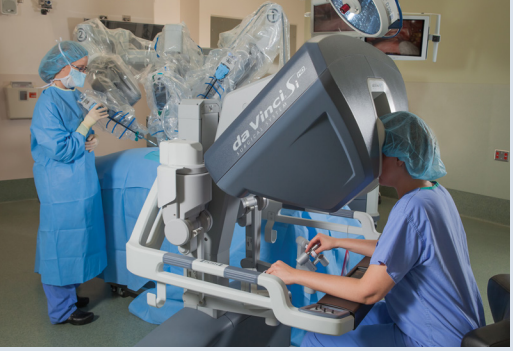


















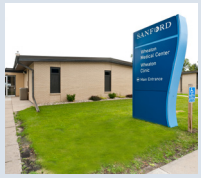




# SANFORD HEALTH

## Sanford Health Network

# 2018 Community Health Needs Assessment

dba Sanford Aberdeen Medical Center EIN # 46-0388596

Dear Community Members,

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

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

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

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

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

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

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

Sincerely,

Ashley Erickson

Ashley Erickson
Executive Director
Sanford Medical Center Aberdeen

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# 2018

# Executive Summary

### Purpose

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

### Our Guiding Principles

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

### Regulatory Requirements

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

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

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

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

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

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

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

## Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholder's concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health distributed the survey link via email to stakeholders and key leaders located within Brown and Edmunds counties. Data collection occurred during November 2017. A total of 54 community stakeholders participated in the survey.

   B. *Resident Survey*
   The resident survey tool includes questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a link to the survey was published in the local newspaper. A total of 119 community residents participated in the survey.

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

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

E. *Prioritization Process*
The primary and secondary research data was analyzed to develop the top unmet needs. The analyzed list of needs was developed into a worksheet. A multi-voting methodology from the American Society for Quality was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to complete the multi-voting exercise.

2. Secondary Research
   A. The 2018 County Health Rankings were reviewed and included in the report and in the asset mapping process.
   B. The U.S. Census Bureau estimates were reviewed.
   C. Community Commons were reviewed and specific data sets were considered. The Community Commons link is https://www.communitycommons.org/maps-data/.

## Limitations of the Study

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

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

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

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

# Key Findings

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

**Economic Well-Being**
Community stakeholders are most concerned about a skilled labor force (ranking 3.53).

**Children and Youth**
Community stakeholders are most concerned about childhood obesity (3.65) and substance abuse by youth (3.54).

**Aging Population**
Community stakeholders are most concerned about the cost of memory care (3.89) and the cost of long term care (3.83).

**Safety**
Community stakeholders are most concerned about abuse of prescription drugs (3.50).

**Health Care Access**
Community stakeholders are most concerned about access to affordable health insurance coverage (3.87) and access to affordable health care (3.75).

**Mental Health and Substance Abuse**
Community stakeholders are most concerned about drug use and abuse (3.62).

Resident survey participants are facing the following issues:

- 75% report that they are overweight or obese
- 49% report that they have been diagnosed with depression
- 49% report that they have been diagnosed with anxiety
- 44% self-report binge drinking at least 1X/month
- 30% self-report that they have drugs in their home that are not being used

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

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

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

# Implementation Strategies

## Priority 1: Health Care Access

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

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

## Priority 2: Mental Health/Behavioral Health and Substance Abuse

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

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

# Sanford Aberdeen Medical Center

# Community Health Needs Assessment

# 2018

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## Acknowledgements

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

Sanford Steering Group:

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

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

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

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

- Brenda Stallman, Traill County Public Health
- Diane Thorson, Ottertail County Public Health
- Juli Ward, Avera Health
- MayLynn Warne, North Dakota Public Health Association

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

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

- Carole Curtis, Sanford Advisory Board
- Cindy Dosch, United Housing Board
- Ashley Erickson, Sanford Aberdeen
- Jim Fischer, Sanford Advisory Board
- Michael Herman, Boys and Girls Club
- Ashley Heyne, South Dakota Department of Health
- Megan Kleinsasser, Aberdeen Health & Rehab Skilled Nursing Center
- Mike Levsen, Mayor of Aberdeen
- Julie Miller, South Dakota Department of Health
- Marie Petersen, Davita Dialysis
- Lexi Pugsley, South Dakota Department of Health
- Bryan Schmidt, Dacotah Bank
- Dan Uhlir, 3M
- Dawn Williams, South Dakota Department of Labor and Regulation

## Description of Sanford Aberdeen Medical Center

**Aberdeen, SD**


Sanford Aberdeen Medical Center is a 48-bed, state-of-the-art hospital designed to meet the growing health care needs of the Aberdeen region and its communities. It opened in July 2012. The facility was designed as a healing environment that focuses on the patient and their family.

Comprehensive services include emergency care/Level IV trauma center, adult and pediatric care, labor and delivery, critical care, cardiac cath lab, inpatient and outpatient surgical and procedural areas, inpatient and outpatient therapies, women's center, laboratory and imaging services.

Sanford Aberdeen Clinic is a multispecialty clinic attached to the medical center providing family medicine, internal medicine, general surgery, cardiology, interventional cardiology, OB/GYN, nephrology and urology services. A Children's Clinic is also located on-site. Satellite clinics integrated with Sanford Aberdeen are located in Ipswich, South Dakota and Ellendale, North Dakota.

Sanford Aberdeen employs 50 clinicians, including physicians and advanced practice providers, and over 450 employees.

## Description of the Community Served

**Aberdeen, SD**

Aberdeen is the county seat of Brown County, SD, with a population of 26,000 people, making it the third largest city in the state. Named for Aberdeen, Scotland, the hometown of Milwaukee Railroad President Alexander Mitchell, the city incorporated in 1881 and quickly became known as the Hub City of the Dakotas. By 1886, a city map showed nine different rail lines converging in Aberdeen from all directions, much like the spokes of a wheel converging at its hub. The combination of multidirectional railways and fertile farmland helped Aberdeen develop into a distribution hub for wholesale goods.

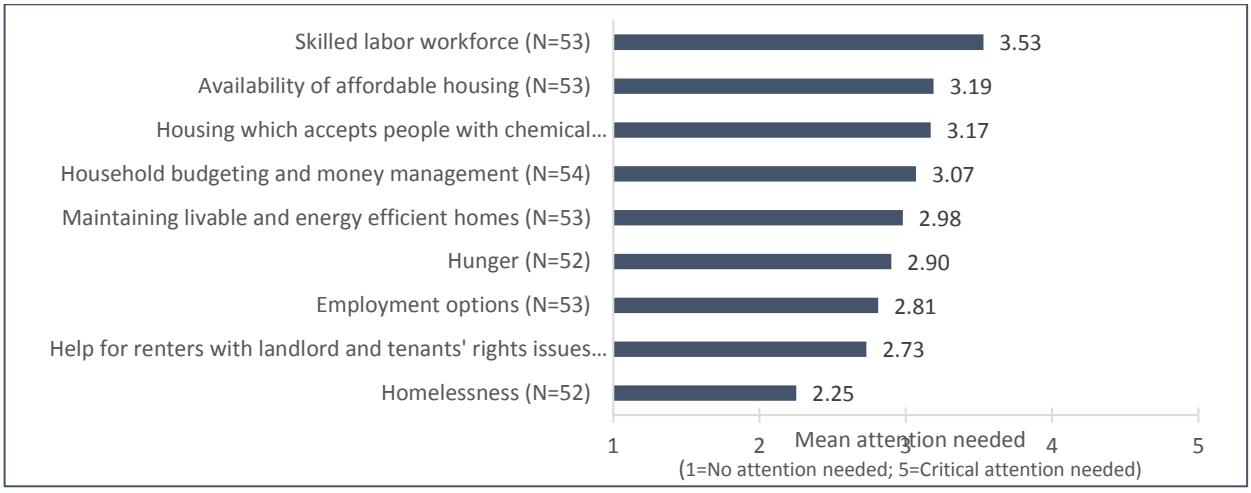
Today, Aberdeen's economy has diversified and the number of businesses has grown to more than 1,500. Large businesses include 3M, Avera, Bethesda Home, Wells Fargo Bank, Wyndham Hotel Group and more. Other industries include agriculture, construction, manufacturing and trade.

# Key Findings

## Community Health Concerns

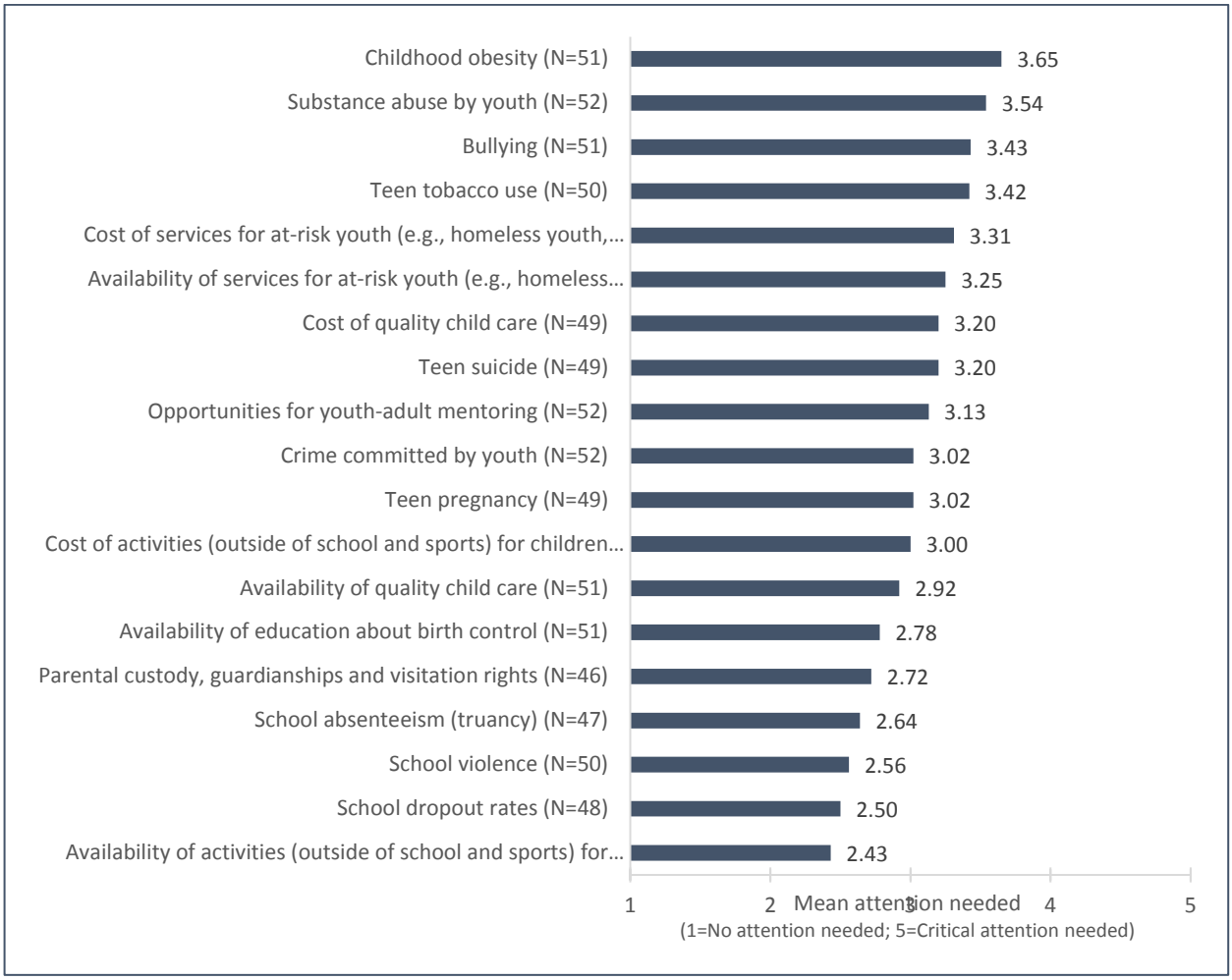
The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.5 or above are considered to be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

**Economic Well-Being: The concern for the community's economic well-being is focused on the need for a skilled workforce.**




*Healthy People 2020* has defined the social determinants of health. "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." The patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

**Children and Youth**: The highest concerns for children and youth include childhood obesity and substance abuse by youth.




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

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

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

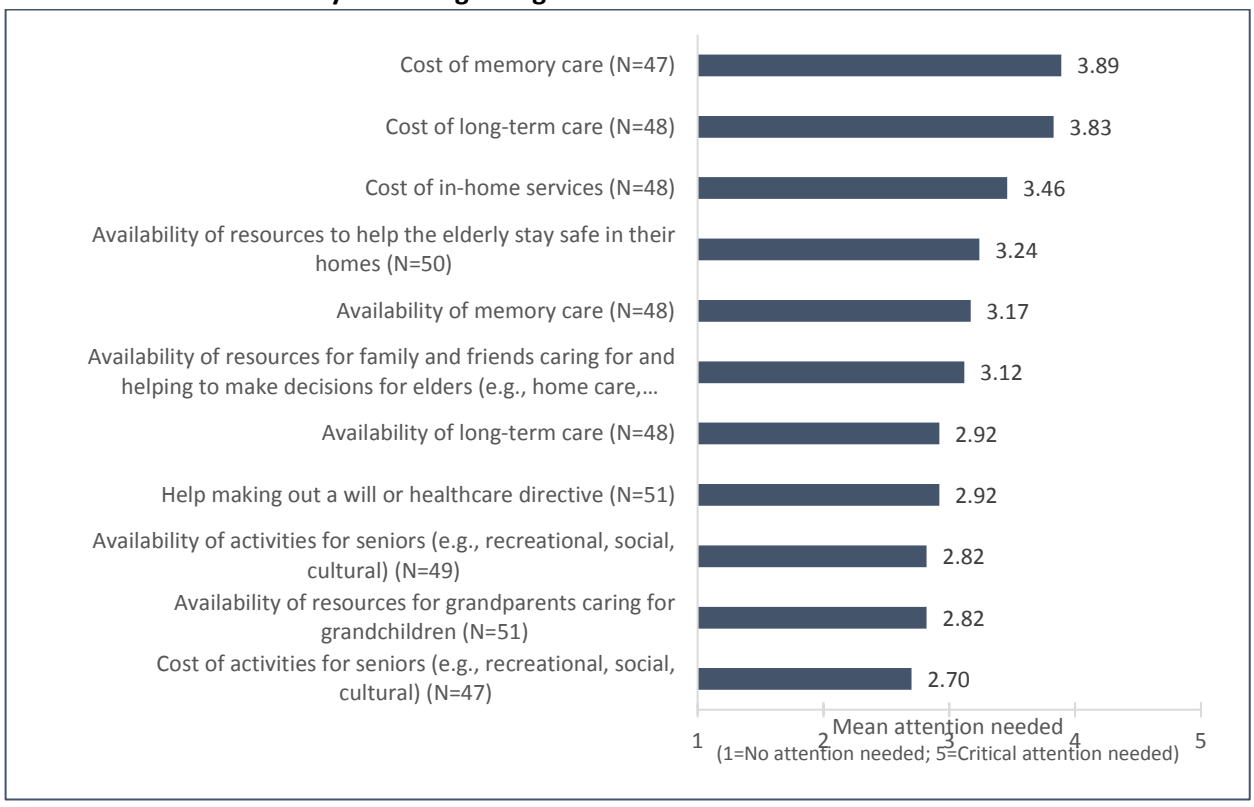
- Poor grades in school
- Engaging in alcohol or drug use at a young age
- Friends and peers who engage in alcohol or drug use
- Persistent, progressive, and generalized substance use, misuse, and use disorders by family members
- Conflict between parents or between parents and children, including abuse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

Protective factors include:

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

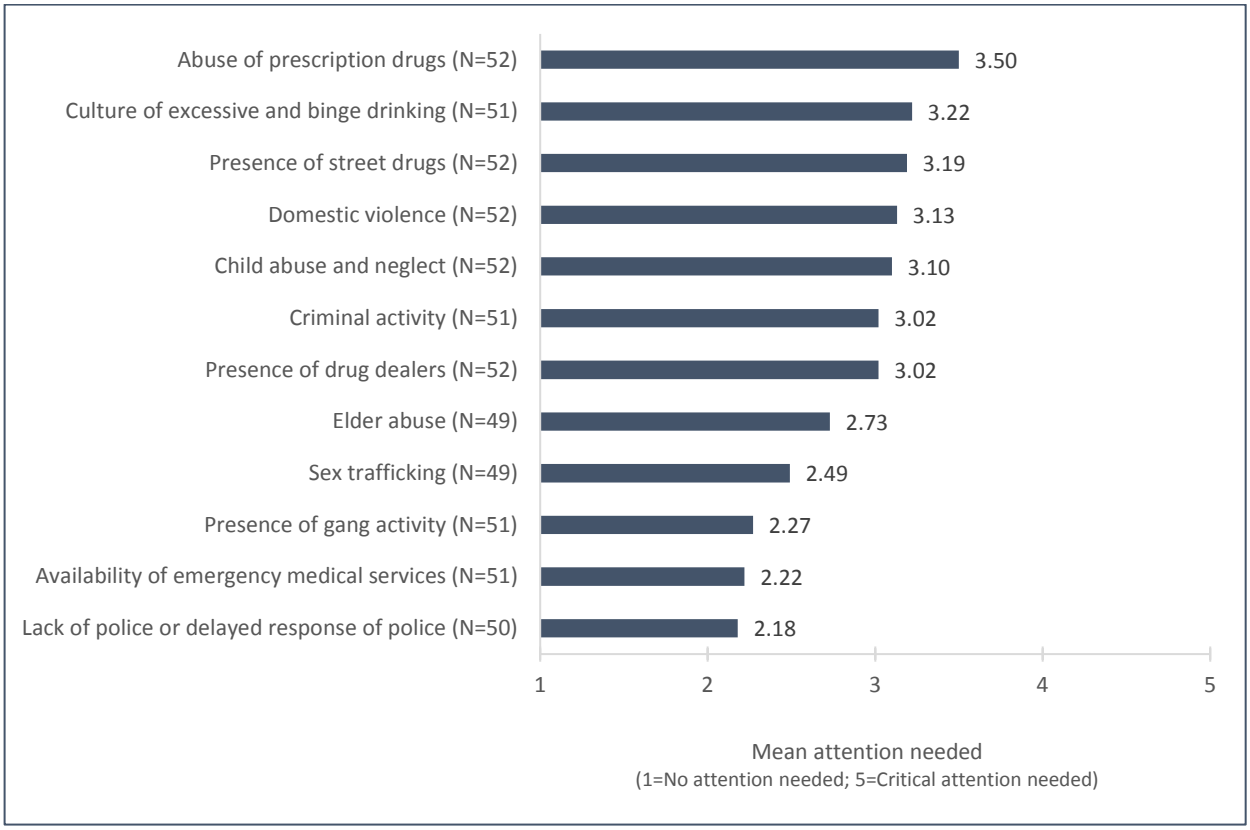
**Aging Population:** The cost of long term care and memory care are top concerns once again and were top concerns during the 2016 CHNA cycle.

**Current state of community issues regarding the AGING POPULATION**



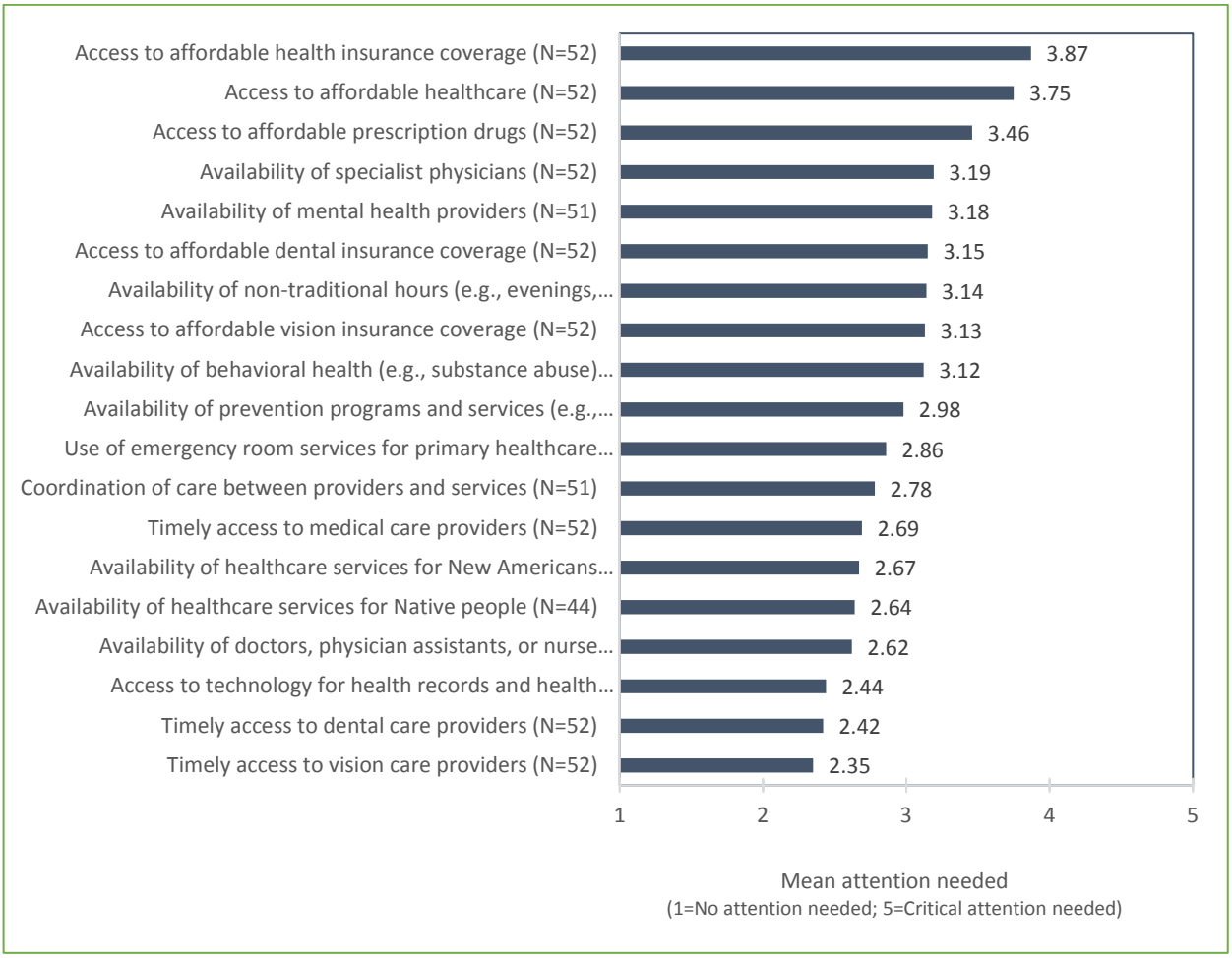

Acording to the U.S. Health and Human Services Administration on Aging, the cost of long term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford providers work to help seniors live healthy independent lives. Sanford social workers, case managers,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

**Safety:** The abuse of prescription drugs is the top concern for safety in the community.




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

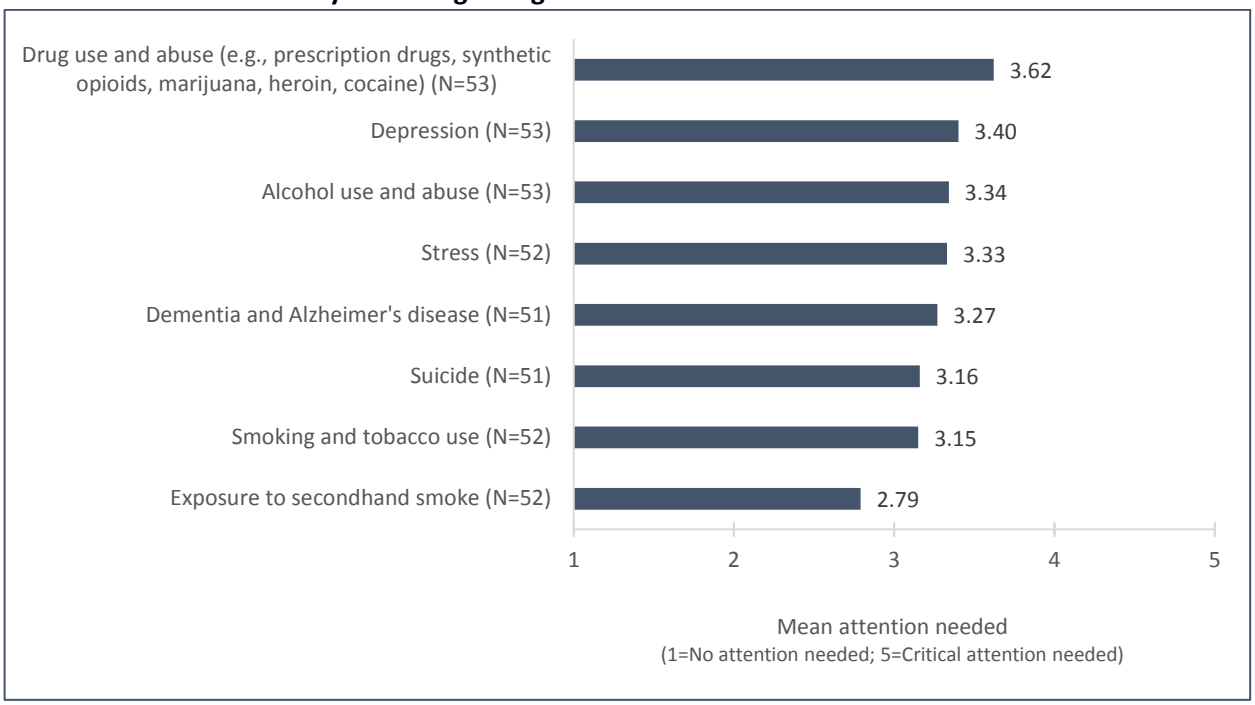
**Health Care and Wellness:** The availability of behavioral health and mental health providers is ranked very high among the top concerns for the community. Access to affordable health insurance, affordable health care, and affordable prescription drugs are all high concerns for community stakeholders.




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

**Mental Health and Substance Abuse:** Depression, alcohol use and abuse, drug use and abuse, dementia and Alzheimer's, stress and suicide are top concerns for the community.

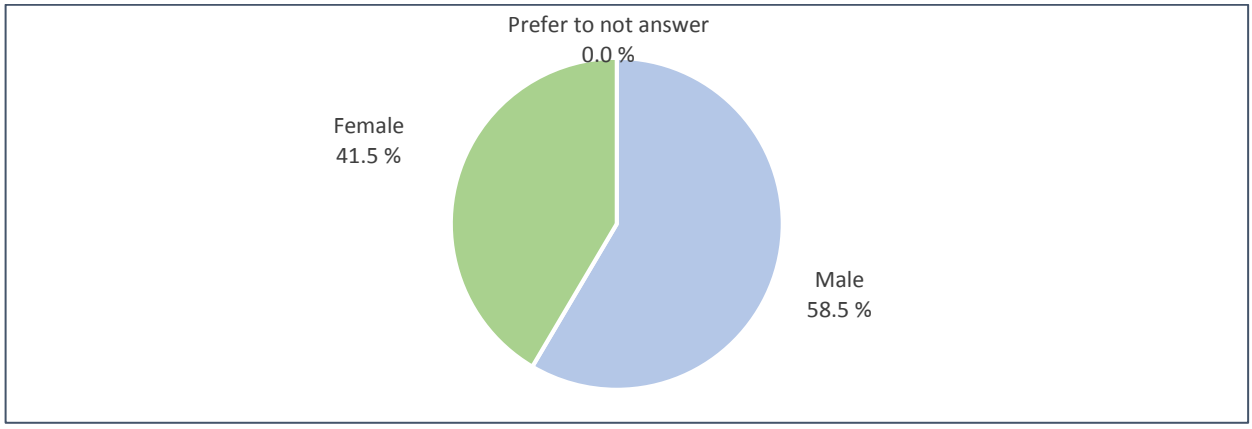
**Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE**



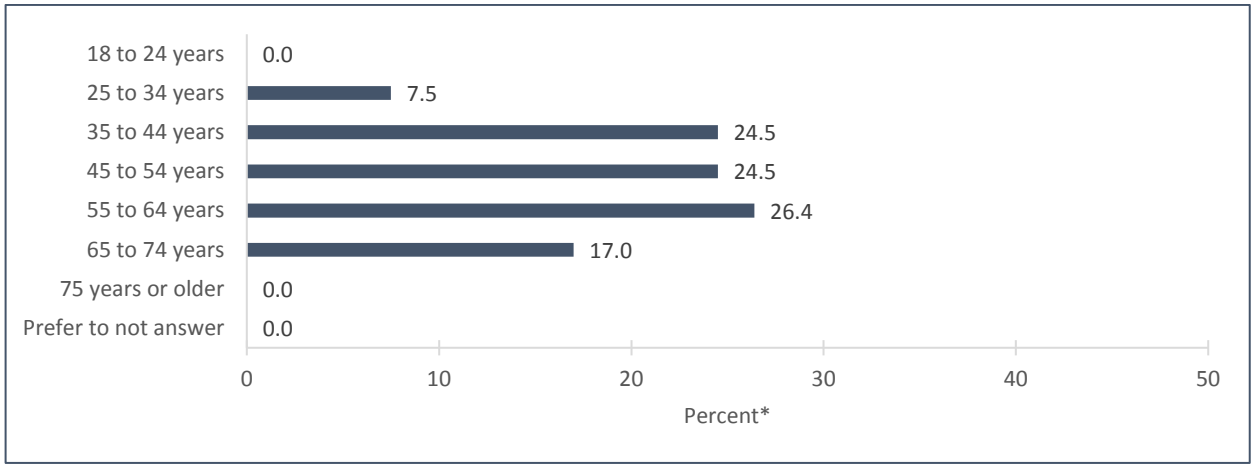

The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental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

## Demographic Information for Key Stakeholder Participants

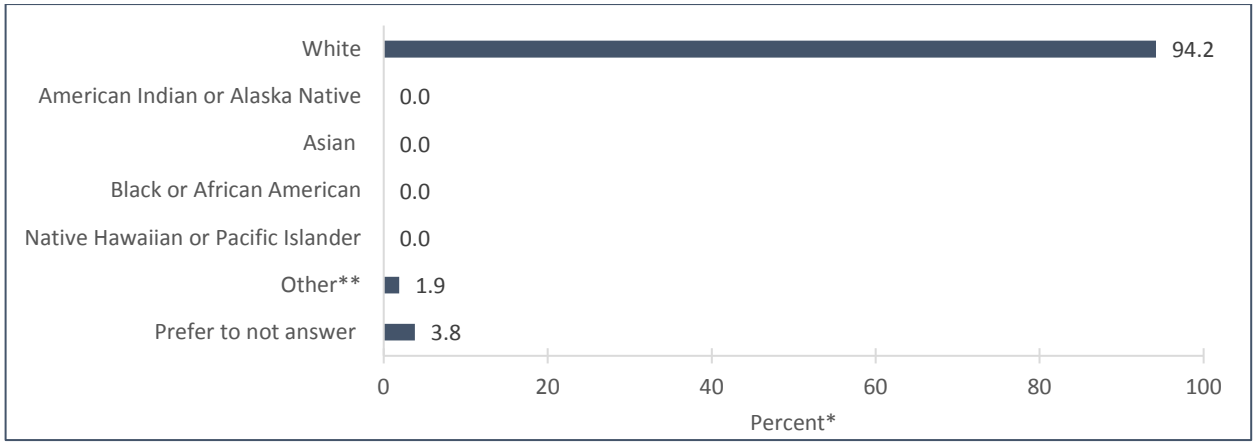
### Biological Gender



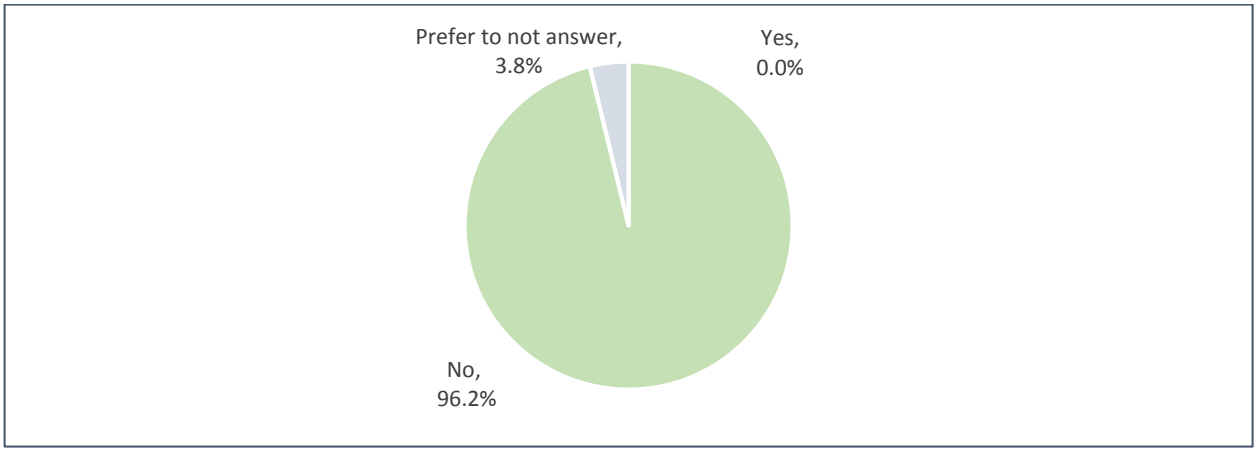

### Age of Respondents



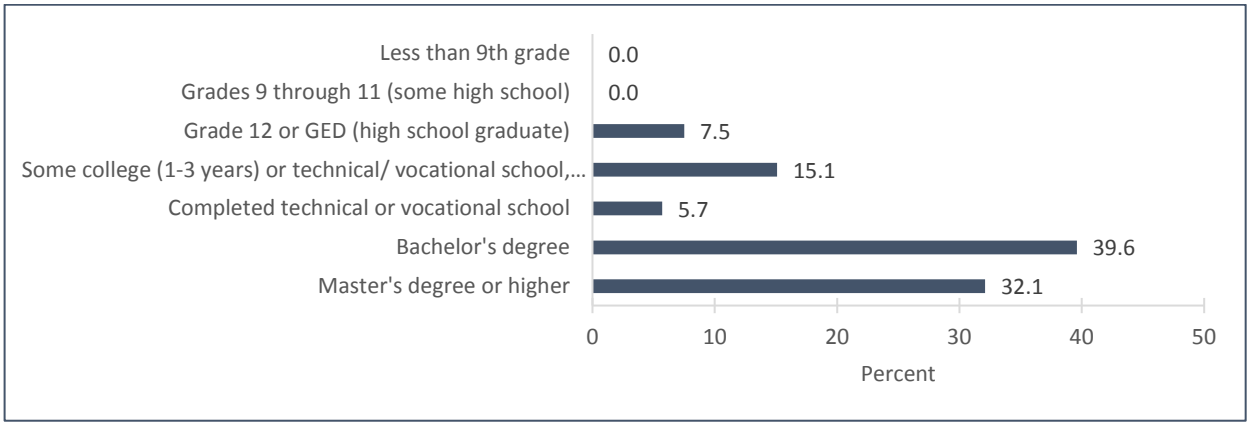

### Race of Participants



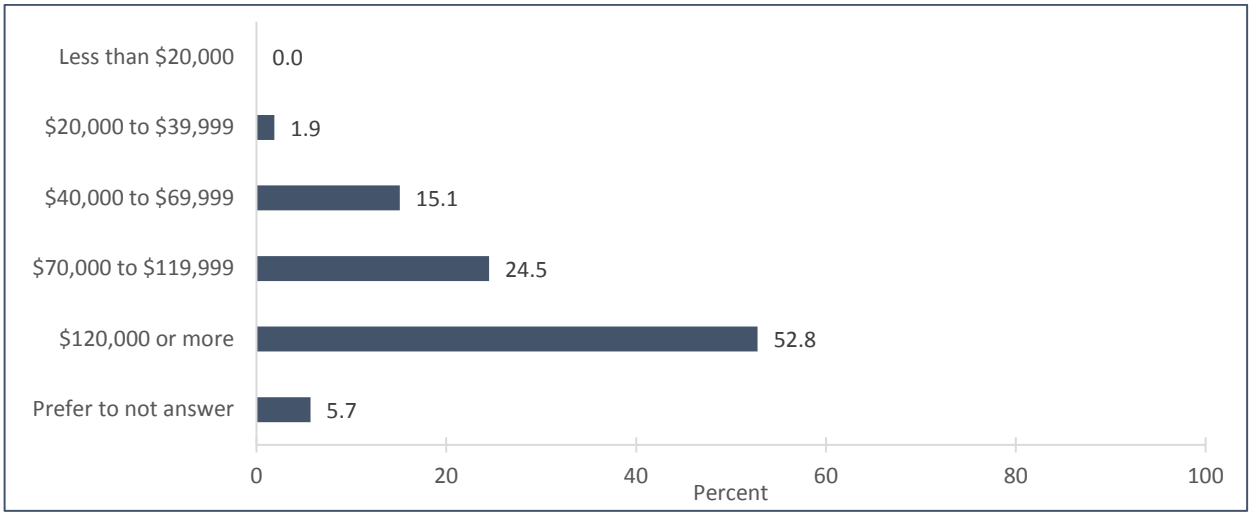
**Whether Respondents are of Hispanic or Latino Origin**




**Highest Level of Education Completed**




**Annual Household Income of Respondents, From All Sources, Before Taxes**



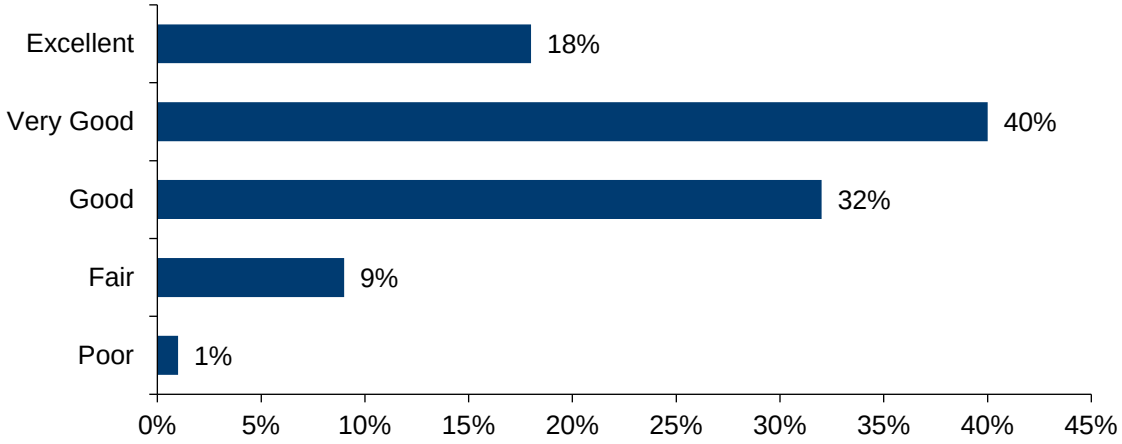
## Residents' Health Concerns

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

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

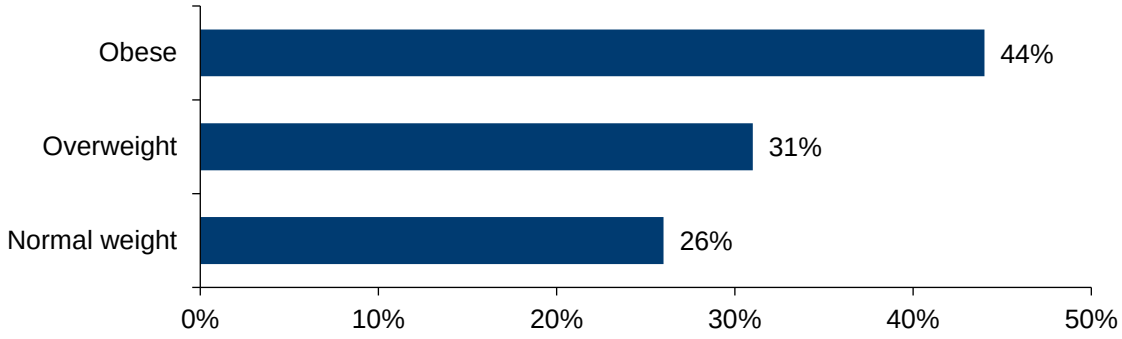
### How would you rate your health?

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



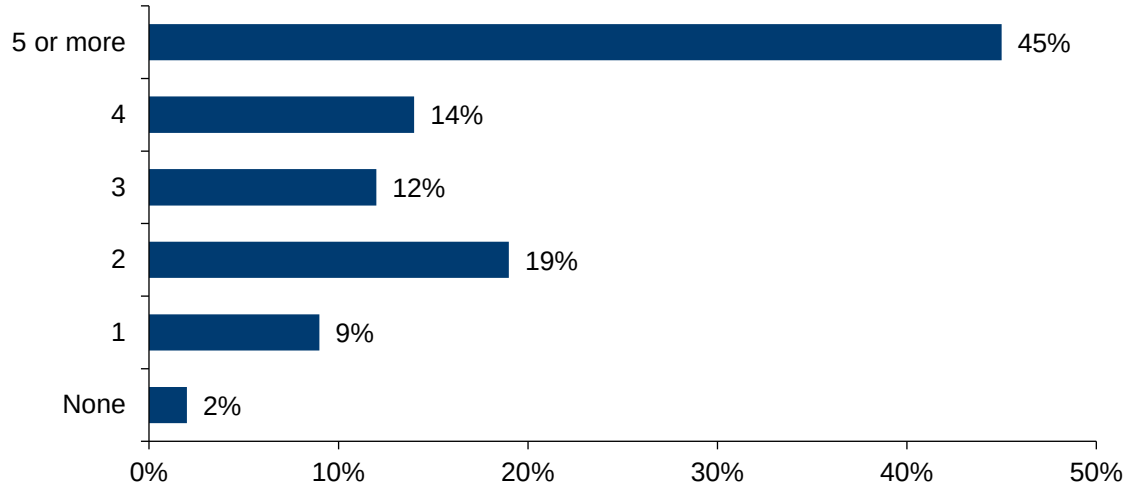

### Body Mass Index (BMI)

Seventy-five percent of survey participants are overweight or obese.



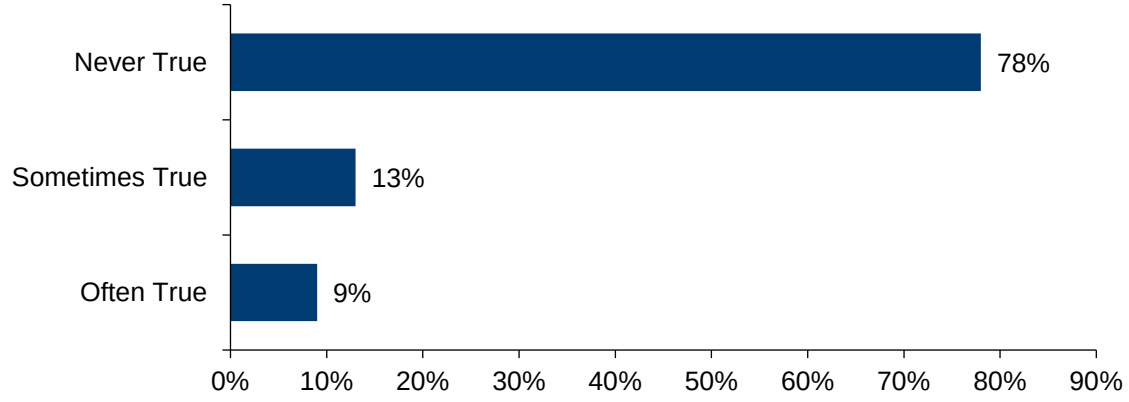
**Total Servings of Fruits, Vegetables and Juice**

Only 45% are consuming the recommended 5 or more daily servings of fruit and vegetables.



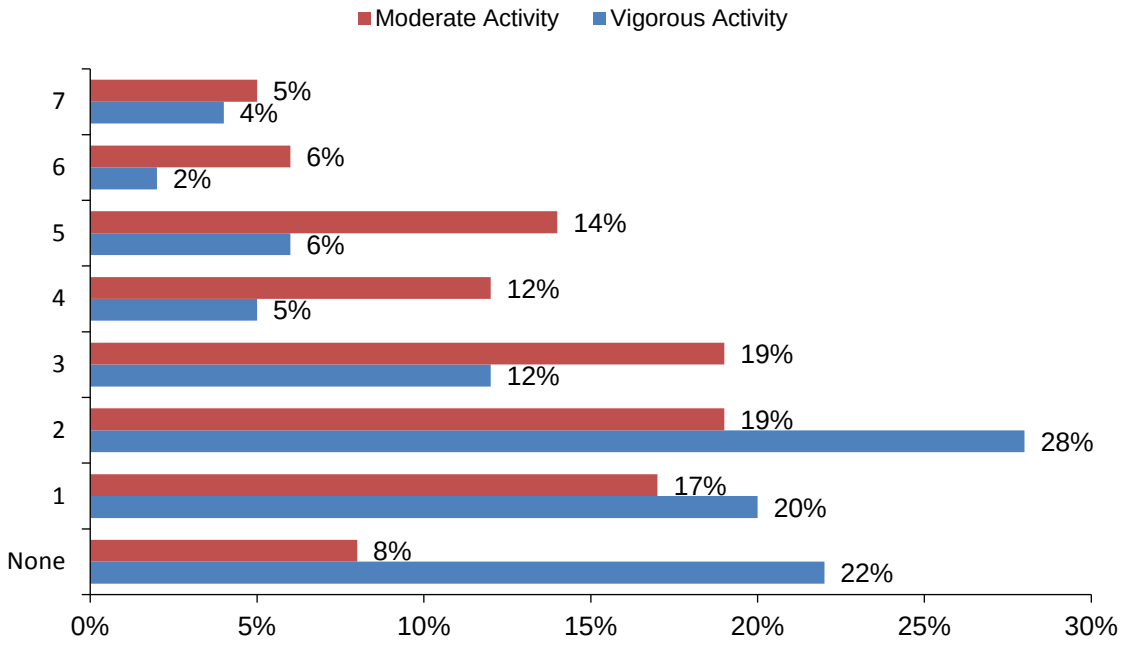

**Food Insecurity**

Twenty-two percent report running out of food before having money to buy more.



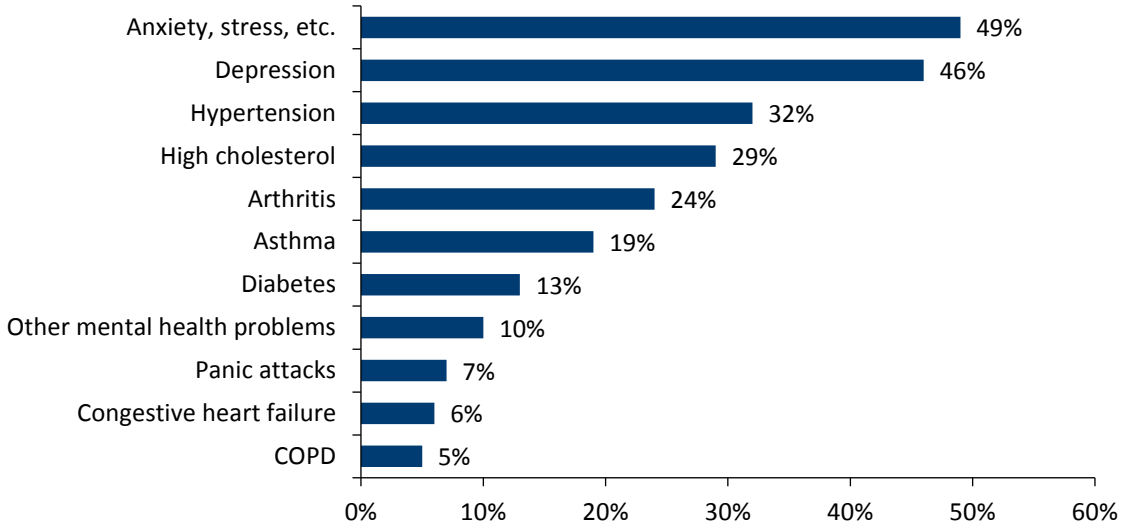
**Days per Week of Physical Activity**

Fifty-six percent have moderate exercise three or more times each week.



