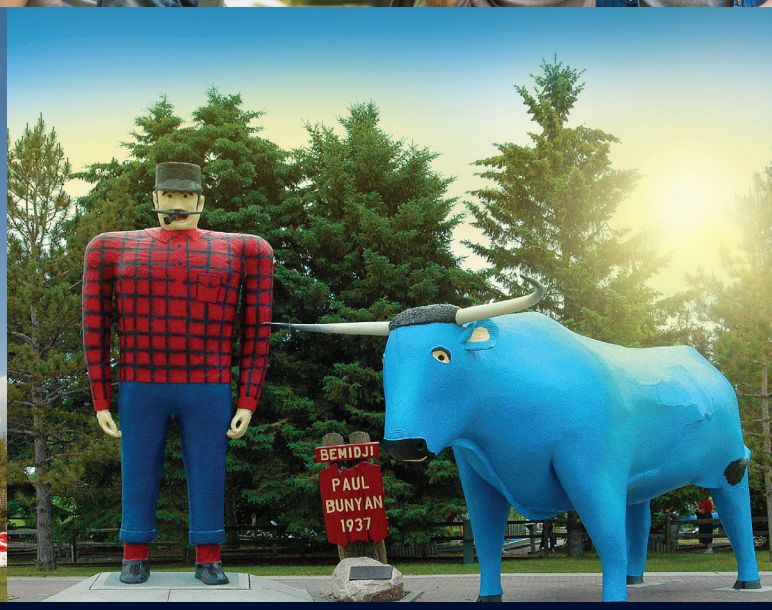

Sanford Medical Center Thief River Falls

2016 Community Health Needs Assessment

SANFORD HEALTH

dba Sanford Thief River Falls Medical Center EIN # 41-0709579

SANFORD HEALTH

Sanford Thief River Falls Medical Center

Community Health Needs Assessment 2016

Dear Community Members,

Sanford Thief River Falls is pleased to present the 2016 Community Health Needs Assessment.

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

During 2015 members of the community were asked to complete a survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. Sanford further analyzed the data, identified unmet needs, and partnered with key community stakeholders to develop a list of resources and assets that were available to address each need. A gap analysis and prioritization exercise was also conducted to identify the most significant health needs, and to further address these needs through the implementation strategies that are included in this document.

Sanford Thief River Falls has set strategy to address the following community health needs:

- Mental Health
- Physical Health

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

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

Sincerely,

Brian Carlson
Chief Executive Officer
Sanford Thief River Falls Medical Center

Sanford Thief River Falls Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

SANFORD HEALTH

Sanford Thief River Falls Medical Center

Community Health Needs Assessment
2016

Purpose

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

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

Study Design and Methodology

1. Non-Generalizable Survey

   An on-line non-generalizable survey was conducted through a partnership between Sanford and Pennington County Public Health. The CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various agencies, at times using a snowball approach. Data collection occurred throughout the month of March 2015 and a total of 57 respondents participated in the on-line survey.

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

   A Likert scale was developed to determine the respondent's highest concerns. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized.

2. Community Stakeholder Meeting

   Community stakeholders were invited to a meeting to review the findings from assessment research and to discuss the top health issues facing the community. Community stakeholders discussed the findings and helped to determine key priorities for the community. Those priorities will be addressed in the implementation strategies for 2017-2019.

3. Community Asset Mapping

   Asset mapping was conducted by reviewing the data and identifying the unmet needs from the various surveys and data sets. Each unmet need was researched to determine what resources were available in the community to address the needs. Once gaps were determined the group proceeded to the prioritization process. A multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes the 2015 County Health Rankings for Pennington County.

Key Findings – Primary Research

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

Economics: Respondents were most concerned about affordable housing (4.14) in regards to economics in Pennington County. Homelessness and hunger were not considered to be high concerns.

Transportation: Respondents ranked the availability of good walking or biking options as alternatives to driving (3.54) as a moderately high concern.

Aging: The top ranking concern among respondents overall is the cost of long term care (3.87). The availability of memory care (3.57) and the availability of resources to help the elderly stay safe in their homes (3.56) are additional high concerns for the aging population.

Children and Youth: In this category, the availability and cost of quality infant care (3.93) (3.82), the availability and cost of quality childcare (3.86) (3.75), the availability and cost of activities for children and youth (3.82), bullying (3.75), the cost of quality childcare (3.75) and the availability of services for youth at risk (3.53) are ranked as high concerns.

Safety: The presence of street drugs and alcohol in the community (3.91), the presence of drug dealers in the community (4.75), and domestic violence (3.55) are the highest safety concerns of the respondents.

Health Care: The health care indicator addressed access to healthcare and the cost concerns. Access to affordable health insurance (3.82), access to affordable prescription drugs (3.79), access to affordable healthcare (3.75), the availability of non-traditional hours (3.73), the cost of affordable dental insurance coverage (3.54), and the use of emergency room services for primary healthcare are the highest concerns among the respondents in the healthcare access category.

Physical Health: Obesity (4.04), inactivity and lack of exercise (4.02), poor nutrition and eating habits (4.00), cancer (3.77) and chronic disease (3.73) are the highest physical health concerns.

Mental Health/Behavioral Health: Drug use and abuse (3.89), underage drug use and abuse (3.84), underage drinking (3.82), alcohol use and abuse (3.79), depression (3.82), stress (3.82), suicide (3.55), and smoking and tobacco use (3.55) are the highest concerns for mental health/behavioral health.

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

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcome for the state of Minnesota is 5,038 per 100,000. Pennington County has a higher rate at 6,045.

Poor or fair health: 10% of adults nationally report poor or fair health compared to 11% in Minnesota.

The average number of days reported in the last 30 as unhealthy mental health days is 2.5 in Pennington County. Minnesota as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 6.5% in Pennington County. The state of Minnesota is at 6.5%.

Health Factors

The percent of adults who are currently smoking is 19% in Pennington County. The percentage of current smokers in the state of Minnesota is 16%.

The adult population in Pennington County considered obese with a BMI over 30 is 26%. Additionally, 26% of the population in the state of Minnesota is obese.

The percent of adults reporting excessive or binge drinking is 20% in Pennington. Minnesota reports 19% are binge drinkers statewide.

Driving deaths that have alcohol involvement is at 29% in Pennington County. Alcohol involvement in driving deaths is at 31% in Minnesota.

Sexually transmitted infections number 171 in Pennington County, which is substantially lower than in Minnesota (336). The national benchmark is 138. This is based on a per 100,000 population rate.

The teen birth rate is higher in Minnesota (24) than the national benchmark (20). The teen birth rate is 30 in Pennington County.

The clinical care outcomes indicate that the percentage of uninsured adults is 9% in Minnesota and 9% in Pennington County.

The ratio of population to primary care physicians is 1,113:1 in Minnesota. Pennington County's ratio is 1,279:1.The ratio of population to mental health providers is 529:1 in Minnesota. Pennington County's ratio is 743:1. The number of professionally active dentists in Minnesota is 1,404:1; and in Pennington County the ratio is 2,017:1.

Preventable hospital stays 56 in Pennington County, 45 in Minnesota, and 41 nationally. Diabetic screening is at 87% in Pennington County and 88% in Minnesota as a whole. Mammography screening is at 78.7% in Pennington County and 66.7% in Minnesota.

The social and economic factor outcomes indicate that Minnesota is at 78% for high school graduation. Pennington County has a graduation rate of 88%. Post-secondary education (or some post-secondary education) is at 69.3% in Pennington County and 73.3% in Minnesota.

The unemployment rate is 5.7% in Pennington County and 5.1% in Minnesota. The child poverty rate is 15% in Pennington County and 14% in Minnesota.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is lower in Pennington County at 19.2, and the state of Minnesota ranks at 13.2.

The percentage of children in single parent households is 27% in Pennington County and 28% in Minnesota.

Violent crime is lower in Pennington County at 131 cases per 100,000 population than in Minnesota, which has 229 cases per 100,000 population.

The following needs were brought forward for prioritization:

- Economics – affordable housing
- Transportation - availability of good walking trails or biking paths
- Children and Youth – cost and availability of quality infant care, services for at-risk youth, school cost and availability of quality child care, bullying, cost and availability of activities for children and youth, and teen pregnancy
- Aging – cost of long term care, availability of memory care, and resources to help the elderly stay in their homes
- Safety – the presence of street drugs and alcohol in the community, presence of drug dealers in the community, domestic violence
- Healthcare Access – access to affordable health insurance, access to affordable prescription drugs, access to affordable healthcare, the availability of non-traditional hours, the cost of affordable dental insurance coverage, and the use of emergency room services for primary healthcare
- Physical Health – cancer, chronic disease, obesity, poor nutrition and inactivity

- Mental Health – depression, stress, suicide, and substance use and abuse
- Preventive Health – flu vaccines, immunizations and routine visits with a primary care provider and dentist

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

- Mental Health
- Physical Health

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

- Priority 1: Mental Health
- Priority 2: Physical Health

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

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

Many factors contribute to mental health problems, including:

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

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

Sanford has made mental/behavioral health a significant priority and has developed strategies for the mental health and behavioral health of the area by securing CMS certification for the new Sanford Behavioral Center, developing a partial hospitalization program, and establishing partnerships with regional behavioral health organizations.

Priority 2: Physical Health

Sanford has made children and youth a significant priority and has developed strategies to improve the health of children and youth by expanding the Sanford Wellness Center to provide a youth fitness area, collaborating with community organizations to develop a community center model, and to create a partnership with local schools and child care providers to implement Sanford fit.

Sanford *fit* is an on-line community health activation initiative created by Sanford Health that provides engaging programs and resources to kids, families, leaders and role models across numerous settings to promote and activate healthy choices. The four key factors of healthy choices, a healthy body and healthy life included in *fit* are, MOOD – Emotions and Attitudes and RECHARGE – Sleep and Relaxation, FOOD – Mindful Nutrition Choices, and MOVE – Physical Activity Levels.

Sanford will focus on the physical health of patients by enrolling patients in the Medical Home program to provide education on nutrition, exercise and wellness. A multi-disciplinary medical team will work together to help patients meet their health goals.

Sanford Thief River Falls Medical Center

Community Health Needs Assessment 2016

Table of Contents

Purpose

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

Our Guiding Principles:

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

Acknowledgements

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

Sanford Enterprise Steering Group:

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

- Joy Johnson, COO Bemidji Region
- Kirk Christy, CFO, Bismarck Region
- Carrie McLeod, MBA, MS, LRD,CDE, Enterprise Lead, Enterprise Community Health/Community Benefit

Sanford Thief River Falls Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health /Community Benefit
- Brian Carlson, Sanford Thief River Falls Medical Center

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

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

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

The following Thief River Falls and Pennington County community stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Anita Cardinal, Pennington County Public Health
- Curtis Christensen, Farmer
- Mark Borseth, Community Services Director, City of Thief River Falls
- Kevin Ballard, Clinic Director, Sanford Thief River Falls
- Colleen Hoffman, Hoffman, Philipp and Knutson, PLLC
- Janell Hudson, CCO, Sanford Thief River Falls
- Shannon Jesme, Accountant/Finance Administrator, Northland Community and Technical College
- Brian Carlson, CEO, Sanford Thief River Falls
- Rob Lovejoy, COO, Sanford thief River Falls
- Hannah Shirkey, CFO, Sanford Thief River Falls

Description of Sanford Thief River Falls Medical Center

Sanford Thief River Falls Medical Center is a state-of-the-art, 25-bed Critical Access Hospital and attached multi-specialty provider-based clinic serving people in Pennington and surrounding counties. The new $60 million medical center campus opened in 2014.

Sanford Thief River Falls Medical Center is equipped with the most advanced technology and includes emergency and urgent care rooms, labor, delivery and postpartum suites, medical, surgical and intensive care and operating rooms. More than 30 medical specialties are offered so patients and families don't have to travel far to get expert care. Expanded services are available in cardiology, ear, nose and throat, gastroenterology, cancer, neurology, nephrology, neuropsychology, oncology, orthopedic surgery, pediatrics, urology and more. Sanford participates and leads in many health care education and training opportunities throughout the community and has a community wellness center.

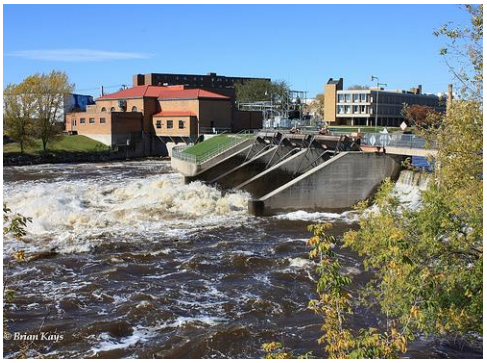
Inpatient and outpatient behavioral health services are available at a separate facility in downtown Thief River Falls.

Sanford Thief River Falls employs 45 clinicians, including physicians and advanced practice providers and over 600 employees.

Description of the Community Served

Thief River Falls, located in northwest Minnesota, is one of the largest communities in that region with a population over 8,000. It takes its name from the falls of the Red Lake River where it meets with the Thief River. Thief River Falls serves as a hub of economic activity with major employers including snowmobile manufacturer Arctic Cat, electronic parts distributor Digi-Key Corporation and is the birthplace of Steiger Tractor.

The Thief River Falls area is rich in natural beauty with forests, rivers, parks and wildlife. The community offers numerous options for recreation and physical activity, most prominently the Ralph Englestad hockey arena. Popular outdoor activities include fishing, snowmobiling, hunting, skating and bird watching. The community boasts many well-maintained parks and a bike trail system. There are several fitness centers in town including Sanford Health Thief River Falls Wellness Center, which recently relocated to new, larger space with expanded fitness programs and options.



Study Design and Methodology

1. Non-Generalizable Survey

   An on-line non-generalizable survey was conducted of residents in Pennington County, Minnesota. The survey instrument was developed in partnership with Pennington County Public Health, members of the Greater Fargo-Moorhead Community Health Needs Assessment collaborative, Sioux Falls community collaborative, Bismarck community collaborative, public health leaders from across the enterprise, and researchers at the Center for Social Research (CSR) at North Dakota State University (NDSU). The CSR developed and maintained links to the on-line survey tool. The website address for the survey instrument was distributed via e-mail to various agencies, at times using a snowball approach**.** Data collection occurred throughout the month of March 2015 and a total of 57 respondents participated in the on-line survey.

   The purpose of the non-generalizable survey of residents in the greater Thief River Falls and Pennington County area was to learn about the perceptions of area community leaders regarding community health, their personal health, preventive health, and the prevalence of disease. This group included community leaders and agency leaders representing public health, city government, law enforcement, chronic disease and disparity.

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

2. Community Stakeholder Meeting

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

3. Community Asset Mapping

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

   Each unmet need was researched to determine what resources were available in the community to address the needs. The community stakeholder group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. A multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes County Health Rankings for Pennington County.

Limitations of the Study

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

A good faith effort was made to secure input from a broad base of the community. Additionally, invitations were extended to county and community leaders and organizations and agencies representing diverse populations and disparities.

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

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

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

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

Key Findings

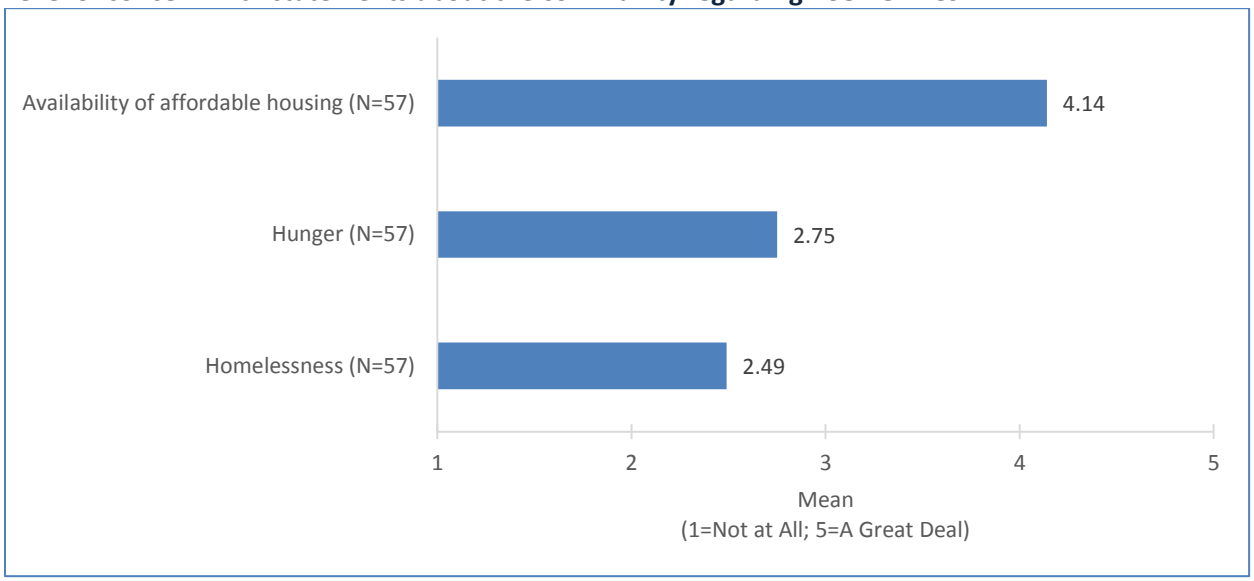
Primary Research

Community Health Concerns

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

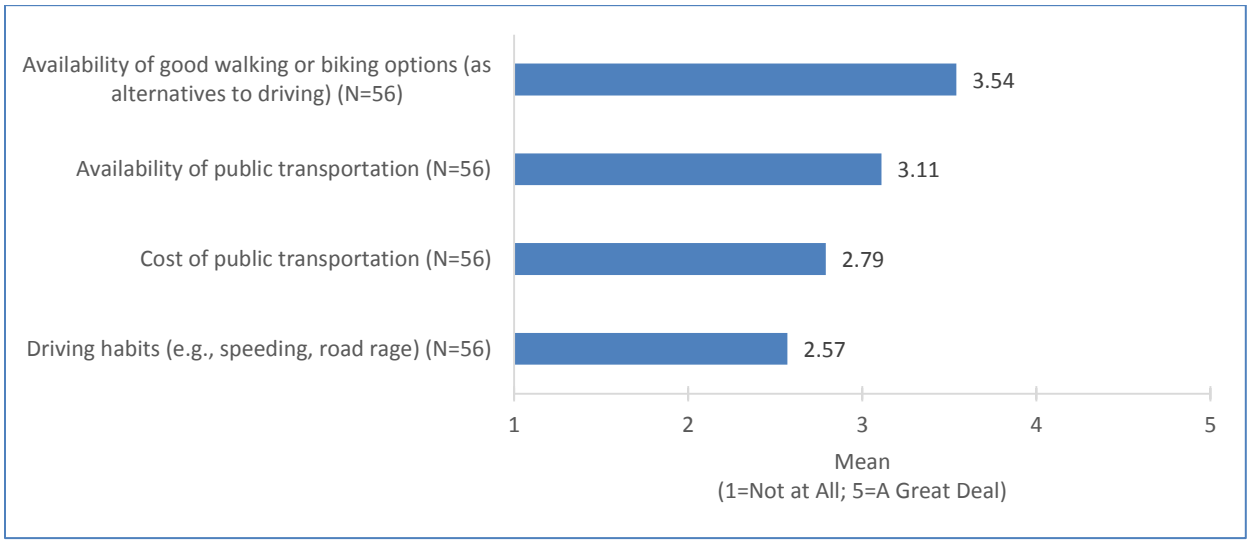
Economics: The availability of affordable housing ranks highest of concerns among community stakeholders.

Level of concern with statements about the community regarding ECONOMICS



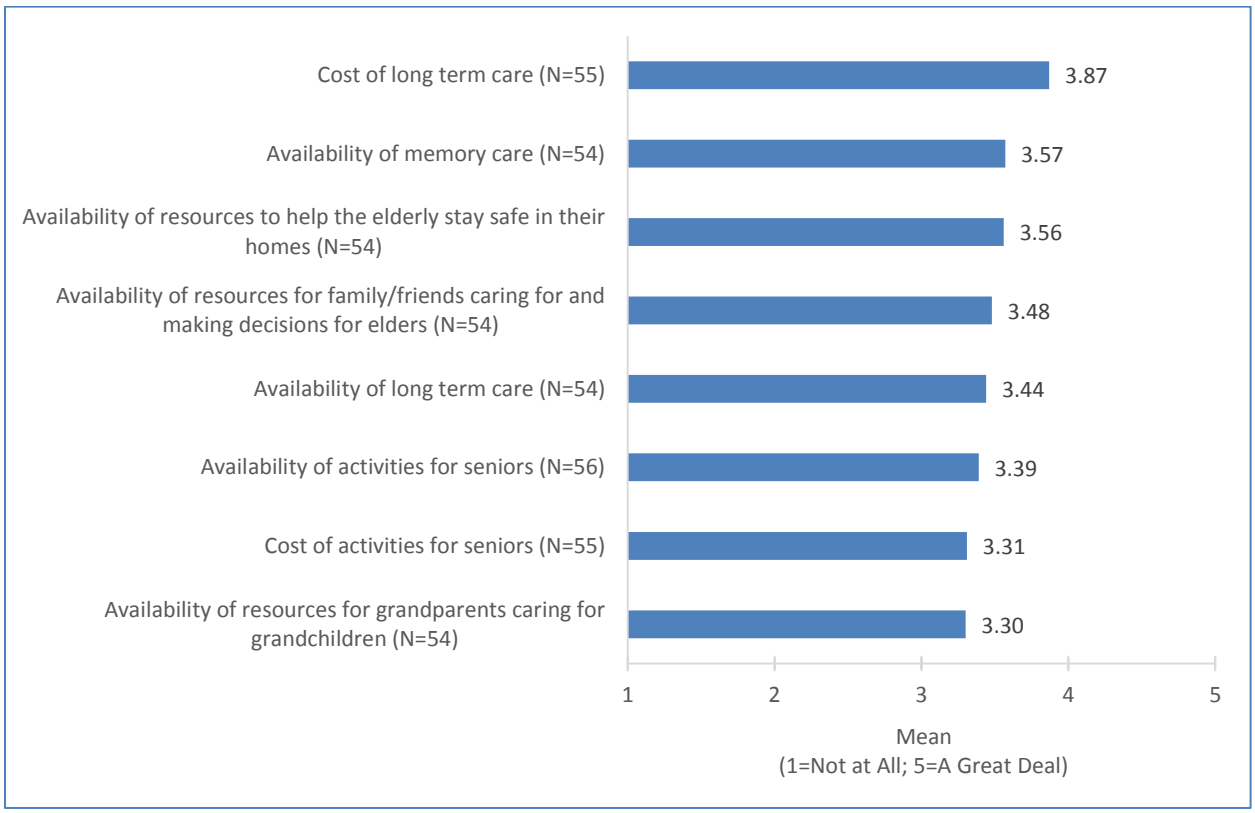
Transportation: The availability of good walking or biking options is a moderate concern of the community stakeholders.

Level of concern with statements about the community regarding TRANSPORTATION



Aging Population: The cost of long term care is the highest concern for the survey respondents. The availability of memory care and the availability of resources to help the elderly stay in their homes are also high concerns for the survey respondents.

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

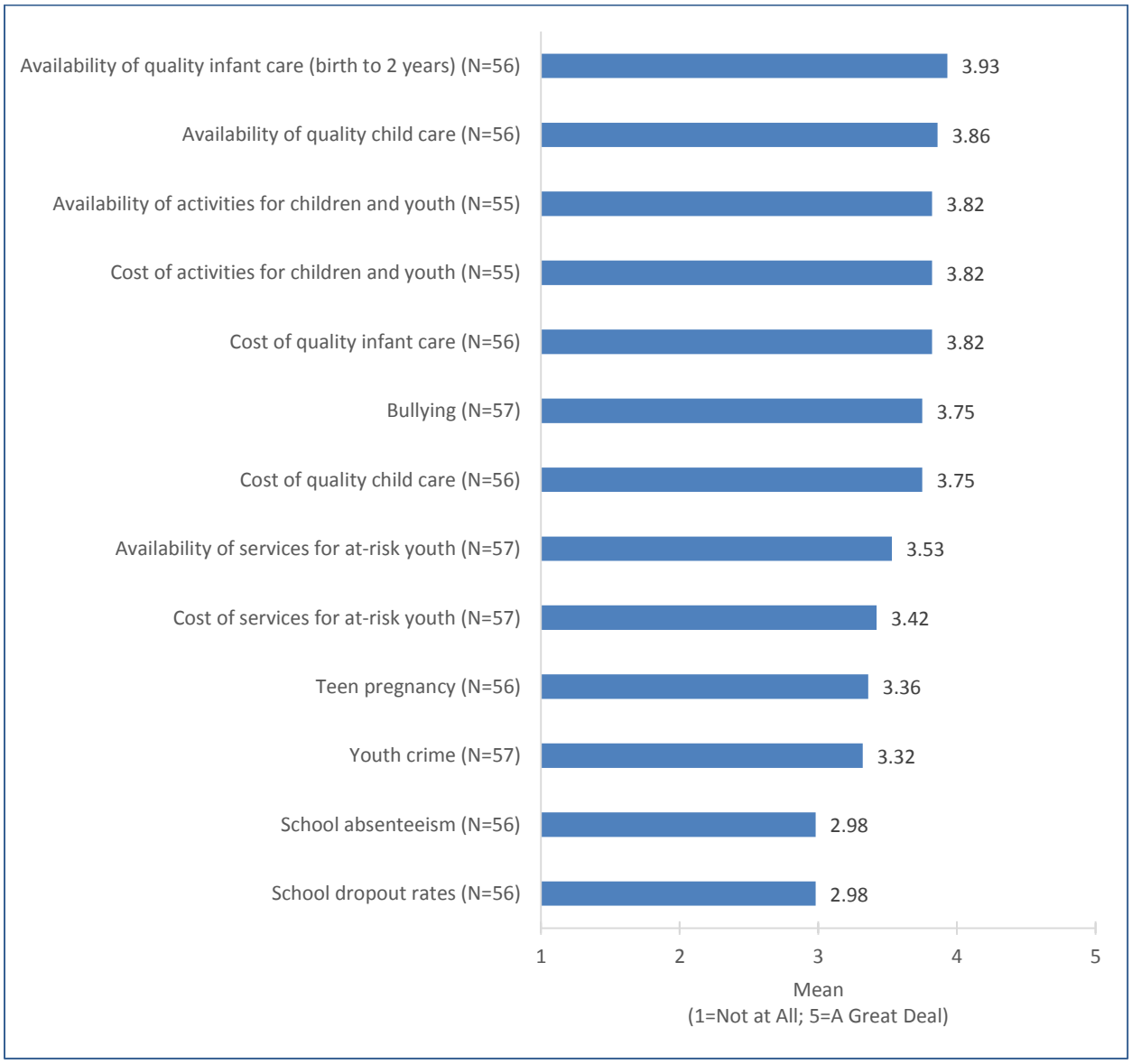


Sanford is working collaboratively to coordinate care for the aging population. Social workers, case managers, and discharge planners are working collaboratively with area service providers to assure safe

discharge, and when appropriate, to assist in transitions from levels of care. Sanford is also a home health service provider.

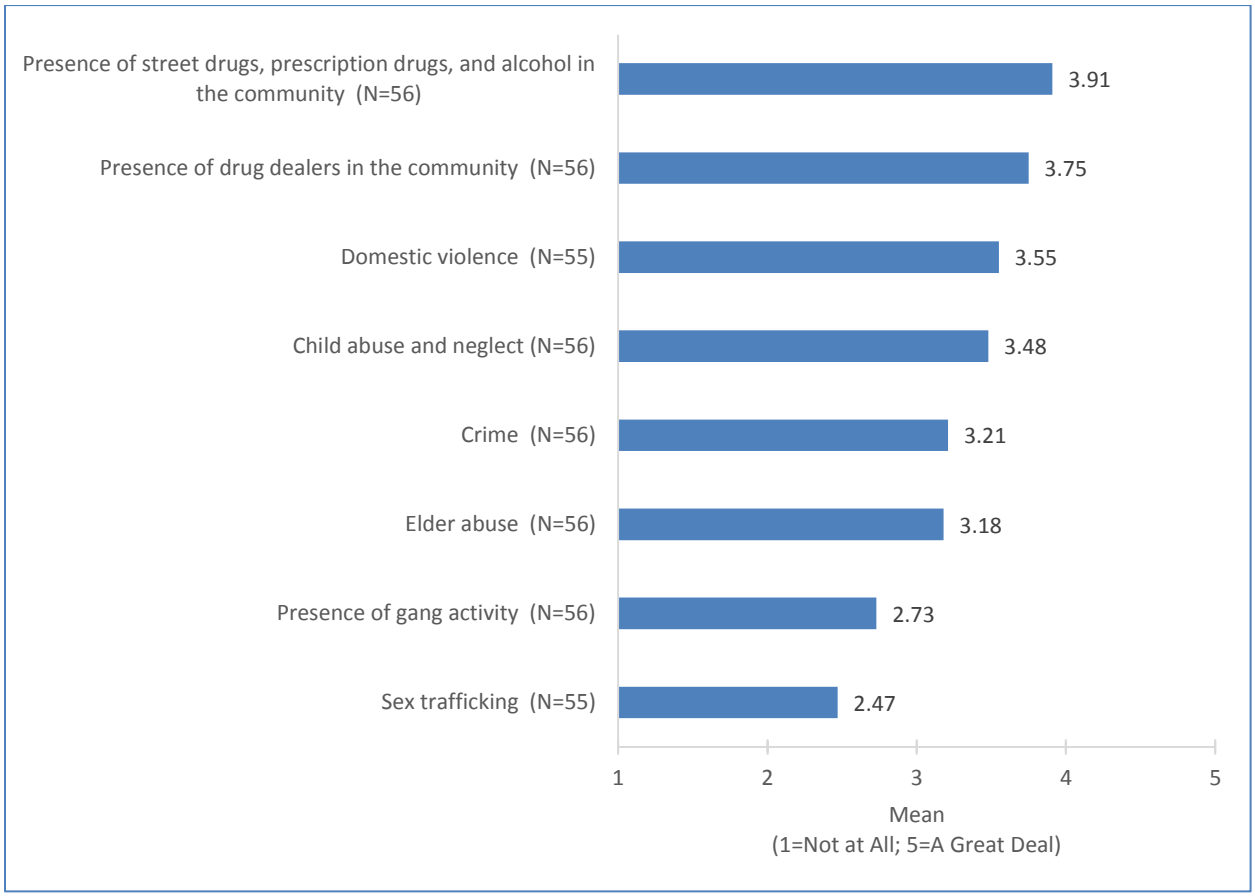
Children and Youth: Respondents have very high concerns for the children and youth of the community. The availability of quality infant care and quality of child care are the top concerns and rank highest on the Likert scale and the cost of these services is also a high ranking concern. Bullying, the cost and availability of activities for children and youth, and the availability of services for at-risk youth are all moderately high concerns.

