2019 Community Health Needs Assessment

Community Memorial Hospital
Burke, SD

BECAUSE WE CARE

Community Memorial Hospital
Burke, SD

Community Health Needs Assessment
2019

Dear Community Members,

Community Memorial Hospital is pleased to present the 2019 Community Health Needs Assessment.

Part of the comprehensive assessment work is to identify unmet health needs in the community. Community stakeholders helped to prioritize the unmet needs for further implementation strategy development. We are grateful to all the community members who joined us in this important work.

During late 2017 and early 2018, we asked community members to complete a survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. Community Memorial Hospital (CMH) further analyzed the data, identified unmet needs, and partnered with key community stakeholders to develop a list of resources and assets that were available to address each need. A gap analysis and prioritization exercise were conducted to identify the most significant health needs and to further address these needs through the implementation strategies that are included in this document.

Community Memorial Hospital has set strategy to address the following community health needs:

- Mental Health
- Health Care and Wellness

The report focuses on community assets as well as community health needs. The asset map/resource list is included in this document along with the action steps that will be taken to address each identified need.

At CMH, patient care extends beyond our bricks and mortar. As a not-for-profit organization, ensuring that the benefits of health care reach the broad needs of communities is at the core of who we are. Through our work with communities, we can bring health and healing to the people who live and work across our communities. Together, we can fulfill this mission.

Sincerely,

Mistie Sachtjen
Chief Executive Officer
Community Memorial Hospital

Community Memorial Hospital
Burke, SD

Community Health Needs Assessment
2019

EXECUTIVE SUMMARY

Community Memorial Hospital

Community Health Needs Assessment
2019

Purpose

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

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

Study Design and Methodology

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

1. Non-Generalizable Survey
The Center for Social Research at North Dakota State University developed and maintained links to the online survey tool. NDSU distributed the website address for the survey instrument via e-mail to various key community stakeholders and agencies, at times using a snowball approach**.** A total of 31 respondents participated in the online survey during December 2017 and January 2018.

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

A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.5 and above were included as needs to be addressed and prioritized. Many of the identified needs ranking < 3.5 are being addressed by CMH and community partners; however, 3.5 and above was the focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting
Burke Community Hospital invited community stakeholders to a meeting to review the early findings from the survey and to discuss the top health issues or health-related issues facing the community. Community stakeholders helped to determine key priorities for the community.

3. Community Asset Mapping
Upon review of the data and identifying the unmet needs from the various surveys and data sets, asset mapping was conducted. Researched was done on any unmet needs to determine what resources were available in the community to address those needs. Once gaps were determined, the community stakeholder group proceeded to the prioritization process, utilizing a multi-voting methodology to determine which top priorities would be developed into implementation strategies.

4. Secondary Research
The secondary data includes Robert Wood Johnson *County Health Rankings* for Gregory County, and the *Focus on South Dakota – A Picture of Health* study conducted by the Helmsley Charitable Trust. Indicators reviewed for this assessment include population data, vital statistics, adult behavioral risk factors, crime, and child risk.

Key Findings – Primary Research

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

1. **Economics:** Respondents were most concerned about the availability of affordable housing.

2. **Children and Youth:** Bullying was the top concern among respondents for children and youth. Childhood obesity and availability of education about birth control are also concerns.

3. **Health Care and Wellness:** The health care indicator addresses access to health care and cost concerns. Access to affordable health insurance and availability of mental health providers ranked as top concerns among survey respondents.

4. **Aging:** The number one ranking concern among respondents overall is the cost of long-term care. The cost and availability of memory care and the availability of long-term care also rank as top concerns for the aging.

5. **Safety:** Respondents are most concerned about the abuse of prescription drugs and excessive drinking or binge drinking.

6. **Mental Health/Substance Abuse**: Alcohol use and abuse, drug use and abuse, stress, and depression are high concerns among survey respondents.

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

Health Outcomes

	Gregory County	Tripp County	Charles Mix County	South Dakota	National
Premature Death (years of life lost before age 75 per 100,000 population)		7,500	14,900	7,300	5,400
Poor or Fair Health	14%	14%	17%	12%	12%
# unhealthy mental health days in the last 30 days	3.1	3.2	3.5	2.9	3.1
% live births with low birth weight (<2500g)	4.0%	8.0%	6.0%	6.0%	6.0%

Health Factors

	Gregory County	Tripp County	Charles Mix County	South Dakota	National
% adults currently smoking	17%	17%	21%	18%	14%
% adults considered obese (BMI > 30)	30%	34%	33%	31%	26%
% adults reporting excessive or binge drinking	16%	17%	17%	20%	13%
# alcohol-impaired driving deaths	14%	50%	82%	36%	13%
# sexually transmitted infections	214	184	884	504	152.8
Teen birth rate (# of births per 1,000 female pop. 15-19)	33	35	50	28	14
% uninsured adults	15%	15%	17%	10%	6%
Ratio of population to primary care Physicians	1,390:1	1,100:1	1,570:1	1,320:1	1,050:1
Ratio of population to mental health providers		290:1	1890:1	590:1	310:1
Ratio of population to dentists	2,110:1	1,090:1	2,360:1	1,690:1	1,260:1
Preventable hospital stays (per 100,000 Medicare enrollees)	10,397	6,018	7,018	4,724	2,765
Mammography screening	48%	37%	42%	49%	49%
High school graduation rate	77%	88%	81%	84%	96%
College (at least some post-secondary education)	68%	52%	55%	68%	73%
Unemployment rate	3.6%	2.9%	3.7%	3.3%	2.9%
% child poverty	21%	27%	35%	16%	11%
Social associations	31.2	21.8	20.2	16.4	21.9

	Gregory County	Tripp County	Charles Mix County	South Dakota	National
(# membership associations per 10,000 people)					
% children in single-parent households	37%	25%	43%	31%	20%
Violent crime		147	161	373	63
Food insecurity	12%	14%	13%	12%	9%
Home ownership	70%	69%	68%	68%	80%
% children eligible for free/reduced lunch	49%	47%	80%	38%	32%
Annual median household income	$38,400	$42,700	$42,200	$56,900	$67,100

Based on survey data, the following needs were brought forward for prioritization:

- **Economics** – availability of affordable housing, skilled labor workforce, employment options
- **Children and Youth** – bullying, childhood obesity, availability of education about birth control
- **Healthcare and Wellness** – access to affordable health insurance coverage, availability of mental health providers, availability of behavioral health, access to affordable health care
- **Aging** – cost of long-term care, cost of memory care, availability of long-term care
- **Safety** – abuse of prescription drugs, culture of excessive and binge drinking
- **Mental Health / Substance Abuse** – alcohol use and abuse, drug use and abuse, stress, depression

Sanford has determined the 2020-2022 implementation strategies for the following needs:

- Mental Health
- Health Care and Wellness

Implementation Strategies

Priority 1: Mental Health

Mental Health continues to be a concern in our community and is a serious issue. As a facility, we have made tremendous strides in this area and will continue to push to make improvements. We plan to continue and expand our collaboration with Prairie Hills Counseling by offering community educational classes, providing new services such as equine training, horse powered reading, etc.

We have added tele-med services for Mental Health services based in Sioux Falls and will continue to promote this service as well.

Priority 2: Healthcare and Wellness

Healthcare and Wellness has been a top priority of our facility for several years and continues to be of high importance for both our facility and our community members. Leading a healthy lifestyle plays an integral role in people's lives both physically and mentally. Studies have shown a direct correlation to increased health concerns for those individuals that do not lead an active lifestyle.

As a facility, we will continue to work with our local fitness organizations in both Burke and Bonesteel to offer a variety of exercise classes at no charge to the public. The addition of Post 36 Fitness Center was added in Bonesteel in 2019. We will work to add new classes at both locations and provide more classes. We will also work with Fitness on Main to host and improve upon our annual wellness challenges. We will be hosting both Spring and Fall Health Fairs that include lab tests at either no cost or a reduced cost.

We will also be collaborating with local fitness groups and our local Dietician to offer a variety of nutritional education opportunities to community members. We hope to get community members educated on their health and the little things they can do that will impact there overall physical health substantially.

Community Memorial Hospital

Community Health Needs Assessment
2019

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Purpose of the Community Health Needs Assessment

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

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

Our Mission: Excellence in the provision of health care and related services, governed as a Not-For-Profit Community Organization, serving the needs of our people with superior quality and value.

Our Guiding Principles:

- All health care is a community asset
- Care should be delivered as close to home as possible
- Integrated care delivers the best quality and efficiency
- Community involvement and support is essential to success

Acknowledgements

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

Burke Community Memorial Hospital Steering Group:

- Mistie Sachtjen, Administrator
- Helen Holmes, Director of Nursing
- Tami Lyon, Business Office Manager
- Tammy Knight, Clinic Manager

- Ashley Peck, Radiology Manager
- Cheryl Schmitt, Lab Manager
- Andrew Hamilton, Director of Plant Operations
- Nancy Johnson, Dietary Manager

We express our gratitude to the following community collaborative members for their expertise with the CHNA process. From planning, development and analysis of the community health needs assessment to completing the survey, numerous community members contributed to this project for which we are grateful. We extend special thanks to physicians, nurses, school leadership and school board members, representatives from the Native American community, representatives for the mentally and physically disabled, social services, the county sheriff, non-profit organizations, and public health officers for their participation in this work. Together we are reaching our vision "to improve the human condition through exceptional care, innovation and discovery.

- Mike Glover – Finance Officer, City of Burke
- Kristi Carlson – Office Assistant, Gregory County Community Health
- Todd Halsne – RN, Burke Community Memorial Hospital
- Kelsea K. Sutton – Lawyer, First Fidelity Bank
- Bille H. Sutton – Investment Services Officer, First Fidelity Bank
- Nancy Johnson – Dietary Manager, Burke Community Memorial Hospital
- Cheryl Schmitt – Lab Manager, Burke Community Memorial Hospital
- Ashley Peck – Radiology Manager, Burke Community Memorial Hospital
- Doug Spitzenberger – Board Member, Burke Community Memorial Hospital
- Alec Brady – Operations Manager, First Fidelity Bank
- Katelyn Brady – Marketing, First Fidelity Bank
- Megan Smith – Family Medicine Physician, Burke Community Memorial Hospital
- Andrew Hamilton – Maintenance Supervisor, Burke Community Memorial Hospital
- Whitney Hutchison – Pharmacy Student, SDSU
- Tom Glover – Mayor, City of Burke and Board Member, Burke Community Memorial Hospital
- Erik Person – Superintendent, Burke School District
- Tyler Van Metre – Pharmacist, Burke Community Memorial Hospital
- Jerry Peterson – Retired Pharmacy Board Chair
- Rachelle Norberg – Lawyer
- Charlene Juran – Elderly/Disabled HUD Housing Executive Director
- George Kenzy – President, First Fidelity Bank
- Jim Waterbury – Gregory County Auditor
- Joe Fahrenbacher – Publisher, The Burke Gazette
- Kate Witt – Teacher
- Kim Vosita – Store Manager
- Mark Otten – Pre K-12 Principal
- Mel Juran – President, Missouri Valley Mutual Insurance
- Randy Sachtjen – COO, First Fidelity Bank
- Sara Grimm – Rancher
- Susan Chytka
- Vern Witt – Business Owner
- Vickie Dobesh - Retail

Description of Community Memorial Hospital, Burke, SD

Community Memorial Hospital, Inc. (CMH) is a 16-bed critical access hospital located in Burke, South Dakota, providing a full range of diagnostic and therapeutic services for the community. It provides inpatient and skilled swing beds and 24-hour emergency services. CMH operates two provider-based rural health clinics located in the communities of Burke and Bonesteel. Community Memorial Hospital was incorporated in 1945 and first opened its doors in 1948. It is the largest employer in the community with 62 employees.

Description of Community Served

Burke, SD Burke has a population of 604 residents and is the county seat of Gregory County, a rural farming and ranching community located in south central South Dakota. The economy is primarily agricultural, including businesses and services that support agriculture producers. Education and health services account for the largest non-agriculture industries. The area serves as a recreational destination for many neighboring counties with world-class hunting, fishing and recreational activities on the Missouri River.

Study Design and Methodology

Primary Research

Key Stakeholder Survey - A non-generalizable online survey was conducted by Burke Community Memorial Hospital with the assistance Sanford Health, public health leadership, and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. The website address for the survey instrument was distributed via e-mail to community stakeholders and various agencies, at times using a snowball approach. Data collection occurred throughout December 2017 and January 2018 with a total of 31 respondents participated in the online survey.

The purpose of this non-generalizable survey of community members and key stakeholders in the greater Burke area was to learn about the perceptions of area community leaders regarding community health, their personal health, preventive health, and the prevalence of disease. This group included community leaders and agency leaders representing chronic disease and disparity.

A Likert scale was developed to determine the respondent's highest concerns. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized. As stated in the generalizable survey methodology, many of the identified needs that ranked below 3.5 are being addressed by Burke Community Memorial Hospital. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

Resident Survey – The resident survey 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 87 community residents participated in the survey.

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

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

Prioritization Process - The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the

American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to complete the multi-voting exercise.

Secondary Research
The secondary data includes 2019 County Health Rankings and the Focus on South Dakota – A Picture of Health study for Gregory County, Tripp County and Charles Mix County.

Limitations of the Study

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

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

Burke Community Memorial Hospital extended a good faith effort to engage all of the aforementioned community representatives in the survey process. In some cases there were surveys submitted without names or without a specified area of expertise or affiliation. We worked closely with public health experts throughout the assessment process.

Public comments and response to the community health needs assessment and the implementations strategies are welcome on the Sanford website under “About Sanford” in the Community Health Needs Assessment section.

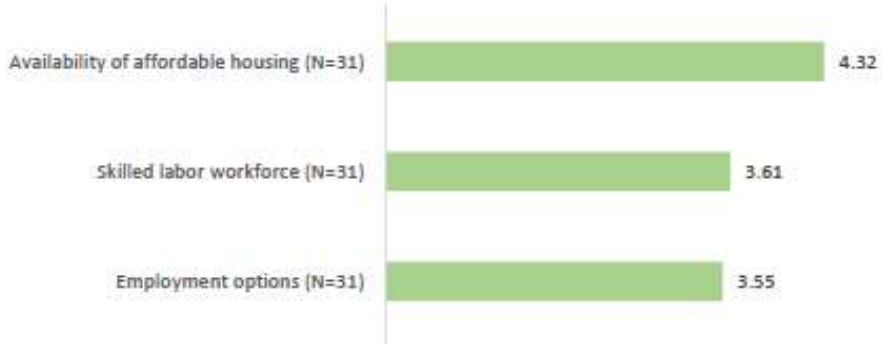
Key Findings

Community Health Concerns

Economics

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

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



Children and Youth

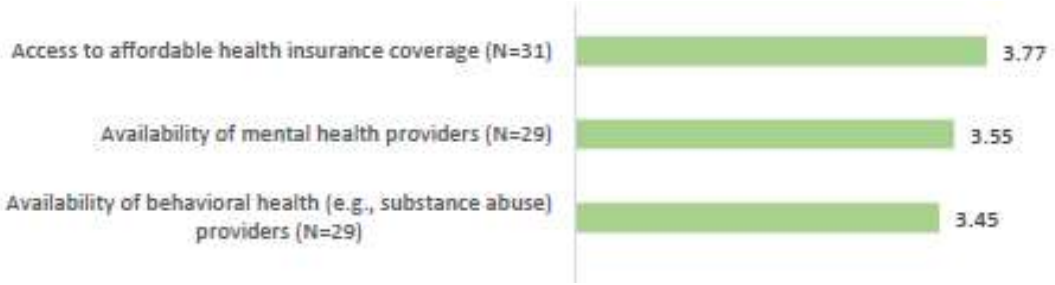
The highest concern regarding children and youth is bullying. Childhood obesity and the availability of education about birth control were other top concerns mentioned.

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

Health Care and Wellness

Access to care includes the ability to gain entry into a health system or provider service. Access can include the availability of health care providers and a workforce available to address the needs. Limited access can challenge the ability to receive appropriate levels of care and may pave the way to the utilization of higher cost entry points into the system through the emergency room. The top concern among survey respondents is access to affordable health insurance.

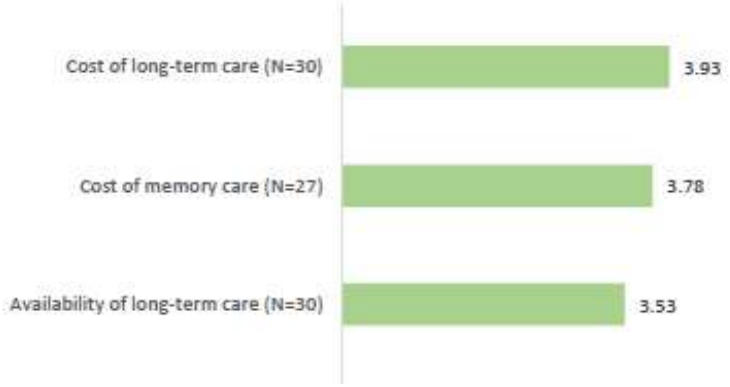
Level of concern with statements about the community regarding HEALTH CARE
(1=no attention needed; 5=critical attention needed)



Aging Population

The greatest area of concern among survey respondents is for the aging population, including the cost of long-term care, the availability of memory care, and the availability of long-term care. Secondary research indicates 24.8% of the population in Gregory County is 65 years of age or older.

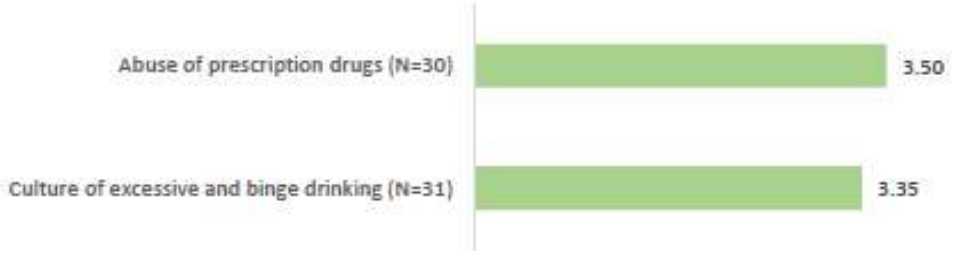
Level of concern with statements about the community regarding the AGING POPULATION
(1=no attention needed; 5=critical attention needed)



Safety

Respondents have high levels of concern with respect to safety issues such as the abuse of prescription drugs and a culture of excessive and binge drinking. Secondary research finds that alcohol-impaired driving deaths have reached 14% in Gregory County, 82% in Charles Mix County and 50% in Tripp County.

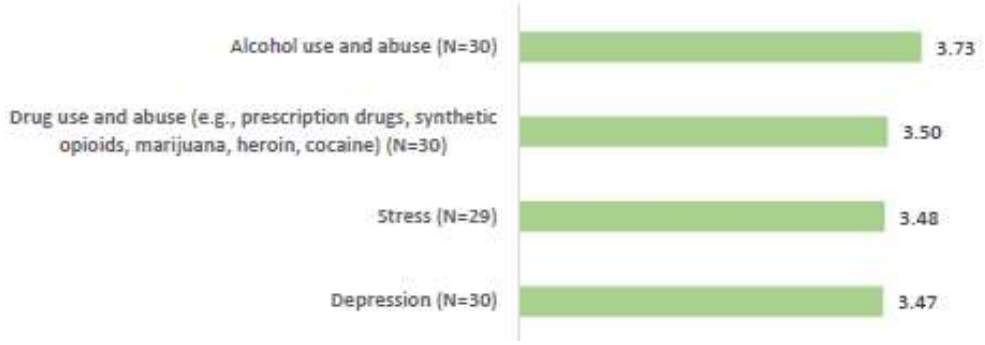
Level of concern with statements about the community regarding SAFETY
(1=no attention needed; 5=critical attention needed)



Mental Health and Substance Abuse

The highest concerns among survey respondents are alcohol use and abuse, drug use and abuse, stress, and depression.

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

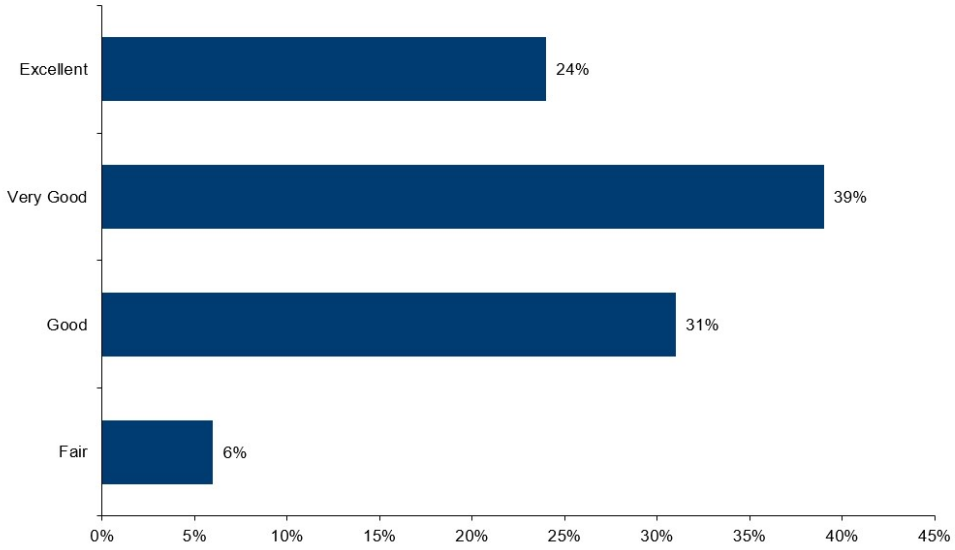


Personal Health Concerns

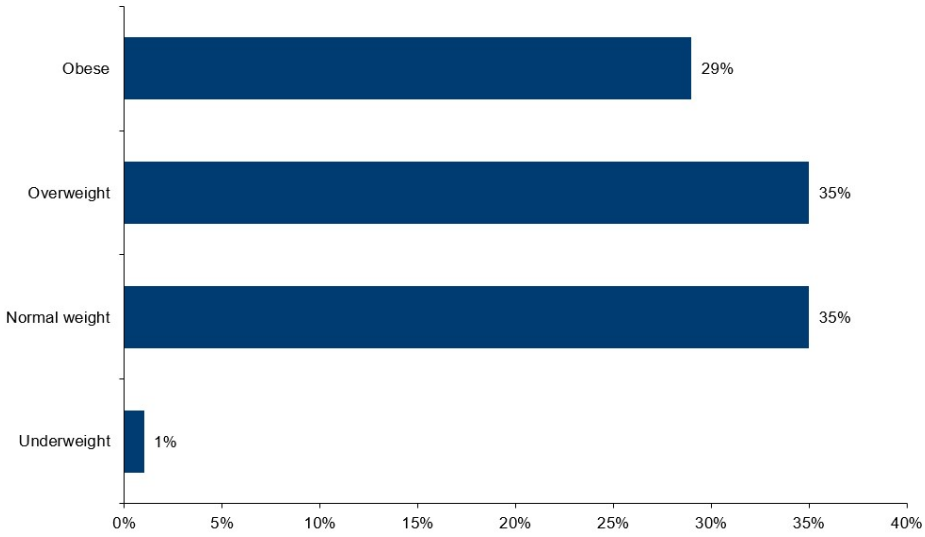
Respondents' Personal Health Status

The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI), which calculates weight status using an individual's weight and height, 64% of respondents reported themselves as overweight or obese. However, the vast majority (94%) of community respondents rate their own health as excellent, very good, or good.

Respondents' rating of their health in general:



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



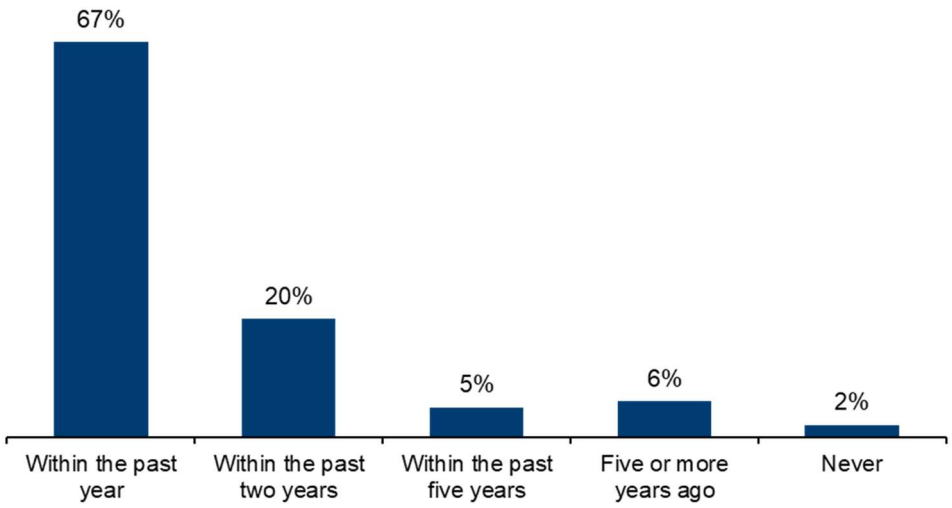
Obesity is a common but serious disease. Obesity can have adverse effects on health and lead to a reduced life expectancy. Adults with a BMI > 25 are overweight and adults with a BMI > 30 are obese. According to the CDC, obesity and being overweight are the second leading cause of preventable deaths,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

Health conditions related to obesity:

- Coronary heart disease
- Type 2 diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension
- Dyslipidemia
- Stroke
- Liver and gallbladder disease
- Sleep apnea and respiratory problems
- Osteoarthritis
- Gynecological problems

Nationally, approximately 39% of adults are obese. For more information on BMI, visit the Center for Diseases Control and Prevention: www.cdc.gov/healthyweight/assessing/bmi/

Length of time since respondents last visited a doctor or health care provider for a routine physical exam:



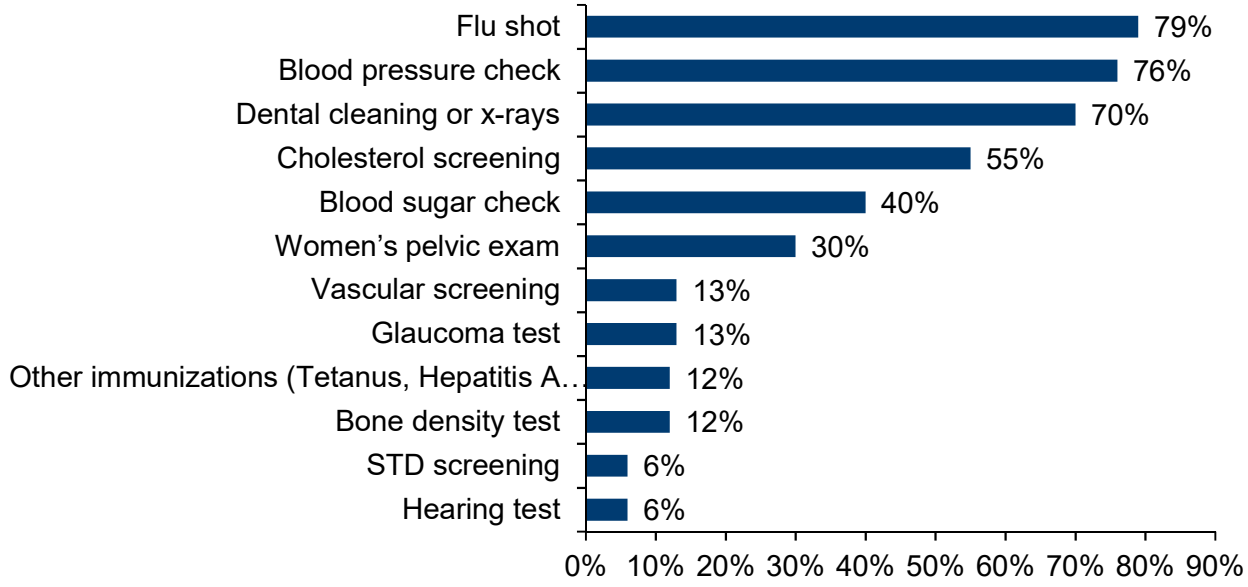
Within the past year, 67% visited a doctor or health care provider for a routine physical. Respondents indicated that the main barriers to a routine check-up were that they did not need to see a doctor or the time was not convenient. Fear and cost were also mentioned as barriers.

Preventive Health

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

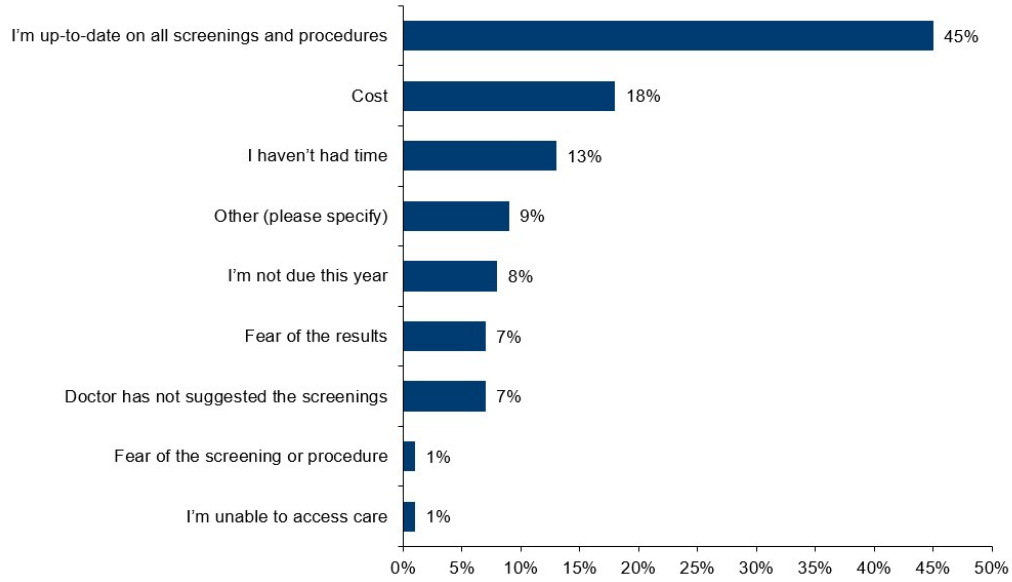
cholesterol screening. However, there are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, glaucoma test, hearing screening, immunizations, STD test, vascular screening, colorectal cancer screening, prostate cancer, etc. Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate.

Whether or not respondents have had preventative screenings in the past year by type:



Community – Gregory / Tripp / Charles Mix Counties. Sample Size = 82. Base: Blood pressure check (n=62), Blood sugar check (n=33), Bone density test (n=10), Cholesterol screening (n=45), Dental cleaning or x-rays (n=57), Flu shot (n=65), Other immunizations (Tetanus, Hepatitis A or B) (n=10), Glaucoma test (n=11), Hearing test (n=5), Women's pelvic exam (n=25), STD screening (n=5), Vascular screening (n=11).

Of respondents who have not had preventative screenings in the past year, reasons why they have not, by type of screening:



Community – Gregory / Tripp / Charles Mix Counties. Sample Size = 82. Base: I'm up-to-date on all screenings and procedures (n=38), Doctor has not suggested the screenings (n=6), Cost (n=15), I'm unable to access care (n=1), Fear of the screening or procedure (n=1), Fear of the results (n=6), I'm not due this year (n=7), I haven't had time (n=11), Other (please specify) (n=8).

Screenings

- *Breast cancer screening*: According to the Center for Disease Control (CDC), a mammogram is an X-ray of the breast. Mammograms are the best way to find breast cancer early, when it is easier to treat and before it is big enough to feel or cause symptoms. Having regular mammograms can lower the risk of dying from breast cancer. The United States Preventive Services Task Force recommends that if you are 50 to 74 years old, be sure to have a screening mammogram every two years. If you are 40 to 49 years old, talk to your doctor about when to start and how often to get a screening mammogram.

- *Cervical cancer screening*: Cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up. Two screening tests can help prevent cervical cancer or find it early:

    - The Pap test (or Pap smear) looks for pre-cancers, cell changes on the cervix that might become cervical cancer if they are not treated appropriately. The Pap test is recommended for all women between the ages of 21 and 65 years old, and can be done in a doctor's office or clinic.
    - The HPV test looks for the virus that can cause these cell changes (human papillomavirus) (http://www.cdc.gov/cancer/hpv/basic_info/)

- *Colorectal cancer screening*: Colorectal cancer almost always develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can also find colorectal cancer early, when treatment works best. Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends

screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 and continuing until age 75.

- *Prostate cancer screening*: The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:
    - Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.
    - Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than age 65).
    - Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).

  After this discussion, those men who want to be screened should be tested with the prostate specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as a part of screening. If, after this discussion, a man is unable to decide if testing is right for him, the screening decision can be made by the health care provider, who should take into account the patient's general health preferences and values.

  Assuming no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test: Men who choose to be tested who have a PSA of less than 2.5 ng/mL may only need to be retested every 2 years. Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher. Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone, is important when making decisions about screening.

  Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing becomes available. Further discussions are also needed to take into account changes in the patient's health, values and preferences.

- *Skin cancer screening*: The U.S. Preventive Services Task Force (USPSTF) has concluded there is not enough evidence to recommend for or against routine screening (total body examination by a doctor) to find skin cancers early. The USPSTF recommends that doctors: 1) Be aware that fair-skinned men and women aged 65 and older, and people with atypical moles or more than 50 moles, are at greater risk for melanoma; 2) Look for skin abnormalities when performing physical examinations for other reasons.

<u>Flu Vaccines</u>

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the survey indicate that 21% of respondents did not have a flu shot last year. The Center for Disease Control states that influenza

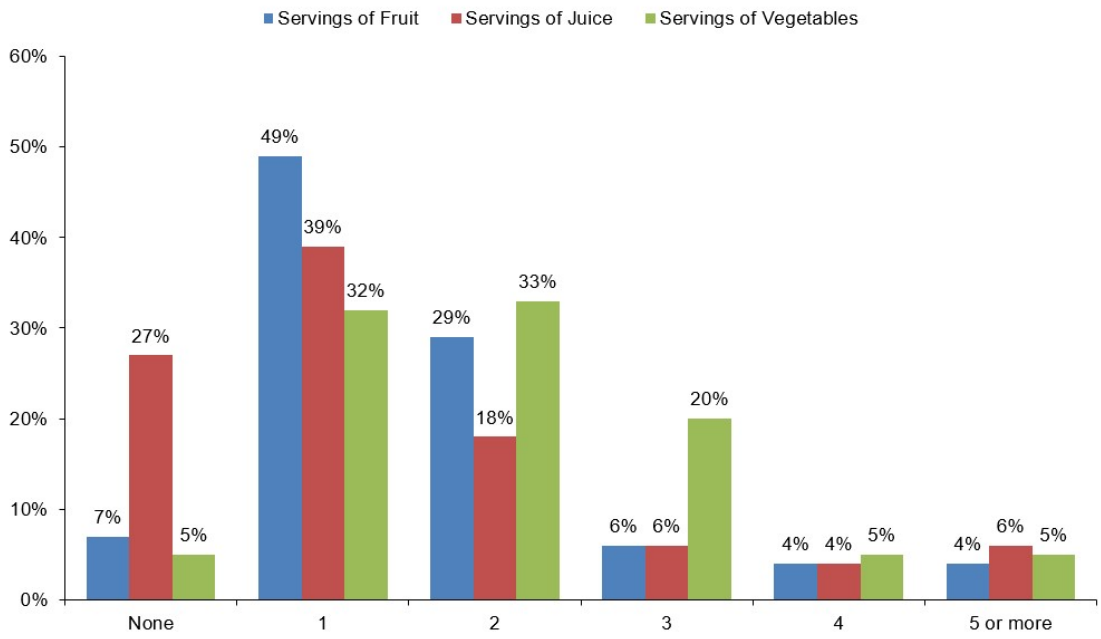
is a serious disease that can lead to hospitalization and sometimes death. Even healthy people can get sick from the flu and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies provide protection against infection with the viruses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

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 30% of respondents reported having 3 or more servings of vegetables the prior day, and 14% reported having 3 or more servings of fruits the prior day.

The U.S. Department of Health and Human Services, U.S. Department of Agriculture Dietary Guidelines for Americans recommends that individuals consume 3 to 5 servings of vegetables per day and 2 to 4 servings of fruit per day depending on age. A diet high in fruits and vegetables is associated with decreased risk for chronic diseases. In addition, because fruits and vegetables have low energy density (i.e., few calories relative to volume), eating them as part of a reduced-calorie diet can be beneficial for weight management.

