towers, 216 N. McKenzie St., Luverne • Rock Creek Townhomes, 304 Pine St., Luverne • Rock Creek Townhomes, 300 Oak St., Luverne Physically & Mentally Handicapped Housing - 7 homes - 123 W. Main St., Luverne Food resources: • #Luv1LuvAll Senior Nutrition, George Bonnema, 507-920-3802 • Prairie Ally Public Food Forest • WIC, 2 Roundwind Rd., Luverne • SNAP, Southwest Health and Human Services, 2 Roundwind Rd., Luverne • Teal's Grocery, 205 E. Warren, Luverne • Food Shelf, 109 N. Freeman Ave., Luverne • ATLAS of Rock County • SHARE yearly holiday food distribution • New Life Celebration Church, monthly food distribution • Farmers Market, E. Main St., Luverne • River Bend Farm (CSA), 1237 N. River Rd., Luverne • Meals on Wheels, LSS Senior Nutrition Program, 319 E. Lincoln, Luverne • Senior Meals, Senior Center, 319 E. Lincoln, Luverne	
Children & Youth	Availability of quality child care 4.42 Cost of quality child care 3.89 Availability of services for at-risk youth 3.68 Substance abuse by youth 3.63 Bullying 3.58			Child Care resources: • #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 • Most current list of updated licensed childcare providers are located on Southwest Health and Human Services website. www.swmhhs.com • Kiddy Care, 720 W. Main, Luverne	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	Cost of services for at-risk youth 3.56 Teen suicide 3.53			• Marian's Day Care, 504 N. Freeman, Luverne • Horsn' Around Daycare, 692 – 160th Ave., Luverne • Abbey Behr, Elm St., Luverne • Nancy J. Davis, 161st St., Luverne • Ali Dinger, Luverne MN • Amy Domagala, E. Maple, Luverne • Heather Frahm, E. Oakland Ave., Luverne • Kathie Hendricks, E. Veterans Dr., Luverne • Brenda Johnson, E. Oakland, Luverne • Amber Lais, E. Crawford, Luverne • Joleah Kay Mann, N. Blue Mound, Luverne • Daci L. Moss, 80th Ave., Luverne • Betty Mulder, 503 Rapp, Luverne • Amber K. Nath, W. Main, Luverne • Lisa M. Nath, 1001 Linden, Luverne • Heather Roberts, S. Donaldson St., Luverne • Anne Shelton, E. Barck St., Luverne • Tori M. Snyder, Barck St., Luverne • Brittany Strassburg, Service Dr., Luverne • Abby Moeller, W. Luverne, Luverne • Jennifer Nath Huls, W. Luverne, Luverne • Peggy Johnson, SE Park St., Luverne • Kaycee Johnston Sina, 160th Ave., Luverne • Amy Jo Lape, 100th Ave., Luverne • Nicollette McLendon, Brandenburg St., Luverne • Peyten Petersen, Elmwood Ave., Luverne Services for at-risk youth: • Luverne Public School Child Guide Program • Big Buddies Program • Luverne Back Pack Program	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Southwest Crisis Center, 114 W. Main #200, Luverne • SW Mental Health Center, 216 E. Luverne St., Luverne • School Counselors, 709 n. Kniss Ave., Luverne • Luverne Counseling, 118 W. Main, Luverne • Text4life – teen hotline • Project turnabout Substance Abuse resources: • Sanford Luverne Substance Use Assessments and Outpatient program, Stephanie Pierce, 507-283-2321 • Southwest Health and Human Services, Luverne MN • SW Mental Health Center, 216 E. Luverne St., Luverne • Luverne Counseling, 118 W. Main, Luverne • SAMHSA – 1-800-662-4357 • AA program, Stephanie Pierce, 507-283-2321 Bullying resources: • Rock County Sheriff, 1000 N. Bluemound Ave., Luverne • Luverne Police, 1000 N. Bluemound Ave., Luverne • School District counselors, 709 N. Kniss Ave., Luverne • Luverne Counseling, 118 W. Main, Luverne • Luverne School Child Guide Program Suicide/Mental Health resources: • #Luv1LuvAll Brain Health Team, Angela Nolz 605-770-8830 • Text4life – Teen hotline • Sanford Luverne, 1601 Sioux Valley Dr., Luverne • Sanford Adrian, 601 Louisiana Ave., Adrian • Sanford Edgerton, 733 Main Ave., Edgerton • Southwest Crisis Center • Luverne Public School Counselors, 709 N. Kniss Ave., Luverne	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Southwest Mental Health Center, 2316 E. Luverne St., Luverne • Luverne Counseling, 118 W. Main, Luverne • National Suicide Prevention Lifeline – 1-800-273-8255 • IMALIVE Suicide Prevention Hotline – 1-800-784-2433 • SAMHSA – 1-800-662-4357 • Text4life	
Aging Population	Cost of long term care 3.79 Cost of memory care 3.74 Cost of in-home services 3.53			• #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 • Senior Linkage Line • ACE of SW Minnesota Long Term Care resources: • Oasis Care Home, 514 Britz Dr., Luverne • Good Samaritan Society - Luverne, 110 S. Walnut Ave., Luverne • The Oaks, 201 Oak Dr. Luverne • Poplar Creek Assisted Living, 201 Oak Dr., Luverne • MN Veterans Home, 1300 N. Kniss Ave., Luverne • Senior Linkage Line Memory Care resources: • Alzheimer's Assn. – Alz.org • Oasis Care Home, 514 Britz Dr., Luverne • Good Samaritan Society - Luverne, 110 S. Walnut Ave., Luverne • The Oaks, 201 Oak Dr. Luverne • Poplar Creek Assisted Living, 201 Oak Dr., Luverne • MN Veterans Home, 1300 N. Kniss Ave., Luverne • Senior Linkage Line In-Home Services: • #Luv1LuvAll Senior Nutrition Issue Team, George Bonnema, 507-920-3802 • Sanford Luverne Home Health and Hospice, McKenzie St., Luverne, 507-283-1805 • Good Samaritan Society Luverne	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Sanford Durable Medical Equipment, 402 E. Main St., Luverne • Regional resource – MN River Area Agency on Aging • Southwest Health and Human Services, 2 Roundwind Rd, Luverne MN • Meals on Wheels, 319 E. Lincoln, Luverne • Senior Linkage Line	
Safety	21% report having drugs in their home that they are not using	21% report having drugs in their home that they are not using		Drug Take-Back Program: • Rock Co. Sheriff, 1000 N. Blue Mound Ave., Luverne	
Health Care Access	Access to affordable health insurance coverage 4.00 Access to affordable dental insurance coverage 3.79 Availability of non-traditional hours 3.68 Availability of mental health providers 3.58 Access to affordable prescription drugs 3.53			• #Luv1LuvAll Healthcare Access Issue Team, Mary Brown, 507-220-1193 • #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 • Senior Linkage Line • ACE of SW Minnesota • Heartland Express Transportation Health Insurance resources: • MN Sure – MNSure.org • General Assistance / MA, Southwest Health and Human Services, 2 Roundwind Rd, Luverne, MN • Sanford Health Plan, 300 Cherapa Place, Sioux Falls • Kozlowski Insurance, 626 S. Kniss Ave., Luverne • Heidebrink & Associates, 224 E. Main, Luverne • Cattnach Agency, 701 S. Kniss Ave., Luverne • Buffalo Ridge Insurance, 808 S. Kniss Ave., Luverne Dental Insurance resources: • #Luv1LuvAll Rock County Oral Health Task Force, Wanda Jarchow, 507-283-9664 • Kozlowski Insurance, 626 S. Kniss Ave., Luverne • Delta Dental – deltadentalsd.com Mental Health resources:	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• #Luv1LuvAll Brain Health Issue Team, Angela Nolz, 605-770-8830 • #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 • Southwest Crisis Center • Sanford Luverne, 1601 Sioux Valley Dr., Luverne • Sanford Adrian, 601 Louisiana Ave., Adrian • Sanford Edgerton, 733 Main Ave., Edgerton • Luverne Public School Counselors, 709 N. Kniss Ave., Luverne • Southwest Mental Health Center, 2316 E. Luverne St., Luverne • Luverne Counseling, 118 W. Main, Luverne Prescription Assistance programs: • Lewis Family Drug prescription program • CancerCare co-payment assistance, 800-813-4673 • Freedrugcard.us • Rxfreecard.com • Medsavercard.com • Yourrxcard.com • Medicationdiscountcard.com • Needymeds.org/drugcard • Caprxprogram.org • Gooddaysfromcdf.org • NORD Patient Assistance Program, rarediseases.org • Patient Access Network Foundation, panfoundation.org • Pfizer RC Pathways, pfizerRX pathways.com • RXhope.com • Prescriptionassistance.info • Minnesota Care – 1-800-657-3761 • MN Drug Card – mndrugcard.com • Partnership for Prescription Assistance – pparx.org/intro.php • Benefitscheckup.org • RxAssist – rxassist.org • RxOutreach – rxoutreach.com • Together RX Access Program – togetherrxaccess.com	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Glaxo Smith Kline – bridgestoaccess.gsk.com • Merck – merck.com/merkhelps • Novartis – patientassistncenow.com • Pfizer – pfizerhlepfulanswers.com • AARP Prescription Discount Program – aarppharmacy.com • PlanPlus – planplushealthcare.com • FamilyWize – familywise.org • Senior Linkage Line	
Mental Health & Substance Abuse	Depression 3.74 Drug use and abuse 3.74 Alcohol use and abuse 3.58 21% report a diagnosis of depression 40% report a diagnosis of anxiety/stress 11% currently smoke cigarettes 38% report binge drinking at least 1x/month	21% report a diagnosis of depression 40% report a diagnosis of anxiety/stress 11% currently smoke cigarettes 38% report binge drinking at least 1x/month		Mental Health resources: • #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 • #Luv1LuvAll Brain Health Issue Team, Angela Nolz 605-770-8830 • Southwest Crisis Center • Southwest Health and Human Services, 2 Roundwind Rd, Luverne • Sanford Luverne, 1601 Sioux Valley Dr., Luverne • Sanford Adrian, 601 Louisiana Ave., Adrian • Sanford Edgerton, 733 Main Ave., Edgerton • School Counselors, 709 N. Kniss Ave., Luverne • Southwest Mental Health Center, 2316 E. Luverne St., Luverne • Luverne Counseling, 118 W. Main, Luverne Substance Abuse resources: • Sanford Luverne Substance Use Assessments and Outpatient program, Stephanie Pierce, 507-283-2321 • AA program, Stephanie Pierce, 507-283-2321 • SW Mental Health Center, 216 E. Luverne St., Luverne • Luverne Counseling, 118 W. Main, Luverne • SAMHSA – 1-800-662-4357 Tobacco Cessation resources: • Sanford Luverne Smoking Cessation, Respiratory Care	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				department, Julia Silvrants, 507-283-2321 • Sanford Luverne Clinic, 1601 Sioux Valley Dr., Luverne • Sanford Adrian Clinic, 601 Louisiana Ave., Adrian • Sanford Edgerton Clinic, 733 Main Ave., Edgerton • Southwest Health and Human Services, 2 Roundwind Rd., Luverne • QuitPlan, MN Dept. of Health – 651-201-5000 • ClearWay MN – Clearwaymn.org	
Wellness	29% have been diagnosed with high cholesterol & hypertension 25% have been diagnosed with arthritis 39% report that they are obese 27% report that they are overweight 61% do not consume the recommended 5 or more fruits/vegetables per day 50% do not get moderate exercise at least 3x/week 14% have not had a routine check-up in more than 1 year 28% did not have a flu shot this past year 27% report not seeing their dentist in more than 1 year	29% have been diagnosed with high cholesterol & hypertension 25% have been diagnosed with arthritis 39% report that they are obese 27% report that they are overweight 61% do not consume the recommended 5 or more fruits/vegetables per day 50% do not get moderate exercise at least 3x/week 14% have not had a routine check-up in more than 1 year 28% did not have a flu shot this past year 27% report not seeing their		• #Luv1LuvAll One-Stop Access to Resources, ATLAS of Rock County, 507-449-5777 Chronic Disease resources: • Sanford's Better Choices Better Health, 1601 Sioux Valley Dr., Luverne • Sanford Luverne Clinic, 1601 Sioux Valley Dr., Luverne • Sanford Adrian Clinic, 601 Louisiana Ave., Adrian • Sanford Edgerton Clinic, 733 Main Ave., Edgerton • Sanford Luverne Rehab Dept, 507-283-2321 • Prairie Rehab • Southwest Health and Human Services, 2 Roundwind Rd., Luverne • American Heart Assn. – heart.org • Arthritis Found. – arthritis.org Obesity resources: • Sanford Luverne Clinic, 1601 Sioux Valley Dr., Luverne • Sanford Adrian Clinic, 601 Louisiana Ave., Adrian • Sanford Edgerton Clinic, 733 Main Ave., Edgerton • Southwest Health and Human Services, 2 Roundwind Rd., Luverne • Power Fitness, 205 E. Main, Luverne • Aquatic Center & Fitness, 802 N. Blue Mound, Luverne	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
		dentist in more than 1 year		• Parks Dept. organized activities, 305 E. Luverne St., Luverne • Luverne School organized activities, 709 N. Kniss Ave., Luverne • Walking & Biking Paths – Evergreen Park, 501 Brandenburg St., Luverne • Luverne LOOP walking path • Blue Mound State Park • Blue Mound Bike Trail, starts on Blue Mound Ave., Luverne • Golf, 1520 – 111th St., Luverne • Swimming, 802 N. Blue Mound, Luverne • Ice Skating, 601 W. Hatting St., Luverne • Bowling, 117 N. Cedar, Luverne • Parks & Playgrounds: o Blue Mound State Park o City Park, 700 E. Main, Luverne o Redbird Field & Skateboard Park, 700 E. Main, Luverne o Riverside Park, Main St., Luverne o Sitting Bull Park, Estey & Dodge Sts., Luverne o Rotary Park, S. Hwy. 75, Luverne o Buffalo Bill Park, S. Donaldson St., Luverne o Evergreen Park, 501 Brandenburg St., Luverne o Hawkinson Park, west side of town, Luverne o Kolbert Park, SW side of town, Luverne o Longhorn Park – Adams & Spring Streets, Luverne o Moccasin Park – Spring & Luverne Streets, Luverne o Prairie Moon Park, Luverne o Tonto Park, Luverne o Veteran's Memorial Park, behind MN Veterans Home Healthy Eating resources: • County Extension Office (nutrition & meal planning	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				info), 2 Roundwind Rd., Luverne • Teal's Grocery, 205 E. Warren, Luverne • Rock County Food Shelf, 109 N. Freeman Ave., Luverne • ATLAS of Rock County • Luverne Back Pack Program • New Life Celebration Church, monthly food distribution • Farmers Market, E. Main St., Luverne • Prairie Ally Public Food Forest, Blue Mound Ave. • River Bend Farm (CSA), 1237 N. River Rd., Luverne Physical Activity resources: • Power Fitness, 205 E. Main, Luverne • Aquatic Center & Fitness, 802 N. Blue Mound, Luverne • Blue Mound State Park • Luverne LOOP walking path • Parks Dept. organized activities, 305 E. Luverne St., Luverne • School Dept. organized activities, 709 N. Kniss Ave., Luverne • Walking & Biking Paths – Evergreen Park, 501 Brandenburg St., Luverne • Blue Mound Bike Trail, starts on Blue Mound Ave., Luverne • Golf, 1520 – 111th St., Luverne • Swimming, 802 N. Blue Mound, Luverne • Ice Skating, 601 W. Hatting St., Luverne • Bowling, 117 N. Cedar, Luverne • Parks & Playgrounds: o City Park, 700 E. Main, Luverne o Redbird Field & Skateboard Park, 700 E. Main, Luverne o Riverside Park, Main St., Luverne o Sitting Bull Park, Estey & Dodge Sts., Luverne o Rotary Park, S. Hwy. 75, Luverne o Buffalo Bill Park, S. Donaldson St., Luverne	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				○ Evergreen Park, 501 Brandenburg St., Luverne ○ Hawkinson Park, west side of town, Luverne ○ Kolbert Park, SW side of town, Luverne ○ Longhorn Park – Adams & Spring Streets, Luverne ○ Moccasin Park – Spring & Luverne Streets, Luverne ○ Prairie Moon Park, Luverne ○ Tonto Park, Luverne ○ Veteran's Memorial Park, behind MN Veterans Home ○ Blue Mound State Park Routine Check-up/Flu Shot resources: • Sanford Luverne Clinic, 1601 Sioux Valley Dr., Luverne • Sanford Adrian Clinic, 601 Louisiana Ave., Adrian • Sanford Edgerton Clinic, 733 Main Ave., Edgerton • Lewis Family Drug, 202 S. Kniss, Luverne (gives flu shots) • SHOPKO pharmacy Dental resources: • #Luv1LuvAll Rock County Oral Health Task Force, Wanda Jarchow, 507-283-9664 • Luverne Family Dental, 115 E. Main, Luverne • Adrian Family Dental, Main St Adrian • UCare Dental bus – Worthington, MN • Sanford Luverne Clinic – Dental Varnish for kids, 1601 Sioux Valley Dr, Luverne	

Key Stakeholder Survey

Sanford Luverne Medical Center

Community Health Needs Assessment
Results from an October 2017 Non-Generalizable
Online Survey of Community Stakeholders

November 2017

SANFORD

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an October 2017 online survey of community leaders and key stakeholders identified by Sanford Luverne Medical Center. 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.** Data collection occurred in the month of October. A total of 21 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

Current State of Health and Wellness Issues within the Community

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, HEALTH CARE AND WELLNESS, and MENTAL HEALTH AND SUBSTANCE ABUSE.

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

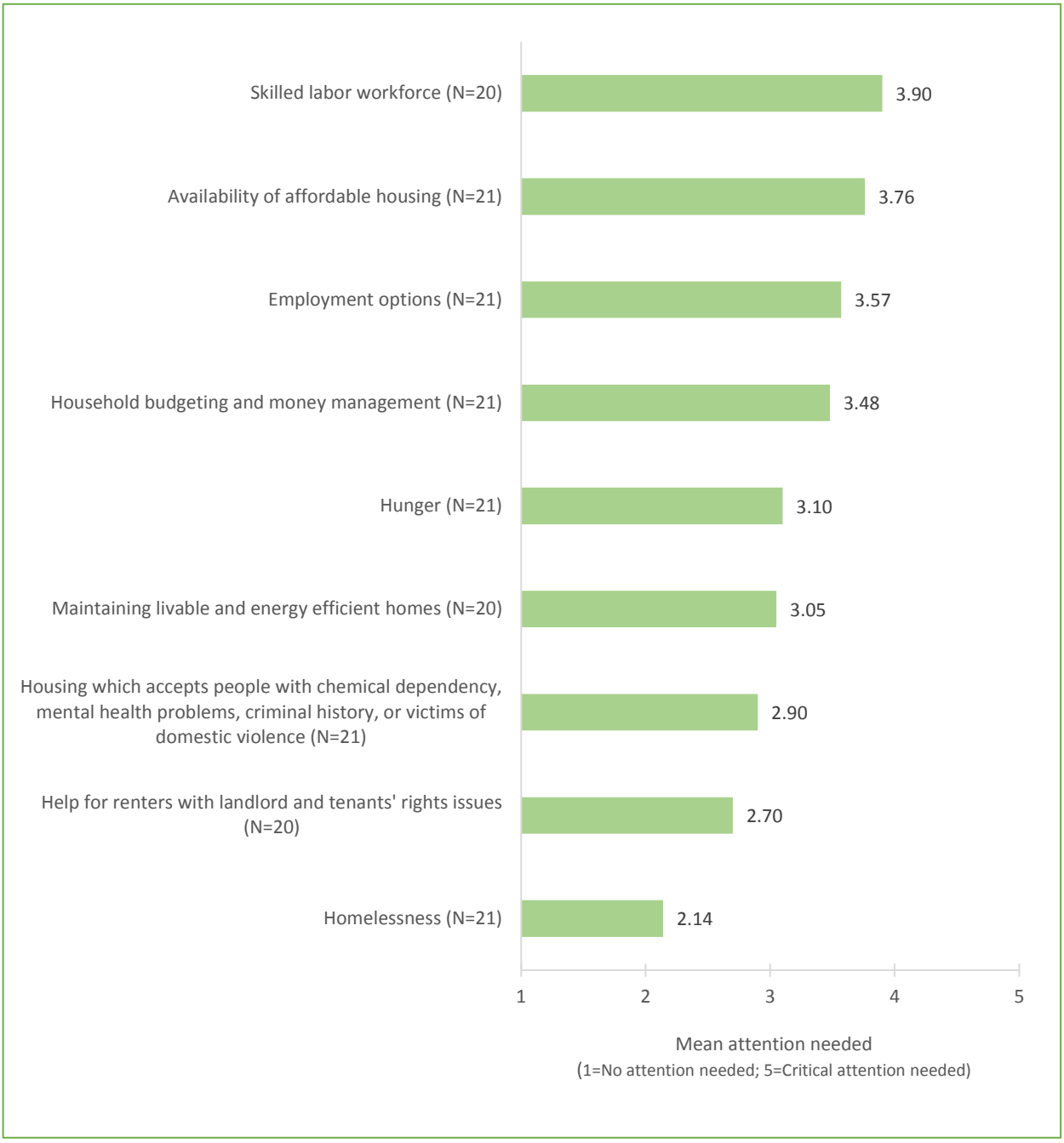


Figure 2. Current state of community issues regarding TRANSPORTATION

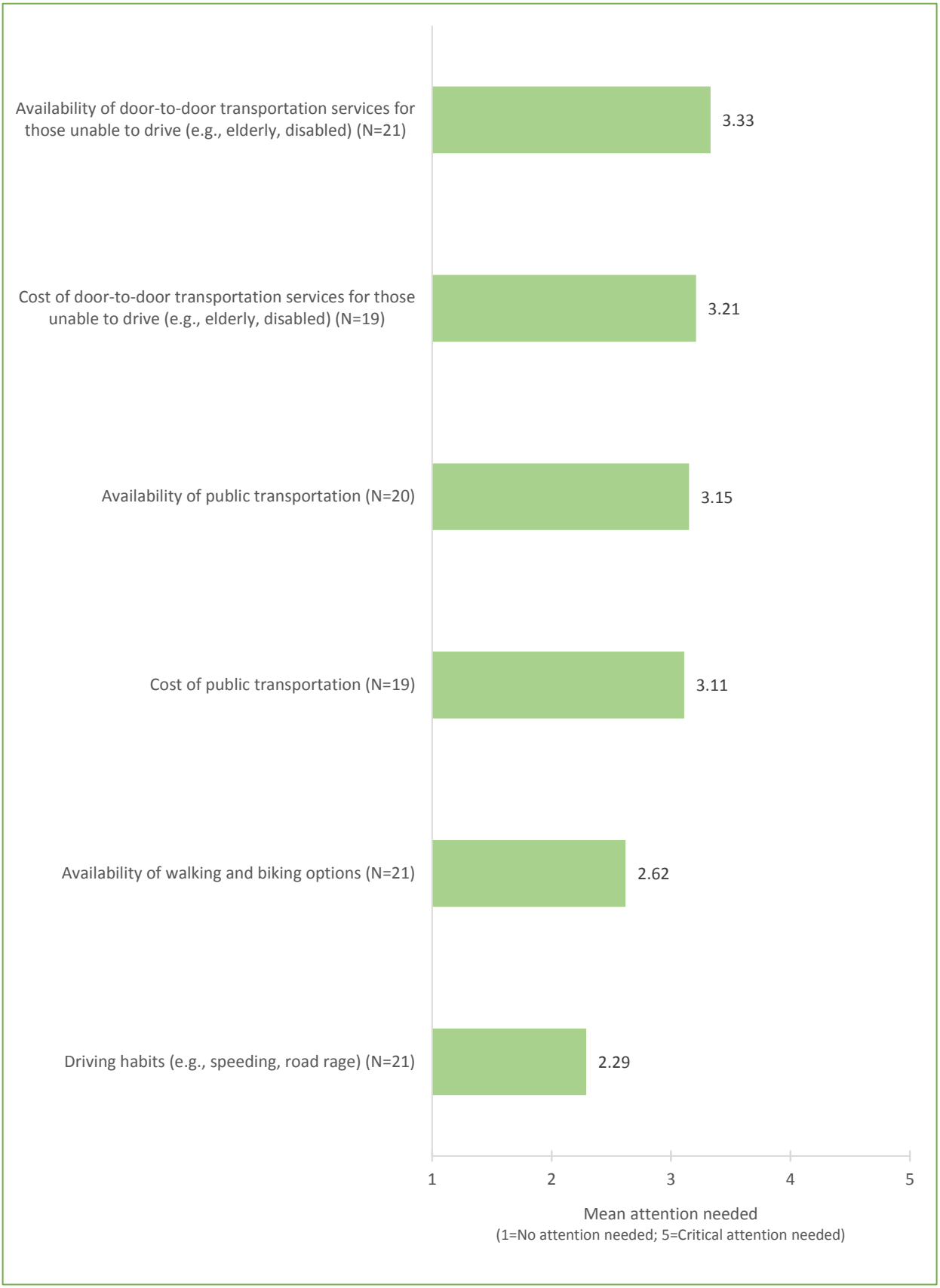


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

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

Figure 5. Current state of community issues regarding SAFETY

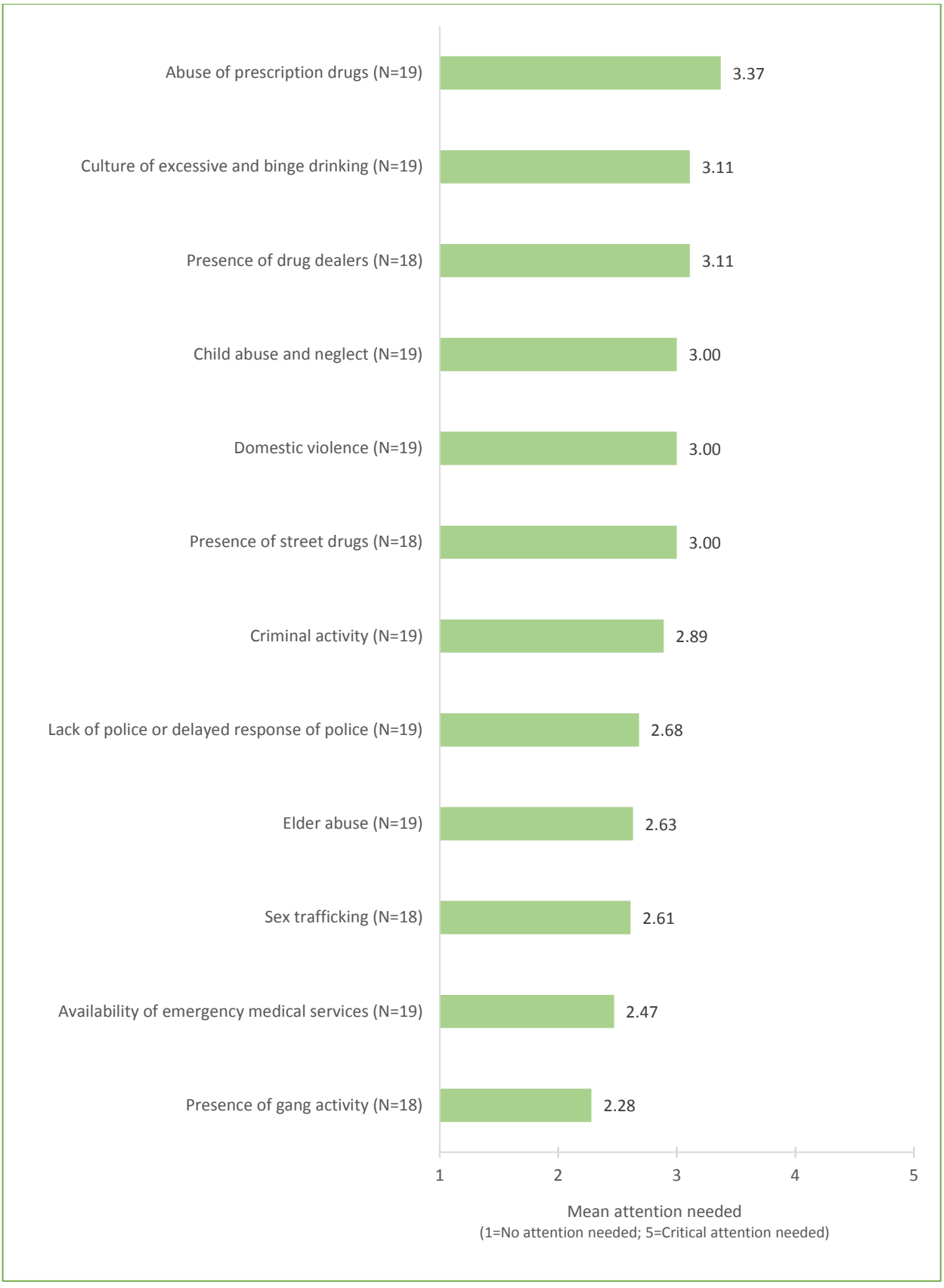
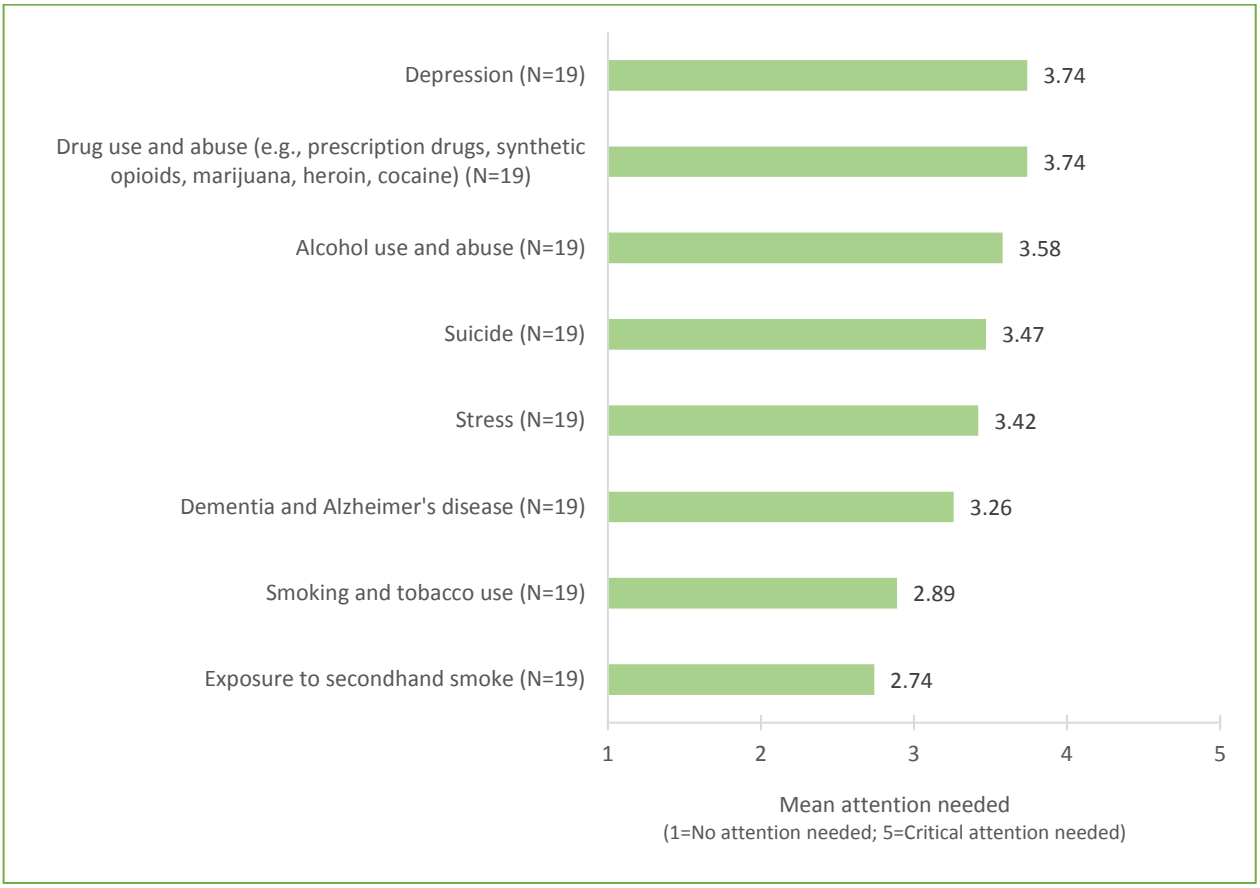


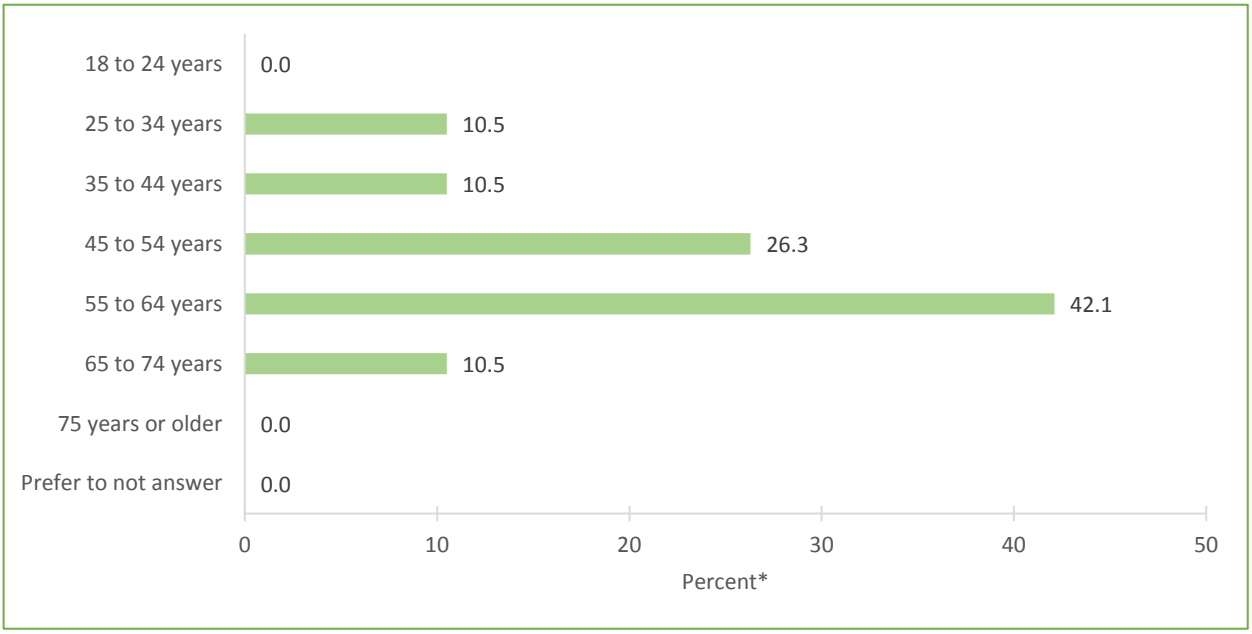
Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

