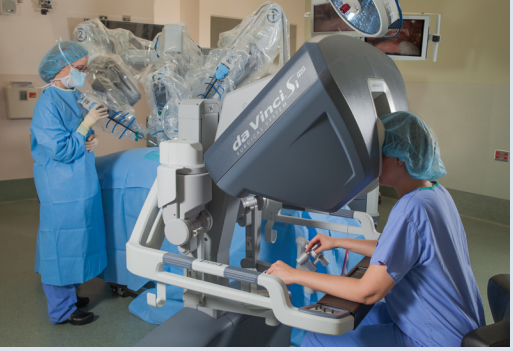


















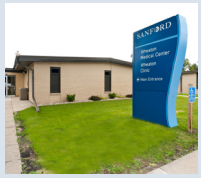




SANFORD HEALTH

Sanford Health Network

2018 Community Health Needs Assessment

dba Sanford Clear Lake Medical Center EIN# 46-0388596

Dear Community Members,

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

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

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

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

- *Transportation*
- *Physical Health*

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

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

Sincerely,

Lori Sisk

Lori Sisk, RN, MHA
Senior Director
Sanford Clear Lake Medical Center

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Sanford Medical Center Clear Lake

Community Health Needs Assessment

2018

Executive Summary

Purpose

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

Our Guiding Principles

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

Regulatory Requirements

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

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

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

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

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

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

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

Study Design and Methodology

1. Primary Research
   A. *Key Stakeholder Survey*
   An online survey was conducted with identified community key stakeholders. The study concentrated on the stakeholder's concerns for the community specific to economic well-being, transportation, children and youth, the aging population, safety, health care and wellness, mental health and substance abuse. The study was conducted through a partnership between Sanford Health, and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Sanford Health distributed the survey link via email to stakeholders and key leaders located within Deuel County. Data collection occurred during November 2017. A total of 22 community stakeholders participated in the survey.

   B. *Resident Survey*
   The resident survey tool includes questions about the respondent's personal health. An online survey was developed in partnership with public health experts from across the Sanford footprint. The Minnesota Health Department reviewed and advised Sanford about key questions that they request of the SHIP surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a link to the survey was published in the local newspaper. A total of 27 community residents participated in the survey.

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

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

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

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

Limitations of the Study

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

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

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

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

Key Findings

Community Health Concerns
The key findings are based on the key stakeholder survey, the resident survey and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.0 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.0; however, the high ranking needs of 3.0 or above are considered for the prioritization process. The resident survey addresses personal health needs and concern. The secondary research provides further understanding of the health of the community and in many cases the indicators are aligned and validate our findings.

Economic Well-Being
Community stakeholders are most concerned about employment options (ranking 3.50), need for a skilled labor force (3.29), the availability of affordable housing (3.14) and the need for budgeting and money management.

Transportation
Community stakeholders are most concerned about the availability (and cost) of door-to-door transportation services for those unable to drive (3.45) and the availability of public transportation (3.33).

Children and Youth
Community stakeholders are most concerned about childhood obesity (3.26) and bullying (3.11).

Aging Population
Community stakeholders are most concerned about the cost of long term care (3.42), memory care (3.37), the availability of activities for seniors (3.11), the availability of memory care (3.06), and the availability of resources and cost of services to help the elderly stay in the homes (3.00).

Safety
Community stakeholders are most concerned about abuse of prescription drugs (3.00).

Health Care Access
Community stakeholders are most concerned about the availability of behavioral health providers (3.26), the availability of mental health providers (3.26), access to affordable health insurance coverage (3.16), and access to affordable health care (3.00).

Mental Health and Substance Abuse
Community stakeholders are most concerned about depression (3.16), stress (3.11), and tobacco use (3.05).

Resident survey participants are facing the following issues:

- 73% report that they are overweight or obese
- 50% self-report binge drinking at least 1X/month
- 47% report that they have arthritis
- 35% have hypertension
- 29% report that they have been diagnosed with anxiety
- 24% report that they have been diagnosed with depression
- 23% have not seen their health care provider in more than a year

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

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

- Transportation
- Physical Health

Implementation Strategies

Priority 1: Transportation

The University of Minnesota's Rural Health Research Center reports that transportation is a concern for rural residents. A social determinant of health, affordable transportation is fundamental to mental, physical, and emotional well-being. Individuals with disabilities, those with low incomes, seniors, and others who may not have reliable access to transportation depend on public and private transportation to access health services, obtain food and other basic needs, and to engage with their communities.

Sanford Clear Lake has made transportation a significant priority and has developed a strategy to work in collaboration with community organizations to explore options for the local community and county members.

Priority 2: Physical Health

According to the Centers for Disease Control, obesity is a complex health issue to address. Obesity can be caused from a combination of contributing factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors in our society include the food and physical activity environment, education and skills, and food marketing and promotion.

Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and is associated with morbidity and illnesses including diabetes, heart disease, stroke, and some types of cancer.

Sanford Clear Lake has made physical health specific to obesity a significant priority and has developed strategy to improve physical health and reduce the negative health effects of obesity.

Sanford Clear Lake Medical Center

Community Health Needs Assessment

2018

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Acknowledgements

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

Sanford Steering Group:

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

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

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

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

- Becky Secore, Beltrami Public Health
- Julie Sorby, Family HealthCare Center
- Brenda Stallman, Traill County Public Health
- Diane Thorson, Ottertail County Public Health
- Juli Ward, Avera Health
- MayLynn Warne, North Dakota Public Health Association

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

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

- Gary DeJong, County Commissioner
- Morgan Engelkes, USD Intern
- Gerry Law, Community Board Member
- Sheila Pitts, Interim DON, Sanford Health
- Ellen Schmahl, City Finance Officer
- Lori Sisk, Senior Director, Sanford Health
- Darla Toben, Patient Access Manager, Sanford Health

Description of Sanford Clear Lake Medical Center – Clear Lake, SD

Sanford Clear Lake Medical Center is a community-based, 20-bed acute care Critical Access Hospital serving over 4,500 people in Deuel County in southeastern South Dakota. The nearest tertiary center is in Sioux Falls, SD, approximately 100 miles to the south. The medical center is located in a medically underserved area with high infant mortality, poverty and an elderly population.

Sanford Clear Lake Medical Center offers 24-hour emergency room services, and has an attached rural health clinic with 1 full-time provider and 1 full-time nurse practitioner. Other services include home health care, community health, and an off-site wellness center. Sanford Clear Lake has an active outreach program to provide same day outpatient surgery, cardiac rehab and other cardiology services, therapies, podiatry, nephrology, psychology, radiology and lab.

Description of the Community Served – Clear Lake, SD

Clear Lake is located in Deuel County in southeastern South Dakota. It has a population of 1,200 and was named after the local Clear Lake. It is home to two community parks, a pool, athletic complex, six churches and the Deuel County Courthouse.

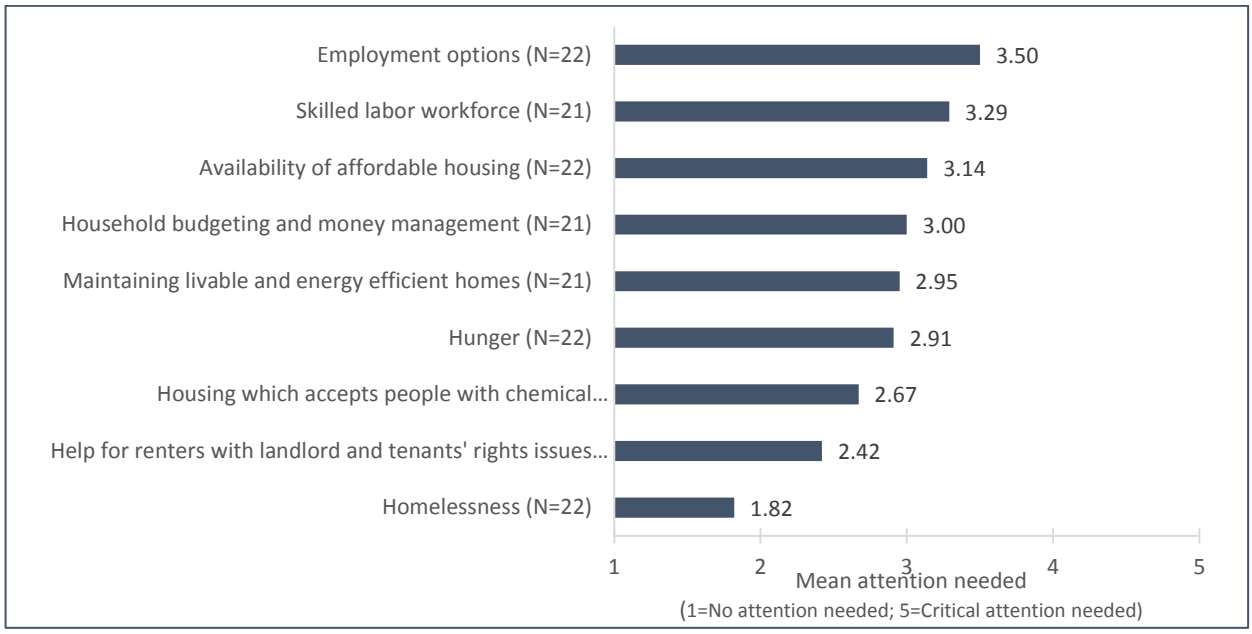
Clear Lake hosts one of the largest rodeos in the area, drawing thousands of people to the town. It is held in the nation's most natural rodeo bowl in the Coteau Hills, a native grassland prairie formed by glaciers. During the rodeo, visitors and residents alike enjoy camping, community garage and yard sales, and a parade.

Key Findings

Community Health Concerns

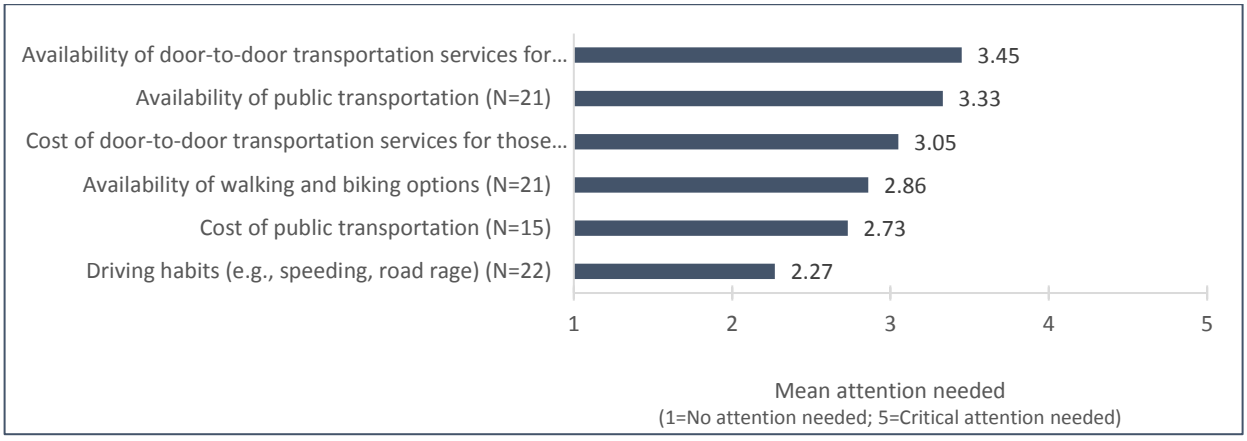
The key findings are based on the key stakeholder survey, the resident survey, and secondary research. The key stakeholder survey ranked key indicators on a Likert scale with 1 meaning no attention needed and 5 meaning critical attention needed. Survey results ranking 3.0 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.0; however, the high ranking needs of 3.0 or above are considered for the prioritization process. The resident survey addresses personal health needs and concerns. The secondary research provides further understanding of the health of the community, and in some cases, the indicators align with and validate our findings.

Economic Well-Being: The concern for the community's economic well-being is focused on the need for employment options, a skilled workforce, affordable housing, and household budgeting and money management.



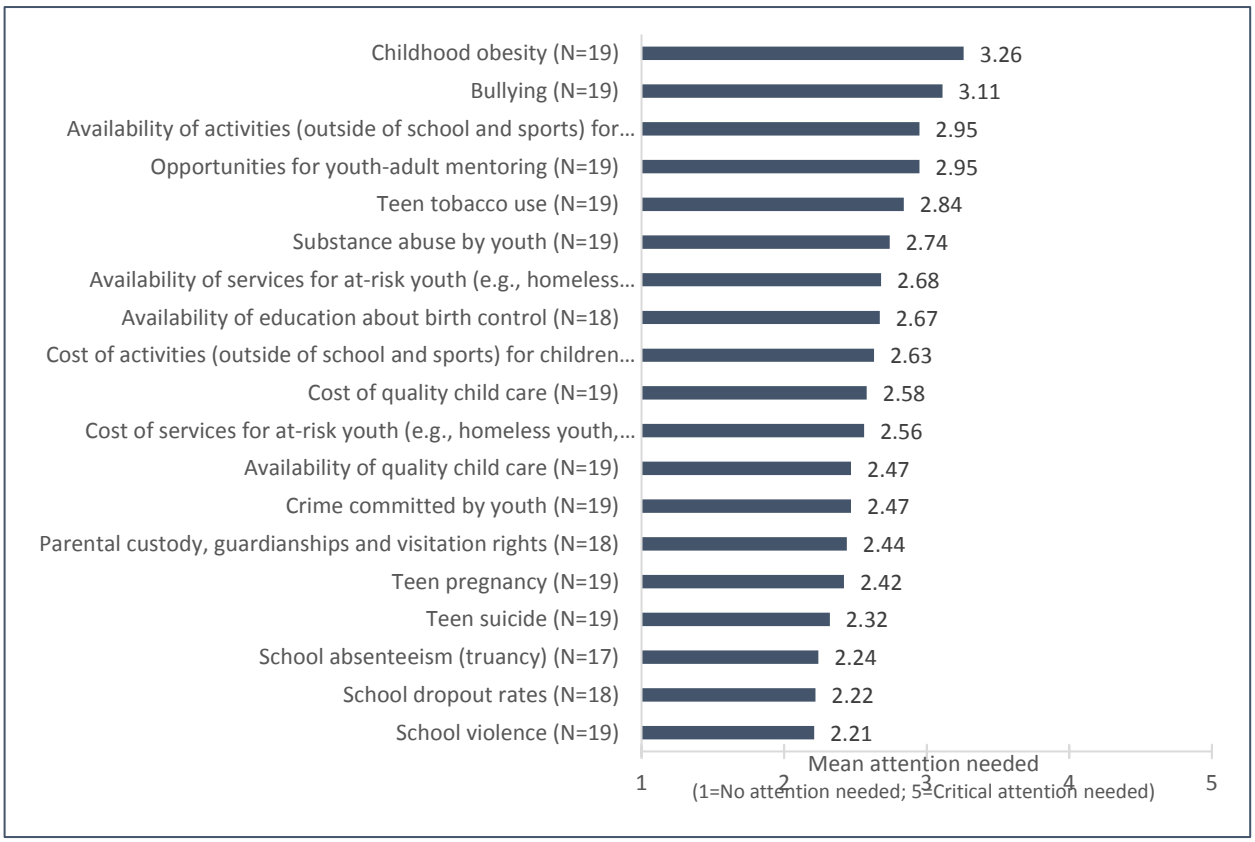
Healthy People 2020 has defined the social determinants of health. "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Conditions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

Transportation: The concern for the community's transportation needs is the availability and cost of door-to-door services for people who are not able to drive, and also the availability of public transportation.



Transportation is considered a social determinant of health and is fundamental to mental, physical, and emotional well-being. Individuals with disabilities, those with low incomes, seniors, and others who may not have reliable access to transportation depend on public and private transportation to access health services, obtain food and other basic needs, and to engage with their communities.

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



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

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

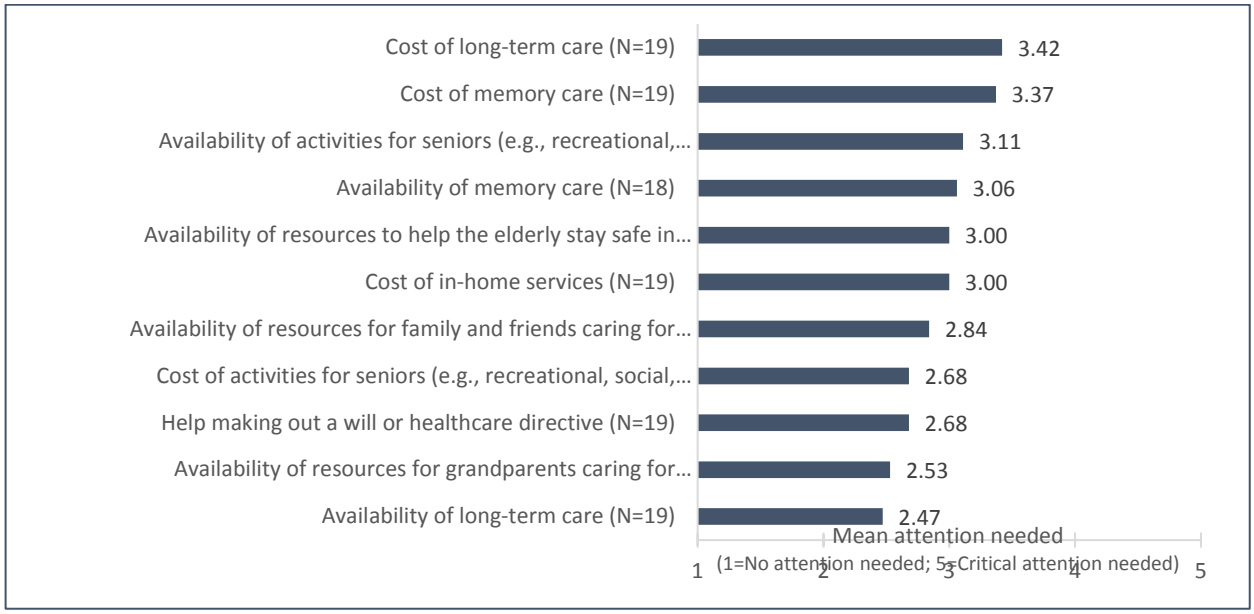
Youth may also be more likely to try drugs because of circumstances or events called risk factors. Examples of risk factors include:

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

Protective factors include:

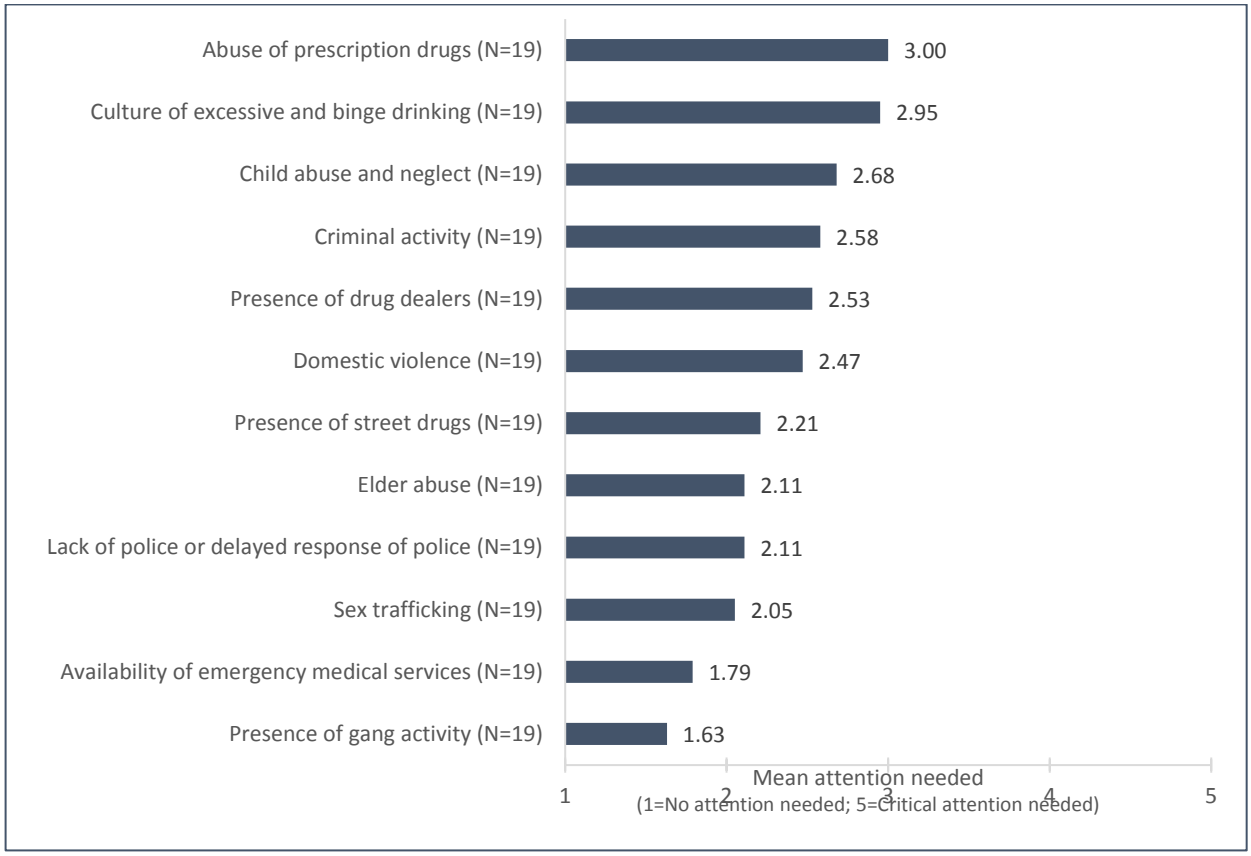
- Having high self-esteem
- Attending a school with policies against using alcohol and drugs
- Having an adult role model who doesn't use tobacco or drugs or misuse alcohol
- Participating in athletic, community, or faith-based groups
- Living in a community with youth activities that prohibit drugs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

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



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

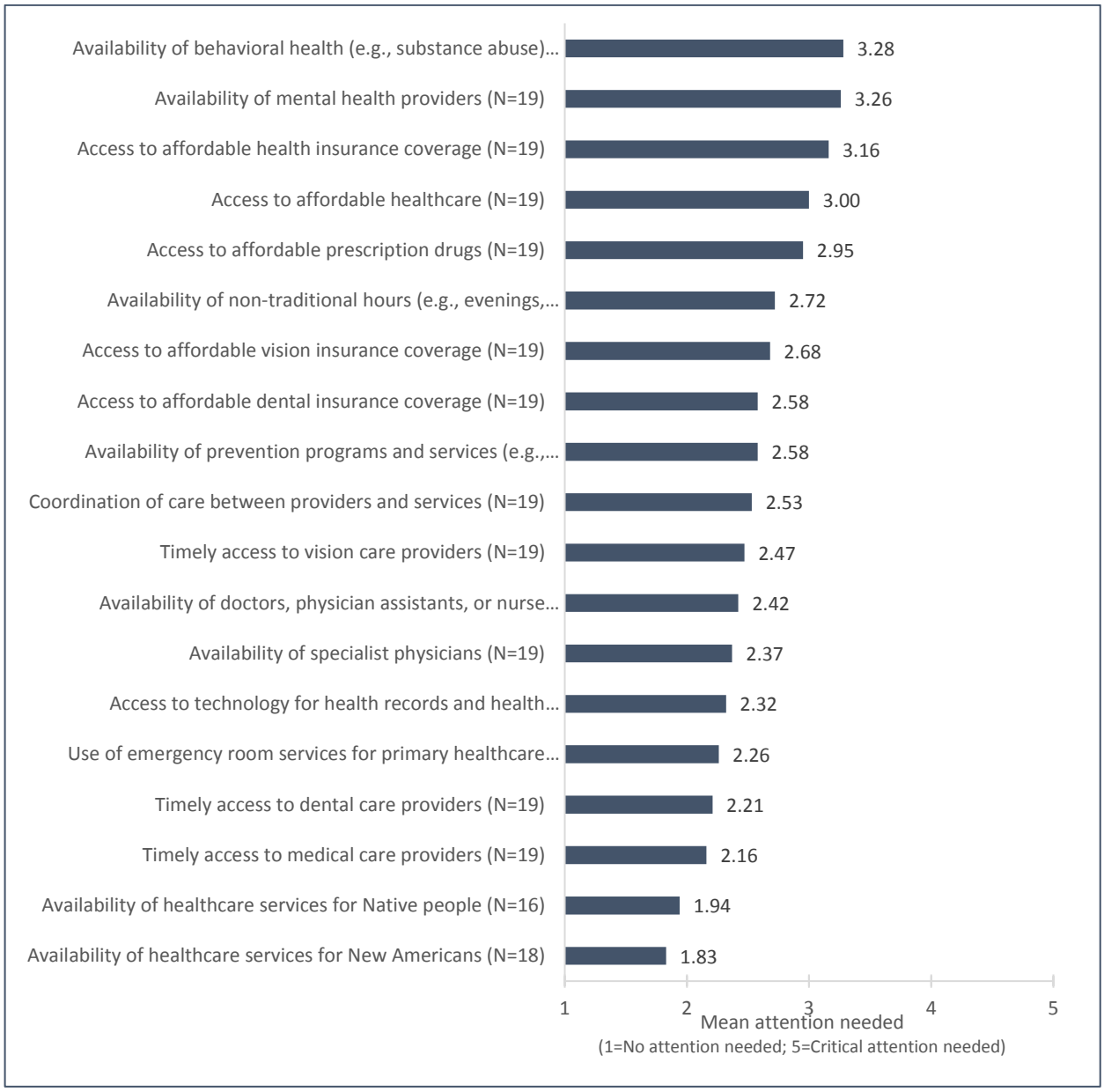
Safety: The abuse of prescription drugs is the top concern for safety in the community.



Current State of Community Issues Regarding Safety

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

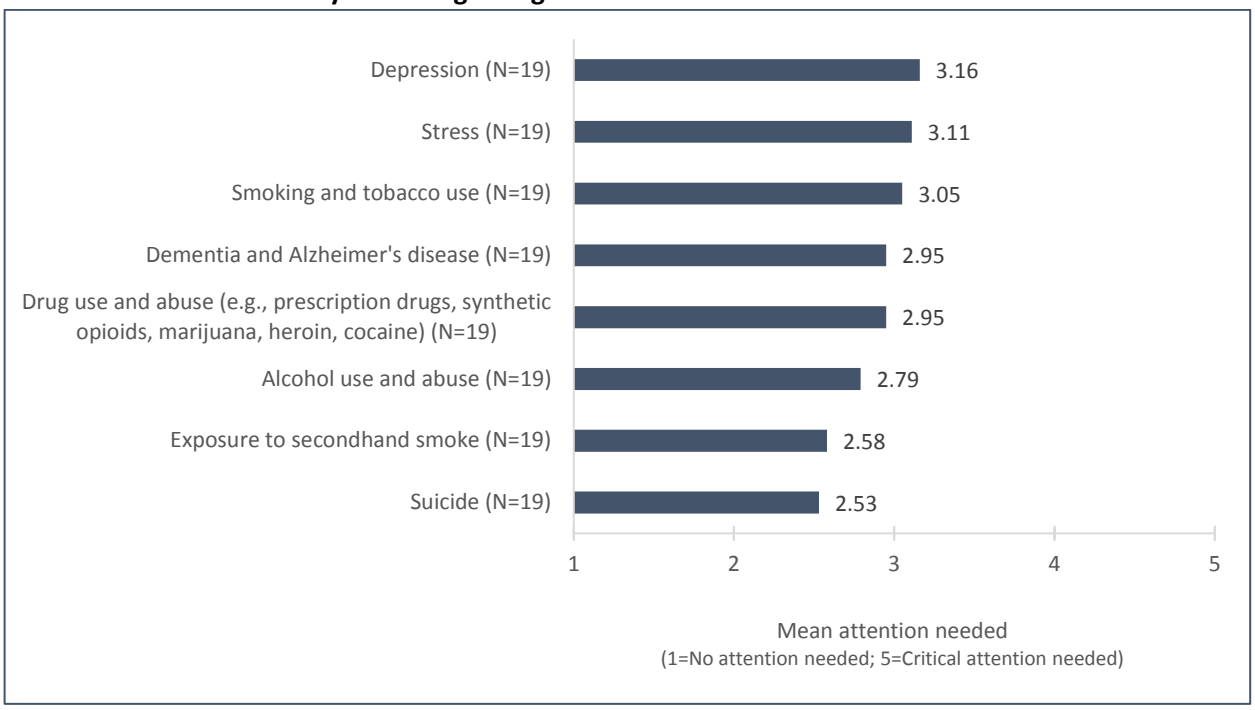
Health Care and Wellness: The availability of behavioral health and mental health providers are ranked very high among the top concerns for the community. Access to affordable health insurance and affordable health care, affordable prescription drugs are all high concerns for community stakeholders.



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

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

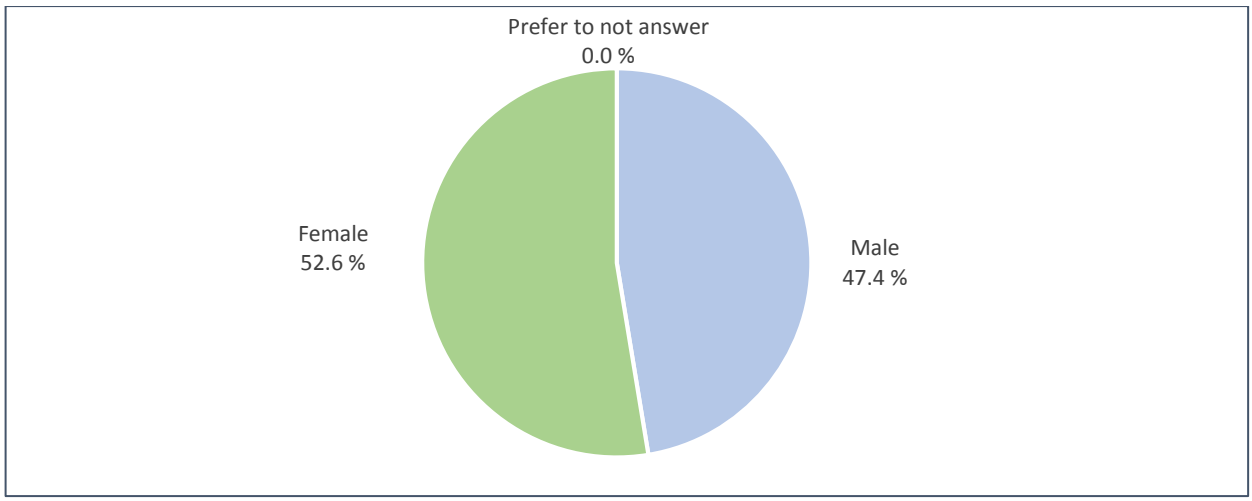
Current state of community issues regarding MENTAL HEALTH AND SUBSTANCE ABUSE



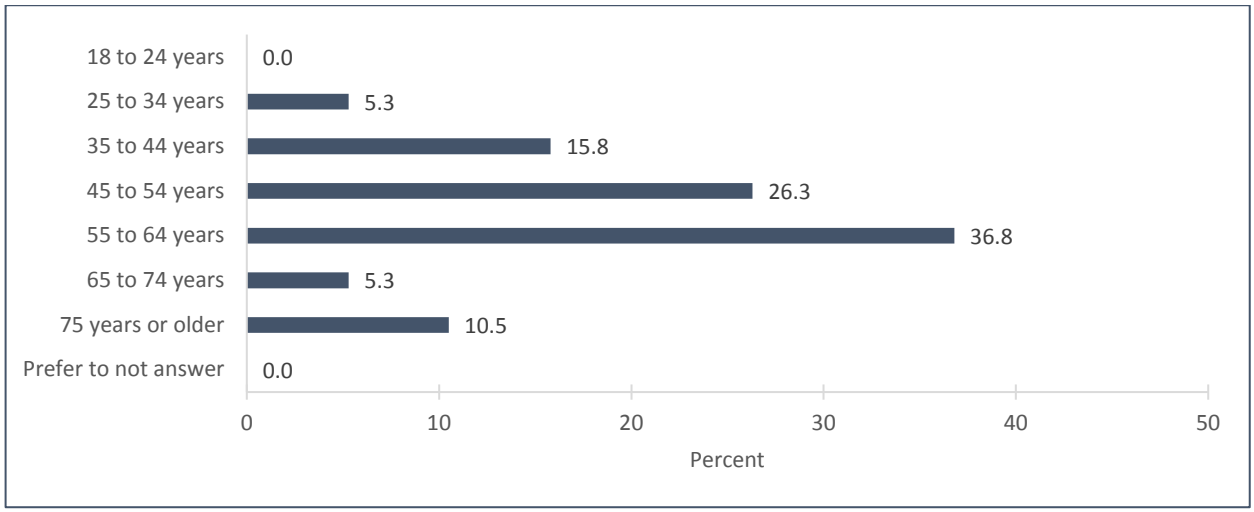
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults age 18 and older in the United States had a serious mental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

Demographic Information for Key Stakeholder Participants

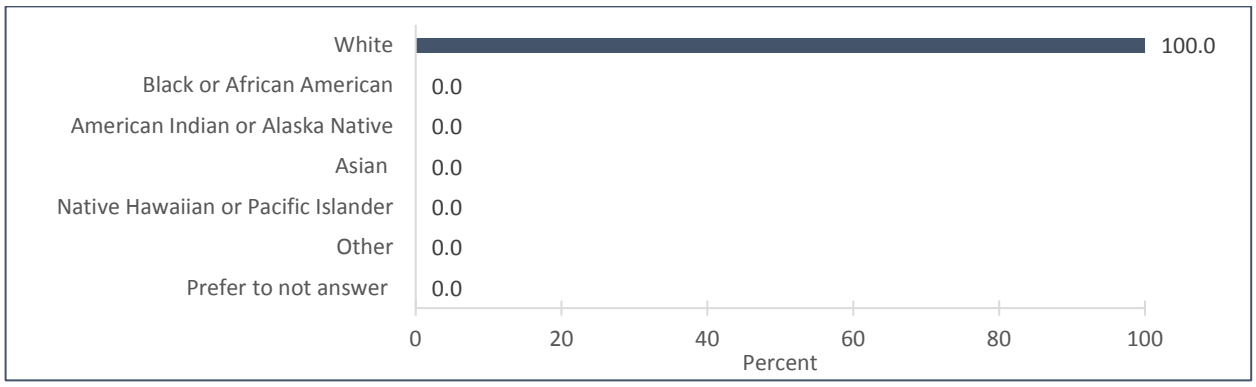
Biological Gender



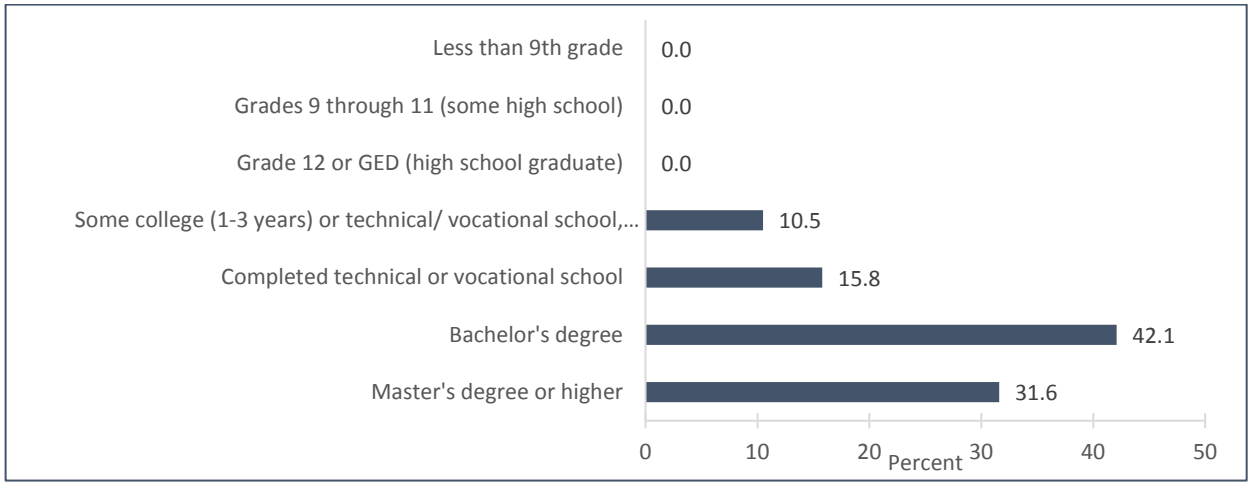
Age of Respondents



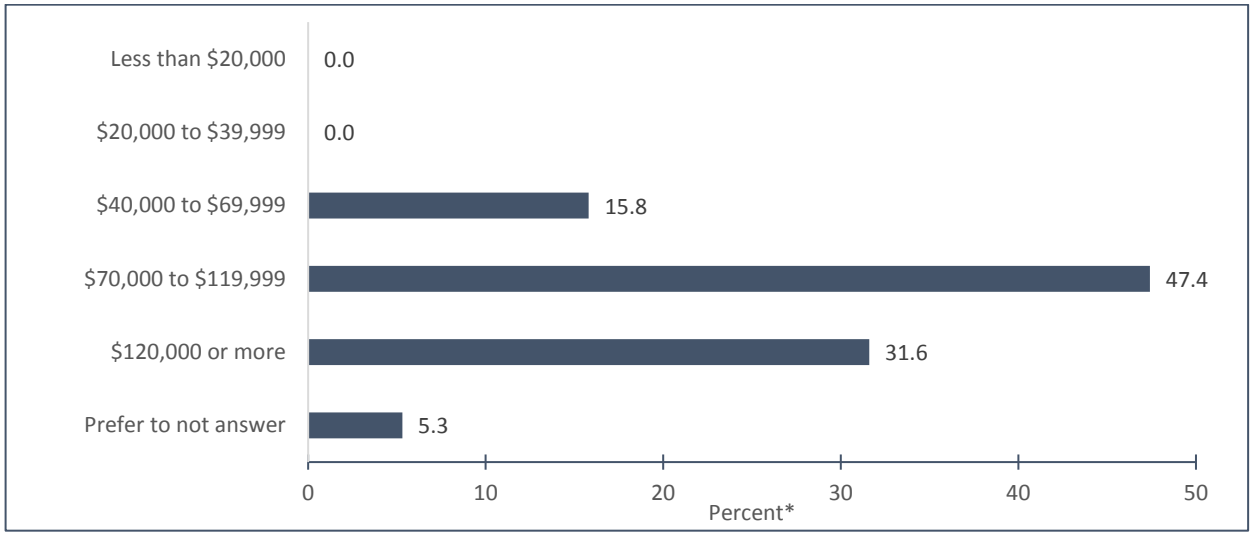
Race of Participants



Highest Level of Education Completed



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



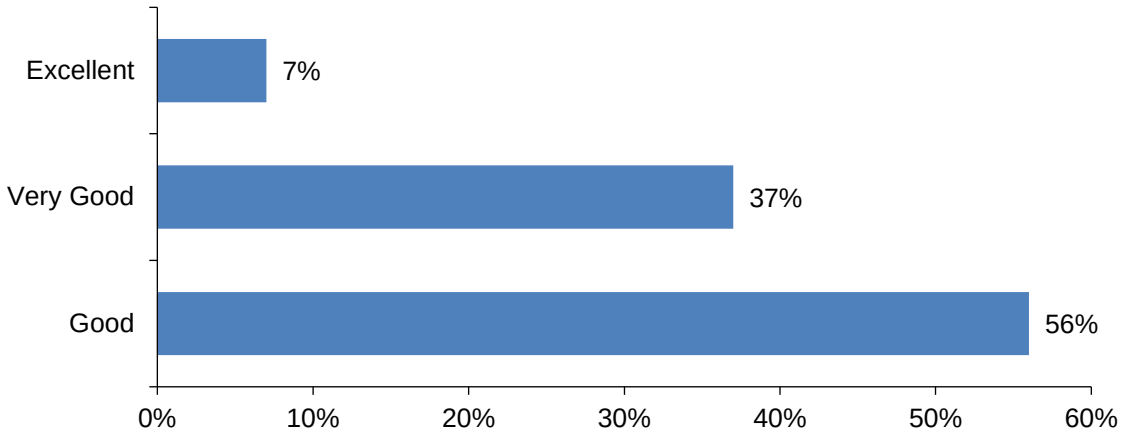
Residents' Health Concerns

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

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

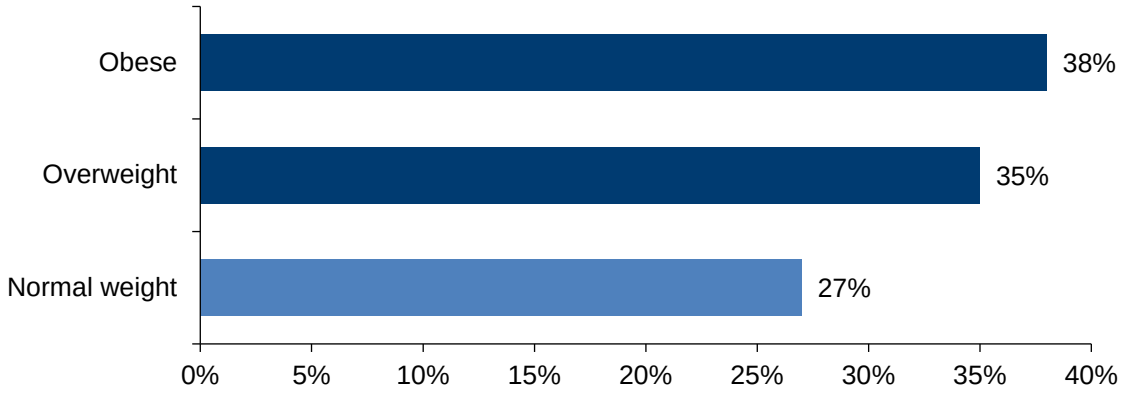
How would you rate your health?

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



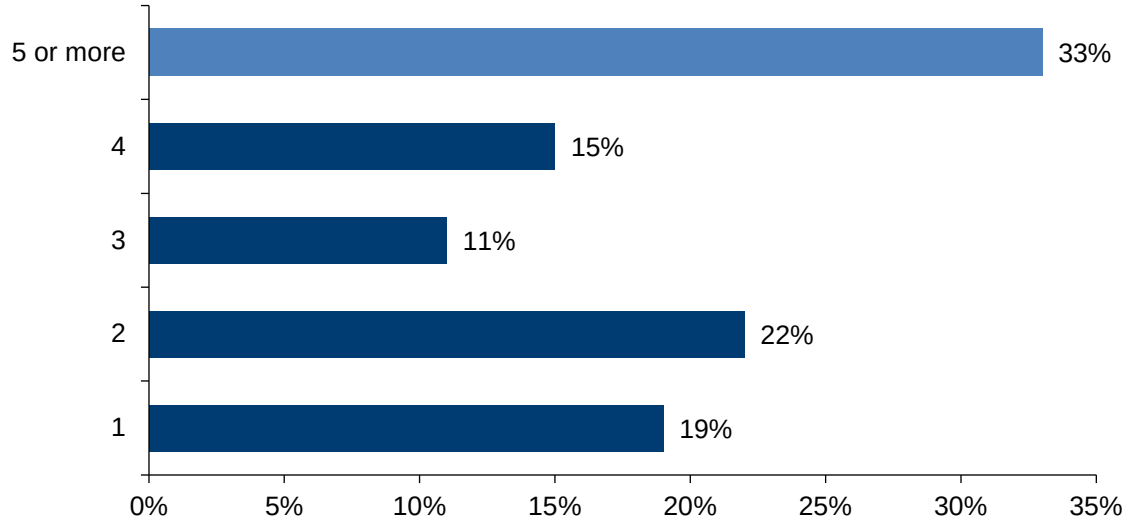
Body Mass Index (BMI)

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



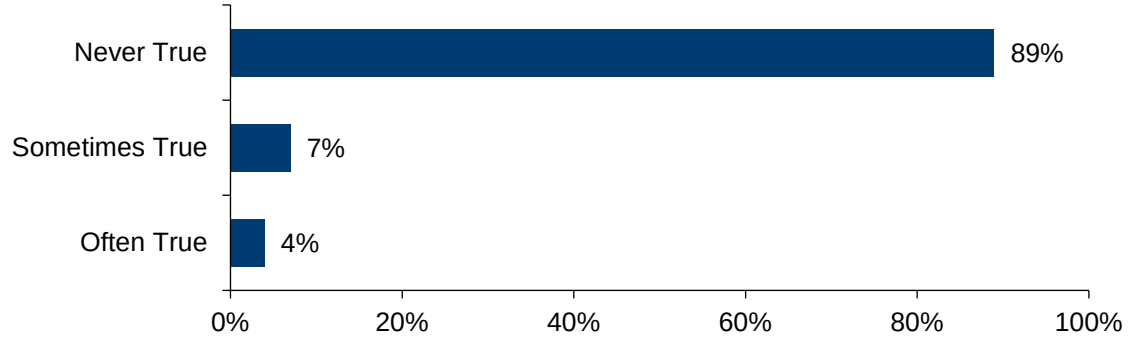
Total Servings of Fruits, Vegetables and Juice

Only 33% are consuming the recommended 5 or more daily servings of fruit and vegetables.