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



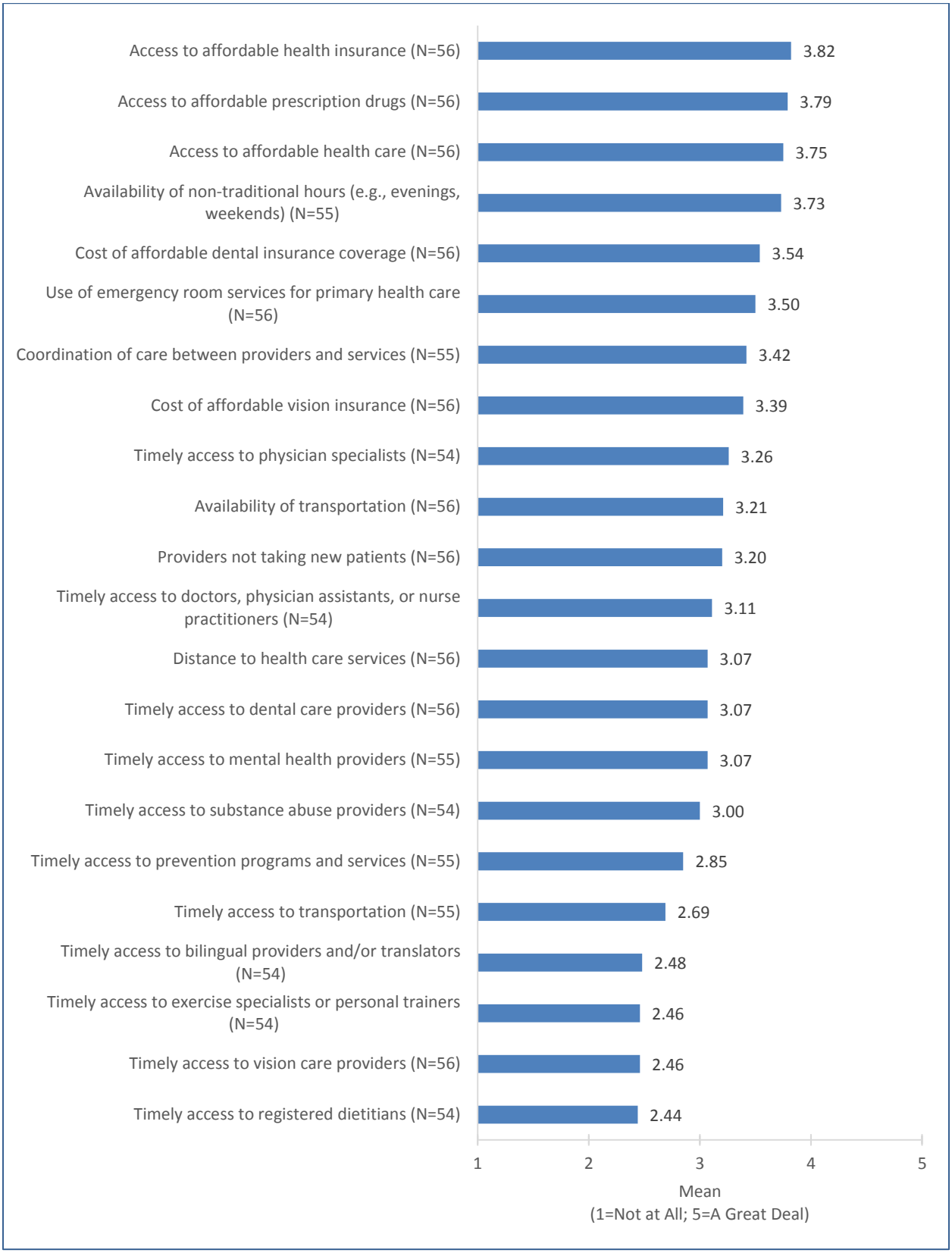
Safety: The presence of street drugs, prescription drugs, and alcohol and drug dealers in the community are the top concerns. Child abuse and neglect and domestic violence are all concerns that rank high among the survey respondents.

Level of concern with statements about the community regarding SAFETY



Healthcare Access: Access to affordable health insurance and affordable prescription drugs are the highest of concerns among survey respondents. Access to affordable healthcare, the availability of non-traditional hours, the cost of affordable dental insurance, and the use of the emergency department for primary care are high ranking concerns among the survey respondents.

Level of concern with statements about the community regarding HEALTHCARE



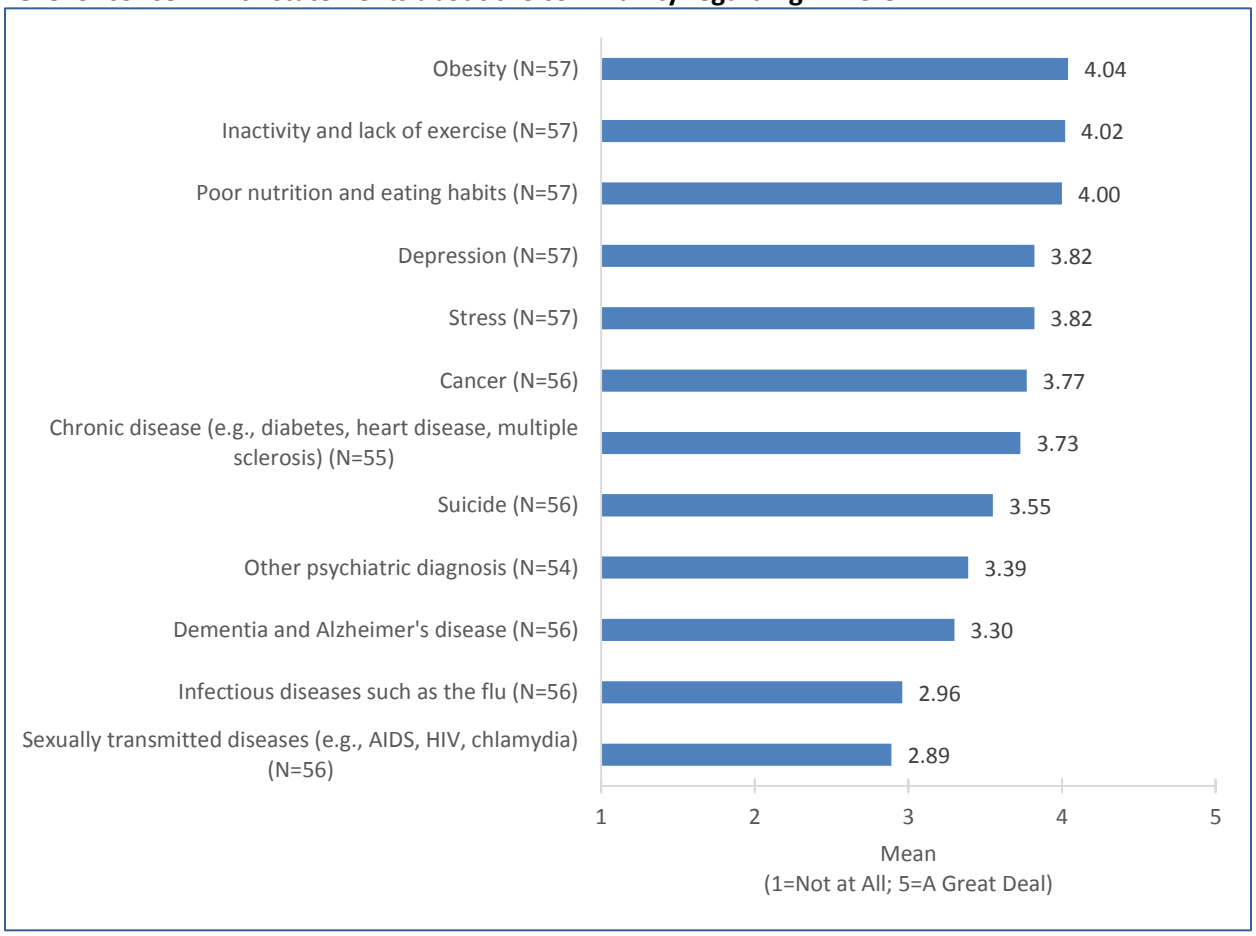
Sanford provides the Community Care Program and a financial assistance policy to address assistance to all who qualify for charity care. During fiscal year 2014 Sanford contributed over $51 million for charity care for our patient population who required care without the ability to pay for services. Sanford has financial counselors available at clinic and medical center facilities to assist patients with applications for assistance and access needs. Social workers, case managers and discharge planners work collaboratively with area service providers to assure that safe discharges are possible and appropriate resources are engaged.

One example of a community resource that is addressing the access needs of patients is Sanford's My Sanford Nurse program (formerly called Ask-A-Nurse). My Sanford Nurse served 324,295 individuals from throughout the footprint and nation during fiscal year 2014 and provided a community benefit of over $1.8M with more than 45,965 nursing staff hours. There is no fee for this service.

Physical Health: The top physical health concern among the survey respondents is obesity, followed by poor nutrition, inactivity and chronic disease.

Mental Health: Depression, stress and suicide are the highest concerns for mental health.

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



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

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

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

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

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

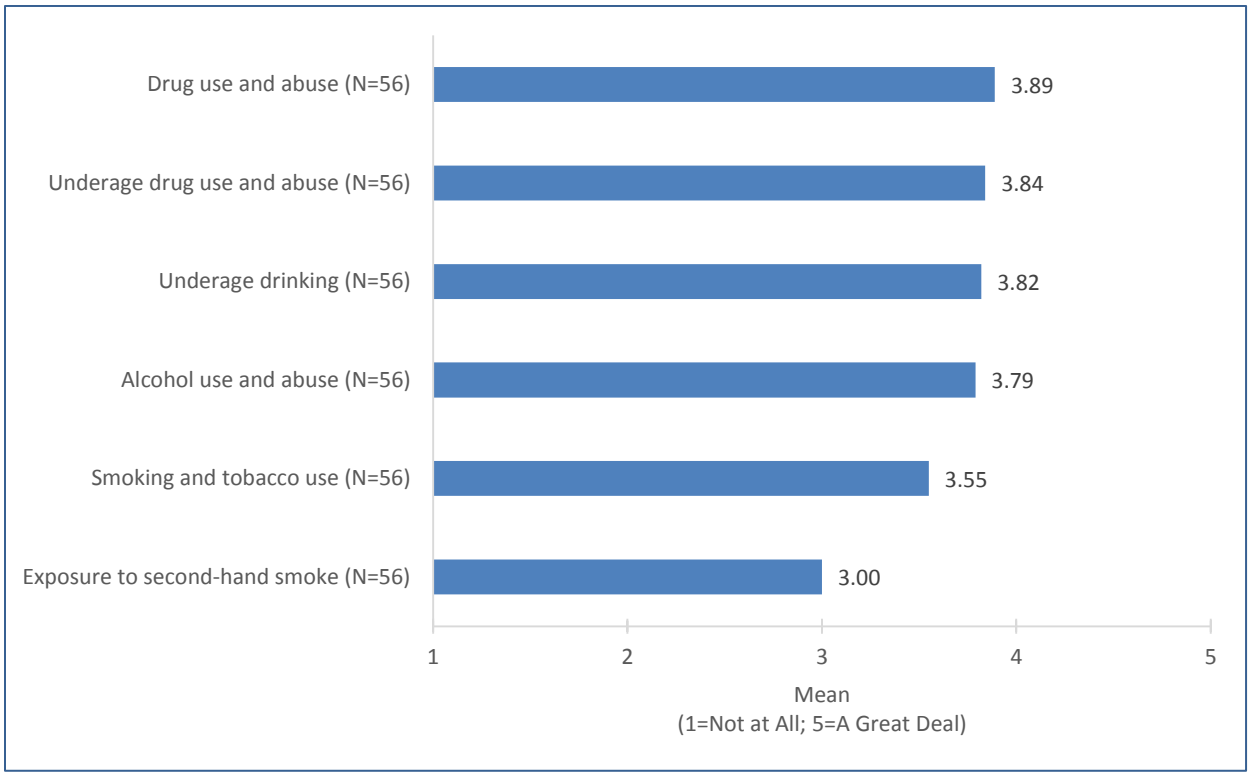
- We are also reaching thousands of students through several pilot school programs:
    - *fit*4Schools – *fit*4Schools, which includes unique *fit*-based lessons integrated into daily classroom activities, is in its final phase of development. It is being piloted in seven elementary schools in the Sanford region.

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

- Looking Forward
    - *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:
        - Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between healthcare providers and families.
        - Health Coaches – Exploring meaningful ways for health coaches to promote healthy choices with children and adults.
        - Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach efforts.
        - *fit*Club 4 Boys – 10-week after school program for boys, ages 8-12, to develop knowledge of *fit* principles and healthy behavior choices.
        - *fit* Parent/child – Class for parents and children to understand healthy choices and the benefits of living a healthy lifestyle.

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

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



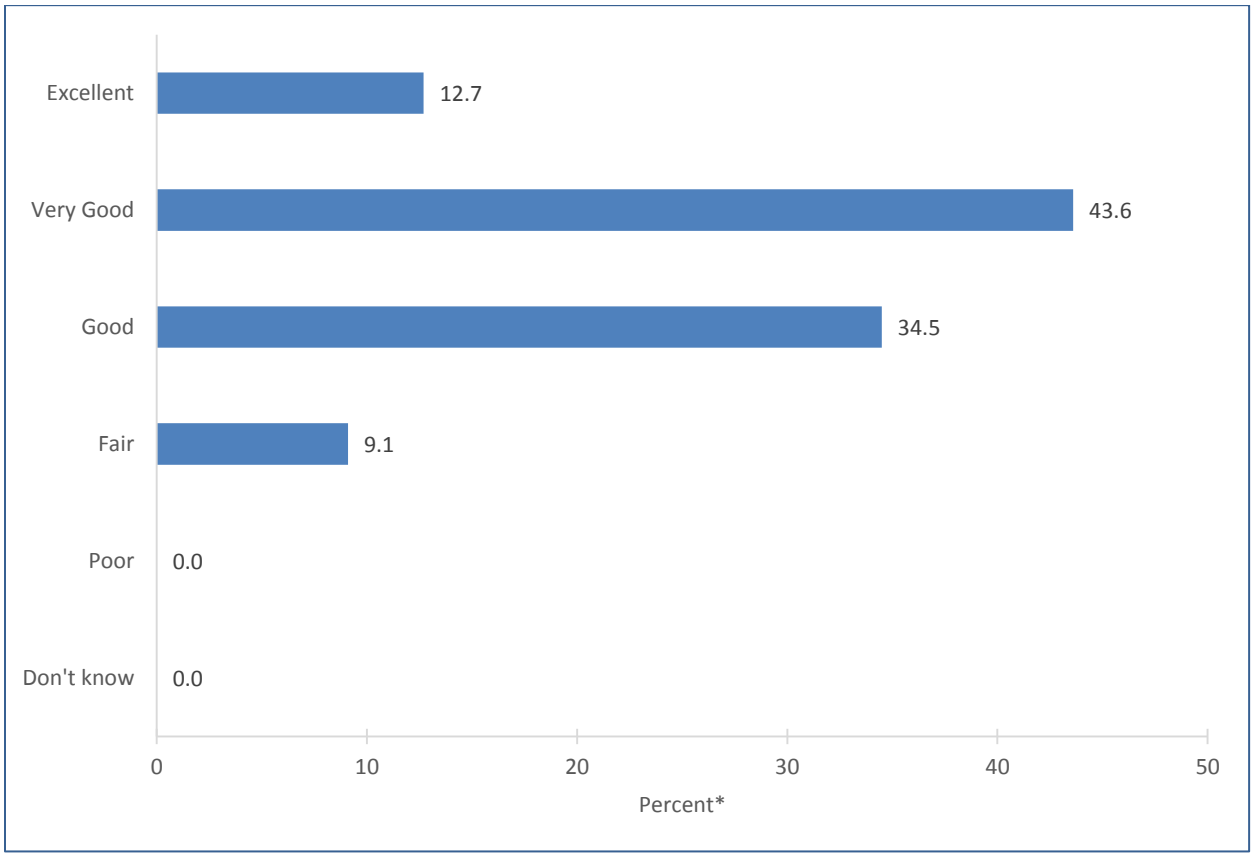
Personal Health Concerns

Respondents' Personal Health Status

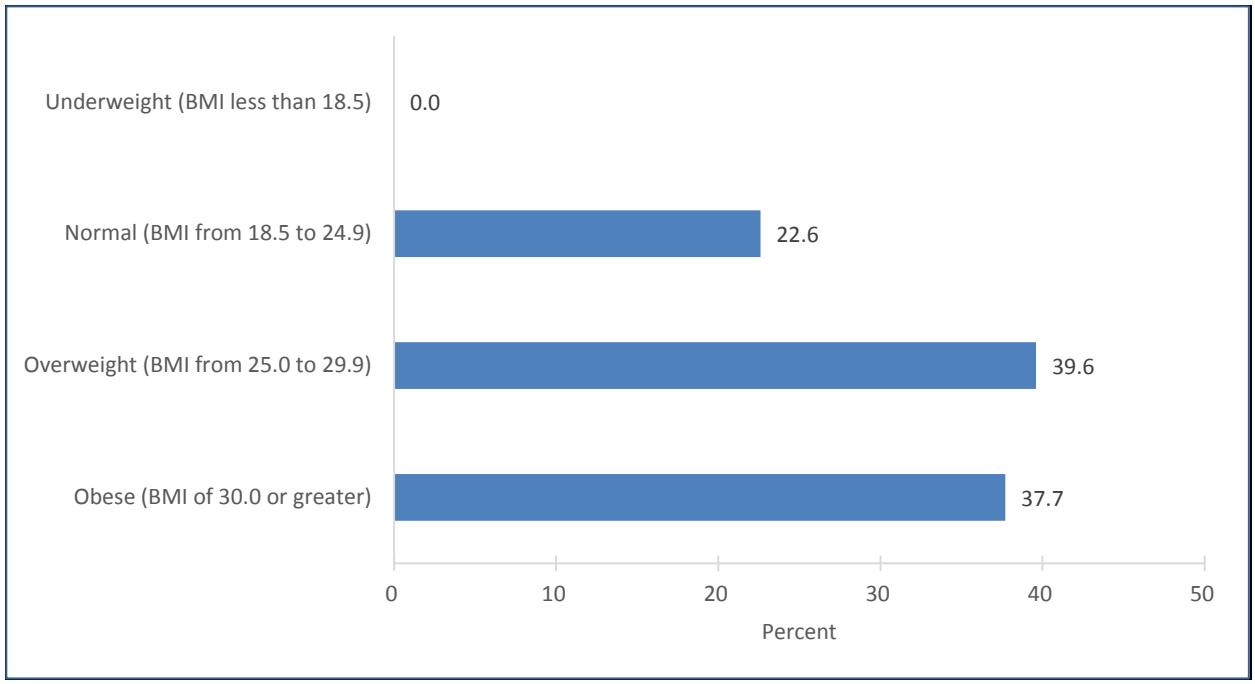
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area are overweight or obese. However, the vast majority of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, over 78% of respondents visited a doctor or healthcare provider for a routine physical and over 79% visited a dentist or dental clinic.

Personal health is rated good or better by 90.8% of the survey respondents.

Respondents' rating of their health in general



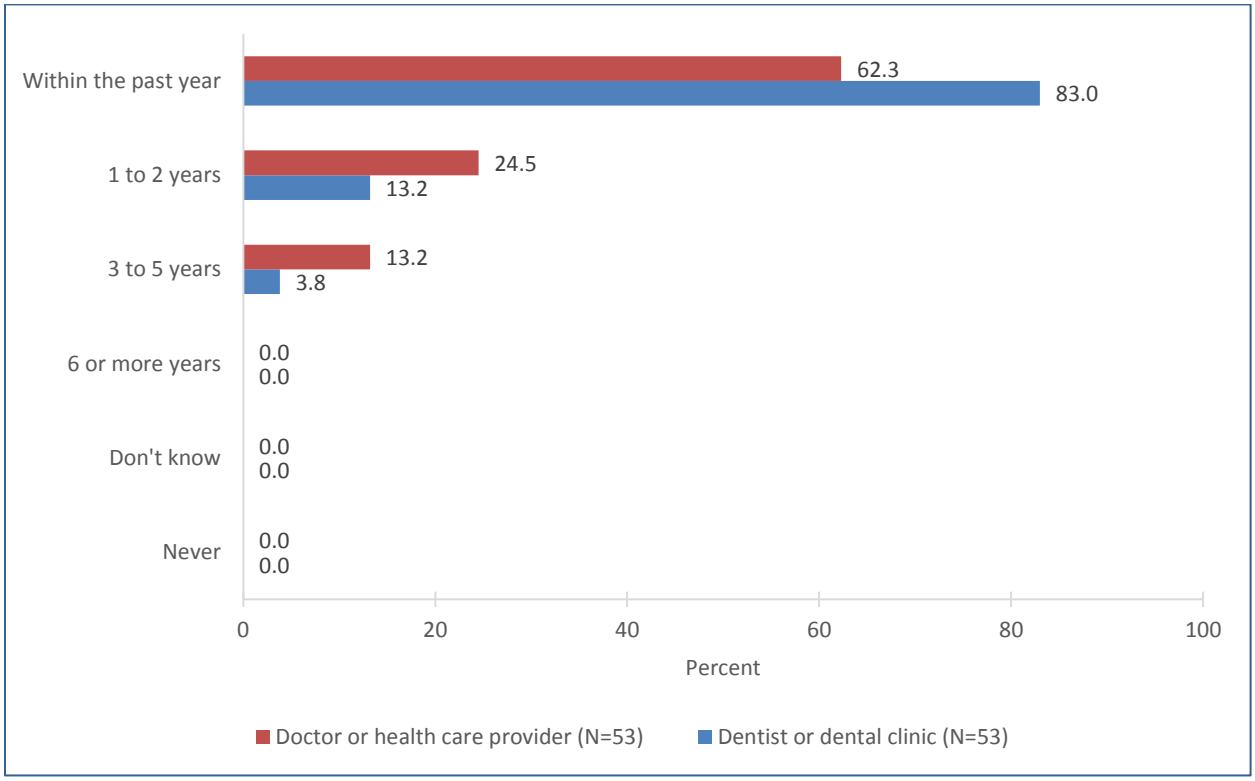
Respondents' weight status based on the Body Mass Index (BMI) scale



Preventive Health

Among survey respondents, 37.7% have not seen a provider in more than 1 year and 17% have waited more than 1 year to see their dentist.

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



Preventive healthcare promotes the detection and prevention of illness and disease and is another important component of good health and well-being. Community results indicate that within the past year, the majority of respondents had a blood pressure screening, blood sugar screening, cholesterol screening, and dental screening.

There are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, cardio screening, glaucoma test, hearing screening, immunizations, STD test, vascular screening, colorectal cancer screening, prostate cancer screening [males], and skin cancer screening) in the past year. Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate. The age demographics for survey respondents included a younger group of which 50% are under age 45.

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=53)	81.1	18.9	100.0
Blood sugar screening (N=52)	51.9	48.1	100.0
Bone density test (N=51)	7.8	92.2	100.0
Cardiovascular screening (N=51)	5.9	94.1	100.0
Cholesterol screening (N=52)	50.0	50.0	100.0
Dental screening and X-rays (N=53)	83.0	17.0	100.0
Flu shot (N=53)	92.5	7.5	100.0
Glaucoma test (N=53)	54.7	45.3	100.0
Hearing screening (N=51)	2.0	98.0	100.0
Immunizations (N=51)	17.6	82.4	100.0
Pelvic exam (N=37 Females)	67.6	32.4	100.0
STD (N=51)	3.9	96.1	100.0
Vascular screening (N=51)	3.9	96.1	100.0
CANCER SCREENINGS			
Breast cancer screening (N=37 Females)	48.6	51.4	100.0
Cervical cancer screening (N=36 Females)	58.3	41.7	100.0
Colorectal cancer screening (N=53)	22.6	77.4	100.0
Prostate cancer screening (N=16 Males)	31.3	68.8	100.1
Skin cancer screening (N=52)	23.1	76.9	100.0

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

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

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

- The Pap test (or Pap smear) looks for *pre-cancers*, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- The HPV test looks for the virus (human papillomavirus(http://www.cdc.gov/cancer/hpv/basic_info/)) that can cause these cell changes.

The Pap test is recommended for **all women between the ages of 21 and 65 years** old and can be done in a doctor's office or clinic.

Colorectal cancer screening: Colorectal cancer almost always develops from *precancerous polyps* (abnormal growths) in the colon or rectum. Screening tests can also find colorectal cancer early, when treatment works best. Regular screening, **beginning at age 50**, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy **beginning at age 50 years and continuing until age 75 years.**

Prostate cancer screening: The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their healthcare provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:

- **Age 50 for men who are at average risk** of prostate cancer and are expected to live at least 10 more years.
- **Age 45 for men at high risk** of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than age 65).
- **Age 40 for men at even higher risk** (those with more than one first-degree relative who had prostate cancer at an early age).

After this discussion, those men who want to be screened should be tested with the prostate-specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as a part of screening.

If, after this discussion, a man is unable to decide if testing is right for him, the screening decision can be made by the healthcare provider, who should take into account the patient's general health preferences and values.

Assuming no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test:

- Men who choose to be tested who have a PSA of less than 2.5ng/mL may only need to be retested every 2 years.
- Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.

Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone, is important when making decisions about screening.

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

Skin cancer screening: The U.S. Preventive Services Task Force (USPSTF) has concluded there is not enough evidence to recommend for or against routine screening (total body examination by a doctor) to find skin cancers early.

The USPSTF recommends that doctors:

- Be aware that fair-skinned men and women aged 65 and older, and people with atypical moles or more than 50 moles, are at greater risk for melanoma.
- Look for skin abnormalities when performing physical examinations for other reasons.

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the generalizable survey indicate that 37% of respondents did not have a flu shot last year.

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

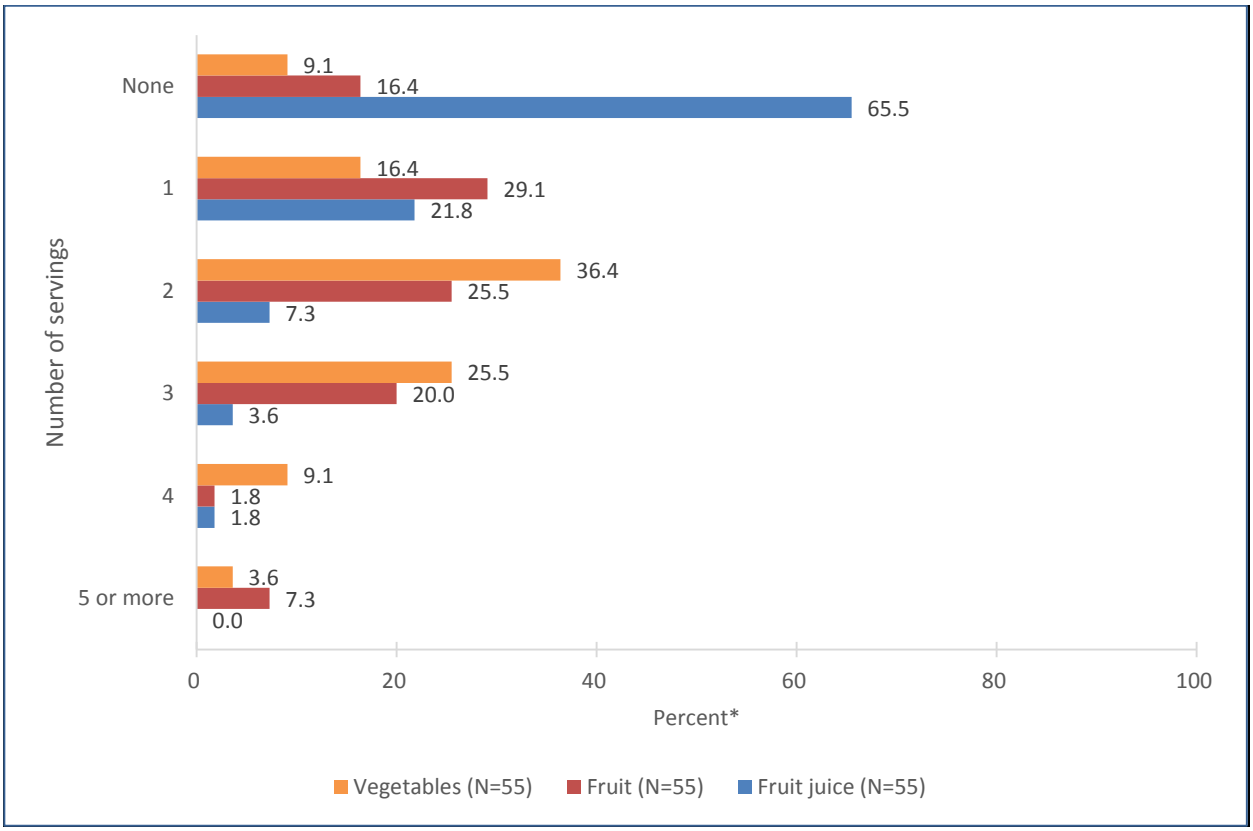
Sanford Health employees are required to have an annual flu vaccine as a protective measure for our patients as well as our staff. Sanford holds annual flu blitz events to increase the number of community members both pediatric and adult who receive the flu vaccine.

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 38.2% of respondents reported having 3 or more servings of vegetables the prior day, and only 21.8% reported having 3 or more fruits each day.

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

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

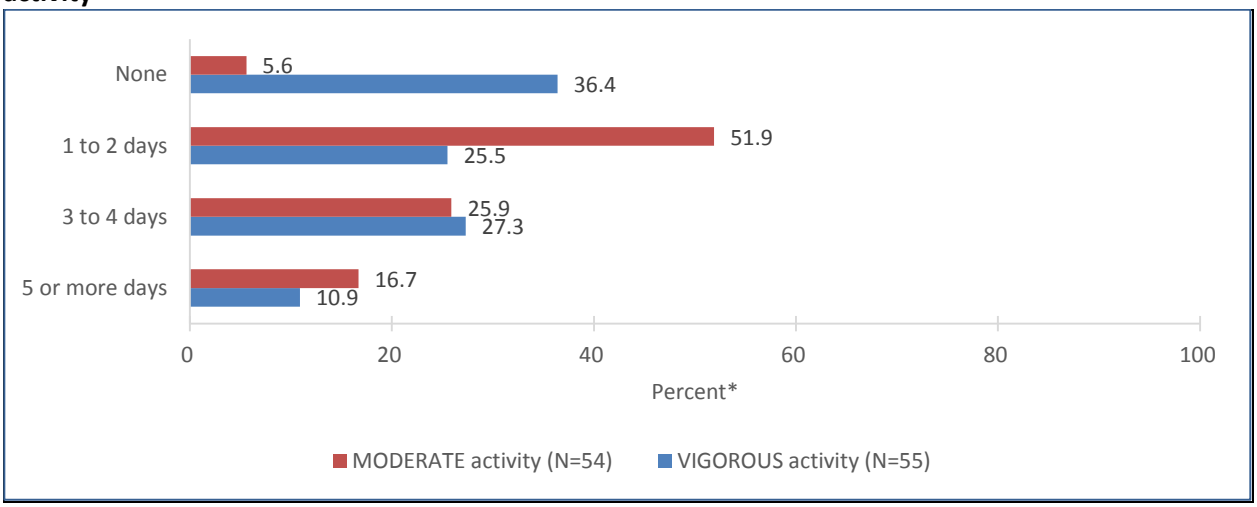


Physical Activity Levels

Study results find that 42.6% of respondents meet physical activity guidelines with moderate activity 3 or more times per week. Vigorous activity is engaged in by 38.2% of the respondents 3 or more time per week.