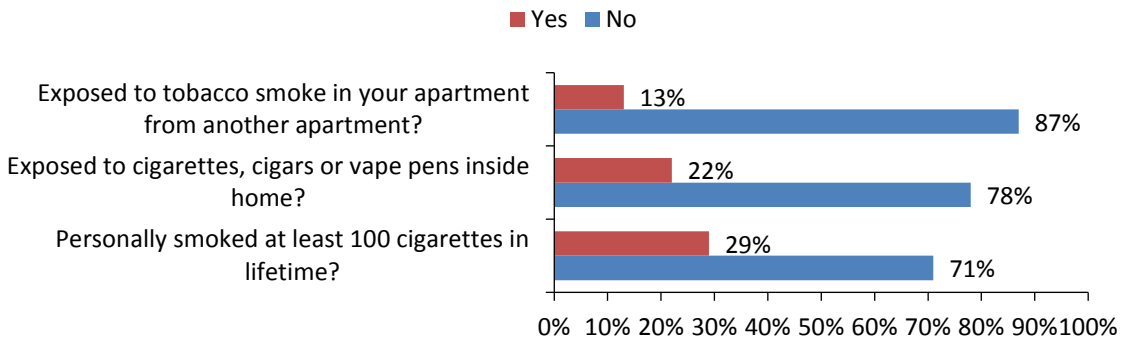

**Past Diagnosis**

Anxiety, depression, hypertension, high cholesterol, and arthritis are the top diagnoses for the survey participants.



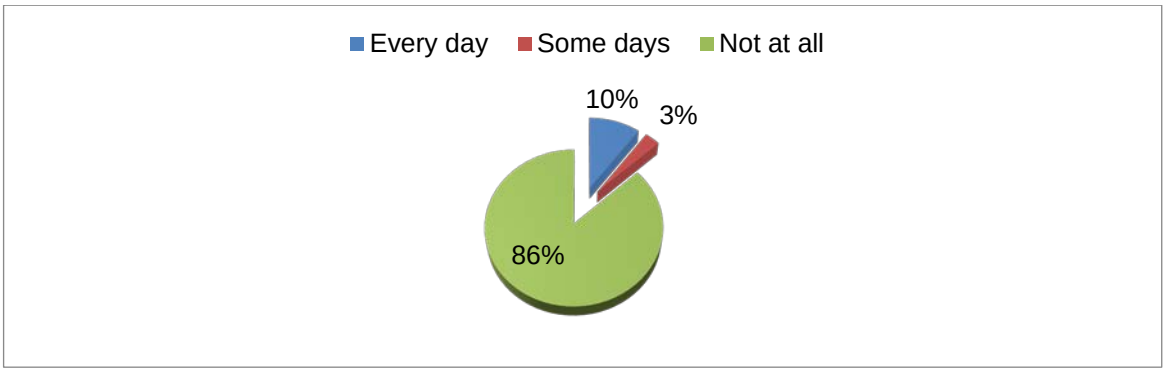
**Exposure to Tobacco Smoke**

Twenty-two percent are exposed to cigarettes, cigars or vape pens and forty-nine percent have smoked in their lifetime.



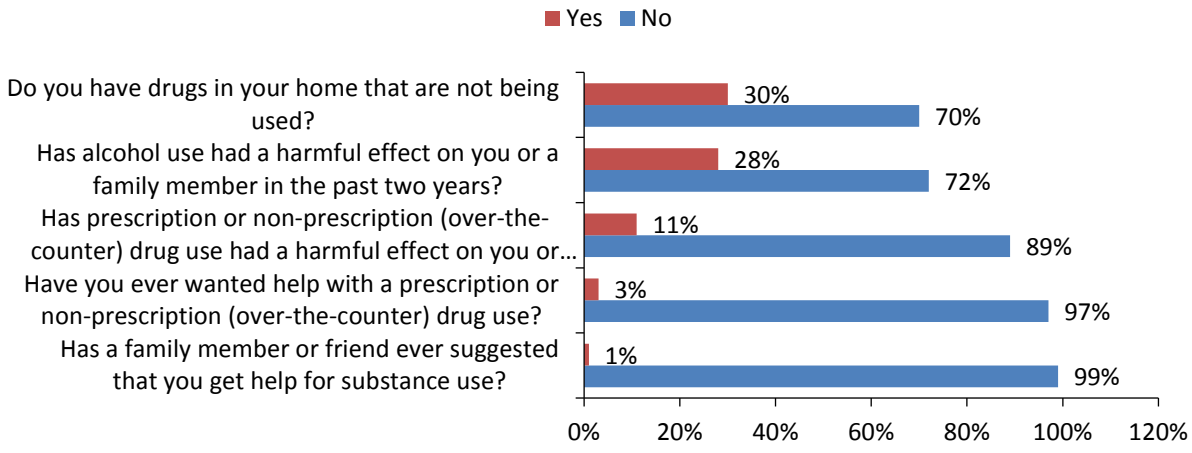

**Do you currently smoke cigarettes?**

Thirteen percent currently smoke cigarettes.



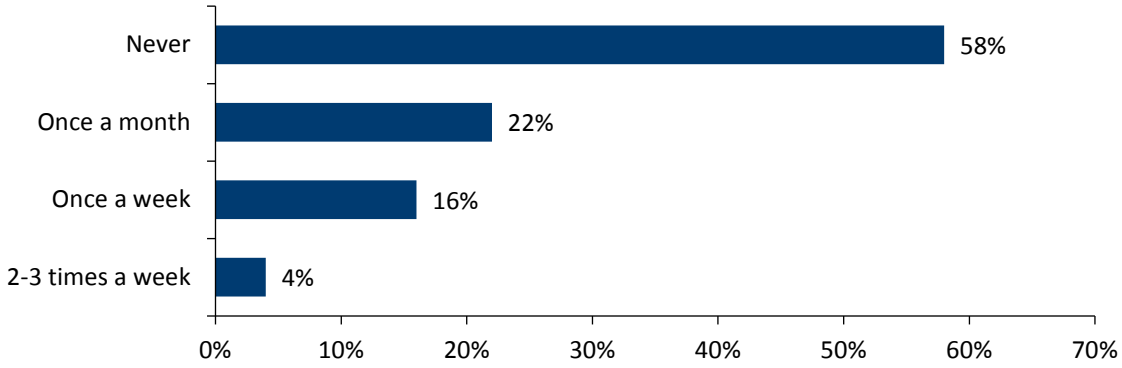
**Drug and Alcohol Issues**

Thirty percent have drugs in their home that they are no longer using. Twenty-eight percent report that alcohol has had a harmful effect on them or a member of their family.

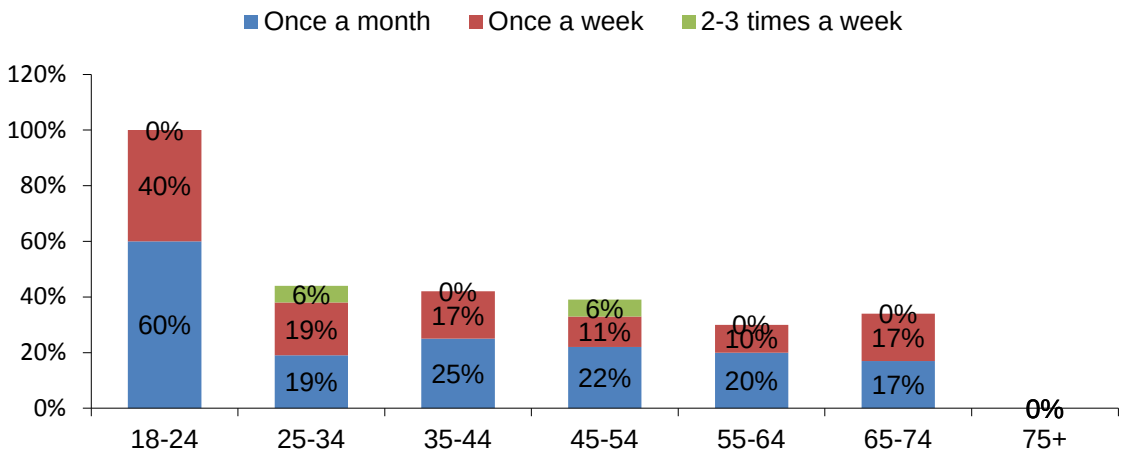



**Binge Drinking**

Forty-two percent binge drink at least once per month.

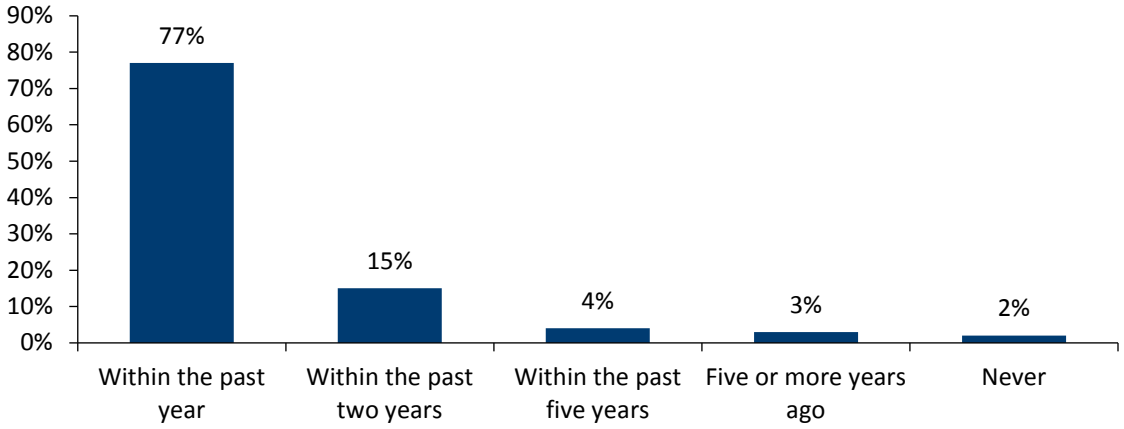


**Binge Drinking past 30 days by Age**



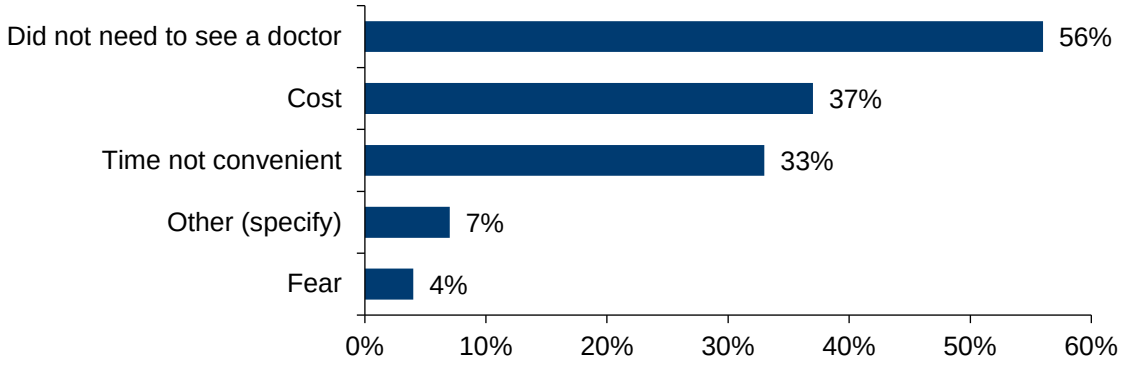

**How long has it been since you last visited a doctor or health care provider for a routine check-up?**

Twenty-three percent have not had a routine check-up in more than a year.



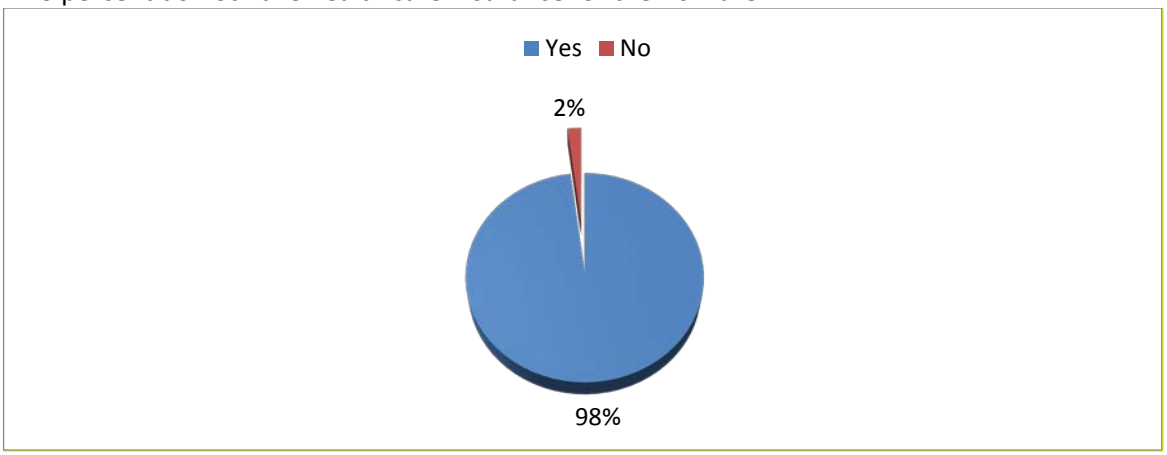

**Barriers to Routine Check-up**

Fifty-six percent of survey respondents report not needing a routine check-up.



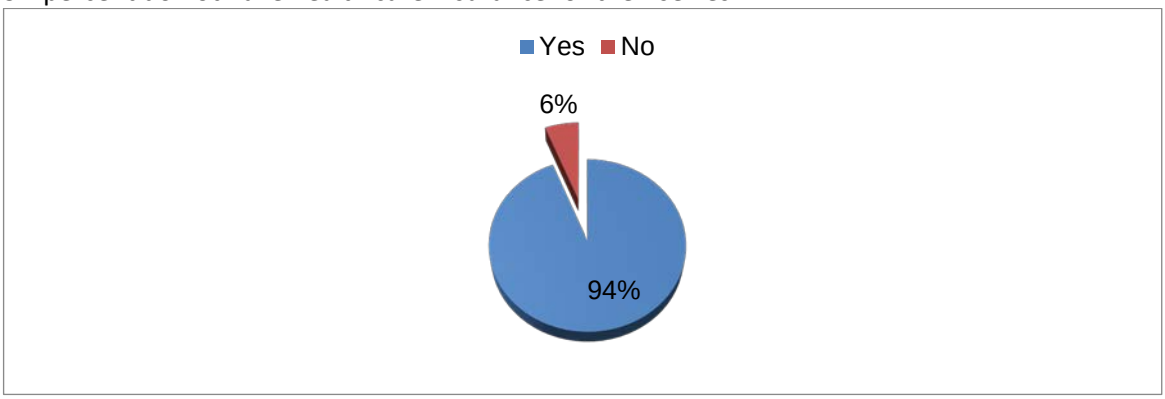
**Do you have health care coverage for your children or dependents?**

Two percent do not have health care insurance for their children.



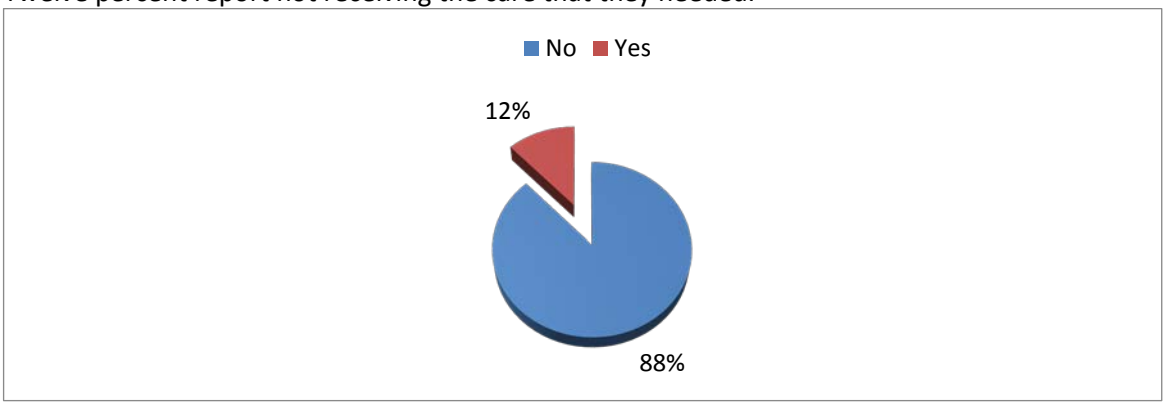

**Do you currently have any kind of health insurance?**

Six percent do not have health care insurance for themselves.

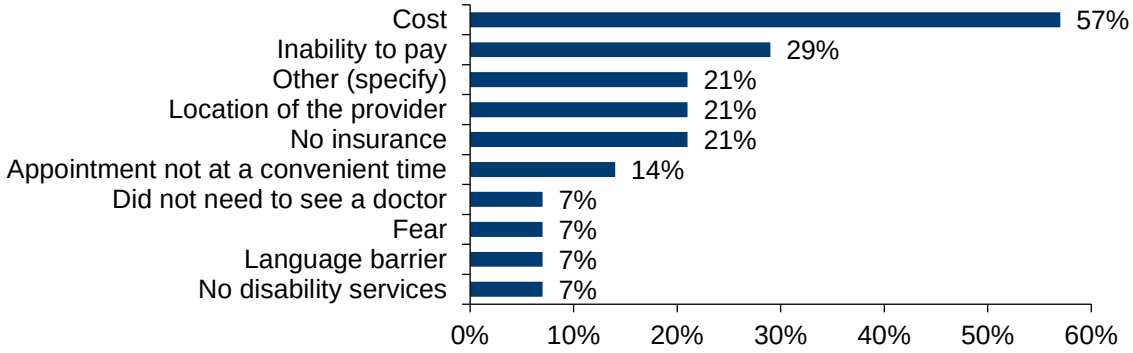



**In the past year, did you or someone in your family need medical care, but did not receive the care they needed?**

Twelve percent report not receiving the care that they needed.

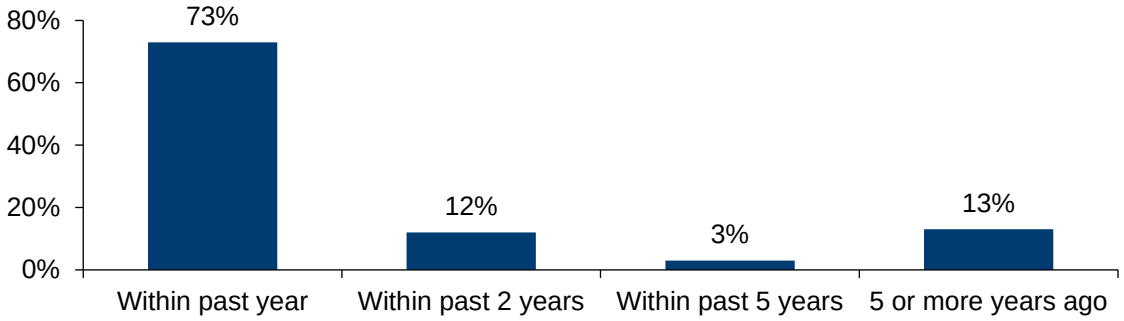


**Barriers to receiving care**

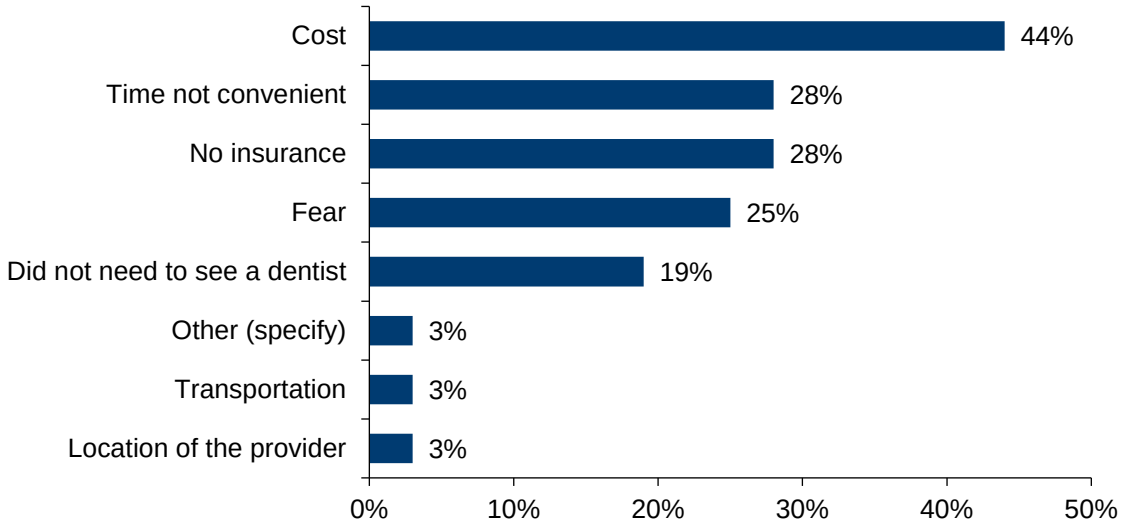



**How long has it been since you last visited a dentist?**

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

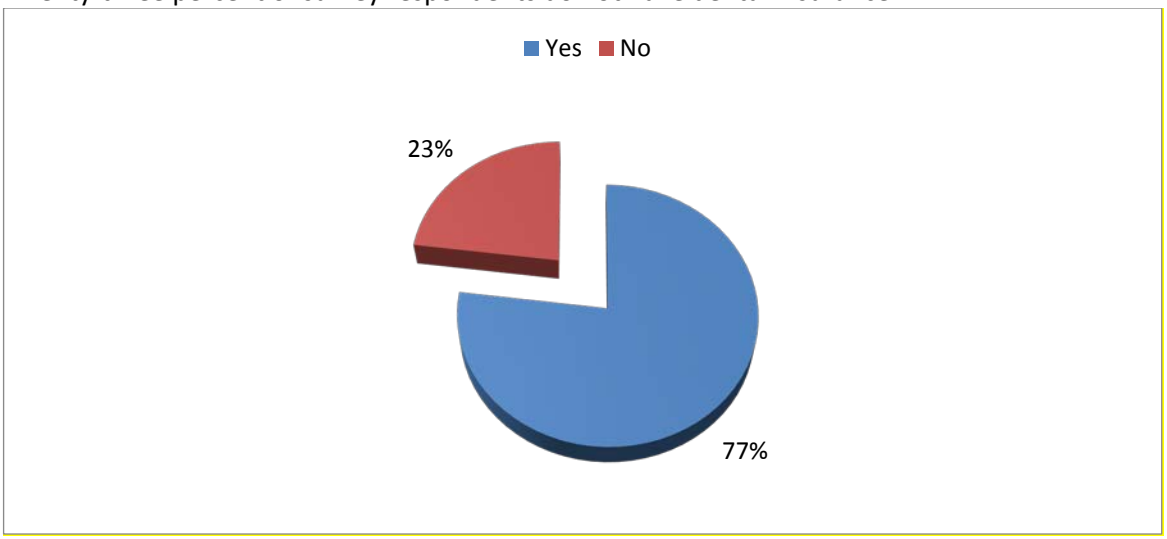



**Barriers to Visiting the Dentist**



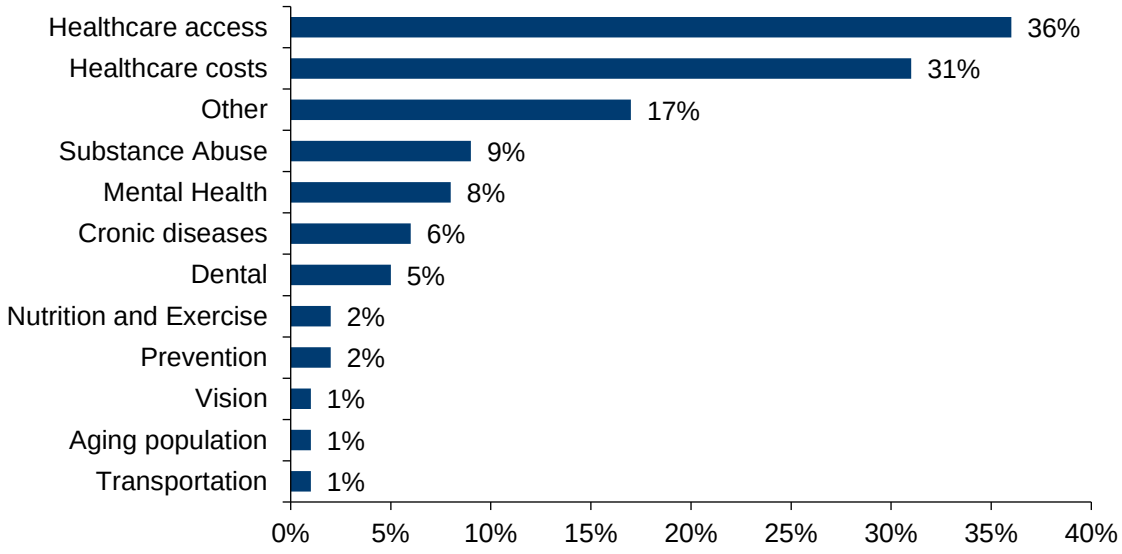
**Do you have any kind of dental care or oral health insurance coverage?**

Twenty-three percent of survey respondents do not have dental insurance.



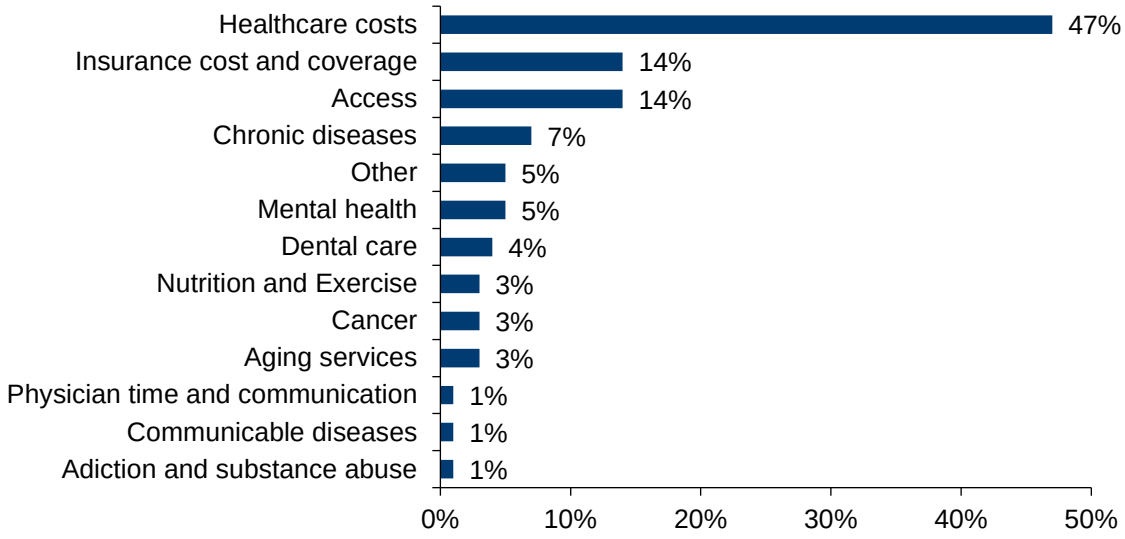

**Most Important Community Issues**

Health care costs and health care access are the top concerns of respondents when considering the needs of their community.



**Most Important Issue for Family**

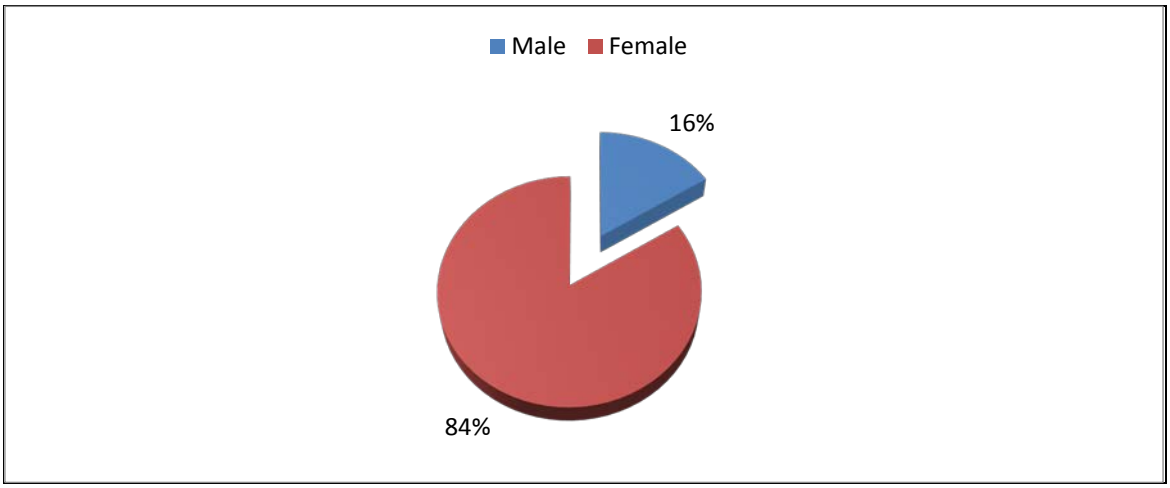
Health care costs and insurance cost and coverage are the top concerns of survey respondents as they consider the needs for their family.



## Demographic Information for Community Resident Participants

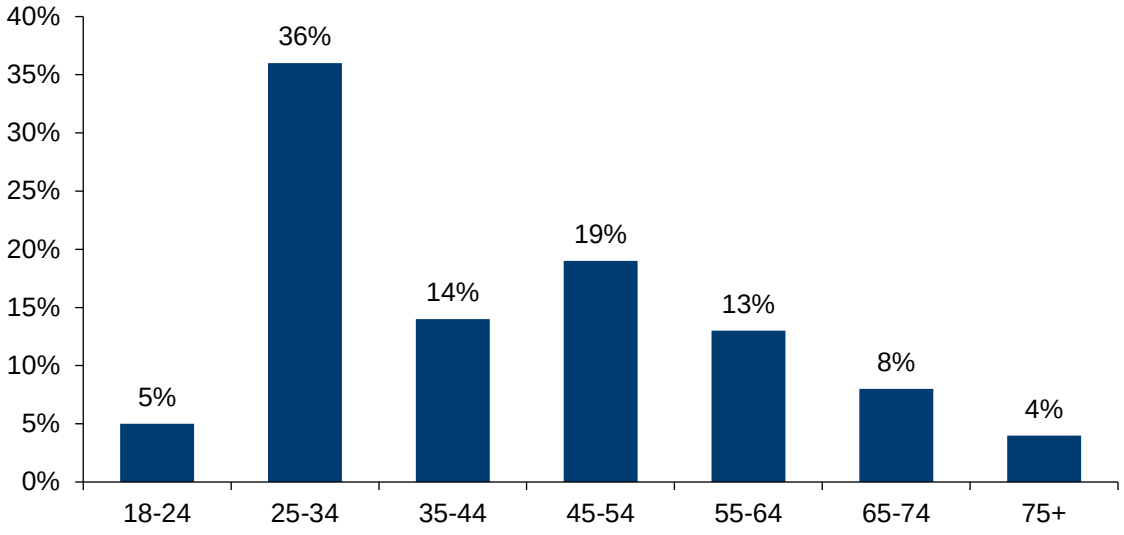
**Biological Gender**

Only 16% of the survey participants were male.

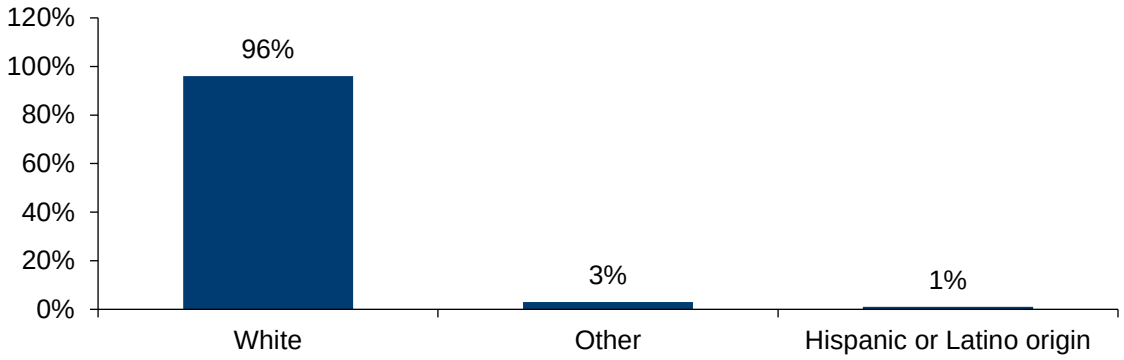



**Age**

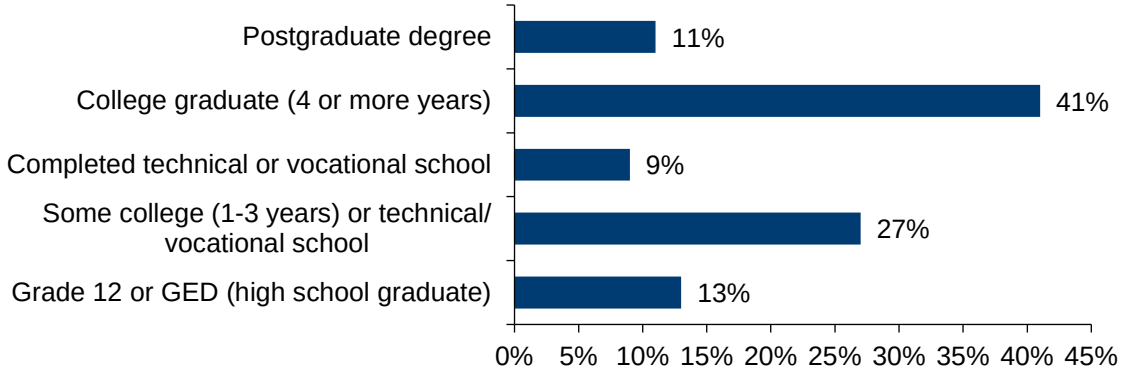
Every age group was represented among the survey participants; however, only 4% fell into the 75+ age and only 5% fell in the 18-24 age group.



**Ethnicity**

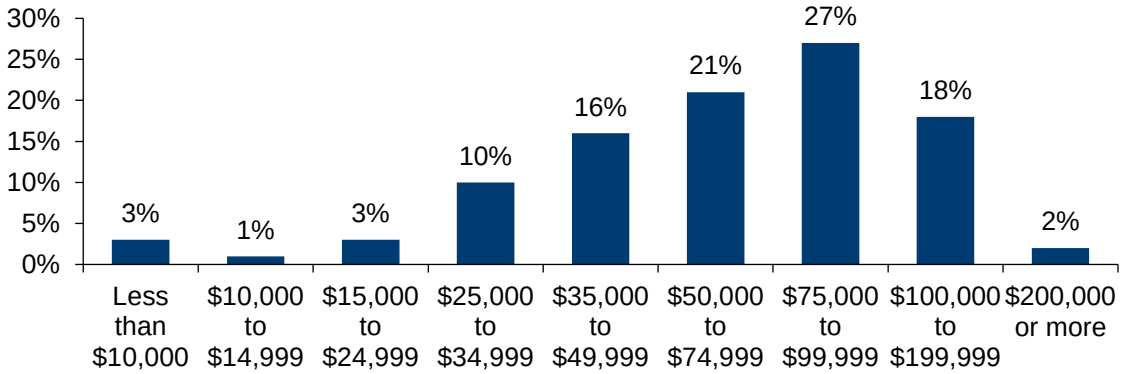



**Education Level**




**Total Annual Household Income**

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



# Secondary Research Findings

**Census Data**

| | |
|---|---|
| Population of Brown County and Edmunds County, South Dakota | 43,080 |
| % below 18 years of age | 23.8% Brown<br>23.2% Edmunds |
| % 65 and older | 16.2% Brown<br>21.5% Edmunds |
| % White – non-Hispanic | 87.7% Brown<br>95.6% Edmunds |
| American Indian | 3.5% Brown<br>0.9% Edmunds |
| Hispanic | 2.7% Brown<br>1.8% Edmunds |
| African American | 1.6% Brown<br>0.4% Edmunds |
| Asian | 2.9% Brown<br>0.4% Edmunds |
| % Female | 50.6% Brown<br>49.5% Edmunds |
| % Rural | 28.9% Brown<br>100% Edmunds |

**County Health Rankings**

| | Brown County | Edmunds County | State of South Dakota | U.S. Top Performers |
|---|---|---|---|---|
| Adult smoking | 15% | 14% | 18% | 14% |
| Adult obesity | 33% | 28% | 31% | 26% |
| Physical inactivity | 22% | 28% | 22% | 20% |
| Excessive drinking | 18% | 18% | 20% | 13% |
| Alcohol related driving deaths | 18% | 0% | 37% | 13% |
| Food insecurity | 11% | 10% | 12% | 10% |
| Uninsured adults | 12% | 12% | 14% | 7% |
| Uninsured children | 6% | 9% | 7% | 3% |
| Children in poverty | 12% | 14% | 17% | 12% |
| Children eligible for free or reduced lunch | 35% | 27% | 42% | 33% |
| Diabetes monitoring | 91% | 86% | 84% | 91% |
| Mammography screening | 76% | 78% | 66% | 71% |
| Median household income | $53,000 | $55,500 | $54,900 | $65,600 |

## Health Needs and Community Resources Identified

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

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

The asset mapping process identified needs from the following:

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

Please see the asset map in the Appendix.

# Sanford Aberdeen
# 2019 Community Health Needs Assessment
# Prioritization Worksheet

**Criteria to Identify Priority Problem**

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

**Criteria to Identify Intervention for Problem**

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

| Health Indicator/Concern |
|---|
| **Economic Well-Being**<br>• Skilled labor workforce 3.53<br>22% of resident respondents report running out of food before they had money to buy more |
| **Children and Youth**<br>• Childhood obesity 3.65<br>• Substance abuse by youth 3.54 |
| **Aging Population**<br>• Cost of memory care 3.89<br>• Cost of long term care 3.83 |
| **Safety**<br>• Abuse of prescription drugs 3.50 |
| **Health Care Access**<br>• Access to affordable health insurance coverage 3.87<br>• 6% report that they do not have health insurance<br>• Access to affordable health care 3.75 |
| **Mental Health and Substance Abuse**<br>• Drug use and abuse 3.62<br>• 30% self-report that they have drugs in their home that are not being used<br>• 49% report that they have been diagnosed with depression<br>• 49% that they have been diagnosed with anxiety/stress<br>• 13% currently smoke cigarettes<br>• 44% self-report that they binge drink<br>• 28% report that alcohol use has had a harmful effect on themselves or a family member in the past 2 years |
| **Wellness**<br>• 44% reported not getting moderate activity 3 or more times/week<br>• 44% report that they are obese<br>• 31% report that they are overweight<br>• 55% of residents do not consume 5 or more fruits/vegetables each day<br>• 32% have been diagnosed with hypertension<br>• 29% have been diagnosed with high cholesterol<br>• 24% have been diagnosed with arthritis<br>• 24% report not having a routine check-up in more than a year<br>• 33% have not had a flu shot this year<br>• 28% report not having visited a dentist in more than a year |

# Implementation Strategies

# 2018 Community Health Needs Assessment

## How Sanford is Addressing the Community Needs

| Identified Concerns | How Sanford Aberdeen is Addressing the Community Needs |
|---|---|
| **ECONOMIC WELL BEING** | |
| Skilled labor workforce | Sanford has many programs in place to address workforce development, including the Sons and Daughters scholarship program, the Heart of Tomorrow Program, internships for college students who are interested in health care careers, and health career programs for high school students. |
| Residents run out of food before they have money to buy more – 22% | Sanford supports local food banks by holding annual food drives with Sanford Health as a drop-off site for the community and employees to donate. |
| **CHILDREN AND YOUTH** | |
| Childhood obesity | Sanford dietitians provide nutrition education through the following:<br>• Cooking classes and nutrition education to student athletes<br>• Nutrition presentations to groups with cancer and other chronic conditions (breast cancer, COPD, diabetes, etc.)<br>• Participation in community health fairs<br>• Nutrition education for pregnant women and new moms (*B4 Baby*)<br>• *Introduction of Solids* (nutrition class series) for new parents<br>• Participation in TV, radio, and newspaper interviews regarding nutrition topics in the news<br>• Diabetes Prevention Program<br>• *Cooking with the Cardiologist* for community members to attend<br>• Participation in various community youth events through the schools (middle school/high school) promoting good nutrition<br><br>Sanford *fit* is an online resource to address activity, nutrition, mood and energy and is available free of charge. The focus is for children and youth. |
| Substance abuse by youth | Sanford Children's CHILD Services is available to address substance abuse, child abuse and neglect, and early intervention/prevention. The Integrated Health Therapist (IHT) serves as an integral core team member within the patient-centered Medical Home. The IHT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The IHT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The IHT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management. |
| **AGING POPULATION** | |
| Cost of memory care | Sanford clinicians work to keep seniors healthy and living independently as long as possible. The recent Good Samaritan affiliation will provide Sanford Health with expertise in the area of long term care, assisted living services, and help to create efficiencies for members in the communities that we serve. |

| Identified Concerns | How Sanford Aberdeen is Addressing the Community Needs |
|---|---|
| Cost of long term care | Sanford clinicians work to keep seniors healthy and living independently as long as possible. The recent Good Samaritan affiliation will provide Sanford Health with expertise in the area of long term care, assisted living services, and help to create efficiencies for members in the communities that we serve. |
| **SAFETY** | |
| Abuse of prescription drugs | In April of 2016, the Sanford Quality Committee announced the formation of a Controlled Substance Stewardship Committee (CSSC) because they saw a need and a responsibility to not only protect our patients, but support physicians and APPs who prescribe high-risk medications. The goal was to ensure patients are safe and well treated and that physicians are educated in how to treat patients while being good stewards of the use of opioids.<br><br>Through education, resources and support, the CSSC has helped providers prescribe responsibly by taking advantage of One Chart technology, implementing protocols for conditions such as low back pain, migraine, and weaning patients from opiates when necessary. An enterprise pain agreement with workflows and guidelines was established using best practices. |
| **HEALTH CARE ACCESS** | |
| Access to affordable health insurance coverage – 6% of resident survey participants do not have health insurance | Sanford financial counselors and social workers are available to assist patients in finding the appropriate plan and with enrollment. Sanford Health provides health insurance options to the community via marketplace and works with a third party vendor to assist uninsured patients with finding insurance coverage. |
| Access to affordable health care | Financial counselors are available to help patients who need free or discounted care. |
| **MENTAL HEALTH & SUBSTANCE ABUSE** | |
| Drug use and abuse | The Integrated Health Therapist (IHT) serves as an integral core team member within the patient-centered Medical Home. The IHT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The IHT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The IHT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management.<br><br>IHT Key Points:<br>• IHT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease.<br>• IHT works to ensure seamless interface between primary care and specialty and/or community-based resources.<br>• They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. |
| Drugs in the home that are not being used – 30% | A *Take Back Program* is available in the community through law enforcement. Sanford clinicians will encourage patients to take their unused medications to the take back site. |

| Identified Concerns | How Sanford Aberdeen is Addressing the Community Needs |
|---|---|
| Diagnosed with depression – 49% | Sanford Primary Care Providers (PCPs) screen patients for depression using the PHQ-9 assessment tool. Patients are assessed at every PCP visit. |
| Diagnosed with anxiety/stress – 49% | Sanford clinicians assess and provide treatment for anxiety and stress. |
| Currently smoke cigarettes – 13% | The Integrated Health Therapist (IHT) serves as an integral core team member within the patient-centered Medical Home. The IHT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The IHT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The IHT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management.<br><br>IHT Key Points:<br>• IHT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease.<br>• IHT works to ensure seamless interface between primary care and specialty and/or community-based resources.<br>• They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. |
| Binge drink – 44% | The Integrated Health Therapist (IHT) serves as an integral core team member within the patient-centered Medical Home. The IHT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The IHT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The IHT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management.<br><br>IHT Key Points:<br>• IHT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease.<br>• IHT works to ensure seamless interface between primary care and specialty and/or community-based resources.<br>• They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. |

| Identified Concerns | How Sanford Aberdeen is Addressing the Community Needs |
|---|---|
| Alcohol use has had a harmful effect on themselves or a family member in the past 2 years – 28% | The Integrated Health Therapist (IHT) serves as an integral core team member within the patient-centered Medical Home. The IHT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The IHT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The IHT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and that patients are receiving appropriate behavioral health management.<br><br>IHT Key Points:<br>• IHT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease.<br>• IHT works to ensure seamless interface between primary care and specialty and/or community-based resources.<br>• They are able to assist in mental health crisis management and intervention within the clinic setting helping ensure patient safety. |
| **WELLNESS** | |
| Don't get moderate activity 3 or more times/week – 44% | Sanford Primary Care Providers (PCPs) recommend exercise during each clinic visit. |
| Overweight or obese – 75% | Sanford dietitians provide nutrition education through the following:<br>• Cooking classes and nutrition education to student athletes<br>• Nutrition presentations to groups with cancer and other chronic conditions (breast cancer, COPD, diabetes, etc.)<br>• Participation in community health fairs<br>• Nutrition education for pregnant women and new moms (*B4 Baby*)<br>• *Introduction of Solids* (nutrition class series) for new parents<br>• Participation in TV, radio, and newspaper interviews regarding nutrition topics in the news<br>• Diabetes Prevention Program<br>• *Cooking with the Cardiologist* for community members to attend<br>• Participation in various community youth events through the schools (middle school/high school) promoting good nutrition |
| Do not eat 5 or more fruits/vegetables per day – 55% | Sanford dietitians provide nutritional education that recommends five or more fruits and vegetables daily. Public Health leaders were invited to learn about the findings of the survey research. |
| Diagnosed with hypertension – 32% | Sanford dietitians are available to provide medical nutrition therapy to reduce hypertension. Sanford providers provide treatment for hypertension. Sanford Better Choices, Better Health is available free of charge and is a six-week self-management course for people living with a chronic disease. |
| Diagnosed with high cholesterol – 29% | Sanford dietitians are available to provide medical nutrition therapy to reduce cholesterol. Sanford providers provide treatment for high cholesterol. Sanford Better Choices, Better Health is available free of charge and is a six-week self-management course for people living with a chronic disease. |

| Identified Concerns | How Sanford Aberdeen is Addressing the Community Needs |
|---|---|
| Diagnosed with arthritis – 24% | Sanford providers provide medical management for arthritis. Sanford Better Choices, Better Health is available free of charge and is a six-week self-management course for people living with a chronic disease. |
| Haven't had a routine check-up in more than 1 year – 24% | Sanford Heath recommends routine check-ups to promote primary prevention. |
| Have not had a flu shot this year – 33% | Sanford PCPs recommend flu shots to their patients and provide the flu vaccine each fall/winter. |
| Have not visited a dentist in more than a year – 28% | Sanford does not provide dental care; however, the results of this research will be shared with the local dental association. |

# Implementation Strategies - 2018

Priority 1: Health Care Access

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

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

Priority 2: Mental Health/Behavioral Health and Substance Abuse

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

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

## Implementation Strategy Action Plan – 2018

## Community Health Needs Assessment

**Priority 1: Health Care Access**

**Projected Impact: Community members understand health care insurance options and no one is denied health care**

**Goal 1: Create a tutorial for community members who seek to secure health care coverage**

| Actions/Tactics | Measurable Outcomes & Timeline | Dedicated Resources/ Budget/Resource Assumptions | Leadership | Note any community partnerships and collaborations - if applicable |
|---|---|---|---|---|
| Develop a cross walk of insurance plans and their coverage options | A tutorial is in place for distribution to local social service outlets | Social Services<br>Financial Services | Ashley Erickson<br>Jeffrey Poppen<br>Sanford Health Plan | Leaders from Payor Groups |
| Patients and community members receive information about the Sanford Community Care Program | # of individuals receiving Community Care in 2019, 2020, 2021 | Financial Counselors<br>Marketing | Ashley Erickson<br>Jeffrey Poppen | Local media outlets providing PSAs |

**Priority 2: Mental Health and Substance Abuse**

**Projected Impact: Mental health services are available in Aberdeen and there is a reduction of opioid prescriptions at Sanford Health**

**Goal 1: Psychiatry services are available at Sanford Aberdeen**

| Actions/Tactics | Measurable Outcomes & Timeline | Dedicated Resources/ Budget/Resource Assumptions | Leadership | Note any community partnerships and collaborations - if applicable |
|---|---|---|---|---|
| Telemedicine outreach is available from Sanford Sioux Falls to Sanford Aberdeen | # of referrals during FY 2019, 2020, 2021 | Office Staff<br>Nurses | Ashley Erickson<br>Clinic Leadership | |

**Goal 2: Reduce the severity of depression**

| Actions/Tactics | Measurable Outcomes & Timeline | Dedicated Resources/ Budget/Resource Assumptions | Leadership | Note any community partnerships and collaborations - if applicable |
|---|---|---|---|---|
| Integrated Health Therapists are available in the primary care setting to assess, provide therapy or refer patients for services | # of visits for IHT<br><br># of referrals for psychology/psychiatry services | IHT<br>Clinic Leadership | Ashley Erickson<br>IHT | |
| All PCP visits include depression screening using the PHQ-9 assessment tool | % of patients with major depression and an initial score of 9 or greater whose six month PHQ-9 score is less than 5 | | | |

**Goal 3: CDC and Sanford standards of opioid prescribing practices are fully integrated**

| Actions/Tactics | Measurable Outcomes & Timeline | Dedicated Resources/ Budget/Resource Assumptions | Leadership | Note any community partnerships and collaborations - if applicable |
|---|---|---|---|---|
| Analyze compliance with Sanford's accepted opioid prescribing standard | % reduction in opioid prescriptions for FY 2019, 2020, 2021 | Medical Director<br>Pharm D | Quality Cabinet<br>Ashley Erickson | |

## Demonstrating Impact - FY 2017-2019 Action Plan

**<u>Priority 1</u>: Physical Health**

**Goal: Improve Care of Patients with Obesity Diagnosis**

| Actions/Tactics | Measureable Outcomes | Resources | Leadership | Community partnerships and collaborations |
|---|---|---|---|---|
| Provide Sanford *fit* program to the local schools and child care centers | Sanford *fit* is available to all students and families in the area through classroom and *fit* website | Sanford *fit* Leadership<br>Teachers | Sanford Leaders | Local schools<br>Child Care Leaders |

**<u>Priority 2</u>: Mental Health**

**Goal: Improve Care of Patients with Depression Diagnosis**

| Actions/Tactics | Measureable Outcomes | Resources | Leadership | Community partnerships and collaborations |
|---|---|---|---|---|
| Develop Sanford *My Chart* capabilities for depression assessment | Percentage of patients with major depression or dysthymia and an initial PHQ-9 score greater than nine whose six-month PHQ-9 score was less than five | Sanford Clinical Services<br>IT Leadership | CMO, CNO, Clinic Director | |
| Provide education on workflow to all RN Health Coaches and panel specialists to standardize workflow | All RN Health Coaches and staff in primary care staff receive education on workflow | All RN Health Coaches | CMO, CNO, Clinic Director | |

# Demonstrating Impact – Addressing the Needs

## Physical Health

**Goal: Improve Care of Patients with Obesity Diagnosis**

Sanford Aberdeen Medical Center focused on the pediatrics population by providing Sanford *fit* program materials to area schools and childcare centers; promoting health and wellness. Sanford *fit* is available to all students and families through classroom and/or online through Sanford *fit* website. In addition, Sanford continues to offer the following educational sessions for the community:

- Cooking classes and nutrition education for student athletes
- Nutrition presentations to groups with cancer and other chronic conditions (breast cancer, COPD, diabetes, etc.)
- Participation in community health fairs
- Nutrition education for pregnant women and new moms (*B4 Baby*)
- *Introduction of Solids* (nutrition class series) for new parents
- TV, radio, and newspaper interviews regarding nutrition topics in the news
- Diabetes Prevention Program
- *Cooking with the Cardiologist* for community members
- Participation in various community youth events through the schools (middle school/high school) promoting good nutrition

## Mental Health

**Goal: Improve Care of Patients with Depression Diagnosis**

Sanford Health developed a depression assessment tool for patients to complete during a clinic visit. Education to local teams on the assessment tool for clinicians to use in treatment plans for patients provided a quality measure for depression readmission for 6 months and 12 months for our teams to monitor. Sanford Aberdeen Medical Center also added an Integrated Health Therapist (IHT) to the team as a resource along with RN Health Coaches and care coordination assistant.