Number of servings of fruit/vegetables/juice respondents had the day prior:

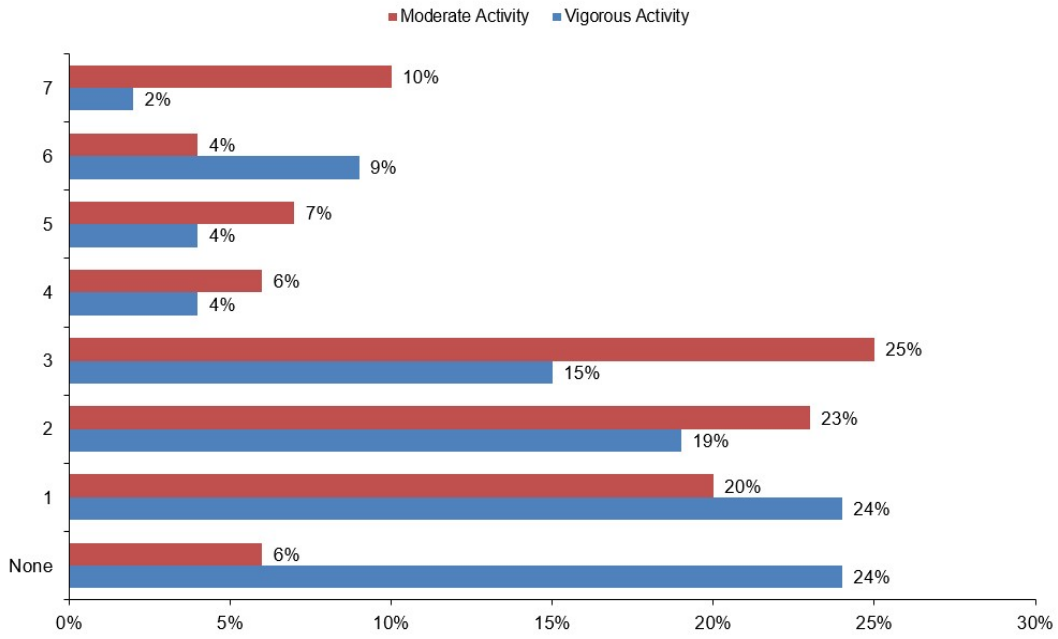


Sample Size = variable. (Community = Gregory / Tripp / Charles Mix Counties.)

Physical Activity Levels

Study results suggest that the majority of respondents do meet physical activity guidelines. 52% of respondents engage in moderate activity three or more times per week and 34% engage in vigorous activity three or more times per week. Guidelines from the Centers for Disease Control and Prevention recommend that individuals participate in 150 minutes of moderate physical activity per week or 75 minutes of vigorous physical activity per week to help sustain and improve health.

Days per week of moderate or vigorous physical activity:

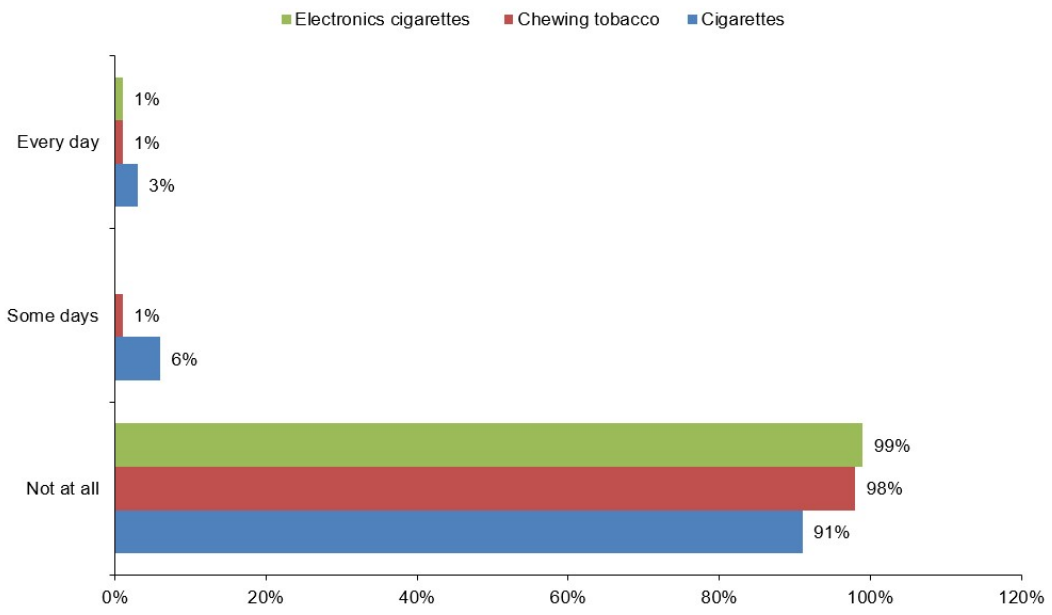


Sample Size = variable. (Community = Gregory / Tripp / Charles Mix Counties.)

Tobacco Use

Study results indicate that the vast majority (91%) of community respondents are not currently tobacco users. Respondents indicated that 3% smoke daily and 6% smoke on some days, with the majority not smoking at all. However, secondary research through the County Health Rankings finds that 17% of Gregory County, 21% of Charles Mix County, and 17% of Tripp County are current smokers. The national benchmark per CDC data is 14%.

How often respondents currently use tobacco:



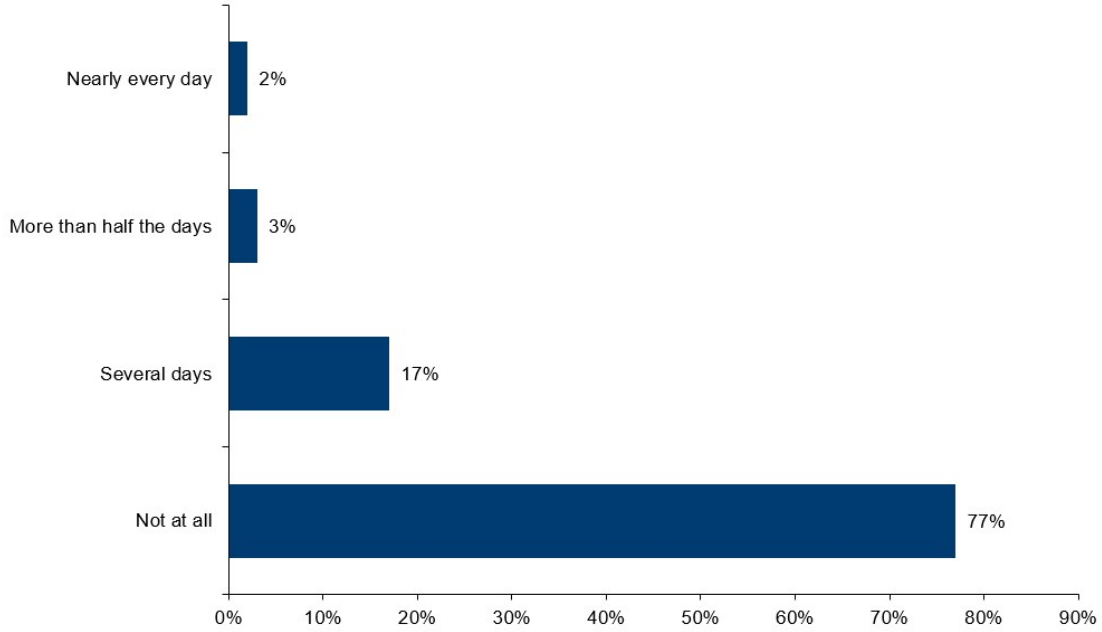
Sample Size = variable. (Community = Gregory / Tripp / Charles Mix Counties.)

Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act, and feel. Mental health influences physical health, how we handle stress, how we make choices, and how we relate to others.

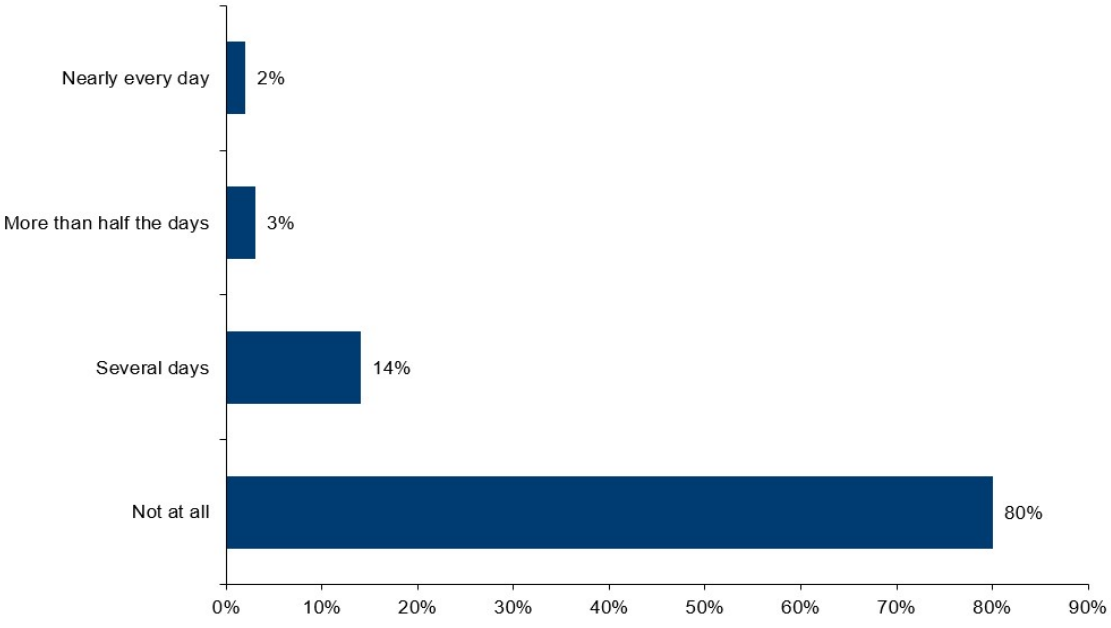
23% of survey respondents self-report that in the last month, there were days when their mental health was not good (feeling down, depressed, or hopeless), with 20% reporting having days in the past month where they had little interest or pleasure in doing things.

Respondents indicating they felt down, depressed, or hopeless:



Base: Not at All (N=66), Several Days (N=15), More Than Half the Days (N=3), Nearly Every Day (N=2). Sample Size = 86. (Community = Gregory / Tripp / Charles Mix Counties.)

Respondents indicating they had little interest or pleasure in doing things:

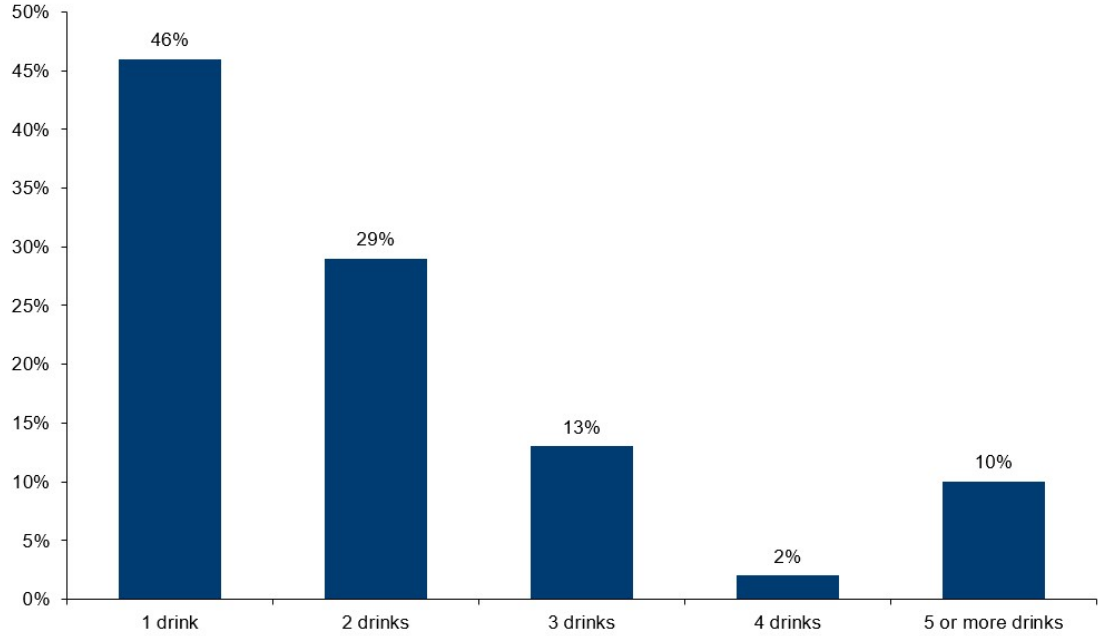


Base: Not at All (N=69), Several Days (N=12), More Than Half the Days (N=3), Nearly Every Day (N=2). Sample Size = 86. (Community = Gregory / Tripp / Charles Mix Counties.)

Substance Abuse Responses

Substance abuse is also a mental health disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and can stem from mental health concerns. In the Burke community, 25% reported having 3 or more drinks on days that they consumed.

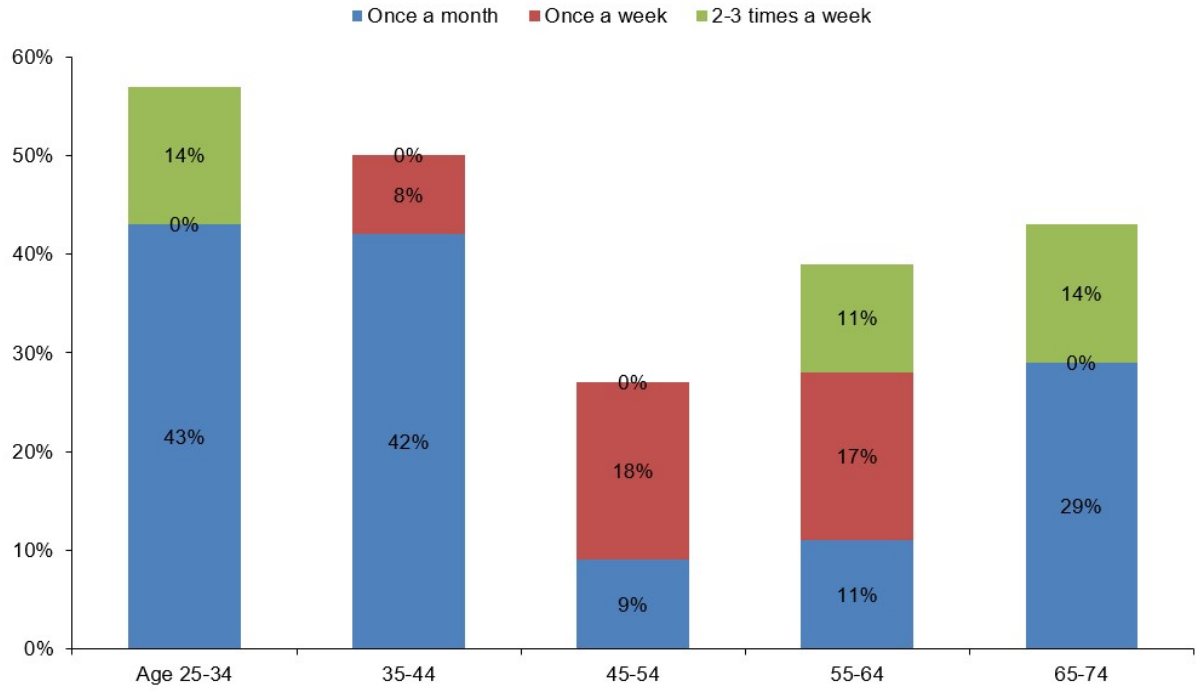
During the past month on days that respondents drank, average number of drinks per day consumed:



Base: 1 drink (N=24), 2 drinks (N=15), 3 drinks (N=7), 4 drinks (N=1), 5 or more drinks (N=5). Sample Size = 52. (Community = Gregory / Tripp / Charles Mix Counties.)

Binge Drinking: 24% of survey respondents reported that they binge drink at least once per month. Secondary research through the County Health Rankings indicates that 16% of Gregory County, 17% of Charles Mix County, and 17% of Tripp County residents report binge drinking.

Incidence of binge drinking in the past 30 days by age, according to survey respondents:



Base: 25-34 (n=7), 35-44 (n=6), Once a month (n=13), Never (n=32), Sample Size = 55. (Community = Gregory / Tripp / Charles Mix Counties.)

Overall, 16% of respondents report alcohol use has had harmful effects on themselves or a family member in the past two years. Other forms of substance abuse include the use of prescription or non-prescription drugs. Two percent of survey respondents say prescription or non-prescription drug abuse has had harmful effects on themselves or a family member in the past two years.

Demographics

General Population Data by County

	Gregory County	Tripp County	Charles Mix County
Total population	4,209	5,480	9,319
Median age	45.8	46.5	36.0
Median household income	$42,679	$48,409	$44,104
% living below poverty level	15.3%	19.7%	21.4%
Unemployment rate	2.9%	2.5%	3.5%
% high school graduate or higher	87.5%	89.4%	87.3%

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

Survey Respondents

Of the respondents, 55% were female and 45% were male. Over 90% of respondents owned their own homes, 81% were employed with 12.9% self-employed, and 55% had completed at least some post-secondary education. Thirteen percent of those surveyed are military veterans.

Zip code of respondents

Zip code	# of respondents
57523	23
57317	2
57533	2
57529	1
57538	1

Health Needs and Community Resources Identified

One of the requirements for a community health needs assessment is to identify the resources that are available in the community to address unmet needs. Asset mapping was conducted by reviewing the primary and secondary research and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources were available in the community to address the needs.

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

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

The asset map includes identified needs from the following:

- Identified needs from the non-generalizable survey
- Community stakeholders review and further development
- Secondary research data
- Community resources that are available to address the need(s)

The Asset Map can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Economic Well-Being
- Children and Youth
- Health Care and Wellness
- The Aging Population
- Safety
- Mental Health and Substance Abuse

Burke Community Memorial Hospital 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, leaders will communicate these findings with community leaders and experts who can best focus on a solution to the concern. A document sharing what Burke Community Memorial Hospital is doing to address the needs or explaining why it is not addressing the needs is in the Appendix.

Members of the community stakeholder group determined that Mental Health and Healthcare and Wellness are top unmet needs. Sanford has developed the 2020-2022 implementation strategies to address these top issues.

Addressing the Needs

Identified Concerns	How Burke Community Hospital is Addressing the Needs
Economic Well-Being - Cost of affordable housing - Skilled labor workforce - Employment options	- Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders. - Community Memorial is the largest employer is town and has added new positions opening up a few new employment opportunities.
Children and Youth - Bullying	- Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders. - Community Memorial will share findings with school administration.
Healthcare and Wellness - Access to affordable health insurance - Availability of mental health providers	- Community Memorial Hospital will host community health fairs which include lab draws at a reduced rate or no charge. - The hospital also has a charity care program that is available to those in need. - Community Memorial Hospital continues to makes strides improving increased availability to mental health services. Services are now available 4 days a week on site.
Aging - Cost of long-term care - Cost of memory care - Availability of long-term care	- Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders.
Safety - Abuse of prescription drugs	- Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders. - Community Memorial Hospital added a Med Drop Box in the clinic for people to safely discard of their prescription medications.
Mental Health - Alcohol use and abuse - Drug use and abuse	- Community Memorial Hospital was responsible for getting Mental Health services on site 4 days a week. Counseling is a key part of substance abuse.

2020-2022 Implementation Strategies

Implementation Strategies

Priority 1: Mental Health

Mental Health continues to be a concern in our community and is a serious issue. As a facility we have made tremendous strides in this area and will continue to push to make improvements. We plan to continue and expand our collaboration with Prairie Hills Counseling by offering community educational classes, providing new services such as equine training, horse powered reading, etc.

We have added tele-med services for Mental Health services based in Sioux Falls and will continue to promote this service as well.

Priority 2: Healthcare and Wellness

Healthcare and Wellness has been a top priority of our facility for several years and continues to be of high importance for both our facility and our community members. Leading a healthy lifestyle plays an integral role in people's lives both physically and mentally. Studies have shown a direct correlation to increased health concerns for those individuals that do not lead an active lifestyle.

As a facility we will continue to work with our local fitness organizations in both Burke and Bonesteel to offer a variety of exercise classes at no charge to the public. The addition of Post 36 Fitness Center was added in Bonesteel in 2019. We will work to add new classes at both locations and provide more classes. We will also work with Fitness on Main to host and improve upon our annual wellness challenges. We will be hosting both Spring and Fall Health Fairs that include lab tests at either no cost or a reduced cost.

We will also be collaborating with local fitness groups and our local Dietician to offer a variety of nutritional education opportunities to community members. We hope to get community members educated on their health and the little things they can do that will impact there overall physical health substantially.

Community Health Needs Assessment Implementation Strategy for Burke Community Memorial Hospital 2020-2022 Plan

Priority 1: Mental Health/Behavioral Health and Substance Abuse

Projected Impact: Increased awareness of mental health resources available to those in need

Goal 1: Develop and distribute mental health services directory to community groups

Actions/Tactics	Measurable Outcomes	Resources	Leadership	Community Partnerships / Collaborations (if applicable)
Identify programs currently in place	Resources in a 60 miles radius of Burke will be looked at	CMH Staff	CMH Leadership	
Develop and distribute a directory of mental health services to groups identified as high risk	Develop a directory ready for distribution by July 1, 2020	CMH Staff	CMH Leadership	

Goal 2: Decrease substance abuse within the community

Actions/Tactics	Measurable Outcomes	Resources	Leadership	Community Partnerships / Collaborations (if applicable)
Partner with the local school district to provide information on substance abuse	Attendance and number of reported incidents	CMH Staff School Administration	CMH Leadership	Local High School
Educate public on take back program	Publish education material in the paper and on social media	CMH Staff	CMH Leadership	

Priority 2: Healthcare and Wellness

Projected Impact: Improve quality of life of community members through increased physical activity.

Goal 1: Promote physical activity within the community.

Actions/Tactics	Measurable Outcomes	Resources	Leadership	Community Partnerships / Collaborations (if applicable)
Community Health Fairs	Participation of community members	CMH Staff	CMH Leadership	To be offered in fall and spring
Wellness Challenges	Participation of community members	CMH Staff	CMH Leadership	Fitness on Main
Free Exercise Classes offered to the public	Participation of community members	Fitness Instructors	CMH Leadership Fitness on Main Leadership and Post 36 Leadership	Fitness on Main Post 36 Fitness

Goal 2: Promote a healthy lifestyle and reduce negative health effects of obesity within the community

Actions/Tactics	Measurable Outcomes	Resources	Leadership	Community Partnerships / Collaborations (if applicable)
Free Blood Pressure Screenings (annually)	Participation of community members	CMH Staff	CMH Leadership	Fitness on Main
Nutrition Education Classes	Participation of community members	CMH Staff	CMH Leadership	Contract Dietician
Nutrition Counseling	Increase in number of dietary consults and RN Health Coach visits	Contract Dietician	Providers	Contract Dietician

2016 Implementation Strategy Impact

The 2016 Community Health Needs Assessment served as a catalyst to lift up Mental Health and Physical Health services as implementation strategies for the 2017-2019 timespan. The 2016 strategies have served a broad reach across our community and region. The impact has been positive and the work will continue into the future through new or continued programming and services. The following strategies were implemented.

Demonstrating Impact

The 2016 Community Health Needs Assessment identified the following needs and developed implementation strategies to address the unmet needs:

Priority 1: Physical Health

- Provided Spring and Fall Health Fairs with free lab draws
- Partnered with Fitness on Main and Post 36 Fitness to offer free exercise classes for the public
- Featured an Annual Community Weight Loss Challenge in collaboration with Fitness on Main
- Presented Sanford *fit* program to our local school district

Priority 2: Mental Health

- Increased completions of PQh-9s in Clinic
- Secured a mental health counselor on site four days a week
- Began offering tele-med services for behavioral health
- Decreased patients being prescribed pain medications by 54%
- Installation of Med Drop Box in the clinic for individuals to safely discard their prescription medications

The 2016 Community Health Needs Assessment helped identify concerns within the community and determine areas of improvement. Implementation strategies were put in place that have been very successful overall. Community members have been very appreciative of the strategies and it has reflected in a positive impact. As a facility, we look forward to continuing such work and making improvements.

Community Feedback from the 2016 CHNA

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

Community members have provided very positive feedback on the work the hospital has done to improve both physical and mental health in the community. The addition of counseling services in the community has been highly praised and is a huge benefit to community members and members of surrounding communities.

APPENDIX

Primary Research

Burke Community Memorial Hospital and Health Services - Asset Mapping

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Focus on South Dakota Report for Gregory County and/or County Health Rankings	Community resources that are available to address the need
Economics • Cost of affordable housing 4.32 • Skilled labor workforce 3.61 • Employment options 3.55		10% of county residents have housing problems (overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities) Median household income ($38,400) is below SD Avg. of $56,900.	Affordable housing resources: • Burke Housing & Redevelopment Commission – 605-775-2676 Low income apartments: • Rosebud Apts. – 605-775-2531 • Parkview Manor – 605-775-2531 Rural Office of Community Services • Karen Janousek - 605-487-7635 Employment resources: • Winner Department of Labor and Regulation Office – 605-842-0474 • SD Works - link • DLR On-the-Job Training Program – 605-773-4133
Children and Youth • Bullying 3.52	Bullying cited as top issue by community stakeholders	SD ranks 21 out of 50 for incidence of bullying	Bullying resources: • Sheriff – 605-775-2626 • Police – 605-775-2282 • Burke School – 605-775-2645 • Burke Clinic – 605-775-2621 • Burke Wellness Coalition • The Rock (Youth Center) 605 -775-2950 • DSS Child Protective Services Office for Gregory County – 605-842-0400
Healthcare and Wellness • Access to affordable health insurance coverage 3.77 • Availability of mental health providers 3.55	8% of residents do not have any kind of health insurance and 10% of children in the county are uninsured Stakeholders indicated depression was a top concern with 22% of respondents	6.2% have unmet medical needs 2.9% have unmet prescription needs Gregory County residents average 3.1 mentally unhealthy days per month	Insurance resources: • SD DHS Prescription Assistance Program 605-773-3656 • Farm Bureau Insurance – 605-775-8290 • The Insurance Center- 605-775-2602 • Southern Dakota Insurance Agency – 605-775-2097 • SD Medicaid / DSS – 800-305-3064 Mental health resources: • Burke Clinic – 605-775-2621 • SD Division of Behavioral Health – 605-367-5236

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Focus on South Dakota Report for Gregory County and/or County Health Rankings	Community resources that are available to address the need
	feeling down, depressed, or hopeless		• Southern Plains Behavioral Health Clinic, Gregory, SD (12 mi. from Burke) – 605-835-8505 • Prairie Hills Counseling – 605-831-0119 • National Suicide Prevention Hotline – 1-800-273-8255 • NAMI of South Dakota – 605-271-1871
Aging population • Cost of Long-term Care 3.93 • Cost of Memory Care 3.78 • Availability of Long-term Care 3.53		24.8% are 65 years or older Gregory County life expectancy for women is 81.4	LTC resources: • TLC Assisted Living Home 605-775-6316 Memory care resources: • TLC Assisted Living Home 605-775-6316 Low income apartments: • Rosebud Apts. – 605-775-2531 • Parkview Manor – 605-775-2676 Winner Long-Term Services and Supports Office – 605-842-8419 SD Medicaid / DSS – 800-305-3064 Rural Office of Community Service (Senior Nutrition Provider) – 605-384-3883 Dakota at Home Aging and Disability Resource Center – 605-773-5990
Safety • Abuse of prescription drugs 3.50	12% of survey respondents indicated substance abuse was the most important community issue	11% of county residents indicate they have frequent physical distress (14 or more days of poor physical health per month)	• Sheriff – 605-775-2626 • Police – 605-775-2282 • Main Gate Counseling Services, Winner – 605-842-0312 • SD Opioid Resource Hotline – 1-800-920-4343 • Burke Clinic – 605-775-2631
Mental Health/ Behavioral Health • Alcohol use and abuse 3.73 • Drug use and abuse 3.50	22% of survey respondents felt down, depressed, or hopeless at least several days (or more) over the	11.6% of county residents have depression and 6.7% have anxiety	• Burke Clinic – 605-775-2631 • Alcoholics Anonymous – Winner Westside Group – Trinity Episcopal Church – 605-842-2211 • SD Division of Behavioral Health – 605-367-5236

Identified community concern	Community stakeholders - specific areas of concern	Secondary Data - Focus on South Dakota Report for Gregory County and/or County Health Rankings	Community resources that are available to address the need
	previous two weeks	21.3% have abused alcohol	• Southern Plains Behavioral Health Clinic, Gregory, SD (12 mi. from Burke) – 605-835-8505 • National Suicide Prevention Hotline – 1-800-273-8255 • Prairie Hills Counseling – 605-831-0119 • NAMI of South Dakota – 605-271-1871

Secondary Data Sources

www.countyhealthrankings.org

https://helmsleytrust.org/publication/focus-south-dakota-picture-health

www.census.gov

https://www.childhelp.org/blog/states-ranked-biggest-bullying/

Burke Community Memorial Hospital
2019 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote
Economics • Cost of affordable housing 4.32 • Skilled labor workforce 3.61 • Employment options 3.55	1	
Children and Youth • Bullying 3.52	3	
Healthcare and Wellness • Access to affordable health insurance 3.77 • Availability of mental health providers 3.55	10	**PRIORITY NEED**
Aging • Cost of long-term care 3.93 • Cost of memory care 3.78 • Availability of long-term care 3.53	1	
Safety • Abuse of prescription drugs 3.50	2	
Mental Health • Alcohol use and abuse 3.73 • Drug use and abuse 3.50	10	**PRIORITY NEED**

Community Memorial Hospital

Community Health Needs Assessment

Results from a non-generalizable online survey

December 2017 and January 2018

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an online survey of community leaders and key stakeholders identified by Sanford Burke 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.** A total of 31 respondents participated in the online survey.

