2019 Community Health Needs Assessment

Viborg, SD

PIONEER MEMORIAL
HOSPITAL & HEALTH SERVICES

Pioneer Memorial
Hospital & Health Services

Viborg, South Dakota

Community Health Needs Assessment 2019

Pioneer Memorial
Hospital & Health Services

Dear Community Members,

Pioneer Memorial Hospital and Health Services (PMHHS) is pleased to present the 2019 Community Health Needs Assessment.

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

During December 2017 and January 2018 members of the community were asked to complete a survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. Pioneer Memorial Hospital and Health Services in partnership with Sanford Health, further analyzed the data, identified unmet needs, and collaborated with key community stakeholders to develop a list of resources and assets that were available to address each need. A gap analysis and prioritization exercise were also conducted to identify the most significant health needs and to further address these needs through the implementation strategies that are included in this document.

Pioneer Memorial Hospital and Health Services has set strategy to address the following community health needs:

- Aging Population - Senior Care Education
- Mental Health - Education

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

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

Sincerely,

Thomas Richter
Chief Executive Officer
Community Memorial Hospital

Pioneer Memorial
Hospital & Health Services

Community Health Needs Assessment
2019
EXECUTIVE SUMMARY

Pioneer Memorial
Hospital & Health Services

Community Health Needs Assessment
2019

Purpose

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

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

Study Design and Methodology

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

1. Non-Generalizable Survey
The Center for Social Research at North Dakota State University developed and maintained links to the online survey tool. NDSU distributed the website address for the survey instrument via e-mail to various key community stakeholders and agencies, at times using a snowball approach**.** 11 total respondents participated in the online survey during December 2017 and January 2018.

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

A Likert scale was developed to determine the respondent's highest concerns, with 1 as not at all

and 5 meaning a great deal. Needs ranking 3.5 and above were included as needs to be addressed and prioritized. Many of the identified needs ranking < 3.5 are being addressed by PMH and community partners; however, 3.5 and above was the focus for the purpose of the required prioritization.

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

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

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

Key Findings – Primary Research

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

1. **Economics:** Employment options was the highest ranked economic concern at 3.73. Affordable housing and maintaining livable and energy-efficient homes were also top concerns at 3.55 and 3.5 respectively.

2. **Children and Youth:** Bullying ranks highest of the concerns for children and youth with a ranking of 3.5. Other top concerns were the cost (3.5) and availability (3.4) of quality child care.

3. **Health Care and Wellness:** Access to affordable health insurance was of highest concern to survey respondents at 3.89. Availability of mental health providers was another key concern ranking at 3.88.

4. **Aging Population:** At 4.10, the cost of Long-Term Care and the cost of Memory Care were the top concerns among survey respondents. Additionally, the availability of resources for family and friends caring for and helping to make decisions for elders ranked 3.7.

5. **Mental Health/Behavioral Health**: Survey respondents indicated that depression was the top mental health concern at 3.13. Alcohol use and abuse was also mentioned as a concern, ranking at 3.0.

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

Health Outcomes

	Turner County	National	South Dakota
Premature Death (years of life lost before age 75 per 100,000 population)	8,000	5,400	7,300
Poor or Fair Health	11%	12%	12%
# unhealthy mental health days in the last 30 days	2.6	3.1	2.9
% live births with low birth weight (<2500g)	4%	6%	6%

Health Factors

	Turner County	National	South Dakota
% adults currently smoking	14%	14%	18%
% adults considered obese (BMI > 30)	35%	26%	31%
% adults reporting excessive or binge drinking	18%	13%	20%
# alcohol-impaired driving deaths	33%	13%	36%
# sexually transmitted infections	158.4	152.8	504
Teen birth rate (# of births per 1,000 female pop. 15-19)	9	14	28
% uninsured adults	9%	6%	10%
Ratio of population to primary care Physicians	8,320:1	1,050:1	1,320:1
Ratio of population to mental health providers	8,320:1	310:1	590:1
Ratio of population to dentists	4,160:1	1,260:1	1,690:1
Preventable hospital stays (per 100,000 Medicare enrollees)	4,872	2,765	4,724
Mammography screening	47%	49%	49%
High school graduation rate	91%	96%	84%
College (at least some post-secondary education)	69%	73%	68%
Unemployment rate	3.2%	2.9%	3.3%
% child poverty	11%	11%	16%
Social associations (# membership associations per 10,000 people)	26.5	21.9	16.4
% children in single-parent households	25%	20%	31%
Violent crime	139	63	373
Food insecurity	9%	9%	12%
Home ownership	78%	80%	68%
% children eligible for free/reduced lunch	33%	32%	38%
Annual median household income	$56,200	$67,100	$56,900

The following needs were brought forward for prioritization:

- Economics: Employment options, affordable housing and maintaining livable and energy-efficient homes.
- Children and Youth: Bullying and quality childcare (cost and availability).
- Health Care and Wellness: Access to affordable health insurance and availability of mental health providers.
- Aging Population: Cost of Long-Term Care and Memory Care.
- Mental Health: Depression and alcohol use and abuse.

PMHHS, with the recommendations from community stakeholders, has determined the 2022-2022 implementation strategies for the following needs:

- Aging Population - Senior Care Education
- Mental Health - Education

Implementation Strategies

Priority 1: Aging Population - Senior Care Education

According 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. PMHHS providers and social workers work with seniors to help them access the care and resources needed. The facility has a directory of senior care resources available and the staff refers patients to area service providers and resources to ensure safe discharge and transition to appropriate levels of care.

Pioneer Memorial Hospital and Health Services has set strategy to help educate the community on how to access more affordable senior care services. The primary goal of this work is to improve awareness of resources, assistance programs and strategies to make health, housing and personal care services more economically accessible. PMHHS will sponsor seminars and vendor fairs on a variety of senior care topics including estate planning for nursing home Medicaid eligibility, subsidies available for health insurance, and available in-home services and financial assistance programs. Additionally, low-cost lab tests (Direct Tests) and free or reduced-cost screenings will be offered as part of this effort to help seniors plan for and live healthy independent lives.

Priority 2: Mental Health - Education

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

Many factors contribute to mental health problems, including:

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

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

PMHHS has prioritized mental/behavioral health as a top priority and has set strategy to ensure that community members experiencing depression, anxiety, post-traumatic stress or suicidal thoughts will learn how they can access treatment. PMHHS will create awareness throughout the community about mental health services, resources, and assistance programs through multiple means including news releases, newsletters, brochures, resource guides, social media, and the hospital web site.

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Purpose of the Community Health Needs Assessment

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

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

Mission: Committed to health, healing, and community.

Vision: Pioneer Memorial Hospital & Health Services is a progressive leader dedicated to the delivery of the highest quality of medical, health, and senior living services.

Values: Pioneer Memorial Hospital & Health Services guiding principles are:

- Caring and compassion
- Respect, dignity and honesty
- Safety and quality
- Proactive response to changing needs
- Cooperation and collaboration
- Financial and fiscal responsibility

Acknowledgements

PMHHS would like to acknowledge and thank the Sanford Health Enterprise Steering Committee, and the Center for Social Research at North Dakota State University for their assistance and expertise while performing the assessment and analysis of the community health data.

Pioneer Memorial Leadership:

- Thomas Richter, Chief Executive Officer
- Tonya Rudd, Clinic Director
- Sharon Jacobsen, Director of Nursing
- Lori Hisel, Director of Human Resources
- Anne Christiansen, Chief Financial Officer
- Krista Schaeffer, Director of Nursing, Nursing Home
- Lindsey Hauger, Assistant Administrator, Long-Term Care

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

- Thomas Richter, CEO – Pioneer Memorial
- Gary Ward, Attorney – Ward Law Firm
- Lindsey Hauger, Assistant Administrator – Pioneer Memorial
- Brett Mellem, Superintendent – Viborg-Hurley School District
- Kris Vander Kooy, Manager – Tri-Cross Dairy
- Deb Hauger, R.N. – Turner County Community Health
- Sharon Jacobsen, Director of Nursing – Pioneer Memorial
- Anne Christiansen, CFO – Pioneer Memorial
- Gloria Peterson – Viborg Ambulance
- Michelle Paulson – Director of Social Services – Pioneer Memorial
- Krista Schaeffer, R.N. – Pioneer Memorial LTC
- Tonya Rudd, Director of Clinic Operations – Pioneer Memorial
- Denise Hanisch, M.D. – Pioneer Memorial
- Lori Hisel, Director of Support Services – Pioneer Memorial
- Scott Larsen – Merchants State Bank
- Melanie Parsons, Owner – Parsons Insurance Agency
- Brenda Brue – Public Transportation
- John Chicoine – Retired Doctor of Chiropractic
- Bryon Nogelmeier - Sheriff

Description of Pioneer Memorial Hospital and Health Services - Viborg, SD

Established in 1959, Pioneer Memorial Hospital and Health Services has long been serving the community of Viborg and the surrounding area. Pioneer Memorial Hospital is a 12-bed, critical access acute and swing bed care, community non-profit hospital that serves the residents of Turner County and the surrounding area. PMHHS also includes Viborg Medical Clinic, Centerville Medical Clinic, and Parker Medical Clinic, all certified rural health clinics, a 52-bed skilled nursing facility, 10-unit assisted living facility, and 20-unit independent living facility.

Pioneer Memorial has two physicians and four advanced practice providers on staff and several outreach specialists who travel to Viborg to serve local patients and residents.

The hospital's mission - "Committed to health, healing and community" - is complementary to its values of compassion, safety, quality of care, and fiscal responsibility as it aims to be a proactive force in the community to changing needs. Pioneer Memorial is governed by a nine-member Board of Directors.

Description of the Community Served

The town of Viborg, population 782, is located in the southeastern corner of South Dakota. Residents and visitors to Viborg enjoy stunning landscapes, local eateries, and movies at the Lund Theater. Several state parks are close by including Lewis and Clark Recreation Area, Newton Hills State Park, and Union Grove State Park.

Study Design and Methodology

Primary Research

Key Stakeholder Survey - A non-generalizable online survey was conducted by Pioneer Memorial Hospital with the assistance Sanford Health, public health leadership, and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. The website address for the survey instrument was distributed via e-mail to community stakeholders and various agencies, at times using a snowball approach. Data collection occurred throughout December 2017 and January 2018 with a total of 11 respondents participated in the online survey.

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

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

Resident Survey - The resident survey included questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the Statewide Health Improvement Partnership (SHIP) surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a notice was posted in the local newspaper to invite residents to take the survey. The newspaper post included a URL for the survey. A total of 78 community residents participated in the survey.

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

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

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

Secondary Research

The secondary data includes the 2019 County Health Rankings as well as the Focus on South Dakota – A Picture of Health study for Turner County.

Limitations of the Study

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

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

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

Public comments and response to the community health needs assessment and the implementation strategies are welcome on the PMHHS website using the “contact us” information.

Pioneer Memorial
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Key Findings

Community Health Concerns

Economics

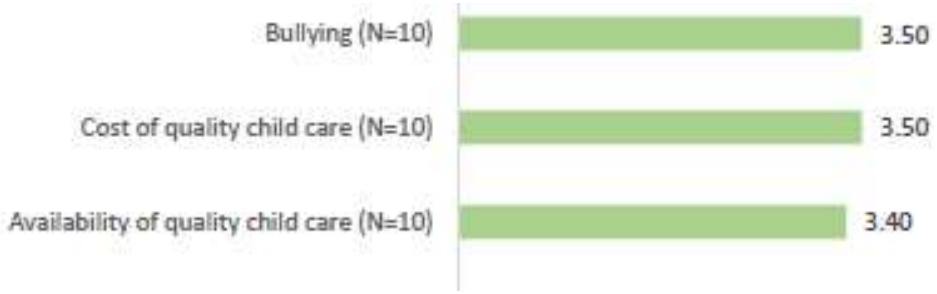
The availability of employment options is of high concern for the respondents of the survey. Other concerns included availability of affordable housing and maintaining livable and energy efficient homes.

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

Children and Youth

The highest concern regarding children and youth is bullying. Cost and availability of quality childcare were other top concerns mentioned.

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



Health Care and Wellness

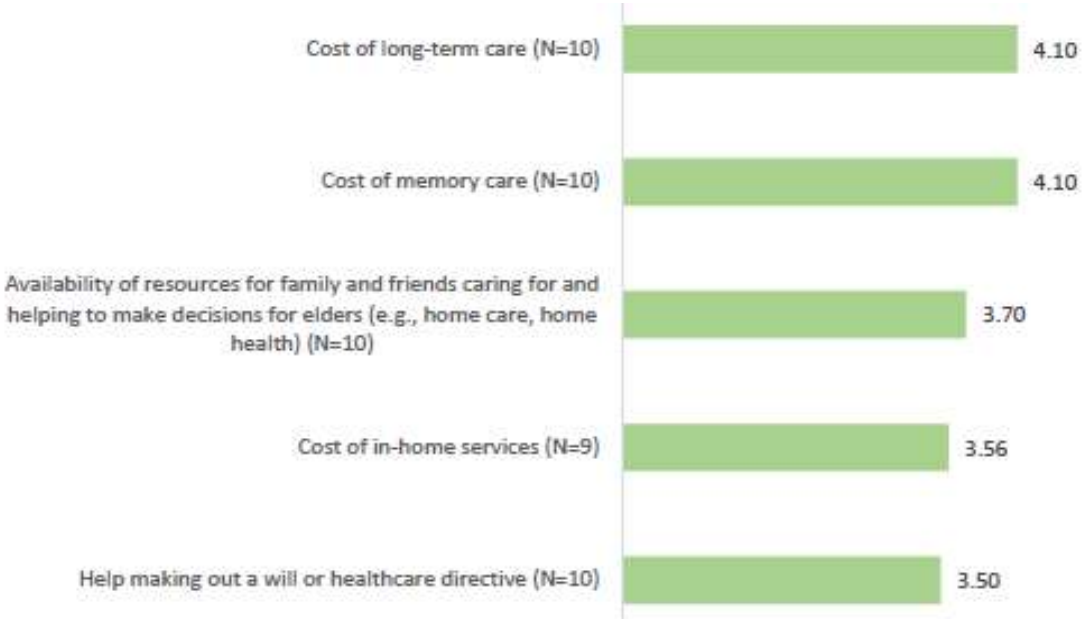
Access to affordable health insurance coverage was the top concern among survey respondents. *County Health Rankings* for Turner County finds that 9% of the population is uninsured. Other concerns included availability of mental health providers and behavioral health providers.

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

Aging Population

Survey respondents have a high concern about the cost of long-term care and memory care. Respondents also indicated concern about availability of resources for caring for elders, cost of in-home services for the elderly, and help making out a will or healthcare directive.

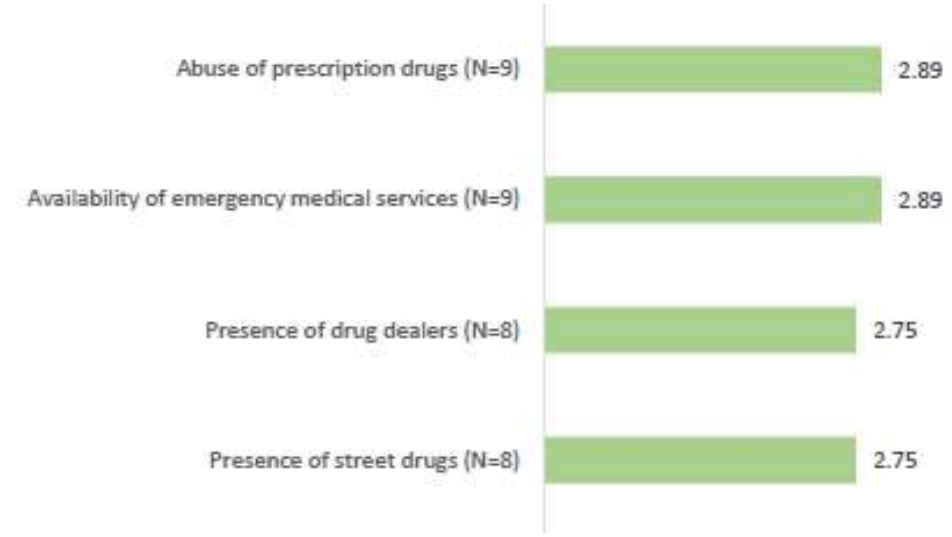
Level of concern with statements about the community regarding THE AGING POPULATION (1=no attention needed; 5=critical attention needed)



Safety

While respondents shared a variety of safety concerns, no individual item ranked greater than 3.0 on the scale. Top concerns that surfaced include abuse of prescription drugs, availability of emergency services, and the presence of drug dealers and street drugs in the community. *County Health Rankings* for Turner County finds that 33% of driving deaths involve alcohol impairment and that 18% of county residents report binge drinking or heavy drinking.

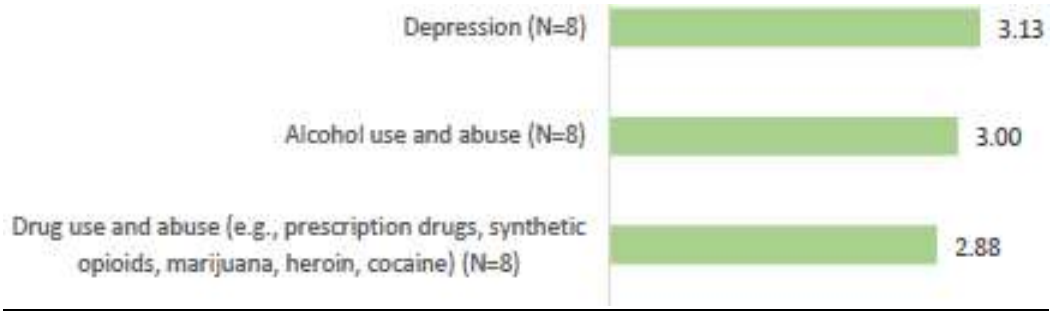
Level of concern with statements about the community regarding SAFETY (1=no attention needed; 5=critical attention needed)



Mental Health and Substance Use

Depression was the highest ranked mental health concern among survey respondents. Alcohol and drug use and abuse for the general adult population were also concerns. Secondary data indicates that 35.6% of county residents have abused alcohol.

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

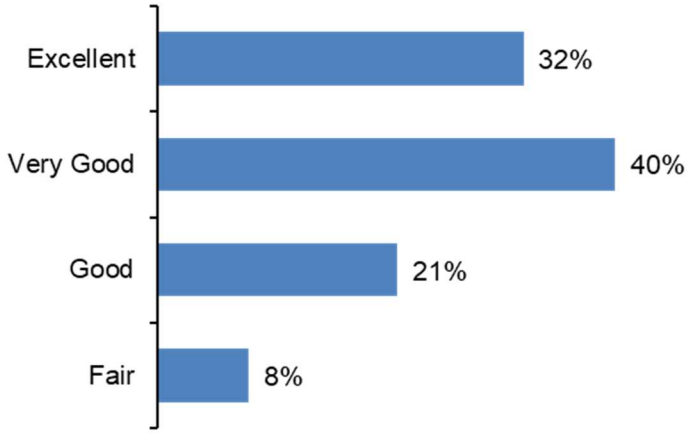


Personal Health Concerns

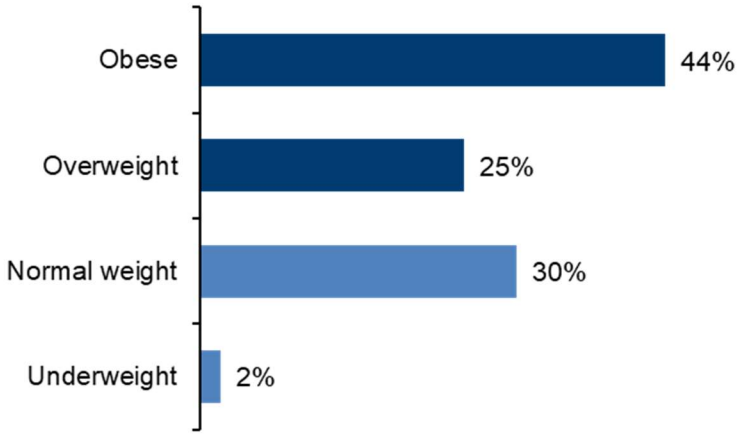
Respondents' Personal Health Status

The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI), which calculates weight status using an individual's weight and height, 69% of respondents reported themselves as overweight or obese. However, the vast majority (98%) of community respondents rate their own health as excellent, very good, or good.

Respondents' rating of their health in general:



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



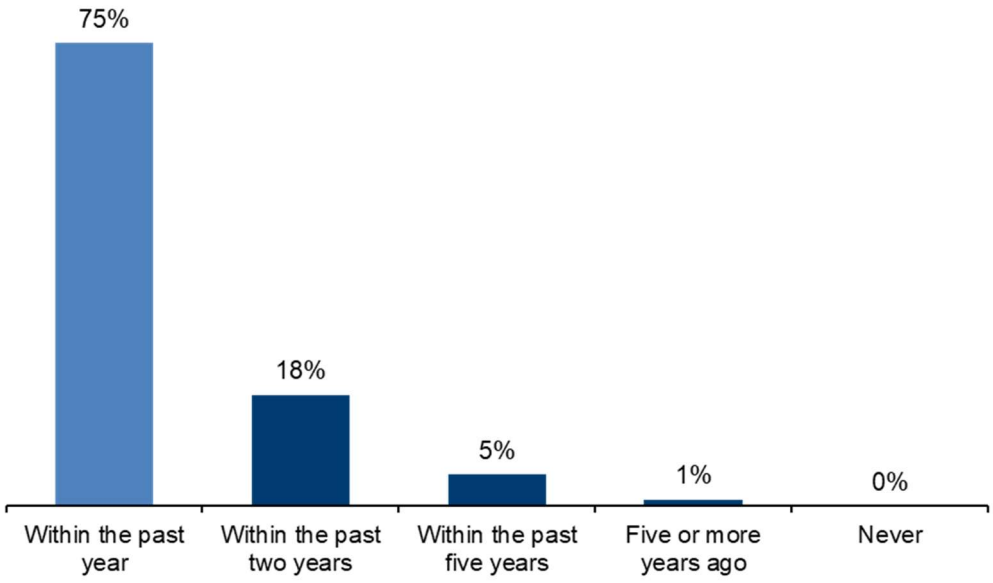
Obesity is a common but serious disease. Obesity can have adverse effects on health and lead to a reduced life expectancy. Adults with a BMI > 25 are overweight and adults with a BMI > 30 are obese. According to the CDC, obesity and being overweight are the second leading cause of preventable deaths,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

Health conditions related to obesity:

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

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

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

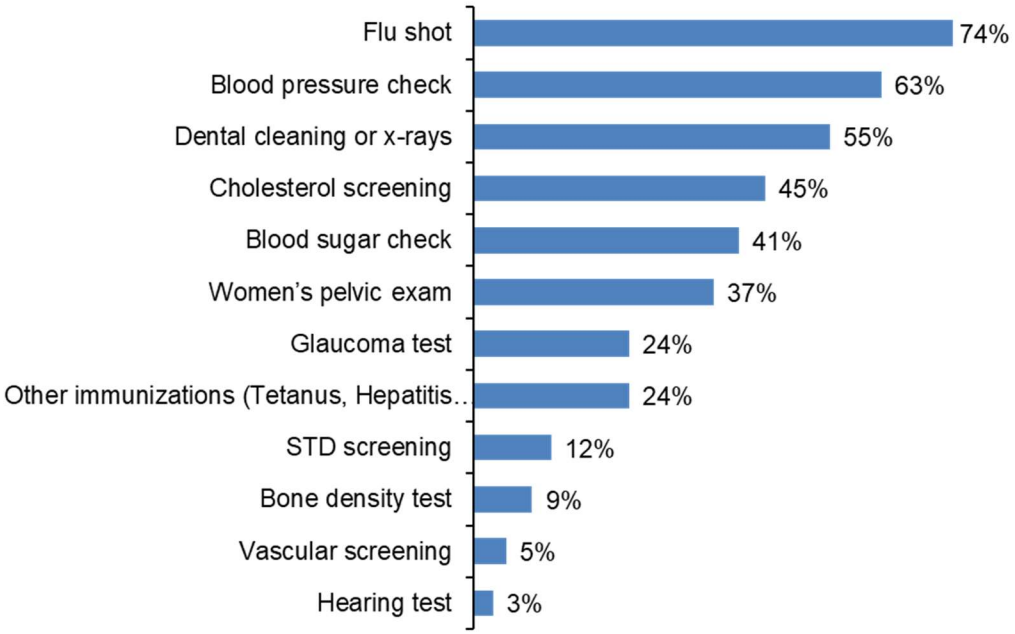


Within the past year, 75% visited a doctor or health care provider for a routine physical. Respondents indicated that the main barriers to a routine check-up were cost, no need to be seen, transportation issues, inconvenient appointment times, and fear.

Preventive Health

Preventive health care promotes the detection and prevention of illness and disease and is another important component of good health and well-being. Community results indicate that within the past year, the majority of respondents had a blood pressure, blood sugar, cholesterol screening, dental screening, flu shot, pelvic exam (females), and breast cancer screening (females). However there are many screenings and tests that a majority of respondents did not receive (i.e. bone density test, cardio screening, glaucoma screening, hearing screening, immunizations, STD test, colorectal screening, prostate cancer screening {males}, and skin cancer screening) in the past year. Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate.

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



Of respondents who have not had preventative screenings in the past year, reasons indicated include cost (30%), haven't had time (21%), fear of screening or procedure (8%), doctor has not suggested the screening (8%), fear of results (5%), and unable to access care (4%).

*Percentages do not total 100.0 due to multiple responses.

Screenings

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

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

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

- *Colorectal cancer screening*: Colorectal cancer almost always develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can also find colorectal cancer early, when

treatment works best. Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 50 and continuing until age 75.

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

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

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

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

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

<u>Flu Vaccines</u>

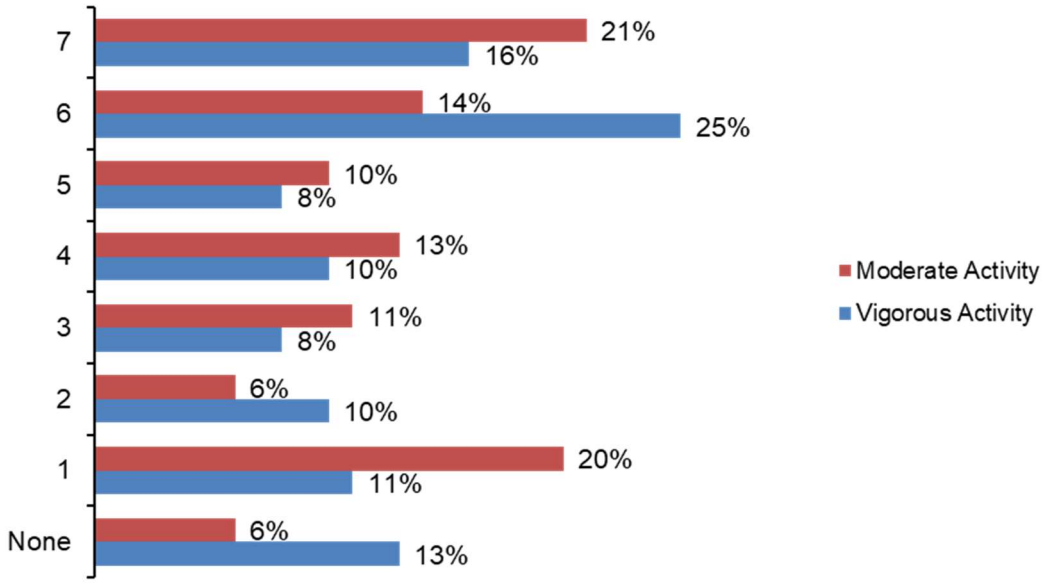
The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the survey indicate that 26% of respondents did not have a flu shot last year. The Center for Disease Control states that influenza is a serious disease that can lead to hospitalization and sometimes death. Even healthy people can get sick from the flu

and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies provide protection against infection with the viruses that are in the vaccine.

Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines. 42% of survey respondents reported three or fewer days of vigorous activity and 44% reported three or fewer days of moderate activity. Guidelines from the Centers for Disease Control and Prevention recommend that individuals participate in 150 minutes of moderate physical activity per week or 75 minutes of vigorous physical activity per week to help sustain and improve health.

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

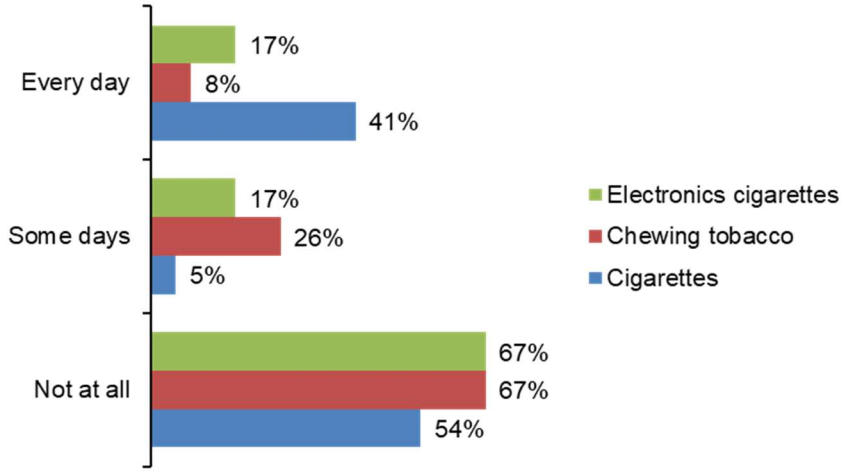


Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users with 67% indicating they do not use any form of tobacco. Additionally, 72% of self-identified smokers who responded to the survey have tried to quit in the past 12 months.

Secondary research through the 2019 *County Health Rankings* finds that 14% of Turner County residents are current smokers, which aligns with the U.S. average of 14%.

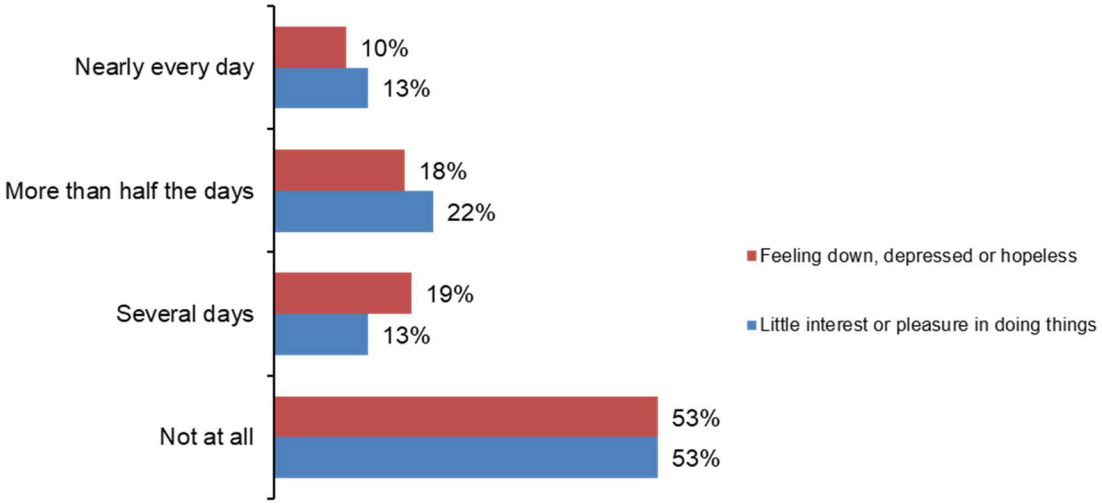
How often respondents currently smoke cigarettes or e-cigarettes and use chewing tobacco or snuff



Mental Health

Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others around us. Among Turner County respondents, mental health is a moderately high area of concern.

Percentage of respondents who have felt down, depressed, hopeless, or had little interest or pleasure in doing things several days or more over the past two weeks:

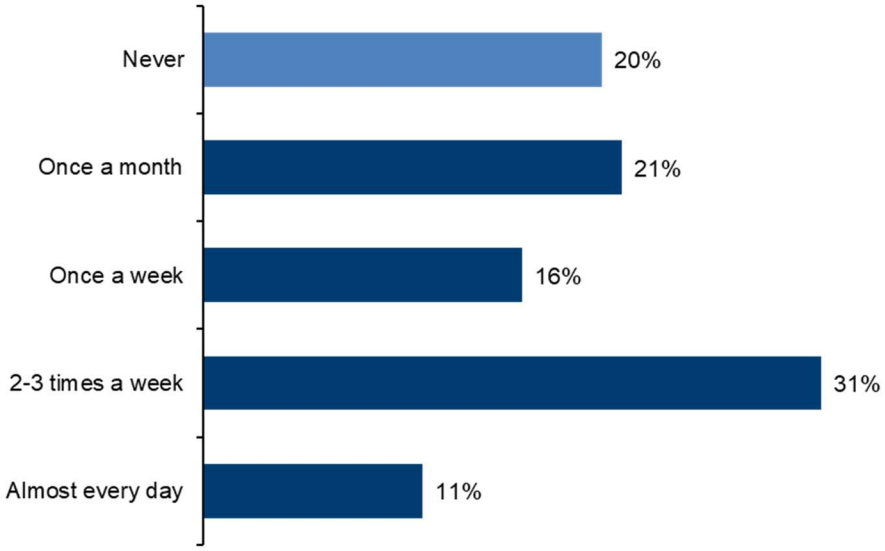


Substance Abuse Responses

Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In the Viborg community, 91% of survey respondents drank alcoholic beverages during the previous month. 31% of survey respondents report that alcohol has had a harmful effect on themselves or on a family member in the past two years and 24% indicate that a family member or friend has suggested they get help for substance use.

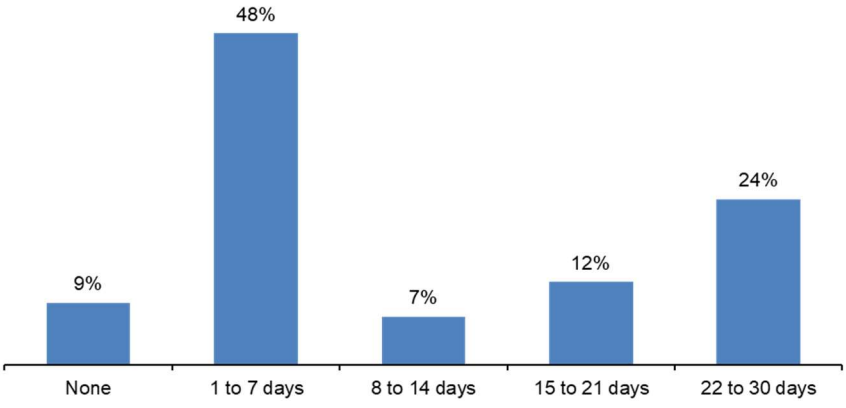
Additionally, 31% of respondents report binge drinking which is defined by the CDC as 4 drinks for females and 5 drinks for makes on the same occasion.

Frequency of binge drinking in the past 30 days:

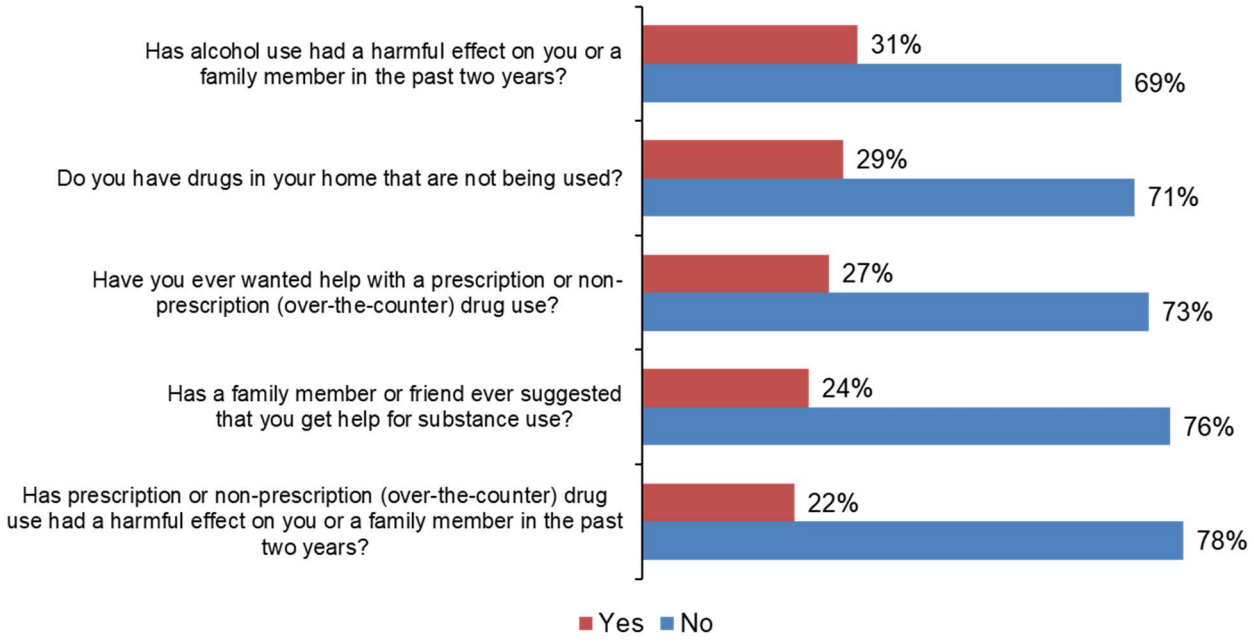


Secondary research through the 2015 *County Health Rankings* indicates that 18% of Turner County residents report excessive drinking. (See Appendix).