The Integrated Health Therapist (IHT) serves as an integral core team member within the patient-centered Medical Home. The IHT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The IHT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning.

## Community Feedback from the 2016 Community Health Needs Assessment

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

# Appendix

# Primary Research

# Aberdeen Asset Map

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| Economic Well Being | Skilled labor workforce 3.53<br><br>22% of resident respondents report running out of food before they had money to buy more | 22% of resident respondents report running out of food before they had money to buy more | Children living in poverty 12% Brown County, 14% Edmunds County | Employment agencies/resources:<br>• SD Dept. of Labor, 8 - 2nd Ave. SE, Aberdeen<br>• SD Job Service, 420 S. Roosevelt St., Aberdeen<br>• Express Employment Professionals, 221 – 6th Ave. SE, Aberdeen<br>• Experience Works, 100 S. Spring Ave., Sioux Falls<br><br>Major employers:<br>• 3M, 610 County Rd. 19, Aberdeen<br>• Avera St. Luke's, 305 S. State St., Aberdeen<br>• Bethesda Home, 1224 S. High St., Aberdeen<br>• Hub City, 2914 Industrial Ave., Aberdeen<br>• Kessler's, 615 – 6th Ave. SE, Aberdeen<br>• Midstates Inc., 4820 Capital Ave. NE, Aberdeen<br>• Molded Fiber Glass SD, 1401 Brown Co. 19 N., Aberdeen<br>• Sanford Medical Center, 2905 – 3rd Ave. SE, Aberdeen<br>• WalMart, 3820 – 7th Ave. SE, Aberdeen<br>• Wells Fargo, 204 – 1st St. S., Aberdeen<br>• Wyndham Hotel Group, 1910 – 8th Ave. NE, Aberdeen<br><br>Food resources:<br>• Good Shepherd Lutheran (meals & commodity food distribution), 1429 N. Dakota St., Aberdeen<br>• Meals on Wheels, 1301 – 7th Ave. SE, Aberdeen<br>• SNAP, 3401 – 10th Ave. SE, Aberdeen<br>• WIC, 402 S. Main St., Aberdeen<br>• Salvation Army (free lunch, food pantry, senior food box), 1003 – 6th Ave. SW, Aberdeen<br>• Senior Meals program, 405 – 8th Ave. NW, Aberdeen<br>• Kessler's Foods, 615 – 6th Ave. SE, Aberdeen<br>• Ken's Super Fair Foods, 2105 – 6th Ave. SE, Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Kaw Lah Asian Market, 608 S. Congress St., Aberdeen | |
| Aging Population | Cost of memory care 3.89<br><br>Cost of long term care 3.83 | | | Memory Care resources:<br>• Red Rose Care Home, 2522 – 13th Ave. SE, Aberdeen<br>• Angelhaus, 1717 E. Melgaard Rd., Aberdeen<br>• Primrose Retirement Community, 1701 – 3rd Ave. SE, Aberdeen<br>• Primrose Cottages<br>• Bethesda Towne Square, 1425 – 15th Ave. SE, Aberdeen<br>• ManorCare, 400 – 8th Ave. NW, Aberdeen<br>• Avera Mother of Joseph Retirement Community, 1002 N. Jay St., Aberdeen<br>• Nano Nagle Village, 1002 N. Jay St., Aberdeen<br>• Alzheimer's Association, alz.org<br>• Heidie Holmstrom, Alzheimer's Therapist, 419 Moccasin Dr., Aberdeen<br>• Brain Injury Support Group, rehab center at 305 S. State St., Aberdeen<br>• Memory Care Support Group for Caregivers, 1324 – 12th Ave. SE, Aberdeen<br><br>Long Term Care resources:<br>• SD Dept. of Social Services, 3401 – 10th Ave. SE, Aberdeen<br>• Red Rose Care Home, 2522 – 13th Ave. SE, Aberdeen<br>• Angelhaus, 1717 E. Melgaard Rd., Aberdeen<br>• Primrose Retirement Community, 1701 – 3rd Ave. SE, Aberdeen<br>• Primrose Cottages, 1518 Meadowbrook Ct., Aberden<br>• Primrose Place, 1801 – 3rd Ave. SE, Aberdeen<br>• Bethesda Towne Square, 1425 – 15th Ave. SE, Aberdeen<br>• ManorCare, 400 – 8th Ave. NW, Aberdeen<br>• Avera Mother of Joseph Retirement Community, 1002 N. Jay St., Aberdeen<br>• Nano Nagle Village, 1002 N. Jay St., Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Aberdeen Health & Rehab, 1700 US 281, Aberdeen | |
| Safety | Abuse of prescription drugs 3.50 | | | Prescription Drug Abuse resources:<br>• SAMHSA Helpline, 800-662-4357<br>• Avera Worthmore Addiction Services, 1206 S. Main, Aberdeen<br>• NADRIC Treatment Center, 1400 – 15th Ave. NW, Aberdeen<br>• NA meetings<br>o Faith United Methodist, 503 S. Jay St., Aberdeen<br>o St. Mark's Episcopal, 1410 N. Kline, Aberdeen<br>o The Yellow House, 519 S. Arch St., Aberdeen | |
| Health Care Access | Access to affordable health insurance coverage 3.87<br><br>6% report that they do not have health insurance<br><br>Access to affordable health care 3.75 | 6% report that they do not have health insurance | | Health Insurance resources:<br>• SHINE (Senor Health Information & Insurance Education), SHINE@activegen.org<br>• SD Division of Insurance, 124 S. Euclid, Pierre<br>• Mark Mehlhoff Insurance, 706 S. Main St., Aberdeen<br>• Avera Health Plans, 522 S. Arch St., Aberdeen<br>• Sanford Health Plan, 300 Cherapa Place, Sioux Falls<br>• Rhodes Anderson Insurance, 401 S. Main St., Aberdeen<br><br>Affordable Health Care resources:<br>• Sanford Community Care program, 3015 – 3rd Ave. SE, Aberdeen<br>• Avera Charity Care program, 305 S. State St., Aberdeen<br>• U.S. Indian Health, 115 – 4th Ave. SE, Aberdeen<br>• City Health Dept., 123 S. Lincoln, Aberdeen<br>• Brown Co. Community health Center, 402 S. Main, Aberdeen<br>• Community Health Center, 506 S. Wilson, Aberdeen<br>• VA Clinic, 2301 – 8th Ave. NE, Aberdeen<br>• AngelKare Home Health, 801 – 12th Ave. SE, Aberdeen<br>• Avera Home Health, 305 S. State St., Aberdeen<br>• Avera Hospice, 305 S. State St., Aberdeen<br>• Bethesda Home Care, 1324 – 12th Ave. SE, Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Avera HME, 418 S. 2nd St., Aberdeen<br>• Prairie Innovations HME, P O Box 887, Aberdeen<br>• PSI Healthcare, Inc., 1108 – 6th Ave. SE, Aberdeen | |
| Mental Health and Substance Abuse | Drug use and abuse 3.62<br><br>30% self-report that they have drugs in their home that are not being used<br><br>49% report that they have been diagnosed with depression<br><br>49% report they have been diagnosed with anxiety/stress<br><br>13% currently smoke cigarettes<br><br>44% self-report that they binge drink<br><br>28% report that alcohol use has had a harmful effect on themselves or a family member in the past 2 years | 30% self-report that they have drugs in their home that are not being used<br><br>49% report that they have been diagnosed with depression<br><br>49% report they have been diagnosed with anxiety/stress<br><br>13% currently smoke cigarettes<br><br>44% self-report that they binge drink<br><br>28% report that alcohol use has had a harmful effect on themselves or a family member in the past 2 years | Excessive drinking 18% in Brown and Edmunds Counties<br><br>Alcohol-impaired driving deaths 18% Brown, 0% in Edmunds<br><br>Adult smoking 15% in Brown and 14% in Edmunds | Substance Abuse resources:<br>• SAMHSA Helpline, 800-662-4357<br>• Avera Worthmore Addiction Services, 1206 S. Main, Aberdeen<br>• NADRIC Treatment Center, 1400 – 15th Ave. NW, Aberdeen<br>• AA, 519 S. Arch St., Aberdeen<br>• AA, 1723 S. Main, Aberdeen<br>• AA Clubhouse, 513 St. Arch St., Aberdeen<br>• Al-Anon, 1429 N. Dakota St., Aberdeen<br>• Al-Anon, 502 S. Lincoln St., Aberdeen<br>• Al-Anon Family Group, 1429 N. Dakota St., Aberdeen<br>• Alateen, 1429 N. Dakota St., Aberdeen<br>• Alano Society, P O Box 164, Aberdeen<br>• NA meetings<br>o Faith United Methodist, 503 S. Jay St., Aberdeen<br>o St. Mark's Episcopal, 1410 N. Kline, Aberdeen<br>o The Yellow House, 519 S. Arch St., Aberdeen<br><br>Drug Take-Back Programs:<br>• Aberdeen Police, 114 SE 2nd Ave., Aberdeen<br><br>Mental Health resources:<br>• Anxiety/Depression Management Support Group, 514 S. Main St., Aberdeen<br>• Depression Awareness, Recognition & Treatment, 800-421-4211<br>• Awakening Counseling Service, 2002 S. Main, Aberdeen<br>• NE Mental Health, 628 Circle Dr., Aberdeen<br>• Grief Share Support Group, 502 S. Lincoln, Aberdeen<br>• Grief Share Support Group, 1620 Milwaukee Ave., Aberdeen<br>• Grief Programs, 310 – 15th Ave. SE, Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • HALOS (Healing After a Loved One's Suicide), 502 S. Lincoln St., Aberdeen<br>• Divorced, Widowed & Separated Support Group, 310 – 15th Ave. SE, Aberdeen<br>• EMDR (Eye Movement, Desensitization Reprocessing – treatment for PTSD, abuse, trauma), 514 S. Main St., Aberdeen<br>• Northern Plains Psychological Associates, 405 – 8th Ave. NW, Aberdeen<br>• Behavior Care Specialists, 405 S. Washington, Aberdeen<br>• Lutheran Social Services, 202 S. Main, Aberdeen<br>• Breakthrough Psychologists, 404 S. Lincoln, Aberdeen<br>• Avera Psychiatric Associates, 201 S. Lloyd St., Aberdeen<br>• Avera Behavioral Health Program, 105 S. State, Aberdeen<br>• VA Clinic, 2301 – 8th Ave. NE, Aberdeen<br>• Catholic Family Services Counseling, 310 – 15th Ave. SE, Aberdeen<br>• NSU Counseling Center, 1200 S. Jay St., Aberdeen<br>• Aberdeen Boys & Girls Club (counseling available to anyone who wants it) , 111 – 1st Ave. SE, Aberdeen<br>• New Beginnings Center, 1601 Milwaukee Ave. NE, Aberdeen<br>• Professional Counseling Service, 508 S. Boyd St., Aberdeen<br>• Intercept EAP Counselor, P O Box 403, Aberdeen<br>• Footsteps Counseling, 514 S. Main, Aberdeen<br>• Dakota Counseling, 121 – 4th Ave. SW, Aberdeen<br>• Stephen Ministry, 619 – 8th Ave. NW, Aberdeen<br>• Suicide Prevention Hotline – 800-273-8255<br>• Survivors Support Group, 2005 S. Merton, Aberdeen<br>• Veterans Support Group, 502 S. Lincoln St., Aberdeen<br>• Widow Support Group, 2201 – 6th Ave. SE, Aberdeen<br>Tobacco Cessation resources: | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Holly Reich, PsyD, smoking cessation counselor, 405 – 8th Ave. NW, Aberdeen<br>• Quitline – SDQuitline.com<br>• Sanford Clinic, 3015 – 3rd Ave. SE, Aberdeen<br>• Avera Clinic, 105 S. State St., Aberdeen<br>• VA Clinic, 2301 – 8th Ave. NE, Aberdeen<br>• U.S. Indian Health Clinic, 115 – 4th Ave. SE, Aberdeen<br>• City Health Dept., 123 S. Lincoln, Aberdeen<br>• SD Dept. of Health, 600 E. Capitol, Pierre<br>• No-Smoke.org | |
| Wellness | 44% report not getting moderate activity 3 or more times/week<br><br>44% report that they are obese<br><br>31% report that they are overweight<br><br>55% of residents do not consume 5 or more fruits/vegetables each day<br><br>32% have been diagnosed with hypertension<br><br>29% have been diagnosed with high cholesterol<br><br>24% have been diagnosed with arthritis<br><br>24% report not having a routine check-up in more than a year<br><br>33% have not had a flu shot this year<br><br>28% report not having visited a dentist in more than a year | 44% report not getting moderate activity 3 or more times/week<br><br>44% report that they are obese<br><br>31% report that they are overweight<br><br>55% of residents do not consume 5 or more fruits/vegetables each day<br><br>32% have been diagnosed with hypertension<br><br>29% have been diagnosed with high cholesterol<br><br>24% have been diagnosed with arthritis<br><br>24% report not having a routine check-up in more than a year<br><br>33% have not had a flu shot this year<br><br>28% report not having visited a dentist in more than a year | Adult obesity 33% in Brown County, 28% in Edmunds | Physical Fitness resources:<br>• Massenomics, 209 Railroad Ave. SE, Aberdeen<br>• School District activities, 1224 S. 3rd St., Aberdeen<br>• Park District activities, 225 SE 3rd Ave., Aberdeen<br>• YWCA, 5 S. State Street, Aberdeen<br>• Next Generation Performance Center, 3315 – 6th Ave. SE, Aberdeen<br>• Open Gym, 3315 – 6th Ave. SE, Aberdeen<br>• Crossfit Rails, 821 Railroad Ave. SE, Aberdeen<br>• Pilates Mat Classes, 225 – 3rd Ave. SE, Aberdeen<br>• PIYO Live Athletic Training, 401 Washington St., Aberdeen<br>• Women's Morning Classes, 401 Washington St., Aberdeen<br>• Walk for Health, 401 Washington St., Aberdeen<br>• Seniors Open Gym, 401 Washington St., Aberdeen<br>• Anytime Fitness, 321 S. Main, Aberdeen<br>• Snap Fitness, 1601 – 6th Ave. SE, Aberdeen<br>• ARCC Dance Program, 225 – 3rd Ave. SE, Aberdeen<br>• Curves, 2201 – 6th Ave. SE, Aberdeen<br>• Heart & Sole program, 300 W. 11th St., Sioux Falls | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Barnett Center at NSU (indoor walking track), 1200 S. Jay St., Aberdeen<br>• Balance Fitness, 2201 – 6th Ave. SE, Aberdeen<br>• Profiling Beauty Health & Wellness Studio, 224 – 1st Ave. SE, Aberdeen<br>• TM Fitness, 18 – 2nd Ave. SE, Aberdeen<br>• Body By Design, 1225 – 6th Ave. SE, Aberdeen<br>• Total Package MedSpa, 1400 -6th Ave. SE, Aberdeen<br>• Richmond Lake Recreation Area, 37908 Youth Camp Rd., Aberdeen<br>• Aquatic Center, 10th Ave. SE & Dakota St., Aberdeen<br>• Lee Park Golf Course, 1028 – 8th Ave. NW, Aberden<br>• Wylie Park/Storybook Land, 225 – 3rd Ave. SE, Aberdeen<br><br>Obesity resources:<br>• Profile by Sanford, 2905 – 3rd Ave. SE, Aberdeen<br>• FitPath Nutrition, 5 S. State Street, Aberdeen<br>• TOPS, 502 S. Lincoln, Aberdeen<br>• Weight Loss Center, 901 – 6th Ave. SE, Aberdeen<br>• Sanford Clinic dieticians, 3015 – 3rd Ave. SE, Aberdeen<br>• Avera Clinic dieticians, 105 S. State St., Aberdeen<br>• U. S. Indian Health, 115 – 4th Ave. SE, Aberdeen<br>• City Health Dept., 123 S. Lincoln, Aberdeen<br>• Brown Co. Community Health Center, 402 S. Main, Aberdeen<br>• Community Health Center, 506 S. Wilson, Aberdeen<br>• Nutritional Counseling (Rocky Steinert), 508 S, Boyd Street, Aberdeen<br>• Medical Weight Management – Maria Lao, MD, 815 – 1st Ave. SE, Aberdeen<br>• Avera Comprehensive Weight Management Program, 815 – 1st Ave. SE, Aberdeen<br>• Weight Loss Surgery (Curtis Peer, MD), 3015 - 3rd Ave. SE, Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Lifestyle Solutions Nutrition Center, 924 – 6th Ave. SE, Aberdeen<br><br>Healthy Food resources:<br>• Nutrition Education, 2905 – 3rd Ave. SE, Aberdeen<br>• Kessler's Foods, 615 – 6th Ave. SE, Aberdeen<br>• Ken's Super Fair Foods, 2105 – 6th Ave. SE, Aberdeen<br>• Kaw Lah Asian Market, 608 S. Congress St., Aberdeen<br>• Wheat Growers Farmers Market, 908 Lamont St. S., Aberdeen<br>• Aberdeen Farmers Market, 2nd Ave. & Jay St., Aberdeen<br>• CSAs:<br>o Amy's Heirloom Garden, 814 S. Kline St., Aberdeen<br>o Natural Abundance, 125 S. Main, Aberdeen<br>o Englehart Farm, 1011 – 6th Ave. SE, Aberdeen<br>o Prairiehill Farms, 12961 – 387 Ave., Aberdeen<br>o Concord Farms, 13350 – 379 Ave., Aberd3een<br>o Douglas Miller Farms, 1760 S. 4th St., Aberdeen<br>o Schaunaman's Farm, 321 – 9th Ave. NE, Aberdeen<br><br>Mental Health resources:<br>• Anxiety/Depression Management Support Group, 514 S. Main St., Aberdeen<br>• Depression Awareness, Recognition & Treatment, 800-421-4211<br>• Awakening Counseling Service, 2002 S. Main, Aberdeen<br>• NE Mental Health, 628 Circle Dr., Aberdeen<br>• Grief Share Support Group, 502 S. Lincoln, Aberdeen<br>• Grief Share Support Group, 1620 Milwaukee Ave., Aberdeen<br>• Grief Programs, 310 – 15th Ave. SE, Aberdeen<br>• HALOS (Healing After a Loved One's Suicide), 502 S. Lincoln St., Aberdeen<br>• Divorced, Widowed & Separated Support Group, 310 – 15th Ave. SE, Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • EMDR (Eye Movement, Desensitization Reprocessing – treatment for PTSD, abuse, trauma), 514 S. Main St., Aberdeen<br>• Northern Plains Psychological Associates, 405 – 8th Ave. NW, Aberdeen<br>• Behavior Care Specialists, 405 S. Washington, Aberdeen<br>• Lutheran Social Services, 202 S. Main, Aberdeen<br>• Breakthrough Psychologists, 404 S. Lincoln, Aberdeen<br>• Avera Psychiatric Associates, 201 S. Lloyd St., Aberdeen<br>• Avera Behavioral Health Program, 105 S. State, Aberdeen<br>• VA Clinic, 2301 – 8th Ave. NE, Aberdeen<br>• Catholic Family Services Counseling, 310 – 15th Ave. SE, Aberdeen<br>• NSU Counseling Center, 1200 S. Jay St., Aberdeen<br>• Aberdeen Boys & Girls Club (counseling available to anyone who wants it) , 111 – 1st Ave. SE, Aberdeen<br>• New Beginnings Center, 1601 Milwaukee Ave. NE, Aberdeen<br>• Professional Counseling Service, 508 S. Boyd St., Aberdeen<br>• Intercept EAP Counselor, P O Box 403, Aberdeen<br>• Footsteps Counseling, 514 S. Main, Aberdeen<br>• Dakota Counseling, 121 – 4th Ave. SW, Aberdeen<br>• Stephen Ministry, 619 – 8th Ave. NW, Aberdeen<br>• Suicide Prevention Hotline – 800-273-8255<br>• Survivors Support Group, 2005 S. Merton, Aberdeen<br>• Veterans Support Group, 502 S. Lincoln St., Aberdeen<br>• Widow Support Group, 2201 – 6th Ave. SE, Aberdeen<br>Chronic Disease resources:<br>• Look Good Feel Better, c/o American Cancer Society, cancer.org<br>• American Cancer Society, 4904 S. Technopolis Dr., Sioux Falls | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • American Heart Association, Heart.org<br>• Arthritis Foundation, P O Box 90445, Sioux Falls<br>• Multiple Sclerosis Support Group, 502 S. Lincoln St., Aberdeen<br>• Diabetes Support Group, 305 S. State St., Aberdeen<br>• Sanford Diabetes Support Groups, 2903 – 3rd Ave. SE, Aberdeen<br>• Sanford's Better Choices Better Health, 1305 W. 18th St., Aberdeen<br>• Pain Management Center, 815 – 1st Ave. SE, Aberdeen<br>• Cancer Support Group, 502 S. Lincoln St., Aberdeen<br>• Chronic Pain Support Group, 502 S. Lincoln St., Aberdeen<br>• Parkinson's Support Group, 1324 – 12th Ave. SE, Aberdeen<br>• Sanford Clinic, 3015 – 3rd Ave. SE, Aberdeen<br>• Avera Clinic, 105 S. State St., Aberdeen<br>• U.S. Indian Health, 115 – 4th Ave. SE, Aberdeen<br>• City Health Dept., 123 S. Lincoln, Aberdeen<br>• Brown Co. Community Health Center, 402 S. Main, Aberdeen<br>• Community Health Center, 506 S. Wilson, Aberdeen<br>• Aberdeen Stroke Club, 305 S. State Street, Aberdeen<br>• Eating Disorders Support Group, 3100 E. 49th St., Sioux Falls<br>• Kids with Diabetes Stroke Group, 2905 – 3rd Ave. SE, Aberdeen<br><br>Resources for routine check-ups & flu shots:<br>• Sanford Clinic, 3015 – 3rd Ave. SE, Aberdeen<br>• Avera Clinic, 105 S. State St., Aberdeen<br>• Aberdeen Pediatrics, 201 Lloyd St., Aberdeen<br>• U.S. Indian Health, 115 – 4th Ave. SE, Aberdeen<br>• City Health Dept., 123 S. Lincoln, Aberdeen<br>• Brown Co. Community Health Center, 402 S. Main, Aberdeen | |

| Identified concern | Key stakeholder survey | Resident survey | Secondary data – County Health Rankings 2018 | Community resources available to address the need | Gap ? |
|---|---|---|---|---|---|
| | | | | • Community Health Center, 506 S. Wilson, Aberdeen<br>• VA Clinic, 2301 – 8th Ave. NE, Aberdeen<br>• Pharmacies that give flu shots:<br>  o Shopko, 500 N. Hwy 281, Aberdeen<br>  o Jones Drug, 816 – 6th Ave. SE, Aberdeen<br>  o Plaza Pharmacy, 2201 – 6th Ave. SE, Aberdeen<br>  o State Street Pharmacy, 105 S. State St., Aberdeen<br>  o United Clinic Pharmacy, 3015 – 3rd Ave. SE, Aberdeen<br><br>Dental resources:<br>• Carrels & Bain Dental, 805 S. State St., Aberdeen<br>• The Best Dental Center, 1021 Circle Dr., Aberdeen<br>• Aberdeen Dental, 216 - 6th Ave. SE, Aberdeen<br>• Aberdeen Smiles, 1409 – 6th Ave. SE, Aberdeen<br>• Aberdeen Family Dental, 221 – 6th Ave. SE, Aberdeen<br>• Prairie Ridge Endo, 701 N. 4th St., Aberdeen<br>• Joseph Rigg Dental, 1315 – 6th Ave. SE, Aberdeen<br>• Smile Solutions, 105 – 6th Ave. SE, Aberdeen<br>• Van Laecken Ortho, 631 S. Roosevelt St., Aberdeen | |

# Key Stakeholder Survey

# Sanford Aberdeen Medical Center

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

November 2017

SANFORD

**STUDY DESIGN and METHODOLOGY**

The following report includes non-generalizable survey results from an October 2017 online survey of community leaders and key stakeholders identified by Sanford Aberdeen Medical Center. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. **Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred during the month of October and the first week of November. A total of 54 respondents participated in the online survey.

## TABLE OF CONTENTS

# SURVEY RESULTS

## Current State of Health and Wellness Issues within the Community

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

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

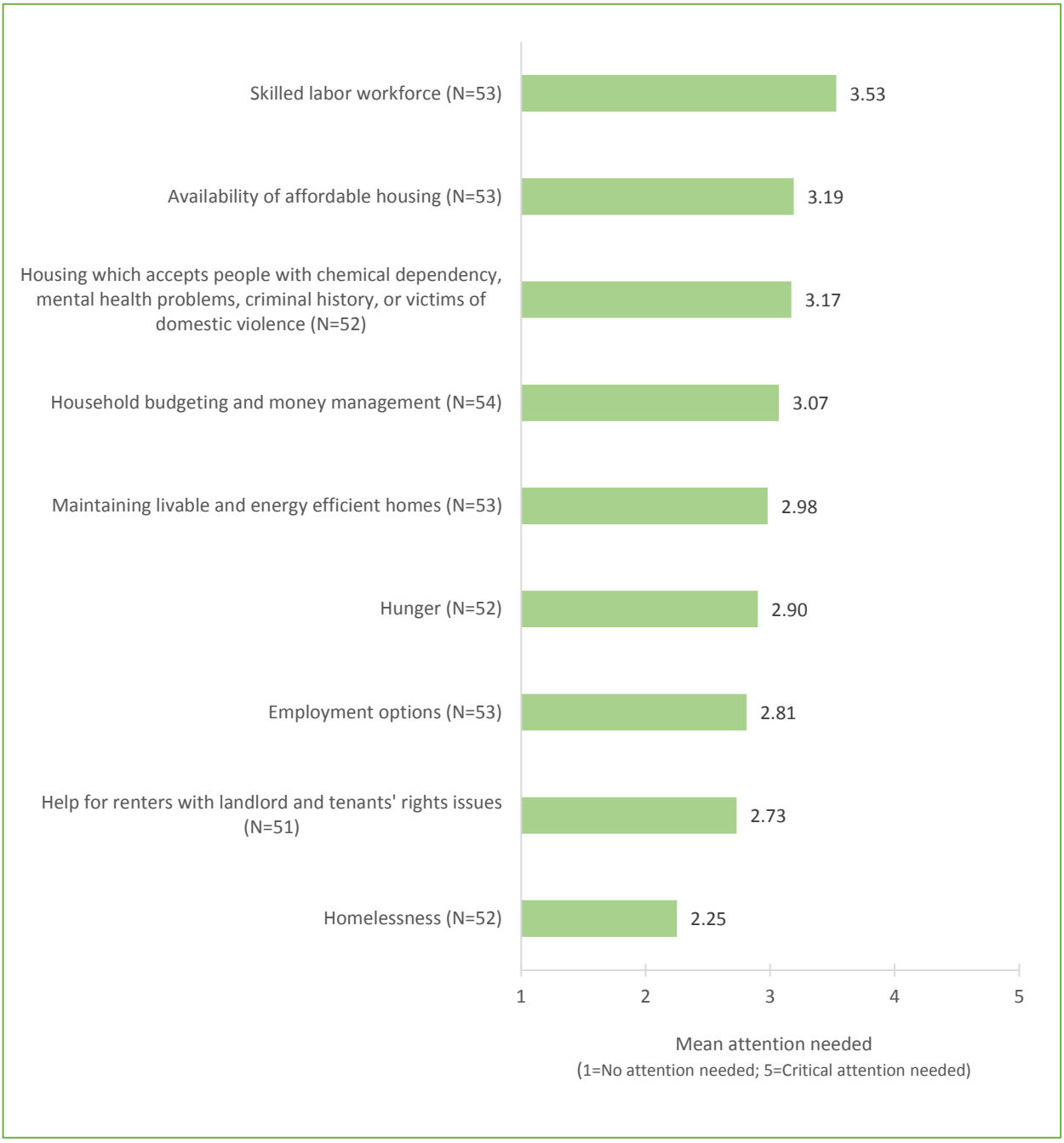


Figure 2. Current state of community issues regarding TRANSPORTATION

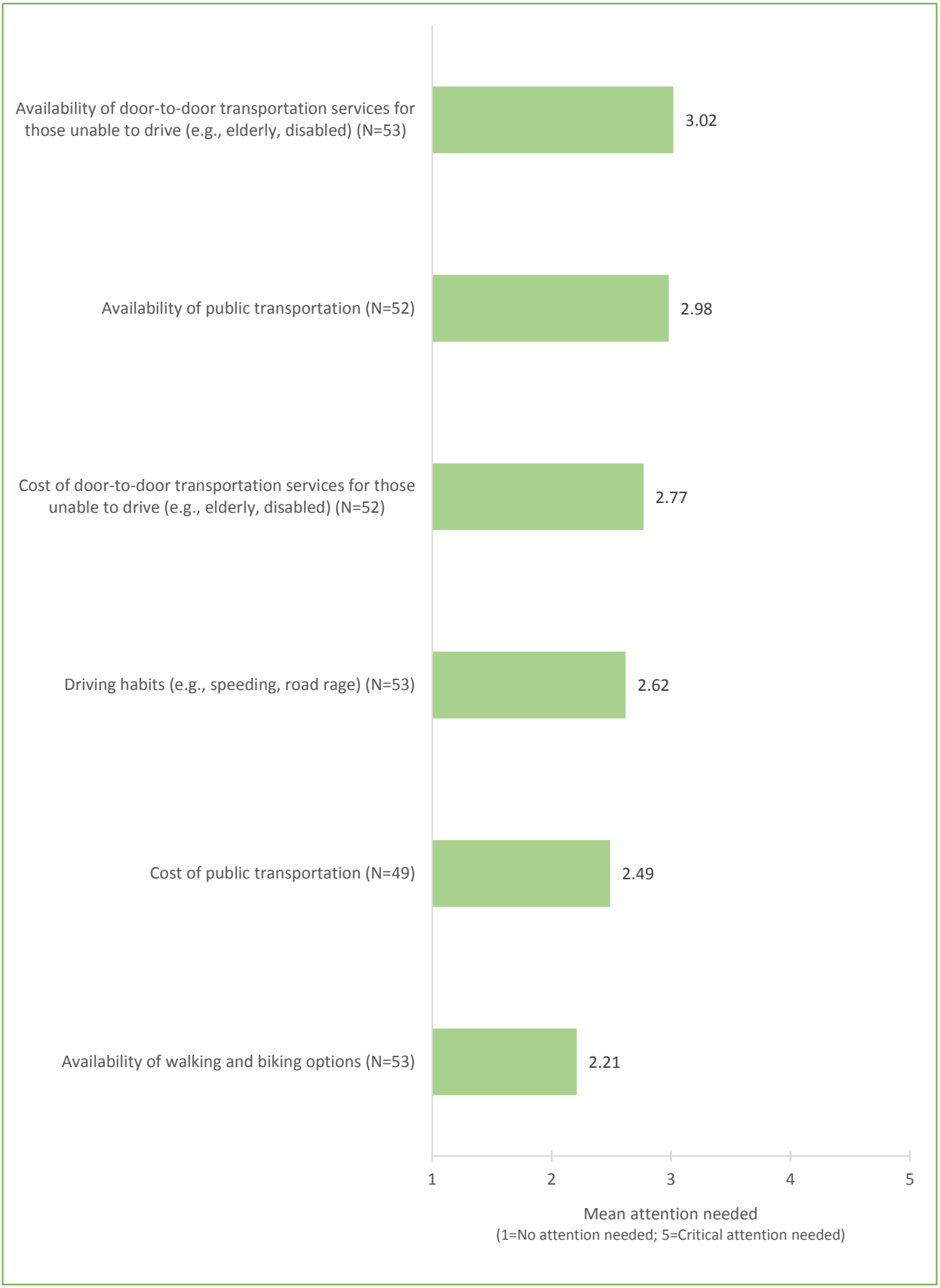


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

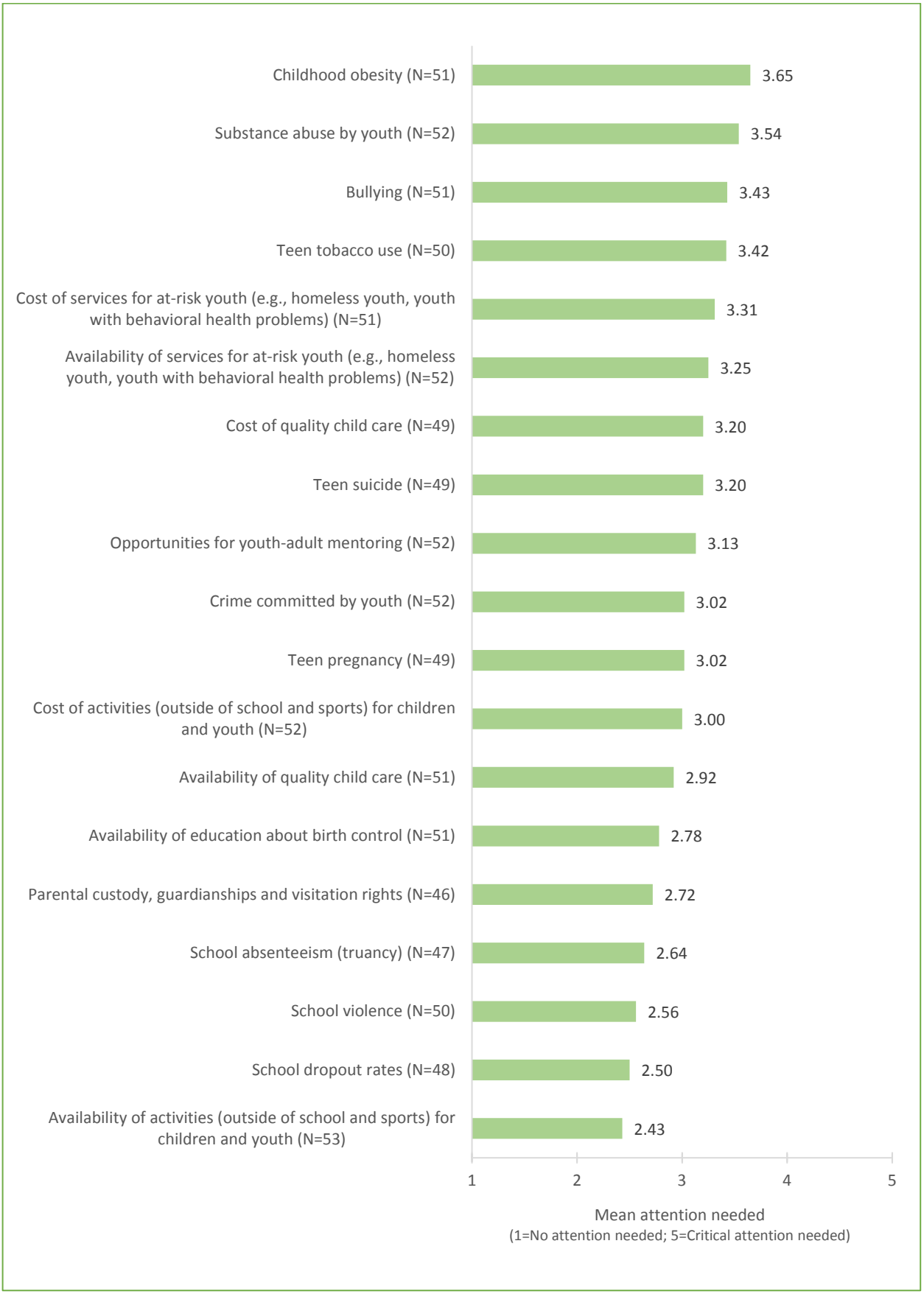

Childhood obesity (N=51)
3.65
Substance abuse by youth (N=52)
3.54
Bullying (N=51)
3.43
Teen tobacco use (N=50)
3.42
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=51)
3.31
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=52)
3.25
Cost of quality child care (N=49)
3.20
Teen suicide (N=49)
3.20
Opportunities for youth-adult mentoring (N=52)
3.13
Crime committed by youth (N=52)
3.02
Teen pregnancy (N=49)
3.02
Cost of activities (outside of school and sports) for children and youth (N=52)
3.00
Availability of quality child care (N=51)
2.92
Availability of education about birth control (N=51)
2.78
Parental custody, guardianships and visitation rights (N=46)
2.72
School absenteeism (truancy) (N=47)
2.64
School violence (N=50)
2.56
School dropout rates (N=48)
2.50
Availability of activities (outside of school and sports) for children and youth (N=53)
2.43
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

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

Figure 5. Current state of community issues regarding SAFETY

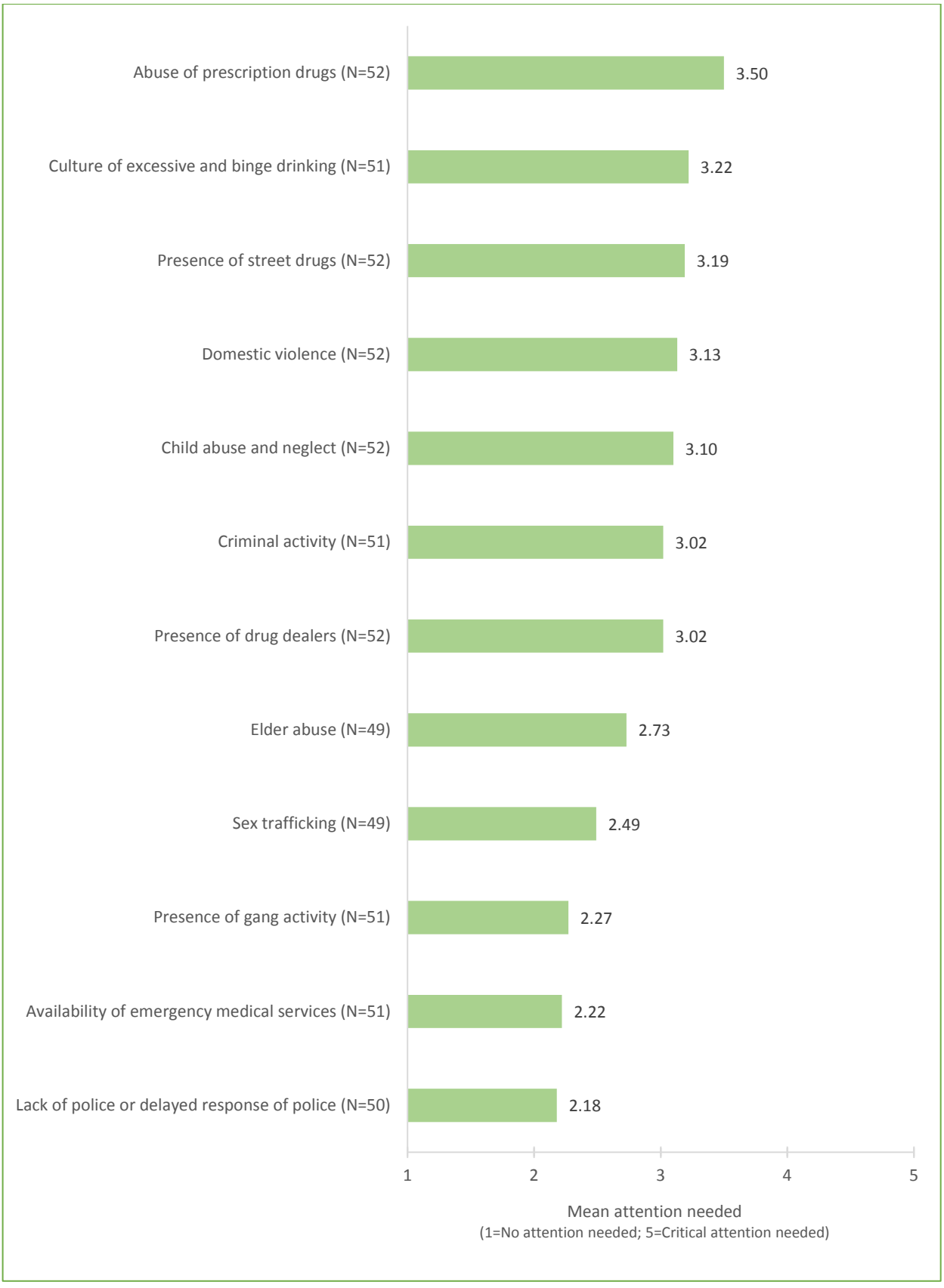
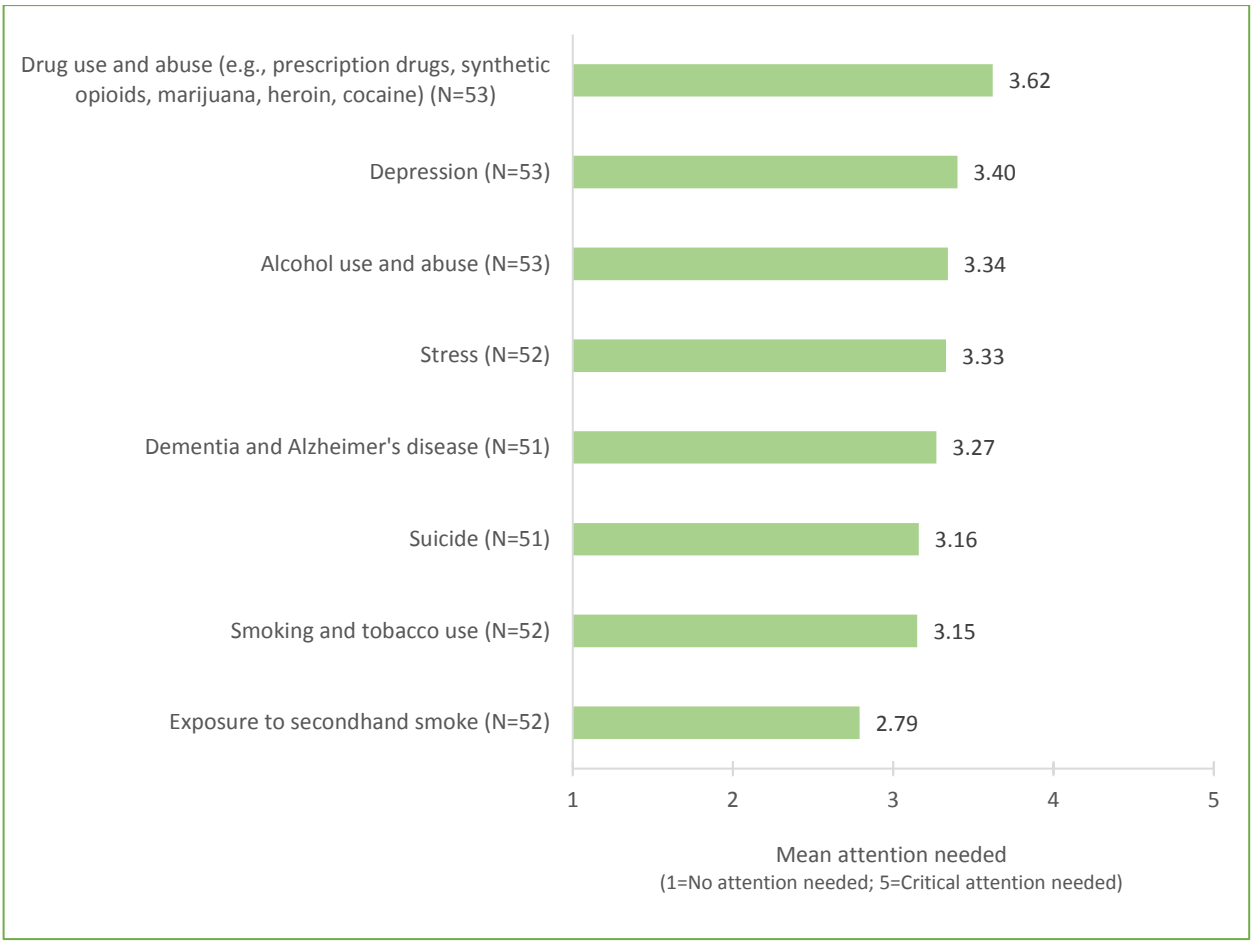


Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

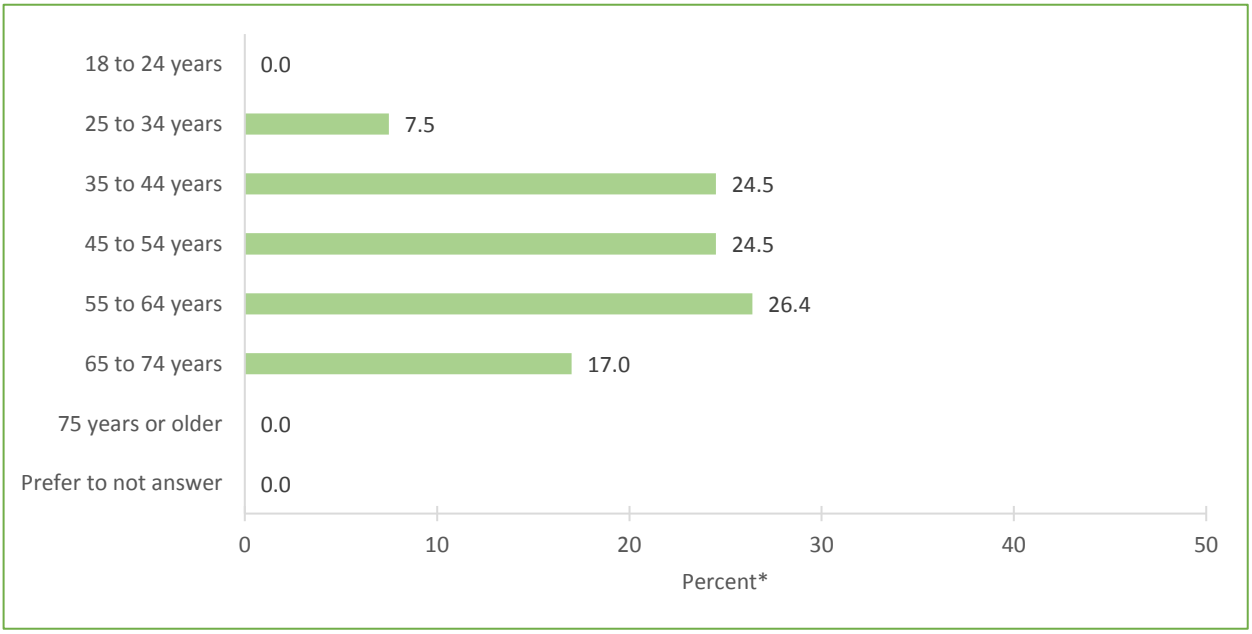

Access to affordable health insurance coverage (N=52)
3.87
Access to affordable healthcare (N=52)
3.75
Access to affordable prescription drugs (N=52)
3.46
Availability of specialist physicians (N=52)
3.19
Availability of mental health providers (N=51)
3.18
Access to affordable dental insurance coverage (N=52)
3.15
Availability of non-traditional hours (e.g., evenings, weekends) (N=50)
3.14
Access to affordable vision insurance coverage (N=52)
3.13
Availability of behavioral health (e.g., substance abuse) providers (N=52)
3.12
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=50)
2.98
Use of emergency room services for primary healthcare (N=49)
2.86
Coordination of care between providers and services (N=51)
2.78
Timely access to medical care providers (N=52)
2.69
Availability of healthcare services for New Americans (N=45)
2.67
Availability of healthcare services for Native people (N=44)
2.64
Availability of doctors, physician assistants, or nurse practitioners (N=52)
2.62
Access to technology for health records and health education (N=52)
2.44
Timely access to dental care providers (N=52)
2.42
Timely access to vision care providers (N=52)
2.35
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