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



Demographic Information

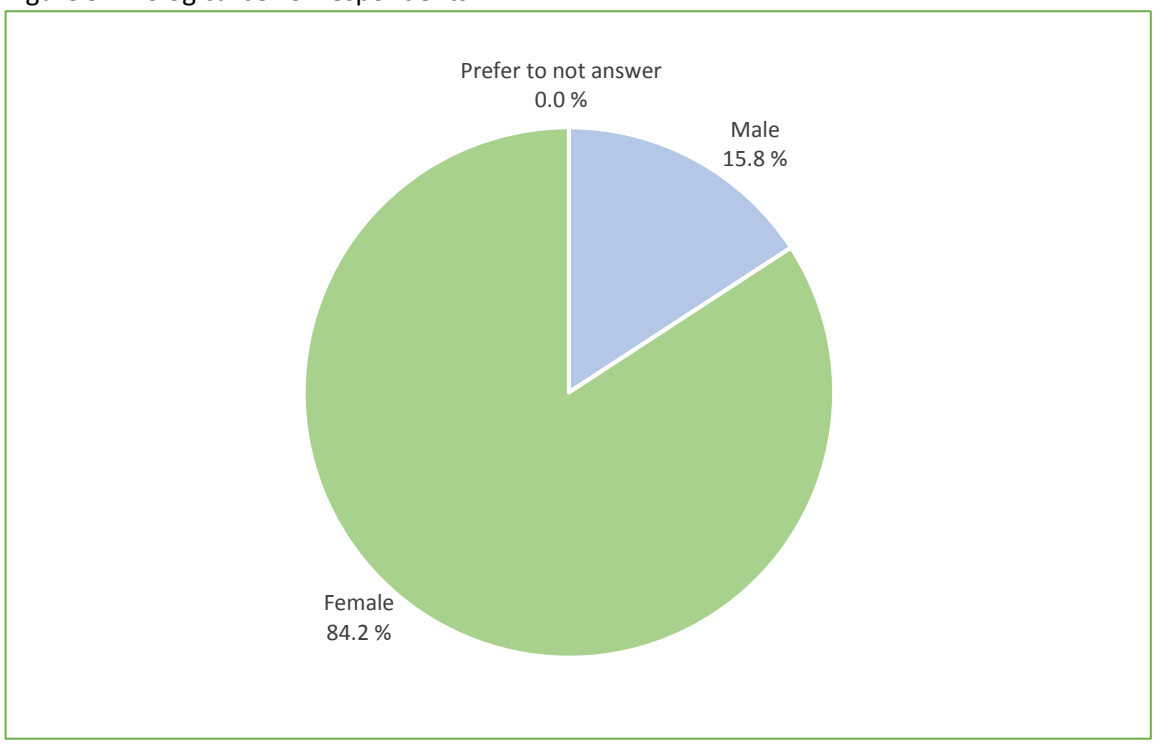
Figure 8. Age of respondents



N=19

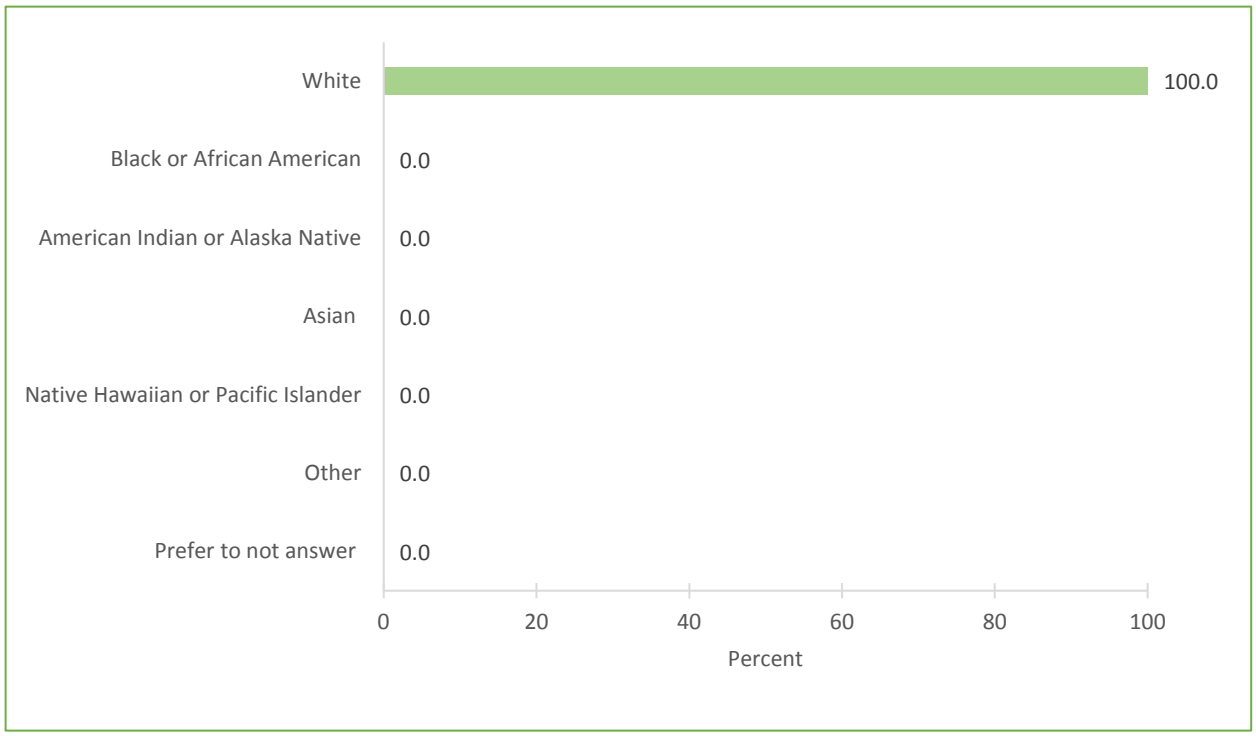
*Percentages do not total 100.0 due to rounding.

Figure 9. Biological sex of respondents



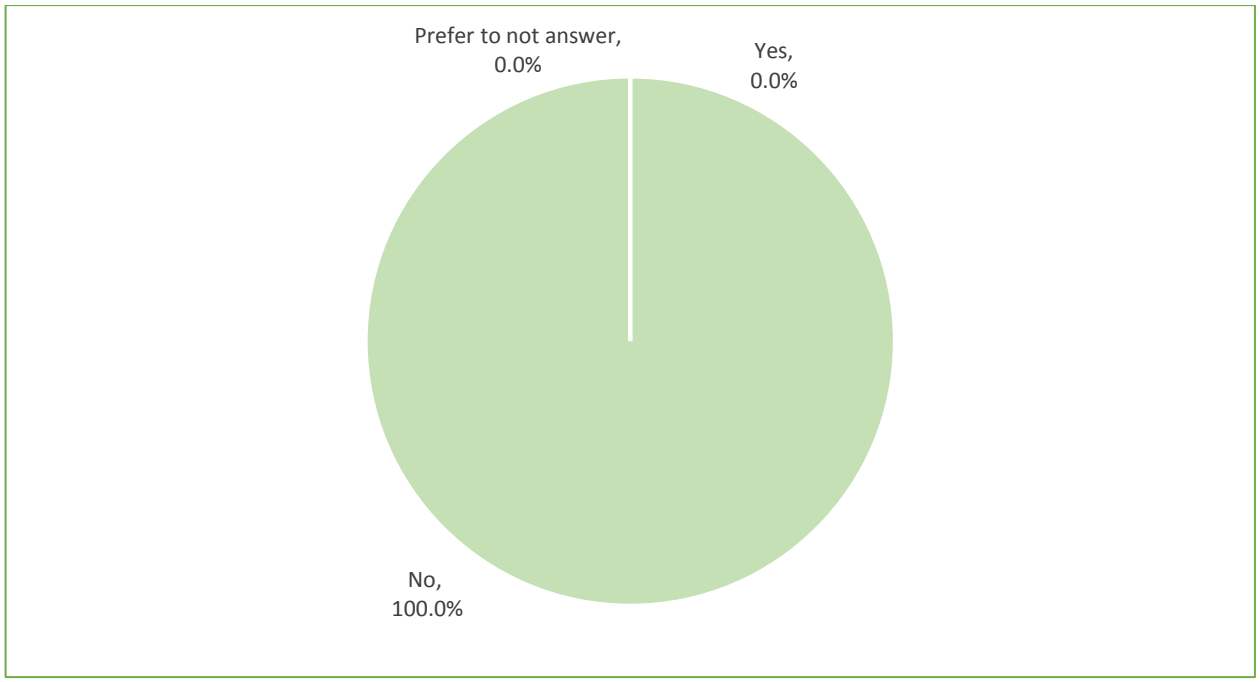
N=19

Figure 10. Race of respondents



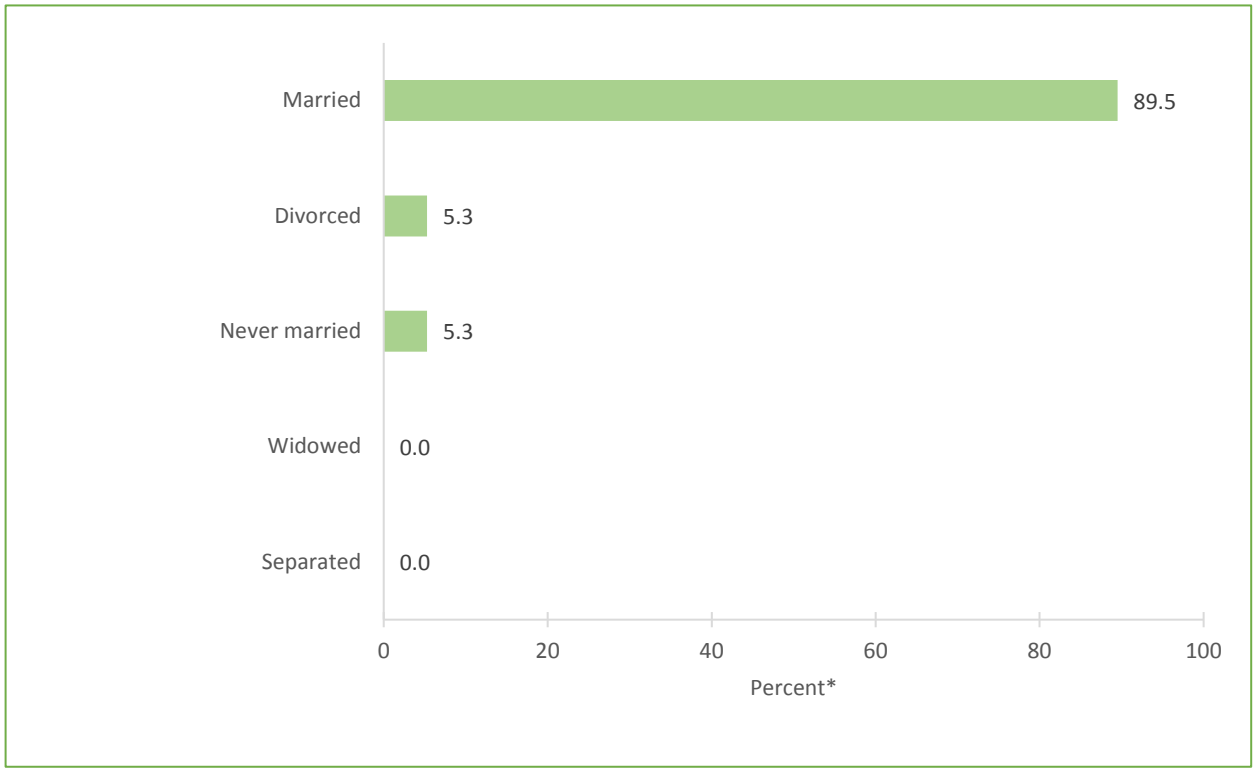
N=19

Figure 11. Whether respondents are of Hispanic or Latino origin



N=19

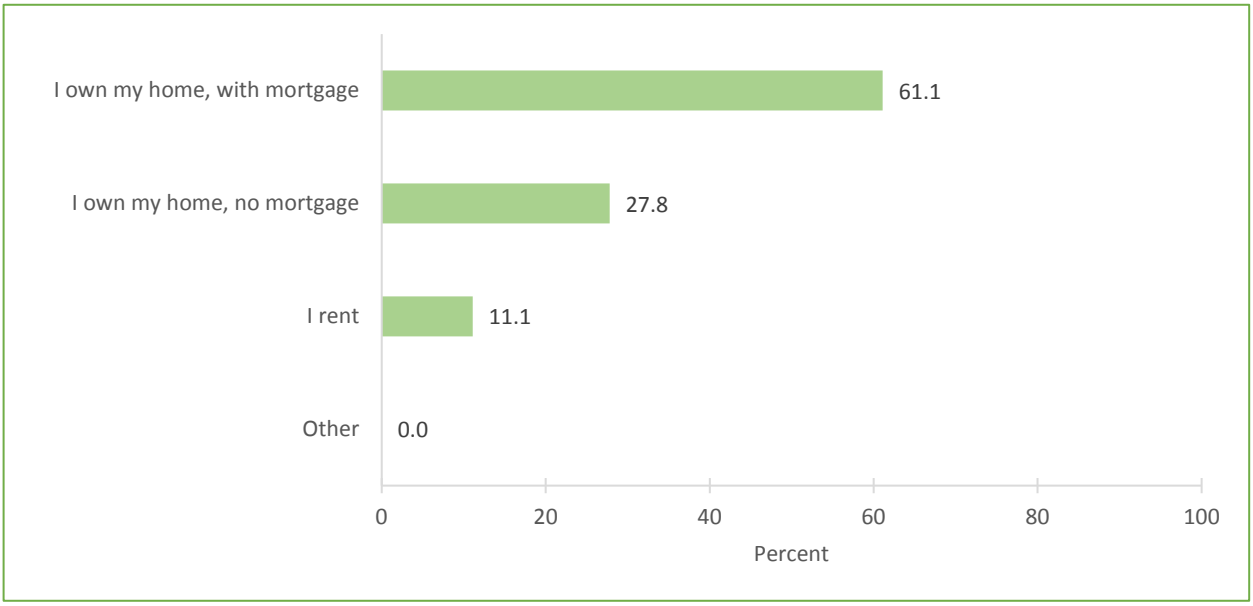
Figure 12. Marital status of respondents



N=19

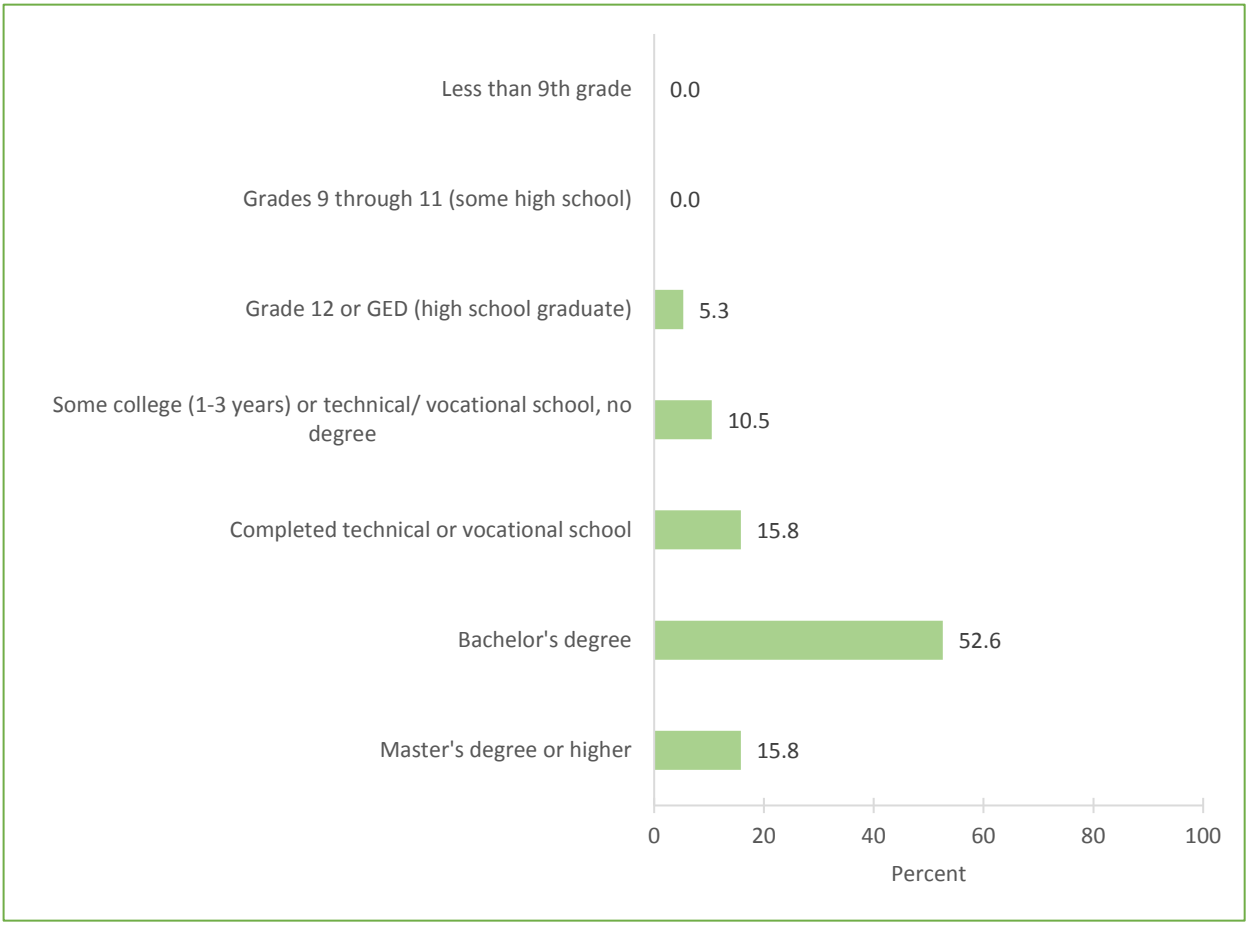
*Percentages do not total 100.0 due to rounding.

Figure 13. Living situation of respondents



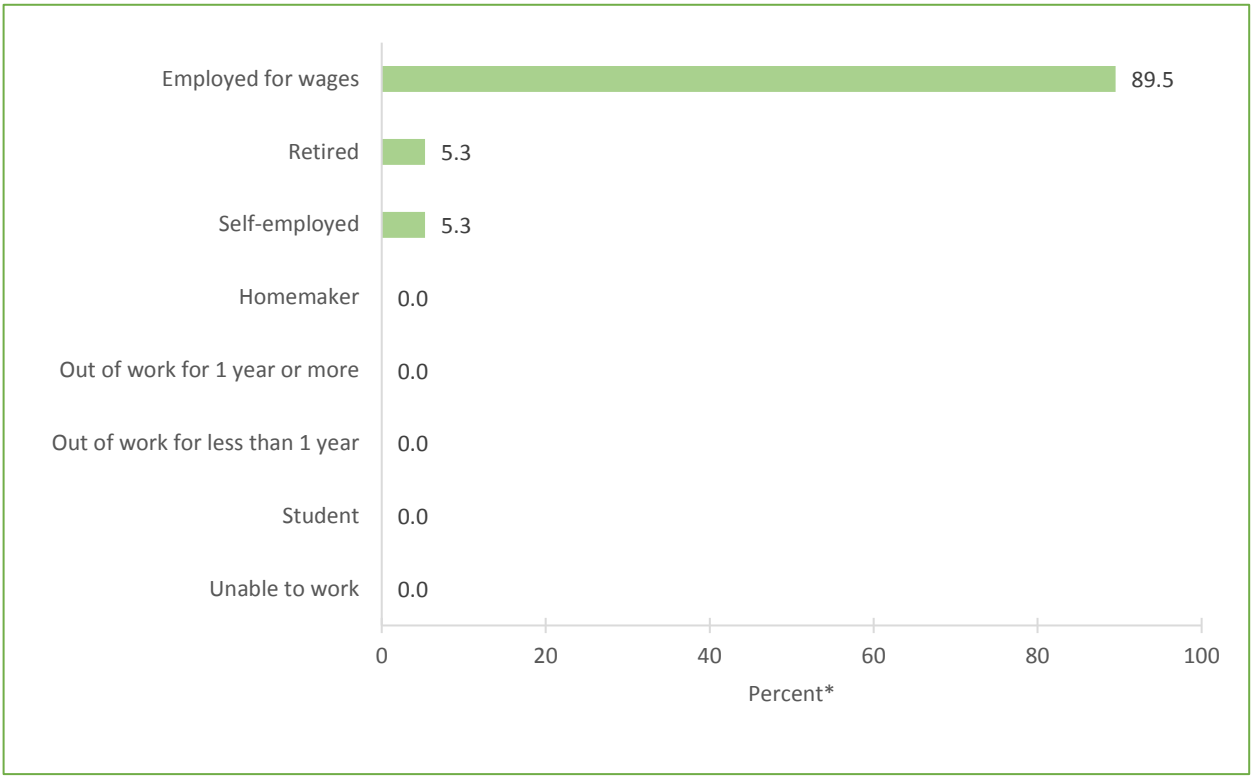
N=18

Figure 14. Highest level of education completed by respondents



N=19

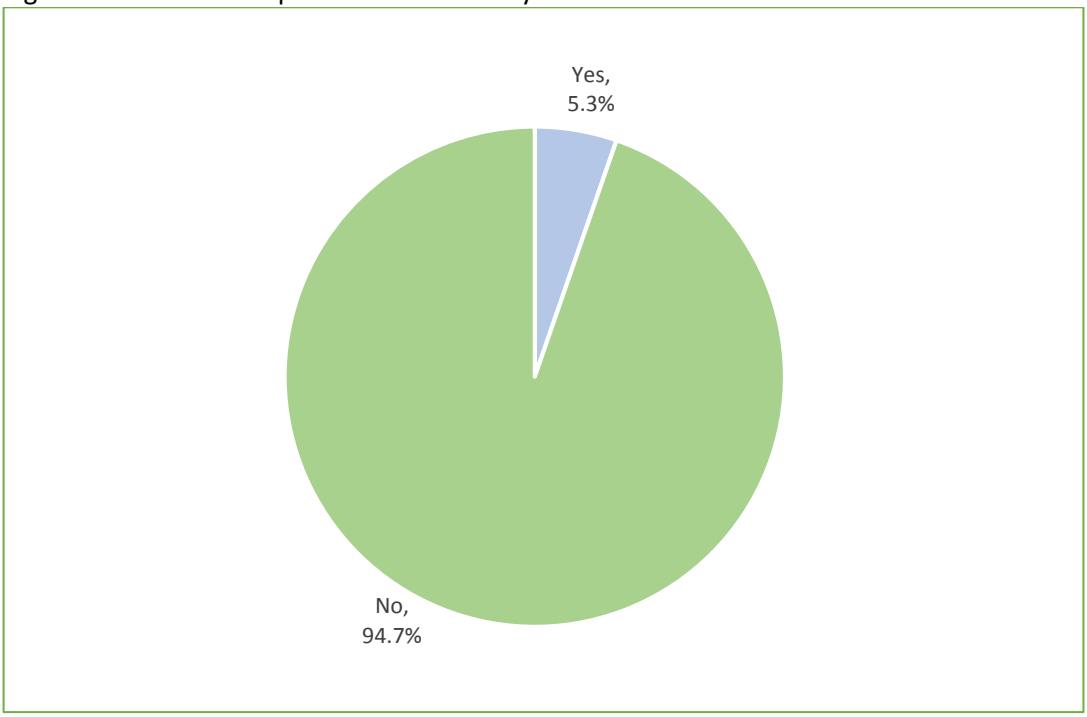
Figure 15. Employment status of respondents



N=19

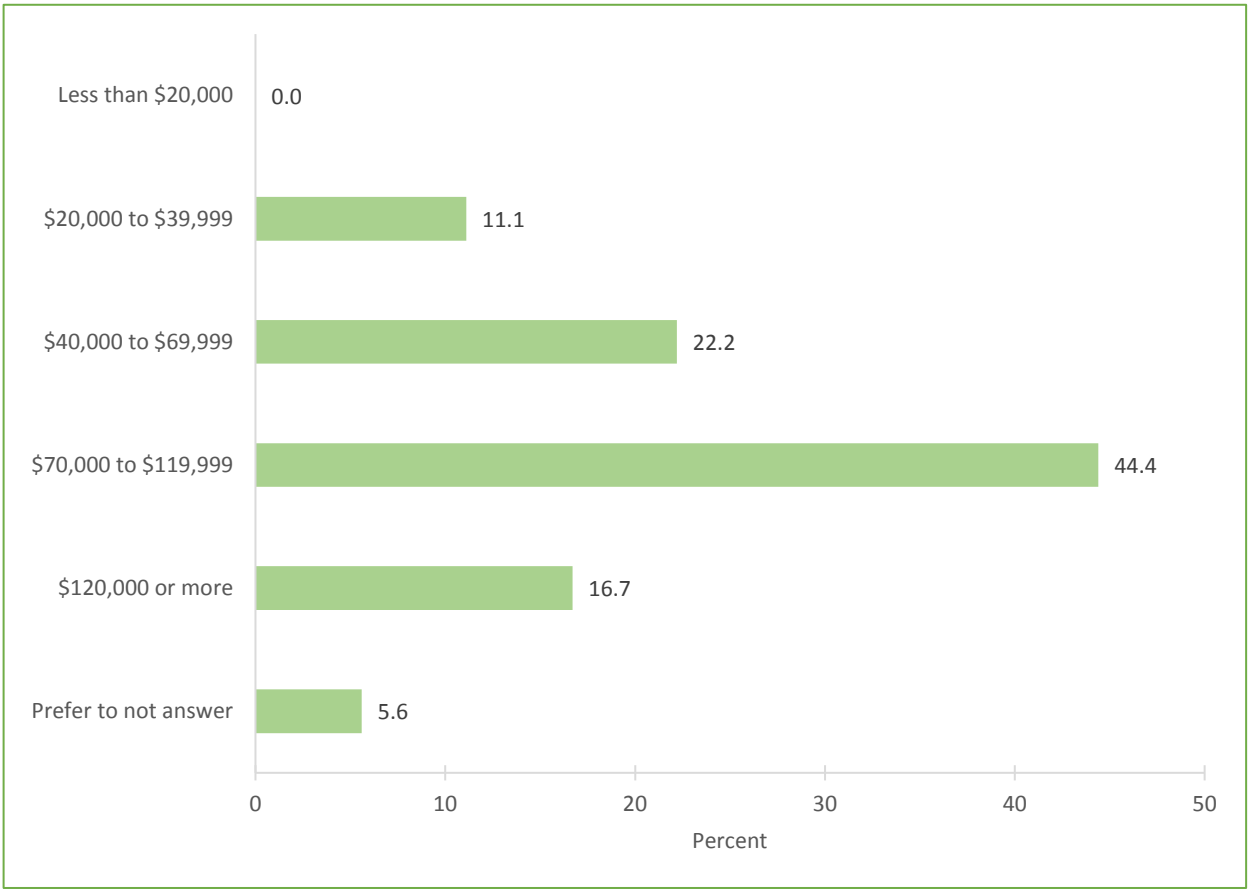
*Percentages do not total 100.0 due to rounding.

Figure 16. Whether respondents are military veterans



N=19

Figure 17. Annual household income of respondents, from all sources, before taxes



N=18

Table 1. Zip code of respondents

Zip code	Number of respondents
56156	12
56128	3
56138	2
56173	1
56178	1

N=19

Table 2. Comments from respondents

Comments
Affordable childcare options are a critical need in our community.

APPENDIX TABLE

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

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=21)	3.76	0.0	9.5	33.3	28.6	28.6	0.0	100.0
Employment options (N=21)	3.57	0.0	4.8	47.6	33.3	14.3	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=21)	2.70	4.8	33.3	42.9	14.3	0.0	4.8	100.1
Homelessness (N=21)	2.14	23.8	42.9	28.6	4.8	0.0	0.0	100.1
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=21)	2.90	14.3	23.8	33.3	14.3	14.3	0.0	100.0
Household budgeting and money management (N=21)	3.48	0.0	9.5	47.6	28.6	14.3	0.0	100.0
Hunger (N=21)	3.10	0.0	23.8	47.6	23.8	4.8	0.0	100.0
Maintaining livable and energy efficient homes (N=20)	3.05	0.0	20.0	55.0	25.0	0.0	0.0	100.0
Skilled labor workforce (N=20)	3.90	0.0	0.0	35.0	40.0	25.0	0.0	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=21)	3.33	0.0	23.8	28.6	38.1	9.5	0.0	100.0
Availability of public transportation (N=20)	3.15	0.0	30.0	35.0	25.0	10.0	0.0	100.0
Availability of walking and biking options (N=21)	2.62	9.5	38.1	33.3	19.0	0.0	0.0	99.9
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=21)	3.21	0.0	19.0	33.3	38.1	0.0	9.5	99.9
Cost of public transportation (N=21)	3.11	0.0	23.8	38.1	23.8	4.8	9.5	100.0
Driving habits (e.g., speeding, road rage) (N=21)	2.29	9.5	57.1	28.6	4.8	0.0	0.0	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=19)	3.16	5.3	26.3	26.3	31.6	10.5	0.0	100.0
Availability of education about birth control (N=19)	2.89	0.0	42.1	26.3	31.6	0.0	0.0	100.0
Availability of quality child care (N=19)	4.42	0.0	5.3	5.3	31.6	57.9	0.0	100.1
Availability of services for at-risk youth (e.g., homeless youth, youth	3.68	0.0	10.5	31.6	36.8	21.1	0.0	100.0

Statements	Mean**	Percent of respondents* Level of attention needed 1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
with behavioral health problems) (N=19)								
Bullying (N=19)	3.58	0.0	21.1	26.3	26.3	26.3	0.0	100.0
Childhood obesity (N=19)	3.47	0.0	10.5	31.6	57.9	0.0	0.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=19)	3.37	0.0	21.1	31.6	36.8	10.5	0.0	100.0
Cost of quality child care (N=19)	3.89	0.0	5.3	21.1	52.6	21.1	0.0	100.1
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=18)	3.56	0.0	16.7	22.2	50.0	11.1	0.0	100.0
Crime committed by youth (N=19)	2.84	0.0	31.6	52.6	15.8	0.0	0.0	100.0
Opportunities for youth-adult mentoring (N=19)	3.21	0.0	21.1	42.1	31.6	5.3	0.0	100.1
Parental custody, guardianships and visitation rights (N=19)	3.00	0.0	31.6	42.1	21.1	5.3	0.0	100.1
School absenteeism (truancy) (N=19)	2.95	0.0	26.3	52.6	21.1	0.0	0.0	100.0
School dropout rates (N=19)	2.63	0.0	42.1	52.6	5.3	0.0	0.0	100.0
School violence (N=18)	2.67	0.0	44.4	44.4	11.1	0.0	0.0	99.9
Substance abuse by youth (N=19)	3.63	0.0	21.1	10.5	52.6	15.8	0.0	100.0
Teen pregnancy (N=19)	3.05	0.0	31.6	36.8	26.3	5.3	0.0	100.1
Teen suicide (N=19)	3.53	0.0	21.1	26.3	31.6	21.1	0.0	100.1
Teen tobacco use (N=19)	3.42	0.0	26.3	15.8	47.4	10.5	0.0	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=19)	3.37	0.0	10.5	47.4	36.8	5.3	0.0	100.0
Availability of long-term care (N=19)	3.00	5.3	21.1	47.4	21.1	5.3	0.0	100.2
Availability of memory care (N=19)	3.47	0.0	10.5	36.8	47.4	5.3	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=19)	3.32	0.0	10.5	52.6	31.6	5.3	0.0	100.0
Availability of resources for grandparents caring for grandchildren (N=19)	3.21	0.0	15.8	52.6	26.3	5.3	0.0	100.0
Availability of resources to help the elderly stay safe in their homes (N=19)	3.32	0.0	15.8	42.1	36.8	5.3	0.0	100.0
Cost of activities for seniors (e.g., recreational, social, cultural) (N=19)	3.11	0.0	31.6	31.6	31.6	5.3	0.0	100.1
Cost of in-home services (N=19)	3.53	0.0	5.3	47.4	36.8	10.5	0.0	100.0
Cost of long-term care (N=19)	3.79	0.0	5.3	26.3	52.6	15.8	0.0	100.0
Cost of memory care (N=19)	3.74	0.0	5.3	26.3	57.9	10.5	0.0	100.0
Help making out a will or healthcare directive (N=19)	2.84	5.3	26.3	47.4	21.1	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
SAFETY								
Abuse of prescription drugs (N=19)	3.37	0.0	15.8	42.1	31.6	10.5	0.0	100.0
Availability of emergency medical services (N=19)	2.47	5.3	52.6	31.6	10.5	0.0	0.0	100.0
Child abuse and neglect (N=19)	3.00	0.0	21.1	57.9	21.1	0.0	0.0	100.1
Criminal activity (N=19)	2.89	0.0	21.1	68.4	10.5	0.0	0.0	100.0
Culture of excessive and binge drinking (N=19)	3.11	0.0	21.1	47.4	31.6	0.0	0.0	100.1
Domestic violence (N=19)	3.00	0.0	21.1	57.9	21.1	0.0	0.0	100.1
Elder abuse (N=19)	2.63	5.3	31.6	57.9	5.3	0.0	0.0	100.1
Lack of police or delayed response of police (N=19)	2.68	10.5	26.3	47.4	15.8	0.0	0.0	100.0
Presence of drug dealers (N=19)	3.11	0.0	21.1	47.4	21.1	5.3	5.3	100.2
Presence of gang activity (N=19)	2.28	21.1	31.6	36.8	5.3	0.0	5.3	100.1
Presence of street drugs (N=19)	3.00	15.8	15.8	26.3	26.3	10.5	5.3	100.0
Sex trafficking (N=19)	2.61	15.8	26.3	36.8	10.5	5.3	5.3	100.0
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=19)	3.79	0.0	15.8	21.1	31.6	31.6	0.0	100.1
Access to affordable health insurance coverage (N=19)	4.00	0.0	5.3	21.1	42.1	31.6	0.0	100.1
Access to affordable health care (N=19)	3.79	0.0	5.3	36.8	31.6	26.3	0.0	100.0
Access to affordable prescription drugs (N=19)	3.53	0.0	10.5	36.8	42.1	10.5	0.0	99.9
Access to affordable vision insurance coverage (N=18)	3.39	0.0	22.2	27.8	38.9	11.1	0.0	100.0
Access to technology for health records and health education (N=19)	2.95	0.0	26.3	52.6	21.1	0.0	0.0	100.0
Availability of behavioral health (substance abuse) providers (N=19)	3.26	0.0	26.3	31.6	31.6	10.5	0.0	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=19)	2.79	5.3	36.8	31.6	26.3	0.0	0.0	100.0
Availability of health care services for Native people (N=19)	2.75	5.3	36.8	21.1	15.8	5.3	15.8	100.1
Availability of health care services for New Americans (N=19)	2.61	10.5	36.8	26.3	21.1	0.0	5.3	100.0
Availability of mental health providers (N=19)	3.58	0.0	21.1	31.6	15.8	31.6	0.0	100.1
Availability of non-traditional hours (e.g., evenings, weekends) (N=19)	3.68	0.0	15.8	26.3	31.6	26.3	0.0	100.0
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=19)	3.00	5.3	26.3	47.4	5.3	15.8	0.0	100.1
Availability of specialist physicians (N=19)	3.05	5.3	31.6	26.3	26.3	10.5	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Coordination of care between providers and services (N=18)	3.22	5.6	16.7	44.4	16.7	16.7	0.0	100.1
Timely access to medical care providers (N=19)	3.16	5.3	26.3	31.6	21.1	15.8	0.0	100.1
Timely access to dental care providers (N=19)	3.05	5.3	36.8	15.8	31.6	10.5	0.0	100.0
Timely access to vision care providers (N=19)	2.95	5.3	36.8	26.3	21.1	10.5	0.0	100.0
Use of emergency room services for primary healthcare (N=19)	3.32	5.3	15.8	36.8	26.3	15.8	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=19)	3.58	0.0	15.8	15.8	63.2	5.3	0.0	100.1
Dementia and Alzheimer's disease (N=19)	3.26	5.3	10.5	36.8	47.4	0.0	0.0	100.0
Depression (N=19)	3.74	0.0	5.3	26.3	57.9	10.5	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=19)	3.74	0.0	10.5	21.1	52.6	15.8	0.0	100.0
Exposure to secondhand smoke (N=19)	2.74	10.5	31.6	36.8	15.8	5.3	0.0	100.0
Smoking and tobacco use (N=19)	2.89	5.3	21.1	52.6	21.1	0.0	0.0	100.1
Stress (N=19)	3.42	0.0	5.3	52.6	36.8	5.3	0.0	100.0
Suicide (N=19)	3.47	0.0	15.8	31.6	42.1	10.5	0.0	100.0

*Percentages may not total 100.0 due to rounding.