Number of days with at least one drink in the past month:



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



Demographics

General Population Data

	Turner County
Total population	8,347
Median age	43.7
Median household income	$54,294
% living below poverty level	10.6%
Unemployment rate	3.2%
% high school graduate or higher	92.9%

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

Survey Respondents

Of the respondents, 25% were female and 75% were male. All respondents owned their own homes, 62.5% were employed with 25% self-employed, and 87.5% had completed at least some post-secondary education. Thirteen percent of those surveyed are military veterans.

Zip code of respondents

Zip code	# of respondents
57070	4
57053	3
57014	1

N=8

Health Needs and Community Resources Identified

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

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

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

The asset map includes identified needs from the following:

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

The Asset Map can be found in the Appendix

Prioritization

The following needs were brought forward for prioritization:

- Economics – employment options and affordable housing
- Children and Youth – bullying and cost/availability of child care
- Health Care and Wellness – access to affordable health insurance and availability of mental health providers
- Aging Population – cost of long-term are and memory care and availability of resources for caring for elders
- Mental Health – depression and alcohol use and abuse

PMHHS is addressing all of the assessed needs that fall within our scope of work. In some cases the need is one where we do not have the expertise to adequately address the need; however, PMHHS leaders will communicate these findings with community leaders and experts who can best focus on solutions to the concerns. A document that shares what PMHHS is doing to address the need or explains why PMHHS is not addressing the need can be found in the Appendix.

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

- Aging Population - Senior Care Education
- Mental Health - Education

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Addressing the Needs

Identified Concerns	How Pioneer Memorial is addressing the needs
Economic Well-Being • Employment options • Affordable housing availability • Maintaining livable and energy efficient homes	Pioneer Memorial will address this need by sharing the findings with the Viborg Economic Development Committee and Viborg City Council.
Children and Youth • Bullying • Cost and availability of child care	Pioneer Memorial will address this need by sharing the findings of the CHNA with school leaders and community leaders.
Healthcare and Wellness • Access to affordable health insurance • Availability of mental health providers	Pioneer Memorial will address this need by sharing the findings of the CHNA with law enforcement, primary care providers and community leaders.
Aging • Cost of long-term care • Cost of memory care • Availability of resources for caregivers and decision-makers for elders • Help making out a will or health care directive	This need will be addressed by improving awareness of resources, assistance programs and strategies to make health, housing and personal care services more economically accessible. Pioneer Memorial will sponsor seminars on a variety of related topics along with low cost lab tests and free or reduced-cost screenings.
Mental Health • Depression • Alcohol use and abuse	Pioneer Memorial will create awareness around mental health services, resources, and assistance programs by providing information through news releases, newsletters, social media, resource guides, and the PMHHS website. Pioneer Memorial will address alcohol use and abuse by sharing the findings of the CHNA with primary care providers in the service area.

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2020-2022 Implementation Strategies

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Implementation Strategy

2020-2022 Action Plan

Priority 1: Senior Care Education

Projected Impact: Seniors age 65 and older and their family/caregiver will learn how to access more affordable health care services.

Goal 1: Improve awareness of resources, assistance programs and strategies to make health, housing and personal care services more economically accessible.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships / collaborations (if applicable)
Sponsor seminars on estate planning for nursing home Medicaid eligibility	Number of attendees	Marketing Coordinator Social Service Supervisor	Administrative Team	Attorney
Sponsor seminars on nursing home Medicaid eligibility and application process	Number of attendees	Marketing Coordinator Social Service Supervisor	Administrative Team	SD Department of Social Services Attorney
Sponsor seminars on subsidies available for health insurance	Number of attendees	Marketing Coordinator	Administrative Team	Insurance Agent
Sponsor seminars and vendor fairs on available in-home services and financial assistance programs	Number of attendees	Marketing Coordinator	Administrative Team	Home Health Agencies Durable Medical Equipment Hospice Agencies Support Groups
Provide education and promotion of low cost lab tests (Direct Tests) and free or reduced cost screenings	Number of individuals using Direct Tests and participating in free or reduced cost screenings	Marketing Coordinator Clinic Director Lab supervisor Practitioners	Administrative Team	

Priority 2: Mental Health Education

Projected Impact: Community members experiencing depression, anxiety, post-traumatic stress or suicidal thoughts will learn how they can access treatment.

Goal 1: The community will become more aware of mental health services, resources and assistance programs.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships / collaborations (if applicable)
Provide information through news releases, web site, PMHHS Lifeline newsletter, brochures, resource guides, social media,	Number of articles published	Marketing Coordinator Practitioners	Administrative Team	Changing Behavioral Health Counselors

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2016 Implementation Strategy Impact

2016 Implementation Strategies

The 2016 Community Health Needs Assessment served as a catalyst to lift up physical health, mental health, and behavioral health as implementation strategies for the 2017-2019 timespan. The following strategies were implemented.

Concerns Identified	2017-2019 Implementation Strategies
Physical Health	• Implement Sanford *fit* program in local schools • Implement Bountiful Basket program in Viborg • Provide nutrition education and cooking classes • Expand 'Biggest Loser Challenge' to communities in service area • Develop walking programs for community members • Encourage age appropriate colonoscopies • Promote the American Cancer Society recommendation for skin cancer screens
Mental Health / Behavioral Health	• Utilize Sanford MyChart capabilities for depression assessment • Reduce dependence on opioid drugs

These strategies have served a broad reach across our community and region. The impact has been positive and the work will continue into the future through new or continued programming and services.

Impact of the Strategy to Improve Nutrition, Physical Health, and Obesity Rates in the Community

1. The Sanford *fit* kids program was distributed in October 2017 to the following schools: Viborg-Hurley, Centerville, Parker, and Irene-Waconia. There were no additional schools in 2018.
2. The Bountiful Basket program was discontinued in our service area. We are evaluating other options for this service. In 2018, the Cameron Colony provided a farmers market with seasonal fruits and vegetables to the Viborg Community.
3. Pioneer Memorial Hospital provided the following nutrition education and cooking classes in 2018: A) Slide and Dice – hands-on demonstration on proper techniques on slicing and dicing vegetables and fruit. B) "Are Food Labels Confusing" presented by Charlotte Rommereim, RD. C) "Facts About How Your Food Supply is Raised" presented by Charlotte Rommereim, RD. D) Deb Hauger, Public Health Nurse, presented on the following topics: Healthy vs. Unhealthy Drinks; Sugar & Dental; Food Safety, Eat the Rainbow Healthy Kids, Feeding Healthy Children, Eat Fruits & Vegetables; Recipe Ideas for In-Season Fruits & Vegetables; Salmonella Outbreak – Food Safety; Pre-Diabetes & Controlling Diabetes, and Nutrition to 2nd & 3rd Classes.
4. The "Biggest Loser Challenge" was expanded to all the communities in our service area. There were 73 participants in 2018 and 38 in 2017.
5. A Community Walking Program was developed in 2018 with 60 participants. The program promoted walking your way to better health and connecting with friends. The program ran from June 1 to July 31.
6. Pioneer Memorial Hospital & Health Services hosted the Danish Days 5K Run and 1-Mile Walk in 2017 and 2018. In 2018, there were 88 walkers and 27 runners. The event will again be hosted in 2019.
7. The Rehab Wellness Program meets 3 days / week with an average of 8-9 participants. The Community Wellness Center is operated by Pioneer Memorial.
8. Sanford Heart Screenings were offered during Danish Days in July 2018 to promote healthy hearts and identify individuals at risk for heart disease.

9. Providers continued to encourage patients to have age-appropriate colonoscopies during the patient's office visit. The baseline colonoscopies in 2016 were 40, and 30 colonoscopies were performed in 2017. In 2018, there were 38 colonoscopies performed.
10. Skin Cancer Screenings were not held in 2018, but will be offered again in 2019. Skin Cancer Screenings were held in 2017 at three clinics: Center Clinic on 11/14/17 with 7 screenings in which 4 needed a scheduled procedure (lesion removal/biopsy). Viborg Clinic on 11/20/17 with 21 screenings in which 11 needed a scheduled procedure. Parker Clinic on 11/28/17 with 3 screenings. Deb Hauger, Public Health Nurse, provided an educational presentation on "Sun Exposure and Skin Cancer" in August 2018.

Impact of the Strategy to Improve Care of Patients with Depression Diagnosis

1. The depression assessment tool was utilized in Sanford OneChart to provide follow-up care for patients whose initial PHQ-9 score was greater than 12. The PHQ-9 form is a questionnaire that is used as a screening tool for identifying depression. A low score is preferred, and as the score increases, the patient is more likely to be suffering from some form of depression. A patient with a score over 12 may have major depression or dysthymia.
    a. In 2018: There were 391 screenings completed with 57 screenings that were 12 or greater. Based on the screenings that were completed, 14.5% of the patients have moderate to severe levels of depression. Depression follow-up care was provided at 100% for these 57 patients.
    b. In 2017: There were 584 screenings completed with 55 screenings that were 12 or greater. Based on the screenings that were completed, 9.4% of the patients have moderate to severe level of depression. Depression follow-up care was provided at 100% for these 55 patients.
2. No action was taken for establishing mental health telemedicine services and/or outreach clinic in 2017 and 2018. In 2019, an outreach mental health clinic was established with Changing Behavioral Health.
3. An e-prescribing software along with fingerprint readers was implemented in FY2017. Prior to this software, the providers gave the patient a paper prescription for narcotics. A paper script increases the risk of the patient making fraudulent copies and access to narcotics. With the e-prescribing software, the provider's fingerprint is required to electronically submit a script to a pharmacy to be filled. The South Dakota Prescription Drug Monitoring Program (PDMP) is also utilized by the providers and nursing staff.
4. Education was provided during the year on the use of opioids and the use of pain contracts. The baseline measurement for the number of patients on a pain contract was 23 patients in FY2016, and the number of patients on pain contracts remained at 23 for FY2017. In 2018, there were 34 patients on a pain contract, and during the year, 8 contracts were terminated.

2016 Community Feedback

Pioneer Memorial Hospital and Health Services is prepared to accept feedback on our Community Health Needs Assessment and has provided online comment fields for ease of access on our website. There have been no comments or questions to date.

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APPENDIX

Pioneer Memorial Hospital & Health Services

Primary Research

Pioneer Memorial Hospital & Health Services - Asset Mapping

Identified community concern	Community stakeholders specific areas of concern	Secondary Data - Focus on South Dakota Report and County Health Rankings	Community resources that are available to address the need
Economics • Employment options 3.73 • Affordable housing availability 3.55 • Maintaining livable and energy efficient homes 3.5	11% of respondents say 'money problems' are a concern	Turner County unemployment 3.2% 9% of county residents indicate they have housing problems (overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities 47% of residents have commutes to work that exceed 30 minutes	Employment resources: • SD Dept. of Labor Job Service Office (Sioux Falls, 45 mi) – 605-367-5300 • SD Works - link • DLR On-the-Job Training Program – 605-773-4133 • Start Today SD Apprenticeship Program - link • Veterans Employment Info – link • Regional Job Search Sources – www.viborgsd.org Low-income apartments: • Village Apartments – 605-326-5464 • Danish Villa Apartments – 605-263-3941 • Meadowland Apartments – 605-271-4663 • Dox Apartments – 605-263-3941 • Washington Square Apartments – 605-263-3941 SD Housing Development Authority (SDHDA) – 605-773-3181 Governor's House Program Southeastern Council – 605-681-8184 Parker Housing and Redevelopment Commission – (Parker, 19 mi) – 605-297-4918

Identified community concern	Community stakeholders specific areas of concern	Secondary Data - Focus on South Dakota Report and County Health Rankings	Community resources that are available to address the need
Children and Youth • Bullying 3.5 • Cost 3.5 and availability 3.4 of quality child care	Stakeholders also raised up lack of youth-adult mentoring opportunities as a concern	14.2% have 3 or more ACEs (Adverse Childhood Experiences – physical/sexual/emotional abuse, mental illness of a household member, alcoholism of a household member, drug use by a household member, divorce/separation of a parent, domestic violence towards a parent, incarceration of a household member) 3.6% have 5 or more ACEs 12% of children live in poverty	Bullying / at-risk youth resources: • Turner Co. Sheriff - 605-297-3225 • Police – 605-766-6600 • Viborg Hurley Schools - 605-766-5418 • Child Protective Services (Vermillion, 34 mi) -605-677-6800 • Big Brothers Big Sisters (Sioux Falls, 45 mi) – 605-334-1632 Childcare resources: • SD Department of Social Services, Child Care Services – 800-227-3020 • Childcare Helpline – 605-339-4357 • Parker Learning Center (Parker, 17 mi) – 605-297-3456 • Hurley Daycare – Before & After School Program (Hurley, 8 mi) – 605-238-5221 • Viborg Summer Recreation Program – 605-326-5103
Healthcare and Wellness • Access to affordable health insurance 3.89 • Availability of mental health providers 3.88	8% of respondents do not have any type of health insurance coverage Approximately 47% felt down, depressed, hopeless, or had little interest or pleasure in doing things several days or more over the previous two weeks	13.2% report unmet medical needs 7.6% report unmet prescription needs 49.3% report unmet mental health needs 20.2% of Turner County residents report having depression, anxiety, PTSD, bipolar, OR addiction issues	Insurance resources: • Parson's Insurance 605-326-5358 • Healthcare.gov – 800-318-2596 • Falls Community Health – 605-978-6890 • Community Healthcare Association of the Dakotas – 605-275-2423 – or link SD DHS Prescription Assistance Program 605-773-3656 SD Medicaid / DSS – 800-305-3064 Viborg Clinic – 605-326-5201

Identified community concern	Community stakeholders specific areas of concern	Secondary Data - Focus on South Dakota Report and County Health Rankings	Community resources that are available to address the need
			Behavioral health resources: • NAMI SD (Sioux Falls, 45 mi) – 605-271-1871 • SD Human Services Center (Yankton, 36 mi) – 605-665-3100 • Southeastern Behavioral Health (Sioux Falls, 45 mi) - 605-336-0510 • Pioneer Memorial Hospital 605-326-5161 • SD Division of Behavioral Health – 605-367-5236
Aging population • Cost of LTC 4.10 • Cost of memory care 4.10 • Availability of resources for family and friends caring for and helping to make decisions for elders 3.7 • Cost of in-home services 3.56 • Help making out a will or health care directive 3.5		26% are 65 years or older 11% of county residents are uninsured	LTC Resources: • Pioneer Memorial Nursing Home – 605-326-5161 • Pioneer Inn (assisted living) • Pioneer Villa (congregate housing.) • Pioneer Haven (memory care) • Evergreen Assisted Living Center Sanford home medical equipment: • Canton SD – 605-987-0061 • Vermillion SD – 605-624-4955 Sanford Visiting Nurse Association (Vermillion, 34 mi) – 605-624-2611 SD Long-Term Services and Supports Office – (Vermillion, 34 mi) - 605-677-6800 SD DHS Prescription Assistance Program 605-773-3656 Senior Center (Parker, 17mi) – 605-297-0176 Insurance resources: • Parson's Insurance 605-326-5358

Identified community concern	Community stakeholders specific areas of concern	Secondary Data - Focus on South Dakota Report and County Health Rankings	Community resources that are available to address the need
			• SD Medicaid / DSS – 800-305-3064 Legal resources: • East River Legal Services (Sioux Falls, 43 mi) – 605-336-9230 • Dakota Plains Legal Services (Sioux Falls, 43 mi) – 605-698-3971 • SD Legal Self-Help - link
Mental Health/ Behavioral Health • Depression 3.13 • Alcohol use and abuse 3.00	31% of survey respondents indicated alcohol has had a harmful effect on themselves or a family member in the past two years Approximately 47% felt down, depressed, hopeless, or had little interest or pleasure in doing things several days or more over the past two weeks	12.4% have depression 9.9% have anxiety 6.2% deal with PTSD 1.4% are bipolar 35.6% have abused alcohol	Substance Abuse resources: • AA – 605-326-5479 • SD Human Service Center Adolescent Dependency Program (Yankton) 605-668-3315 • Gateway CD Treatment Center (Yankton) 605-668-3218 Mental Health resources: • Viborg Clinic – 605-326-5201 • Pioneer Memorial Hospital 605-326-5161 • Heartland Psychological Services (Yankton, 37mi.) 605-665-0841 • Human Service Center (Yankton, 37 mi.) 605-668-3100 • Lewis & Clark Behavioral Health (Yankton, 37 mi) 605-665-4606 • Collective Perspective Counseling (Beresford, 21 mi.) 605-321-0826

Viborg Pioneer Memorial Hospital and Health Services
2019 Community Health Needs Assessment Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote
Economics • Employment options 3.73 • Affordable housing availability 3.55 • Maintaining livable and energy efficient homes 3.5		
Children and Youth • Bullying 3.5 • Cost 3.5 and availability 3.4 of quality child care		
Health Care and Wellness • Access to affordable health insurance 3.89 • Availability of mental health providers 3.88		
Aging Population • Cost of LTC 4.10 • Cost of memory care 4.10 • Availability of resources for family and friends caring for and helping to make decisions for elders 3.7 • Cost of in-home services 3.56 • Help making out a will or health care directive 3.5	Voted #1 Priority	
Mental Health • Depression 3.13 • Alcohol use and abuse 3.00	Voted #2 Priority	

Pioneer Memorial
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Community Health Needs Assessment

Results from a non-generalizable online survey

December 2017 and January 2018

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an online survey of community leaders and key stakeholders identified by Pioneer Memorial Hospital & Health System. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. **Therefore, it is important to note that the data in this report are not generalizable to the community.** A total of 11 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

Current State of Health and Wellness Issues in 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

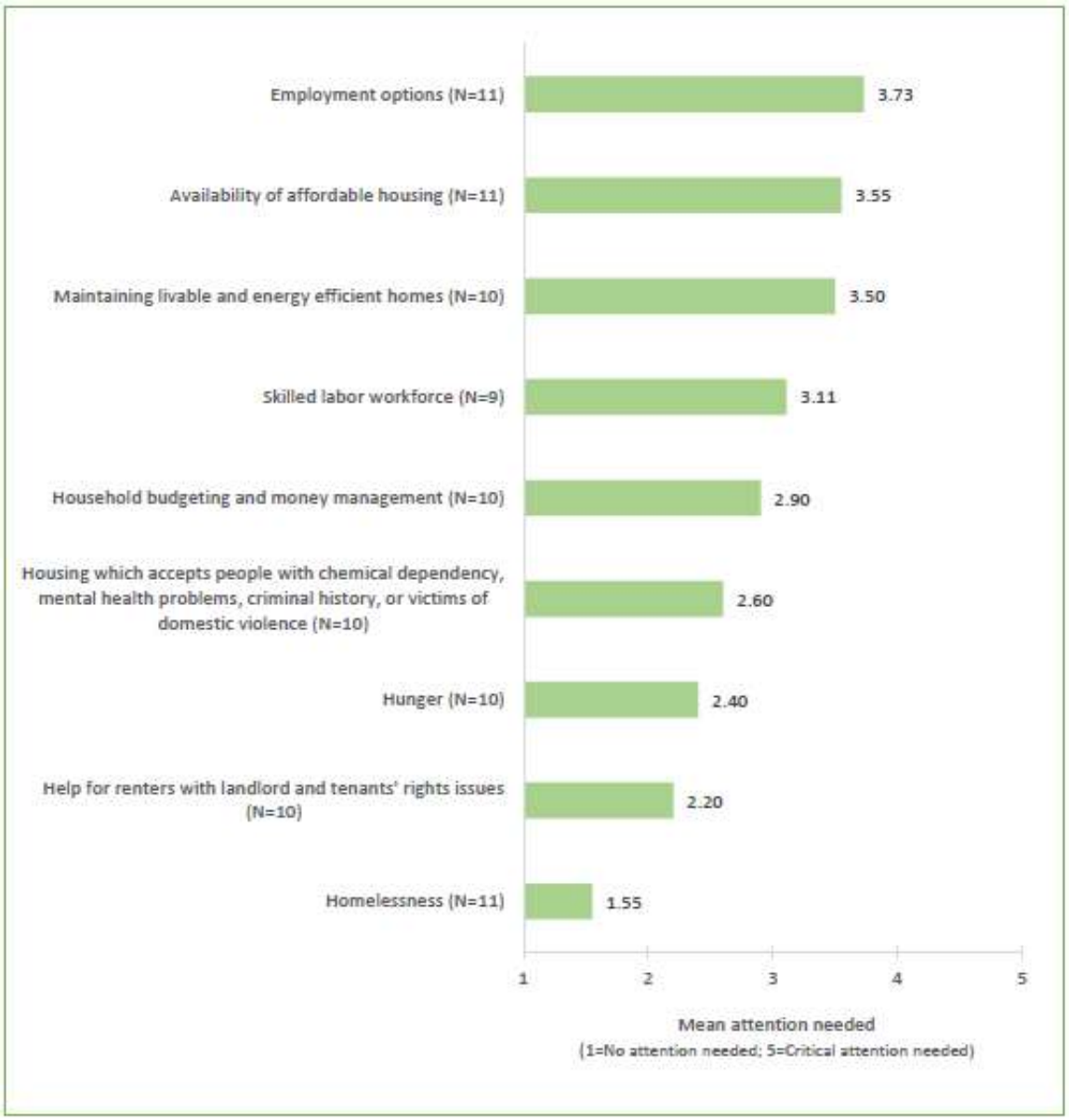


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

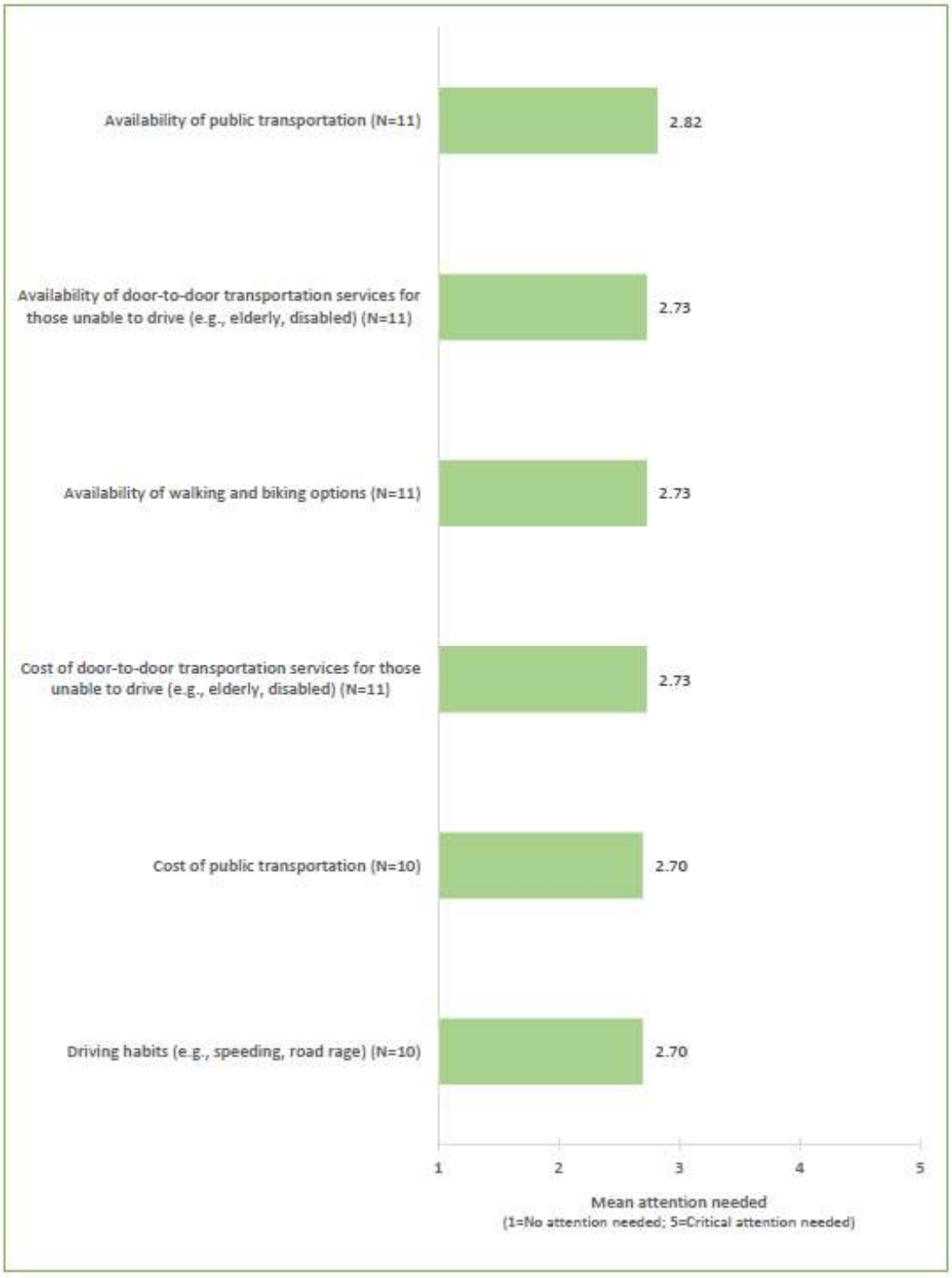


Figure 3. Level of concern with statements about the community regarding CHILDREN AND YOUTH

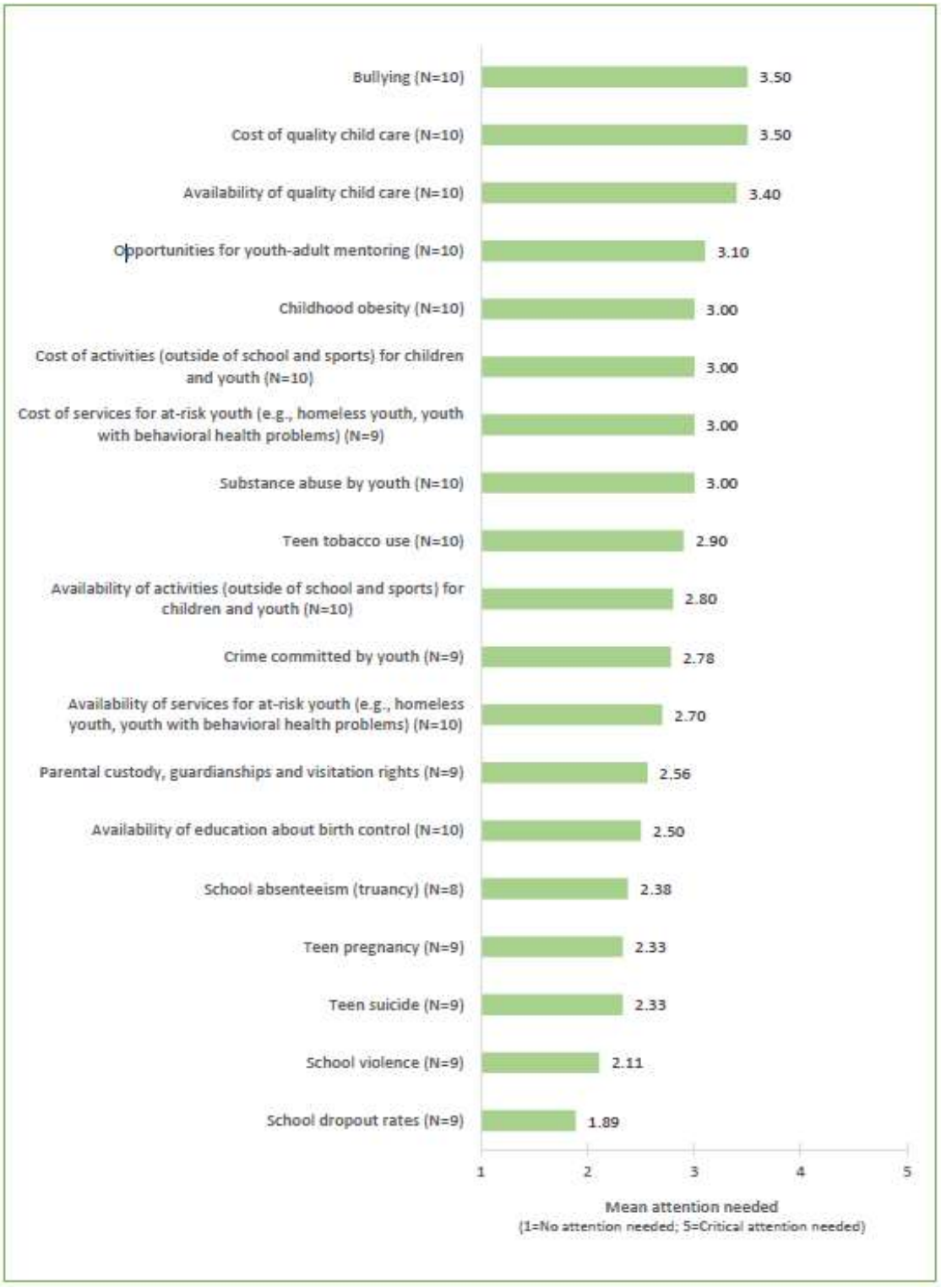


Figure 4. Current state of community issues regarding the AGING POPULATION

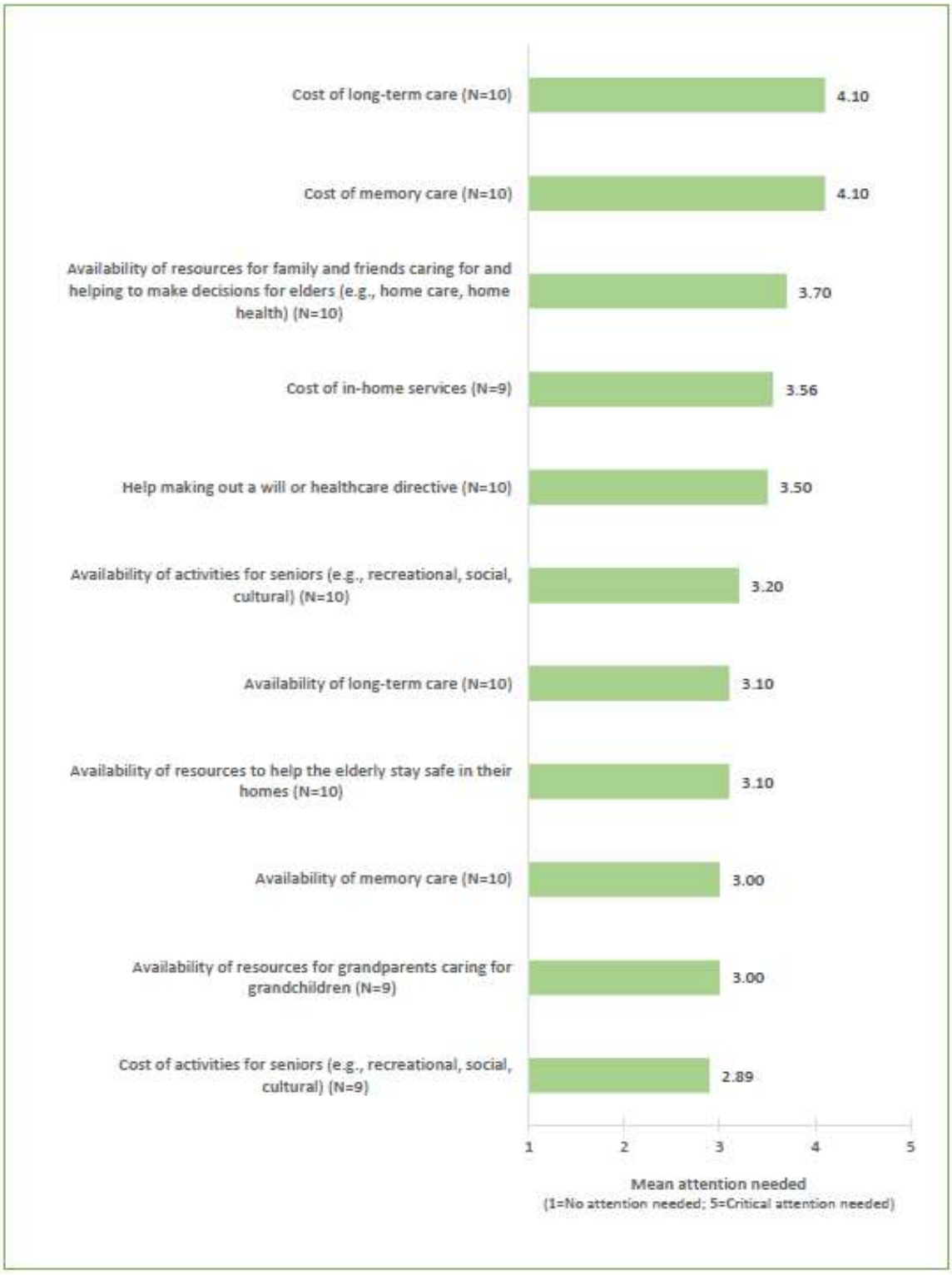


Figure 5. Current state of community issues regarding SAFETY

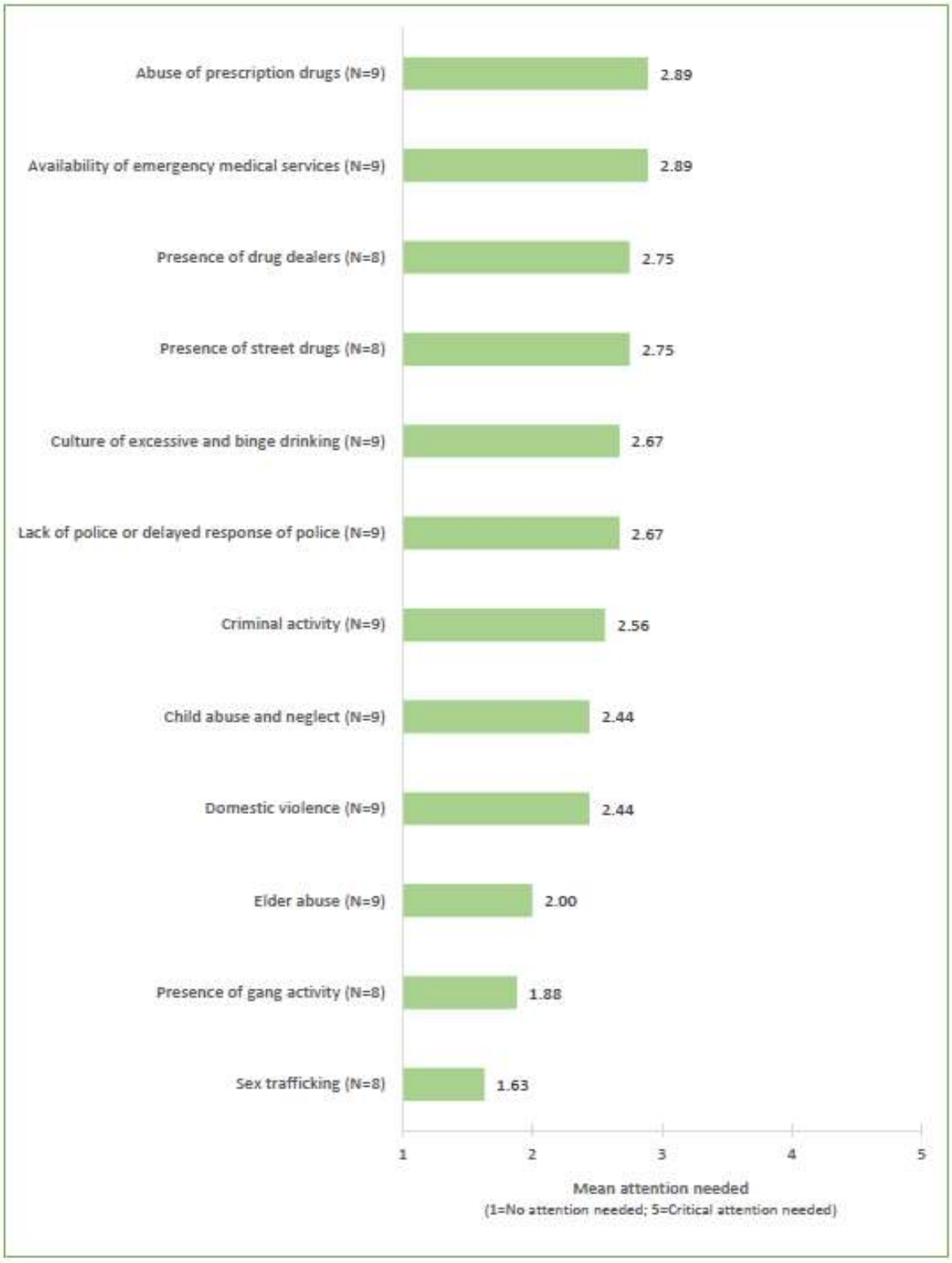
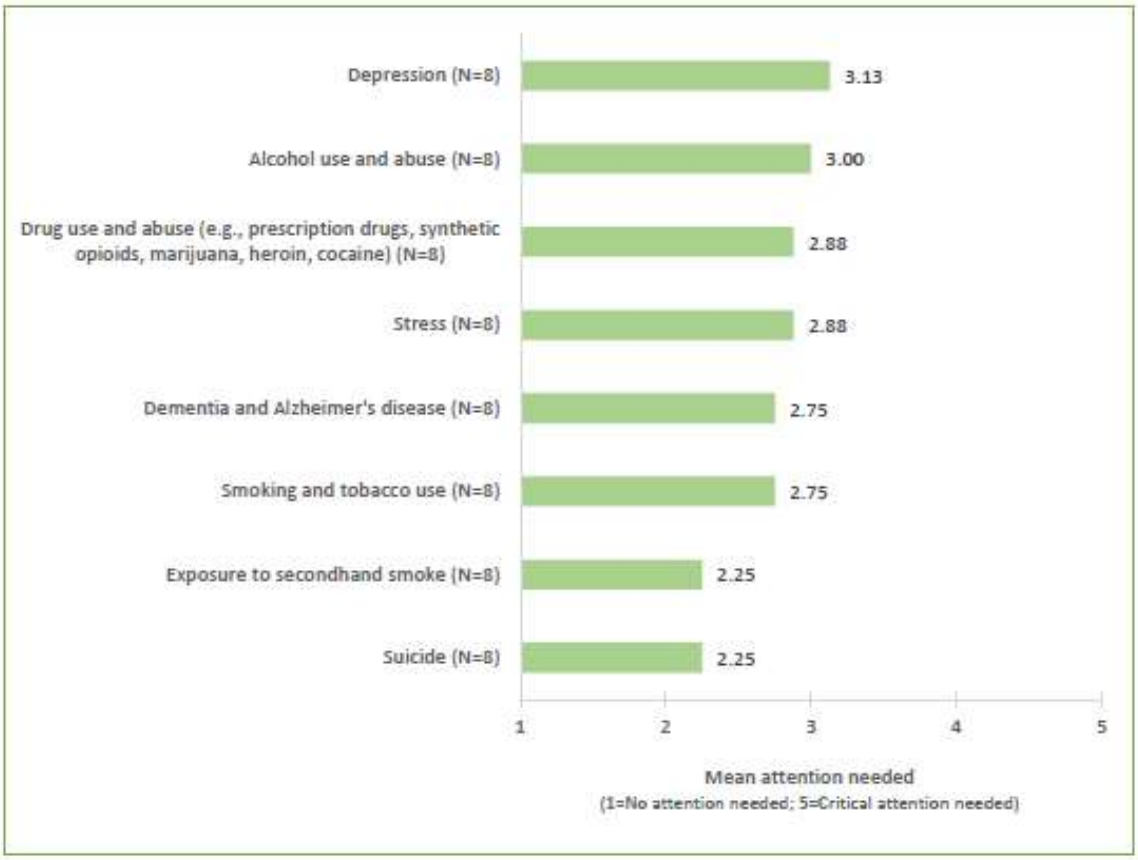