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

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

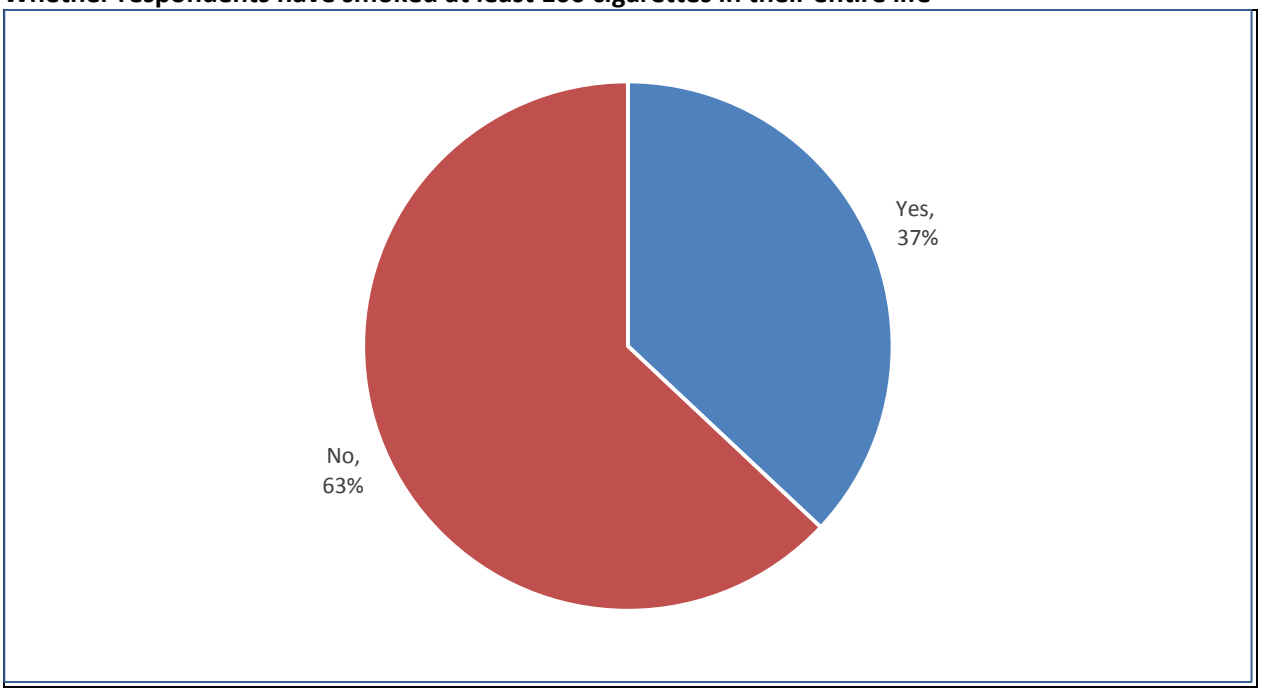


Tobacco Use

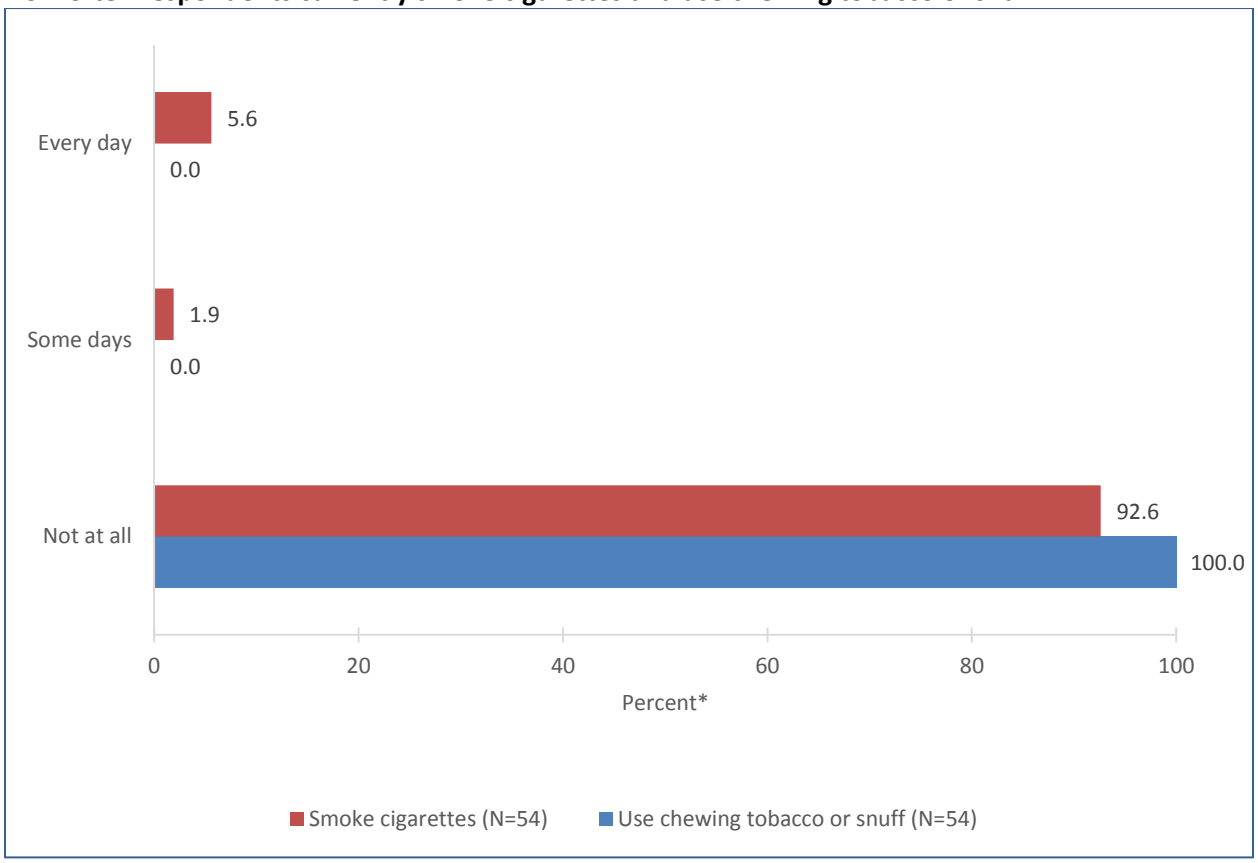
Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 37% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates a former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the 2015 County Health Rankings finds that 19% of Pennington County residents are current smokers.

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



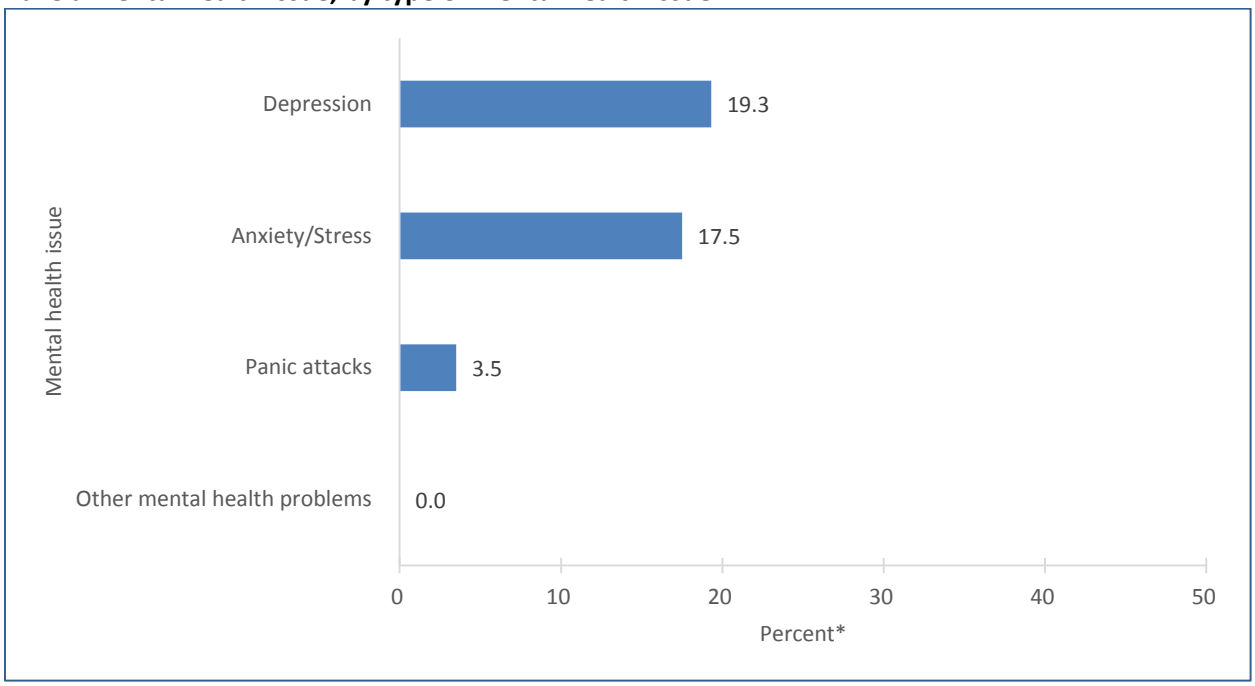
How often respondents currently smoke cigarettes and use chewing tobacco or snuff



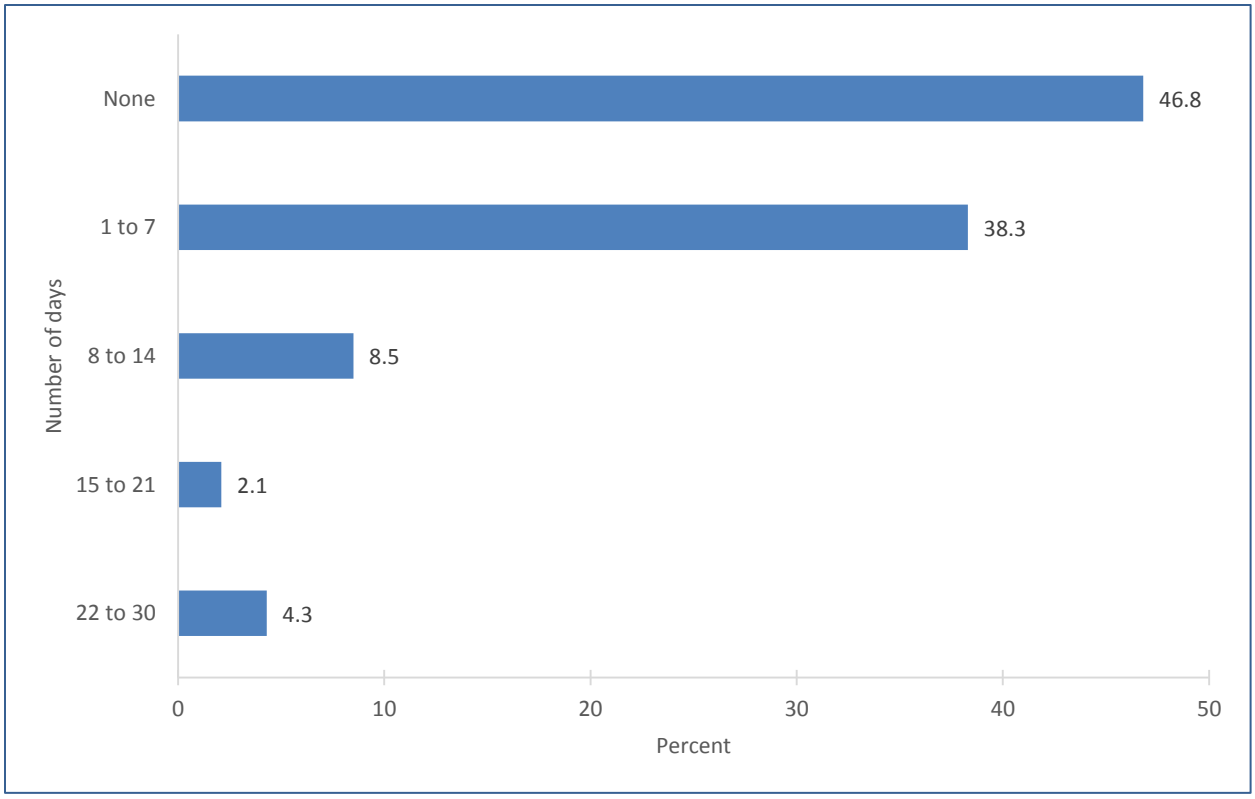
Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others. Among Pennington respondents, mental health is a moderately high area of concern, particularly suicide, depression, stress, other psychiatric diagnoses, dementia and Alzheimer's disease. More than 17% of respondents have been told by a doctor or health professional that they have anxiety or stress and over 19% have been told that they have depression. In addition, more than half of respondents self-report that in the last month, there were days when their mental health was not good.

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



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

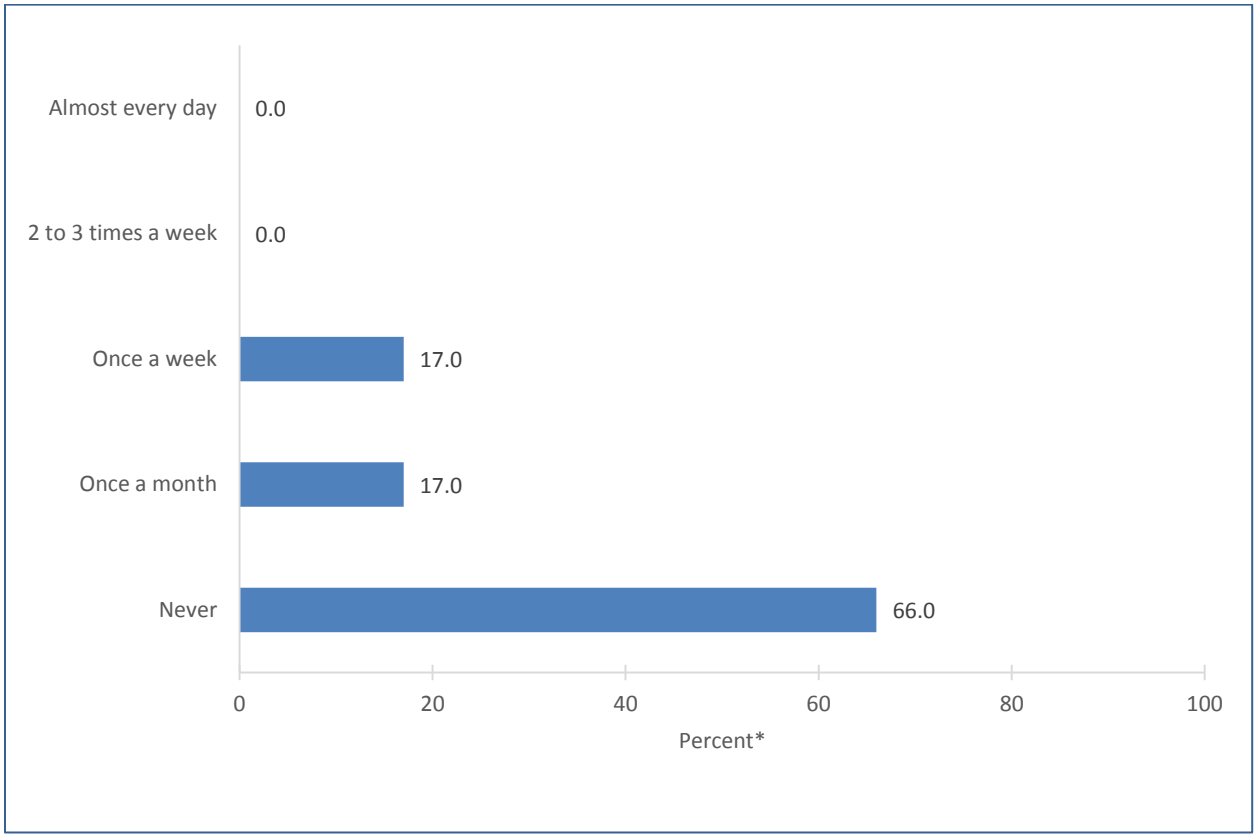


Substance Abuse Responses

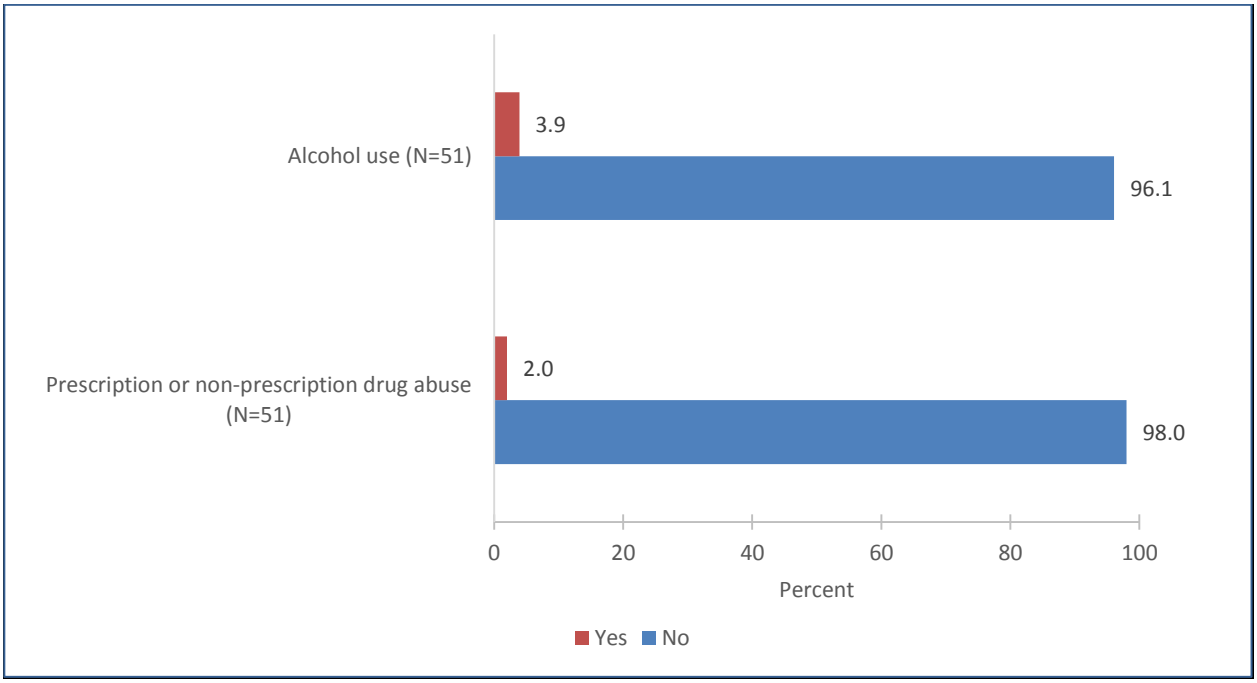
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In Thief River Falls and Pennington County, 78.4% of respondents drank alcoholic beverages on at least one of the days in the last month. On days they drank, 20% of respondents drank an average of 3 or more drinks per day. In regards to binge drinking, 34% report binge drinking at least once per month.

Secondary research through the 2015 County Health Ranking indicates that 20% of Pennington County residents report excessive drinking. (See Appendix)

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



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



Only 3.9% percent of respondents reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking.

Other forms of substance abuse include the use of prescription or non-prescription drugs. Only 2% of the respondents reported having had a problem with prescription or non-prescription drug abuse.

Demographics

Total Population – 2010 U.S. Census Bureau

- **Pennington County: 13,930**

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	945	6.8	484	3.5	462	3.3
5-9	899	6.5	438	3.1	461	3.3
10-14	926	6.6	472	3.4	454	3.3
15-19	927	6.7	501	3.6	426	3.1
20-24	861	6.2	447	3.2	414	3.0
25-29	884	6.3	434	3.1	450	3.2
30-34	853	6.1	438	3.1	415	3.0
35-39	883	6.3	461	3.3	422	3.0
40-44	767	5.5	415	3.0	352	2.5
45-49	984	7.1	477	3.4	507	3.6
50-54	1,069	7.7	523	3.8	546	3.9
55-59	928	6.7	489	3.5	439	3.2
60-64	791	5.7	365	2.6	426	3.1
65-69	625	4.5	297	2.1	328	2.4
70-74	454	3.3	217	1.6	237	1.7
75-79	381	2.7	167	1.2	214	1.5
80-84	347	2.5	121	0.9	226	1.6
85 and over	405	2.9	124	0.9	281	2.0
Median age	38.9		37.7		40.4	

Population by Race

	Pennington	Percent
White	13,067	93.8
Black or African American	192	1.4
American Indian or Alaska Native	213	1.5
Asian	87	0.6
Native Hawaiian or other Pacific Islander	1	0.0
Hispanic or Latino	380	2.7

The median income in Pennington County, Minnesota is $34,216. Residents in Pennington County living below the poverty level are at 7.7%. The unemployment rate in Pennington County, Minnesota is 5.7%.

Health Needs and Community Resources Identified

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

Sanford Health and community partners developed the asset map. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

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

The asset map process includes identified needs from the following:

- The non-generalizable survey
- Secondary research data
- Community resources that are available to address the need(s)

The asset map can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Economics – affordable housing
- Transportation – availability of walking and biking paths
- Aging – cost and availability of long term care and availability of memory care, availability of resources to help seniors stay in their homes
- Children and Youth – cost and availability of quality child care and quality infant care, bullying, availability of services for at-risk youth, teen pregnancy, and the cost and availability of activities for children and youth
- Safety – presence of drug dealers and street drugs and alcohol in the community, and domestic violence
- Healthcare Access – access to affordable health insurance and prescription drugs, the cost affordable dental insurance, the availability of non-traditional hours and the use of emergency services for primary care
- Physical Health – cancer, obesity, chronic disease, poor nutrition and inactivity
- Mental Health – depression, stress, suicide, underage substance use and abuse and alcohol use, adult drug use and abuse and alcohol use, and smoking and tobacco use
- Preventive Health – flu vaccines, routine physicals

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

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

Community stakeholders partnered with Sanford to determine that access to healthcare and physical/mental health are top unmet needs for further implementation strategies.

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

- Mental/Behavioral Health
- Physical Health

How Sanford is Addressing the Needs

Sanford Thief River Falls Medical Center

Identified Concerns	How Sanford Thief River Falls is addressing the needs
Economics • Availability of affordable housing	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders. Additionally Sanford is working with developers directly to build market rate family housing on the former hospital site.
Transportation • Availability of good walking or biking paths	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders.
Aging • Cost of long term care • Availability of memory care • Availability of resources to help the elderly stay safe in their homes	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders. Sanford will also be represented at various local and state associations dedicated to positively impacting the identified issues.
Children and Youth • Availability of quality infant care • Availability of quality childcare • Availability of activities for children and youth • Cost of activities for children and youth • Cost of quality infant care • Bullying • Cost of quality child care • Teen pregnancy • Availability of services for at-risk youth	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders. Sanford has a variety of services available that can positively impact some of the identified concerns, e.g., outpatient mental health services, residential treatment programs, and continues to develop more services that will impact children and youth.
Safety • Presence of street drugs and alcohol in the community • Presence of drug dealers in the community • Domestic violence	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders.
Healthcare • Access to affordable health insurance • Access to affordable prescription drugs • Access to affordable healthcare • Availability of non-traditional hours	Sanford addresses this need by providing charity care through the Community Care Program and has a discounted rate for those who qualify for assistance. Sanford is also addressing the access issues through a recruitment plan and is actively recruiting for additional

Identified Concerns	How Sanford Thief River Falls is addressing the needs
• Cost of affordable dental insurance coverage • Use of emergency room services for primary healthcare	providers. Sanford TRF has prioritized this as a high need and has developed an implementation strategy to improve access.
Physical Health • Obesity • Inactivity/lack of exercise • Poor nutrition and eating habits • Cancer • Chronic disease (hypertension, high cholesterol, arthritis, diabetes)	Sanford has prioritized behavioral and mental health as an implementation strategy for FY 2016 – 2018.
Mental Health • Depression • Stress • Suicide • Drug use and abuse • Under age drug use and abuse • Underage drinking • Alcohol use/abuse • Smoking and tobacco use	Sanford has prioritized behavioral and mental health as an implementation strategy for FY 2016 – 2018.
Preventive Health • Flu shots (34.6% reported that children 6 months or older did not get a flu shot or flu mist each year) • Immunizations (32% of respondents report having immunizations in the past year, and respondents report that 98% of their children are current on their immunizations) • 21.7% have not seen a healthcare provider in the past year - 30.9% have not seen a dentist in the past year	Sanford is addressing this need by sharing these concerns and the results of the CHNA with community leaders and various public health agencies in our service area. Sanford TRF has also implemented Same Day Sanford, an enterprise standard developed to increase access to primary care and hopefully improve immunization percentages as well.

SANFORD HEALTH

2016 Implementation Strategy

Sanford Thief River Falls Medical Center

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

Mental health includes emotional, psychological and social well-being. It affects how people think, feel and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Access to mental/behavioral healthcare includes the ability to gain entry into a health system or provider service. Access can include the availability of healthcare providers and a workforce available to address the needs. Limited access can challenge the ability to receive appropriate levels of care and may pave the way to the utilization of higher cost entry points into the system through the emergency room.

Sanford is working to secure CMS certification for the new behavioral health center and the development of a partial hospitalization program. Sanford will also work to develop partnerships with regional behavioral health organizations. This priority was determined in partnership with community members who participated in the prioritization discussion.

Priority 2: Physical Health

Physical health is defined by the World Health Organization (WHO) as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Community members participating in the community health needs assessment survey indicated that obesity, inactivity and poor nutrition are top concerns for physical health.

Sanford has determined that physical and mental health are top priorities and has set strategy to increase preventative healthcare including dietitian services and implementation of the advanced medical home model. This priority was determined in partnership with community members who participated in the prioritization discussion.

Community Health Needs Assessment

Implementation Strategy for Sanford Thief River Falls Medical Center

FY 2017-2020 Action Plan

Priority 1: Mental Health / Behavioral Health

Projected Impact: Sanford TRF is a service provider for the behavioral health needs of the region

Goal 1: CMS Certification of Sanford Behavioral Health Center

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships
Preparation for certification survey	Certification by CMS as a free-standing psychiatric hospital	Sanford – Local and Network	Sanford – Local and Network	
Engage consultant to perform a mock readiness survey in advance of the actual survey	Completion of the survey and recommendations received. Development of plan of correction.	Sanford – Local and Network Joint Commission Resources	Reps from respective organizations	

Goal 2: Development of a Partial Hospitalization Program

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships
Complete a S.W.O.T. analysis of proposed program	Report developed from stakeholder input	Sanford Local	Sanford Local	
Complete a Return On Investment analysis of proposed program	Report completed and distributed to key decision makers	Sanford – Local and Network	Reps from each organization	
Development of space and implementation of new program	Actual implementation of the program	Sanford – Local and Network	Reps from each organization	

Goal 3: Develop partnerships with regional behavioral health organizations

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships
Evaluate opportunities for partnerships with regional organizations	Listing of potential regional organizations that provide behavioral health services	Sanford – Local and System	Sanford – Local and System	
Work with Sanford system resources as necessary to develop regional partnerships	New partnerships developed with regional organizations	Sanford – Local and System	Sanford – Local and System	

Priority 2: Physical Health

Projected Impact: The health and wellness of the community is improved through the Wellness Center, specialists, and available services for the community members

Goal 1: Expanded Wellness Center

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships
Sanford Foundation Thief River Falls fundraising campaign "Kids Unite" is raising money to develop a kids fitness area as part of our existing wellness center - $250,000 goal	Fundraising goal achieved by the end of fiscal year 2016	Southeast Campus	Foundation staff and committees	

Goal 2: Develop Community Center

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships
In partnership with various community organizations develop a community center model that meets the fitness needs of the community as identified by previous studies	Progress made toward planning, development and completion of a self-sustaining community center	Sanford – Local and System, TRForward planning committee comprised of community leaders and businesses, local legislators for funding assistance, City of Thief River Falls	Reps from all of the various resources	City of Thief River Falls

Goal 3: Improve the availability for exercise and nutrition education across the community

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships
Provide Sanford *fit* Program to the local schools and child care providers	Sanford *fit* is available to all students and families in the area through classroom and *fit* website	Sanford *fit* leadership Classroom teachers	Sanford leaders	Local schools Child care leaders

Goal 4: Continued growth of Sanford Medical Home

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships
Enroll more patients in our Medical Home Provide enhanced education on wellness, nutrition, exercise, etc.	Increased numbers of patients enrolled / served	Medical Home Staff, Hospital / Clinic dietitians, Sanford Profile, Physical and Occupational Therapies	Reps from each organization	

SANFORD HEALTH

2013 Implementation Strategy Impact

Demonstrating Impact

The 2013 community health needs assessment served as a catalyst to lift up obesity and mental health services as implementation strategies for the 2013-2016 timespan. The following strategies were implemented.

Priority: Substance Abuse Services

- Participate in the Sanford enterprise implementation strategy for Sanford One Mind
- Establish systemic care plan for prescription drug abuse cases including behavioral health, primary care, and medical home departments
- Establish reliable network for detoxification and inpatient chemical dependency treatment centers
- Establish coordination of care between chemical dependency and mental health professionals
- Develop reliable chemical dependency outpatient services for adolescents
- Improve access to chemical dependency assessments for community

Priority: Care Coordination and Chronic Disease Management

- Participate in the Sanford enterprise implementation strategy for obesity
- Integrate dietician services with dialysis services
- Establish integrated approach to behavioral health within the function of primary care
- Implement Integrated EMR platform across clinic and hospital-based services
- Fully implemented hospitalist program with established connectivity to outpatient providers
- Establish comprehensive pain management program
- Refine and promote practices and communications of Medical Home team: RN health coaches, tobacco cessation specialist, outpatient social worker, cardiac rehab, dieticians, etc.
- Connect long term care facilities to providers and inpatient services

Priority: Access

- Expand urology coverage
- Create more complete oncology outreach program
- Improve access in general to “primary care” areas: family med/internal med/OB/GYN/pediatrics/psychology/psychiatry
- Satellite employer clinic model
- APP-MD team model
- Establish outreach dermatology services in TRF
- Establish neurology outreach services
- Establish comprehensive pain management clinic

Impact of Strategy to Address Substance Abuse

Sanford implemented a new EMR during February 2014 and has added e-prescribing. A chemical dependency counselor has been hired to work in the outpatient clinic. A new behavioral health center opened during 2015 and Sanford is working to receive CMS certification. Sanford is also working to establish a collaboration of partner organizations focused on behavioral healthcare to meet the needs of the regional community.

Impact of Strategy to Address Care Coordination

RN health coaches and Medical Home have been implemented to work with all patients with a chronic disease. Services are expanded to bring specialty practices to Thief River Falls on an outreach basis.

Impact of Strategy to Address Access

Sanford provides a Community Care program as the charity care program addressing free or reduced rates to patients who qualify and have need for medical care. Sanford TRF has implemented Same Day Sanford to increase access to primary care and improve immunization percentages.

Impact of the Strategy to Address Mental Health Services

Behavioral health services have been integrated into all primary care settings through behavioral health screening, PHQ-9 screening, and two behavioral health triage therapists. Additionally, a peer support advocate was added to assist those with chemical addition in accessing desired interventions.

Impact of the Strategy to Address Obesity

The Sanford Health *fit* initiative, a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life. In 2016 a new *fit* initiative will be available for 20,000 classroom teachers. The classroom curriculum has numerous modules that teachers can access and implement in part or comprehensively.