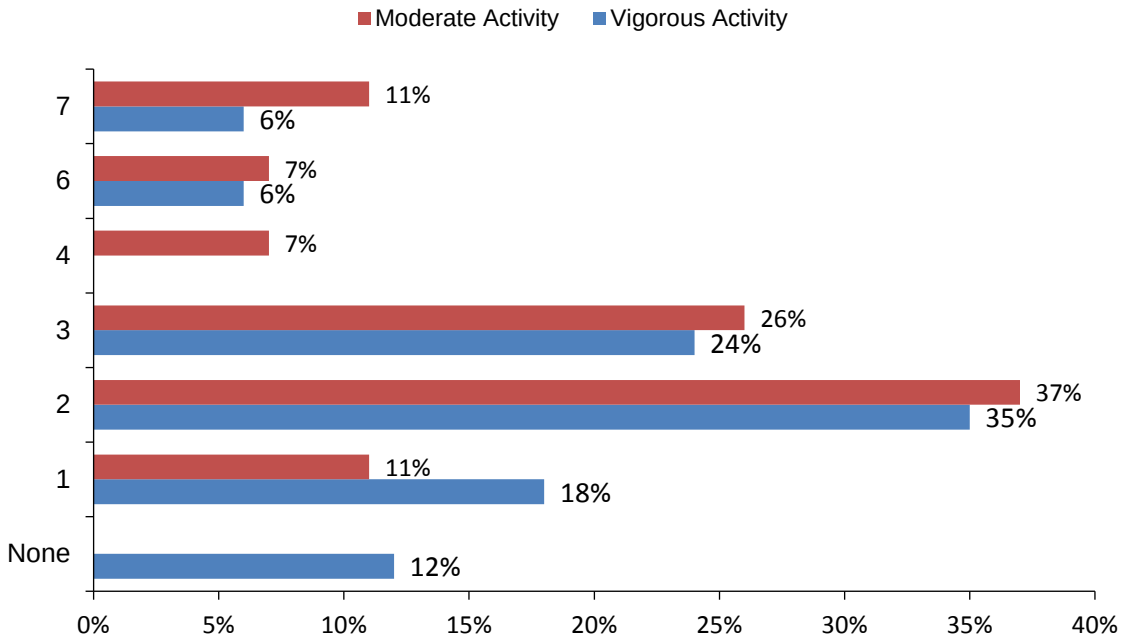
Food Insecurity

Eleven percent report running out of food before having money to buy more.



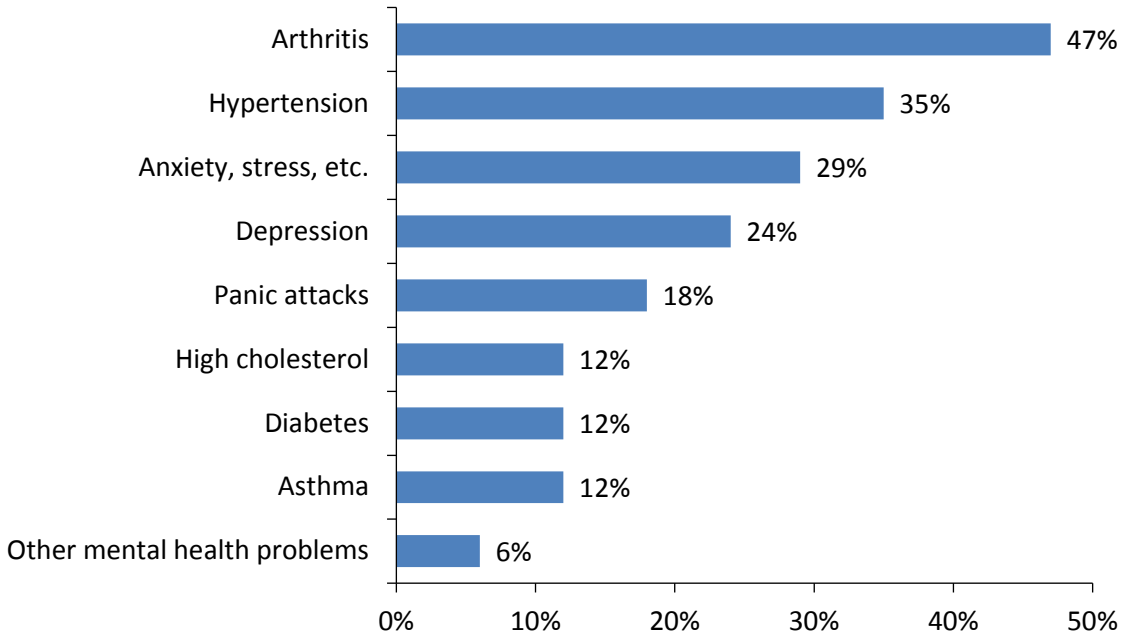
Days per Week of Physical Activity

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



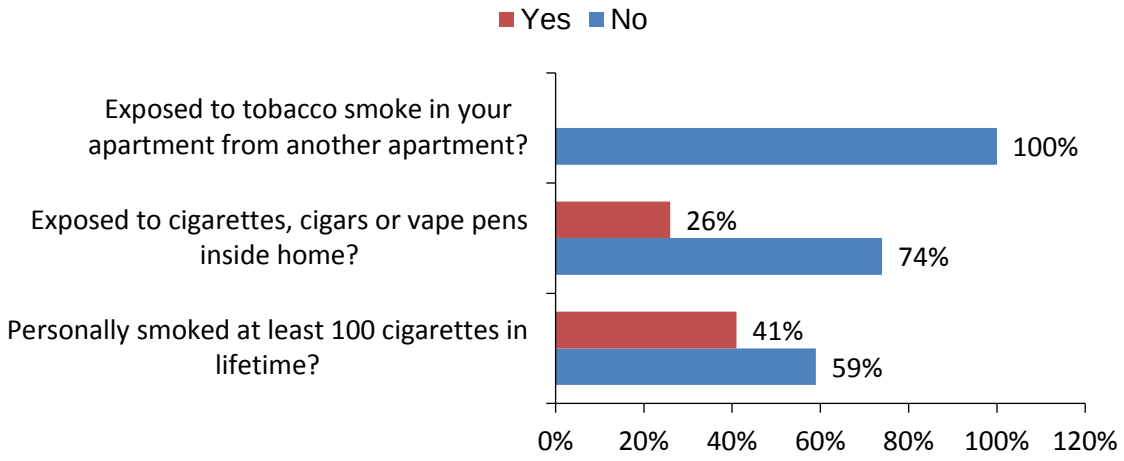
Past Diagnosis

Arthritis, hypertension, anxiety and depression are the top diagnoses for the survey participants.



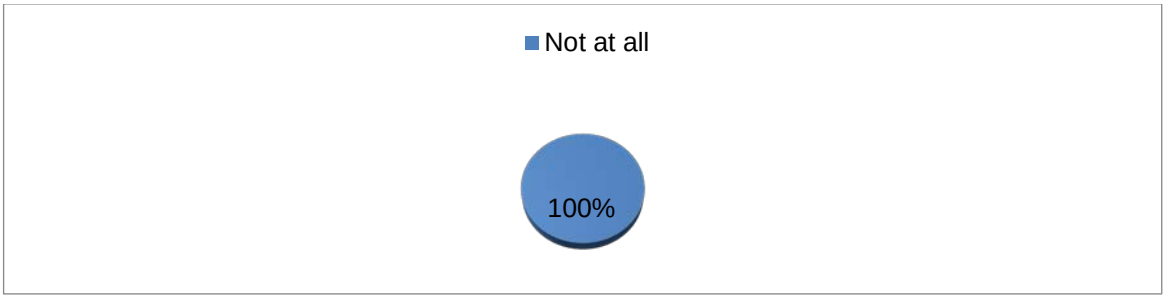
Exposure to Tobacco Smoke

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



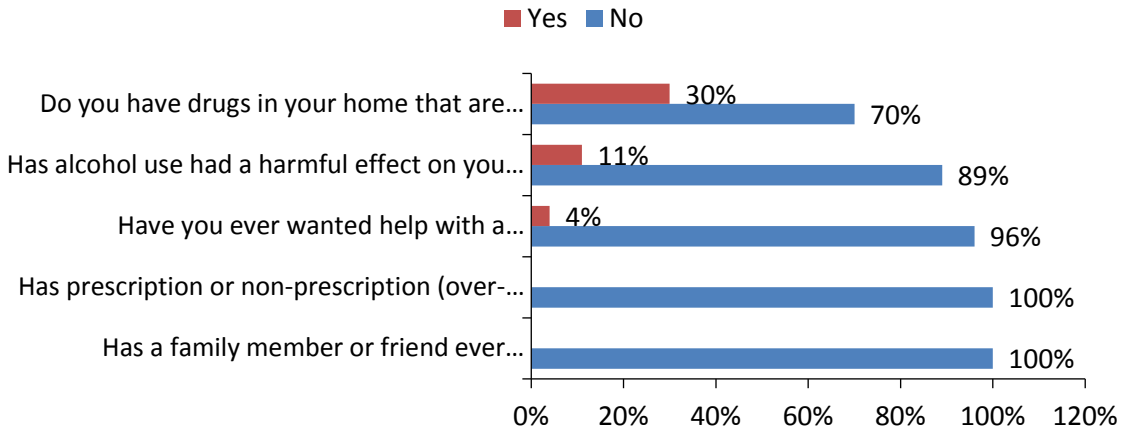
Do you currently smoke cigarettes?

No one among the survey participants currently smoke cigarettes.



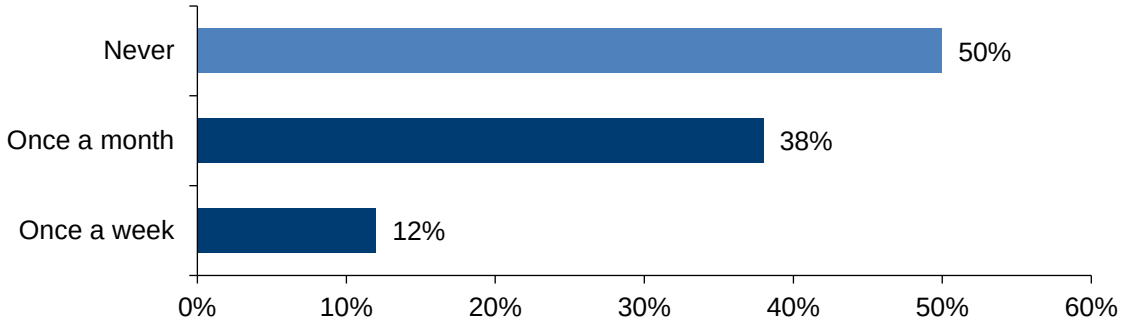
Drug and Alcohol Issues

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



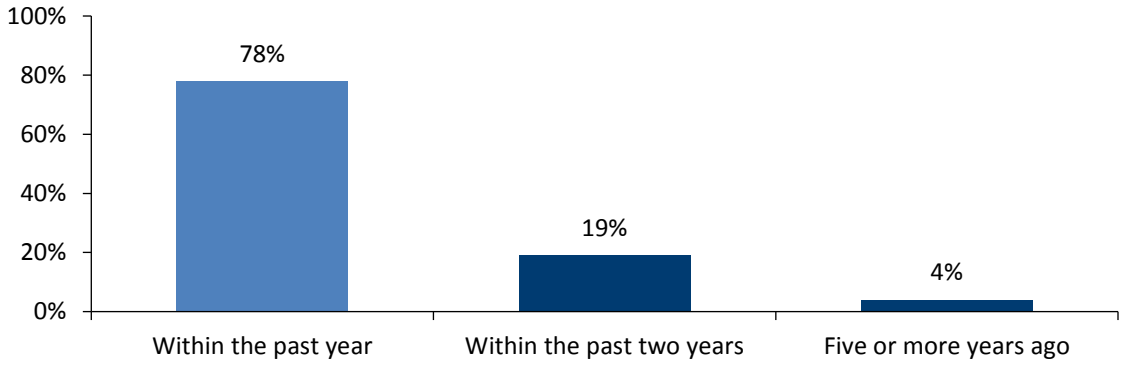
Binge Drinking

Fifty percent binge drink at least once per month.



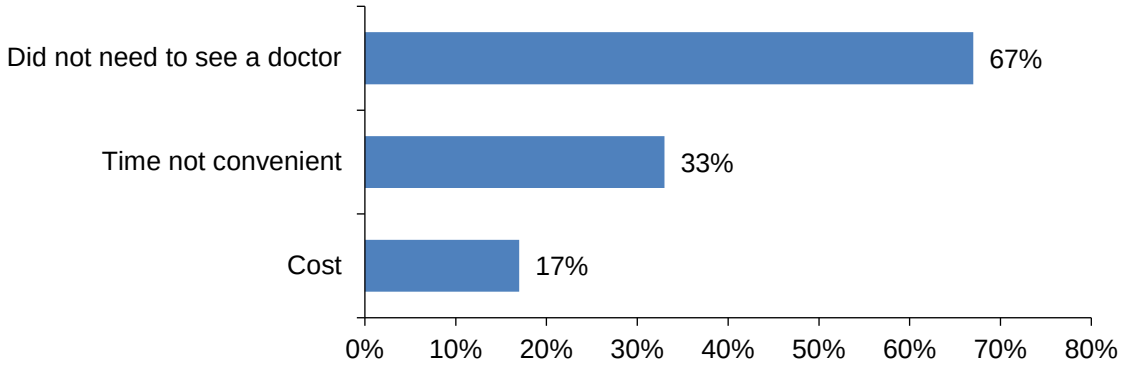
How long has it been since you last visited a doctor or health care provider for a routine check-up?

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



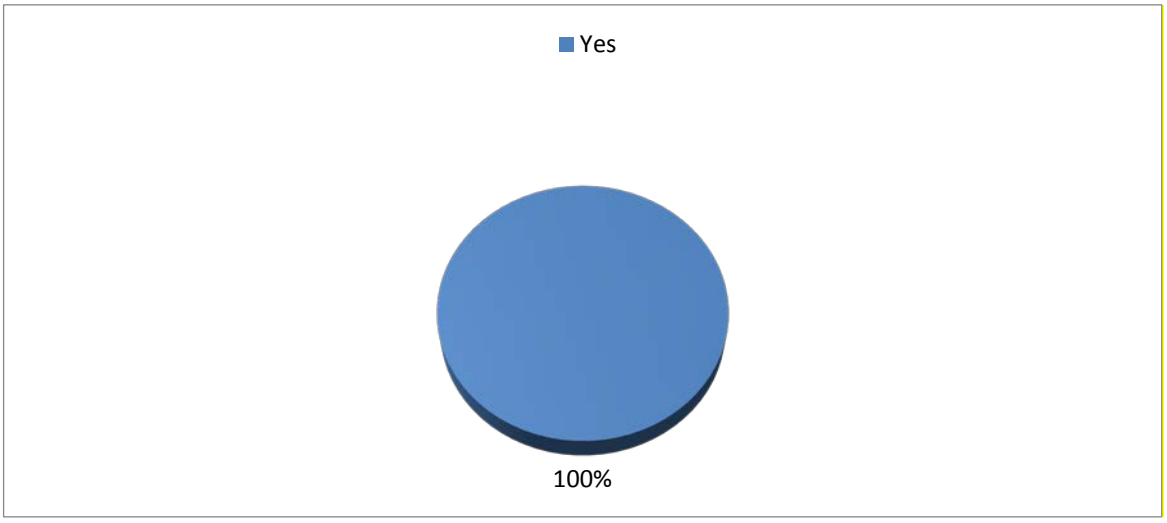
Barriers to Routine Check-up

Sixty-seven percent of survey respondents report not needing a routine check-up.



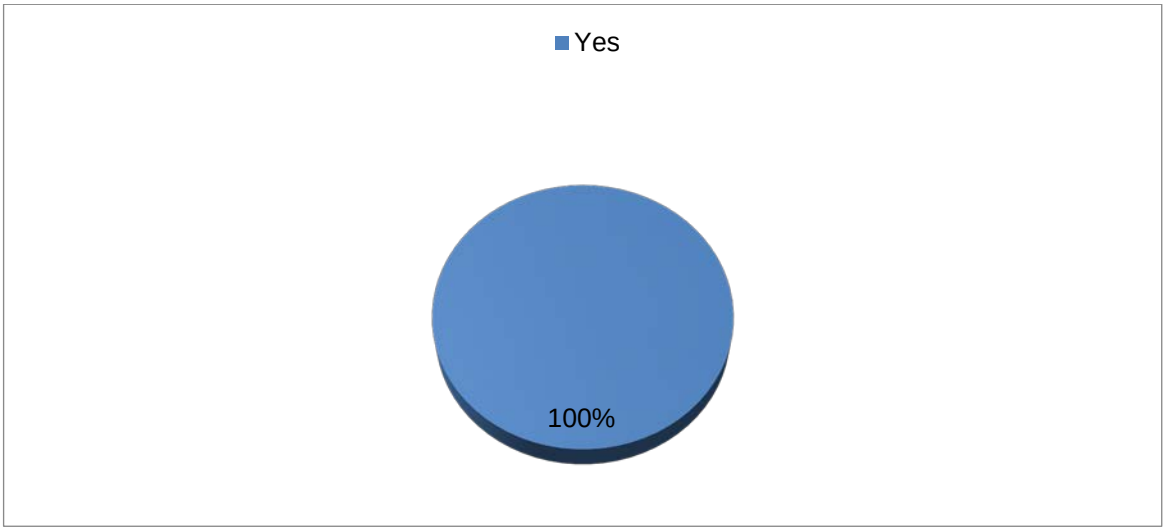
Do you have health care coverage for your children or dependents?

One hundred percent of survey participants have health care insurance for their children.

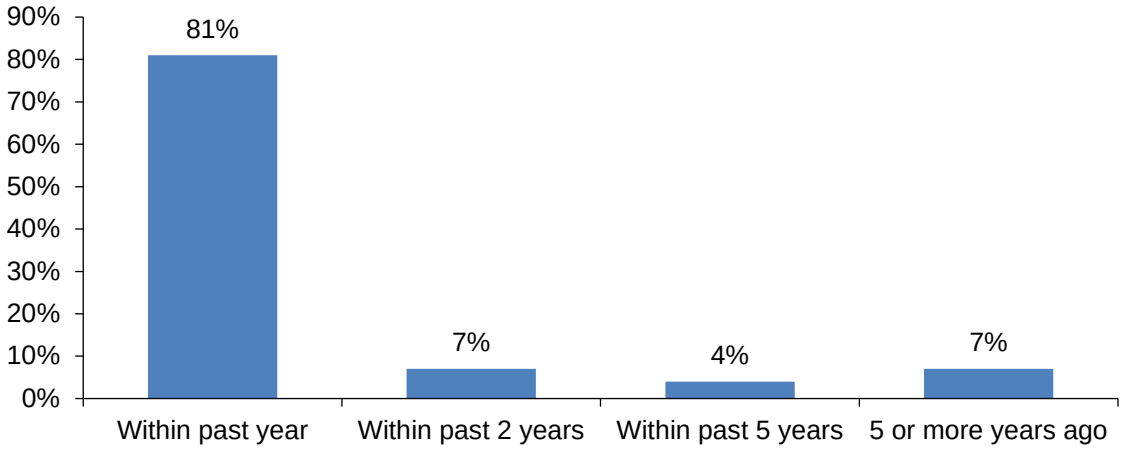


Do you currently have any kind of health insurance?

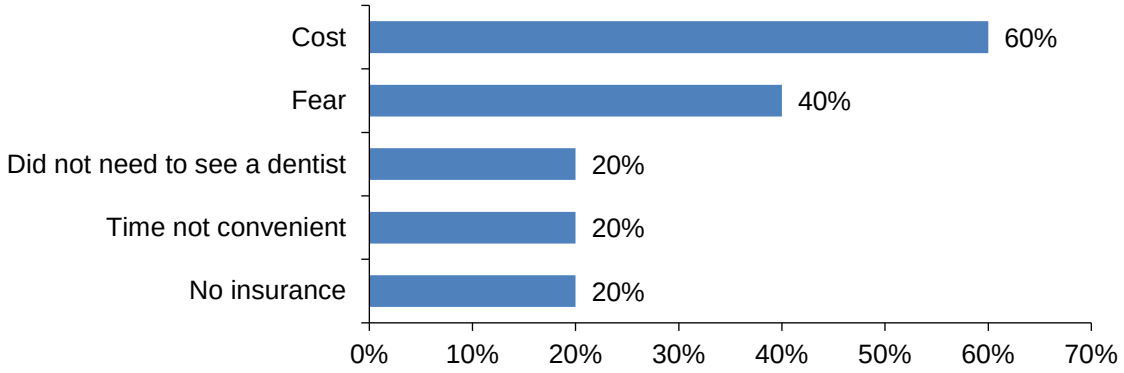
One hundred percent of survey respondents have health care insurance for themselves.



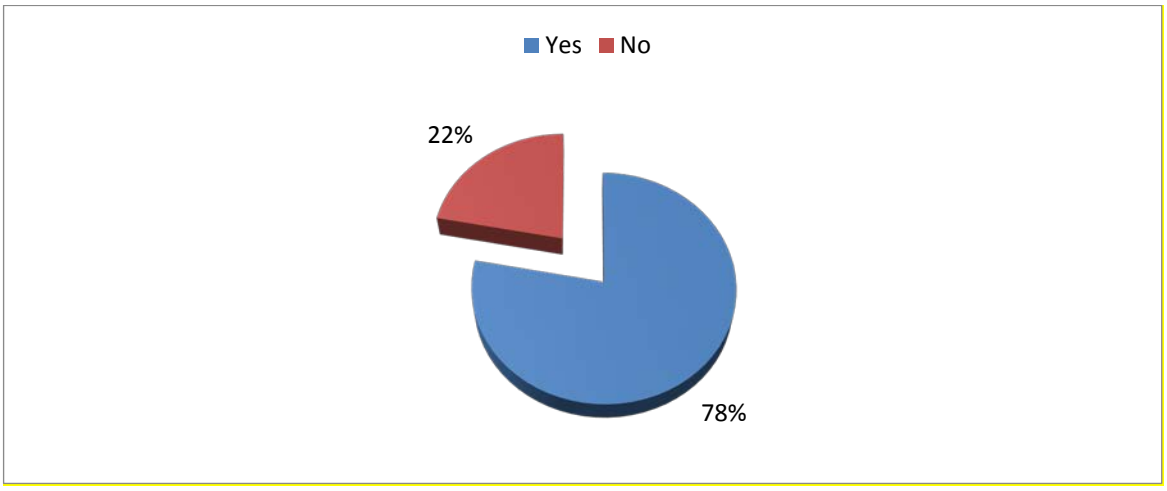
How long has it been since you last visited a dentist?
Twenty-seven percent have not visited a dentist in more than a year.



Barriers to Visiting the Dentist

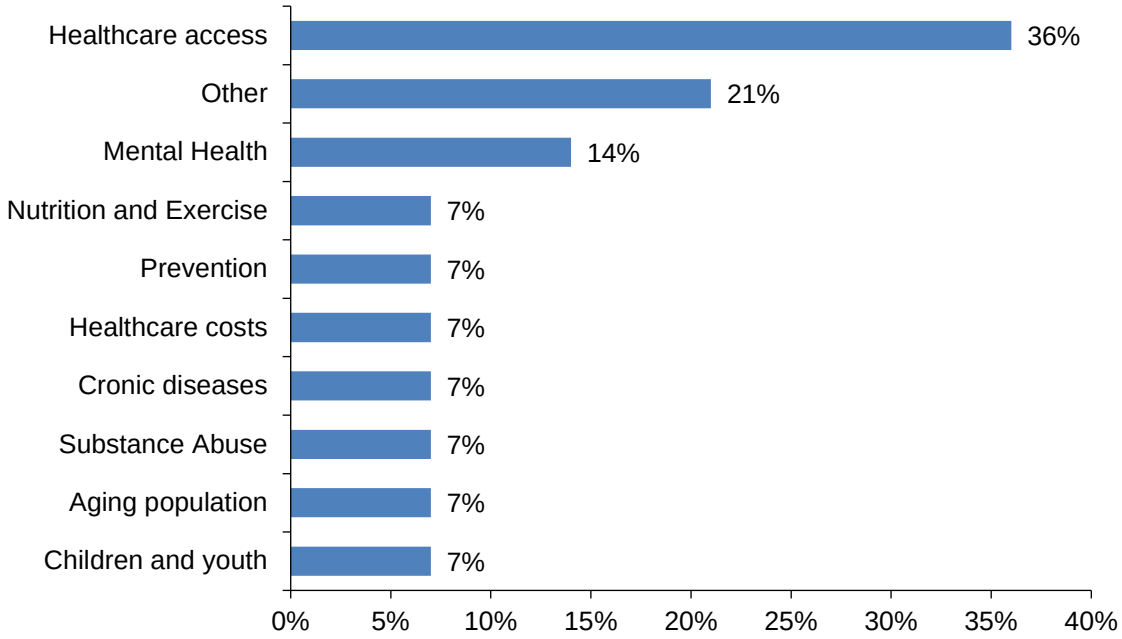


Do you have any kind of dental care or oral health insurance coverage?
Twenty-two percent of survey respondents do not have dental insurance**.**



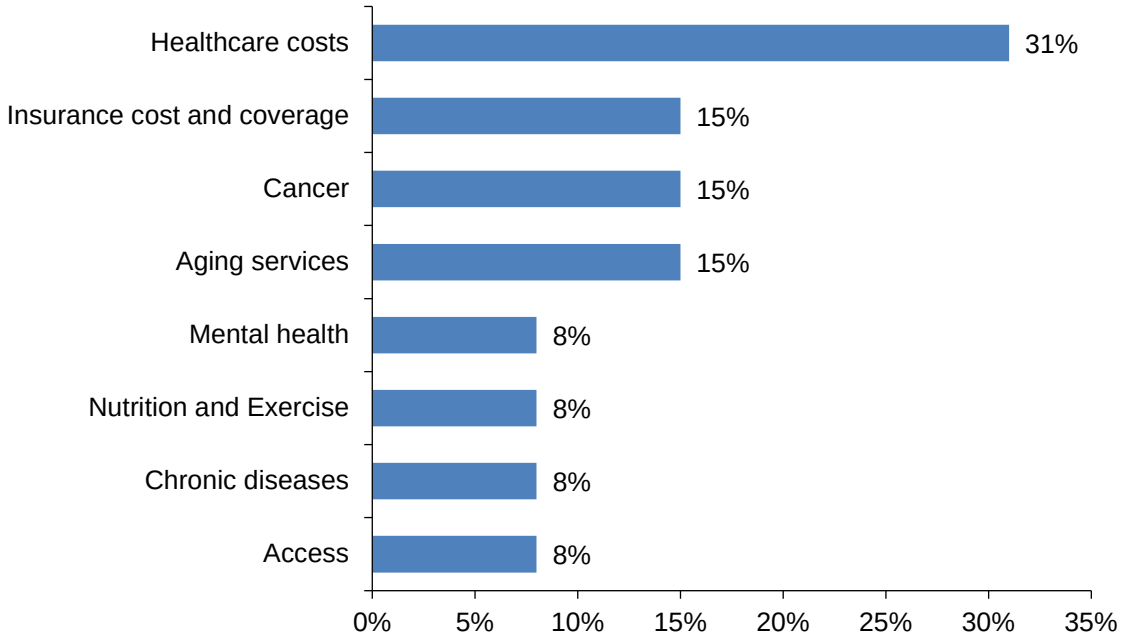
Most Important Community Issues

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



Most Important Issue for Family

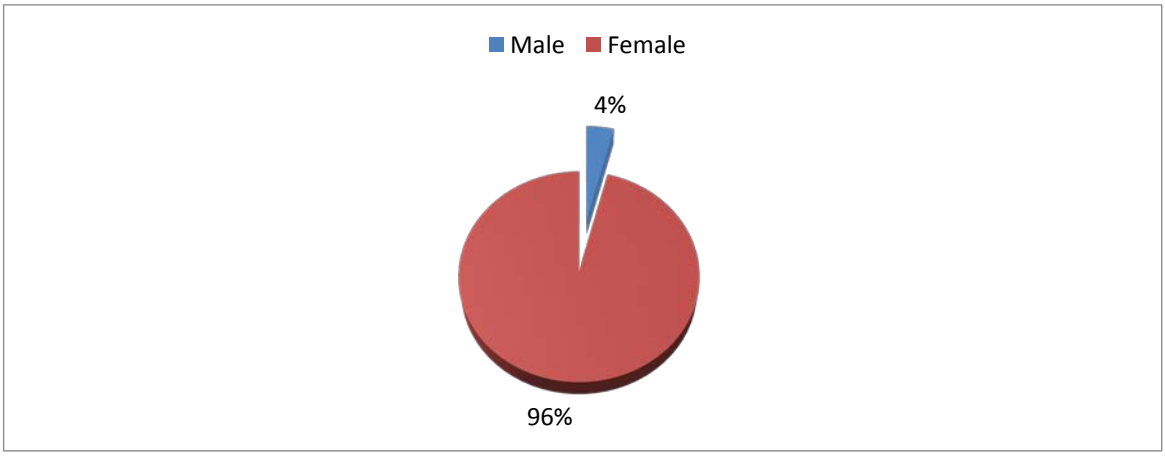
Health care costs and insurance cost and coverage, cancer and aging services are the top concerns of survey respondents as they consider the needs for their family.



Demographic Information for Community Resident Participants

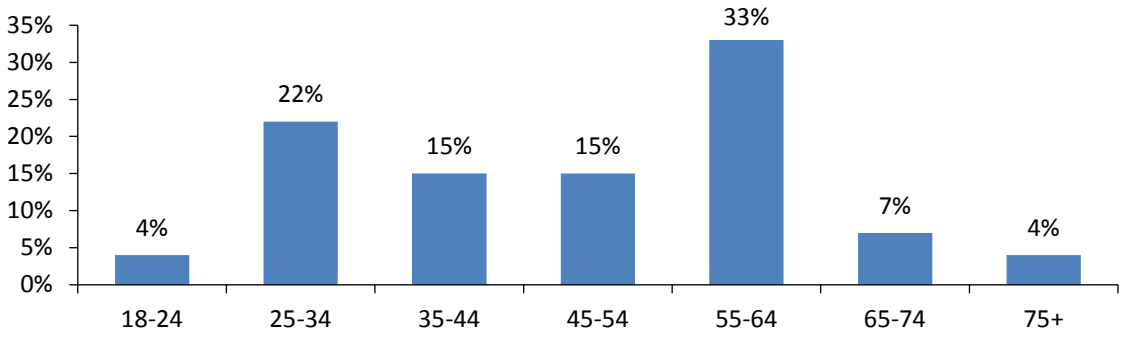
Biological Gender

Only 4% of the survey participants were male.

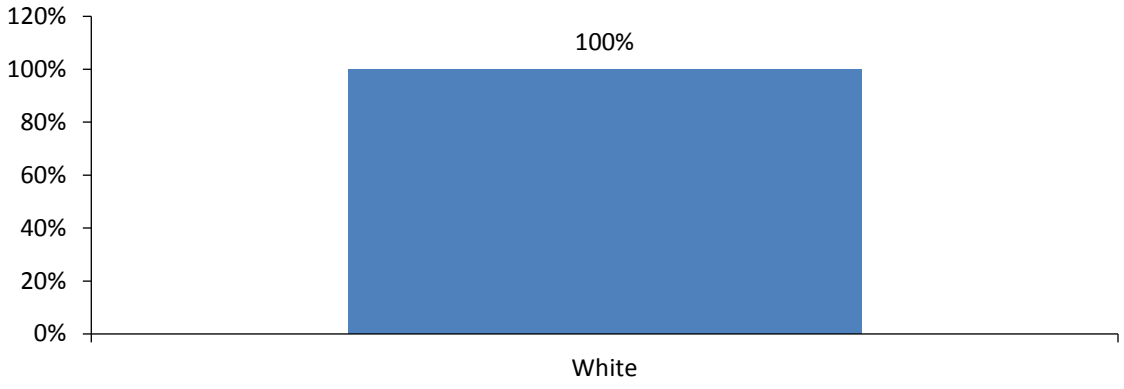


Age

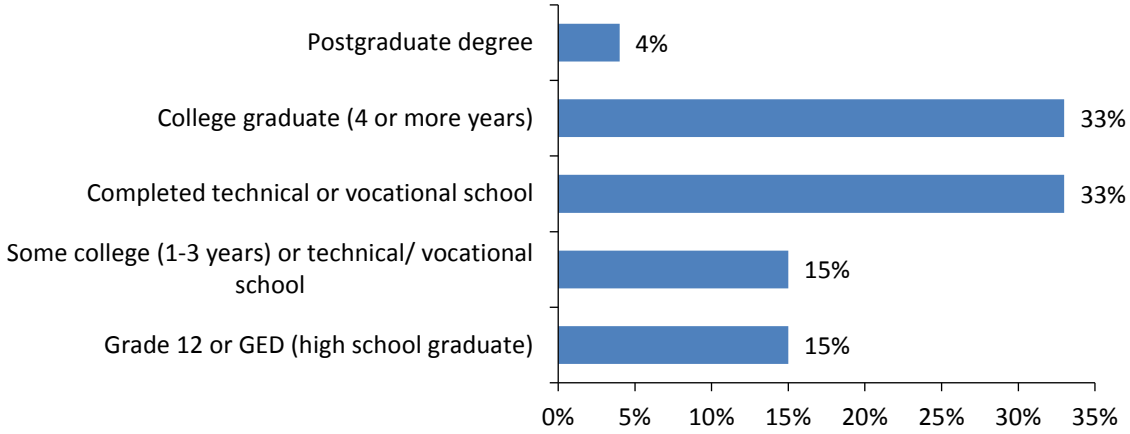
Every age group was represented among the survey participants; however, only 4% fell into the 75+-year age and only 4% fell in the 18-24 age group.



Ethnicity

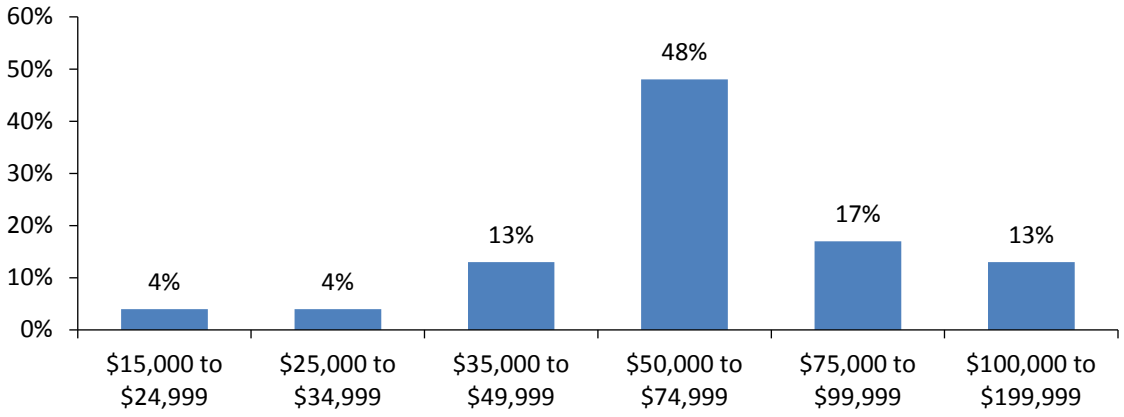


Education Level



Total Annual Household Income

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



Secondary Research Findings

Census Data

Population of Deuel County, South Dakota	4,231
% below 18 years of age	23.1
% 65 and older	21.6
% White – non-Hispanic	94.9
American Indian	0.4
Hispanic	2.9
African American	0.8
Asian	0.1
% Female	48.1
% Rural	100

County Health Rankings

	Deuel County	State of South Dakota	U.S. top Performers
Adult smoking	14%	18%	14%
Adult obesity	34%	31%	26%
Physical inactivity	28%	22%	20%
Excessive drinking	19%	20%	13%
Alcohol related driving deaths	0%	37%	13%
Food insecurity	10%	12%	10%
Uninsured adults	13%	14%	7%
Uninsured children	9%	7%	3%
Children in poverty	13%	17%	12%
Children eligible for free or reduced lunch	34%	42%	33%
Diabetes monitoring	94%	84%	91%
Mammography screening	69%	66%	71%
Median household income	$53,500	$54,900	$65,600

Health Needs and Community Resources Identified

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

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

The asset mapping process identified needs from the following:

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

Please see the asset map in the Appendix.

Clear Lake 2019 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern
Economic Well-Being • Employment options 3.50 • Skilled labor workforce 3.29 • Availability of affordable housing 3.14 • Household budgeting and money management 3.00 • 15% report worry about having enough food before they can buy more
Transportation • Availability of door-to door transportation services for those unable to drive 3.45 • Availability of public transportation 3.33 • Cost of door-to-door transportation services for those unable to drive 3.05
Children and Youth • Childhood obesity 3.26 • Bullying 3.11
Aging Population • Cost of long term care 3.42 • Cost of memory care 3.37 • Availability of activities for seniors 3.11 • Availability of memory care 3.06 • Availability of resources to help the elderly stay safe in their homes 3.00 • Cost of in-home services 3.00
Safety • Abuse of prescription drugs 3.00
Healthcare Access • Availability of behavioral health 3.28 • Availability of mental health providers 3.26 • Access to affordable health insurance coverage 3.16 • Access to affordable health care 3.00
Mental Health and Substance Abuse • Depression 3.16 24% self-report having depression • Stress 3.11 29% self-report having anxiety/stress • Smoking and tobacco use 3.05 11% report that they currently smoke • 50% report that they binge drink at least 1X/month
Wellness • 38% report obesity • 35% report overweight • 67% do not get 5 or more fruits/vegetables/day • 50% report getting moderate activity 3 or more days/week • 47% report having arthritis • 35% report having hypertension • 23% report not having seen their healthcare provider in more than 1 year • 18% report not having seen their dentist in more than 1 year

How Sanford Clear Lake Medical Center is Addressing the Needs

Identified Concerns	How Sanford Clear Lake is Addressing the Community Needs
ECONOMIC WELL BEING	
Employment options	SCLMC maintains an active list of vacant positions ranging from entry level positions to professional positions on the Sanford Careers website.
Skilled labor workforce	Tuition reimbursement programs are available for current staff interested in educational opportunities that are advantageous for both the staff and the operation. Sanford Clear Lake supports Deuel Area Development, which occasionally offers career and self-improvement workshops to members of the community. Sanford Clear Lake has supported similar workshops through sponsorships. They provide job shadow opportunities for high school seniors, and host a medical careers tour for local students at Deuel School. SCLMC also hosts students needing to fulfill internships and/or clinical rotations for post-secondary programs. Sanford has many programs in place to address workforce development, including the Sons and Daughters scholarship program, the Heart Of Tomorrow Program, internships for college students who are interested in health care careers, and health career programs for high school students.
Availability of affordable housing	SCLMC does not directly deal with housing, but does offer a resource directory that guides community members to various resources available to assist with housing options.
Household budgeting & money management	SCLMC has offered personal finance basic education to staff at SCLMC. SCLMC maintains a resource directory to guide community members in finding resources available for money management. Charity care is offered at Sanford Canby via the Sanford Health charity care policy.
TRANSPORTATION	
Availability of door-to-door transportation services for those unable to drive	SCLMC does not directly offer transportation services but does offer a resource directory that guides community members to various resources available to assist with transportation options. Non-emergency e-visits are offered through the clinic if patients are unable to drive to their appointments.
Availability of public transportation	SCLMC does not directly offer transportation services but does offer a resource directory that guides community members to various resources available to assist with transportation options. Non-emergency e-visits are offered through the clinic if patients are unable to drive to their appointments.
Cost of door-to-door transportation services for those unable to drive	SCLMC does not directly offer transportation services but does offer a resource directory that guides community members to various resources available to assist with transportation options. Non-emergency e-visits are offered through the clinic if patients are unable to drive to their appointments.
CHILDREN AND YOUTH	
Childhood obesity	Sanford Clear Lake offers family wellness center memberships; a discount is offered for multiple month sign-ups. SCLMC sponsors local athletic events held in the community.
Bullying	SCLMC does not directly offer resources for bullying, but does support Deuel School and the efforts made in reducing bullying through programs such as Rachel's Challenge.
AGING POPULATION	
Cost of long term care	Sanford providers work to keep seniors healthy and living independently as long as possible Although SCLMC cannot directly impact long term care rates, community

Identified Concerns	How Sanford Clear Lake is Addressing the Community Needs
	members can utilize the SCLMC resource directory for financial assistance resources. The recent Good Sam affiliation will provide the organization with expertise in the area of long-term care and assisted living services and help to create efficiencies for members in the communities that we serve.
Cost of memory care	Although SCLMC cannot directly impact the cost of memory care, community members can utilize the SCLMC resource directory for financial assistance resources. The recent Good Sam affiliation will provide the organization with expertise in the area of long term care and assisted living services and help to create efficiencies for members in the communities that we serve.
Availability of activities for seniors	Sanford Clear Lake provides financial support to the Clear Lake Chamber of Commerce, which offers activities for seniors.
Availability of memory care	SCLMC is equipped with a Wanderguard system to prevent patient elopement.
Availability of resources to help the elderly stay safe in their homes	Sanford Home Health services are available in the community.
Cost of in-home services	Although SCLMC cannot directly impact the cost of in-home services, community members can utilize the SCLMC resource directory for financial assistance resources.
SAFETY	
Abuse of prescription drugs	Sanford Clinic has implemented a pain contract process to address prescription drug abuse.
HEALTH CARE AND WELLNESS	
Availability of behavioral health	While mental health services are not readily available in the community, the SCLMC resource directory guides community members to the nearest available mental health resources.
Availability of mental health	While mental health services are not readily available in the community, the SCLMC resource directory guides community members to the nearest available mental health resources.
Access to affordable health insurance coverage	Health insurance is offered to Sanford Clear Lake employees. Sanford Health insurance is also offered in the community through local insurance agents.
Access to affordable health care	RN Health Coach and pharmacy staff work to assist with providing affordable prescription drugs through discount programs.
MENTAL HEALTH AND SUBSTANCE ABUSE	
Depression	Medical Home patients are routinely evaluated for mental health. The SCLMC resource guide provides a listing of available mental health resources.
Stress	Lunch and Learn sessions are offered to staff to assist with stress management and dealing with change.
Smoking & tobacco use	Smoking and tobacco cessation is offered through clinic. RN Health Coach is available to assist with cessation.

Implementation Strategies

Implementation Strategies - 2018

Priority 1: Transportation

The University of Minnesota's Rural Health Research Center reports that transportation is a concern for rural residents. A social determinant of health, affordable transportation is fundamental to mental, physical and emotional well-being. Individuals with disabilities, those with low incomes, seniors, and others who may not have reliable access to transportation depend on public and private transportation to access health services, obtain food and other basic needs, and to engage with their communities.

Sanford Health Clear Lake has made transportation a significant priority and has developed a strategy to work in collaboration with community organizations to explore options for the local community and county members.

Priority 2: Physical Health

According the Center for Disease Control, obesity is a complex health issue to address. Obesity can be caused from a combination of contributing factors such as behavior and genetics. Behaviors can include dietary patterns, physical activity, inactivity, medication use, and other exposures. Additional contributing factors in our society include the food and physical activity environment, education and skills, and food marketing and promotion.

Obesity is a serious concern because it is associated with poorer mental health outcomes, reduced quality of life, and is associated with morbidity and illnesses including diabetes, heart disease, stroke, and some types of cancer.

Sanford Health Clear Lake has made physical health specific to obesity a significant priority and has developed strategy to improve physical health and reduce the negative health effects of obesity.

Implementation Strategy Action Plan – 2019-2021

Sanford Clear Lake

<u>Priority 1</u>: Transportation

Projected Impact: Improve availability of transportation options for community members unable to keep appointments due to lack of personal transportation options

Goal 1: Provide an active list of available community members willing to transport patients to appointments at Sanford Clear Lake

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources/Budget/ Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Seek assistance from local volunteer organizations to develop a list to assist with ride arrangements for patients unable to drive to appointments at Sanford Clear Lake	Develop list of available community members willing to drive patients to and from appointments at Sanford Clear Lake	Existing	Administrative team	Local Churches, Volunteer Organizations

<u>Priority 2</u>: Physical Health

Projected Impact: Improve the physical health of the members of the Clear Lake community

Goal 1: Reduce the negative health effects of obesity

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources/Budget/ Resource Assumptions	Leadership	Note any community partnerships and collaborations - if applicable
Utilize Wellness Center resources to encourage physical health and weight loss	Provide an annual weight loss challenge at the Sanford Clear Lake Wellness Center	Existing	Wellness Center staff, Admin Team	
The CHNA planning committee will routinely review events in the community that promote physical activity and review the need to provide sponsorship support to the various events and activities	Meet monthly in years 2019, 2020, and 2021	Existing	Administrative Team	Various community organizations

Impact from the FY 2017-2019 Action Plan

Priority 1: Mental Health

Projected Impact: Offer various resources for those in need of mental health services

Goal 1: Establish Mental Health Telemedicine Services

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations (if applicable)
Involve RN Health Coach in assisting with gathering estimate of how many patients would benefit from mental health services	100% of all medical home patients will be evaluated for need	Tamara Pommer, RN Health Coach	Darla Toben, Business Office Manager; Stephanie Dobbs, CNO	
Involve providers and clinic staff in assisting with gathering estimate of how many patients would benefit from mental health services	100% of all scheduled patients will be evaluated for need	Clinic nurses, clinic providers	Stephanie Dobbs, CNO and Renee Axtell, Outreach coordinator	
Provide a system for patients to get in touch with designated staff if need mental health services	Finalize a system by May 1st, 2016, to help reach patients who do not have PCPs in the community but still need assistance	Darla Toben, Business Office Manager; Kayla Fieber, Marketing Manager; Renee Axtell, Outreach Coordinator	Stephanie Dobbs, CNO	Marketing to get info to public

Goal 2: Develop and distribute a directory of mental health services to various groups/organizations in the community

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations (if applicable)
Research various resources available to assist with mental health issues	Resources in a 50-mile radius of Clear Lake will be researched	Mary Buck, RN	Stephanie Dobbs, CNO	
Identify programs already in place and determine program eligibility	Programs in a 50-mile radius of Clear Lake will be identified	Mary Buck, RN	Stephanie Dobbs, CNO	
Develop and distribute a directory of mental health services to those groups identified as high risk	Develop a directory that is ready for distribution by July 1, 2016	Renee Axtell, Outreach Coordinator; Kayla Fieber, Marketing Manager	Stephanie Dobbs, CNO	Marketing(flyers, ad in paper, DADI website, churches, service organizations, police, SART education, schools)

<u>Priority 2</u>: Physical Health

Projected Impact: Increase compliance with preventive screenings recommendations

Goal 1: Educate on preventive health services that are available at SCLMC

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations (if applicable)
Describe various services available to patients	100% of patients in the service area will be informed of the preventive health services available at SCLMC	Tamara Pommer, RN Health Coach; Renee Axtell, Outreach Coordinator	Stephanie Dobbs, CNO	Marketing, Nursing
Continue to offer current preventive services and better education on the importance of these screenings • Colorectal screening • Mammograms • Vaccinations • Diabetic foot care	90% of patients will have a preventive health service offered each year • ages 51-75 • ages 40-75 • ages 0-18 in Community Health • any diabetic patient	Tamara Pommer, RN Health Coach; Renee Axtell, Outreach Coordinator; Tammy Baer, Community Health RN	Stephanie Dobbs, RN	

Demonstrating Impact – Addressing the Needs

During the 2016 Community Health Needs Assessment research cycle community members were invited to discuss community needs, provide recommendations, and vote on the top priorities to address over the following three years. At Sanford Clear Lake Medical Center, the top priorities addressed through an implementation strategy process include:

- Mental Health
- Physical Health

Measureable outcomes for each priority are routinely analyzed and we are encouraged by the progress that we have made.