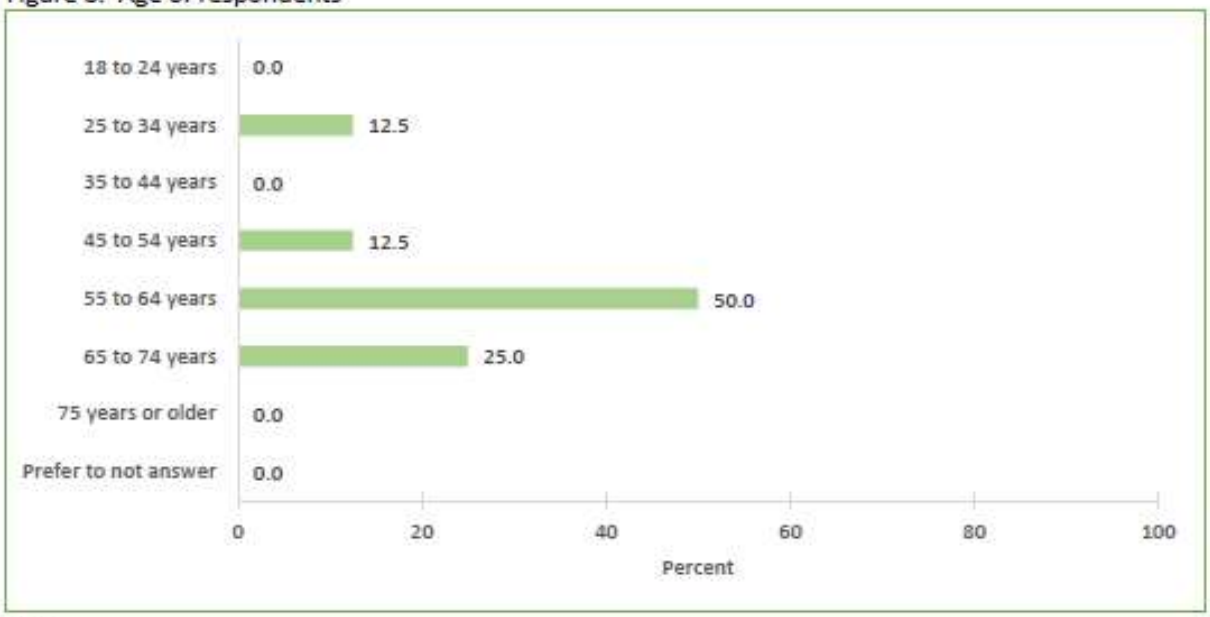
Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

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



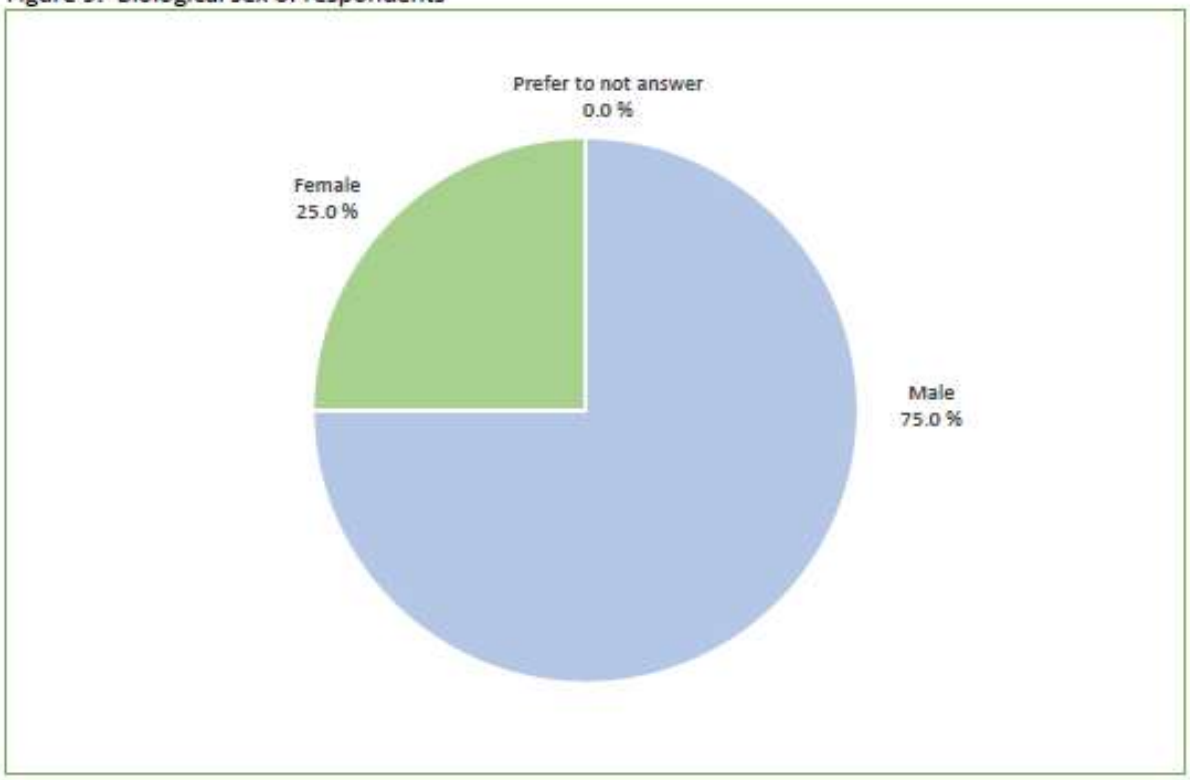
Demographics

Figure 8. Age of respondents



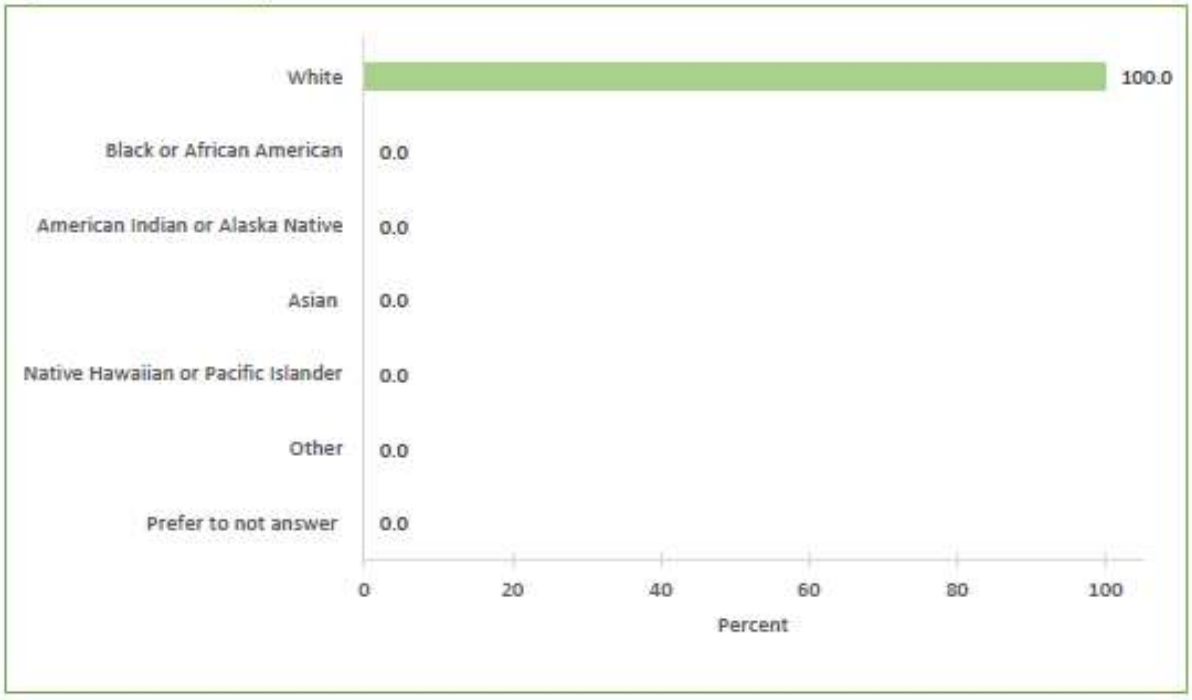
N=8

Figure 9. Biological sex of respondents



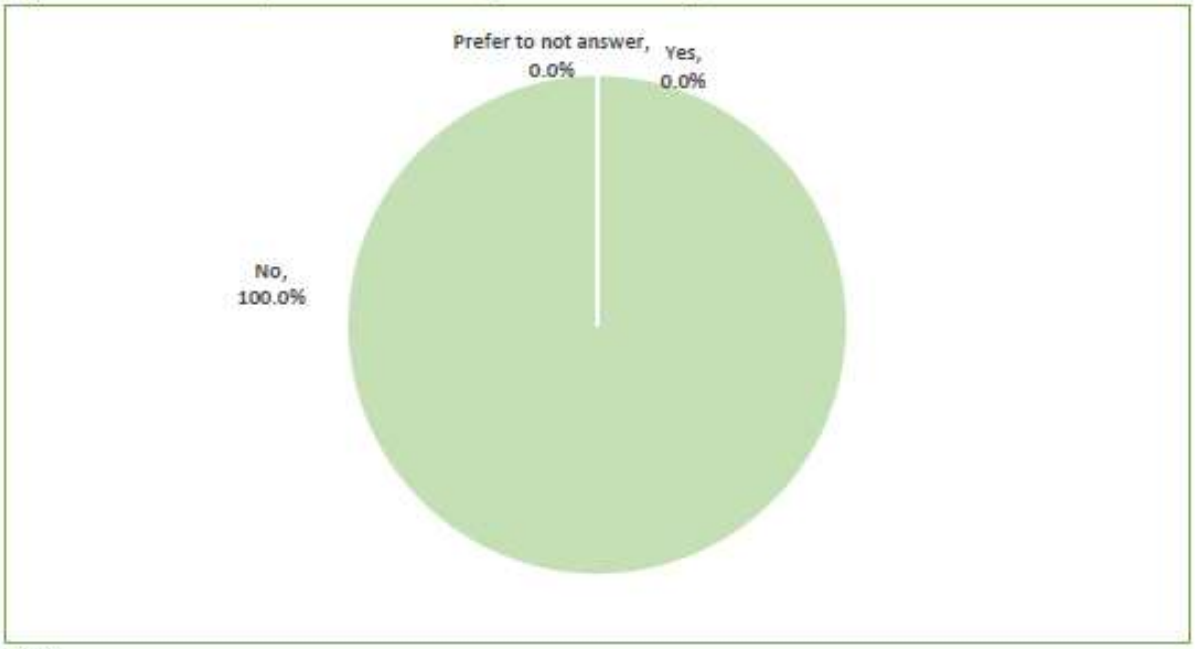
N=8

Figure 10. Race of respondents



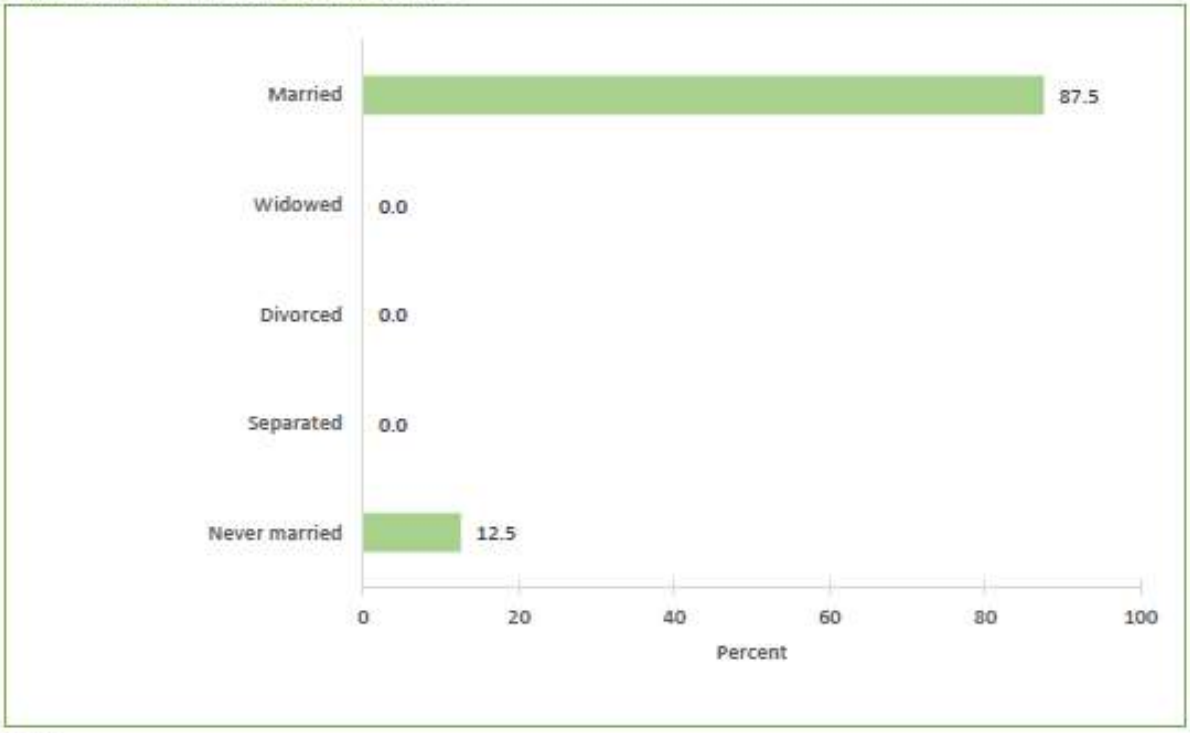
N=8

Figure 11. Whether respondents are of Hispanic or Latino origin



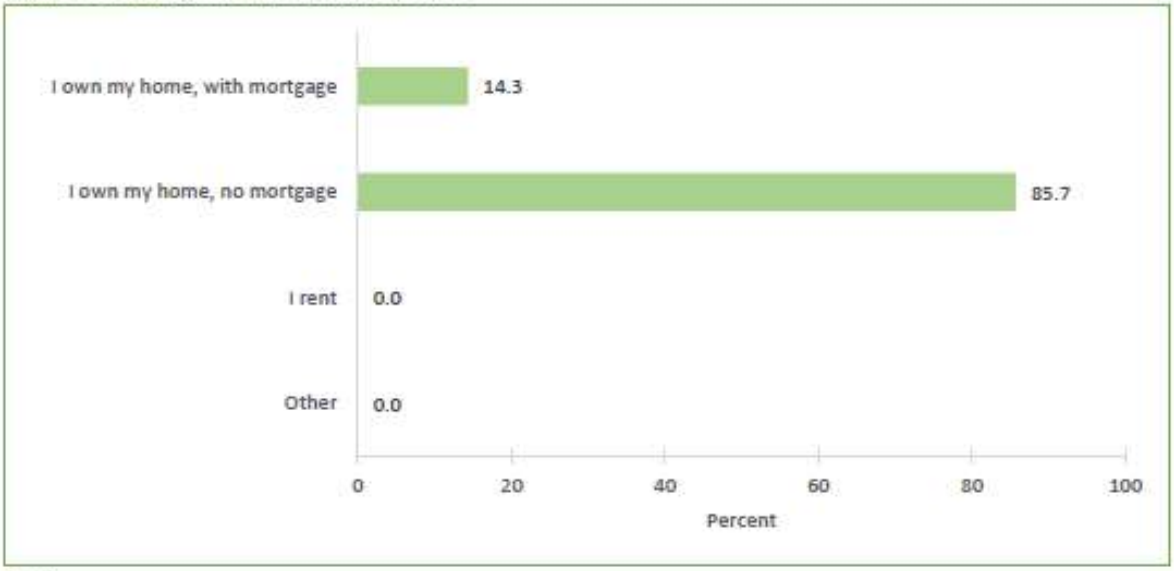
N=8

Figure 12. Marital status of respondents



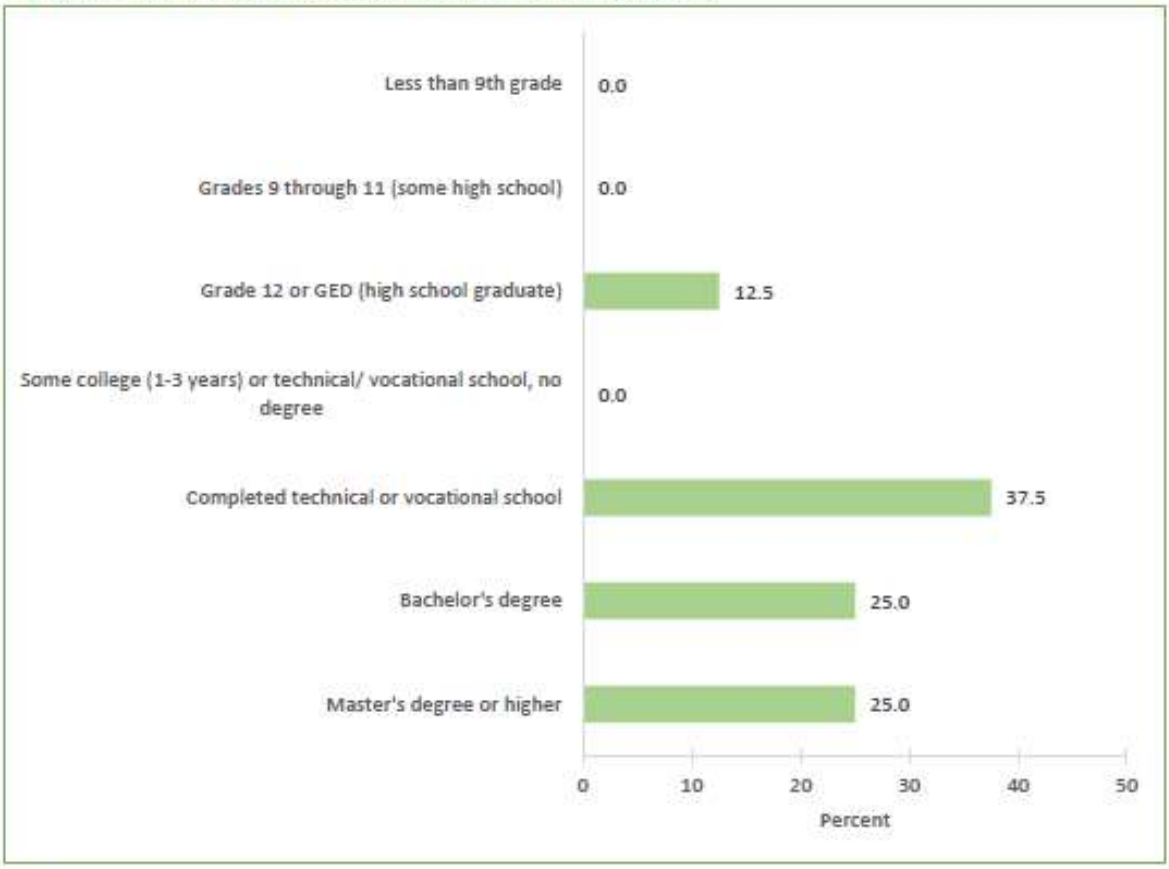
N=8

Figure 13. Living situation of respondents



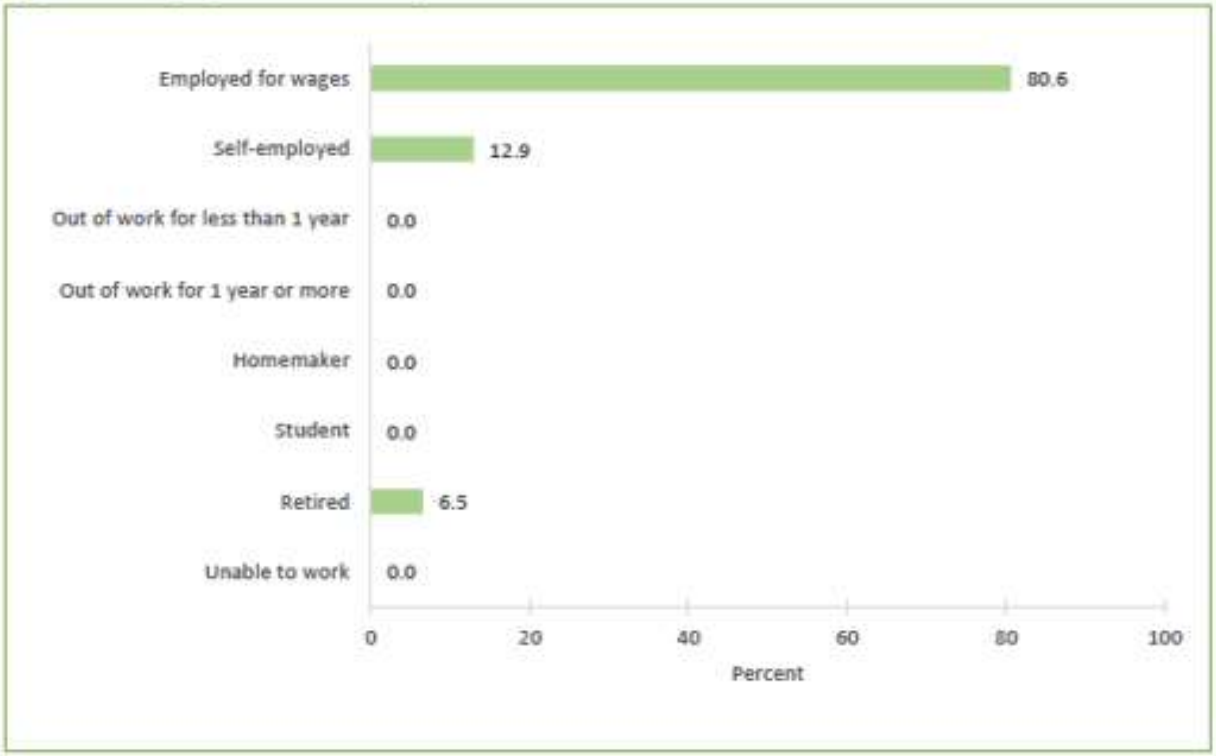
N=7

Figure 14. Highest level of education completed by respondents



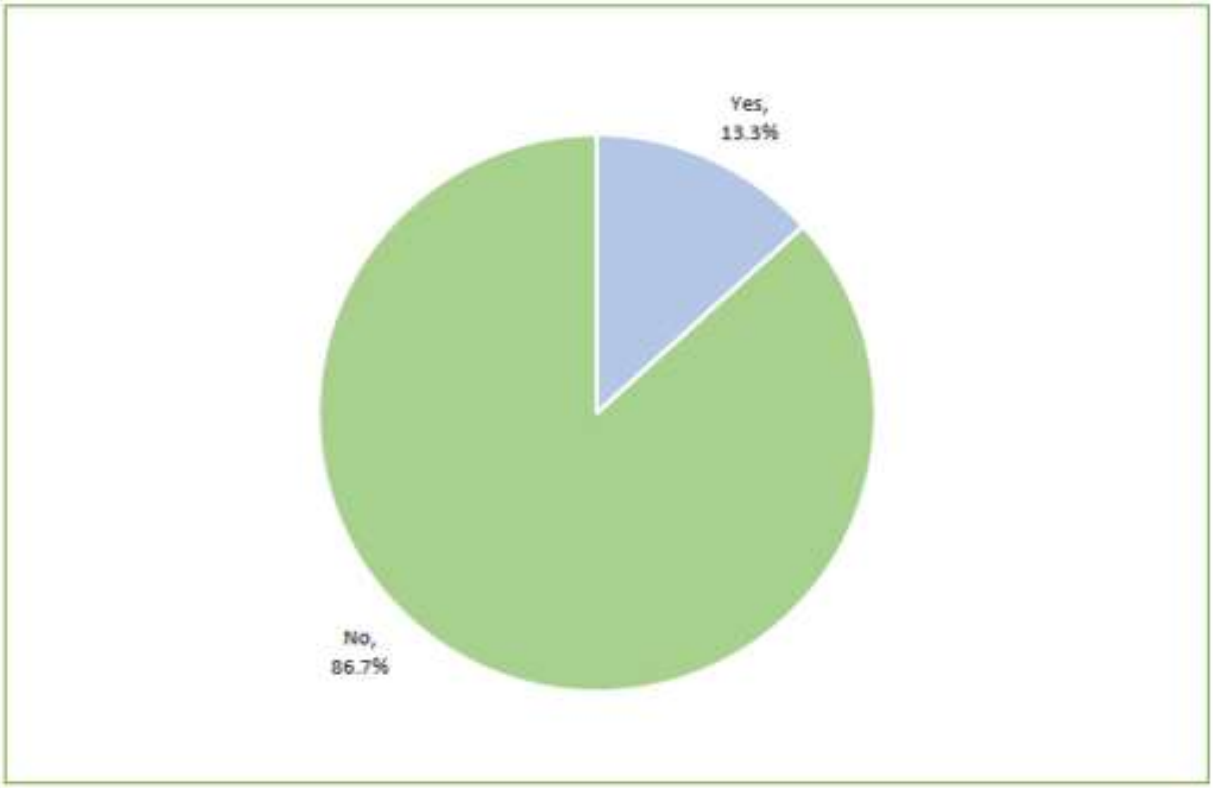
N=8

Figure 15. Employment status of respondents



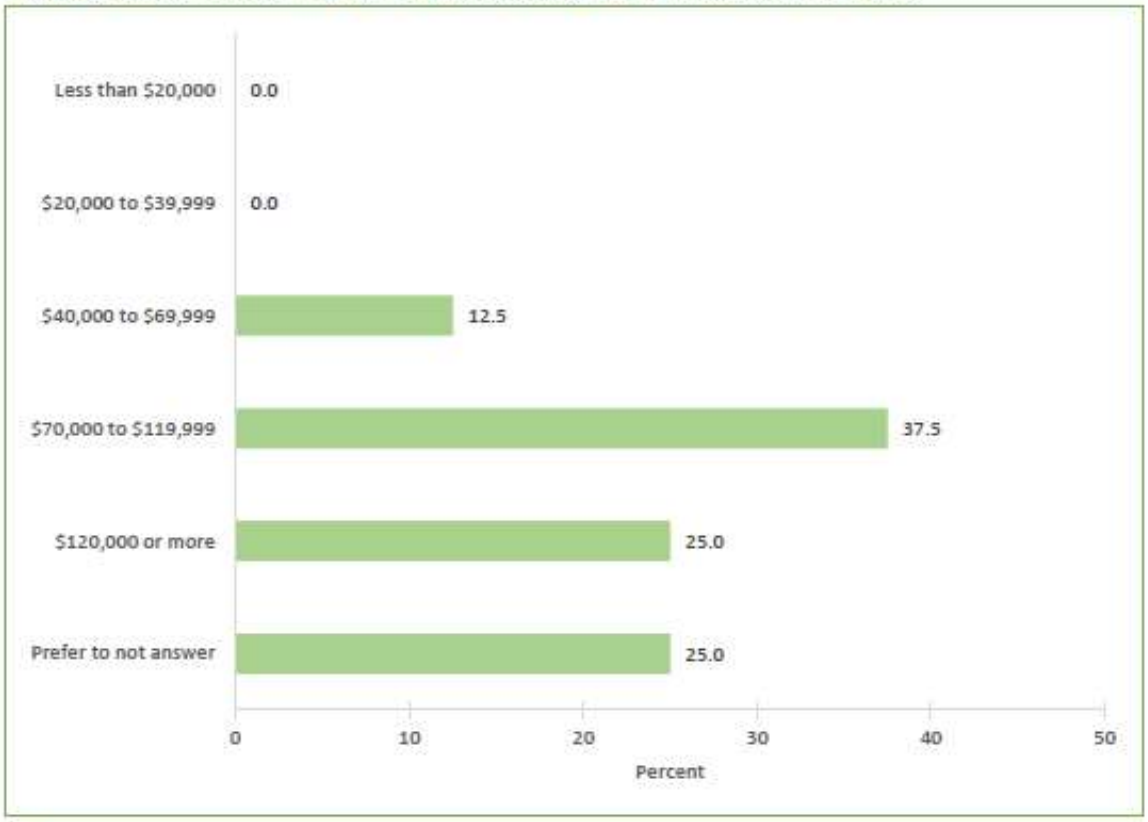
N=31

Figure 16. Whether respondents are military veterans



N=30

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



N=8

Table 1. Zip code of respondents

Zip code	Number of respondents
57070	4
57053	3
57014	1

N=8

Comments from respondents

Comments
There were no additional comments reported.