Profile by Sanford is a personalized retail weight loss program designed by Sanford Health physicians and scientists to be simple, effective and sustainable. With a certified *Profile* coach, personalized meal plans and smart technology to track progress, members see real results. Each weight loss plan is designed with a focus on nutrition, activity and lifestyle.

The enterprise obesity initiative addressed education for providers and education for patients and community members. The first annual Sanford obesity symposium was held in 2014. Over 400 healthcare professionals from the region and beyond registered for the 2014 and 2015 symposiums. The purpose of the symposium is to enhance the knowledge and competence of participants by providing an update on the latest research associated with the prevention, treatment and management of obesity. The target audience includes primary care physicians, pediatricians and specialty care providers, advanced practice providers, licensed registered dietitians, nurses, and other interested healthcare professionals.

The symposium is an opportunity to provide prevention and treatment practice guidelines for the adult and pediatric population. The planning committee includes several published providers who are sought after nationally and internationally for their expertise.

Sanford is taking a comprehensive and multi-faceted approach to obesity prevention and treatment. The impact is demonstrated through the lives of our community members who have had positive outcomes because of our programs and services.

Community Feedback from the 2013 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on our 2013 Community Health Needs Assessment and has provided on-line comment fields for ease of access on our website. There have been no comments to date aside from a question asked about the service area for this report. A reader wanted to know if a separate report was developed for the Lisbon, North Dakota area. Since there is no hospital in Lisbon a community health needs assessment was not conducted solely for that community.

APPENDIX

Primary Research

Sanford Thief River Falls Medical Center 2016 CHNA Asset Map

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
Economics	4.14	• Availability of affordable housing	• Unemployment rate is 5.7% compared to 4% nationally and 5.1% for MN	Affordable housing resources: • TRF Housing & Redevelopment Authority – 218-681-5995 • Rental Rehab Loans – 218-637-2431 • Rehab loans for homeowners 218-637-2435 • ECHO loans for down payment assistance - 218-637-2435 • Public Housing (24 3-BR homes) 218-637-2431 • First Time Homebuyers Program 218-637-2431 • USDA Rural Development 218-681-2843 • HUD (serving Pennington Co.) 218-637-2431 • Inter-County Community Council (loan & grant programs for limited income families) – 218-796-5144 • Low income apartments: ○ Riverside Terrace 763-541-9199 ○ Sherwood Park Townhouses 218-681-6517 ○ Skylite Apts. 218-681-5995 ○ Southwood Park Townhomes 218-681-6519 Employment Resources: • TRF WorkForce Ctr–218-683-8060 • Major employers: ○ Arctic Cat – 218-681-8558 ○ Digi-Key - 218-681-6674 ○ Land O'Lakes 218-681-3146 ○ Northwest Beverage 218-681-1735 ○ Pennington County 218-683-7017 ○ Pepsi – 218-681-3227 ○ Sanford – 218-681-4240 ○ Seven Clans 800-881-0712 ○ TRF City Govt. 218-681-2943 ○ U.S. Post Office - ○ Walmart – 218-683-3643	

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
Transportation	3.54	• Availability of good walking or biking options		Walking/Hiking resources: • Greenwood Trails – 218-681-2519 • River Walk – 218-681-3720 • Agassiz Dunes – 218-739-7576 • Riverland Trail – 218-253-4220 • Wapiti Trail – 218-681-3720 Biking resources: • Red Robe Classic bike ride • Pathfinder Bike Shop 218-681-3116	
Aging population	3.87-3.56	• Cost of long term care • Availability of memory care • Availability of resources to help the elderly stay safe in their homes		LTC resources: • Thief River Care Center 218-683-8100 • Oakland Park Nursing Home 218-681-1675 • Valley Home – 218-681-3286 • Riverside Terrace (retirement apts.) – 218-681-76578 • Sunwood Home – 218-681-7163 Memory Care facilities: • Thief River Care Center 218-683-8100 • Oakland Park Nursing Home 218-681-1675 • Valley Home – 218-681-3286 Resources to help the elderly stay in their homes: • Pennington Co. Social Services – 218-681-2880 • Pennington Co. Human Services – 218-681-2880 • Hospice Red River – 218-681-6189 • Country Health – 218-681-8214 • Northland Community Hospice – 218-681-4240 • Inter County Nursing Service 218-681-0876 • Sanford Healthcare Accessories – 218-683-2588 • Lincare – 218-681-8214 • First Care Medical Services 218-681-6189 • S & S Rehab Products 218-681-3710 • Behavioral Dynamics, Inc. 218-681-6033 • Life Alert – 877-830-3543 • Quick Response Alert 877-315-7332 • Heritage Senior Center 218-681-2793	

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
				• Caregiver Support through LSS – 218-280-3773 • Heritage Center congregate meals & home delivery – 218-681-2793 • Meals on Wheels – 218-681-6861 • Weatherization – 218-796-5144 • Energy Assistance – 218-796-5144	
Children and Youth	3.93-3.53	• Availability of quality infant care • Availability of quality childcare • Availability of activities for children and youth • Cost of activities for children and youth • Cost of quality infant care • Bullying • Cost of quality child care • Availability of services for at-risk youth	• Teen birth rate is 30 for Pennington County compared to 20 nationally, and 24 statewide	Child Care Centers: • Tri Valley Child Care Resource & Referral – 800-543-7382 • Discovery Place – 218-681-5202 • Community Church Daycare 218-681-5327 • Sullivan Day Care -218-681-1179 • TRF Child Care – 218-681-7454 • Greenwood Learning Center 218-681-2472 • Head Start – 888-778-4008 After School Activities: • TRF School System – 218-681-8711 • St. Bernard's Catholic School 218-681-1539 • Park & Recreation Dept. 218-681-2519 • Family Time Fitness – 218-681-6709 Sanford WebMD Fit Kids Clinics: • Sanford Health – 218-681-4747 • Sedra Medical Clinic 218-683-5137 • Inter County Nursing Service 218-681-0876 Services for at-risk youth: • Big Brother/Big Sister 219-681-8711 • WIC – 218-874-7845 • Violence Intervention Project 218-681-5557 • Umbrella Tree Safety Center 218-681-5557 • Child Protection – 218-681-2880 Support for teen moms: • Family Advocacy program 218-681-8711 • Communities Caring for Children (prenatal care) – 218-681-0876	

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
				• Prenatal & Childbirth Education – 218-681-4240 (Sanford) • Prenatal & Childbirth Education – 218-681-0876 (Inter County Nursing Service)	
Safety	3.91-3.55	• Presence of street drugs, and alcohol in the community • Presence of drug dealers in the community • Domestic violence	• Violent crime is 131 compared to 229 across MN and 59 nationally	Pennington County Sheriff 218-681-6161 TRF Police Dept. – 218-681-6161 State Patrol – 218-681-0942 Substance Abuse resources: • Sanford Behavioral Health Center 218-681-4350 • Sanford Behavioral Health Clinic 218-681-4351 • Pathfinder Children's Treatment Center – 218-683-7180 • Riverview Recovery Center 218-281-9200 • Glenmore Recovery Center 701-683-8011 • Narcotics Anonymous • Alcoholics Anonymous Domestic Violence resources: • Penn. Co. Sheriff 218-681-6161 • TRF Police Dept. – 218-681-6161 • State Patrol – 218-681-0942 • Violence Intervention Project 218-681-5557 • Umbrella Tree Safety Center 218-681-5557 • Child Protection – 218-681-2880	
Healthcare	3.82-3.50	• Access to affordable health insurance • Access to affordable prescription drugs • Access to affordable health care • Availability of non-traditional hrs. • Cost of affordable dental insurance coverage • Use of emergency room services for primary health care		Sanford Health Community Care Program – 218-681-4240	

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
Physical Health	4.04 – 3.55	• Obesity (77.3% have BMI of overweight or obese) • Inactivity and lack of exercise (42.6% have moderate exercise 3 or more times/week, and 38.2% have vigorous activity 3 or more times/week • Poor nutrition and eating habits (Only 38.2% have 3 or more vegetables/d, and only 21.8% have 3 or more fruits/d) • Cancer • Chronic Disease (hypertension, high cholesterol)	• The obesity rate is 26% compared to 26% in MN and 28% nationally • The inactivity rate is 22% – with a 65% access to exercise opportunities in Noble County • STDs are at 171 compared to 138 nationally • Diabetic monitoring is at 87% compared to 90% nationally	Clinics: • Sanford Health – 218-681-4747 • Sedra Medical Clinic 218-683-5137 • Inter County Nursing Service 218-681-0876 Physical Fitness resources: • Sanford Wellness Center 218-683-4367 • TRF School System athletics 218-681-8711 • St. Bernard's Catholic School athletics – 218-681-1539 • Park & Recreation Dept. 218-681-2519 • Studio K Fitness – 218-686-0752 • Anytime Fitness – 218-681-1305 • Family Time Fitness – 218-681-6709 • Healthy U – 218-689-4791 • Curves – 800-615-7352 • Tae Kwon Do – 218-681-2462 • Natural Health & Fitness 218-681-1565 Sanford Dietitians Cancer resources: • Roger Maris Cancer Center • Sanford Cancer Biology Research Center in SF • American Cancer Society Sanford Medical Home RN Health Coach Sanford WebMD Fit Kids Chronic Disease resources: • Better Choices/Better Health • American Heart Association • The Sanford Project – to cure Type 1 Diabetes in Denny Sanford's lifetime Nutrition Education: • Extension Office • WIC Program Farmers Markets: • Cabin View Gardens - 218-681-1155 • TRF Farmers Market 218-964-5370	

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
Mental Health/Behavioral Health (Substance Abuse)	3.98 – 3.69	• Depression (19.3% report depression – 50% have 1 or more days/mos. when their mental health was not good) • Stress (17.5% report Anxiety/stress) • Suicide • Drug use and abuse • Under age drug use and abuse • Underage drinking • Alcohol use and abuse (20% report consuming 3 or more drinks/d when they consume, and 34% have binge level drinking at least 1 time/mos.) • Smoking and tobacco use	• Excessive drinking is at 20% compared to 19% across MN and 10% nationally • 29% of traffic deaths were alcohol impaired • 19% of adults smoke in	Sanford One Care Clinics: • Sanford Health – 218-681-4747 • Sedra Medical Clinic 218-683-5137 • Inter County Nursing Service 218-681-0876 Mental Health resources: • Sanford Behavioral Health Center 218-681-4350 • Sanford Behavioral Health Clinic – 218-681-4351 • Pathfinder Children's Treatment Center – 218-683-7180 • Northwestern Mental Health Center – 218-281-3940 • Ann Johnson – 605-328-6585 • Nancy Rust – 218-681-2718 Substance Abuse resources: • Sanford Behavioral Health Center 218-681-4350 • Sanford Behavioral Health Clinic 218-681-4351 • Pathfinder Children's Treatment Center – 218-683-7180 • Riverview Recovery Center 218-281-9200 • Glenmore Recovery Center 701-683-8011 • Narcotics Anonymous • Alcoholics Anonymous	
Preventive Health		• Flu shots (92.5% of respondents have had a flu shot and report that 60.9% of children age 6 month or older have not had a flu shot). However, 39.1% reported that children 6 mos. or older did not get a flu shot or flu mist last year.		Clinics: • Sanford Health – 218-681-4747 • Sedra Medical Clinic 218-683-5137 • Inter County Nursing Service 218-681-0876 Dentists: • Helmich Dental – 218-681-4041 • TRF Family Dentistry 218-681-2545 • Ben Sayler, DDS – 218-681-1700 • Bryce Bray, DDS – 681-3233 (will provide a 5% discount) • John Yoon, DDS – 218-681-1700 • Michael Eickman, DDS 218-681-2545 • Thomas Dimich, DDS 218-681-2545 • John Seaverson, DDS 218-681-4041 • Donald Goodrich, DDS 218-681-3254 • Martin Duchscher, DDS 218-681-4506	

Identified concern	Key stakeholder survey	Specific areas of concern	Secondary data	Community resources that are available to address the need	Gap?
		• 37.7% have not seen a healthcare provider in the past year • 17% have not seen a dentist in the past year			

Thief River Falls 2016 Community Health Needs Assessment - Prioritization Worksheet

Criteria to Identify Priority Problem
- Cost and/or return on investment
- Availability of solutions
- Impact of problem
- Availability of resources (staff, time, money, equipment) to solve problem
- Urgency of solving problem (H1N1 or air pollution)
- Size of problem (e.g. # of individuals affected)

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economics • Availability of affordable housing 4.14 (1)	X		
Transportation • Availability of good walking or biking paths 3.54			
Aging • Cost of long term care 3.87 (8) • Availability of memory care 3.57 • Availability of resources to help the elderly stay safe in their homes 3.56			
Children and Youth • Availability of quality infant care 3.93 (5) • Availability of quality childcare 3.86 (9) • Availability of activities for children and youth 3.82 • Cost of activities for children and youth 3.82 • Cost of quality infant care 3.82 • Bullying 3.75 • Cost of quality child care 3.75 • Availability of services for at-risk youth 3.53	XX		
Safety • Presence of street drugs, and alcohol in the community 3.91 (6) • Presence of drug dealers in the community 3.75 • Domestic violence 3.55	X		
Healthcare • Access to affordable health insurance 3.82 • Access to affordable prescription drugs 3.79 • Access to affordable healthcare 3.75 • Availability of non-traditional hours 3.73 • Cost of affordable dental insurance coverage 3.54 • Use of emergency room services for primary healthcare 3.50	X		
Physical Health • Obesity 4.04 (2) • Inactivity and lack of exercise 4.02 (3) • Poor nutrition and eating habits 4.00 (4) • Cancer 3.77 • Chronic Disease (hypertension, high cholesterol 3.73	XXXXX XXX		
Mental Health • Depression 3.82 • Stress 3.82 • Suicide 3.55 • Drug use and abuse 3.89 (7) • Under age drug use and abuse 3.84 • Underage drinking 3.82 • Alcohol use and abuse 3.79 • Smoking and tobacco use 3.55	XXXXX		
Preventive Health • Flu shots (92.5% of respondents have had a flu shot and report that 60.9% of children age 6 months or older have not had a flu shot). However, 39.1% reported that children 6 months or older did not get a flu shot or flu mist each year. • 37.7% have not seen a healthcare provider in the past year • 17% have not seen a dentist in the past year	XX		

Present: Anita Cardinal, Curtis Christensen, Mark Borseth, Brian Carlson, Kevin Ballard, Colleen Hoffman, Janelle Hudson, Shannon Jesme, Hannah Shirkey, Rob Lovejoy

Sanford Thief River Falls Medical Center

Community Health Needs Assessment

Results from a March 2015 Non-Generalizable On-line Survey

August 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a March 2015 on-line survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the on-line survey tool. Members of the Community Health Collaborative invited viewers to access the on-line survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach**. Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred throughout the month of March 2015 and a total of 57 respondents participated in the on-line survey.

TABLE OF CONTENTS

SURVEY RESULTS

General Health and Wellness Concerns about the Community

In Figures 1 through 9, respondents were asked to rate their level of concern with various statements regarding ECONOMICS, TRANSPORTATION, the ENVIRONMENT, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTHCARE, PHYSICAL AND MENTAL HEALTH, and SUBSTANCE USE AND ABUSE. Results are presented as a mean, using a 1 to 5 scale, with 1 being "not at all concerned" and 5 being "a great deal of concern". Figure 10 presents a mean of satisfaction with the availability of wellness and fitness activities in the community, using a 1 to 5 scale, with 1 being "not at all satisfied" and 5 being "extremely satisfied".

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

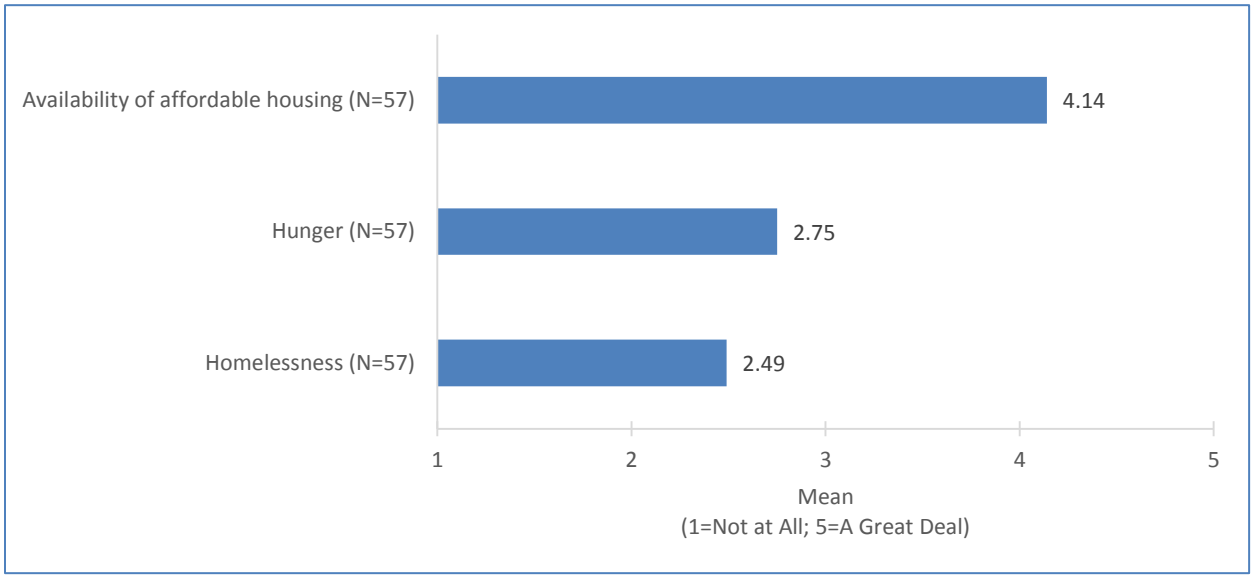


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

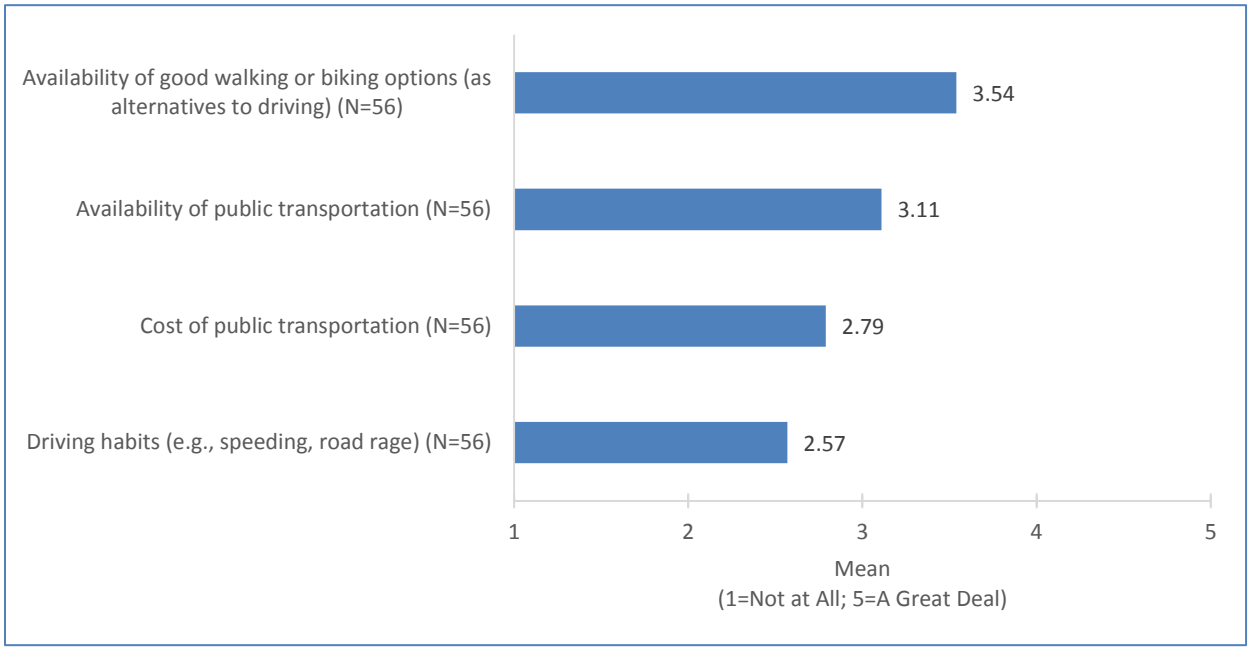


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

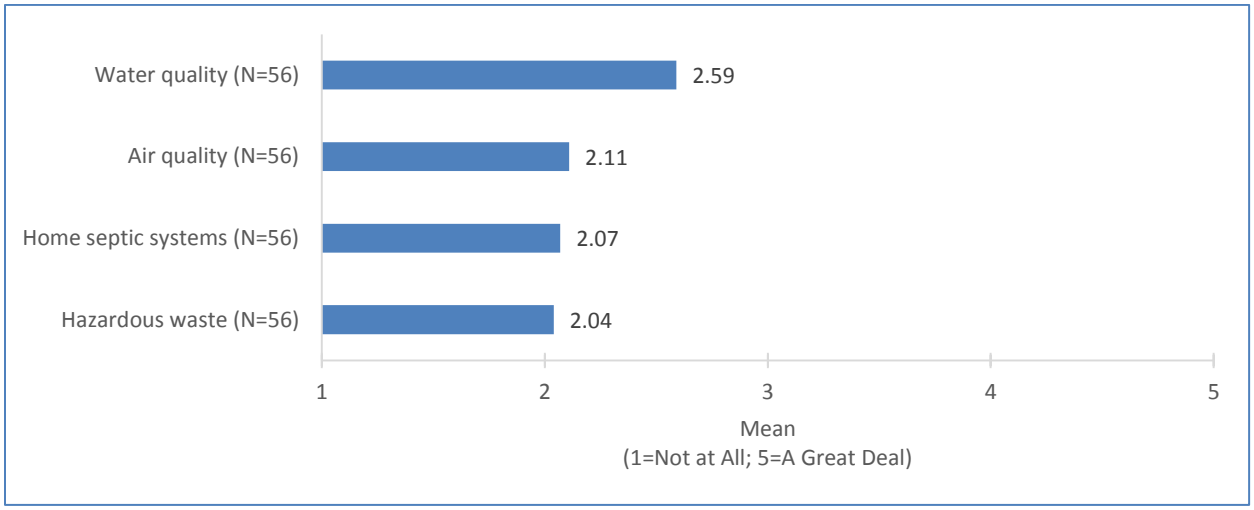


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

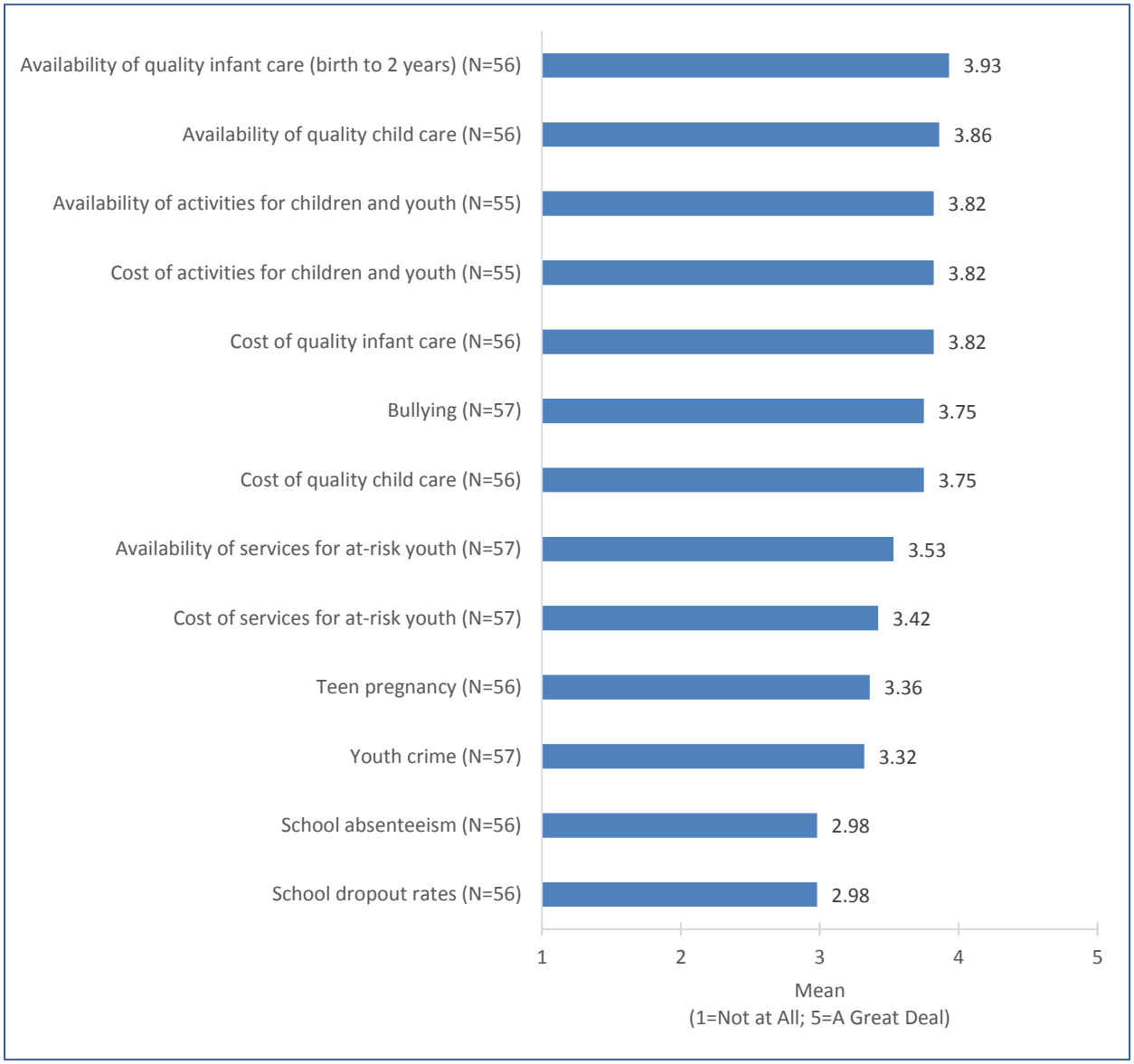


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

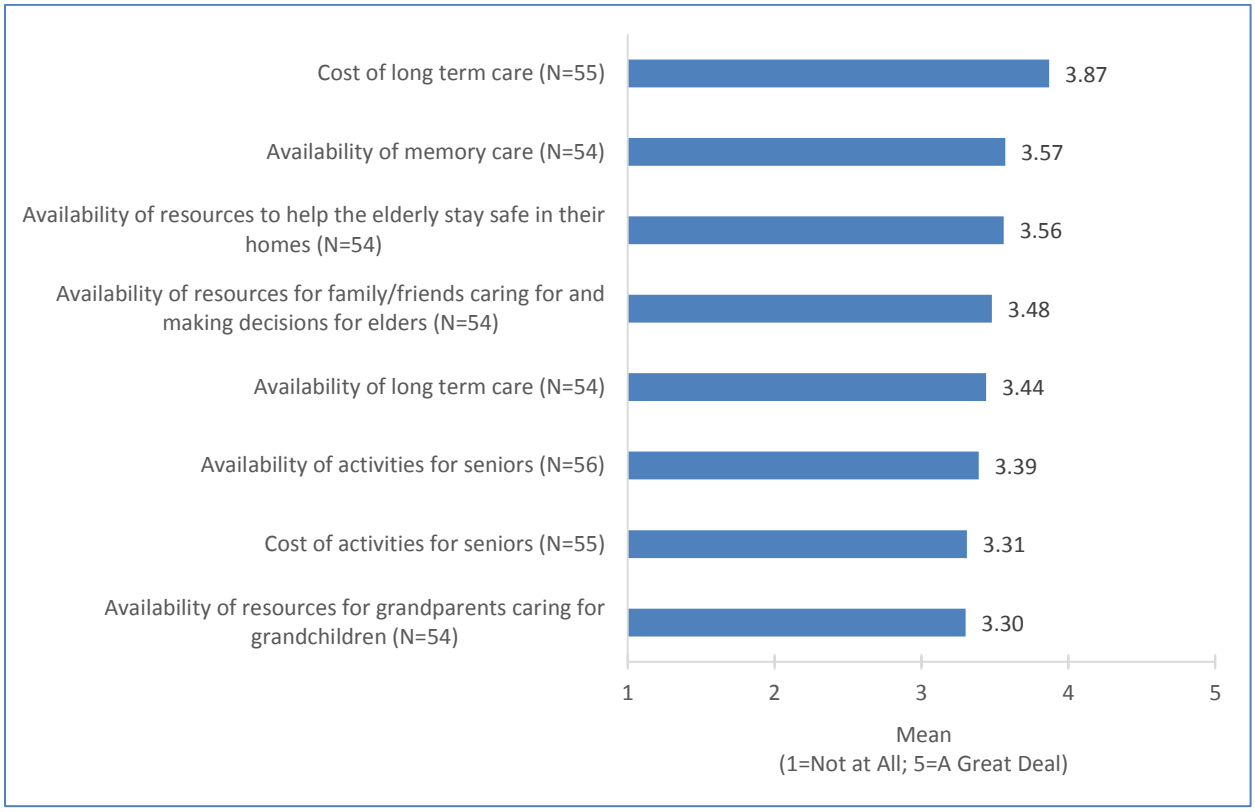


Figure 6. Level of concern with statements about the community regarding SAFETY

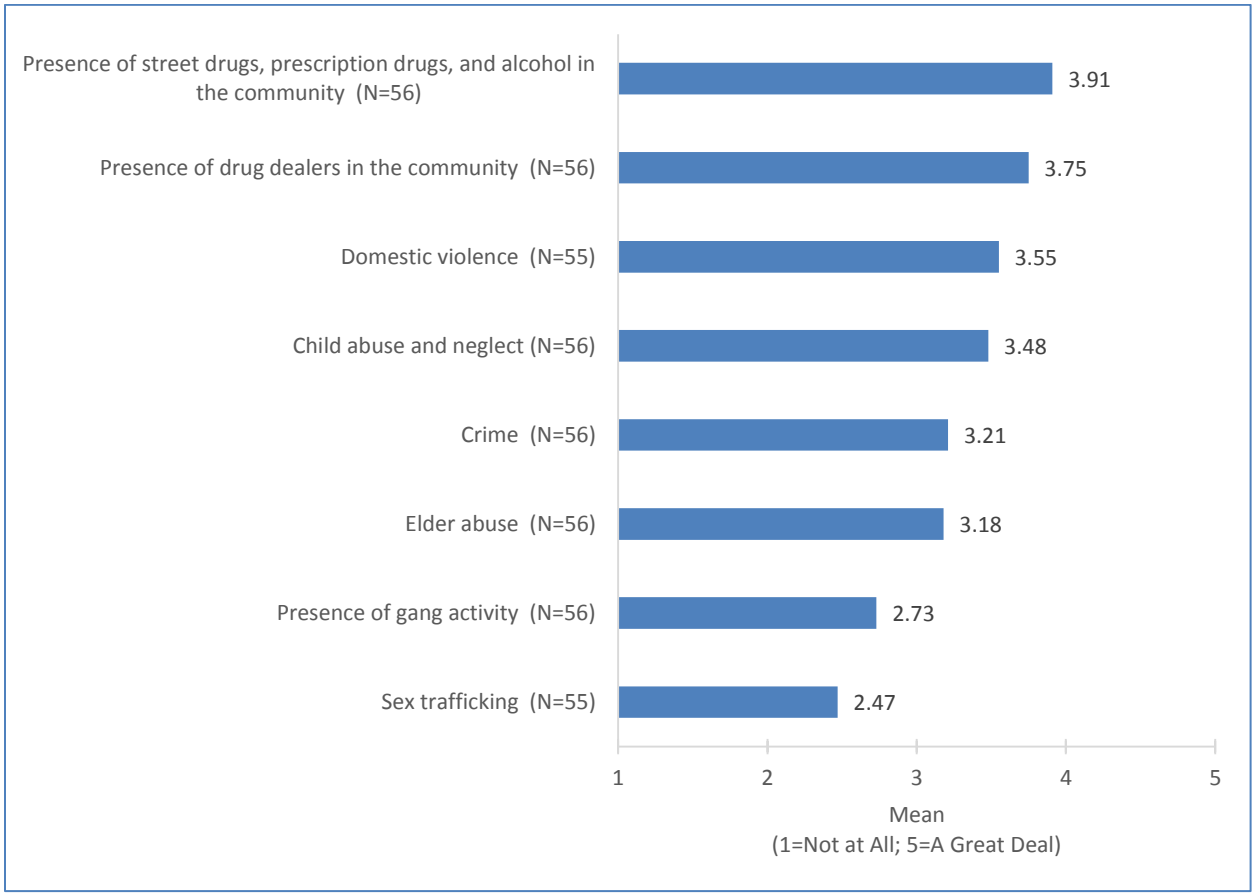


Figure 7. Level of concern with statements about the community regarding HEALTHCARE