The first goal of establishing mental health telemedicine services was projected to impact the community by offering various resources for mental health services. This work has allowed Sanford Clear Lake to bring forth real data to validate the mental health disparity in the Clear Lake community. This data has been shared with Sanford enterprise leadership in order to further pave the way for expansion of mental health services in the rural areas. Previous grant work has offered technological capability to allow telemedicine services when providers and/or patients are not able to travel for a face-to-face visit. Sanford Clear Lake continues to support the recruitment efforts of mental health professionals.

A great deal of work has been completed in the electronic medical record (EMR) to identify the patients that may be in need of mental health services. Through the Medical Home program, RN Health Coach, and PHQ-9 screening, Sanford Clear Lake can offer/refer mental health services to those with scores indicative of depression. The goal was to evaluate 100% of Medical Home patients for mental health needs. Sanford Clear Lake met this goal and continues to complete the PHQ-9 screening every six months for patients with a depression diagnosis, as well as diabetes diagnosis, and those on Medical Home. Additionally, screenings occur with well child checks including athletic physicals for children/youth age 12 and older. The Columbia Suicide Screening tool is also used to identify patients at risk for suicide. This tool cascades questions depending on patient responses.

Another strategy to aid in the identification of patients with mental health needs was to finalize a system to reach patients who do not have a primary care provider (PCP) listed in the EMR. This strategy has been successful, as a formal process has been implemented. When patients present for a visit, the registrar discusses the PCP and inquires with the patient if a PCP can be named in the EMR. If the patient agrees, the patient is registered with a provider at Sanford Clear Lake Medical Center which allows the PCP to address preventive health maintenance.

With the limited mental health resources available in the Clear Lake community, research was conducted to develop and distribute a Clear Lake Area Resource Directory. This strategy has been successful in addressing both mental and physical health in our population. The directory not only includes resources to address mental and physical health, but also resources such as employment, financial assistance, housing, nutrition, pre-planning, protective services, support groups, education, etc. The resource directory is readily available for patients in the clinic setting when these needs are identified. Additionally, the directories are distributed to each hospital patient upon admission. The directory is reviewed periodically for accuracy, with the latest revision occurring in May 2018.

The second goal to educate the population on preventive health services available at Sanford Clear Lake Medical Center was projected to impact the community by increasing compliance with preventive screening

recommendations. The strategy for meeting this goal included describing the various preventive services available to 100% of our patients. Through the use of the EMR, 100% of our patients with overdue health maintenance screenings are easily identified. The clinic support nurse reviews overdue health maintenance with patients at each visit. The nurse prepares and pends orders as patient agrees. If a patient refuses, a gap sheet indicating the patient's refusal is given to the provider to use as a tool to educate the patient on the importance of preventive health and encourage the patient to complete the preventive health maintenance.

The preventive health maintenance work continues, and providers are involved in the improvements and progress made through performance improvement and quality assurance studies.

Community Feedback from the 2016 Community Health Needs Assessment

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

Appendix

Primary Research

Clear Lake Asset Map

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Economic Well Being	Employment options 3.50 Skilled labor workforce 3.29 Availability of affordable housing 3.14 Household budgeting and money management 3.00		Unemployment 4.6% Children living in poverty 13%	Employment resources: • Deuel Area Development, Inc., 408 – 4th St. West Major employers: • Buffalo Ridge Resort & Business Center, • Deuel County offices, 47625 – 181st Street • Good Samaritan Society, 913 Colonel Pete Street South • Sanford Clear Lake Medical Center, 701 – 3rd Ave. S. • South Dakota Partners, Inc., 205 SD Hwy 22 E • Tech Ord, 47600 180th Street • Interstate Telecommunications Cooperative, Inc., 312 4th St W • H-D Electric Cooperative, Inc., 423 3rd Ave S • Deuel County Farmers Union (Cenex), 106 SD Hwy 22 Nearby employment agencies: • Anderson Arthur, 115 N. Lake Hendricks Dr., Hendricks SD • Availability Employment Services, 521 – 6th St., Ste 101, Brookings, SD • Career Advantage, 910 – 4th St., Ste H, Brookings, SD • Career One Stop, 2001 – 9th Ave. SW, Watertown SD • Employment Connections, 28 – 1st Ave. NW, Watertown, SD • Experience Works, 2001 – 9th Ave. SW, Watertown, SD • Express Employment Professionals, 1018 - 14th St. SE, Watertown SD • FreeStar Healthcare Staffing, Inc., 931 – 2nd Ave. SW, Watertown SD Low Income Housing resources: • Inter-Lakes Community Action Partnership, 408 – 4th St. W.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
				Money Management resources: • Deuel Co. Extension, 419 – 3rd Ave. South • Deuel Co. National Bank, 305 - 4th St. W.	
Transportation	Availability of door-to-door transportation services for those unable to drive 3.45 Availability of public transportation 3.33 Cost of door-to-door transportation services for those unable to drive 3.05			Transportation resources: • Clear Lake Ambulance Service, Main Street • Inter-Lakes Community Action Partnership, 408 – 4th St. W. • Watertown Transit?	
Children and Youth	Childhood obesity 3.26 Bullying 3.11			Obesity resources: • Cardinal Gym, 424 – 5th St. W. • Cardinal Gymnastics, 3rd Ave. S. • Clear Lake Golf Club, 603 SD 22 • Country Twisters Gymnastics, 602 – 3rd Avenue South • Park District, 811 Golf View Drive • Rachel's Challenge • Sanford WebMD Fit Kids • Sanford Clear Lake dieticians, 701 – 3rd Ave. S. • Sanford Clear Lake Wellness Center, 305 – 3rd Avenue South Bullying resources: • Clear Lake School District, 410 – 5th St. W. • Clear Lake Police, 400 – 4th St. W. • Deuel Co. Sheriff, 400 – 4th St. W. • StopBullying.gov	
Aging Population	Cost of long term care 3.42 Cost of memory care 3.37 Availability of activities for seniors 3.11 Availability of memory care 3.06			Long Term Care resources: • Deuel Co. Good Samaritan Center, 913 Colonel Peter St. Memory Care resources: • Deuel Co. Good Samaritan Center, 913 Colonel Pete St.	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
	Availability of resources to help the elderly stay safe in their homes 3.00 **Cost of in-home services 3.00**			**Activities for Seniors:** • **Clear Lake City Library, 125 – 3rd Ave. S.** • **Deliver Meals on Wheels, 213 – 3rd Ave. S.** • **Golf Club, 603 SD 22** • **Sanford Clear Lake Wellness Center, 305 – 3rd Avenue South** • **Senior Center, 413 – 9th Ave.** • **Volunteer at schools, 410 – 5th St. West** • **Volunteer in 4-H clubs, 419 – 3rd Ave. South** • **Volunteer at hospital, 701 – 3rd Ave. S.** • **Volunteer at nursing home, 913 Colonel Pete St.** • **Volunteer at community center, 218 – 3rd Ave. S.** **Resources to help the elderly stay in their homes:** • **Avera Home Medical Equipment, 1508 – 4th St. NE, Watertown** • **Clear Lake Ambulance Service, Main Street** • **Congregate Meals/Frozen Meals/ Home Delivered Meals, 213 – 3rd Ave. S.** • **SNAP (Supplemental Nutrition Assistance Program), 408 – 4th Street** • **Goehring Pharmacy, 411 – 3rd Ave. South** • **Inter-Lakes Community Action Partnership, 408 – 4th St. W.** • **Lewis Family Drug, 404 – 3rd Ave. S.** • **Maynard's Foods, 108 – 3rd Ave. S.** • **Midwest Medical Service, 615 – 6th St. SE, Watertown** • **Sanford Clinic, 701 – 3rd Ave. S.** • **Sanford Home Care, 701 – 3rd Ave. South** • **Sanford Home Medical Equipment, 1313 St. Olaf Ave. N., Canby** **In-home services:** • **Sanford Health Home Care**	

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need	Gap?
Safety	Abuse of prescription drugs 3.00			Abuse of prescription drugs resources: • Clear Lake Police, 400 – 4th St. W. • Deuel Co. Sheriff, 400 – 4th St. W.	
Health Care and Wellness	Availability of behavioral health 3.28 Availability of mental health providers 3.26 Access to affordable health insurance coverage 3.16 Access to affordable health care 3.00	73% self-report obesity 47% arthritis diagnosis 35% hypertension diagnosis	Adult obesity 34%	Mental Health/Behavioral Health resources: • Sanford Clear Lake Clinic, 701 – 3rd Ave. S. • Deuel Co. Public Health, 701 -3rd Ave. S. • Deuel Co. Social Services, Clear Lake SD • Human Service Center, 123 19th St NE, Watertown, SD 605-886-0123 Affordance Insurance resources: • Anderson Agency, 410 – 3rd Ave. S. • DCN Insurance, 320 – 3rd Ave. S. • Get Covered South Dakota (Community Healthcare Assn.), 300 S. Phillips, Sioux Falls Affordable Health Care resources: • Deuel Co. Public Health, 701 – 3rd Ave. S. • Sanford Clear Lake Clinic, 701 – 3rd Ave. S.	
Mental Health and substance Abuse	Depression 3.16 Stress 3.11 Smoking and tobacco use 3.05	50% self-report that they binge drink 28% anxiety diagnosis 24% depression diagnosis		Mental Health resources: • Sanford Clear Lake Clinic, 701 – 3rd Ave. S. • Deuel Co. Public Health, 701 -3rd Ave. S. • Deuel Co. Social Services, Clear Lake SD Smoking Cessation resources: • Sanford Clear Lake Clinic, 701 – 3rd Ave. S. • SD QuitLine, 600 E. Capitol Ave., Pierre	

Key Stakeholder Survey

Sanford Clear Lake Medical Center

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

November 2017

SANFORD

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an October 2017 online survey of community leaders and key stakeholders identified by Sanford Clear Lake Medical Center. This study was conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative distributed the survey link via e-mail to stakeholders and key leaders, located within various agencies in the community, and asked them to complete the online survey. **Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred during the month of October and the first week of November. A total of 22 respondents participated in the online survey.

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SURVEY RESULTS

Current State of Health and Wellness Issues Within the Community

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

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

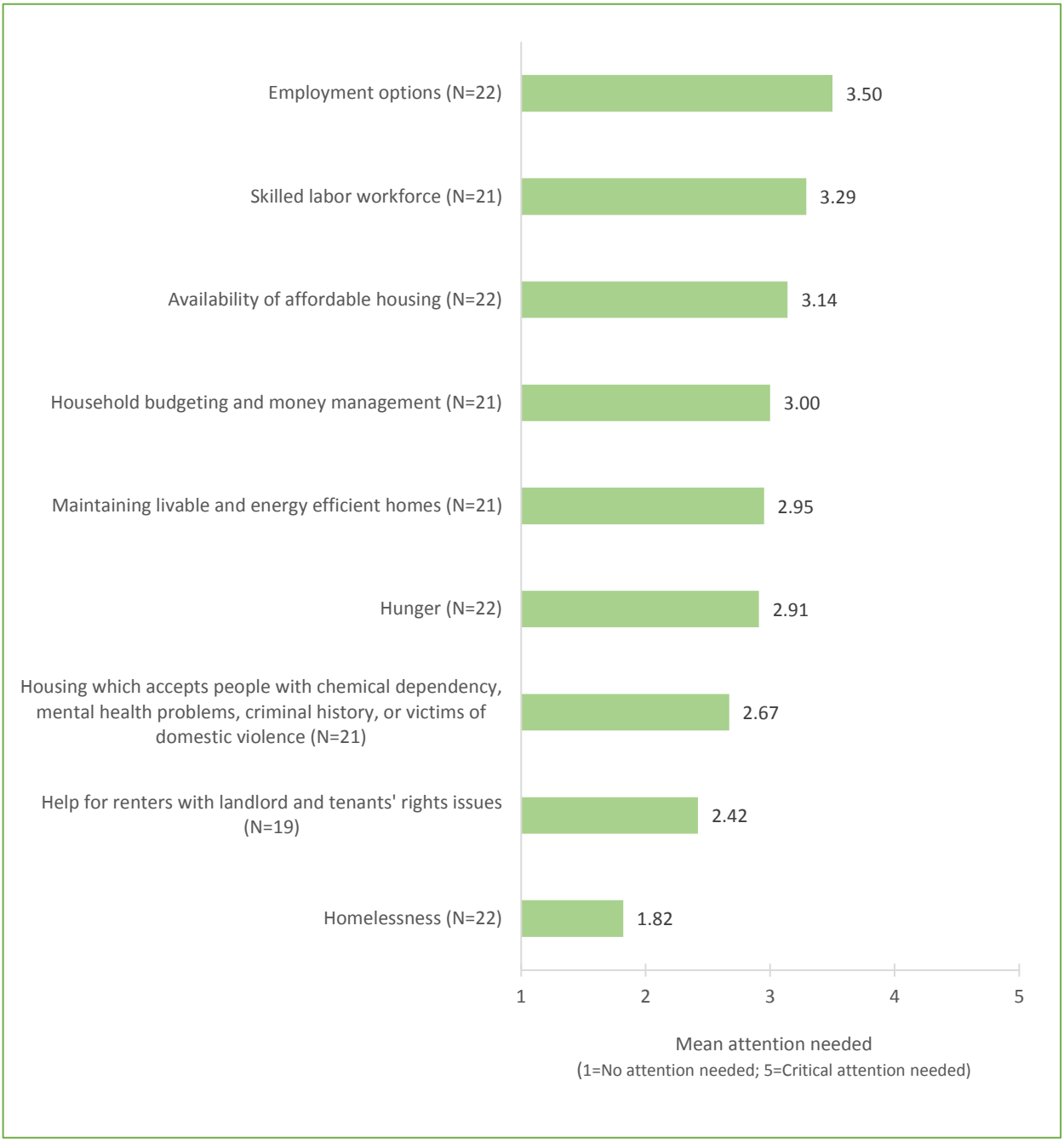


Figure 2. Current state of community issues regarding TRANSPORTATION

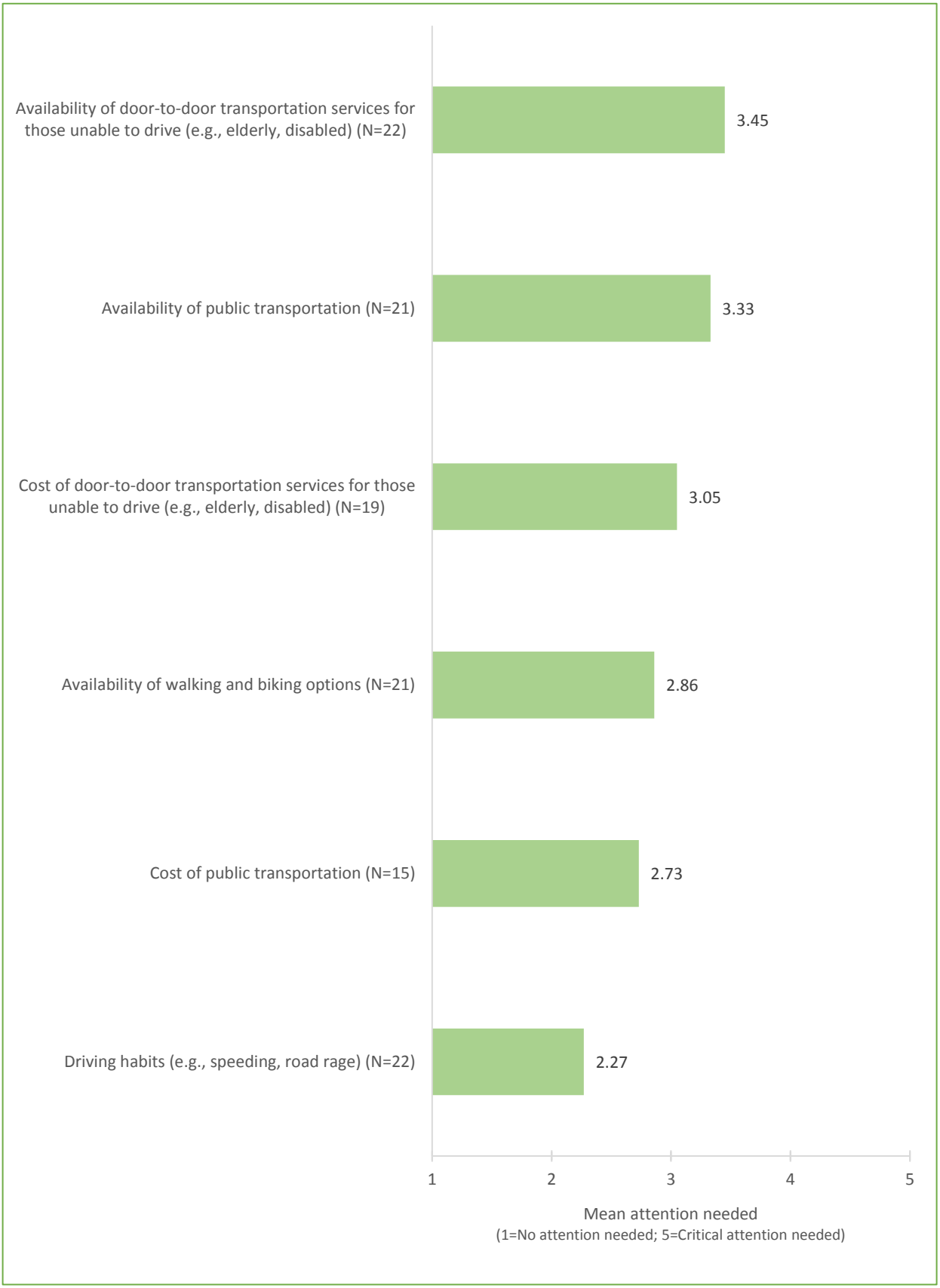


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

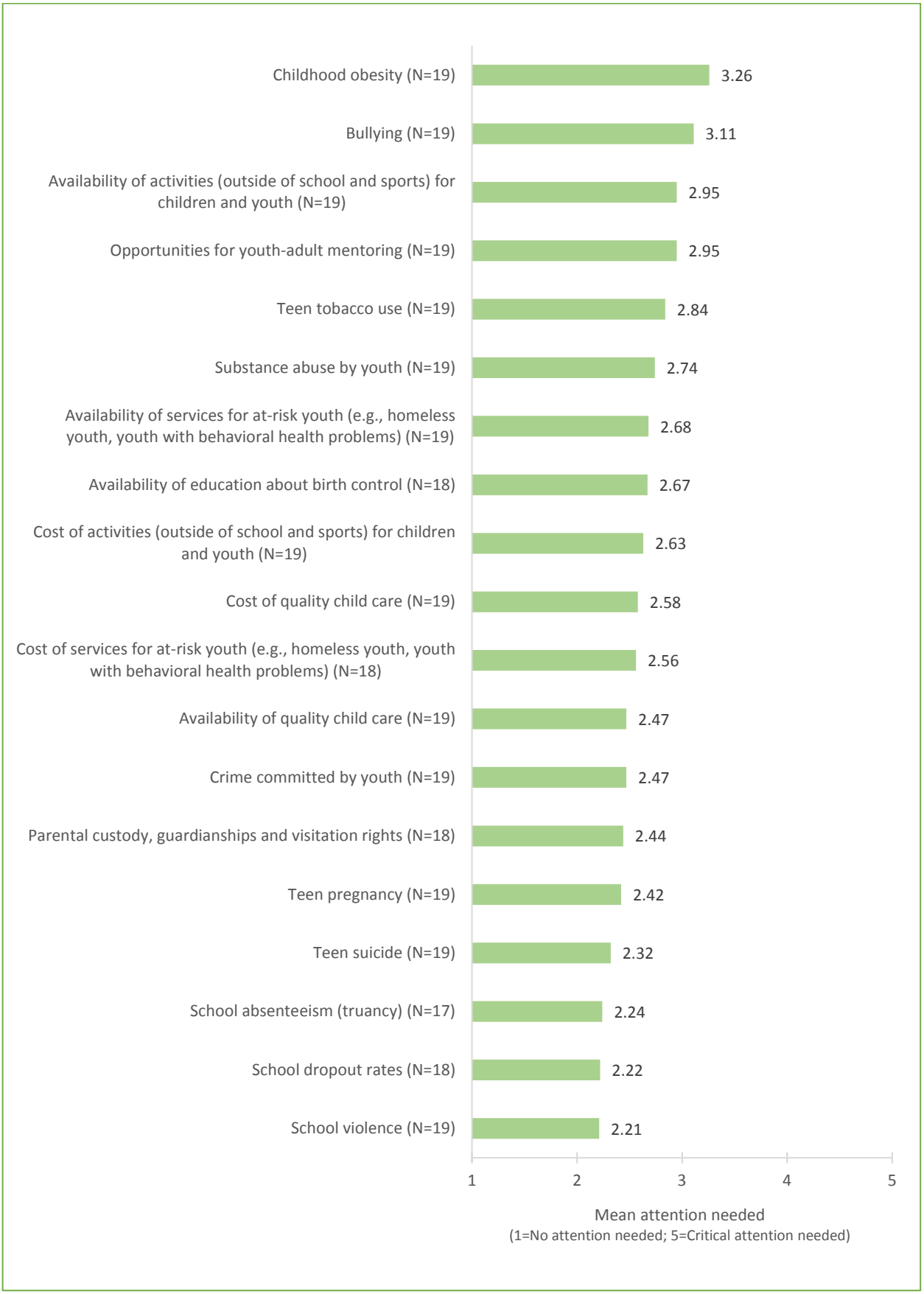

Childhood obesity (N=19)
3.26
Bullying (N=19)
3.11
Availability of activities (outside of school and sports) for children and youth (N=19)
2.95
Opportunities for youth-adult mentoring (N=19)
2.95
Teen tobacco use (N=19)
2.84
Substance abuse by youth (N=19)
2.74
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=19)
2.68
Availability of education about birth control (N=18)
2.67
Cost of activities (outside of school and sports) for children and youth (N=19)
2.63
Cost of quality child care (N=19)
2.58
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=18)
2.56
Availability of quality child care (N=19)
2.47
Crime committed by youth (N=19)
2.47
Parental custody, guardianships and visitation rights (N=18)
2.44
Teen pregnancy (N=19)
2.42
Teen suicide (N=19)
2.32
School absenteeism (truancy) (N=17)
2.24
School dropout rates (N=18)
2.22
School violence (N=19)
2.21
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

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

Figure 5. Current state of community issues regarding SAFETY

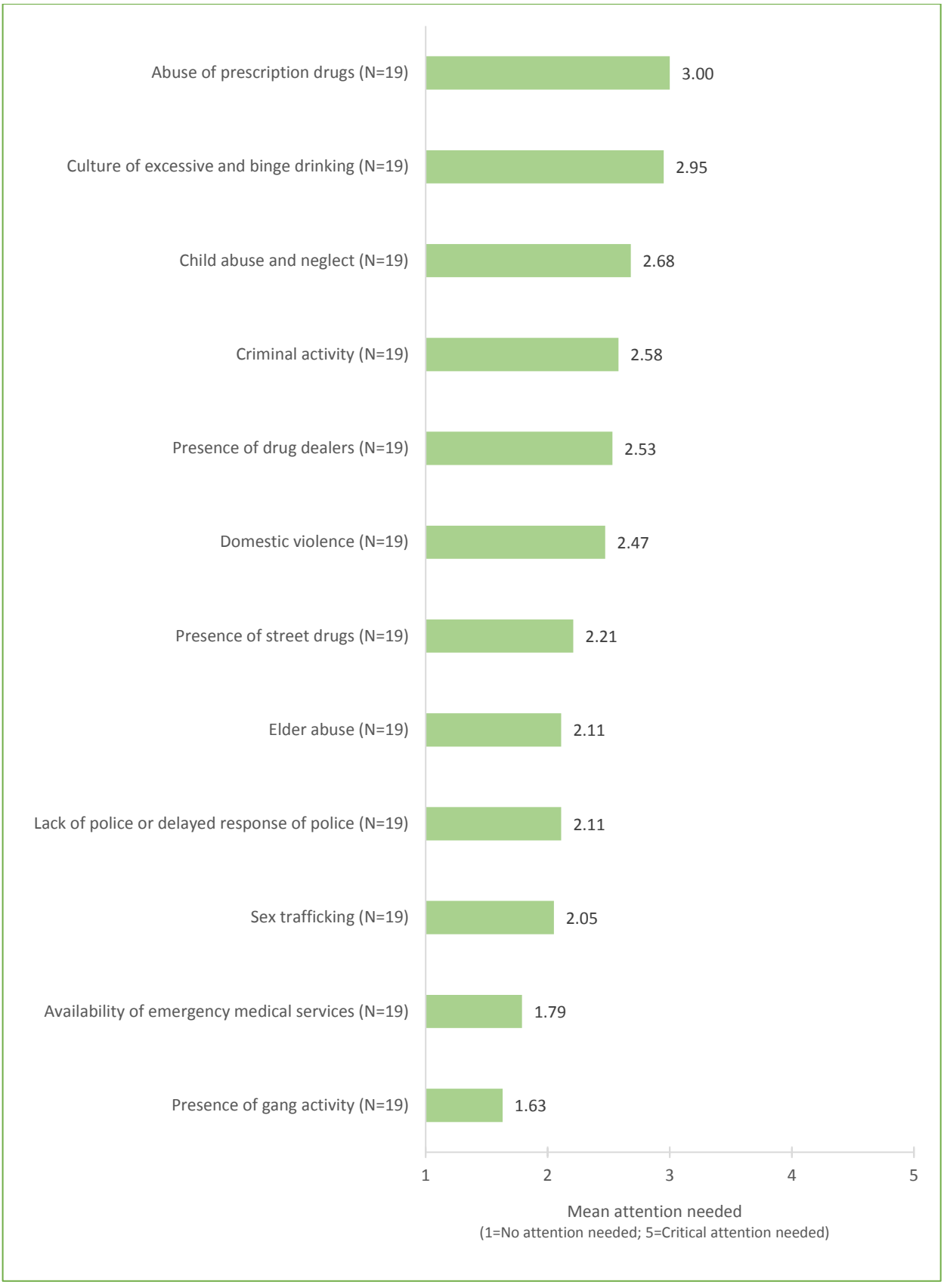


Figure 6. Current state of community issues regarding HEALTHCARE AND WELLNESS

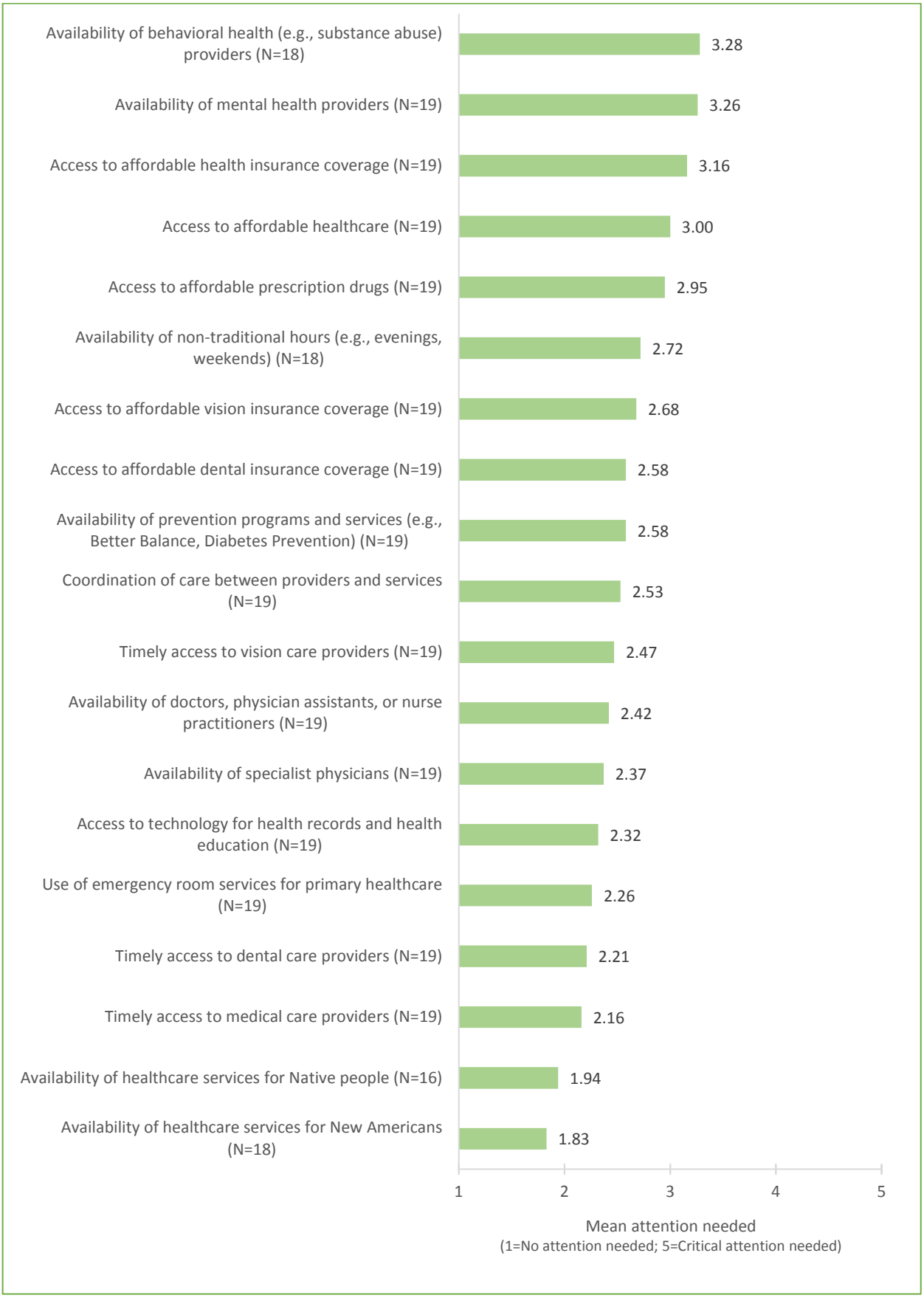
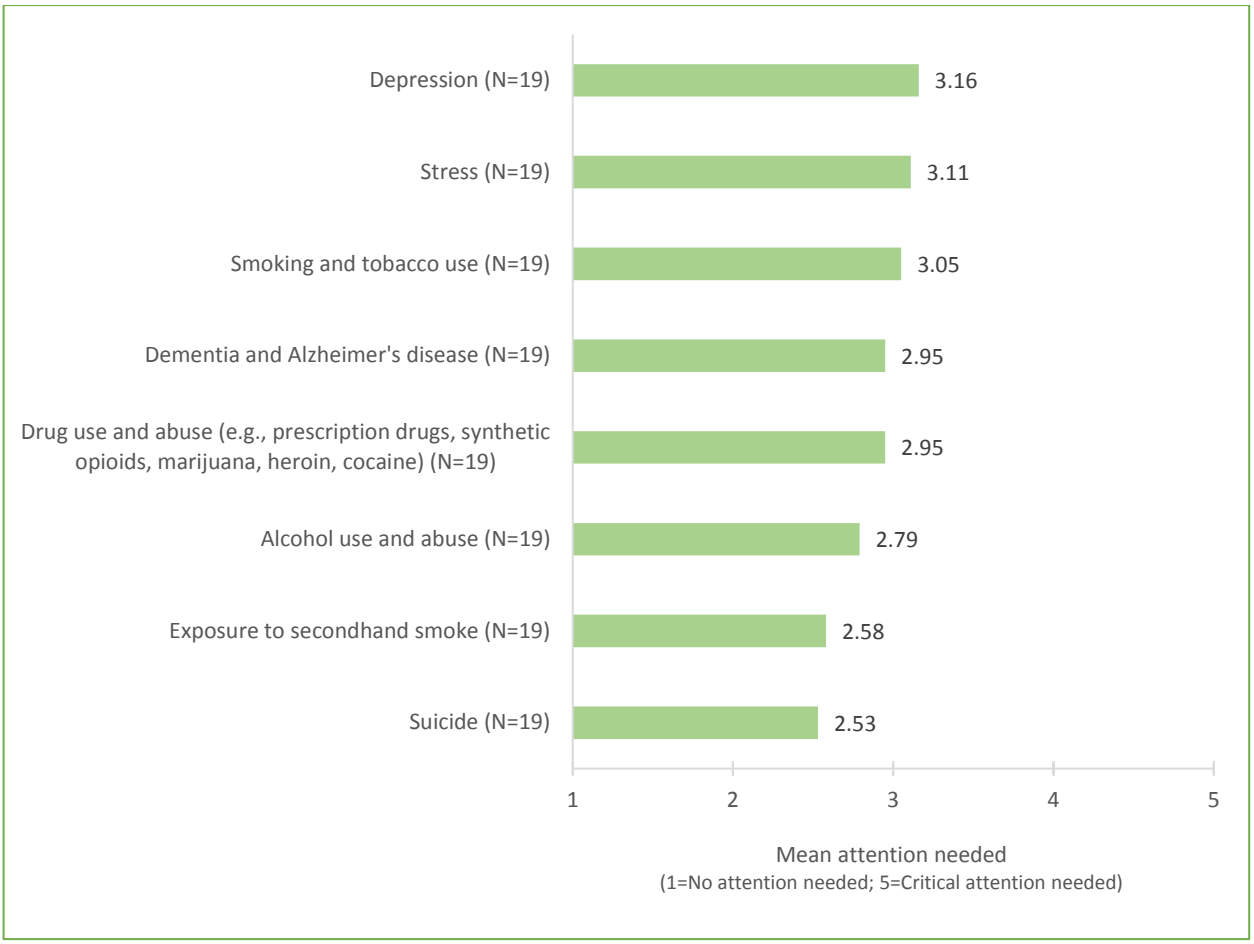
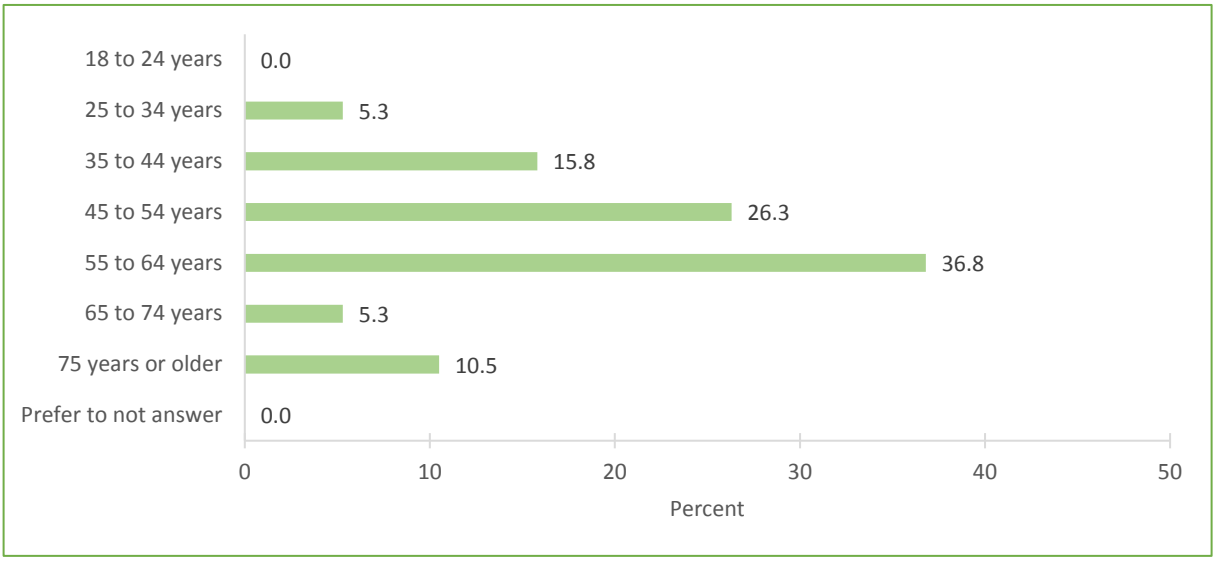

Availability of behavioral health (e.g., substance abuse) providers (N=18)
3.28
Availability of mental health providers (N=19)
3.26
Access to affordable health insurance coverage (N=19)
3.16
Access to affordable healthcare (N=19)
3.00
Access to affordable prescription drugs (N=19)
2.95
Availability of non-traditional hours (e.g., evenings, weekends) (N=18)
2.72
Access to affordable vision insurance coverage (N=19)
2.68
Access to affordable dental insurance coverage (N=19)
2.58
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=19)
2.58
Coordination of care between providers and services (N=19)
2.53
Timely access to vision care providers (N=19)
2.47
Availability of doctors, physician assistants, or nurse practitioners (N=19)
2.42
Availability of specialist physicians (N=19)
2.37
Access to technology for health records and health education (N=19)
2.32
Use of emergency room services for primary healthcare (N=19)
2.26
Timely access to dental care providers (N=19)
2.21
Timely access to medical care providers (N=19)
2.16
Availability of healthcare services for Native people (N=16)
1.94
Availability of healthcare services for New Americans (N=18)
1.83
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