TABLE OF CONTENTS

Survey Results

Current State of Health and Wellness Issues Within the Community

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

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

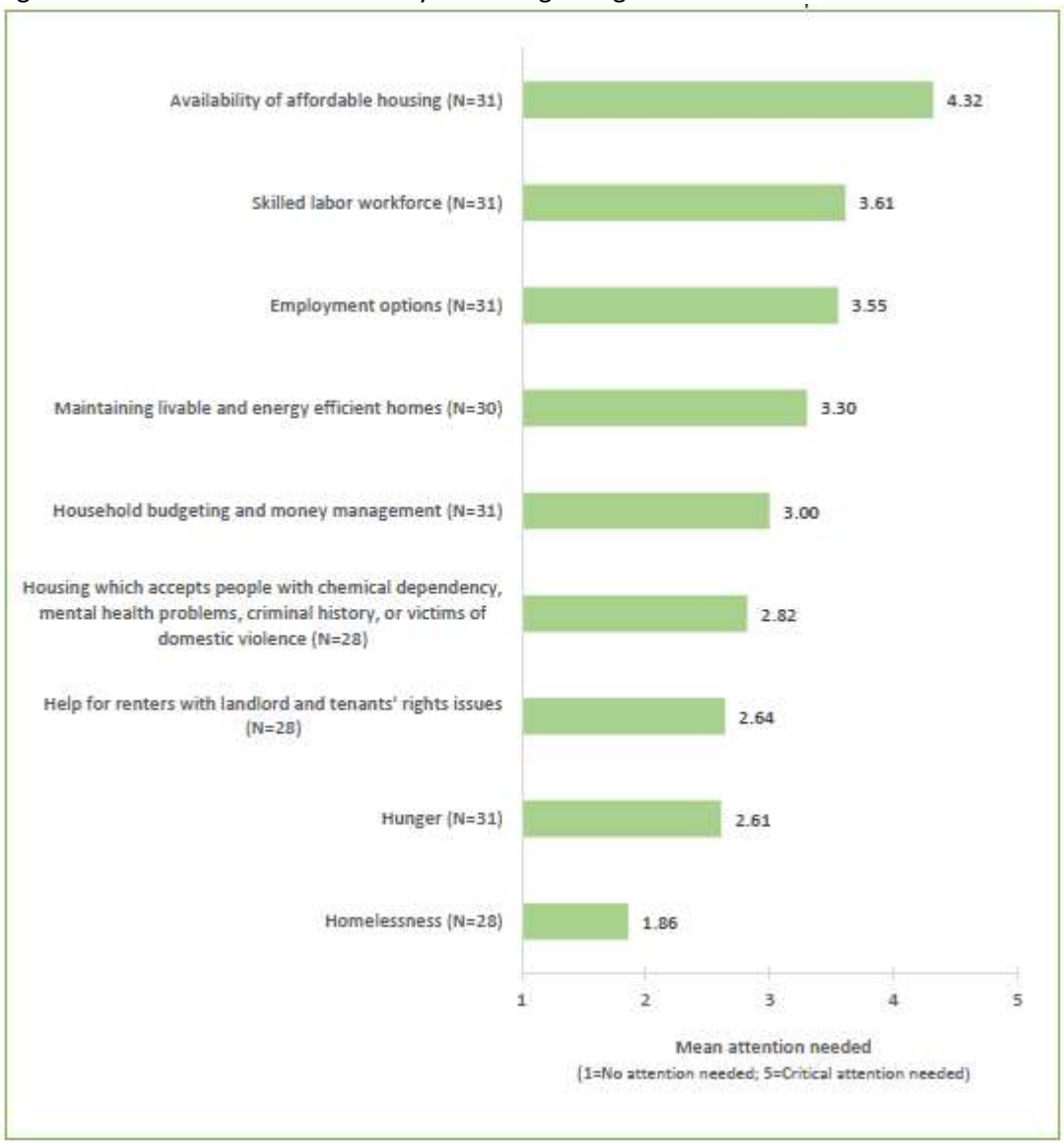


Figure 2. Current state of community issues regarding TRANSPORTATION

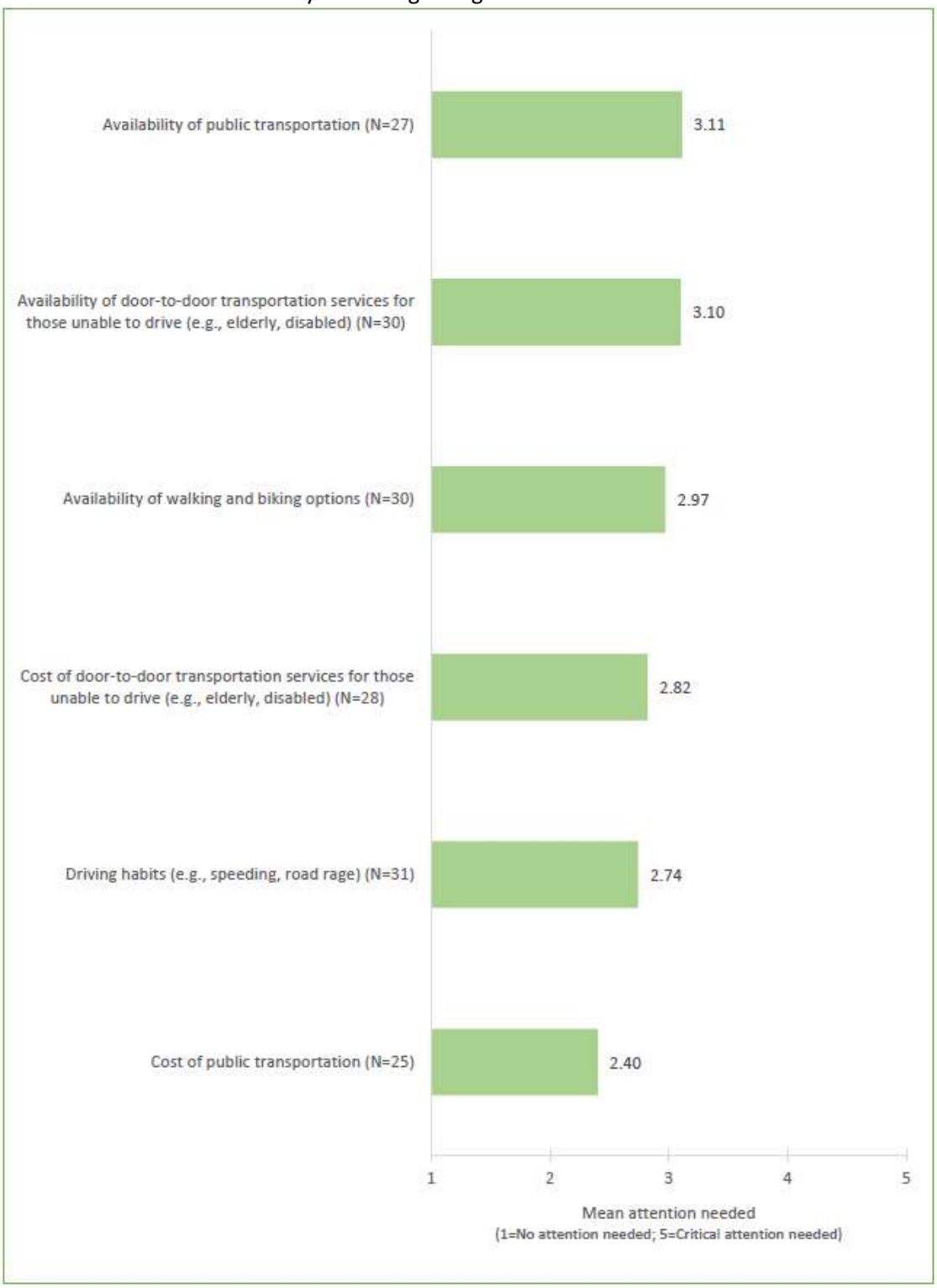


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

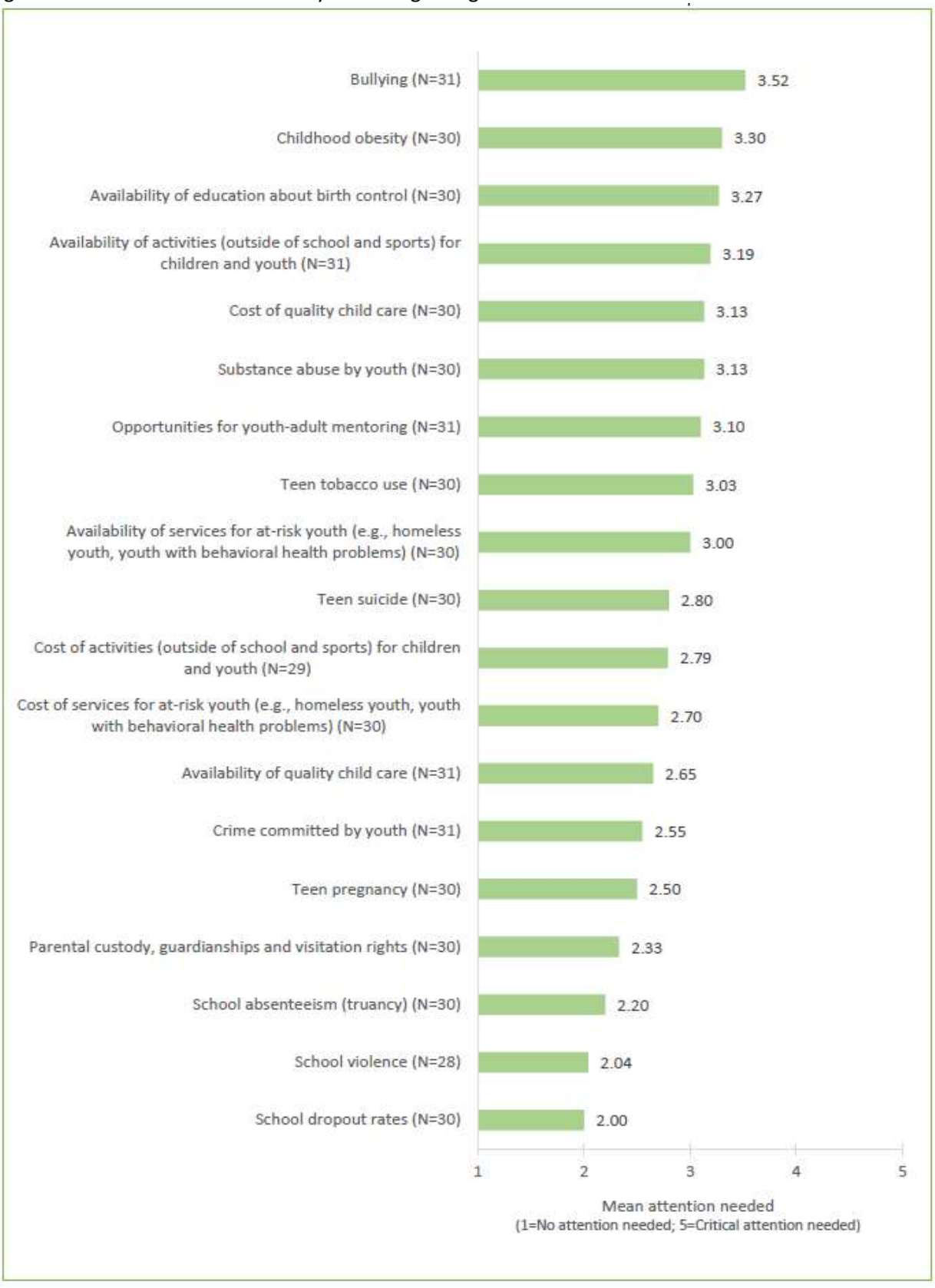


Figure 4. Current state of community issues regarding the AGING POPULATION

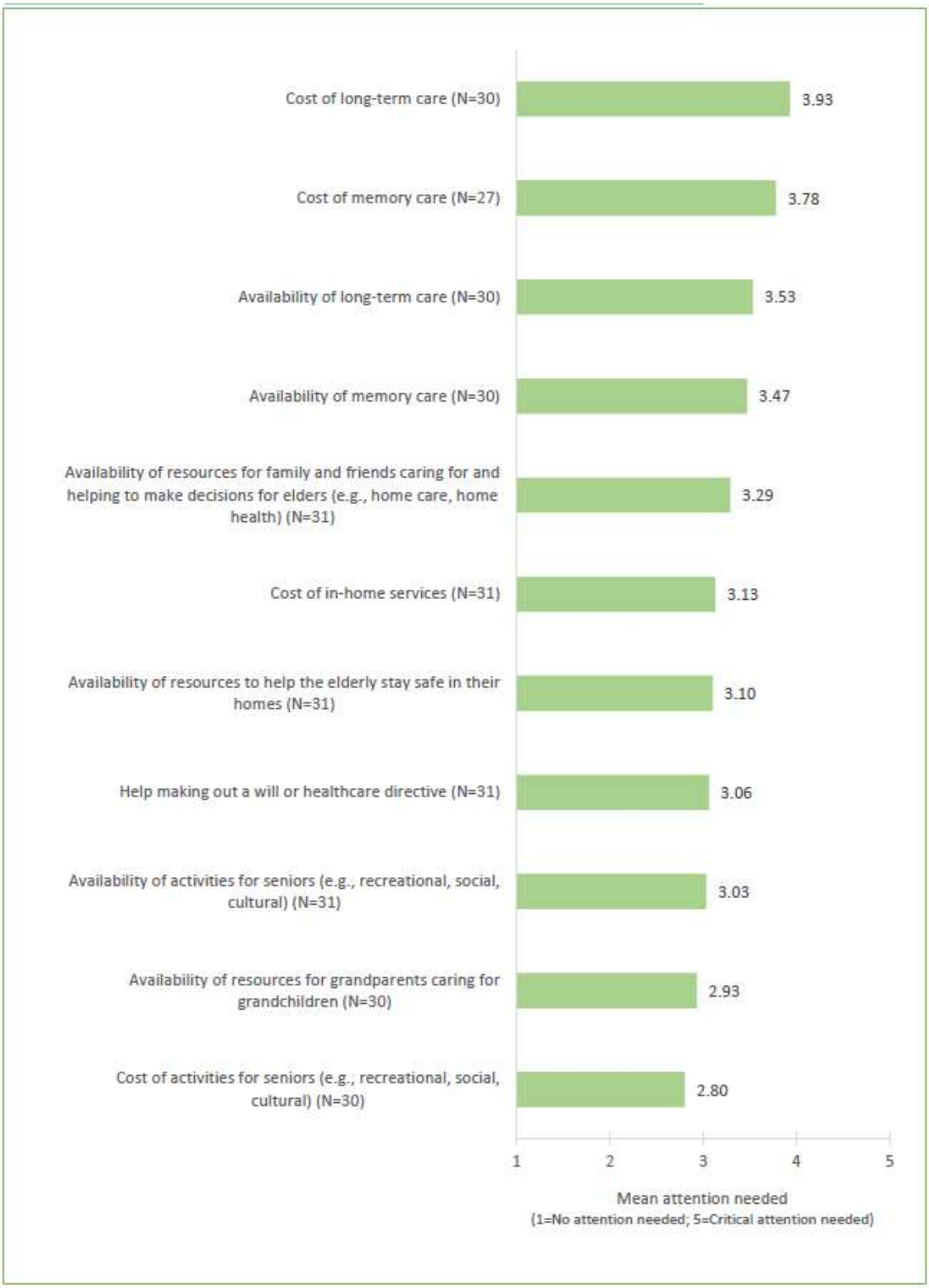


Figure 5. Current state of community issues regarding SAFETY

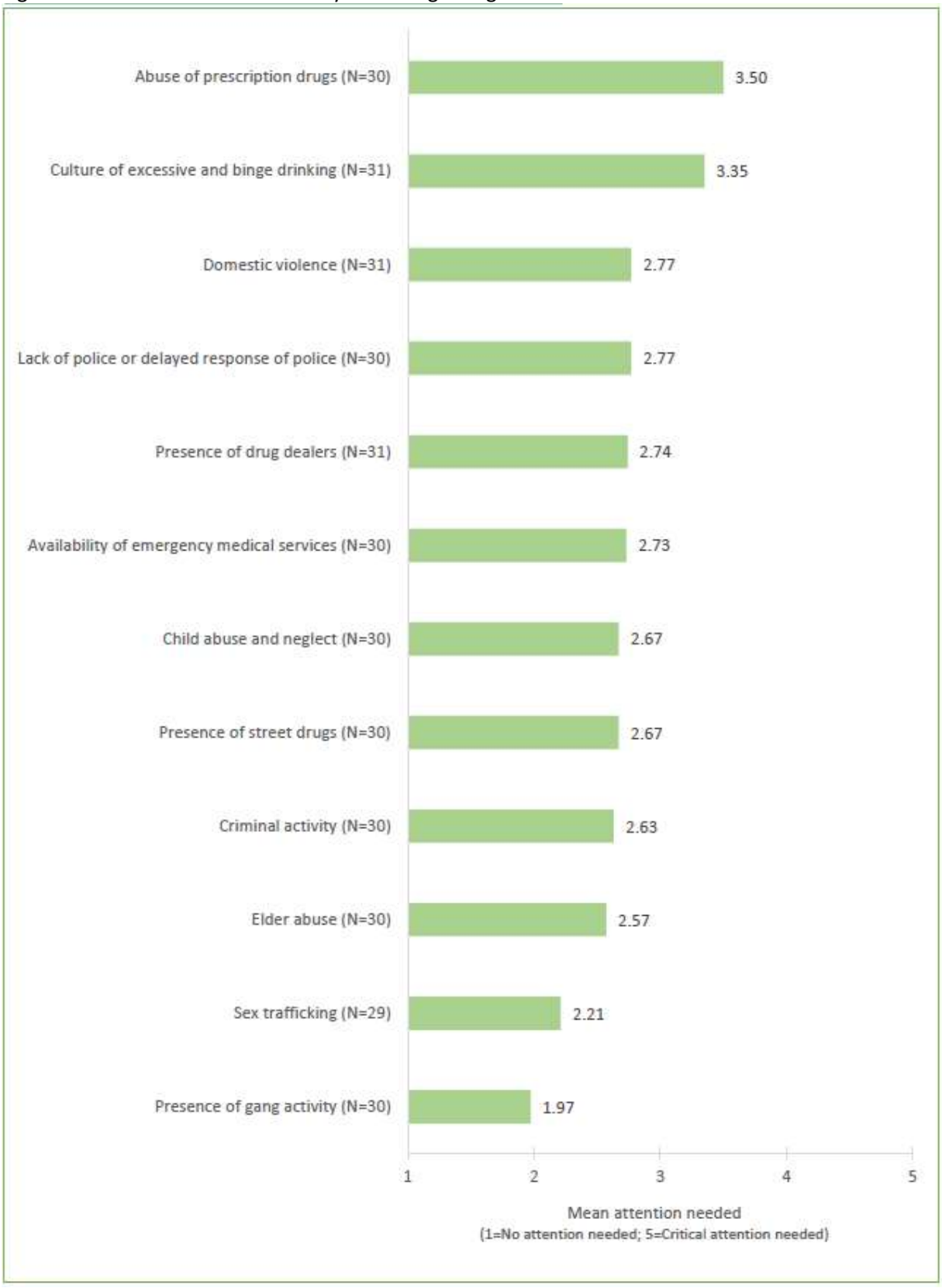


Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

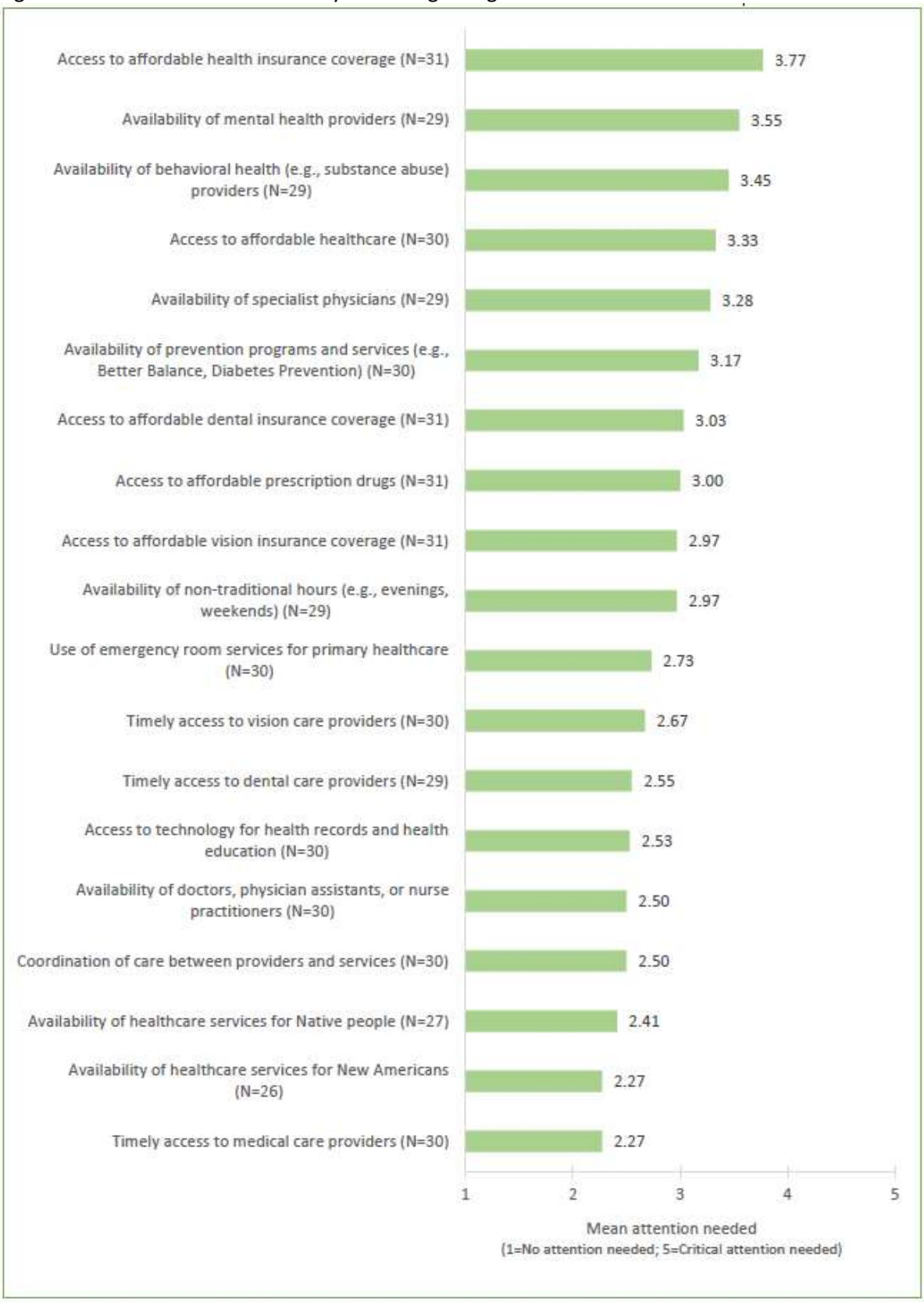
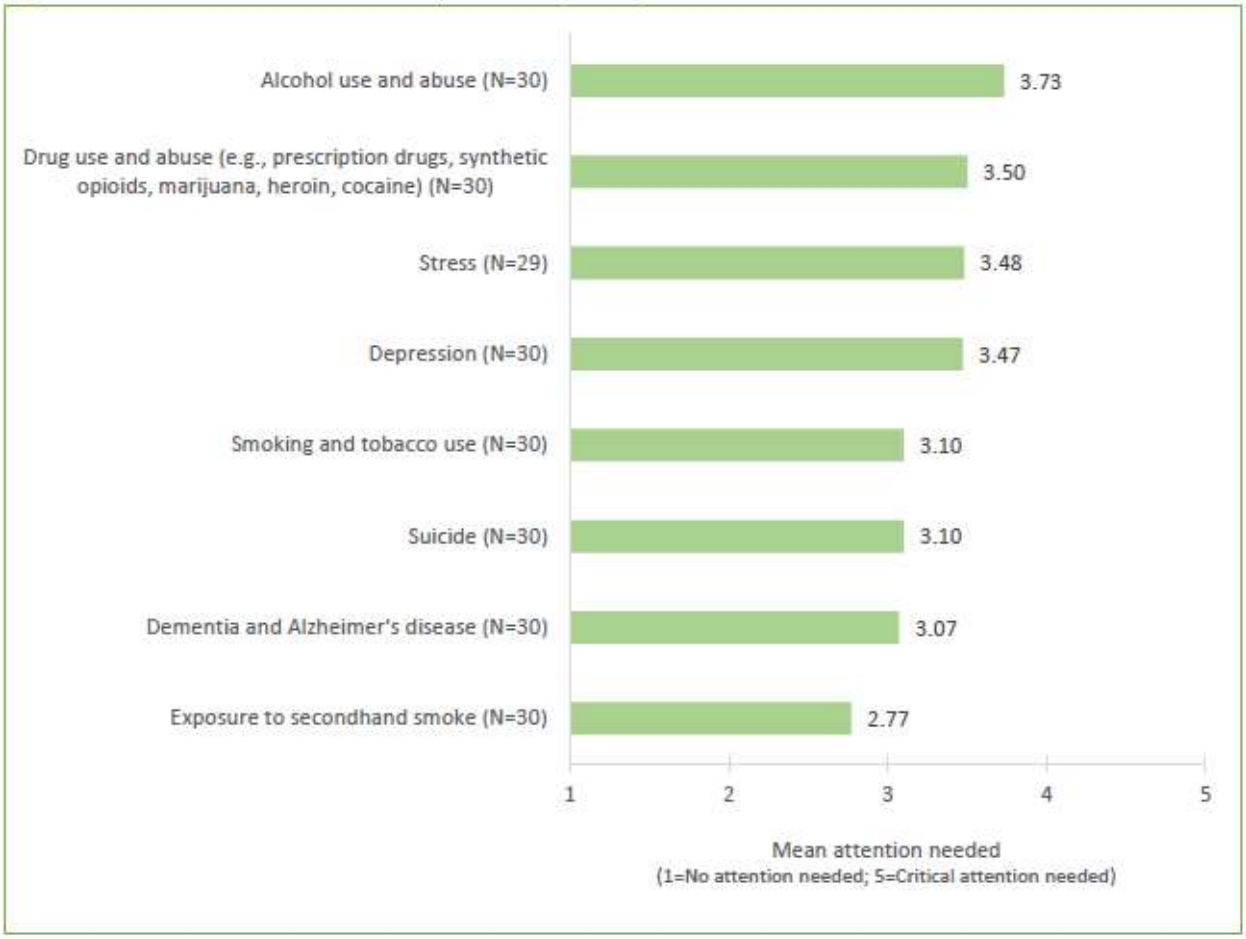
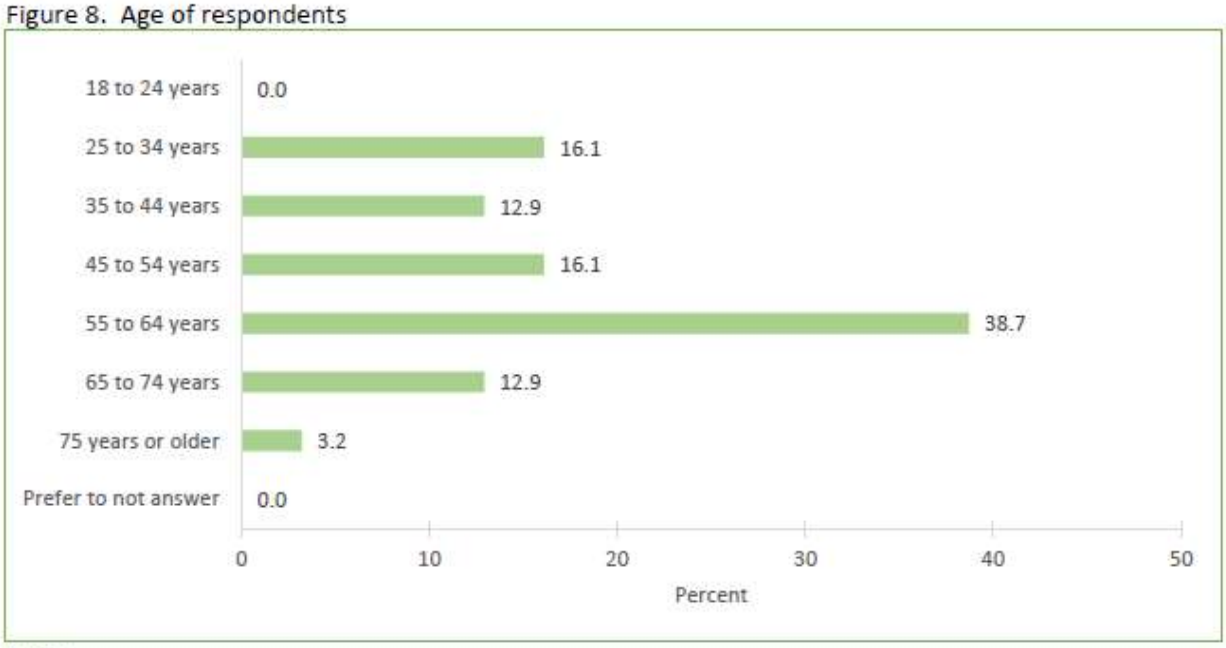


Figure 7. Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



Demographic Information

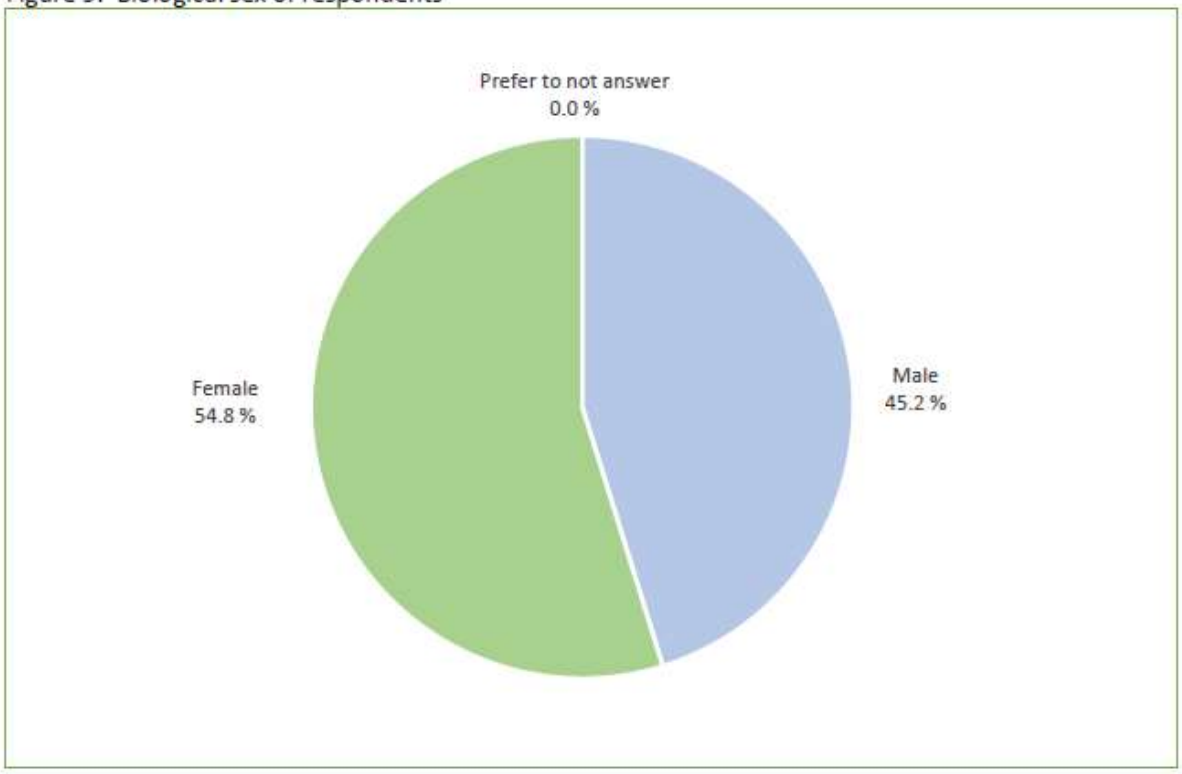
Figure 8. Age of respondents



N=31

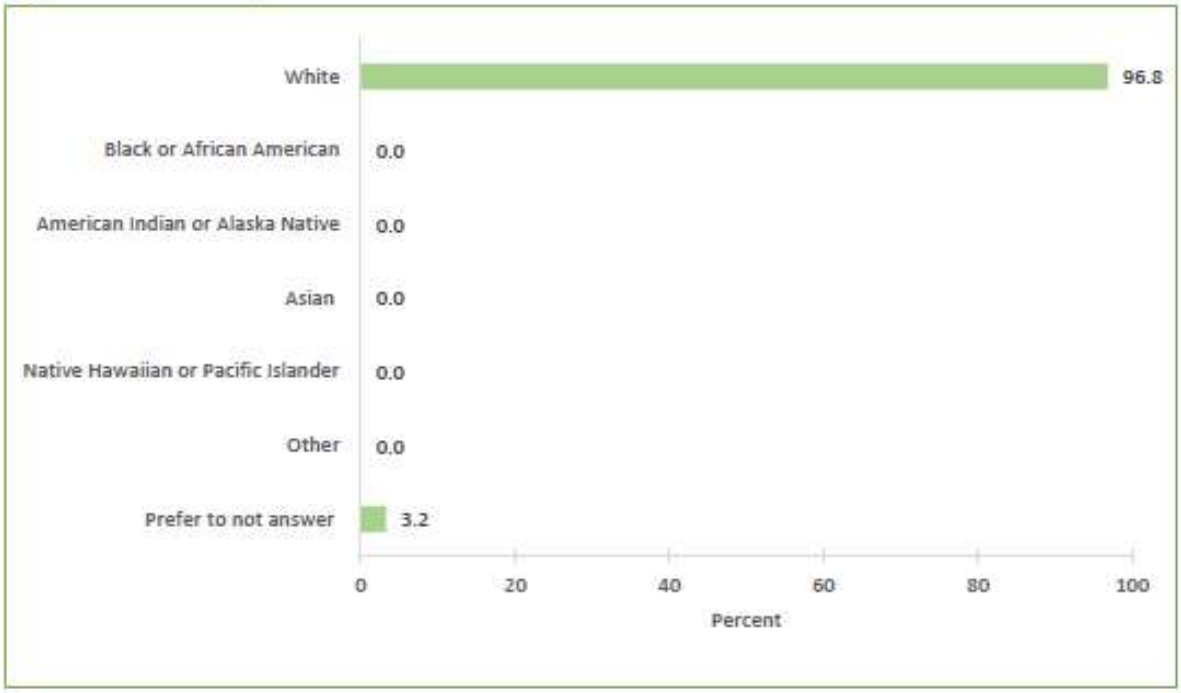
*Percentages do not total 100.0 due to rounding.

Figure 9. Biological sex of respondents



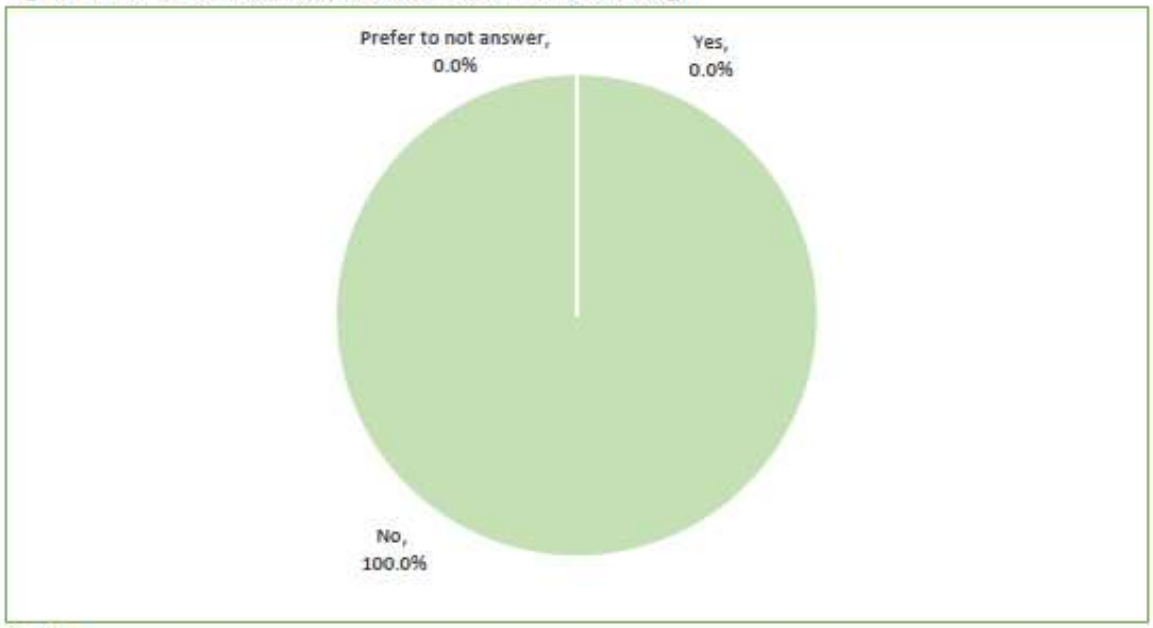
N=31

Figure 10. Race of respondents



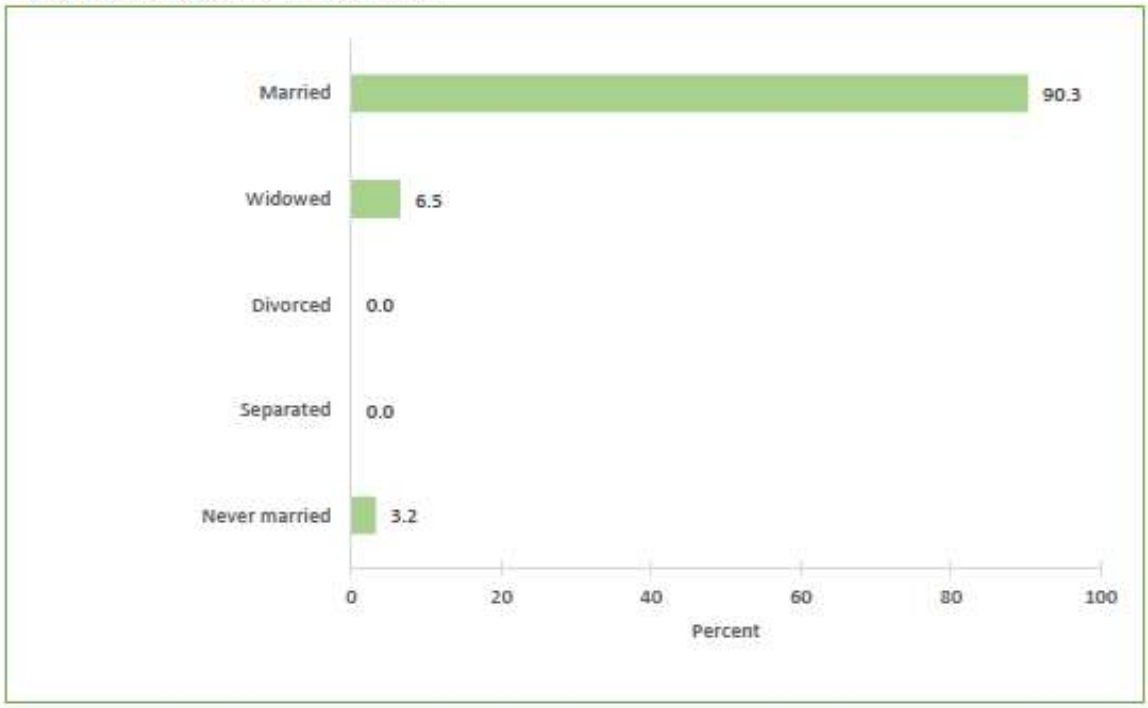
N=31

Figure 11. Whether respondents are of Hispanic or Latino origin



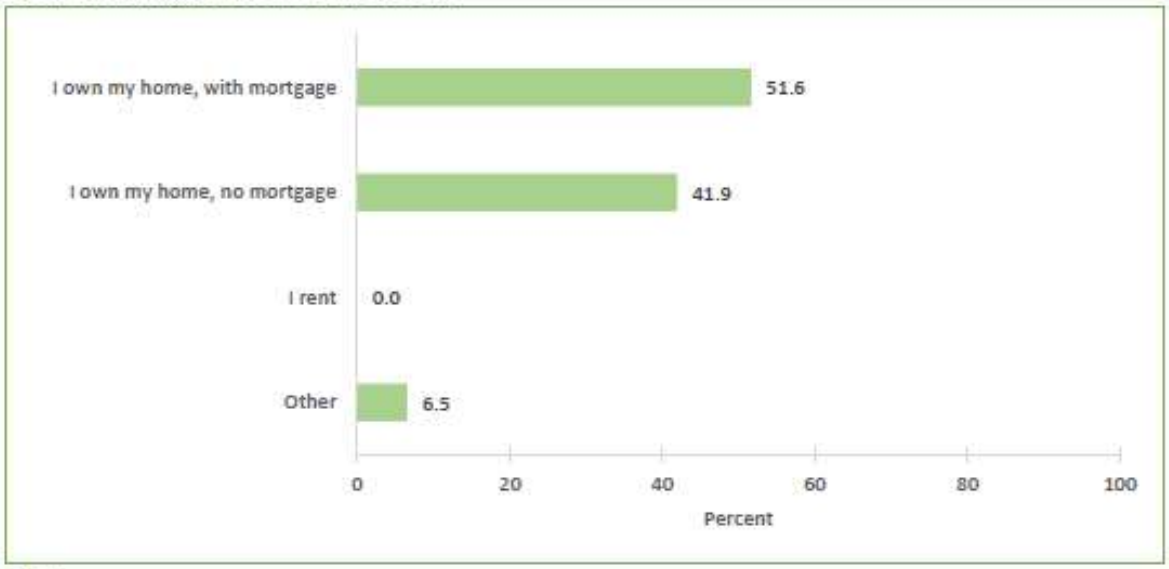
N=31

Figure 12. Marital status of respondents



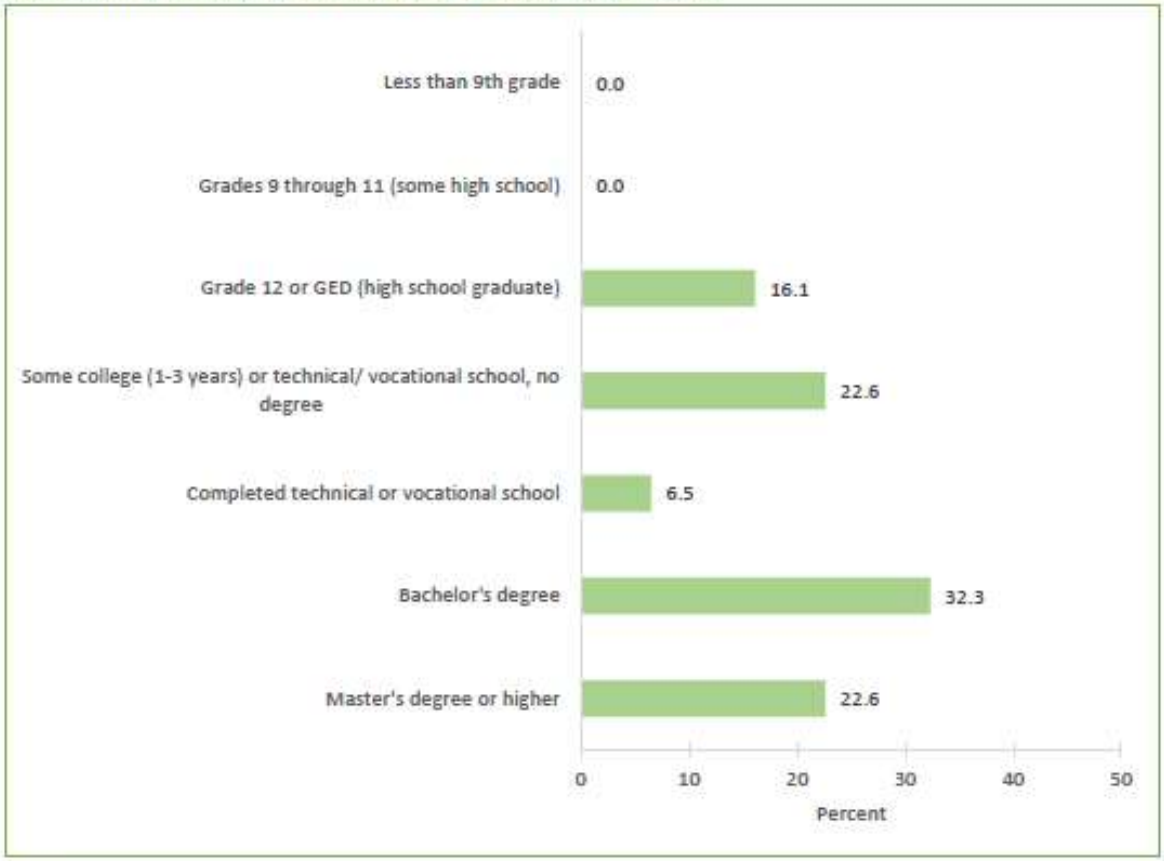
N=31

Figure 13. Living situation of respondents



N=31

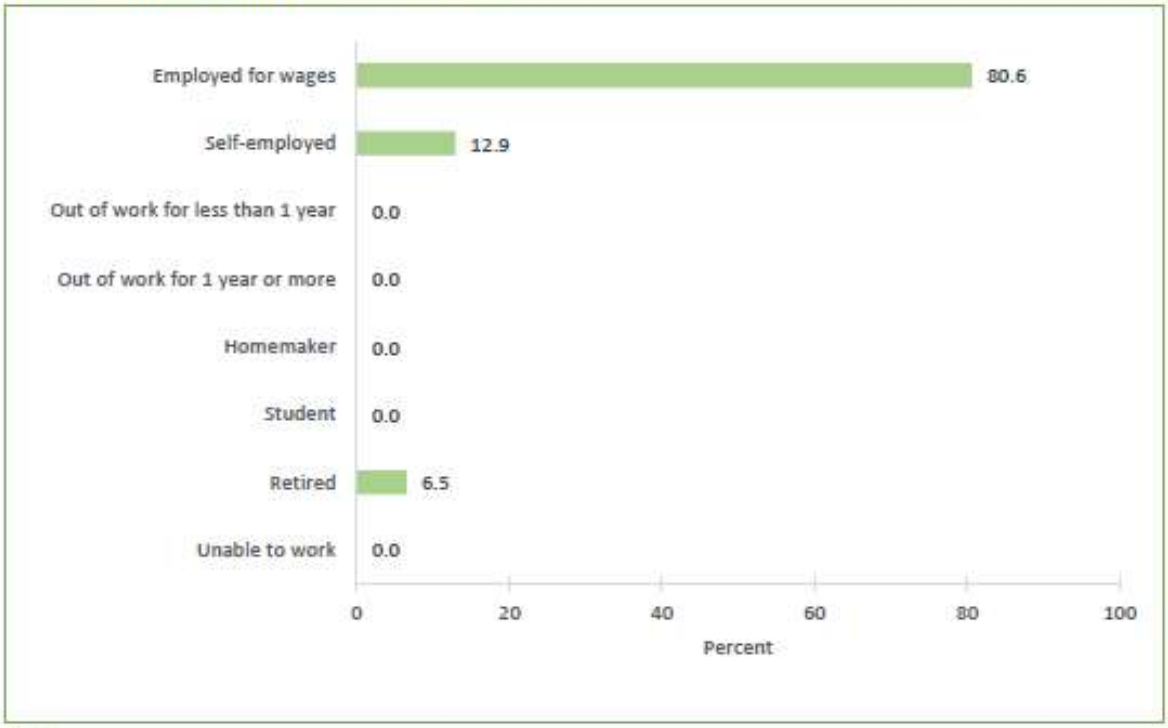
Figure 14. Highest level of education completed by respondents



