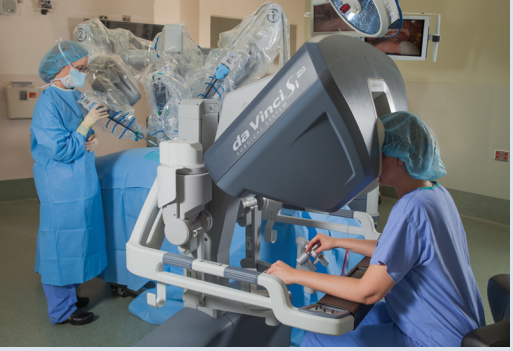


















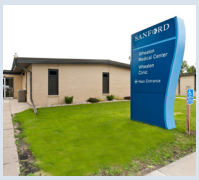






SANFORD HEALTH

Sanford Medical Center Sioux Falls USD

2018 Community Health Needs Assessment

dba Sanford USD Medical Center EIN# 45-0227855

Dear Community Members,

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

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

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

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

- *Economic Well-Being – Workforce Development*
- *Behavioral Health and Mental Health Access*

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

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

Sincerely,

Paul Hanson
President
Sanford Sioux Falls USD Medical Center

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Sanford Medical Center Sioux Falls USD

Community Health Needs Assessment

2018

Executive Summary

Purpose

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

Our Guiding Principles

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

Regulatory Requirements

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

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

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

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

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

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

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

Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholder's concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health and the Sioux Falls Department of Health distributed the survey link via email to stakeholders and key leaders located within Lincoln, Turner, McCook and Minnehaha counties. Data collection occurred from December 2017-January 2018. A total of 35 community stakeholders participated in the survey.

   B. *Resident Survey*
   The resident survey tool includes questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was sent to a representative sample of the Minnehaha, Lincoln, McCook and Turner counties populations secured through Qualtrics, a qualified vendor. A total of 547 community residents participated in the survey.

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

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

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

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

Limitations of the Study

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

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

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

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

Key Findings

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

Economic Well-Being
Community stakeholders are most concerned that there is a need for affordable housing (ranking 4.11), a skilled labor force (3.97), housing that accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence (9.91), and a high concern for homelessness (3.62).

Transportation
Community stakeholders are most concerned about the need for door-to-door transportation for community members who do not drive (3.60) and the availability of public transportation (3.51).

Children and Youth
Community stakeholders are most concerned about substance abuse by youth (3.67), childhood obesity (3.61), the availability of services for at-risk youth (3.58), bullying (3.55), crime committed by youth (3.52), and teen suicide (3.52).

Aging Population
Community stakeholders are most concerned about the cost of long term care and memory care (3.50).

Safety
Community stakeholders are most concerned about abuse of prescription drugs (4.00).

Health Care Access
Community stakeholders are most concerned about the availability of behavioral health providers (3.83), the availability of mental health providers (3.80), access to affordable prescription drugs (3.64), and access to affordable health care (3.63).

Mental Health and Substance Abuse
Community stakeholders are most concerned about drug use and abuse (4.07), depression (3.83), alcohol use and abuse (3.70), and suicide (3.52).

Resident survey participants are facing the following issues:

- 68% report that they are overweight or obese
- 58% self-report binge drinking at least 1X/month
- 37% have been diagnosed with depression
- 31% report running out of food before having money to buy more
- 31% have been diagnosed with high cholesterol
- 28% have a diagnosis of hypertension
- 30% currently smoke cigarettes

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

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

- Economic Well-Being – Workforce Development
- Behavioral Health and Mental Access

Implementation Strategies

Priority 1: Economic Well-Being – Workforce Development

The Council on Social Work Education reports that economic well-being may be achieved by individuals, families and communities through public policies that ensure the ability to build financial knowledge and skills, access to safe and affordable financial products and economic resources, and opportunities for generating income and asset building. It occurs within a context of economic justice within which labor markets provide opportunities for secure full employment with adequate compensation and benefits for all. Sanford has made economic well-being a significant priority and has developed a strategic plan to provide workforce and skilled labor opportunities in the Sioux Falls area and across the system.

Priority 2: Behavioral Health and Mental Health Access

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

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

Sanford Sioux Falls USD Medical Center

Community Health Needs Assessment

2018

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Acknowledgements

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

Sanford Steering Group:

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

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

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

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

- Ruth Roman, Fargo Cass Public Health
- Kay Schwartzwalter, Center for Social Research, NDSU
- Becky Secore, Beltrami Public Health
- Julie Sorby, Family HealthCare Center
- Brenda Stallman, Traill County Public Health
- Diane Thorson, Ottertail County Public Health
- Juli Ward, Avera Health
- MayLynn Warne, North Dakota Public Health Association

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

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

- Paul Amundson, MD, CVS Caremark
- Angie Bakke, EmBe
- Bridget Benson, First Dakota National Bank
- David Benson, American Cancer Society
- Angie Brown, Wellmark Blue Cross and Blue Shield
- Tony Burke, Feeding South Dakota
- Chad Campbell, Bishop Dudley Hospitality House
- Karla Cazer, Sanford Health
- Tallon Cazer, City of Sioux Falls Public Works
- Michael Christensen, Falls Area Bicyclists
- Monique Christensen, City of Sioux Falls, Siouxland Libraries
- Brian Christiaansen, City of Sioux Falls Fire Rescue
- Alicia Collura, City of Sioux Falls Public Health
- Mike Cooper, City of Sioux Falls Planning & Building Services
- Jim David, City of Sioux Falls, City Council Office
- Rana DeBoer, City of Sioux Falls Human Resources
- Tisha DeGross, LifeScape
- Morgan Douthit, Avera Health Plans
- Katie Dunn, City of Sioux Falls Human Relations
- Courtney Ehlers, Avera McKennan Hospital & University Health Center
- Jodi Fick, City of Sioux Falls, Siouxland Libraries
- Jill Franken, City of Sioux Falls Public Health
- Erik Gaikowski, AARP
- Alyssa, Gehle, City of Sioux Falls Public Health
- Brad Goodroad, City of Sioux Falls Fire Rescue
- Darwin Goodspeed, Sioux Falls VA Health Care System
- Kris Graham, Southeastern Behavioral Healthcare
- Lisa Groon, American Cancer Society
- Jean Gross, Delta Dental of South Dakota
- Kim Hansen, Southeastern Behavioral Healthcare
- Candy Hanson, Sioux Falls THRIVE
- Randy Hartman, City of Sioux Falls, Sioux Area Metro

- Jennifer Haubert, Sanford Health
- Lindsey Holmquest, AARP
- Caitlin Hurley, Avera McKennan Hospital & University Health Center
- Jill Ireland, American Cancer Society
- Darcy Jensen, Prairie View Prevention
- Tamera Jerke-Liesinger, The Banquet
- Teresa Kaltenbach, Face It TOGETHER®
- Don Kearney, City of Sioux Falls Parks & Recreation
- Janet Kittams, Helpline Center
- Kevin Kolb, City of Sioux Falls Communications
- Kristi Kranz, Sioux Empire United Way
- Maria Krell, Bishop Dudley Hospitality House
- Debbie Lancto, Avera Health Plans
- Sara Lindquist, NAMI Sioux Falls
- Mike Lynch, Forward Sioux Falls
- Michelle Markgraf, The Compass Center
- Jenny McDonald, Sanford Health
- Anne McFarland, LifeScape
- Carrie McLeod, Sanford Health
- Loren McManus, City of Sioux Falls Police Department
- Leah Mergen, City of Sioux Falls, Falls Community Health
- Chrissy Meyer, American Heart Association
- Mary Michaels, City of Sioux Falls Public Health
- Teresa Miller, Avera Health
- Stephanie Monroe, Volunteers of America
- Lori Montis, Minnehaha County
- Leslie Morrow, Alzheimer's Association
- Andrew Munce, Sanford USD Medical Center
- Megan Myers, Feeding South Dakota
- Dyan Nelson, Avera Medical Group McGreevy
- Josh Neugebauer, Raven Industries
- Stacia Nissen, South Dakota Urban Indian Health
- Marilyn Paddock, Avera Heart Hospital of South Dakota
- Patty Peters, MD, Avera Medical Group McGreevy
- Jay Powell, Sioux Empire United Way
- Sarah Prenger, Sanford Health
- Aileen Profir, City of Sioux Falls Communications
- Brett Quall, Community Outreach
- Chad Quissell, City of Sioux Falls Parks & Recreation
- Christina Riss, Sioux Empire United Way
- Lisa Sanderson, Parent Connection
- Molly Satter, Sioux Falls School District
- Connie Schmidt, Sanford Health
- Teri Schmidt, Sioux Falls Convention & Visitors Bureau
- Angela Schoffelman, Avera McKennan Hospital & University Health Center
- Jessica Sexe, City of Sioux Falls Public Works
- Andrew Siebenborn, City of Sioux Falls Police Department

- Kylee Sivertson, Lutheran Social Services
- Jon Sommoervold, Tallgrass
- Russ Sorensen, City of Sioux Falls Planning & Building Services
- Carol Spader, Wellness Wisdom That Works
- Barbara Teal, Sioux Falls VA Health Care System
- Bob Thimjon, Ramkota Companies
- Sr. Mary Thomas, Avera McKennan Hospital & University Health Center
- Nancy Thompson, Volunteers of America
- Priscilla Thornton, Active Generations
- Jennifer Tinguely, MD, City of Sioux Falls, Falls Community Health
- Kristin Tuttle, LifeScape
- Wyatt Urlacher, South Dakota Urban Indian Health
- Sara Van'T Hul, Avera McKennan Hospital & University Health Center
- Julie Ward, Avera McKennan Hospital & University Health Center
- Jody Willis, Avera McKennan Hospital & University Health Center
- Janelle Zerr, City of Sioux Falls Finance

Description of the Medical Center

Sanford USD Medical Center, Soux Falls, SD

Sanford USD Medical Center is a 545-bed tertiary medical center in Sioux Falls, SD. It provides comprehensive, multi-specialty care for patients from across the Midwest. It is the largest hospital in South Dakota and a Level II Trauma Center serviced by AirMed air ambulance that extensively covers the vast geographic region and offers four specialized transport teams including adult, pediatric, neonatal and maternal.

As a provider of highly specialized services, Sanford USD offers Centers of Excellence in heart and vascular, children's services, cancer, neuroscience, trauma, orthopedics and sports medicine, and women's services. It serves as the primary teaching hospital for the Sanford School of Medicine, located at the University of South Dakota in Vermillion. Sanford employs more than 12,000 people in the Sioux Falls area, including 500 board-certified physicians and 350 advanced practice providers (APPs) in 80 medical specialties. Sanford USD Medical Center is accredited by The Joint Commission and is a designated Magnet hospital by the American Nurses Credentialing Center.

Through its mission, *dedicated to health and healing*, and its vision *to deliver a flawless experience that inspires*, Sanford is making medical care accessible to the entire region.

Children's Castle

Sanford Children's Castle of Care serves pediatric patients in a five-state area and through Sanford World Clinics in Duncan, OK; Oceanside, CA; and Klamath Falls, OR. State-of-the-art neonatal intensive care and pediatric intensive care units offer 24/7 care by local specialists. This includes 135 pediatric specialists in 34 unique medical areas of expertise. The model of CARE focuses on excellence in **C**linical services, **A**dvocacy, **R**esearch and **E**ducation.

Heart Hospital

Sanford Heart Hospital is a state-of-the-art hospital offering highly advanced, integrated and personalized heart care from experienced heart specialists. All services for heart patients – emergency care, outpatient testing, surgery, rehab, catheterization, consultation with specialists – are consolidated into one building attached to the medical center, allowing for easy access. Within Sanford Heart Hospital, patients receive personalized health care where comfort, well-being, compassion, communication and empowered choices allow them to experience their healing journey in a positive life-changing way.

Orthopedics and Sports

Sanford Orthopedic and Sports Medicine has a depth of services and specialties to treat sprains, strains, tears, breaks, joint pain and concussions. We offer expert physicians with years of experience in diagnosis, surgery and nonsurgical treatments. Sanford is a regional leader in sports medicine and works with over 125 club, high school, collegiate and semi-professional teams.

Cancer Center

Sanford's Cancer Center and Edith Sanford Breast Center combine to form a unique beacon of expert cancer and breast care throughout the region. Through the generosity of Denny Sanford, we've been able to design and construct a space that supports advanced cancer care and breast care delivery models of the future, encompassing the whole person built on a foundation of distinguished research and supporting team-based care. Sanford participates in nationwide studies through the National Cancer Institute (NCI). One of the main objectives of the NCI Community Cancer Centers Program is to reduce cancer care disparities among underserved populations through education, prevention, screening, treatment, and patient-family support programs.

Ava's House

Ava's House is a 20-suite hospice facility for adult and pediatric patients. It offers 24-hour nursing care and is one of only four facilities in the nation with inpatient pediatric hospice services. The home-like environment provides a setting for patients to receive exceptional care while families and guests celebrate the life of their loved one. Ava's house was made possible through philanthropy and the *Gift of Time* charitable giving campaign. It opened in 2017.

Women's

Sanford's Women's offers state-of-the art obstetric and gynecological care for women of all ages in several locations throughout a four-state area. Care is provided by specialists in OB/GYN, maternal-fetal medicine, uro-gynecology, reproductive endocrinology, certified nurse midwives and more. Sanford Women's Plaza is a unique destination that provides women with a variety of health options, all in one location.

Imagenetics

Sanford Health is embedding the latest in genomic medicine into primary care through Imagenetics. This program provides physicians with unprecedented patient-specific information to better identify effective medications and risk for inherited disease in order to design a care plan for the future. Sanford Imagenetics was established in 2014 thanks to a generous gift of $125 million from philanthropist Denny Sanford.

Sanford Health Innovations

Combining an inventive spirit, multidisciplinary expertise, and a comprehensive research infrastructure, Sanford Health Innovations develops and commercializes game-changing technologies to provide new solutions for improved patient care.

Sanford Health Plan

Sanford Health Plan is a community-based, non-profit health insurance company that offers product lines for individuals, families and businesses in North Dakota, South Dakota, Minnesota and Iowa. Sanford Health Plan's regional network of 18,000 providers includes Sanford Health practitioners and providers as well as those affiliated with other health systems or in independent practice. The health plan also maintains a nationwide network for members living or traveling outside of the service area. There are currently 175,000 enrolled Sanford Health Plan members.

Description of the Community Served

Sioux Falls is the most populous city in the state of South Dakota and the 143rd-most populous city in the United States. As of 2018, Sioux Falls had an estimated population of 183,200. The metropolitan population of 259,094 accounts for 29% of South Dakota's population. It is the primary city of the Sioux Falls-Sioux City Designated Market Area (DMA), a larger media market region that covers parts of four states and has a population of 1,043,450. Chartered in 1856 on the banks of the Big Sioux River, the city is situated in the rolling hills at the junction of Interstate 90 and Interstate 29.

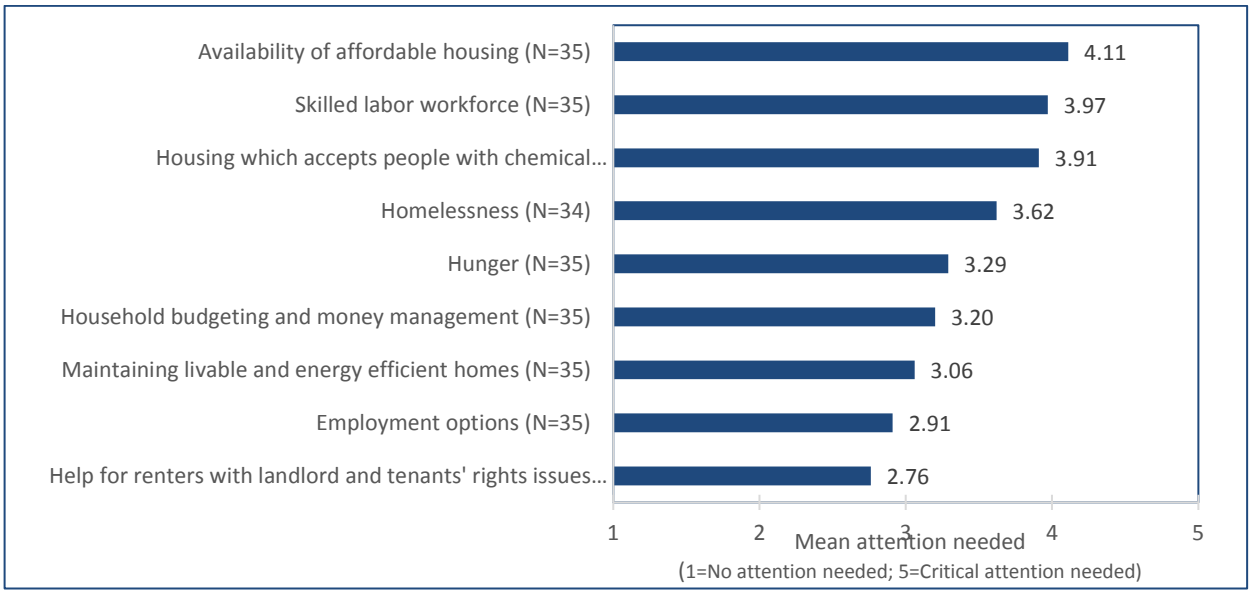
Sanford Health is the largest employer in Sioux Falls. Sioux Falls is ranked number one on Forbes' list of *Best Small Places for Business and Careers*, and provides a home base for financial services, renewable energy industry, health care and expertise in manufacturing, research and back-office operations. Key industries include medical device manufacturing, biomedical research, data centers and customer care services.

Key Findings

Community Health Concerns

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

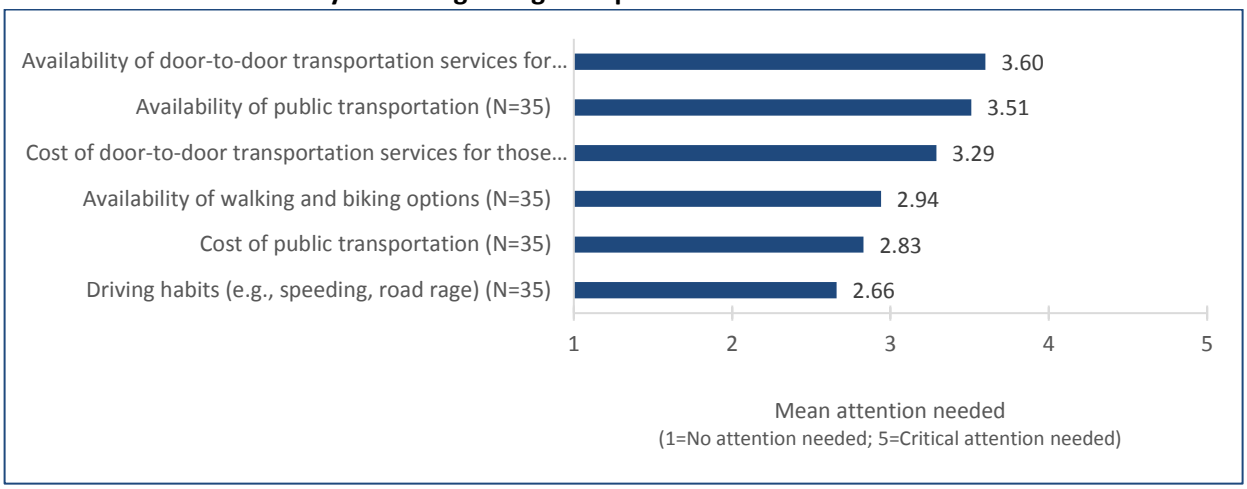
Economic Well-Being: The concern for the community's economic well-being is focused on the need for available affordable housing, a skilled workforce, housing that accepts people in recovery, mental illness, criminal history or victims of domestic abuse, and homelessness.



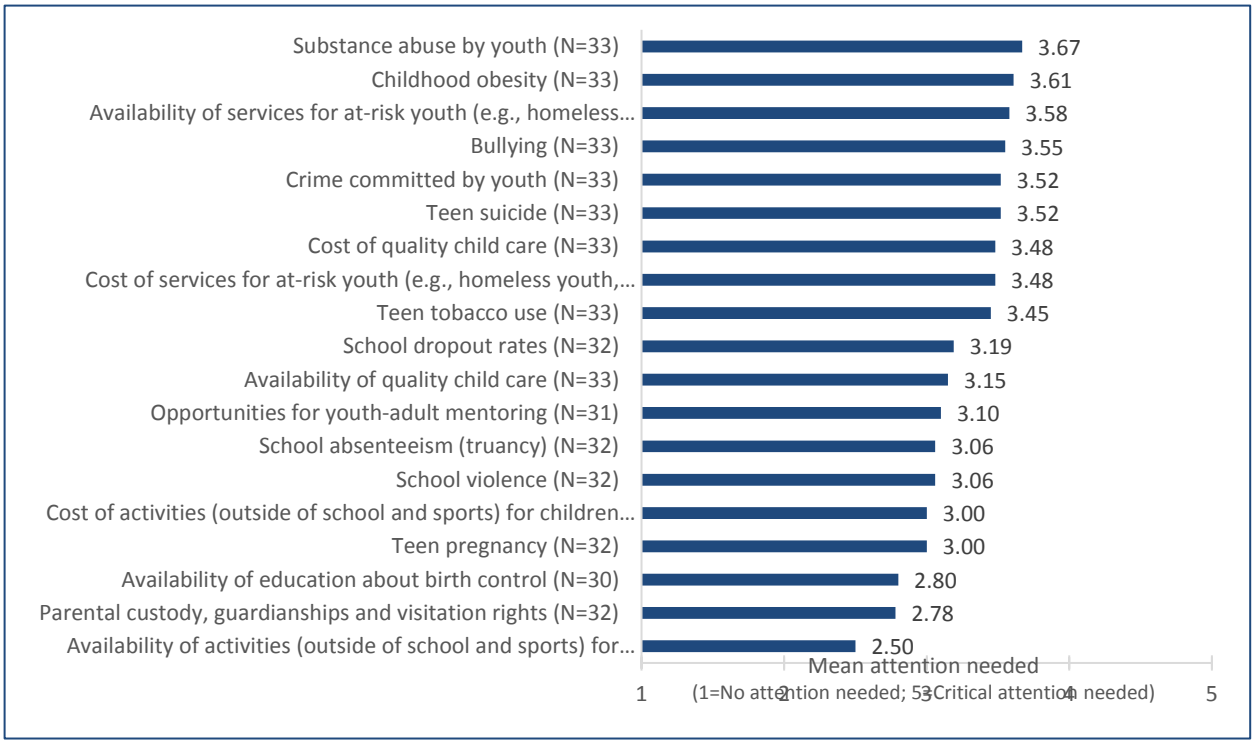
Healthy People 2020 has defined the social determinants of health. "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Conditions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

Transportation: The concern for transportation focuses on the need for door-to-door transportation for those unable to drive and the availability of public transportation.

Current state of community issues regarding transportation



Children and Youth: The highest concerns for children and youth are numerous and include substance abuse by youth, childhood obesity, the need for services for at-risk youth, bullying, crime committed by youth, and teen suicide.



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

Researchers have identified *risk factors* that can increase a person's chances for misuse, and *protective factors* that can reduce the risk. However, many people with risk factors do not abuse substances. The risk factors for

substance abuse among youth include boredom, stress, curiosity, the desire to feel grown up, or to lessen peer pressure.

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

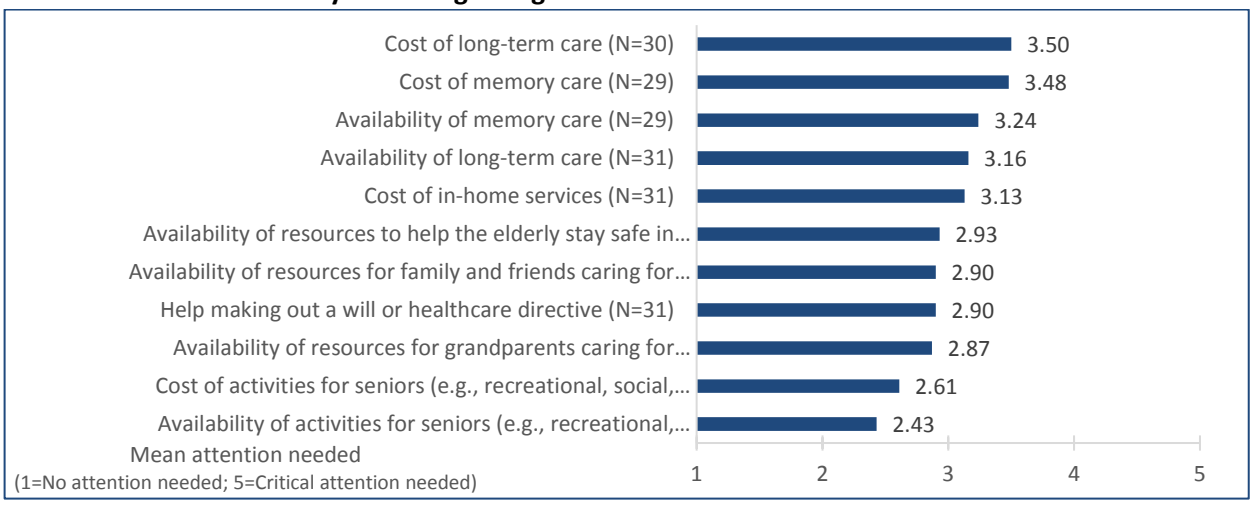
- Poor grades in school
- Engaging in alcohol or drug use at a young age
- Friends and peers who engage in alcohol or drug use
- Persistent, progressive, and generalized substance use, misuse, and use disorders by family members
- Conflict between parents or between parents and children, including abuse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

Protective factors include:

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

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

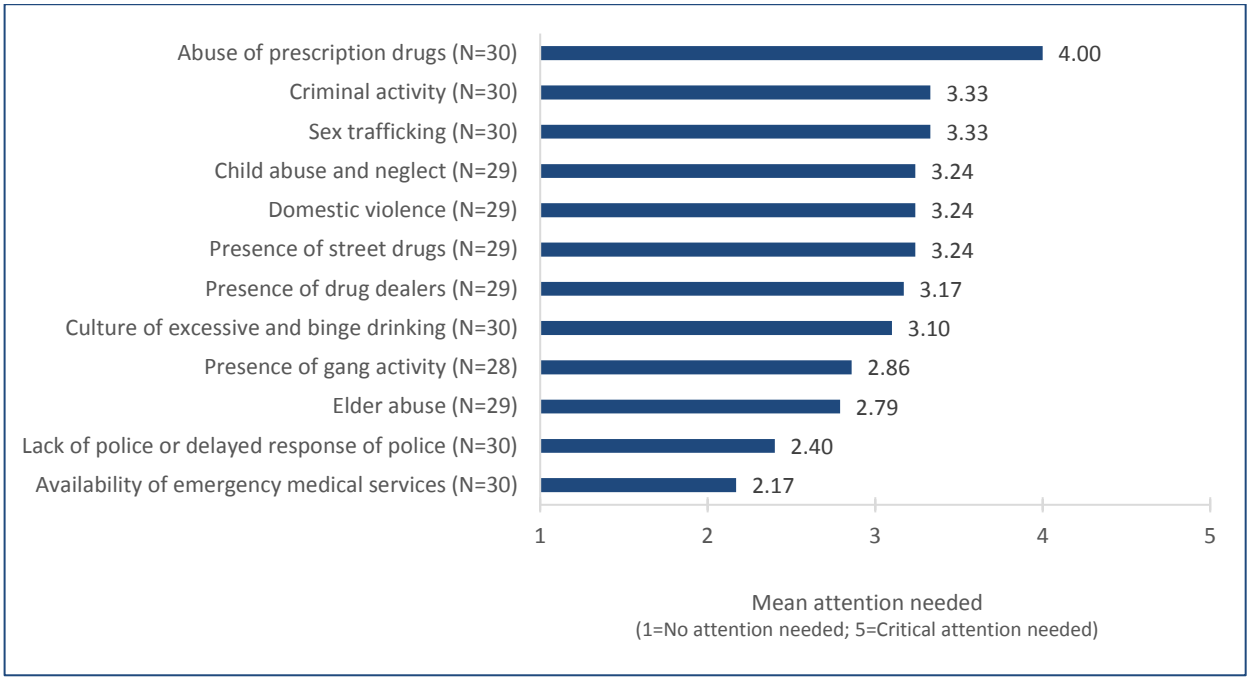
Current state of community issues regarding the AGING POPULATION



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

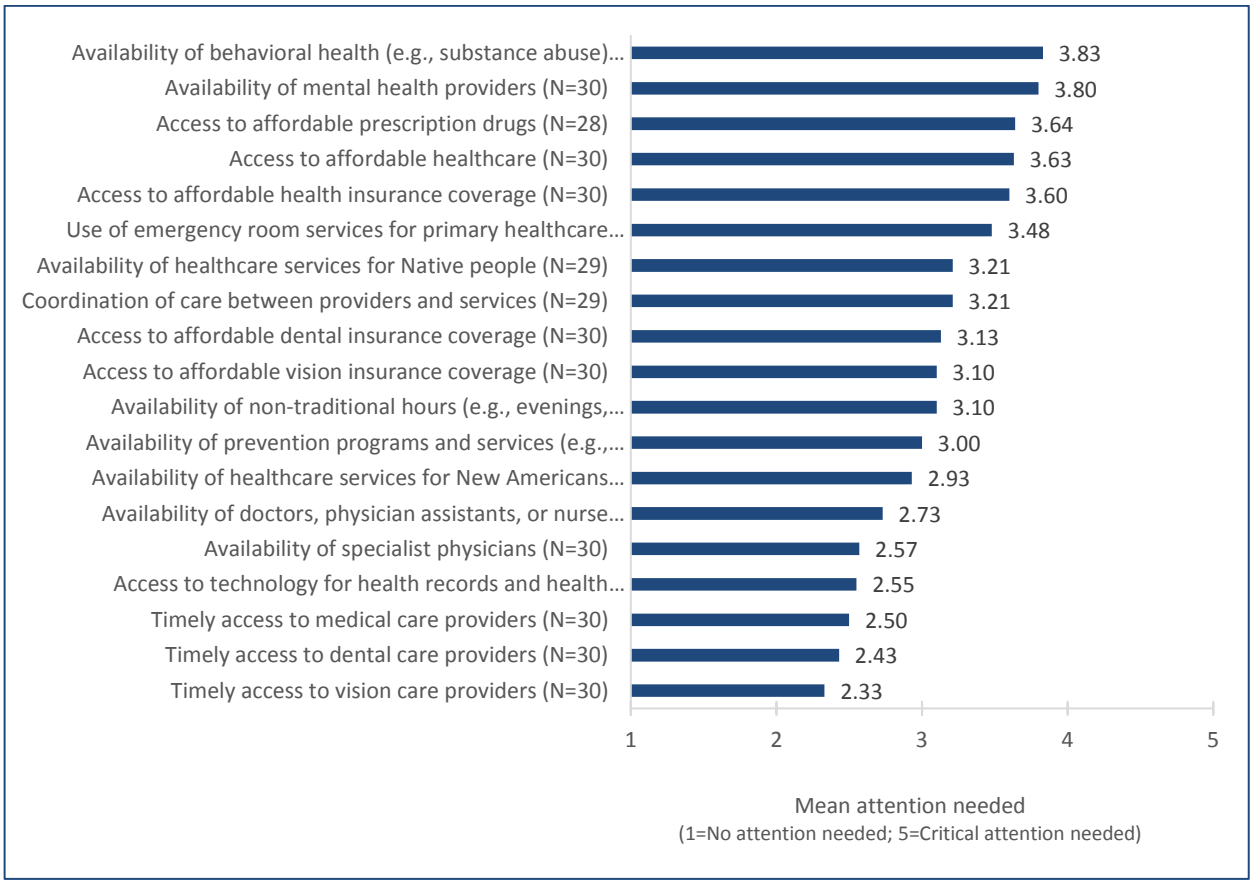
Safety: The abuse of prescription drugs is the top concern for safety in the community.

Current state of community issues regarding SAFETY



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

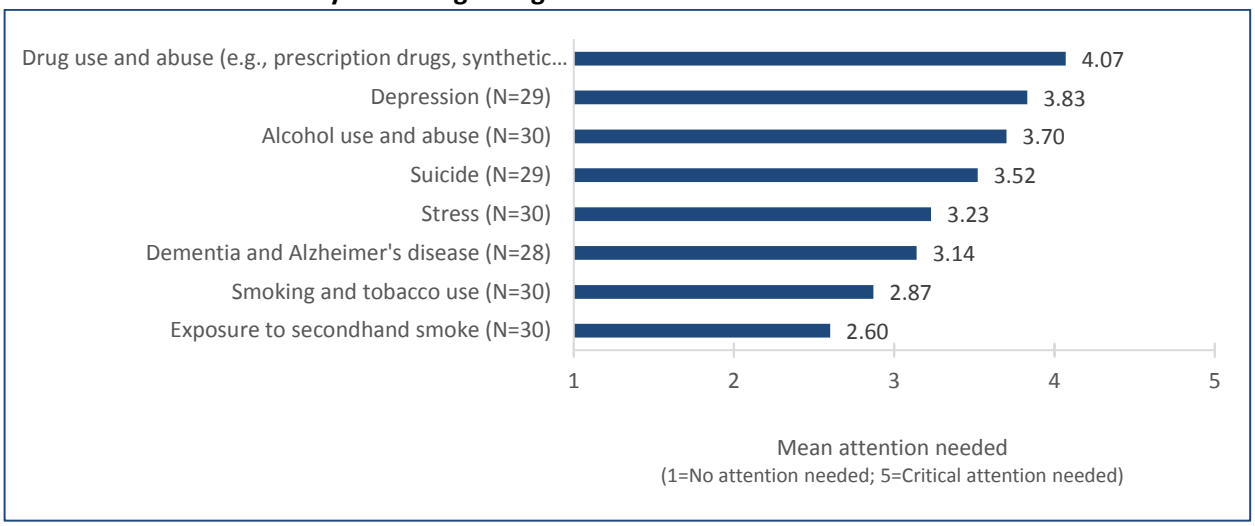
Health Care and Wellness: The availability of behavioral health and mental health providers is ranked very high among the top concerns for the community. Access to affordable health insurance, affordable health care, and affordable prescription drugs are all high concerns for community stakeholders.



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

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

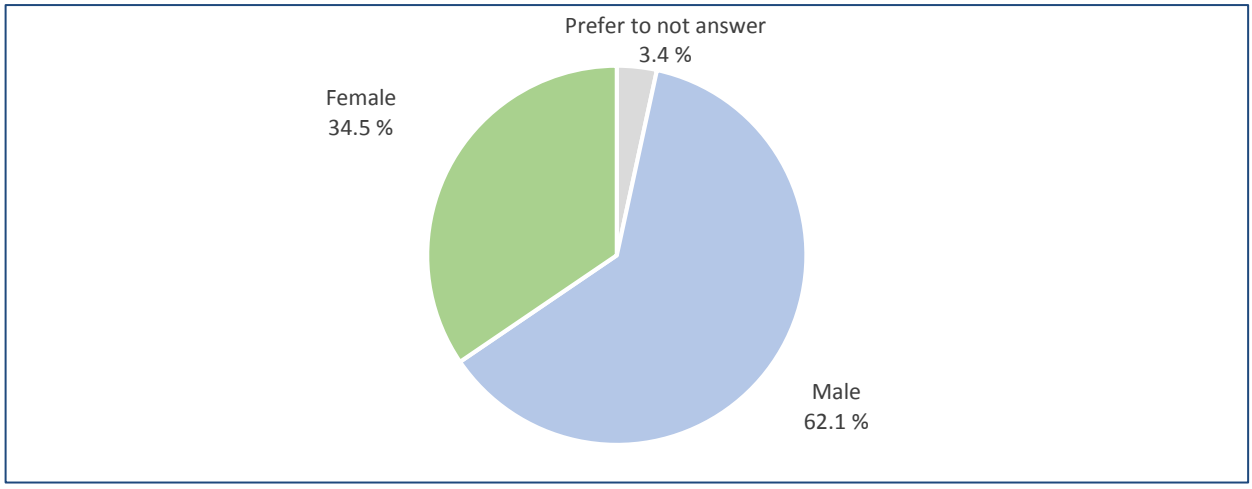
Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



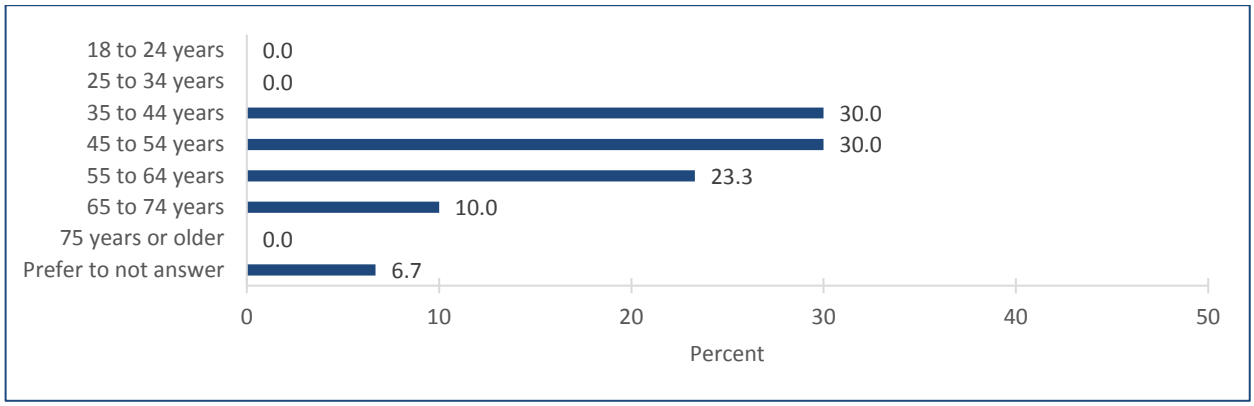
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental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

Demographic Information for Key Stakeholder Participants

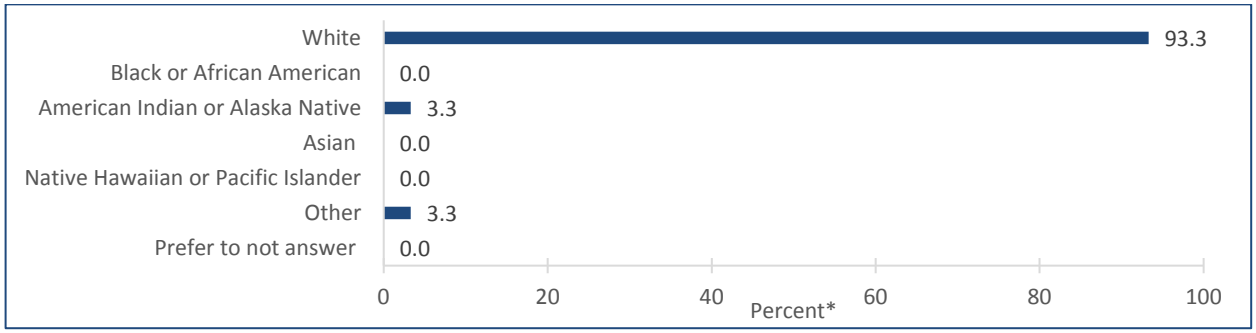
Biological Gender



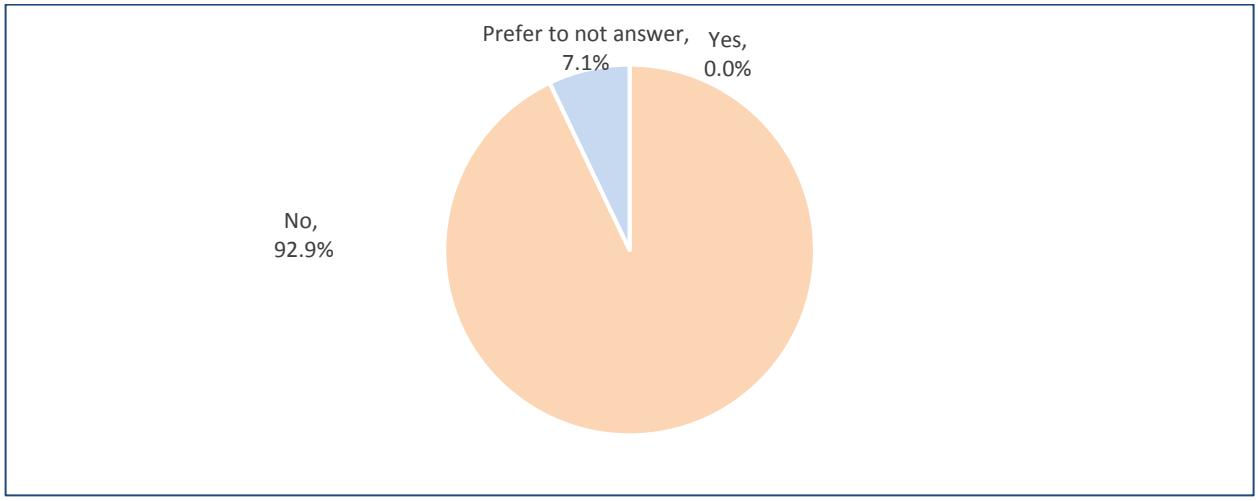
Age of Respondents



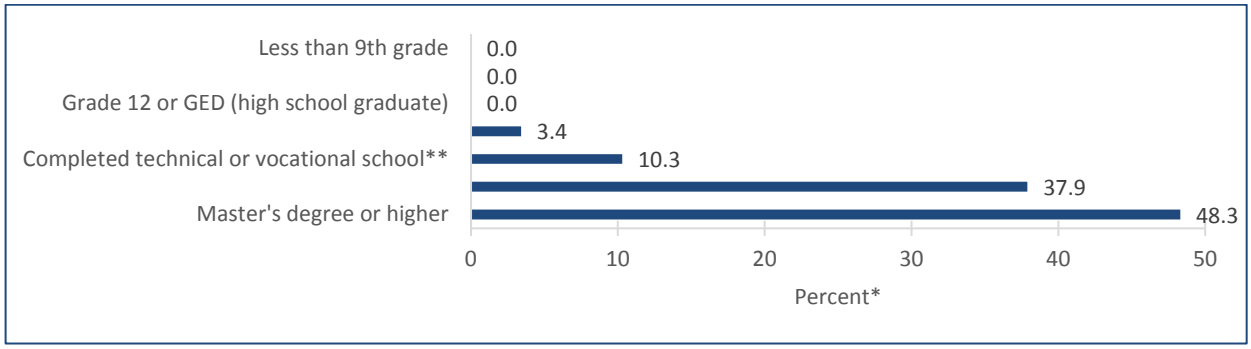
Race of Participants



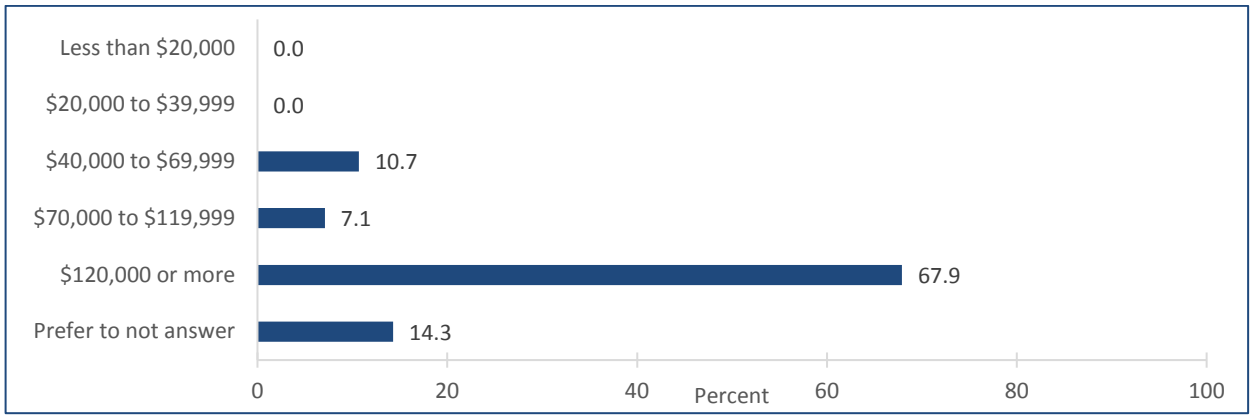
Whether Respondents are of Hispanic or Latino Origin



Highest Level of Education Completed



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



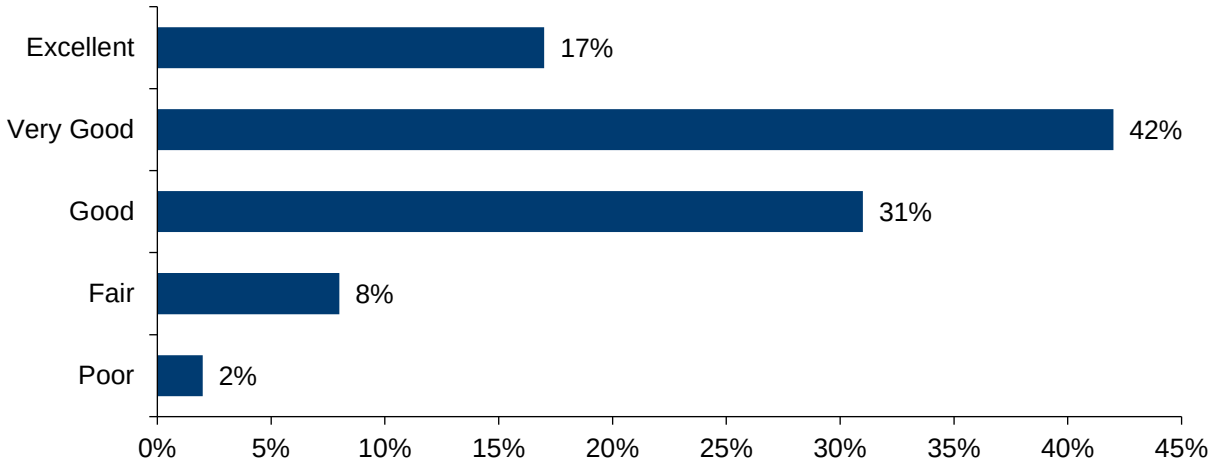
Residents' Health Concerns

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

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

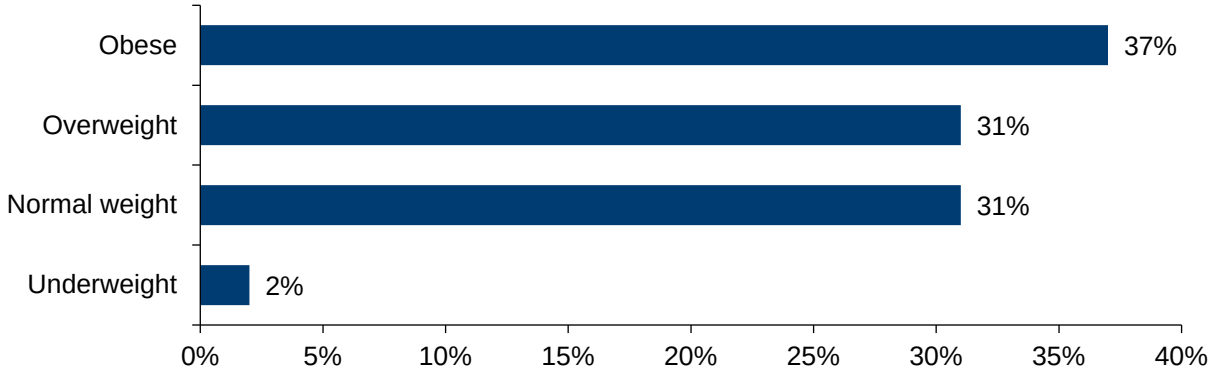
How would you rate your health?

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



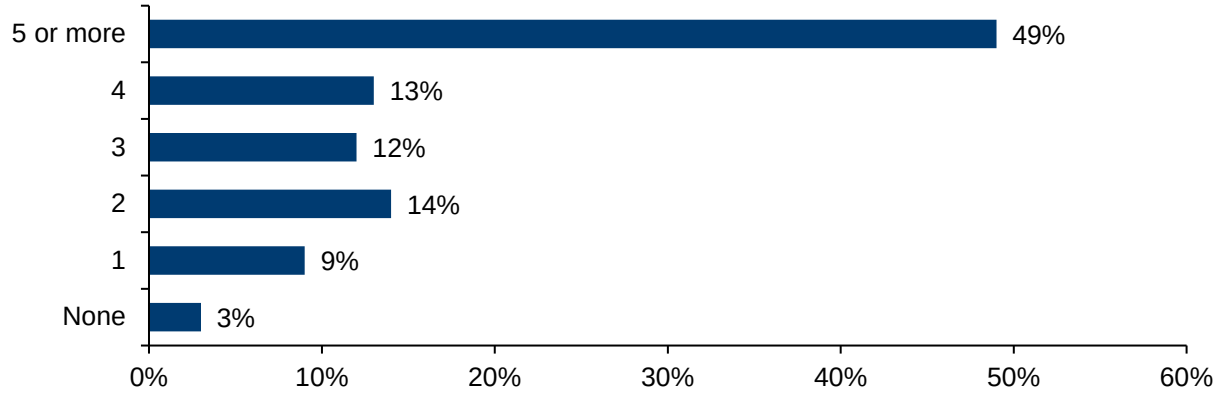
Body Mass Index (BMI)

Sixty-eight percent of survey participants are overweight or obese.



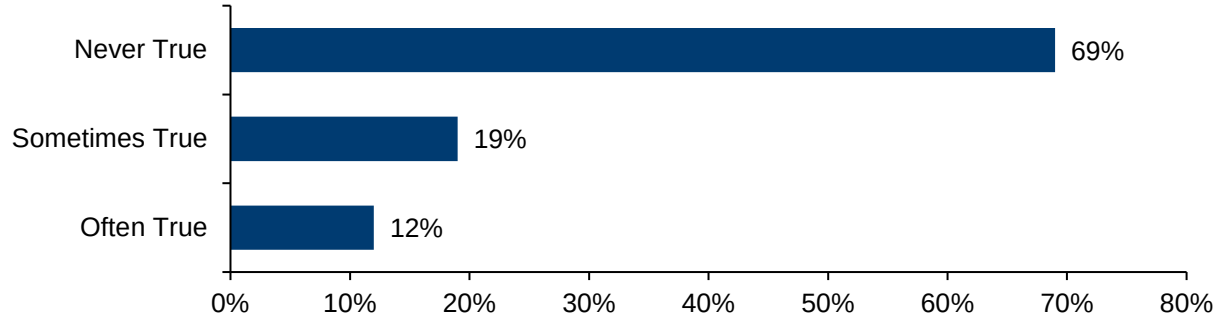
Total Servings of Fruits, Vegetables and Juice

Only 49% are consuming the recommended 5 or more daily servings of fruit and vegetables.



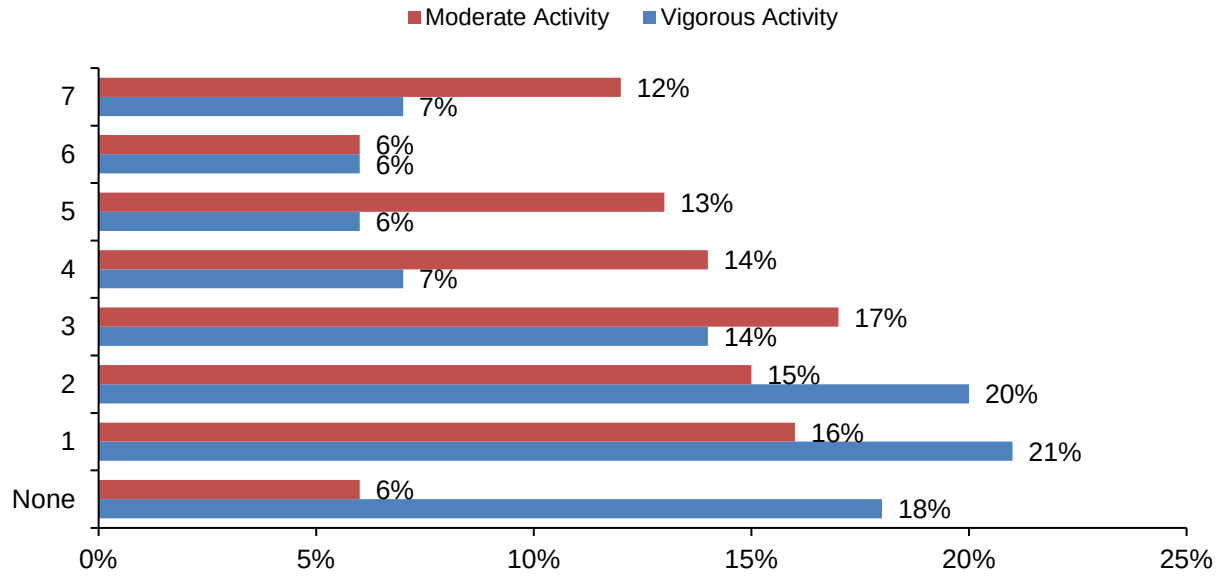
Food insecurity

Thirty-one percent report running out of food before having money to buy more.