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



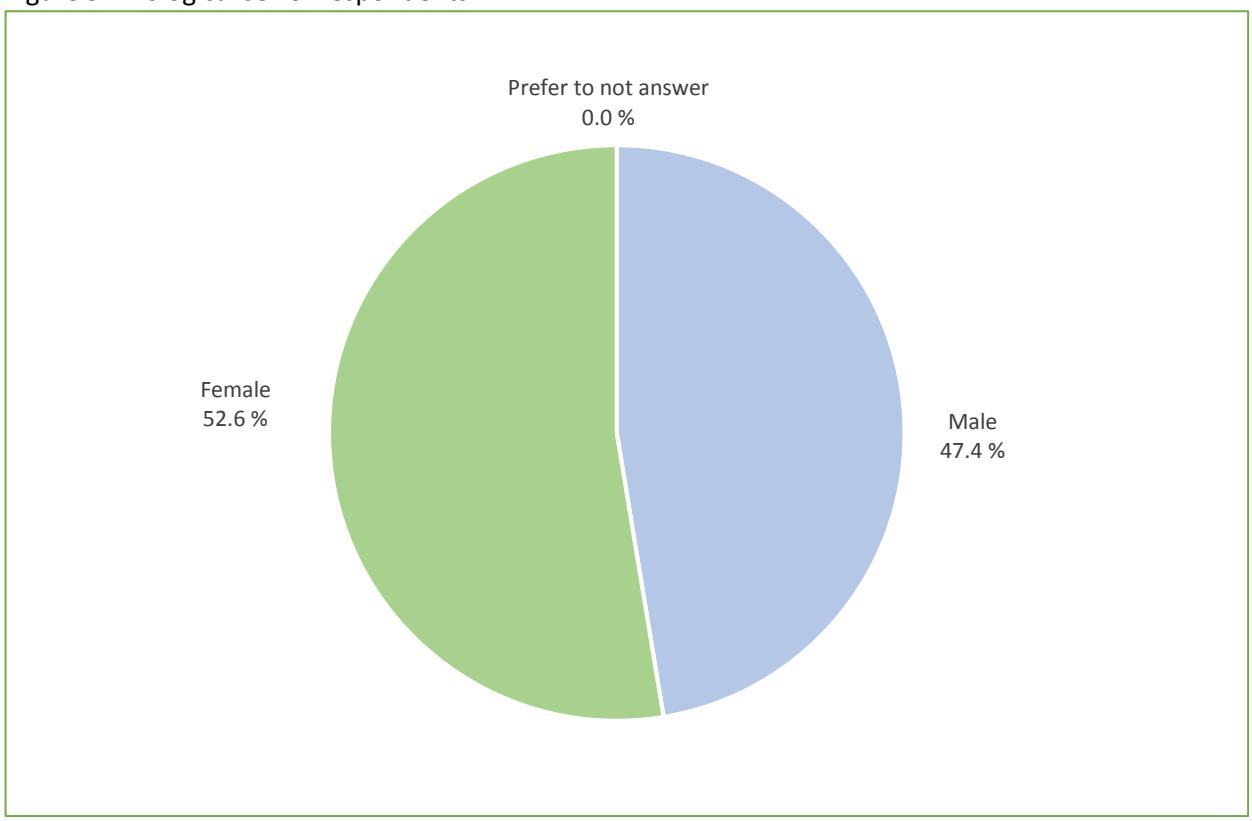
Demographic Information

Figure 8. Age of respondents



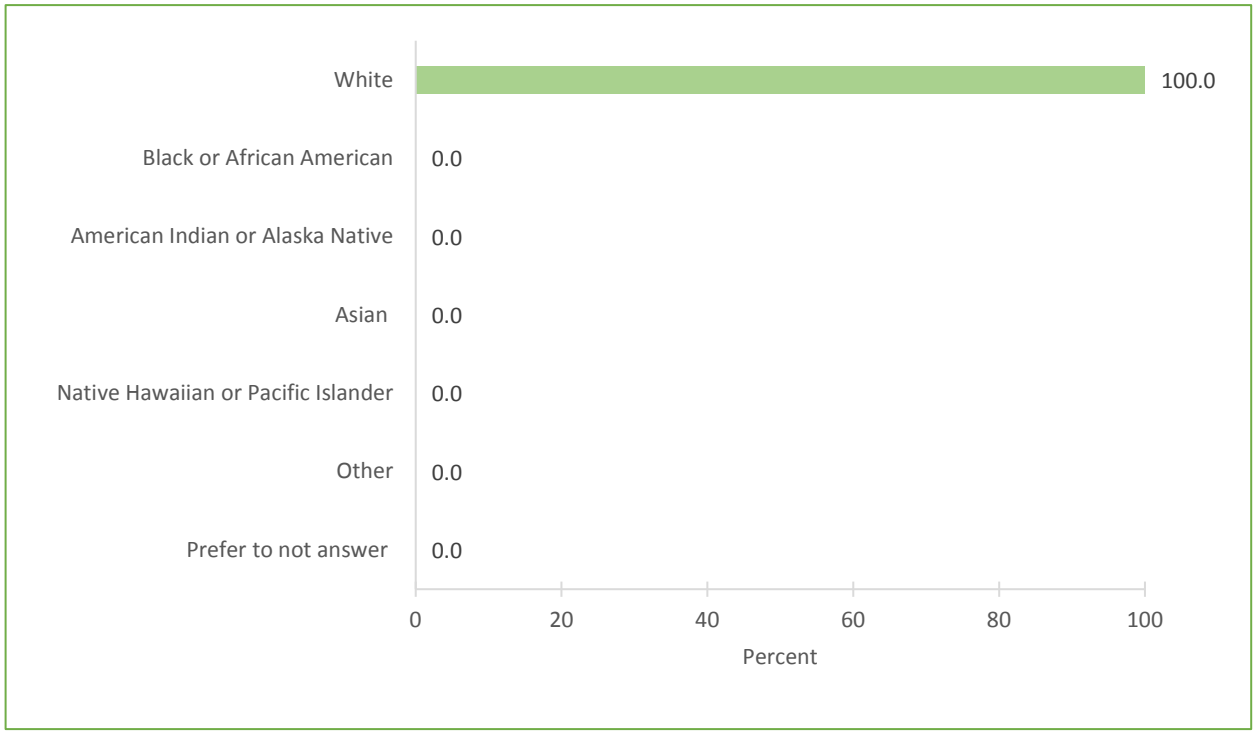
N=19

Figure 9. Biological sex of respondents



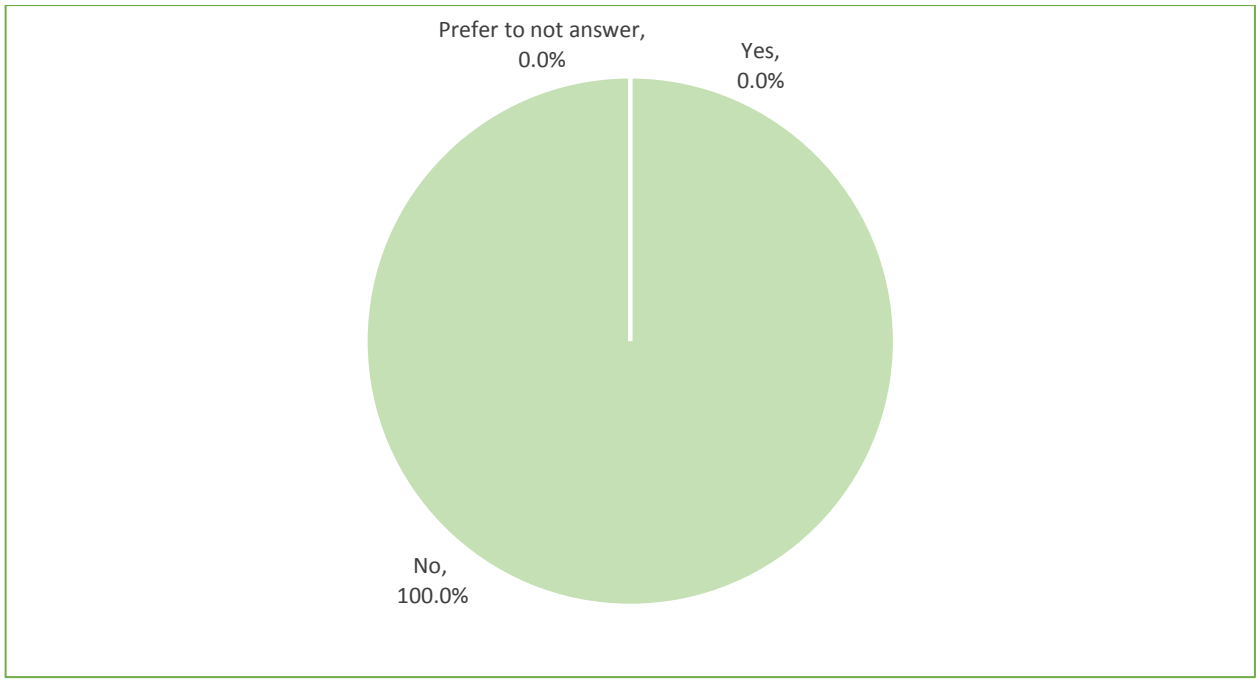
N=19

Figure 10. Race of respondents



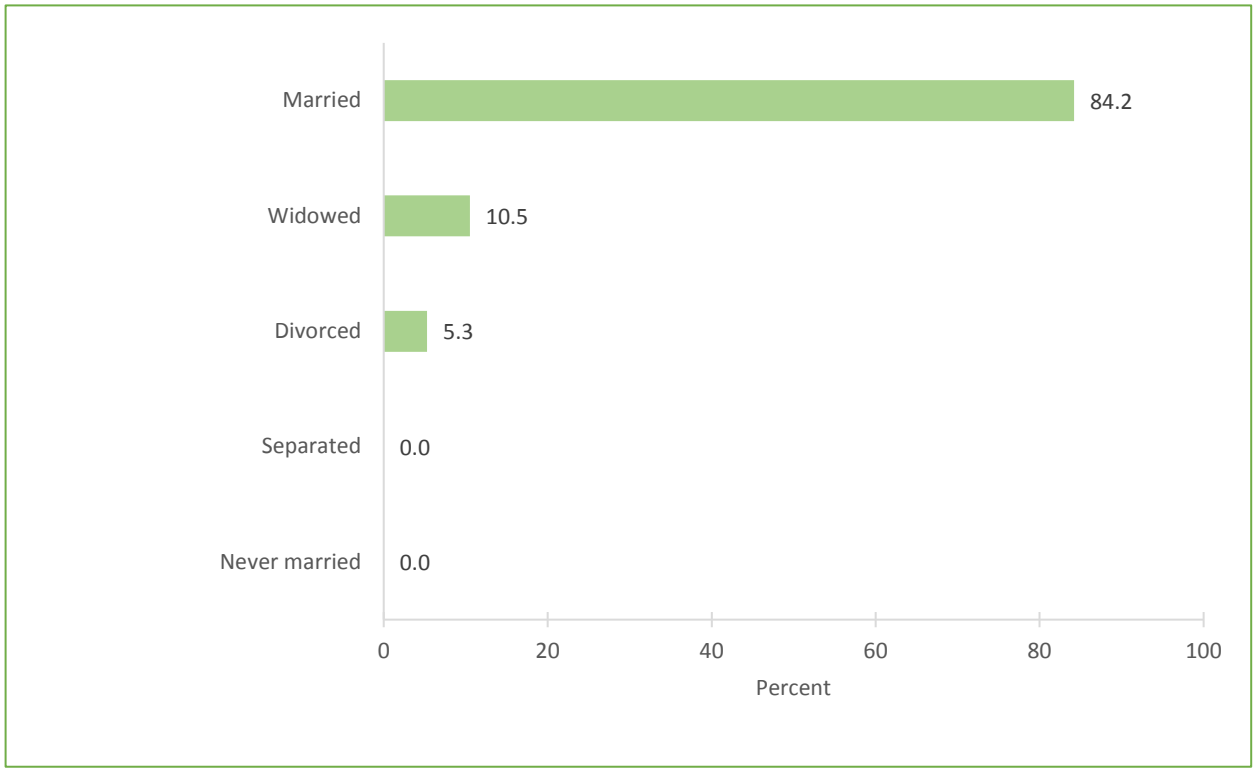
N=19

Figure 11. Whether respondents are of Hispanic or Latino origin



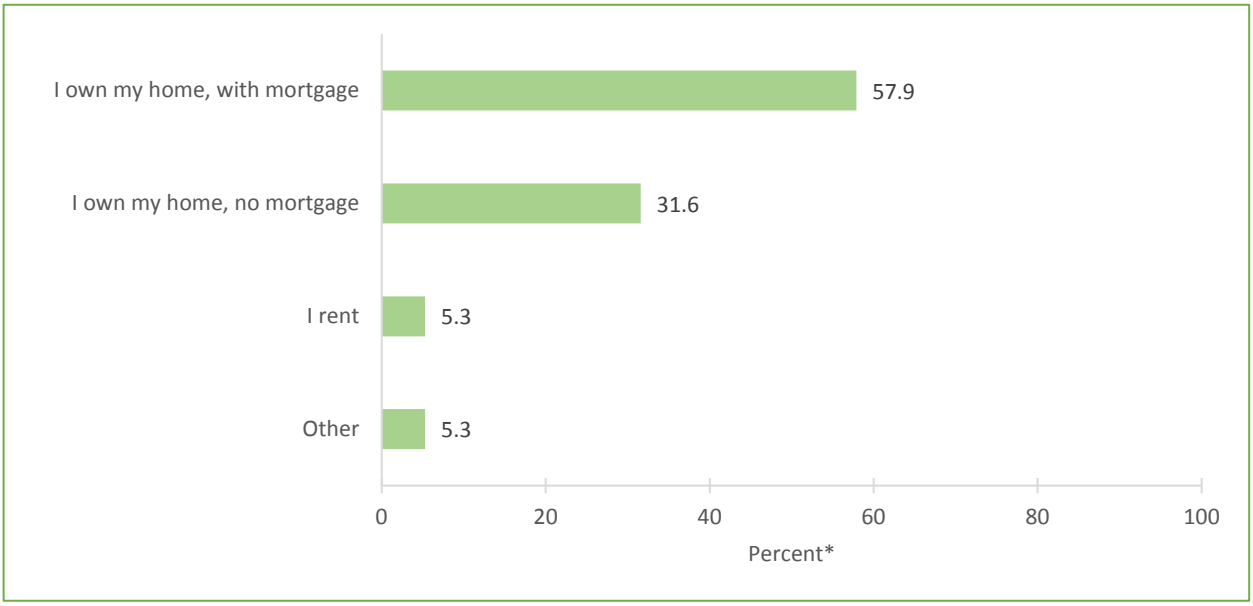
N=19

Figure 12. Marital status of respondents



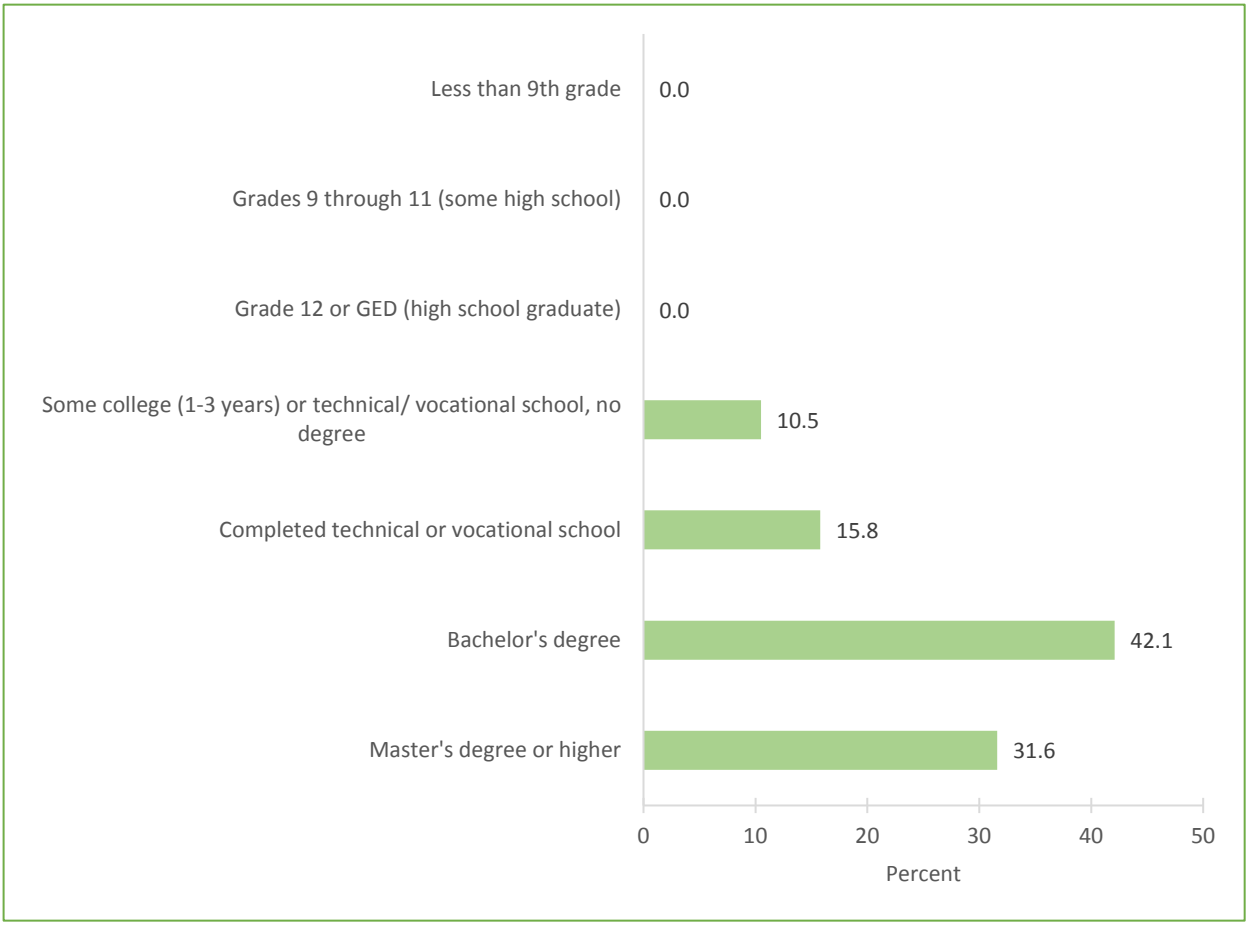
N=19

Figure 13. Living situation of respondents



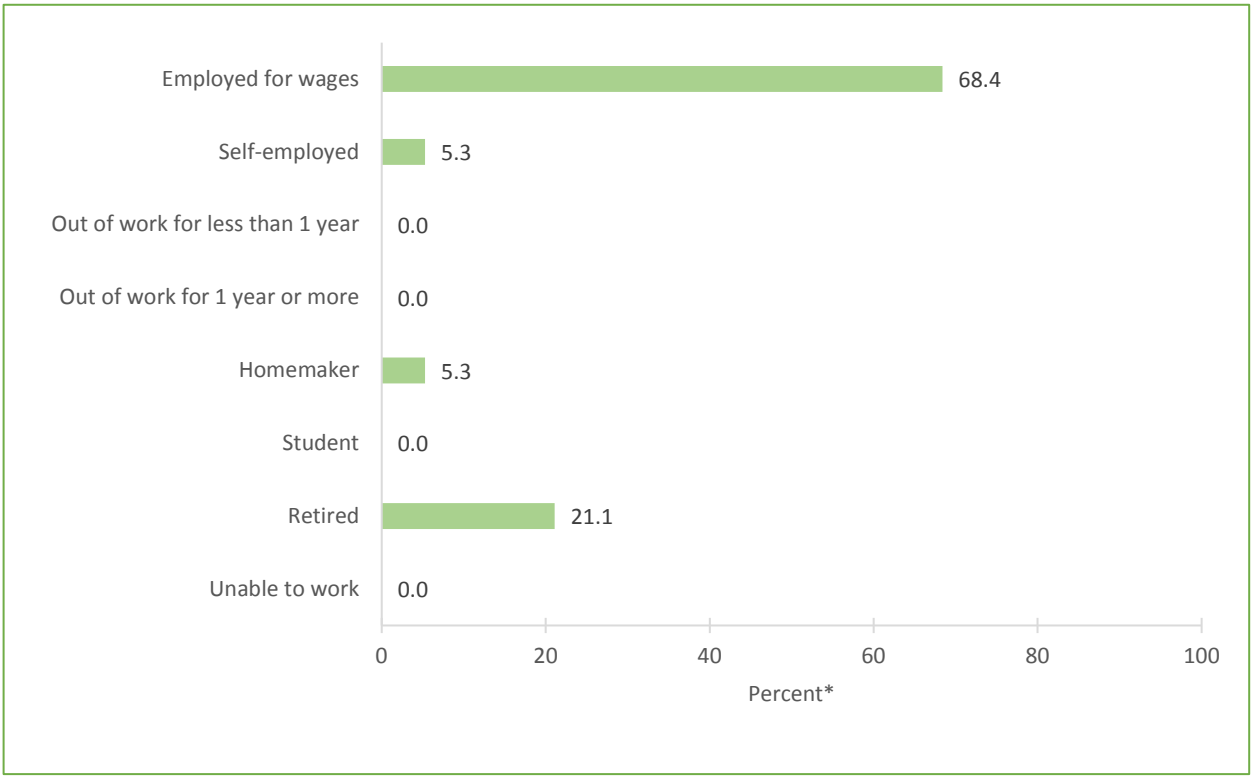
N=19 *Percentages do not total 100.0 due to rounding.

Figure 14. Highest level of education completed by respondents



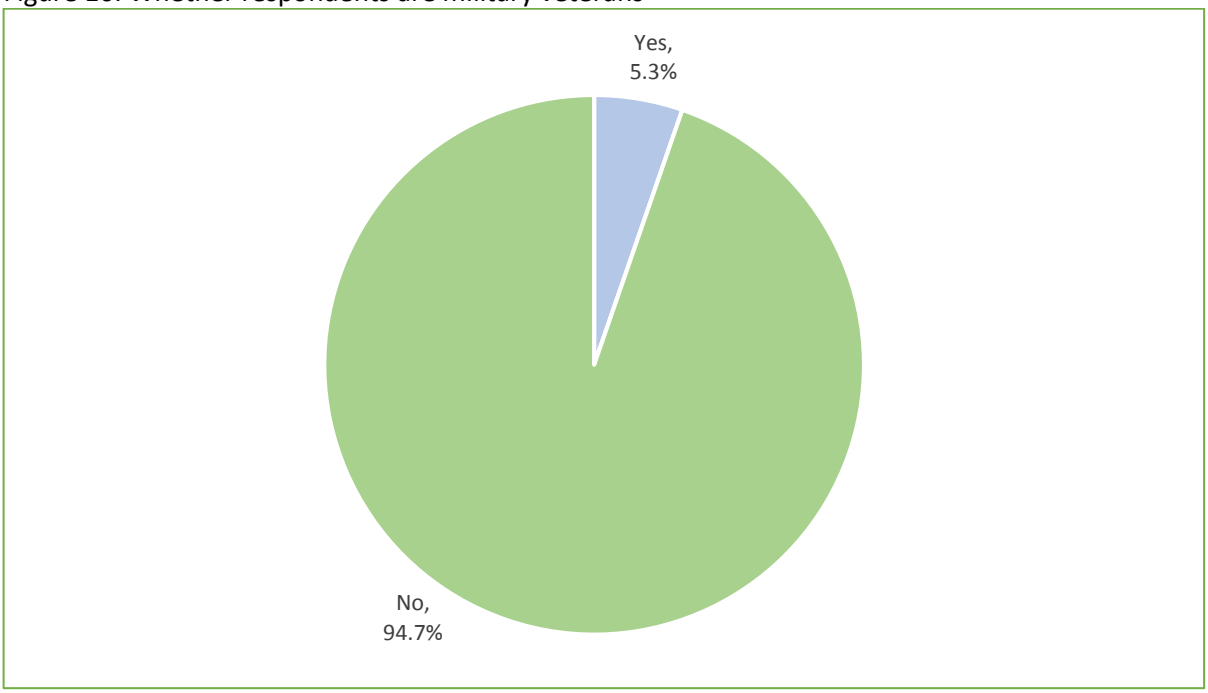
N=19

Figure 15. Employment status of respondents



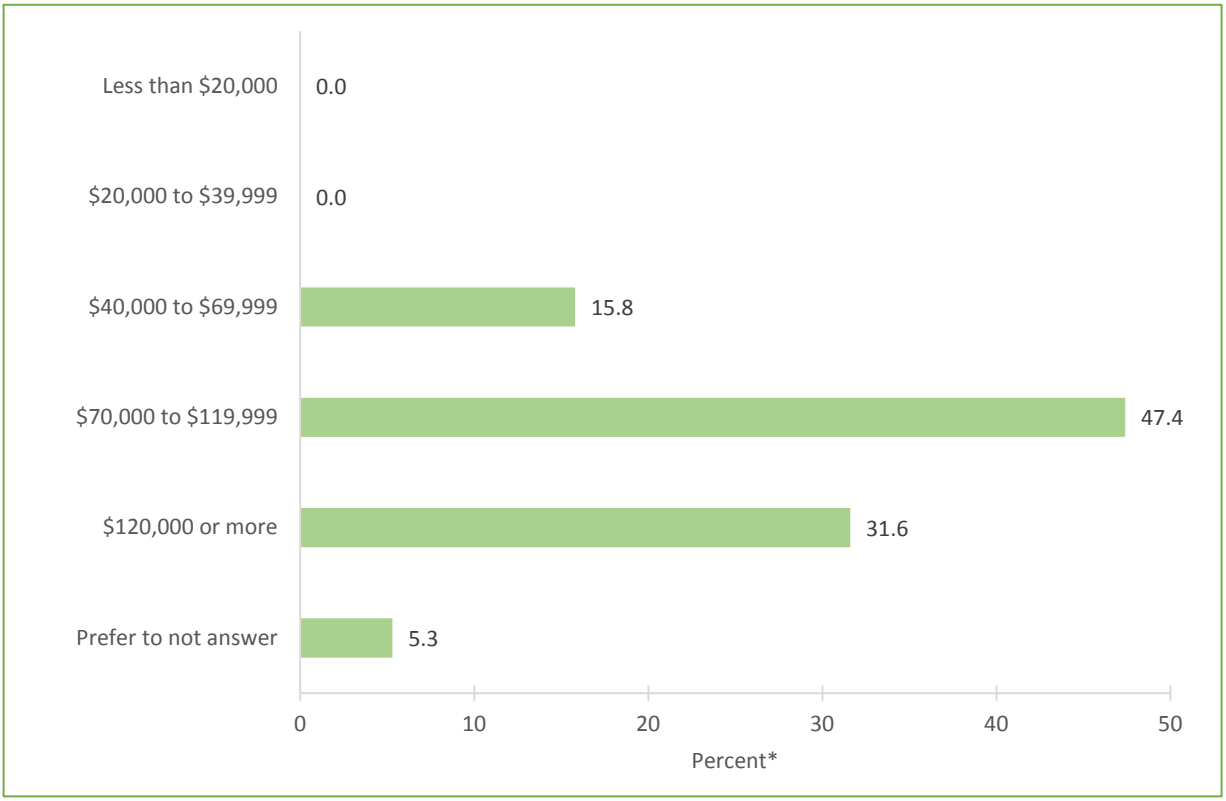
N=19
*Percentages do not total 100.0 due to rounding.

Figure 16. Whether respondents are military veterans



N=19

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



N=19

*Percentages do not total 100.0 due to rounding.

Table 1. Zip code of respondents

Zip code	Number of respondents
57226	17
57268	1

N=18

Table 2. Comments from respondents

Comments
Access to hospital is great in my location. The quality of the resident doctor is concerning.
Would like to see bike/walking path for children to get to the football field. Would also like to see more public transportation options as this is limited for the elderly who don't drive. Would like to see a larger facility for wellness with basketball courts, etc. (ex. small version of YMCA or Milbank's Unity Square).

APPENDIX TABLE

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

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=22)	3.14	0.0	18.2	54.5	22.7	4.5	0.0	99.9
Employment options (N=22)	3.50	0.0	0.0	50.0	50.0	0.0	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=20)	2.42	0.0	55.0	40.0	0.0	0.0	5.0	100.0
Homelessness (N=22)	1.82	27.3	63.6	9.1	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=21)	2.67	9.5	42.9	23.8	19.0	4.8	0.0	100.0
Household budgeting and money management (N=22)	3.00	0.0	18.2	59.1	18.2	0.0	4.5	100.0
Hunger (N=22)	2.91	0.0	18.2	72.7	9.1	0.0	0.0	100.0
Maintaining livable and energy efficient homes (N=21)	2.95	0.0	23.8	57.1	19.0	0.0	0.0	99.9
Skilled labor workforce (N=22)	3.29	0.0	18.2	40.9	27.3	9.1	4.5	100.0
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=22)	3.45	0.0	22.7	31.8	22.7	22.7	0.0	99.9
Availability of public transportation (N=22)	3.33	4.5	22.7	22.7	27.3	18.2	4.5	99.9
Availability of walking and biking options (N=22)	2.86	9.1	31.8	27.3	18.2	9.1	4.5	100.0
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=20)	3.05	5.0	30.0	35.0	5.0	20.0	5.0	100.0
Cost of public transportation (N=20)	2.73	5.0	30.0	25.0	10.0	5.0	25.0	100.0
Driving habits (e.g., speeding, road rage) (N=22)	2.27	9.1	54.5	36.4	0.0	0.0	0.0	100.0
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=19)	2.95	5.3	26.3	42.1	21.1	5.3	0.0	100.1
Availability of education about birth control (N=19)	2.67	5.3	36.8	36.8	15.8	0.0	5.3	100.0
Availability of quality child care (N=19)	2.47	10.5	47.4	26.3	15.8	0.0	0.0	100.0
Availability of services for at-risk youth (e.g., homeless youth, youth	2.68	5.3	31.6	52.6	10.5	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
with behavioral health problems) (N=19)								
Bullying (N=19)	3.11	0.0	21.1	47.4	31.6	0.0	0.0	100.1
Childhood obesity (N=19)	3.26	0.0	21.1	42.1	26.3	10.5	0.0	100.0
Cost of activities (outside of school and sports) for children and youth (N=19)	2.63	0.0	57.9	26.3	10.5	5.3	0.0	100.0
Cost of quality child care (N=19)	2.58	10.5	42.1	26.3	21.1	0.0	0.0	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=19)	2.56	5.3	42.1	36.8	10.5	0.0	5.3	100.0
Crime committed by youth (N=19)	2.47	5.3	47.4	42.1	5.3	0.0	0.0	100.1
Opportunities for youth-adult mentoring (N=19)	2.95	0.0	31.6	42.1	26.3	0.0	0.0	100.0
Parental custody, guardianships and visitation rights (N=19)	2.44	0.0	68.4	15.8	5.3	5.3	5.3	100.1
School absenteeism (truancy) (N=18)	2.24	5.6	66.7	16.7	5.6	0.0	5.6	100.2
School dropout rates (N=19)	2.22	5.3	63.2	26.3	0.0	0.0	5.3	100.1
School violence (N=19)	2.21	10.5	57.9	31.6	0.0	0.0	0.0	100.0
Substance abuse by youth (N=19)	2.74	0.0	36.8	52.6	10.5	0.0	0.0	99.9
Teen pregnancy (N=19)	2.42	0.0	68.4	21.1	10.5	0.0	0.0	100.0
Teen suicide (N=19)	2.32	5.3	63.2	26.3	5.3	0.0	0.0	100.1
Teen tobacco use (N=19)	2.84	0.0	31.6	52.6	15.8	0.0	0.0	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=19)	3.11	0.0	21.1	52.6	21.1	5.3	0.0	100.1
Availability of long-term care (N=19)	2.47	5.3	47.4	42.1	5.3	0.0	0.0	100.1
Availability of memory care (N=18)	3.06	0.0	33.3	33.3	27.8	5.6	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=19)	2.84	0.0	42.1	42.1	5.3	10.5	0.0	100.0
Availability of resources for grandparents caring for grandchildren (N=19)	2.53	0.0	57.9	31.6	10.5	0.0	0.0	100.0
Availability of resources to help the elderly stay safe in their homes (N=19)	3.00	0.0	36.8	36.8	15.8	10.5	0.0	99.9
Cost of activities for seniors (e.g., recreational, social, cultural) (N=19)	2.68	0.0	57.9	21.1	15.8	5.3	0.0	100.1
Cost of in-home services (N=19)	3.00	0.0	42.1	21.1	31.6	5.3	0.0	100.1
Cost of long-term care (N=19)	3.42	0.0	21.1	26.3	42.1	10.5	0.0	100.0
Cost of memory care (N=19)	3.37	0.0	21.1	31.6	36.8	10.5	0.0	100.0
Help making out a will or healthcare directive (N=19)	2.68	0.0	52.6	31.6	10.5	5.3	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	
SAFETY								
Abuse of prescription drugs (N=19)	3.00	0.0	36.8	31.6	26.3	5.3	0.0	100.0
Availability of emergency medical services (N=19)	1.79	36.8	47.4	15.8	0.0	0.0	0.0	100.0
Child abuse and neglect (N=19)	2.68	0.0	47.4	42.1	5.3	5.3	0.0	100.1
Criminal activity (N=19)	2.58	0.0	52.6	36.8	10.5	0.0	0.0	99.9
Culture of excessive and binge drinking (N=19)	2.95	0.0	26.3	52.6	21.1	0.0	0.0	100.0
Domestic violence (N=19)	2.47	5.3	47.4	42.1	5.3	0.0	0.0	100.1
Elder abuse (N=19)	2.11	15.8	57.9	26.3	0.0	0.0	0.0	100.0
Lack of police or delayed response of police (N=19)	2.11	15.8	63.2	15.8	5.3	0.0	0.0	100.1
Presence of drug dealers (N=19)	2.53	10.5	42.1	31.6	15.8	0.0	0.0	100.0
Presence of gang activity (N=19)	1.63	36.8	63.2	0.0	0.0	0.0	0.0	100.0
Presence of street drugs (N=19)	2.21	15.8	52.6	26.3	5.3	0.0	0.0	100.0
Sex trafficking (N=19)	2.05	21.1	52.6	26.3	0.0	0.0	0.0	100.0
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=19)	2.58	5.3	47.4	31.6	15.8	0.0	0.0	100.1
Access to affordable health insurance coverage (N=19)	3.16	5.3	26.3	31.6	21.1	15.8	0.0	100.1
Access to affordable health care (N=19)	3.00	5.3	26.3	47.4	5.3	15.8	0.0	100.1
Access to affordable prescription drugs (N=19)	2.95	5.3	26.3	47.4	10.5	10.5	0.0	100.0
Access to affordable vision insurance coverage (N=19)	2.68	5.3	36.8	42.1	15.8	0.0	0.0	100.0
Access to technology for health records and health education (N=19)	2.32	5.3	63.2	26.3	5.3	0.0	0.0	100.1
Availability of behavioral health (e.g., substance abuse) providers (N=18)	3.28	0.0	22.2	38.9	27.8	11.1	0.0	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=19)	2.42	10.5	57.9	15.8	10.5	5.3	0.0	100.0
Availability of health care services for Native people (N=19)	1.94	15.8	57.9	10.5	0.0	0.0	15.8	100.0
Availability of healthcare services for New Americans (N=19)	1.83	26.3	57.9	10.5	0.0	0.0	5.3	100.0
Availability of mental health providers (N=19)	3.26	0.0	31.6	21.1	36.8	10.5	0.0	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=18)	2.72	0.0	50.0	27.8	22.2	0.0	0.0	100.0
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=19)	2.58	0.0	57.9	31.6	5.3	5.3	0.0	100.1
Availability of specialist physicians (N=19)	2.37	0.0	68.4	26.3	5.3	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	
Coordination of care between providers and services (N=19)	2.53	5.3	57.9	21.1	10.5	5.3	0.0	100.1
Timely access to medical care providers (N=19)	2.16	10.5	63.2	26.3	0.0	0.0	0.0	100.0
Timely access to dental care providers (N=19)	2.21	10.5	57.9	31.6	0.0	0.0	0.0	100.0
Timely access to vision care providers (N=19)	2.47	5.3	42.1	52.6	0.0	0.0	0.0	100.0
Use of emergency room services for primary healthcare (N=19)	2.26	10.5	57.9	26.3	5.3	0.0	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=19)	2.79	5.3	15.8	73.7	5.3	0.0	0.0	100.1
Dementia and Alzheimer's disease (N=19)	2.95	5.3	26.3	42.1	21.1	5.3	0.0	100.1
Depression (N=19)	3.16	0.0	10.5	68.4	15.8	5.3	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=19)	2.95	0.0	26.3	57.9	10.5	5.3	0.0	100.0
Exposure to secondhand smoke (N=19)	2.58	0.0	63.2	15.8	21.1	0.0	0.0	100.1
Smoking and tobacco use (N=19)	3.05	0.0	15.8	63.2	21.1	0.0	0.0	100.1
Stress (N=19)	3.11	0.0	15.8	57.9	26.3	0.0	0.0	100.0
Suicide (N=19)	2.53	0.0	52.6	42.1	5.3	0.0	0.0	100.0

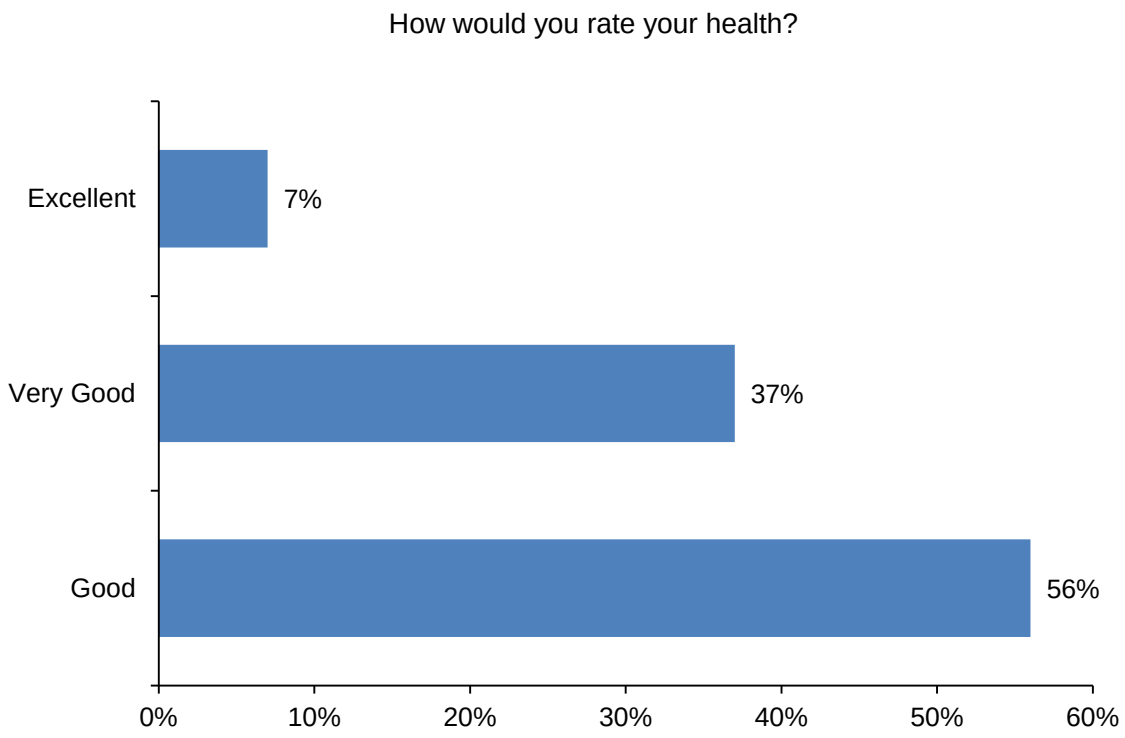
*Percentages may not total 100.0 due to rounding.

**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.

Clear Lake CHNA Survey Report

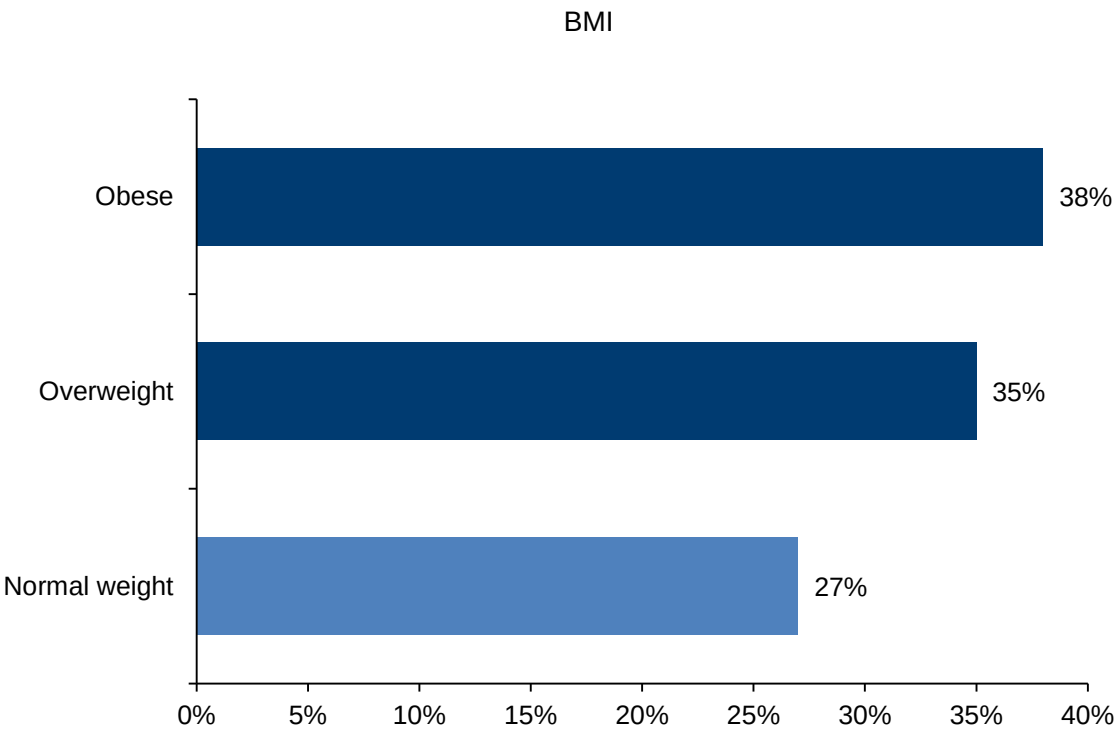
February 27, 2018

Charts Exported by MarketSight®



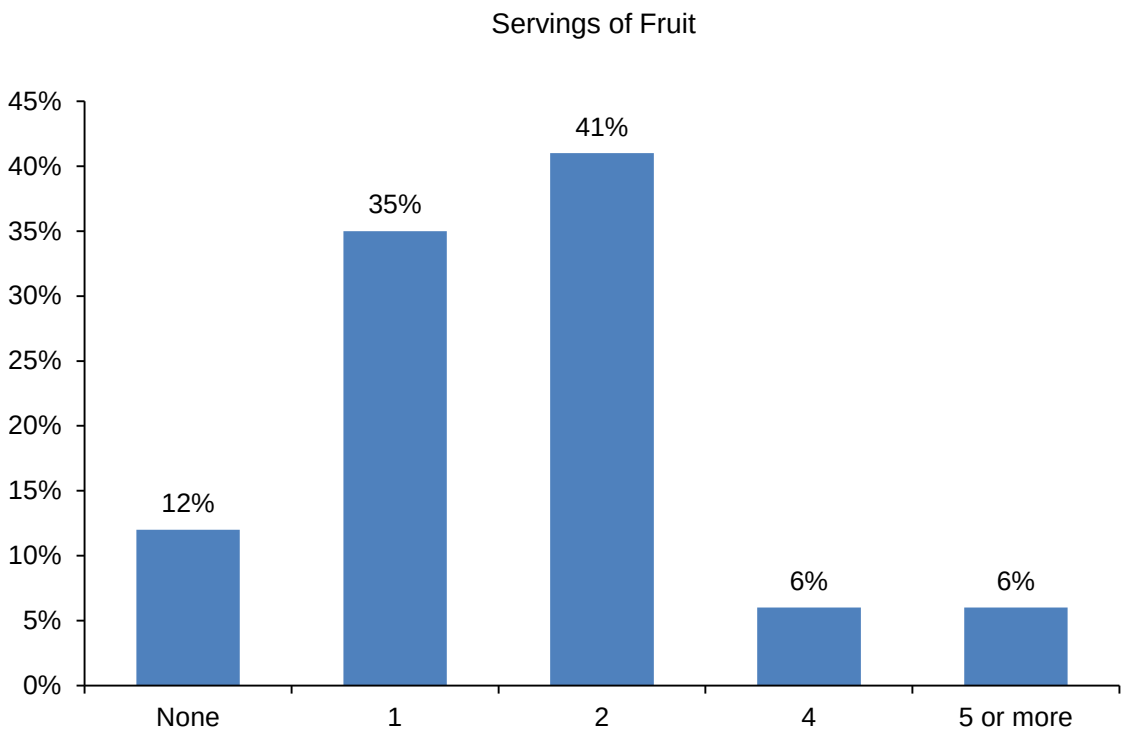
Base: Good (n=15), Very Good (n=10), Excellent (n=2), Sample Size = 27

(Community = Deuel)



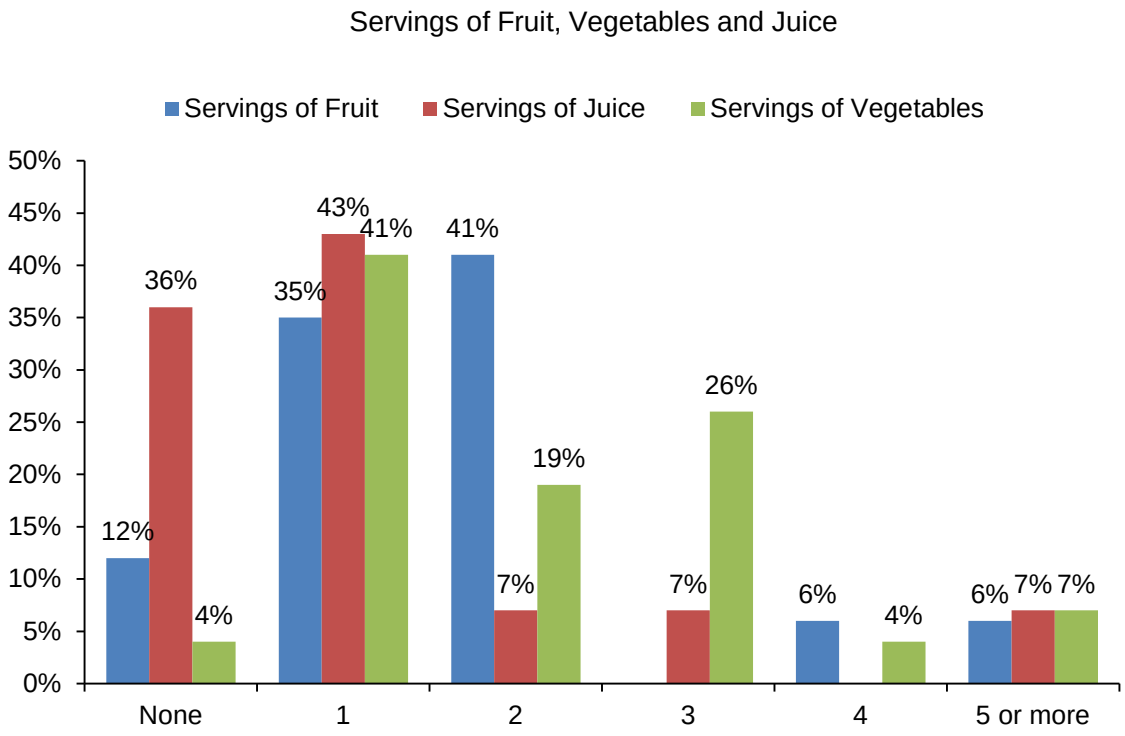
Base: Normal weight (n=7), Overweight (n=9), Obese (n=10), Sample Size = 26

(Community = Deuel)



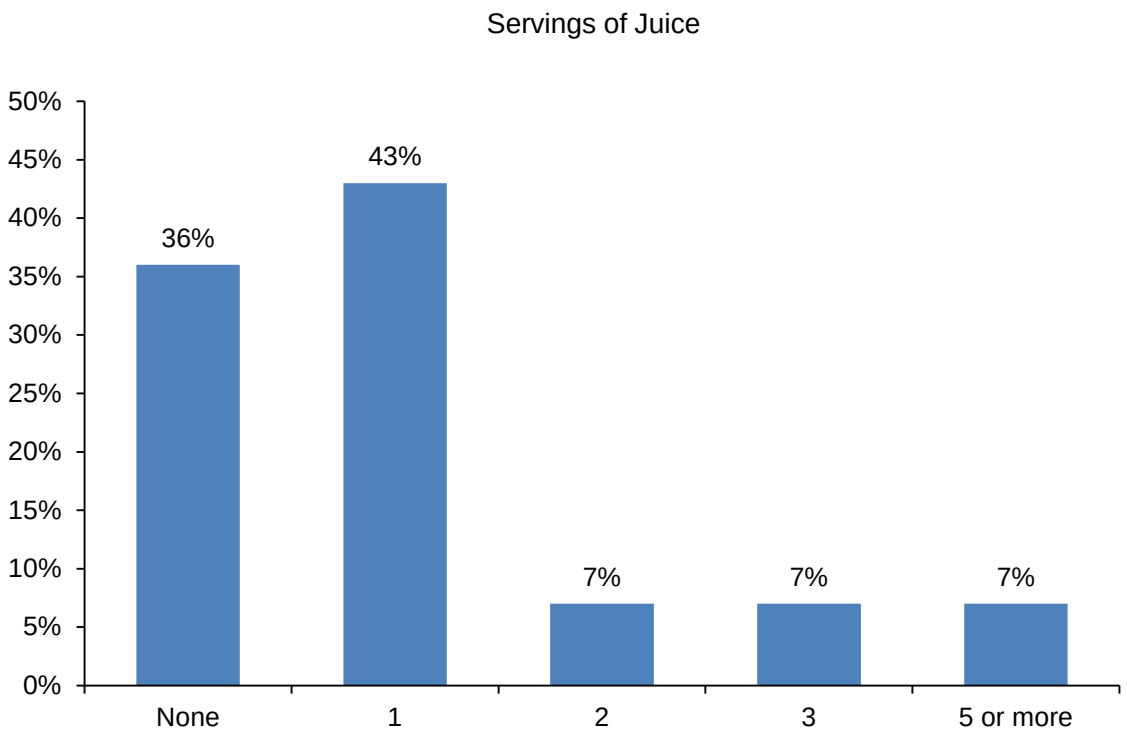
Base: None (n=2), 1 (n=6), 2 (n=7), 4 (n=1), 5 or more (n=1), Sample Size = 17

(Community = Deuel)



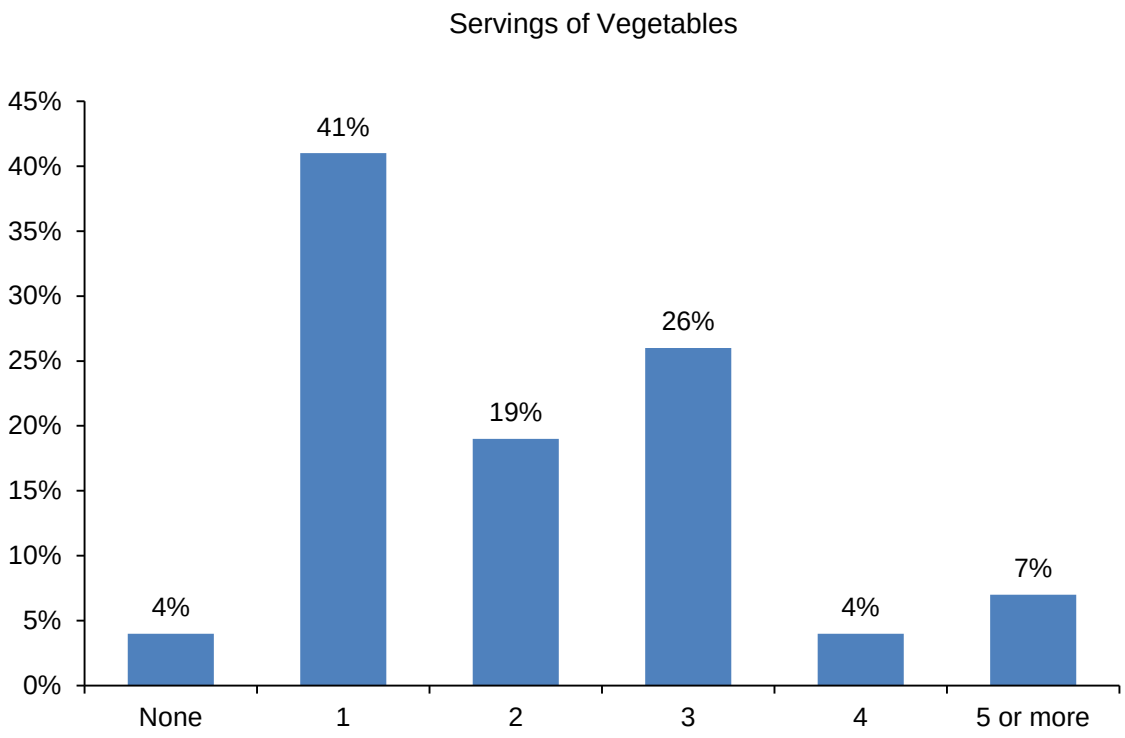
Sample Size = Variable

(Community = Deuel)