N=31

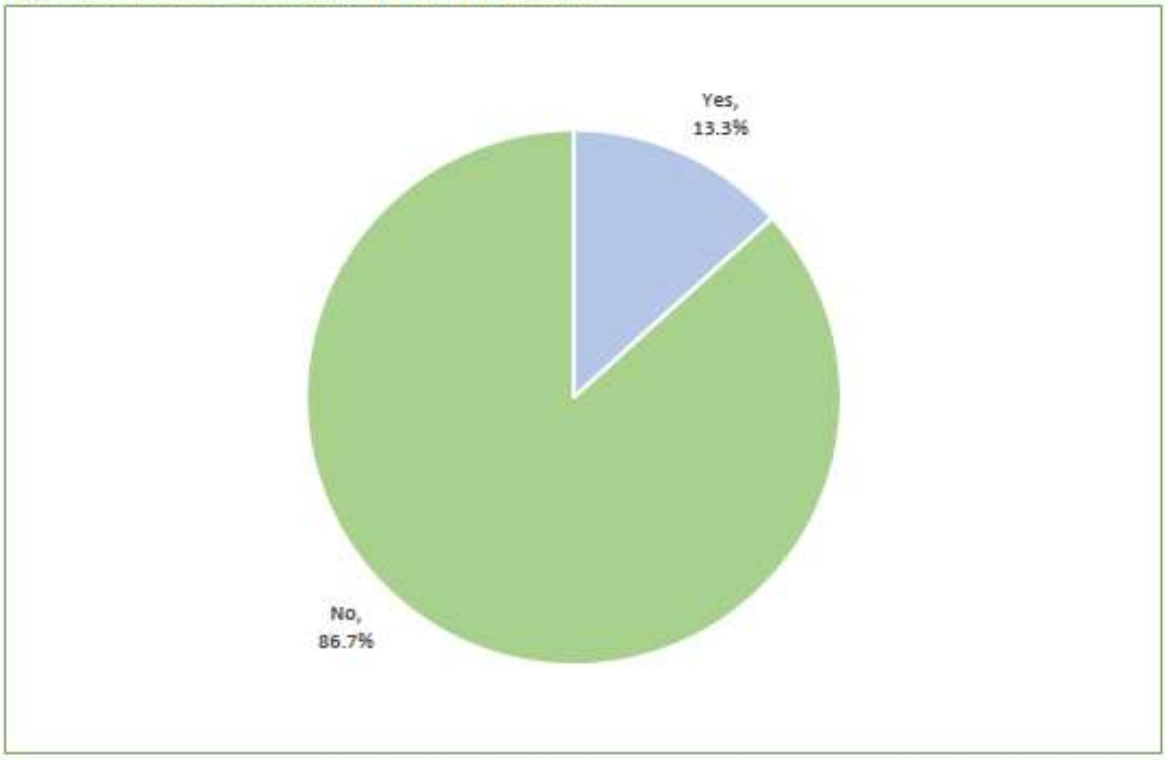
*Percentages do not total 100.0 due to rounding.

Figure 15. Employment status of respondents



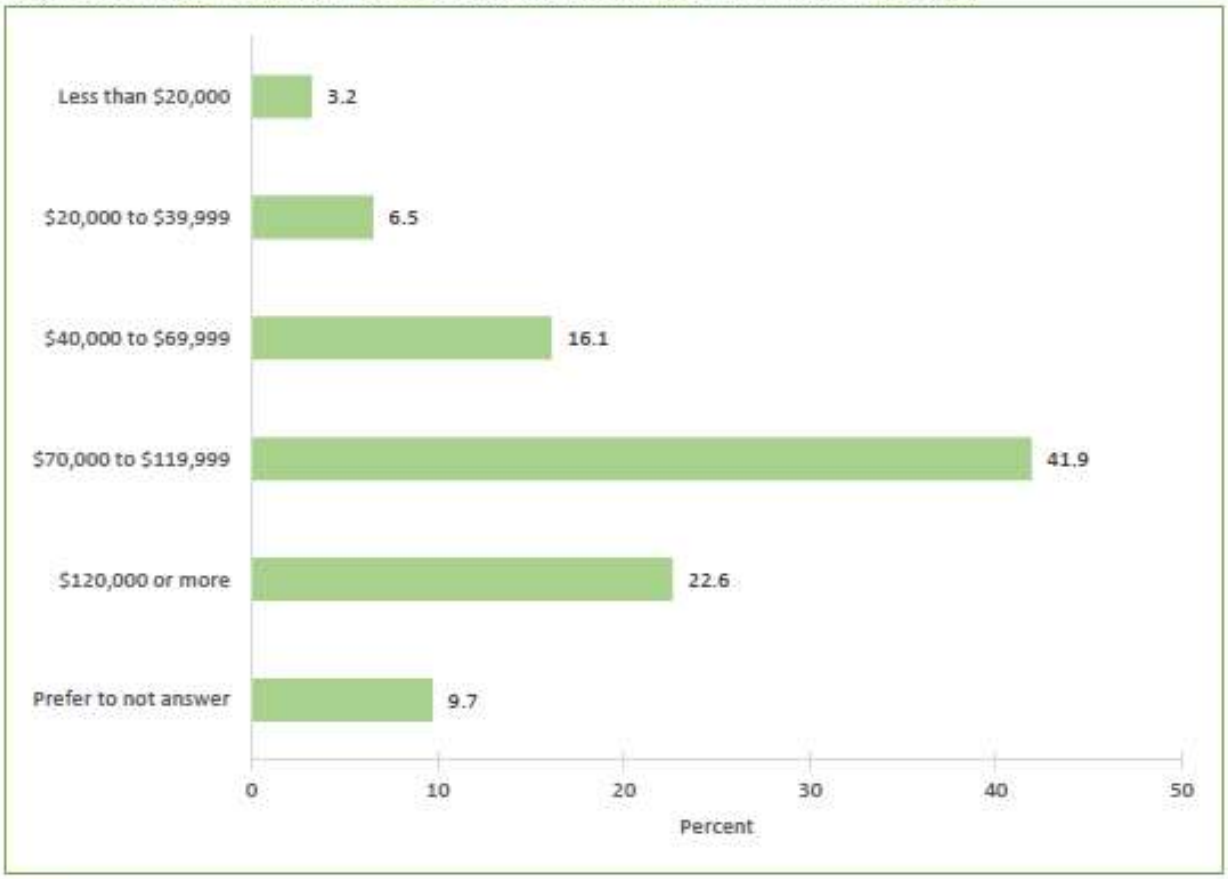
N=31

Figure 16. Whether respondents are military veterans



N=30

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



N=31

Table 1. Zip code of respondents

Zip code	Number of respondents
57523	23
57317	2
57533	2
57529	1
57538	1

N=29

Table 2. Comments from respondents

Comments
No comments provided by respondents.

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

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=31)	4.32	0.0	3.2	12.9	32.3	51.6	0.0	100.0
Employment options (N=31)	3.55	3.2	0.0	41.9	48.4	6.5	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=30)	2.64	0.0	46.7	36.7	6.7	3.3	6.7	100.1
Homelessness (N=31)	1.86	29.0	45.2	16.1	0.0	0.0	9.7	100.0
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=29)	2.82	6.9	20.7	51.7	17.2	0.0	3.4	99.9
Household budgeting and money management (N=31)	3.00	0.0	22.6	58.1	16.1	3.2	0.0	100.0
Hunger (N=31)	2.61	6.5	38.7	45.2	6.5	3.2	0.0	100.1
Maintaining livable and energy efficient homes (N=31)	3.30	0.0	12.9	48.4	29.0	6.5	3.2	100.0
Skilled labor workforce (N=31)	3.61	3.2	0.0	45.2	35.5	16.1	0.0	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=31)	3.10	0.0	12.9	61.3	22.6	0.0	3.2	100.0
Availability of public transportation (N=31)	3.11	6.5	16.1	35.5	19.4	9.7	12.9	100.1
Availability of walking and biking options (N=30)	2.97	3.3	36.7	33.3	13.3	13.3	0.0	99.9
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=30)	2.82	6.7	33.3	26.7	23.3	3.3	6.7	100.0
Cost of public transportation (N=30)	2.40	13.3	33.3	30.0	3.3	3.3	16.7	99.9
Driving habits (e.g., speeding, road rage) (N=31)	2.74	3.2	32.3	51.6	12.9	0.0	0.0	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=31)	3.19	3.2	12.9	48.4	32.3	3.2	0.0	100.0
Availability of education about birth control (N=30)	3.27	0.0	10.0	56.7	30.0	3.3	0.0	100.0
Availability of quality child care (N=31)	2.65	12.9	22.6	51.6	12.9	0.0	0.0	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=30)	3.00	0.0	26.7	50.0	20.0	3.3	0.0	100.0
Bullying (N=31)	3.52	0.0	12.9	32.3	45.2	9.7	0.0	100.1

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Childhood obesity (N=30)	3.30	0.0	13.3	46.7	36.7	3.3	0.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=31)	2.79	6.5	22.6	48.4	16.1	0.0	6.5	100.1
Cost of quality child care (N=31)	3.13	3.2	12.9	51.6	25.8	3.2	3.2	99.9
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=31)	2.70	3.2	38.7	38.7	16.1	0.0	3.2	99.9
Crime committed by youth (N=31)	2.55	0.0	48.4	48.4	3.2	0.0	0.0	100.0
Opportunities for youth-adult mentoring (N=31)	3.10	0.0	19.4	54.8	22.6	3.2	0.0	100.0
Parental custody, guardianships and visitation rights (N=31)	2.33	3.2	61.3	29.0	3.2	0.0	3.2	99.9
School absenteeism (truancy) (N=30)	2.20	10.0	63.3	23.3	3.3	0.0	0.0	99.9
School dropout rates (N=30)	2.00	20.0	60.0	20.0	0.0	0.0	0.0	100.0
School violence (N=28)	2.04	17.9	60.7	21.4	0.0	0.0	0.0	100.0
Substance abuse by youth (N=30)	3.13	3.3	16.7	43.3	36.7	0.0	0.0	100.0
Teen pregnancy (N=30)	2.50	0.0	56.7	40.0	0.0	3.3	0.0	100.0
Teen suicide (N=30)	2.80	3.3	36.7	40.0	16.7	3.3	0.0	100.0
Teen tobacco use (N=30)	3.03	0.0	30.0	40.0	26.7	3.3	0.0	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=31)	3.03	0.0	16.1	64.5	19.4	0.0	0.0	100.0
Availability of long-term care (N=30)	3.53	0.0	6.7	43.3	40.0	10.0	0.0	100.0
Availability of memory care (N=30)	3.47	0.0	10.0	46.7	30.0	13.3	0.0	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=31)	3.29	0.0	9.7	58.1	25.8	6.5	0.0	100.1
Availability of resources for grandparents caring for grandchildren (N=30)	2.93	3.3	20.0	60.0	13.3	3.3	0.0	99.9
Availability of resources to help the elderly stay safe in their homes (N=31)	3.10	0.0	19.4	58.1	16.1	6.5	0.0	100.1
Cost of activities for seniors (e.g., recreational, social, cultural) (N=31)	2.80	0.0	29.0	58.1	9.7	0.0	3.2	100.0
Cost of in-home services (N=31)	3.13	0.0	19.4	51.6	25.8	3.2	0.0	100.0
Cost of long-term care (N=31)	3.93	0.0	0.0	22.6	58.1	16.1	3.2	100.0
Cost of memory care (N=29)	3.78	0.0	6.9	20.7	51.7	13.8	6.9	100.0
Help making out a will or healthcare directive (N=31)	3.06	0.0	16.1	64.5	16.1	3.2	0.0	99.9
SAFETY								
Abuse of prescription drugs (N=31)	3.50	0.0	12.9	35.5	35.5	12.9	3.2	100.0
Availability of emergency medical services (N=31)	2.73	16.1	29.0	19.4	29.0	3.2	3.2	99.9
Child abuse and neglect (N=31)	2.67	0.0	41.9	45.2	9.7	0.0	3.2	100.0
Criminal activity (N=30)	2.63	3.3	36.7	53.3	6.7	0.0	0.0	100.0

Statements	Mean**	Percent of respondents* Level of attention needed 1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Culture of excessive and binge drinking (N=31)	3.35	3.2	9.7	48.4	25.8	12.9	0.0	100.0
Domestic violence (N=31)	2.77	0.0	35.5	51.6	12.9	0.0	0.0	100.0
Elder abuse (N=31)	2.57	0.0	48.4	41.9	6.5	0.0	3.2	100.0
Lack of police or delayed response of police (N=31)	2.77	0.0	48.4	25.8	19.4	3.2	3.2	100.0
Presence of drug dealers (N=31)	2.74	3.2	35.5	45.2	16.1	0.0	0.0	100.0
Presence of gang activity (N=31)	1.97	35.5	38.7	16.1	3.2	3.2	3.2	99.9
Presence of street drugs (N=31)	2.67	9.7	35.5	29.0	22.6	0.0	3.2	100.0
Sex trafficking (N=31)	2.21	19.4	45.2	19.4	9.7	0.0	6.5	100.2
HEALTHCARE AND WELLNESS								
Access to affordable dental insurance coverage (N=31)	3.03	0.0	25.8	51.6	16.1	6.5	0.0	100.0
Access to affordable health insurance coverage (N=31)	3.77	0.0	12.9	25.8	32.3	29.0	0.0	100.0
Access to affordable healthcare (N=30)	3.33	3.3	23.3	33.3	16.7	23.3	0.0	99.9
Access to affordable prescription drugs (N=31)	3.00	6.5	22.6	45.2	16.1	9.7	0.0	100.1
Access to affordable vision insurance coverage (N=31)	2.97	3.2	16.1	67.7	6.5	6.5	0.0	100.0
Access to technology for health records and health education (N=30)	2.53	6.7	36.7	53.3	3.3	0.0	0.0	100.0
Availability of behavioral health (e.g., substance abuse) providers (N=29)	3.45	0.0	13.8	44.8	24.1	17.2	0.0	99.9
Availability of doctors, physician assistants, or nurse practitioners (N=30)	2.50	16.7	33.3	33.3	16.7	0.0	0.0	100.0
Availability of healthcare services for Native people (N=28)	2.41	21.4	28.6	35.7	7.1	3.6	3.6	100.0
Availability of healthcare services for New Americans (N=29)	2.27	20.7	31.0	31.0	6.9	0.0	10.3	99.9
Availability of mental health providers (N=29)	3.55	0.0	17.2	34.5	24.1	24.1	0.0	99.9
Availability of non-traditional hours (e.g., evenings, weekends) (N=29)	2.97	6.9	17.2	51.7	20.7	3.4	0.0	99.9
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=30)	3.17	0.0	16.7	56.7	20.0	6.7	0.0	100.1
Availability of specialist physicians (N=30)	3.28	3.3	3.3	56.7	30.0	3.3	3.3	99.9
Coordination of care between providers and services (N=30)	2.50	3.3	50.0	40.0	6.7	0.0	0.0	100.0
Timely access to medical care providers (N=30)	2.27	23.3	30.0	43.3	3.3	0.0	0.0	99.9
Timely access to dental care providers (N=29)	2.55	10.3	31.0	51.7	6.9	0.0	0.0	99.9
Timely access to vision care providers (N=30)	2.67	6.7	33.3	46.7	13.3	0.0	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	
Use of emergency room services for primary healthcare (N=30)	2.73	13.3	23.3	43.3	16.7	3.3	0.0	99.9
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=31)	3.73	0.0	3.2	35.5	41.9	16.1	3.2	99.9
Dementia and Alzheimer's disease (N=31)	3.07	0.0	16.1	58.1	22.6	0.0	3.2	100.0
Depression (N=31)	3.47	0.0	6.5	41.9	45.2	3.2	3.2	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=31)	3.50	0.0	6.5	38.7	48.4	3.2	3.2	100.0
Exposure to secondhand smoke (N=31)	2.77	0.0	38.7	45.2	9.7	3.2	3.2	100.0
Smoking and tobacco use (N=31)	3.10	0.0	22.6	45.2	25.8	3.2	3.2	100.0
Stress (N=31)	3.48	0.0	9.7	35.5	41.9	6.5	6.5	100.1
Suicide (N=31)	3.10	3.2	22.6	35.5	32.3	3.2	3.2	100.0

*Percentages may not total 100.0 due to rounding.

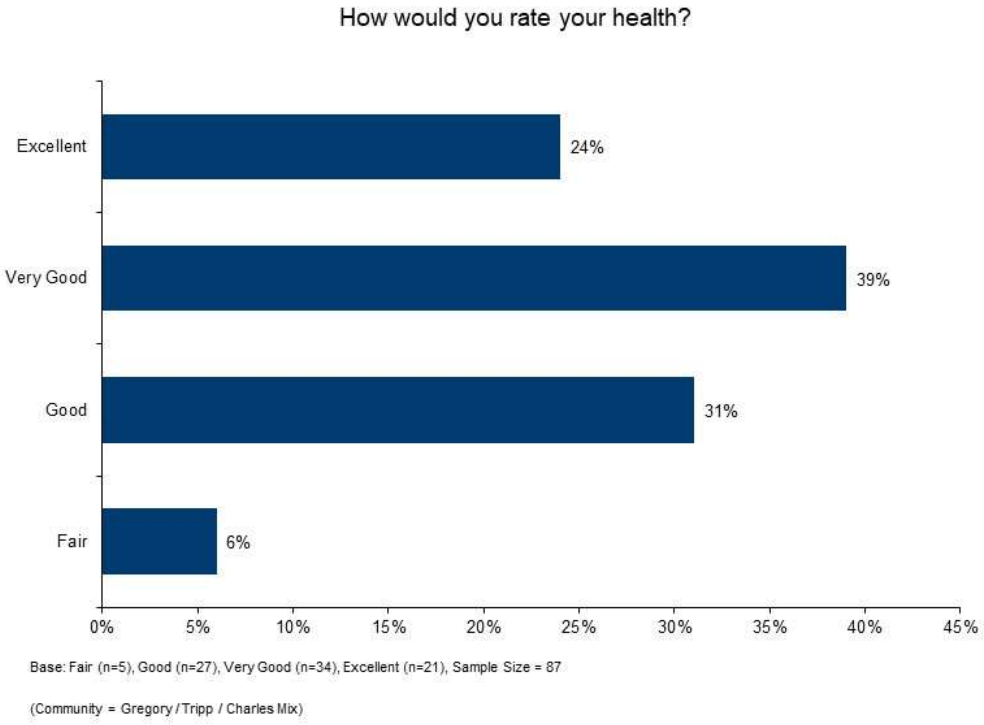
**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflect total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

Resident Survey

Burke CHNA Survey Results

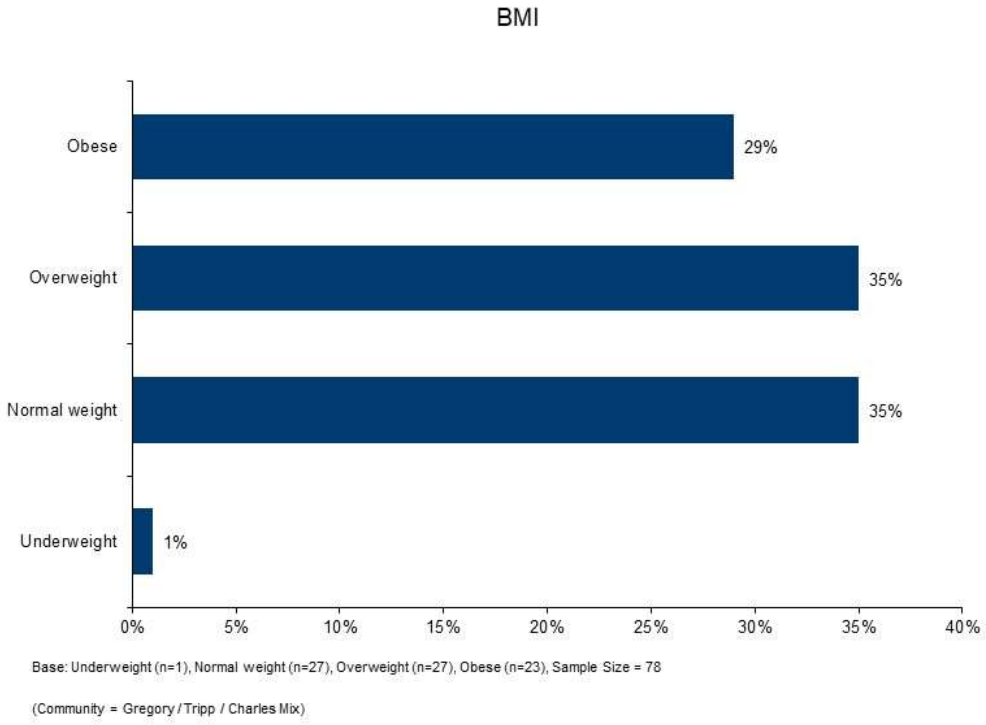
February 26, 2018

Charts Exported by MarketSight®



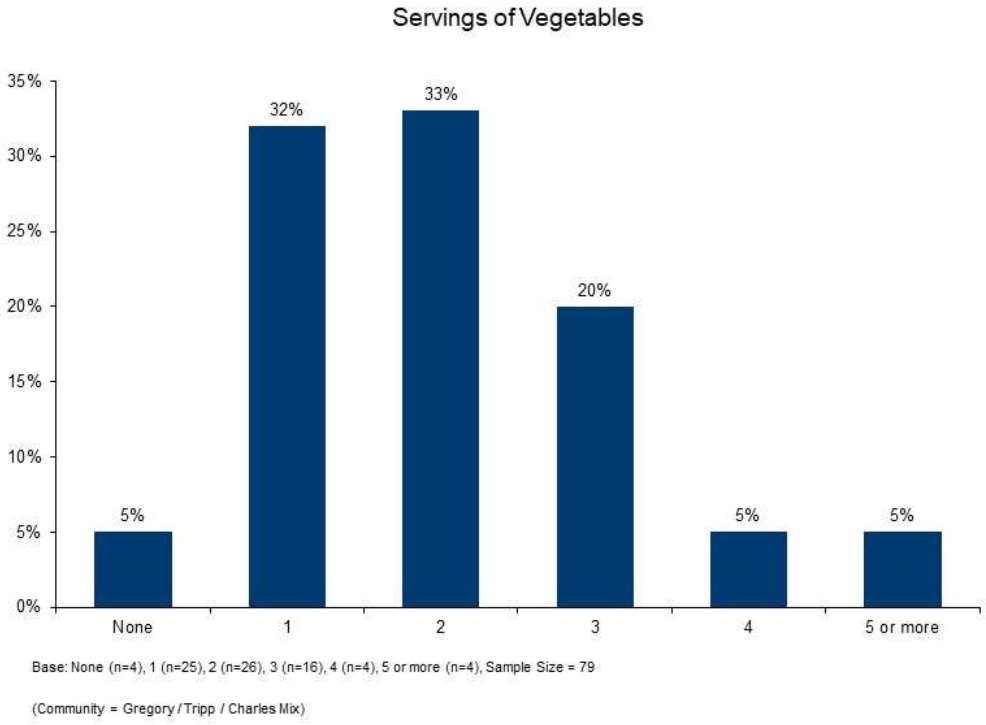
Base: Fair (n=5), Good (n=27), Very Good (n=34), Excellent (n=21), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)



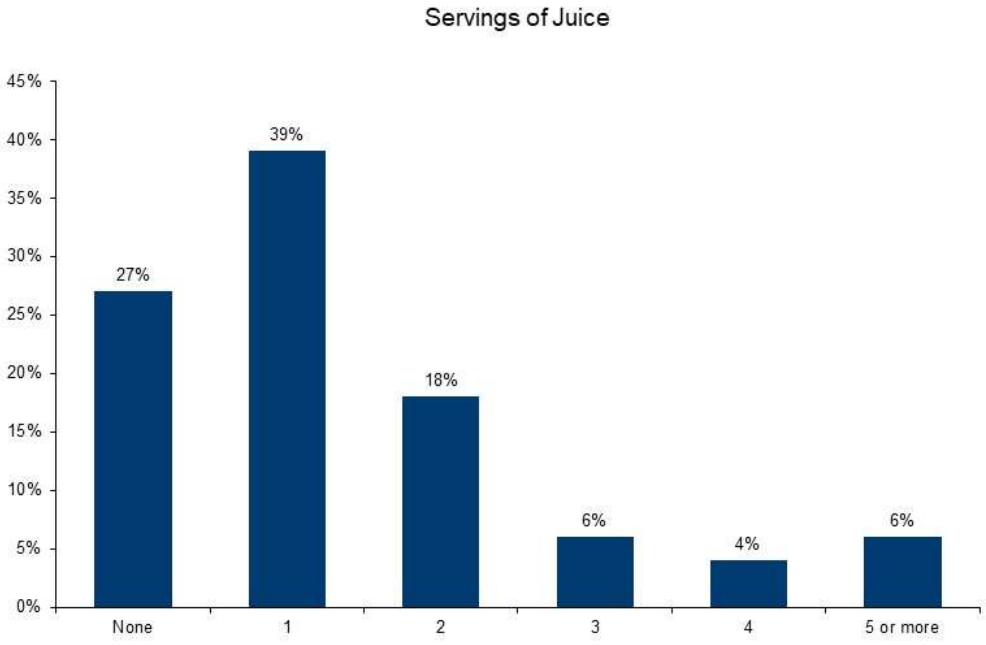
Base: Underweight (n=1), Normal weight (n=27), Overweight (n=27), Obese (n=23), Sample Size = 78

(Community = Gregory / Tripp / Charles Mix)



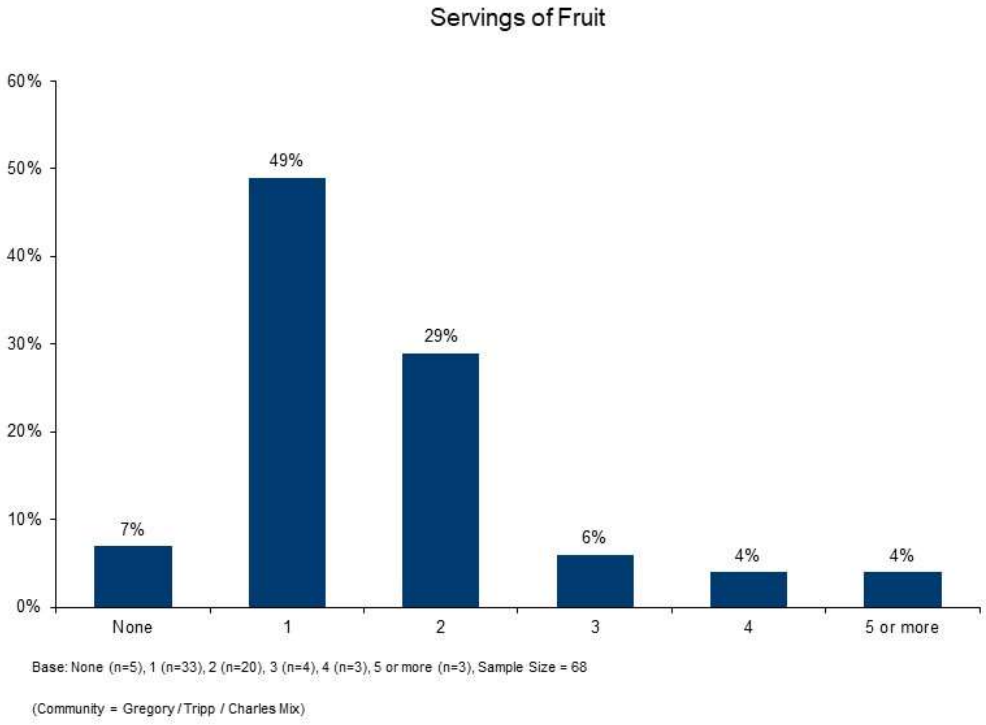
Base: None (n=4), 1 (n=25), 2 (n=26), 3 (n=16), 4 (n=4), 5 or more (n=4), Sample Size = 79

(Community = Gregory / Tripp / Charles Mix)



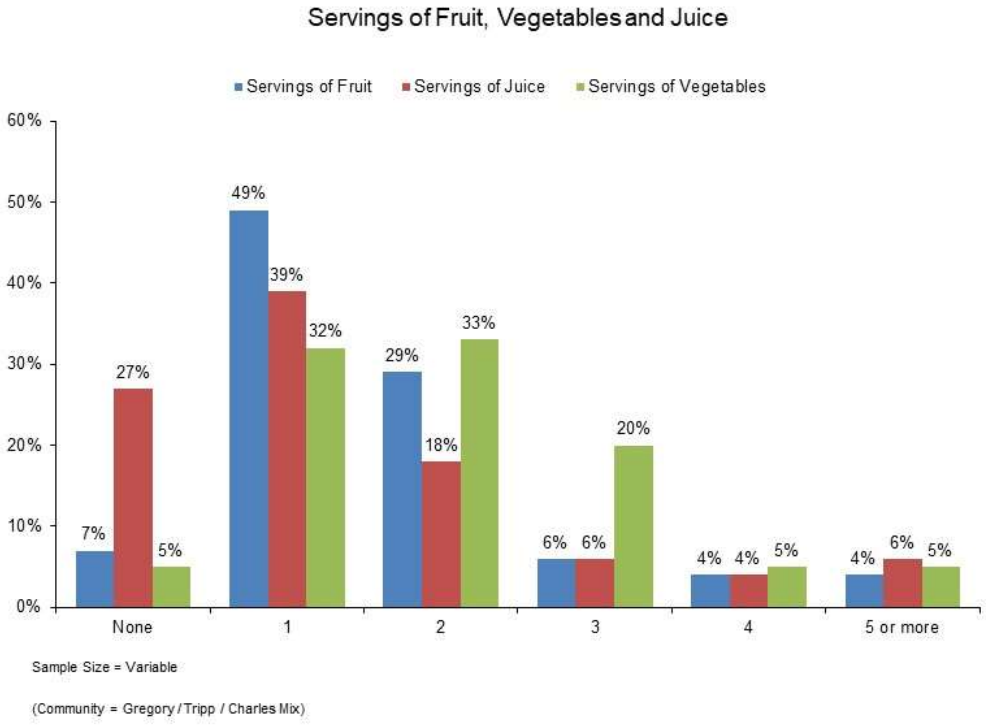
Base: None (n=13), 1 (n=19), 2 (n=9), 3 (n=3), 4 (n=2), 5 or more (n=3), Sample Size = 49

(Community = Gregory / Tripp / Charles Mix)

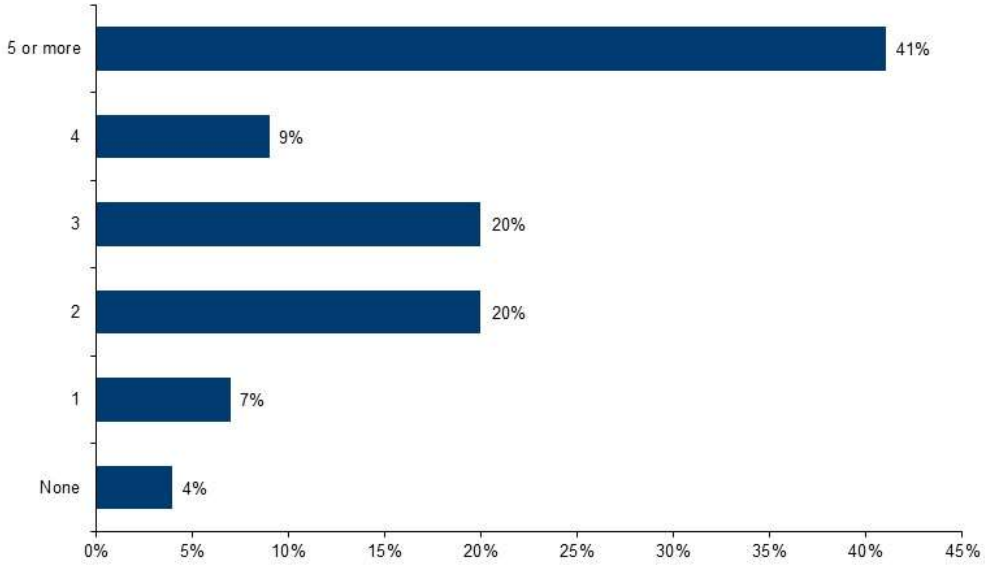


Base: None (n=5), 1 (n=33), 2 (n=20), 3 (n=4), 4 (n=3), 5 or more (n=3), Sample Size = 68

(Community = Gregory / Tripp / Charles Mix)


Servings of Fruit, Vegetables and Juice
Servings of Fruit
Servings of Juice
Servings of Vegetables
60%
50%
40%
30%
20%
10%
0%
7%
27%
5%
49%
39%
32%
29%
18%
33%
6%
6%
20%
4%
4%
5%
4%
6%
5%
None
1
2
3
4
5 or more
Sample Size = Variable
(Community = Gregory / Tripp / Charles Mix)

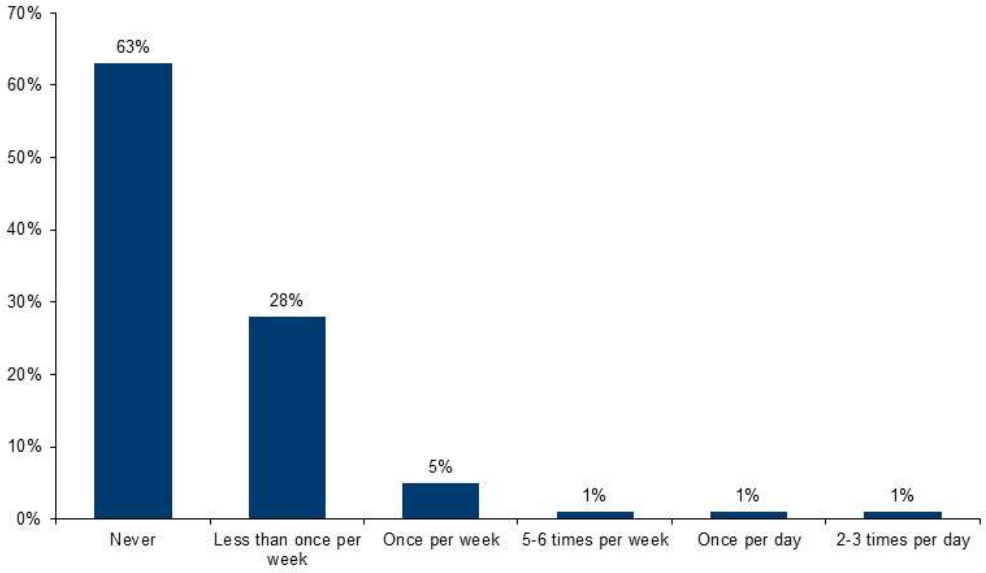
Total Servings of Fruits, Vegetables and Juice



Base: None (n=3), 1 (n=6), 2 (n=16), 3 (n=16), 4 (n=7), 5 or more (n=34), Sample Size = 82

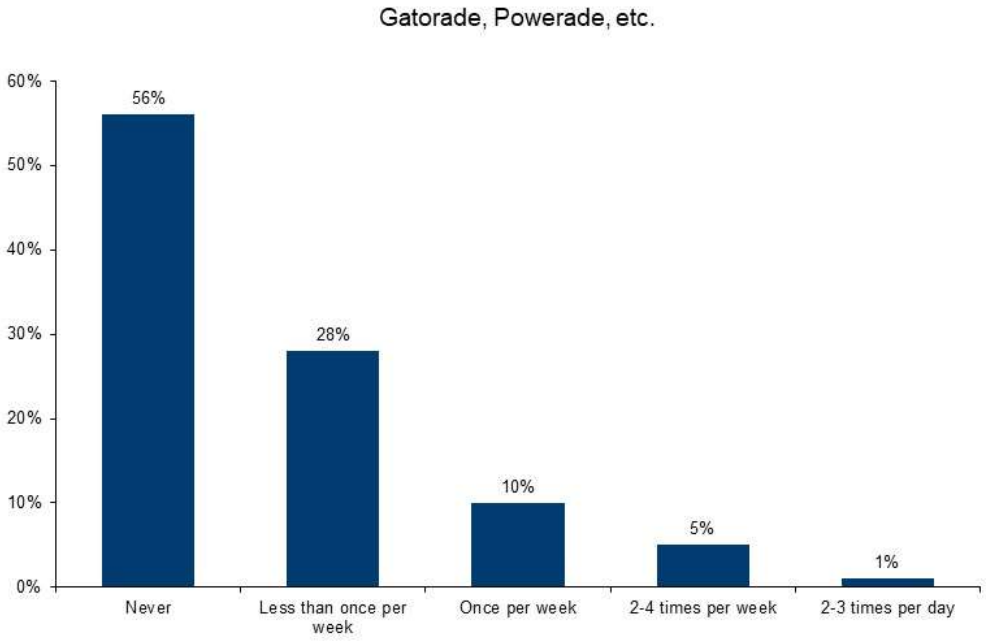
(Community = Gregory / Tripp / Charles Mix)

Snapple, Flavored Teas, Capri Sun, etc.