APPENDIX TABLE

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

Statements	Mean**	Percent of respondents*						Total
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=11)	3.55	0.0	9.1	36.4	45.5	9.1	0.0	100.1
Employment options (N=11)	3.73	0.0	0.0	54.5	18.2	27.3	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=11)	2.20	18.2	45.5	18.2	9.1	0.0	9.1	100.1
Homelessness (N=11)	1.55	45.5	54.5	0.0	0.0	0.0	0.0	100.0
Housing which accepts people with chemical dependency, mental health problems, criminal history, or victims of domestic violence (N=11)	2.60	0.0	54.5	18.2	18.2	0.0	9.1	100.0
Household budgeting and money management (N=11)	2.90	0.0	36.4	27.3	27.3	0.0	9.1	100.1
Hunger (N=11)	2.40	0.0	54.5	36.4	0.0	0.0	9.1	100.0
Maintaining livable and energy efficient homes (N=11)	3.50	0.0	9.1	36.4	36.4	9.1	9.1	100.1
Skilled labor workforce (N=11)	3.11	0.0	0.0	72.7	9.1	0.0	18.2	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=11)	2.73	0.0	36.4	54.5	9.1	0.0	0.0	100.0
Availability of public transportation (N=11)	2.82	0.0	27.3	63.6	9.1	0.0	0.0	100.0
Availability of walking and biking options (N=11)	2.73	18.2	36.4	9.1	27.3	9.1	0.0	100.1
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=11)	2.73	0.0	27.3	72.7	0.0	0.0	0.0	100.0
Cost of public transportation (N=11)	2.70	0.0	27.3	63.6	0.0	0.0	9.1	100.0
Driving habits (e.g., speeding, road rage) (N=11)	2.70	9.1	27.3	36.4	18.2	0.0	9.1	100.1
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=10)	2.80	10.0	30.0	30.0	30.0	0.0	0.0	100.0
Availability of education about birth control (N=10)	2.50	20.0	50.0	0.0	20.0	10.0	0.0	100.0
Availability of quality child care (N=10)	3.40	0.0	20.0	40.0	20.0	20.0	0.0	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=10)	2.70	0.0	60.0	20.0	10.0	10.0	0.0	100.0
Bullying (N=10)	3.50	0.0	20.0	30.0	30.0	20.0	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Childhood obesity (N=10)	3.00	0.0	20.0	60.0	20.0	0.0	0.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=10)	3.00	0.0	30.0	50.0	10.0	10.0	0.0	100.0
Cost of quality child care (N=10)	3.50	0.0	0.0	60.0	30.0	10.0	0.0	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=9)	3.00	0.0	33.3	44.4	11.1	11.1	0.0	99.9
Crime committed by youth (N=10)	2.78	0.0	40.0	30.0	20.0	0.0	10.0	100.0
Opportunities for youth-adult mentoring (N=10)	3.10	0.0	10.0	70.0	20.0	0.0	0.0	100.1
Parental custody, guardianships and visitation rights (N=10)	2.56	10.0	40.0	30.0	0.0	10.0	10.0	100.0
School absenteeism (truancy) (N=9)	2.38	22.2	22.2	33.3	11.1	0.0	11.1	99.9
School dropout rates (N=10)	1.89	20.0	60.0	10.0	0.0	0.0	10.0	100.0
School violence (N=9)	2.11	11.1	77.8	0.0	11.1	0.0	0.0	100.0
Substance abuse by youth (N=10)	3.00	10.0	20.0	40.0	20.0	10.0	0.0	100.0
Teen pregnancy (N=10)	2.33	10.0	50.0	20.0	10.0	0.0	10.0	100.0
Teen suicide (N=9)	2.33	11.1	66.7	11.1	0.0	11.1	0.0	100.0
Teen tobacco use (N=10)	2.90	0.0	40.0	40.0	10.0	10.0	0.0	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=10)	3.20	0.0	20.0	60.0	0.0	20.0	0.0	100.0
Availability of long-term care (N=10)	3.10	10.0	30.0	20.0	20.0	20.0	0.0	100.0
Availability of memory care (N=10)	3.00	10.0	30.0	30.0	10.0	20.0	0.0	100.0
Availability of resources for family and friends caring for and helping to make decisions for elders (e.g., home care, home health) (N=10)	3.70	0.0	10.0	50.0	0.0	40.0	0.0	100.0
Availability of resources for grandparents caring for grandchildren (N=9)	3.00	11.1	44.4	11.1	0.0	33.3	0.0	99.9
Availability of resources to help the elderly stay safe in their homes (N=10)	3.10	0.0	40.0	20.0	30.0	10.0	0.0	100.0
Cost of activities for seniors (e.g., recreational, social, cultural) (N=9)	2.89	11.1	22.2	44.4	11.1	11.1	0.0	99.9
Cost of in-home services (N=9)	3.56	0.0	22.2	33.3	11.1	33.3	0.0	99.9
Cost of long-term care (N=10)	4.10	0.0	0.0	30.0	30.0	40.0	0.0	100.0
Cost of memory care (N=10)	4.10	0.0	0.0	30.0	30.0	40.0	0.0	100.0
Help making out a will or healthcare directive (N=10)	3.50	0.0	10.0	50.0	20.0	20.0	0.0	100.0
SAFETY								
Abuse of prescription drugs (N=9)	2.89	0.0	44.4	22.2	33.3	0.0	0.0	99.9
Availability of emergency medical services (N=9)	2.89	11.1	33.3	22.2	22.2	11.1	0.0	99.9
Child abuse and neglect (N=9)	2.44	0.0	55.6	44.4	0.0	0.0	0.0	100.0
Criminal activity (N=9)	2.56	0.0	55.6	33.3	11.1	0.0	0.0	100.0
Culture of excessive and binge drinking (N=9)	2.67	0.0	55.6	22.2	22.2	0.0	0.0	100.0

Statements	Mean**	Percent of respondents*						
		Level of attention needed						
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Domestic violence (N=9)	2.44	0.0	55.6	44.4	0.0	0.0	0.0	100.0
Elder abuse (N=9)	2.00	22.2	55.6	22.2	0.0	0.0	0.0	100.0
Lack of police or delayed response of police (N=9)	2.67	0.0	55.6	22.2	22.2	0.0	0.0	100.0
Presence of drug dealers (N=8)	2.75	0.0	50.0	25.0	25.0	0.0	0.0	100.0
Presence of gang activity (N=8)	1.88	25.0	62.5	12.5	0.0	0.0	0.0	100.0
Presence of street drugs (N=8)	2.75	12.5	25.0	37.5	25.0	0.0	0.0	100.0
Sex trafficking (N=8)	1.63	37.5	62.5	0.0	0.0	0.0	0.0	100.0
HEALTHCARE AND WELLNESS								
Access to affordable dental insurance coverage (N=9)	3.33	0.0	11.1	55.6	22.2	11.1	0.0	100.0
Access to affordable health insurance coverage (N=9)	3.89	0.0	0.0	33.3	44.4	22.2	0.0	99.9
Access to affordable healthcare (N=9)	3.33	0.0	11.1	55.6	22.2	11.1	0.0	100.0
Access to affordable prescription drugs (N=9)	3.22	0.0	22.2	44.4	22.2	11.1	0.0	99.9
Access to affordable vision insurance coverage (N=9)	3.22	0.0	22.2	44.4	22.2	11.1	0.0	99.9
Access to technology for health records and health education (N=9)	2.56	0.0	55.6	33.3	11.1	0.0	0.0	100.0
Availability of behavioral health (e.g., substance abuse) providers (N=9)	3.44	0.0	11.1	55.6	11.1	22.2	0.0	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=9)	3.22	11.1	22.2	33.3	0.0	33.3	0.0	99.9
Availability of healthcare services for Native people (N=8)	2.00	25.0	62.5	0.0	12.5	0.0	0.0	100.0
Availability of healthcare services for New Americans (N=7)	2.00	28.6	57.1	0.0	14.3	0.0	0.0	100.0
Availability of mental health providers (N=8)	3.88	0.0	0.0	37.5	37.5	25.0	0.0	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=8)	3.38	0.0	25.0	37.5	12.5	25.0	0.0	100.0
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=8)	2.88	0.0	37.5	37.5	25.0	0.0	0.0	100.0
Availability of specialist physicians (N=8)	2.88	0.0	25.0	62.5	12.5	0.0	0.0	100.0
Coordination of care between providers and services (N=8)	2.88	12.5	25.0	25.0	37.5	0.0	0.0	100.0
Timely access to medical care providers (N=8)	2.50	12.5	37.5	37.5	12.5	0.0	0.0	100.0
Timely access to dental care providers (N=8)	2.38	12.5	50.0	25.0	12.5	0.0	0.0	100.0
Timely access to vision care providers (N=8)	2.38	12.5	50.0	25.0	12.5	0.0	0.0	100.0
Use of emergency room services for primary healthcare (N=8)	2.75	0.0	37.5	50.0	12.5	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	
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=8)	3.00	0.0	37.5	37.5	12.5	12.5	0.0	100.0
Dementia and Alzheimer's disease (N=8)	2.75	0.0	37.5	50.0	12.5	0.0	0.0	100.0
Depression (N=8)	3.13	0.0	12.5	62.5	25.0	0.0	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=8)	2.88	0.0	37.5	37.5	25.0	0.0	0.0	100.0
Exposure to secondhand smoke (N=8)	2.25	0.0	75.0	25.0	0.0	0.0	0.0	100.0
Smoking and tobacco use (N=8)	2.75	0.0	37.5	50.0	12.5	0.0	0.0	100.0
Stress (N=8)	2.88	0.0	25.0	62.5	12.5	0.0	0.0	100.0
Suicide (N=8)	2.25	0.0	75.0	25.0	0.0	0.0	0.0	100.0

*Percentages may not total 100.0 due to rounding.

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

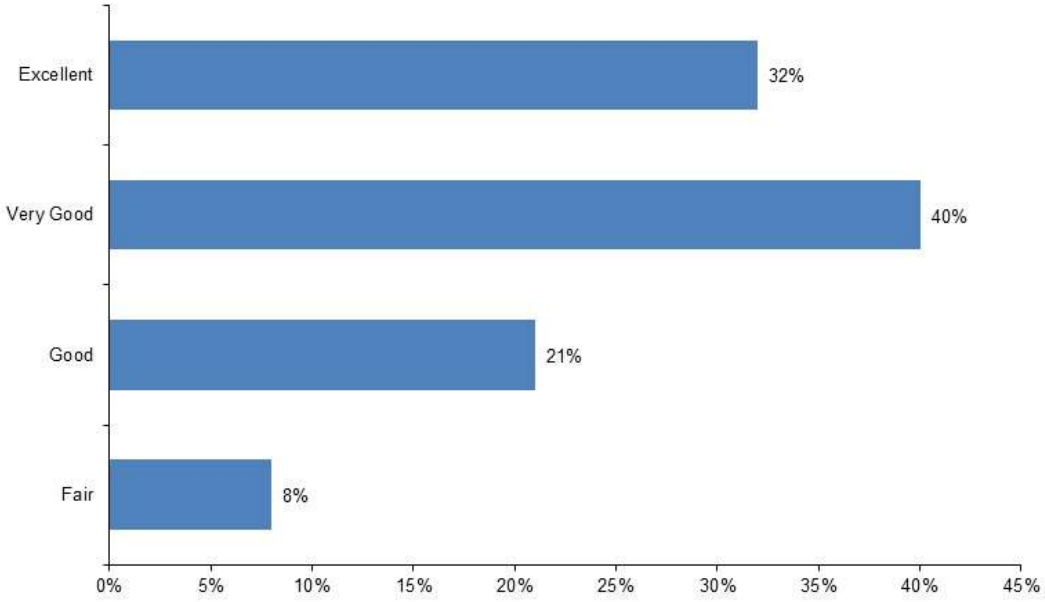
Resident Survey

Viborg CHNA Survey Report

March 08, 2018

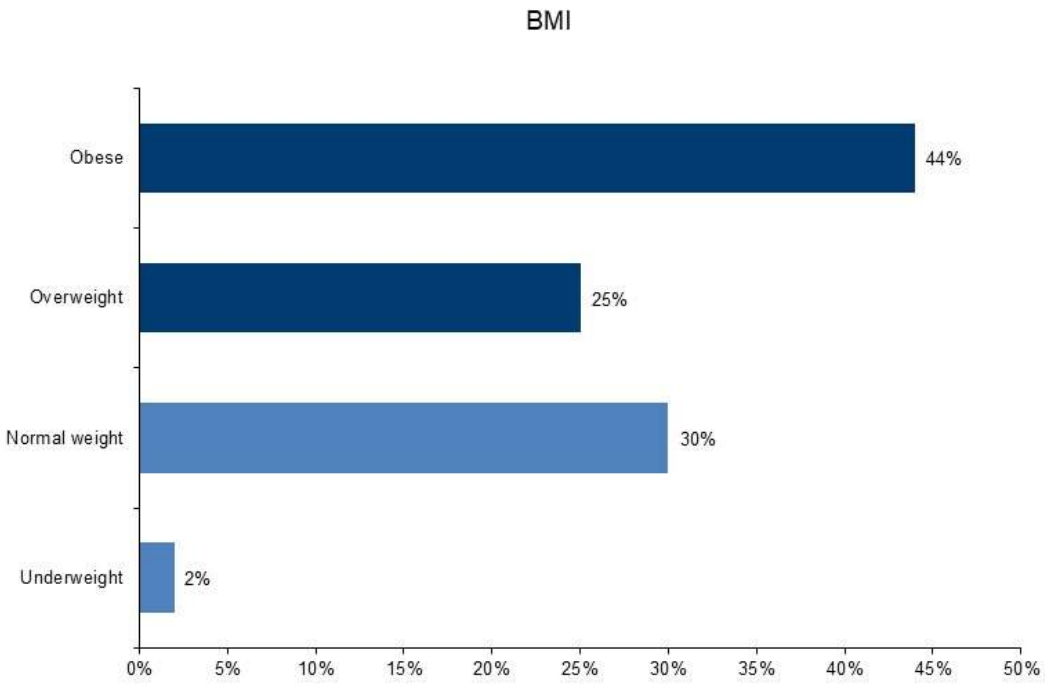
Charts Exported by MarketSight®

How would you rate your health?



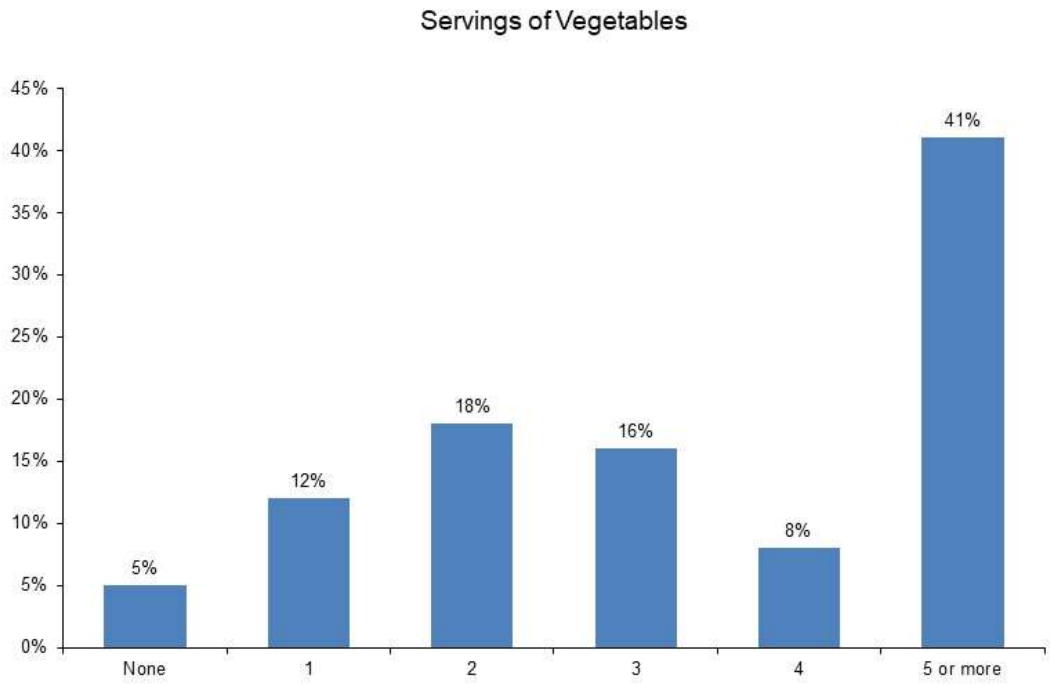
Base: Fair (n=6), Good (n=16), Very Good (n=31), Excellent (n=25), Sample Size = 78

(Community 2 = Turner)



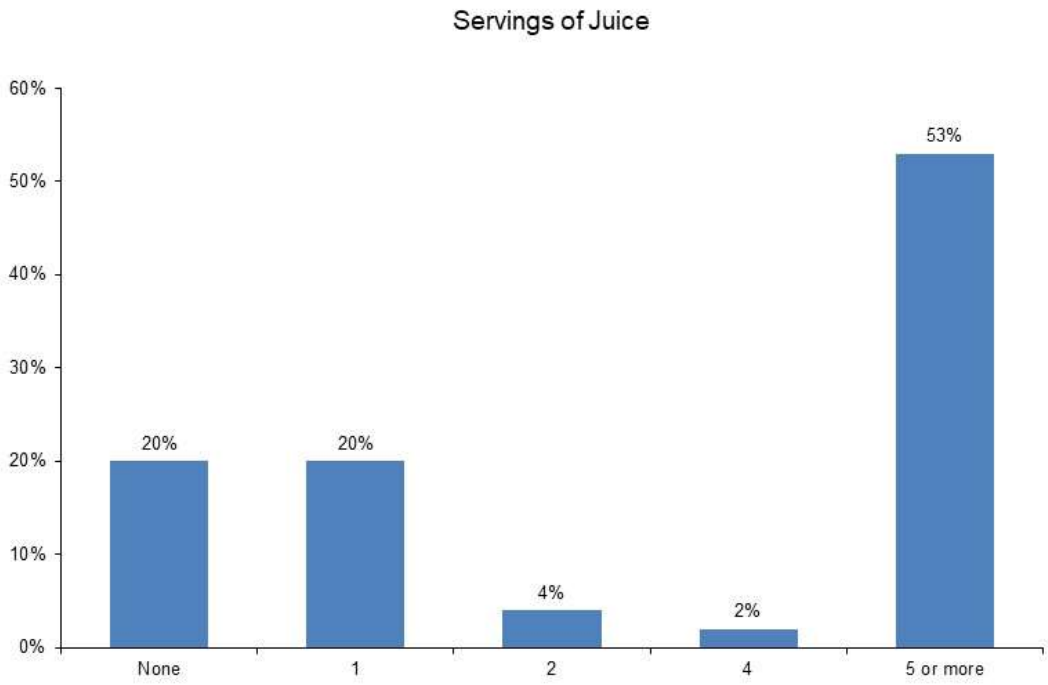
Base: Underweight (n=1), Normal weight (n=18), Overweight (n=15), Obese (n=27), Sample Size = 61

(Community 2 = Turner)



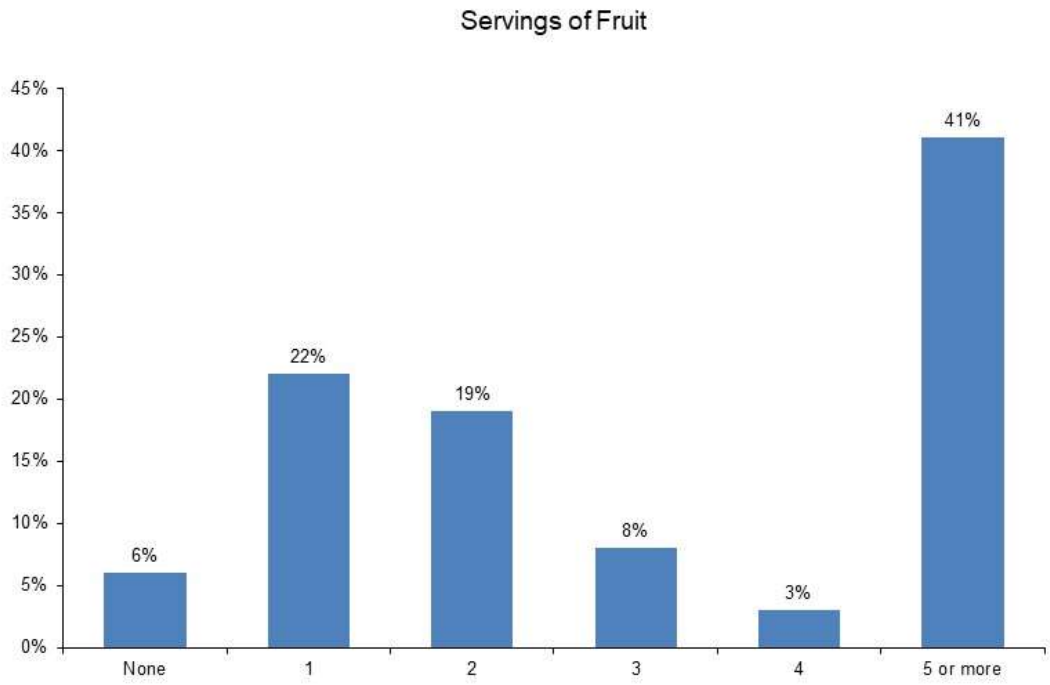
Base: None (n=4), 1 (n=9), 2 (n=13), 3 (n=12), 4 (n=6), 5 or more (n=30), Sample Size = 74

(Community 2 = Turner)



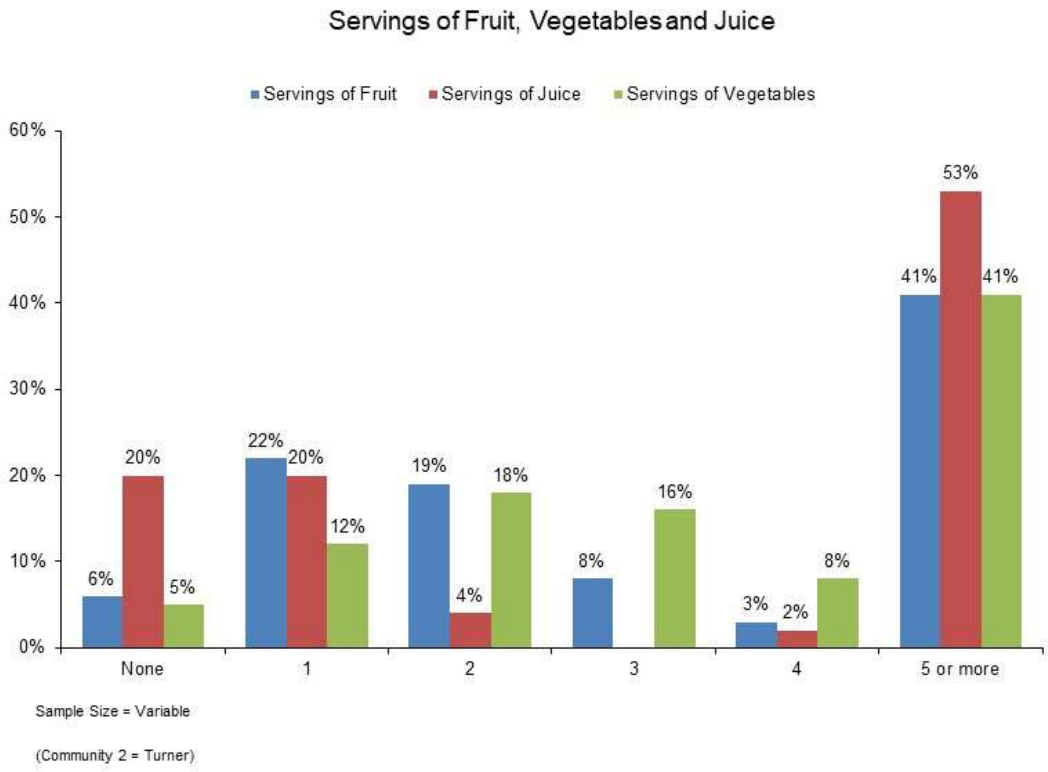
Base: None (n=10), 1 (n=10), 2 (n=2), 4 (n=1), 5 or more (n=26), Sample Size = 49

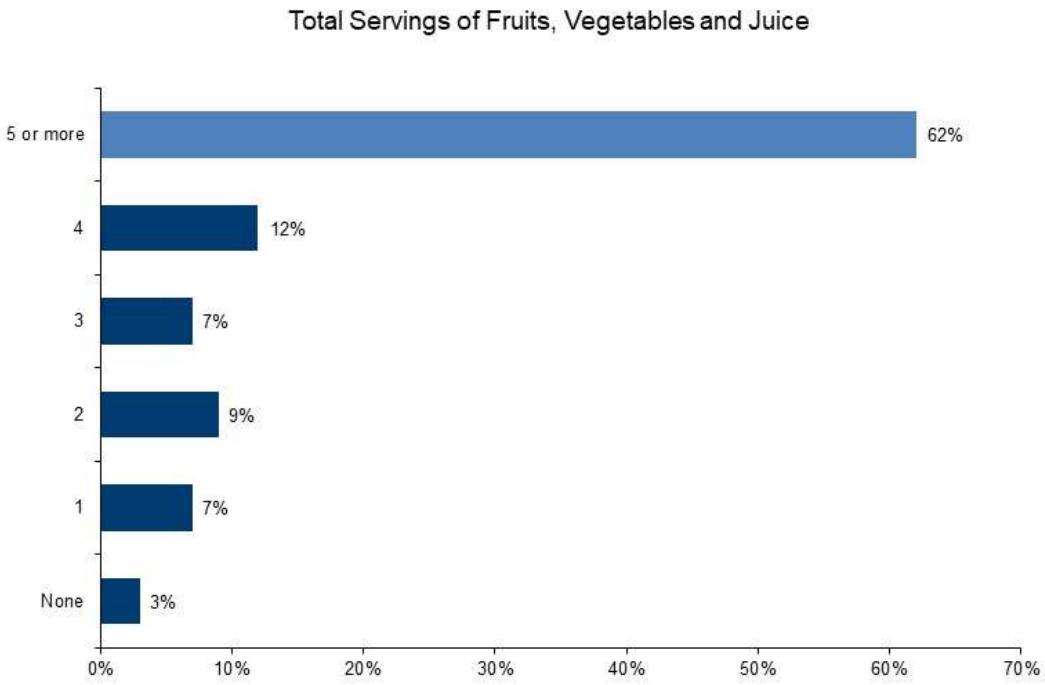
(Community 2 = Turner)



Base: None (n=4), 1 (n=14), 2 (n=12), 3 (n=5), 4 (n=2), 5 or more (n=26), Sample Size = 63

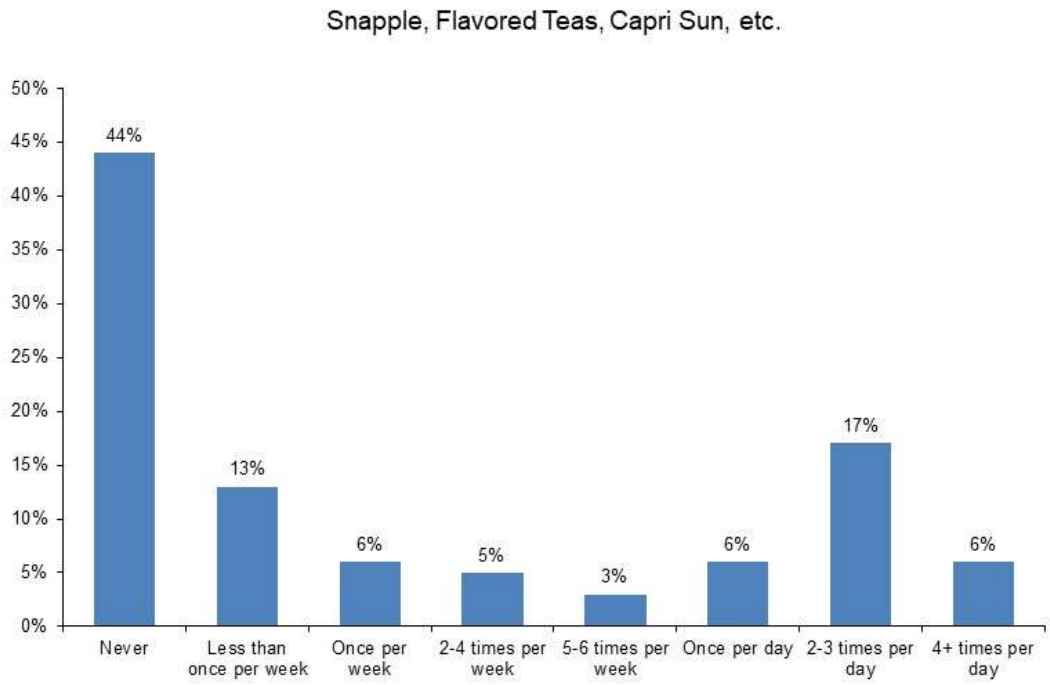
(Community 2 = Turner)


Servings of Fruit, Vegetables and Juice
Servings of Fruit
Servings of Juice
Servings of Vegetables
60%
50%
40%
30%
20%
10%
0%
6%
20%
5%
22%
20%
12%
19%
4%
18%
8%
16%
3%
2%
8%
41%
53%
41%
None
1
2
3
4
5 or more
Sample Size = Variable
(Community 2 = Turner)



Base: None (n=2), 1 (n=5), 2 (n=7), 3 (n=5), 4 (n=9), 5 or more (n=46), Sample Size = 74

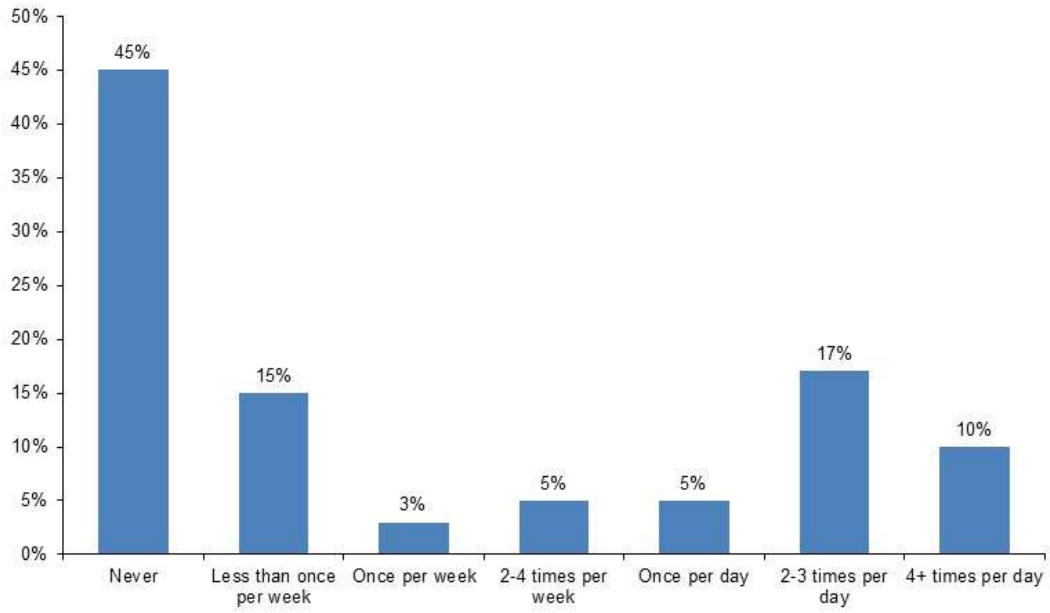
(Community 2 = Turner)



Base: Never (n=34), Less than once per week (n=10), Once per week (n=5), 2-4 times per week (n=4), 5-6 times per week (n=2), Once per day (n=5), 2-3 times per day (n=13), 4+ times per day (n=5), Sample Size = 78

(Community 2 = Turner)

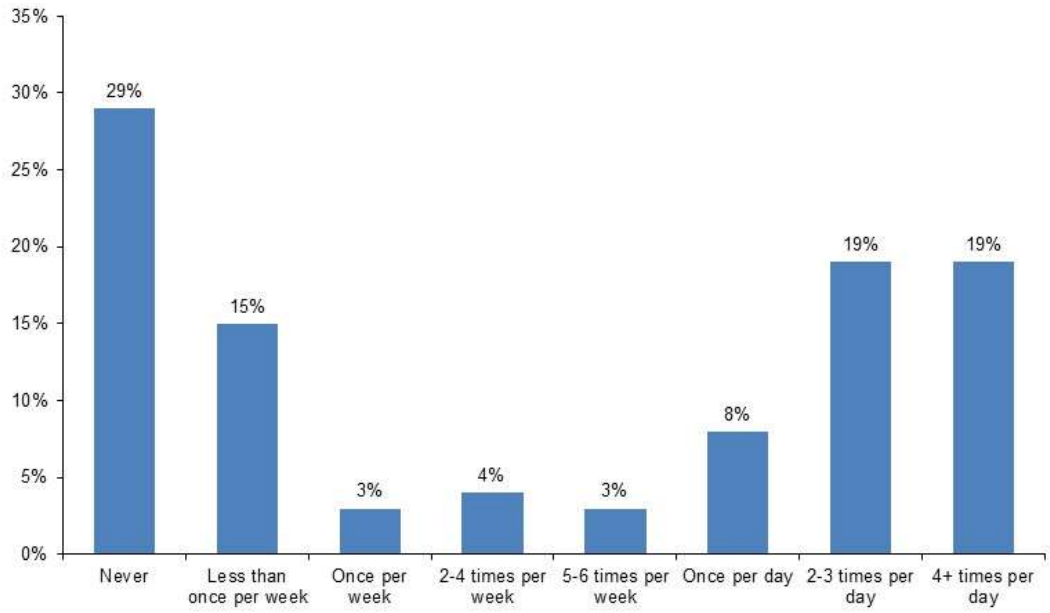
Gatorade, Powerade, etc.



Base: Never (n=35), Less than once per week (n=12), Once per week (n=2), 2-4 times per week (n=4), Once per day (n=4), 2-3 times per day (n=13), 4+ times per day (n=8), Sample Size = 78

(Community 2 = Turner)

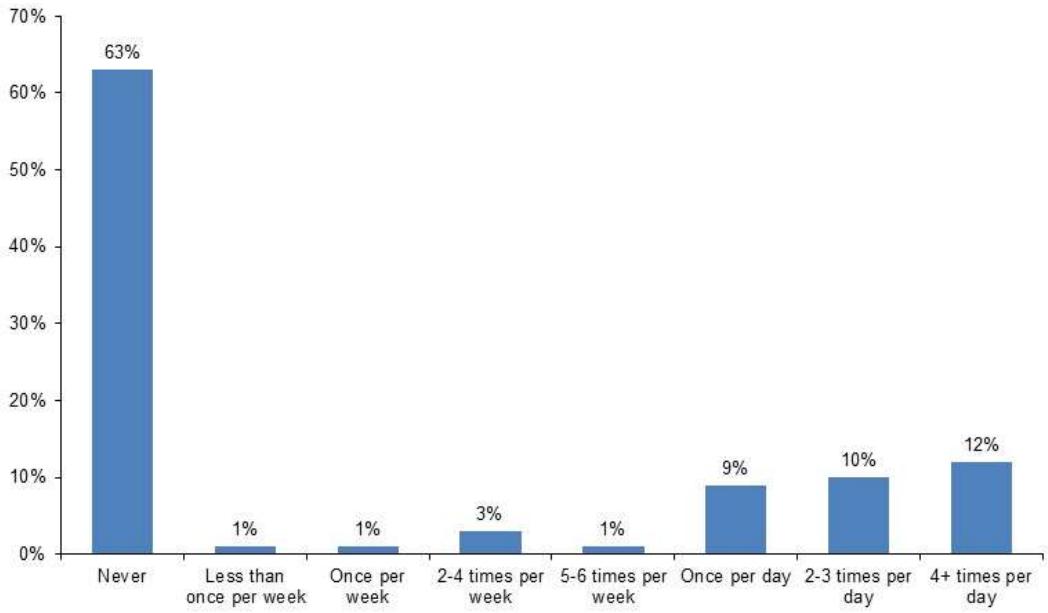
Soda or Pop



Base: Never (n=23), Less than once per week (n=12), Once per week (n=2), 2-4 times per week (n=3), 5-6 times per week (n=2), Once per day (n=6), 2-3 times per day (n=15), 4+ times per day (n=15), Sample Size = 78

(Community 2 = Turner)

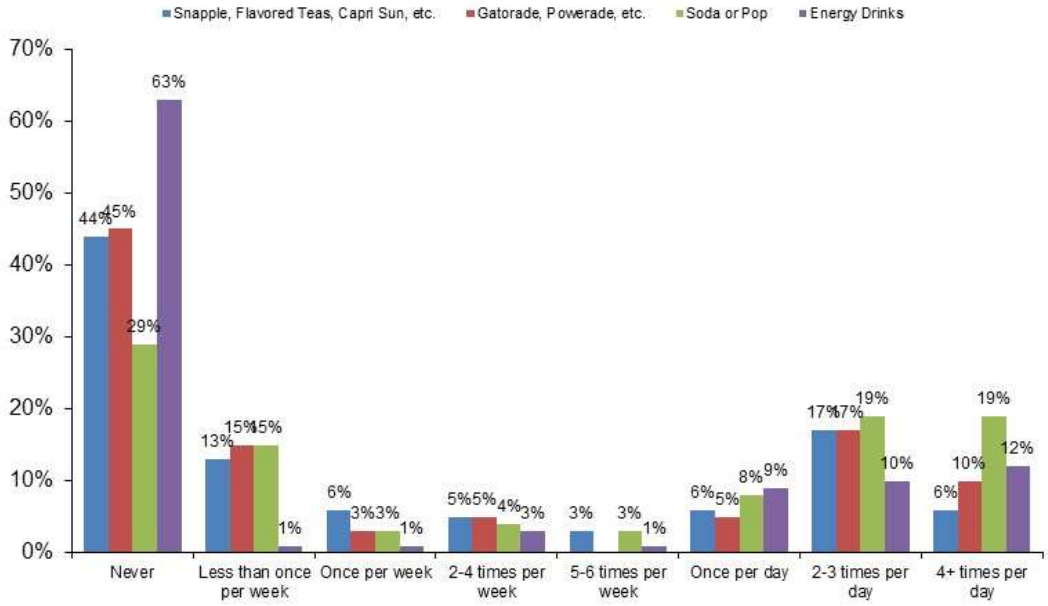
Energy Drinks



Base: Never (n=49), Less than once per week (n=1), Once per week (n=1), 2-4 times per week (n=2), 5-6 times per week (n=1), Once per day (n=7), 2-3 times per day (n=8), 4+ times per day (n=9), Sample Size = 78

(Community 2 = Turner)

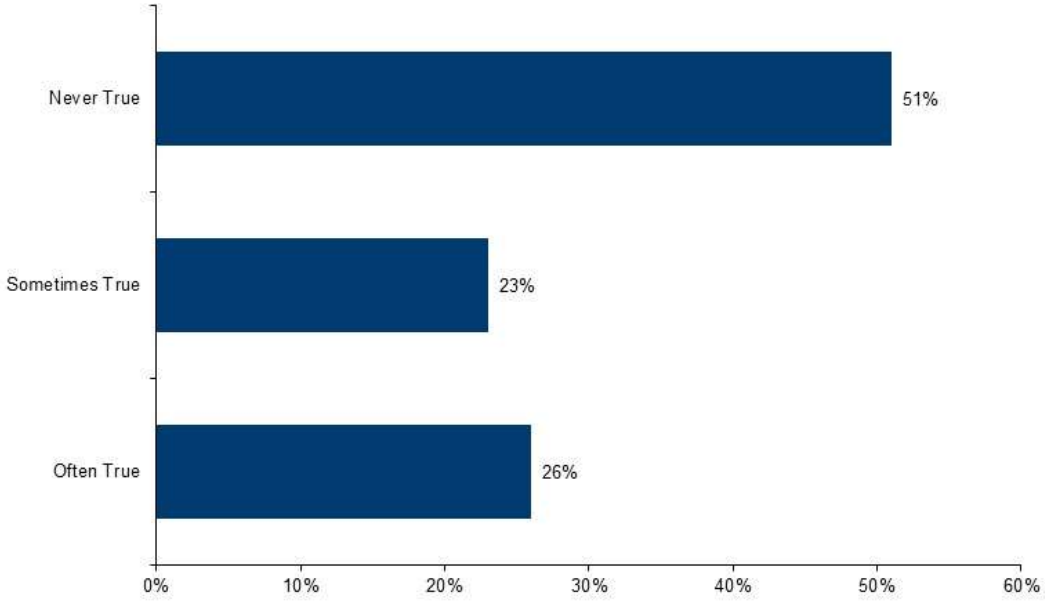
Sugar Sweetened Drinks



Sample Size = 78

(Community 2 = Turner)