**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflect total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

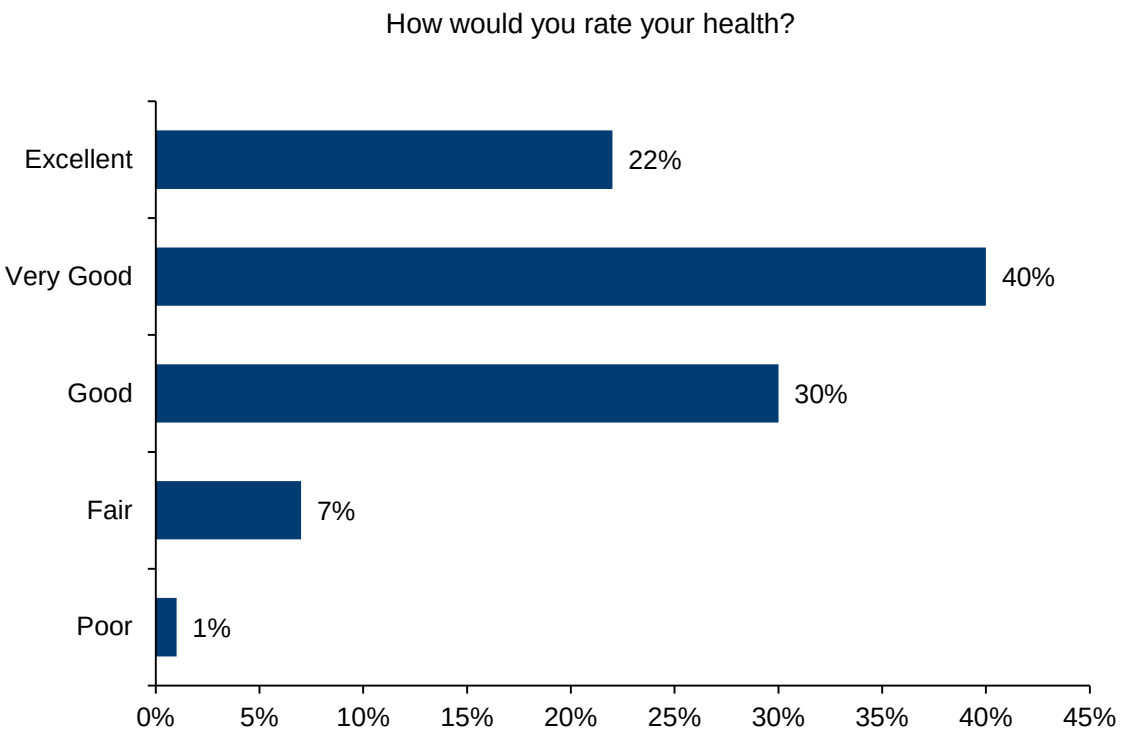
Resident Survey

Luverne CHNA Survey Report

NOTE: Missing 3 Aging Charts

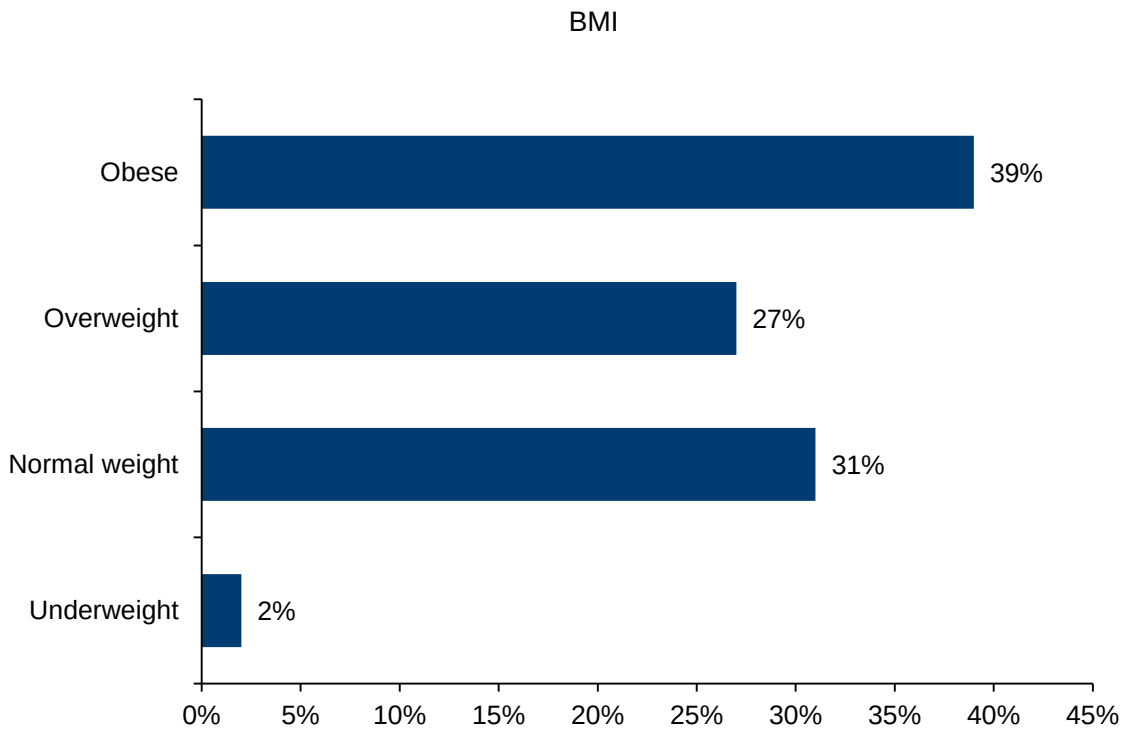
February 27, 2018

Sanford Health



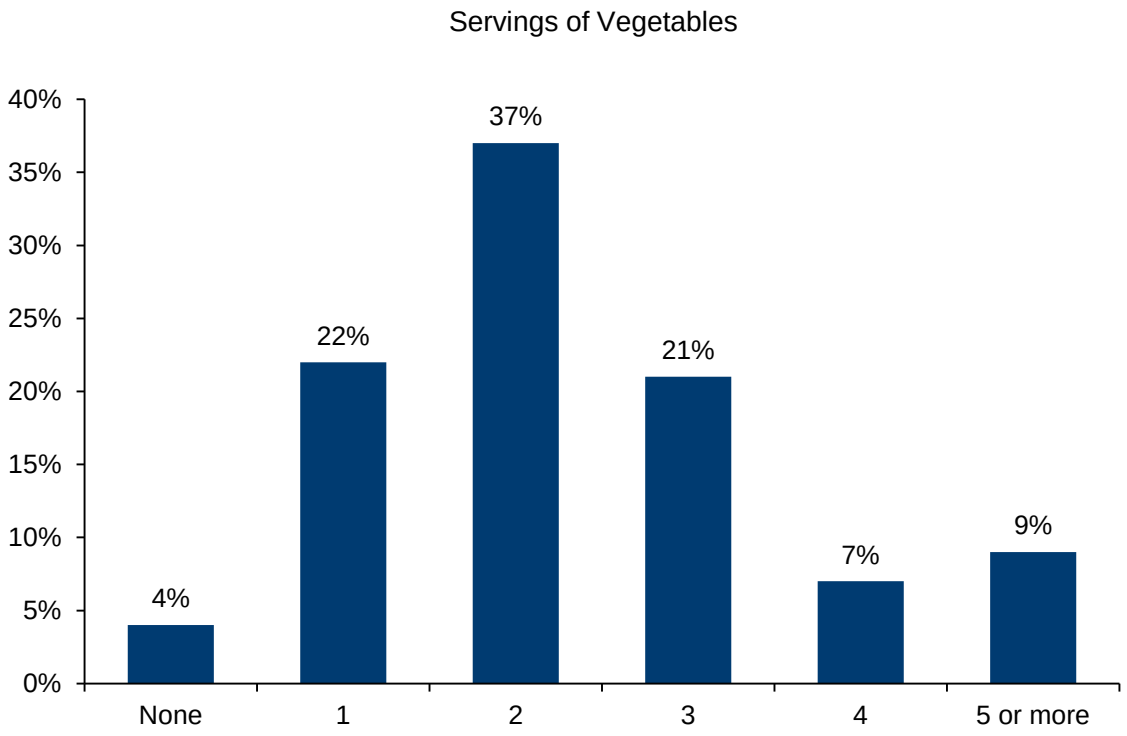
Base: Poor (n=1), Fair (n=7), Good (n=30), Very Good (n=40), Excellent (n=22), Sample Size = 100

(Community = Rock / Pipestone)



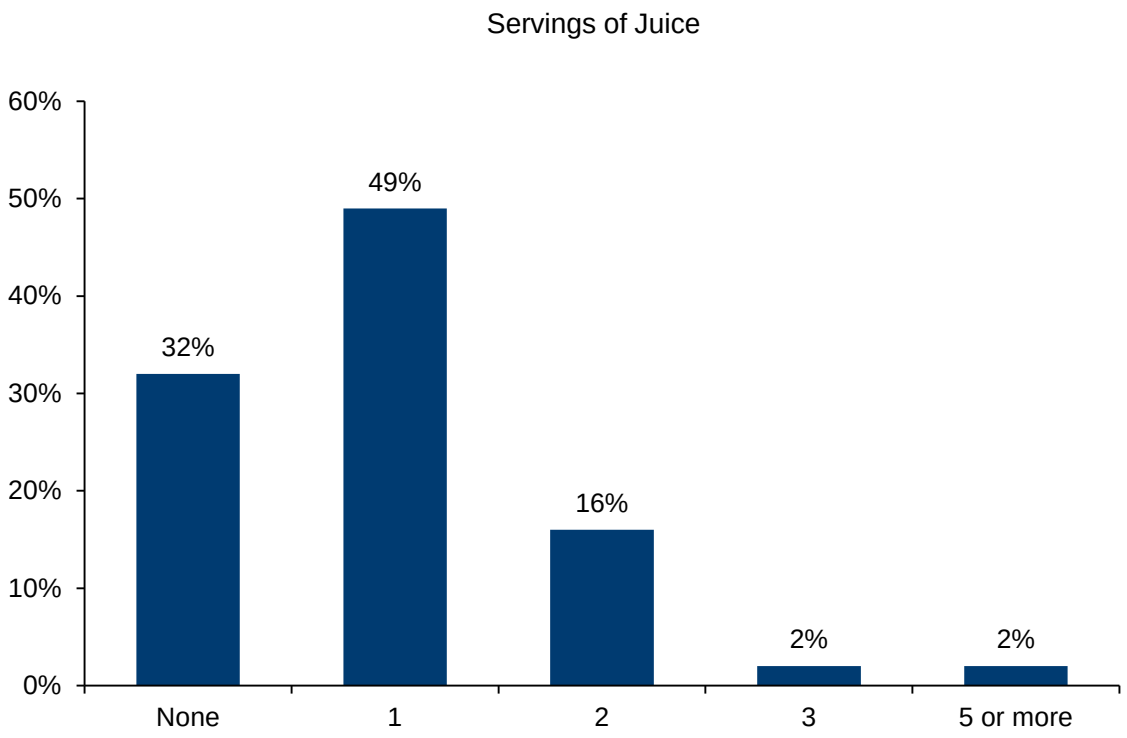
Base: Underweight (n=2), Normal weight (n=31), Overweight (n=27), Obese (n=39), Sample Size = 99

(Community = Rock / Pipestone)



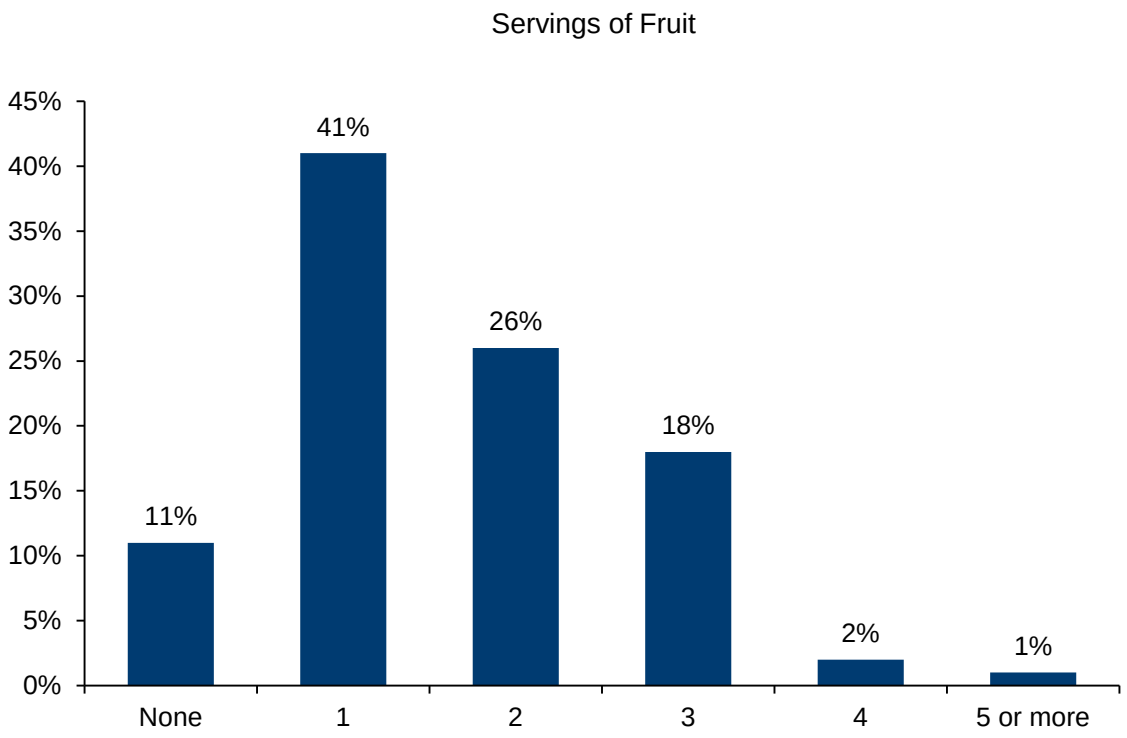
Base: None (n=4), 1 (n=20), 2 (n=33), 3 (n=19), 4 (n=6), 5 or more (n=8), Sample Size = 90

(Community = Rock / Pipestone)



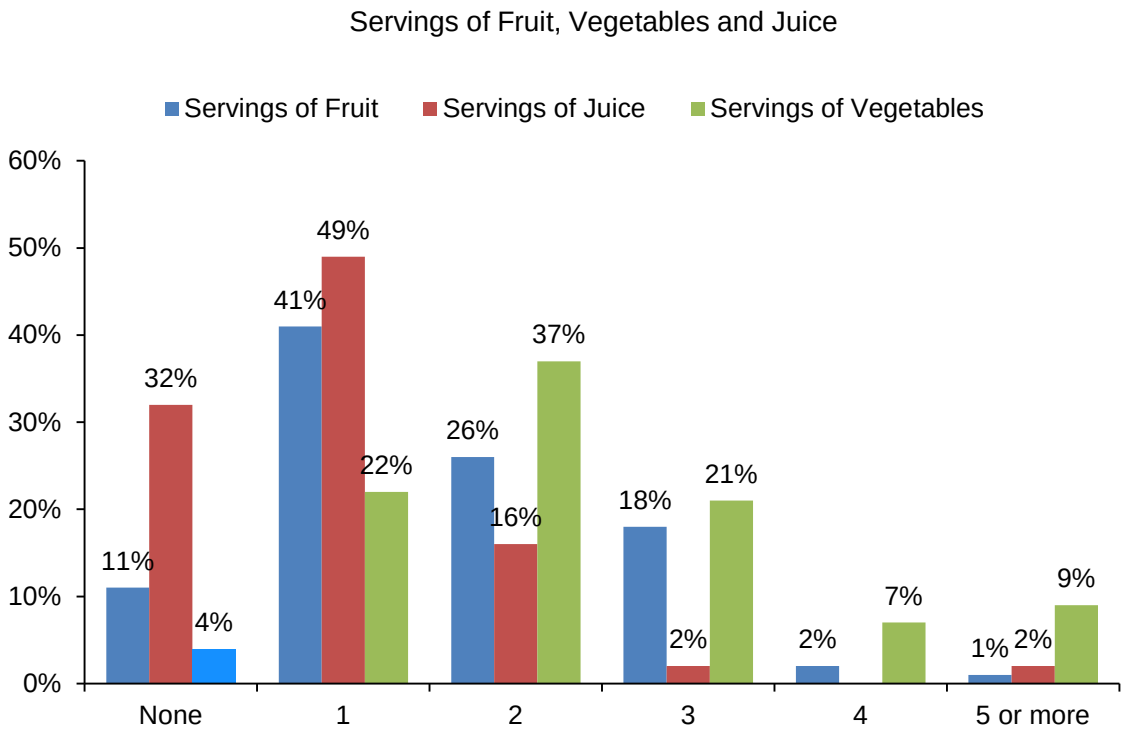
Base: None (n=18), 1 (n=28), 2 (n=9), 3 (n=1), 5 or more (n=1), Sample Size = 57

(Community = Rock / Pipestone)



Base: None (n=9), 1 (n=33), 2 (n=21), 3 (n=14), 4 (n=2), 5 or more (n=1), Sample Size = 80

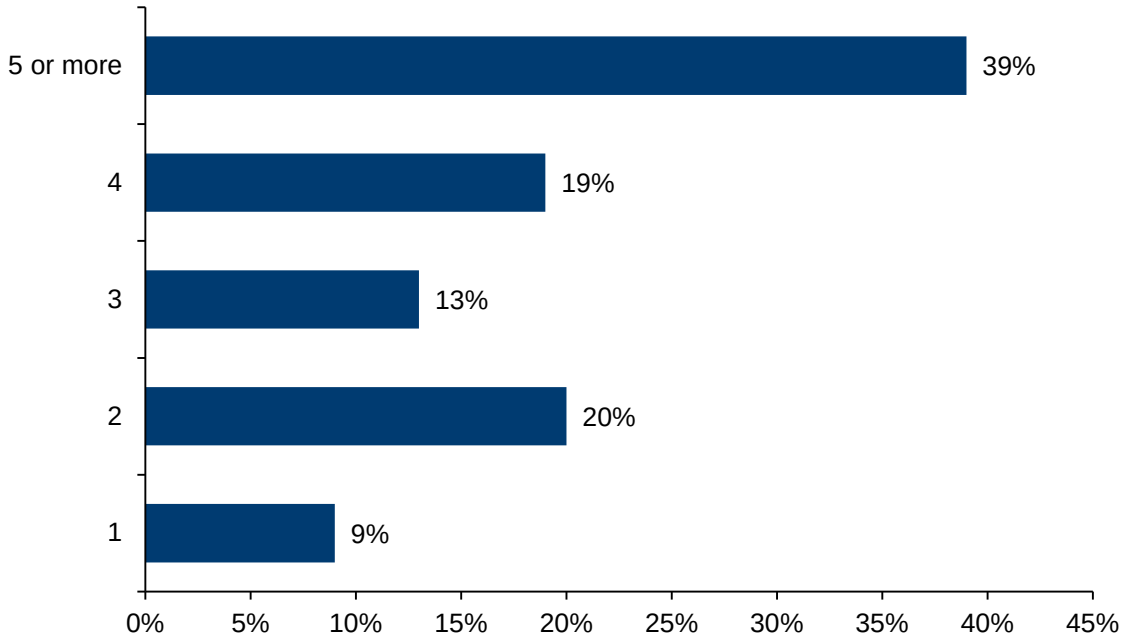
(Community = Rock / Pipestone)



Sample Size = Variable

(Community = Rock / Pipestone)

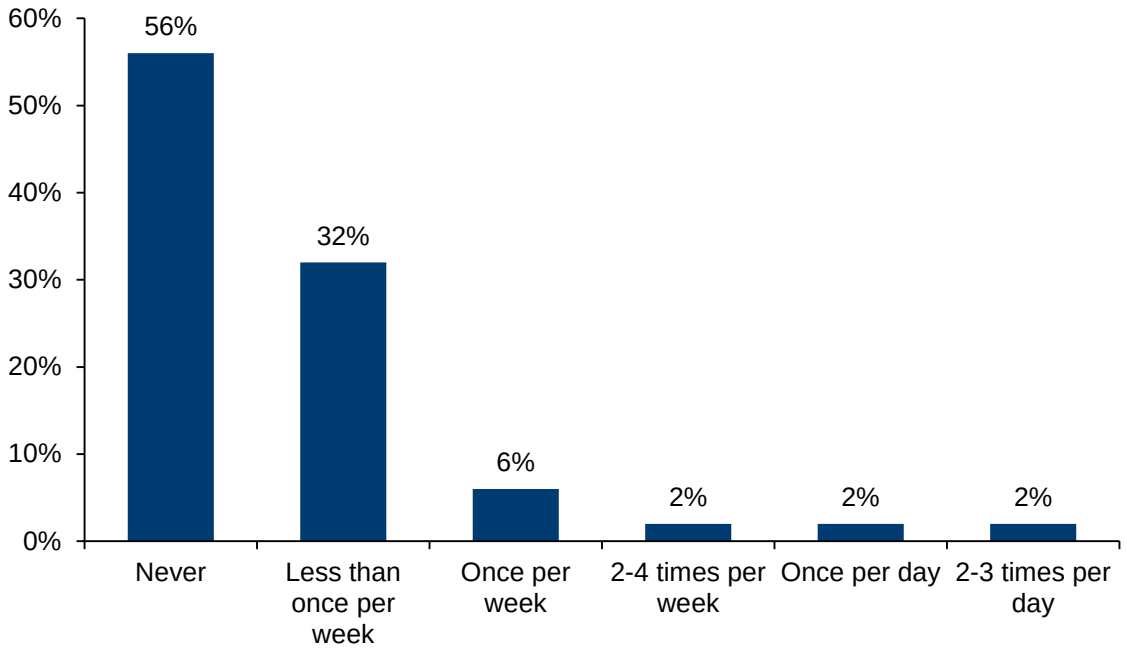
Total Servings of Fruits, Vegetables and Juice



Base: 1 (n=8), 2 (n=19), 3 (n=12), 4 (n=18), 5 or more (n=37), Sample Size = 94

(Community = Rock / Pipestone)

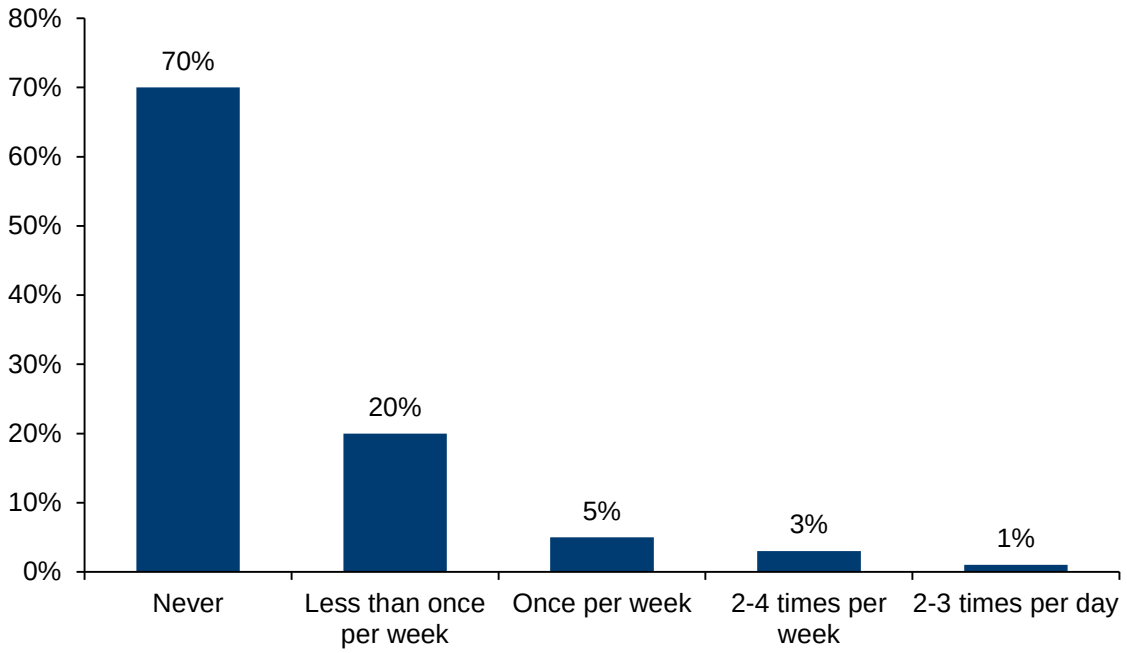
Snapple, Flavored Teas, Capri Sun, etc.



Base: Never (n=55), Less than once per week (n=31), Once per week (n=6), 2-4 times per week (n=2), Once per day (n=2), 2-3 times per day (n=2), Sample Size = 98

(Community = Rock / Pipestone)

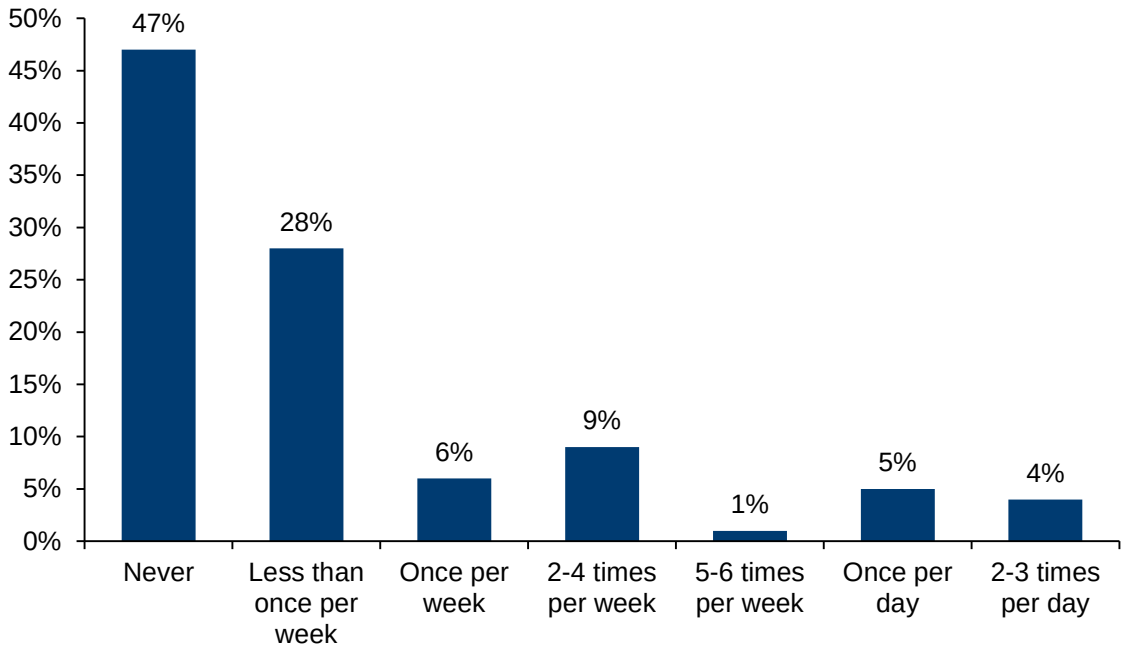
Gatorade, Powerade, etc.