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



## Demographic Information

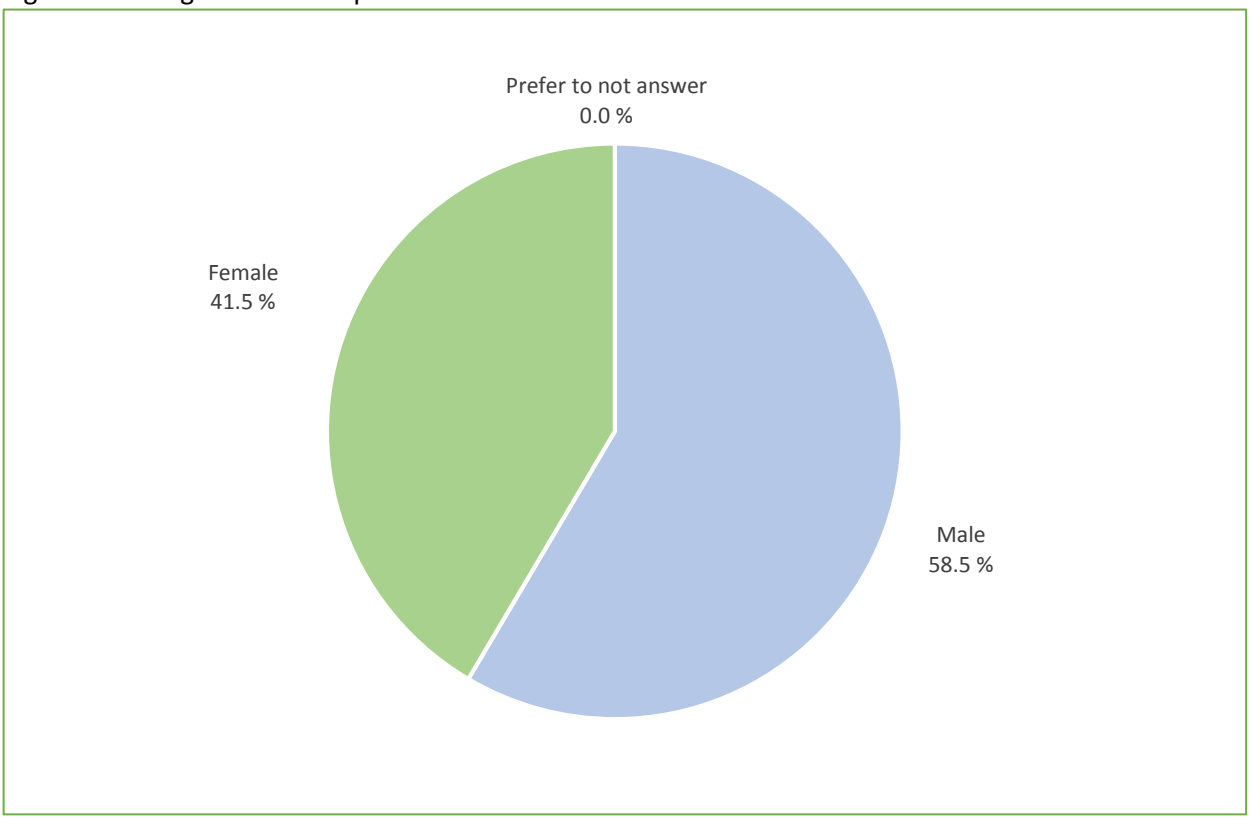
Figure 8. Age of respondents




N=53

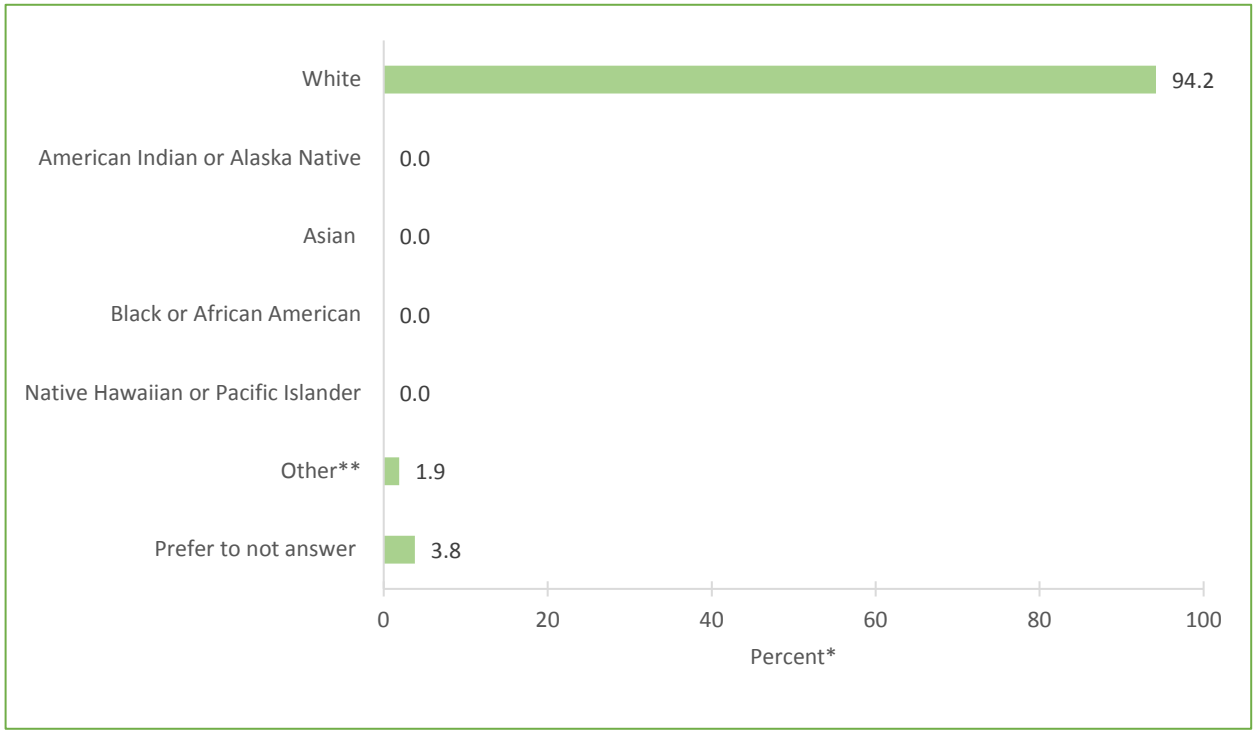
*Percentages do not total 100.0 due to rounding.

Figure 9. Biological sex of respondents




N=53

Figure 10. Race of respondents

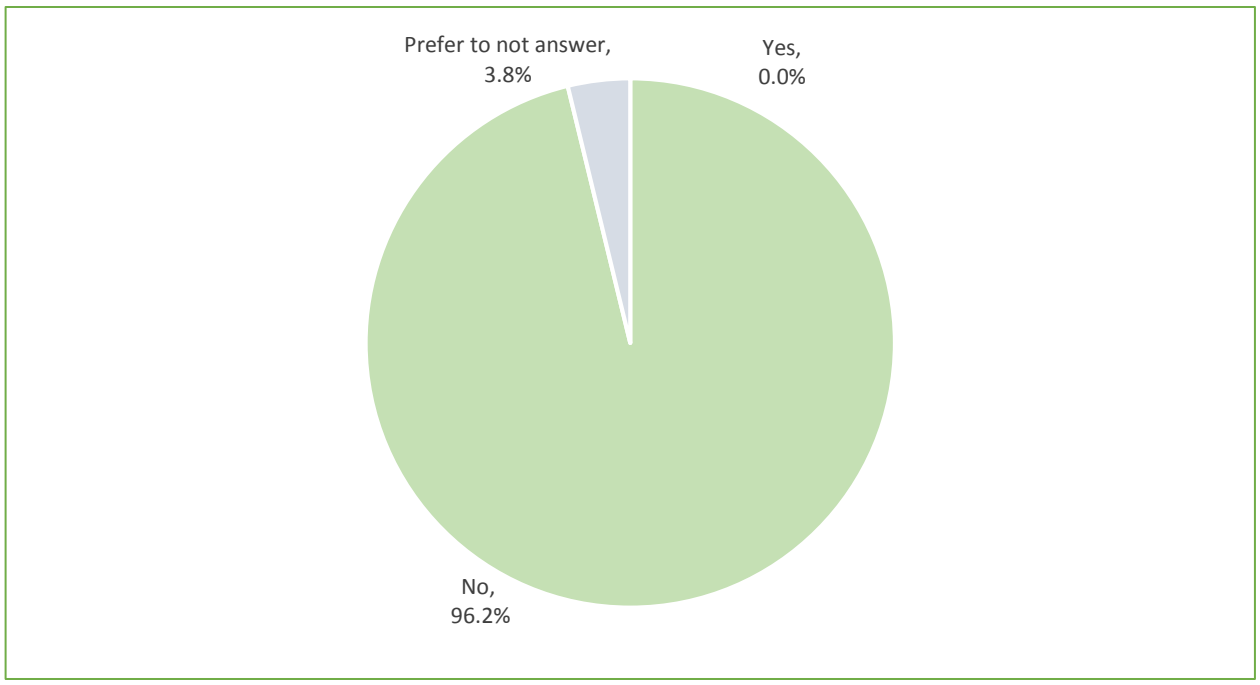



N=52

*Percentages do not total 100.0 due to rounding.

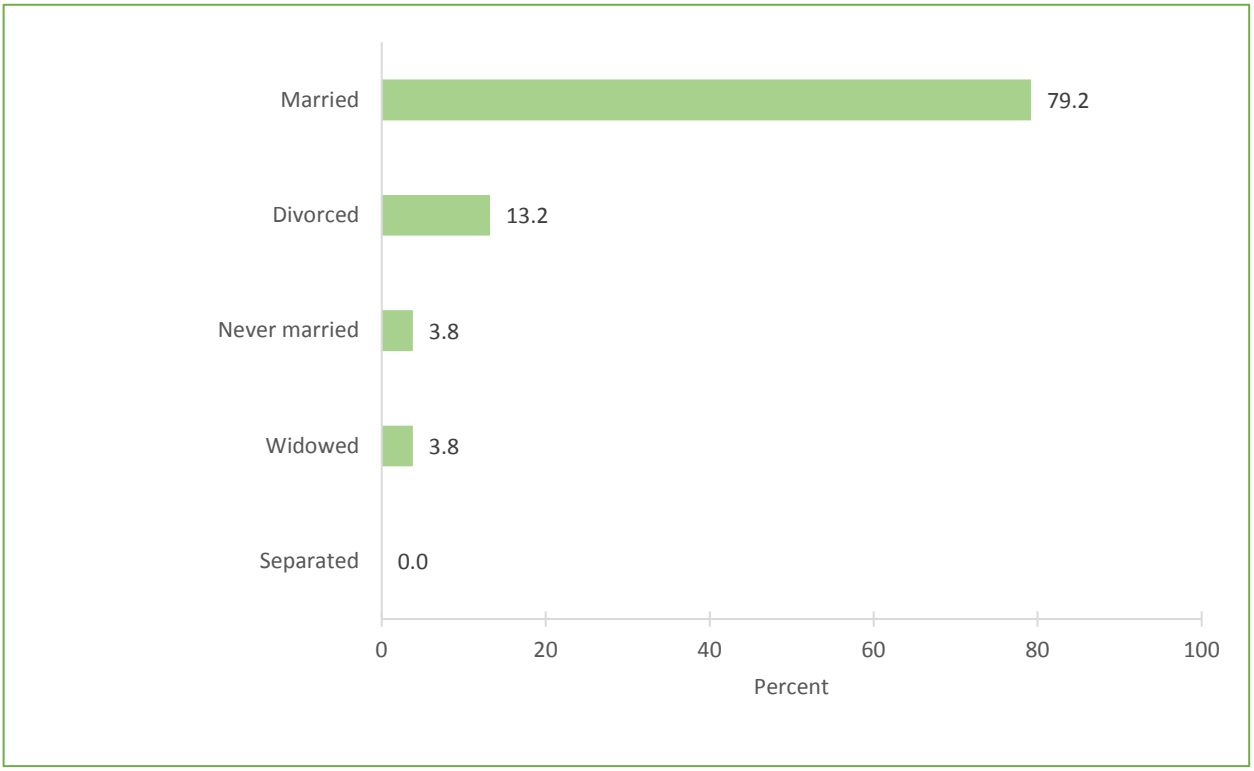
**Other response is “American”.

Figure 11. Whether respondents are of Hispanic or Latino origin



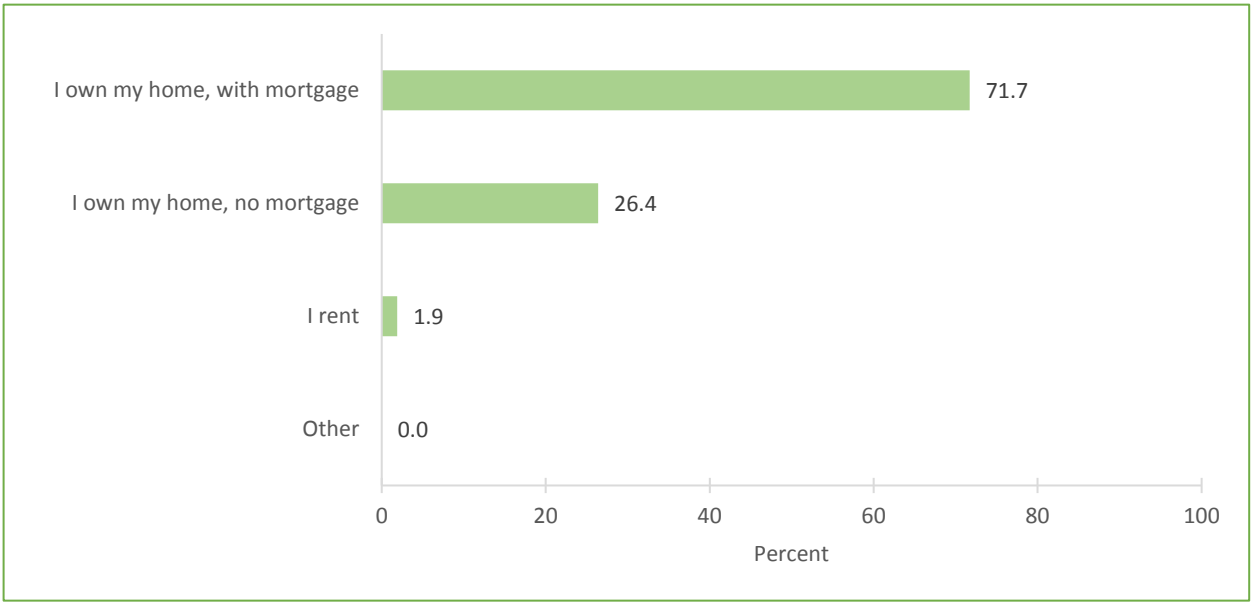

N=52

Figure 12. Marital status of respondents



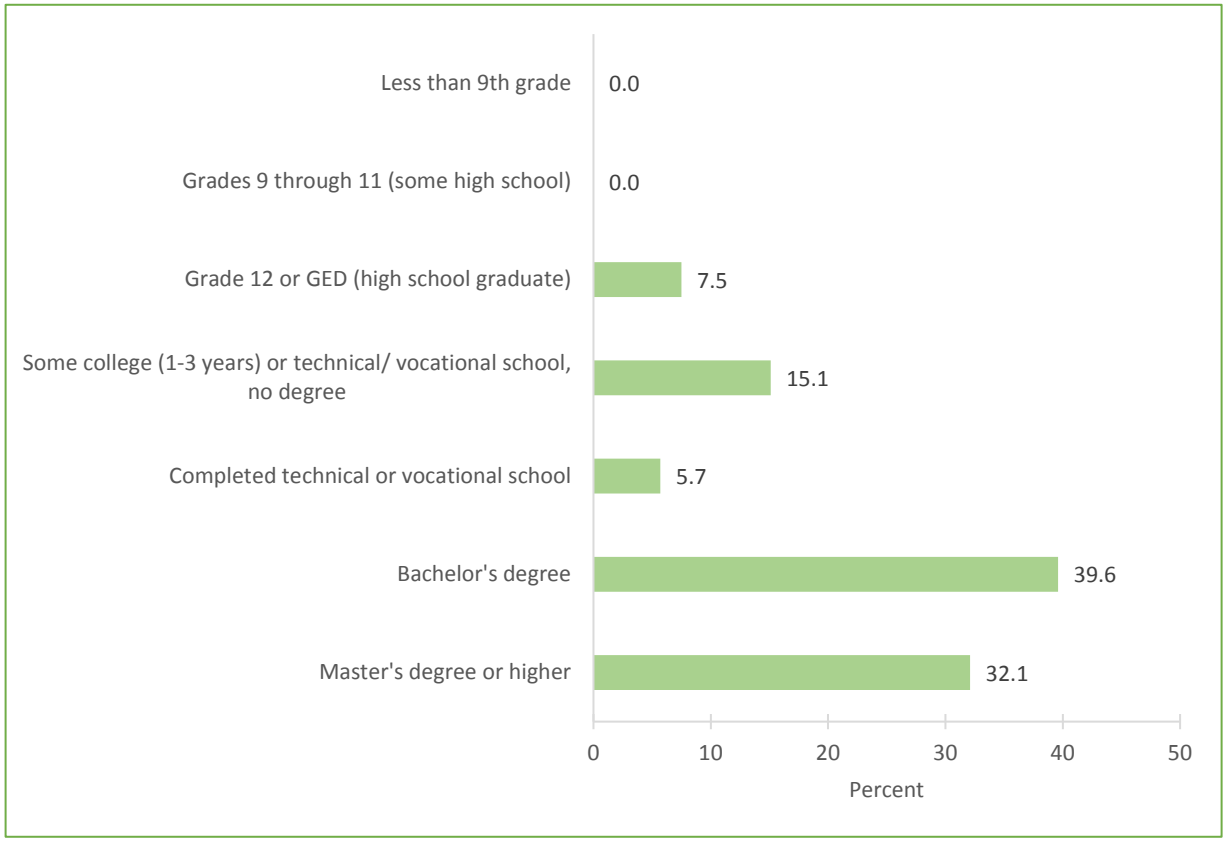

N=53

Figure 13. Living situation of respondents



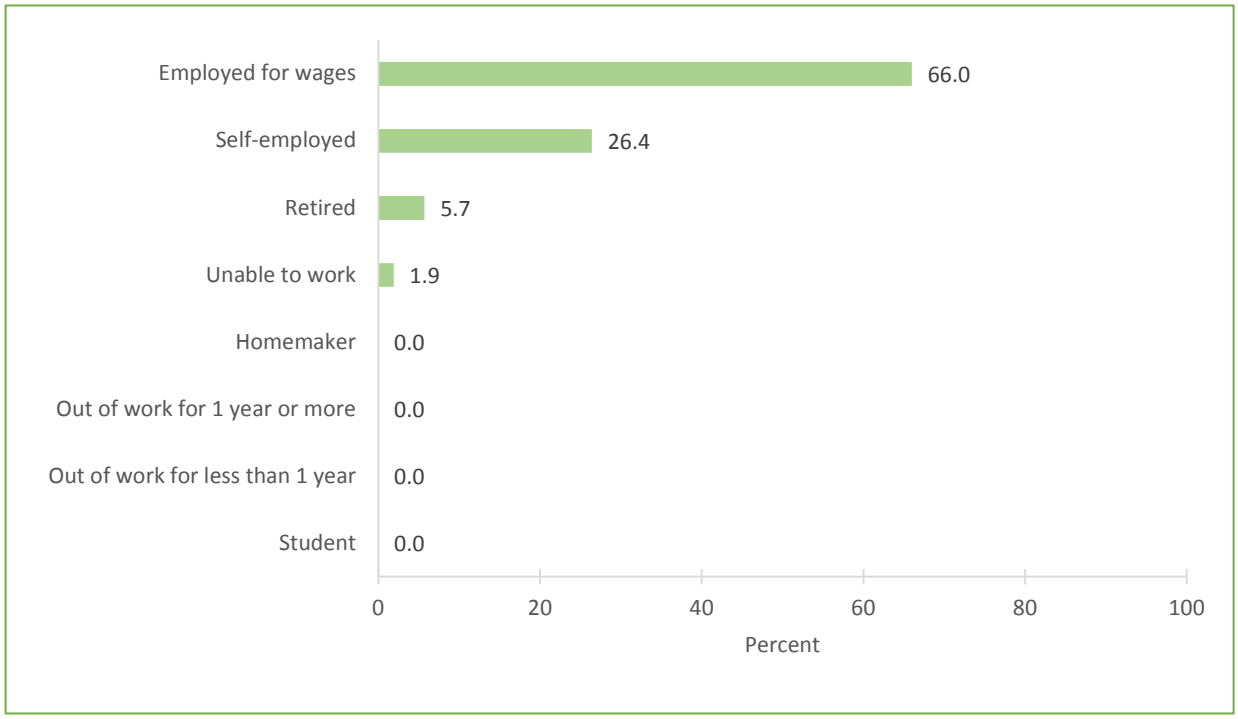

N=53

Figure 14. Highest level of education completed by respondents



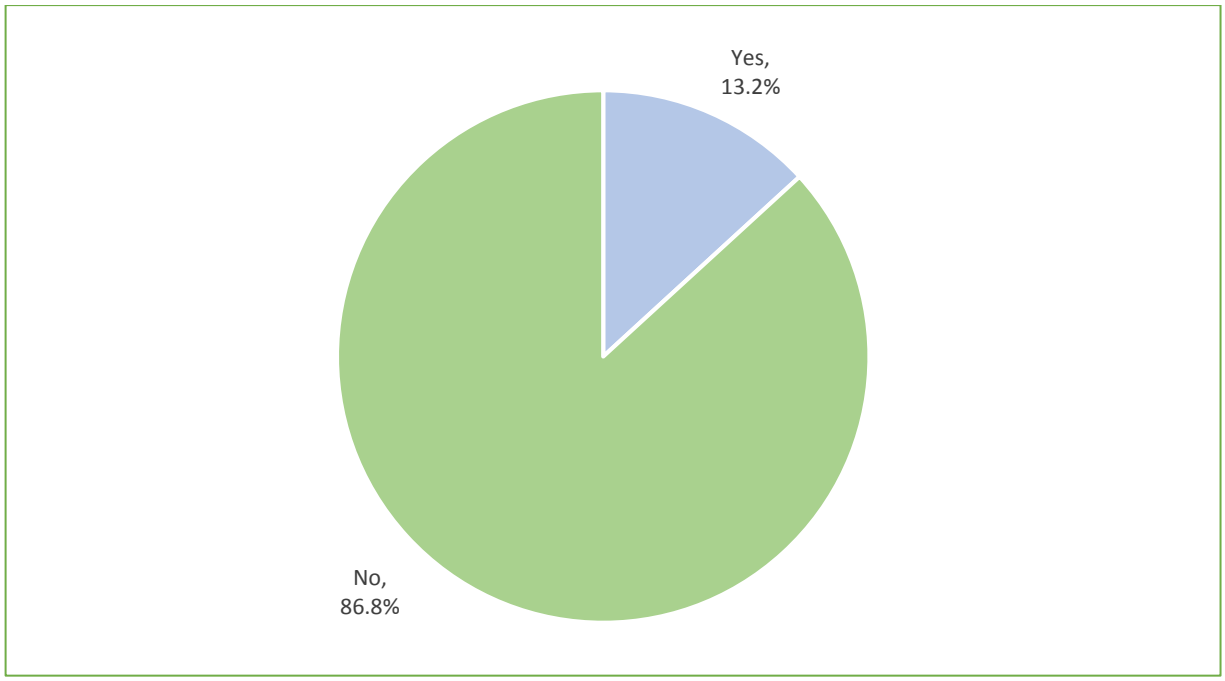

N=53

Figure 15. Employment status of respondents



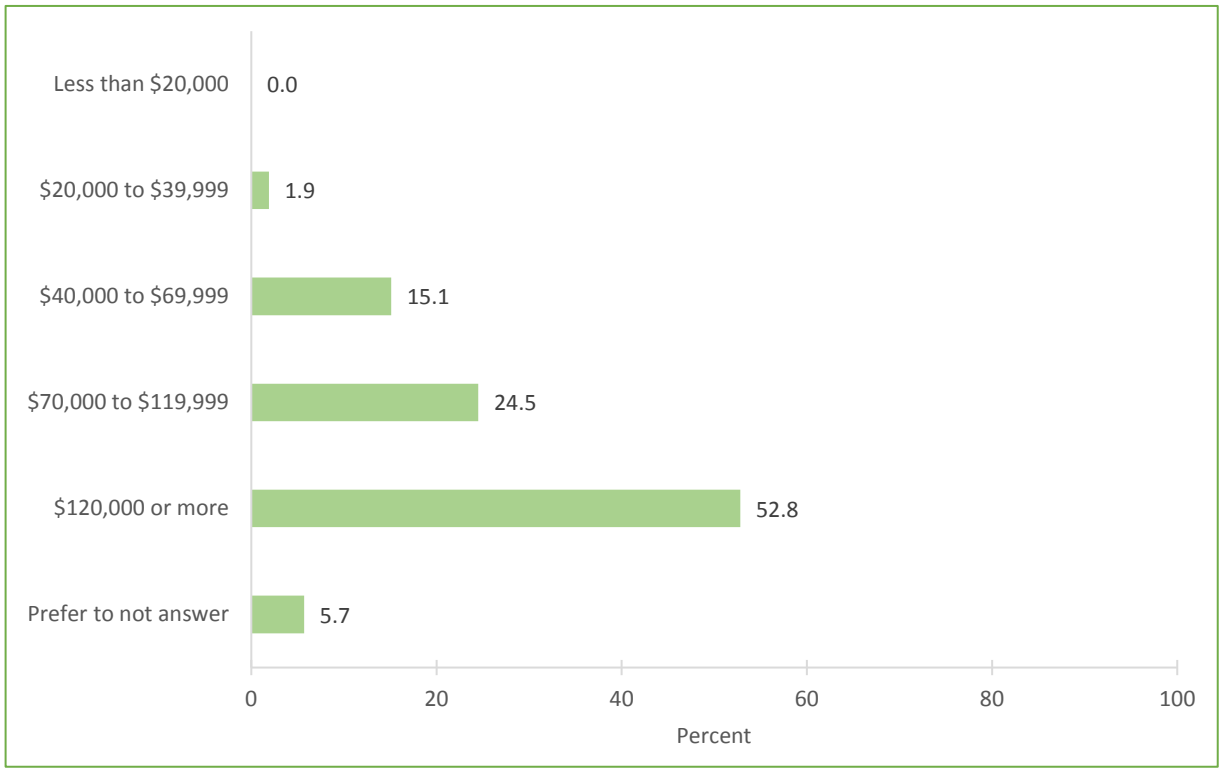

N=53

Figure 16. Whether respondents are military veterans




N=53

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




N=53

Table 1. Zip code of respondents

| Zip code | Number of respondents |
|---|---|
| 57401 | 44 |
| 57451 | 5 |
| 57601 | 2 |
| 57449 | 1 |
| 57469 | 1 |

N=53

Table 2. Comments from respondents

| Comments |
|---|
| A lot of the questions I felt I should have researched before I answered. Good survey. |
| I think in general Aberdeen is a safe environment with better than expected access to medical care services due to serving an entire region vs. only the local population - some areas that I answered I was not greatly familiar with and put little need due to not being aware of any problems - but assuming that there is always a little that can be done to improve a situation. |
| [Hospital] Emergency Room is wonderful. [Hospital] is terrible. |
| The inability of most insured individuals to use both health care centers/physicians/services available in Aberdeen is a serious issue - especially for those seeking specialist care. |
| The time to fix problems is early…example a small leak in the kitchen can become a disaster....that is the same with non treated health physical or mental.... We are very fortunate to have two Regional Health Centers in our community! |
| There is a need for specialized health care in Aberdeen, especially with the elderly and those suffering from ALZ or Dementia. |
| There needs to be a very close look taken at the opioid epidemic. I knew 3 people in Aberdeen who died this past summer from this addiction....from something that physicians are prescribing for their patients all in the name of profitability for drug companies. There needs to be a focus on alternative medicine and less leaning on the hard opioids which are highly addictive. |

# APPENDIX TABLE

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

| Statements | Mean** | Percent of respondents* | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Level of attention needed | | | | | | Total |
| | | 1 None | 2 Little | 3 Moderate | 4 Serious | 5 Critical | NA | |
| **ECONOMIC WELL-BEING ISSUES** | | | | | | | | |
| Availability of affordable housing (N=53) | 3.19 | 5.7 | 18.9 | 37.7 | 26.4 | 11.3 | 0.0 | 100.0 |
| Employment options (N=54) | 2.81 | 9.3 | 22.2 | 48.1 | 14.8 | 3.7 | 1.9 | 100.0 |
| Help for renters with landlord and tenants' rights issues (N=53) | 2.73 | 7.5 | 34.0 | 35.8 | 15.1 | 3.8 | 3.8 | 100.0 |
| Homelessness (N=53) | 2.25 | 9.4 | 62.3 | 18.9 | 7.5 | 0.0 | 1.9 | 100.0 |
| Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=52) | 3.17 | 1.9 | 21.2 | 42.3 | 26.9 | 7.7 | 0.0 | 100.0 |
| Household budgeting and money management (N=54) | 3.07 | 3.7 | 27.8 | 33.3 | 27.8 | 7.4 | 0.0 | 100.0 |
| Hunger (N=53) | 2.90 | 0.0 | 35.8 | 41.5 | 15.1 | 5.7 | 1.9 | 100.0 |
| Maintaining livable and energy efficient homes (N=53) | 2.98 | 0.0 | 32.1 | 41.5 | 22.6 | 3.8 | 0.0 | 100.0 |
| Skilled labor workforce (N=53) | 3.53 | 0.0 | 15.1 | 32.1 | 37.7 | 15.1 | 0.0 | 100.0 |
| **TRANSPORTATION ISSUES** | | | | | | | | |
| Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=53) | 3.02 | 5.7 | 30.2 | 34.0 | 17.0 | 13.2 | 0.0 | 100.1 |
| Availability of public transportation (N=52) | 2.98 | 9.6 | 28.8 | 25.0 | 26.9 | 9.6 | 0.0 | 99.9 |
| Availability of walking and biking options (N=53) | 2.21 | 20.8 | 41.5 | 34.0 | 3.8 | 0.0 | 0.0 | 100.1 |
| Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=53) | 2.77 | 9.4 | 32.1 | 32.1 | 20.8 | 3.8 | 1.9 | 100.1 |
| Cost of public transportation (N=51) | 2.49 | 15.7 | 37.3 | 27.5 | 11.8 | 3.9 | 3.9 | 100.1 |
| Driving habits (e.g., speeding, road rage) (N=53) | 2.62 | 5.7 | 49.1 | 28.3 | 11.3 | 5.7 | 0.0 | 100.1 |
| **CHILDREN AND YOUTH** | | | | | | | | |
| Availability of activities (outside of school and sports) for children and youth (N=53) | 2.43 | 13.2 | 43.4 | 32.1 | 9.4 | 1.9 | 0.0 | 100.0 |
| Availability of education about birth control (N=52) | 2.78 | 7.7 | 26.9 | 44.2 | 17.3 | 1.9 | 1.9 | 99.9 |

| Statements | Mean** | Percent of respondents* Level of attention needed 1 None | 2 Little | 3 Moderate | 4 Serious | 5 Critical | NA | Total |
|---|---|---|---|---|---|---|---|---|
| Availability of quality childcare (N=52) | 2.92 | 1.9 | 32.7 | 36.5 | 25.0 | 1.9 | 1.9 | 99.9 |
| Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=52) | 3.25 | 0.0 | 17.3 | 46.2 | 30.8 | 5.8 | 0.0 | 100.1 |
| Bullying (N=52) | 3.43 | 3.8 | 11.5 | 36.5 | 30.8 | 15.4 | 1.9 | 99.9 |
| Childhood obesity (N=52) | 3.65 | 1.9 | 3.8 | 34.6 | 44.2 | 13.5 | 1.9 | 99.9 |
| Cost of activities (outside of school and sports) for children and youth (N=53) | 3.00 | 0.0 | 28.3 | 47.2 | 17.0 | 5.7 | 1.9 | 100.1 |
| Cost of quality childcare (N=51) | 3.20 | 3.9 | 17.6 | 37.3 | 29.4 | 7.8 | 3.9 | 99.9 |
| Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=52) | 3.31 | 0.0 | 19.2 | 36.5 | 34.6 | 7.7 | 1.9 | 99.9 |
| Crime committed by youth (N=52) | 3.02 | 0.0 | 25.0 | 51.9 | 19.2 | 3.8 | 0.0 | 99.9 |
| Opportunities for youth-adult mentoring (N=52) | 3.13 | 0.0 | 23.1 | 50.0 | 17.3 | 9.6 | 0.0 | 100.0 |
| Parental custody, guardianships and visitation rights (N=49) | 2.72 | 6.1 | 34.7 | 32.7 | 20.4 | 0.0 | 6.1 | 100.0 |
| School absenteeism (truancy) (N=50) | 2.64 | 6.0 | 40.0 | 32.0 | 14.0 | 2.0 | 6.0 | 100.0 |
| School dropout rates (N=51) | 2.50 | 7.8 | 39.2 | 39.2 | 7.8 | 0.0 | 5.9 | 99.9 |
| School violence (N=51) | 2.56 | 7.8 | 39.2 | 39.2 | 11.8 | 0.0 | 2.0 | 100.0 |
| Substance abuse by youth (N=52) | 3.54 | 0.0 | 17.3 | 32.7 | 28.8 | 21.2 | 0.0 | 100.0 |
| Teen pregnancy (N=52) | 3.02 | 1.9 | 28.8 | 34.6 | 23.1 | 5.8 | 5.8 | 100.0 |
| Teen suicide (N=51) | 3.20 | 0.0 | 33.3 | 23.5 | 25.5 | 13.7 | 3.9 | 99.9 |
| Teen tobacco use (N=52) | 3.42 | 1.9 | 15.4 | 36.5 | 25.0 | 17.3 | 3.8 | 99.9 |
| **THE AGING POPULATION** | | | | | | | | |
| Availability of activities for seniors (e.g., recreational, social, cultural) (N=52) | 2.82 | 1.9 | 28.8 | 51.9 | 7.7 | 3.8 | 5.8 | 99.9 |
| Availability of long term care (N=51) | 2.92 | 3.9 | 27.5 | 41.2 | 15.7 | 5.9 | 5.9 | 100.1 |
| Availability of memory care (N=52) | 3.17 | 0.0 | 25.0 | 38.5 | 17.3 | 11.5 | 7.7 | 100.0 |
| Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=51) | 3.12 | 0.0 | 19.6 | 52.9 | 15.7 | 7.8 | 3.9 | 99.9 |
| Availability of resources for grandparents caring for grandchildren (N=52) | 2.82 | 1.9 | 30.8 | 48.1 | 17.3 | 0.0 | 1.9 | 100.0 |
| Availability of resources to help the elderly stay safe in their homes (N=52) | 3.24 | 1.9 | 13.5 | 50.0 | 21.2 | 9.6 | 3.8 | 100.0 |
| Cost of activities for seniors (e.g., recreational, social, cultural) (N=52) | 2.70 | 5.8 | 30.8 | 38.5 | 15.4 | 0.0 | 9.6 | 100.1 |
| Cost of in-home services (N=52) | 3.46 | 1.9 | 7.7 | 36.5 | 38.5 | 7.7 | 7.7 | 100.0 |
| Cost of long-term care (N=52) | 3.83 | 0.0 | 7.7 | 21.2 | 42.3 | 21.2 | 7.7 | 100.1 |

| Statements | Mean** | Percent of respondents* | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Level of attention needed | | | | | | |
| | | 1 None | 2 Little | 3 Moderate | 4 Serious | 5 Critical | NA | Total |
| Cost of memory care (N=52) | 3.89 | 0.0 | 7.7 | 19.2 | 38.5 | 25.0 | 9.6 | 100.0 |
| Help making out a will or healthcare directive (N=52) | 2.92 | 3.8 | 25.0 | 48.1 | 17.3 | 3.8 | 1.9 | 99.9 |
| **SAFETY** | | | | | | | | |
| Abuse of prescription drugs (N=52) | 3.50 | 0.0 | 13.5 | 36.5 | 36.5 | 13.5 | 0.0 | 100.0 |
| Availability of emergency medical services (N=51) | 2.22 | 21.6 | 39.2 | 35.3 | 3.9 | 0.0 | 0.0 | 100.0 |
| Child abuse and neglect (N=52) | 3.10 | 0.0 | 23.1 | 46.2 | 28.8 | 1.9 | 0.0 | 100.0 |
| Criminal activity (N=51) | 3.02 | 0.0 | 23.5 | 52.9 | 21.6 | 2.0 | 0.0 | 100.0 |
| Culture of excessive and binge drinking (N=51) | 3.22 | 2.0 | 15.7 | 45.1 | 33.3 | 3.9 | 0.0 | 100.0 |
| Domestic violence (N=52) | 3.13 | 1.9 | 19.2 | 44.2 | 32.7 | 1.9 | 0.0 | 99.9 |
| Elder abuse (N=50) | 2.73 | 8.0 | 36.0 | 28.0 | 26.0 | 0.0 | 2.0 | 100.0 |
| Lack of police or delayed response of police (N=50) | 2.18 | 14.0 | 58.0 | 24.0 | 4.0 | 0.0 | 0.0 | 100.0 |
| Presence of drug dealers (N=52) | 3.02 | 1.9 | 34.6 | 30.8 | 25.0 | 7.7 | 0.0 | 100.0 |
| Presence of gang activity (N=52) | 2.27 | 9.6 | 63.5 | 13.5 | 11.5 | 0.0 | 1.9 | 100.0 |
| Presence of street drugs (N=52) | 3.19 | 1.9 | 28.8 | 28.8 | 28.8 | 11.5 | 0.0 | 99.8 |
| Sex trafficking (N=49) | 2.49 | 6.1 | 59.2 | 16.3 | 16.3 | 2.0 | 0.0 | 99.9 |
| **HEALTH CARE AND WELLNESS** | | | | | | | | |
| Access to affordable dental insurance coverage (N=52) | 3.15 | 1.9 | 28.8 | 30.8 | 28.8 | 9.6 | 0.0 | 99.9 |
| Access to affordable health insurance coverage (N=52) | 3.87 | 0.0 | 11.5 | 25.0 | 28.8 | 34.6 | 0.0 | 99.9 |
| Access to affordable health care (N=52) | 3.75 | 0.0 | 13.5 | 26.9 | 30.8 | 28.8 | 0.0 | 100.0 |
| Access to affordable prescription drugs (N=52) | 3.46 | 1.9 | 15.4 | 34.6 | 30.8 | 17.3 | 0.0 | 100.0 |
| Access to affordable vision insurance coverage (N=52) | 3.13 | 1.9 | 23.1 | 42.3 | 25.0 | 7.7 | 0.0 | 100.0 |
| Access to technology for health records and health education (N=52) | 2.44 | 7.7 | 53.8 | 25.0 | 13.5 | 0.0 | 0.0 | 100.0 |
| Availability of behavioral health (e.g., substance abuse) providers (N=52) | 3.12 | 3.8 | 23.1 | 42.3 | 19.2 | 11.5 | 0.0 | 99.9 |
| Availability of doctors, physician assistants, or nurse practitioners (N=52) | 2.62 | 9.6 | 42.3 | 28.8 | 15.4 | 3.8 | 0.0 | 99.9 |
| Availability of health care services for Native people (N=50) | 2.64 | 10.0 | 32.0 | 30.0 | 12.0 | 4.0 | 12.0 | 100.0 |
| Availability of health care services for New Americans (N=50) | 2.67 | 10.0 | 30.0 | 32.0 | 16.0 | 2.0 | 10.0 | 100.0 |
| Availability of mental health providers (N=52) | 3.18 | 1.9 | 25.0 | 38.5 | 19.2 | 13.5 | 1.9 | 100.0 |
| Availability of non-traditional hours (e.g., evenings, weekends) (N=51) | 3.14 | 3.9 | 17.6 | 43.1 | 27.5 | 5.9 | 2.0 | 100.0 |

| Statements | Mean** | Percent of respondents* | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Level of attention needed | | | | | | |
| | | 1 None | 2 Little | 3 Moderate | 4 Serious | 5 Critical | NA | Total |
| Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=51) | 2.98 | 2.0 | 17.6 | 60.8 | 15.7 | 2.0 | 2.0 | 100.1 |
| Availability of specialist physicians (N=52) | 3.19 | 1.9 | 32.7 | 19.2 | 36.5 | 9.6 | 0.0 | 99.9 |
| Coordination of care between providers and services (N=51) | 2.78 | 3.9 | 33.3 | 45.1 | 15.7 | 2.0 | 0.0 | 100.0 |
| Timely access to medical care providers (N=52) | 2.69 | 5.8 | 38.5 | 36.5 | 19.2 | 0.0 | 0.0 | 100.0 |
| Timely access to dental care providers (N=52) | 2.42 | 11.5 | 44.2 | 34.6 | 9.6 | 0.0 | 0.0 | 99.9 |
| Timely access to vision care providers (N=52) | 2.35 | 13.5 | 44.2 | 36.5 | 5.8 | 0.0 | 0.0 | 100.0 |
| Use of emergency room services for primary healthcare (N=50) | 2.86 | 8.0 | 32.0 | 30.0 | 22.0 | 6.0 | 2.0 | 100.0 |
| **MENTAL HEALTH AND SUBSTANCE ABUSE** | | | | | | | | |
| Alcohol use and abuse (N=53) | 3.34 | 1.9 | 7.5 | 54.7 | 26.4 | 9.4 | 0.0 | 99.9 |
| Dementia and Alzheimer's disease (N=52) | 3.27 | 1.9 | 19.2 | 32.7 | 38.5 | 5.8 | 1.9 | 100.0 |
| Depression (N=53) | 3.40 | 1.9 | 15.1 | 35.8 | 35.8 | 11.3 | 0.0 | 99.9 |
| Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=53) | 3.62 | 0.0 | 9.4 | 39.6 | 30.2 | 20.8 | 0.0 | 100.0 |
| Exposure to secondhand smoke (N=52) | 2.79 | 7.7 | 34.6 | 32.7 | 21.2 | 3.8 | 0.0 | 100.0 |
| Smoking and tobacco use (N=52) | 3.15 | 1.9 | 25.0 | 36.5 | 28.8 | 7.7 | 0.0 | 99.9 |
| Stress (N=52) | 3.33 | 0.0 | 23.1 | 36.5 | 25.0 | 15.4 | 0.0 | 100.0 |
| Suicide (N=51) | 3.16 | 0.0 | 27.5 | 39.2 | 23.5 | 9.8 | 0.0 | 100.0 |

*Percentages may not total 100.0 due to rounding.

