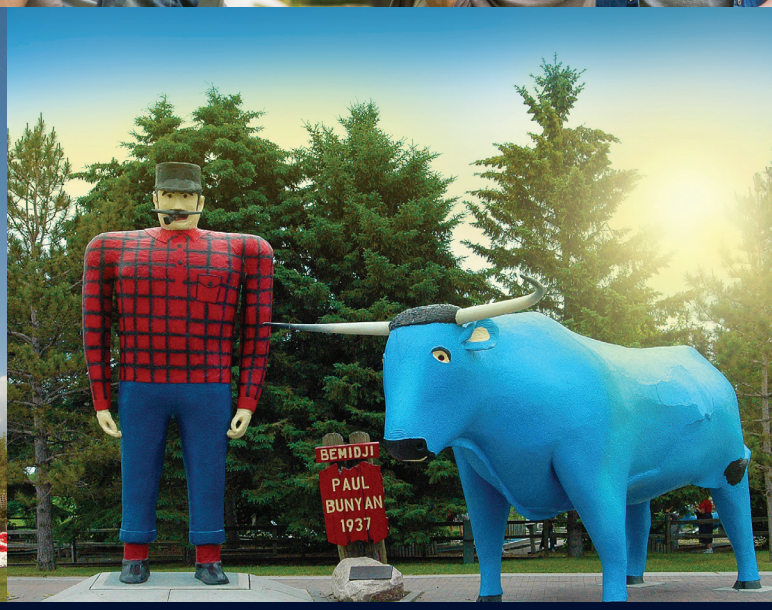


Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

cba Sanford Sheldon Medical Center EIN # 46-0388596

SANFORD HEALTH

Sanford Sheldon Medical Center

Community Health Needs Assessment

2016

Dear Community Members,

Sanford Sheldon Medical Center is pleased to present the 2016 Community Health Needs Assessment.

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

During 2015 members of the community were asked to complete a survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. Sanford 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 was also conducted to identify the most significant health needs and to further address these needs through the implementation strategies that are included in this document.

Sanford Sheldon has set strategy to address the following community health needs:

- Mental Health
- Children and Youth

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 actions that will be taken to address each identified need.

At Sanford Sheldon, 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 our communities is at the core of who we are. Through our work, we can bring health and healing to the people who live and work in our communities. Together, we can fulfill this mission.

Sincerely,

Rick Nordahl
Chief Executive Officer
Sanford Sheldon Medical Center

Sanford Sheldon Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

Sanford Sheldon Medical Center

Community Health Needs Assessment
2016

Purpose

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

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

Study Design and Methodology

1. Non-Generalizable Survey

   A non-generalizable survey was conducted as an on-line survey. 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 the month of April 2015 and a total of 72 respondents participated in the on-line survey.

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

   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 in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by Sanford and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

   Community stakeholders were invited to a meeting to review the findings from assessment research and to discuss the top health issues facing the community. Community stakeholders discussed the

findings and helped to determine key priorities for the community. Those priorities will be addressed in the implementation strategies for 2017-2019.

3. Community Asset Mapping

   Asset mapping was conducted by reviewing the data 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. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes the 2015 County Health Rankings for O'Brien and Sioux counties.

Key Findings – Primary Research

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

Aging: The top ranking concern among respondents overall is the cost of long term care (3.73). According to the U.S. Census Bureau 2010 data 16% of the population in O'Brien County and 10.9% of the population in Sioux County are 70 years or older.

Children and Youth: Bullying (3.80) is the top concern for children and youth. The cost and availability of quality child care (3.71), the availability of quality childcare and the cost of quality infant care (3.64) are also high concerns. Additionally, the cost (3.54) and availability of services for youth at risk (3.60) are high concerns for respondents of the survey.

Safety: The presence of street drugs and alcohol in the community (3.75), the presence of drug dealers in the community, child abuse and neglect (3.69), and domestic violence (3.58) are the highest safety concerns of the respondents.

Health Care: The health care indicator addressed access to health care and the cost concerns. The use of emergency room services for primary health care (3.77), access to affordable health insurance (3.70), timely access to physician specialists (3.61), the availability of non-traditional hours (3.56), timely access to doctors, PAs or NPs (3.54), and timely access to mental health services (3.54) are the highest concerns among the respondents in the health care access category.
Physical Health: Cancer (4.00), chronic disease (3.85), obesity (3.72), poor nutrition (3.72) and inactivity and lack of exercise (3.69) are the highest physical health concerns.

Mental Health/Behavioral Health: Underage drug use and abuse, (3.74), underage drinking (3.71), stress (3.69), smoking and tobacco use (3.68), depression (3.64), alcohol use and abuse (3.60), drug use and abuse (3.58), and dementia and Alzheimer's (3.57) are the highest concerns for mental health/behavioral health.

Key Findings – Secondary Research based on the 2015 County Health Rankings

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcome for the state of Iowa is 5,911 per 100,000. O'Brien County has a higher rate at 6,593 per 100,000 and Sioux County is at 4,134.

Poor or fair health: 7% of adults in O'Brien County and 10% of adults in Sioux County report poor or fair health compared to 10% nationally and 11% in Iowa.

The average number of days reported in the last 30 as unhealthy mental health days is 1.7 in O'Brien County and 1.7% in Sioux County. Iowa as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 6.4% in O'Brien County and 5% in Sioux County. The state of Iowa is at 6.8%.

Health Factors

The percent of adults who are currently smoking is not available in O'Brien County and is at 12% in Sioux County. 18% of adults are current smokers in Iowa.

29% of the adult population in O'Brien County and 27% in Sioux County are considered obese with a BMI over 30. 30% of the population in Iowa is obese.

The percent of adults reporting excessive or binge drinking is 19% in O'Brien County and 14% in Sioux County. Iowa reports 20% are binge drinkers statewide.

Driving deaths that have alcohol involvement is at 29% in O'Brien County and 21% in Sioux County. Alcohol involvement in driving deaths is at 23% in Iowa.

Sexually transmitted infections rank substantially higher than the national benchmark (138) for Iowa (370), are lower in O'Brien County at 127, and in Sioux County at 134%.

The teen birth rate is higher in Iowa (33) than the national benchmark (20). The teen birth rate is 33 in O'Brien County and is 17 in Sioux County.

The clinical care outcomes indicate that the percentage of uninsured adults is 10% in Iowa, 11% in O'Brien County, and 12% in Sioux County.

The ratio of population to primary care physicians is 1,375:1 in Iowa. O'Brien County's ratio is 2,025:1 and Sioux County is 1,371:1.

The ratio of population to mental health providers is 904:1 in Iowa. O'Brien County's ratio is 2,809:1, and Sioux County is 1,570:1.

The number of professionally active dentists in Iowa is 1,670:1; in O'Brien County, 1,560:1; and in Sioux County, 2,468:1.

Preventable hospital stays are 47 in O'Brien County, 49 in Sioux County, 56 in Iowa, and 41 nationally.

Diabetic screening is at 90% in O'Brien County, 92% in Sioux County, and 89% in Iowa as a whole.

Mammography screening is at 65.6% in O'Brien County, 70.8% in Sioux County, and 66.4% in Iowa.

The social and economic factor outcomes indicate that Iowa is at 89% for high school graduation. O'Brien County has a graduation rate of 91%, and Sioux County has a rate of 91%.

Post-secondary education (some post-secondary education) is at 69% in O'Brien County, 61.6% in Sioux County, and 69.1% in Iowa.

The unemployment rate is 3.7% in O'Brien County, 3.3% in Sioux County, and 4.6% in Iowa.

The percentage of child poverty is 12% in O'Brien County and 10% in Sioux County. The child poverty rate is 16% in Iowa.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is higher in O'Brien County at 30.3% and 26.6% in Sioux County. The state of Iowa ranks at 15.6%

The percentage of children in single parent households is 19% in O'Brien County, 14% In Sioux County, and 29% in Iowa.

Violent crime is higher in O'Brien County at 81 per 100,000 population; Sioux County is at 111. Iowa has 263 cases per 100,000 population compared to the national rate of 59.

The following needs were brought forward for prioritization:

- Children and Youth – bullying, cost and availability of quality child care and infant care, services for at-risk youth
- Aging – cost of long term care
- Safety – the presence of street drugs and alcohol in the community, child abuse and neglect, domestic violence
- Health Care Access – use of the emergency department for primary care, access to affordable health insurance, timely access to physician specialists, availability of non-traditional hours, timely access to doctors, PAs and NPS, and timely access to mental health providers
- Physical Health – cancer, chronic disease, obesity, poor nutrition and inactivity
- Mental Health – underage drug use and abuse, underage drinking, stress, smoking and tobacco, depression, alcohol use and abuse, drug use and abuse, Dementia and Alzheimer's
- Preventive Health – flu vaccines

Members of the collaborative determined that children and youth are a top unmet need. Community stakeholders also rated mental illness a top priority.

- Mental Health
- Children and Youth

Sanford has determined the 2017-2019 implementation strategies for the following needs:

- Priority 1: Mental Health
- Priority 2: Children and Youth

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

Mental health includes emotional, psychological, and social well-being. It affects how people think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health problems are common but people with mental health problems can get better and many recover completely.

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to reduce mortality and morbidity from chemical addiction and mental health diseases by recruiting a triage therapist, and working to reduce drug and alcohol abuse in the community by working with the high school counselor to enhance curriculum to include abuse issues.

Priority 2: Children and Youth

An at-risk youth is a child who is less likely to transition successfully into adulthood. Success can include academic success and job readiness, as well as the ability to be financially independent.

Sanford has developed strategies to support the youth in the area by enhancing the community environment. Sanford will work with community development and provide assistance for reopening of a local resource for youth and provide after school programming in a structured environment for our youth. Sanford will support the expansion of day care with capital and will also work with the local day care center to provide quarterly education sessions for students and parents.

Community Health Needs Assessment
Implementation Strategy for Sanford Sheldon Medical Center
FY 2017-2019 Action Plan

Priority 1: Mental Health/Behavioral Health

Projected Impact: Better access to more providers

Goal 1: Hire a triage therapist

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Recruit a triage therapist to improve access to mental health/behavioral health	1 FTE triage therapist is hired	2017 budget addition - 40 hours per week	Nordahl	Seasons Center can assist with capacity

Goal 2: Drug and alcohol awareness in school

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Partner with high school leadership to include substance abuse prevention into the curriculum	Approval of enhanced education curriculum is realized	School educators; Sanford leadership	Dykstra	High school counselor

Priority 2: Children and Youth

Projected Impact: Enhanced community environment for children and youth

Goal 1: Provide a more structured environment for youth

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Provide after school programming for a structured environment for our youth; reopen the local roller rink so that youth have a place to go after school and on weekends	A buyer is found and the local roller rink reopens for youth	Community development assistance	Nordahl Strouth	SCDC partnership

Goal 2: Expansion of community day care infant capacity

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Support expansion of day care with capital and continued education classes for students/parents	Quarterly education programs are conducted	Staff	Dreesen	Children's World day care

SANFORD HEALTH

Sanford Sheldon Medical Center

Community Health Needs Assessment 2016

Table of Contents

Purpose

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

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

Our Guiding Principles:

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

Acknowledgements

Sanford Health 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.

Sanford Enterprise Steering Group:

- JoAnn Kunkel, CFO, Sanford Enterprise
- Michelle Bruhn, CFO, Health Services Division
- Tiffany Lawrence, CPA, Fargo Region Co-Lead, CFO, Sanford Medical Center Fargo
- Bruce Viessman, Sioux Falls Region Co-Lead, CFO, Sanford Health Network
- Martha Leclerc, MS, Vice President, Revenue Management
- Randy Bury, CAO, Health Services Division
- Steve Goetsch, CFO, Sioux Falls Region
- Jane Heilmann, Senior Corporate Communications Strategist
- Joy Johnson, COO Bemidji Region
- Kirk Christy, CFO, Bismarck Region

- Carrie McLeod, MBA, MS, LRD,CDE, Enterprise Lead, Enterprise Community Health/Community Benefit

Sanford Sheldon Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health /Community Benefit
- Shawn Dreesen, Patient Access Manager

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

- Alicia Collura, Sioux Falls Public Health
- Anita Cardinal, Pennington County Public Health
- Ann Malmberg, Essentia Health
- Becky Secore, Beltrami County Public Health Unit
- Brenda Stallman, Traill County Public Health
- Brie Taralson, Essentia Health
- Brittany Ness, Steele County Public Health
- Caitlin Hurley, Avera Health
- Carrie McLeod, Sanford Health
- Dan Heinemann, MD, CMO, Sanford Health Network, Sioux Falls Region
- Gina Nolte, Partnership4Health, Clay County
- Jac McTaggart, Sanford Health
- Jessica Spaeth, City of Halstad
- Joy Johnson, Sanford Health
- Julie Jeske, CHI-St. Alexius Health
- Julie Miller, South Dakota Department of Health
- Julie Ward, Avera Health
- Kathy McKay, Clay County Public Health
- Katie Olson, South Dakota State University
- Kay Schwarzwalter, Center for Social Research, North Dakota State University
- Kim Jacobson, Traill County Public Health
- Kip Littau, South Dakota State University
- Marnie Walth, Sanford Health
- Mary Michaels, Sioux Falls Public Health
- Nancy Fahrenwald, South Dakota State University
- Renae Moch, Burleigh County Public Health
- Roger Baier, Sanford Health
- Ruth Bachmeier, Fargo Cass Public Health
- Sandra Melstad, Public Health Consultant, South Dakota Department of Health
- Stan Kogan, Sioux Falls Public Health
- Stephen Pickard, PhD., North Dakota Department of Health
- Susan Kahler, Burleigh County Public Health
- Teresa Miller, Avera Health

We extend special thanks to the community and county leaders, public health administration, physicians, nurses, representatives supporting disparities, social services, and non-profit organizations, for their participation in this work. Together we are reaching our vision “to improve the human condition through exceptional care, innovation and discovery”.

The following Sheldon key community stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Dr. Ronald Zoutendam, retired physician
- Myrna Wagner, community member
- Michelle DeKok, community member
- Mary Dunn, community member
- Karen Pottebaum, Sanford Sheldon Executive Assistant
- Joni DeKok, Sanford Sheldon Chief Nursing Officer
- Scott Wynia, Sheldon City Manager
- Curt Strouth, Sheldon Chamber of Commerce
- Shawn Dreesen, Sanford Sheldon Patient Access Manager
- Dianne Wolthuizen. Sanford Sheldon Human Resource Manager
- Steve DeVoe, Sanford Sheldon Clinic Director
- Rick Nordahl, Sanford Sheldon Chief Executive Officer

Description of Sanford Sheldon Medical Center

Sanford Sheldon Medical Center is a 25-bed critical access hospital providing inpatient, acute and long term care. In addition, Sanford Sheldon offers a broad range of outpatient services which includes Sanford Sheldon Clinic, Sanford Health Boyden Clinic, Sanford Health Sanborn Clinic, and Sanford Hartley Clinic operating as hospital departments.

Sanford Sheldon provides health care services to over 10,000 residents of O’Brien County and portions of Sioux, Osceola and Lyon counties in northwest Iowa. The nearest tertiary care centers are Mercy Medical in Sioux City, Iowa and Sanford USD Medical Center, which is approximately 70 miles west.

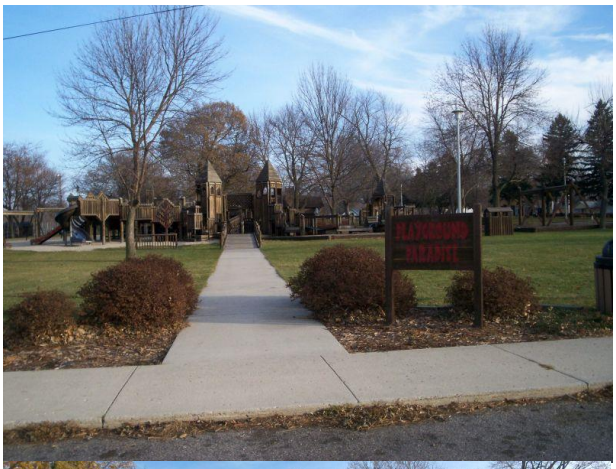
Sanford Sheldon employs 9 medical clinicians (physicians and APPs) and 317 employees. As a member of the Sanford Health Network, Sanford Sheldon offers consulting medical specialists who provide outreach services on a regular basis in areas including general and specialized surgery, cardiology, otolaryngology, urology, obstetrics/gynecology, orthopedics, vascular and podiatry.

Description of the Community Served

Sheldon has a population of 5,188, and is the largest city in O’Brien County, which has a total population of 14,398. Sheldon has always been the hub of transportation, located at the crossroads of Highway 60 and 18. It is predominantly a farming community with other larger employers in finance, manufacturing, health care and education. It is also home to Northwest Iowa Community College, and close to Dordt College and Northwestern College.

The city has many parks with softball fields, basketball courts, picnic shelter, campsites, biking and walking trails and a skate park for skate boarding and rollerblading. Other recreational facilities include the Sheldon Golf and Country Club and the Sheldon Outdoor Family Aquatic Center.

Sheldon is well known for its display of marigolds, which are abundant throughout the summer and fall months.



Study Design and Methodology

1. Non-Generalizable Survey

   A non-generalizable survey was conducted of residents in Sheldon, O'Brien County and Sioux County, Iowa. The survey instrument was developed in partnership with members of the Greater Fargo-Moorhead Community Health Needs Assessment collaborative, Sioux Falls community collaborative, Bismarck community collaborative, public health leaders from across the enterprise and researchers at the Center for Social Research (CSR) at North Dakota State University (NDSU). The CSR developed and maintained links to the on-line 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 the month of April 2015 and a total of 72 respondents participated in the on-line survey.

The purpose of the non-generalizable survey of residents in the greater Sheldon area was to learn about the perceptions of area community stakeholders regarding community health, their personal health, preventive health, and the prevalence of disease. This group included community leaders and agency leaders representing public health, city government, chamber, and representatives for populations with chronic disease and disparity.

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 in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by Sanford and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

   Community stakeholders were invited to a meeting to review the early findings from the generalizable survey and to discuss the top health issues or health related issues facing the community. The community stakeholders helped to determine key priorities for the community.

3. Community Asset Mapping

   Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. The process implemented in this work was based on the McKnight Foundation model - Mapping Community Capacity by John L. McKnight and John P. Kretzmann, Institute for Policy Research at Northwestern University.

   Each unmet need was researched to determine what resources were available in the community to address the needs. The community stakeholder 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. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes County Health Rankings for O'Brien and Sioux counties.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Sheldon, O'Brien and Sioux counties. However, when comparing certain demographic characteristics (i.e., age, income, minority status) with the current population estimates from the U.S. Census Bureau, it was evident that white, more highly educated, and higher income earners were overrepresented. Overrepresentation of this nature is typical in health needs assessments.

Literature reviews indicate that there are non-response rate issues among younger respondents. In particular, response rates to health care and community health needs assessment surveys have often

been found to be higher for older respondents. Studies have also shown lower response rates for socially disadvantaged groups (i.e., socially, culturally, or financially).

A good faith effort was made to secure input from a broad base of the community. The generalizable survey was mailed to a representative group of the area to assure input from all demographics. Additionally, invitations were extended to county and community leaders, organizations and agencies representing diverse populations and disparities.

Additional data was reviewed through secondary research. The data for the secondary research was secured from the County Health Rankings.

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

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

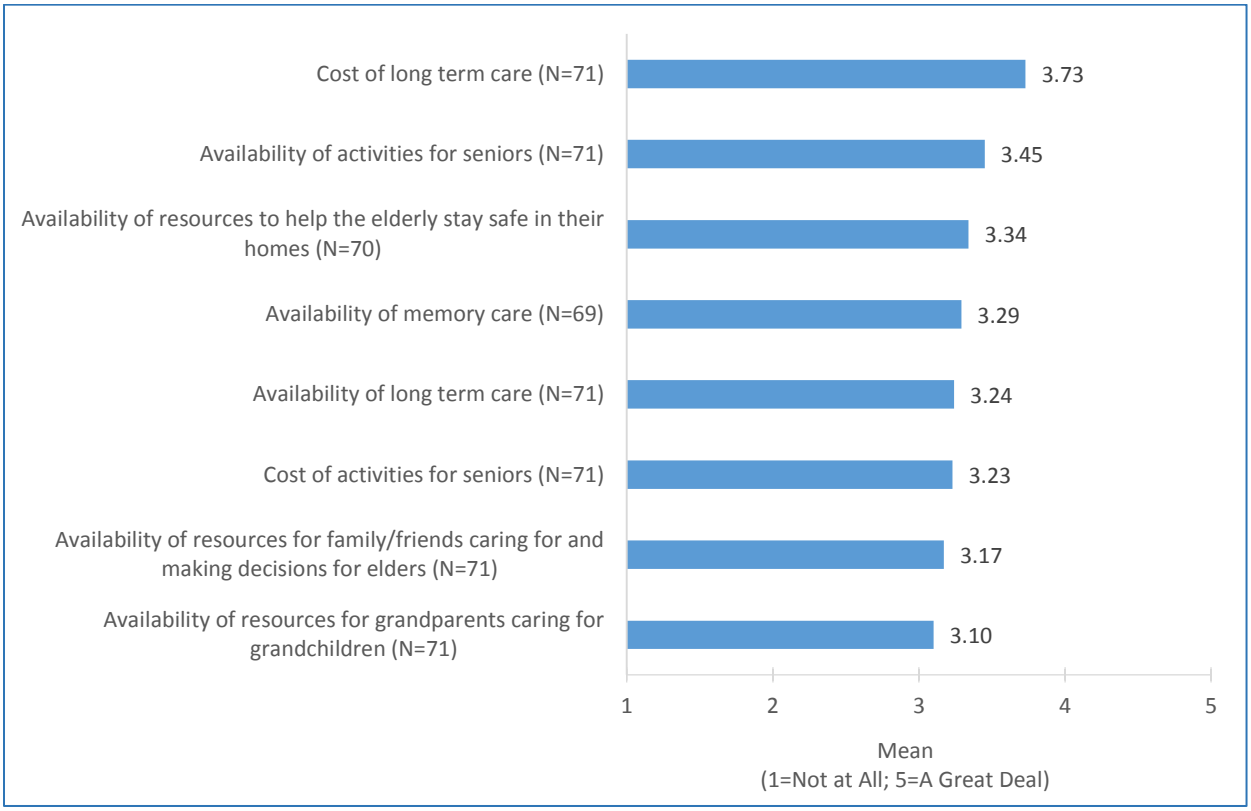
Primary Research

Community Health Concerns

The following concerns ranked highest of all the indicators on the non-generalizable (community stakeholders) surveys.

Aging Population: The cost and availability of long term care is the highest concern for the community stakeholders group.

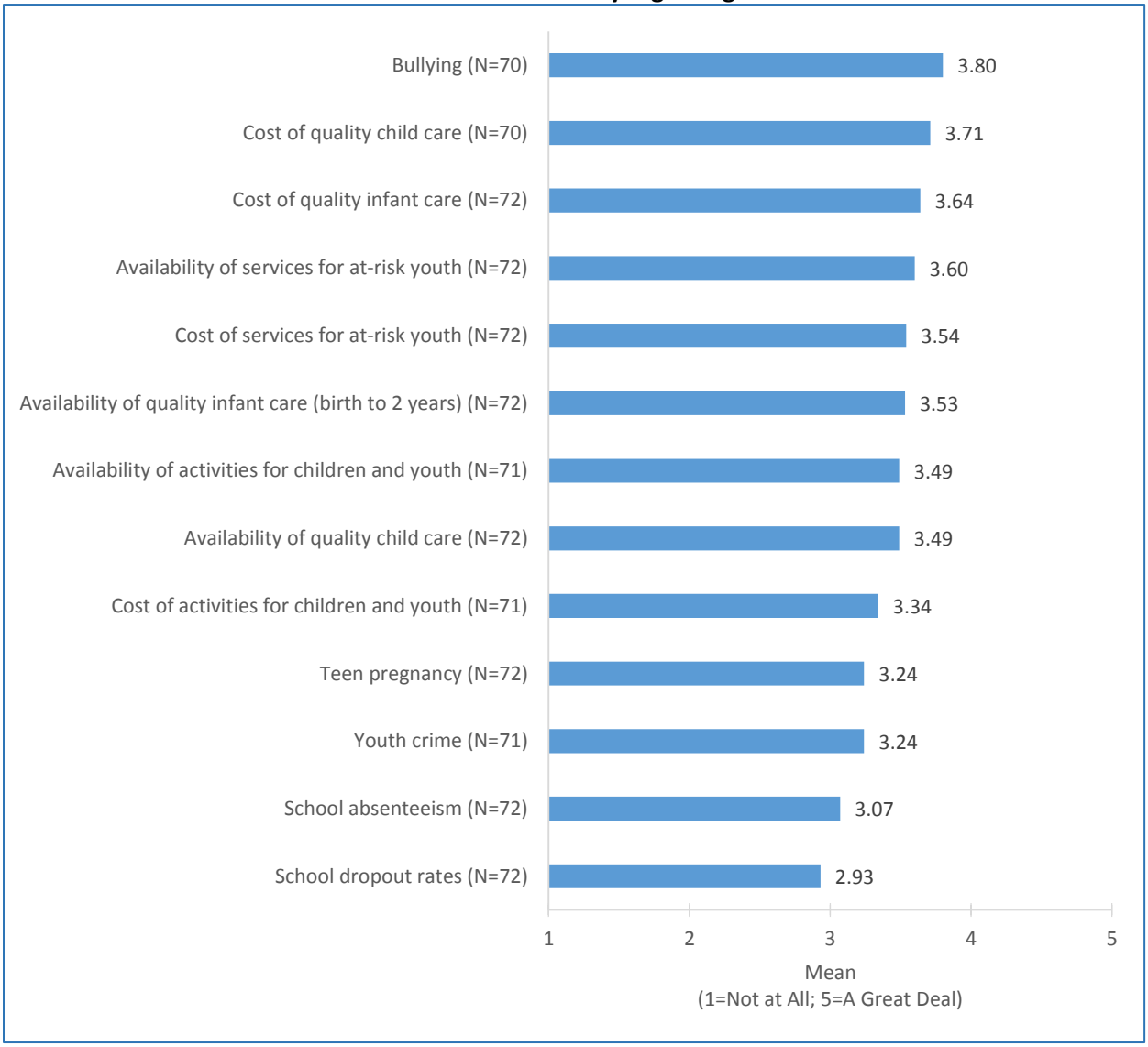
Level of concern with statements about the community regarding the AGING POPULATION



Sanford is working collaboratively with the area aging service providers to coordinate care for the aging population. Social workers, case managers, and discharge planners are working collaboratively with area service providers to assure safe discharge, and when appropriate, to assist in transitions from levels of care.

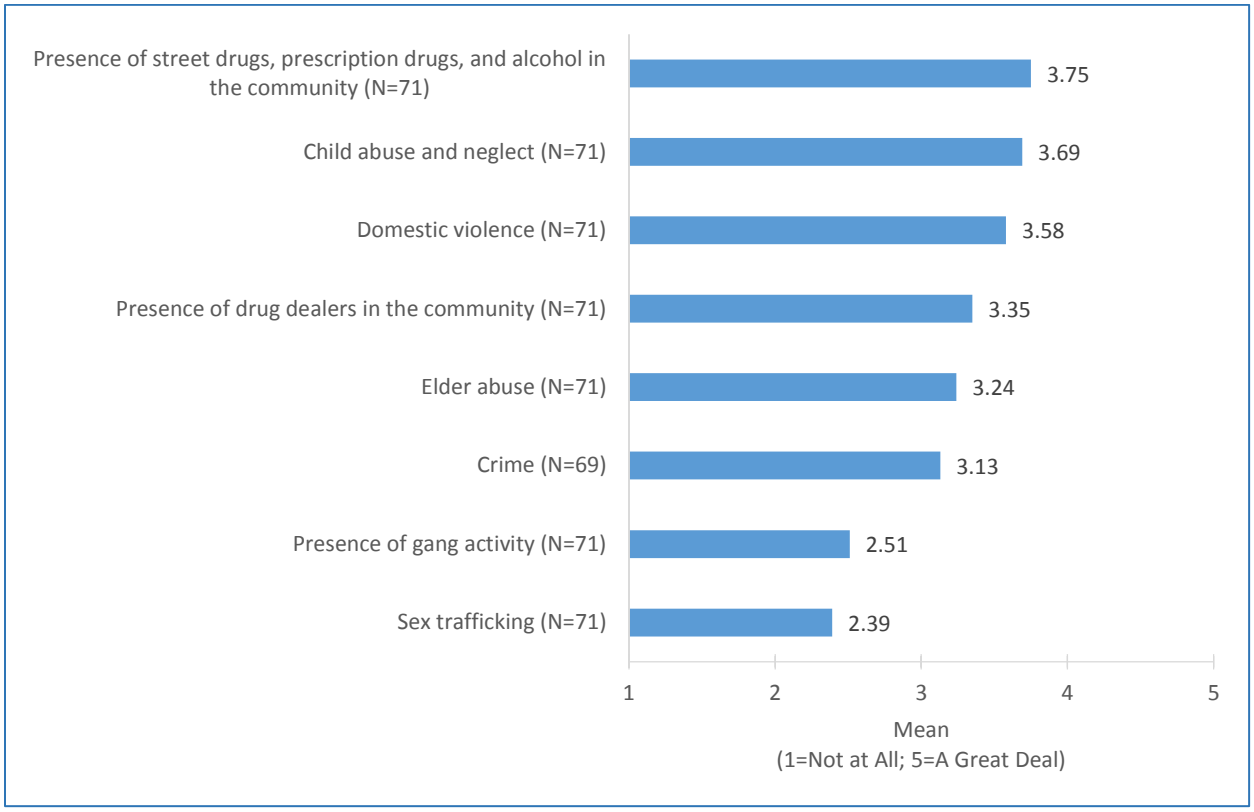
Children and Youth: The community stakeholder survey respondents have very high concerns for the children and youth of the community. Bullying, the cost of quality childcare and infant care, and the availability and cost of services for at-risk youth are the top concerns for the survey respondents.