Base: Never (n=51), Less than once per week (n=23), Once per week (n=4), 5-6 times per week (n=1), Once per day (n=1), 2-3 times per day (n=1), Sample Size = 81

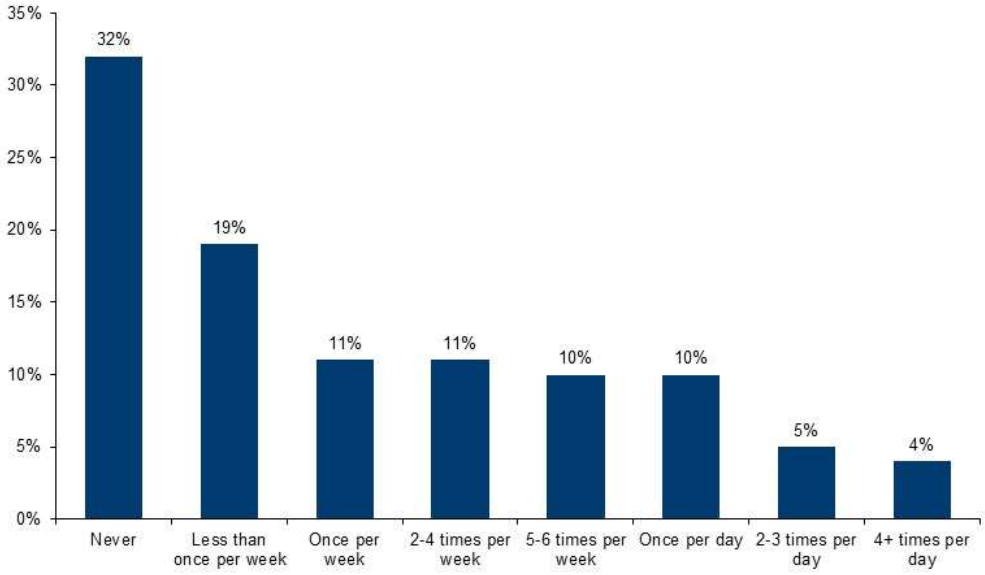
(Community = Gregory / Tripp / Charles Mix)



Base: Never (n=46), Less than once per week (n=23), Once per week (n=8), 2-4 times per week (n=4), 2-3 times per day (n=1), Sample Size = 82

(Community = Gregory / Tripp / Charles Mix)

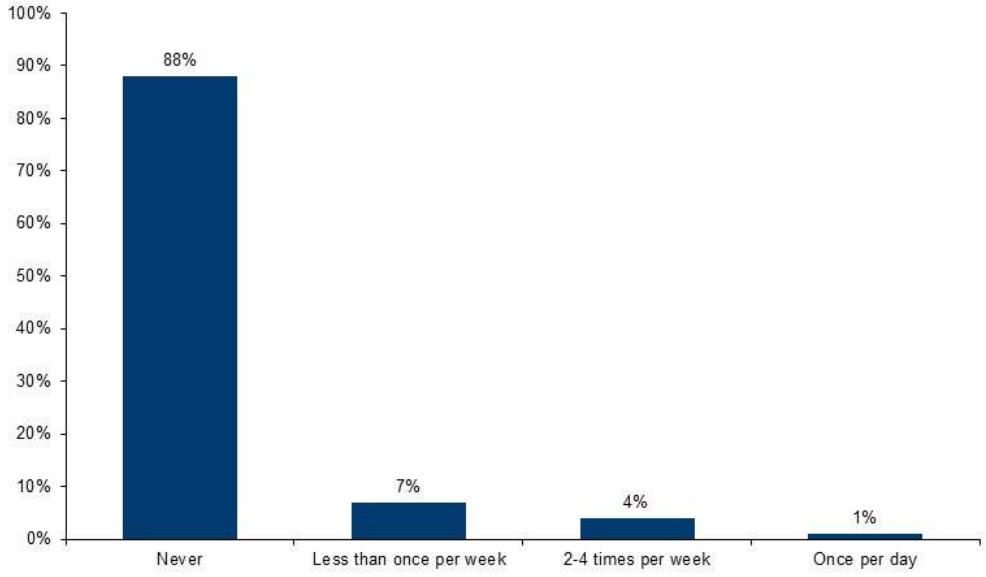
Soda or Pop



Base: Never (n=27), Less than once per week (n=16), Once per week (n=9), 2-4 times per week (n=9), 5-6 times per week (n=8), Once per day (n=8), 2-3 times per day (n=4), 4+ times per day (n=3), Sample Size = 84

(Community = Gregory / Tripp / Charles Mix)

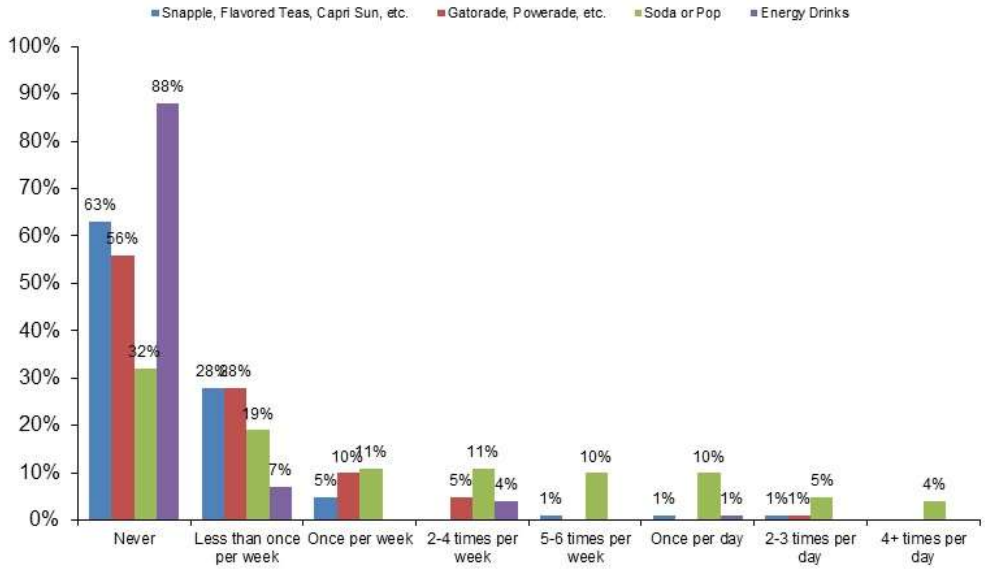
Energy Drinks



Base: Never (n=72), Less than once per week (n=6), 2-4 times per week (n=3), Once per day (n=1), Sample Size = 82

(Community = Gregory / Tripp / Charles Mix)

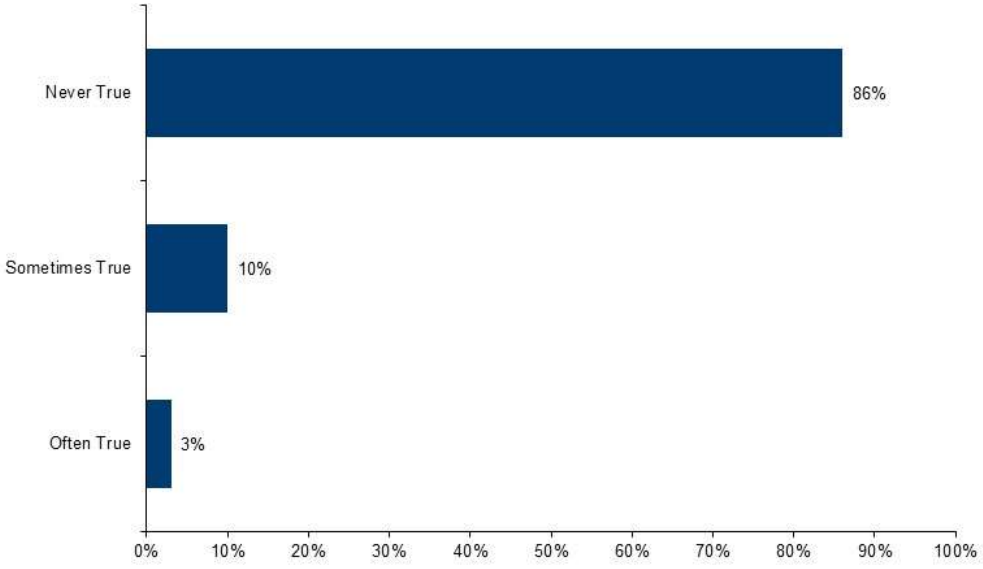
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Gregory / Tripp / Charles Mix)

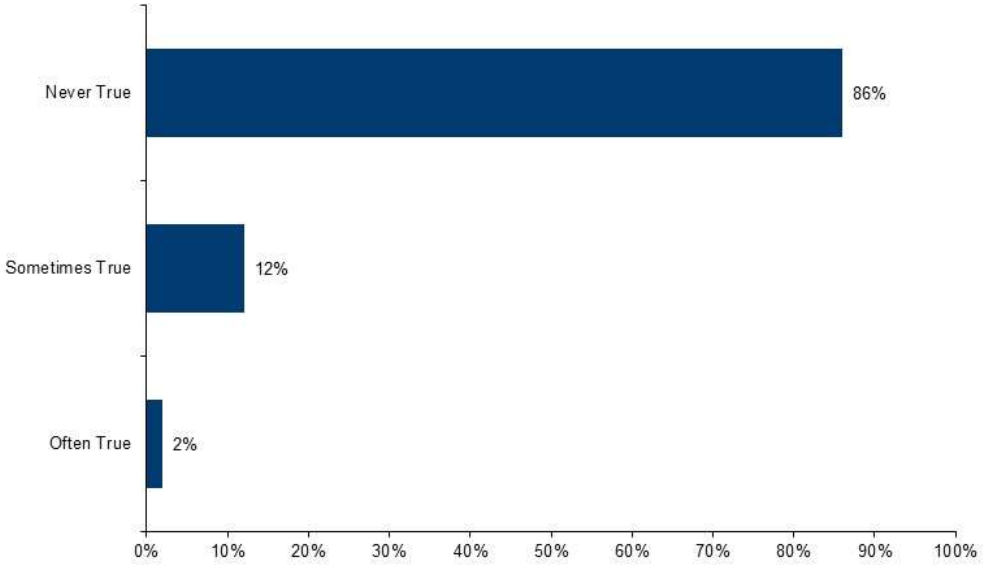
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=3), Sometimes True (n=9), Never True (n=74), Sample Size = 86

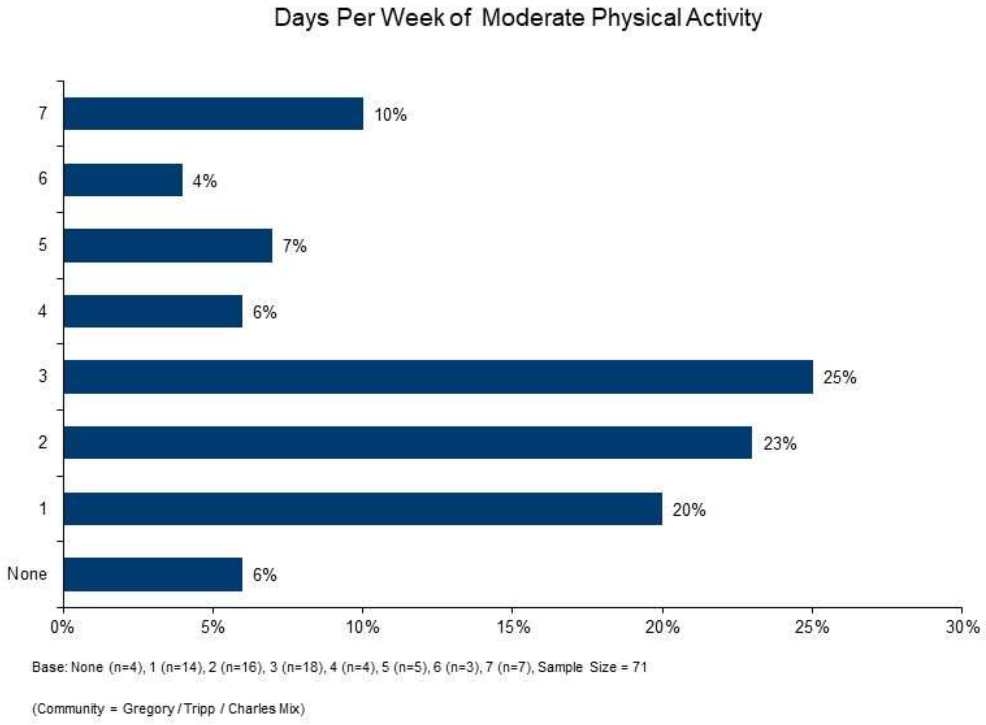
(Community = Gregory / Tripp / Charles Mix)

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



Base: Often True (n=2), Sometimes True (n=10), Never True (n=74), Sample Size = 86

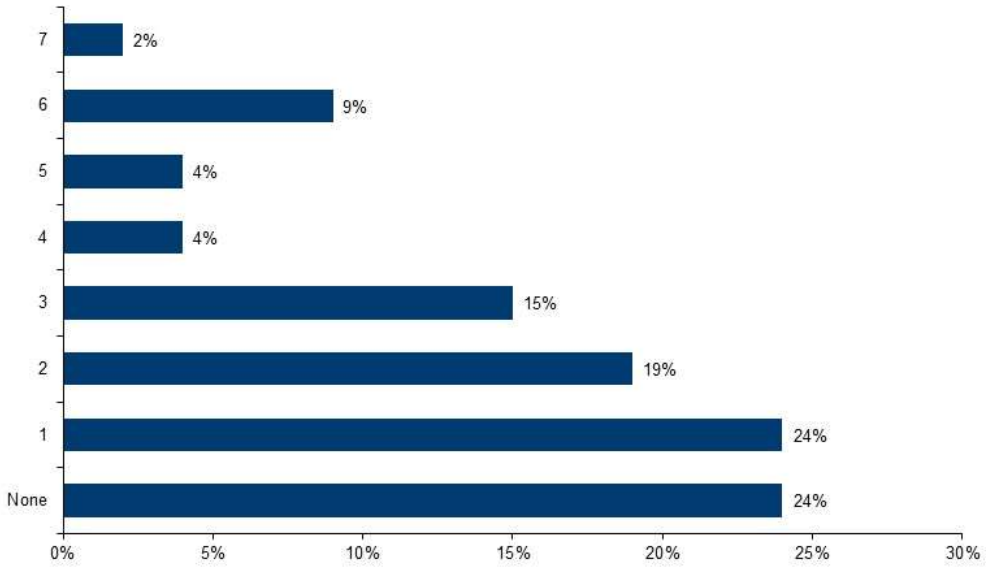
(Community = Gregory / Tripp / Charles Mix)



Base: None (n=4), 1 (n=14), 2 (n=16), 3 (n=18), 4 (n=4), 5 (n=5), 6 (n=3), 7 (n=7), Sample Size = 71

(Community = Gregory / Tripp / Charles Mix)

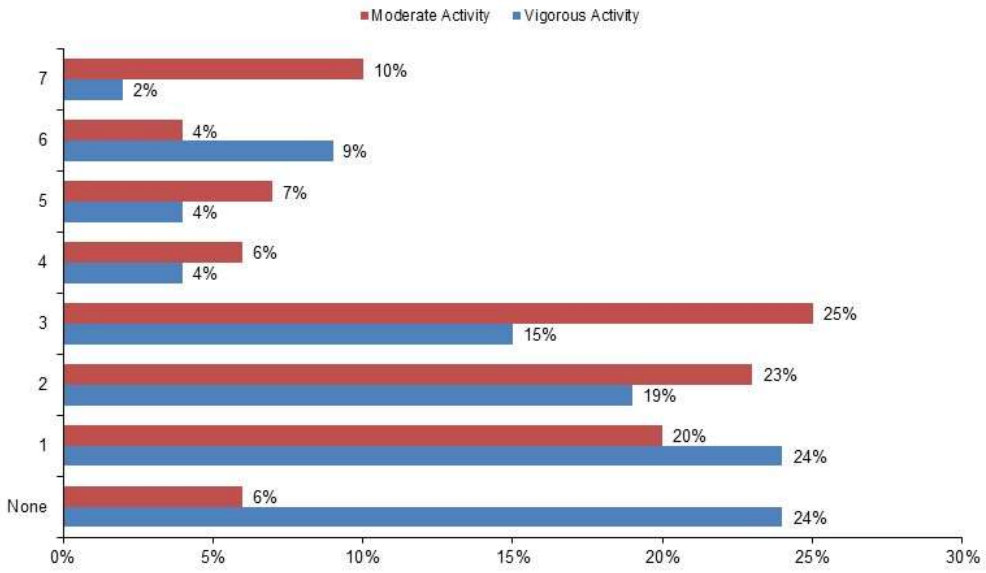
Days Per Week of Vigorous Physical Activity



Base: None (n=13), 1 (n=13), 2 (n=10), 3 (n=8), 4 (n=2), 5 (n=2), 6 (n=5), 7 (n=1), Sample Size = 54

(Community = Gregory / Tripp / Charles Mix)

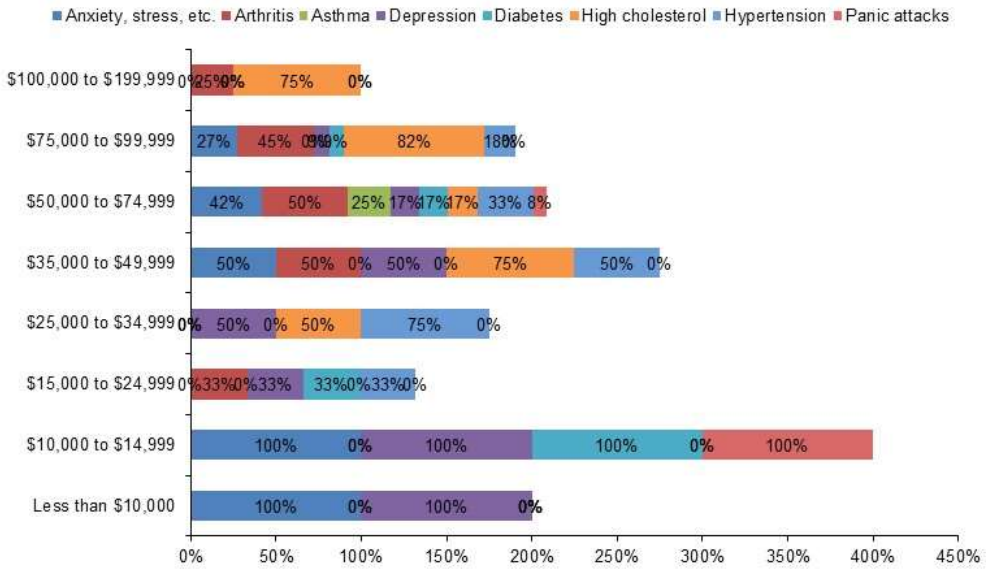
Days Per Week of Physical Activity



Sample Size = Variable

(Community = Gregory / Tripp / Charles Mix)

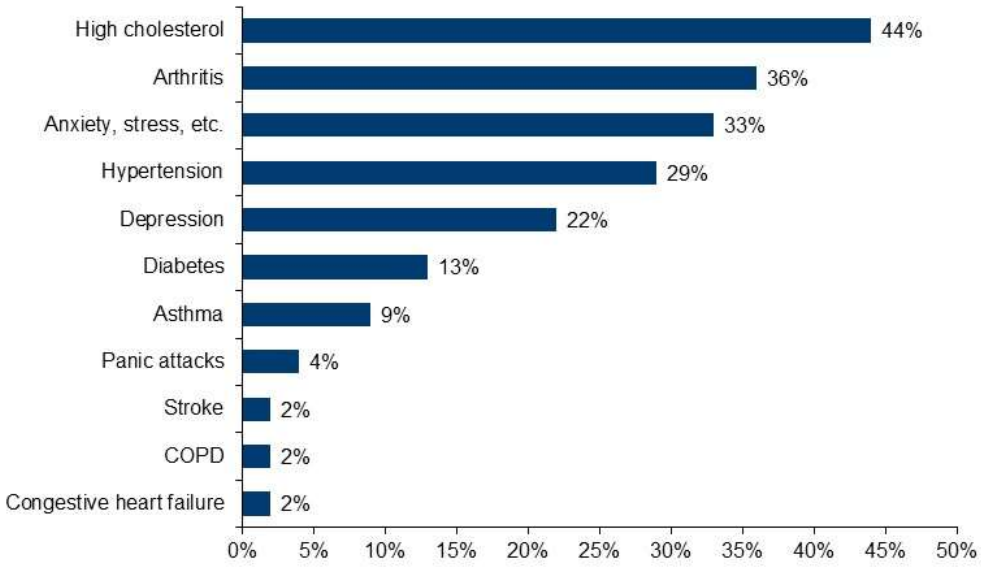
Past Diagnosis by Total Household Income



Base: Less than $10,000 (n=1), $10,000 to $14,999 (n=1), $15,000 to $24,999 (n=3), $25,000 to $34,999 (n=4), $35,000 to $49,999 (n=4), $50,000 to $74,999 (n=12), $75,000 to $99,999 (n=11), $100,000 to $199,999 (n=4), Sample Size = 40

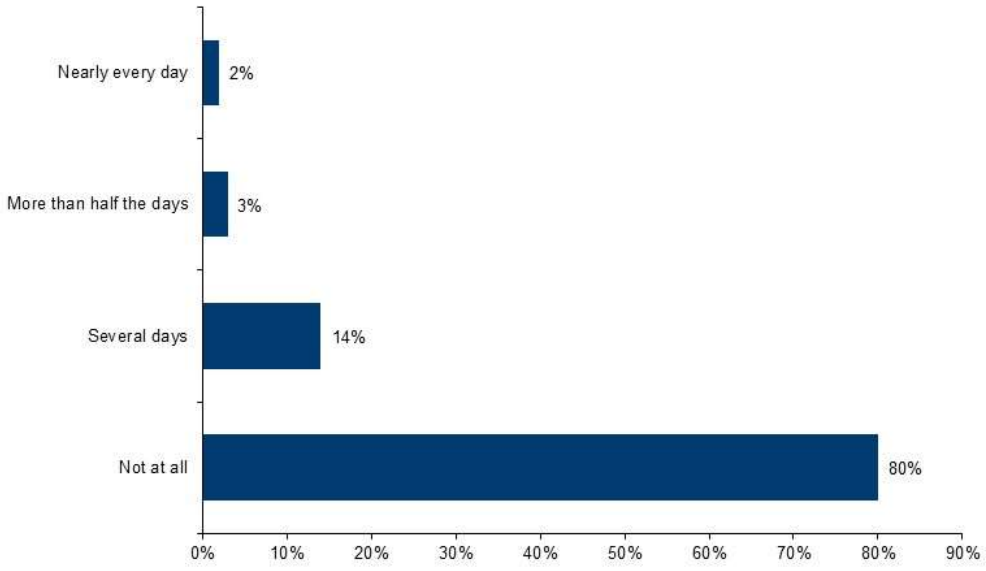
(Community = Gregory / Tripp / Charles Mix)

Past Diagnosis



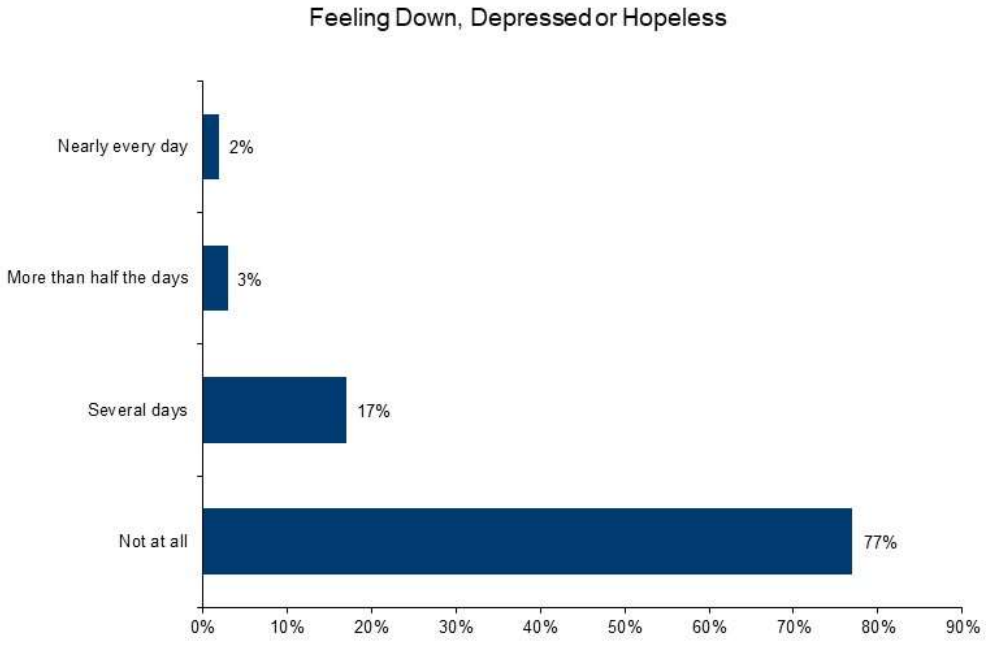
Base: Anxiety, stress, etc. (n=15), Arthritis (n=16), Asthma (n=4), Congestive heart failure (n=1), COPD (n=1), Depression (n=10), Diabetes (n=6), High cholesterol (n=20), Hypertension (n=13), Panic attacks (n=2), Stroke (n=1), Sample Size = 45
(Community = Gregory / Tripp / Charles Mix)

Little Interest or Pleasure in Doing Things



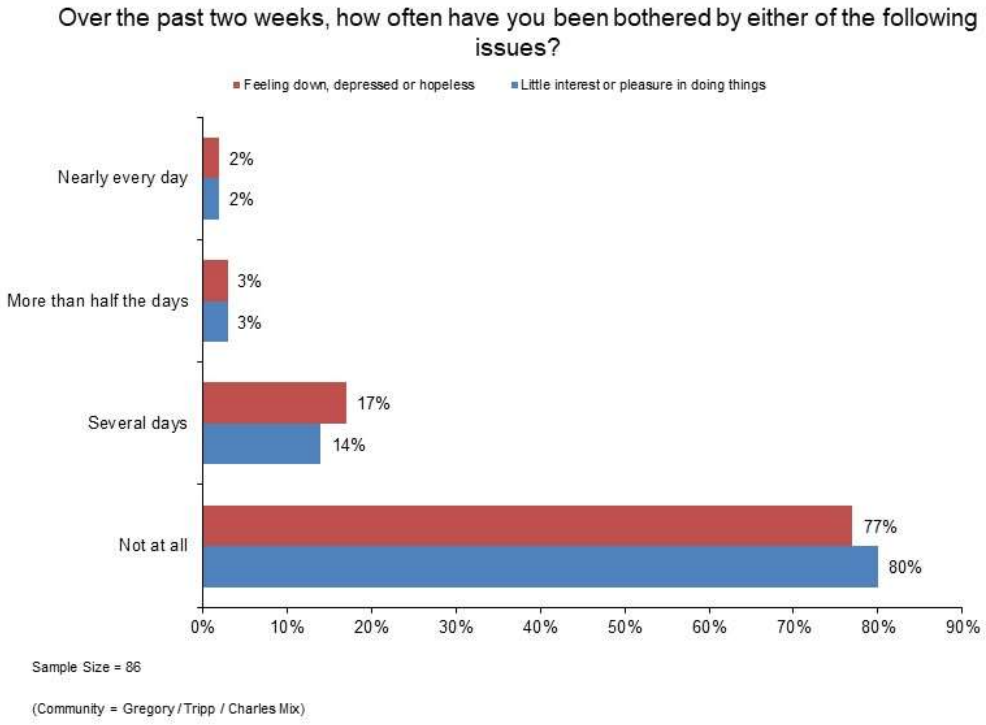
Base: Not at all (n=69), Several days (n=12), More than half the days (n=3), Nearly every day (n=2), Sample Size = 86

(Community = Gregory / Tripp / Charles Mix)



Base: Not at all (n=66), Several days (n=15), More than half the days (n=3), Nearly every day (n=2), Sample Size = 86

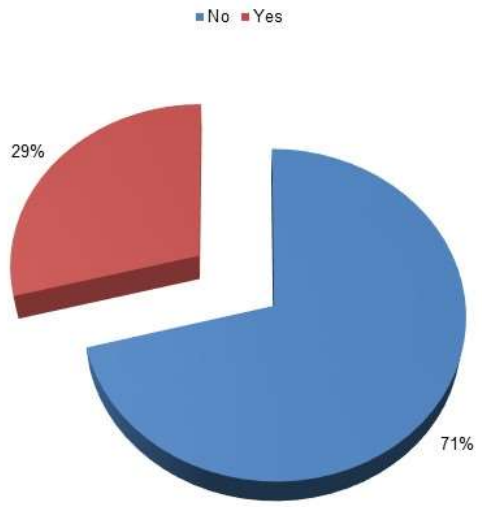
(Community = Gregory / Tripp / Charles Mix)



Sample Size = 86

(Community = Gregory / Tripp / Charles Mix)

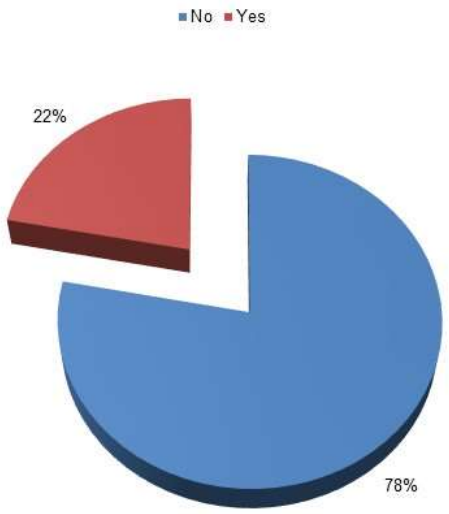
Have you smoked at least 100 cigarettes in your entire life?



Base: Yes (n=25), No (n=62), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

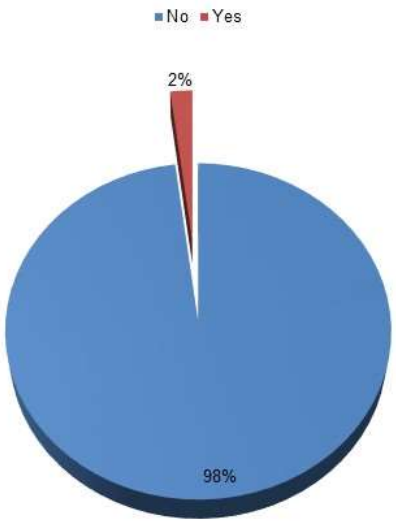
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=19), No (n=68), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

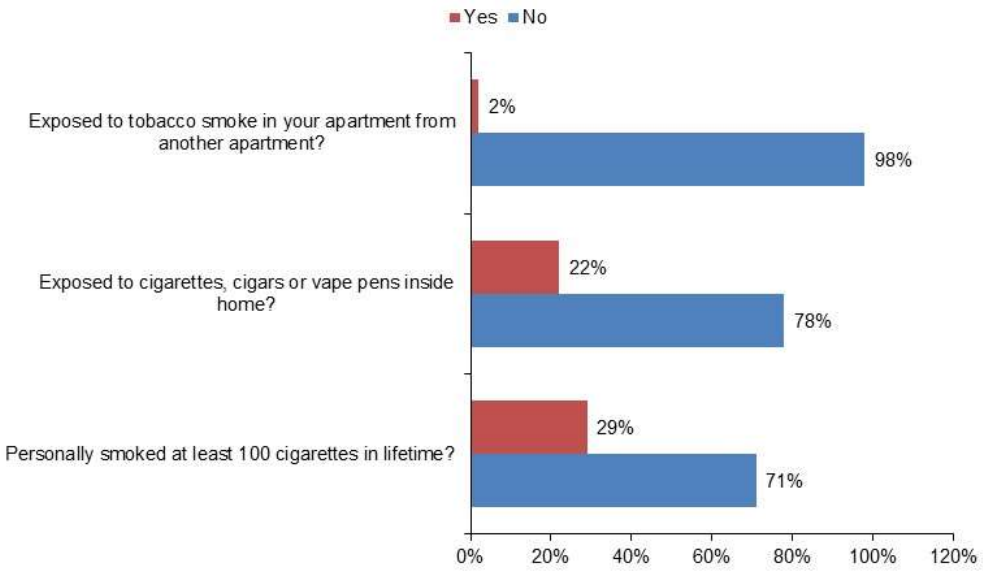
Have you smelled tobacco smoke in your apartment that comes from another apartment?