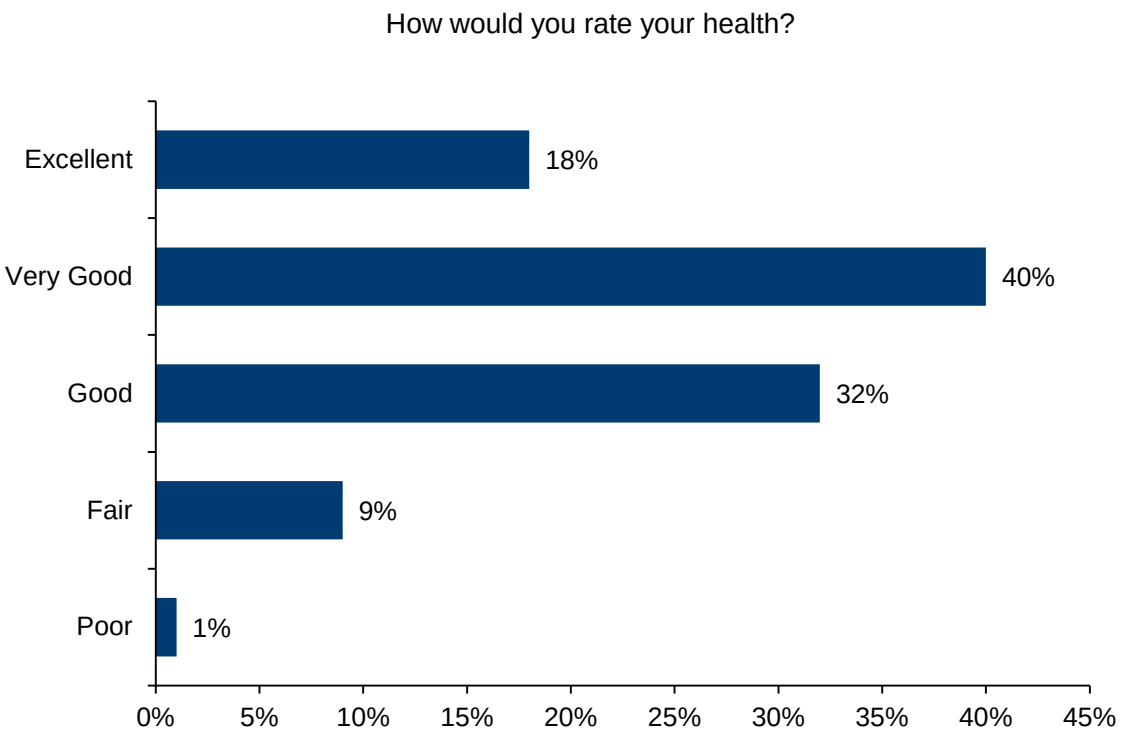
**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflect total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

# Residents' Survey

# Aberdeen CHNA Survey Report

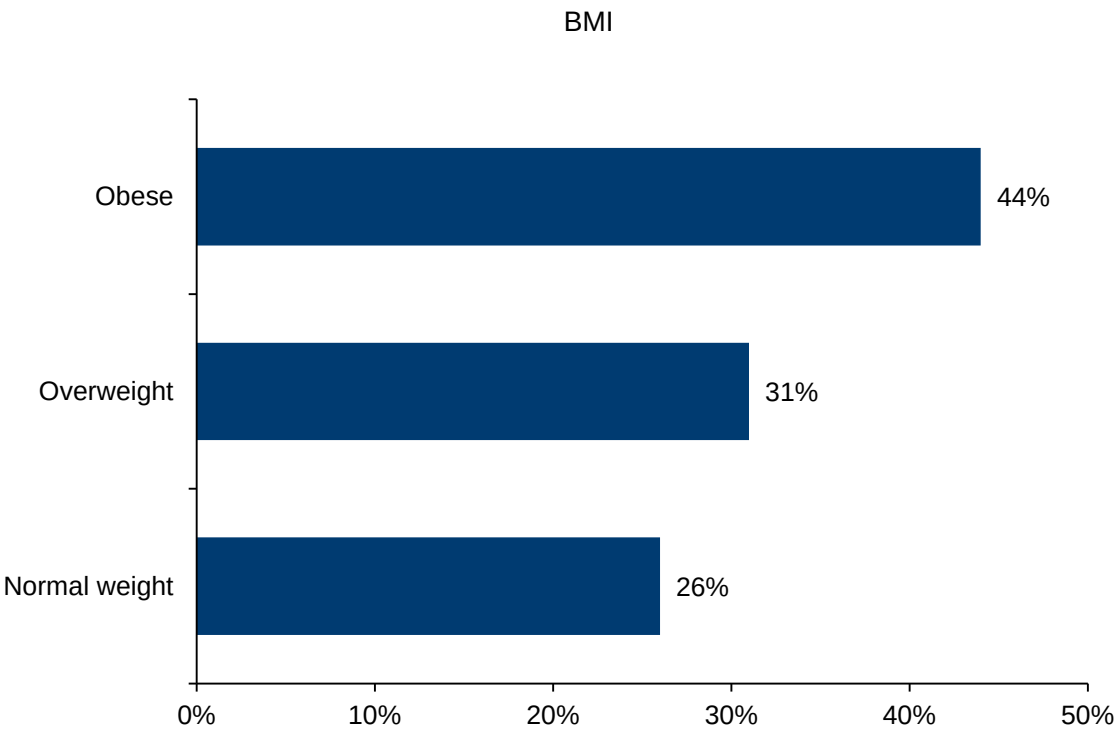
February 26, 2018

Charts Exported by MarketSight®



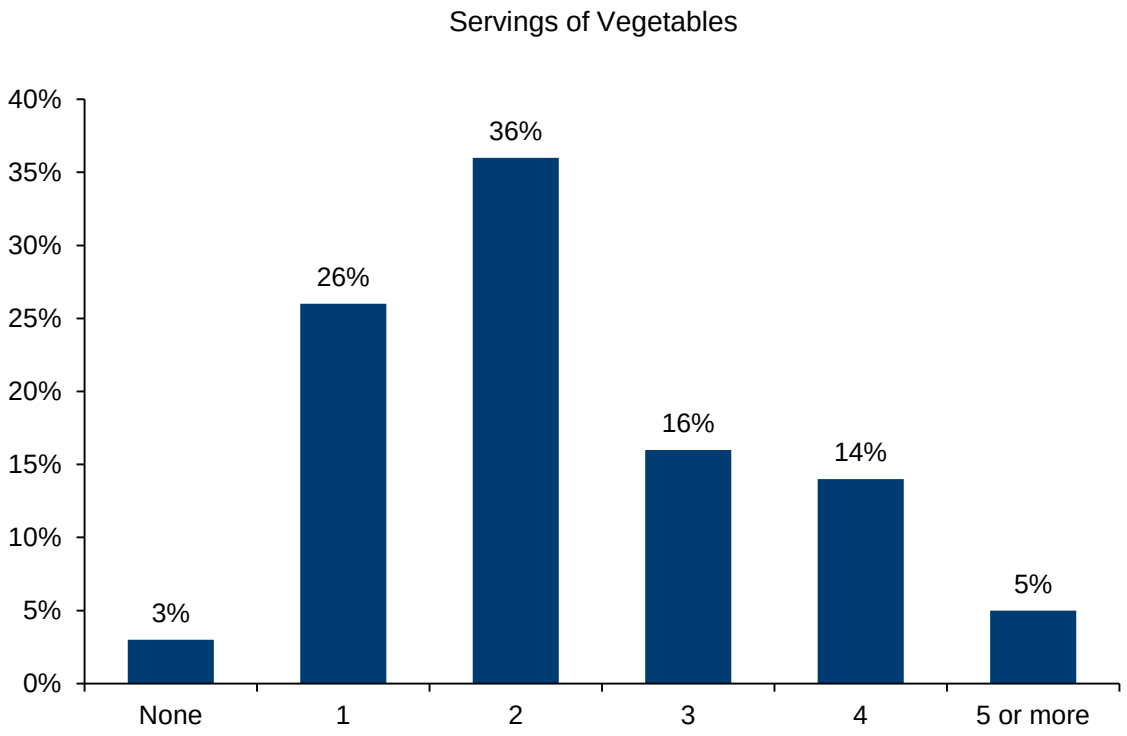

Base: Poor (n=1), Fair (n=10), Good (n=38), Very Good (n=47), Excellent (n=21), Sample Size = 117

(Community = Brown / Edmunds)



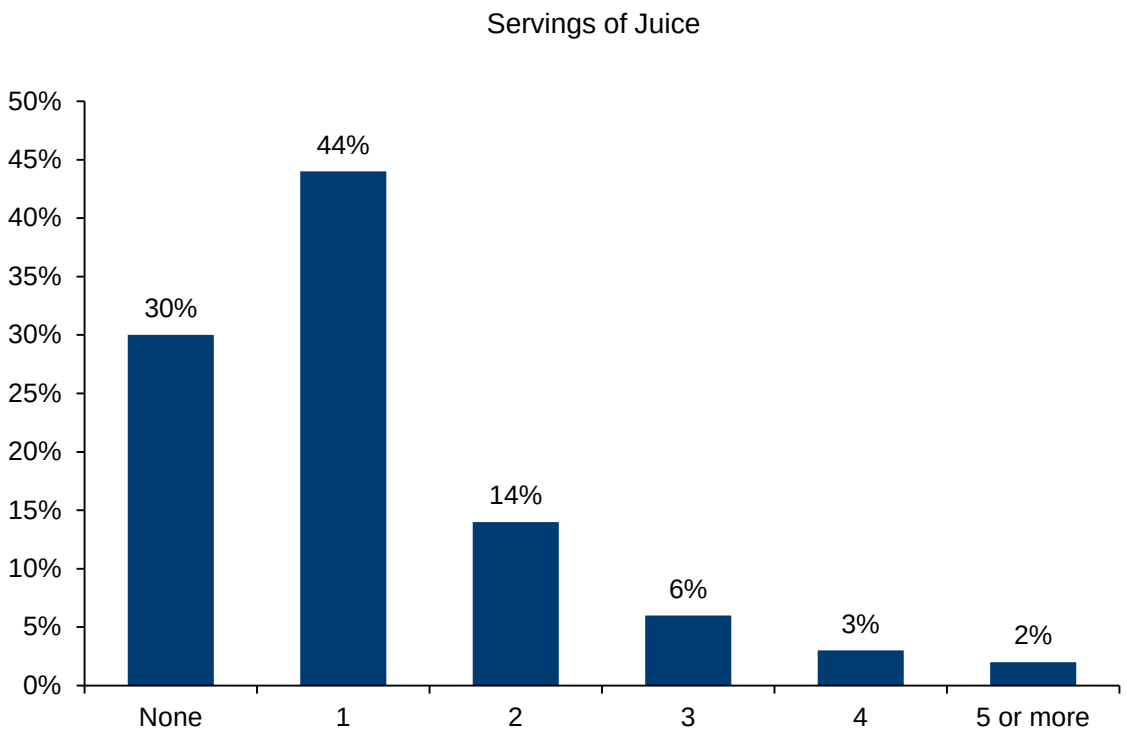

Base: Normal weight (n=30), Overweight (n=36), Obese (n=51), Sample Size = 117

(Community = Brown / Edmunds)



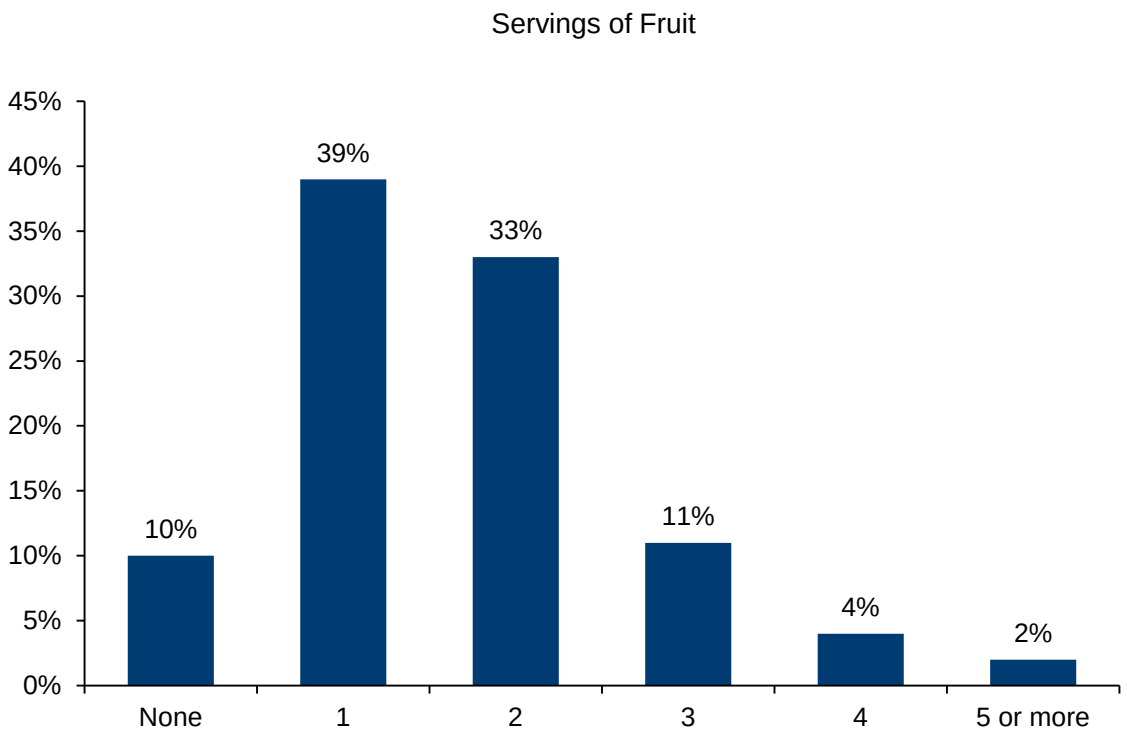

Base: None (n=3), 1 (n=28), 2 (n=38), 3 (n=17), 4 (n=15), 5 or more (n=5), Sample Size = 106

(Community = Brown / Edmunds)



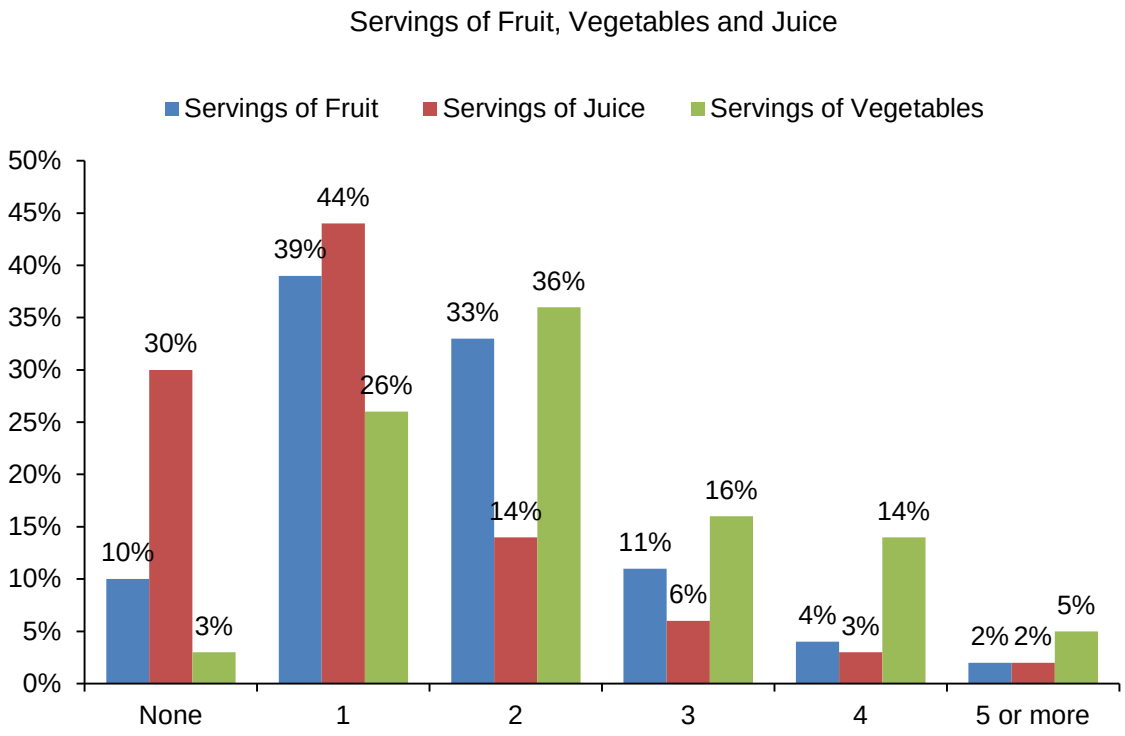

Base: None (n=19), 1 (n=28), 2 (n=9), 3 (n=4), 4 (n=2), 5 or more (n=1), Sample Size = 63

(Community = Brown / Edmunds)




Base: None (n=9), 1 (n=35), 2 (n=30), 3 (n=10), 4 (n=4), 5 or more (n=2), Sample Size = 90

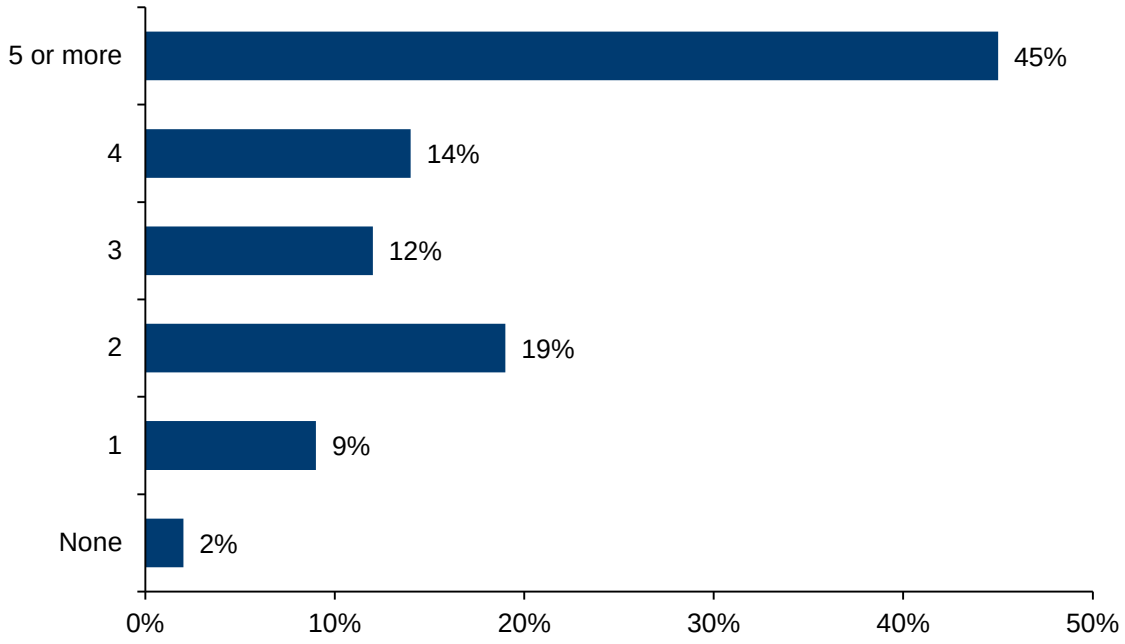
(Community = Brown / Edmunds)




Sample Size = Variable

(Community = Brown / Edmunds)

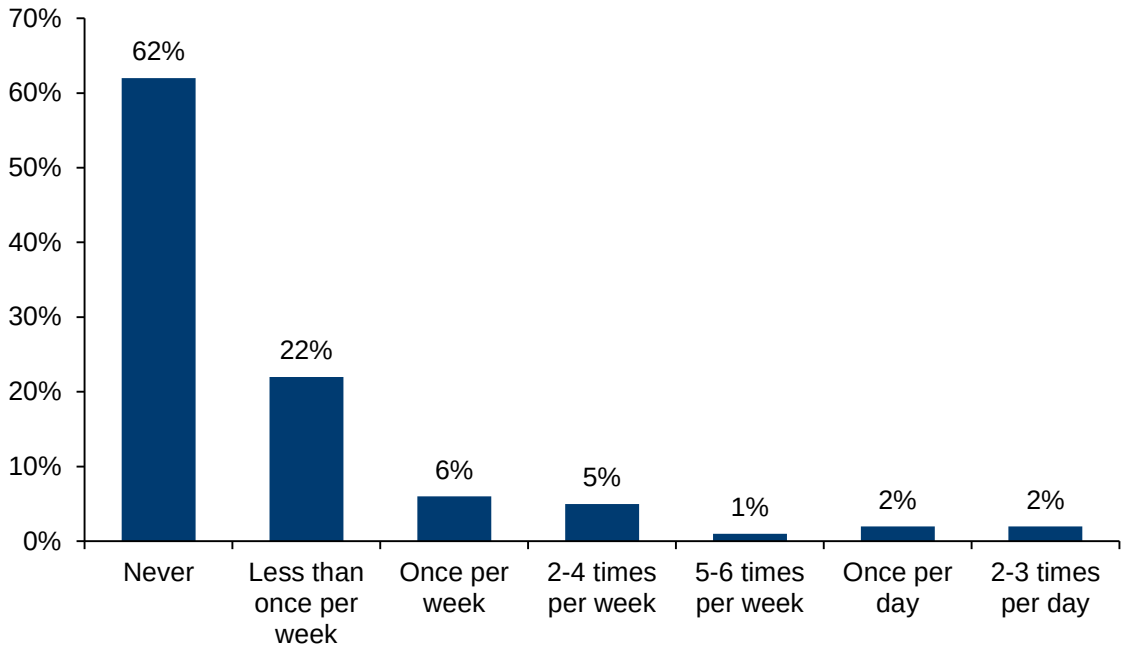
Total Servings of Fruits, Vegetables and Juice




Base: None (n=2), 1 (n=10), 2 (n=21), 3 (n=13), 4 (n=15), 5 or more (n=49), Sample Size = 110

(Community = Brown / Edmunds)

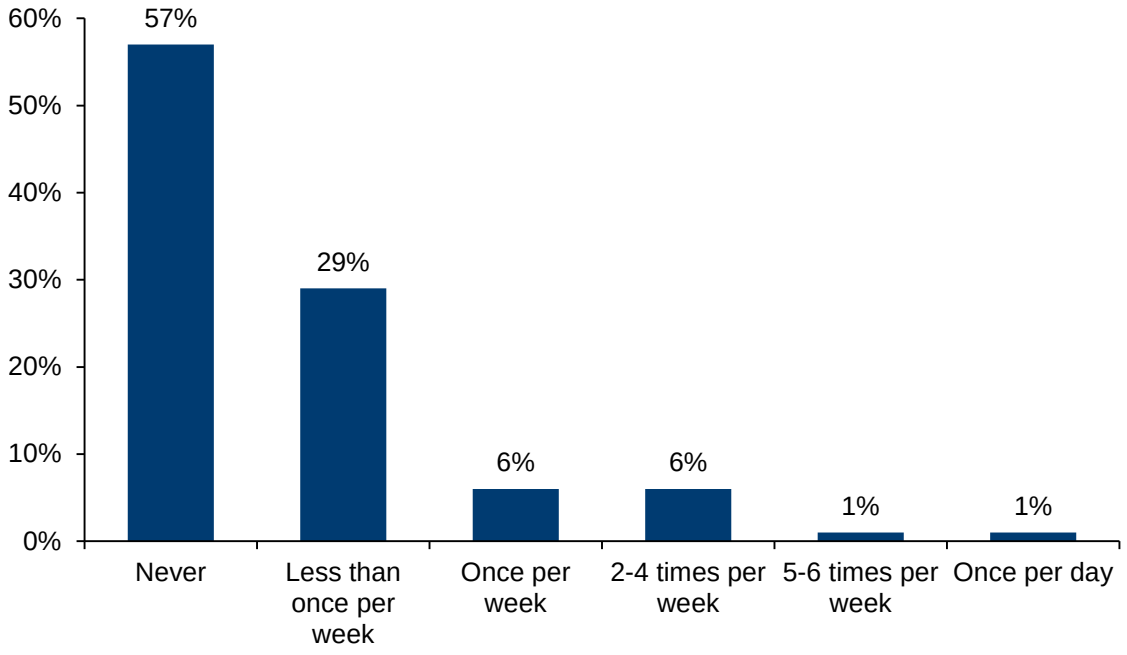
Snapple, Flavored Teas, Capri Sun, etc.




Base: Never (n=72), Less than once per week (n=26), Once per week (n=7), 2-4 times per week (n=6), 5-6 times per week (n=1), Once per day (n=2), 2-3 times per day (n=2), Sample Size = 116

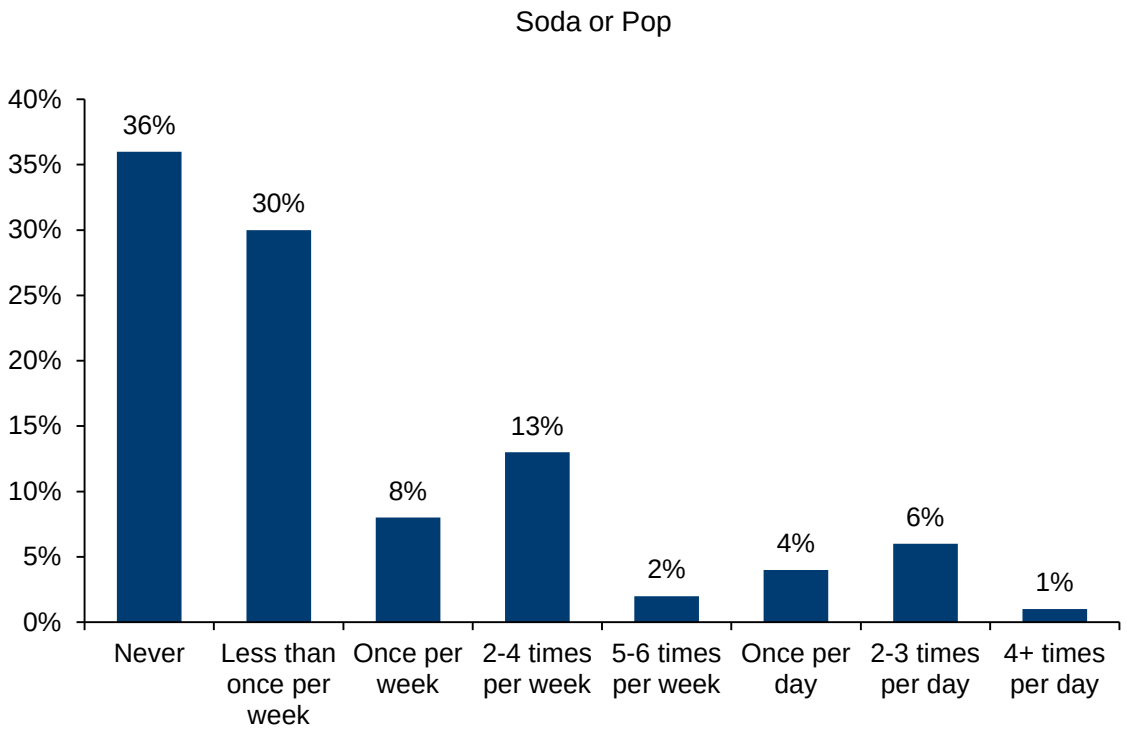
(Community = Brown / Edmunds)

Gatorade, Powerade, etc.




Base: Never (n=66), Less than once per week (n=34), Once per week (n=7), 2-4 times per week (n=7), 5-6 times per week (n=1), Once per day (n=1), Sample Size = 116

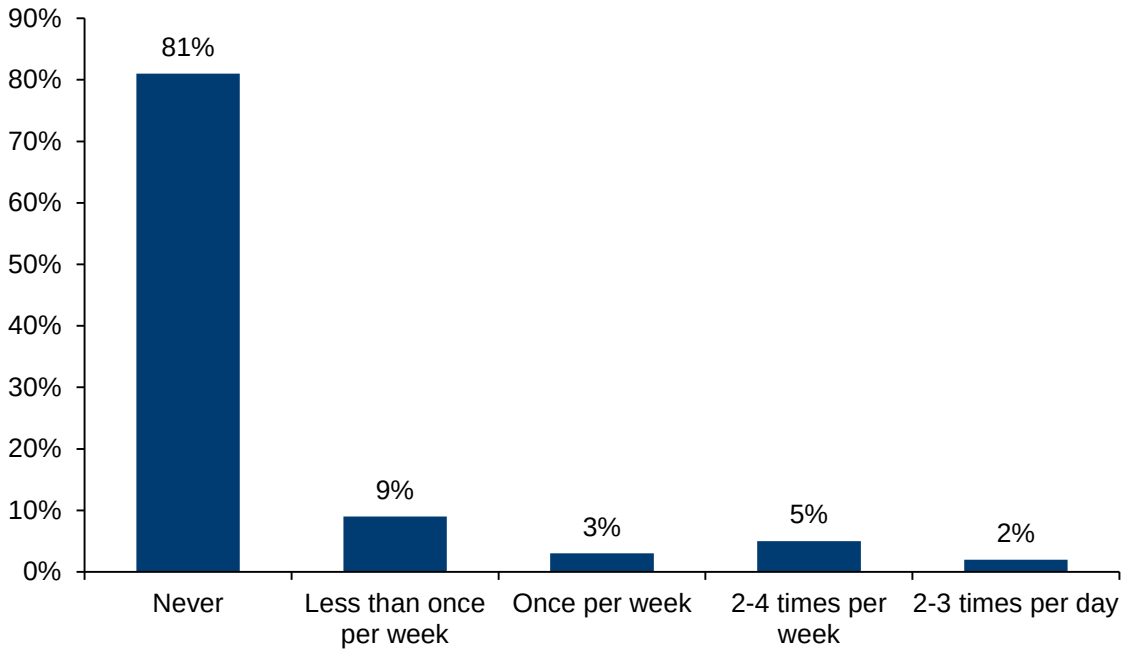
(Community = Brown / Edmunds)




Base: Never (n=43), Less than once per week (n=35), Once per week (n=10), 2-4 times per week (n=15), 5-6 times per week (n=2), Once per day (n=5), 2-3 times per day (n=7), 4+ times per day (n=1), Sample Size = 118

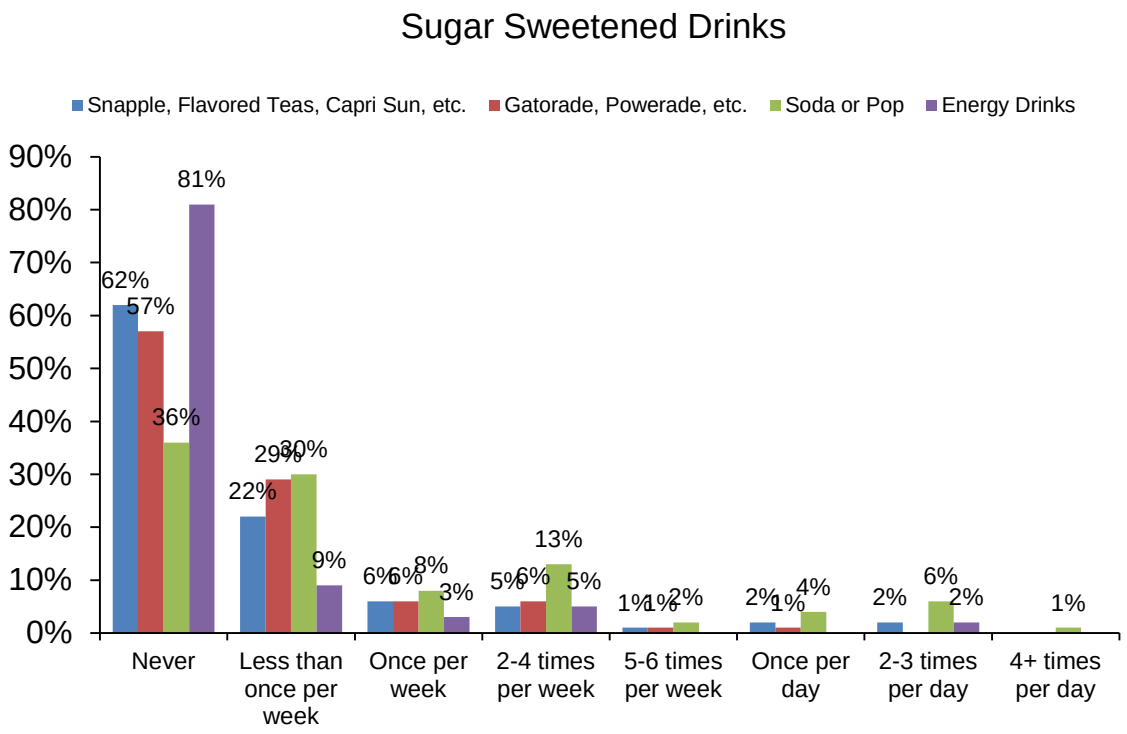
(Community = Brown / Edmunds)

## Energy Drinks




Base: Never (n=94), Less than once per week (n=11), Once per week (n=3), 2-4 times per week (n=6), 2-3 times per day (n=2), Sample Size = 116

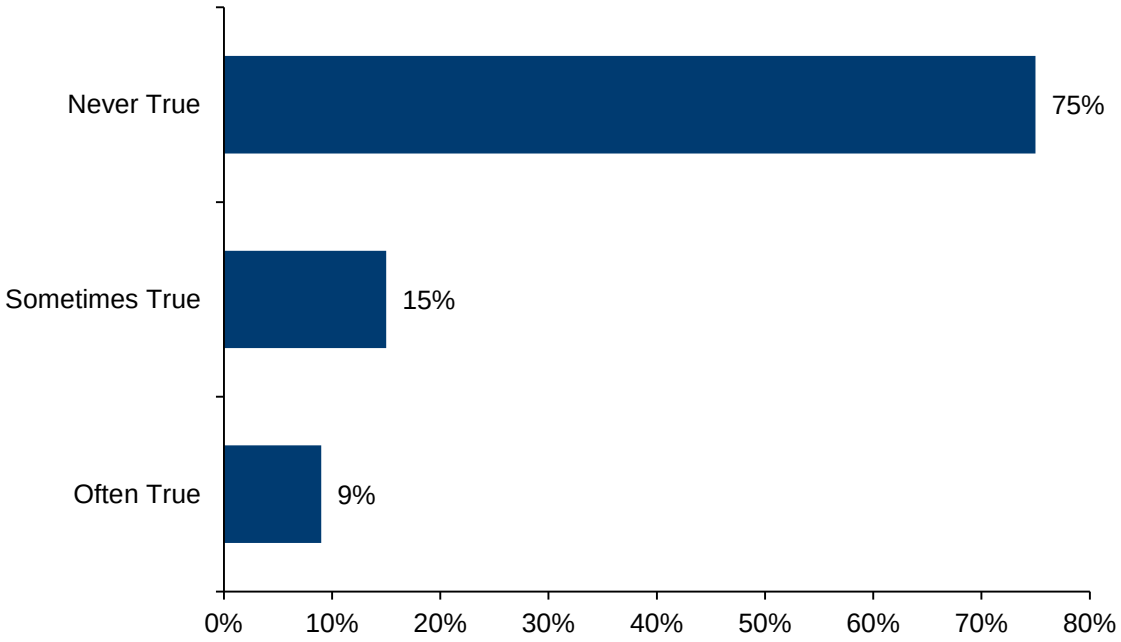
(Community = Brown / Edmunds)




Sample Size = Variable

(Community = Brown / Edmunds)

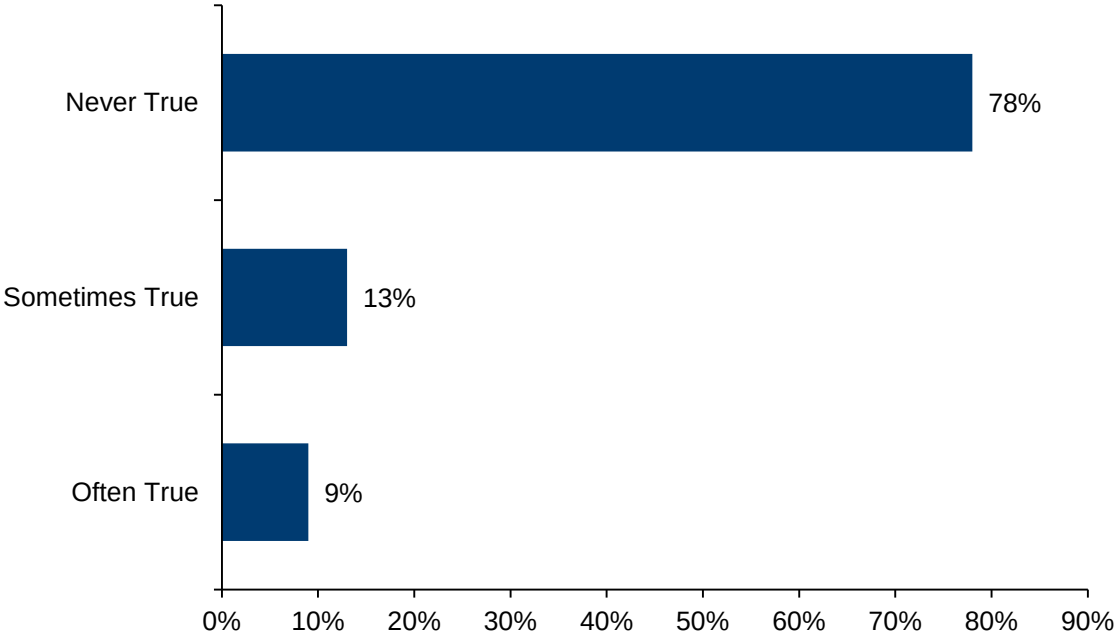
Worried whether our food would run out before we got money to buy more.




Base: Often True (n=11), Sometimes True (n=18), Never True (n=89), Sample Size = 118

(Community = Brown / Edmunds)

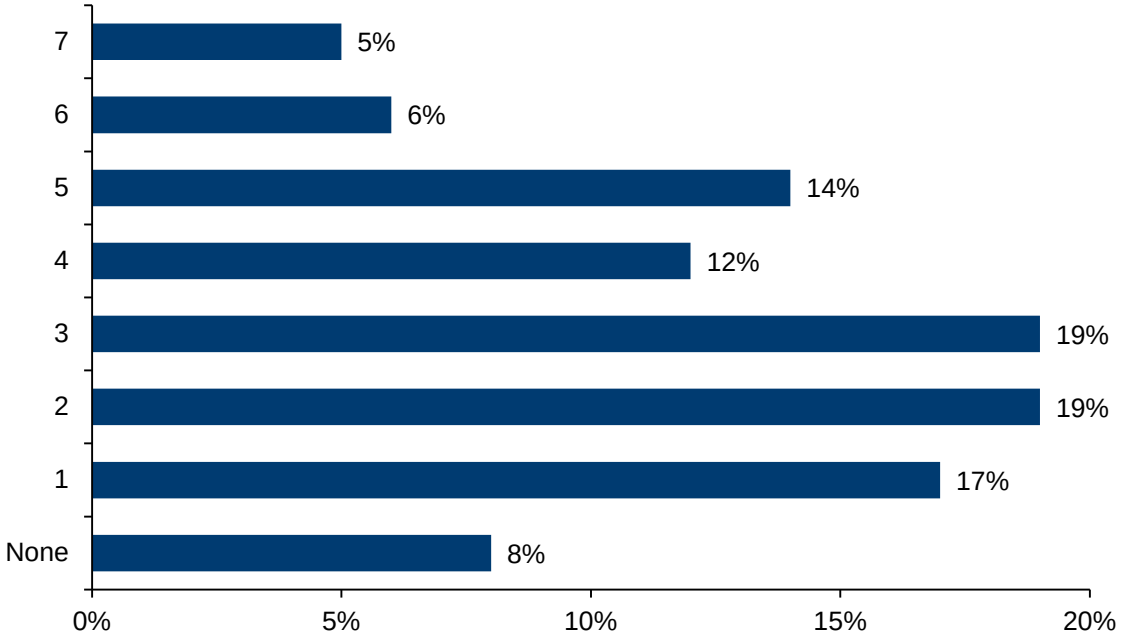
The food that we bought just didn’t last, and we didn’t have money to get more.




Base: Often True (n=11), Sometimes True (n=15), Never True (n=92), Sample Size = 118

(Community = Brown / Edmunds)

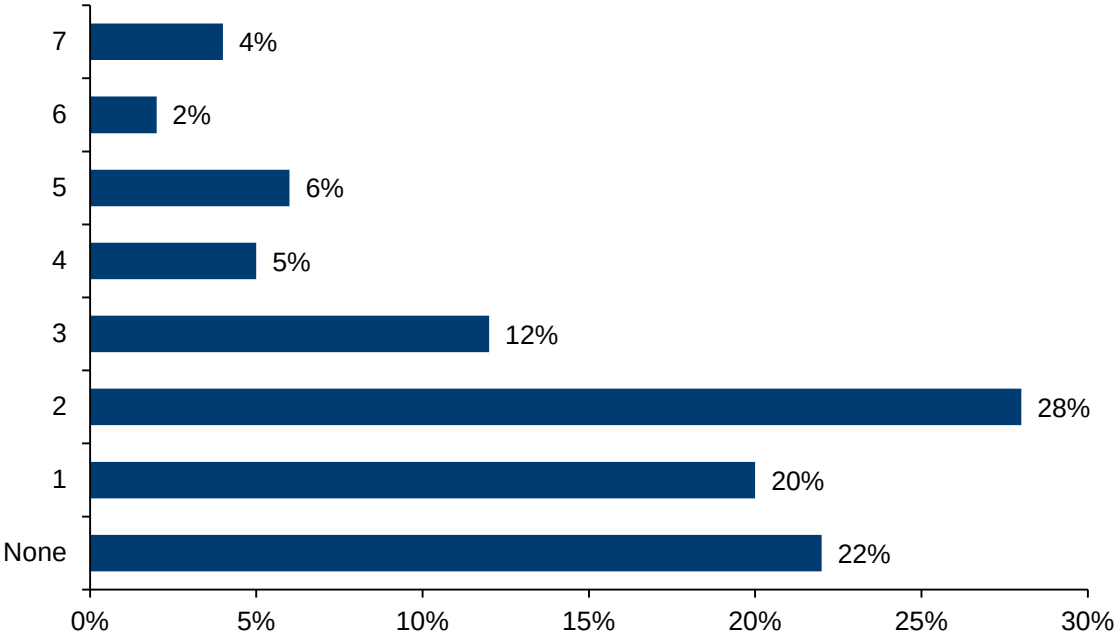
Days Per Week of  Moderate Physical Activity




Base: None (n=8), 1 (n=18), 2 (n=20), 3 (n=20), 4 (n=12), 5 (n=14), 6 (n=6), 7 (n=5), Sample Size = 103

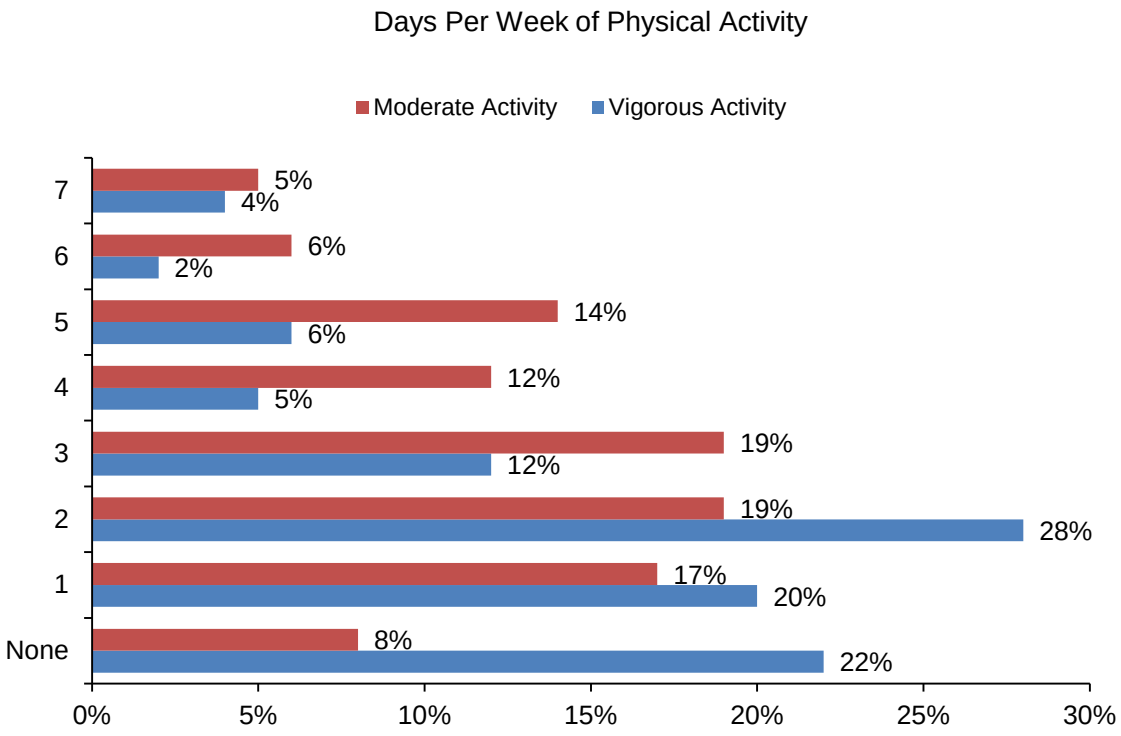
(Community = Brown / Edmunds)

Days Per Week of  Vigorous Physical Activity




Base: None (n=18), 1 (n=16), 2 (n=23), 3 (n=10), 4 (n=4), 5 (n=5), 6 (n=2), 7 (n=3), Sample Size = 81

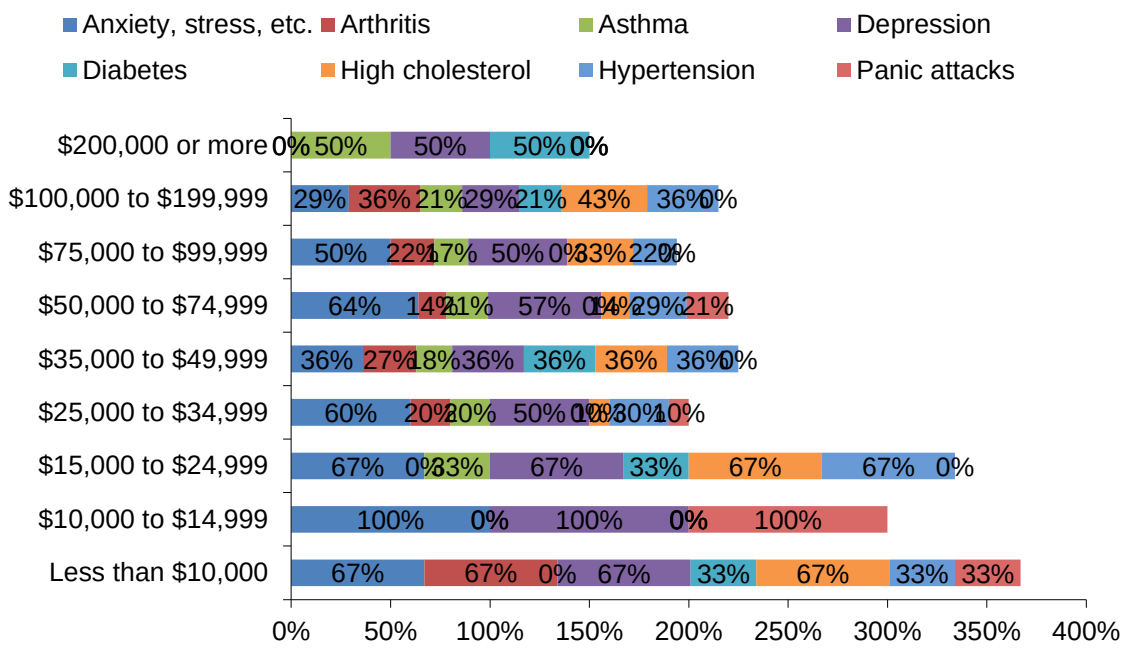
(Community = Brown / Edmunds)




Sample Size = Variable

(Community = Brown / Edmunds)

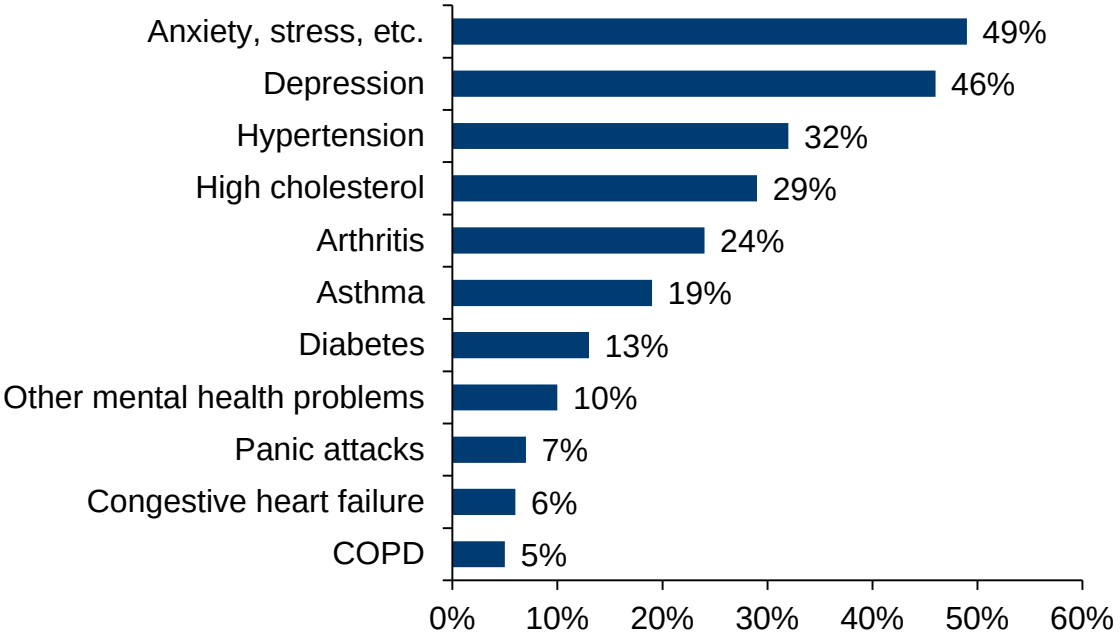
## Past Diagnosis by Total Household Income



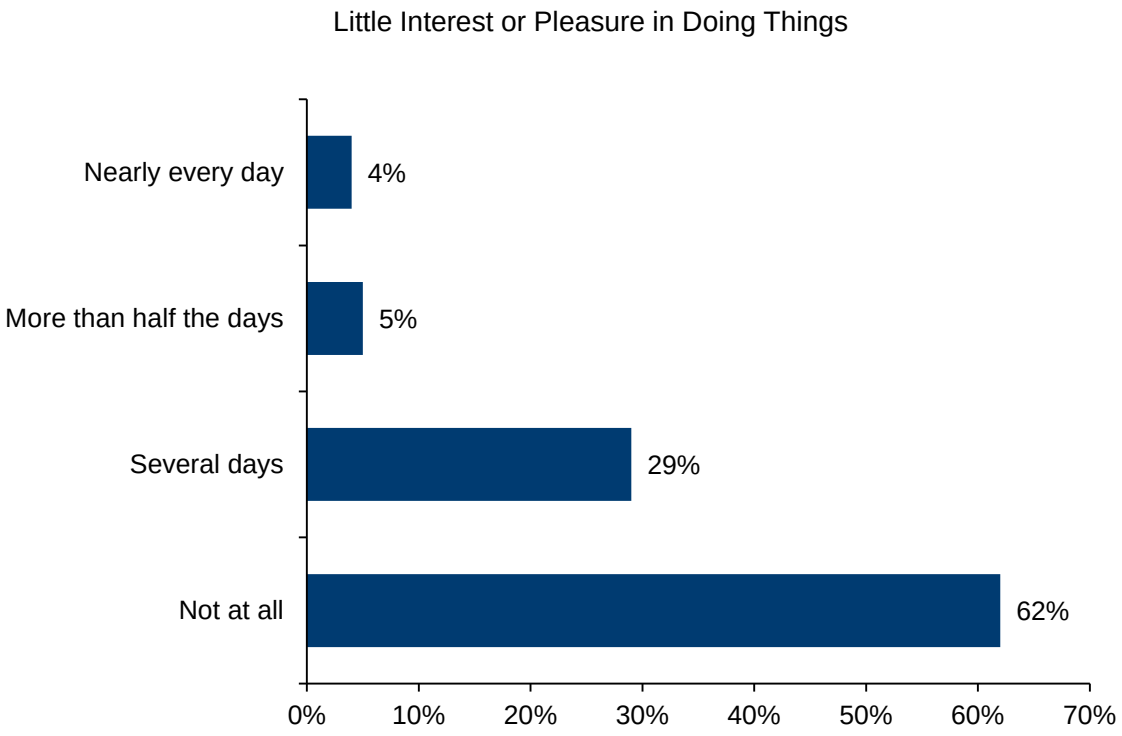

Base: Less than $10,000 (n=3), $10,000 to $14,999 (n=1), $15,000 to $24,999 (n=3), $25,000 to $34,999 (n=10), $35,000 to $49,999 (n=11), $50,000 to $74,999 (n=14), $75,000 to $99,999 (n=18), $100,000 to $199,999 (n=14), $200,000 or more (n=2), Sample Size = 76

(Community = Brown / Edmunds)

