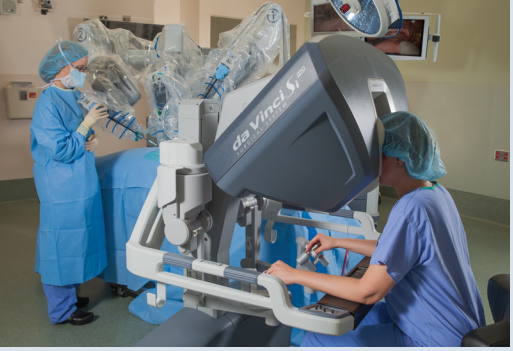

















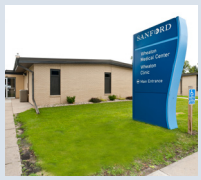

SANFORD®
HEALTH

Sanford Health Network

2018 Community Health Needs Assessment

dba Sanford Tracy Medical Center EIN# 46-0388596

Dear Community Members,

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

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

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

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

- Wellness
- Health Care Access

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

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

Sincerely,

Stacy Barstad

Stacy Barstad
Senior Director
Sanford Tracy Medical Center

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Sanford Tracy Medical Center

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).

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

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

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

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

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

Finally, hospitals are to be transparent with the findings and make the written CHNA report available to anyone who asks for 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 Tracy community and Lyon County. Data collection occurred during November 2017. A total of 17 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 Statewide Health Improvement Partnership (SHIP) surveys and those questions were included in the resident survey. Questions specific to American Indian residents were developed by the North Dakota Public Health Association. The survey was posted on Facebook and a notice was posted in the local newspaper to invite residents to take the survey. The newspaper post included a URL for the survey. A total of 137 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 Tracy and Lyon County, Minnesota. 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.

The Internal Revenue Code 501(r) statute requires that a broad base of key community stakeholders have input into the needs of the community. Those community members specified in the statute include: persons who represent the broad interests of the community served by the hospital facility including those with special expertise in public health; Federal, tribal, regional, state and or local health or other departments or agencies with information relevant to the health needs of the community served; 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 response 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 3.5 or above are considered to be high ranking. Sanford is addressing many of the needs that ranked below 3.5; however, the high ranking needs of 3.5 or above are considered for the prioritization process. The resident survey addresses personal health needs and concern. The secondary research provides further understanding of the health of the community and in some cases the indicators are aligned and validate our findings.

Economic Well-Being
Community stakeholders are most concerned that there is a need for employment options and the availability of a skilled labor force (ranking 3.53).

Children and Youth
Community stakeholders are most concerned about childhood obesity (3.71) and the availability of quality childcare (3.65).

Aging Population
Community stakeholders are most concerned about the cost of long-term care (3.88), the cost of memory care (3.88), and the availability of memory care (3.59).

Health Care Access
Community stakeholders are most concerned about the availability of doctors and advanced level providers (4.35), the availability mental health providers (4.18), access to affordable health insurance (3.94), the availability of behavioral health (substance abuse) providers (3.76), the availability of specialist physicians (3.76), the availability of affordable health care (3.65), access to affordable prescription drugs (3.59), the use of emergency room services for primary health care (3.59), and the availability of non-traditional hours (3.53).

Mental Health and Substance Abuse
Community stakeholders are most concerned about depression (3.71), stress (3.59), and dementia and Alzheimer's (3.53).

Thirty-five percent of resident survey participants report that they have been diagnosed with depression and 43% report a diagnosis of anxiety/stress.

Resident survey participants are facing the following issues:

- 70% report that they are overweight or obese
- 46% self-report binge drinking at least 1X/month
- 43% report a diagnosis of high cholesterol
- 35% a diagnosis of hypertension
- 24% self-report that they have drugs in their home they are not using
- 20% have not visited a dentist in more than a year
- 19% currently smoke cigarettes
- 13% report running out of food before having money to buy more
- 10% report that alcohol use has had a harmful effect on them or a member of their family in the past two years

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

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

- *Wellness*
- *Health Care Access*

Implementation Strategies

Priority 1: Wellness

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 Tracy 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.

Priority 2: Health Care Access

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

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

Sanford Tracy Medical Center

Community Health Needs Assessment

2018

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Community Health Needs Assessment
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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 Bemidji
- 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 Bemidji
- 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
- Dan Heinemann, M.D., Chief Medical Office, Vice-President, Health Network
- 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, Director, Sanford Community Health Improvement/Community Benefit
- Jac McTaggart, Senior Director, Sanford Hillsboro and Sanford Mayville
- Rick Nordahl, Senior Director, Sanford Sheldon
- Erica Peterson, Senior Director, Sanford Chamberlain
- Gwen Post, Director of Nursing and Clinical Services, Sanford Worthington
- Dawn Schnell, Senior Director, Sanford Jackson
- Lori Sisk, Senior Director, Sanford Canby and Sanford Clear Lake
- Jennifer Tewes, Clinic Supervisor, Sanford Jackson
- Tim Tracy, Senior Director, Sanford Vermillion
- Ruth Twedt, Manager of Ancillary Services, Sanford Clear Lake
- Marnie Walth, Senior Legislative Affairs Specialist, Sanford Bismarck
- Jennifer Weg, Executive Director, Sanford Worthington

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

- Clinton Alexander, Fargo Moorhead Native American Center
- Kristin Bausman, Becker County Public Health
- Justin Bohrer, Fargo Cass Public Health
- Cynthia Borgen, Beltrami Public Health
- Jackie Buboltz, Essentia Health
- Anita Cardinal, Pennington County Public Health
- Leah Deyo, Essentia Health
- Peter Ekadu, Nobles County Public Health
- Stacie Golombiecki, Nobles County Public Health
- Christian Harris, New American Consortium
- Caitlyn Hurley, Avera Health
- Deb Jacobs, Wilkin County Public Health
- Joy Johnson, Sanford Health
- Ann Kinney, 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 Tracy community stakeholders participated in community discussions and helped to formulate the priorities for our implementation strategies:

- Kris Ambuehl, Tracy City Administrator
- Stacy Barstad, CEO, Sanford Medical Center
- Denise Clouse, Sanford Medical Center
- Cookie Cooreman, TAMF Foundation Board
- Dale Johnson III, Fire Chief, Tracy Fire Department
- Gordon Kopperud, Sanford Medical Center
- Krista Kopperud, Southwest Health and Human Services
- Jason Lichty, Tracy Police Chief
- Becky Luft, Sanford Medical Center
- Michelle Salfer, Southwest Health and Human Services
- Jeri Schons, DON, Sanford Medical Center
- Carol Snyder, TAMF Foundation

Description of Sanford Tracy Medical Center

Sanford Tracy Medical Center is a 25-bed Critical Access Hospital located in Lyon County in southwest Minnesota. Since 2001 Sanford Tracy has enjoyed a collaborative relationship with Sanford Westbrook Medical Center. As neighboring communities, these two health care facilities share executive leadership and managerial staffing in the areas of radiology, laboratory, human resources and marketing/community relations. The efficiency and cost effectiveness of these shared resources allows each facility to redirect valuable time, energy and financial assets into direct patient care. The two Critical Access Hospitals provide services for approximately 9,400 people.

Built by the City of Tracy in 1960 as a municipal hospital, the hospital became a leased member Sanford Health Network in 1998 and is a designated Level IV Trauma facility. Additional renovation and expansion was completed in 2010, which increased space in the clinic to accommodate additional primary care providers and provide space for visiting medical specialists.

The hospital campus consists of a primary care clinic, medical specialty outpatient clinic, and a 30-apartment senior living facility. In addition, two satellite medical clinics are located in the neighboring communities of Balaton (12 miles to the west) and Walnut Grove (7 miles to the east). The service area of Sanford Tracy includes the communities of Tracy, Currie, Balaton, Amiret, Walnut Grove, Milroy and Revere. The population of this area is approximately 5,740. Sanford Tracy employs 1.5 clinicians and 103 employees.

Description of the Community Served

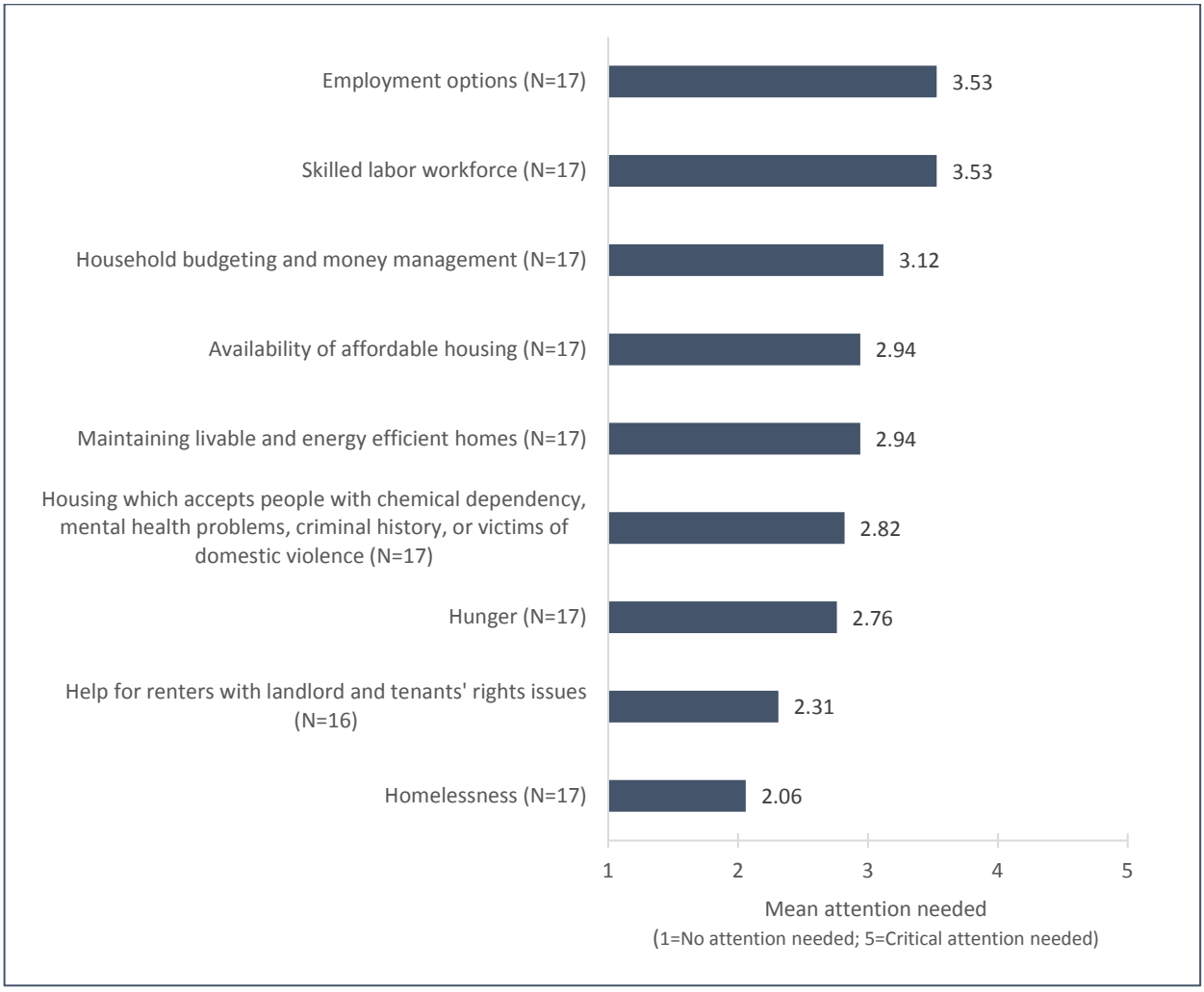
Tracy is a city of 2,300 people located in Lyon County, Minnesota. It is situated in a thriving agricultural area with an active retail environment. It is home to Tracy-Milroy-Balaton High School and Elementary School, Tracy Food Pride, a public day care facility, retail shops, and a public library. In addition, numerous churches, city and county parks, an aquatic center, and recreation amenities are available. Seniors are well served with a choice of affordable housing options. Tracy has everything to satisfy families who work in the city or commute from nearby communities.

Key Findings

Community Health Concerns

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

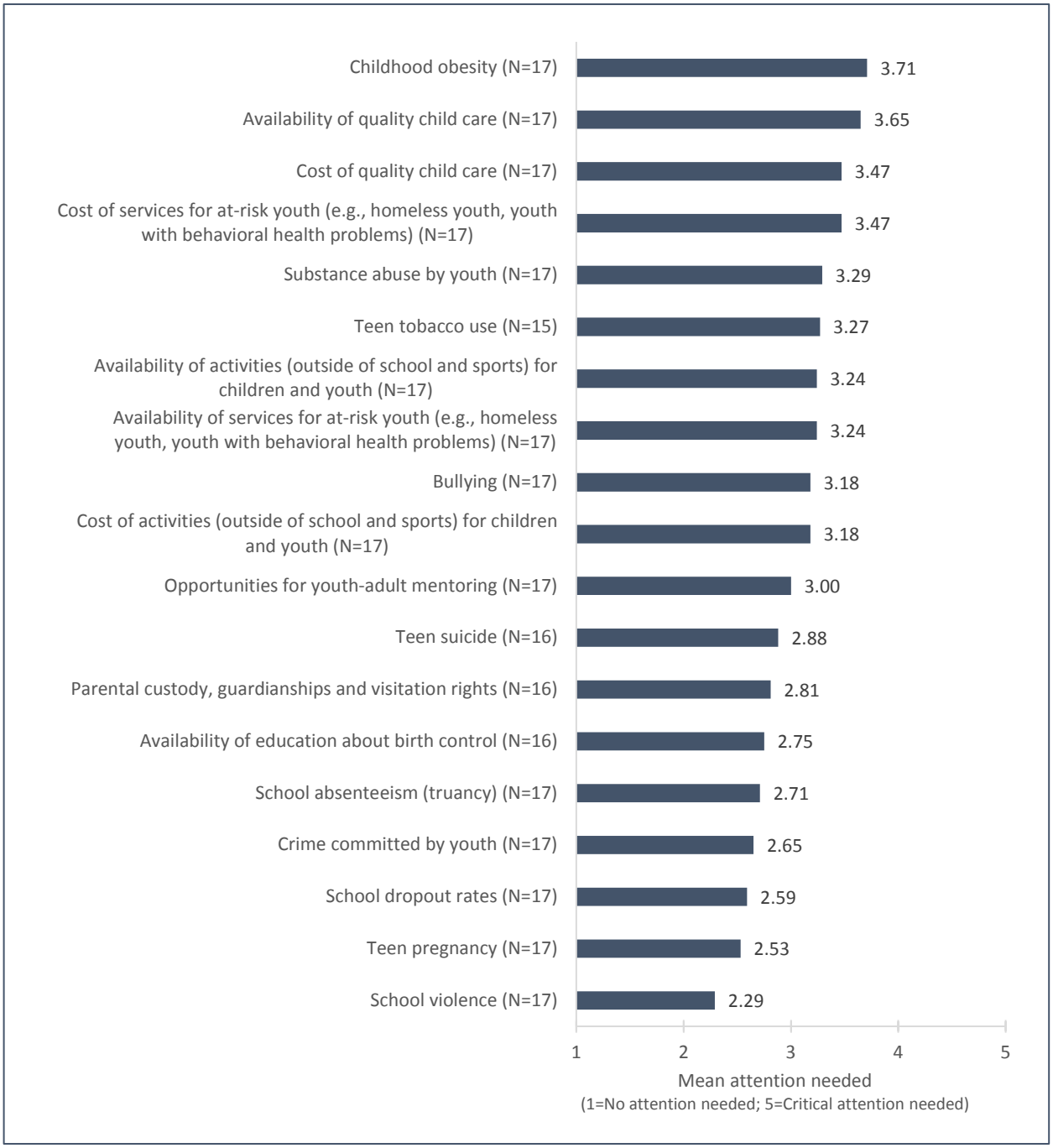
Economic Well-Being: The concern for the community's economic well-being is focused on the need for employment options and a skilled labor workforce.



Healthy People 2020 has defined the social determinants of health. "Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood)

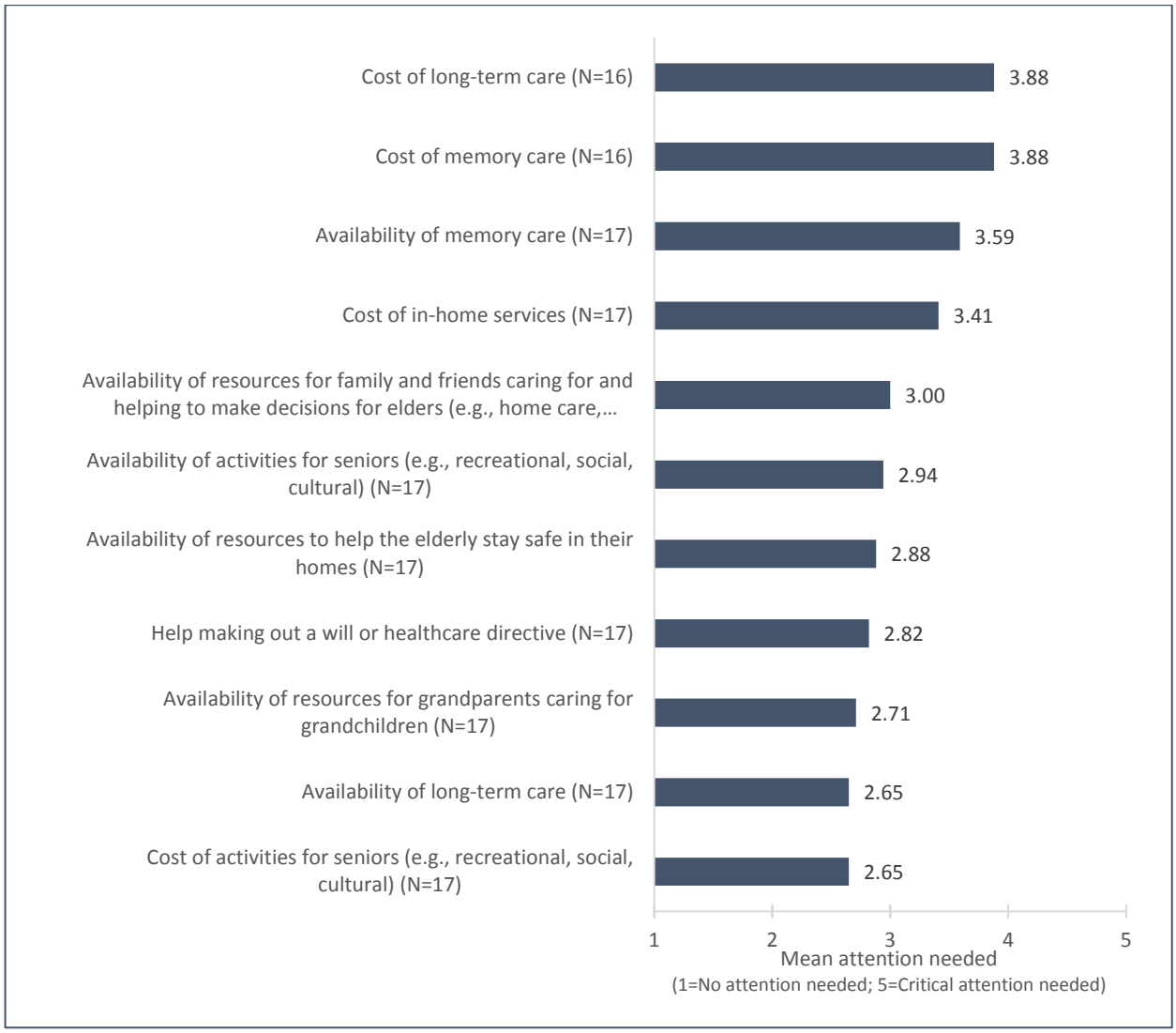
have been referred to as “place.” The patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

Children and Youth: The concern for children and youth is highest for childhood obesity and for the availability of quality childcare.



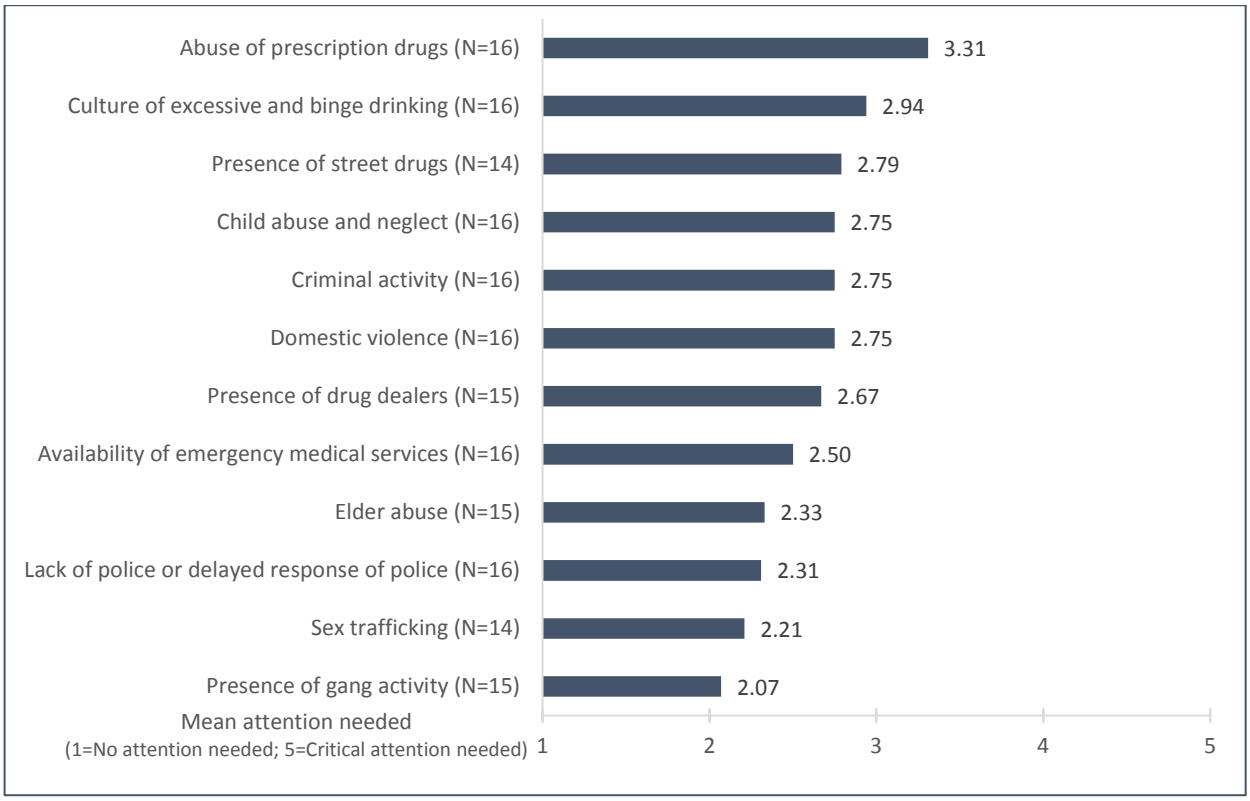
Childhood Obesity and Child Well-being: According to the CDC, childhood obesity can have immediate and long-term effects on physical, social, and emotional health. Children with obesity are at higher risk for chronic health conditions including asthma, sleep apnea, bone and joint problems, type 2 diabetes, and risk factors for heart disease.

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



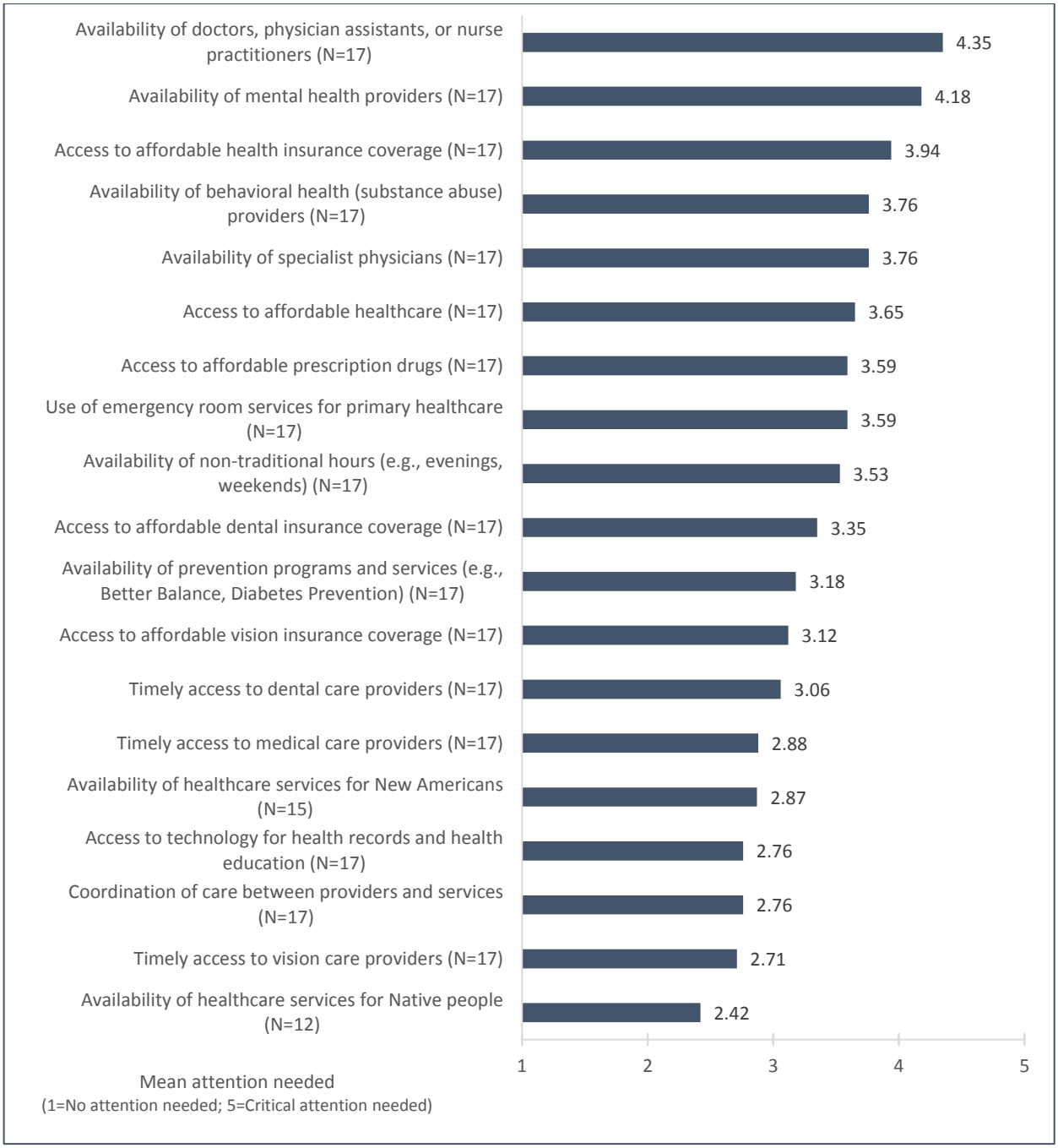
According to the U.S. Health and Human Services Administration on Aging, the cost of long term care depends on the type and duration of care you need, the provider you use, and where you live. Sanford providers work to help seniors live healthy independent lives. Sanford social workers, case managers, 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 concerns for safety in the community although it ranked below 3.5.