Base: Yes (n=2), No (n=85), Sample Size = 87

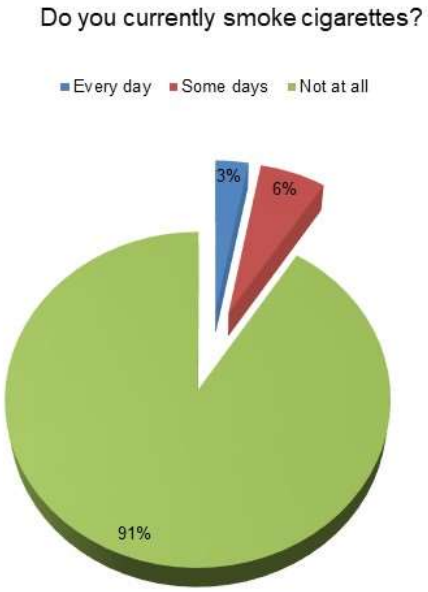
(Community = Gregory / Tripp / Charles Mix)

Exposure to Tobacco Smoke



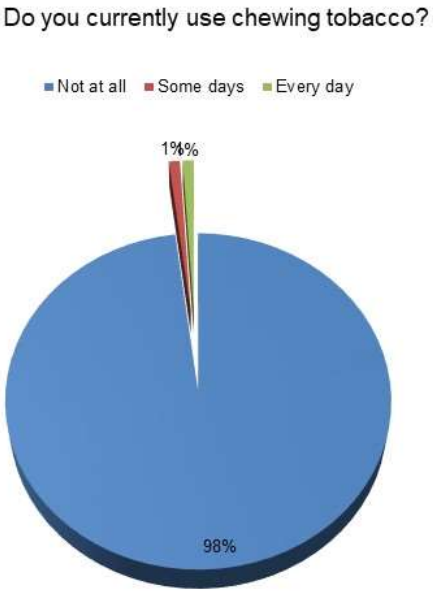
Base: Personally smoked at least 100 cigarettes in lifetime? (n=87), Exposed to cigarettes, cigars or vape pens inside home? (n=87), Exposed to tobacco smoke in your apartment from another apartment? (n=87), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)



Base: Not at all (n=79), Some days (n=5), Every day (n=3), Sample Size = 87

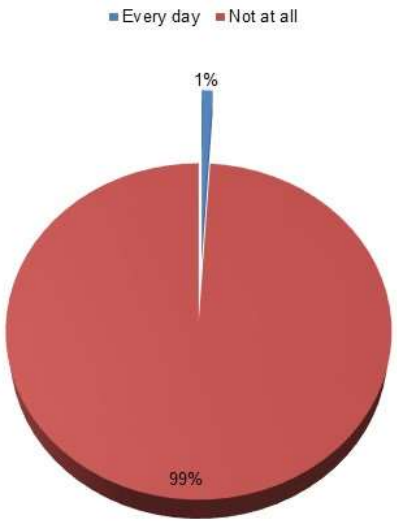
(Community = Gregory / Tripp / Charles Mix)



Base: Not at all (n=83), Some days (n=1), Every day (n=1), Sample Size = 85

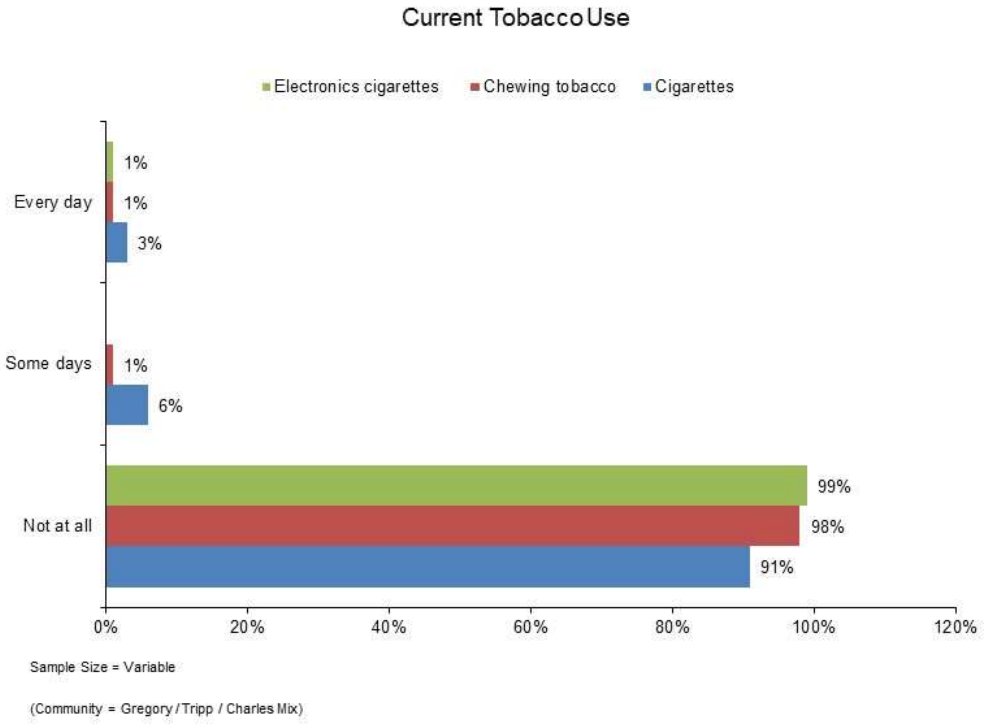
(Community = Gregory / Tripp / Charles Mix)

Do you currently use electronics cigarettes or vape?



Base: Not at all (n=83), Every day (n=1), Sample Size = 84

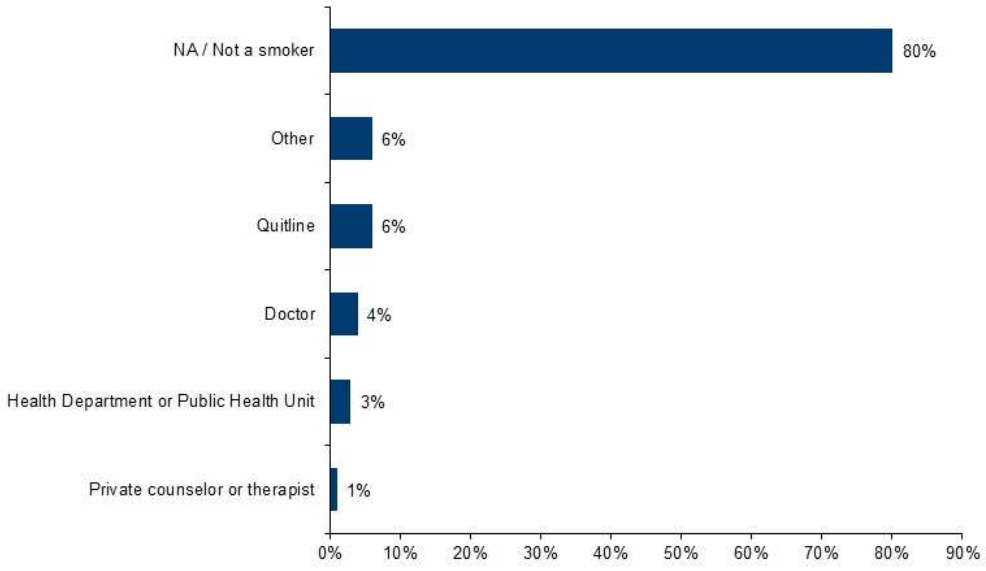
(Community = Gregory / Tripp / Charles Mix)



Sample Size = Variable

(Community = Gregory / Tripp / Charles Mix)

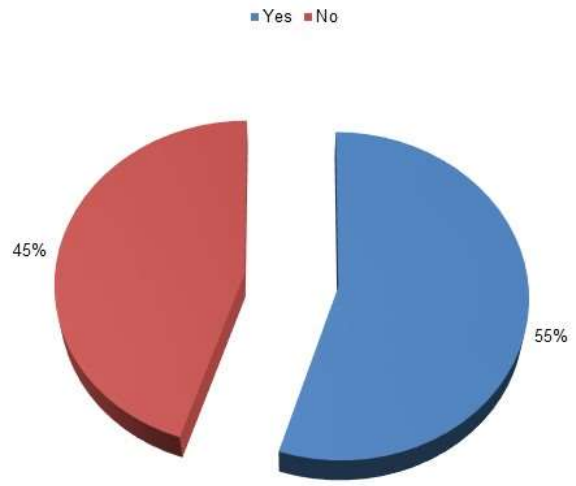
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=63), Quitline (n=5), Doctor (n=3), Private counselor or therapist (n=1), Health Department or Public Health Unit (n=2), Other (n=5), Sample Size = 79

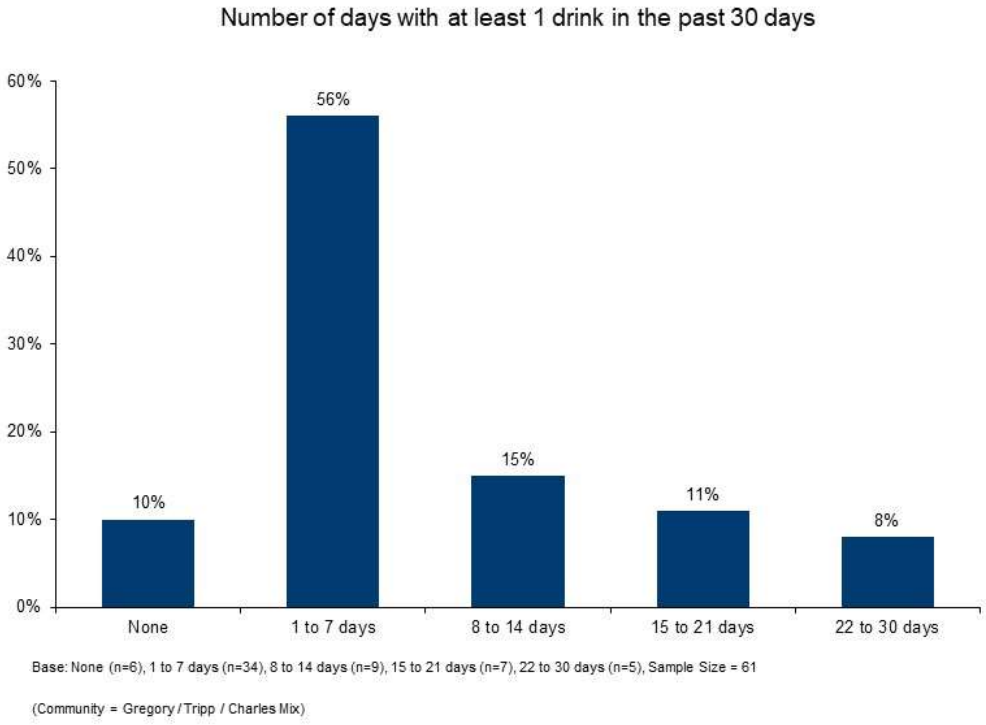
(Community = Gregory / Tripp / Charles Mix)

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



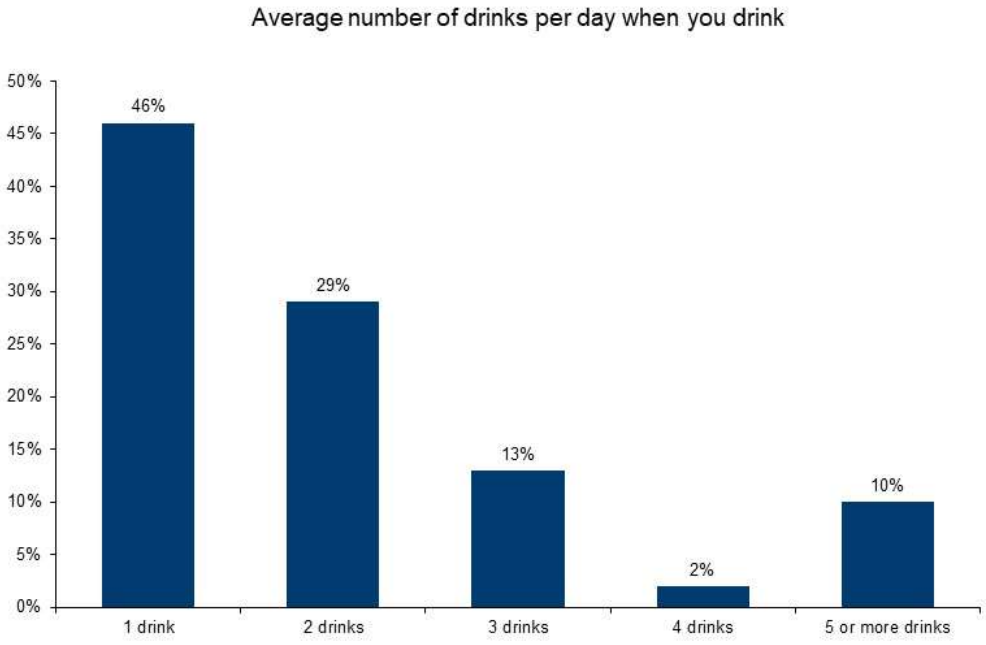
Base: Yes (n=6), No (n=5), Sample Size = 11

(Community = Gregory / Tripp / Charles Mix)



Base: None (n=6), 1 to 7 days (n=34), 8 to 14 days (n=9), 15 to 21 days (n=7), 22 to 30 days (n=5), Sample Size = 61

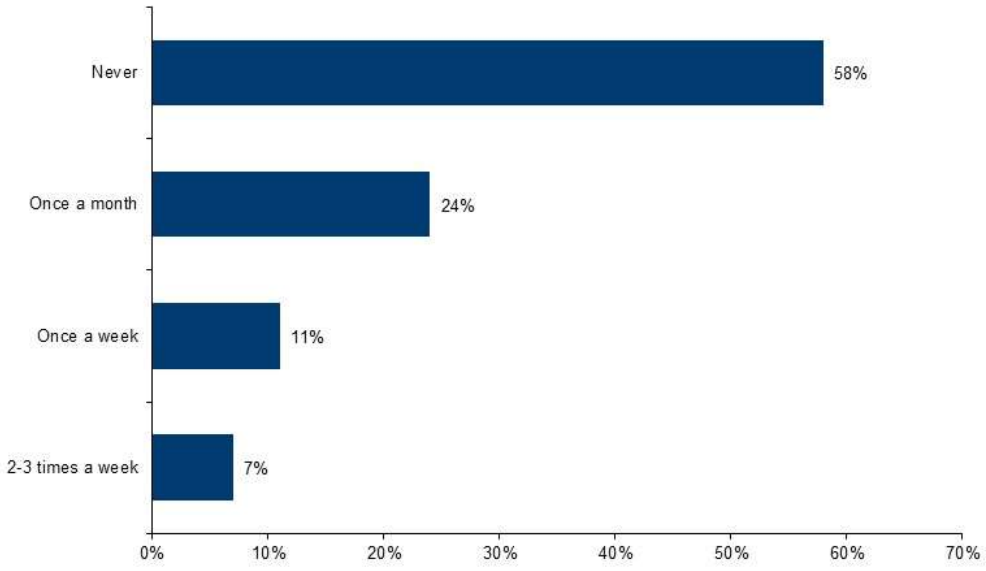
(Community = Gregory / Tripp / Charles Mix)



Base: 1 drink (n=24), 2 drinks (n=15), 3 drinks (n=7), 4 drinks (n=1), 5 or more drinks (n=5), Sample Size = 52

(Community = Gregory / Tripp / Charles Mix)

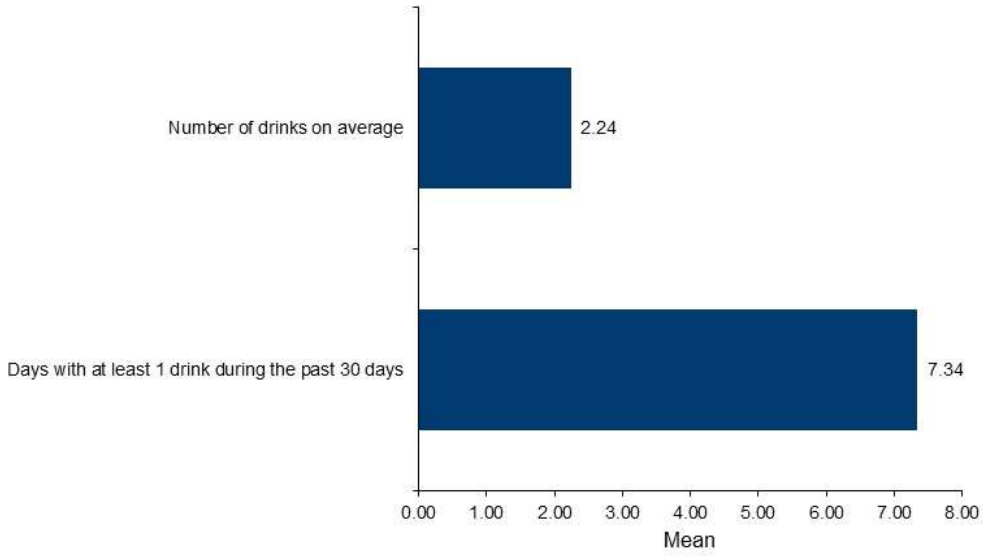
Binge Drinking



Base: 2-3 times a week (n=4), Once a week (n=6), Once a month (n=13), Never (n=32), Sample Size = 55

(Community = Gregory / Tripp / Charles Mix)

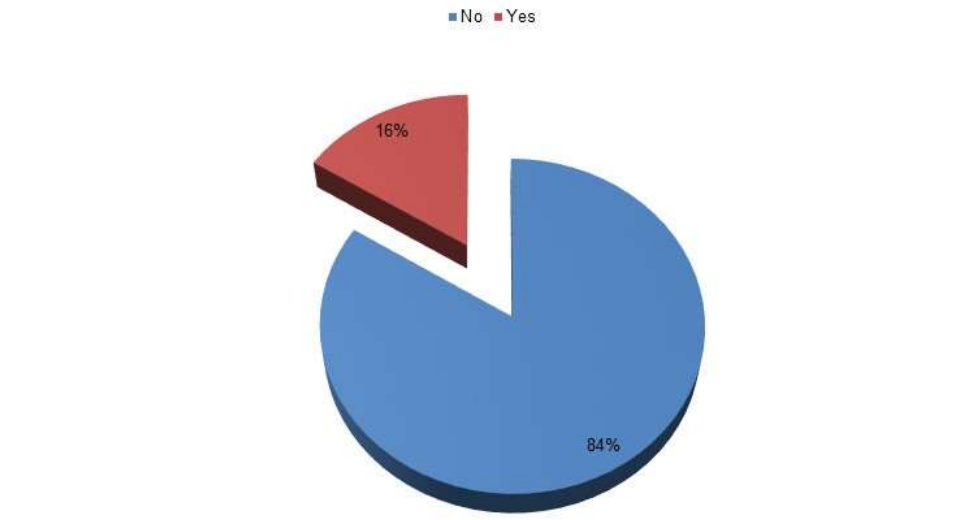
Average Alcohol Use During the Past 30 Days



Base: Days with at least 1 drink during the past 30 days (n=61), Number of drinks on average (n=54), Sample Size = Variable

(Community = Gregory / Tripp / Charles Mix)

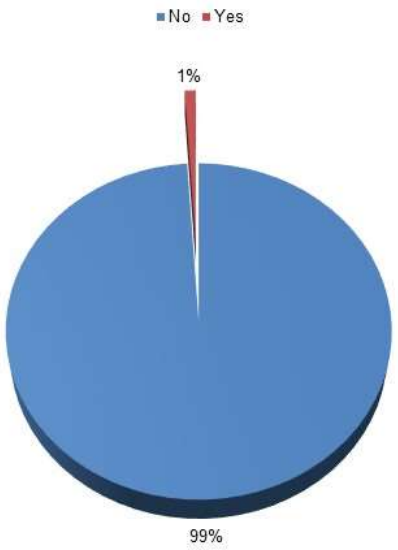
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=14), No (n=71), Sample Size = 85

(Community = Gregory / Tripp / Charles Mix)

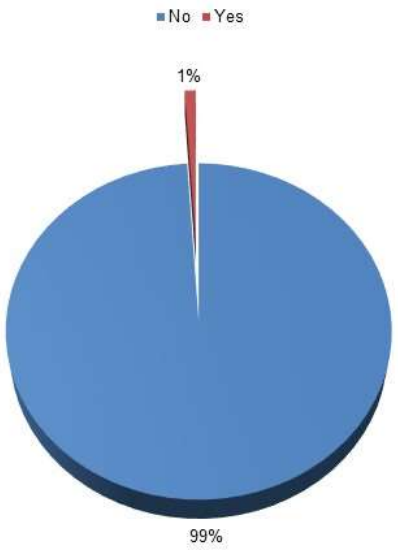
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=1), No (n=86), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

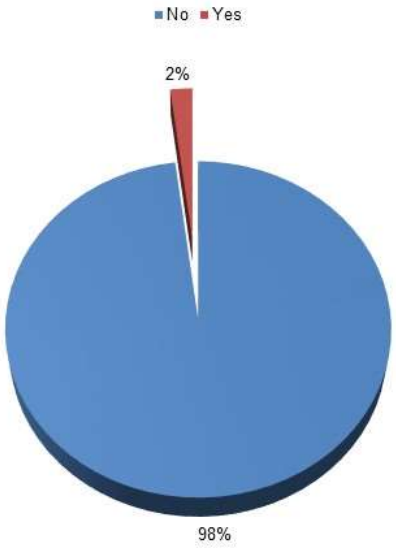
Has a family member or friend ever suggested that you get help for substance use?



Base: Yes (n=1), No (n=86), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

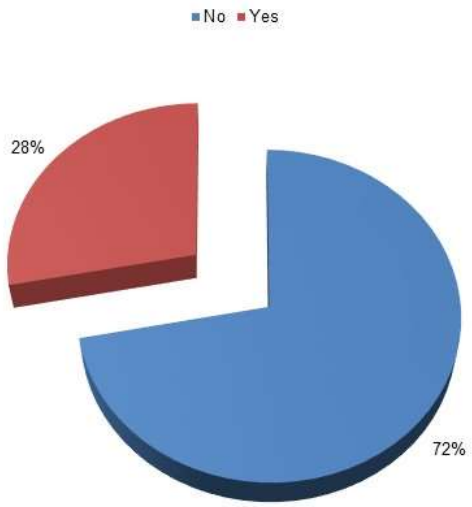
Has prescription or non-prescription drug use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=2), No (n=85), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

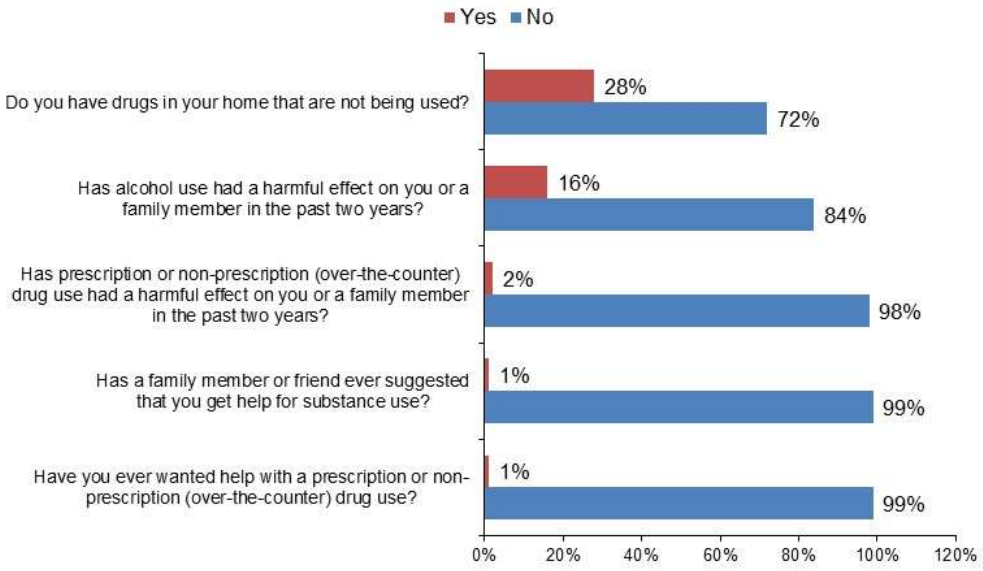
Do you have drugs in your home that are not being used?



Base: Yes (n=24), No (n=63), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

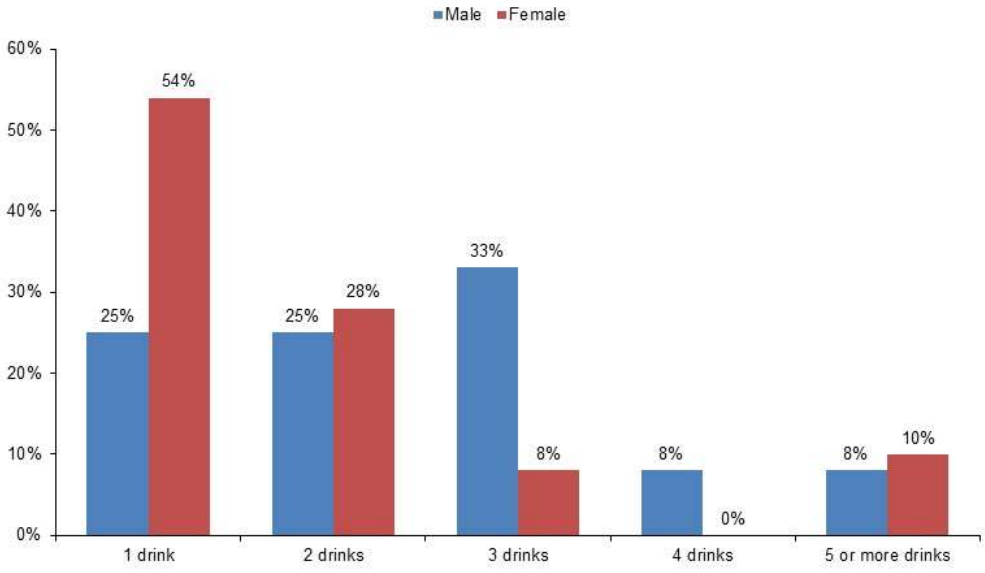
Drug and Alcohol Issues



Sample Size = Variable

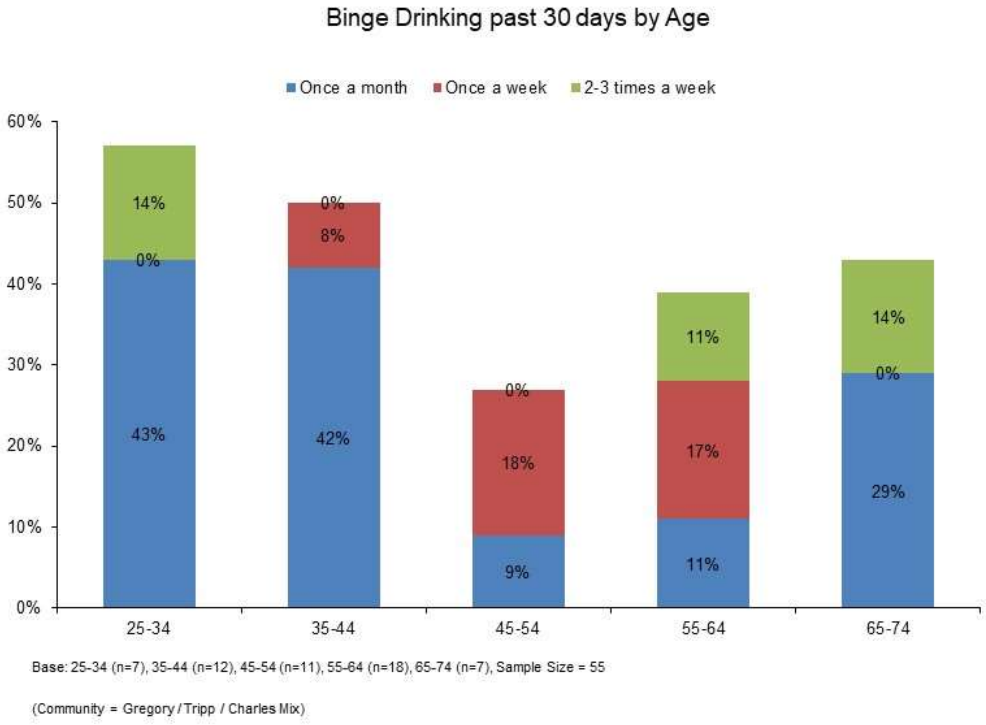
(Community = Gregory / Tripp / Charles Mix)

Average number of drinks per day when you drink by gender



Base: 1 drink (n=24), 2 drinks (n=14), 3 drinks (n=7), 4 drinks (n=1), 5 or more drinks (n=5), Sample Size = 51

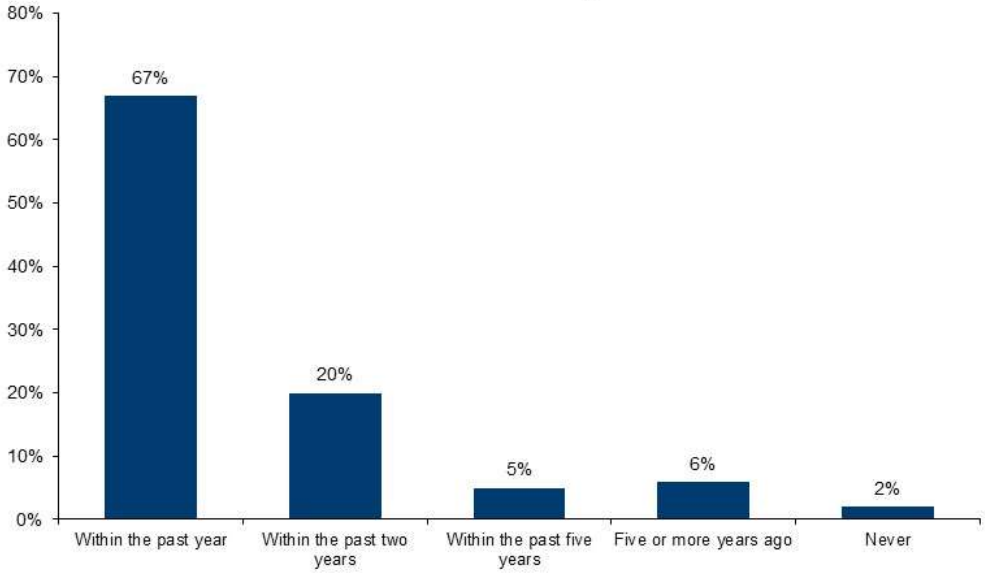
(Community = Gregory / Tripp / Charles Mix)



Base: 25-34 (n=7), 35-44 (n=12), 45-54 (n=11), 55-64 (n=18), 65-74 (n=7), Sample Size = 55

(Community = Gregory / Tripp / Charles Mix)

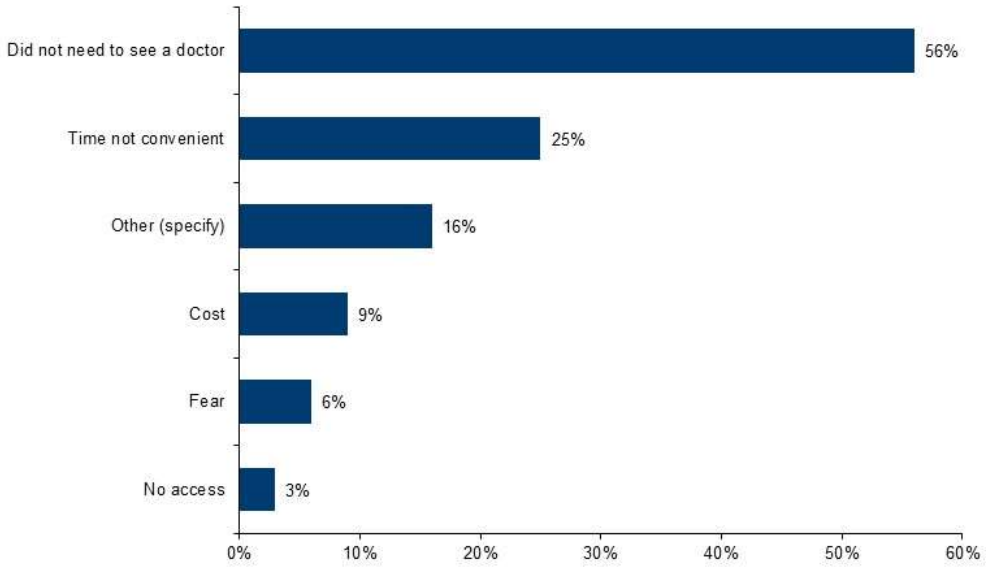
How long has it been since you last visited a doctor or health care provider for a routine checkup?