## Past Diagnosis

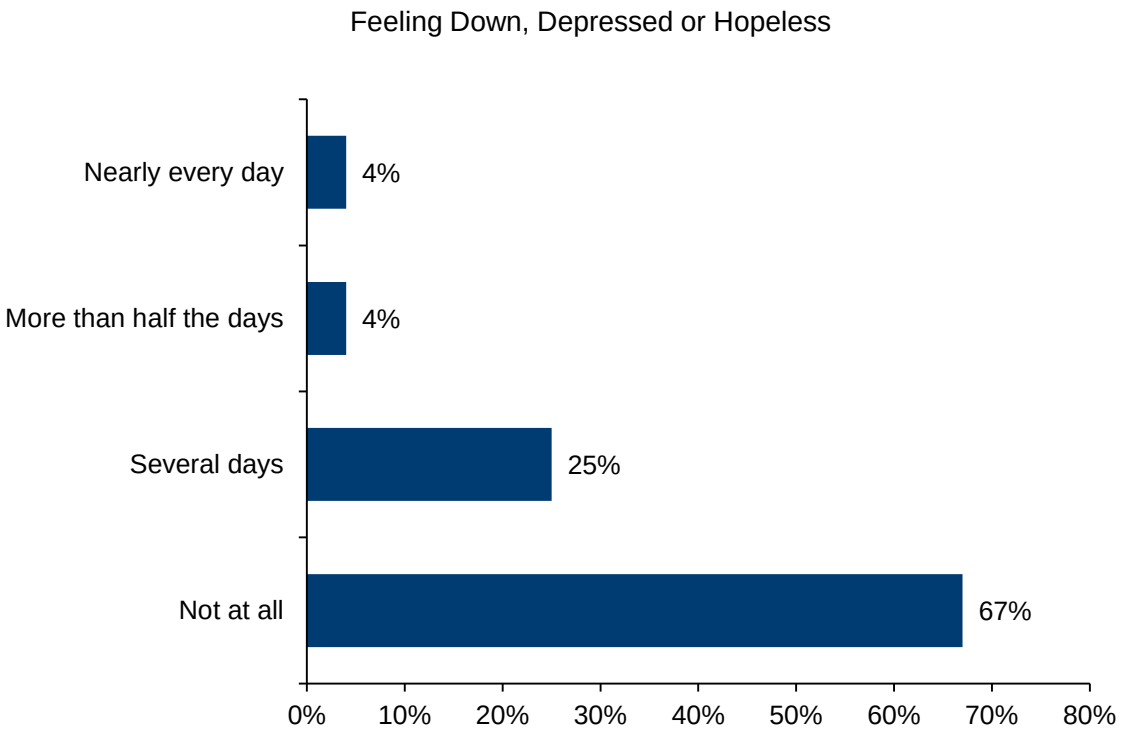



Base: Anxiety, stress, etc. (n=41), Arthritis (n=20), Asthma (n=16), Congestive heart failure (n=5), COPD (n=4), Depression (n=39), Diabetes (n=11), High cholesterol (n=24), Hypertension (n=27), Other mental health problems (n=8), Panic attacks (n=6), Sample Size = 84
(Community = Brown / Edmunds)




Base: Not at all (n=72), Several days (n=34), More than half the days (n=6), Nearly every day (n=5), Sample Size = 117

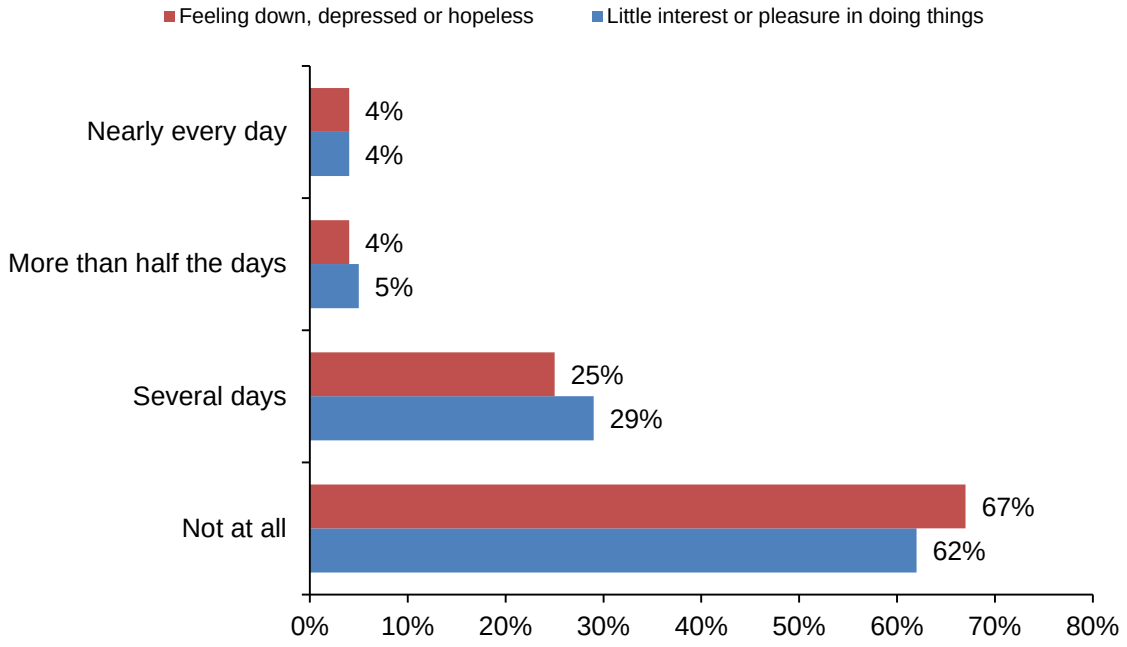
(Community = Brown / Edmunds)




Base: Not at all (n=76), Several days (n=28), More than half the days (n=5), Nearly every day (n=5), Sample Size = 114

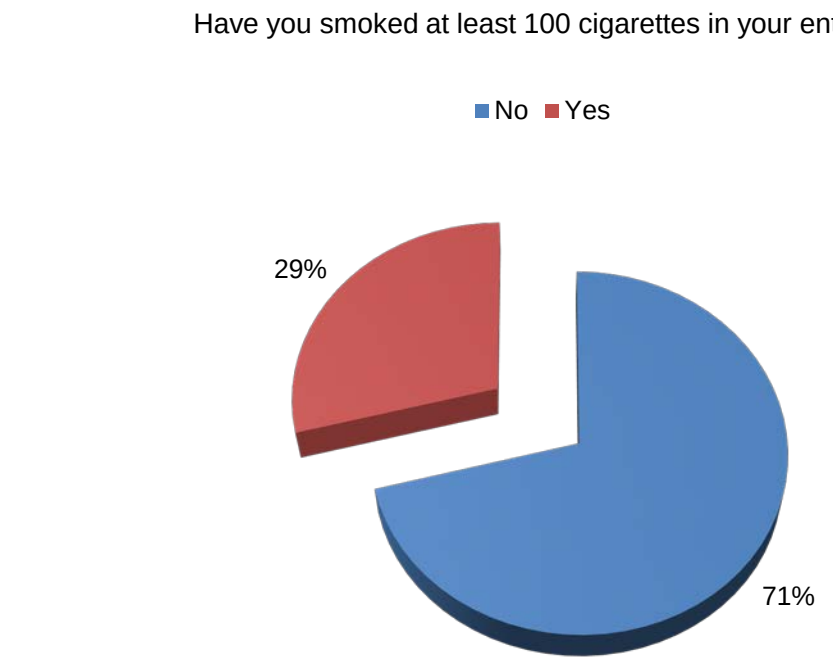
(Community = Brown / Edmunds)

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




Sample Size = Variable

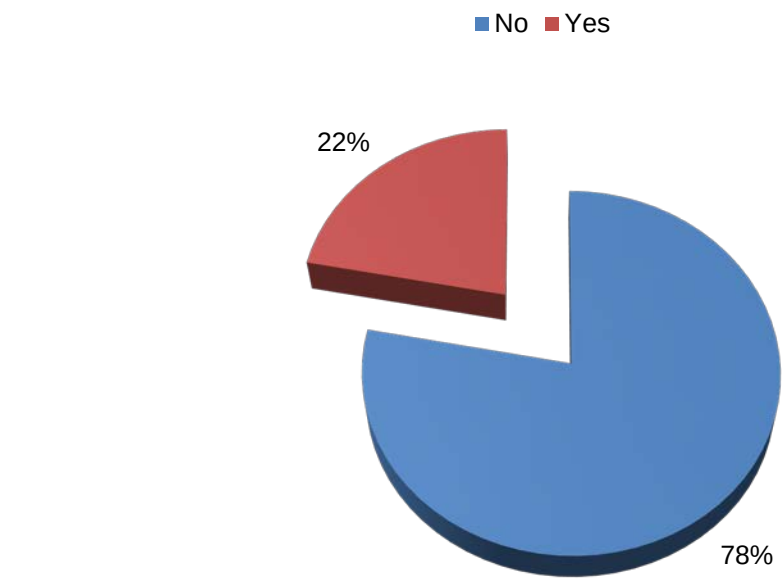
(Community = Brown / Edmunds)




Base: Yes (n=34), No (n=83), Sample Size = 117

(Community = Brown / Edmunds)

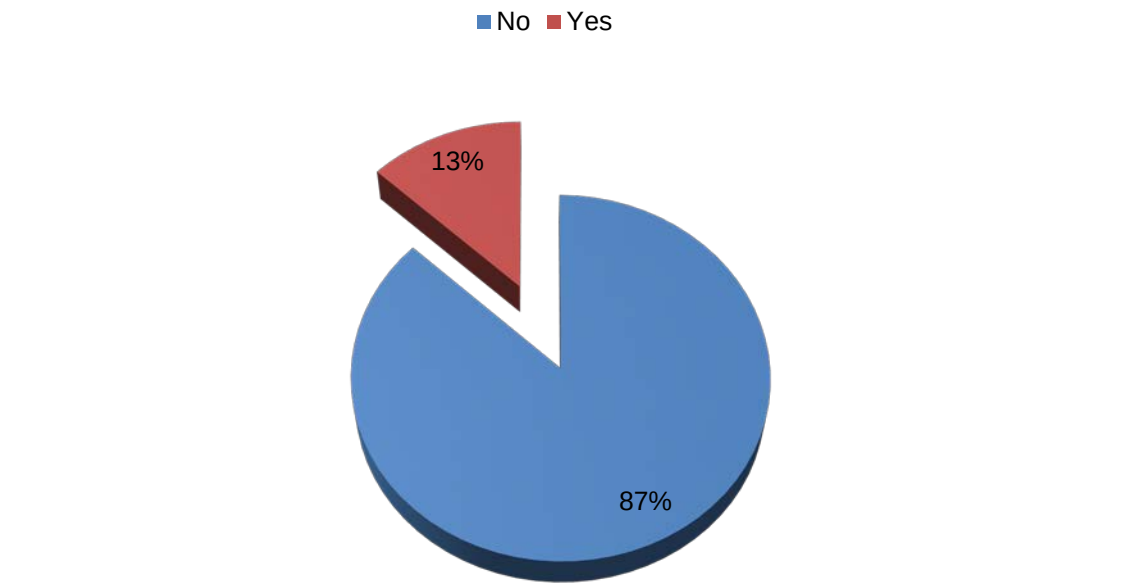
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?




Base: Yes (n=26), No (n=91), Sample Size = 117

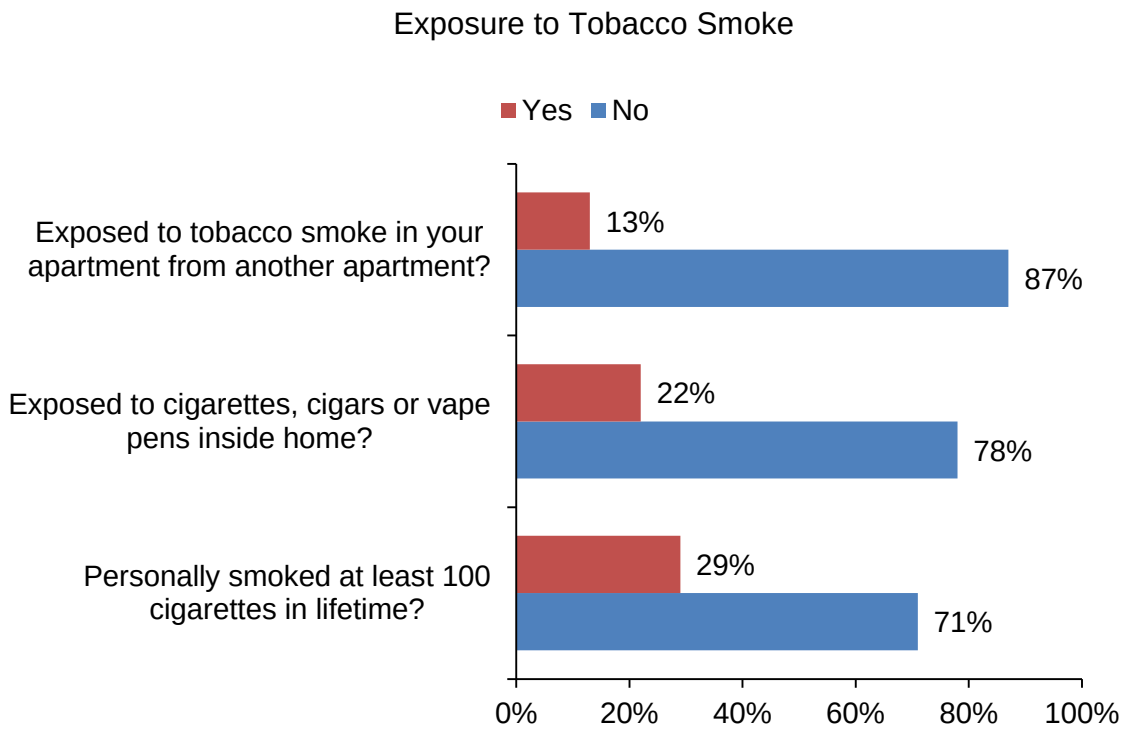
(Community = Brown / Edmunds)

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



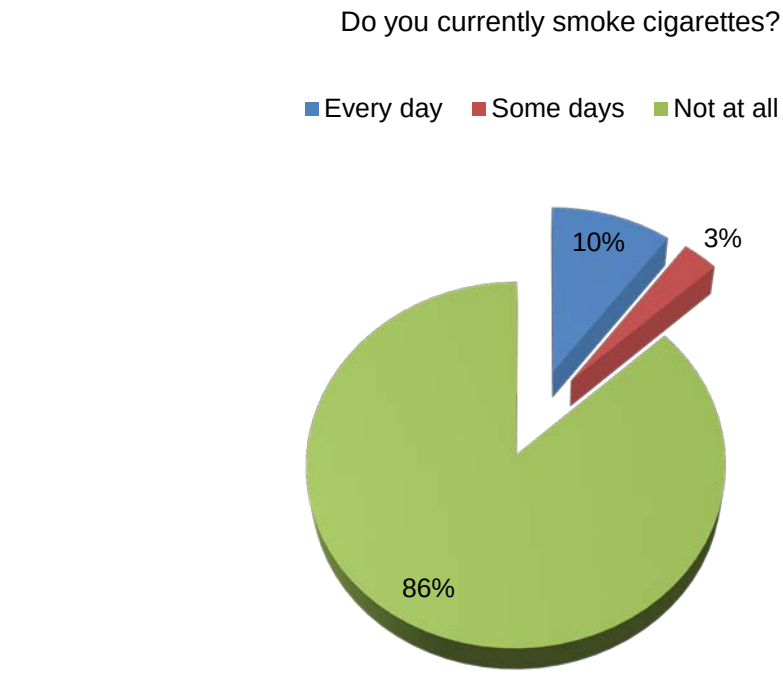

Base: Yes (n=15), No (n=101), Sample Size = 116

(Community = Brown / Edmunds)



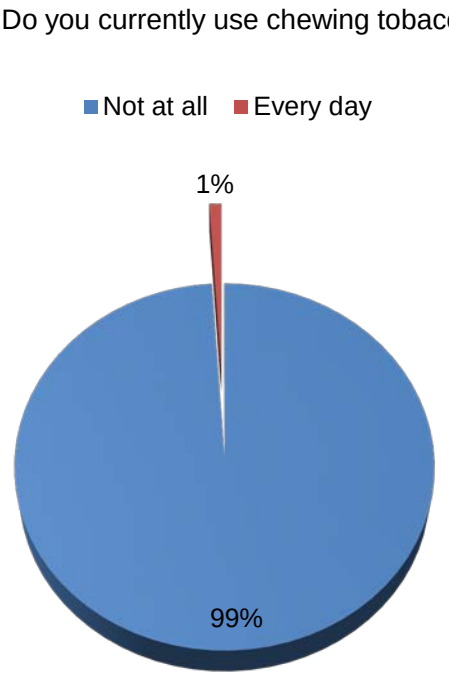

Base: Personally smoked at least 100 cigarettes in lifetime? (n=117), Exposed to cigarettes, cigars or vape pens inside home? (n=117), Exposed to tobacco smoke in your apartment from another apartment? (n=116), Sample Size = Variable

(Community = Brown / Edmunds)




Base: Not at all (n=101), Some days (n=4), Every day (n=12), Sample Size = 117

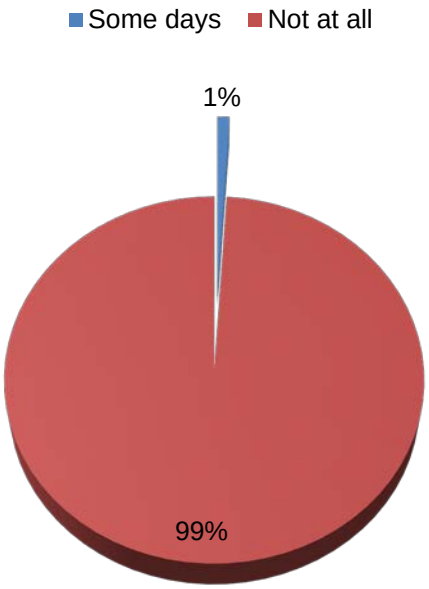
(Community = Brown / Edmunds)




Base: Not at all (n=114), Every day (n=1), Sample Size = 115

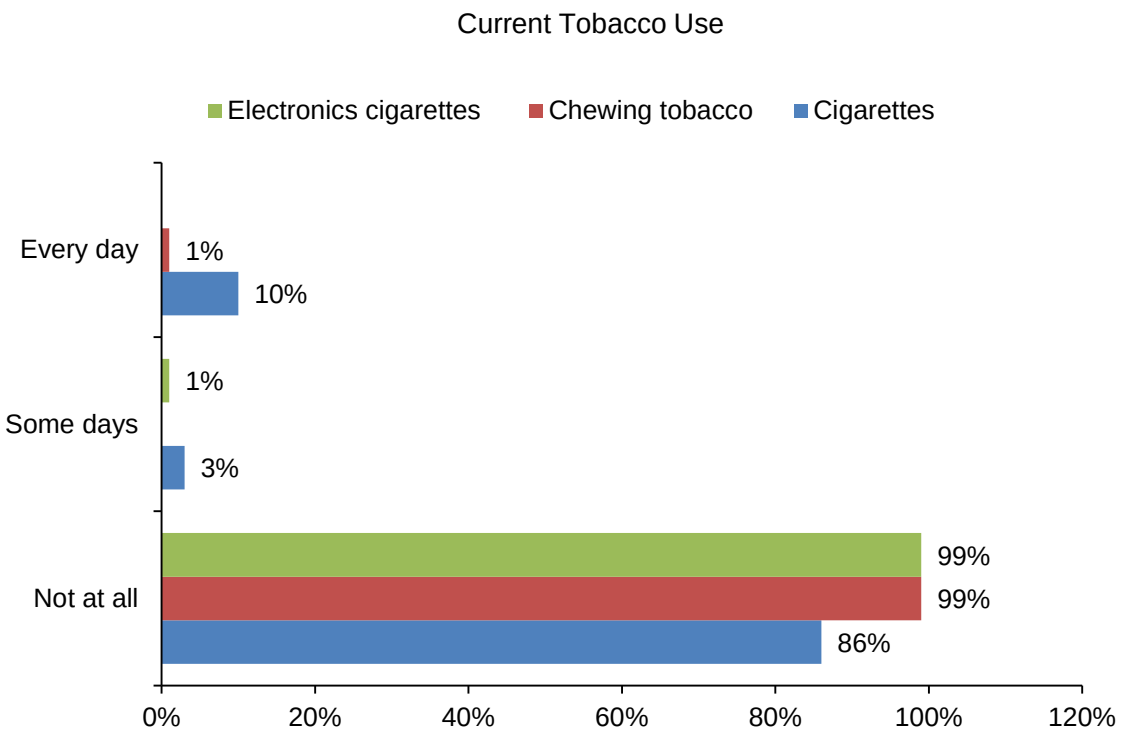
(Community = Brown / Edmunds)

Do you currently use electronics cigarettes or vape?




Base: Not at all (n=114), Some days (n=1), Sample Size = 115

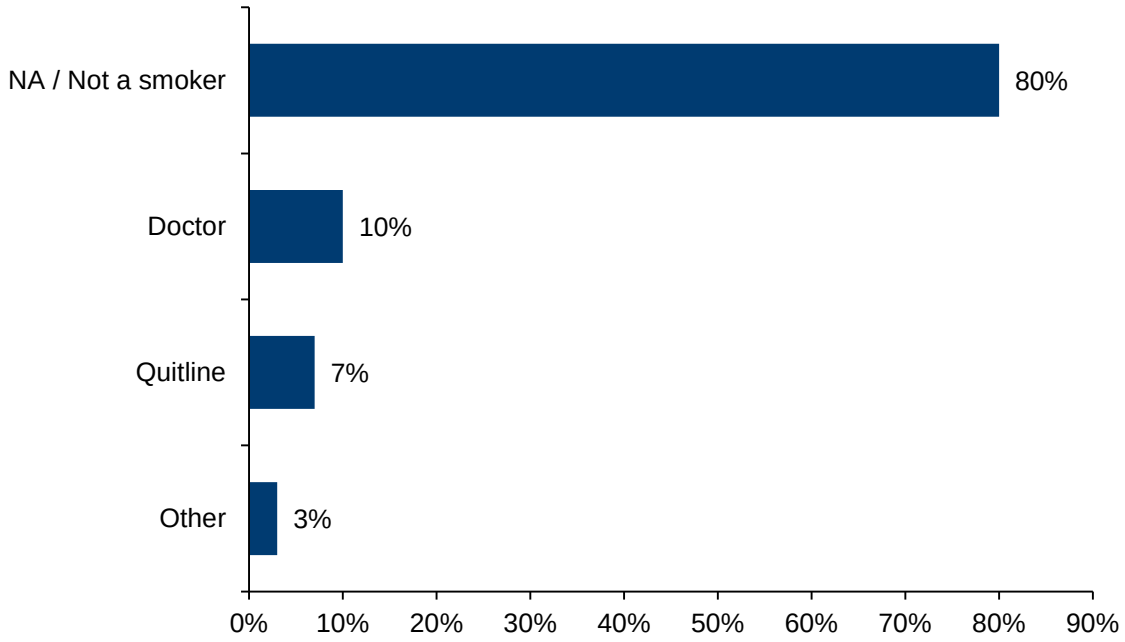
(Community = Brown / Edmunds)




Sample Size = Variable

(Community = Brown / Edmunds)

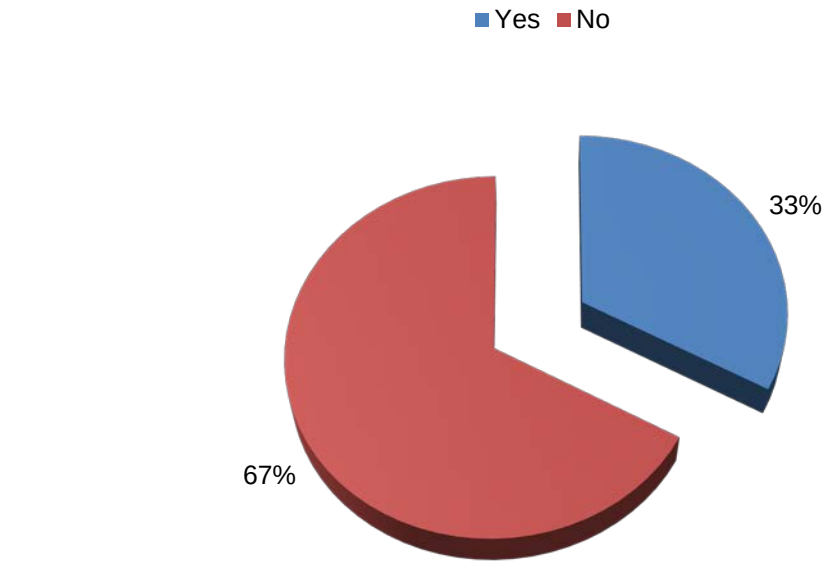
Where would you go for help if you wanted to quit using tobacco products?




Base: NA / Not a smoker (n=89), Quitline (n=8), Doctor (n=11), Other (n=3), Sample Size = 111

(Community = Brown / Edmunds)

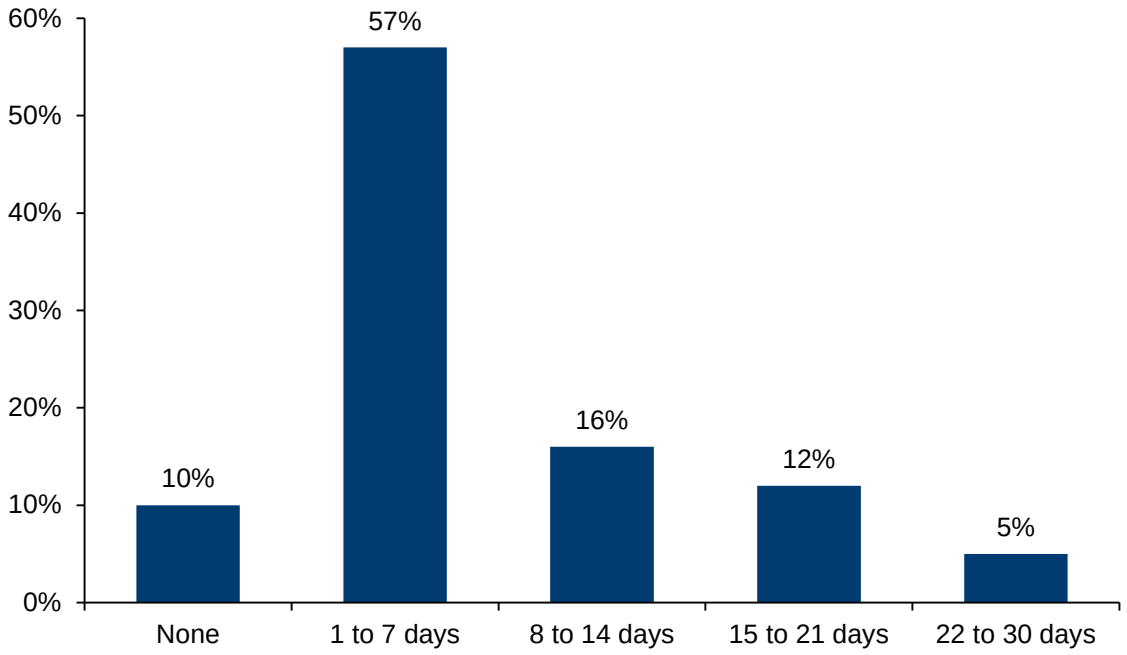
During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit? (Smokers only)




Base: Yes (n=6), No (n=12), Sample Size = 18

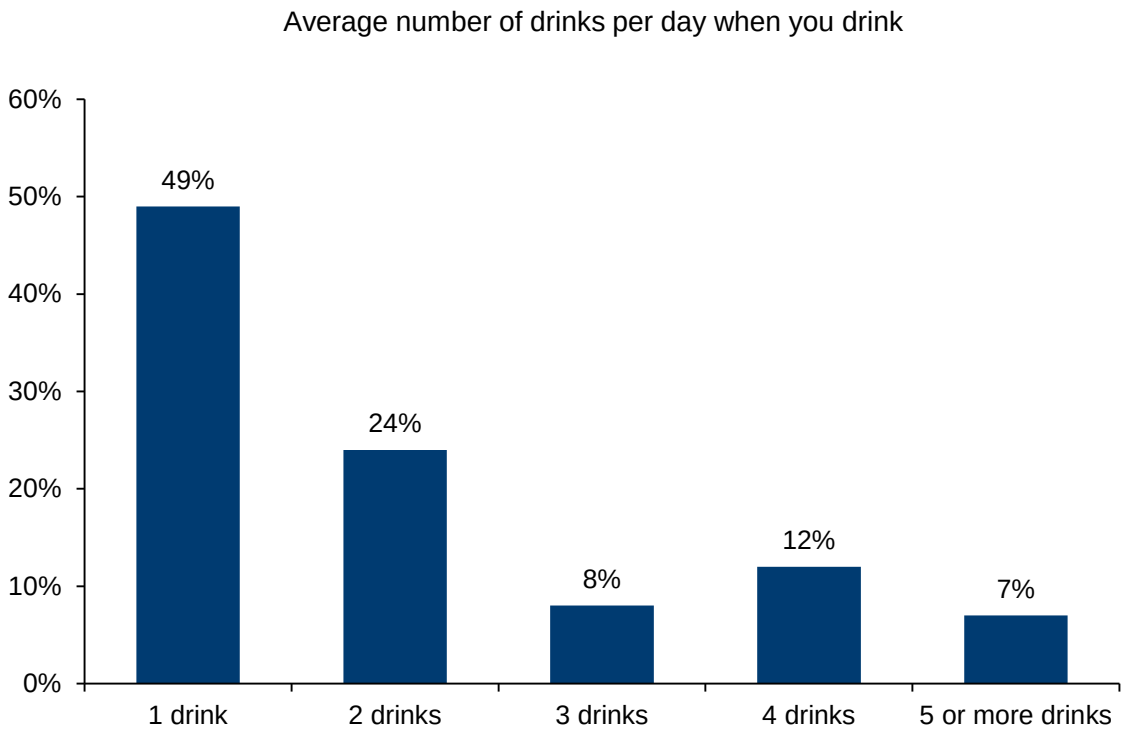
(Community = Brown / Edmunds)

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



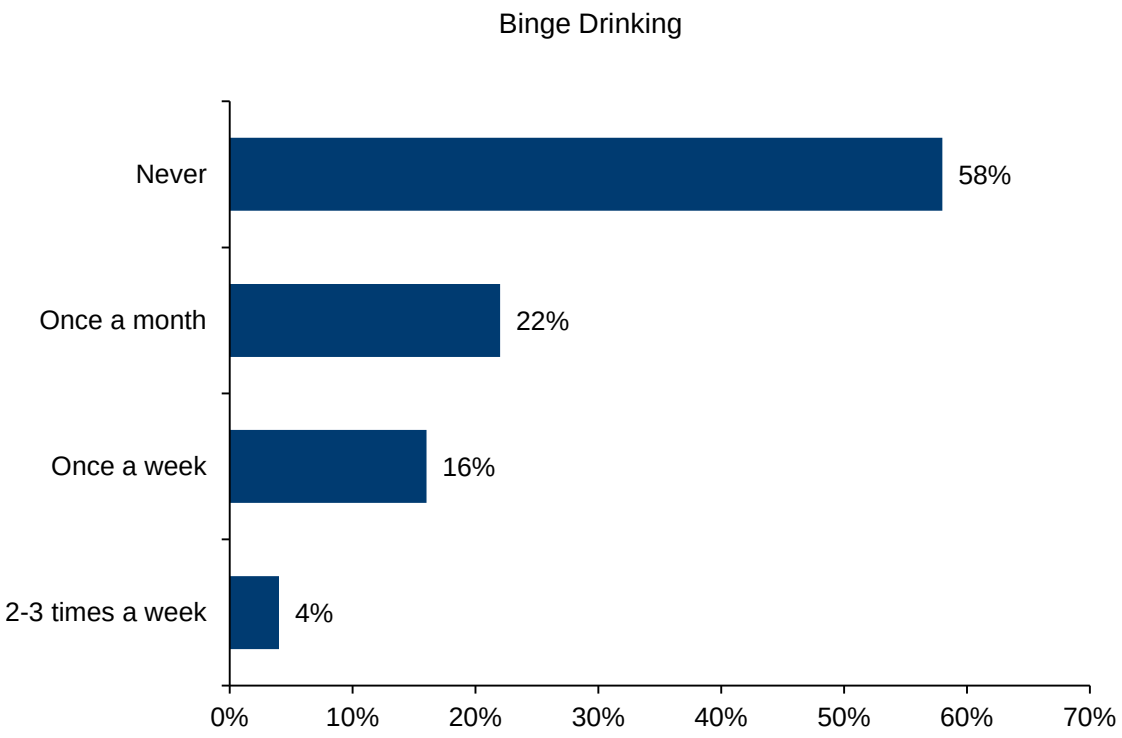

Base: None (n=9), 1 to 7 days (n=54), 8 to 14 days (n=15), 15 to 21 days (n=11), 22 to 30 days (n=5), Sample Size = 94

(Community = Brown / Edmunds)




Base: 1 drink (n=42), 2 drinks (n=20), 3 drinks (n=7), 4 drinks (n=10), 5 or more drinks (n=6), Sample Size = 85

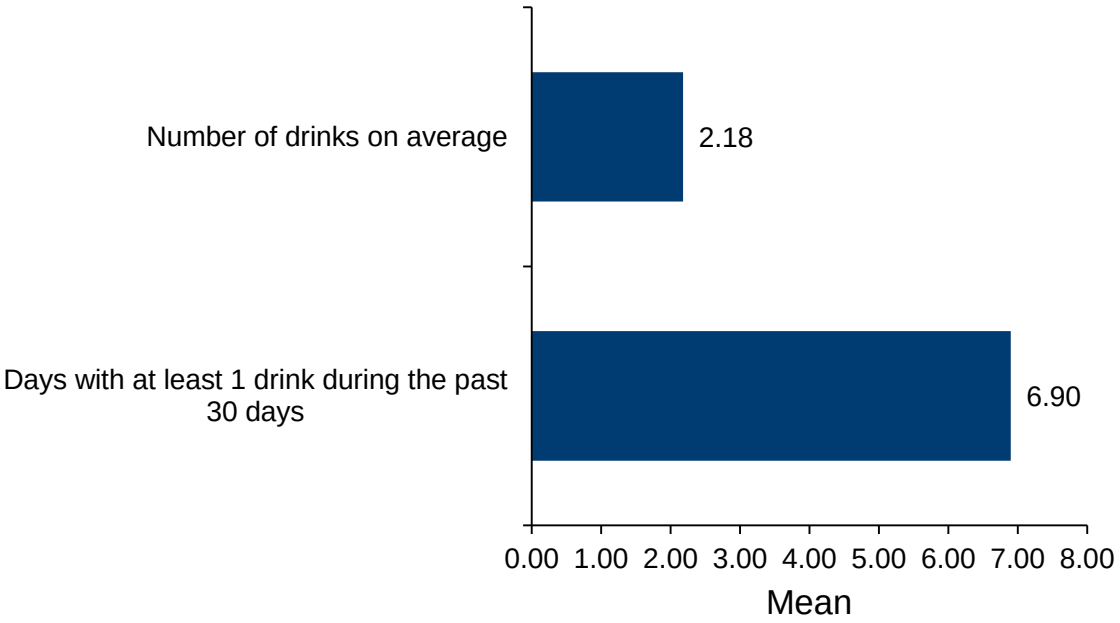
(Community = Brown / Edmunds)




Base: 2-3 times a week (n=3), Once a week (n=14), Once a month (n=19), Never (n=49), Sample Size = 85

(Community = Brown / Edmunds)

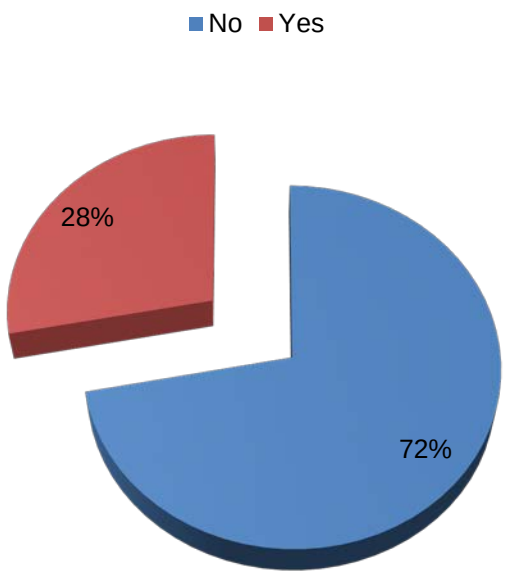
## Average Alcohol Use During the Past 30 Days




Base: Days with at least 1 drink during the past 30 days (n=94), Number of drinks on average (n=85), Sample Size = Variable

(Community = Brown / Edmunds)

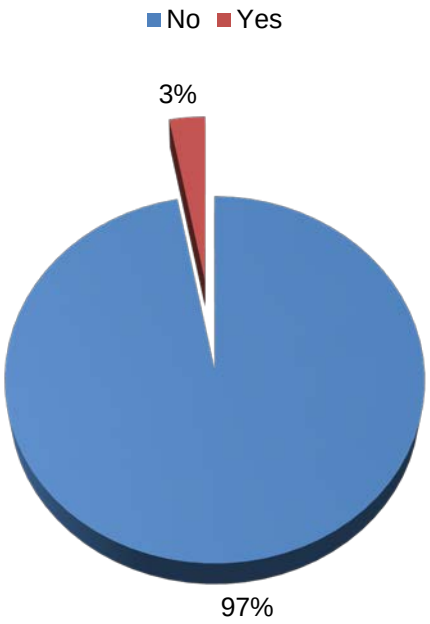
Has alcohol use had a harmful effect on you or a family member in the past two years?




Base: Yes (n=33), No (n=83), Sample Size = 116

(Community = Brown / Edmunds)

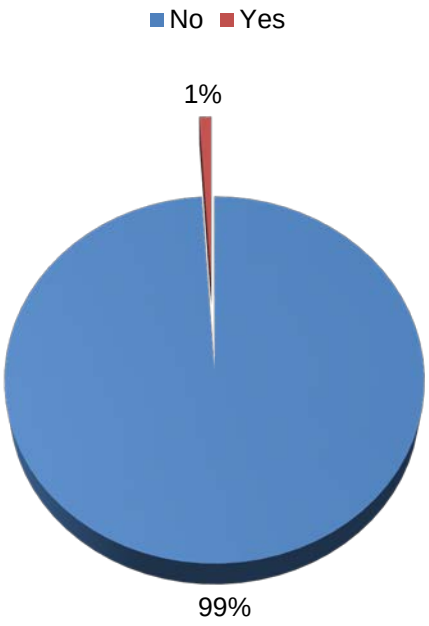
Have you ever wanted help with a prescription or non-prescription drug use?




Base: Yes (n=3), No (n=114), Sample Size = 117

(Community = Brown / Edmunds)

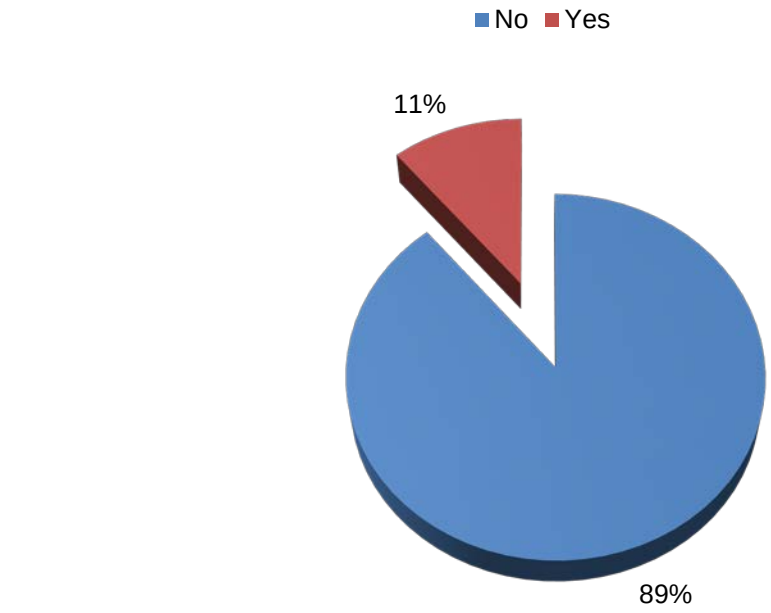
Has a family member or friend ever suggested that you get help for substance use?




Base: Yes (n=1), No (n=115), Sample Size = 116

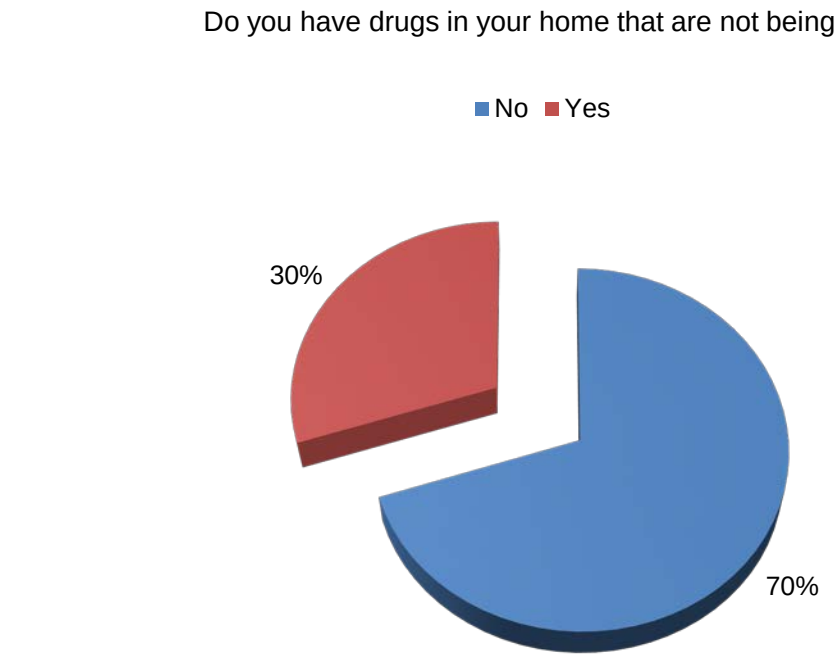
(Community = Brown / Edmunds)

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



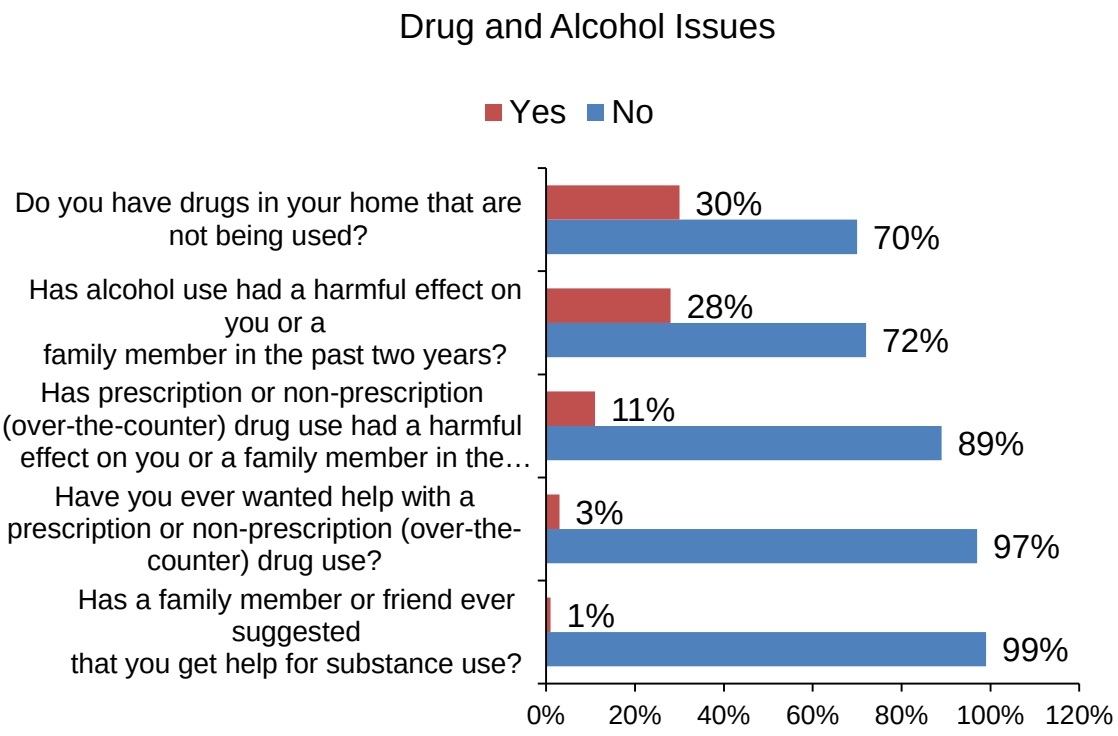

Base: Yes (n=13), No (n=104), Sample Size = 117

(Community = Brown / Edmunds)




Base: Yes (n=35), No (n=81), Sample Size = 116

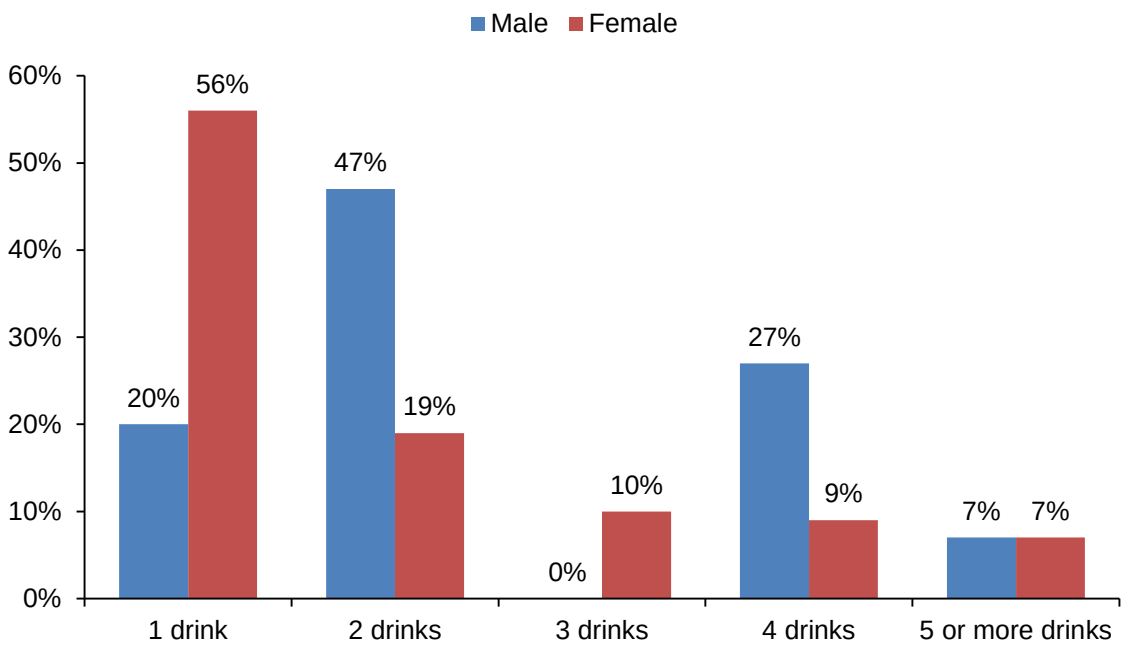
(Community = Brown / Edmunds)




Sample Size = Variable

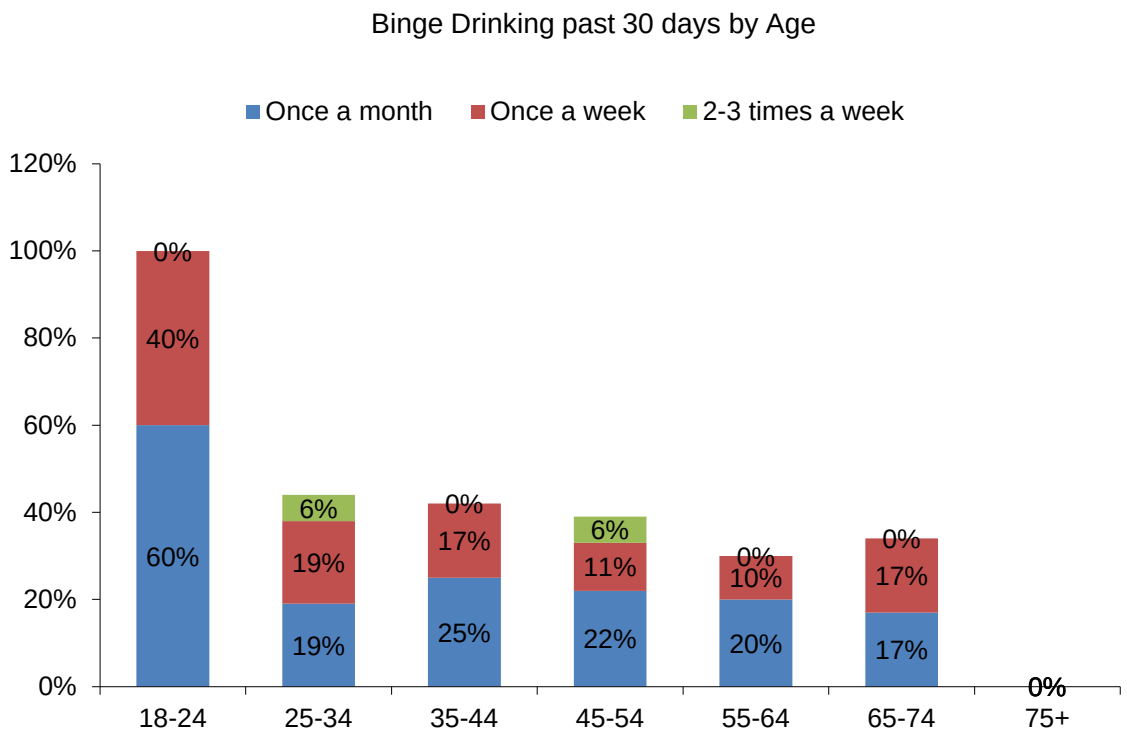
(Community = Brown / Edmunds)