Base: Never (n=69), Less than once per week (n=20), Once per week (n=5), 2-4 times per week (n=3), 2-3 times per day (n=1), Sample Size = 98

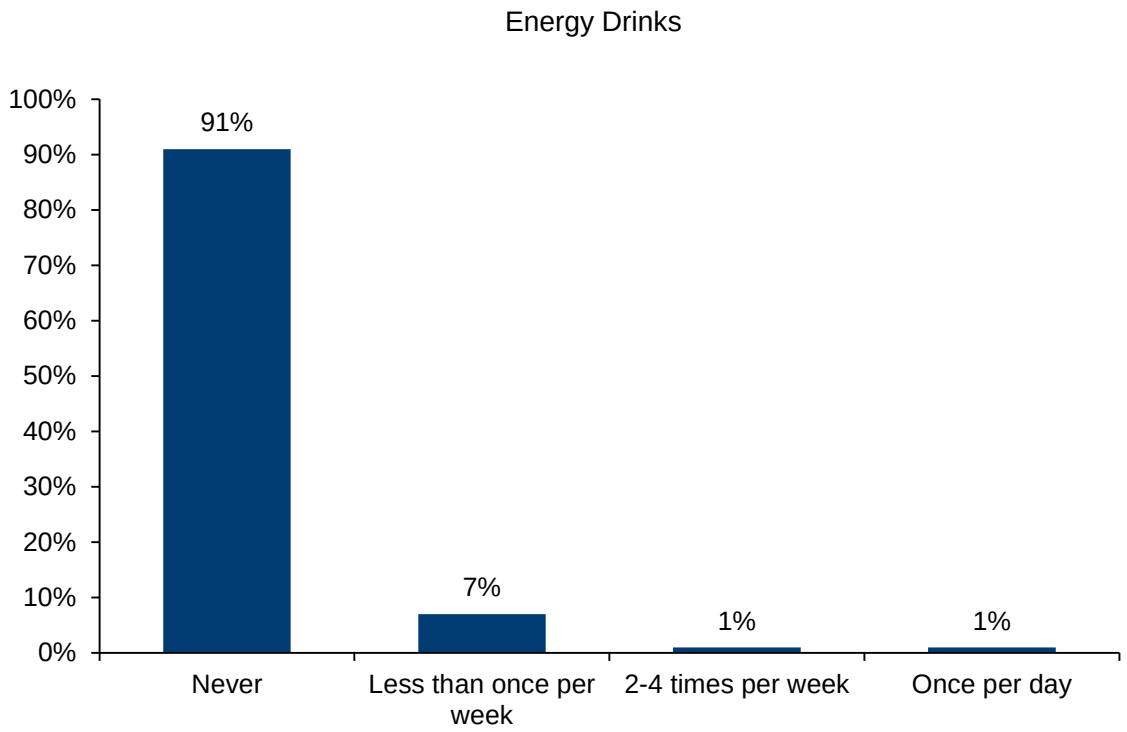
(Community = Rock / Pipestone)

Soda or Pop



Base: Never (n=47), Less than once per week (n=28), Once per week (n=6), 2-4 times per week (n=9), 5-6 times per week (n=1), Once per day (n=5), 2-3 times per day (n=4), Sample Size = 100

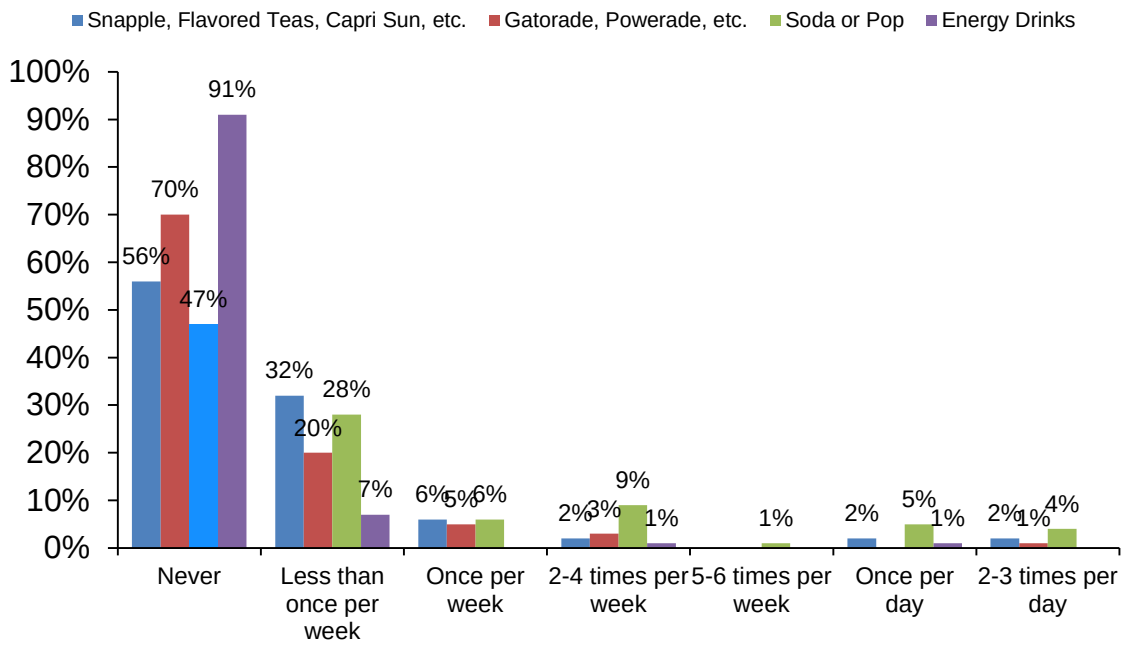
(Community = Rock / Pipestone)



Base: Never (n=89), Less than once per week (n=7), 2-4 times per week (n=1), Once per day (n=1), Sample Size = 98

(Community = Rock / Pipestone)

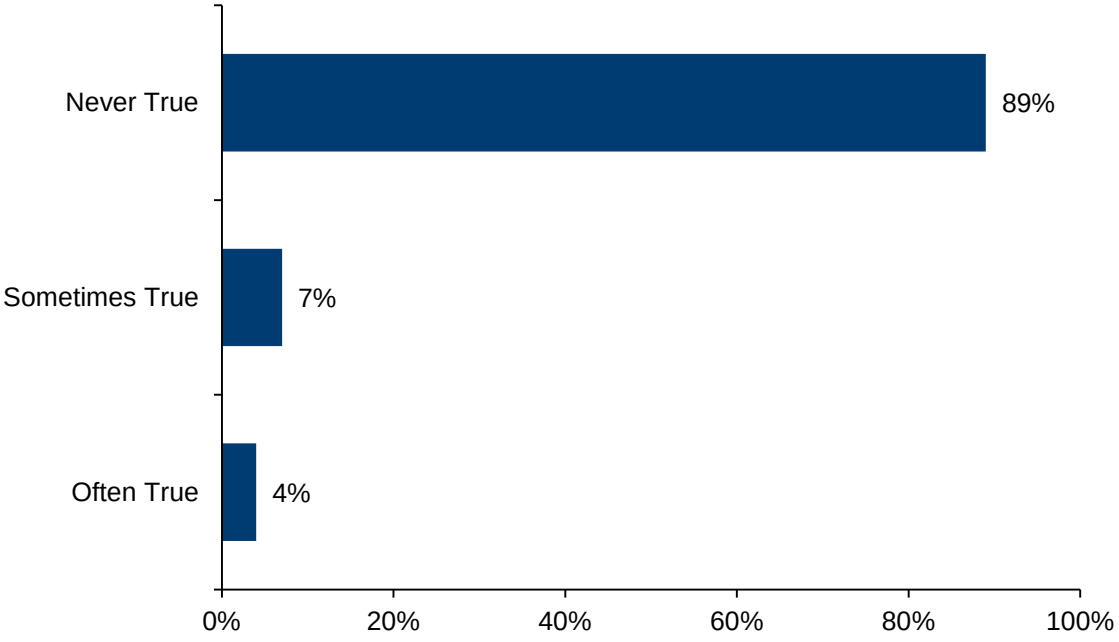
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Rock / Pipestone)

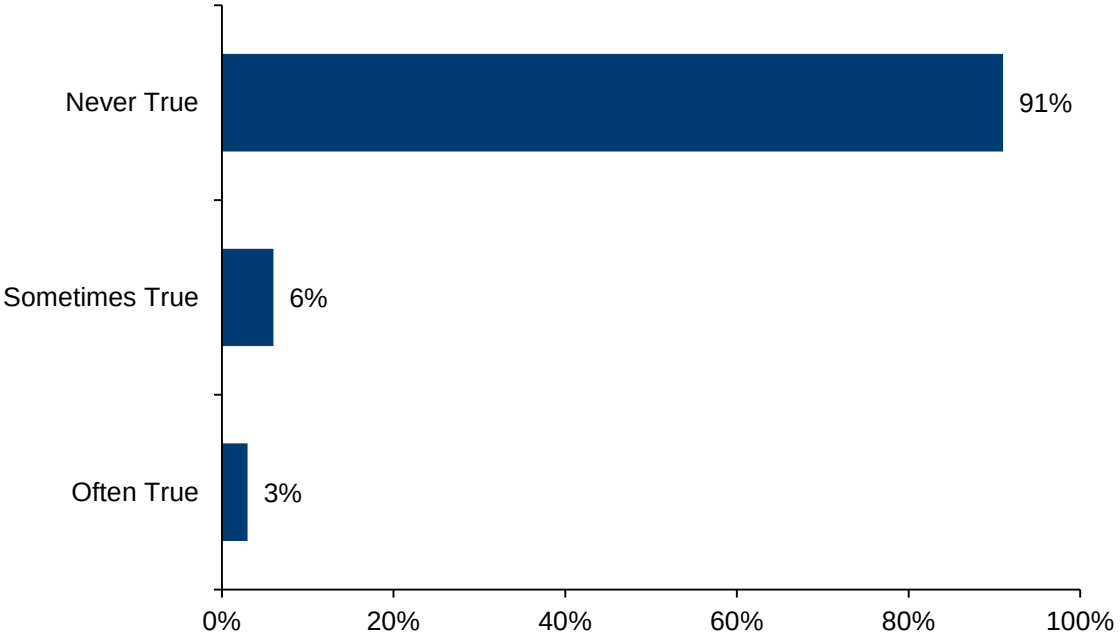
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=4), Sometimes True (n=7), Never True (n=89), Sample Size = 100

(Community = Rock / Pipestone)

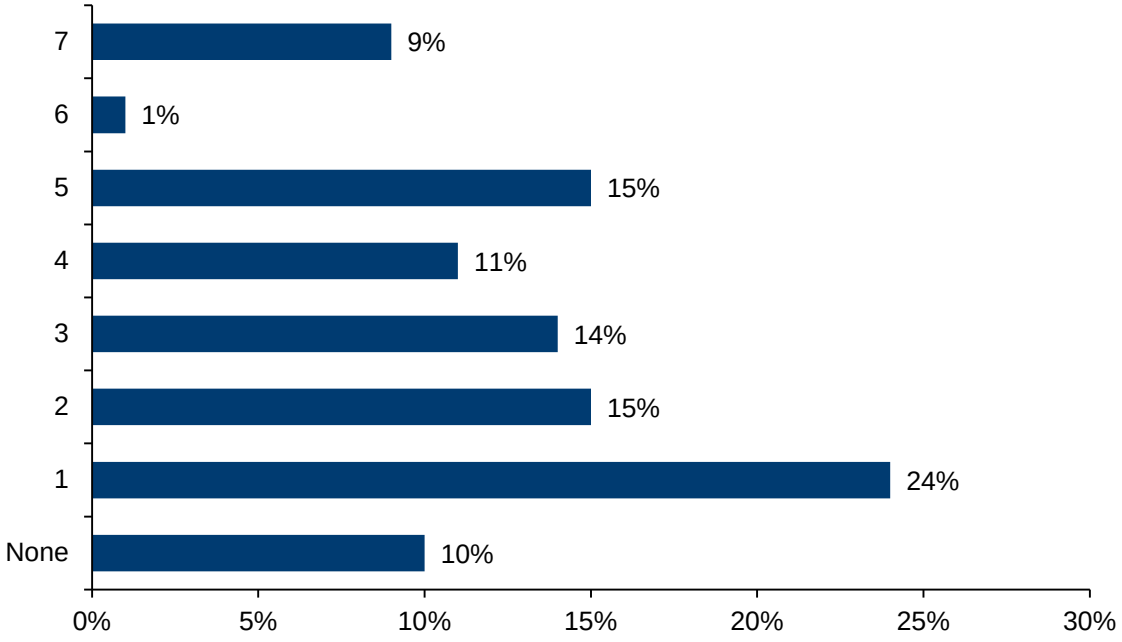
The food that we bought just didn’t last, and we didn’t have money to get more.



Base: Often True (n=3), Sometimes True (n=6), Never True (n=91), Sample Size = 100

(Community = Rock / Pipestone)

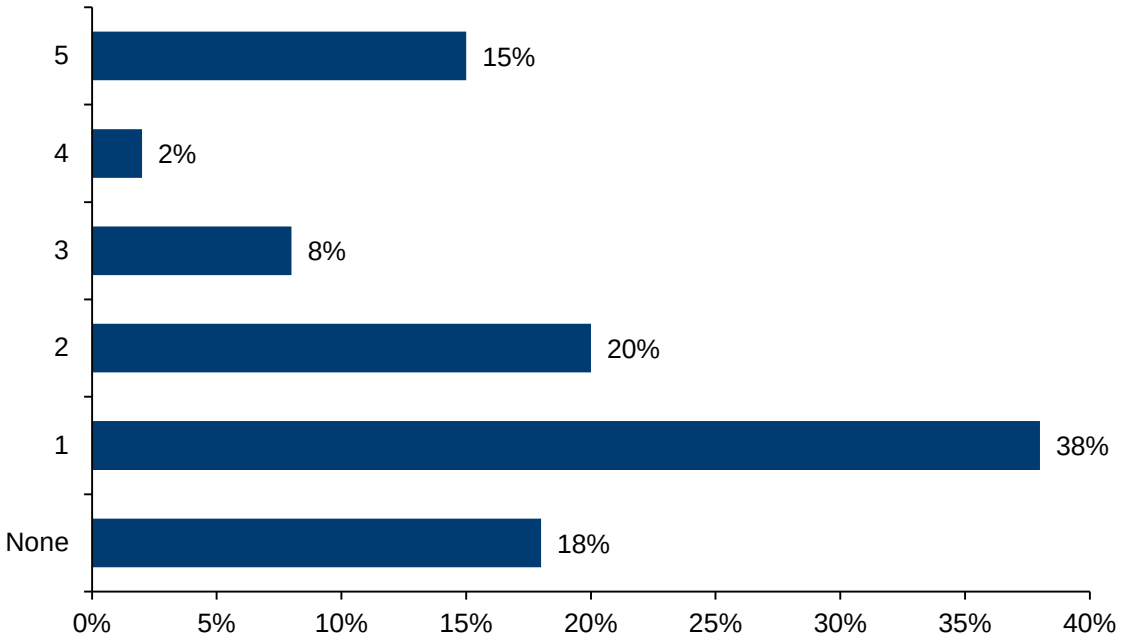
Days Per Week of Moderate Physical Activity



Base: None (n=9), 1 (n=22), 2 (n=14), 3 (n=13), 4 (n=10), 5 (n=14), 6 (n=1), 7 (n=8), Sample Size = 91

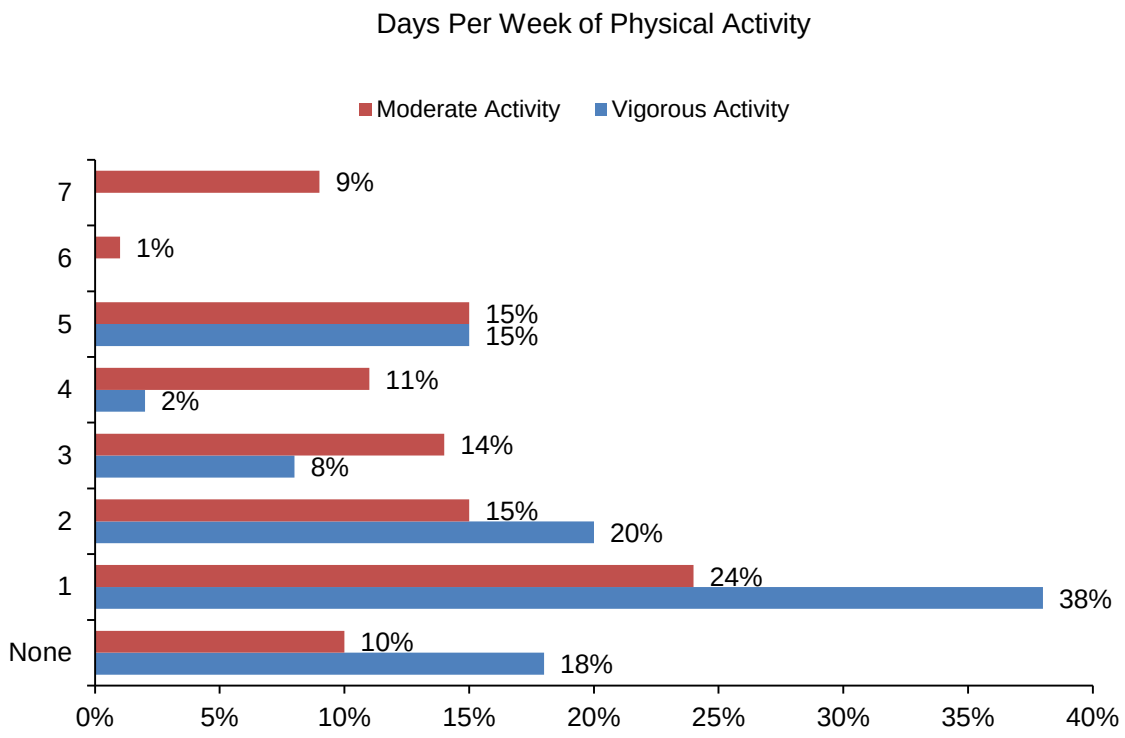
(Community = Rock / Pipestone)

Days Per Week of Vigorous Physical Activity



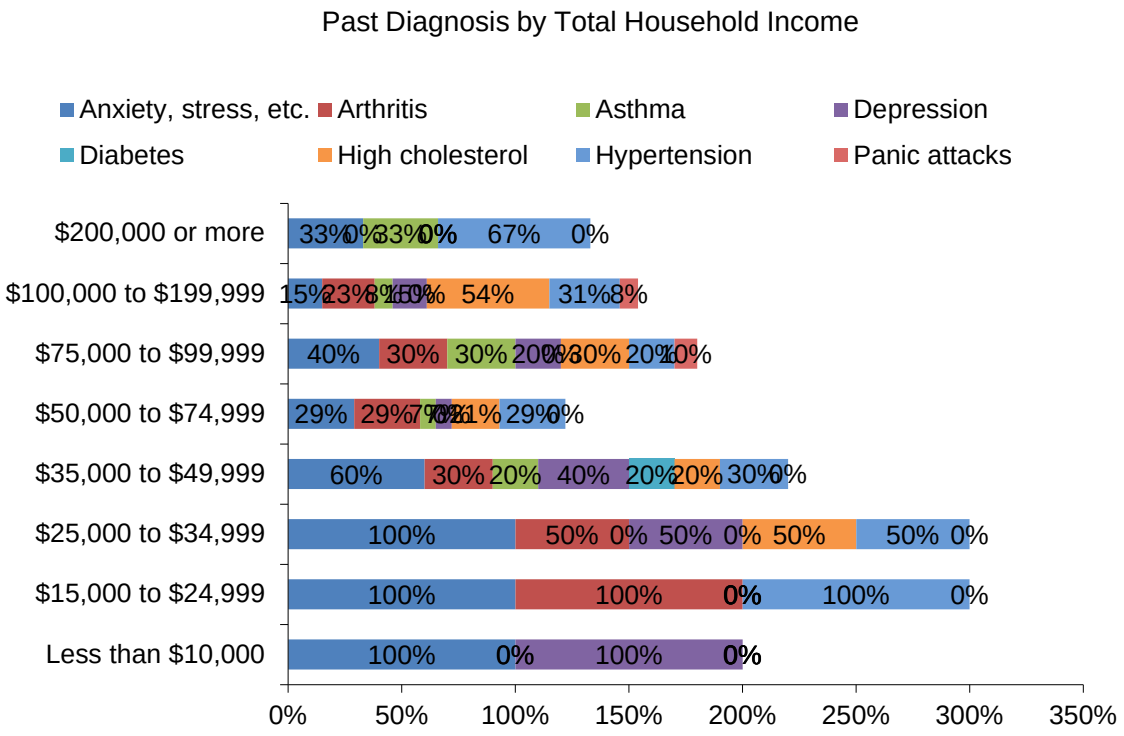
Base: None (n=12), 1 (n=25), 2 (n=13), 3 (n=5), 4 (n=1), 5 (n=10), Sample Size = 66

(Community = Rock / Pipestone)



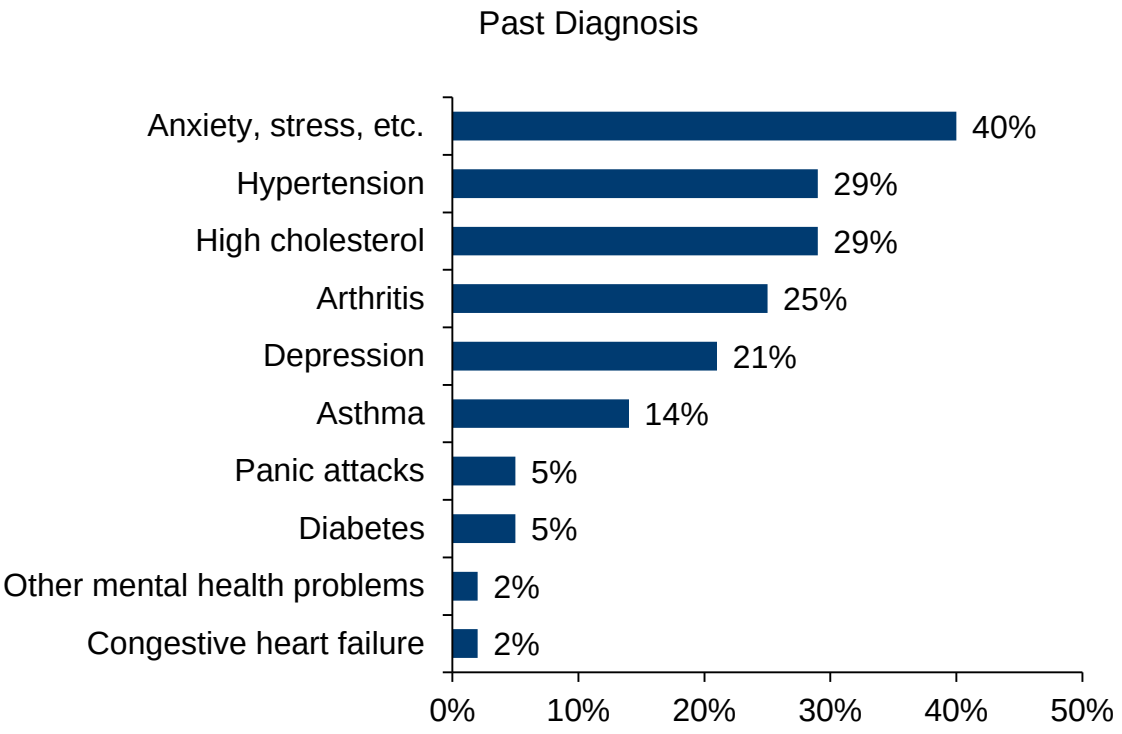
Sample Size = Variable

(Community = Rock / Pipestone)

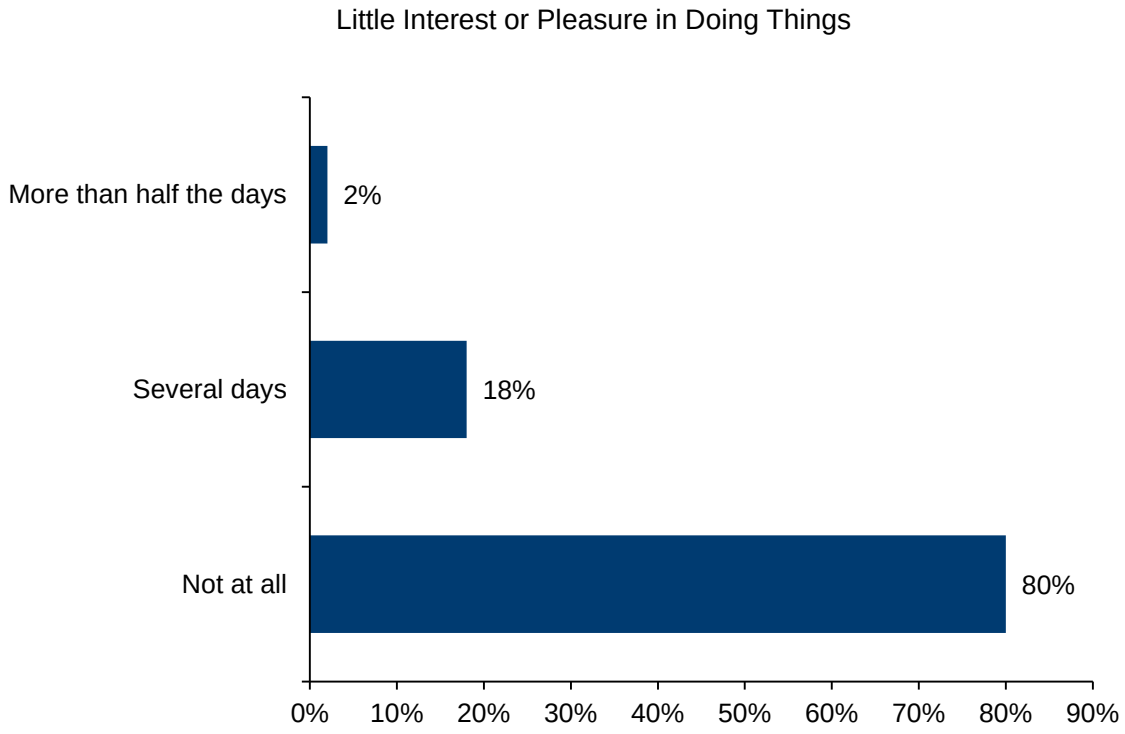


Base: Less than $10,000 (n=1), $15,000 to $24,999 (n=1), $25,000 to $34,999 (n=2), $35,000 to $49,999 (n=10), $50,000 to $74,999 (n=14), $75,000 to $99,999 (n=10), $100,000 to $199,999 (n=13), $200,000 or more (n=3), Sample Size = 54

(Community = Rock / Pipestone)

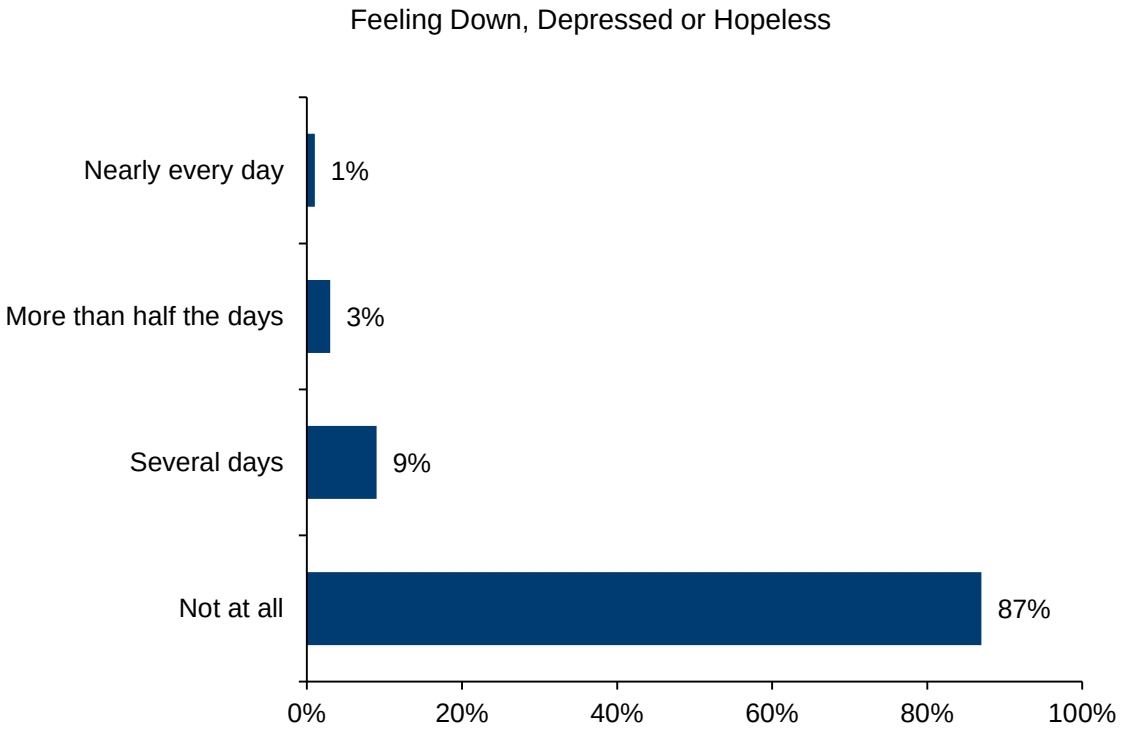


Base: Anxiety, stress, etc. (n=25), Arthritis (n=16), Asthma (n=9), Congestive heart failure (n=1), Depression (n=13), Diabetes (n=3), High cholesterol (n=18), Hypertension (n=18), Other mental health problems (n=1), Panic attacks (n=3), Sample Size = 63 (Community = Rock / Pipestone)



Base: Not at all (n=80), Several days (n=18), More than half the days (n=2), Sample Size = 100

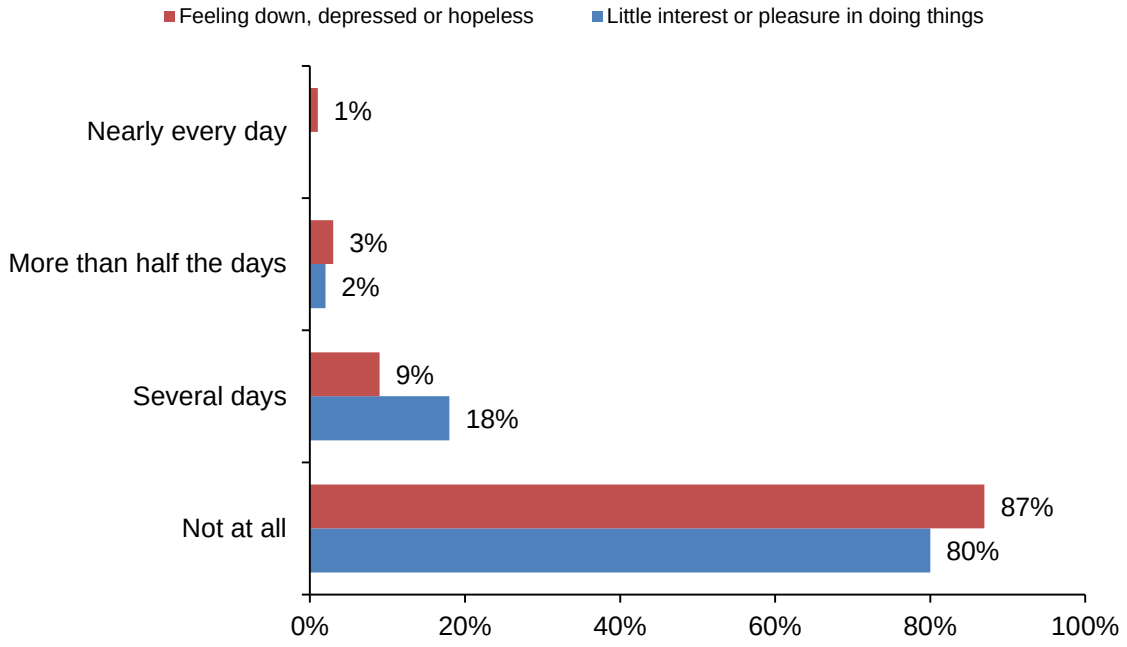
(Community = Rock / Pipestone)



Base: Not at all (n=87), Several days (n=9), More than half the days (n=3), Nearly every day (n=1), Sample Size = 100

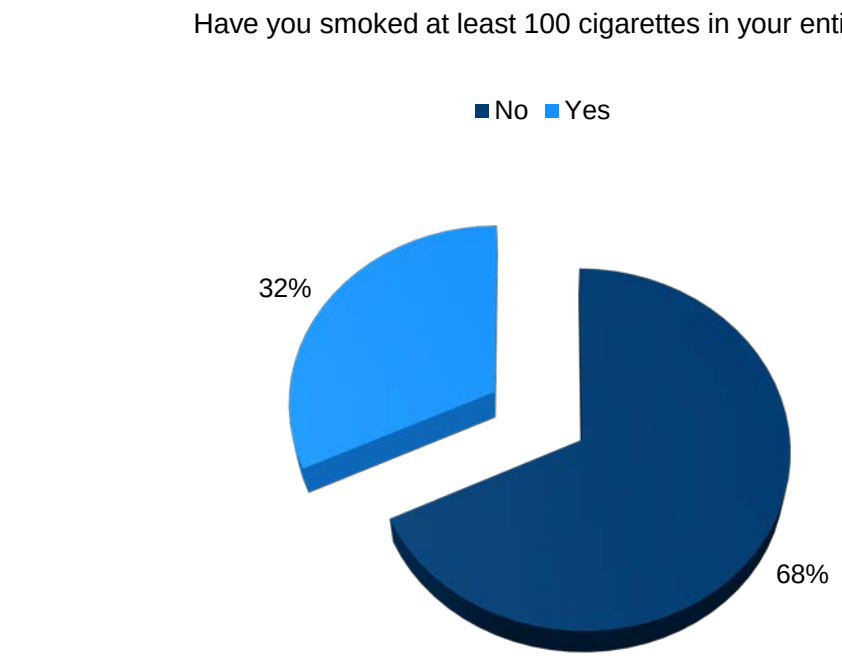
(Community = Rock / Pipestone)

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



Sample Size = 100

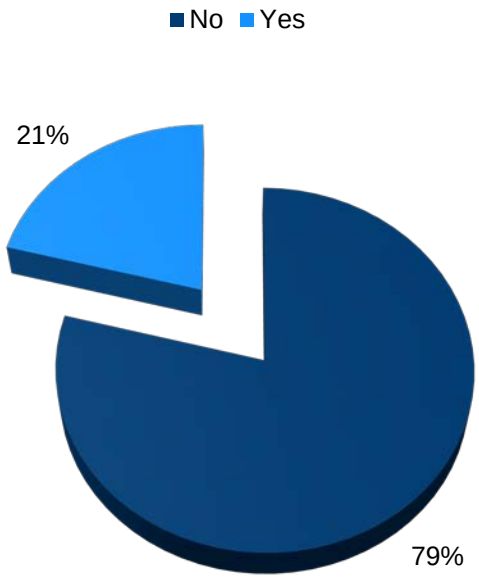
(Community = Rock / Pipestone)



Base: Yes (n=32), No (n=68), Sample Size = 100

(Community = Rock / Pipestone)

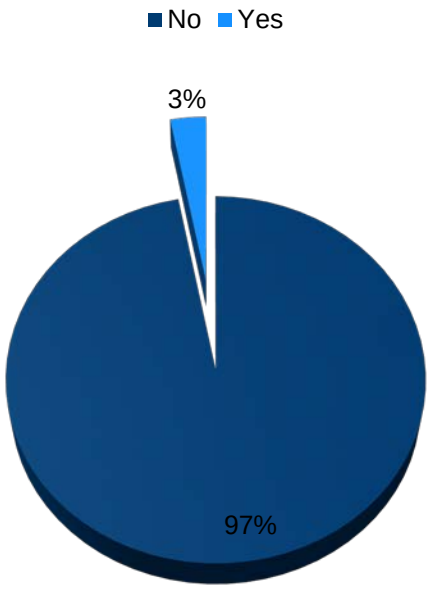
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=21), No (n=79), Sample Size = 100