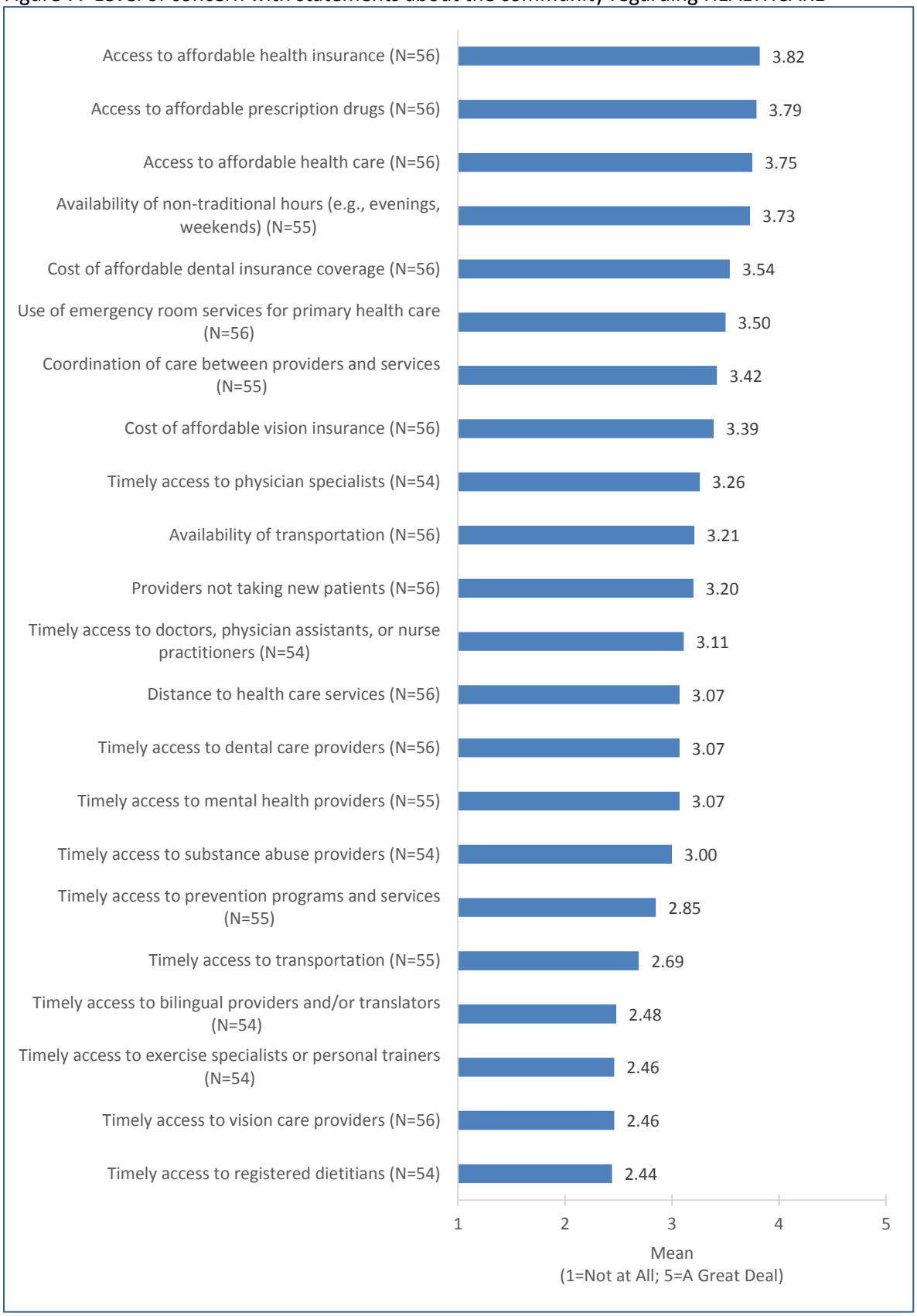


Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

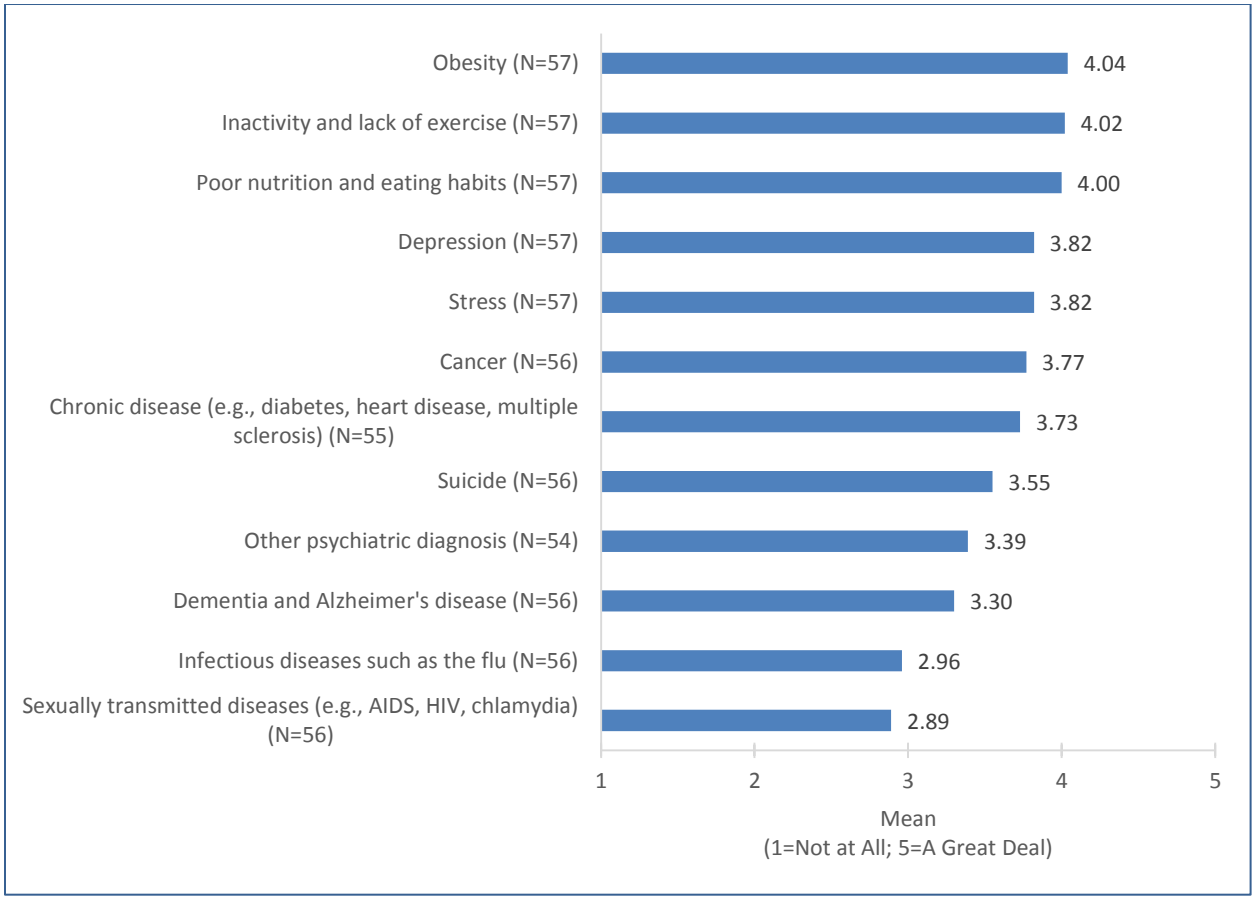


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

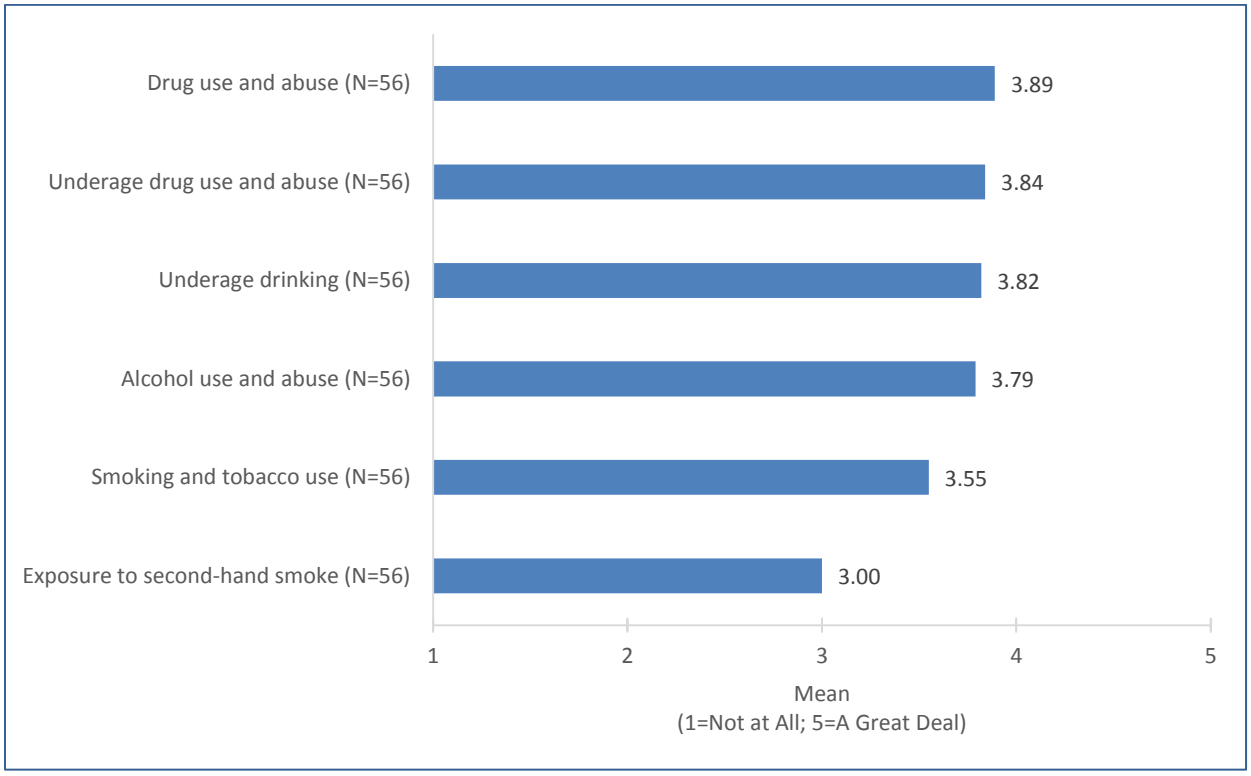
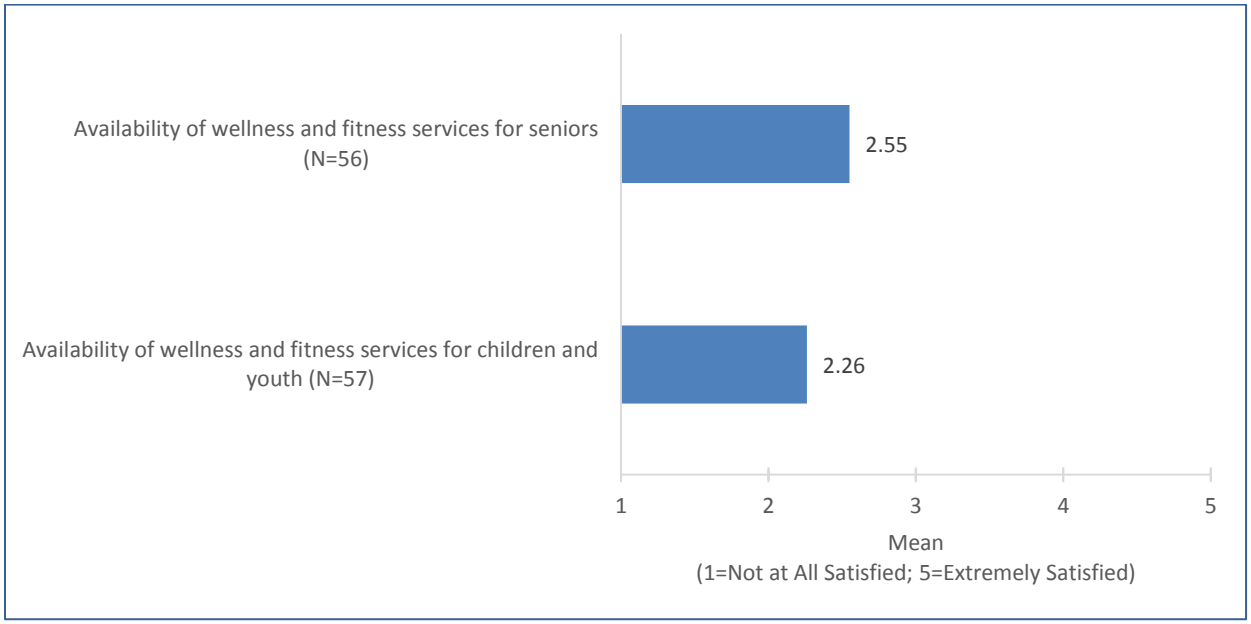
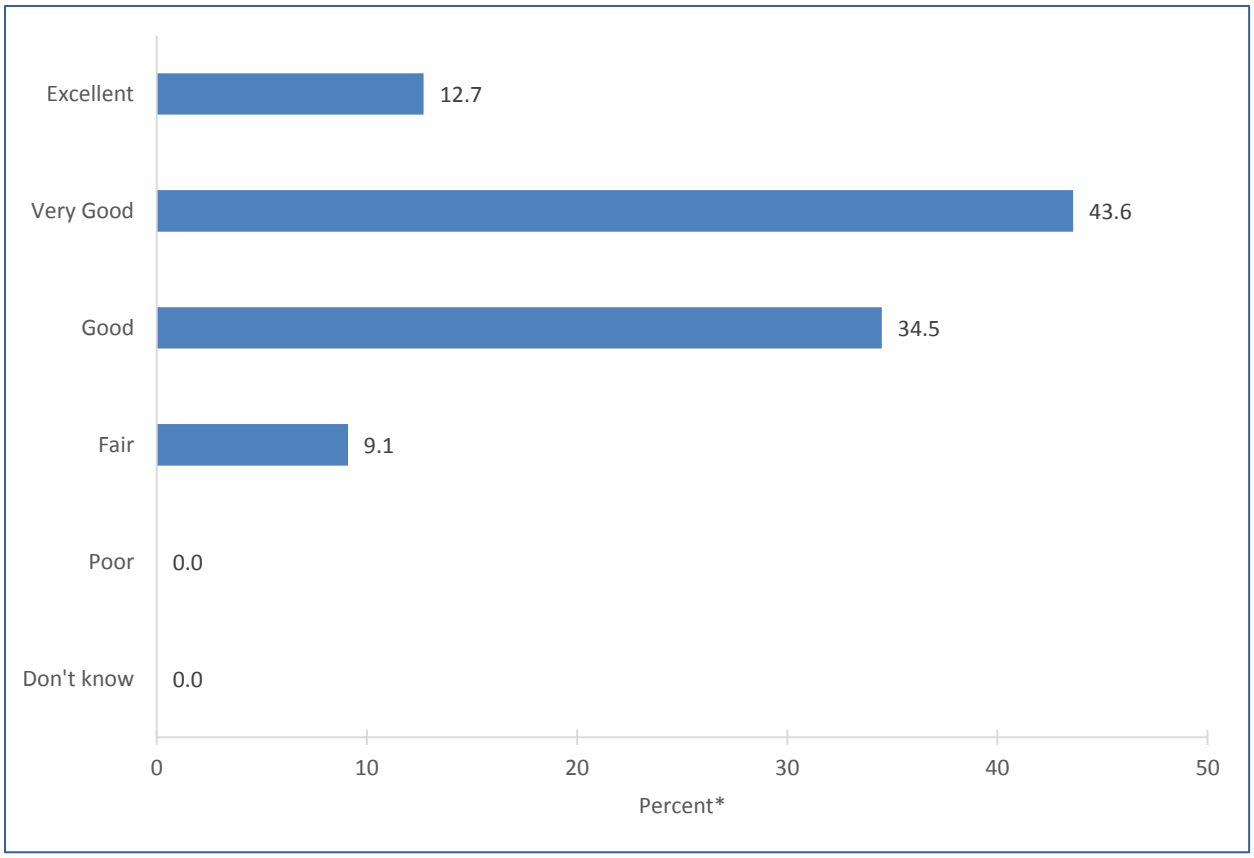


Figure 10. Level of satisfaction with the availability of wellness and fitness activities in the community



General Health

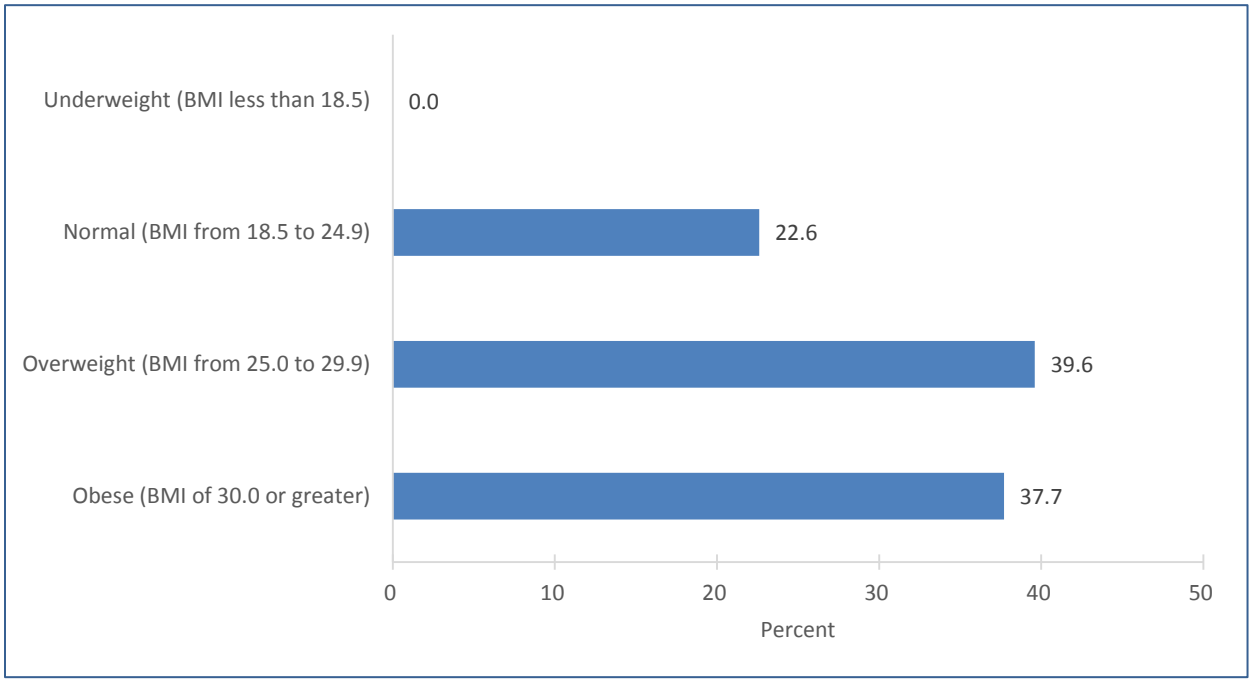
Figure 11. Respondents' rating of their health in general



N=55

*Percentages do not total 100.0 due to rounding

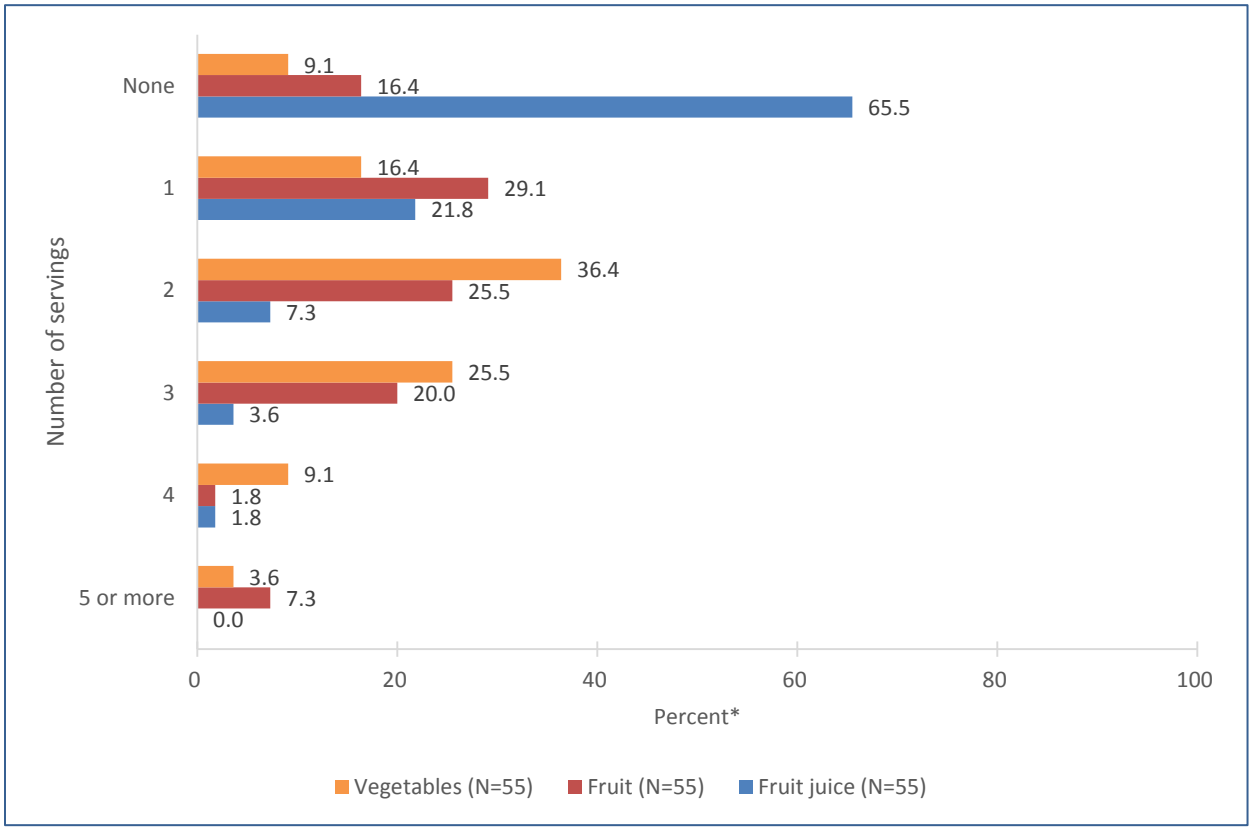
Figure 12. Respondents' weight status based on the Body Mass Index (BMI) scale



N=53

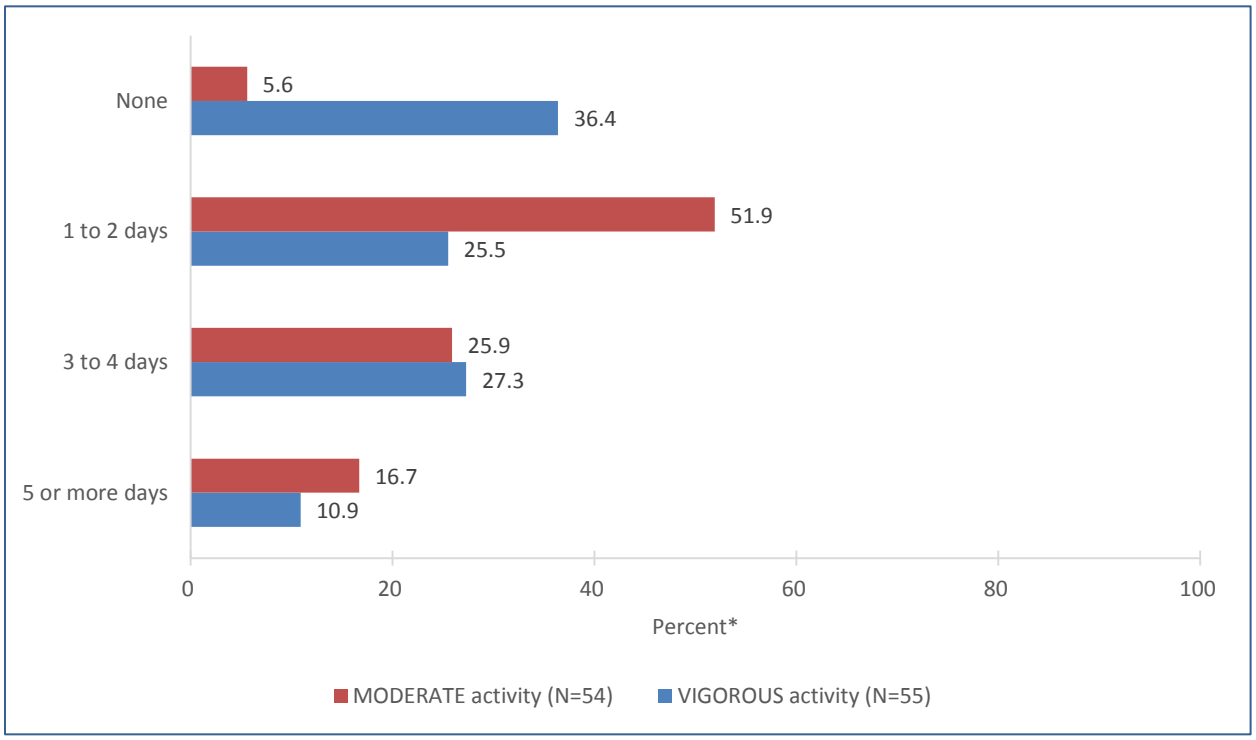
*For information about the BMI, visit the Centers for Disease Control and Prevention, *About BMI for Adults*, at http://www.cdc.gov/healthyweight/assessing/bmi/.

Figure 13. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday



*Percentages may not total 100.0 due to rounding.

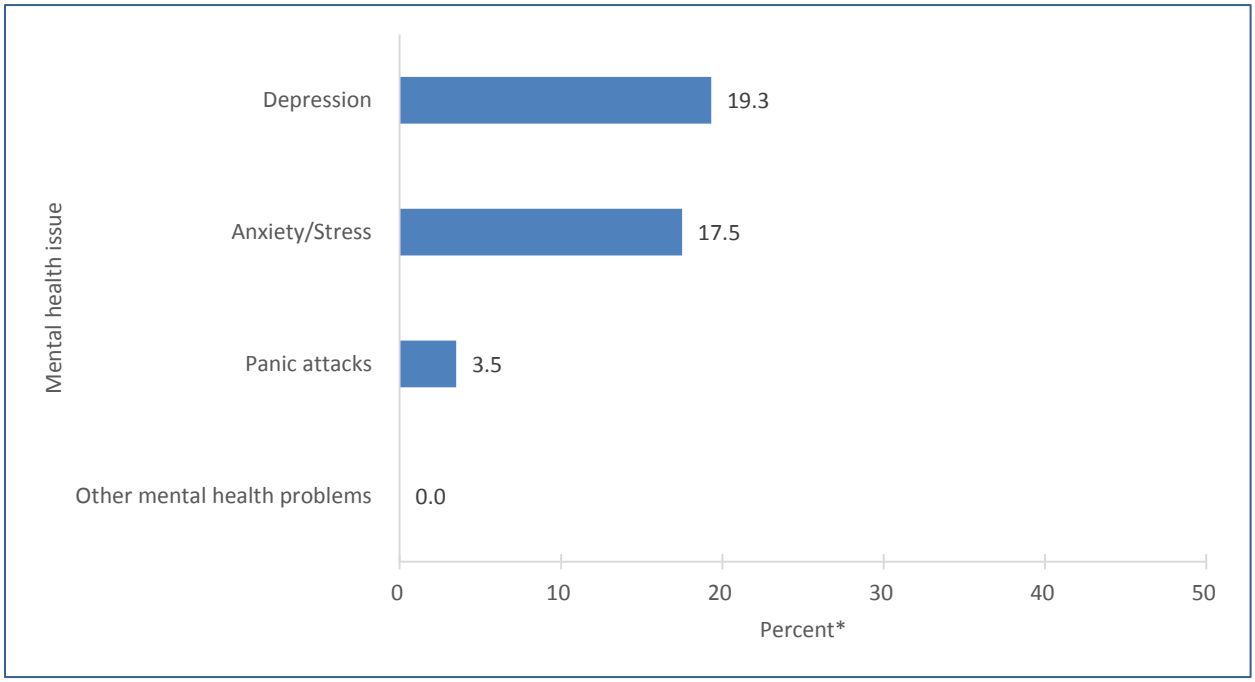
Figure 14. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



*Percentages may not total 100.0 due to rounding.