Average number of drinks per day when you drink by gender




Base: 1 drink (n=42), 2 drinks (n=20), 3 drinks (n=7), 4 drinks (n=10), 5 or more drinks (n=6), Sample Size = 85

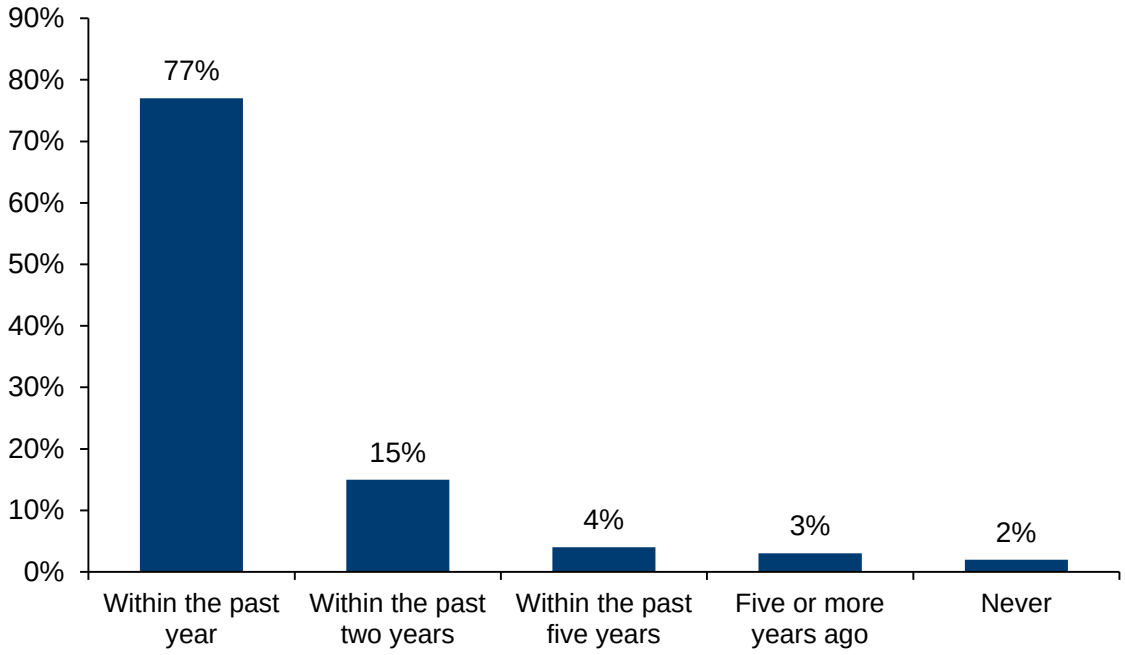
(Community = Brown / Edmunds)




Base: 18-24 (n=5), 25-34 (n=31), 35-44 (n=12), 45-54 (n=18), 55-64 (n=10), 65-74 (n=6), 75+ (n=3), Sample Size = 85

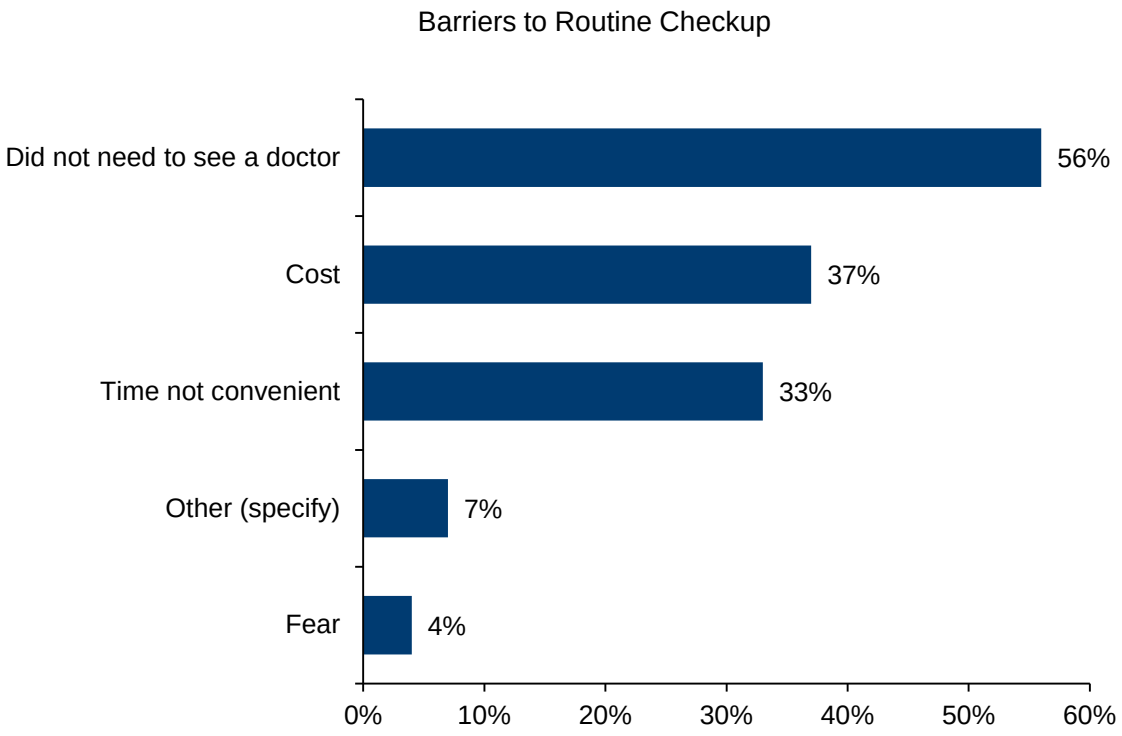
(Community = Brown / Edmunds)

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




Base: Within the past year (n=90), Within the past two years (n=17), Within the past five years (n=5), Five or more years ago (n=3), Never (n=2), Sample Size = 117

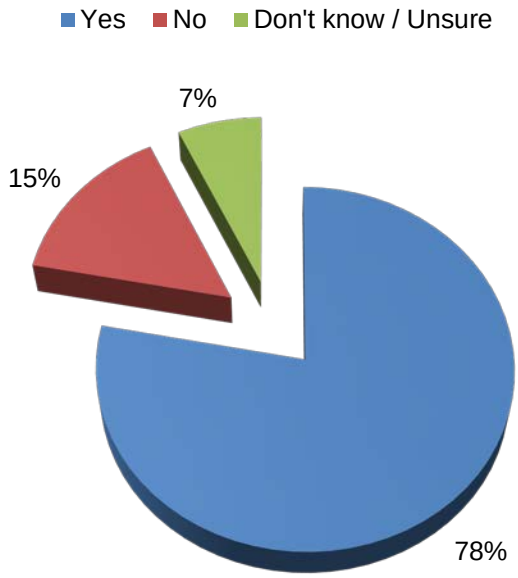
(Community = Brown / Edmunds)




Base: Cost (n=10), Fear (n=1), Time not convenient (n=9), Did not need to see a doctor (n=15), Other (specify) (n=2), Sample Size = 27

(Community = Brown / Edmunds)

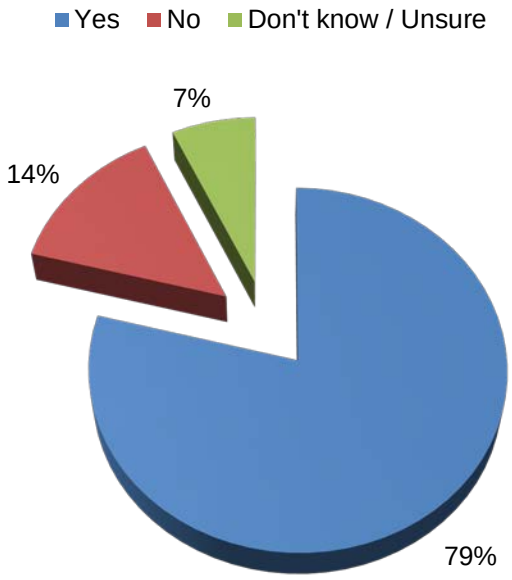
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?




Base: Yes (n=91), No (n=18), Don't know / Unsure (n=8), Sample Size = 117

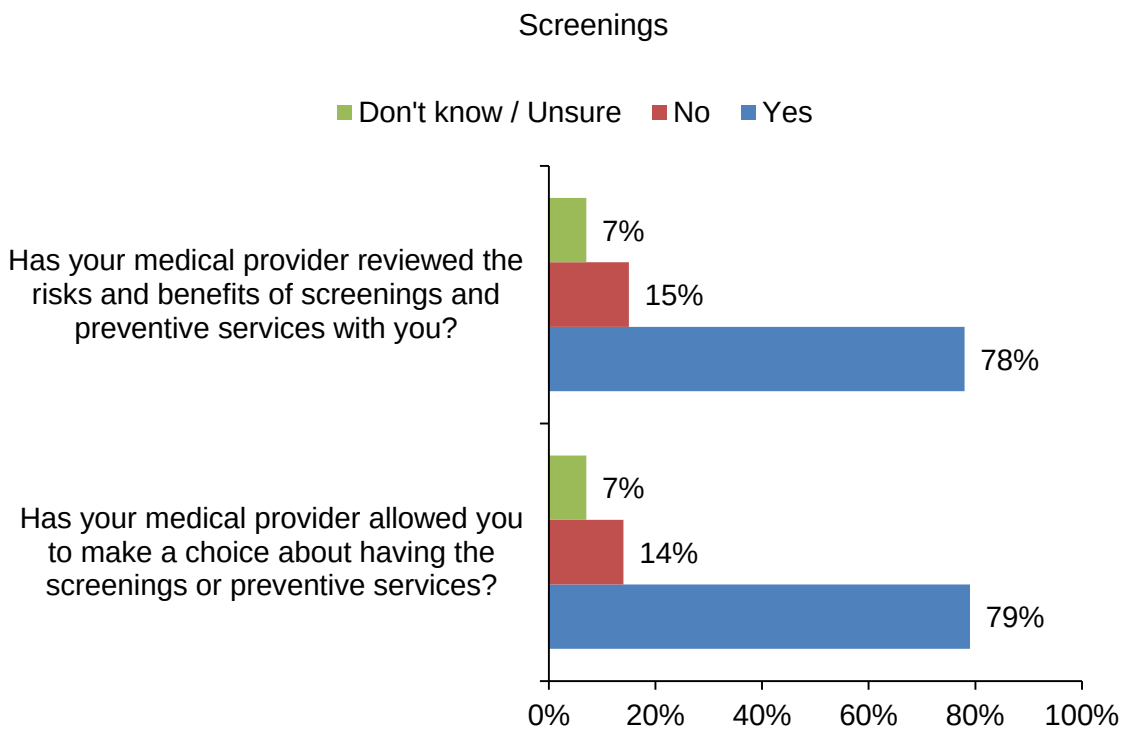
(Community = Brown / Edmunds)

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




Base: Yes (n=93), No (n=16), Don't know / Unsure (n=8), Sample Size = 117

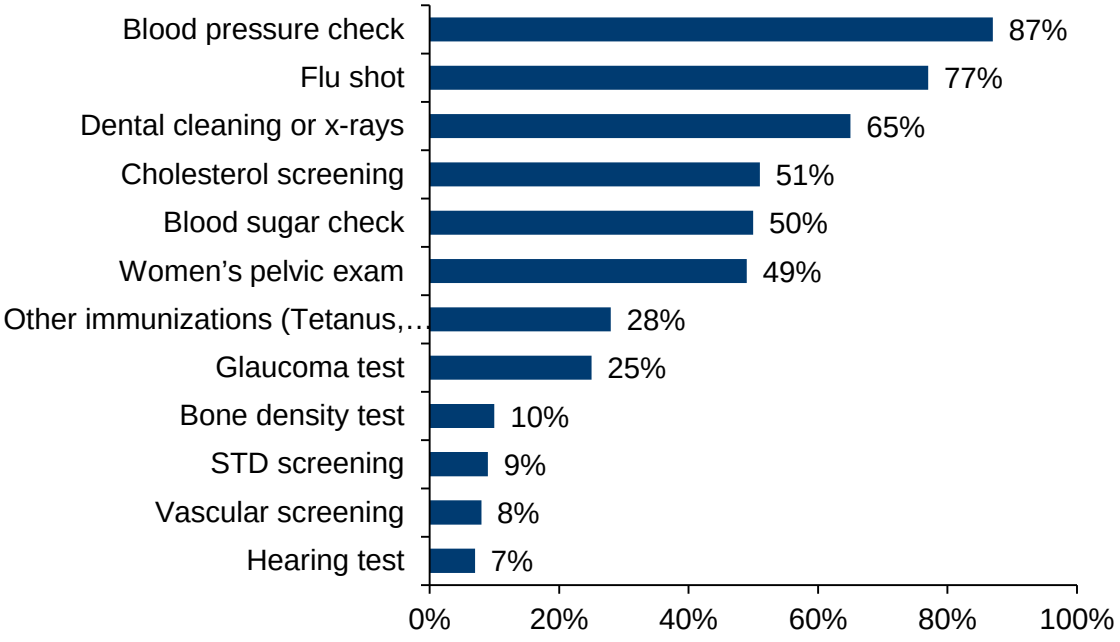
(Community = Brown / Edmunds)




Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=117), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=117), Sample Size = 117

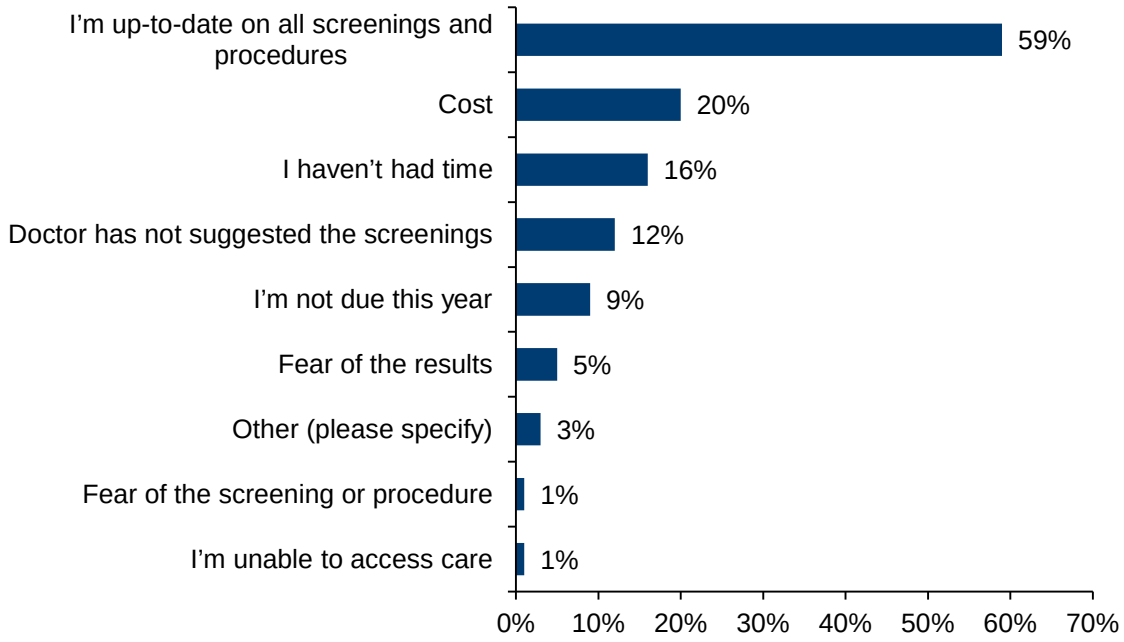
(Community = Brown / Edmunds)

## Preventive Procedures Last Year



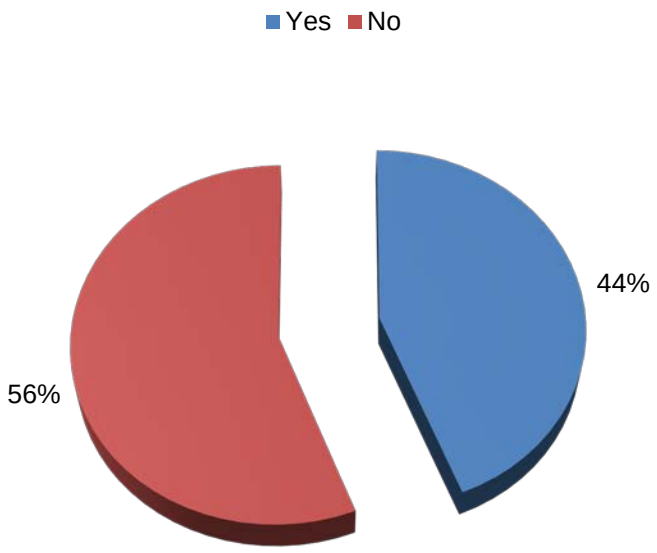

Base: Blood pressure check (n=97), Blood sugar check (n=55), Bone density test (n=11), Cholesterol screening (n=57), Dental cleaning or x-rays (n=72), Flu shot (n=86), Other immunizations (Tetanus, Hepatitis A or B) (n=31), Glaucoma test (n=28), Hearing test (n=8), Women's pelvic exam (n=54), STD screening (n=10), Vascular screening (n=9), Sample Size = 111
(Community = Brown / Edmunds)

## Barriers for Preventive Procedures



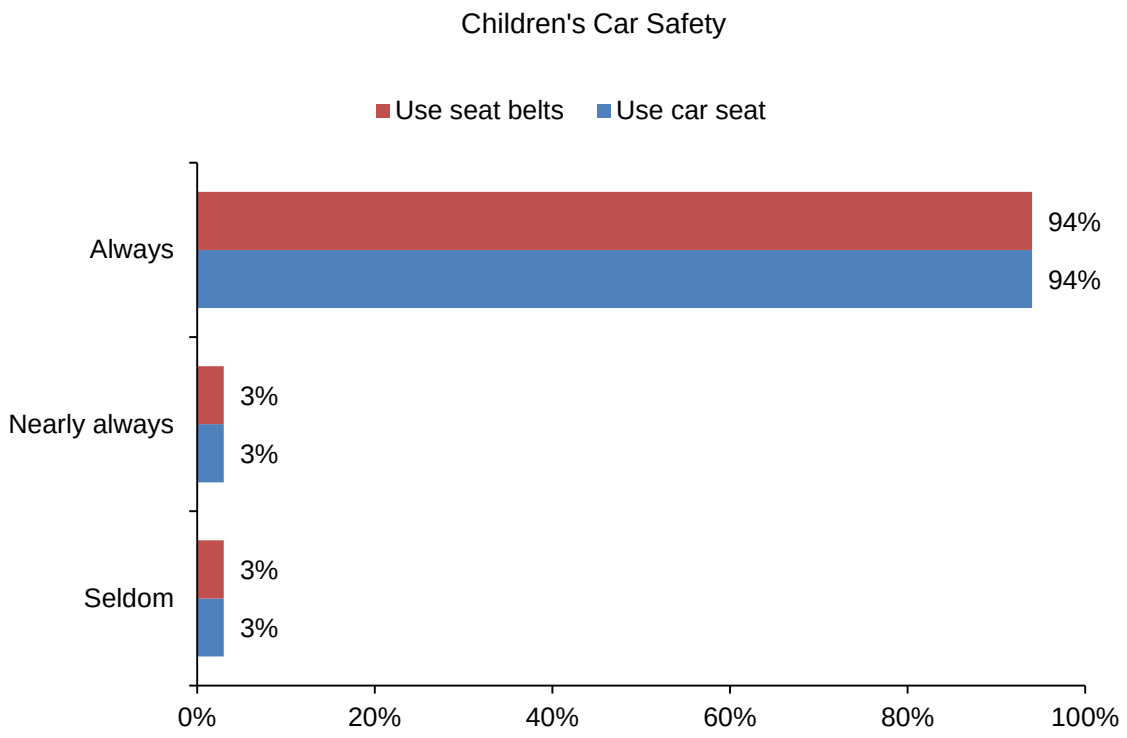

Base: I'm up-to-date on all screenings and procedures (n=69), Doctor has not suggested the screenings (n=14), Cost (n=23), I'm unable to access care (n=1), Fear of the screening or procedure (n=1), Fear of the results (n=6), I'm not due this year (n=10), I haven't had time (n=18), Other (please specify) (n=3), Sample Size = 116
(Community = Brown / Edmunds)

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




Base: Yes (n=51), No (n=66), Sample Size = 117

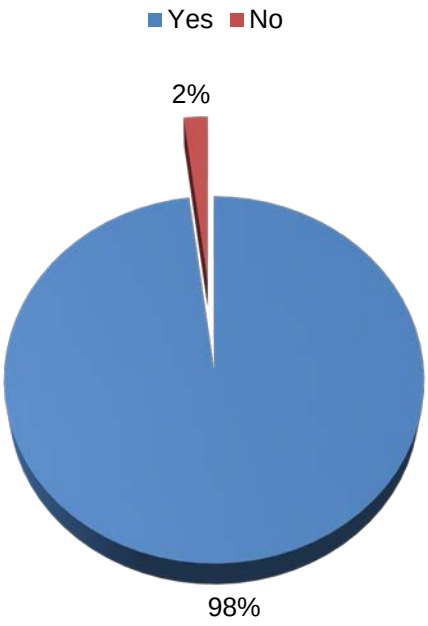
(Community = Brown / Edmunds)




Sample Size = Variable

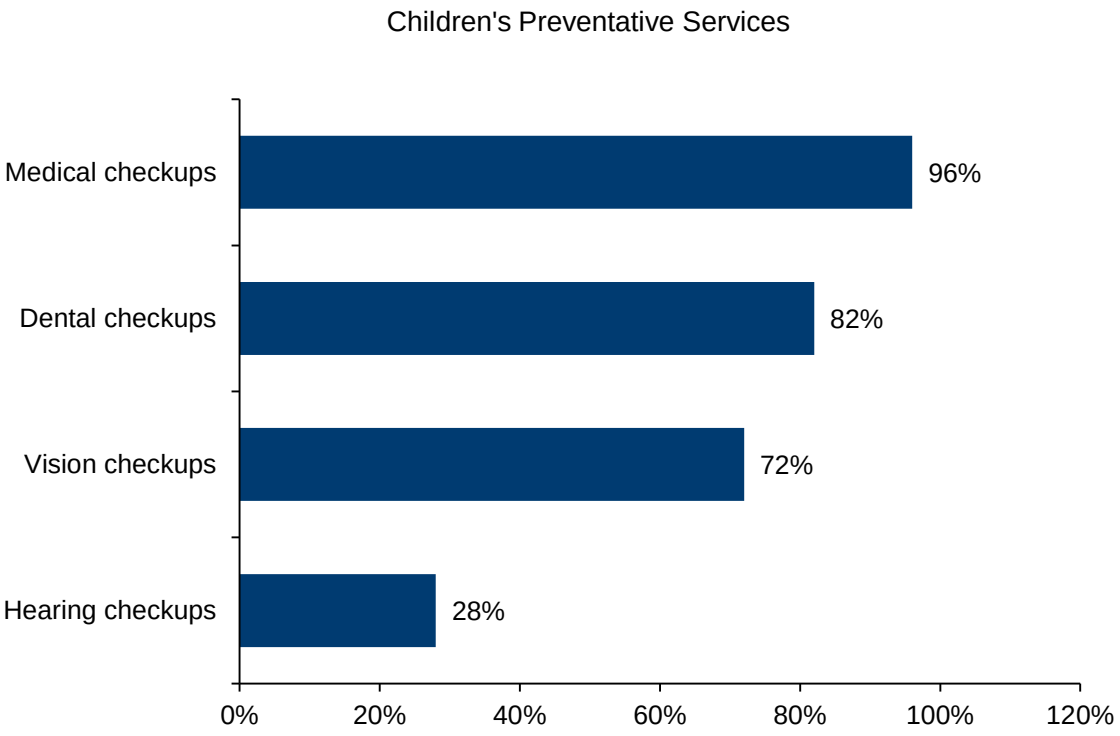
(Community = Brown / Edmunds)

Do you have healthcare coverage for your children or dependents?




Base: Yes (n=50), No (n=1), Sample Size = 51

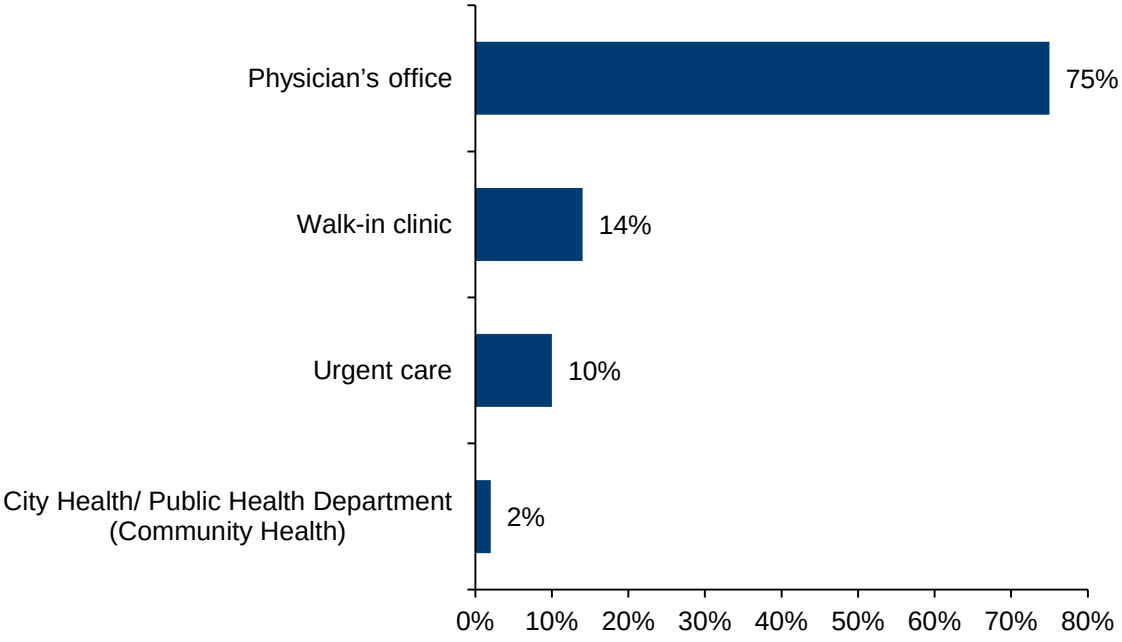
(Community = Brown / Edmunds)




Base: Dental checkups (n=41), Vision checkups (n=36), Hearing checkups (n=14), Medical checkups (n=48), Sample Size = 50

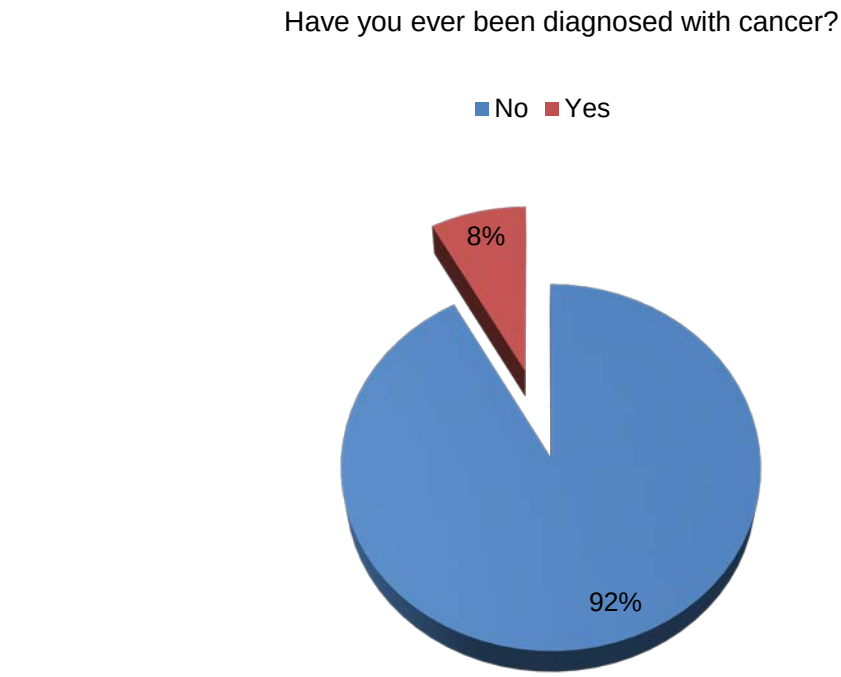
(Community = Brown / Edmunds)

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



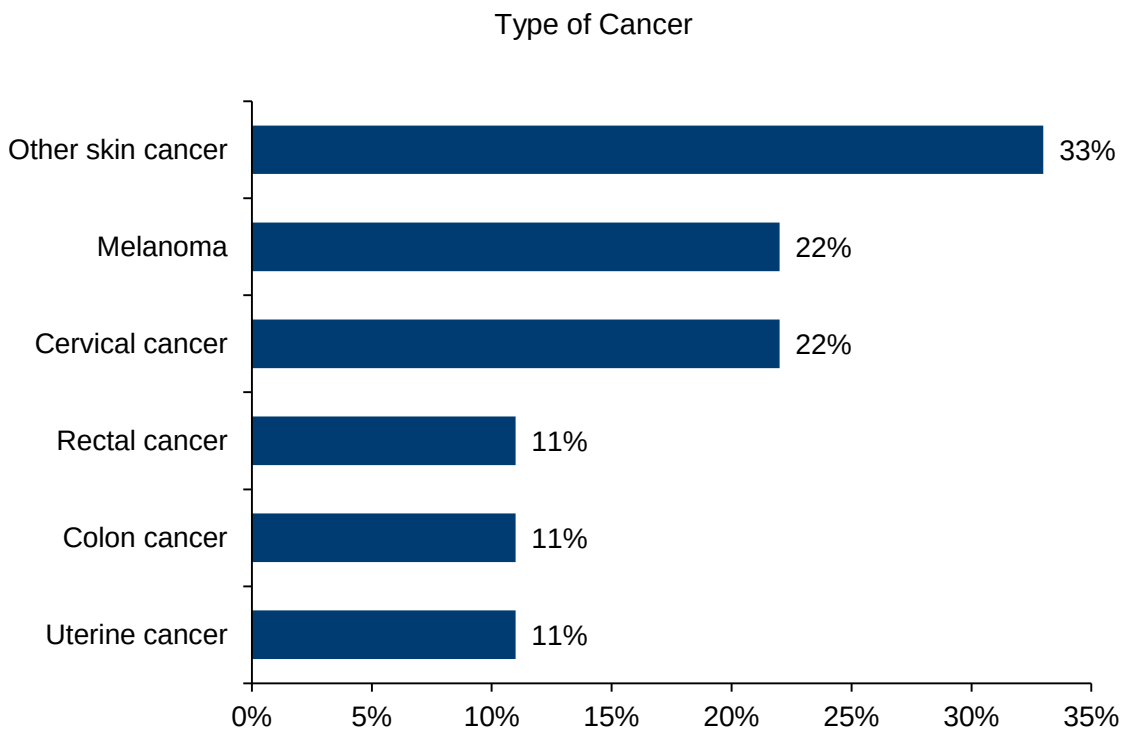

Base: Physician's office (n=38), Urgent care (n=5), Walk-in clinic (n=7), City Health/ Public Health Department (Community Health) (n=1), Sample Size = 51

(Community = Brown / Edmunds)




Base: Yes (n=9), No (n=108), Sample Size = 117

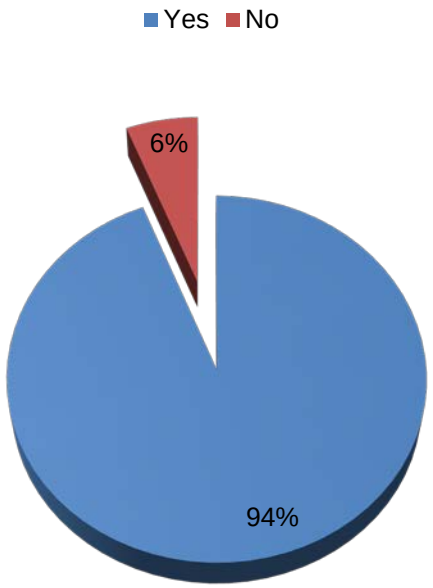
(Community = Brown / Edmunds)




Base: Uterine cancer (n=1), Cervical cancer (n=2), Colon cancer (n=1), Melanoma (n=2), Other skin cancer (n=3), Rectal cancer (n=1), Sample Size = 9

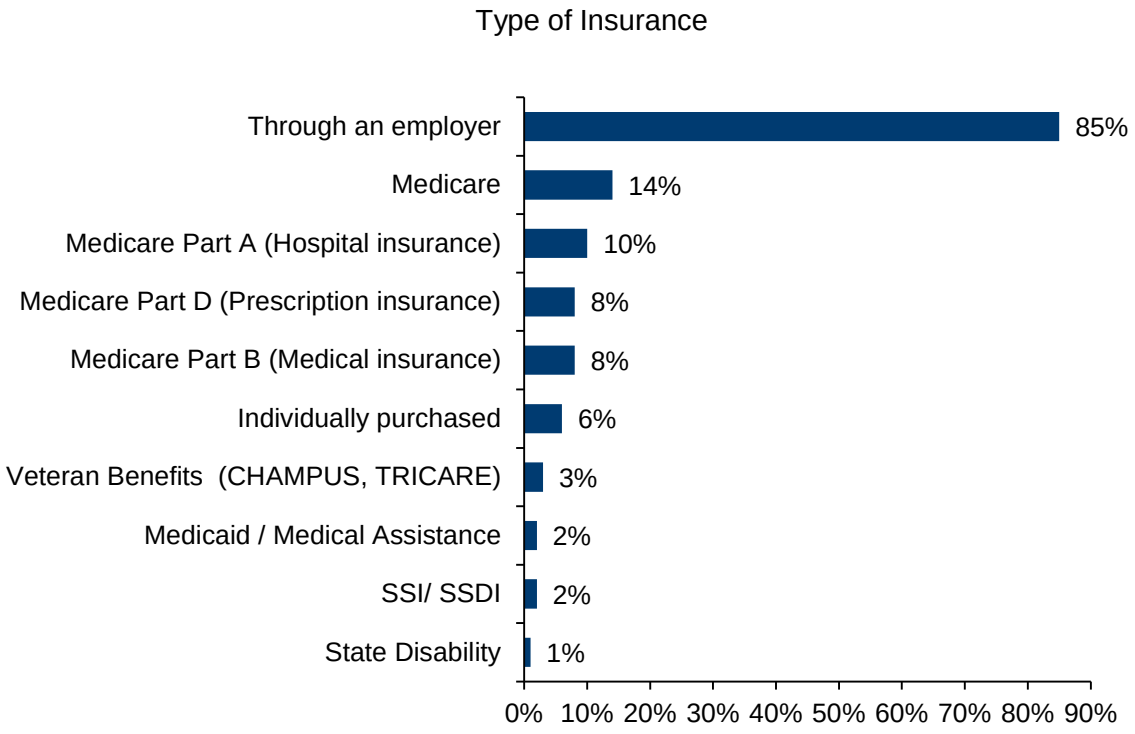
(Community = Brown / Edmunds)

Do you currently have any kind of health insurance?



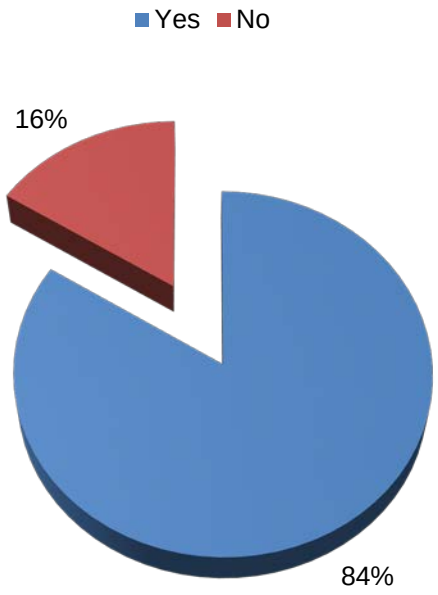

Base: Yes (n=110), No (n=7), Sample Size = 117

(Community = Brown / Edmunds)




Base: Through an employer (n=94), Individually purchased (n=7), Medicare (n=15), Medicare Part A (Hospital insurance) (n=11), Medicare Part B (Medical insurance) (n=9), Medicare Part D (Prescription insurance) (n=9), State Disability (n=1), SSI/ SSDI (n=2), Medicaid / Medical Assistance (n=2), Veteran Benefits (CHAMPUS, TRICARE) (n=3), Sample Size = 110
(Community = Brown / Edmunds)

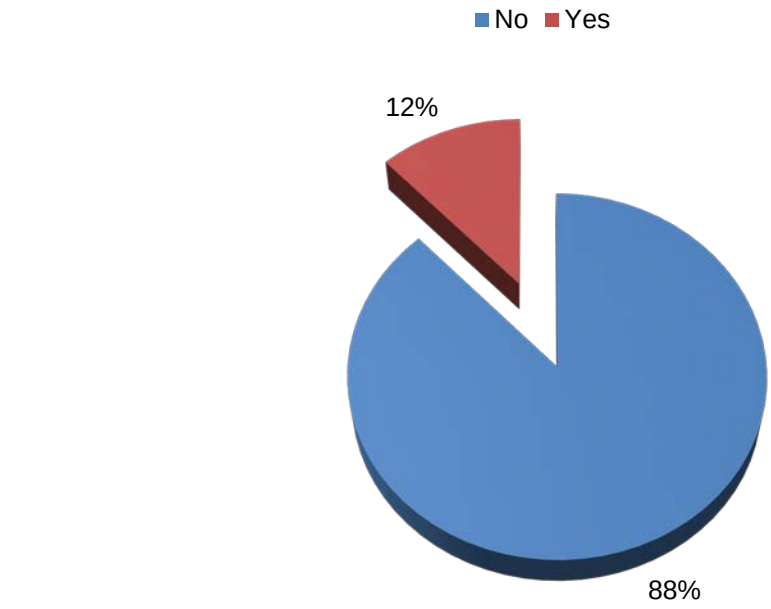
Do you have an established primary healthcare provider?




Base: Yes (n=98), No (n=19), Sample Size = 117

(Community = Brown / Edmunds)

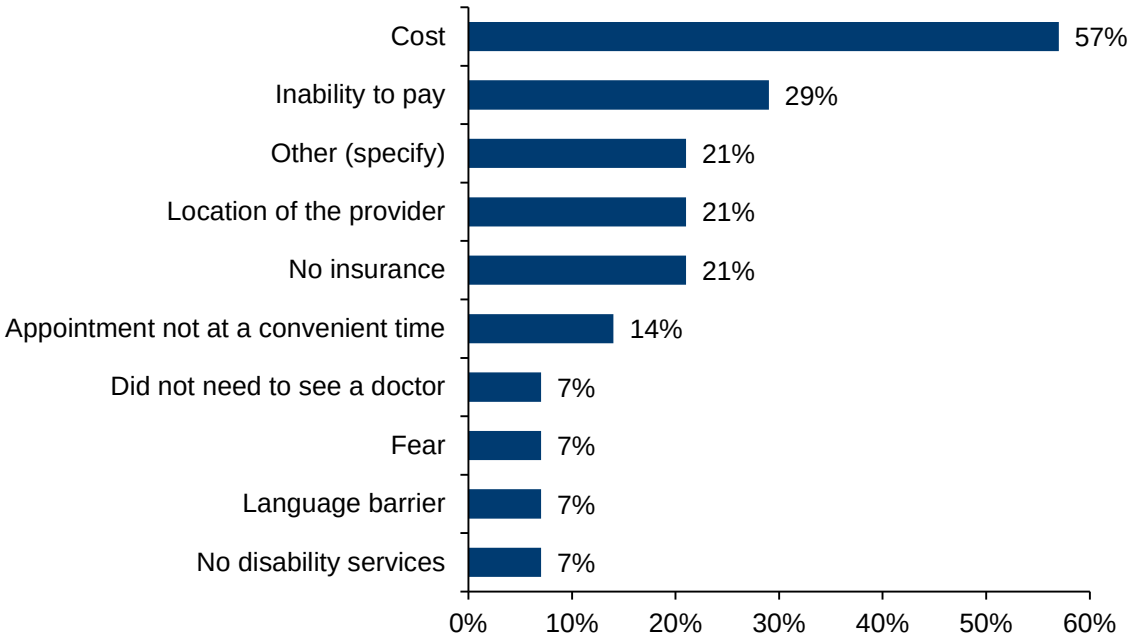
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?




Base: Yes (n=14), No (n=103), Sample Size = 117

(Community = Brown / Edmunds)

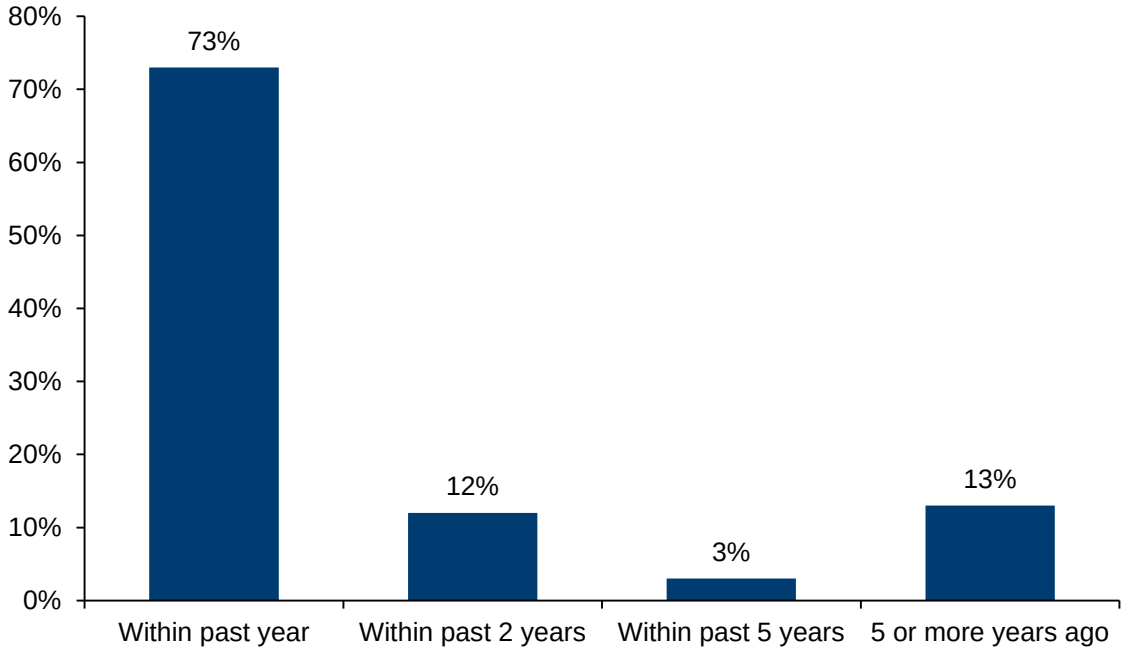
## Barriers to Receiving Care Needed




Base: Inability to pay (n=4), Appointment not at a convenient time (n=2), No disability services (n=1), No insurance (n=3), Language barrier (n=1), Location of the provider (n=3), Cost (n=8), Fear (n=1), Did not need to see a doctor (n=1), Other (specify) (n=3)

(Community = Brown / Edmunds)

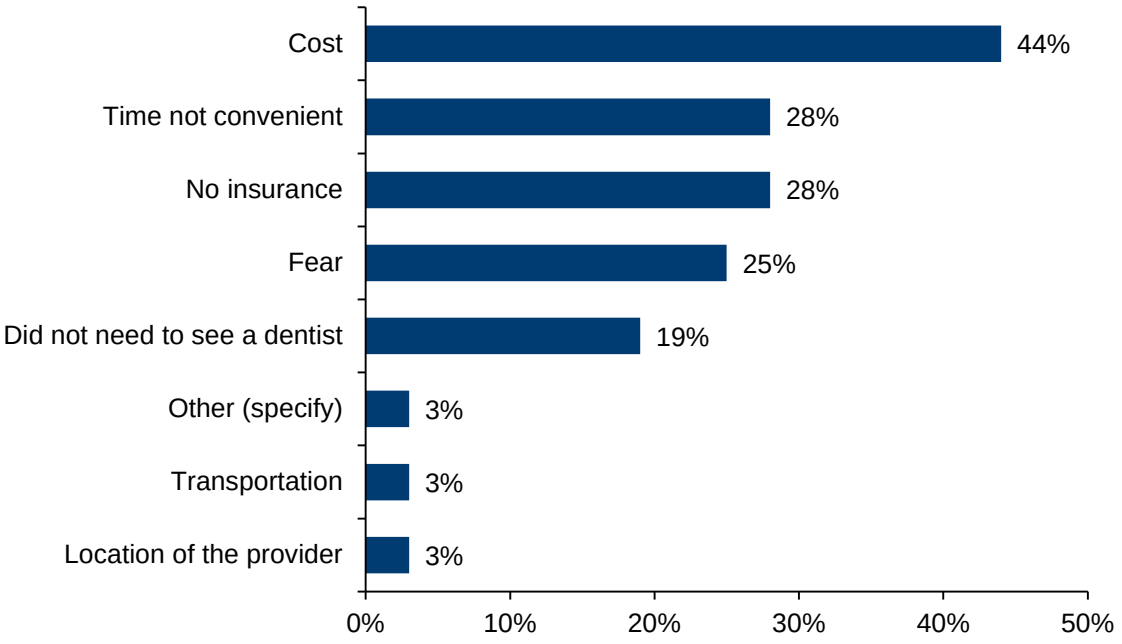
How long has it been since you last visited a dentist?




Base: Within past year (n=85), Within past 2 years (n=14), Within past 5 years (n=3), 5 or more years ago (n=15), Sample Size = 117

(Community = Brown / Edmunds)

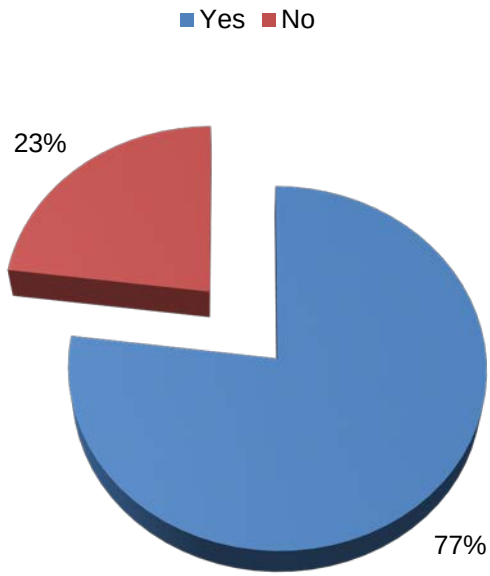
## Barriers to Visiting the Dentist




Base: No insurance (n=9), Location of the provider (n=1), Cost (n=14), Fear (n=8), Transportation (n=1), Time not convenient (n=9), Did not need to see a dentist (n=6), Other (specify) (n=1), Sample Size = 32

(Community = Brown / Edmunds)

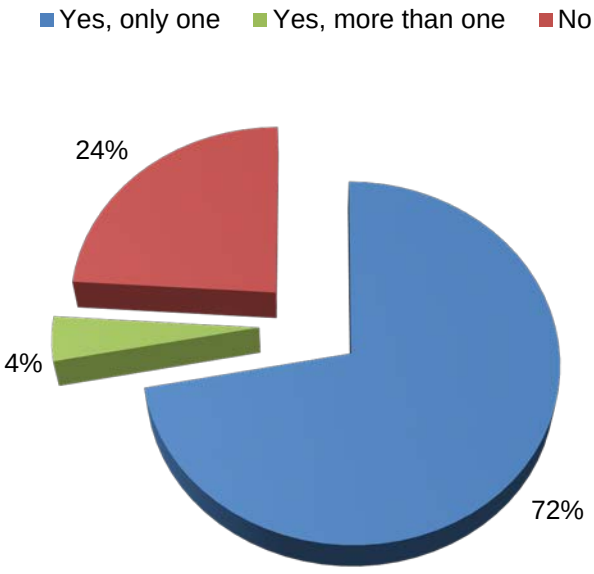
Do you have any kind of dental care or oral health insurance coverage?