Level of concern with statements about the community regarding CHILDREN AND YOUTH



Safety: The presence of street drugs, prescription drugs and alcohol, and drug dealers in the community are the top concerns. Child abuse and neglect and domestic violence are all concerns that rank high among the survey respondents.

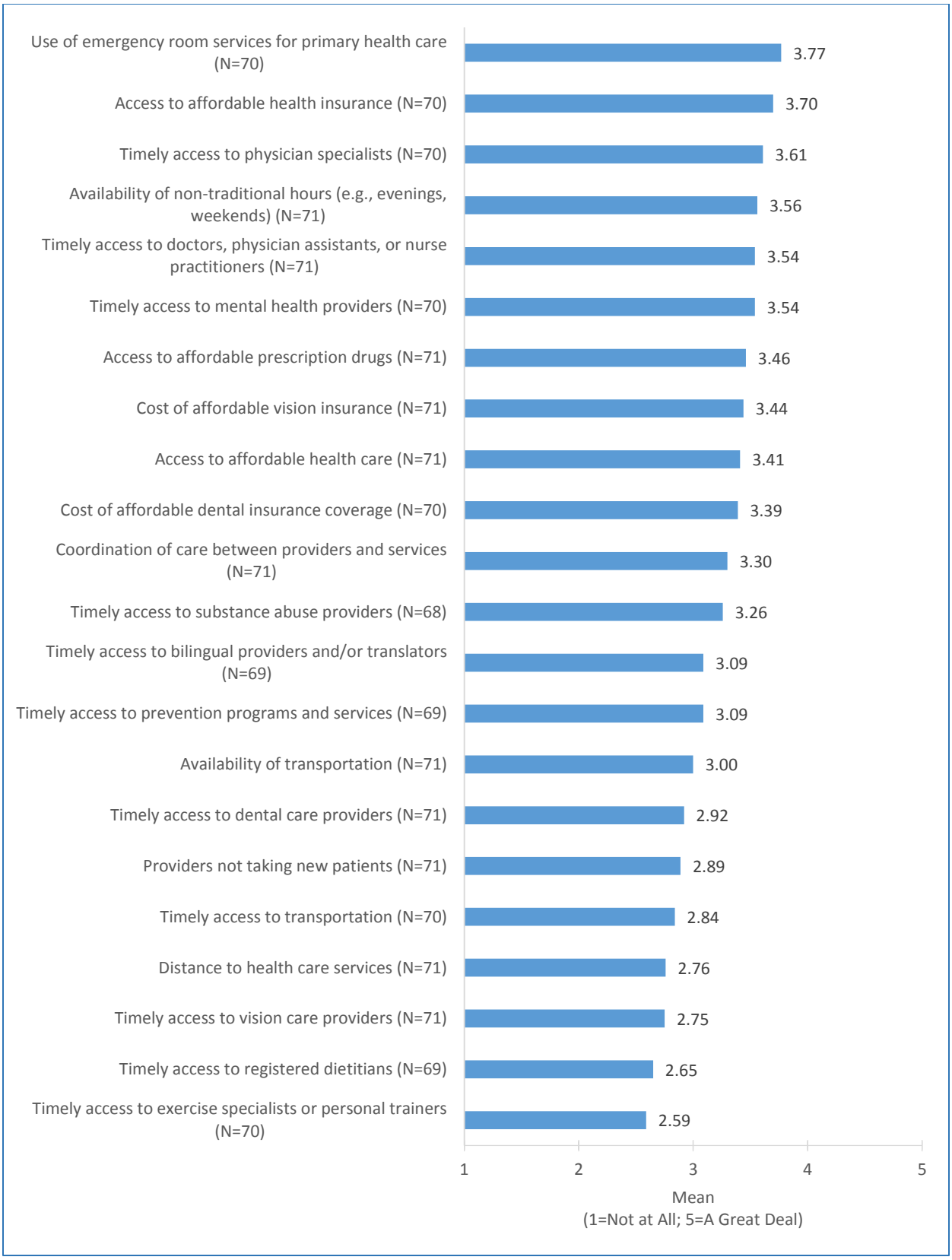
Level of concern with statements about the community regarding SAFETY



Sanford Sheldon will address substance abuse in the community through the 2017-2019 implementation strategies.

Health Care Access: Community stakeholders ranked the use of the emergency department for primary care as the top concern in the access category. Community stakeholders ranked access to affordable health insurance as their second top concern. Timely access to physician specialists, availability of non-traditional hours, timely access to doctors, physician assistants or nurse practitioners and mental health providers are all high concerns among survey respondents.

Level of concern with statements about the community regarding HEALTH CARE


Use of emergency room services for primary health care (N=70)
3.77
Access to affordable health insurance (N=70)
3.70
Timely access to physician specialists (N=70)
3.61
Availability of non-traditional hours (e.g., evenings, weekends) (N=71)
3.56
Timely access to doctors, physician assistants, or nurse practitioners (N=71)
3.54
Timely access to mental health providers (N=70)
3.54
Access to affordable prescription drugs (N=71)
3.46
Cost of affordable vision insurance (N=71)
3.44
Access to affordable health care (N=71)
3.41
Cost of affordable dental insurance coverage (N=70)
3.39
Coordination of care between providers and services (N=71)
3.30
Timely access to substance abuse providers (N=68)
3.26
Timely access to bilingual providers and/or translators (N=69)
3.09
Timely access to prevention programs and services (N=69)
3.09
Availability of transportation (N=71)
3.00
Timely access to dental care providers (N=71)
2.92
Providers not taking new patients (N=71)
2.89
Timely access to transportation (N=70)
2.84
Distance to health care services (N=71)
2.76
Timely access to vision care providers (N=71)
2.75
Timely access to registered dietitians (N=69)
2.65
Timely access to exercise specialists or personal trainers (N=70)
2.59
1
2
3
4
5
Mean
(1=Not at All; 5=A Great Deal)

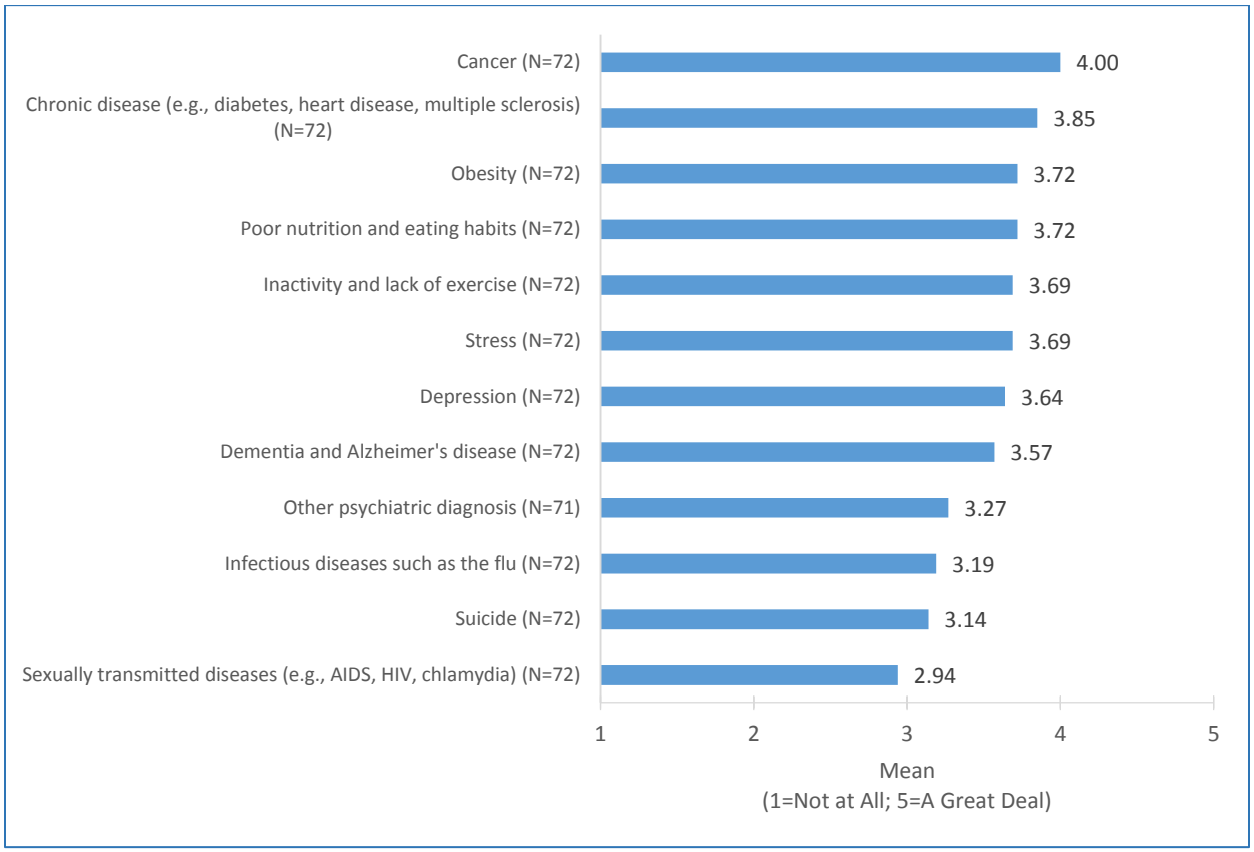
Sanford is addressing the utilization of the emergency department for primary care by connecting patients to primary care providers. Clinic hours are expanded to offer alternatives to the overuse of the emergency department. The clinic is open from 8:00 a.m. to 8:00 p.m. and on Saturday mornings. Sanford Sheldon has also expanded specialist schedules through the use of tele-medicine, and has recruited a new provider for enhanced access to care.

Prescription drugs are made available at a free or reduced rate for patients who are unable to pay. Sanford Sheldon offers charity care to patients unable to pay for medical treatment. Sanford's community care policy defines qualifications and financial counselors are available to assist patients who qualify for free or subsidized care. Financial counselors also assist with enrollment for patients who qualify for public programs. Sanford employs a financial counselor in the oncology program to assist uninsured and underinsured cancer patients with applications for reduced rates or community care for chemotherapy medications.

Sanford is expanding mental health services in primary care clinics and at the medical center to offer psychiatric tele-health services. Social workers, case managers and discharge planners work collaboratively with area service providers to assure that safe discharges and possible and appropriate resources are engaged. Finally, Sanford is promoting video and on-line visits 24/7 for health plan members.

Physical Health: The top physical health concern among the community stakeholders is cancer. Chronic disease, obesity, poor nutrition and inactivity are also high ranking concerns among this group.

Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH



Sanford has cancer prevention and support groups that meet regularly for patients with a cancer diagnosis. Cancer patients and those who live with a chronic disease benefit from a healthy lifestyle including optimal nutrition and exercise. Sanford offers exercise programming for patients on site. Nutrition counseling and obesity management programs are expanding to meet the assessed need.

The chronic disease self-management Better Choices, Better Health Program at Sanford is offered free of charge to community members. Better Choices, Better Health is modeled after Stanford University's chronic disease self-management program. The workshops are 2 ½ hours long and meet weekly for 6 weeks. The program is facilitated by two trained lay leaders, and one or both of them have a chronic condition themselves. Research has found that after participating in the program, individuals are better able to manage their symptoms, communicate more easily with their doctors, are less limited by the disease, and generally feel better.

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and

motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* nitiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents benefit from their own set of resources where they can find tips and tools on becoming healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites, including videos, slideshows, games, articles, and even *fit* songs.

- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.

- *fit*4Schools – *fit*4Schools includes unique *fit*-based lessons integrated into daily classroom activities. *fit*4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:
    - Reached 50,000 schools
    - 180,000 page views from educators across the country
    - 12,000 lesson plan downloads, representing 600,000+ students

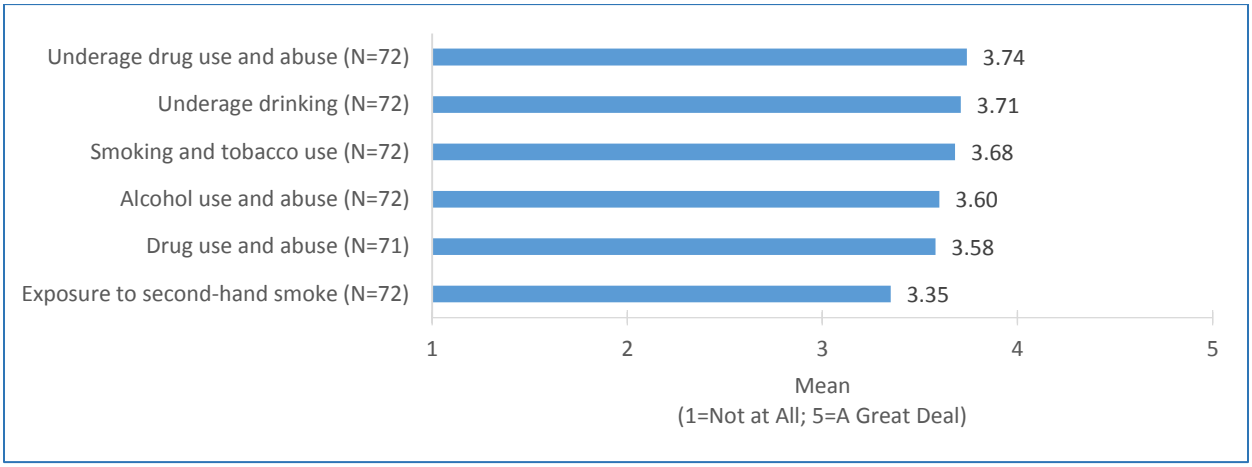
- Community
    - The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint. *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
    - Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
    - MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.
    - eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward
    - *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:
        - Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between health care providers and families.

- Health Coaches – Exploring meaningful ways for health coaches to promote healthy choices with children and adults.
- Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach efforts.
- *fit*Club 4 Boys – 10-week after school program for boys, ages 8-12, to develop knowledge of *fit* principles and healthy behavior choices.
- *fit* Parent/child – Class for parents and children to understand healthy choices and the benefits of living a healthy lifestyle.

Mental Health /Behavioral Health: The top mental health/behavioral health concerns are underage drug use and abuse, underage drinking, smoking and tobacco, alcohol use and abuse, and drug use and abuse.

Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

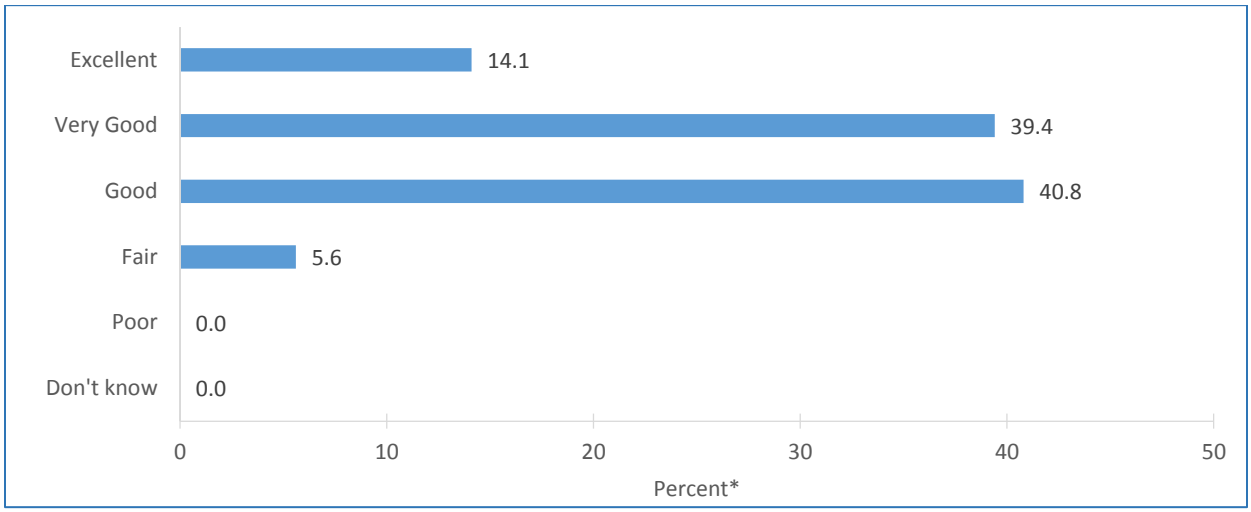


Personal Health Concerns

Respondents' Personal Health Status

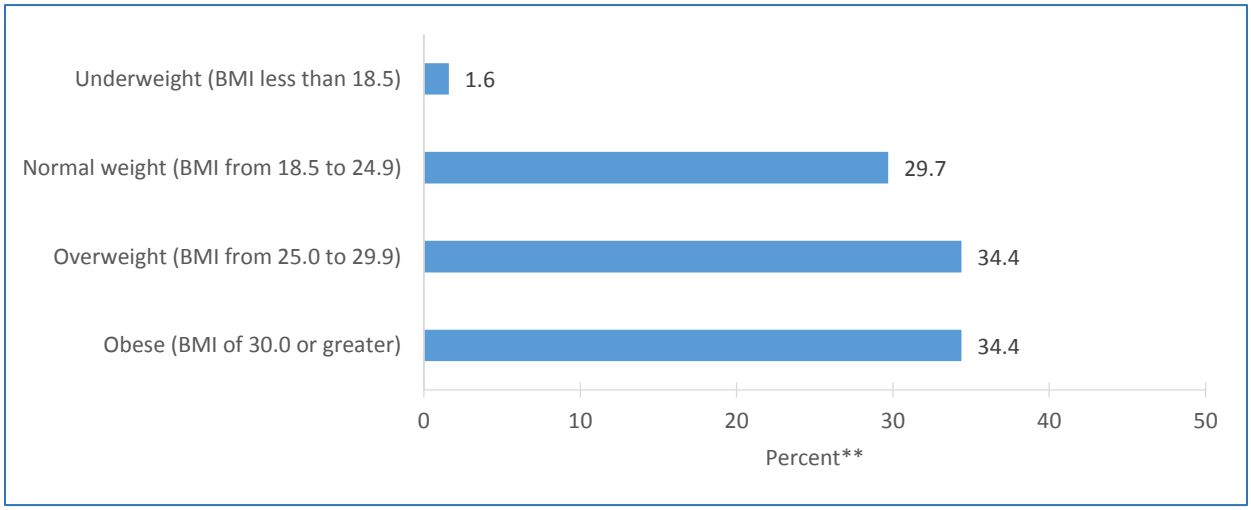
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area are overweight or obese. However, the vast majority of community respondents rate their own health as excellent, very good or good. With good overall health habits in mind, it is important to note that within the past year, 66% of respondents visited a doctor or health care provider for a routine physical and over 71% visited a dentist or dental clinic.

Respondents' rating of their health in general



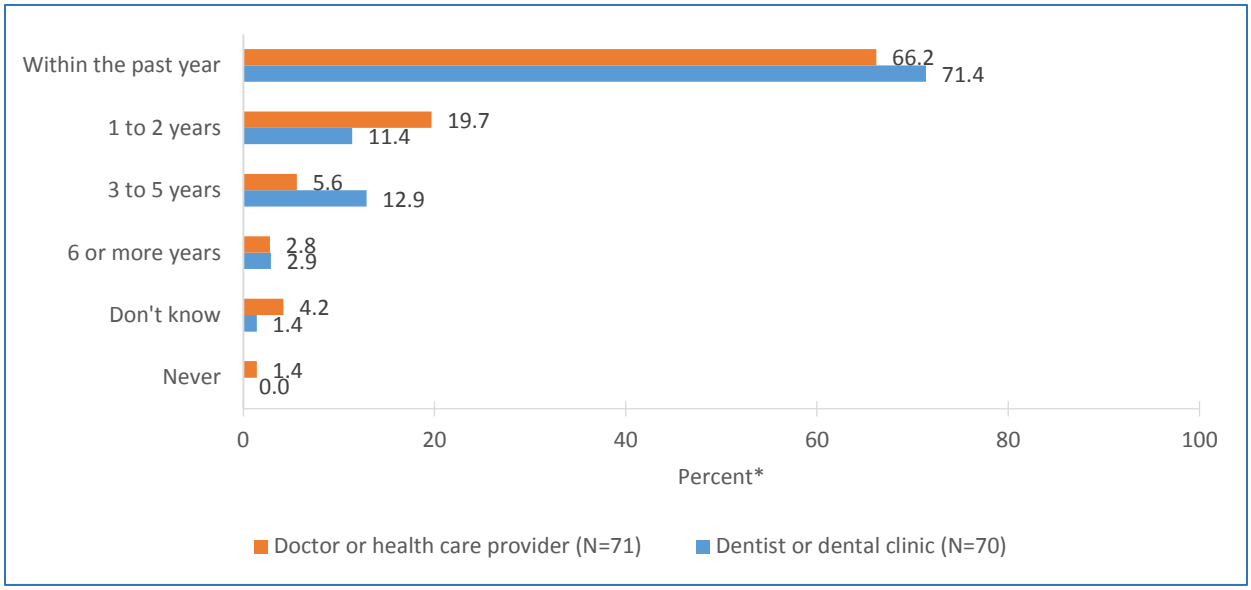
94.3% of the community stakeholders rate their health as good or better

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



68.8% of the key stakeholder respondents report a BMI that is overweight or obese.

Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason



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 blood pressure screening, blood sugar screening, cholesterol screening, and dental screening. Flu shots and pelvic exams (females) were higher among the community stakeholder group than the generalizable group. Breast cancer screening (females) was lower among the community stakeholders than the generalizable group. Over 44% of the generalizable group had not had a cervical cancer screening in the past year.

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

Whether or not respondents have had preventive screenings in the past year, by type of screening

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=71)	78.9	21.1	100.0
Blood sugar screening (N=71)	54.9	45.1	100.0
Bone density test (N=69)	11.6	88.4	100.0
Cardiovascular screening (N=69)	20.3	79.7	100.0
Cholesterol screening (N=71)	54.9	45.1	100.0
Dental screening and X-rays (N=70)	74.3	25.7	100.0
Flu shot (N=71)	77.5	22.5	100.0
Glaucoma test (N=71)	39.4	60.6	100.0
Hearing screening (N=69)	10.1	89.9	100.0
Immunizations (N=69)	30.4	69.6	100.0
Pelvic exam (N=47 Females)	51.1	48.9	100.0
STD (N=69)	10.1	89.9	100.0
Vascular screening (N=68)	11.8	88.2	100.0
CANCER SCREENINGS			
Breast cancer screening (N= 46 Females)	63.0	37.0	100.0
Cervical cancer screening (N=47 Females)	40.4	59.6	100.0
Colorectal cancer screening (N=69)	20.3	79.7	100.0
Prostate cancer screening (N=23 Males)	21.7	78.3	100.0
Skin cancer screening (N=69)	14.5	85.5	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=15)	60.0	33.3	6.7	0.0	0.0	0.0	0.0
Blood sugar screening (N=32)	43.8	37.5	3.1	0.0	0.0	0.0	9.4
Bone density test (N=61)	41.0	42.6	6.6	0.0	0.0	0.0	4.9
Cardiovascular screening (N=55)	40.0	49.1	3.6	0.0	0.0	0.0	3.6
Cholesterol screening (N=32)	43.8	37.5	6.3	0.0	0.0	0.0	9.4
Dental screening and X-rays (N=18)	38.9	5.6	16.7	5.6	0.0	0.0	38.9
Flu shot (N=16)	25.0	12.5	6.3	0.0	0.0	0.0	50.0
Glaucoma test (N=43)	51.2	39.5	7.0	0.0	0.0	0.0	2.3
Hearing screening (N=62)	56.5	32.3	3.2	0.0	0.0	0.0	4.8
Immunizations (N=48)	52.1	25.0	4.2	0.0	0.0	0.0	10.4
Pelvic exam	47.8	21.7	0.0	0.0	0.0	0.0	17.4

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
(N=23 Females)							
STD (N=62)	69.4	11.3	1.6	0.0	0.0	0.0	6.5
Vascular screening (N=60)	53.3	35.0	5.0	0.0	0.0	0.0	5.0

- *For most types of screenings, the most common reasons for not getting the test or procedure are that it is not necessary and the doctor has not suggested one.*
- *For dental screening and x-rays, the most common reason for not being tested that it is not necessary followed by cost.*
- *For the flu shot screening, most respondents cite that it was not necessary or other reasons for not getting the shot.*
- *42.2% of the survey respondents were under 45 years of age.*

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

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.

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 years and continuing until age 75 years.

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 2.5ng/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:

- 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.
- Look for skin abnormalities when performing physical examinations for other reasons.

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the generalizable survey indicate that 37% 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 even 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.

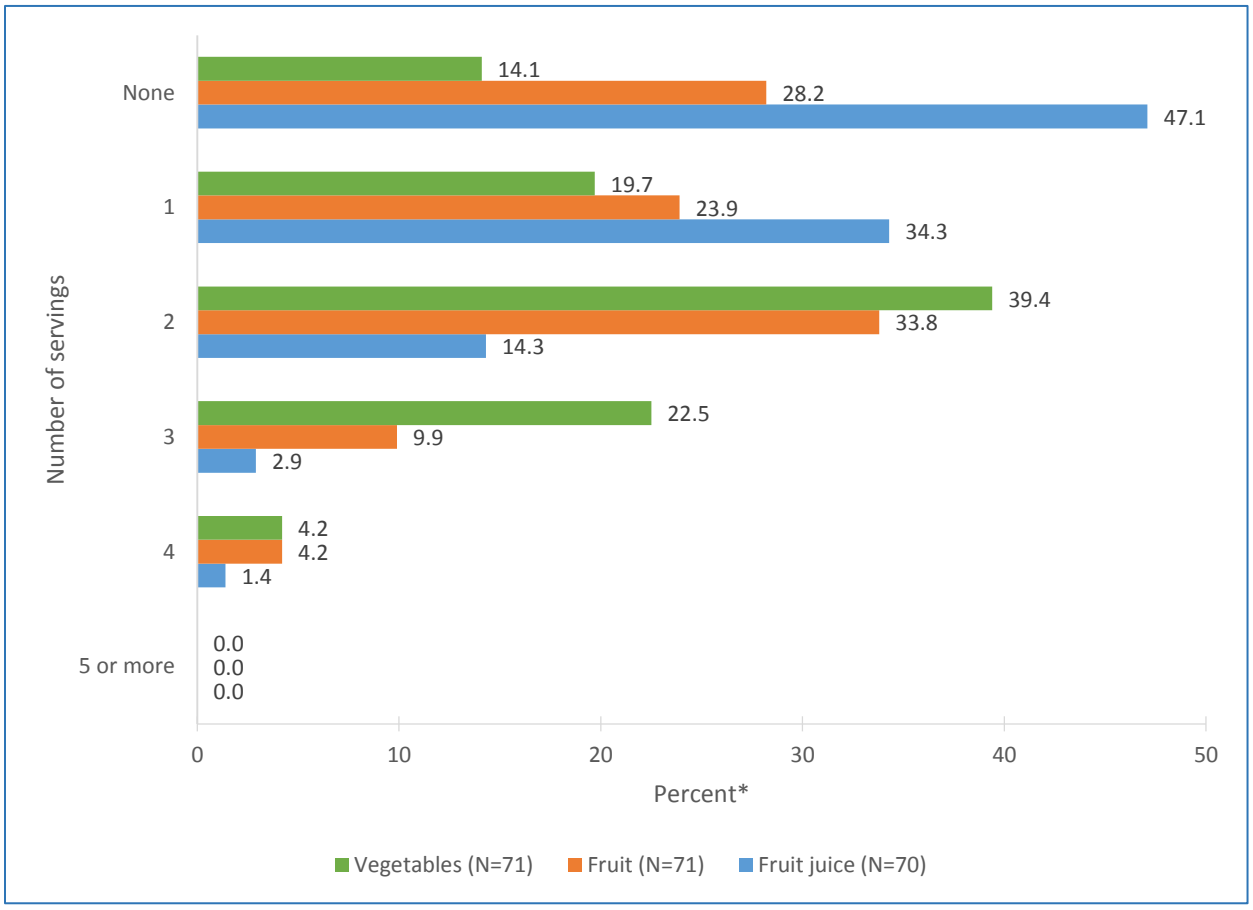
Sanford Health employees are required to have an annual flu vaccine as a protective measure for our patients as well as our staff.

