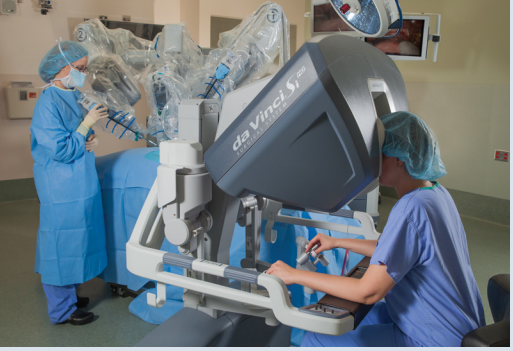


















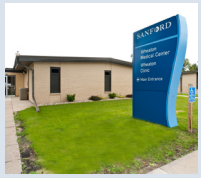


SANFORD HEALTH

Sanford Health Network

2018 Community Health Needs Assessment

dba Sanford Vermillion Medical Center EIN# 46-0388596

Dear Community Members,

Sanford Vermillion Medical Center 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:

- *Economic Well-Being*
- *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 Vermillion 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,

Tim Tracy
Senior Director
Sanford Vermillion Medical Center

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Sanford Vermillion Medical Center

Community Health Needs Assessment

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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 implementation 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 need or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on 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 Vermillion community and Clay and Union counties. Data collection occurred during November 2017. A total of 164 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 95 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/.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Vermillion and Clay and Union counties, South Dakota. 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.

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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 affordable housing (ranking 3.56).

Children and Youth
Community stakeholders are most concerned about substance abuse by youth (3.57), and childhood obesity (3.53).

Aging Population
Community stakeholders are most concerned about the cost of long-term care (3.87), the cost of memory care (3.75), and the cost of in-home services.

Safety
Community stakeholders are most concerned about the culture of excessive drinking (3.61).

Health Care Access
Community stakeholders are most concerned about access to affordable insurance (3.73), the availability of mental health providers (3.61), access to affordable health care (3.58), access to affordable prescription drugs (3.51), and access to behavioral health (substance abuse) providers (3.50).

Mental Health and Substance Abuse
Community stakeholders are most concerned about alcohol use and abuse (3.69), drug use and abuse (3.62), and depression (3.53).

Resident survey participants are facing the following issues:

- 69% report that they are overweight or obese
- 41% self-report binge drinking at least 1X/month
- 33% have a diagnosis of hypertension
- 38% have high cholesterol
- 31% self-report that they have drugs in their home they are not using
- 23% have not visited a dentist in more than a year
- 6% currently smoke cigarettes

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

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

- *Economic Well-Being*
- *Mental Health/Behavioral Health and Substance Abuse*

Implementation Strategies

Priority 1: Economic Well Being

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.

Sanford Vermillion has made affordable housing and economic well-being a significant priority and has developed strategies to work with community partners and community leaders to improve the availability of affordable housing in the community.

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 Vermillion Medical Center

Community Health Needs Assessment

2018

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Community Health Needs Assessment

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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
- Julie 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 Vermillion community stakeholders participated in community discussions and helped to formulate the priorities for our implementation strategies:

- Damon Alvey, Vermillion School District
- Cindy Benzel, Sanford Health
- Jeff Berens, Sanford Health
- Brook Bernes, Sanford Health
- Sami Cusick, Public Health WIC
- Shannon Fairholm, Vermillion School Board
- Julie Girard, Sanford Health
- Andy Howe, Clay County Sheriff
- John Howe, USD Student Services
- Linda Kogel, Attorney
- Valerie Lubben, Sanford Health
- Mary Merrigan, Sanford Health
- Travis Mockler, County Commissioner
- Brock Mueller, Sanford Health
- Mary Olson, Physician
- Rachel Olson, Sanford Health
- Teresa Powell-Johnson, Vermillion Food Pantry
- John Prescott, City of Vermillion
- Carmen Stewart, Head Start
- Tim Tracy, Sanford Health
- Linda Wymar, Vermillion Food Pantry

Description of Sanford Vermillion Medical Center

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

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

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

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

Description of the Community Served

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

Key Findings

Community Health Concerns

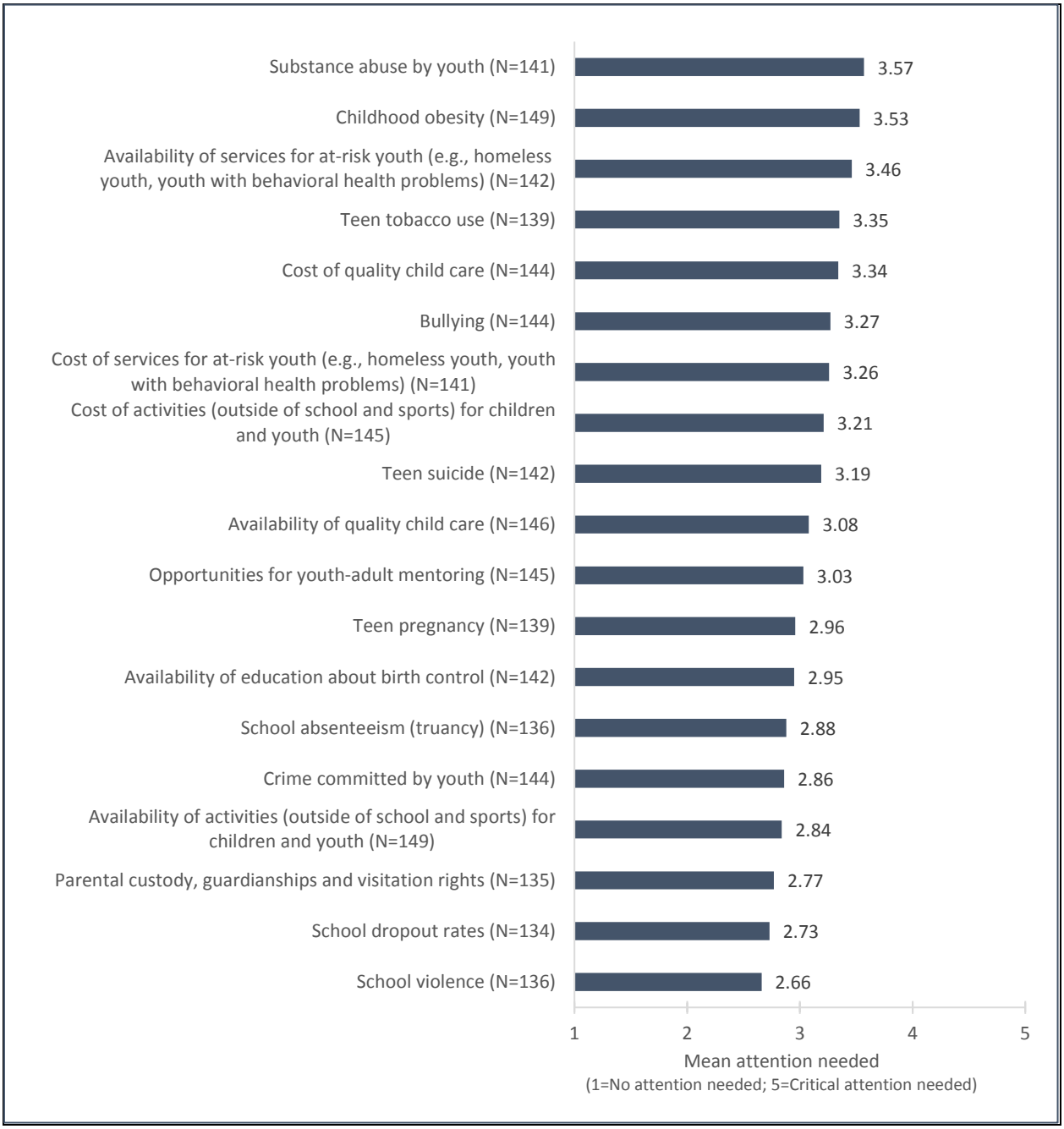
The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.5 or above are considered to be 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 for affordable housing.

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 substance abuse, and childhood obesity.



According to the Centers for Disease Control, obesity is a complex health issue to address. Obesity can be caused from a combination of contributing factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors in our society include the food and physical activity environment, education and skills, and food marketing and promotion.

Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and is associated with morbidity and illnesses including diabetes, heart disease, stroke, and some types of cancer.

Sanford has developed strategy to address obesity through medical interventions and through community programs such as Sanford*fit.*

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.

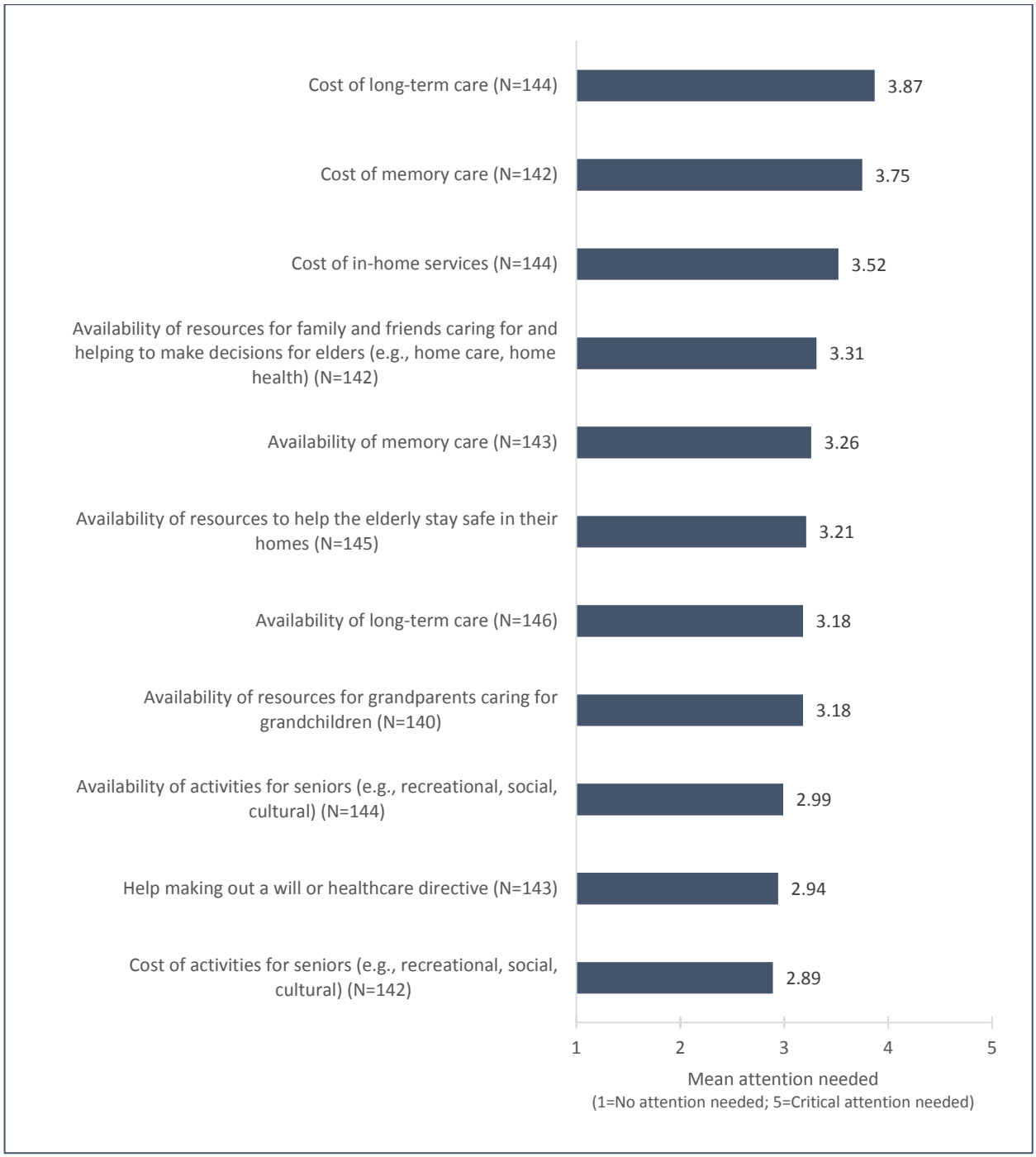
Youth may also be more likely to try drugs because of circumstances or events called risk factors. Examples of risk factors include:

- 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:

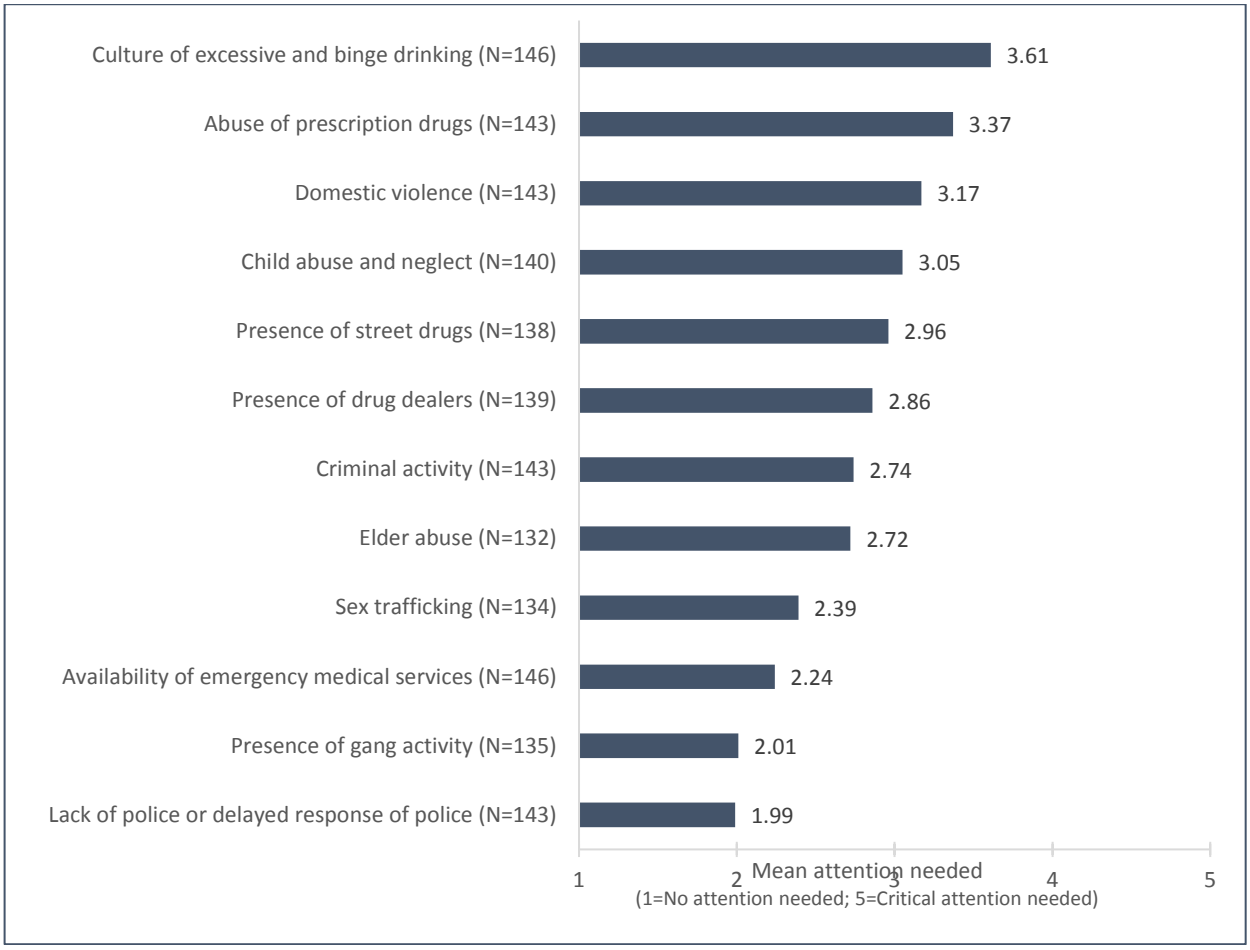
- Having high self-esteem
- Attending a school with policies against using alcohol and drugs
- Having an adult role model who doesn't use tobacco or drugs or misuse alcohol
- Participating in athletic, community, or faith-based groups
- Living in a community with youth activities that prohibit drugs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



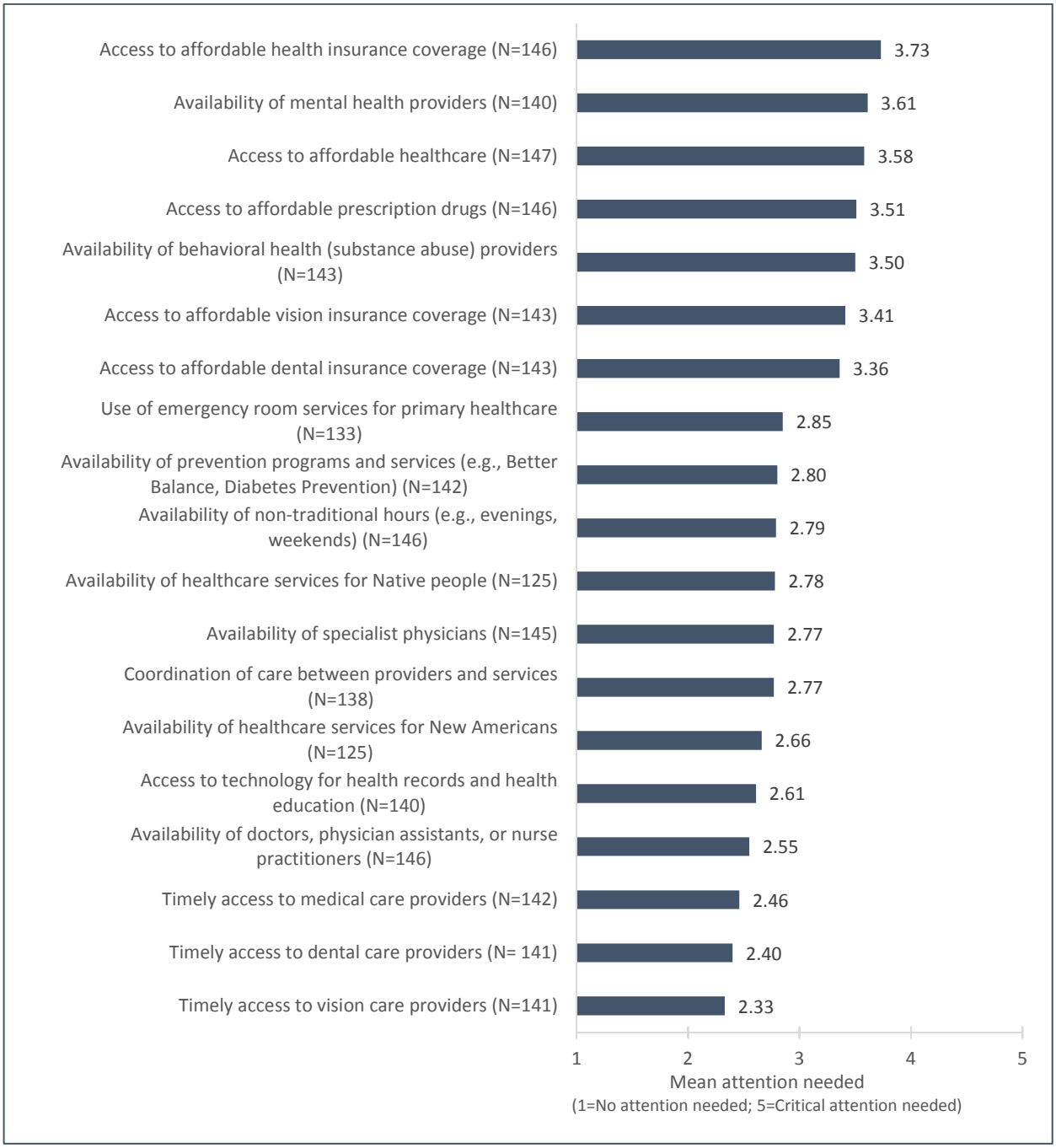
According to the U.S. Health and Human Services Administration on Aging, the cost of long-term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford providers work to help seniors live healthy independent lives. Sanford social workers, case managers, 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.

Safety: The presence of street drugs, culture of excessive drinking, and abuse of prescription drugs, are top concerns for safety in the community.



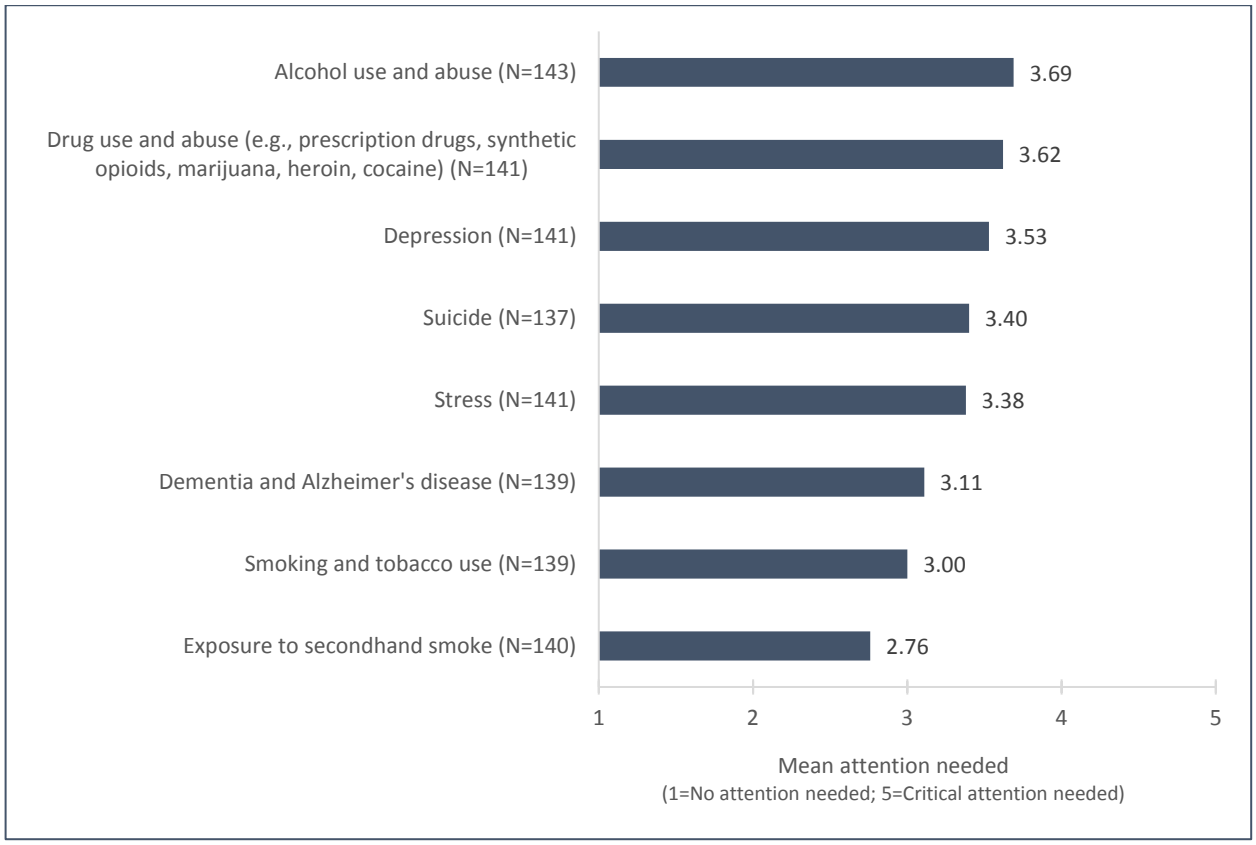
The National Institute on Drug Abuse states that the misuse of prescription drugs means taking a medication in a manner or dose other than what was prescribed; or taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., to get high). The term *non-medical use* of prescription drugs also refers to these categories of misuse. The three classes of medication most commonly misused are opioids, central nervous system depressants (this category includes tranquilizers, sedatives, and hypnotics) and stimulants - most often prescribed to treat attention deficit hyperactivity disorder (ADHD). Prescription drug misuse can have serious medical consequences. Providers at Sanford Health have reduced opioid prescriptions over the last three years in an effort to have fewer pills in circulation and a reduced opportunity for misuse.

Health Care and Wellness: Access to affordable health insurance, the availability of mental health providers, access to affordable health care, aces to affordable prescription drugs and behavioral health providers 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.

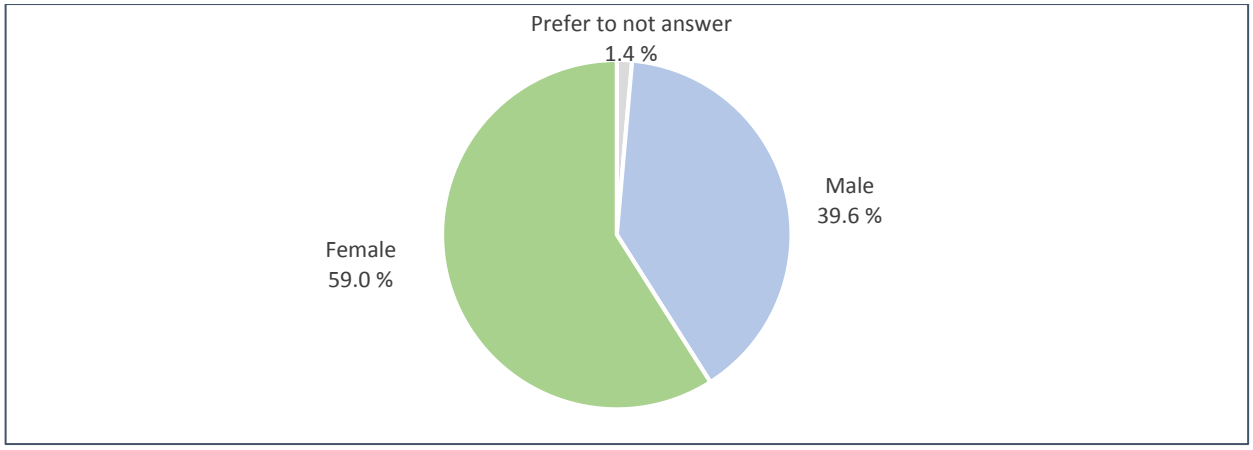
Mental Health and Substance Abuse: Alcohol use and abuse, drug use and abuse, and depression are top concerns for the community.



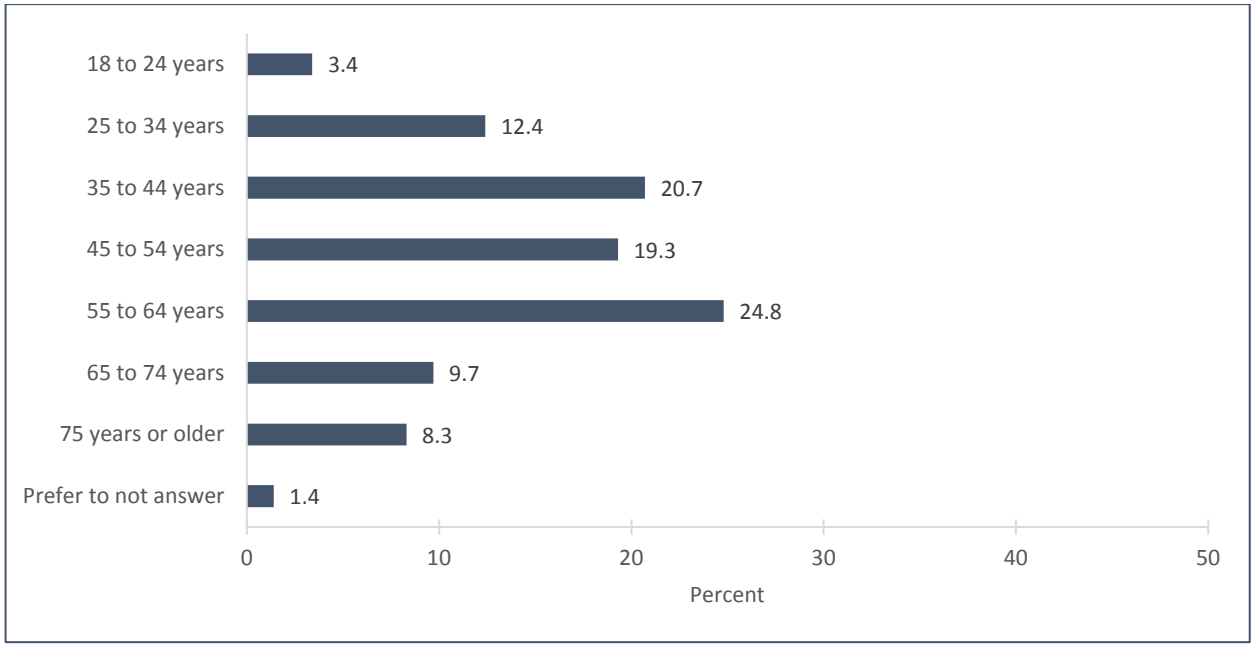
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental 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

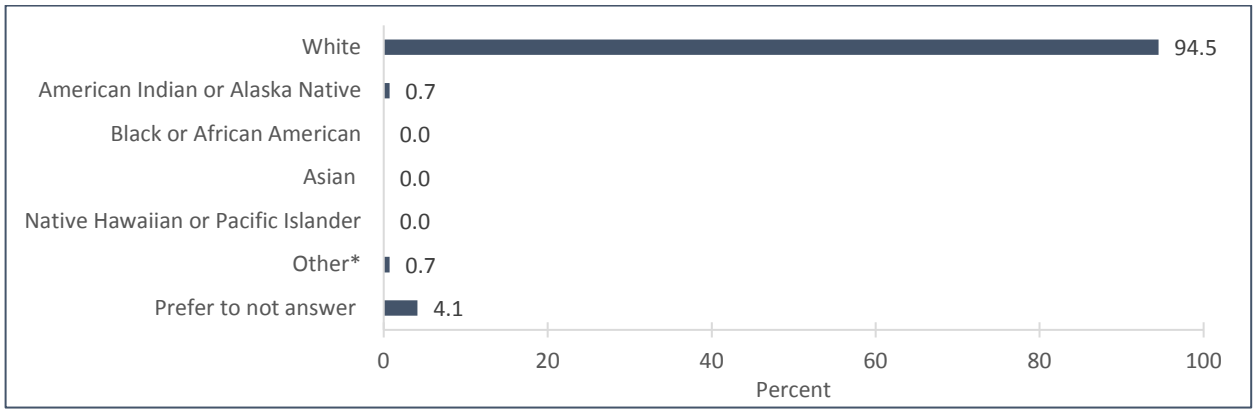
Biological Gender



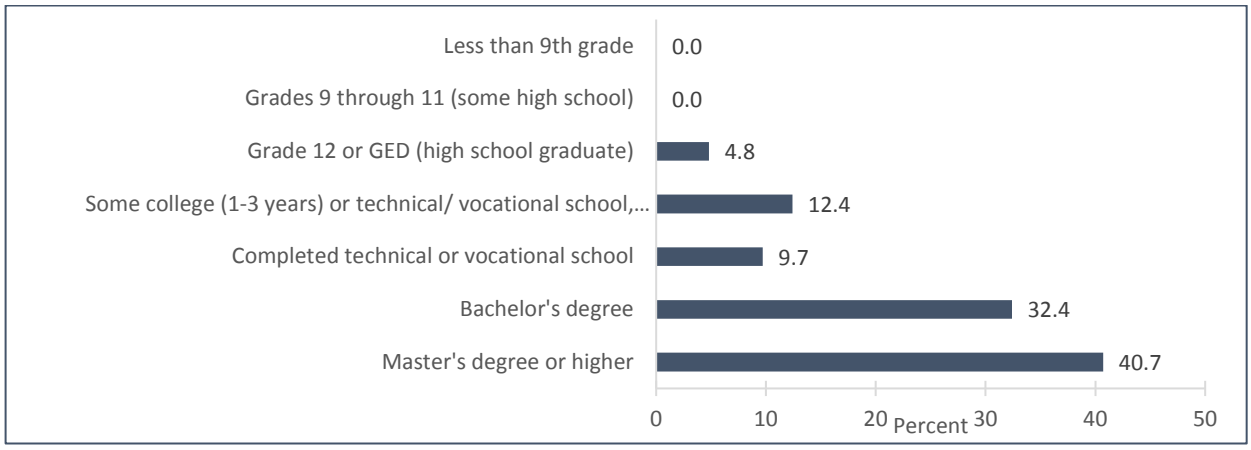
Age of Participants



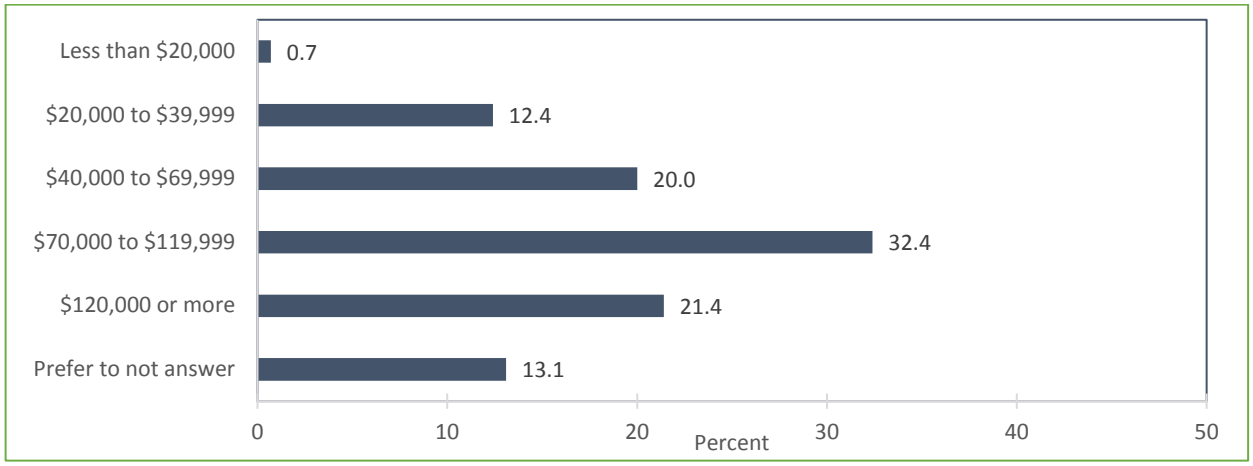
Race of Participants



Highest Level of Education Completed



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



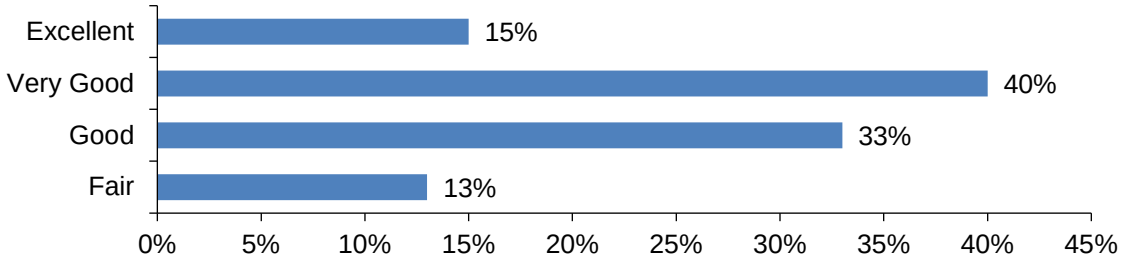
Residents' Health Concerns

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.

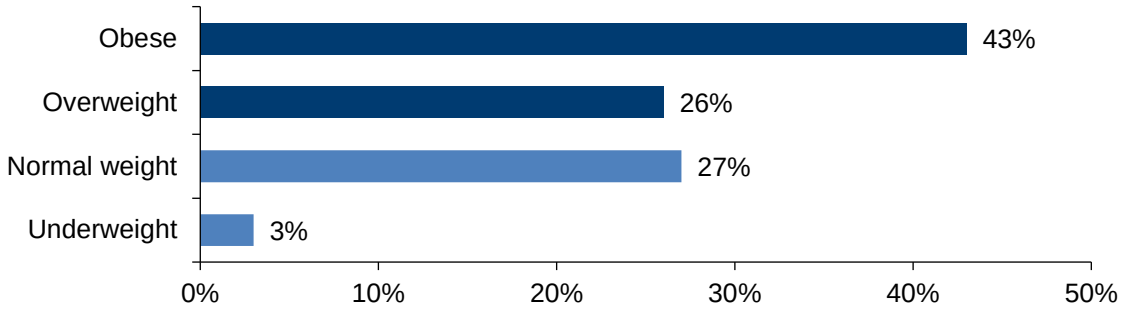
How would you rate your health?

Eighty-seven percent of survey participants rated their health as good or better.



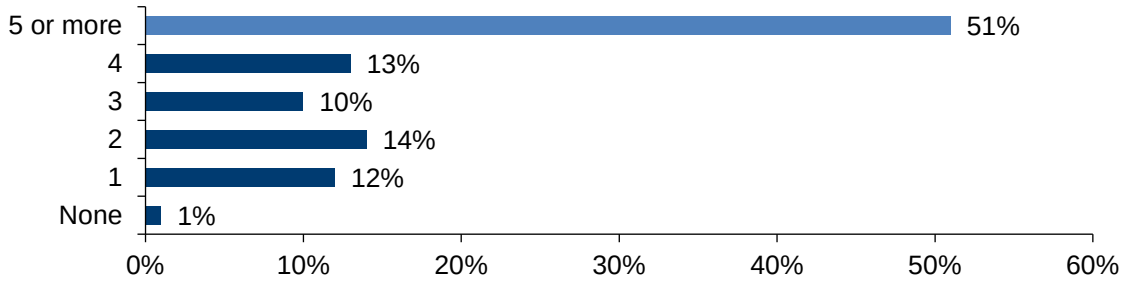
Body Mass Index

Forty-three percent of participants are overweight or obese.



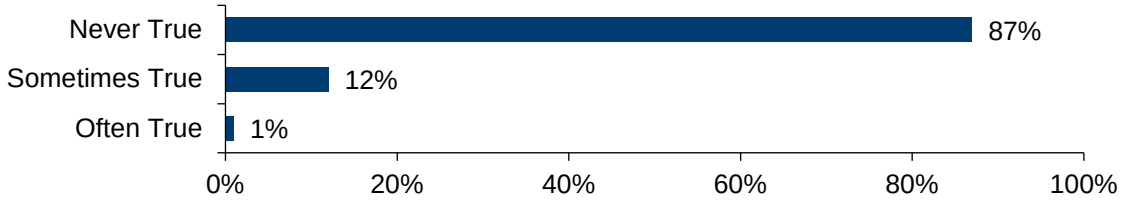
Total daily servings of fruits and vegetables

Only 51% are getting their recommended 5 or more a day servings of fruits and vegetables.



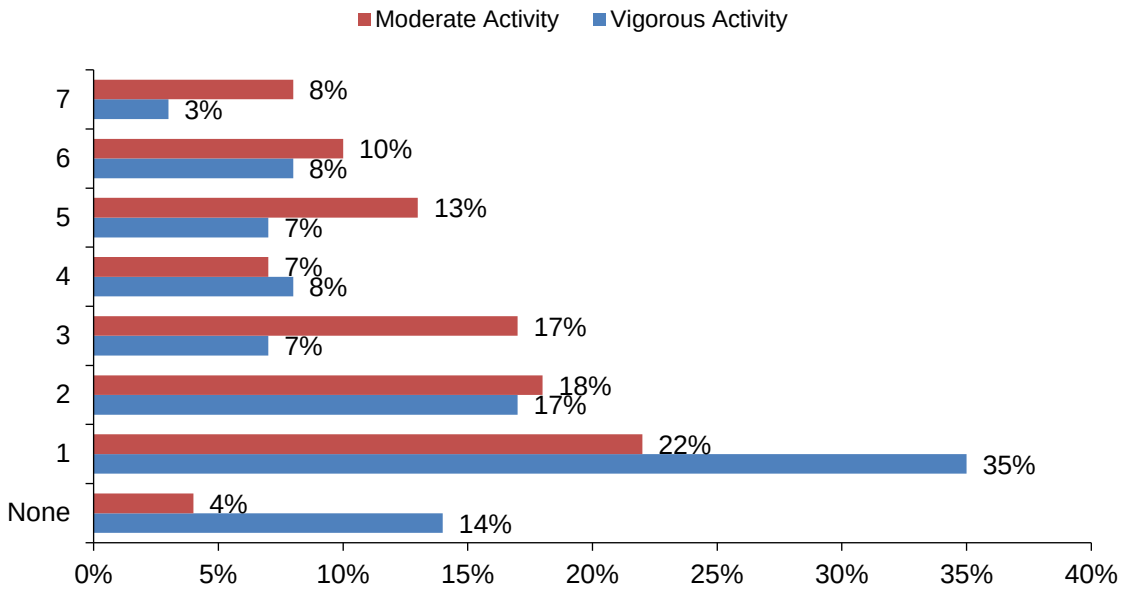
The food that we bought just didn't last, and we didn't have money to get more.

Thirteen percent of survey participants ran out of food.



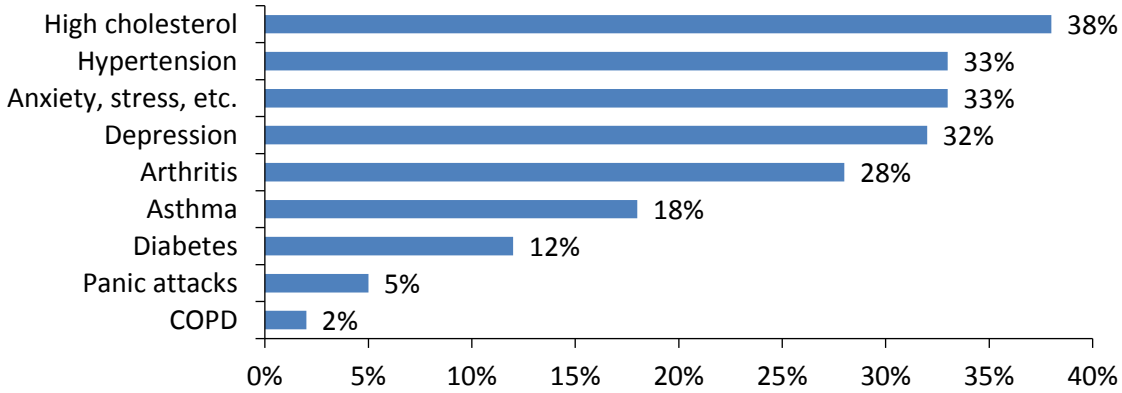
Days per week of physical activity

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



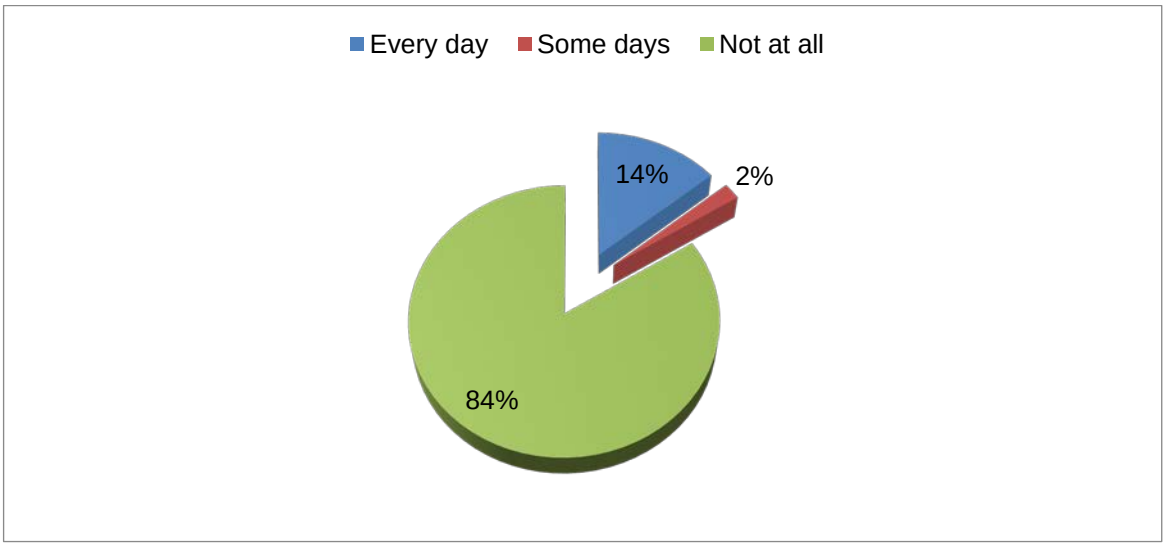
Past diagnosis

High cholesterol, hypertension, anxiety, depression and arthritis are the top chronic disease issues among survey participants.