Base: Yes (n=90), No (n=27), Sample Size = 117

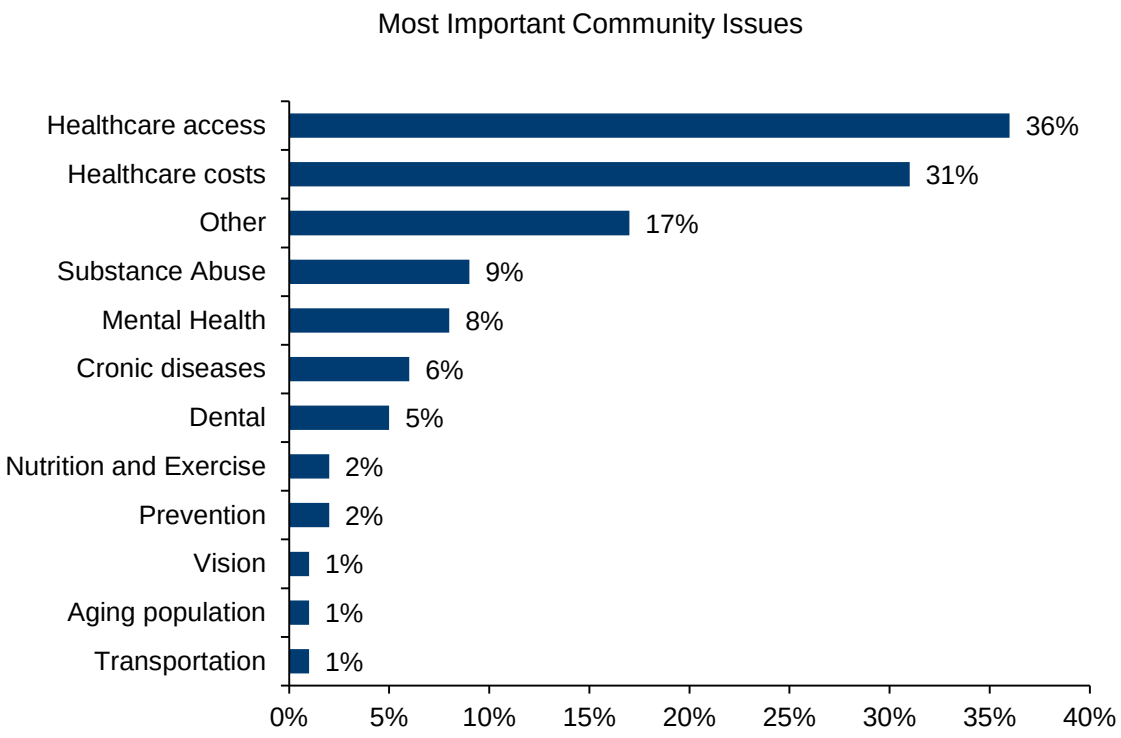
(Community = Brown / Edmunds)

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




Base: Yes, only one (n=84), Yes, more than one (n=5), No (n=28), Sample Size = 117

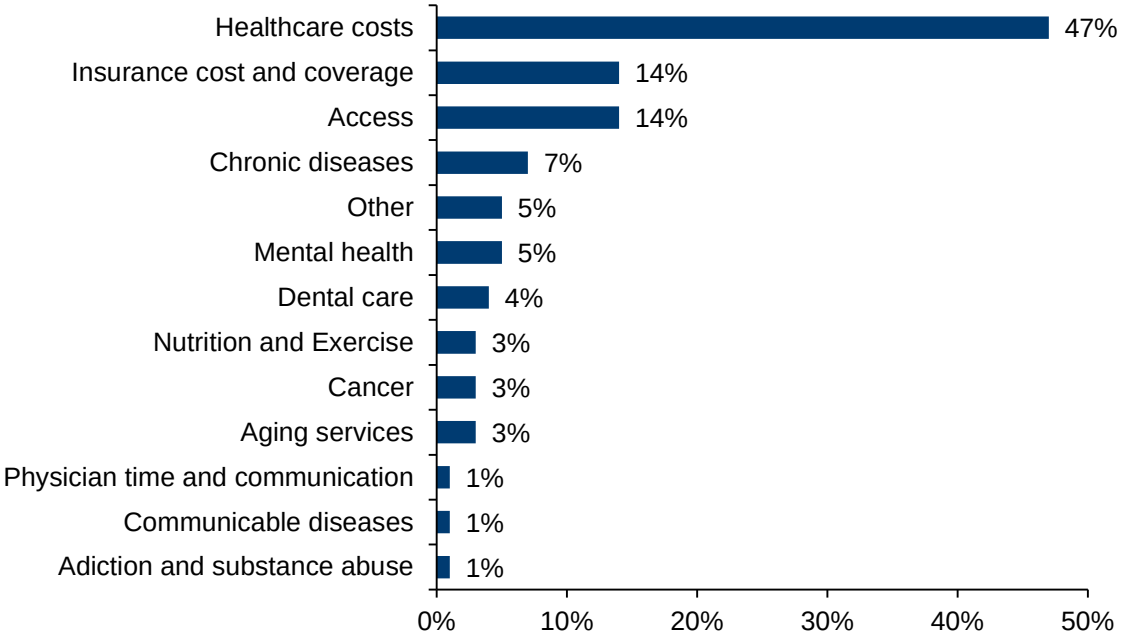
(Community = Brown / Edmunds)




Base: Transportation (n=1), Aging population (n=1), Healthcare access (n=31), Mental Health (n=7), Substance Abuse (n=8), Chronic diseases (n=5), Healthcare costs (n=27), Dental (n=4), Prevention (n=2), Vision (n=1), Nutrition and Exercise (n=2), Other (n=15), Sample Size = 91

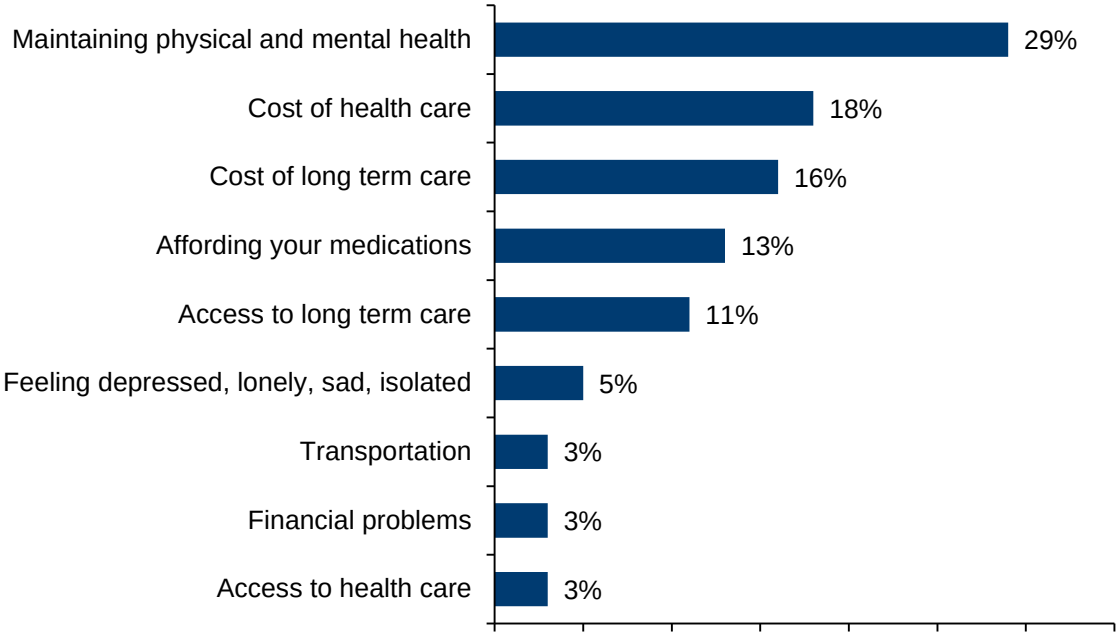
(Community = Brown / Edmunds)

## Most Important Issue for Family



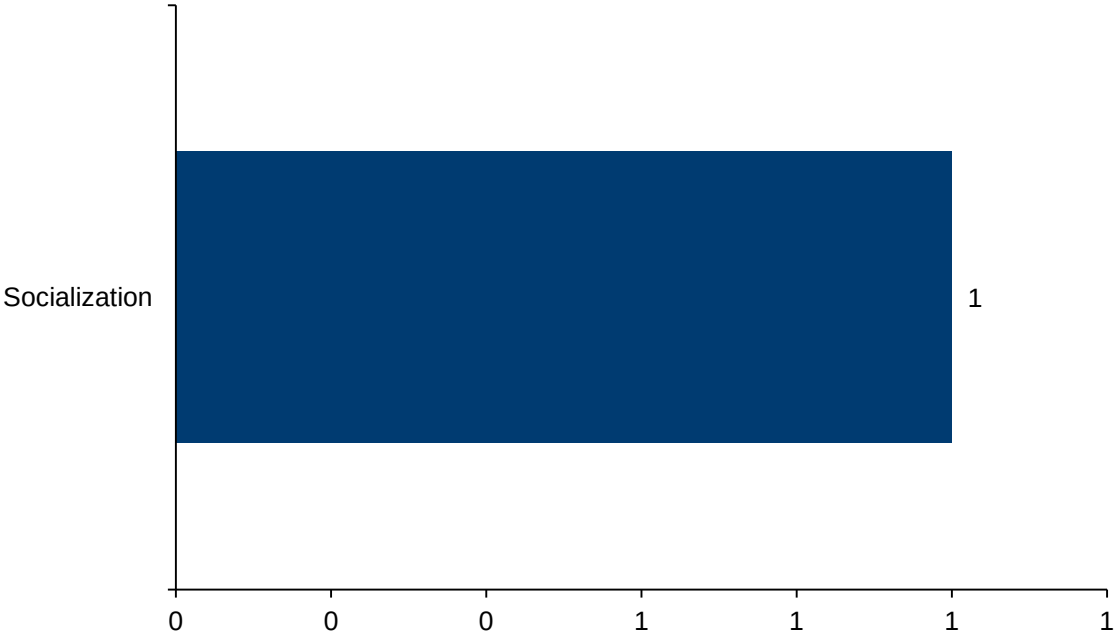

Base: Access (n=10), Addiction and substance abuse (n=1), Aging services (n=2), Cancer (n=2), Chronic diseases (n=5), Communicable diseases (n=1), Healthcare costs (n=34), Dental care (n=3), Nutrition and Exercise (n=2), Insurance cost and coverage (n=10), Mental health (n=4), Physician time and communication (n=1), Other (n=4), Sample Size = 89
(Community = Brown / Edmunds)

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




Base: Access to health care (n=1), Cost of health care (n=7), Affording your medications (n=5), Maintaining physical and mental health (n=11), Feeling depressed, lonely, sad, isolated (n=2), Access to long term care (n=4), Cost of long term care (n=6), Financial problems (n=1), Transportation (n=1), Sample Size = 17
(Community = Brown / Edmunds)

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




Base: Socialization (n=1), Sample Size = 1

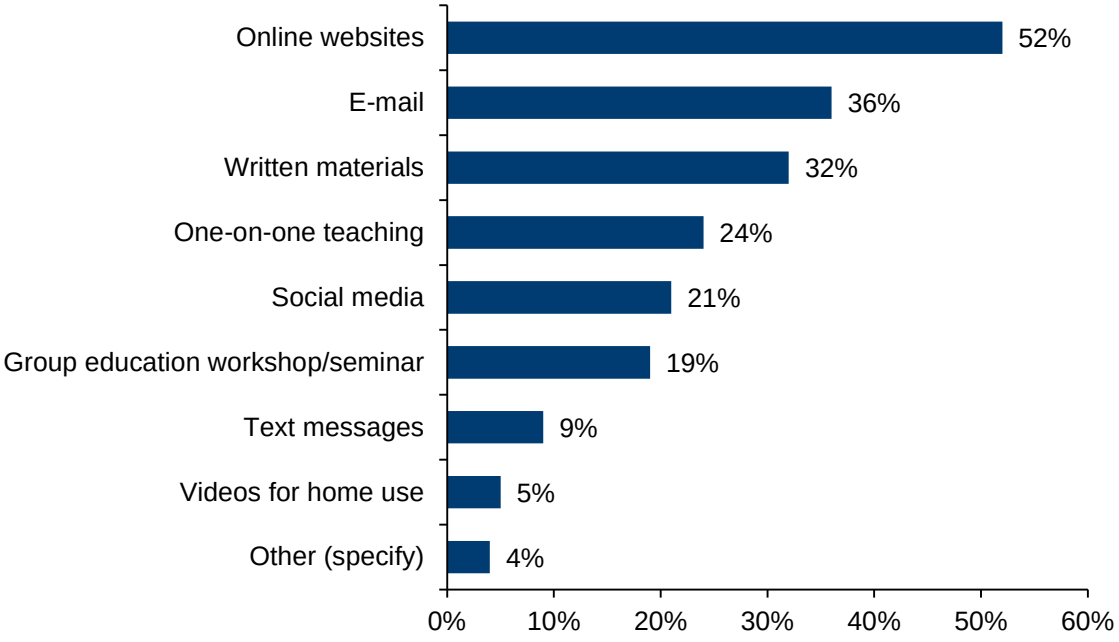
(Community = Brown / Edmunds)

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


Base: No (n=1), Sample Size = 1

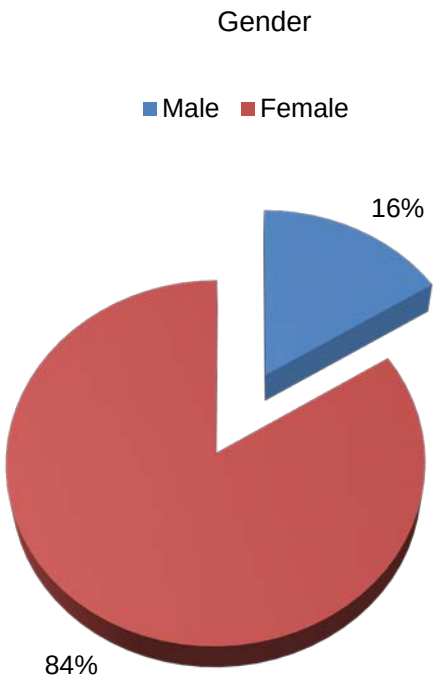
(Community = Brown / Edmunds)

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



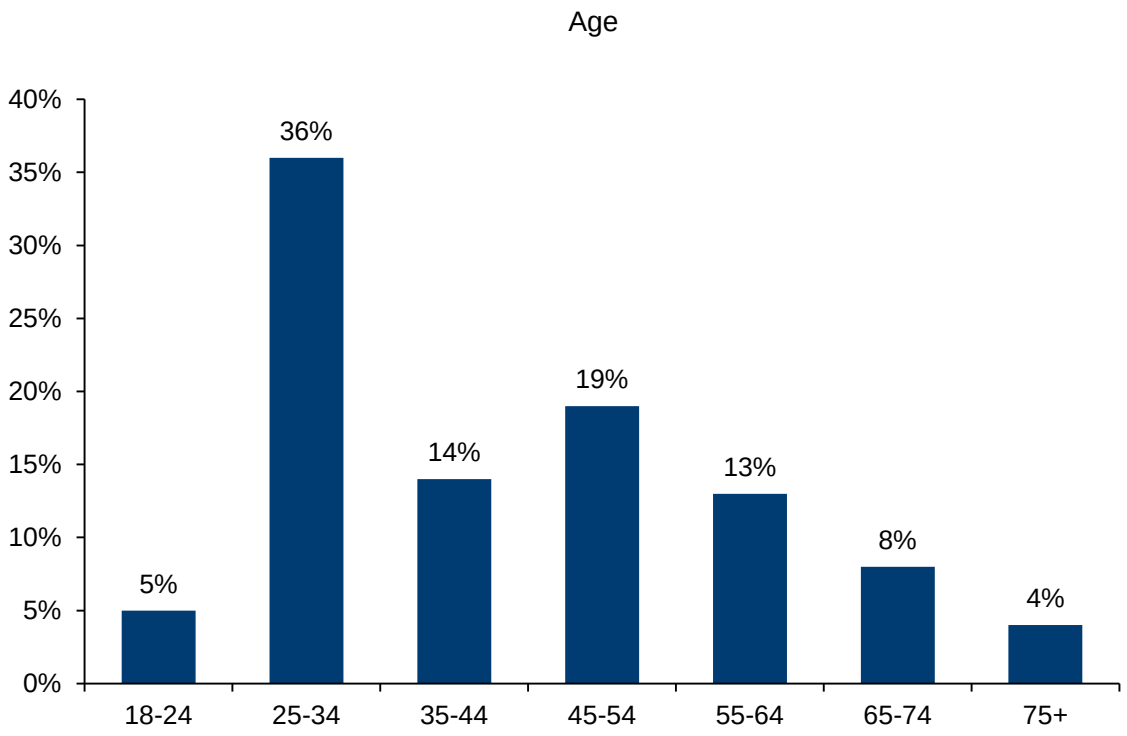

Base: Written materials (n=36), Videos for home use (n=6), Social media (n=24), Text messages (n=10), One-on-one teaching (n=27), E-mail (n=41), Group education workshop/seminar (n=22), Online websites (n=59), Other (specify) (n=5), Sample Size = 113

(Community = Brown / Edmunds)



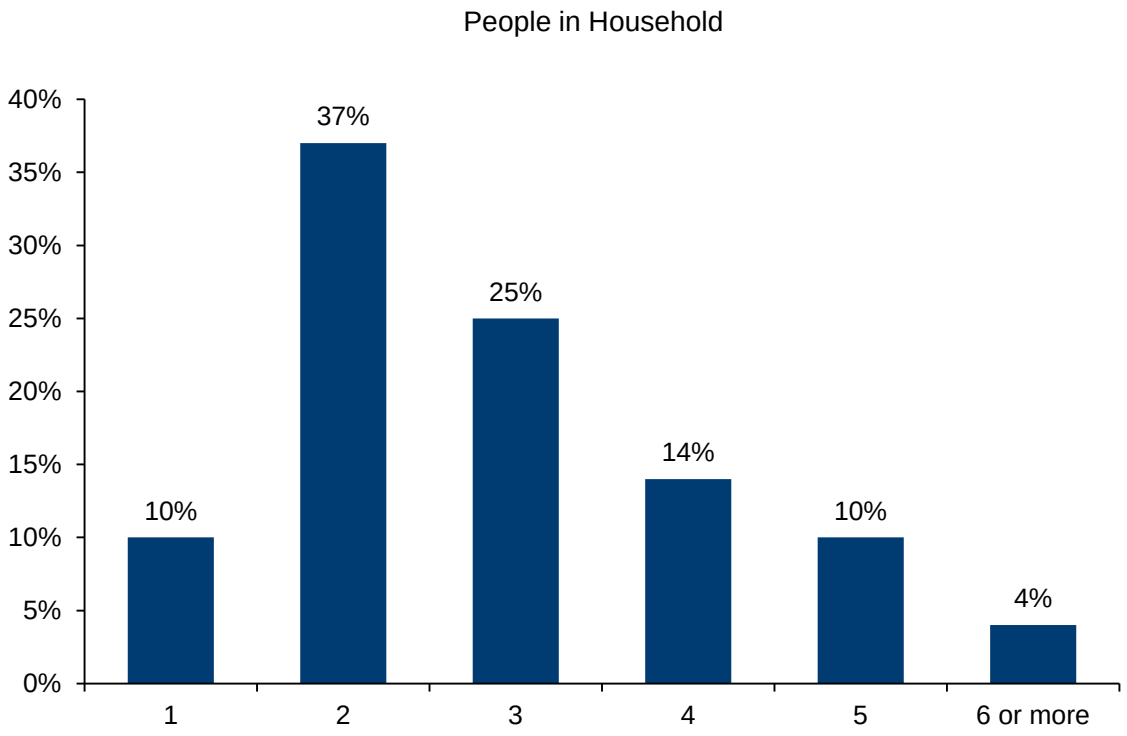

Base: Male (n=18), Female (n=97), Sample Size = 115

(Community = Brown / Edmunds)



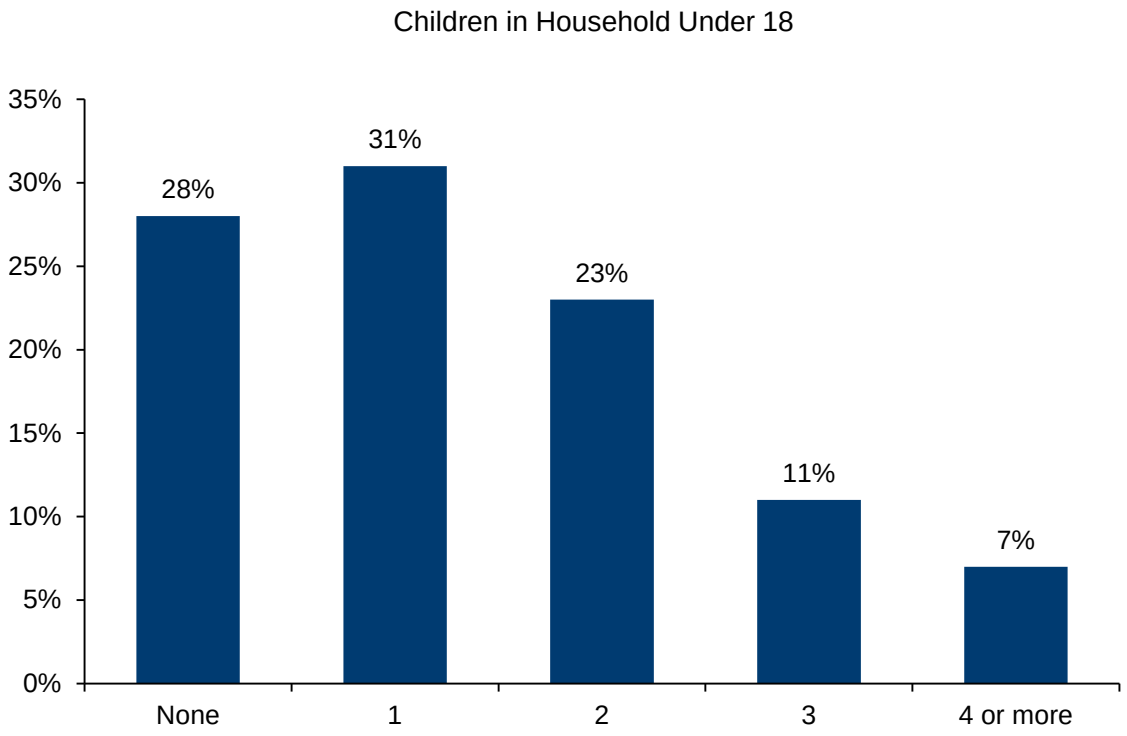

Base: 18-24 (n=6), 25-34 (n=41), 35-44 (n=16), 45-54 (n=22), 55-64 (n=15), 65-74 (n=9), 75+ (n=4), Sample Size = 113

(Community = Brown / Edmunds)



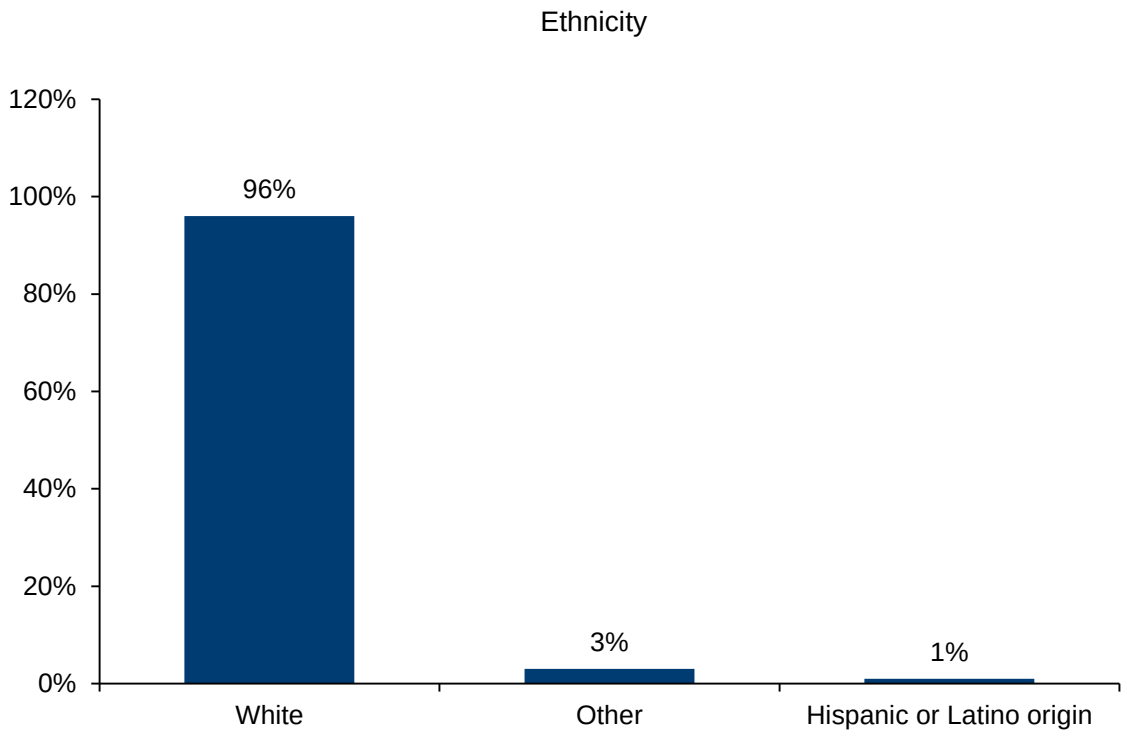

Base: 1 (n=11), 2 (n=42), 3 (n=28), 4 (n=16), 5 (n=11), 6 or more (n=5), Sample Size = 113

(Community = Brown / Edmunds)




Base: None (n=20), 1 (n=22), 2 (n=16), 3 (n=8), 4 or more (n=5), Sample Size = 71

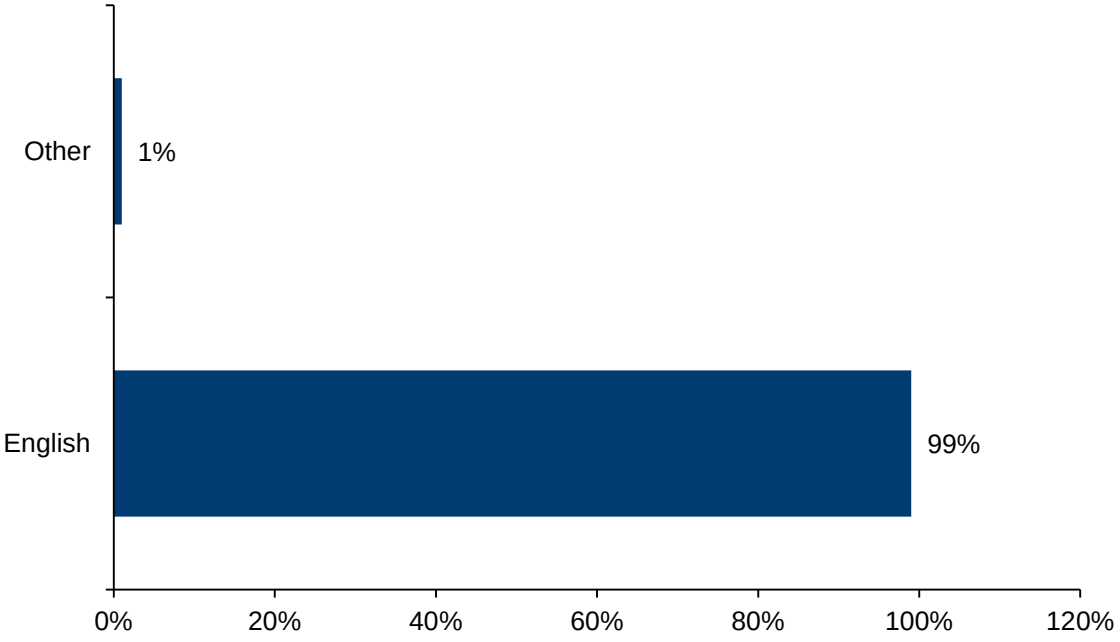
(Community = Brown / Edmunds)




Base: White (n=112), Hispanic or Latino origin (n=1), Other (n=4), Sample Size = 117

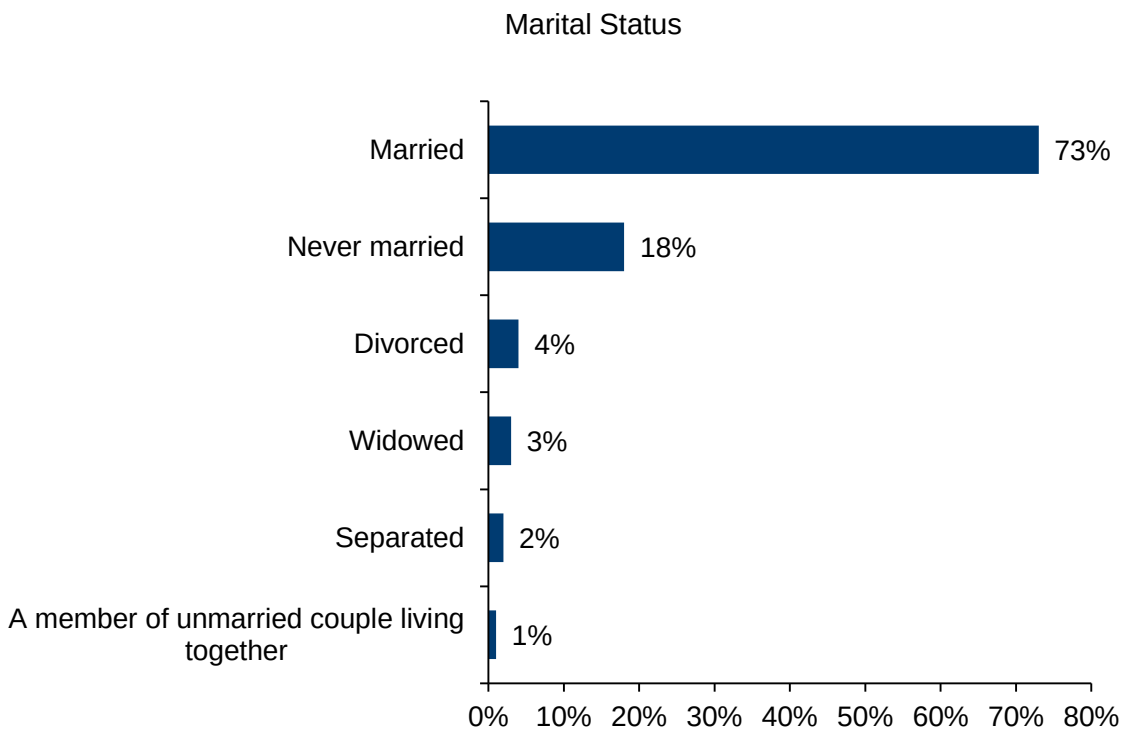
(Community = Brown / Edmunds)

## Language Spoken in Home



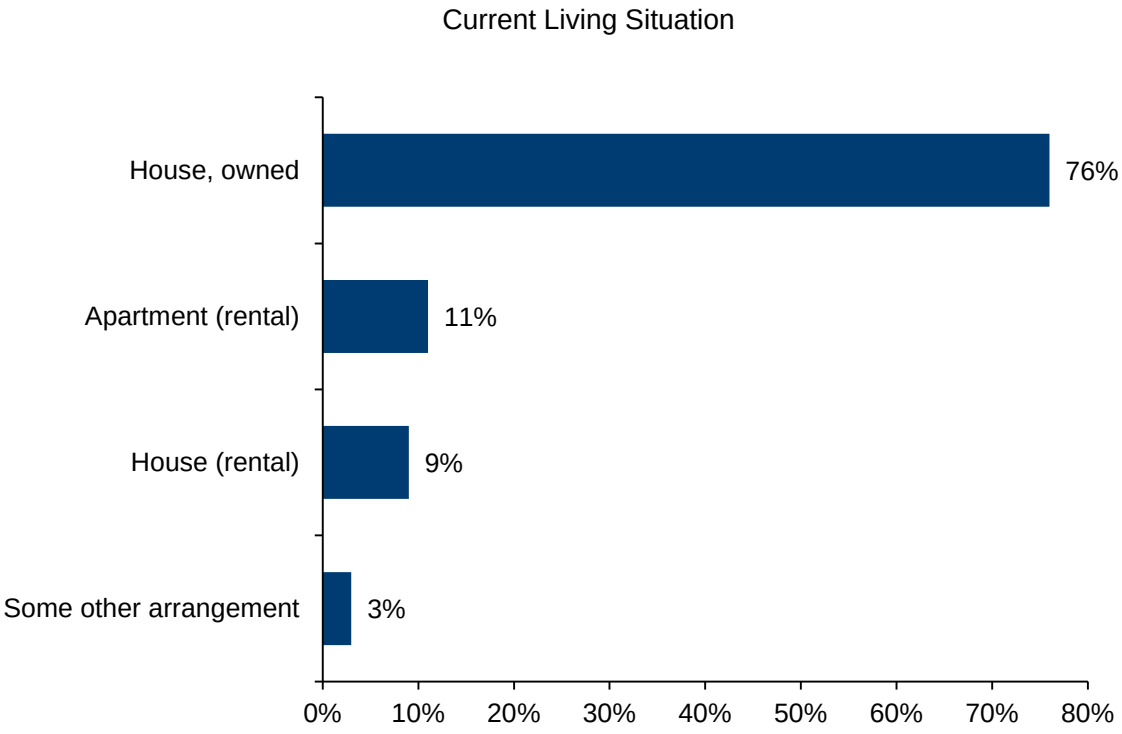

Base: English (n=115), Other (n=1), Sample Size = 116

(Community = Brown / Edmunds)



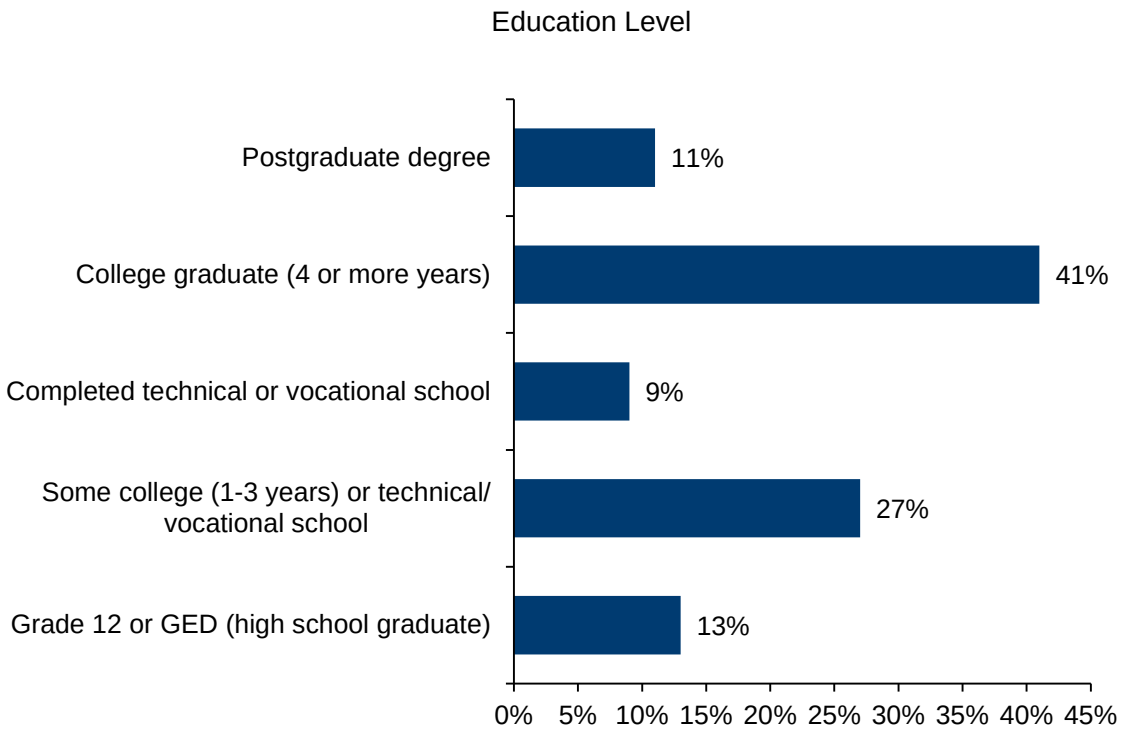

Base: Never married (n=21), Married (n=85), Divorced (n=5), Widowed (n=3), Separated (n=2), A member of unmarried couple living together (n=1), Sample Size = 117

(Community = Brown / Edmunds)



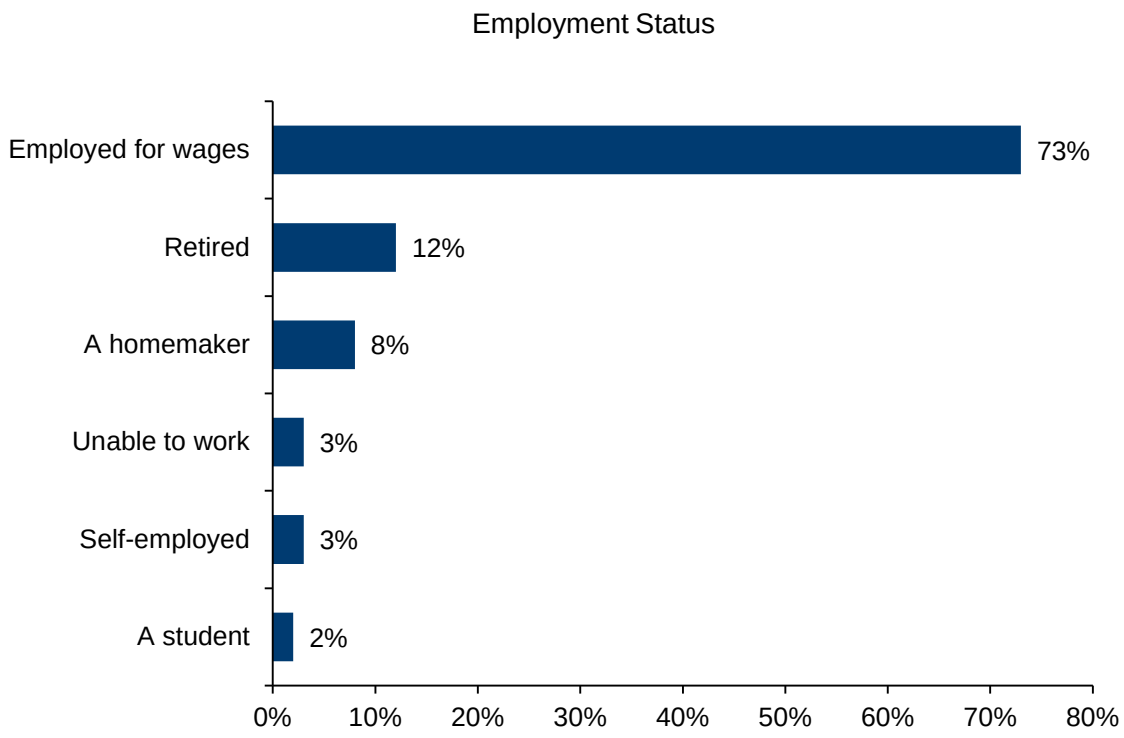

Base: House, owned (n=88), House (rental) (n=11), Apartment (rental) (n=13), Some other arrangement (n=4), Sample Size = 116

(Community = Brown / Edmunds)



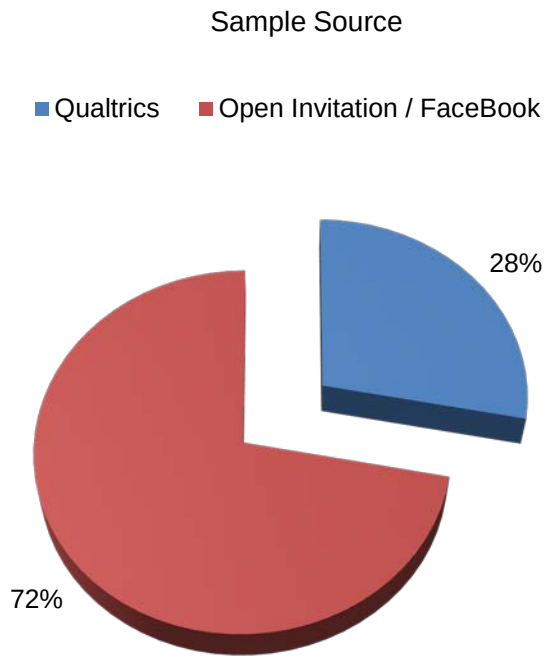

Base: Grade 12 or GED (high school graduate) (n=15), Some college (1-3 years) or technical/ vocational school (n=31), Completed technical or vocational school (n=10), College graduate (4 or more years) (n=47), Postgraduate degree (n=13), Sample Size = 116

(Community = Brown / Edmunds)




Base: Employed for wages (n=85), Self-employed (n=4), A homemaker (n=9), A student (n=2), Retired (n=14), Unable to work (n=3), Sample Size = 117

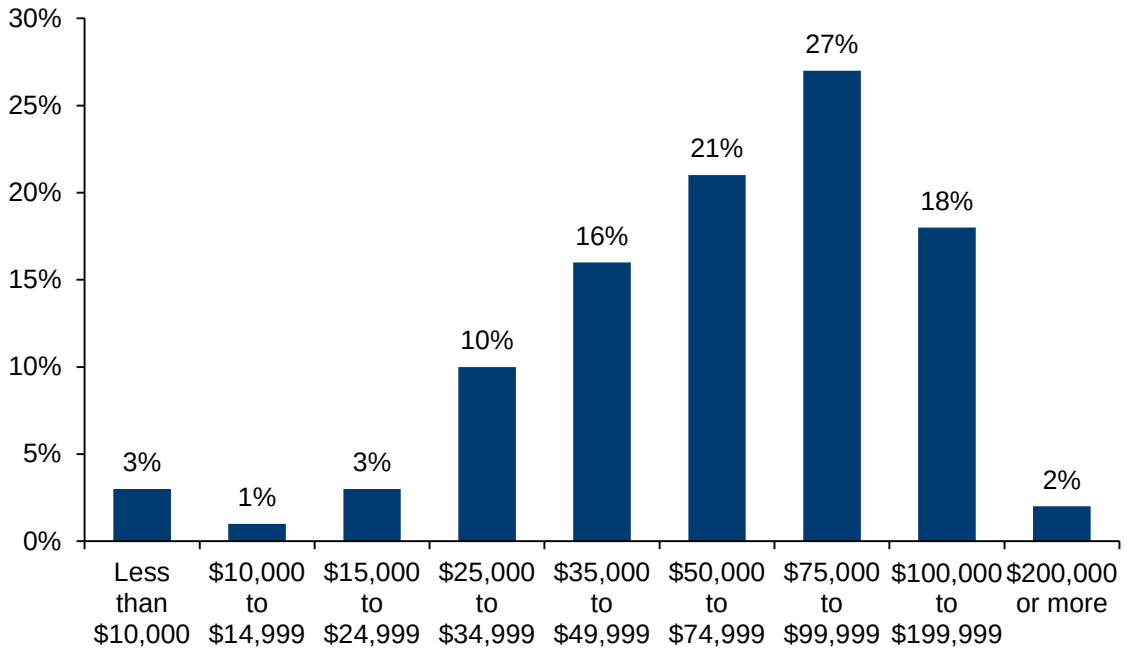
(Community = Brown / Edmunds)




Base: Qualtrics (n=33), Open Invitation / Facebook (n=85), Sample Size = 118

(Community = Brown / Edmunds)

## Total Household Income




Base: Less than $10,000 (n=3), $10,000 to $14,999 (n=1), $15,000 to $24,999 (n=3), $25,000 to $34,999 (n=11), $35,000 to $49,999 (n=17), $50,000 to $74,999 (n=23), $75,000 to $99,999 (n=29), $100,000 to $199,999 (n=19), $200,000 or more (n=2), Sample Size = 108

(Community = Brown / Edmunds)

## Aberdeen 2019 Community Health Needs Assessment
## Prioritization Worksheet

### Criteria to Identify Priority Problem

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

### Criteria to Identify Intervention for Problem

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

| Health Indicator/Concern | Round 1 Vote | Round 2 Vote | Round 3 Vote |
|---|---|---|---|
| **Economic Well-Being**<br>• Skilled labor workforce 3.53<br>22% of resident respondents report running out of food before they had money to buy more | 1 | | |
| **Children and Youth**<br>• Childhood obesity 3.65<br>• Substance abuse by youth 3.54 | **4** | | |
| **Aging Population**<br>• Cost of memory care 3.89<br>• Cost of long term care 3.83 | 1 | | |
| **Safety**<br>• Abuse of prescription drugs 3.50 | 1 | | |
| **Health Care Access**<br>• Access to affordable health insurance coverage 3.87<br>• 6% report that they do not have health insurance<br>• Access to affordable health care 3.75 | 6 | | |
| **Mental Health and Substance Abuse**<br>• Drug use and abuse 3.62<br>• 30% self-report that they have drugs in their home that are not being used<br>• 49% report that they have been diagnosed with depression<br>• 49% that they have been diagnosed with anxiety/stress<br>• 13% currently smoke cigarettes<br>• 44% self-report that they binge drink<br>• 28% report that alcohol use has had a harmful effect on themselves or a family member in the past 2 years | 8 | | |
| **Wellness**<br>• 44% reported not getting moderate activity 3 or more tomes/week<br>• 44% report that they are obese<br>• 31% report that they are overweight<br>• 55% of residents do not consume 5 or more fruits/vegetables each day<br>• 32% have been diagnosed with hypertension<br>• 29% have been diagnosed with high cholesterol<br>• 24% have been diagnosed with arthritis<br>• 24% report not having a routine checkup in more than a year<br>• 33% have not had a flu shot this year<br>• 28% report not having visited a dentist in more than a year | 5 | | |

# Secondary Research

# Definitions of Key Indicators


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

This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in
calculating the 2018 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County*
*Health Rankings* web site for your state.

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

**Contents:**



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

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

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

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

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

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

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

## County Health Rankings

| | South Dakota | Brown (BW), SDx | Edmunds (ED), SDx |
|---|---|---|---|
| Health Outcomes | | 13 | 37 |
| Length of Life | | 15 | 33 |
| Premature death | 7,000 | 6,100 | |
| Quality of Life | | 21 | 26 |
| Poor or fair health | 12% | 10% | 11% |
| Poor physical health days | 3.1 | 2.9 | 2.9 |
| Poor mental health days | 2.9 | 2.8 | 2.7 |
| Low birthweight | 6% | 6% | |
| Health Factors | | 8 | 6 |
| Health Behaviors | | 23 | 8 |
| Adult smoking | 18% | 15% | 14% |
| Adult obesity** | 31% | 33% | 28% |
| Food environment index** | 6.6 | 8.1 | 7.3 |
| Physical inactivity** | 22% | 22% | 28% |
| Access to exercise opportunities | 72% | 74% | 56% |
| Excessive drinking | 20% | 18% | 18% |
| Alcohol-impaired driving deaths | 37% | 18% | 0% |
| Sexually transmitted infections** | 462.9 | 354.1 | |
| Teen births | 30 | 22 | 11 |
| Clinical Care | | 5 | 25 |
| Uninsured | 12% | 10% | 11% |
| Primary care physicians | 1,290:1 | 1,620:1 | 4,000:1 |
| Dentists | 1,710:1 | 1,960:1 | 3,950:0 |
| Mental health providers | 610:1 | 300:1 | |
| Preventable hospital stays | 50 | 38 | 53 |
| Diabetes monitoring | 84% | 91% | 86% |
| Mammography screening | 66% | 76% | 78% |
| Social & Economic Factors | | 16 | 5 |
| High school graduation** | 84% | 90% | |
| Some college | 68% | 68% | 76% |
| Unemployment | 2.8% | 2.5% | 2.2% |
| Children in poverty | 17% | 12% | 14% |
| Income inequality | 4.1 | 4.1 | 4.4 |
| Children in single-parent households | 32% | 28% | 10% |
| Social associations | 16.5 | 17.8 | 15.0 |
| Violent crime** | 322 | 227 | 0 |
| Injury deaths | 76 | 68 | 80 |
| Physical Environment | | 32 | 11 |
| Air pollution - particulate matter | 7.7 | 8.2 | 7.7 |
| Drinking water violations | | No | No |
| Severe housing problems | 12% | 11% | 9% |
| Driving alone to work | 80% | 82% | 72% |
| Long commute - driving alone | 14% | 7% | 21% |

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