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 26.7% of respondents reported having 3 or more servings of vegetables the prior day, and 14.1% in the non-generalizable group reported having 3 or more vegetables each day.

According to the U.S. Department of Health and Human Services, U.S. Department of Agriculture - Dietary Guidelines for Americans, it is recommended that individuals consume 3 to 5 servings of vegetables per day and 2 to 4 servings of fruit per day depending on age. A meal plan 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 meal plan can be beneficial for weight management.

Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday



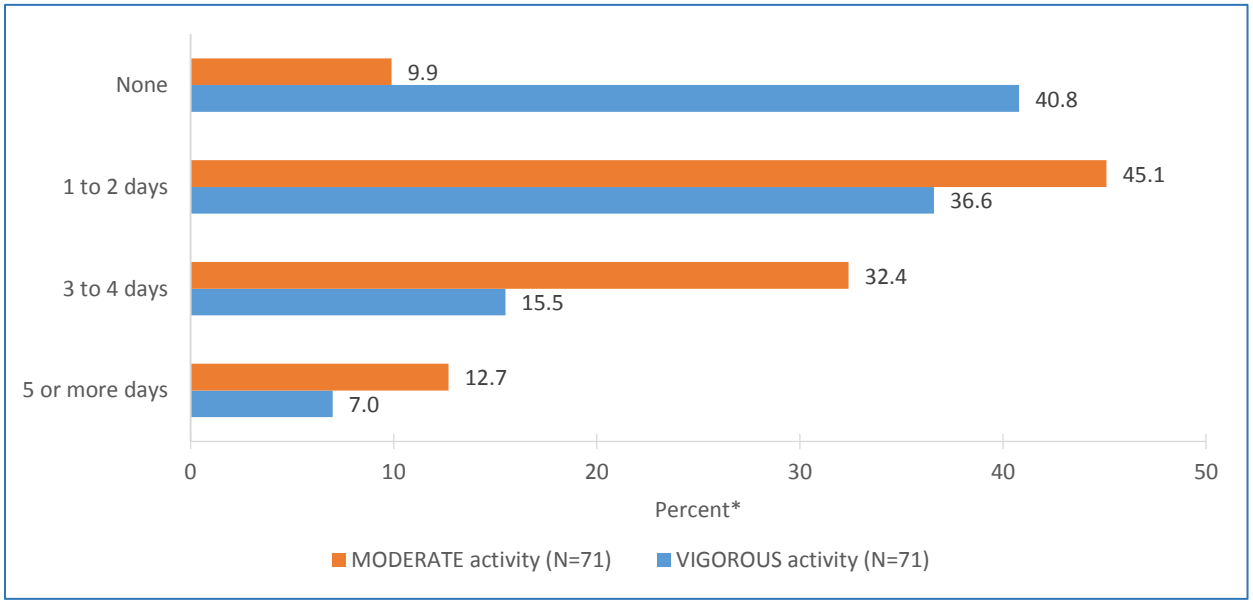
Sanford Sheldon's clinical dietitian is engaged with the local farmer's market to provide healthy nutrition sessions and recipes.

Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines. 45.1% of respondents engage in moderate activity 3 or more times per week and 28.2% engage in vigorous activity 3 or more times per week.

Guidelines from the Centers for Disease Control and Prevention recommend that individuals participate in 150 minutes of moderate physical activity per week or 75 minutes of vigorous physical activity per week to help sustain and improve health.

Number of days in an average week respondents engage in MODERATE and VIGOROUS activity

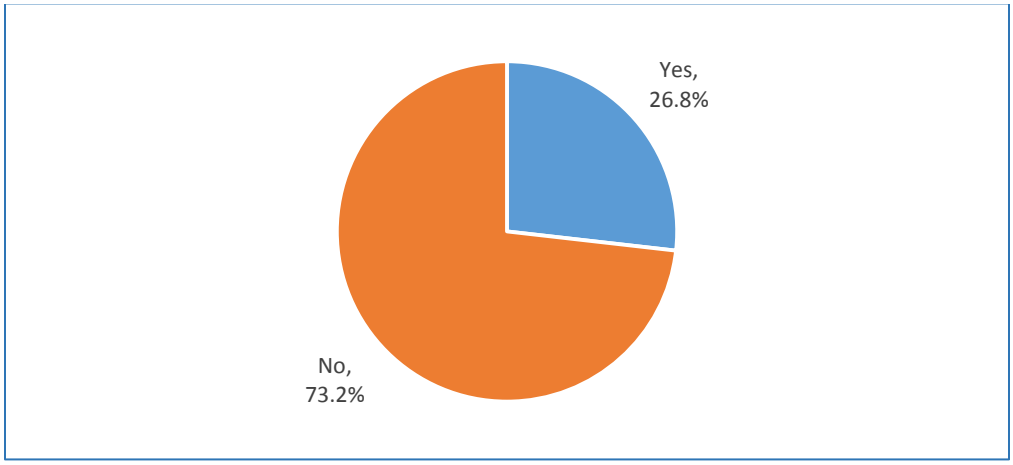


Tobacco Use

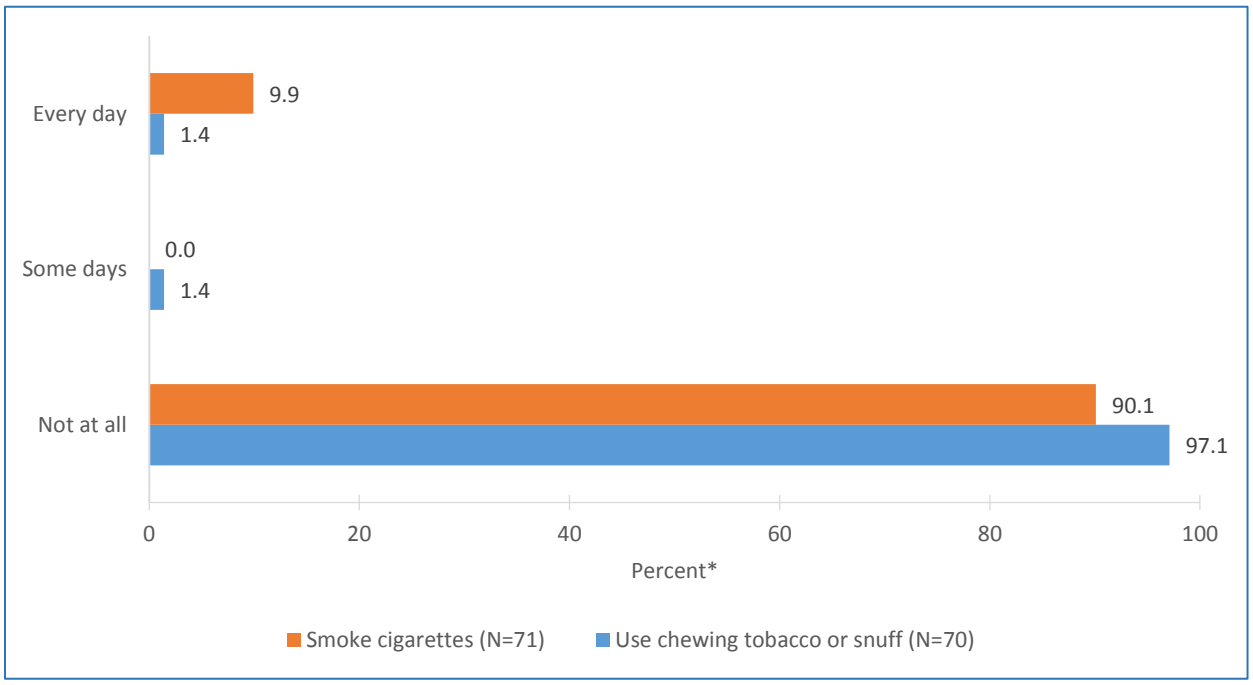
Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 26.8% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates a former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the 2015 County Health Rankings finds that 12% of Sioux County residents are current smokers. The data is not available for O'Brien County.

Whether respondents have smoked at least 100 cigarettes in their entire life



How often respondents currently smoke cigarettes and use chewing tobacco or snuff

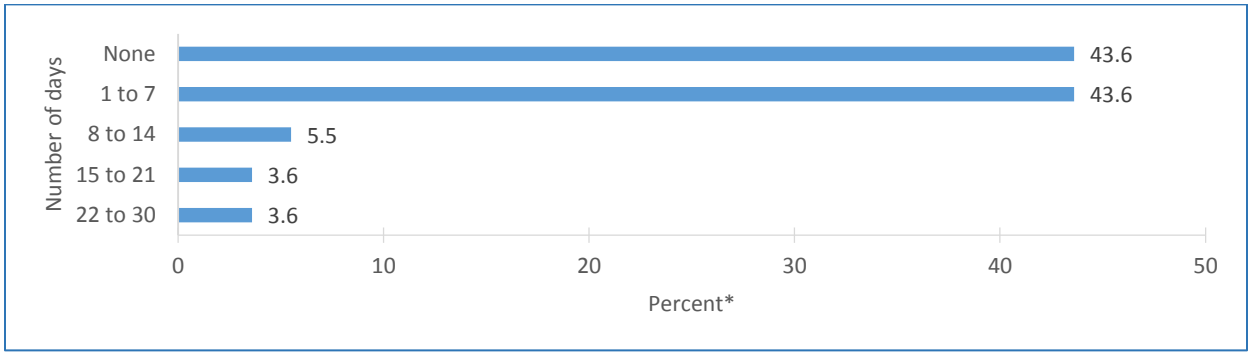


Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others. Among respondents, mental health is a moderately high area of concern, particularly stress, depression, and dementia and Alzheimer's disease.

More than 23% of respondents have been told or diagnosed by a doctor or health professional that they have anxiety or stress and nearly 21% have been told they have depression. In addition, 45.3% of the respondents reported days in the past month when their mental health was not good.

Number of days in the last month that respondents' mental health was not good

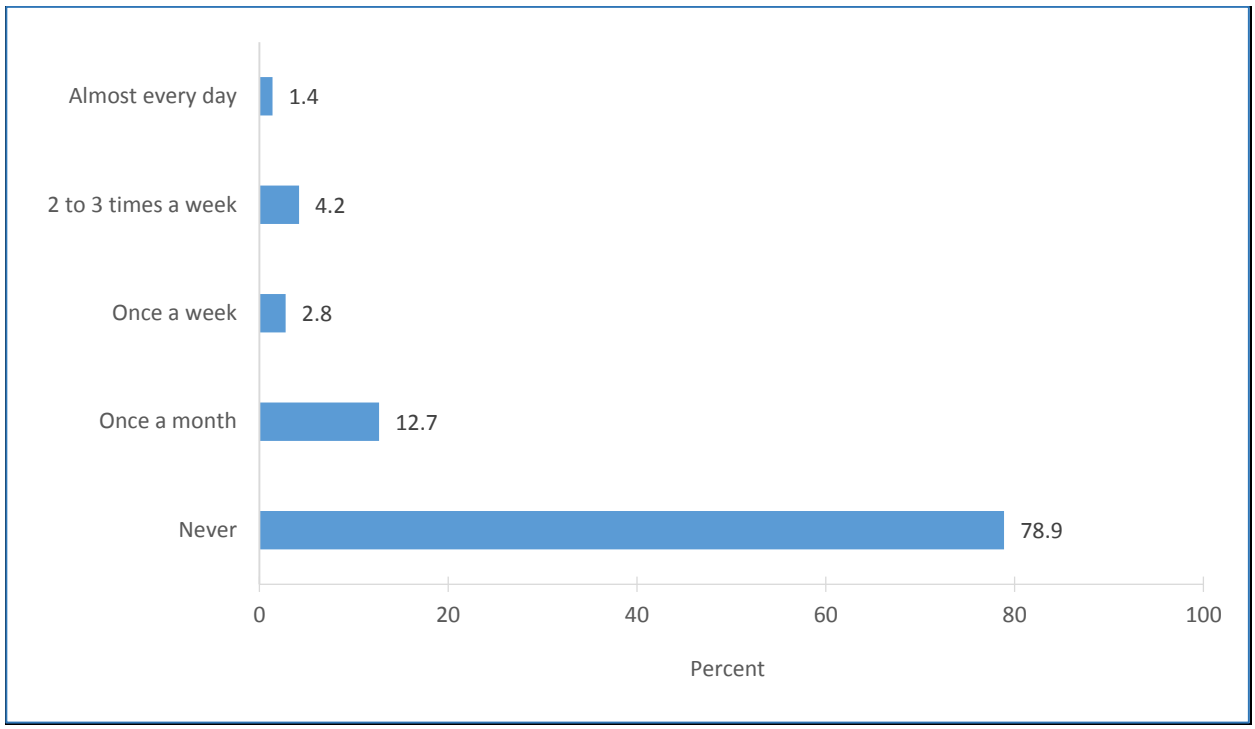


Substance Abuse Responses

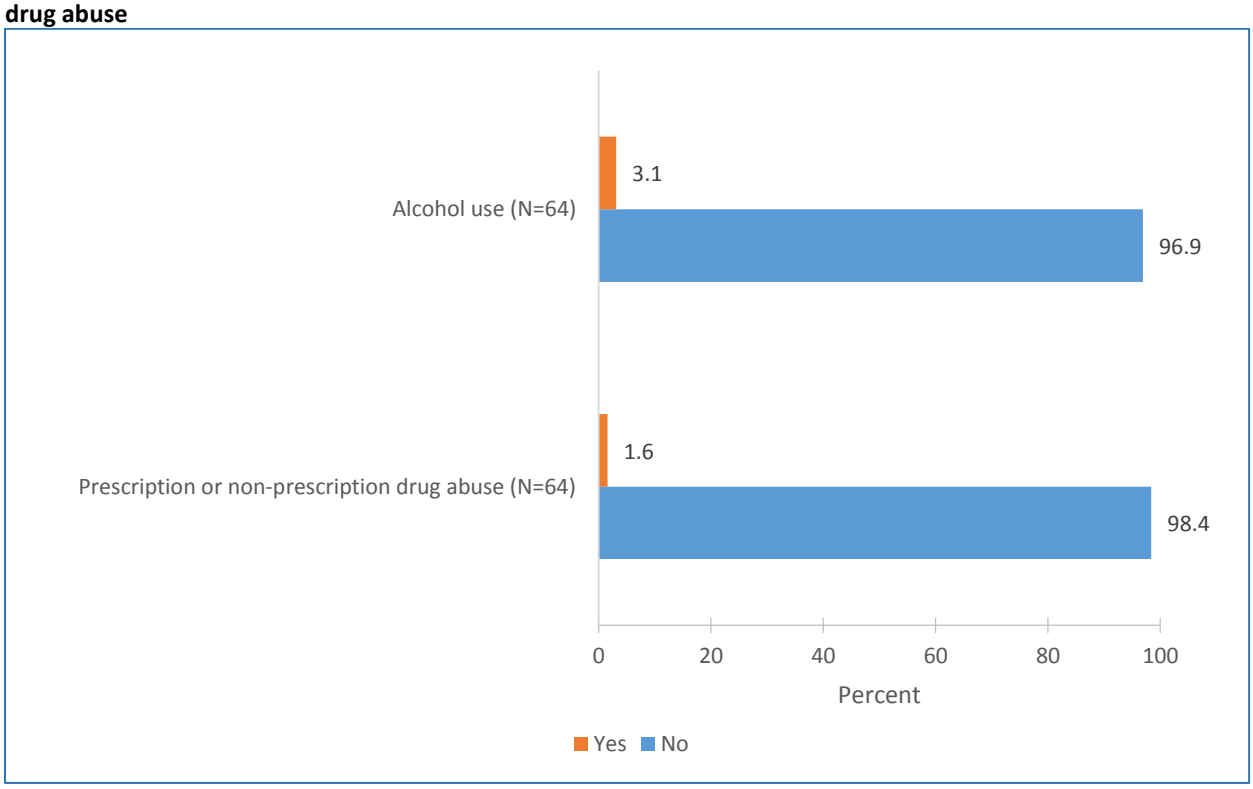
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In the greater Sheldon area, 65.2% of the community stakeholders drank alcoholic beverages on at least one of the days in the last month. On days they drank, 23.2% of respondents in the community stakeholder group drank an average of 3 or more drinks per day. In regards to binge drinking, 21.1% of community stakeholders report binge drinking at least once per month.

Secondary research through the 2015 County Health Rankings indicates that 13% of O'Brien County residents and 14% of Sioux County residents report excessive drinking. (See Appendix)

Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (Binge drinking is defined by the CDC as 4 drinks for females, 5 drinks for males) on the same occasion



Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse



3.1% percent of respondents from the community stakeholder group reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking.

Other forms of substance abuse include the use of prescription or non-prescription drugs. 1.6% of the community stakeholders in the area reported having had a problem with prescription or non-prescription drug abuse.

Demographics

Total Population – 2010 U.S. Census Bureau

- O'Brien County: 14,398
- Sioux County: 33,704

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	O'Brien: 933 Sioux: 2,639	O'Brien: 6.4 Sioux: 7.8	O'Brien: 473 Sioux: 1,334	O'Brien: 3.3 Sioux: 4.0	O'Brien: 449 Sioux: 1,305	O'Brien: 3.1 Sioux: 3.9
5-9	O'Brien: 937 Sioux: 2,555	O'Brien: 6.5 Sioux: 7.6	O'Brien: 518 Sioux: 1,284	O'Brien: 3.6 Sioux: 3.8	O'Brien: 419 Sioux: 1,271	O'Brien: 2.9 Sioux: 3.8
10-14	O'Brien: 948 Sioux: 2,385	O'Brien: 6.6 Sioux: 7.1	O'Brien: 499 Sioux: 1,206	O'Brien: 3.5 Sioux: 3.6	O'Brien: 449 Sioux: 1,179	O'Brien: 3.1 Sioux: 3.5
15-19	O'Brien: 887 Sioux: 3,090	O'Brien: 6.2 Sioux: 9.2	O'Brien: 483 Sioux: 1,584	O'Brien: 3.4 Sioux: 4.7	O'Brien: 404 Sioux: 1,506	O'Brien: 2.8 Sioux: 4.5
20-24	O'Brien: 656 Sioux: 2,985	O'Brien: 4.6 Sioux: 8.9	O'Brien: 346 Sioux: 1,524	O'Brien: 2.4 Sioux: 4.5	O'Brien: 310 Sioux: 1,461	O'Brien: 2.2 Sioux: 4.3
25-29	O'Brien: 800 Sioux: 2,084	O'Brien: 5.6 Sioux: 6.2	O'Brien: 425 Sioux: 1,107	O'Brien: 3.0 Sioux: 3.3	O'Brien: 375 Sioux: 977	O'Brien: 2.6 Sioux: 2.9
30-34	O'Brien: 786 Sioux: 1,961	O'Brien: 5.5 Sioux: 5.8	O'Brien: 414 Sioux: 1,028	O'Brien: 2.9 Sioux: 3.1	O'Brien: 372 Sioux: 933	O'Brien: 2.6 Sioux: 2.8
35-39	O'Brien: 691 Sioux: 1,700	O'Brien: 4.8 Sioux: 5.0	O'Brien: 362 Sioux: 859	O'Brien: 2.5 Sioux: 2.5	O'Brien: 329 Sioux: 841	O'Brien: 2.3 Sioux: 2.5
40-44	O'Brien: 783 Sioux: 1,729	O'Brien: 5.4 Sioux: 5.1	O'Brien: 405 Sioux: 901	O'Brien: 2.8 Sioux: 2.7	O'Brien: 378 Sioux: 828	O'Brien: 2.6 Sioux: 2.5
45-49	O'Brien: 1,013 Sioux: 2,062	O'Brien:7.0 Sioux: 6.1	O'Brien: 486 Sioux: 1.071	O'Brien: 3.4 Sioux: 3.2	O'Brien: 527 Sioux: 991	O'Brien: 3.7 Sioux: 2.9
50-54	O'Brien: 1,168 Sioux: 2,243	O'Brien: 8.1 Sioux: 6.7	O'Brien: 608 Sioux: 1,129	O'Brien: 4.2 Sioux: 3.3	O'Brien: 560 Sioux: 1,114	O'Brien: 3.9 Sioux: 3.3
55-59	O'Brien: 1,082 Sioux: 2,011	O'Brien 7.5 :Sioux: 6.0	O'Brien: 544 Sioux: 1,028	O'Brien: 3.8 Sioux: 3.1	O'Brien: 538 Sioux: 983	O'Brien: 3.7 Sioux: 2.9
60-64	O'Brien: 788 Sioux: 1,452	O'Brien: 5.5 Sioux: 4.3	O'Brien: 388 Sioux: 732	O'Brien: 2.7 Sioux: 2.2	O'Brien: 400 Sioux: 720	O'Brien: 2.8 Sioux: 2.1
65-69	O'Brien: 616 Sioux: 1,166	O'Brien: 4.3 Sioux: 3.5	O'Brien: 300 Sioux: 546	O'Brien: 2.1 Sioux: 1.6	O'Brien: 316 Sioux: 620	O'Brien: 2.2 Sioux: 1.8
70-74	O'Brien: 562 Sioux: 1,029	O'Brien: 3.9 Sioux: 3.1	O'Brien: 259 Sioux: 471	O'Brien: 1.8 Sioux: 1.4	O'Brien: 303 Sioux: 558	O'Brien: 2.1 Sioux: 1.7

	Number	Percent	Males	Percent	Females	Percent
75-79	O'Brien: 625 Sioux: 914	O'Brien: 4.3 Sioux: 2.7	O'Brien: 259 Sioux: 392	O'Brien: 1.8 Sioux: 1.2	O'Brien: 366 Sioux:	O'Brien: 2.5 Sioux:
80-84	O'Brien: 554 Sioux: 828	O'Brien: 3.8 Sioux: 2.5	O'Brien: 224 Sioux: 325	O'Brien: 1.6 Sioux: 1.0	O'Brien: 330 Sioux: 503	O'Brien:2.3 Sioux: 1.5
85 and over	O'Brien: 580 Sioux: 871	O'Brien: 4.0 Sioux: 2.6	O'Brien: 173 Sioux: 310	O'Brien: 1.2 Sioux: 0.9	O'Brien:407 Sioux: 561	O'Brien: 2.8 Sioux: 1.7
Median age	O'Brien:43.6 Sioux: 32.7		O'Brien: 40.8 Sioux: 31.7		O'Brien:46.6 Sioux: 33.8	

Population by Race

	O'Brien	Percent	Sioux	Percent
White	13,829	96	31,441	93.3
Black or African American	67	0.5	129	0.4
American Indian or Alaska Native	18	0.1	96	0.3
Asian	82	0.6	272	0.8
Native Hawaiian or other Pacific Islander	1	0.0	4	0.0
Hispanic or Latino	545	3.8	3,001	8.9

The per capita personal income in O'Brien County, Iowa is $17,281. 7.3% in O'Brien County are living below the poverty level. The unemployment rate in O'Brien County, Iowa is 3.7%.

The per capita personal income in Sioux County, Iowa is $25,343. 7.5% in Sioux County are living below the poverty level. The unemployment rate in Sioux County, Iowa is 3.3%.

Health Needs and Community Resources Identified

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

Sanford Health and community partners developed the asset map. 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. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

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

The asset map process includes identified needs from the following:

- The non-generalizable survey
- Concerns expressed by the key stakeholder group
- Secondary research data
- Community resources that are available to address the need(s)

The Asset Map document can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Children and Youth – bullying, cost and availability of quality child care and infant care, services for at-risk youth
- Aging – cost of long term care
- Safety – the presence of street drugs and alcohol in the community, child abuse and neglect, domestic violence
- Health Care Access – use of the emergency department for primary care, access to affordable health insurance, timely access to physician specialists, availability of non-traditional hours, timely access to doctors, PAs and NPs, timely access to mental health providers
- Physical Health – cancer, chronic disease, obesity, poor nutrition, inactivity
- Mental Health – underage drug use and abuse, underage drinking, stress, smoking and tobacco, depression, alcohol use and abuse, drug use and abuse, dementia and Alzheimer's
- Preventive Health – flu vaccines

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

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

Members of the collaborative determined that children and youth and mental health are top unmet needs for further implementation strategies.

Sanford has determined the 2016-2019 implementation strategies for the following needs:

- Mental Health
- Children and Youth

2016 Community Health Needs Assessment

Sanford Sheldon Medical Center

ADDRESSING THE NEEDS

Identified Concerns	How Sanford Sheldon is Addressing the Needs
Aging • Cost of long term care	Keeping the cost structure below the market for long term care in Sheldon
Children and Youth • Bullying • Cost of quality child care • Cost of quality infant care • Availability of services for at-risk youth • Cost of services for at-risk youth • Availability of quality infant care	• Sponsoring anti-bullying speakers in the school • Supporting the community day care with a capital campaign • Supporting the community day care with a capital campaign • Making appropriate referrals to DHS when we suspect at-risk youth need services • Supporting after school hours programming to keep at-risk youth in a more structured setting • Supporting the expansion of our community day care infant capacity - capital dollars
Safety • Presence of street drugs, prescription drugs, and alcohol in the community • Child abuse and neglect • Domestic violence	• Great relationship with the local law enforcement community to identify drug related issues and education • Partnering with DHS when abuse and or neglect may be identified • Partnering with the Crisis Center to ensure access when domestic violence may be an issue
Health Care • Use of emergency room services for primary health care • Access to affordable health insurance • Timely access to physician specialists • Availability of non-traditional hours • Timely access to doctors, PAs or NPs • Timely access to mental health providers	• Direct referrals to primary care out of the ED • Presumptive eligibility for non-insured patients • Enhanced specialist schedule through telemedicine • Expanding clinic hours to 8am to 8pm and Saturday mornings • Hired another doctor for better access • Requesting a triage therapist to expand our mental health capacity
Physical Health • Cancer • Chronic Disease • Obesity • Poor nutrition • Inactivity	• Cancer prevention and support groups that meet regularly • Health Coach that works the registries to ensure chronic disease management is controlled better • Engage the farmers market with dietician to provide healthy eating sessions and recipes • Partner with HyVee on healthy eating programing for the community

Identified Concerns	How Sanford Sheldon is Addressing the Needs
	• Sponsor an athletic trainer and a Live Healthy Sheldon annual activity and weight loss program
Mental Health/Behavioral Health • Underage drug use and abuse • Underage drinking • Stress • Smoking and tobacco • Depression • Alcohol use and abuse • Drug use and abuse • Dementia and Alzheimer's	• Engage with the school on education of drug and drinking abuse through our school educator • Primary care providers use One Chart to identify stressors • Primary care providers provide education on smoking and tobacco cessation • Depression screening is done on each primary care visit • Alcohol and drug use is identified through primary care visits • Dementia and Alzheimer's support group at our senior care facility meets regularly
Preventive Health	Primary care providers encourage regular check-ups to ensure prevention is the focus

SANFORD HEALTH

2016 Implementation Strategy

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

Mental health includes emotional, psychological, and social well-being. It affects how people think, feel and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

Mental health problems are common but people with mental health problems can get better and many recover completely.

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to reduce mortality and morbidity from chemical addiction and mental health diseases by recruiting a triage therapist, and working to reduce drug and alcohol abuse in the community by working with the high school counselor to enhance curriculum to include abuse issues.

Priority 2: Children and Youth

An at-risk youth is a child who is less likely to transition successfully into adulthood. Success can include academic success and job readiness, as well as the ability to be financially independent.

Sanford has developed strategies to support the youth in the area by enhancing the community environment. Sanford will work with community development and provide assistance for reopening of a local resource for youth and provide after school programming in a structured environment for our youth. Sanford will support the expansion of day care with capital and will also work with the local day care center to provide quarterly education sessions for students and parents.

Community Health Needs Assessment
Implementation Strategy for Sanford Sheldon Medical Center
FY 2017-2019 Action Plan

Priority 1: Mental Health/Behavioral Health

Projected Impact: Better access to more providers

Goal 1: Hire a triage therapist

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Recruit a triage therapist to improve access to mental health/behavioral health	1 FTE triage therapist is hired	2017 budget addition - 40 hours per week	Nordahl	Seasons Center can assist with capacity

Goal 2: Drug and alcohol awareness in school

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Partner with high school leadership to include substance abuse prevention into the curriculum	Approval of enhanced education curriculum is realized	School educators; Sanford leadership	Dykstra	High school counselor

Priority 2: Children and Youth

Projected Impact: Enhanced community environment for children and youth

Goal 1: Provide a more structured environment for youth

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Provide after school programming for a structured environment for our youth; reopen the local roller rink so that youth have a place to go after school and on weekends	A buyer is found and the local roller rink reopens for youth	Community development assistance	Nordahl Strouth	SCDC partnership

Goal 2: Expansion of community day care infant capacity

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Support expansion of day care with capital and continued education classes for students/parents	Quarterly education programs are conducted	Staff	Dreesen	Children's World day care

SANFORD HEALTH

2013 Implementation Strategy Impact

Demonstrating Impact

The 2013 Community Health Needs Assessment served as a catalyst to lift up obesity and mental health services as implementation strategies for 2013-2016. The following strategies were implemented.