Base: None (n=5), 1 (n=6), 2 (n=1), 3 (n=1), 5 or more (n=1), Sample Size = 14

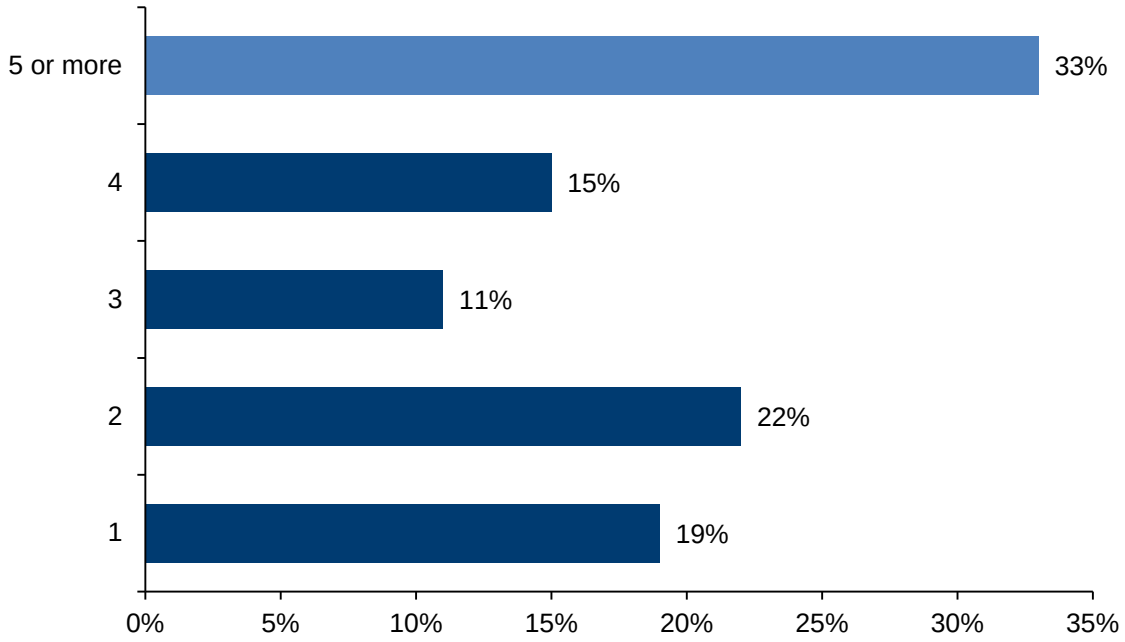
(Community = Deuel)



Base: None (n=1), 1 (n=11), 2 (n=5), 3 (n=7), 4 (n=1), 5 or more (n=2), Sample Size = 27

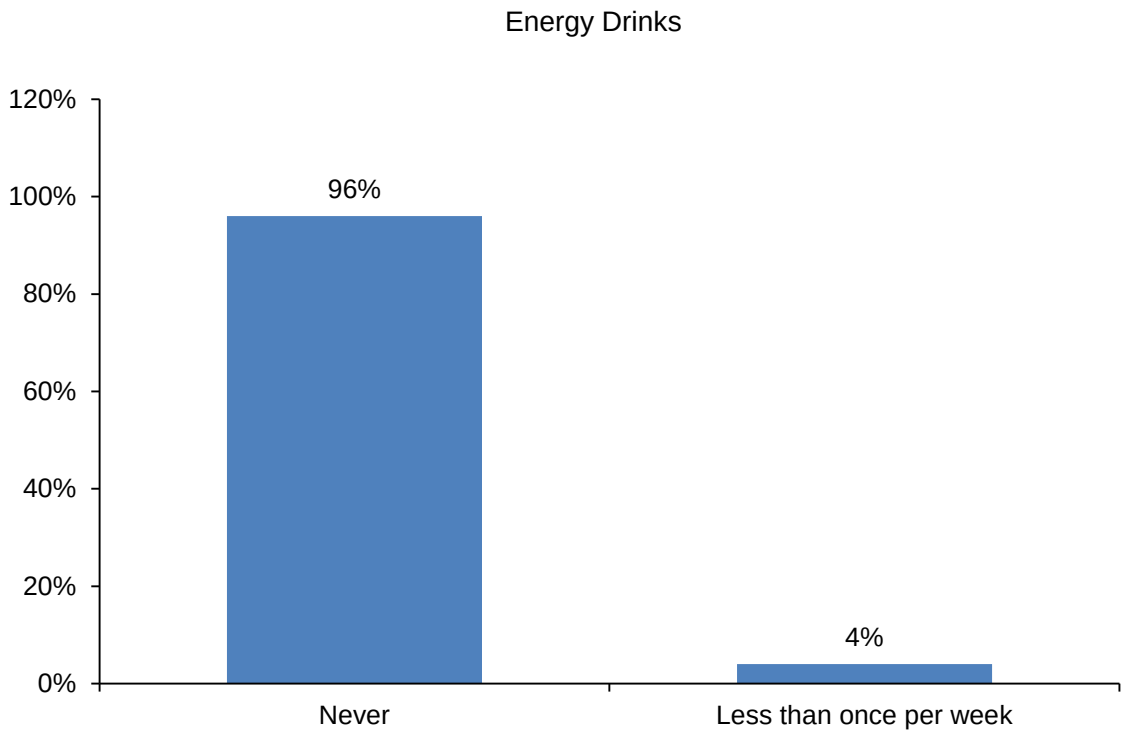
(Community = Deuel)

Total Servings of Fruits, Vegetables and Juice



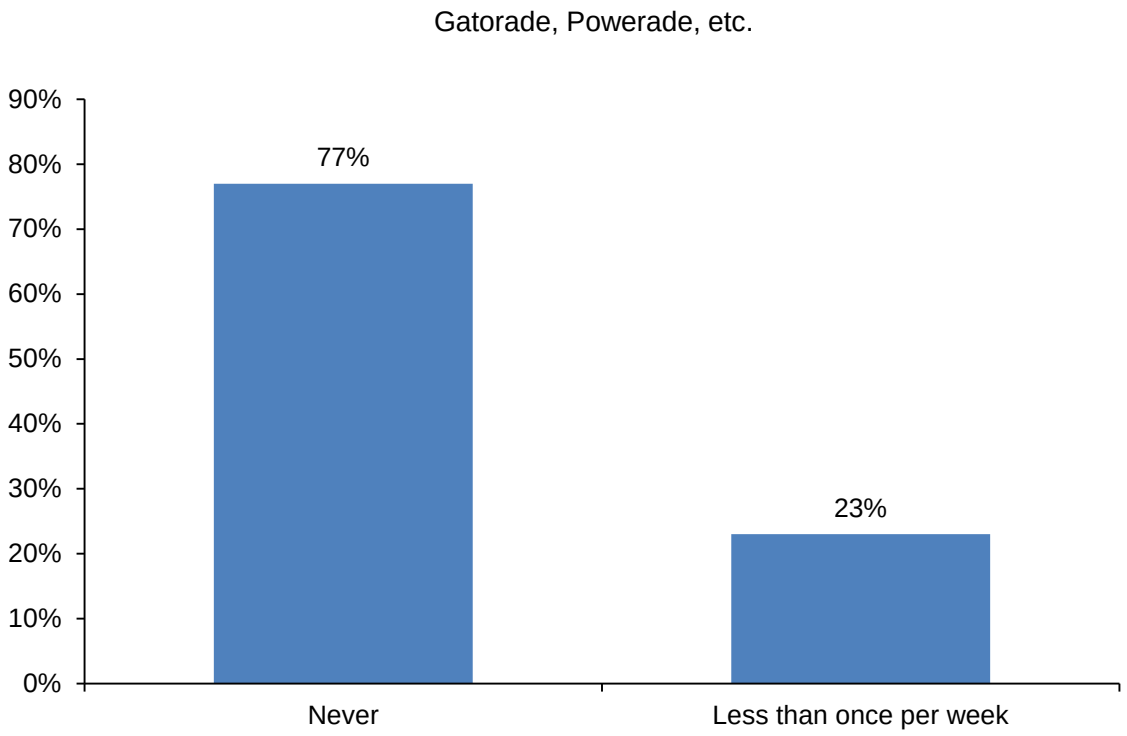
Base: 1 (n=5), 2 (n=6), 3 (n=3), 4 (n=4), 5 or more (n=9), Sample Size = 27

(Community = Deuel)



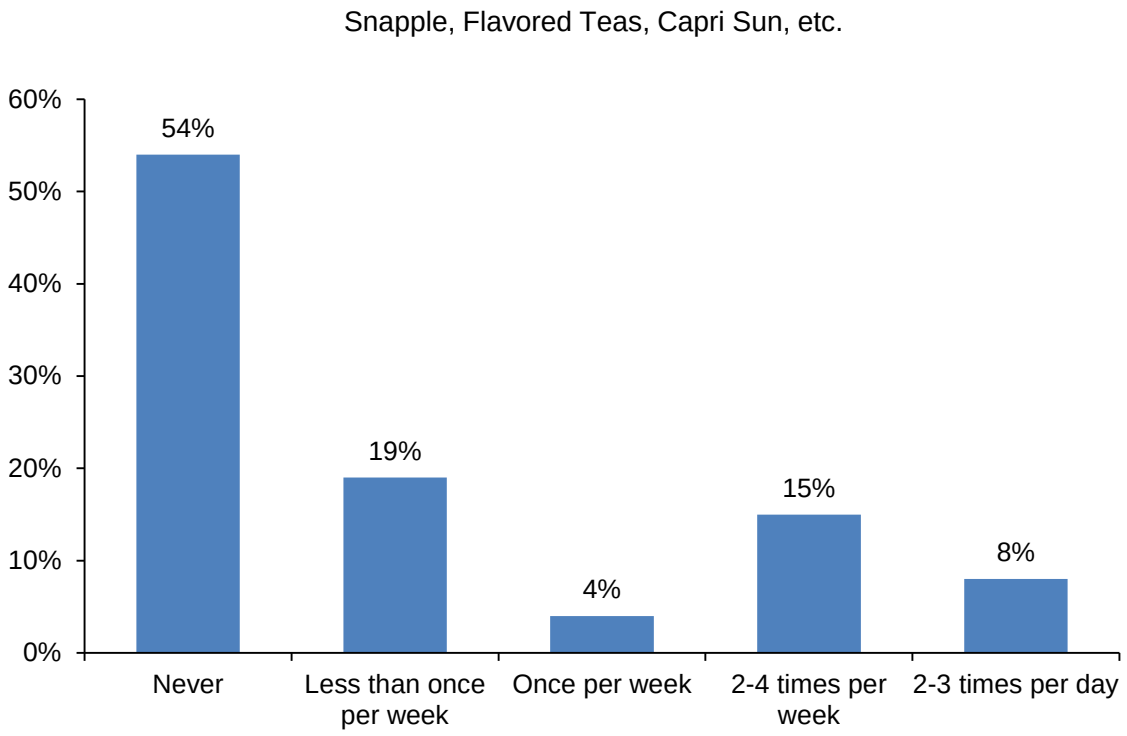
Base: Never (n=25), Less than once per week (n=1), Sample Size = 26

(Community = Deuel)



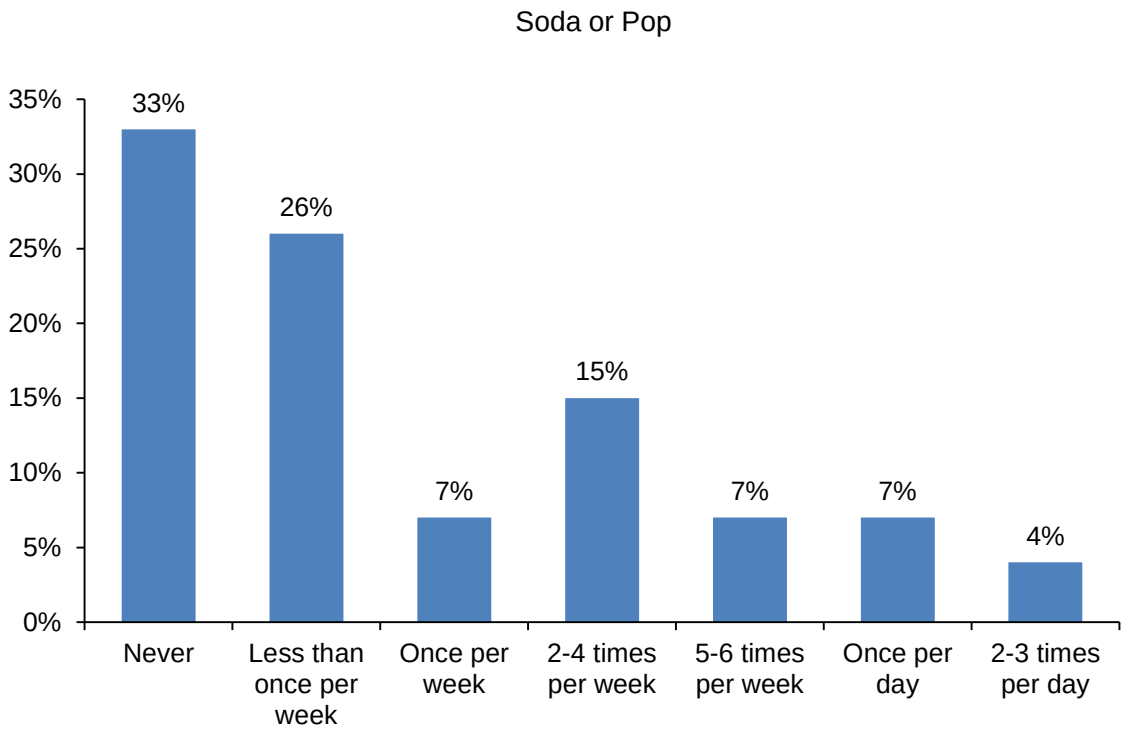
Base: Never (n=20), Less than once per week (n=6), Sample Size = 26

(Community = Deuel)



Base: Never (n=14), Less than once per week (n=5), Once per week (n=1), 2-4 times per week (n=4), 2-3 times per day (n=2), Sample Size = 26

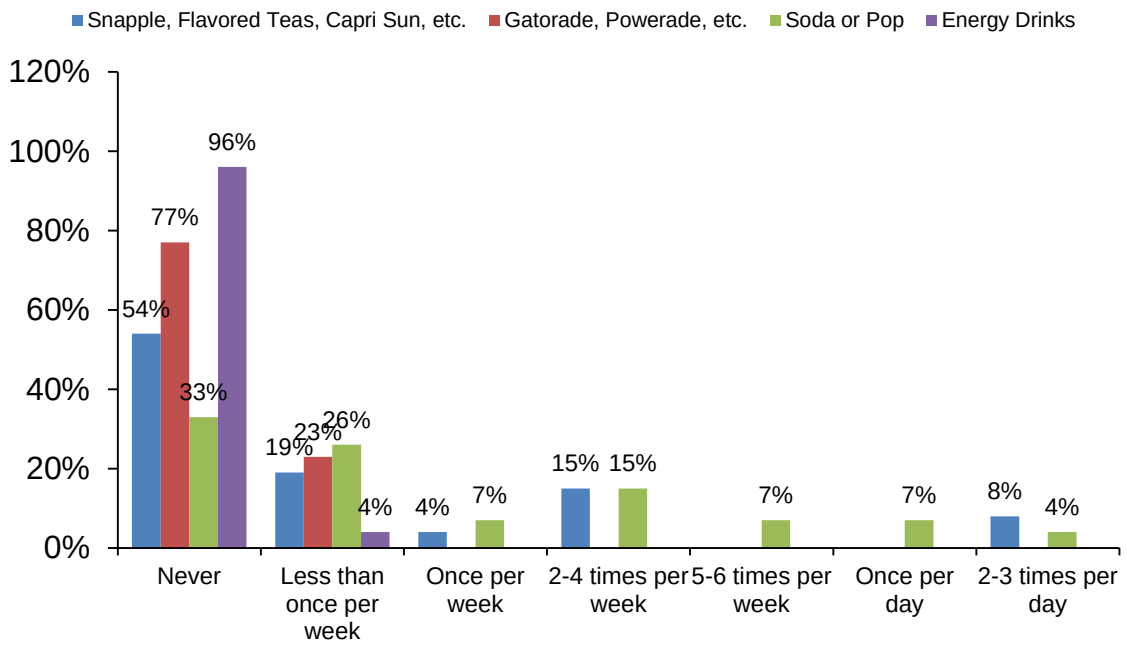
(Community = Deuel)



Base: Never (n=9), Less than once per week (n=7), Once per week (n=2), 2-4 times per week (n=4), 5-6 times per week (n=2), Once per day (n=2), 2-3 times per day (n=1), Sample Size = 27

(Community = Deuel)

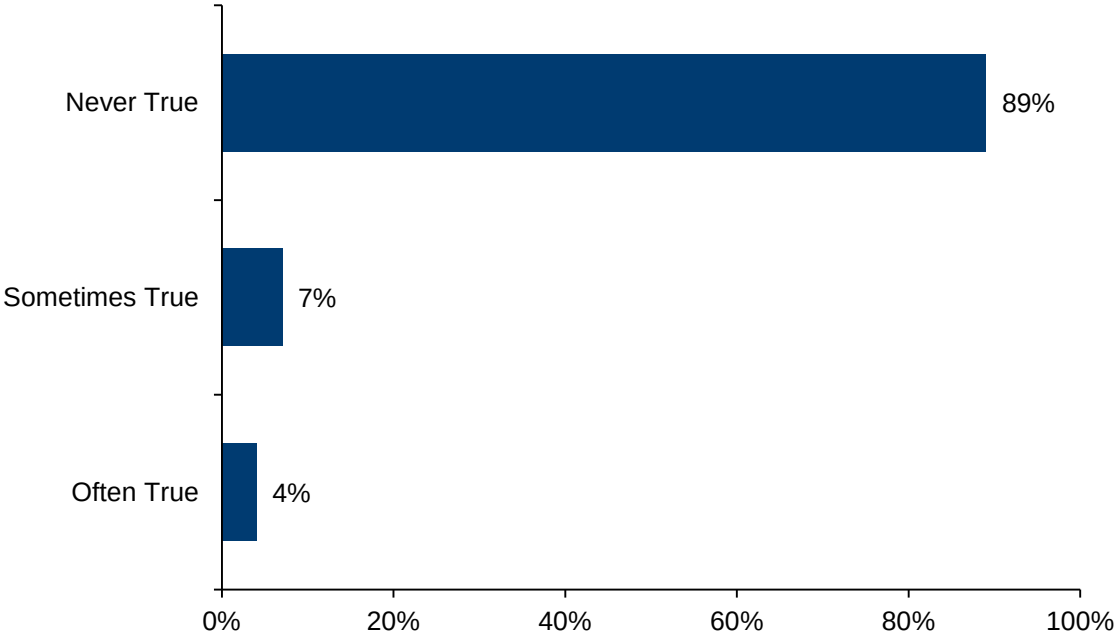
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Deuel)

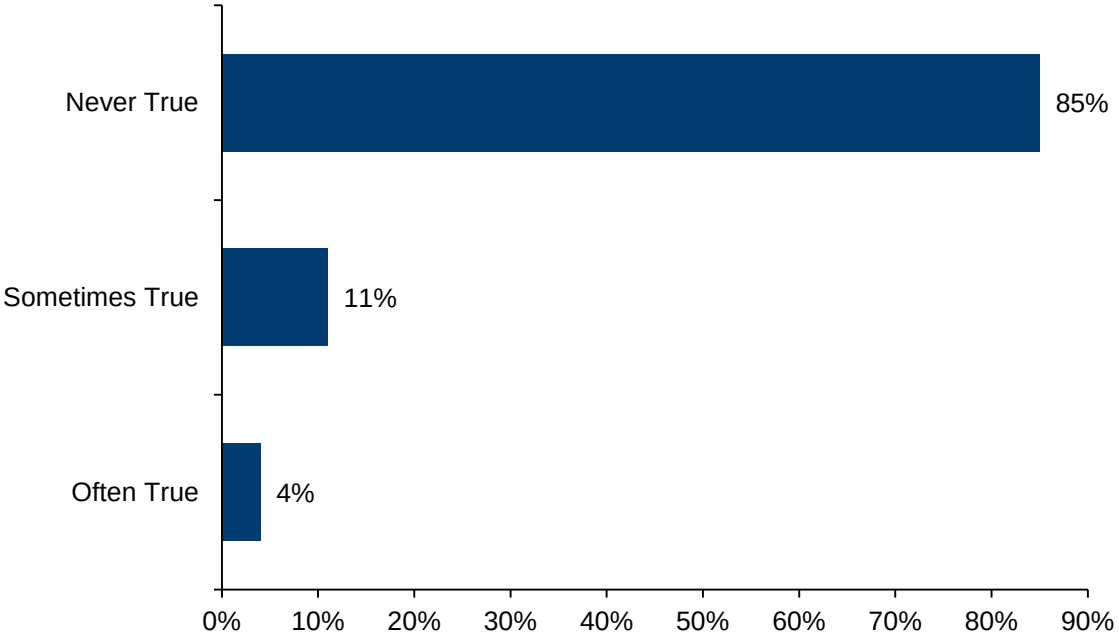
The food that we bought just didn’t last, and we didn’t have money to get more.



Base: Often True (n=1), Sometimes True (n=2), Never True (n=24), Sample Size = 27

(Community = Deuel)

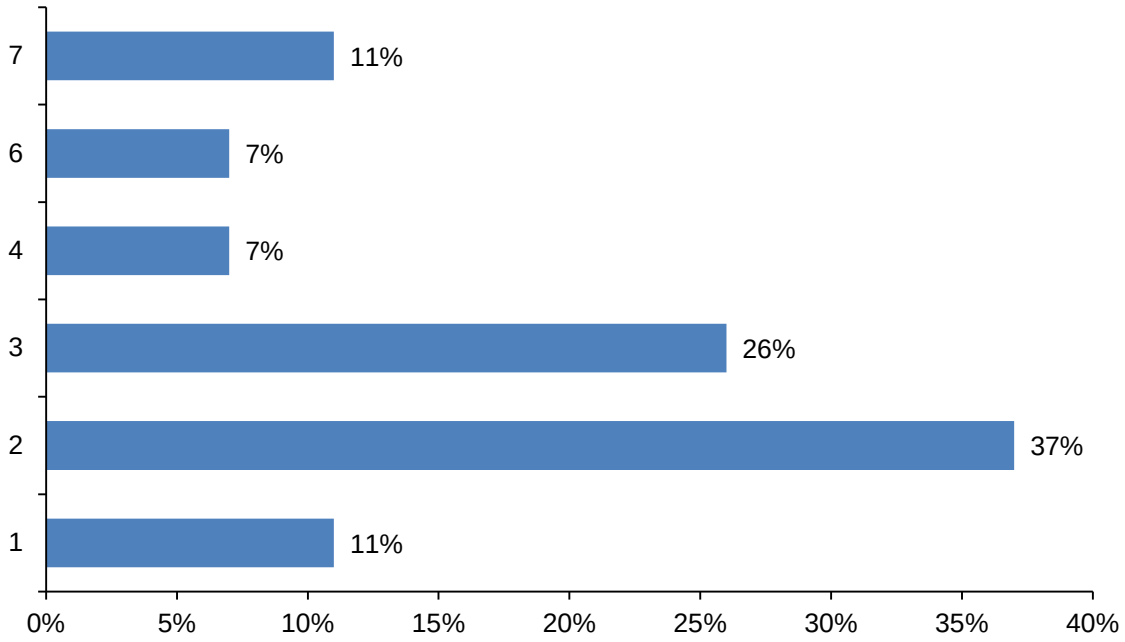
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=1), Sometimes True (n=3), Never True (n=23), Sample Size = 27

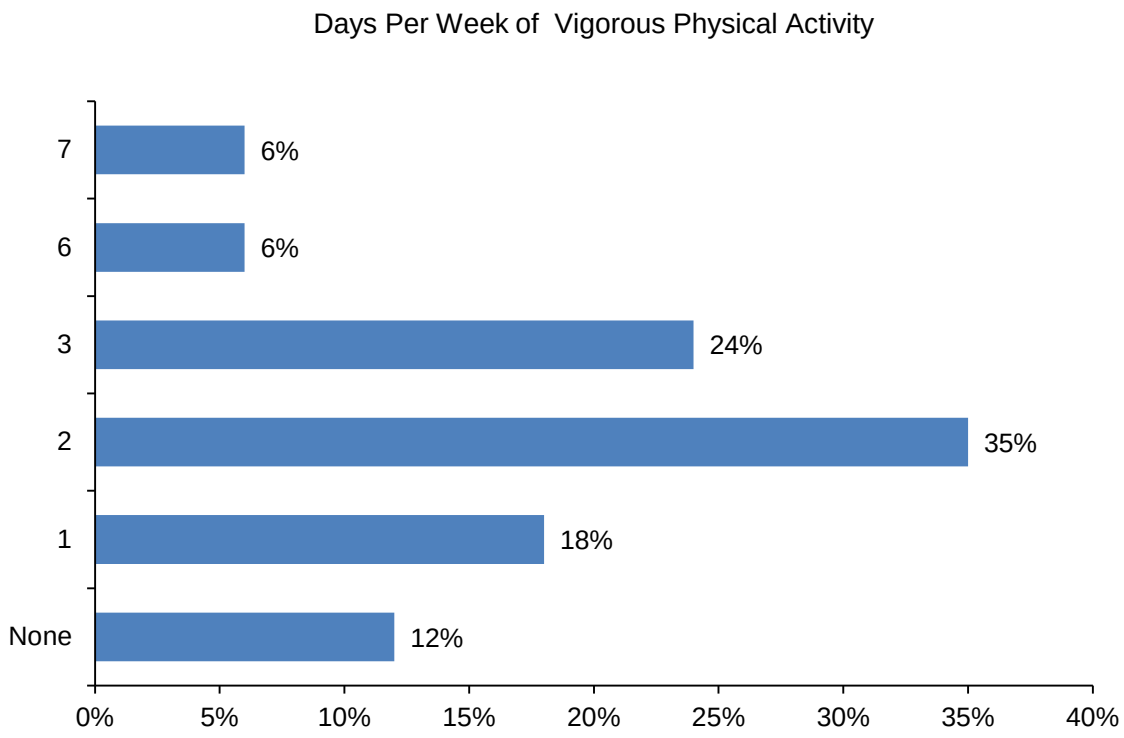
(Community = Deuel)

Days Per Week of Moderate Physical Activity



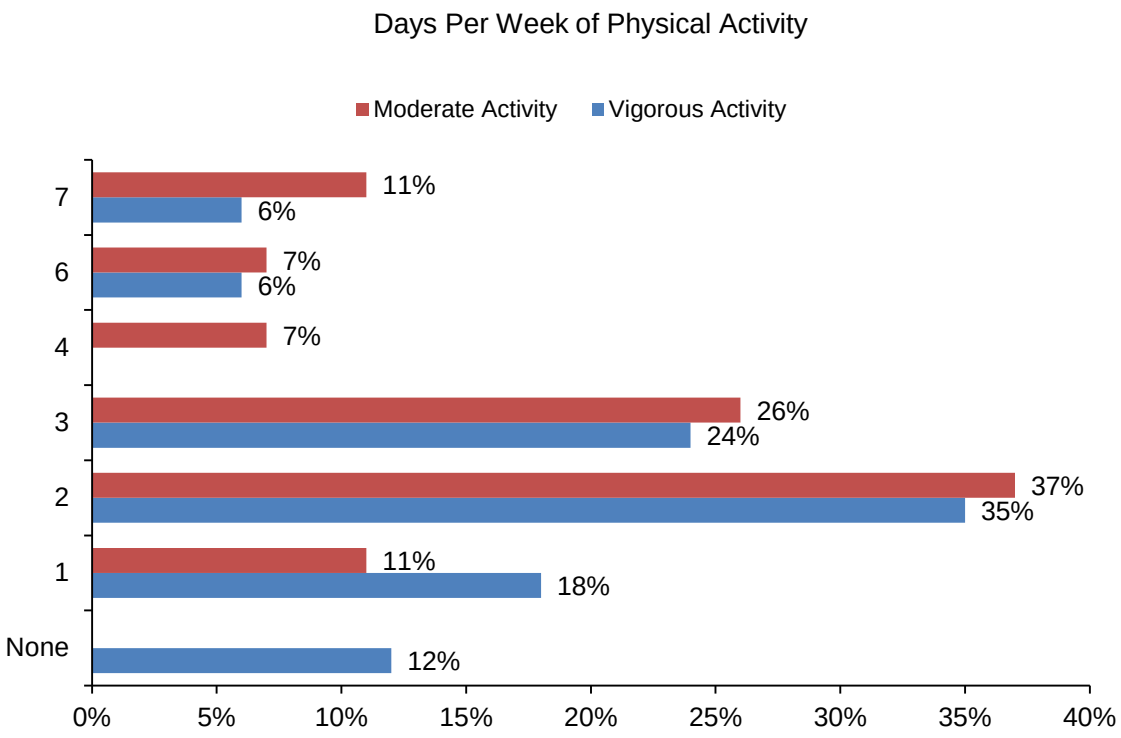
Base: 1 (n=3), 2 (n=10), 3 (n=7), 4 (n=2), 6 (n=2), 7 (n=3), Sample Size = 27

(Community = Deuel)



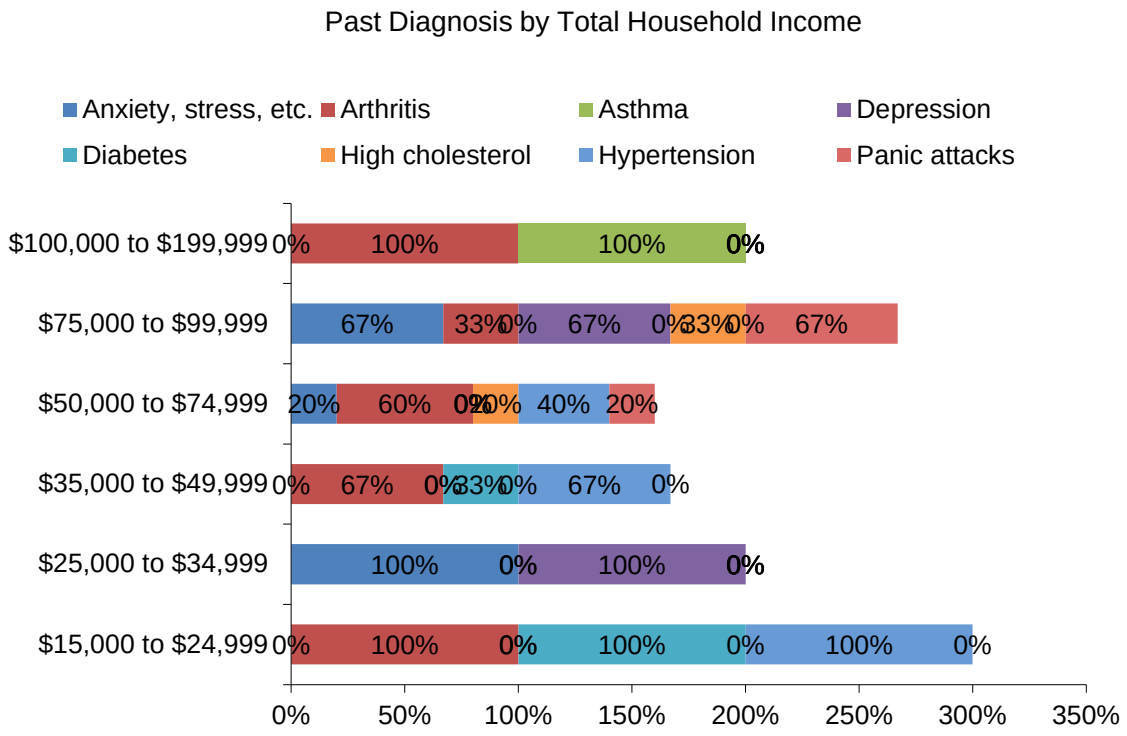
Base: None (n=2), 1 (n=3), 2 (n=6), 3 (n=4), 6 (n=1), 7 (n=1), Sample Size = 17

(Community = Deuel)



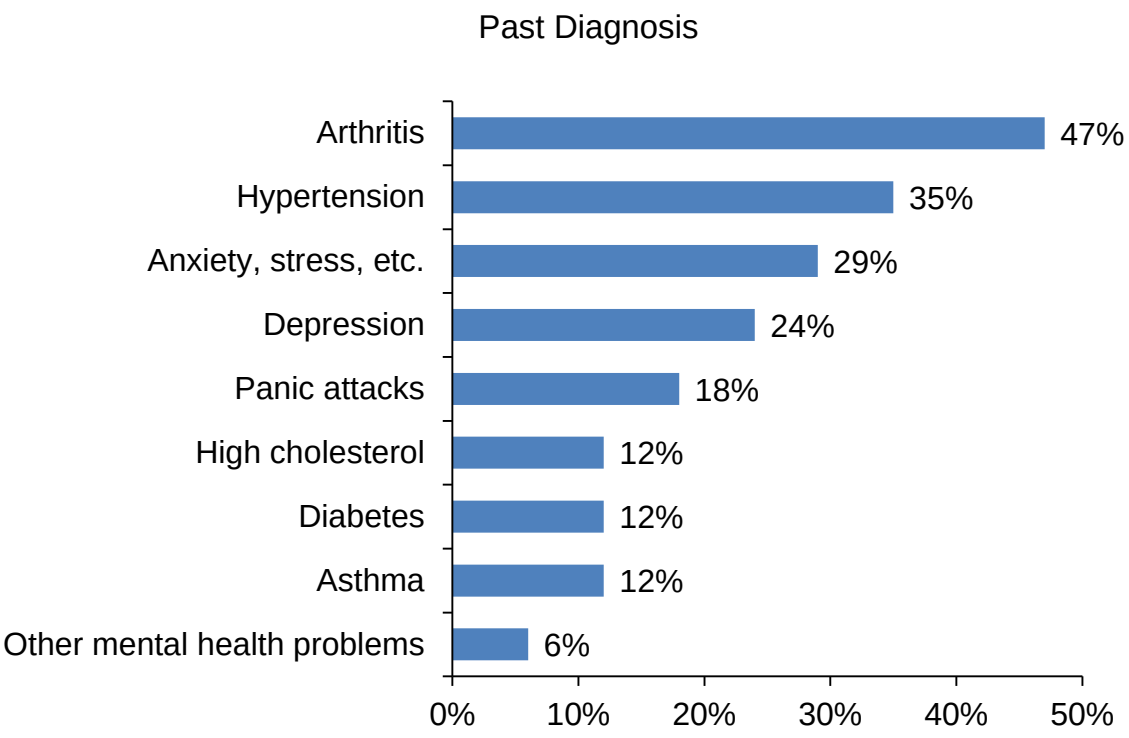
Sample Size = Variable

(Community = Deuel)

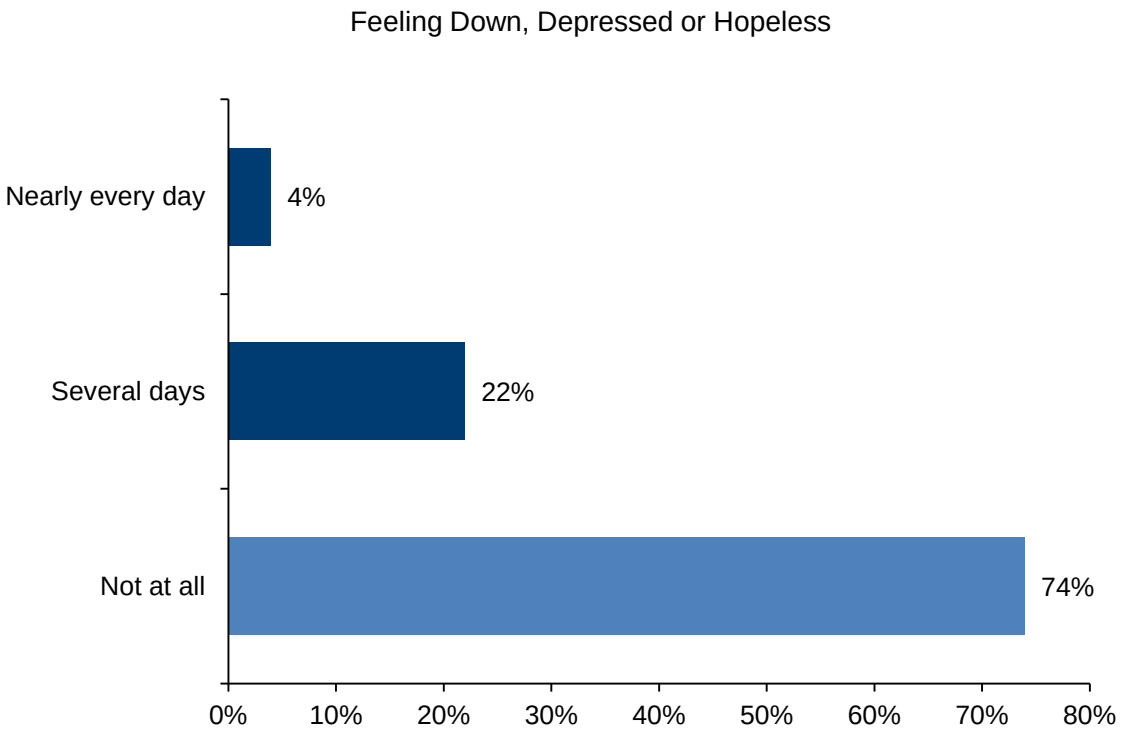


Base: $15,000 to $24,999 (n=1), $25,000 to $34,999 (n=1), $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=5), $75,000 to $99,999 (n=3), $100,000 to $199,999 (n=1), Sample Size = 14

(Community = Deuel)

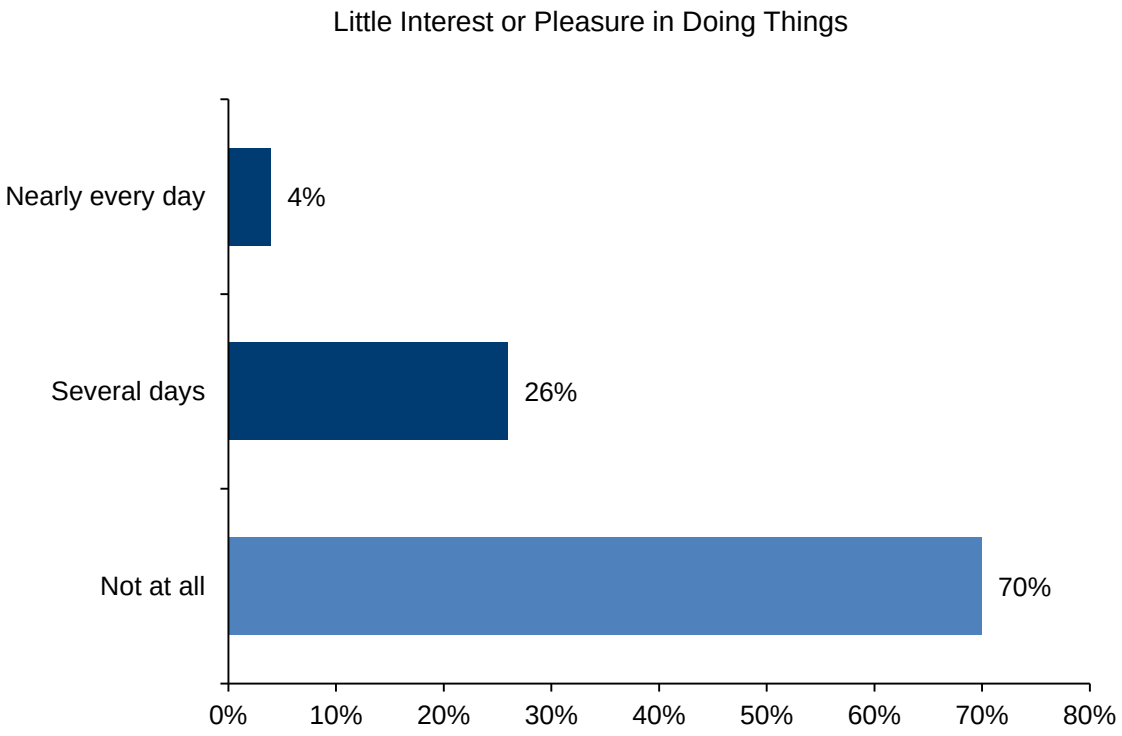


Base: Anxiety, stress, etc. (n=5), Arthritis (n=8), Asthma (n=2), Depression (n=4), Diabetes (n=2), High cholesterol (n=2), Hypertension (n=6), Other mental health problems (n=1), Panic attacks (n=3), Sample Size = 17
(Community = Deuel)



Base: Not at all (n=20), Several days (n=6), Nearly every day (n=1), Sample Size = 27

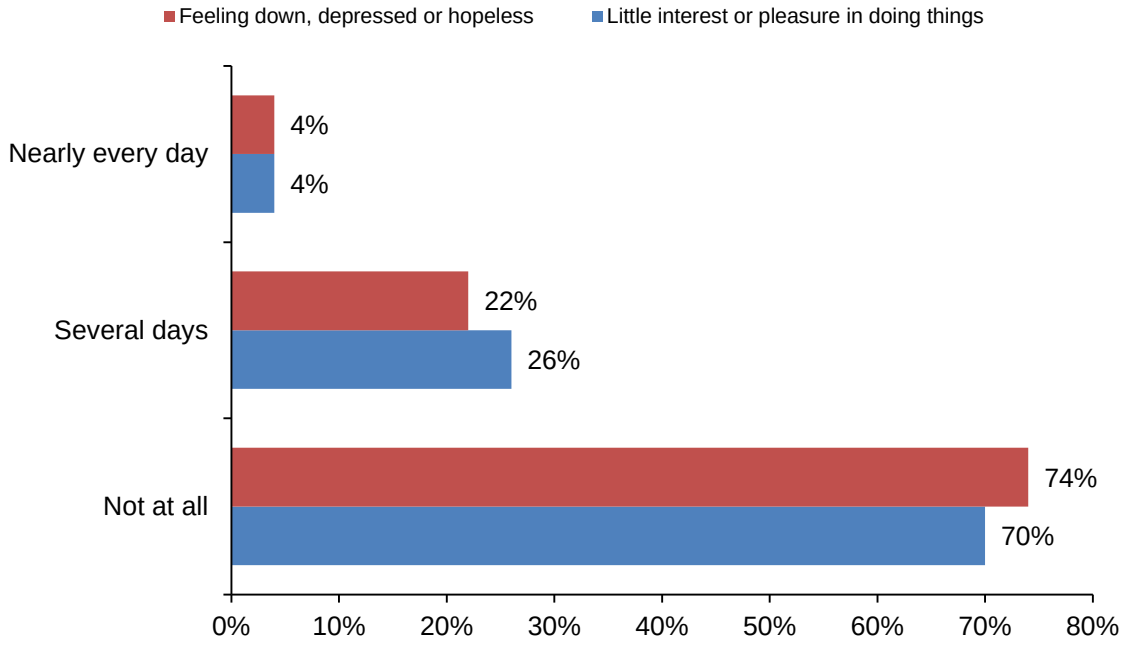
(Community = Deuel)



Base: Not at all (n=19), Several days (n=7), Nearly every day (n=1), Sample Size = 27

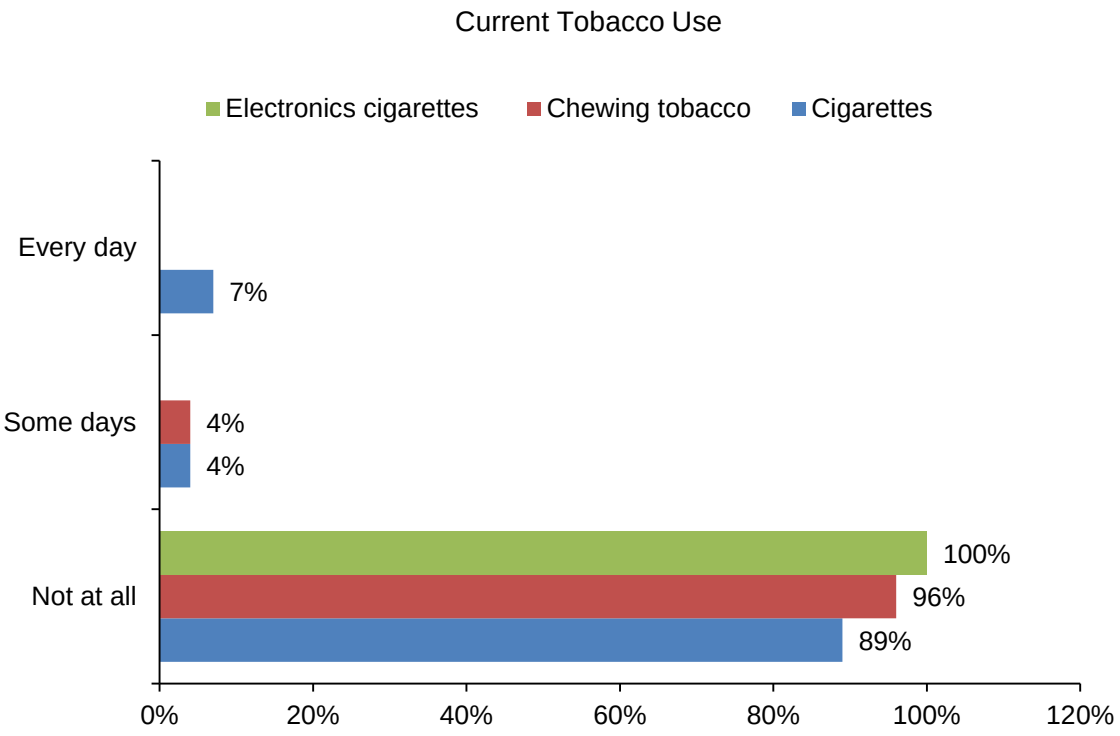
(Community = Deuel)