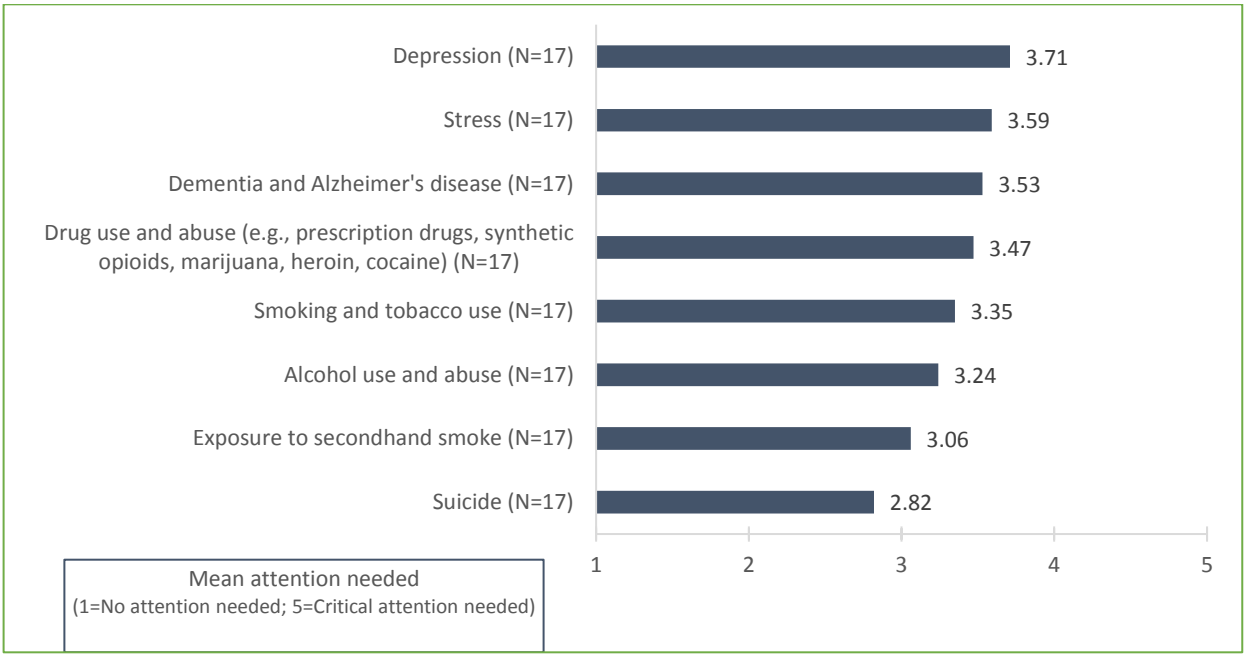
The National Institute on Drug Abuse states that the misuse of prescription drugs means taking a medication in a manner or dose other than what was prescribed; or taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to feel euphoria (i.e., 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 doctors and mid-level providers, mental health and behavioral health providers, access to affordable health insurance coverage, the availability of physician specialists, access to affordable health care, access to affordable prescription drugs, use of the emergency room for primary care needs, and the availability of non-traditional hours are ranked very high among the top concerns for the community.



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.

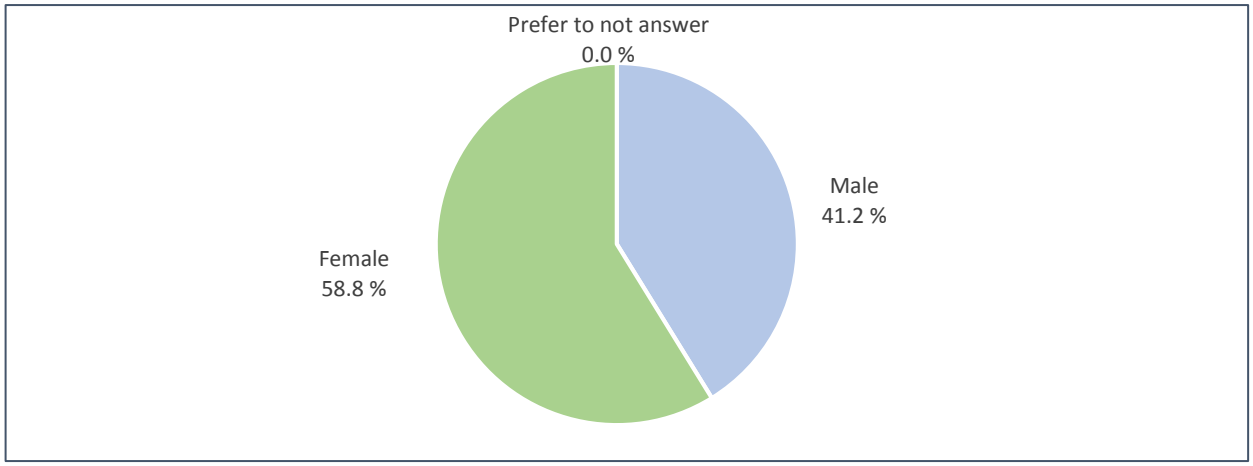
Mental Health and Substance Abuse: Depression, stress, dementia and Alzheimer's disease are top concerns for the community.



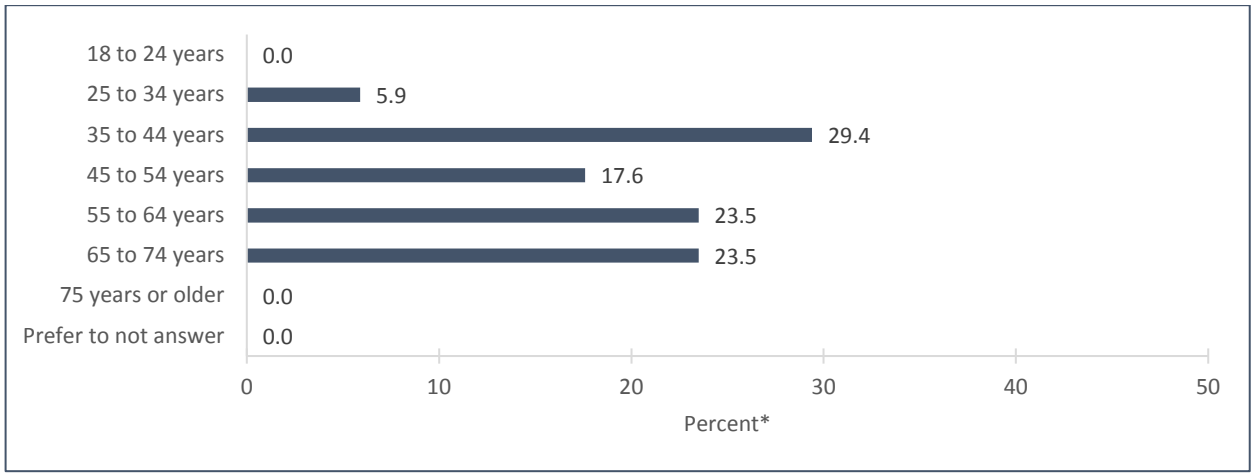
The Substance Abuse and Mental Health Services Administration reports that "Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities. In 2014, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness, and 1.7 million of which were aged 18 to 25. Also, 15.7 million adults (aged 18 or older) and 2.8 million youth (aged 12 to 17) had a major depressive episode during the past year. In 2014, an estimated 22.5 million Americans aged 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

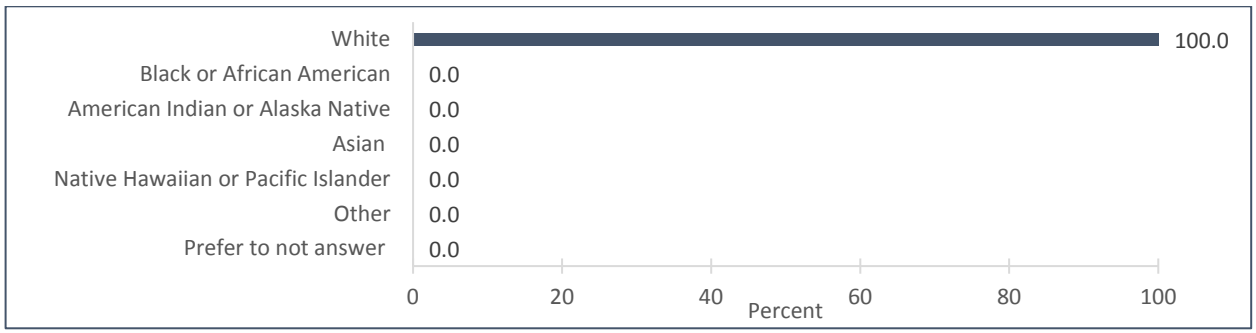
Biological Gender



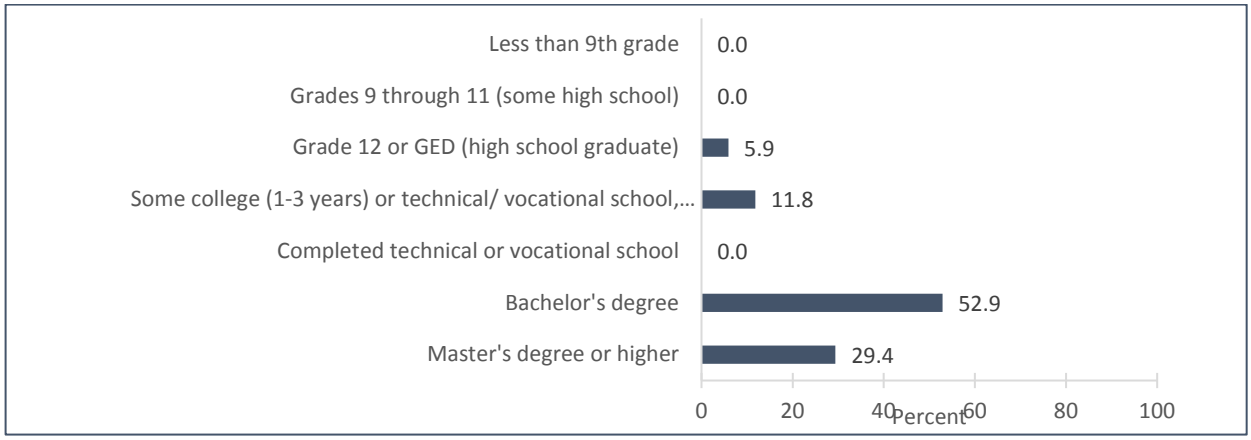
Age of Participants



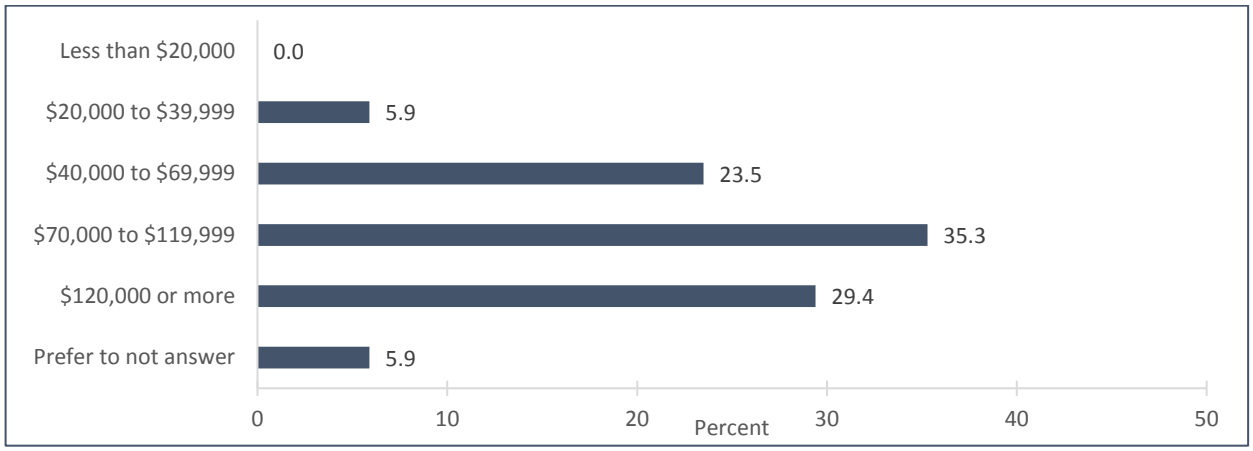
Race of Participants



Highest Level of Education Completed



Annual Household Income of Respondents, from all sources, before taxes



Resident's Health Concerns

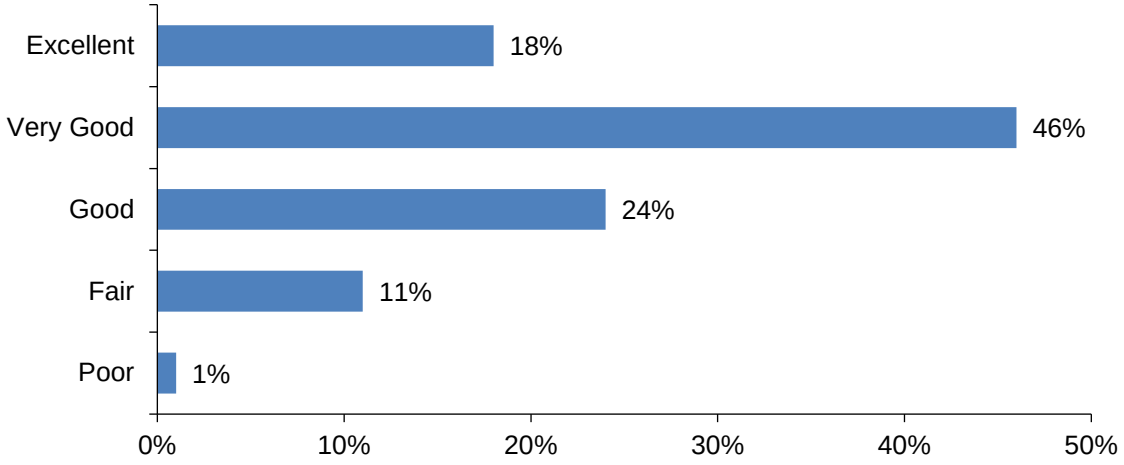
Health is personal and it starts in our homes, schools, workplaces, neighborhoods, and communities. Eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor for routine check-ups can positively influence our health.

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

Resident's Health Concerns

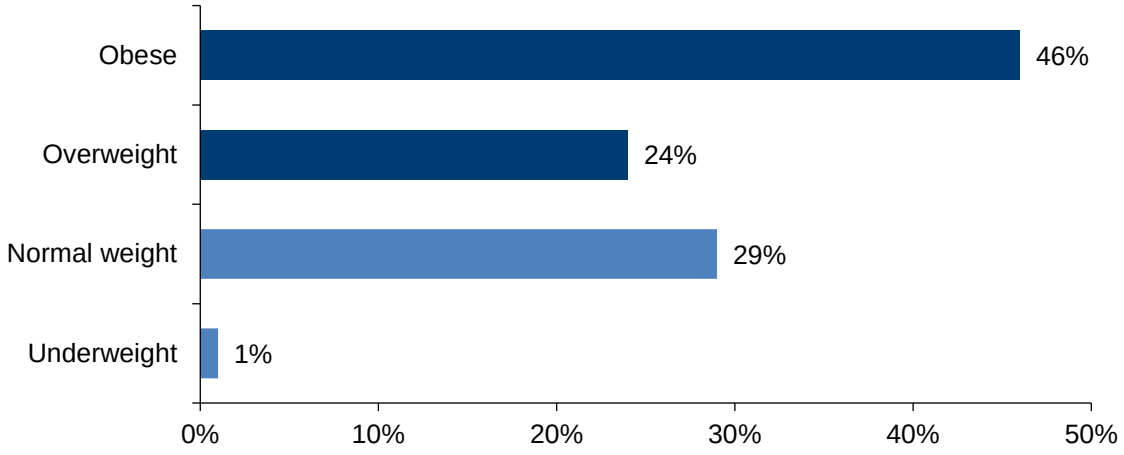
How would you rate your health?

Eighty-eight percent of survey participants rated their health as good or better.



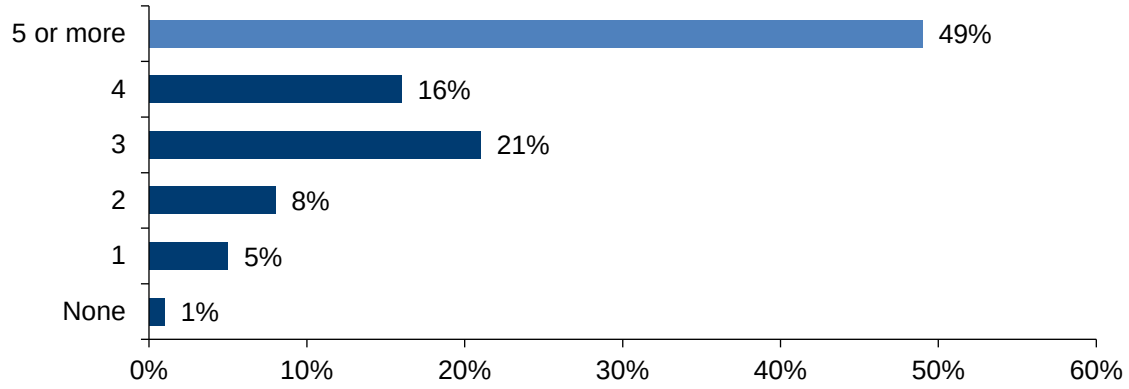
BMI

Seventy percent of participants are overweight or obese.



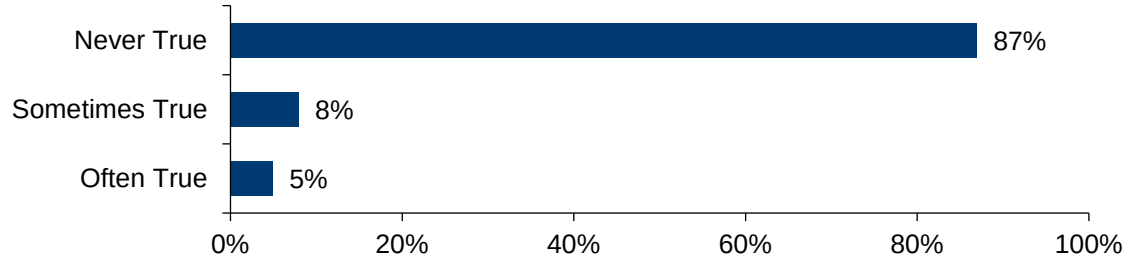
Total daily servings of fruits and vegetables

Only 49% are getting their recommended five or more a day servings of fruits and vegetables.



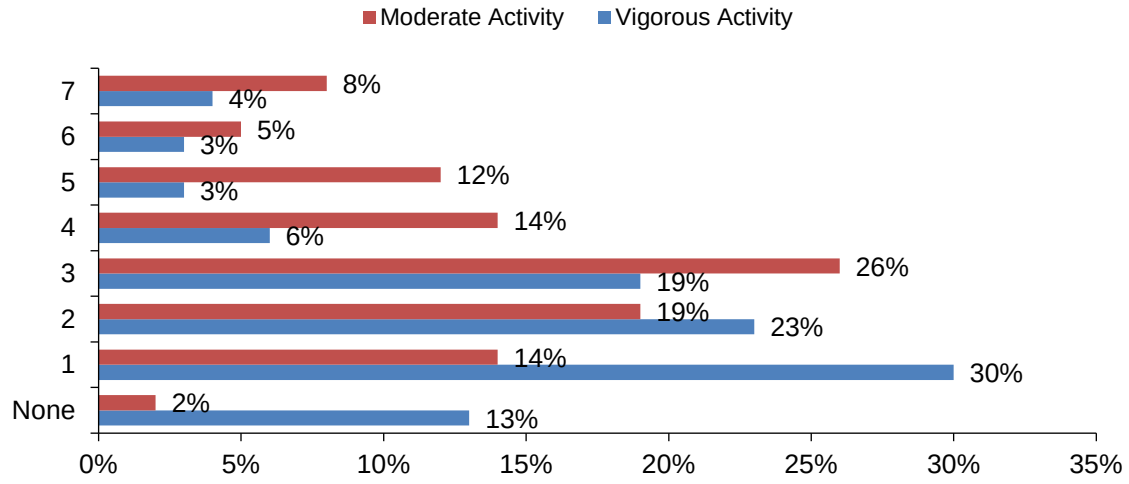
Food did not last until there was money to buy more

Thirteen percent of survey participants run out of food before they have money to purchase more.



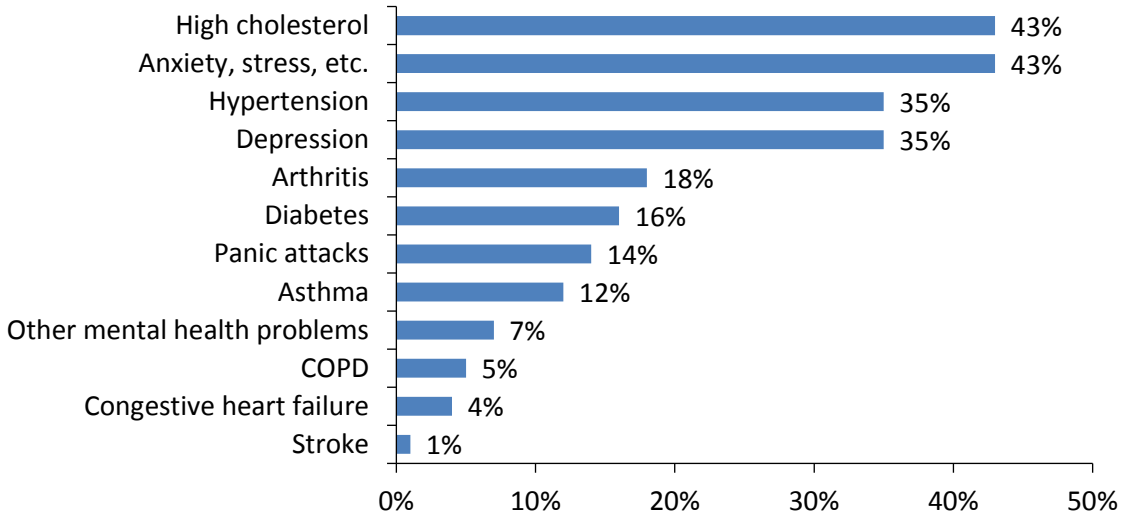
Days per week of physical activity

Sixty-five percent of survey participants have moderate physical activity three or more times each week.



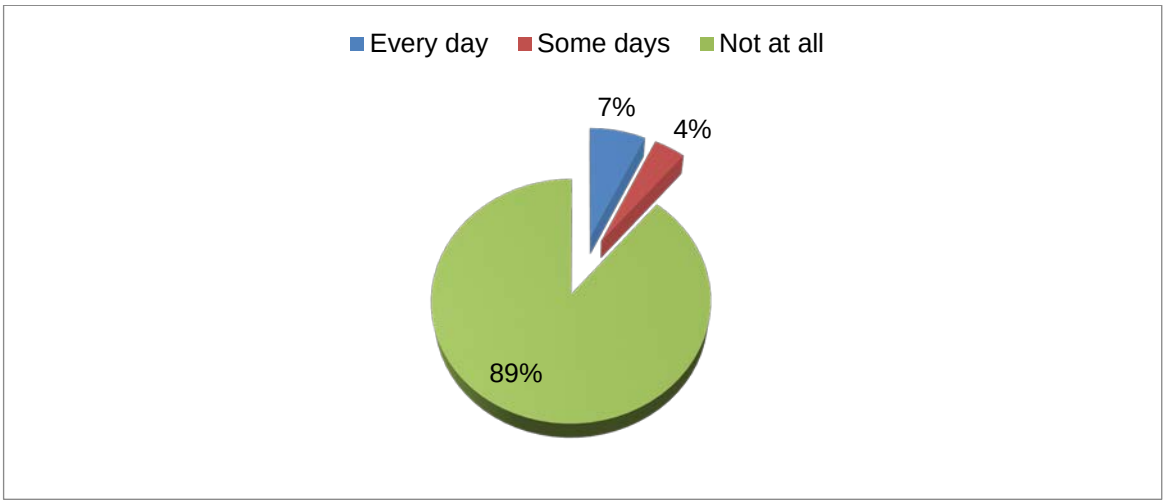
Past diagnosis

Depression and anxiety are ranking very high among survey participants. High cholesterol, anxiety, hypertension and depression are the top chronic disease issues among survey participants.