Base: Within the past year (n=55), Within the past two years (n=16), Within the past five years (n=4), Five or more years ago (n=5), Never (n=2), Sample Size = 82

(Community = Gregory / Tripp / Charles Mix)

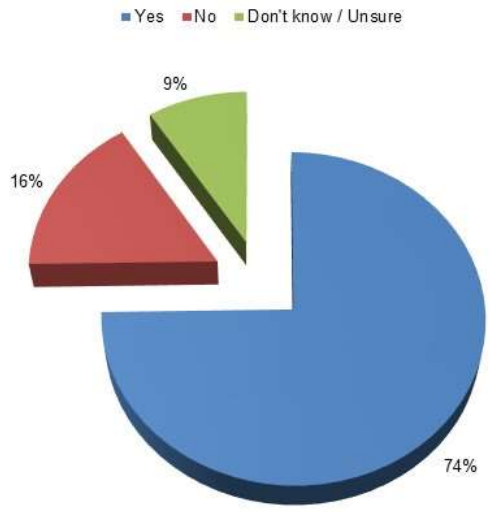
Barriers to Routine Checkup



Base: No access (n=1), Cost (n=3), Fear (n=2), Time not convenient (n=8), Did not need to see a doctor (n=18), Other (specify) (n=5), Sample Size = 32

(Community = Gregory / Tripp / Charles Mix)

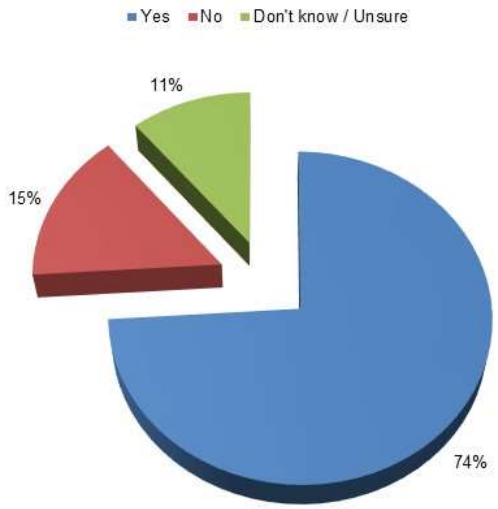
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=63), No (n=14), Don't know / Unsure (n=8), Sample Size = 85

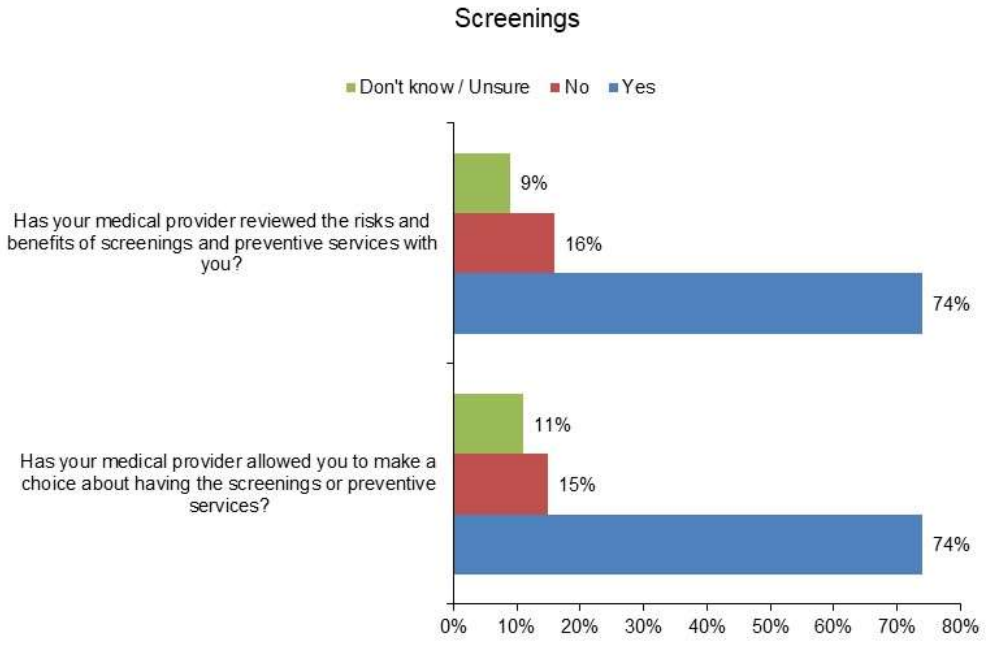
(Community = Gregory / Tripp / Charles Mix)

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



Base: Yes (n=63), No (n=13), Don't know / Unsure (n=9), Sample Size = 85

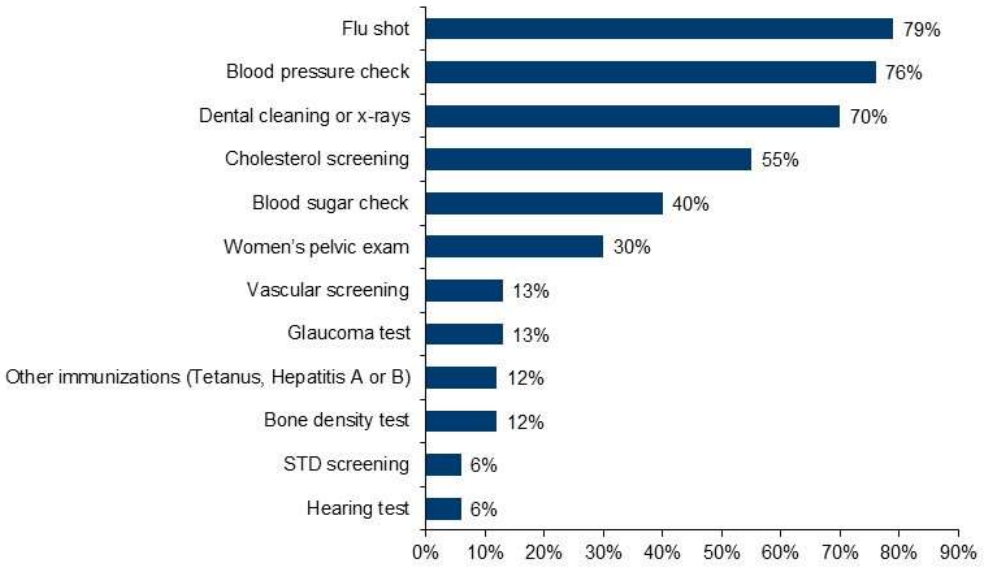
(Community = Gregory / Tripp / Charles Mix)



Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=85), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=85), Sample Size = 85

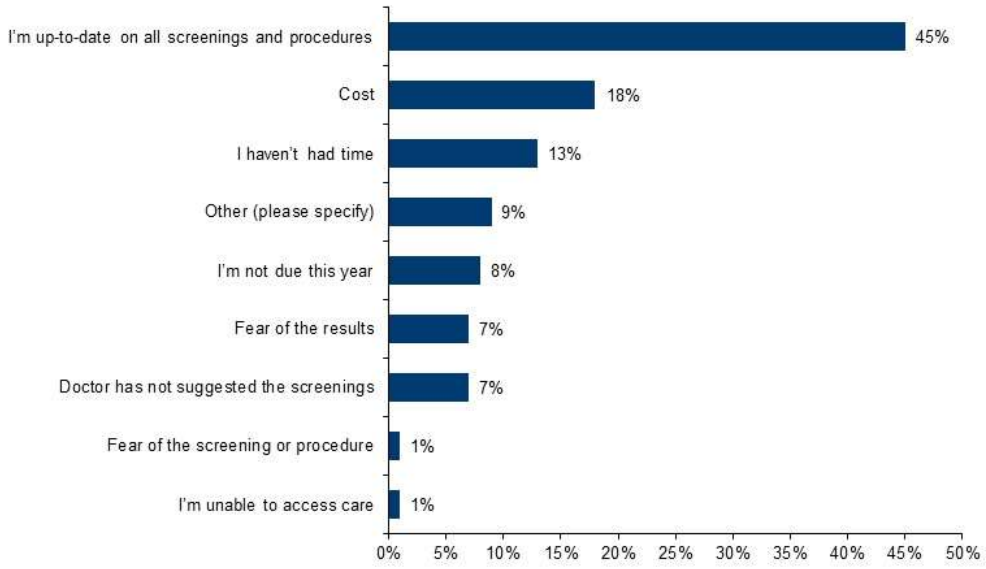
(Community = Gregory / Tripp / Charles Mix)

Preventive Procedures Last Year



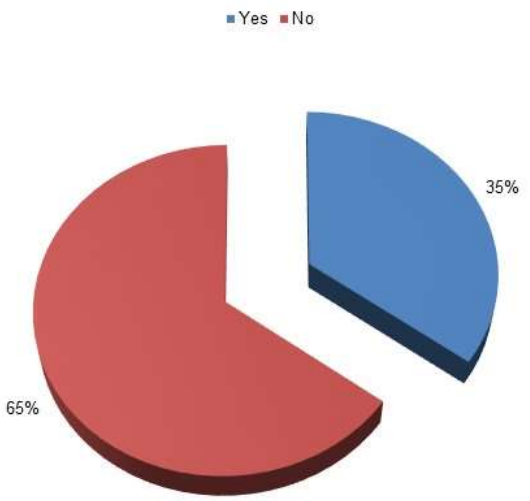
Base: Blood pressure check (n=62), Blood sugar check (n=33), Bone density test (n=10), Cholesterol screening (n=45), Dental cleaning or x-rays (n=57), Flu shot (n=65), Other immunizations (Tetanus, Hepatitis A or B) (n=10), Glaucoma test (n=11), Hearing test (n=5), Women's pelvic exam (n=25), STD screening (n=5), Vascular screening (n=11), Sample Size = 82
(Community = Gregory / Tripp / Charles Mix)

Barriers for Preventive Procedures



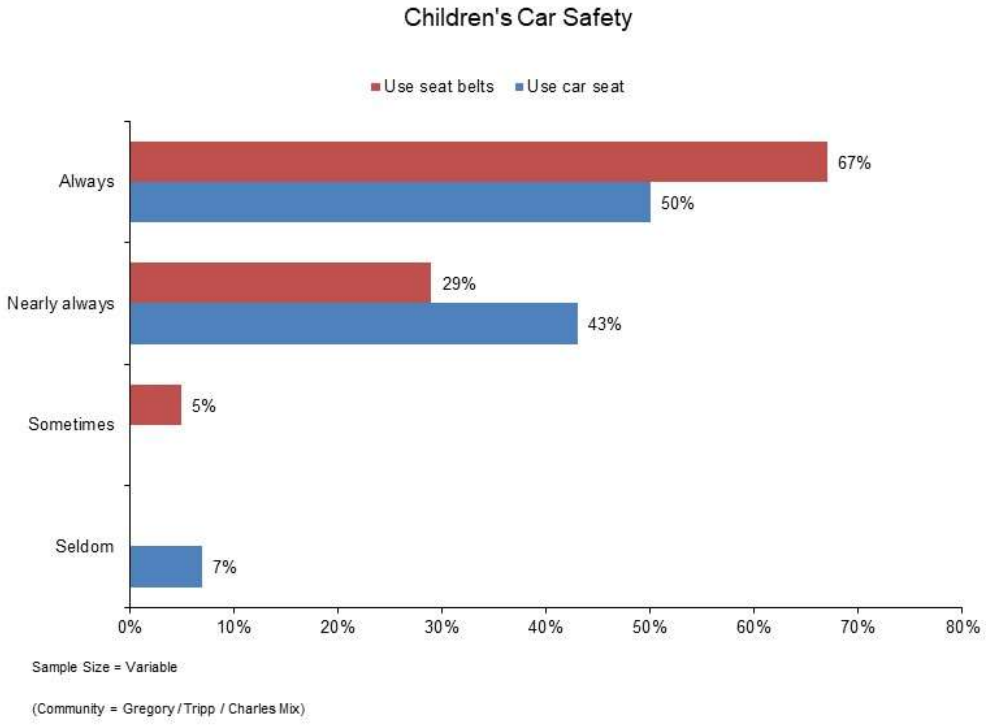
Base: I'm up-to-date on all screenings and procedures (n=38), Doctor has not suggested the screenings (n=6), Cost (n=15), I'm unable to access care (n=1), Fear of the screening or procedure (n=1), Fear of the results (n=6), I'm not due this year (n=7), I haven't had time (n=11), Other (please specify) (n=8),
Sample Size = 85
(Community = Gregory / Tripp / Charles Mix)

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



Base: Yes (n=30), No (n=56), Sample Size = 86

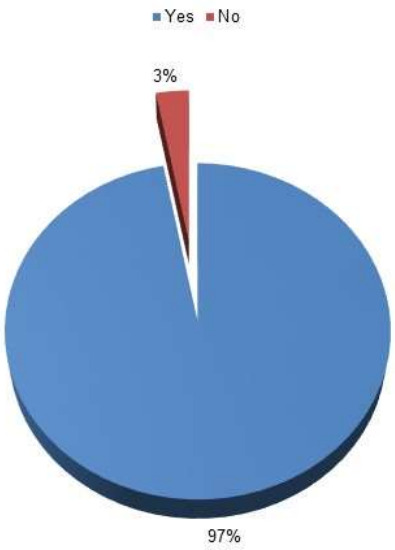
(Community = Gregory / Tripp / Charles Mix)



Sample Size = Variable

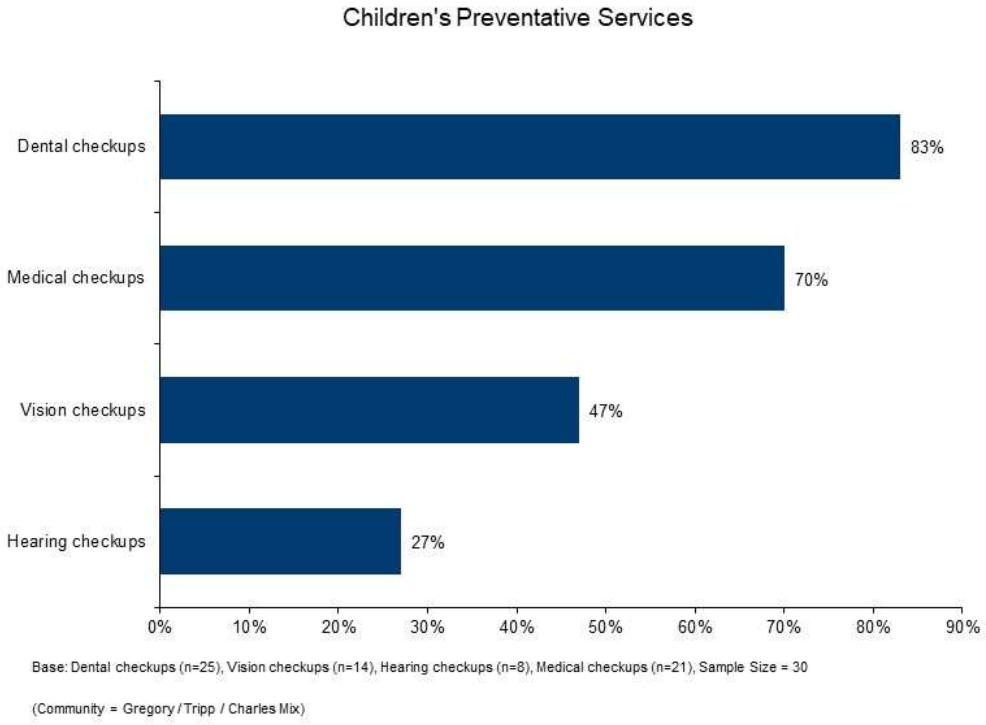
(Community = Gregory / Tripp / Charles Mix)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=30), No (n=1), Sample Size = 31

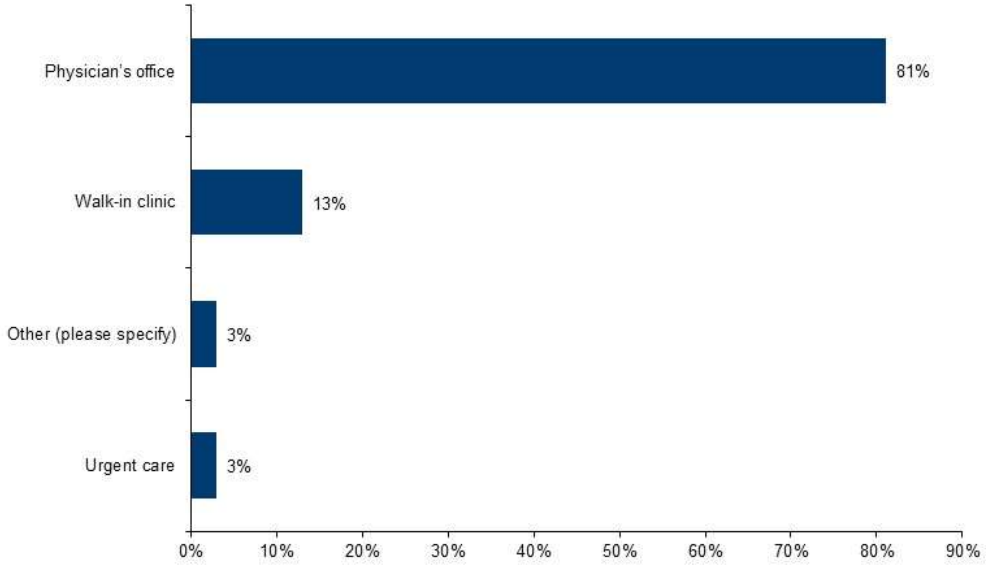
(Community = Gregory / Tripp / Charles Mix)



Base: Dental checkups (n=25), Vision checkups (n=14), Hearing checkups (n=8), Medical checkups (n=21), Sample Size = 30

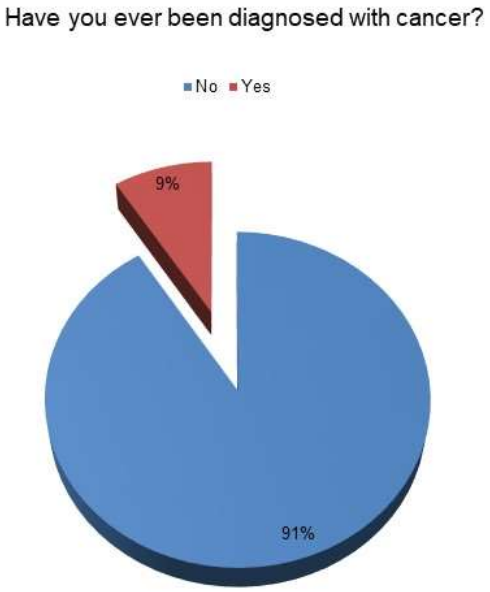
(Community = Gregory / Tripp / Charles Mix)

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



Base: Physician's office (n=25), Urgent care (n=1), Walk-in clinic (n=4), Other (please specify) (n=1), Sample Size = 31

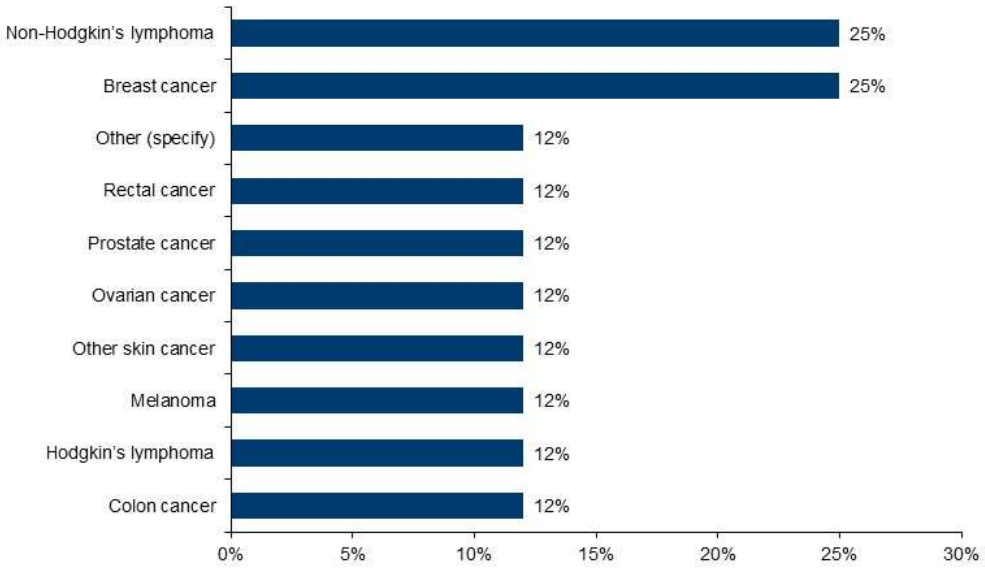
(Community = Gregory / Tripp / Charles Mix)



Base: Yes (n=8), No (n=79), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

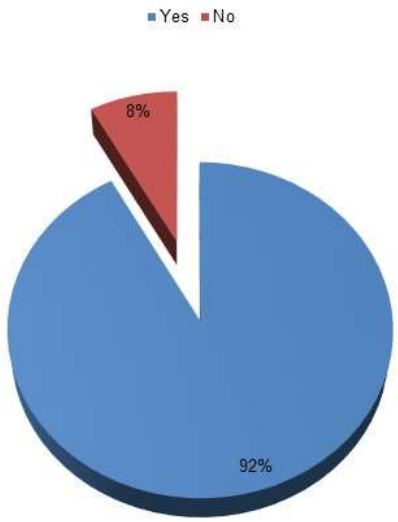
Type of Cancer



Base: Breast cancer (n=2), Colon cancer (n=1), Hodgkin's lymphoma (n=1), Melanoma (n=1), Non-Hodgkin's lymphoma (n=2), Other skin cancer (n=1), Ovarian cancer (n=1), Prostate cancer (n=1), Rectal cancer (n=1), Other (specify) (n=1), Sample Size = 8

(Community = Gregory / Tripp / Charles Mix)

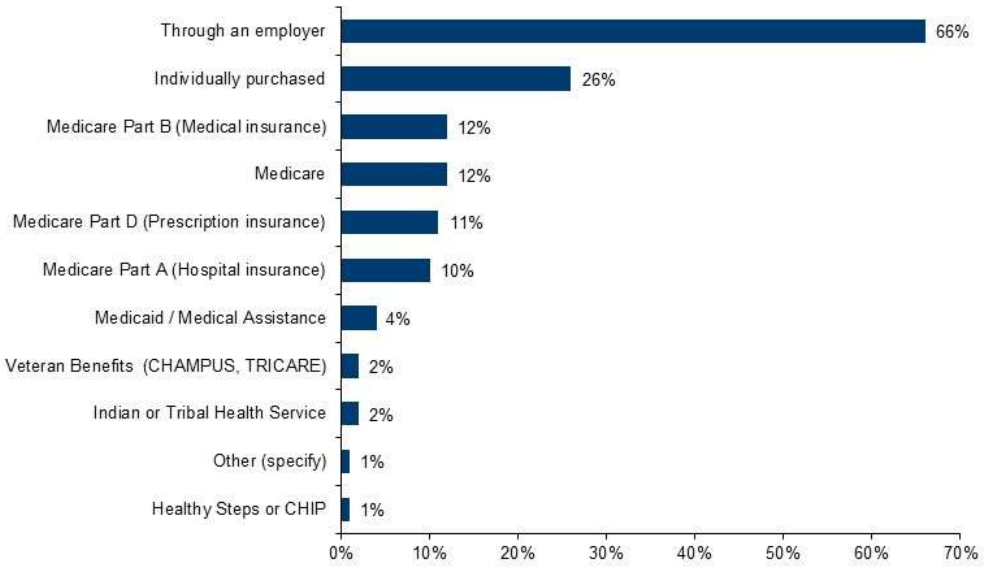
Do you currently have any kind of health insurance?



Base: Yes (n=80), No (n=7), Sample Size = 87

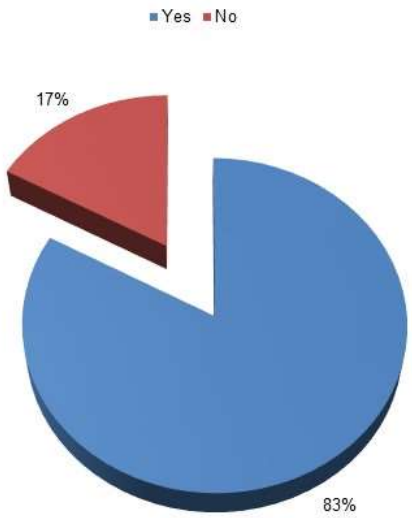
(Community = Gregory / Tripp / Charles Mix)

Type of Insurance



Base: Through an employer (n=53), Individually purchased (n=21), Indian or Tribal Health Service (n=2), Medicare (n=10), Medicare Part A (Hospital insurance) (n=8), Medicare Part B (Medical insurance) (n=10), Medicare Part D (Prescription insurance) (n=9), Medicaid / Medical Assistance (n=3), Veteran Benefits (CHAMPUS, TRICARE) (n=2), Healthy Steps or CHIP (n=1), Other (specify) (n=1), Sample Size = 80
(Community = Gregory / Tripp / Charles Mix)

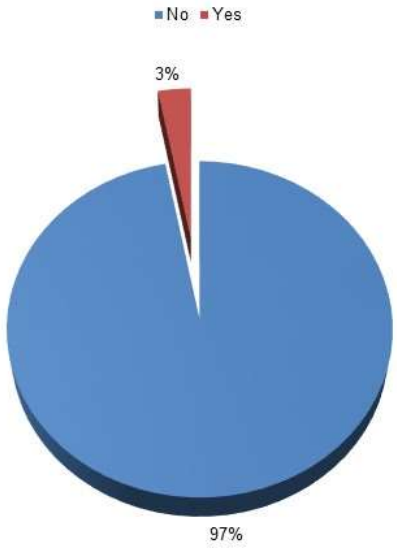
Do you have an established primary healthcare provider?



Base: Yes (n=71), No (n=15), Sample Size = 86

(Community = Gregory / Tripp / Charles Mix)

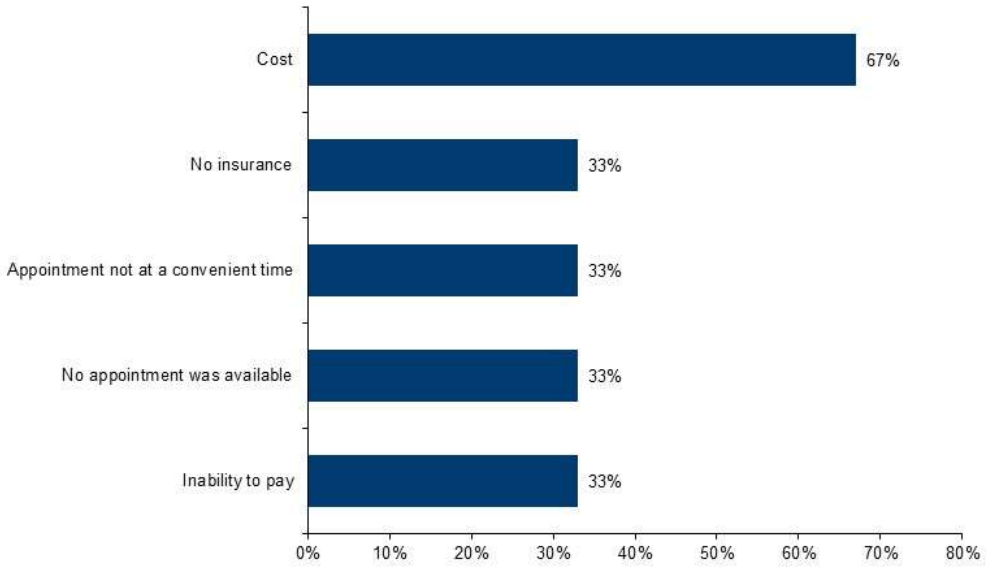
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?



Base: Yes (n=3), No (n=84), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

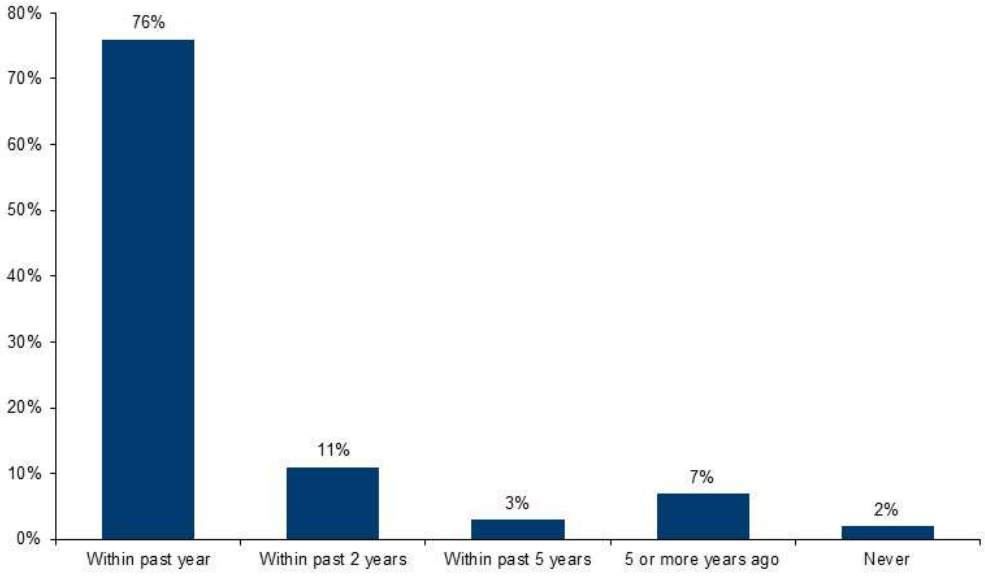
Barriers to Receiving Care Needed



Base: Inability to pay (n=1), No appointment was available (n=1), Appointment not at a convenient time (n=1), No insurance (n=1), Cost (n=2)

(Community = Gregory / Tripp / Charles Mix)

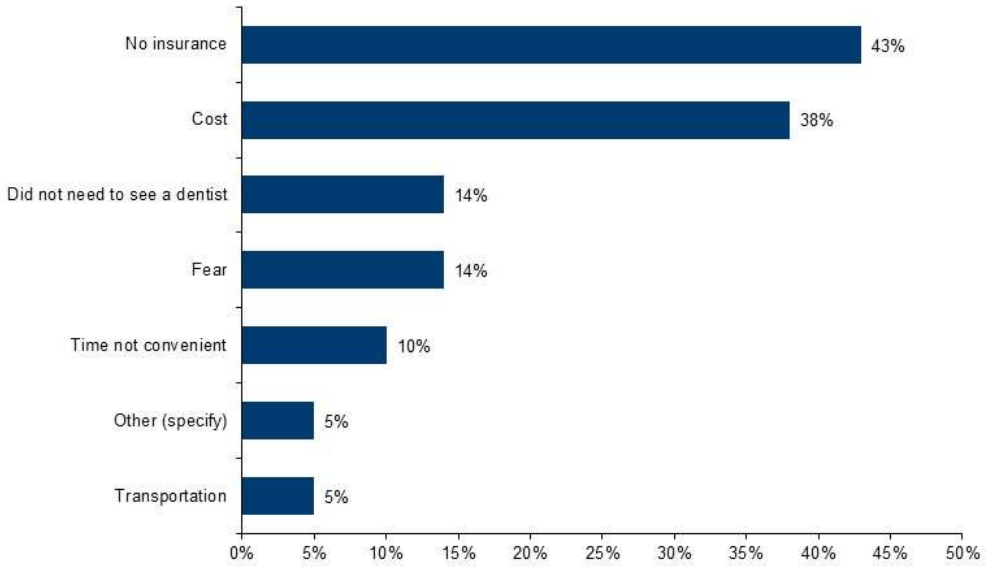
How long has it been since you last visited a dentist?



Base: Within past year (n=66), Within past 2 years (n=10), Within past 5 years (n=3), 5 or more years ago (n=6), Never (n=2), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

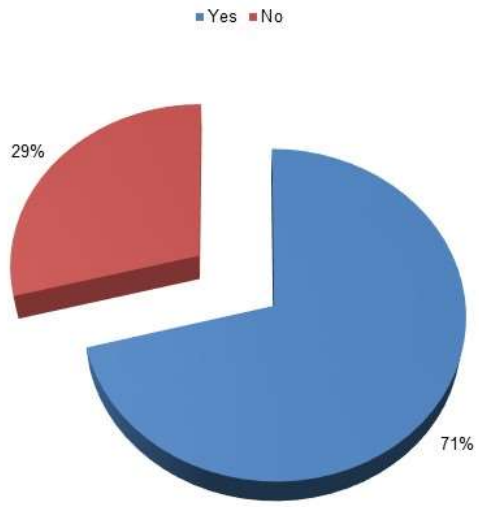
Barriers to Visiting the Dentist



Base: No insurance (n=9), Cost (n=8), Fear (n=3), Transportation (n=1), Time not convenient (n=2), Did not need to see a dentist (n=3), Other (specify) (n=1), Sample Size = 21

(Community = Gregory / Tripp / Charles Mix)

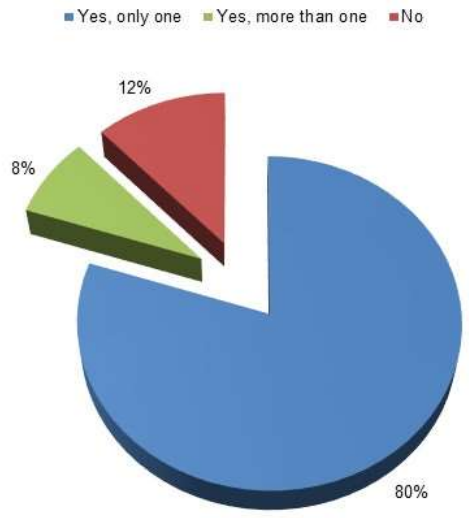
Do you have any kind of dental care or oral health insurance coverage?



Base: Yes (n=61), No (n=25), Sample Size = 86

(Community = Gregory / Tripp / Charles Mix)

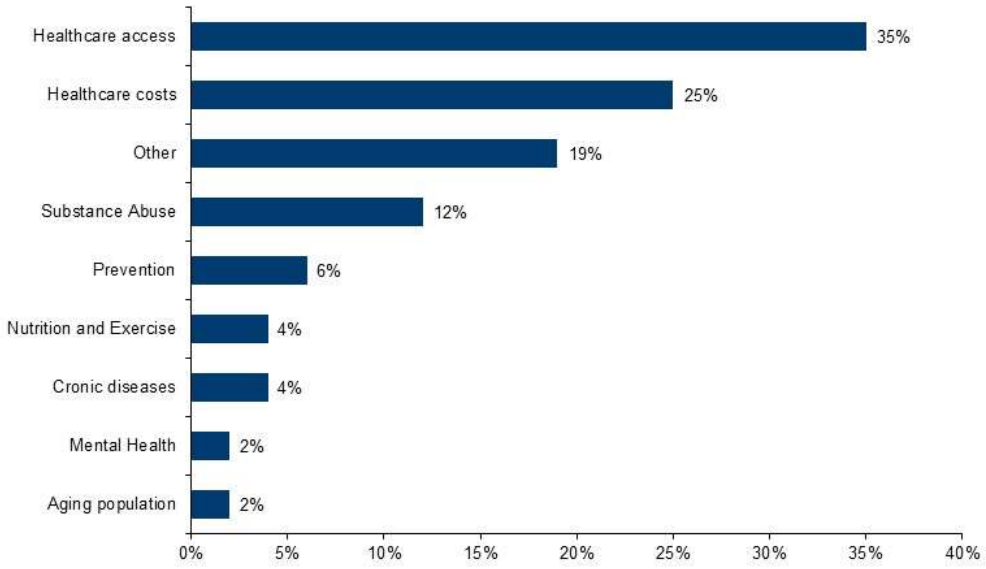
Do you have a dentist that you see for routine care?



Base: Yes, only one (n=69), Yes, more than one (n=7), No (n=10), Sample Size = 86

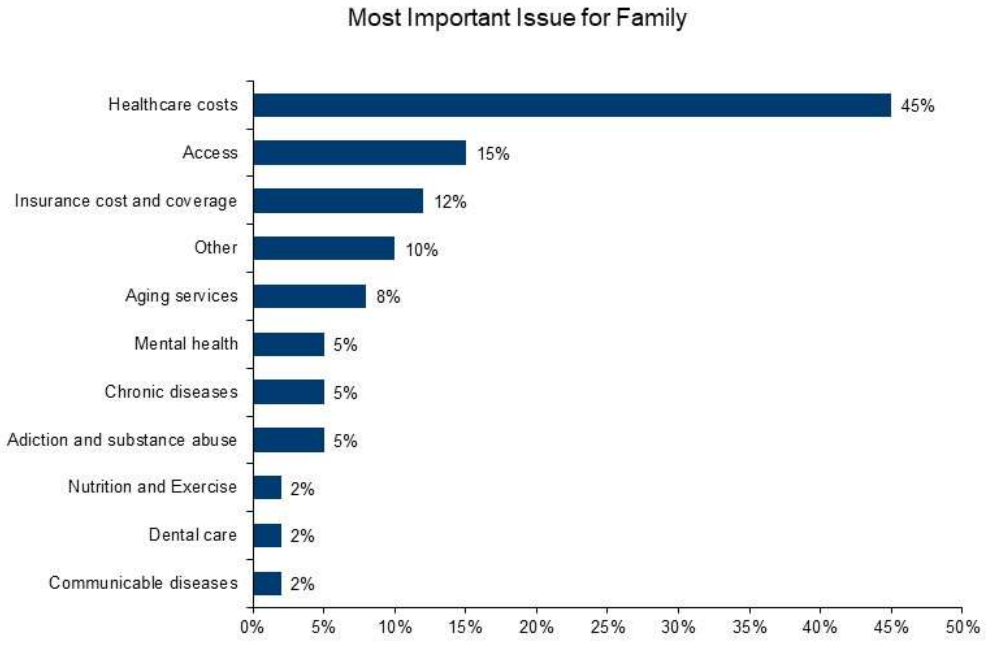
(Community = Gregory / Tripp / Charles Mix)

Most Important Community Issues



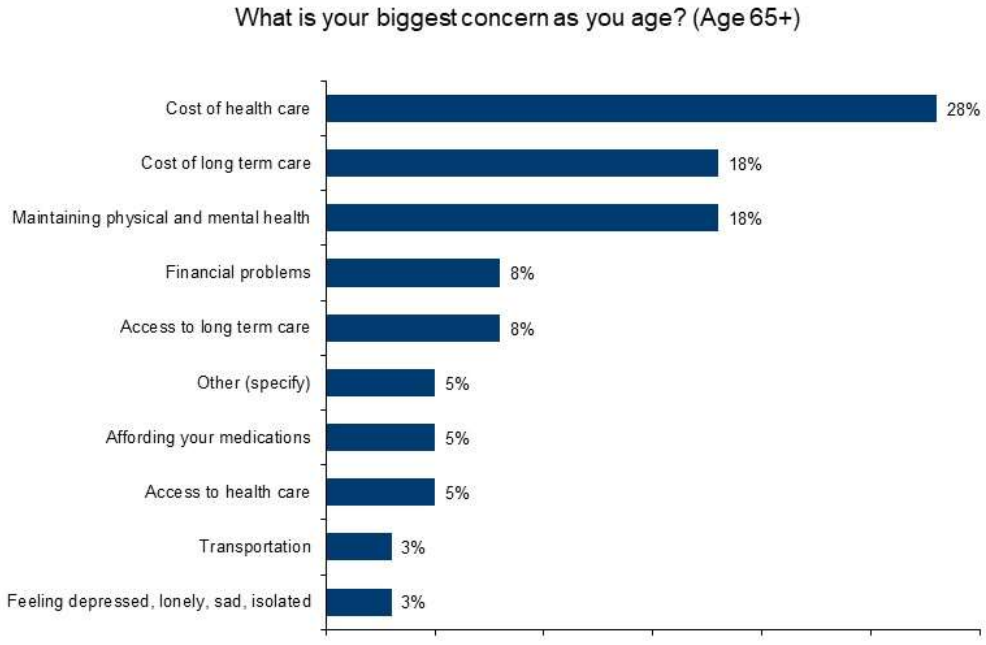
Base: Aging population (n=1), Healthcare access (n=17), Mental Health (n=1), Substance Abuse (n=6), Cronic diseases (n=2), Healthcare costs (n=12), Prevention (n=3), Nutrition and Exercise (n=2), Other (n=9), Sample Size = 52

(Community = Gregory / Tripp / Charles Mix)