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



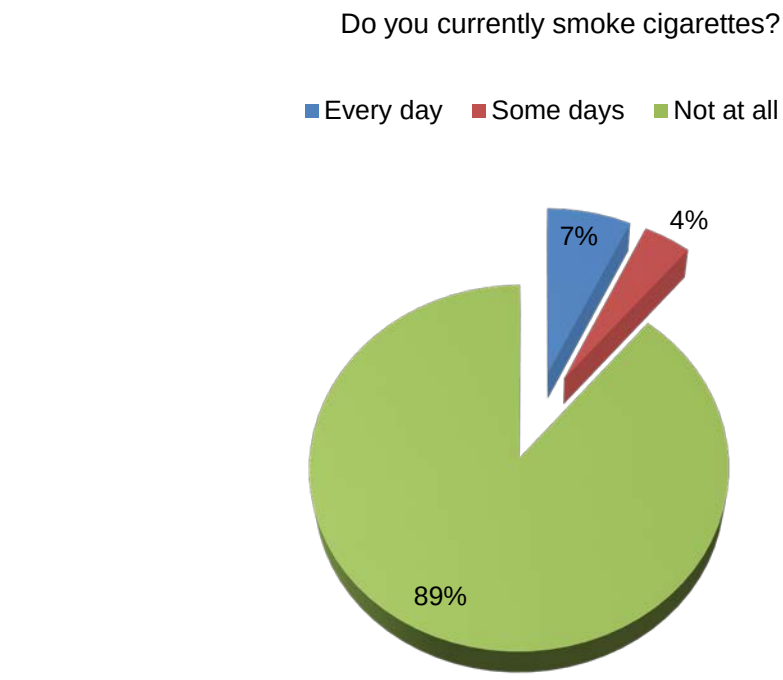
Sample Size = 27

(Community = Deuel)



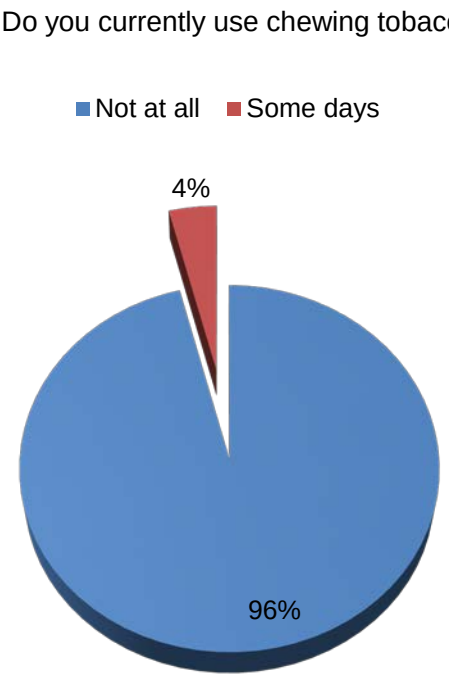
Sample Size = 27

(Community = Deuel)



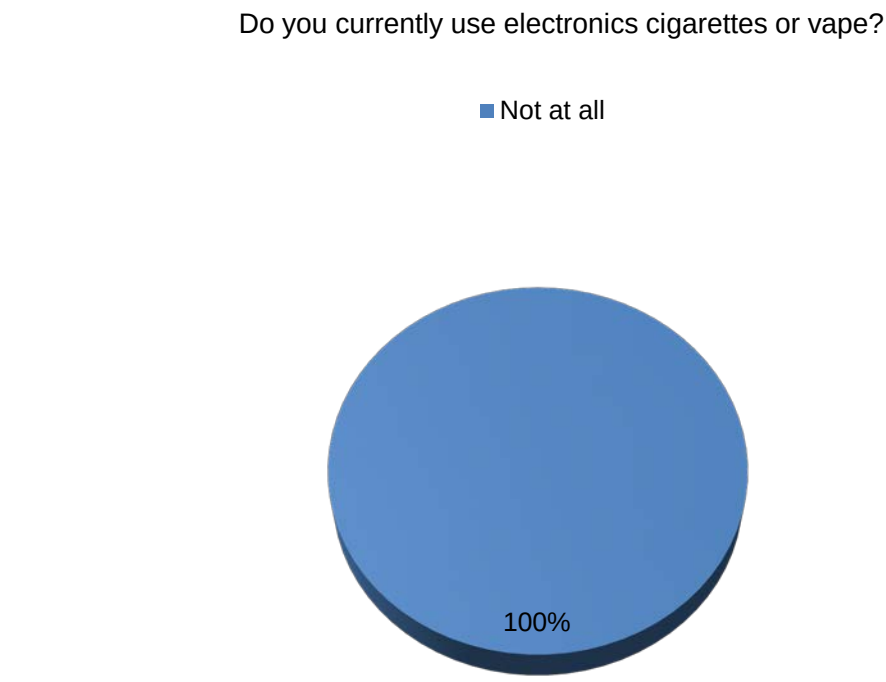
Base: Not at all (n=24), Some days (n=1), Every day (n=2), Sample Size = 27

(Community = Deuel)



Base: Not at all (n=26), Some days (n=1), Sample Size = 27

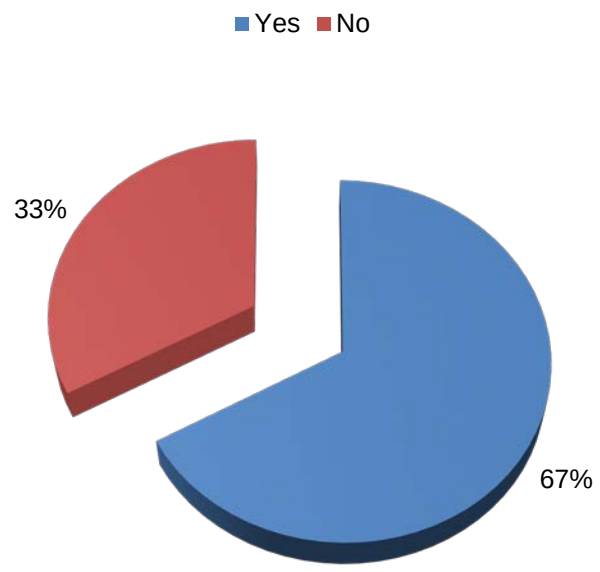
(Community = Deuel)



Base: Not at all (n=27), Sample Size = 27

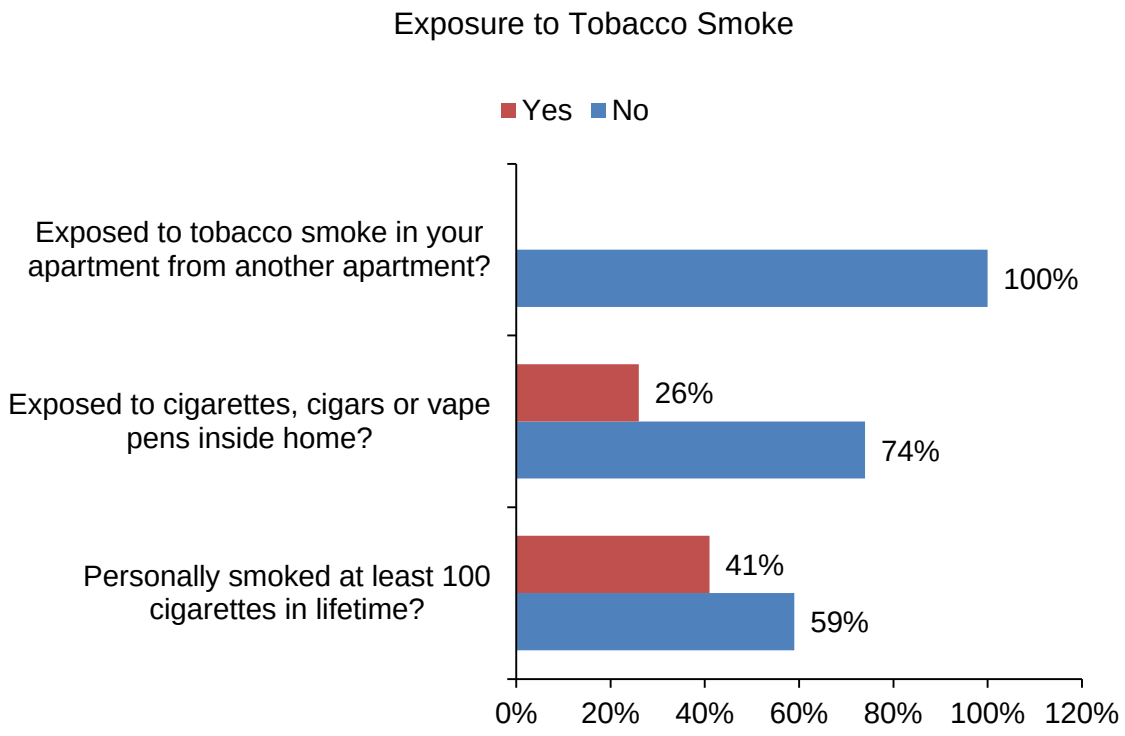
(Community = Deuel)

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=2), No (n=1), Sample Size = 3

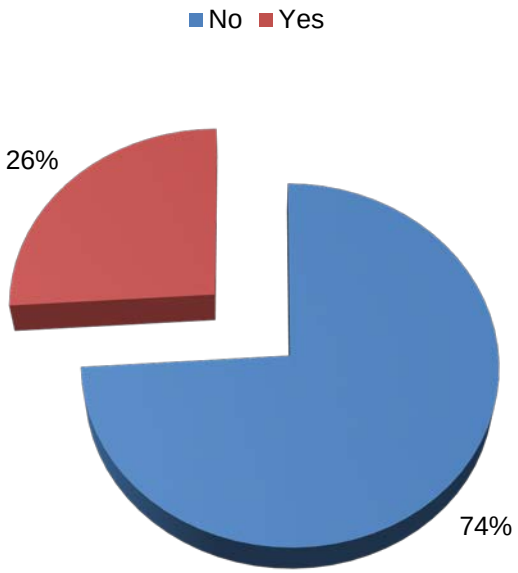
(Community = Deuel)



Base: Personally smoked at least 100 cigarettes in lifetime? (n=27), Exposed to cigarettes, cigars or vape pens inside home? (n=27), Exposed to tobacco smoke in your apartment from another apartment? (n=27), Sample Size = 27

(Community = Deuel)

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



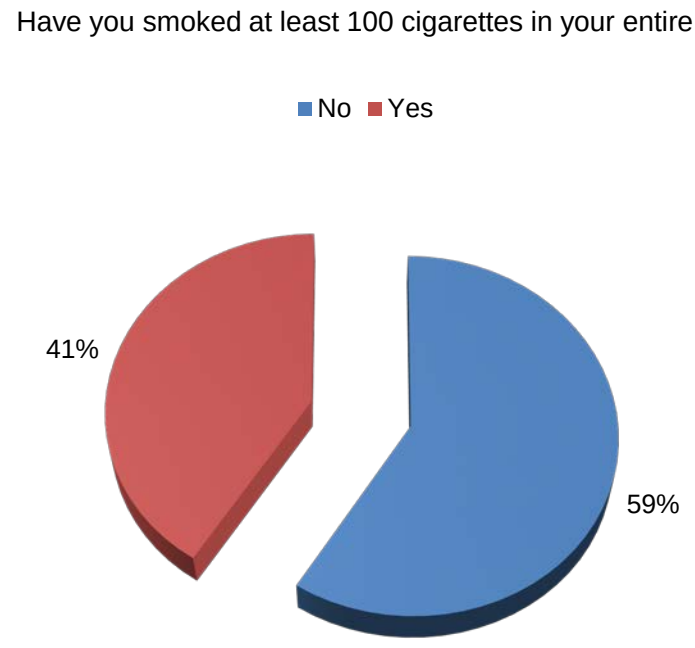
Base: Yes (n=7), No (n=20), Sample Size = 27

(Community = Deuel)

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

Base: No (n=27), Sample Size = 27

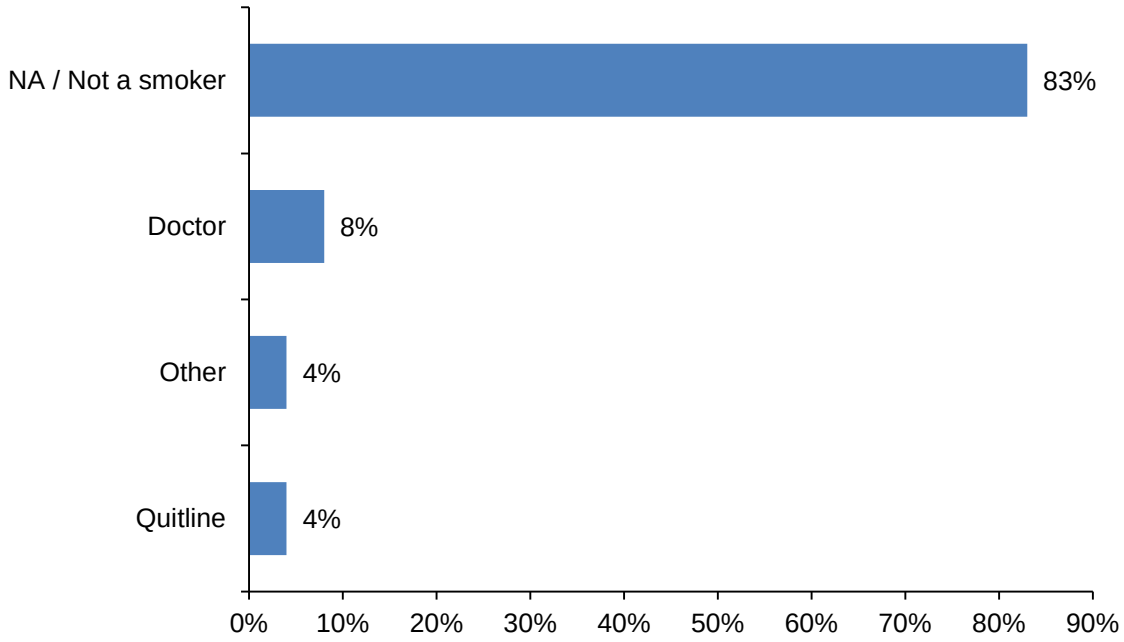
(Community = Deuel)



Base: Yes (n=11), No (n=16), Sample Size = 27

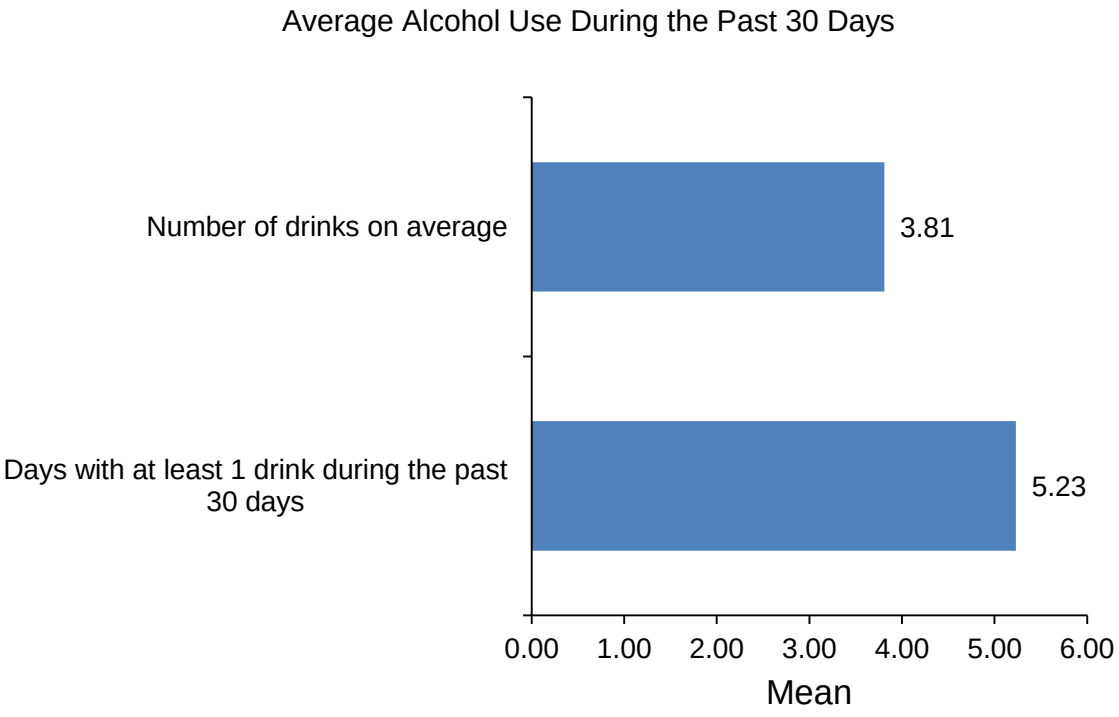
(Community = Deuel)

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



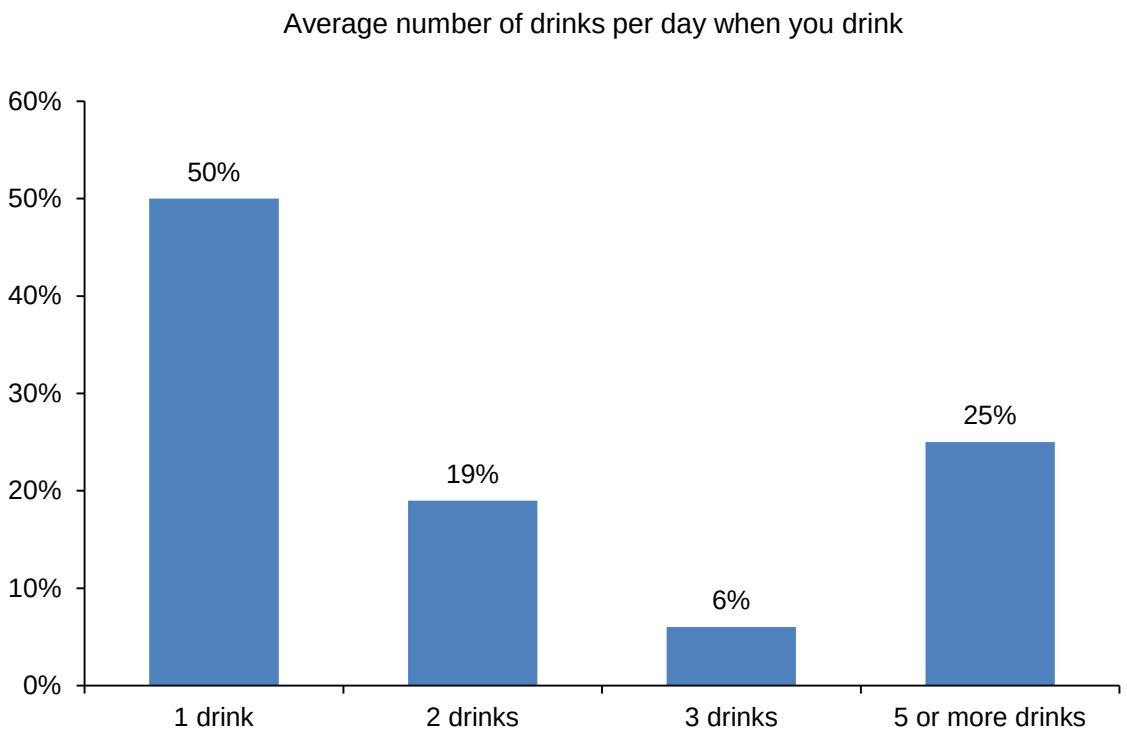
Base: NA / Not a smoker (n=20), Quitline (n=1), Doctor (n=2), Other (n=1), Sample Size = 24

(Community = Deuel)



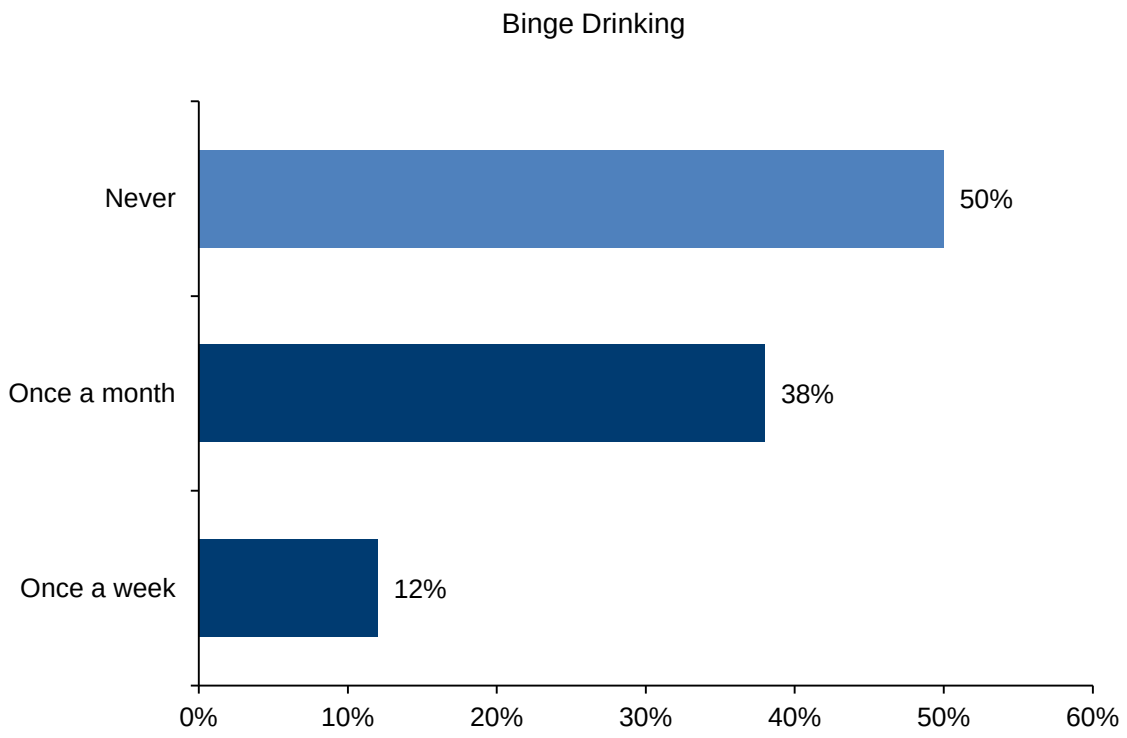
Base: Days with at least 1 drink during the past 30 days (n=22), Number of drinks on average (n=16), Sample Size = Variable

(Community = Deuel)



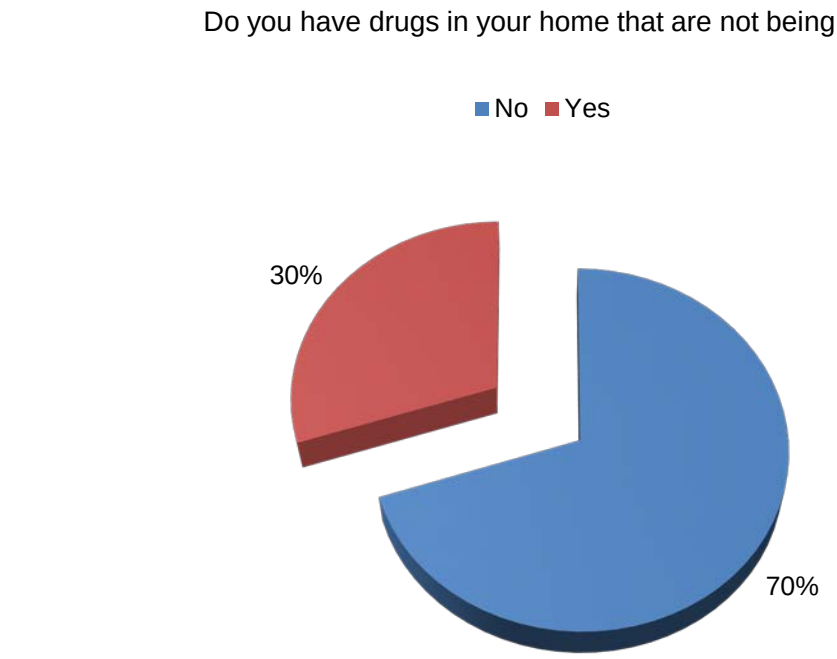
Base: 1 drink (n=8), 2 drinks (n=3), 3 drinks (n=1), 5 or more drinks (n=4), Sample Size = 16

(Community = Deuel)



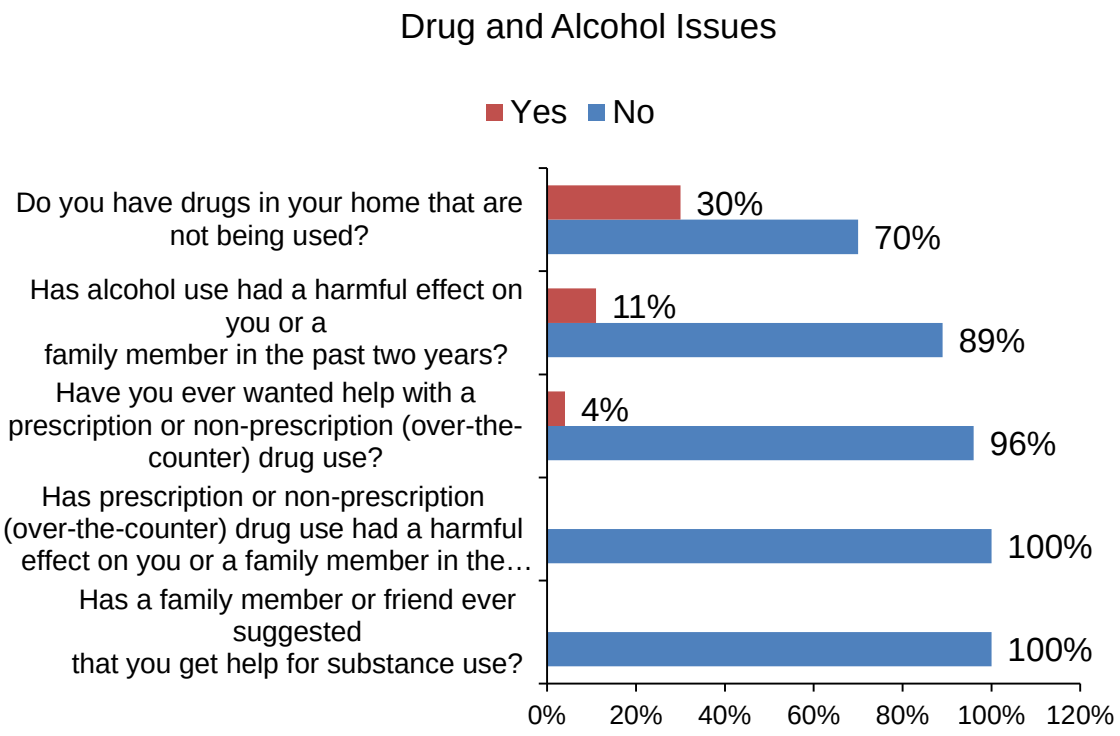
Base: Once a week (n=2), Once a month (n=6), Never (n=8), Sample Size = 16

(Community = Deuel)



Base: Yes (n=8), No (n=19), Sample Size = 27

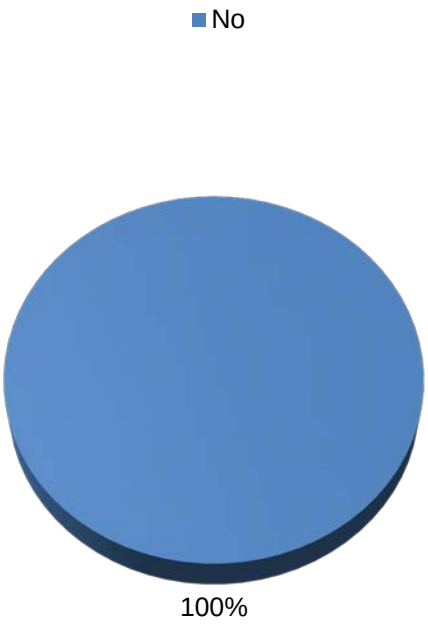
(Community = Deuel)



Sample Size = 27

(Community = Deuel)

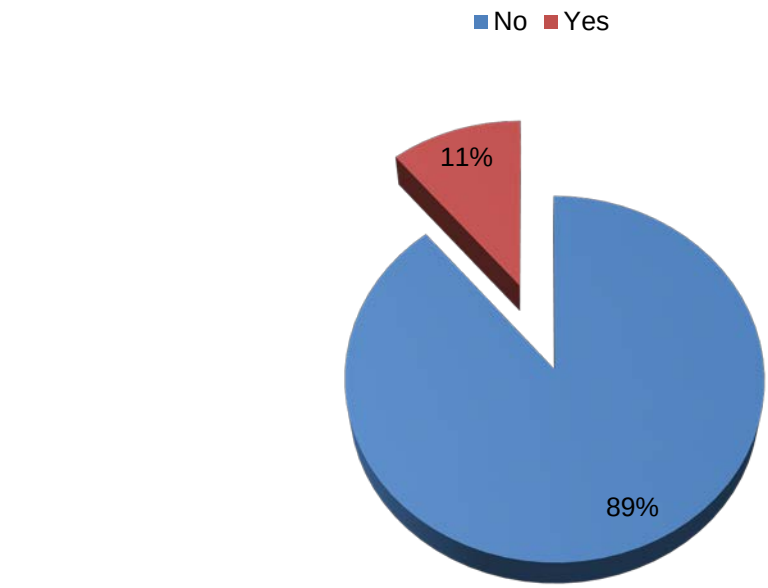
Has a family member or friend ever suggested that you get help for substance use?



Base: No (n=27), Sample Size = 27

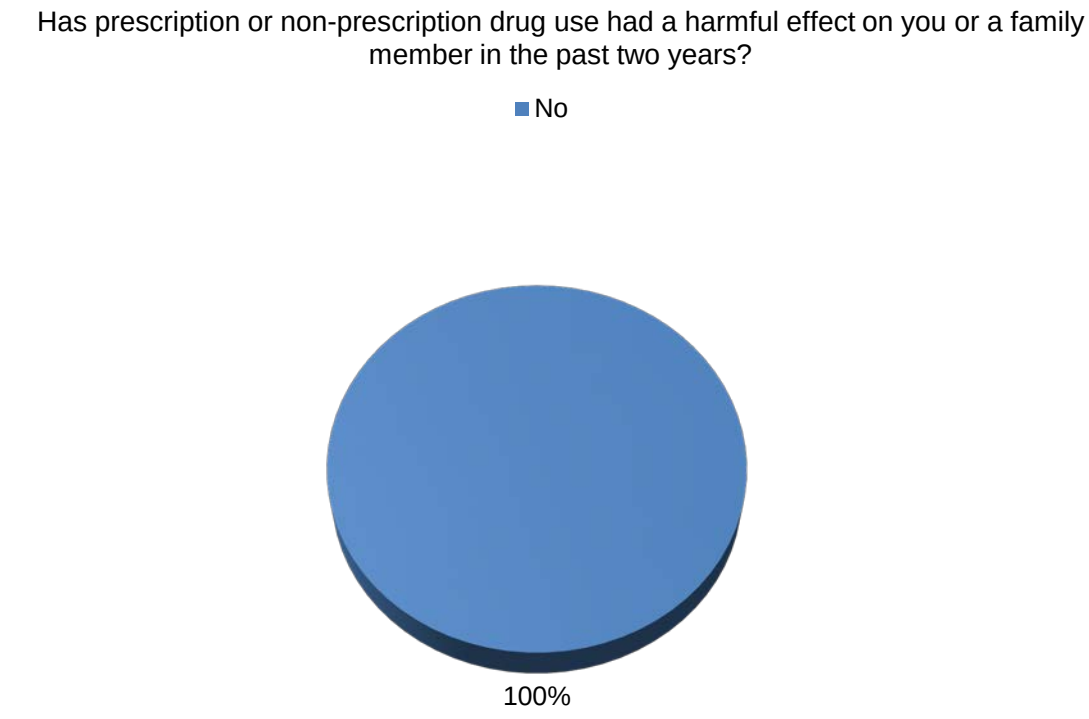
(Community = Deuel)

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



Base: Yes (n=3), No (n=24), Sample Size = 27

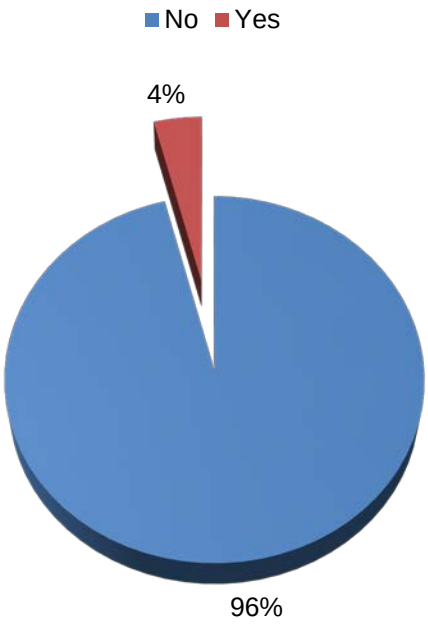
(Community = Deuel)



Base: No (n=27), Sample Size = 27

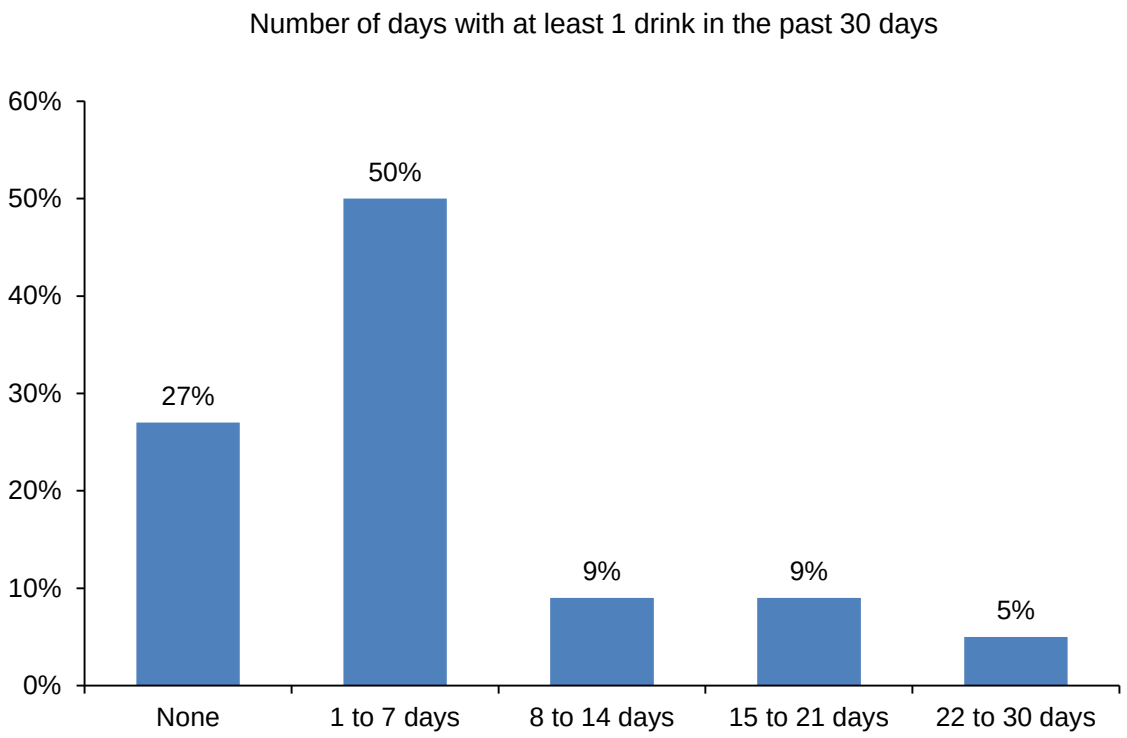
(Community = Deuel)

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



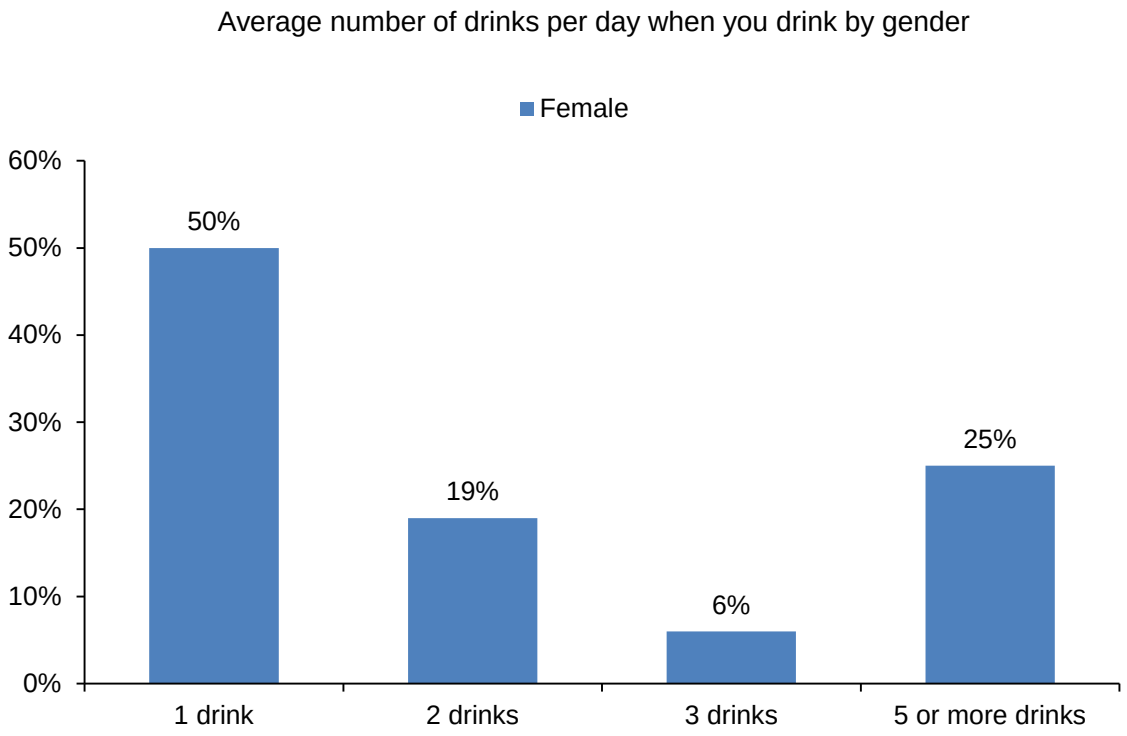
Base: Yes (n=1), No (n=26), Sample Size = 27

(Community = Deuel)



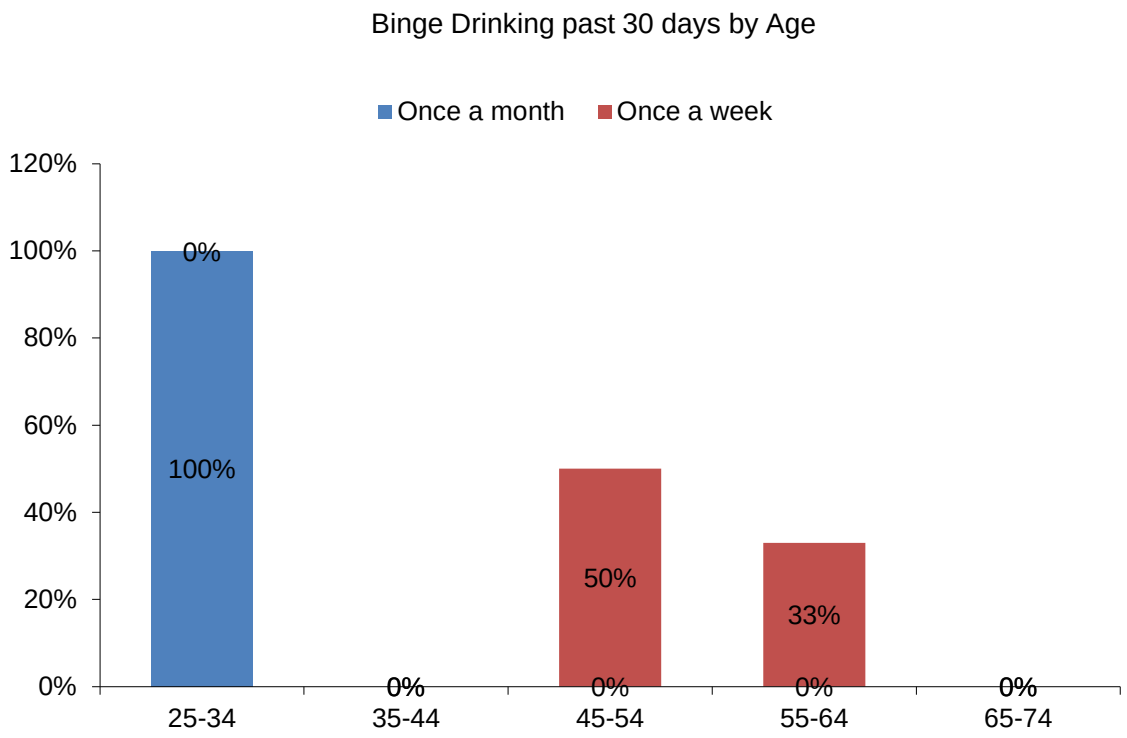
Base: None (n=6), 1 to 7 days (n=11), 8 to 14 days (n=2), 15 to 21 days (n=2), 22 to 30 days (n=1), Sample Size = 22

(Community = Deuel)



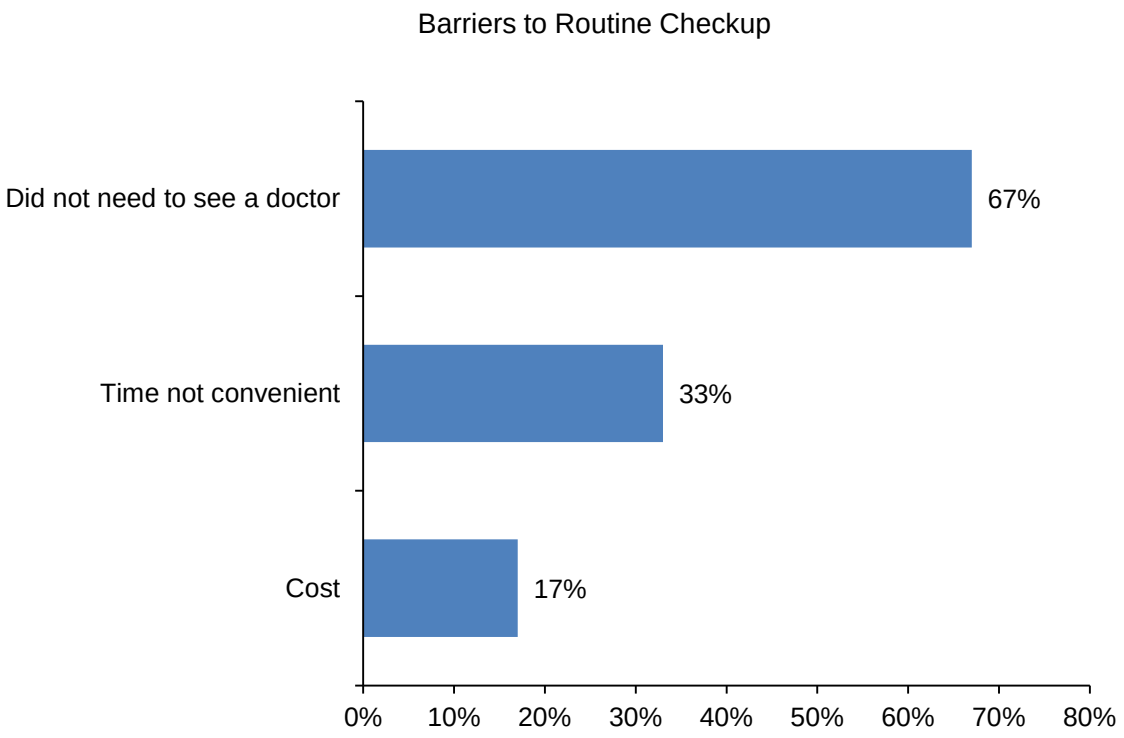
Base: 1 drink (n=8), 2 drinks (n=3), 3 drinks (n=1), 5 or more drinks (n=4), Sample Size = 16

(Community = Deuel)



Base: 25-34 (n=6), 35-44 (n=3), 45-54 (n=2), 55-64 (n=3), 65-74 (n=2), Sample Size = 16

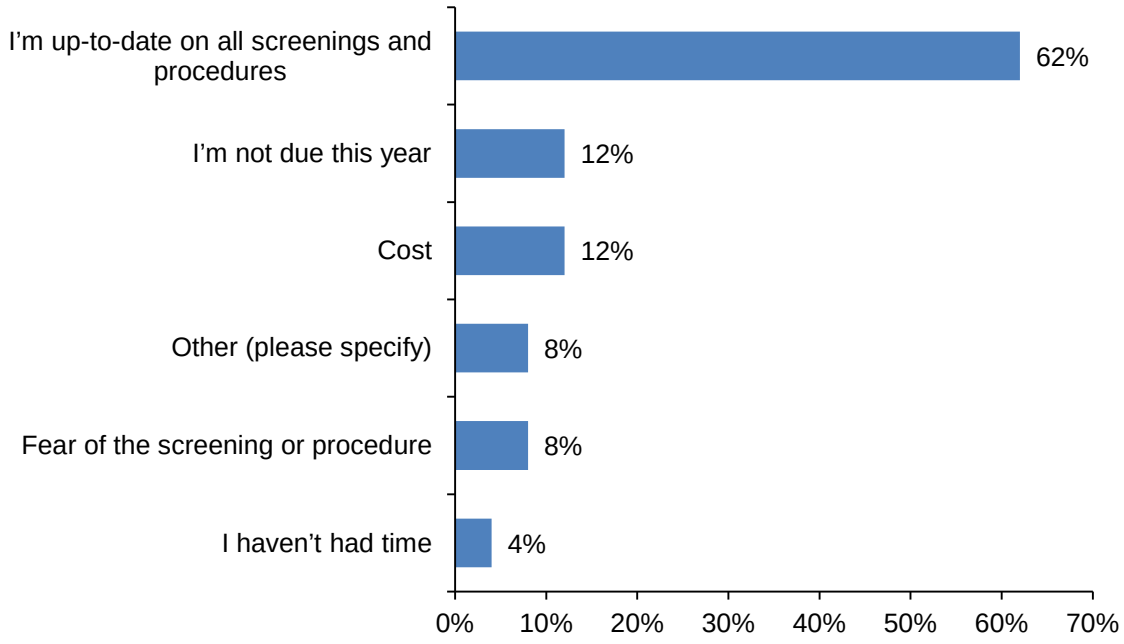
(Community = Deuel)



Base: Cost (n=1), Time not convenient (n=2), Did not need to see a doctor (n=4), Sample Size = 6

(Community = Deuel)

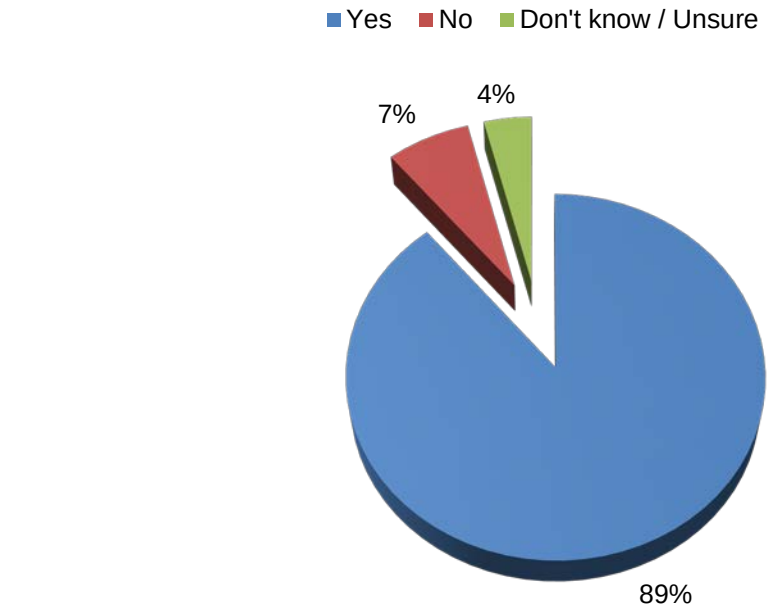
Barriers for Preventive Procedures



Base: I'm up-to-date on all screenings and procedures (n=15), Cost (n=3), Fear of the screening or procedure (n=2), I'm not due this year (n=3), I haven't had time (n=1), Other (please specify) (n=2), Sample Size = 24

(Community = Deuel)

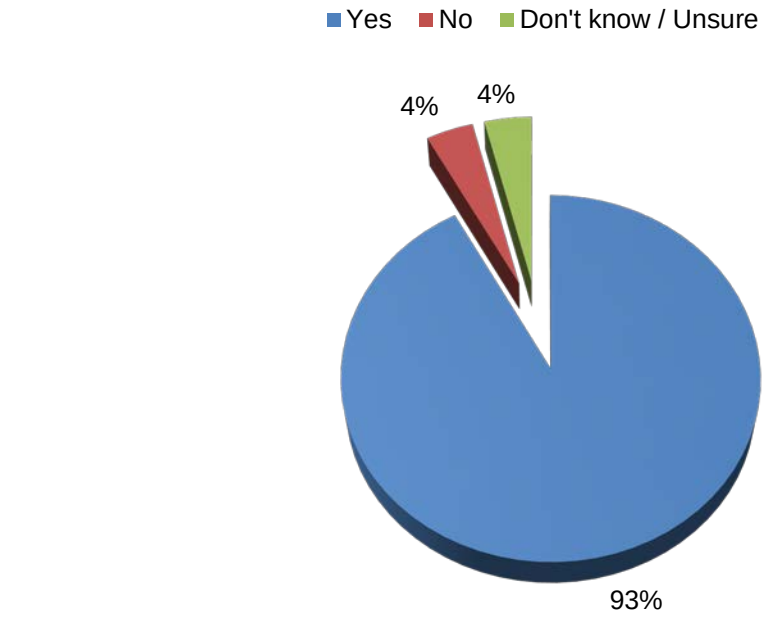
Has your medical provider allowed you to make a choice about having screenings or preventive services?