Mental Health

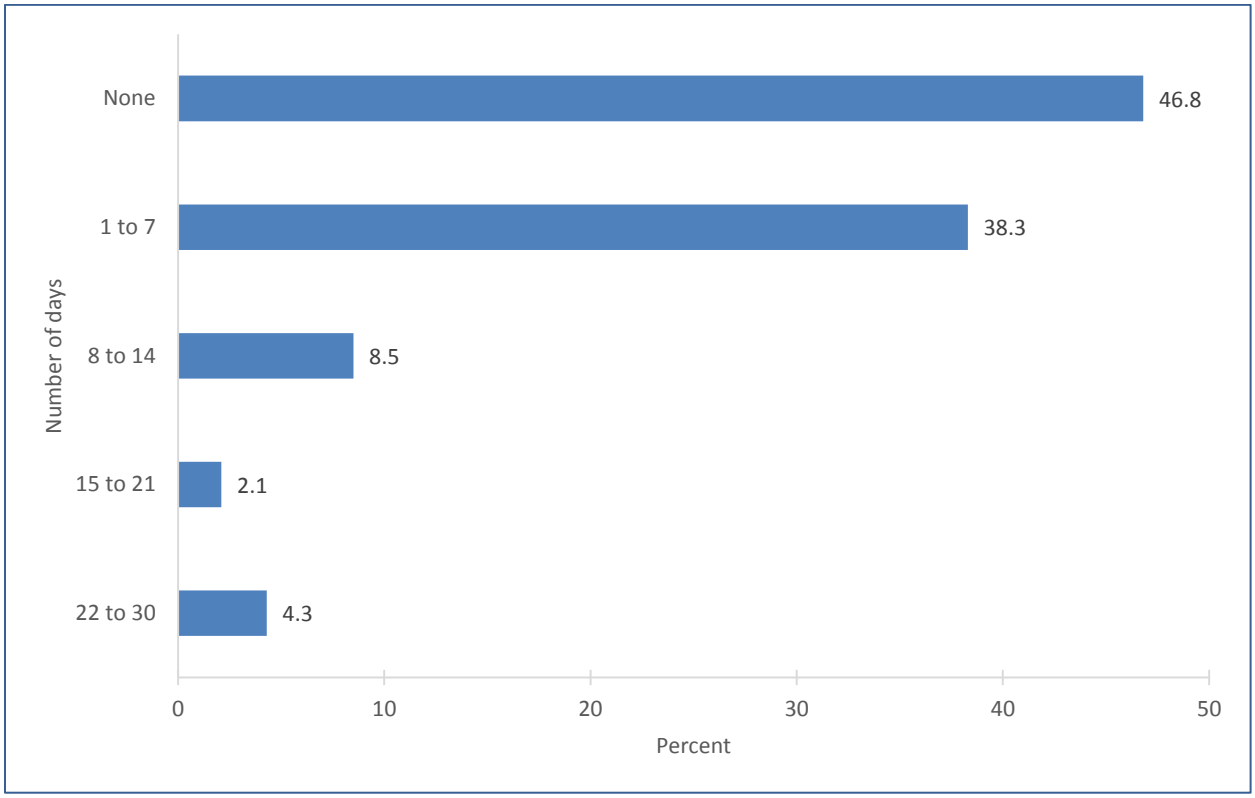
Figure 15. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=57

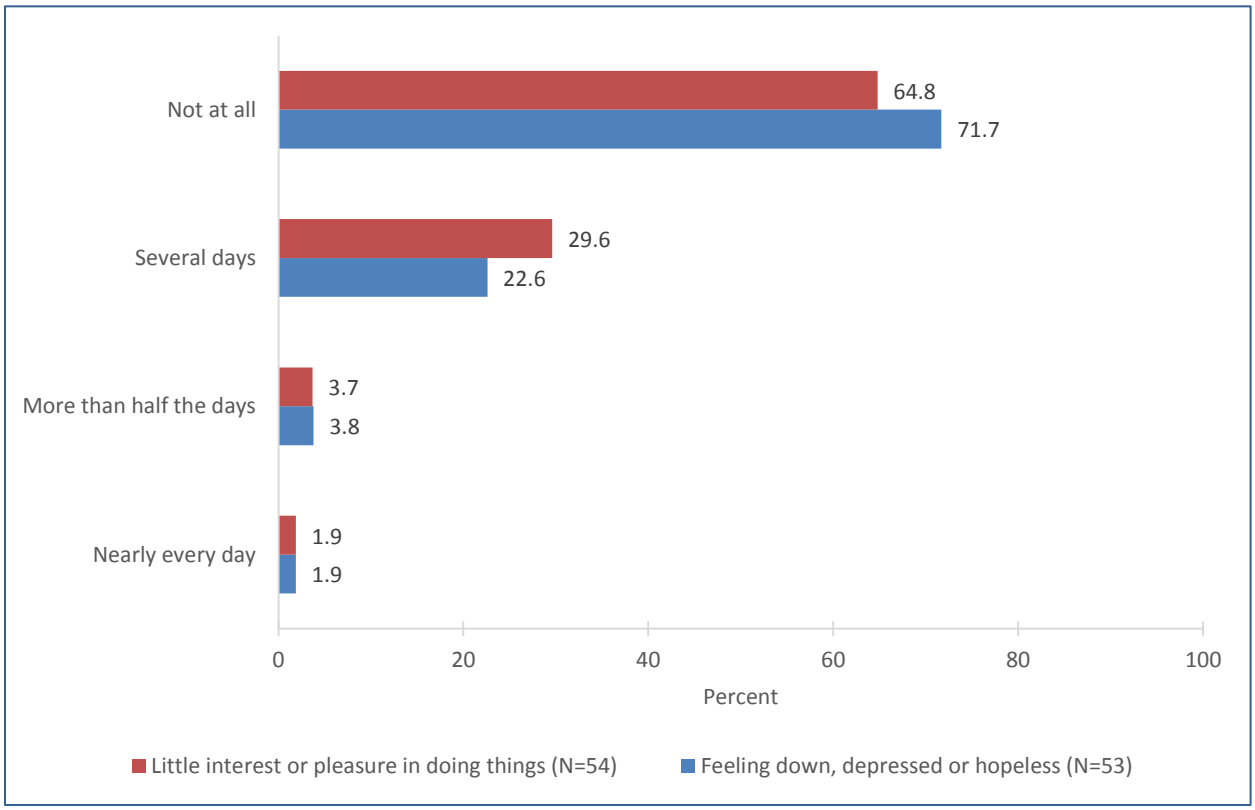
*Percentages do not total 100.0 due to multiple responses.

Figure 16. Number of days in the last month that respondents' mental health was not good



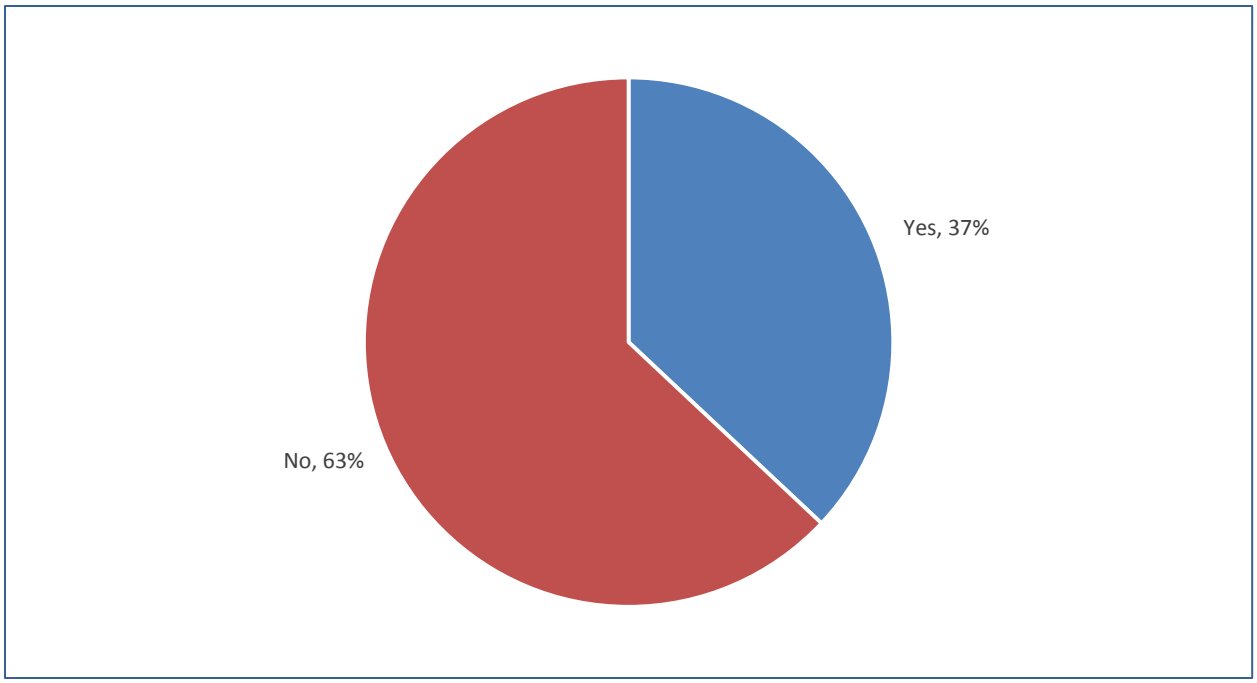
N=47

Figure 17. How often, over the past two weeks, respondents have been bothered by mental health issues



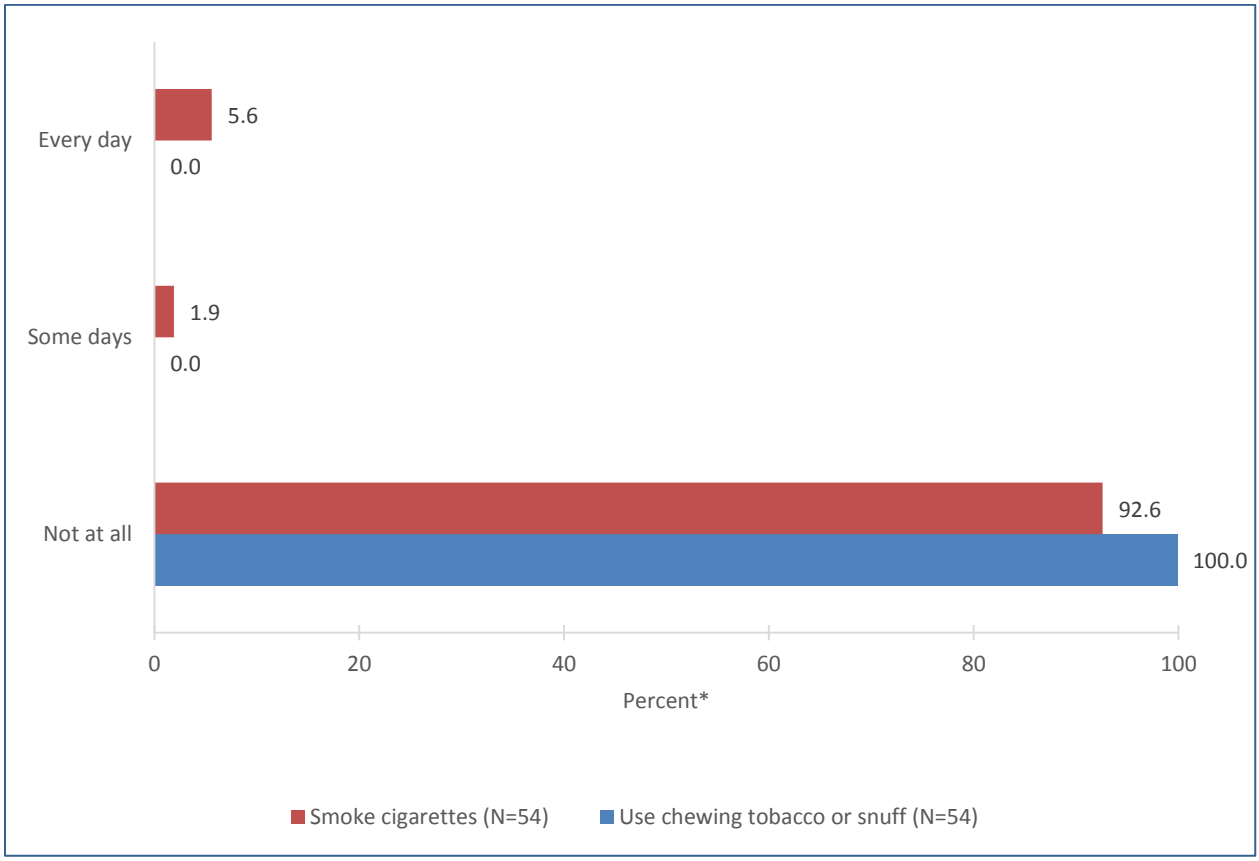
Tobacco Use

Figure 18. Whether respondents have smoked at least 100 cigarettes in their entire life



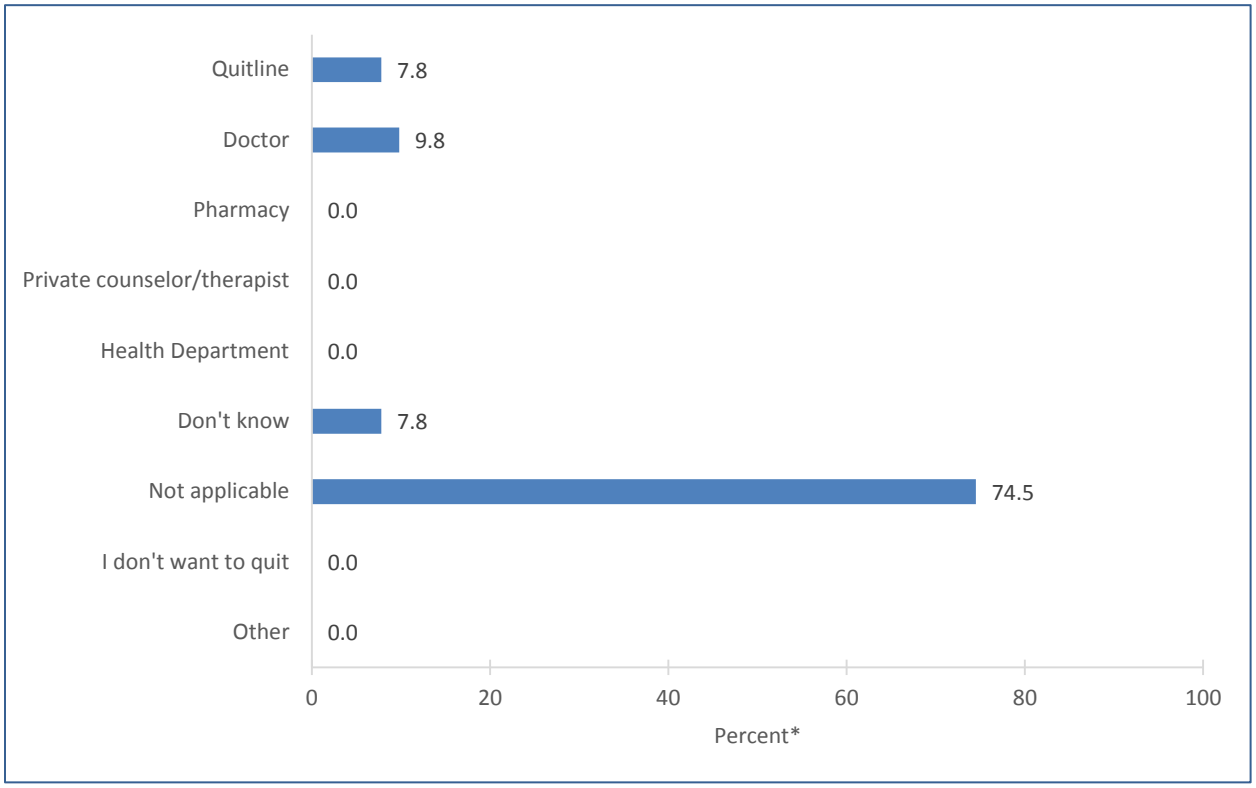
N=54

Figure 19. How often respondents currently smoke cigarettes and use chewing tobacco or snuff



*Percentages may not total 100.0 due to rounding

Figure 20. Location respondents would first go if they wanted help to quit using tobacco

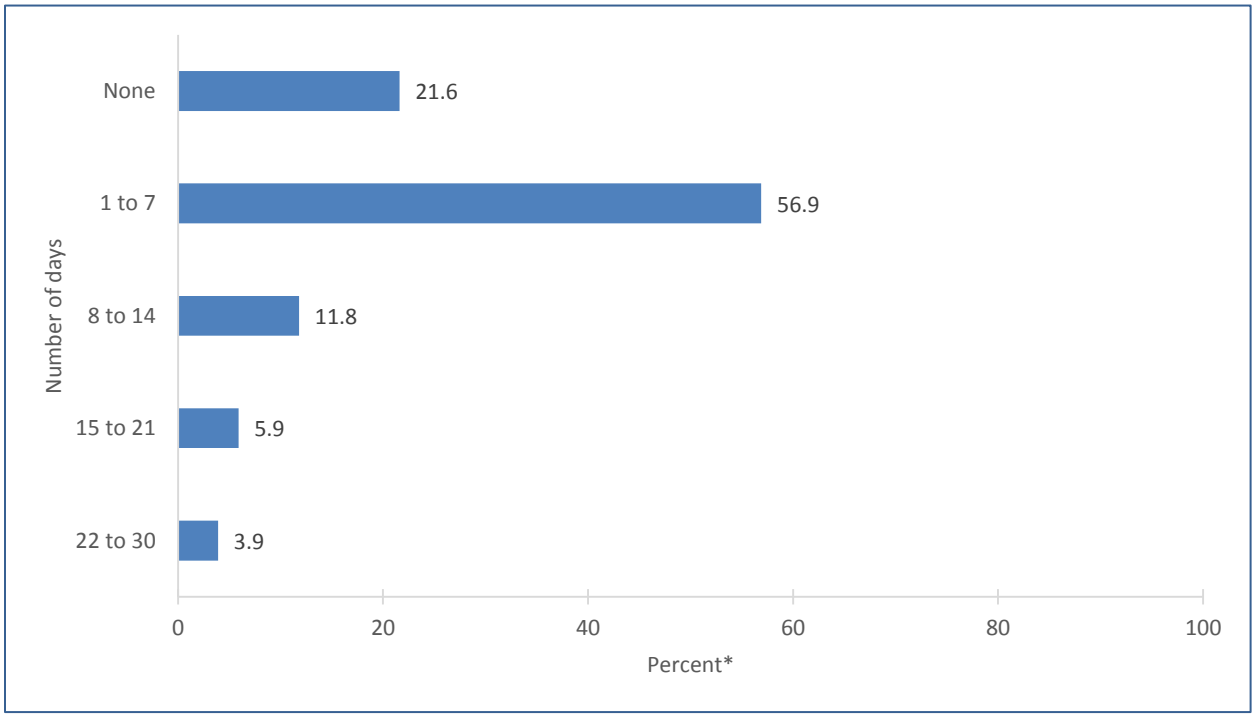


N=51

*Percentages do not total 100.0 due to rounding

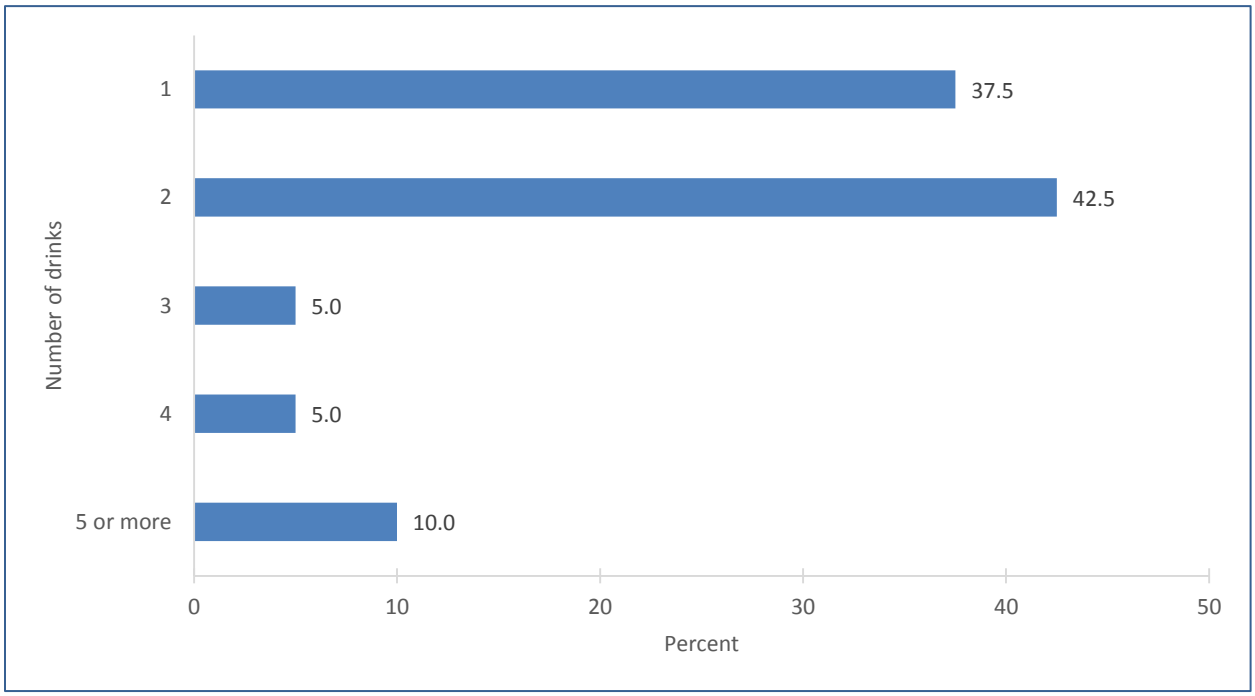
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

Figure 21. Number of days during the past month that respondents had at least one drink of any alcoholic beverage



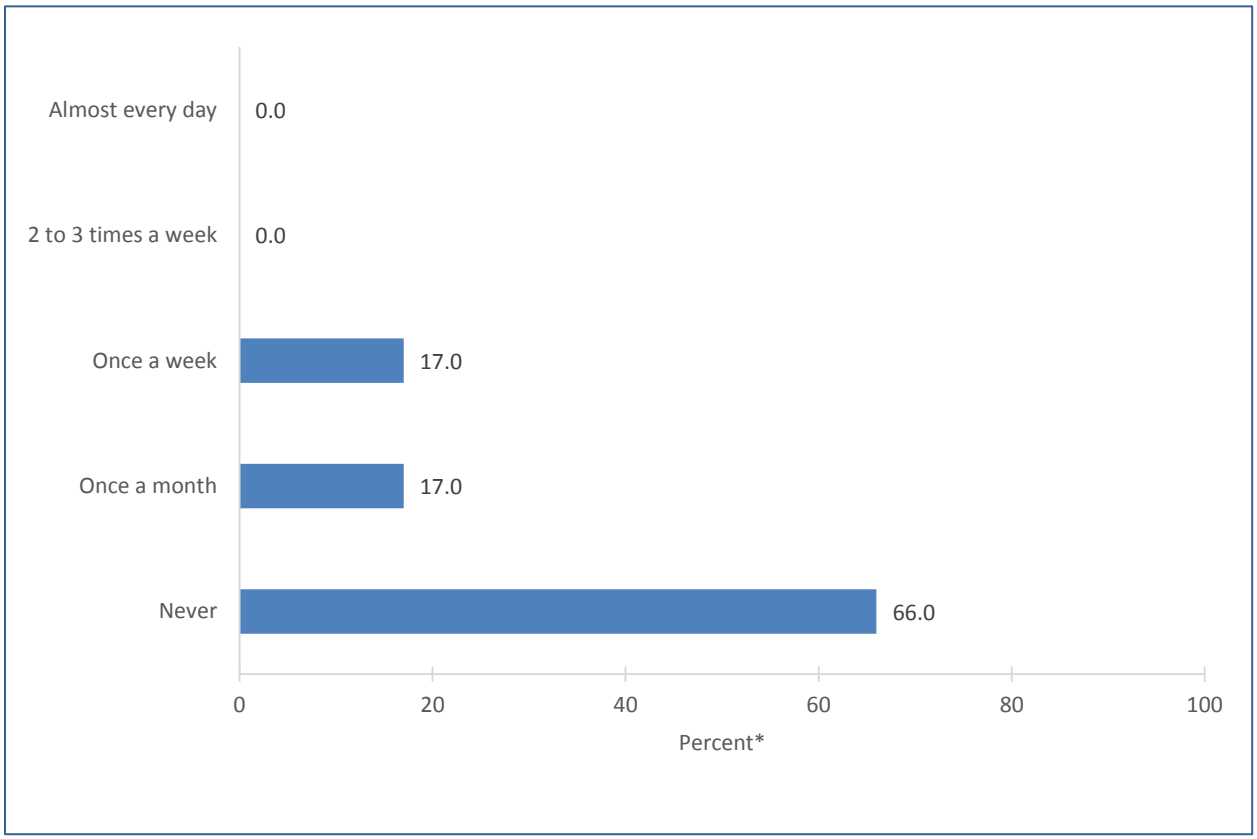
N=51 *Percentages do not total 100.0 due to rounding.

Figure 22. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=40

Figure 23. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion



N=53 *Percentages do not total 100.0 due to rounding

Figure 24. Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse

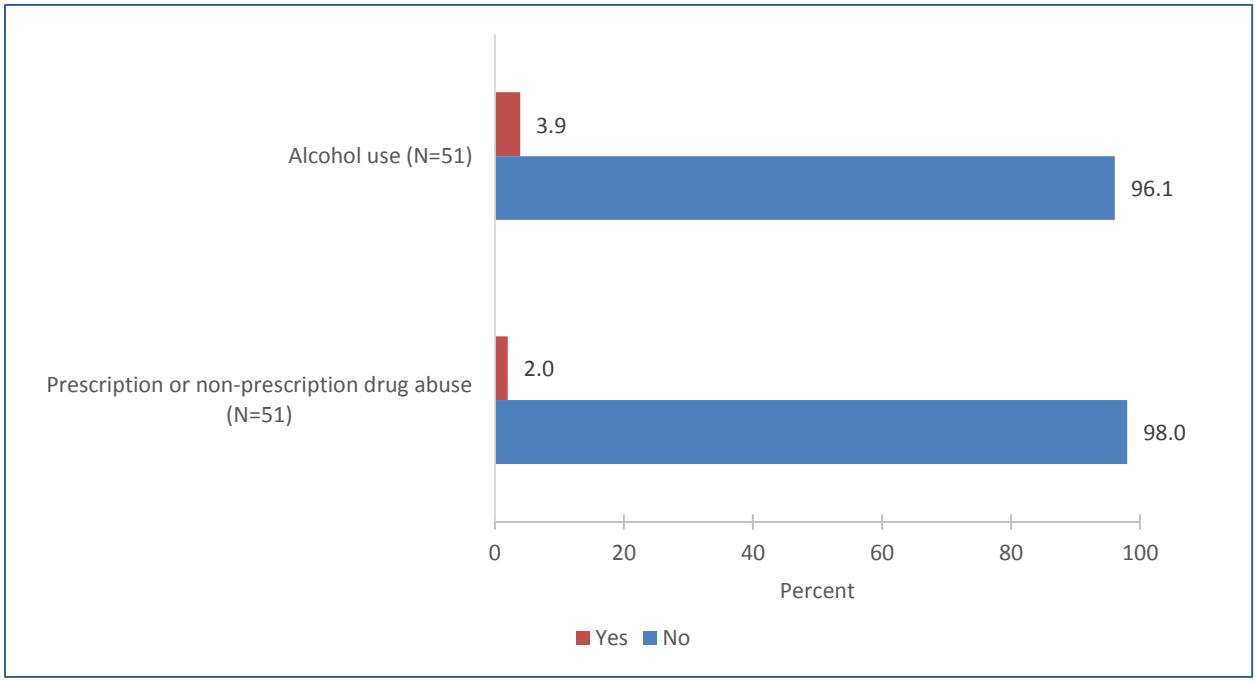


Figure 25. Of respondents who had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

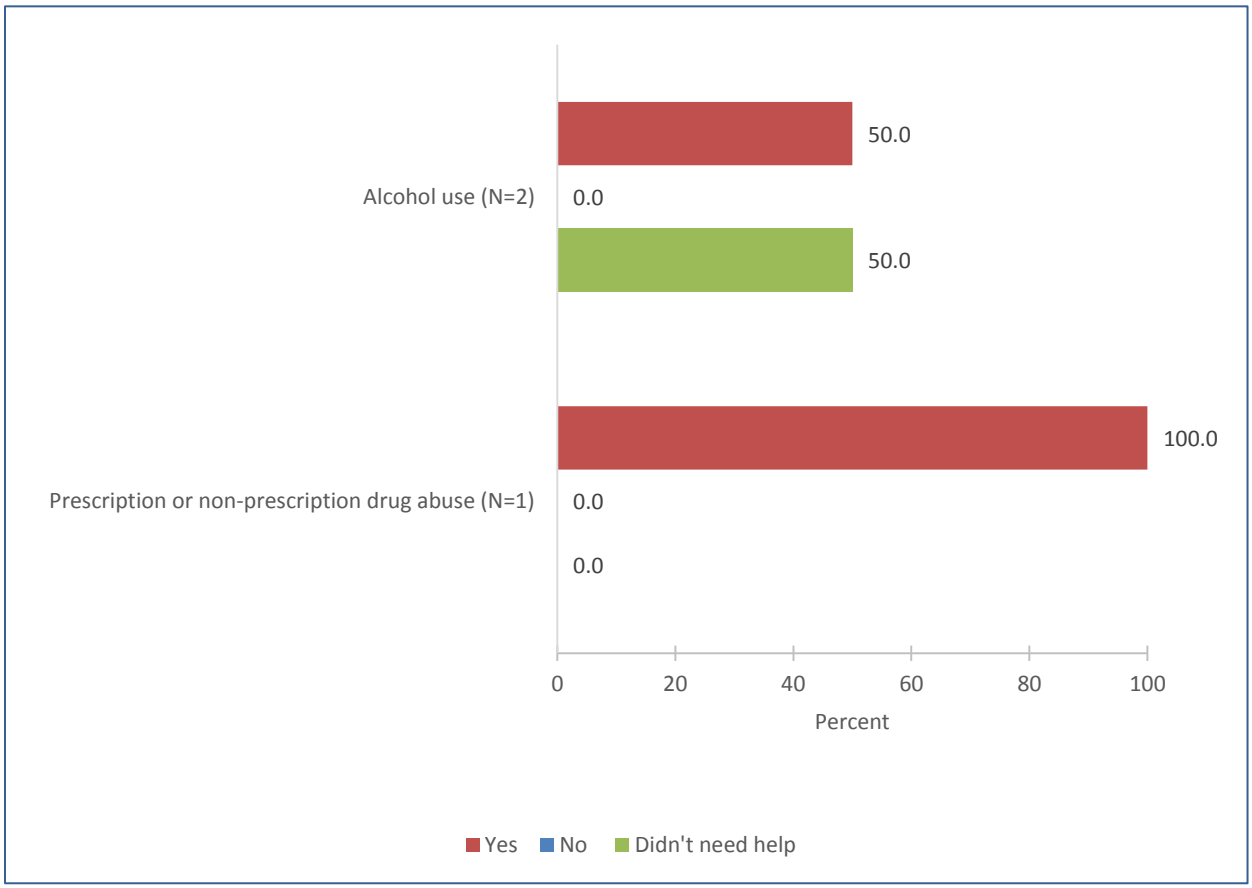
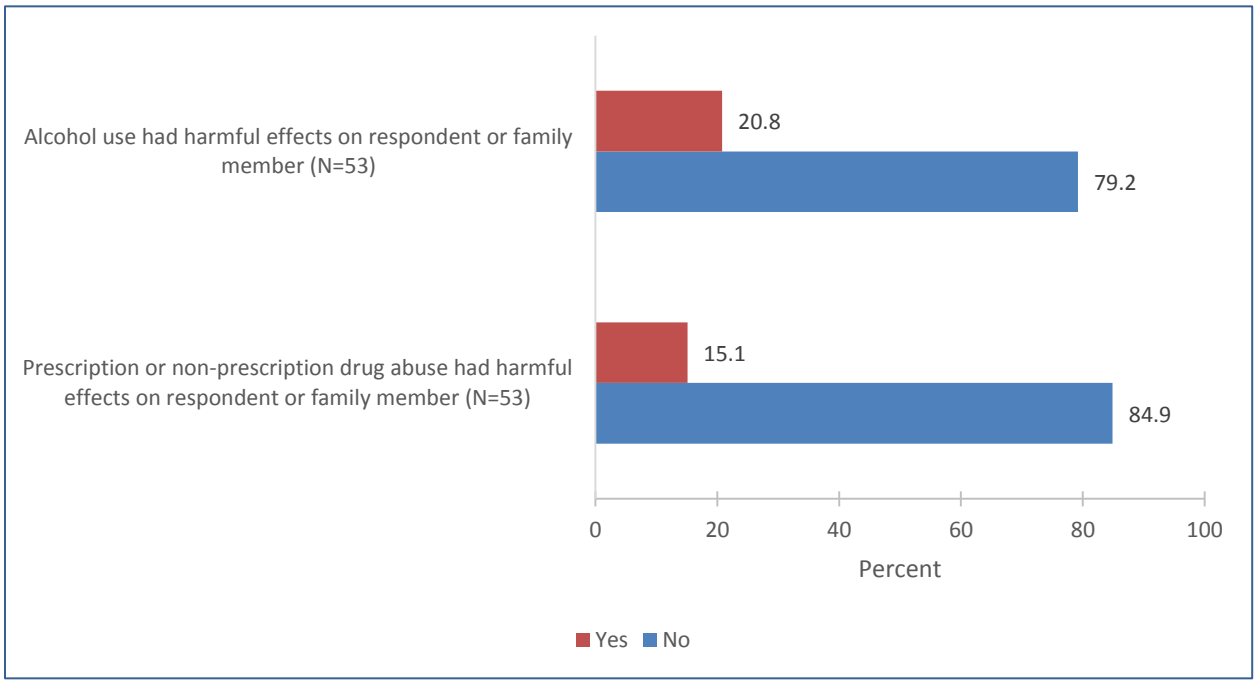