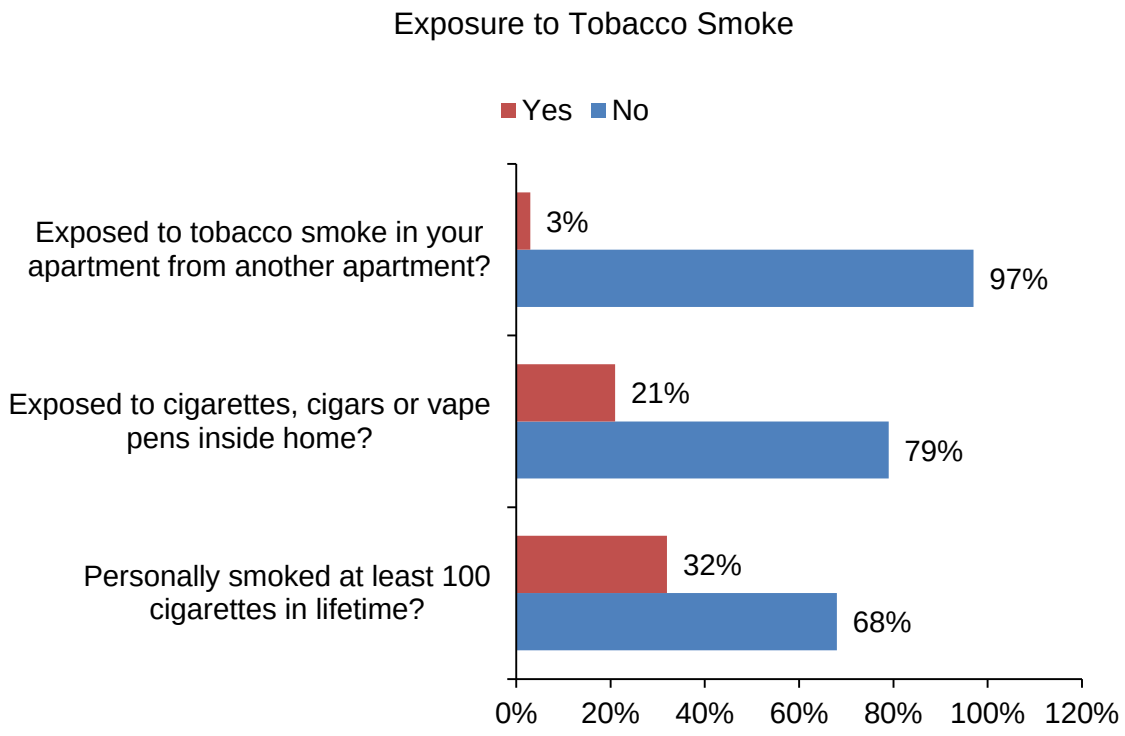
(Community = Rock / Pipestone)

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



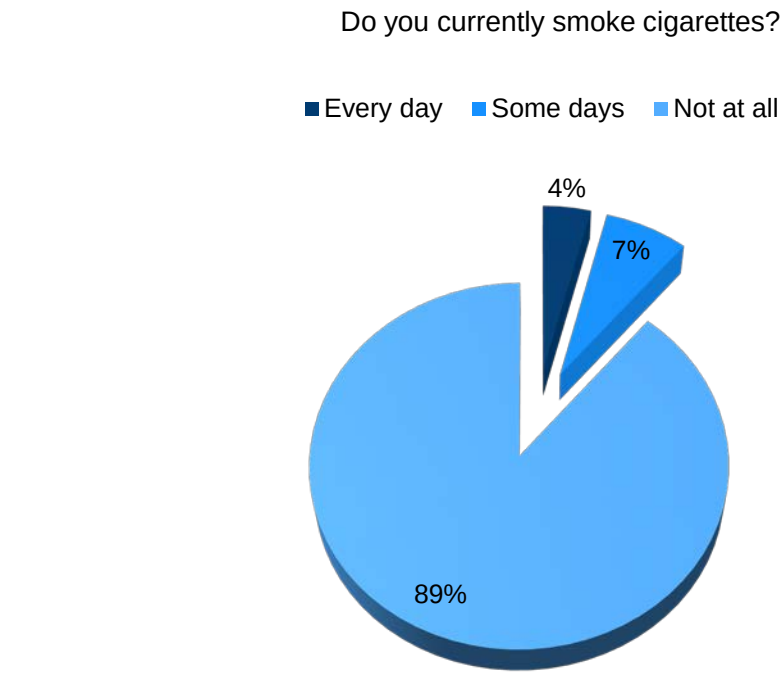
Base: Yes (n=3), No (n=97), Sample Size = 100

(Community = Rock / Pipestone)



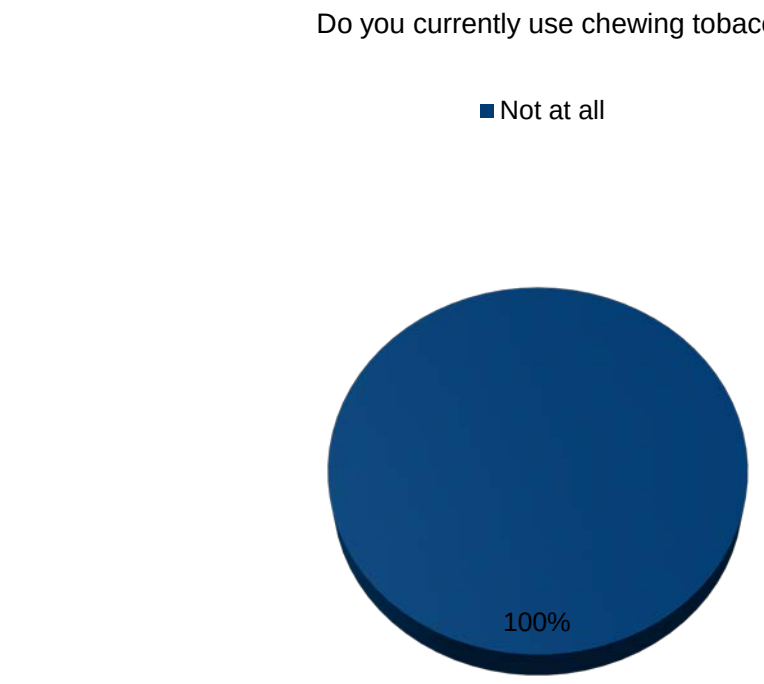
Base: Personally smoked at least 100 cigarettes in lifetime? (n=100), Exposed to cigarettes, cigars or vape pens inside home? (n=100), Exposed to tobacco smoke in your apartment from another apartment? (n=100), Sample Size = 100

(Community = Rock / Pipestone)



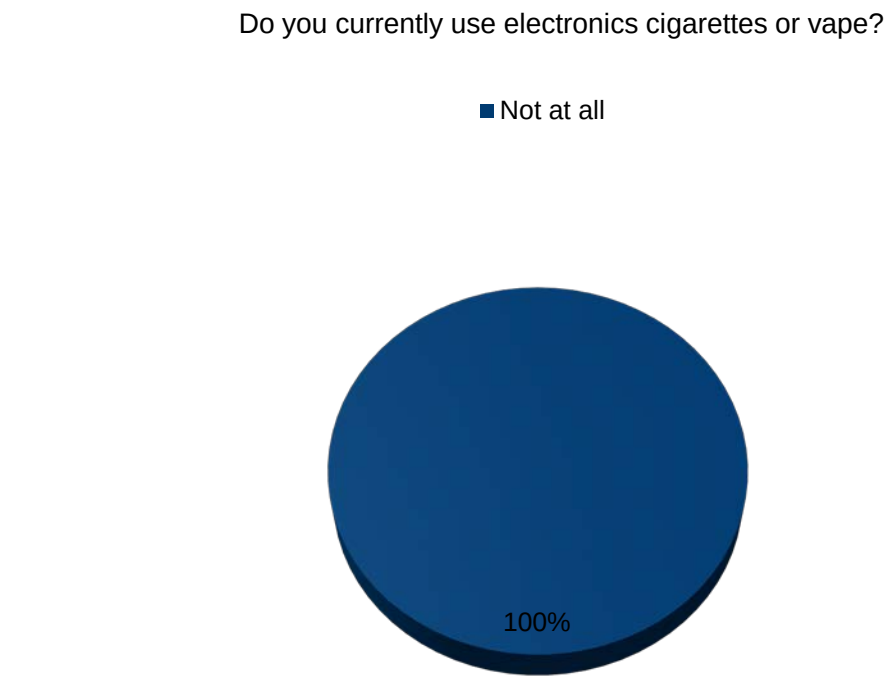
Base: Not at all (n=89), Some days (n=7), Every day (n=4), Sample Size = 100

(Community = Rock / Pipestone)



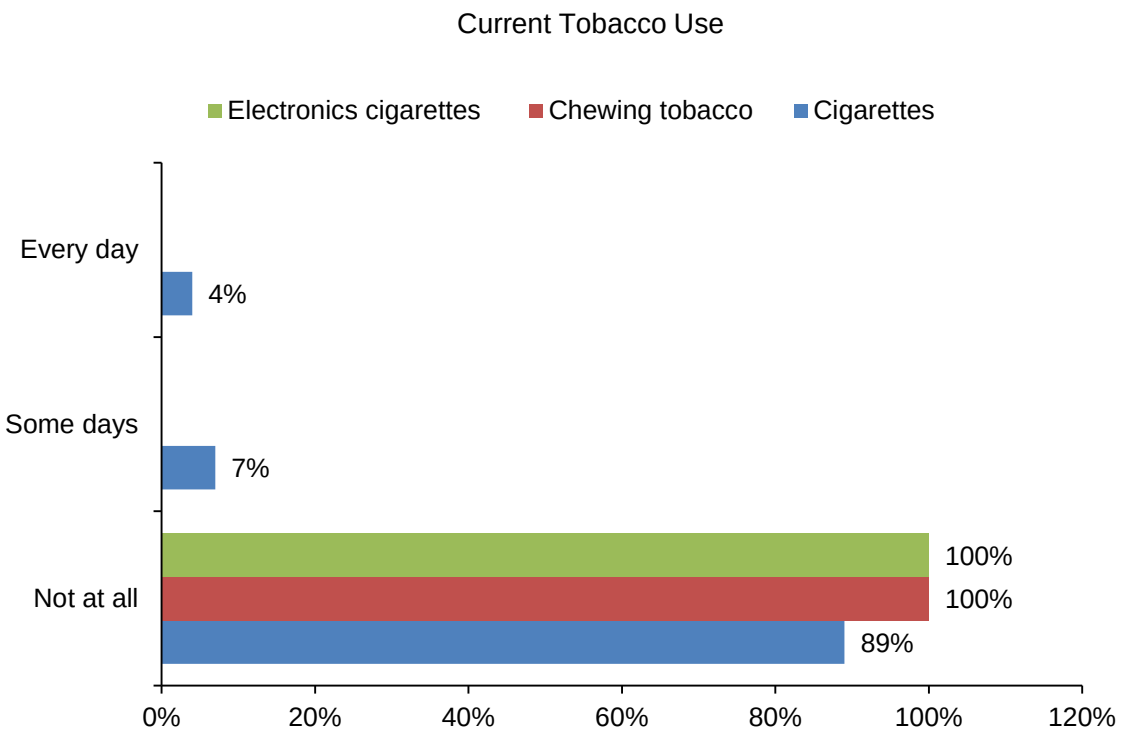
Base: Not at all (n=100), Sample Size = 100

(Community = Rock / Pipestone)



Base: Not at all (n=100), Sample Size = 100

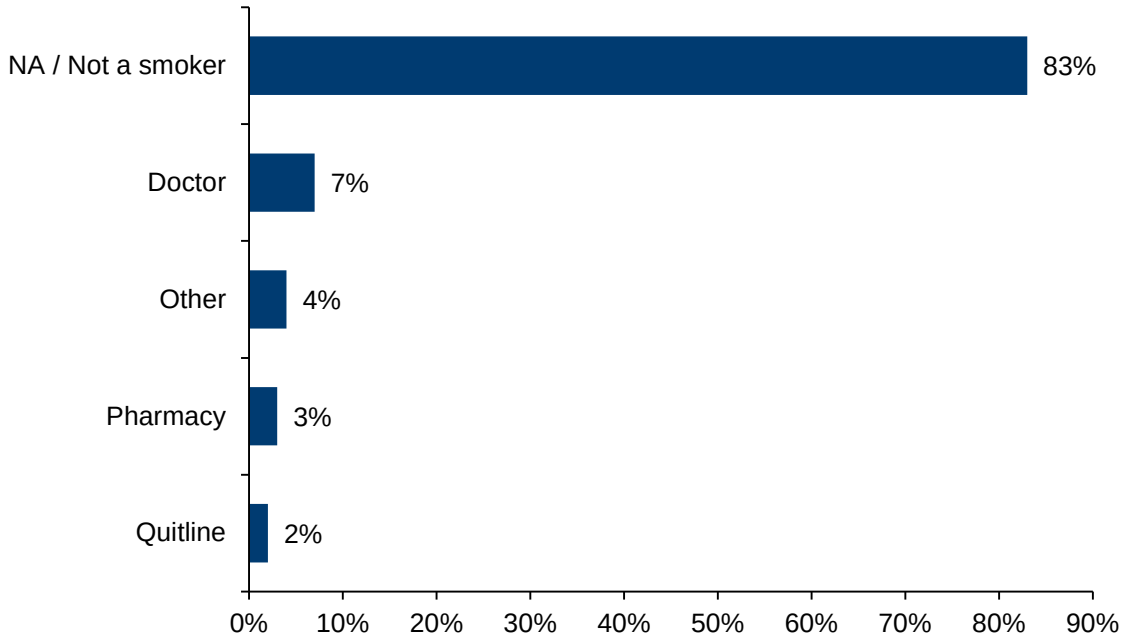
(Community = Rock / Pipestone)



Sample Size = 100

(Community = Rock / Pipestone)

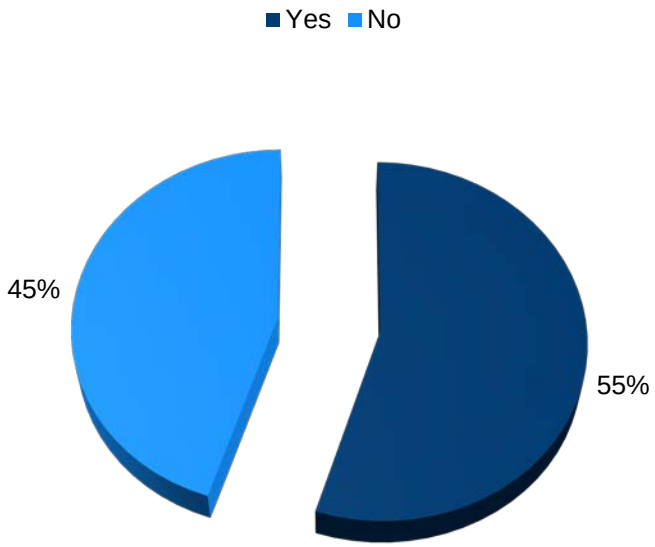
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=78), Quitline (n=2), Doctor (n=7), Pharmacy (n=3), Other (n=4), Sample Size = 94

(Community = Rock / Pipestone)

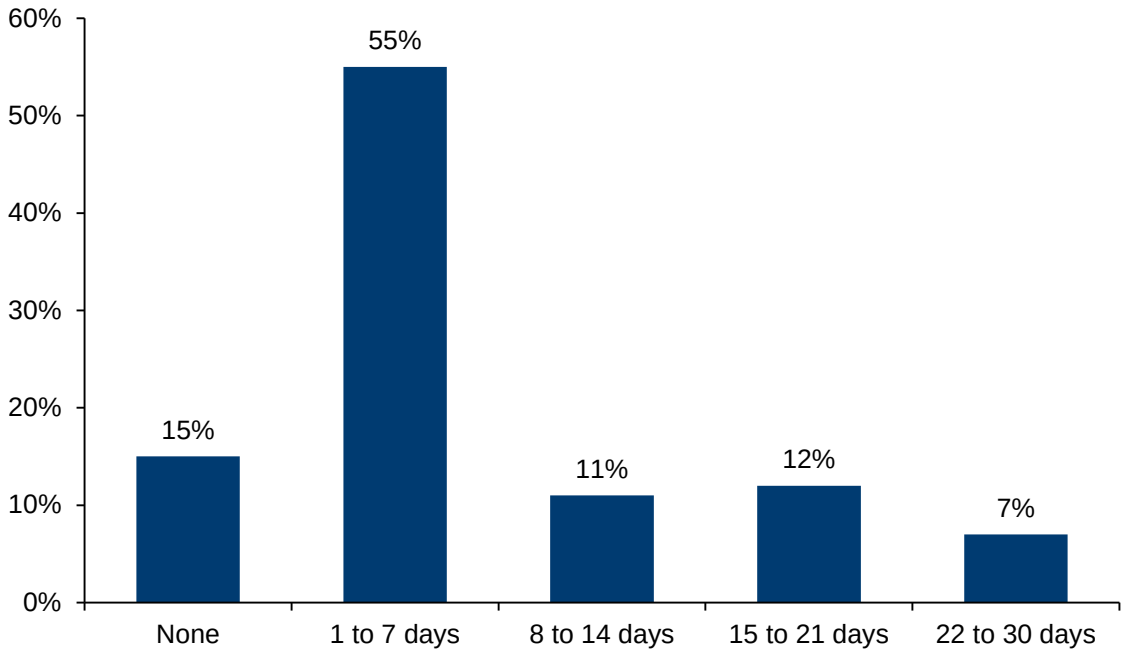
During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit? (Smokers only)



Base: Yes (n=6), No (n=5), Sample Size = 11

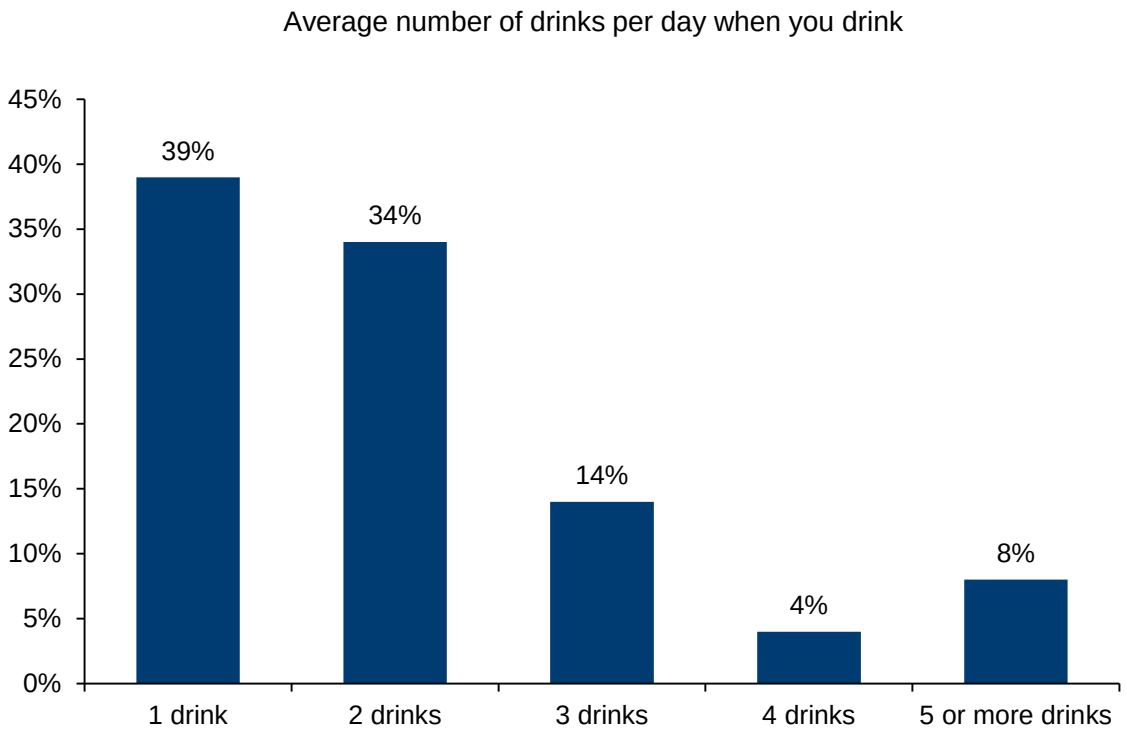
(Community = Rock / Pipestone)

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



Base: None (n=13), 1 to 7 days (n=47), 8 to 14 days (n=9), 15 to 21 days (n=10), 22 to 30 days (n=6), Sample Size = 85

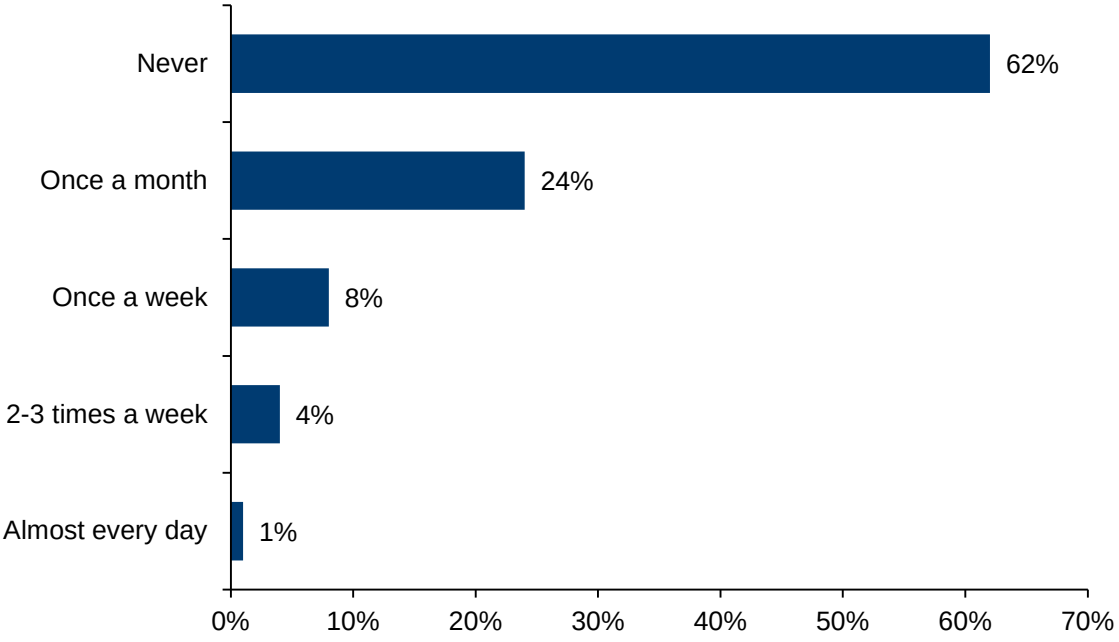
(Community = Rock / Pipestone)



Base: 1 drink (n=28), 2 drinks (n=24), 3 drinks (n=10), 4 drinks (n=3), 5 or more drinks (n=6), Sample Size = 71

(Community = Rock / Pipestone)

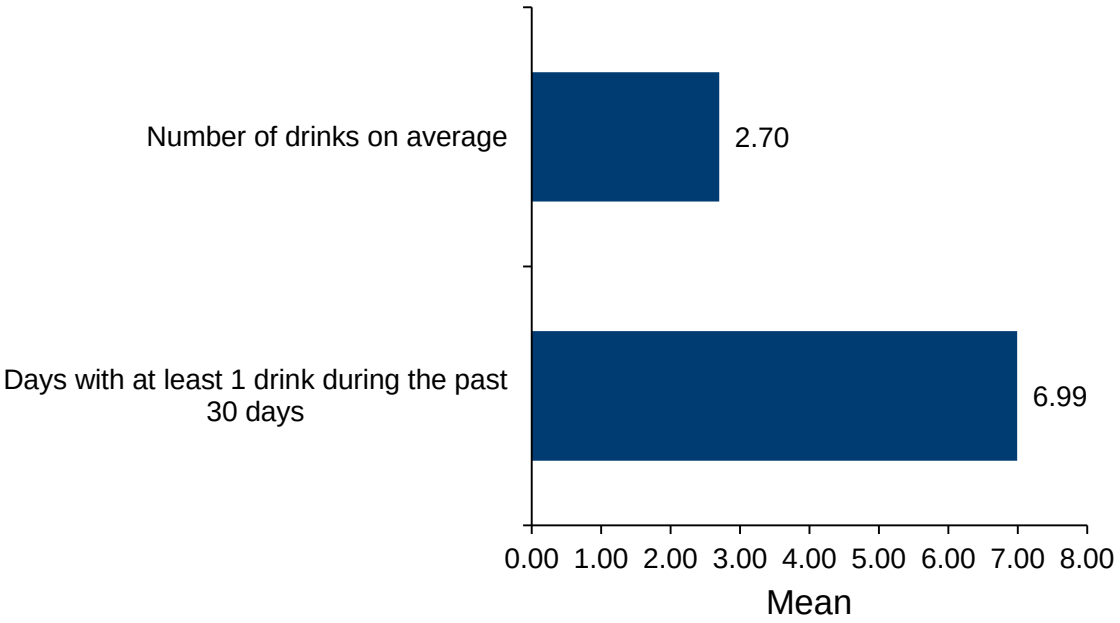
Binge Drinking



Base: Almost every day (n=1), 2-3 times a week (n=3), Once a week (n=6), Once a month (n=17), Never (n=45), Sample Size = 72

(Community = Rock / Pipestone)

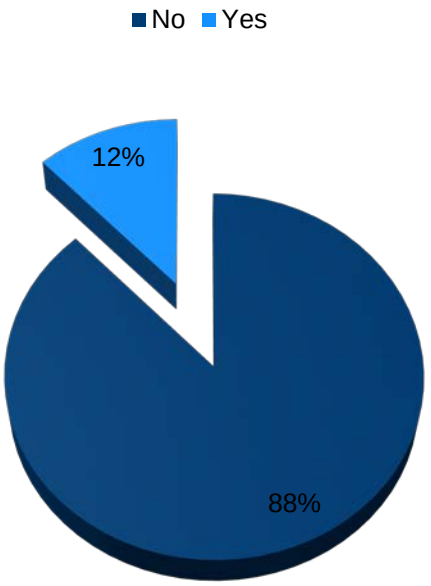
Average Alcohol Use During the Past 30 Days



Base: Days with at least 1 drink during the past 30 days (n=85), Number of drinks on average (n=71), Sample Size = Variable

(Community = Rock / Pipestone)

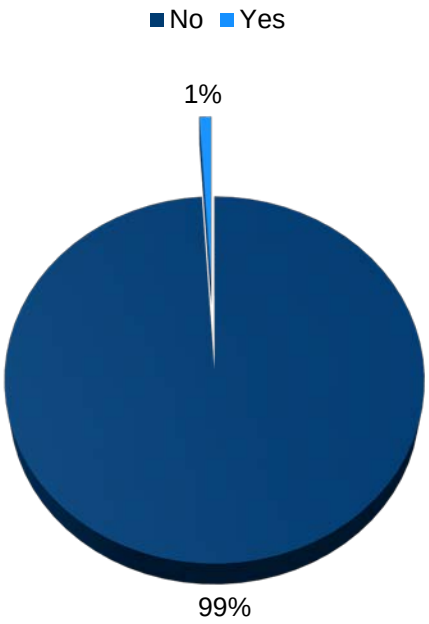
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=12), No (n=87), Sample Size = 99

(Community = Rock / Pipestone)

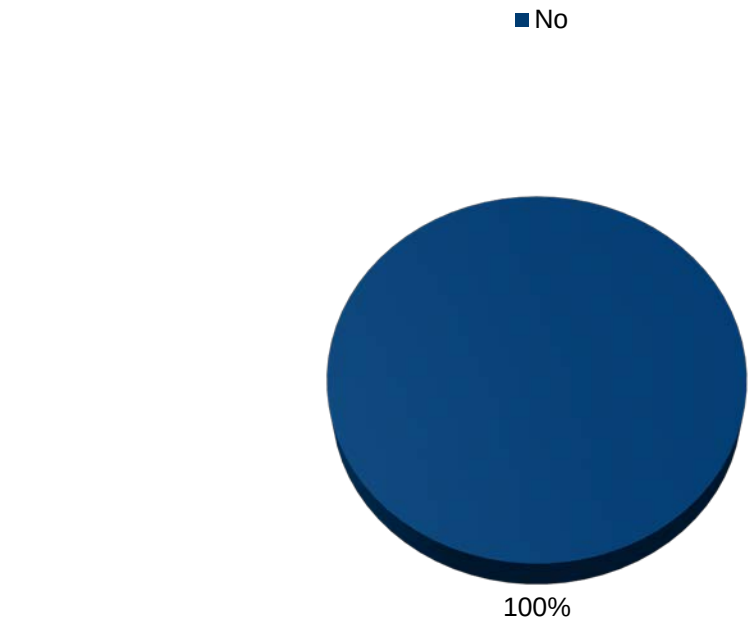
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=1), No (n=99), Sample Size = 100

(Community = Rock / Pipestone)

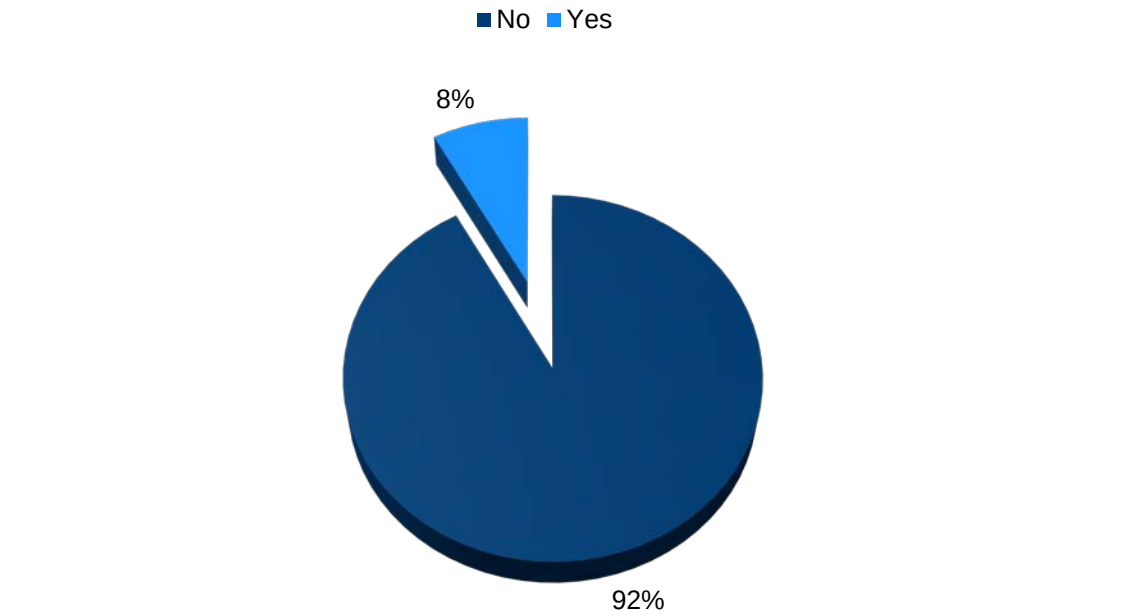
Has a family member or friend ever suggested that you get help for substance use?