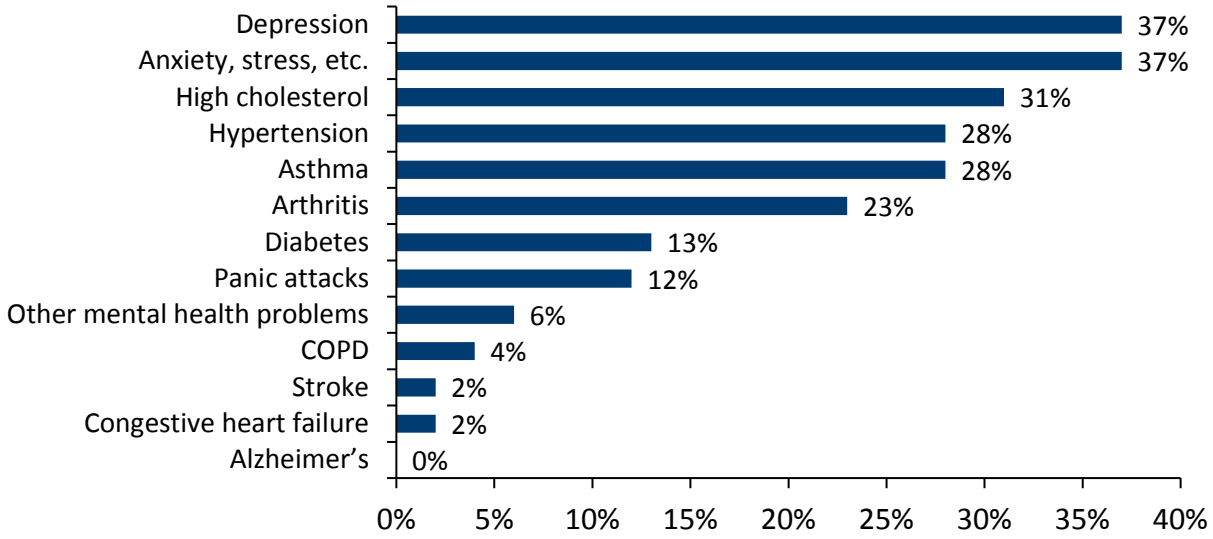
Days per Week of Physical Activity

Sixty-two percent have moderate exercise three or more times each week.



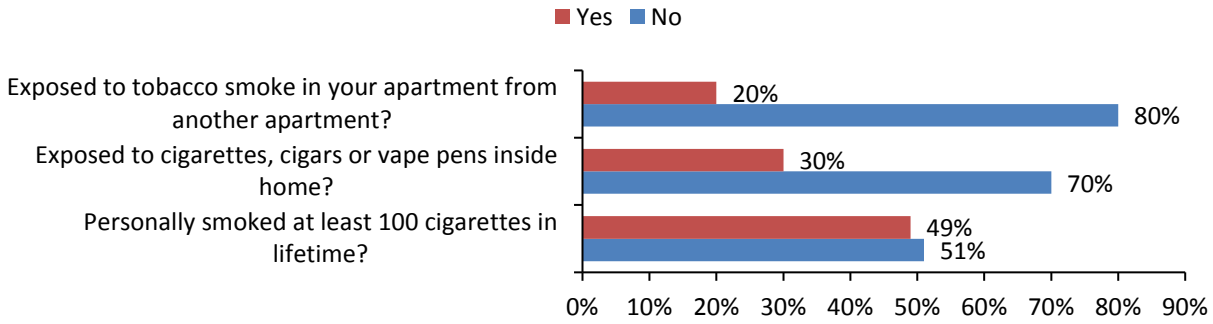
Past Diagnosis

Depression, anxiety, high cholesterol, hypertension and arthritis are the top diagnoses for the survey participants**.**



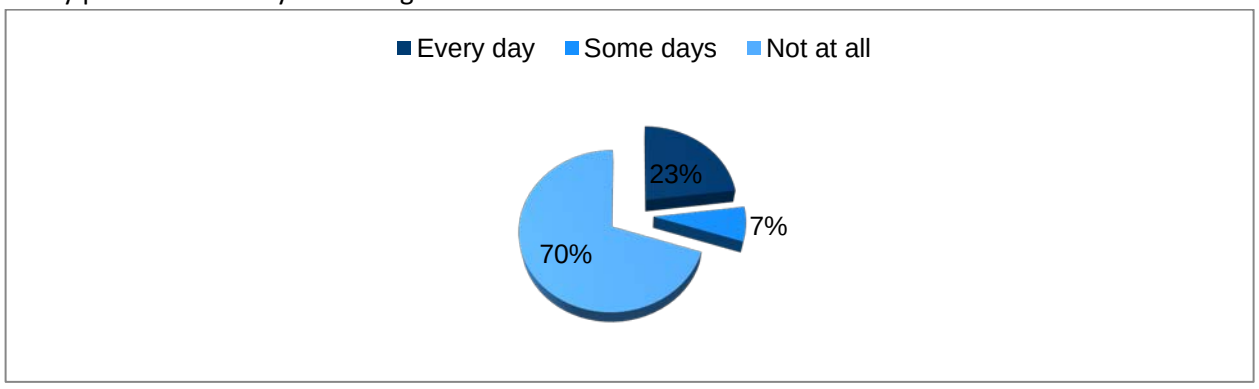
Exposure to Tobacco Smoke

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



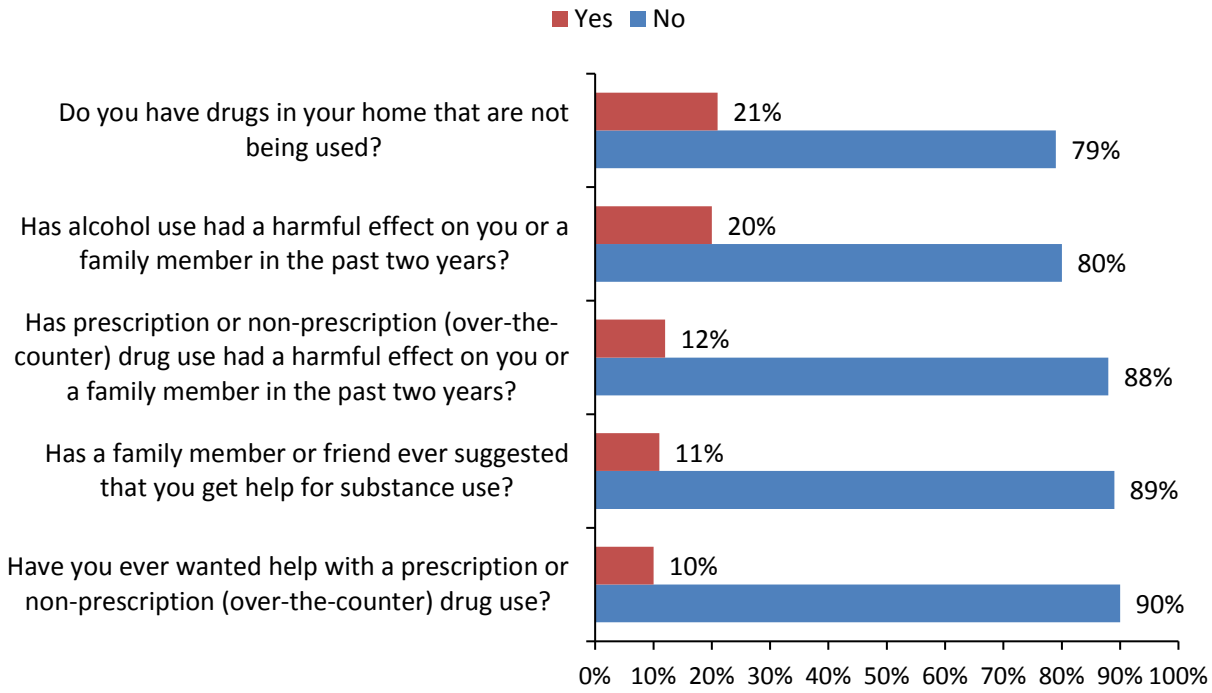
Do you currently smoke cigarettes?

Thirty percent currently smoke cigarettes.



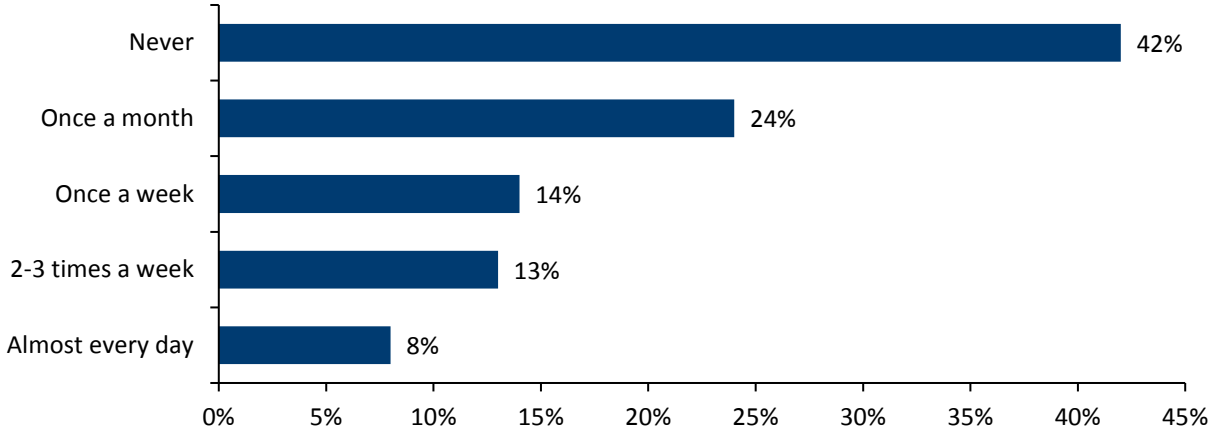
Drug and Alcohol Issues

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

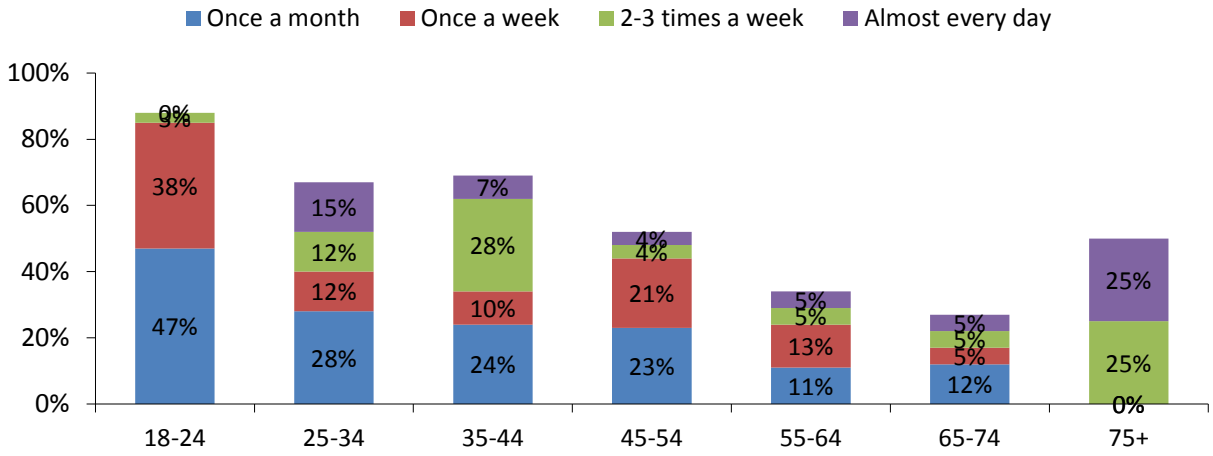


Binge Drinking

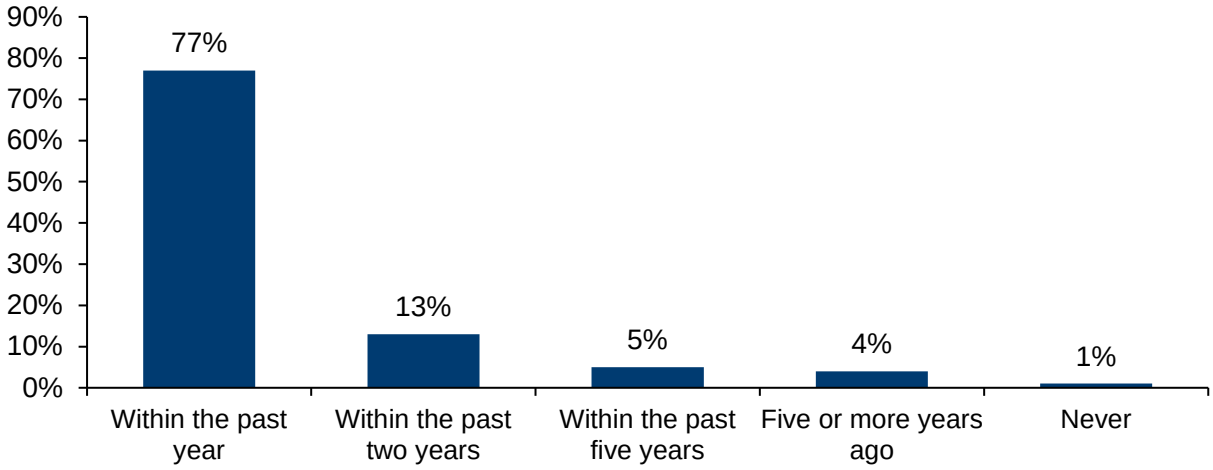
Fifty-eight percent binge drink at least once per month.



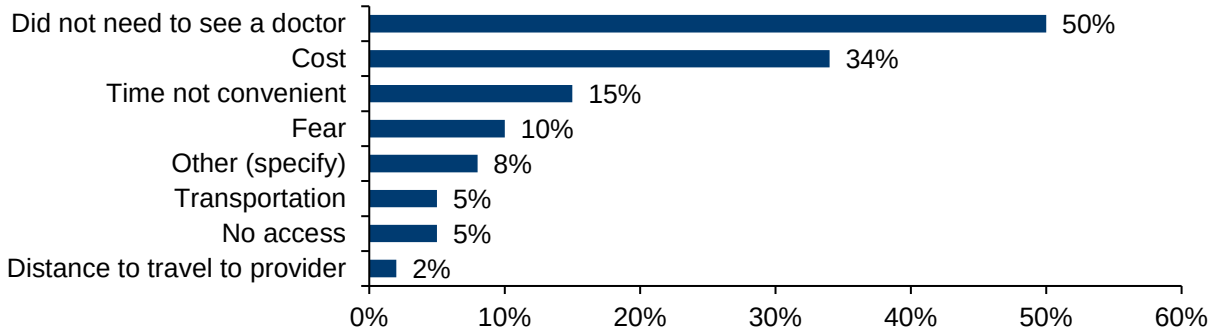
Binge Drinking Past 30 days by Age



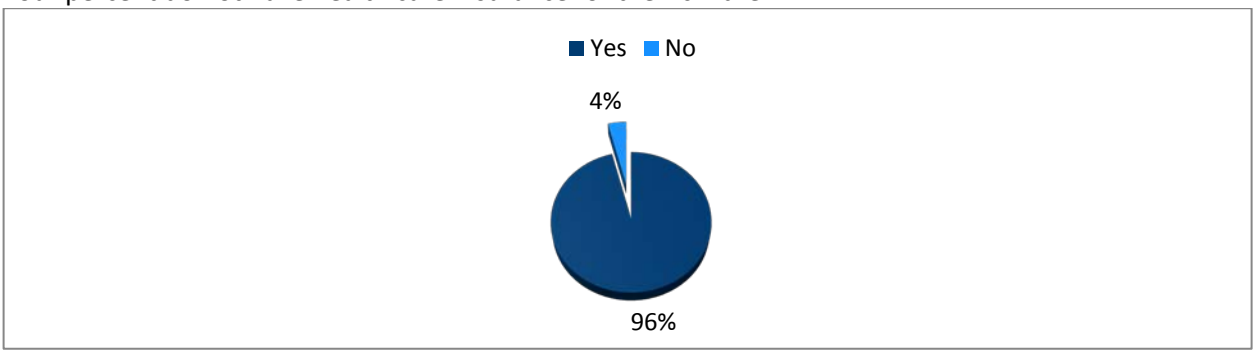
How long has it been since you last visited a doctor or health care provider for a routine check-up?
Twenty-three percent have not had a routine check-up in more than a year.



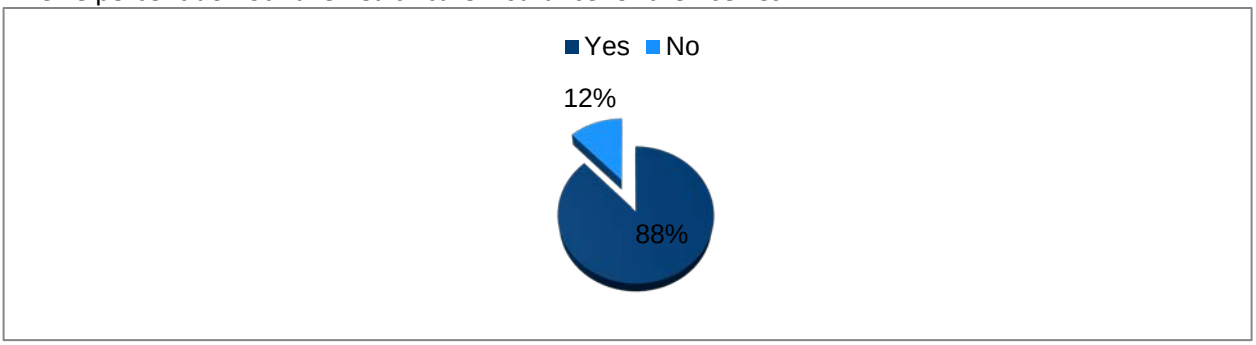
Barriers to Routine Check-up
Fifty percent of survey respondents report not needing a routine check-up.



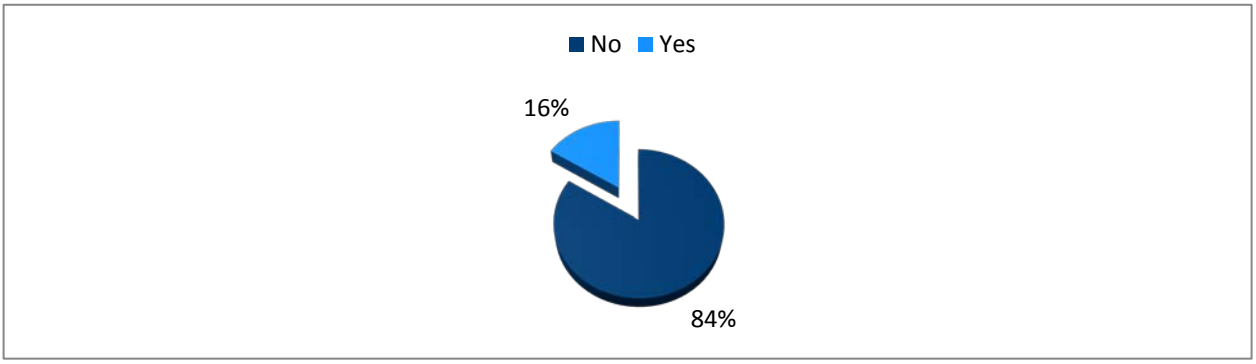
Do you have health care coverage for your children or dependents?
Four percent do not have health care insurance for their children.



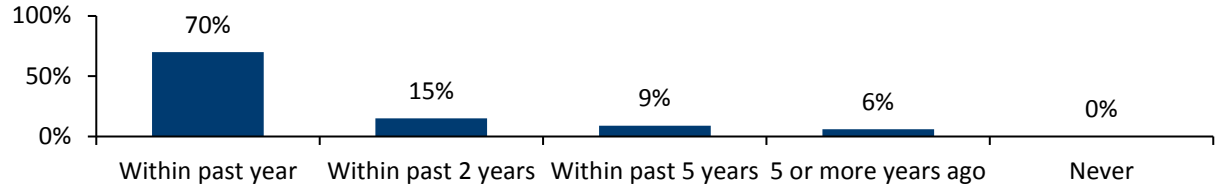
Do you currently have any kind of health insurance?
Twelve percent do not have health care insurance for themselves.



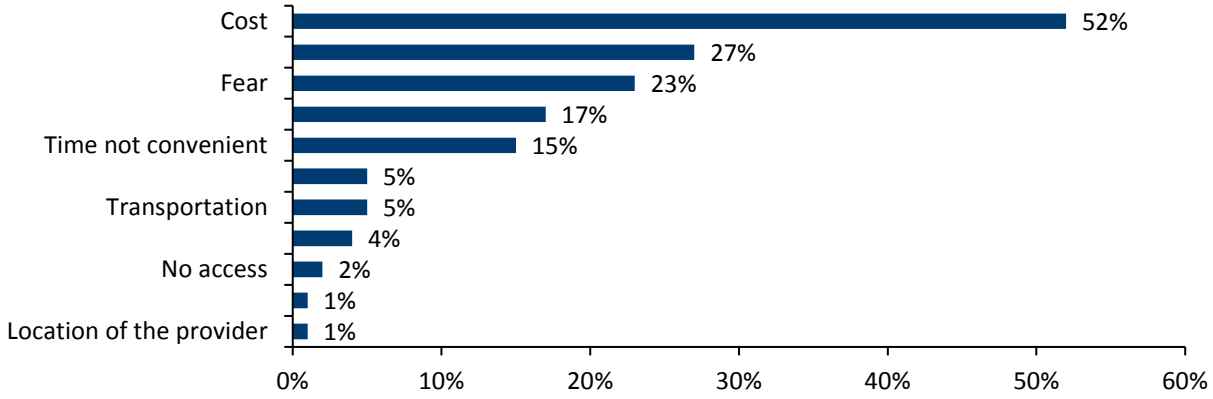
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?
Sixteen percent report not receiving the care that they needed.



How long has it been since you last visited a dentist?
Twenty-one percent have not visited a dentist in more than a year.

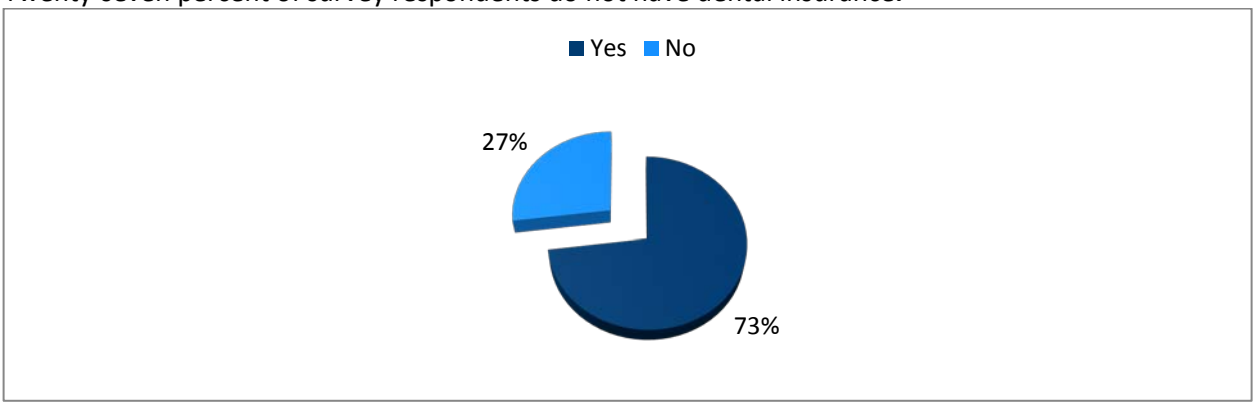


Barriers to Visiting the Dentist



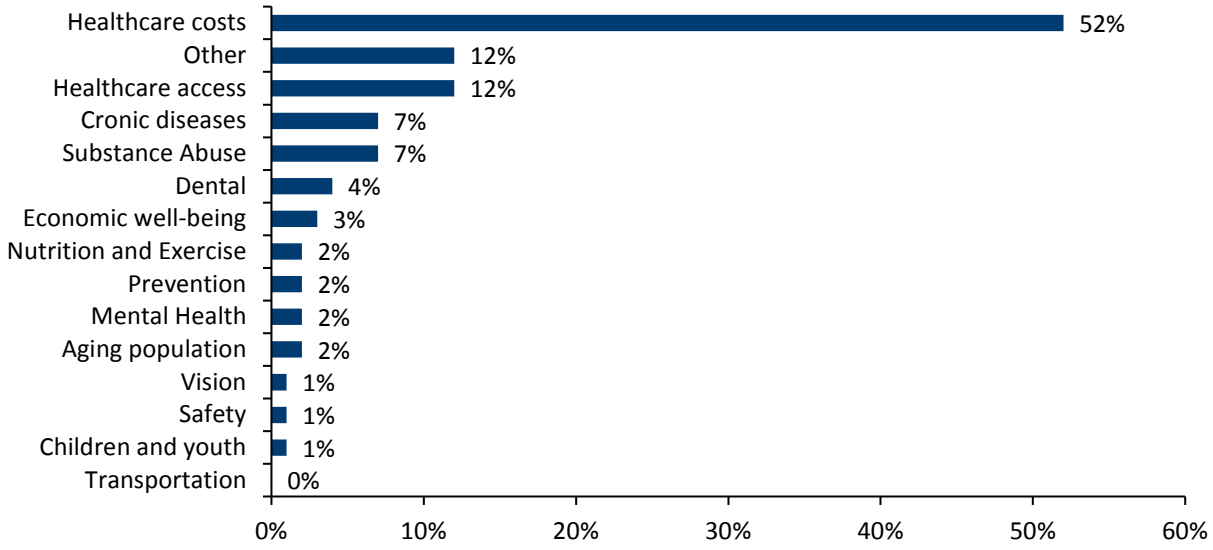
Do you have any kind of dental care or oral health insurance coverage?

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



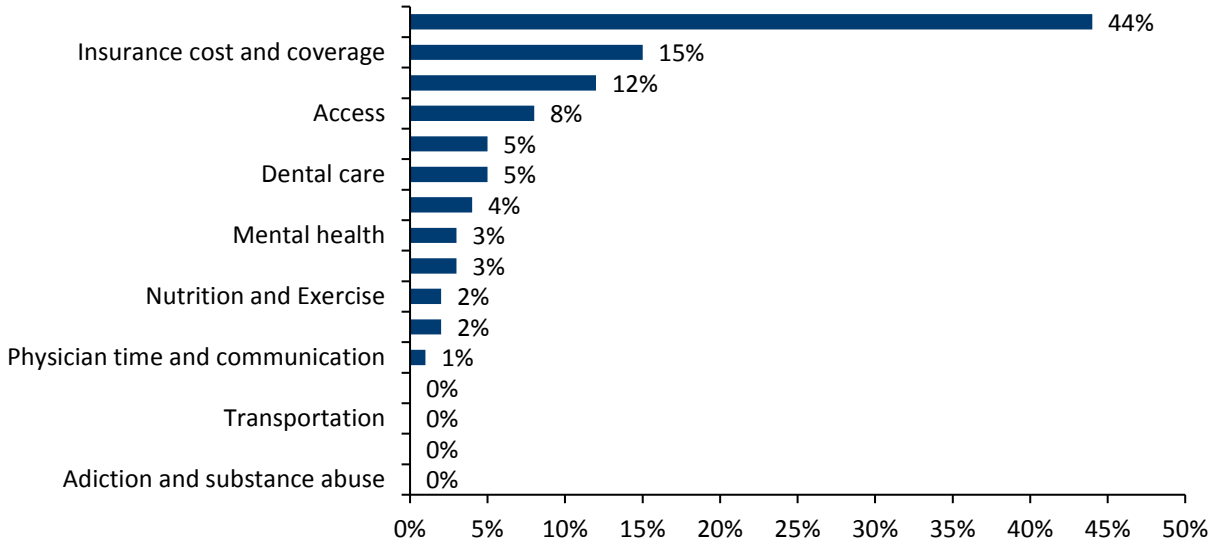
Most Important Community Issues

Health care costs and health care access are the top concerns of respondents for their community.

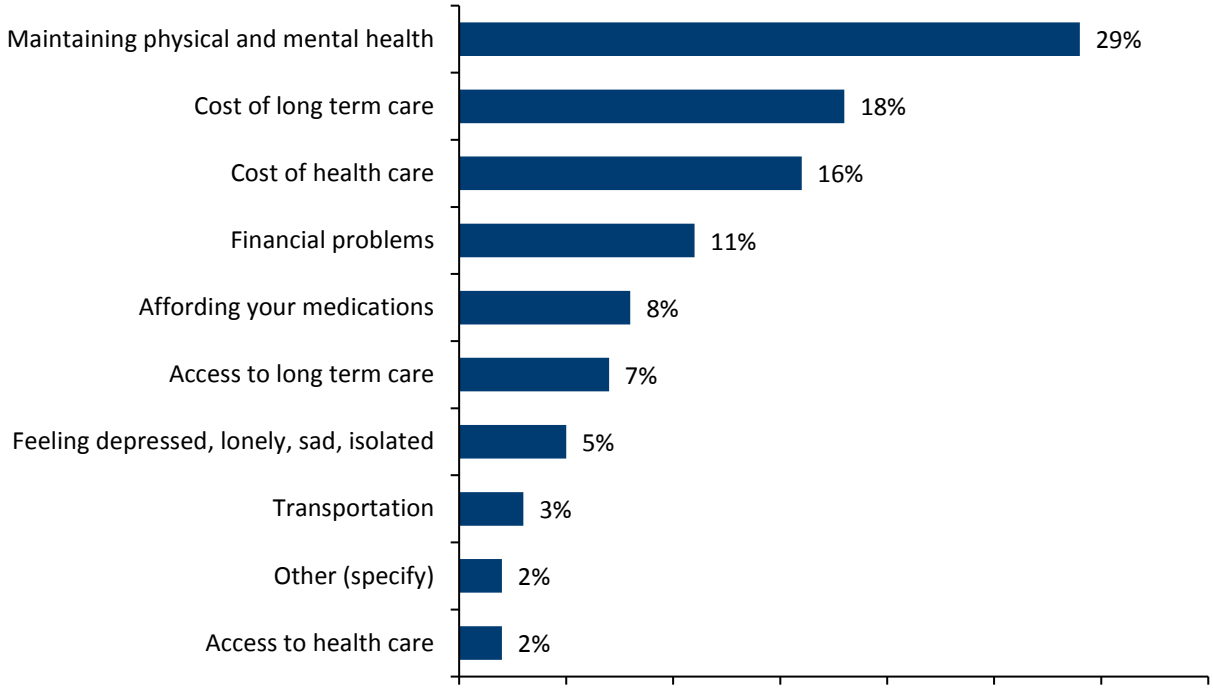


Most Important Issue for Family

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



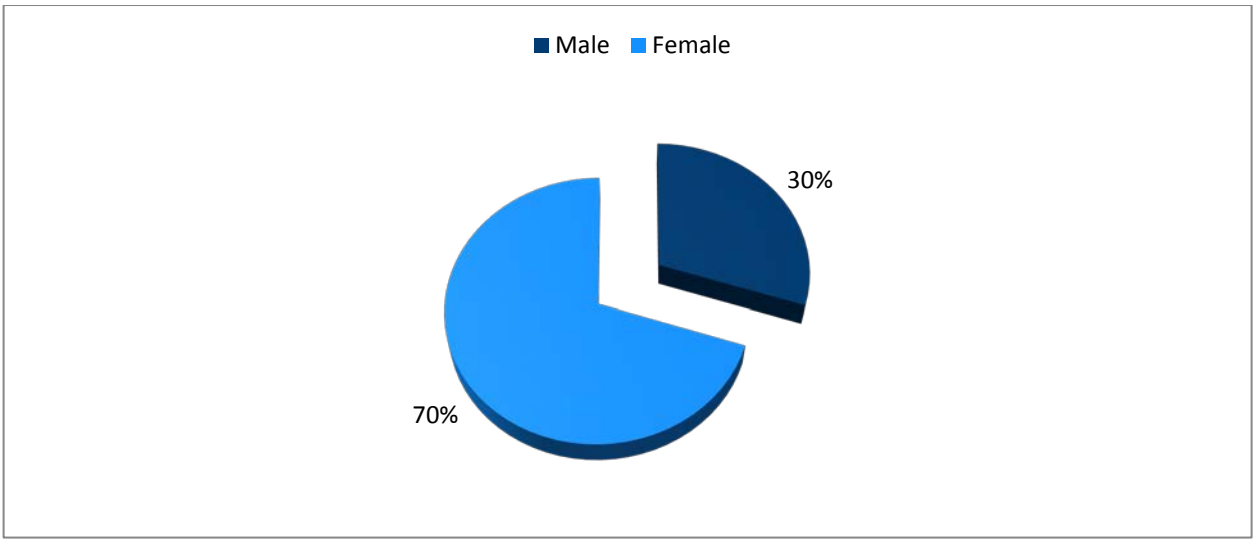
What is your biggest concern as you age? (Age 65+)



Demographic Information for Community Resident Participants

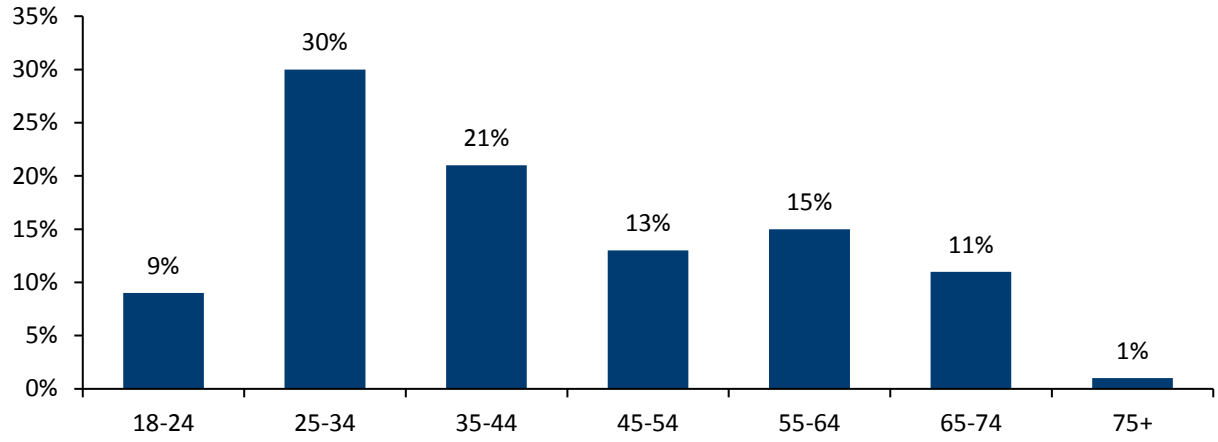
Biological Gender

Only 30% of the survey participants were male.

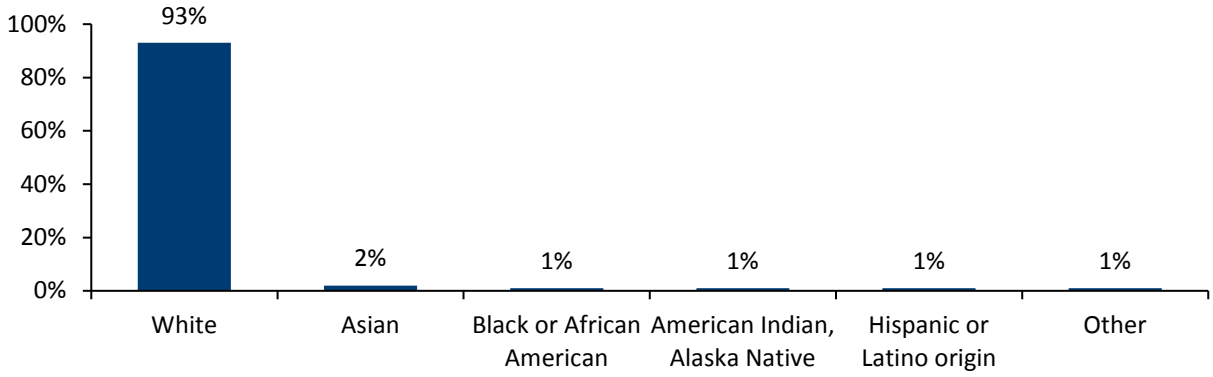


Age

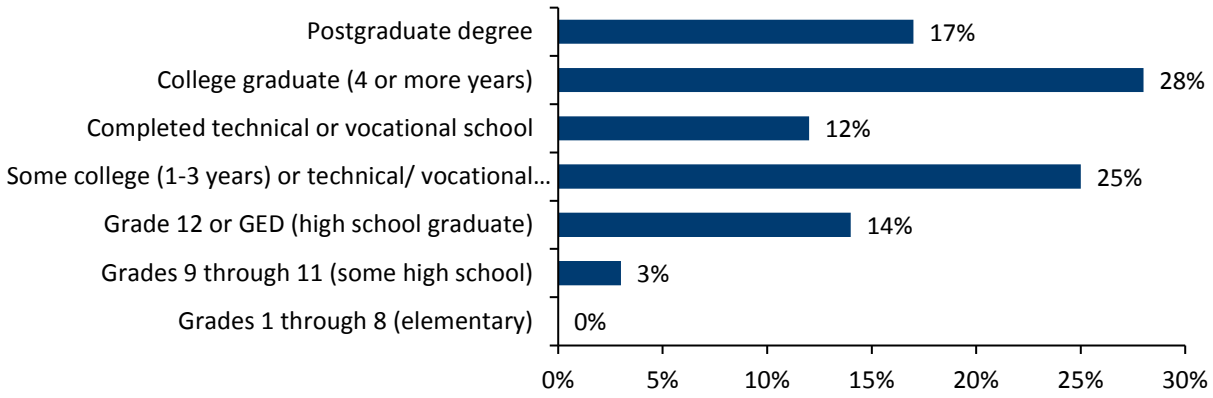
Every age group was represented among the survey participants; however, only 1% fell into the 75+-year age.



Ethnicity

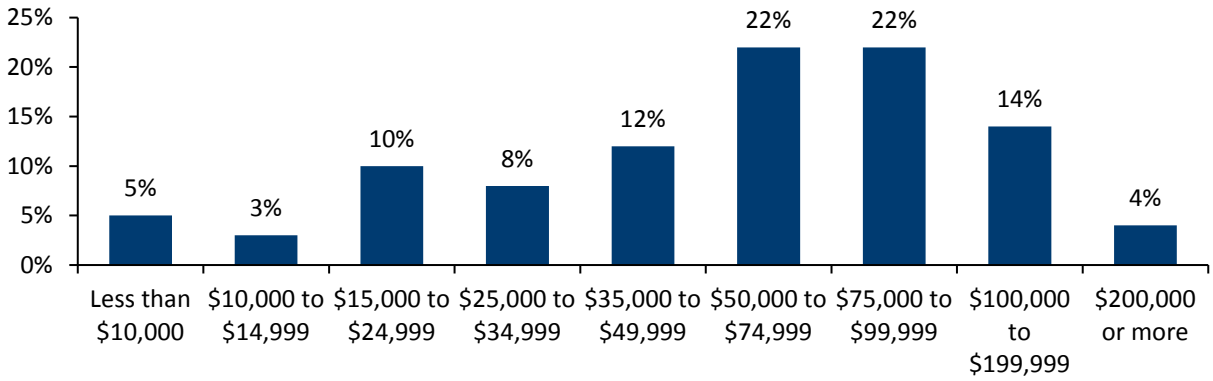


Education Level



Total Annual Household Income

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



Secondary Research Findings

Census Data

255,729 - Population of Minnehaha, Lincoln, McCook and Turner counties in South Dakota

	Minnehaha	Lincoln	McCook	Turner
% below 18 years of age	25.3	28.6	26.6	23.5
% 65 and older	12.9	11.6	19.9	20.8
% White – non-Hispanic	83.3	93.6	94.4	95.8
American Indian	2.7	0.6	1.0	1.0
Hispanic	4.8	1.9	3.2	2.1
African American	5.1	1.3	0.4	0.4
Asian	2.3	1.3	0.2	0.2
% Female	49.7	50.3	49.6	49.8
% Rural	13.6	29.3	100	100

County Health Rankings

	Minnehaha County	Lincoln County	McCook County	Turner County	State of South Dakota	U.S. Top Performers
Adult smoking	16%	14%	14%	14%	18%	14%
Adult obesity	30%	29%	31%	34%	31%	26%
Physical inactivity	20%	20%	25%	25%	22%	20%
Excessive drinking	20%	20%	19%	18%	20%	13%
Alcohol related driving deaths	22%	22%	43%	43%	37%	13%
Food insecurity	12%	8%	9%	10%	12%	10%
Uninsured adults	12%	7%	11%	12%	14%	7%
Uninsured children	6%	4%	8%	8%	7%	3%
Children in poverty	11%	4%	12%	12%	17%	12%
Children eligible for free or reduced lunch	41%	17%	28%	31%	42%	33%
Diabetes monitoring	88%	89%	86%	92%	84%	91%
Mammography screening	71%	77%	56%	73%	66%	71%
Median household income	$60,200	$84,600	$59,000	$58,800	$54,900	$65,600

Health Needs and Community Resources Identified

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

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

The asset mapping process identified needs from the following:

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

Please see the asset map in the Appendix.

Sioux Falls 2018 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern
Economic Well-Being • Availability of affordable housing 4.11 • Skilled labor force 3.97 • Housing which accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence 3.91 • Homelessness 3.62 • 31% report not having enough food
Transportation • Availability of door-to-door transportation services for those unable to drive 3.60 • Availability of public transportation 3.51
Children and Youth • Substance abuse by youth 3.67 • Childhood obesity 3.61 • Availability of services for at-risk youth 3.58 • Bullying 3.55 • Crime committed by youth 3.52 • Teen suicide 3.52
Aging Population • Cost of long term care 3.50
Safety • Abuse of prescription drugs 4.00 • 58% binge drink - resident survey
Healthcare Access • Availability of behavioral health providers 3.83 • Availability of mental health providers 3.80 • Access to affordable prescription drugs 3.64 • Access to affordable health care 3.63 o 23 % report not having seen a health care provider in > 1 yr. • Access to affordable health insurance coverage 3.60
Mental Health and Substance Abuse • Drug use and abuse 4.07 • Depression 3.83 37% report a diagnosis • Alcohol use and abuse 3.70 o 58% report binge drinking • Suicide 3.52 • Tobacco use - 30 %currently smoke cigarettes
Health and Wellness • 51% Not getting enough fruits and vegetables • 38% Not getting enough exercise • 31% Overweight 37% obese • High cholesterol • Hypertension

2018 Community Health Needs Assessment

How Sanford Sioux Falls is Addressing the Community Needs

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
ECONOMIC WELL BEING	
Availability of affordable housing	Sanford USD Medical Center provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community-based services including: • Establishing a primary care provider • Referrals to mental health and substance abuse resources • Medication assistance • Food and housing assistance There are times when access to community services cannot be arranged in the moment. Sanford will observe the patient in the hospital if supported by medical necessity. During this time, arrangements will be made with community resources. Sanford will often provide medications and transportation as needed until safe transition can be arranged. The Sanford Sports Complex donated land for the development of affordable housing.
Skilled labor force	Sanford has many programs in place to address workforce development, including the Sons and Daughters scholarship program, the Heart Of Tomorrow Program, LPNS to STTs, Surgical Tech Program, internships for college students who are interested in health care careers, and health career programs for high school students.
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence	Sanford USD Medical Center provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community-based services including: • Establishing a primary care provider • Referrals to mental health and substance abuse resources • Medication assistance • Food and housing assistance

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
Homelessness	Sanford works with the city leaders to address homelessness and support services in the community. Sanford USD Medical Center provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community-based services including: • Establishing a primary care provider • Referrals to mental health and substance abuse resources • Medication assistance • Food and housing assistance
Food insecurity (31% of resident survey participants)	Sanford employees volunteer at The Banquet and other community programs that address hunger. Sanford USD Medical Center provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community-based services including: • Establishing a primary care provider • Referrals to mental health and substance abuse resources • Medication assistance • Food and housing assistance
TRANSPORTATION	
Availability of door-to-door transportation services for those unable to drive	Sanford Case Management and Social Work screens patients and provides taxi vouchers where needed.
Availability of public transportation	Sanford provides vouchers to help support the transportation needs of patients. Lyft, taxi services and the Downtown Sioux Falls Trolley are available to serve patients.
CHILDREN & YOUTH	
Substance abuse by youth	Sanford supports *Face it Together*, a behavioral health approach to recovery. The BHTT serves as an integral core team member within the patient-centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
	health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting, helping ensure patient safety.
Childhood obesity	Sanford has invested in athletic facilities such as the Pentagon, Fieldhouse, and additional sports fields to promote activity. Sanford CHILD Services addresses pediatric obesity. Sanford provides *fit*Care classes for childcare providers in 29 counties in northeast and southeast South Dakota, focusing on health and well-being relevant to pediatric obesity prevention. Sanford provides Physical Activity Technical Assistance to childcare providers in 16 counties in southeast South Dakota to assist caregivers in putting more physical activity into a child's day in order to prevent pediatric obesity. Sanford *fit* provides *fit*Club4 Girls in 8 schools within the Sioux Falls School District, focusing on health and well-being relevant to pediatric obesity prevention. Camp Fuel, a week-long camp held at the Sanford Wellness Center for kids ages 9-12, teaches them about healthy eating and physical activity. Sanford dietitians provide general nutrition education for K-12 students in Sioux Falls schools and surrounding communities and cooking classes and nutrition education to Boy and Girl Scouts. Sanford provides the *Fuel Up to Play 60* Coach for the Brandon Valley School District. (FUTP 60 is an in-school program that promotes healthy eating and physical activity.) Sanford provides primary prevention through nutrition education for pregnant women and new moms (B4 Baby, New Baby & Me, and Centering Pregnancy).

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
Availability of services for at-risk youth	Sanford's *Child's Voice* is a nationally accredited Child Advocacy Center that provides medical evaluations for children who may be victims of abuse and neglect.
Bullying	Sanford Children's CHILD Services conducts social emotional trainings and technical assistance to childcare providers in 29 counties in southeast and northeast South Dakota to address the needs of young children learning social skills early and to prevent bullying.
Crime committed by youth	Sanford has recruited additional child psychiatry providers as of 2018. This is in addition to adding behavioral triage therapists to all adult and pediatric primary care clinics. The intent is to identify and treat youths at risk. Physical wellness and structured activities such as team sports have been identified as strategies to reduce suicide and crime.
Teen suicide	Sanford has recruited both adult and child psychiatry providers in an effort to more than double the size of the current Sanford psychiatry group. Sanford has also invested in placing behavioral health triage therapists in all primary care clinics. They serve to provide immediate access to mental health screening as need is identified. Sanford also invests in 24/7 access to inpatient mental health counselors and psychiatry and psychology.
AGING POPULATION	
Cost of long term care	Sanford providers work to keep seniors healthy and living independently as long as possible. One program that assists in transitioning a patient from the medical center to home is the transitional nursing program. At Sanford USD Medical Center in Sioux Falls, Advanced Practice Providers (APP) and experienced nurse case managers provide nursing care to support complex patients for a defined period after discharge from the hospital, usually 4 weeks. The patient is referred and assessed prior to discharge to assure that early identification and response to health risks is planned. This is a multidisciplinary approach working with the health care team. Services provided include: • Home visit soon after discharge • Medication review • Health status monitoring • Provide/reinforce discharge education • Assures follow-up appointments are made and accessible to the patient • Telephone encounters are provided to continue monitoring and provide support • Additional home visits are made based on patient need • The nurse coordinates care with patients provider and the team • The transition nurse provides a warm hand-off to the clinic and provider at the end of the transition period • Research has demonstrated a reduction in readmission, decreased cost, decreased length of stay The recent Good Samaritan affiliation will provide the organization with expertise in the area of long term care and assisted living services and help to create efficiencies for members in the communities that we serve.

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
SAFETY	
Abuse of prescription drugs	In April of 2016, the Sanford Quality Cabinet announced the formation of a Controlled Substance Stewardship Committee (CSSC) because they saw a need and a responsibility to not only protect our patients, but support physicians and APPs who prescribe high-risk medications. The goal was to ensure patients are safe and well treated and that physicians are educated in how to treat patients while being good stewards of the use of opioids. Through education, resources and support, the CSSC has helped providers prescribe responsibly by taking advantage of One Chart technology, implementing protocols for conditions such as low back pain, migraine, and weaning patients from opiates when necessary. An enterprise pain agreement with workflows and guidelines was established using best practices. A 30% reduction in prescription of opioids was achieved by 2018.
Binge drink – 58%	Sanford Health Psychiatry and Psychology Clinic provides a Licensed Addiction Counselor to provide outpatient addiction/chemical dependency care. Sanford has added a Peer Support Advocate (PSA) position to enhance addiction services provided by Sanford Health: • The PSA brings an understanding and insight from the perspective of "lived experience" that can be extremely helpful to the patient struggling with addiction. • The primary role of the PSA is to assist and direct people in recovery from addiction to the proper resources for ongoing care, promoting accountability and mitigating relapse. • Examples of the above would be: assist patient with successfully attending after-care appointments, assist with successful completion of tasks outlined by the treatment team's plan of action, and ultimately improve duration of sustained adherence to treatment plan. Sanford is participating in the community initiative to address behavioral health.
HEALTH CARE ACCESS	
Availability of behavioral health (substance abuse) providers	Sanford has embedded Integrated Health Therapists into all primary care locations. Sanford Health Psychiatry and Psychology Clinic provides a Licensed Addiction Counselor to provide outpatient addiction/chemical dependency care. Sanford has added a Peer Support Advocate (PSA) position to enhance addiction services provided by Sanford Health: • The PSA brings an understanding and insight from the perspective of "lived experience" that can be extremely helpful to the patient struggling with addiction.

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
	• The primary role of the PSA is to assist and direct people in recovery from addiction to the proper resources for ongoing care, promoting accountability and mitigating relapse. • Examples of the above would be: assist patient with successfully attending after-care appointments, assist with successful completion of tasks outlined by the treatment team's plan of action, and ultimately improve duration of sustained adherence to treatment plan. Sanford is participating in the community initiative to address behavioral health.
Availability of mental health providers	Sanford has recruited both adult and child psychiatry providers in an effort to more than double the size of the current Sanford Psychiatry group. Sanford has also invested in placing behavioral health triage therapists in all primary care clinics. They serve to provide immediate access to mental health screening as need is identified. Sanford also invests in 24/7 access to inpatient mental health counselors and psychiatry and psychology.
Access to affordable prescription drugs	Sanford's formulary addresses the cost of drugs and includes the highest quality medications at affordable prices. A drug replacement and subsidy program for cancer patients is available for infusion and oral chemotherapy. Sanford USD Medical Center provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community based services including: • Establishing a primary care provider • Referrals to mental health and substance abuse resources • Medication assistance • Food and housing assistance
Access to affordable health care	Sanford contributed nearly $300 million in charity care during FY 2017. Financial counselors are available to help patients who need free or discounted care. Sanford secured a HRSA grant to address health care access. The HRSA grant increases access to inter-professional health care services by deploying these services further into the community and homes where daily self-care occurs. Co-ops are held four times each week in four community settings. HRSA Co-ops target those receiving Medicare, Medicaid or those who are uninsured. Early outcomes indicate potential reduced cost of health care.
Have not seen a health care provider in over one year – 23%	Sanford USD Medical Center provides nurse case managers in the emergency department to support complex patients who access care in this setting, working with the multidisciplinary team to support the needs of the individual. The nurse case manager is available to consult with patients who need additional support to manage complex social, health or chronic

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
	conditions and provides referrals to resources in the community as appropriate for the assessed needs. The nurse case manager is a broker of services, linking the individual to community-based services including: • Establishing a primary care provider • Referrals to mental health and substance abuse resources • Medication assistance • Food and housing assistance
Access to affordable health insurance coverage	Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations. The Sanford Health Plan is available for people seeking affordable health insurance coverage.
MENTAL HEALTH & SUBSTANCE ABUSE	
Drug use & abuse	The Sanford Quality Cabinet has implemented a program to reduce opioid prescriptions.
Depression	The BHTT serves as an integral core team member within the patient-centered medical home. The BHTT works with the physician, advanced practice provider, RN Health Coach, nurses, care coordinator assistant, peer support advocate and community partners, all of whom work collaboratively to provide the best care to patients. The BHTT is an important resource for patients and team members for issues related to mental and behavioral health, chemical health, and psychosocial aspects of health and disease, and lifestyle management to support optimal patient functioning. The BHTT is integral in the adult and teen screening performed in the primary care clinics. They provide diagnostic assessments and determine disposition triaged according to level of clinical acuity and medical and psychosocial complexity, on-site crisis assessment and crisis intervention, brief counseling, referrals, and education services across the continuum of care. They also provide follow-up to ensure continuity of care and those patients are receiving appropriate behavioral health management. BHTT Key Points: • BHTT role is patient-centered and focuses on assisting the primary care medical team in identifying, triaging and effectively helping patients manage behavioral health problems or psychosocial comorbidities of their chronic medical disease. • BHTT works to ensure seamless interface between primary care and specialty and/or community based resources. • They are able to assist in mental health crisis management and intervention within the clinic setting, helping ensure patient safety.
Alcohol use and abuse	Sanford Health Psychiatry and Psychology Clinic provides a Licensed Addiction Counselor to provide outpatient addiction/chemical dependency care. Sanford has added a Peer Support Advocate (PSA) position to enhance addiction services provided by Sanford Health: • The PSA brings an understanding and insight from the perspective of “lived experience” that can be extremely helpful to the patient struggling with addiction.