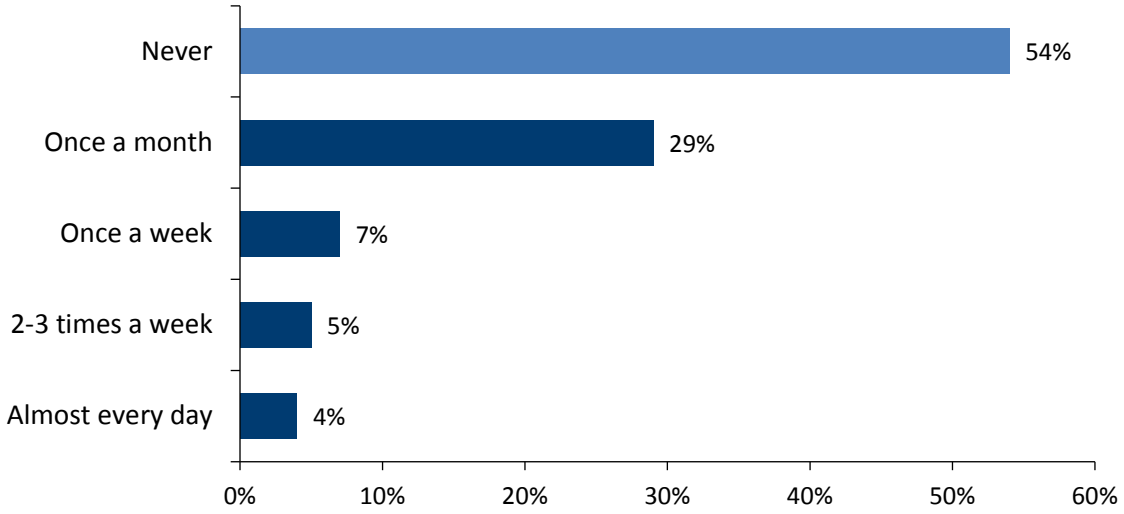
Tobacco Use

Eleven percent of survey participants currently smoke cigarettes. Sixteen percent smoke cigarettes every day.

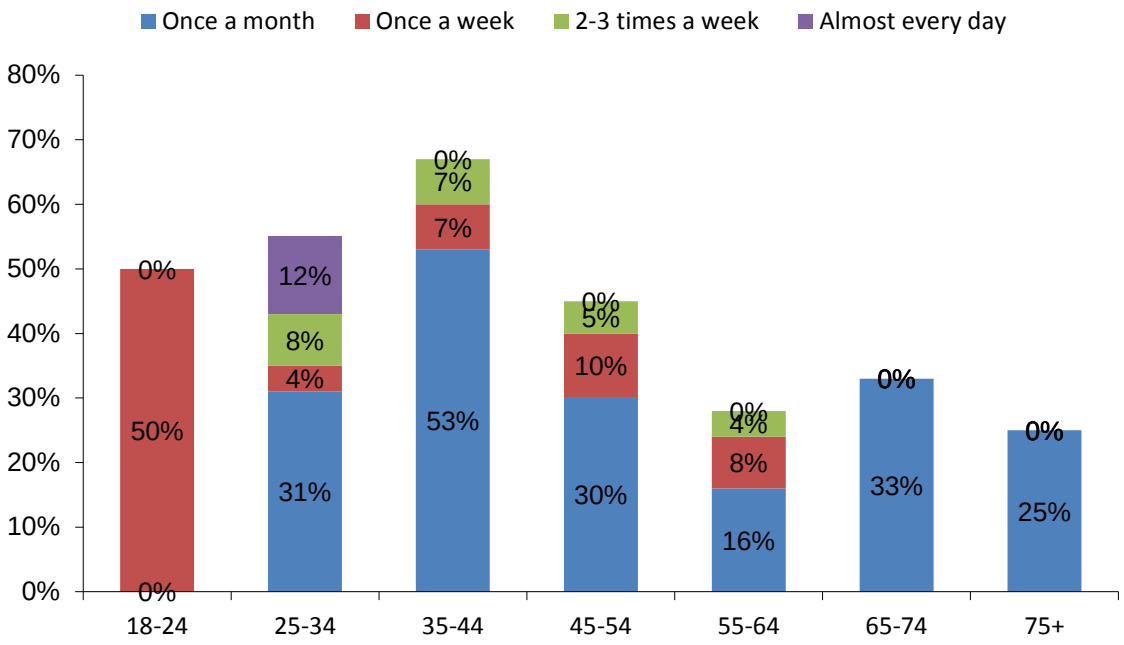


Binge drinking

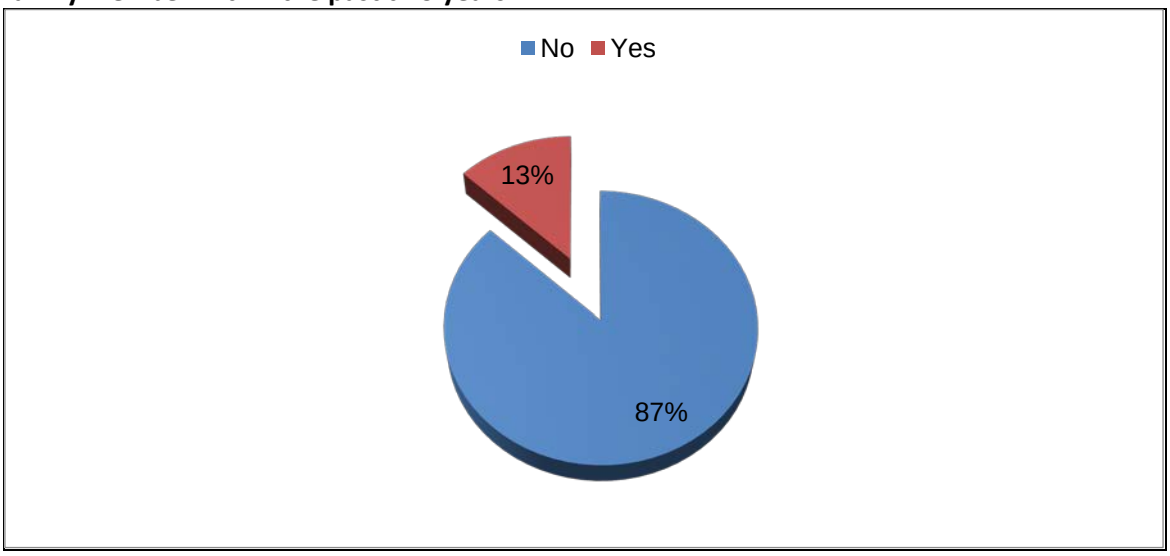
Forty-six percent of survey participants self-report that they binge drink at least once per month.



Binge drinking by age

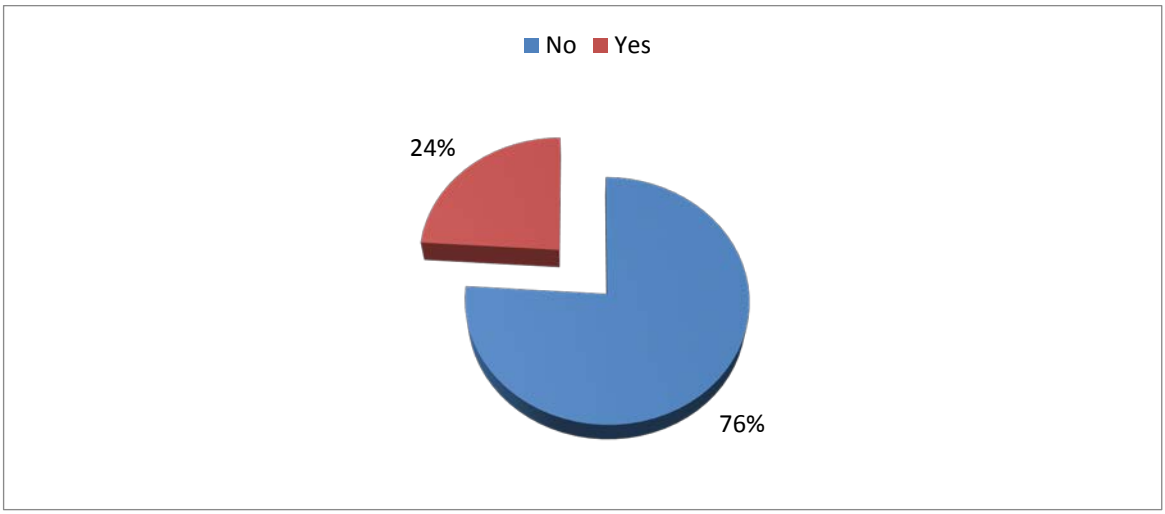


Thirteen percent of survey participants report that alcohol has had a harmful effect on themselves or a family member within the past two years.



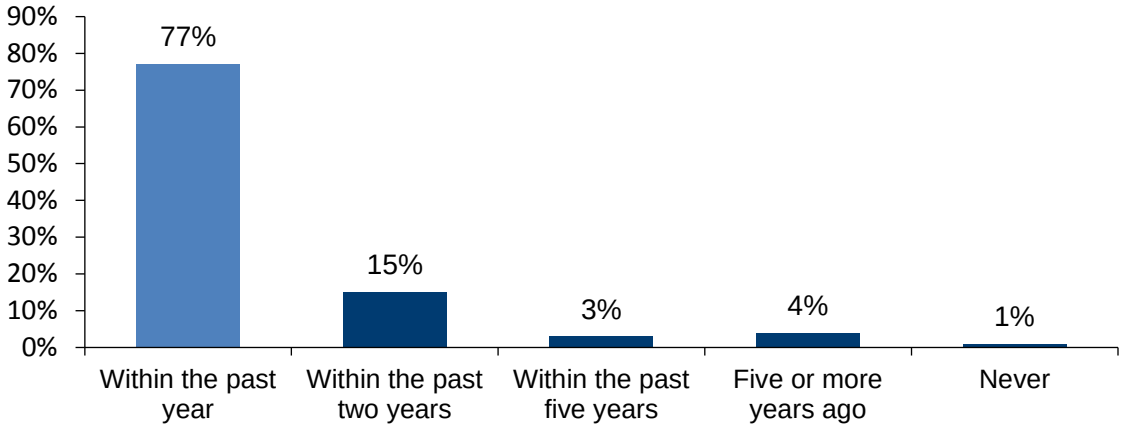
Do you have drugs in your home that are not being used?

Twenty-four percent have drugs in their home that they are no longer using.



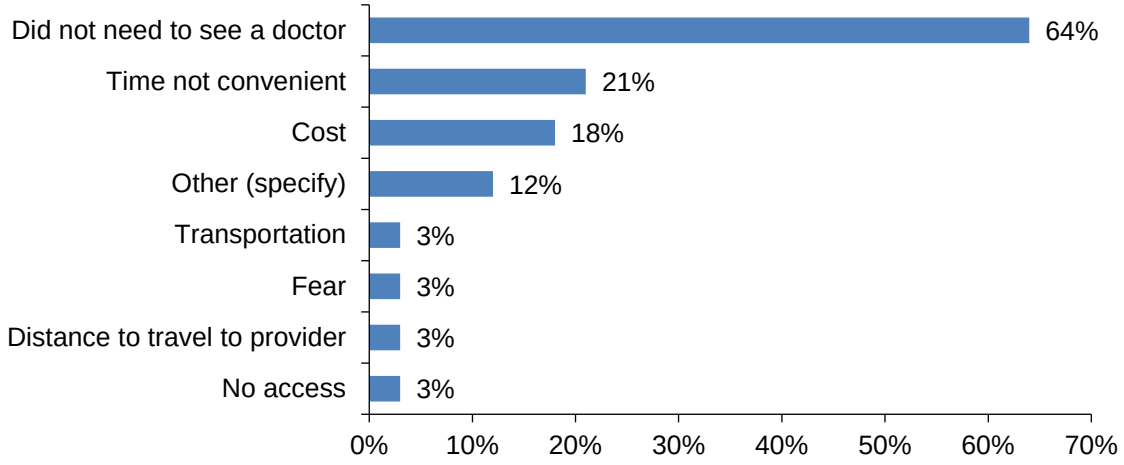
How long has it been since you visited a doctor or health care provider for a routine check-up?

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



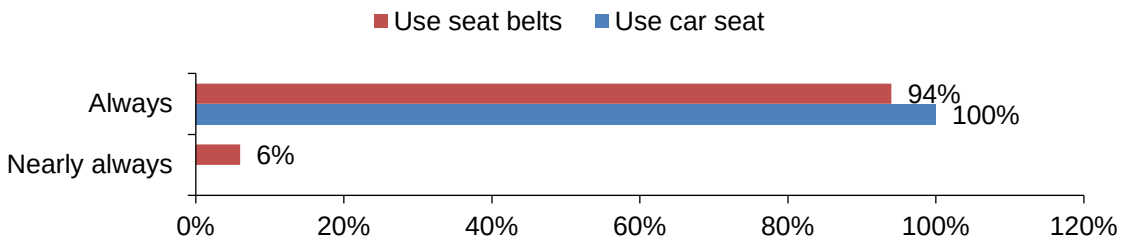
Barriers to routine check-up

Sixty-four percent of survey participants stated that they did not need to see a doctor in the past year.



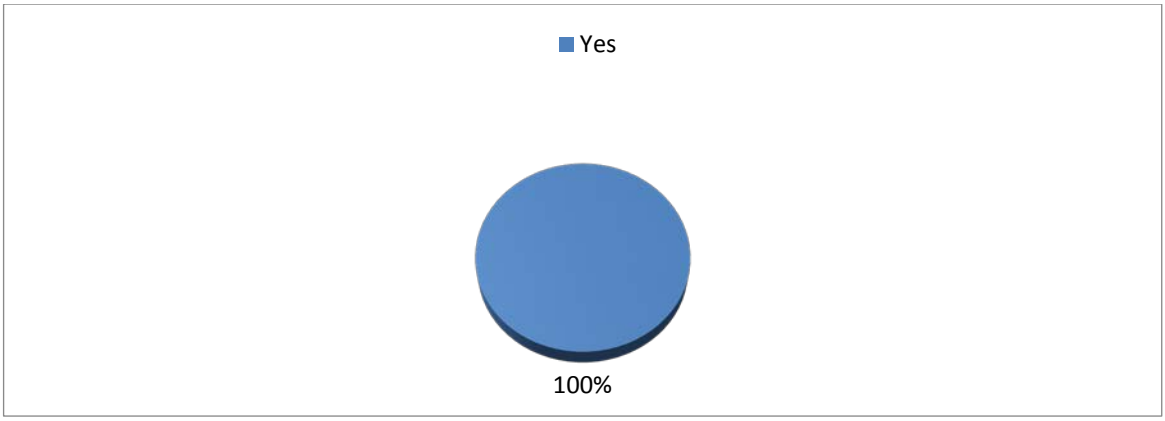
Child car safety

Six percent do not always use seat belts for their children but 100% percent use car seats.



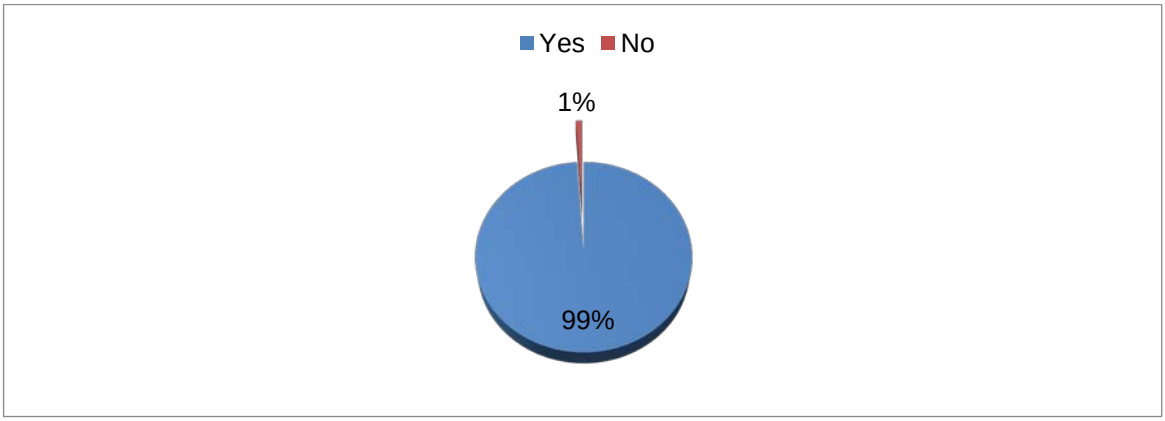
Do you have health care coverage for your children or dependents?

One hundred percent have health insurance for their children or dependents.

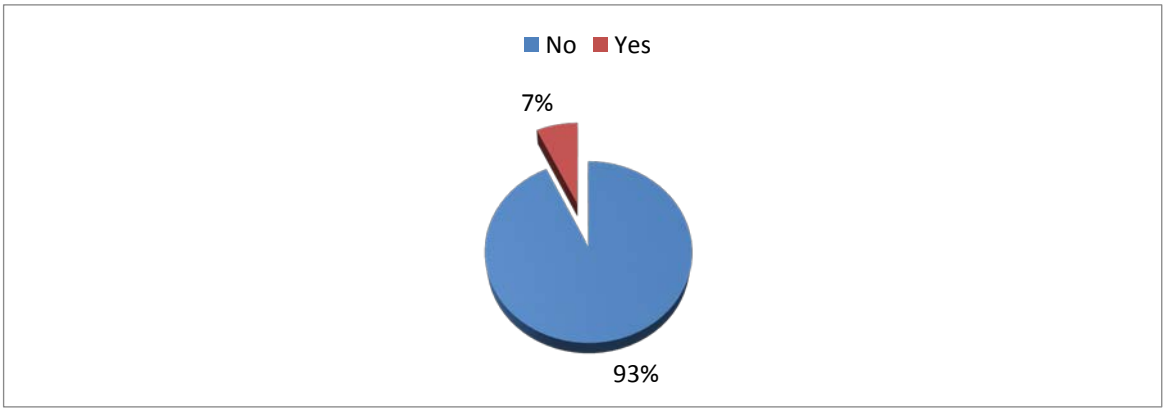


Do you currently have any kind of health insurance?

Only 1% of survey participants do not have health insurance.

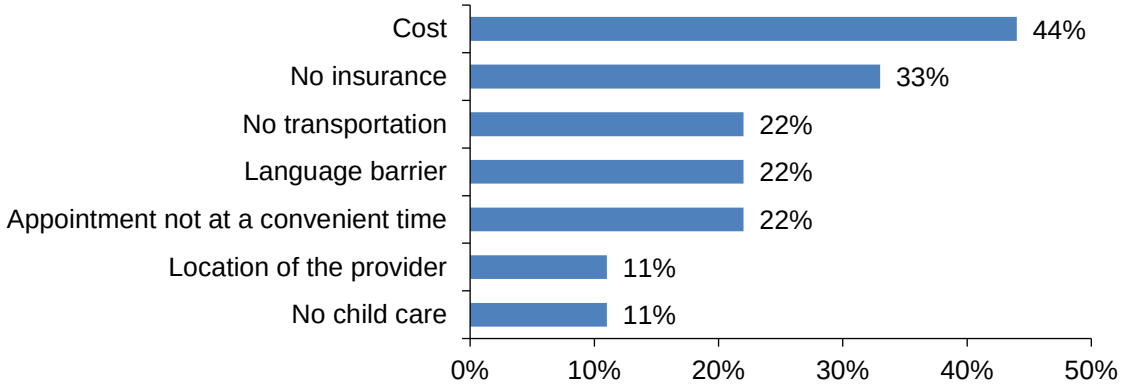


In the past year, did you or someone in your family need medical care, but did not receive the care they needed?
Seven percent report not receiving the café needed in the past year.



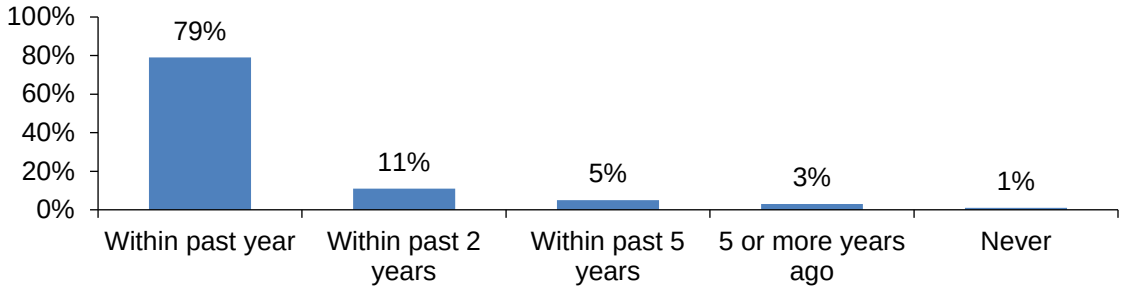
Barriers to Receiving Care Needed

Cost and no insurance coverage are the main barriers to receiving care.



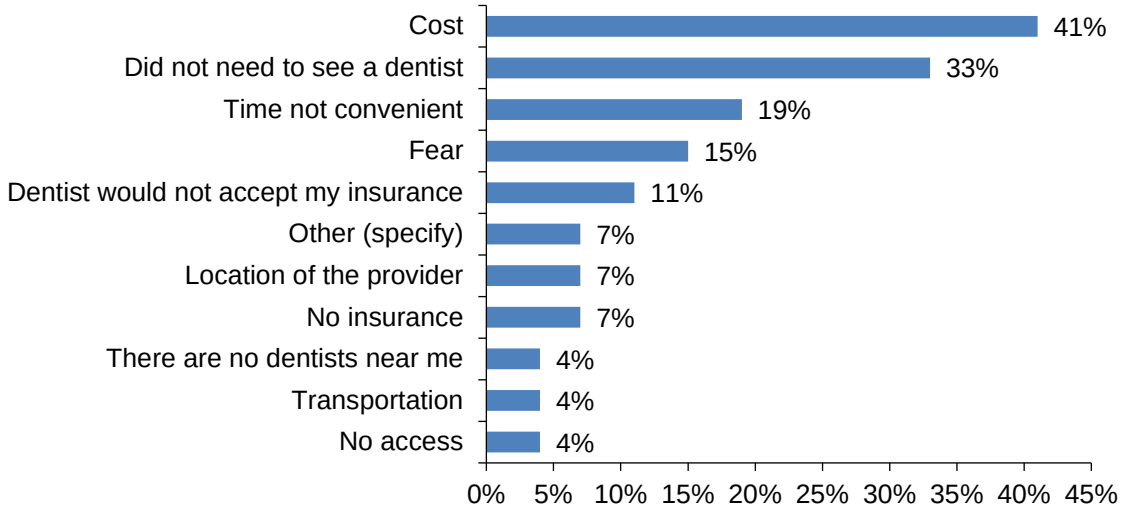
How long has it been since you visited a dentist?

Twenty percent of survey participants have not visited a dentist in more than a year.



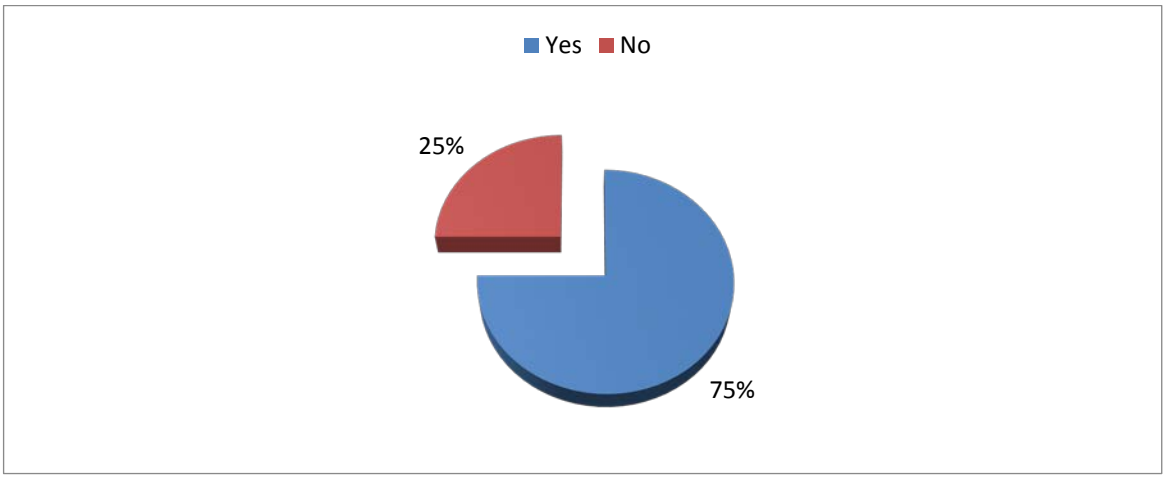
Barriers to visiting a dentist

Cost and convenient time are reported barriers to visiting a dentist.