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

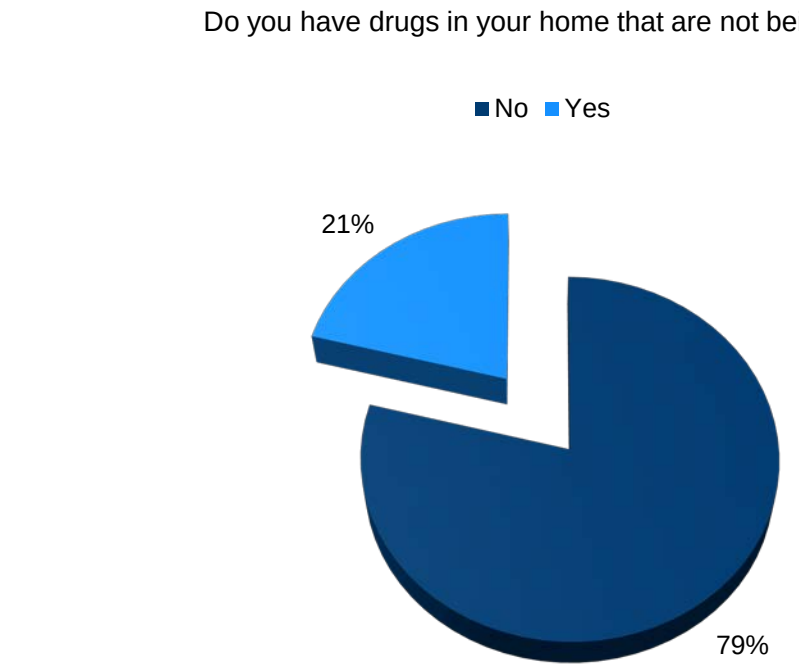
(Community = Rock / Pipestone)

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



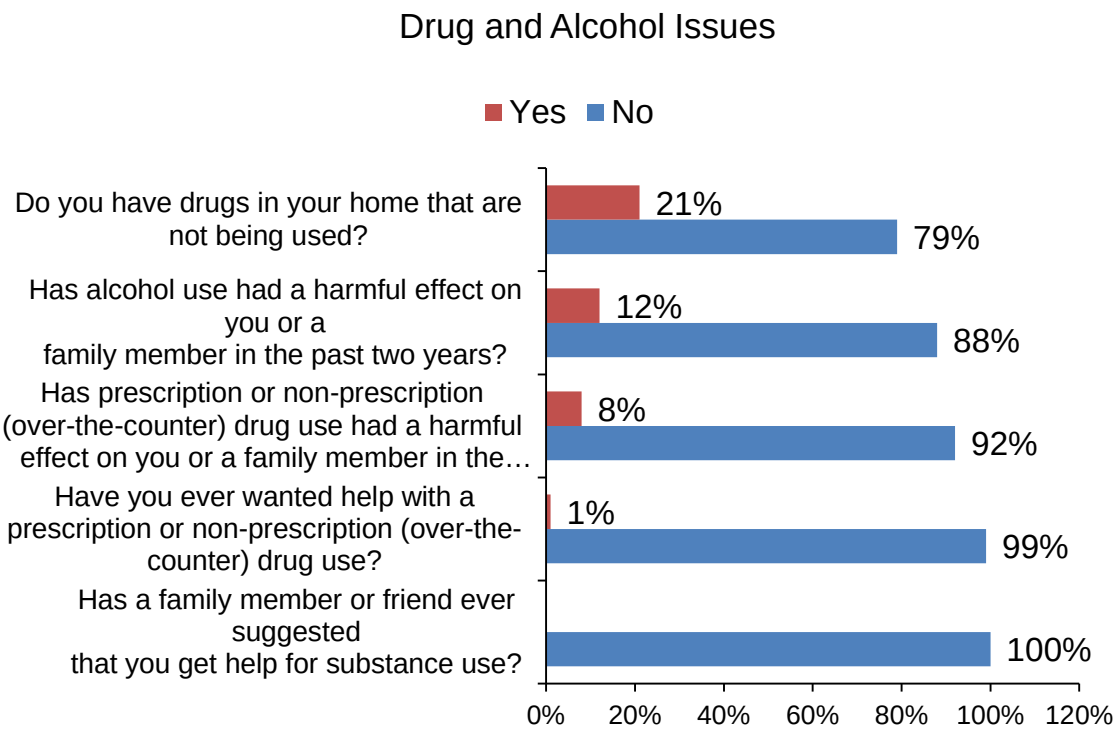
Base: Yes (n=8), No (n=92), Sample Size = 100

(Community = Rock / Pipestone)



Base: Yes (n=21), No (n=79), Sample Size = 100

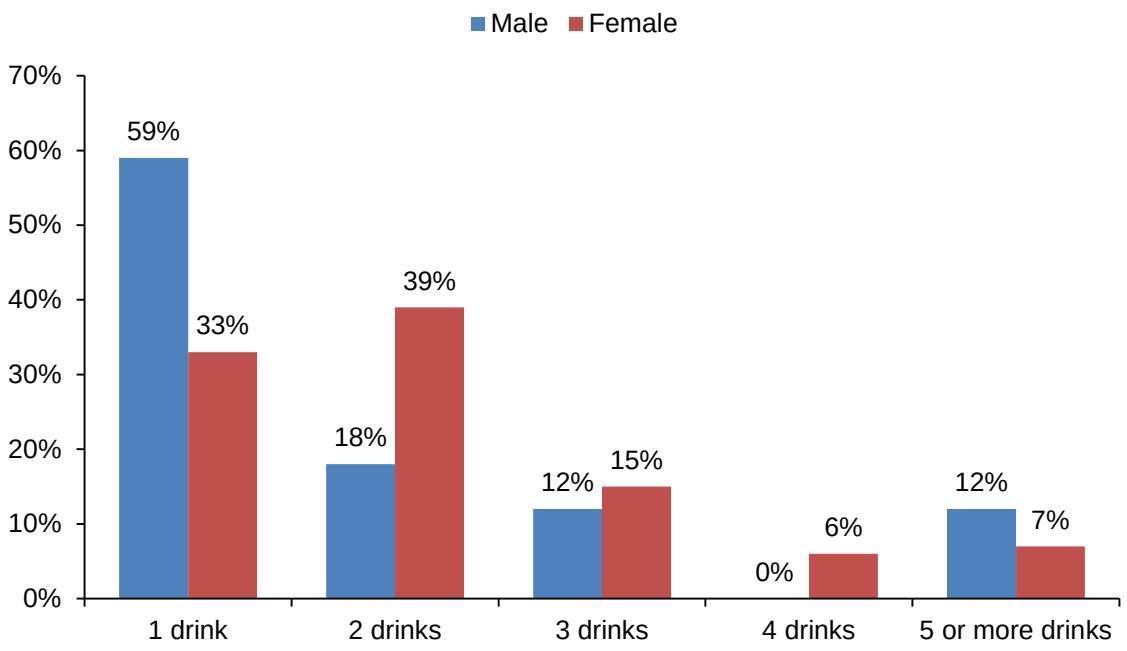
(Community = Rock / Pipestone)



Sample Size = Variable

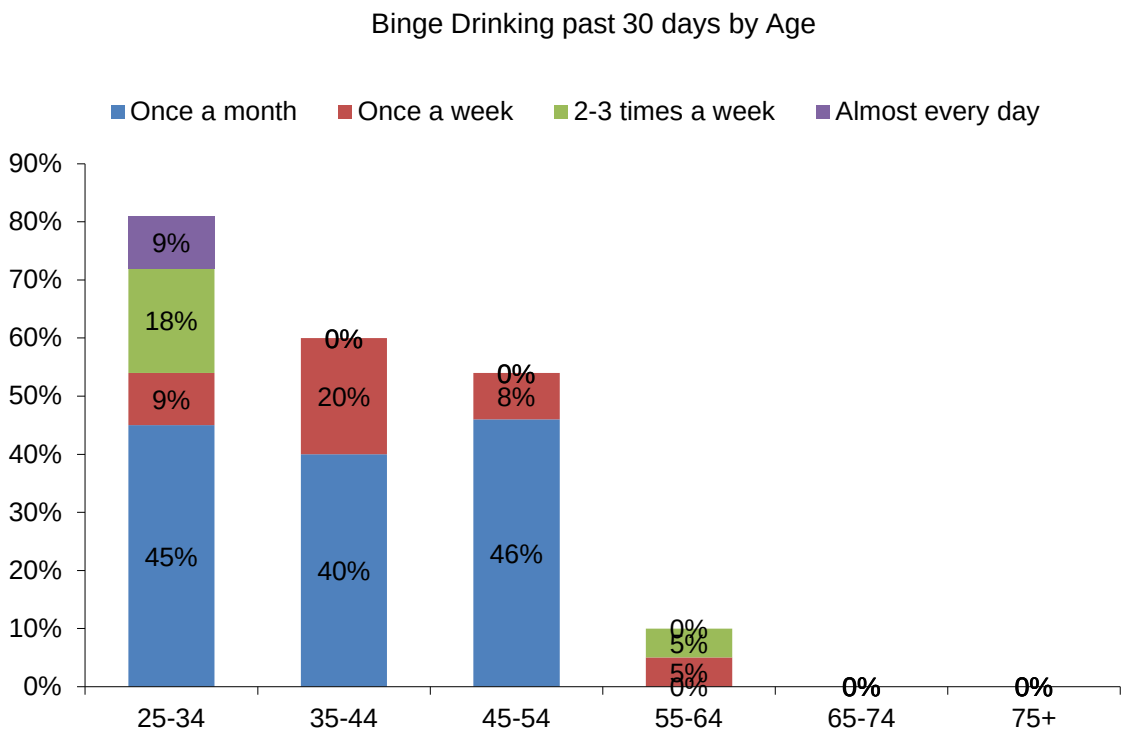
(Community = Rock / Pipestone)

Average number of drinks per day when you drink by gender



Base: 1 drink (n=28), 2 drinks (n=24), 3 drinks (n=10), 4 drinks (n=3), 5 or more drinks (n=6), Sample Size = 71

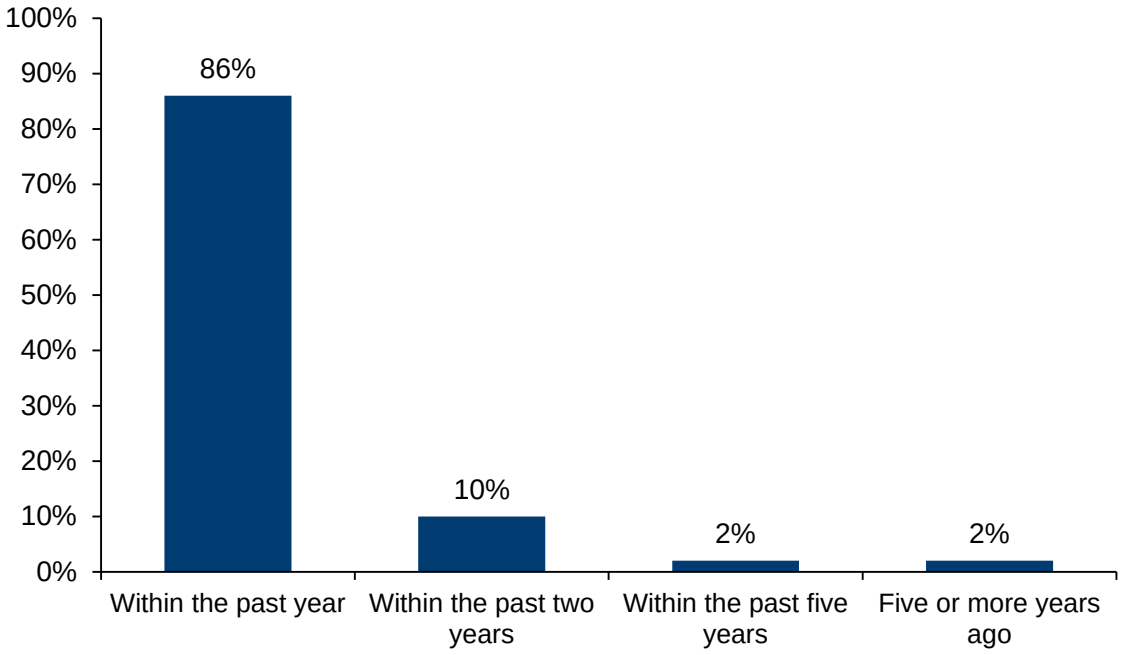
(Community = Rock / Pipestone)



Base: 25-34 (n=11), 35-44 (n=15), 45-54 (n=13), 55-64 (n=22), 65-74 (n=10), 75+ (n=1), Sample Size = 72

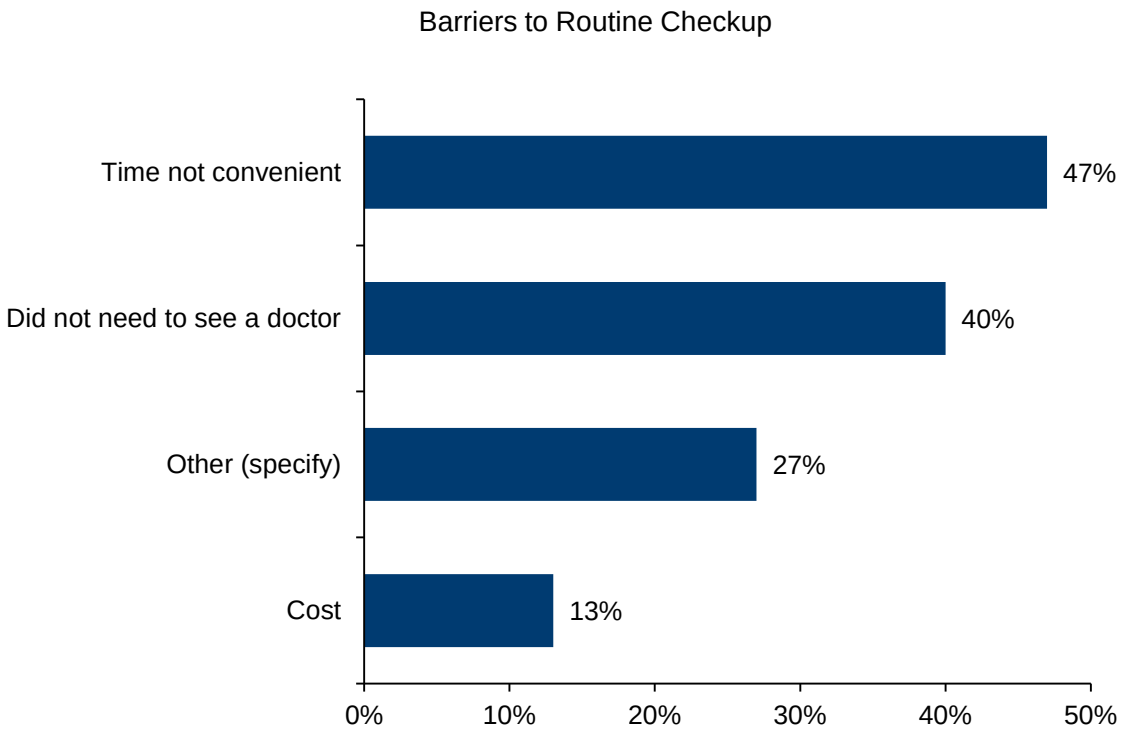
(Community = Rock / Pipestone)

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=85), Within the past two years (n=10), Within the past five years (n=2), Five or more years ago (n=2), Sample Size = 99

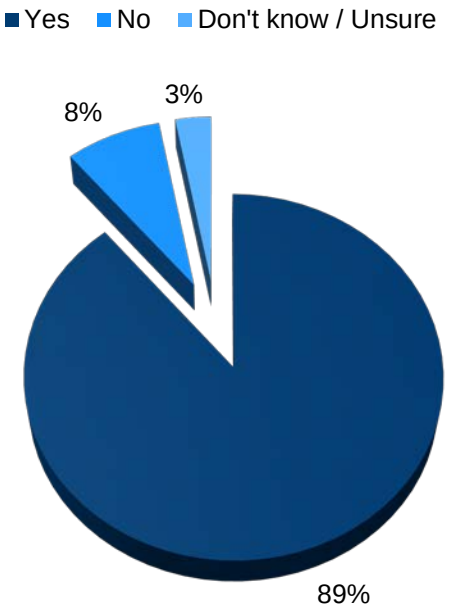
(Community = Rock / Pipestone)



Base: Cost (n=2), Time not convenient (n=7), Did not need to see a doctor (n=6), Other (specify) (n=4), Sample Size = 15

(Community = Rock / Pipestone)

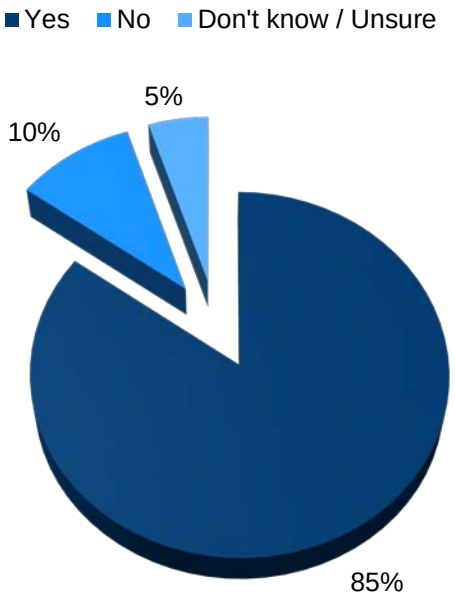
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=89), No (n=8), Don't know / Unsure (n=3), Sample Size = 100

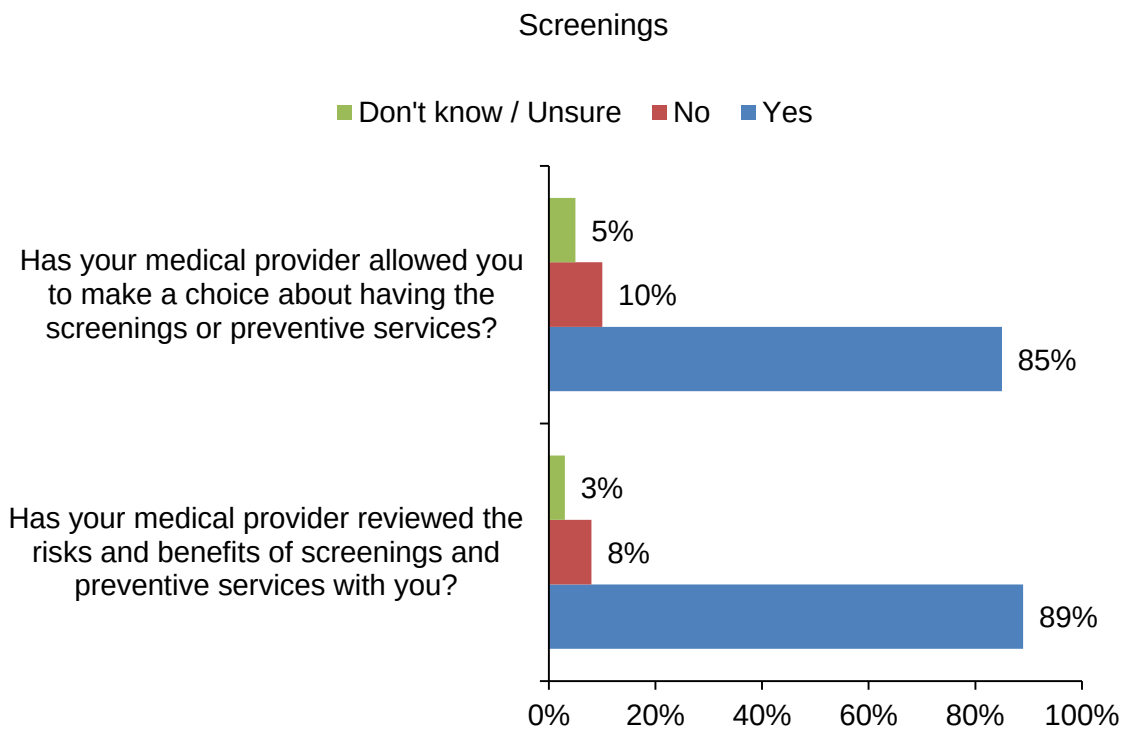
(Community = Rock / Pipestone)

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



Base: Yes (n=85), No (n=10), Don't know / Unsure (n=5), Sample Size = 100

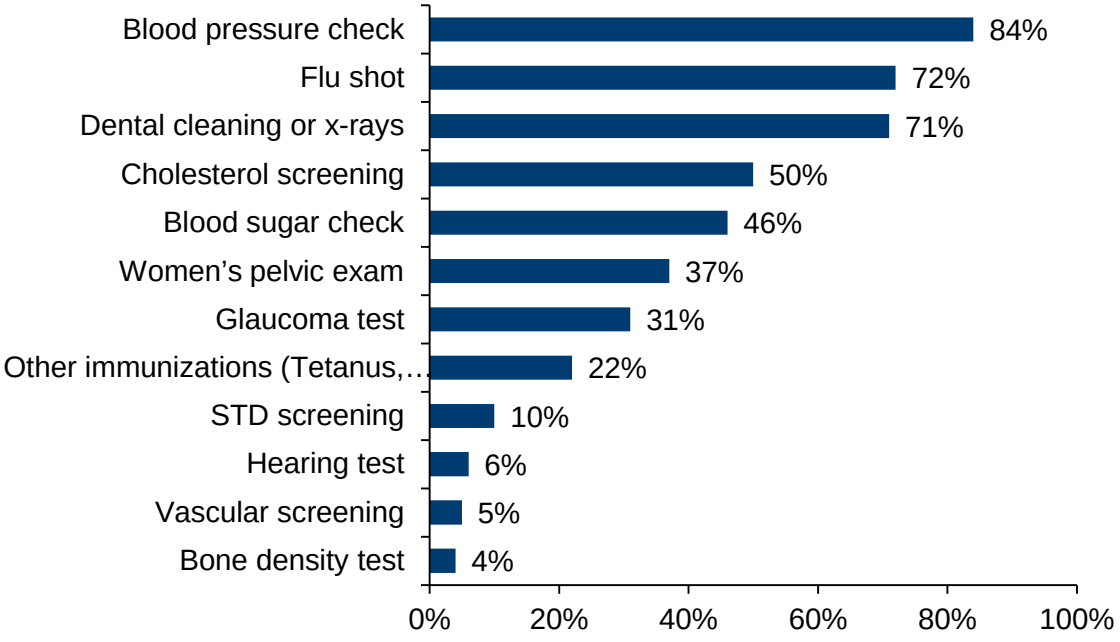
(Community = Rock / Pipestone)



Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=100), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=100), Sample Size = 100

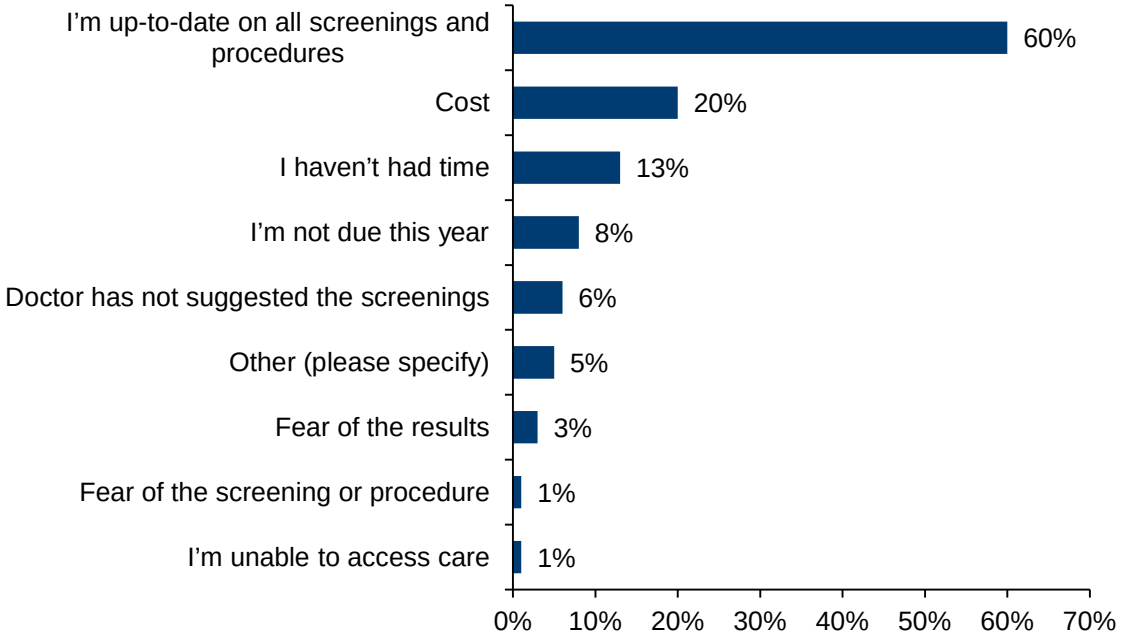
(Community = Rock / Pipestone)

Preventive Procedures Last Year



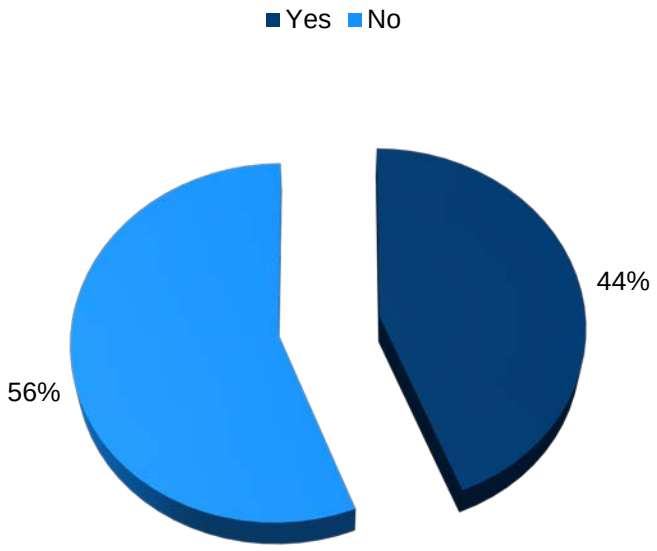
Base: Blood pressure check (n=82), Blood sugar check (n=45), Bone density test (n=4), Cholesterol screening (n=49), Dental cleaning or x-rays (n=70), Flu shot (n=71), Other immunizations (Tetanus, Hepatitis A or B) (n=22), Glaucoma test (n=30), Hearing test (n=6), Women's pelvic exam (n=36), STD screening (n=10), Vascular screening (n=5), Sample Size = 98
(Community = Rock / Pipestone)

Barriers for Preventive Procedures



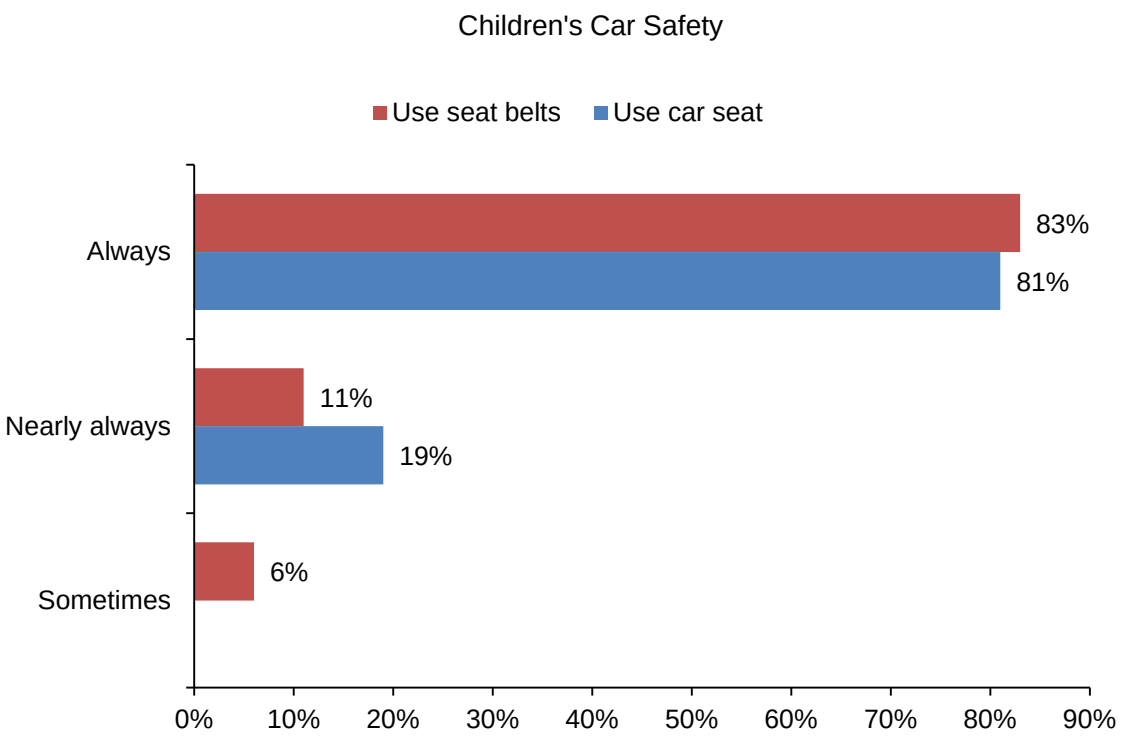
Base: I'm up-to-date on all screenings and procedures (n=58), Doctor has not suggested the screenings (n=6), Cost (n=19), I'm unable to access care (n=1), Fear of the screening or procedure (n=1), Fear of the results (n=3), I'm not due this year (n=8), I haven't had time (n=13), Other (please specify) (n=5),
Sample Size = 97
(Community = Rock / Pipestone)

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



Base: Yes (n=44), No (n=55), Sample Size = 99

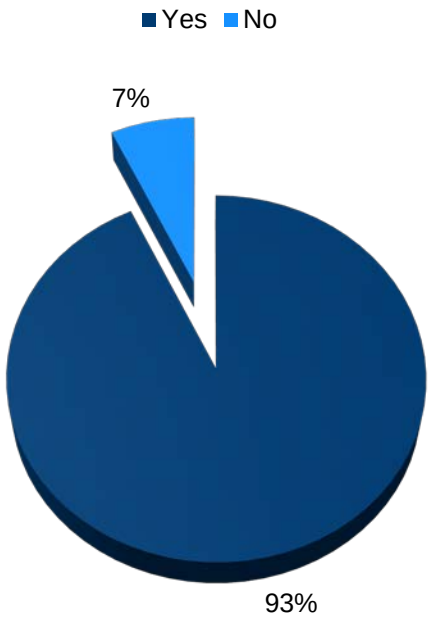
(Community = Rock / Pipestone)



Sample Size = Variable

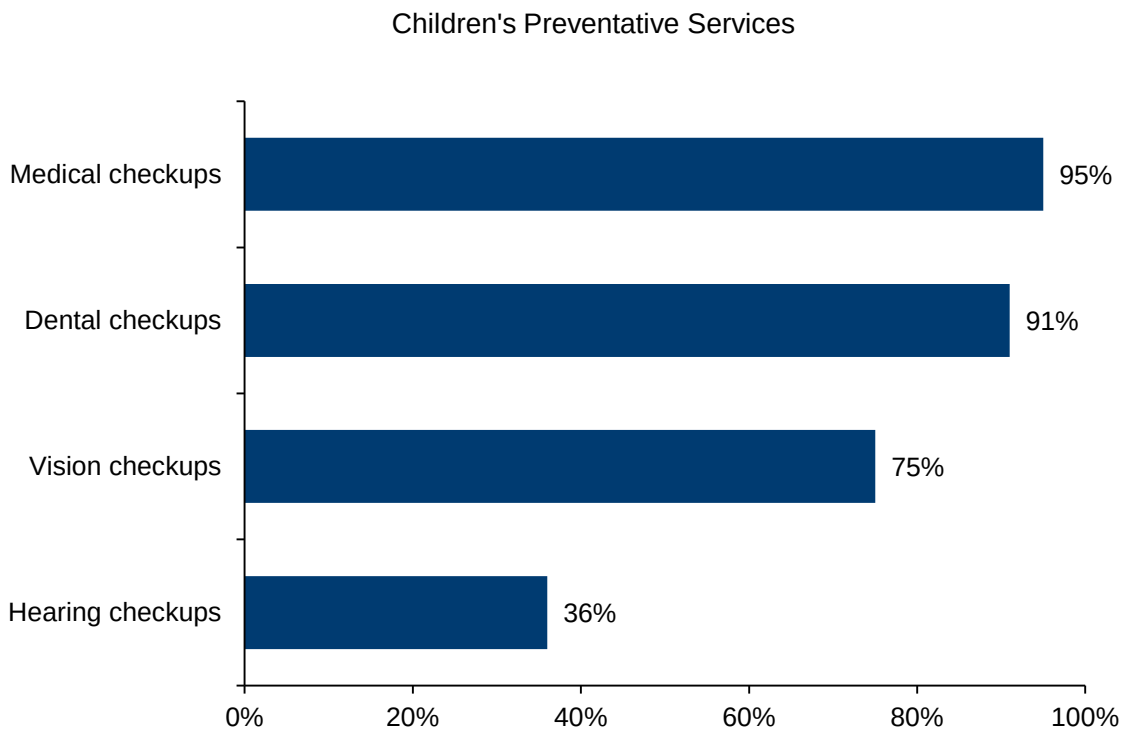
(Community = Rock / Pipestone)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=42), No (n=3), Sample Size = 45

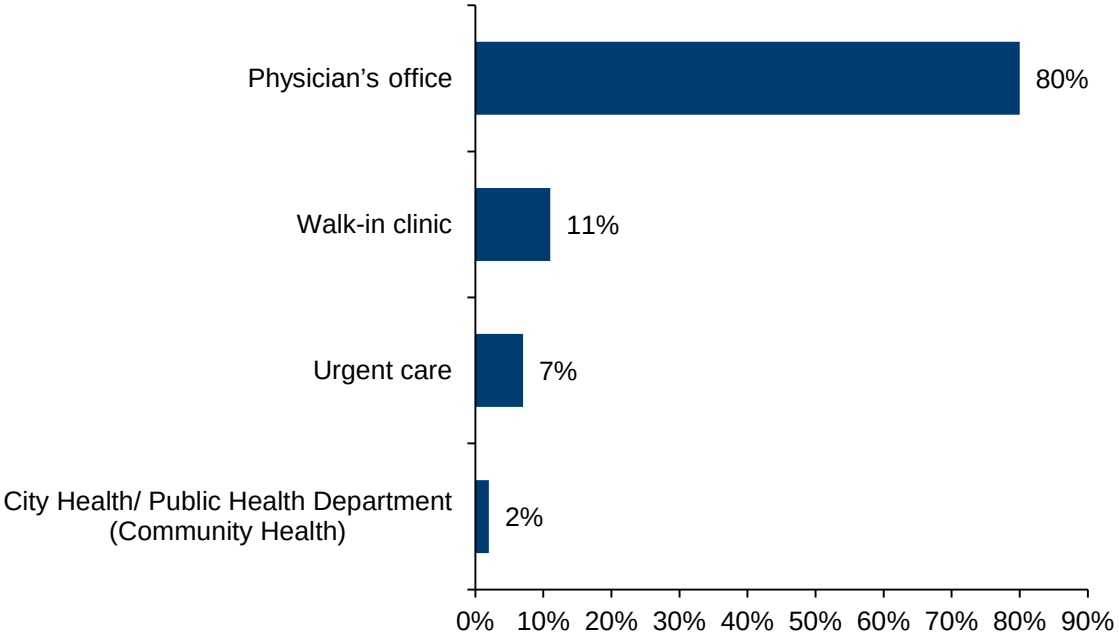
(Community = Rock / Pipestone)



Base: Dental checkups (n=40), Vision checkups (n=33), Hearing checkups (n=16), Medical checkups (n=42), Sample Size = 44

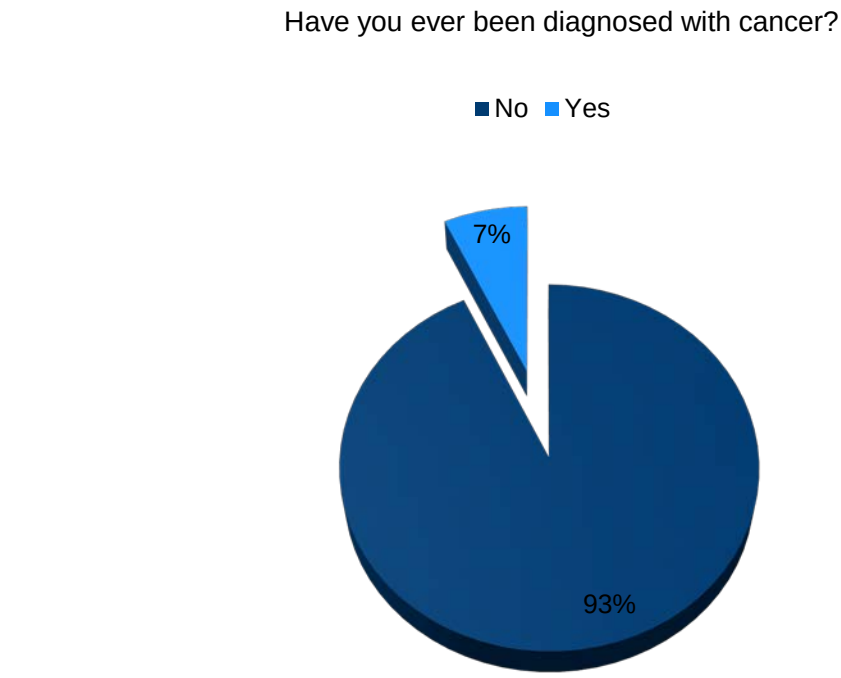
(Community = Rock / Pipestone)

Where do you most often take your children when they are sick and need to see a health care provider?



