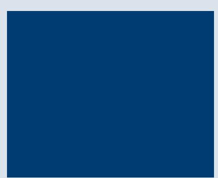
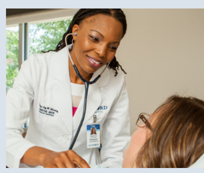
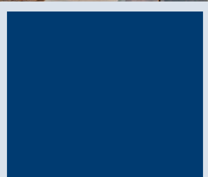
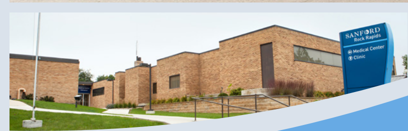
SANFORD HEALTH









SANFORD HEALTH

Dear Community Members,

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

- *Availability of Mental Health Services*
- *Aging Services*

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 Webster 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,

Isaac Gerdes
Senior Director
Sanford Webster Medical Center

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Sanford Webster Medical Center

Community Health Needs Assessment

2018

Executive Summary

Purpose

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

Our Guiding Principles

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

Regulatory Requirements

Federal regulations stipulate that non-profit medical centers conduct a community health needs assessment at least once every three years and prioritize the needs for the purpose of implementations strategy development and submission in accordance with the Internal Revenue Code 501(r).

Internal Revenue Code 501(r) requires that each hospital must have: (1) conducted a community health needs assessment in the applicable taxable year; (2) adopted an implementation strategy for meeting the community health needs identified in the assessment; and (3) created transparency by making the information widely available.

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

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

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

Hospitals are to address each and every assessed needs or defend why we are not addressing the needs. Once the needs have been identified and prioritized, hospitals are required to develop an implementation strategy to address the top needs. The strategies are reported on IRS Form 990 and a status report must be provided each year on IRS 990 Schedule H.

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for the report. Sanford places the CHNA reports and the implementation strategies on the Sanford website. Hospitals are required to keep three cycles of assessments on the web site. The 2018 report will be Sanford's third report cycle since the requirements were enacted in 2010.

Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
      An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholders' concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health distributed the survey link via email to stakeholders and key leaders located within the Webster community and Day County. Data collection occurred during November 2017. A total of 33 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 29 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 Webster and Day County, 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.

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

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

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

Key Findings

Community Health Concerns

The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.0 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.0; however, the high ranking needs of 3.0 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 3.30), a need to maintain energy efficient homes (3.21), household budgeting and money management skills (3.18), and a skilled labor force (3.18).

Children and Youth
Community stakeholders are most concerned about childhood obesity (3.57), substance abuse by youth (3.48), bullying (3.47), the availability and cost of services for at-risk youth (3.30), opportunities for adult-youth mentoring (3.30), teen tobacco use (3.08),education about birth control (3.04), and the availability of activities for youth and children (3.03).

Aging Population
Community stakeholders are most concerned about the cost of long-term care (3.82), the availability and cost of memory care (3.46), the availability of resources for family and friends caring for seniors (3.37), the cost of in-home services (3.34), the availability of activities for seniors (3.20), the availability of resources for grandparents caring for their grandchildren (3.17, and the availability of resources to help seniors stay in their homes (3.10).

Safety
Community stakeholders are most concerned about the presence of street drugs (3.80), the culture of excessive drinking (3.69), the presence of drug dealers (3. 53), abuse of prescription drugs (4.48), domestic violence (3.28), criminal activity (3.23), and child abuse and neglect (3.11).

Health Care Access
Community stakeholders are most concerned about the availability of mental health providers (3.76), the availability of behavioral health (substance abuse) providers (3.66), access to affordable health insurance (3.40), access to affordable prescription drugs (3.20), access to affordable health care (3.10), and access to affordable vision insurance (3.03).

Mental Health and Substance Abuse
Community stakeholders are most concerned about alcohol use and abuse (3.77), drug use and abuse (3.73), depression (3.60), dementia and Alzheimer's disease (3.33), tobacco use (3.32), and stress (3.30).

Twenty-one percent of resident survey participants report that they have been diagnosed with depression, and 32% report a diagnosis of anxiety/stress.

Resident survey participants are facing the following issues:

- 68% report that they are overweight or obese
- 25% self-report binge drinking at least 1X/month
- 16% have not visited a dentist in more than a year
- 17% report that alcohol use has had a harmful effect on them or a member of their family in the past two years
- 28% self-report that they have drugs in their home they are not using
- 53% have a diagnosis of hypertension and 42% have high cholesterol
- 10% currently smoke cigarettes

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

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

- *Availability of Mental Health Services*
- *Aging Services*

Implementation Strategies

Priority 1: Availability of Mental Health Services

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.

Priority 2: Aging Services

According to the Administration for Community Living, families are the major provider of long-term care for older adults and people with disabilities in the U.S. Research indicates that caregiving also exacts a significant emotional, physical and financial toll. With nearly half of all caregivers older than age 50, many are vulnerable to a decline in their own health. Studies have shown that coordinated support services can reduce caregiver depression, anxiety and stress, and enable them to provide care longer, which avoids or delays the need for costly institutional care.

Sanford has made the aging population a significant priority and has developed strategies to support caregivers through community services. The creation of collaborative partners will provide the necessary support to make a positive impact on caregivers and to provide the tools to support their work.

Sanford Webster Medical Center

Community Health Needs Assessment

2018

Sanford Webster Medical Center

Community Health Needs Assessment 2018

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Acknowledgements

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

Sanford Steering Group:

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

- Paul Gerhart, Director of Fiscal Services, Sanford Canton
- Julie Girard, Improvement Advisor, Sanford Vermillion
- Paul Hanson, President, Sanford Sioux Falls
- Joy Johnson, VP, Operations, Sanford Bemidji
- JoAnn Kunkel, Chief Financial Officer, Sanford Health
- Mary Lake, Executive Assistant, Sanford Health Network Fargo Region
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- 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 Webster community stakeholders participated in community discussions and helped to formulate the priorities for our implementation strategies:

- Arnie Anderson, Educator
- Lori Ash, Retired Nurse
- Tammy Block, Webster Public Schools
- Ashley Ewing, CNO, Sanford Webster Medical Center
- Evelyn Christensen, Supervisor, Sanford Webster Clinic
- Isaac Gerdes, CEO, Sanford Webster Medical Center
- Kim Kaufman, RN Health Coach, Sanford Webster Medical Center
- Mike McCarlson, Clergy
- Stacy Mount, community key stakeholder
- Tandra Schmidt, community key stakeholder
- Travis Tupper, Life Insurance Agent
- Mike Wiley, Athletic Director, Webster Public Schools
- Dave Wyman, Physical Therapist Sanford Webster Medical Center

Description of Sanford Webster Medical Center

Sanford Webster Medical Center is a 25-bed Critical Access Hospital providing emergency services, radiology, lab, rehabilitation and respiratory care services. It includes an adjoining rural health clinic.

Sanford Webster employs 4 clinicians including physicians and advanced practice providers, and 70 employees.

Description of the Community Served

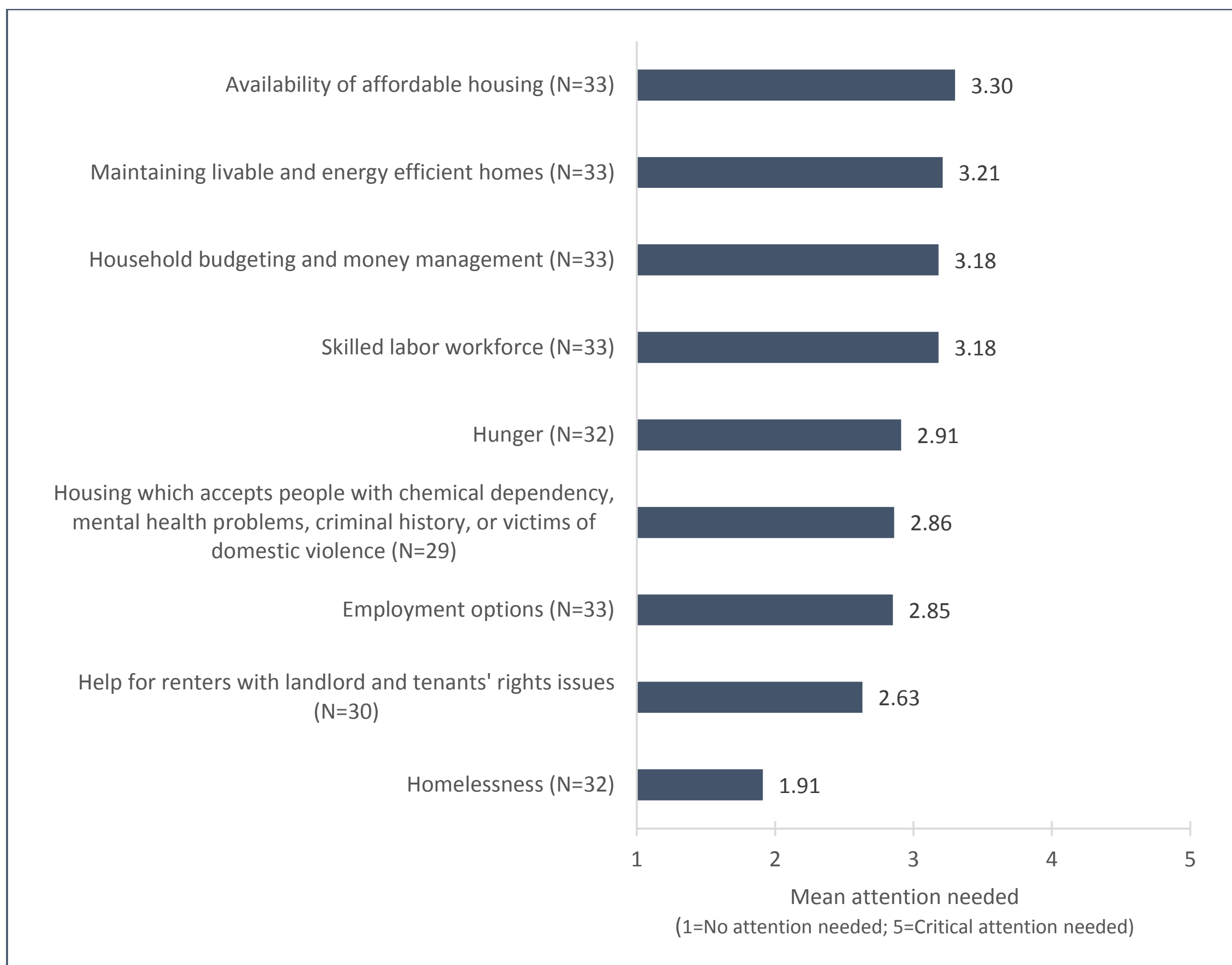
Webster is a town of 1,800 people and the county seat of Day County, South Dakota. Tom Brokaw, a retired television anchorman for NBC is a native of Webster. The city has an airport, campground/RV park, golf course, library, park and pool/aquatic center. Businesses include industrial, lodging/camping, real estate, recreation, repair and construction and services.

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 3.0 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.0; however, the high ranking needs of 3.0 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.

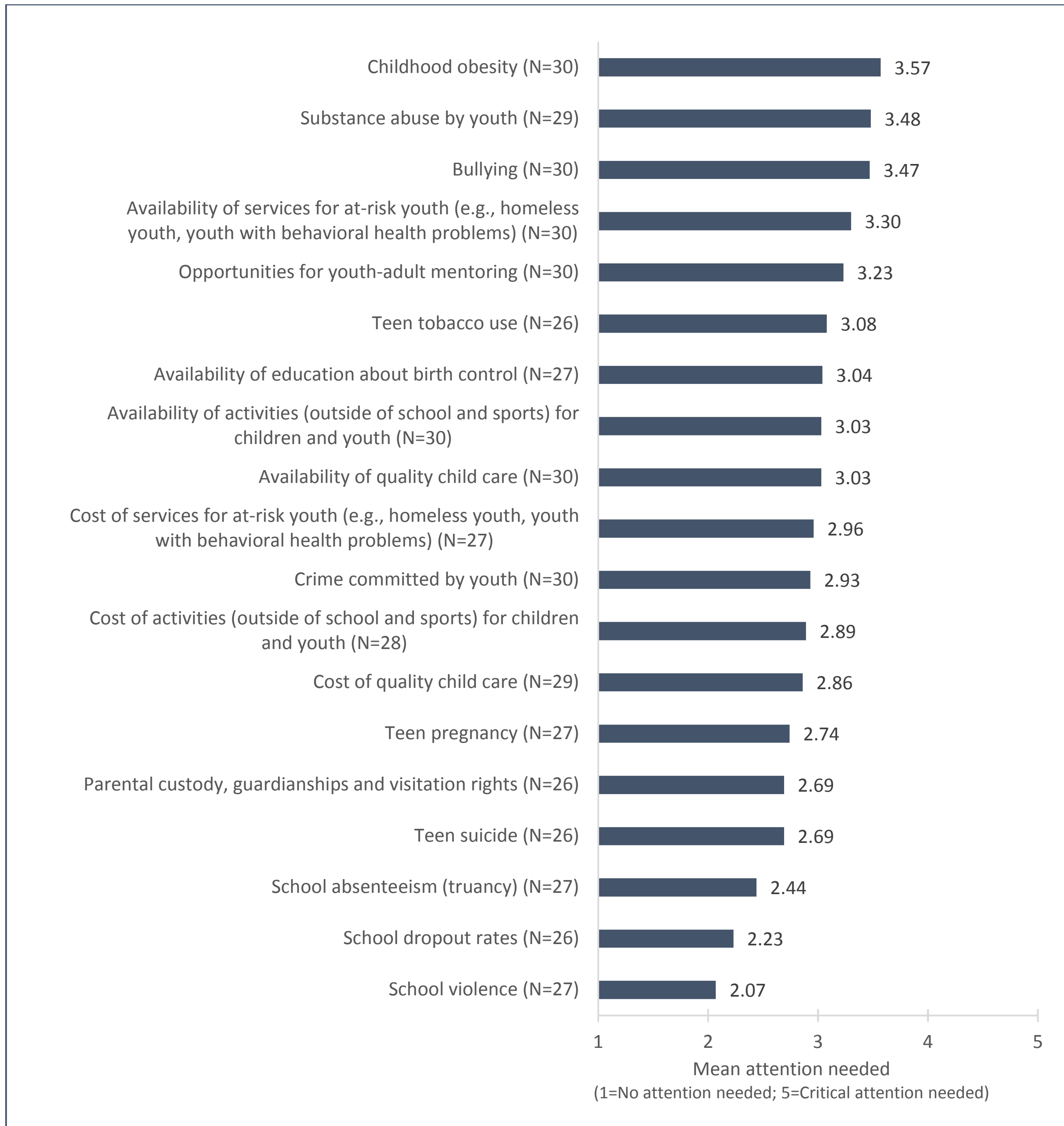
Economic Well-Being: The concern for the community's economic well-being is focused on the need for affordable housing, maintaining livable and energy efficient homes, household budgeting and money management, and the need for a skilled labor force.



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 childhood obesity, substance abuse, bullying, the availability of services for at-risk youth, opportunities for mentoring, teen tobacco use, education about birth control, the availability of activities for children and the availability of quality childcare.



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.

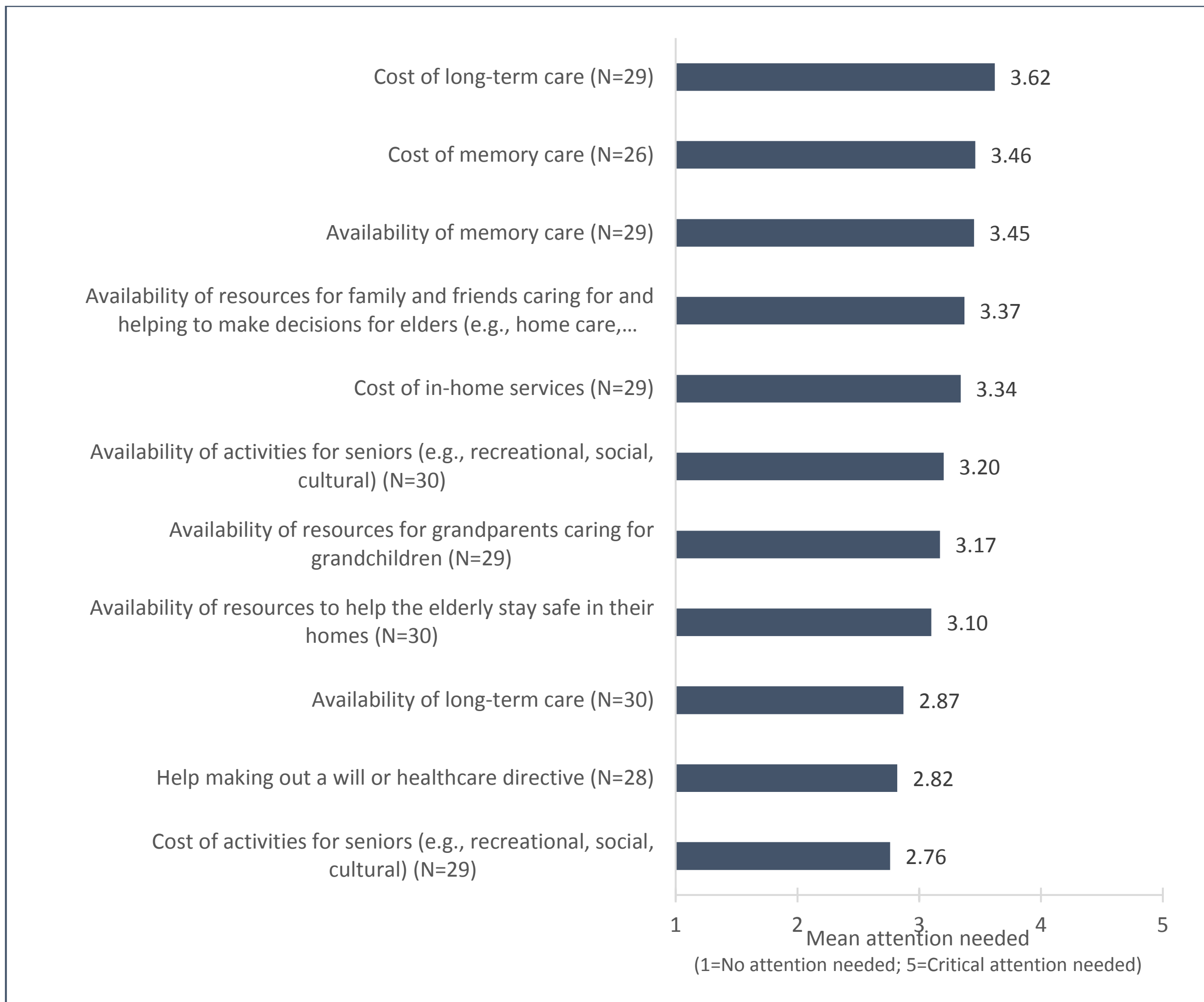
Youth may also be more likely to try drugs because of circumstances or events called risk factors. Examples of risk factors include:

- 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:

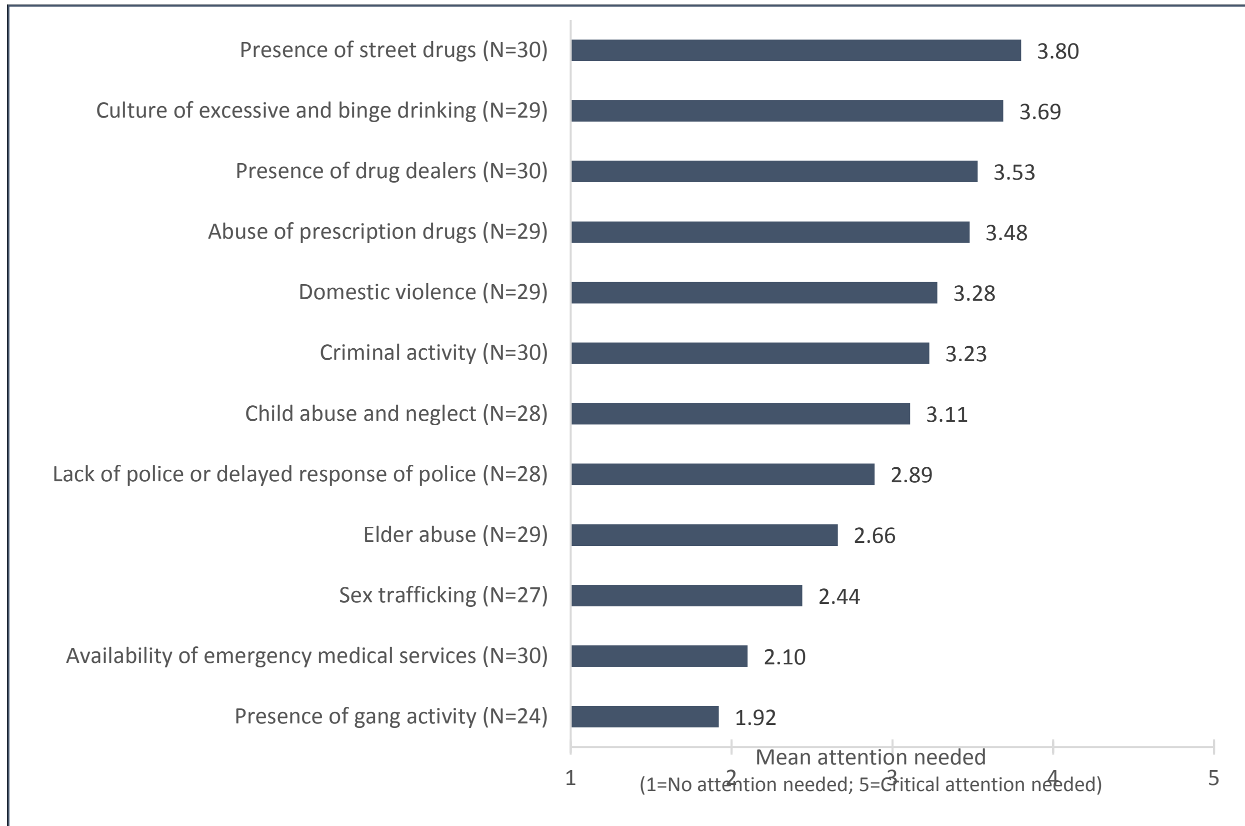
- Having high self-esteem
- Attending a school with policies against using alcohol and drugs
- Having an adult role model who doesn't use tobacco or drugs or misuse alcohol
- Participating in athletic, community, or faith-based groups
- Living in a community with youth activities that prohibit drugs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



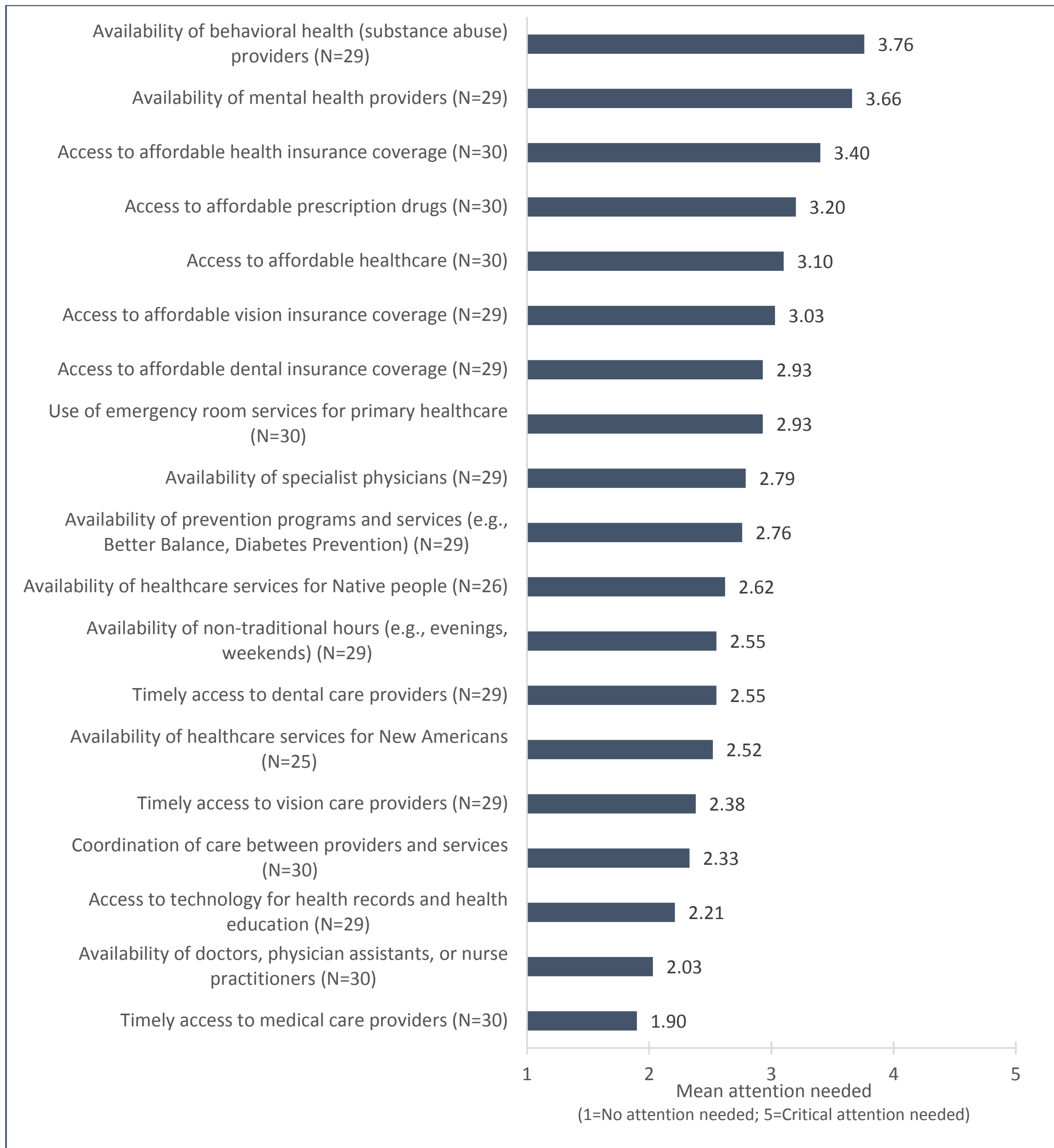
According to the U.S. Health and Human Services Administration on Aging, the cost of long-term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford providers work to help seniors live healthy independent lives. Sanford social workers, case managers, 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, the presence of drug dealers, abuse of prescription drugs, domestic violence, criminal activity and child abuse, are top concerns for safety in the community.



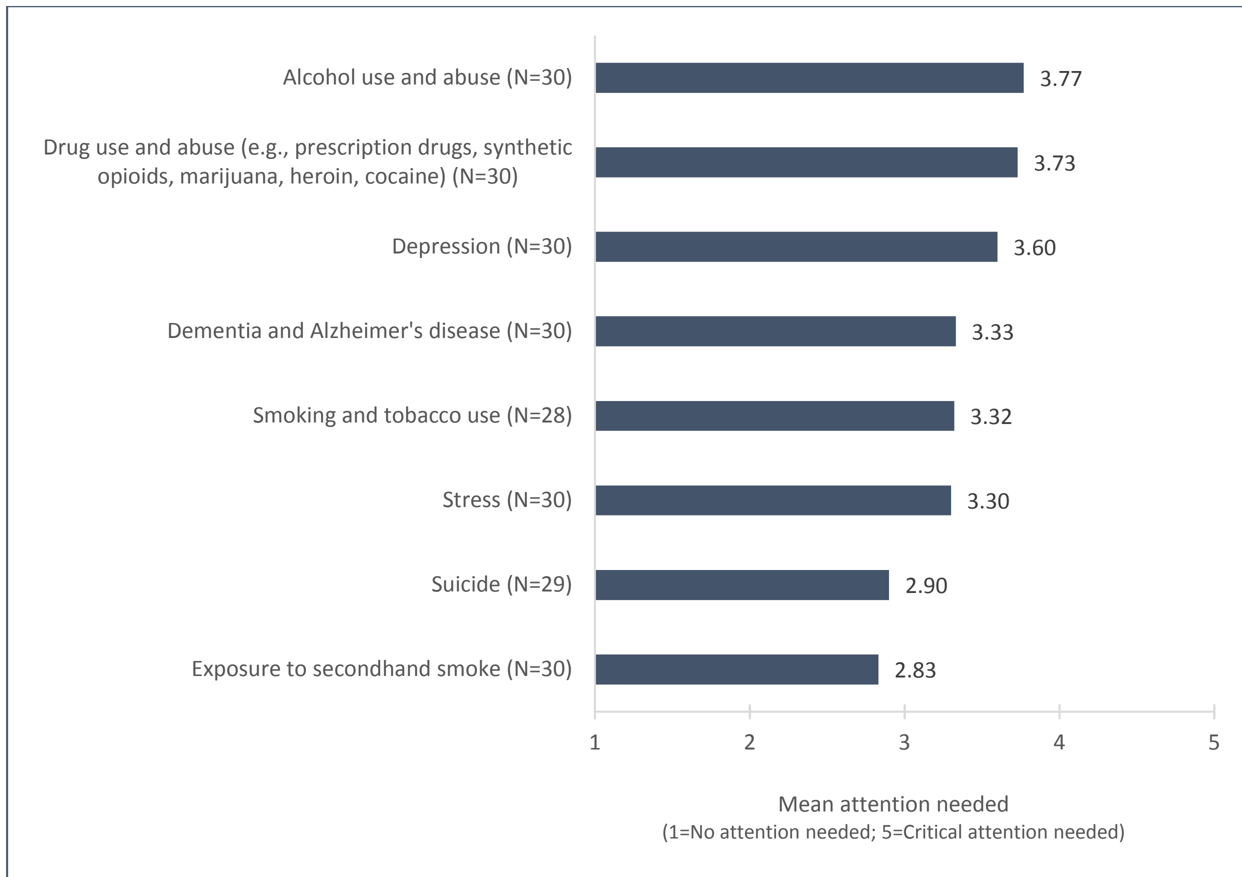
The National Institute on Drug Abuse states that the misuse of prescription drugs means taking a medication in a manner or dose other than what was prescribed; or taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., 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: The availability of mental health and behavioral health providers is 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.

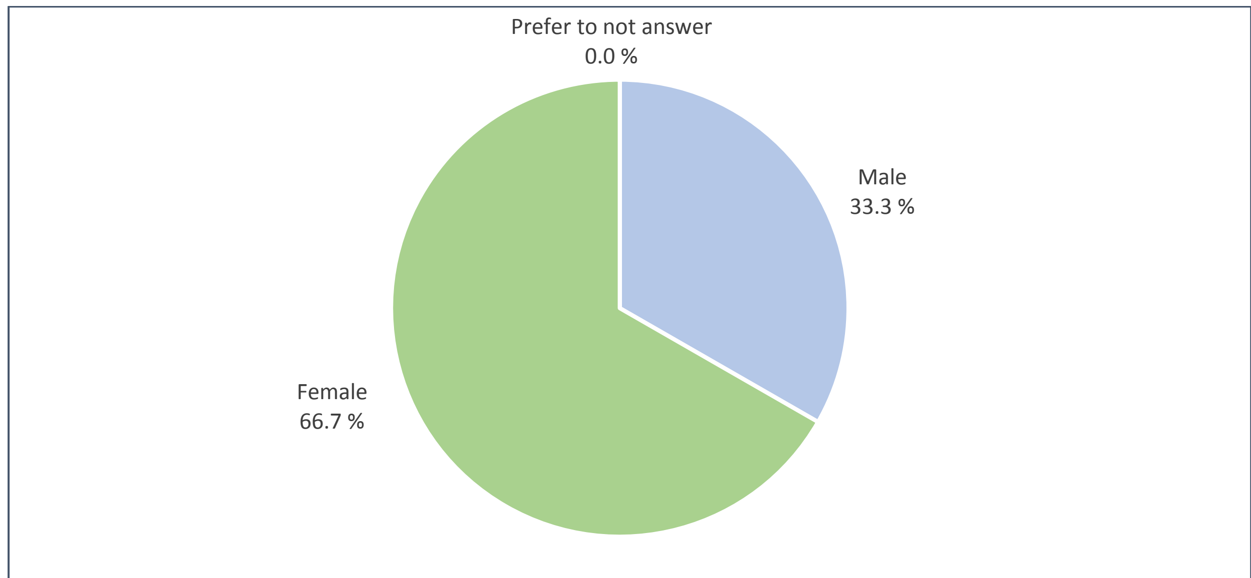
Mental Health and Substance Abuse: Alcohol use and abuse, drug use and abuse, depression, dementia and Alzheimer's disease, tobacco use and stress are top concerns for the community.



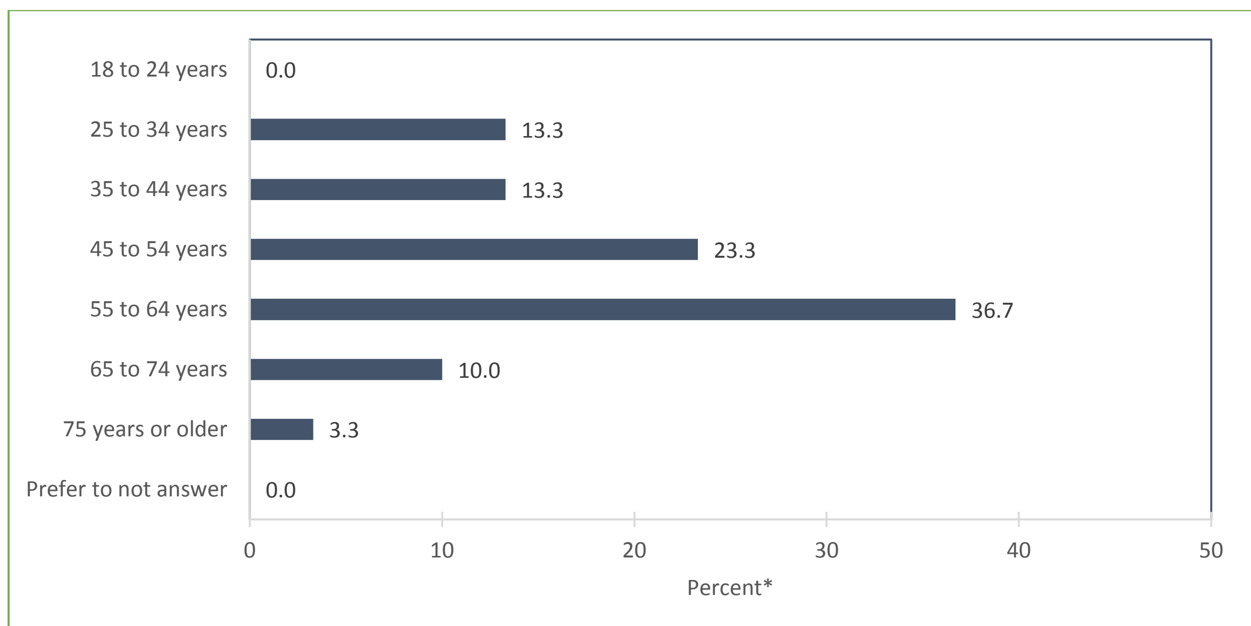
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental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

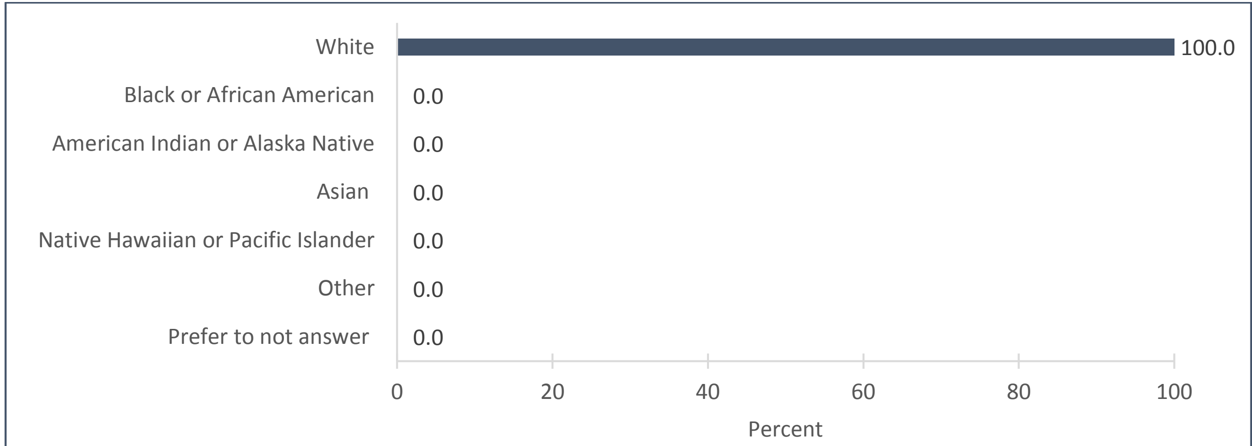
Biological Gender



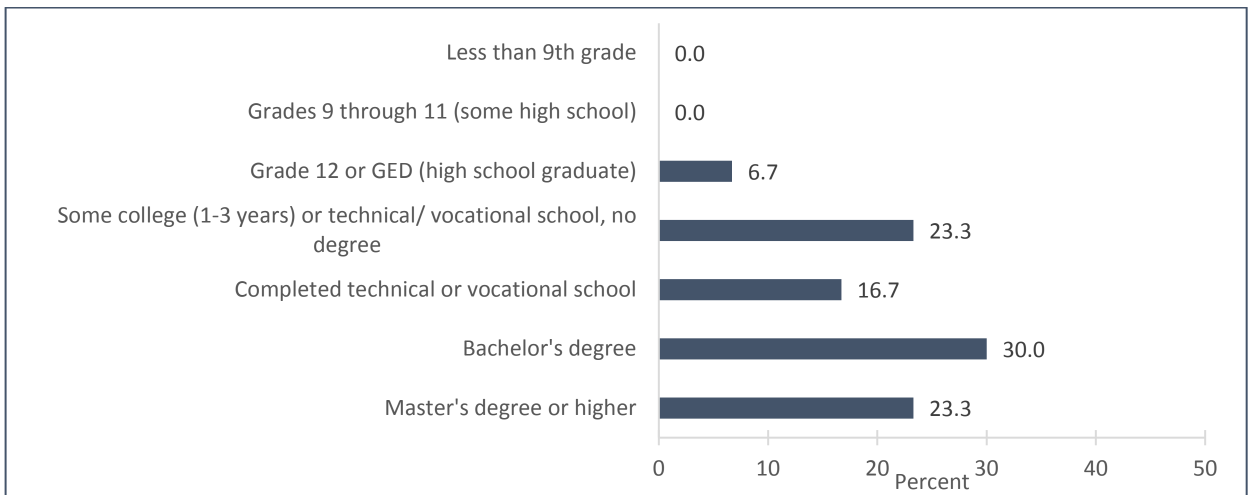
Age of Participants



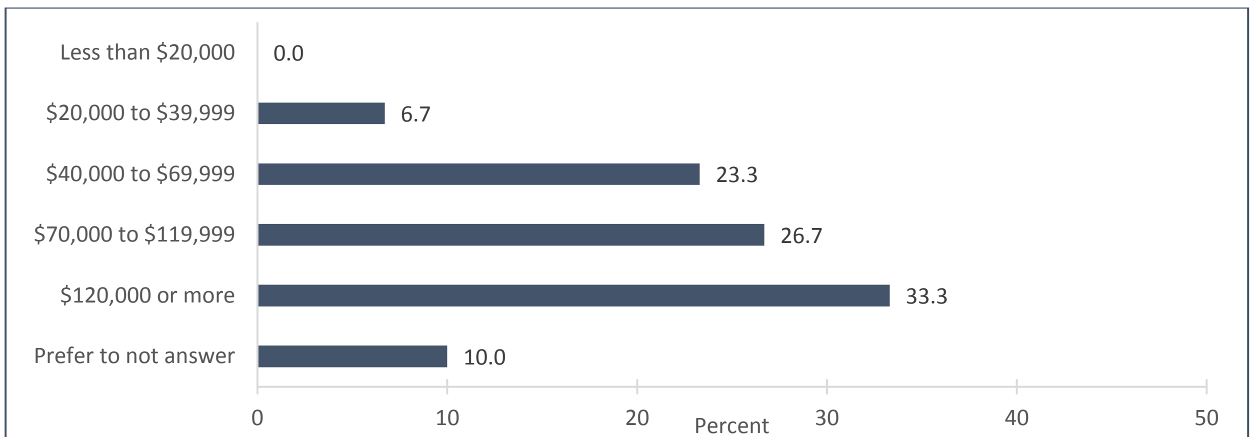
Race of Participants



Highest Level of Education Completed



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



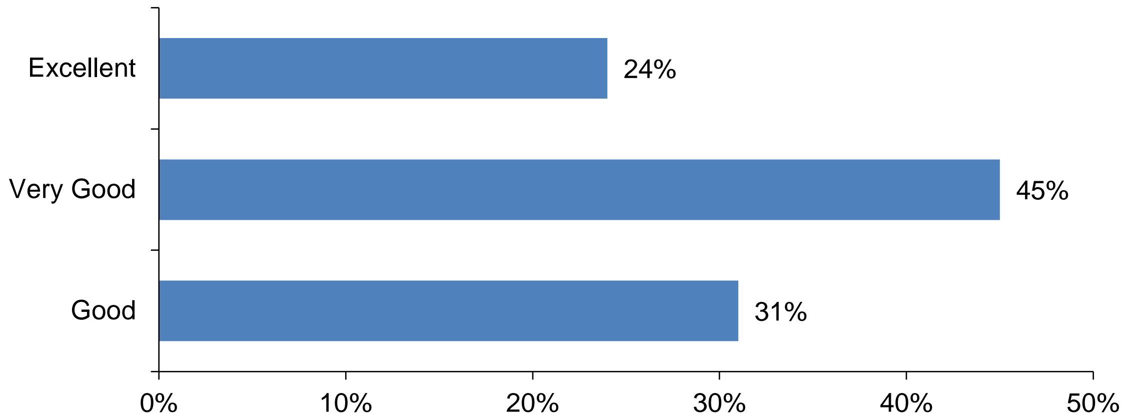
Residents' Health Concerns

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.