Base: Yes (n=24), No (n=2), Don't know / Unsure (n=1), Sample Size = 27

(Community = Deuel)

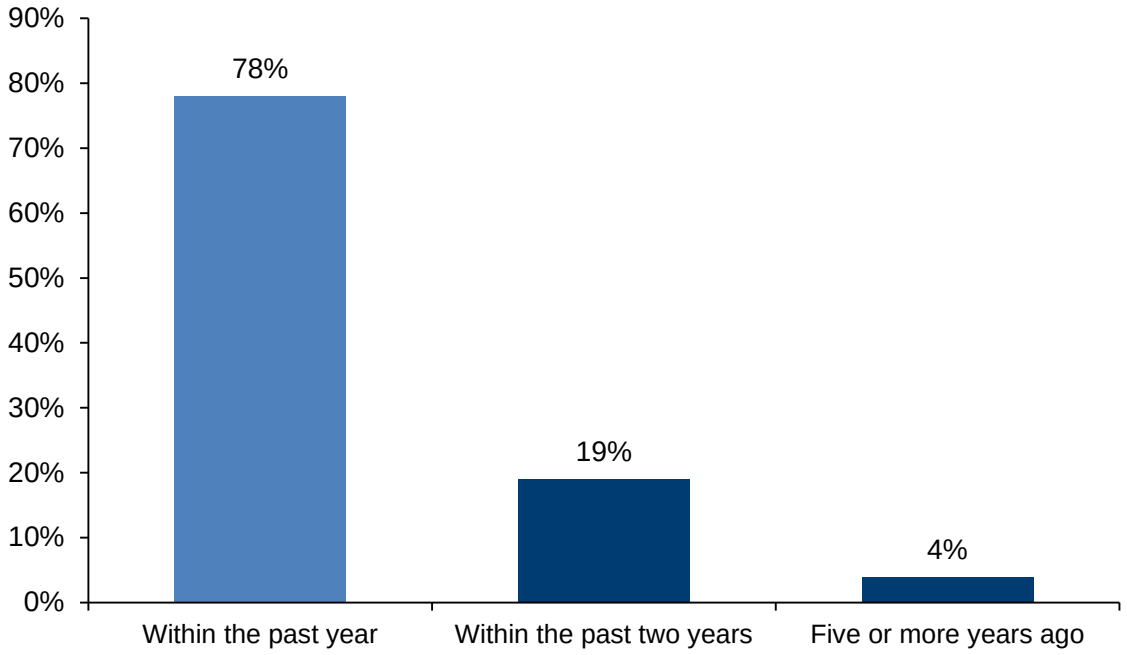
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=25), No (n=1), Don't know / Unsure (n=1), Sample Size = 27

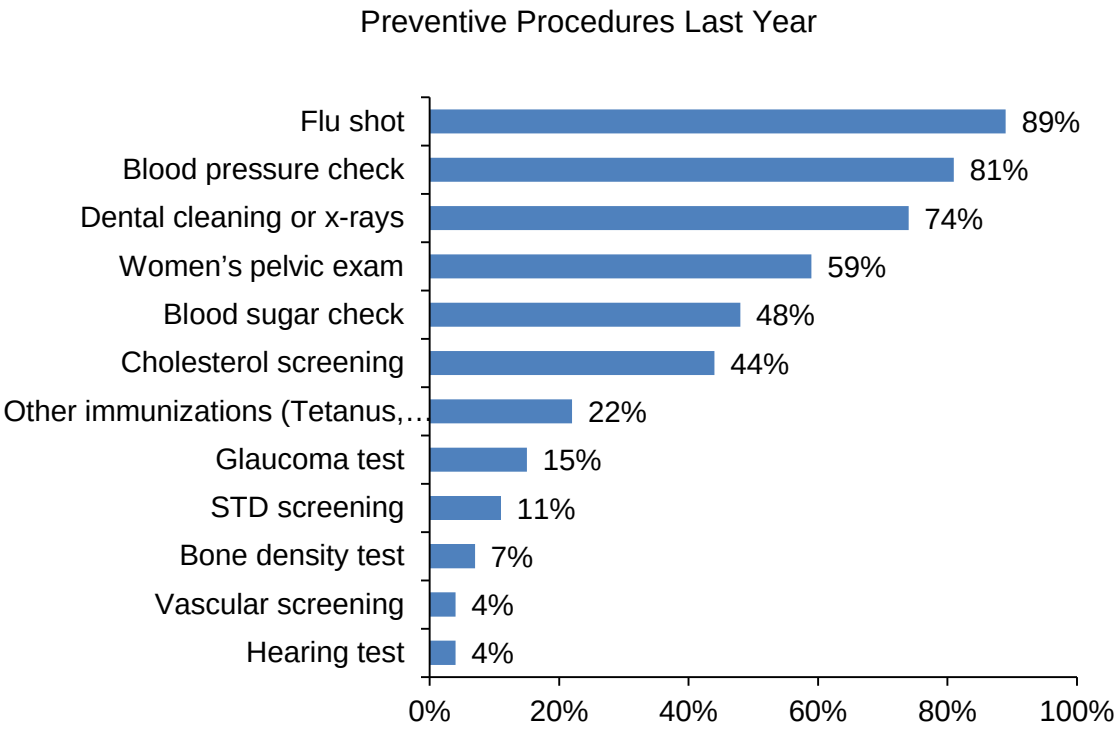
(Community = Deuel)

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

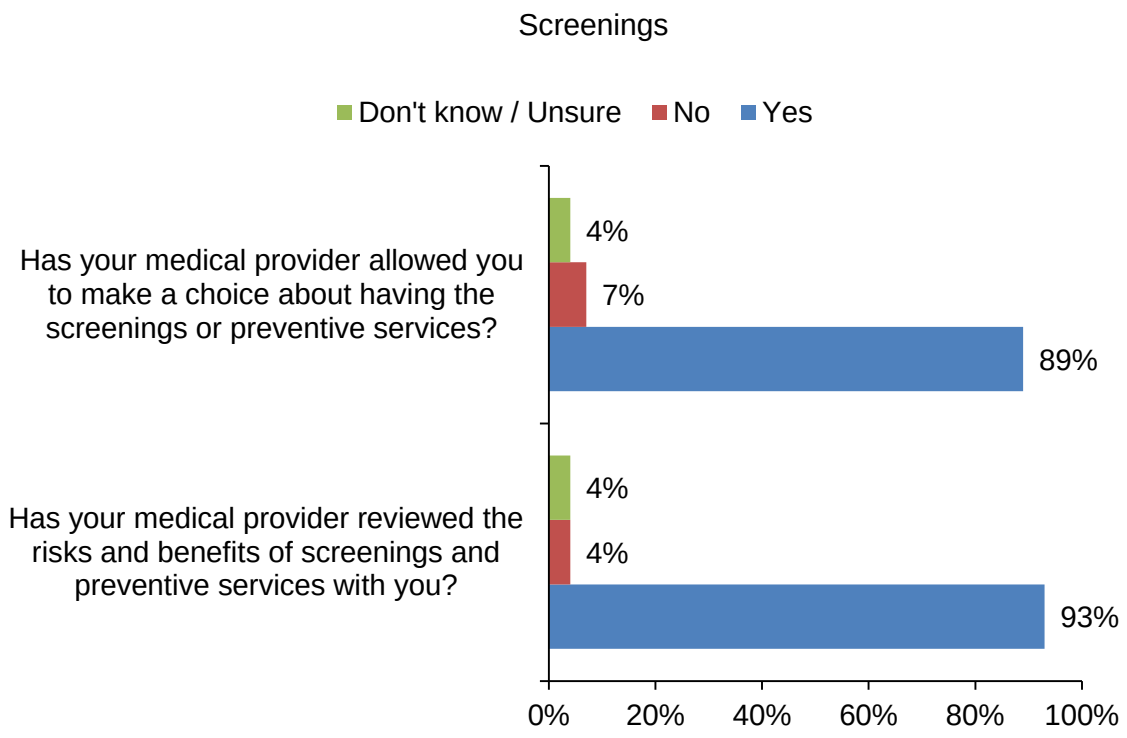


Base: Within the past year (n=21), Within the past two years (n=5), Five or more years ago (n=1), Sample Size = 27

(Community = Deuel)

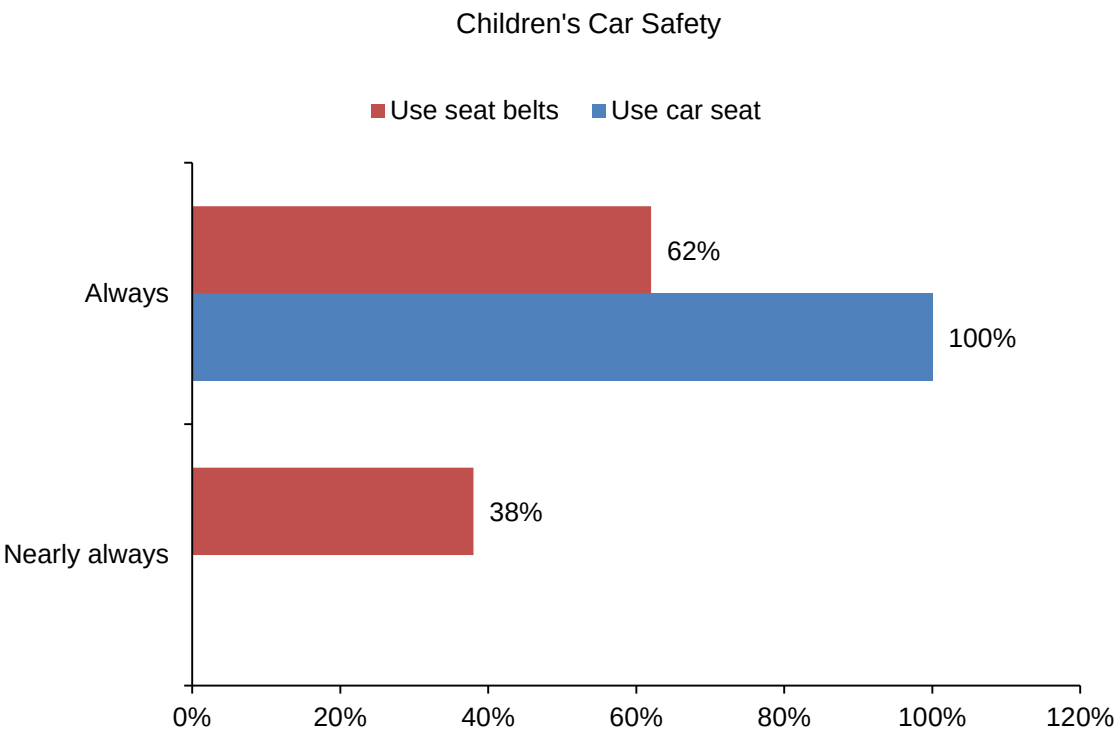


Base: Blood pressure check (n=22), Blood sugar check (n=13), Bone density test (n=2), Cholesterol screening (n=12), Dental cleaning or x-rays (n=20), Flu shot (n=24), Other immunizations (Tetanus, Hepatitis A or B) (n=6), Glaucoma test (n=4), Hearing test (n=1), Women's pelvic exam (n=16), STD screening (n=3), Vascular screening (n=1), Sample Size = 27
(Community = Deuel)



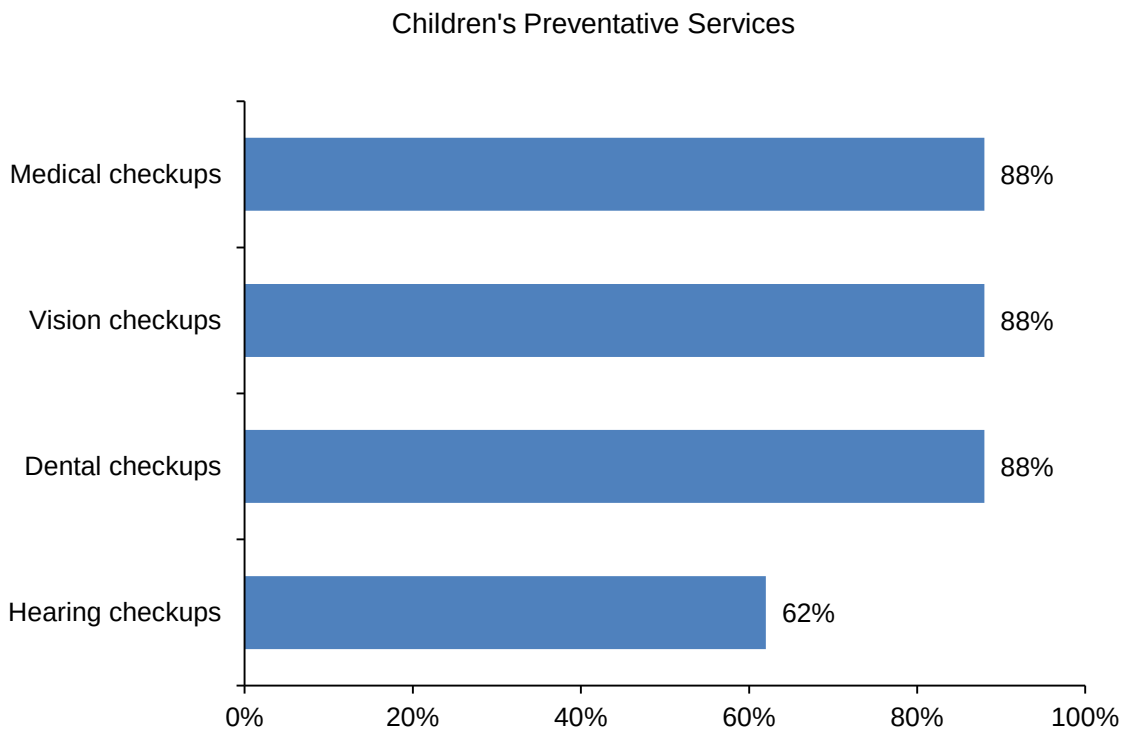
Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=27), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=27), Sample Size = 27

(Community = Deuel)



Sample Size = Variable

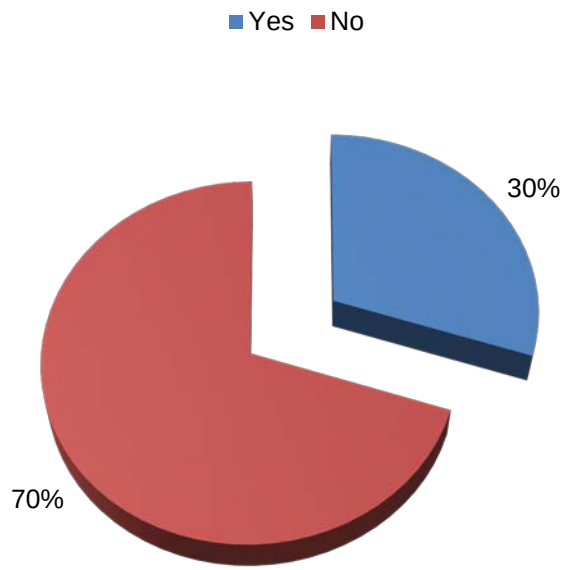
(Community = Deuel)



Base: Dental checkups (n=7), Vision checkups (n=7), Hearing checkups (n=5), Medical checkups (n=7), Sample Size = 8

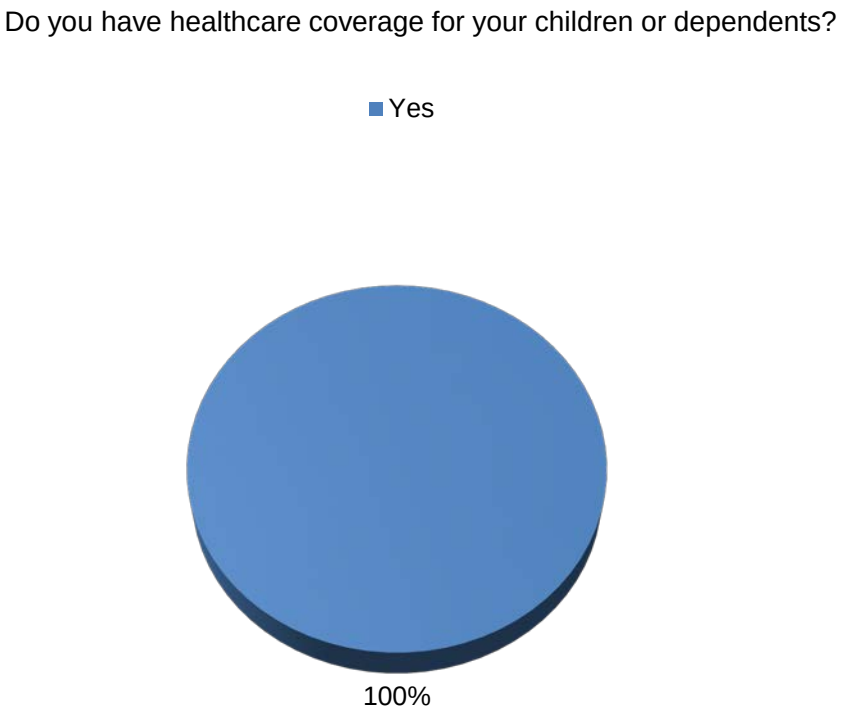
(Community = Deuel)

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



Base: Yes (n=8), No (n=19), Sample Size = 27

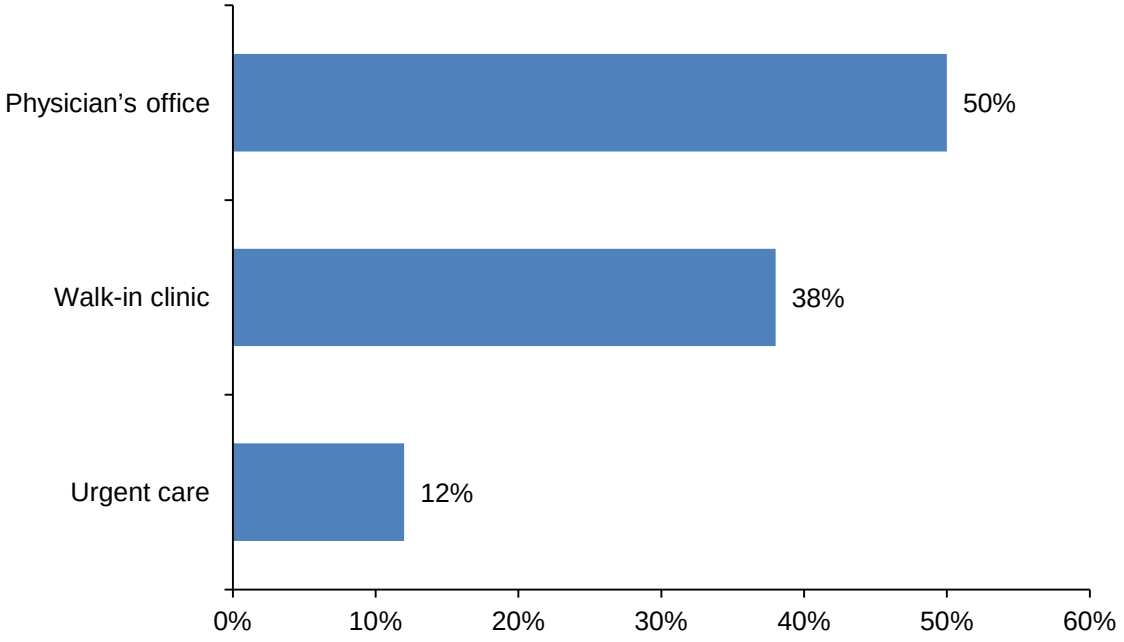
(Community = Deuel)



Base: Yes (n=8), Sample Size = 8

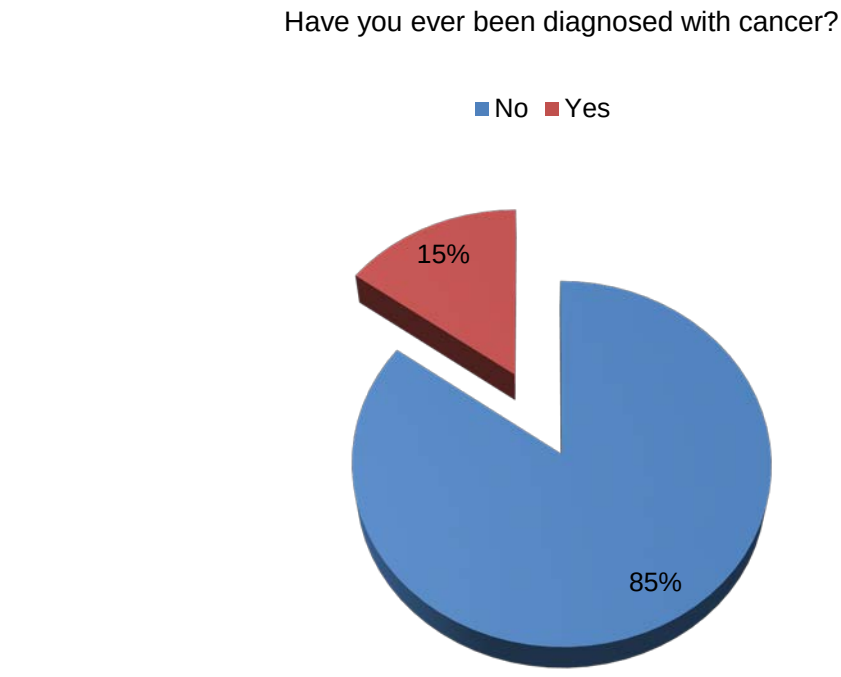
(Community = Deuel)

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



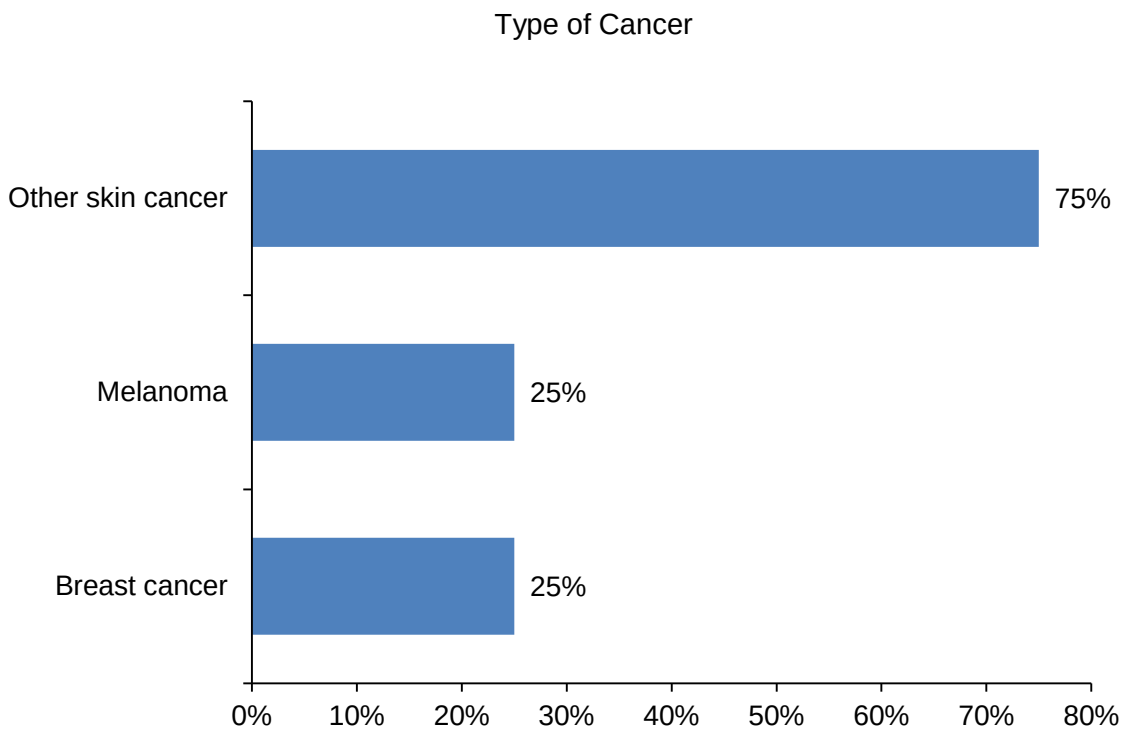
Base: Physician's office (n=4), Urgent care (n=1), Walk-in clinic (n=3), Sample Size = 8

(Community = Deuel)



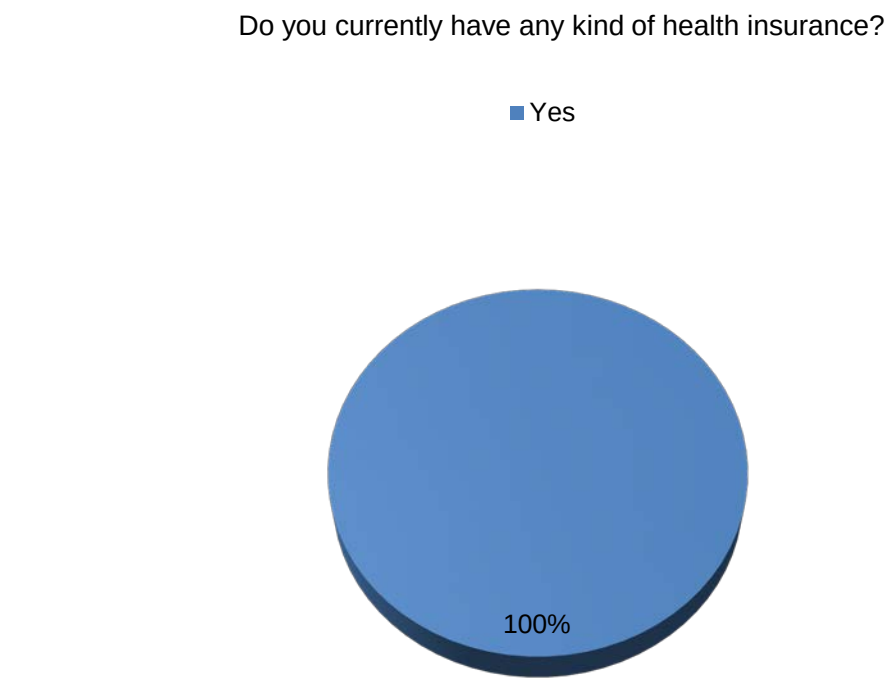
Base: Yes (n=4), No (n=23), Sample Size = 27

(Community = Deuel)



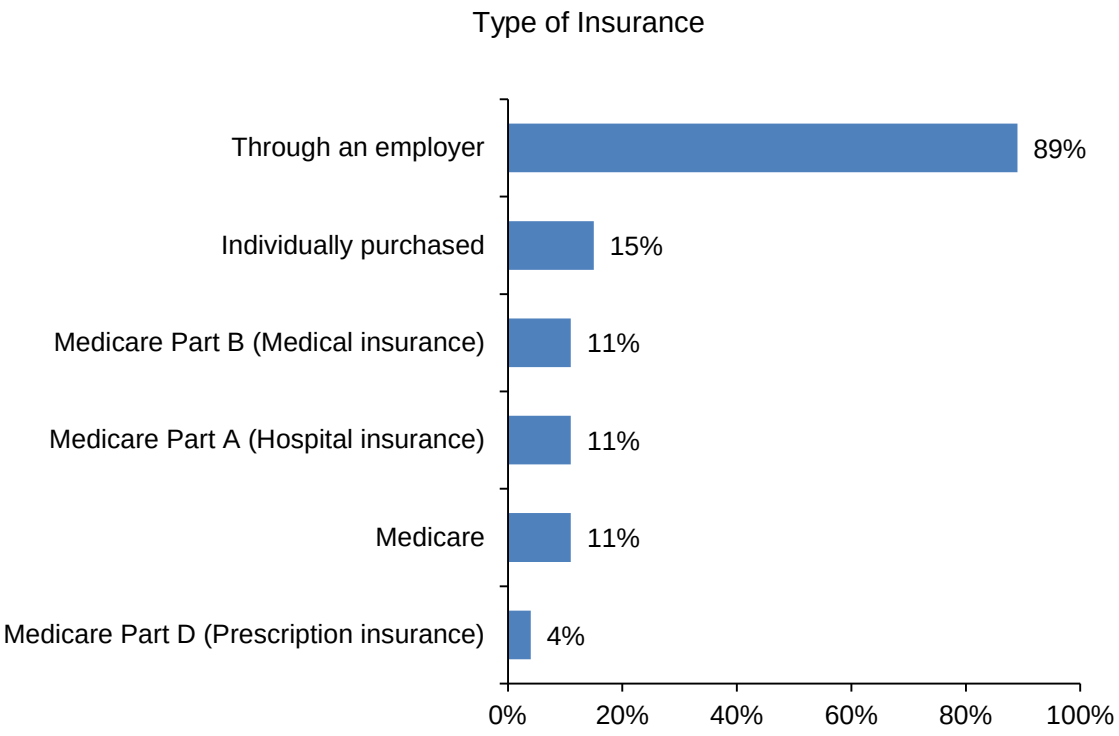
Base: Breast cancer (n=1), Melanoma (n=1), Other skin cancer (n=3), Sample Size = 4

(Community = Deuel)



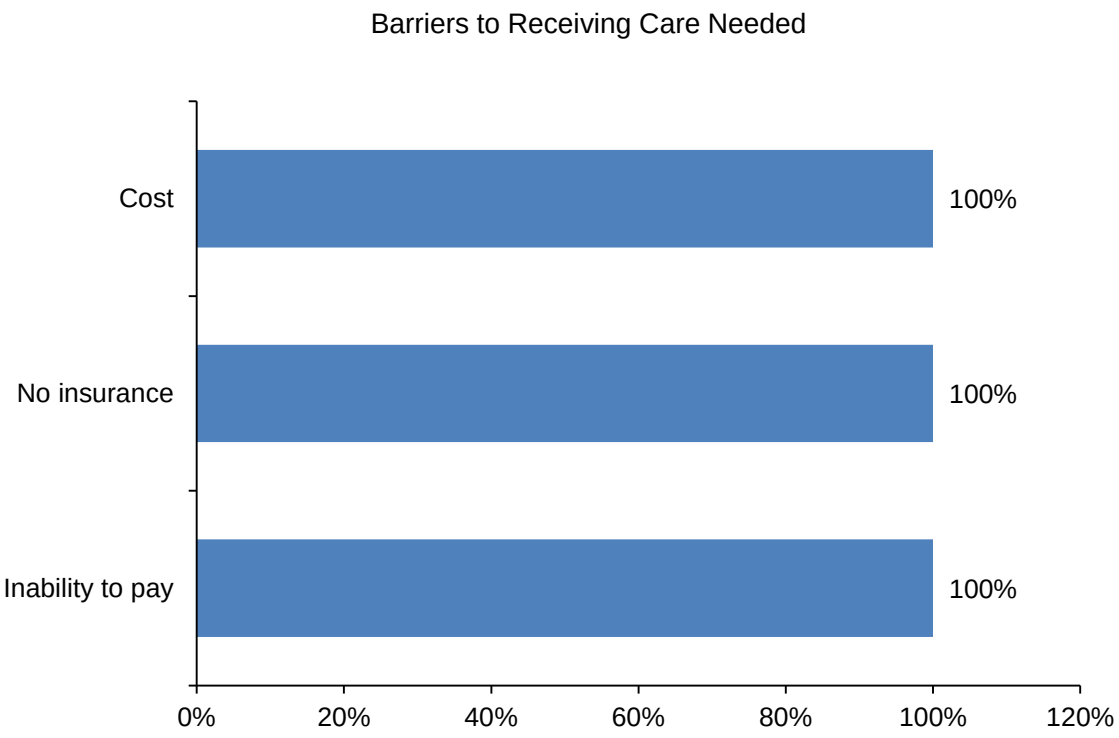
Base: Yes (n=27), Sample Size = 27

(Community = Deuel)



Base: Through an employer (n=24), Individually purchased (n=4), Medicare (n=3), Medicare Part A (Hospital insurance) (n=3), Medicare Part B (Medical insurance) (n=3), Medicare Part D (Prescription insurance) (n=1), Sample Size = 27

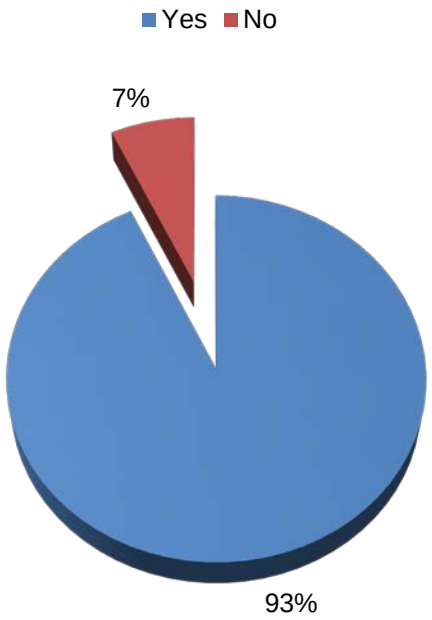
(Community = Deuel)



Base: Inability to pay (n=1), No insurance (n=1), Cost (n=1)

(Community = Deuel)

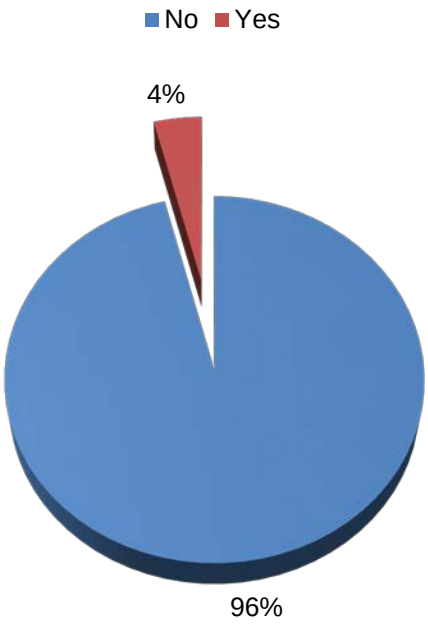
Do you have an established primary healthcare provider?



Base: Yes (n=25), No (n=2), Sample Size = 27

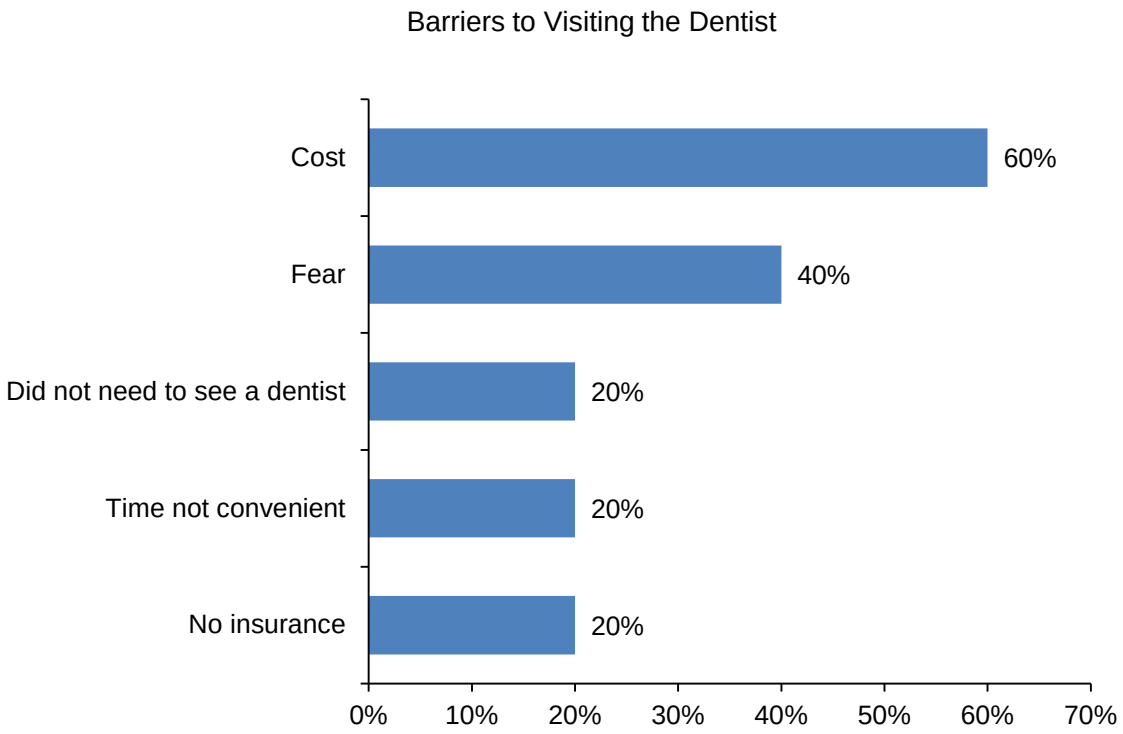
(Community = Deuel)

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=1), No (n=26), Sample Size = 27

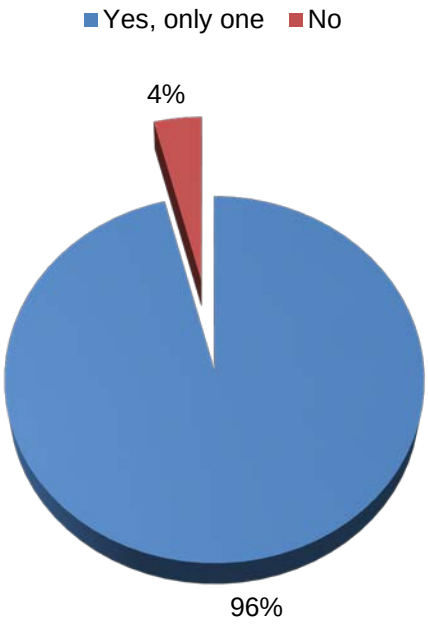
(Community = Deuel)



Base: No insurance (n=1), Cost (n=3), Fear (n=2), Time not convenient (n=1), Did not need to see a dentist (n=1), Sample Size = 5

(Community = Deuel)

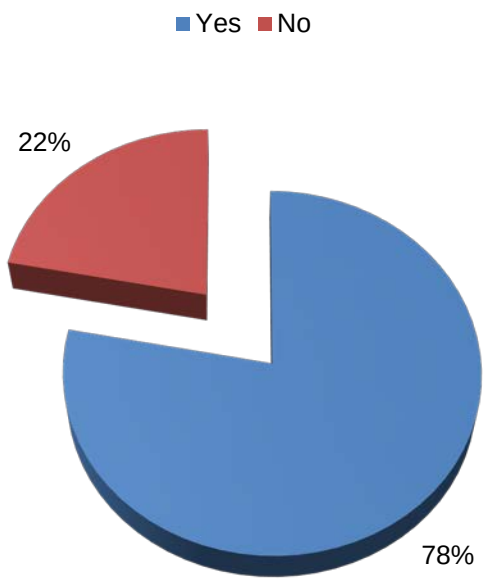
Do you have a dentist that you see for routine care?



Base: Yes, only one (n=26), No (n=1), Sample Size = 27

(Community = Deuel)

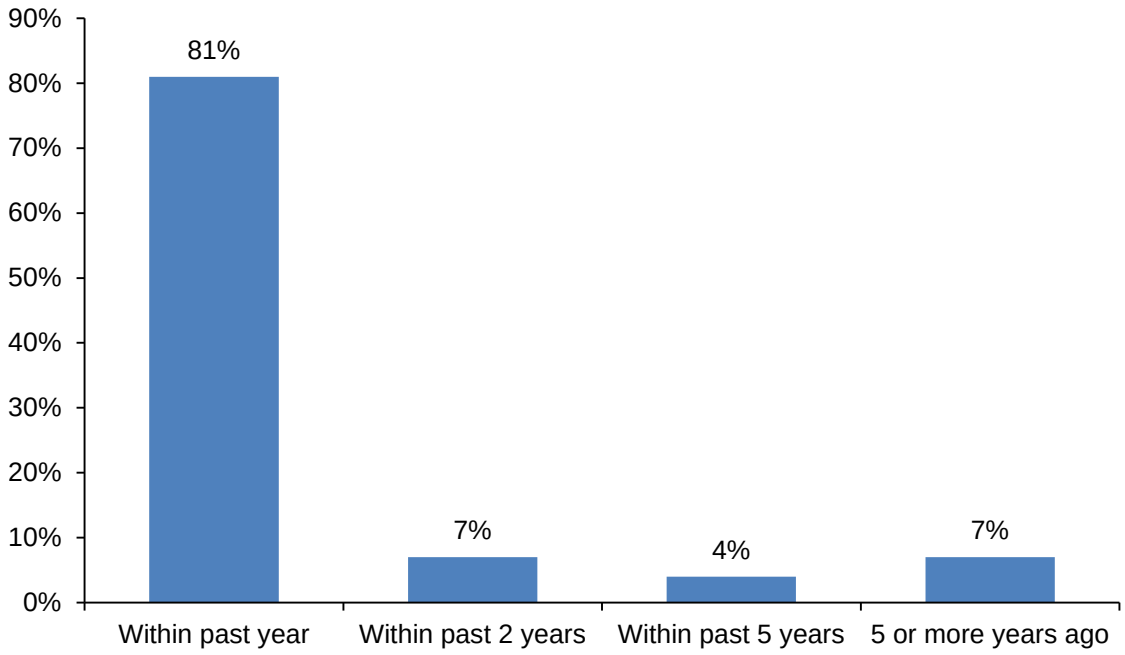
Do you have any kind of dental care or oral health insurance coverage?