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
	• The primary role of the PSA is to assist and direct people in recovery from addiction to the proper resources for ongoing care, promoting accountability and mitigating relapse. • Examples of the above would be: assist patient with successfully attending after-care appointments, assist with successful completion of tasks outlined by the treatment team's plan of action and ultimately improve duration of sustained adherence to treatment plan Sanford is participating in the community initiative to address behavioral health.
Binge drinking – 58%	Sanford Health Psychiatry and Psychology Clinic provides a Licensed Addiction Counselor to provide outpatient addiction/chemical dependency care. Sanford has added a Peer Support Advocate (PSA) position to enhance addiction services provided by Sanford Health: • The PSA brings an understanding and insight from the perspective of "lived experience" that can be extremely helpful to the patient struggling with addiction. • The primary role of the PSA is to assist and direct people in recovery from addiction to the proper resources for ongoing care, promoting accountability and mitigating relapse. • Examples of the above would be: assist patient with successfully attending after-care appointments, assist with successful completion of tasks outlined by the treatment team's plan of action and ultimately improve duration of sustained adherence to treatment plan. Sanford is participating in the community initiative to address behavioral health.
Suicide	Sanford has recruited both adult and child psychiatry providers in an effort to more than double the size of the current Sanford psychiatry group. Sanford has also invested in placing behavioral health triage therapists in all primary care clinics. They serve to provide immediate access to mental health screening as need is identified. Sanford also invests in 24/7 access to inpatient mental health counselors and psychiatry and psychology.
Currently smoke cigarettes – 30%	Sanford's annual performance improvement plan includes smoking cessation in the setting of chronic disease. In addition to behavioral health triage therapists, Sanford has invested in providing RN Health Coaches to all primary care clinics. Both roles assist providers in counseling patients on smoking cessation and helping patients access the South Dakota Quit Line.
HEALTH & WELLNESS	
Not eating enough fruits/vegetables – 51%	Sanford dietitians provide general nutrition education presentations to employees of Sioux Falls businesses. Sanford works in partnership with the Sioux Falls Health Department on numerous health promotion programs.
Not getting enough exercise – 38%	Sanford has invested in athletic facilities such as the Pentagon, Fieldhouse, and additional sports fields to promote activity.

Identified Concerns	How Sanford Sioux Falls USD is Addressing the Community Needs
	Sanford Women's Mutch Center for Health Enrichment. Provides Healthy Lifestyle Coaching for the public, nutrition consultations for the public, and small group fitness for women with classes specifically designed for bone health and individuals struggling with physical movement due to chronic disease.
Overweight – 68% of resident survey participants	Sanford has invested in athletic facilities such as the Pentagon, Fieldhouse, and additional sports fields to promote activity. Sanford provides one-on-one nutrition counseling for Wellness Center and Mutch Women's members.
High cholesterol	Sanford's annual performance improvement plan includes measures focused on hypertension control and cholesterol treatment. A Sanford Quality team to achieve success in cholesterol treatment and hypertension control supports the provider team. Sanford dietitians are available to provide medical nutrition therapy to reduce cholesterol. Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations.
Hypertension	Sanford's annual performance improvement plan includes measures focused on hypertension control and cholesterol treatment. A Sanford Quality team to achieve success in cholesterol treatment and hypertension control supports the provider team. Sanford patients with hypertension currently are controlled at a rate of 89%. Sanford dietitians are available to provide medical nutrition therapy to reduce hypertension. Sanford exercise specialists provide exercise therapy to reduce hypertension. Sanford has: walk in, video visits, e-visits, online scheduling, and same day access in all primary care locations.

Implementation Strategies

Implementation Strategies - 2018

Priority 1: Economic Well-Being – Workforce Development

The Council on Social Work Education reports that economic well-being may be achieved by individuals, families and communities through public policies that ensure the ability to build financial knowledge and skills, access to safe and affordable financial products and economic resources, and opportunities for generating income and asset building. It occurs within a context of economic justice within which labor markets provide opportunities for secure full employment with adequate compensation and benefits for all. Sanford has made economic well-being a significant priority and has developed a strategic plan to provide workforce and skilled labor opportunities in the Sioux Falls area and across the system.

Priority 2: Behavioral Health and Mental Health Access

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

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

Sanford USD Community Health Needs Assessment
Implementation Strategy Action Plan for 2019-2021

<u>Priority 1</u>: Economic Well-Being - Workforce Development

Projected Impact: A skilled workforce is enhanced and growing in the Sioux Falls community

Goal 1: Recruit, support and develop a skilled workforce

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Increase clinical and non-clinical Internships from higher education organizations	# of completed internships Clinical internships = 78 Non-clinical internships = 328 We are hoping to increase our non-clinical internships to 600 in 2019, 800 in 2020 and 1,000 in 2021.	We have added an internship coordinator in the Sioux Falls region and along with our recruitment team we have placed over 400 internships. We pay our interns a competitive rate of $10.08 and we give them a meaningful internship made up of 400 hours.	Karla Haugan	We are continuing to increase our investment in our strategic internship program to attract and engage talent as they near graduation. We are partnering with surrounding schools such as Augustana University, University of Sioux Falls, USD, SDSU, Mount Marty, etc.
Sponsor individuals who are pursuing the LPN program	# of LPN sponsorships # of graduates from the LPN program Current sponsorships that have been placed are 12	Current 2018 LPN sponsorships are 24 and we are hoping to double this number next year. We sponsor approximately $10,000 per LPN. Of the 24 we have had half of these graduate and start employment with us.	Karla Haugan	We are committed to "growing our own" by offering sponsorships for those who commit to work at Sanford Health following graduation. We have partnered with Southeast Tech, Mitchell Tech, and Lake Area Tech to assist us with being our academic partner.
Sanford Scholars – Sons and Daughters	There are 160 current participants in the Sons & Daughters program 23 Sons & Daughters	There is an ongoing commitment to continue to provide both Sons & Daughters Scholar Loans and $1,000 Medical School Acceptance Scholarships to program participants who are in medical school, residency and fellowship.	Karla Haugan	Through the Sons & Daughters program we reach out to and include participants from many communities in many states throughout the Sanford footprint and beyond.

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
	Scholar Loans have been awarded YTD in 2018. Since August of 2016, 102 $1,000 Sons & Daughters Medical School Acceptance Scholarships have been awarded to Sons & Daughters participants. 14 Sons & Daughters participants have signed to become or have become Sanford Physicians.	We anticipate continued growth in the number of loan and scholarship recipients in this and upcoming years.		We are able to do this because of our ability to reach out to and include family members of Sanford employees in the program.
Support students enrolling in health career programs through the Heart of Tomorrow	# of students in the Heart of Tomorrow Program 100-110 each year Cost of scholarships in 2019, 2020, 2021 2019 - $115,000 2020 - $110,000 2021 - $110,000	Each year we award 100 – 110, $1,000 scholarships based on GPA and regional placement. We assure that we award recipients in all of our areas where we are located.	Karla Haugan	During the past 10 years, Sanford Health has invested in the Heart of Tomorrow program to assist children of our employees with post-secondary education expenses. Nearly 1/3 of the recipients have chosen Sanford Health as their employer of choice.
Recruit and support Residents and Fellows	# completing the residency and fellowship programs	Pediatric Residency; Surgical Residency; Cardiac Fellowship; Cardiac Interventional Fellowship.	Karla Haugan	We are an Academic Medical Center that supports the recruitment and support of Residents and Fellows. We also dedicate a department of Academic Affairs to support education and Sanford funded Residency/Fellowships:

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
				Pediatric Residency; Surgical Residency; Cardiac Fellowship; Cardiac Interventional Fellowship. We continue to expand these services. Plus, we are looking to add a Neurology and Ortho Residency. We allocate millions of dollars to these activities each year, and it grows each year. We partner with outside health care organizations and system facilities to enhance student learning.

<u>Priority 2</u>: Behavioral Health and Mental Health Access

Projected Impact: Behavioral health and mental health services are available and have capacity for patients and community members

Goal 1: Integrated Health Therapists (IHT) are embedded in primary care centers

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
IHT services are provided in all Sanford primary care settings in the Sioux Falls market	# of visits 10,000+	IHTs Clinical Leadership	Terri Carlson, Ann Hamilton	Many within the community, i.e. Southeastern Behavioral, Keystone, LifeScape, Volunteers of America, Falls Community Health

Goal 2: A formal recruitment plan is in place for behavioral health specialty services

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
An active recruitment plan is in place	# of providers recruited during 2019, 2020, 2021	Currently 17 providers including 4 physicians, 4 Advanced Practice Providers, 3 psychologists, 6 therapists. Will add 7 new physicians/ providers in 2019.	Terri Carlson, Ann Hamilton, Dr. Rajesh Singh and Dr. David Ermer	Children's Home Society, LifeScape – both child and adult services, Volunteers of America, Southeastern Behavioral, Falls Community Health

Goal 3: PHQ-9 demonstrates improved scores for patients with depression

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Reduce the severity of depression	% of patients with major depression or dysthymia and an initial score greater than 9 whose 6 month PHQ-9 score is < 5	IHTs in Clinic - Quality department has worked with each clinic, via clinical leadership, to educate on PHQ9 and optimal depression care.	Mike Wilde, MD; Andy Munce, Terri Carlson	Outside organizations to enhance provider and student education

Goal 4: Community Triage Program

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Explore the feasibility of a community triage program	Community leaders to determine if a community triage center will be executed	Update from Behavioral Health Stakeholders Meeting held on September 27, 2018. Kari Benz from Minnehaha County, Department of Health shared data from their 50K grant mapping project to demonstrate the need for a triage center. • 24% of jail population have mental health issues. • 100 people are top utilizers	Paul Hanson, Terri Carlson, Monica Huber	Sioux Falls Department of Health Behavioral Health partners in the community

Actions/Tactics	Measurable outcomes & timeline	Dedicated resources/Budget/Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
		• Top 5% of these individuals are 20 people having 16 or more jail bookings • 2016 data from both Avera and Sanford ER visits showed 5,300 encounters with a cost of $40 million or $6,000 cost per encounter • 4,000 of these patients went back home with an average stay of 3 hours • Mayor TenHaken, Sheriff Milstead and other BH community stakeholders highly support the need for a triage center • Will need funding from both health care systems and community support to make the triage center happen. No funding amount was shared at this meeting.		

Impact from the FY 2017-2019 Action Plan
Community Health Needs Assessment
Implementation Strategy for Sioux Falls USD Medical Center

<u>Priority 1</u>: Crime/Safety - Pharmaceutical Narcotics in our Community

Projected Impact: Alternative pain management methods are adopted across the enterprise and narcotic usage is reduced

Goal 1: Standardize narcotic prescribing protocols across the enterprise to reduce usage

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations
Policies and procedures to address the prescription of narcotics are standardized across the enterprise	Track narcotic prescriptions Identify areas for improvement	Behavioral Health Triage Therapists Physicians	Dr. Mike Wilde Dr. Dan Heinemann Dr. Allison Suttle	Sioux Falls Police Department

<u>Priority 2</u>: Physical Health - Chronic Disease

Projected Impact: Improve chronic disease outcomes

Goal 1: Improve care of patients with overweight or obesity diagnosis

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Patients who are overweight or obese will be referred to internal/external services	Internal referrals are tracked Change in BMI is monitored through quality metrics	Kelly Hasvold/ Quality Team Health Coaches Exercise specialists Sanford Dietitians Sanford *fit*	Dr. Mike Wilde Dr. Dan Heinemann Dr. Allison Suttle	
Provide Sanford *fit* to the local schools and childcare centers	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 Childcare leaders

Goal 2: Diabetes – Improve Care of Patients with Diabetes

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Adopt optimal diabetes care for patients ages 18-75 with diabetes	Systolic B/P <140 Diastolic B/P < 90 LDL – per statin indications HbA1C < 8 Tobacco free Daily aspirin if Ischemic Vascular Disease	Kelly Hasvold/Quality Team Health Coaches Exercise Specialists Sanford Dietitians	Dr. Mike Wilde Dr. Dan Heinemann Dr. Allison Suttle	

Goal 3: – Improve Care of Patients with Hypertension

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Standardized hypertension protocols are in place in all primary care settings	B/P < 140/90 for ages 18-59 B/P < 140/90 for age 60+ with DM, vascular or renal disease B/P < 150/90 for age 60 without DM, vascular or renal disease	Kelly Hasvold/Quality Team Health Coaches Exercise specialists Sanford Dietitians	Dr. Mike Wilde Dr. Dan Heinemann Dr. Allison Suttle	

Goal 4: – Improve Care of Patients with Ischemic Vascular Disease

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Adopt standardized protocols for optimal vascular care	Systolic B/P <140 Diastolic B/P < 90 LDL – per statin indications Tobacco free Daily aspirin if Ischemic Vascular Disease	Kelly Hasvold/Quality Team Health Coaches Exercise Specialists Sanford Dietitians	Dr. Mike Wilde Dr. Dan Heinemann Dr. Allison Suttle	

Demonstrating Impact – 2017- 2019 Strategies

Crime/Safety – Reduce Pharmaceutical Narcotics in our Community

Sanford developed strategy to reduce narcotic use across the system by providing alternative pain management methods. Policies and procedures to address the prescription of narcotics have been standardized across the health care system. Pain medication prescriptions are continuously tracked and studied to identify areas for improvement. There has been a 28% reduction in the prescription of narcotics since beginning this initiative in 2017.

Physical Health – Chronic Disease

Sanford has set strategy to improve the care of patients with overweight or obesity diagnosis. Patients who are overweight will be referred to internal and external services including registered dietitians, exercise physiologists, and RN Health Coaches. From 2017 through Q3 of 2018, the referrals for follow-up interventions have increased. The current rate of referral is 46.2%.

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 children, 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, throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life. Since 2017, Sanford has presented the Sanford *fit* program to live audiences and has reached 5,075 individuals. The online program is available nationwide.

Improve Care of Patients with Diabetes

Sanford has set strategy to provide optimal diabetes care and to measure the outcomes for systolic and diastolic blood pressure, LDL cholesterol, hemoglobin A1C, tobacco use and aspirin use. These outcomes are part of the optimal care recommendations for people living with diabetes. Currently at Sanford, 49.4% of patients with diabetes are at optimal outcomes.

Improve Care of Patients with Hypertension

Sanford has set strategy to address hypertension through standardized protocol, frequent blood pressure monitoring, and referral. Outcomes measures include a blood pressure of less than 140/90 for all ages 18-59, and for age 60+ with diabetes, vascular or renal disease. For patients 60 or older without diabetes, vascular or renal disease, the goal is a blood pressure of 150/90. Eighty-eight percent of patients with hypertension are now under control with a blood pressure of <140/90.

Improve Care of Patients with Ischemic Vascular Disease

Sanford has set strategy to address ischemic vascular disease by standardizing protocols for optimal vascular care. Outcome measures include systolic blood pressure <140, diastolic blood pressure < 90, LDL statin indications, tobacco free recommendations, and a daily use of aspirin. Currently at Sanford 63% have met the outcomes for optimal care.

Community Feedback from the 2016 Community Health Needs Assessment

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

Appendix

Primary Research

Sioux Falls Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Economic Well Being	Availability of affordable housing 4.11 Skilled labor force 3.97 Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence 3.91 Homelessness 3.62 31% report not having enough food	31% report not having enough food		Housing resources: • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Community Outreach (financial assistance for rent/deposit, prevention of eviction), 225 E. 11th Street • Fair Housing Program, 224 W. 9th • Habitat for Humanity, 721 E. Amidon • Homebuyers Assistance Program, 224 W. 9th St. • HUD South Dakota, 2400 W. 49 St. • Inter-Lakes Community Action Partnership, 505 N. Western Ave. • LSS Center for Financial Resources (homeownership counseling), 705 E. 41st St. • Moving Assistance Program, 2707 W. 33rd Street (for those who cannot afford to move to a better or safer living situation) • Safe Home, 320 W. 3rd St. (permanent housing for persistently homeless adults who have severe alcohol issues) • SD Housing Locator – sdhousingsearch.com • Section 8 Housing Voucher, 630 S. Minnesota Ave. • Sioux Empire Housing Partnership, 200 N. Phillips Ave. • Sioux Falls Community Development - Affordable Housing, 2235 W. 10th St. • Sioux Falls Housing, 630 S. Minn. Avenue • Sioux Falls Housing & Redevelop. Commission, 224 W. 9th Street Low Income Apts.: • Baha Townhouses, 4017 S. Baha Avenue • Baumgartner Apts., 425-1/2 N. Nesmith • Beadle Plaza, 1000 E. 14th St. • Canterbury House, 3501 S. Terry Ave.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Cathedral Heights Senior Affordable Apts., 720 W. 5th St. • Collins Apts., 520 N. Spring • Creekside Apts., 4800 W. 57th St. • Crescent Villa, 5501 W. 46th St. • City Center Apts., 620 N. Main Ave. • Eastview Apts., 3300 E. 11th St. • Falls Park Apts., 3601 N. Career Avenue • Falls View Apts., 313 W. 2nd St. • Greenway Apts., 3008 E. 26 St. • Harvest Apts., 3210 E. 31st St. • Hawthorne Hall, 4021 S. Hawthorne Ave. • Heritage Apts., 1818 E. 3rd St. • Horizon Apts., 4601 Tennis • Hospitality Apts., 3510-B S. Terry • Huey Apts., 112 N. Phillips Ave. • L'Abri, 100 W. 6th • Meadowland Apts., 3601 S. Marion Road • Murray Apts., 2500 W. Madison St. • Olive Grove, 4904 Kirkwood Circle • Pasque Meadows, E. Brennan & 3rd Street • Spring Hill Apts., 16th St. & Blaine Avenue • Tower of David Senior Apts., 320 S. 3rd Avenue • Town Park Apts., 2068 S. Cleveland • Western Heights Apts., 2201 West 46th St. Skilled Labor/Employment resources: • Aerotek, 5016 S. Bur Oak Pl. • Bridges Employment Resource Center, 2300 W. 46th St. • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Command Center, 409 S. 2nd Ave. • Dress for Success (provides professional attire for job interviews & career development tools for women), 620 W. 18th St. • DSS Child Care Services (provides financial help for	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				those seeking employment) - 800-227-3020 • Employment Edge, 4320 S. Louise Avenue • Experience Works, 2116 S. Minn. Avenue • Express Employment, 434 S. Kiwanis • Farmworker Jobs Program, 811 E. 10th St. • Goodwill Job Center, 3400 S. Norton Avenue • IMKO, 4309 S. Racket Drive • Job Service, 811 E. 10th St. • Key Staffing, 500 N. Western Ave. • LSS Center for New Americans, 300 E. 6th St. (provides employment services) • People Ready, 201 W. 37th St. • Pro Force Services, 2221 W. Russell Street • SD Dept. of Labor, 811 E. 10th St. • Spartan Staffing, 201 W. 37th St. • Spherion, 4320 S. Arway Drive • Tradesmen International, 8609 W. 26th Street • Workforce Solutions, Chamber of Commerce, 101 Pierce St. Homelessness resources: • Berakhah House, 400 N. Western Avenue • Bishop Dudley Hospitality House, 101 N. Indiana Ave. • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Community Outreach (financial assistance for rent/deposit, prevention of eviction), 225 E. 11th Street • Dept. of Human Services (energy assistance), 521 N. Main Ave. • Furniture Mission (provides furniture/mattresses), 209 N. Nesmith Avenue • Goodwill (provides household items), 3400 W. Norton Avenue • Habitat for Humanity, 721 E. Amidon St. • HOME Tenant Based Rental Assistance, 630 S. Minn. Ave. • Hope Prison Ministry (provides clothes, housing, etc. for those	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				getting out of prison) - 605-338-7626 • Inter-Lakes Community Action Partnership (security deposit for permanent hsg), 505 N. Western Avenue • King's Kloset (provides household items), 100 E. 17th St. • Love, Inc. (utility & rent assistance), 111 E. 6th St. • LSS Center for Financial Resources (homeownership counseling), 705 E. 41st St. • Minnehaha Co. Human Services (financial assistance with rent/deposits, etc.), 521 N. Main Avenue • Moving Assistance Program, 2707 W. 33rd Street (for those who cannot afford to move to a better or safer living situation) • Necessities for Neighbors (monthly distribution of household items), 5509 W. 41st Street • Safe Home, 320 W. 3rd St. (permanent housing for persistently homeless adults who have severe alcohol issues) • St. Francis House, 1301 E. Austin Street • Salvation Army (emergency assistance with rent/mortgage to prevent eviction), 900 N. Cliff Ave. • Society of St. Vincent de Paul (provides furniture, household items, financial assistance with rent/utilities), 431 N. Cliff Avenue • Union Gospel Mission, 701 E. 8th Street Hunger resources: • Backpack Program & School Pantry Program, 4701 N. Westport Ave. • Banquet, The (meals for those who are homeless), 900 E. 8th St. • Banquet West (dinners), 100 N. Lyon Blvd. • Bishop Dudley Hosp. House (daily lunches), 101 N. Indiana Ave.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Community Gardens, c/o Live Well Sioux Falls, 521 N. Main Avenue • Kids Against Hunger, 2400 S. Minn. Avenue • Meals on Wheels, 2300 W. 46th St. • Senior Box Program, 4701 N. Westport Ave. • SNAP Program, 811 E. 10th St. • WIC Program, 1200 West Ave. *Food Pantries:* • Church of Christ, 400 E. 41st St. • Crossroads Community Church, 1515 N. North Dr. • Cross Pointe Baptist, 2201 S. Marion Rd. • Eastside Lutheran, 1300 E. 10th St. • Faith Temple Food Giveaway, 2121 W. 33rd St. • Food to You Mobile Food Pantry – 605-336-3597 • Good Samaritan Pantry, 401 W. 2nd Street • Good Samaritan Village, 3901 S. Marion Rd. • Jesus Only Apostolic, 1120 E. Benson Rd. • King of Glory, 6120 S. Charger Cir. • Luther Manor, 1500 W. 38th St. • Mobile Food Pantry, 4701 N. Westport Ave. • Mt. of Olives Ministries, 3808 S. Marion Rd. • Nightwatch Canteen (breakfasts & dinners), 401 S. Spring Ave. • Peace Lutheran, 5509 W. 41st St. • Ridgecrest Baptist, 1034 N. Spring Avenue • St. Katharine Drexel Parish (weekly bag of food), 1800 S. Katie Avenue • Salvation Army, 800 N. Cliff Ave. • Set Free Ministries, 3812 N. Cliff Avenue • SF Food Bank, 4701 N. Westport Avenue • SF Food Pantry, 417 N. Phillips Avenue • SF Seminary, 2100 S. Summit	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Union Gospel Mission (3 meals/ day), 220 N. Weber Ave. *Farmers Markets:* • Gundy's Farmers Market, 8th & Railroad Center • Falls Park Farmers Market, P O Box 2531 • MTM Euro Farmers Market, 5315 W. 41st St. • Prairie Farmers Market, 300 N. Cherapa Place • Sioux Empire Farmers Market, 401 E. 8th St. *Grocery Stores:* • ALDI, 2808 S. Louise • Andy's Affiliated Foods, 1025 S. Cleveland • Beeryozka Grocery, 3301 E. 26th St. • Fareway, 1431 W. 41st St. • Franklin Food Market, 711 N. Cliff Ave. • Global Foods, 1002 W. 6th St. • Hy-Vee (several locations) • Mercato, 631 W. 11th St. • Pomegranate Market, 4815 S. Louise • Sunshine Foods, 530 S. 2nd Ave. • Tienda America, 114 S. Franklin Ave. • Thanh Mai, 824 E. Rice St. • The Co-op Natural Foods, 410 W. 18th St. • Walmart, 7821 S. Minn. Ave.	
Transportation	Availability of door-to-door transportation services for those unable to drive 3.60 Availability of public transportation 3.51			Transportation resources: • Bowden Youth Center, 430 W. 11th Street • Calvary Episcopal Cathedral, 500 S. Main Ave. (gas assistance) • Center of Hope, 225 E. 11th St., (low cost bikes for work; bike repair) • Disabled American Veterans, 1519 W. 51st Street • Elite Taxi, 2915 E., Bragstad Drive • Pass-It-On – 605-367-4217 (bus passes) • Project C.A.R., 327 S. Dakota Ave. • Sioux Area Metro (SAM), 120 E. 11th Street	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Sioux Empire Wheels to Work, 805 E. Pam Rd. • Sioux Falls Immunization Coalition, 300 S. Phillips Ave. • Sioux Falls Wheelchair Transit Plus, 123 W. 43rd St. • Siouxland Paratransit Services, 208 N. Detroit Avenue • Wheelchair Express, 614 N. Kiwanis Avenue • Workers on Wheels (WOW), 230 W. 46th St.	
Children and Youth	Substance abuse by youth 3.67 Childhood obesity 3.61 Availability of services for at-risk youth 3.58 Bullying 3.55 Crime committed by youth 3.52 Teen suicide 3.52			Substance Abuse resources: • Al-Anon, 41 W. Sioux Street • Alcoholics Anonymous, 1000 N. West Avenue • Arch Halfway House, 516 W. 12th Street • Avera Behavioral Health, 4400 W. 69th St. • Avera Addiction Recovery Program, 2412 S. Cliff Avenue • Bartels Counseling, 6330 S. Western Avenue • Carroll Institute, 310 S. 1st Ave. • Choices Recovery, 2701 S. Minn. Ave. • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Clarity Counseling, 101 S Reid St. • Counseling Resources, 4109 S. Carnegie Circle • Dakota Drug & Alcohol Prevention, 822 E. 41st St. • Emerald Psychological Services, 5032 S. Bur Oak Place • Face It Together, 5020 S. Tennis Lane; 231 S. Phillips Ave. • First Step, 4320 S. Louise Ave. • Glory Home, 4000 S. West Ave. • Gorman, Stacy Counseling, 6809 S. Minn. Ave. • Great Plains Psychological Services, 4105 S. Carnegie Place • Heisler Treatment Center, 1401 W. 51st St. • Integrative Wellness, 5000 S. Minn. Avenue • Keystone Outreach, 7511 S. Louise Ave. • LaVelle & Associates, 5024 S. Bur Oak Place • Minnehaha Co. Detox Center, 500 N. Minn. Ave.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Narcotics Anonymous meetings (many locations) • New Day Counseling, 1320 E. Rushmore Drive • Phillips Mental Health, 6209 E. Silver Maple Circle • Prairie View Prevention Services, 822 E. 41st St. (school-based intervention) • Psychiatric Services, LLC, 101 S. Reid Street • Psychotherapy Associates, 2210 W. Brown Place • Renew Counseling, 5201 W. Western Avenue • Restoration Treatment Services, 225 E. 11th Street • Safe Home, 320 W. 3rd St. (permanent housing for persistently homeless adults who have severe alcohol issues) • Sanford Behavioral Health, 2400 W. 49th Street • Sioux Falls Treatment Center, 2519 W. 8th St. • Sioux Falls Urban Indian Health, 711 N. Lake Ave. • Sioux Falls Wellness Counseling, 5201 S. Western Avenue • Stolsmark, Erin, Inc., 6809 S. Minn. Avenue • Stronghold Counseling, 4300 S. Louise • Tallgrass Recovery / Transitional Living Corp., 27048 Tallgrass Ave. • VA Medical Center, 2501 W. 22nd Street • Volunteers of America Dakotas, 1310 – 51st St. Childhood Obesity resources: • Live Well Sioux Falls, 521 N. Main Avenue • Sanford *fit*, sanfordfit.org • Sanford Pediatric Clinics, 69th & Louise; 26th & Sycamore • SF Parks & Recreation Dept. programs, 100 E. 6th Street • Avera Pediatric Clinic, 1417 S. Cliff Ave. • Avera Pediatric Childhood Obesity Videos, 3900 W. Avera Dr.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				Services for At-Risk Youth: • Alpha Center (pregnancy options counseling), 3405 S. Kiwanis Ave. • Avera Behavioral Health Center – Adolescent Group Therapy, 4400 W. 69th St. • Berakhah House, 400 N. Western Circle • Birthright, 101 N. Indiana Ave. • Bowden Youth Center, 430 W. 11th Street • Center for Disabilities (birth to 3), 1400 W. 22nd Street • Children's Home Society, 801 N. Sycamore Avenue • Children's Inn, 409 N. Western Ave. • Family Visitation Center (safe environment for non-custodial parent visits), 311 E. 14th Street • LifeScape, 1020 W. 18th Street • LSS Arise Youth Center East, 621 E. Presentation Street • Planned Parenthood (pregnancy testing for teens), 6511 W. 41st St. • Planning Life/New Haven (pregnancy testing, STD info), 225 E. 11th Street • Prairie View Prevention Services, 822 E. 41st St. • VOA LifeMarks Behavioral Health (crisis intervention for youth), 1310 W. 51st Street Bullying – counselors who work with children: • Avera Pediatrics Clinic, 1417 S. Cliff Ave. • Dakota Oak Counseling, 3220 W. 57th St. • Great Plains Psychological Services, 4109 S. Carnegie Circle • Sanford Behavioral Health, 2400 W. 49th St. • Sanford Pediatric Clinics, 69th & Louise; 26th & Sycamore Crime resources: • Crime Stoppers – 605-367-7007 • Crime Victims resources, 7090 Governor's Drive, Pierre	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Sioux Falls Police, 320 W. 4th St. • Sioux Falls Sheriff, 320 W. 4th St. Teen Suicide resources: • Avera Behavioral Health, 4400 W. 69th Street • Central SD Survivors of Suicide Support Group, meets at 925 E. Sioux Ave., Pierre • Friends & Families of Suicides support group, 1413 E. 5th St. • Helpline Center / Suicide Support, 1000 N. West Ave. • National Suicide Prevention Lifeline – 800-273-8255 • Sanford Behavioral Health, 2400 W. 49th St. • Sioux Falls Suicide Prevention Helpline – 605-339-8599 • Surviving After Suicide support group, 1000 N. West Avenue *Therapists who work with suicide ideation:* • Bartels Counseling, 6330 S. Western Avenue • Burroughs Counseling, 5032 S. Bur Oak Place • Chan, Amber M. (Mindful DBT, LLC), 5708 S. Remington Pl. • Dixon, Stacy L., 6116 S. Lyncrest Avenue • Evenson Counseling, 3101 W. 41st Street • Harp, Tina, 3101 W. 41st Street • Integrative Wellness, 5000 S. Minnesota Avenue • Journey Therapy, 1500 S. Sycamore • LaVelle & Associates, 5024 S. Bur Oak Place • Moore Counseling, 4801 W. 41st Street • Renew Counseling Services, 5201 S. Western Avenue • Sadowski Counseling, 3201 S. Prairie Avenue • SF Wellness Center, 5201 S. Western Avenue • Weires Consulting, 4410 S. Tennis Lane • Wellspring Therapy Center, 6901 Lyncrest Place	
Aging Population	Cost of long term care 3.50			Long Term Care resources:	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Avera Prince of Peace, 4513 S. Prince of Peace Place • Bethany Lutheran Home, 1901 S. Holly Ave. • Dow Rummel Village, 1321 W. Dow Rummel St. • Golden Living Center, 3900 S. Cathy Avenue • Good Samaritan, 401 W. 2nd St. • Luther Manor, 1500 W. 38th St. • Southridge Healthcare, 3600 S. Norton Avenue Home Care/Respite Care resources: • Comfort Keepers, 4300 S. Louise Ave. • Home Instead – 605-274-2273 • Home Style Health Assistance of SF - 605-610-8448 • Sanford Home Care, 2710 W. 12th Street • Sanford Home Medical Equipment, 2710 W. 12th Street • SD Dept. of Human Services respite care program, 3800 E. Hwy. 34, Pierre • Synergy Home Care, 108 E. 38th St. Assisted Living resources: • Avera Prince of Peace, 4513 S. Prince of Peace Place • Cayman Court, 4101 W. Cayman Street • Dow Rummel Village, 1321 W. Dow Rummel St. • Edgewood Vista, 3409 E. 5th St.; 3401 W. Ralph Rogers Rd. • Good Samaritan Society, 1722 & 3901 S. Marion Rd. • Green Leaf, 3409 E. 5th St. • Inn on Westport, 4000 S. Westport Ave. • Meadows on Sycamore, 130 N. Sycamore • Prairie Crossings, 1800 S. Dorothy Avenue • Primrose Retirement Community, 7400 S. Louise Ave. • Stoney Brook Suites, 4501 E. Pampas Place • Trail Ridge, 3408 W. Ralph Rogers Road	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Washington Crossing, 4709 E. 6th Street • Waterford, 111 W. 17th St.	
Safety	Abuse of prescription drugs 4.00 58% binge drink – resident survey	58% binge drink		Prescription Drug Abuse resources: • Minnehaha Sheriff, 320 W. 4th St. • Sioux Falls Police, 320 W. 4th St. Substance Abuse resources: • Al-Anon, 41 W. Sioux Street • Alcoholics Anonymous, 1000 N. West Avenue • Arch Halfway House, 516 W. 12th Street • Avera Behavioral Health, 4400 W. 69th St. • Avera Addiction Recovery Program, 2412 S. Cliff Avenue • Bartels Counseling, 6330 S. Western Avenue • Carroll Institute, 310 S. 1st Ave. • Choices Recovery, 2701 S. Minn. Ave. • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Clarity Counseling, 101 S Reid St. • Counseling Resources, 4109 S. Carnegie Circle • Dakota Drug & Alcohol Prevention, 822 E. 41st St. • Emerald Psychological Services, 5032 S. Bur Oak Place • Face It Together, 5020 S. Tennis Lane; 231 S. Phillips Ave. • First Step, 4320 S. Louise Ave. • Glory Home, 4000 S. West Ave. • Gorman, Stacy Counseling, 6809 S. Minn. Ave. • Great Plains Psychological Services, 4105 S. Carnegie Place • Heisler Treatment Center, 1401 W. 51st St. • Integrative Wellness, 5000 S. Minn. Avenue • Keystone Outreach, 7511 S. Louise Ave. • LaVelle & Associates, 5024 S. Bur Oak Place • Minnehaha Co. Detox Center, 500 N. Minn. Ave. • Narcotics Anonymous meetings (many locations)	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• New Day Counseling, 1320 E. Rushmore Drive • Phillips Mental Health, 6209 E. Silver Maple Circle • Prairie View Prevention Services, 822 E. 41st St. (school-based intervention) • Psychiatric Services, LLC, 101 S. Reid Street • Psychotherapy Associates, 2210 W. Brown Place • Renew Counseling, 5201 W. Western Avenue • Restoration Treatment Services, 225 E. 11th Street • Safe Home, 320 W. 3rd St. (permanent housing for persistently homeless adults who have severe alcohol issues) • Sanford Behavioral Health, 2400 W. 49th Street • Sioux Falls Treatment Center, 2519 W. 8th St. • Sioux Falls Urban Indian Health, 711 N. Lake Ave. • Sioux Falls Wellness Counseling, 5201 S. Western Avenue • Stolsmark, Erin, Inc., 6809 S. Minn. Avenue • Stronghold Counseling, 4300 S. Louise • Tallgrass Recovery / Transitional Living Corp., 27048 Tallgrass Ave. • VA Medical Center, 2501 W. 22nd Street • Volunteers of America Dakotas, 1310 – 51st St.	
Health Care Access	Availability of behavioral health providers 3.83 Availability of mental health providers 3.80 Access to affordable prescription drugs 3.64 Access to affordable health care 3.63 23% report not having seen a health care provider in over 1 year			Mental/Behavioral Health Resources: • Avera Behavioral Health, 4400 W. 69th Street • Behavior Management Counseling Service, 3610 S. Western Avenue • Bartels Counseling, 6330 S. Western Avenue • Bethesda Christian Counseling, 400 S. Sycamore Ave. • Caminado Juntois (Spanish speaking counselor), 617 E. 7th St.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	Access to affordable health insurance coverage 3.60			• Catholic Family Services, 523 N. Duluth Avenue • Center for Family Medicine, 1115 E. 20th Street • Children's Home Society, 801 N. Sycamore Avenue • Christensen, Barbara, Inc., 6809 S. Minnesota Avenue • Clarity Counseling, 101 S Reid St. • Compass Center, 1800 W. 12th St. • Community Counseling Clinic, 2109 S. Norton Avenue • Conrad Counseling, 5024 S. Bur Oak Place • Credo Counseling, 5024 S. Bur Oak Place • Dakota Oak Counseling, 3220 W. 57th Street • Digatono, Daniel T. Counseling, 4410 S. Tennis Lane • Discover Wellness, 2121 W. 63 Pl. • Emerald Psychological Services, 5032 S. Bur Oak Place • Emotions Anonymous support group, P. O. Box 4245 • Encompass Mental Health, 100 S. Spring Avenue • Ericsson, Kristen Counseling, 600 N. Main Avenue • Evenson Counseling, 3701 W. 49th Street • Family Service, Inc., 2210 W. Brown Place • Family Ties Christian Counseling, 3500 S. Phillips Ave. • Four Directions Counseling, 101 S. Reid St. • Glow – Glorious Lifestyle – Optimal Weight, 1601 E. 69th St. • Gorman, Stacy Counseling, 6809 S. Minn. Ave. • Great Plains Psychological Services, 4105 S. Carnegie Place • Guth, Mary T. Counseling, 3610 S. Western Ave. • Hansen-Mayer, Brenda, 1601 E. 69th Street • Harp, Tina Counseling, 6509 S. Cliff Avenue • Hauck, Stacey Counseling, 1601 E. 69th Street	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Helpline Center / 211 Response, 1000 N. West Ave. • Heuermann Counseling Clinic, 2210 S. Brown Place (free short-term counseling) • Holm, Ellen Counseling, 4410 S. Tennis Lane • Huffman, Darla Counseling, 6809 S. Minn. Avenue • Integrative Wellness, 5000 S. Minn. Avenue • Journey Counseling, 6209 S. Pinnacle Place • Journey Therapy, 1500 S. Sycamore • Kannan Clinic, 6709 S. Minn. Ave. • Keiser, Kimberly & Assoc., 6320 S. Western Avenue • Key Solutions, 3800 S. Kiwanis Ave. • LaVelle & Associates, 5024 S. Bur Oak Place • LifeGate Christian Counseling, 6820 W. 26th Street • LifeMarks Behavioral Health, 1310 W. 51st St. • LifeScape, 1020 W. 18th Street • Lighting a New Way, 1500 S. Sycamore Ave. • LSS Counseling, 705 E. 41st Street • Maass, Ronda Counseling, 5510 S. Tennis Lane • Moore Counseling, 4801 W. 41st St. • NAMI (National Alliance on Mental Illness), 121 S. Main Ave. • New Day Counseling, 1320 E. Rushmore Drive • New Idea Counseling, 2500 W. 49th Street • Phillips Mental Health, 6209 E. Silver Maple Circle • Psychiatric Services, LLC, 101 S. Reid Street • Psychological Solutions, 6810 S. Lyncrest Avenue • Psychotherapy Associates, 2210 W. Brown Place • Renew Counseling, 5201 W. Western Avenue • Resolutions Counseling, 6116 S. Lyncrest Avenue	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Restoration Counseling, 6809 S. Minn. Avenue • Restoration Treatment Services, 225 E. 11th Street • Ritzman Counseling, 1601 E. 69 St. • Salmen, Latanda, LLC, 4001 W. Valhalla Blvd. • Sanford Behavioral Health, 2400 W. 49th Street • Sanford Women's Mental Health Services, 5019 S. Western Avenue • SE Behavioral HealthCare, 100 W. 5th St., 2000 S. Summit Place • Sioux Empire Christian Counseling, 2000 S. Sycamore Avenue • Sioux Falls Psychological Services, 2109 S. Norton Avenue • Sioux Falls Wellness Counseling, 5201 S. Western Avenue • Sorenson, Dianna S. Counseling, 4608 S. Briarwood Ave. • Sozo Counseling Care, 3500 S. Phillips Avenue • Stolsmark, Erin, Inc., 6809 S. Minn. Avenue • Stronghold Counseling, 4300 S. Louise Avenue • VA, 2501 W. 22nd Street • Vet Center, 3200 W. 49th Street • Watson-Miller, Rebecca Counseling, 2500 W. 49th Street • Wellspring Therapy Center, 6901 S. Lyncrest Place Prescription Assistance programs: • CancerCare Co-payment Assistance Foundation 866-552-6729 • Freedrugcard.us • Rxfreecard.com • Medsavercard.com • Yourrxcard.com • Medicationdiscountcard.com • Needymeds.org/drugcard • Caprxprogram.org • Southdakotarxcard.com • Gooddaysfromcdf.org • NORD Patient Assistance Programs	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• SD Partnership for Prescription Assistance - pparx.org • Patient Access Network (PAN) Foundation – panfoundation.org • Pfizer RX Pathways – pfizerrxpathways.com • RXhope.com Health Care resources: • Avera McKennan, 1325 S. Cliff Ave. • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Destiny Outreach after hours medical clinic (for uninsured), 225 E. 11th Street • Falls Community Health, 521 N. Main Avenue • Glow – Glorious Lifestyle – Optimal Weight, 1601 E. 69th St. • Sanford Family Medicine Clinics – 26th & Sycamore, 49th & Oxbow, 69th & Minnesota, 69th & Louise, 41st & Sertoma, 34th & Kiwanis, 4th & Sycamore • Sanford Internal Medicine Clinic, 1321 W. 22nd Street • Sanford Children's Clinics, 26th & Sycamore, 69th & Louise • Sanford Acute Care & Walk-In, 26th & Sycamore, 41st & Sertoma, 69th & Minnesota, Walk-in at 900 E. 54th Street N. • Sioux Falls VA Center, 2501 W. 22nd Street • South Dakota Urban Indian Health, 711 N. Lake Ave. • USD Dental Clinic, 521 N. Main Ave. Health Insurance resources: • Avera Health Plan, 3816 S. Elmwood Ave. • Dakota Care, 2600 W. 49th St. • Medica, 5032 S. Bur Oak Pl. • Midwest Employee Benefits, 5000 S. MacArthur Lane • Sanford Health Plan, 300 N. Cherapa Place • SD Medical Insurance Program, 700 Governors Drive, Pierre • Wellmark Blue Cross Blue Shield, 1601 W. Madison Street	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Mental Health & Substance Abuse	Drug use and abuse 4.07 Depression 3.83 37% report a diagnosis of depression Alcohol use and abuse 3.70 58% report binge drinking Suicide 3.52 Tobacco use 30% currently smoke cigarettes	30% currently smoke cigarettes		Substance Abuse resources: • Al-Anon, 41 W. Sioux Street • Alcoholics Anonymous, 1000 N. West Avenue • Arch Halfway House, 516 W. 12th Street • Avera Behavioral Health, 4400 W. 69th St. • Avera Addiction Recovery Program, 2412 S. Cliff Avenue • Bartels Counseling, 6330 S. Western Avenue • Carroll Institute, 310 S. 1st Ave. • Choices Recovery, 2701 S. Minn. Ave. • City of Sioux Falls Homeless Outreach, 224 W. 9th St. • Clarity Counseling, 101 S Reid St. • Counseling Resources, 4109 S. Carnegie Circle • Dakota Drug & Alcohol Prevention, 822 E. 41st St. • Emerald Psychological Services, 5032 S. Bur Oak Place • Face It Together, 5020 S. Tennis Lane; 231 S. Phillips Ave. • First Step, 4320 S. Louise Ave. • Glory Home, 4000 S. West Ave. • Gorman, Stacy Counseling, 6809 S. Minn. Ave. • Great Plains Psychological Services, 4105 S. Carnegie Place • Heisler Treatment Center, 1401 W. 51st St. • Integrative Wellness, 5000 S. Minn. Avenue • Keystone Outreach, 7511 S. Louise Ave. • LaVelle & Associates, 5024 S. Bur Oak Place • Minnehaha Co. Detox Center, 500 N. Minn. Ave. • Narcotics Anonymous meetings (many locations) • New Day Counseling, 1320 E. Rushmore Drive • Phillips Mental Health, 6209 E. Silver Maple Circle • Prairie View Prevention Services, 822 E. 41st St. (school-based intervention) • Psychiatric Services, LLC, 101 S. Reid Street • Psychotherapy Associates, 2210 W. Brown Place	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Renew Counseling, 5201 W. Western Avenue • Restoration Treatment Services, 225 E. 11th Street • Safe Home, 320 W. 3rd St. (permanent housing for persistently homeless adults who have severe alcohol issues) • Sanford Behavioral Health, 2400 W. 49th Street • Sioux Falls Treatment Center, 2519 W. 8th St. • Sioux Falls Urban Indian Health, 711 N. Lake Ave. • Sioux Falls Wellness Counseling, 5201 S. Western Avenue • Stolsmark, Erin, Inc., 6809 S. Minn. Avenue • Stronghold Counseling, 4300 S. Louise • Tallgrass Recovery / Transitional Living Corp., 27048 Tallgrass Ave. • VA Medical Center, 2501 W. 22nd Street • Volunteers of America Dakotas, 1310 – 51st St. Mental/Behavioral Health Resources: • Avera Behavioral Health, 4400 W. 69th Street • Behavior Management Counseling Service, 3610 S. Western Avenue • Bartels Counseling, 6330 S. Western Avenue • Bethesda Christian Counseling, 400 S. Sycamore Ave. • Caminado Juntois (Spanish speaking counselor), 617 E. 7th St. • Catholic Family Services, 523 N. Duluth Avenue • Center for Family Medicine, 1115 E. 20th Street • Children's Home Society, 801 N. Sycamore Avenue • Christensen, Barbara, Inc., 6809 S. Minnesota Avenue • Clarity Counseling, 101 S Reid St. • Compass Center, 1800 W. 12th St.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Community Counseling Clinic, 2109 S. Norton Avenue • Conrad Counseling, 5024 S. Bur Oak Place • Credo Counseling, 5024 S. Bur Oak Place • Dakota Oak Counseling, 3220 W. 57th Street • Digatono, Daniel T. Counseling, 4410 S. Tennis Lane • Discover Wellness, 2121 W. 63 Pl. • Emerald Psychological Services, 5032 S. Bur Oak Place • Emotions Anonymous support group, P. O. Box 4245 • Encompass Mental Health, 100 S. Spring Avenue • Ericsson, Kristen Counseling, 600 N. Main Avenue • Evenson Counseling, 3701 W. 49th Street • Family Service, Inc., 2210 W. Brown Place • Family Ties Christian Counseling, 3500 S. Phillips Ave. • Four Directions Counseling, 101 S. Reid St. • Glow – Glorious Lifestyle – Optimal Weight, 1601 E. 69th St. • Gorman, Stacy Counseling, 6809 S. Minn. Ave. • Great Plains Psychological Services, 4105 S. Carnegie Place • Guth, Mary T. Counseling, 3610 S. Western Ave. • Hansen-Mayer, Brenda, 1601 E. 69th Street • Harp, Tina Counseling, 6509 S. Cliff Avenue • Hauck, Stacey Counseling, 1601 E. 69th Street • Helpline Center / 211 Response, 1000 N. West Ave. • Heuermann Counseling Clinic, 2210 S. Brown Place (free short-term counseling) • Holm, Ellen Counseling, 4410 S. Tennis Lane • Huffman, Darla Counseling, 6809 S. Minn. Avenue • Integrative Wellness, 5000 S. Minn. Avenue • Journey Counseling, 6209 S. Pinnacle Place	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Journey Therapy, 1500 S. Sycamore • Kannan Clinic, 6709 S. Minn. Ave. • Keiser, Kimberly & Assoc., 6320 S. Western Avenue • Key Solutions, 3800 S. Kiwanis Ave. • LaVelle & Associates, 5024 S. Bur Oak Place • LifeGate Christian Counseling, 6820 W. 26th Street • LifeMarks Behavioral Health, 1310 W. 51st St. • LifeScape, 1020 W. 18th Street • Lighting a New Way, 1500 S. Sycamore Ave. • LSS Counseling, 705 E. 41st Street • Maass, Ronda Counseling, 5510 S. Tennis Lane • Moore Counseling, 4801 W. 41st St. • NAMI (National Alliance on Mental Illness), 121 S. Main Ave. • New Day Counseling, 1320 E. Rushmore Drive • New Idea Counseling, 2500 W. 49th Street • Phillips Mental Health, 6209 E. Silver Maple Circle • Psychiatric Services, LLC, 101 S. Reid Street • Psychological Solutions, 6810 S. Lyncrest Avenue • Psychotherapy Associates, 2210 W. Brown Place • Renew Counseling, 5201 W. Western Avenue • Resolutions Counseling, 6116 S. Lyncrest Avenue • Restoration Counseling, 6809 S. Minn. Avenue • Restoration Treatment Services, 225 E. 11th Street • Ritzman Counseling, 1601 E. 69 St. • Salmen, Latanda, LLC, 4001 W. Valhalla Blvd. • Sanford Behavioral Health, 2400 W. 49th Street • Sanford Women's Mental Health Services, 5019 S. Western Avenue	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• SE Behavioral HealthCare, 100 W. 5th St., 2000 S. Summit Place • Sioux Empire Christian Counseling, 2000 S. Sycamore Avenue • Sioux Falls Psychological Services, 2109 S. Norton Avenue • Sioux Falls Wellness Counseling, 5201 S. Western Avenue • Sorenson, Dianna S. Counseling, 4608 S. Briarwood Ave. • Sozo Counseling Care, 3500 S. Phillips Avenue • Stolsmark, Erin, Inc., 6809 S. Minn. Avenue • Stronghold Counseling, 4300 S. Louise Avenue • VA, 2501 W. 22nd Street • Vet Center, 3200 W. 49th Street • Watson-Miller, Rebecca Counseling, 2500 W. 49th Street • Wellspring Therapy Center, 6901 S. Lyncrest Place Tobacco Cessation resources: • Avera Health, 1325 S. Cliff Ave. • Avera Walking Forward Program for American Indians, 3900 W. Avera Drive • Falls Community Health Clinic, 521 N. Main Avenue • National Cancer Institute Smoking QuitLine – 877-448-7848 • Prairie View Prevention Services, 822 E. 41st Street (school-based intervention) • QuitLine, SDQuitline.com • QuitNow – 800-784-8669 • Sanford Clinics – all locations • Sanford Health lung screen, 1205 S. Grange Avenue • Sanford Health Plan (covers meds for smoking cessation), 300 N. Cherapa Place • SD Department of Health, 600 E. Capitol Ave., Pierre (many resources)	
Health & Wellness	51% not getting enough fruits & vegetables			Healthy Nutrition resources: • Avera dietitians, 3900 W. Avera Drive	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	38% not getting enough exercise 31% overweight 37% obese High cholesterol Hypertension			• Community Garden, Leaders Park, 500 Leadale Avenue • County Extension classes, 2001 E. 8th Street • Falls Community Clinic dietitians, 521 E. Main Avenue • Great Life nutritional classes, 4500 S. Tennis Lane • Hy-Vee dieticians (several locations) • Sanford dietitians, 1305 W. 18th St. • SE Technical Institute classes, 2205 N. Career Avenue • SF Urban Indian Health, 711 N. Lake Avenue • VA dietitians, 2501 W. 22nd St. *Farmers Markets:* • Gundy's Farmers Market, 8th & Railroad Center • Falls Park Farmers Market, P O Box 2531 • MTM Euro Farmers Market, 5315 W. 41st St. • Prairie Farmers Market, 300 N. Cherapa Place • Sioux Empire Farmers Market, 401 E. 8th St. *Grocery Stores* • ALDI, 2808 S. Louise • Andy's Affiliated Foods, 1025 S. Cleveland • Beeryozka Grocery, 3301 E. 26th St. • Fareway, 1431 W. 41st St. • Franklin Food Market, 711 N. Cliff Ave. • Global Foods, 1002 W. 6th St. • Hy-Vee (several locations) • Mercato, 631 W. 11th St. • Pomegranate Market, 4815 S. Louise • Sunshine Foods, 530 S. 2nd Ave. • Tienda America, 114 S. Franklin Ave. • Thanh Mai, 824 E. Rice St. • The Co-op Natural Foods, 410 W. 18th St. • Walmart, 7821 S. Minn. Ave. Physical Activity resources: • SF Parks & Recreation Dept. programs, 100 E. 6th Street *Fitness Centers:* • 9 Round Fitness	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• X Fitness, 112 W. 39th St. • 24/7 Fitness, 300 N. Dakota Ave. • Anytime Fitness, 2320 S. Marion Rd.; 3212 E. 10th St. • Avera McKennan Fitness Center, 3400 S. Southeastern Ave. • Air Madness, 310 W. Industrial Dr., Harrisburg • Champion Legacy Dance Studio, 3320 S. Bedford Avenue • Coast to Coast Fitness, 27294 Verbey Place, Tea • Cross Fit SF, 3505 S. Phillips • Cross Fit Phos, 4601 E. Arrowhead Pkwy. • FAF Cross Fit, 523 N. Kiwanis • Farrell's Extreme Bodyshaping, 6010 S. Minnesota Ave. • Fitness 19 • Fit Body Boot Camp, 3504 S. Minn. Avenue • Form Fitness, 2210 W. 69th St. • Great Life, 11th & Dakota • Great Life Woodlake Athletic Club, 4600 S. Tennis Lane • Kosama, 5909 S. Louise • Planet Fitness, 1509 W. 41st St. • Powerhouse Gym, 915 S. Marion Road • Primal SF Gym, 3400 W. 49th St. • Sanford Wellness Center, 4201 S. Oxbow Ave. • Sharps Gym, 3900 W. 12th St. • Snap Fitness, 1516 S. Sycamore • Timeless Fitness, 101 N. Main Ave. • Touchmark Health & Fitness Club, 111 W. 17th St. • Tryon gym, 5122 S. Cliff Ave. • Ultimate Fitness, 4831 S. Louise • YWCA, 300 W. 11th St. *Golf Courses:* • Bakker Crossing Golf Course, 47172 S. Clubhouse Rd. • Elmwood Golf Course, 2604 W. Russell St. • Kuehn Park Golf Course, 2901 S. Kuehn Pk. Rd. • Minnehaha Golf Course, 3101 W. 22nd Street • Prairie Green Golf Course, 600 E. 69th St.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Willow Run Golf Course, 8000 E. Arrowhead Pkwy. *Ice Skating:* • Sherman Park Rink, 2705 W. 12th Street *Snowshoeing:* • Big Sioux Park, 1800 E. 18th St. *Cross Country Skiing:* • Spencer Park, I-229 & South Cliff Ave. • Sertoma Park, W. 49th St. & Oxbow Ave. • Great Bear Ski Valley, 5901 E. Rice Street *Mountain Biking:* • Leaders Park, 500 Leadale Ave. *Biking Clubs:* • Falls Area Bicyclists, P.O. Box 91741 • Falls Area Single Track – fallsareasingletrack@gmail.com *Bike Trails:* • Yankton Trail Park, 3901 S. Minn. Ave. *Hiking:* • Cherry Rock Park, 1800 E. 18th St. • Falls Park, 131 E. Falls Park Dr. • Family Park, S. Ellis Road • Great Bear, 5901 E. Rice St. • Outdoor Campus, 4500 S. Oxbow Ave. *Disc Golf:* • Spencer Park, 3501 S. Cliff Ave. • Tomar Park, 100 W. Twin Oakes Rd • Tuthill Park, 3500 S. Cliff Ave. *Public Swimming Pools:* • Drake Springs Family Aquatic Center, 301 S. Fairfax Avenue • EmBe Downtown, 300 W. 11th St. • Great Life, 4600 S. Tennis Lane • Kuehn Park Pool, 2309 Kuehn Park Road • Midco Aquatic Center, 1601 S. Western Avenue • Terrace Park Family Aquatic Center, 1001 W. Madison Street *Tennis Courts:* • Country Club, 3400 W. 22nd St. • Great Life, 4600 S. Tennis Lane • Huether Family Match Pointe, 4210 Bobhalla Dr.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Kuehn Park, 2501 S. Kuehn Pk. Rd. • Laurel Oak Park, 3401 E. 49th St. • McKennan Park Tennis Courts, 408 E. 21st Street • Sanford Sports Complex, 2210 W. Pentagon Place • Tennis Courts, 1099 N. Menlo Ave. • Tomar Park, 100 W. Twin Oaks Rd. *Bowling:* • Eastway Bowl, 3201 E. 10th St. • Empire Bowl, 3800 S. Westport Avenue • Great Life Suburban Lanes, 2621 S. Spring Avenue • Sport Bowl, 1901 W. Burnside St. Obesity resources: • SF Weight Loss Surgery Support Group, 1305 W. 18th Street *Clinics:* • Avera dieticians, 1325 S. Cliff Ave. • Falls Community Health dieticians, 521 N. Main Avenue • Sanford dieticians – 26th & Sycamore, 49th & Oxbow, 69th & Minnesota, 69th & Louise, 41st & Sertoma, 34th & Kiwanis, 4th & Sycamore • Sioux Falls VA Center dieticians, 2501 W. 22nd Street *Weight Loss Programs:* • Glow – Glorious Lifestyle – Optimal Weight, 1601 E. 69th St. (counseling for food/weight issues) • Healthy Systems, 3101 W. 41st St. • Ideal Weight Loss Program, 4703 E. 26th St. • Jenny Craig, 2524 W. 41st St. • Profile by Sanford, 401 W. 69th St. • Simply Ideal Weight Loss, 5109 S. Crossing Pl. • Sioux Falls Clinic, 5109 S. Cliff Ave. • Sioux Falls Fit Body Boot Camp, 3504 S. Minnesota Ave. • True Body Weight Management, 5011 S. Louise • Weigh to Go, 3801 W. 34th St.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				• Weight Watchers, 2101 W. 41st St. Chronic Conditions resources: • American Cancer Society, 4904 S. Technopolis Dr. • American Heart Assn., heart.org • Arthritis Foundation, P O Box 90445 • Avera, 1325 S. Cliff Ave. • Eating Disorders Support Group, 3100 E. 49th St. • Sanford's Better Choices Better Health – c/o Sanford Sioux Falls • Sanford Medical Home, c/o Sanford Sioux Falls	

Key Stakeholder Survey

Sanford Sioux Falls Medical Center

Community Health Needs Assessment
Results from a November 2017 Non-Generalizable
Online Survey of Community Stakeholders

February 2018

SANFORD

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a November 2017 online survey of community leaders and key stakeholders identified by Sanford Sioux Falls Medical Center. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. **Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred during the months of November and December 2017 and January 2018. A total of 35 respondents participated in the online survey.