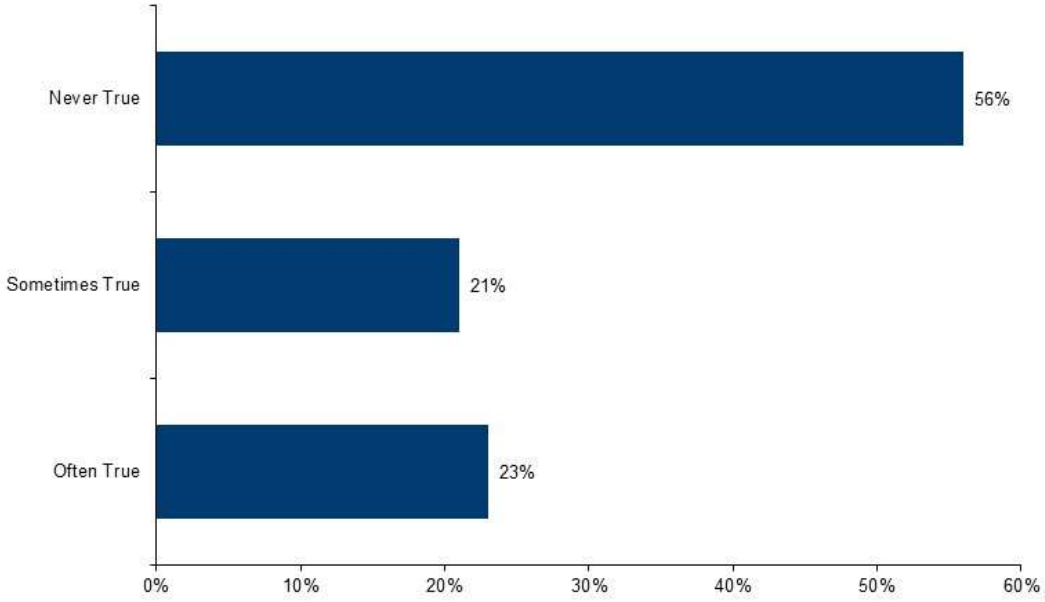
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=20), Sometimes True (n=18), Never True (n=40), Sample Size = 78

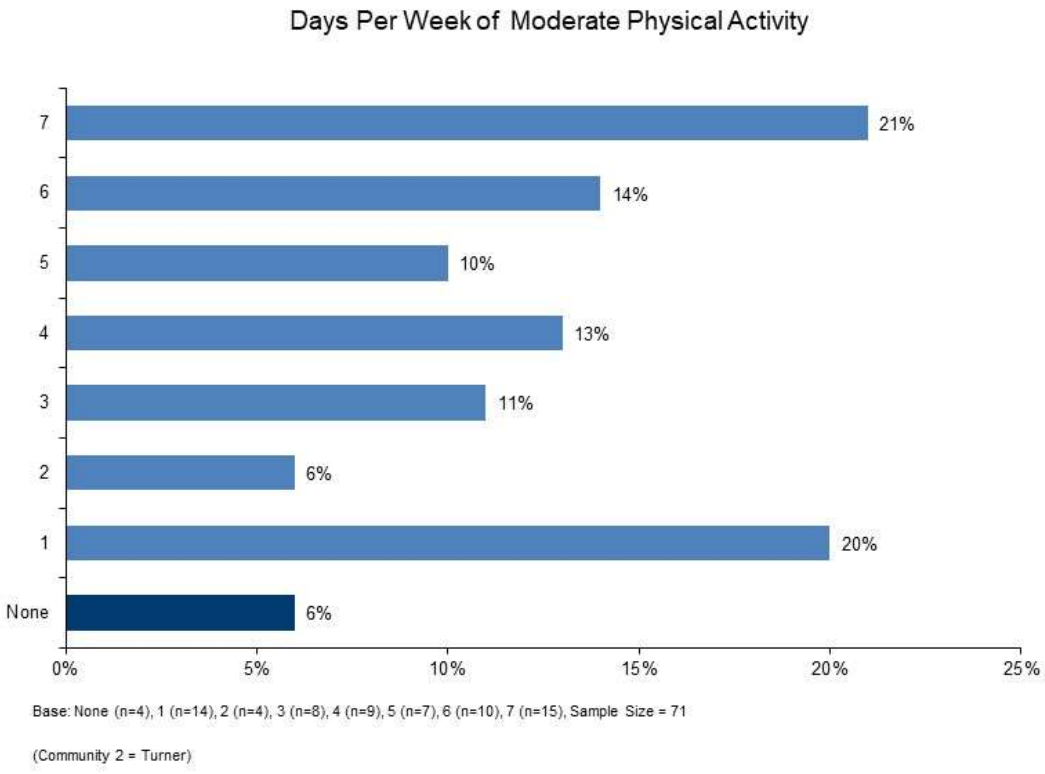
(Community 2 = Turner)

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



Base: Often True (n=18), Sometimes True (n=16), Never True (n=44), Sample Size = 78

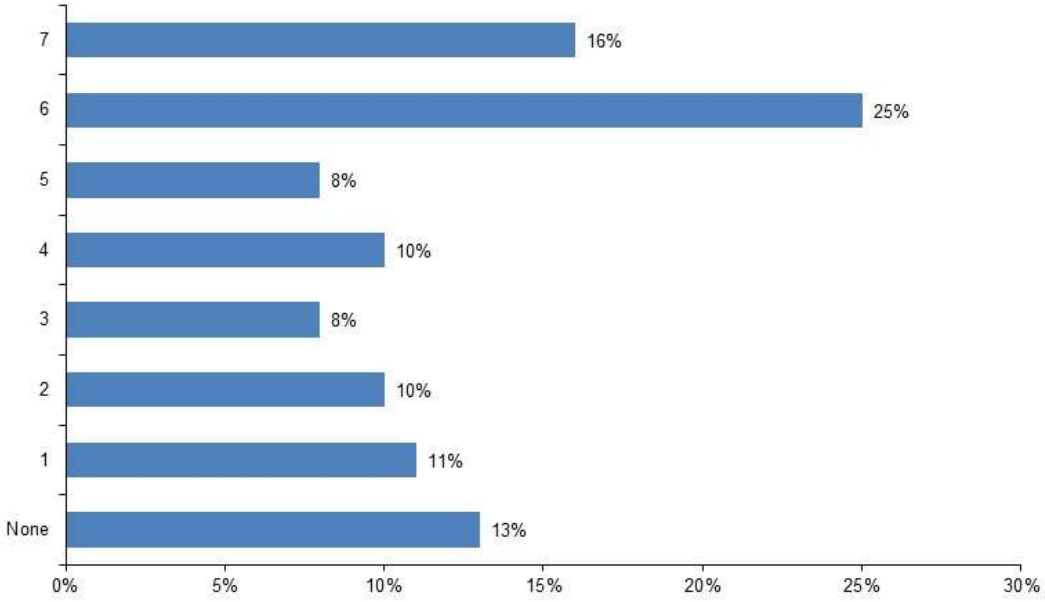
(Community 2 = Turner)



Base: None (n=4), 1 (n=14), 2 (n=4), 3 (n=8), 4 (n=9), 5 (n=7), 6 (n=10), 7 (n=15), Sample Size = 71

(Community 2 = Turner)

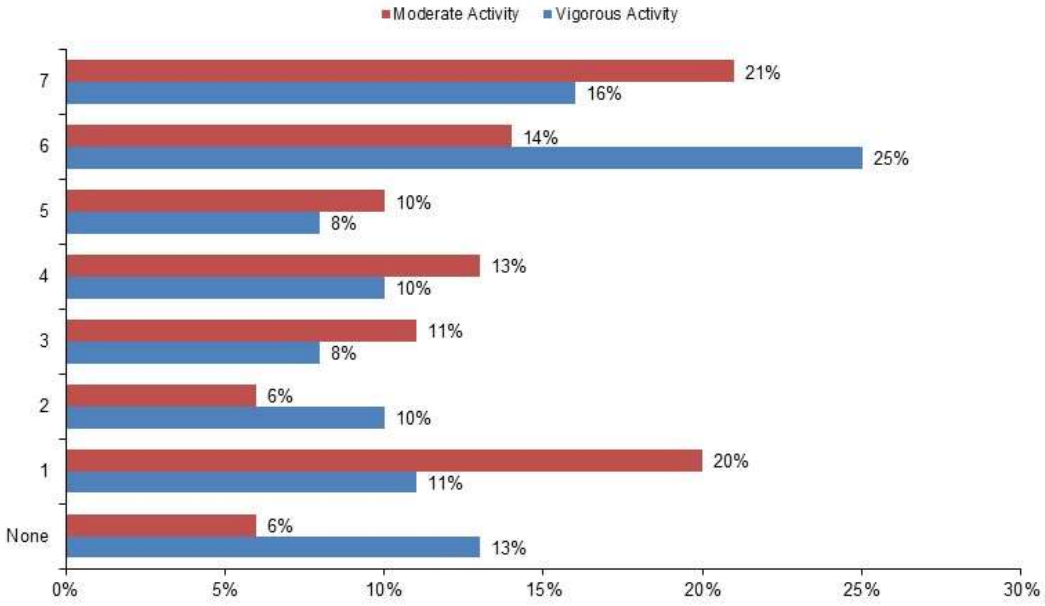
Days Per Week of Vigorous Physical Activity



Base: None (n=8), 1 (n=7), 2 (n=6), 3 (n=5), 4 (n=6), 5 (n=5), 6 (n=16), 7 (n=10), Sample Size = 63

(Community 2 = Turner)

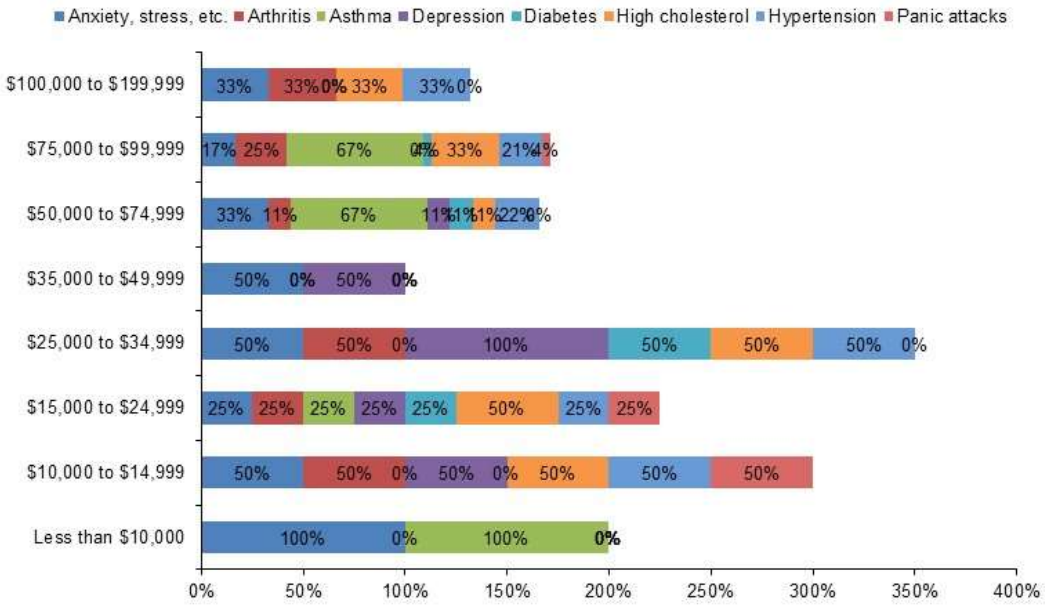
Days Per Week of Physical Activity



Sample Size = Variable

(Community 2 = Turner)

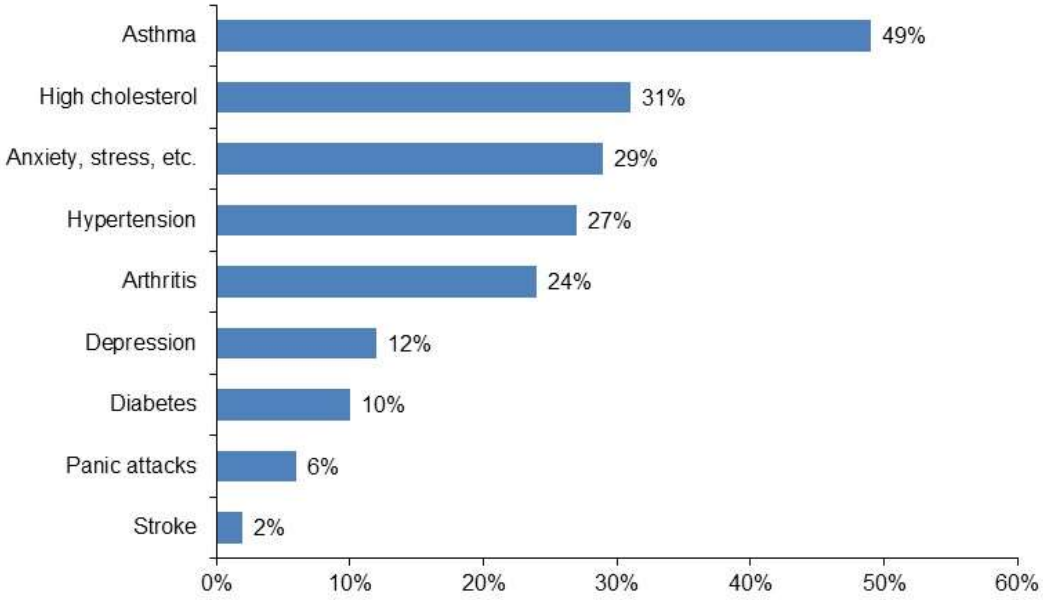
Past Diagnosis by Total Household Income



Base: Less than $10,000 (n=1), $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=4), $25,000 to $34,999 (n=2), $35,000 to $49,999 (n=2), $50,000 to $74,999 (n=9), $75,000 to $99,999 (n=24), $100,000 to $199,999 (n=3), Sample Size = 47

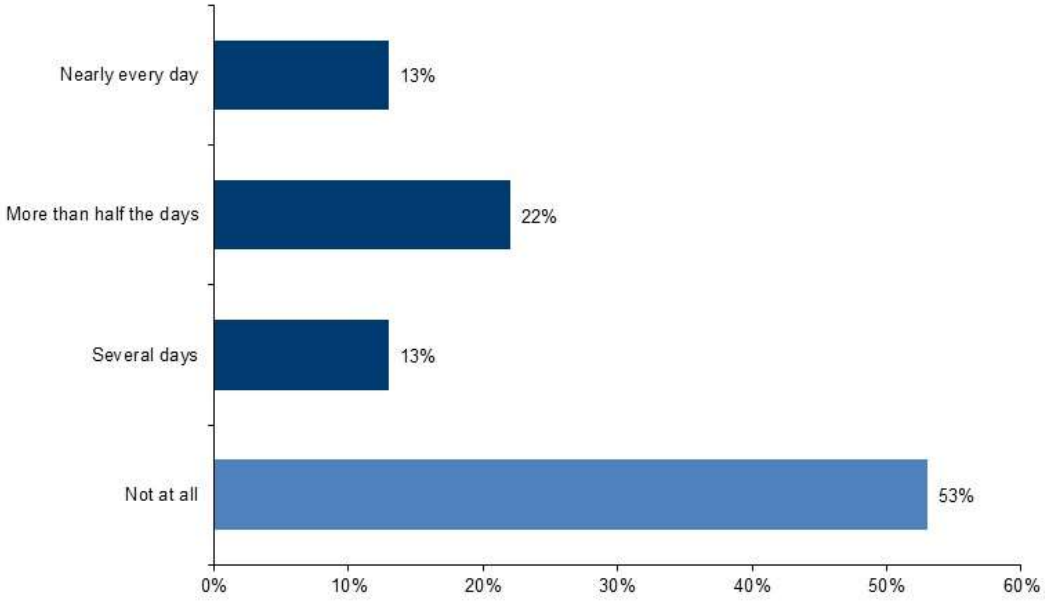
(Community 2 = Turner)

Past Diagnosis



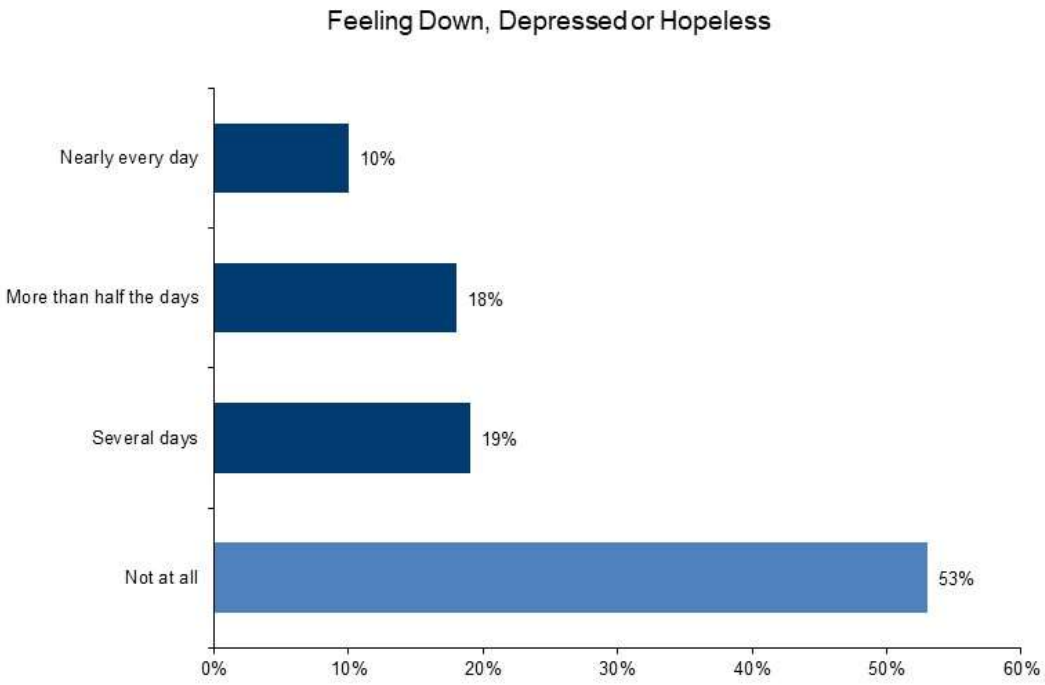
Base: Anxiety, stress, etc. (n=14), Arthritis (n=12), Asthma (n=24), Depression (n=6), Diabetes (n=5), High cholesterol (n=15), Hypertension (n=13), Panic attacks (n=3), Stroke (n=1), Sample Size = 49
(Community 2 = Turner)

Little Interest or Pleasure in Doing Things



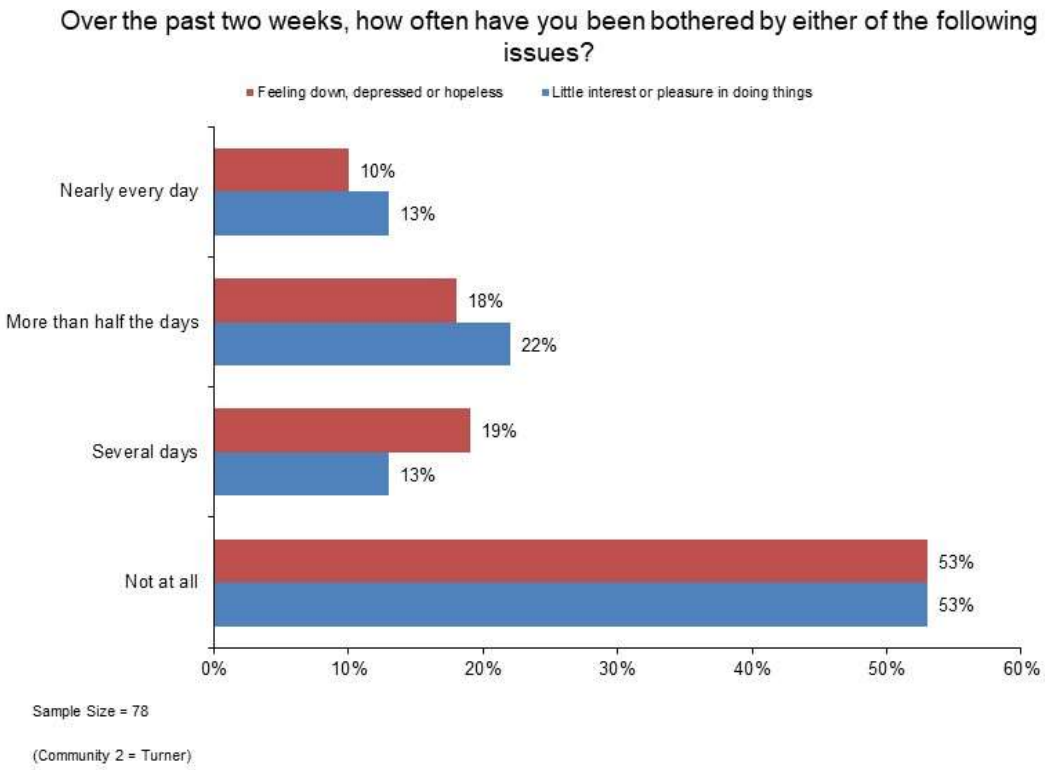
Base: Not at all (n=41), Several days (n=10), More than half the days (n=17), Nearly every day (n=10), Sample Size = 78

(Community 2 = Turner)



Base: Not at all (n=41), Several days (n=15), More than half the days (n=14), Nearly every day (n=8), Sample Size = 78

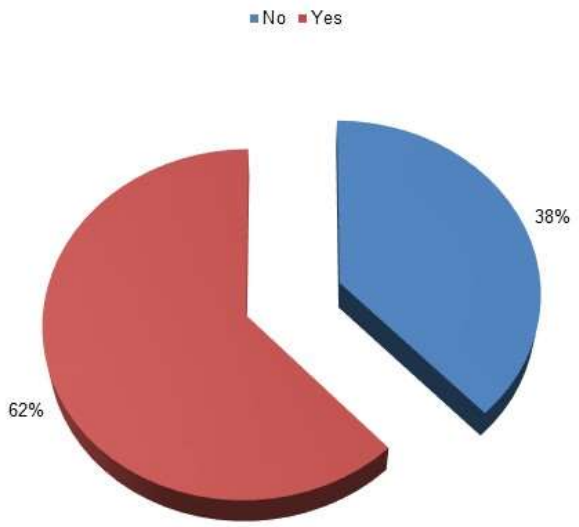
(Community 2 = Turner)



Sample Size = 78

(Community 2 = Turner)

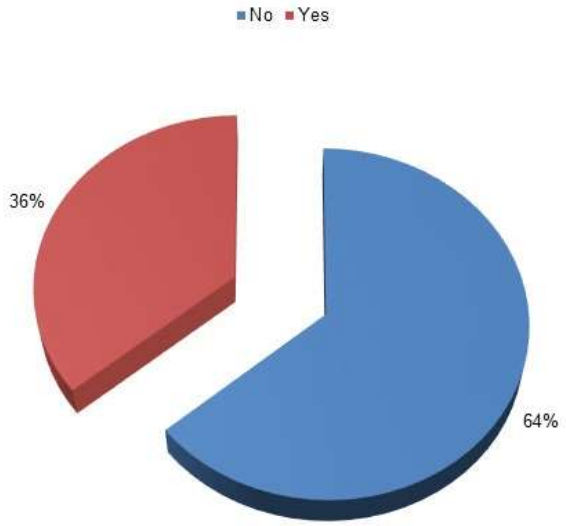
Have you smoked at least 100 cigarettes in your entire life?



Base: Yes (n=48), No (n=30), Sample Size = 78

(Community 2 = Turner)

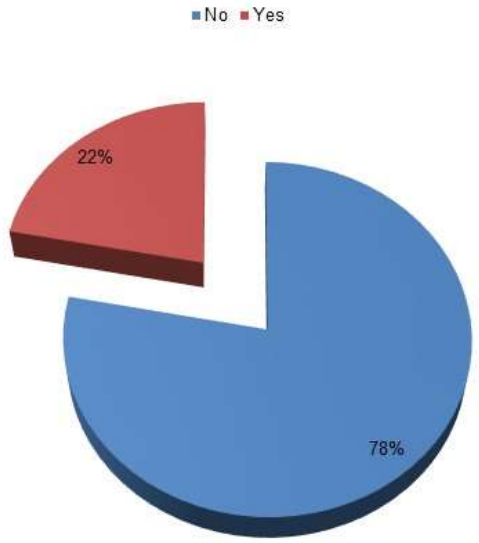
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=28), No (n=50), Sample Size = 78

(Community 2 = Turner)

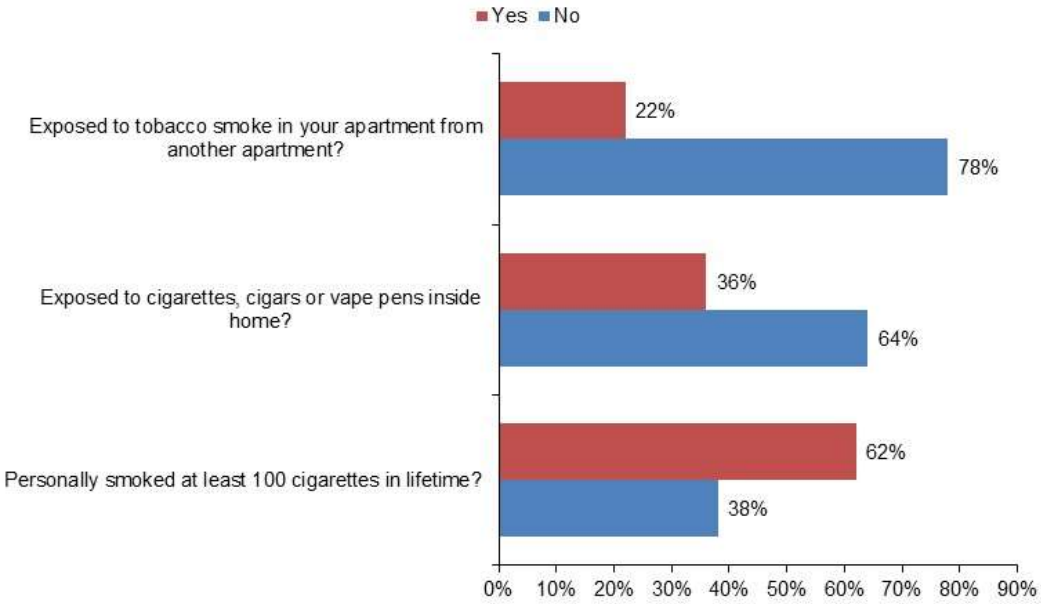
Have you smelled tobacco smoke in your apartment that comes from another apartment?



Base: Yes (n=17), No (n=60), Sample Size = 77

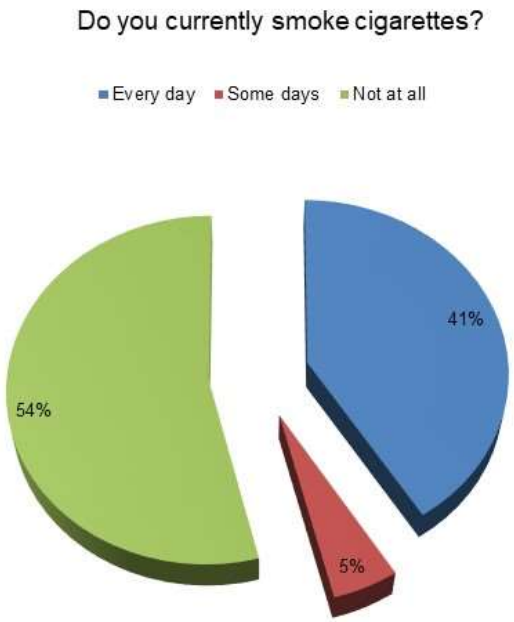
(Community 2 = Turner)

Exposure to Tobacco Smoke



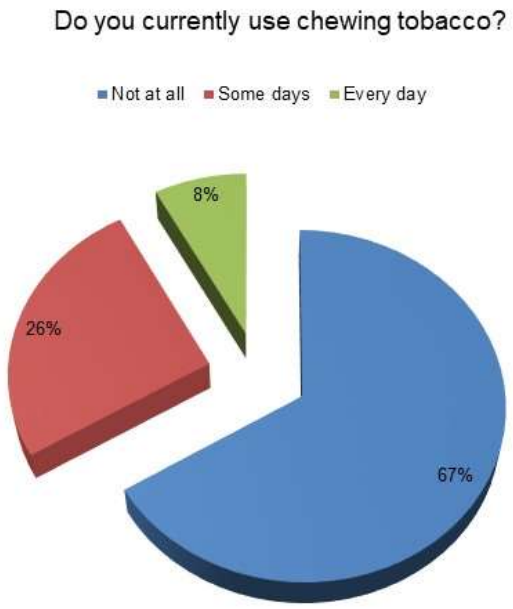
Base: Personally smoked at least 100 cigarettes in lifetime? (n=78), Exposed to cigarettes, cigars or vape pens inside home? (n=78), Exposed to tobacco smoke in your apartment from another apartment? (n=77), Sample Size = Variable

(Community 2 = Turner)



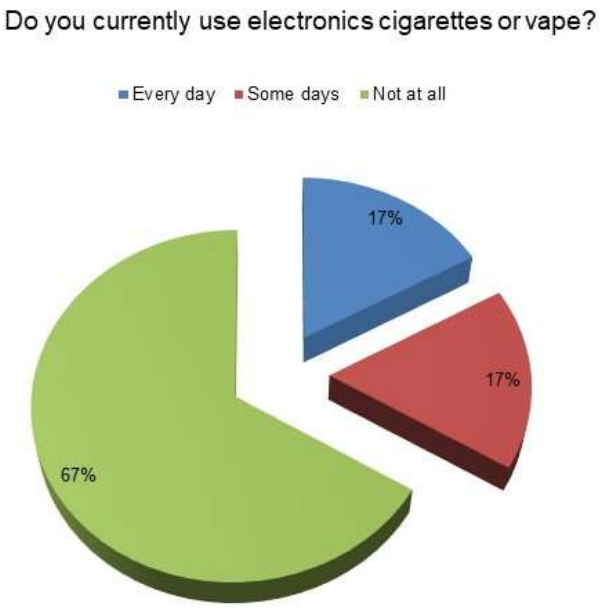
Base: Not at all (n=42), Some days (n=4), Every day (n=32), Sample Size = 78

(Community 2 = Turner)



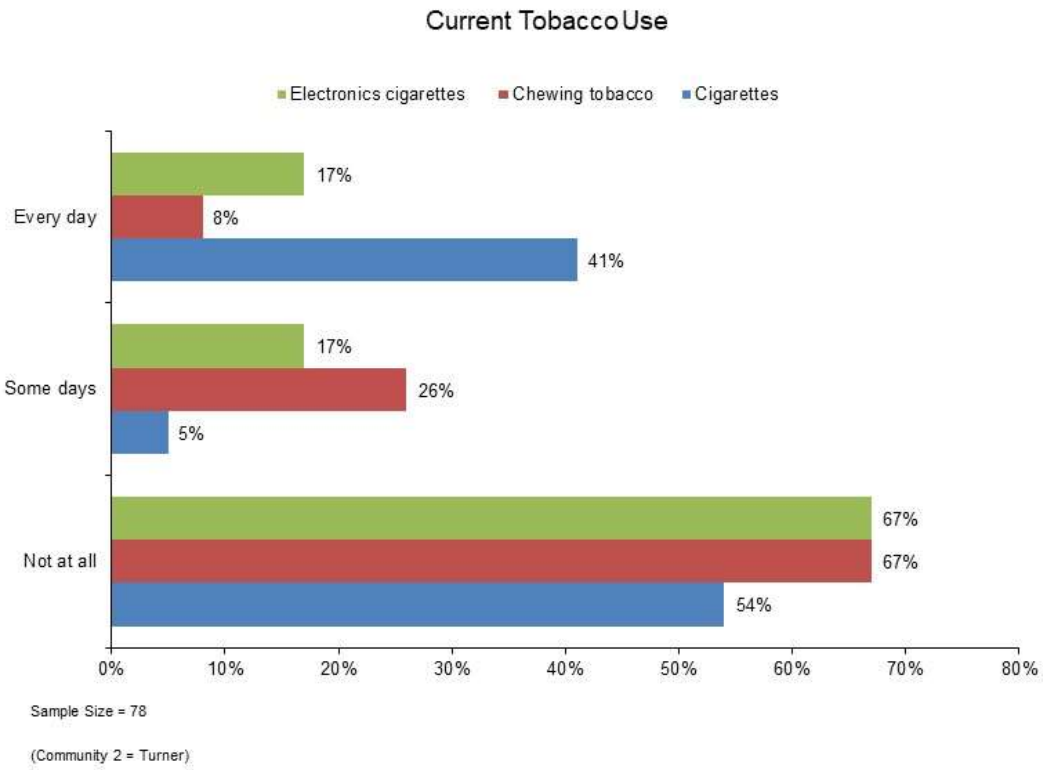
Base: Not at all (n=52), Some days (n=20), Every day (n=6), Sample Size = 78

(Community 2 = Turner)



Base: Not at all (n=52), Some days (n=13), Every day (n=13), Sample Size = 78

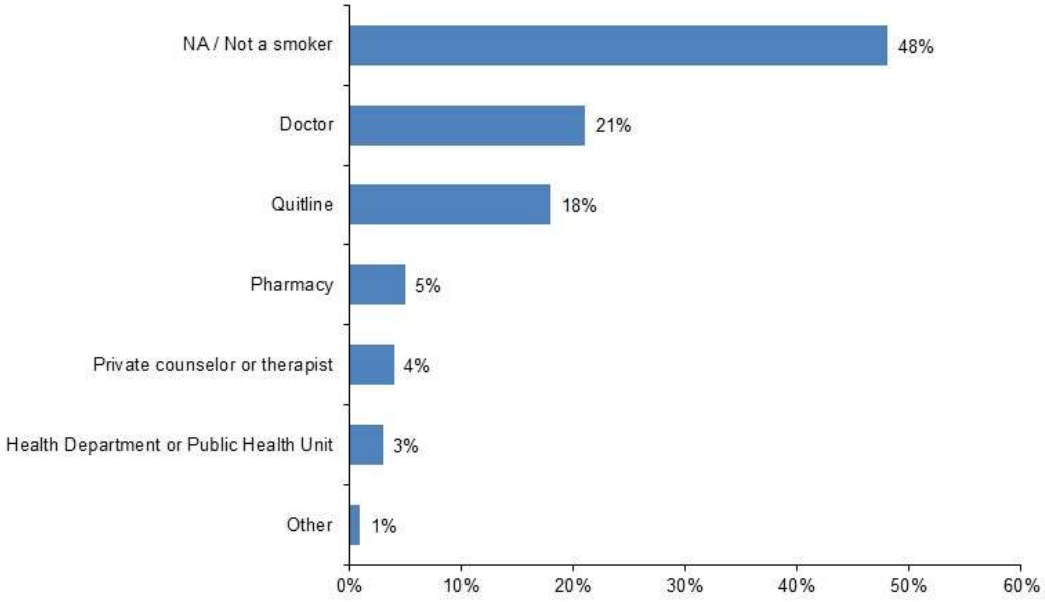
(Community 2 = Turner)



Sample Size = 78

(Community 2 = Turner)

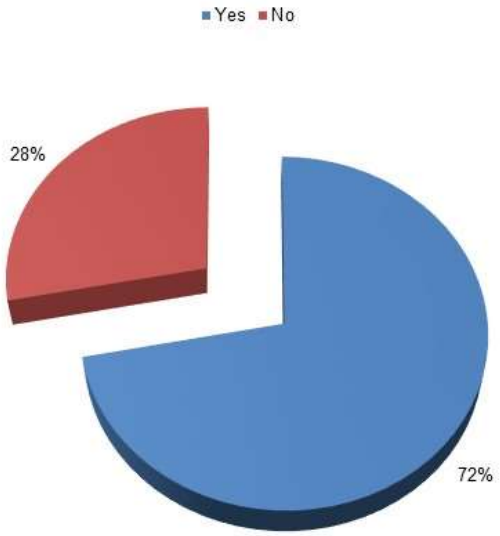
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=35), Quitline (n=13), Doctor (n=15), Pharmacy (n=4), Private counselor or therapist (n=3), Health Department or Public Health Unit (n=2), Other (n=1), Sample Size = 73