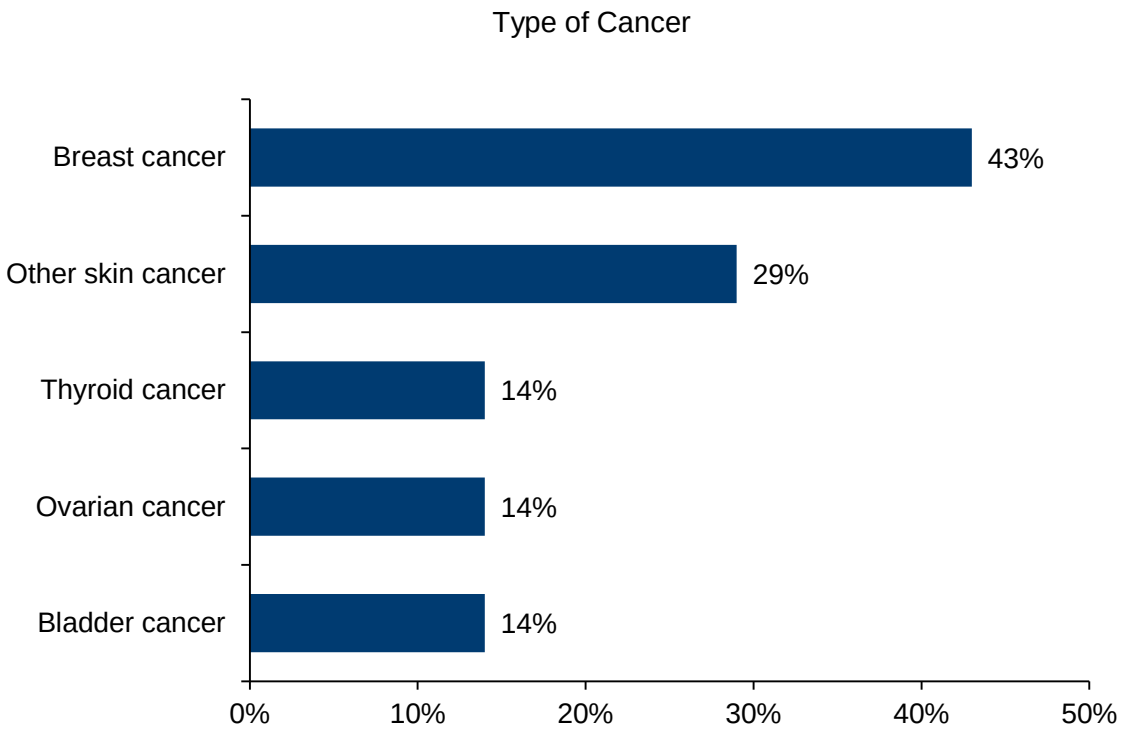
Base: Physician's office (n=35), Urgent care (n=3), Walk-in clinic (n=5), City Health/ Public Health Department (Community Health) (n=1), Sample Size = 44

(Community = Rock / Pipestone)



Base: Yes (n=7), No (n=93), Sample Size = 100

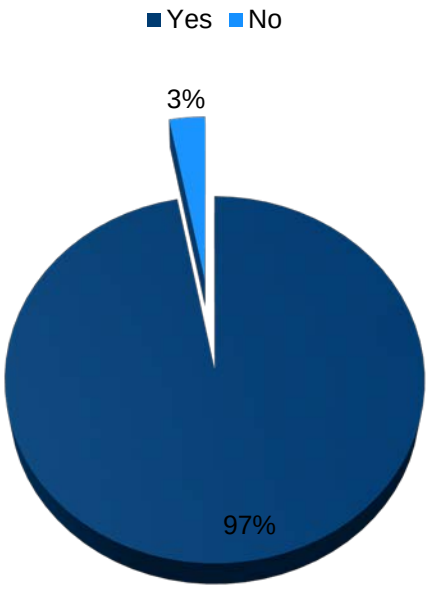
(Community = Rock / Pipestone)



Base: Bladder cancer (n=1), Breast cancer (n=3), Other skin cancer (n=2), Ovarian cancer (n=1), Thyroid cancer (n=1), Sample Size = 7

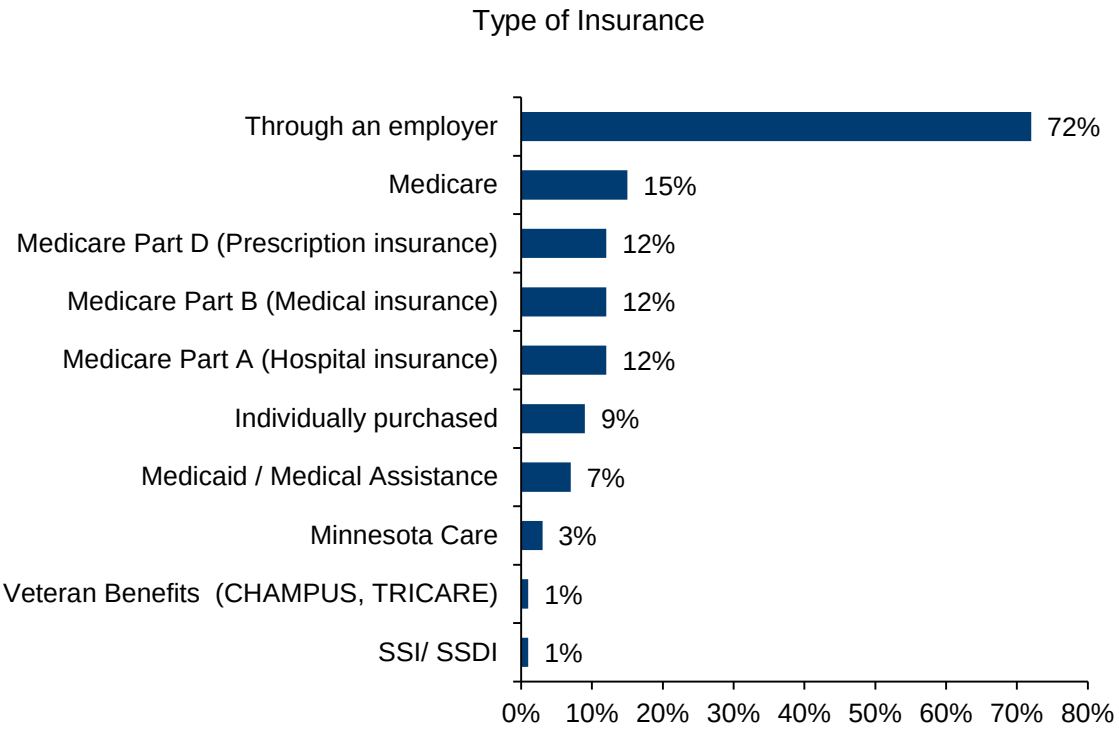
(Community = Rock / Pipestone)

Do you currently have any kind of health insurance?



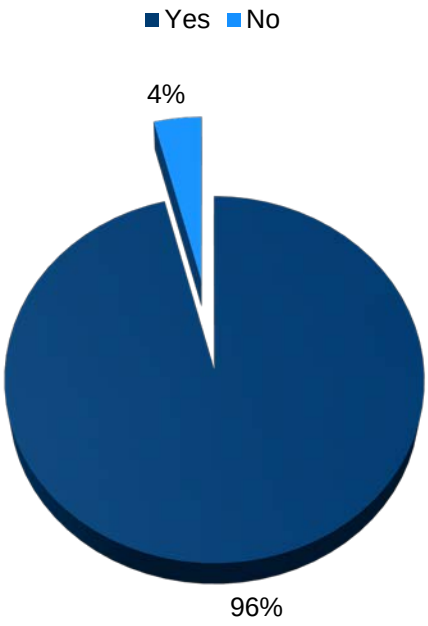
Base: Yes (n=97), No (n=3), Sample Size = 100

(Community = Rock / Pipestone)



Base: Through an employer (n=70), Individually purchased (n=9), Medicare (n=15), Medicare Part A (Hospital insurance) (n=12), Medicare Part B (Medical insurance) (n=12), Medicare Part D (Prescription insurance) (n=12), SSI/ SSDI (n=1), Medicaid / Medical Assistance (n=7), Minnesota Care (n=3), Veteran Benefits (CHAMPUS, TRICARE) (n=1), Sample Size = 97
(Community = Rock / Pipestone)

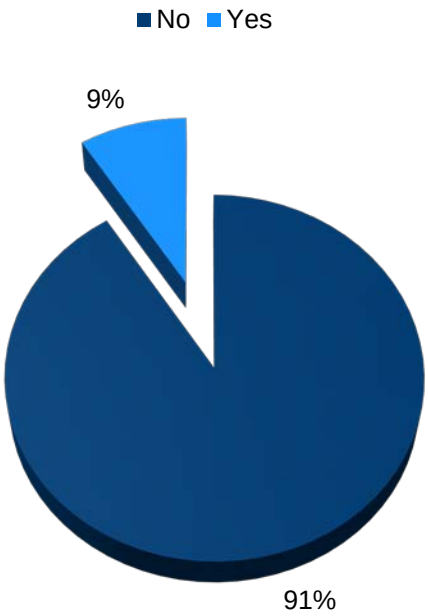
Do you have an established primary healthcare provider?



Base: Yes (n=96), No (n=4), Sample Size = 100

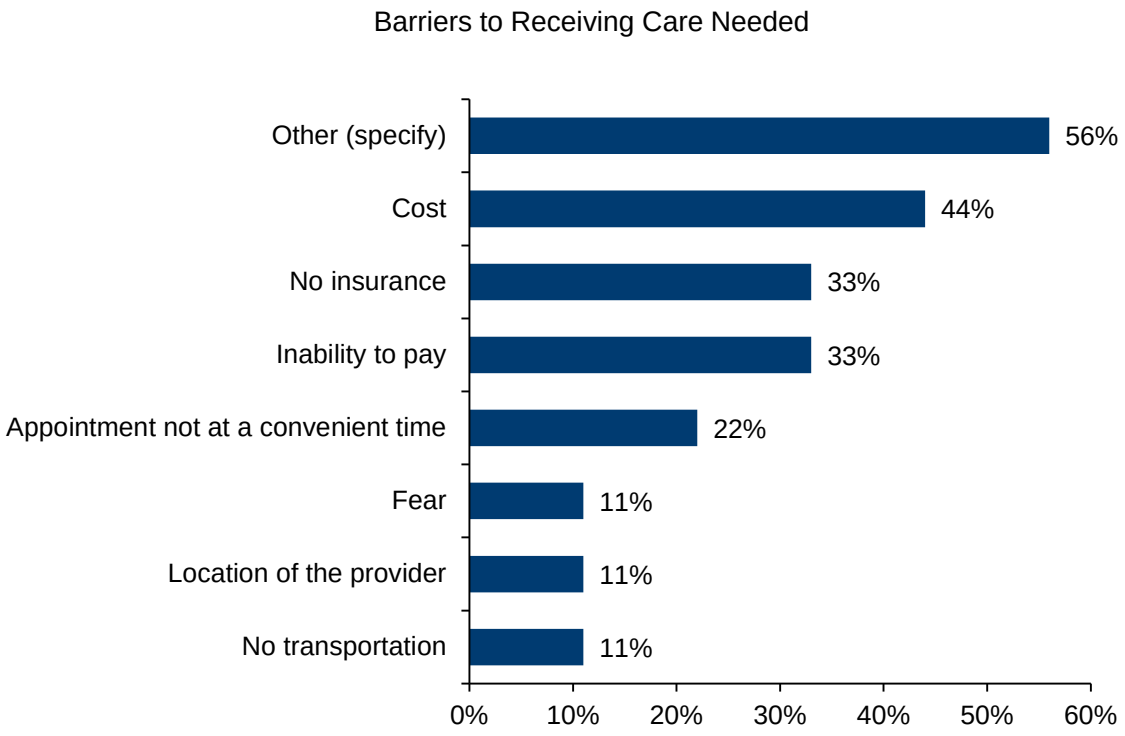
(Community = Rock / Pipestone)

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



Base: Yes (n=9), No (n=91), Sample Size = 100

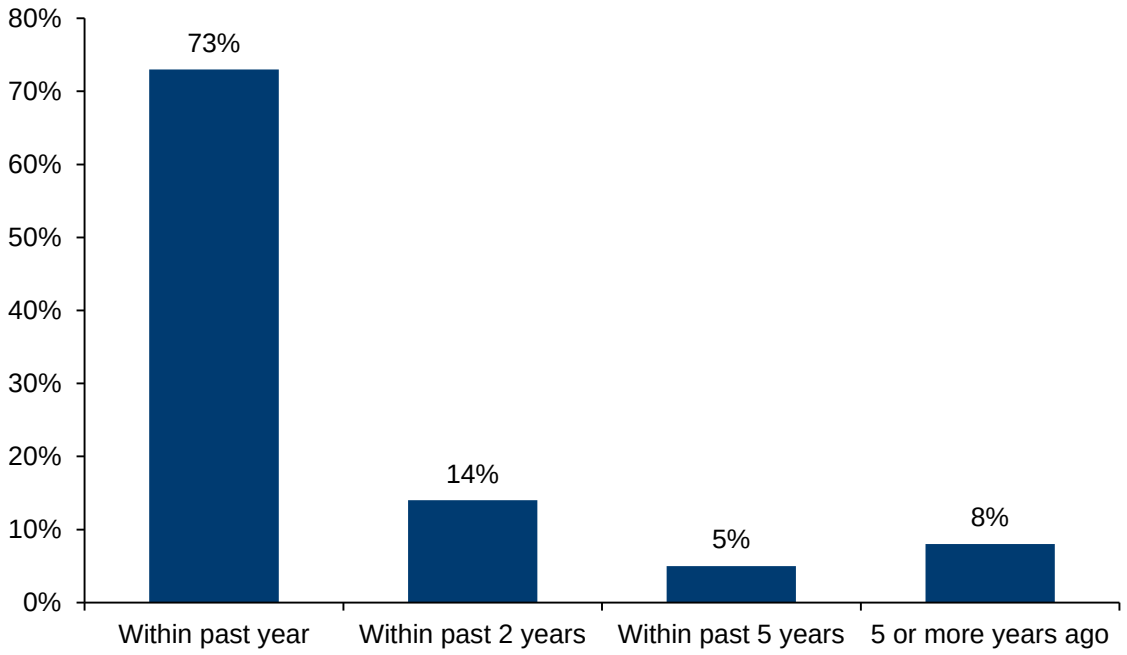
(Community = Rock / Pipestone)



Base: Inability to pay (n=3), Appointment not at a convenient time (n=2), No insurance (n=3), No transportation (n=1), Location of the provider (n=1), Cost (n=4), Fear (n=1), Other (specify) (n=5)

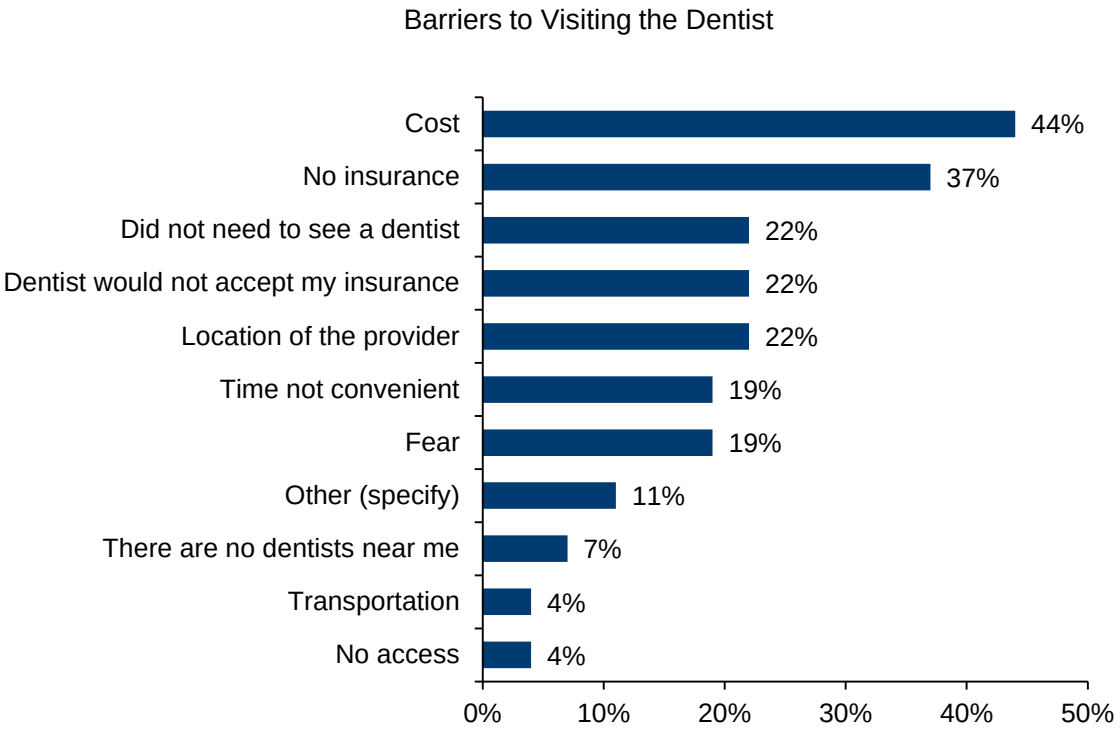
(Community = Rock / Pipestone)

How long has it been since you last visited a dentist?



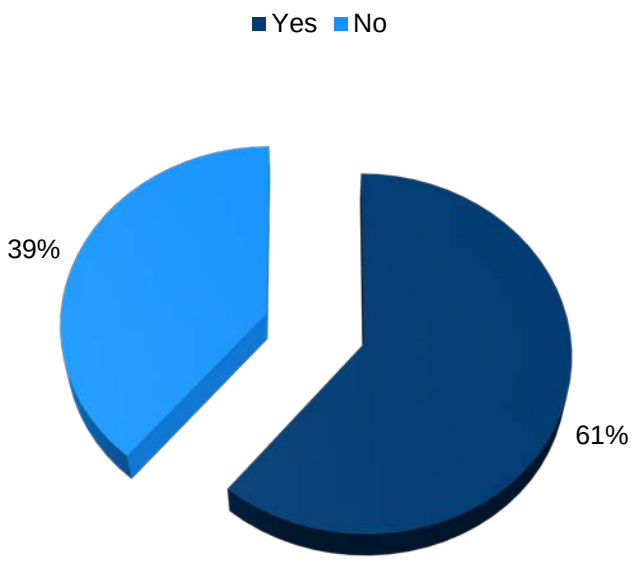
Base: Within past year (n=73), Within past 2 years (n=14), Within past 5 years (n=5), 5 or more years ago (n=8), Sample Size = 100

(Community = Rock / Pipestone)



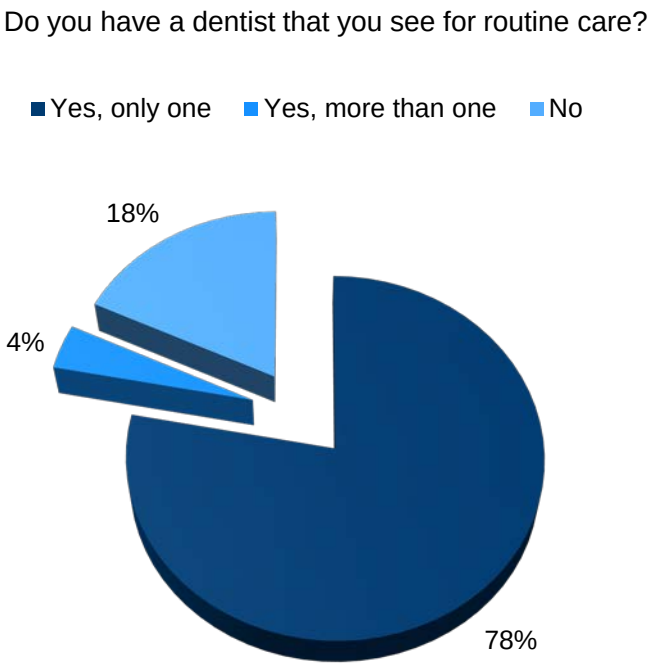
Base: No access (n=1), No insurance (n=10), Location of the provider (n=6), Cost (n=12), Fear (n=5), Transportation (n=1), Time not convenient (n=5), There are no dentists near me (n=2), Dentist would not accept my insurance (n=6), Did not need to see a dentist (n=6), Other (specify) (n=3), Sample Size = 27
(Community = Rock / Pipestone)

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



Base: Yes (n=61), No (n=39), Sample Size = 100

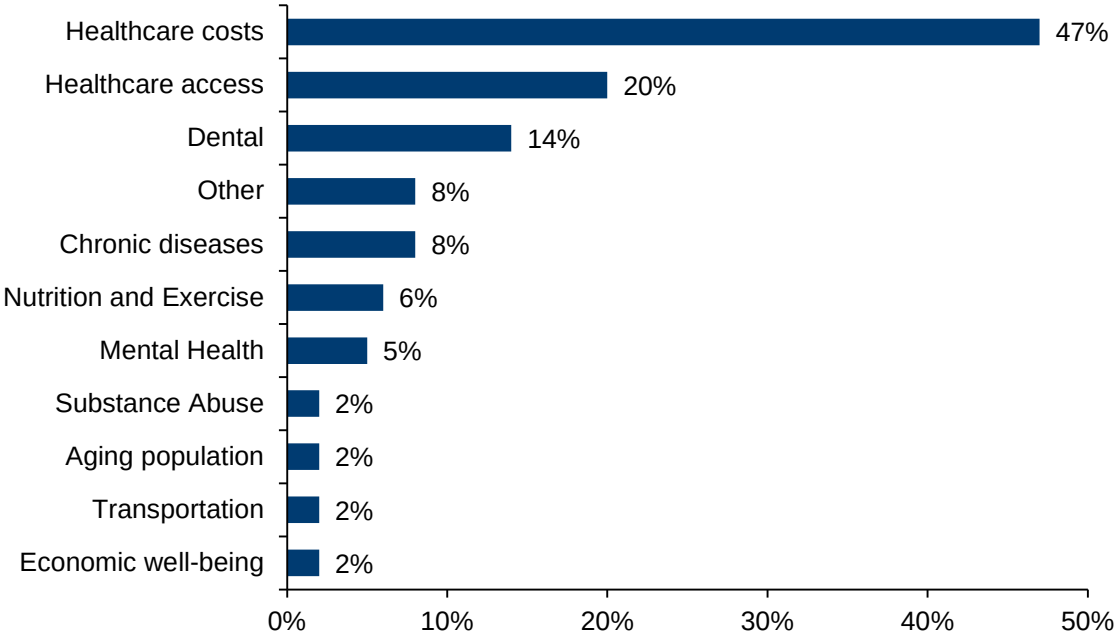
(Community = Rock / Pipestone)



Base: Yes, only one (n=76), Yes, more than one (n=4), No (n=18), Sample Size = 98

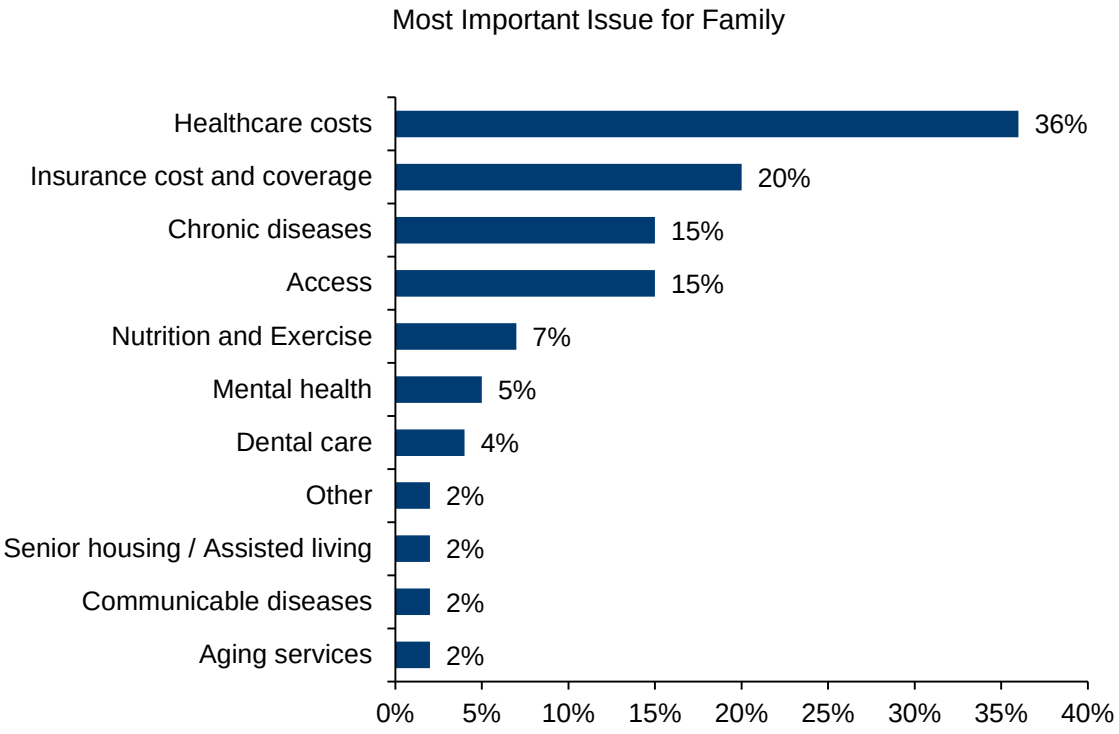
(Community = Rock / Pipestone)

Most Important Community Issues



Base: Economic well-being (n=1), Transportation (n=1), Aging population (n=1), Healthcare access (n=13), Mental Health (n=3), Substance Abuse (n=1), Cronic diseases (n=5), Healthcare costs (n=30), Dental (n=9), Nutrition and Exercise (n=4), Other (n=5), Sample Size = 69

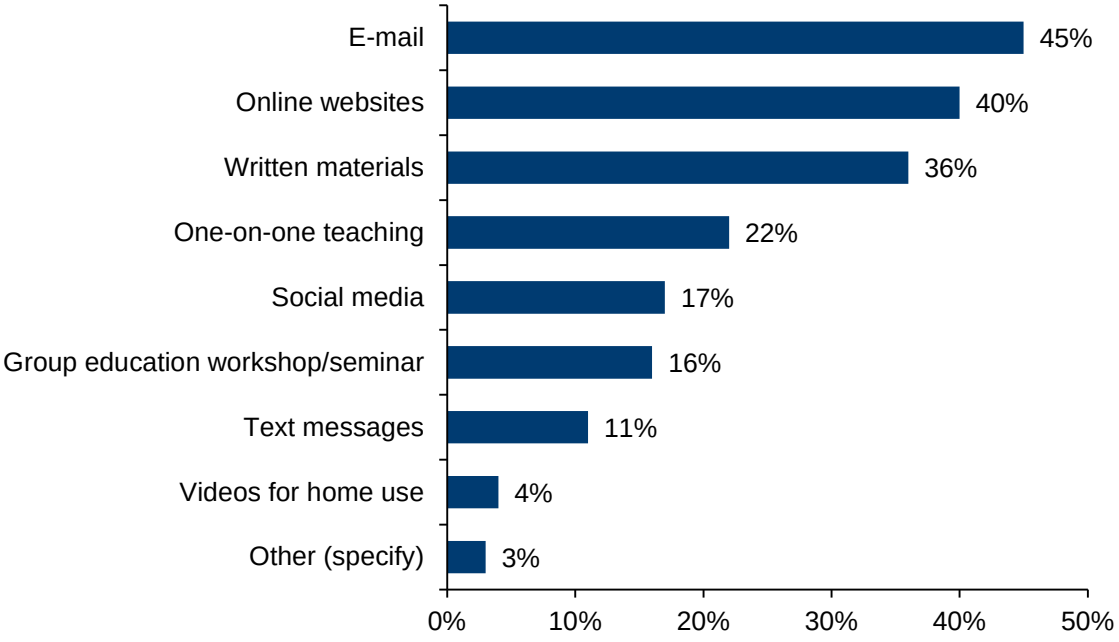
(Community = Rock / Pipestone)



Base: Access (n=8), Aging services (n=1), Chronic diseases (n=8), Communicable diseases (n=1), Healthcare costs (n=20), Dental care (n=2), Nutrition and Exercise (n=4), Insurance cost and coverage (n=11), Mental health (n=3), Senior housing / Assisted living (n=1), Other (n=1), Sample Size = 68

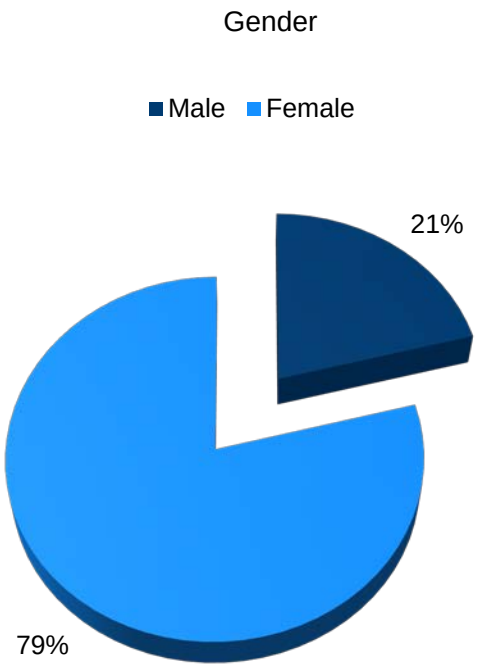
(Community = Rock / Pipestone)

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



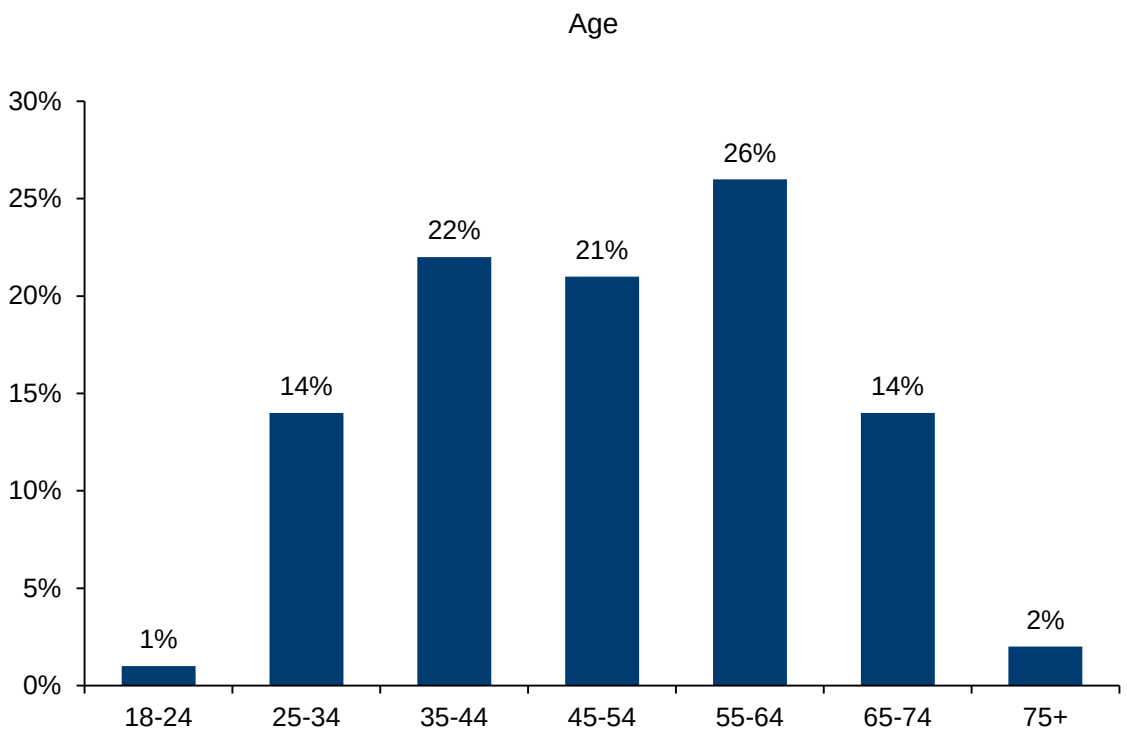
Base: Written materials (n=35), Videos for home use (n=4), Social media (n=16), Text messages (n=11), One-on-one teaching (n=21), E-mail (n=43), Group education workshop/seminar (n=15), Online websites (n=38), Other (specify) (n=3), Sample Size = 96