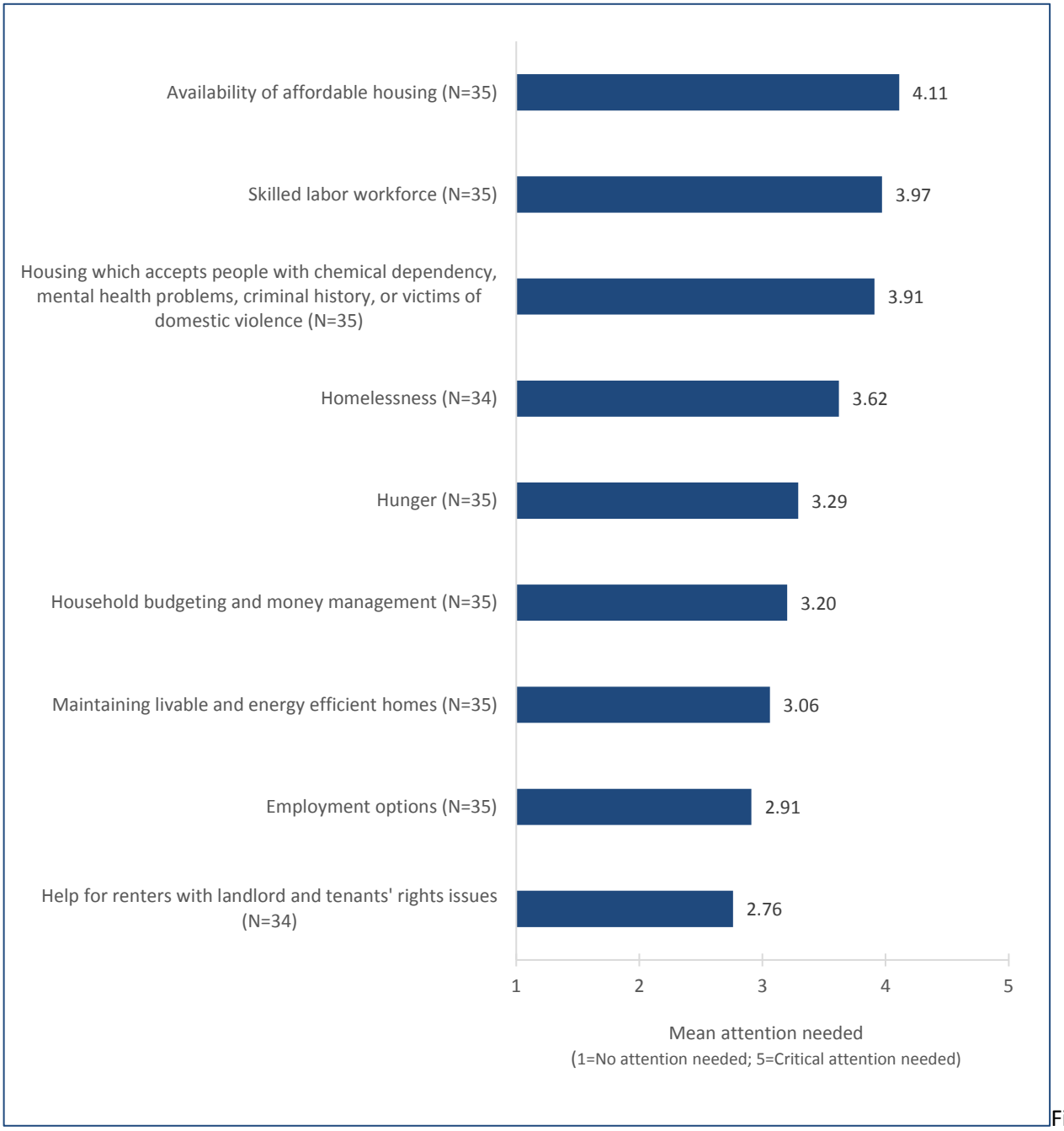
TABLE OF CONTENTS

SURVEY RESULTS

Current State of Health and Wellness Issues within the Community

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

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



Figure

2. Current state of community issues regarding TRANSPORTATION

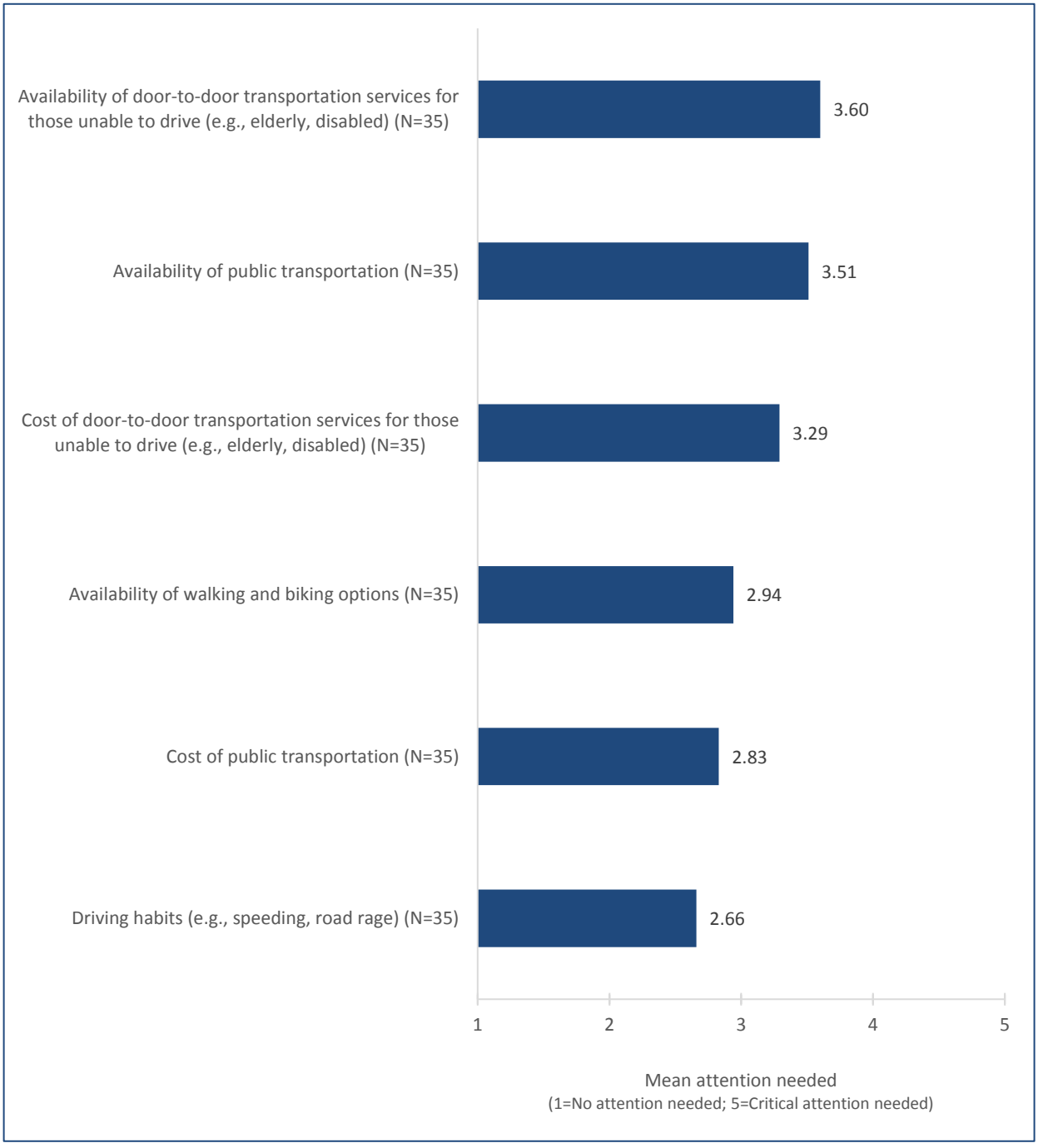


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

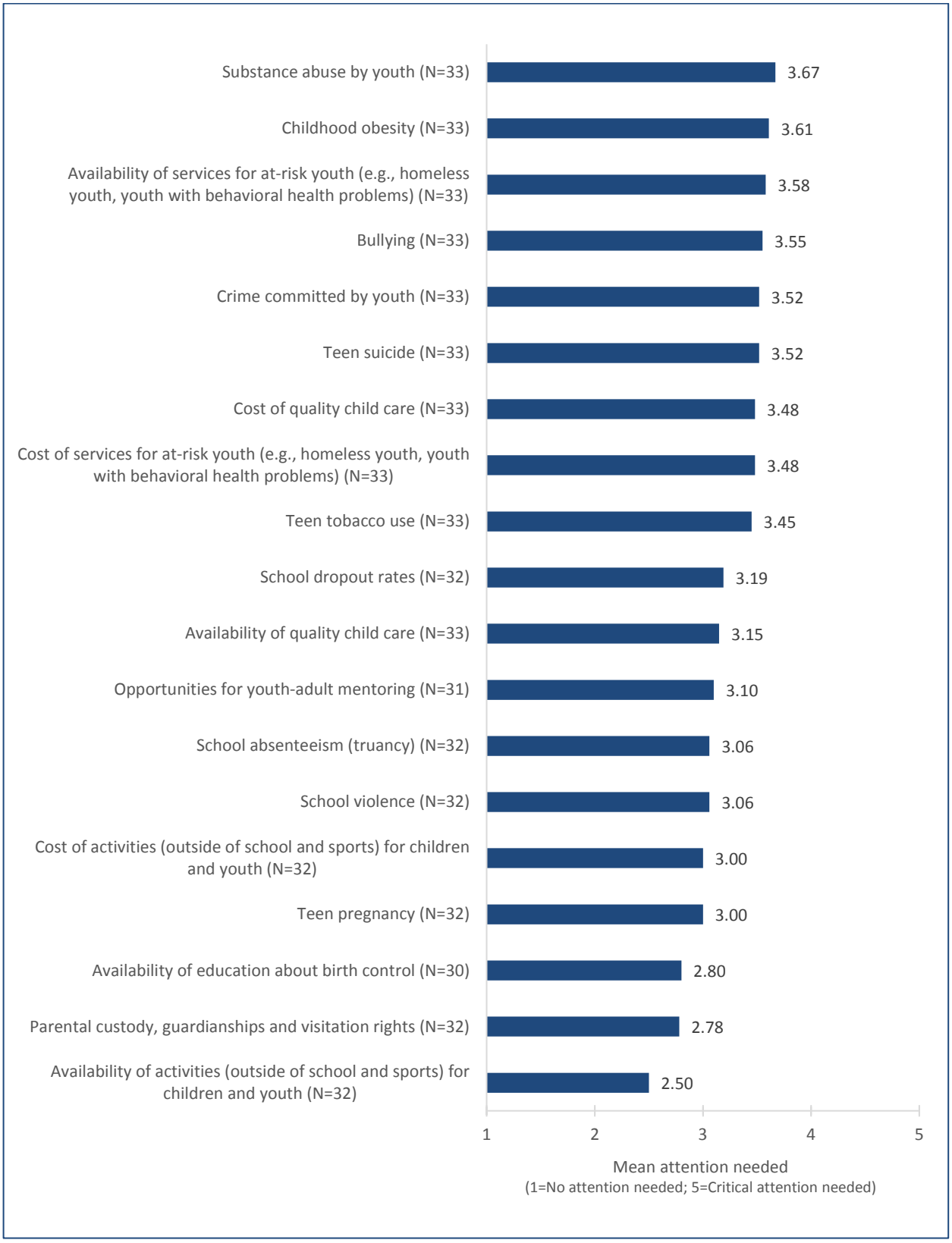


Figure 4. Current state of community issues regarding the AGING POPULATION

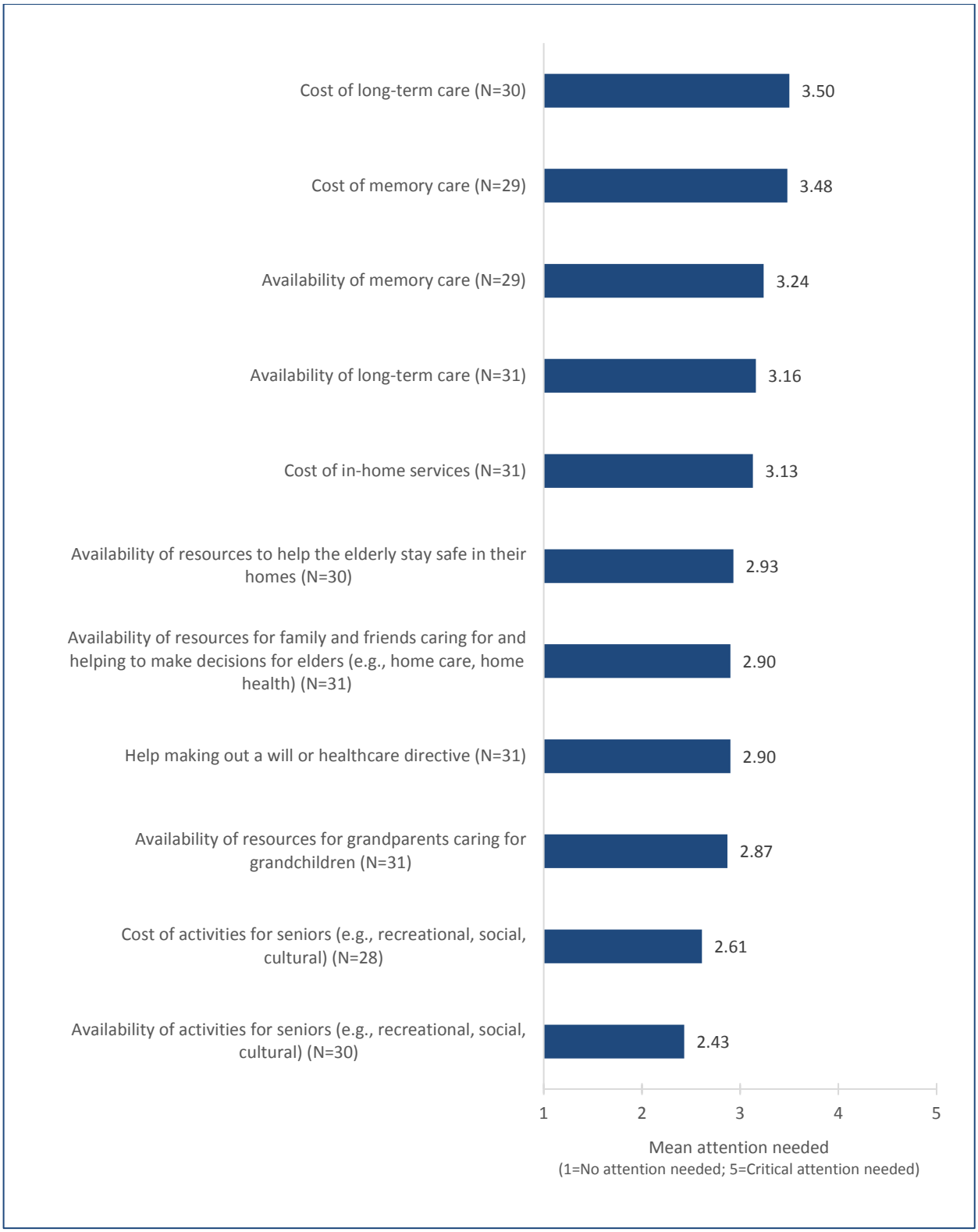


Figure 5. Current state of community issues regarding SAFETY

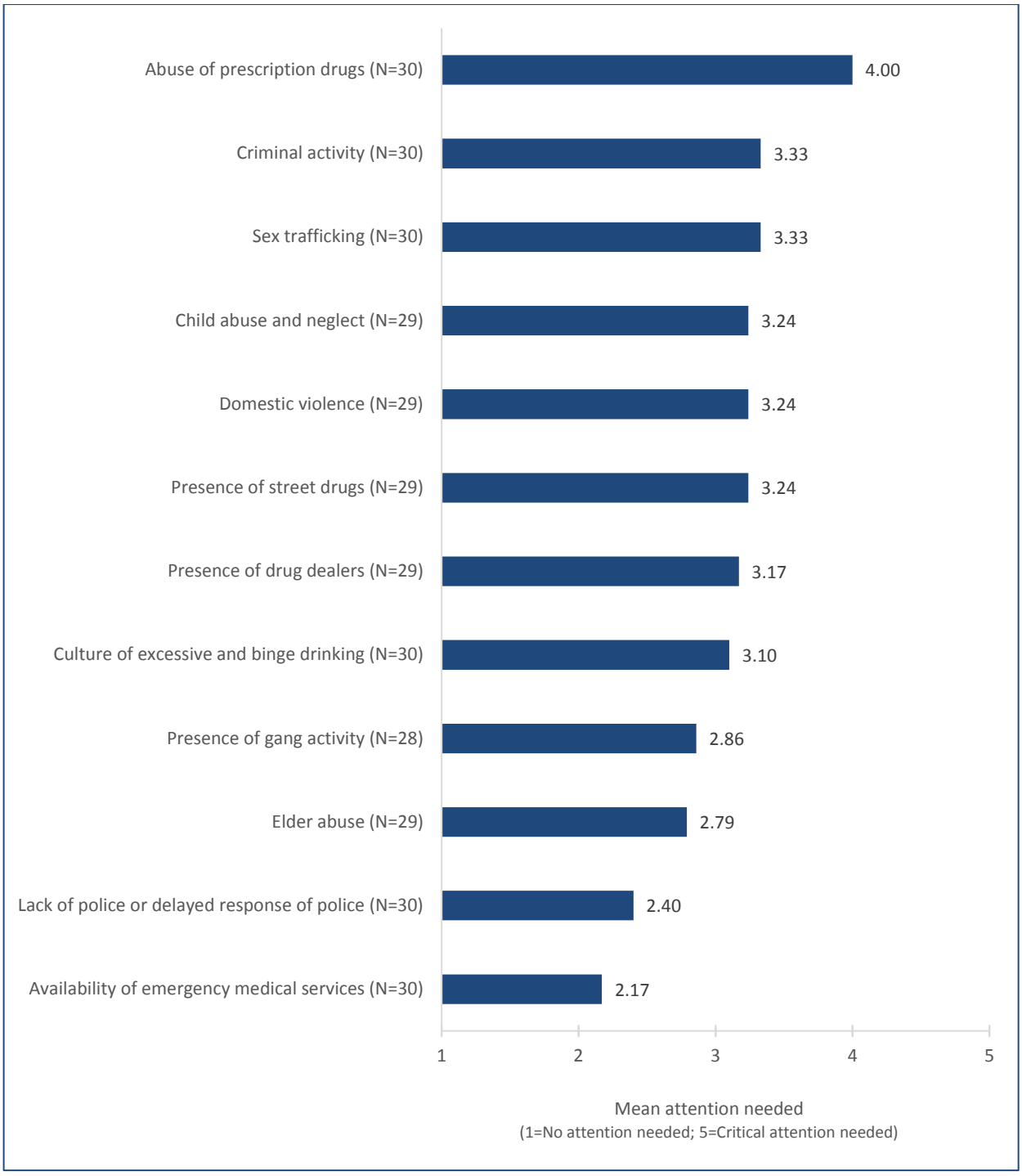


Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

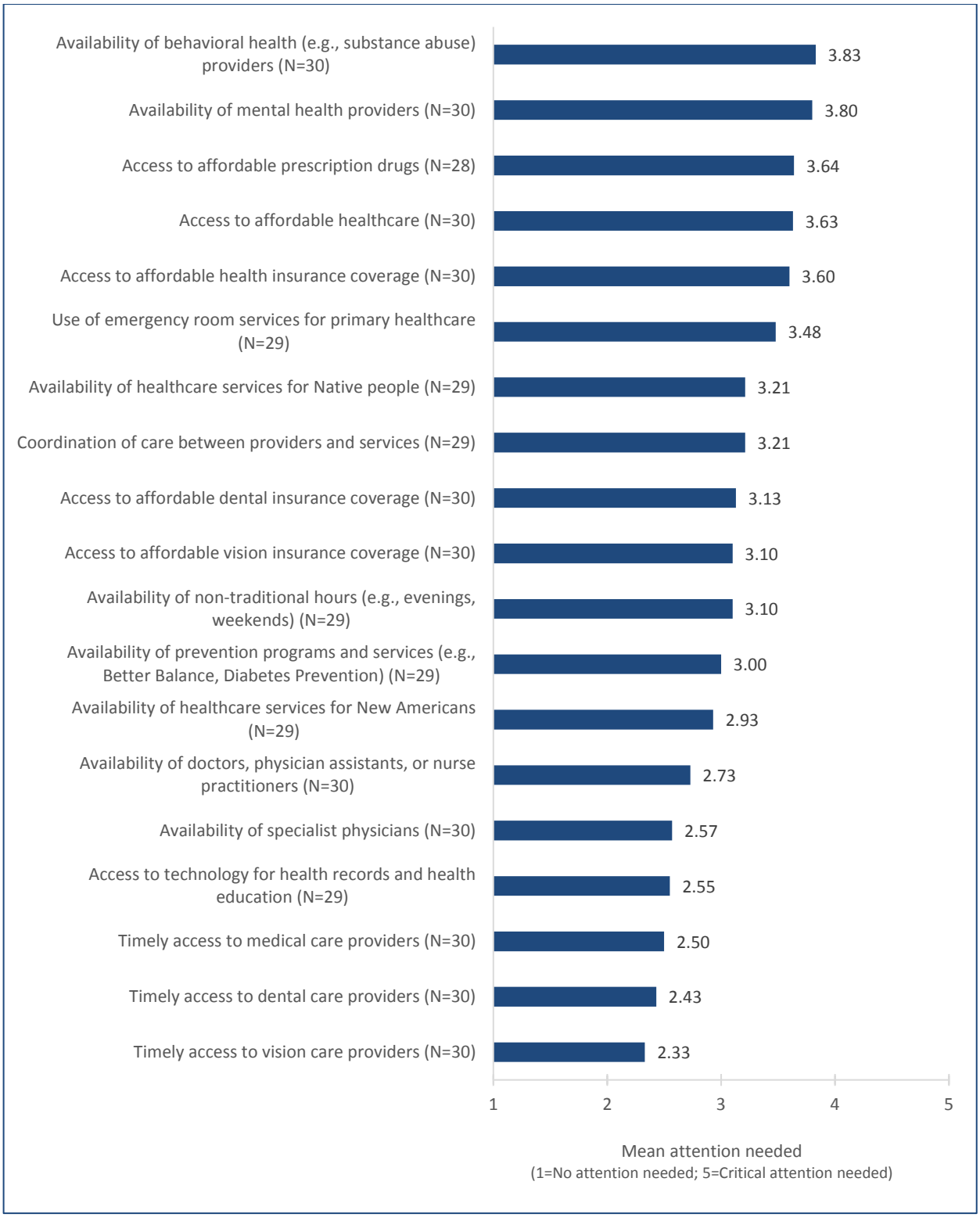
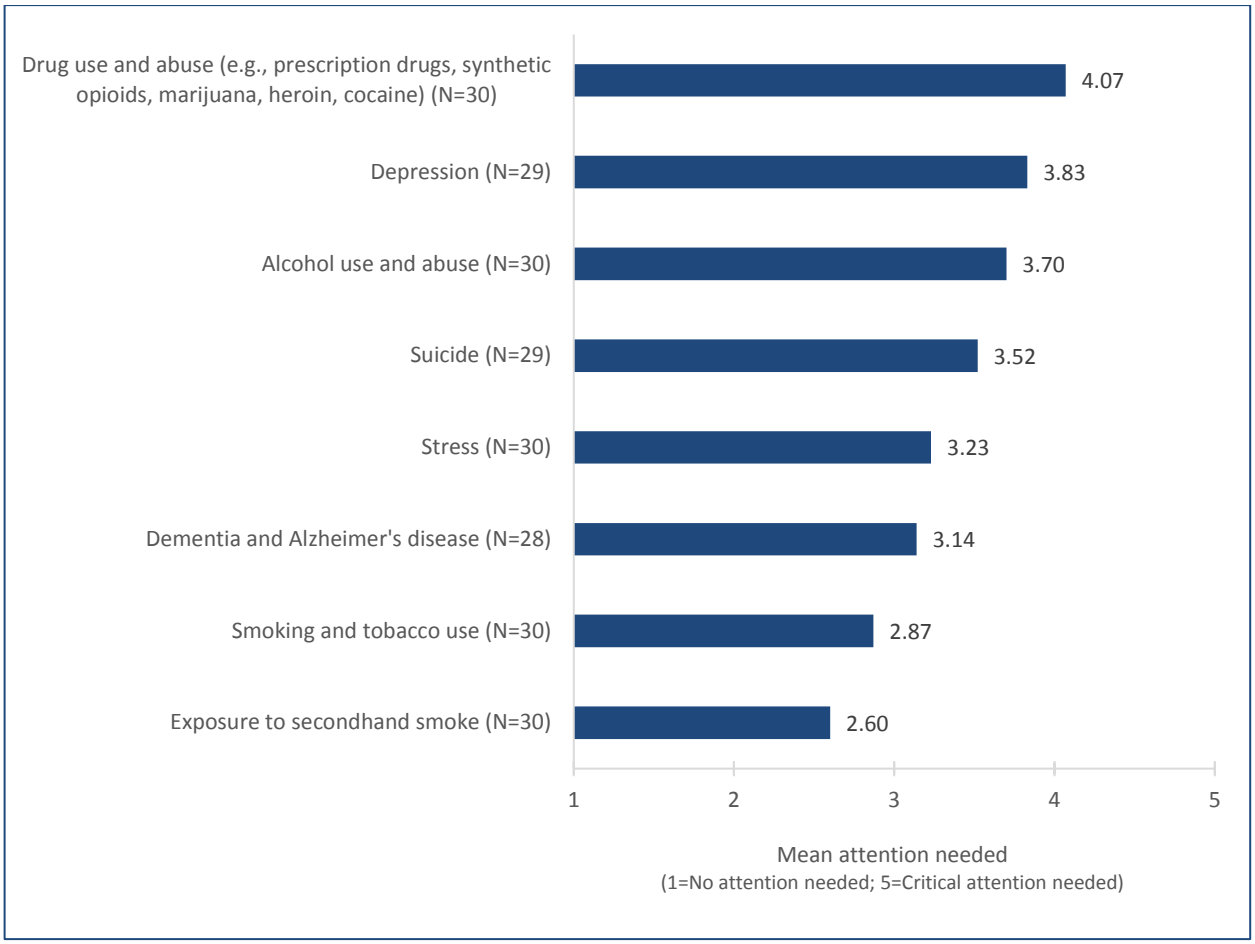
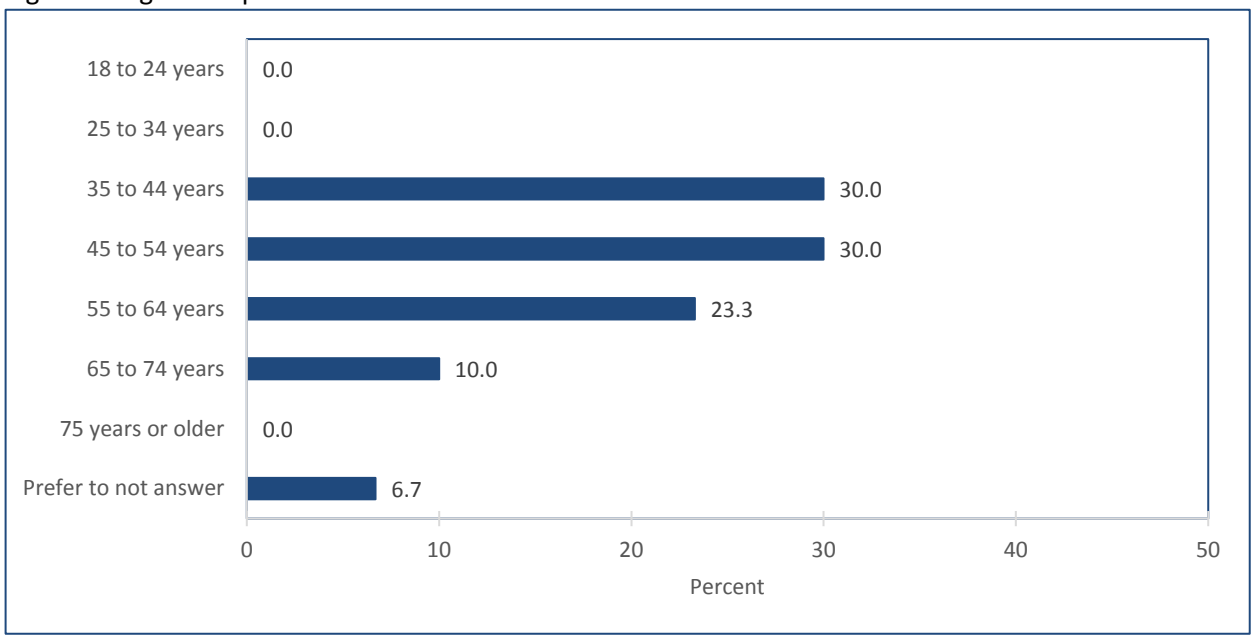


Figure 7. Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



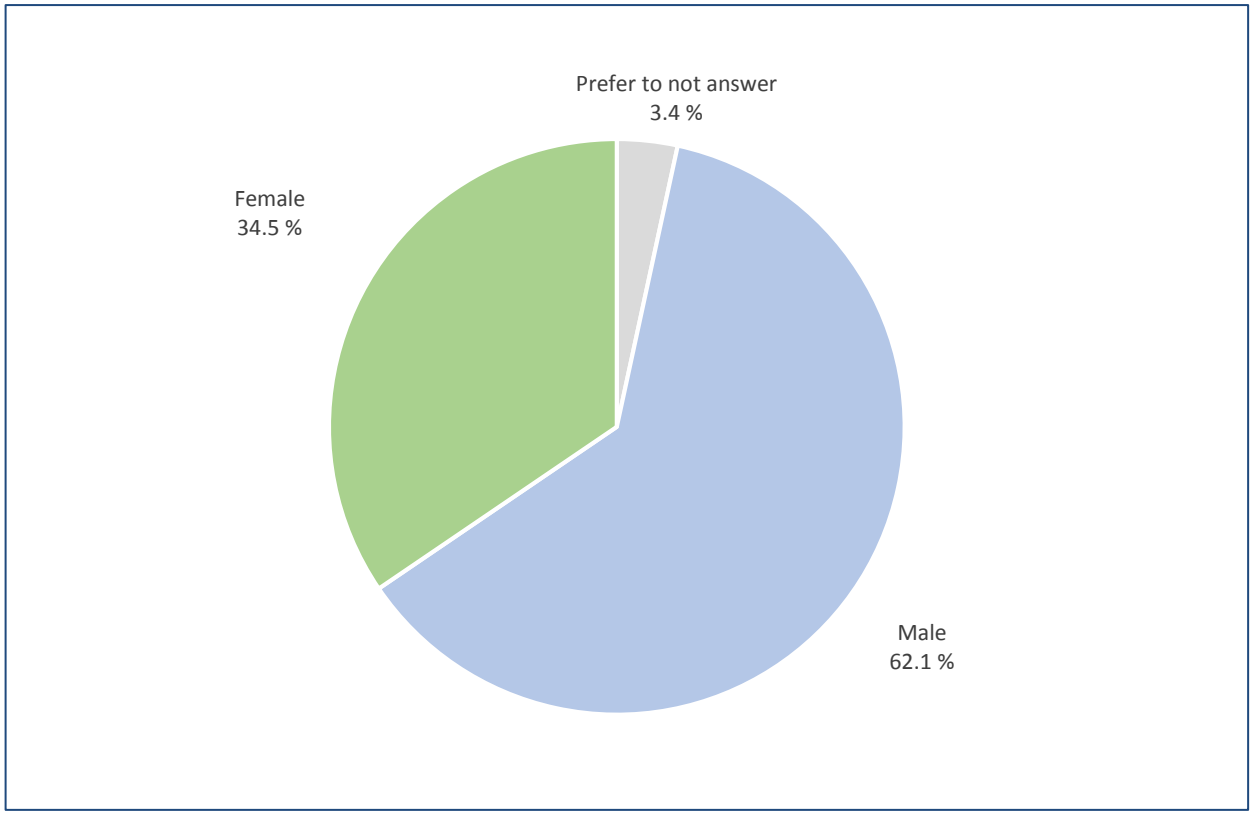
Demographic Information

Figure 8. Age of respondents



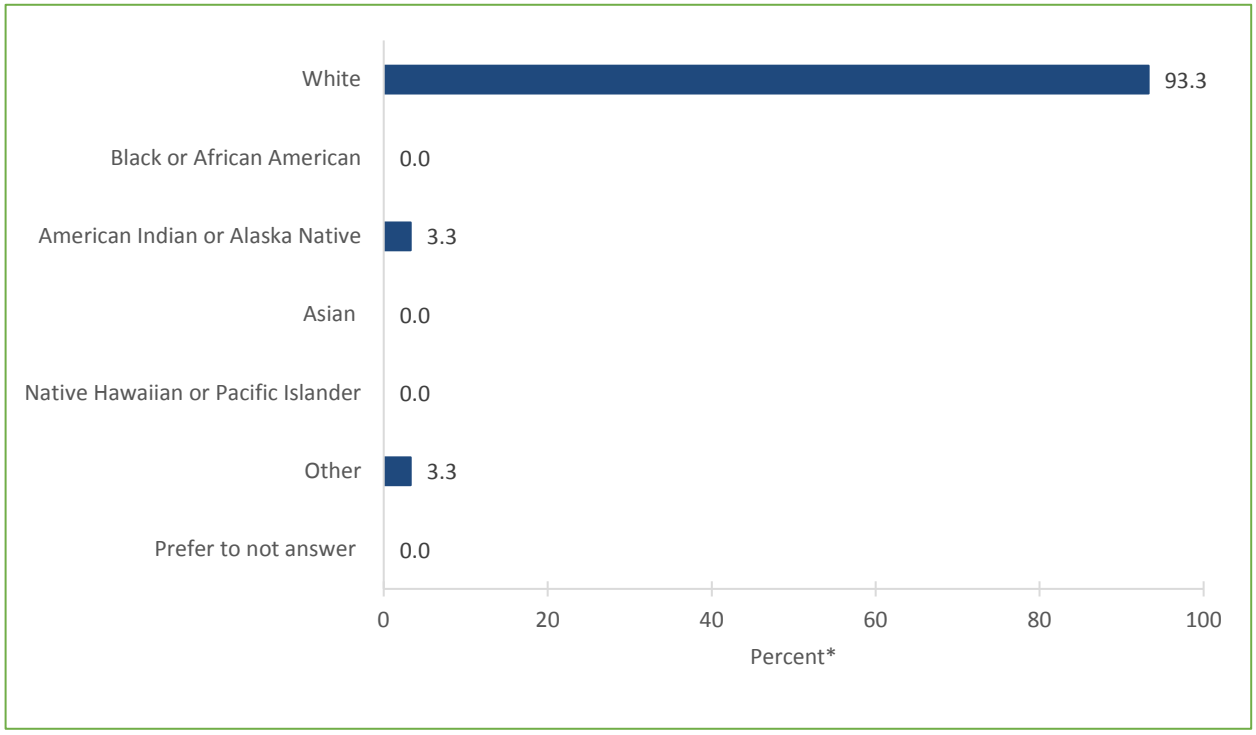
N=30

Figure 9. Biological sex of respondents



N=29

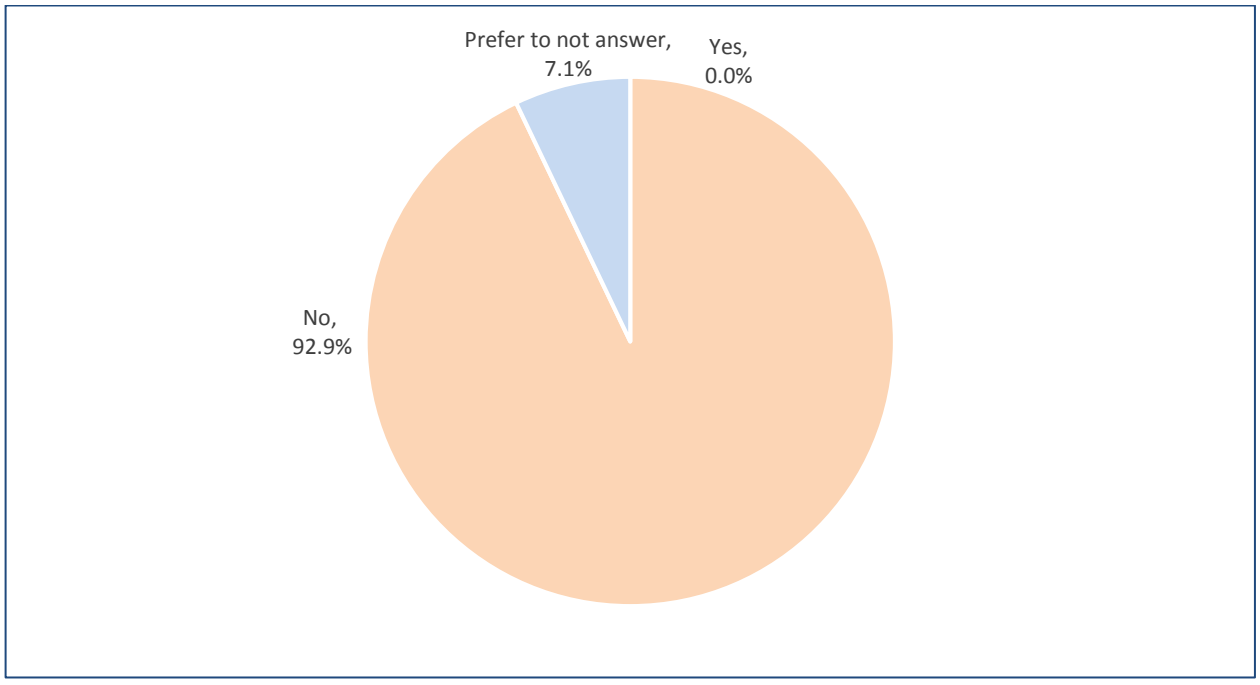
Figure 10. Race of respondents



N=30

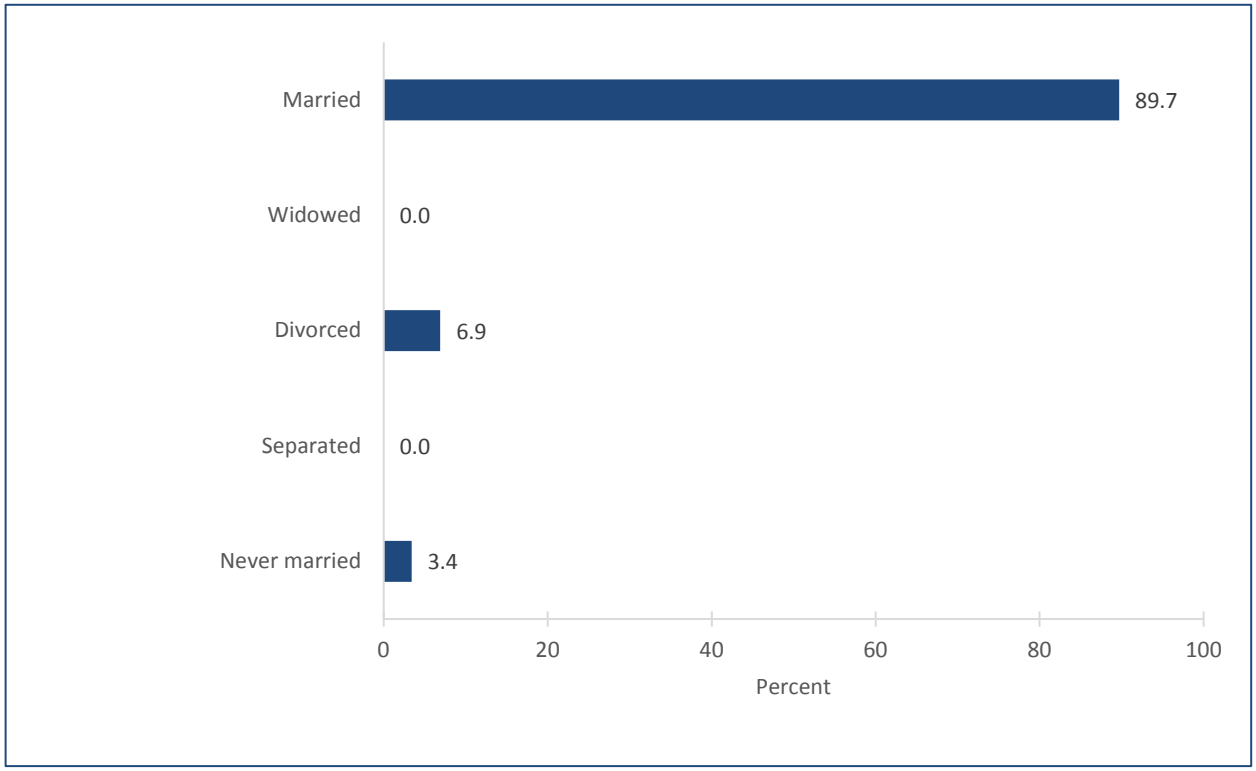
*Percentages do not total 100.0 due to rounding.

Figure 11. Whether respondents are of Hispanic or Latino origin



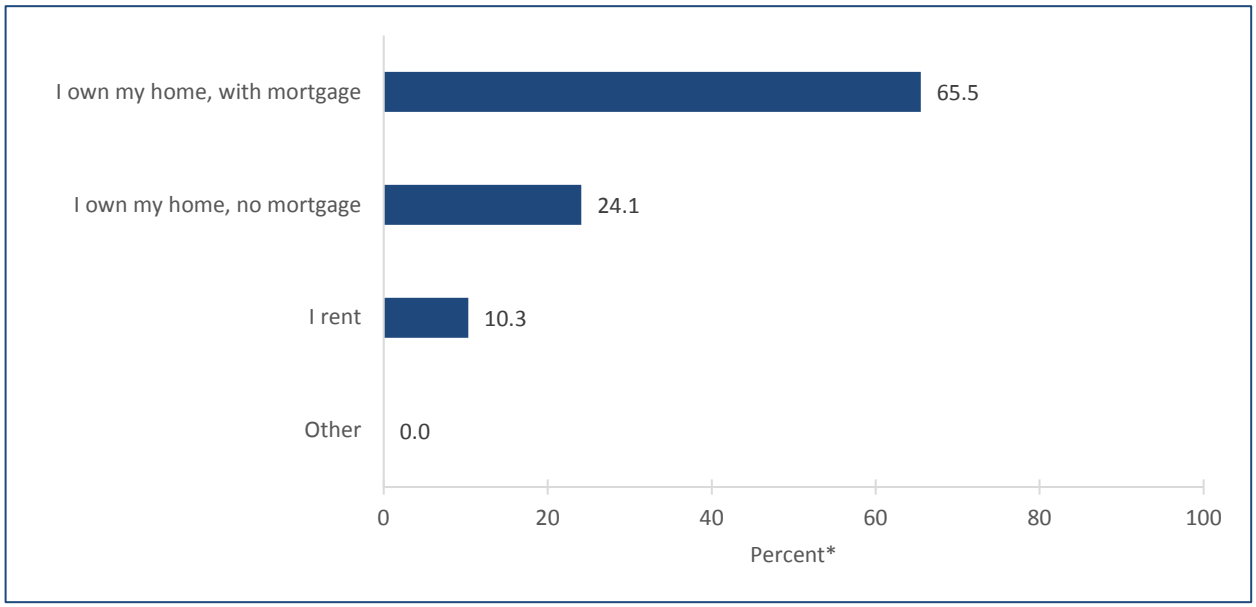
N=28

Figure 12. Marital status of respondents



N=29

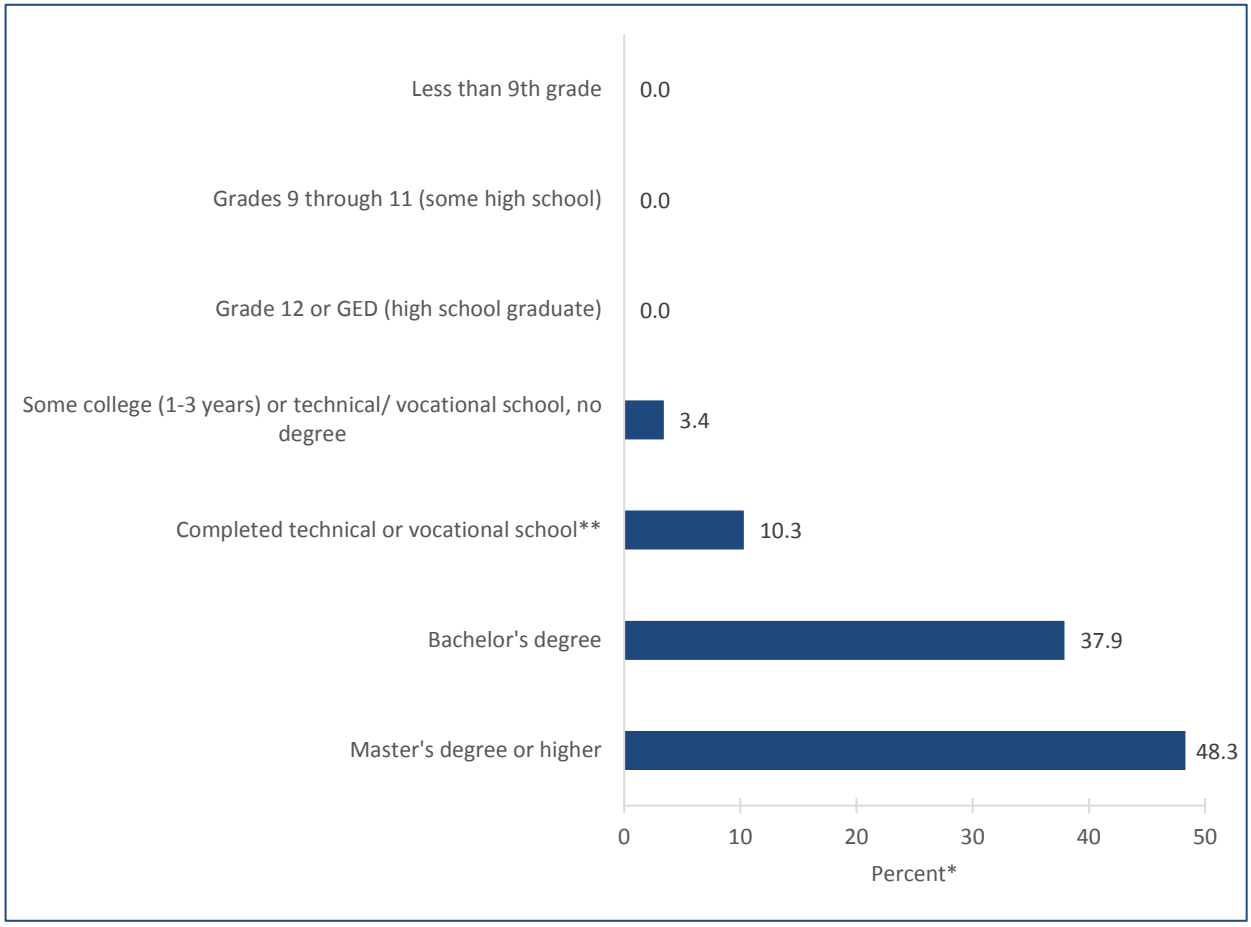
Figure 13. Living situation of respondents



N=29

*Percentages do not total 100.0 due to rounding.

Figure 14. Highest level of education completed by respondents

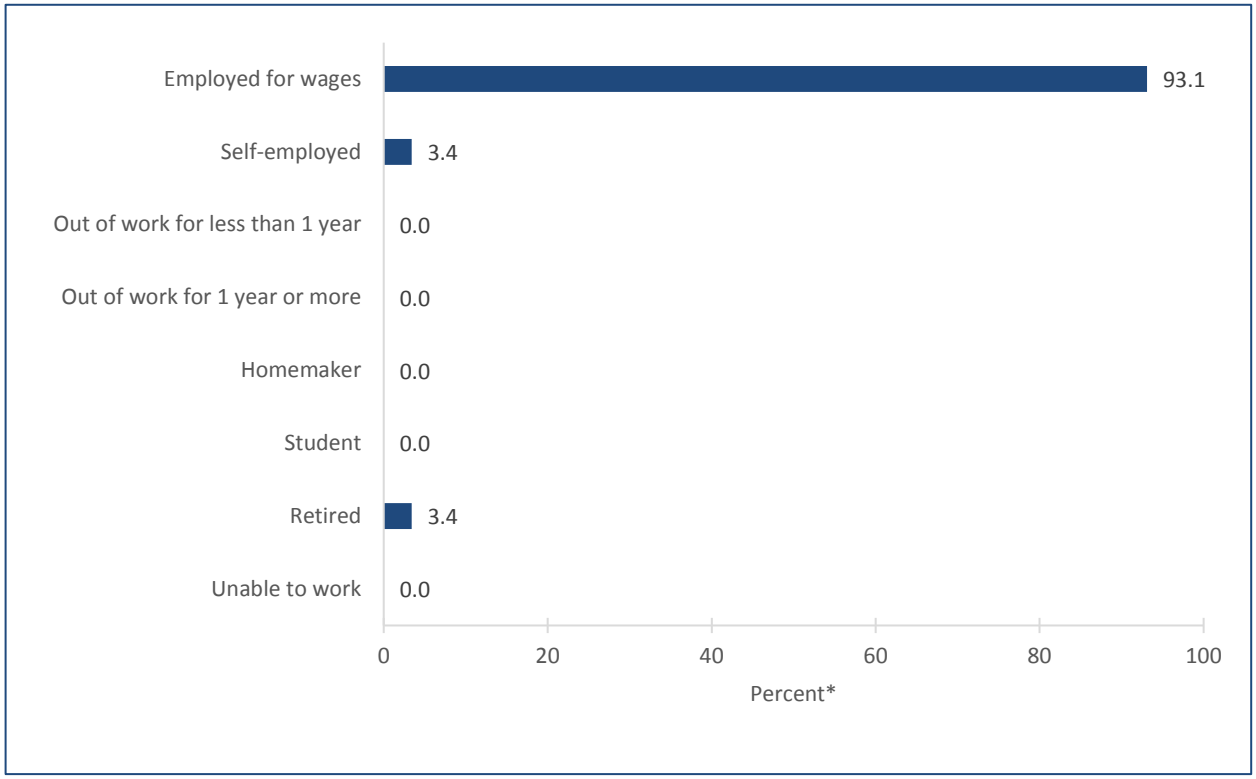


N=29

*Percentages do not total 100.0 due to rounding.