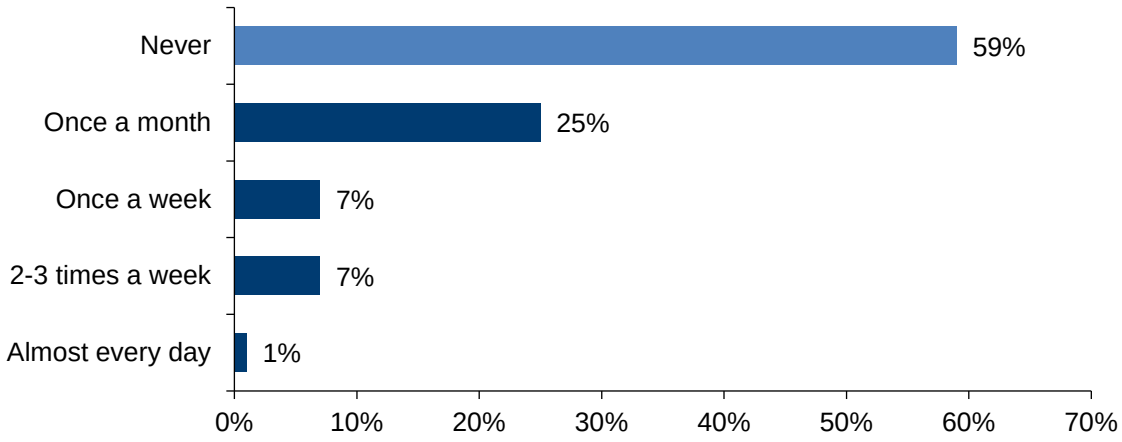
Tobacco use

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

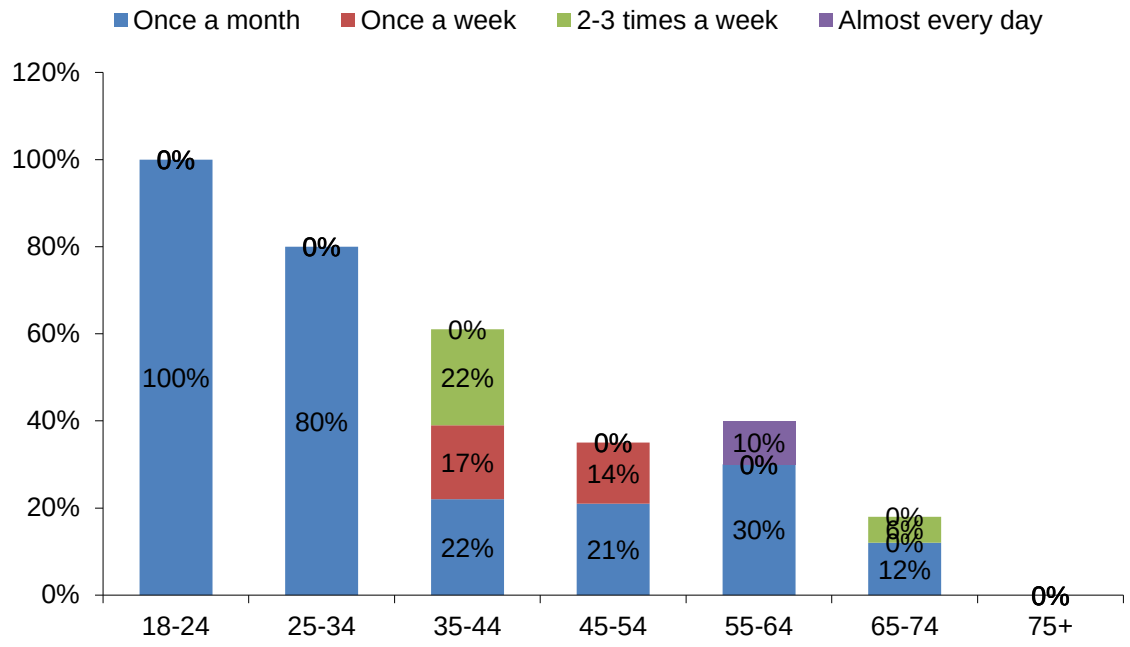


Binge drinking

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

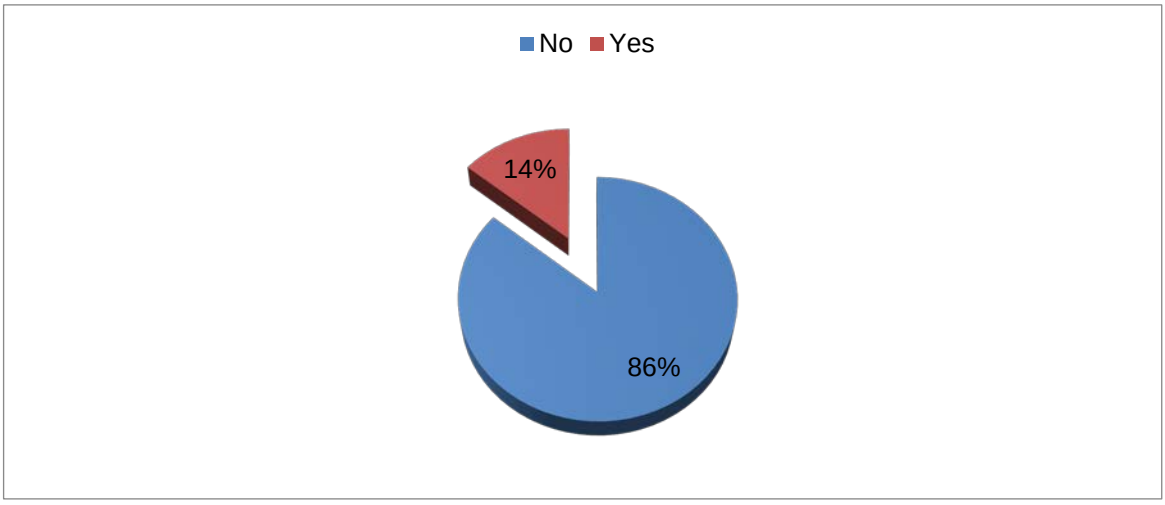


Binge drinking by age



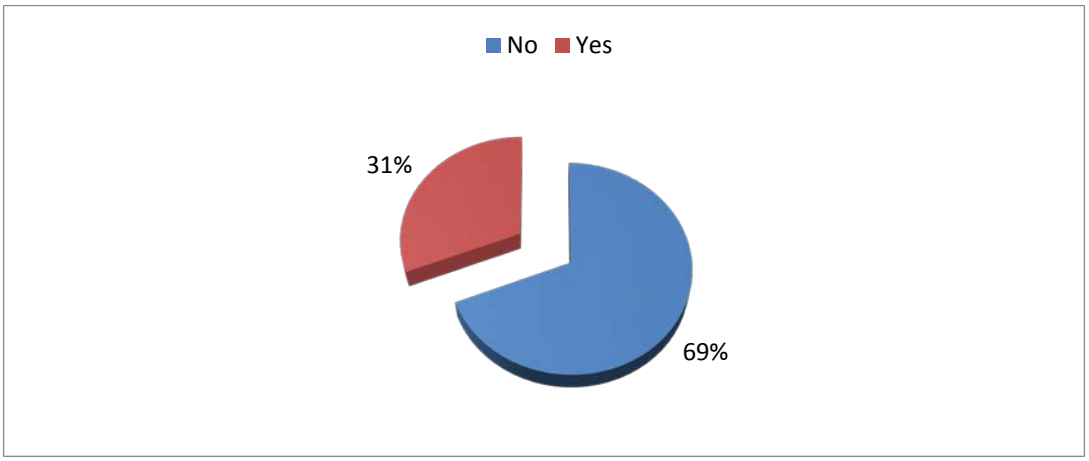
Has alcohol had a harmful effect on you or a family member in the past two years?

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



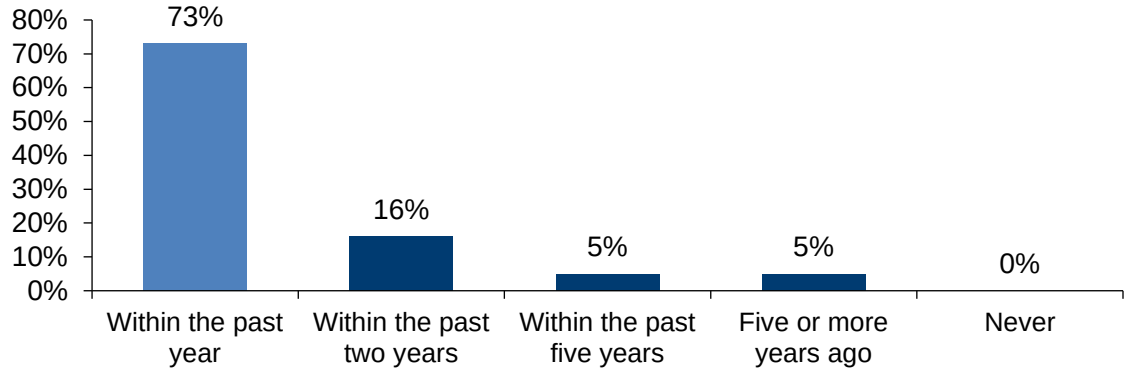
Do you have drugs in your home that are not being used?

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



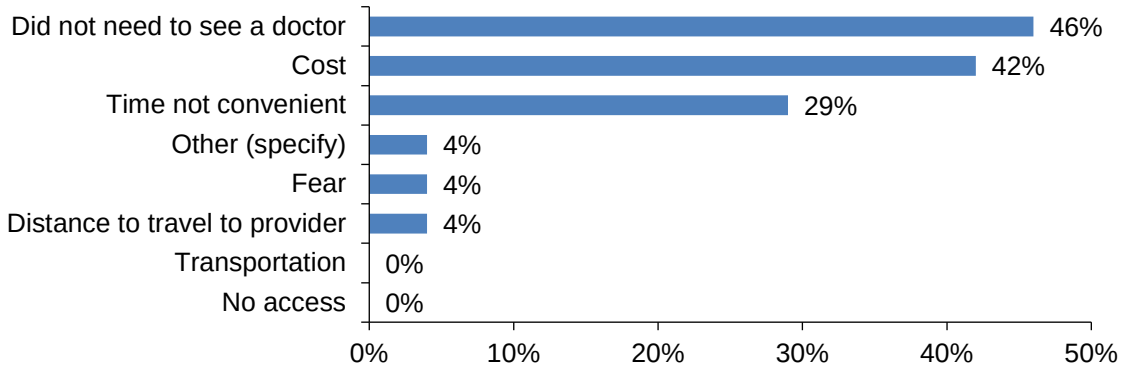
How long has it been since you visited a doctor or health care provider for a routine check-up?

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



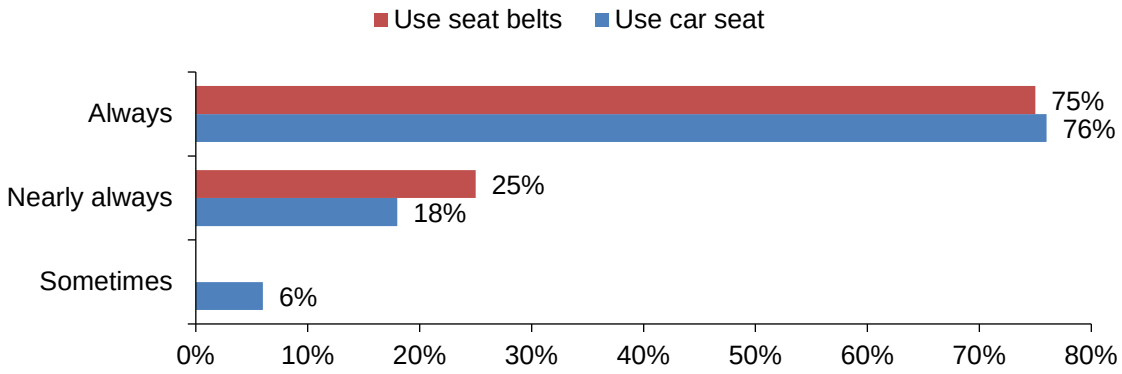
Barriers to routine check-up

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



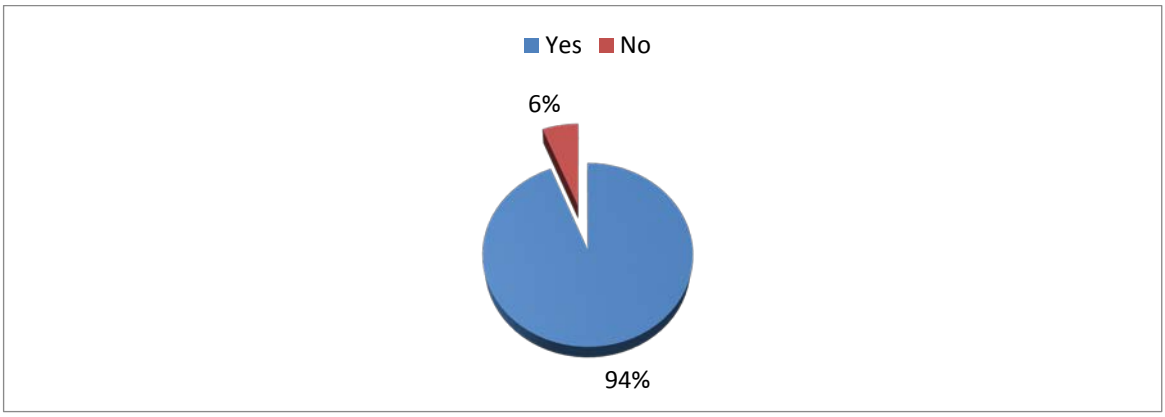
Child car safety

Twenty-five percent do not always use seat belts for their children, and twenty-four percent do not always use car seats.



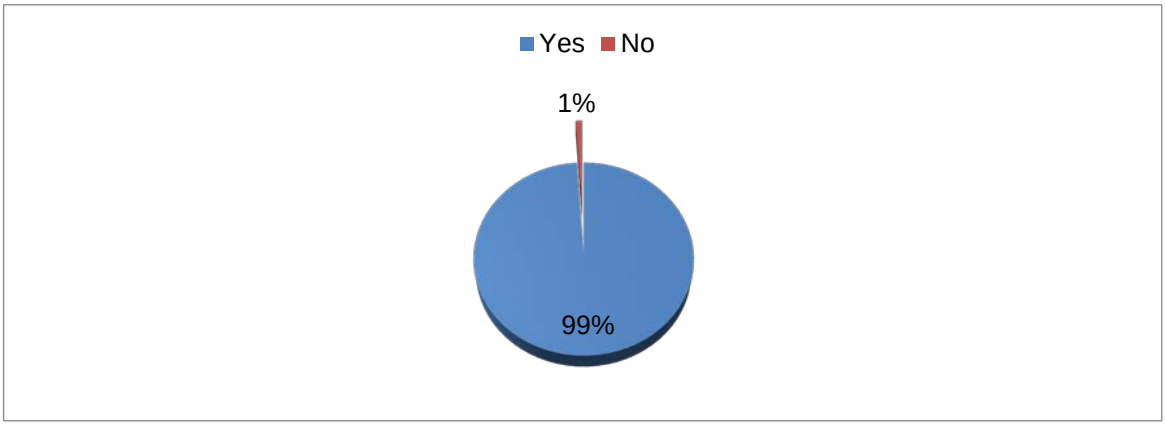
Do you have health care coverage for your children or dependents?

Ninety-four percent of survey participants have health insurance for their children or dependents.



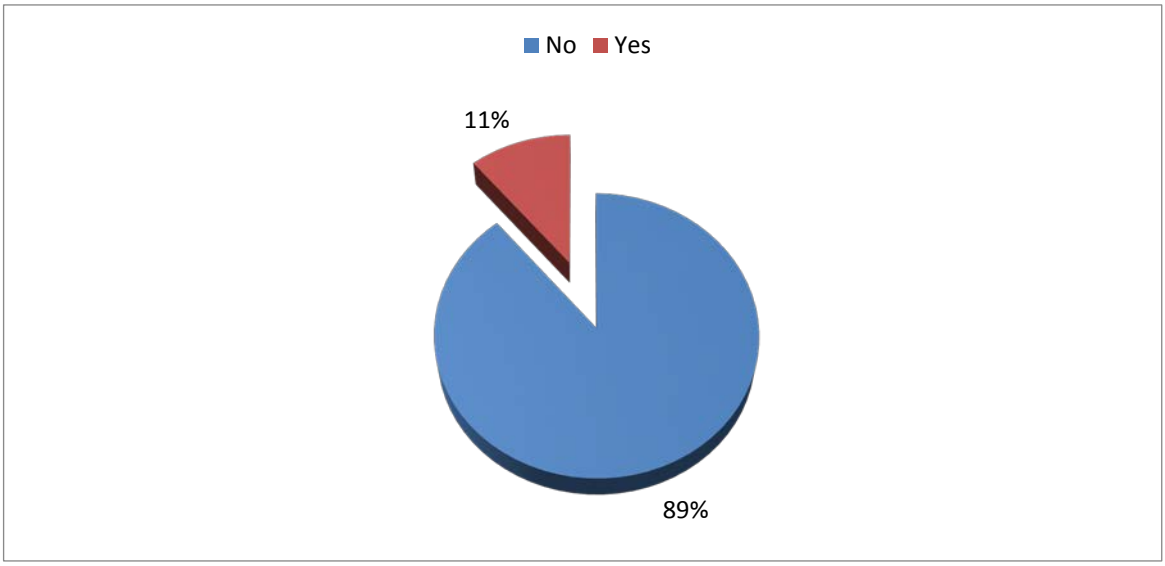
Do you currently have any kind of health insurance?

Ninety-nine percent of survey participants have health insurance.



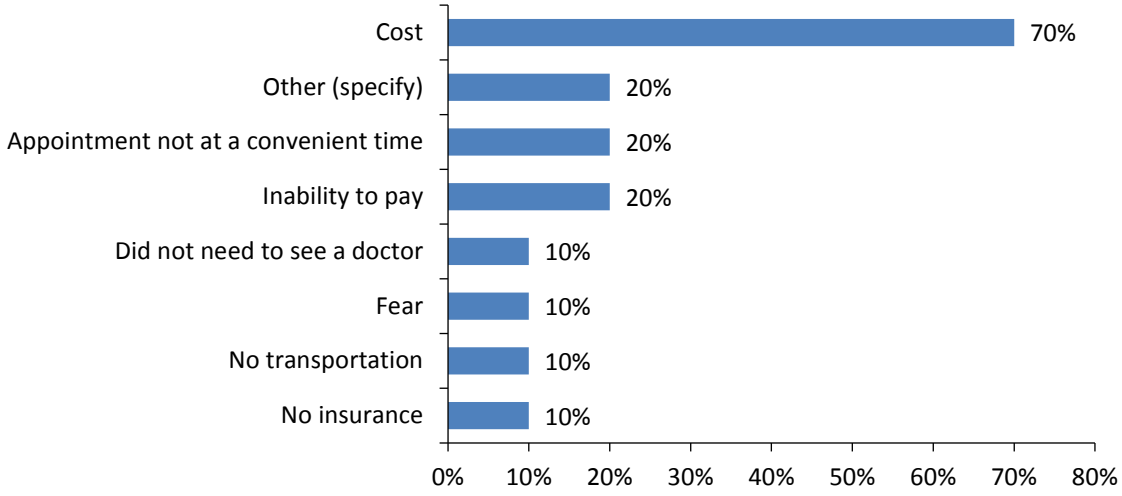
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?

Eleven percent of survey participants report not receiving the care they needed.



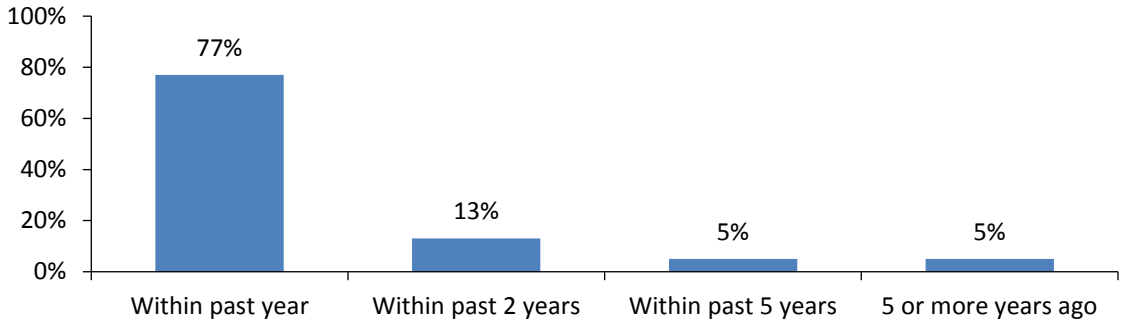
Barriers to Receiving Care Needed

Cost was a barrier for 70% of survey participants.



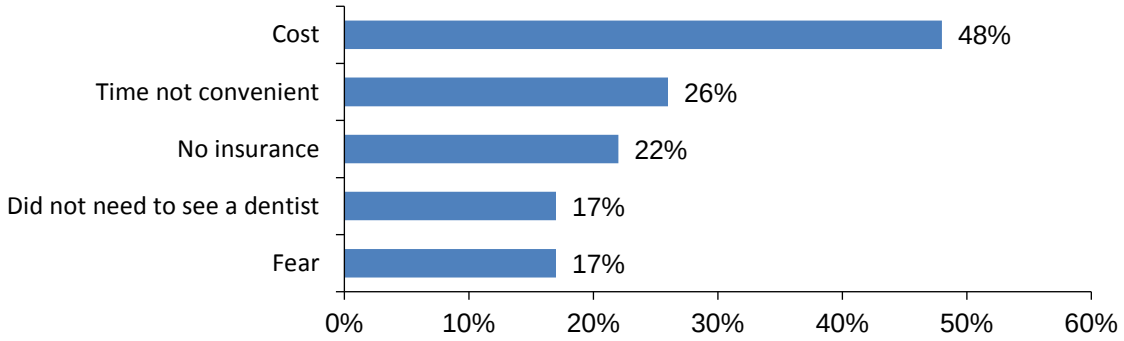
How long has it been since you visited a dentist?

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



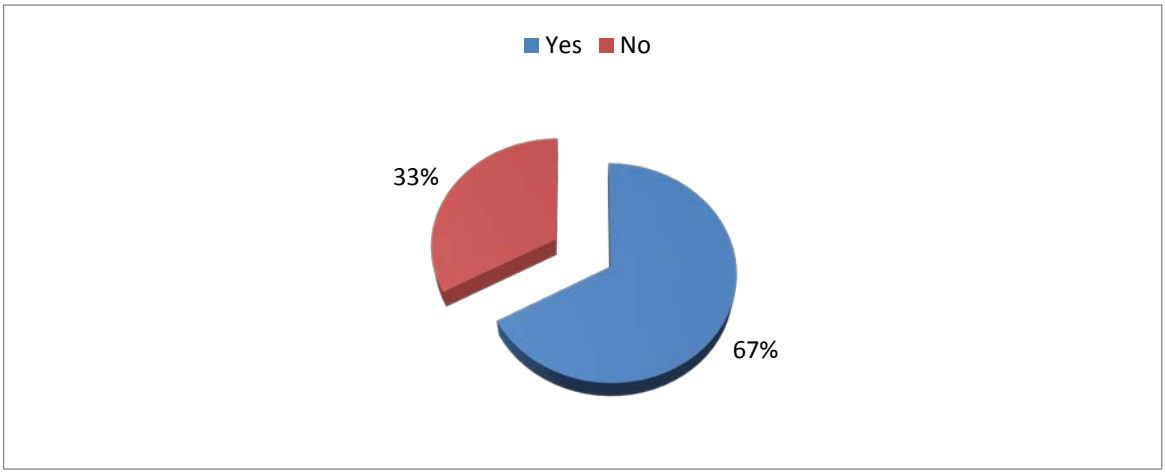
Barriers to visiting a dentist

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



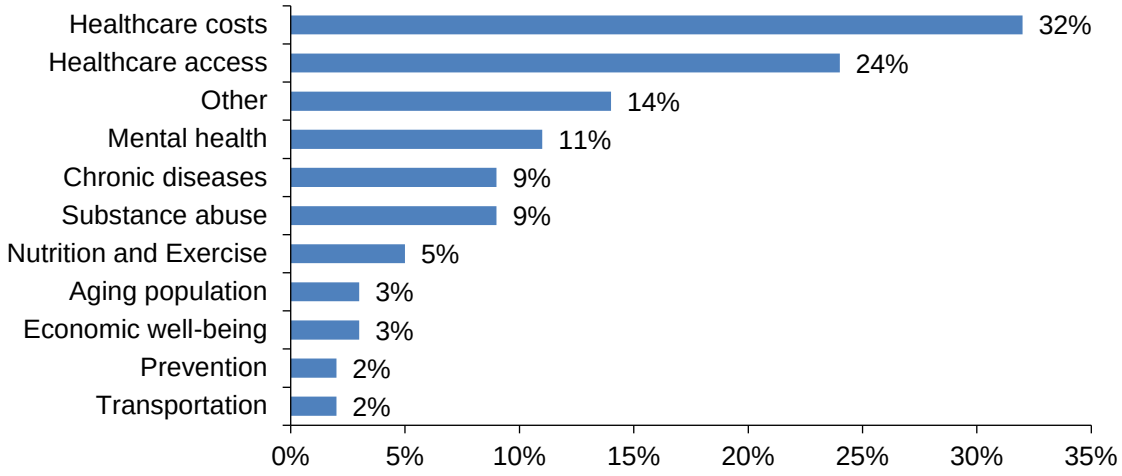
Do you have any type of dental insurance coverage?

Twenty-one percent of survey participants do not have dental insurance.



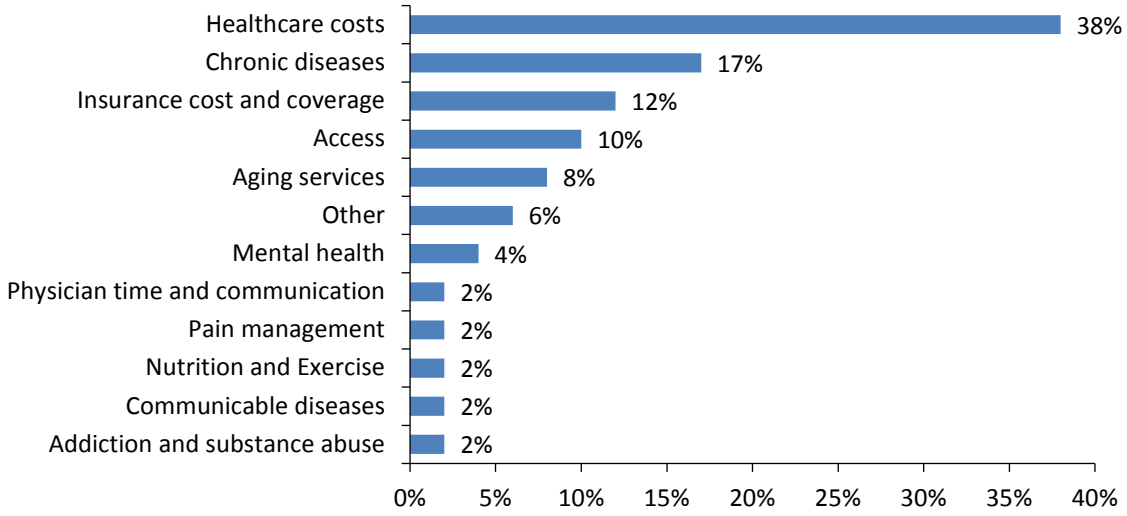
What are the most important community issues for you?

The cost of health care is a high concern for 32% of survey participants.



What are the most important community issues for your family?

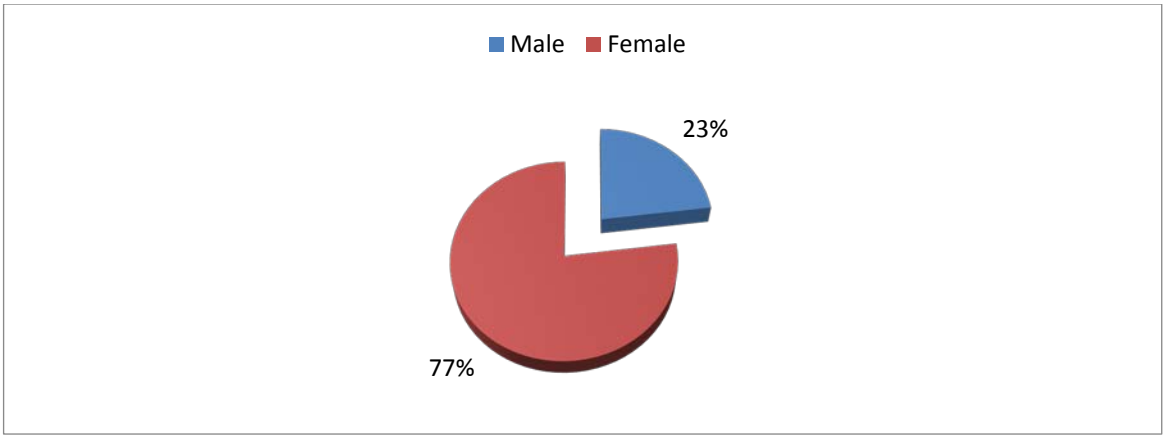
When asked what is the most important issue for the participant's family, access and health care costs were the top concerns.



Demographic Information for Community Resident Participants

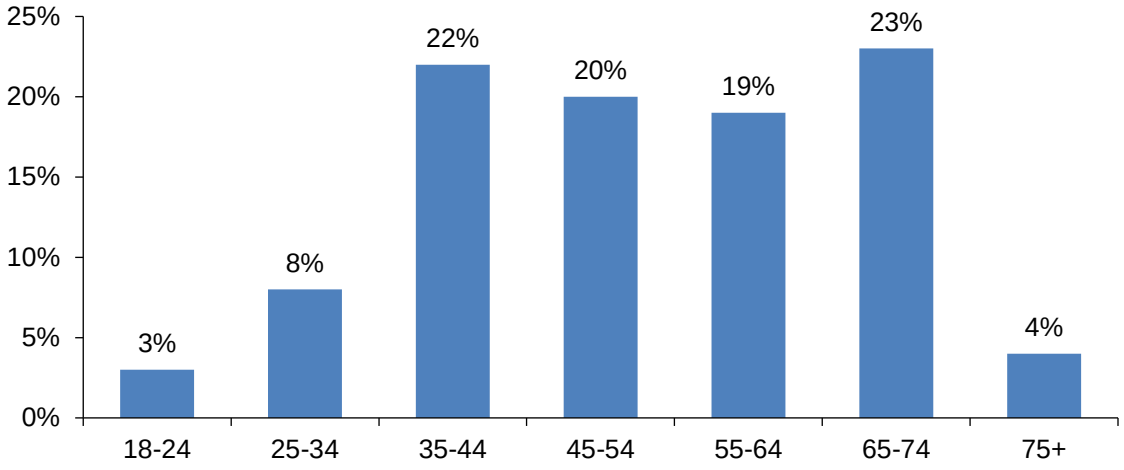
Biological Gender

Only 23% of the survey participants were male.

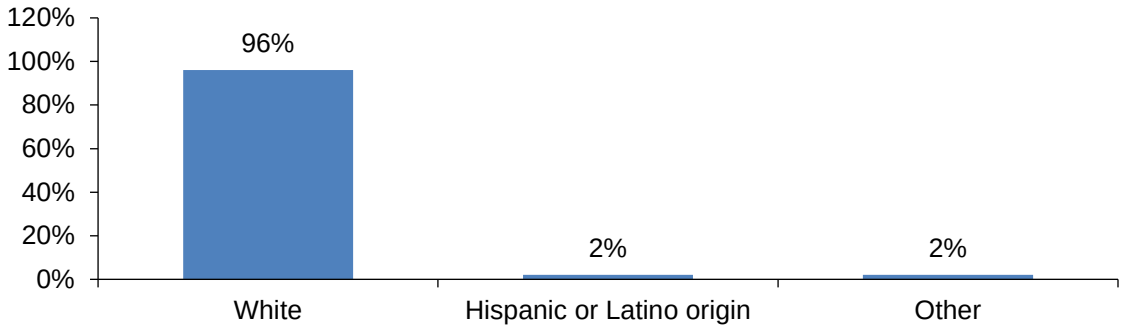


Age

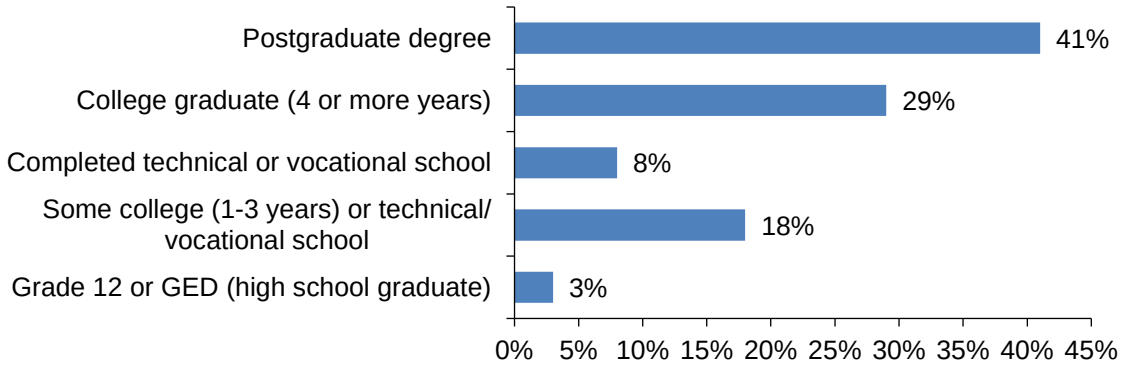
Every adult age group was represented.



Ethnicity

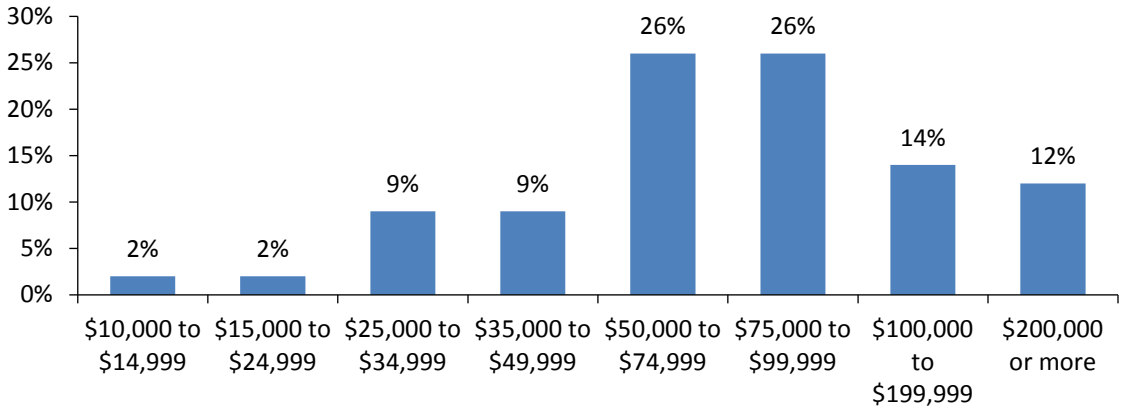


Education Level



Total Annual Household Income

Four percent of survey respondents live at or below the Federal Poverty Level for a family of four.



Secondary Research Findings

Census Data

	Clay County	Union County
Population	14,056	14,934
% below 18 years of age	17.4	24.2
% 65 and older	11.8	16.6
% White – non-Hispanic	88.2	92.5
American Indian	3.2	0.9
Hispanic	2.6	3.1
African American	1.7	0.9
Asian	2.3	1.3
% Female	50.4	49.3
% Rural	24.3	61.4

County Health Rankings

	Clay County	Union County	State of South Dakota	U.S. Top Performers
Adult smoking	18%	14%	18%	14%
Adult obesity	32%	30%	31%	26%
Physical inactivity	20%	22%	22%	20%
Excessive drinking	23%	21%	20%	13%
Alcohol-related driving deaths	17%	9%	37%	13%
Food insecurity	17%	9%	12%	10%
Uninsured adults	8%	5%	14%	7%
Uninsured children	8%	5%	7%	3%
Children in poverty	17%	8%	17%	12%
Children eligible for free or reduced lunch	35%	20%	42%	33%
Diabetes monitoring	81%	90%	84%	91%
Mammography screening	60%	62%	66%	71%
Median household income	$42,200	74,900	$54,900	$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

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.

The following concerns were brought forward for prioritization:

Criteria to Identify Priority Problems

- 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 2 votes • Availability of affordable housing 3.56 5 votes • 13% report that they run out of food before having enough money to buy more 3 votes
Children and Youth 1 vote • Substance abuse by youth 3.57 1 vote • Childhood obesity 3.53 1 vote
Aging Population • Cost of long-term care 3.87 • Cost of memory care 3.75 • Cost of in-home services 3.52
Safety • Culture of excessive and binge drinking 3.61 3 votes
Health Care Access • Access to affordable health insurance coverage 3.73 1 vote • Availability of mental health providers 3.61 1 vote • Access to affordable health care 3.58 2 votes • Access to affordable prescription drugs 3.51 • Availability of behavioral health (substance abuse) providers 3.50 • 33% of residents report not having health insurance
Mental Health and Substance Abuse 1 vote • Alcohol use and abuse 3.69 4 votes • 41% self-report binge drinking at least ix/month • Drug use and abuse 3.62 2 votes • 31% report that they have drugs in their home that are not being used • Depression 3.53 – 32% report a diagnosis • 33% report a diagnosis of anxiety/stress • 16% currently smoke cigarettes
Wellness • 38% report a diagnosis of high cholesterol • 33% report a diagnosis of hypertension • 28% report a diagnosis of arthritis • 26% report that they have not had a routine check-up in more than 1 year • 23% have not seen their dentist in more than 1 year • 20% have not had their flu shot this year • 45% do not get moderate activity 3 or more times each week 1 vote • 49% do not get their 5 or more servings of fruit/vegetables/day • 43% report that they are obese 1 vote • 26% report that they are overweight 1 vote

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

Implementation Strategies

How Sanford Vermillion 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 Vermillion is Addressing the Community Needs
ECONOMIC WELL BEING	
Availability of affordable housing	Sanford Vermillion is addressing the need for affordable housing by working with the City of Vermillion and Vermillion Area Chamber and Development Company (VCDC) to support the creation of additional affordable housing units on Mickelson Avenue and with the Bliss Pointe development project. The Bliss Pointe project adds 71 new lots for homes and an additional 15 acres to be developed in Phase 2 for multi-family housing units. Additionally Sanford Vermillion has addressed the need for affordable senior housing units by establishing a 29-bed Assisted Living Center on its campus. Many new apartment developments throughout Vermillion are also currently being constructed for additional housing units near the college campus to assist college students with housing needs. Appropriate referrals are made to the local Vermillion Housing & Development Commission (HUD) for housing assistance by SVMC providers as well.
Run out of food before they have money to buy more – 13%	Sanford Vermillion addresses by supporting community assistance programs through volunteer work by its staff and directly sponsoring programs such as the local Welcome Table at least twice a year to provide a free meal to anyone needing it in the community. The Welcome Table is provided by a local business or group each month who supplies the meal, staff and clean up. Sanford Vermillion also has a member of its Executive Team who is on the Vermillion Food Pantry board and volunteers there. SVMC providers refer patients as appropriate to the Food Pantry, which is open Monday-Friday and is available to any Clay county resident who falls within the income guidelines. Sanford Vermillion providers also refer patients as appropriate to the SNAP Program for food stamps/assistance. The Vermillion community also offers the Backpack Program for weekend meal assistance for children's families who sign up for it. Additionally a federal grant allows the Vermillion School District to offer a free summer lunch program for all children in Vermillion and the high school offers Tanager Take Out, which is a school-based food pantry to supplement the Backpack Program to assist students and families with food over the weekend. Sanford Vermillion has also helped to sponsor a truck delivery service, which has come twice per year to the Vermillion community to distribute free food commodities to anyone who arrives to pick up.
CHILDREN & YOUTH	
Substance abuse by youth	Sanford Vermillion is addressing the concern of substance abuse by our youth in the community by supporting the local DARE program in the Vermillion School District as well as encouraging our providers to provide community education to local students and groups on this topic and related topics. The SVMC providers seek appropriate resources and referrals when needed for their patients and a licensed addiction counselor was added to the SVMC Allied Health Staff to assist with patient evaluations and referrals to treatment centers and mental health services as appropriate. SVMC has also expanded the availability of mental health

Identified Concerns	How Sanford Vermillion is Addressing the Community Needs
	services at SVMC by adding evening mental health counseling appointments and adding a full time integrated health therapist to see patients in the clinic.
Childhood obesity	Sanford Vermillion is addressing the childhood obesity concern with the Sanford *fit* program they have sponsored in the Vermillion School District for the last several years that approximately 750 Kindergarten through 5th grade students participate in annually. Sanford Vermillion also offers monthly Sanford Profile outreach services for weight loss consultation and product purchase for the Vermillion community. Sanford Vermillion also supports wellness and exercise for all ages through the Sanford Vermillion *Great Strides* program, which encourages teams to exercise in a 6-week team competition. There also is an annual health and wellness fair that Sanford Vermillion provides for the Vermillion community that includes many free and reduced health screenings and has events focused solely for children. The Sanford Vermillion dietitian is also available for referrals for nutritional consultation. Sanford Vermillion also sponsors a number of wellness program events each year that over 3,500 community members have participated in, and also supports the City of Vermillion's expanded bike path.
AGING POPULATION	
Cost of long-term care	Sanford Vermillion is addressing the concern of the cost of long-term care by its participation in Lifelong Learning Institute, Sanford Health's current lobbying efforts for adequate Medicaid payments to cover cost of LTC, and referrals to state legislatures to address this important concern each year. SVMC also works to keep costs down at its own nursing home and assisted living center by keeping a conservative budget and only raises rates when absolutely necessary to cover its own costs of providing care.
Cost of memory care	Sanford Vermillion is addressing the concern of the cost of long-term care by its participation in Lifelong Learning Institute, Sanford Health's current lobbying efforts for adequate Medicaid payments to cover cost of LTC, and referrals to state legislatures to address this important concern each year. SVMC also works to keep costs down at its own nursing home and assisted living center by keeping a conservative budget and only raises rates when absolutely necessary to cover its own costs of providing care.
Cost of in-home services	Sanford Vermillion is addressing the concern of the cost of long-term care by its participation in Lifelong Learning Institute, Sanford Health's current lobbying efforts for adequate Medicaid payments to cover cost of LTC, and referrals to state legislatures to address this important concern each year.
SAFETY	
Culture of excessive & binge drinking	To address the community safety concerns of excessive and binge drinking among the Vermillion community, Sanford Vermillion has taken numerous actions including adding a Licensed Addiction Counselor to the SVMC Allied Health Staff, providing a SVMC representative on the USD Alcohol and Suicide Prevention Committee, and adding evening appointment availability for the SVMC Mental Health Counselor. SVMC has also hired an Integrated Health Therapist to address additional counseling needs and make referrals for additional mental health services as needed who is available for face-to-face visits and telehealth visits for the extended community. Additionally appropriate referrals are made to the community Mental Health Therapists as well including the local Licensed Practicing Counselor or Lewis and Clark Behavioral Health Services. SVMC providers also can refer patients to the various local AA programs and meetings that are held throughout the community and USD students are referred to

Identified Concerns	How Sanford Vermillion is Addressing the Community Needs
	either the USD Counseling Center or the USD Psychological Services Center for any counseling needs at no additional cost to them. Additionally, Sanford Vermillion works with and supports local law enforcement and USD Campus Police efforts with community legal needs related to excessive and binge drinking.
HEALTH CARE ACCESS	
Access to affordable health insurance coverage	Sanford Vermillion is addressing the need for affordable health insurance coverage to the Vermillion community by offering different insurance plans through Sanford Health Plan to it 250-plus employees. Sanford Vermillion also accepts most insurance plans, participates in the Medicaid/Medicare program, and offers a financial assistance program for the under-insured and those without health care insurance. Sanford Vermillion staff also refer patients to MedData for assistance with health care bills. The SVMC Wellness Program also offers free and reduced cost health, wellness and laboratory screenings and vaccinations at various community events and health fairs so community members can save on cost of an office visit for these items.
Availability of mental health providers	To address the concerns of availability of mental health providers for the Vermillion community, Sanford Vermillion has taken numerous actions including adding a Licensed Addiction Counselor to the SVMC Allied Health Staff, adding evening appointment availability for the SVMC Mental Health Counselor and hiring a full time Integrated Health Therapist (IHT) at our clinic. The IHT is able to address additional counseling needs, make referrals for additional mental health services as needed and is available for face-to-face visits as well as telehealth visits for the extended community. SVMC also has a Certified Nurse Practitioner specializing in Psychiatry seeing patients of all ages monthly at SVMC's Outreach Clinic. Additionally, the Vermillion community also has available to them other Mental Health Therapists in the community other than the ones at Sanford Vermillion including a Licensed Practicing Counseling and Lewis and Clark Behavioral Health Services who employs staff that work solely in the Vermillion community and have an office here for counseling services. They also see children in the school district at the schools. USD students are referred to either the USD Counseling Center or the USD Psychological Services Center for any counseling needs at no additional cost to them.
Access to affordable health care	Sanford Vermillion is addressing the need for access to affordable health care by offering clinic, outpatient, inpatient, emergency, acute care, and long-term care services to the Vermillion community 7 days per week. Sanford Vermillion also offers a competitive benefit package to its 250+ staff which includes health, dental and vision coverage to assist with accessing affordable health care. Sanford Vermillion accepts most insurance plans, participates in the Medicaid/Medicare program, and offers a financial assistance program for the under-insured and those without health care insurance. Sanford Vermillion staff also refer patients to MedData for assistance with health care bills. The SVMC Wellness Program also offers free and reduced cost health, wellness and laboratory screenings and vaccinations at various community events and health fairs so community members can save on cost of an office visit for these items. Sanford Vermillion also refers patients and community members as appropriate to the SD Department of Health Community Health Nurse Services for free or reduced health care services. There are also two other primary health clinics in Vermillion open Monday through Friday.

Identified Concerns	How Sanford Vermillion is Addressing the Community Needs
Access to affordable prescription drugs	Sanford Vermillion is addressing the community need for affordable prescription drugs by enlisting the SVMC RN Health Coach to assist our patients with finding prescription assistance programs such as Needymeds.com or the program available through MedData.
Availability of behavioral health (substance abuse) providers	To address the concerns of the availability of behavioral health providers for substance abuse in the Vermillion community, Sanford Vermillion has taken numerous actions. We have added a Licensed Addiction Counselor to the SVMC Allied Health Staff to assist with patient evaluations and referrals to treatment centers as appropriate, added evening appointment availability for the SVMC Mental Health Counselor and hired a full-time Integrated Health Therapist (IHT) at our clinic. The IHT is able to address additional counseling needs, make referrals for additional mental health services as needed and is available for face-to-face visits as well as telehealth visits for the extended community. SVMC also has a Certified Nurse Practitioner specializing in Psychiatry seeing patients of all ages monthly at SVMC's Outreach Clinic. Additionally, the Vermillion community also has available to them other Mental Health Therapists in the community other than the ones at Sanford Vermillion, including a Licensed Practicing Counseling and Lewis and Clark Behavioral Health Services who employs staff that work solely in the Vermillion community and have an office here for counseling services. They also see children in the school district at the schools. USD students are referred to either the USD Counseling Center or the USD Psychological Services Center for any counseling needs at no additional cost to them.
Don't have health insurance – 33%	Sanford Vermillion is addressing the need for health insurance coverage to the Vermillion community by offering different insurance plans through Sanford Health Plan to it 250+ employees. Sanford Vermillion also participates in the Medicaid/Medicare program and offers a financial assistance program for the under-insured and those without health care insurance. Sanford Vermillion staff also refer patients to MedData for assistance with health care bills. The SVMC Wellness Program also offers free and reduced cost health, wellness and laboratory screenings and vaccinations at various community events and health fairs so community members can save on the cost of an office visit for these items.
MENTAL HEALTH & SUBSTANCE ABUSE	
• Alcohol use & abuse • Binge drink at least 1 x / month – 41% • Drug use & abuse • Have drugs in the home that are not being used – 31% • Depression • Diagnosis of depression – 37% • Diagnosis of anxiety/stress – 33% • Currently smoke cigarettes – 16%	To address the community mental health and substance abuse concerns of alcohol use and abuse, binge drinking, drug use, depression and anxiety, Sanford Vermillion has taken numerous actions. We have added a Licensed Addiction Counselor to the SVMC Allied Health Staff, provided a SVMC representative on the USD Alcohol and Suicide Prevention Committee, and increased the availability of our Mental Health Therapist by adding evening appointment availability. SVMC has also hired an Integrated Health Therapist to address additional counseling needs and make referrals for additional mental health services as needed who is available for face-to-face visits and telehealth visits for the extended community. Additionally appropriate referrals are made to the community Mental Health Therapists as well including the local Licensed Practicing Counselor or Lewis and Clark Behavioral Health Services. SVMC providers also can refer patients to the various local AA programs and meetings that are held throughout the community and USD students are referred to either the USD Counseling Center or the USD Psychological Services Center for any counseling needs at no additional cost to them. Additionally, Sanford

Identified Concerns	How Sanford Vermillion is Addressing the Community Needs
	Vermillion works with and supports local law enforcement and USD Campus Police efforts related to excessive and binge drinking. Sanford Vermillion also supports the School District's DARE program that each student completes to reduce substance abuse. To address the community concern for having drugs in the home that are not being used, Sanford Vermillion refers patients and community members to the local police department's disposal of unused meds program at the police station. In addition, to address the need of community members who currently are smoking, Sanford Vermillion's Respiratory Therapist and all providers provide our patients with smoking cessation counseling at clinic appointments and inpatient stays. Resources to quit and referrals to the SD Quitline are also given to patients and community members by the SVMC staff at visits and various wellness events.
WELLNESS	
• Diagnosed with high cholesterol – 38% • Diagnosed with hypertension – 33% • Diagnosis of arthritis – 28% • Have not had a routine check-up in more than 1 year – 26% • Have not seen their dentist in more than 1 year – 23% • Have not had a flu shot this year – 20% • Do not get moderate exercise at least 3 x / week – 45% • Do not eat 5+ fruits/vegetables each day – 49% • Obese – 43% • Overweight – 26%	Sanford Vermillion is addressing the needs of the Vermillion community with high cholesterol, hypertension, arthritis, those without a routine medical or dental check-up or flu shot in last year, and those who are obese or overweight or do not exercise or eat enough fruit or vegetables in a number of different ways. The SVMC Health Coach assists patients with hypertension and have set goals for their patients with hypertension to get at or below 140/90, which we are currently at 92%. The SVMC Wellness Program offers free and reduced cost health, wellness and laboratory screenings including cholesterol checks, blood pressure screenings and flu vaccinations at various community events and health fairs. The Wellness Program also provides many community flu shot events where people of all ages can come and get their flu shot for a small fee or if they have certain insurances, we will bill it for them. We also have been doing drive-through flu shot clinics where the community can drive through a parking lot and get their vaccination without even exiting their vehicle. SVMC also offers the *Great Strides* walking incentive program to promote community fitness and exercise. The SVMC Dietitian is available for nutritional counseling for patients of all ages. Sanford Vermillion also provides Heart Healthy Cooking educational events and an Annual Health Fair with numerous stations for health and wellness education and free/reduced wellness and laboratory screenings available to the public. Sanford Vermillion has also been providing the Sanford *fit* program in the Vermillion School District for the past several years, which teaches 750 students annually about nutrition and reducing childhood obesity. Sanford Profile outreach services at SVMC are also available monthly for weight loss consultation and product purchase. Sanford Vermillion also supports the City of Vermillion with the expanded bike path around the city to encourage biking and walking. There are also two fitness facilities in Vermillion - USD Wellness Center and Anytime Fitness. Sanford Vermillion providers also refer patient for dental services to area dental providers as appropriate.