Implementation Strategy – Access – 12 month plan

- Devise and implement a plan to create optimal coverage of the emergency department utilizing APPs.
- Recruit additional physicians to meet the needs of the patient base and growth.
- Utilize Health Coach to manage reduce repeat visits.
- Offer a physician assistant in the Sheldon clinic for acute care appointments open with daily access.

Implementation Strategy – Recruitment

- Continue to work to recruit at a minimum of two additional physicians.
- Work closely with Sanford Physician Recruitment department to ensure we are actively promoting the opportunities in Sheldon.

Implementation Strategy – Preventative Services

- Continue to offer the current preventive services and better educate the community on the importance and value of these screenings.
- Work with Sanford Health and the outreach providers to determine the preventive services opportunities that are needed in the communities.

Impact of the Access Strategy

Sanford has recruited a physician and advanced practice providers to create full coverage and improve access in the Emergency Room. Additionally, health coaches are in place to work with patients. Sanford Sheldon has also opened a same day service to meet the needs of those in the community who need immediate care. The 2015 survey data indicates that community members remain concerned about the use of the emergency department for primary care services. Community members are continuing to be concerned about timely access to providers.

Impact of the Recruitment Strategy

Sanford was successful in the recruitment of two additional physicians for the community, allowing the addition of a same day clinic and full coverage in the emergency department.

Impact of the Preventive Services Strategy

Sanford continues to offer preventive health screening and is working to create awareness of the need for screenings and what the criteria is by age group. Sanford also provides health fairs and employee screening for primary prevention.

Community Feedback from the 2013 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on the 2013 Community Health Needs Assessment and has provided on-line comment fields for ease of access on our website. There have been no comments to date.

APPENDIX

Primary Research

Sheldon 2016 CHNA Asset Map

Identified concern	Key stakeholder survey	Key stakeholder focus group	Secondary data *County Rankings (CR)*	Community resources that are available to address the need	Gap?
Children and Youth	• Bullying 3.80 • Cost of quality child care 3.71 • Cost of quality infant care 3.64 • Availability of services for at-risk youth 3.60 • Cost of services for at-risk youth 3.54 • Availability of quality infant care 3.53		Teen births were 33 /1000 female population ages 15-19, compared to 20 national average and 30 statewide (CR)	Sanford One Care Sanford WebMD Fit Kids Seasons Center for Behavioral Health 800-242-5101 Community Partnership for safety & wellbeing of children (CPPC) 712-363-3363 Sheldon Schools 712-324-2435 St. Patrick's Catholic School 712-324-3181 City Parks Department 712-324-2769 Child Care resources: • Sheldon/O'Brien Head Start 712-324-3825 • NW IA Community College 712-324-3825 • Northwestern College • Dordt University • Noah's Ark Preschool 712-324-3049 • Rachel Ginger-Klein 712-324-5103 • Christine Reiter 712-324-2629 • Jennifer Bruns 712-324-2360 • Ruthann Chapman 712-324-5246 • Sheldon Community Day Care 712-324-4837 • Glenda Klein • Nicole Vanbeek 712-324-0194	X

Identified concern	Key stakeholder survey	Key stakeholder focus group	Secondary data *County Rankings (CR)*	Community resources that are available to address the need	Gap?
				• Stacie Vanbeek 712-324-7320 • Melissa Provost	
Aging Population	• Cost of long term care 3.73	Education about LTC insurance is needed		Sanford Health Plan provides community education and Medicare information sessions 2 x per year Long-Term Care facilities • Sanford Sheldon Care Center 712-324-6450 • Cobble Creek Assisted Living 712-324-7404 • Fieldcrest Assisted Living 712-324-2338	X
Safety	• Presence of street drugs, prescription drugs, and alcohol in the community 3.75 • Child abuse and neglect 3.69 • Domestic violence 3.58		29% of driving deaths were alcohol impaired	Sanford One Care Sheldon Police Department 712-324-2525	X
Health Care	• Use of emergency room services for primary health care 3.77 • Access to affordable health insurance 3.70 • Timely access to physician specialists 3.61 • Availability of non-traditional hours 3.56 • Timely access to doctors, PAs or NPs 3.54 • Timely access to mental health providers 3.54			Sanford Sheldon Med Center 712-324-5041 Sanford Sheldon Clinic 712-324-6450 Seasons Center for Behavioral Health 800-242-5101	X

Identified concern	Key stakeholder survey	Key stakeholder focus group	Secondary data *County Rankings (CR)*	Community resources that are available to address the need	Gap?
Physical Health	• Cancer 4.00 • Chronic Disease 3.85 13.9% report hypertension 12.5% of respondents reported high cholesterol 11.1% report arthritis • Obesity 3.72 BMI – overweight or obese – 68.8% • Poor nutrition 3.72 Only 26.7% have 3 or more veggies/day and only 14.1% have 3 or more fruits /day • Inactivity 3.69 Only 45.1% have 3 or more days with moderate activity, and 28.2% have 3 or more days of vigorous activity		High incidence of premature death (% of potential life lost before age 75 per 100,000 population) (CR) Adult obesity 29% compared to the national rate of 25% (BMI greater than 30) (CR) Physical inactivity 23% compared to the national 20% (% of adults ages 20 or over reporting no leisure time physical activity) (CR)	Sanford Cancer Biology Research Center Sanford dietitians Sanford WebMD Fit Kids Sanford One Care Sanford Sheldon Medical Center 712-324-5041 Sanford Sheldon Clinic 712-324-6450 Exercise resources: • Aquatic Center 712-324-4771 • Courtyard Fitness 712-324-2085 • Lifelong Learning & Recreation Center (2 sites) 712-324-5061 /712-324-6152 • City of Sheldon Recreation 324-2769	X

Identified concern	Key stakeholder survey	Key stakeholder focus group	Secondary data *County Rankings (CR)*	Community resources that are available to address the need	Gap?
Mental Health/Substance Use and Abuse	• Underage drug use and abuse 3.74 Underage drinking 3.71 • Stress 3.69 23.6% report they have been told by a doctor that they have anxiety or stress • Smoking& tobacco 3.68 26.8% of respondents have smoked at least 100 cigarettes in their life, however only 9.9% of respondents currently report daily use • Depression 3.64 56.3% of respondents reported 1 or more days in the last month when mental health was not good; 20.8% have been told that they are depressed • Alcohol use and abuse 3.60; 23.2% of respondents reported consuming 3 or more alcoholic drinks/day, 21.1% reported drinking 4-5 alcoholic drinks per occasion at least once per month; Only 3.1% report having a problem with alcohol use; 21.1% report that alcohol use had harmful effects on the family, and 11.3% reported that drug abuse had harmful effects. • Drug use and abuse 3.58 • Dementia and Alzheimer's 3.57		Excessive drinking is 13% compared to the national rate of 10% the state rate of 20% (CR)	Sanford One Care Medical Home Model (Health Coach) Sanford Sheldon Med Center 712-324-5041 Sanford Sheldon Clinic 712-324-6450 Sheldon Care Center (has services for dementia) 712-324-6450 Seasons Center for Behavioral Health 800-242-5101 AA meets weekly at the Medical Center	X

Identified concern	Key stakeholder survey	Key stakeholder focus group	Secondary data *County Rankings (CR)*	Community resources that are available to address the need	Gap?
Preventive Health	22.5% did not receive a flu shot within the last year 69.6% did not have immunizations within the last year 25% of respondents reported that children living in their household did not receive flu shots		Sexually transmitted infections – 127 compared to 138 nationally and 370 statewide (# of newly diagnosed chlamydia cases per 100,000 population) (CR)	Flu shots: • Sanford Sheldon Clinic 712-324-6450 • HyVee Pharmacy 712-324-0020 • Lewis Drug 712-324-4331	X

Sheldon 2016 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 (H1N1 or air pollution)
- Size of problem (e.g. # of individuals affected)

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Aging • Cost of long term care 3.73 (7)	XX		
Children and Youth • Bullying 3.80 (3) • Cost of quality child care 3.71(9) • Cost of quality infant care 3.64 • Availability of services for at-risk youth 3.60 • Cost of services for at-risk youth 3.54 • Availability of quality infant care 3.53	**XXXX**	**XXXXX XX** **#2 Priority**	
Safety • Presence of street drugs, prescription drugs and alcohol in the community 3.75 (5) • Child abuse and neglect 3.69 • Domestic violence 3.58	XXX		
Health Care • Use of emergency room services for primary health care 3.77 (4) • Access to affordable health insurance 3.70 (10) • Timely access to physician specialists 3.61 • Availability of non-traditional hours 3.56 • Timely access to doctors, PAs or NPs 3.54 • Timely access to mental health providers 3.54	XXXX	XXXX	
Physical Health • Cancer 4.00 (1) • Chronic Disease 3.85 (2) • Obesity 3.72 (8) • Poor nutrition 3.72 (8) • Inactivity 3.69	**XXX**		
Mental Health/Behavioral Health • Underage drug use and abuse 3.74 (6) • Underage drinking 3.71 (9) • Stress 3.69 • Smoking and tobacco 3.68 • Depression 3.64 • Alcohol use and abuse 3.60 • Drug use and abuse 3.58 • Dementia and Alzheimer's 3.57	**XXXXX** **#1 Priority**		
Preventive Health	X		

Present: Dr. Ronald Zoutendam, Myrna Wagner, Michelle DeKok, Mary Dunn, Karen Pottebaum, Joni DeKok, Scott Wynia, Curt Strouth, Shawn Dreesen, Dianne Wolthuizen, Steve DeVoe, Rick Nordahl

Sanford Sheldon Medical Center

Community Health Needs Assessment

Results from an April 2015 Non-Generalizable

Online Survey

August 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an April 2015 online survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative invited viewers to access the online survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach**. Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred throughout the month of April 2015 and a total of 72 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

General Health and Wellness Concerns about the Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various statements regarding ECONOMICS, TRANSPORTATION, the ENVIRONMENT, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTH CARE, PHYSICAL AND MENTAL HEALTH, and SUBSTANCE USE AND ABUSE.

Figure 1. Level of concern with statements about the community regarding ECONOMICS

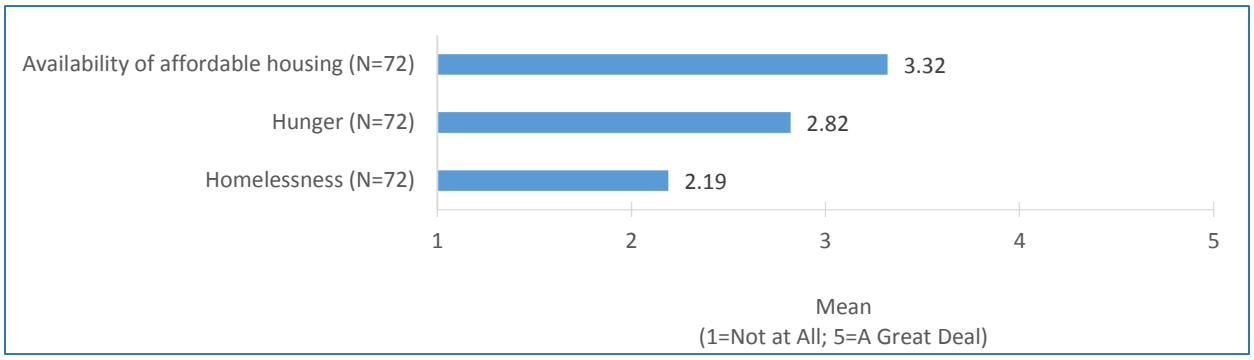


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

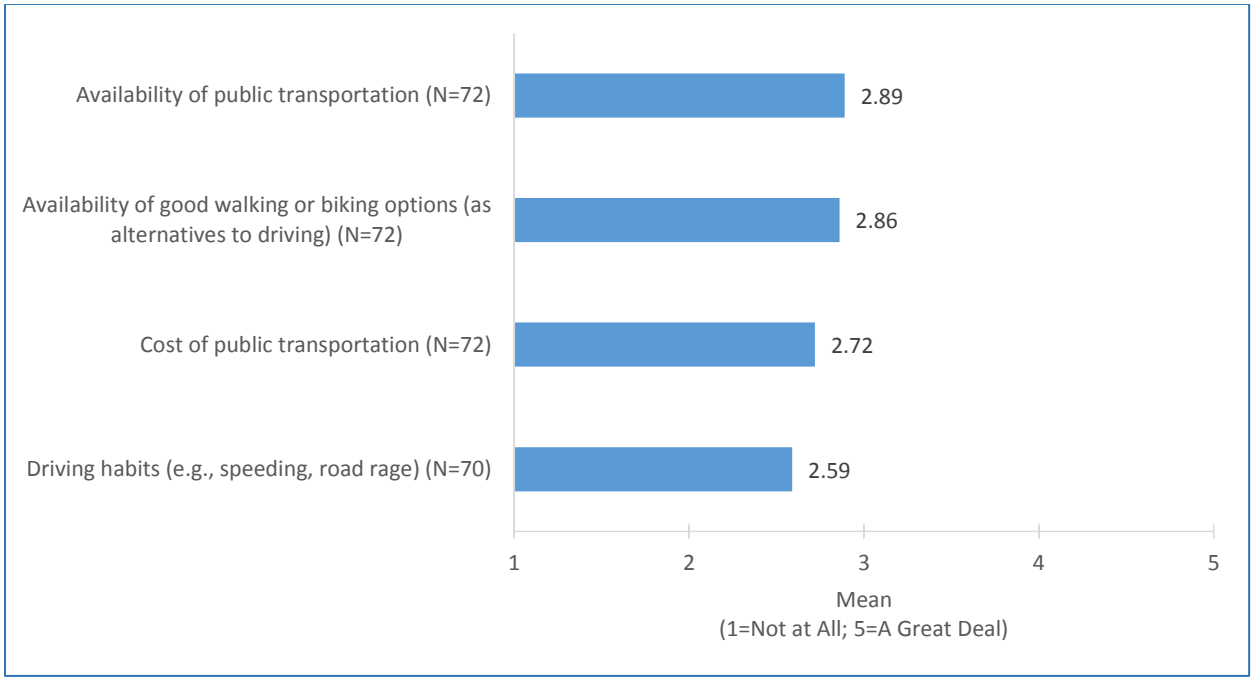


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

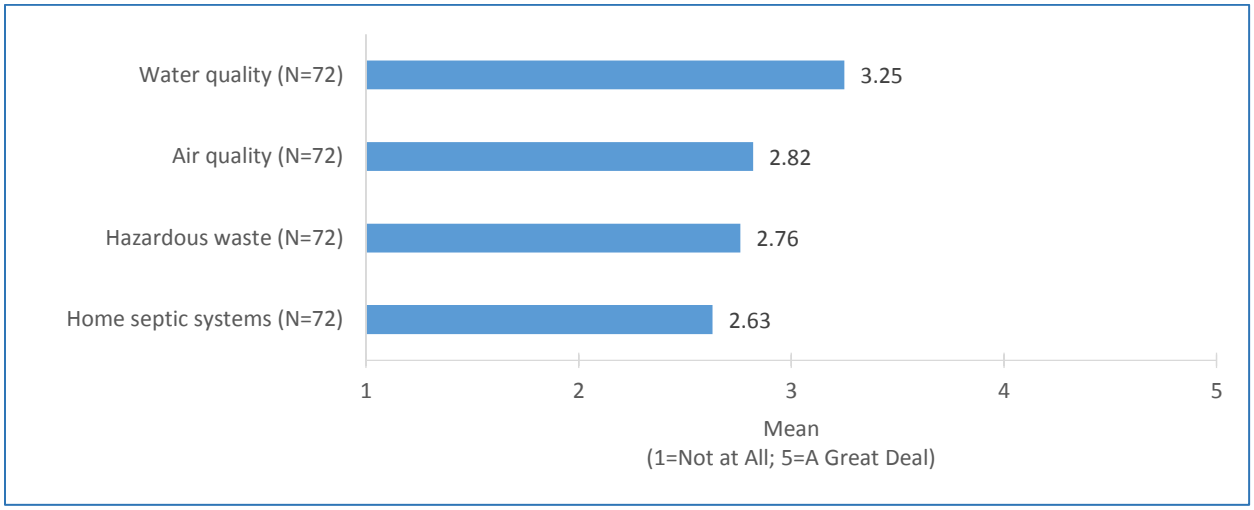


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

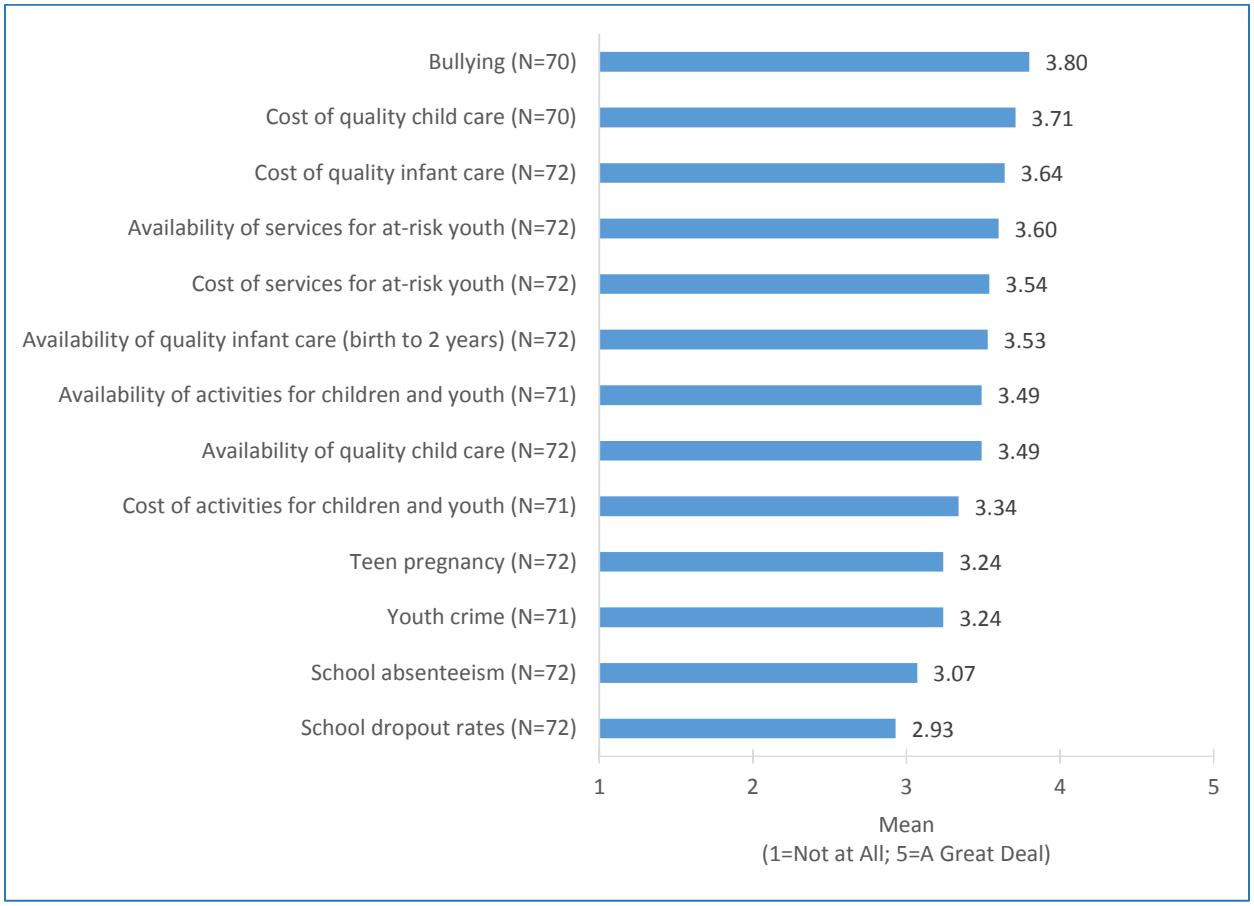


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

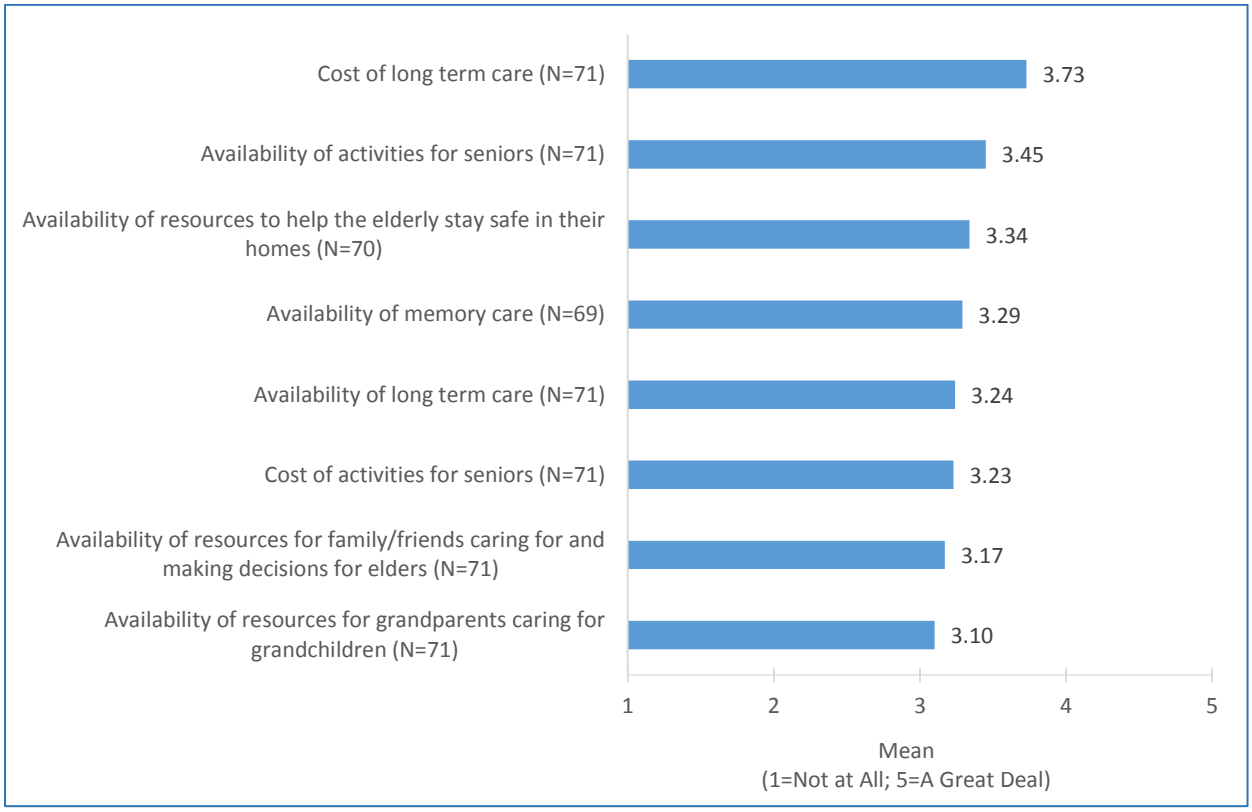


Figure 6. Level of concern with statements about the community regarding SAFETY

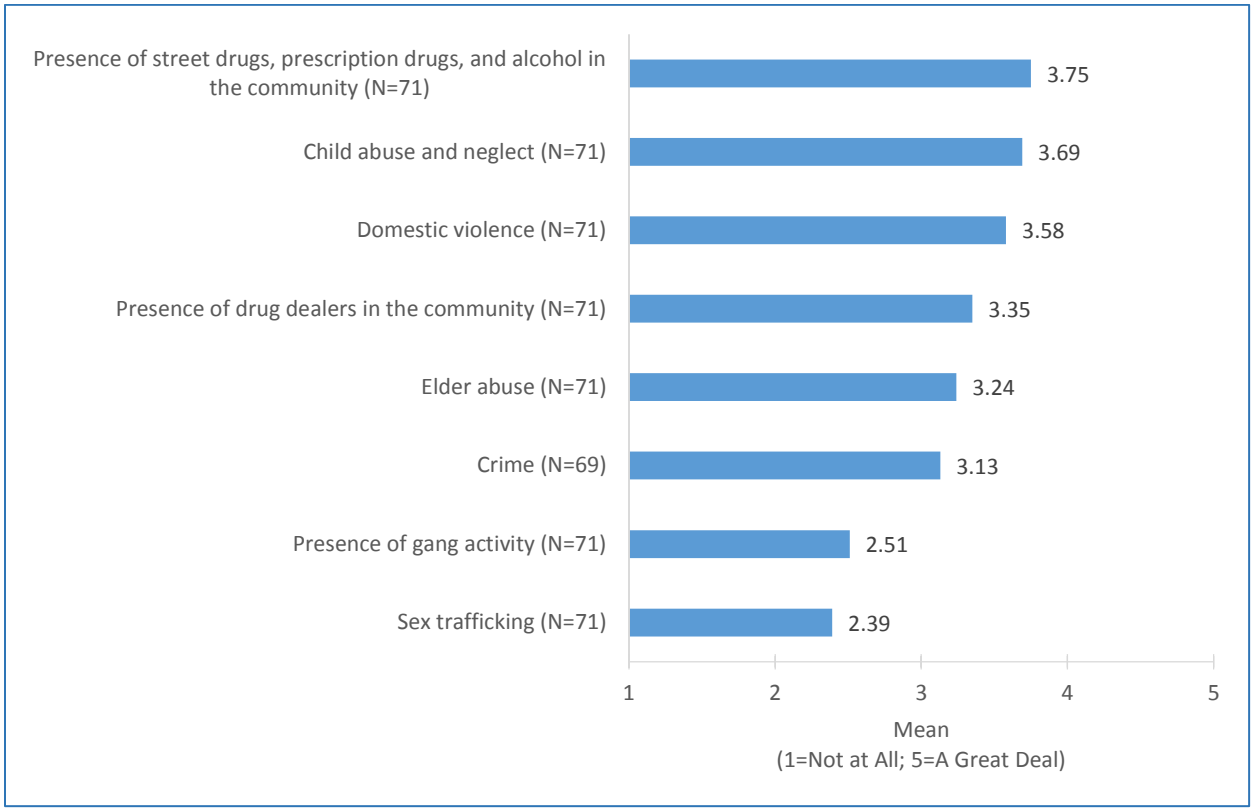


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

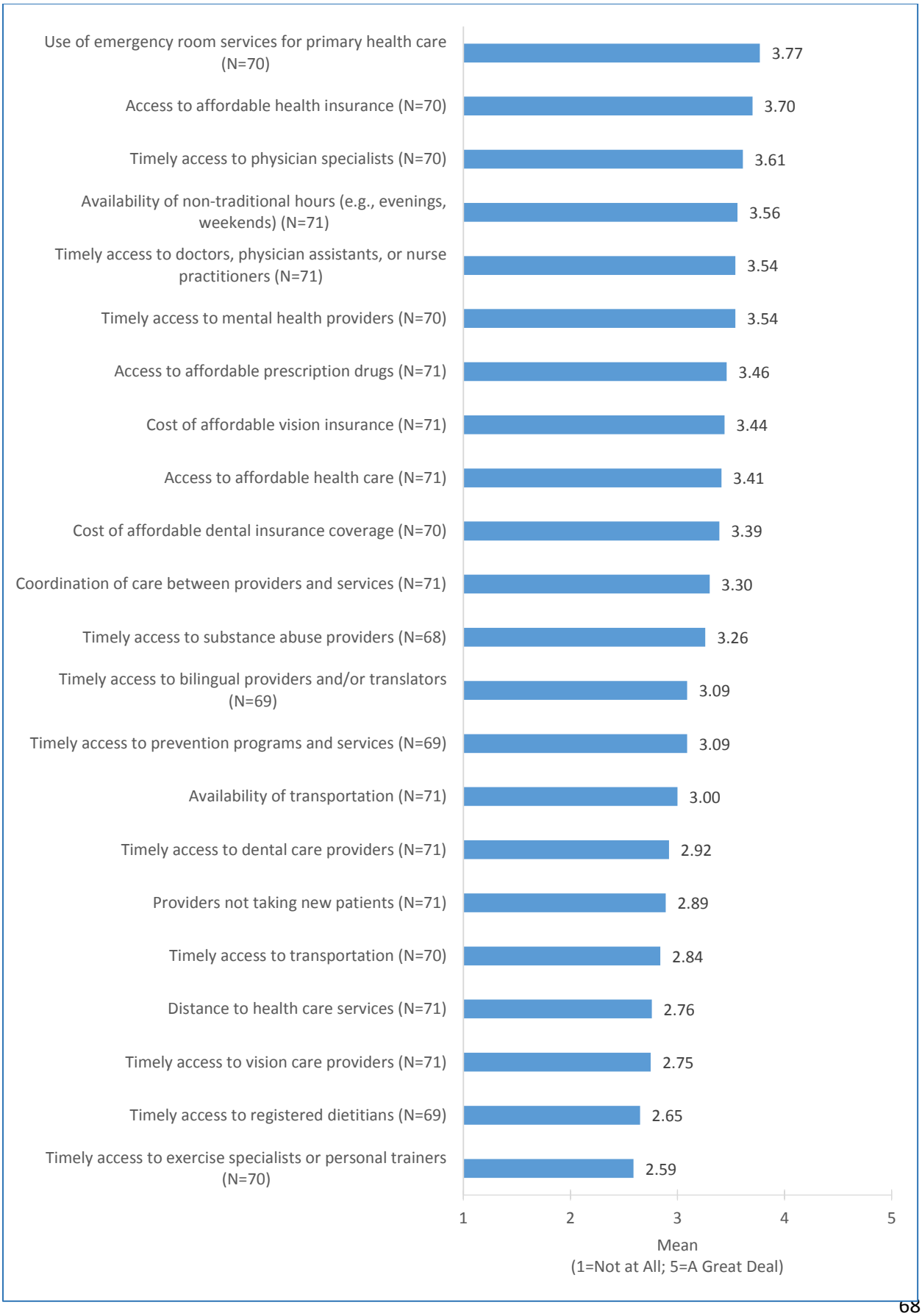
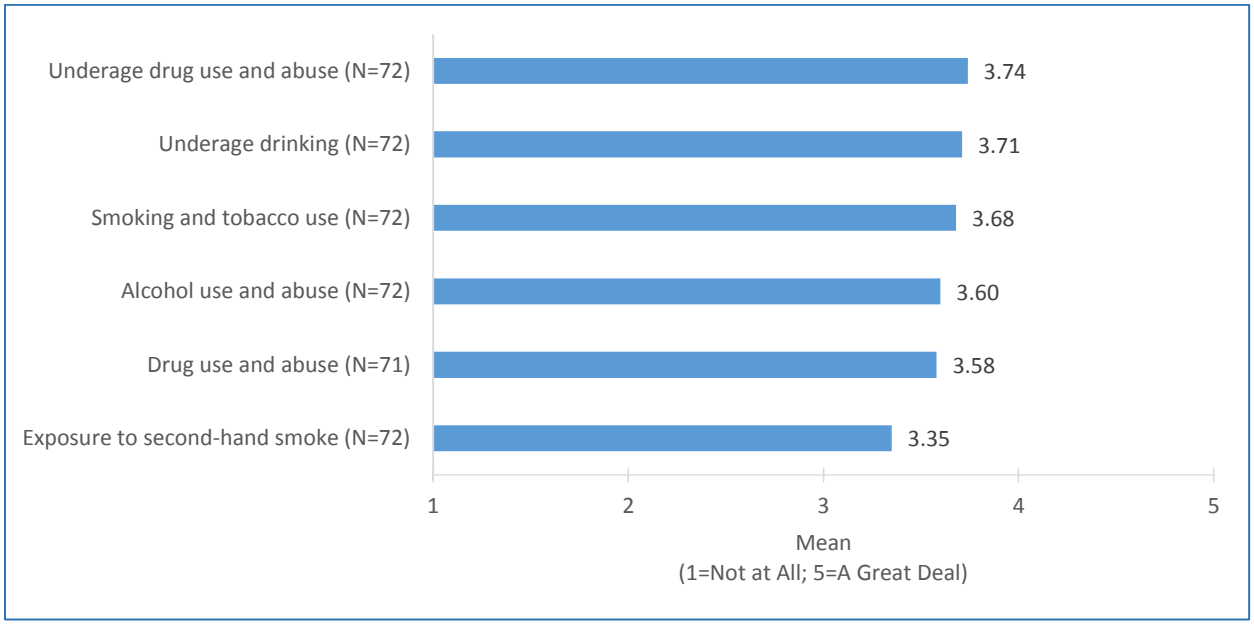