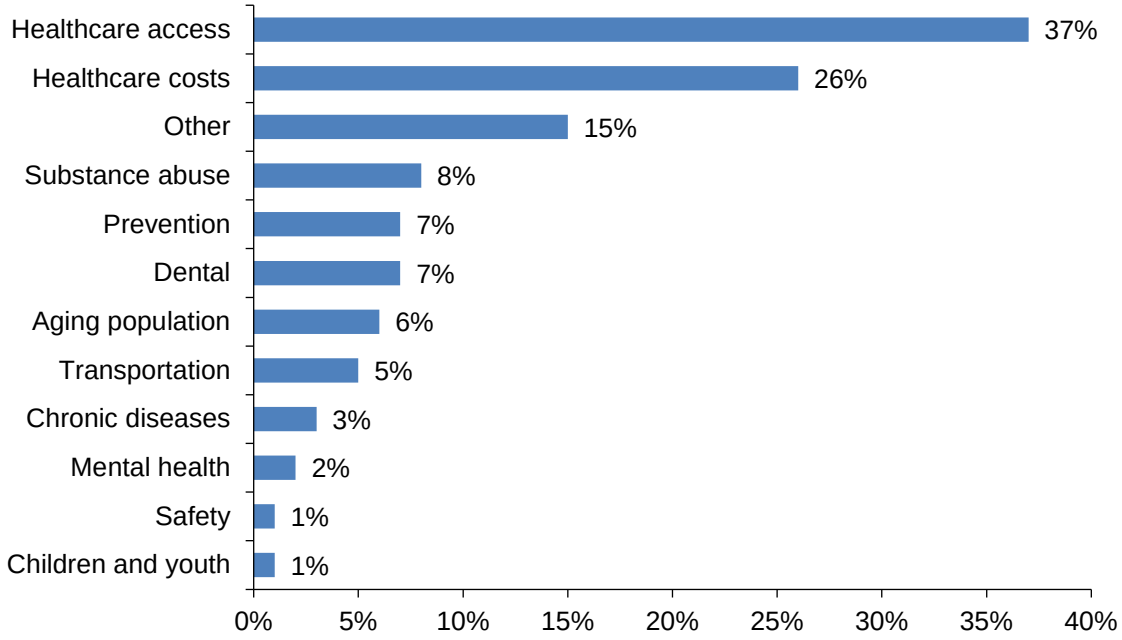
Do you have any type of dental insurance coverage?

Twenty-five percent of survey participant do not have dental insurance.



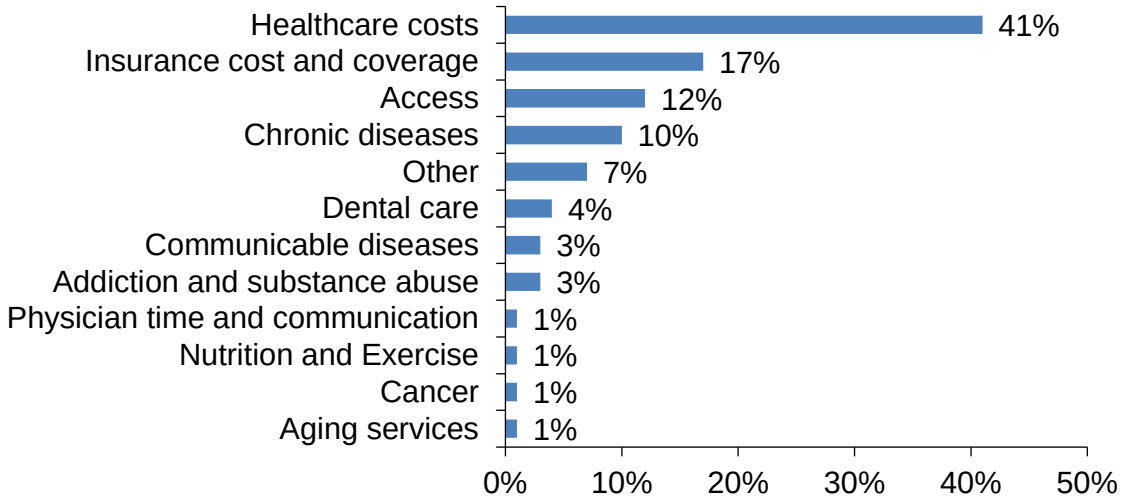
What are the most important community issues for you?

Access to healthcare is a high concern for 37% of survey participants and the cost of health care is a high concern for 26% of survey participants.



What are the most important community issues for your family?

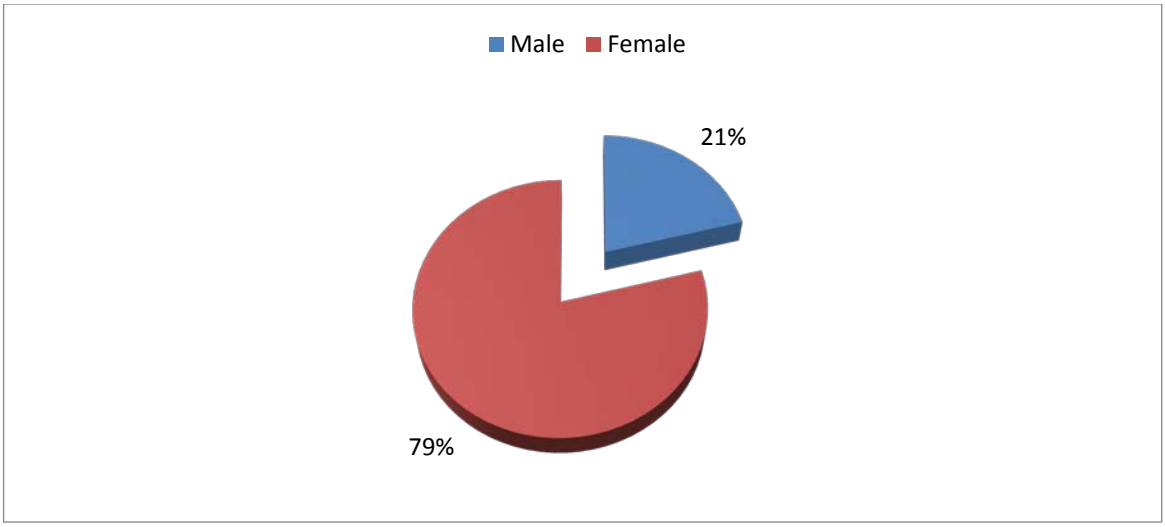
When asked what is the most important issue for the participant's family, health care cost and insurance cost and coverage that were the top concerns.



Demographic Information for Community Resident Participants

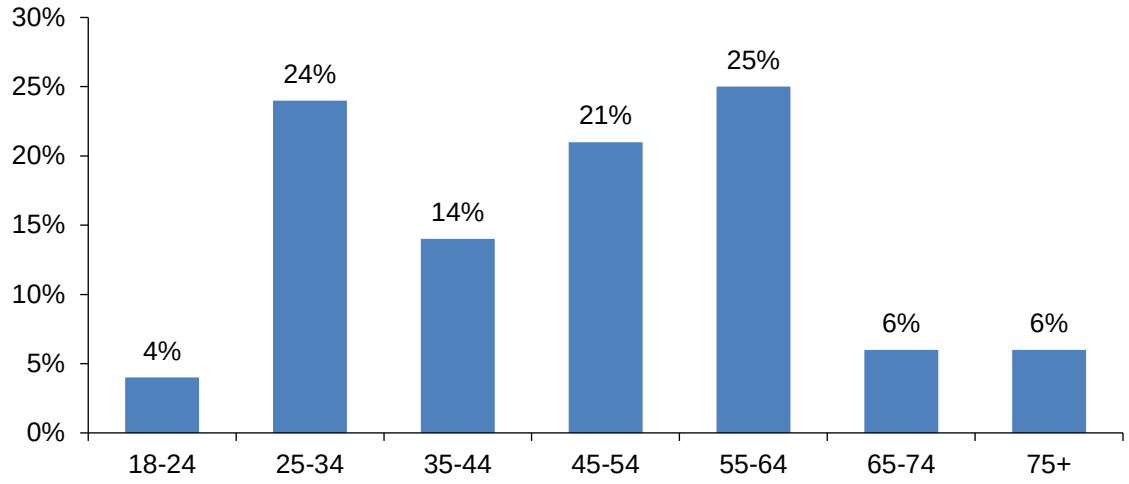
Biological Gender

Only 21% of the survey participants were male.

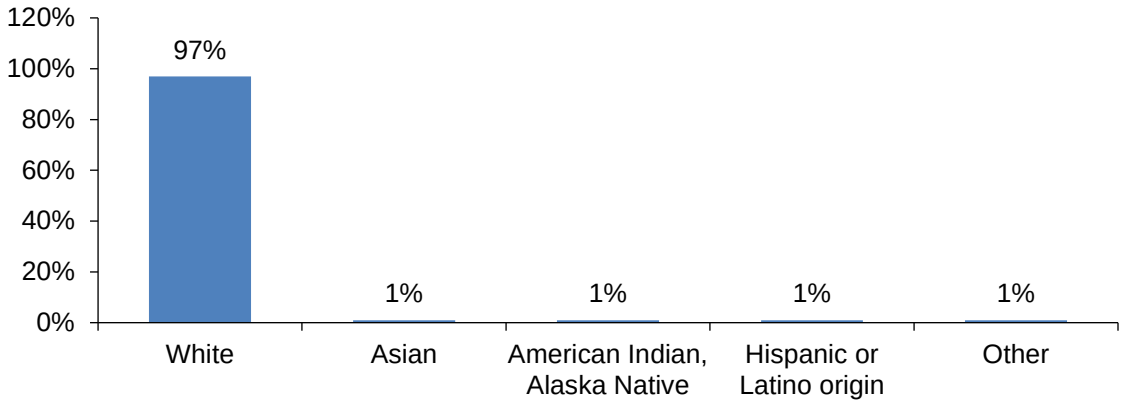


Age

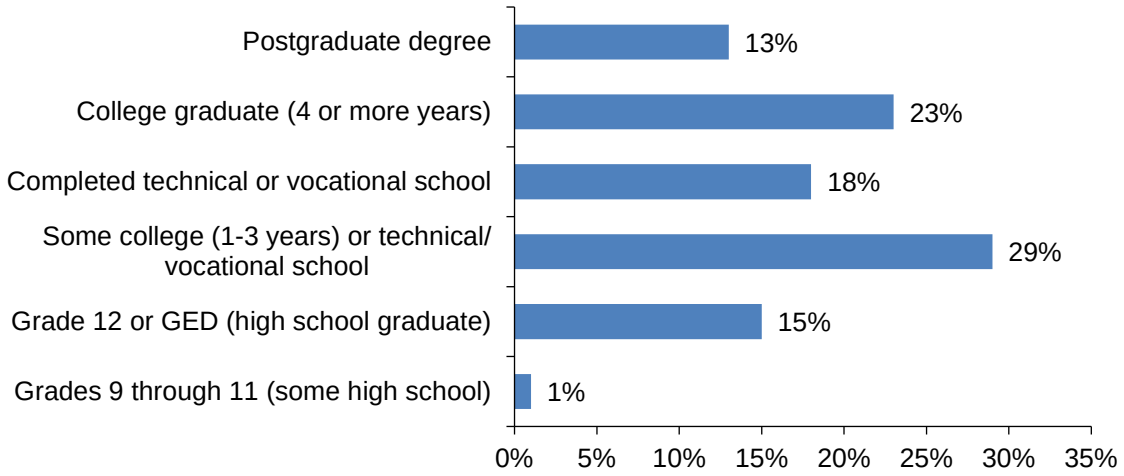
Every age group was represented among the survey participants.



Ethnicity

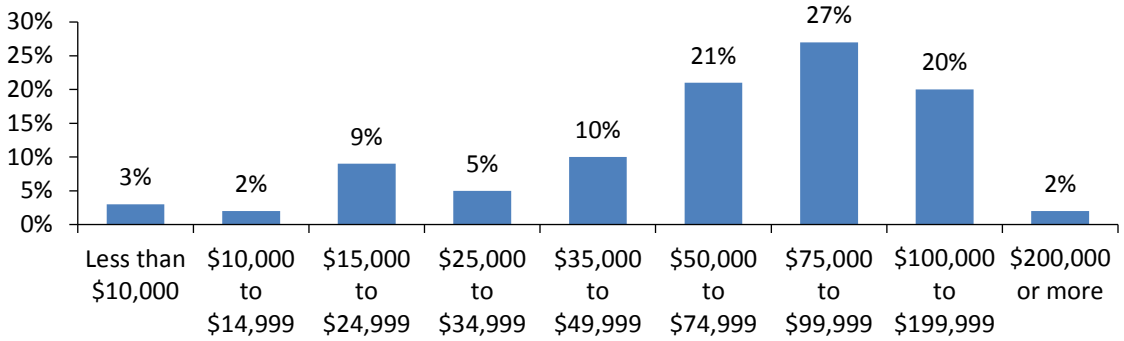


Education Level



Total Annual Household Income

Fourteen percent of survey participants have an annual household income at or below the FPL for a family of four.



Secondary Research Findings

Census Data

Population of Lyon County, Minnesota	25,669
% below 18 years of age	25.3
% 65 and older	15.0
% White – non-Hispanic	84.8
American Indian	0.8
Hispanic	6.4
African American	2.8
Asian	4.1
% Female	50.0
% Rural	47.9

County Health Rankings

	Lyon County	State of Minnesota	U.S. Top Performers
Adult smoking	16%	15%	14%
Adult obesity	29%	27%	26%
Physical inactivity	21%	20%	20%
Excessive drinking	26%	23%	13%
Alcohol-related driving deaths	13%	30%	13%
Food insecurity	10%	10%	10%
Uninsured adults	5%	6%	7%
Uninsured children	4%	3%	3%
Children in poverty	15%	13%	12%
Children eligible for free or reduced lunch	43%	38%	33%
Diabetes monitoring	92%	88%	91%
Mammography screening	75%	65%	71%
Median household income	$53,000	$65,100	$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.

Prioritization Worksheet

A multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies. Key community stakeholders met with medical center leaders to discuss community needs and complete the multi-voting exercise.

The following needs were brought forward for prioritization:

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 3.53 • Skilled labor workforce 3.53 • 11% report running out of food before they had money to buy more
Children and Youth • Childhood obesity 3.71 • Availability of quality childcare 3.65
Aging Population • Cost of long-term care 3.88 • Cost of memory care 3.88 • Availability of memory care 3.59
Safety • 24% report that they have drugs in their home that they are not using
Health Care Access • Availability of doctors, physician assistants or nurse practitioners 4.35 • Availability of mental health providers 4.18 • Access to affordable health insurance coverage 3.94 • Availability of behavioral health (substance abuse) providers 3.76 • Availability of specialist physicians 3.76 • Access to affordable health care 3.65 • Access to affordable prescription drugs 3.59 • Availability of non-traditional hours 3.53
Mental Health and Substance Abuse • 46% of residents self-report that they binge drink at least 1X/month • Depression 3.71 • 35% of residents report a diagnosis of depression • 43% report a diagnosis of anxiety/stress • Stress 3.59 • Dementia and Alzheimer's disease 3.53 • 11% currently smoke cigarettes
Wellness • 43% have a diagnosis of high cholesterol • 35% have a diagnosis of hypertension • 46% report that they are obese • 24% report that they are overweight

- 51% do not get the recommended 5 or more fruits/vegetables/day
- 35% do not get moderate exercise on 3 or more days/week
- 23% have not had a routine check-up in more than 1 year
- 16% have not had a flus shot this year
- 20% have not visited their dentist in more than 1 year

Please see the multi-voting prioritization worksheet in the Appendix.

How Sanford Tracy is Addressing the Needs

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

Identified Concerns	How Sanford Tracy is Addressing the Community Needs
ECONOMIC WELL BEING	
Employment options	Sanford is one of the largest employers in Tracy, MN. Any open positions are advertised locally. Additionally, city leaders were available to hear the findings of the CHNA research.
Skilled labor workforce	Sanford Tracy offers summer internship opportunities for high school and college students each year. In addition, training for current staff is a requirement. For example, all staff, including administration, must be certified in CPR every 2 years. Supporter of the Tracy Area Schools and St. Mary's Elementary School.
Run out of food before they have money to buy more – 11%	Sanford Tracy holds an internal fundraising campaign each year in March to raise dollars and collect food to donate to the local Tracy Food Shelf. Information about food resources is provided to patients
CHILDREN & YOUTH	
Childhood obesity	Sanford *fit*Club is provided for the Tracy Area Elementary 4th grade class. Sanford *fit* is offered weekly from January through the end of the school year. Sanford *fit* teaches students about eating right, exercising, getting enough rest, and emotional well-being.
Availability of quality childcare	Sanford Tracy does not directly provide childcare; however, a list of community resources is provided to patients.
AGING POPULATION	
Cost of long-term care	Sanford Tracy provides social workers to help patients with their long-term care decisions during discharge planning. Resources are available to help patients who leave Sanford Tracy and transfer to long-term care
Cost of memory care	Sanford Tracy does not provide memory care; however, Sanford Tracy provides social workers to help patients with their memory care decisions during discharge planning.
Availability of memory care	Sanford Tracy provides a directory of resources to help patients who transfer from Sanford Tracy to a memory care facility
SAFETY	
Have drugs in the home that are not being used – 24%	Sanford Tracy provides Information cards that include locations of drug drop-off sites. A prescription drug drop-off location is available at the Tracy police station from 8 a.m. to noon, Monday through Friday.
HEALTH CARE ACCESS	
Availability of doctors, physician assistants or nurse practitioners	Sanford Tracy has an active recruitment program working to secure additional full-time providers. There are locum providers who are in Tracy almost every day,
Availability of mental health providers	Mental health providers are available in the community and Sanford Tracy works to create awareness of the services by advertising mental health services.
Access to affordable health insurance coverage	Sanford Tracy has financial counselors available to help patients in need of financial assistance. Charity Care is available to qualified patients at a free or reduced rate. The Sanford Health Plan is advertised and marketed in the area.
Availability of behavioral health (substance abuse) providers	Mental health providers are available in the community and Sanford Tracy works to create awareness of the services by advertising mental health services.
Availability of specialist physicians	Specialist physicians and services are available at Sanford Tracy and Sanford Tracy works to create awareness of the services by advertising the specialist physicians.

Identified Concerns	How Sanford Tracy is Addressing the Community Needs
Access to affordable health care	Sanford Tracy has financial counselors available to help patients in need of financial assistance. Charity Care is available to qualified patients at a free or reduced rate. The Sanford Health Plan is advertised and marketed in area.
Access to affordable prescription drugs	Sanford Tracy has financial counselors available to help patients in need of financial assistance. The Sanford Health Plan is advertised and marketed in area.
Availability of non-traditional hours	Sanford Health Tracy Clinic is open with appointments starting at 8 a.m. Monday through Friday. Sanford Health Tracy Clinic Saturday hours are available from 9 a.m. – 12 p.m.
MENTAL HEALTH & SUBSTANCE ABUSE	
• Binge drink at least 1 x / month – 46% • Depression • Diagnosis of depression – 35% • Diagnosis of anxiety/stress – 43% • Stress • Dementia & Alzheimer's Disease • Currently smoke cigarettes – 11%	Sanford Tracy has behavior health providers embedded into the Sanford Health Tracy Clinic to help with various mental health issues. Sanford Tracy primary care providers work with the mental health providers for referrals and proper placement. Sanford Tracy has two MSW (Master Social Workers) on staff to help with resources and identifying abuse issues.
WELLNESS	
• Diagnosed with high cholesterol – 43% • Diagnosed with hypertension – 35% • Obese – 46% • Overweight – 24% • Do not eat 5+ fruits/vegetables each day – 51% • Do not get moderate exercise at least 3 x / week – 35% • Have not had a routine check-up in more than 1 year – 23% • Have not had a flu shot this year – 16% • Have not seen their dentist in more than 1 year – 20%	Sanford Tracy has an RN Health Coach and is a certified Medical Home. Both help to monitor and help patients with compliance of their health care. Sanford Tracy offer preventive services, screenings and wellness services, including public education on different chronic diseases annually, education and screening during their annual Health Fair and at community events. Sanford Tracy promotes Sanford Profile and Sanford *fit* programs. The Sanford Tracy Wellness Director has offered exercise "boot camps" for the public. Additional resources are available at Sanford Tracy regarding chronic illness, diet and nutrition. Sanford Tracy also provides dietitian services.

Implementation Strategies

Implementation Strategies – 2019-2021

Priority 1: Wellness

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 Tracy 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.

Priority 2: Health Care Access

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

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

Community Health Needs Assessment
Implementation Strategy Action Plan
2019 - 2021

<u>Priority #1</u> - Wellness

Projected Impact: Improvement in physical and chronic health and overall wellness of Tracy community members

Goal 1: Utilize dietitian services

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Increase awareness and utilization of dietitian services to reach patients with chronic conditions	Increase in number of telemedicine visits with dietitian	Medical Staff/ RN Health Coach	Sammons/ Kolar/ LeTendre	N/A

Goal 2: Provide needed medical supplies to low income and in-need patients

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Utilize grant funding from the United Way of Southwest Minnesota to start pilot program to provide medical supplies to low income and in-need patients	Purchase medical supplies with seed money from UWSWMN	RN Health Coach/ Diabetic Educator/ Medical Staff	LeTendre/Alms	Grant monies received from United Way of Southwest MN
Present project at medical staff and nursing staff meetings	All medical staff and nursing staff educated on resources/project	RN Health Coach/ Diabetic Educator	LeTendre/Alms	N/A

Goal 3: Expand Sanford *fit* program

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Utilize Sanford *fit* club program in Tracy Area Elementary 4th Grade	Complete annual 19-week program	Community Relations	Clouse	Tracy Area Elementary School
Increase awareness and utilization of Sanford's *fit* online resources	Distribute flyers in clinic, hospital and schools	Community Relations	Clouse	Tracy Area Elementary School
Increase awareness and utilization of Sanford's *fit* family and daycare platforms	Present Sanford *fit* at one parent event and to local daycare providers	Community Relations	Clouse	Tracy Area Elementary School/ Local Daycares

<u>Priority 2:</u> Health Care Access

Projected Impact: Improved access to health care through education and awareness

Goal 1: Awareness of mental health telemedicine services and local behavioral health providers available to patients

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Create awareness of mental health and behavioral health providers and services available at Sanford Tracy	Availability of Services communicated to public at least twice a year	Community Relations	Clouse	Southwest Health and Human Services/ Southwest Mental Health Center
Referrals	Availability of services communicated to outside providers and facilities	Clinic/Community Relations	Clouse Behavioral Health Team Sammons	Southwest Health and Human Services/ Southwest Mental Health Center

Goal 2: Increase of specialist physicians to outreach clinic

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Work with Sanford Health specialty clinics in Sioux Falls to get new specialists to come to Tracy outreach clinic	1-2 new specialists over next 3 years, along with maintaining current specialists	Outreach Clinic	Barstad/Lamb/Schons	N/A

Goal 3: Provide needed medical supplies to low-income and in-need patients

Actions/Tactics	Measurable Outcomes & Timeline	Dedicated Resources	Leadership	Note any community partnerships and collaborations - if applicable
Utilize grant funding from the United Way of Southwest Minnesota to start pilot program to provide medical supplies to low income and in-need patients	Purchase medical supplies with seed money from UWSWMN	RN Health Coach/ Diabetic Educator/ Medical Staff	LeTendre/Alms	Grant monies received from United Way of Southwest MN
Present project at medical staff and nursing staff meetings	All medical staff and nursing staff educated on resources/project	RN Health Coach/ Diabetic Educator	LeTendre/Alms	N/A

Demonstrating Impact
2017-2019 Implementation Strategies

Priority 1: **Mental Health**

Projected Impact: To help with access and overall awareness of community of resources for mental health services

Goal 1: Decrease the time that patients are in the ER prior to placement

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community Partnerships and Collaborations
Continue discussion on holding patients and resources to help with placing patients quickly	Track and evaluate turnaround time for patients who come into ER and placement availability	State of MN, State Bed Tracker, Providers and Nursing Staff	Barstad/ Schons/ Deadrick-Nelson Wee	Local police and ambulance departments for transportation

Goal 2: Awareness of treatment of drug programs to community members

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community Partnerships and Collaborations
Work with community partners to create new recovery program options for community members	Alcohol and Drug Treatment program(s) awareness is marketed to community providers	Public Health, Community and City Leaders	Behavioral Health Team/ Barstad/ Sammons	City of Tracy leaders/Lyon County Public Health

Goal 3: Work with Minnesota Department of Health on pilot project for integrating behavioral health into Critical Access Hospitals

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community Partnerships and Collaborations
The National Rural Health Resource Center's - Rural Health Innovations has received a Flex grant for our office to provide technical assistance for improving the health of rural communities by increasing communication, partnership and collaboration among Critical Access Hospitals, behavioral and mental health providers and other community partners	Successfully having more of a presence of behavioral health resources and providers in our Critical Access Hospital at Sanford Tracy	MN Dept. of Health, Community Partners	Barstad Schons Sammons Luft	Lyon County Public Health

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

Projected Impact: To help community improve their physical health and overall chronic health conditions

Goal 1: Medical Home and RN Health Coach utilization

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community Partnerships and Collaborations
Increase awareness and utilization of Medical Home and RN Health Coach to reach obese patients	Track through running patient registry and follow up on eligible patients	Medical Staff/ RN Health Coach	Sammon/Kolar/ Morman	N/A

Goal 2: Sanford *fit* Kids utilization

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community Partnerships and Collaborations
Work with Sanford *fit* Kids and work with community to bring this service more visibility	Presentations at school and at various community groups	Medical Staff/Schools/ Athletic Trainer/ Marketing	Clouse/Radke/ Barstad	Tracy Public Schools

Demonstrating Impact through Outcomes
2017-2019

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 Tracy Medical Center, the top priorities addressed through an implementation strategy process include:

1) Mental Health
2) Physical Health

Mental Health

Goal 1: **Decrease the time that patients are in the ER prior to placement**

- Goal 2: Work with community partners to create new recovery program options for community members
- Goal 3: Work with Minnesota Department of Health on pilot project for integrating behavioral health into Critical Access Hospitals

The mental health strategy continues to be a top priority and a work in progress for Sanford Tracy. Work continues on implementation of a telehealth behavioral health placement program for the Sanford Tracy emergency room. Mental health placement has been and continues to be a major issue throughout the state of Minnesota, especially in rural areas. Although the Minnesota Department of Health project did not come to fruition, Sanford continues to search for opportunities to develop and grow behavioral health services in Tracy. Sanford provides child psychiatric care via telemedicine and a family nurse practitioner and two LICSWs providing behavioral health services. Sanford continues to seek additional specialists and telemedicine opportunities for Sanford Tracy. Sanford Tracy has worked to make the public and community partners aware of the services available through advertising and promotion. This includes mental health presentations by providers at community groups like Kiwanis, print and digital advertising, and informational newspaper articles. Updated informational materials, in process of creation, will inform both patients and area providers (at other hospitals and clinics) of Sanford behavioral health services.