Implementation Strategies – 2019-2021

Priority 1: Economic Well Being

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.

Sanford Vermillion has made affordable housing and economic well-being a significant priority and has developed strategies to work with community partners and community leaders to improve the availability of affordable housing in the community.

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.

Community Health Needs Assessment
Implementation Strategy Action Plan – 2019-2021

Priority 1: Economic Well Being – Availability of Affordable Housing & Food

Projected Impact: Upon completion of the action plan, the Vermillion Community would see at least an increase in the awareness of the availability of affordable housing units in Vermillion.

Goal 1: Sanford Vermillion will request and participate in the conduction of a Housing Inventory for the city of Vermillion to determine the number of reduced income units currently in Vermillion.

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
SVMC to work with City of Vermillion and Vermillion Housing Authority to complete a Housing Inventory for the city of Vermilion to identify number of reduced income units available.	Completed Housing Inventory done by 12/2021	Work with City of Vermillion to establish budget and resource needs	Timothy Tracy Cindy Benzel	Vermillion Housing Authority City of Vermillion

Goal 2: Sanford Vermillion will encourage collaboration in the second phase of housing development at Bliss Pointe in Vermillion to increase the number of affordable housing units.

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Sanford Vermillion will collaborate with the Vermillion Chamber & Development Company (VCDC) and City of Vermillion to participate in the second phase of housing development at Bliss Pointe in Vermillion which includes developing an additional 15 acres of land for multi-family housing units.	Phase 2 development by 12/2021 with increase in number of affordable housing units	SVMC representatives will attend planning sessions for Phase 2 development and collaborate with City and VCDC on resource needs for Phase 2	Timothy Tracy Mary Merrigan	Vermillion Chamber & Development Company City of Vermillion

Goal 3: Sanford Vermillion will request an inventory of the food assistance programs available in the community and work with its community partners to build an awareness campaign for existing programs.

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
SVMC will work with its community partners to request an inventory of food assistance programs available to the community, identify any gaps and assist with locating needed resources to fill the gaps.	An inventory will be completed by 1/2021	Staff time to assist with inventory and review it	Mary Merrigan Julie Girard	Vermillion Food Pantry City of Vermillion Department of Social Services Vermillion School District
SVMC will work with its community partners to build a community awareness campaign for the existing food assistance programs.	Awareness campaign completed by 12/2021	SVMC representative time to assist with awareness campaigns as needed	SVMC Executive Team	Vermillion Food Pantry City of Vermillion Department of Social Services Vermillion School District Vermillion Chamber & Development Company

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

Projected Impact: By increasing mental health services in the community and working with its community partners, Sanford Vermillion could have a positive impact on the percentage of its community that report abusing alcohol and drugs.

Goal 1: Sanford Vermillion will increase the number of mental health services available in the Vermillion community.

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Sanford Vermillion will work with its own mental health providers, outreach providers, and community providers to identify where and how services can be increased such as using more telehealth, and increasing clinic hours available.	Number of mental health services provided; By 12/2021	Staffing; Telehealth equipment needs and updates	Tim Tracy Rachel Olson	Debra Gapp, LPC Lewis & Clark Behavioral Health Sanford Health

Demonstrating Impact from the 2017-2019 Implementation Strategies

Priority 1: Mental Health

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

Goal 1: Increase mental health services in the Vermillion community

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

Priority 2: Physical Health

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

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

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Provide monthly cooking classes to diabetic registry patients	Number of attendees; healthy lifestyle changes	Dietician	SVMC	Aramark
Safe bike to work/school program	Number of children biking to work; number of employees	Athletic Trainer	SVMC	Vermillion School District Vermillion Parks & Rec
Fund Sanford *fit* program with local schools	Increased activities for youth and reduction in pediatric obesity	Fund *fit* Program Coordinator	SVMC	Vermillion School District
Increase fruits & Veggies through bountiful basket or co-ops	Number of members in co-ops	Dietitian	SVMC	Vermillion Chamber - Farmers Market
Walk to work program for Sanford Vermillion employees	Number of in-town employees walking to work	Wellness Committee	SVMC	
Children's healthy cooking classes with parents	Number of attendees	Wellness Committee	SVMC	HyVee United Way
Provide Sanford health fair with free and reduced screenings; healthy education	Number of attendees	Wellness Committee	SVMC	USD Medical School

Demonstrating Impact from the 2017-2019 Implementation 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 Vermillion Medical Center, the top priorities addressed through an implementation strategy process include:

1. Mental Health Services
2. Physical Health/Poor Nutrition and Eating Habits in the Community

Improving the Mental Health Services in the Vermillion Community

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

Sanford has prioritized depression as a top priority and has set strategy to perform assessments for depression and to improve PHQ-9 scores for patients who are diagnosed with depression. The goal was to improve PHQ-9 scores for patients with depression. We have shown a 4% improvement in this short time with the percentage of patients with major depression or dysthymia who had an initial PHQ-9 score greater than nine whose six-month PHQ-9 score was less than five.

The goal of increasing the availability and number of mental health services in the Vermillion community was also set by Sanford Vermillion. Several strategies have been implemented to achieve this goal. The Mental Health Counselor now offers evening appointments in addition to regular daytime appointments. Sanford Vermillion also has hired a psychologist as their Integrated Health Therapist who works full-time offering mental health services to the extended community via face-to-face visits and through telehealth visits. Sanford Vermillion has also continued to provide a Certified Nurse Practitioner who specializes in Psychiatry to its monthly outreach services. She provides psychiatric services for patients of all ages from pediatrics to elderly monthly at the Sanford Clinic Vermillion.

Sanford Vermillion also credentialed and added to their allied health staff a Licensed Addiction Counselor to assist with patients in need of evaluation and/or rehabilitation services in the clinic, emergency room and inpatient setting.

Sanford Vermillion also has the equipment and medical staff credentialed to provide psychiatric outreach services via telemedicine services through our facility and Sanford USD Medical Center as another strategy to increase availability of services in the community.

We also collaborate with USD through our student health contract to offer the USD students counseling services on campus at the USD Counseling Center and the USD Psychological Services Center.

The other mental health services in the community are still available although they have not increased in availability; they have not decreased in number of providers or services.

Improve the Community's Physical Health with Education and Programs Sponsored by Sanford Vermillion

Through its RN Health Coach program, providers, dietitian and wellness programs, Sanford Vermillion has implemented several initiatives to achieve their goals set to reduce obesity in the community, improve their nutritional awareness, and improve the community's overall physical health.

For reducing obesity in the community, several strategies have been established. For children, Sanford Vermillion has been working with the Vermillion School District for several years implementing the Sanford Health *fit* initiative. This initiative continues to grow and has reached approximately 750 children this past year in grades kindergarten through 5th grade. It has been very well received in the community. Supported by the clinical experts of Sanford Health, *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food/nutrition, Move/activity, Mood/behavioral health and Recharge/sleep. Sanford's *fit* initiative has come a long way since its inception in 2010. Through Sanford *fit* we are actively working to promote healthy lifestyles in homes, schools, and throughout the community by way of technology, engaging programs and utilizing key role models in a child's life. For Sanford Vermillion, we are utilizing our athletic trainer to implement the program in the schools.

Sanford Vermillion also continues to encourage the Vermillion community to engage in all forms of exercise including sponsoring and hosting a number of events throughout the year such as Relay for Life. We also continue to host our annual community *Great Strides* walking program contest every spring for 6 weeks where 200 to 300 community members participate.

The RN Health Coach at Sanford Clinic Vermillion also continues to work with the diabetic and hypertension patients proactively to ensure they come in for their health maintenance visits and labs timely. Sanford has set strategies to provide optimal diabetic care and to measure outcomes for systolic and diastolic blood pressures, LDL cholesterol, hemoglobin A1c, tobacco use and aspirin use for people living with diabetes.

Sanford Vermillion has also set strategies to address hypertension through a standardized protocol, frequent blood pressure monitoring, and referral as appropriate for patients with hypertension. Outcome measures include a blood pressure of less than 140/90 for all ages 18-59 and for age 60+ with diabetes, vascular or renal disease. For patients age 60 or older without diabetes, vascular or renal disease the goal is blood pressure of 150/90 or less. We are currently meeting this goal with 92.1% of our hypertension patients having blood pressure of less than 140/90.

The Sanford Vermillion wellness program also makes over 3,000 community contacts per year through its various health screening and community vaccination events. We also continue to hold an annual health fair with free and reduced health screenings and a variety of reduced laboratory testing available along with a wealth of community educational offerings in which approximately 350 community members participate annually.

Educating the community on healthy nutrition was another strategy that Sanford Vermillion implemented by working with our dietitian and visiting cardiologist to provide healthy cooking classes to focused audiences to teach heart healthy cooking of delicious meals. These classes of 60 attendees were held at the local steakhouse, were sold out events, and the feedback has been very positive. We look forward to providing additional sessions in the future.

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 Vermillion Medical Center's CHNA.

Appendix

Primary Research

Vermillion Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
Economic Well Being	Availability of affordable housing 3.56 13% report that they run out of food before having enough money to buy more	13% report that they run out of food before having enough money to buy more	12% uninsured in Clay County, 7% in Union County 17% of children in Clay county live in poverty – 8% in Union County	Housing resources: • Vermillion Housing Authority, 25 Center St., Vermillion • CCCS of LSS SD (housing counseling agency), 816 E. Clark St., Vermillion • University Rentals, 844 E. Cherry St., Vermillion • Clark's Landing, 1305 E. Clark St., Vermillion • Dakota View, 1000 Elm St., Vermillion • Westgate Mobile Homes, 1312 Westgate Dr., Vermillion • Premier Real Estate, 1216 E. Cherry St., Vermillion • Dakota Realty, 125 E. Cherry St., Vermillion • Maloney Real Estate, 108 E. Main, Vermillion Low Income Apts.: • Applewood Court, 923 W. Clark, Vermillion • Cressman Court, 200 Hall St., Vermillion • Oakwood Apts., 1100-a E. Clark, Vermillion • Walnut St. Apts., 601 Elm St., Vermillion • Town Square Apts., 505 W. Main St., Vermillion • Madison Park Townhomes, 315 N. Norbeck St., Vermillion Food resources: • Vermillion Area Farmers Market, 515 High St., Vermillion • Morse Farmers Market, 3414 South Dakota St., Vermillion • Heikes Family Farm (CSA), 1408 – 317th St., Vermillion • Hy-Vee Grocery, 526 W. Cherry, Vermillion • Walmart Supercenter, 1207 Princeton Ave., Vermillion • Food Pantry, 816 E. Clark St., Vermillion • WIC program, 211 W. Main, Vermillion • SNAP program, 114 Market St., Vermillion

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
Children & Youth	Substance abuse by youth 3.57 Childhood obesity 3.53		17% of children in Clay county live in poverty – 8% in Union County	Substance Abuse resources: • Sanford Clinic Vermillion MSW & Psychologist Mental Health Therapy Services • Gapp Counseling Service, PO Box 553, Vermillion • Lewis & Clark Behavioral Health, 200 W. Main St., Vermillion • Vermillion Prevention Coalition, 414 E. Clark St., Vermillion • USD Psych Services Center (for students), 411 E. Clark St., Vermillion • USD Student Counseling Center (Cook House), 414 E. Clark St., Vermillion • Glory House, 4000 South West Ave., Sioux Falls • Keystone Outreach, 1010 E. 2nd St., Canton • Sioux Falls VA Medical Center, 2501 W. 22nd St., Sioux Falls • Tallgrass Recovery, 27048 S. Tallgrass Ave., Sioux Falls • Bartels Counseling, 6330 S. Western Ave., Sioux Falls • Choices Recovery, 2701 S. Minn. Ave., Sioux Falls • Jackson Recovery Center, 2309 Jackson St., Sioux Falls • Carroll Institute, 310 South 1st Ave., Sioux Falls • Sioux Falls Urban Indian Health, 711 N. Lake Ave., Sioux Falls • Transitional Living Corp., 27048 Tallgrass Ave., Sioux Falls • Sioux Falls Treatment Center, 2519 W. 8th St., Sioux Falls • Arch Halfway House, 516 W. 12th St., Sioux Falls • Changes & Choices Recovery Center, 310 S. 1st Ave., Sioux Falls • Face It Together, 5020 S. Tennis LN, Sioux Falls • Face It Together, 231 S. Phillips Ave., Sioux Falls • Minnehaha Co. Detox Center, 415 N. Dakota Ave., Sioux Falls Childhood Obesity resources: • Sanford Fit program – sanfordfit.org • Sanford dietitians, 20 S. Plum St., Vermillion • Hy-Vee dietitians, 525 W. Cherry St., Vermillion

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Vermillion school system athletic activities, 17 Prospect St., Vermillion • Parks & Recreation Dept., 603 Princeton St., Vermillion • USD Wellness Center, 1031 N. Univ. St., Vermillion • Youth Basketball, USD, 414 E. Clark St., Vermillion • Youth Soccer, PO Box 174, Vermillion • The Bluffs Golf Course, 2021 E. Main St., Vermillion • Barstow Ice Rink, Barstow St., Vermillion • Vermillion Fast Pitch Softball – retsubtsohg@yahoo.com • VADO Dance Organization, 13 E. Cherry Street • VAST Swim Team, 1101 N. Dakota St., Vermillion, SD • Walking/Hiking/Biking Trails – Cotton Park, 501 S. Dakota St., Vermillion • Parks & Playgrounds: o Lion's Park, Princeton/High Street, Vermillion o Jaycee Park, 218 12th St., Vermillion o Cotton Park, 501 S. Dakota St., Vermillion o Barstow Park, Carr/Cherry St., Vermillion o Prentis Park, Plum and Main St., Vermillion o Bliss Pointe Park, 1400 Rockwell Tr., Vermillion o Bluffs park, Augusta and Oakmont St., Vermillion o Ty Park, Brandon St/Burbank Rd, Vermillion o Rotary Park, N.Cottage St/Rice St., Vermillion • Swimming Pools: o Dakota Dome Pool, 1100 N. Dakota St., Vermillion o Prentis Plunge, Prentis Ave., Vermillion
Aging Population	Cost of long term care 3.87 Cost of memory care 3.75			Long Term Care resources: • SD Dept. of Social Services, 114 Market St., Vermillion • Sanford Dakota Gardens, 126 S. Plum St., Vermillion

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
	Cost of in-home services 3.52			• SD Dept. of Human Services respite care program, E. Hwy 34, Pierre • Sanford Care Center, 20 S. Plum St., Vermillion Memory Care resources: • Sanford Care Center, 20 S. Plum St., Vermillion • Alzheimer's Assn. – Alz.org In-Home Services: • HeartPrint Home Care, 2610 South Dakota 50, Vermillion • Sanford Home Care/Hospice, 848 E. Cherry St., Vermillion • Sanford Home Medical Equipment, 900 E. Cherry St., Vermillion • Home medical supplies – o Davis Pharmacy, 5 W. Cherry St., Vermillion o Walmart Pharmacy, 1207 Princeton Ave., Vermillion o Hy-Vee Pharmacy, 525 W. Cherry St., Vermillion
Safety	Culture of excessive and binge drinking 3.61		Alcohol impaired driving deaths 17% in Clay County, 9% in Union County	Substance Abuse resources: • Sanford Clinic Vermillion MSW & Psychologist Mental Health Therapy Services • USD Student Counseling Center (Cook House), 414 E. Clark St., Vermillion • Vermillion Prevention Coalition, 414 E. Clark St., Vermillion • USD Psych Services Center (for students), 411 E. Clark St., Vermillion • Gapp Counseling Service, PO Box 553, Vermillion • Lewis & Clark Behavioral Health, 200 W. Main St., Vermillion • Glory House, 4000 South West Ave., Sioux Falls • Keystone Outreach, 1010 E. 2nd St., Canton • Sioux Falls VA Medical Center, 2501 W. 22nd St., Sioux Falls • Tallgrass Recovery, 27048 S. Tallgrass Ave., Sioux Falls • Bartels Counseling, 6330 S. Western Ave., Sioux Falls • Choices Recovery, 2701 S. Minn. Ave., Sioux Falls • Jackson Recovery Center, 2309 Jackson St., Sioux Falls

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Carroll Institute, 310 South 1st Ave., Sioux Falls • Sioux Falls Urban Indian Health, 711 N. Lake Ave., Sioux Falls • Transitional Living Corp., 27048 Tallgrass Ave., Sioux Falls • Sioux Falls Treatment Center, 2519 W. 8th St., Sioux Falls • Arch Halfway House, 516 W. 12th St., Sioux Falls • Changes & Choices Recovery Center, 310 S. 1st Ave., Sioux Falls • Face It Together, 5020 S. Tennis LN, Sioux Falls • Face It Together, 231 S. Phillips Ave., Sioux Falls • Minnehaha Co. Detox Center, 415 N. Dakota Ave., Sioux Falls
Health Care Access	Access to affordable health insurance coverage 3.73 Availability of mental health providers 3.61 Access to affordable health care 3.58 Access to affordable prescription drugs 3.51 Availability of behavioral health (substance abuse) providers 3.50 33% of residents report not having health insurance	33% of residents report not having health insurance	Ratio of primary care providers in Clay County 1,750:1 and in Union County 1,150:1 Ratio of mental health providers in Clay County 2,010:1 and in Union County 2,990:1 Ratio of dentists in Clay County 1,570:1 and In Union County 1,490:1	Health Insurance resources: • Sanford Health Plan, 300 Cherapa Pl., Sioux Falls • Farm Bureau Ins., 120 E. Main, Vermillion • State Farm Ins., 16 E. Main, Vermilion • American Family Ins., 112 W. Main, Vermillion • HUB International, 15 E. Main, Vermillion Mental Health resources: • Sanford Clinic Vermillion MSW & Psychologist Mental Health Therapy Services • USD Student Counseling Center (Cook House), 414 E. Clark St., Vermillion • Vermillion Prevention Coalition, 414 E. Clark St., Vermillion • USD Psych Services Center (for students), 411 E. Clark St., Vermillion • Gapp Counseling, PO Box 553, Vermillion • Lewis & Clark Behavioral Health, 200 W. Main, Vermillion • Dakota Oak Counseling, 3220 W. 57th St., Sioux Falls • Sioux Falls Psychological Services, 2109 S. Norton Ave., Sioux Falls • Great Plains Psychological Services, 4105 S. Carnegie Cir., Sioux falls

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Southeastern Behavioral Healthcare, 2000 S. Summit Ave., Sioux Falls Health Care Resources: • Sanford Vermillion Clinic & Medical Center, 20 S. Plum St., Vermillion. Services include: o Sanford Community Care Program o Sanford Medical Home o Sanford Case Managers o Sanford Social Worker • USD Student Health Clinic (has discounted rates offered to students), 20 S. Plum St., Vermillion • Vermillion Medical Clinic, 101 S. Plum, Vermillion • Olson Medical Clinic, 1330 E. Main, Vermillion • Public Health, 211 W. Main, Vermillion • HeartPrint Home Care, 2610 South Dakota 50, Vermillion • Sanford Home Care/Hospice, 848 E. Cherry St., Vermillion • Sanford Home Medical Equipment, 900 E. Cherry St., Vermillion • Home Medical Supplies: o Davis Pharmacy, 5 W. Cherry St., Vermillion o Walmart Pharmacy, 1207 Princeton Ave., Vermillion o Hy-Vee Pharmacy, 525 W. Cherry St., Vermillion Prescription Assistance programs: • CancerCare co-payment assistance, 800-813-4673 • Freedrugcard.us • Rxfreecqrd.com • Medsavercard.com • Yourrxcard.com • Medicationdiscountcard.com • Nedymeds.org/drugcard • Caprxprogram.org • Southdakotarxcard.com • Gooddaysfromcdf.org • NORD Patient Assistance Program, rarediseases.org

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• SD Partnership for Prescription Assistance, pparx.org • Patient Access Network Foundation, panfoundation.org • Pfizer RC Pathways, pfizerRX pathways.com • RXhope.com Substance Abuse resources: • Sanford Clinic Vermillion MSW & Psychologist Mental Health Therapy Services • USD Student Counseling Center (Cook House), 414 E. Clark St., Vermillion • Vermillion Prevention Coalition, 414 E. Clark St., Vermillion • USD Psych Services Center (for students), 411 E. Clark St., Vermillion • Gapp Counseling Service, PO Box 553, Vermillion • Lewis & Clark Behavioral Health, 200 W. Main St., Vermillion • Glory House, 4000 South West Ave., Sioux Falls • Keystone Outreach, 1010 E. 2nd St., Canton • Sioux Falls VA Medical Center, 2501 W. 22nd St., Sioux Falls • Tallgrass Recovery, 27048 S. Tallgrass Ave., Sioux Falls • Bartels Counseling, 6330 S. Western Ave., Sioux Falls • Choices Recovery, 2701 S. Minn. Ave., Sioux Falls • Jackson Recovery Center, 2309 Jackson St., Sioux Falls • Carroll Institute, 310 South 1st Ave., Sioux Falls • Sioux Falls Urban Indian Health, 711 N. Lake Ave., Sioux Falls • Transitional Living Corp., 27048 Tallgrass Ave., Sioux Falls • Sioux Falls Treatment Center, 2519 W. 8th St., Sioux Falls • Arch Halfway House, 516 W. 12th St., Sioux Falls • Changes & Choices Recovery Center, 310 S. 1st Ave., Sioux Falls

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Face It Together, 5020 S. Tennis LN, Sioux Falls • Face It Together, 231 S. Phillips Ave., Sioux Falls • Minnehaha Co. Detox Center, 415 N. Dakota Ave., Sioux Falls
Mental Health & Substance Abuse	Alcohol use and abuse 3.69 41% self-report binge drinking at least 1x/month Drug use and abuse 3.62 31% report that they have drugs in their home that are not being used Depression 3.53 32% report a diagnosis of depression 33% report a diagnosis of anxiety/stress 16% currently smoke cigarettes	41% self-report being drinking at least 1x/day 31% report that they have drugs in their home that are not being used 32% report a diagnosis of depression 33% report a diagnosis of anxiety/stress 16% currently smoke cigarettes	Excessive drinking in Clay County 23% and in Union County 21% Adult smoking in Clay County 18% and in Union County 14%	Substance Abuse resources: • Sanford Clinic Vermillion MSW & Psychologist Mental Health Therapy Services • USD Student Counseling Center (Cook House), 414 E. Clark St., Vermillion • Vermillion Prevention Coalition, 414 E. Clark St., Vermillion • USD Psych Services Center (for students), 411 E. Clark St., Vermillion • Gapp Counseling Service, PO Box 553, Vermillion • Lewis & Clark Behavioral Health, 200 W. Main St., Vermillion • Glory House, 4000 South West Ave., Sioux Falls • Keystone Outreach, 1010 E. 2nd St., Canton • Sioux Falls VA Medical Center, 2501 W. 22nd St., Sioux Falls • Tallgrass Recovery, 27048 S. Tallgrass Ave., Sioux Falls • Bartels Counseling, 6330 S. Western Ave., Sioux Falls • Choices Recovery, 2701 S. Minn. Ave., Sioux Falls • Jackson Recovery Center, 2309 Jackson St., Sioux Falls • Carroll Institute, 310 South 1st Ave., Sioux Falls • Sioux Falls Urban Indian Health, 711 N. Lake Ave., Sioux Falls • Transitional Living Corp., 27048 Tallgrass Ave., Sioux Falls • Sioux Falls Treatment Center, 2519 W. 8th St., Sioux Falls • Arch Halfway House, 516 W. 12th St., Sioux Falls • Changes & Choices Recovery Center, 310 S. 1st Ave., Sioux Falls • Face It Together, 5020 S. Tennis LN, Sioux Falls • Face It Together, 231 S. Phillips Ave., Sioux Falls

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Minnehaha Co. Detox Center, 415 N. Dakota Ave., Sioux Falls Drug Take Back Programs: • Vermillion Police, 15 Washington St., Vermillion • Union Co. Sheriff, 209 E. Main, Elk Point Mental Health resources: • Sanford Clinic Vermillion MSW & Psychologist Mental Health Therapy Services • USD Student Counseling Center (Cook House), 414 E. Clark St., Vermillion • Vermillion Prevention Coalition, 414 E. Clark St., Vermillion • USD Psych Services Center (for students), 411 E. Clark St., Vermillion • Gapp Counseling, PO Box 553, Vermillion • Lewis & Clark Behavioral Health, 200 W. Main, Vermillion • Dakota Oak Counseling, 3220 W. 57th St., Sioux Falls • Sioux Falls Psychological Services, 2109 S. Norton Ave., Sioux Falls • Great Plains Psychological Services, 4105 S. Carnegie Cir., Sioux falls • Southeastern Behavioral Healthcare, 2000 S. Summit Ave., Sioux Falls Tobacco Cessation resources: • Sanford Clinic Vermillion, 20 S. Plum St., Vermillion • USD Student Health Clinic (for students), 20 S. Plum St., Vermillion • Olson Medical Clinic, 1330 E. Main, Vermillion • Vermillion Medical Clinic, 101 S. Plum St., Vermillion • Public Health, 211 W. Main, Vermillion • Quitline - SDQuitline.com • SD Dept. of Health, 600 E. Capitol Ave., Pierre (has many resources)
Wellness	38% report a diagnosis of high cholesterol	38% report a diagnosis of high cholesterol	Adult obesity in Clay County 32% and in Union County 30%	Chronic Disease resources:

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
	33% report a diagnosis of hypertension 28% report a diagnosis of arthritis 26% report that they have not had a routine check-up in more than 1 year 23% have not seen their dentist in more than 1 year 20% have not had their flu shot this year 45% do not get moderate activity 3 or more times each week 49% do not get their 5 or more servings of fruits/vegetables per day 43% report that they are obese 26% report that they are overweight	33% report a diagnosis of hypertension 28% report a diagnosis of arthritis 26% report that they have not had a routine check-up in more than 1 year 23% have not seen their dentist in more than 1 year 20% have not had their flu shot this year 45% do not get moderate activity 3 or more times each week 49% do not get their 5 or more servings of fruits/vegetables per day 43% report that they are obese 26% report that they are overweight		• Better Choices Better Health, Sanford Clinic, 20 S. Plum St., Vermillion • American Heart Assn . – heart.org • Arthritis Foundation, PO Box 90445, Sioux Falls • Sanford Clinic Vermillion, 20 S. Plum St., Vermillion • Sanford Vermillion Medical Center, 20 S. Plum St., Vermillion • Vermillion Medical Clinic, 101 S. Plum St., Vermillion • Olson Medical Clinic, 1330 E. Main, Vermillion • Public Health, 211 W. Main, Vermillion • FYZICAL therapy & balance, 1407 E. Cherry St., Vermillion Routine Check-Up/Flu Shot resources: • Sanford Clinic Vermillion, 20 S. Plum St., Vermillion • USD Student Health Clinic (for students), 20 S. Plum St., Vermillion • Vermillion Medical Clinic, 101 S. Plum St., Vermillion • Olson Medical Clinic, 1330 E. Main, Vermillion • Public Health, 211 W. Main, Vermillion Dental resources: • Knutson Family Dentistry, 1714 E. Cherry St., Vermillion • Houska Dental Clinic, 1302 E. Main, Vermillion • Vermillion Dental Health, 11 Court St., Vermillion • USD Dental Hygiene Department, 414 E. Clark St., Vermillion • Medicaid Referral Center – 800-627-3961 • Dakota Smiles mobile unit (for those who do not have a dental home) – deltadentalSD.com Physical Activity resources: • Vermillion school system athletic activities, 17 Prospect St., Vermillion • Parks & Recreation Dept., 603 Princeton St., Vermillion

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need

				• USD Wellness Center, 1031 N. Univ. St., Vermillion
				• Anytime Fitness, 838 E. Cherry St., Vermillion
				• FYZICAL, 1407 E. Cherry St., Vermillion
				• Youth Basketball, USD, 414 E. Clark St., Vermillion
				• Youth Soccer, PO Box 174, Vermillion
				• VADO Dance Organization, 13 E. Cherry Street
				• VAST Swim Team, 1101 N. Dakota St., Vermillion, SD
				• The Bluffs Golf Course, 2021 E. Main St., Vermillion
				• Barstow Ice Rink, Barstow St., Vermillion
				• Vermillion Fast Pitch Softball – retsubtsohg@yahoo.com
				• Walking/Hiking/Biking Trails – Cotton Park, 501 S. Dakota St., Vermillion
				• Parks & Playgrounds:
				  o Lion's Park, Princeton/High Street, Vermillion
				  o Jaycee Park, 218 12th St., Vermillion
				  o Cotton Park, 501 S. Dakota St., Vermillion
				  o Barstow Park, Carr/Cherry St., Vermillion
				  o Prentis Park, Plum and Main St., Vermillion
				  o Bliss Pointe Park, 1400 Rockwell Tr., Vermillion
				  o Bluffs park, Augusta and Oakmont St., Vermillion
				  o Ty Park, Brandon St/Burbank Rd, Vermillion
				  o Rotary Park, N.Cottage St/Rice St., Vermillion
				• Swimming Pools:
				  o Dakota Dome Pool, 414 E. Clark St., Vermillion
				  o Prentis Plunge, Prentis Ave., Vermillion
				
				Healthy Food resources:
				• Vermillion Area Farmers Market, 515 High St., Vermillion
				• Morse Farmers Market, 3414 South Dakota St., Vermillion
				• Heikes Family Farm (CSA), 1408 – 317th St., Vermillion

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Hy-Vee Grocery, 526 W. Cherry, Vermillion • Walmart Supercenter, 1207 Princeton Ave., Vermillion Obesity resources: • Sanford Profile Coach, 20 S. Plum St., Vermillion • Sanford dietitians, 20 S. Plum St., Vermillion • Hy-Vee dietitians, 525 W. Cherry St., Vermillion

Key Resident Survey

Sanford Vermillion 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 Vermillion 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, including but not limited to the Chamber of Commerce and leadership groups within the University of South Dakota, 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 164 respondents participated in the online survey.

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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

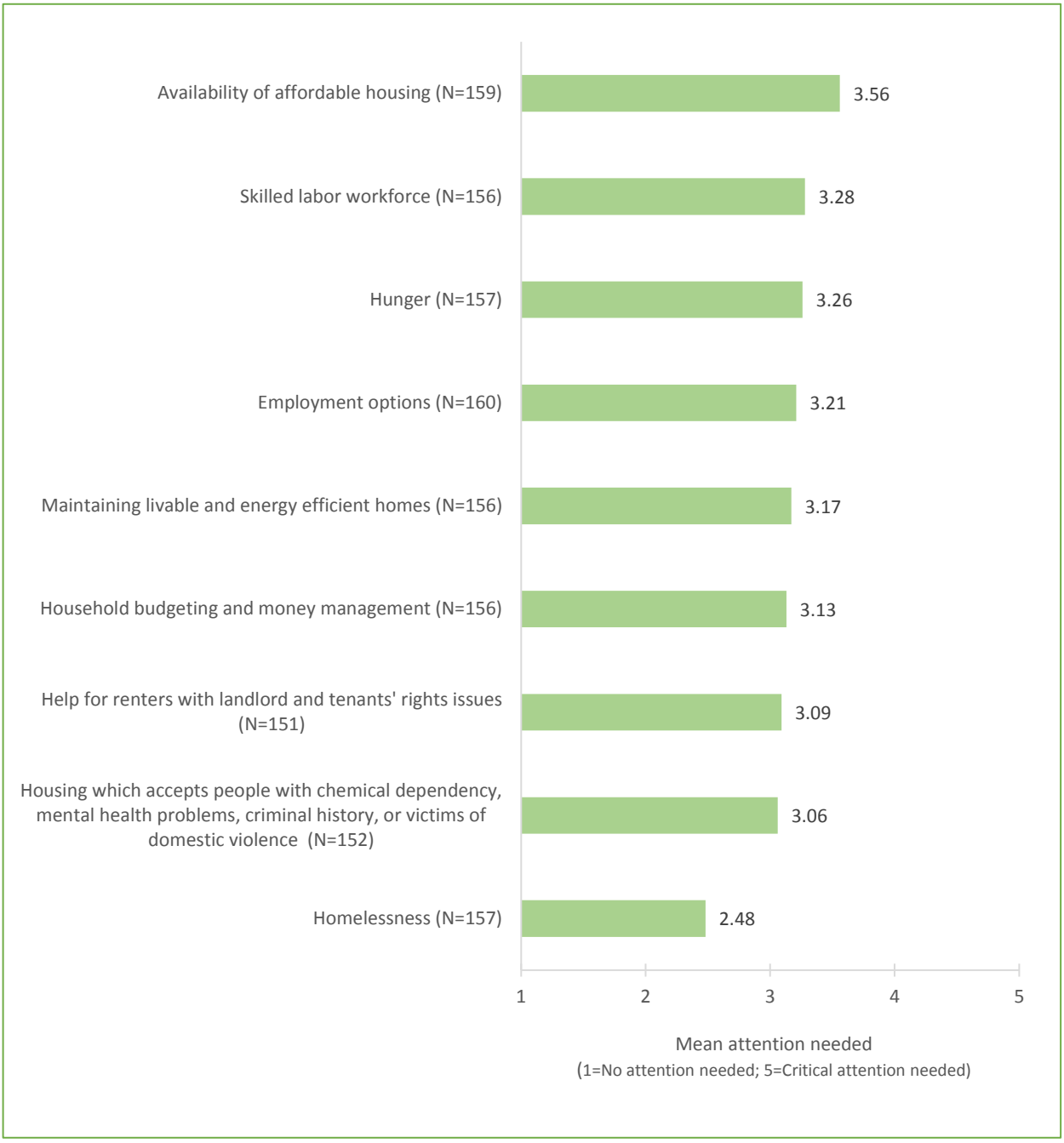


Figure 2. Current state of community issues regarding TRANSPORTATION

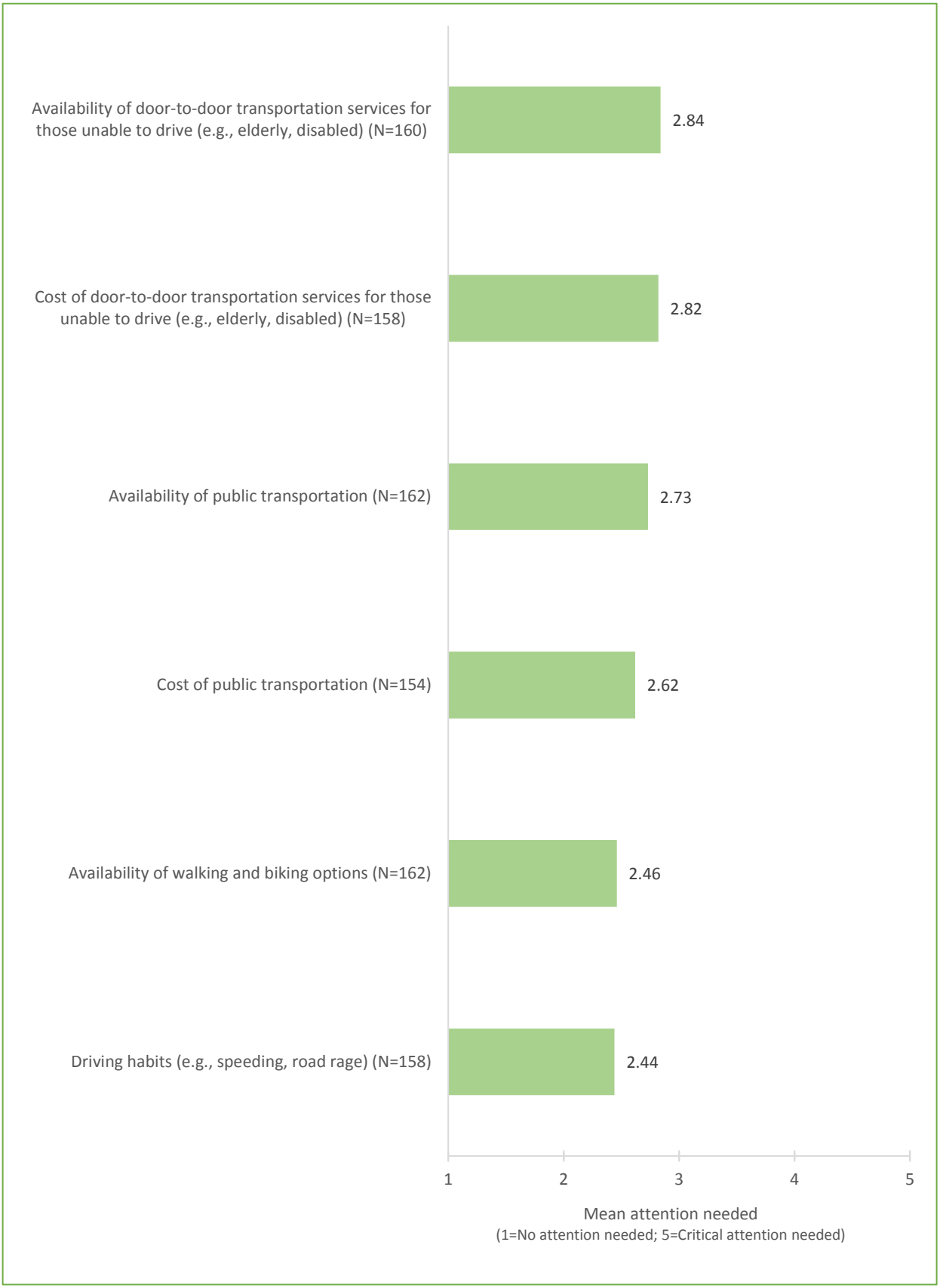


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

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

Figure 5. Current state of community issues regarding SAFETY

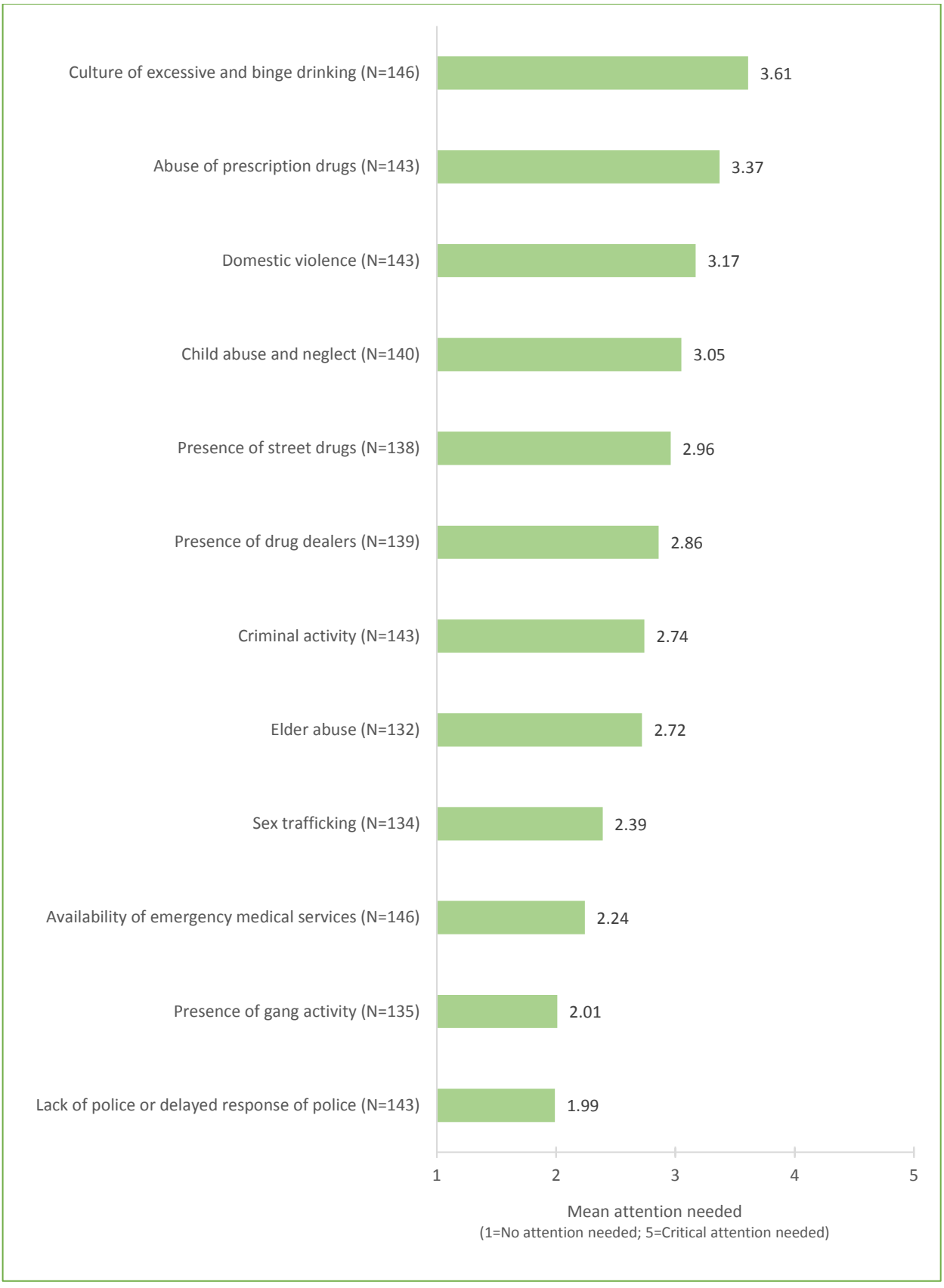


Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

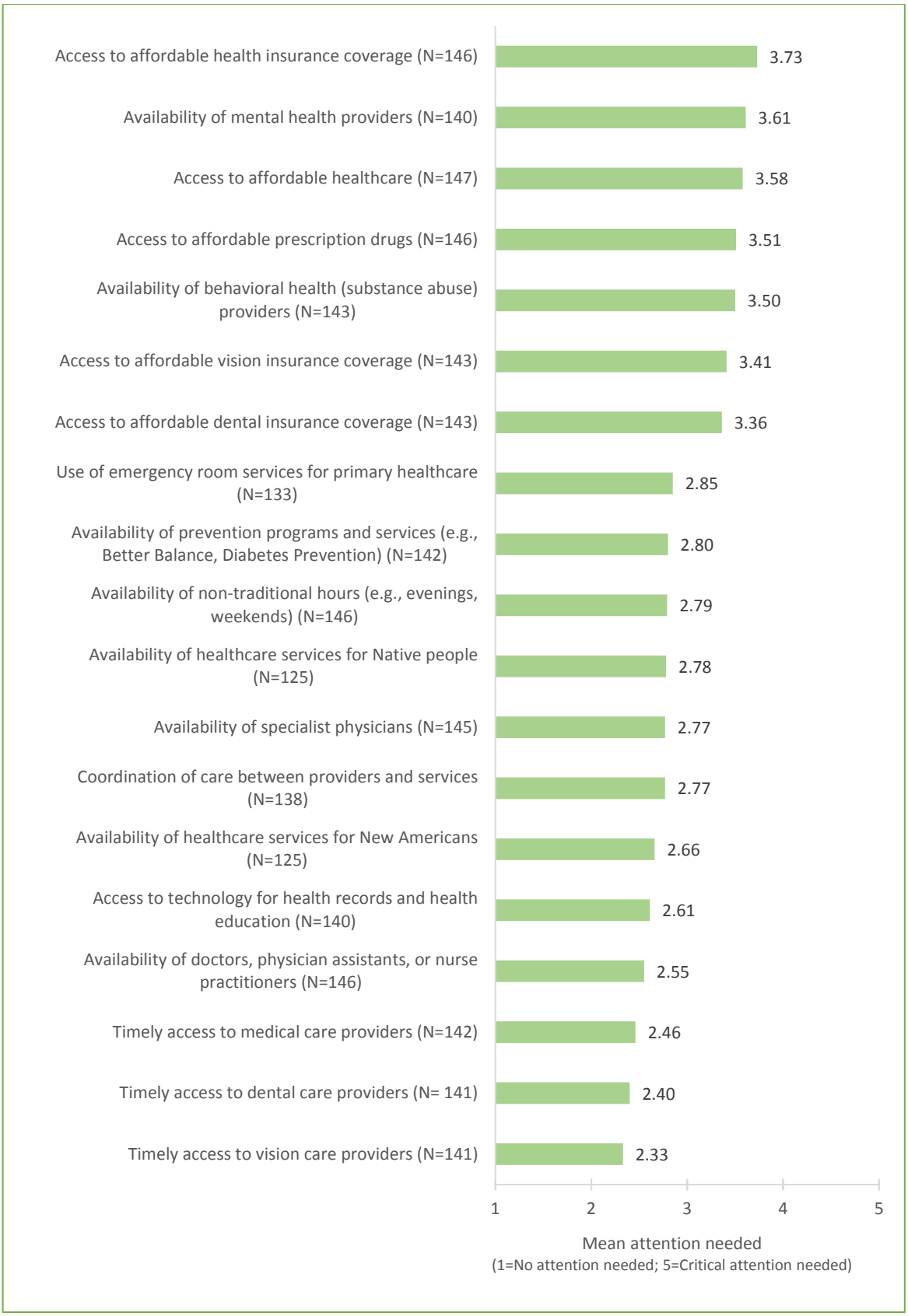
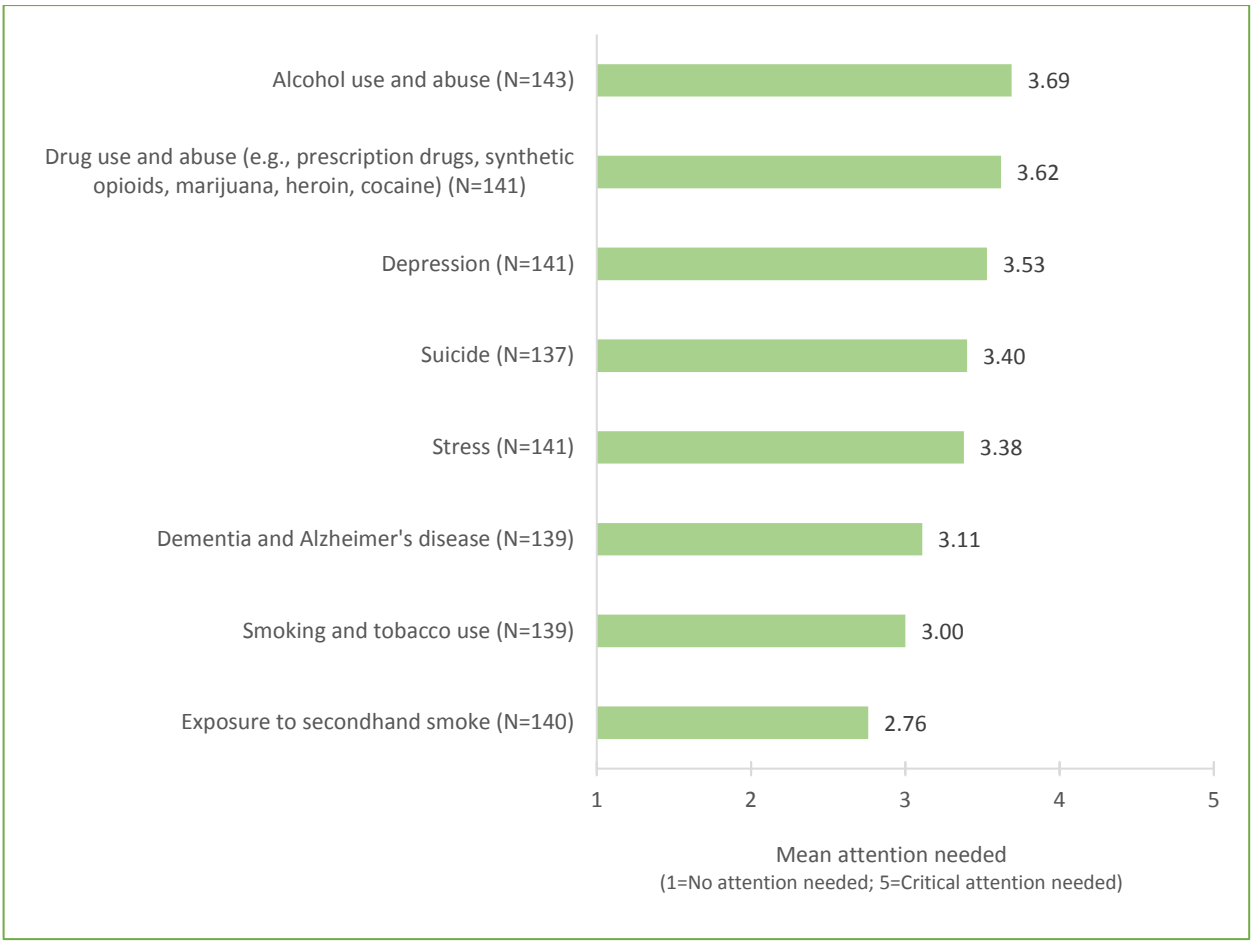
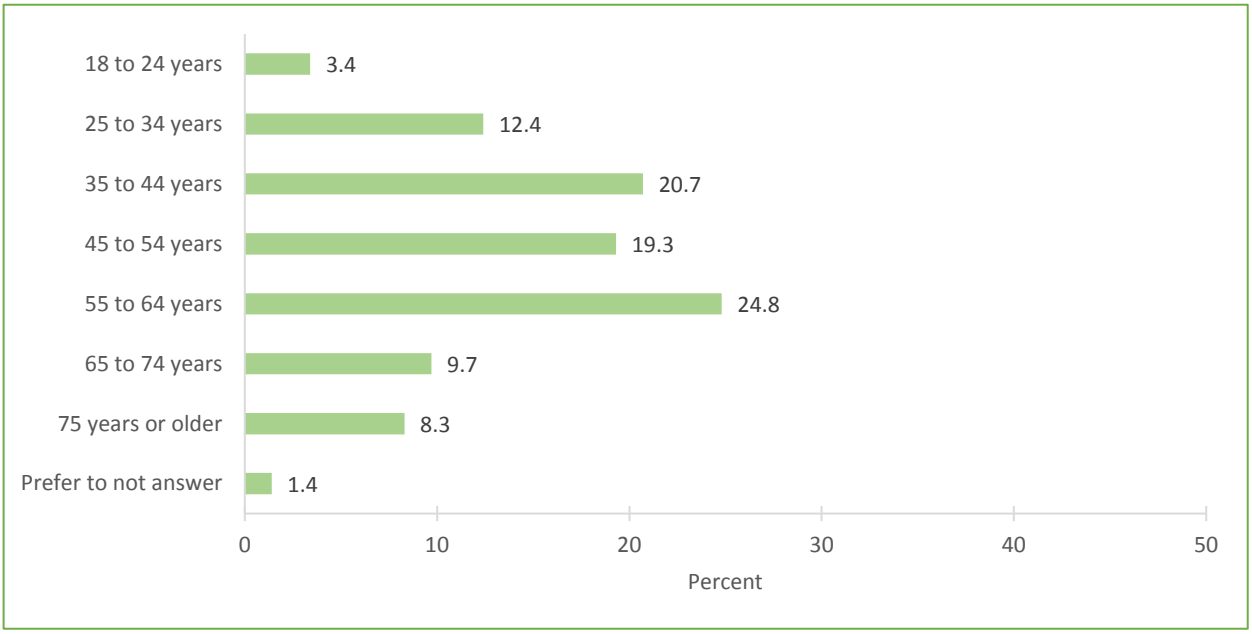