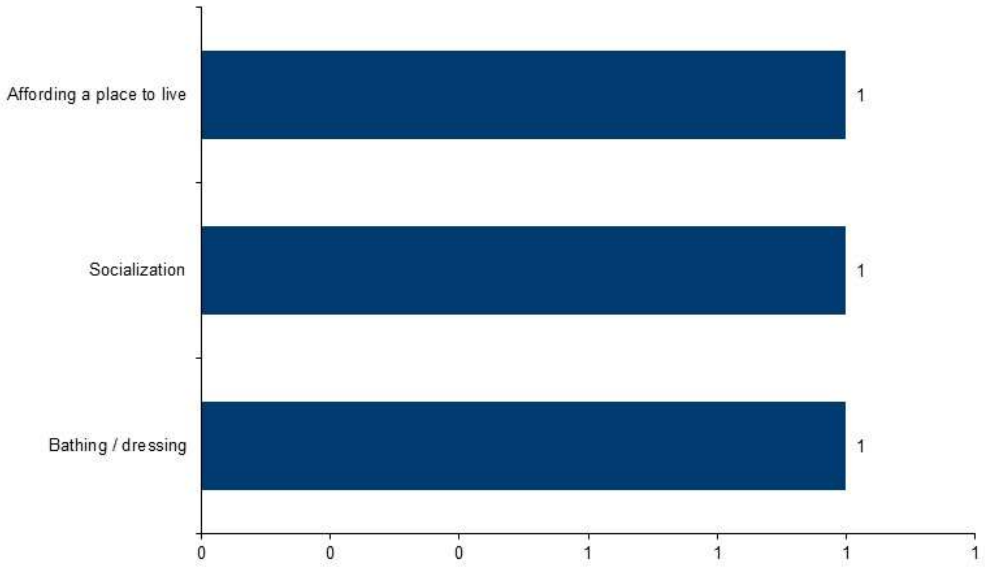
Base: Access (n=6), Adiction and substance abuse (n=2), Aging services (n=3), Chronic diseases (n=2), Communicable diseases (n=1), Healthcare costs (n=18), Dental care (n=1), Nutrition and Exercise (n=1), Insurance cost and coverage (n=5), Mental health (n=2), Other (n=4), Sample Size = 49

(Community = Gregory / Tripp / Charles Mix)



Base: Access to health care (n=2), Cost of health care (n=11), Affording your medications (n=2), Maintaining physical and mental health (n=7), Feeling depressed, lonely, sad, isolated (n=1), Access to long term care (n=3), Cost of long term care (n=7), Financial problems (n=3), Transportation (n=1), Other (specify) (n=2), Sample Size = 15
(Community = Gregory / Tripp / Charles Mix)

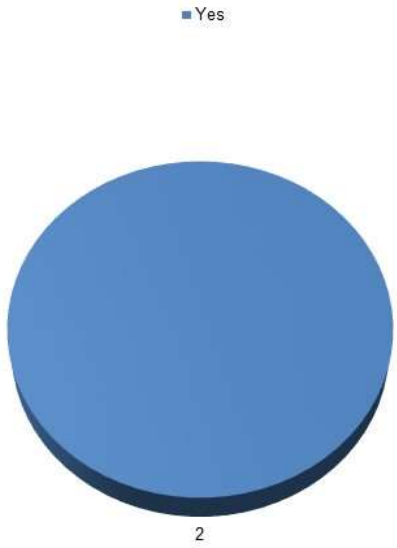
Which of these tasks do you need assistance with? (Age 65+)



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

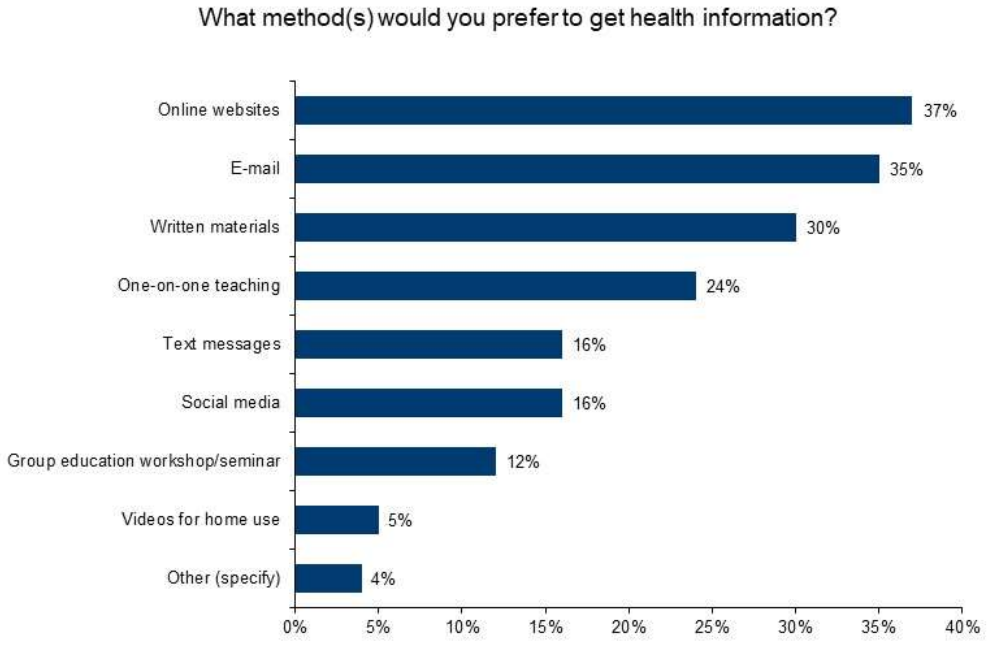
(Community = Gregory / Tripp / Charles Mix)

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



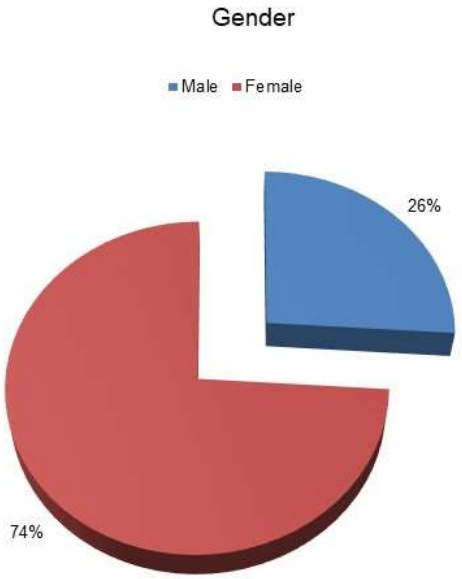
Base: Yes (n=2), Sample Size = 2

(Community = Gregory / Tripp / Charles Mix)



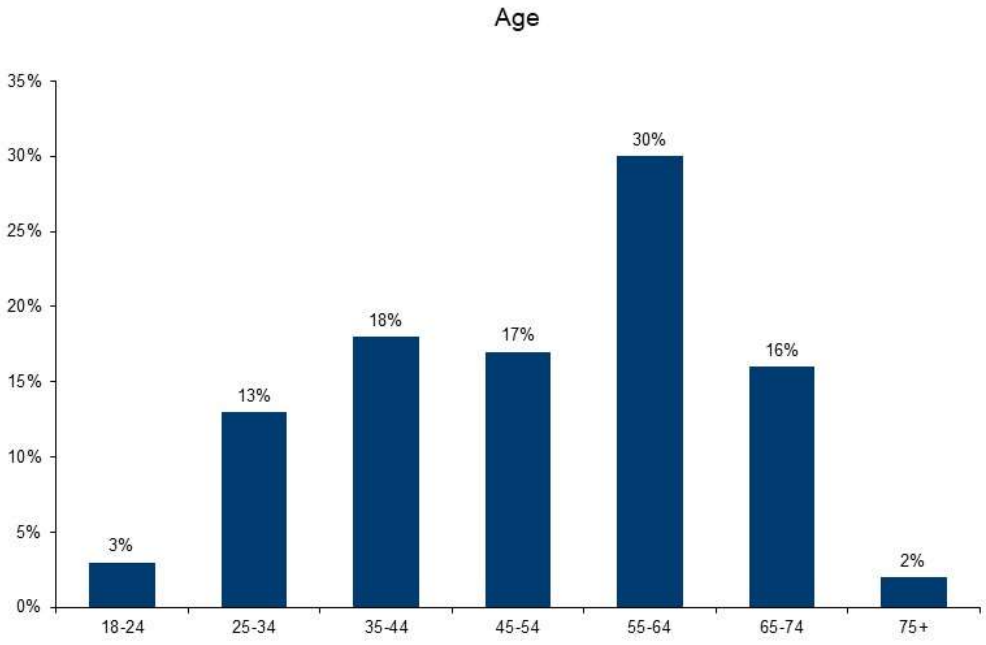
Base: Written materials (n=25), Videos for home use (n=4), Social media (n=13), Text messages (n=13), One-on-one teaching (n=20), E-mail (n=29), Group education workshop/seminar (n=10), Online websites (n=30), Other (specify) (n=3), Sample Size = 82

(Community = Gregory / Tripp / Charles Mix)



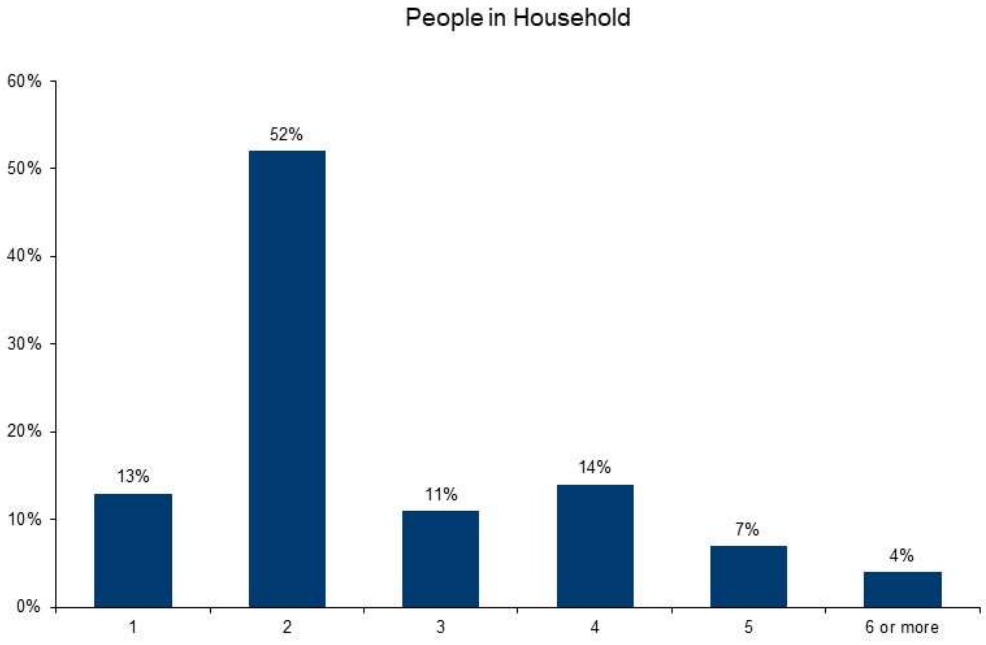
Base: Male (n=22), Female (n=64), Sample Size = 86

(Community = Gregory / Tripp / Charles Mix)



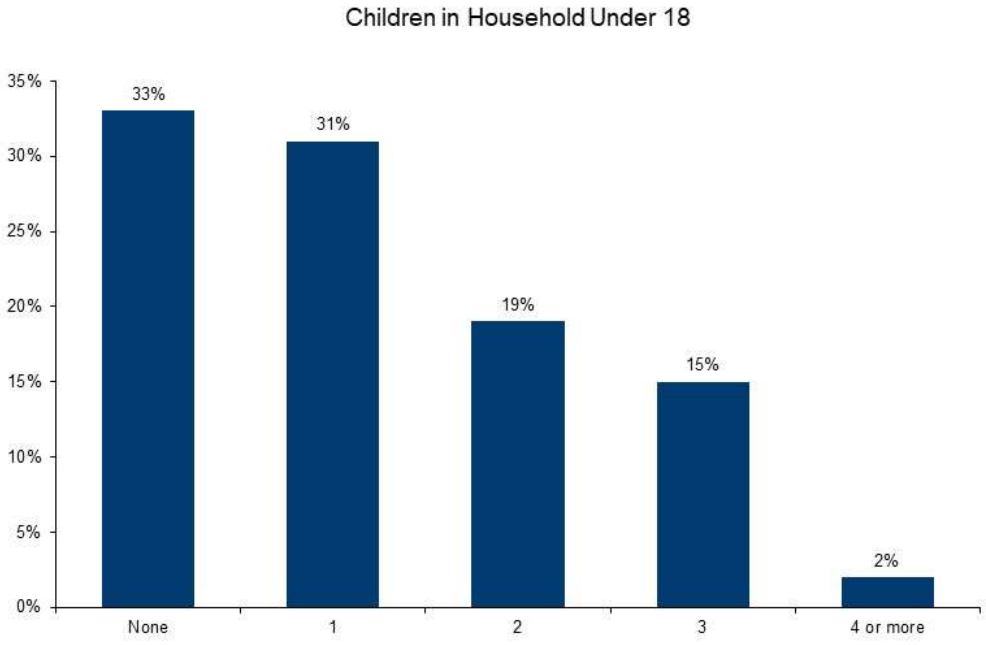
Base: 18-24 (n=3), 25-34 (n=11), 35-44 (n=16), 45-54 (n=15), 55-64 (n=26), 65-74 (n=14), 75+ (n=2), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)



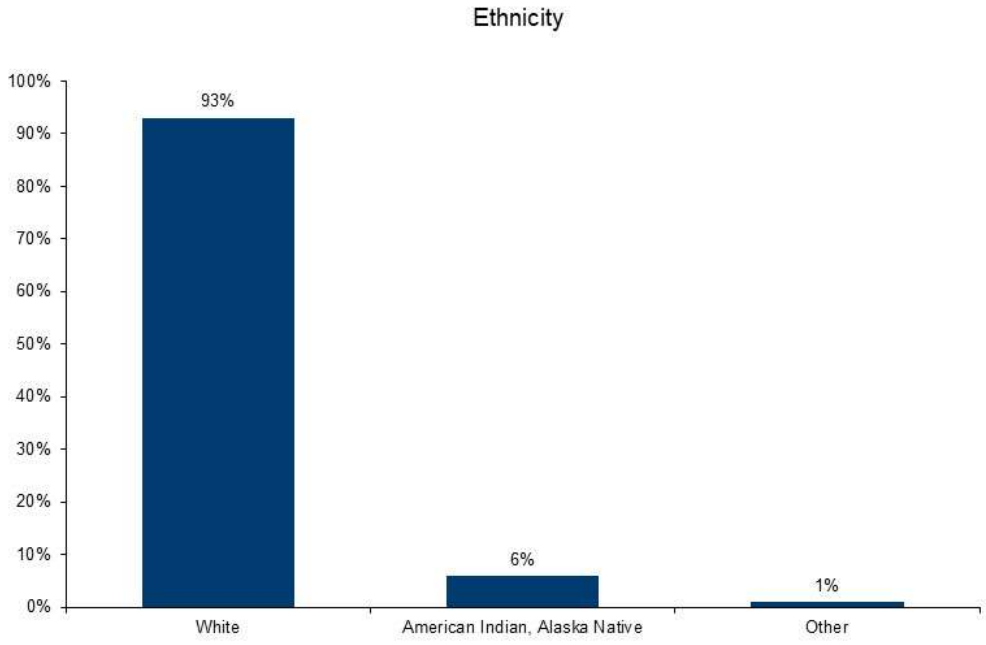
Base: 1 (n=11), 2 (n=44), 3 (n=9), 4 (n=12), 5 (n=6), 6 or more (n=3), Sample Size = 85

(Community = Gregory / Tripp / Charles Mix)



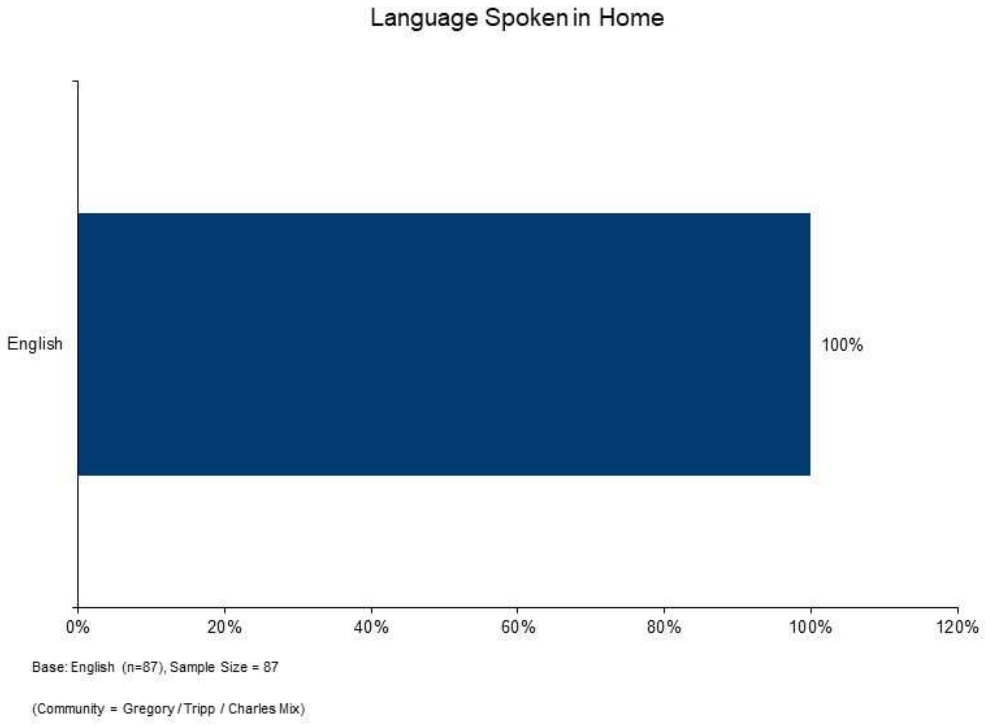
Base: None (n=16), 1 (n=15), 2 (n=9), 3 (n=7), 4 or more (n=1), Sample Size = 48

(Community = Gregory / Tripp / Charles Mix)



Base: White (n=81), American Indian, Alaska Native (n=5), Other (n=1), Sample Size = 87

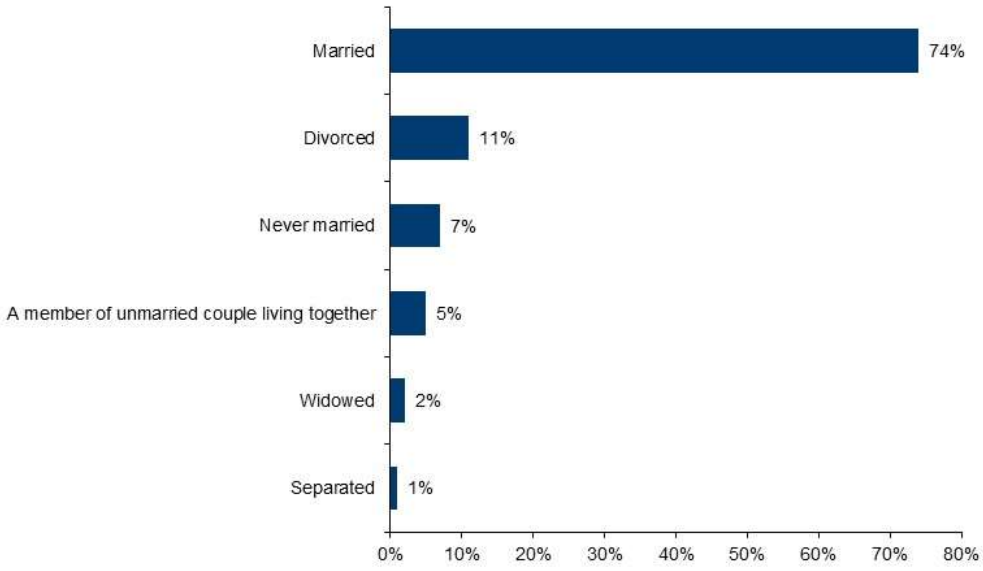
(Community = Gregory / Tripp / Charles Mix)



Base: English (n=87), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

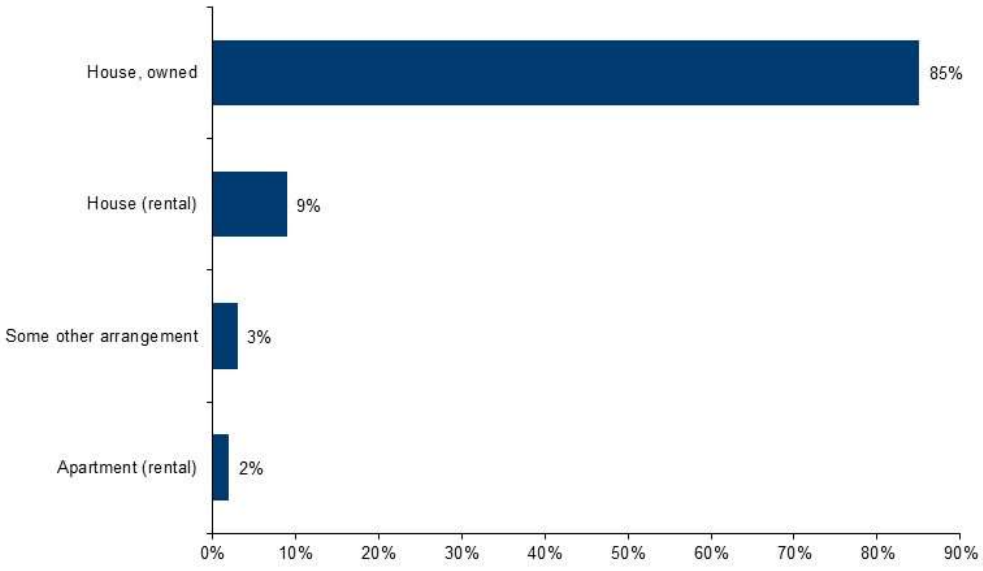
Marital Status



Base: Never married (n=6), Married (n=64), Divorced (n=10), Widowed (n=2), Separated (n=1), A member of unmarried couple living together (n=4), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

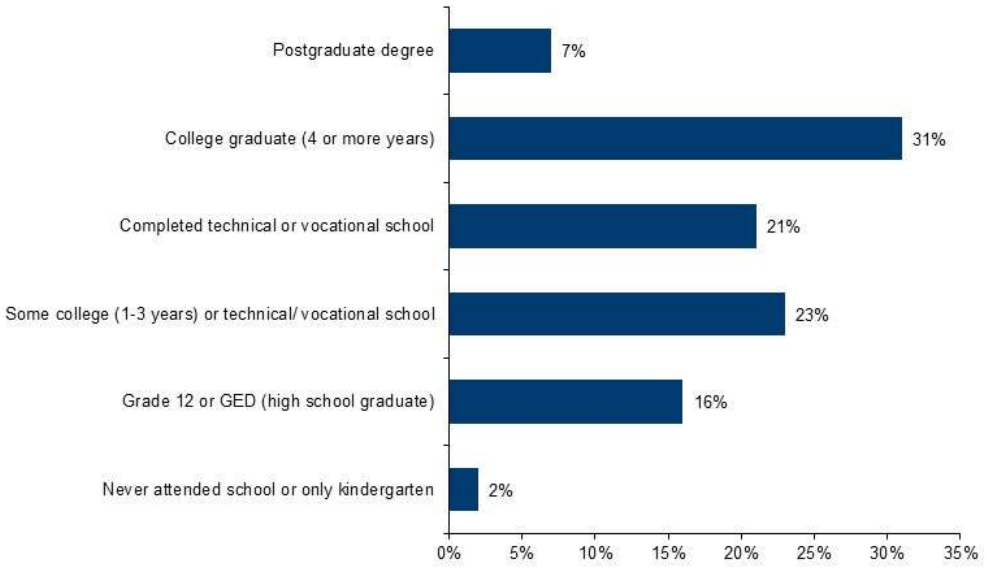
Current Living Situation



Base: House, owned (n=74), House (rental) (n=8), Apartment (rental) (n=2), Some other arrangement (n=3), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)

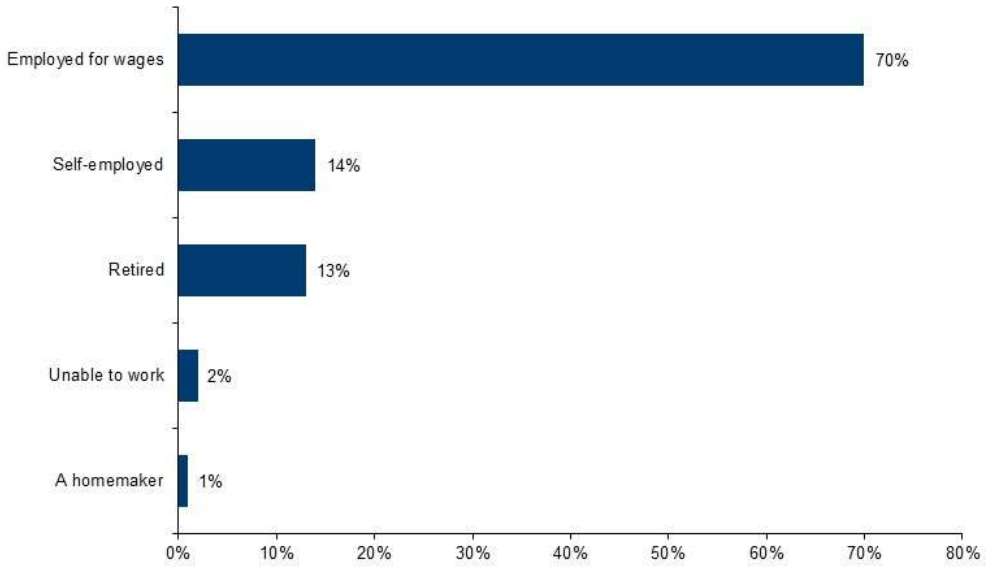
Education Level



Base: Never attended school or only kindergarten (n=2), Grade 12 or GED (high school graduate) (n=14), Some college (1-3 years) or technical/ vocational school (n=20), Completed technical or vocational school (n=18), College graduate (4 or more years) (n=27), Postgraduate degree (n=6), Sample Size = 87

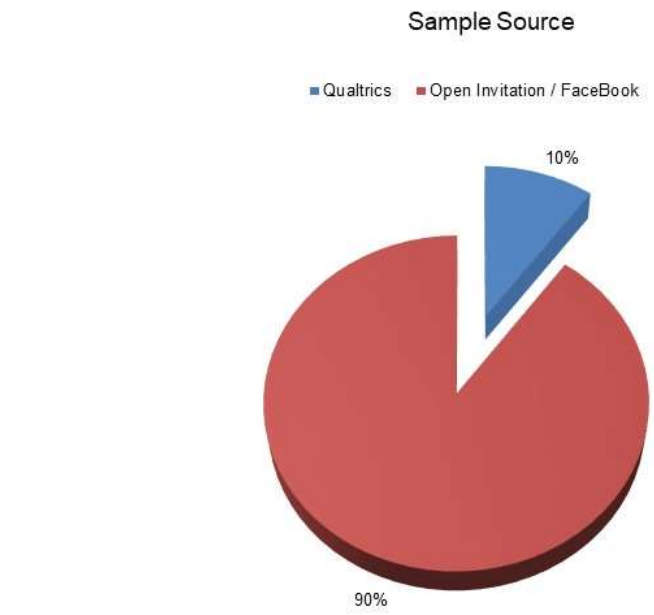
(Community = Gregory / Tripp / Charles Mix)

Employment Status



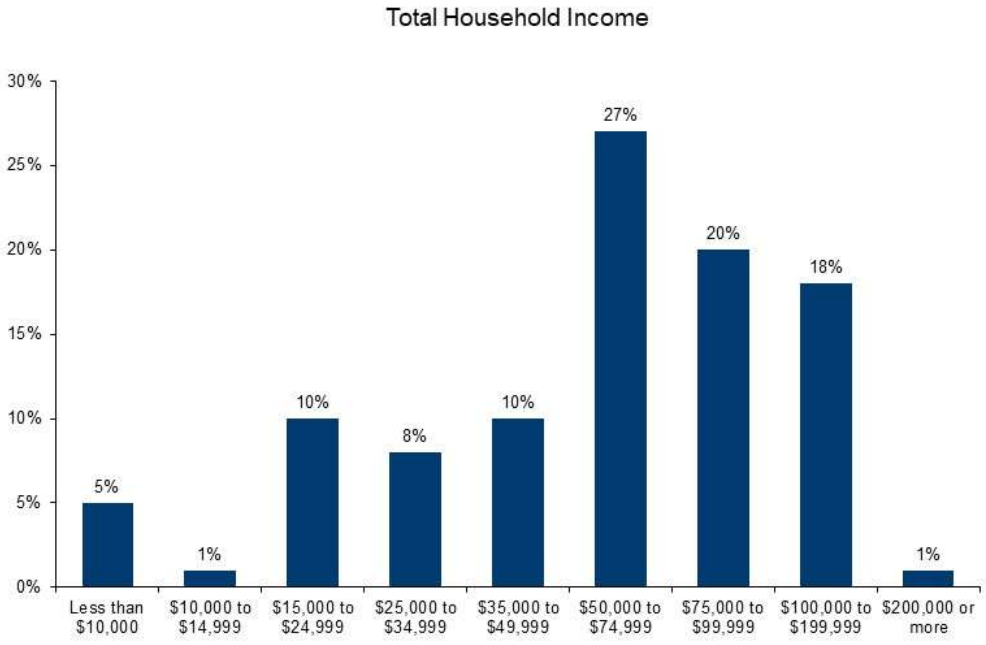
Base: Employed for wages (n=61), Self-employed (n=12), A homemaker (n=1), Retired (n=11), Unable to work (n=2), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)



Base: Qualtrics (n=9), Open Invitation / FaceBook (n=78), Sample Size = 87

(Community = Gregory / Tripp / Charles Mix)



Base: Less than $10,000 (n=4), $10,000 to $14,999 (n=1), $15,000 to $24,999 (n=8), $25,000 to $34,999 (n=6), $35,000 to $49,999 (n=8), $50,000 to $74,999 (n=21), $75,000 to $99,999 (n=16), $100,000 to $199,999 (n=14), $200,000 or more (n=1), Sample Size = 79

(Community = Gregory / Tripp / Charles Mix)

Secondary Research

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in calculating the 2019 County Health Rankings. In addition, the file contains additional measures that are reported on the County Health Rankings web site for your state.

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

Contents:

- Outcomes & Factors Rankings
- Outcomes & Factors Sub Rankings
- Ranked Measures Data (including measure values, confidence intervals* and z-scores**)
- Additional Measures Data (including measure values and confidence intervals*)
- Ranked Measure Sources and Years
- Additional Measure Sources and Years

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

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

Measure	Data Elements	Description
	YPLL Rate (White)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Whites
Poor or fair health	**% Fair/Poor**	Percentage of adults that report fair or poor health
	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

Measure	Data Elements	Description
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Access to exercise opportunities	**% With Access**	Percentage of the population with access to places for physical activity
	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)

Measure	Data Elements	Description
Dentists	# Dentists	Number of dentists
	Dentist Rate	Dentists per 100,000 population
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	Mental Health Providers per 100,000 population
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	**Preventable Hosp. Rate**	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Preventable Hosp. Rate (Black)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Blacks
	Preventable Hosp. Rate (Hispanic)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Hispanics
	Preventable Hosp. Rate (White)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Whites
Mammography screening	**% Screened**	Percentage of female Medicare enrollees having an annual mammogram (age 65-74)
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Screened (Black)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Blacks
	% Screened (Hispanic)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Hispanics
	% Screened (White)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Whites
Flu vaccinations	**% Vaccinated**	Percentage of annual Medicare enrollees having an annual flu vaccination
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Vaccinated (Black)	Percentage of annual Medicare enrollees having an annual flu vaccination for Blacks
	% Vaccinated (Hispanic)	Percentage of annual Medicare enrollees having an annual flu vaccination for Hispanics
	% Vaccinated (White)	Percentage of annual Medicare enrollees having an annual flu vaccination for Whites
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education

Measure	Data Elements	Description
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in poverty	**% Children in Poverty**	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Children in Poverty (Black)	Percentage of Black children (under age 18) living in poverty - from the 2013-2017 ACS
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty - from the 2013-2017 ACS
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2013-2017 ACS
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations per 10,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	Annual Average Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000

Measure	Data Elements	Description
	95% CI - Low	95% confidence interval as reported by CDC Wonder
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**Presence of violation**	County affected by a water violation: 1-Yes, 0-No
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	**% Severe Housing Problems**	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Severe Housing Cost Burden	Percentage of households with high housing costs
	Overcrowding	Percentage of households with overcrowding
	Inadequate Facilities	Percentage of households with lack of kitchen or plumbing facilities
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	**% Drive Alone**	Percentage of workers who drive alone to work
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Drive Alone (Black)	Percentage of Black workers who drive alone to work
	% Drive Alone (Hispanic)	Percentage of Hispanic workers who drive alone to work
	% Drive Alone (White)	Percentage of non-Hispanic White workers who drive alone to work
Long commute - driving alone	# Workers who Drive Alone	Number of workers who commute in their car, truck or van alone
	% Long Commute - Drives Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Gregory County

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

	Gregory County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
HEALTH OUTCOMES					**23**
Length of Life					33
Premature Death			5,400	7,300	
Quality of Life					6
Poor or fair health	14%	13-14%	12%	12%	
Poor physical health days	3.4	3.2-3.5	3.0	3.1	
Poor mental health days	3.1	2.9-3.2	3.1	2.9	
Low birth weight	4%		6%	6%	
HEALTH FACTORS					**48**
Health Behaviors					25
Adult smoking	17%	16-17%	14%	18%	
Adult obesity	30%	24-37%	26%	31%	
Food environment index	7.4		8.7	6.6	
Physical inactivity	27%	20-35%	19%	20%	
Access to exercise opportunities	53%		91%	72%	
Excessive drinking	16%	15-17%	13%	20%	
Alcohol-impaired driving deaths	14%	1-39%	13%	36%	
Sexually transmitted infections	214.2		152.8	504.5	
Teen births	33	22-48	14	28	
Clinical Care					54
Uninsured	15%	13-17%	6%	10%	
Primary care physicians	1,390:1		1,050:1	1,320:1	
Dentists	2,110:1		1,260:1	1,690:1	
Mental health providers			310:1	590:1	
Preventable hospital stays	10,397		2,765	4,724	
Mammography screening	48%		49%	49%	
Flu vaccinations	34%		52%	45%	
Social & Economic Factors					44
High school graduation	77%		96%	84%	
Some college	68%	59-78%	73%	68%	
Unemployment	3.6%		2.9%	3.3%	
Children in poverty	21%	14-28%	11%	16%	
Income inequality	4.7	3.8-5.6	3.7	4.2	
Children in single-parent households	37%	27-47%	20%	31%	
Social associations	31.2		21.9	16.4	
Violent crime			63	373	
Injury deaths	119	77-175	57	80	
Physical Environment					20
Air pollution – particulate matter	6.0		6.1	5.6	
Drinking water violations	No				

	Gregory County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Severe housing problems	10%	8-13%	9%	12%	
Driving alone to work	76%	72-80%	72%	80%	
Long commute – driving alone	14%	10-18%	15%	15%	

Tripp County

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

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

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Severe housing problems	11%	7-15%	9%	12%	
Driving alone to work	77%	73-81%	72%	80%	
Long commute – driving alone	10%	6-13%	15%	15%	

Charles Mix County

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

	Charles Mix County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
HEALTH OUTCOMES					**52**
Length of Life					53
Premature Death	14,900	11,900-18,000	5,400	7,300	
Quality of Life					44
Poor or fair health	17%	16-17%	12%	12%	
Poor physical health days	3.9	3.7-4.0	3.0	3.1	
Poor mental health days	3.5	3.4-3.7	3.1	2.9	
Low birth weight	6%	4-7%	6%	6%	
HEALTH FACTORS					**53**
Health Behaviors					51
Adult smoking	21%	20-22%	14%	18%	
Adult obesity	33%	27-41%	26%	31%	
Food environment index	8.0		8.7	6.6	
Physical inactivity	21%	15-27%	19%	20%	
Access to exercise opportunities	55%		91%	72%	
Excessive drinking	17%	16-18%	13%	20%	
Alcohol-impaired driving deaths	82%	75-87%	13%	36%	
Sexually transmitted infections	884.6		152.8	504.5	
Teen births	50	41-59	14	28	
Clinical Care					52
Uninsured	17%	15-19%	6%	10%	
Primary care physicians	1,570:1		1,050:1	1,320:1	
Dentists	2,360:1		1,260:1	1,690:1	
Mental health providers	1,890:1		310:1	590:1	
Preventable hospital stays	7,018		2,765	4,724	
Mammography screening	42%		49%	49%	
Flu vaccinations	33%		52%	45%	
Social & Economic Factors					53
High school graduation	81%		96%	84%	
Some college	55%	48-61%	73%	68%	
Unemployment	3.7%		2.9%	3.3%	
Children in poverty	35%	26-45%	11%	16%	
Income inequality	5.3	4.8-5.9	3.7	4.2	
Children in single-parent households	43%	37-50%	20%	31%	
Social associations	20.2		21.9	16.4	
Violent crime	161		63	373	
Injury deaths	143	111-182	57	80	
Physical Environment					55
Air pollution – particulate matter	6.8		6.1	5.6	
Drinking water violations	Yes				

	Charles Mix County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Severe housing problems	12%	10-15%	9%	12%	
Driving alone to work	78%	75-81%	72%	80%	
Long commute – driving alone	8%	6-10%	15%	15%	

Gregory County

Focus on SD Report – 2019

Charles Mix County

Focus on SD Report – 2019

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