Use of emergency room services for primary health care (N=70)
3.77
Access to affordable health insurance (N=70)
3.70
Timely access to physician specialists (N=70)
3.61
Availability of non-traditional hours (e.g., evenings, weekends) (N=71)
3.56
Timely access to doctors, physician assistants, or nurse practitioners (N=71)
3.54
Timely access to mental health providers (N=70)
3.54
Access to affordable prescription drugs (N=71)
3.46
Cost of affordable vision insurance (N=71)
3.44
Access to affordable health care (N=71)
3.41
Cost of affordable dental insurance coverage (N=70)
3.39
Coordination of care between providers and services (N=71)
3.30
Timely access to substance abuse providers (N=68)
3.26
Timely access to bilingual providers and/or translators (N=69)
3.09
Timely access to prevention programs and services (N=69)
3.09
Availability of transportation (N=71)
3.00
Timely access to dental care providers (N=71)
2.92
Providers not taking new patients (N=71)
2.89
Timely access to transportation (N=70)
2.84
Distance to health care services (N=71)
2.76
Timely access to vision care providers (N=71)
2.75
Timely access to registered dietitians (N=69)
2.65
Timely access to exercise specialists or personal trainers (N=70)
2.59
1
2
3
4
5
Mean
(1=Not at All; 5=A Great Deal)

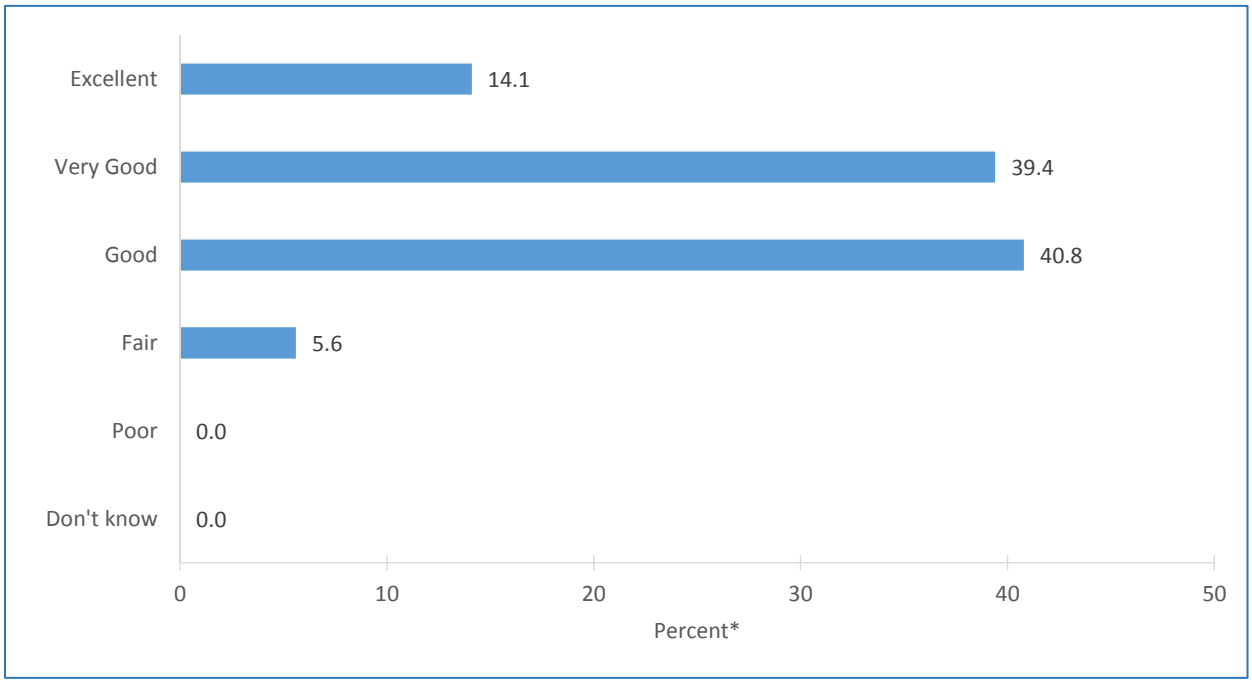
Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



General Health

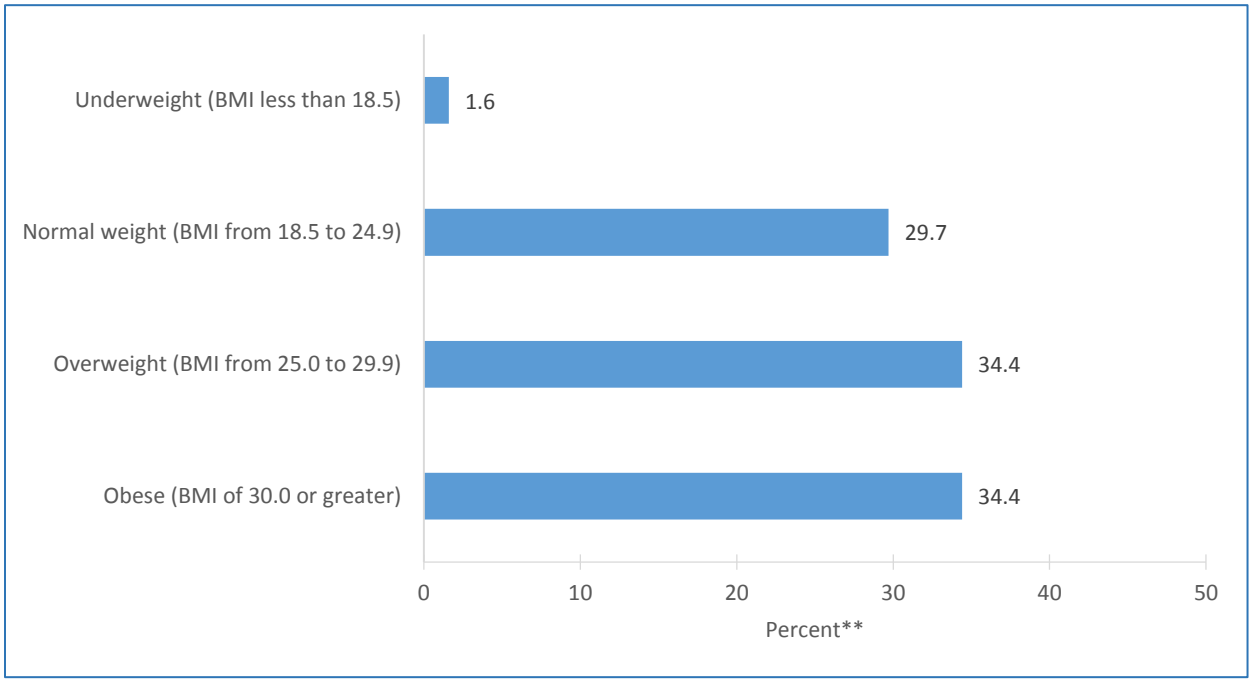
Figure 10. Respondents' rating of their health in general



N=71

*Percentages do not total 100.0 due to rounding.

Figure 11. Respondents' weight status based on the Body Mass Index (BMI*) scale

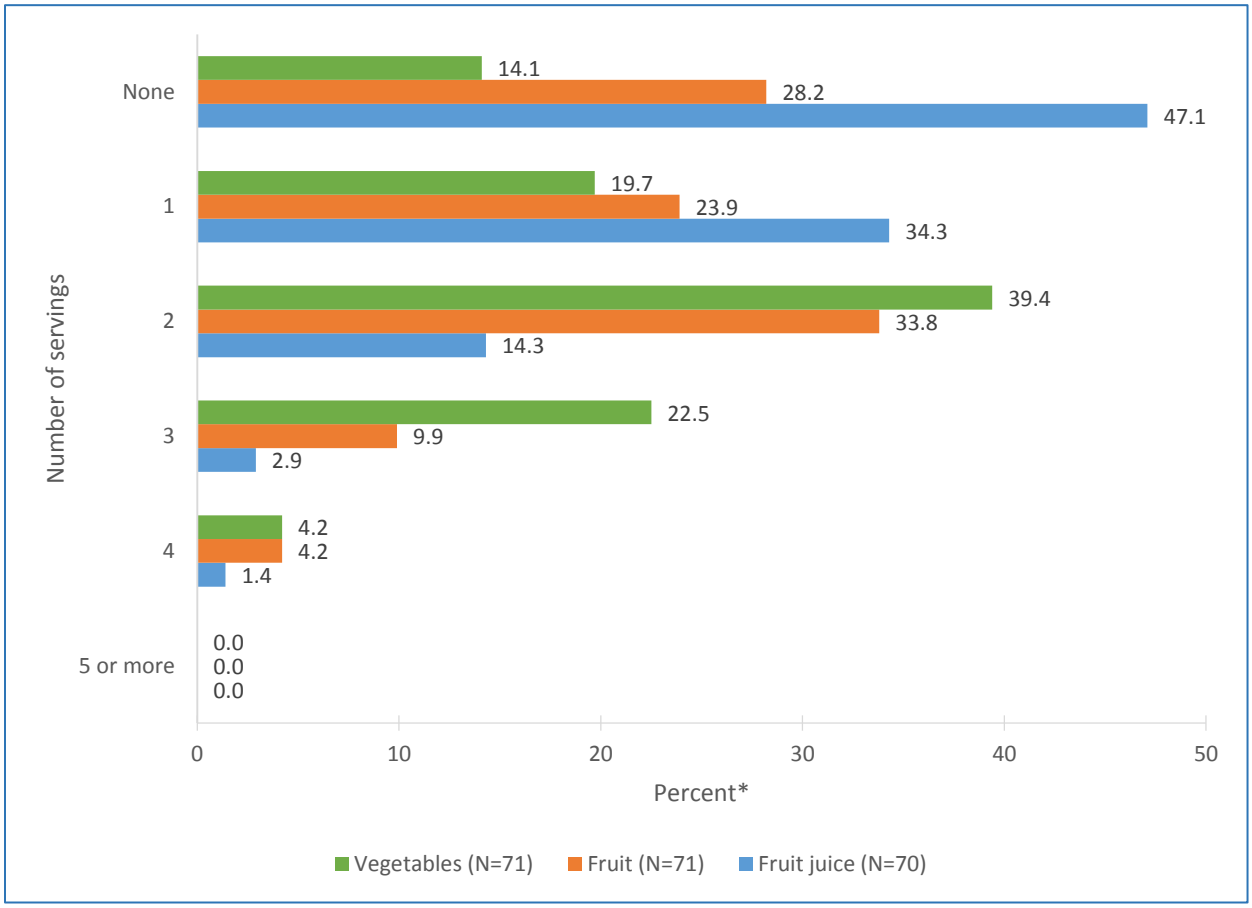


N=64

*For information about the BMI, visit the Centers for Disease Control and Prevention, *About BMI for Adults*, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/.

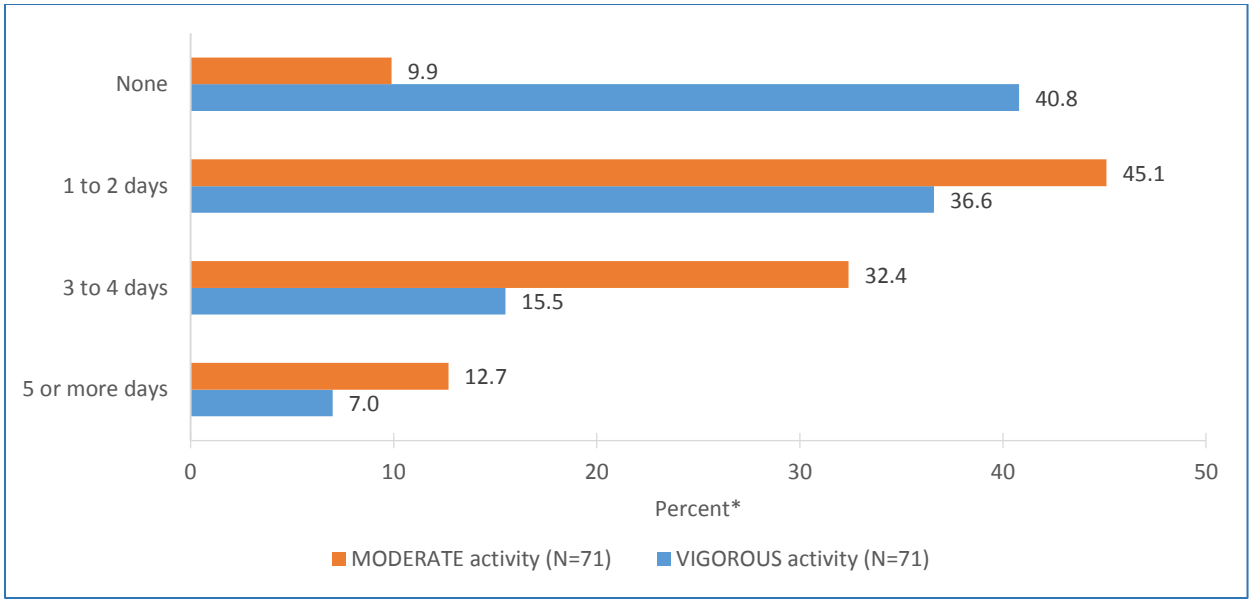
**Percentages do not total 100.0 due to rounding.

Figure 12. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday



*Percentages may not total 100.0 due to rounding.

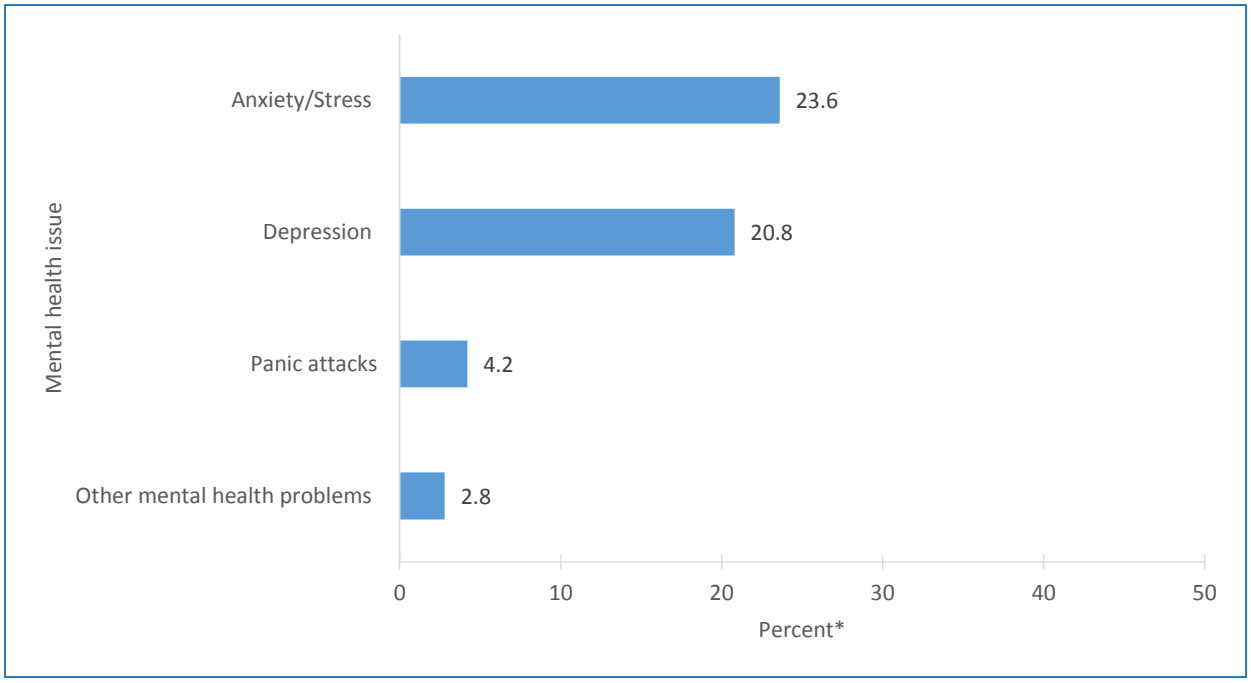
Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



*Percentages do not total 100.0 due to rounding.

Mental Health

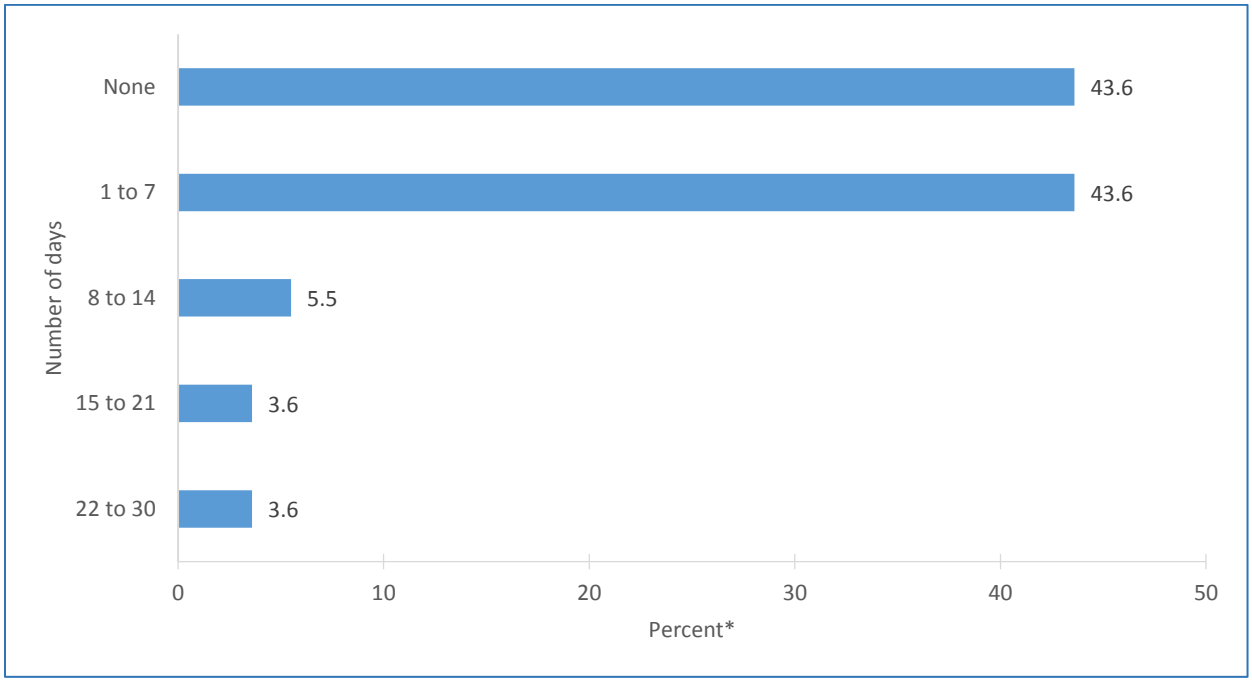
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=72

*Percentages do not total 100.0 due to multiple responses.

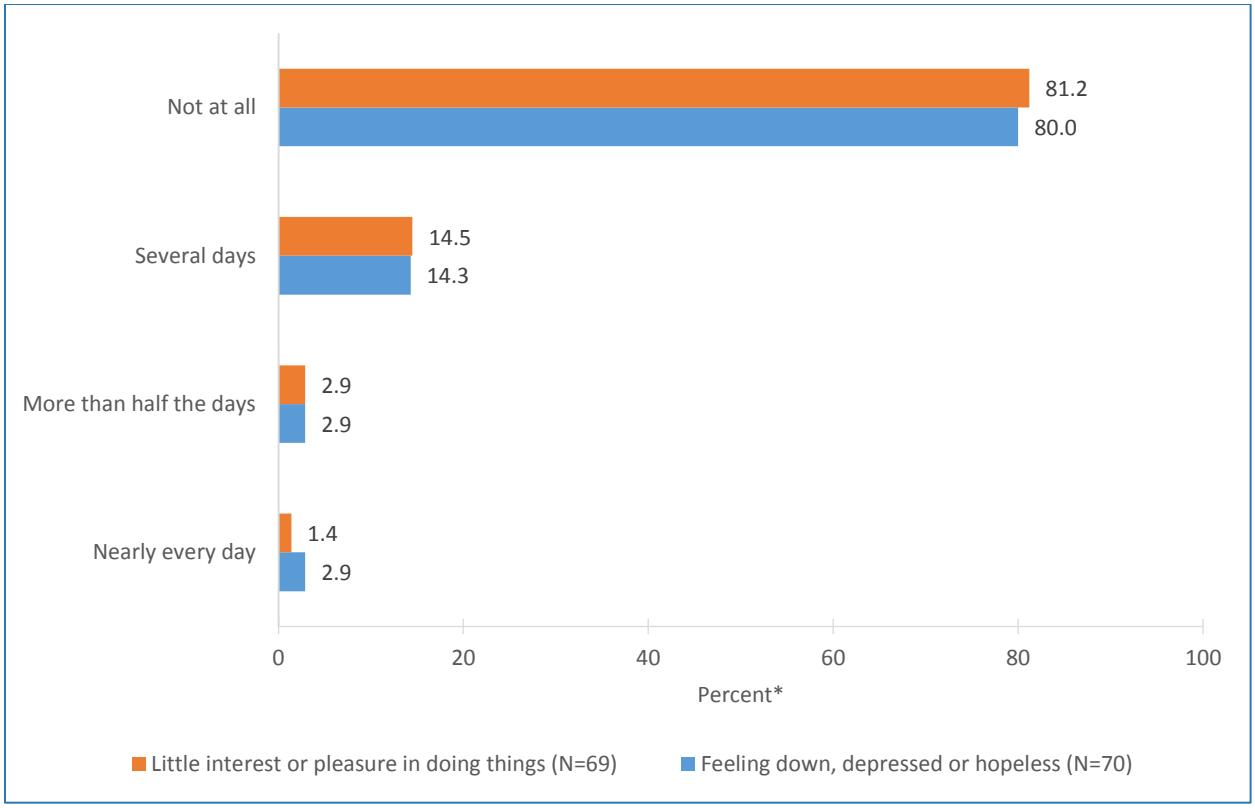
Figure 15. Number of days in the last month that respondents' mental health was not good



N=55

*Percentages do not total 100.0 due to rounding.

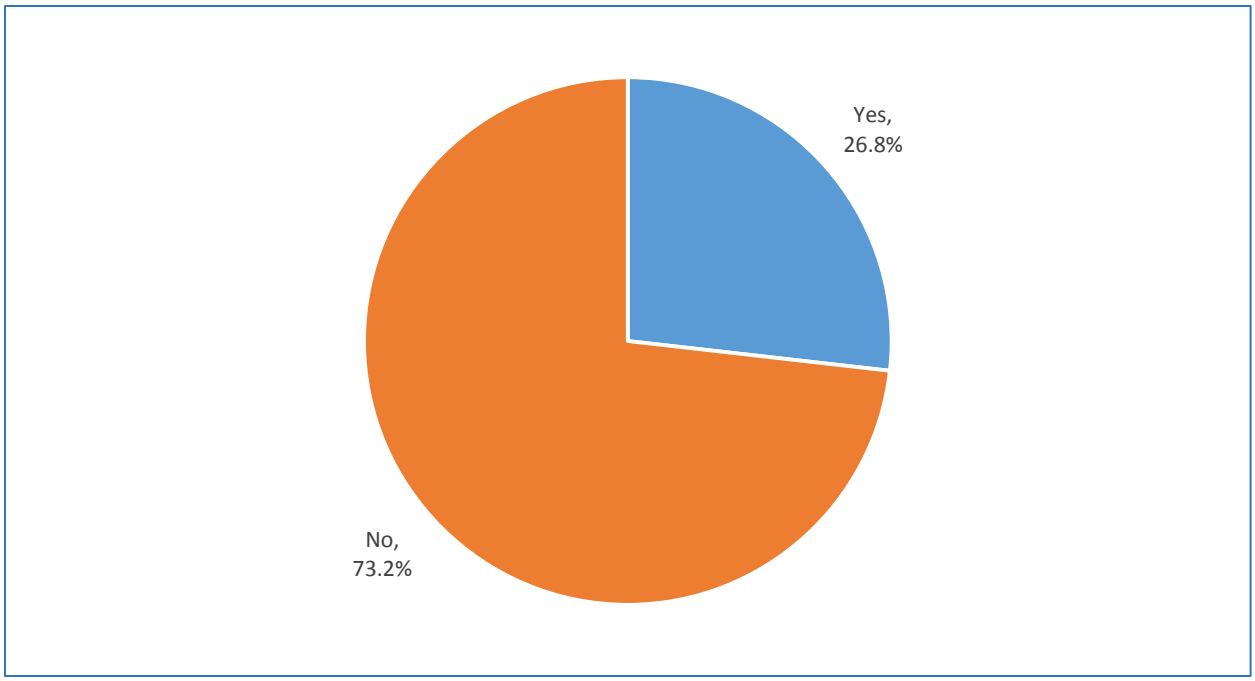
Figure 16. How often, over the past two weeks, respondents have been bothered by mental health issues



*Percentages may not total 100.0 due to rounding.