Figure 26. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

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

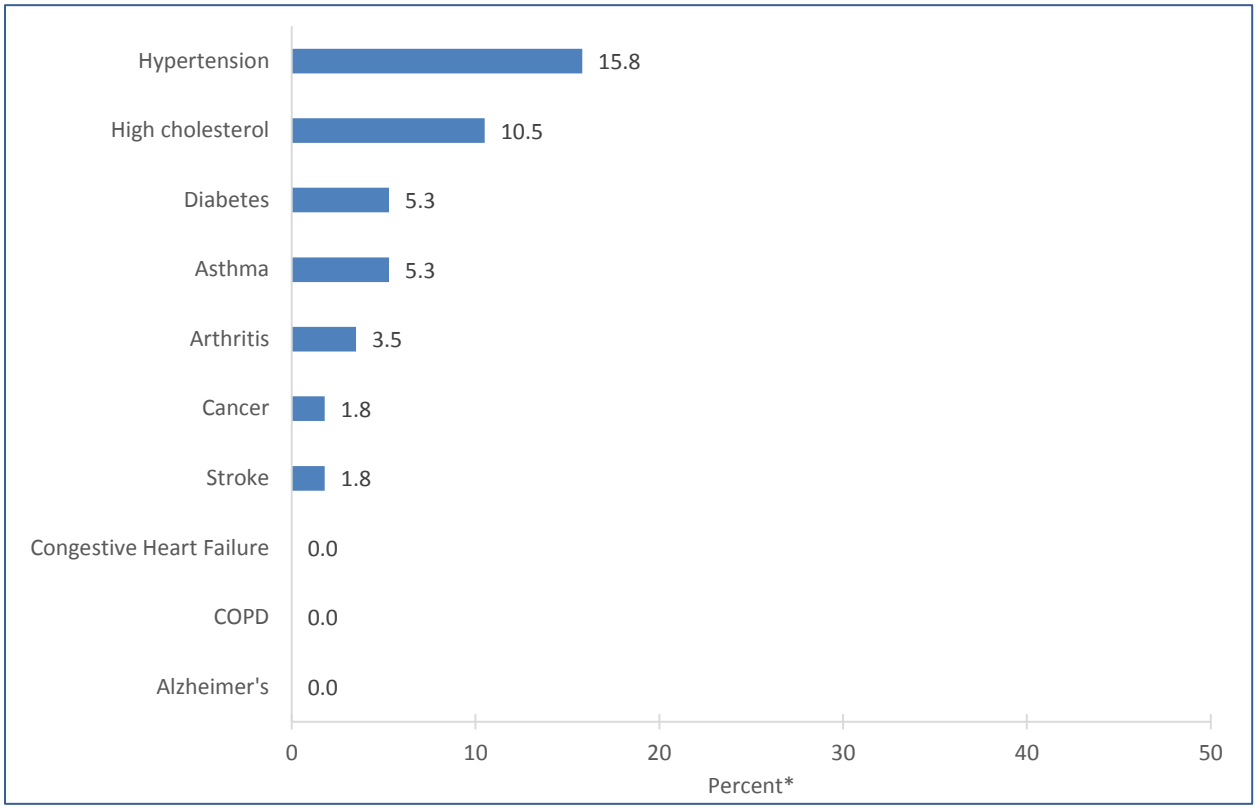
Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=53)	81.1	18.9	100.0
Blood sugar screening (N=52)	51.9	48.1	100.0
Bone density test (N=51)	7.8	92.2	100.0
Cardiovascular screening (N=51)	5.9	94.1	100.0
Cholesterol screening (N=52)	50.0	50.0	100.0
Dental screening and X-rays (N=53)	83.0	17.0	100.0
Flu shot (N=53)	92.5	7.5	100.0
Glaucoma test (N=53)	54.7	45.3	100.0
Hearing screening (N=51)	2.0	98.0	100.0
Immunizations (N=51)	17.6	82.4	100.0
Pelvic exam (N=37 Females)	67.6	32.4	100.0
STD (N=51)	3.9	96.1	100.0
Vascular screening (N=51)	3.9	96.1	100.0
CANCER SCREENINGS			
Breast cancer screening (N=37 Females)	48.6	51.4	100.0
Cervical cancer screening (N=36 Females)	58.3	41.7	100.0
Colorectal cancer screening (N=53)	22.6	77.4	100.0
Prostate cancer screening (N=16 Males)	31.3	68.8	100.1
Skin cancer screening (N=52)	23.1	76.9	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=10)	50.0	10.0	10.0	0.0	0.0	0.0	30.0
Blood sugar screening (N=25)	40.0	28.0	12.0	0.0	0.0	0.0	12.0
Bone density test (N=47)	53.2	34.0	2.1	0.0	0.0	0.0	4.3
Cardiovascular screening (N=48)	45.8	39.6	2.1	0.0	0.0	0.0	4.2
Cholesterol screening (N=26)	38.5	26.9	11.5	0.0	0.0	0.0	11.5
Dental screening and X-rays (N=9)	22.2	11.1	22.2	11.1	0.0	11.1	22.2
Flu shot (N=4)	50.0	0.0	0.0	0.0	0.0	0.0	50.0
Glaucoma test (N=24)	50.0	29.2	8.3	0.0	0.0	0.0	8.3
Hearing screening (N=50)	56.0	28.0	4.0	0.0	2.0	0.0	4.0
Immunizations (N=42)	66.7	19.0	0.0	0.0	0.0	2.4	7.1
Pelvic exam (N=12 Females)	25.0	16.7	25.0	0.0	0.0	0.0	33.3
STD (N=49)	77.6	12.2	0.0	0.0	0.0	0.0	4.1
Vascular screening (N=49)	53.1	34.7	2.0	0.0	0.0	0.0	6.1
CANCER SCREENINGS							
Breast cancer screening (N=19)	68.4	10.5	5.3	0.0	5.3	0.0	15.8
Cervical cancer screening (N=15 Females)	53.3	6.7	13.3	0.0	0.0	0.0	20.0
Colorectal cancer screening (N=41)	63.4	14.6	4.9	2.4	0.0	0.0	9.8
Prostate cancer screening (N=11 Males)	36.4	36.4	0.0	0.0	9.1	0.0	9.1
Skin cancer screening (N=40)	52.5	32.5	2.5	0.0	2.5	0.0	7.5

*Percentages do not total 100.0 due to multiple responses.

Figure 27. Whether respondents have any of the following chronic diseases



N=57

*Percentages do not total 100.0 due to multiple responses.

Figure 28. Length of time since respondents last visited a doctor or healthcare provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason

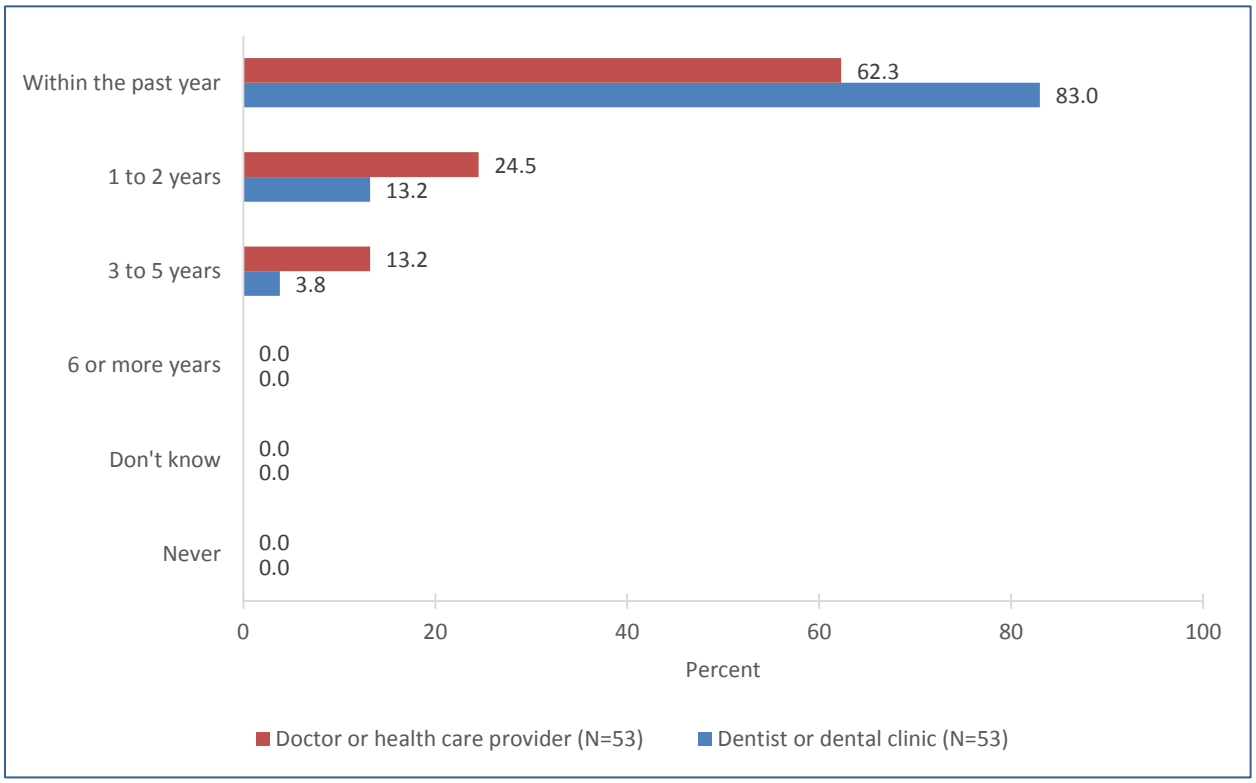
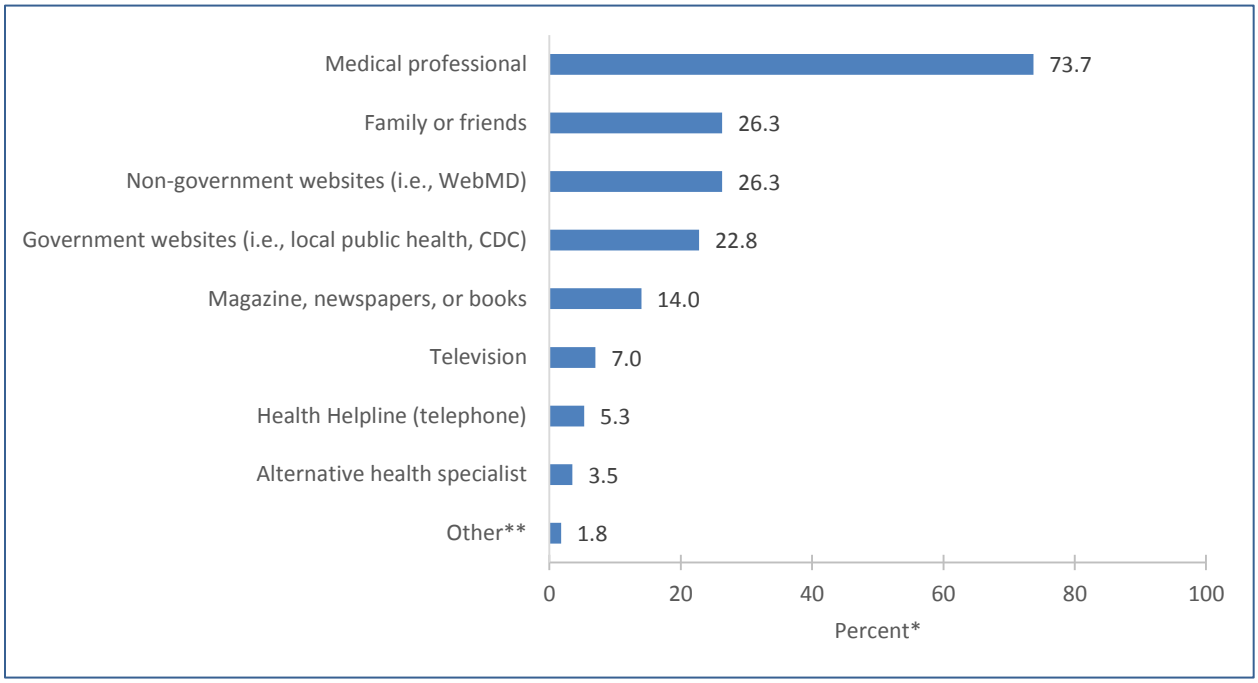
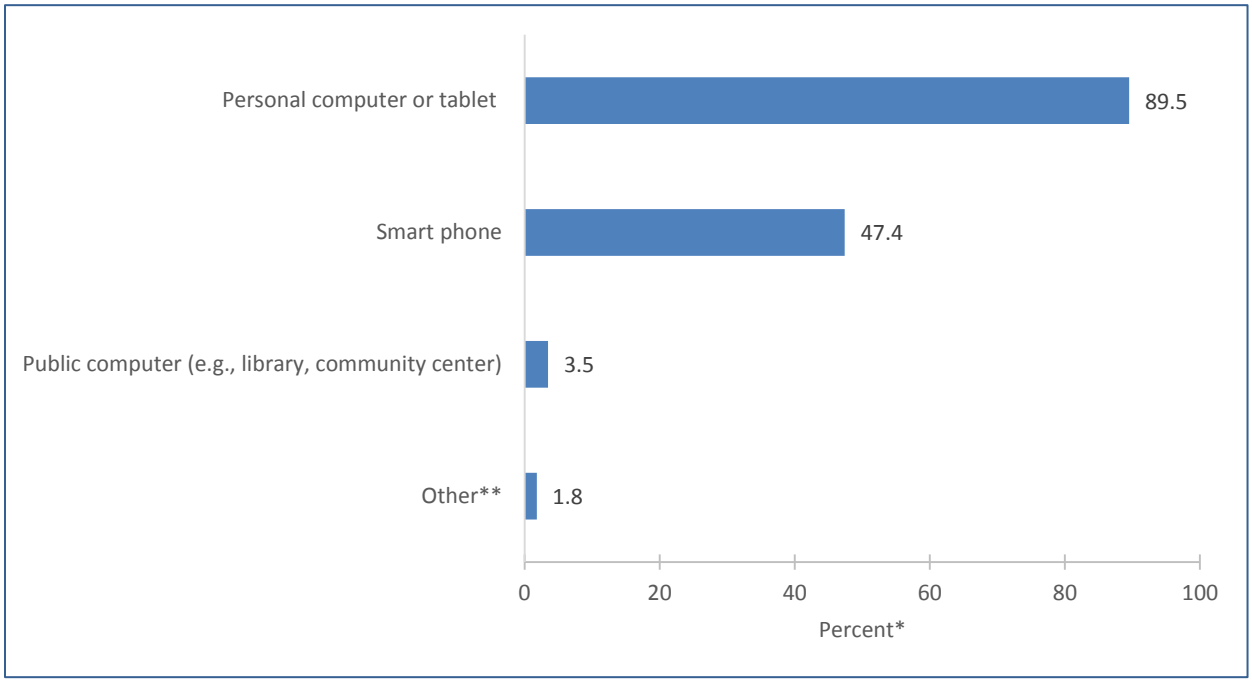


Figure 29. Where respondents get most of their health information



N=57 *Percentages do not total 100.0 due to multiple responses.
**Other response is "At work – I work for public health".

Figure 30. Best way for respondents to access technology for health information



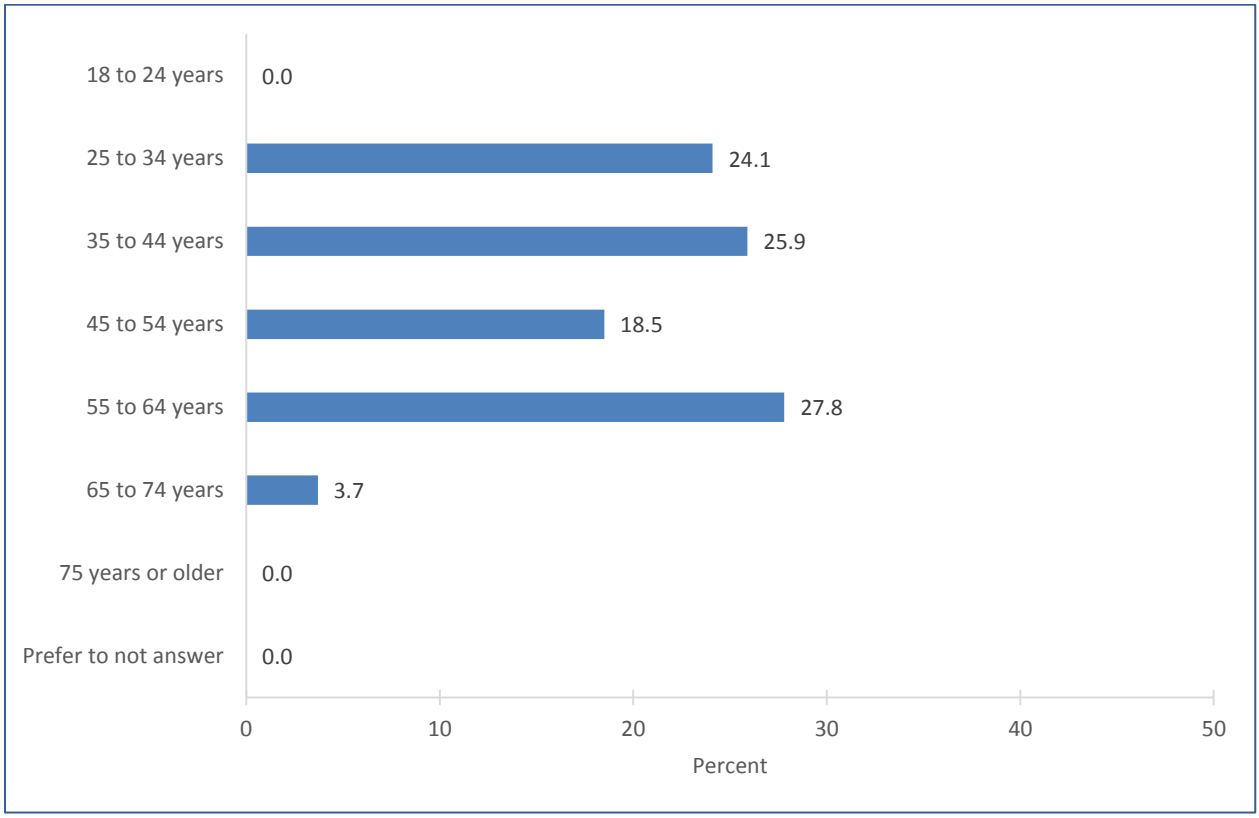
N=57

*Percentages do not total 100.0 due to multiple responses.

**Other response is “at work”.

Demographic Information

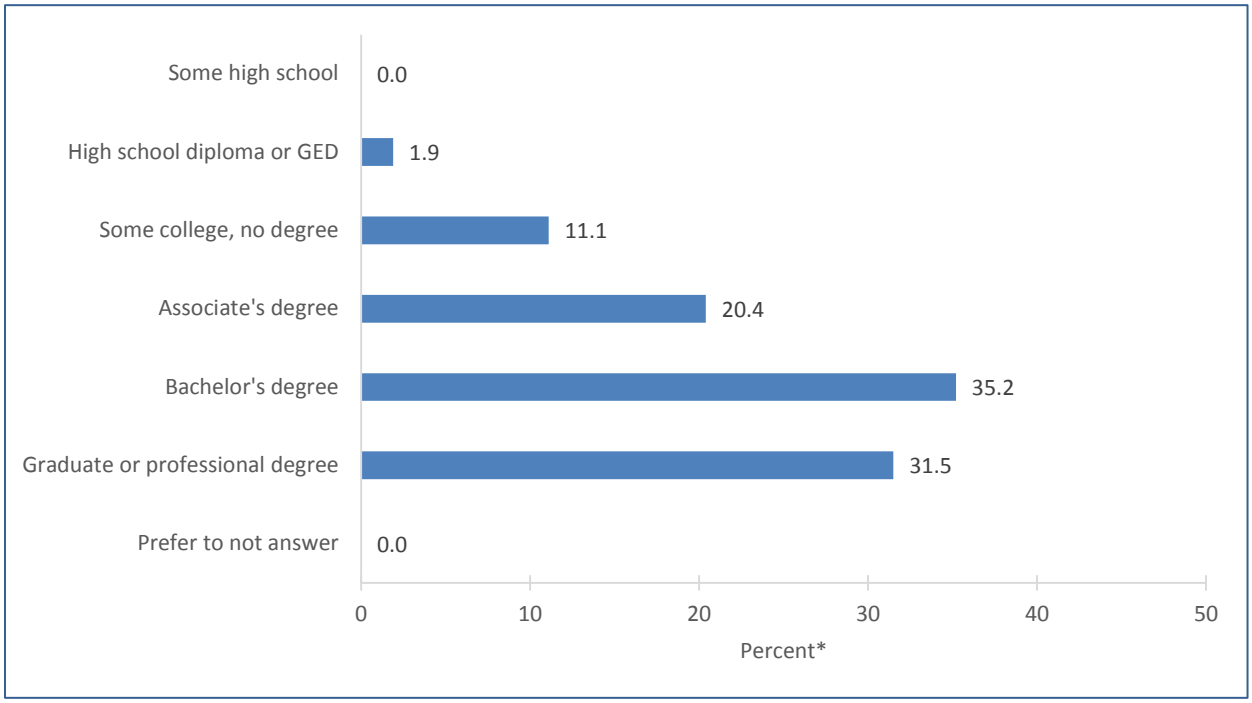
Figure 31. Age of respondents



N=54

*Percentages do not total 100.0 due to rounding

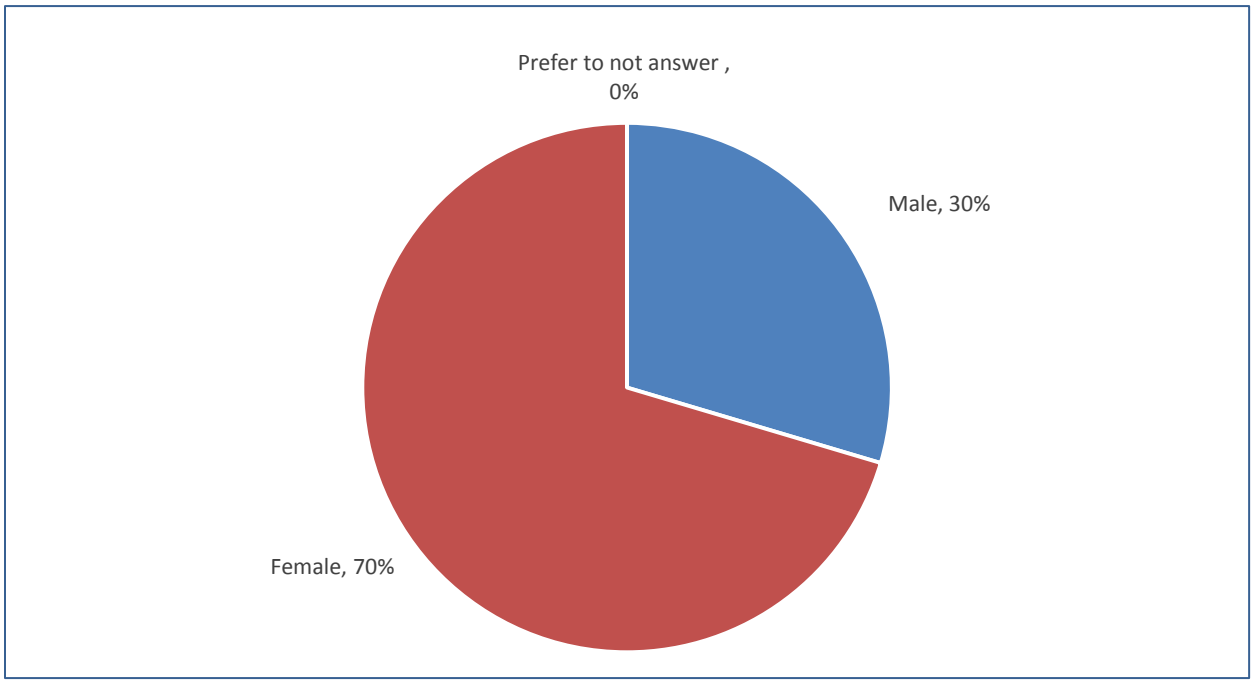
Figure 32. Highest level of education of respondents



N=54

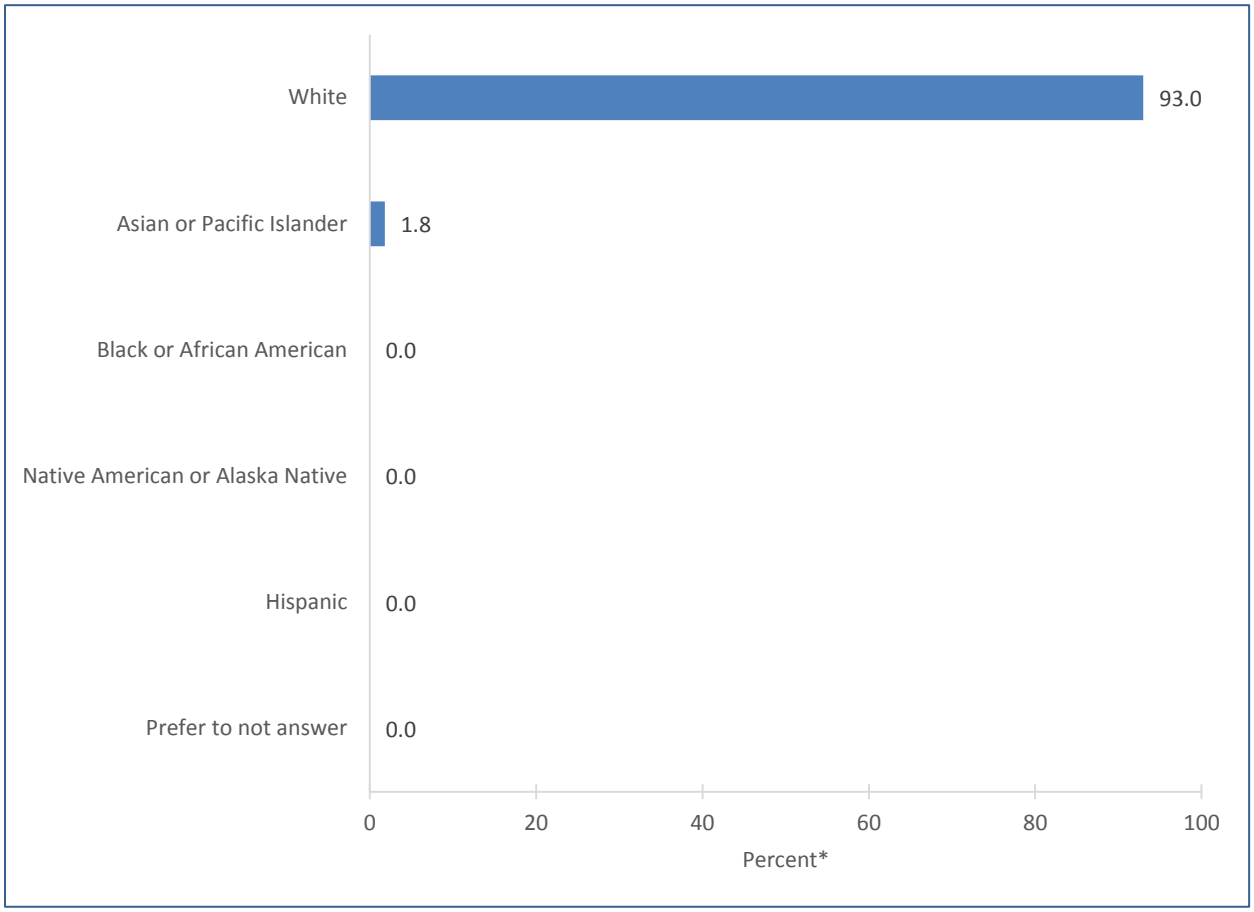
*Percentages do not total 100.0 due to rounding.