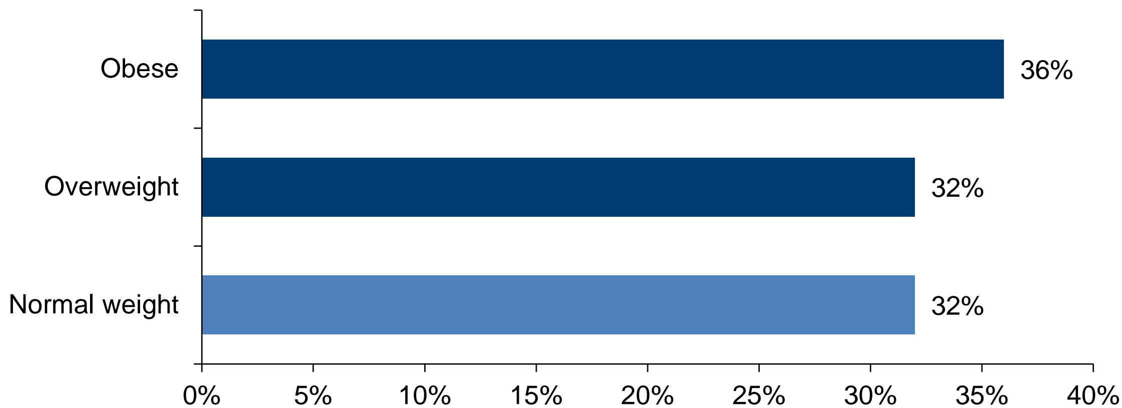
How would you rate your health?

One-hundred percent of survey participants rated their health as good or better.



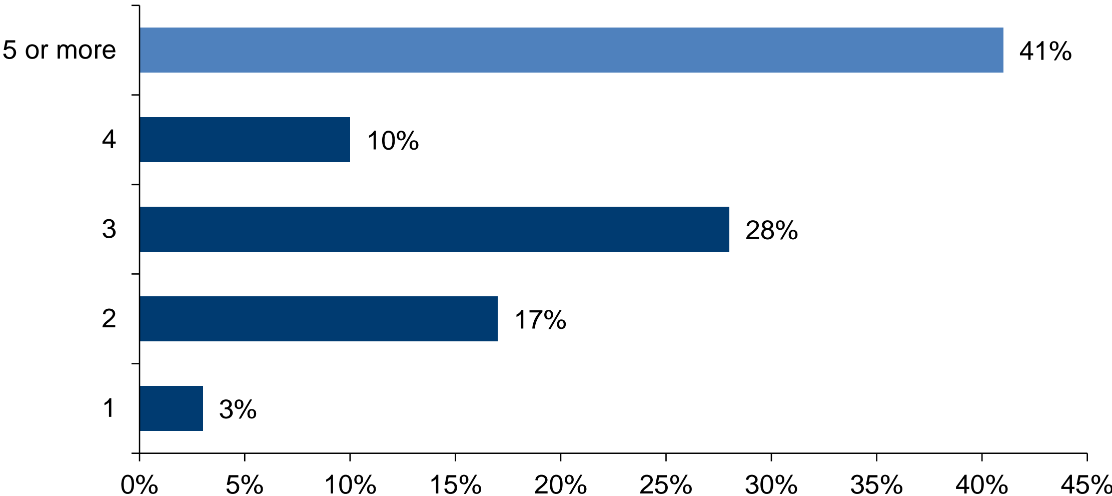
Body Mass Index

Sixty-eight percent of participants are overweight or obese.



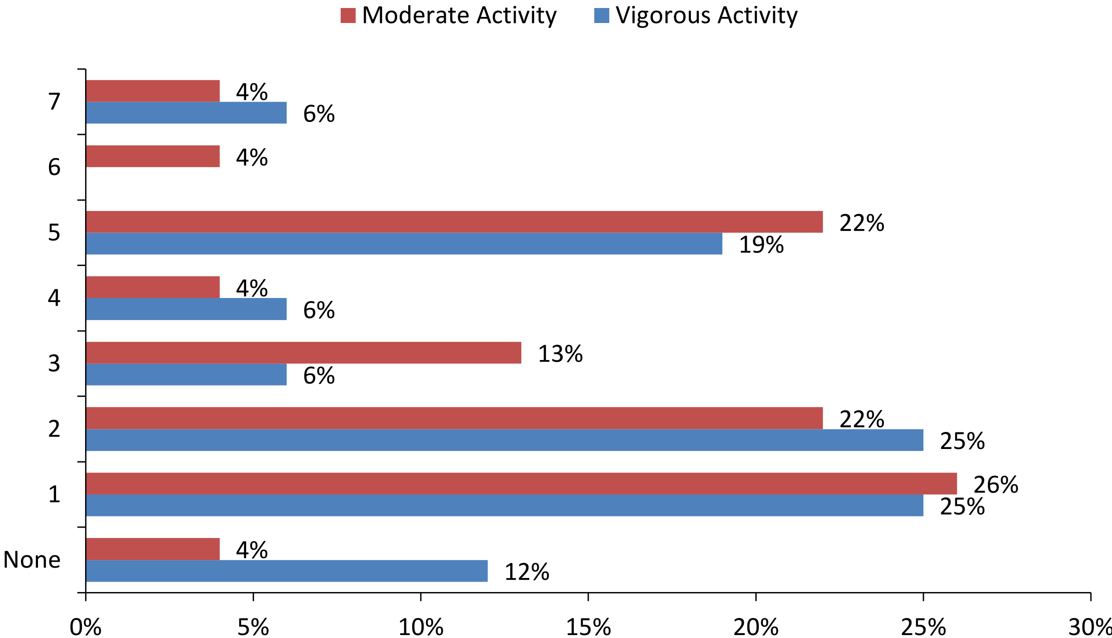
Total daily servings of fruits and vegetables

Only 41% are getting their recommended five or more a day servings of fruits and vegetables.



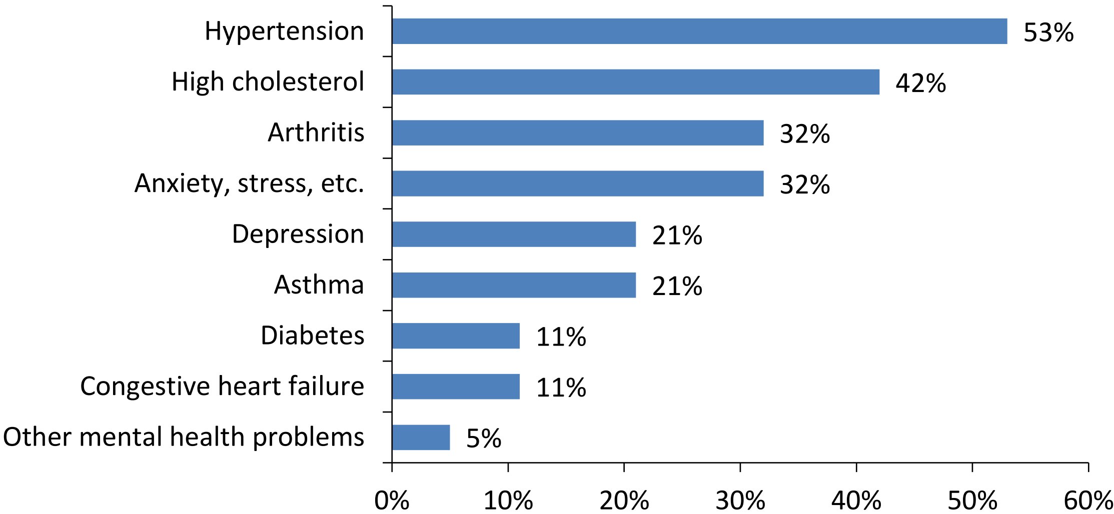
Days per week of physical activity

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



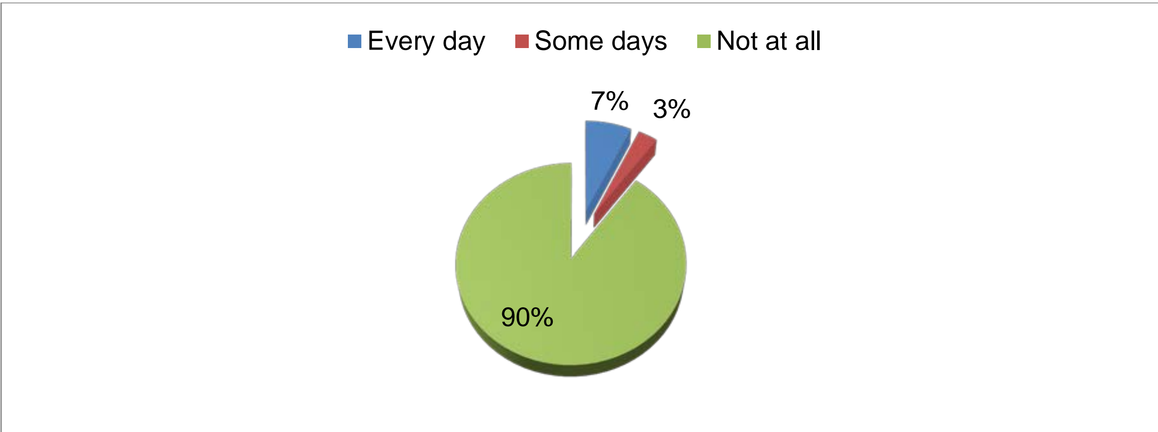
Past diagnosis

Hypertension, high cholesterol, arthritis and anxiety are the top chronic disease issues among survey participants.



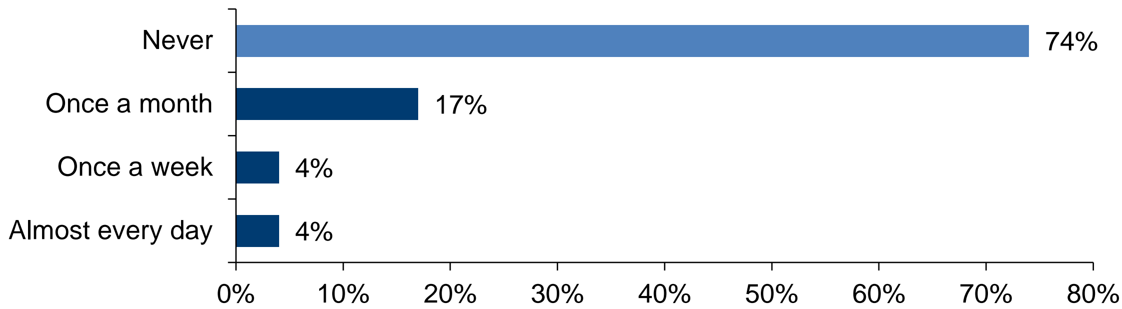
Tobacco use

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

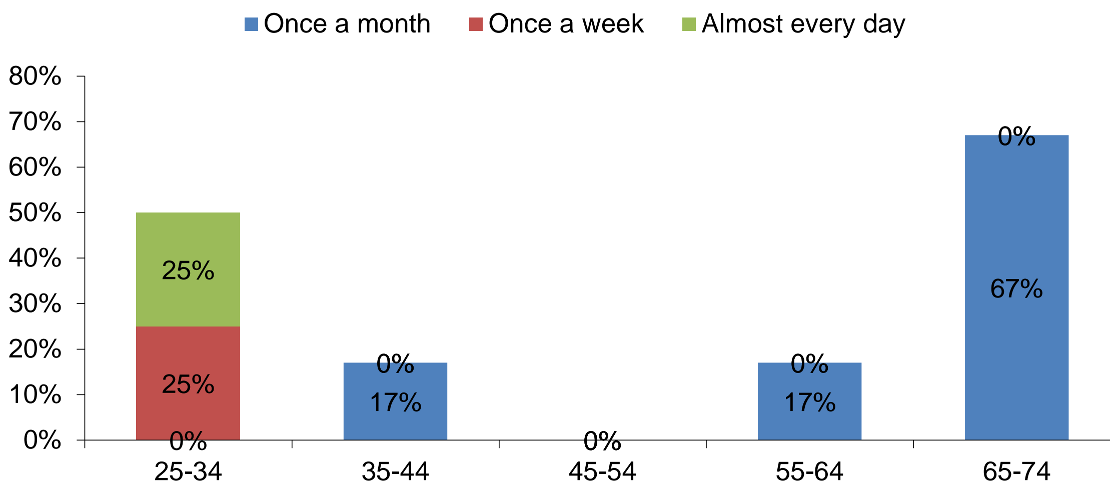


Binge drinking

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

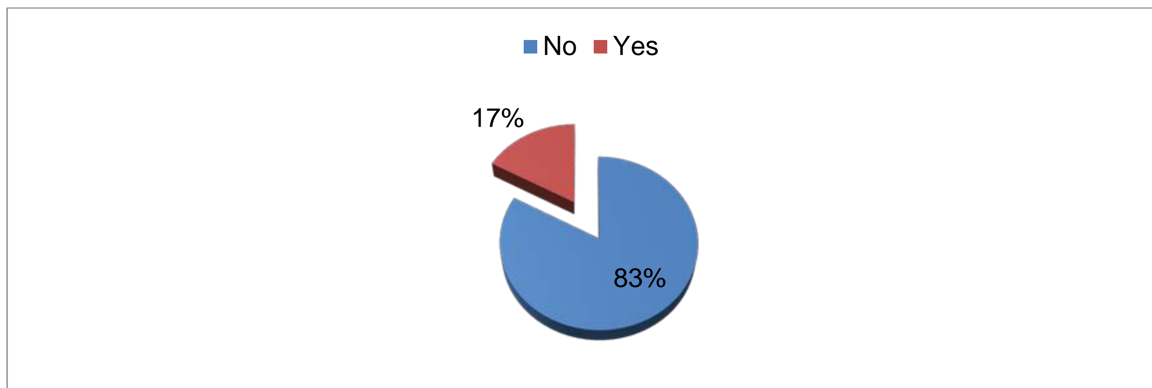


Binge drinking by age



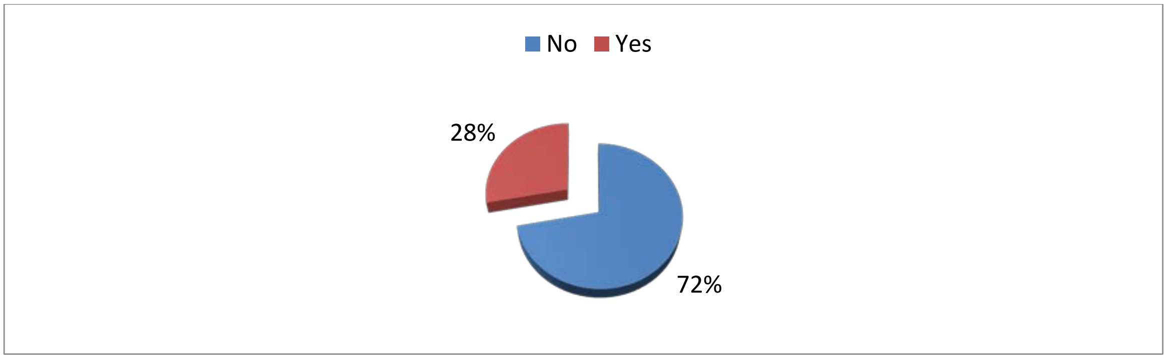
Has alcohol had a harmful effect on you or a family member in the past two years?

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



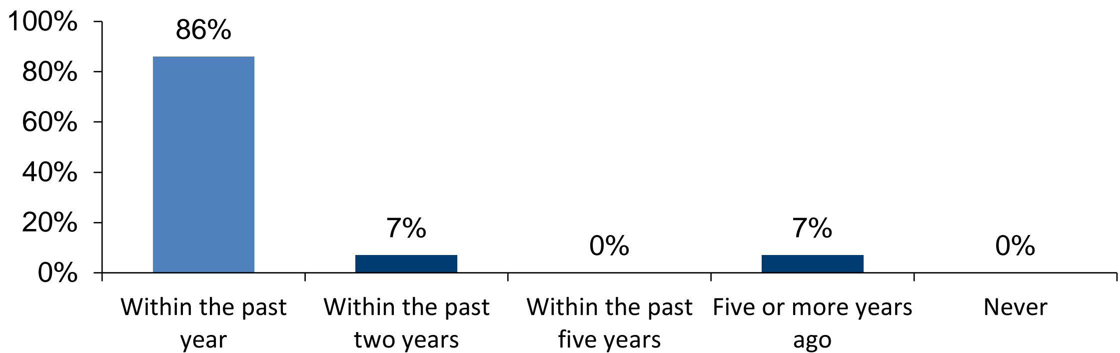
Do you have drugs in your home that are not being used?

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



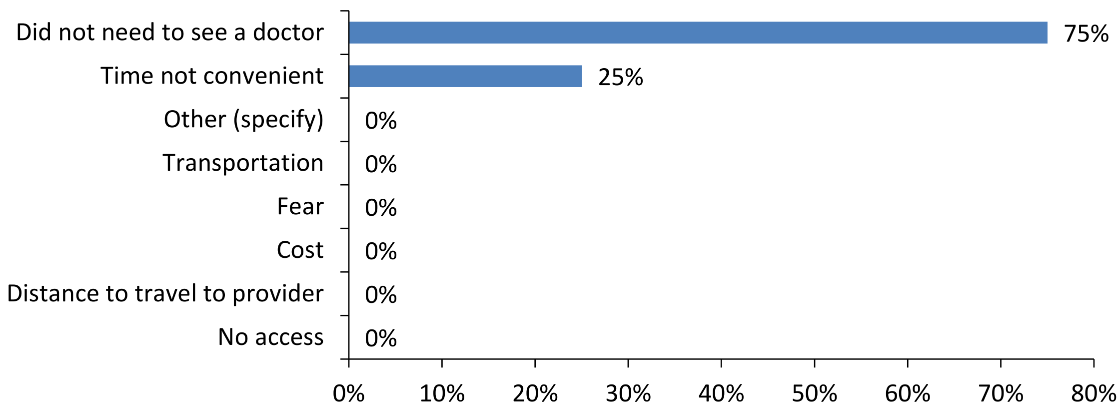
How long has it been since you visited a doctor or health care provider for a routine check-up?

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



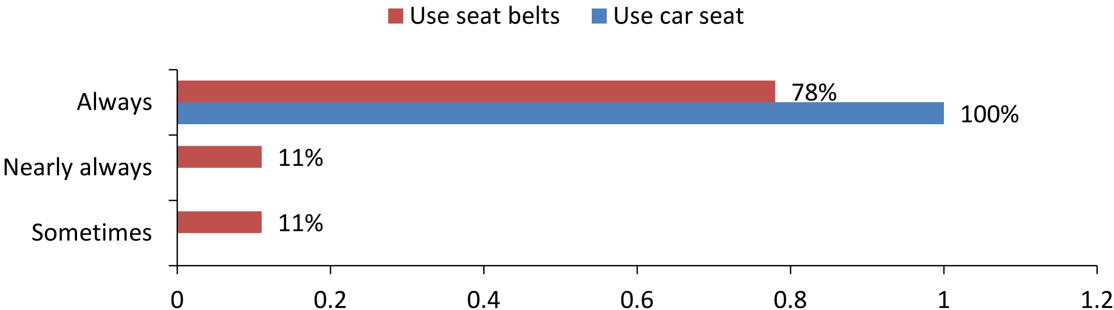
Barriers to Routine check-up

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



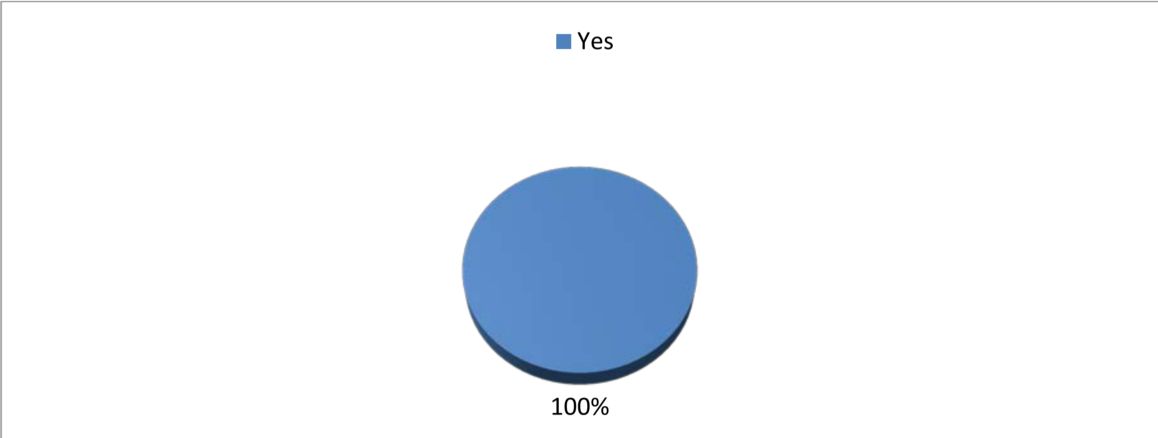
Child car safety

Twenty-two percent do not always use seat belts for their children.



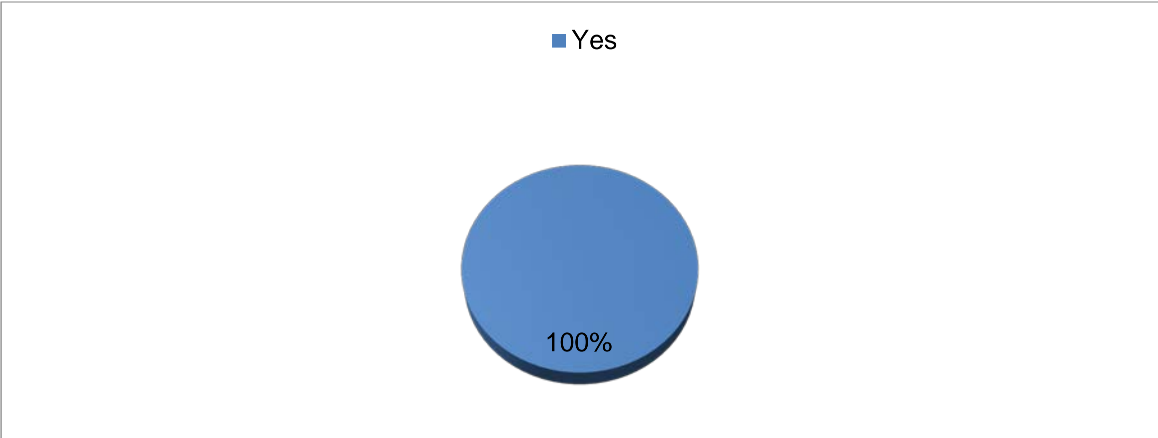
Do you have health care coverage for your children or dependents?

One hundred percent of survey participants have health insurance for their children or dependents.



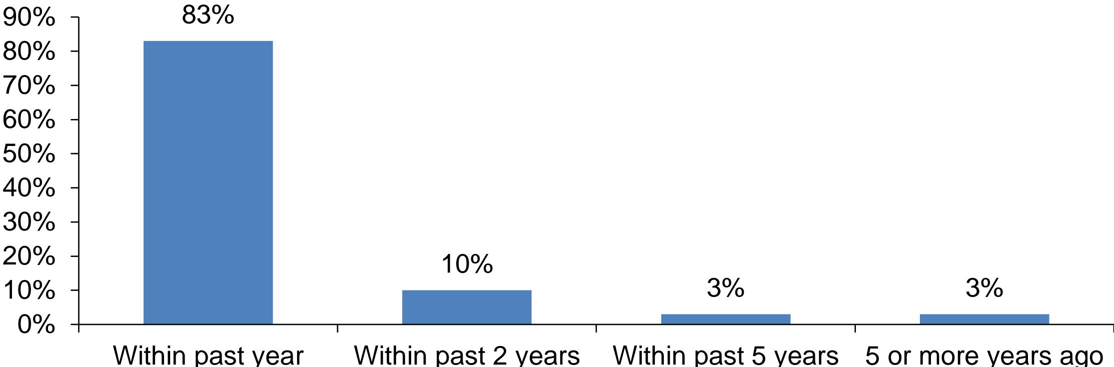
Do you currently have any kind of health insurance?

One hundred percent of survey participants have health insurance.



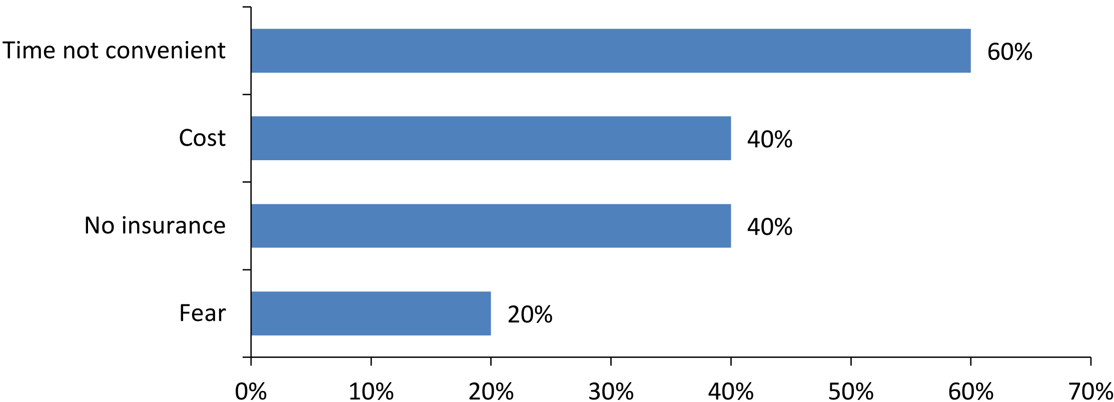
How long has it been since you visited a dentist?

Sixteen percent of survey participants have not visited a dentist in more than a year.



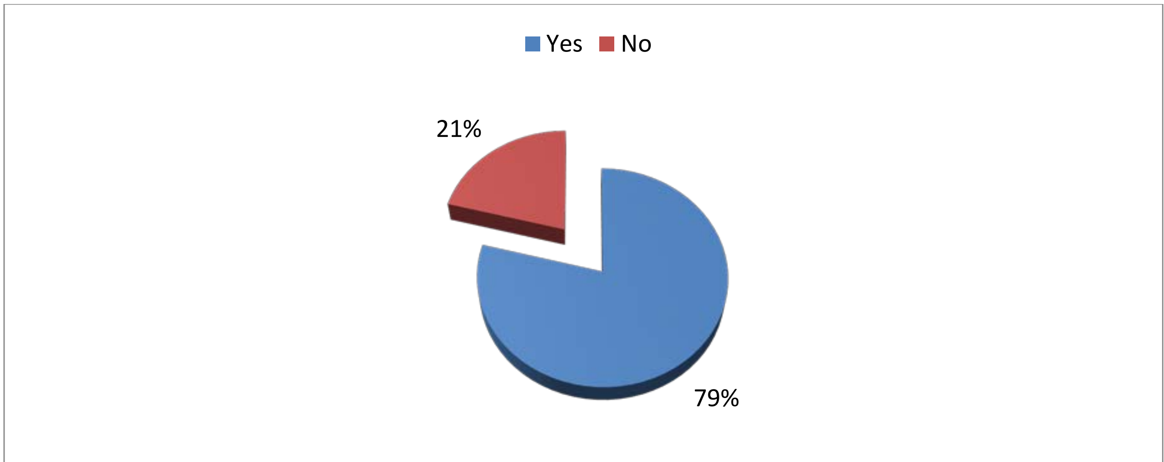
Barriers to visiting a dentist

Convenient time, cost and no insurance are reported barriers to visiting a dentist.



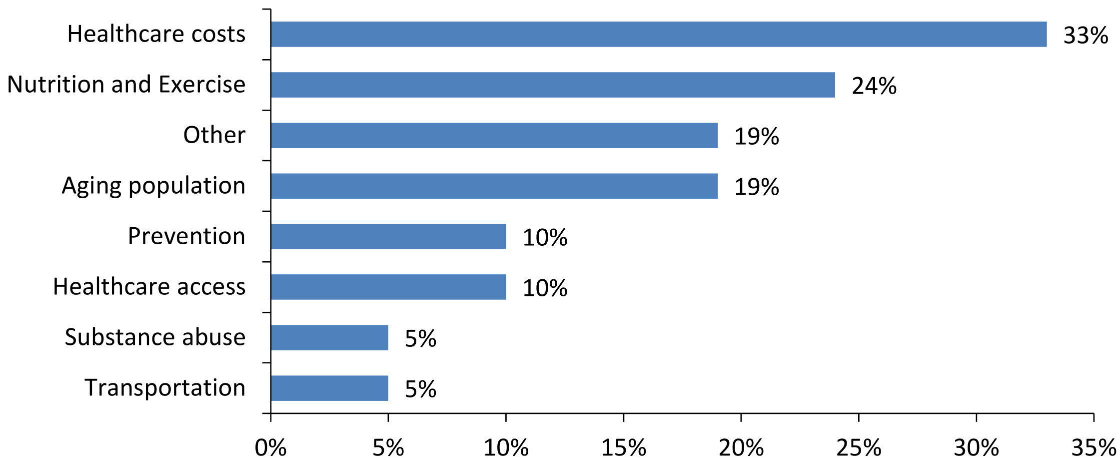
Do you have any type of dental insurance coverage?

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



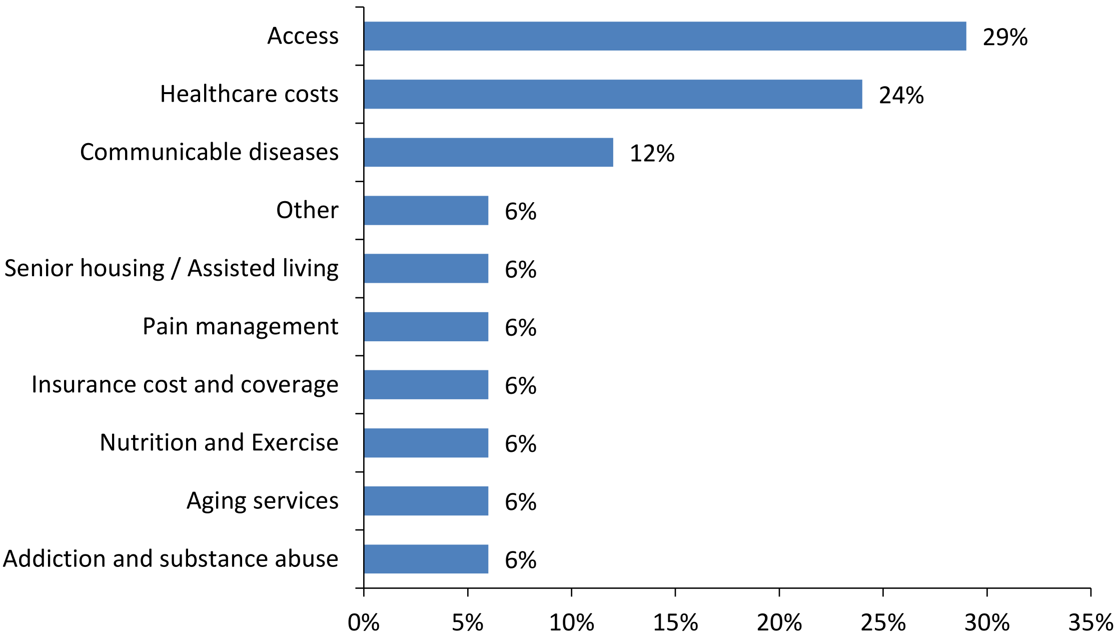
What are the most important community issues for you?

The cost of health care is a high concern for 33% of survey participants. The need for good nutrition and exercise is the second highest concern.



What are the most important community issues for your family?

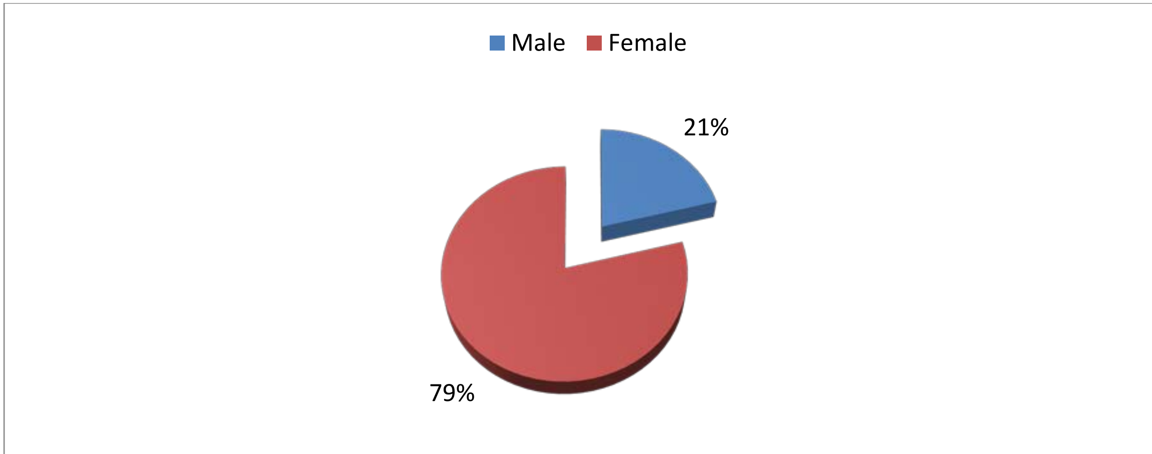
When asked what is the most important issue for the participant's family, access and health care costs were the top concerns.



Demographic Information for Community Resident Participants

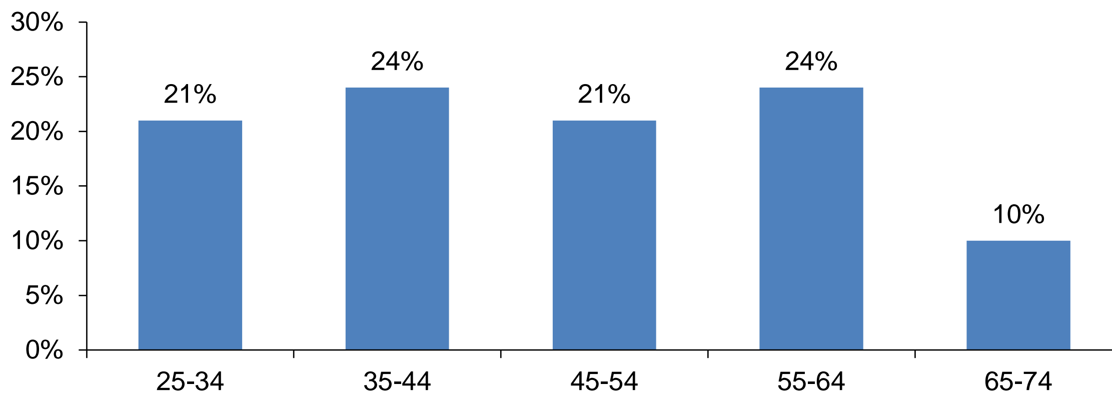
Biological Gender

Only 21% of the survey participants were male.

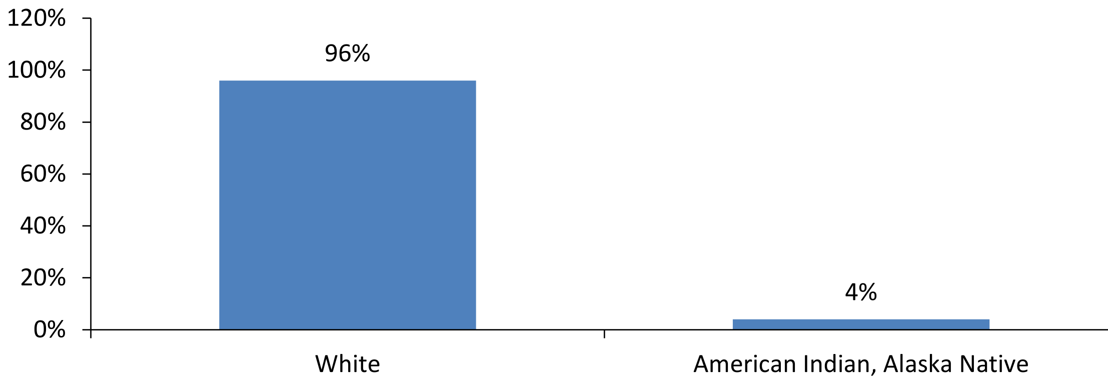


Age

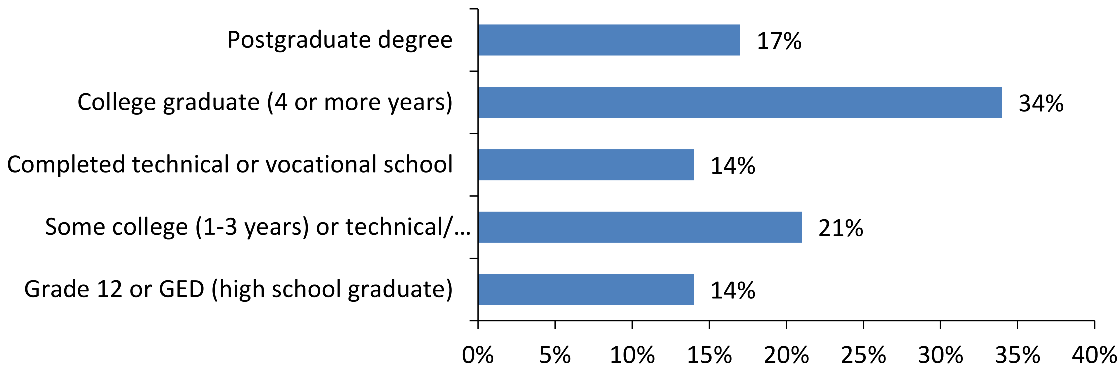
The 18 – 24 year age group was not represented among the survey participants, even with the utilization of Facebook to reach this demographic.



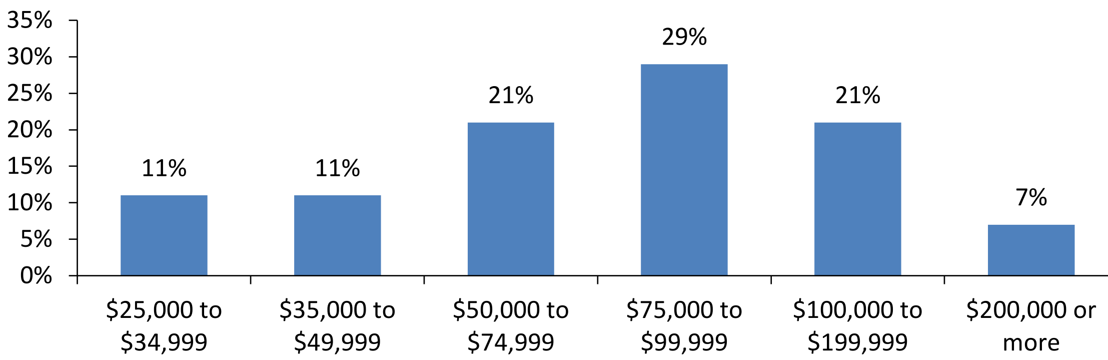
Ethnicity



Education Level



Total Annual Household Income



Secondary Research Findings

Census Data

Population of Day County, South Dakota	5,571
% below 18 years of age	22.4
% 65 and older	25.3
% White – non-Hispanic	85.8
American Indian	9.7
Hispanic	2.4
African American	0.4
Asian	0.5
% Female	48.9
% Rural	100

County Health Rankings

	Day County	State of South Dakota	U.S. Top Performers
Adult smoking	16%	18%	14%
Adult obesity	34%	31%	26%
Physical inactivity	23%	22%	20%
Excessive drinking	17%	20%	13%
Alcohol related driving deaths	40%	37%	13%
Food insecurity	14%	12%	10%
Uninsured adults	18%	14%	7%
Uninsured children	12%	7%	3%
Children in poverty	18%	17%	12%
Children eligible for free or reduced lunch	34%	42%	33%
Diabetes monitoring	88%	84%	91%
Mammography screening	74%	66%	71%
Median household income	$43,600	$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 Worksheet

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

The following needs were brought forward for prioritization:

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern
Economic Well-Being • Availability of affordable housing 3.30 • Maintaining livable and energy efficient homes 3.21
Children and Youth • Childhood obesity 3.57 • Substance abuse by youth 3.48 • Bullying 3.47 • Availability of services for at-risk youth 3.30 • Opportunities for youth-adult mentoring 3.23
Aging Population • Cost of long-term care 3.62 • Cost of memory care 3.46 • Availability of memory care 3.45 • Availability of resources for family and friends caring for and helping to make decisions for elders 3.37 • Cost of in-home services 3.34 • Availability of activities for seniors 3.20
Safety • Presence of street drugs 3.80 • Culture of excessive and binge drinking 3.69 • Presence of drug dealers 3.53 • Abuse of prescription drugs 3.48 • Domestic violence 3.28 • Criminal activity 3.23
Health Care Access • Availability of behavioral health (substance abuse) providers 3.76 • Availability of mental health providers 3.66 • Access to affordable health insurance coverage 3.40 • Access to affordable prescription drugs 3.20
Mental Health and Substance Abuse • Alcohol use and abuse 3.77 • 25% self-report that they binge drink at least 1X/month • Drug use and abuse 3.73

Health Indicator/Concern
• Depression 3.60 • Dementia and Alzheimer's disease 3.33 • Smoking and tobacco use 3.32 10% self-report that they currently smoke cigarettes • Stress 3.30 • 32% have been diagnosed with anxiety/stress • 221% have been diagnosed with depression • 28% self-report that they have drugs in their home that are not being used
Wellness • 36% report that they are obese • 32% report that they are overweight • 59% do not get 5 or more fruits/vegetables/day • 53% do not get moderate exercise 3 or more times/week • 53% have been diagnosed with hypertension • 42% have been diagnosed with high cholesterol • 32% have been diagnosed with arthritis • 21% have been diagnosed with asthma • 14% have not seen their physician for a routine check-up in over 1 year • 16% have not seen their dentist in over 1 year

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

Implementation Strategies

How Sanford Webster 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 Webster is Addressing the Community Needs
ECONOMIC WELL BEING	
Availability of affordable housing Maintaining livable & energy efficient homes	Sanford has invited community leaders to learn about the assessed needs.
CHILDREN & YOUTH	
Childhood obesity	Primary care providers address the issue of obesity with their patients, emphasizing exercise and diet and referrals to the clinical dietitian. The Sanford *fit* program is available online and in the classroom.
Substance abuse by youth	All patients are assessed by PCPS and Integrative Health Triage Therapists are in clinics to provide early intervention and referral. Treatment services are also available within our Behavioral Health Services. The BHTT serves as an integral core team member within the patient-centered Medical Home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate, and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triage according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management. BHTT key points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety.
Bullying	Sanford has invited community leaders to learn about the assessed needs.
Availability of services for at-risk youth	Sanford has invited community leaders to learn about the assessed needs.
Opportunities for youth/adult mentoring	Sanford has invited community leaders to learn about the assessed needs.