**One respondent answered “associates degree” in the comments section and did not respond to this question. The response was added here to account for the missing selection.

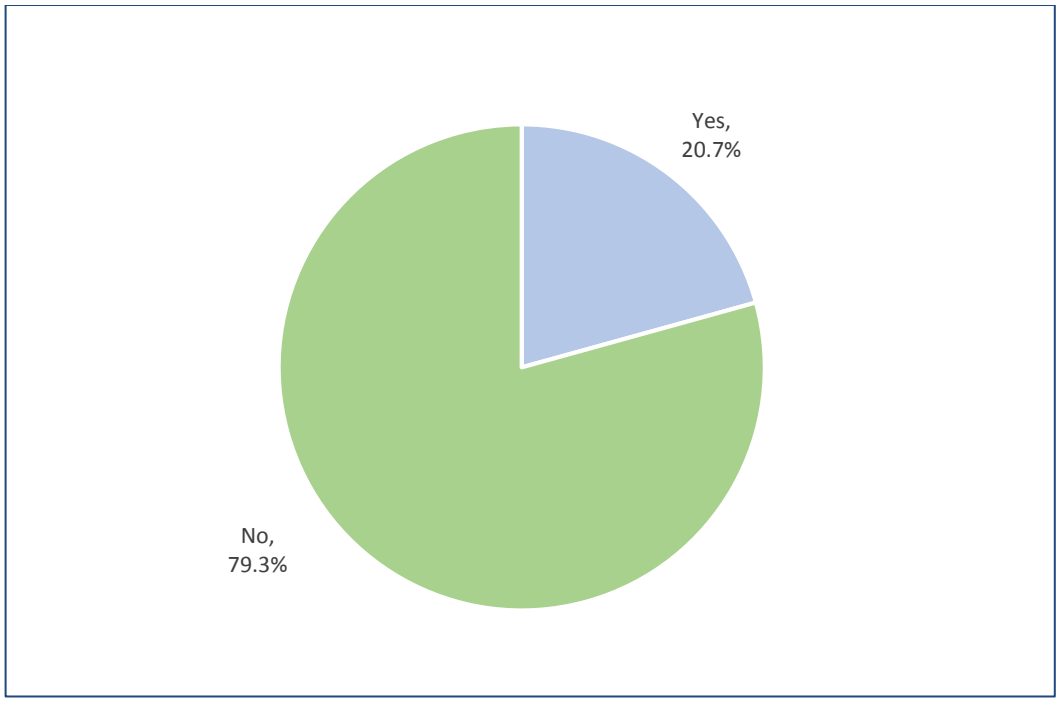
Figure 15. Employment status of respondents



N=29

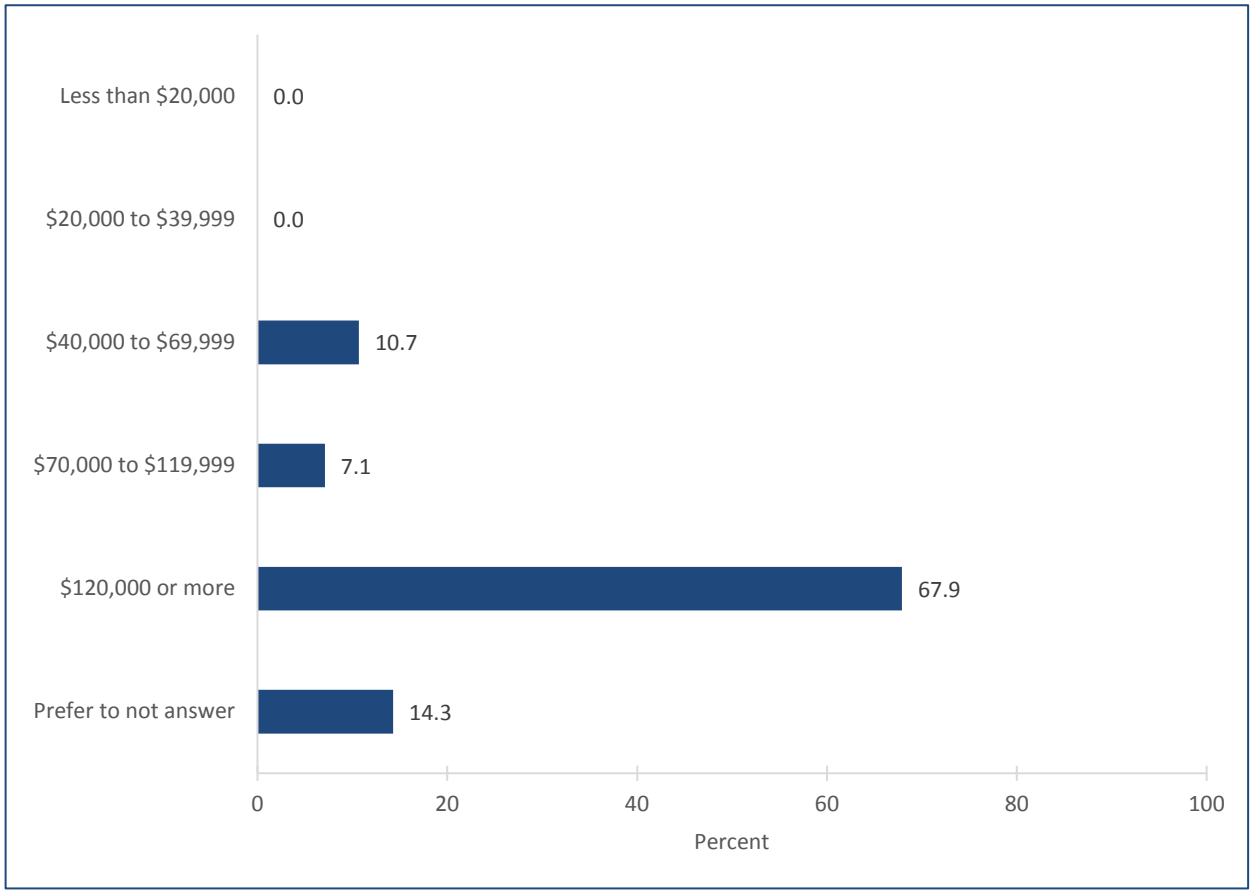
*Percentages do not total 100.0 due to rounding.

Figure 16. Whether respondents are military veterans



N=29

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



N=28

Table 1. Zip code of respondents

Zip code	Number of respondents
57103	7
57110	6
57104	4
57108	4
57033	2
57105	2
57106	2
57020	1
57107	1

N=29

Table 2. Comments from respondents

Comments
We need to pay our existing Medicaid providers at higher rates before the state considers expanding to new services.
With all health care there should be a differentiation of what is critical (a right) and what is desired (a want). We have differentiation in housing, food, cars, clothing, travel, and most everything else. People make decisions as to where to spend their money. Health care, other than Lasiks and elective plastic surgery, have been exempt from this differentiation. Another factor that should be considered is compliant patient vs non-compliant patient. If a person will not follow the doctor's recommendation, why should we keep paying to treat them? If someone won't mow their lawn or control the weeds, the City will intervene. The diabetic who will not stop eating bad things keeps getting treated. The heart patient who is told to lose weight and exercise but won't do either is still treated.

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

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=35)	4.11	0.0	5.7	14.3	42.9	37.1	0.0	100.0
Employment options (N=35)	2.91	5.7	31.4	37.1	17.1	8.6	0.0	99.9
Help for renters with landlord and tenants' rights issues (N=35)	2.76	0.0	34.3	54.3	5.7	2.9	2.9	100.1
Homelessness (N=34)	3.62	0.0	8.8	32.4	47.1	11.8	0.0	100.1
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=35)	3.91	0.0	2.9	25.7	48.6	22.9	0.0	100.1
Household budgeting and money management (N=35)	3.20	0.0	20.0	48.6	22.9	8.6	0.0	100.1
Hunger (N=35)	3.29	0.0	8.6	57.1	31.4	2.9	0.0	100.0
Maintaining livable and energy efficient homes (N=35)	3.06	8.6	8.6	54.3	25.7	2.9	0.0	100.1
Skilled labor workforce (N=35)	3.97	0.0	5.7	22.9	40.0	31.4	0.0	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=35)	3.60	0.0	5.7	48.6	25.7	20.0	0.0	100.0
Availability of public transportation (N=35)	3.51	2.9	11.4	37.1	28.6	20.0	0.0	100.0
Availability of walking and biking options (N=35)	2.94	8.6	17.1	51.4	17.1	5.7	0.0	99.9
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=35)	3.29	2.9	17.1	40.0	28.6	11.4	0.0	100.0
Cost of public transportation (N=35)	2.83	5.7	25.7	51.4	14.3	2.9	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Driving habits (e.g., speeding, road rage) (N=35)	2.66	8.6	40.0	34.3	11.4	5.7	0.0	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=32)	2.50	9.4	40.6	40.6	9.4	0.0	0.0	100.0
Availability of education about birth control (N=32)	2.80	9.4	34.4	25.0	15.6	9.4	6.3	100.1
Availability of quality child care (N=33)	3.15	0.0	21.2	48.5	24.2	6.1	0.0	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=33)	3.58	0.0	3.0	42.4	48.5	6.1	0.0	100.0
Bullying (N=33)	3.55	0.0	3.0	51.5	33.3	12.1	0.0	99.9
Childhood obesity (N=33)	3.61	0.0	6.1	42.4	36.4	15.2	0.0	100.1
Cost of activities (outside of school and sports) for children and youth (N=32)	3.00	6.3	18.8	50.0	18.8	6.3	0.0	100.2
Cost of quality child care (N=33)	3.48	0.0	6.1	48.5	36.4	9.1	0.0	100.1
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=33)	3.48	0.0	12.1	33.3	48.5	6.1	0.0	100.0
Crime committed by youth (N=33)	3.52	0.0	9.1	45.5	30.3	15.2	0.0	100.1
Opportunities for youth-adult mentoring (N=32)	3.10	0.0	15.6	62.5	12.5	6.3	3.1	100.0
Parental custody, guardianships and visitation rights (N=33)	2.78	0.0	36.4	48.5	9.1	3.0	3.0	100.0
School absenteeism (truancy) (N=33)	3.06	0.0	27.3	45.5	15.2	9.1	3.0	100.1
School dropout rates (N=32)	3.19	0.0	18.8	50.0	25.0	6.3	0.0	100.1
School violence (N=33)	3.06	0.0	27.3	39.4	27.3	3.0	3.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Substance abuse by youth (N=33)	3.67	0.0	0.0	48.5	36.4	15.2	0.0	100.1
Teen pregnancy (N=32)	3.00	0.0	25.0	56.3	12.5	6.3	0.0	100.1
Teen suicide (N=33)	3.52	0.0	15.2	39.4	24.2	21.2	0.0	100.0
Teen tobacco use (N=33)	3.45	0.0	12.1	45.5	27.3	15.2	0.0	100.1
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=31)	2.43	6.5	48.4	35.5	6.5	0.0	3.2	100.1
Availability of long-term care (N=32)	3.16	6.3	18.8	34.4	28.1	9.4	3.1	100.1
Availability of memory care (N=31)	3.24	3.2	12.9	41.9	29.0	6.5	6.5	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=32)	2.90	0.0	25.0	56.3	15.6	0.0	3.1	100.0
Availability of resources for grandparents caring for grandchildren (N=32)	2.87	0.0	28.1	53.1	15.6	0.0	3.1	99.9
Availability of resources to help the elderly stay safe in their homes (N=31)	2.93	3.2	25.8	45.2	19.4	3.2	3.2	100.0
Cost of activities for seniors (e.g., recreational, social, cultural) (N=30)	2.61	10.0	30.0	40.0	13.3	0.0	6.7	100.0
Cost of in-home services (N=32)	3.13	3.1	21.9	37.5	28.1	6.3	3.1	100.0
Cost of long-term care (N=31)	3.50	0.0	12.9	32.3	41.9	9.7	3.2	100.0
Cost of memory care (N=30)	3.48	0.0	13.3	36.7	33.3	13.3	3.3	99.9
Help making out a will or healthcare directive (N=31)	2.90	3.2	32.3	45.2	9.7	9.7	0.0	100.1
SAFETY								
Abuse of prescription drugs (N=30)	4.00	0.0	0.0	30.0	40.0	30.0	0.0	100.0
Availability of emergency medical services (N=30)	2.17	13.3	63.3	16.7	6.7	0.0	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Child abuse and neglect (N=29)	3.24	0.0	20.7	48.3	17.2	13.8	0.0	100.0
Criminal activity (N=30)	3.33	0.0	16.7	46.7	23.3	13.3	0.0	100.0
Culture of excessive and binge drinking (N=30)	3.10	6.7	16.7	46.7	20.0	10.0	0.0	100.1
Domestic violence (N=29)	3.24	3.4	17.2	41.4	27.6	10.3	0.0	99.9
Elder abuse (N=29)	2.79	6.9	27.6	48.3	13.8	3.4	0.0	100.0
Lack of police or delayed response of police (N=30)	2.40	13.3	60.0	6.7	13.3	6.7	0.0	100.0
Presence of drug dealers (N=30)	3.17	0.0	30.0	36.7	13.3	16.7	3.3	100.0
Presence of gang activity (N=29)	2.86	0.0	44.8	31.0	10.3	10.3	3.4	99.8
Presence of street drugs (N=30)	3.24	0.0	33.3	23.3	23.3	16.7	3.3	99.9
Sex trafficking (N=30)	3.33	0.0	23.3	30.0	36.7	10.0	0.0	100.0
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=30)	3.13	3.3	20.0	43.3	26.7	6.7	0.0	100.0
Access to affordable health insurance coverage (N=30)	3.60	3.3	10.0	20.0	56.7	10.0	0.0	100.0
Access to affordable health care (N=30)	3.63	3.3	3.3	30.0	53.3	10.0	0.0	99.9
Access to affordable prescription drugs (N=28)	3.64	3.6	7.1	28.6	42.9	17.9	0.0	100.1
Access to affordable vision insurance coverage (N=30)	3.10	3.3	26.7	30.0	36.7	3.3	0.0	100.0
Access to technology for health records and health education (N=30)	2.55	10.0	36.7	36.7	13.3	0.0	3.3	100.0
Availability of behavioral health (e.g., substance abuse) providers (N=30)	3.83	0.0	3.3	36.7	33.3	26.7	0.0	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=30)	2.73	6.7	36.7	36.7	16.7	3.3	0.0	100.1

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Availability of health care services for Native people (N=29)	3.21	3.4	34.5	17.2	27.6	17.2	0.0	99.9
Availability of health care services for New Americans (N=29)	2.93	3.4	34.5	34.5	20.7	6.9	0.0	100.0
Availability of mental health providers (N=30)	3.80	0.0	23.3	10.0	30.0	36.7	0.0	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=29)	3.10	3.4	24.1	37.9	27.6	6.9	0.0	99.9
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=29)	3.00	3.4	27.6	44.8	13.8	10.3	0.0	99.9
Availability of specialist physicians (N=30)	2.57	13.3	33.3	36.7	16.7	0.0	0.0	100.0
Coordination of care between providers and services (N=29)	3.21	3.4	27.6	31.0	20.7	17.2	0.0	99.9
Timely access to medical care providers (N=30)	2.50	13.3	46.7	20.0	16.7	3.3	0.0	100.0
Timely access to dental care providers (N=30)	2.43	13.3	43.3	30.0	13.3	0.0	0.0	99.9
Timely access to vision care providers (N=30)	2.33	13.3	50.0	26.7	10.0	0.0	0.0	100.0
Use of emergency room services for primary healthcare (N=29)	3.48	0.0	17.2	37.9	24.1	20.7	0.0	99.9
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=30)	3.70	0.0	6.7	36.7	36.7	20.0	0.0	100.1
Dementia and Alzheimer's disease (N=29)	3.14	0.0	17.2	55.2	17.2	6.9	3.4	99.9
Depression (N=30)	3.83	0.0	3.3	36.7	30.0	26.7	3.3	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=30)	4.07	0.0	3.3	20.0	43.3	33.3	0.0	99.9

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Exposure to secondhand smoke (N=30)	2.60	6.7	43.3	40.0	3.3	6.7	0.0	100.0
Smoking and tobacco use (N=30)	2.87	0.0	36.7	43.3	16.7	3.3	0.0	100.0
Stress (N=30)	3.23	6.7	10.0	43.3	33.3	6.7	0.0	100.0
Suicide (N=29)	3.52	0.0	6.9	51.7	24.1	17.2	0.0	99.9

*Percentages may not total 100.0 due to rounding.

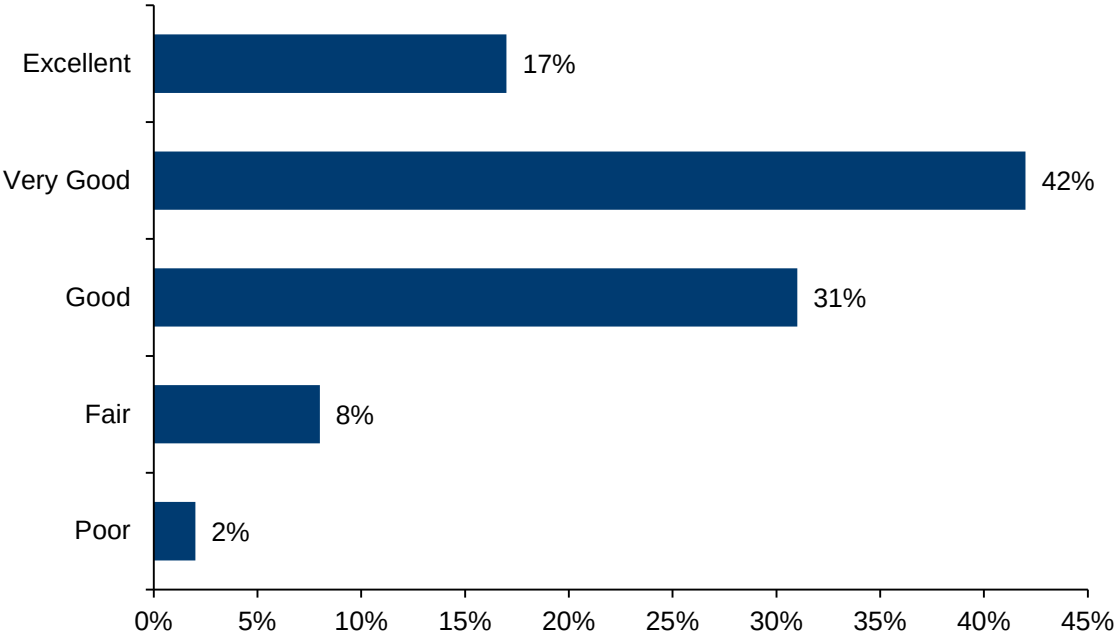
**NA (not applicable) responses were excluded when calculating the Means. As a result, the number of responses (N) in Appendix Table 1, which reflect total responses, may differ from the Ns in Figures 1 through 7, which exclude NA.

Sioux Falls CHNA Survey Report

February 26, 2018

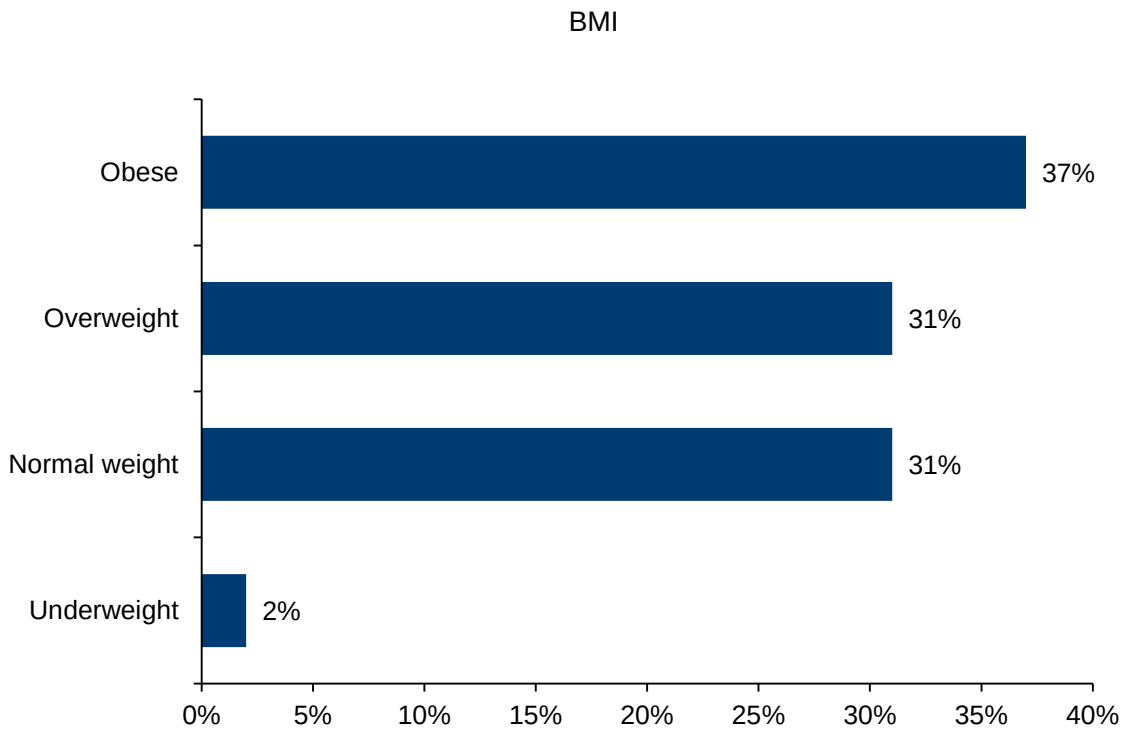
Sanford Health

How would you rate your health?



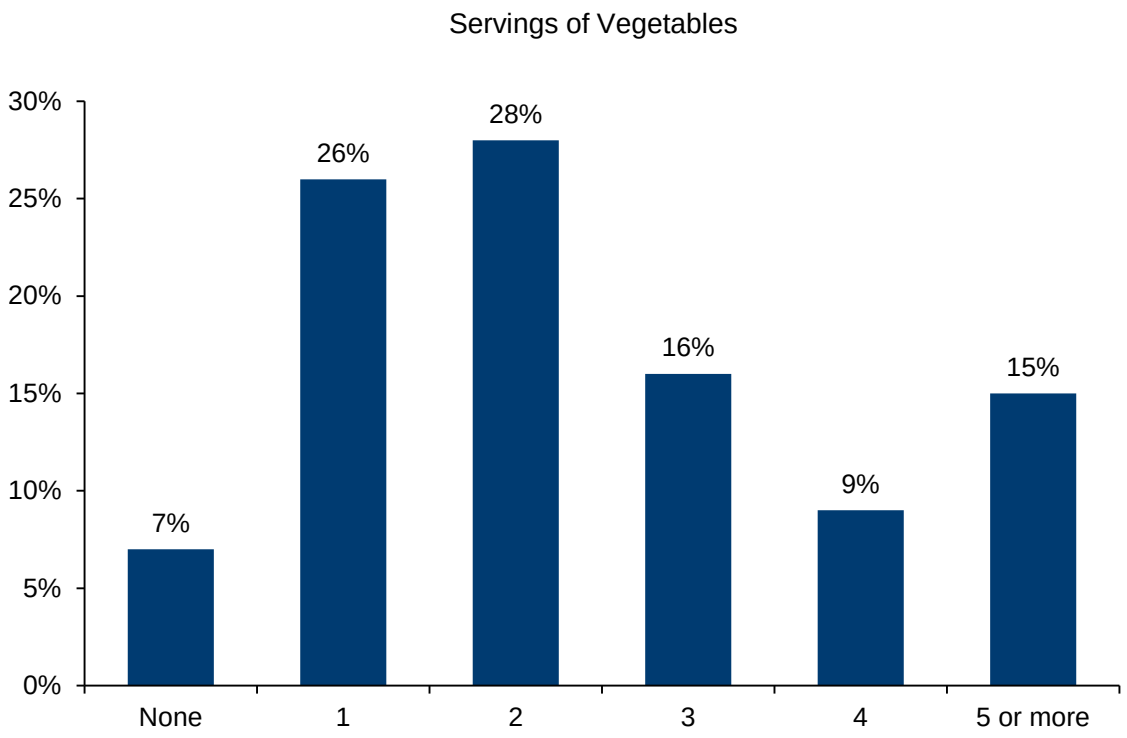
Base: Poor (n=9), Fair (n=46), Good (n=171), Very Good (n=232), Excellent (n=96), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)



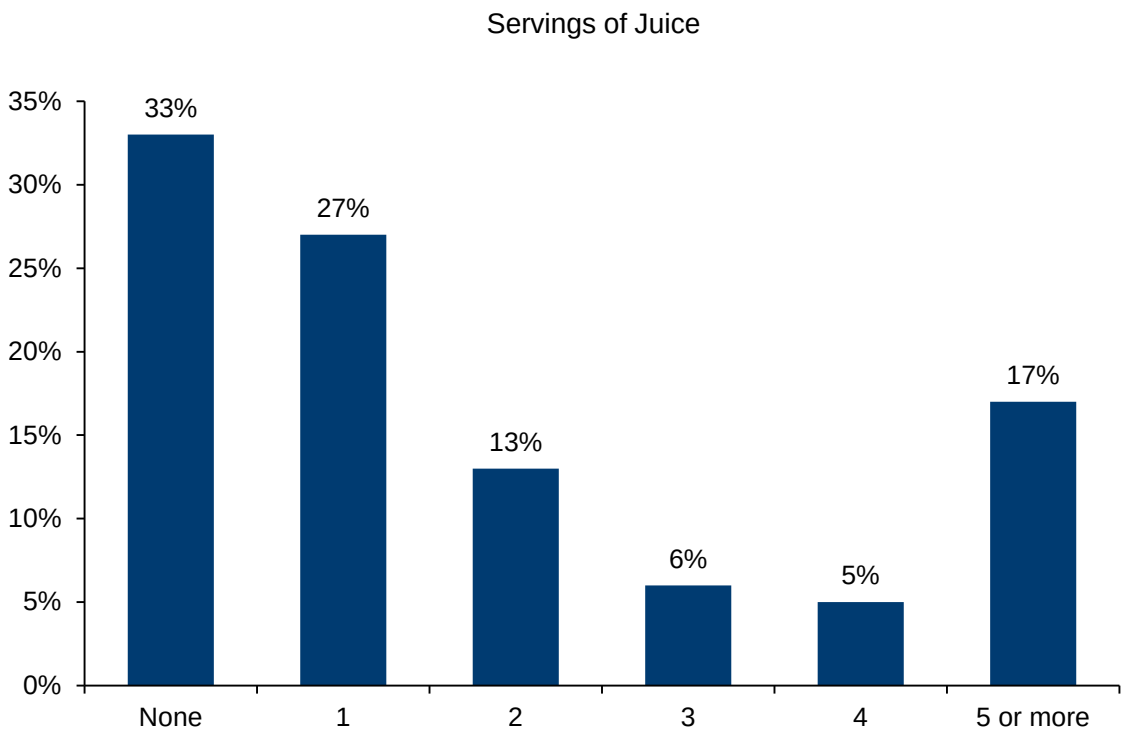
Base: Underweight (n=8), Normal weight (n=156), Overweight (n=159), Obese (n=186), Sample Size = 509

(Community = Minnehaha / Lincoln / Turner / McCook)



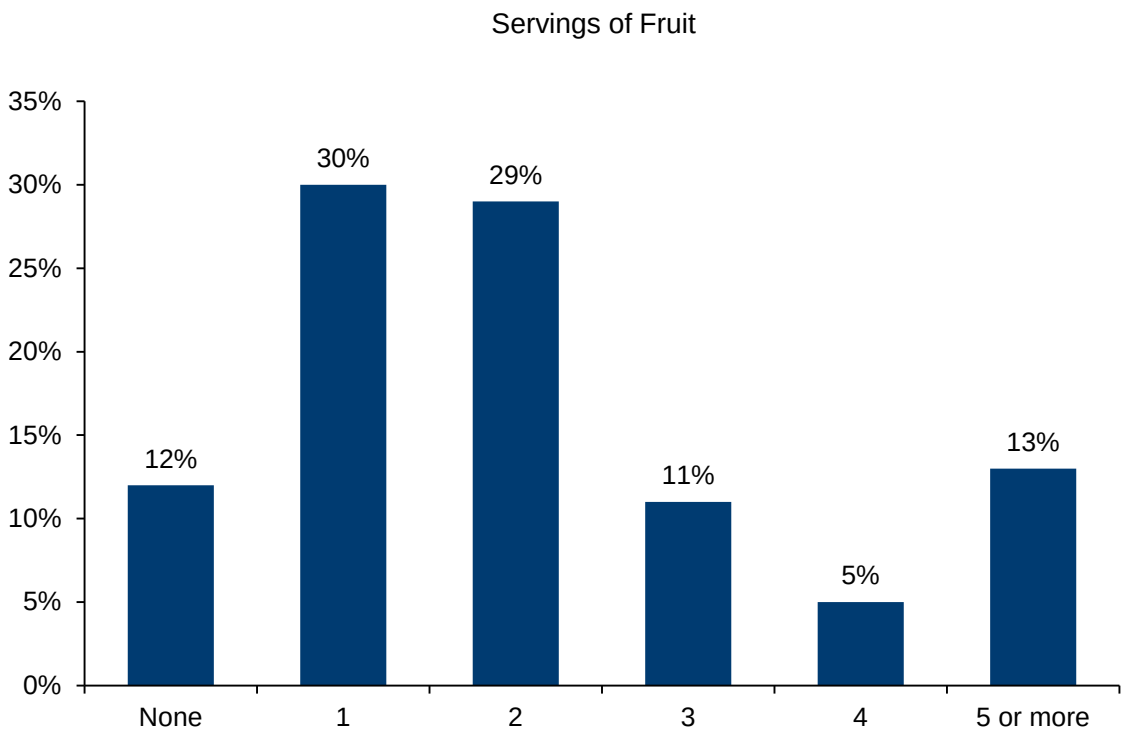
Sample Size = 525

(Community = Minnehaha / Lincoln / Turner / McCook)



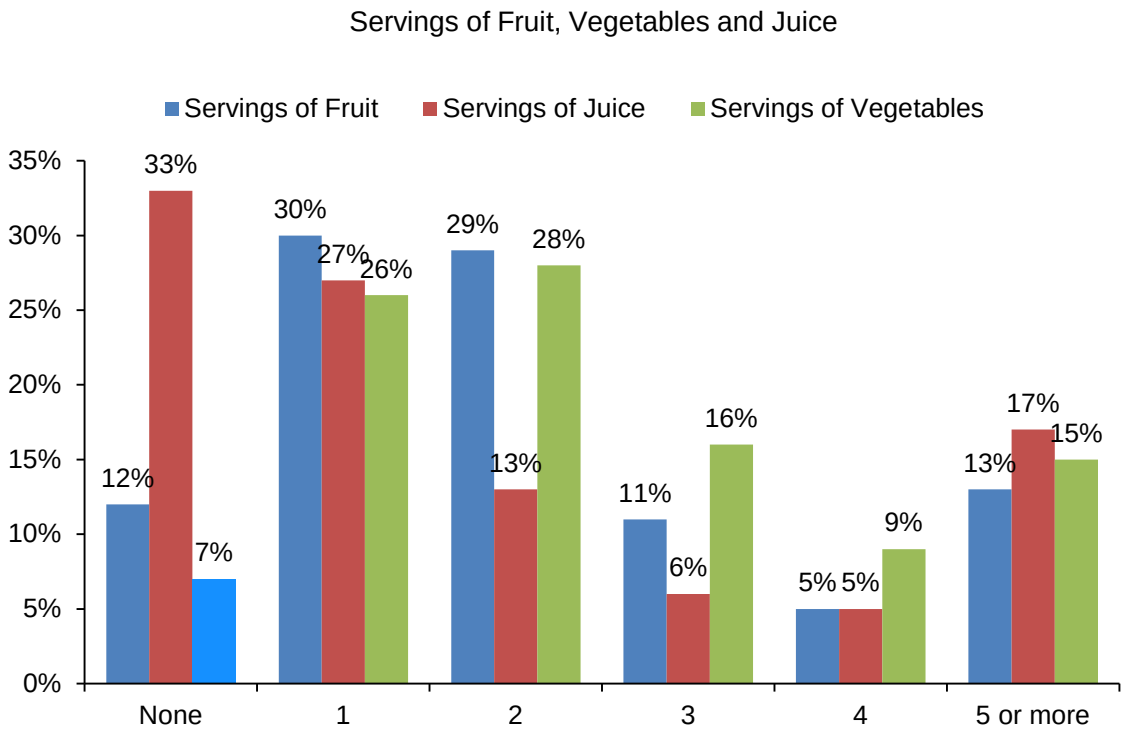
Base: None (n=130), 1 (n=107), 2 (n=50), 3 (n=24), 4 (n=21), 5 or more (n=66), Sample Size = 398

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: None (n=56), 1 (n=141), 2 (n=135), 3 (n=51), 4 (n=23), 5 or more (n=62), Sample Size = 468

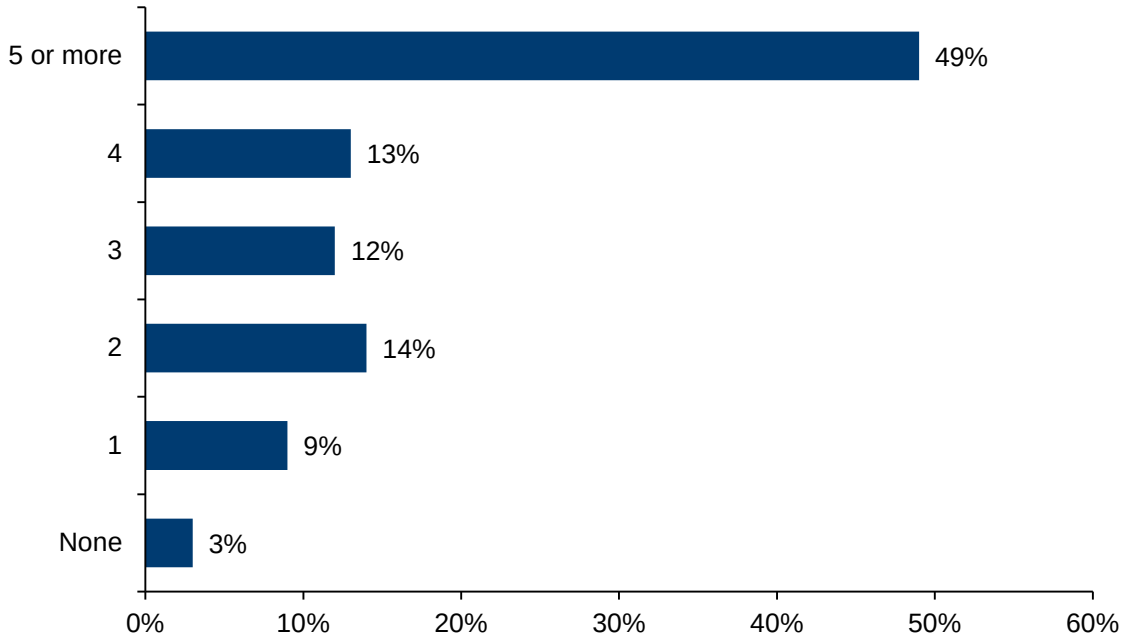
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

(Community = Minnehaha / Lincoln / Turner / McCook)

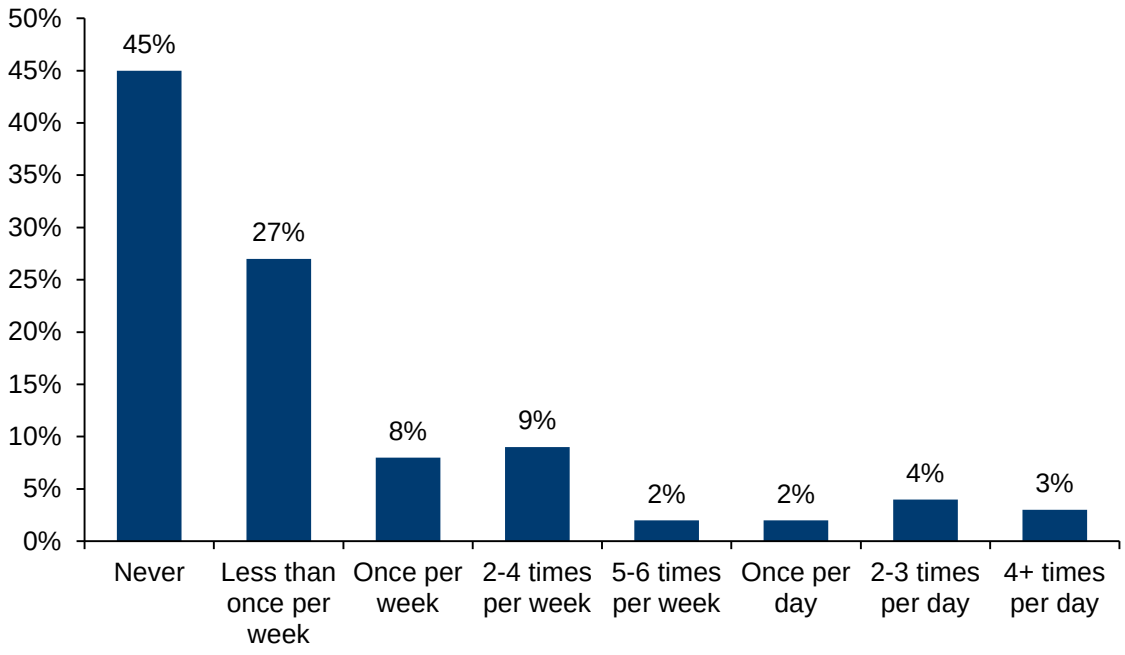
Total Servings of Fruits, Vegetables and Juice



Base: None (n=15), 1 (n=50), 2 (n=73), 3 (n=66), 4 (n=69), 5 or more (n=266), Sample Size = 539

(Community = Minnehaha / Lincoln / Turner / McCook)

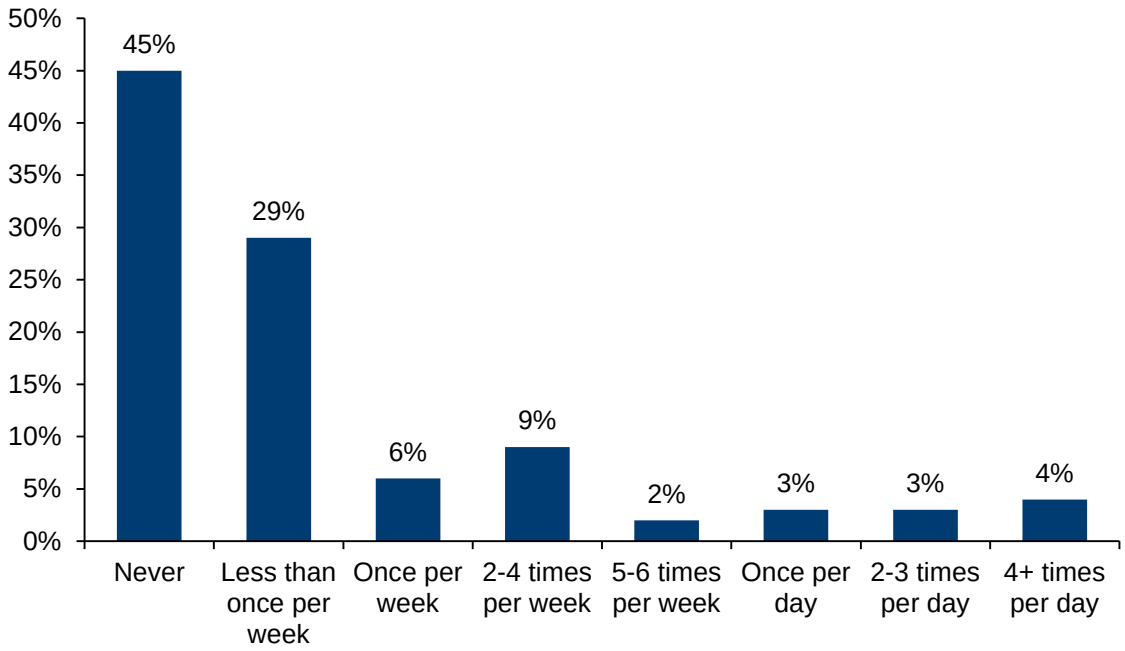
Snapple, Flavored Teas, Capri Sun, etc.



Base: Never (n=244), Less than once per week (n=147), Once per week (n=45), 2-4 times per week (n=51), 5-6 times per week (n=11), Once per day (n=11), 2-3 times per day (n=21), 4+ times per day (n=16), Sample Size = 546

(Community = Minnehaha / Lincoln / Turner / McCook)

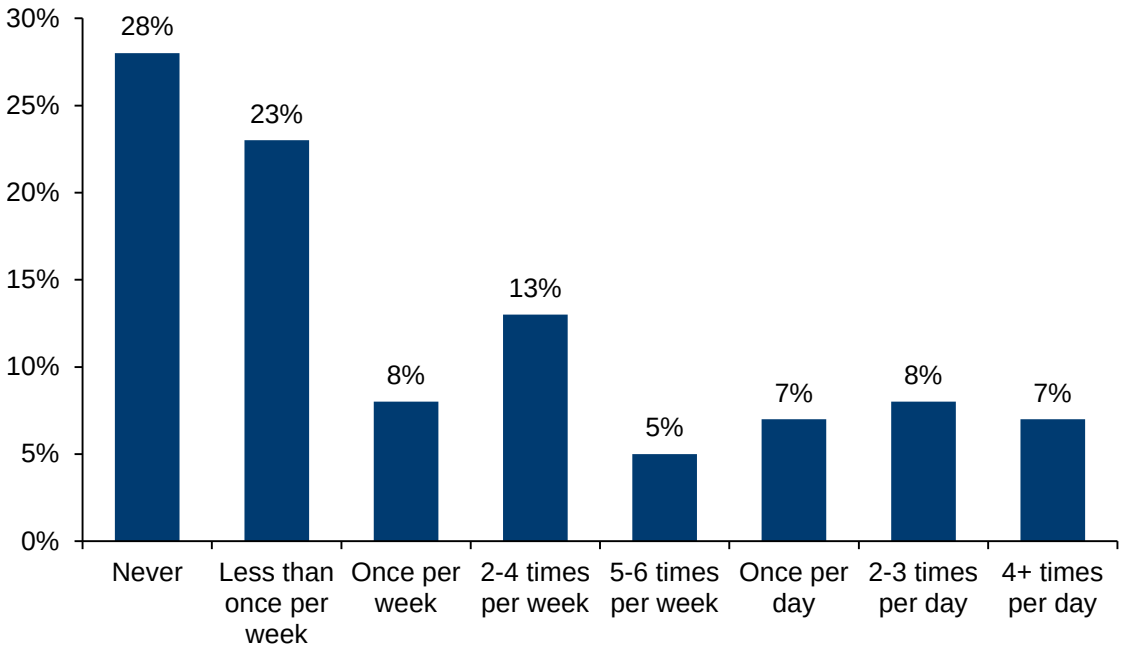
Gatorade, Powerade, etc.



Base: Never (n=245), Less than once per week (n=157), Once per week (n=35), 2-4 times per week (n=48), 5-6 times per week (n=10), Once per day (n=14), 2-3 times per day (n=15), 4+ times per day (n=21), Sample Size = 545

(Community = Minnehaha / Lincoln / Turner / McCook)

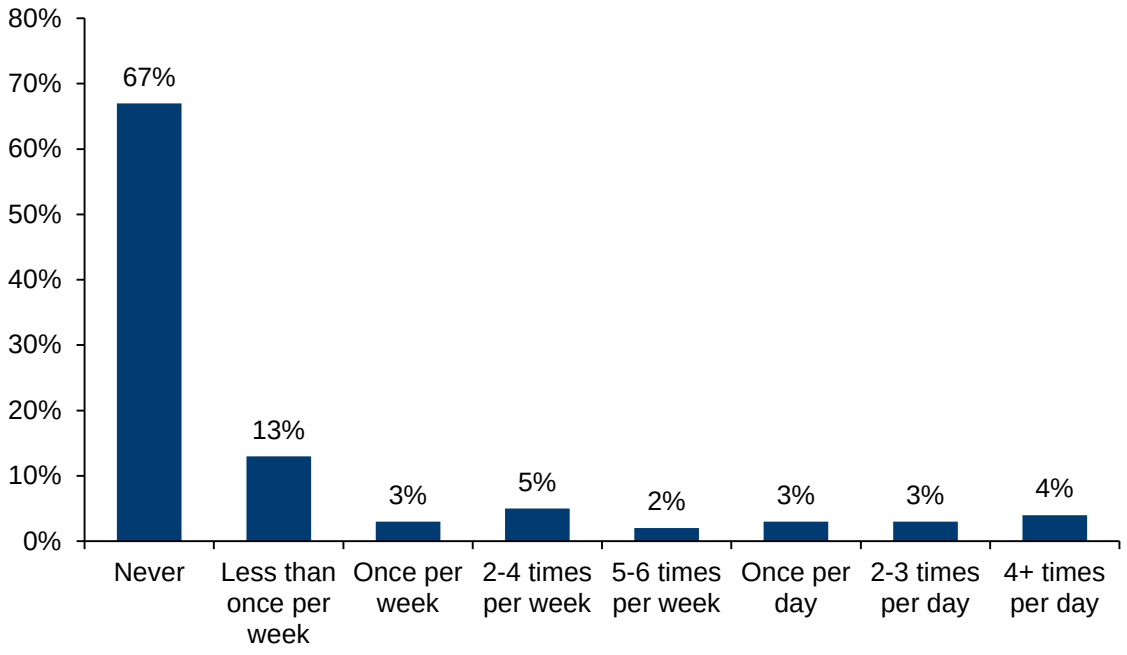
Soda or Pop



Base: Never (n=154), Less than once per week (n=129), Once per week (n=45), 2-4 times per week (n=69), 5-6 times per week (n=29), Once per day (n=41), 2-3 times per day (n=45), 4+ times per day (n=38), Sample Size = 550

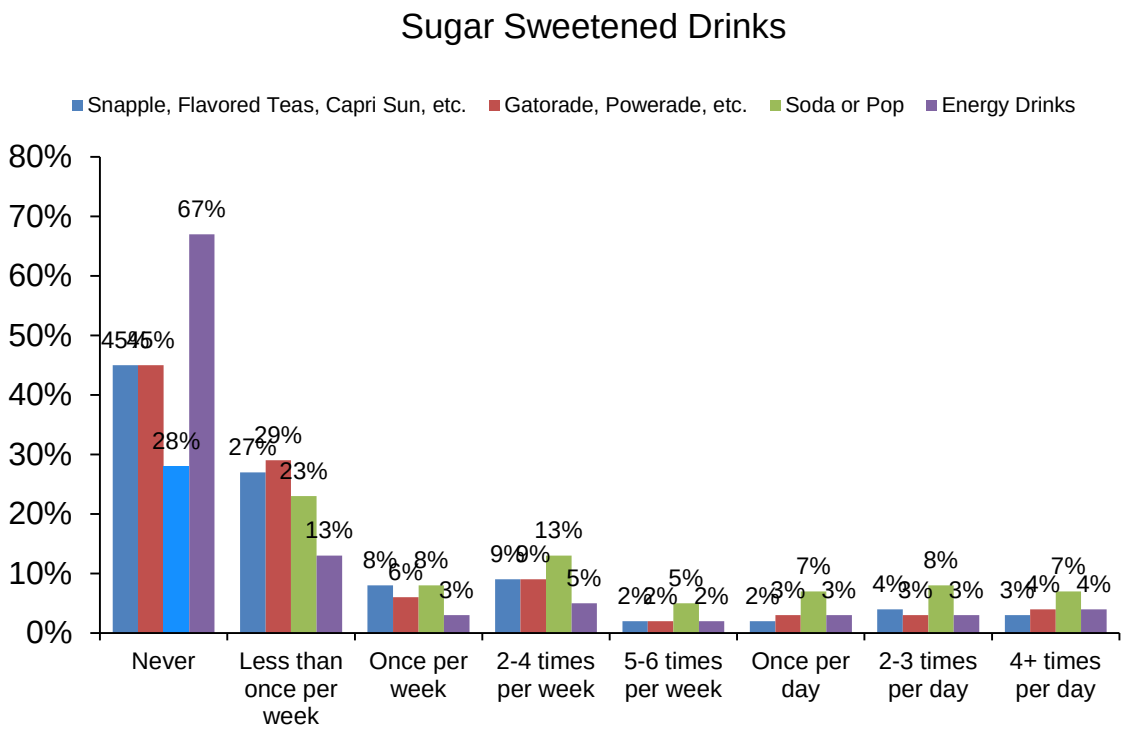
(Community = Minnehaha / Lincoln / Turner / McCook)

Energy Drinks



Base: Never (n=365), Less than once per week (n=71), Once per week (n=17), 2-4 times per week (n=29), 5-6 times per week (n=10), Once per day (n=19), 2-3 times per day (n=14), 4+ times per day (n=22), Sample Size = 547

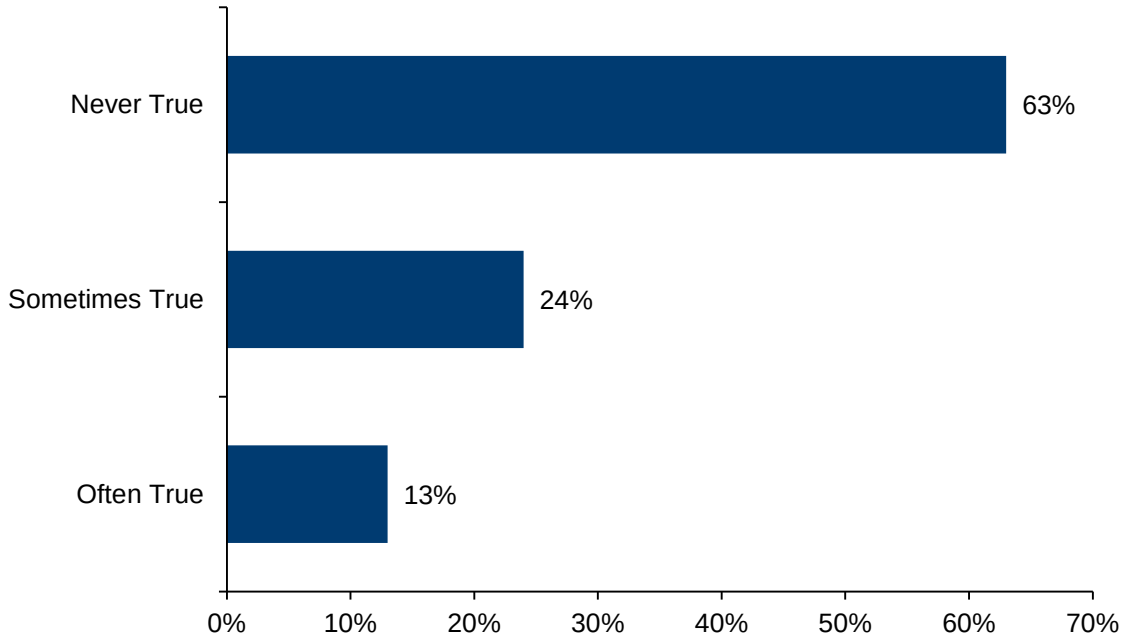
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

(Community = Minnehaha / Lincoln / Turner / McCook)

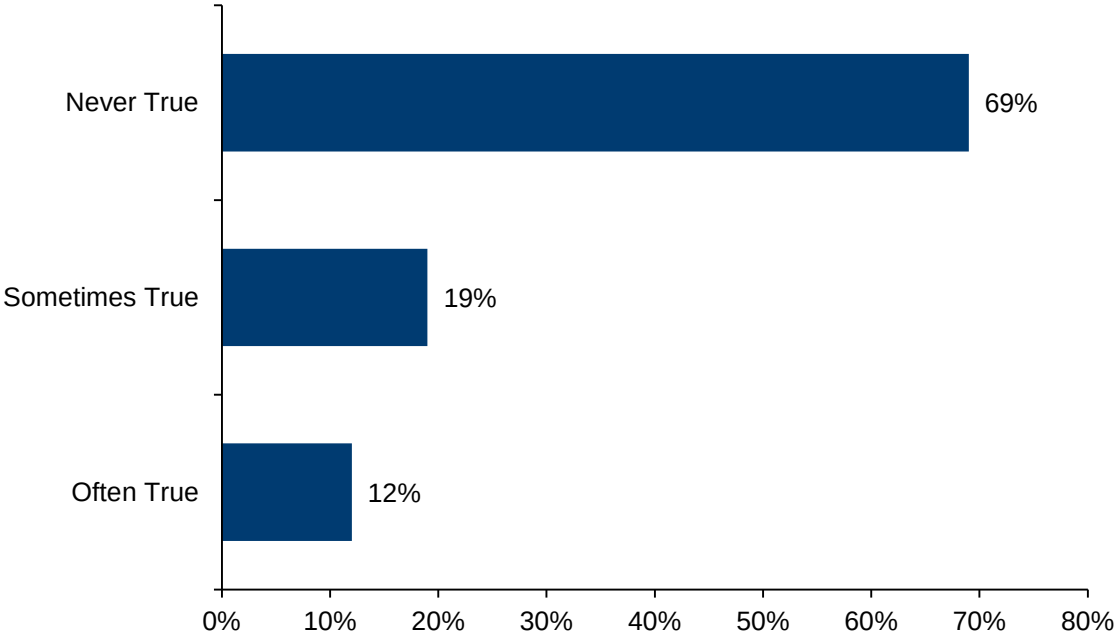
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=73), Sometimes True (n=131), Never True (n=350), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)

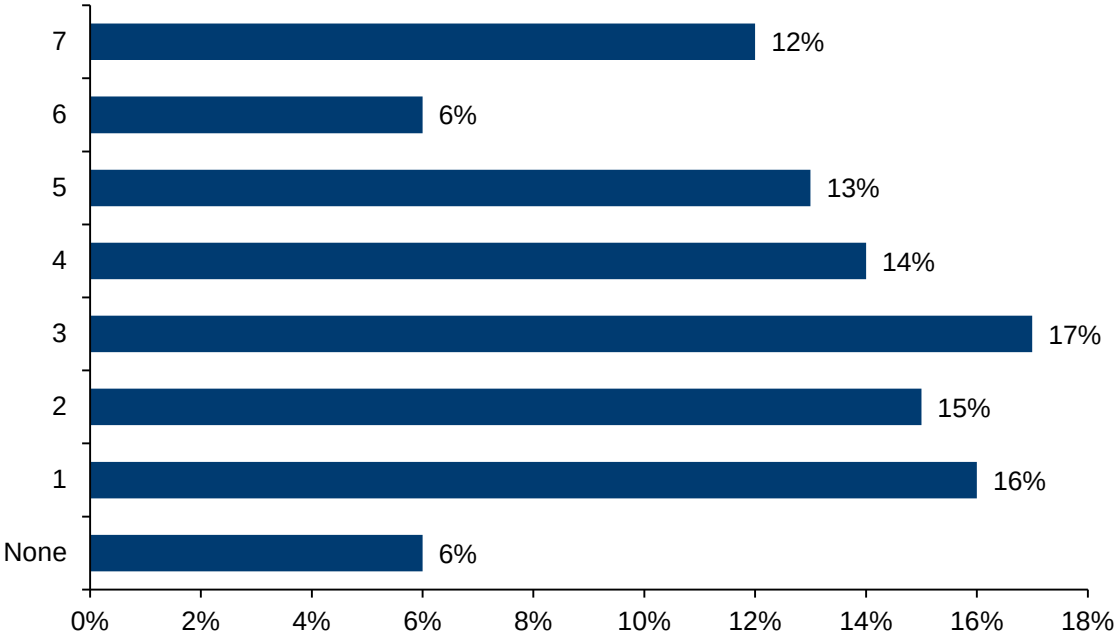
The food that we bought just didn’t last, and we didn’t have money to get more.