Figure 7. Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



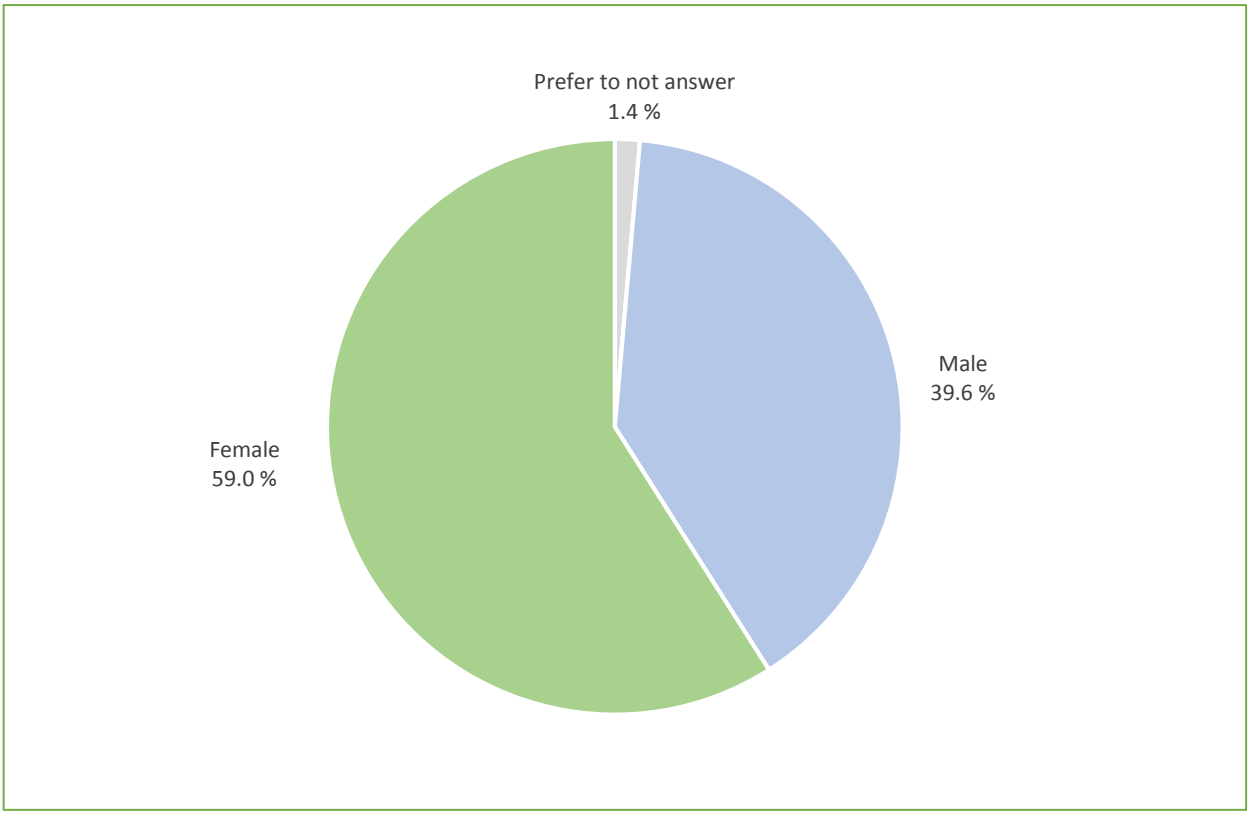
Demographic Information

Figure 8. Age of respondents



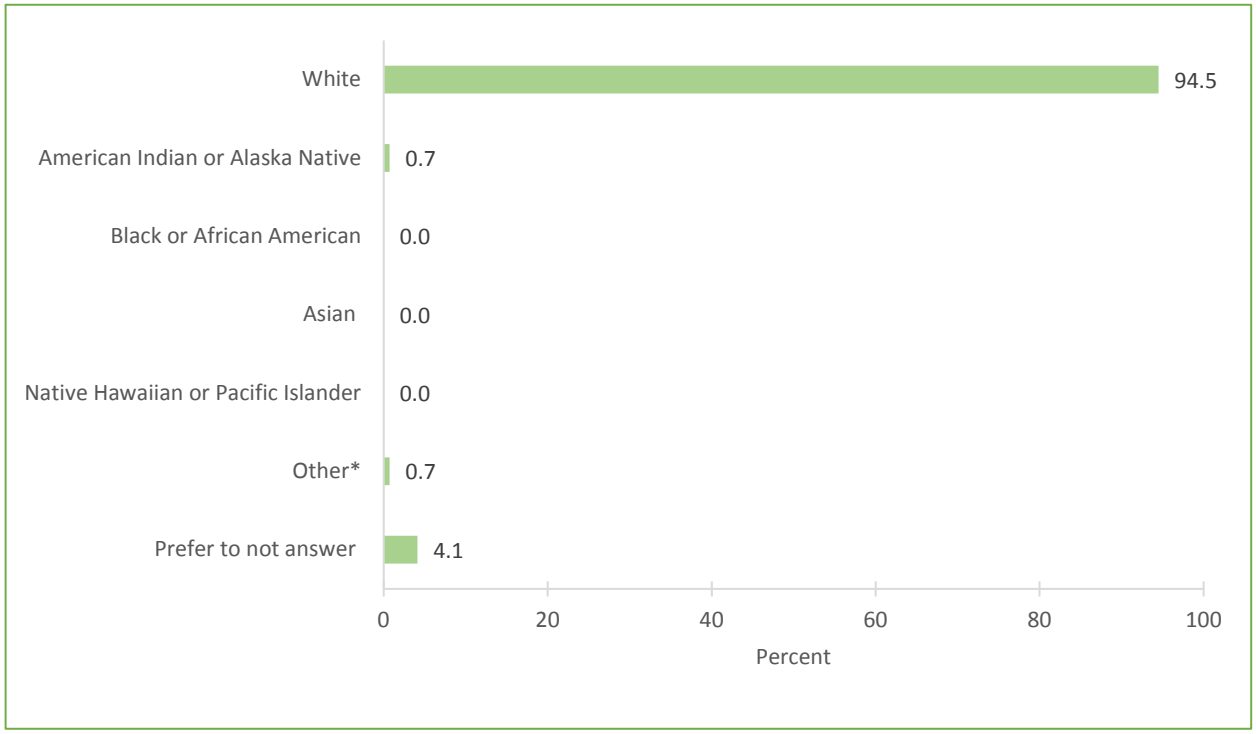
N=145

Figure 9. Biological sex of respondents



N=144

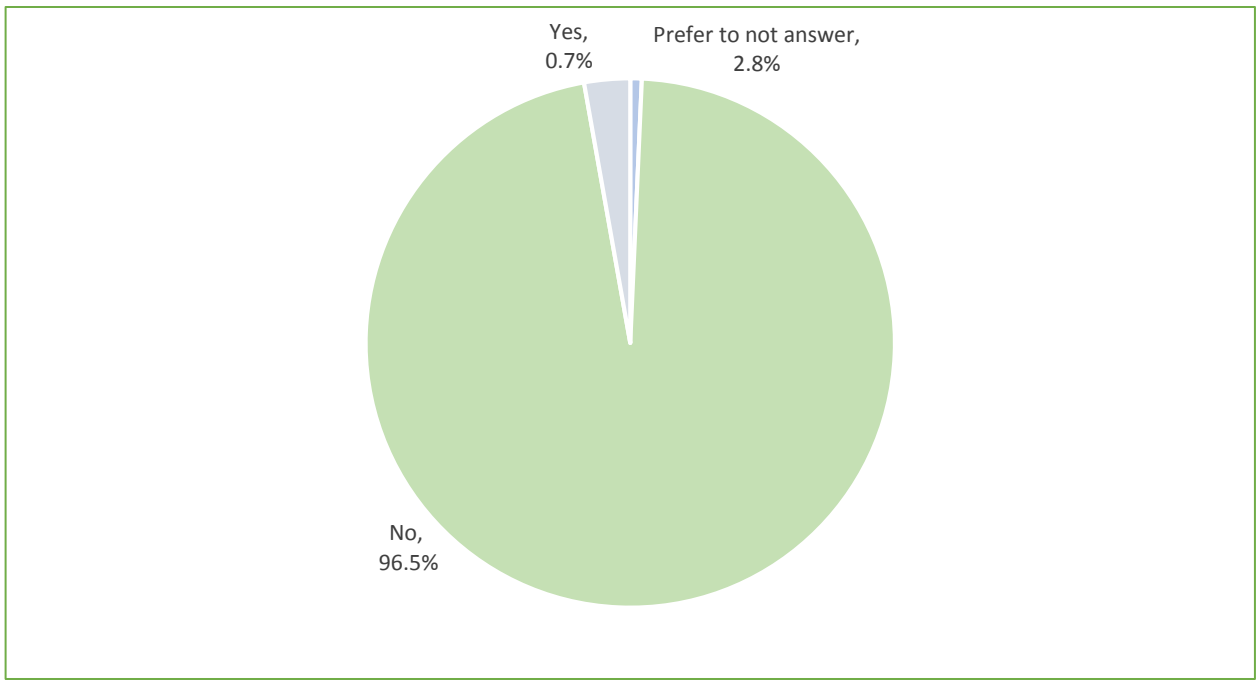
Figure 10. Race of respondents



N=145

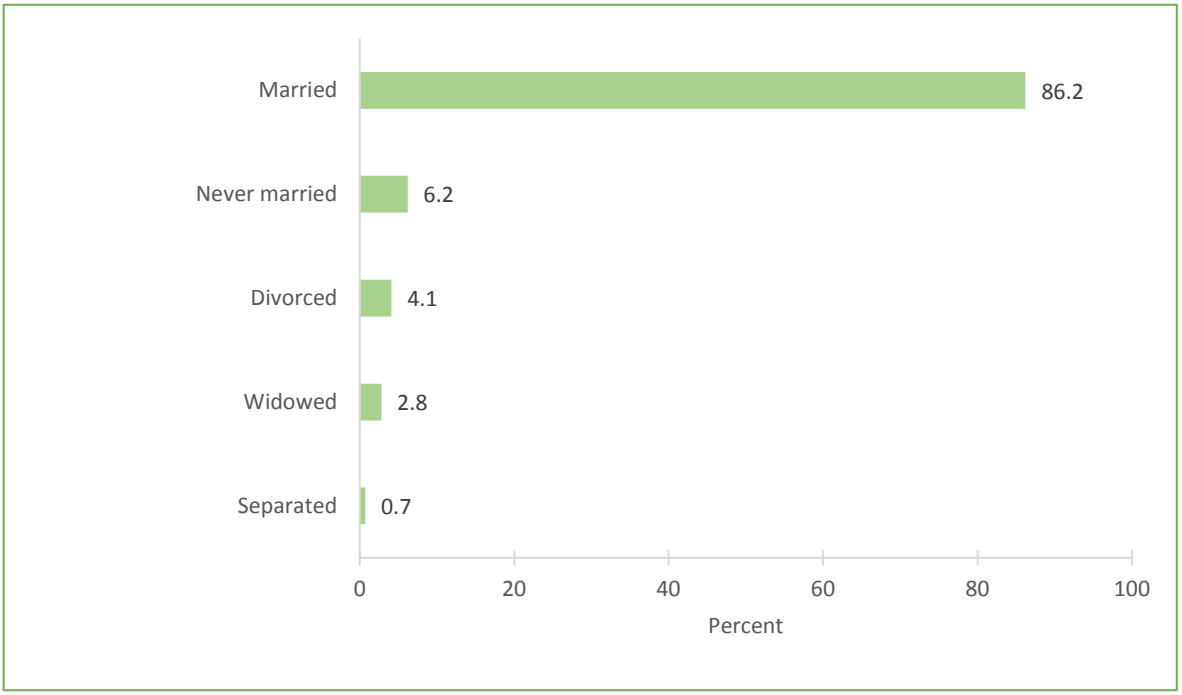
*Other response is “two or more races”.

Figure 11. Whether respondents are of Hispanic or Latino origin



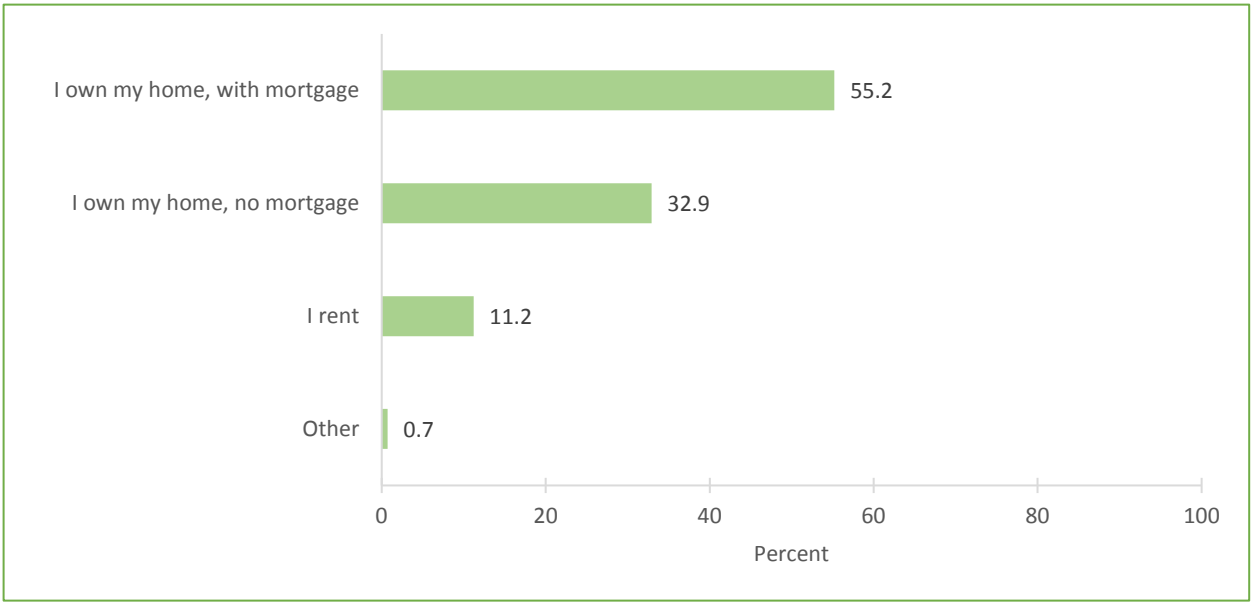
N=143

Figure 12. Marital status of respondents



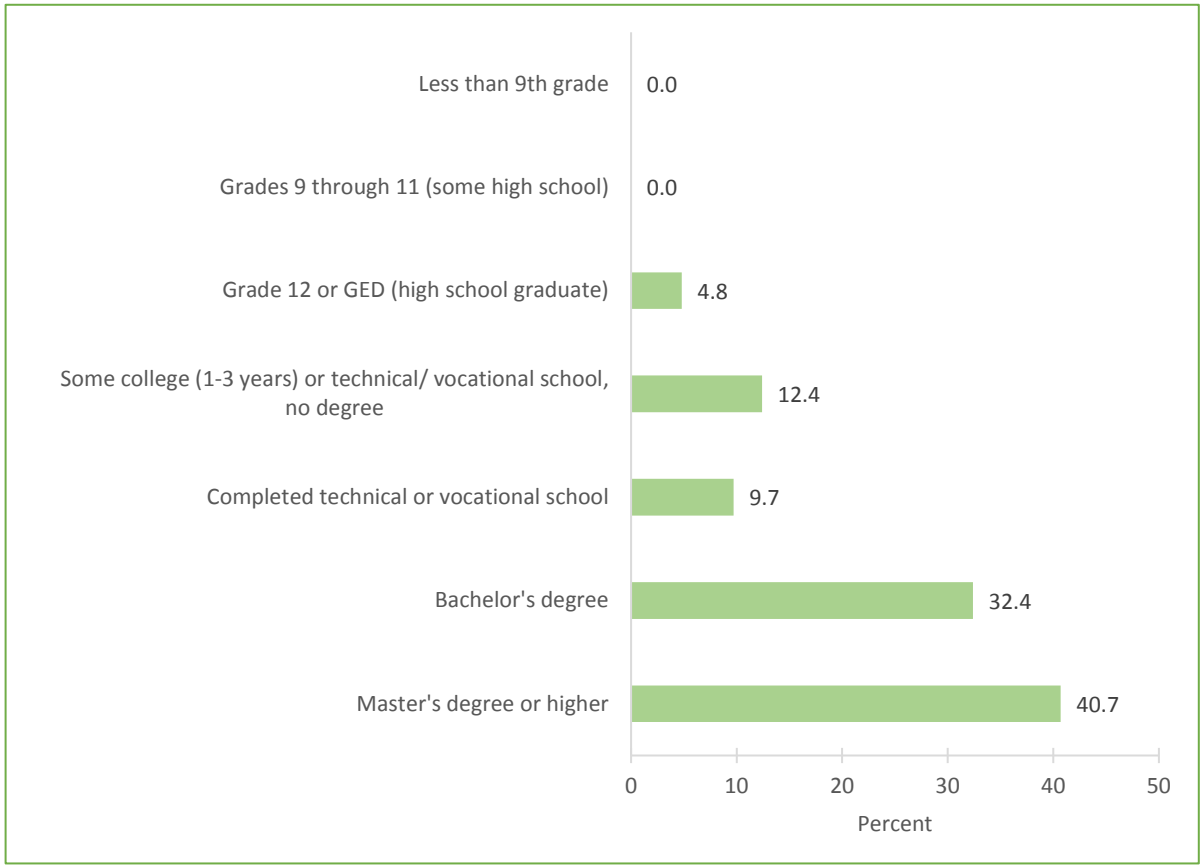
N=145

Figure 13. Living situation of respondents



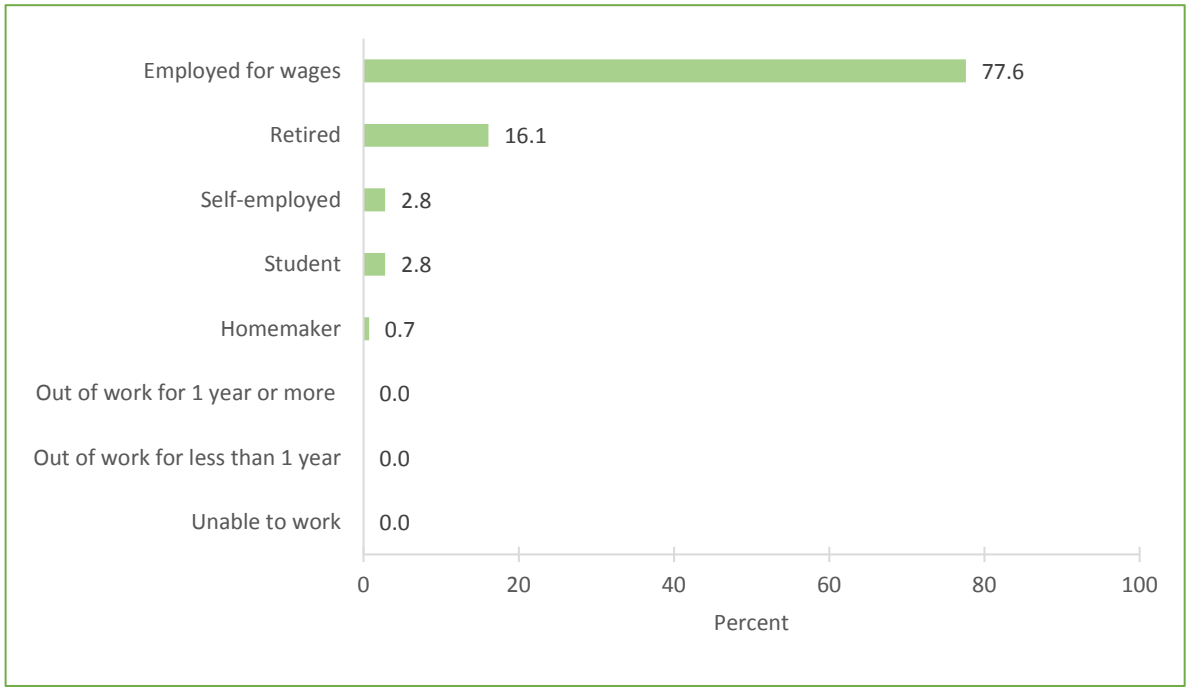
N=143

Figure 14. Highest level of education completed by respondents



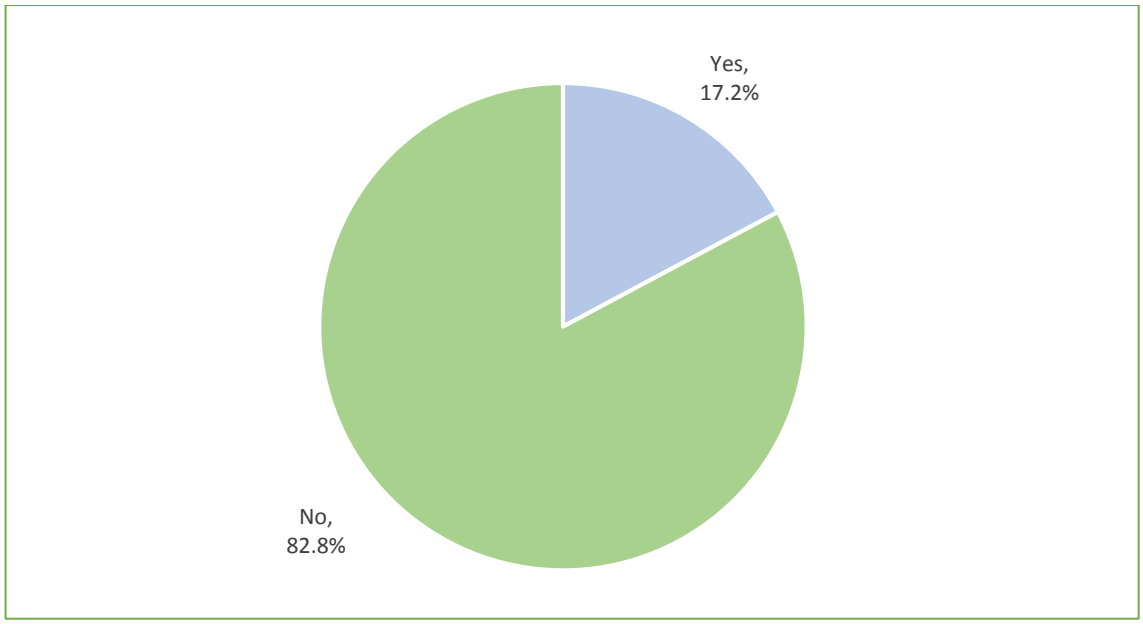
N=145

Figure 15. Employment status of respondents



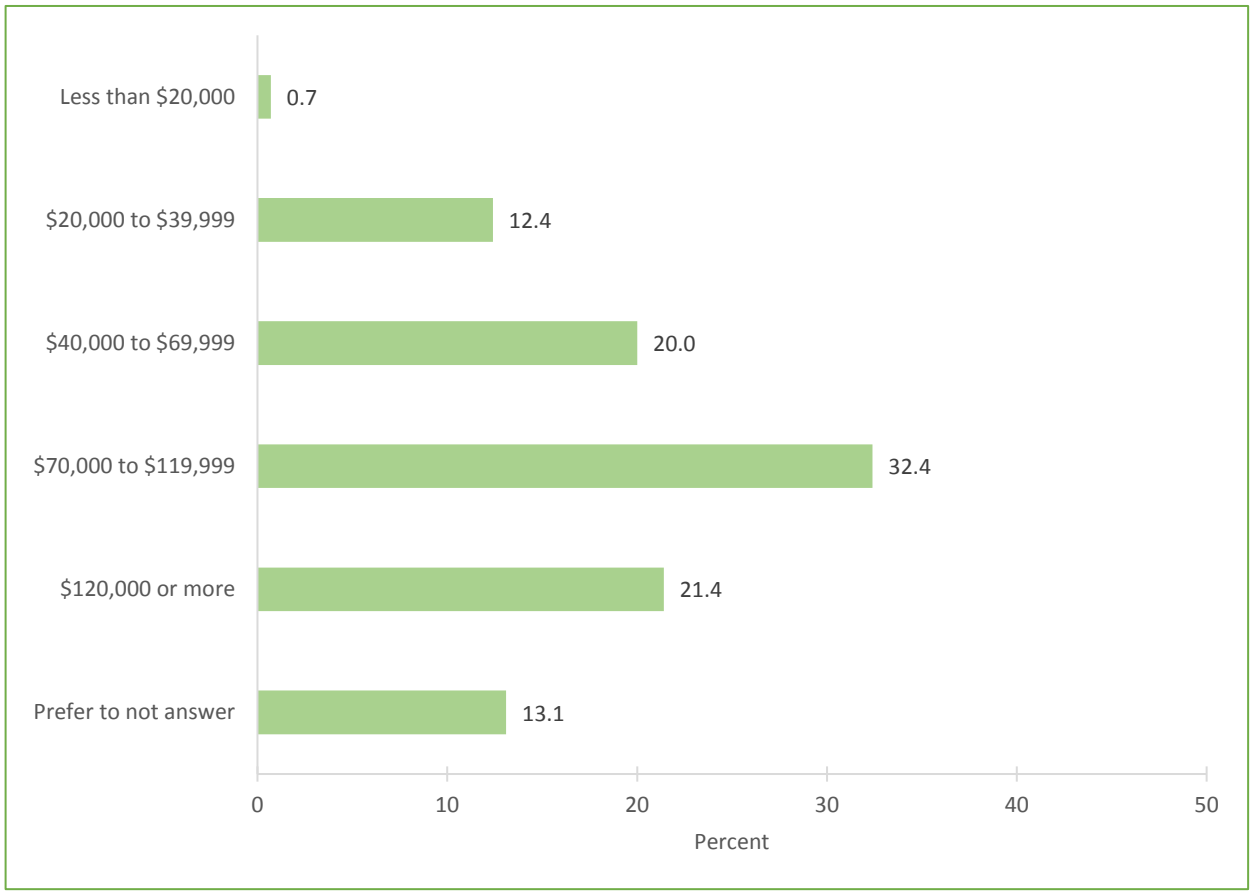
N=143

Figure 16. Whether respondents are military veterans



N=145

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



N=146

Table 1. Zip code of respondents

Zip code	Number of respondents
57069	125
57010	4
57025	3
57078	2
57014	2
68757	1
68739	1
57108	1
57049	1
57038	1
57001	1

N=164

Table 2. Comments from respondents

Comments
Health care costs need to be brought under control before it breaks our economy.
Health care should be one payer - it is a right.
I see a need for mental and behavioral health services including family and marriage counseling, addiction/abuse counseling, and easy availability of treatment for depression and mental illness
I think the community provides lots of programming for 18-24 yr. olds but we need much more programming for primary school students and the elderly population who battle loneliness, inactivity, and lack the ability to pay for or access opportunities for socializing/learning/etc.
My answers mostly reflect the Vermillion community as I am more familiar with services there due to my work.
Not sure why anyone would use ED for primary health care... seems like a waste of resources.
Thank you for surveying these important issues.
The lack of availability for mental health and substance abuse for afterhours puts unneeded pressure on other services such as the emergency room and law enforcement. The lack of juvenile mental health is absurd. Having to drive a juvenile to Sioux Falls for treatment?
Why do you need my zip code?

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=162)	3.56	1.2	11.1	35.2	32.7	17.9	1.9	100.0
Employment options (N=162)	3.21	4.3	15.4	42.6	27.8	8.6	1.2	99.9
Help for renters with landlord and tenants' rights issues (N=158)	3.09	3.8	22.2	39.9	21.5	8.2	4.4	100.0
Homelessness (N=160)	2.48	3.8	56.3	28.1	7.5	2.5	1.9	100.1
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=158)	3.06	4.4	19.6	46.8	16.5	8.9	3.8	100.0
Household budgeting and money management (N=159)	3.13	1.3	24.5	42.1	20.8	9.4	1.9	100.0
Hunger (N=160)	3.26	1.3	21.9	37.5	25.0	12.5	1.9	100.1
Maintaining livable and energy efficient homes (N=158)	3.17	3.2	19.0	40.5	29.7	6.3	1.3	100.0
Skilled labor workforce (N=160)	3.28	1.3	17.5	42.5	25.6	10.6	2.5	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=162)	2.84	6.8	30.9	38.3	16.7	6.2	1.2	100.1
Availability of public transportation (N=163)	2.73	9.8	31.9	37.4	15.3	4.9	0.6	99.9
Availability of walking and biking options (N=163)	2.46	17.8	37.4	30.1	8.6	5.5	0.6	100.0
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=162)	2.82	9.3	28.4	35.8	19.1	4.9	2.5	100.0
Cost of public transportation (N=160)	2.62	13.1	31.9	33.8	13.8	3.8	3.8	100.2
Driving habits (e.g., speeding, road rage) (N=159)	2.44	13.8	44.0	29.6	8.2	3.8	0.6	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=152)	2.84	8.6	28.3	37.5	17.8	5.9	2.0	100.1
Availability of education about birth control (N=150)	2.95	6.0	28.0	32.7	20.7	7.3	5.3	100.0
Availability of quality child care (N=150)	3.08	5.3	19.3	43.3	20.7	8.7	2.7	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth	3.46	2.0	11.6	37.4	30.6	15.0	3.4	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
with behavioral health problems) (N=147)								
Bullying (N=146)	3.27	2.1	16.4	41.1	30.8	8.2	1.4	100.0
Childhood obesity (N=151)	3.53	2.0	9.9	35.1	37.1	14.6	1.3	100.0
Cost of activities (outside of school and sports) for children and youth (N=150)	3.21	2.7	17.3	42.7	25.3	8.7	3.3	100.0
Cost of quality child care (N=149)	3.34	3.4	14.8	37.6	27.5	13.4	3.4	100.1
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=145)	3.26	2.8	17.9	37.2	30.3	9.0	2.8	100.0
Crime committed by youth (N=146)	2.86	2.1	37.0	38.4	15.1	6.2	1.4	100.2
Opportunities for youth-adult mentoring (N=148)	3.03	2.7	24.3	45.9	17.6	7.4	2.0	99.9
Parental custody, guardianships and visitation rights (N=144)	2.77	5.6	29.2	44.4	10.4	4.2	6.3	100.1
School absenteeism (truancy) (N=145)	2.88	4.1	32.4	37.2	11.0	9.0	6.2	99.9
School dropout rates (N=144)	2.73	4.2	38.9	34.7	8.3	6.9	6.9	99.9
School violence (N=144)	2.66	5.6	40.3	34.7	8.3	5.6	5.6	100.1
Substance abuse by youth (N=147)	3.57	0.7	9.5	36.1	33.3	16.3	4.1	100.0
Teen pregnancy (N=146)	2.96	1.4	29.5	42.5	15.8	6.2	4.8	100.2
Teen suicide (N=147)	3.19	3.4	26.5	29.9	21.8	15.0	3.4	100.0
Teen tobacco use (N=145)	3.35	2.1	17.2	36.6	24.8	15.2	4.1	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=150)	2.99	6.0	21.3	42.7	20.0	6.0	4.0	100.0
Availability of long-term care (N=151)	3.18	7.3	18.5	31.1	28.5	11.3	3.3	100.0
Availability of memory care (N=150)	3.26	4.7	18.7	31.3	28.7	12.0	4.7	100.1
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=149)	3.31	2.0	16.8	37.6	27.5	11.4	4.7	100.0
Availability of resources for grandparents caring for grandchildren (N=148)	3.18	2.0	22.3	37.2	23.0	10.1	5.4	100.0
Availability of resources to help the elderly stay safe in their homes (N=149)	3.21	3.4	18.1	40.3	25.5	10.1	2.7	100.1
Cost of activities for seniors (e.g., recreational, social, cultural) (N=148)	2.89	6.8	25.7	41.2	16.2	6.1	4.1	100.1
Cost of in-home services (N=151)	3.52	2.0	11.3	35.1	29.1	17.9	4.6	100.0
Cost of long-term care (N=150)	3.87	0.0	9.3	22.7	35.3	28.7	4.0	100.0
Cost of memory care (N=151)	3.75	2.0	9.9	24.5	31.1	26.5	6.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Help making out a will or healthcare directive (N=150)	2.94	3.3	28.7	41.3	14.7	7.3	4.7	100.0
SAFETY								
Abuse of prescription drugs (N=146)	3.37	1.4	15.8	38.4	30.1	12.3	2.1	100.1
Availability of emergency medical services (N=147)	2.24	22.4	40.8	27.2	7.5	1.4	0.7	100.0
Child abuse and neglect (N=143)	3.05	0.7	28.7	43.4	15.4	9.8	2.1	100.1
Criminal activity (N=145)	2.74	2.8	38.6	42.1	11.7	3.4	1.4	100.0
Culture of excessive and binge drinking (N=147)	3.61	0.0	14.3	31.3	32.7	21.1	0.7	100.1
Domestic violence (N=145)	3.17	0.7	20.7	46.2	22.8	8.3	1.4	100.1
Elder abuse (N=140)	2.72	4.3	39.3	32.1	15.7	2.9	5.7	100.0
Lack of police or delayed response of police (N=146)	1.99	26.0	52.7	15.1	2.7	1.4	2.1	100.0
Presence of drug dealers (N=144)	2.86	6.9	33.3	34.7	9.7	11.8	3.5	99.9
Presence of gang activity (N=142)	2.01	23.2	54.9	12.0	2.8	2.1	4.9	99.9
Presence of street drugs (N=144)	2.96	7.6	32.6	25.7	15.3	14.6	4.2	100.0
Sex trafficking (N=140)	2.39	14.3	47.9	20.7	7.9	5.0	4.3	100.1
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=146)	3.36	3.4	19.9	28.8	29.5	16.4	2.1	100.1
Access to affordable health insurance coverage (N=147)	3.73	1.4	15.0	21.8	32.0	29.3	0.7	100.2
Access to affordable health care (N=148)	3.58	2.7	19.6	21.6	28.4	27.0	0.7	100.0
Access to affordable prescription drugs (N=147)	3.51	1.4	17.0	32.7	25.9	22.4	0.7	100.1
Access to affordable vision insurance coverage (N=146)	3.41	3.4	19.9	29.5	24.0	21.2	2.1	100.1
Access to technology for health records and health education (N=142)	2.61	11.3	39.4	31.0	10.6	6.3	1.4	100.0
Availability of behavioral health (substance abuse) providers (N=144)	3.50	2.8	13.9	35.4	25.0	22.2	0.7	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=147)	2.55	14.3	39.5	27.2	13.6	4.8	0.7	100.1
Availability of health care services for Native people (N=138)	2.78	14.5	23.2	31.9	9.4	11.6	9.4	100.0
Availability of health care services for New Americans (N=138)	2.66	14.5	29.0	29.7	7.2	10.1	9.4	99.9
Availability of mental health providers (N=143)	3.61	2.1	14.0	30.8	24.5	26.6	2.1	100.1
Availability of non-traditional hours (e.g., evenings, weekends) (N=147)	2.79	10.9	32.0	32.7	14.3	9.5	0.7	100.1

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=145)	2.80	4.8	37.9	33.8	14.5	6.9	2.1	100.0
Availability of specialist physicians (N=145)	2.77	9.0	37.9	28.3	16.6	8.3	0.0	100.1
Coordination of care between providers and services (N=140)	2.77	10.0	36.4	27.1	16.4	8.6	1.4	99.9
Timely access to medical care providers (N=144)	2.46	18.1	39.6	25.0	9.0	6.9	1.4	100.0
Timely access to dental care providers (N=143)	2.40	19.6	40.6	24.5	7.7	6.3	1.4	100.1
Timely access to vision care providers (N=143)	2.33	18.9	45.5	22.4	6.3	5.6	1.4	100.1
Use of emergency room services for primary healthcare (N=139)	2.85	12.2	28.1	30.9	10.8	13.7	4.3	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=144)	3.69	0.7	9.7	30.6	37.5	20.8	0.7	100.0
Dementia and Alzheimer's disease (N=141)	3.11	3.5	24.1	39.0	22.0	9.9	1.4	99.9
Depression (N=143)	3.53	0.7	9.1	39.2	36.4	13.3	1.4	100.1
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=142)	3.62	0.7	10.6	35.2	31.7	21.1	0.7	100.0
Exposure to secondhand smoke (N=142)	2.76	8.5	36.6	31.7	14.1	7.7	1.4	100.0
Smoking and tobacco use (N=142)	3.00	4.2	24.6	44.4	16.2	8.5	2.1	100.0
Stress (N=144)	3.38	2.1	16.7	34.7	31.3	13.2	2.1	100.1
Suicide (N=140)	3.40	0.7	20.0	36.4	20.7	20.0	2.1	99.9

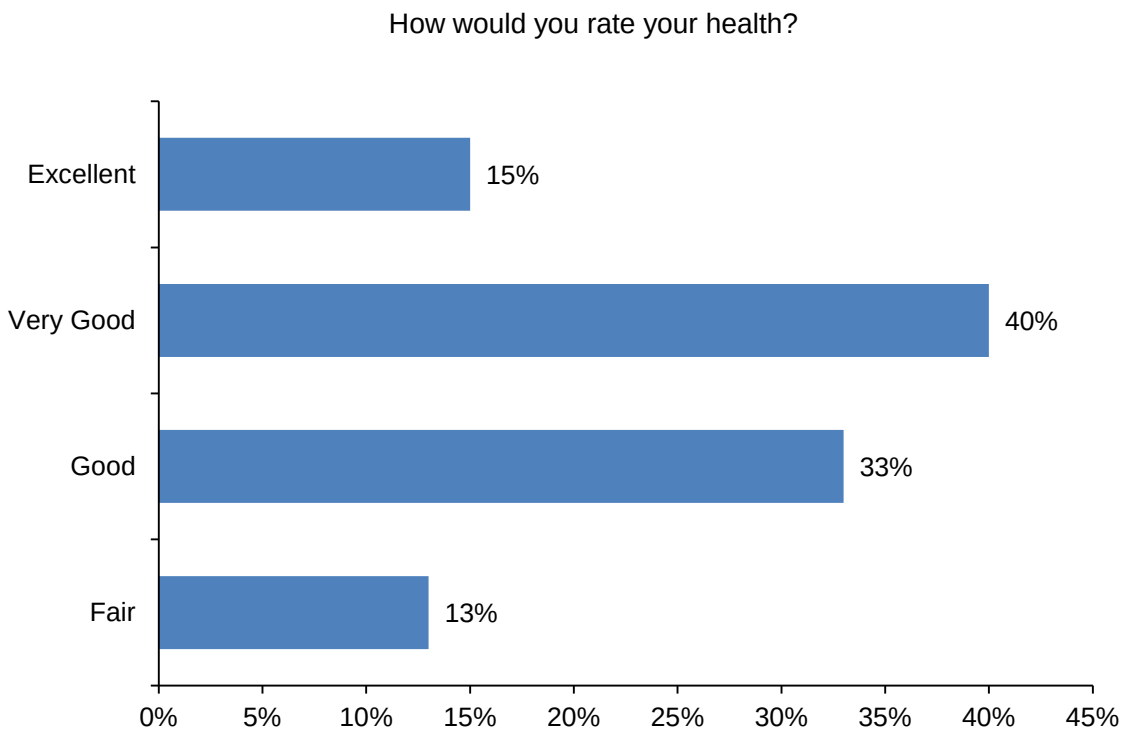
*Percentages may not total 100.0 due to rounding.