Identified Concerns	How Sanford Webster is Addressing the Community Needs
AGING POPULATION	
Cost of long-term care Cost of memory care Availability of memory care	• Sanford providers work to keep seniors healthy and living independently as long as possible. • The recent Good Samaritan affiliation will provide the organization with expertise in the area of long-term care and assisted living services and will help to create efficiencies for members in the communities that we serve. • Sanford has invited community leaders to learn about the assessed needs.
Availability of resources for family & friends caring for & helping to make decisions for elders	• Sanford providers work to keep seniors healthy and living independently as long as possible. • Sanford has invited community leaders to learn about the assessed needs.
Cost of in-home services	Sanford providers work to keep seniors healthy and living independently as long as possible.
Availability of activities for seniors	Sanford has invited community leaders to learn about the assessed needs.
SAFETY	
Presence of street drugs Culture of excessive & binge drinking Presence of drug dealers Abuse of prescription drugs Domestic violence Criminal activity	• In April of 2016, the Sanford Quality Cabinet announced the formation of a Controlled Substance Stewardship Committee (CSSC) because they saw a need and a responsibility to not only protect our patients, but support physicians and APPs who prescribe high-risk medications. The goal was to ensure patients are safe and well treated and that physicians are educated in how to treat patients while being good stewards of the use of opioids. • Through education, resources and support, the CSSC has helped providers prescribe responsibly by taking advantage of One Chart technology, implementing protocols for conditions such as low back pain, migraine, and weaning patients from opiates when necessary. An enterprise pain agreement with workflows and guidelines was established using best practices. • A 30% reduction in prescription of opioids was achieved by 2018. Sanford has invited community leaders to learn about the assessed needs.
HEALTH CARE ACCESS	
Availability of behavioral health (substance abuse) providers	All patients are assessed by PCPs and Integrative Health Triage Therapists are in clinics to provide early intervention and referral. Treatment services are also available within our Behavioral Health Services.
Availability of mental health providers	All patients are assessed by PCPs and Integrative Health Triage Therapists are in clinics to provide early intervention and referral. Treatment services are also available within our Behavioral Health Services.
Access to affordable health insurance coverage	Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations. The Sanford Health Plan is available for people seeking affordable health insurance coverage. Financial counselors are available to help enroll patients in the Community Care Program that provides free or reduced costs of care.
Access to affordable prescription drugs	Sanford's formulary addresses the cost of drugs and includes the highest quality medications at affordable prices.

Identified Concerns	How Sanford Webster is Addressing the Community Needs
MENTAL HEALTH & SUBSTANCE ABUSE	
Alcohol use & abuse Binge drink at least 1 x / month – 25% Drug use & abuse Depression Dementia & Alzheimer's Disease Smoking & tobacco use Currently smoke cigarettes – 10% Stress Diagnosed with anxiety/stress – 32% Diagnosed with depression – 21% Have drugs in the home that are not being used – 28%	All patients are assessed by PCPS and Integrative Health Triage Therapists are in clinics to provide early intervention and referral. Treatment services are also available within our Behavioral Health Services. The BHTT serves as an integral core team member within the patient-centered Medical Home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate, and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triage according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management. BHTT key points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. Smoking is assessed by PCPs and programs are offered to stop smoking, including medication-assisted withdrawal management
WELLNESS	
Obese – 36% Overweight – 32% Do not eat 5+ fruits/vegetables per day – 59% Do not get moderate exercise 3+ times per week – 53% Diagnosed with hypertension – 53% Diagnosed with high cholesterol – 42% Diagnosed with arthritis – 32% Diagnosed with asthma – 21% Have not had a routine check-up in over a year – 14% Have not seen a dentist in over a year – 16%	Primary care providers address the issue of obesity with their patients, emphasizing healthy lifestyle, exercise and diet and referrals to the clinical dietitian. Sanford dietitians are available to provide medical nutrition therapy to reduce hypertension and high cholesterol and other chronic diseases. Sanford exercise specialists provide exercise therapy. Sanford has walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations. Primary care providers are available to address all of these needs with patients and community members.

Implementation Strategies – 2019 - 2021

Priority 1: Availability of Mental Health Services

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.

Priority 2: Aging Services

According to the Administration for Community Living, families are the major provider of long-term care for older adults and people with disabilities in the U.S. Research indicates that caregiving also exacts a significant emotional, physical, and financial toll. With nearly half of all caregivers older than age 50, many are vulnerable to a decline in their own health. Studies have shown that coordinated support services can reduce caregiver depression, anxiety, and stress, and enable them to provide care longer, which avoids or delays the need for costly institutional care.

Sanford has made the aging population a significant priority and has developed strategies to support caregivers through community services. The creation of collaborative partners will provide the necessary support to make a positive impact on caregivers and to provide the tools to support their work.

Implementation Strategy Action Plan – 2019 - 2021

Priority 1: Availability of Mental Health Services

Projected Impact: (IRS mandatory) Access to mental health services are available for the community of Webster

Goal 1: Improve access for those who need mental health specialty care

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations-if applicable
Psychology services will be available through telemedicine	# of visits	Dr. Daniels, nursing and office staff resources	Isaac Gerdes, Ashley Ewing, Evelyn Christensen	
Integrated health therapists are available for patients	# of patients seen	IHT therapists	Isaac Gerdes, Ashley Ewing, Evelyn Christensen	

Goal 2: Psychiatry services are available at Sanford Webster Medical Center

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations-if applicable
Telemedicine outreach from Sioux Falls for a Clinical Psychiatrist	Outreach is established - # of referrals during FY 2019, 2020, 2021	Nursing and office staff	Isaac Gerdes, Ashley Ewing, Evelyn Christensen	Dr. Daniels and the Webster Medical staff would collaborate with the Clinical Psychiatrist to serve the patients who are in need of these services in the community

Goal 3: The Bridging Health Program will provide an integrated approach to physical and mental health services

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations-if applicable
Bridging Health and Home Program partners with and provides mental health services	# of participants or # of visits	The IDT team - two FTEs	Carley Swanson, Isaac Gerdes, Ashley Ewing, Evelyn Christensen	We have many community partners working with us on this project. We have a community advisory board along with a partnership with the Day County Arts Building.

Priority 2: **Aging Services**

Projected Impact: (IRS mandatory) Caregivers are supported through community service providers

Goal 1: A collaboration is established for caregiver support

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations-if applicable
Sanford will participate in the Caregiver Support Group	# of participants # of meetings # of programs for caregivers	Carley Swanson, Isaac Gerdes, Ashley Ewing, Evelyn Christensen Medical Staff	Carley Swanson, Isaac Gerdes, Ashley Ewing, Evelyn Christensen	The Medical Center is collaborating with the Bethesda Home for a space to host the support group. We have had Medical Center staff attend the meetings to help with questions and resources.

Goal 2: Better Balance is established to help community members prevent falls

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations-if applicable
Better Balance classes are available to the community	# of classes in 2019, 2020, 2021	Physical therapy staff time and resources to offer the services	Carley Swanson, Isaac Gerdes, Kyle Hubsch	If this is a strategy it might be important for Sanford to lead

Implementation Strategies Action Plan – 2017 – 2019

Priority 1: Physical Health

Projected Impact: Healthier Day County residents

Goal 1: PT Wellness

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
We will offer(for a nominal monthly fee) the use of our PT equipment to the public for their workout needs, but for liability purposes this can only be offered during PT/OT business hours.	The number of people utilizing this program is expected to increase from year to year.	PT/OT staff and equipment; minimal supplies	Rehab Director David Wyman, PT and all PT/OT staff	

Goal 2: Nutrition counseling

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
We have a contract with a Registered Dietitian who comes monthly and consults with patients referred by our clinic providers on their eating habits and nutritional needs. We also have an RN Health Coach in the clinic who meets with patients regarding weight loss, dietary issues, etc.	Increase in the number of dietary consults and RN Health Coach visits	Contracted dietitian, employed RN Health Coach	Clinic providers	

Goal 3: American Cancer Society promotions

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Hand out referral cards in the clinic and hospital for the Watertown chapter of the American Cancer Society (which covers Day County) to our local cancer patients and their family members.	An increase in the ACS benefits utilized by Day Co residents	American Cancer Society	Providers, Nurses, Social Services	American Cancer Society Watertown, SD

<u>Priority 2</u>: Safety

<u>Projected Impact</u>: Community members, multi-generational

<u>Goal 1</u>: Community presentation of ideas on how to handle aggressive behavior (attacker, shooter, etc.)

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
We have a MOAB (Management of Aggressive Behavior) instructor on staff who will be training our employees about what to do in the event of an active shooter or aggressive patient/visitor. Once she gets comfortable with her training, we would like to offer an informational version (less of the physical exercises, but would still help people think about what to do in the situation) to the public, or to the school/businesses.	Everyone hears about the shootings and attacks in the media these days. Even though we hope it never happens here, we believe that knowledge is power; and knowing what to do ahead of time if the situation occurs should help our community members feel safer at home and when traveling.	MOAB instructor time	Andrea Schuring, MOAB instructor, Executive Team and Dept Managers to promote within and market in the community	Day Co Emergency Management team

<u>Goal 2</u>: Day County docudrama presentation

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Have hospital personnel lead/participate in a reenactment of a DUI crash resulting in death, arrest, etc. Timing would be before prom, to be done every other year for all juniors and seniors in Day County.	Reduce number of alcohol- and drug-related accidents among teens	Sanford Webster staff and some supplies	We have a PA on staff who volunteers with the Webster Key Club and has been instrumental in organizing this event.	We will work with local Emergency Management, police, ambulance, funeral home, students and parents, possibly even helicopter if available.

<u>Goal 3</u>: Power Sports program

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Physical therapist and a COTA will do an annual summer sports Power Program, teaching students how to maximize their workout techniques, improve jumping ability, etc.	We believe this program will encourage students to participate in sports and continue beyond high school, thus discouraging drug and alcohol use.	Physical therapist, Certified OT Assistant, and supplies from those depts.	Kyle Hubsch, DPT	Webster and Waubay Schools will promote the program for us

Demonstrating Impact - 2017-2019 Strategies

Goal 1 - Physical Health

The strategy of opening up Sanford's physical therapy equipment to the community has been a huge success. On average, 15-20 community members use the equipment each week. Sanford's PT staff has offered Better Balance classes in the community to help people who are struggling with physical health and for those who want to maintain their physical health.

Sanford's dietician meets with patients and individuals on a referral basis in the clinic. Medical Nutrition Therapy has been a very successful program. Sanford's dietician helps patients with chronic conditions. Nutrition continues to be a concern and this service will be key moving forward.

Goal 2: Safety

According to the CDC, every day 28 people in the United States die in motor vehicle accidents. Sanford Webster decided to combat this important safety issue by working with the local Key Club and by providing expert level presentation for community groups. Sanford PA, Lola Pollard, who is also the Key Club President, gave presentations and education sessions to that group about safety. Local law enforcement also continues to do DUI checkpoints in the county to keep the population safe.

Drug use and violence continues to increase in Day County and the United States. Sanford staff took the MOAB training. MOAB training presents principles, techniques, and skills for recognizing, reducing and managing violent and aggressive behavior. The training has been helpful and the staff is better able to manage aggressive behaviors.

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 Webster Medical Center's CHNA.

Appendix

Primary Research

Webster Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Economic Well Being	Availability of affordable housing 3.30 Maintaining livable and energy efficient homes 3.21			Housing resources: • Day Co. Housing Development, 711 W. 1st St., Webster • Webster Housing Authority, 1101 E. 7th St., Webster • Larsen Realty, 519 Main St., Webster • Dakota View Realty, 13967 SD 25, Webster • Vander Linden Properties, SD 25, Webster Low Income Housing: • Downtown Manor, 713 – 1st St. W., Webster Home Maintenance resources: • Mills Home Services, 630 Western Ave., Webster • Day Co. HVAC, 14104 – 428th Ave., Webster • Glacial Lakes Electric, 43170 US Hwy 12, Webster • Knight Construction, 701 W. Hwy. 12, Webster • Webster Lumber & Home Center, 14053 SD 25, Webster • GCC Ready Mix Concrete, 14109 – 436 Ave., Webster • Decorative Concrete Restoration, 44030 – 142nd St., Webster • North Star Mechanical, 115 E. 5th Ave., Webster • Ackerman Tree Service, 74 E. 3rd Ave., Webster • Foothills Contracting, 701 US 12, Webster • Holmquist Construction, 14111 – 428th Ave., Webster • Bierschbach Electric, 44015 – 147th St., Webster • Dave's Electric, 1008 E. 1st St., Webster • Hoverstadt's Electric, 43650 – 152nd St., Webster • Wayne's Heating & A/C, 115 E. 5th Ave., Webster	
Children and Youth	Childhood obesity 3.57 Substance abuse by youth 3.48			Childhood Obesity resources: • Family & Community Health Services, 711 W. 1st, Webster	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	Bullying 3.47 Availability of services for at-risk youth 3.30 Opportunities for youth/adult mentoring 3.23			• Sanford Clinic dieticians, 101 Peabody Dr., Webster • I Grow nutrition programs for children through SD Ext. – Kimberly.wilson-sweebe@sdstate.edu • Day Co. Extension Service nutrition classes, 711 – 1st St. W., Webster • Farmers Market, So. Main & Hwy. 25, Webster • Open Gym & other school district activities, 52 E. 9th Ave., Webster • Park District activities, 603 E. 8th Ave., Webster • Just for Kix dance classes, 711 W. 1st St., Webster • All American Saddle Club, 43495 – 143rd St., Webster • Webster Youth Wrestling, 198 W. 11th Ave., Webster • Webster Armory, gym & fitness center, 100 W. 11th Ave., Webster • Webster Golf Club, 1030 W. 3rd St., Webster • Webster Aquatic Center, 201 – 12th Ave. E., Webster • L & L Bowling, 14038 SD 25, Webster • Webster City Park, 237-101 13th Ave. E., Webster Substance Abuse resources: • Northeastern Mental Health Center, 830 Co. Rd. 12, Webster • DUI Alcohol Classes, alcoholdrugcourses.com Bullying resources: • Webster Police, 602 – 1st St. W., Webster • Day Co. Sheriff, 710 – 2nd St. W., Webster • School Counselors, 102 East 9th Ave., Webster • Northeastern Mental Health Center, 830 Co. Rd. 12, Webster • Needs Anonymous, 504 Main St., Webster • Family Support Program, East 7th Ave., Webster	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• YMCA Aberdeen, 5 S. State St., Aberdeen Services for At-Risk Youth: • YMCA Aberdeen, 5 S. State St., Aberdeen • Northeastern Mental Health Center, 830 Co. Rd. 12, Webster Youth/Adult Mentoring resources: • Volunteer with 4-H, Day Co. Extension Office, 711 – 1st St. W., Webster • Volunteer with Boy Scouts, c/o 800 N. West Ave., Sioux Falls • Volunteer with Girl Scouts, 1101 S. Marion Rd., c/o Sioux Falls • Volunteer at public school classes & activities, 52 E. 9th Ave., Webster • Volunteer with park district youth activities, 603 E. 8th Ave., Webster	
Aging Population	Cost of long term care 3.62 Cost of memory care 3.46 Availability of memory care 3.45 Availability of resources for family and friends caring for and helping to make decision for elders 3.37 Cost of in-home services 3.34 Availability of activities for seniors 3.20			Long Term Care resources: • Bethesda Home, 129 W. Hwy. 12, Webster • Heritage Village, 119 U S Hwy 12, Webster • Strand Kjorsvig Rest Home, 801 Main, Roslyn • Sun Dial Manor, 410 - 2nd St. S., Bristol • Sanford Clinic, 101 Peabody Dr., Webster Memory Care resources: • Alzheimer's Support Group, 1209 Main, Webster • Alzheimer's Assn. - Alz.org • Bethesda Home, 129 W. Hwy. 12, Webster • Strand Kjorsvig Rest home, 801 Main, Roslyn • Sun Dial Manor, 410 – 2nd St. S., Bristol Resources for those making decisions for the elderly: • Planning for Health Care Decisions, SD Dept. of Social Services, 700 Governors Dr., Pierre	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Advance Care Planning consultation, Sanford Clinic, 101 Peabody Dr., Webster In-Home Services: • Sanford Home Care, 101 Peabody Dr., Webster • Homecare Services, P O Box 7258, Pierre or NE Branch, 122 N. Main, Waubay Activities for Seniors: • Senior Center activities, 500 Main, Webster • Park District activities, 603 E. 8th Ave., Webster • All American Saddle Club, 43495 – 143rd St., Webster • Webster Armory (gym & fitness center), 100 W. 11th Ave., Webster • TLC Fitness Center, 1290 N. Main St., Webster • Webster Golf Club, 1030 W. 3rd St., Webster • Webster Aquatic Center, 201 – 12th Ave. E., Webster • L & L Bowling, 14038 SD 25, Webster • Webster City Park, 237-101 13th Ave. E., Webster • Northern Plains Adventures (hunting), US 12, Webster • Cottonwood Lake Public Shooting Area, Webster SD • Volunteer with 4-H, Day Co. Extension Office, 711 – 1st St. W., Webster • Volunteer with Boy Scouts, c/o 800 N. West Ave., Sioux Falls • Volunteer with Girl Scouts, c/o 1101 S. Marion Rd., Sioux Falls • Volunteer at Sanford Webster Medical Center, 1401 W. 1st St., Webster • Museum of Wildlife, Science & Industry, 760 US 12, Webster • Day County Museum, 711 W. 1st St., Webster • Public Library, 800 Main St., Webster • Webster Area Book Club, c/o Library, 800 Main St., Webster	

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

Safety	Presence of street drugs 3.80
	
	Culture of excessive and binge drinking 3.69
	
	Presence of drug dealers 3.53
	
	Abuse of prescription drugs 3.48
	
	Domestic violence 3.28
	
	Criminal activity 3.23
				Resources to combat street drugs/illegal drinking/drug dealers/other criminal activity:
				• Webster Police, 602 – 1st St. W., Webster
				• Day Co. Sheriff, 710 - 2nd St. W., Webster
				
				Substance Abuse resources:
				• Northeastern Mental Health Center, 830 Co. Rd. 12, Webster
				• DUI Alcohol Classes, alcoholdrugcourse.com
				
				Prescription Drug Abuse resources:
				• Webster Police, 602 -1st St. W., Webster
				• Day Co. Sheriff, 710 – 2nd St. W., Webster
				
				Domestic Violence resources:
				• Safe Harbor, 2005 S. Merton St., Aberdeen
				• The Beacon Center, 801 Jenson Ave. S., Watertown
				• Victim Service Program, DSS, 700 Governors Dr., Pierre
				• Protection Orders:
				  ○ Day Co. Sheriff, 710 – 2nd St. W., Webster
				  ○ Tribal, tribalprotectionorder.org
				• YMCA Aberdeen, 5 S. State S., Aberdeen
				• Webster Police, 602 – 1st St. W., Webster
				• Day Co. Sheriff, 710 – 2nd St. W., Webster
				• Child Protection, 2001 – 9th Ave. SW, Watertown	

Health Care Access	Availability of behavioral health (substance abuse) providers 3.76 Availability of mental health providers 3.66 Access to affordable health insurance coverage 3.40			Substance Abuse resources: • Northeastern Mental Health Center, 830 Co. Rd. 12, Webster • DUI Alcohol Classes, alcoholdrugclasses.com Mental Health resources: • Sanford Clinic, 101 Peabody Dr., Webster • Northeastern Mental Health Center, 830 Co. Rd. 12, Webster	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	Access to affordable prescription drugs 3.20			Affordable Health Insurance resources: • Medicaid & Children's Health Insurance, Social Services Dept., 711 W. 1st St., Webster • Sanford Health Plan, 300 N. Cherapa Place, Sioux Falls • DakotaCare, 722 Main, Webster • Bill Markve & Associates, 15 W. 7th Ave., Webster Prescription Assistance resources: • 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 • SD Partnership for Prescription Assistance, pparx.org • Patient Access Network Foundation, panfoundation.org • Pfizer RC Pathways, pfizerRX pathways.com • RXhope.com	
Mental Health and Substance Abuse	Alcohol use and abuse 3.77 25% self-report that they binge drink at least 1x/month Drug use and abuse 3.73 Depression 3.60 Dementia and Alzheimer's Disease 3.33 Smoking and tobacco use 3.32	25% self-report that they binge drink at least 1x/month 10% self-report that they currently smoke cigarettes 32% have been diagnosed with anxiety/stress 21% have been diagnosed with depression 28% self-report that they have drugs in their home that are not being used		Substance Abuse resources: • Northeastern Mental Health Center, 830 Co. Rd. 12, Webster • DUI Alcohol Classes, alcoholdrugclasses.com Mental Health resources: • School Counselors, 102 E. 9th Ave., Webster • Northeastern Mental Health Center, Armory, 101 W. 11th St. Webster • Needs Anonymous, 504 Main St., Webster • Family Support Program, East 7th Ave., Webster	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	10% self-report that they currently smoke cigarettes Stress 3.30 32% have been diagnosed with anxiety/stress 21% have been diagnosed with depression 28% self-report that they have drugs in their home that are not being used			Dementia/Alzheimer's resources: • Alzheimer's Support Group, 1209 Main, Webster • Alzheimer's Assn. - Alz.org Drug Take-Back Programs: • Webster Police, 602 – 1st St. W., Webster • Day Co. Sheriff, 710 – 2nd St. W., Webster Tobacco Cessation resources: • Quitline, SDQuitline.com • SD Dept. of Health, 600 E. Capitol Ave., Pierre (has many resources) • Sanford Clinic, 101 Peabody Dr., Webster • Public Health, 711 W. 1st, Webster	
Wellness	36% report that they are obese 32% report that they are overweight 59% do not get 5 or more fruits/vegetables/day 53% do not get moderate exercise 3 or more times/week 53% have been diagnosed with hypertension 42% have been diagnosed with high cholesterol 32% have been diagnosed with arthritis 21% have been diagnosed with asthma 14% have not seen their physician for a routine check-up in over 1 year	36% report that they are obese 32% report that they are overweight 59% do not get 5 or more fruits/vegetables/day 53% do not get moderate exercise 3 or more times/week 53% have been diagnosed with hypertension 42% have been diagnosed with high cholesterol 32% have been diagnosed with arthritis 21% have been diagnosed with asthma 14% have not seen their physician for a routine check-up in over 1 year		Obesity resources: • Family & Community Health Services, 711 W. 1st, Webster • Sanford Clinic dieticians, 101 Peabody Dr., Webster • I Grow nutrition programs for children through SD Ext. – Kimberly.wilson-sweebe@sdstate.edu • Farmer Market, So. Main & Hwy. 25, Webster • Open Gym & other school district activities, 52 E. 9th Ave., Webster • Park District activities, 603 E. 8th Ave., Webster • Just for Kix dance classes, 711 W. 1st St., Webster • All American Saddle Club, 43495 – 143rd St., Webster • Webster Youth Wrestling, 198 W. 11th Ave., Webster • Webster Armory (gym & fitness center), 100 W. 11th Ave., Webster • TLC Fitness Center, 1290 N. Main St., Webster • Webster Golf Club, 1030 W. 3rd St., Webster • Webster Aquatic Center, 201 – 12th Ave. E., Webster • L & L Bowling, 14038 SD 25, Webster • Webster City Park, 237-101 13th Ave. E., Webster	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	16% have not seen their dentist in over 1 year	16% have not seen their dentist in over 1 year		• Northern Plains Adventures (hunting), US 12, Webster • Cottonwood Lake Public Shooting Area, Webster SD Healthy Food / Nutrition Education resources: • Webster Farmers Market, So. Main & Hwy. 25, Webster • Day Co. Extension Service nutrition classes, 711 – 1st St. W., Webster • I Grow nutrition programs for children through SD Ext. – Kimberly.wilson-sweebe@sdstate.edu • Family & Community Health Services, 711 W. 1st, Webster • YMCA Aberdeen, 5 S. State St., Aberdeen • Mike's Jack & Jill grocery store, 1300 Main St., Webster • Community Education classes, Webster School District, 52 E. 9th Ave., Webster • Sanford dieticians, 101 Peabody Dr., Webster • Senior Meals, Golden Age Center, 500 Main, Webster • Area 4 Senior Nutrition Program, 507 Main St., Webster Physical Fitness resources: • Open Gym & other school district activities, 52 E. 9th Ave., Webster • Park District activities, 603 E. 8th Ave., Webster • Just for Kix dance classes, 711 W. 1st St., Webster • All American Saddle Club, 43495 – 143rd St., Webster • Webster Youth Wrestling, 198 W. 11th Ave., Webster • Webster Armory (gym & fitness center), 100 W. 11th Ave., Webster • TLC Fitness Center, 1290 N. Main St., Webster • Webster Golf Club, 1030 W. 3rd St., Webster • Webster Aquatic Center, 201 – 12th Ave. E., Webster	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• L & L Bowling, 14038 SD 25, Webster • Webster City Park, 237-101 13th Ave. E., Webster • Northern Plains Adventures (hunting), US 12, Webster • Cottonwood Lake Public Shooting Area, Webster SD Chronic Disease resources: • Family & Community Health Services, 711 W. 1st, Webster • Sanford Clinic, 101 Peabody Dr., Webster • Sanford Better Choices, Better Health, 300 Cherapa, Sioux Falls • Bridging Health & Home, support group for chronic disease, Sanford Clinic, 101 Peabody Dr., Webster • American Heart Association, Heart.org or PO Box 90545, Sioux Falls • Arthritis Foundation, P O Box 90445, Sioux Falls • American Lung Association, Lung.org or 490 Concordia Ave., St. Paul Regular Check-Up/Flu Shot resources: • Family & Community Health Services, 711 W. 1st, Webster • Sanford Clinic, 101 Peabody Dr., Webster Dental resources: • Donated Dental Services Program (DDS), 605-224-4012 • Embrace Dentistry, 101 Peabody, Webster • Dr. John Sorbel, 700 Main, Webster	

Key Stakeholder Survey

Sanford Webster Medical Center

Community Health Needs Assessment

Results from an October 2017 Non-Generalizable

Online Survey of Community Stakeholders

November 2017

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 Webster Medical Center. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. **Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred in the month of October. A total of 33 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, HEALTHCARE AND WELLNESS, and MENTAL HEALTH AND SUBSTANCE ABUSE.

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

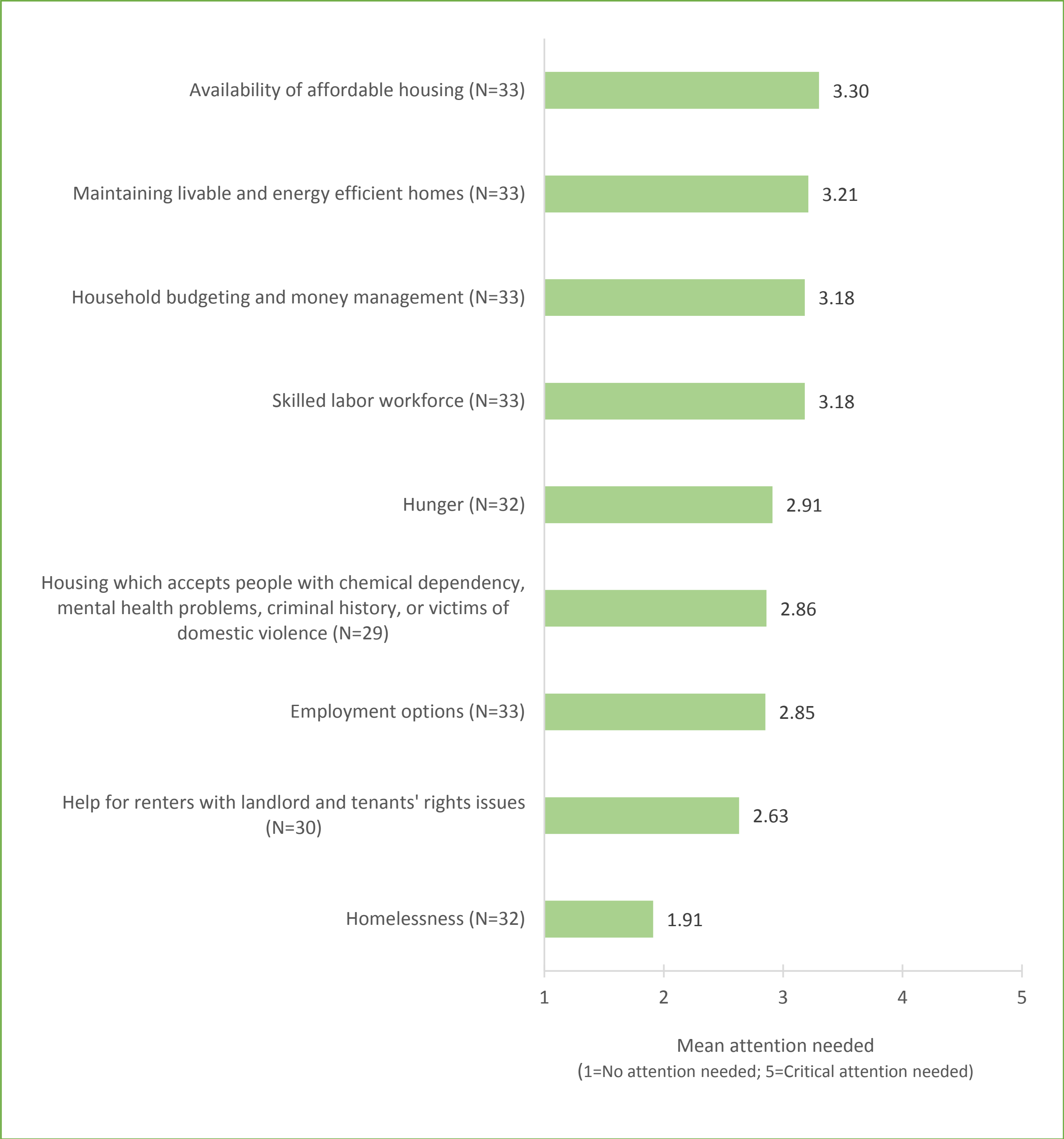


Figure 2. Current state of community issues regarding TRANSPORTATION

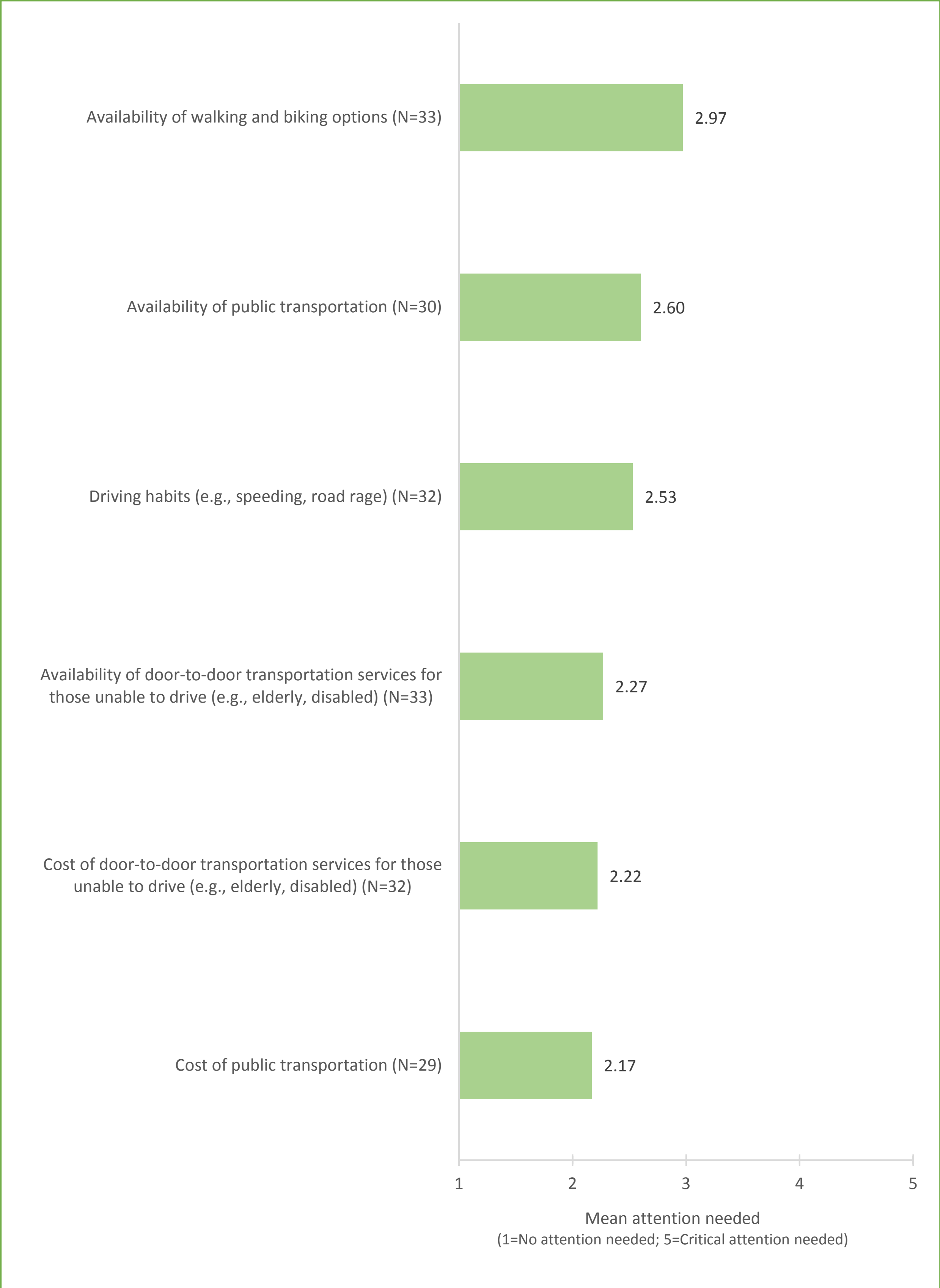


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

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

Figure 5. Current state of community issues regarding SAFETY

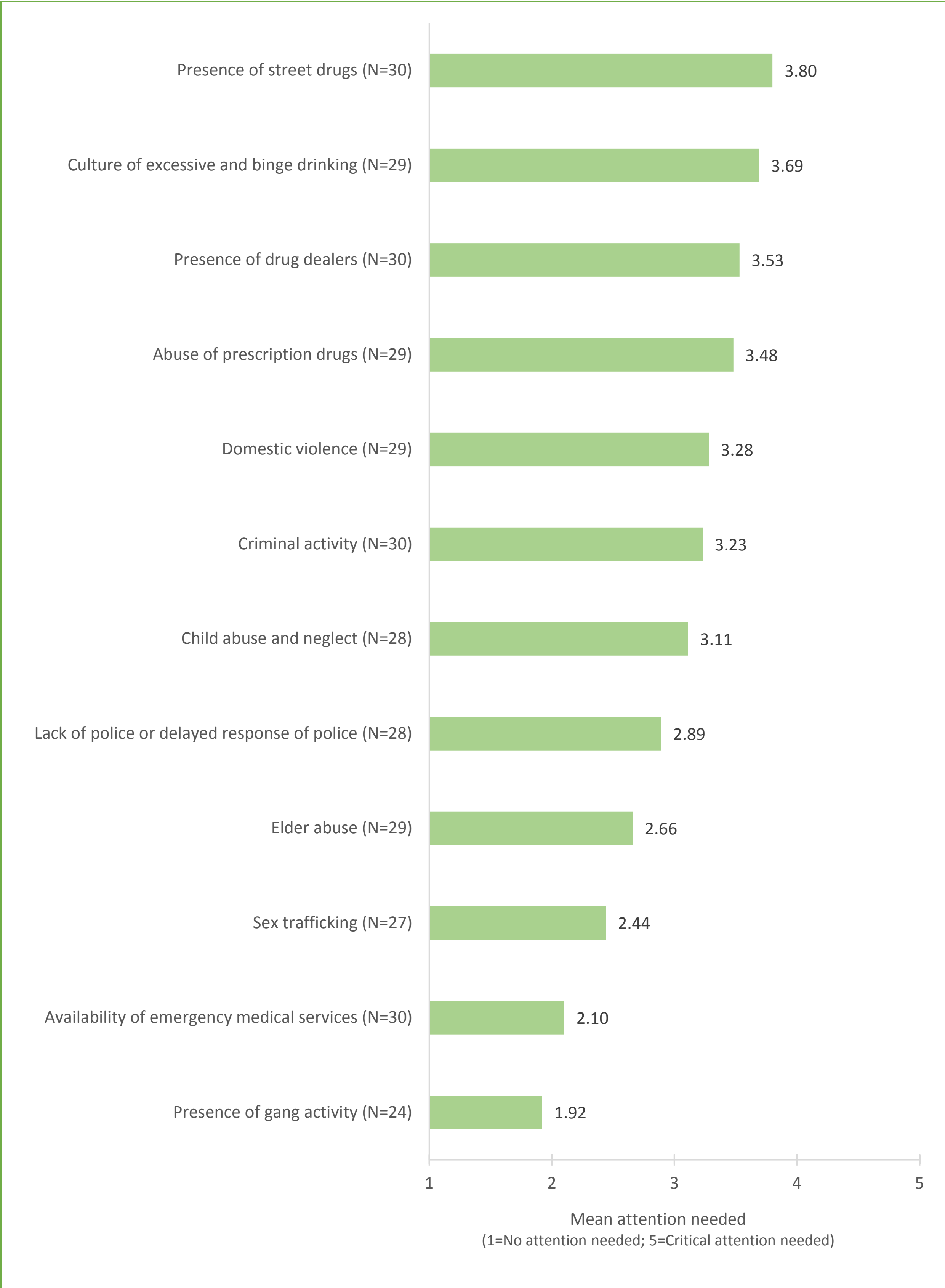
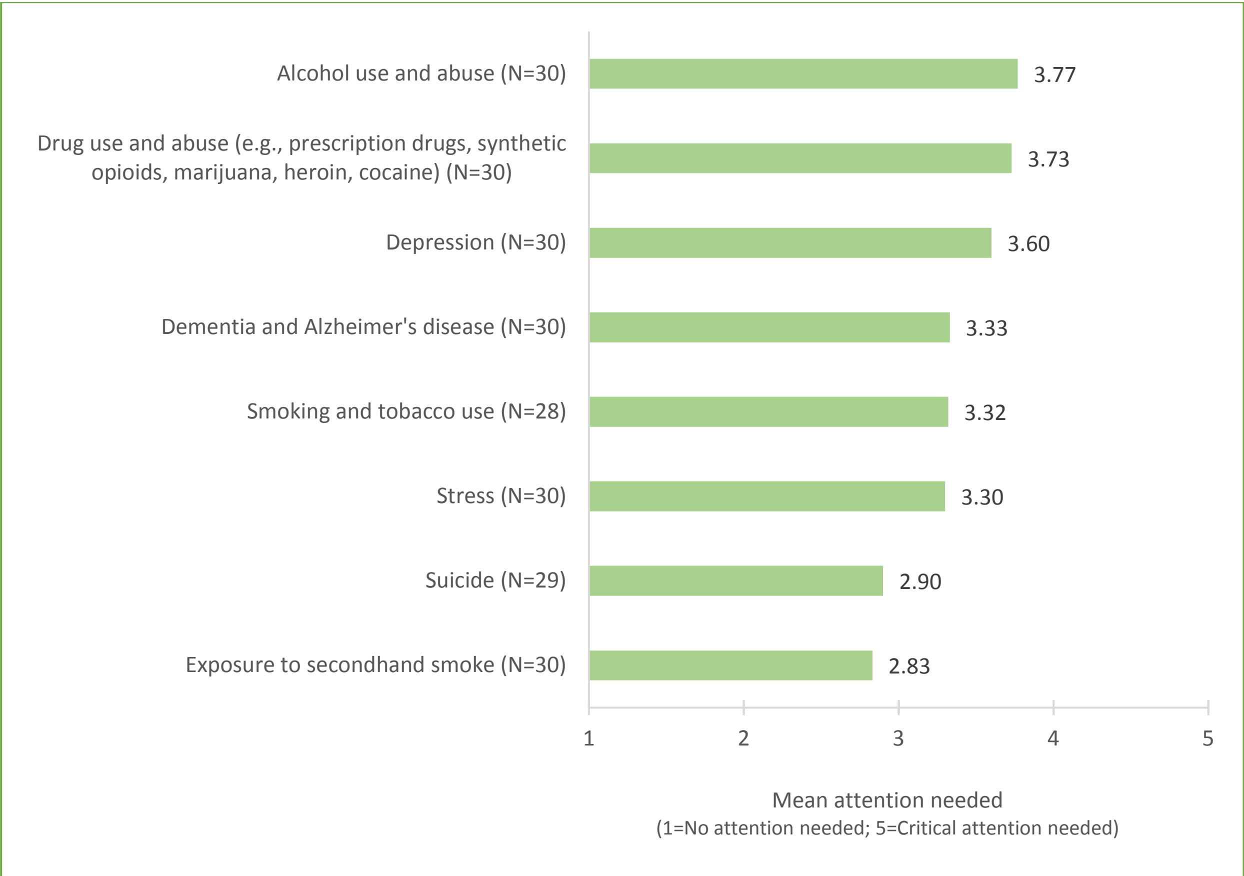