Physical Health

- Goal 1: Medical Home and RN Health Coach utilization
- Goal 2: Sanford *fit* Kids utilization
- Goal 3: Utilizing Sanford Profile services

Sanford Tracy has increased the local patient chronic conditions registry and demonstrated improvement in the Minnesota measurement scores. The Sanford RN Health Coach has been instrumental in reaching and following up with patients with chronic conditions. The RN Health Coach continues to work closely with providers, to reach and help patients to manage their chronic illnesses.

Starting in January of 2016, Sanford Tracy completed a 19-week Sanford *fit* program with the Tracy Area Elementary School 4th grade classes. The program was a customized version of Sanford *fit*Club. Two Sanford Tracy staff members met with the Tracy Area Elementary 4th grade physical education classes once a week (Wednesdays) for 25 minutes each. The students learned all about Sanford *fit* and making good, healthy choices regarding their food, move (exercise), mood and recharge (sleep/rest). In addition, the students had

weekly challenge cards they took home to complete during the remainder of the week. This included having their parents or guardians sign their challenge cards to receive credit. When bringing back completed challenge cards, students worked their way towards end of the year prizes, but also took home activities and exposed their families' to *fit*. The program completed its second year in May of 2018. After a successful pilot year, at the beginning of the 2018 program the students completed a *fit*club "test". The students would take this test again in May after 19 weeks of learning about *fit*. The students increased their correct answers by more than 24% from the first test to the last. Each week, the Sanford Tracy staff could see the students engaging and absorbing the information through the fun activities. The program received positive feedback by the Tracy Area Elementary School physical education teacher and principal and will continue into the coming years.

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 Tracy Medical Center's CHNA.

Appendix

Primary Research

TRACY ASSET MAP

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
Economic Well Being	Employment options 3.53 Skilled labor workforce 3.53	11% report running out of food before they had money to buy more	10% food insecurity	Employment resources: • Economic Development Assn., 336 Morgan St., Tracy Major Employers: • Tracy School District, 934 Pine St., Tracy • Sanford Tracy, 249 – 5th St. E., Tracy • City of Tracy, 336 Morgan St., Tracy • Tracy Food Pride, 1105 Morgan St, Tracy • North Star Homes, 900 – 4th St. E., Tracy • Minnwest Bank, 250 – 3rd St., Tracy • Premium Plant Services, 900 – 4th St. E., Tracy • Harvest States, 301 South St., Tracy Food resources: • Grocery Stores: o Tracy Food Pride, 1105 Morgan St., Tracy o Tracy Food Market, 701 Craig Ave., Tracy o Super Oriental Market, 136 – 3rd St., Tracy o Asia Grocery, 106 – 3rd St., Tracy • Tracy Farmers Market, 1045 Craig Ave., Tracy • Kitchen Table Food Pantry, 231 – 2nd St., Tracy • CSAs within 1 hr. of Tracy: o Schreier Farm, 2135 – 191st St., Tracy o Gardner Bees, 28260 – 130th St., Sleepy Eye o Kleine's Country Farm, 26471 – 370th Ave., Westbrook o Omega Maiden Oils, 37574 co. Rd. 11, Lamberton o Holmberg Orchard, 12697 – 325th St., Vesta o Jubilee Fruits & Vegetables, 1310 Mtn. Lk. Rd., Mountain Lake o Krienke Foods, 35584 Co. Rd. 8, Mountain lake

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				○ Ron's Veggies, 86750 – 150th St., Sacred Heart ○ Sonja's Farm Fresh, 8157 – 160th St., Sacred Heart • WIC, 607 W. Main, Marshall • SNAP, 607 W. Main, Marshall
Children & Youth	Childhood obesity 3.71 Availability of quality child care 3.65		15% children in poverty Children eligible for free and reduced lunch 43%	Childhood Obesity resources: • Sanford Clinic, 249 – 5th St. E., Tracy • Sanford dieticians, 249 – 5th St. E., Tracy • Sanford Fit Kids – sanfordfit.org • Public Health Dept., 607 W. Main, Tracy • Parks & Playgrounds: ○ Greenwood Park, Greenwd. Ave. & Adams St., Tracy ○ Legion Park, Craig & 10th Streets, Tracy ○ Tornado Memorial Park, Hwy 14 & 5th St., Tracy ○ Central Park, 2nd & Rowland Sts., Tracy ○ Roadside Park, Hwy 14 & Center St., Tracy ○ Swift Lake Park, 1342 Co. Rd. 11, Tracy ○ Nehl's Park, Hwy 14, Tracy ○ Softball Complex, behind 900 – 4th St. E., Tracy ○ Werner Park, E. Hollett & 1st St., Tracy ○ Sebastian Park, 2nd St. E. & Elm St., Tracy Child Care resources: • Kids World, 310 Pine St., Tracy • Gwen Andree, 237 State St., Tracy • Lavonne Johnson, 3rd St., Tracy • Gloria Klein, Morgan St., Tracy • Donna Lanoue, Maple Ln, Tracy • Tonia Nordsiden, Adams St., Tracy • Wee World Preschool, 162 Morgan, Tracy
Aging Population	Cost of long term care 3.88 Cost of memory care 3.88 Availability of memory care 3.59		15% - 65 years and older	Long Term Care resources: • Prairie View Health Care Center, 2250 – 5th St. E., Tracy Memory Care resources: • Prairie View Health Care Center, 2250 – 5th St. E., Tracy • Alzheimer's Disease, alz.org

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
Safety	24% report that they have drugs in their home that they are not using	24% report that they have drugs in their home that they are not using	Excessive drinking 26% Alcohol impaired driving deaths 13%	Drug Take-Back Programs: • Lyon Co. Law Enforcement Center, 611 W. Main, Marshall • Murray Co Sheriff, 2500 -28th St., Slayton
Health Care Access	Availability of doctors, physician assistants or nurse practitioners 4.35 Availability of mental health providers 4.18 Access to affordable health insurance coverage 3.94 Availability of behavioral health (substance abuse) providers 3.76 Availability of specialist physicians 3.76 Access to affordable health care 3.65 Access to affordable prescription drugs 3.59 Availability of non-traditional hours 3.53		Uninsured 5%	Mental Health resources: • Sanford Tracy, 249 – 5th St. E., Tracy • Prairie View Health Care Center, 250 – 5th St. E., Tracy • Southwest Health & Human Services (serving Lyon Co.), 607 W. Main, Marshall • Helping to Heal (counselor), 192 – 3rd St., Tracy Health Insurance resources: • Sanford Health Plan, 300 N. Cherapa Place, Sioux Falls • MNSure – MNSure.org • State Farm, 125 – 4th St., Tracy • Insurance Advisors, 379 Morgan, Tracy Substance Abuse resources: • Project Turnabout, 1220 Birch St., Marshall Health Care resources: • O'Brien Court, 410 State St., Tracy • Sanford Tracy, 249 – 5th St. E., Tracy • Prairie View Health Care Center, 250 – 5th St. E., Tracy • Tracy Ambulance Service, 105 Center St., Tracy • Public Health Dept., 607 W. Main, Tracy Prescription Assistance programs: • CancerCare co-payment assistance, 800-813-4673 • Freedrugcard.us • Rxfreecqrd.com • Medsavercard.com • Yourrxcard.com • Medicationdiscountcard.com • Needymeds.org/drugcard • Caprxprogram.org • Gooddaysfromcdf.org • NORD Patient Assistance Program, rarediseases.org • Patient Access Network Foundation, panfoundation.org

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• Pfizer RC Pathways, pfizerRX pathways.com • RXhope.com • Prescriptionassistance.info • Minnesota Care – 1-800-657-3761 • MN Drug Card – mndrugcard.com • Partnership for Prescription Assistance – pparx.org/intro.php • Benefitscheckup.org • RxAssist – rxassist.org • RxOutreach – rxoutreach.com • Together RX Access Program – togetherrxaccess.com • Glaxo Smith Kline – bridgestoaccess.gsk.com • Merck – merck.com/merkhelps • Novartis – patientassistncenow.com • Pfizer – pfizerhlepfulanswers.com • AARP Prescription Discount Program – aarppharmacy.com • PlanPlus – planplushealthcare.com • FamilyWize – familywise.org
Mental Health & Substance Abuse	46% of residents self-report that they binge drink at least 1x/month Depression 3.71 35% of residents report a diagnosis of depression 43% report a diagnosis of anxiety/stress Stress 3.59 Dementia and Alzheimer's Disease 3.53 11% currently smoke cigarettes	46% of residents self-report that they binge drink at least 1x/month 35% of residents report a diagnosis of depression 43% report a diagnosis of anxiety/stress 11% currently smoke cigarettes	Excessive drinking 26%	Substance Abuse resources: • Project Turnabout, 1220 Birch St., Marshall Mental Health resources: • Sanford Tracy, 249 – 5th St. E., Tracy • Southwest Health & Human Services, 607 W. Main, Marshall • Avera Behavioral Health, 300 S. Bruce St., Marshall • Western Mental Health Center, 1212 E. College Dr., Marshall Dementia/Alzheimer's resources: • Sanford Tracy, 249 – 5th St. E., Tracy • Prairie View Health Care Center, 250 – 5th St. E., Tracy Tobacco Cessation resources: • Sanford Tracy, 249 – 5th St. E., Tracy • Public Health Dept., 607 W. Main, Tracy • QuitPlan, MN Dept. of Health – 651-201-5000 • Southwest Health & Human Services, 607 W. Main, Marshall

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				• ClearWay MN – Clearwaymn.org
Wellness	43% have a diagnosis of high cholesterol 35% have a diagnosis of hypertension 46% report that they are obese 24% report that they are overweight 51% do not get the recommended 5 or more fruits/vegetables per day 35% do not get moderate exercise on 3 or more days/week 23% have not had a routine check-up in more than 1 year 16% have not had a flu shot this year 20% have not visited their dentist in more than 1 year	43% have a diagnosis of high cholesterol 35% have a diagnosis of hypertension 46% report that they are obese 24% report that they are overweight 51% do not get the recommended 5 or more fruits/vegetables per day 35% do not get moderate exercise on 3 or more days/week 23% have not had a routine check-up in more than 1 year 16% have not had a flu shot this year 20% have not visited their dentist in more than 1 year	Adult obesity 29% Adult smoking 16%	Chronic Disease resources: • Sanford Tracy, 249 – 5th St. E., Tracy • Sanford Medical Home, 249 – 5th St. E., Tracy • Sanford's Better Choices Better Health, 249 – 5th St. E., Tracy • Public Health Dept., 607 W. Main, Tracy • American Heart Assn. – heart.org Obesity resources: • Sanford Tracy, 249 – 5th St. E., Tracy • Sanford dieticians, 249 – 5th St. E., Tracy • Public Health Dept., 607 W. Main, Tracy Healthy Eating resources: • Grocery Stores: o Tracy Food Pride, 1105 Morgan St., Tracy o Tracy Food Market, 701 Craig Ave., Tracy o Super Oriental Market, 136 – 3rd St., Tracy o Asia Grocery, 106 – 3rd St., Tracy • Tracy Farmers Market, 1045 Craig Ave., Tracy • CSAs within 1 hr. of Tracy: o Schreier Farm, 2135 – 191st St., Tracy o Gardner Bees, 28260 – 130th St., Sleepy Eye o Kleine's Country Farm, 26471 – 370th Ave., Westbrook o Omega Maiden Oils, 37574 co. Rd. 11, Lamberton o Holmberg Orchard, 12697 – 325th St., Vesta o Jubilee Fruits & Vegetables, 1310 Mtn. Lk. Rd., Mountain Lake o Krienke Foods, 35584 Co. Rd. 8, Mountain lake o Ron's Veggies, 86750 – 150th St., Sacred Heart o Sonja's Farm Fresh, 8157 – 160th St., Sacred Heart

Identified concern	Key stakeholder survey	Resident survey	Secondary data	Community resources available to address the need
				Physical Activity resources: • Fitness Depot, 600 E. Union St., Tracy • Sanford Fit Kids – sanfordfit.org • Parks & Recreation Dept., 336 Morgan St., Tracy • School District activities, 934 Pine St., Tracy • Golf, 10752 US 14, Tracy • Tracy Aquatic Center, 283 Elm, Tracy • Tracy Bowling Lanes, 242 Morgan, Tracy • Softball Complex, E. Craig Ave., Tracy • Mountain Bike Trail, 2683 - 234th Ave., Marshall • Hiking & Biking Trails • Parks & Playgrounds: o Greenwood Park, Greenwd. Ave. & Adams St., Tracy o Legion Park, Craig & 10th Streets, Tracy o Tornado Memorial Park, Hwy 14 & 5th St., Tracy o Central Park, 2nd & Rowland Sts., Tracy o Roadside Park, Hwy 14 & Center St., Tracy o Swift Lake Park, 1342 Co. Rd. 11, Tracy o Nehl's Park, Hwy 14, Tracy o Softball Complex, behind 900 – 4th St. E., Tracy o Werner Park, E. Hollett & 1st St., Tracy o Sebastian Park, 2nd St. E. & Elm St., Tracy **Routine Check-up/Flu Shot resources:** • Sanford Tracy, 249 – 5th St. E., Tracy • Public Health Dept., 607 W. Main, Tracy • Pharmacies that give flu shots: o Lewis Family Drug, 131 – 3rd St., Tracy o Thrifty White, 321 W. Main, Marshall **Dental resources:** • Prairie Lakes Family Dentist, 212 – 3rd St., Tracy

Key Stakeholder Survey

Sanford Tracy 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 Tracy 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 through the first week of November. A total of 17 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

Current State of Health and Wellness Issues Within the Community

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

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

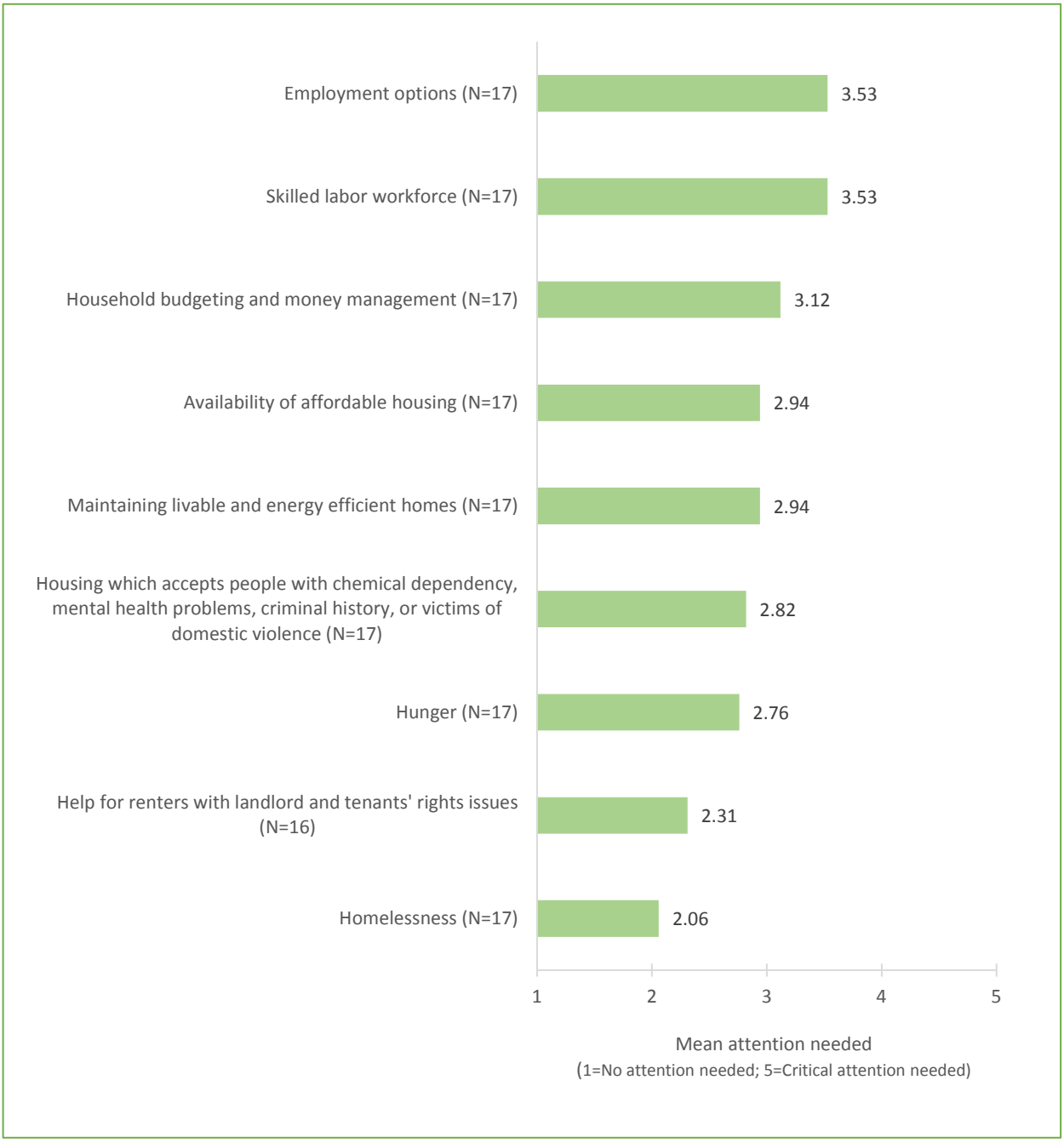


Figure 2. Current state of community issues regarding TRANSPORTATION

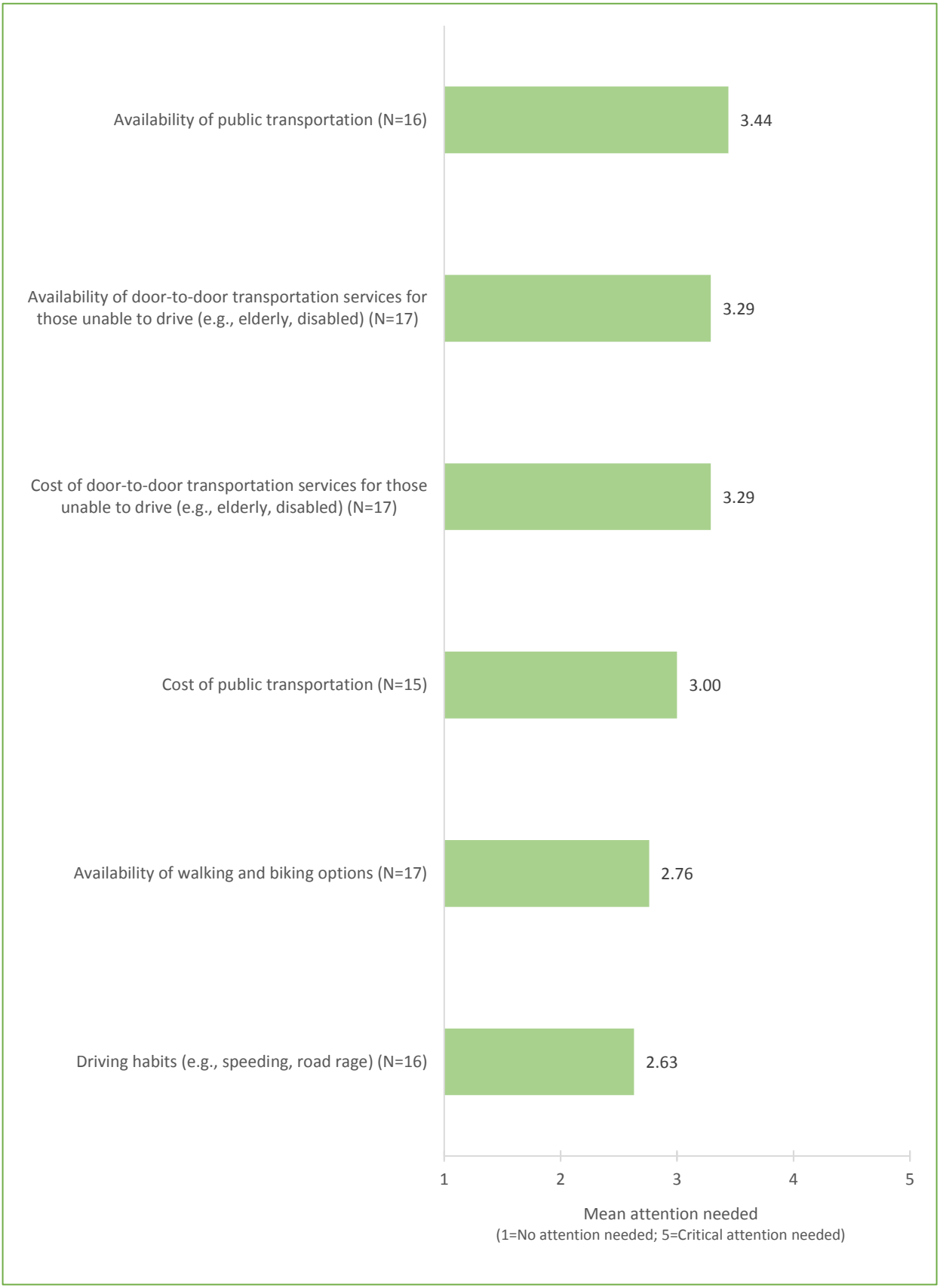


Figure 3. Current state of community issues regarding CHILDREN AND YOUTH

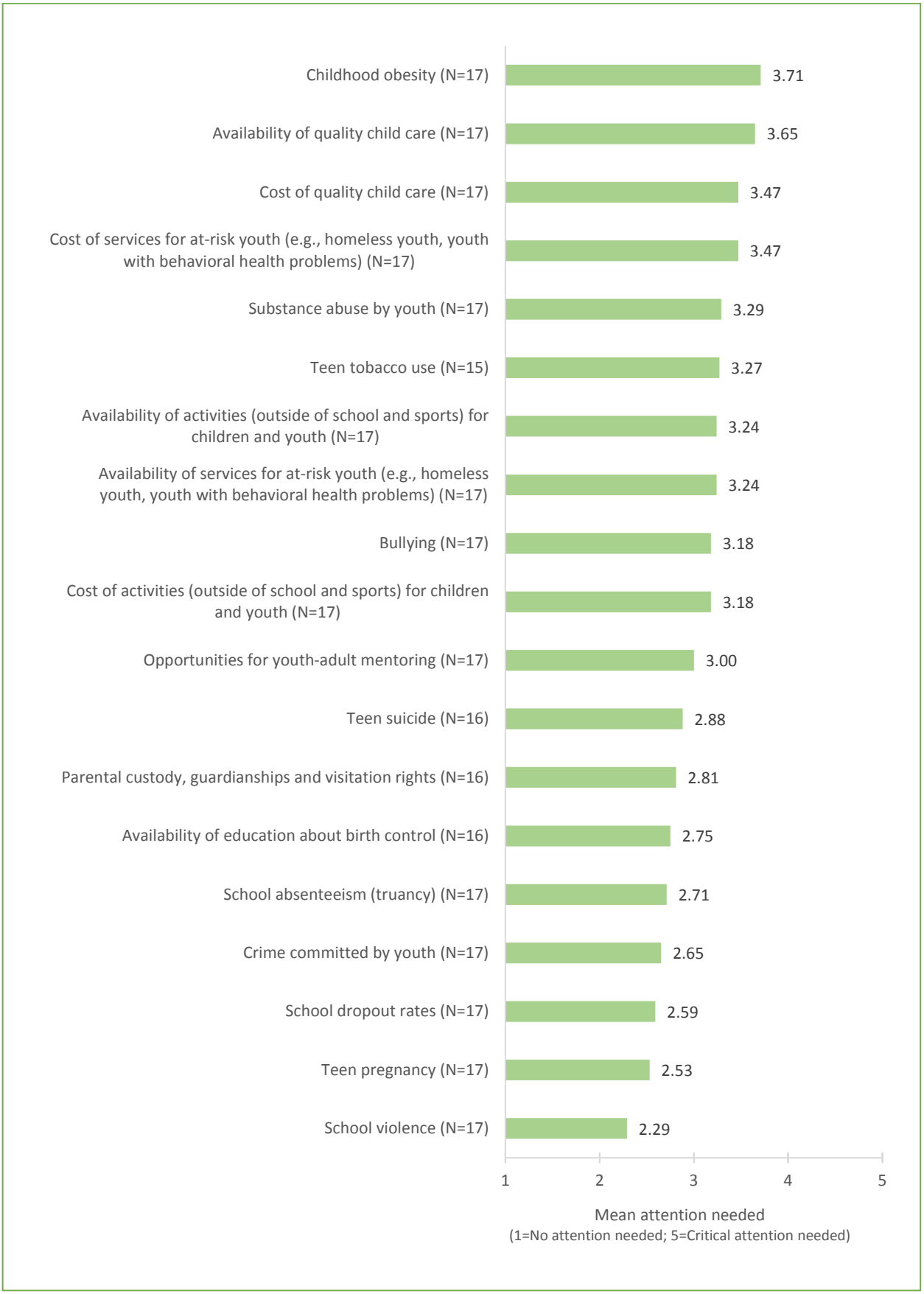

Childhood obesity (N=17)
3.71
Availability of quality child care (N=17)
3.65
Cost of quality child care (N=17)
3.47
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=17)
3.47
Substance abuse by youth (N=17)
3.29
Teen tobacco use (N=15)
3.27
Availability of activities (outside of school and sports) for children and youth (N=17)
3.24
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=17)
3.24
Bullying (N=17)
3.18
Cost of activities (outside of school and sports) for children and youth (N=17)
3.18
Opportunities for youth-adult mentoring (N=17)
3.00
Teen suicide (N=16)
2.88
Parental custody, guardianships and visitation rights (N=16)
2.81
Availability of education about birth control (N=16)
2.75
School absenteeism (truancy) (N=17)
2.71
Crime committed by youth (N=17)
2.65
School dropout rates (N=17)
2.59
Teen pregnancy (N=17)
2.53
School violence (N=17)
2.29
1
2
3
4
5
Mean attention needed
(1=No attention needed; 5=Critical attention needed)