Base: Often True (n=66), Sometimes True (n=105), Never True (n=383), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)

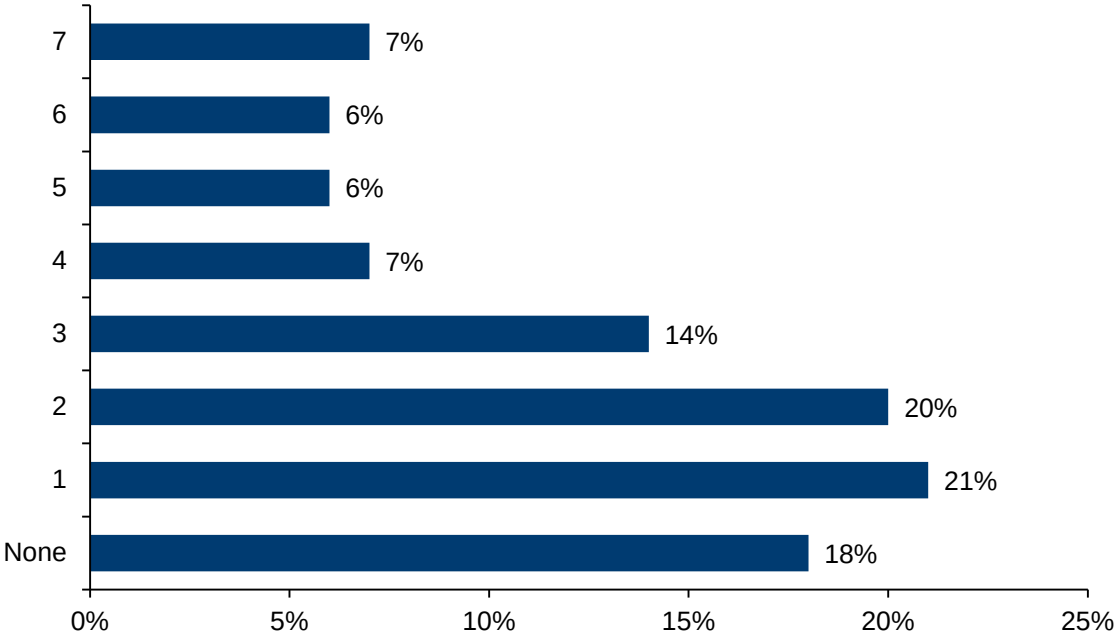
Days Per Week of Moderate Physical Activity



Base: None (n=32), 1 (n=85), 2 (n=79), 3 (n=86), 4 (n=73), 5 (n=67), 6 (n=31), 7 (n=64), Sample Size = 517

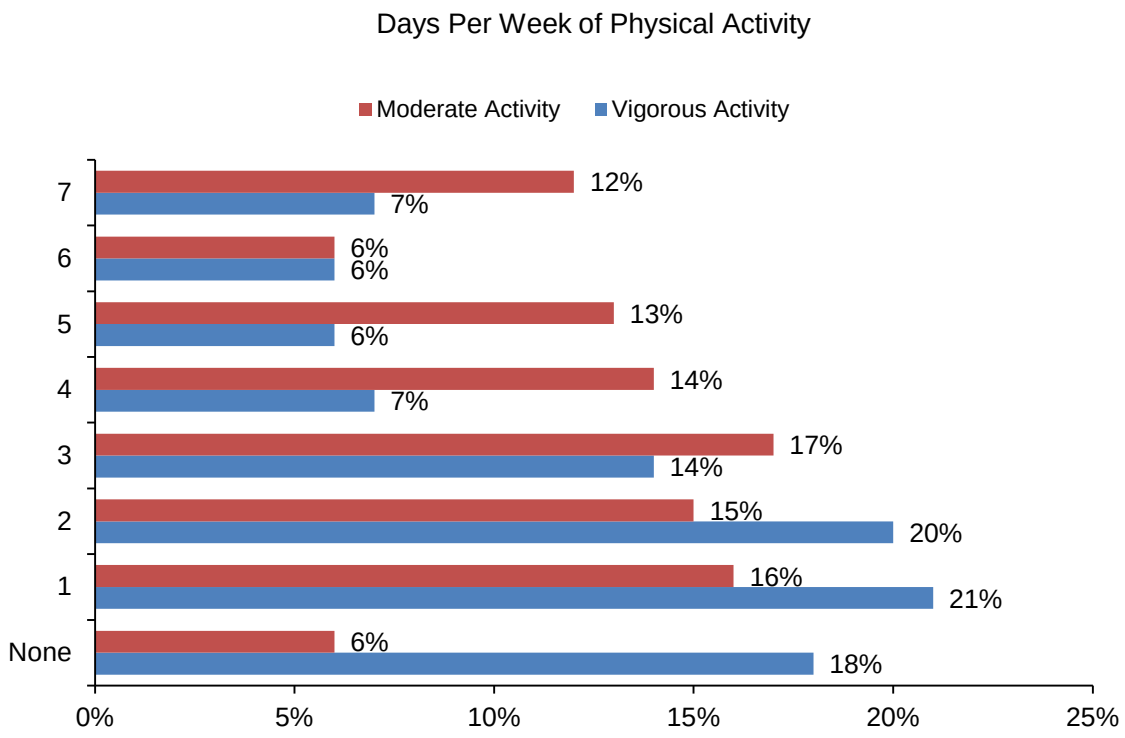
(Community = Minnehaha / Lincoln / Turner / McCook)

Days Per Week of Vigorous Physical Activity



Base: None (n=81), 1 (n=96), 2 (n=92), 3 (n=62), 4 (n=32), 5 (n=28), 6 (n=27), 7 (n=33), Sample Size = 451

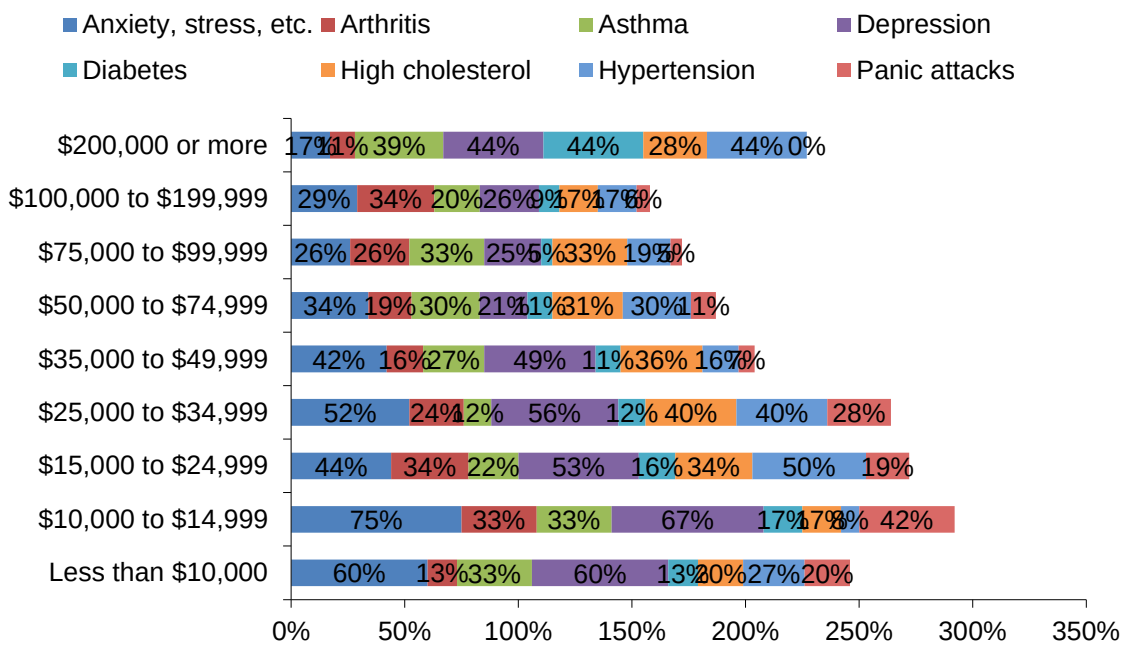
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

(Community = Minnehaha / Lincoln / Turner / McCook)

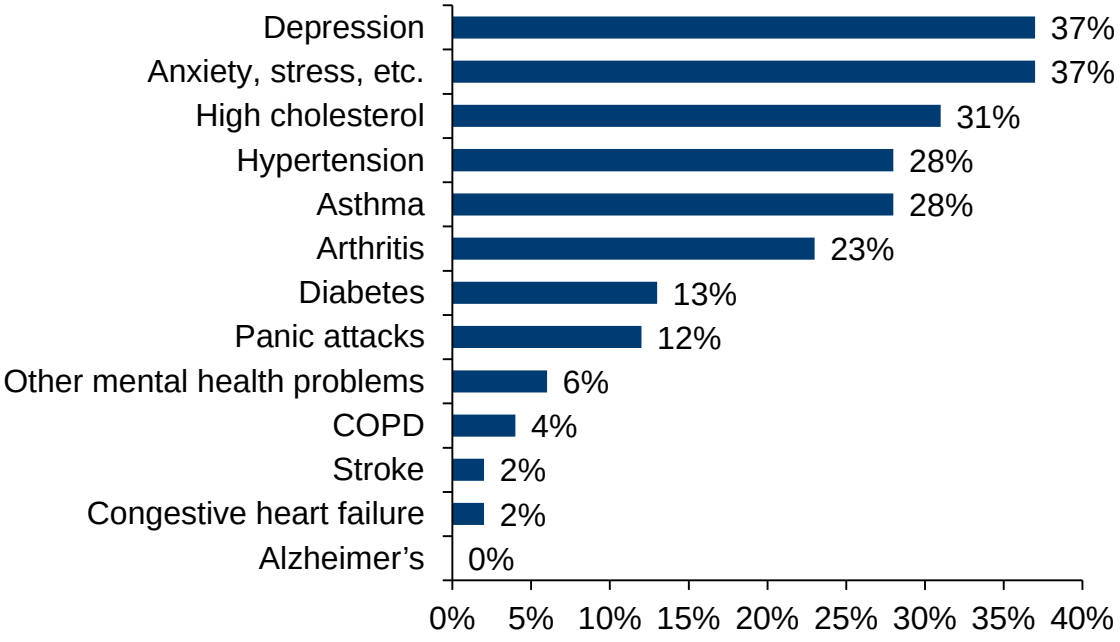
Past Diagnosis by Total Household Income



Base: Less than $10,000 (n=15), $10,000 to $14,999 (n=12), $15,000 to $24,999 (n=32), $25,000 to $34,999 (n=25), $35,000 to $49,999 (n=45), $50,000 to $74,999 (n=70), $75,000 to $99,999 (n=57), $100,000 to $199,999 (n=35), $200,000 or more (n=18), Sample Size = 309

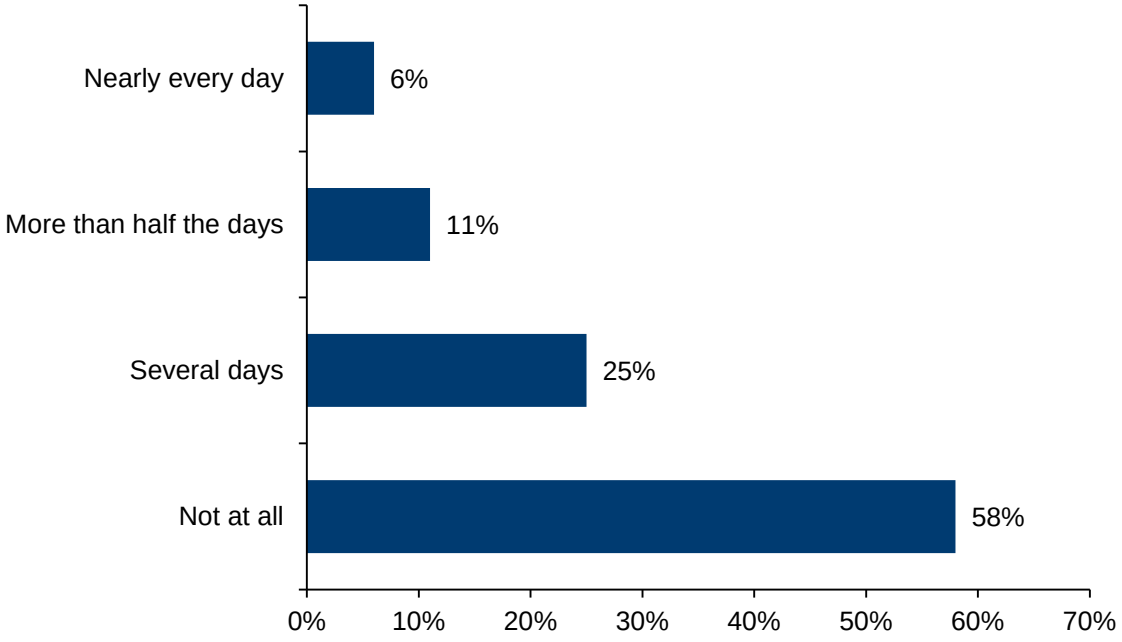
(Community = Minnehaha / Lincoln / Turner / McCook)

Past Diagnosis



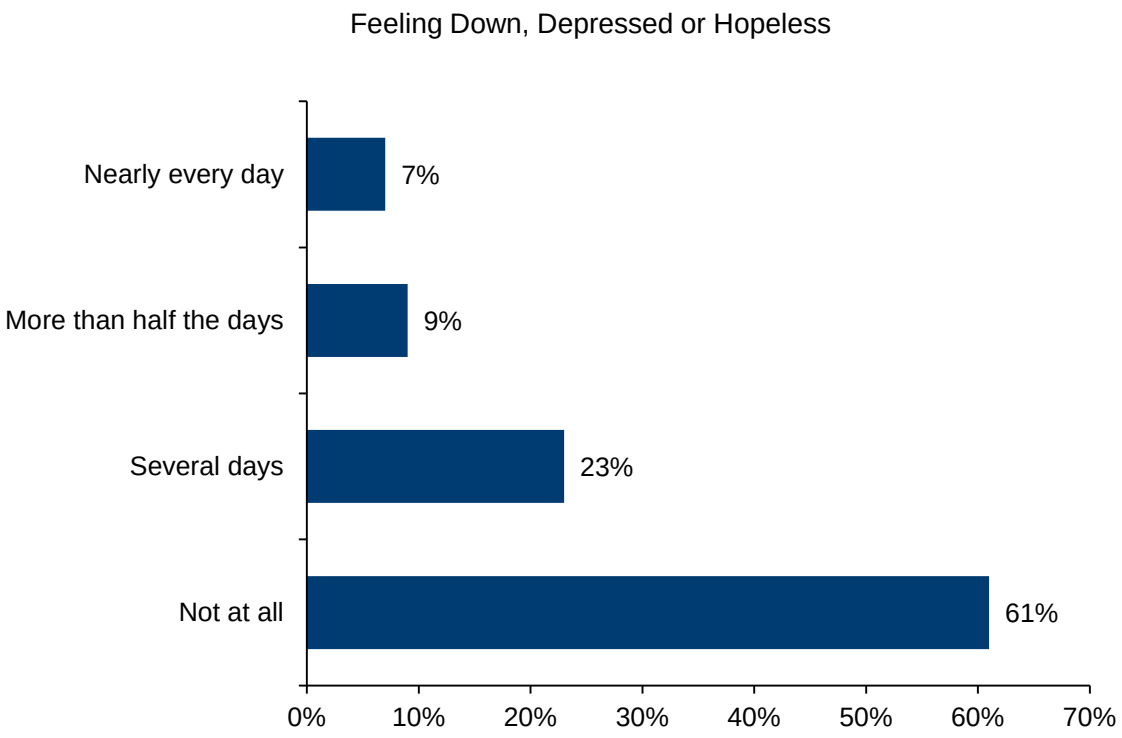
Base: Alzheimer's (n=1), Anxiety, stress, etc. (n=121), Arthritis (n=77), Asthma (n=92), Congestive heart failure (n=5), COPD (n=13), Depression (n=121), Diabetes (n=43), High cholesterol (n=101), Hypertension (n=93), Other mental health problems (n=19), Panic attacks (n=39), Stroke (n=5), Sample Size = 330

Little Interest or Pleasure in Doing Things



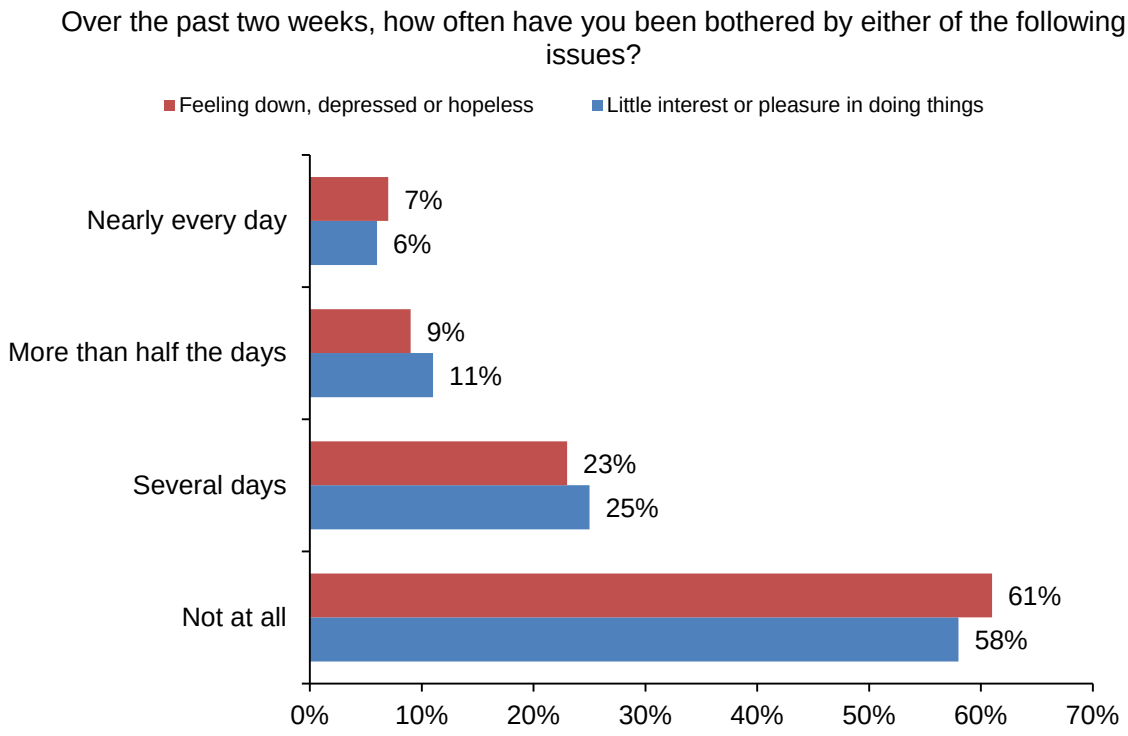
Base: Not at all (n=322), Several days (n=136), More than half the days (n=60), Nearly every day (n=36), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Not at all (n=336), Several days (n=128), More than half the days (n=51), Nearly every day (n=38), Sample Size = 553

(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

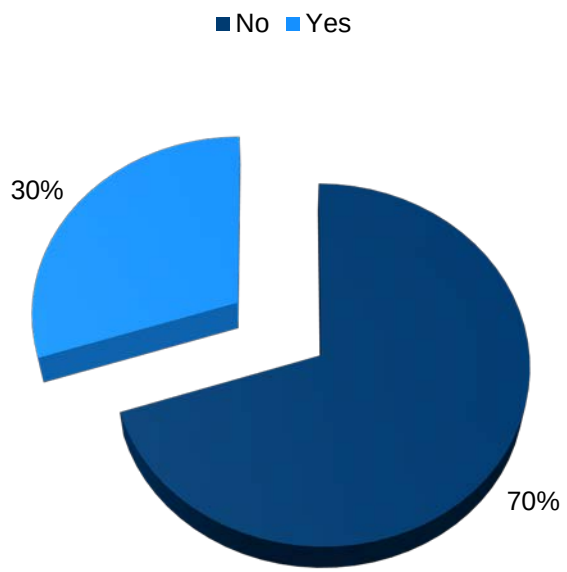
(Community = Minnehaha / Lincoln / Turner / McCook)

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

Base: Yes (n=272), No (n=282), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)

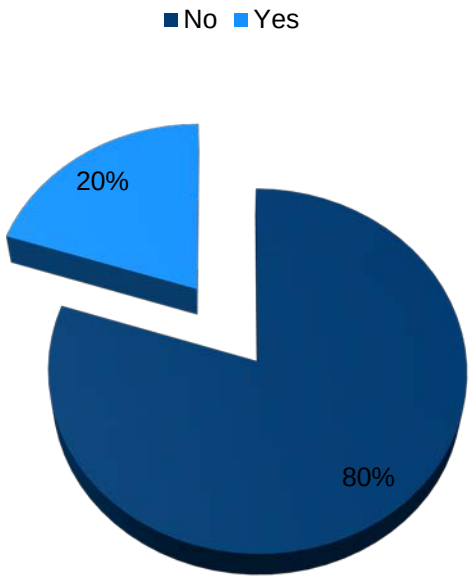
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Sample Size = 554

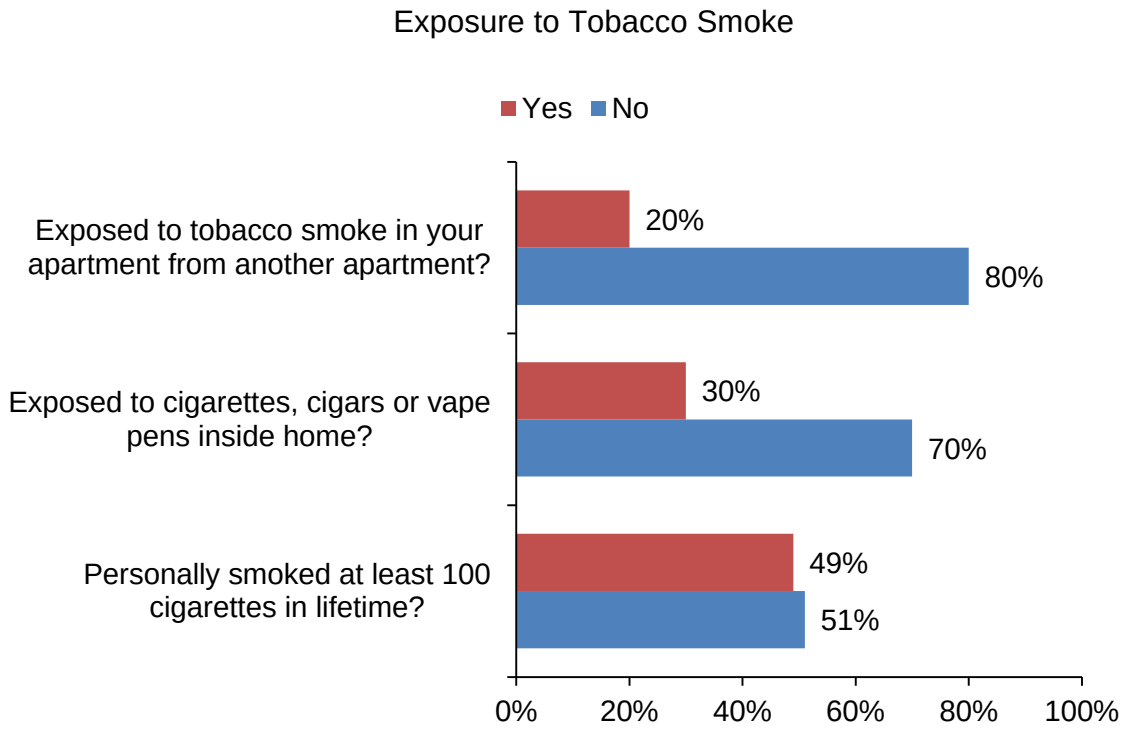
(Community = Minnehaha / Lincoln / Turner / McCook)

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

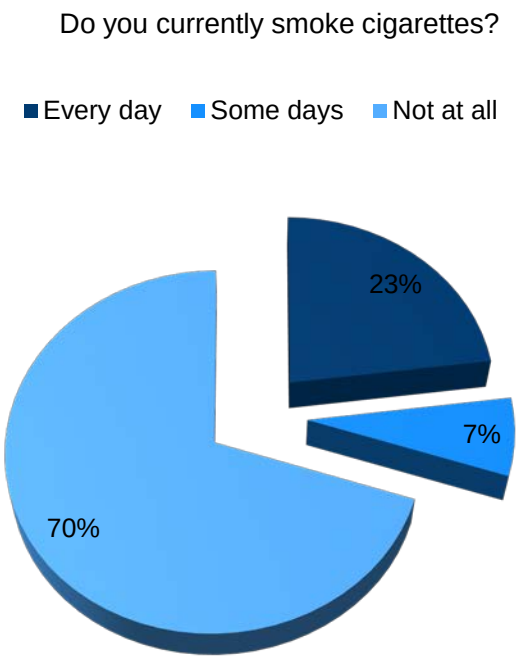


Base: Yes (n=108), No (n=443), Sample Size = 551

(Community = Minnehaha / Lincoln / Turner / McCook)

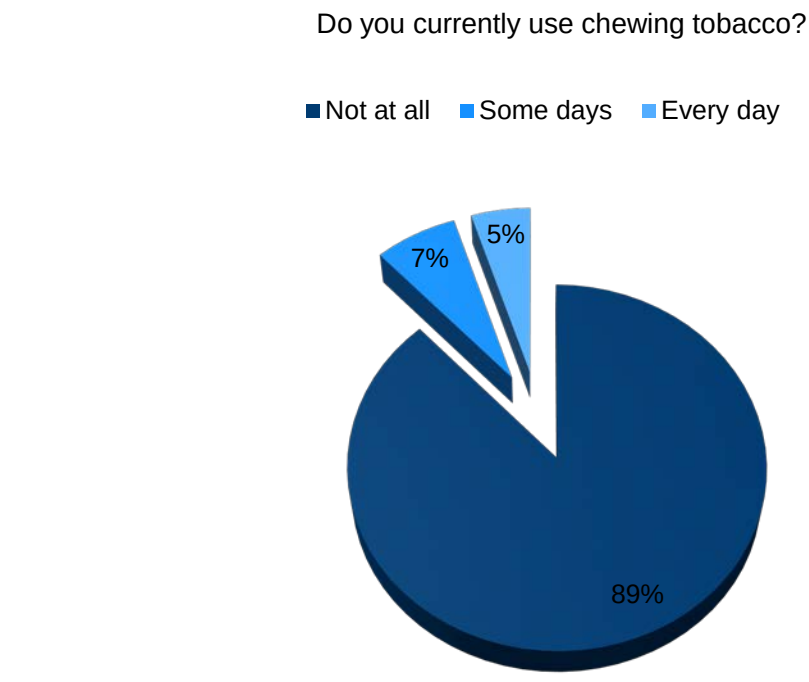


Base: Personally smoked at least 100 cigarettes in lifetime? (n=554), Exposed to cigarettes, cigars or vape pens inside home? (n=554), Exposed to tobacco smoke in your apartment from another apartment? (n=551), Sample Size = Variable
(Community = Minnehaha / Lincoln / Turner / McCook)



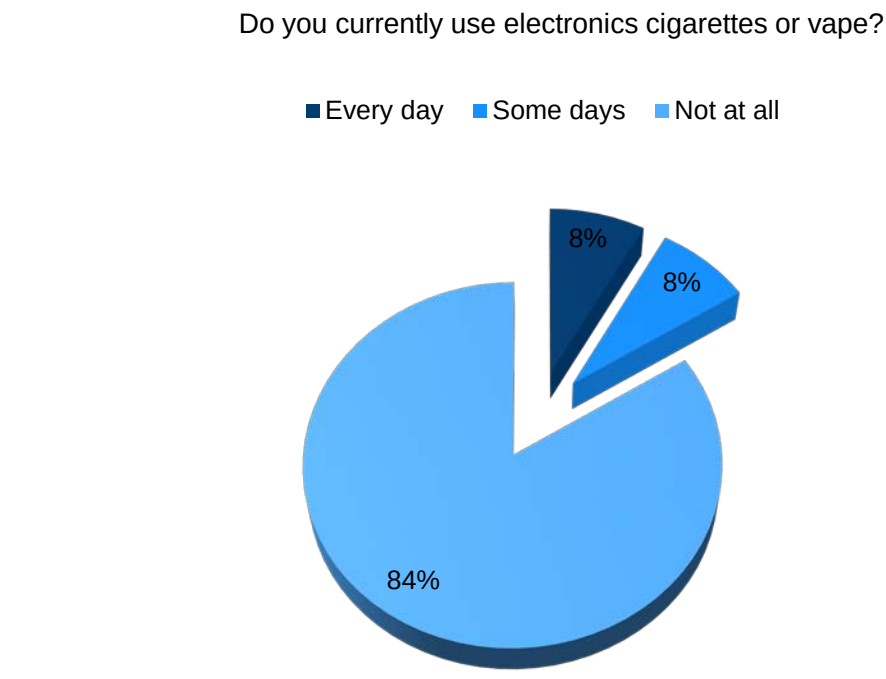
Base: Not at all (n=387), Some days (n=40), Every day (n=127), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)



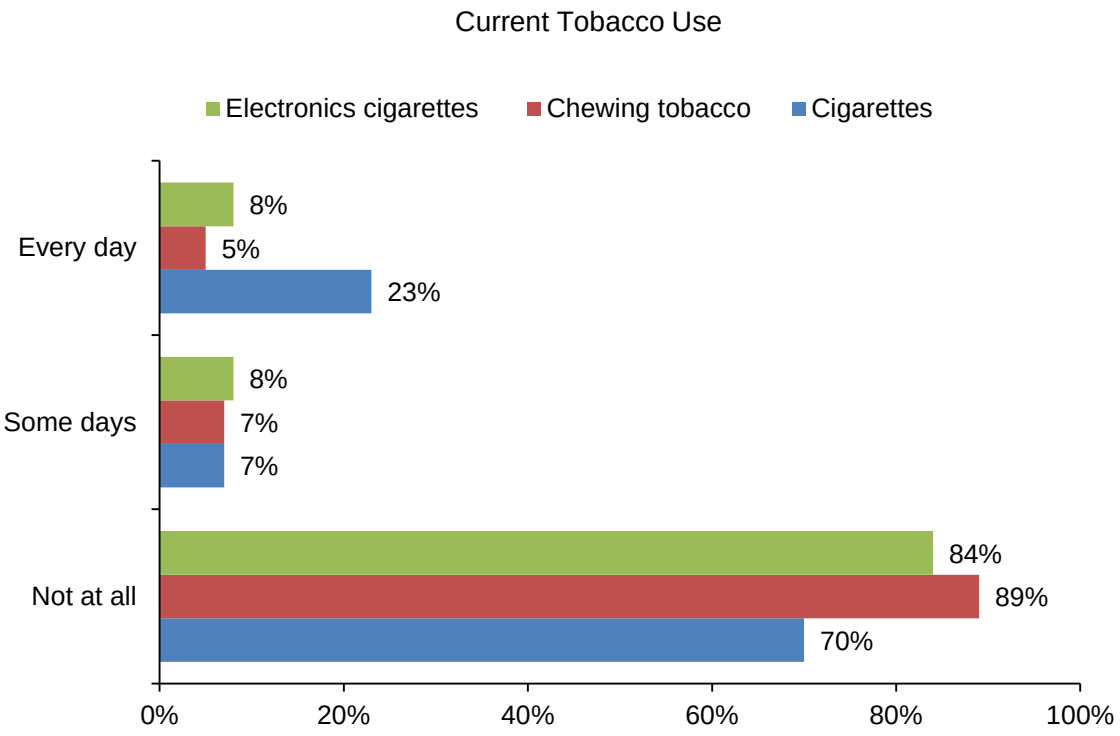
Base: Not at all (n=490), Some days (n=36), Every day (n=25), Sample Size = 551

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Not at all (n=465), Some days (n=44), Every day (n=43), Sample Size = 552

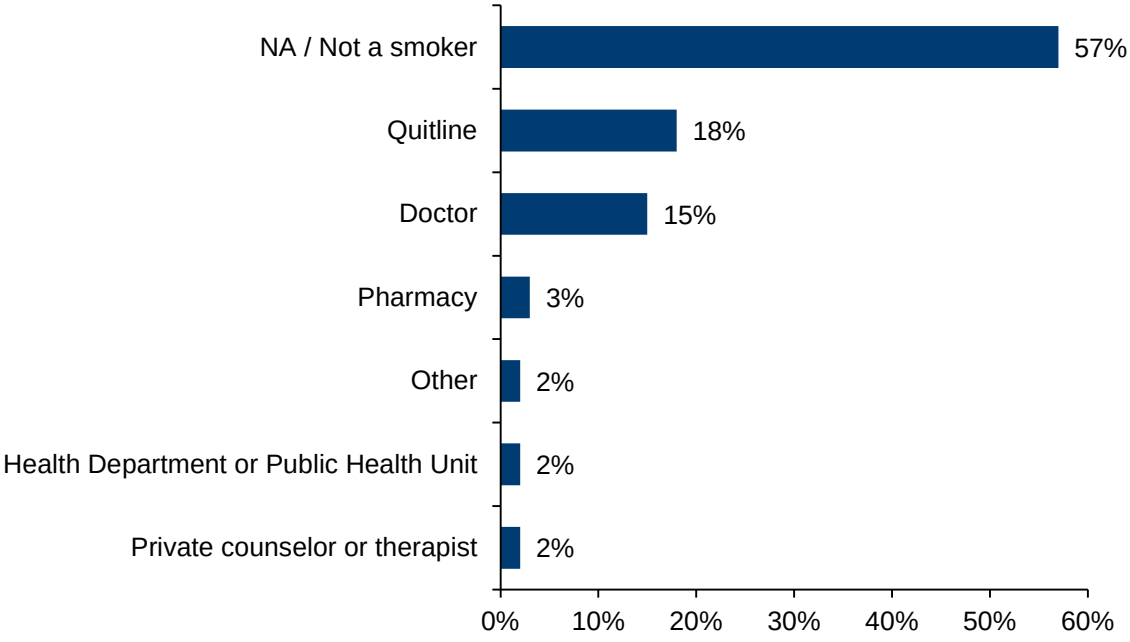
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

(Community = Minnehaha / Lincoln / Turner / McCook)

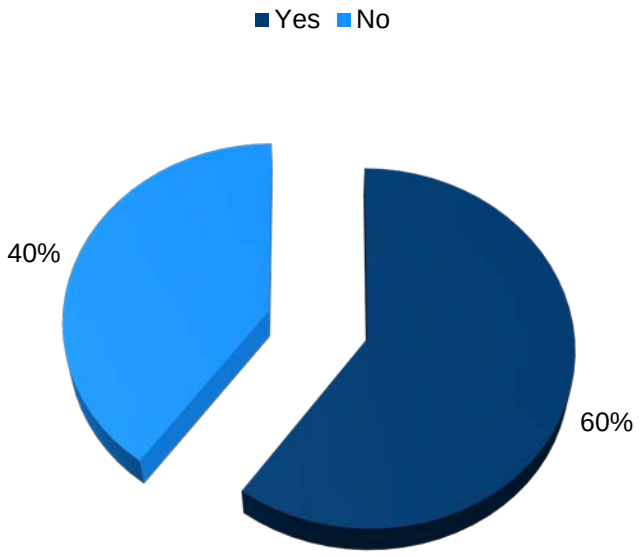
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=285), Quit line (n=91), Doctor (n=73), Pharmacy (n=14), Private counselor or therapist (n=12), Health Department or Public Health Unit (n=11), Other (n=12), Sample Size = 498

(Community = Minnehaha / Lincoln / Turner / McCook)

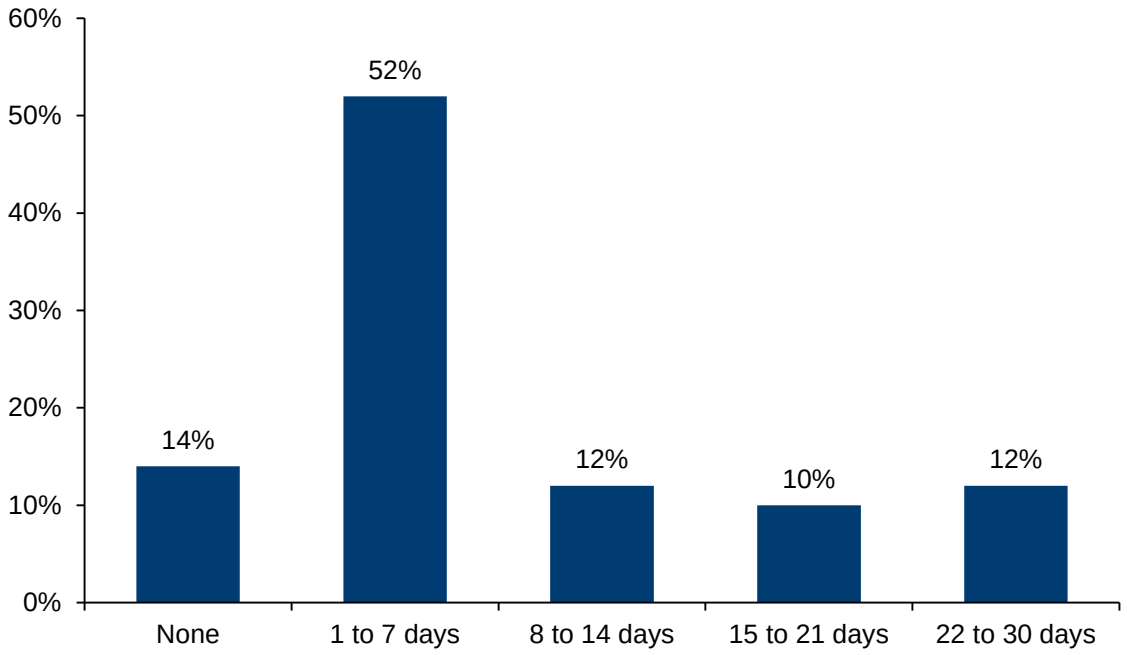
During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit? (Smokers only)



Base: Yes (n=121), No (n=82), Sample Size = 203

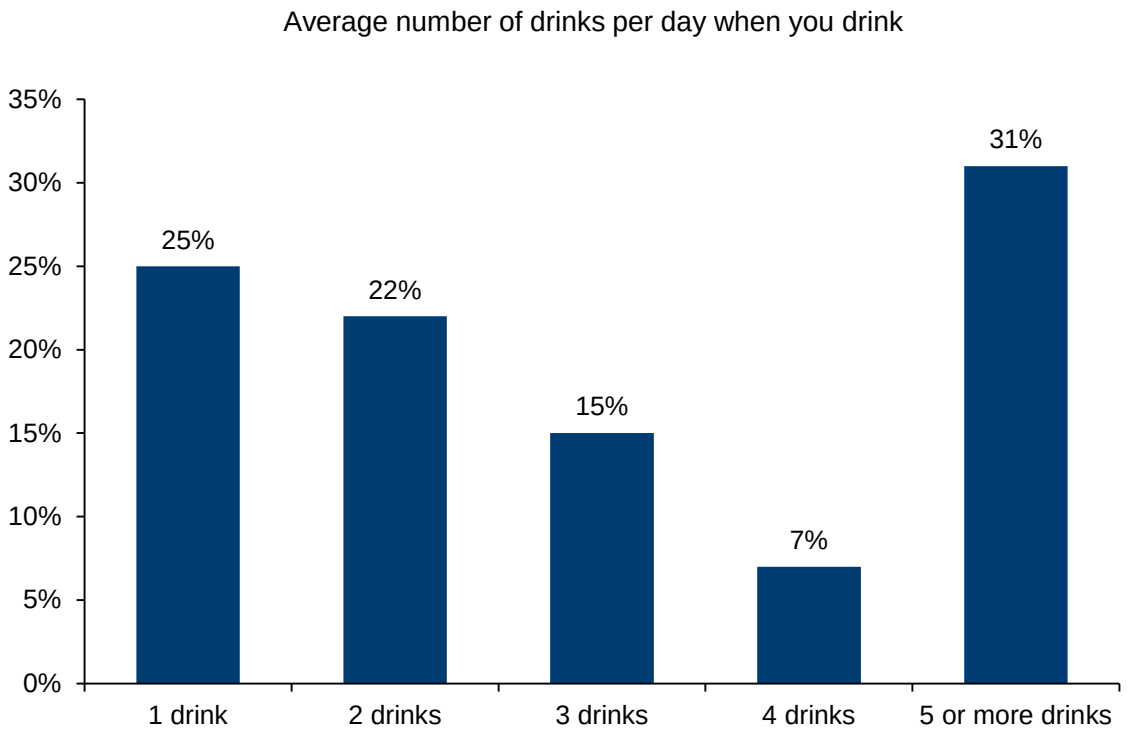
(Community = Minnehaha / Lincoln / Turner / McCook)

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



Base: None (n=66), 1 to 7 days (n=246), 8 to 14 days (n=55), 15 to 21 days (n=47), 22 to 30 days (n=59), Sample Size = 473

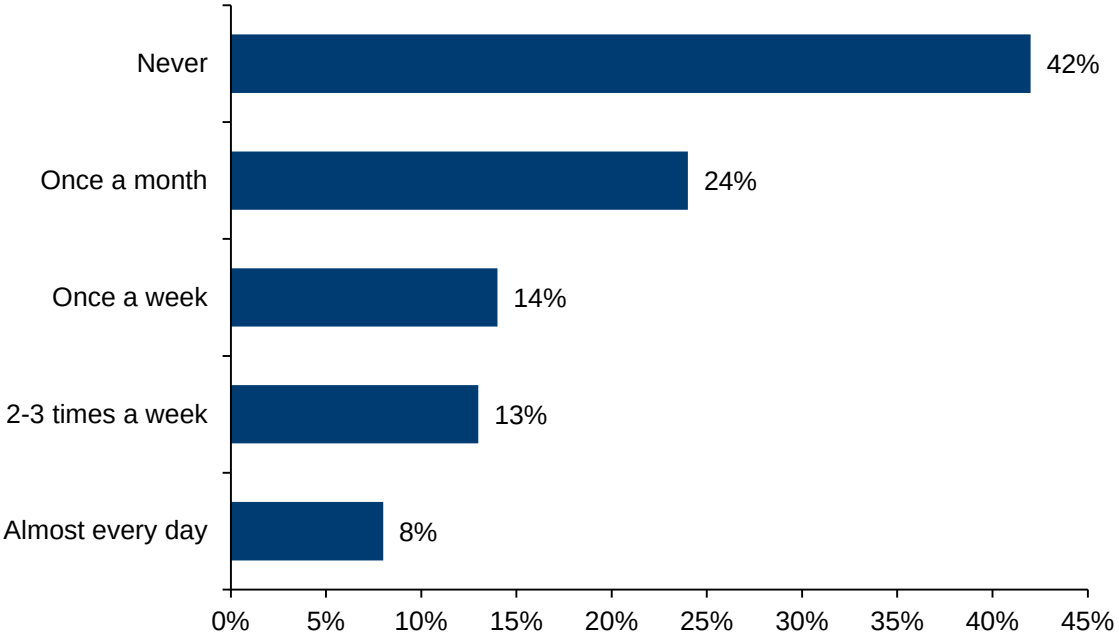
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: 1 drink (n=99), 2 drinks (n=89), 3 drinks (n=59), 4 drinks (n=29), 5 or more drinks (n=123), Sample Size = 399

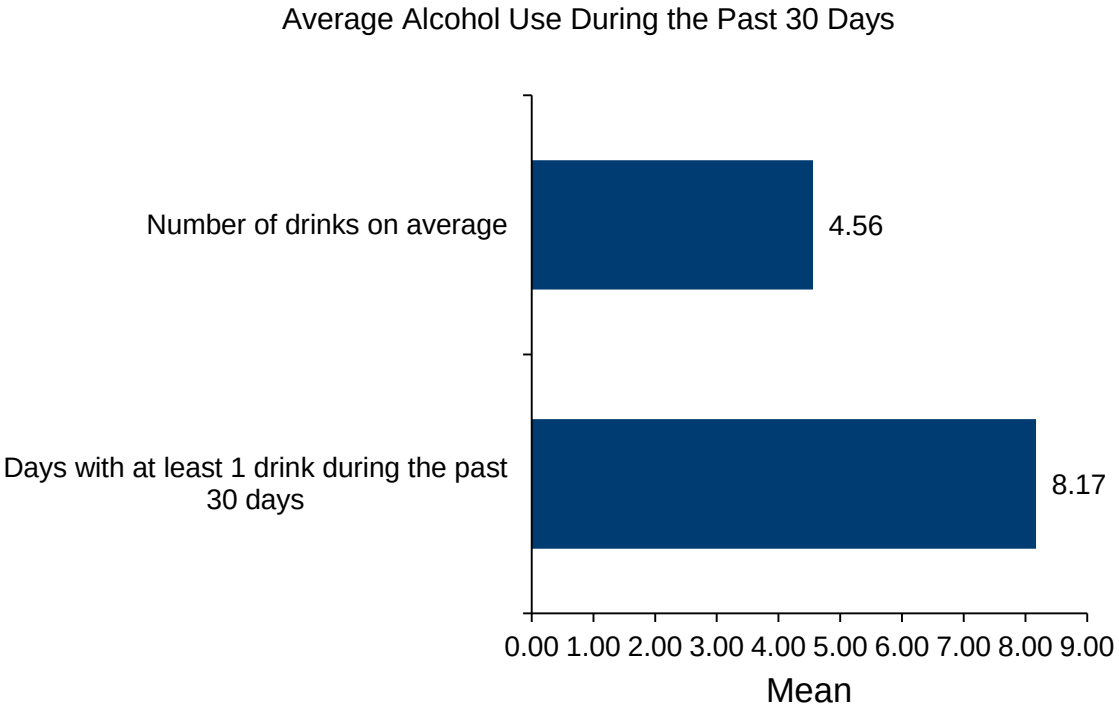
(Community = Minnehaha / Lincoln / Turner / McCook)

Binge Drinking



Base: Almost every day (n=33), 2-3 times a week (n=51), Once a week (n=57), Once a month (n=97), Never (n=169), Sample Size = 407

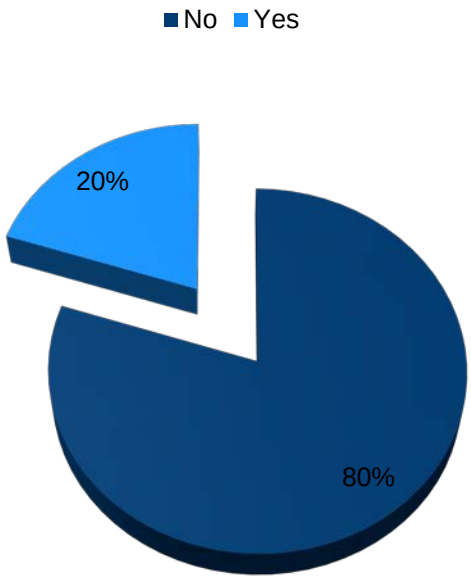
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Days with at least 1 drink during the past 30 days (n=473), Number of drinks on average (n=403), Sample Size = Variable

(Community = Minnehaha / Lincoln / Turner / McCook)

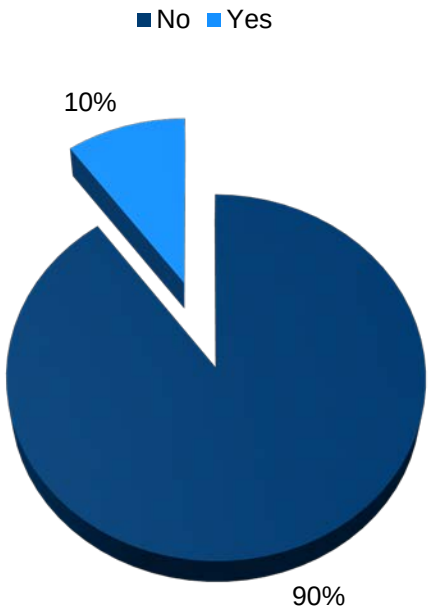
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=109), No (n=442), Sample Size = 551

(Community = Minnehaha / Lincoln / Turner / McCook)

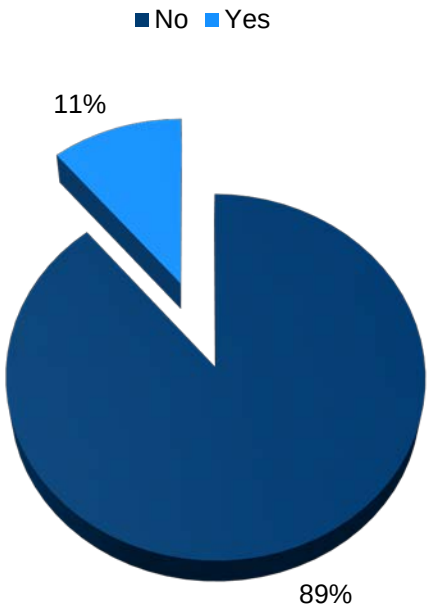
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=53), No (n=501), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)

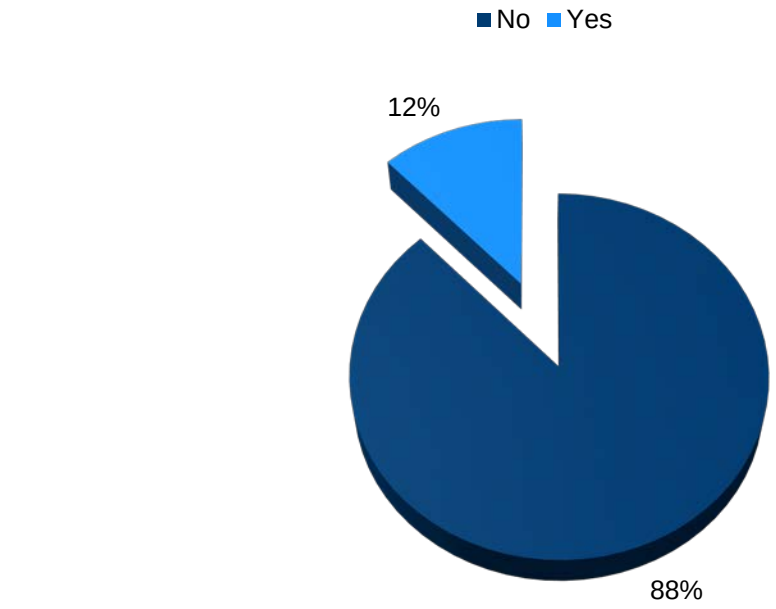
Has a family member or friend ever suggested that you get help for substance use?