Figure 33. Gender of respondents



N=54

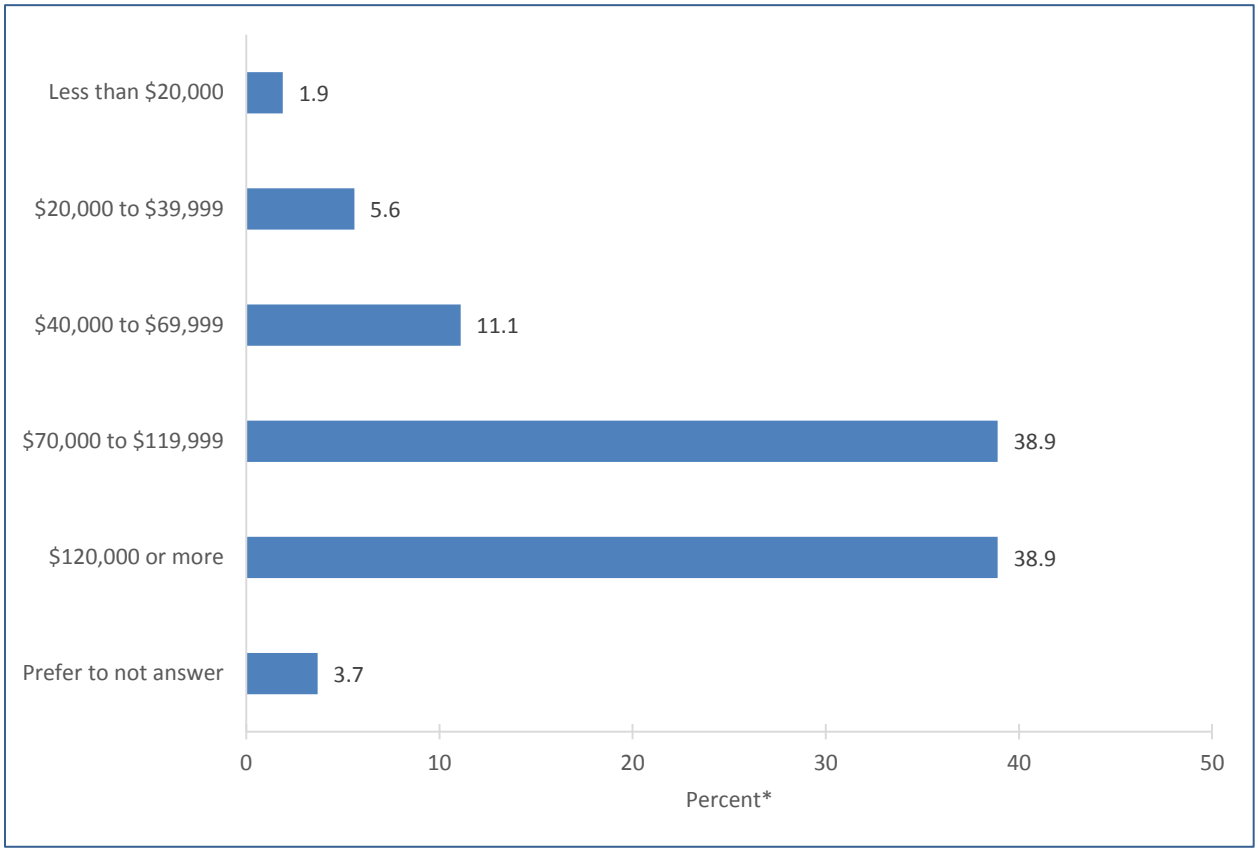
Figure 34. Race and ethnicity of respondents



N=57

*Percentages do not total 100.0 due to multiple responses

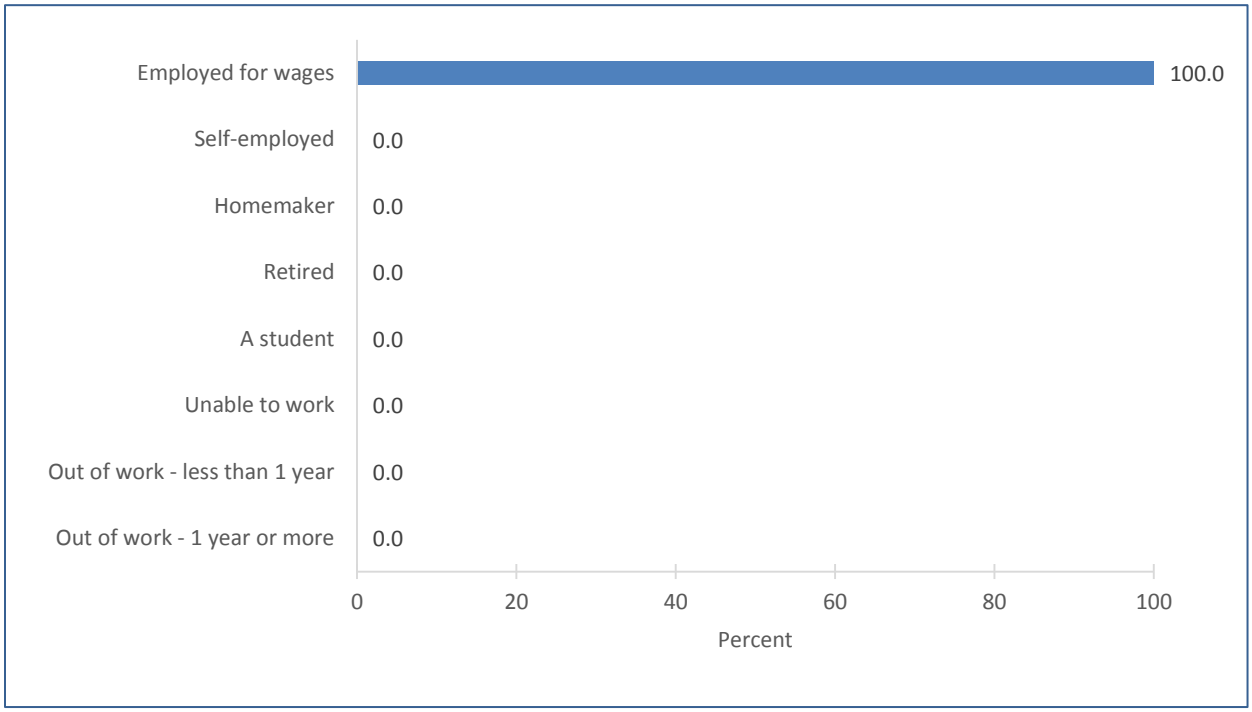
Figure 35. Respondents' annual household income



N=54

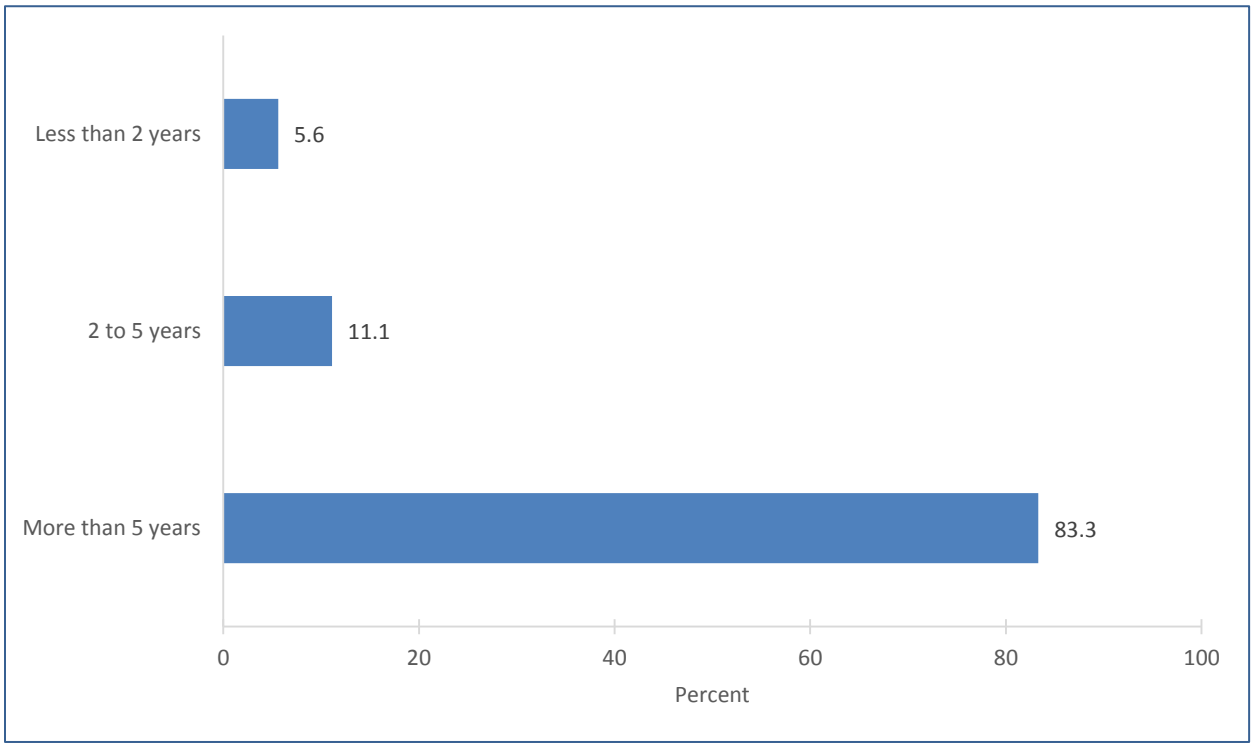
*Percentages do not total 100.0 due to rounding.

Figure 36. Employment status of respondents



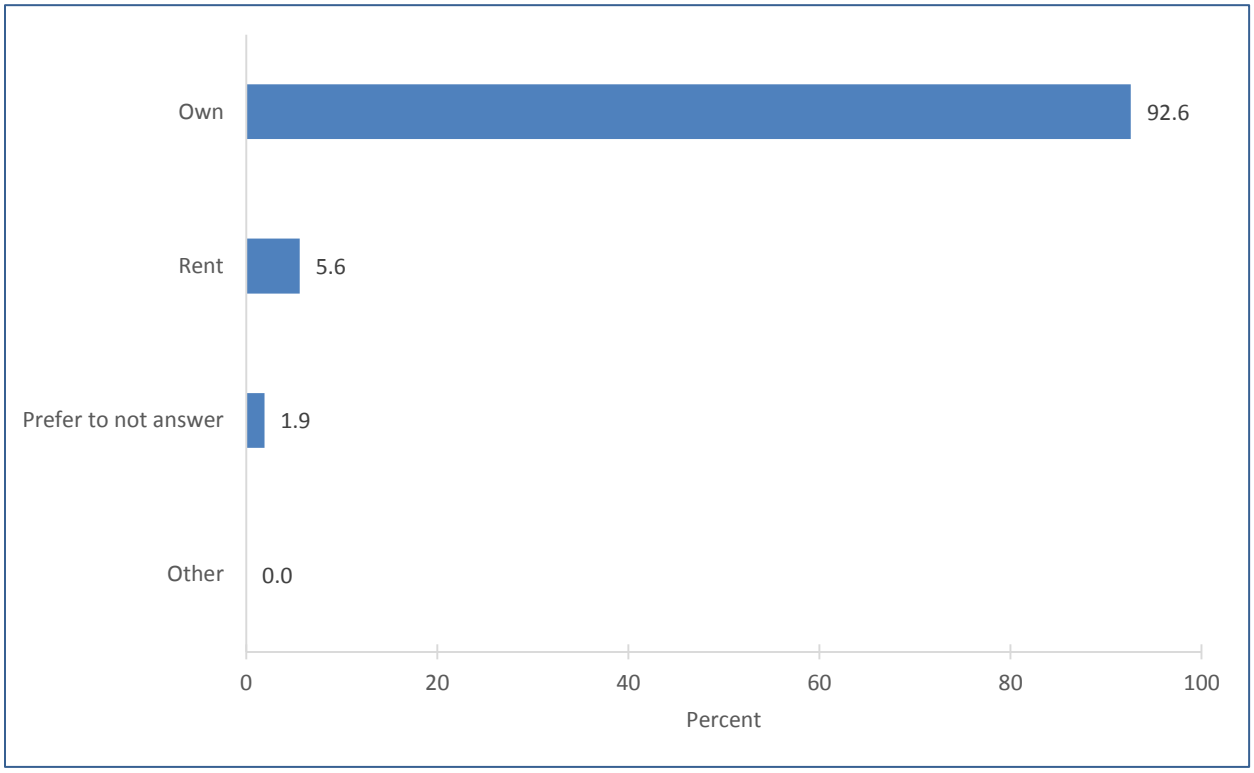
N=54

Figure 37. Length of time respondents have lived in their community



N=54

Figure 38. Whether respondents own or rent their home



N=54

*Percentages do not total 100.0 due to rounding.

Figure 39. Whether respondents have health insurance (private, public, or governmental) and oral health or dental care insurance coverage

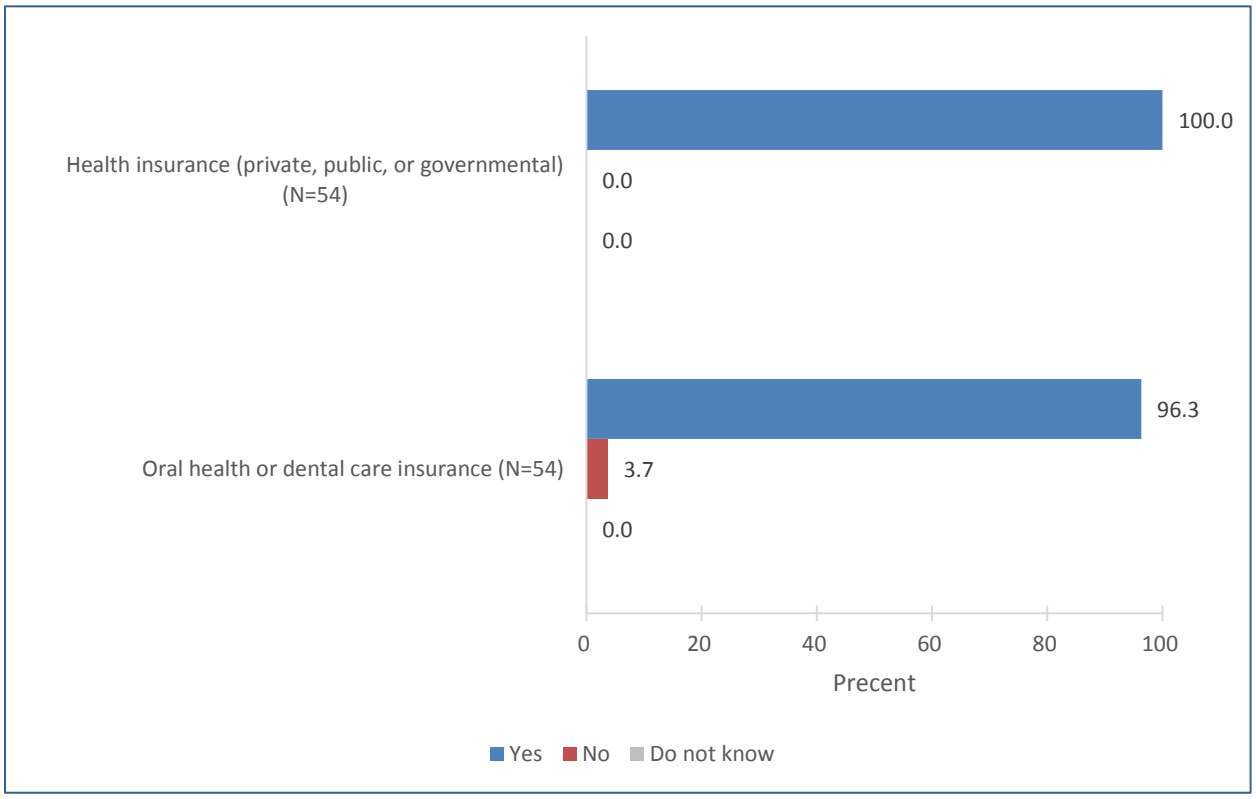
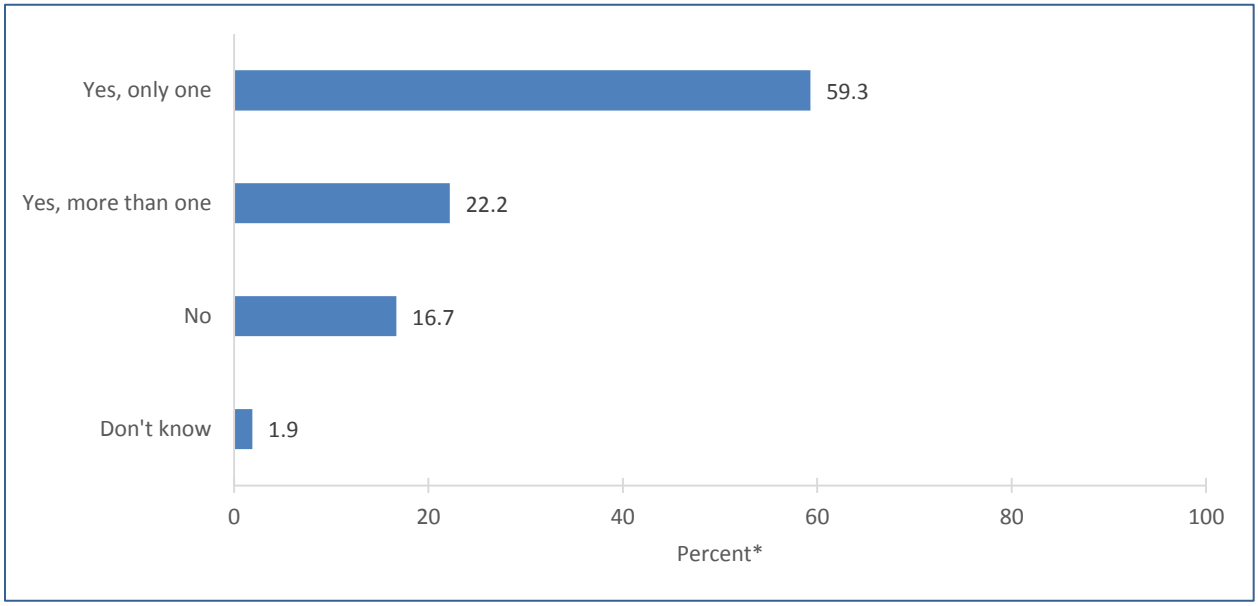


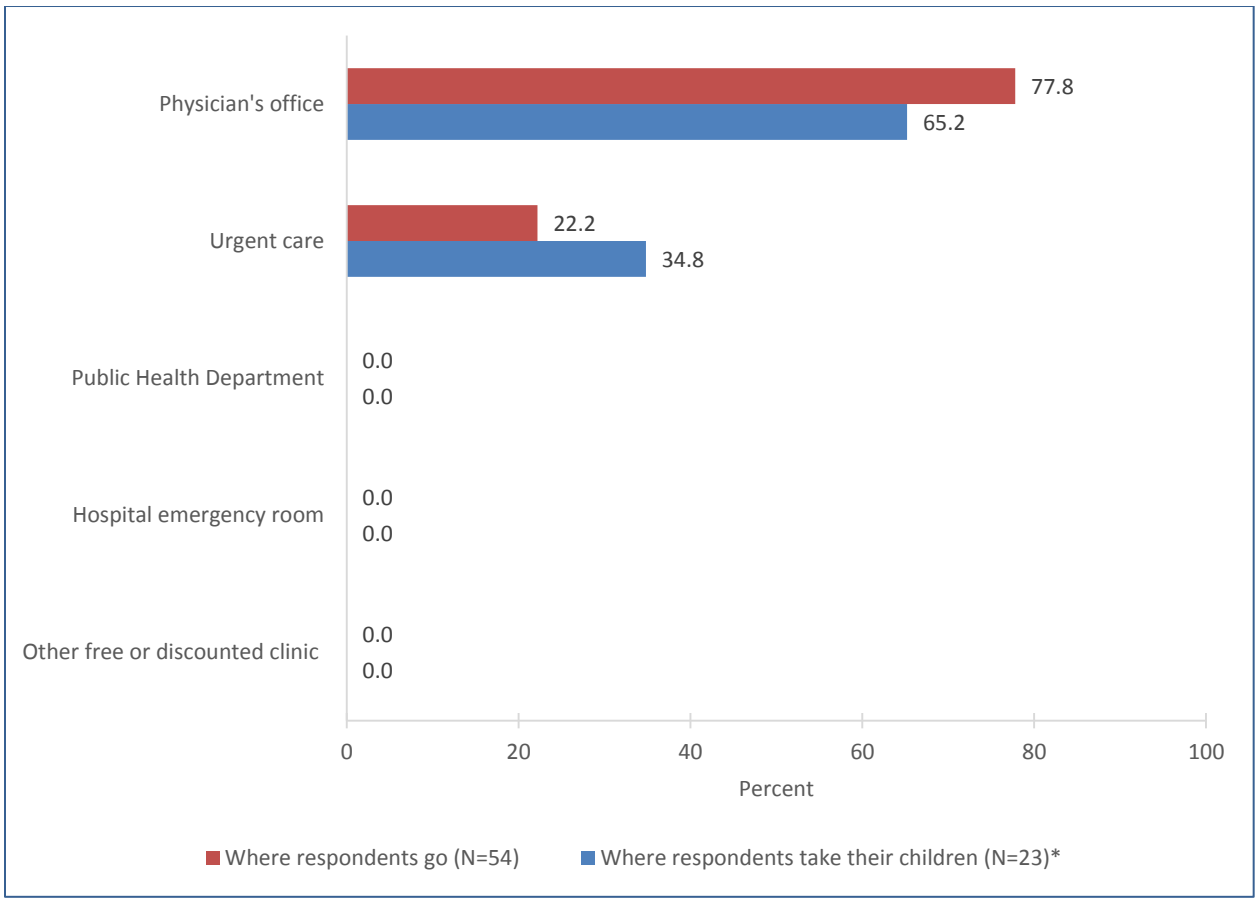
Figure 40. Whether respondents have one person who they think of as their personal doctor or healthcare provider



N=54

*Percentages do not total 100.0 due to rounding.

Figure 41. Facilities that respondents go to most often when sick and take their children when they are sick



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

Figure 42. Number of children younger than 18 and number of adults age 65 or older living in respondents' household

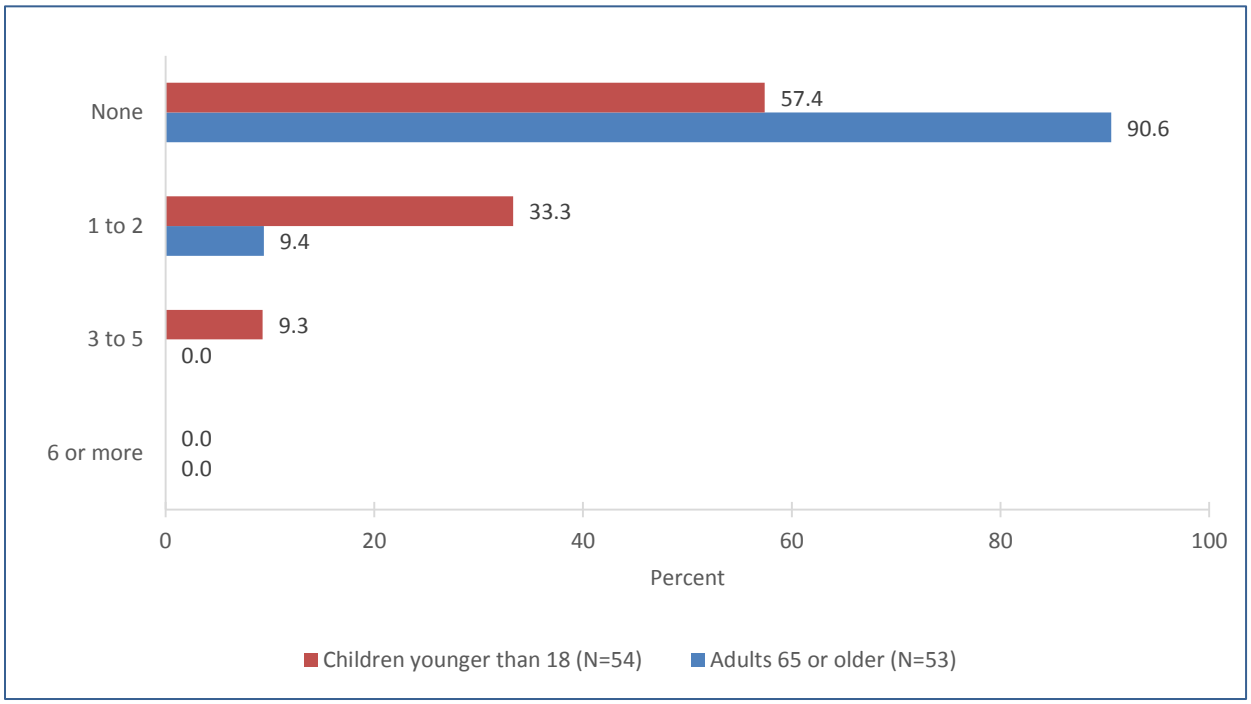
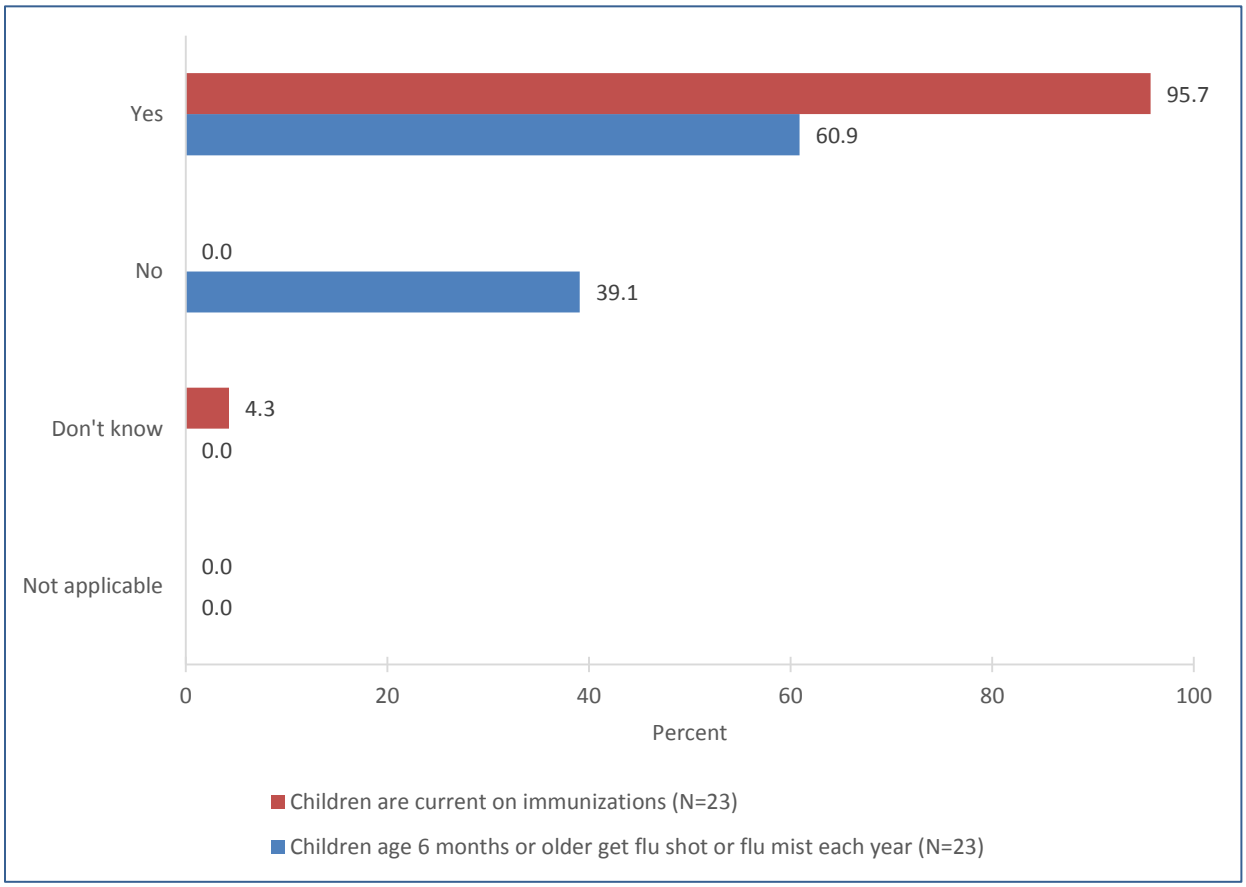


Figure 43. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



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

Table 3. Zip code of respondents

Zip code	Number of respondents
56701	44
56738	2
56754	2
56732	1
56737	1
56742	1
56762	1
58103	1
58201	1
Missing	3

N=57

Definitions of Key Indicators

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

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

Contents:

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

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

Measure	Data Elements	Description
Geographic identifiers	**FIPS**	Federal Information Processing Standard
	State	
	County	
Premature death	# Deaths	Number of deaths under age 75
	Years of Potential Life Lost Rate	Age-adjusted YPLL rate per 100,000
	95% CI – Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Poor or fair health	Sample Size	Number of respondents
	% Fair/Poor	Percent of adults that report fair or poor health
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

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

Measure	Data Elements	Description
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Alcohol-impaired driving deaths	# Alcohol-Impaired Driving Deaths	Number of alcohol-impaired motor vehicle deaths
	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases / Population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	Teen Births	Teen birth count, ages 15-19
	Teen Population	Female population, ages 15-19
	Teen Birth Rate	Teen births / females ages 15-19 * 1,000
	95% CI - Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance
	95% CI - Low	95% confidence interval reported by SAHIE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	PCP Rate	(Number of PCP/population)*100,000
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	(Number of dentists/population)*100,000
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	(Number of MHP/population)*100,000
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	# Medicare Enrollees	Number of Medicare enrollees
	Preventable Hosp. Rate	Discharges for Ambulatory Care Sensitive Conditions/Medicare Enrollees * 1,000
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetic monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c

Measure	Data Elements	Description
		test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in poverty	# Children in Poverty	Number of children (under age 18) living in poverty
	% Children in Poverty	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations / Population * 10,000

Measure	Data Elements	Description
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes/population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
	95% CI - Low	95% confidence interval as reported by the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	Pop. In Viol	Average annual population affected by a water violation
	% Pop in Viol	Population affected by a water violation/Total population with public water
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	# Households with Severe Problems	Number of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	# Drive Alone	Number of people who drive alone to work
	# Workers	Number of workers in labor force
	% Drive Alone	Percentage of workers who drive alone to work
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Long commute - driving alone	# Workers who Drive Alone	Number of workers who commute in their car, truck or van alone
	% Long Commute - Drives Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)

Pennington County

	Pennington County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Health Outcomes						61
Length of Life						63
Premature death	6,045		4,660-7,431	5,200	5,038	
Quality of Life						60
Poor or fair health				10%	11%	
Poor physical health days	2.8		1.4-4.2	2.5	2.8	
Poor mental health days	2.5		1.1-3.9	2.3	2.6	
Low birthweight	6.5%		5.2-7.9%	5.9%	6.5%	
Health Factors						25
Health Behaviors						31
Adult smoking	19%		12-29%	14%	16%	
Adult obesity	26%		21-32%	25%	26%	
Food environment index	8.5			8.4	8.3	
Physical inactivity	22%		17-27%	20%	19%	
Access to exercise opportunities	70%			92%	85%	
Excessive drinking	20%		13-31%	10%	19%	
Alcohol-impaired driving deaths	29%			14%	31%	
Sexually transmitted infections	171			138	336	
Teen births	30		24-37	20	24	
Clinical Care						33
Uninsured	9%		8-11%	11%	9%	

	Pennington County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Primary care physicians	1,279:1			1,045:1	1,113:1	
Dentists	2,017:1			1,377:1	1,529:1	
Mental health providers	743:1			386:1	529:1	
Preventable hospital stays	56		45-67	41	45	
Diabetic monitoring	87%		69-100%	90%	88%	
Mammography screening	78.7%		56.4-100.0%	70.7%	66.7%	
Social & Economic Factors						43
High school graduation	88%				78%	
Some college	69.3%		61.9-76.8%	71.0%	73.3%	
Unemployment	5.7%			4.0%	5.1%	
Children in poverty	15%		11-19%	13%	14%	
Income inequality	4.2		3.8-4.6	3.7	4.3	
Children in single-parent households	27%		20-34%	20%	28%	
Social associations	19.2			22.0	13.2	
Violent crime	131			59	229	
Injury deaths	66		48-88	50	56	
Physical Environment						3
Air pollution - particulate matter	11.8			9.5	12.0	
Drinking water violations	0%			0%	1%	
Severe housing problems	8%		6-10%	9%	15%	

	Pennington County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Driving alone to work	73%		70-77%	71%	78%	
Long commute - driving alone	11%		9-13%	15%	29%	
* 90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data						2015

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