Base: Yes (n=21), No (n=6), Sample Size = 27

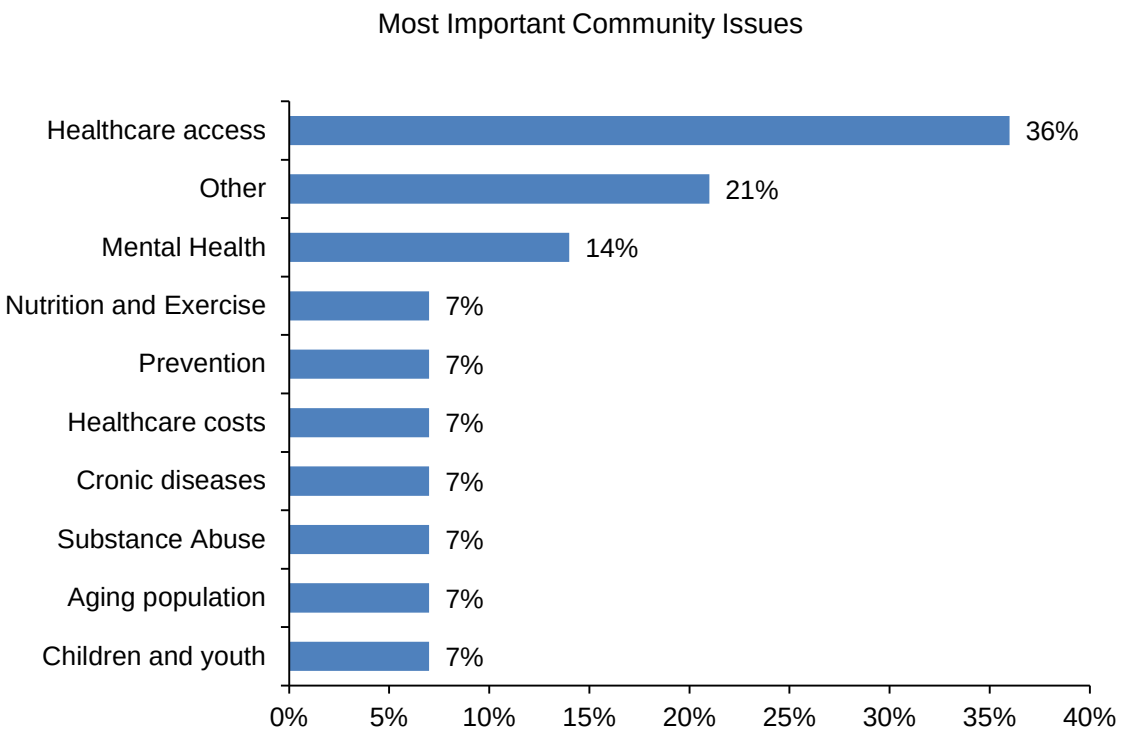
(Community = Deuel)

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



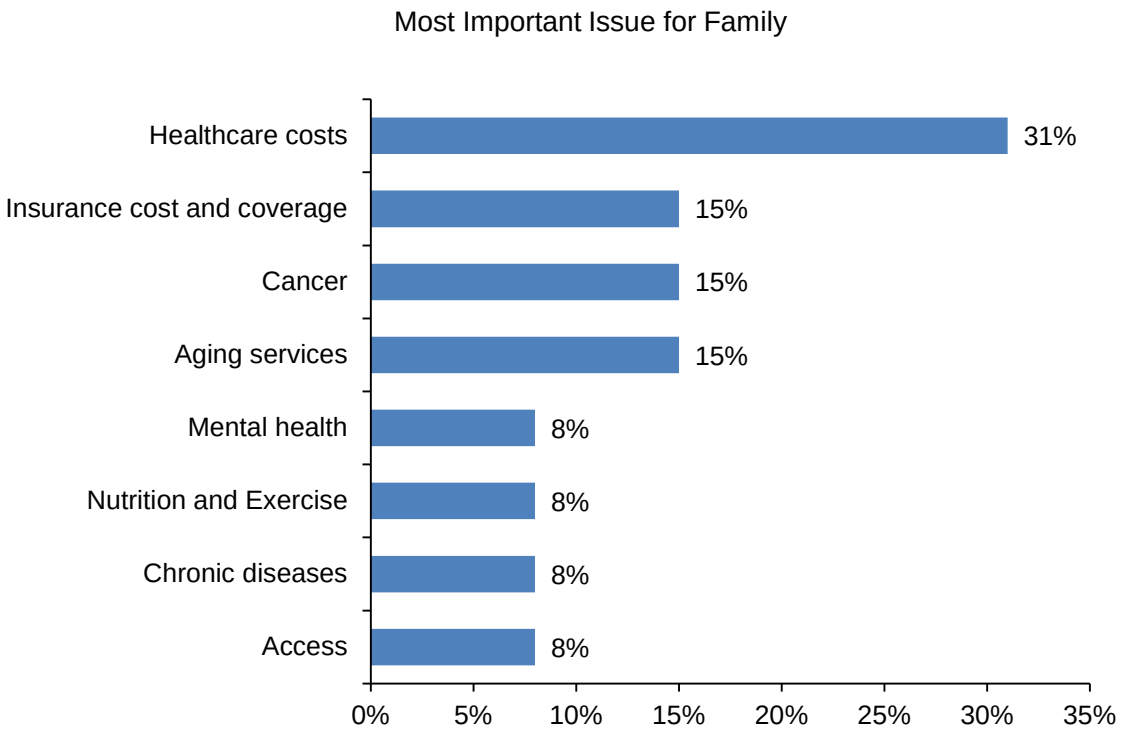
Base: Within past year (n=22), Within past 2 years (n=2), Within past 5 years (n=1), 5 or more years ago (n=2), Sample Size = 27

(Community = Deuel)



Base: Children and youth (n=1), Aging population (n=1), Healthcare access (n=5), Mental Health (n=2), Substance Abuse (n=1), Chronic diseases (n=1), Healthcare costs (n=1), Prevention (n=1), Nutrition and Exercise (n=1), Other (n=3), Sample Size = 16

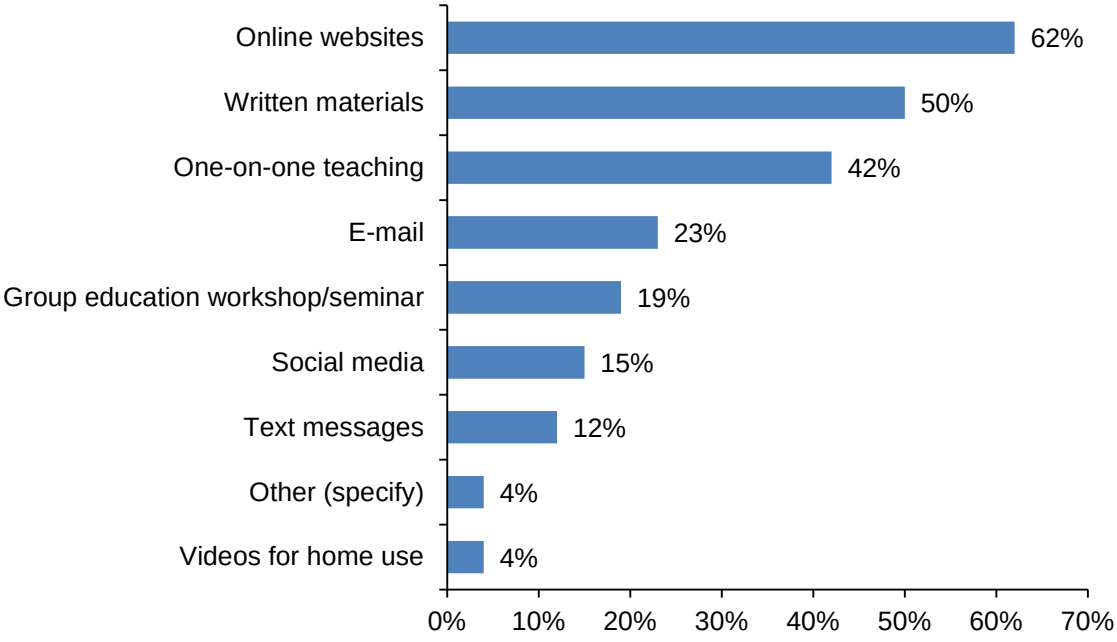
(Community = Deuel)



Base: Access (n=1), Aging services (n=2), Cancer (n=2), Chronic diseases (n=1), Healthcare costs (n=4), Nutrition and Exercise (n=1), Insurance cost and coverage (n=2), Mental health (n=1), Sample Size = 16

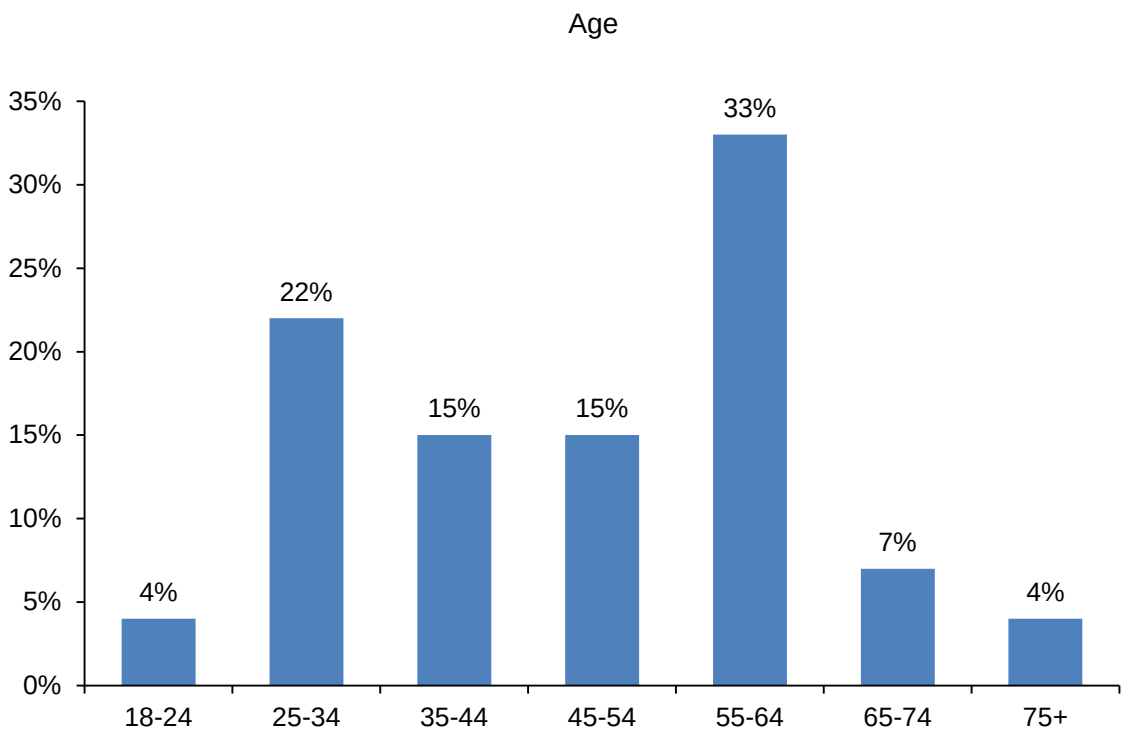
(Community = Deuel)

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



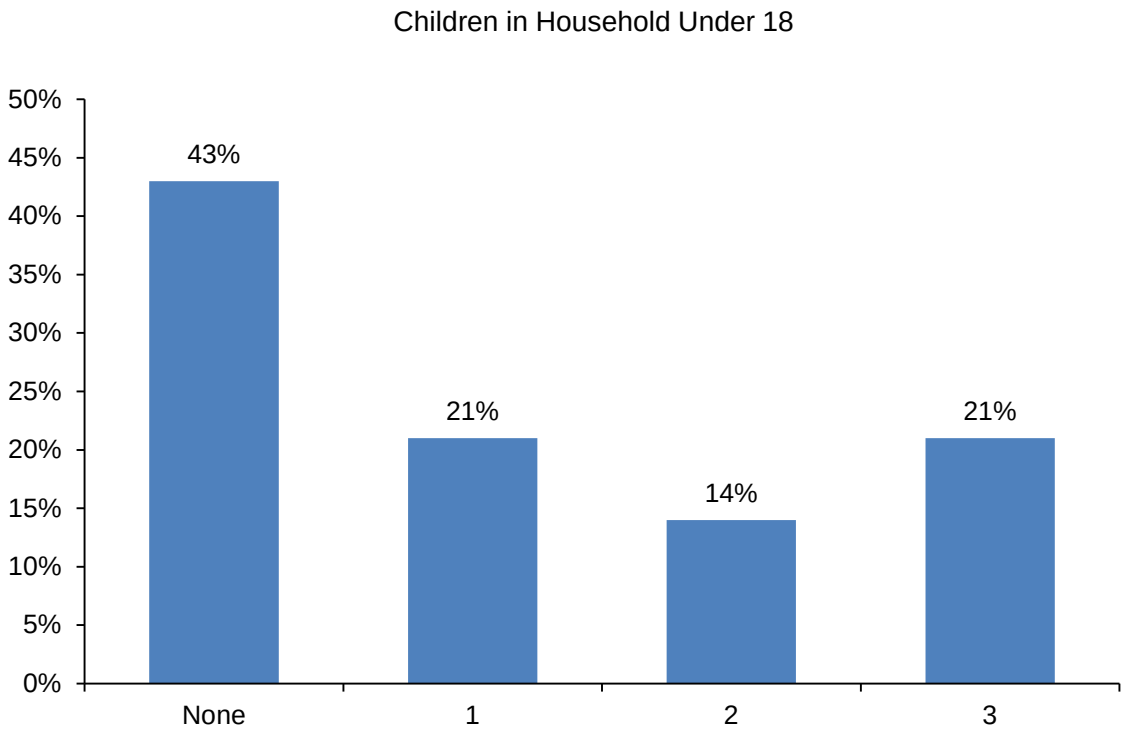
Base: Written materials (n=13), Videos for home use (n=1), Social media (n=4), Text messages (n=3), One-on-one teaching (n=11), E-mail (n=6), Group education workshop/seminar (n=5), Online websites (n=16), Other (specify) (n=1), Sample Size = 26

(Community = Deuel)



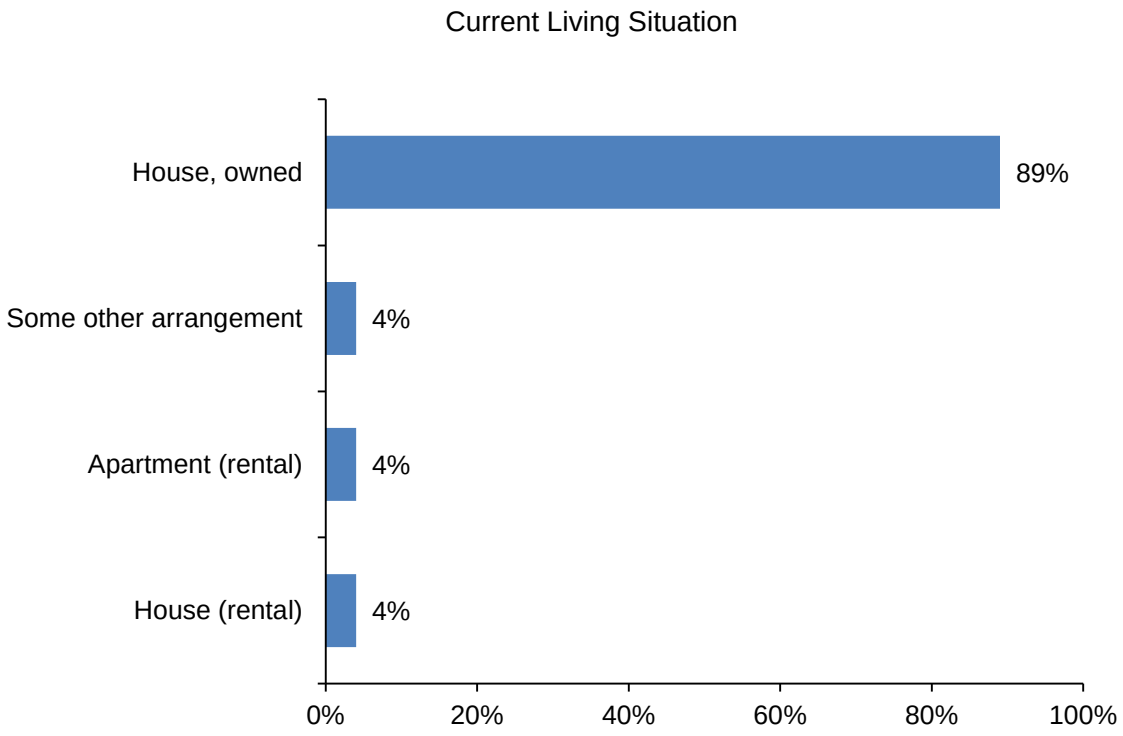
Base: 18-24 (n=1), 25-34 (n=6), 35-44 (n=4), 45-54 (n=4), 55-64 (n=9), 65-74 (n=2), 75+ (n=1), Sample Size = 27

(Community = Deuel)



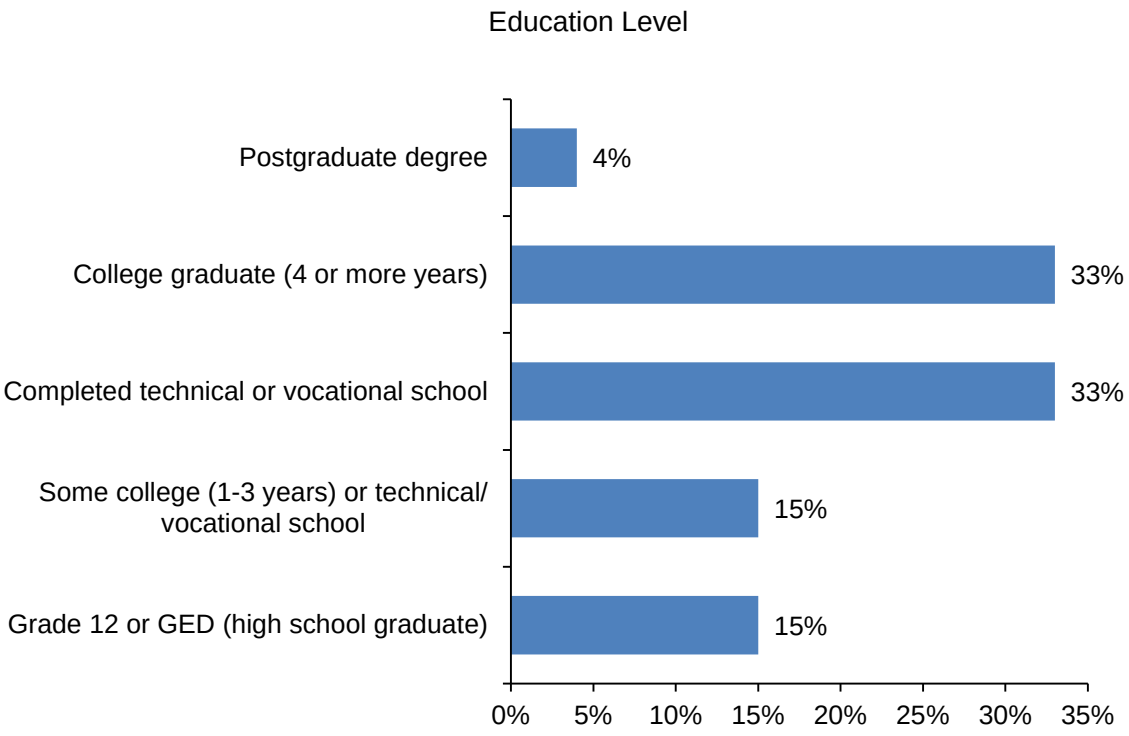
Base: None (n=6), 1 (n=3), 2 (n=2), 3 (n=3), Sample Size = 14

(Community = Deuel)



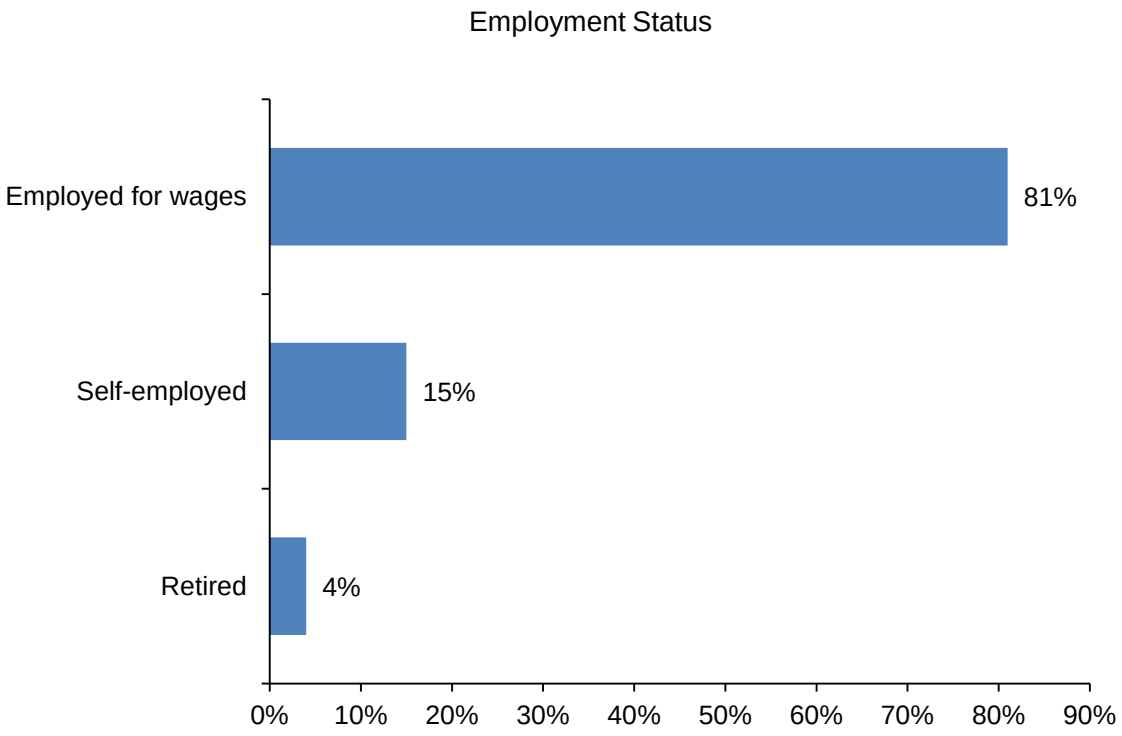
Base: House, owned (n=24), House (rental) (n=1), Apartment (rental) (n=1), Some other arrangement (n=1), Sample Size = 27

(Community = Deuel)



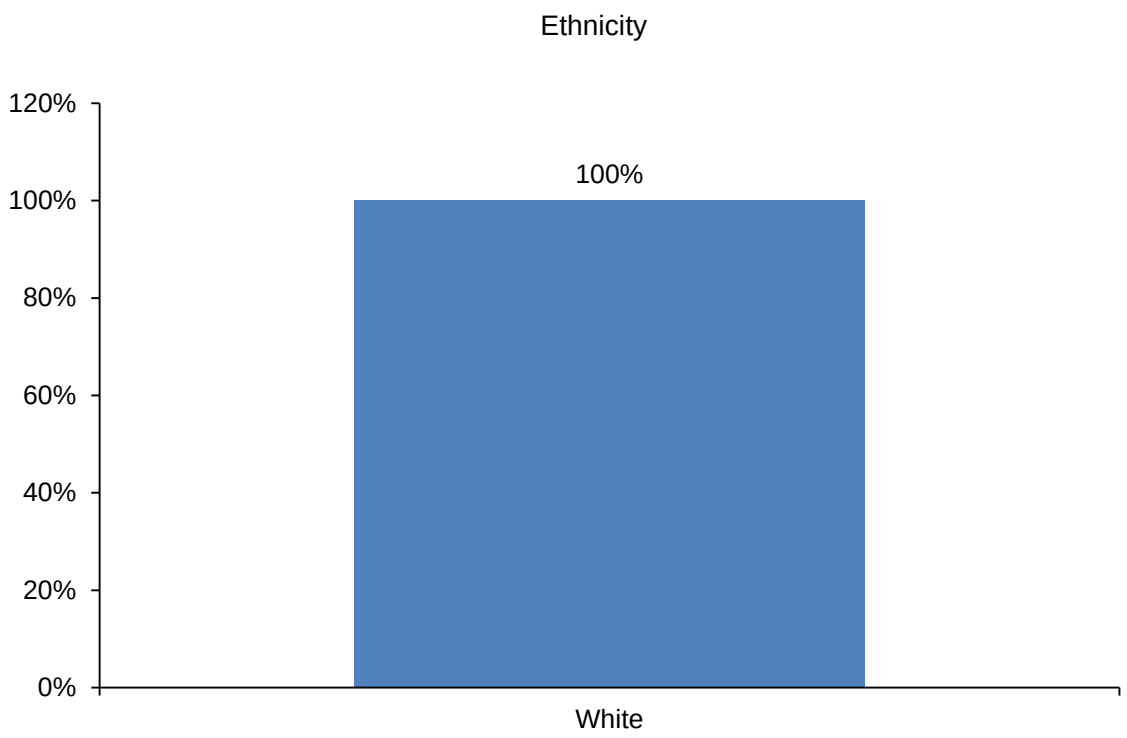
Base: Grade 12 or GED (high school graduate) (n=4), Some college (1-3 years) or technical/ vocational school (n=4), Completed technical or vocational school (n=9), College graduate (4 or more years) (n=9), Postgraduate degree (n=1), Sample Size = 27

(Community = Deuel)



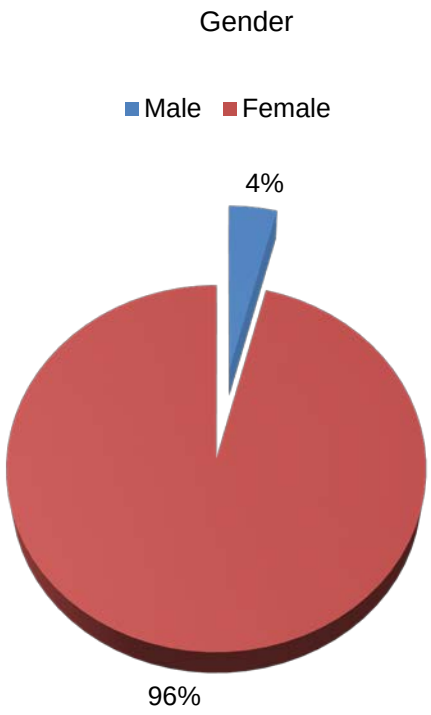
Base: Employed for wages (n=22), Self-employed (n=4), Retired (n=1), Sample Size = 27

(Community = Deuel)



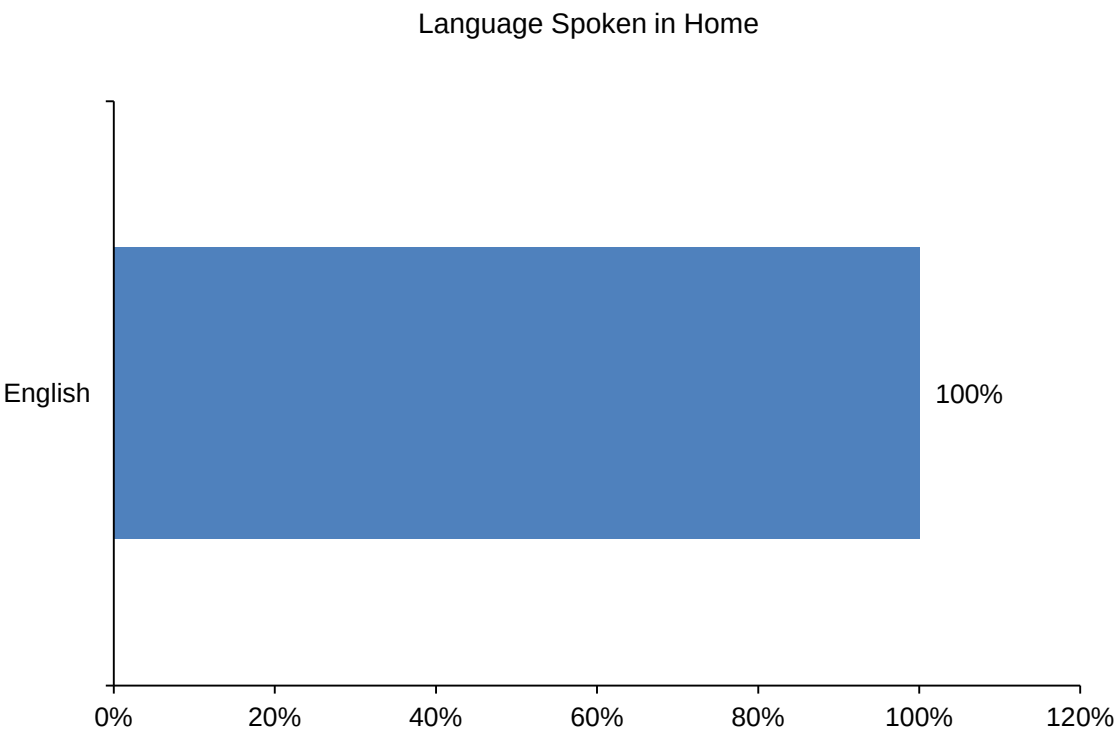
Base: White (n=27), Sample Size = 27

(Community = Deuel)



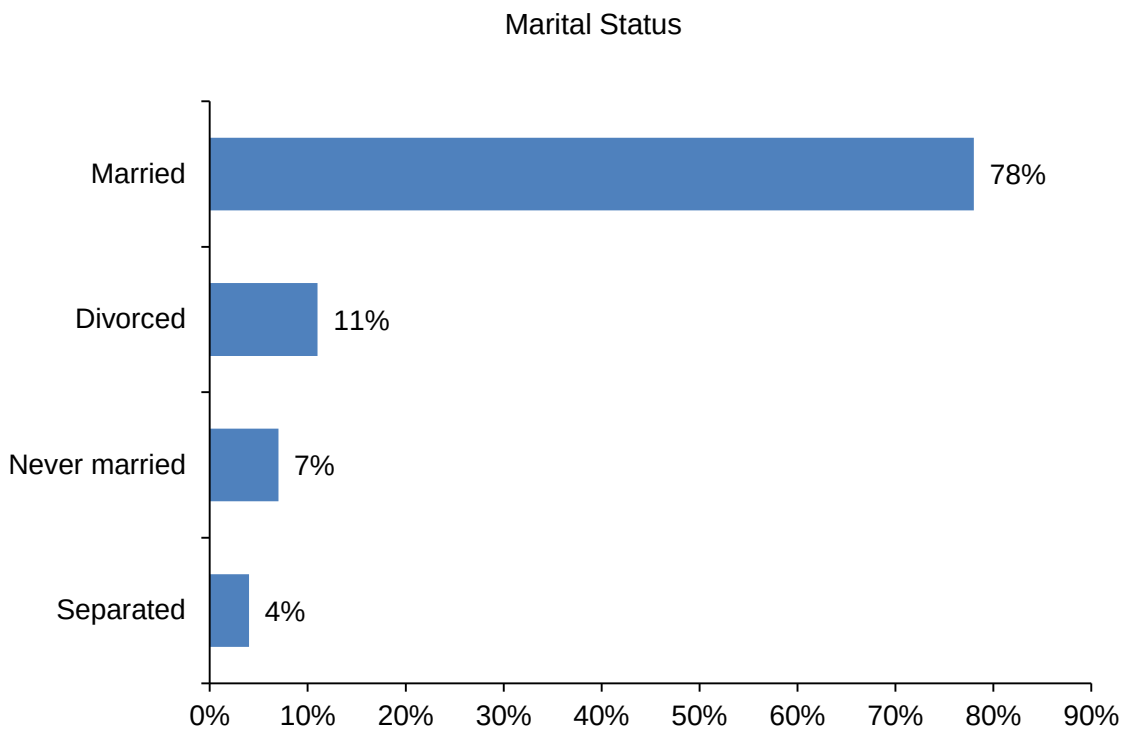
Base: Male (n=1), Female (n=26), Sample Size = 27

(Community = Deuel)



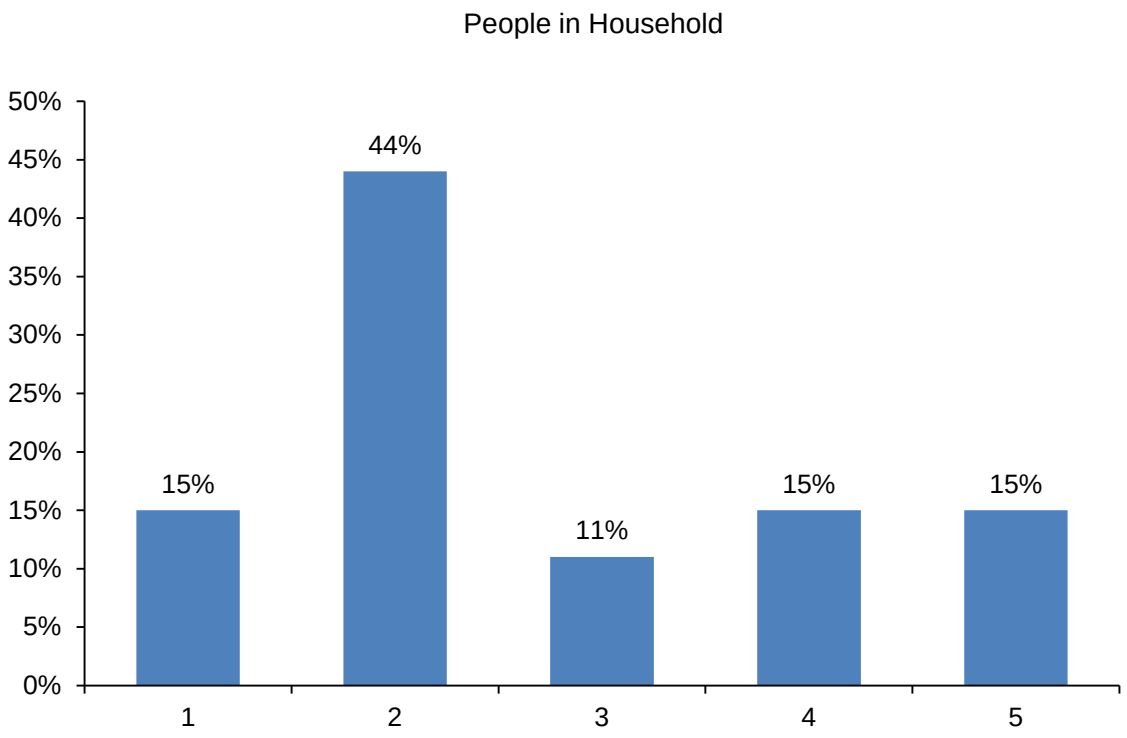
Base: English (n=27), Sample Size = 27

(Community = Deuel)



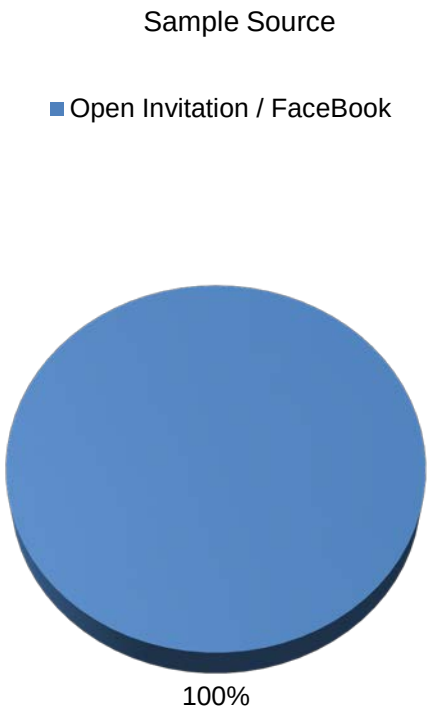
Base: Never married (n=2), Married (n=21), Divorced (n=3), Separated (n=1), Sample Size = 27

(Community = Deuel)



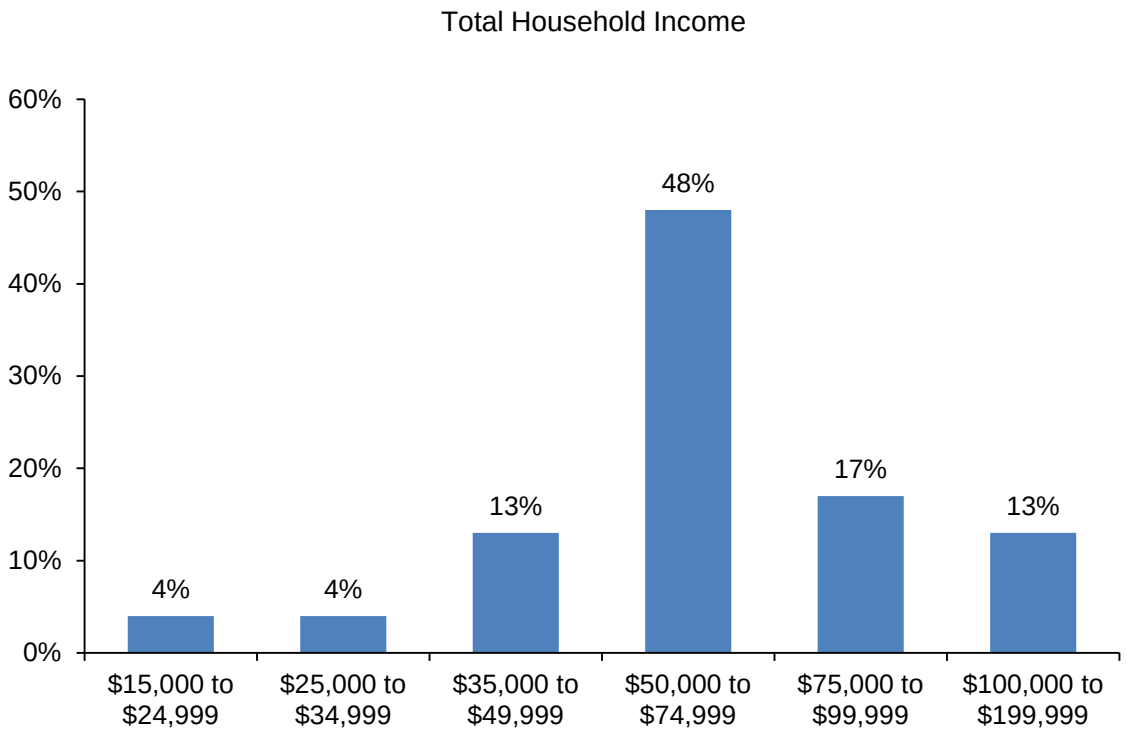
Base: 1 (n=4), 2 (n=12), 3 (n=3), 4 (n=4), 5 (n=4), Sample Size = 27

(Community = Deuel)



Base: Open Invitation / Facebook (n=27), Sample Size = 27

(Community = Deuel)



Base: $15,000 to $24,999 (n=1), $25,000 to $34,999 (n=1), $35,000 to $49,999 (n=3), $50,000 to $74,999 (n=11), $75,000 to $99,999 (n=4), $100,000 to $199,999 (n=3), Sample Size = 23

(Community = Deuel)

Prioritization Worksheet

Clear Lake 2019 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

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

Criteria to Identify Intervention for Problem

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

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economic Well-Being • Employment options 3.50 • Skilled labor workforce 3.29 • Availability of affordable housing 3.14 • Household budgeting and money management 3.00 • 15% report worry about having enough food before they can buy more	**1- Employment options 1**		
Transportation • Availability of door-to door transportation services for those unable to drive 3.45 • Availability of public transportation 3.33 • Cost of door-to-door transportation services for those unable to drive 3.05	**6 - door to door**		
Children and Youth • Childhood obesity 3.26 • Bullying 3.11	**4 - obesity**		
Aging Population • Cost of long-term care 3.42 • Cost of memory care 3.37 • Availability of activities for seniors 3.11 • Availability of memory care 3.06 • Availability of resources to help the elderly stay safe in their homes 3.00 • Cost of in-home services 3.00	**1 Activities for seniors**		
Safety • Abuse of prescription drugs 3.00			
Healthcare Access • Availability of behavioral health 3.28 • Availability of mental health providers 3.26 • Access to affordable health insurance coverage 3.16 • Access to affordable health care 3.00			
Mental Health and Substance Abuse • Depression 3.16 24% self-report having depression • Stress 3.11 29% self-report having anxiety/stress • Smoking and tobacco use 3.05 11% report that they currently smoke • 50% report that they binge drink at least 1X/month	**1- Depression** **2- Smoking and tobacco**		
Wellness • 38% report obesity • 35% report overweight • 67% do not get 5 or more fruits/vegetables/day • 50% report getting moderate activity 3 or more days/week • 47% report having arthritis • 35% report having hypertension • 23% report not having seen their health care provider in more than 1 year • 18% report not having seen their dentist in more than 1 year	**3 – 0besity**		

Secondary Research

Definitions of Key Indicators

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

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

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

Contents:

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)
	Years of Potential Life Lost Rate (Black)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Blacks
	Years of Potential Life Lost Rate (Hispanic)	Age-adjusted YPLL rate per 100,000 for Hispanics
	Years of Potential Life Lost Rate (White)	Age-adjusted YPLL rate per 100,000 for non-Hispanic Whites

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

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

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

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

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

County Health Ranking for Deuel County

	County	State
Population	4,231	865,454
% below 18 years of age	23.1%	24.6%
% 65 and older	21.6%	16.0%
% Non-Hispanic African American	0.8%	1.9%
% American Indian and Alaskan Native	0.4%	9.0%
% Asian	0.1%	1.5%
% Native Hawaiian/Other Pacific Islander	0.0%	0.1%
% Hispanic	2.9%	3.7%
% Non-Hispanic white	94.9%	82.5%
% not proficient in English	0%	1%
% Females	48.1%	49.6%
% Rural	100.0%	43.3%

	Deuel County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Health Outcomes					11
Length of Life					33
Premature death			5,300	7,000	
Quality of Life					3
Poor or fair health **	11%	10-11%	12%	12%	
Poor physical health days **	2.8	2.7-3.0	3.0	3.1	
Poor mental health days **	2.6	2.4-2.8	3.1	2.9	
Low birthweight	4%		6%	6%	
Additional Health Outcomes (not included in overall ranking) +					
Premature age-adjusted mortality	290	210-390	270	330	
Child mortality			40	70	
Infant mortality			4	7	

	County		State		
Frequent physical distress	9%	8-9%	9%	9%	
Frequent mental distress	9%	9-9%	10%	9%	
Diabetes prevalence	11%	8-15%	8%	9%	
HIV prevalence			49	73	
Health Factors					39
Health Behaviors					30
Adult smoking **	14%	13-15%	14%	18%	
Adult obesity	34%	28-40%	26%	31%	
Food environment index	6.6		8.6	6.6	
Physical inactivity	28%	21-35%	20%	22%	
Access to exercise opportunities	56%		91%	72%	
Excessive drinking **	19%	18-20%	13%	20%	
Alcohol-impaired driving deaths	0%	0-42%	13%	37%	
Sexually transmitted infections	185.5		145.1	462.9	
Teen births	17		15	30	
Additional Health Behaviors (not included in overall ranking) +					
Food insecurity	10%		10%	12%	
Limited access to healthy foods	27%		2%	11%	
Drug overdose deaths			10	8	
Drug overdose deaths - modeled	14-15.9		8-11.9	8.4	
Motor vehicle crash deaths			9	16	
Insufficient sleep	24%	23-25%	27%	26%	
Clinical Care					44
Uninsured	12%	10-13%	6%	12%	
Primary care physicians	4,330:1		1,030:1	1,290:1	
Dentists	4,230:1		1,280:1	1,710:1	
Mental health providers			330:1	610:1	

	County		State		
Preventable hospital stays	97	72-121	35	50	
Diabetes monitoring	94%	70-100%	91%	84%	
Mammography screening	69%	48-91%	71%	66%	
Additional Clinical Care (not included in overall ranking) +					
Uninsured adults	13%	11-15%	7%	14%	
Uninsured children	9%	6-11%	3%	7%	
Health care costs	$8,543			$8,345	
Other primary care providers	2,116:1		782:1	801:1	
Social & Economic Factors					35
High school graduation			95%	84%	
Some college	60%		72%	68%	
Unemployment	4.6%		3.2%	2.8%	
Children in poverty	13%	9-17%	12%	17%	
Income inequality	3.3	2.7-3.9	3.7	4.1	
Children in single-parent households	20%	12-29%	20%	32%	
Social associations	25.4		22.1	16.5	
Violent crime	61		62	322	
Injury deaths	70	39-115	55	76	
Additional Social & Economic Factors (not included in overall ranking) +					
Disconnected youth			10%	10%	
Median household income	$53,500	$47,400-59,700	$65,100	$54,900	
Children eligible for free or reduced price lunch	34%		33%	42%	
Residential segregation - black/white			23	63	
Residential segregation - non-white/white			14	56	
Homicides			2	3	
Firearm fatalities			7	11	

	County	State			
Physical Environment					36
Air pollution - particulate matter **	8.5		6.7	7.7	
Drinking water violations	No				
Severe housing problems	9%	6-11%	9%	12%	
Driving alone to work	76%	71-80%	72%	80%	
Long commute - driving alone	27%	22-32%	15%	14%	

Areas to ExploreAreas of Strength

SANFORD HEALTH

019012-00347 9/18