Base: Yes (n=59), No (n=495), Sample Size = 554

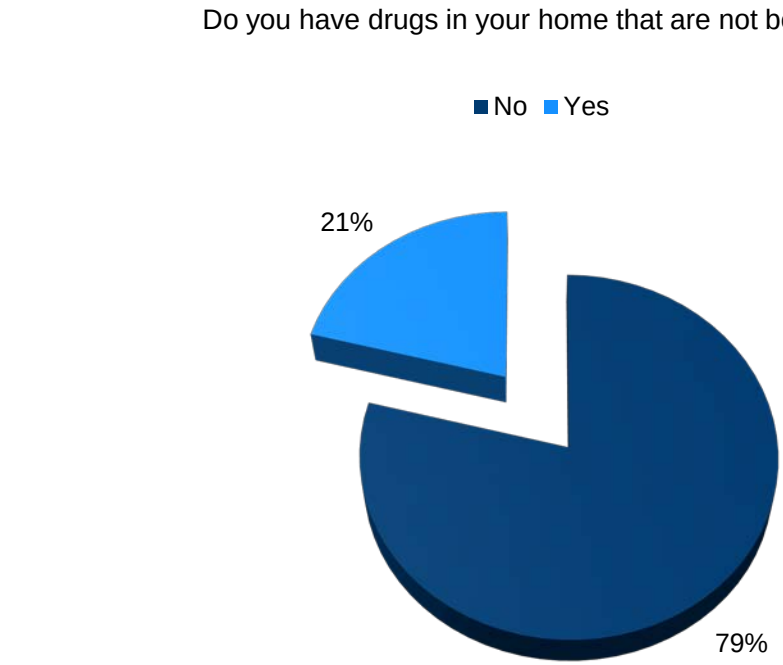
(Community = Minnehaha / Lincoln / Turner / McCook)

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



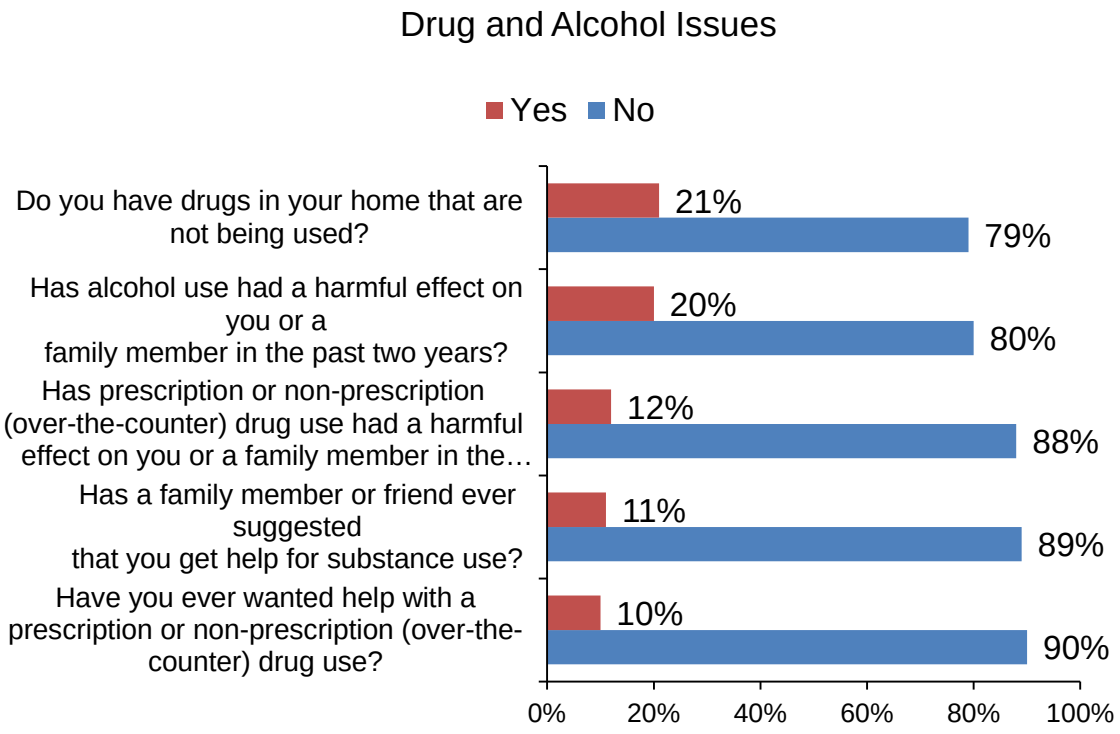
Base: Yes (n=67), No (n=485), Sample Size = 552

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Yes (n=117), No (n=436), Sample Size = 553

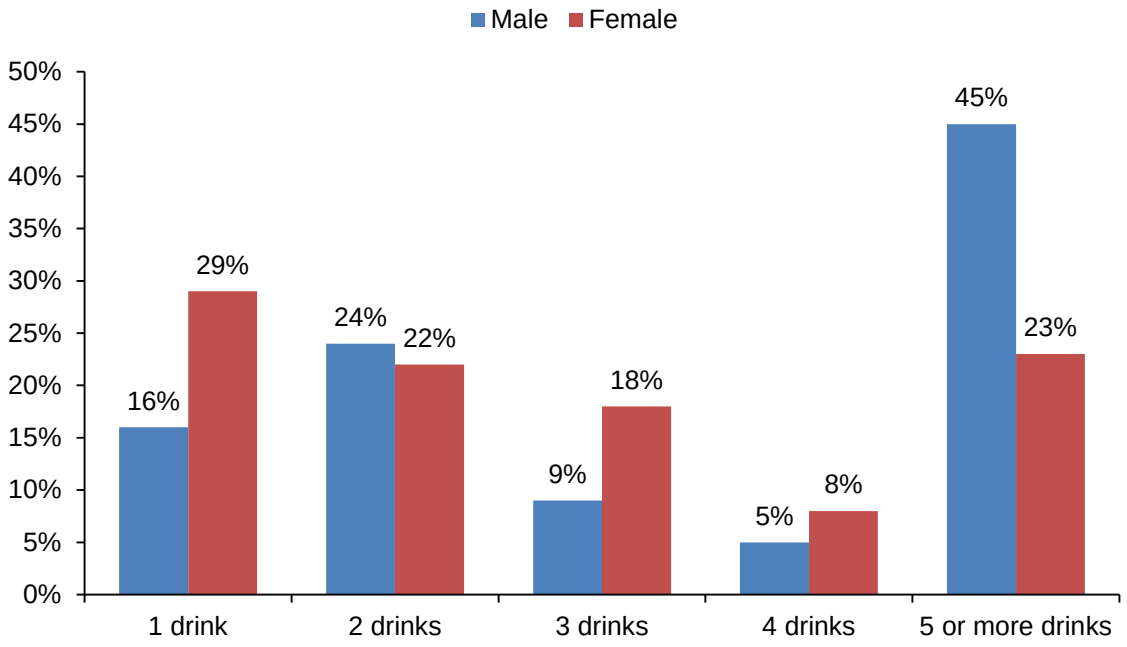
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

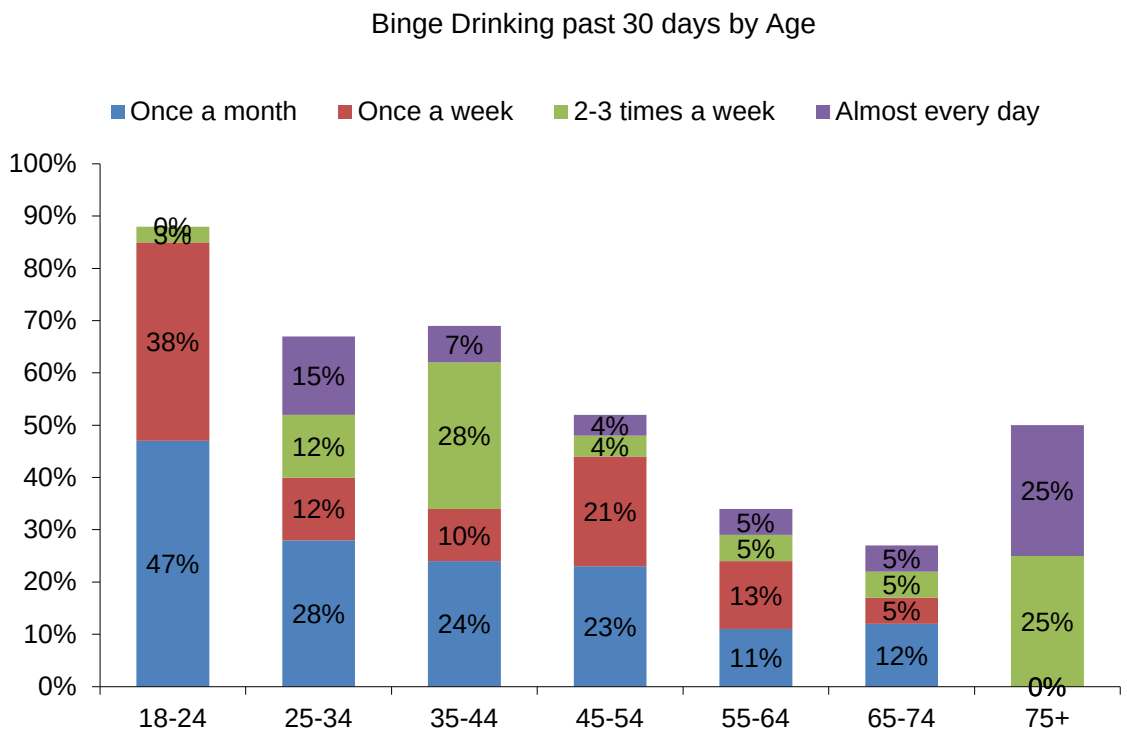
(Community = Minnehaha / Lincoln / Turner / McCook)

Average number of drinks per day when you drink by gender



Base: 1 drink (n=99), 2 drinks (n=89), 3 drinks (n=59), 4 drinks (n=29), 5 or more drinks (n=121), Sample Size = 397

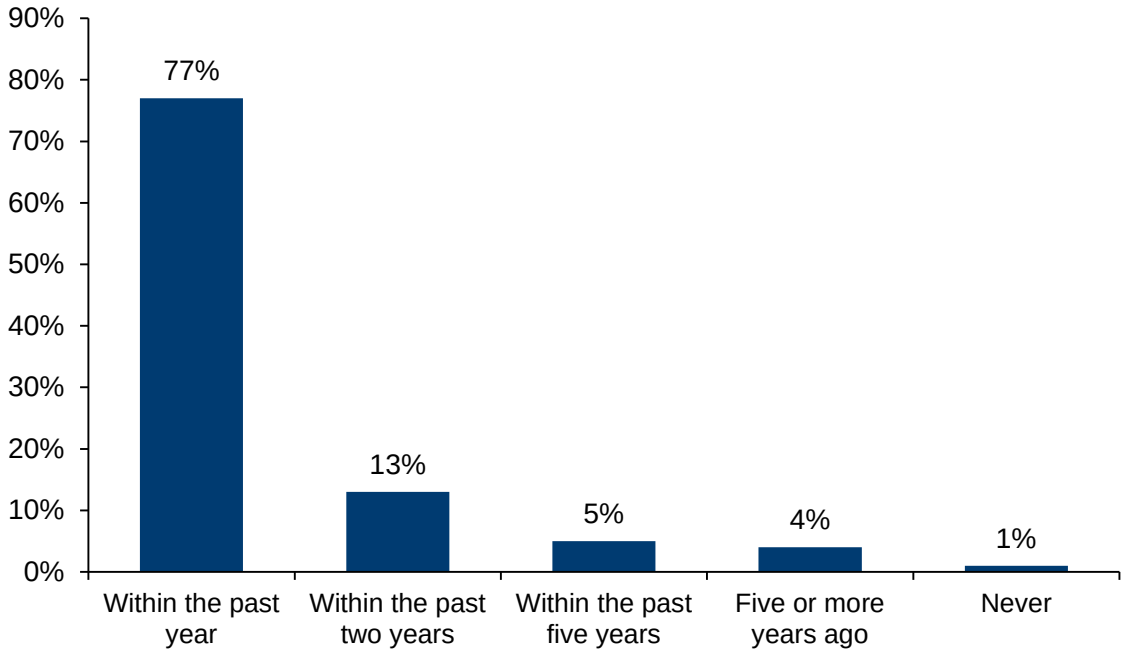
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: 18-24 (n=32), 25-34 (n=130), 35-44 (n=90), 45-54 (n=52), 55-64 (n=55), 65-74 (n=43), 75+ (n=4), Sample Size = 406

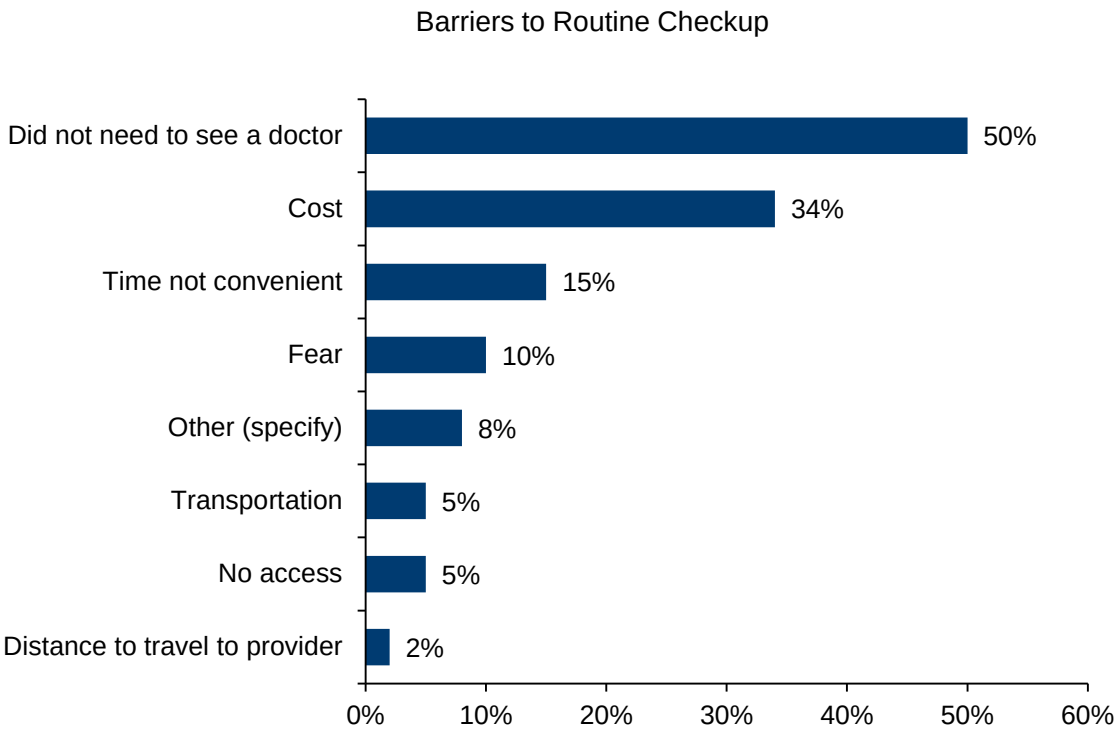
(Community = Minnehaha / Lincoln / Turner / McCook)

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



Base: Within the past year (n=418), Within the past two years (n=73), Within the past five years (n=28), Five or more years ago (n=19), Never (n=3), Sample Size = 541

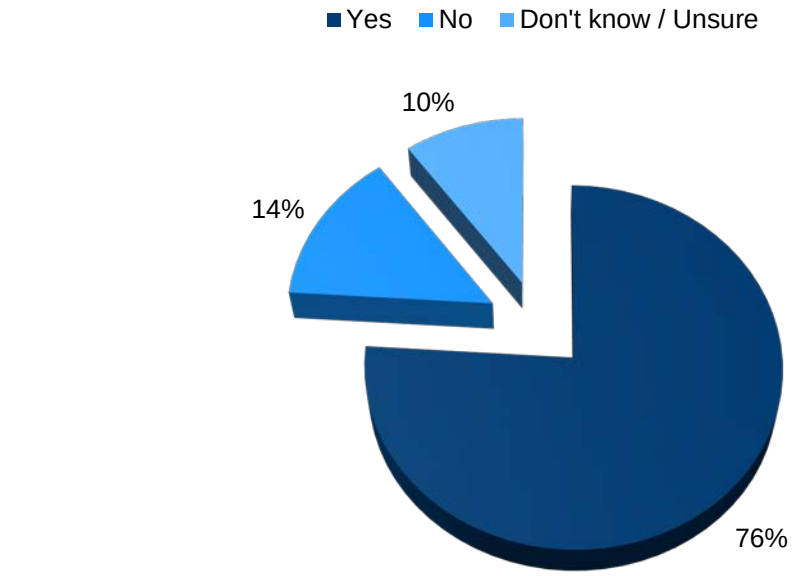
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: No access (n=7), Distance to travel to provider (n=3), Cost (n=46), Fear (n=13), Transportation (n=7), Time not convenient (n=20), Did not need to see a doctor (n=67), Other (specify) (n=11), Sample Size = 135

(Community = Minnehaha / Lincoln / Turner / McCook)

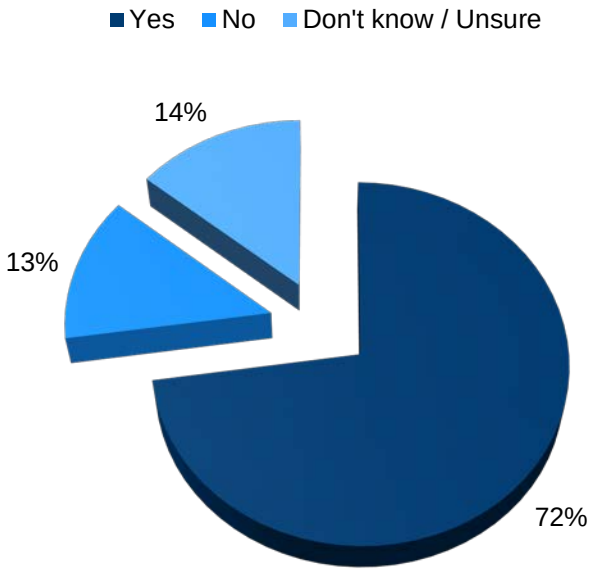
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=419), No (n=78), Don't know / Unsure (n=57), Sample Size = 554

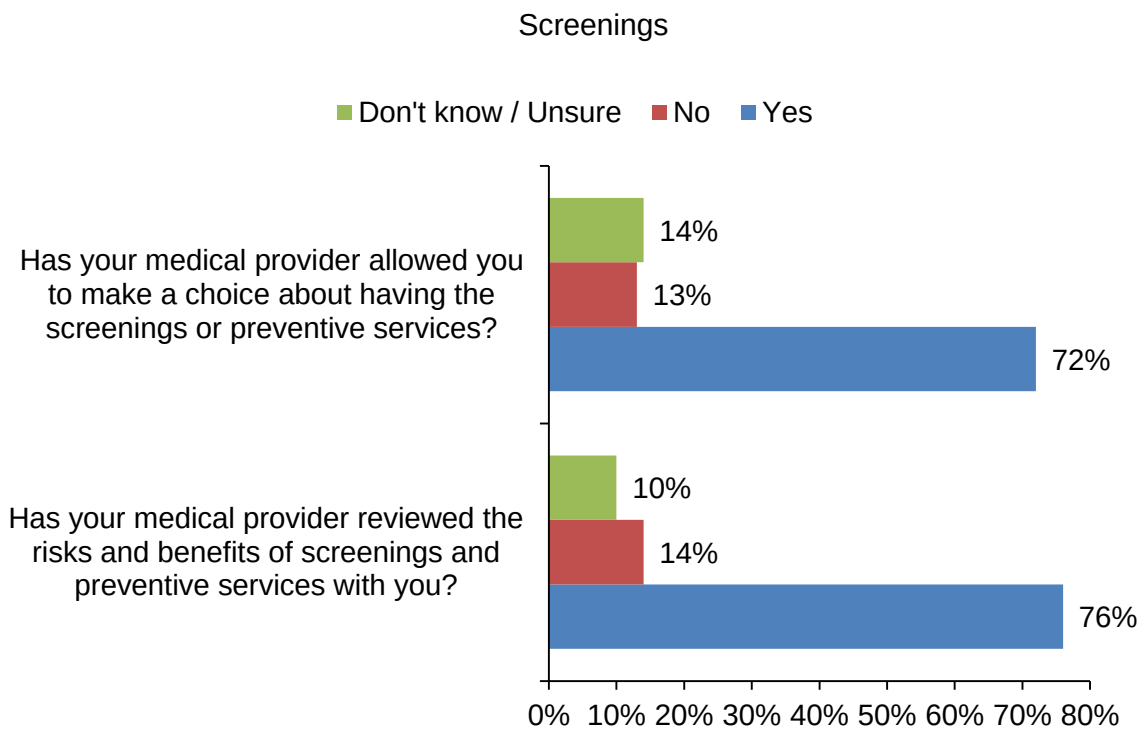
(Community = Minnehaha / Lincoln / Turner / McCook)

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



Base: Yes (n=400), No (n=73), Don't know / Unsure (n=80), Sample Size = 553

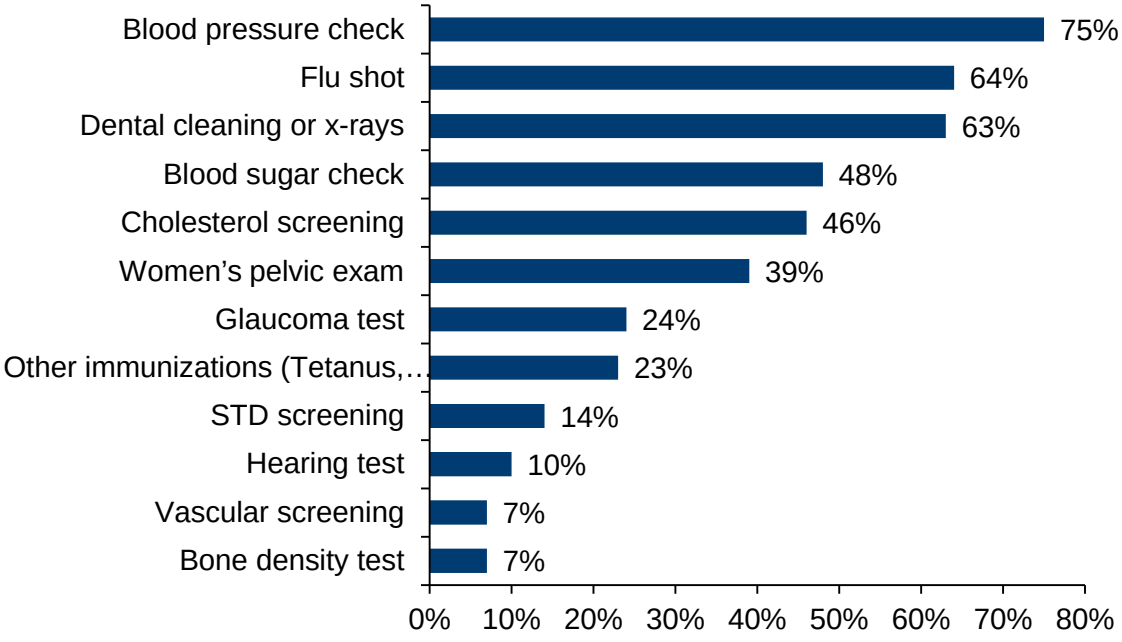
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

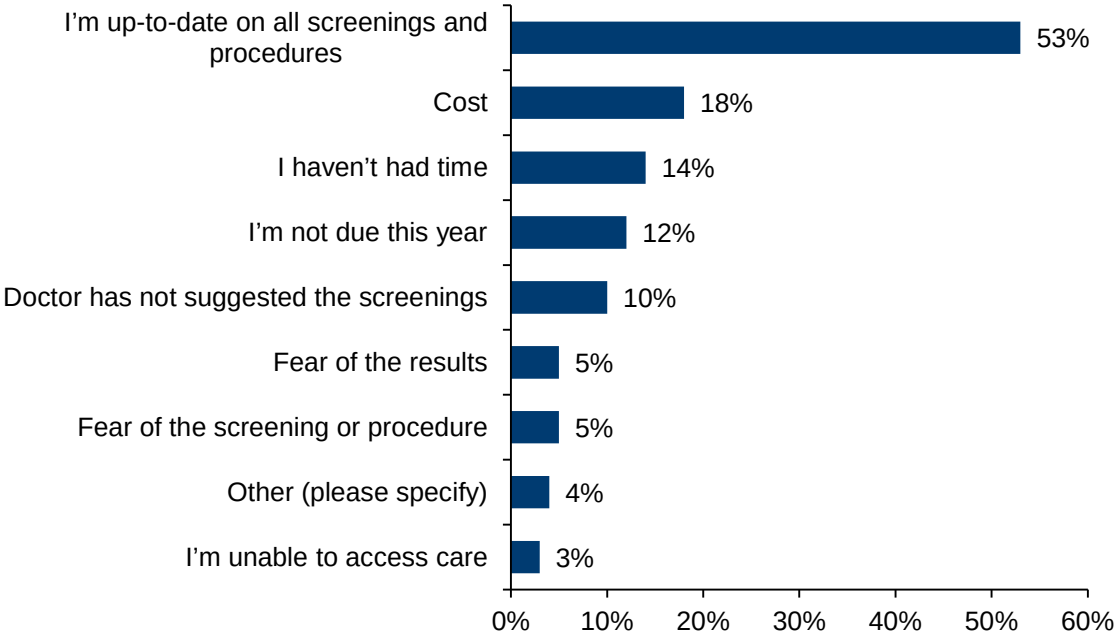
(Community = Minnehaha / Lincoln / Turner / McCook)

Preventive Procedures Last Year



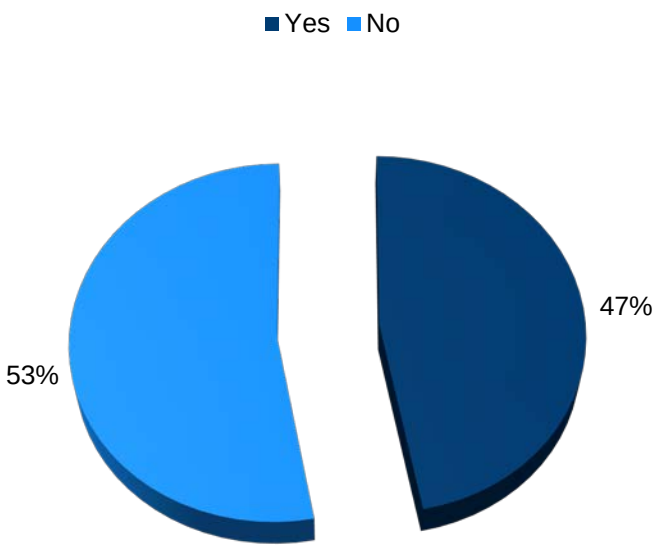
Base: Blood pressure check (n=377), Blood sugar check (n=245), Bone density test (n=35), Cholesterol screening (n=232), Dental cleaning or x-rays (n=318), Flu shot (n=324), Other immunizations (Tetanus, Hepatitis A or B) (n=117), Glaucoma test (n=119), Hearing test (n=50), Women's pelvic exam (n=198), STD screening (n=69), Vascular screening (n=34), Sample Size = 506
(Community = Minnehaha / Lincoln / Turner / McCook)

Barriers for Preventive Procedures



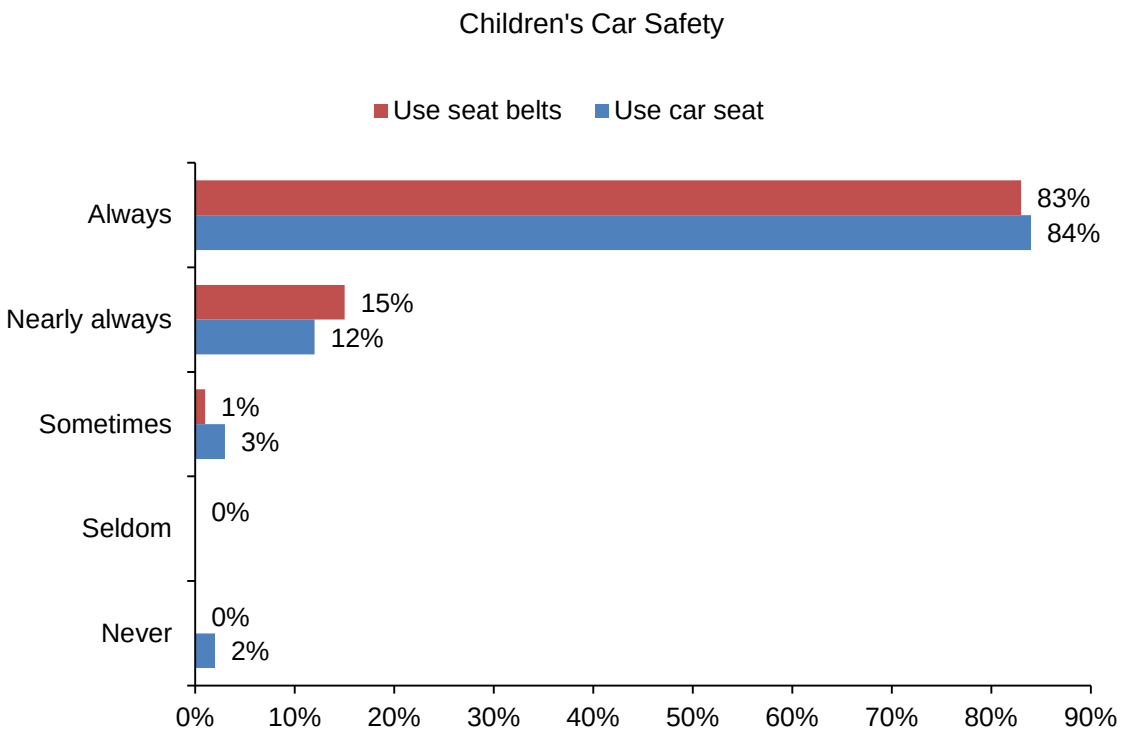
Base: I'm up-to-date on all screenings and procedures (n=288), Doctor has not suggested the screenings (n=52), Cost (n=99), I'm unable to access care (n=16), Fear of the screening or procedure (n=30), Fear of the results (n=27), I'm not due this year (n=64), I haven't had time (n=79), Other (please specify) (n=21), Sample Size = 547
(Community = Minnehaha / Lincoln / Turner / McCook)

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



Base: Yes (n=260), No (n=293), Sample Size = 553

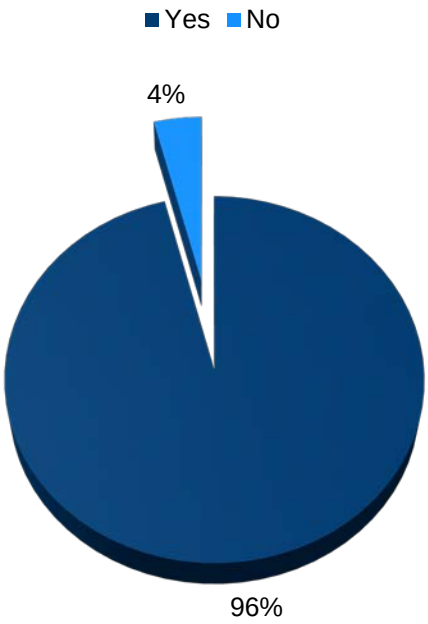
(Community = Minnehaha / Lincoln / Turner / McCook)



Sample Size = Variable

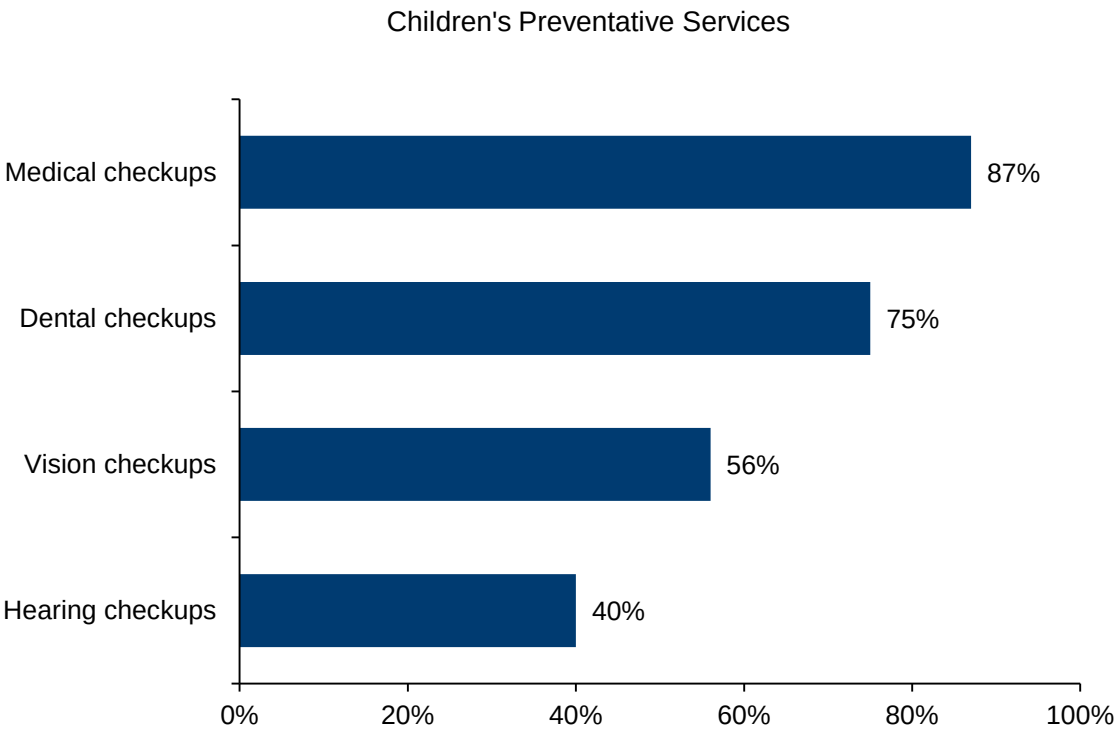
(Community = Minnehaha / Lincoln / Turner / McCook)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=251), No (n=10), Sample Size = 261

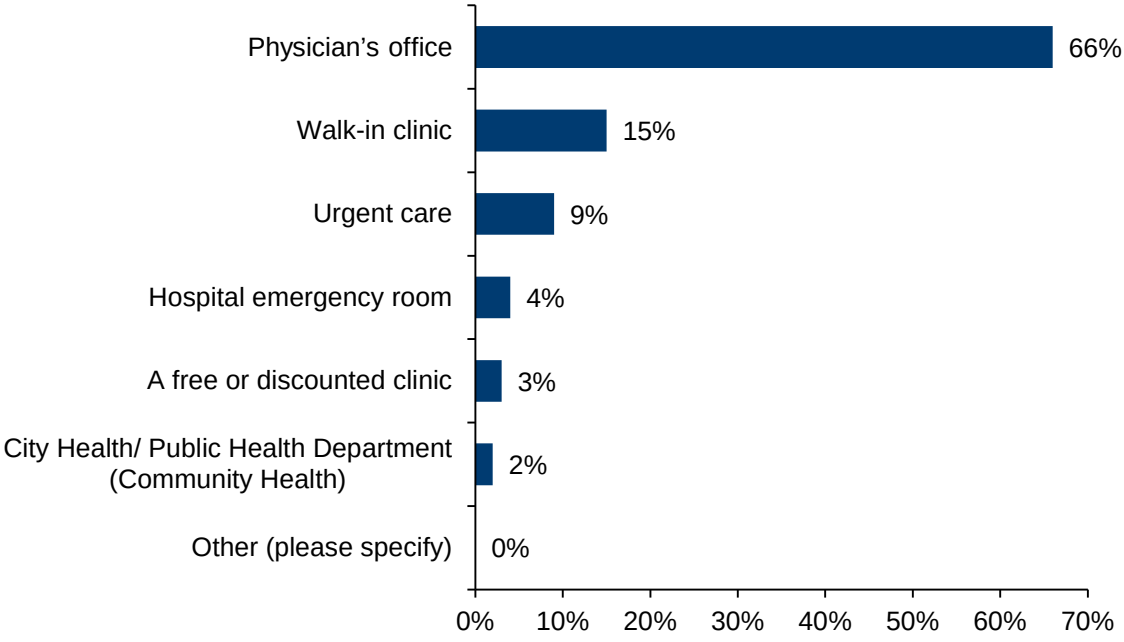
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Dental checkups (n=194), Vision checkups (n=143), Hearing checkups (n=103), Medical checkups (n=223), Sample Size = 257

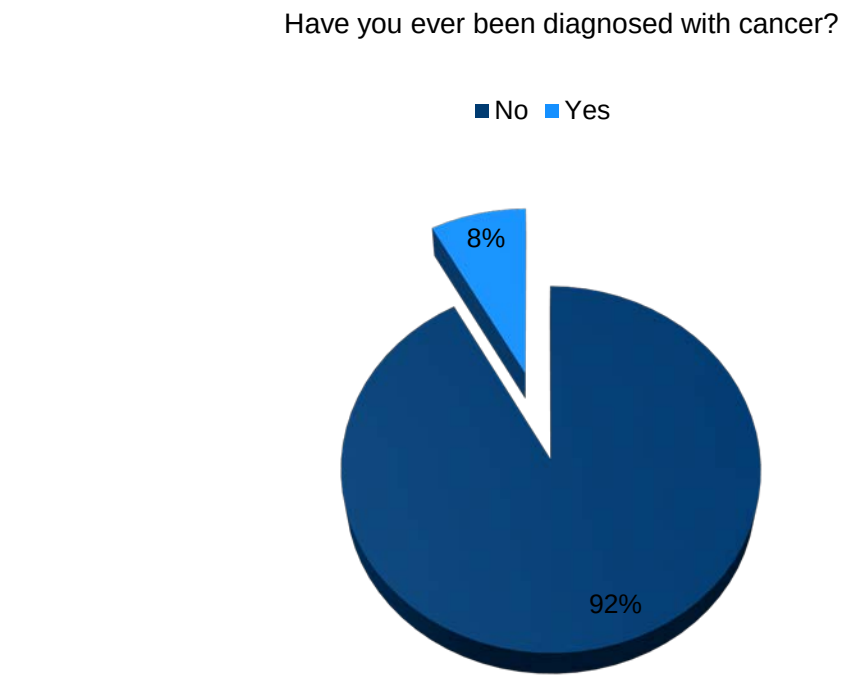
(Community = Minnehaha / Lincoln / Turner / McCook)

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



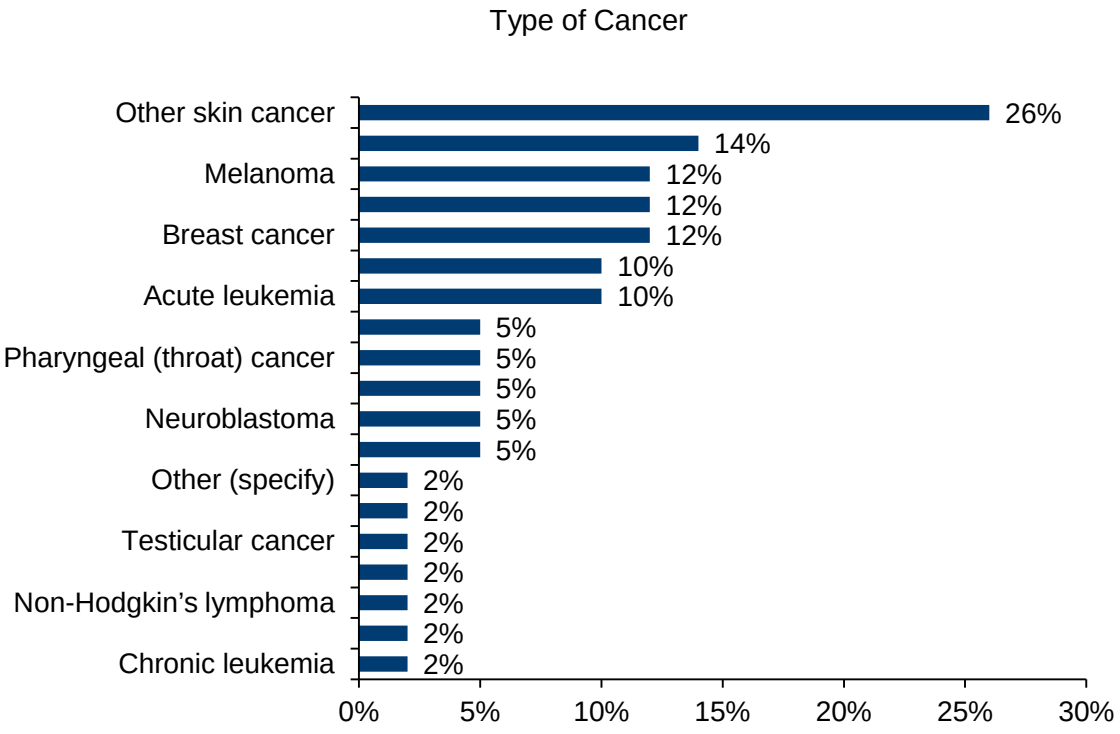
Base: Physician's office (n=171), Hospital emergency room (n=11), Urgent care (n=24), Walk-in clinic (n=40), City Health/ Public Health Department (Community Health) (n=6), A free or discounted clinic (n=7), Other (please specify) (n=1), Sample Size = 260

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Yes (n=43), No (n=511), Sample Size = 554

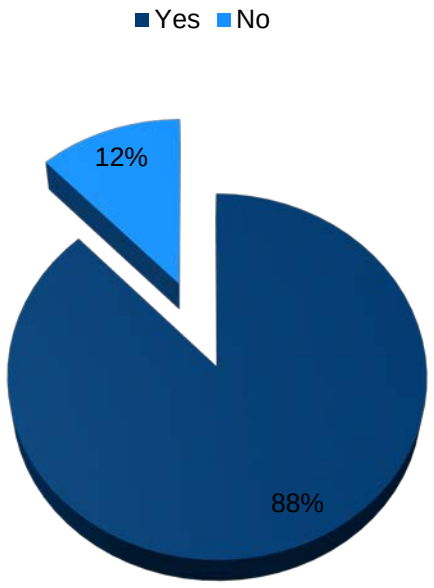
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Acute leukemia (n=4), Uterine cancer (n=4), Breast cancer (n=5), Cervical cancer (n=5), Chronic leukemia (n=1), Colon cancer (n=2), Lung cancer (n=1), Melanoma (n=5), Neuroblastoma (n=2), Non-Hodgkin's lymphoma (n=1), Oral cancer (n=2), Other skin cancer (n=11), Ovarian cancer (n=1), Pharyngeal (throat) cancer (n=2), Prostate cancer (n=6), Rectal cancer (n=2), Testicular cancer (n=1), Thyroid cancer (n=1), Other (specify) (n=1), Sample Size = 42

(Community = Minnehaha / Lincoln / Turner / McCook)

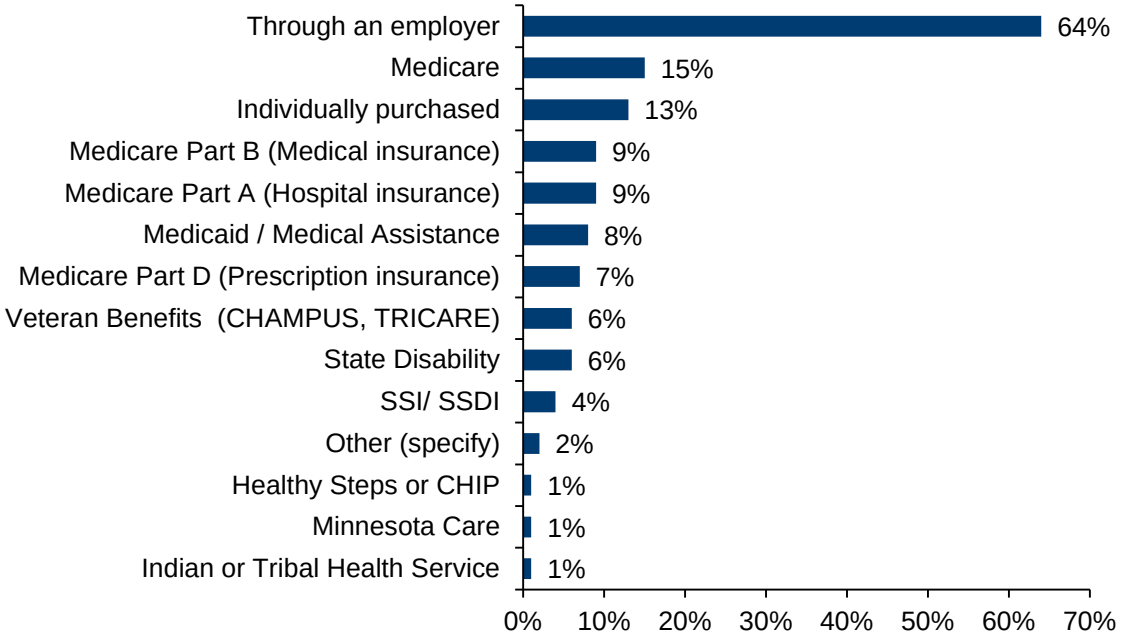
Do you currently have any kind of health insurance?



Base: Yes (n=488), No (n=65), Sample Size = 553

(Community = Minnehaha / Lincoln / Turner / McCook)

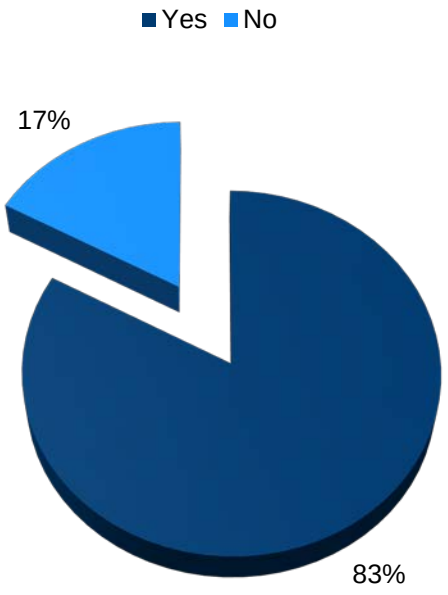
Type of Insurance



Base: Through an employer (n=312), Individually purchased (n=63), Indian or Tribal Health Service (n=5), Medicare (n=75), Medicare Part A (Hospital insurance) (n=45), Medicare Part B (Medical insurance) (n=44), Medicare Part D (Prescription insurance) (n=35), State Disability (n=28), SSI/ SSDI (n=19), Medicaid / Medical Assistance (n=37), Minnesota Care (n=4), Veteran Benefits (CHAMPUS, TRICARE) (n=29), Healthy Steps or CHIP (n=7), Other (specify) (n=10), Sample Size = 487

(Community = Minnehaha / Lincoln / Turner / McCook)

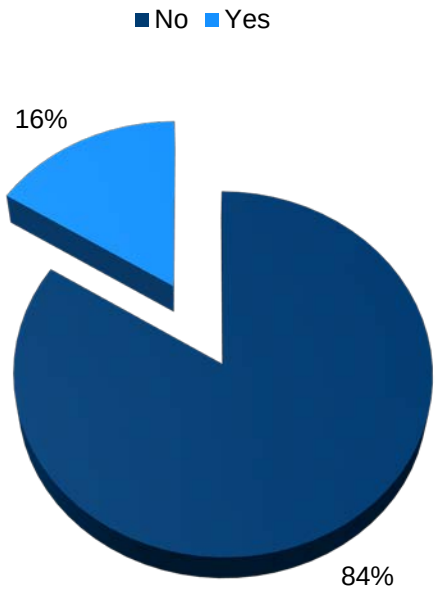
Do you have an established primary healthcare provider?



Base: Yes (n=459), No (n=95), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)

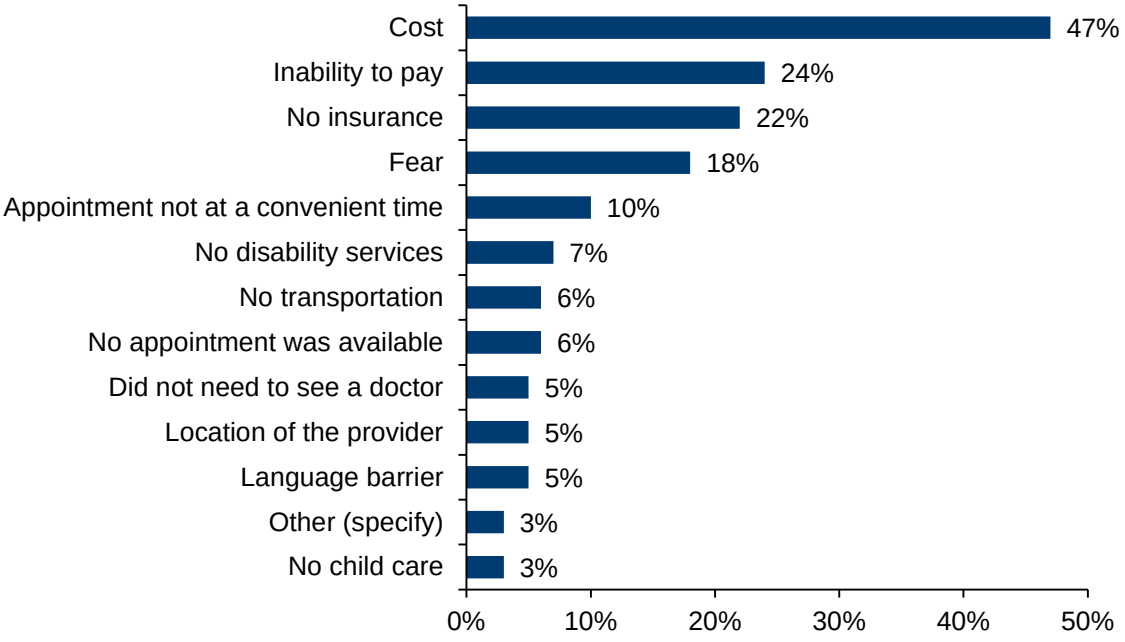
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?