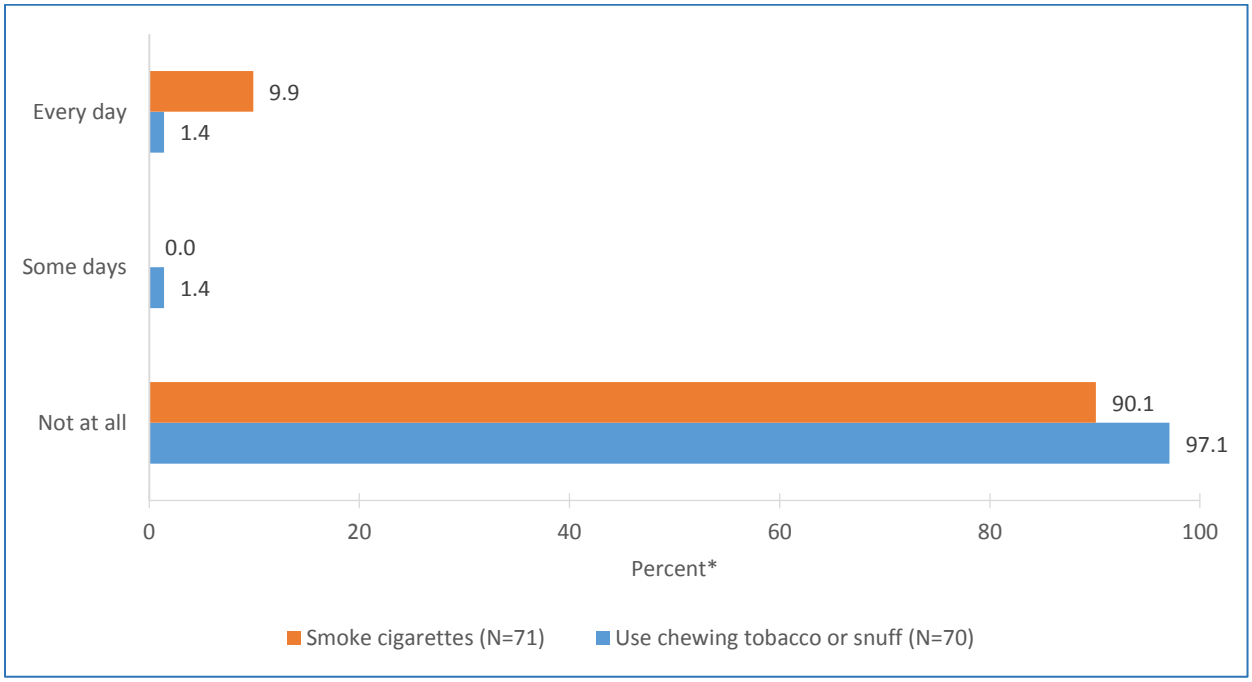
Tobacco Use

Figure 17. Whether respondents have smoked at least 100 cigarettes in their entire life



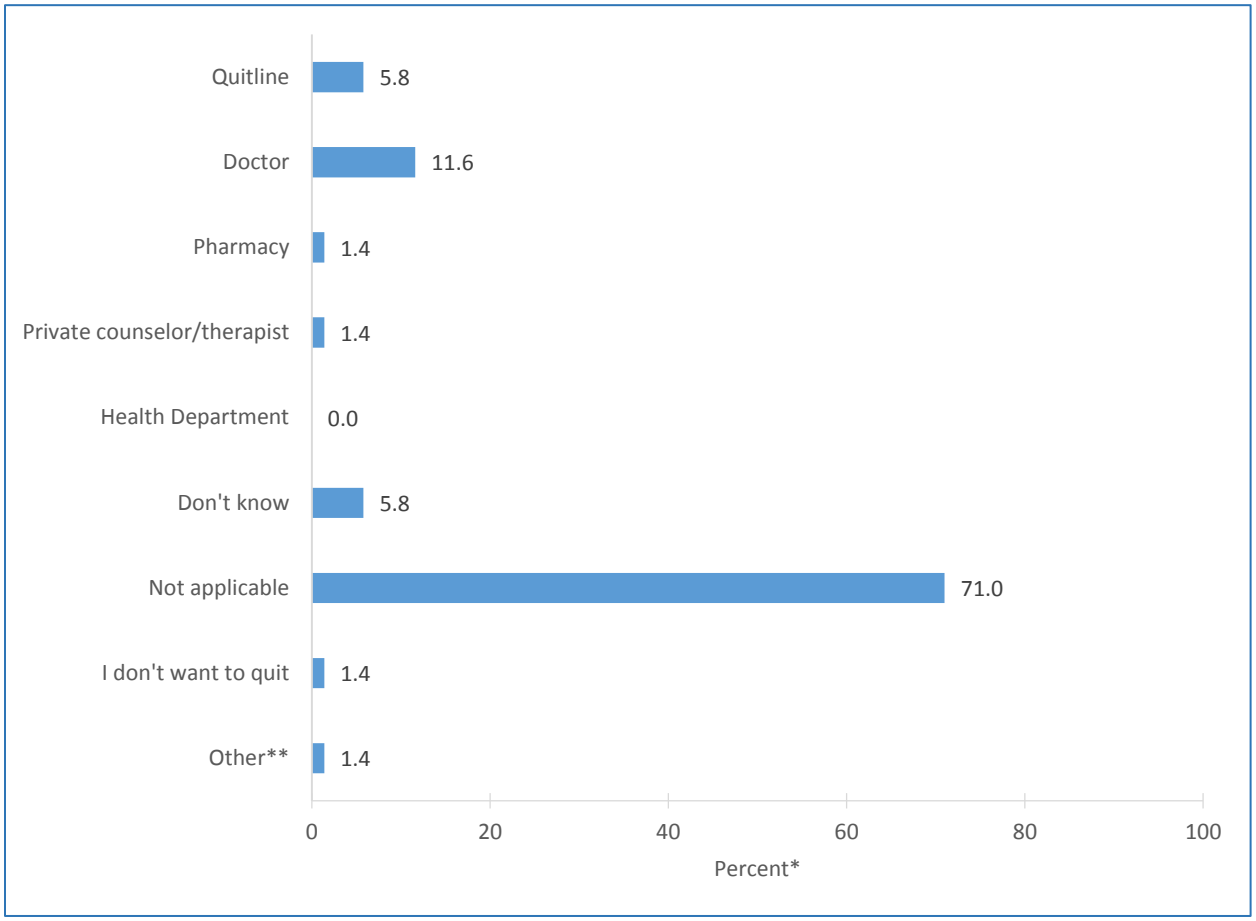
N=71

Figure 18. How often respondents currently smoke cigarettes and use chewing tobacco or snuff



*Percentages may not total 100.0 due to rounding.

Figure 19. Location respondents would first go if they wanted help to quit using tobacco



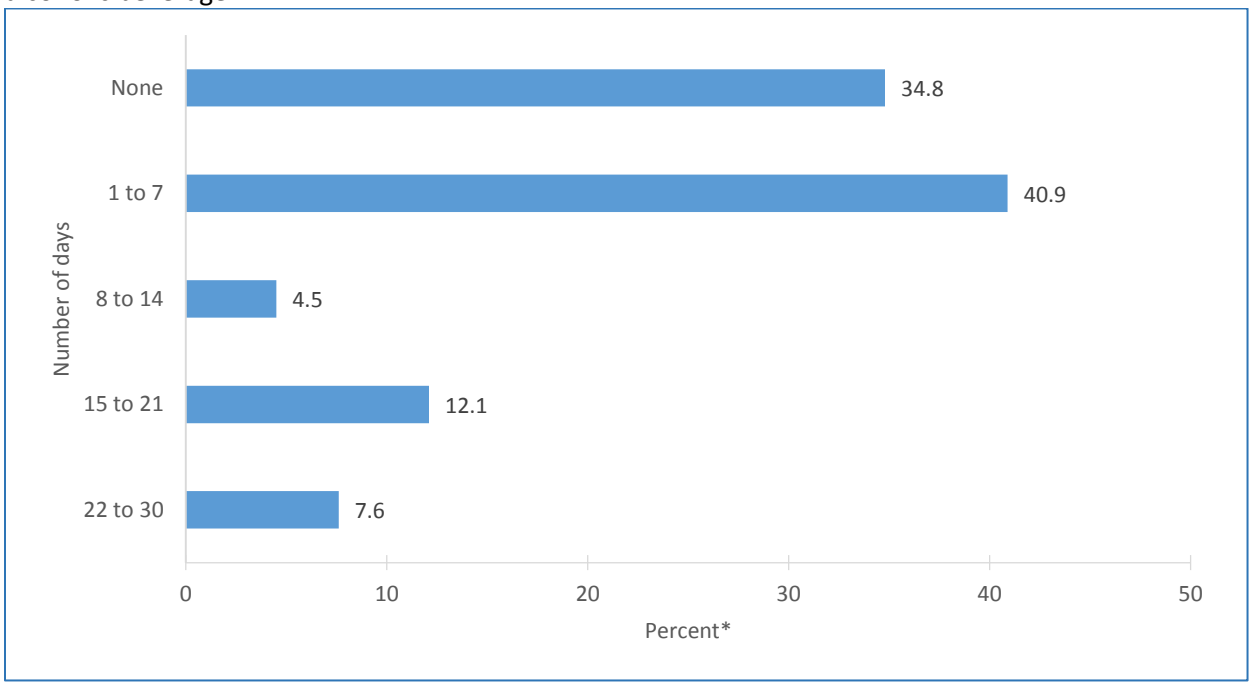
N=69

*Percentages do not total 100.0 due to rounding.

**Other response is “would do it myself”.

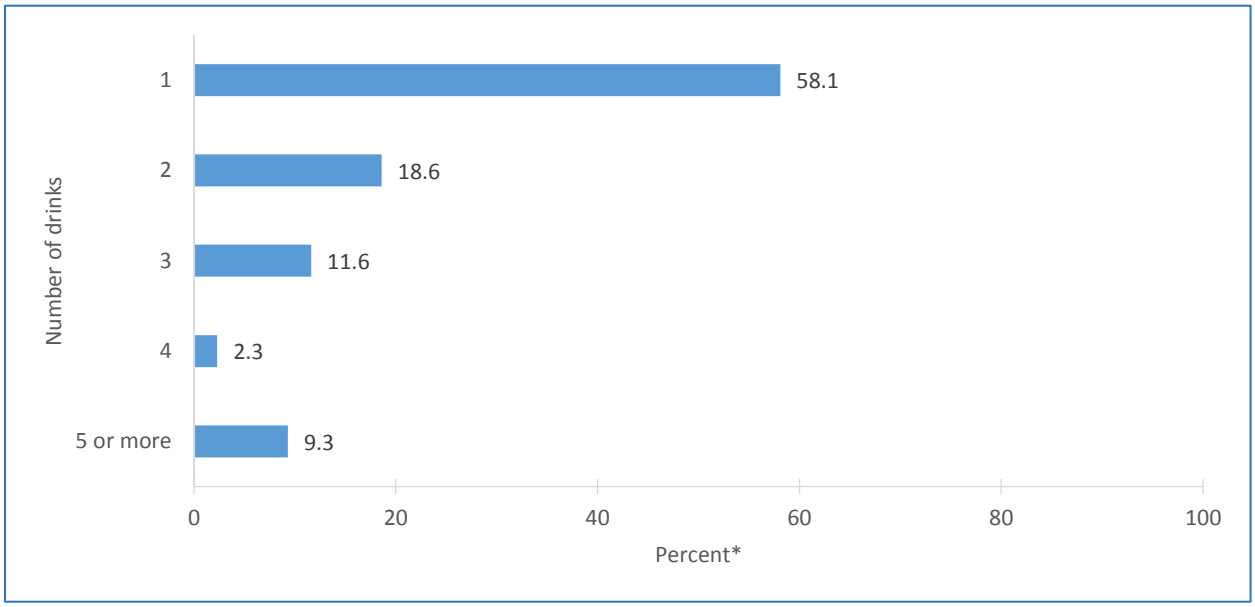
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

Figure 20. Number of days during the past month that respondents had at least one drink of any alcoholic beverage



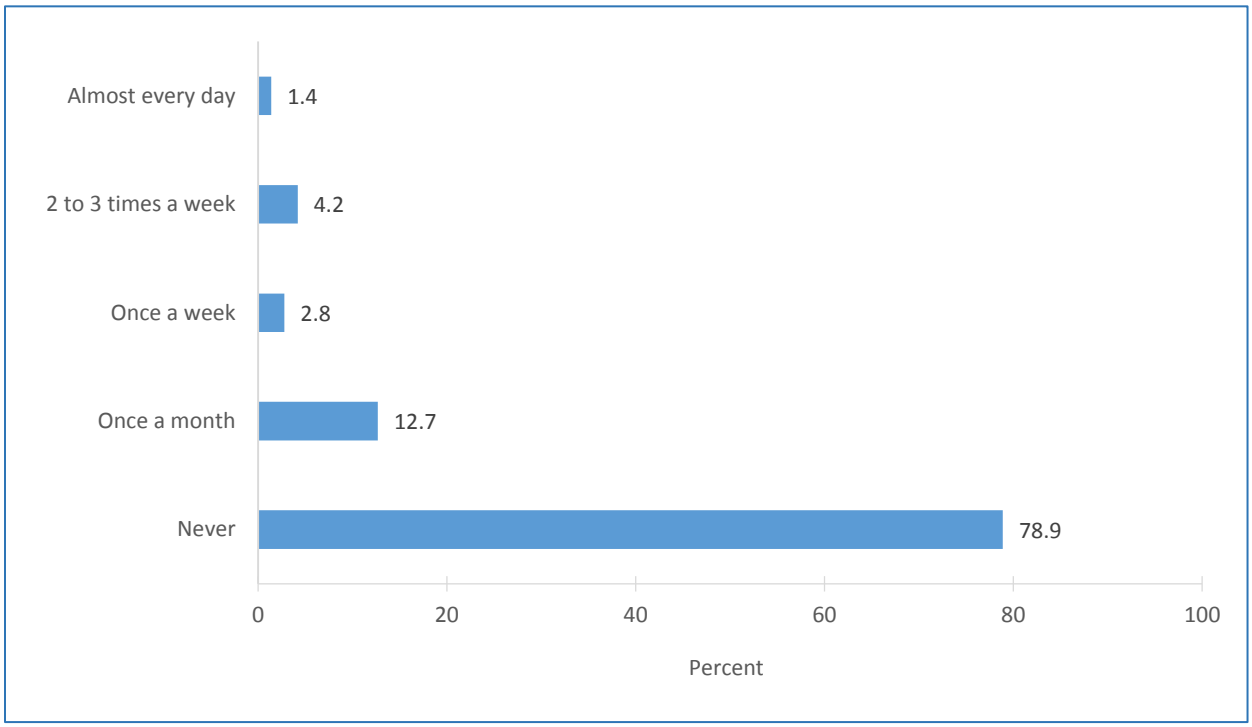
N=66 *Percentages do not total 100.0 due to rounding.

Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=43 *Percentages do not total 100.0 due to rounding.

Figure 22. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion



N=71

Figure 23. Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse

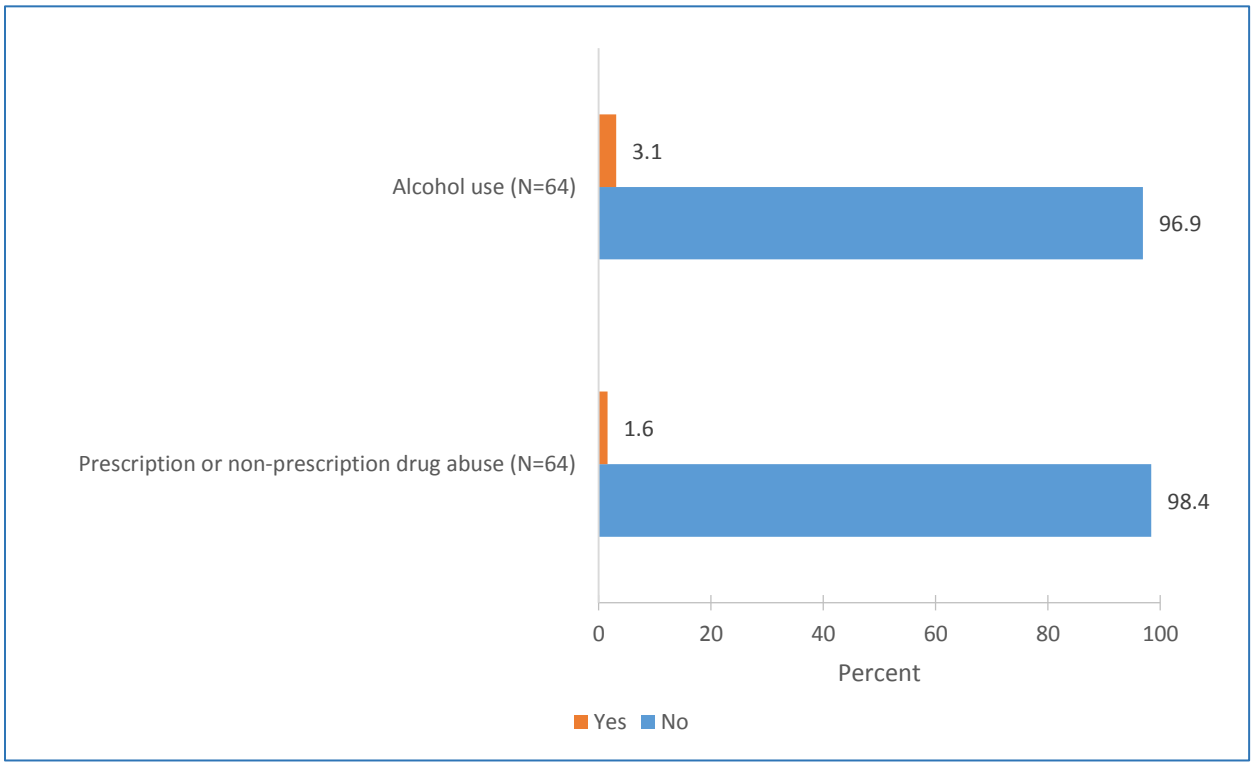


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

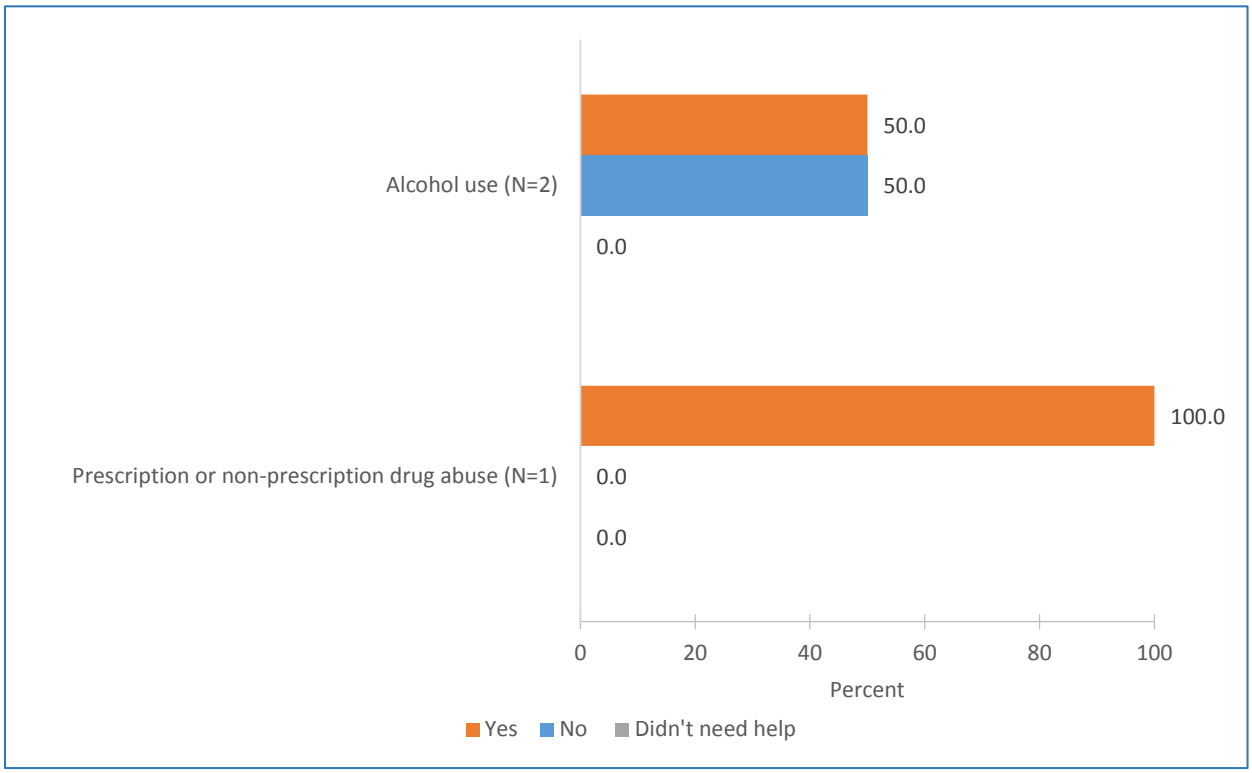
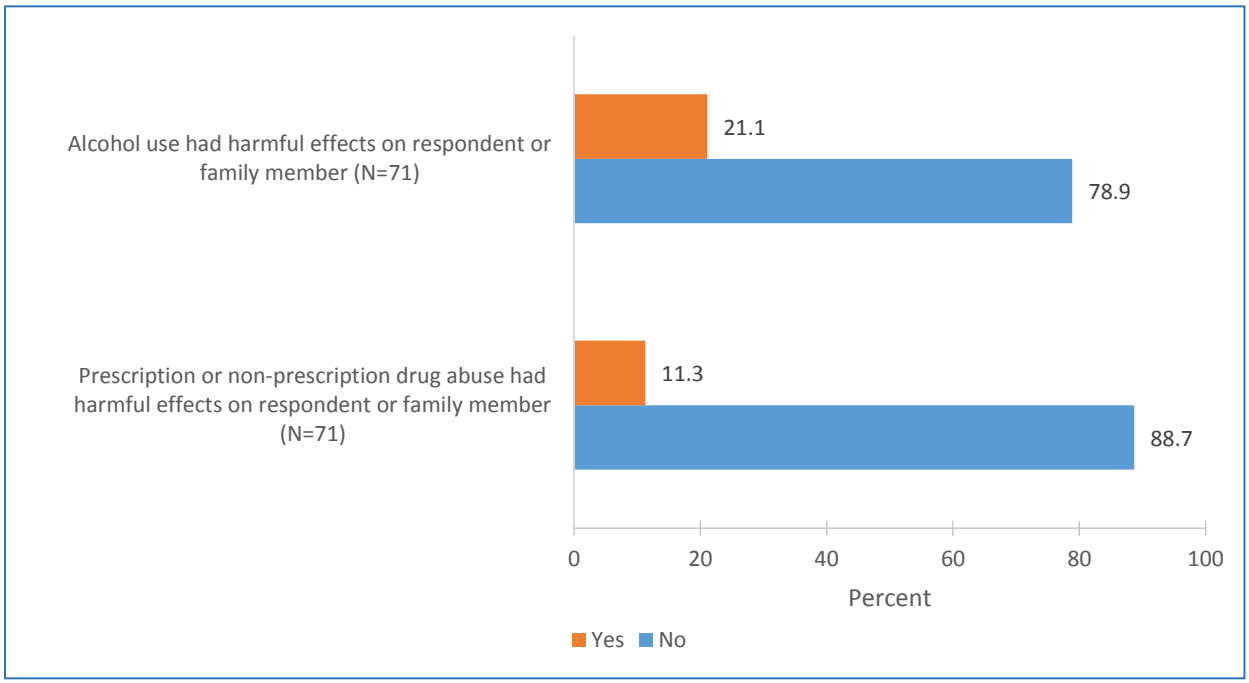


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

Table 1. Whether or not respondents have had preventive screenings in the past year, by type of screening

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=71)	78.9	21.1	100.0
Blood sugar screening (N=71)	54.9	45.1	100.0
Bone density test (N=69)	11.6	88.4	100.0
Cardiovascular screening (N=69)	20.3	79.7	100.0
Cholesterol screening (N=71)	54.9	45.1	100.0
Dental screening and X-rays (N=70)	74.3	25.7	100.0
Flu shot (N=71)	77.5	22.5	100.0
Glaucoma test (N=71)	39.4	60.6	100.0
Hearing screening (N=69)	10.1	89.9	100.0
Immunizations (N=69)	30.4	69.6	100.0
Pelvic exam (N=47 Females)	51.1	48.9	100.0
STD (N=69)	10.1	89.9	100.0
Vascular screening (N=68)	11.8	88.2	100.0
CANCER SCREENINGS			
Breast cancer screening (N= 46 Females)	63.0	37.0	100.0
Cervical cancer screening (N=47 Females)	40.4	59.6	100.0
Colorectal cancer screening (N=69)	20.3	79.7	100.0
Prostate cancer screening (N=23 Males)	21.7	78.3	100.0
Skin cancer screening (N=69)	14.5	85.5	100.0

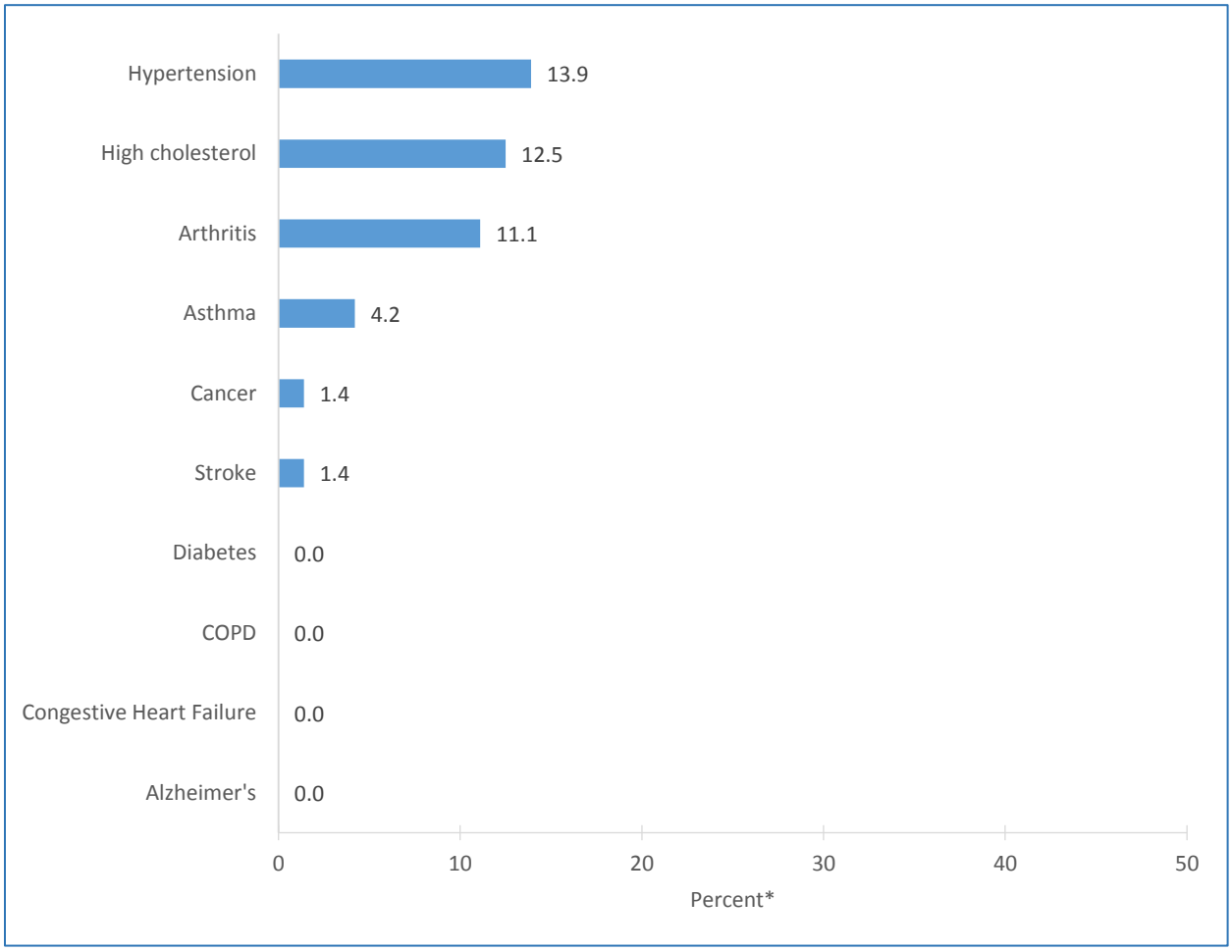
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=15)	60.0	33.3	6.7	0.0	0.0	0.0	0.0
Blood sugar screening (N=32)	43.8	37.5	3.1	0.0	0.0	0.0	9.4
Bone density test (N=61)	41.0	42.6	6.6	0.0	0.0	0.0	4.9
Cardiovascular screening (N=55)	40.0	49.1	3.6	0.0	0.0	0.0	3.6
Cholesterol screening (N=32)	43.8	37.5	6.3	0.0	0.0	0.0	9.4

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Dental screening and X-rays (N=18)	38.9	5.6	16.7	5.6	0.0	0.0	38.9
Flu shot (N=16)	25.0	12.5	6.3	0.0	0.0	0.0	50.0
Glaucoma test (N=43)	51.2	39.5	7.0	0.0	0.0	0.0	2.3
Hearing screening (N=62)	56.5	32.3	3.2	0.0	0.0	0.0	4.8
Immunizations (N=48)	52.1	25.0	4.2	0.0	0.0	0.0	10.4
Pelvic exam (N=23 Females)	47.8	21.7	0.0	0.0	0.0	0.0	17.4
STD (N=62)	69.4	11.3	1.6	0.0	0.0	0.0	6.5
Vascular screening (N=60)	53.3	35.0	5.0	0.0	0.0	0.0	5.0
CANCER SCREENINGS							
Breast cancer screening (N=17 Females)	70.6	11.8	5.9	0.0	0.0	0.0	17.6
Cervical cancer screening (N=28 Females)	46.4	17.9	0.0	0.0	0.0	0.0	35.7
Colorectal cancer screening (N=55)	58.2	21.8	3.6	1.8	0.0	0.0	16.4
Prostate cancer screening (N=18 Males)	55.6	22.2	5.6	0.0	0.0	0.0	11.1
Skin cancer screening (N=59)	49.2	28.8	5.1	0.0	0.0	0.0	16.9

*Percentages may not total 100.0 due to multiple responses.