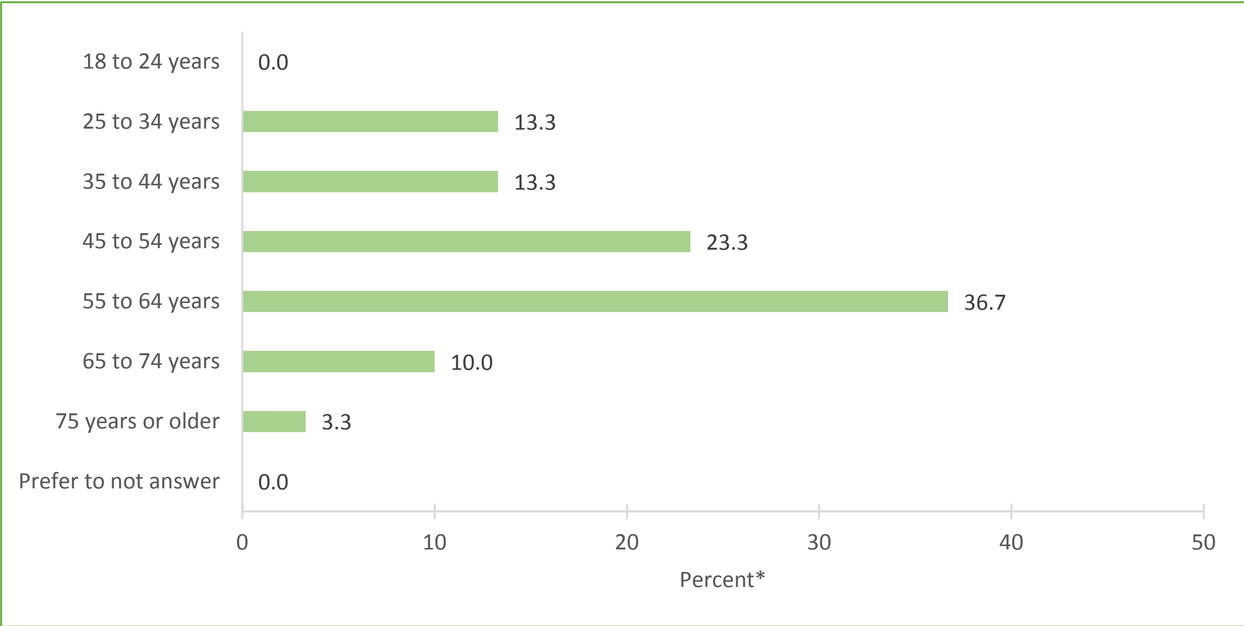
Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

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



Demographic Information

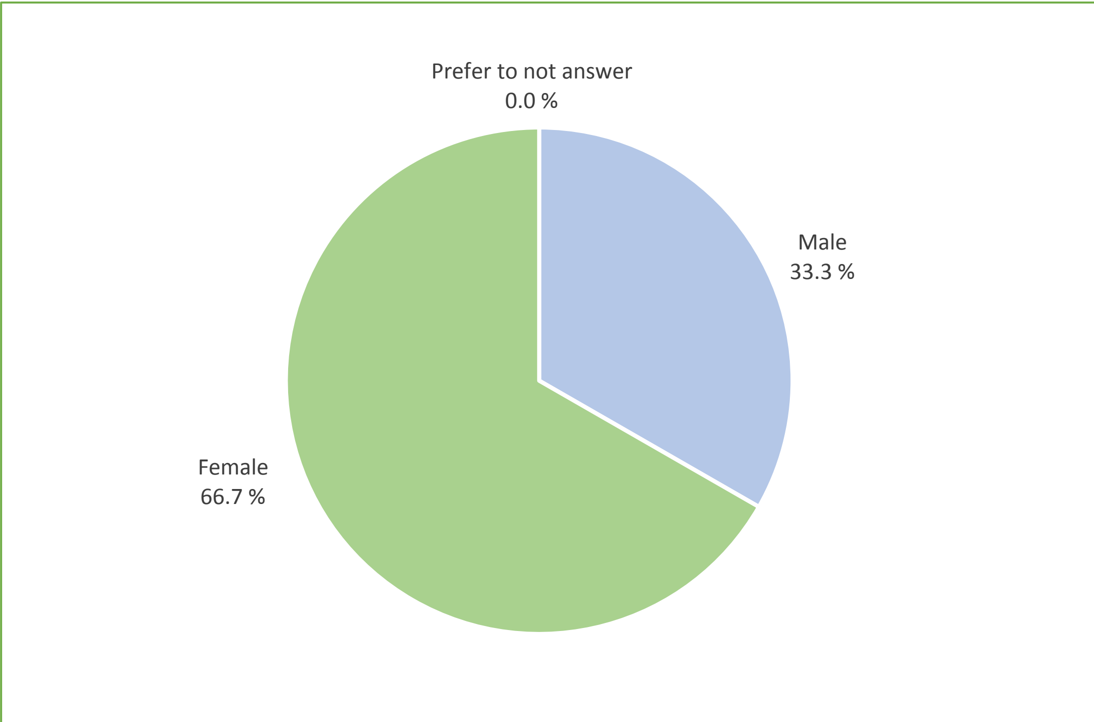
Figure 8. Age of respondents



N=30

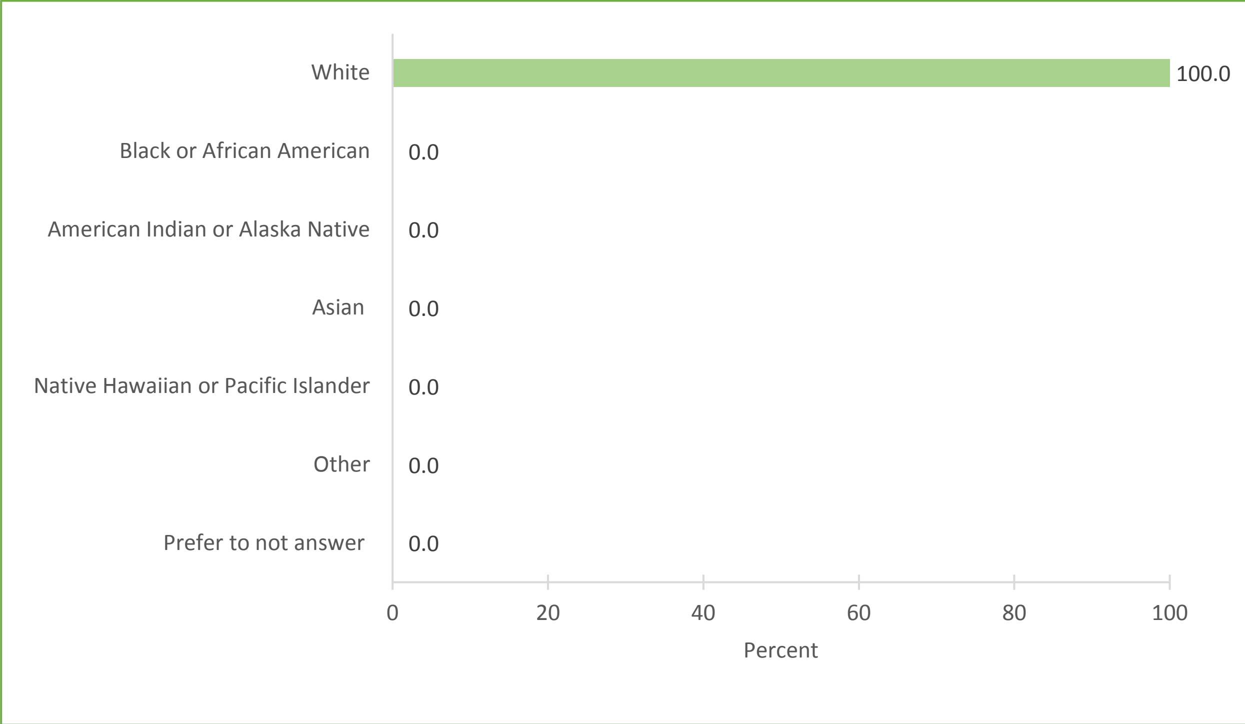
*Percentages do not total 100.0 due to rounding.

Figure 9. Biological sex of respondents



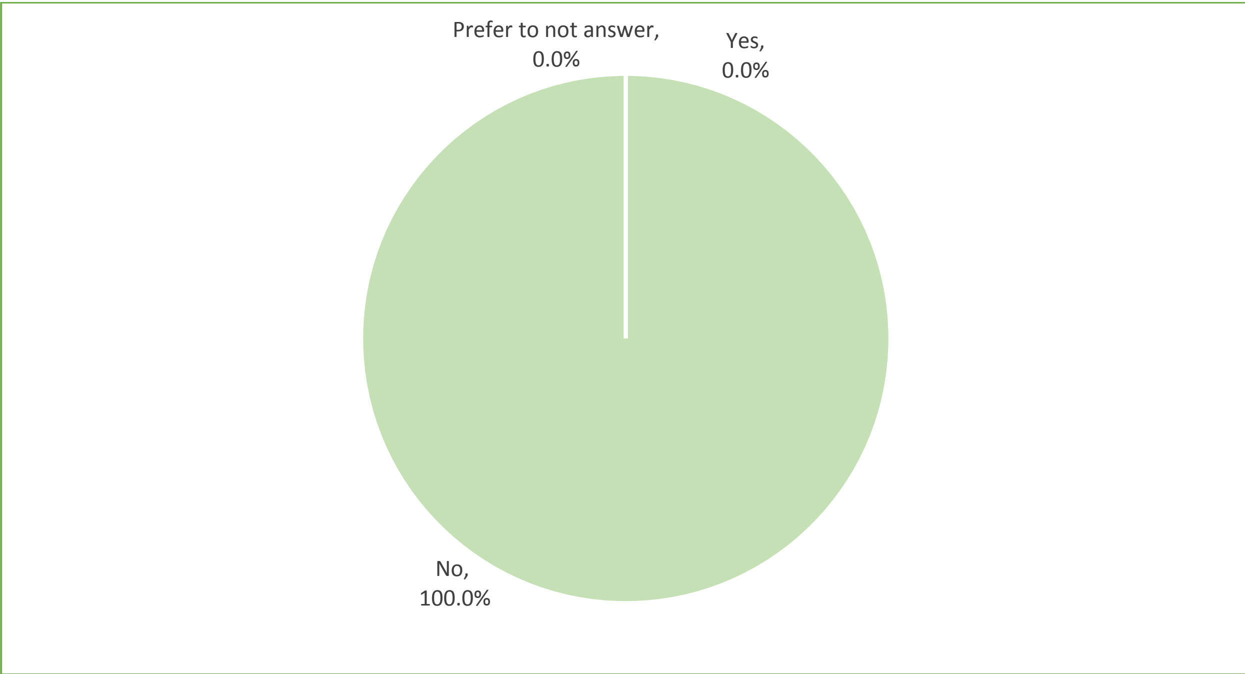
N=30

Figure 10. Race of respondents



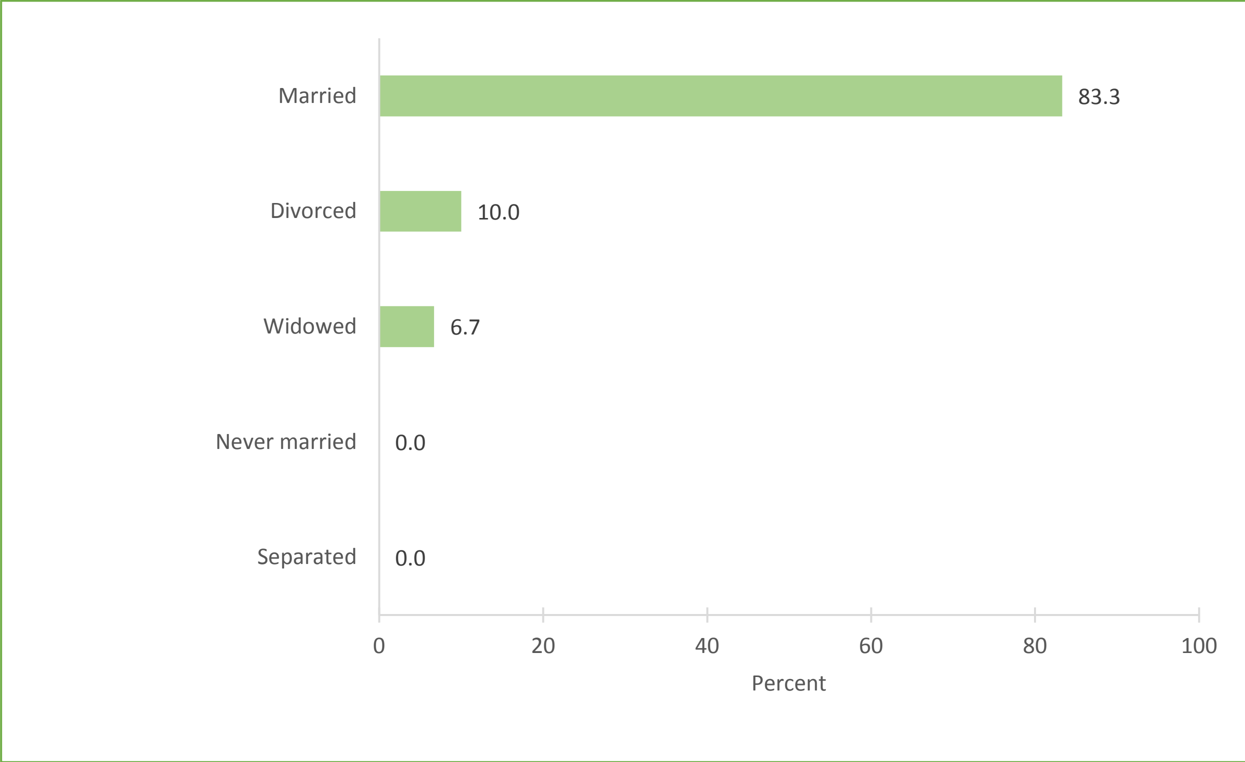
N=30

Figure 11. Whether respondents are of Hispanic or Latino origin



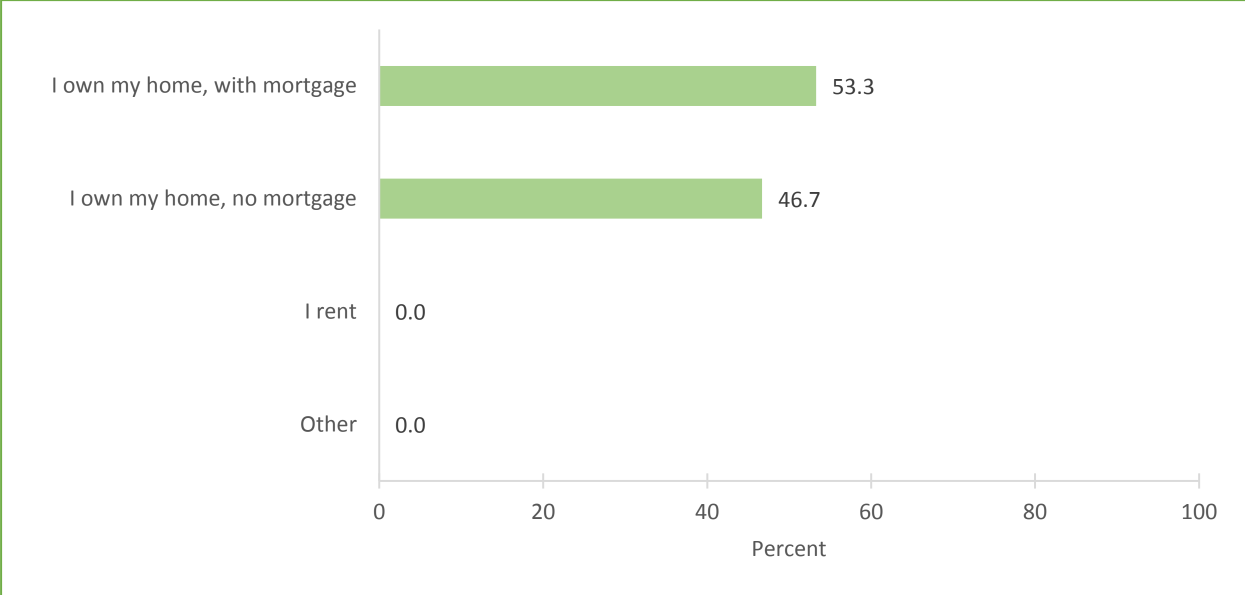
N=29

Figure 12. Marital status of respondents



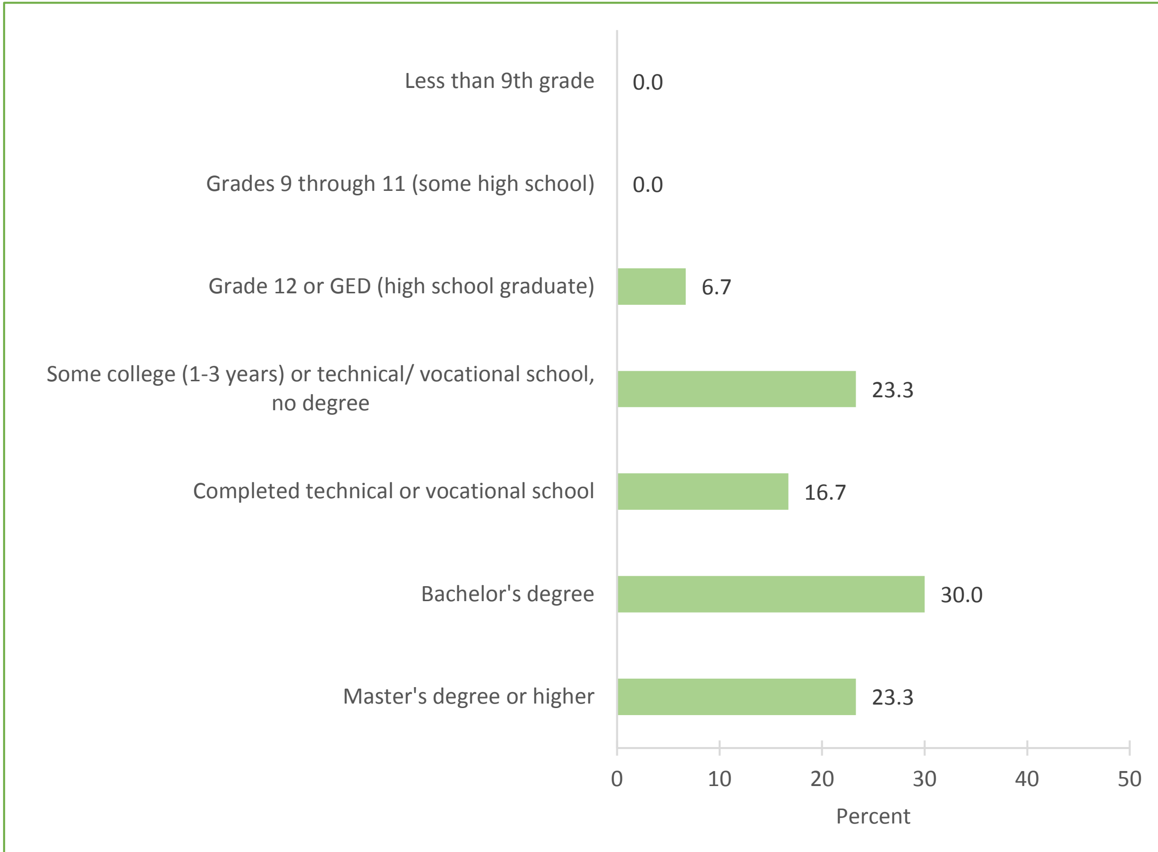
N=30

Figure 13. Living situation of respondents



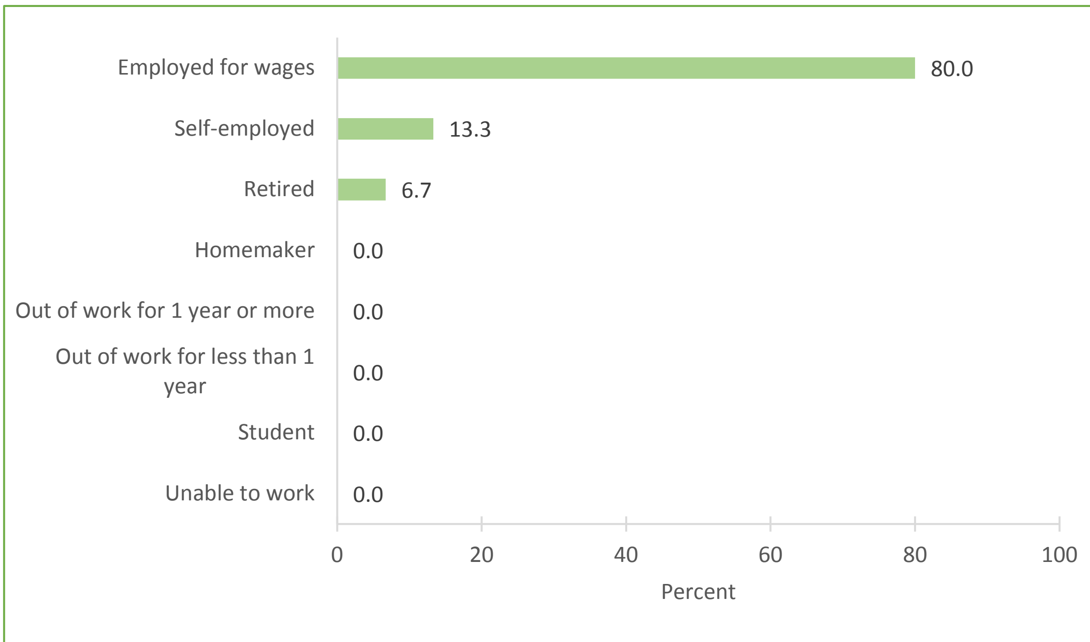
N=30

Figure 14. Highest level of education completed by respondents



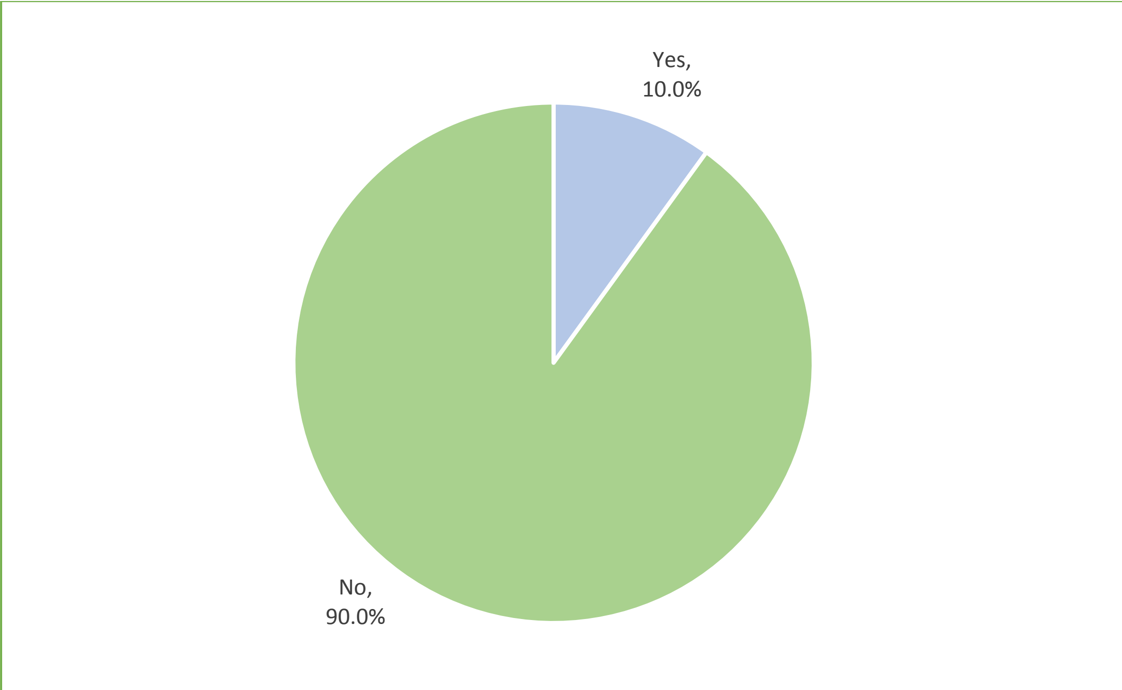
N=30

Figure 15. Employment status of respondents



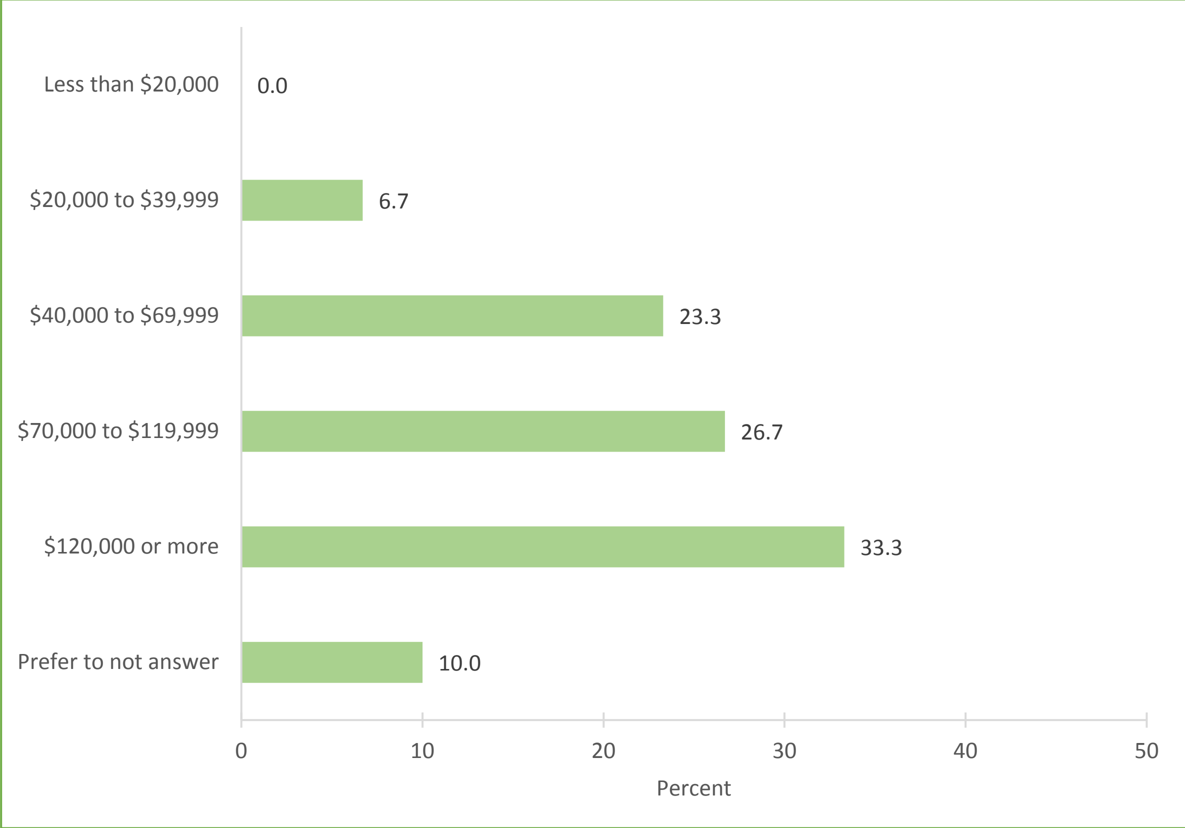
N=30

Figure 16. Whether respondents are military veterans



N=30

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



N=30

Table 1. Zip code of respondents

Zip code	Number of respondents
57274	24
57273	2
58274	1

N=27

Table 2. Comments from respondents

Comments
I think the lack of availability of good quality variety of produce is a problem.
Need for assisted living in Webster is critical, also need for nursing staff
We have an issue in Day County relating to alcohol/drug abuse and stealing. Law enforcement and the State's Attorney have little or no concern regarding these issues. Their lack of concern sends a message to the people of the county that it does no good to report a dangerous situation, as they will do nothing to help/correct this. We are experiencing an upswing in new unemployed people moving to Day County as drug seekers. Law enforcement's complete disregard for the residents' safety and concerns only make this a perfect safe place to come if you do not want to be arrested.
Yes-please, please, please get the drug problems under control. Clean up the dealers-get that element cleaned up and out of here. It is destroying our youth, our families, and the safety of everyone. Any law enforcement that doesn't take this seriously needs to be out and bring in the tougher ones. This is a number one priority. Clean up Day County.

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=33)	3.30	0.0	12.1	48.5	36.4	3.0	0.0	100.0
Employment options (N=33)	2.85	6.1	33.3	33.3	24.2	3.0	0.0	99.9
Help for renters with landlord and tenants' rights issues (N=32)	2.63	15.6	21.9	40.6	12.5	3.1	6.3	100.0
Homelessness (N=32)	1.91	18.8	71.9	9.4	0.0	0.0	0.0	100.1
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=30)	2.86	3.3	36.7	33.3	16.7	6.7	3.3	100.0
Household budgeting and money management (N=33)	3.18	3.0	21.2	39.4	27.3	9.1	0.0	100.0
Hunger (N=32)	2.91	3.1	25.0	53.1	15.6	3.1	0.0	99.9
Maintaining livable and energy efficient homes (N=33)	3.21	0.0	15.2	57.6	18.2	9.1	0.0	100.1
Skilled labor workforce (N=33)	3.18	3.0	15.2	57.6	9.1	15.2	0.0	100.1
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=33)	2.27	18.2	42.4	33.3	6.1	0.0	0.0	100.0
Availability of public transportation (N=33)	2.60	15.2	27.3	30.3	15.2	3.0	9.1	100.1
Availability of walking and biking options (N=33)	2.97	3.0	33.3	33.3	24.2	6.1	0.0	99.9
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=32)	2.22	18.8	50.0	21.9	9.4	0.0	0.0	100.1
Cost of public transportation (N=33)	2.17	18.2	45.5	15.2	9.1	0.0	12.1	100.1
Driving habits (e.g., speeding, road rage) (N=32)	2.53	6.3	43.8	40.6	9.4	0.0	0.0	100.1
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=30)	3.03	10.0	10.0	50.0	26.7	3.3	0.0	100.0
Availability of education about birth control (N=30)	3.04	3.3	20.0	40.0	23.3	3.3	10.0	99.9
Availability of quality childcare (N=30)	3.03	6.7	20.0	40.0	30.0	3.3	0.0	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth	3.30	0.0	13.3	50.0	30.0	6.7	0.0	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=30)								
Bullying (N=30)	3.47	0.0	6.7	53.3	26.7	13.3	0.0	100.0
Childhood obesity (N=30)	3.57	0.0	3.3	50.0	33.3	13.3	0.0	99.9
Cost of activities (outside of school and sports) for children and youth (N=29)	2.89	3.4	27.6	41.4	24.1	0.0	3.4	99.9
Cost of quality child care (N=30)	2.86	10.0	26.7	26.7	33.3	0.0	3.3	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=30)	2.96	3.3	23.3	36.7	26.7	0.0	10.0	100.0
Crime committed by youth (N=30)	2.93	0.0	40.0	30.0	26.7	3.3	0.0	100.0
Opportunities for youth-adult mentoring (N=30)	3.23	0.0	30.0	26.7	33.3	10.0	0.0	100.0
Parental custody, guardianships and visitation rights (N=28)	2.69	0.0	42.9	39.3	7.1	3.6	7.1	100.0
School absenteeism (truancy) (N=27)	2.44	7.4	48.1	37.0	7.4	0.0	0.0	99.9
School dropout rates (N=26)	2.23	11.5	61.5	19.2	7.7	0.0	0.0	99.9
School violence (N=27)	2.07	11.1	74.1	11.1	3.7	0.0	0.0	100.0
Substance abuse by youth (N=29)	3.48	0.0	13.8	44.8	20.7	20.7	0.0	100.0
Teen pregnancy (N=28)	2.74	0.0	39.3	46.4	7.1	3.6	3.6	100.0
Teen suicide (N=28)	2.69	3.6	35.7	39.3	14.3	0.0	7.1	100.0
Teen tobacco use (N=27)	3.08	0.0	37.0	29.6	14.8	14.8	3.7	99.9
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=30)	3.20	0.0	23.3	36.7	36.7	3.3	0.0	100.0
Availability of long-term care (N=30)	2.87	10.0	16.7	56.7	10.0	6.7	0.0	100.1
Availability of memory care (N=29)	3.45	0.0	17.2	34.5	34.5	13.8	0.0	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g. home care, home health) (N=30)	3.37	3.3	13.3	30.0	50.0	3.3	0.0	99.9
Availability of resources for grandparents caring for grandchildren (N=30)	3.17	3.3	13.3	46.7	30.0	3.3	3.3	99.9
Availability of resources to help the elderly stay safe in their homes (N=30)	3.10	3.3	20.0	43.3	30.0	3.3	0.0	99.9
Cost of activities for seniors (e.g., recreational, social, cultural) (N=30)	2.76	3.3	40.0	30.0	23.3	0.0	3.3	99.9
Cost of in-home services (N=30)	3.34	3.3	10.0	46.7	23.3	13.3	3.3	99.9
Cost of long-term care (N=30)	3.62	3.3	6.7	40.0	20.0	26.7	3.3	100.0
Cost of memory care (N=29)	3.46	3.4	6.9	41.4	20.7	17.2	10.3	99.9
Help making out a will or healthcare directive (N=29)	2.82	6.9	27.6	41.4	17.2	3.4	3.4	99.9

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
SAFETY								
Abuse of prescription drugs (N=29)	3.48	0.0	17.2	31.0	37.9	13.8	0.0	99.9
Availability of emergency medical services (N=30)	2.10	33.3	26.7	36.7	3.3	0.0	0.0	100.0
Child abuse and neglect (N=29)	3.11	3.4	17.2	48.3	20.7	6.9	3.4	99.9
Criminal activity (N=30)	3.23	0.0	16.7	50.0	26.7	6.7	0.0	100.1
Culture of excessive and binge drinking (N=30)	3.69	0.0	16.7	16.7	43.3	20.0	3.3	100.0
Domestic violence (N=29)	3.28	0.0	20.7	37.9	34.5	6.9	0.0	100.0
Elder abuse (N=30)	2.66	6.7	36.7	40.0	10.0	3.3	3.3	100.0
Lack of police or delayed response of police (N=30)	2.89	6.7	36.7	20.0	20.0	10.0	6.7	100.1
Presence of drug dealers (N=30)	3.53	3.3	13.3	30.0	33.3	20.0	0.0	99.9
Presence of gang activity (N=27)	1.92	29.6	40.7	14.8	3.7	0.0	11.1	99.9
Presence of street drugs (N=30)	3.80	0.0	16.7	13.3	43.3	26.7	0.0	100.0
Sex trafficking (N=29)	2.44	13.8	41.4	24.1	10.3	3.4	6.9	99.9
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=30)	2.93	10.0	20.0	40.0	20.0	6.7	3.3	100.0
Access to affordable health insurance coverage (N=30)	3.40	6.7	13.3	30.0	33.3	16.7	0.0	100.0
Access to affordable health care (N=30)	3.10	10.0	16.7	40.0	20.0	13.3	0.0	100.0
Access to affordable prescription drugs (N=30)	3.20	10.0	13.3	36.7	26.7	13.3	0.0	100.0
Access to affordable vision insurance coverage (N=30)	3.03	6.7	20.0	36.7	30.0	3.3	3.3	100.0
Access to technology for health records and health education (N=30)	2.21	20.0	46.7	23.3	3.3	3.3	3.3	99.9
Availability of behavioral health (substance abuse) providers (N=30)	3.76	0.0	16.7	23.3	23.3	33.3	3.3	99.9
Availability of doctors, physician assistants, or nurse practitioners (N=30)	2.03	30.0	40.0	26.7	3.3	0.0	0.0	100.0
Availability of health care services for Native people (N=28)	2.62	17.9	35.7	14.3	14.3	10.7	7.1	100.0
Availability of health care services for New Americans (N=29)	2.52	17.2	27.6	27.6	6.9	6.9	13.8	100.0
Availability of mental health providers (N=30)	3.66	6.7	10.0	23.3	26.7	30.0	3.3	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=30)	2.55	13.3	40.0	26.7	10.0	6.7	3.3	100.0
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=30)	2.76	10.0	36.7	26.7	13.3	10.0	3.3	100.0
Availability of specialist physicians (N=30)	2.79	10.0	36.7	26.7	10.0	13.3	3.3	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Coordination of care between providers and services (N=30)	2.33	20.0	43.3	26.7	3.3	6.7	0.0	100.0
Timely access to medical care providers (N=30)	1.90	43.3	33.3	16.7	3.3	3.3	0.0	99.9
Timely access to dental care providers (N=29)	2.55	17.2	37.9	24.1	13.8	6.9	0.0	99.9
Timely access to vision care providers (N=29)	2.38	24.1	34.5	24.1	13.8	3.4	0.0	99.9
Use of emergency room services for primary healthcare (N=30)	2.93	16.7	23.3	26.7	16.7	16.7	0.0	100.1
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=30)	3.77	0.0	6.7	23.3	56.7	13.3	0.0	100.0
Dementia and Alzheimer's disease (N=30)	3.33	0.0	13.3	40.0	46.7	0.0	0.0	100.0
Depression (N=30)	3.60	0.0	3.3	40.0	50.0	6.7	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=30)	3.73	0.0	10.0	26.7	43.3	20.0	0.0	100.0
Exposure to secondhand smoke (N=30)	2.83	10.0	26.7	36.7	23.3	3.3	0.0	100.0
Smoking and tobacco use (N=28)	3.32	0.0	17.9	35.7	42.9	3.6	0.0	100.1
Stress (N=30)	3.30	0.0	16.7	40.0	40.0	3.3	0.0	100.0
Suicide (N=29)	2.90	0.0	31.0	48.3	20.7	0.0	0.0	100.0

*Percentages may not total 100.0 due to rounding.

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

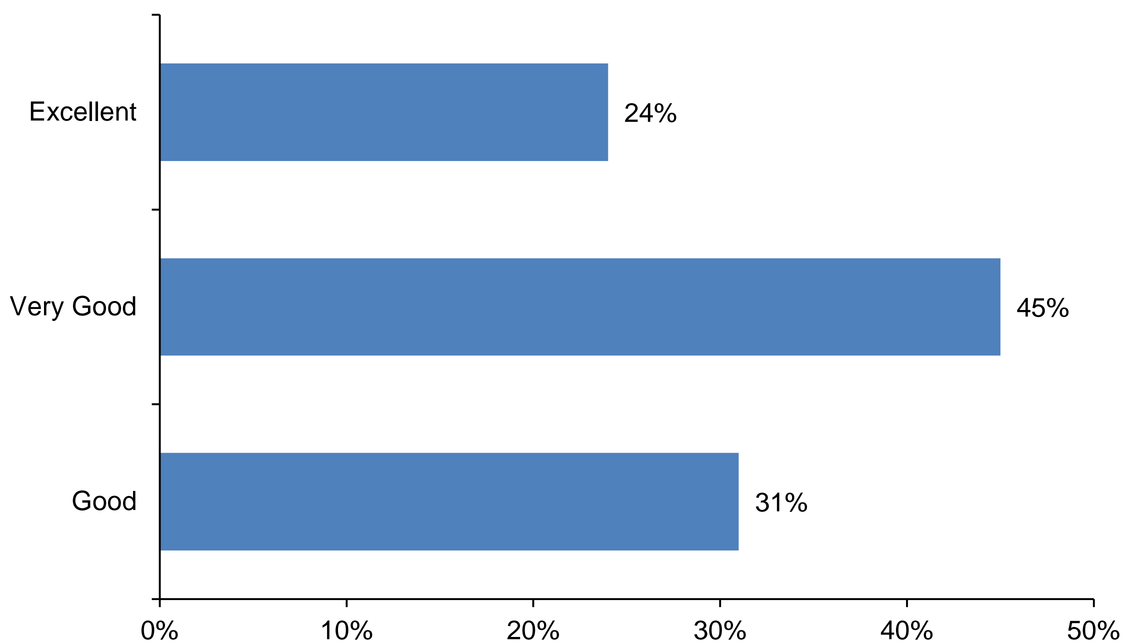
Resident Survey

Webster CHNA Survey Report

March 08, 2018

Charts Exported by MarketSight®

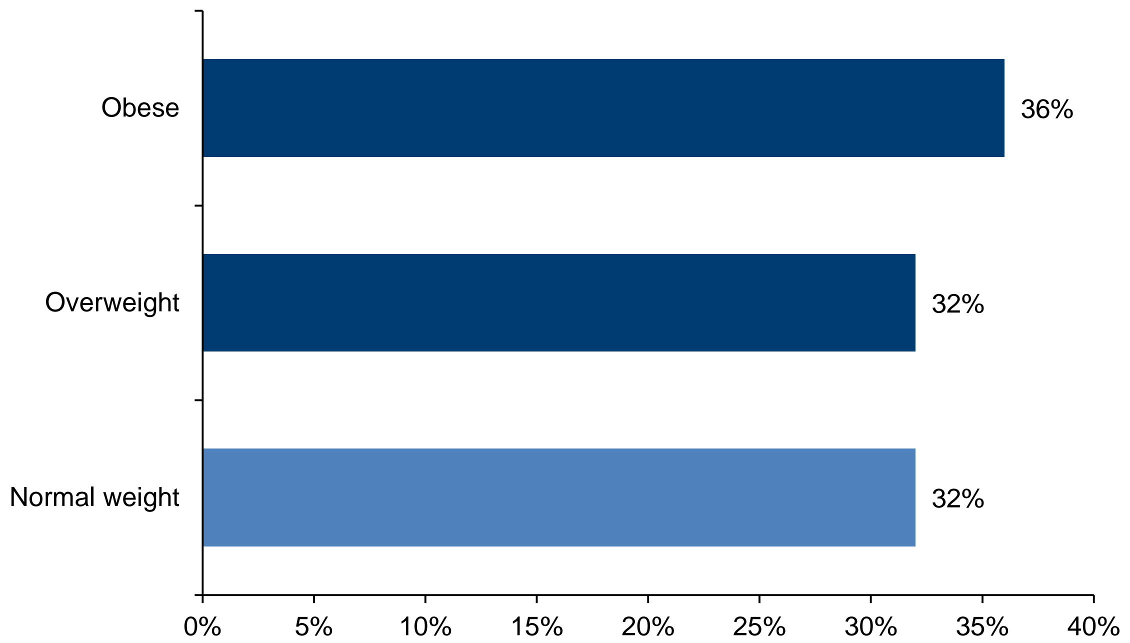
How would you rate your health?