Base: Yes (n=88), No (n=464), Sample Size = 552

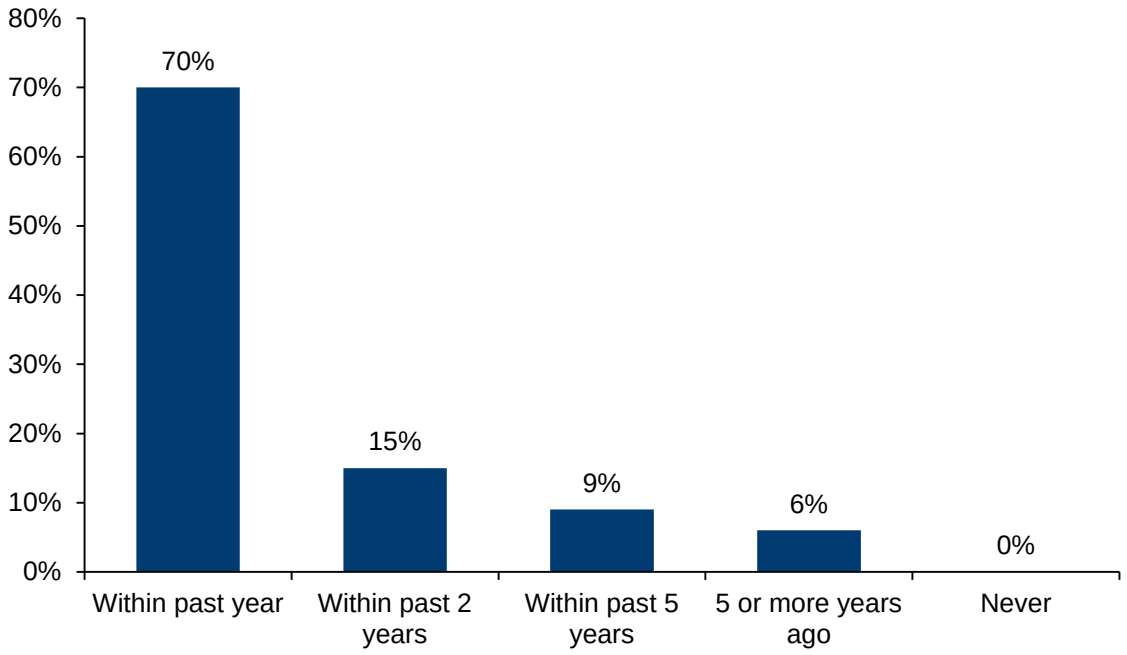
(Community = Minnehaha / Lincoln / Turner / McCook)

Barriers to Receiving Care Needed



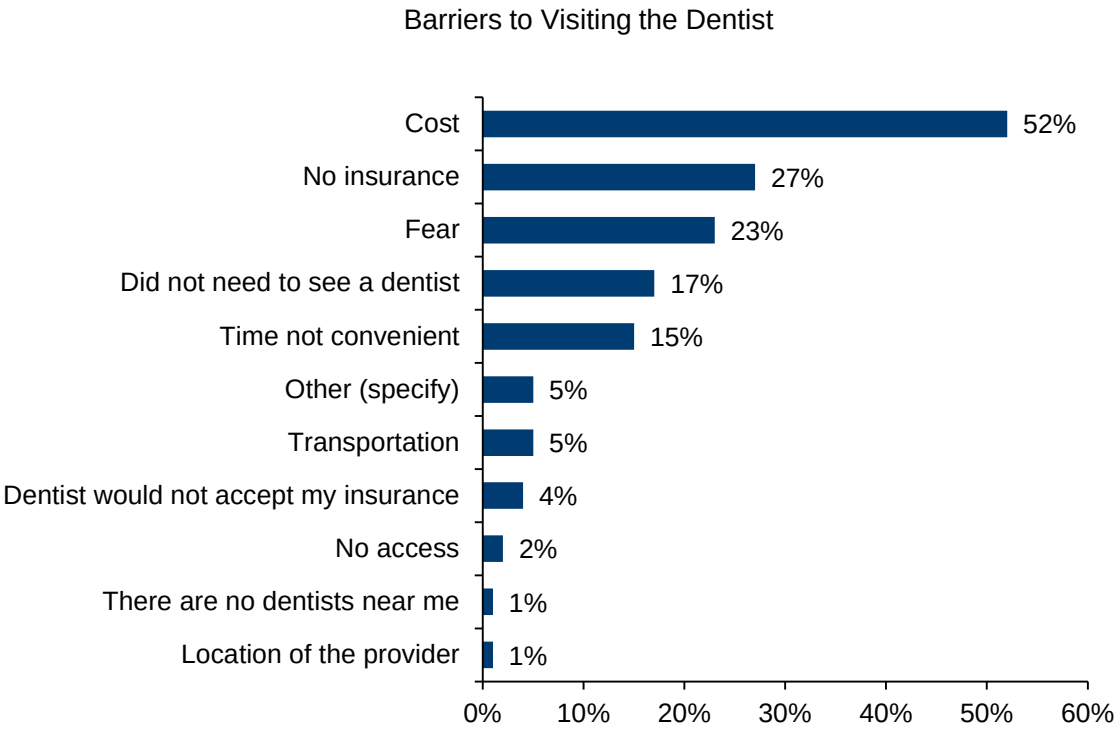
Base: Inability to pay (n=21), No child care (n=3), No appointment was available (n=5), Appointment not at a convenient time (n=9), No disability services (n=6), No insurance (n=19), Language barrier (n=4), No transportation (n=5), Location of the provider (n=4), Cost (n=41), Fear (n=16), Did not need to see a doctor (n=4), Other (specify) (n=3)
(Community = Minnehaha / Lincoln / Turner / McCook)

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



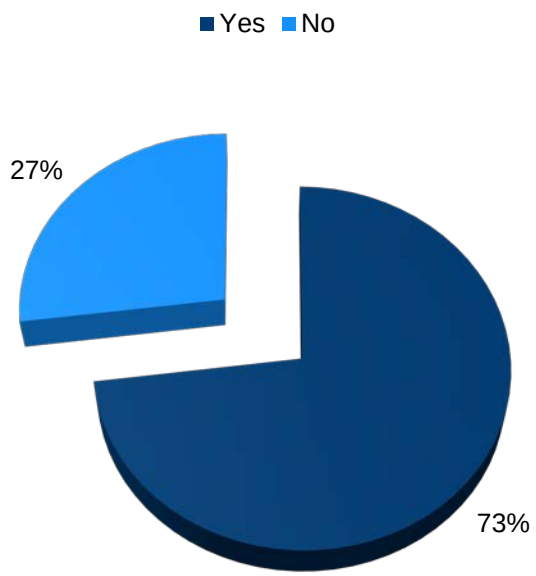
Base: Within past year (n=378), Within past 2 years (n=79), Within past 5 years (n=49), 5 or more years ago (n=33), Never (n=2), Sample Size = 541

(Community = Minnehaha / Lincoln / Turner / McCook)



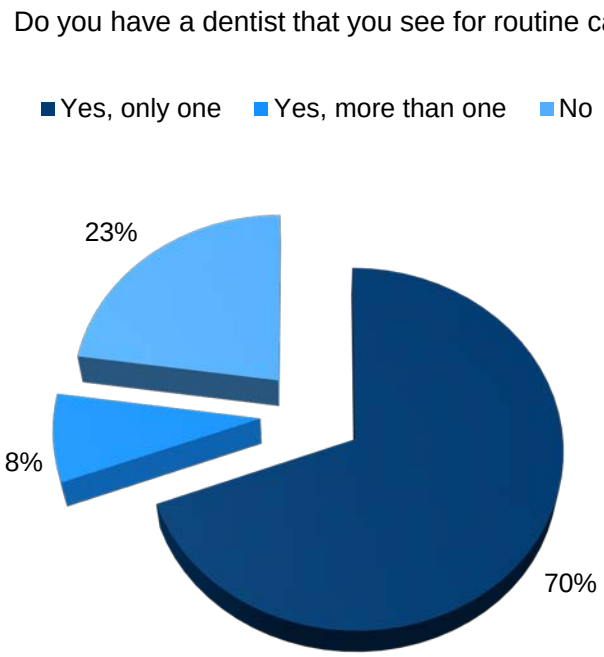
Base: No access (n=3), No insurance (n=46), Location of the provider (n=1), Cost (n=90), Fear (n=39), Transportation (n=9), Time not convenient (n=26), There are no dentists near me (n=2), Dentist would not accept my insurance (n=7), Did not need to see a dentist (n=30), Other (specify) (n=8), Sample Size =172
(Community = Minnehaha / Lincoln / Turner / McCook)

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



Base: Yes (n=393), No (n=146), Sample Size = 539

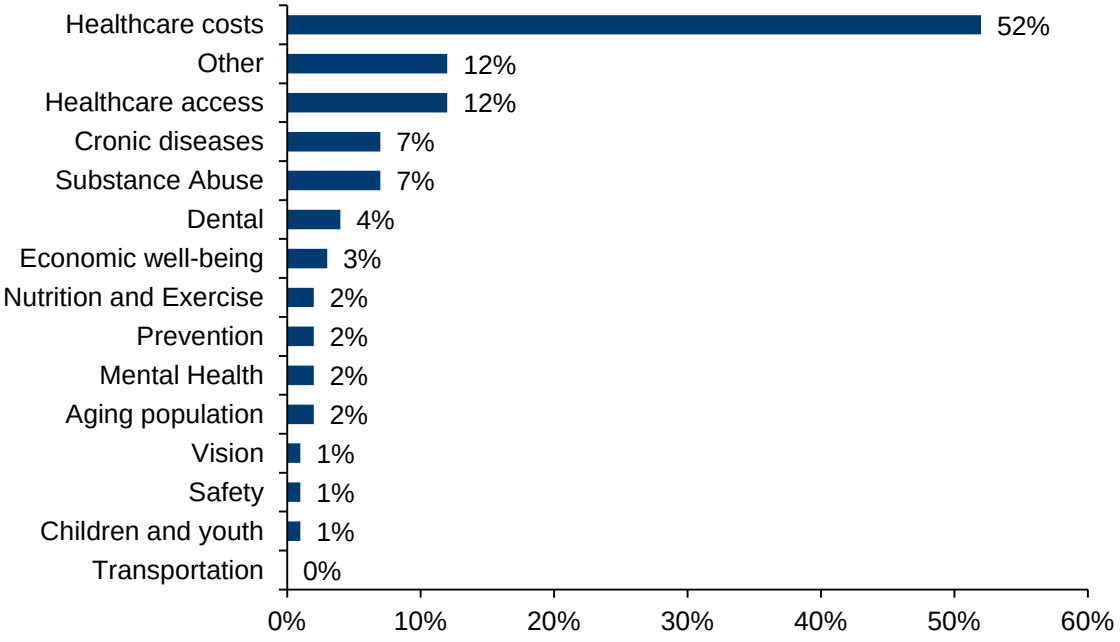
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Yes, only one (n=377), Yes, more than one (n=42), No (n=123), Sample Size = 542

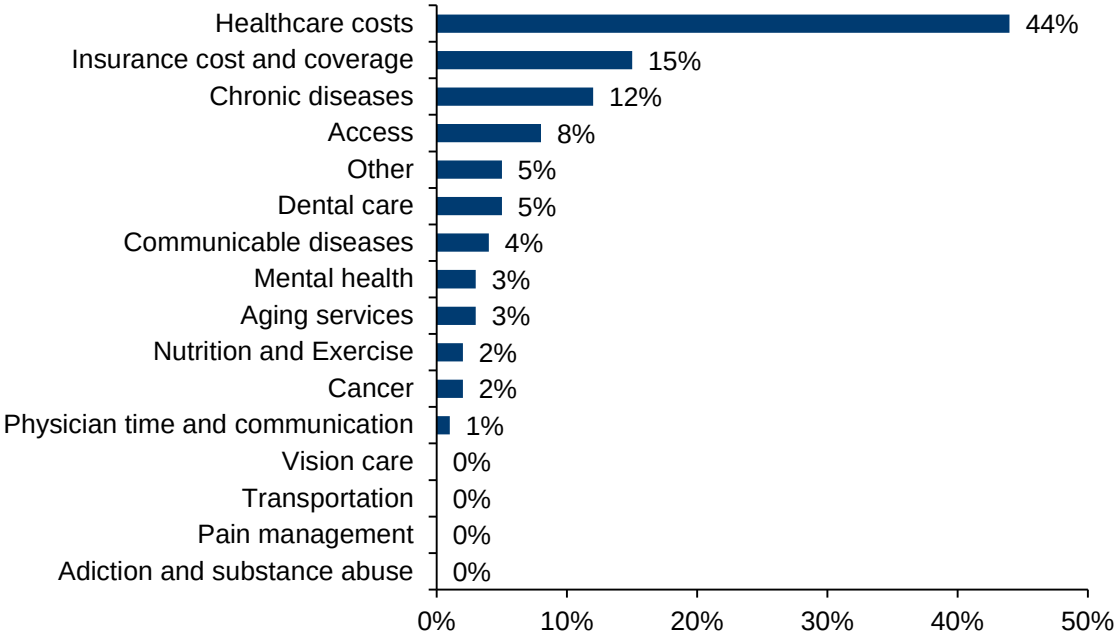
(Community = Minnehaha / Lincoln / Turner / McCook)

Most Important Community Issues



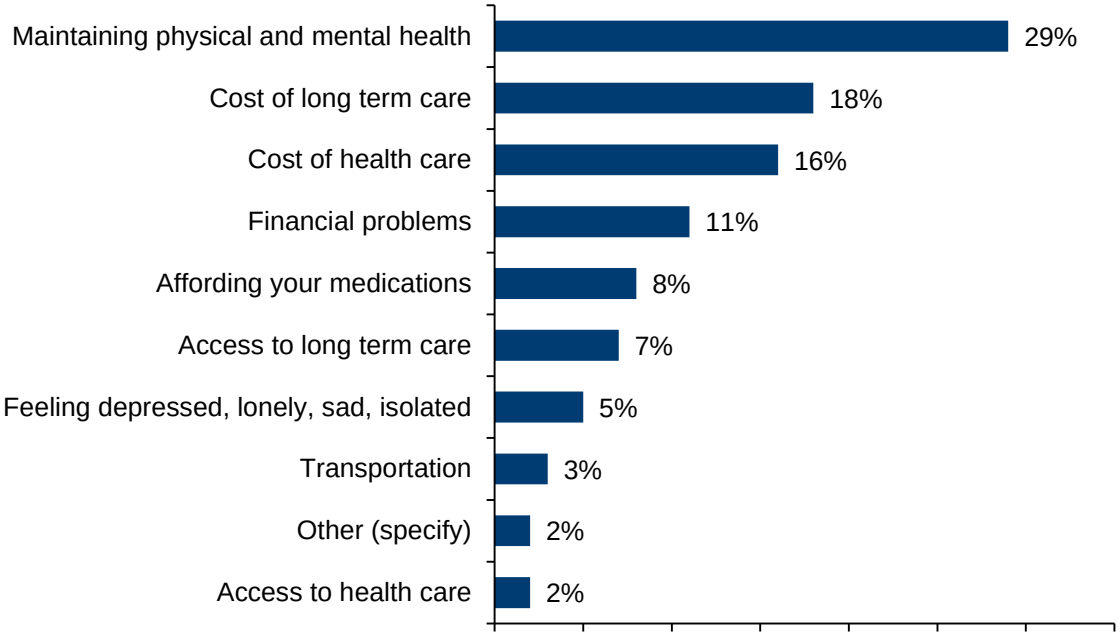
Base: Economic well-being (n=13), Transportation (n=1), Children and youth (n=4), Aging population (n=6), Safety (n=2), Healthcare access (n=47), Mental Health (n=9), Substance Abuse (n=28), Chronic diseases (n=26), Healthcare costs (n=200), Dental (n=15), Prevention (n=6), Vision (n=3), Nutrition and Exercise (n=6), Other (n=44), Sample Size = 491
(Community = Minnehaha / Lincoln / Turner / McCook)

Most Important Issue for Family



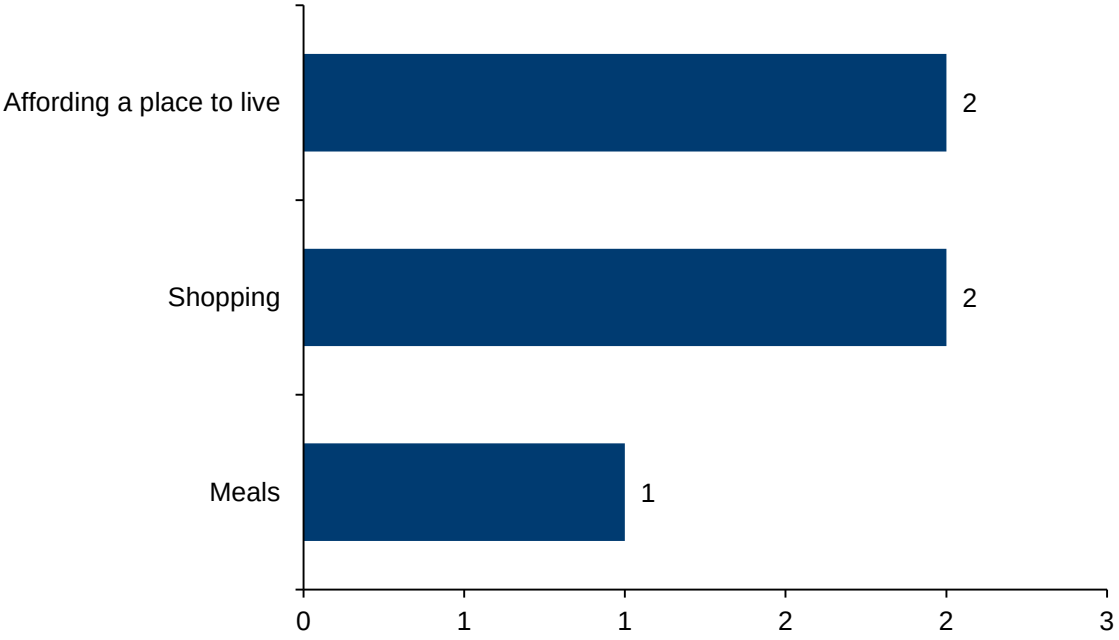
Base: Access (n=24), Addiction and substance abuse (n=1), Aging services (n=9), Cancer (n=7), Chronic diseases (n=37), Communicable diseases (n=11), Healthcare costs (n=136), Dental care (n=15), Nutrition and Exercise (n=7), Insurance cost and coverage (n=48), Mental health (n=8), Pain management (n=1), Transportation (n=1), Physician time and communication (n=3), Vision care (n=1), Other (n=16), Sample Size = 483
(Community = Minnehaha / Lincoln / Turner / McCook)

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



Base: Access to health care (n=3), Cost of health care (n=24), Affording your medications (n=12), Maintaining physical and mental health (n=44), Feeling depressed, lonely, sad, isolated (n=8), Access to long term care (n=11), Cost of long term care (n=27), Financial problems (n=16), Transportation (n=4), Other (specify) (n=3), Sample Size = 68
(Community = Minnehaha / Lincoln / Turner / McCook)

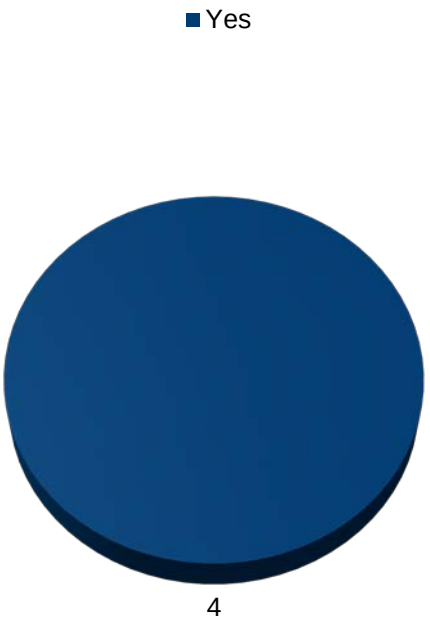
Which of these tasks do you need assistance with? (Age 65+)



Sample Size = 4

(Community = Minnehaha / Lincoln / Turner / McCook)

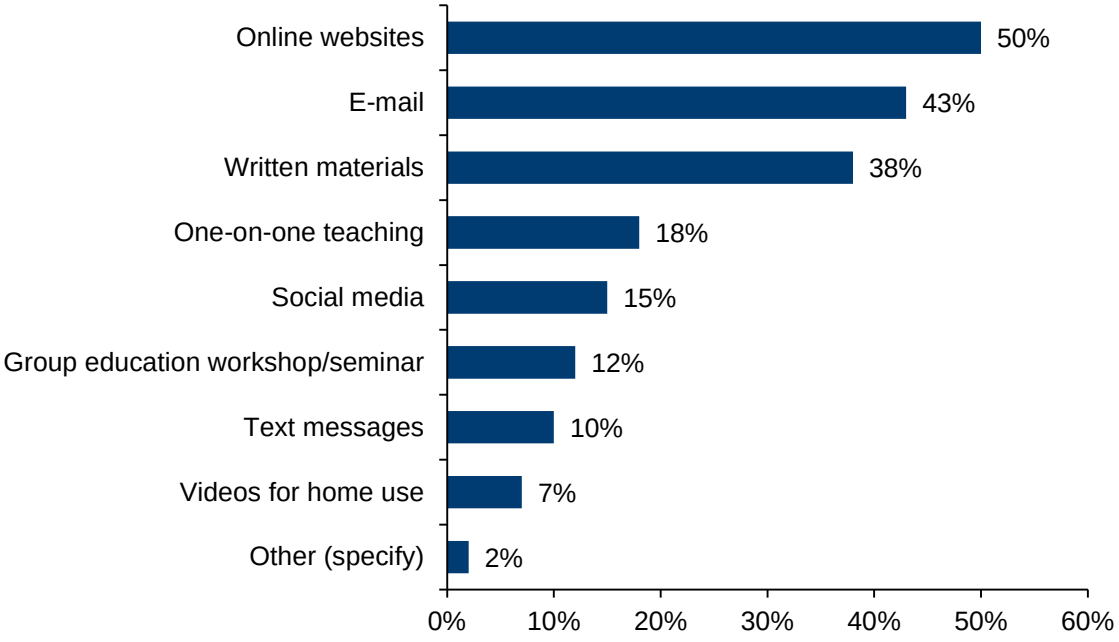
Do you know where to go to get help with the tasks you need assistance with? (Age 65+)



Sample Size = 4

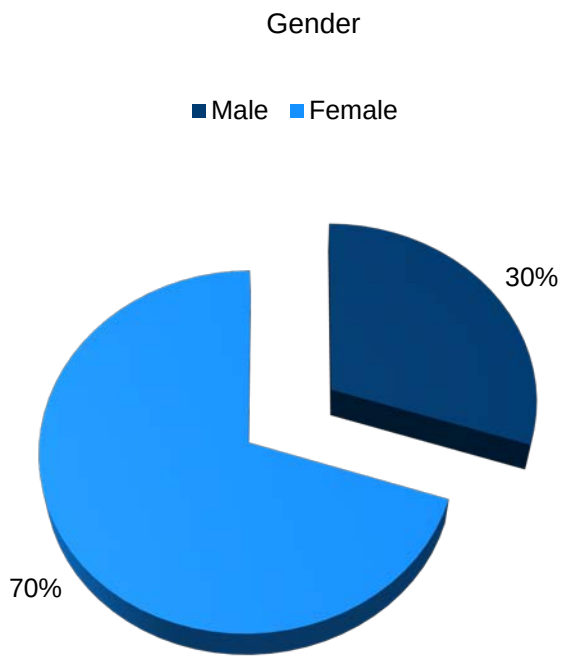
(Community = Minnehaha / Lincoln / Turner / McCook)

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



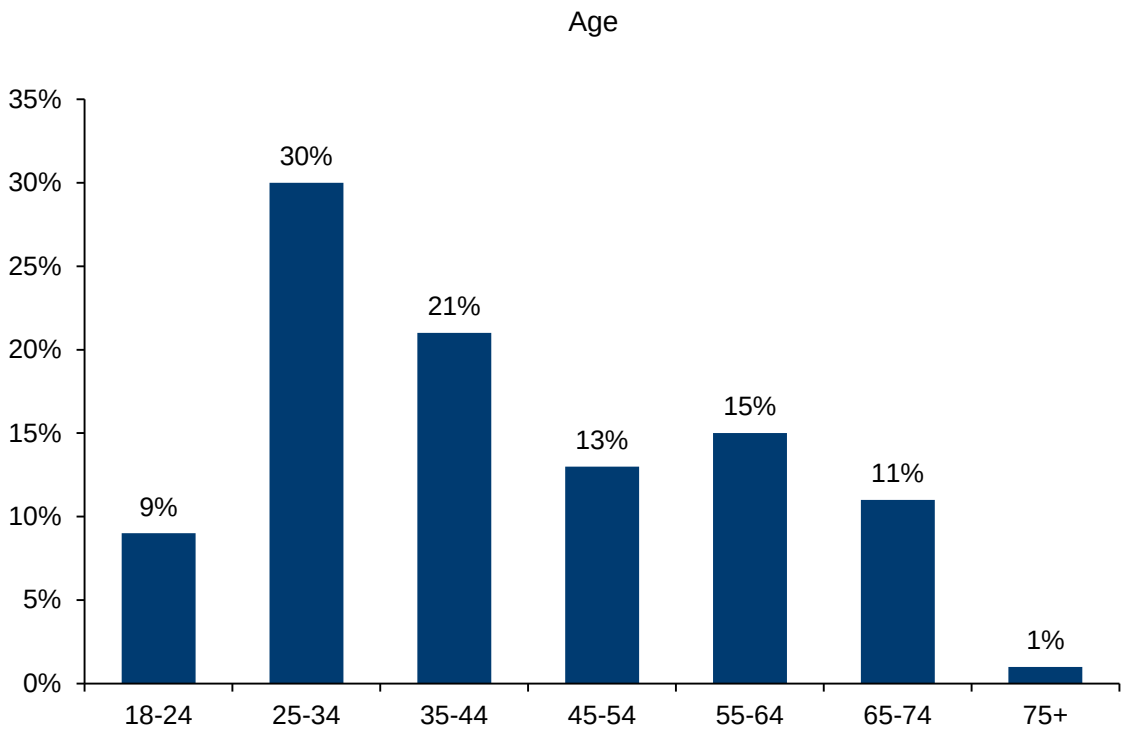
Base: Written materials (n=208), Videos for home use (n=38), Social media (n=81), Text messages (n=54), One-on-one teaching (n=99), E-mail (n=233), Group education workshop/seminar (n=63), Online websites (n=271), Other (specify) (n=13), Sample Size = 546

(Community = Minnehaha / Lincoln / Turner / McCook)



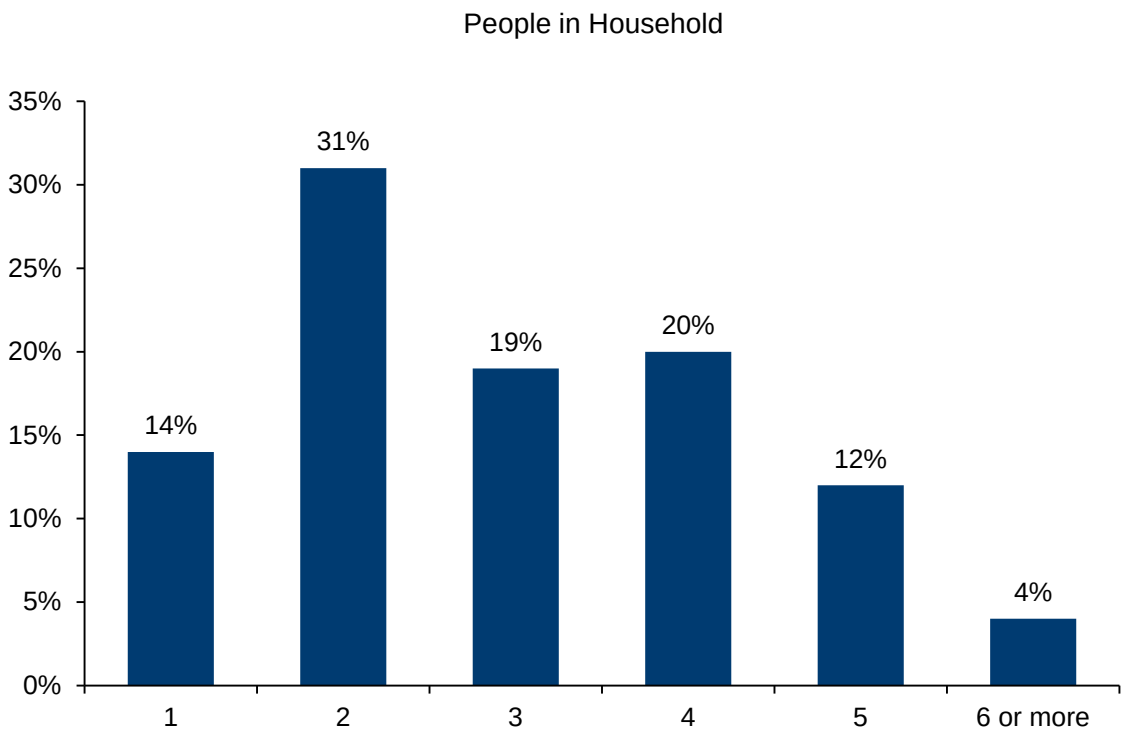
Base: Male (n=164), Female (n=387), Sample Size = 551

(Community = Minnehaha / Lincoln / Turner / McCook)



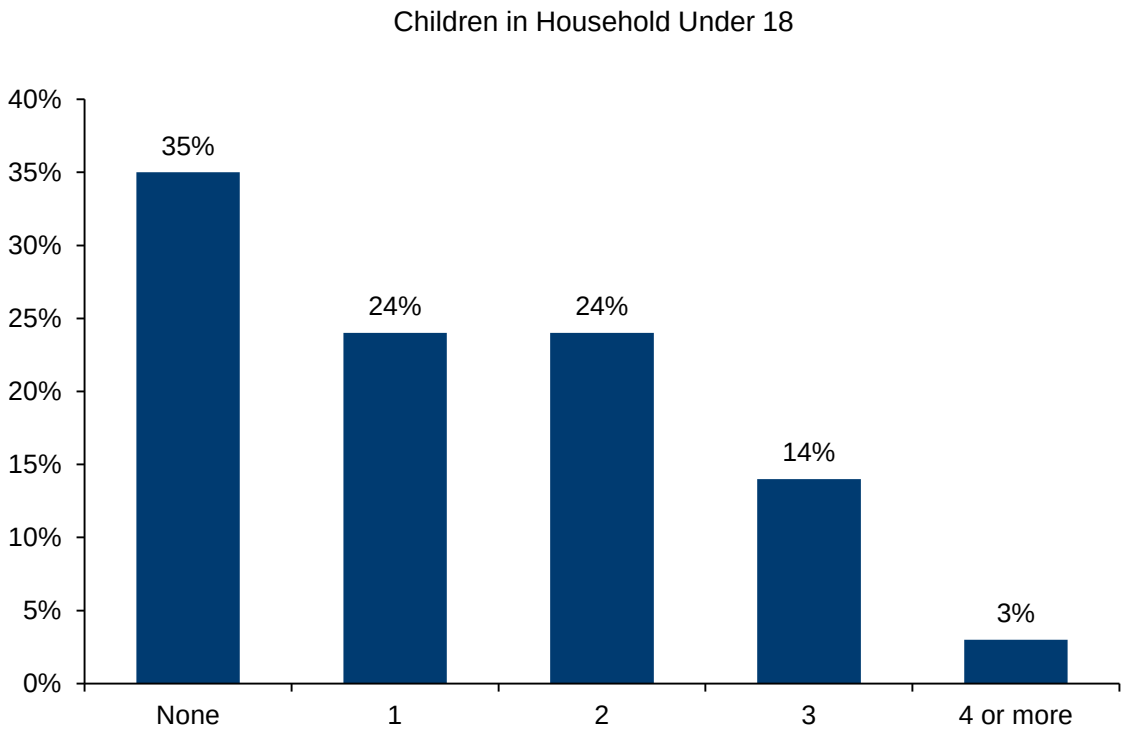
Base: 18-24 (n=49), 25-34 (n=164), 35-44 (n=117), 45-54 (n=72), 55-64 (n=82), 65-74 (n=60), 75+ (n=8), Sample Size = 552

(Community = Minnehaha / Lincoln / Turner / McCook)



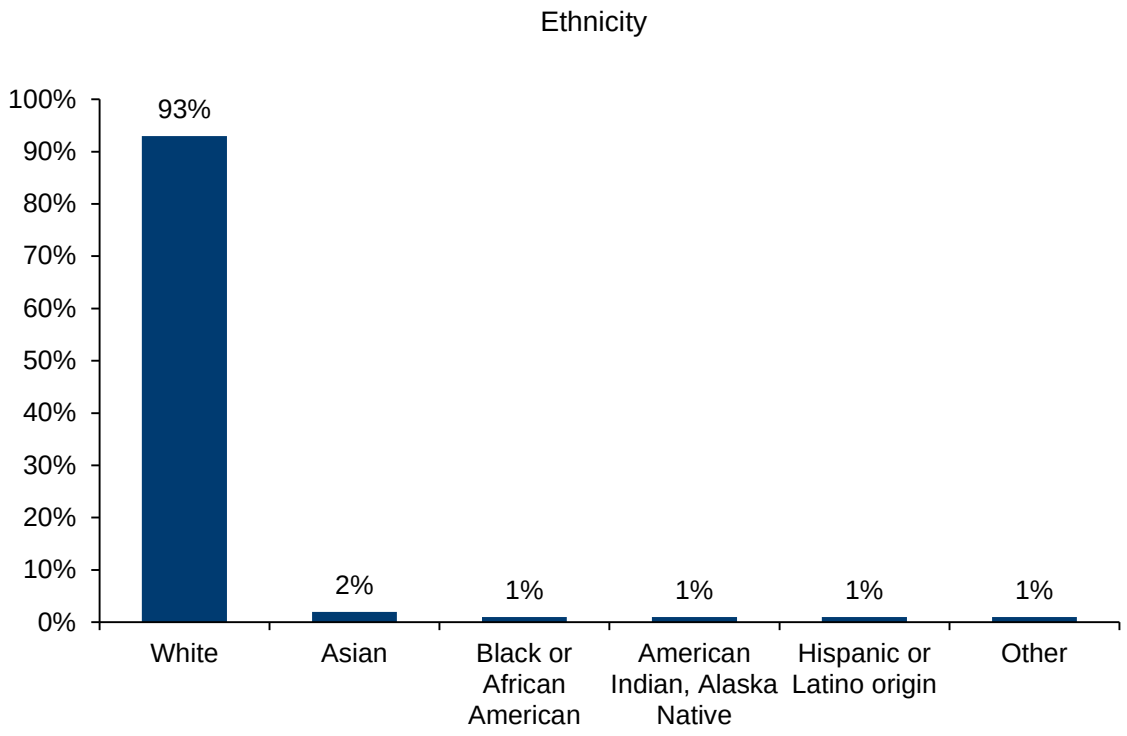
Base: 1 (n=79), 2 (n=173), 3 (n=105), 4 (n=110), 5 (n=64), 6 or more (n=20), Sample Size = 551

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: None (n=143), 1 (n=100), 2 (n=97), 3 (n=58), 4 or more (n=14), Sample Size = 412

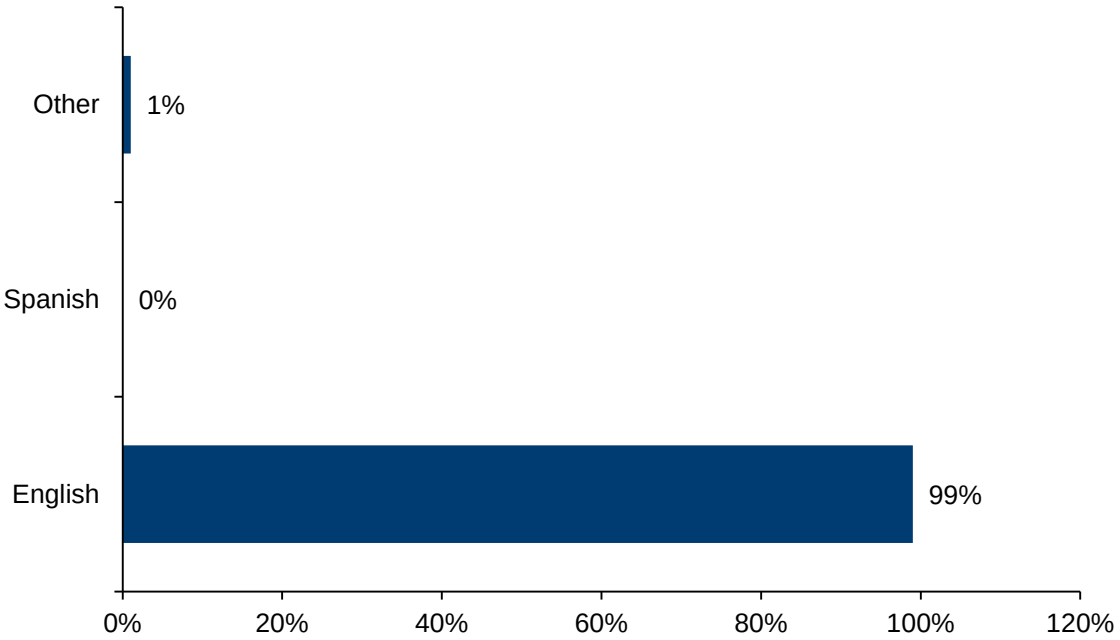
(Community = Minnehaha / Lincoln / Turner / McCook)



Base: White (n=517), Black or African American (n=8), Asian (n=10), American Indian, Alaska Native (n=7), Hispanic or Latino origin (n=5), Other (n=7), Sample Size = 554

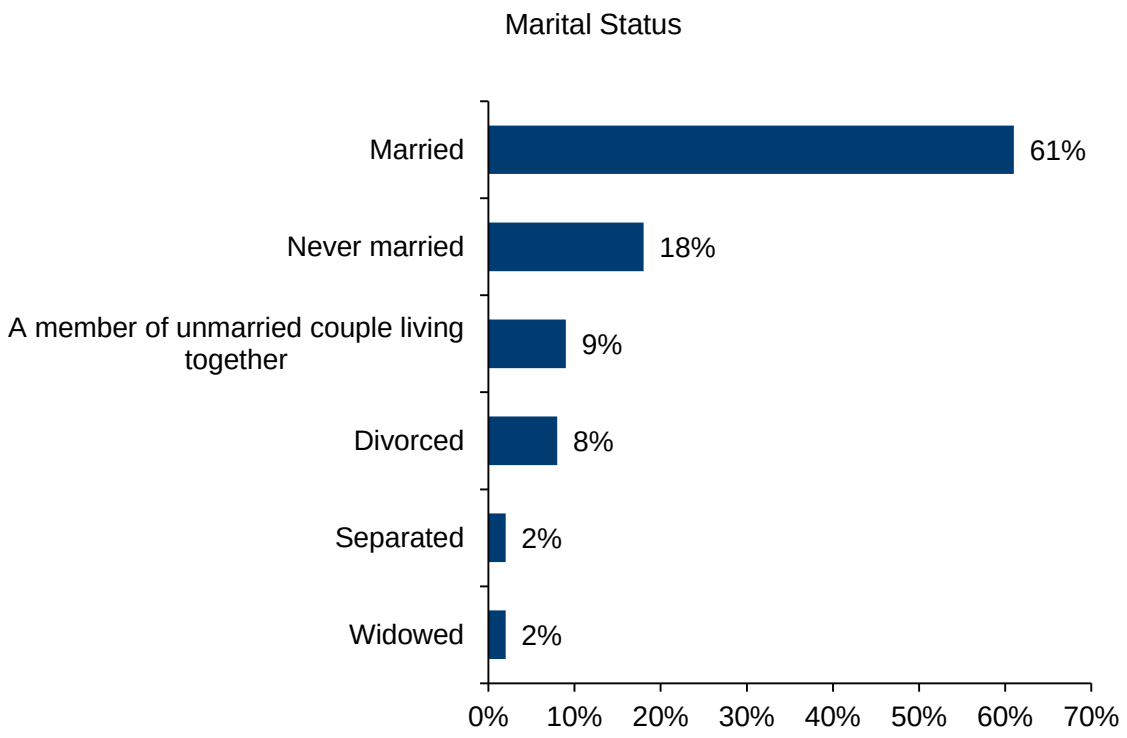
(Community = Minnehaha / Lincoln / Turner / McCook)

Language Spoken in Home



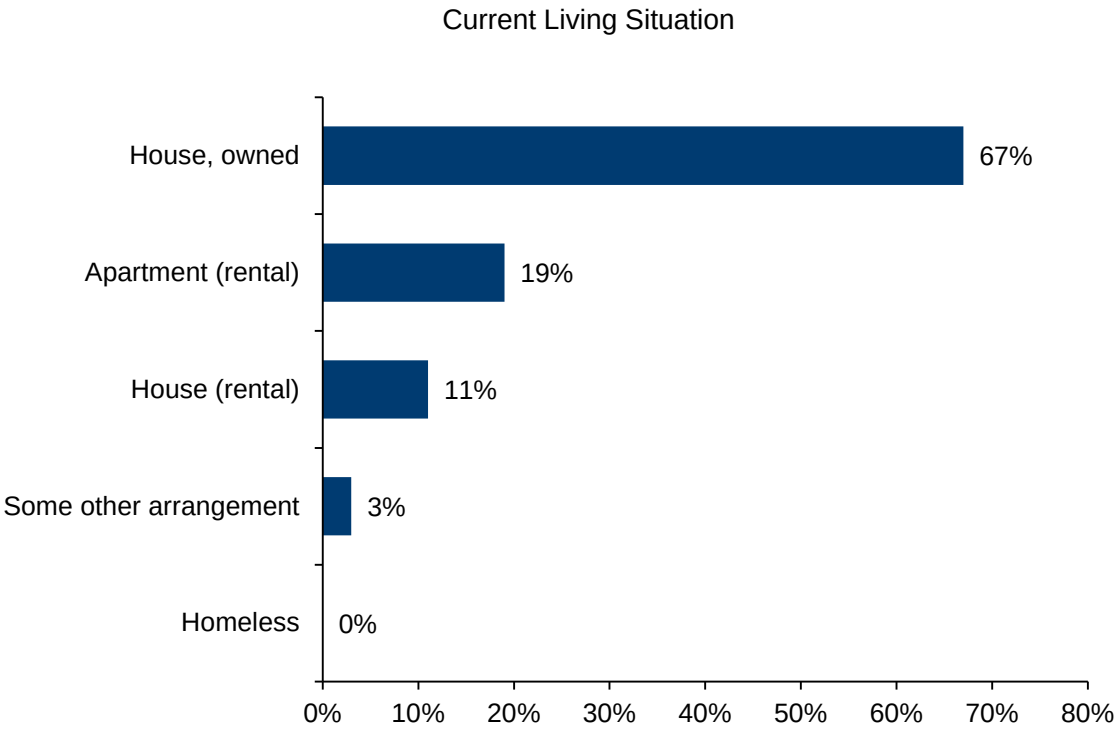
Base: English (n=546), Spanish (n=1), Other (n=5), Sample Size = 552

(Community = Minnehaha / Lincoln / Turner / McCook)



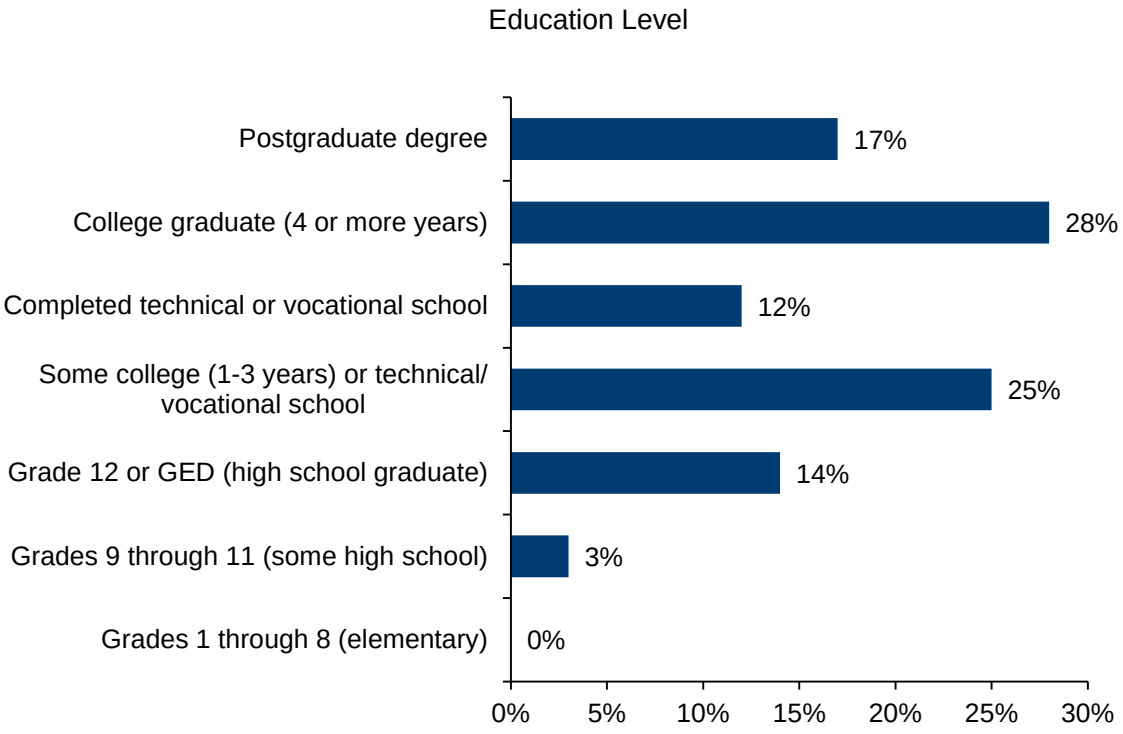
Base: Never married (n=98), Married (n=337), Divorced (n=44), Widowed (n=13), Separated (n=13), A member of unmarried couple living together (n=47), Sample Size = 552

(Community = Minnehaha / Lincoln / Turner / McCook)



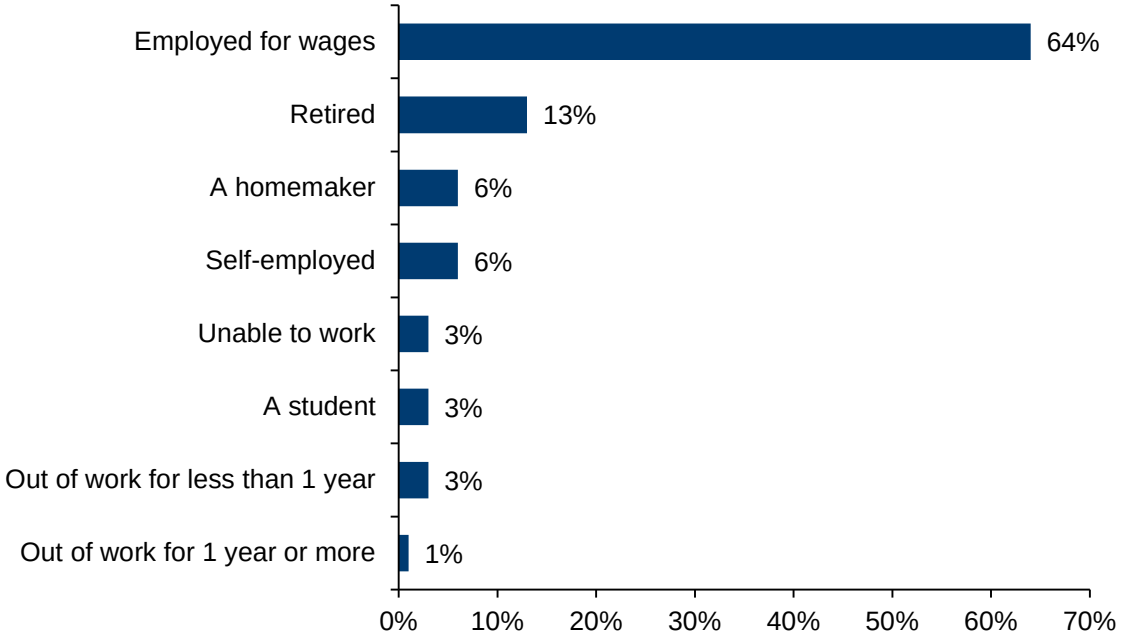
Base: House, owned (n=367), House (rental) (n=58), Apartment (rental) (n=104), Homeless (n=2), Some other arrangement (n=19), Sample Size = 550

(Community = Minnehaha / Lincoln / Turner / McCook)



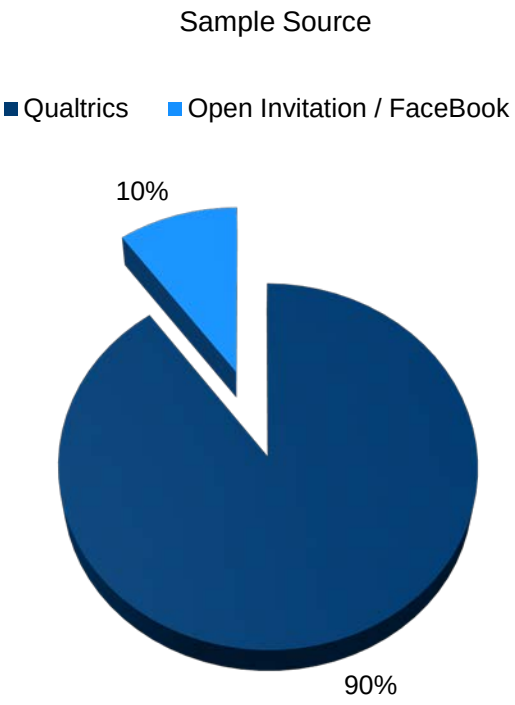
Base: Grades 1 through 8 (elementary) (n=2), Grades 9 through 11 (some high school) (n=16), Grade 12 or GED (high school graduate) (n=76), Some college (1-3 years) or technical/ vocational school (n=137), Completed technical or vocational school (n=69), College graduate (4 or more years) (n=157), Postgraduate degree (n=96), Sample Size = 553
(Community = Minnehaha / Lincoln / Turner / McCook)

Employment Status



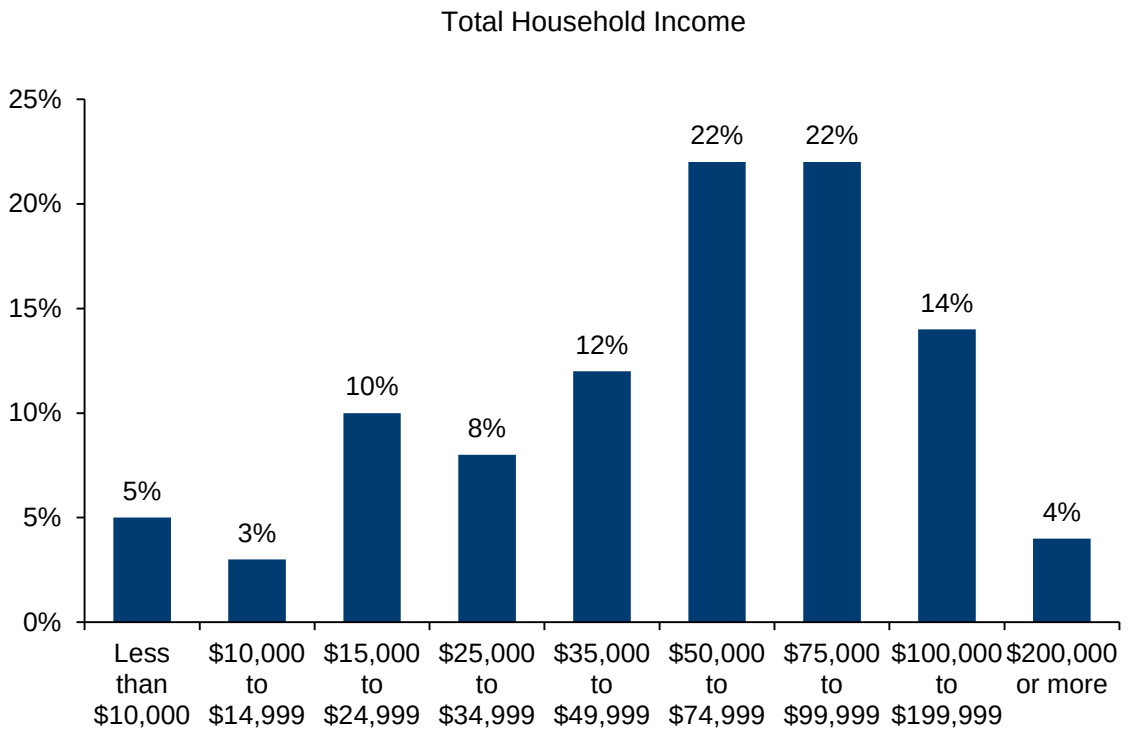
Base: Employed for wages (n=356), Self-employed (n=36), Out of work for less than 1 year (n=15), Out of work for 1 year or more (n=7), A homemaker (n=33), A student (n=19), Retired (n=72), Unable to work (n=16), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Qualtrics (n=500), Open Invitation / Facebook (n=54), Sample Size = 554

(Community = Minnehaha / Lincoln / Turner / McCook)



Base: Less than $10,000 (n=27), $10,000 to $14,999 (n=17), $15,000 to $24,999 (n=51), $25,000 to $34,999 (n=43), $35,000 to $49,999 (n=63), $50,000 to $74,999 (n=116), $75,000 to $99,999 (n=113), $100,000 to $199,999 (n=73), $200,000 or more (n=21), Sample Size = 524

(Community = Minnehaha / Lincoln / Turner / McCook)

Sioux Falls 2018 Community Health Needs Assessment Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economic Well-Being • Availability of affordable housing 4.11 • Skilled labor force 3.97 • Housing which accepts people with chemical dependency, mental health problems, criminal history or victims of domestic violence 3.91 • Homelessness 3.62 • 31% report not having enough food	8		
Transportation • Availability of door-to-door transportation services for those unable to drive 3.60 • Availability of public transportation 3.51			
Children and Youth • Substance abuse by youth 3.67 • Childhood obesity 3.61 • Availability of services for at-risk youth 3.58 • Bullying 3.55 • Crime committed by youth 3.52 • Teen suicide 3.52			
Aging Population • Cost of long term care 3.50			
Safety • Abuse of prescription drugs 4.00 • 58% binge drink - resident survey			
Healthcare Access • Availability of behavioral health providers 3.83 • Availability of mental health providers 3.80 • Access to affordable prescription drugs 3.64 • Access to affordable healthcare 3.63 o 23 % report not having seen a health care provider in > 1 yr. • Access to affordable health insurance coverage 3.60			
Mental Health and Substance Abuse • Drug use and abuse 4.07 • Depression 3.83 37% report a diagnosis • Alcohol use and abuse 3.70 o 58% report binge drinking • Suicide 3.52 • Tobacco use- 30% currently smoke cigarettes	8		
Health and Wellness • 51% Not getting enough fruits and vegetables • 38% Not getting enough exercise • 31% Overweight 37% obese • High cholesterol • Hypertension			

Secondary Data

Definitions of Key Indicators

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

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

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

Contents:

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

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

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

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

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

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

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

County Health Rankings

		South Dakota	Minnehaha (MN) , SD x	Lincoln (LI) , SD x	McCook (MC) , SD x	Turner (TU) , SD x
Length of Life						
Premature age-adjusted mortality		330	310	180	490	340
Child mortality		70	50	40		
Infant mortality		7	5	5		
Quality of Life						
Frequent physical distress		9%	9%	8%	8%	8%
Frequent mental distress		9%	9%	8%	9%	9%
Diabetes prevalence**	(Click for info)	9%	8%	7%	10%	9%
Health Behaviors						
Food insecurity**	(Click for info)	12%	12%	8%	9%	10%
Limited access to healthy foods		11%	5%	1%	10%	1%
Drug overdose deaths		8	10			
Drug overdose deaths - modeled		8.4	8-11.9	4-5.9	6-7.9	6-7.9
Motor vehicle crash deaths		16	10	6		34
Insufficient sleep		26%	26%	24%	24%	24%
Clinical Care						
Uninsured adults		14%	12%	7%	11%	12%
Uninsured children		7%	6%	4%	8%	8%
Health care costs**	(Click for info)	$8,345	$8,520	$8,725	$8,316	$8,606
Other primary care providers		801:1	573:1	1,089:1	1,875:1	2,079:1
Social & Economic Factors						
Disconnected youth		10%	8%			
Median household income		$54,900	$60,200	$84,600	$59,000	$58,800
Children eligible for free or reduced price lunch		42%	41%	17%	28%	31%
Residential segregation - black/white**	(Click for info)	63	49	50		
Residential segregation - non-white/white**	(Click for info)	56	44	20	22	
Homicides		3	3			
Firearm fatalities		11	9	6		
Physical Environment						
Demographics						
Population		865,454	187,318	54,469	5,625	8,317
% below 18 years of age		24.6%	25.3%	28.6%	26.6%	23.5%
% 65 and older		16.0%	12.9%	11.6%	19.9%	20.8%

		South Dakota	Minnehaha (MN) , SD x	Lincoln (LI) , SD x	McCook (MC) , SD x	Turner (TU) , SD x
% Non-Hispanic African American		1.9%	5.1%	1.3%	0.4%	0.4%
% American Indian and Alaskan Native		9.0%	2.7%	0.6%	1.0%	1.0%
% Asian		1.5%	2.3%	1.3%	0.2%	0.2%
% Native Hawaiian/Other Pacific Islander		0.1%	0.1%	0.1%	0.1%	0.1%
% Hispanic		3.7%	4.8%	1.9%	3.2%	2.1%
% Non-Hispanic white		82.5%	83.3%	93.6%	94.4%	95.8%
% not proficient in English		1%	2%	1%	1%	1%
% Females		49.6%	49.7%	50.3%	49.6%	49.8%
% Rural		43.3%	13.6%	29.3%	100.0%	100.0%

** Compare across states with caution 2018

Note: Blank values reflect unreliable or missing data

2018

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SANFORD HEALTH

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