(Community = Rock / Pipestone)



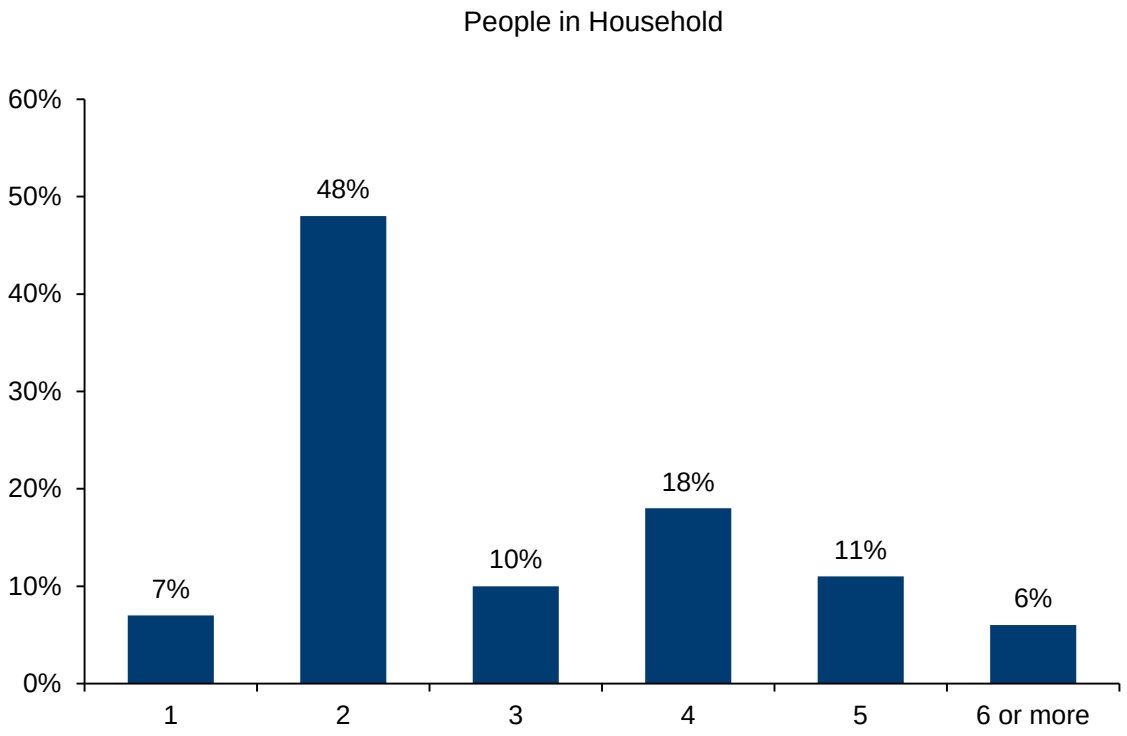
Base: Male (n=21), Female (n=79), Sample Size = 100

(Community = Rock / Pipestone)



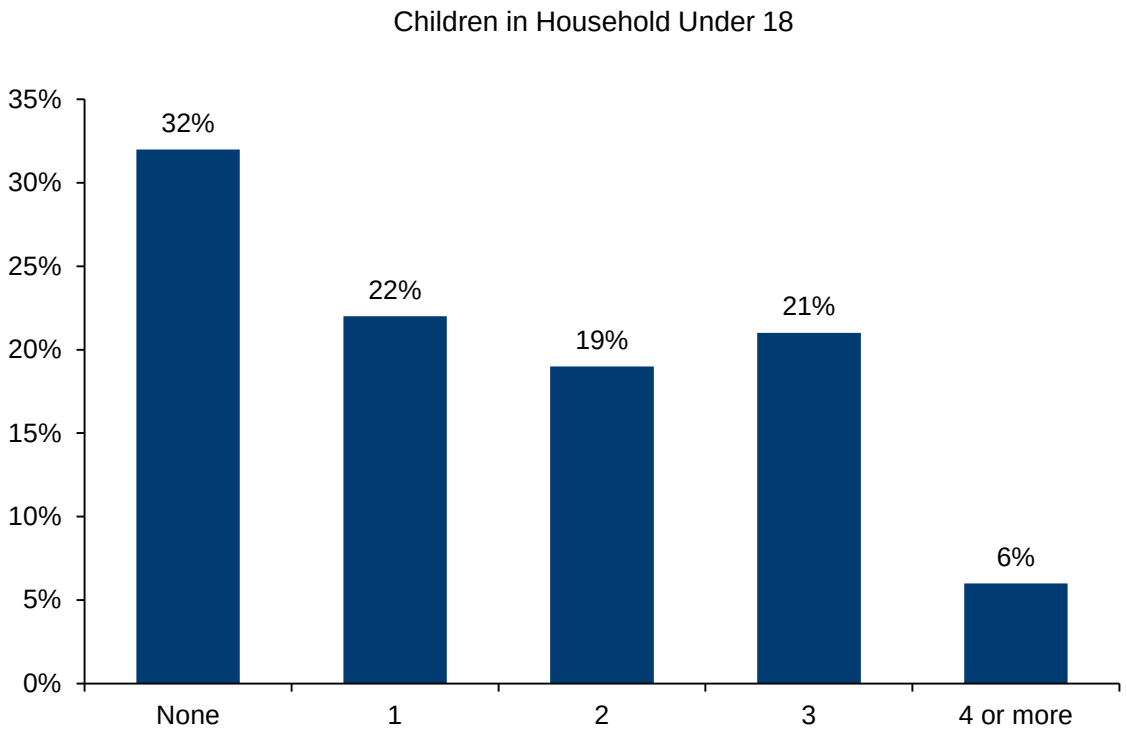
Base: 18-24 (n=1), 25-34 (n=14), 35-44 (n=22), 45-54 (n=21), 55-64 (n=26), 65-74 (n=14), 75+ (n=2), Sample Size = 100

(Community = Rock / Pipestone)



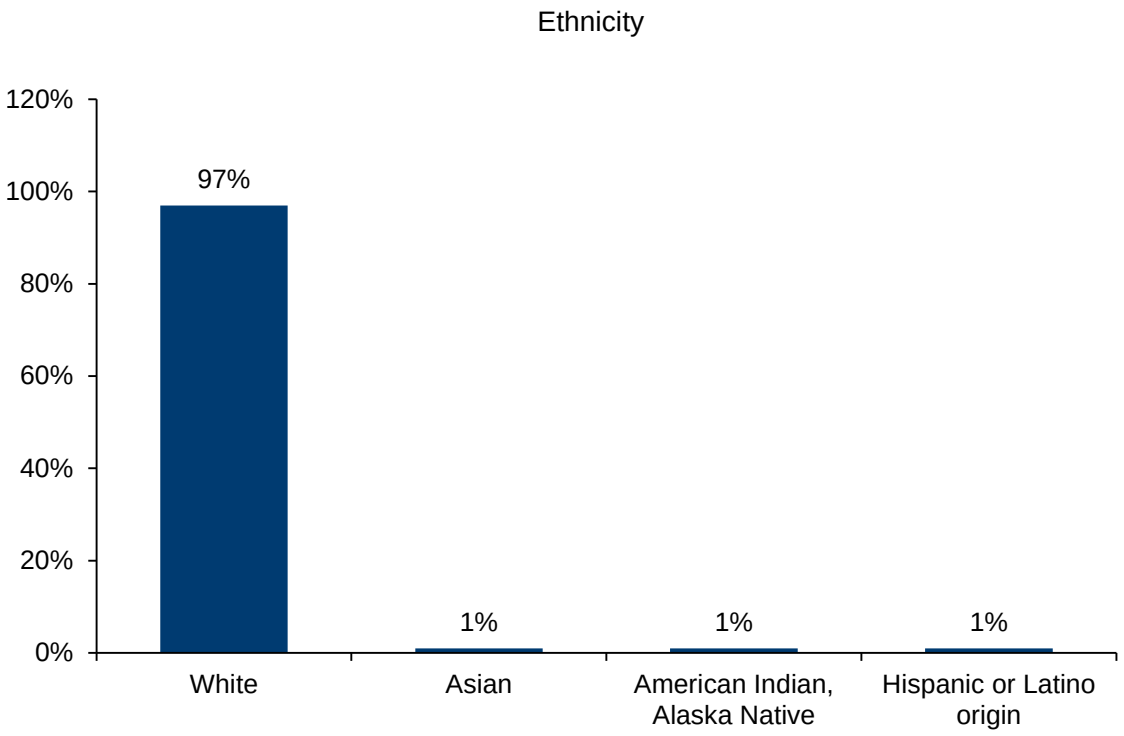
Base: 1 (n=7), 2 (n=48), 3 (n=10), 4 (n=18), 5 (n=11), 6 or more (n=6), Sample Size = 100

(Community = Rock / Pipestone)



Base: None (n=20), 1 (n=14), 2 (n=12), 3 (n=13), 4 or more (n=4), Sample Size = 63

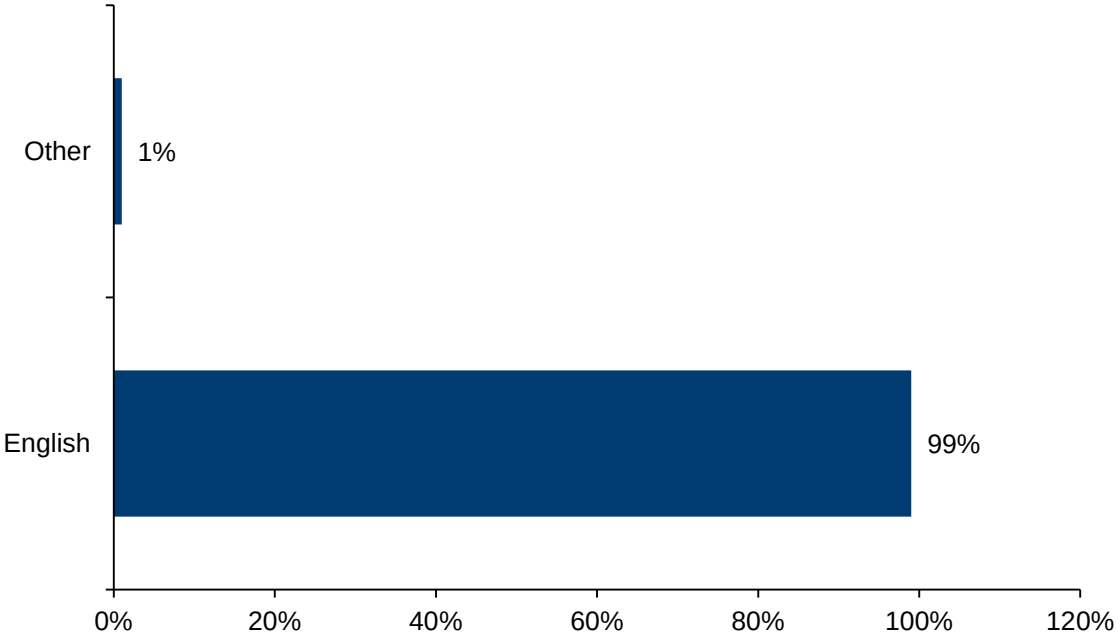
(Community = Rock / Pipestone)



Base: White (n=97), Asian (n=1), American Indian, Alaska Native (n=1), Hispanic or Latino origin (n=1), Sample Size = 100

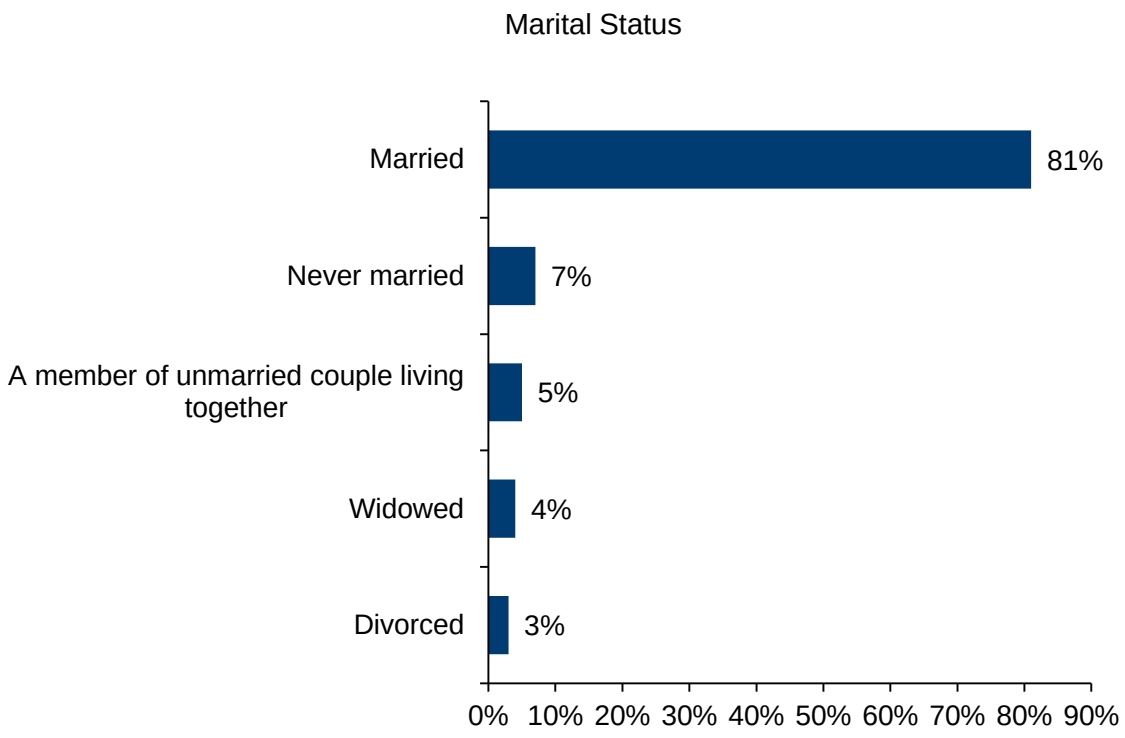
(Community = Rock / Pipestone)

Language Spoken in Home



Base: English (n=98), Other (n=1), Sample Size = 99

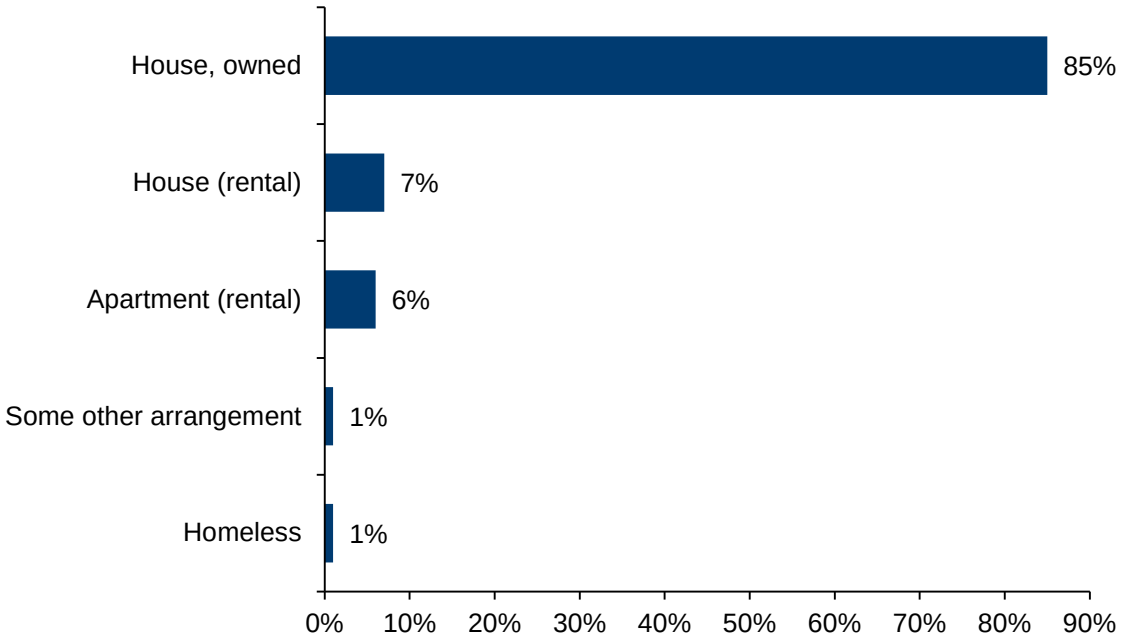
(Community = Rock / Pipestone)



Base: Never married (n=7), Married (n=81), Divorced (n=3), Widowed (n=4), A member of unmarried couple living together (n=5), Sample Size = 100

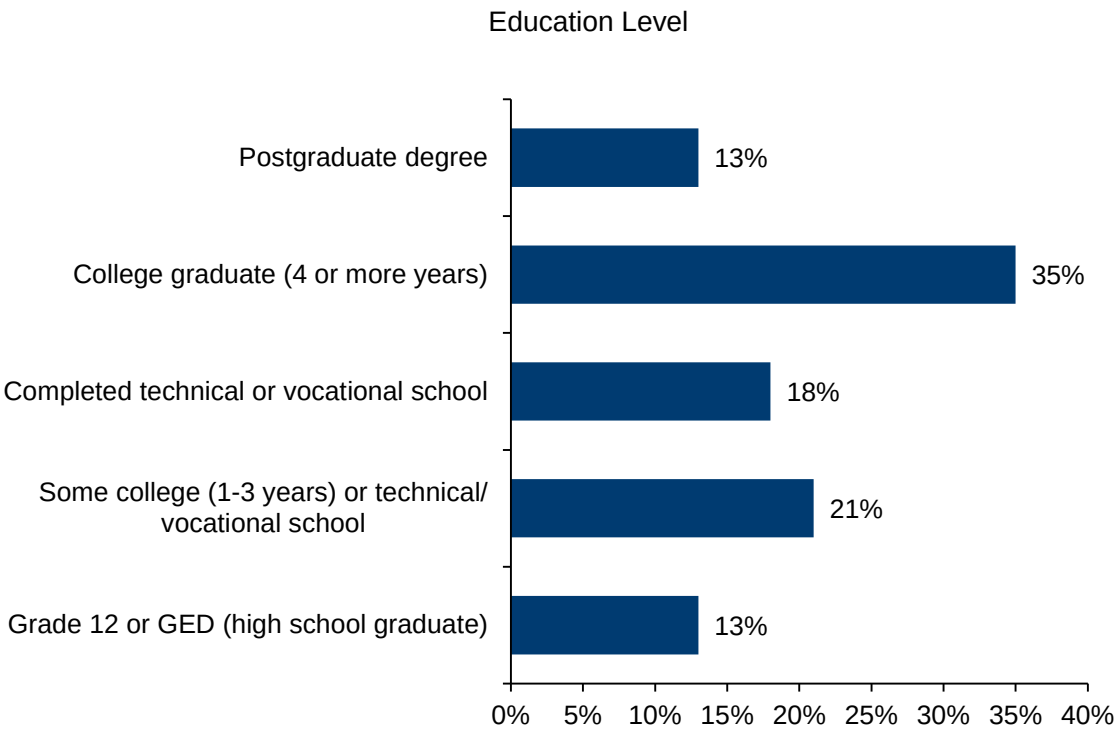
(Community = Rock / Pipestone)

Current Living Situation



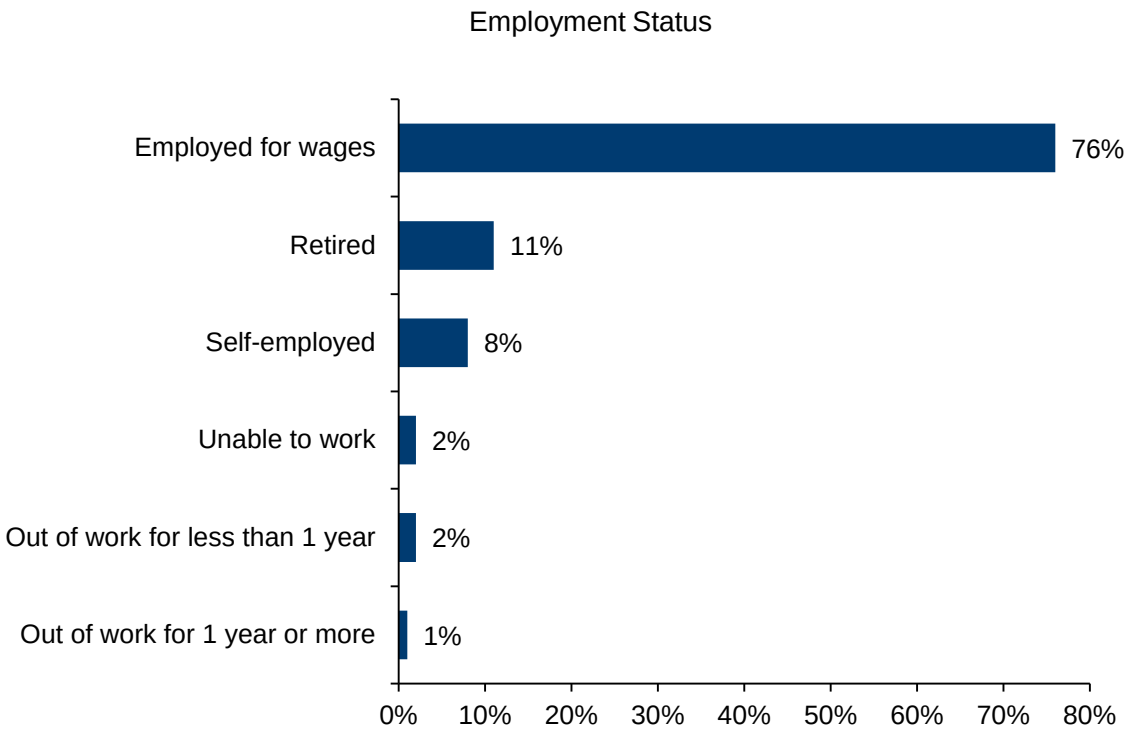
Base: House, owned (n=84), House (rental) (n=7), Apartment (rental) (n=6), Homeless (n=1), Some other arrangement (n=1), Sample Size = 99

(Community = Rock / Pipestone)



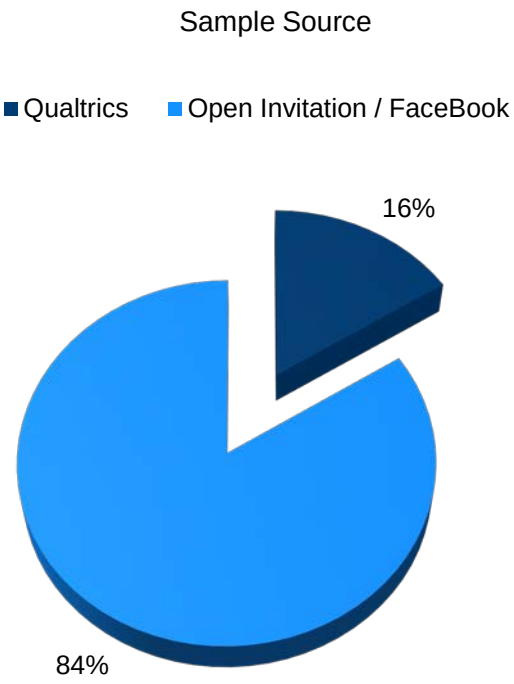
Base: Grade 12 or GED (high school graduate) (n=13), Some college (1-3 years) or technical/ vocational school (n=21), Completed technical or vocational school (n=18), College graduate (4 or more years) (n=35), Postgraduate degree (n=13), Sample Size = 100

(Community = Rock / Pipestone)



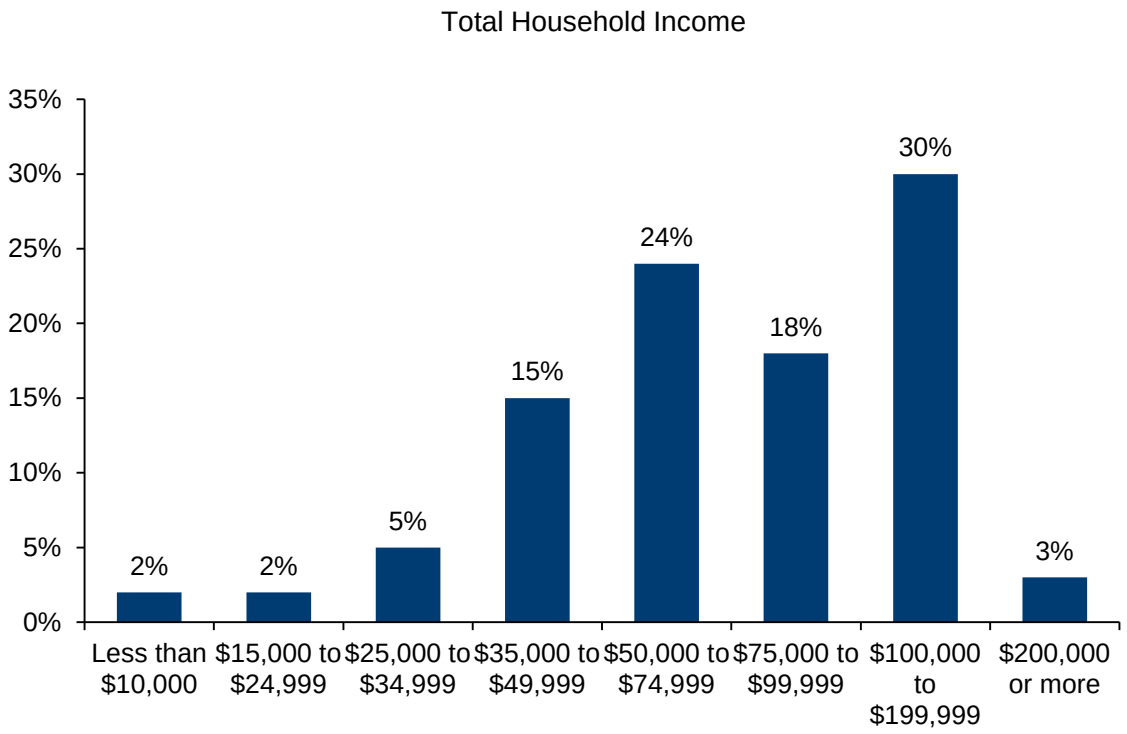
Base: Employed for wages (n=76), Self-employed (n=8), Out of work for less than 1 year (n=2), Out of work for 1 year or more (n=1), Retired (n=11), Unable to work (n=2), Sample Size = 100

(Community = Rock / Pipestone)



Base: Qualtrics (n=16), Open Invitation / FaceBook (n=84), Sample Size = 100

(Community = Rock / Pipestone)



Base: Less than $10,000 (n=2), $15,000 to $24,999 (n=2), $25,000 to $34,999 (n=4), $35,000 to $49,999 (n=13), $50,000 to $74,999 (n=21), $75,000 to $99,999 (n=16), $100,000 to $199,999 (n=26), $200,000 or more (n=3), Sample Size = 87

(Community = Rock / Pipestone)

Sanford Luverne 2018 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economic Well-Being • Skilled labor workforce 3.90 • Availability of affordable housing 3.76 • Employment options 3.57 • 9% report that they run out of food before they have money to buy more	2		
Children and Youth • Availability of quality childcare 4.42 • Cost of quality childcare 3.89 • Availability of services for at-risk youth 3.68 • Substance abuse by youth 3.63 • Bullying 3.58 • Cost of services for at-risk youth 3.56 • Teen suicide 3.53	**6**		
Aging Population • Cost of long-term care 3.79 • Most of memory care 3.74 • Cost of in-home services 3.53	5		
Safety • 21% report having drugs in their home that they are not using			
Healthcare Access • Access to affordable health insurance coverage 4.00 • Access to affordable dental insurance coverage 3.79 • Access to affordable health care 3.79 • Availability of non-traditional hours 3.68 • Availability of mental health providers 3.58 • Access to affordable prescription drugs 3.53	9		
Mental Health and Substance Abuse • Depression 3.74 • Drug use and abuse 3.74 • Alcohol use and abuse 3.58 • 21% report a diagnosis of depression • 40% report a diagnosis of anxiety/stress • 11% currently smoke cigarettes • 38% report binge drinking at least 1X/month	7		

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Wellness • 29% have been diagnosed with high cholesterol and hypertension • 25% have been diagnosed with arthritis • 39% report that they are obese • 27% report that they are overweight • 61% do not consume the recommended 5 or more fruit/ vegetables/d • 50% do not get moderate exercise at least 3X/week • 14% have not had a routine checkup in more than 1 year • 28% did not have a flu shot this past year • 27% report not seeing their dentist in more than 1 year	5		

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 2018 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County*
Health Rankings web site for your state.

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

Contents:

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

Measure	Data Elements	Description
Geographic identifiers	**FIPS**	Federal Information Processing Standard
	State	
	County	
Premature death	**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)
	Years of Potential Life Lost Rate (Black)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Blacks
	Years of Potential Life Lost Rate (Hispanic)	Age-adjusted YPLL rate per 100,000 for Hispanics
	Years of Potential Life Lost 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

Measure	Data Elements	Description
		activity
	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
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	# Medicare Enrollees	Number of Medicare enrollees

Measure	Data Elements	Description
Preventable hospital stays	**Preventable Hosp. Rate**	Discharges for Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetes monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Receiving HbA1c (Black)	Percentage of Black diabetic Medicare enrollees receiving HbA1c test
	% Receiving HbA1c (White)	Percentage of White diabetic Medicare enrollees receiving HbA1c test
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Mammography (Black)	Percentage of Black female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	% Mammography (White)	Percentage of White female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
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 non-Hispanic Black children (under age 18) living in poverty - from the 2012-2016 ACS
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty – f rom the 2012-2016 ACS
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2012-2016 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	# 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 the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**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	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities

Measure	Data Elements	Description
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	**% Drive Alone**	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 non-Hispanic 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)

County Health Rankings

Rock County, Minnesota

County Demographics –	
	State
Population	5,519,952
% below 18 years of age	23.3%
% 65 and older	15.1%
% Non-Hispanic African American	6.0%
% American Indian and Alaskan Native	1.3%
% Asian	4.9%
% Native Hawaiian/Other Pacific Islander	0.1%
% Hispanic	5.2%
% Non-Hispanic white	80.6%
% not proficient in English	2%
% Females	50.2%
% Rural	26.7%

	Rock County	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
45					
Premature death	5,700	4,600-7,000	5,300	5,100	
48					
Poor or fair health	11%	10-11%	12%	12%	

	Rock County	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
Poor physical health days	2.8	2.6-2.9	3.0	3.0	
Poor mental health days	2.9	2.8-3.1	3.1	3.2	
Low birthweight	7%	5-9%	6%	6%	
Premature age-adjusted mortality	260	210-330	270	260	
Child mortality			40	40	
Infant mortality			4	5	
Frequent physical distress	9%	8-9%	9%	9%	
Frequent mental distress	9%	9-10%	10%	10%	
Diabetes prevalence	9%	6-11%	8%	8%	
HIV prevalence			49	171	
13					
5					
Adult smoking	14%	13-14%	14%	15%	
Adult obesity	27%	22-34%	26%	27%	
Food environment index	8.9		8.6	8.9	
Physical inactivity	24%	18-31%	20%	20%	
Access to exercise opportunities	64%		91%	88%	
Excessive drinking	21%	20-22%	13%	23%	
Alcohol-impaired driving deaths	8%	0-25%	13%	30%	
Sexually transmitted infections	146.6		145.1	389.3	
Teen births	16	11-22	15	17	
Food insecurity	9%		10%	10%	
Limited access to healthy foods	3%		2%	6%	

	Rock County	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
Drug overdose deaths			10	11	
Drug overdose deaths - modeled	8-11.9		8-11.9	12.5	
Motor vehicle crash deaths	30	18-46	9	8	
Insufficient sleep	28%	27-30%	27%	30%	
52					
Uninsured	5%	4-6%	6%	5%	
Primary care physicians	960:1		1,030:1	1,110:1	
Dentists	2,390:1		1,280:1	1,440:1	
Mental health providers	1,060:1		330:1	470:1	
Preventable hospital stays	54	42-67	35	37	
Diabetes monitoring	92%	72-100%	91%	88%	
Mammography screening	59%	41-77%	71%	65%	
Uninsured adults	6%	5-7%	7%	6%	
Uninsured children	3%	2-5%	3%	3%	
Health care costs	$9,546			$8,250	
Other primary care providers	9,564:1		782:1	1,020:1	
16					
High school graduation	92%		95%	83%	
Some college	69%	61-76%	72%	74%	
Unemployment	2.3%		3.2%	3.9%	
Children in poverty	11%	8-14%	12%	13%	
Income inequality	4.3	3.6-4.9	3.7	4.4	
Children in single-parent households	18%	13-24%	20%	28%	

	Rock County	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87) (Click for info)
Social associations	27.1		22.1	13.0	
Violent crime	919		62	231	
Injury deaths	86	62-116	55	62	
Disconnected youth			10%	9%	
Median household income	$57,500	$50,900-64,200	$65,100	$65,600	
Children eligible for free or reduced price lunch	30%		33%	38%	
Residential segregation - black/white			23	62	
Residential segregation - non-white/white	16		14	49	
Homicides			2	2	
Firearm fatalities			7	7	
31					
Air pollution - particulate matter	9.2		6.7	9.3	
Drinking water violations	No				
Severe housing problems	12%	9-14%	9%	14%	
Driving alone to work	78%	76-81%	72%	78%	
Long commute - driving alone	26%	22-29%	15%	30%	

Note: Blank values reflect unreliable or missing data

SANFORD HEALTH

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