**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.

Vermillion CHNA Survey Report

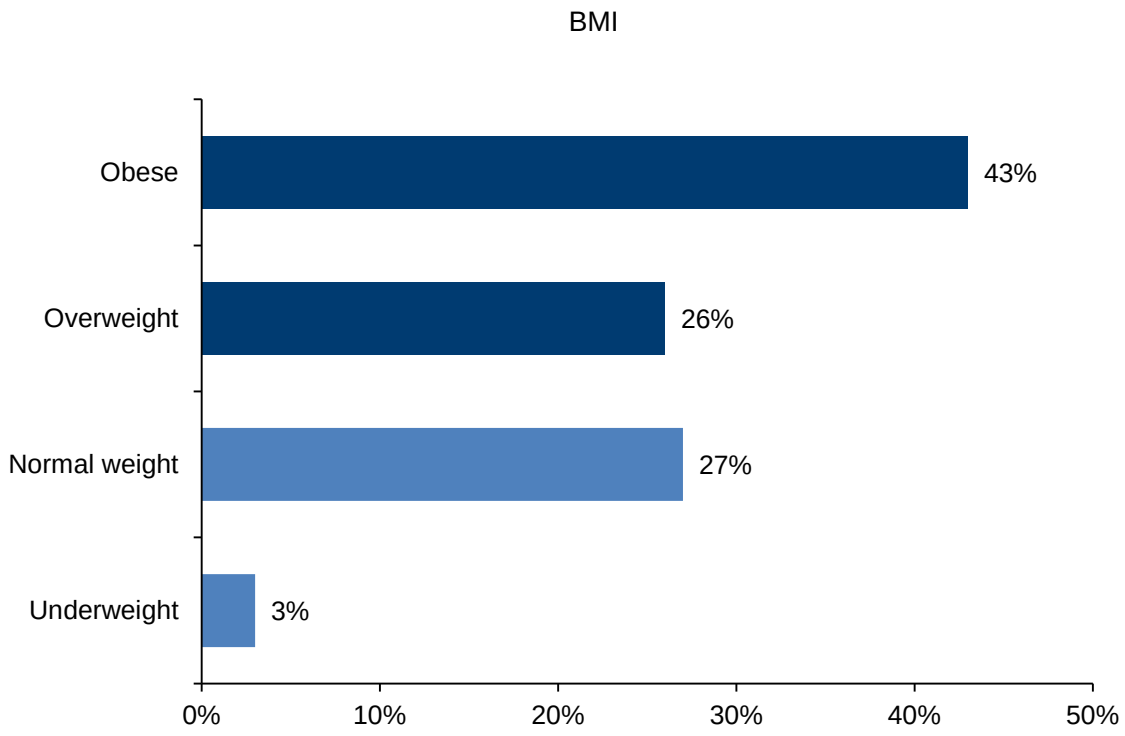
March 08, 2018

Charts Exported by MarketSight®



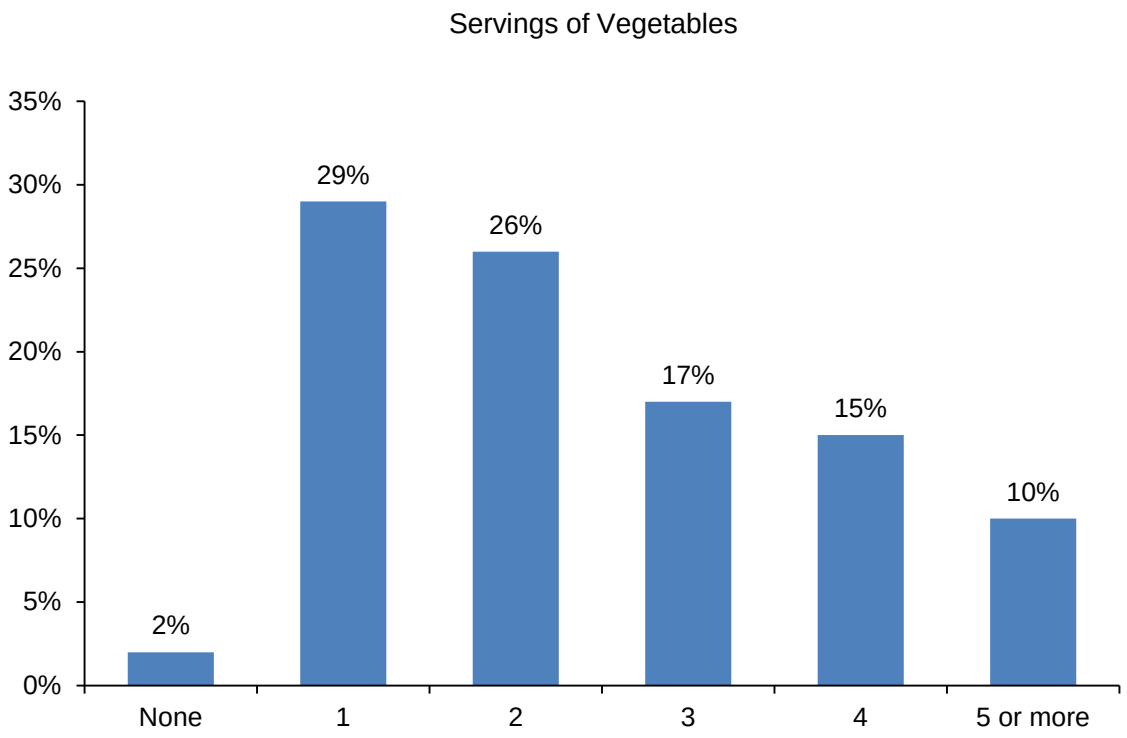
Base: Fair (n=12), Good (n=31), Very Good (n=38), Excellent (n=14), Sample Size = 95

(Community = Clay /Union)



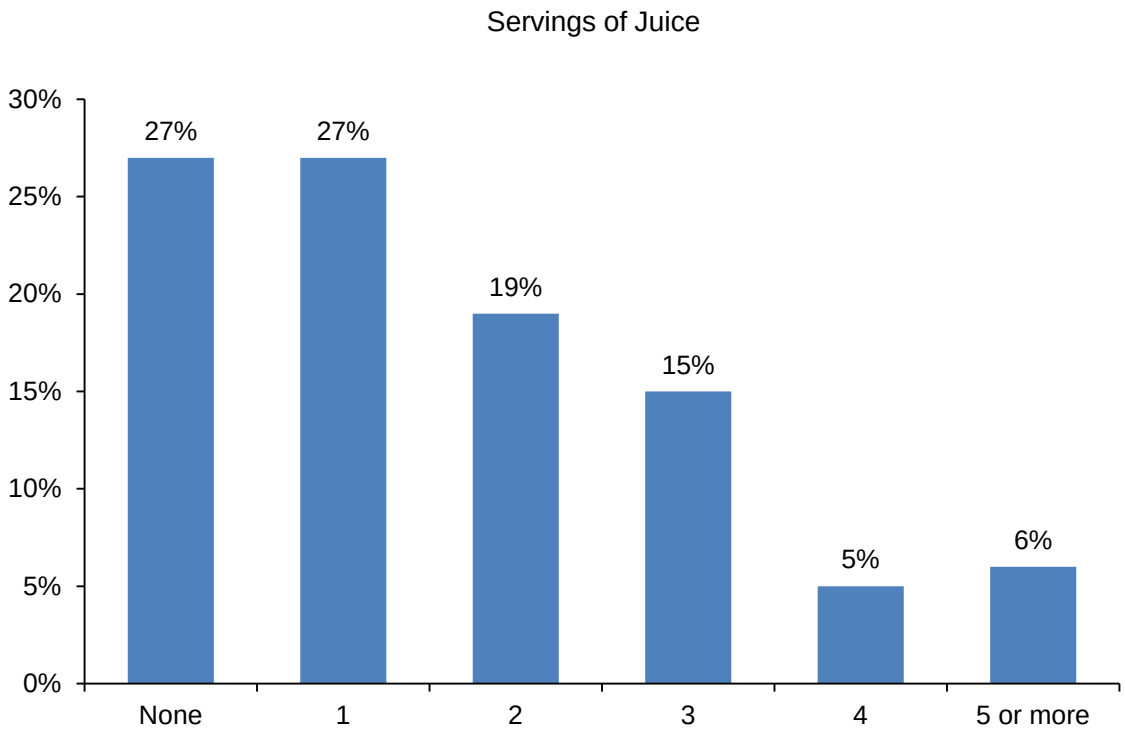
Base: Underweight (n=3), Normal weight (n=24), Overweight (n=23), Obese (n=38), Sample Size = 88

(Community = Clay /Union)



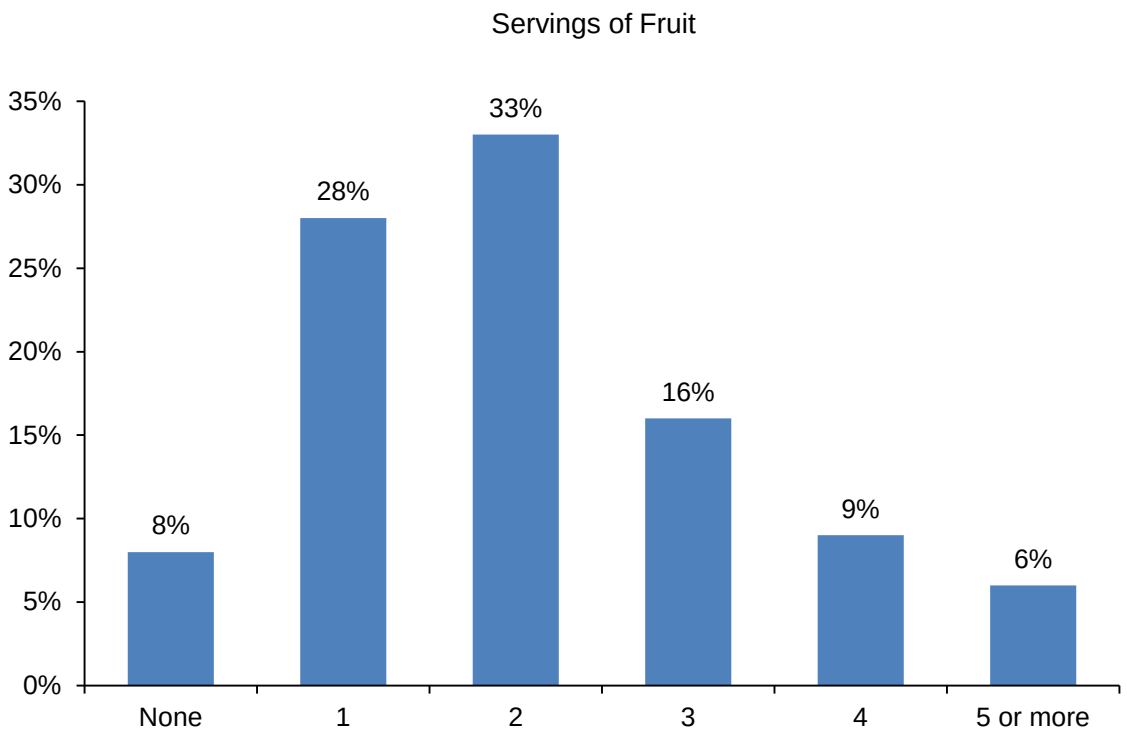
Base: None (n=2), 1 (n=25), 2 (n=22), 3 (n=15), 4 (n=13), 5 or more (n=9), Sample Size = 86

(Community = Clay /Union)



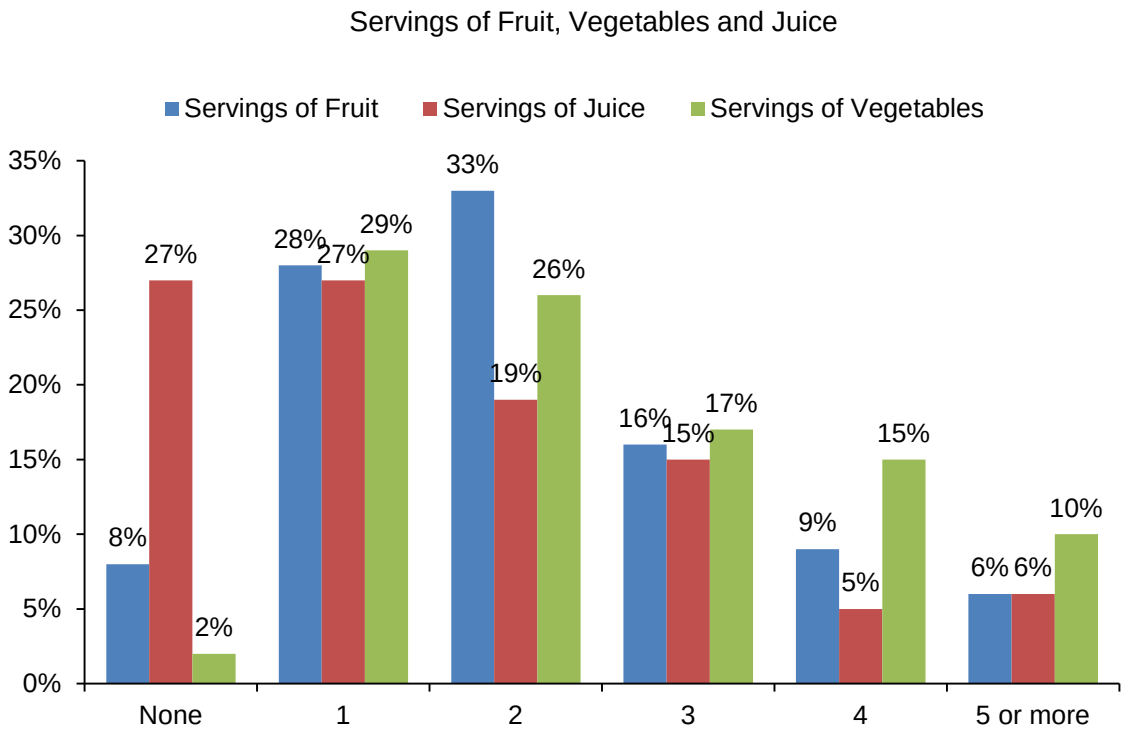
Base: None (n=17), 1 (n=17), 2 (n=12), 3 (n=9), 4 (n=3), 5 or more (n=4), Sample Size = 62

(Community = Clay /Union)



Base: None (n=6), 1 (n=22), 2 (n=26), 3 (n=13), 4 (n=7), 5 or more (n=5), Sample Size = 79

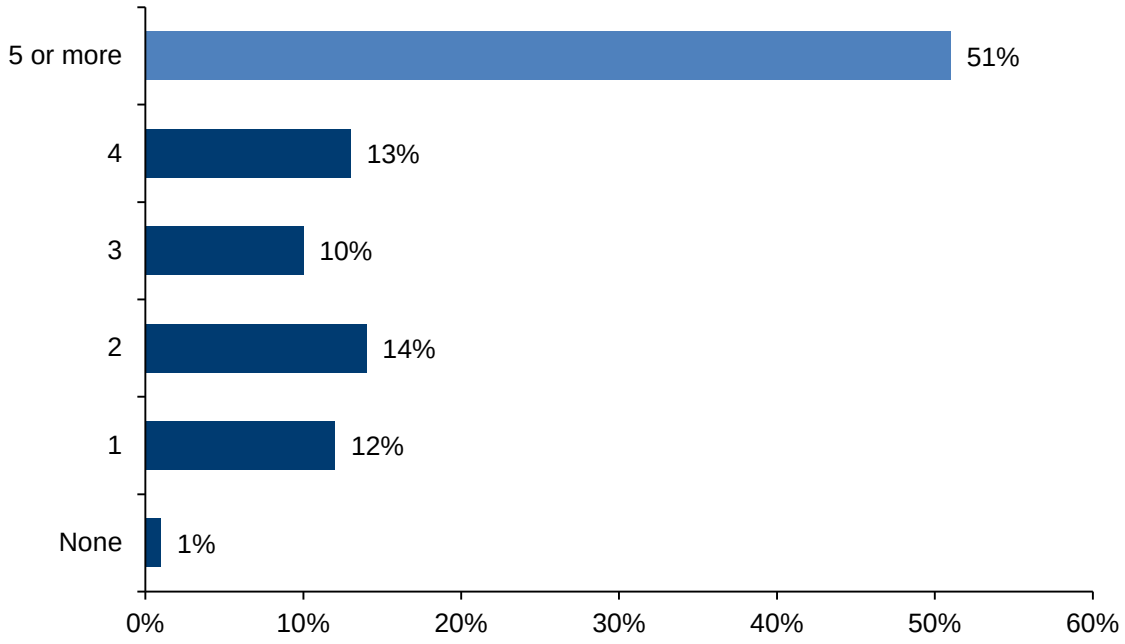
(Community = Clay /Union)



Sample Size = Variable

(Community = Clay /Union)

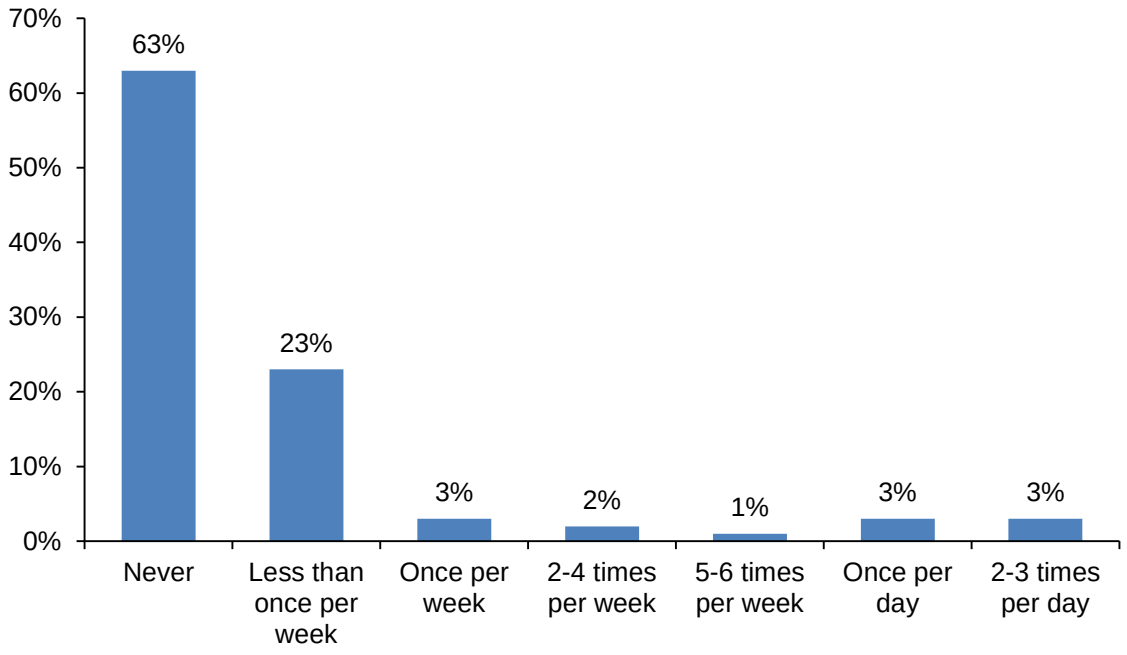
Total Servings of Fruits, Vegetables and Juice



Base: None (n=1), 1 (n=11), 2 (n=13), 3 (n=9), 4 (n=12), 5 or more (n=47), Sample Size = 93

(Community = Clay /Union)

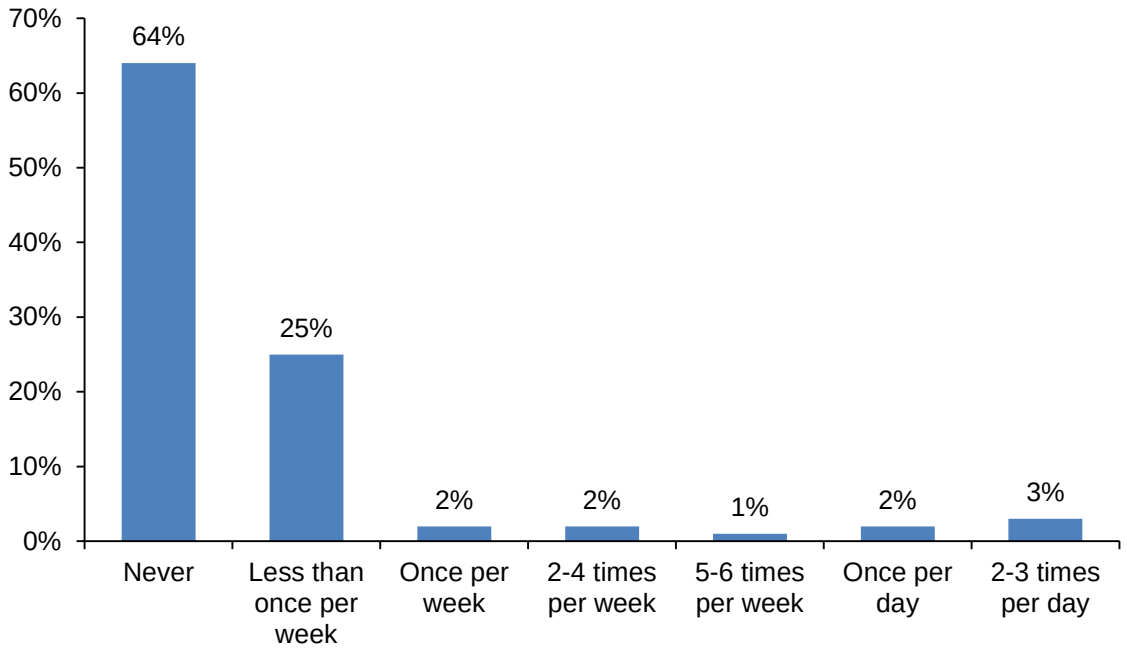
Snapple, Flavored Teas, Capri Sun, etc.



Base: Never (n=57), Less than once per week (n=21), Once per week (n=3), 2-4 times per week (n=2), 5-6 times per week (n=1), Once per day (n=3), 2-3 times per day (n=3), Sample Size = 90

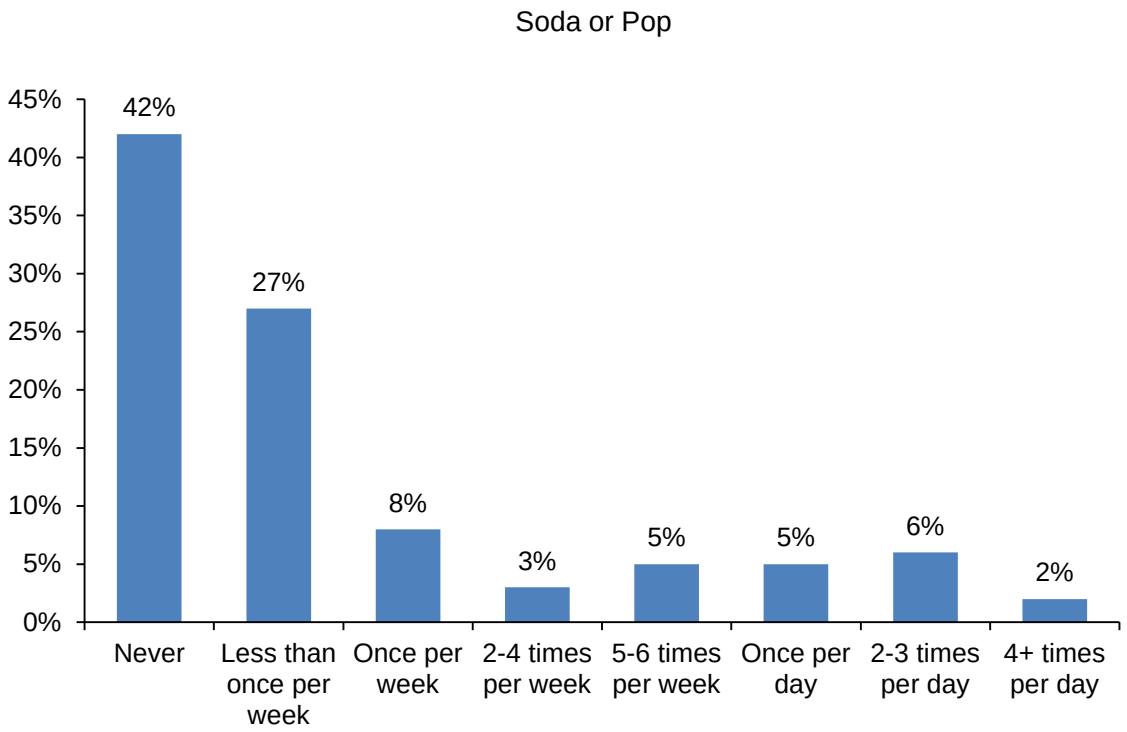
(Community = Clay /Union)

Gatorade, Powerade, etc.



Base: Never (n=58), Less than once per week (n=23), Once per week (n=2), 2-4 times per week (n=2), 5-6 times per week (n=1), Once per day (n=2), 2-3 times per day (n=3), Sample Size = 91

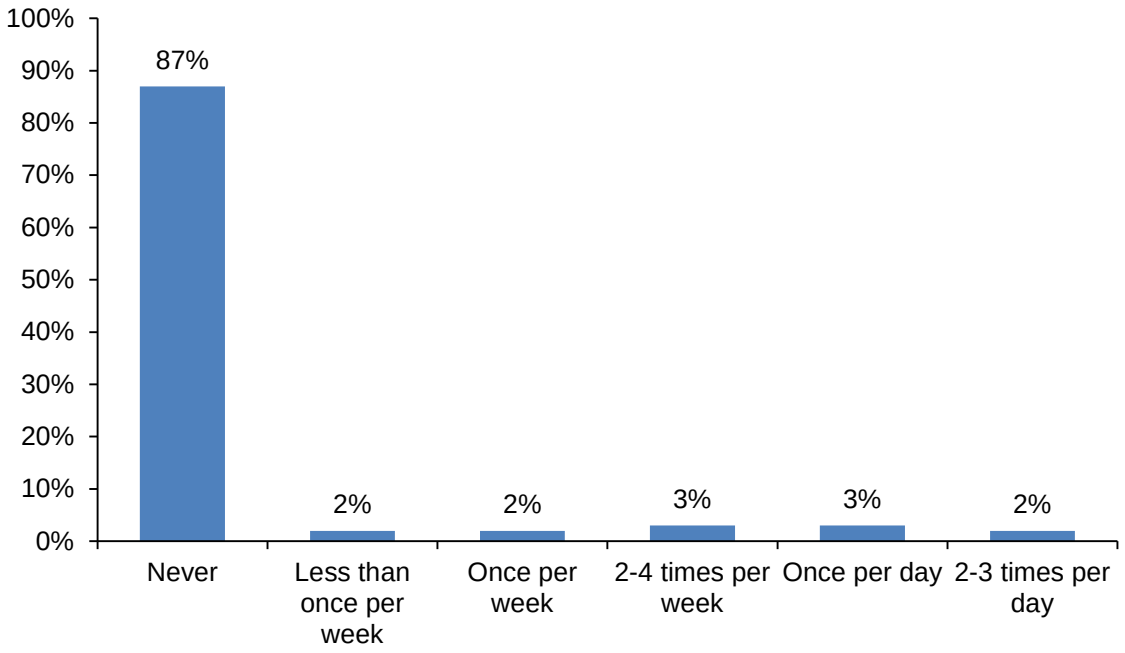
(Community = Clay /Union)



Base: Never (n=40), Less than once per week (n=26), Once per week (n=8), 2-4 times per week (n=3), 5-6 times per week (n=5), Once per day (n=5), 2-3 times per day (n=6), 4+ times per day (n=2), Sample Size = 95

(Community = Clay /Union)

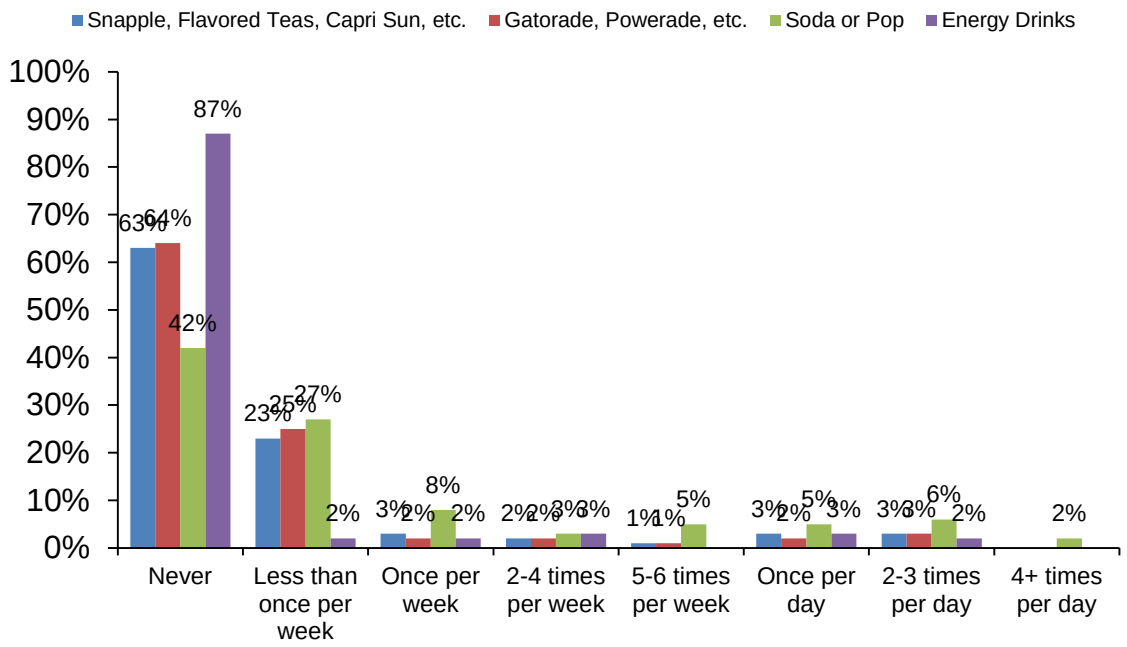
Energy Drinks



Base: Never (n=79), Less than once per week (n=2), Once per week (n=2), 2-4 times per week (n=3), Once per day (n=3), 2-3 times per day (n=2), Sample Size = 91

(Community = Clay /Union)

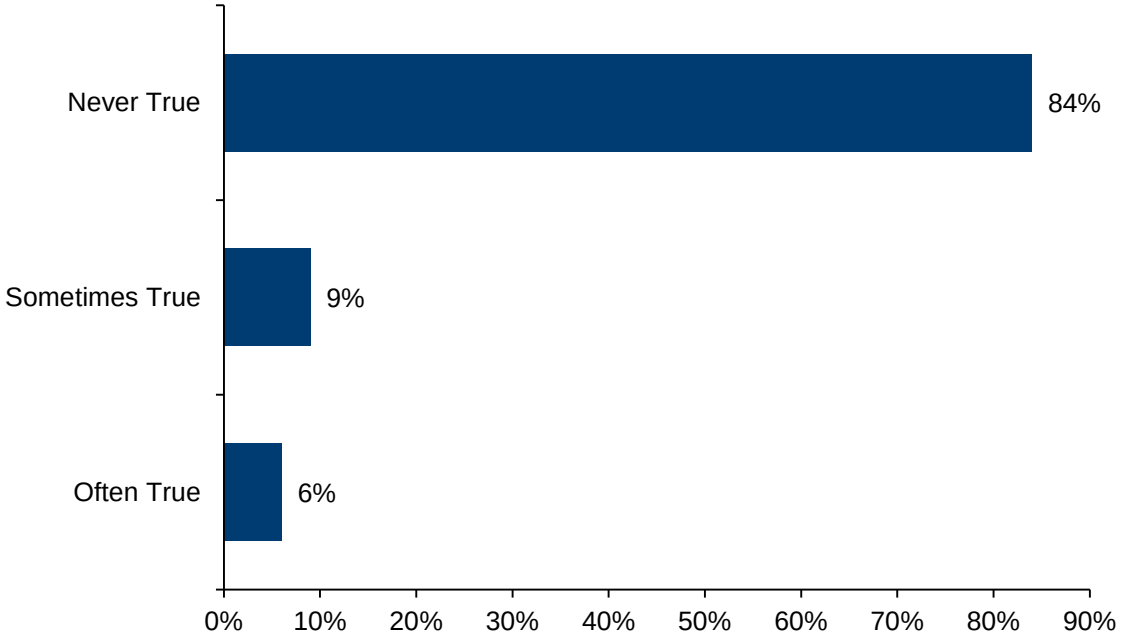
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Clay /Union)

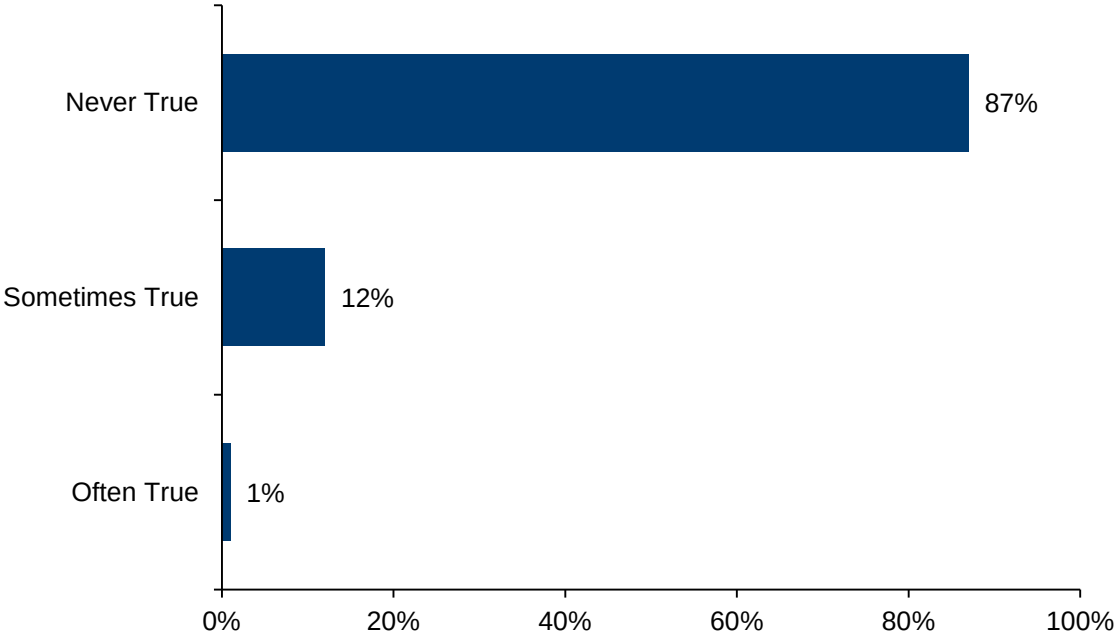
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=6), Sometimes True (n=9), Never True (n=80), Sample Size = 95

(Community = Clay /Union)

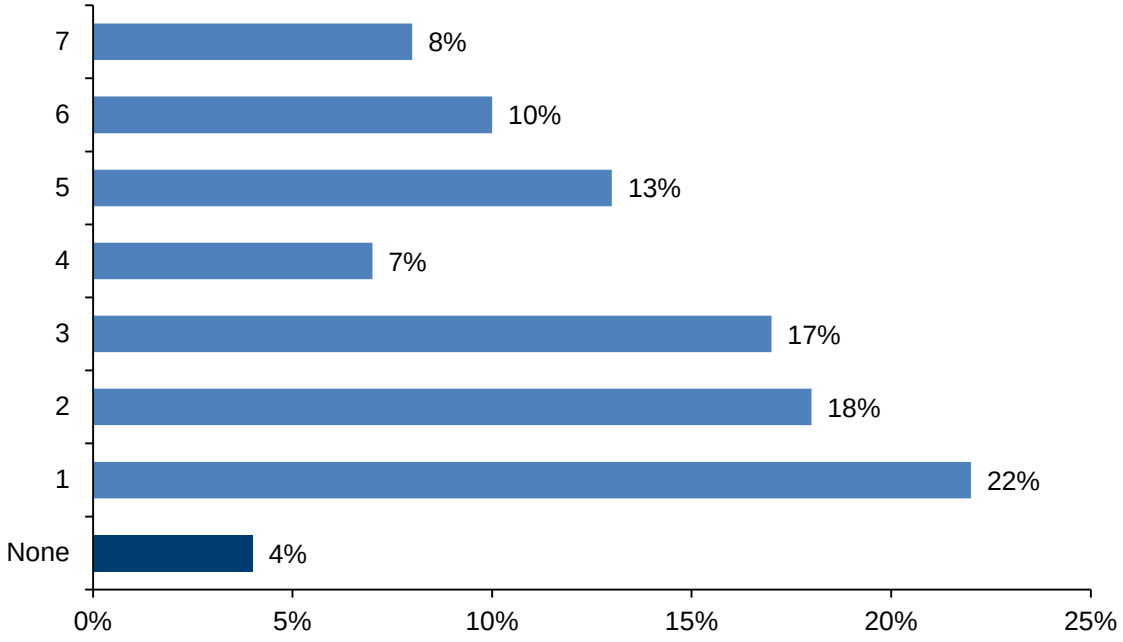
The food that we bought just didn’t last, and we didn’t have money to get more.



Base: Often True (n=1), Sometimes True (n=11), Never True (n=83), Sample Size = 95

(Community = Clay /Union)

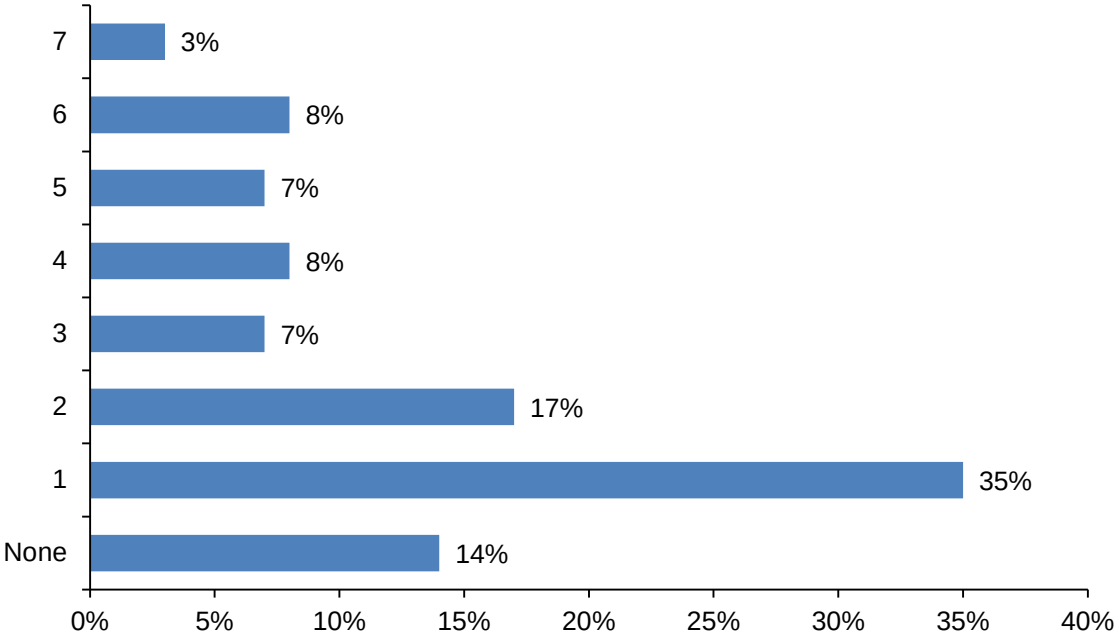
Days Per Week of Moderate Physical Activity



Base: None (n=4), 1 (n=20), 2 (n=16), 3 (n=15), 4 (n=6), 5 (n=12), 6 (n=9), 7 (n=7), Sample Size = 89

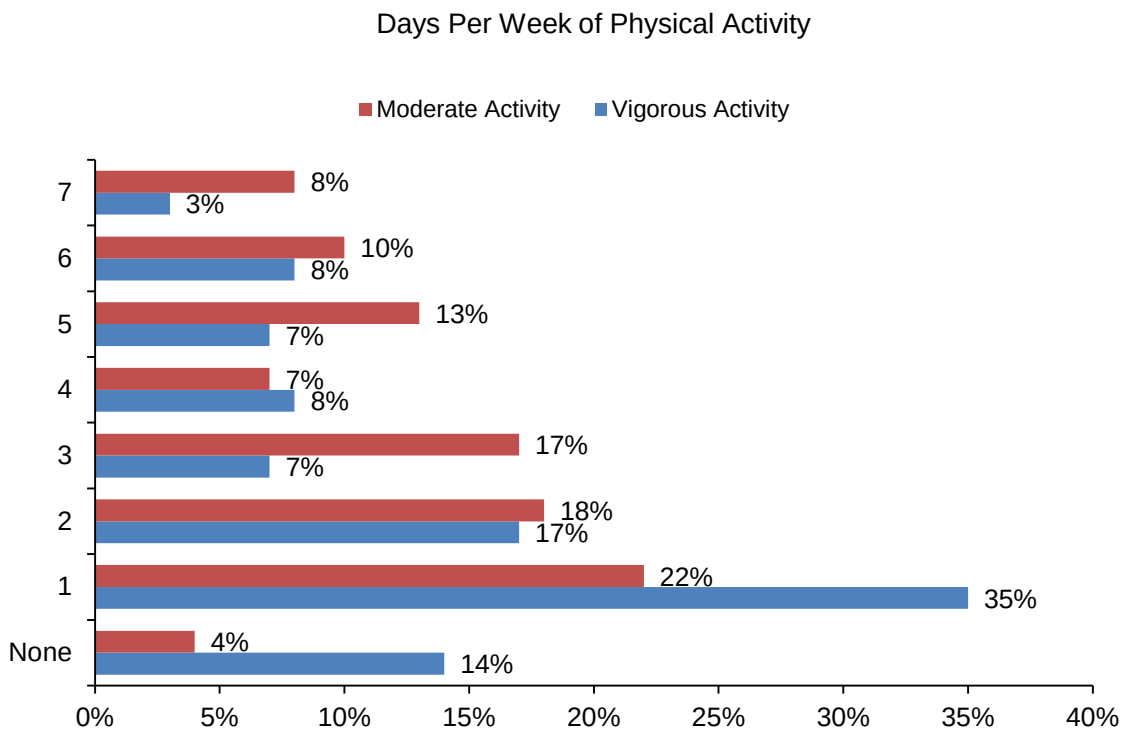
(Community = Clay /Union)

Days Per Week of Vigorous Physical Activity



Base: None (n=10), 1 (n=25), 2 (n=12), 3 (n=5), 4 (n=6), 5 (n=5), 6 (n=6), 7 (n=2), Sample Size = 71

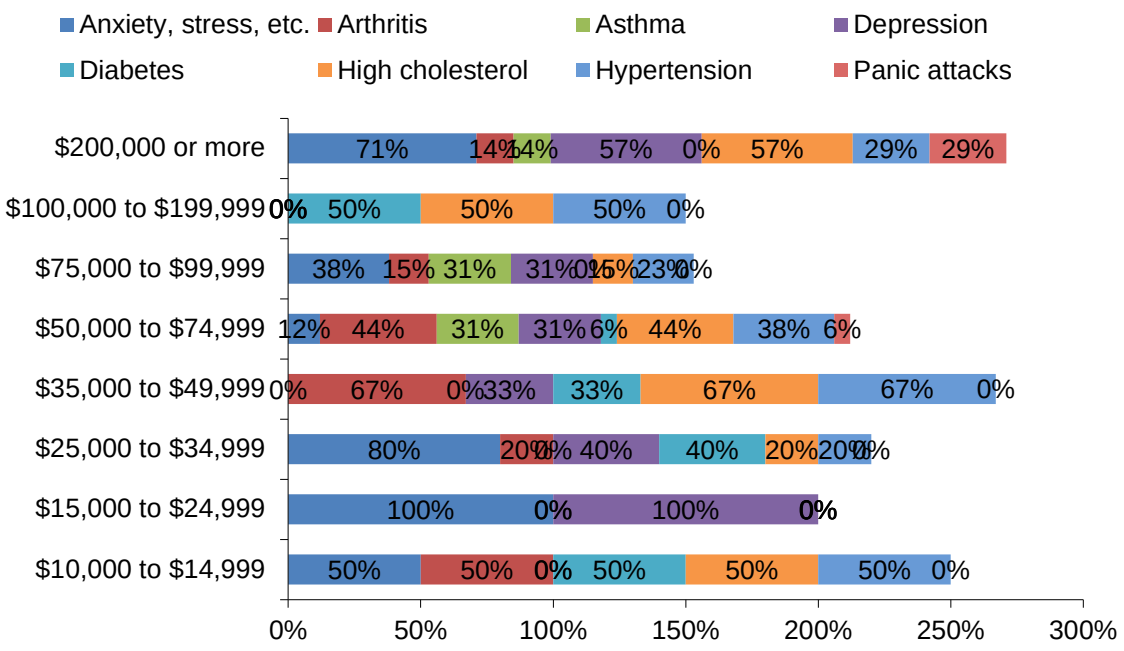
(Community = Clay /Union)



Sample Size = Variable

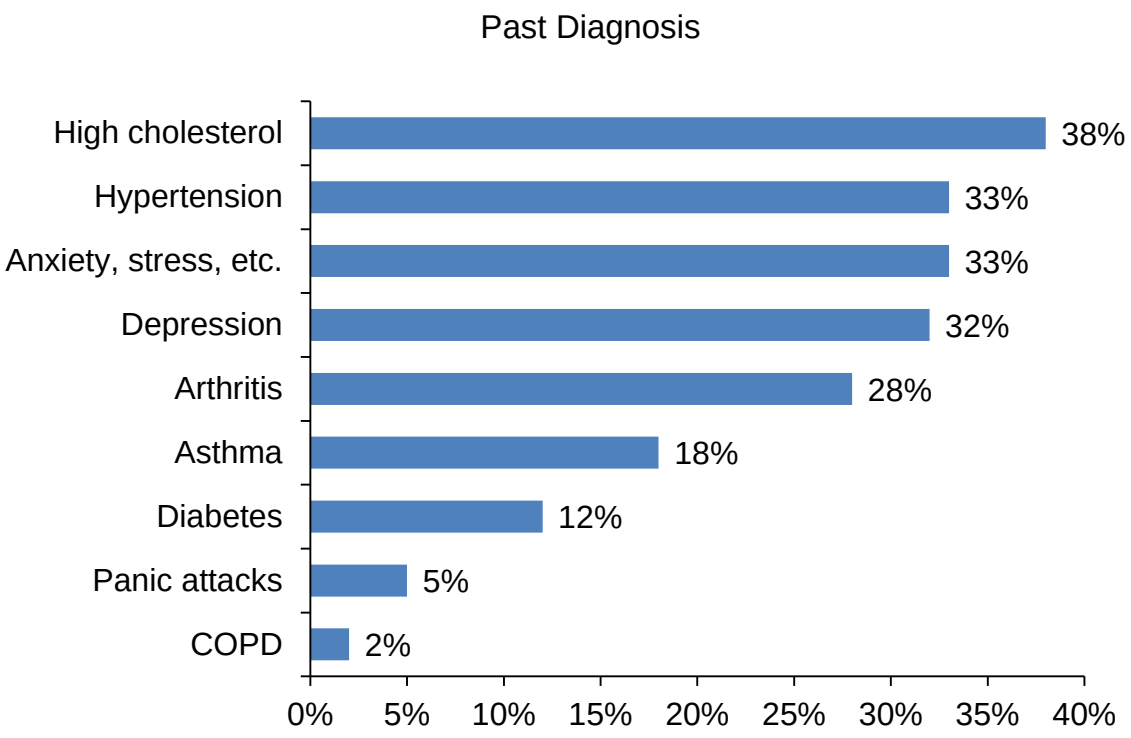
(Community = Clay /Union)

Past Diagnosis by Total Household Income



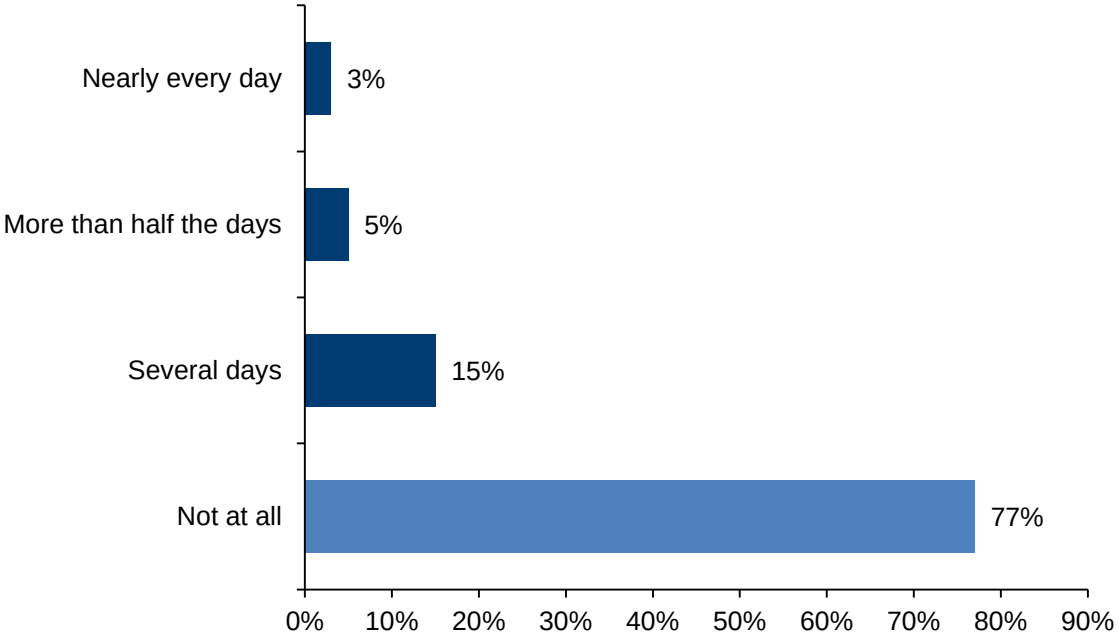
Base: $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=1), $25,000 to $34,999 (n=5), $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=16), $75,000 to $99,999 (n=13), $100,000 to $199,999 (n=4), $200,000 or more (n=7), Sample Size = 51

(Community = Clay /Union)



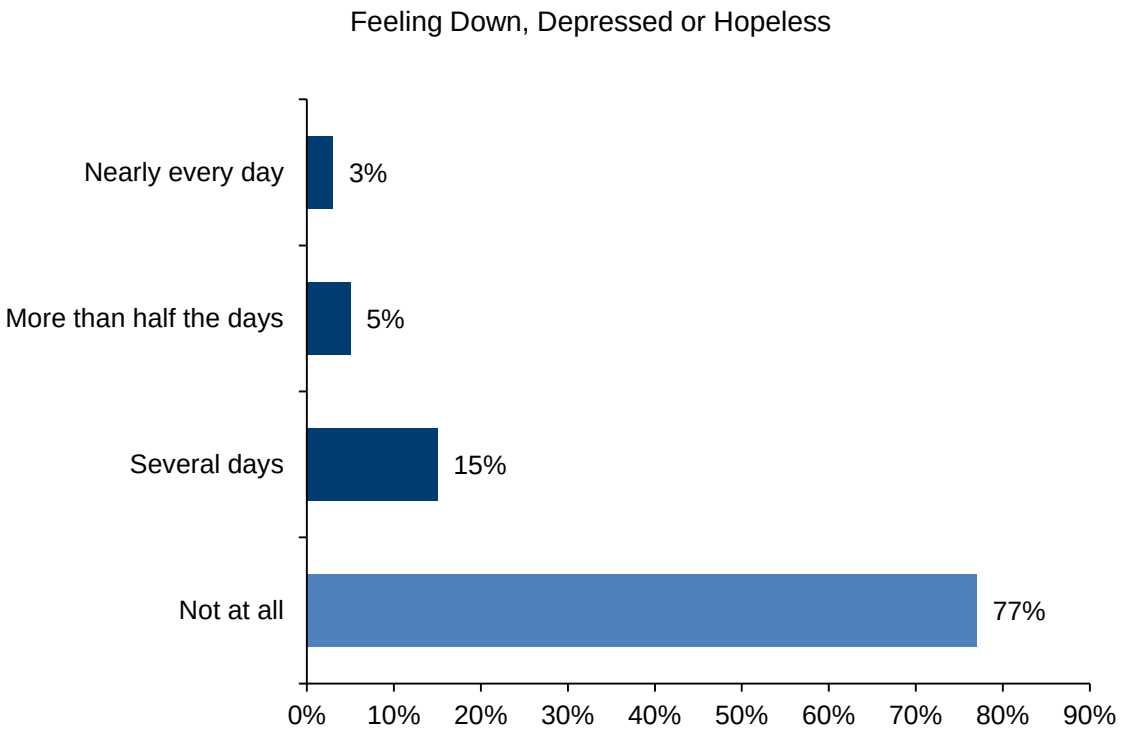
Base: Anxiety, stress, etc. (n=20), Arthritis (n=17), Asthma (n=11), COPD (n=1), Depression (n=19), Diabetes (n=7), High cholesterol (n=23), Hypertension (n=20), Panic attacks (n=3), Sample Size = 60
(Community = Clay /Union)

Little Interest or Pleasure in Doing Things



Base: Not at all (n=73), Several days (n=14), More than half the days (n=5), Nearly every day (n=3), Sample Size = 95