Base: Good (n=9), Very Good (n=13), Excellent (n=7), Sample Size = 29

(Community = Day)

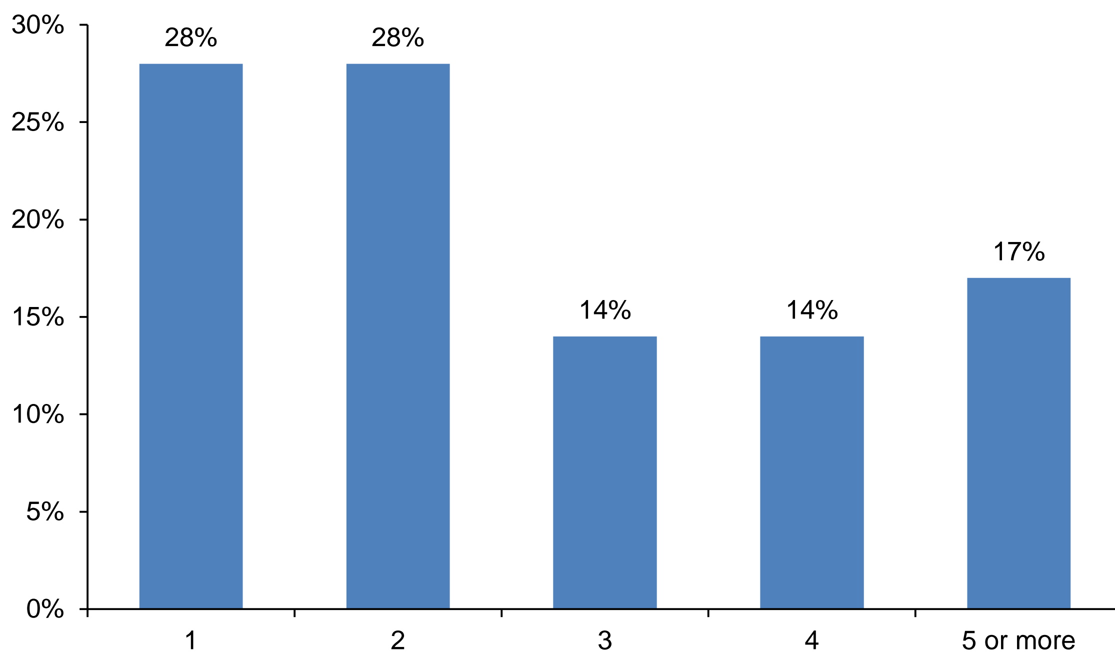
BMI



Base: Normal weight (n=9), Overweight (n=9), Obese (n=10), Sample Size = 28

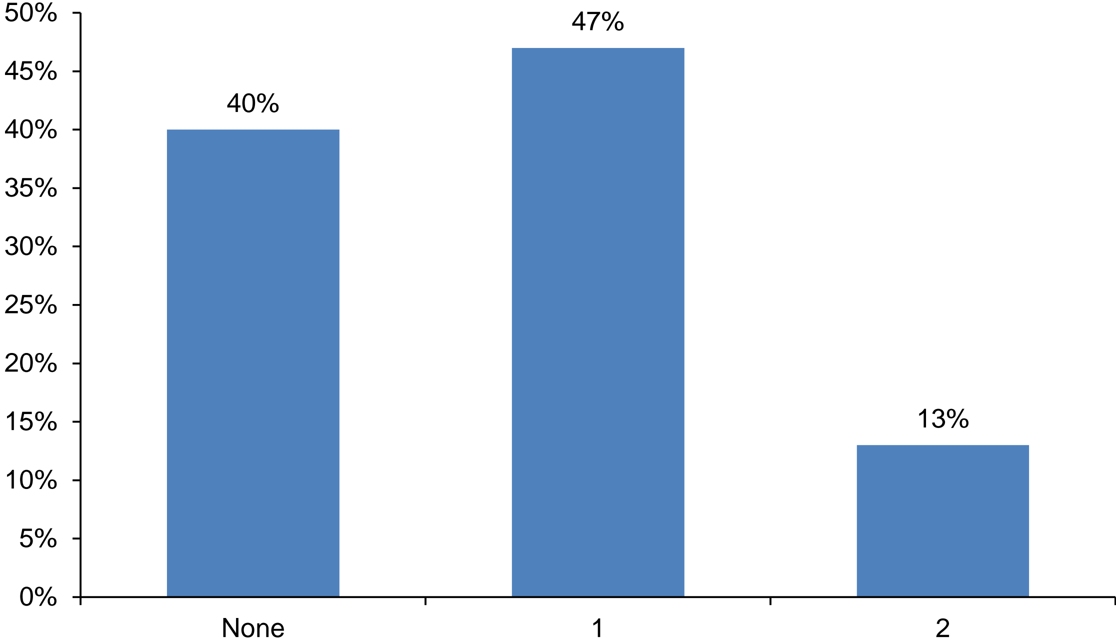
(Community = Day)

Servings of Vegetables



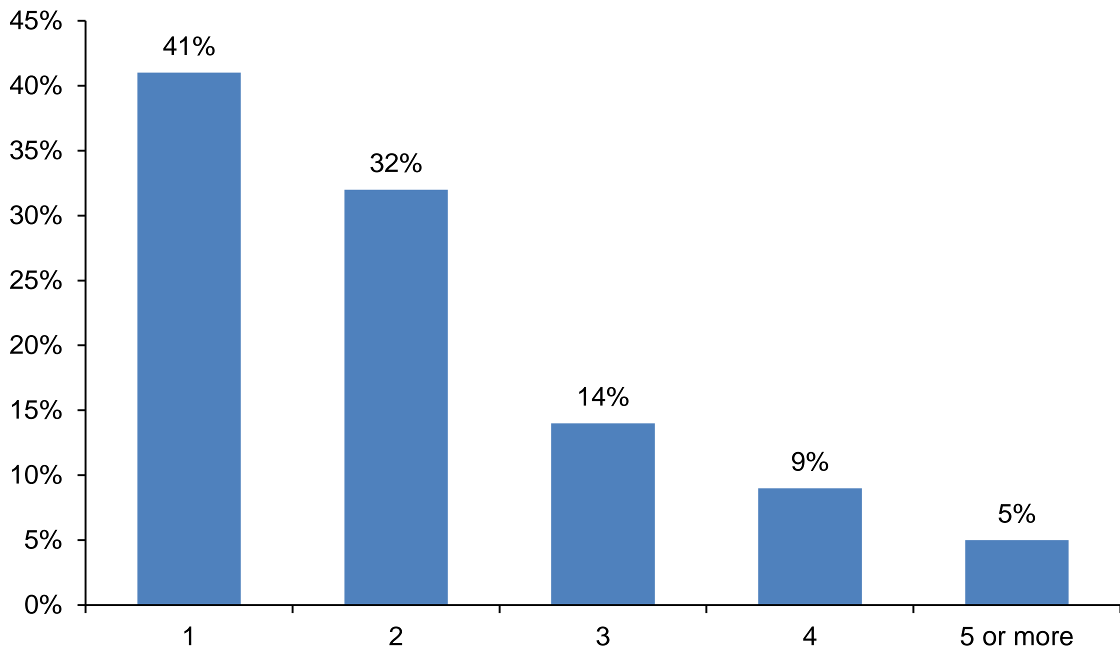
Base: 1 (n=8), 2 (n=8), 3 (n=4), 4 (n=4), 5 or more (n=5), Sample Size = 29

(Community = Day)



Base: None (n=6), 1 (n=7), 2 (n=2), Sample Size = 15

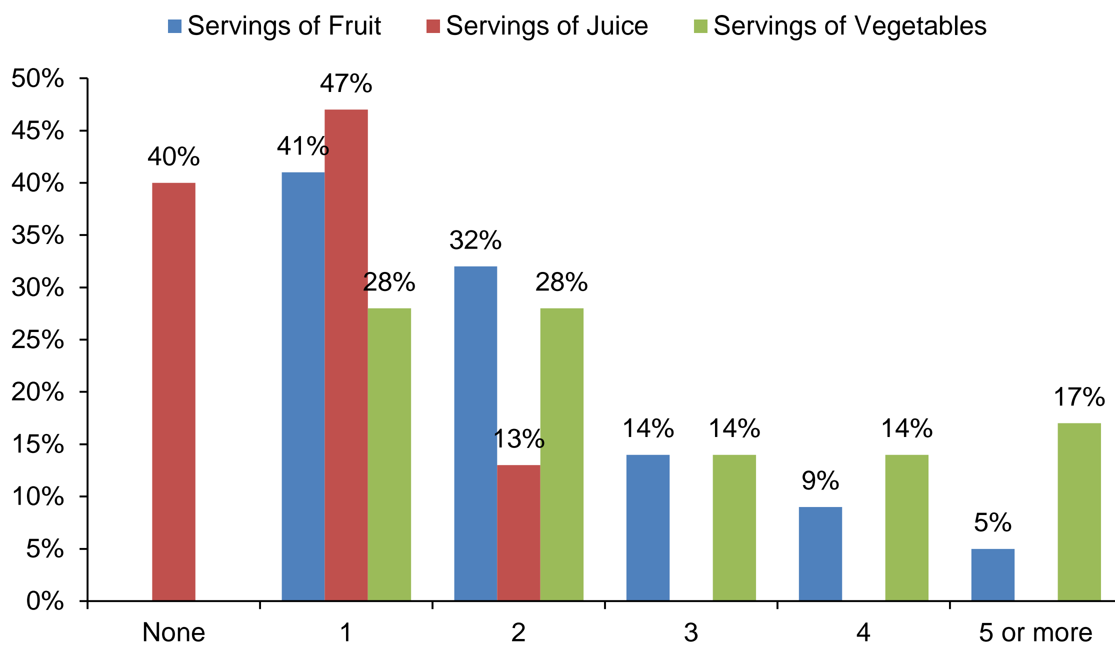
(Community = Day)



Base: 1 (n=9), 2 (n=7), 3 (n=3), 4 (n=2), 5 or more (n=1), Sample Size = 22

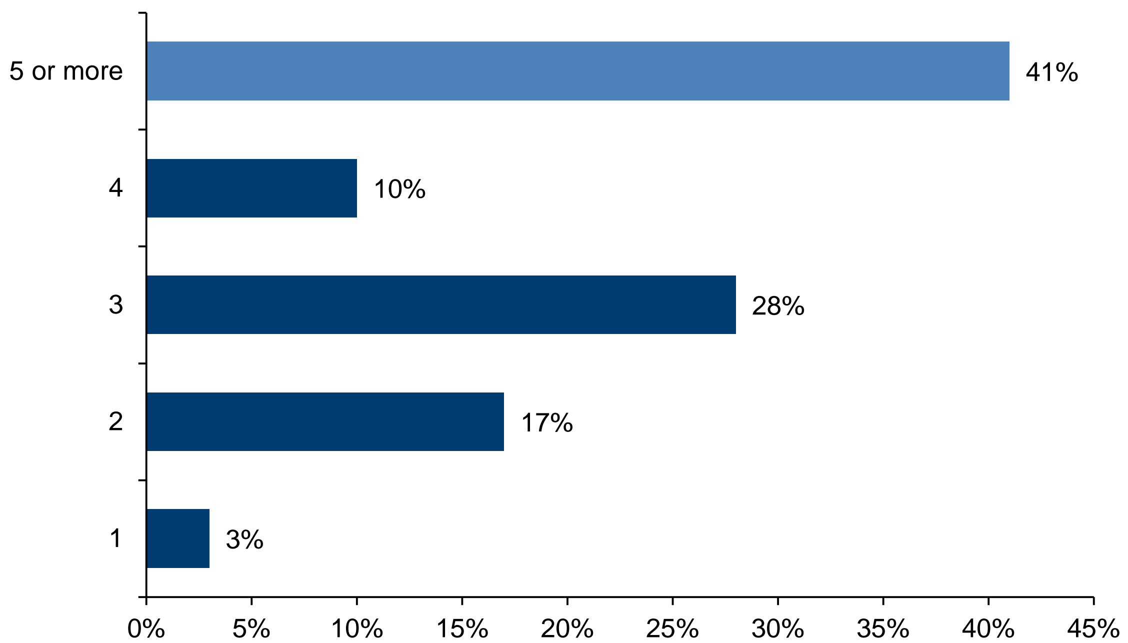
(Community = Day)

Servings of Fruit, Vegetables and Juice



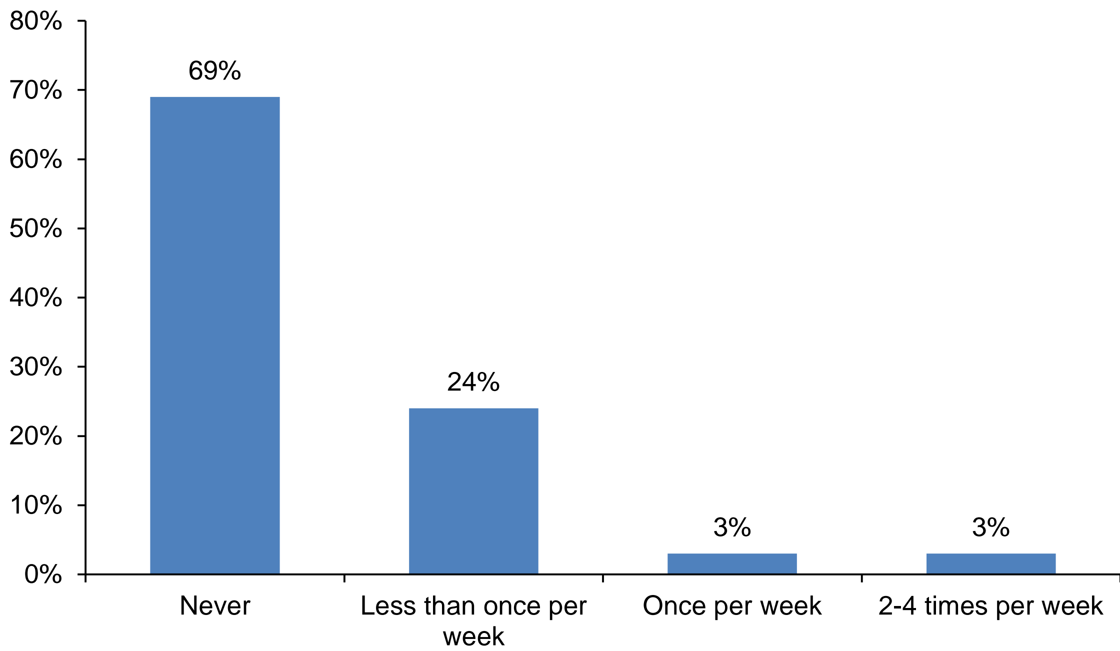
Sample Size = Variable

(Community = Day)



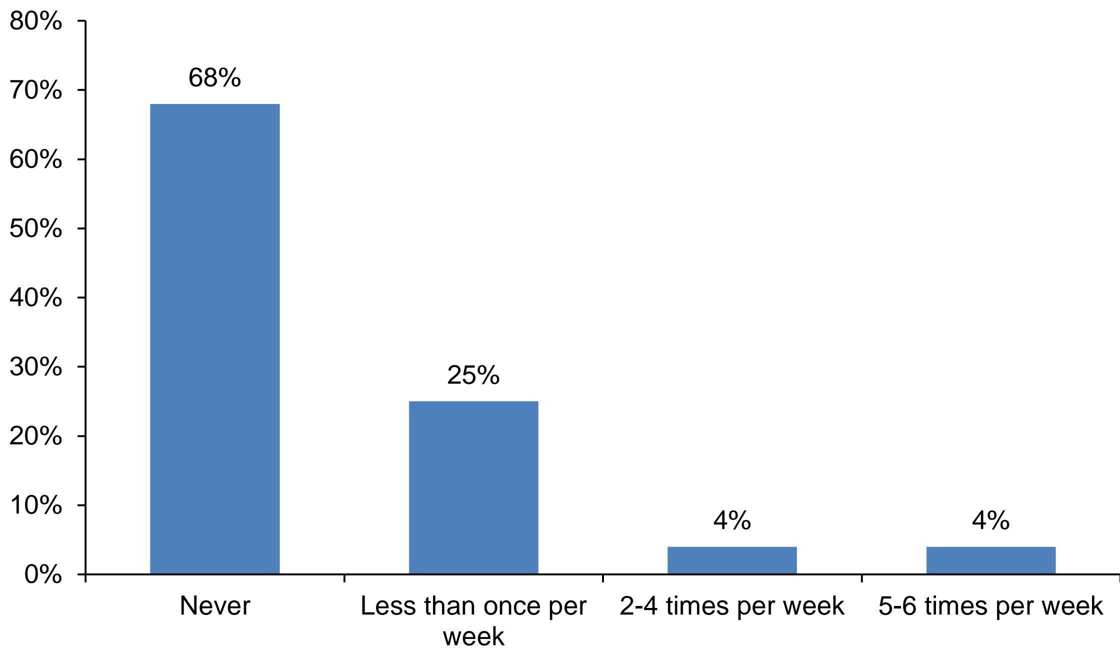
Base: 1 (n=1), 2 (n=5), 3 (n=8), 4 (n=3), 5 or more (n=12), Sample Size = 29

(Community = Day)



Base: Never (n=20), Less than once per week (n=7), Once per week (n=1), 2-4 times per week (n=1), Sample Size = 29

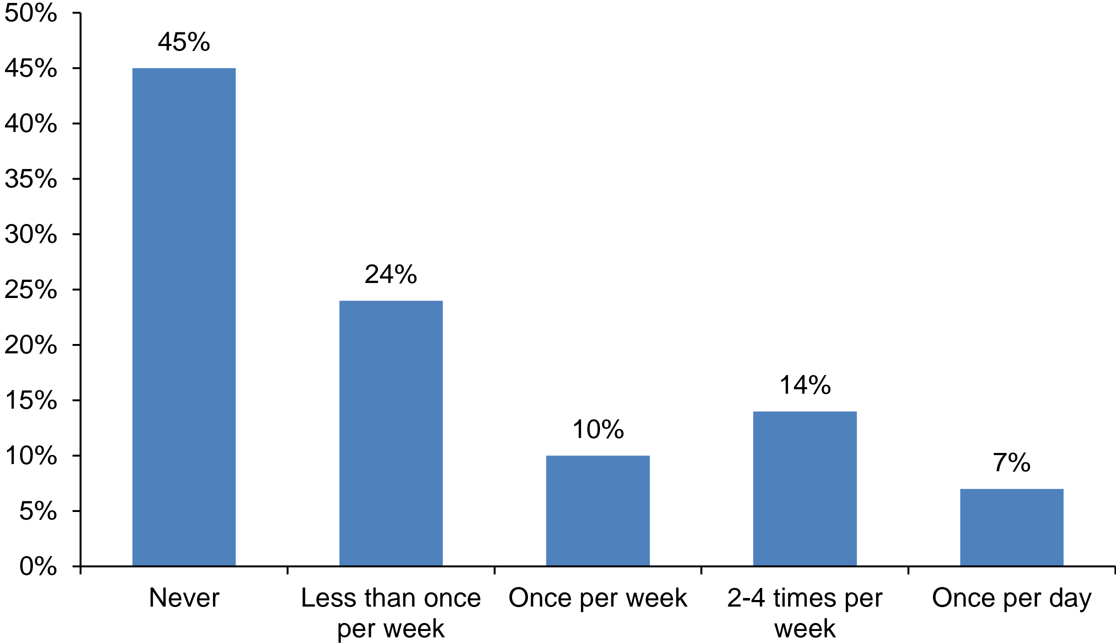
(Community = Day)



Base: Never (n=19), Less than once per week (n=7), 2-4 times per week (n=1), 5-6 times per week (n=1), Sample Size = 28

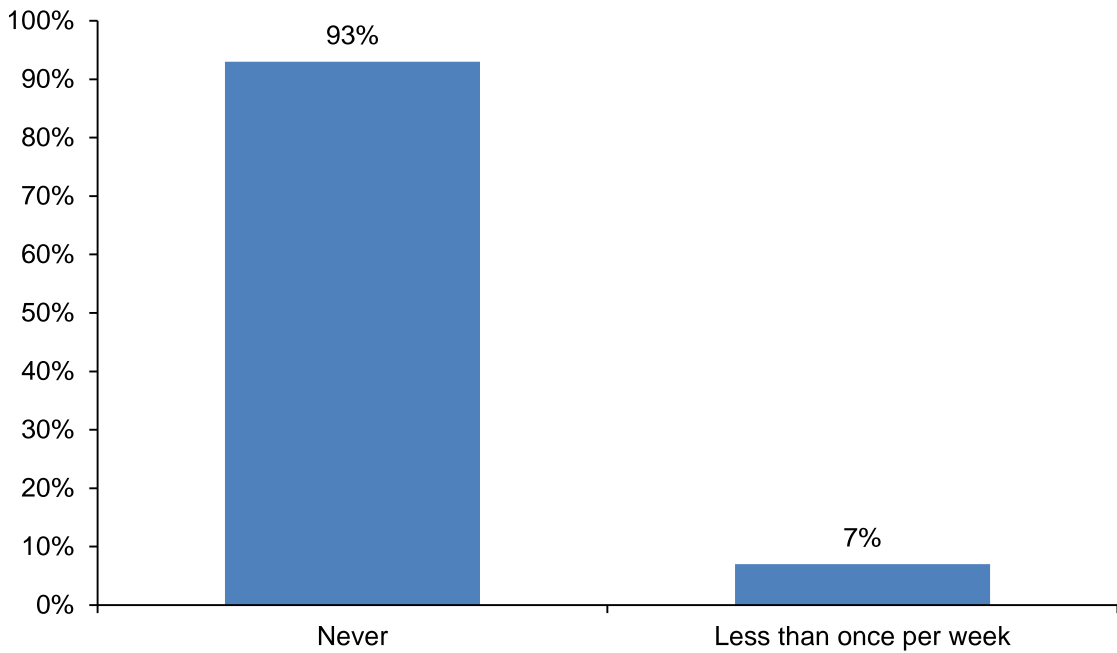
(Community = Day)

Soda or Pop



Base: Never (n=13), Less than once per week (n=7), Once per week (n=3), 2-4 times per week (n=4), Once per day (n=2), Sample Size = 29

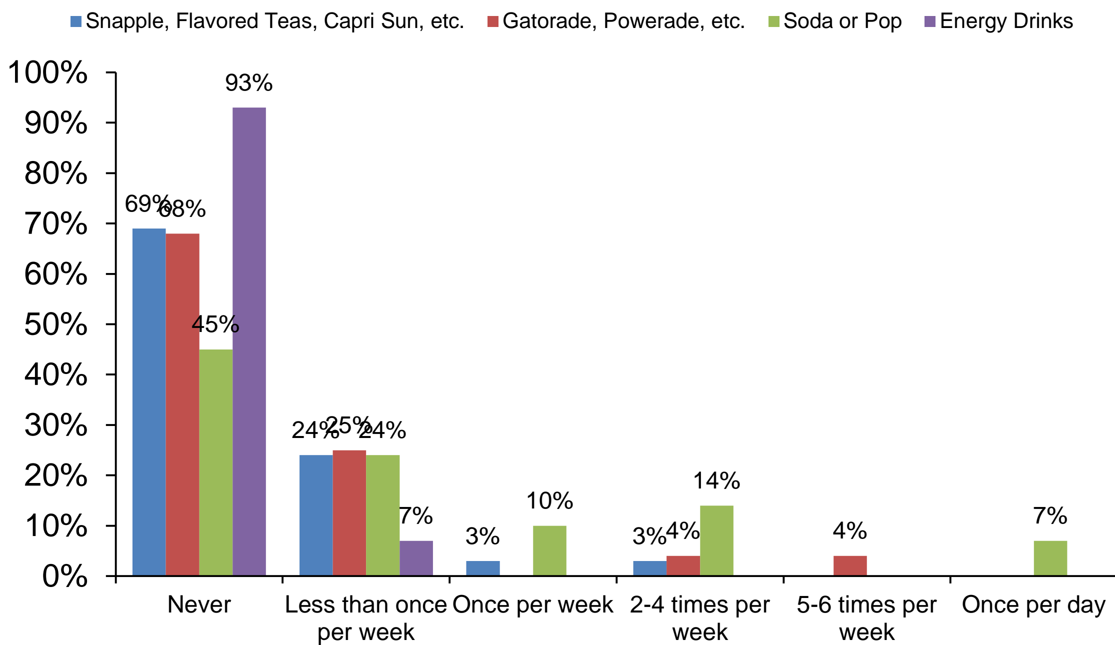
(Community = Day)



Base: Never (n=25), Less than once per week (n=2), Sample Size = 27

(Community = Day)

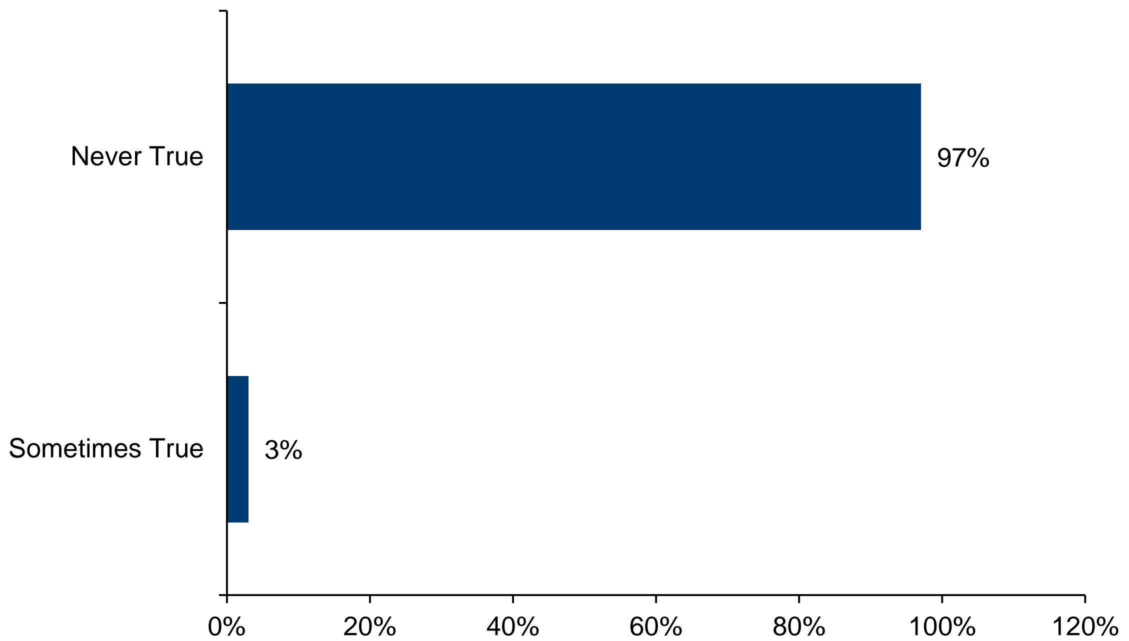
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Day)

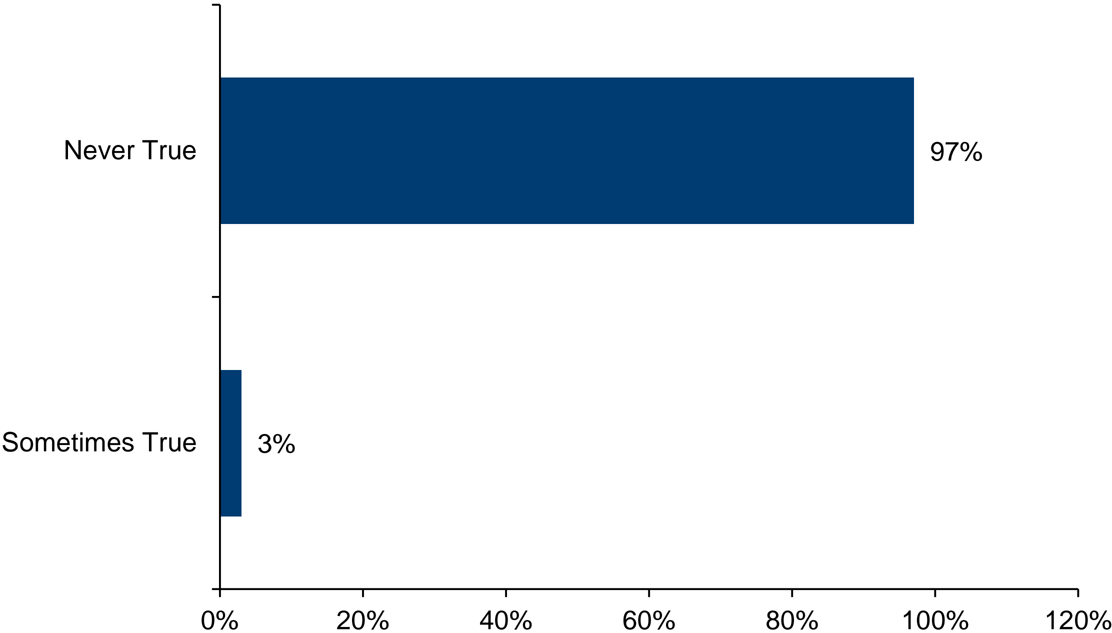
Worried whether our food would run out before we got money to buy more.



Base: Sometimes True (n=1), Never True (n=28), Sample Size = 29

(Community = Day)

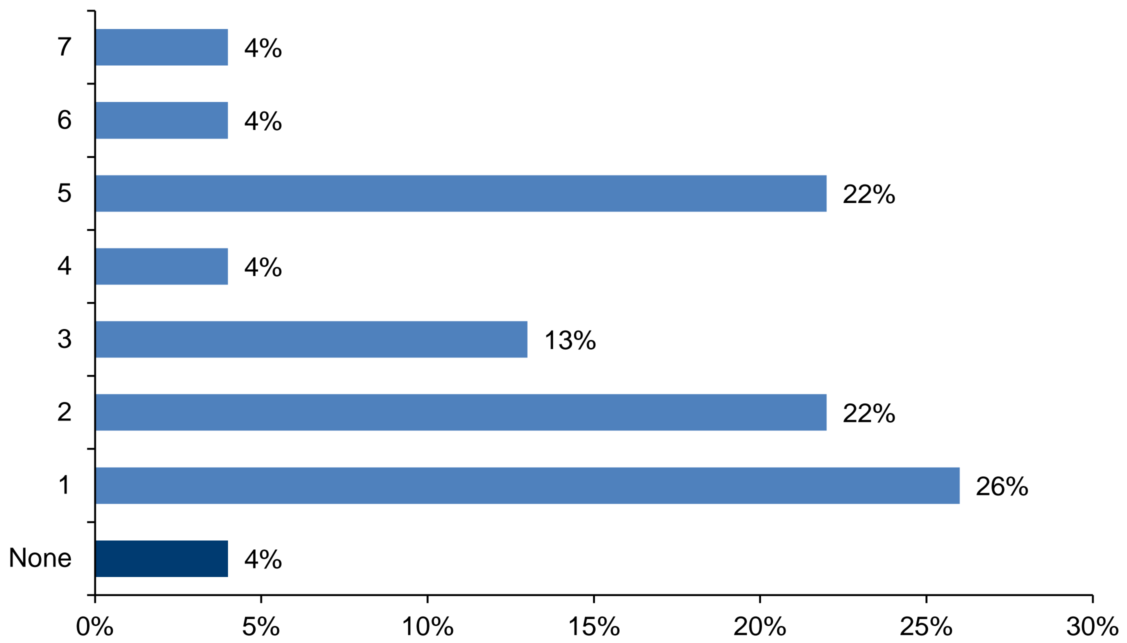
The food that we bought just didn't last, and we didn't have money to get more.



Base: Sometimes True (n=1), Never True (n=28), Sample Size = 29

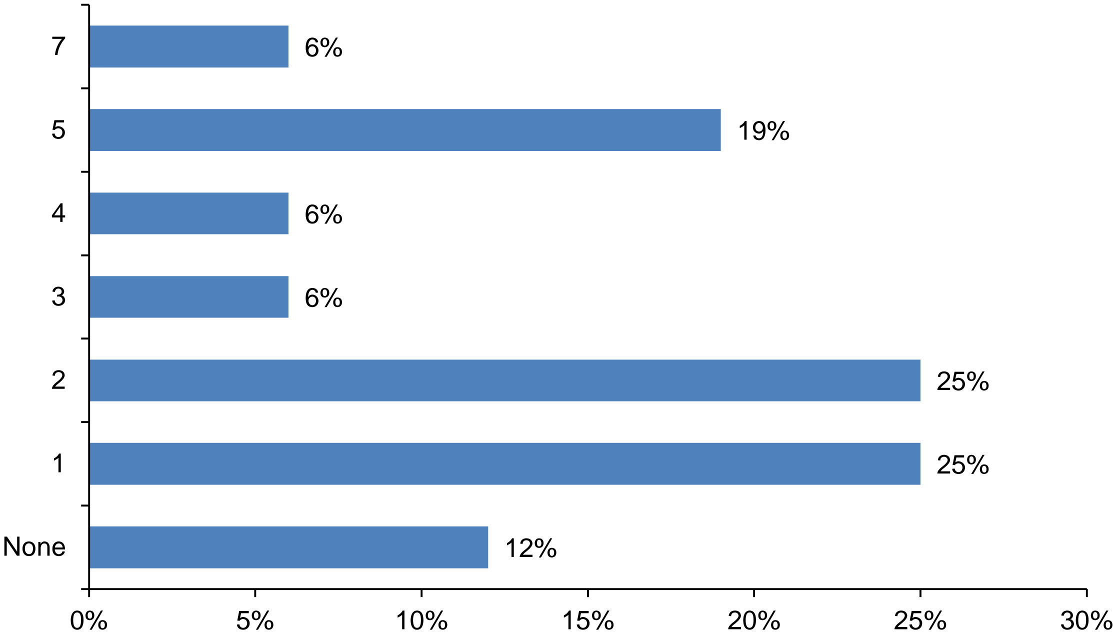
(Community = Day)

Days Per Week of Moderate Physical Activity



Base: None (n=1), 1 (n=6), 2 (n=5), 3 (n=3), 4 (n=1), 5 (n=5), 6 (n=1), 7 (n=1), Sample Size = 23

(Community = Day)

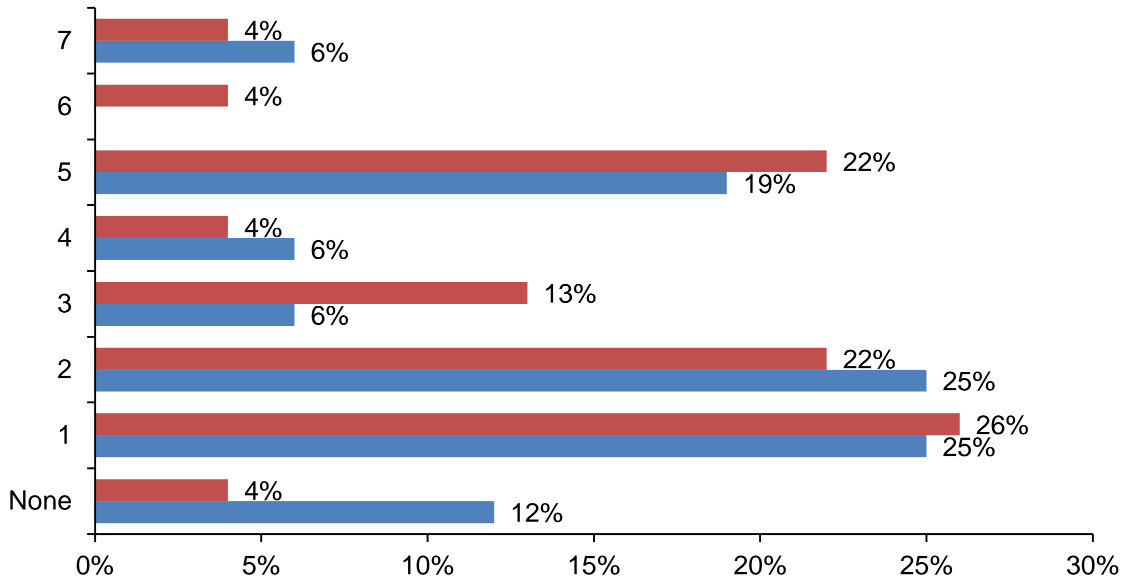


Base: None (n=2), 1 (n=4), 2 (n=4), 3 (n=1), 4 (n=1), 5 (n=3), 7 (n=1), Sample Size = 16

(Community = Day)

Days Per Week of Physical Activity

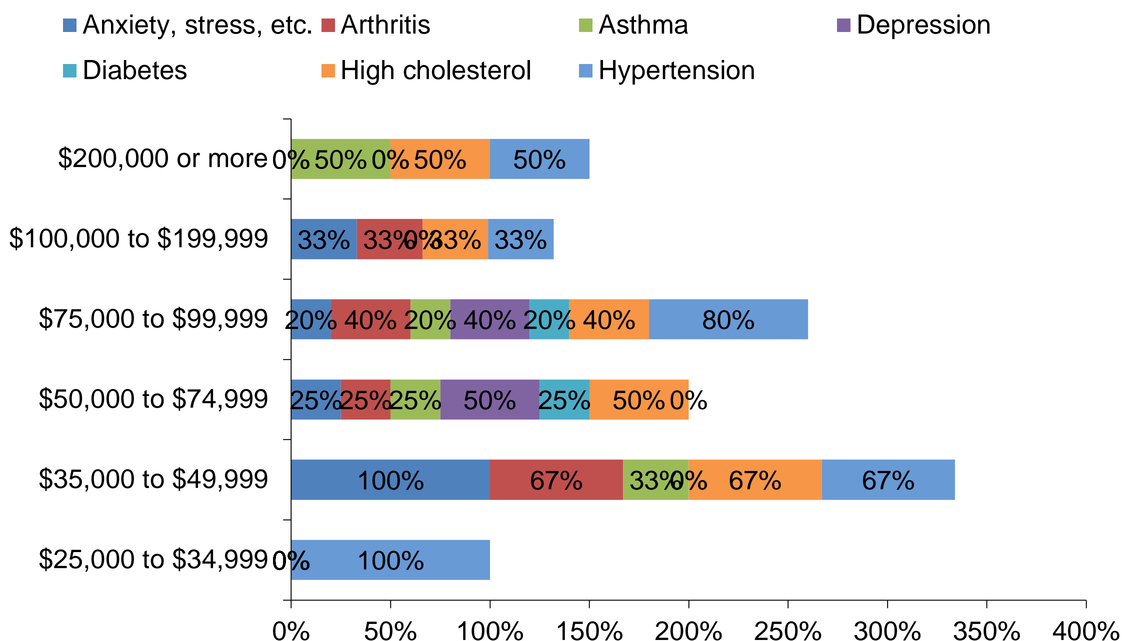
Moderate Activity Vigorous Activity



Sample Size = Variable

(Community = Day)

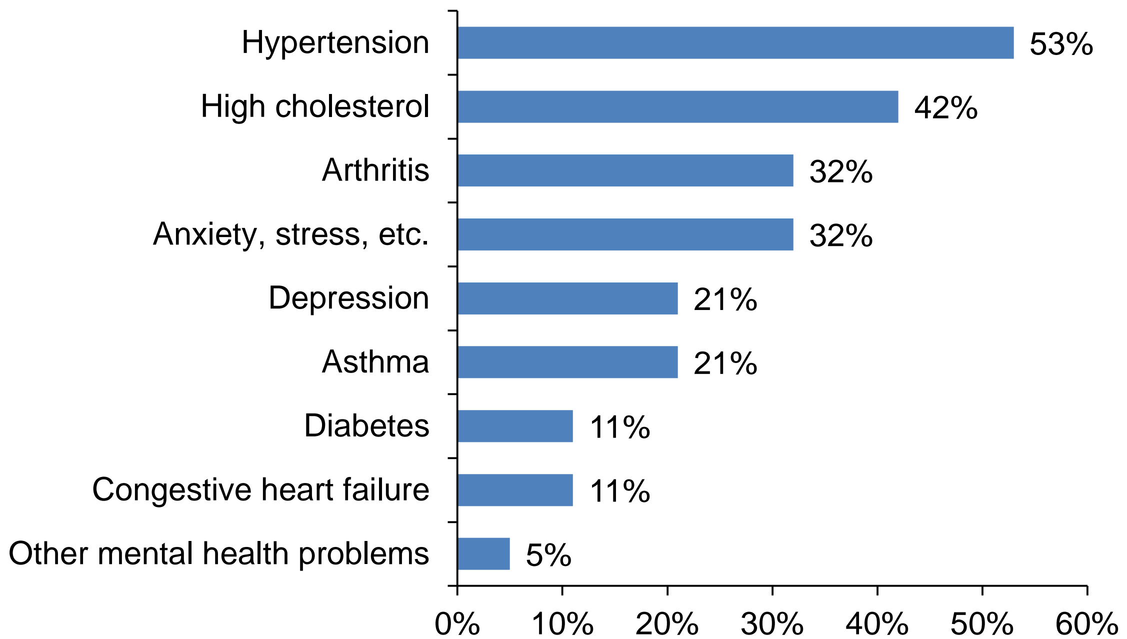
Past Diagnosis by Total Household Income