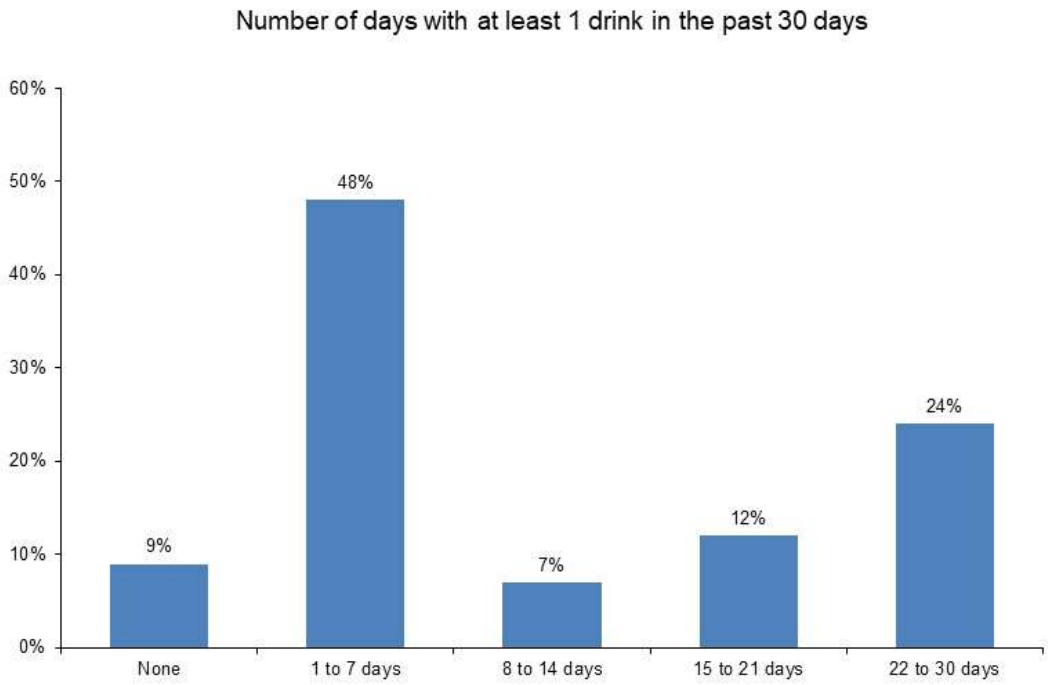
(Community 2 = Turner)

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



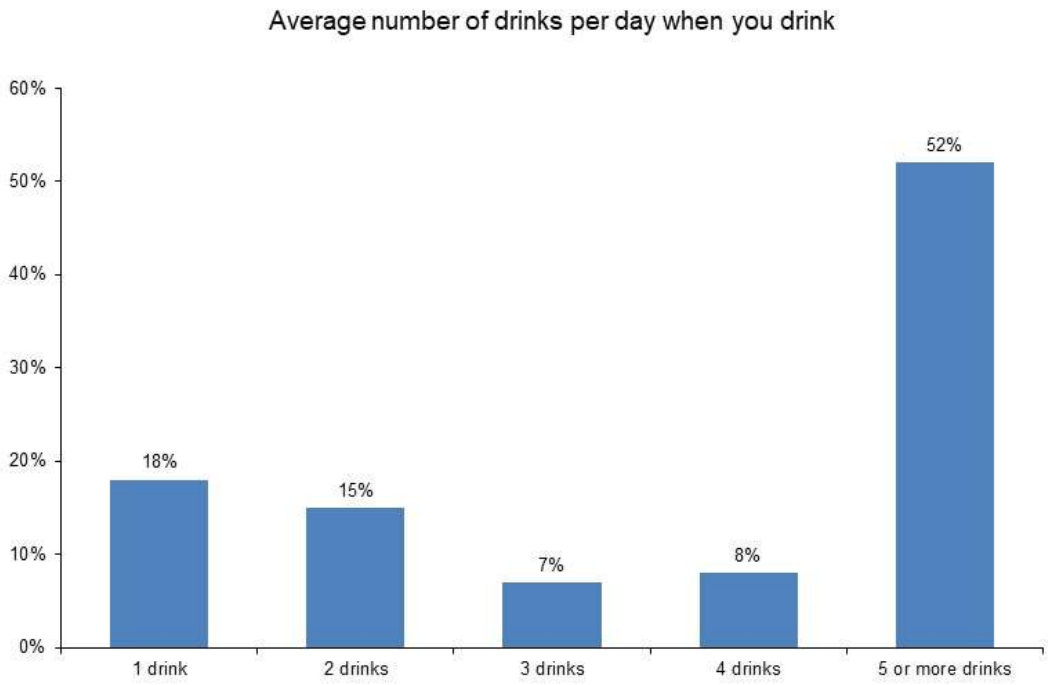
Base: Yes (n=26), No (n=10), Sample Size = 36

(Community 2 = Turner)



Base: None (n=6), 1 to 7 days (n=32), 8 to 14 days (n=5), 15 to 21 days (n=8), 22 to 30 days (n=16), Sample Size = 67

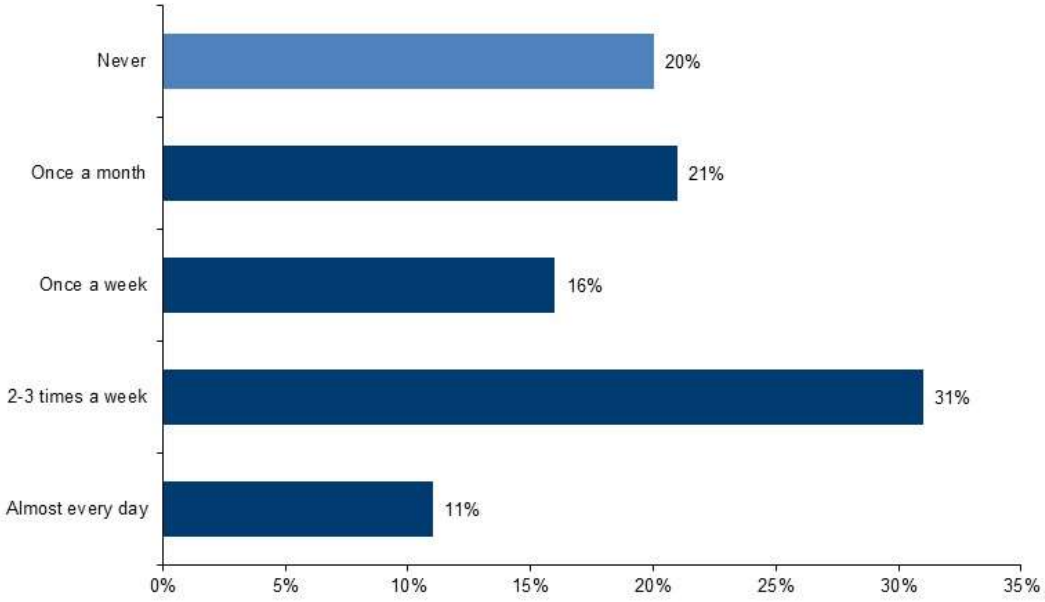
(Community 2 = Turner)



Base: 1 drink (n=11), 2 drinks (n=9), 3 drinks (n=4), 4 drinks (n=5), 5 or more drinks (n=32), Sample Size = 61

(Community 2 = Turner)

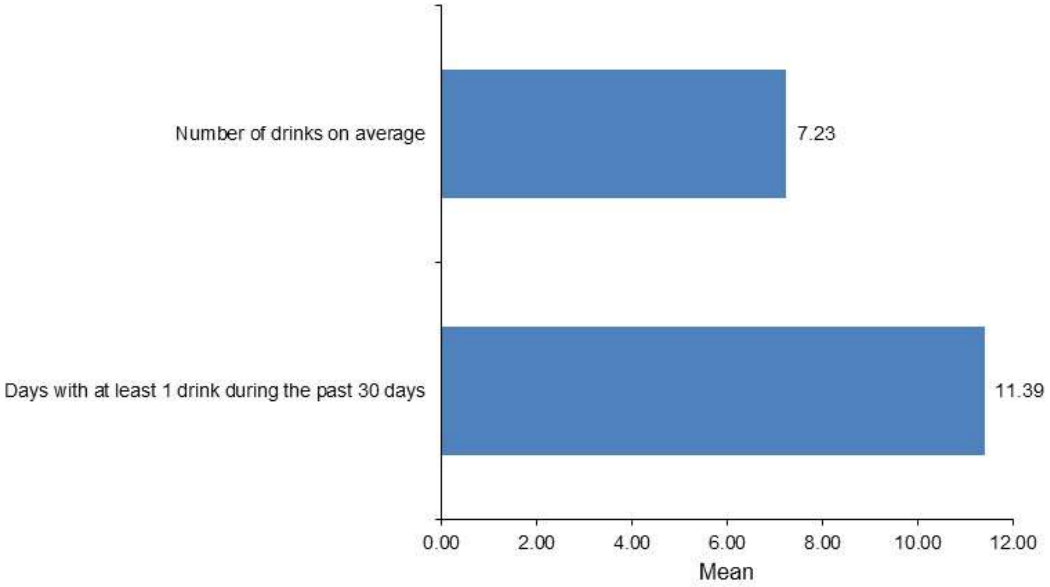
Binge Drinking



Base: Almost every day (n=7), 2-3 times a week (n=19), Once a week (n=10), Once a month (n=13), Never (n=12), Sample Size = 61

(Community 2 = Turner)

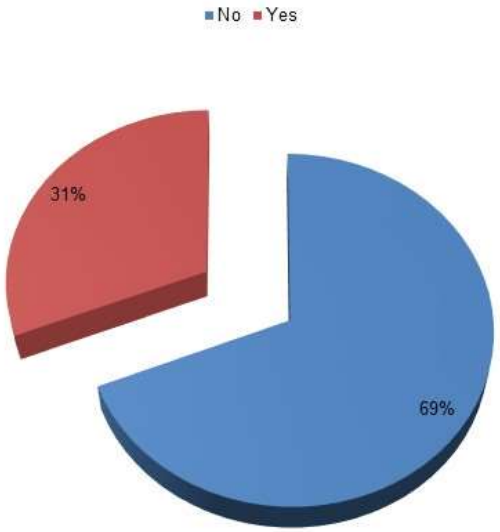
Average Alcohol Use During the Past 30 Days



Base: Days with at least 1 drink during the past 30 days (n=67), Number of drinks on average (n=61), Sample Size = Variable

(Community 2 = Turner)

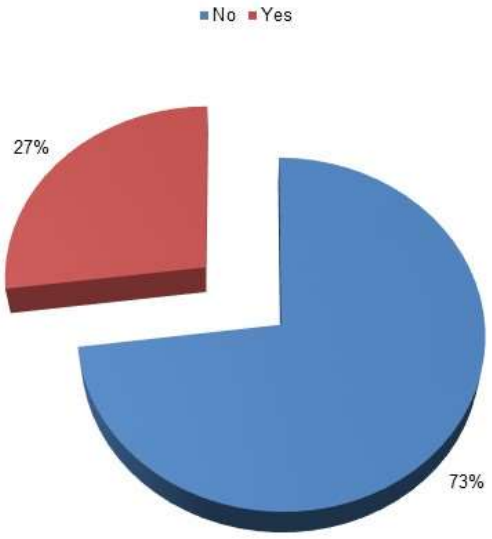
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=24), No (n=53), Sample Size = 77

(Community 2 = Turner)

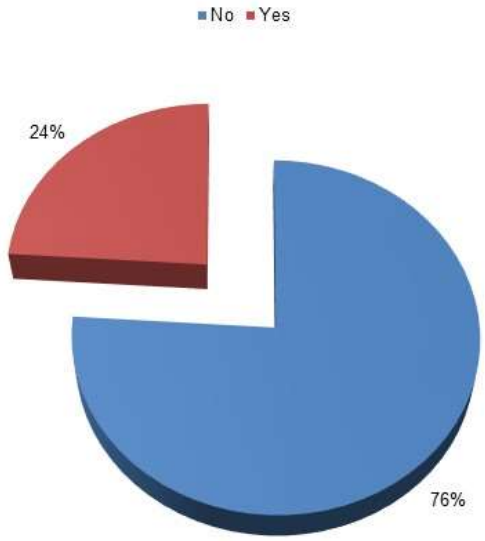
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=21), No (n=57), Sample Size = 78

(Community 2 = Turner)

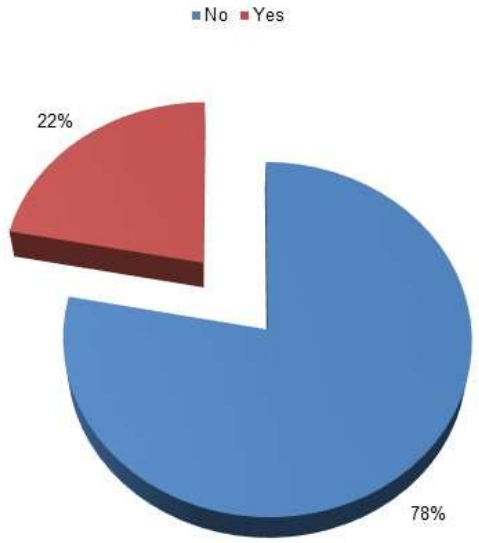
Has a family member or friend ever suggested that you get help for substance use?



Base: Yes (n=19), No (n=59), Sample Size = 78

(Community 2 = Turner)

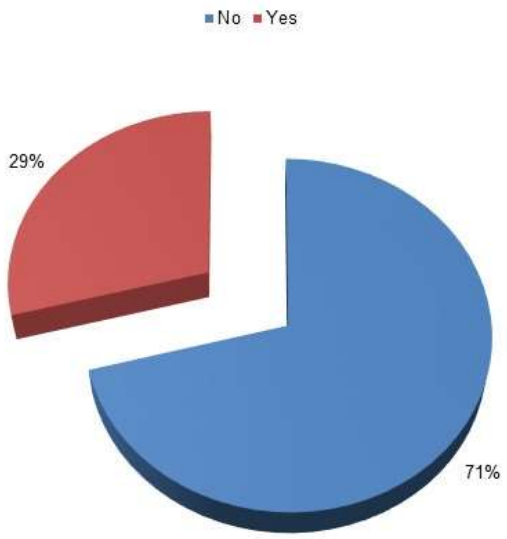
Has prescription or non-prescription drug use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=17), No (n=61), Sample Size = 78

(Community 2 = Turner)

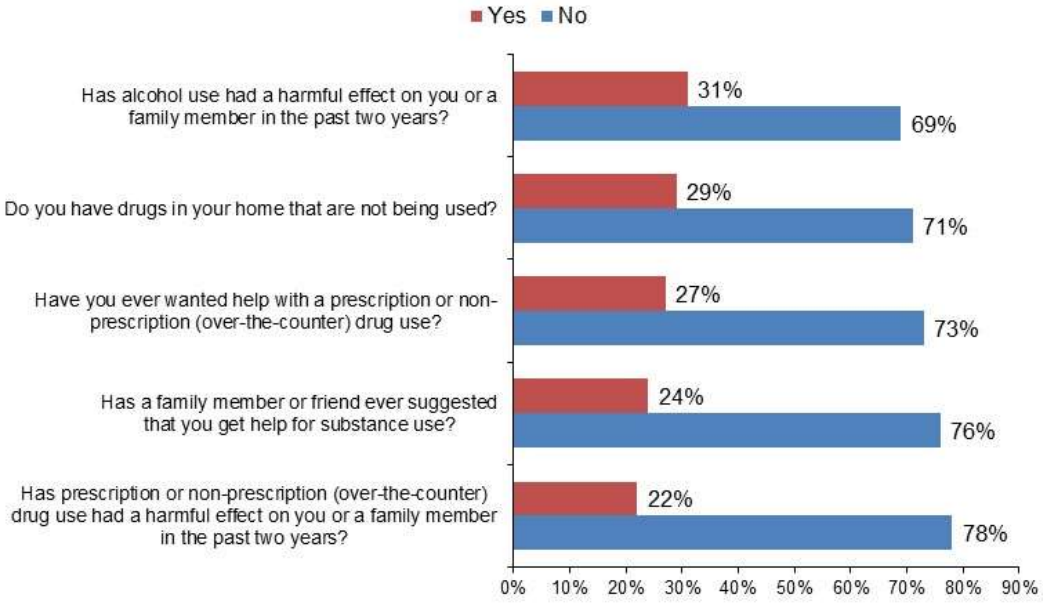
Do you have drugs in your home that are not being used?



Base: Yes (n=22), No (n=55), Sample Size = 77

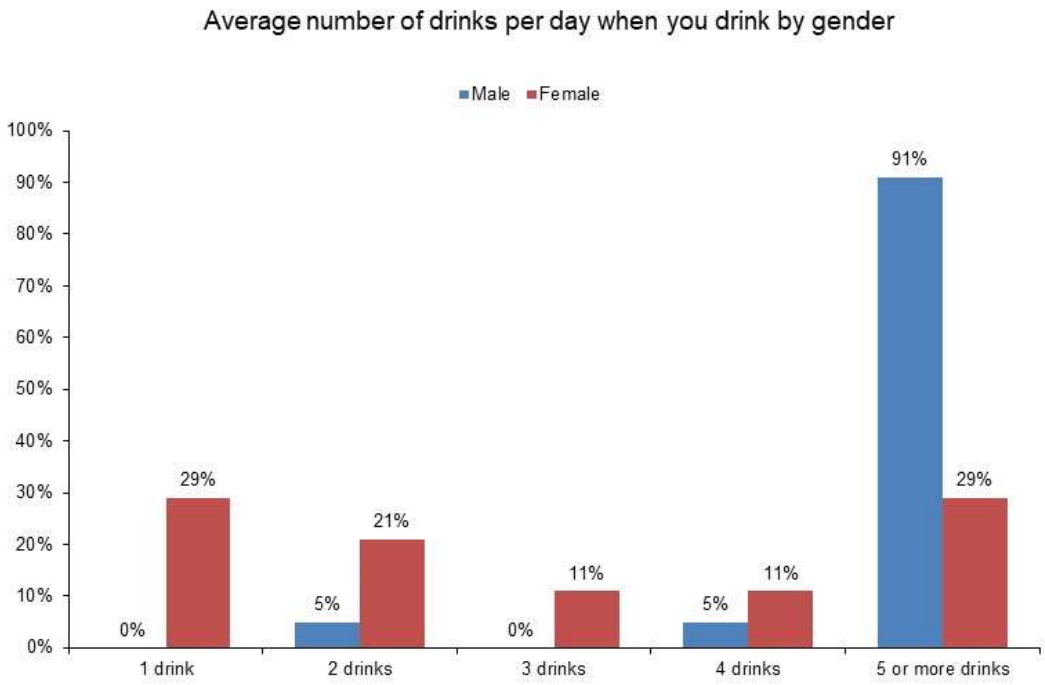
(Community 2 = Turner)

Drug and Alcohol Issues



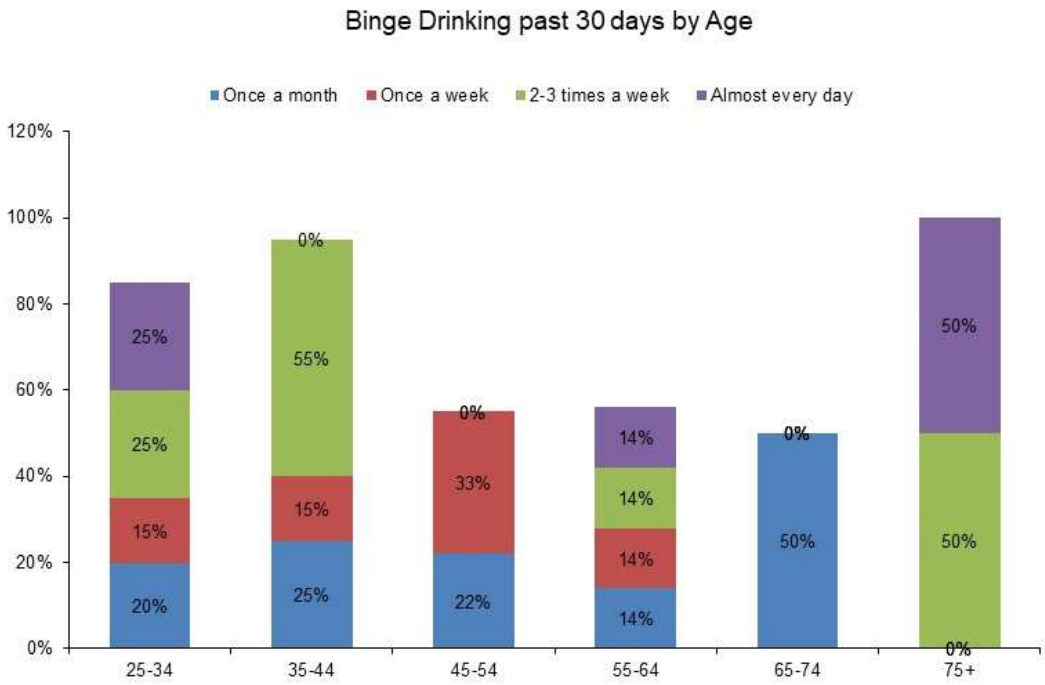
Sample Size = Variable

(Community 2 = Turner)



Base: 1 drink (n=11), 2 drinks (n=9), 3 drinks (n=4), 4 drinks (n=5), 5 or more drinks (n=31), Sample Size = 60

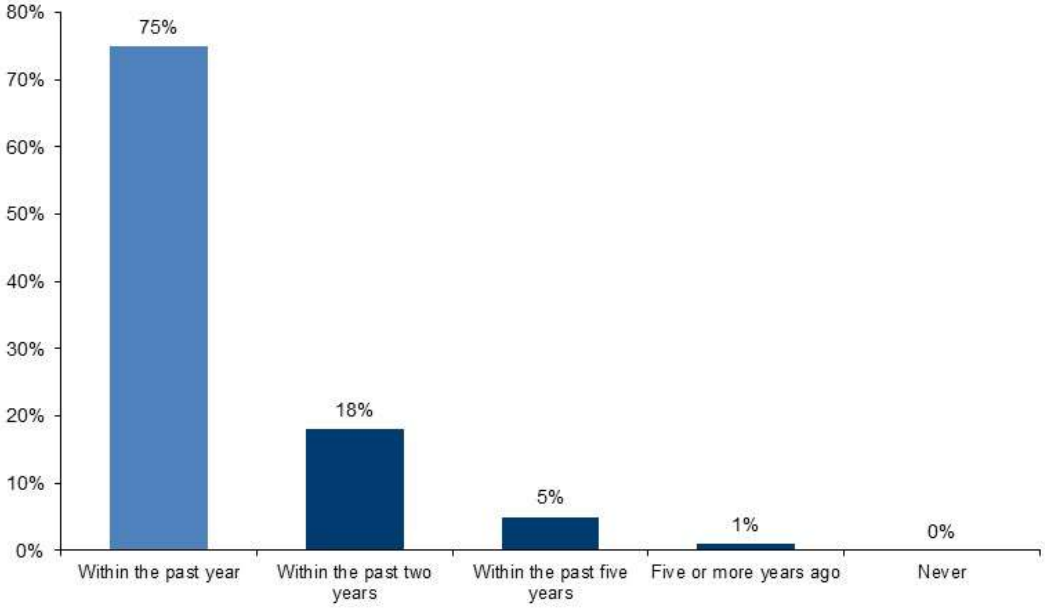
(Community 2 = Turner)



Base: 25-34 (n=20), 35-44 (n=20), 45-54 (n=9), 55-64 (n=7), 65-74 (n=2), 75+ (n=2), Sample Size = 60

(Community 2 = Turner)

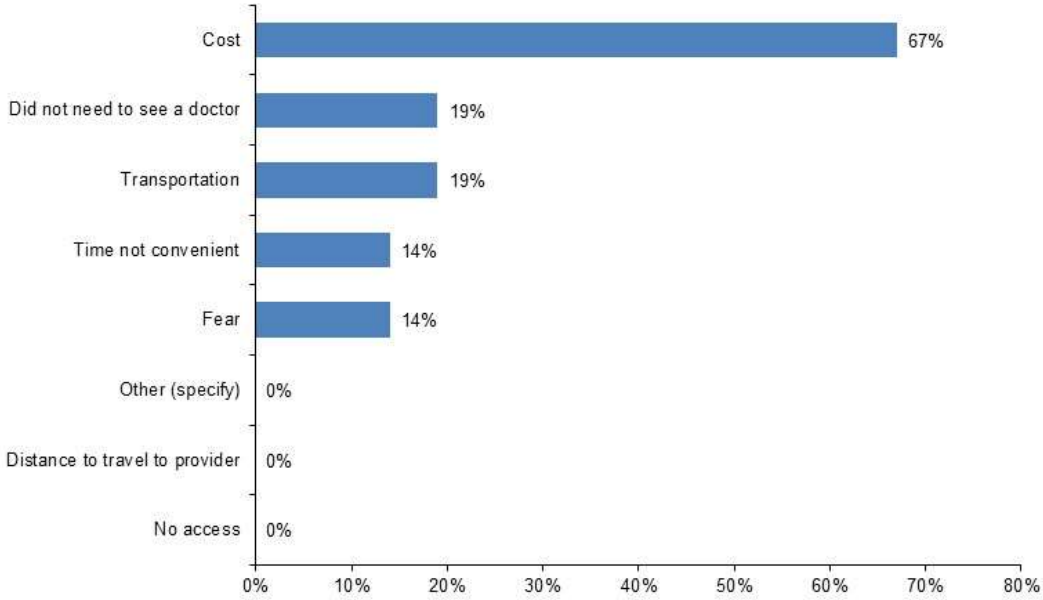
How long has it been since you last visited a doctor or health care provider for a routine checkup?



Base: Within the past year (n=57), Within the past two years (n=14), Within the past five years (n=4), Five or more years ago (n=1), Never (n=0), Sample Size = 76

(Community 2 = Turner)

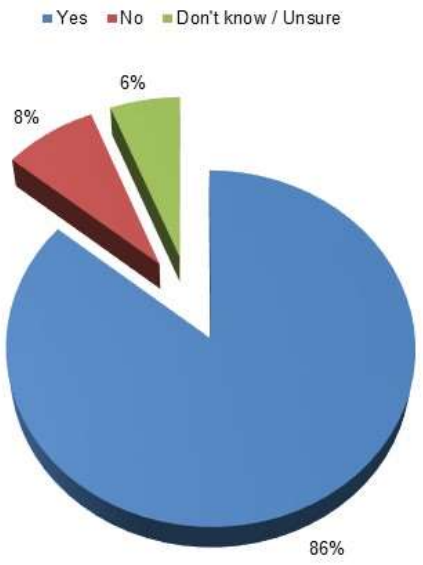
Barriers to Routine Checkup



Base: No access (n=0), Distance to travel to provider (n=0), Cost (n=14), Fear (n=3), Transportation (n=4), Time not convenient (n=3), Did not need to see a doctor (n=4), Other (specify) (n=0), Sample Size = 21

(Community 2 = Turner)

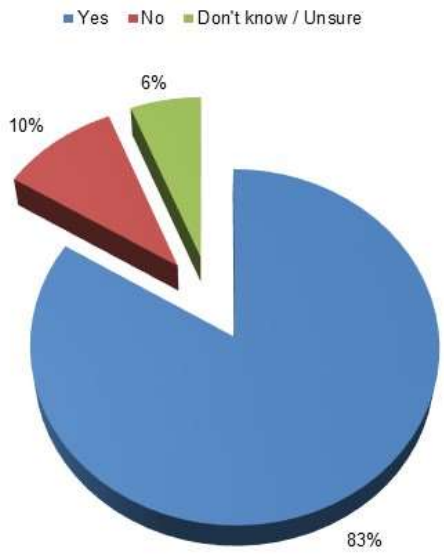
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=67), No (n=6), Don't know / Unsure (n=5), Sample Size = 78

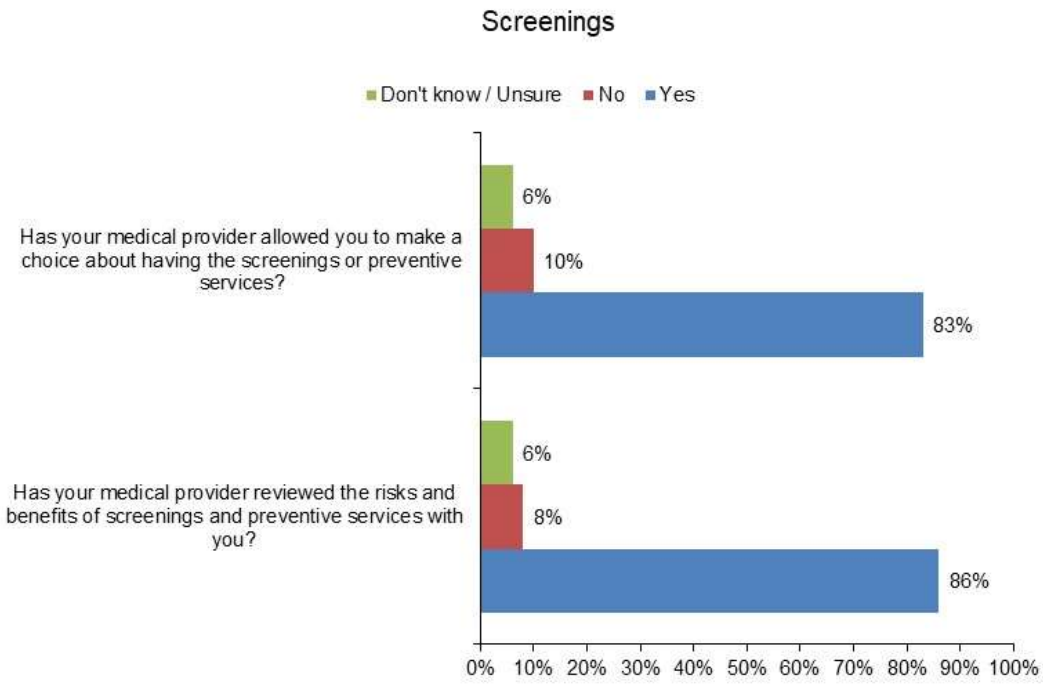
(Community 2 = Turner)

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



Base: Yes (n=65), No (n=8), Don't know / Unsure (n=5), Sample Size = 78

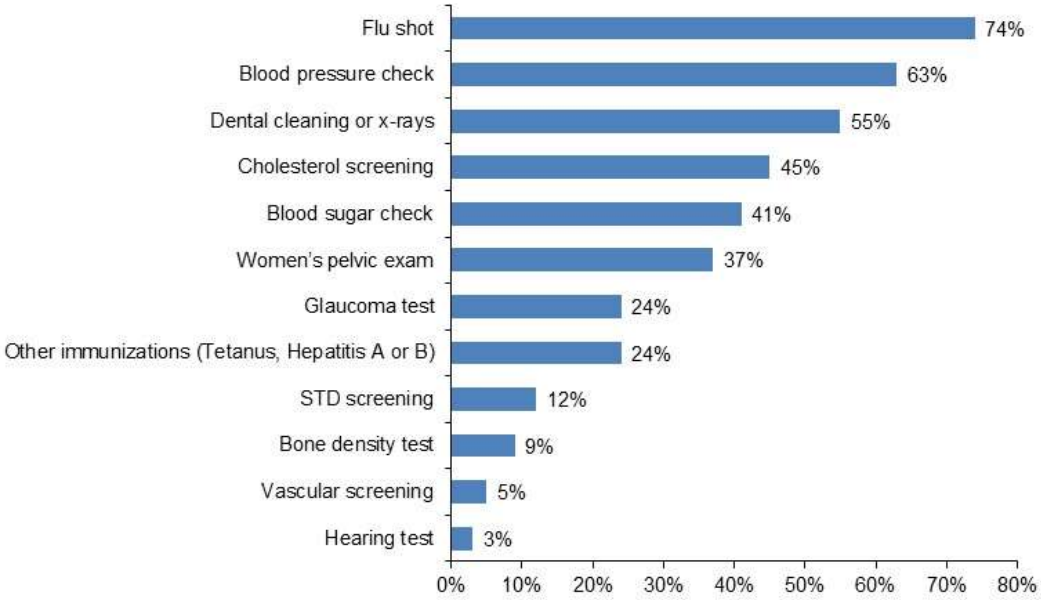
(Community 2 = Turner)



Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=78), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=78), Sample Size = 78

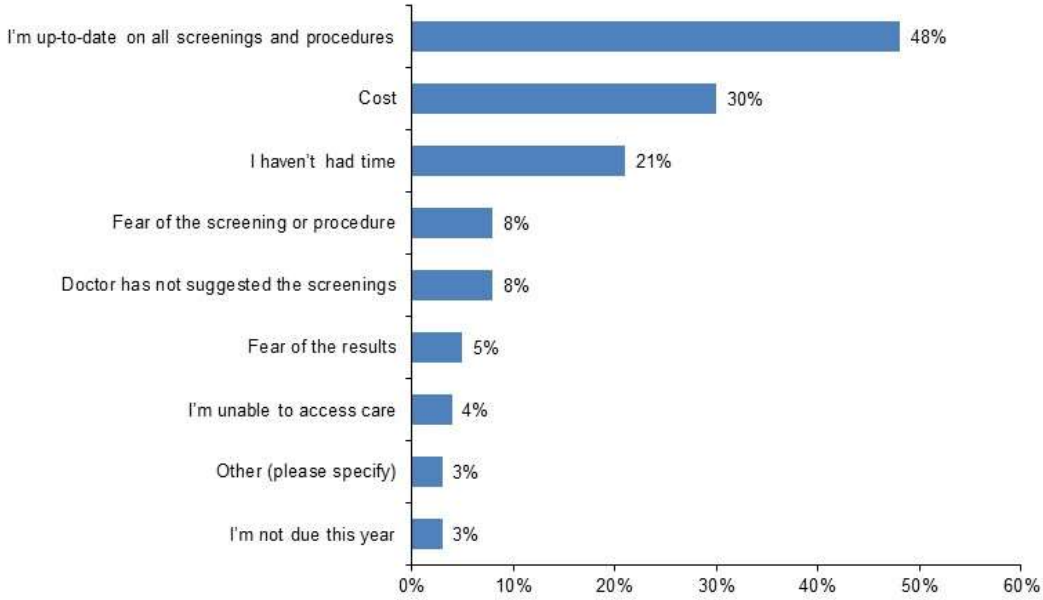
(Community 2 = Turner)

Preventive Procedures Last Year



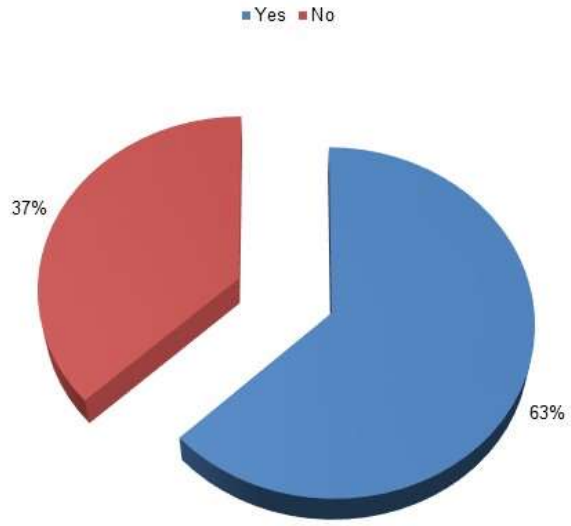
Base: Blood pressure check (n=48), Blood sugar check (n=31), Bone density test (n=7), Cholesterol screening (n=34), Dental cleaning or x-rays (n=42), Flu shot (n=56), Other immunizations (Tetanus, Hepatitis A or B) (n=18), Glaucoma test (n=18), Hearing test (n=2), Women's pelvic exam (n=28), STD screening (n=9), Vascular screening (n=4), Sample Size = 76
(Community 2 = Turner)