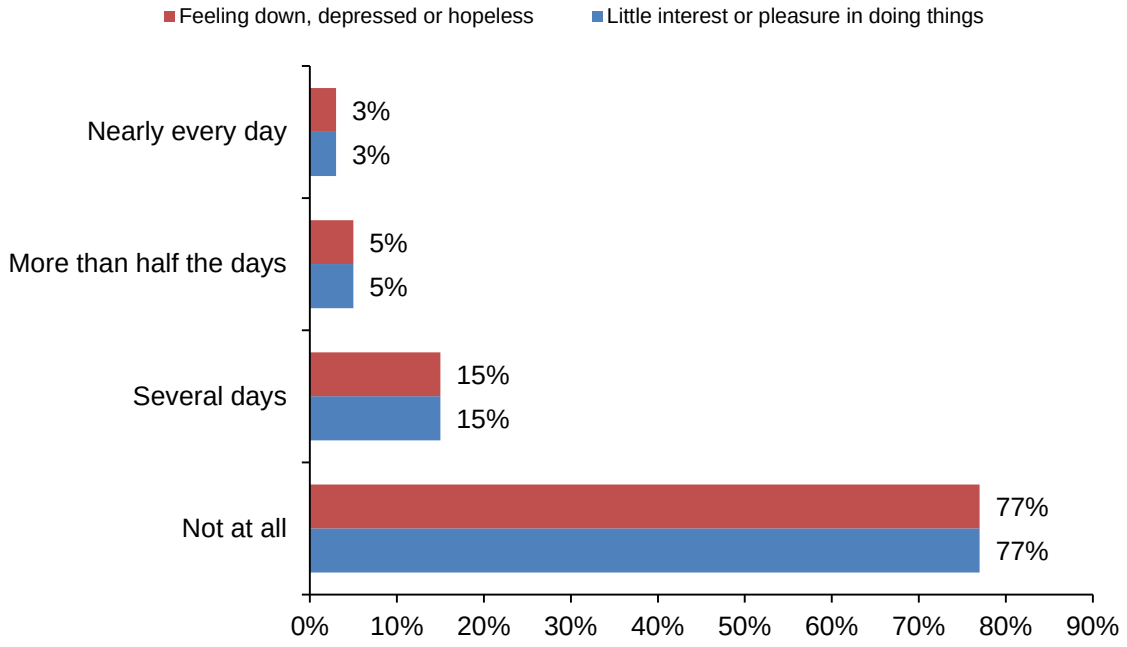
(Community = Clay /Union)



Base: Not at all (n=73), Several days (n=14), More than half the days (n=5), Nearly every day (n=3), Sample Size = 95

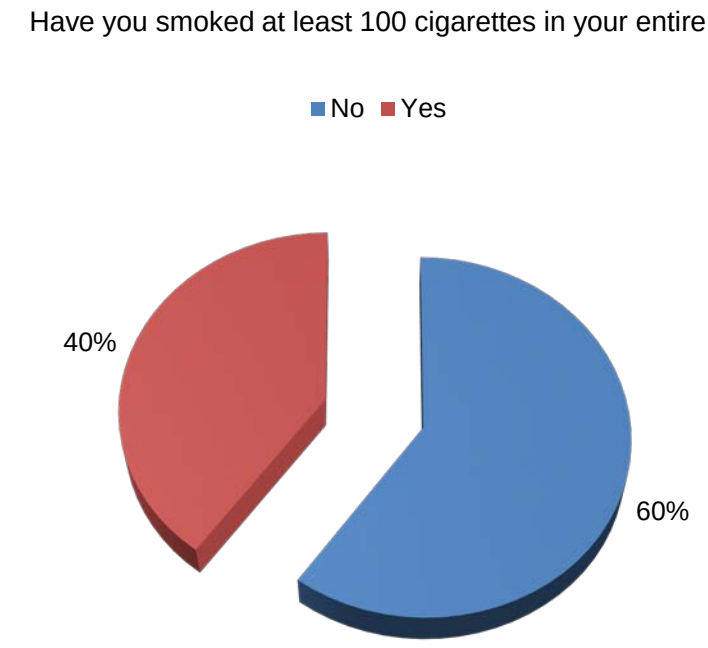
(Community = Clay /Union)

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



Sample Size = 95

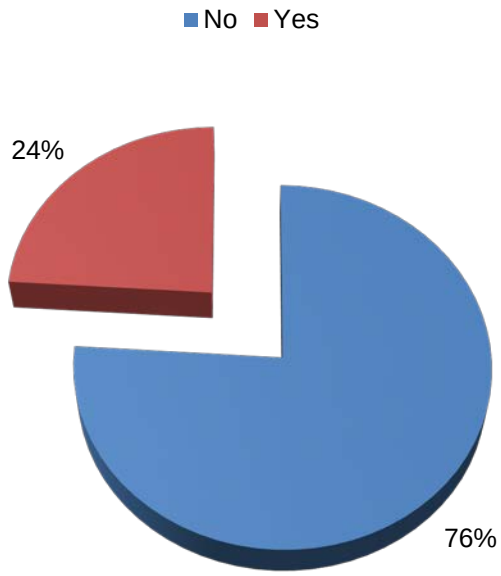
(Community = Clay /Union)



Base: Yes (n=38), No (n=57), Sample Size = 95

(Community = Clay /Union)

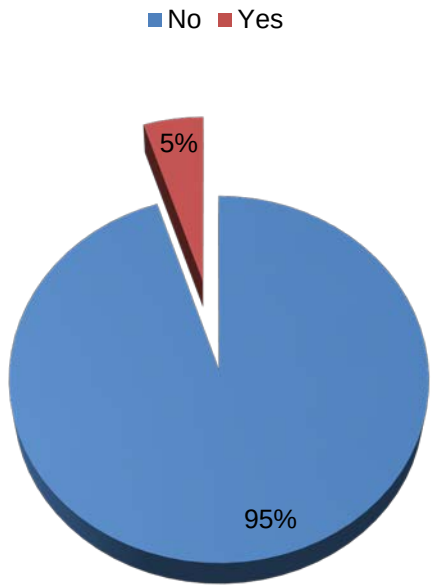
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=23), No (n=72), Sample Size = 95

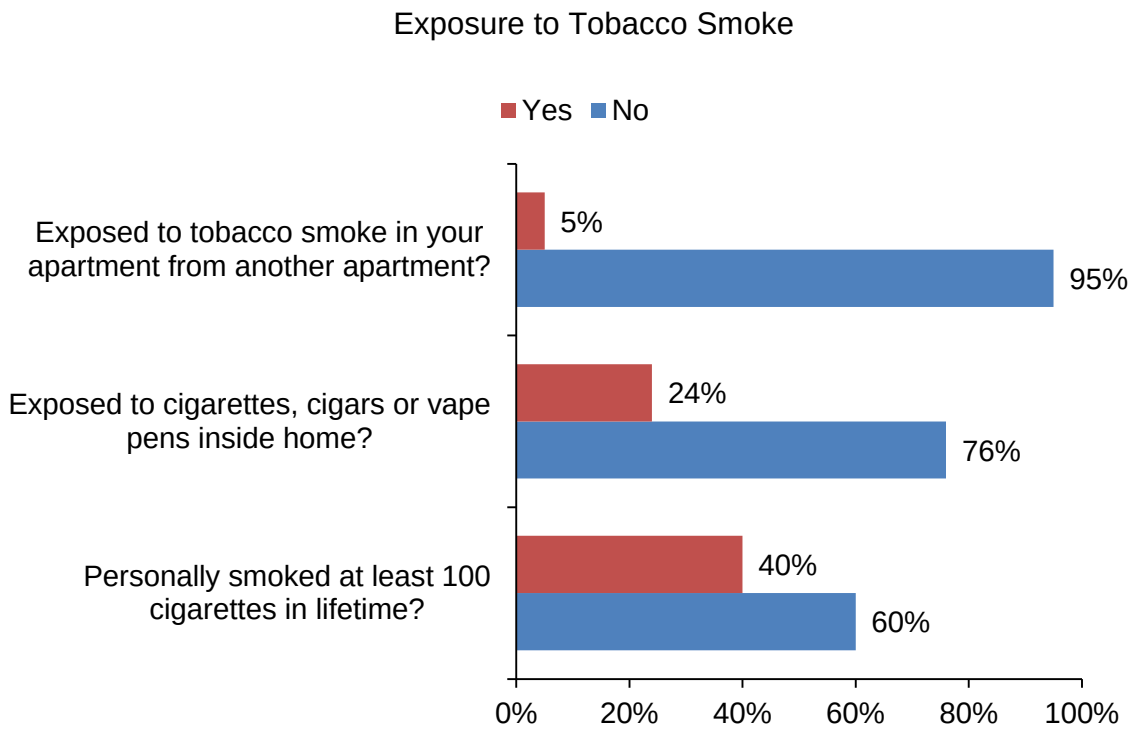
(Community = Clay /Union)

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



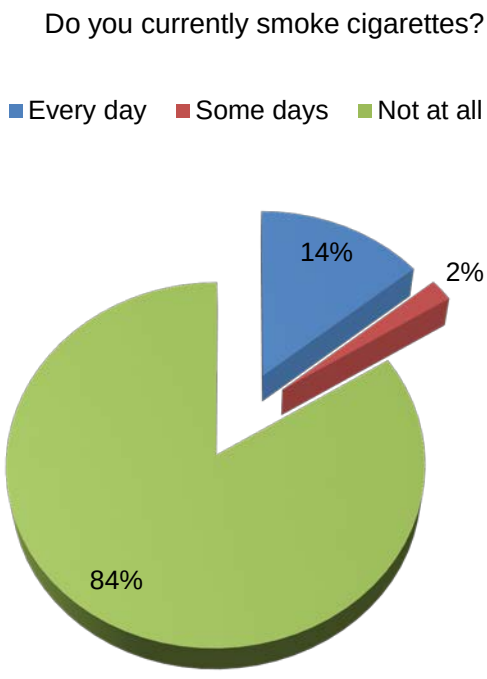
Base: Yes (n=5), No (n=90), Sample Size = 95

(Community = Clay /Union)



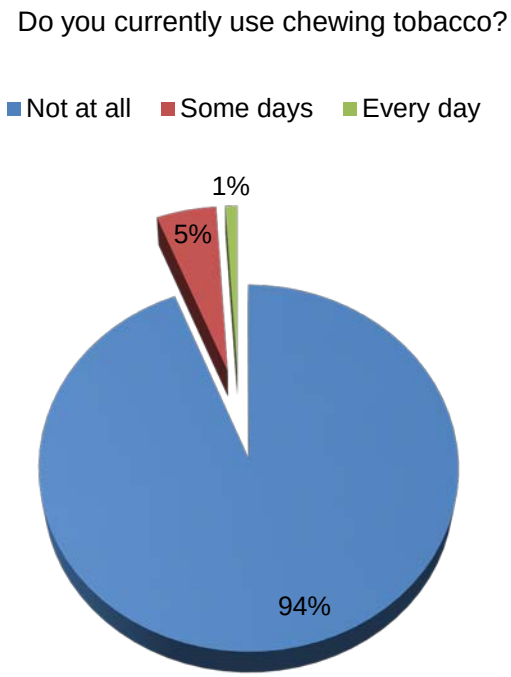
Base: Personally smoked at least 100 cigarettes in lifetime? (n=95), Exposed to cigarettes, cigars or vape pens inside home? (n=95), Exposed to tobacco smoke in your apartment from another apartment? (n=95), Sample Size = 95

(Community = Clay /Union)



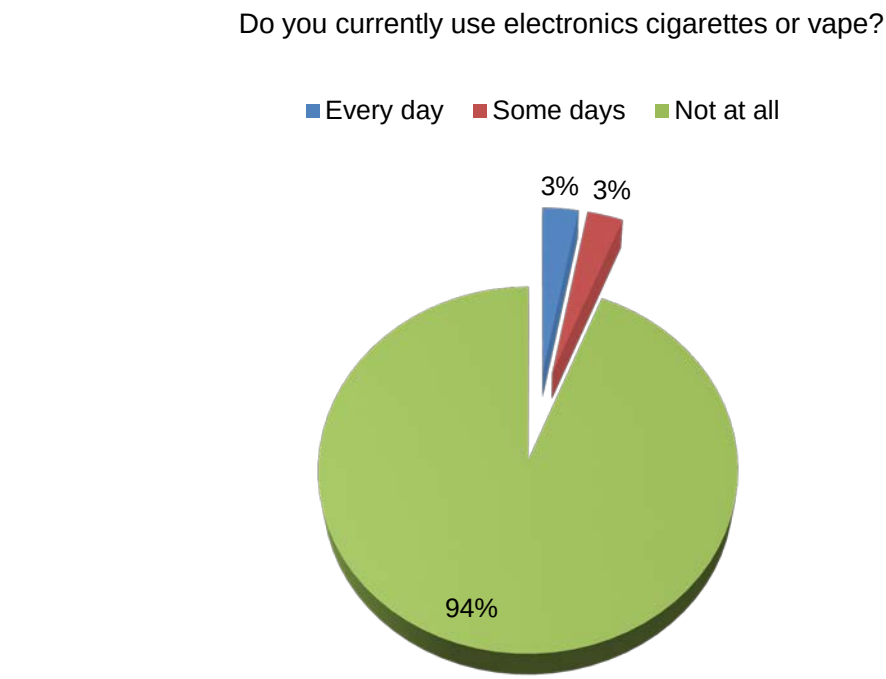
Base: Not at all (n=80), Some days (n=2), Every day (n=13), Sample Size = 95

(Community = Clay /Union)



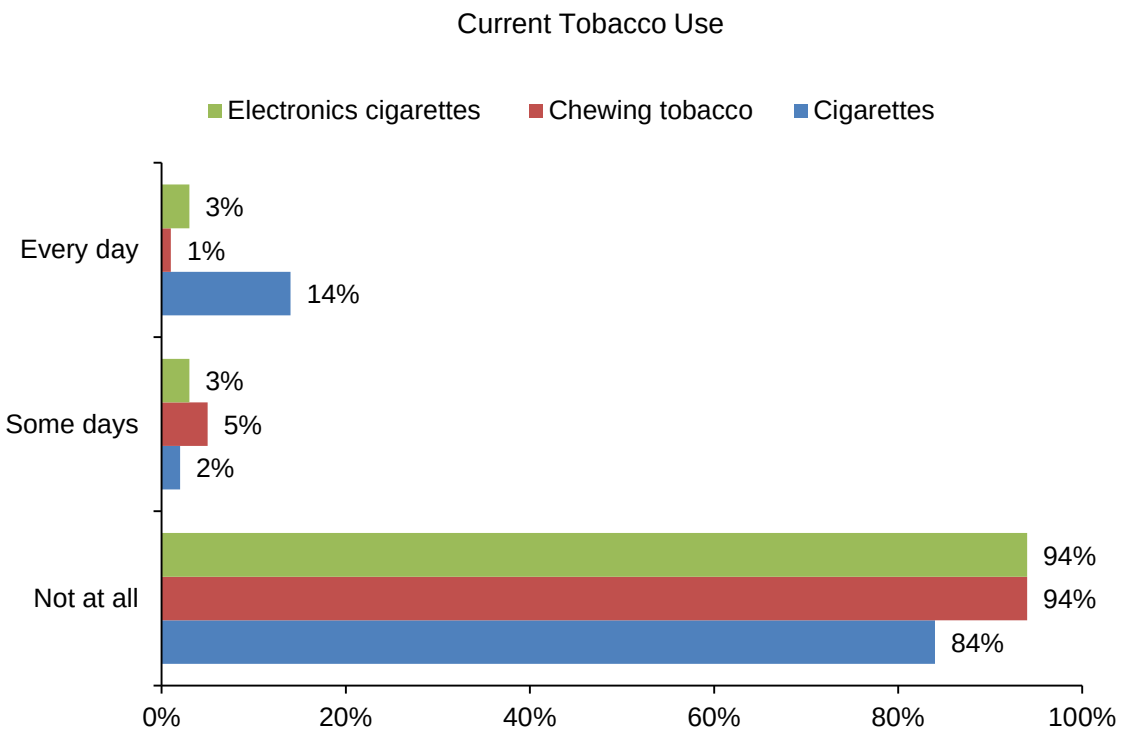
Base: Not at all (n=89), Some days (n=5), Every day (n=1), Sample Size = 95

(Community = Clay /Union)



Base: Not at all (n=89), Some days (n=3), Every day (n=3), Sample Size = 95

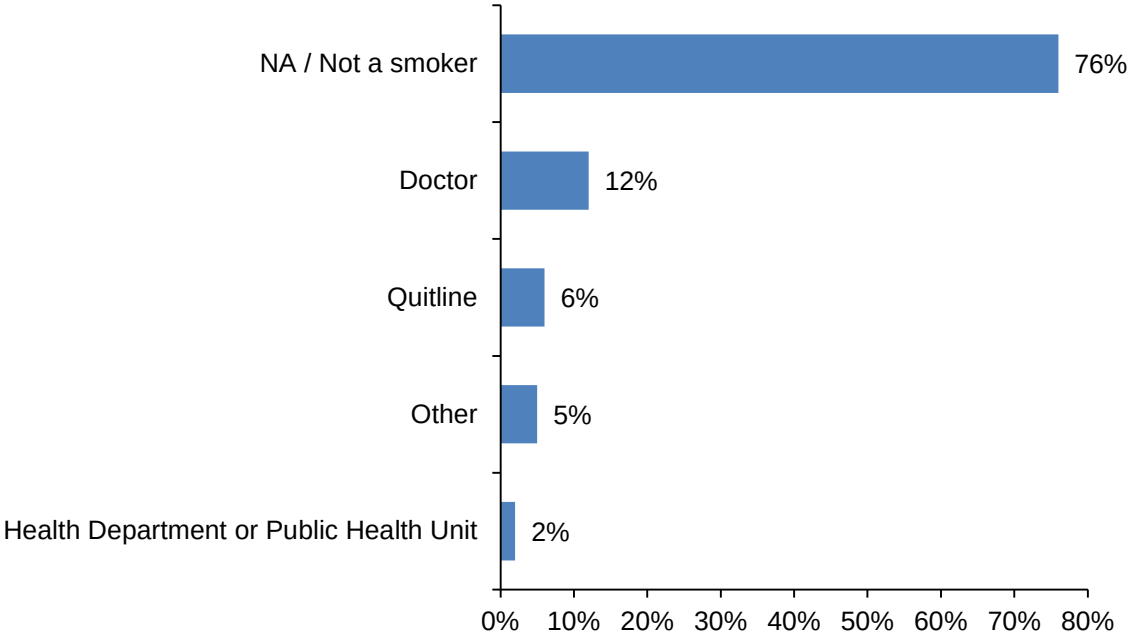
(Community = Clay /Union)



Sample Size = 95

(Community = Clay /Union)

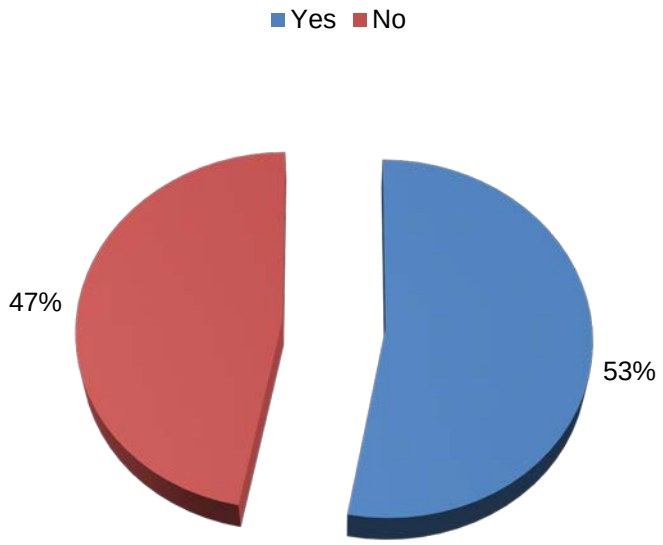
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=65), Quitline (n=5), Doctor (n=10), Health Department or Public Health Unit (n=2), Other (n=4), Sample Size = 86

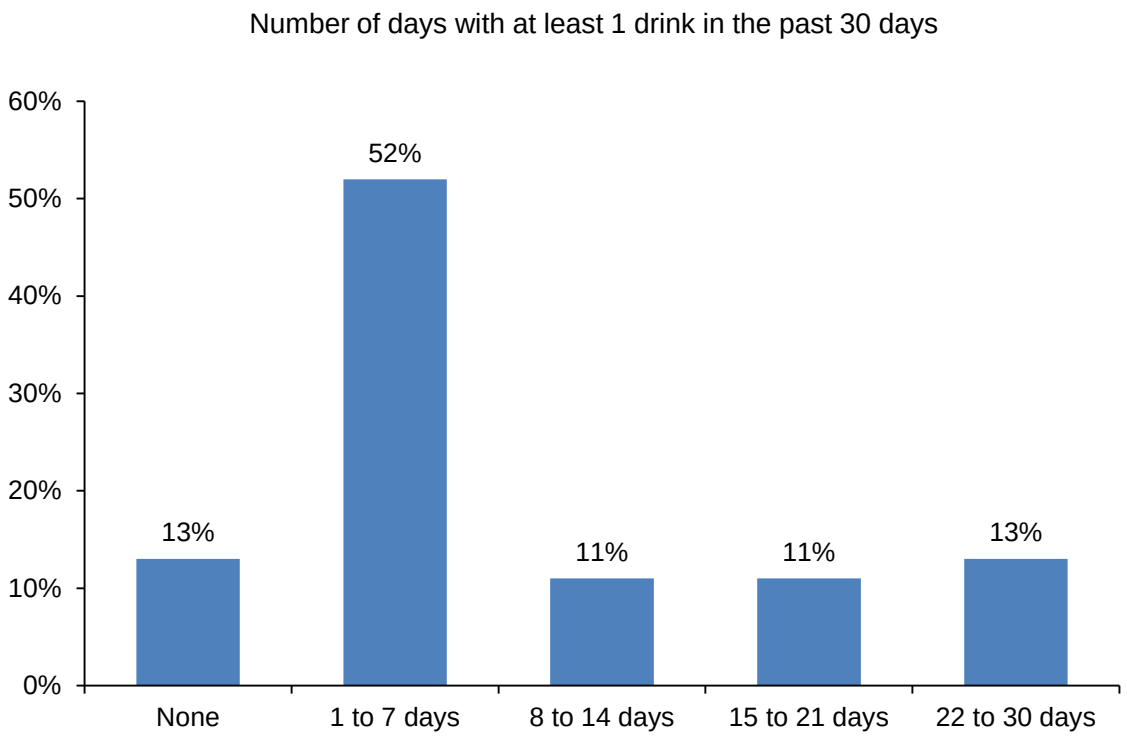
(Community = Clay /Union)

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



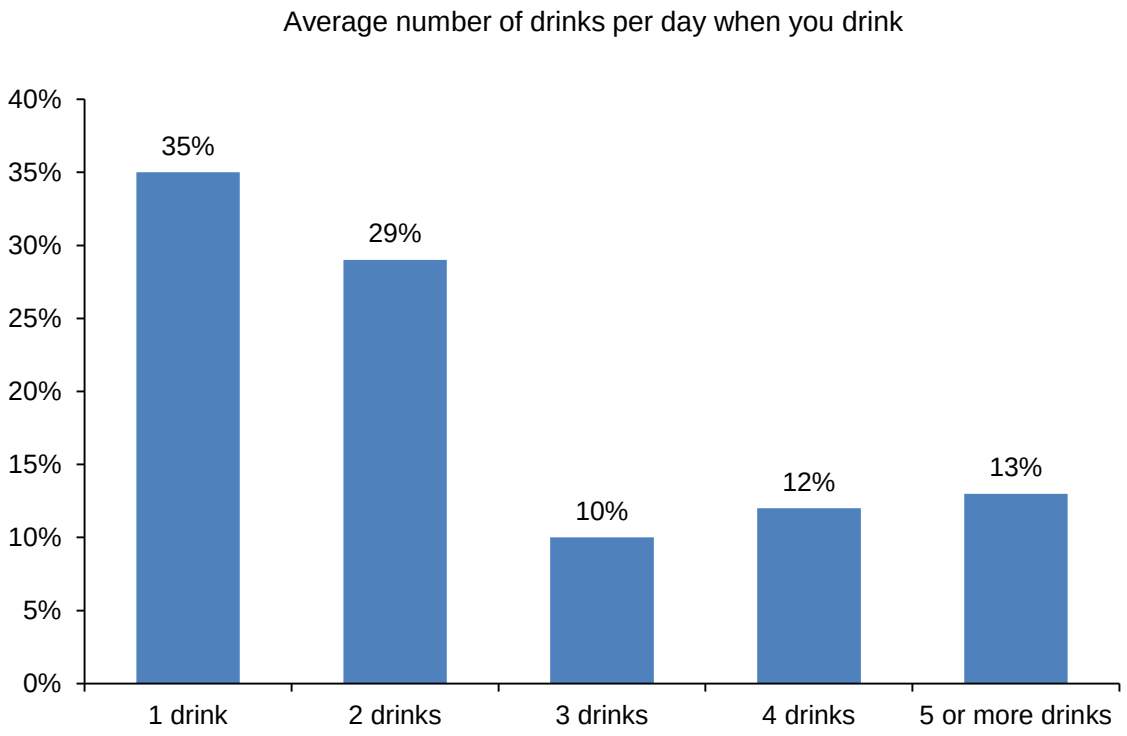
Base: Yes (n=9), No (n=8), Sample Size = 17

(Community = Clay /Union)



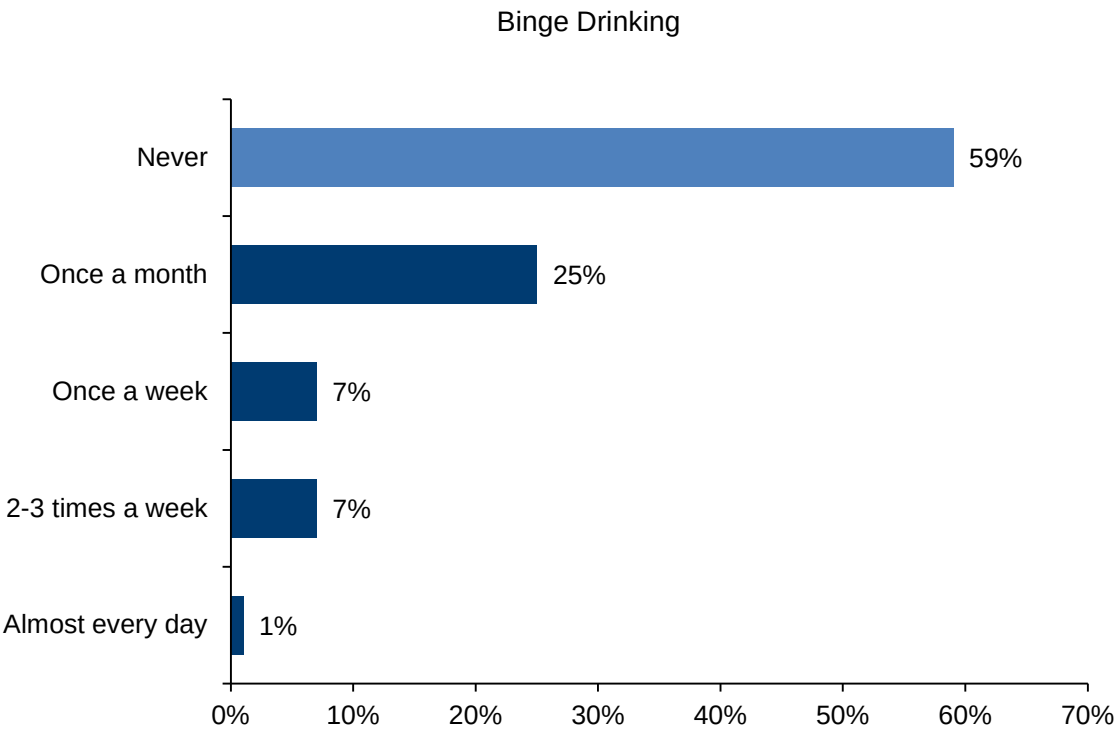
Base: None (n=10), 1 to 7 days (n=41), 8 to 14 days (n=9), 15 to 21 days (n=9), 22 to 30 days (n=10), Sample Size = 79

(Community = Clay /Union)



Base: 1 drink (n=24), 2 drinks (n=20), 3 drinks (n=7), 4 drinks (n=8), 5 or more drinks (n=9), Sample Size = 68

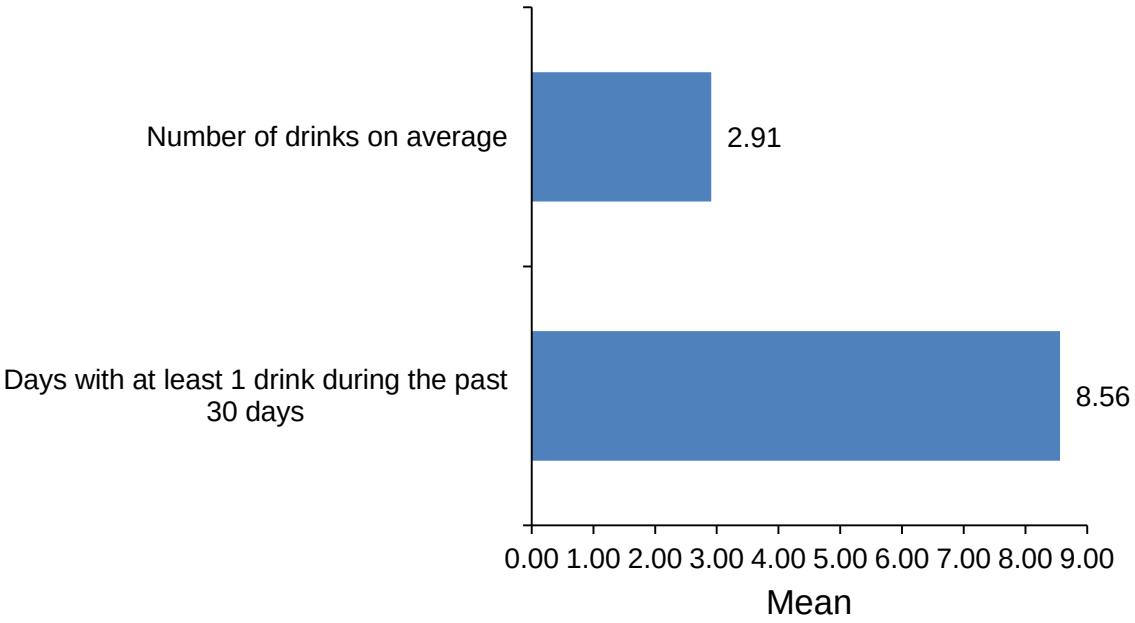
(Community = Clay /Union)



Base: Almost every day (n=1), 2-3 times a week (n=5), Once a week (n=5), Once a month (n=17), Never (n=41), Sample Size = 69

(Community = Clay /Union)

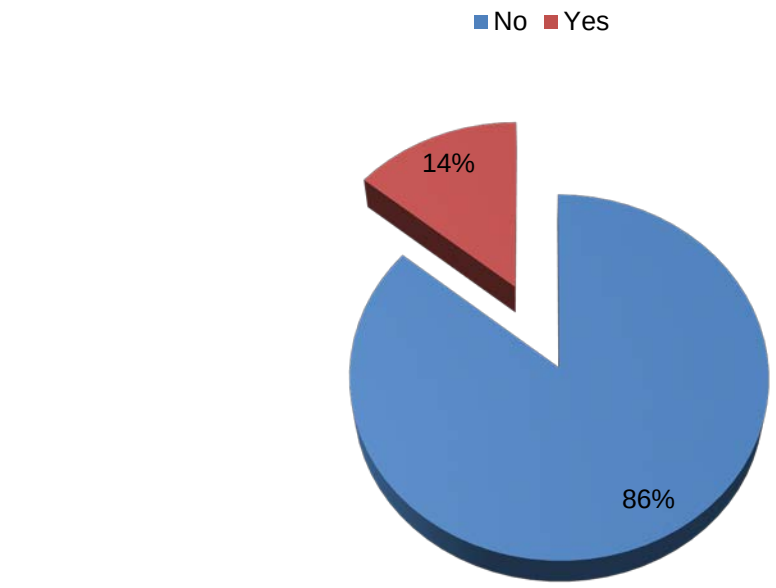
Average Alcohol Use During the Past 30 Days



Base: Days with at least 1 drink during the past 30 days (n=79), Number of drinks on average (n=68), Sample Size = Variable

(Community = Clay /Union)

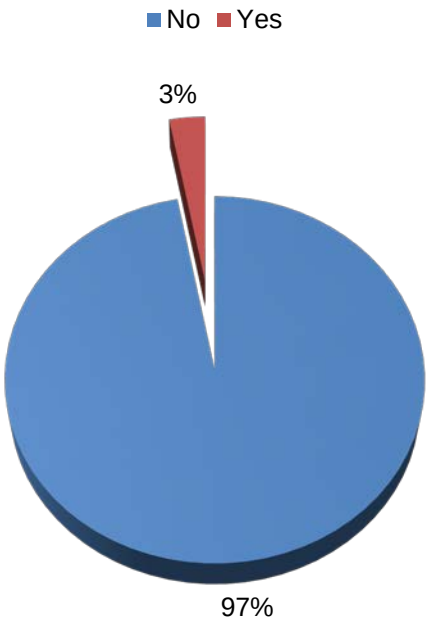
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=13), No (n=82), Sample Size = 95

(Community = Clay /Union)

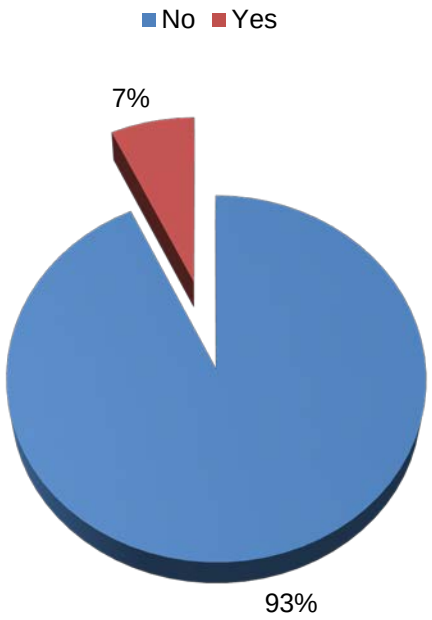
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=3), No (n=92), Sample Size = 95

(Community = Clay /Union)

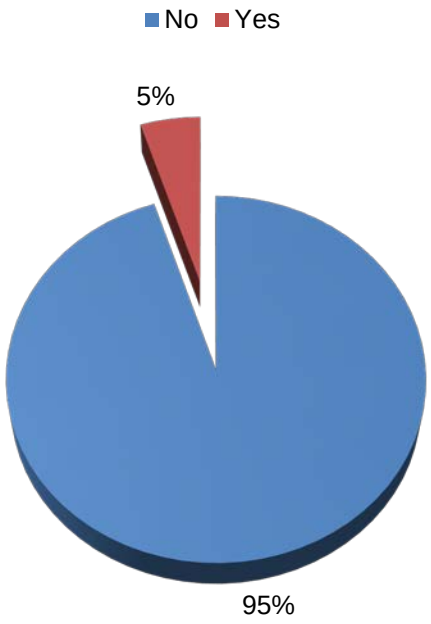
Has a family member or friend ever suggested that you get help for substance use?



Base: Yes (n=7), No (n=88), Sample Size = 95

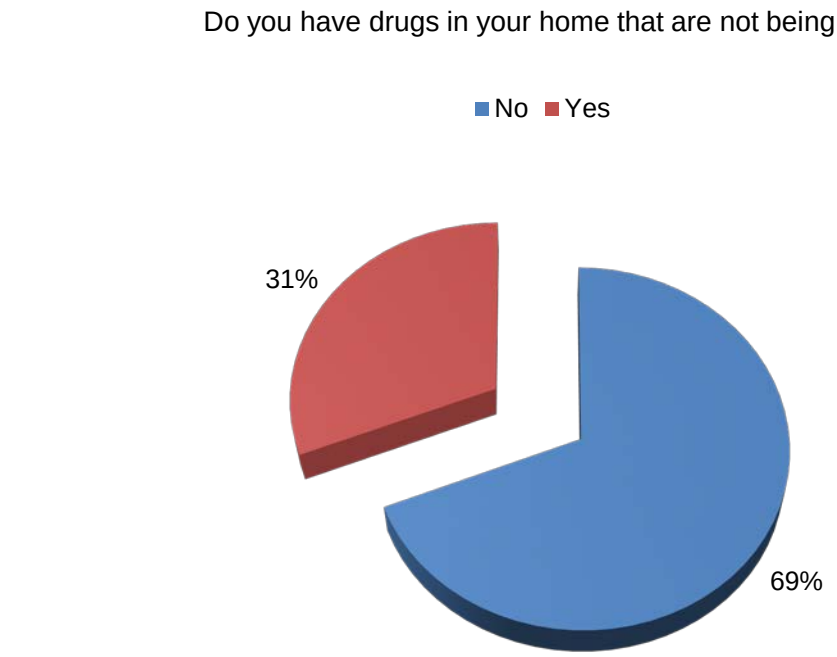
(Community = Clay /Union)

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



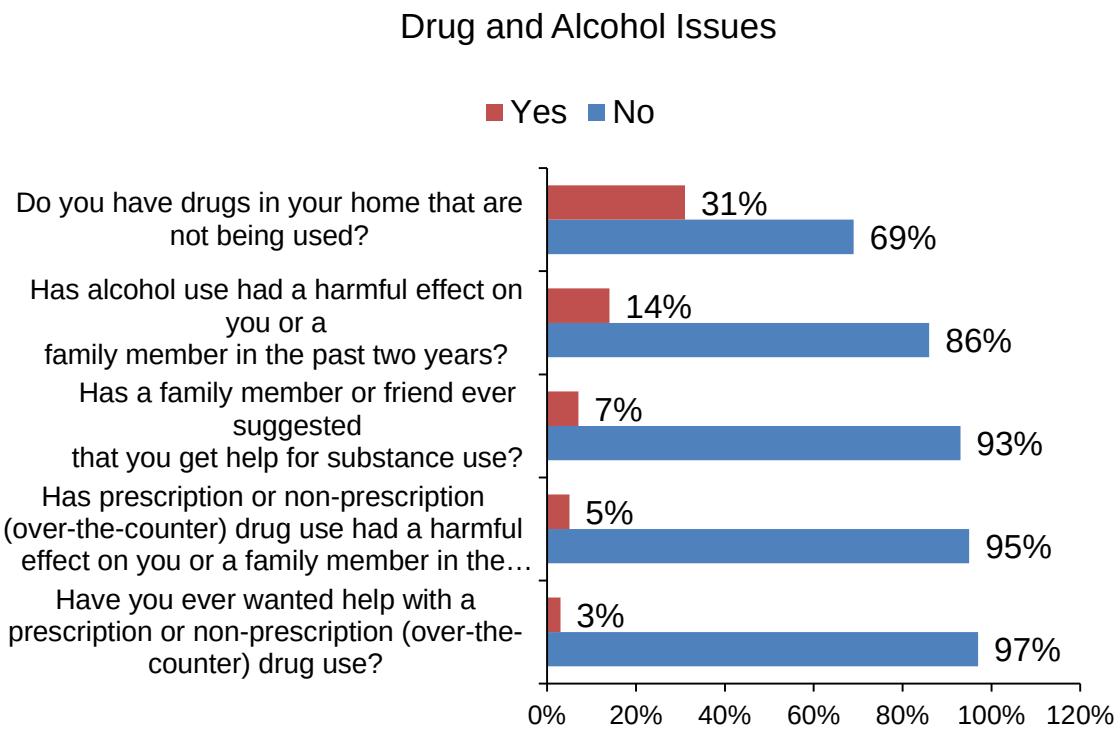
Base: Yes (n=5), No (n=90), Sample Size = 95

(Community = Clay /Union)



Base: Yes (n=29), No (n=66), Sample Size = 95

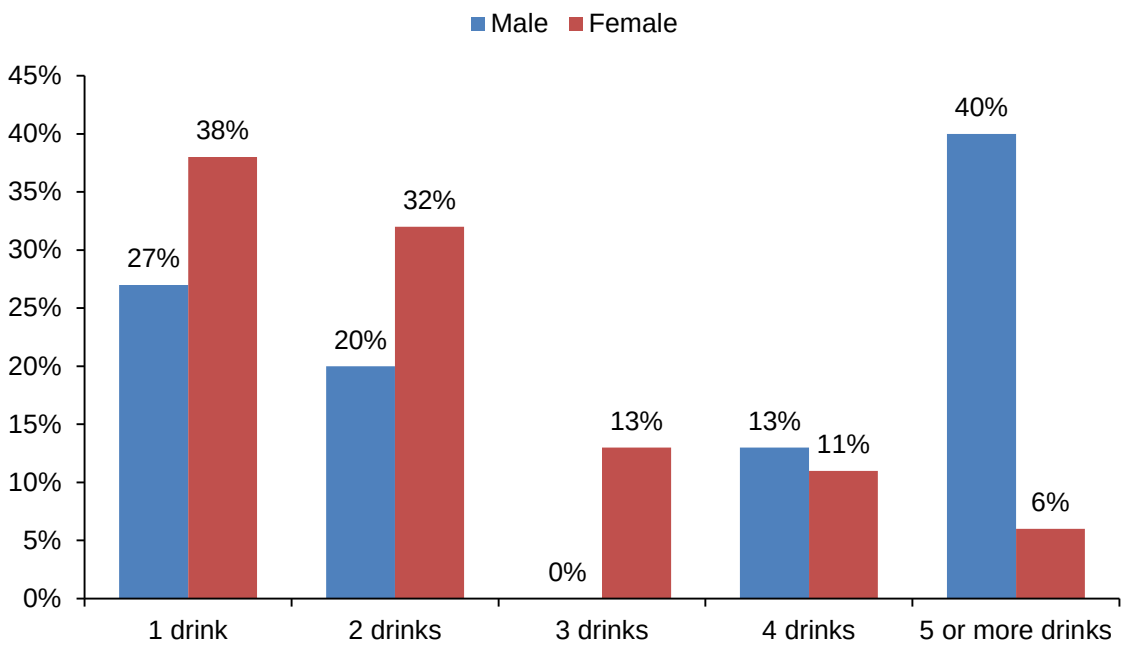
(Community = Clay /Union)



Sample Size = 95

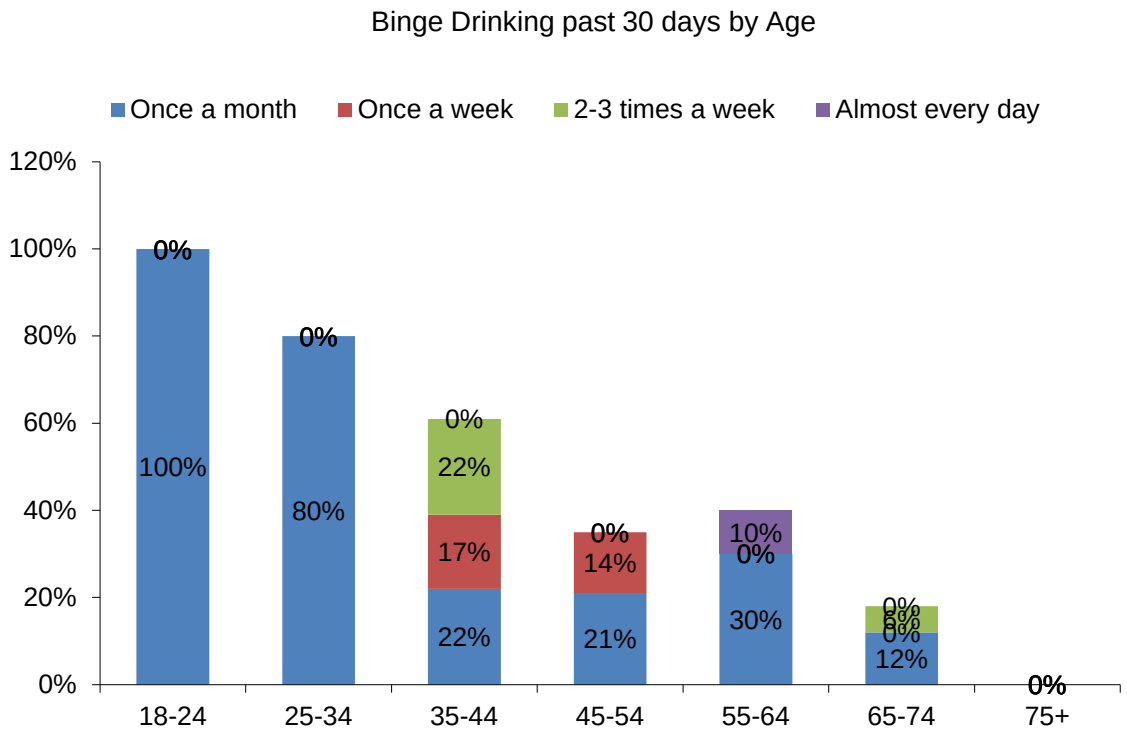
(Community = Clay /Union)

Average number of drinks per day when you drink by gender



Base: 1 drink (n=24), 2 drinks (n=20), 3 drinks (n=7), 4 drinks (n=8), 5 or more drinks (n=9), Sample Size = 68

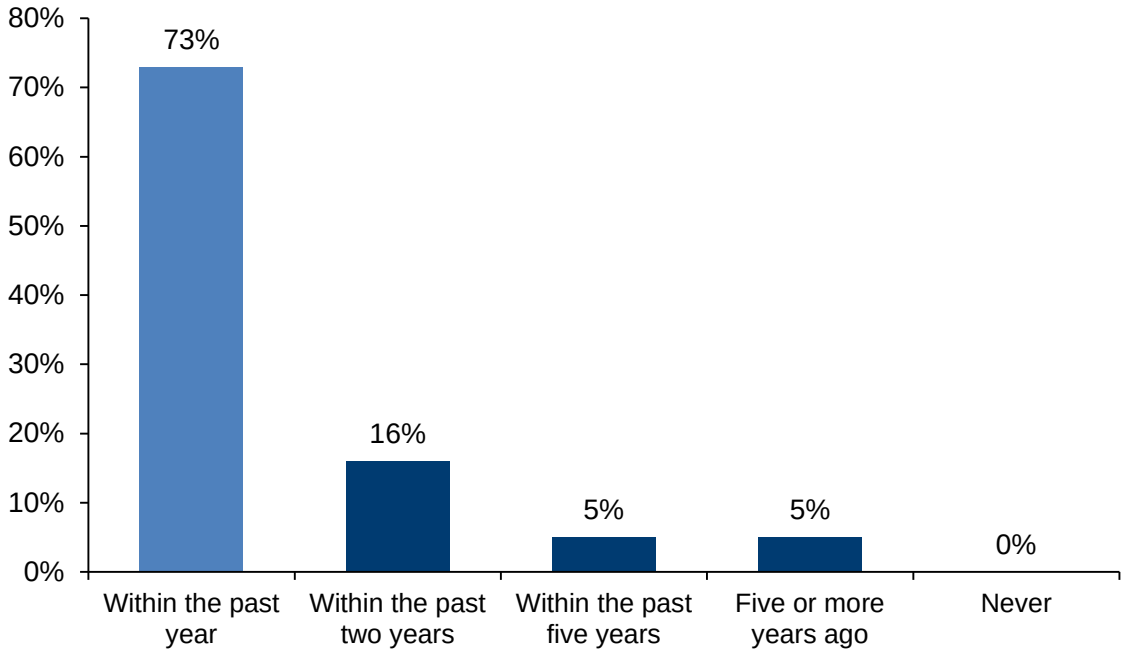
(Community = Clay /Union)



Base: 18-24 (n=1), 25-34 (n=5), 35-44 (n=18), 45-54 (n=14), 55-64 (n=10), 65-74 (n=17), 75+ (n=4), Sample Size = 69