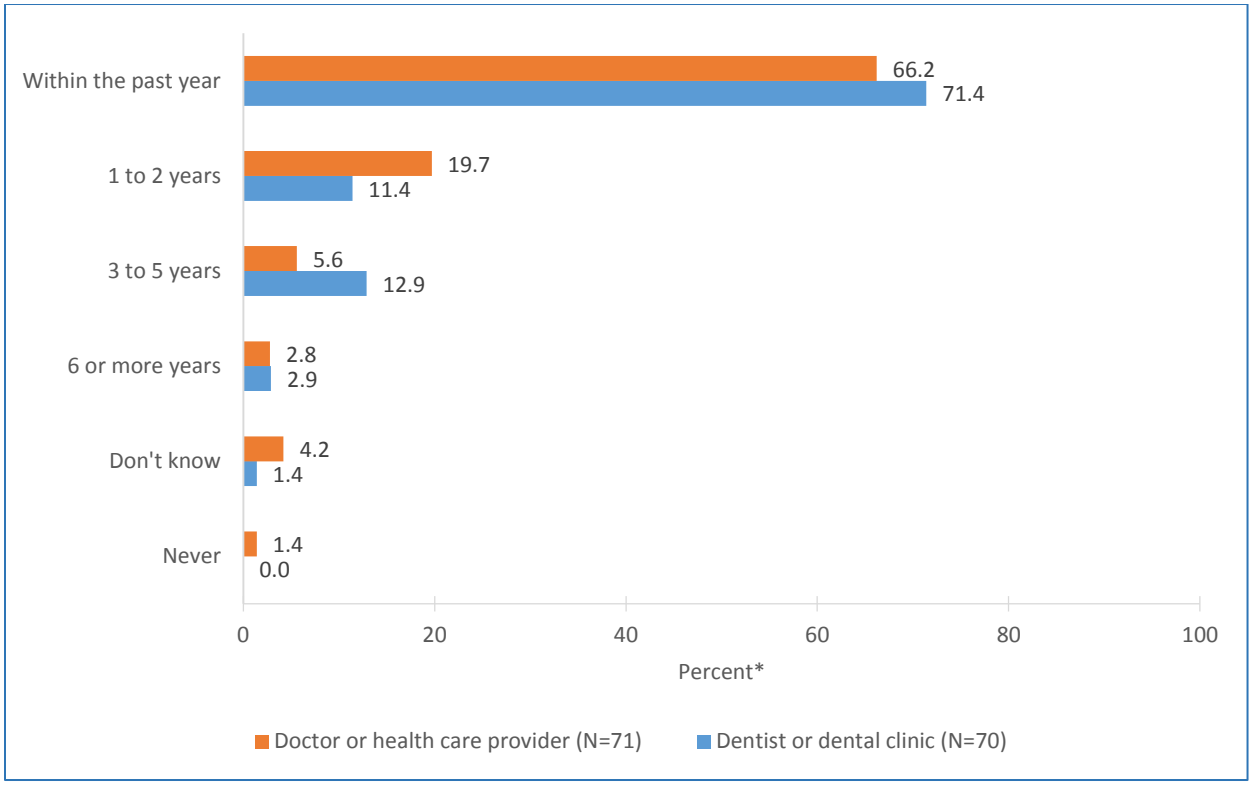
Figure 26. Whether respondents have any of the following chronic diseases



N=72

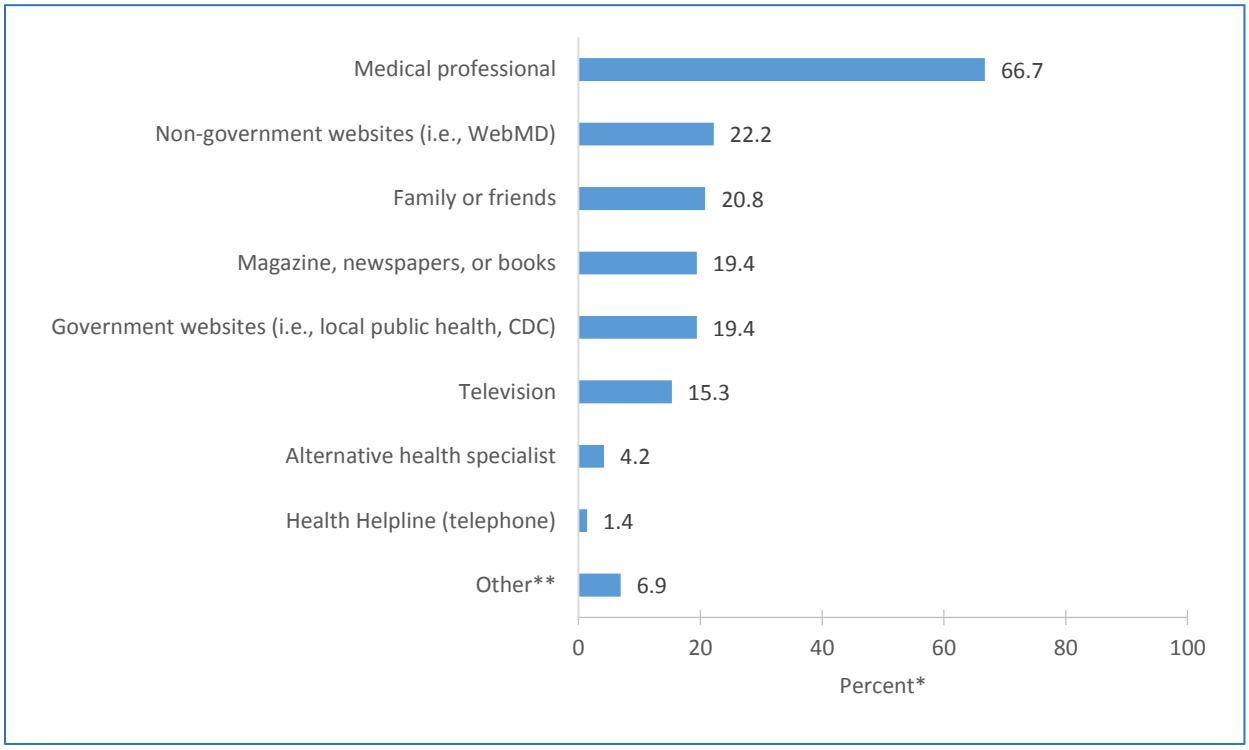
*Percentages do not total 100.0 due to multiple responses.

Figure 27. Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason



*Percentages may not total 100.0 due to rounding.

Figure 28. Where respondents get most of their health information

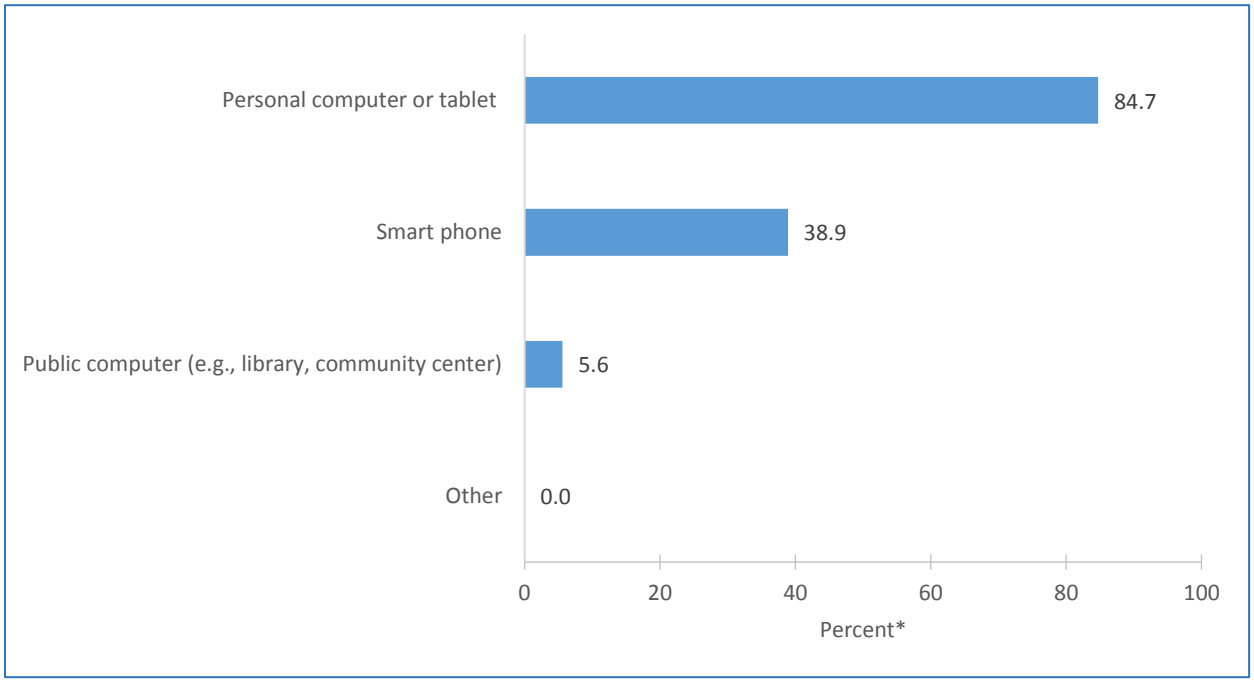


N=72

*Percentages do not total 100.0 due to multiple responses.

**Other responses include “conferences”, “go to the doctor for information”, “I’m a nurse”, “my self-study”, and “work”.

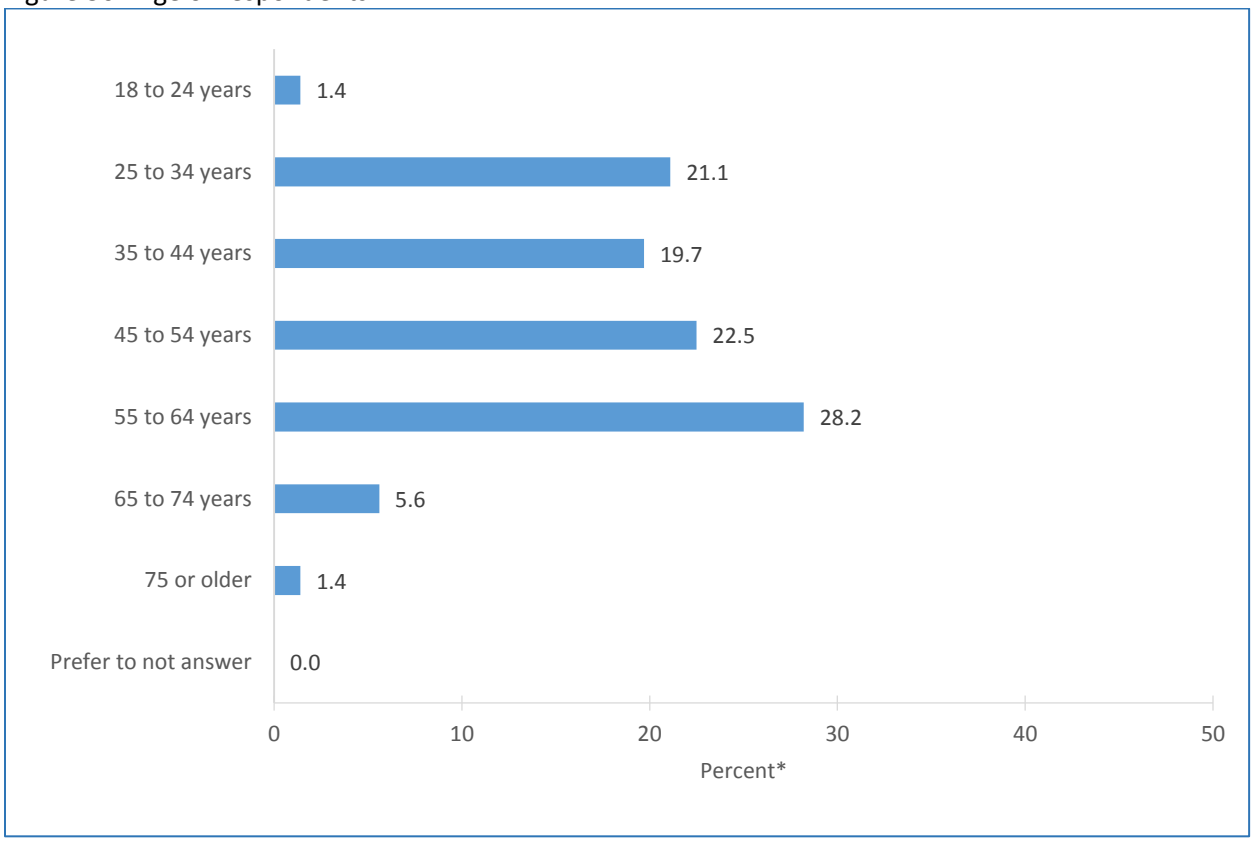
Figure 29. Best way for respondents to access technology for health information



N=72 *Percentages do not total 100.0 due to multiple responses.

Demographic Information

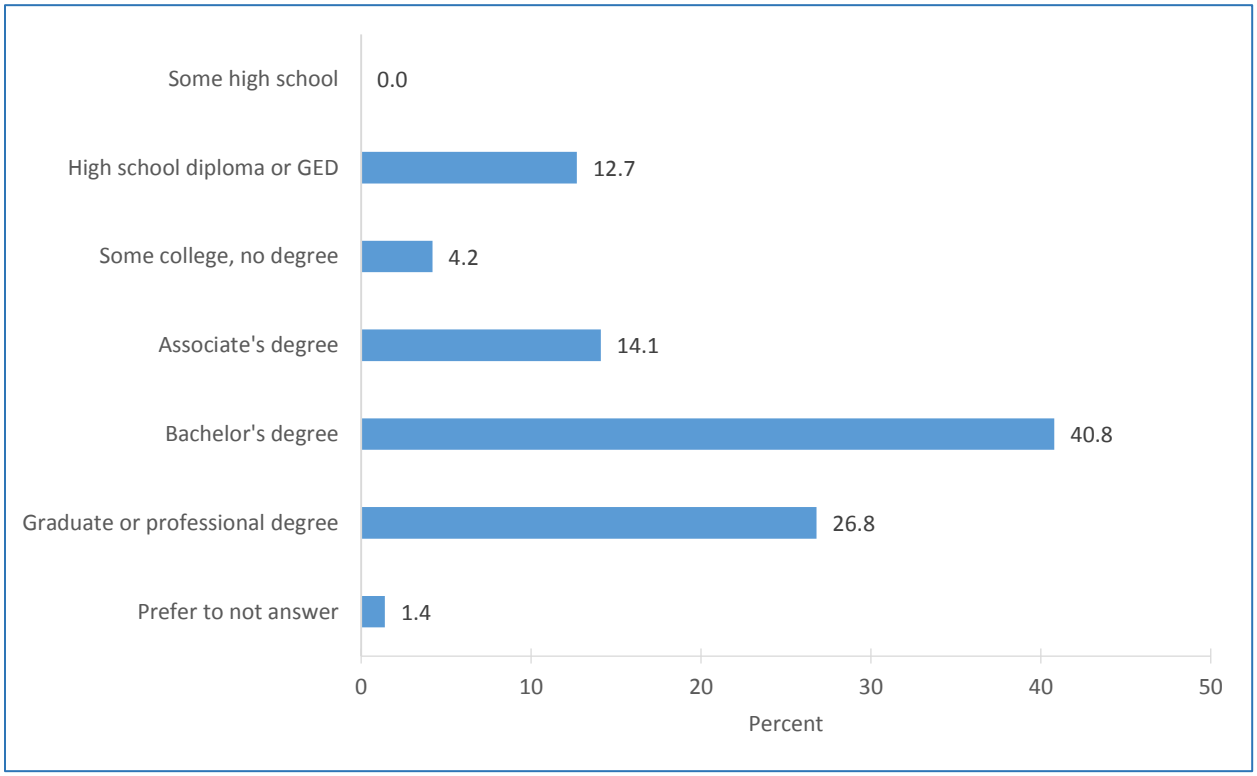
Figure 30. Age of respondents



N=71

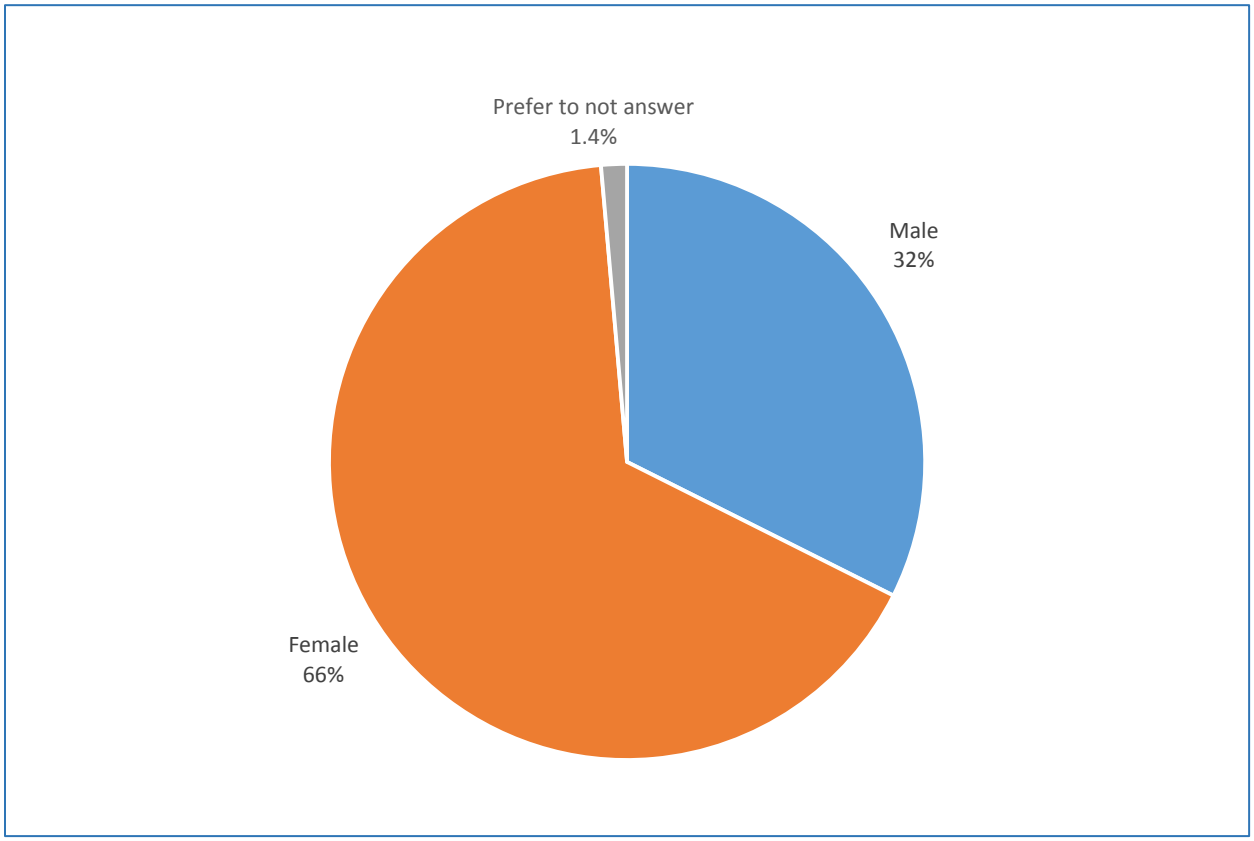
*Percentages do not total 100.0 due to rounding.

Figure 31. Highest level of education of respondents



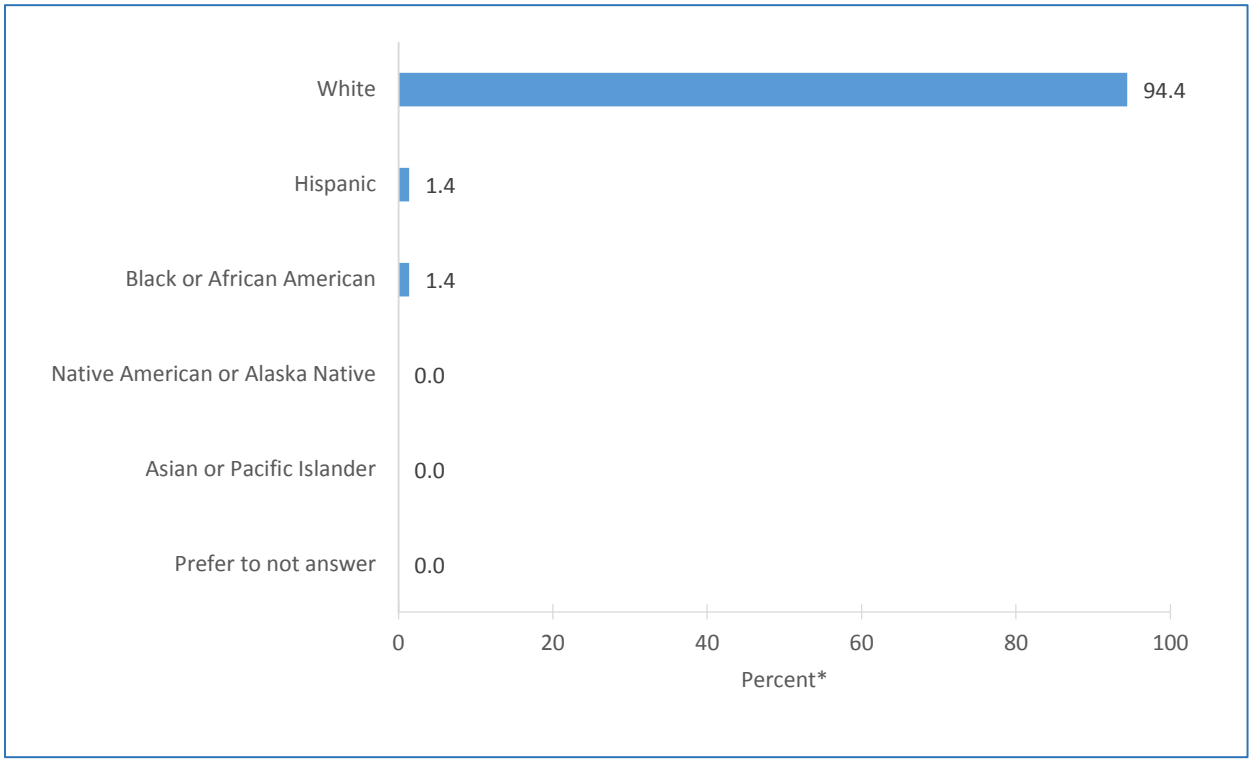
N=71

Figure 32. Gender of respondents



N=71

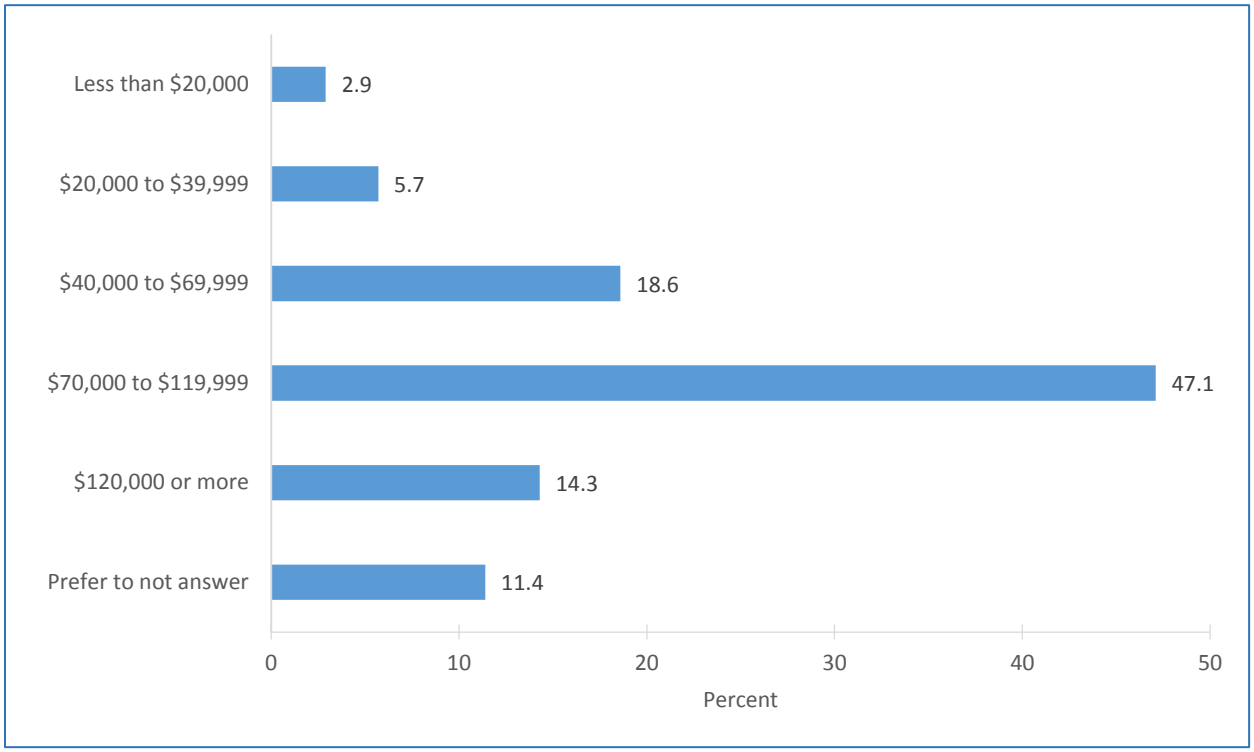
Figure 33. Race and ethnicity of respondents



N=72

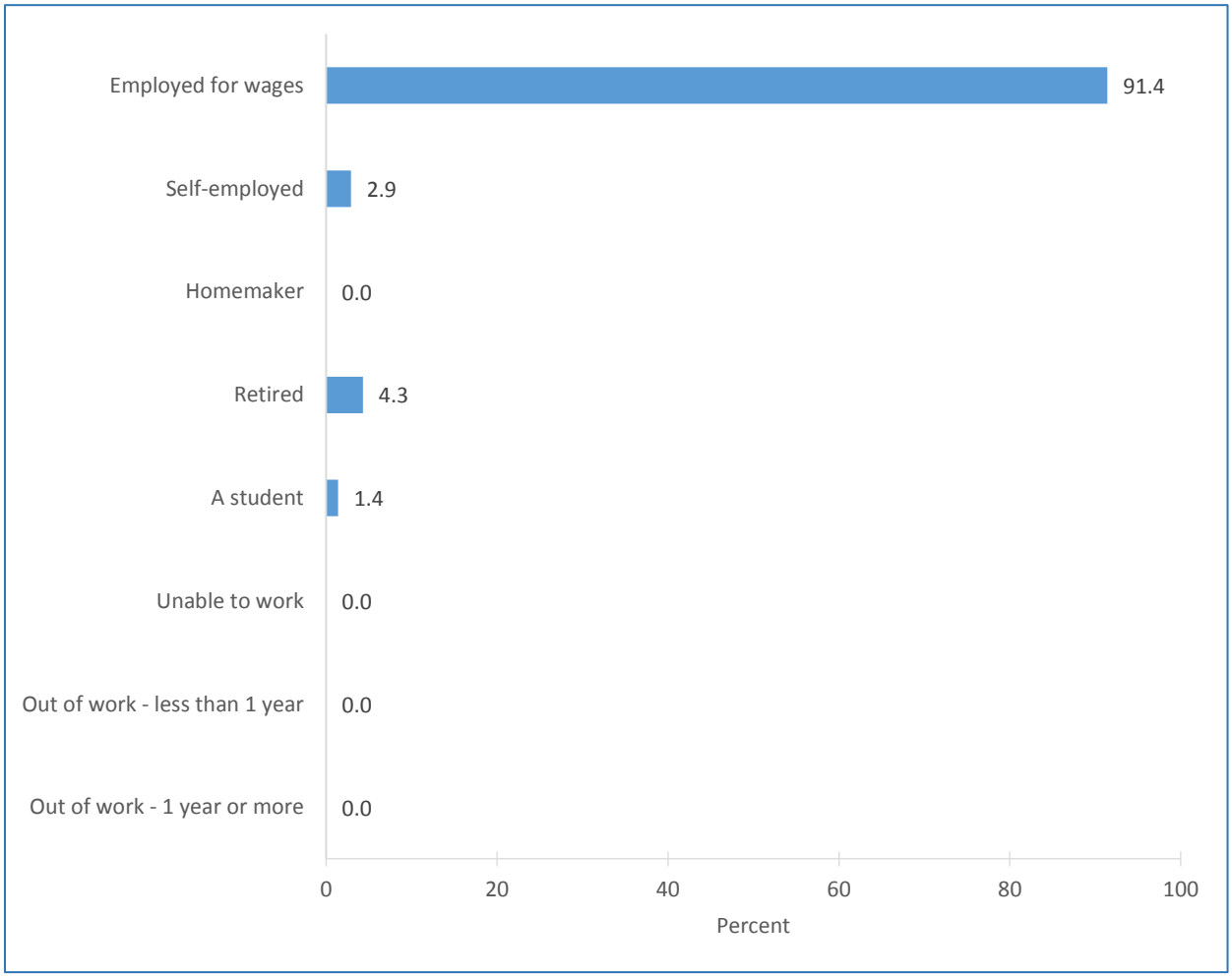
*Percentages do not total 100.0 due to multiple responses.