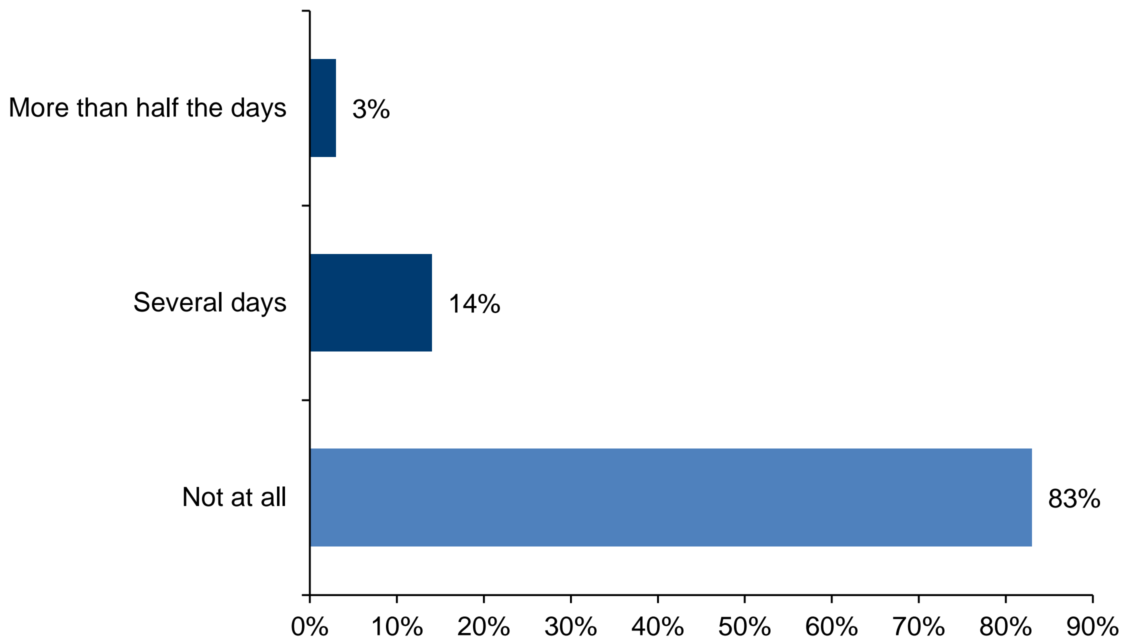
Base: $25,000 to $34,999 (n=1), $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=4), $75,000 to $99,999 (n=5), $100,000 to $199,999 (n=3), $200,000 or more (n=2), Sample Size = 18

(Community = Day)

Past Diagnosis

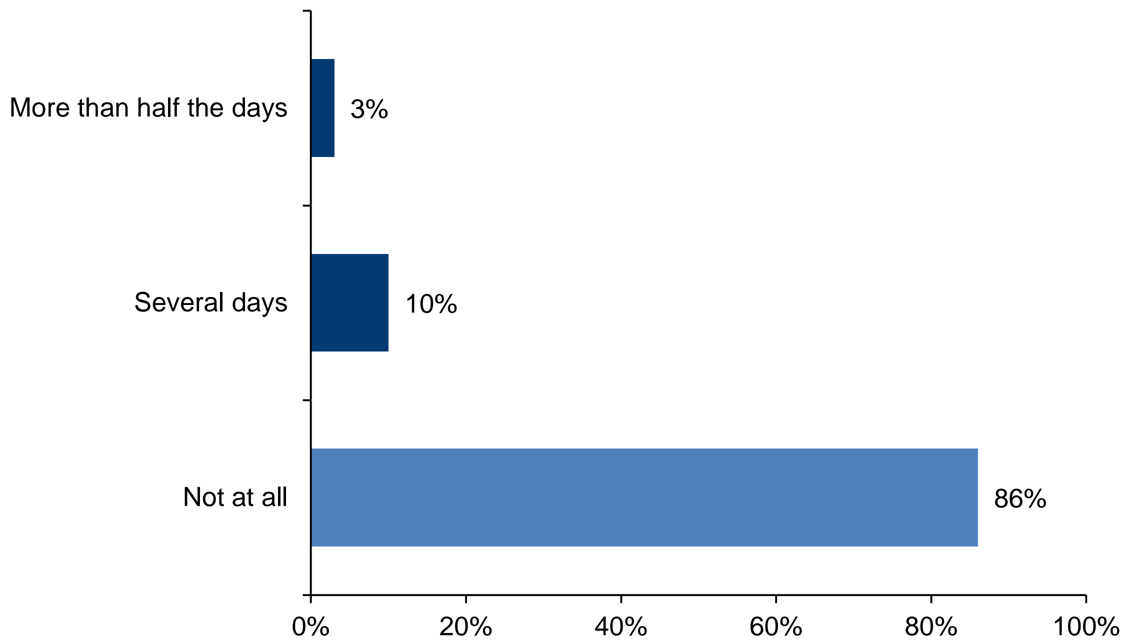


Base: Anxiety, stress, etc. (n=6), Arthritis (n=6), Asthma (n=4), Congestive heart failure (n=2), Depression (n=4), Diabetes (n=2), High cholesterol (n=8), Hypertension (n=10), Other mental health problems (n=1), Sample Size = 19
(Community = Day)



Base: Not at all (n=24), Several days (n=4), More than half the days (n=1), Sample Size = 29

(Community = Day)

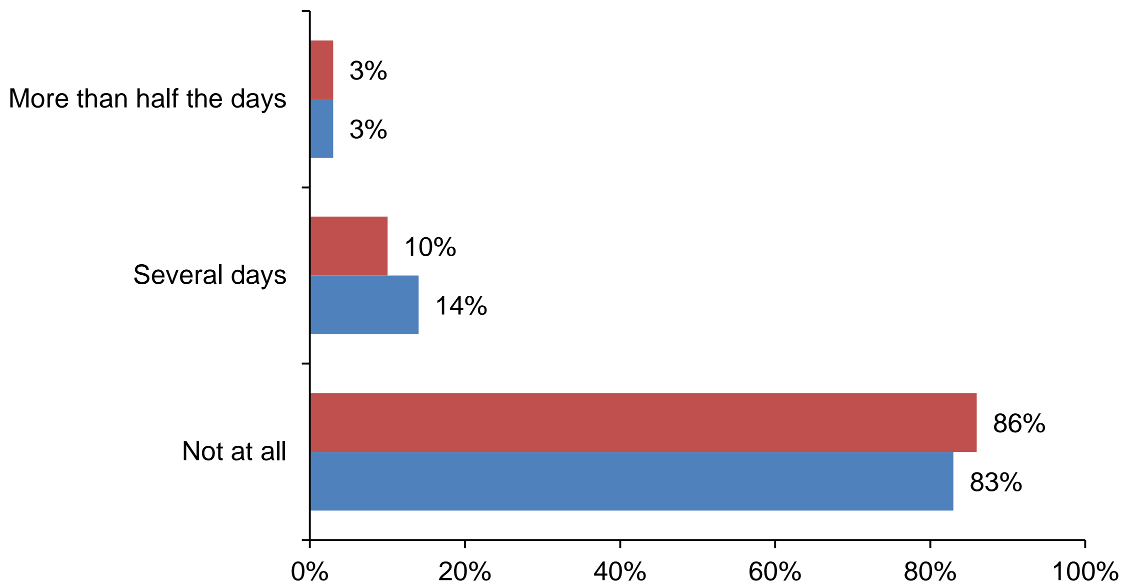


Base: Not at all (n=25), Several days (n=3), More than half the days (n=1), Sample Size = 29

(Community = Day)

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

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

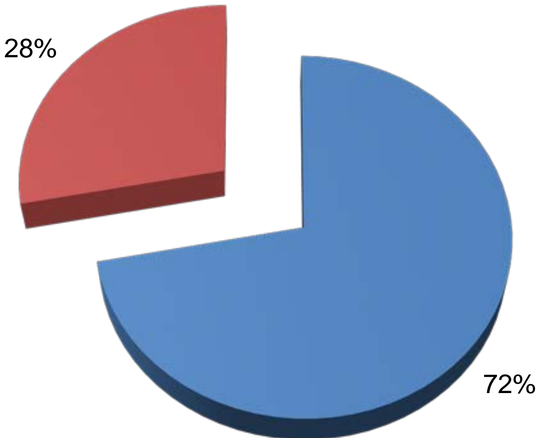


Sample Size = 29

(Community = Day)

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

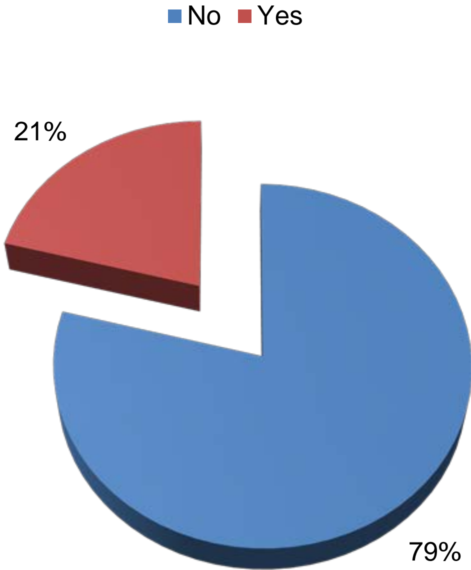
■ No ■ Yes



Base: Yes (n=8), No (n=21), Sample Size = 29

(Community = Day)

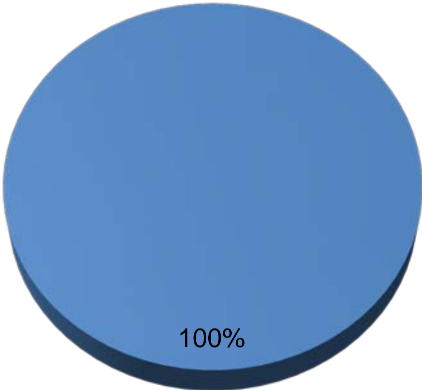
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=6), No (n=22), Sample Size = 28

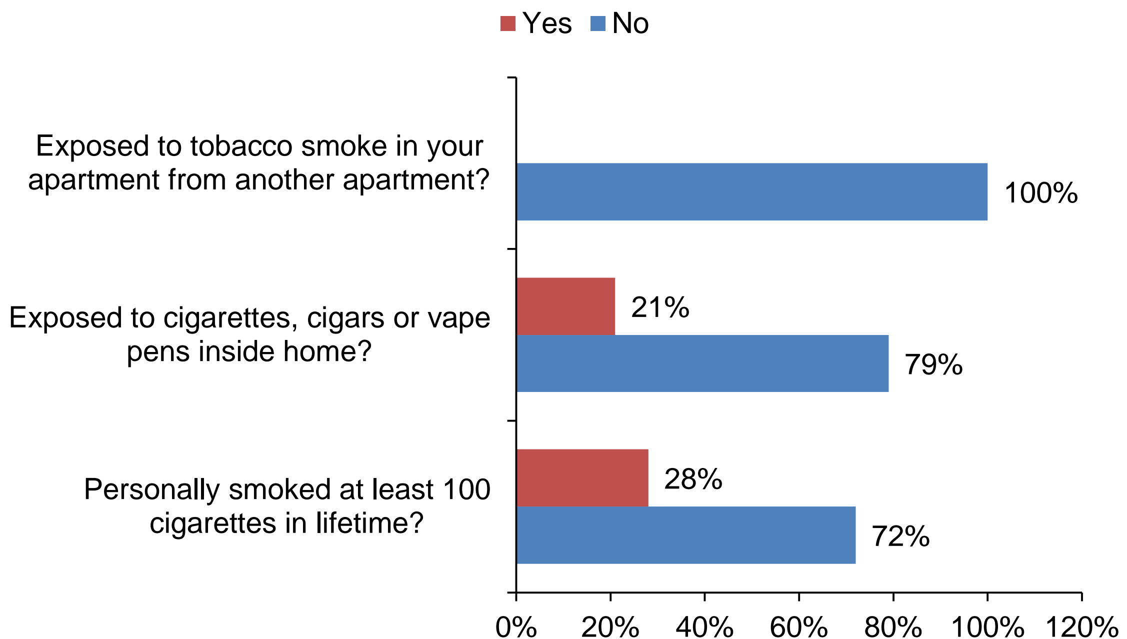
(Community = Day)

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



Base: No (n=29), Sample Size = 29

(Community = Day)

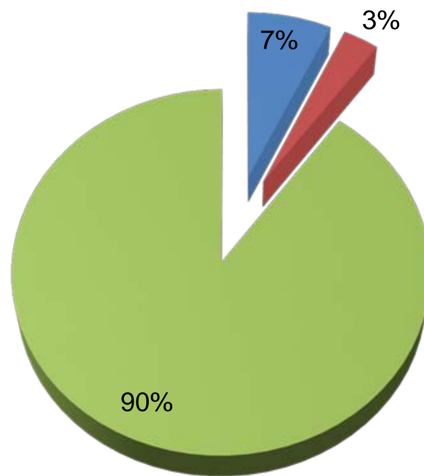


Base: Personally smoked at least 100 cigarettes in lifetime? (n=29), Exposed to cigarettes, cigars or vape pens inside home? (n=28), Exposed to tobacco smoke in your apartment from another apartment? (n=29), Sample Size = Variable

(Community = Day)

Do you currently smoke cigarettes?

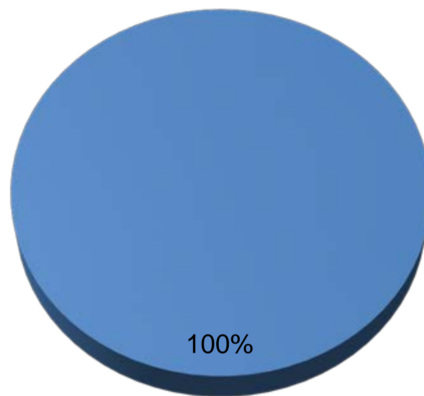
Every day Some days Not at all



Base: Not at all (n=26), Some days (n=1), Every day (n=2), Sample Size = 29

(Community = Day)

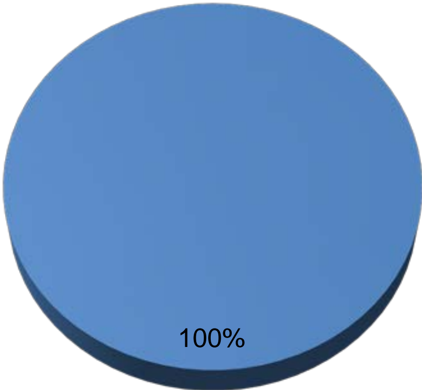
Do you currently use chewing tobacco?



Base: Not at all (n=29), Sample Size = 29

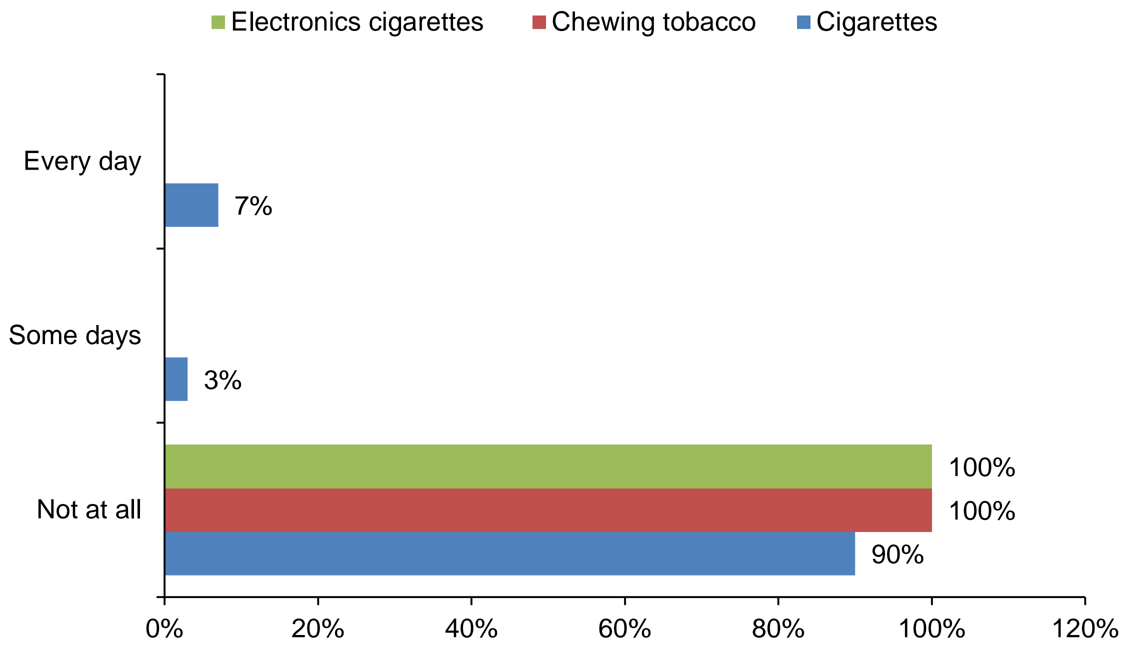
(Community = Day)

Do you currently use electronics cigarettes or vape?



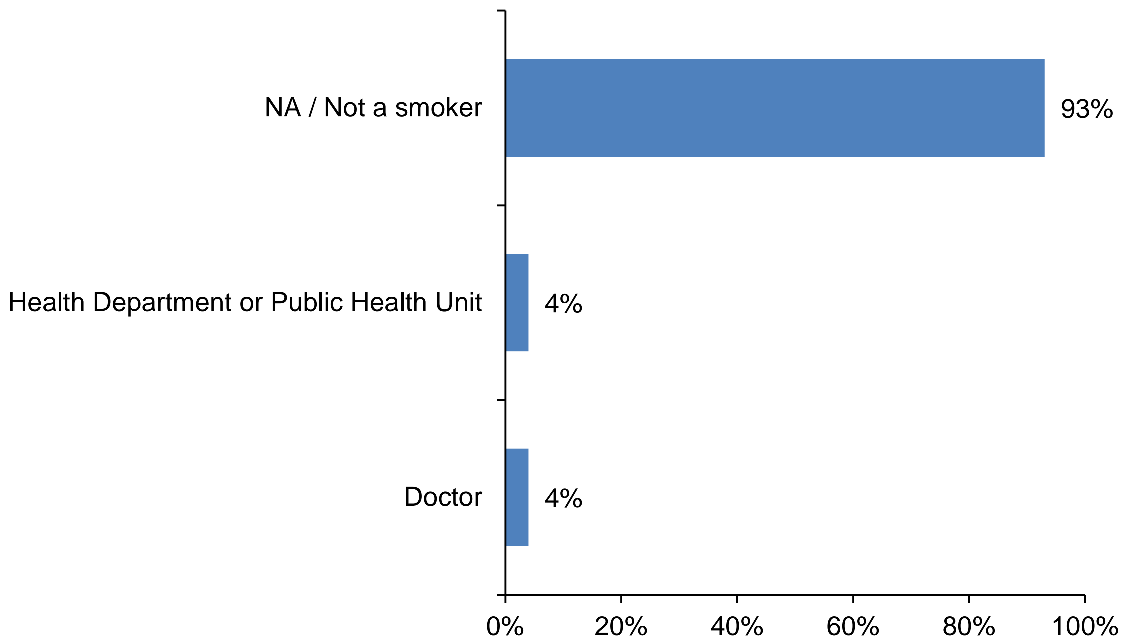
Base: Not at all (n=29), Sample Size = 29

(Community = Day)



Current Tobacco Use
Electronics cigarettes
Chewing tobacco
Cigarettes
Every day
Some days
Not at all
7%
3%
100%
100%
90%
0%
20%
40%
60%
80%
100%
120%
Sample Size = 29
(Community = Day)

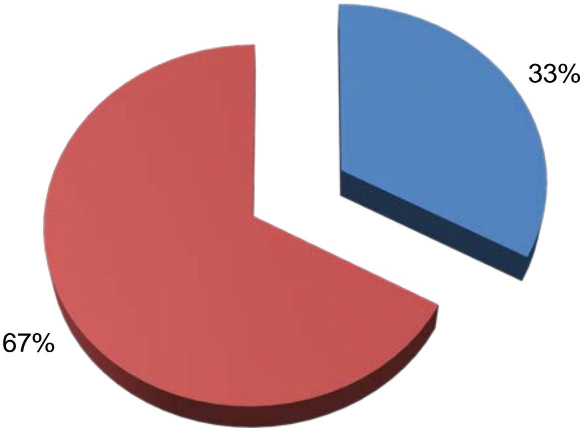
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=25), Doctor (n=1), Health Department or Public Health Unit (n=1), Sample Size = 27

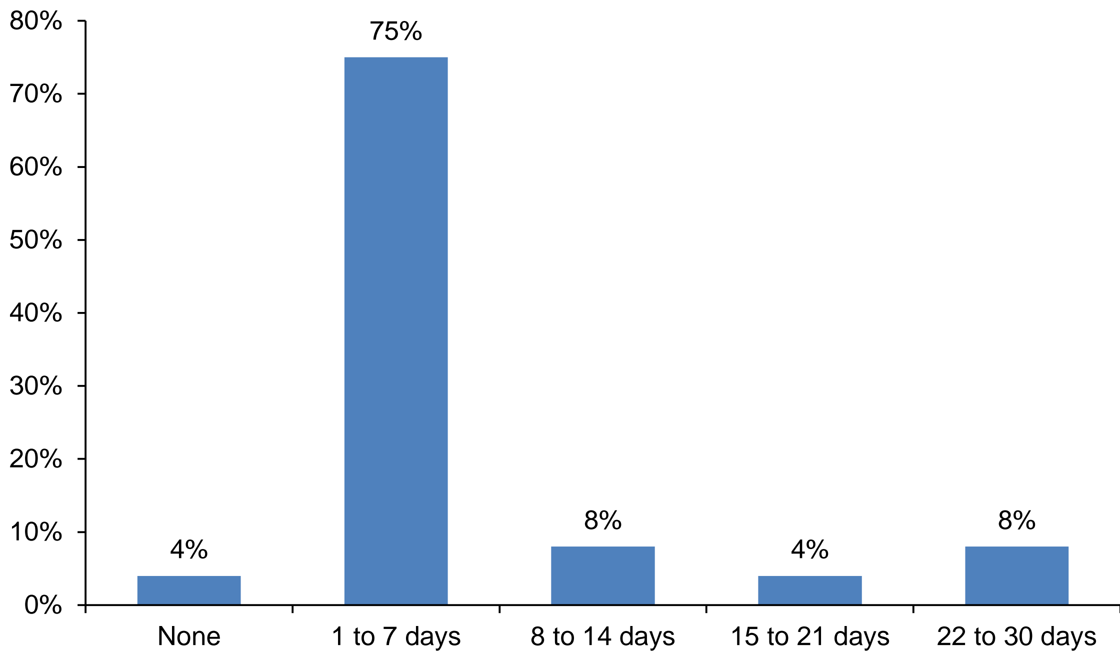
(Community = Day)

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



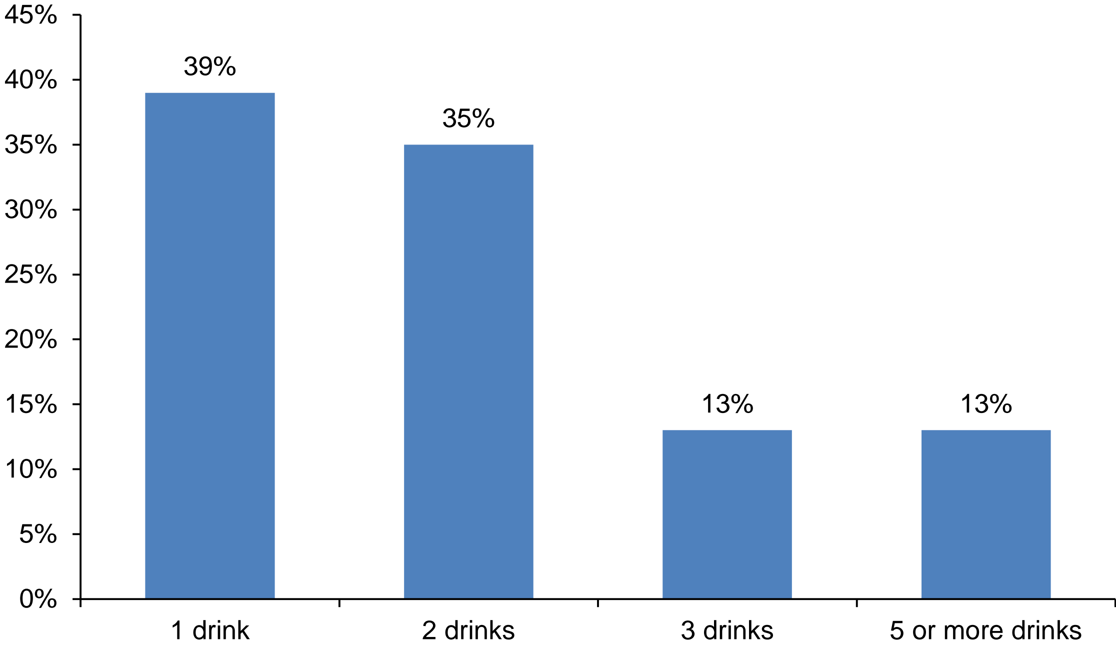
Base: Yes (n=1), No (n=2), Sample Size = 3

(Community = Day)



Base: None (n=1), 1 to 7 days (n=18), 8 to 14 days (n=2), 15 to 21 days (n=1), 22 to 30 days (n=2), Sample Size = 24

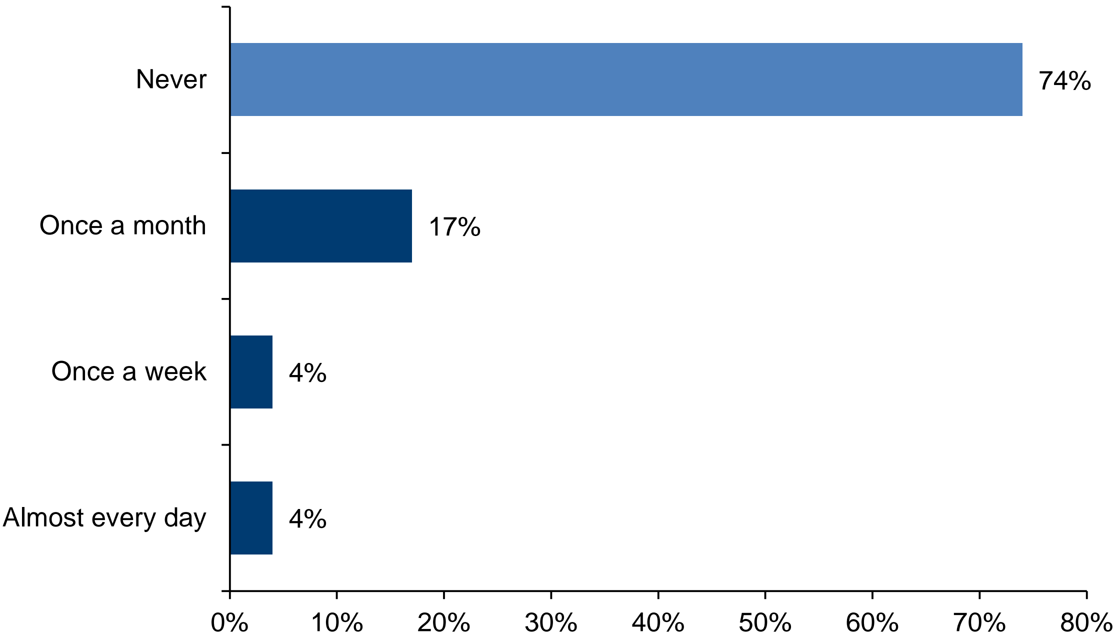
(Community = Day)



Base: 1 drink (n=9), 2 drinks (n=8), 3 drinks (n=3), 5 or more drinks (n=3), Sample Size = 23

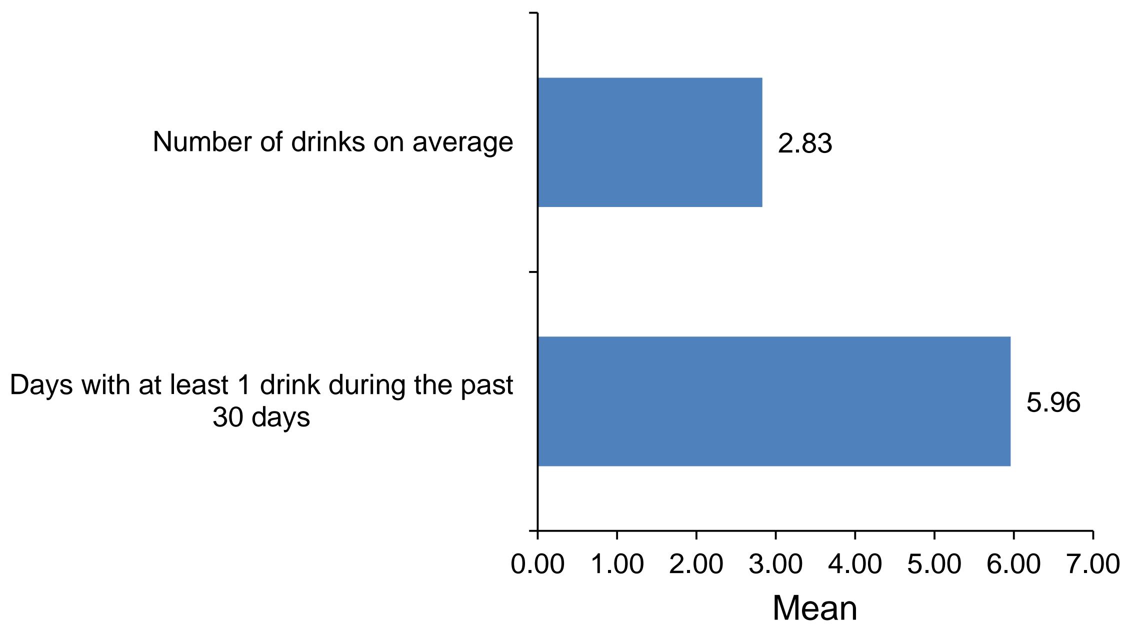
(Community = Day)

Binge Drinking



Base: Almost every day (n=1), Once a week (n=1), Once a month (n=4), Never (n=17), Sample Size = 23

(Community = Day)

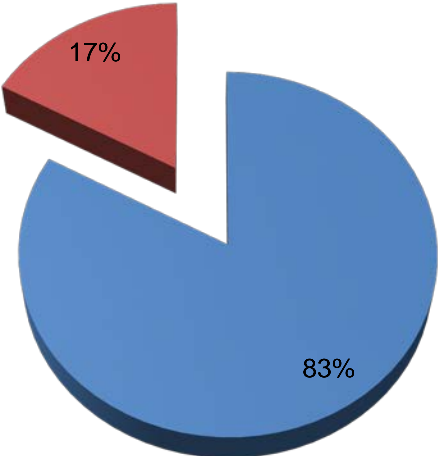


Base: Days with at least 1 drink during the past 30 days (n=24), Number of drinks on average (n=23), Sample Size = Variable

(Community = Day)

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

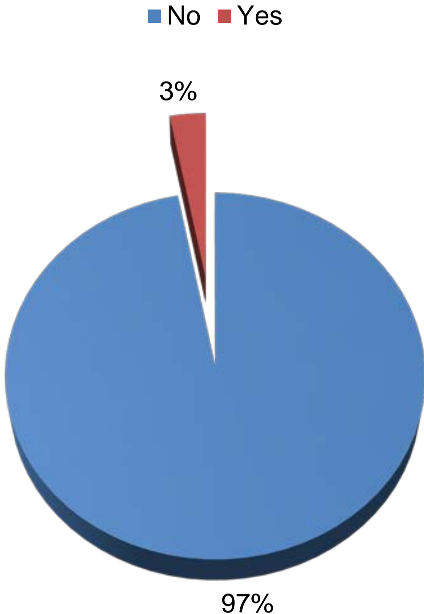
No Yes



Base: Yes (n=5), No (n=24), Sample Size = 29

(Community = Day)

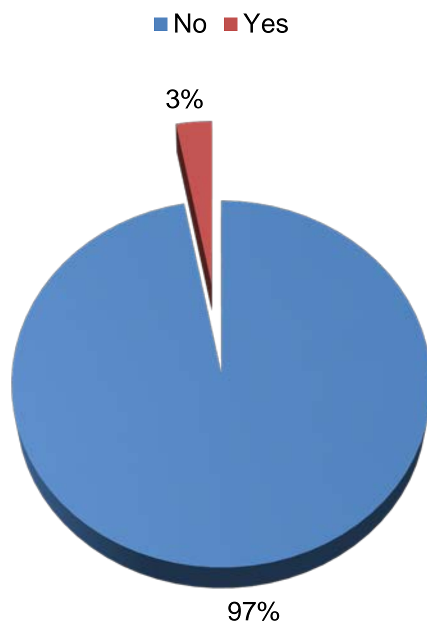
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=1), No (n=28), Sample Size = 29

(Community = Day)

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



Base: Yes (n=1), No (n=28), Sample Size = 29

(Community = Day)

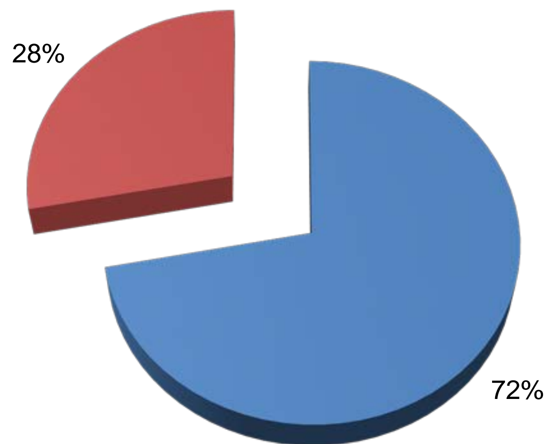
Has prescription or non-prescription drug use had a harmful effect on you or a family member in the past two years?

No Yes

Base: Yes (n=3), No (n=26), Sample Size = 29

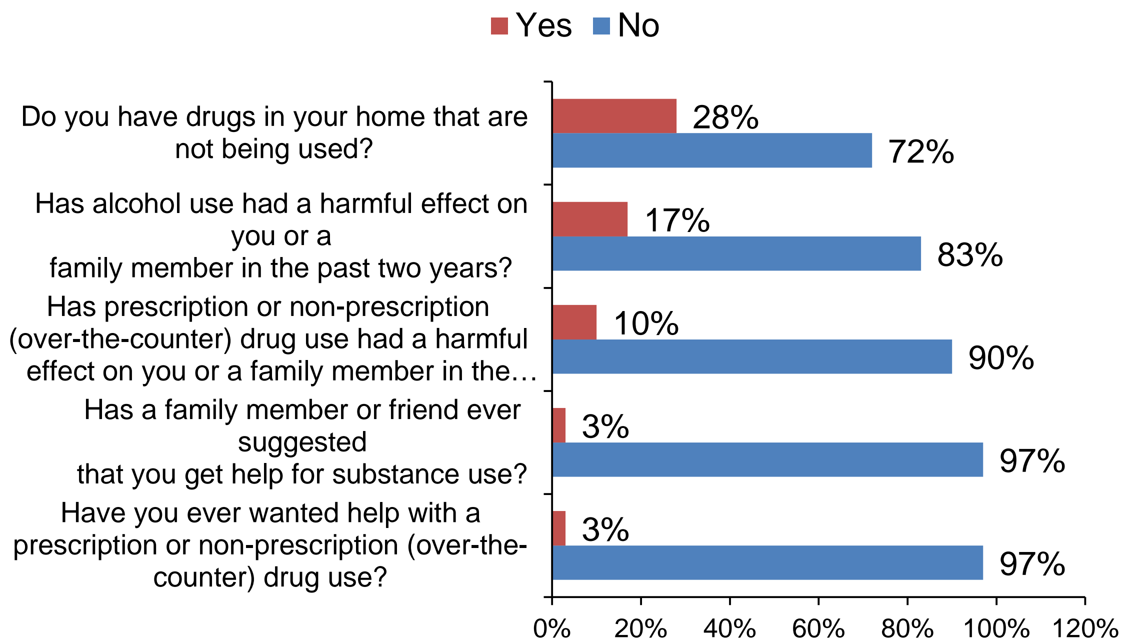
(Community = Day)

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

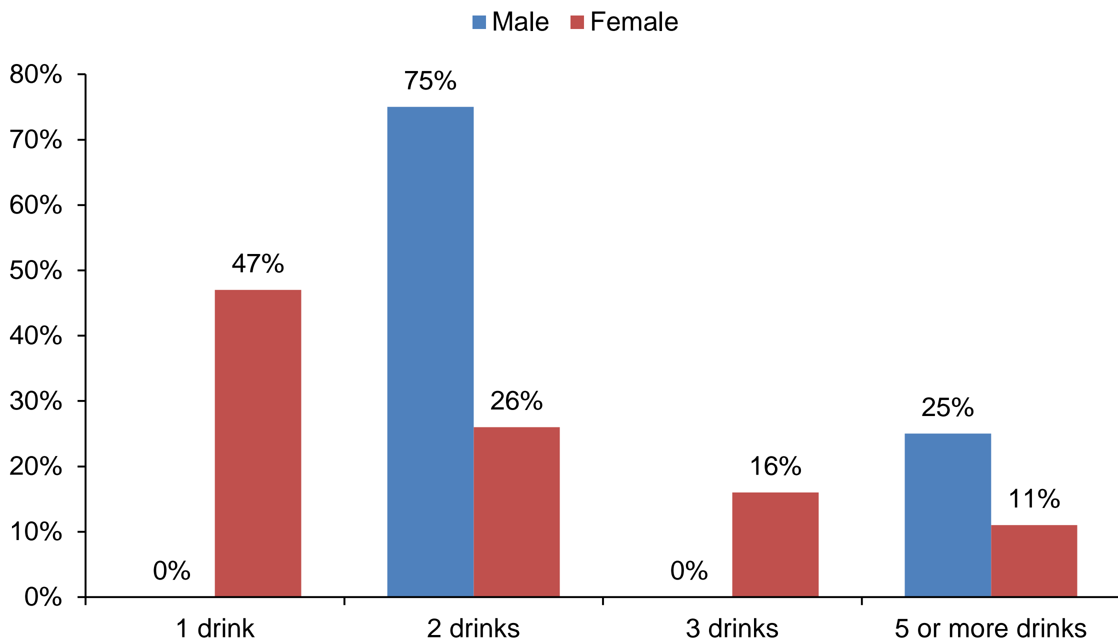


Base: Yes (n=8), No (n=21), Sample Size = 29

(Community = Day)

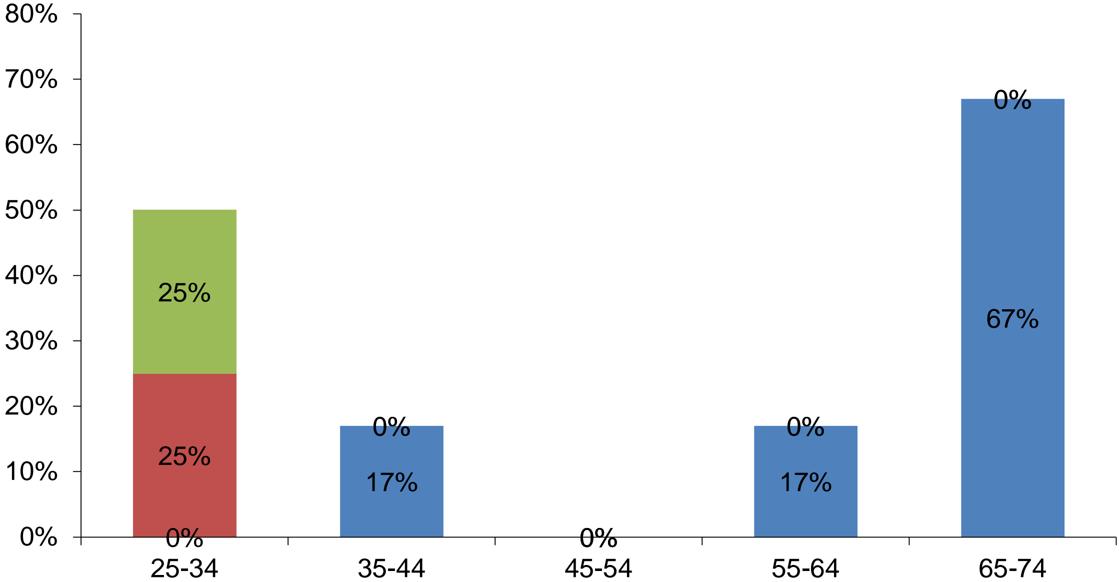


Drug and Alcohol Issues
Yes
No
Do you have drugs in your home that are not being used?
28%
72%
Has alcohol use had a harmful effect on you or a family member in the past two years?
17%
83%
Has prescription or non-prescription (over-the-counter) drug use had a harmful effect on you or a family member in the…
10%
90%
Has a family member or friend ever suggested that you get help for substance use?
3%
97%
Have you ever wanted help with a prescription or non-prescription (over-the-counter) drug use?
3%
97%
0%
20%
40%
60%
80%
100%
120%
Sample Size = 29
(Community = Day)