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

Figure 5. Current state of community issues regarding SAFETY

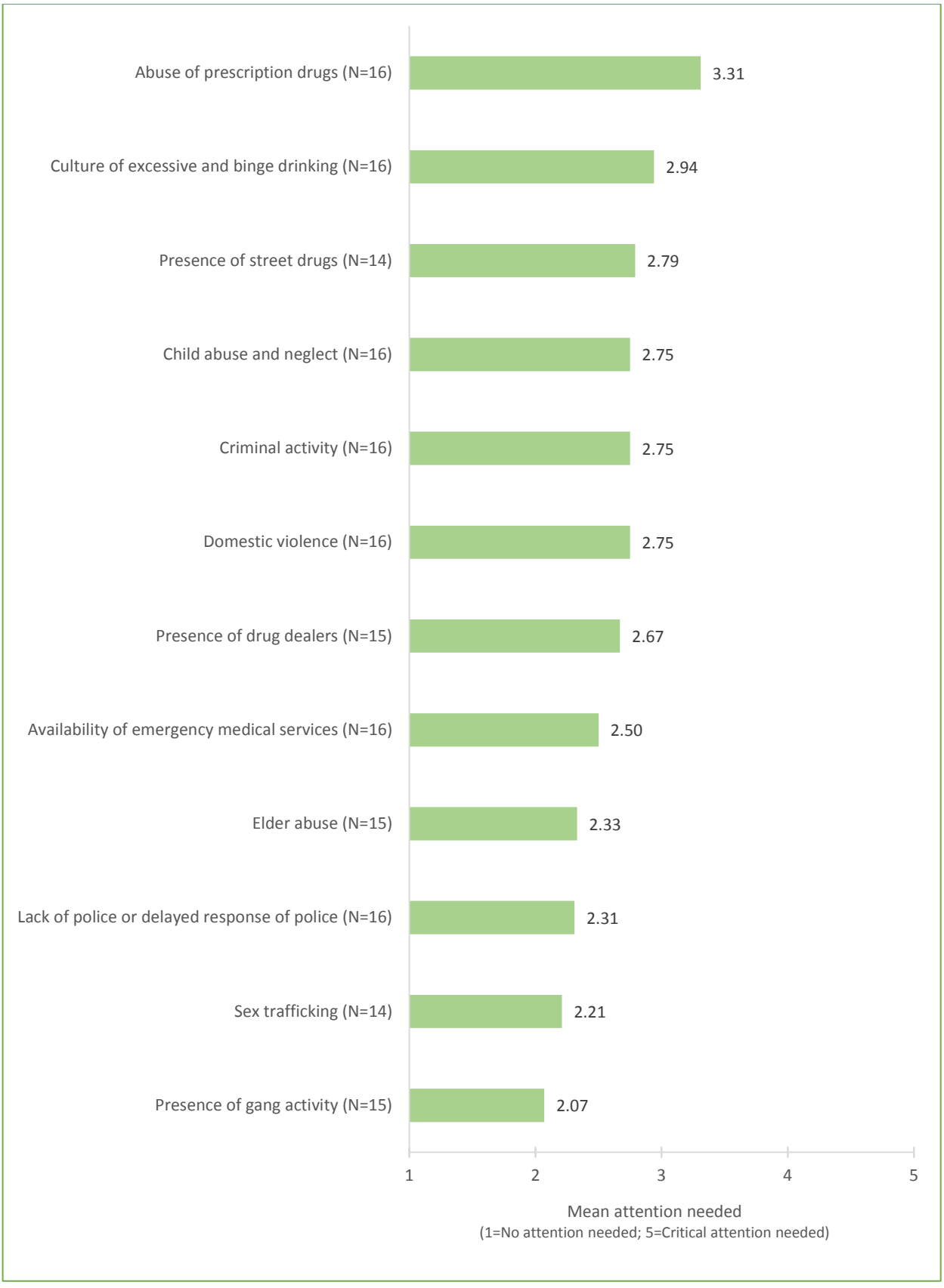
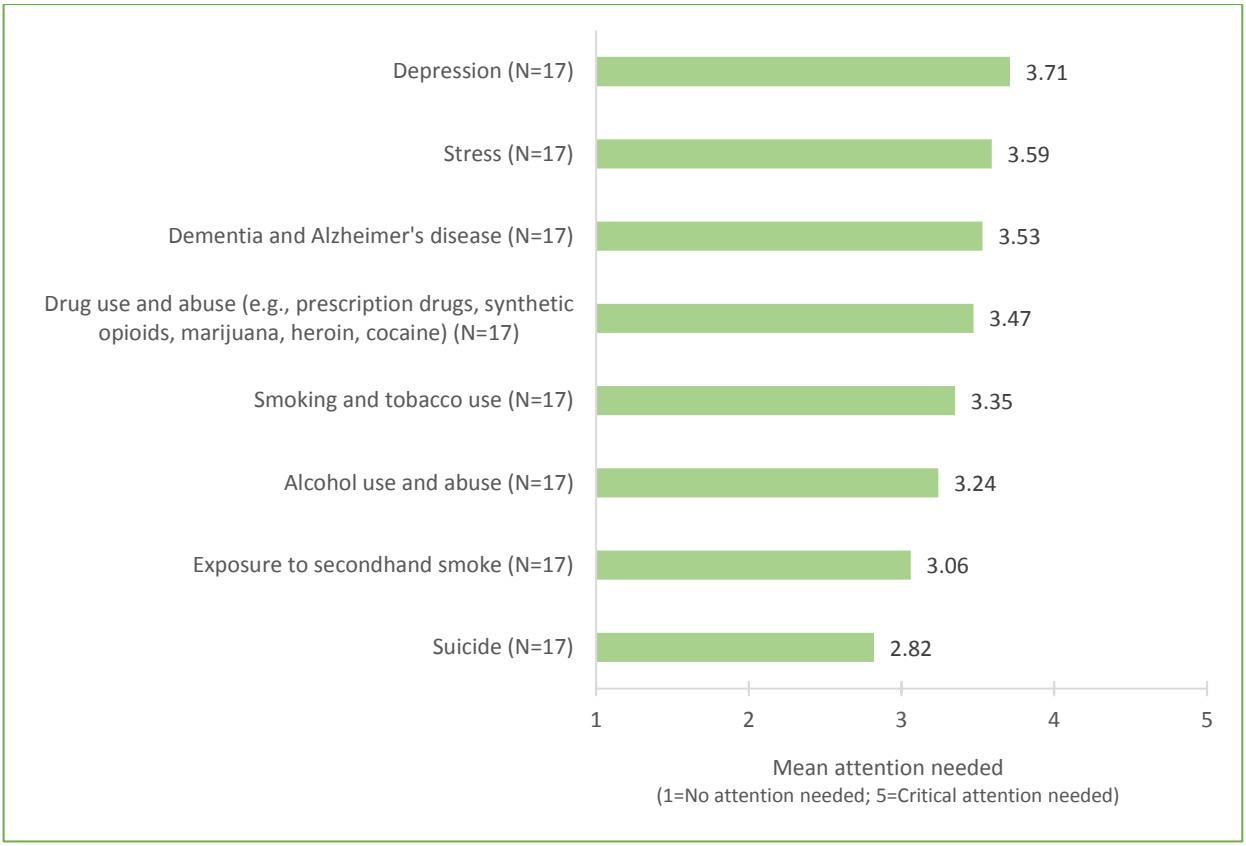


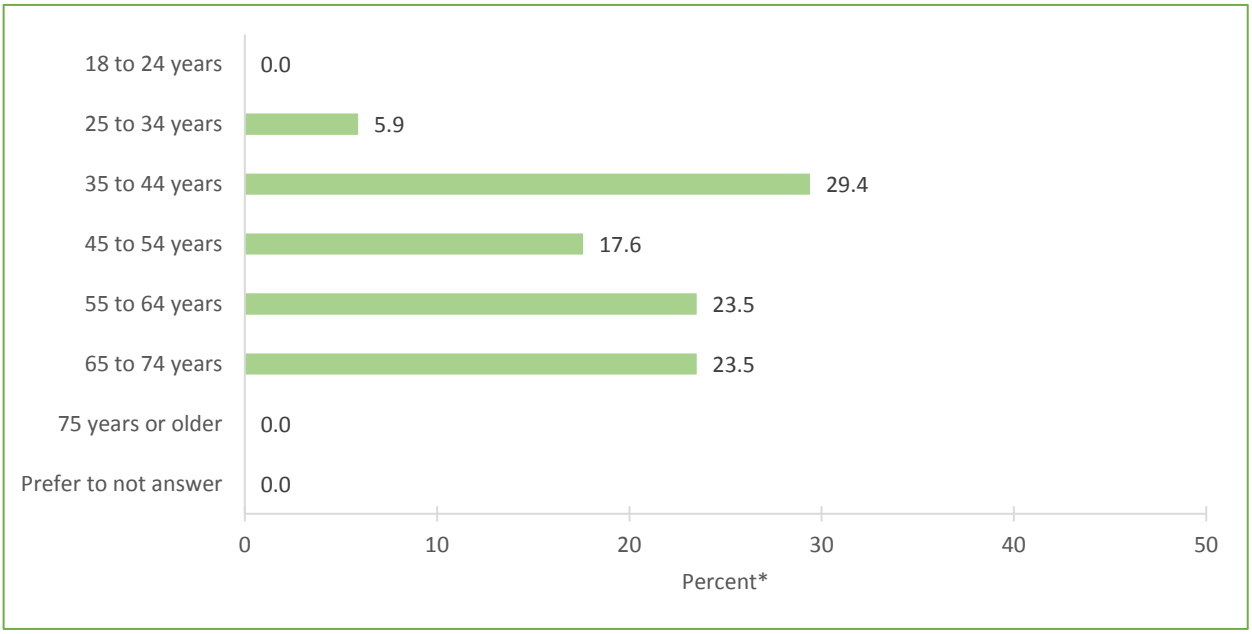
Figure 6. Current state of community issues regarding HEALTH CARE AND WELLNESS

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



Demographic Information

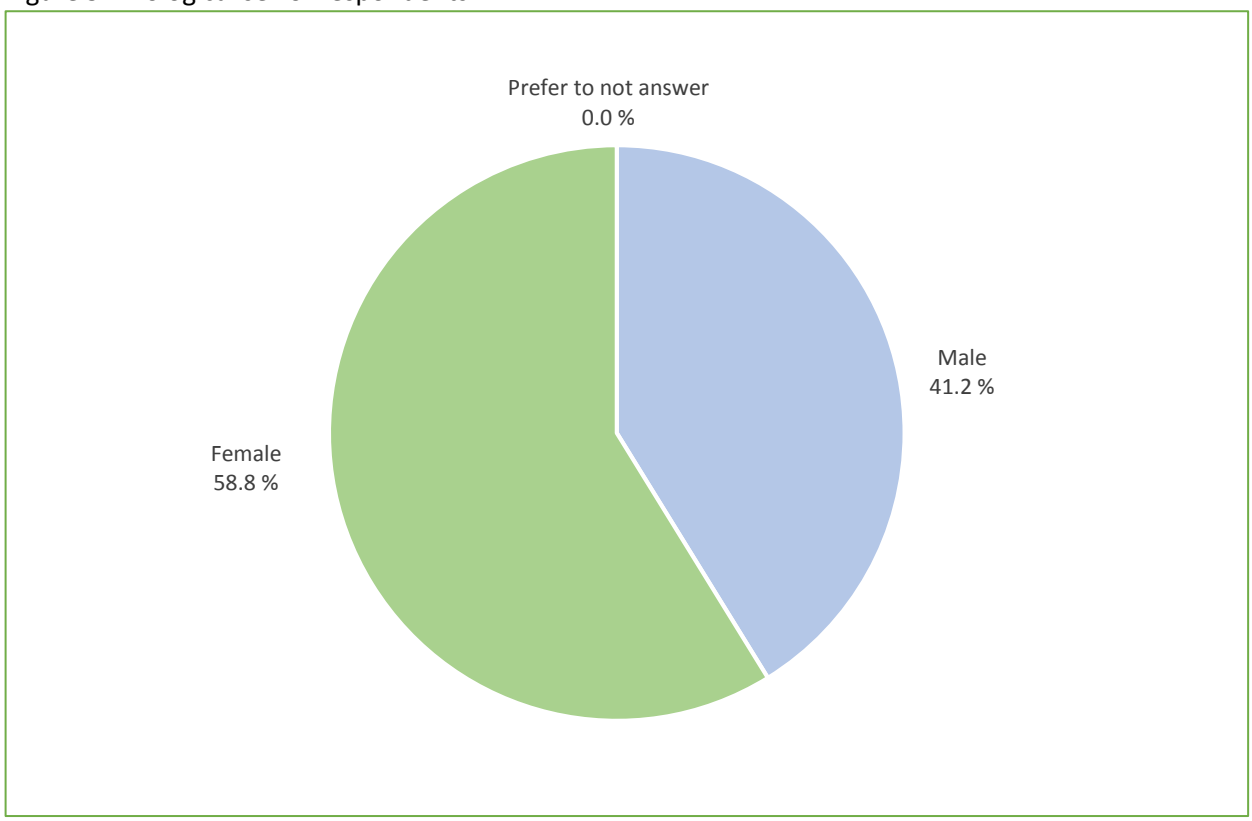
Figure 8. Age of respondents



N=17

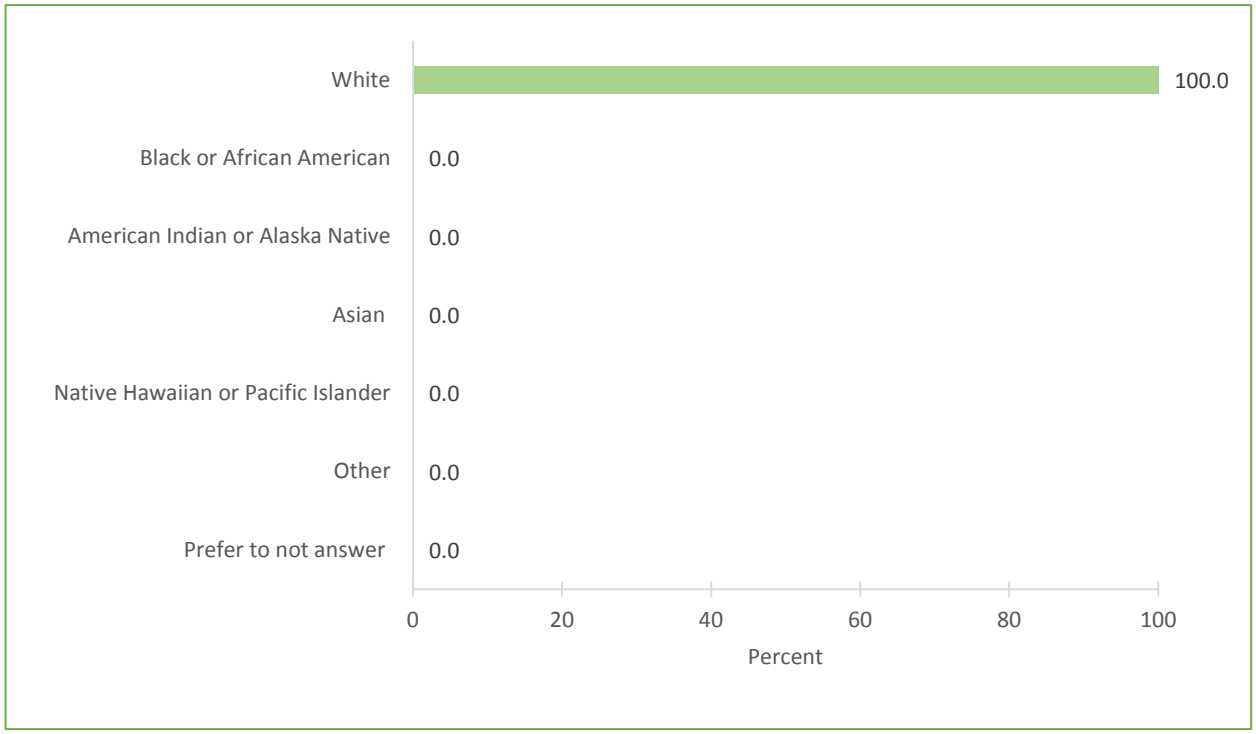
*Percentages do not total 100.0 due to rounding.