Barriers for Preventive Procedures



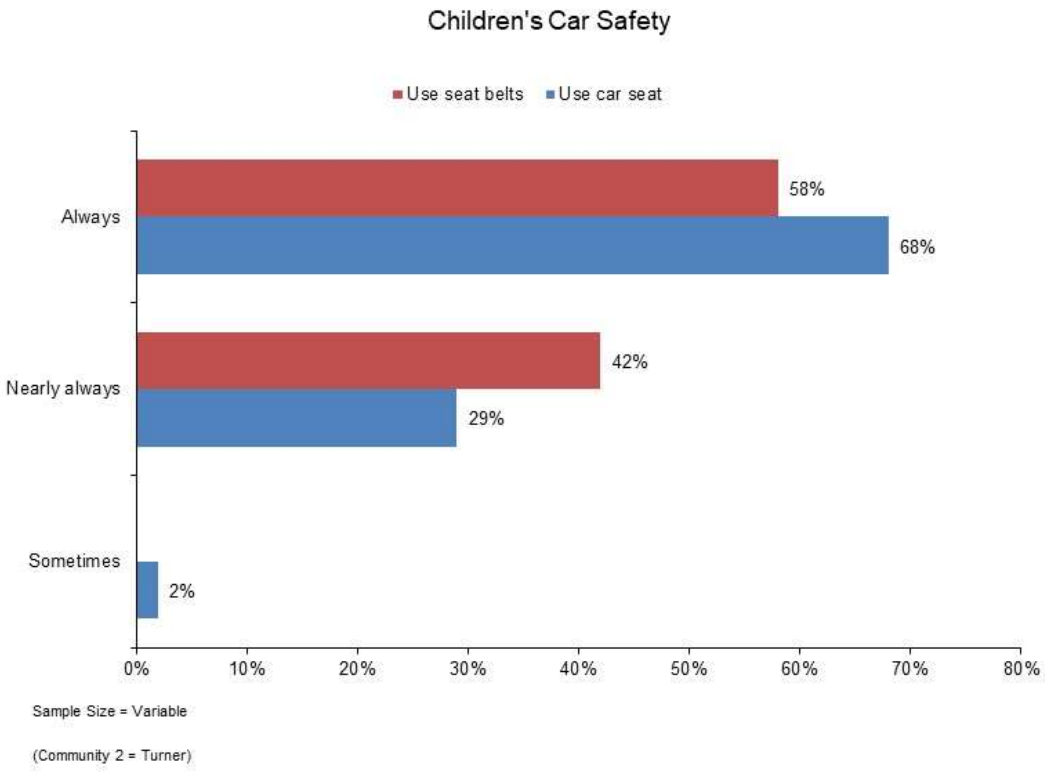
Base: I'm up-to-date on all screenings and procedures (n=37), Doctor has not suggested the screenings (n=6), Cost (n=23), I'm unable to access care (n=3), Fear of the screening or procedure (n=6), Fear of the results (n=4), I'm not due this year (n=2), I haven't had time (n=16), Other (please specify) (n=2),
Sample Size = 77
(Community 2 = Turner)

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

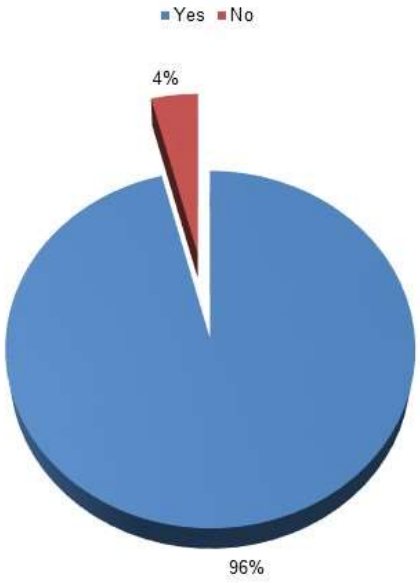


Base: Yes (n=49), No (n=29), Sample Size = 78

(Community 2 = Turner)

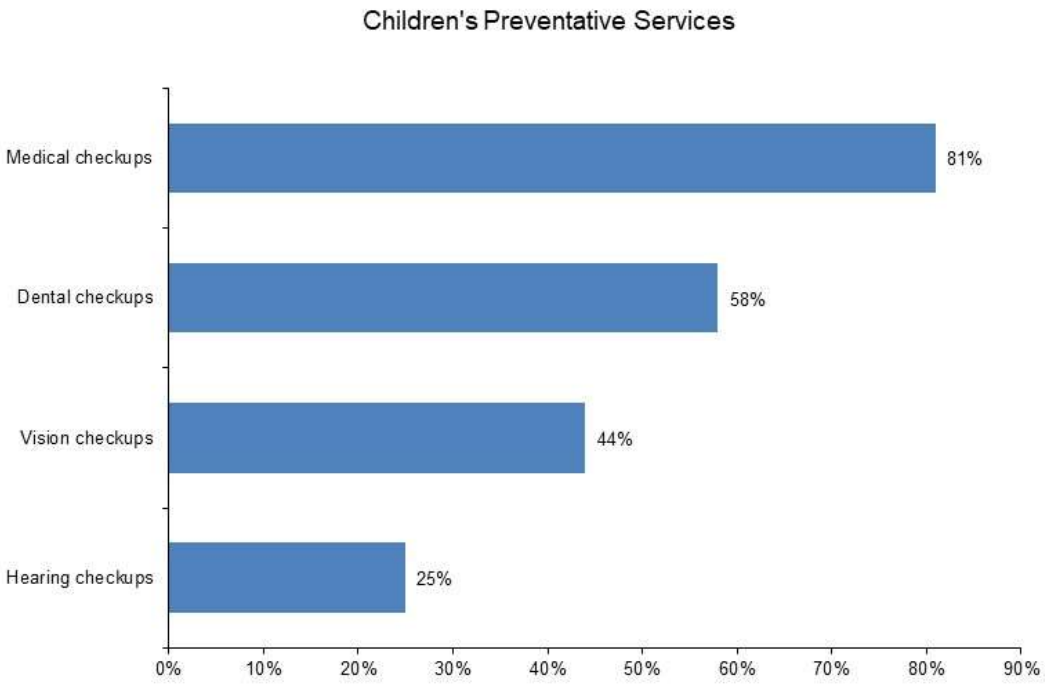

Children's Car Safety
Use seat belts
Use car seat
Always
58%
68%
Nearly always
42%
29%
Sometimes
2%
0%
10%
20%
30%
40%
50%
60%
70%
80%
Sample Size = Variable
(Community 2 = Turner)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=47), No (n=2), Sample Size = 49

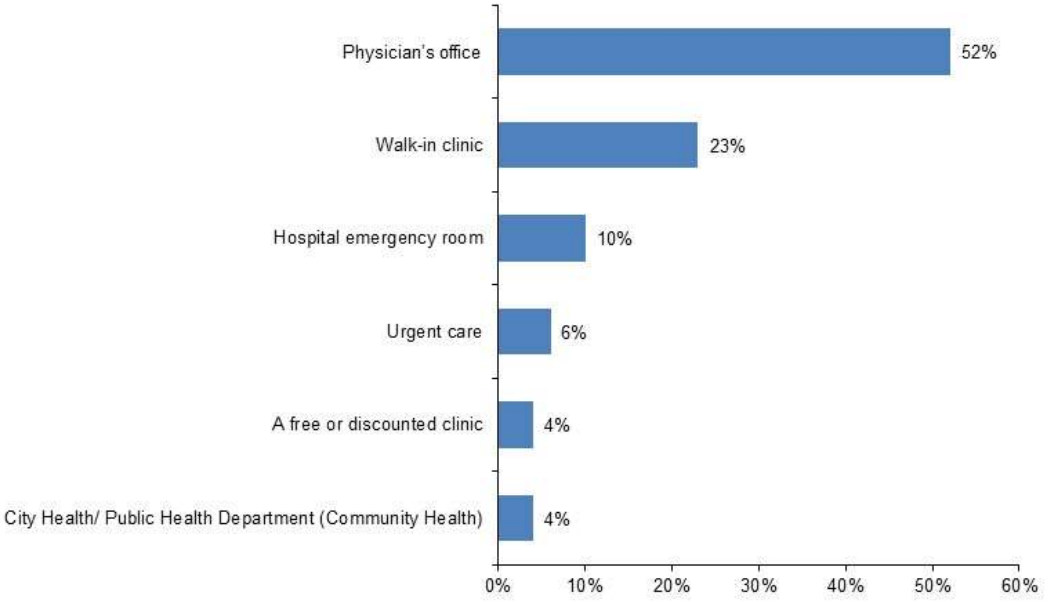
(Community 2 = Turner)



Base: Dental checkups (n=28), Vision checkups (n=21), Hearing checkups (n=12), Medical checkups (n=39), Sample Size = 48

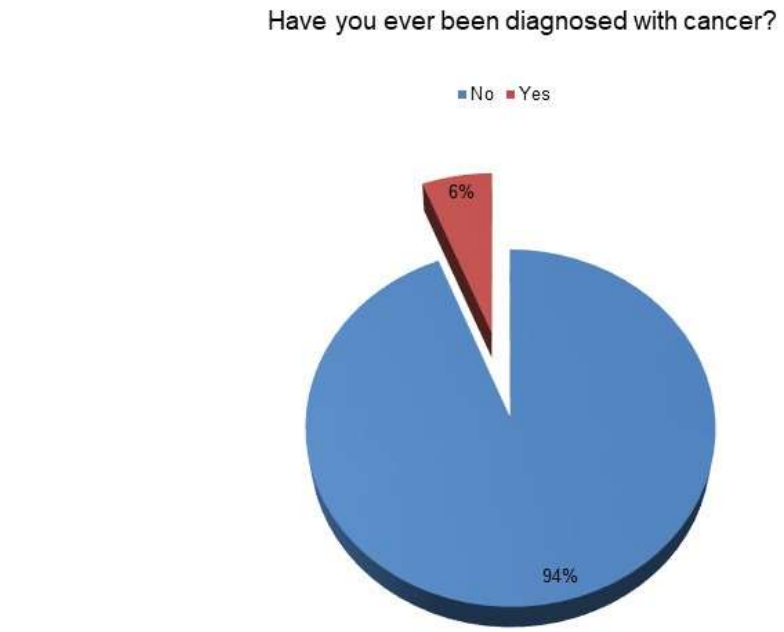
(Community 2 = Turner)

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



Base: Physician's office (n=25), Hospital emergency room (n=5), Urgent care (n=3), Walk-in clinic (n=11), City Health/ Public Health Department (Community Health) (n=2), A free or discounted clinic (n=2), Sample Size = 48

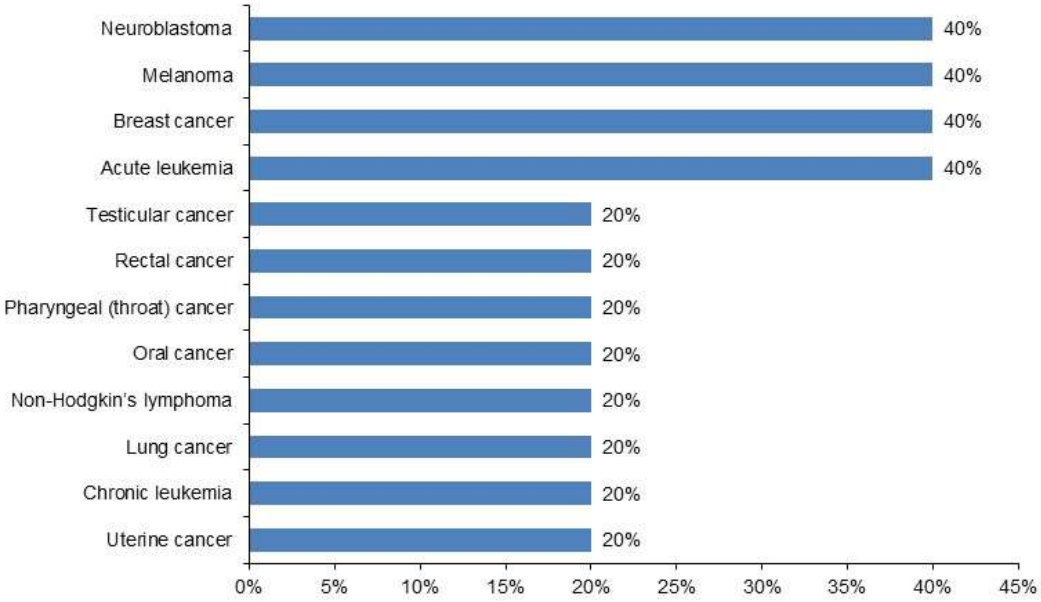
(Community 2 = Turner)



Base: Yes (n=5), No (n=73), Sample Size = 78

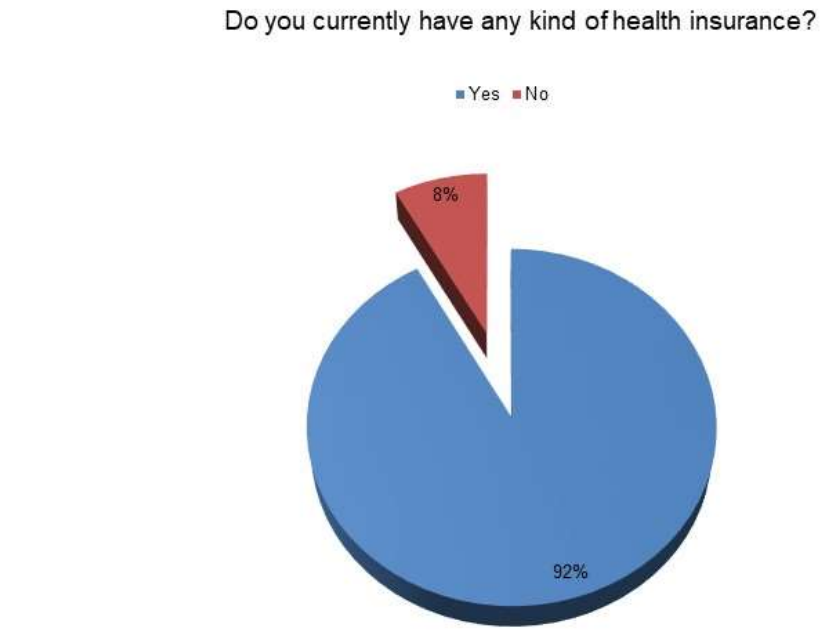
(Community 2 = Turner)

Type of Cancer



Base: Acute leukemia (n=2), Uterine cancer (n=1), Breast cancer (n=2), Chronic leukemia (n=1), Lung cancer (n=1), Melanoma (n=2), Neuroblastoma (n=2), Non-Hodgkin's lymphoma (n=1), Oral cancer (n=1), Pharyngeal (throat) cancer (n=1), Rectal cancer (n=1), Testicular cancer (n=1), Sample Size = 5

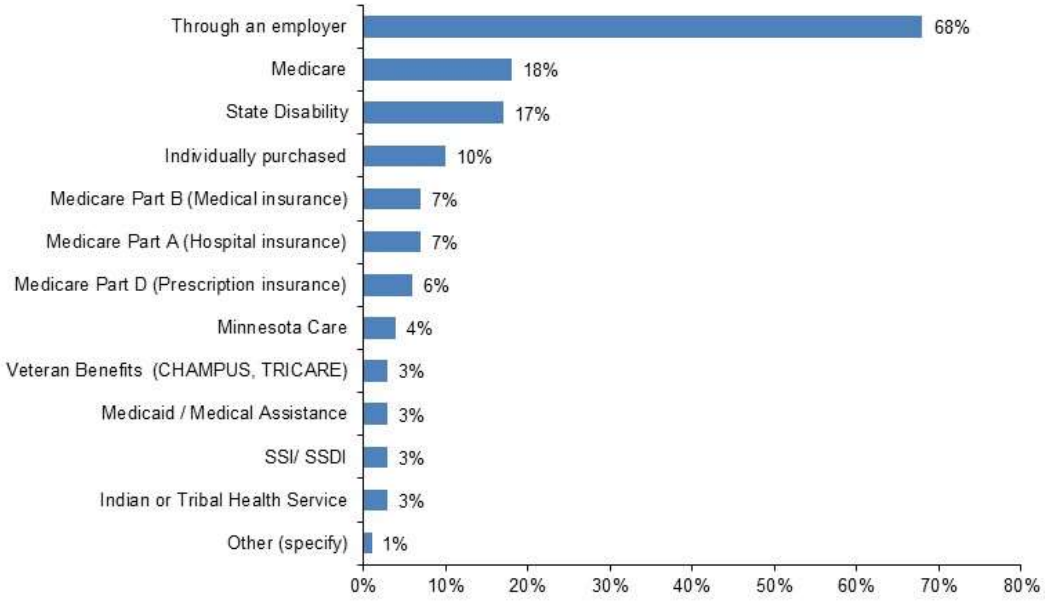
(Community 2 = Turner)



Base: Yes (n=72), No (n=6), Sample Size = 78

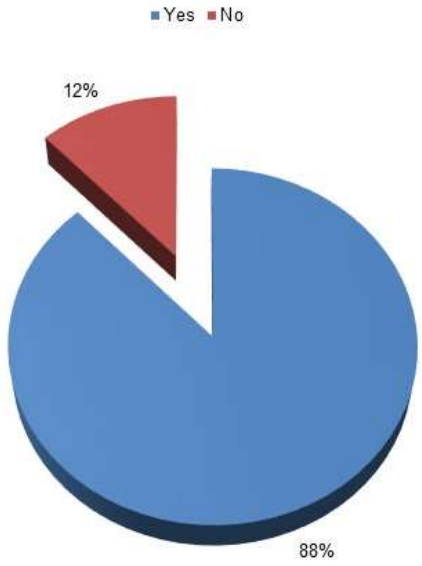
(Community 2 = Turner)

Type of Insurance



Base: Through an employer (n=49), Individually purchased (n=7), Indian or Tribal Health Service (n=2), Medicare (n=13), Medicare Part A (Hospital insurance) (n=5), Medicare Part B (Medical insurance) (n=5), Medicare Part D (Prescription insurance) (n=4), State Disability (n=12), SSI/ SSDI (n=2), Medicaid / Medical Assistance (n=2), Minnesota Care (n=3), Veteran Benefits (CHAMPUS, TRICARE) (n=2), Other (specify) (n=1), Sample Size = 72 (Community 2 = Turner).

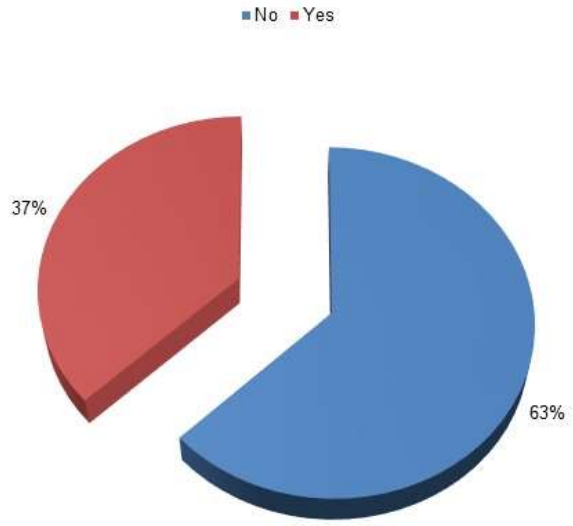
Do you have an established primary healthcare provider?



Base: Yes (n=69), No (n=9), Sample Size = 78

(Community 2 = Turner)

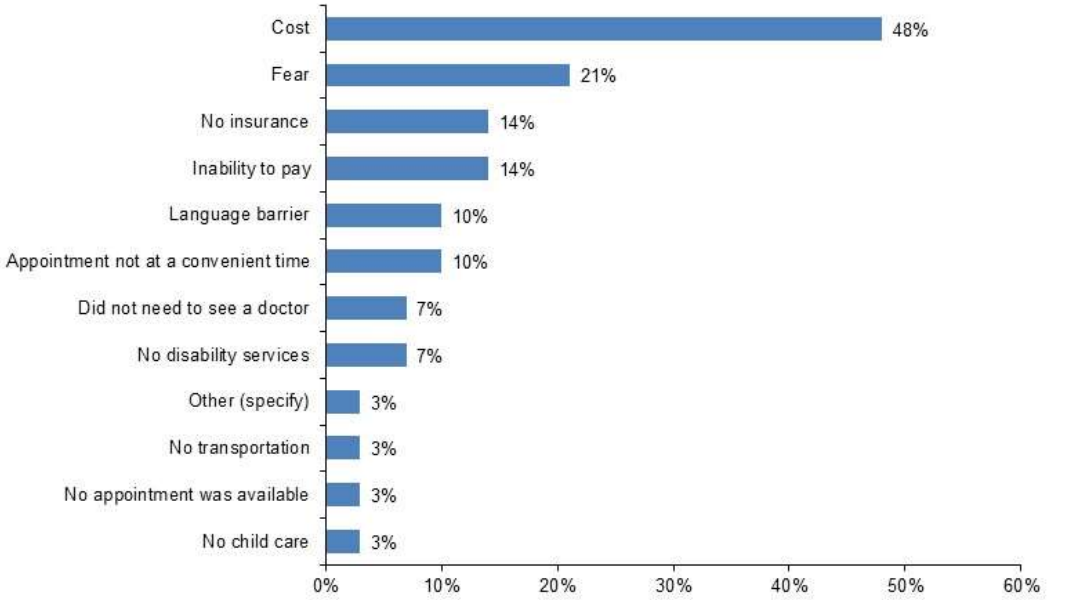
In the past year, did you or someone in your family need medical care, but did not receive the care they needed?



Base: Yes (n=29), No (n=49), Sample Size = 78

(Community 2 = Turner)

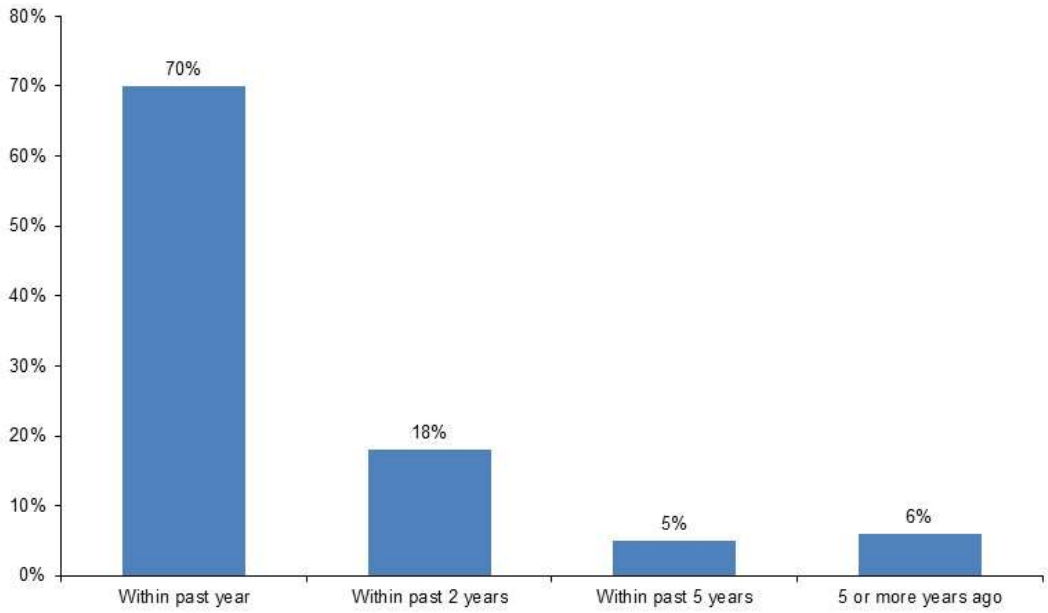
Barriers to Receiving Care Needed



Base: Inability to pay (n=4), No child care (n=1), No appointment was available (n=1), Appointment not at a convenient time (n=3), No disability services (n=2), No insurance (n=4), Language barrier (n=3), No transportation (n=1), Cost (n=14), Fear (n=6), Did not need to see a doctor (n=2), Other (specify) (n=1)

(Community 2 = Turner)

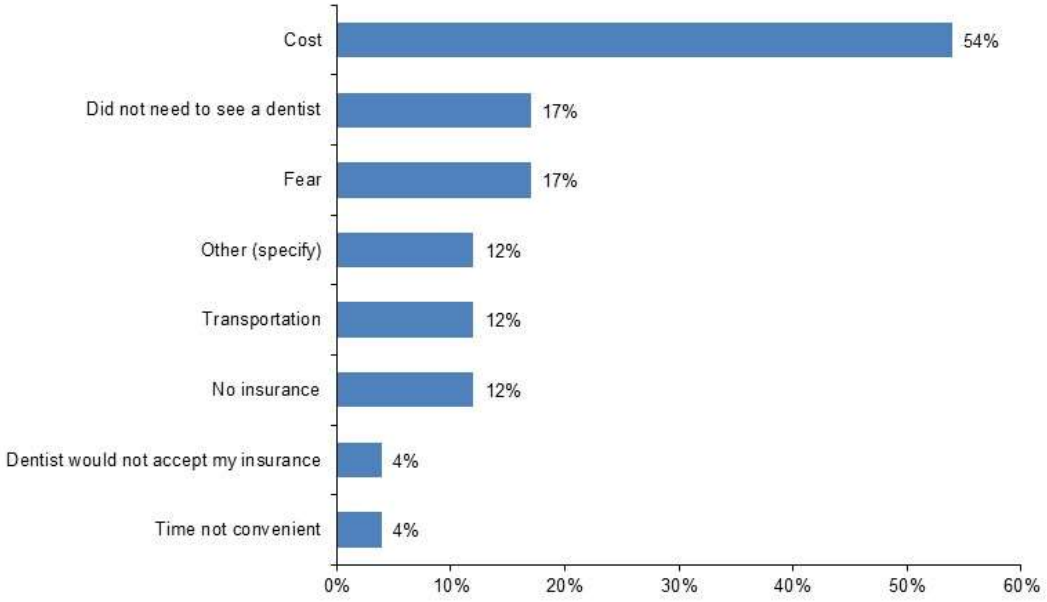
How long has it been since you last visited a dentist?



Base: Within past year (n=54), Within past 2 years (n=14), Within past 5 years (n=4), 5 or more years ago (n=5), Sample Size = 77

(Community 2 = Turner)

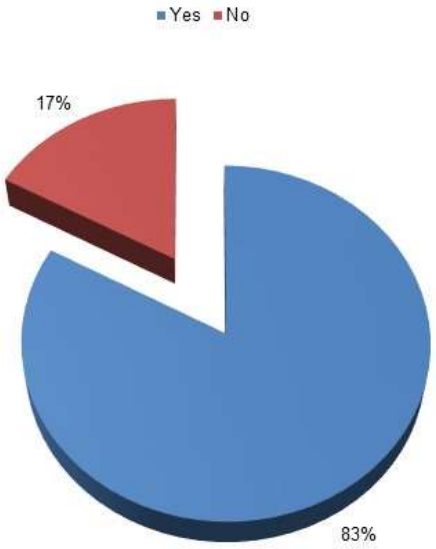
Barriers to Visiting the Dentist



Base: No insurance (n=3), Cost (n=13), Fear (n=4), Transportation (n=3), Time not convenient (n=1), Dentist would not accept my insurance (n=1), Did not need to see a dentist (n=4), Other (specify) (n=3), Sample Size = 24

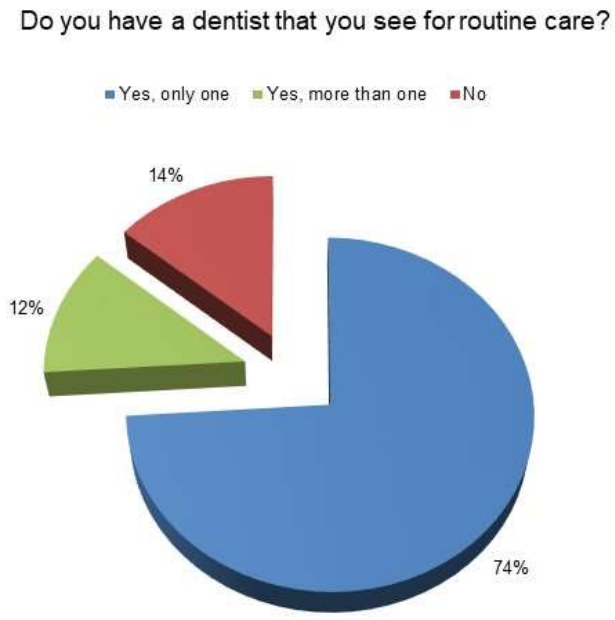
(Community 2 = Turner)

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



Base: Yes (n=65), No (n=13), Sample Size = 78

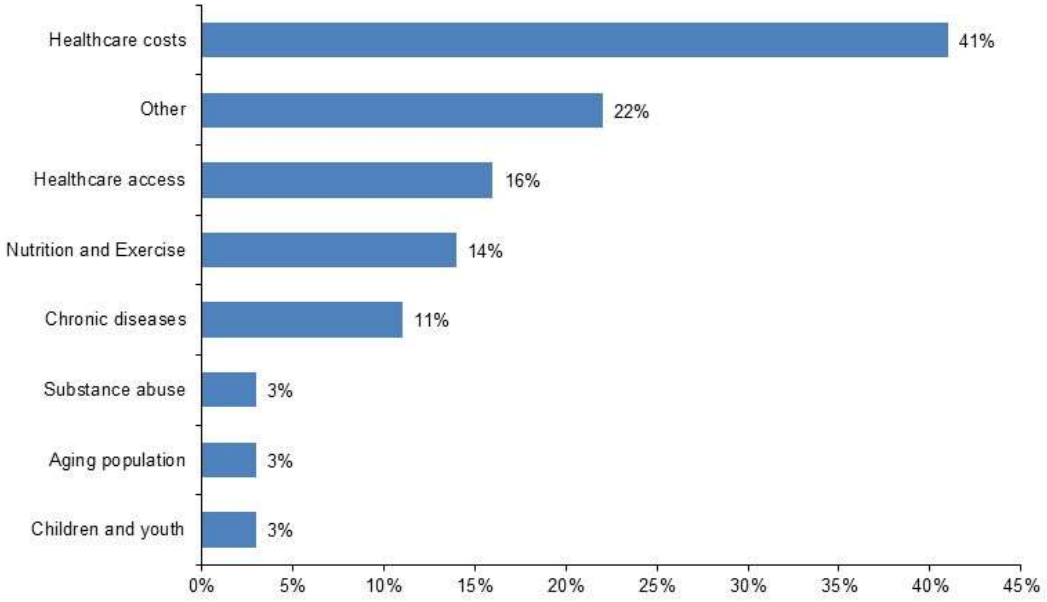
(Community 2 = Turner)



Base: Yes, only one (n=58), Yes, more than one (n=9), No (n=11), Sample Size = 78

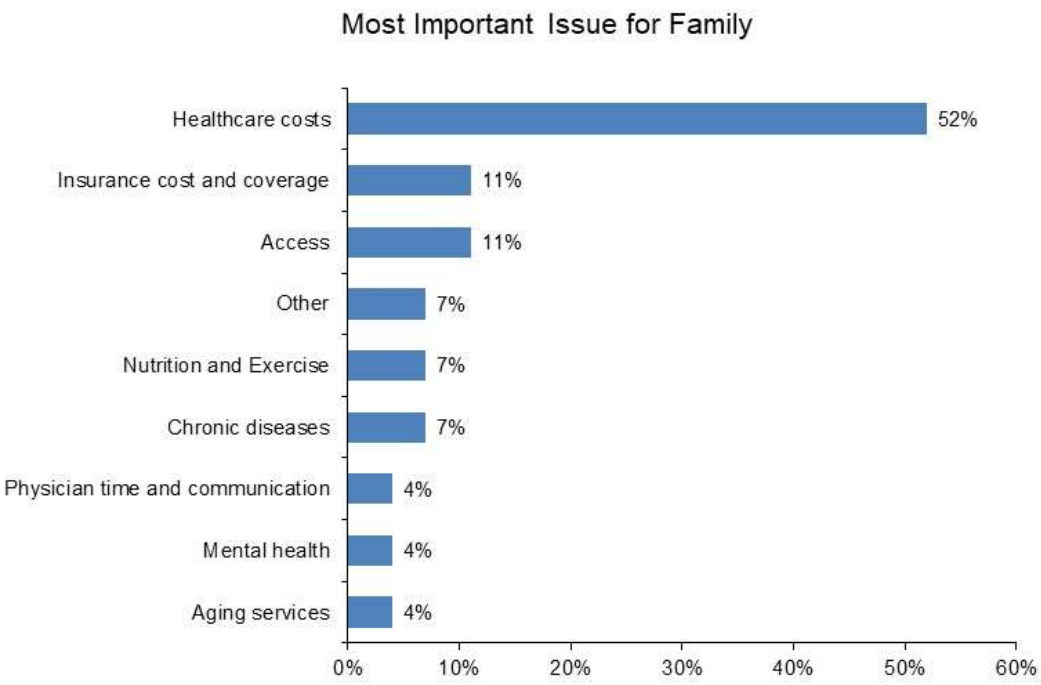
(Community 2 = Turner)

Most Important Community Issues



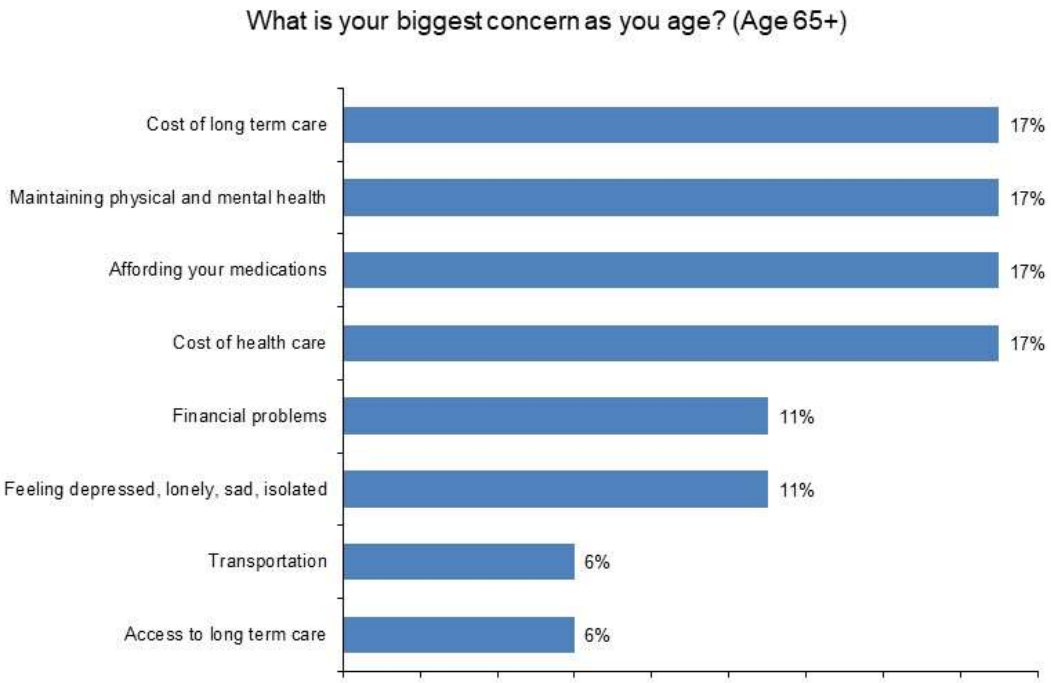
Base: Children and youth (n=1), Aging population (n=1), Healthcare access (n=6), Substance abuse (n=1), Chronic diseases (n=4), Healthcare costs (n=15), Nutrition and Exercise (n=5), Other (n=8), Sample Size = 64

(Community 2 = Turner)



Base: Access (n=3), Aging services (n=1), Chronic diseases (n=2), Healthcare costs (n=14), Nutrition and Exercise (n=2), Insurance cost and coverage (n=3), Mental health (n=1), Physician time and communication (n=1), Other (n=2), Sample Size = 60

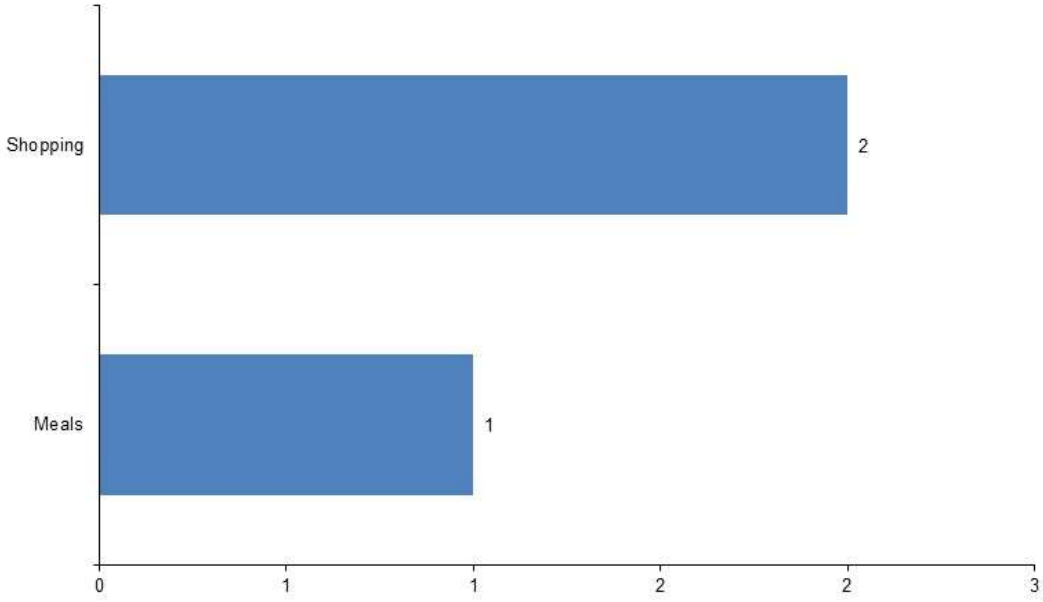
(Community 2 = Turner)