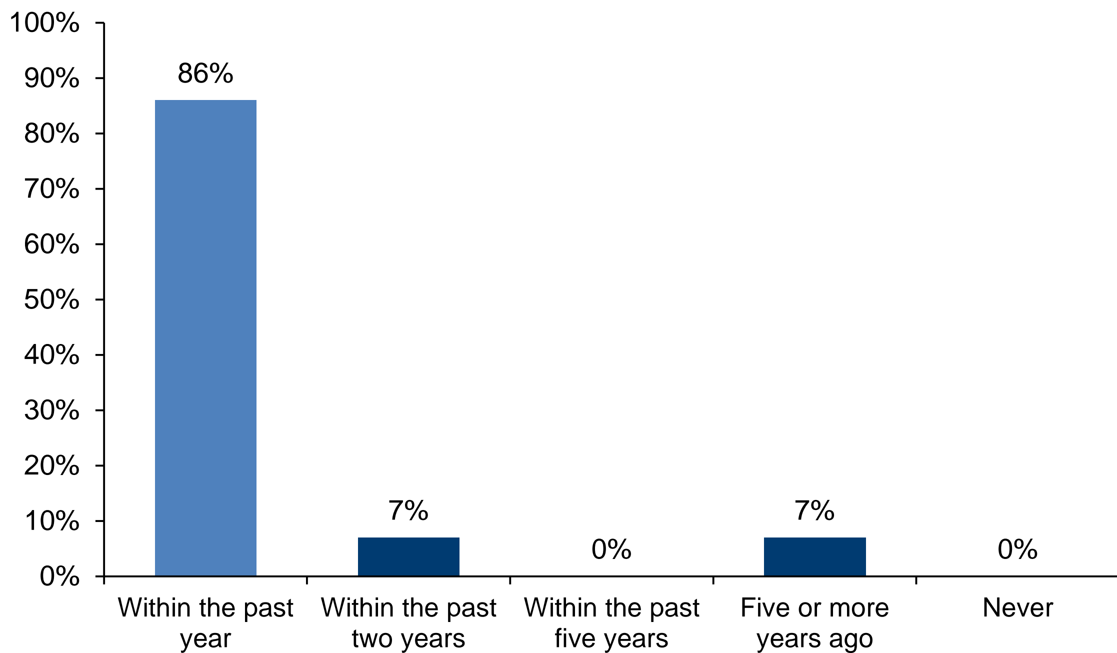
Base: 1 drink (n=9), 2 drinks (n=8), 3 drinks (n=3), 5 or more drinks (n=3), Sample Size = 23

(Community = Day)



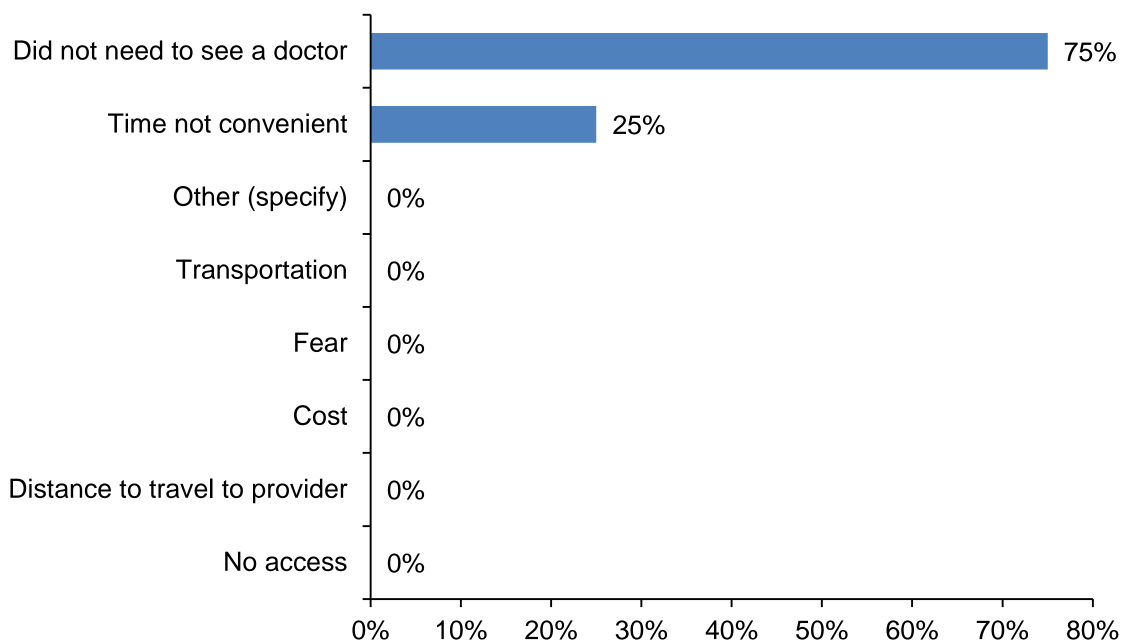
Base: 25-34 (n=4), 35-44 (n=6), 45-54 (n=4), 55-64 (n=6), 65-74 (n=3), Sample Size = 23

(Community = Day)



Base: Within the past year (n=25), Within the past two years (n=2), Within the past five years (n=0), Five or more years ago (n=2), Never (n=0), Sample Size = 29

(Community = Day)

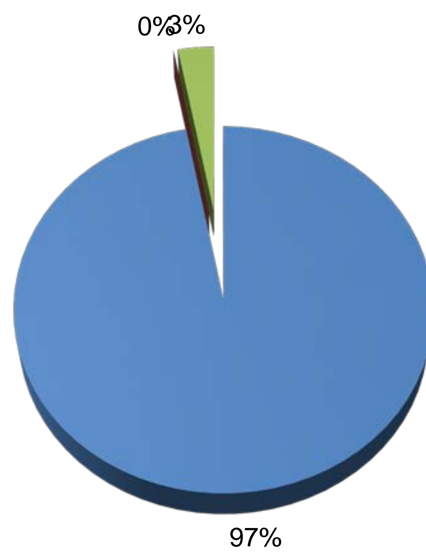


Base: No access (n=0), Distance to travel to provider (n=0), Cost (n=0), Fear (n=0), Transportation (n=0), Time not convenient (n=1), Did not need to see a doctor (n=3), Other (specify) (n=0), Sample Size = 4

(Community = Day)

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

Yes   No   Don't know / Unsure

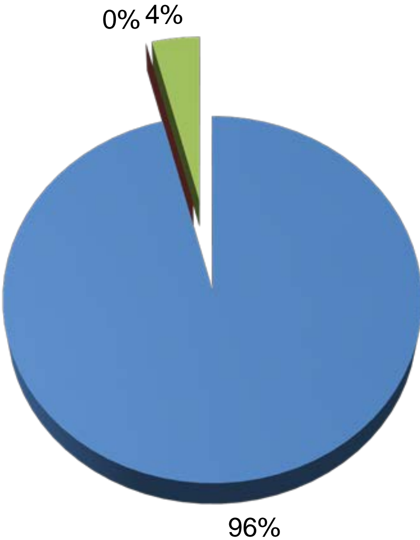


Base: Yes (n=28), No (n=0), Don't know / Unsure (n=1), Sample Size = 29

(Community = Day)

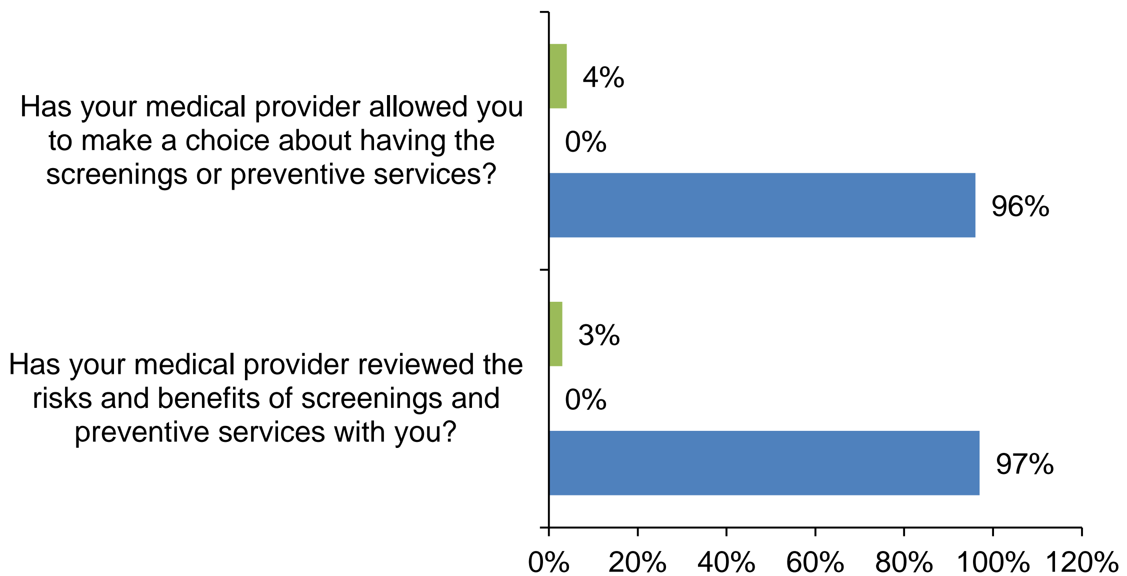
Has your medical provider allowed you to make a choice about having screenings or preventive services?

Yes No Don't know / Unsure



Base: Yes (n=27), No (n=0), Don't know / Unsure (n=1), Sample Size = 28

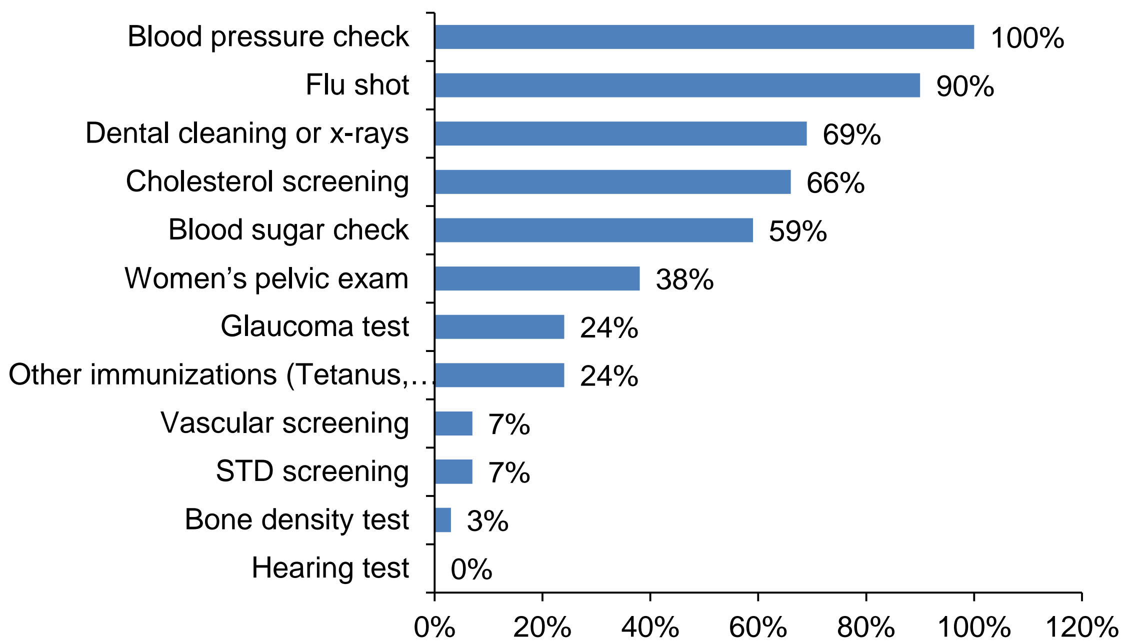
(Community = Day)



Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=28), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=29), Sample Size = Variable

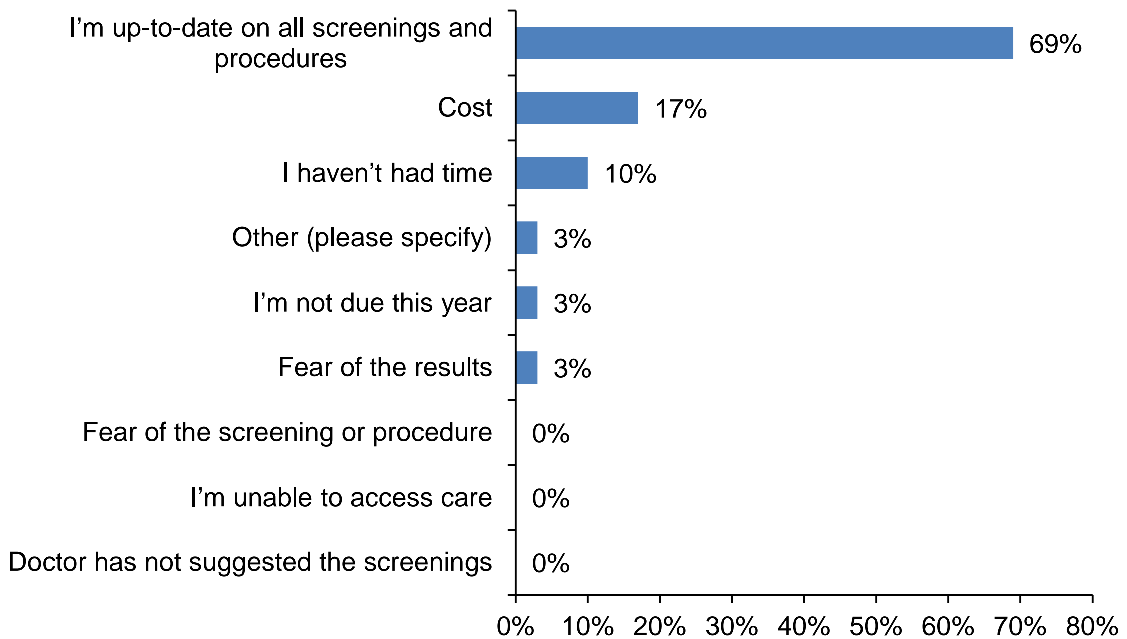
(Community = Day)

Preventive Procedures Last Year



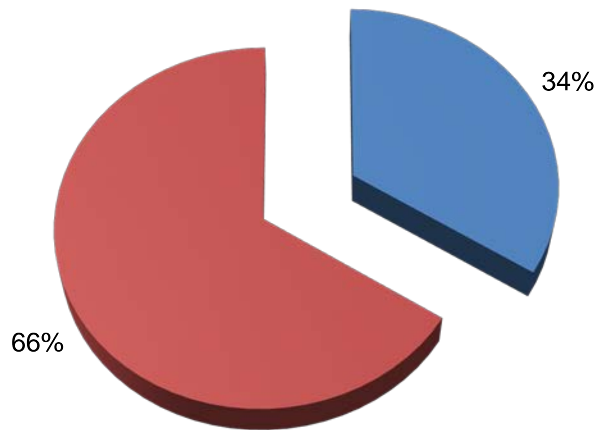
Base: Blood pressure check (n=29), Blood sugar check (n=17), Bone density test (n=1), Cholesterol screening (n=19), Dental cleaning or x-rays (n=20), Flu shot (n=26), Other immunizations (Tetanus, Hepatitis A or B) (n=7), Glaucoma test (n=7), Hearing test (n=0), Women's pelvic exam (n=11), STD screening (n=2), Vascular screening (n=2), Sample Size = 29
(Community = Day)

Barriers for Preventive Procedures



Base: I'm up-to-date on all screenings and procedures (n=20), Doctor has not suggested the screenings (n=0), Cost (n=5), I'm unable to access care (n=0), Fear of the screening or procedure (n=0), Fear of the results (n=1), I'm not due this year (n=1), I haven't had time (n=3), Other (please specify) (n=1),
Sample Size = 29
(Community = Day)

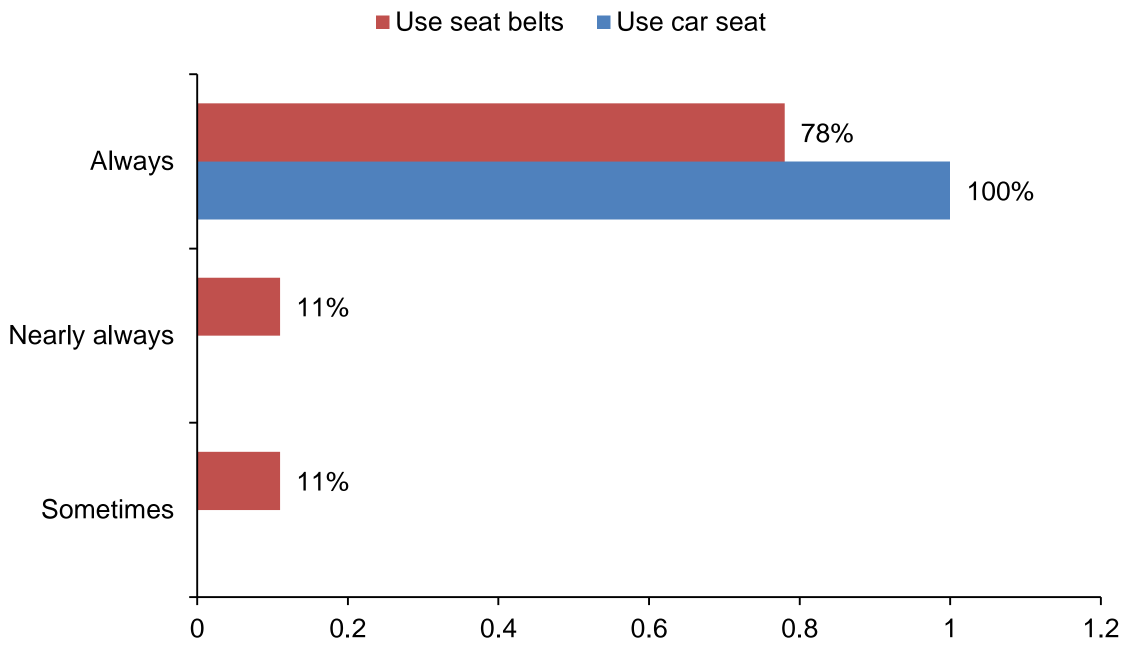
Do you have children under the age of 18 living in your household?



Base: Yes (n=10), No (n=19), Sample Size = 29

(Community = Day)

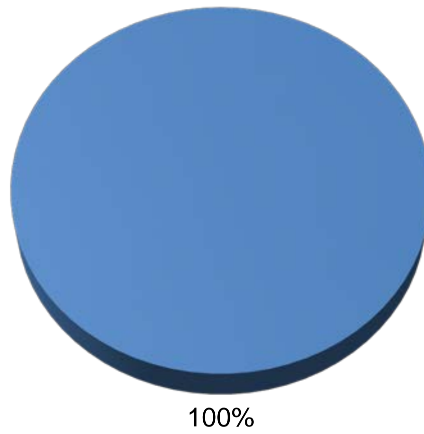
Children's Car Safety



Sample Size = Variable

(Community = Day)

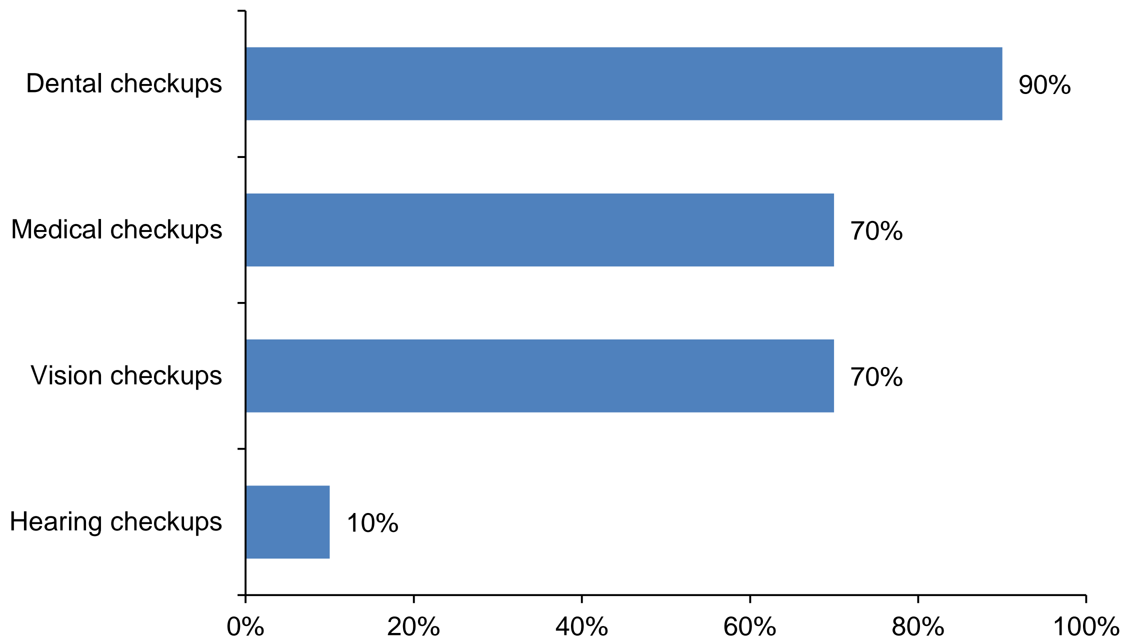
Do you have healthcare coverage for your children or dependents?



Base: Yes (n=10), Sample Size = 10

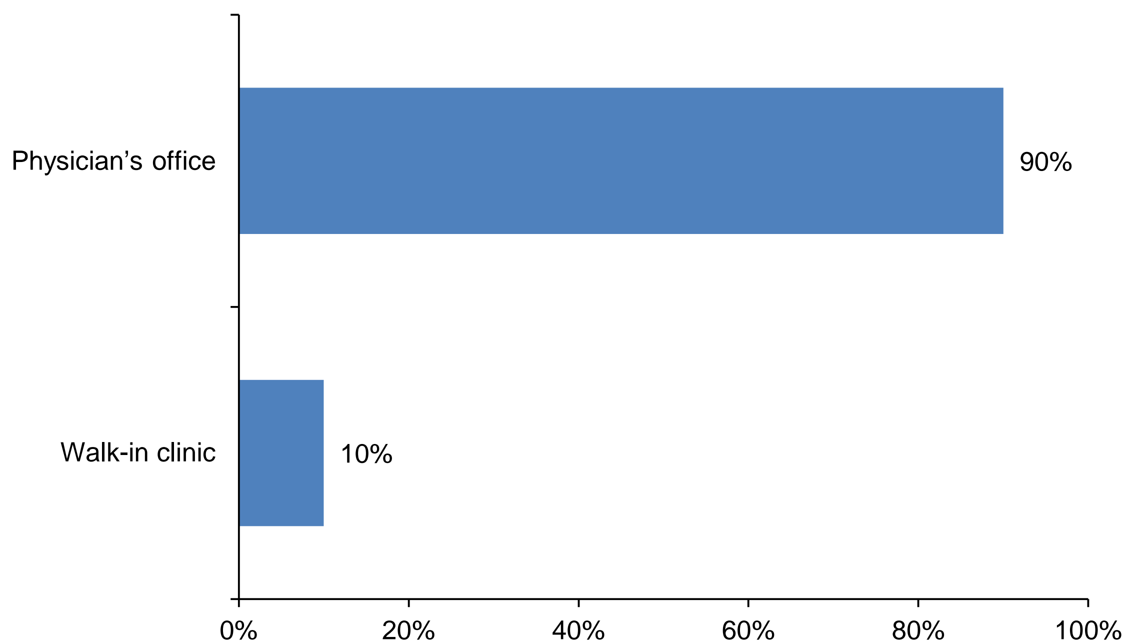
(Community = Day)

Children's Preventative Services



Base: Dental checkups (n=9), Vision checkups (n=7), Hearing checkups (n=1), Medical checkups (n=7), Sample Size = 10

(Community = Day)

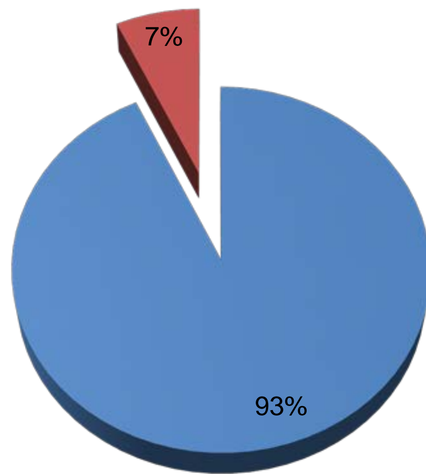


Base: Physician's office (n=9), Walk-in clinic (n=1), Sample Size = 10

(Community = Day)

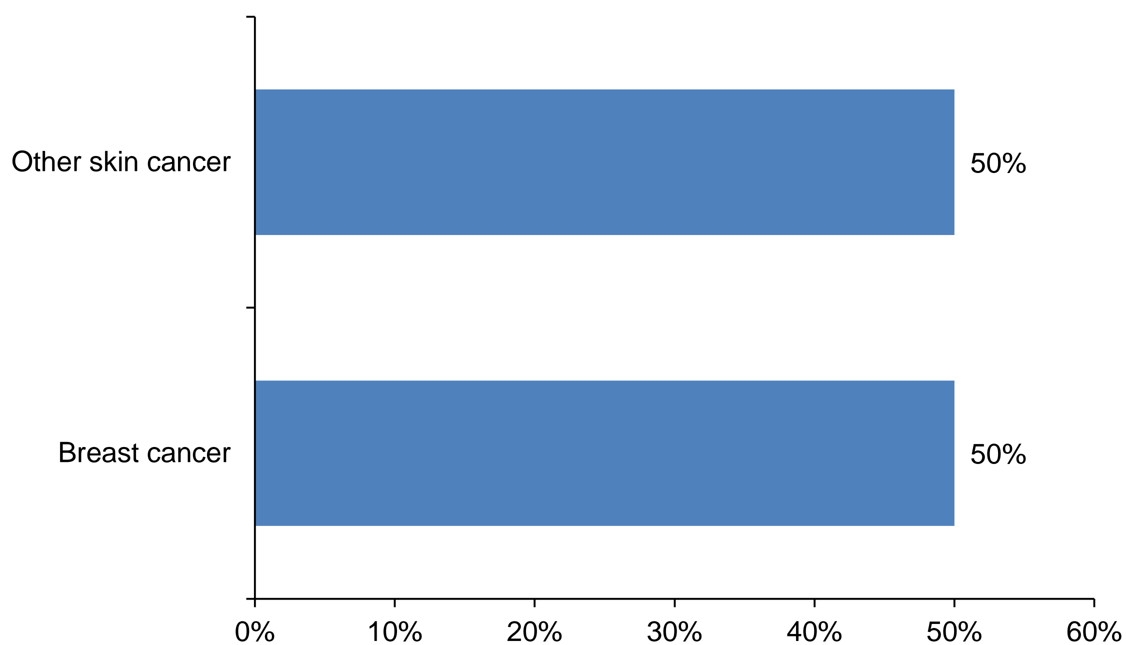
Have you ever been diagnosed with cancer?

■ No ■ Yes



Base: Yes (n=2), No (n=27), Sample Size = 29

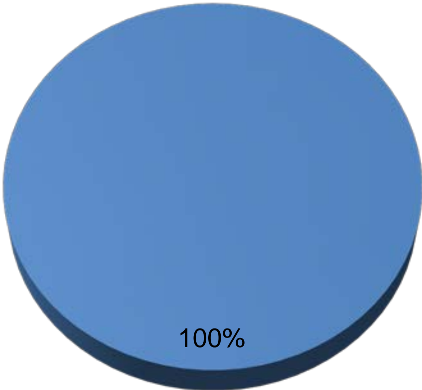
(Community = Day)



Base: Breast cancer (n=1), Other skin cancer (n=1), Sample Size = 2

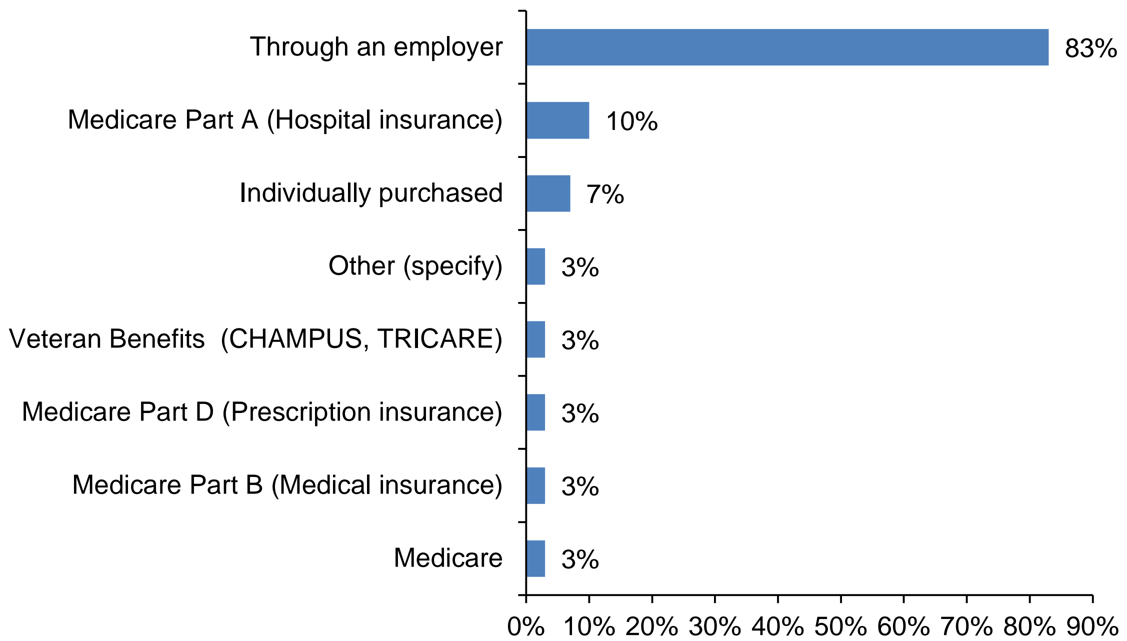
(Community = Day)

Do you currently have any kind of health insurance?



Base: Yes (n=29), Sample Size = 29

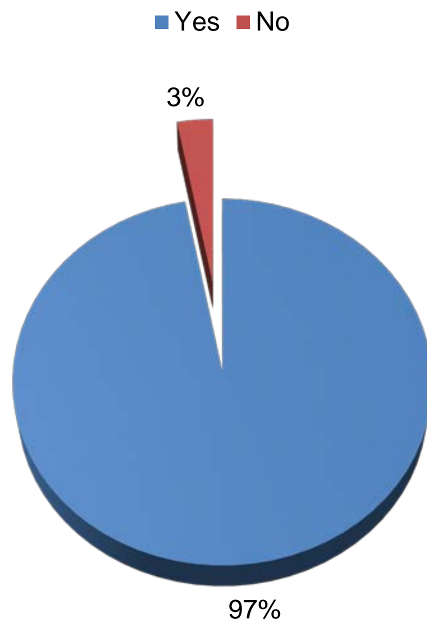
(Community = Day)



Base: Through an employer (n=24), Individually purchased (n=2), Medicare (n=1), Medicare Part A (Hospital insurance) (n=3), Medicare Part B (Medical insurance) (n=1), Medicare Part D (Prescription insurance) (n=1), Veteran Benefits (CHAMPUS, TRICARE) (n=1), Other (specify) (n=1), Sample Size = 29

(Community = Day)

Do you have an established primary healthcare provider?

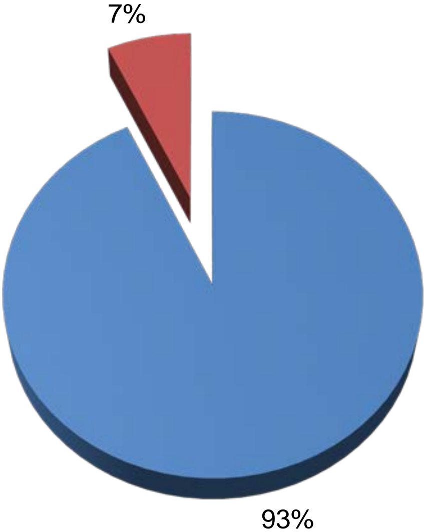


Base: Yes (n=28), No (n=1), Sample Size = 29

(Community = Day)

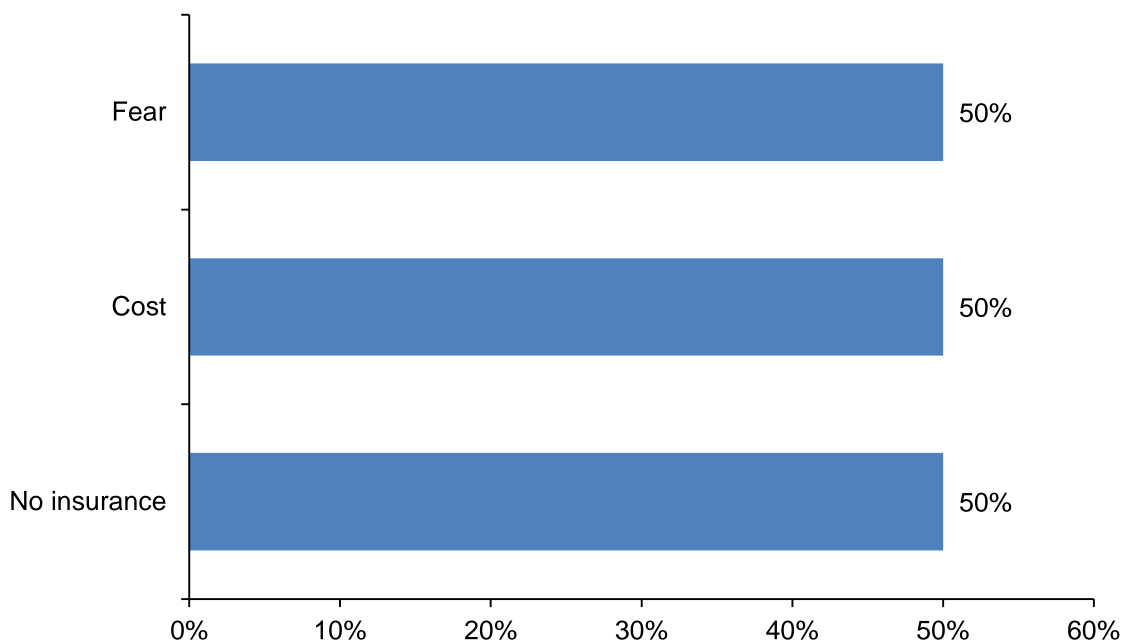
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?

No Yes



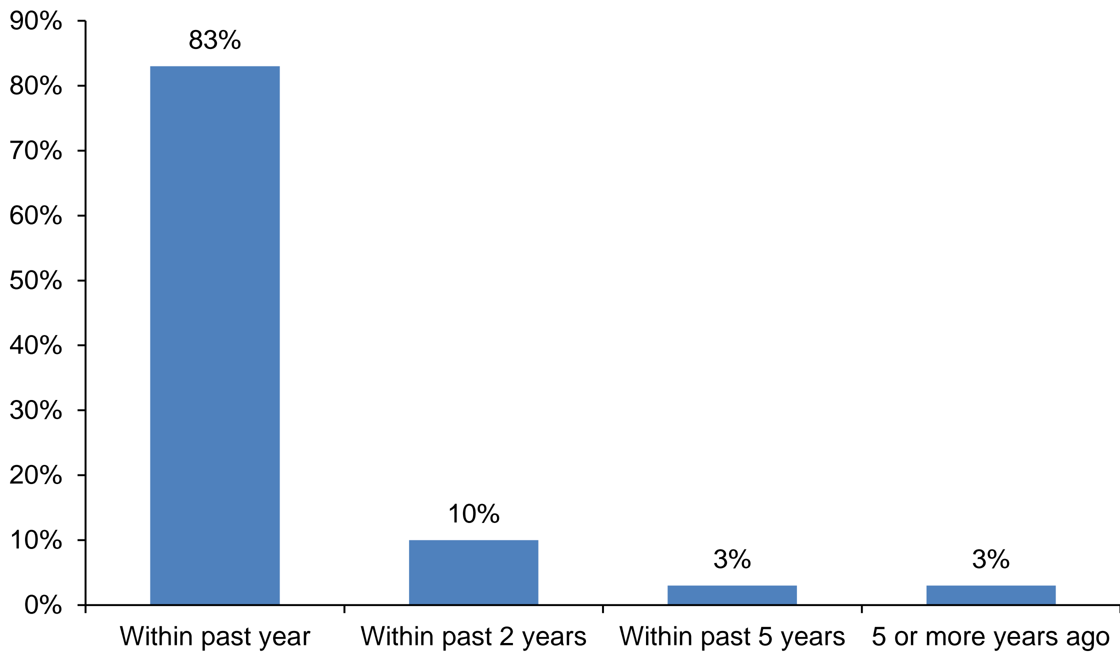
Base: Yes (n=2), No (n=27), Sample Size = 29

(Community = Day)



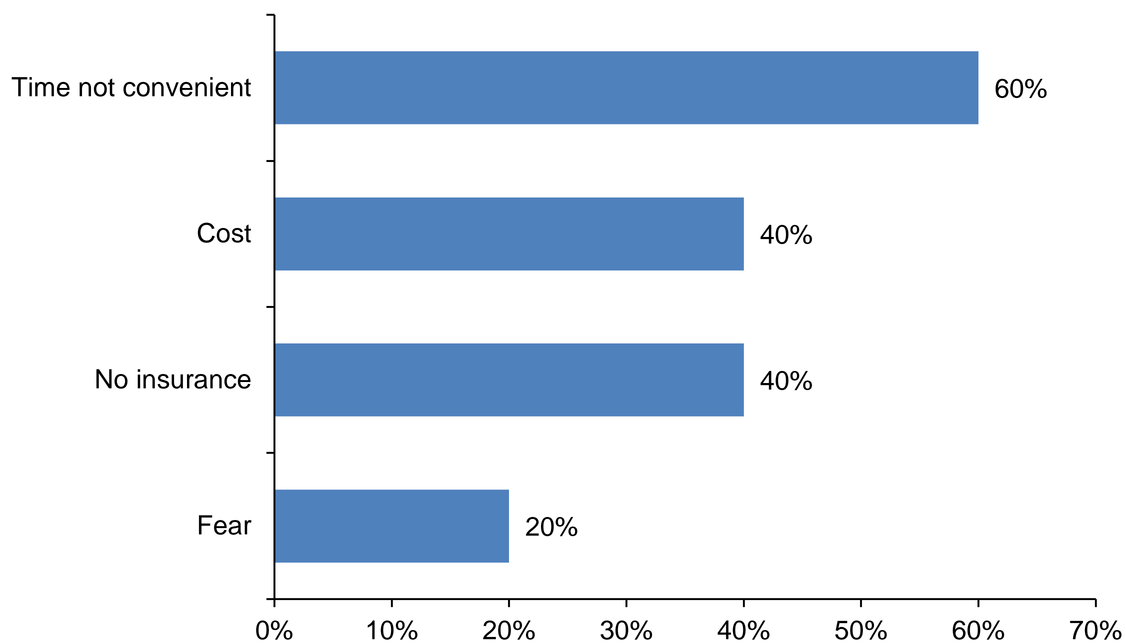
Base: No insurance (n=1), Cost (n=1), Fear (n=1)

(Community = Day)



Base: Within past year (n=24), Within past 2 years (n=3), Within past 5 years (n=1), 5 or more years ago (n=1), Sample Size = 29

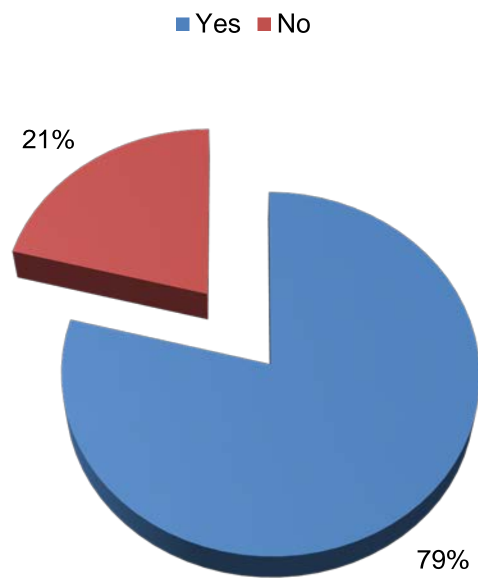
(Community = Day)



Base: No insurance (n=2), Cost (n=2), Fear (n=1), Time not convenient (n=3), Sample Size = 5

(Community = Day)

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

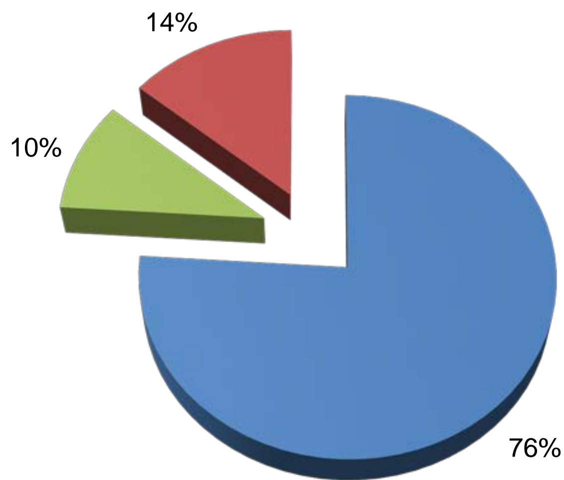


Base: Yes (n=23), No (n=6), Sample Size = 29

(Community = Day)

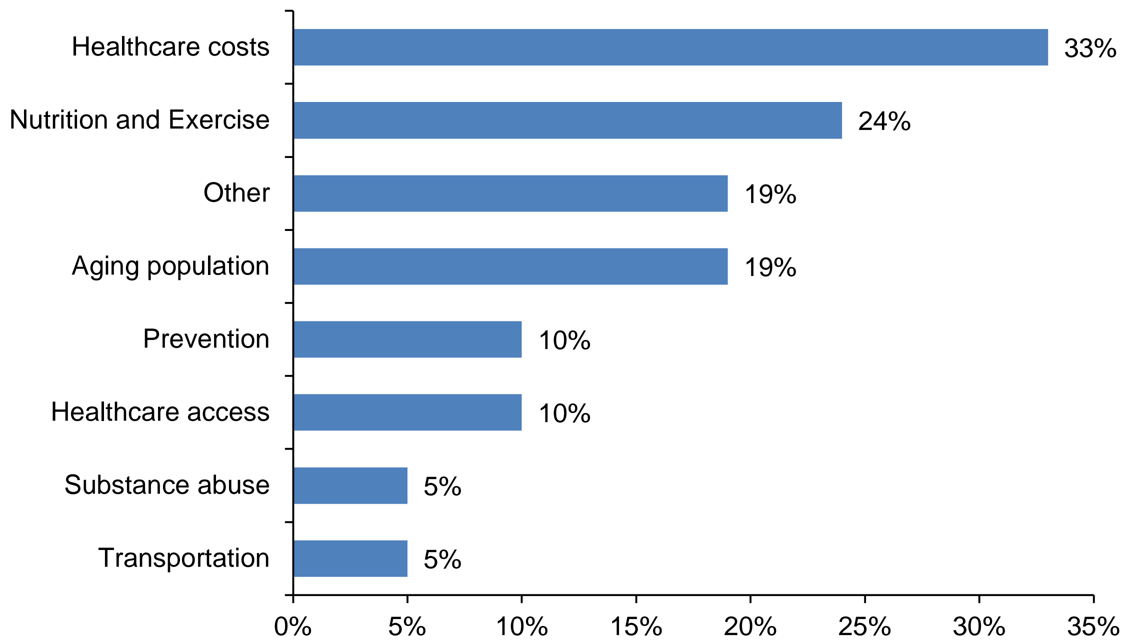
Do you have a dentist that you see for routine care?