Figure 34. Annual household income of respondents



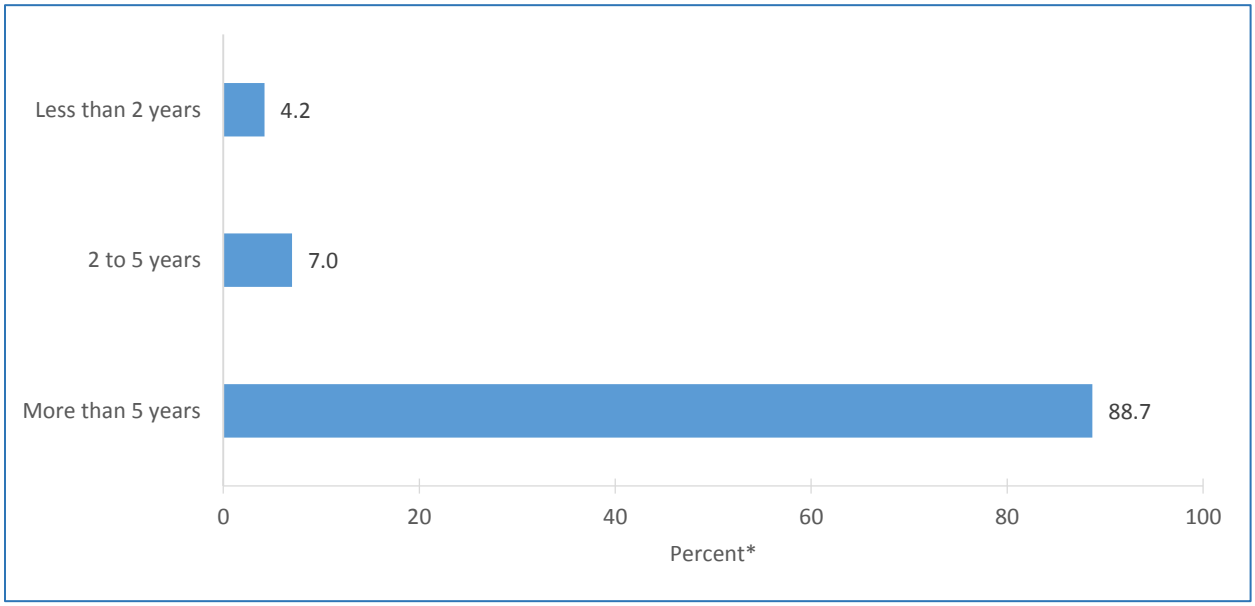
N=70

Figure 35. Employment status of respondents



N=70

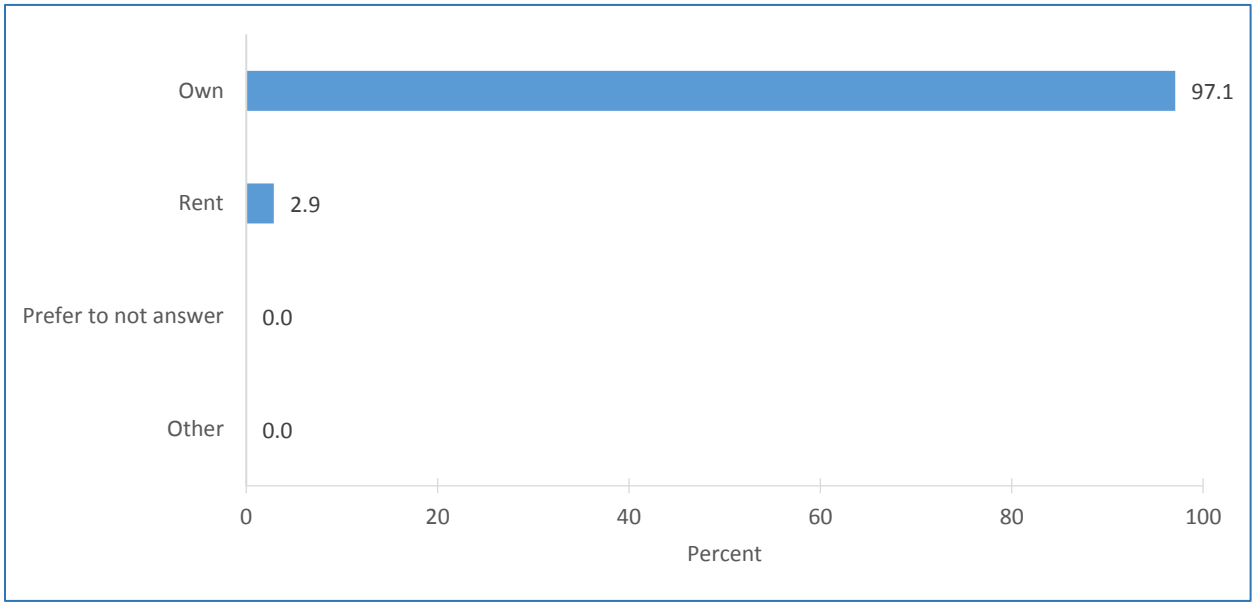
Figure 36. Length of time respondents have lived in their community



N=71

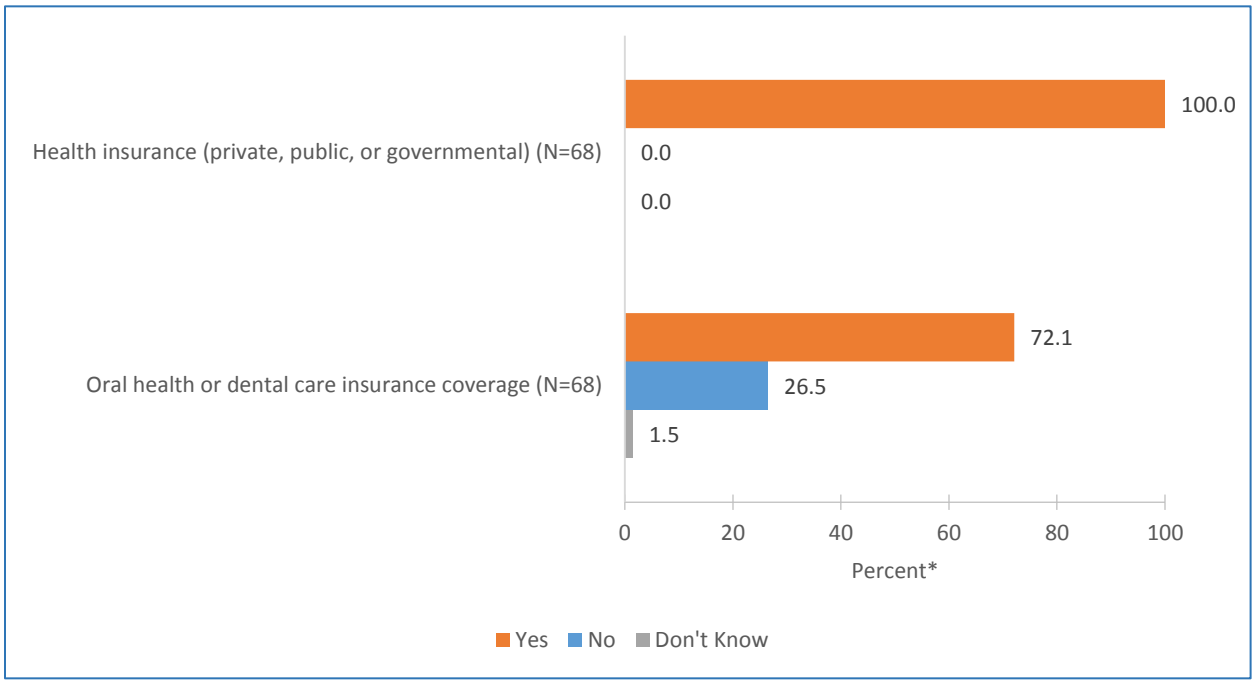
*Percentages do not total 100.0 due to rounding.

Figure 37. Whether respondents own or rent their home



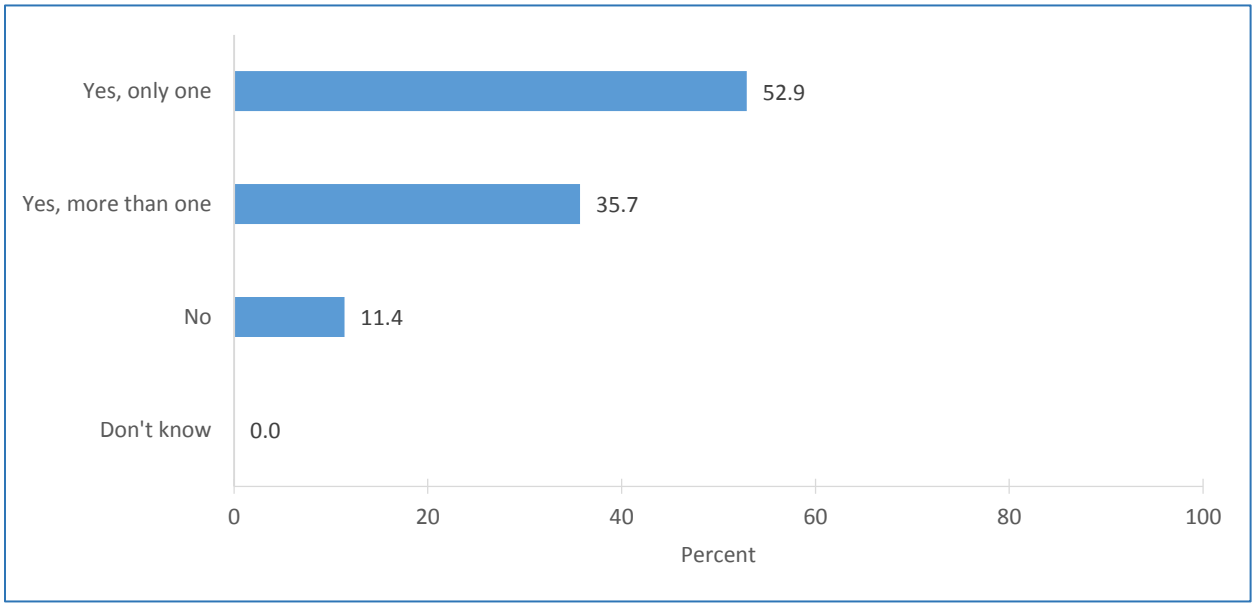
N=69

Figure 38. Whether respondents have health insurance (private, public, or governmental) and oral health or dental care insurance coverage



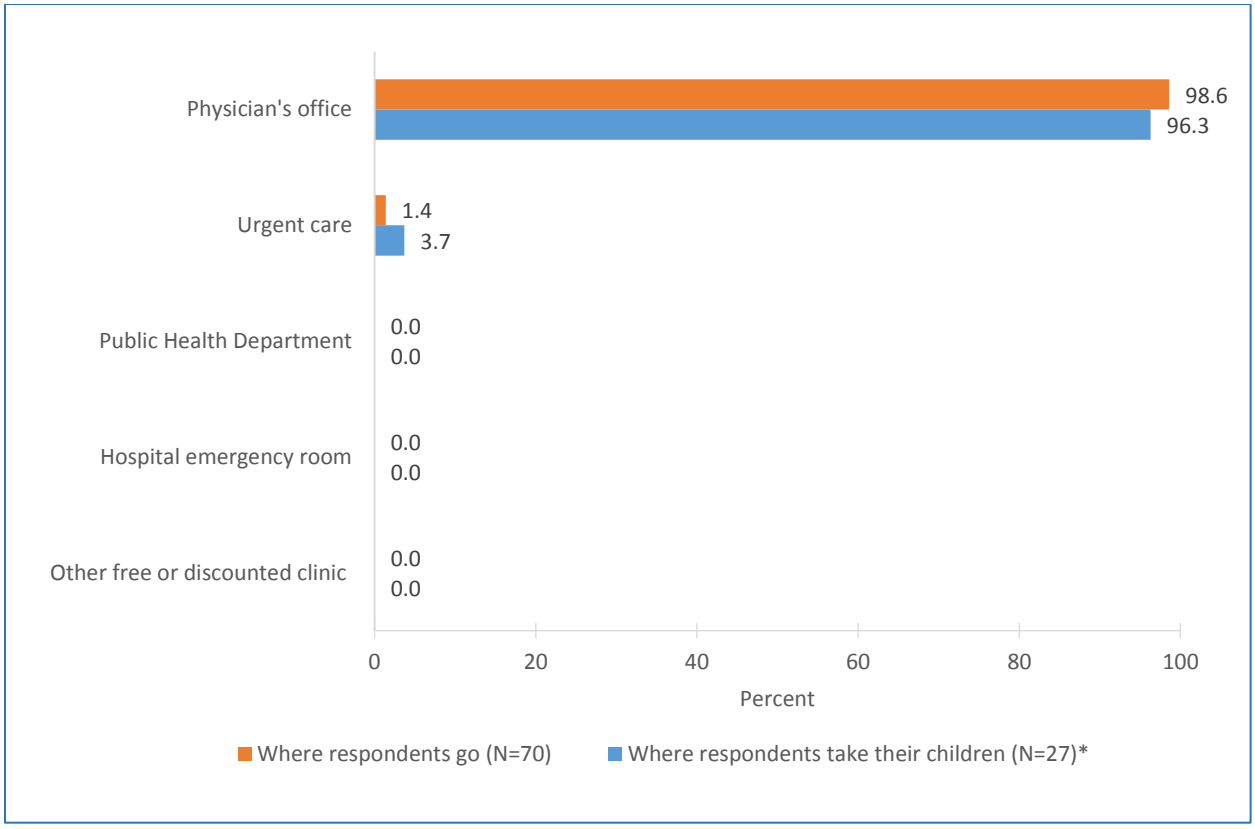
*Percentages may not total 100.0 due to rounding.

Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=70

Figure 40. Facilities that respondents go to most often when sick and take their children when they are sick



*Of respondents who have children younger than age 18 living in their household.

Figure 41. Number of children younger than 18 and number of adults age 65 or older living in respondents' household

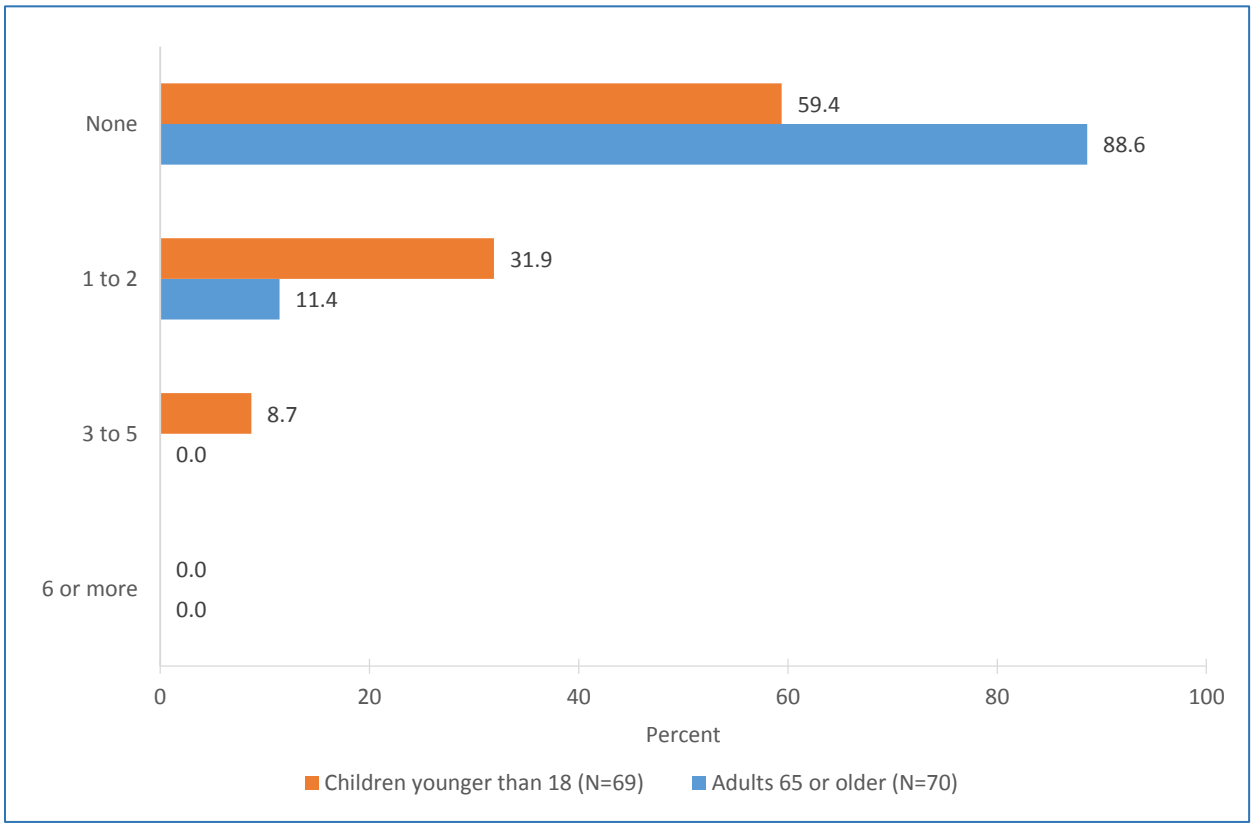
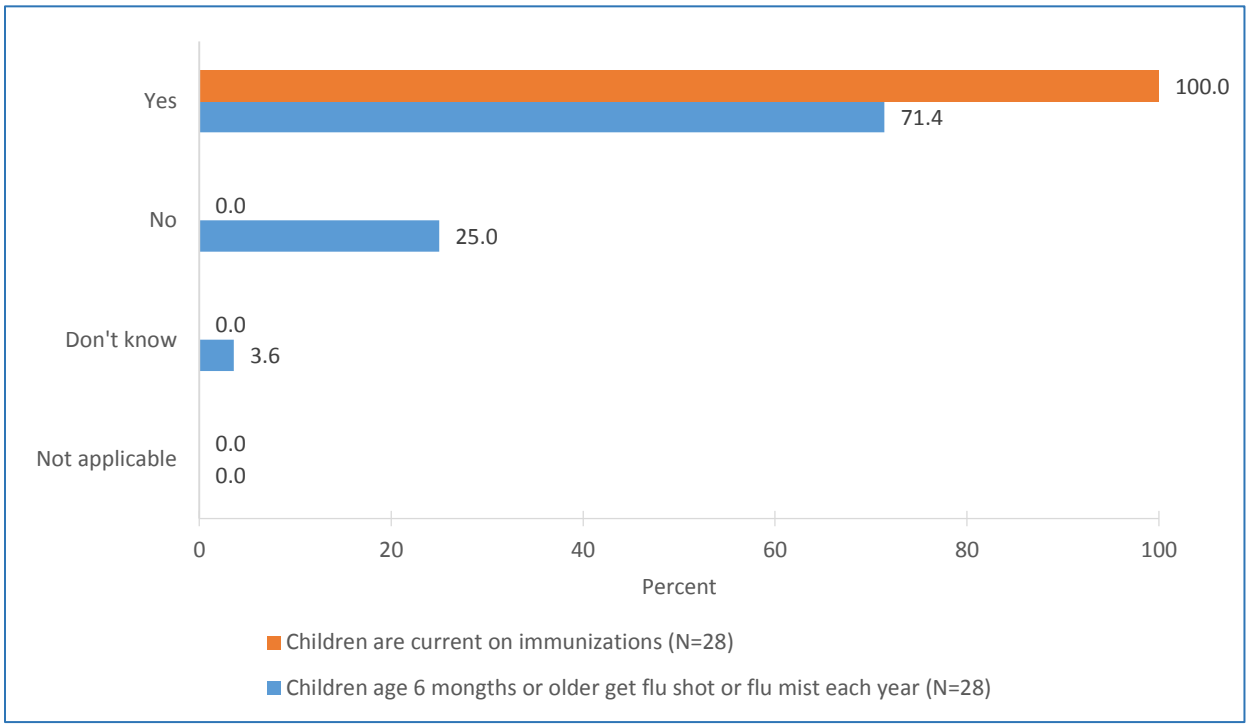


Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



*Of respondents who have children younger than age 18 living in their household.

Table 3. Zip code of respondents

Zip Code	Number of respondents
51201	54
51022	2
51238	2
51248	2
51346	2
51046	1
51234	1
51239	1
51245	1
51249	1

N=67

SANFORD HEALTH

Secondary Research

Definitions of Key Indicators

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in calculating the 2015 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County Health Rankings* web site for your state.

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

Contents:

* 95% confidence intervals are provided where applicable and available.

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

Measure	Data Elements	Description
Geographic identifiers	**FIPS**	Federal Information Processing Standard
	State	
	County	
Premature death	# Deaths	Number of deaths under age 75
	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)
Poor or fair health	Sample Size	Number of respondents
	% Fair/Poor	Percent 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)

Measure	Data Elements	Description
Poor physical health days	Sample Size	Number of respondents
	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	Sample Size	Number of respondents
	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.
	# Low Birthweight Births	Number of low birthweight births
	# Live births	Number of live births
	% LBW	Percentage of births with low birth weight (<2500g)
	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)
Adult smoking	Sample Size	Number of respondents
	% Smokers	Percentage of adults that reported currently smoking
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Adult obesity	**% Obese**	Percentage of adults that report BMI >= 30
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Food environment index	**Food Environment Index**	Indicator of access to healthy foods - 0 is worst, 10 is best
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Physical inactivity	**% Physically Inactive**	Percentage of adults that report no leisure-time physical activity
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Access to exercise opportunities	# With Access	Number of people with 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	Sample Size	Number of respondents
	% Excessive Drinking	Percentage of adults that report excessive drinking
	95% CI - Low	95% confidence interval reported by BRFSS

Measure	Data Elements	Description
	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
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases / Population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	Teen Births	Teen birth count, ages 15-19
	Teen Population	Female population, ages 15-19
	Teen Birth Rate	Teen births / females ages 15-19 * 1,000
	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)
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	(Number of PCP/population)*100,000
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	(Number of dentists/population)*100,000
	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	(Number of MHP/population)*100,000
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	# Medicare Enrollees	Number of Medicare enrollees
	Preventable Hosp. Rate	Discharges for Ambulatory Care Sensitive Conditions/Medicare Enrollees * 1,000
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetic monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c

Measure	Data Elements	Description
		test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in poverty	# Children in Poverty	Number of children (under age 18) living 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)
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 / Population * 10,000

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes/population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
	95% CI - Low	95% confidence interval as reported by the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	Pop. In Viol	Average annual population affected by a water violation
	% Pop in Viol	Population affected by a water violation/Total population with public water
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	# Drive Alone	Number of people who drive alone to work
	# Workers	Number of workers in labor force
	% 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)
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)

O'Brien County

	O'Brien County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Iowa	Rank (of 99)
Health Outcomes						36
Length of Life						60
Premature death	6,593		4,895-8,291	5,200	5,911	
Quality of Life						9
Poor or fair health	7%		5-9%	10%	11%	
Poor physical health days	1.7		0.9-2.4	2.5	2.8	
Poor mental health days	1.7		0.8-2.5	2.3	2.6	
Low birth weight	6.4%		5.0-7.8%	5.9%	6.8%	
Health Factors						18
Health Behaviors						25
Adult smoking				14%	18%	
Adult obesity	29%		23-35%	25%	30%	
Food environment index	7.9			8.4	7.8	
Physical inactivity	23%		18-29%	20%	24%	
Access to exercise opportunities	77%			92%	79%	
Excessive drinking	13%		7-22%	10%	20%	
Alcohol-impaired driving deaths	29%			14%	23%	
Sexually transmitted infections	127			138	370	
Teen births	33		27-40	20	30	
Clinical Care						30
Uninsured	11%		9-12%	11%	10%	
Primary care physicians	2,025:1			1,045:1	1,375:1	
Dentists	1,560:1			1,377:1	1,670:1	

	O'Brien County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Iowa	Rank (of 99)
Mental health providers	2,809:1			386:1	904:1	
Preventable hospital stays	47		39-54	41	56	
Diabetic monitoring	90%		77-100%	90%	89%	
Mammography screening	65.6%		53.1-78.2%	70.7%	66.4%	
Social & Economic Factors						19
High school graduation	91%				89%	
Some college	61.0%		52.2-69.9%	71.0%	69.1%	
Unemployment	3.7%			4.0%	4.6%	
Children in poverty	12%		9-16%	13%	16%	
Income inequality	4.2		3.7-4.7	3.7	4.2	
Children in single-parent households	19%		13-24%	20%	29%	
Social associations	30.3			22.0	15.6	
Violent crime	81			59	263	
Injury deaths	63		46-84	50	59	
Physical Environment						28
Air pollution - particulate matter	12.0			9.5	10.9	
Drinking water violations	0%			0%	7%	
Severe housing problems	9%		7-12%	9%	12%	
Driving alone to work	73%		68-77%	71%	80%	
Long commute - driving alone	19%		15-22%	15%	19%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2015

Sioux County

	Sioux County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Iowa	Rank (of 99)
Health Outcomes						3
Length of Life						4
Premature death	4,134		3,333-4,934	5,200	5,911	
Quality of Life						3
Poor or fair health	10%		7-13%	10%	11%	
Poor physical health days	1.9		1.4-2.3	2.5	2.8	
Poor mental health days	1.7		1.2-2.1	2.3	2.6	
Low birth weight	5.0%		4.3-5.7%	5.9%	6.8%	
Health Factors						4
Health Behaviors						3
Adult smoking	12%		9-16%	14%	18%	
Adult obesity	27%		22-32%	25%	30%	
Food environment index	9.0			8.4	7.8	
Physical inactivity	25%		21-30%	20%	24%	
Access to exercise opportunities	76%			92%	79%	
Excessive drinking	14%		10-18%	10%	20%	
Alcohol-impaired driving deaths	21%			14%	23%	
Sexually transmitted infections	134			138	370	
Teen births	17		15-20	20	30	
Clinical Care						25
Uninsured	12%		10-13%	11%	10%	
Primary care physicians	1,371:1			1,045:1	1,375:1	
Dentists	2,468:1			1,377:1	1,670:1	

	Sioux County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Iowa	Rank (of 99)
Mental health providers	1,570:1			386:1	904:1	
Preventable hospital stays	49		42-55	41	56	
Diabetic monitoring	92%		81-100%	90%	89%	
Mammography screening	70.8%		61.0-80.7%	70.7%	66.4%	
Social & Economic Factors						4
High school graduation	91%				89%	
Some college	61.6%		56.3-66.9%	71.0%	69.1%	
Unemployment	3.3%			4.0%	4.6%	
Children in poverty	10%		7-12%	13%	16%	
Income inequality	3.4		3.0-3.8	3.7	4.2	
Children in single-parent households	14%		10-18%	20%	29%	
Social associations	26.6			22.0	15.6	
Violent crime	111			59	263	
Injury deaths	36		28-46	50	59	
Physical Environment						8
Air pollution - particulate matter	11.9			9.5	10.9	
Drinking water violations	0%			0%	7%	
Severe housing problems	8%		6-10%	9%	12%	
Driving alone to work	71%		68-73%	71%	80%	
Long commute - driving alone	9%		7-10%	15%	19%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2015

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