Base: Cost of health care (n=3), Affording your medications (n=3), Maintaining physical and mental health (n=3), Feeling depressed, lonely, sad, isolated (n=2), Access to long term care (n=1), Cost of long term care (n=3), Financial problems (n=2), Transportation (n=1), Sample Size = 7

(Community 2 = Turner)

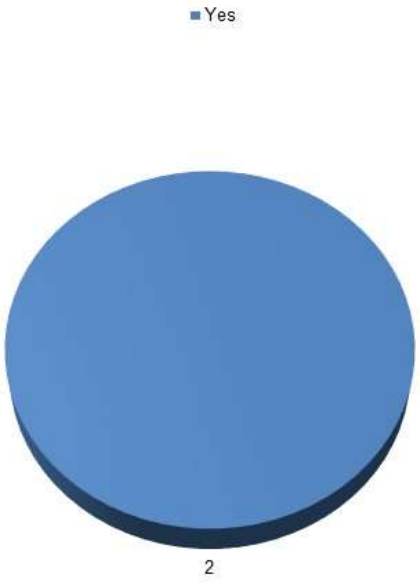
Which of these tasks do you need assistance with? (Age 65+)



Base: Meals (n=1), Shopping (n=2), Sample Size = 2

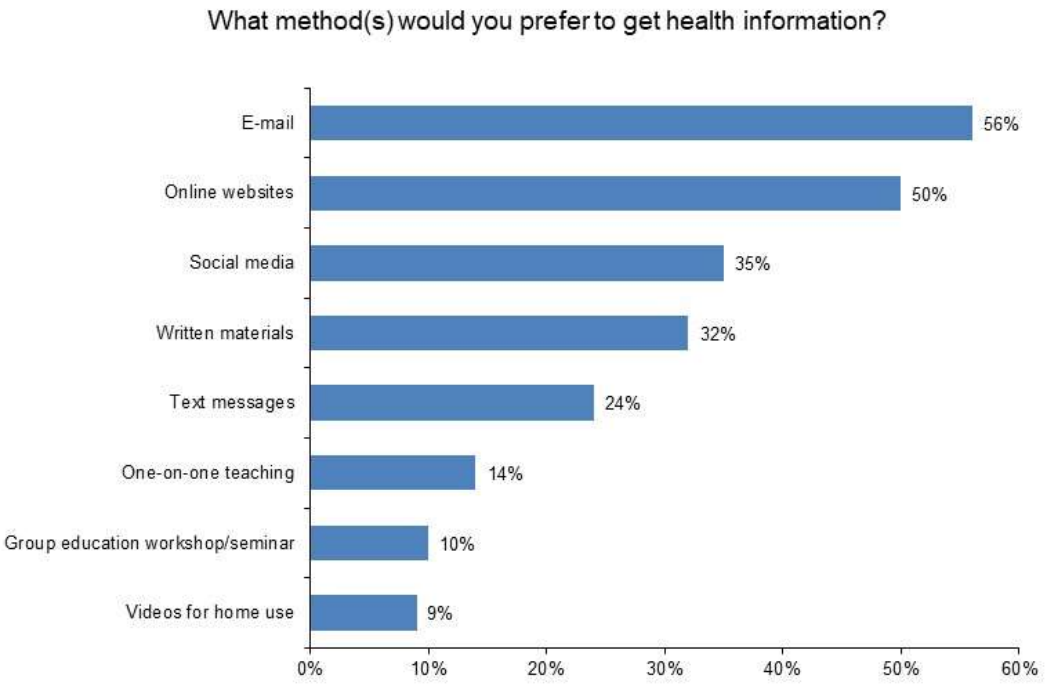
(Community 2 = Turner)

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



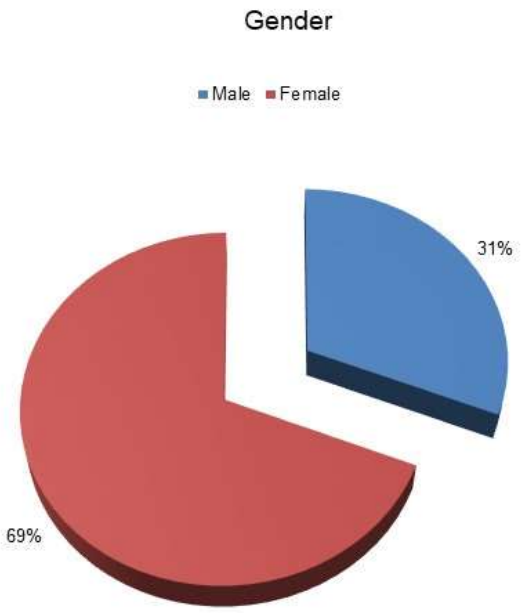
Base: Yes (n=2), Sample Size = 2

(Community 2 = Turner)



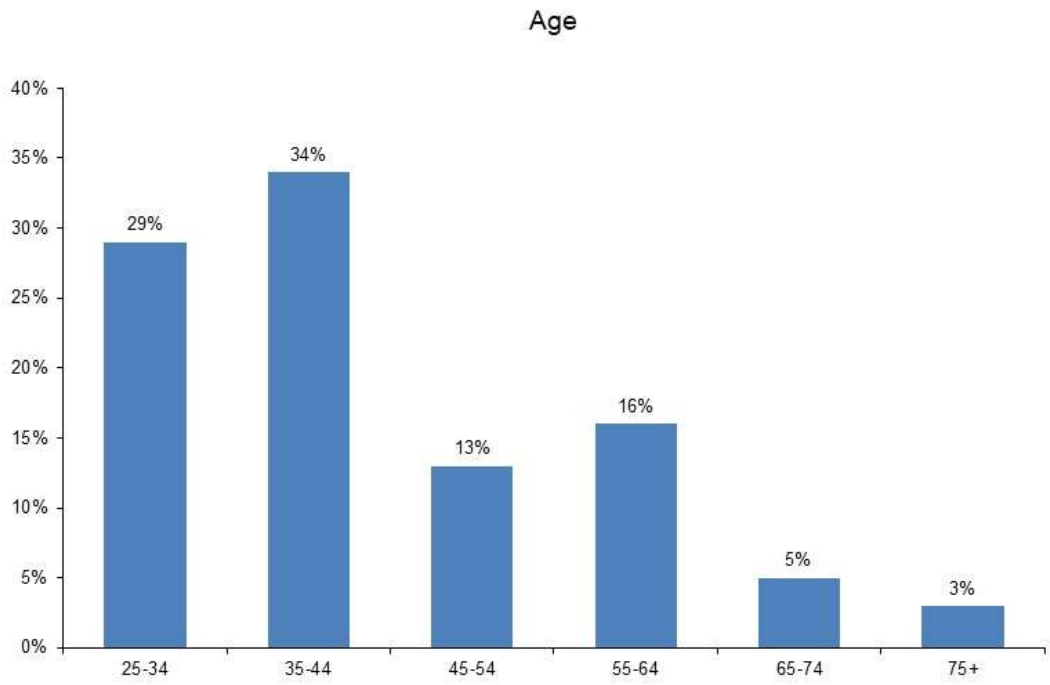
Base: Written materials (n=25), Videos for home use (n=7), Social media (n=27), Text messages (n=19), One-on-one teaching (n=11), E-mail (n=44), Group education workshop/seminar (n=8), Online websites (n=39), Sample Size = 78

(Community 2 = Turner)



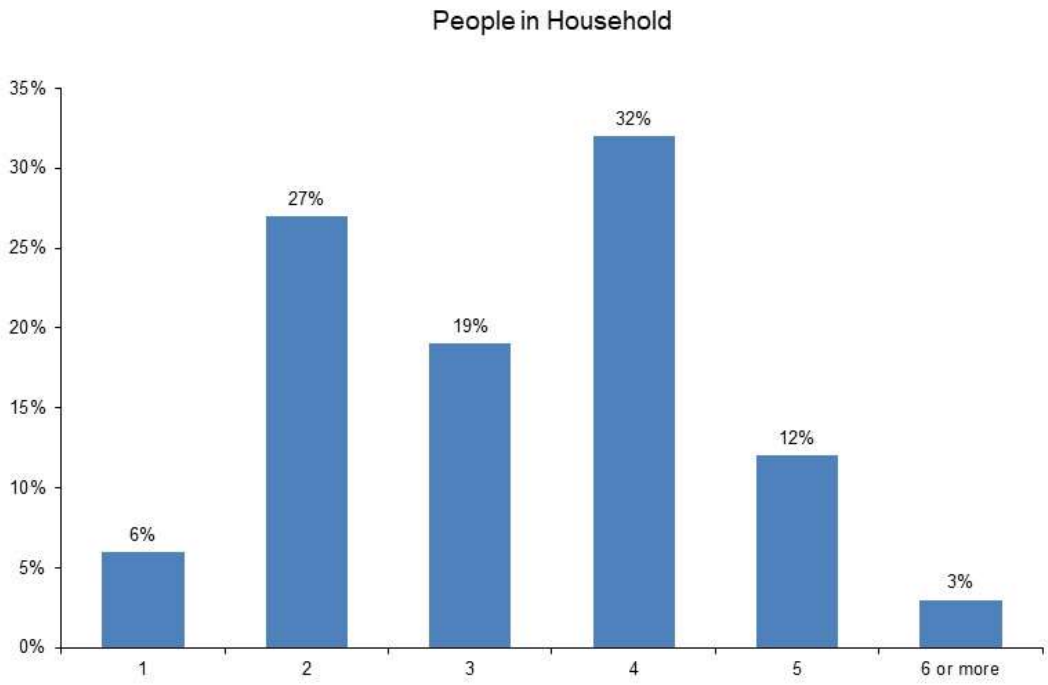
Base: Male (n=24), Female (n=53), Sample Size = 77

(Community 2 = Turner)



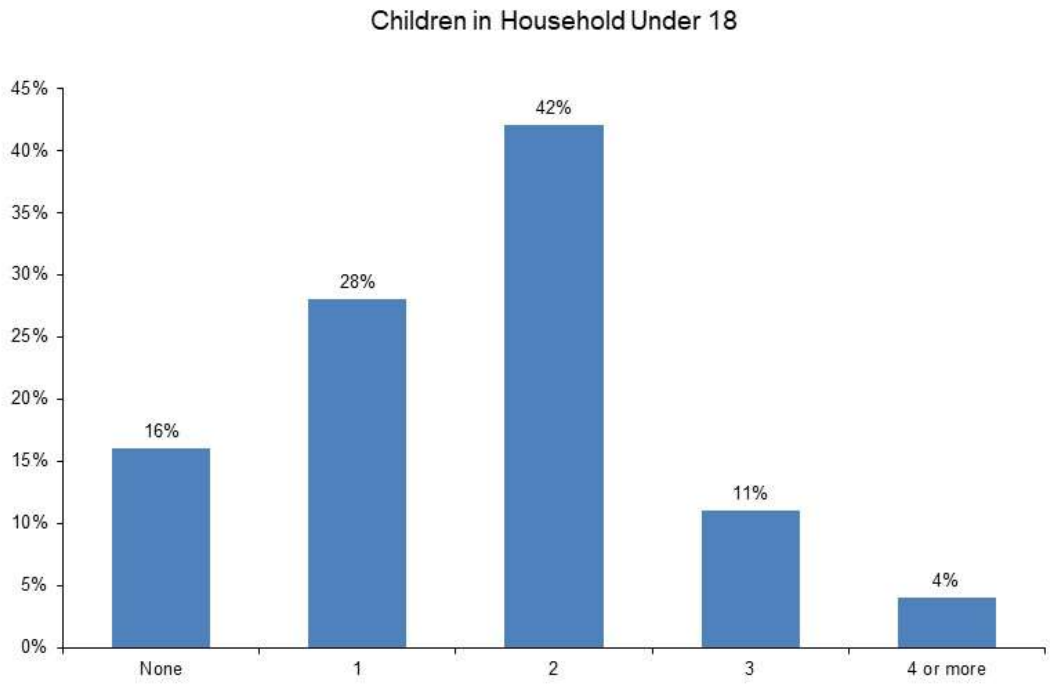
Base: 25-34 (n=22), 35-44 (n=26), 45-54 (n=10), 55-64 (n=12), 65-74 (n=4), 75+ (n=2), Sample Size = 76

(Community 2 = Turner)



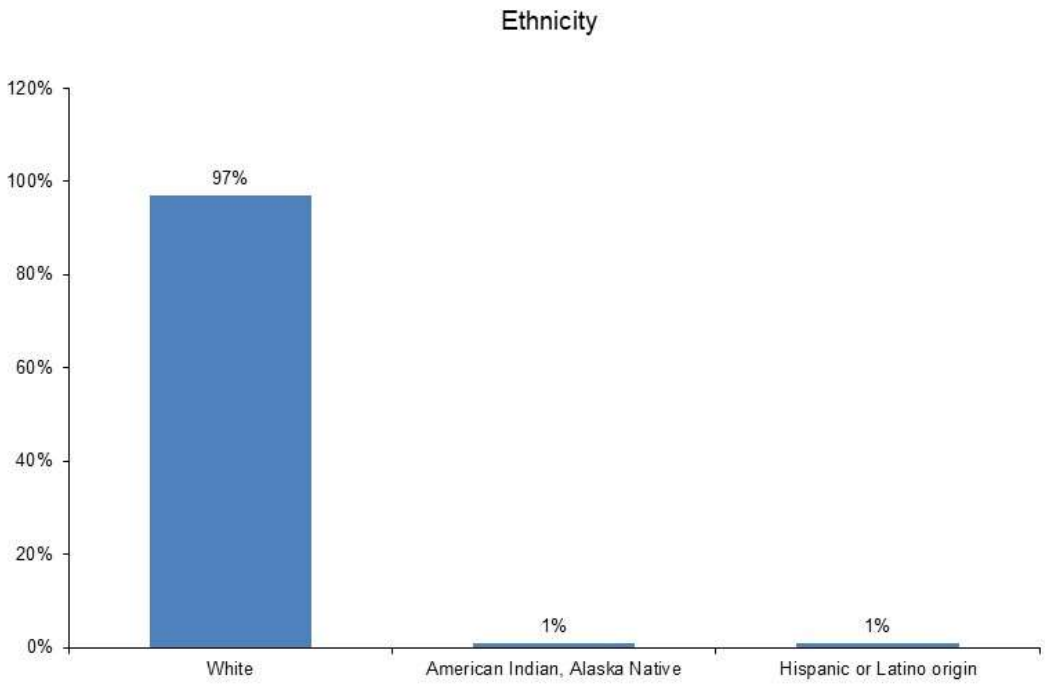
Base: 1 (n=5), 2 (n=21), 3 (n=15), 4 (n=25), 5 (n=9), 6 or more (n=2), Sample Size = 77

(Community 2 = Turner)



Base: None (n=9), 1 (n=16), 2 (n=24), 3 (n=6), 4 or more (n=2), Sample Size = 57

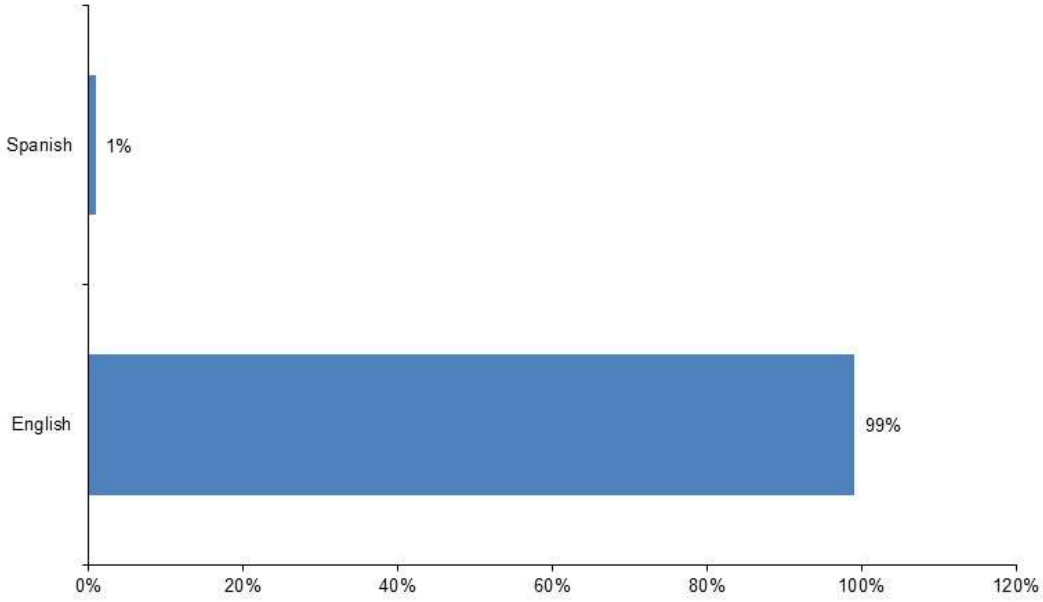
(Community 2 = Turner)



Base: White (n=76), American Indian, Alaska Native (n=1), Hispanic or Latino origin (n=1), Sample Size = 78

(Community 2 = Turner)

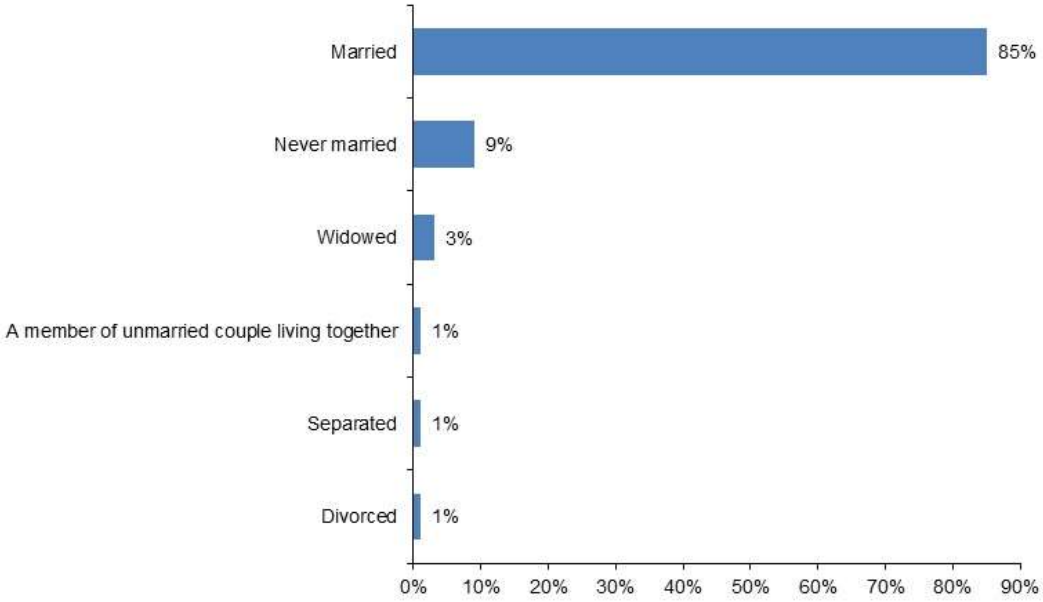
Language Spoken in Home



Base: English (n=77), Spanish (n=1), Sample Size = 78

(Community 2 = Turner)

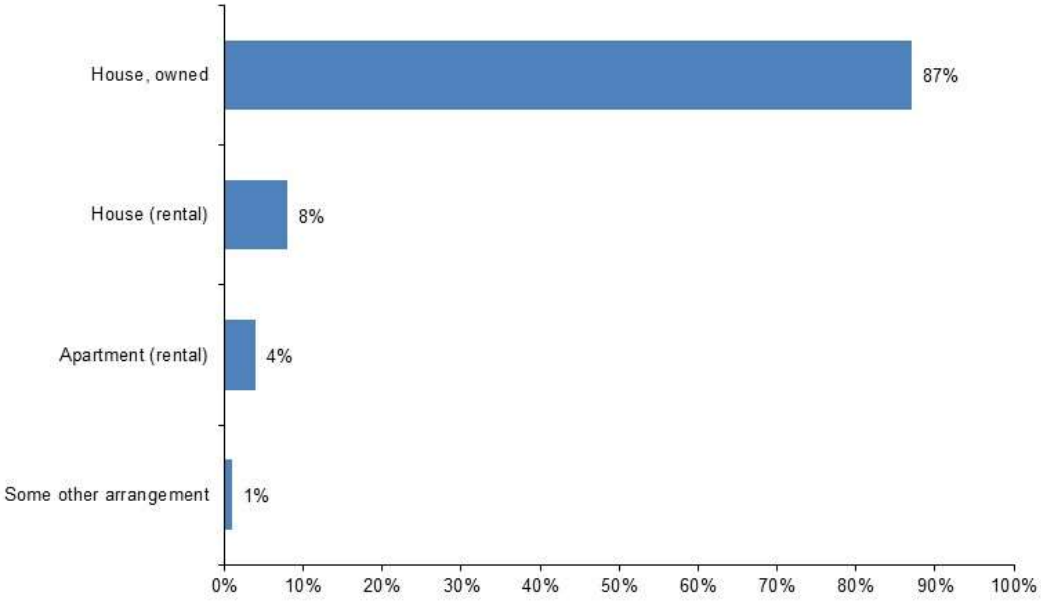
Marital Status



Base: Never married (n=7), Married (n=66), Divorced (n=1), Widowed (n=2), Separated (n=1), A member of unmarried couple living together (n=1), Sample Size = 78

(Community 2 = Turner)

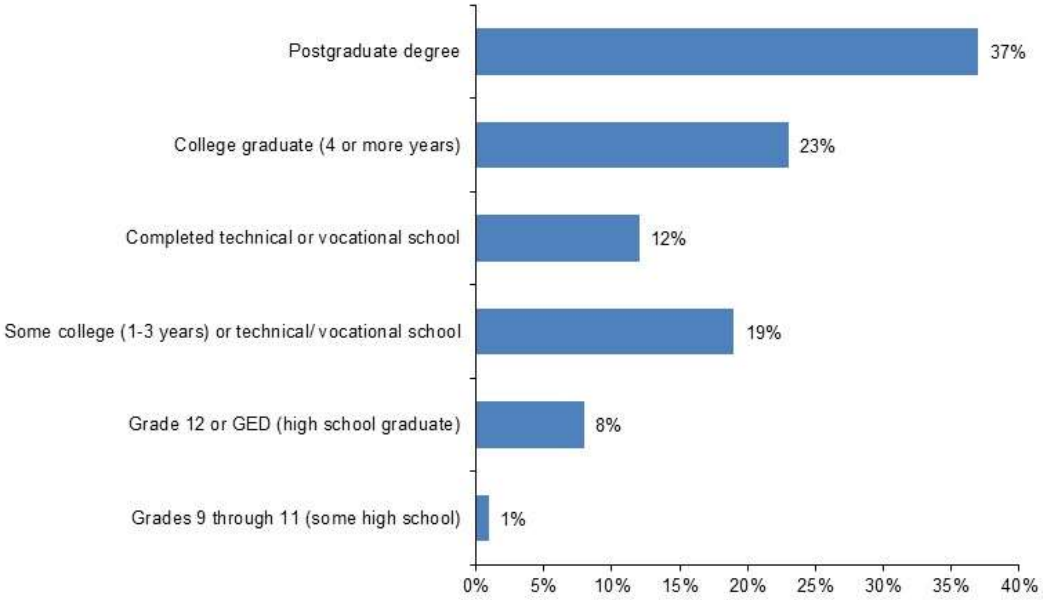
Current Living Situation



Base: House, owned (n=65), House (rental) (n=6), Apartment (rental) (n=3), Some other arrangement (n=1), Sample Size = 75

(Community 2 = Turner)

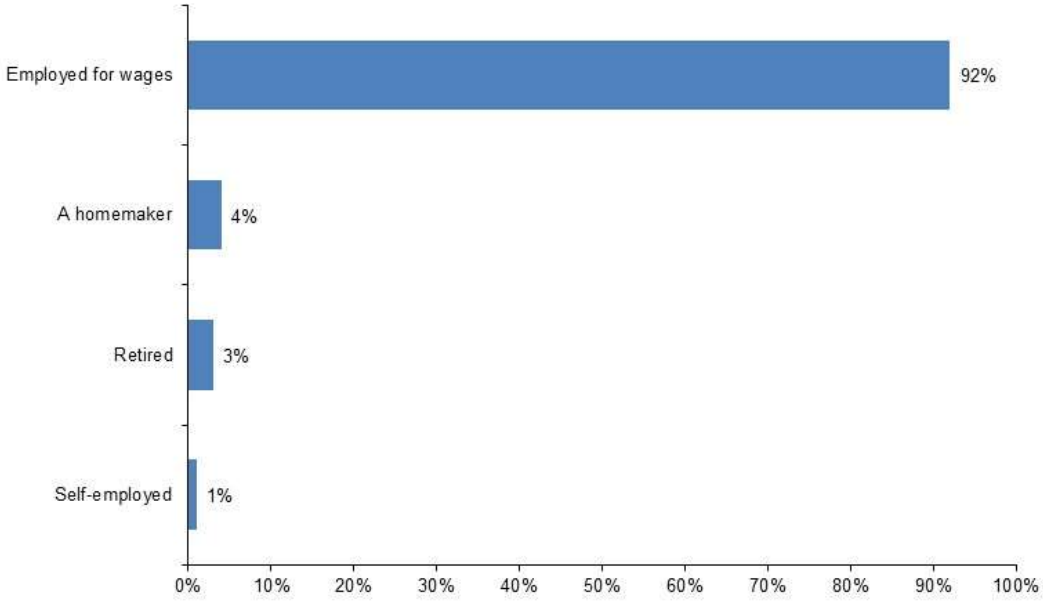
Education Level



Base: Grades 9 through 11 (some high school) (n=1), Grade 12 or GED (high school graduate) (n=6), Some college (1-3 years) or technical/ vocational school (n=15), Completed technical or vocational school (n=9), College graduate (4 or more years) (n=18), Postgraduate degree (n=29), Sample Size = 78

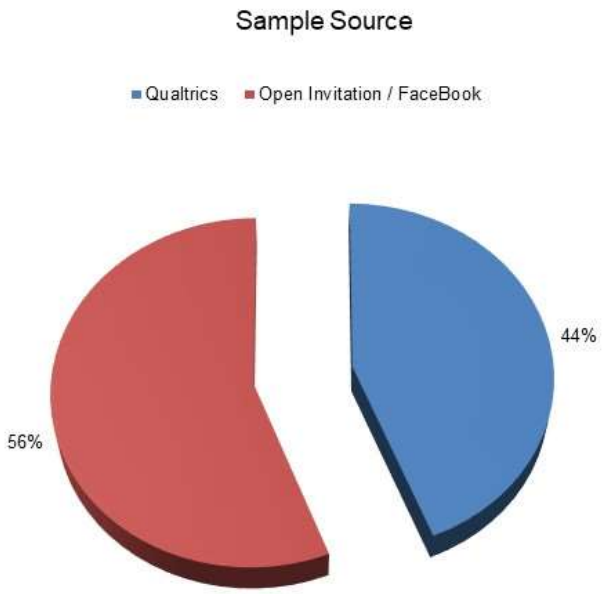
(Community 2 = Turner)

Employment Status



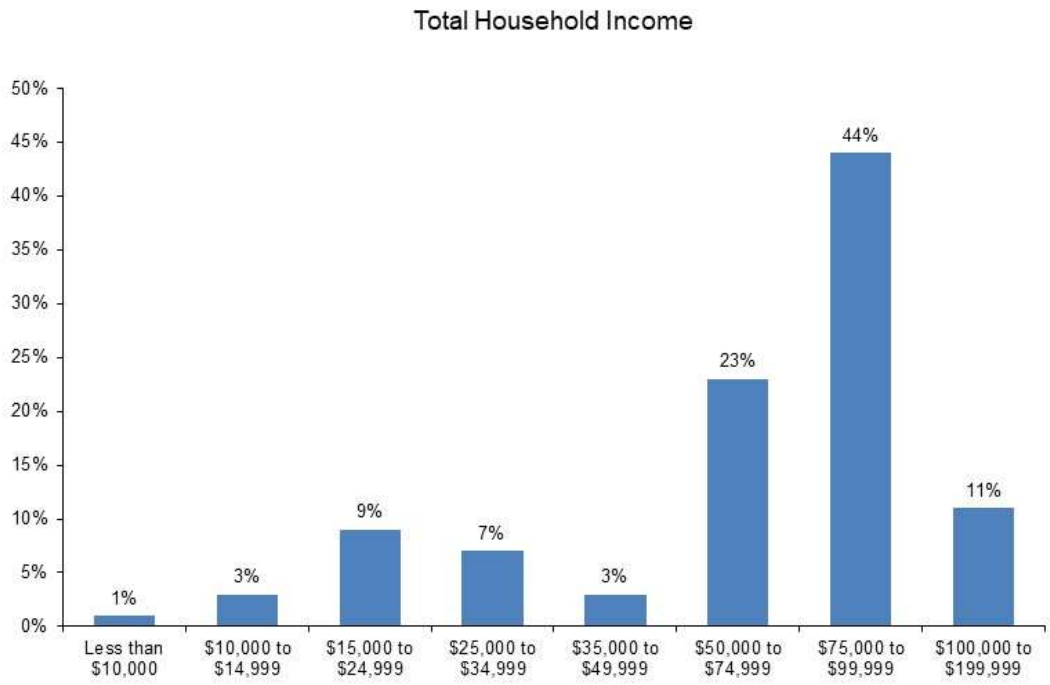
Base: Employed for wages (n=72), Self-employed (n=1), A homemaker (n=3), Retired (n=2), Sample Size = 78

(Community 2 = Turner)



Base: Qualtrics (n=34), Open Invitation / FaceBook (n=44), Sample Size = 78

(Community 2 = Turner)



Base: Less than $10,000 (n=1), $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=7), $25,000 to $34,999 (n=5), $35,000 to $49,999 (n=2), $50,000 to $74,999 (n=17), $75,000 to $99,999 (n=33), $100,000 to $199,999 (n=8), Sample Size = 75

(Community 2 = Turner)

Secondary Research

DEFINITIONS OF KEY INDICATORS
A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute

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

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

Contents:

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

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

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

Measure	Data Elements	Description
	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

Measure	Data Elements	Description
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	**Preventable Hosp. Rate**	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	Preventable Hosp. Rate (Black)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Blacks
	Preventable Hosp. Rate (Hispanic)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Hispanics
	Preventable Hosp. Rate (White)	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees for Whites
Mammography screening	**% Screened**	Percentage of female Medicare enrollees having an annual mammogram (age 65-74)
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Screened (Black)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Blacks
	% Screened (Hispanic)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Hispanics
	% Screened (White)	Percentage of female Medicare enrollees having an annual mammogram (age 65-74) for Whites
Flu vaccinations	**% Vaccinated**	Percentage of annual Medicare enrollees having an annual flu vaccination
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
	% Vaccinated (Black)	Percentage of annual Medicare enrollees having an annual flu vaccination for Blacks
	% Vaccinated (Hispanic)	Percentage of annual Medicare enrollees having an annual flu vaccination for Hispanics
	% Vaccinated (White)	Percentage of annual Medicare enrollees having an annual flu vaccination for Whites
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	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 Black children (under age 18) living in poverty - from the 2013-2017 ACS
	% Children in Poverty (Hispanic)	Percentage of Hispanic children (under age 18) living in poverty - from the 2013-2017 ACS
	% Children in Poverty (White)	Percentage of non-Hispanic White children (under age 18) living in poverty - from the 2013-2017 ACS
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations per 10,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	Annual Average Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes per 100,000 population
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
	95% CI - Low	95% confidence interval as reported by CDC Wonder
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	**Presence of violation**	County affected by a water violation: 1-Yes, 0-No
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Severe housing problems	**% Severe Housing Problems**	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities

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

Turner County

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

	Turner County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
HEALTH OUTCOMES					**7**
Length of Life					27
Premature Death	8,000	5,400-10,700	5,400	7,300	
Quality of Life					4
Poor or fair health	11%	10-11%	12%	12%	
Poor physical health days	2.8	2.6-2.9	3.0	3.1	
Poor mental health days	2.6	2.5-2.8	3.1	2.9	
Low birth weight	4%	3-6%	6%	6%	
HEALTH FACTORS					**33**
Health Behaviors					14
Adult smoking	14%	13-15%	14%	18%	
Adult obesity	35%	30-41%	26%	31%	
Food environment index	9.0		8.7	6.6	
Physical inactivity	19%	15-24%	19%	20%	
Access to exercise opportunities	60%		91%	72%	
Excessive drinking	18%	17-19%	13%	20%	
Alcohol-impaired driving deaths	33%	15-51%	13%	36%	
Sexually transmitted infections	158.4		152.8	504.5	
Teen births	9		14	28	
Clinical Care					36
Uninsured	9%	8-10%	6%	10%	
Primary care physicians	8,320:1		1,050:1	1,320:1	
Dentists	4,160:1		1,260:1	1,690:1	
Mental health providers	8,320:1		310:1	590:1	
Preventable hospital stays	4,872		2,765	4,724	
Mammography screening	47%		49%	49%	
Flu vaccinations	38%		52%	45%	
Social & Economic Factors					16
High school graduation	91%		96%	84%	
Some college	69%	62-75%	73%	68%	
Unemployment	3.2%		2.9%	3.3%	
Children in poverty	11%	8-14%	11%	16%	
Income inequality	4.3	3.7-4.8	3.7	4.2	
Children in single-parent households	25%	19-31%	20%	31%	
Social associations	26.5		21.9	16.4	
Violent crime	139		63	373	
Injury deaths	99	71-134	57	80	
Physical Environment					53
Air pollution – particulate matter	7.7		6.1	5.6	
Drinking water violations	No				
Severe housing problems	9%	7-11%	9%	12%	
Driving alone to work	77%	74-80%	72%	80%	

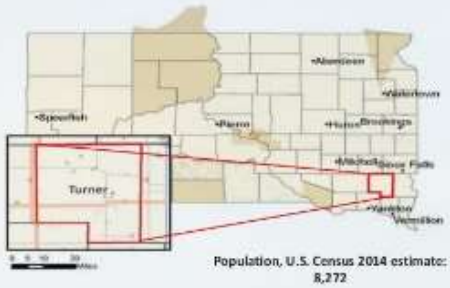
	Turner County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Long commute – driving alone	47%	42-52%	15%	15%	

Turner County

Focus on SD Report – 2019

THE LEONA M. AND HARRY B.
HELMSLEY
CHARITABLE TRUST

SOUTH DAKOTA HEALTH STUDY: TURNER COUNTY RESULTS



Population, U.S. Census 2014 estimate: 8,272

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Turner County Responses: 81	Response Rate: 40%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		TURNER COUNTY (n = 81)
57.4%	Female	49.0%
11.3%	Non-White	0.0%
19.1%	Age 65 and older	26.0%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	22.3%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	14.2%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	3.6%

NEED FOR CARE

75.0%	Need Medical Care	73.0%
79.5%	Need Prescription Medications	73.1%
9.5%	Need Mental Health Care	11.1%
1.1%	Need Alcohol or Drug Treatment	0.0%

ACCESS TO CARE

94.2%	Have a usual place to go for care	92.6%
77.4%	Have a personal doctor/provider	73.7%
13.0%	Unmet medical needs	13.2%
6.4%	Unmet prescription needs	7.6%
35.8%	Unmet mental health needs	49.3%
45.6%	Unmet alcohol or drug abuse needs	N/A

HEALTH PROFILE

SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	TURNER COUNTY (n = 81)
11.4%	Diabetes	15.2%
10.9%	Asthma	3.3%
33.3%	High Blood Pressure	38.2%
8.9%	Heart Disease	14.8%
28.5%	High Cholesterol	34.4%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	4.5%
8.9%	Cancer	13.2%
54.7%	At least one of the above	51.7%
17.0%	Depression	12.4%
17.6%	Anxiety	9.9%
3.4%	PTSD (Post Traumatic Stress Disorder)	6.2%
1.7%	Bipolar Disorder	1.4%
2.6%	Addiction Issues	0.0%
25.5%	At least one of the above	20.2%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	83.2%
5.5%	Depression	8.7%
7.5%	Anxiety	5.5%
6.0%	PTSD (Post-Traumatic Stress Disorder)	3.2%
17.0%	Current Smoker	11.6%
42.4%	Alcohol Abuse	35.6%
6.7%	Marijuana Use (past year)	1.3%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