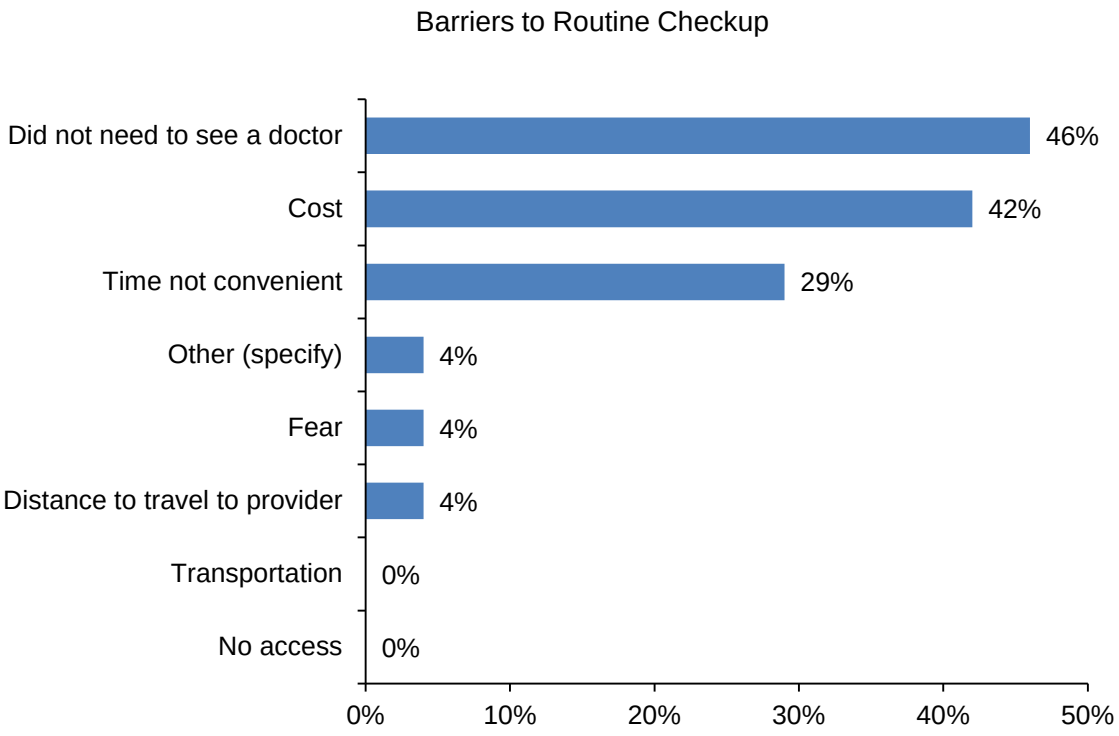
(Community = Clay /Union)

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=69), Within the past two years (n=15), Within the past five years (n=5), Five or more years ago (n=5), Never (n=0), Sample Size = 94

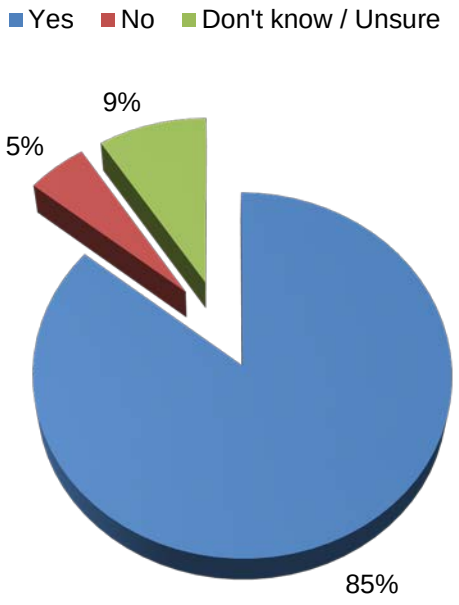
(Community = Clay /Union)



Base: No access (n=0), Distance to travel to provider (n=1), Cost (n=10), Fear (n=1), Transportation (n=0), Time not convenient (n=7), Did not need to see a doctor (n=11), Other (specify) (n=1), Sample Size = 24

(Community = Clay /Union)

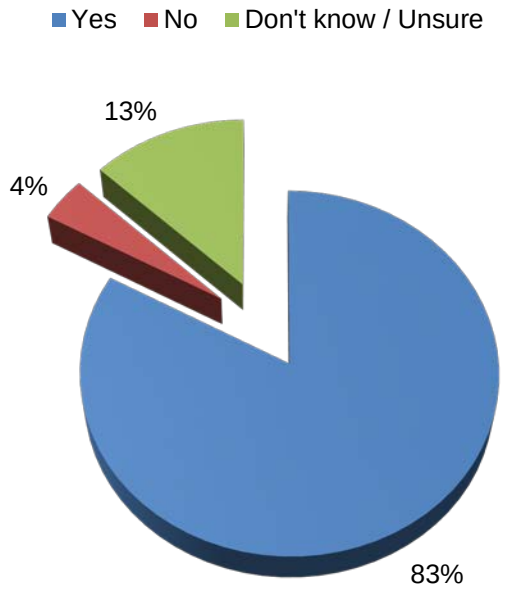
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=81), No (n=5), Don't know / Unsure (n=9), Sample Size = 95

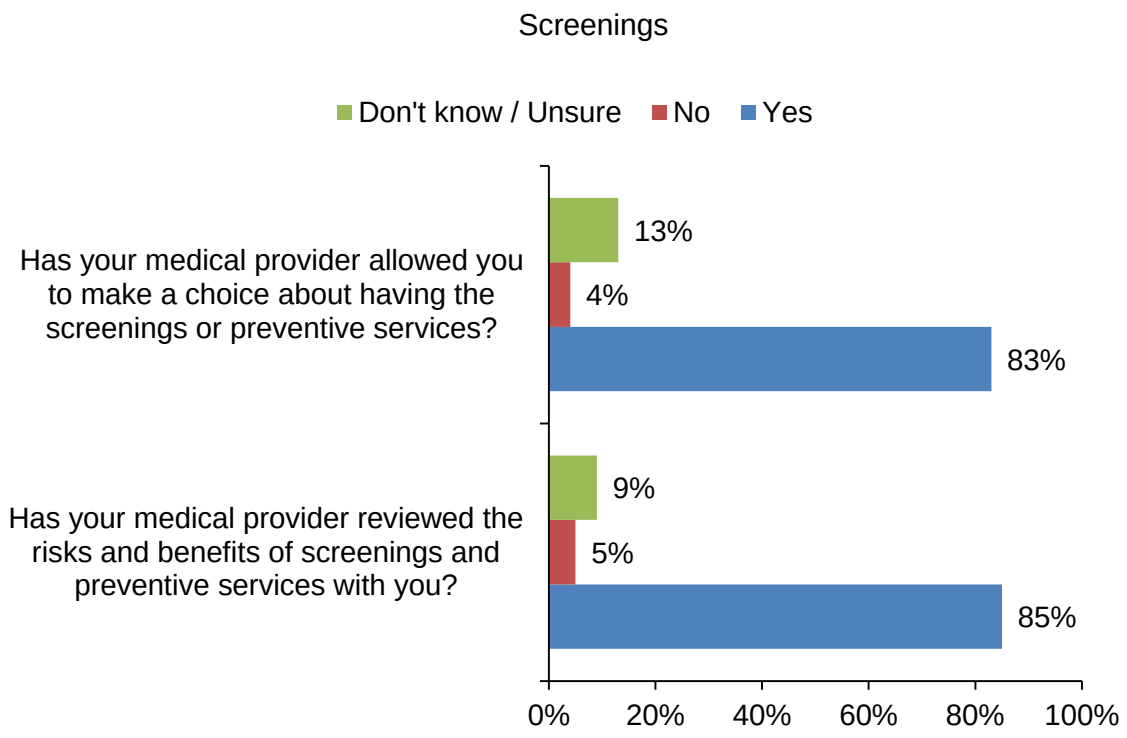
(Community = Clay /Union)

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



Base: Yes (n=79), No (n=4), Don't know / Unsure (n=12), Sample Size = 95

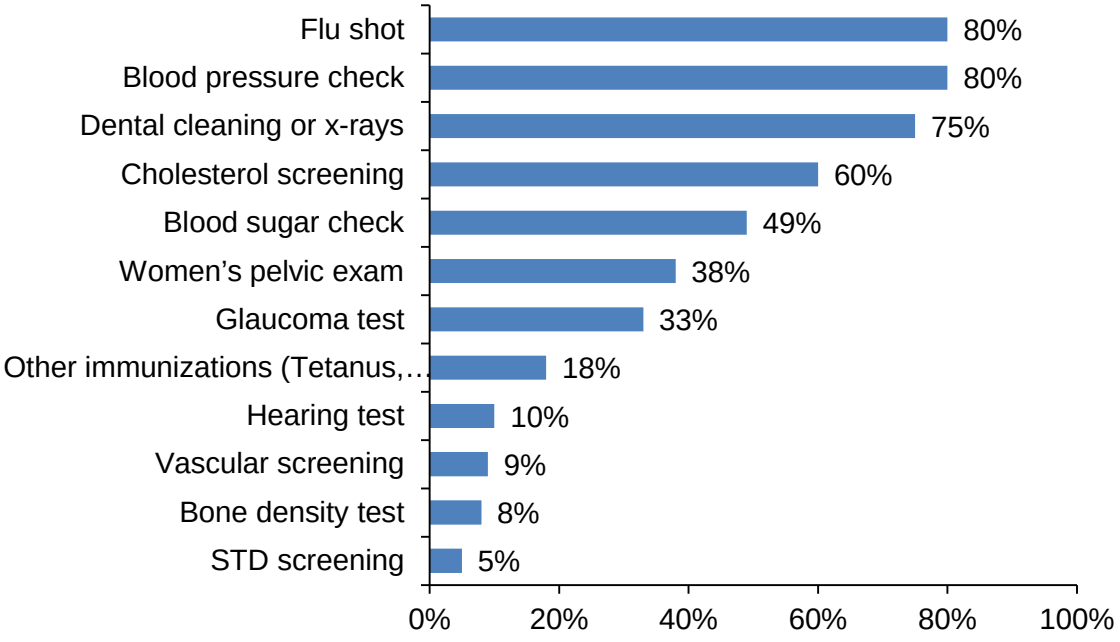
(Community = Clay /Union)



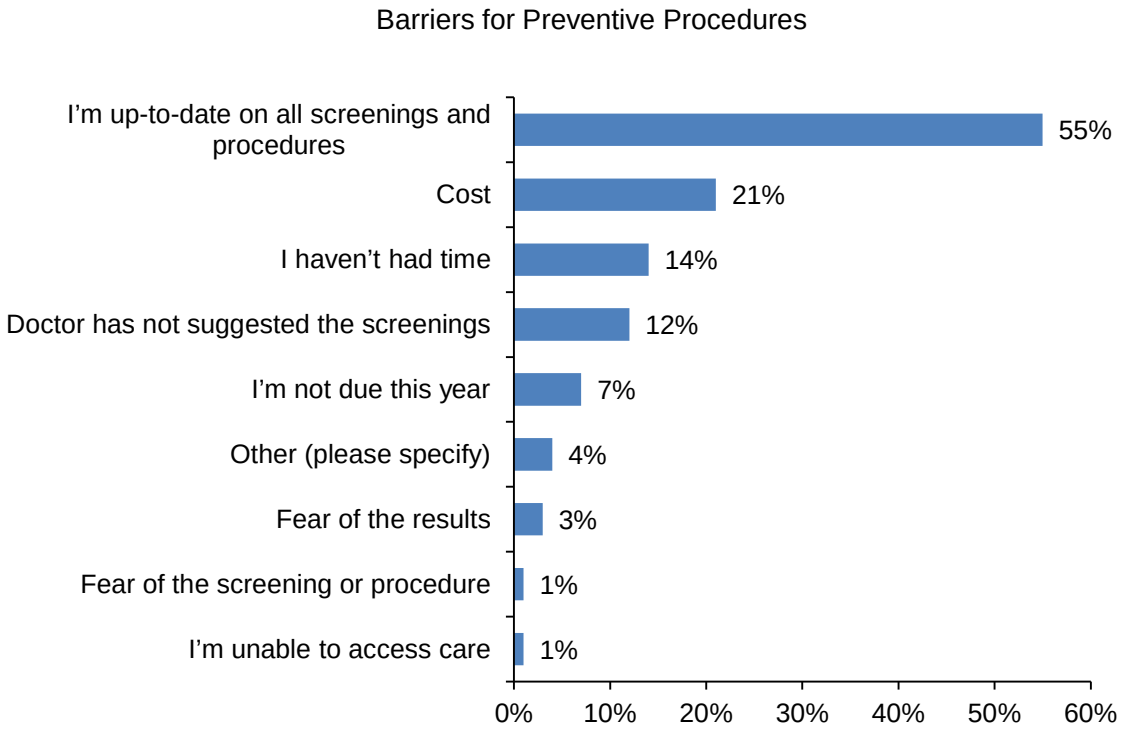
Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=95), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=95), Sample Size = 95

(Community = Clay /Union)

Preventive Procedures Last Year

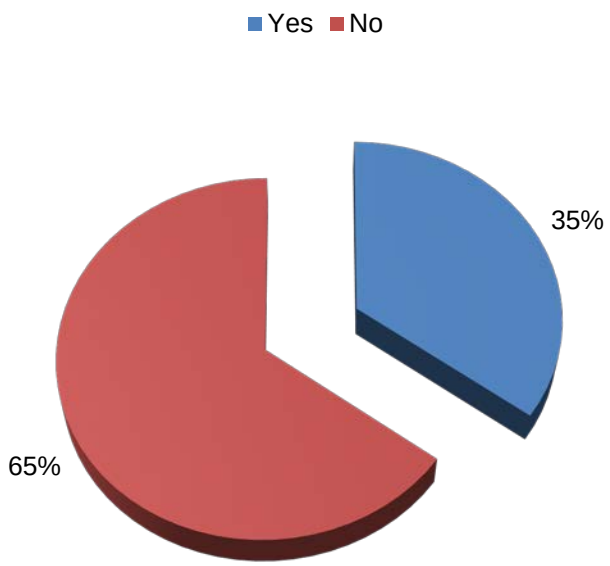


Base: Blood pressure check (n=73), Blood sugar check (n=45), Bone density test (n=7), Cholesterol screening (n=55), Dental cleaning or x-rays (n=68), Flu shot (n=73), Other immunizations (Tetanus, Hepatitis A or B) (n=16), Glaucoma test (n=30), Hearing test (n=9), Women's pelvic exam (n=35), STD screening (n=5), Vascular screening (n=8), Sample Size = 91
(Community = Clay /Union)



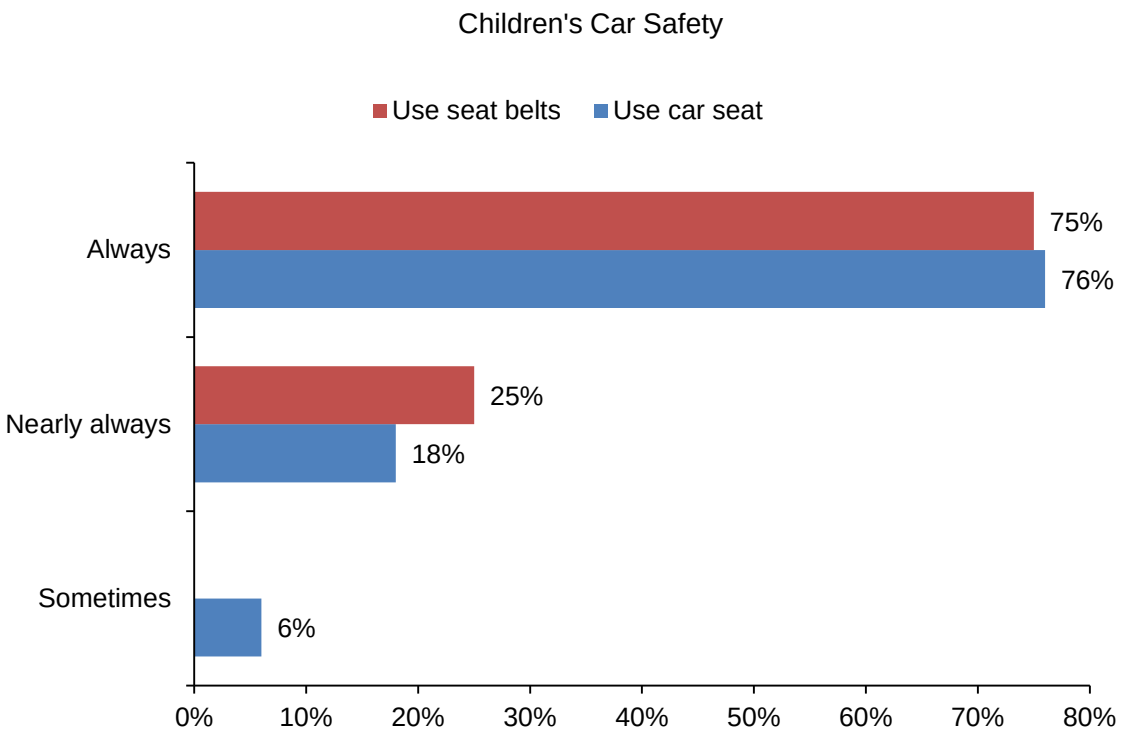
Base: I'm up-to-date on all screenings and procedures (n=51), Doctor has not suggested the screenings (n=11), Cost (n=19), I'm unable to access care (n=1), Fear of the screening or procedure (n=1), Fear of the results (n=3), I'm not due this year (n=6), I haven't had time (n=13), Other (please specify) (n=4), Sample Size = 92
(Community = Clay /Union)

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



Base: Yes (n=33), No (n=62), Sample Size = 95

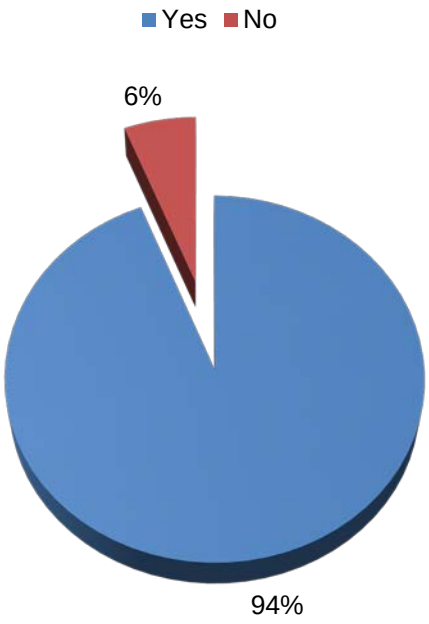
(Community = Clay /Union)



Sample Size = Variable

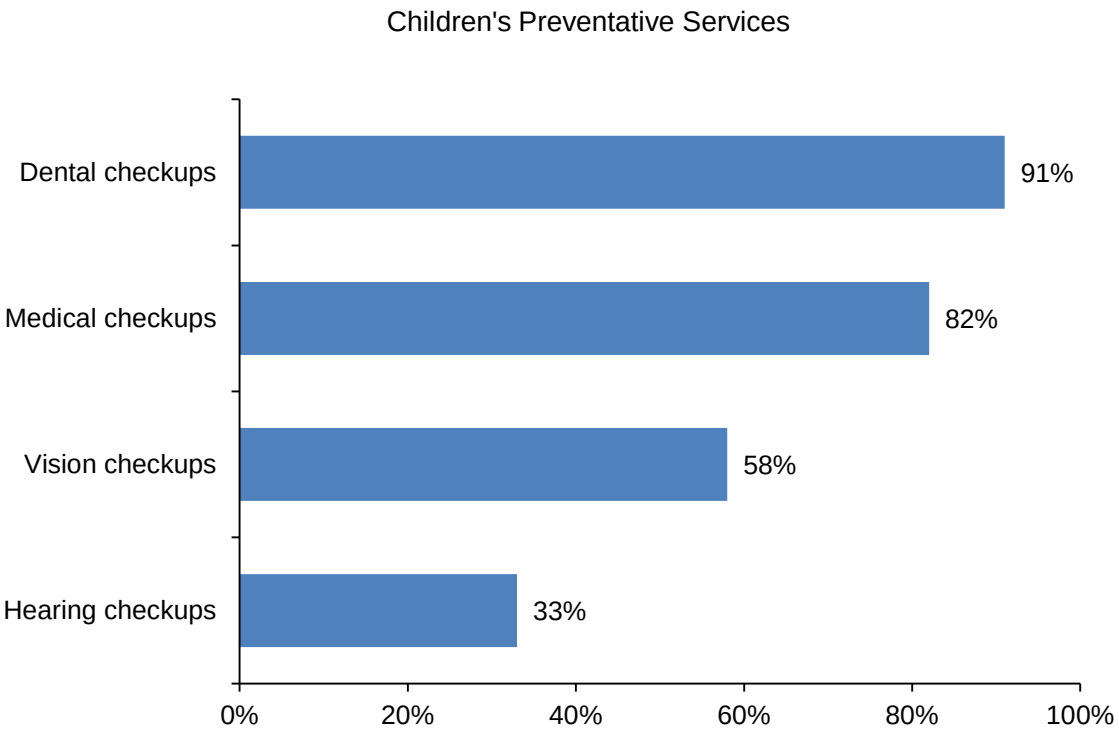
(Community = Clay /Union)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=31), No (n=2), Sample Size = 33

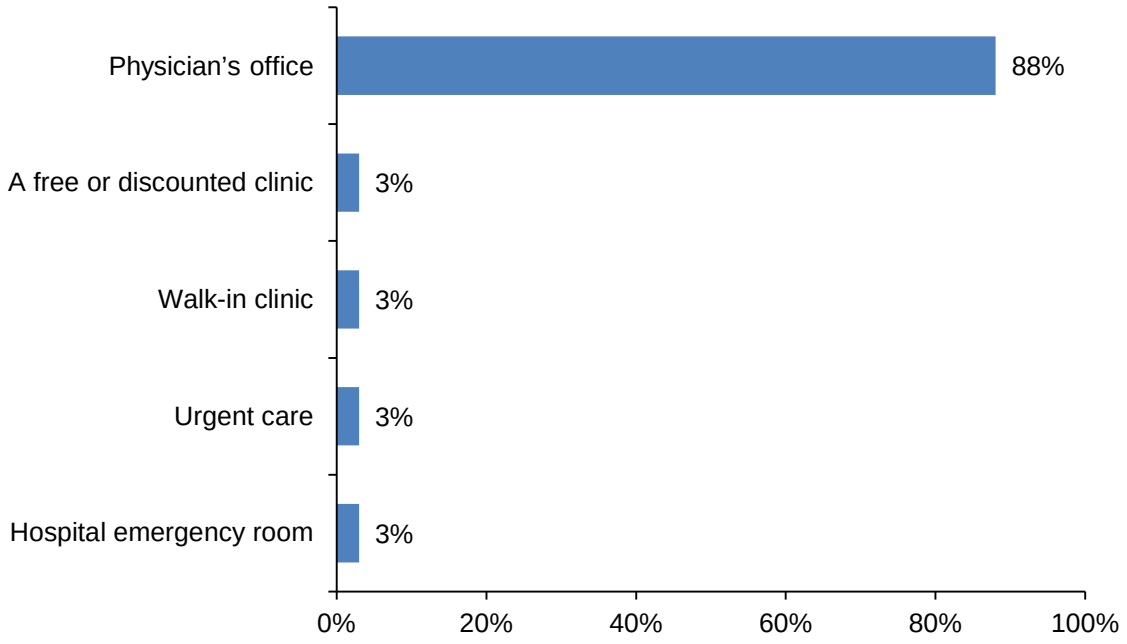
(Community = Clay /Union)



Base: Dental checkups (n=30), Vision checkups (n=19), Hearing checkups (n=11), Medical checkups (n=27), Sample Size = 33

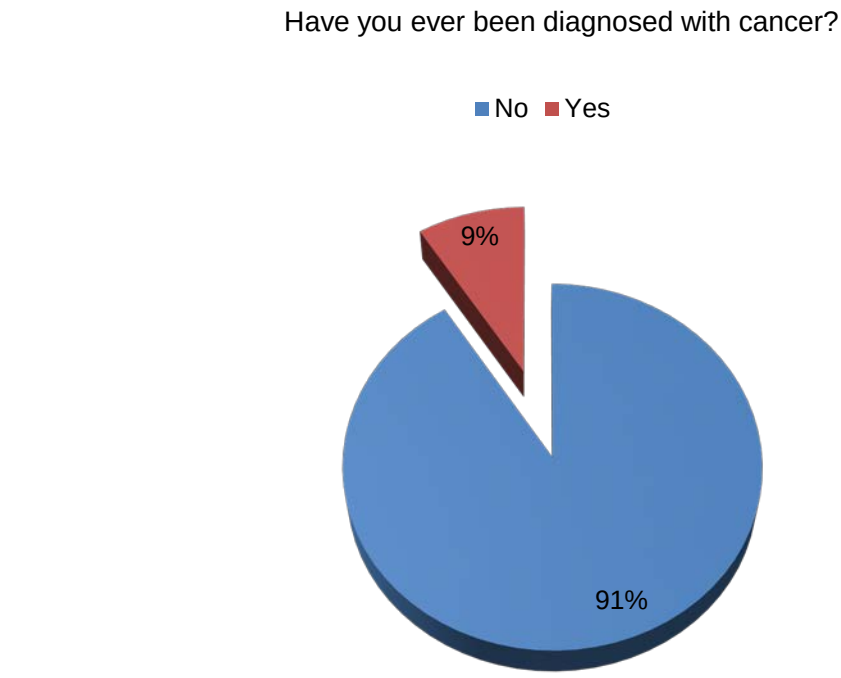
(Community = Clay /Union)

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



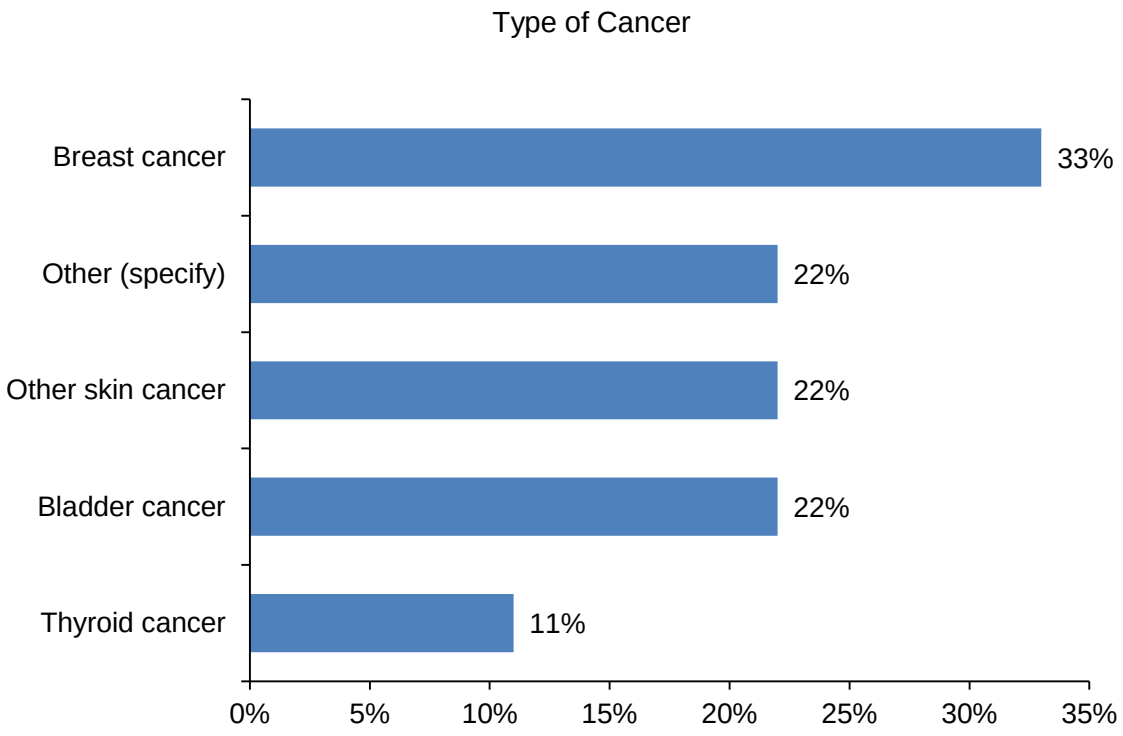
Base: Physician's office (n=28), Hospital emergency room (n=1), Urgent care (n=1), Walk-in clinic (n=1), A free or discounted clinic (n=1), Sample Size = 32

(Community = Clay /Union)



Base: Yes (n=9), No (n=86), Sample Size = 95

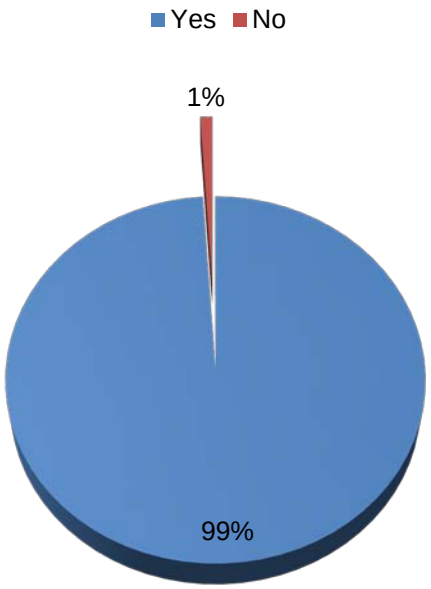
(Community = Clay /Union)



Base: Bladder cancer (n=2), Breast cancer (n=3), Other skin cancer (n=2), Thyroid cancer (n=1), Other (specify) (n=2), Sample Size = 9

(Community = Clay /Union)

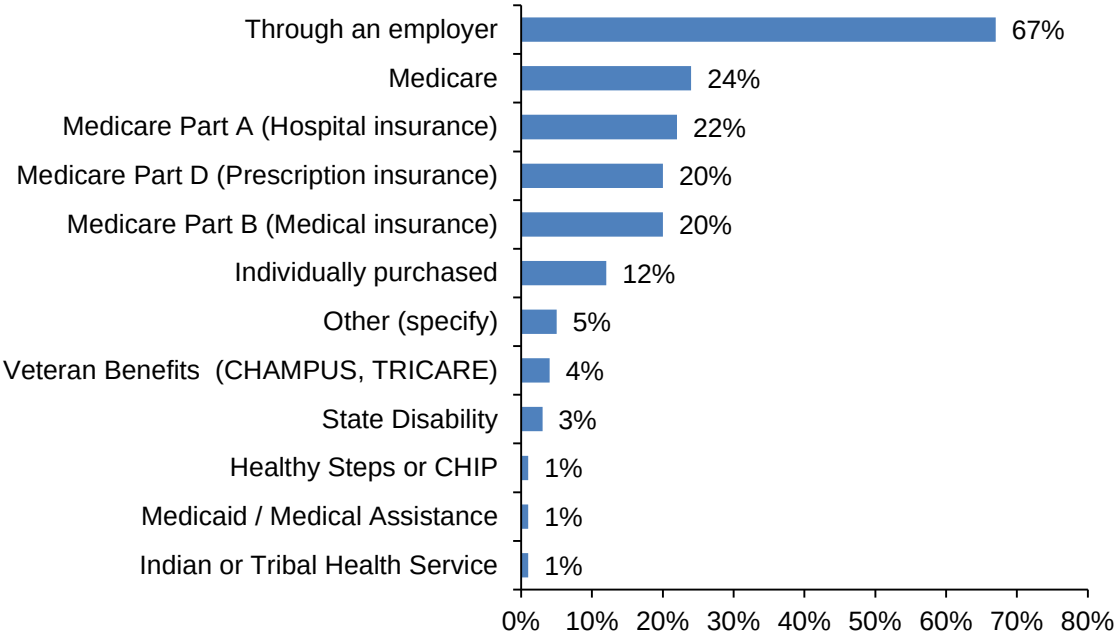
Do you currently have any kind of health insurance?



Base: Yes (n=94), No (n=1), Sample Size = 95

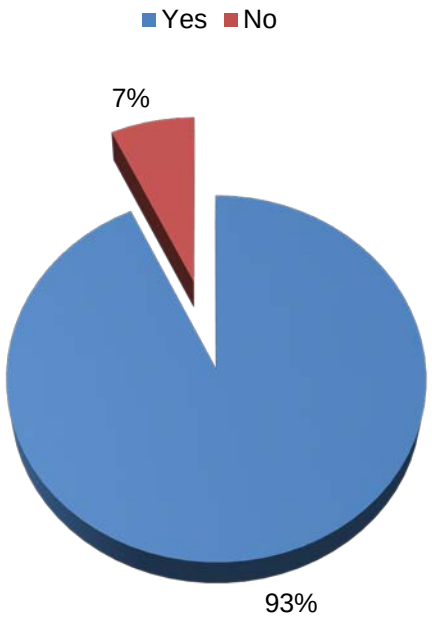
(Community = Clay /Union)

Type of Insurance



Base: Through an employer (n=63), Individually purchased (n=11), Indian or Tribal Health Service (n=1), Medicare (n=23), Medicare Part A (Hospital insurance) (n=21), Medicare Part B (Medical insurance) (n=19), Medicare Part D (Prescription insurance) (n=19), State Disability (n=3), Medicaid / Medical Assistance (n=1), Veteran Benefits (CHAMPUS, TRICARE) (n=4), Healthy Steps or CHIP (n=1), Other (specify) (n=5), Sample Size = 94
(Community = Clay /Union)

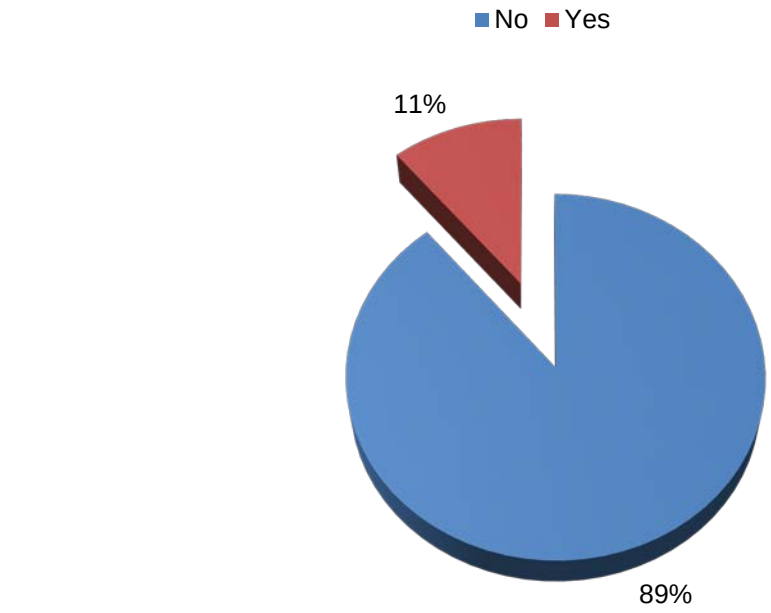
Do you have an established primary healthcare provider?



Base: Yes (n=88), No (n=7), Sample Size = 95

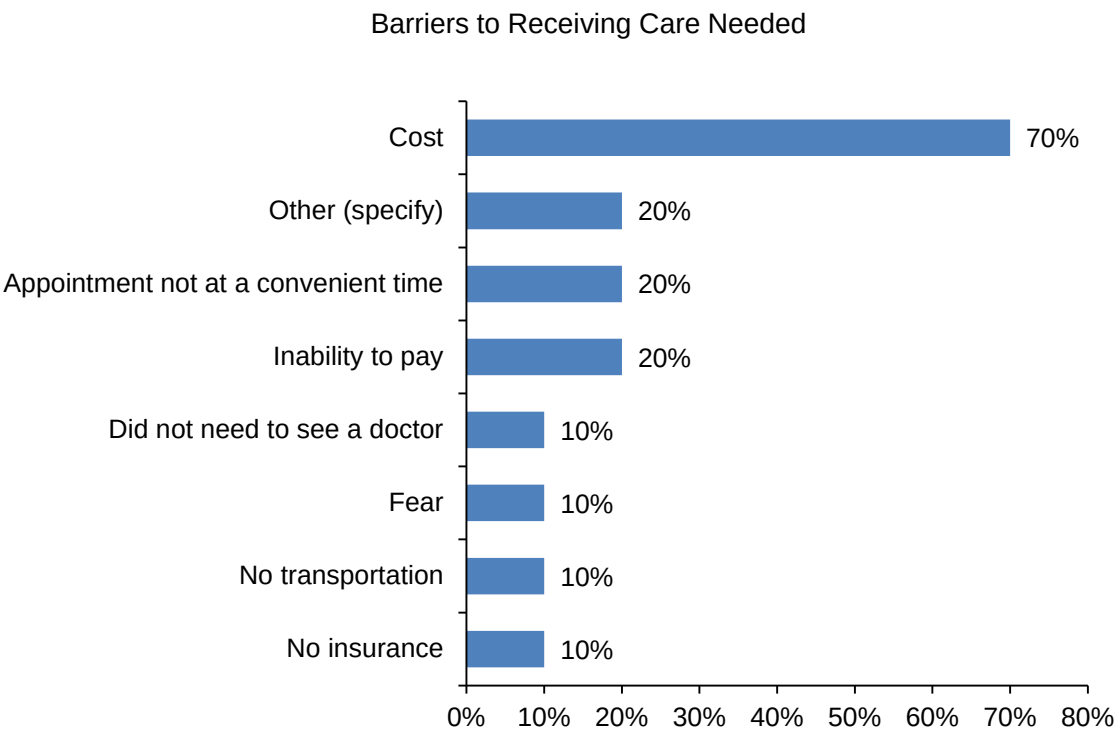
(Community = Clay /Union)

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=10), No (n=85), Sample Size = 95

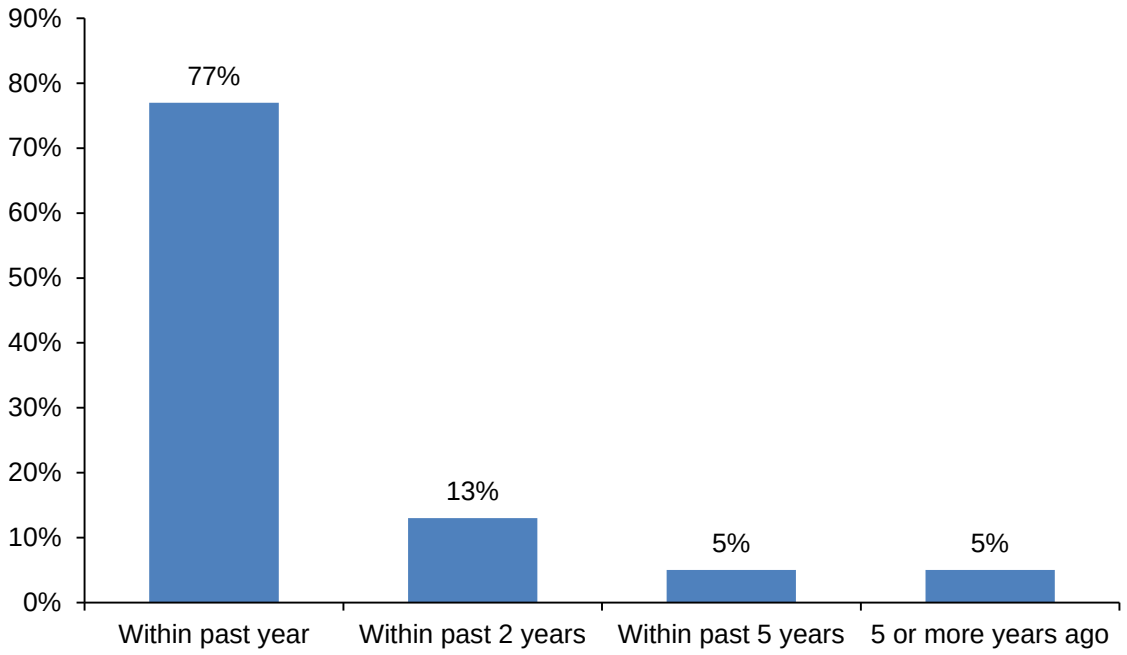
(Community = Clay /Union)



Base: Inability to pay (n=2), Appointment not at a convenient time (n=2), No insurance (n=1), No transportation (n=1), Cost (n=7), Fear (n=1), Did not need to see a doctor (n=1), Other (specify) (n=2)

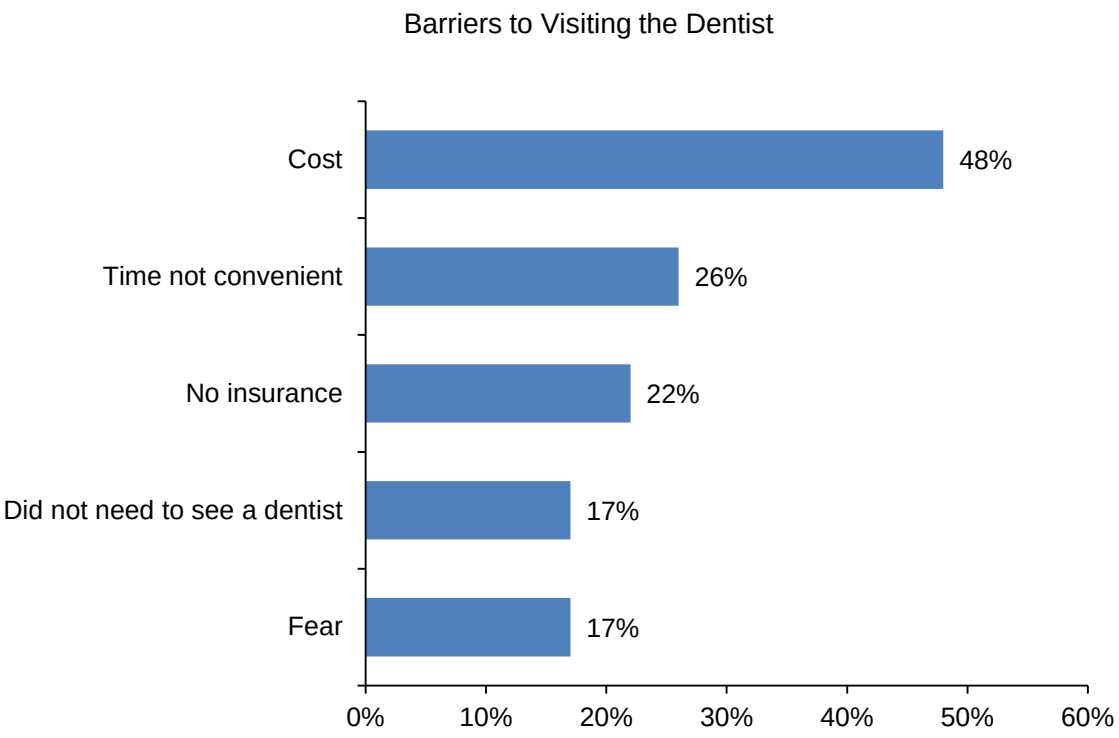
(Community = Clay /Union)

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



Base: Within past year (n=72), Within past 2 years (n=12), Within past 5 years (n=5), 5 or more years ago (n=5), Sample Size = 94

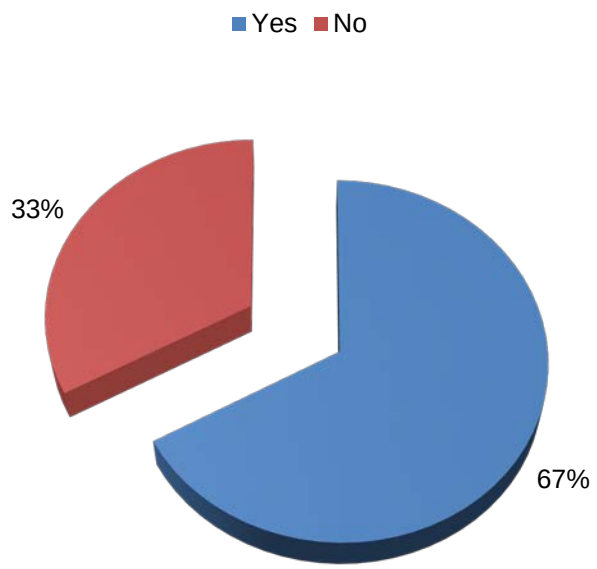
(Community = Clay /Union)



Base: No insurance (n=5), Cost (n=11), Fear (n=4), Time not convenient (n=6), Did not need to see a dentist (n=4), Sample Size = 23

(Community = Clay /Union)

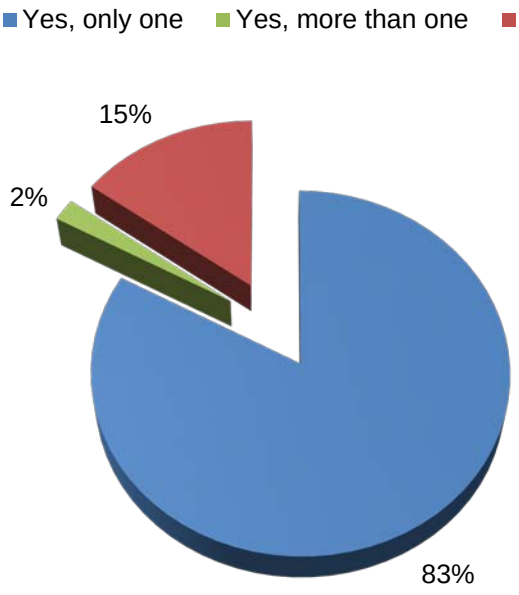
Do you have any kind of dental care or oral health insurance coverage?