Figure 9. Biological sex of respondents



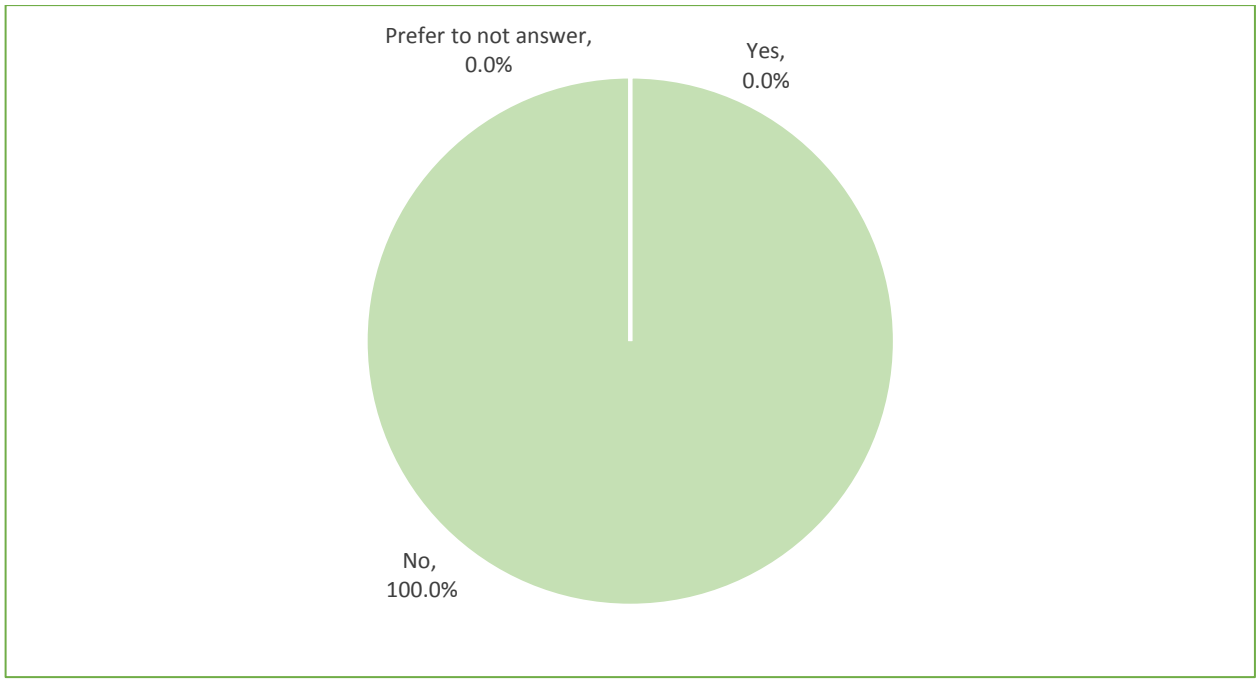
N=17

Figure 10. Race of respondents



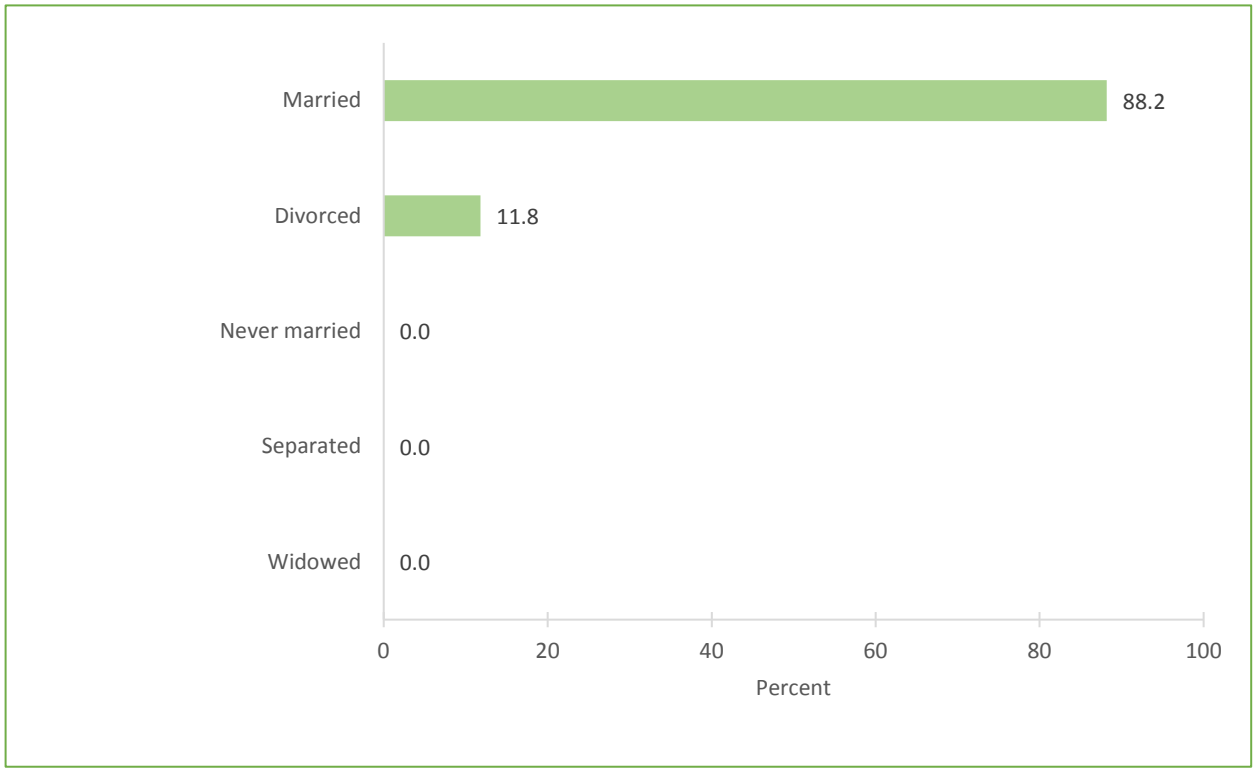
N=17

Figure 11. Whether respondents are of Hispanic or Latino origin



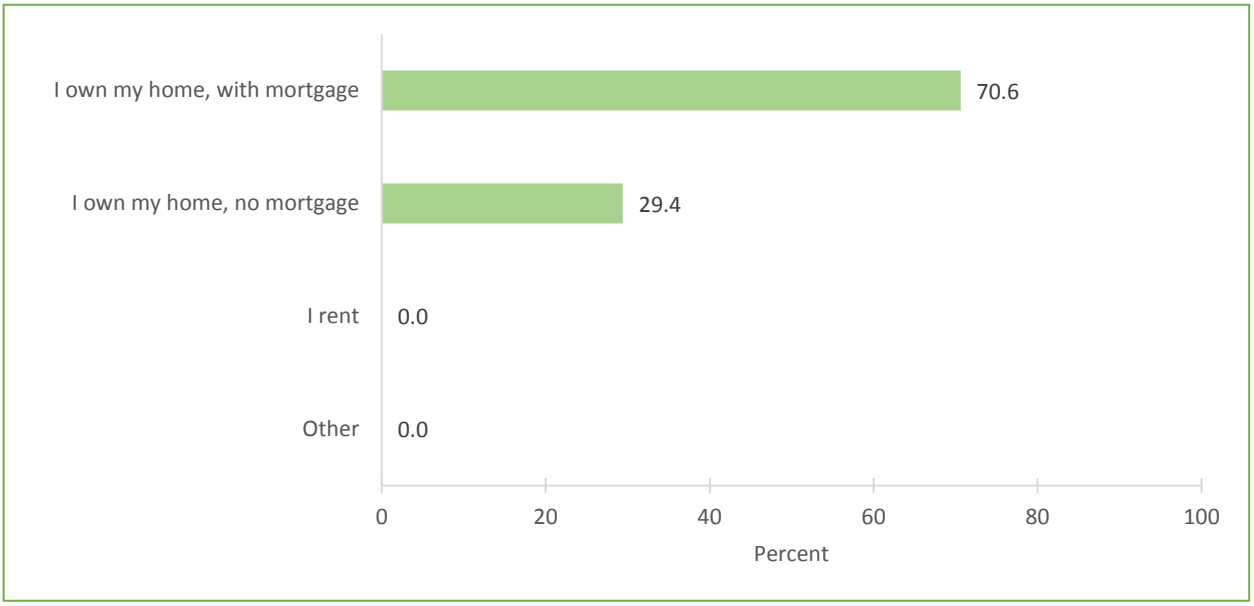
N=17

Figure 12. Marital status of respondents



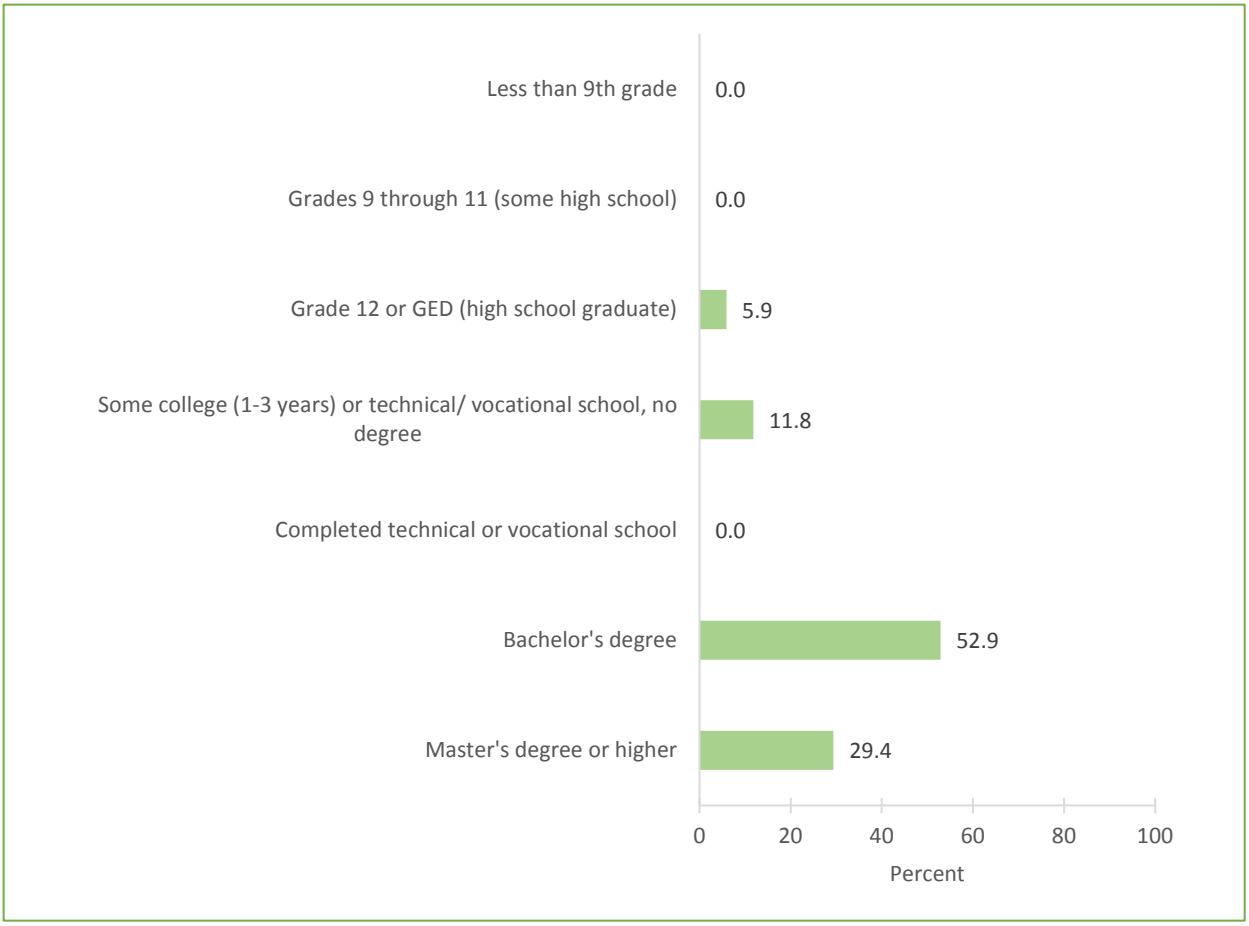
N=17

Figure 13. Living situation of respondents



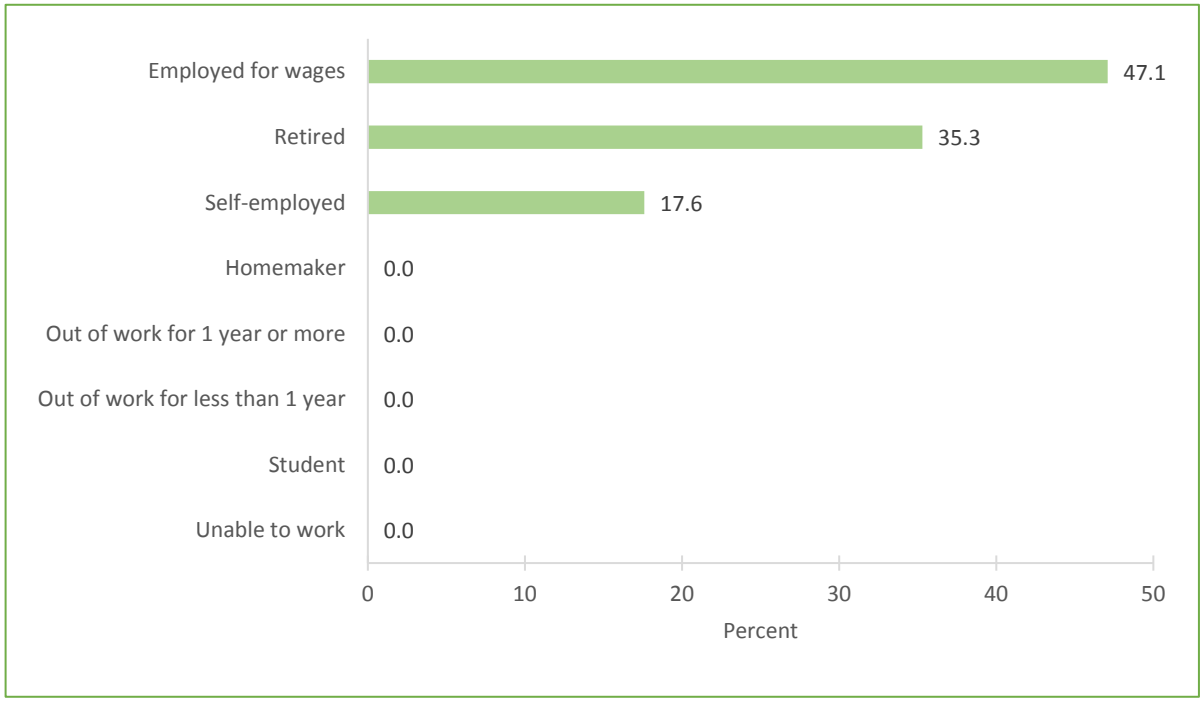
N=17

Figure 14. Highest level of education completed by respondents *



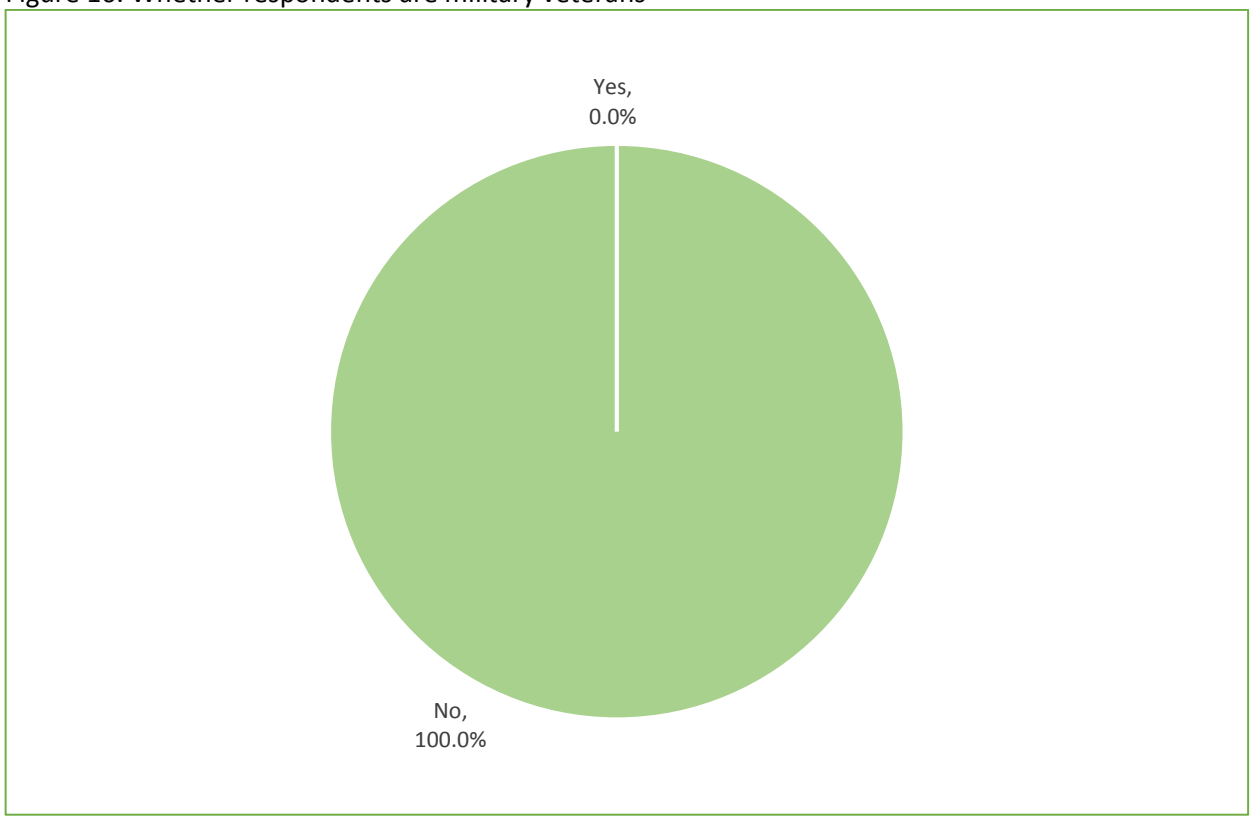
N=17

Figure 15. Employment status of respondents



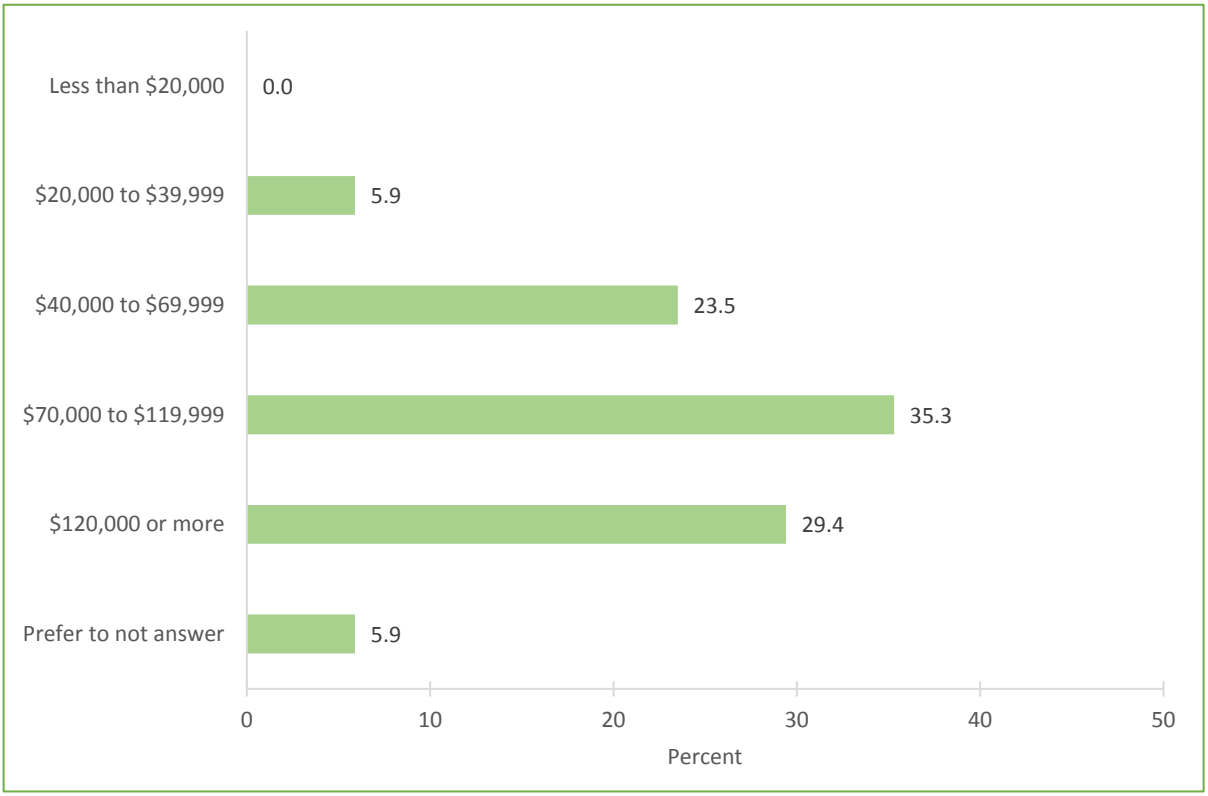
N=17

Figure 16. Whether respondents are military veterans



N=17

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



N=17

Table 1. Zip code of respondents

Zip code	Number of respondents
56175	7
56115	3
56180	2
56101	1
56123	1
56172	1
56263	1

N=16

Table 2. Comments from respondents

Comments
Drug abuse is an issue, take away entitlements. More affordable health care coverage.
Since I live in the country near a small town, I wasn't sure about some of the topics.
Tracy Medical Clinic needs to be more accommodating to the working class. Very difficult to use Tracy clinic because they don't offer hours before the work day or after the work day, especially for routine/wellness exams for adults and children.
Tracy needs to bring in employment to the community, a new housing development, and strengthen leadership at the city council.

APPENDIX TABLE

Statements	Mean**	Percent of respondents* Level of attention needed 1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
ECONOMIC WELL-BEING ISSUES								
Availability of affordable housing (N=17)	2.94	5.9	17.6	58.8	11.8	5.9	0.0	100.0
Employment options (N=17)	3.53	0.0	0.0	58.8	29.4	11.8	0.0	100.0
Help for renters with landlord and tenants' rights issues (N=16)	2.31	12.5	43.8	43.8	0.0	0.0	0.0	100.1
Homelessness (N=17)	2.06	23.5	47.1	29.4	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=17)	2.82	11.8	23.5	41.2	17.6	5.9	0.0	100.0
Household budgeting and money management (N=17)	3.12	0.0	11.8	76.5	0.0	11.8	0.0	100.1
Hunger (N=17)	2.76	0.0	41.2	41.2	17.6	0.0	0.0	100.0
Maintaining livable and energy efficient homes (N=17)	2.94	0.0	17.6	70.6	11.8	0.0	0.0	100.0
Skilled labor workforce (N=17)	3.53	0.0	5.9	47.1	35.3	11.8	0.0	100.1
TRANSPORTATION ISSUES								
Availability of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=17)	3.29	0.0	17.6	41.2	35.3	5.9	0.0	100.0
Availability of public transportation (N=17)	3.44	0.0	5.9	47.1	35.3	5.9	5.9	100.1
Availability of walking and biking options (N=17)	2.76	5.9	29.4	47.1	17.6	0.0	0.0	100.0
Cost of door-to-door transportation services for those unable to drive (e.g., elderly, disabled) (N=17)	3.29	0.0	11.8	52.9	29.4	5.9	0.0	100.0
Cost of public transportation (N=17)	3.00	0.0	23.5	41.2	23.5	0.0	11.8	100.0
Driving habits (e.g., speeding, road rage) (N=16)	2.63	12.5	31.3	37.5	18.8	0.0	0.0	100.1
CHILDREN AND YOUTH								
Availability of activities (outside of school and sports) for children and youth (N=17)	3.24	0.0	11.8	52.9	35.3	0.0	0.0	100.0
Availability of education about birth control (N=17)	2.75	0.0	41.2	35.3	17.6	0.0	5.9	100.0
Availability of quality child care (N=17)	3.65	0.0	0.0	58.8	17.6	23.5	0.0	99.9
Availability of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=17)	3.24	0.0	23.5	41.2	23.5	11.8	0.0	100.0
Bullying (N=17)	3.18	5.9	17.6	35.3	35.3	5.9	0.0	100.0

		Percent of respondents*						
		Level of attention needed						
Statements	Mean**	1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Childhood obesity (N=17)	3.71	0.0	0.0	52.9	23.5	23.5	0.0	99.9
Cost of activities (outside of school and sports) for children and youth (N=17)	3.18	0.0	11.8	58.8	29.4	0.0	0.0	100.0
Cost of quality child care (N=17)	3.47	0.0	0.0	64.7	23.5	11.8	0.0	100.0
Cost of services for at-risk youth (e.g., homeless youth, youth with behavioral health problems) (N=17)	3.47	0.0	5.9	52.9	29.4	11.8	0.0	100.0
Crime committed by youth (N=17)	2.65	0.0	35.3	64.7	0.0	0.0	0.0	100.0
Opportunities for youth-adult mentoring (N=17)	3.00	0.0	17.6	70.6	5.9	5.9	0.0	100.0
Parental custody, guardianships and visitation rights (N=17)	2.81	0.0	35.3	47.1	5.9	5.9	5.9	100.1
School absenteeism (truancy) (N=17)	2.71	5.9	23.5	64.7	5.9	0.0	0.0	100.0
School dropout rates (N=17)	2.59	11.8	23.5	58.8	5.9	0.0	0.0	100.0
School violence (N=17)	2.29	11.8	47.1	41.2	0.0	0.0	0.0	100.1
Substance abuse by youth (N=17)	3.29	0.0	11.8	47.1	41.2	0.0	0.0	100.1
Teen pregnancy (N=17)	2.53	5.9	41.2	47.1	5.9	0.0	0.0	100.1
Teen suicide (N=16)	2.88	0.0	37.5	37.5	25.0	0.0	0.0	100.0
Teen tobacco use (N=15)	3.27	0.0	6.7	60.0	33.3	0.0	0.0	100.0
THE AGING POPULATION								
Availability of activities for seniors (e.g., recreational, social, cultural) (N=17)	2.94	0.0	11.8	82.4	5.9	0.0	0.0	100.1
Availability of long-term care (N=17)	2.65	5.9	29.4	58.8	5.9	0.0	0.0	100.0
Availability of memory care (N=17)	3.59	0.0	5.9	35.3	52.9	5.9	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=17)	3.00	5.9	23.5	35.3	35.3	0.0	0.0	100.0
Availability of resources for grandparents caring for grandchildren (N=17)	2.71	5.9	29.4	58.8	0.0	5.9	0.0	100.0
Availability of resources to help the elderly stay safe in their homes (N=17)	2.88	5.9	23.5	47.1	23.5	0.0	0.0	100.0
Cost of activities for seniors (e.g., recreational, social, cultural) (N=17)	2.65	11.8	29.4	41.2	17.6	0.0	0.0	100.0
Cost of in-home services (N=17)	3.41	5.9	11.8	29.4	41.2	11.8	0.0	100.1
Cost of long-term care (N=17)	3.88	5.9	0.0	23.5	35.3	29.4	5.9	100.0
Cost of memory care (N=17)	3.88	5.9	0.0	23.5	35.3	29.4	5.9	100.0
Help making out a will or healthcare directive (N=17)	2.82	5.9	29.4	41.2	23.5	0.0	0.0	100.0
SAFETY								
Abuse of prescription drugs (N=16)	3.31	0.0	12.5	50.0	31.3	6.3	0.0	100.1

		Percent of respondents*						
		Level of attention needed						
Statements	Mean**	1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	Total
Availability of emergency medical services (N=16)	2.50	6.3	37.5	56.3	0.0	0.0	0.0	100.1
Child abuse and neglect (N=16)	2.75	0.0	25.0	75.0	0.0	0.0	0.0	100.0
Criminal activity (N=16)	2.75	0.0	37.5	50.0	12.5	0.0	0.0	100.0
Culture of excessive and binge drinking (N=16)	2.94	0.0	25.0	56.3	18.8	0.0	0.0	100.1
Domestic violence (N=16)	2.75	0.0	43.8	37.5	18.8	0.0	0.0	100.1
Elder abuse (N=15)	2.33	6.7	60.0	26.7	6.7	0.0	0.0	100.1
Lack of police or delayed response of police (N=16)	2.31	12.5	50.0	31.3	6.3	0.0	0.0	100.1
Presence of drug dealers (N=16)	2.67	12.5	25.0	37.5	18.8	0.0	6.3	100.1
Presence of gang activity (N=16)	2.07	25.0	37.5	31.3	0.0	0.0	6.3	100.1
Presence of street drugs (N=16)	2.79	6.3	18.8	50.0	12.5	0.0	12.5	100.1
Sex trafficking (N=16)	2.21	25.0	31.3	18.8	12.5	0.0	12.5	100.1
HEALTH CARE AND WELLNESS								
Access to affordable dental insurance coverage (N=17)	3.35	11.8	5.9	29.4	41.2	11.8	0.0	100.1
Access to affordable health insurance coverage (N=17)	3.94	0.0	5.9	35.3	17.6	41.2	0.0	100.0
Access to affordable health care (N=17)	3.65	0.0	11.8	47.1	5.9	35.3	0.0	100.1
Access to affordable prescription drugs (N=17)	3.59	0.0	17.6	35.3	17.6	29.4	0.0	99.9
Access to affordable vision insurance coverage (N=17)	3.12	11.8	17.6	35.3	17.6	17.6	0.0	99.9
Access to technology for health records and health education (N=17)	2.76	11.8	17.6	58.8	5.9	5.9	0.0	100.0
Availability of behavioral health (substance abuse) providers (N=17)	3.76	0.0	5.9	35.3	35.3	23.5	0.0	100.0
Availability of doctors, physician assistants, or nurse practitioners (N=17)	4.35	0.0	0.0	17.6	29.4	52.9	0.0	99.9
Availability of health care services for Native people (N=17)	2.42	29.4	11.8	11.8	5.9	11.8	29.4	100.1
Availability of health care services for New Americans (N=16)	2.87	25.0	6.3	31.3	18.8	12.5	6.3	100.2
Availability of mental health providers (N=17)	4.18	0.0	0.0	23.5	35.3	41.2	0.0	100.0
Availability of non-traditional hours (e.g., evenings, weekends) (N=17)	3.53	5.9	5.9	29.4	47.1	11.8	0.0	100.1
Availability of prevention programs and services (e.g., Better Balance, Diabetes Prevention) (N=17)	3.18	5.9	11.8	52.9	17.6	11.8	0.0	100.0
Availability of specialist physicians (N=17)	3.76	0.0	5.9	41.2	23.5	29.4	0.0	100.0
Coordination of care between providers and services (N=17)	2.76	5.9	35.3	41.2	11.8	5.9	0.0	100.1

Statements	Mean**	Percent of respondents*						
		Level of attention needed						Total
		1 None	2 Little	3 Moderate	4 Serious	5 Critical	NA	
Timely access to medical care providers (N=17)	2.88	5.9	17.6	58.8	17.6	0.0	0.0	99.9
Timely access to dental care providers (N=17)	3.06	11.8	5.9	52.9	23.5	5.9	0.0	100.0
Timely access to vision care providers (N=17)	2.71	11.8	23.5	47.1	17.6	0.0	0.0	100.0
Use of emergency room services for primary healthcare (N=17)	3.59	0.0	11.8	23.5	58.8	5.9	0.0	100.0
MENTAL HEALTH AND SUBSTANCE ABUSE								
Alcohol use and abuse (N=17)	3.24	0.0	5.9	64.7	29.4	0.0	0.0	100.0
Dementia and Alzheimer's disease (N=17)	3.53	0.0	5.9	41.2	47.1	5.9	0.0	100.1
Depression (N=17)	3.71	0.0	0.0	35.3	58.8	5.9	0.0	100.0
Drug use and abuse (e.g., prescription drugs, synthetic opioids, marijuana, heroin, cocaine) (N=17)	3.47	0.0	5.9	47.1	41.2	5.9	0.0	100.1
Exposure to secondhand smoke (N=17)	3.06	0.0	23.5	47.1	29.4	0.0	0.0	100.0
Smoking and tobacco use (N=17)	3.35	0.0	5.9	52.9	41.2	0.0	0.0	100.0
Stress (N=17)	3.59	0.0	5.9	35.3	52.9	5.9	0.0	100.0
Suicide (N=17)	2.82	5.9	29.4	41.2	23.5	0.0	0.0	100.0

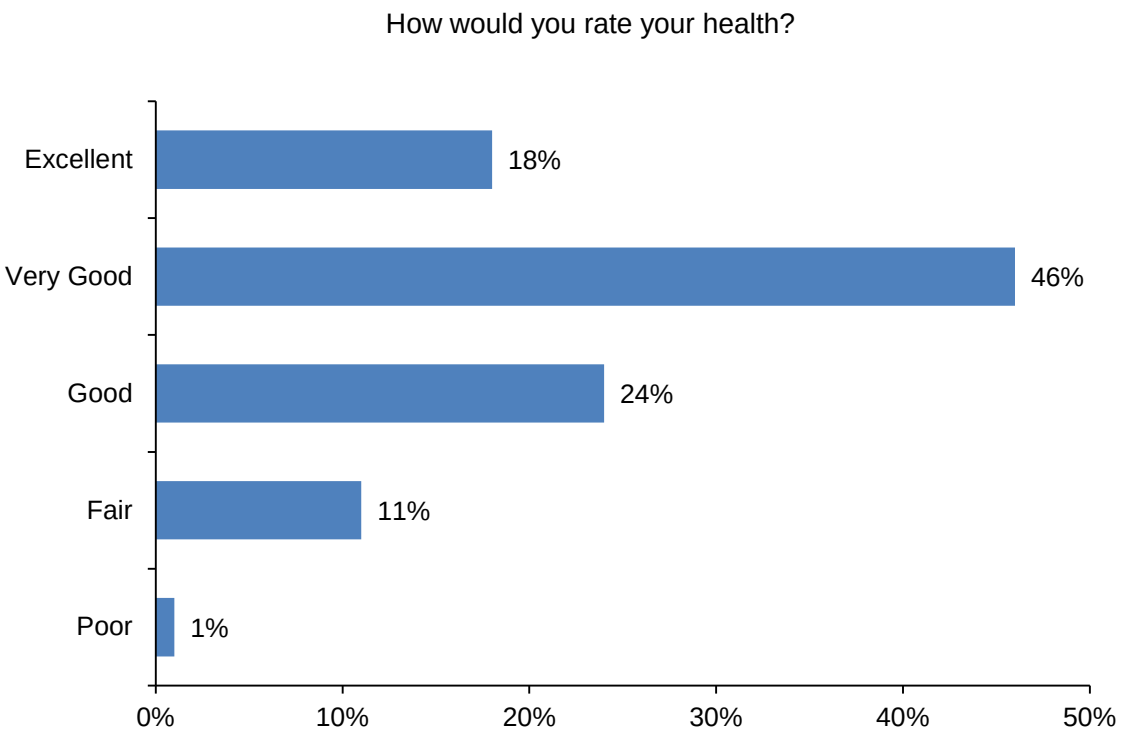
*Percentages may not total 100.0 due to rounding.