Yes, only one   Yes, more than one   No



Base: Yes, only one (n=22), Yes, more than one (n=3), No (n=4), Sample Size = 29

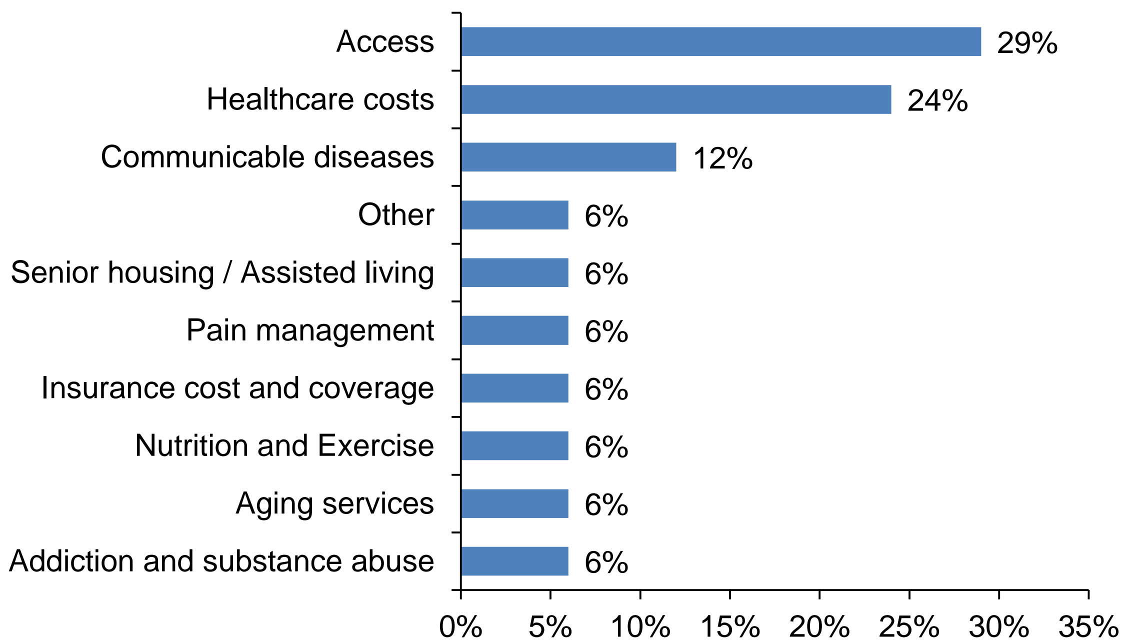
(Community = Day)



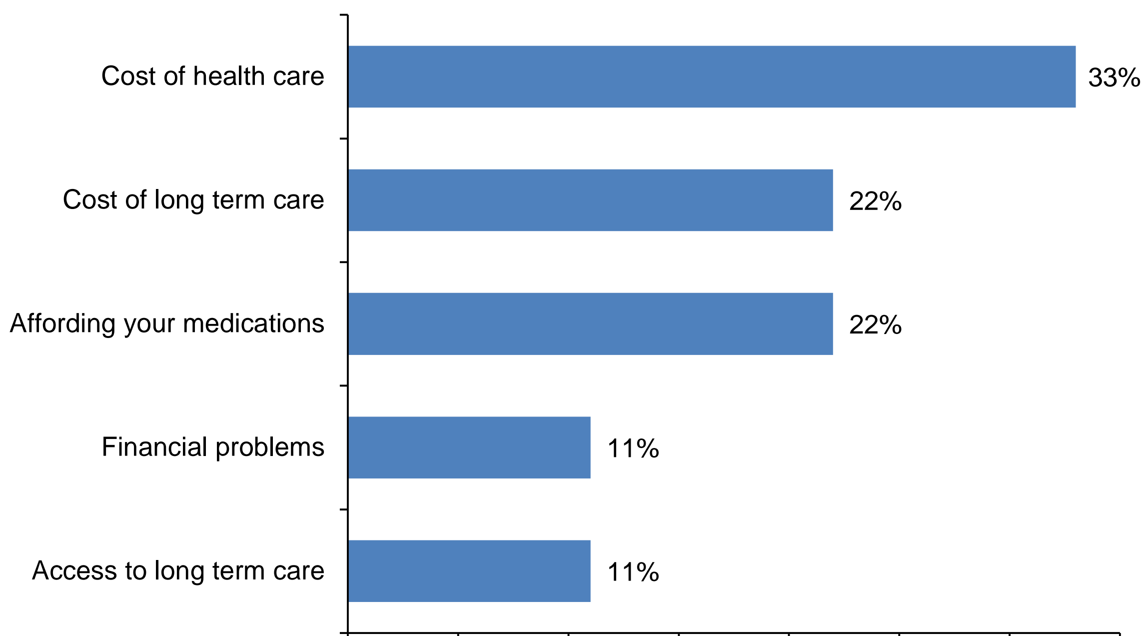
Base: Transportation (n=1), Aging population (n=4), Healthcare access (n=2), Substance abuse (n=1), Healthcare costs (n=7), Prevention (n=2), Nutrition and Exercise (n=5), Other (n=4), Sample Size = 21

(Community = Day)

Most Important Issue for Family



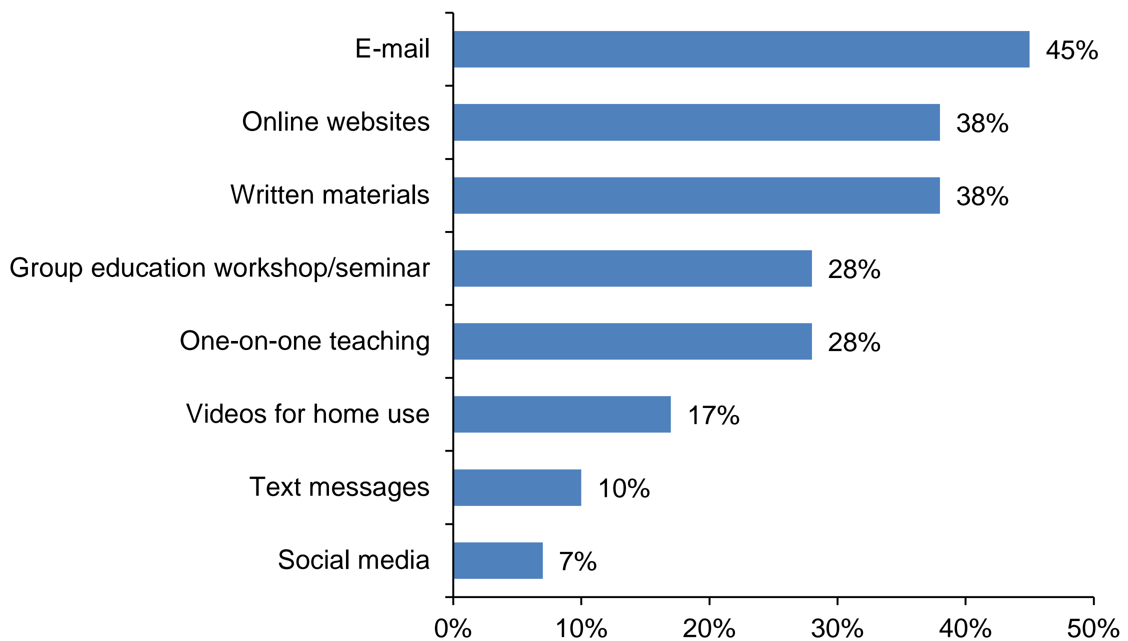
Base: Access (n=5), Addiction and substance abuse (n=1), Aging services (n=1), Communicable diseases (n=2), Healthcare costs (n=4), Nutrition and Exercise (n=1), Insurance cost and coverage (n=1), Pain management (n=1), Senior housing / Assisted living (n=1), Other (n=1), Sample Size = 20
(Community = Day)



Base: Cost of health care (n=3), Affording your medications (n=2), Access to long term care (n=1), Cost of long term care (n=2), Financial problems (n=1), Sample Size = 3

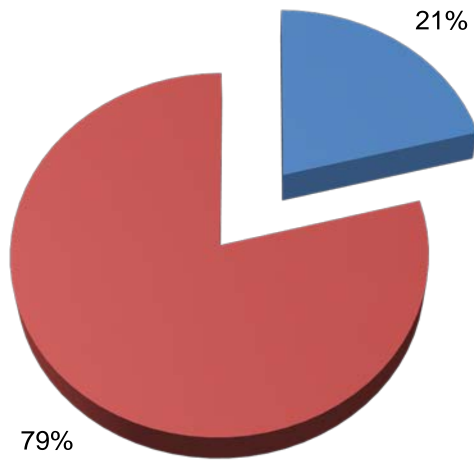
(Community = Day)

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



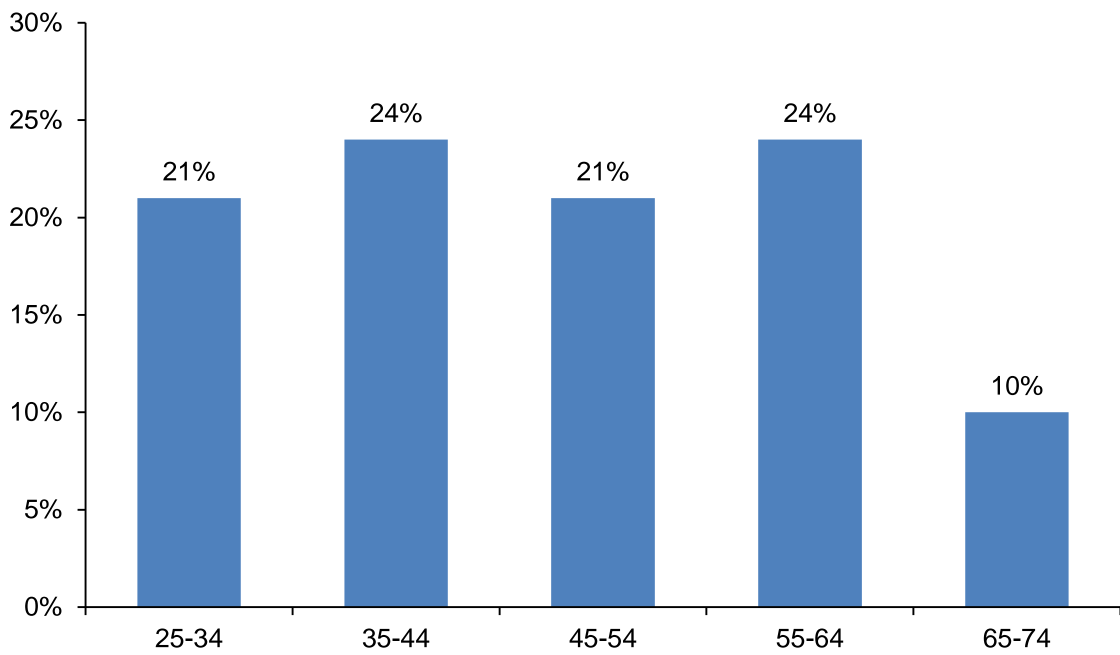
Base: Written materials (n=11), Videos for home use (n=5), Social media (n=2), Text messages (n=3), One-on-one teaching (n=8), E-mail (n=13), Group education workshop/seminar (n=8), Online websites (n=11), Sample Size = 29

(Community = Day)



Base: Male (n=6), Female (n=23), Sample Size = 29

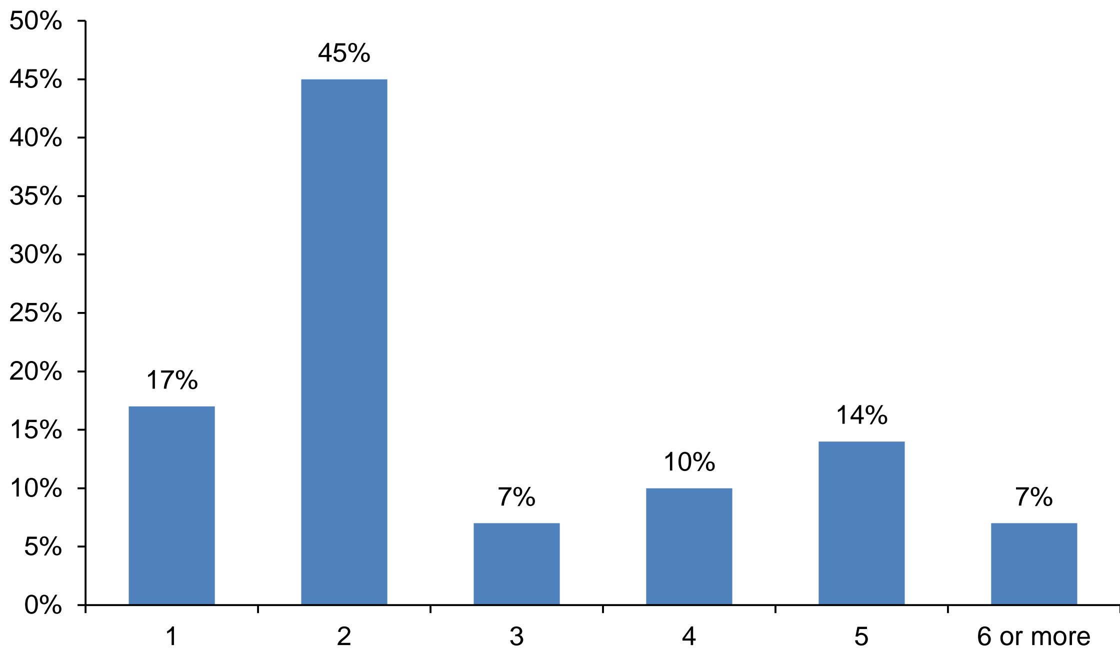
(Community = Day)



Base: 25-34 (n=6), 35-44 (n=7), 45-54 (n=6), 55-64 (n=7), 65-74 (n=3), Sample Size = 29

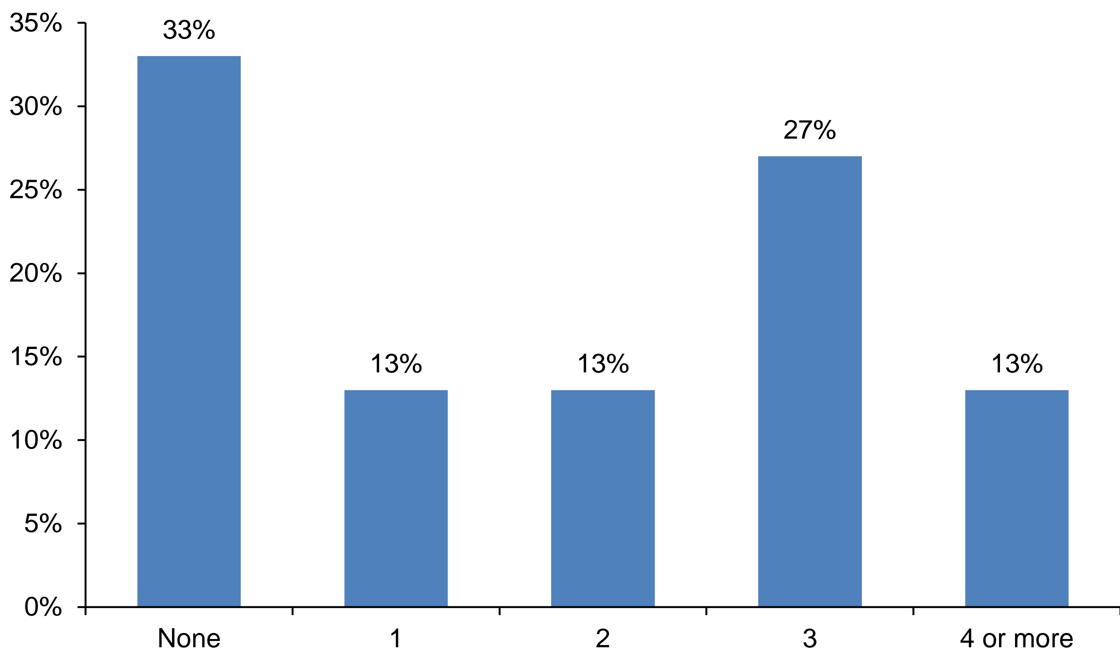
(Community = Day)

People in Household



Base: 1 (n=5), 2 (n=13), 3 (n=2), 4 (n=3), 5 (n=4), 6 or more (n=2), Sample Size = 29

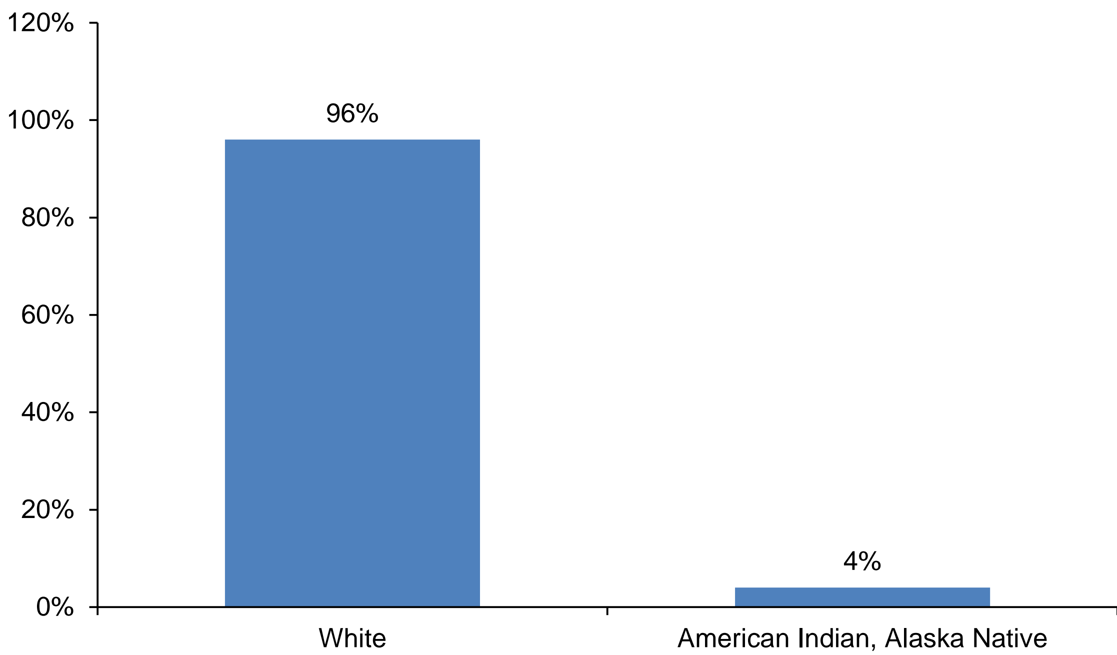
(Community = Day)



Base: None (n=5), 1 (n=2), 2 (n=2), 3 (n=4), 4 or more (n=2), Sample Size = 15

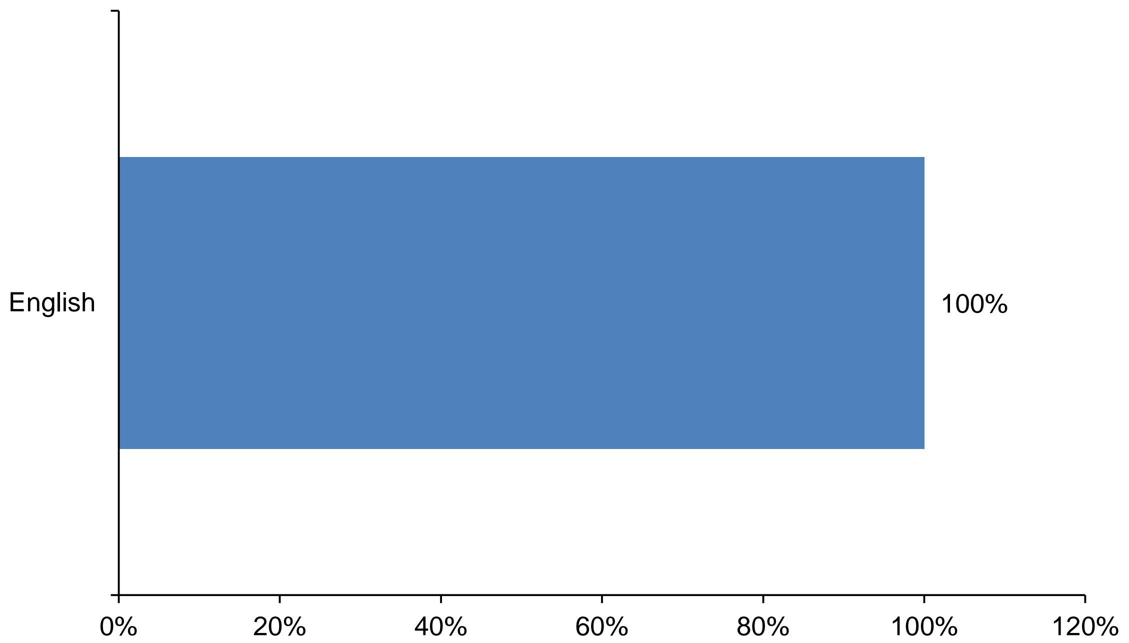
(Community = Day)

Ethnicity



Base: White (n=27), American Indian, Alaska Native (n=1), Sample Size = 28

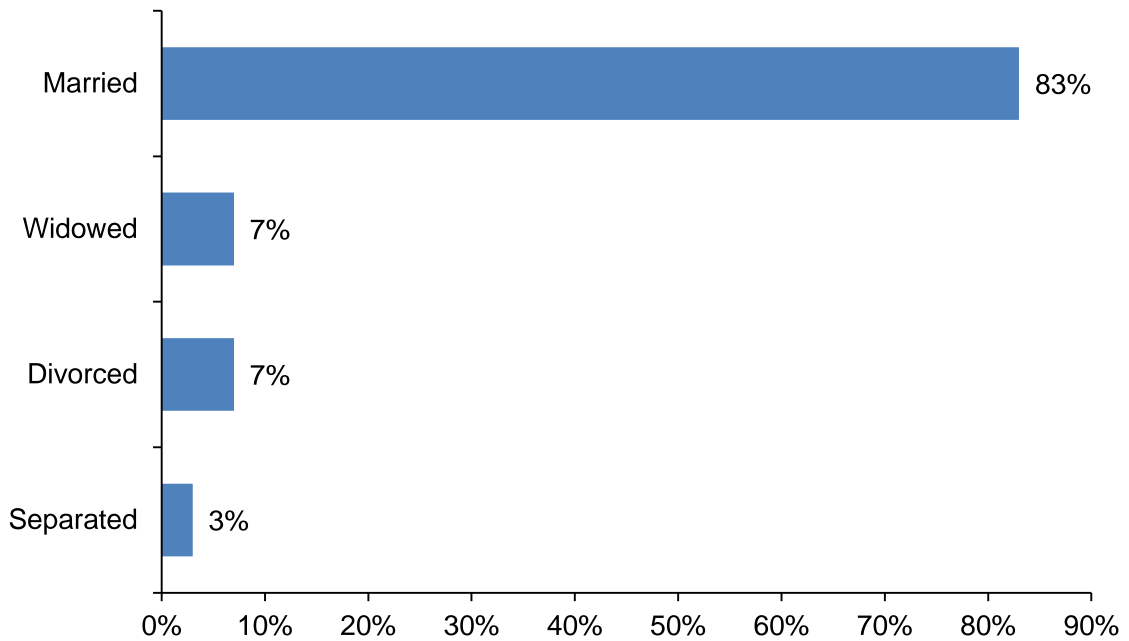
(Community = Day)



Base: English (n=29), Sample Size = 29

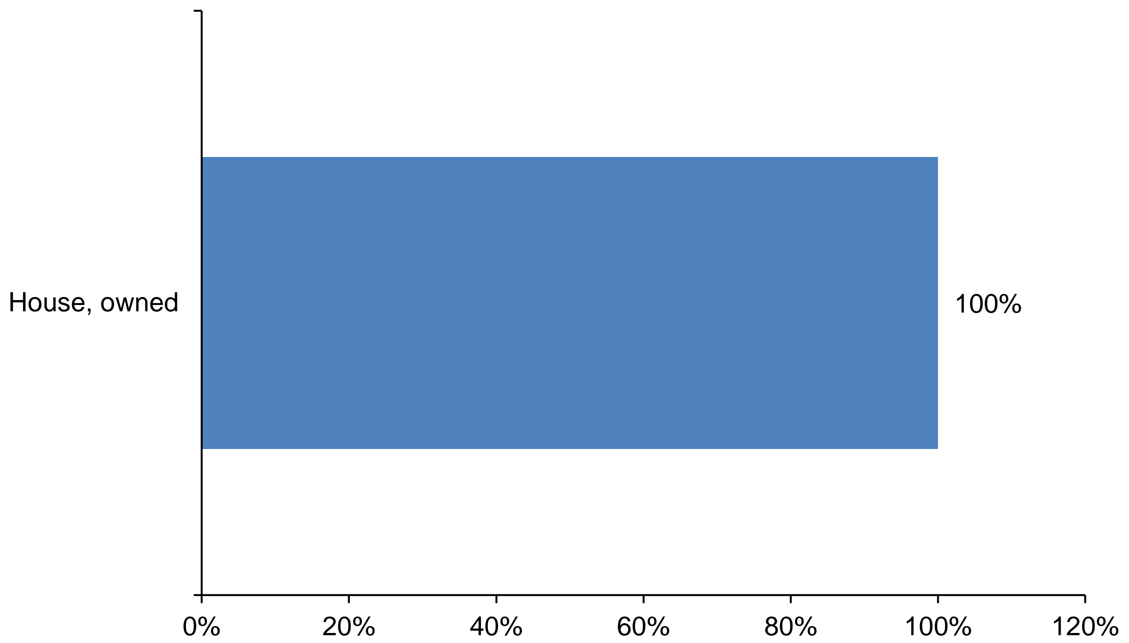
(Community = Day)

Marital Status



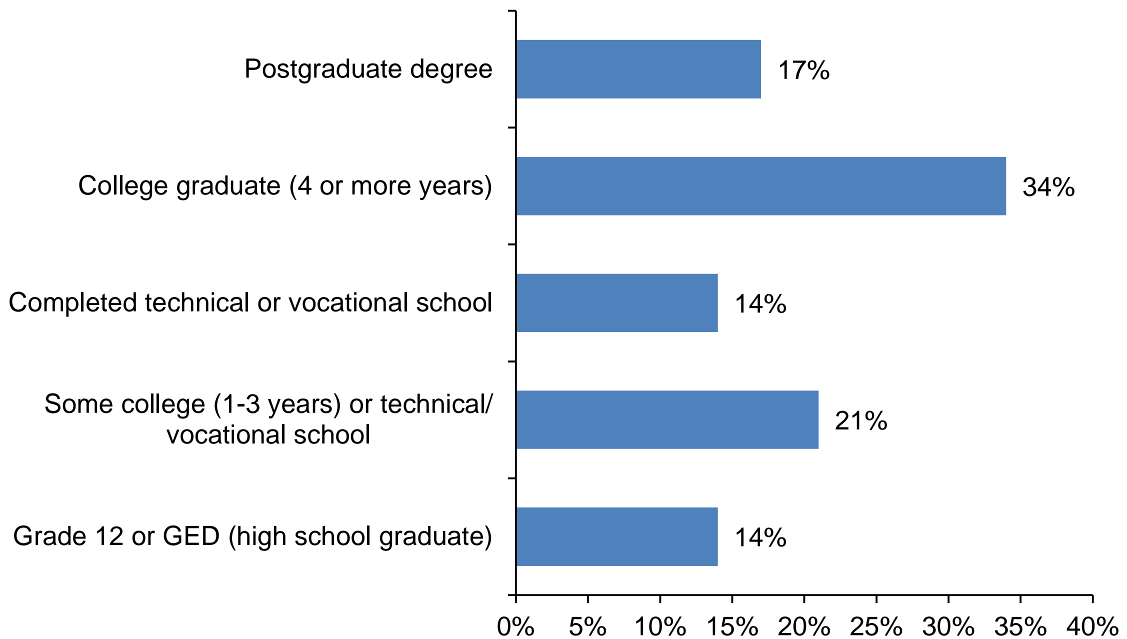
Base: Married (n=24), Divorced (n=2), Widowed (n=2), Separated (n=1), Sample Size = 29

(Community = Day)



Base: House, owned (n=29), Sample Size = 29

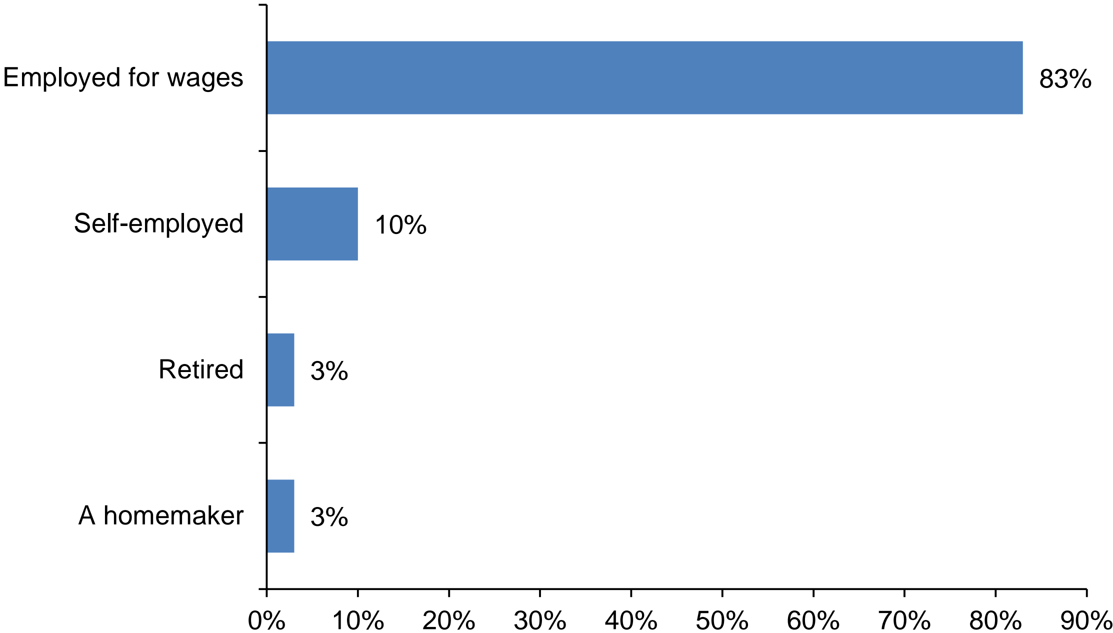
(Community = Day)



Base: Grade 12 or GED (high school graduate) (n=4), Some college (1-3 years) or technical/ vocational school (n=6), Completed technical or vocational school (n=4), College graduate (4 or more years) (n=10), Postgraduate degree (n=5), Sample Size = 29

(Community = Day)

Employment Status



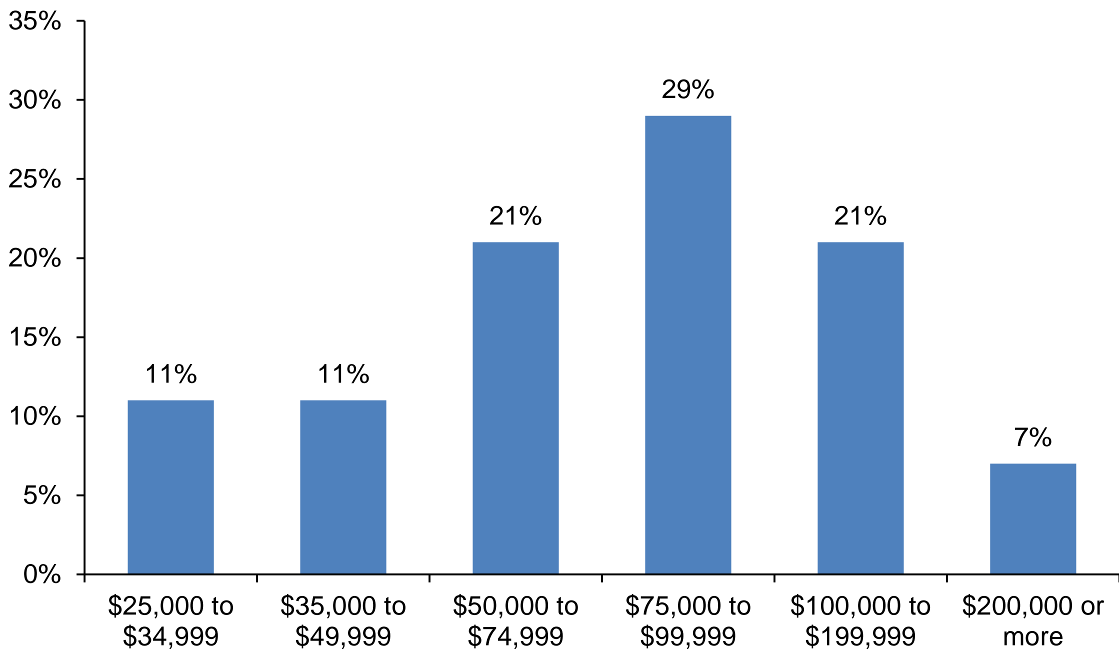
Base: Employed for wages (n=24), Self-employed (n=3), A homemaker (n=1), Retired (n=1), Sample Size = 29

(Community = Day)

Base: Qualtrics (n=2), Open Invitation / FaceBook (n=27), Sample Size = 29

(Community = Day)

Total Household Income



Base: $25,000 to $34,999 (n=3), $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=6), $75,000 to $99,999 (n=8), $100,000 to $199,999 (n=6), $200,000 or more (n=2), Sample Size = 28

(Community = Day)

Webster 2019 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote		Round 2 Vote	Round 3 Vote
Economic Well-Being • Availability of affordable housing 3.30 • Maintaining livable and energy efficient homes 3.21	1 elderly housing			
Children and Youth • Childhood obesity 3.57 • Substance abuse by youth 3.48 • Bullying 3.47 • Availability of services for at-risk youth 3.30 • Opportunities for youth-adult mentoring 3.23	1 for children and youth 1 childhood obesity 2 substance abuse by youth			
Aging Population • Cost of long-term care 3.62 • Cost of memory care 3.46 • Availability of memory care 3.45 • Availability of resources for family and friends caring for and helping to make decisions for elders 3.37 • Cost of in-home services 3.34 • Availability of activities for seniors 3.20	**2 aging population** **2 cost of LTC** **3 availability of resources**			
Safety • Presence of street drugs 3.80 • Culture of excessive and binge drinking 3.69 • Presence of drug dealers 3.53 • Abuse of prescription drugs 3.48 • Domestic violence 3.28 • Criminal activity 3.23	1 safety 2 presence of street drugs 2 abuse of PX drugs			
Health Care Access • Availability of behavioral health (substance abuse) providers 3.76 • Availability of mental health providers 3.66 • Access to affordable health insurance coverage 3.40 • Access to affordable prescription drugs 3.20	2 – availability of behavioral health **6 – availability of mental health** **1 availability of assisted living** **1 health care costs**			

Health Indicator/Concern	Round 1 Vote		Round 2 Vote	Round 3 Vote
Mental Health and Substance Abuse • Alcohol use and abuse 3.77 • 25% self-report that they binge drink at least 1X/month • Drug use and abuse 3.73 • Depression 3.60 • Dementia and Alzheimer's disease 3.33 • Smoking and tobacco use 3.32 10% self-report that they currently smoke cigarettes • Stress 3.30 • 32% have been diagnosed with anxiety/stress • 221% have been diagnosed with depression • 28% self-report that they have drugs in their home that are not being used	2- mental health and substance abuse **4 drug use and abuse**			
Wellness • 36% report that they are obese • 32% report that they are overweight • 59% do not get 5 or more fruits/vegetables/day • 53% do not get moderate exercise 3 or more times/week • 53% have been diagnosed with hypertension • 42% have been diagnosed with high cholesterol • 32% have been diagnosed with arthritis • 21% have been diagnosed with asthma • 14% have not seen their physician for a routine check-up in over 1 year • 16% have not seen their dentist in over 1 year				

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:

Outcomes & Factors Rankings

Outcomes & Factors Sub Rankings

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

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

Ranked Measure Sources and Years

Additional Measure Sources and Years

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

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

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

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

Measure	Data Elements	Description
Preventable hospital stays	**Preventable Hosp. Rate**	Discharges for Ambulatory Care Sensitive Conditions per 1,000 Medicare Enrollees
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetes monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Receiving HbA1c (Black)	Percentage of Black diabetic Medicare enrollees receiving HbA1c test
	% Receiving HbA1c (White)	Percentage of White diabetic Medicare enrollees receiving HbA1c test
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Mammography (Black)	Percentage of Black female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	% Mammography (White)	Percentage of White female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Measure	Data Elements	Description
Children in poverty	**% Children in Poverty**	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Children in Poverty (Black)	Percentage of non-Hispanic Black children (under age 18) living in poverty - from the 2012-2016 ACS
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty – f rom the 2012-2016 ACS
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2012-2016 ACS
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations per 10,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000.
	95% CI - Low	95% confidence interval as reported by the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**Presence of violation**	County affected by a water violation: 1-Yes, 0-No
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities

Measure	Data Elements	Description
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	**% Drive Alone**	Percentage of workers who drive alone to work
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Drive Alone (Black)	Percentage of non-Hispanic Black workers who drive alone to work
	% Drive Alone (Hispanic)	Percentage of Hispanic workers who drive alone to work
	% Drive Alone (White)	Percentage of non-Hispanic White workers who drive alone to work
Long commute - driving alone	# Workers who Drive Alone	Number of workers who commute in their car, truck or van alone
	% Long Commute - Drives Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

County Health Rankings for Day County, South Dakota

;

	County	State
Population	5,571	865,454
% below 18 years of age	22.4%	24.6%
% 65 and older	25.3%	16.0%
% Non-Hispanic African American	0.4%	1.9%
% American Indian and Alaskan Native	9.7%	9.0%
% Asian	0.5%	1.5%
% Native Hawaiian/Other Pacific Islander	0.0%	0.1%
% Hispanic	2.4%	3.7%
% Non-Hispanic white	85.8%	82.5%
% not proficient in English	0%	1%
% Females	48.9%	49.6%
% Rural	100.0%	43.3%

	Day County	Error Margin	Top U.S. Performers	South Dakota
Premature death	5,900	4,500-7,700	5,300	7,000
Poor or fair health	13%	12-13%	12%	12%
Poor physical health days	3.4	3.2-3.6	3.0	3.1
Poor mental health days	3.0	2.8-3.2	3.1	2.9
Low birthweight	6%	4-9%	6%	6%
Premature age-adjusted mortality	310	230-410	270	330
Child mortality			40	70
Infant mortality			4	7
Frequent physical distress	10%	10-11%	9%	9%
Frequent mental distress	10%	10-11%	10%	9%
Diabetes prevalence	11%	8-14%	8%	9%
HIV prevalence			49	73
Adult smoking	16%	15-16%	14%	18%
Adult obesity	34%	28-40%	26%	31%
Food environment index	6.5		8.6	6.6
Physical inactivity	25%	19-31%	20%	22%
Access to exercise opportunities	33%		91%	72%
Excessive drinking	17%	16-17%	13%	20%
Alcohol-impaired driving deaths	40%	23-56%	13%	37%

	Day County	Error Margin	Top U.S. Performers	South Dakota
Sexually transmitted infections	89.5		145.1	462.9
Teen births	25	17-37	15	30
Food insecurity	14%		10%	12%
Limited access to healthy foods	18%		2%	11%
Drug overdose deaths			10	8
Drug overdose deaths - modeled	4-5.9		8-11.9	8.4
Motor vehicle crash deaths			9	16
Insufficient sleep	25%	24-26%	27%	26%
Uninsured	17%	14-19%	6%	12%
Primary care physicians	2,770:1		1,030:1	1,290:1
Dentists	5,570:1		1,280:1	1,710:1
Mental health providers			330:1	610:1
Preventable hospital stays	60	45-75	35	50
Diabetes monitoring	88%	70-100%	91%	84%
Mammography screening	74%	56-91%	71%	66%
Uninsured adults	18%	16-21%	7%	14%
Uninsured children	12%	9-16%	3%	7%
Health care costs	$8,670			$8,345
Other primary care providers	1,114:1		782:1	801:1
High school graduation			95%	84%
Some college	63%	55-72%	72%	68%
Unemployment	4.1%		3.2%	2.8%
Children in poverty	18%	13-23%	12%	17%
Income inequality	4.9	4.4-5.5	3.7	4.1
Children in single-parent households	41%	31-50%	20%	32%
Social associations	19.9		22.1	16.5
Violent crime			62	322
Injury deaths	115	78-162	55	76
Disconnected youth			10%	10%
Median household income	$43,600	$38,100-49,100	$65,100	$54,900
Children eligible for free or reduced price lunch	34%		33%	42%
Residential segregation - black/white			23	63
Residential segregation - non-white/white	57		14	56
Homicides			2	3
Firearm fatalities			7	11
Air pollution - particulate matter	8.2		6.7	7.7
Drinking water violations	No			
Severe housing problems	14%	11-17%	9%	12%
Driving alone to work	72%	68-76%	72%	80%
Long commute - driving alone	20%	15-24%	15%	14%

Note: Blank values reflect unreliable or missing data

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