Base: Yes (n=63), No (n=31), Sample Size = 94

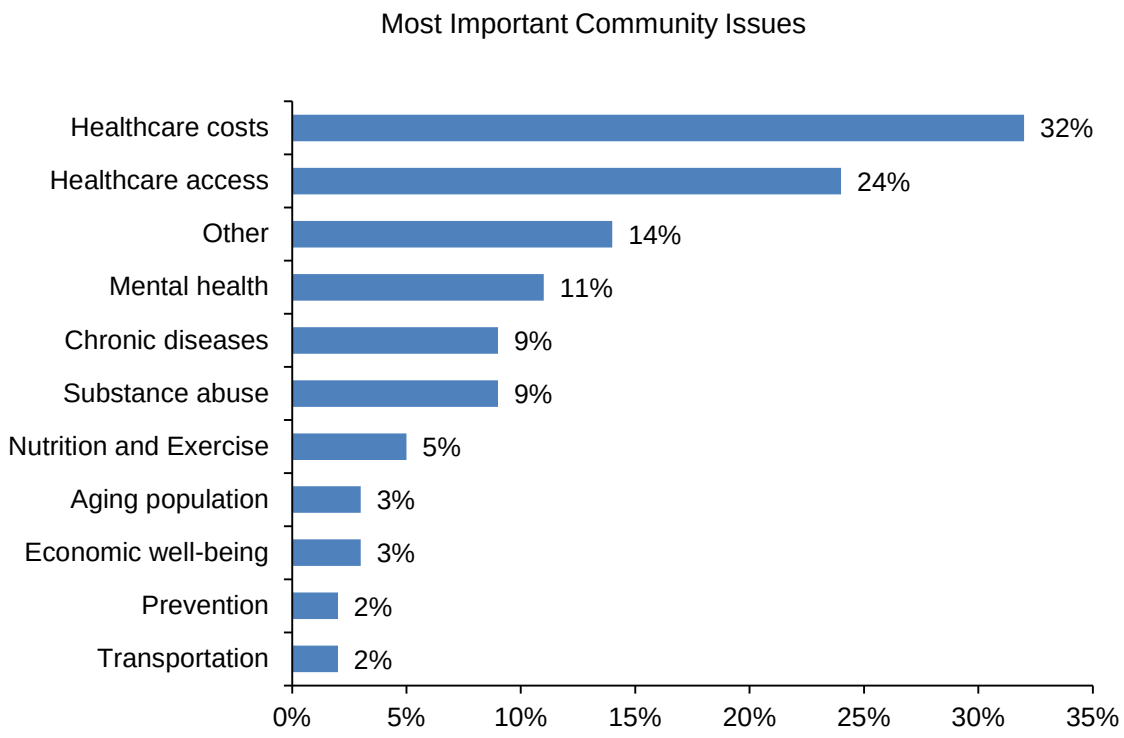
(Community = Clay /Union)

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



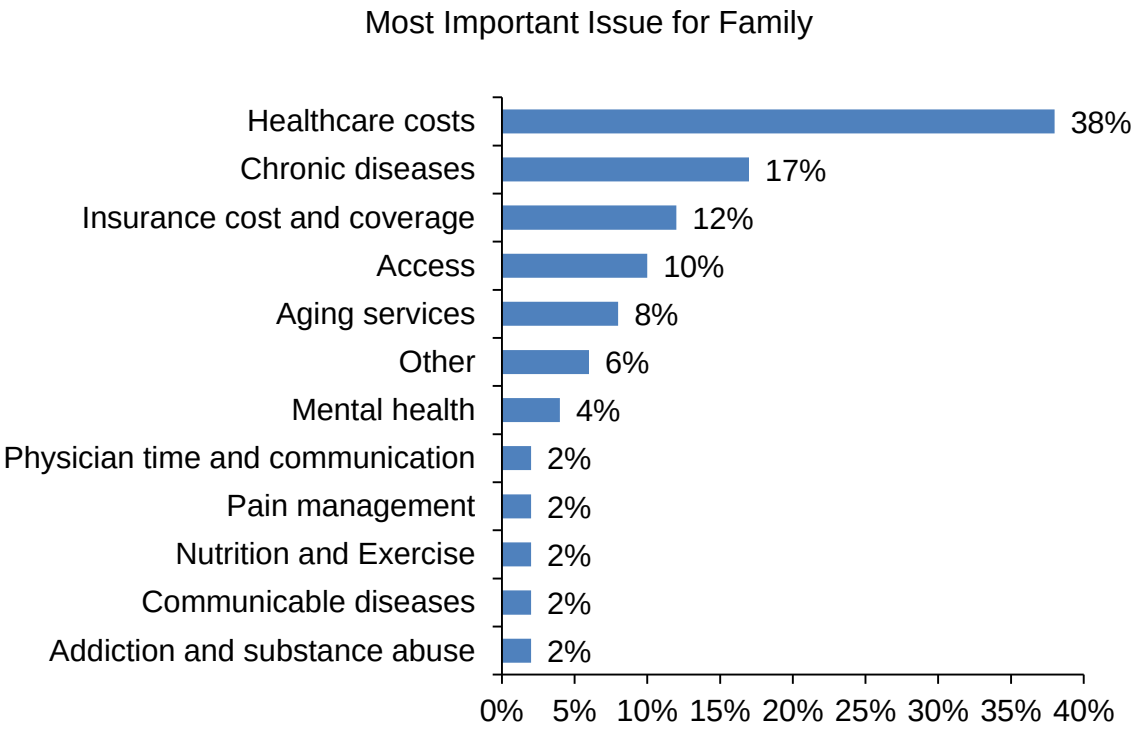
Base: Yes, only one (n=78), Yes, more than one (n=2), No (n=14), Sample Size = 94

(Community = Clay /Union)



Base: Economic well-being (n=2), Transportation (n=1), Aging population (n=2), Healthcare access (n=16), Mental health (n=7), Substance abuse (n=6), Chronic diseases (n=6), Healthcare costs (n=21), Prevention (n=1), Nutrition and Exercise (n=3), Other (n=9), Sample Size = 76

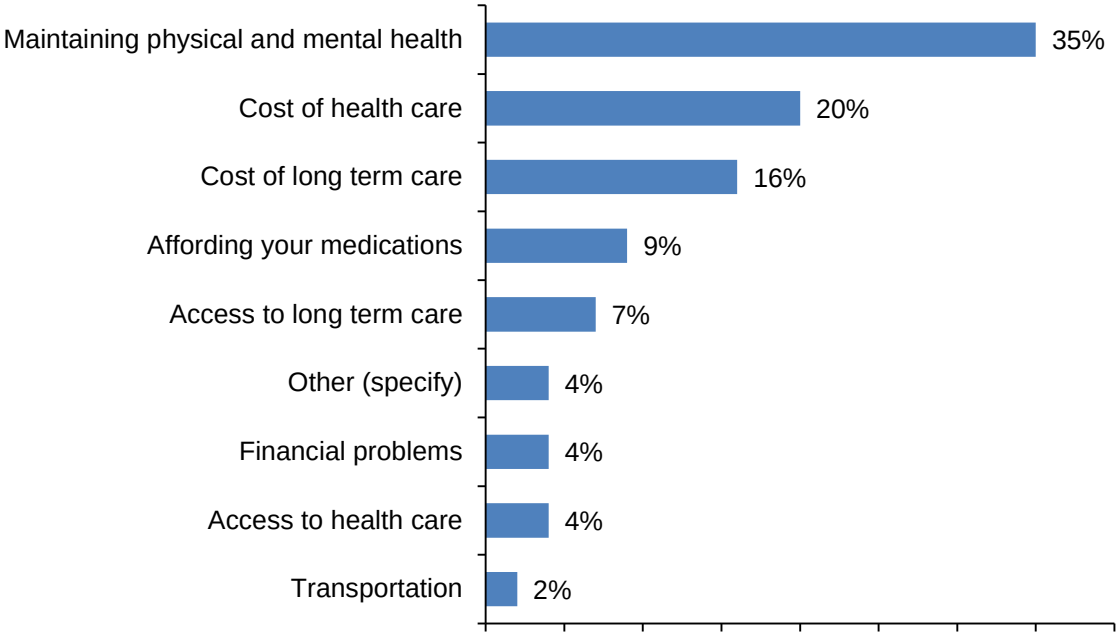
(Community = Clay /Union)



Base: Access (n=5), Addiction and substance abuse (n=1), Aging services (n=4), Chronic diseases (n=8), Communicable diseases (n=1), Healthcare costs (n=18), Nutrition and Exercise (n=1), Insurance cost and coverage (n=6), Mental health (n=2), Pain management (n=1), Physician time and communication (n=1), Other (n=3), Sample Size = 71

(Community = Clay County)

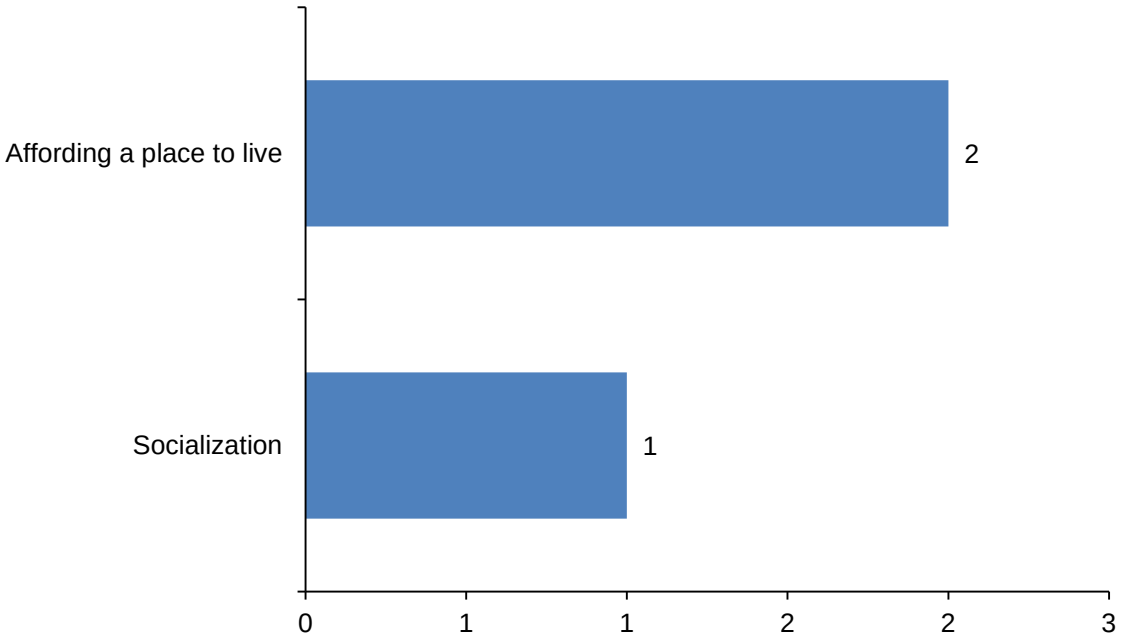
What is your biggest concern as you age? (Age 65+)



Base: Access to health care (n=2), Cost of health care (n=11), Affording your medications (n=5), Maintaining physical and mental health (n=19), Access to long term care (n=4), Cost of long term care (n=9), Financial problems (n=2), Transportation (n=1), Other (specify) (n=2), Sample Size = 25

(Community = Clay /Union)

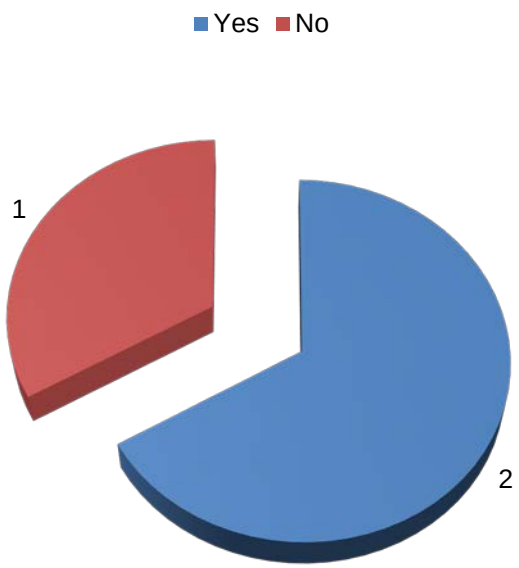
Which of these tasks do you need assistance with? (Age 65+)



Base: Socialization (n=1), Affording a place to live (n=2), Sample Size = 3

(Community = Clay /Union)

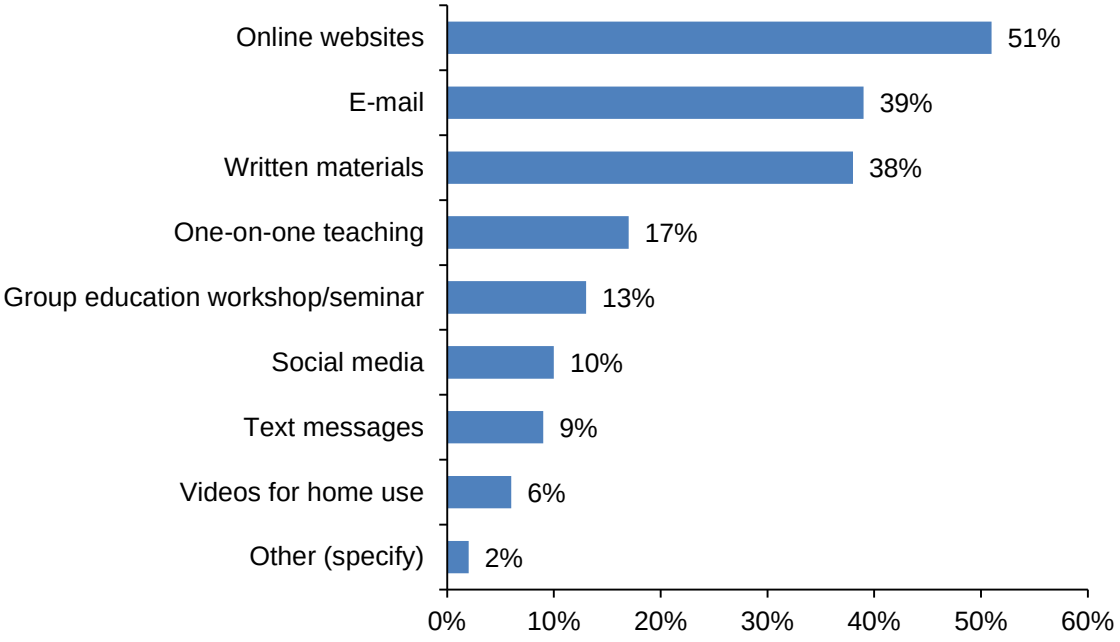
Do you know where to go to get help with the tasks you need assistance with? (Age 65+)



Base: Yes (n=2), No (n=1), Sample Size = 3

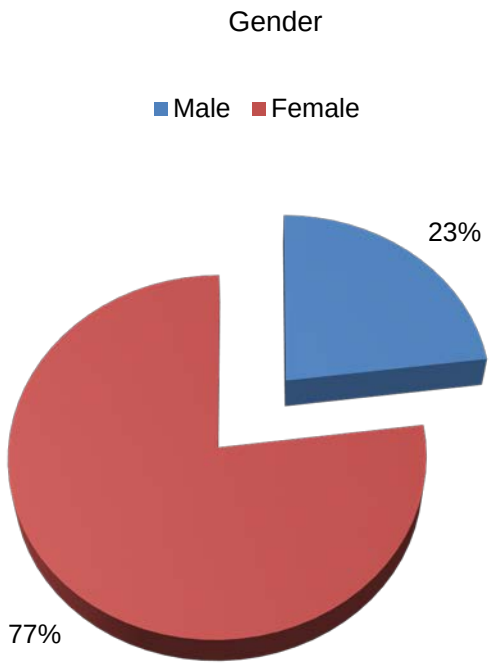
(Community = Clay /Union)

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



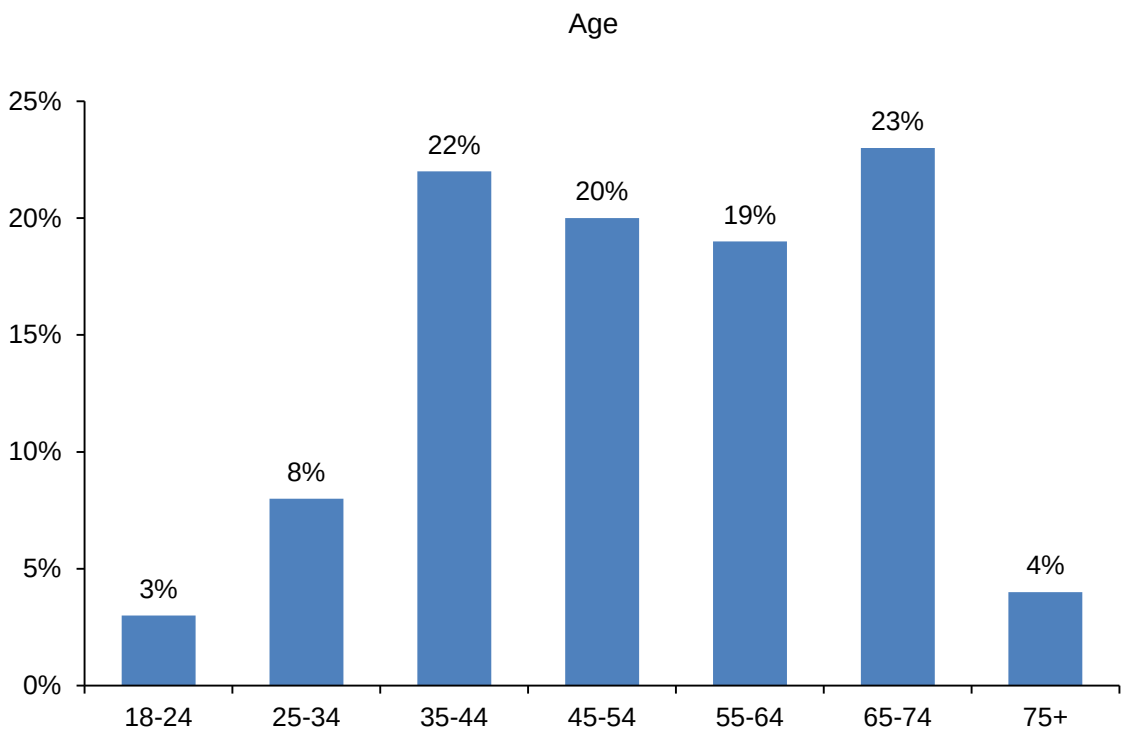
Base: Written materials (n=35), Videos for home use (n=6), Social media (n=9), Text messages (n=8), One-on-one teaching (n=16), E-mail (n=36), Group education workshop/seminar (n=12), Online websites (n=47), Other (specify) (n=2), Sample Size = 93

(Community = Clay /Union)



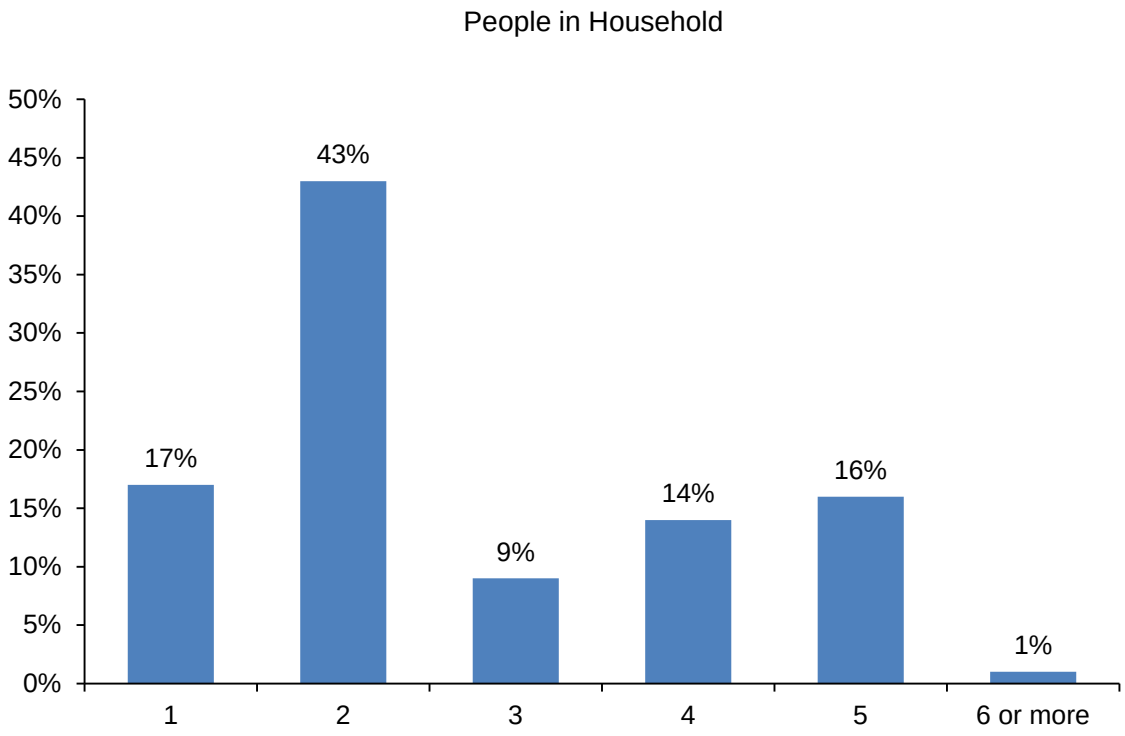
Base: Male (n=22), Female (n=72), Sample Size = 94

(Community = Clay /Union)



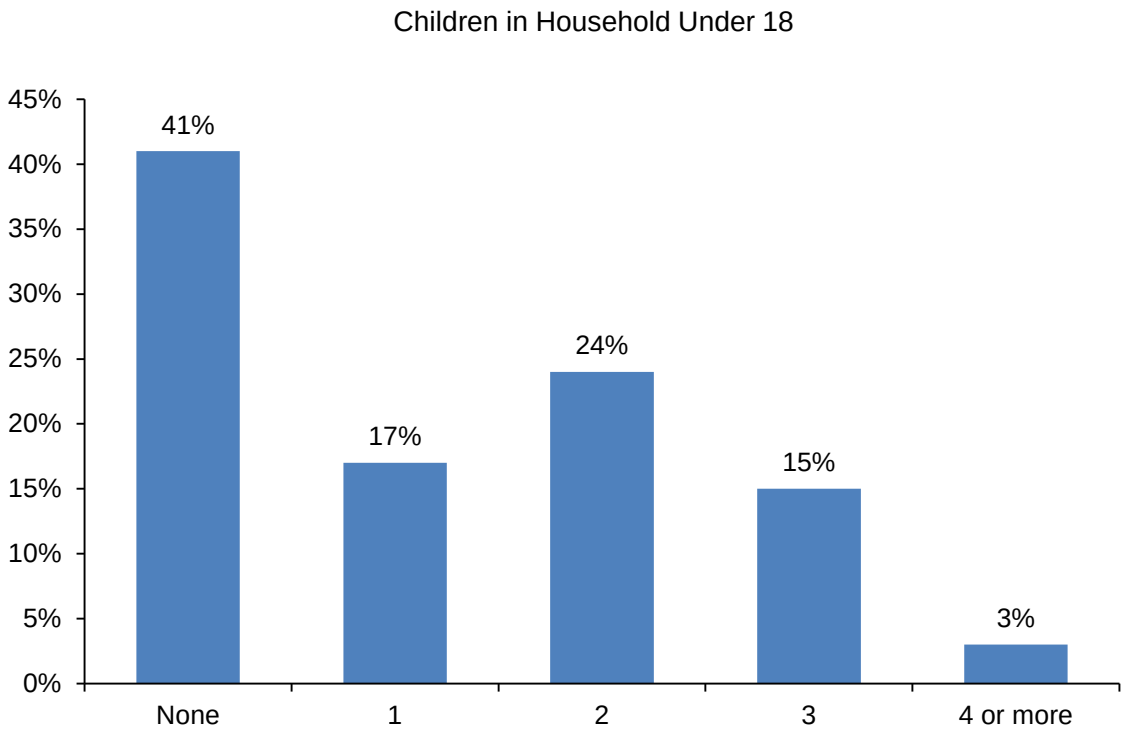
Base: 18-24 (n=3), 25-34 (n=8), 35-44 (n=21), 45-54 (n=19), 55-64 (n=18), 65-74 (n=22), 75+ (n=4), Sample Size = 95

(Community = Clay /Union)



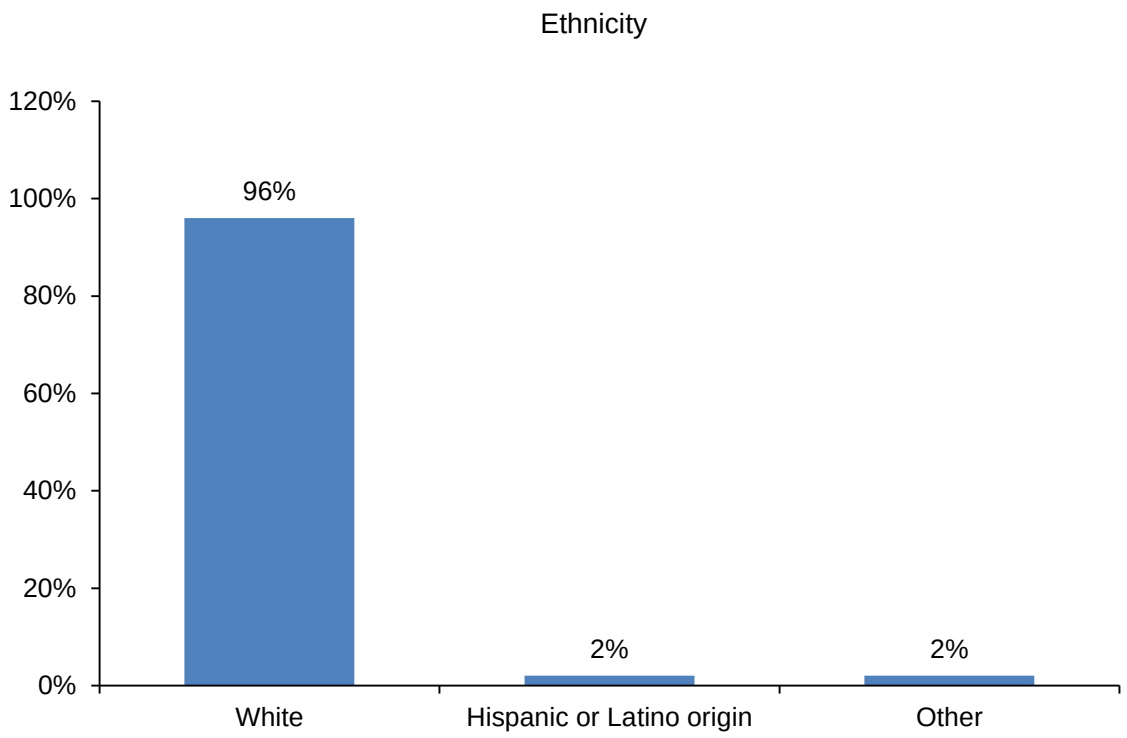
Base: 1 (n=16), 2 (n=41), 3 (n=9), 4 (n=13), 5 (n=15), 6 or more (n=1), Sample Size = 95

(Community = Clay /Union)



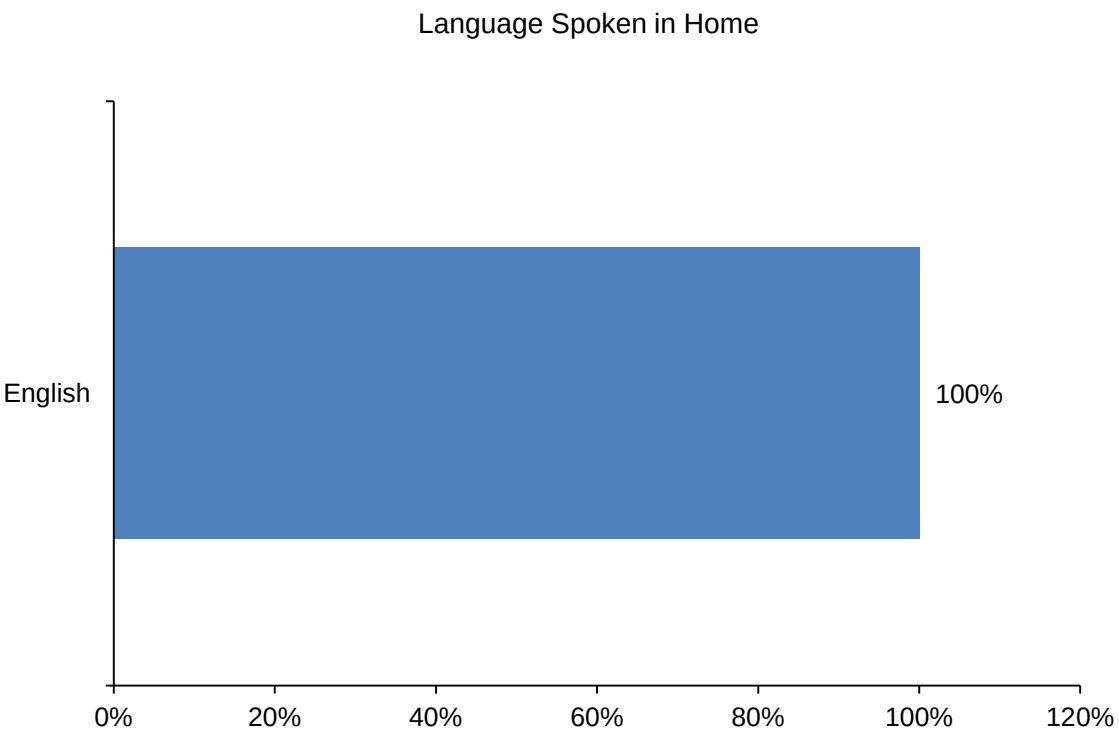
Base: None (n=24), 1 (n=10), 2 (n=14), 3 (n=9), 4 or more (n=2), Sample Size = 59

(Community = Clay /Union)



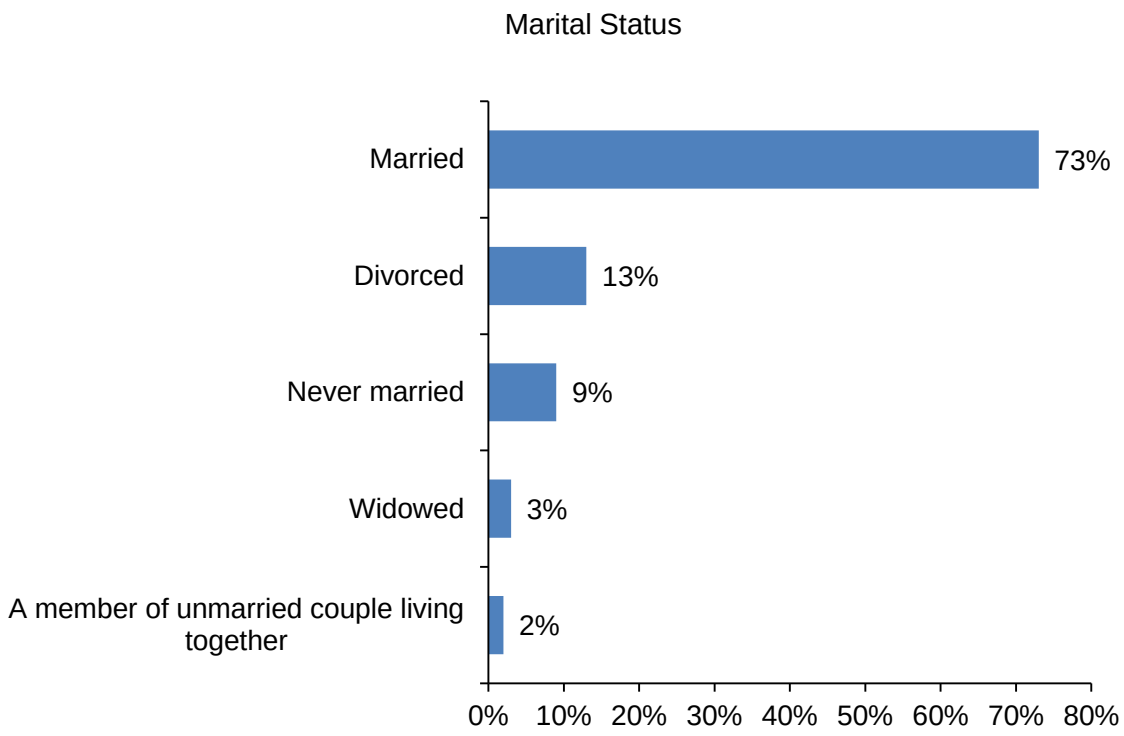
Base: White (n=90), Hispanic or Latino origin (n=2), Other (n=2), Sample Size = 94

(Community = Clay /Union)



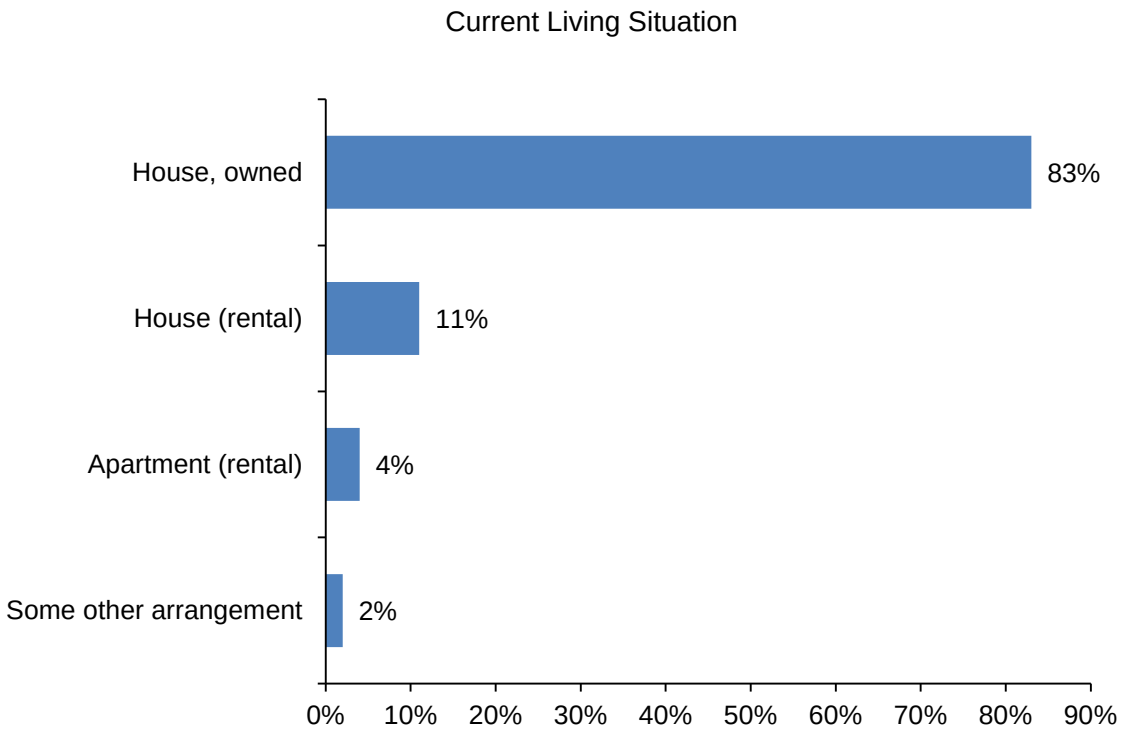
Base: English (n=95), Sample Size = 95

(Community = Clay /Union)



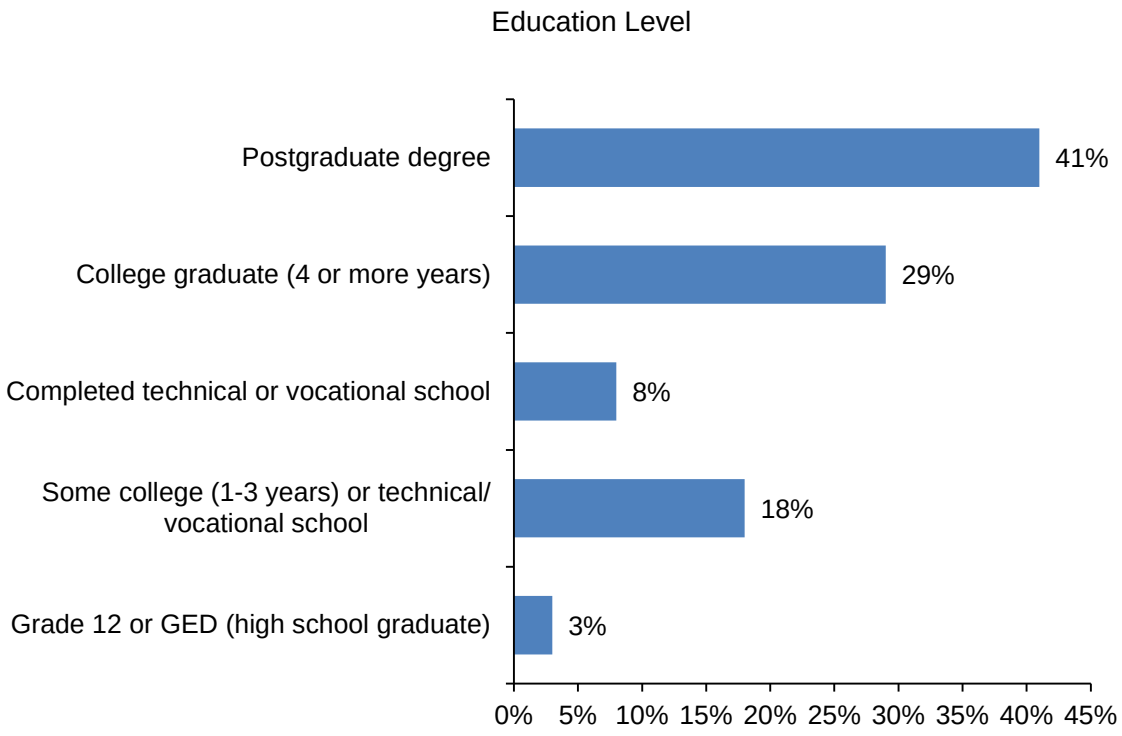
Base: Never married (n=9), Married (n=69), Divorced (n=12), Widowed (n=3), A member of unmarried couple living together (n=2), Sample Size = 95

(Community = Clay /Union)



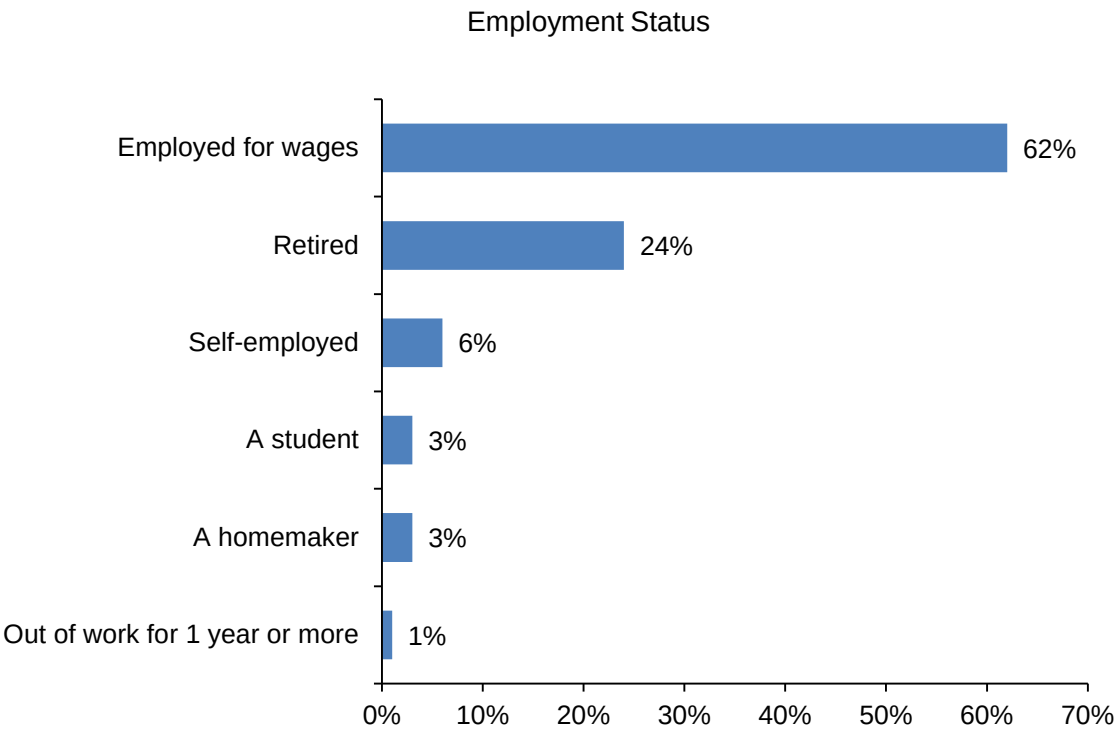
Base: House, owned (n=79), House (rental) (n=10), Apartment (rental) (n=4), Some other arrangement (n=2), Sample Size = 95

(Community = Clay /Union)



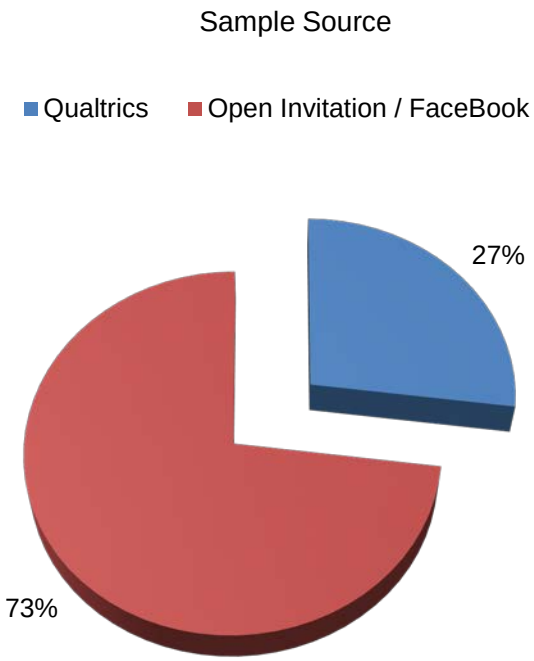
Base: Grade 12 or GED (high school graduate) (n=3), Some college (1-3 years) or technical/ vocational school (n=17), Completed technical or vocational school (n=8), College graduate (4 or more years) (n=28), Postgraduate degree (n=39), Sample Size = 95

(Community = Clay /Union)



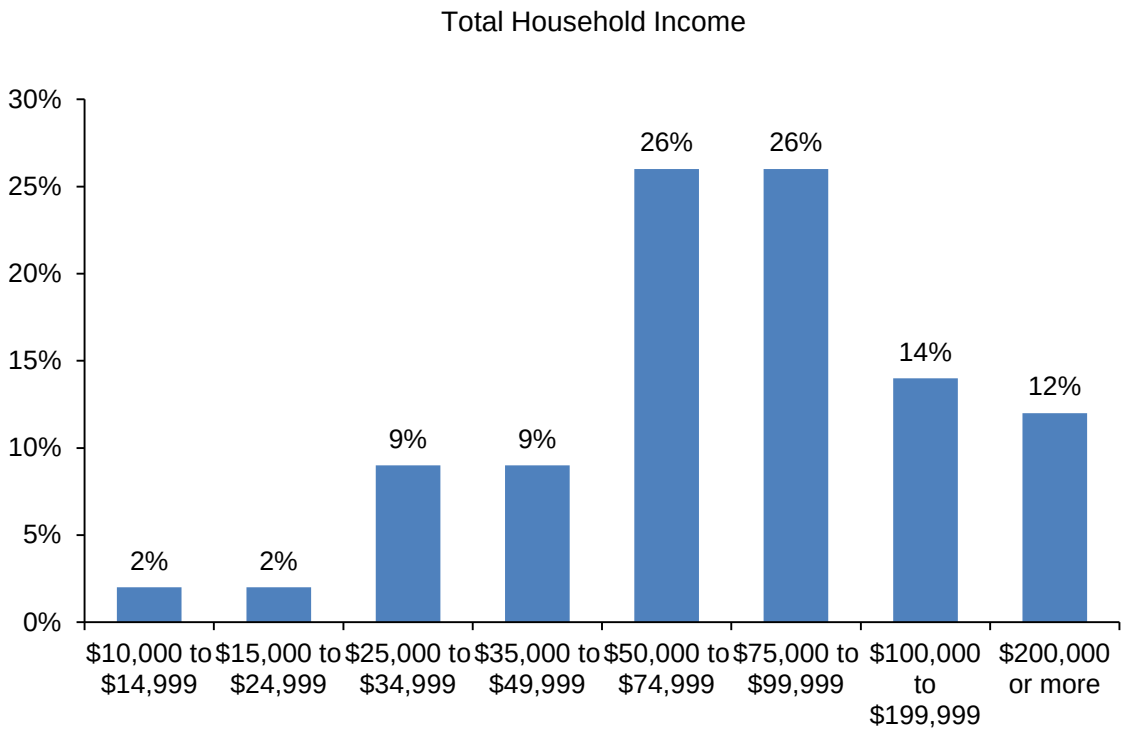
Base: Employed for wages (n=59), Self-employed (n=6), Out of work for 1 year or more (n=1), A homemaker (n=3), A student (n=3), Retired (n=23), Sample Size = 95

(Community = Clay /Union)



Base: Qualtrics (n=26), Open Invitation / FaceBook (n=69), Sample Size = 95

(Community = Clay /Union)



Base: $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=2), $25,000 to $34,999 (n=7), $35,000 to $49,999 (n=7), $50,000 to $74,999 (n=21), $75,000 to $99,999 (n=21), $100,000 to $199,999 (n=11), $200,000 or more (n=10), Sample Size = 81

(Community = Clay /Union)

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 2 votes • Availability of affordable housing 3.56 5 votes • 13% report that they run out of food before having enough money to buy more 3 votes	Top priority 10 votes		
Children and Youth 1 vote • Substance abuse by youth 3.57 1 vote • Childhood obesity 3.53 1 vote			
Aging Population • Cost of long-term care 3.87 • Cost of memory care 3.75 • Cost of in-home services 3.52			
Safety • Culture of excessive and binge drinking 3.61 3 votes			
Health Care Access • Access to affordable health insurance coverage 3.73 1 vote • Availability of mental health providers 3.61 1 vote • Access to affordable health care 3.58 2 votes • Access to affordable prescription drugs 3.51 • Availability of behavioral health (substance abuse) providers 3.50 • 33% of residents report not having health insurance			
Mental Health and Substance Abuse 1 vote • Alcohol use and abuse 3.69 4 votes • 41% self-report binge drinking at least ix/month • Drug use and abuse 3.62 2 votes • 31% report that they have drugs in their home that are not being used • Depression 3.53 – 32% report a diagnosis • 33% report a diagnosis of anxiety/stress • 16% currently smoke cigarettes	2nd priority 7 votes		
Wellness • 38% report a diagnosis of high cholesterol • 33% report a diagnosis of hypertension • 28% report a diagnosis of arthritis • 26% report that they have not had a routine check-up in more than 1 year • 23% have not seen their dentist in ore than 1 year • 20% have not had their flu shot this year • 45% do not get moderate activity 3 or more times each week 1 vote • 49% do not get their 5 or more servings of fruit/vegetables/day • 43% report that they are obese 1 vote • 26% report that they are overweight 1 vote			

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
Poor or fair health	**% Fair/Poor**	Percentage of adults that report fair or poor health

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

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

Measure	Data Elements	Description
		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)
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

Measure	Data Elements	Description
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty – from 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
	% 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)

Measure	Data Elements	Description
	% 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 for Clay and Union Counties in South Dakota

	South Dakota	Union (UN), SDx	Clay (CY), SDx
Health Outcomes		14	16
Length of Life		4	8
Premature death	7,000	4,700	5,300
Quality of Life		34	29
Poor or fair health	12%	9%	15%
Poor physical health days	3.1	2.6	3.5
Poor mental health days	2.9	2.5	3.1
Low birthweight	6%	7%	5%
Health Factors		2	41
Health Behaviors		7	44
Adult smoking	18%	14%	18%
Adult obesity**	31%	30%	32%
Food environment index**	6.6	9.0	6.7
Physical inactivity**	22%	22%	20%
Access to exercise opportunities	72%	64%	84%
Excessive drinking	20%	21%	23%
Alcohol-impaired driving deaths	37%	9%	17%
Sexually transmitted infections**	462.9	179.7	480.9
Teen births	30	12	9
Clinical Care		4	32
Uninsured	12%	7%	12%
Primary care physicians	1,290:1	1,150:1	1,750:1
Dentists	1,710:1	1,490:1	1,570:1
Mental health providers	610:1	2,990:1	2,010:1
Preventable hospital stays	50	39	51
Diabetes monitoring	84%	90%	81%
Mammography screening	66%	62%	60%
Social & Economic Factors		4	27
High school graduation**	84%	93%	83%
Some college	68%	72%	81%
Unemployment	2.8%	2.9%	2.8%
Children in poverty	17%	8%	17%
Income inequality	4.1	3.8	6.2
Children in single-parent households	32%	24%	27%
Social associations	16.5	13.4	13.6
Violent crime**	322	100	266
Injury deaths	76	48	33
Physical Environment		51	58
Air pollution - particulate matter	7.7	9.5	9.1
Drinking water violations		No	Yes
Severe housing problems	12%	7%	23%
Driving alone to work	80%	84%	69%
Long commute - driving alone	14%	24%	20%

	South Dakota	Union (UN) , SD x	Clay (CY) , SD x
Length of Life			
Premature age-adjusted mortality	330	290	330
Child mortality	70		
Infant mortality	7		
Quality of Life			
Frequent physical distress	9%	8%	11%
Frequent mental distress	9%	8%	11%
Diabetes prevalence**	9%	10%	7%
Health Behaviors			
Food insecurity**	12%	9%	17%
Limited access to healthy foods	11%	2%	11%
Drug overdose deaths	8		
Drug overdose deaths - modeled	8.4	6-7.9	6-7.9
Motor vehicle crash deaths	16		
Insufficient sleep	26%	26%	28%
Clinical Care			
Uninsured adults	14%	8%	13%
Uninsured children	7%	5%	8%
Health care costs**	$8,345	$8,591	$9,343
Other primary care providers	801:1	622:1	1,006:1
Social & Economic Factors			
Disconnected youth	10%		
Median household income	$54,900	$74,900	$42,200
Children eligible for free or reduced price lunch	42%	20%	35%
Residential segregation - black/white**	63		30
Residential segregation - non-white/white**	56	27	26
Homicides	3		
Firearm fatalities	11		
Physical Environment			
Demographics			
Population	865,454	14,934	14,086
% below 18 years of age	24.6%	24.2%	17.4%
% 65 and older	16.0%	16.6%	11.8%
% Non-Hispanic African American	1.9%	0.9%	1.7%
% American Indian and Alaskan Native	9.0%	0.9%	3.2%
% Asian	1.5%	1.3%	2.3%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%	0.1%
% Hispanic	3.7%	3.1%	2.6%
% Non-Hispanic white	82.5%	92.5%	88.2%
% not proficient in English	1%	0%	0%
% Females	49.6%	49.3%	50.4%
% Rural	43.3%	61.4%	24.3%

2018

2018 Note: Blank values reflect unreliable or missing data

12/19/18

SANFORD HEALTH

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