**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.

Tracy CHNA Survey Results

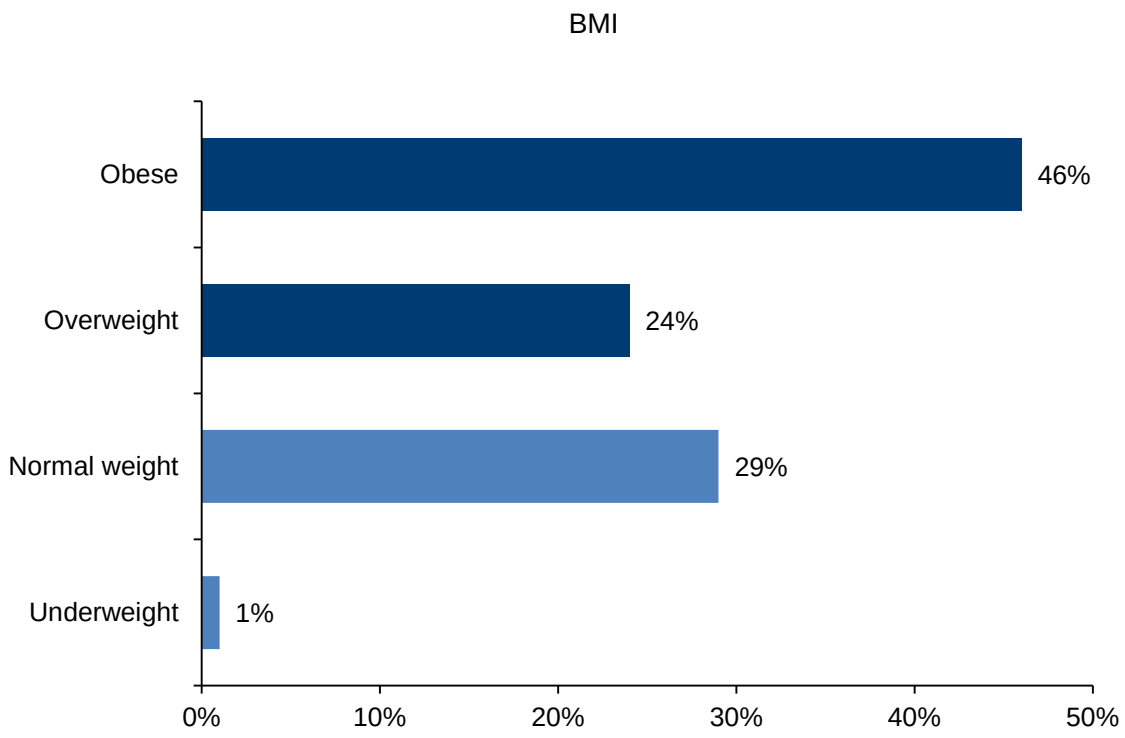
March 08, 2018

Charts Exported by MarketSight®



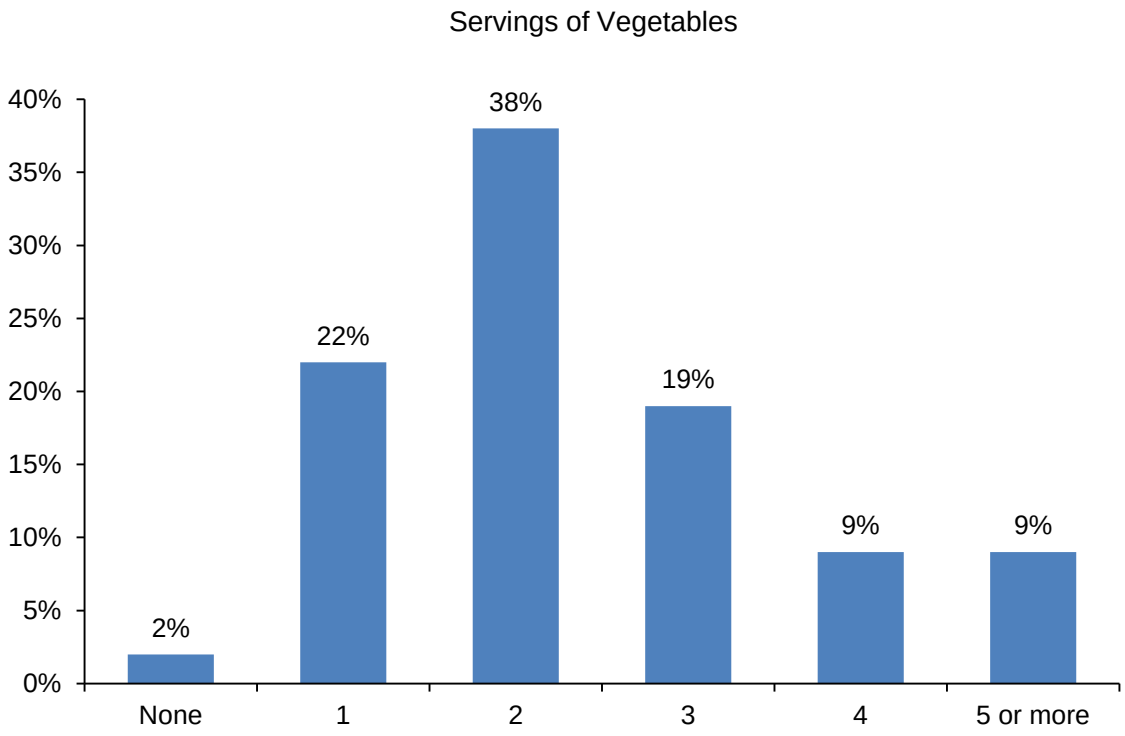
Base: Poor (n=1), Fair (n=15), Good (n=33), Very Good (n=62), Excellent (n=25), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)



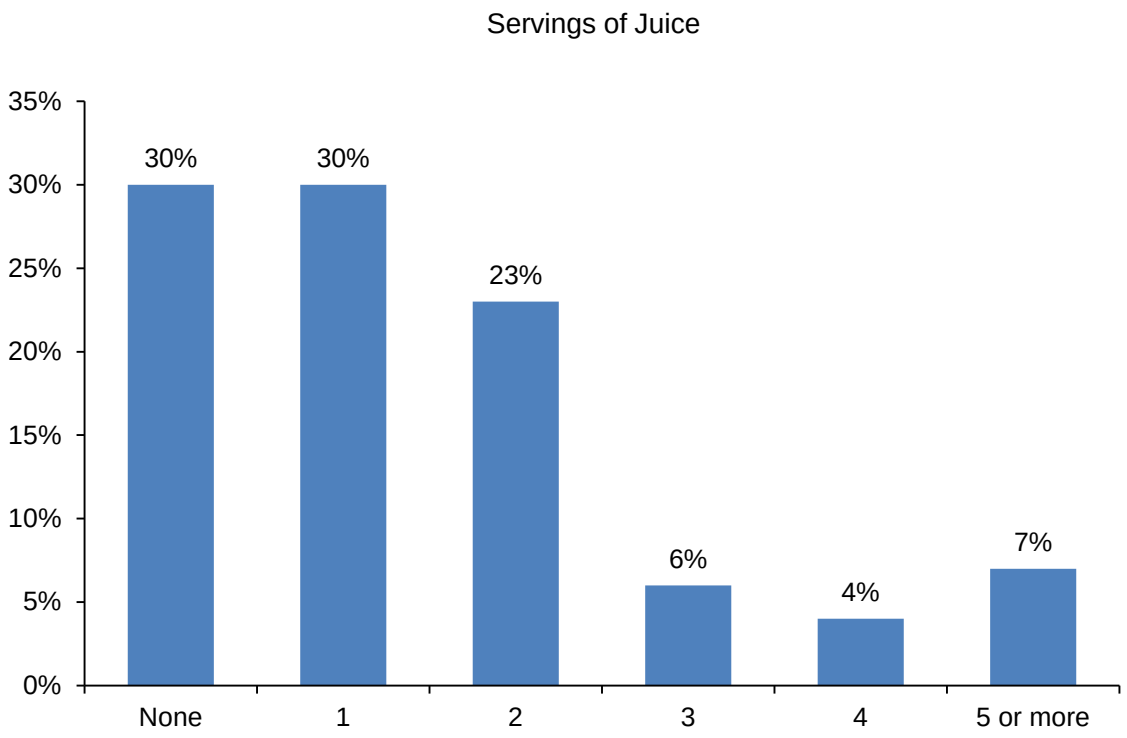
Base: Underweight (n=1), Normal weight (n=38), Overweight (n=32), Obese (n=60), Sample Size = 131

(Community = Lyon / Redwood / Cottonwood /Murray)



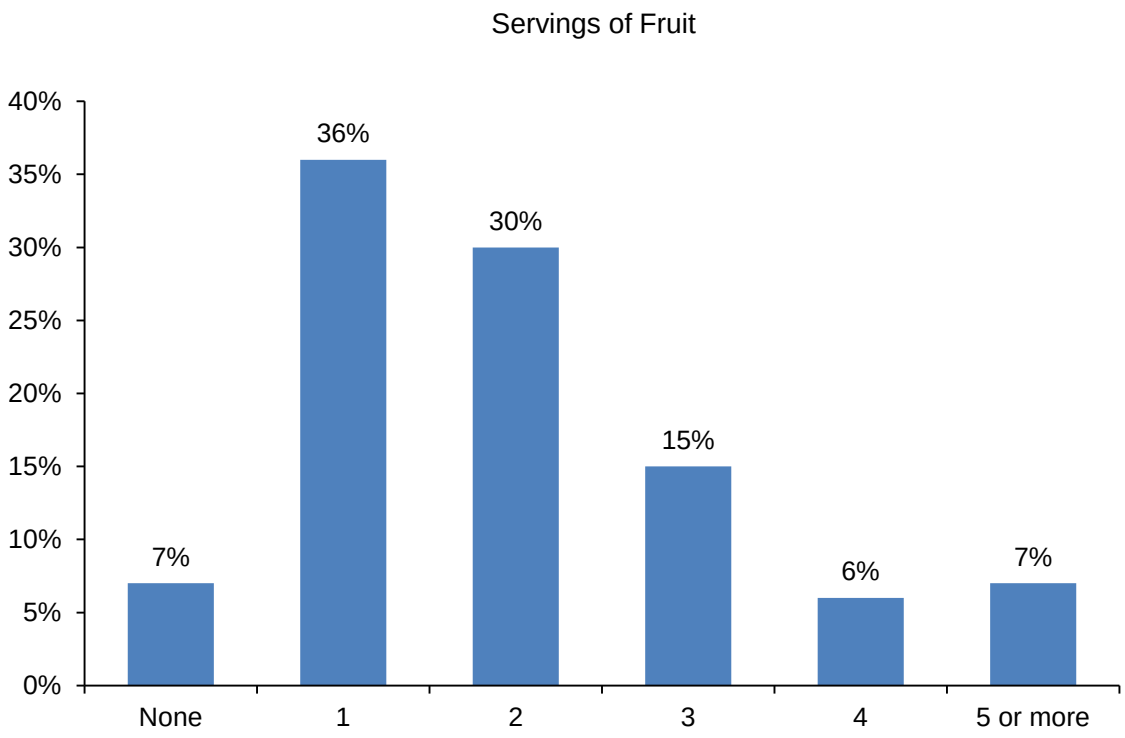
Base: None (n=3), 1 (n=29), 2 (n=49), 3 (n=25), 4 (n=11), 5 or more (n=12), Sample Size = 129

(Community = Lyon / Redwood / Cottonwood /Murray)



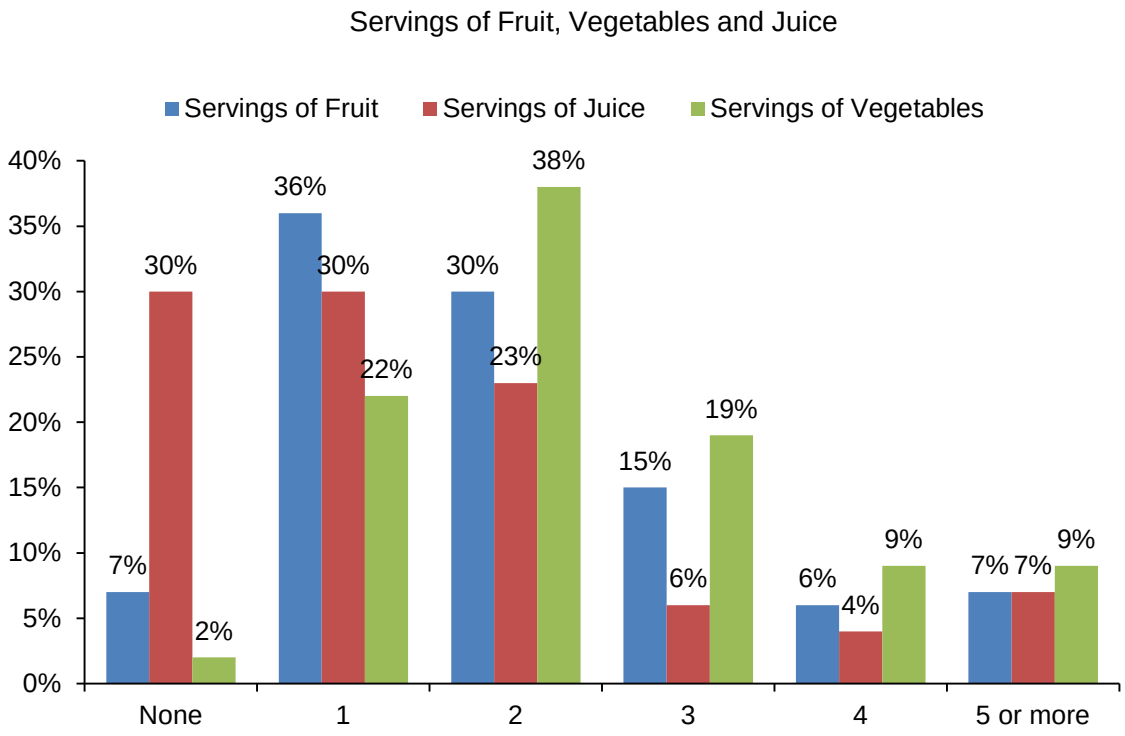
Base: None (n=29), 1 (n=29), 2 (n=23), 3 (n=6), 4 (n=4), 5 or more (n=7), Sample Size = 98

(Community = Lyon / Redwood / Cottonwood /Murray)



Base: None (n=8), 1 (n=42), 2 (n=35), 3 (n=18), 4 (n=7), 5 or more (n=8), Sample Size = 118

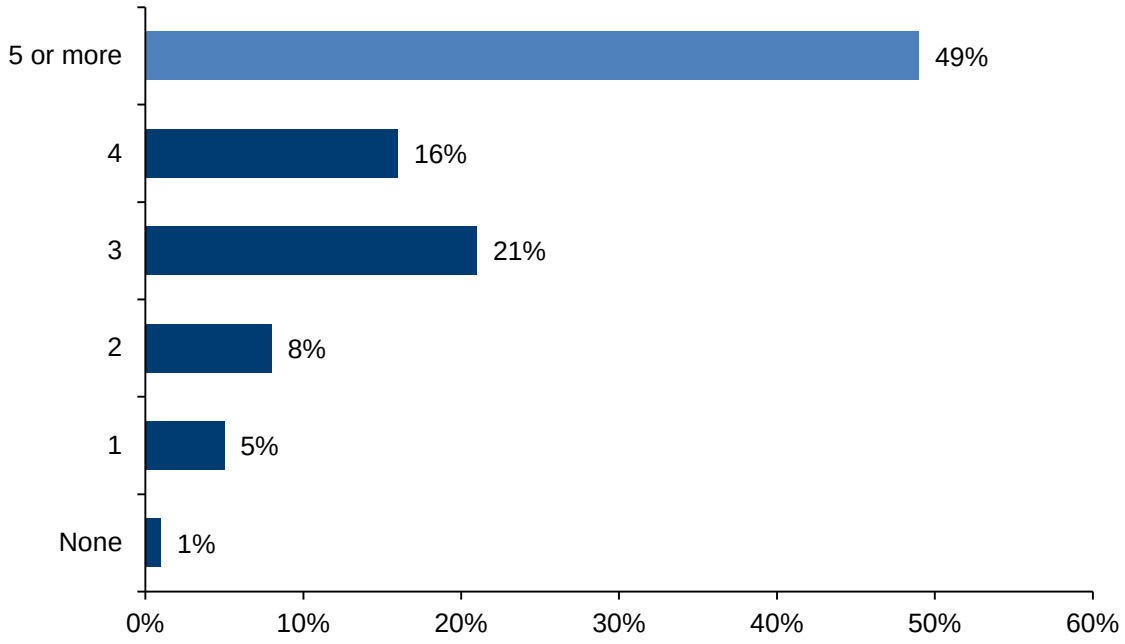
(Community = Lyon / Redwood / Cottonwood /Murray)



Sample Size = Variable

(Community = Lyon / Redwood / Cottonwood /Murray)

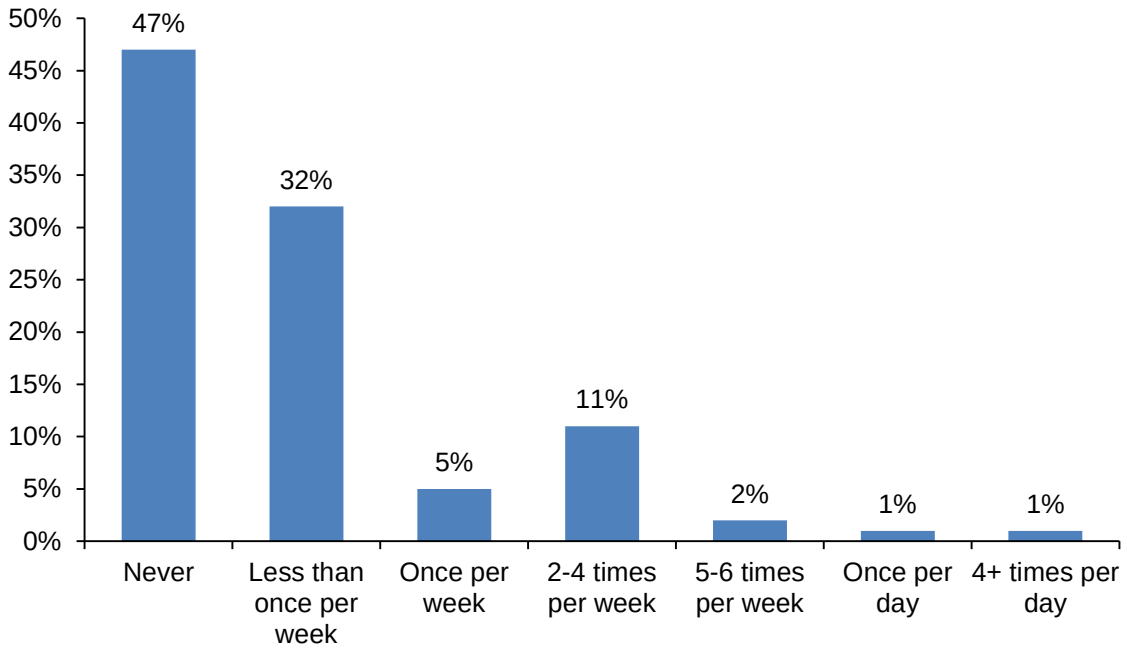
Total Servings of Fruits, Vegetables and Juice



Base: None (n=2), 1 (n=7), 2 (n=11), 3 (n=28), 4 (n=21), 5 or more (n=65), Sample Size = 134

(Community = Lyon / Redwood / Cottonwood /Murray)

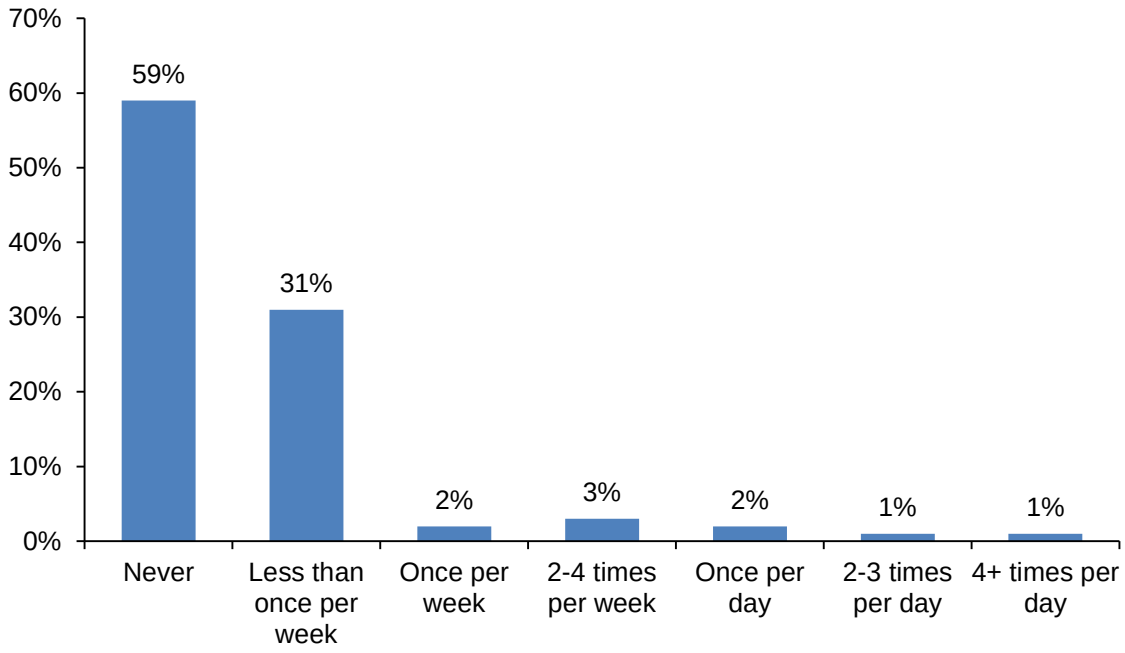
Snapple, Flavored Teas, Capri Sun, etc.



Base: Never (n=64), Less than once per week (n=43), Once per week (n=7), 2-4 times per week (n=15), 5-6 times per week (n=3), Once per day (n=1), 4+ times per day (n=2), Sample Size = 135

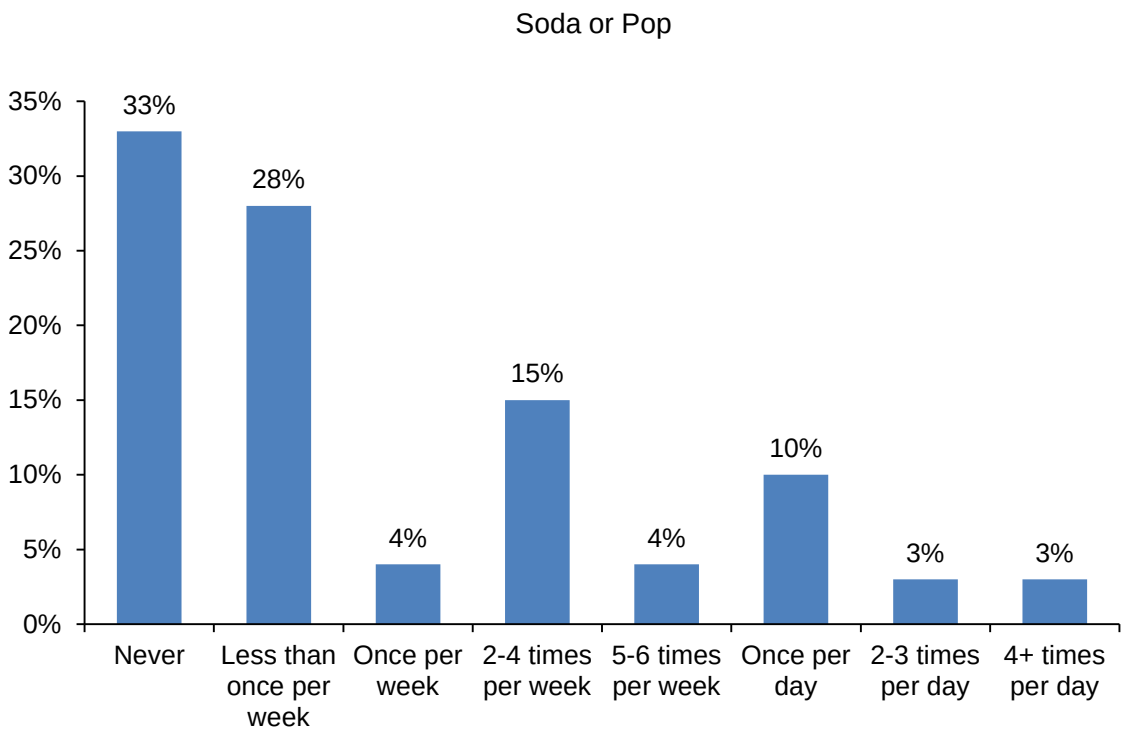
(Community = Lyon / Redwood / Cottonwood /Murray)

Gatorade, Powerade, etc.



Base: Never (n=80), Less than once per week (n=42), Once per week (n=3), 2-4 times per week (n=4), Once per day (n=3), 2-3 times per day (n=2), 4+ times per day (n=1), Sample Size = 135

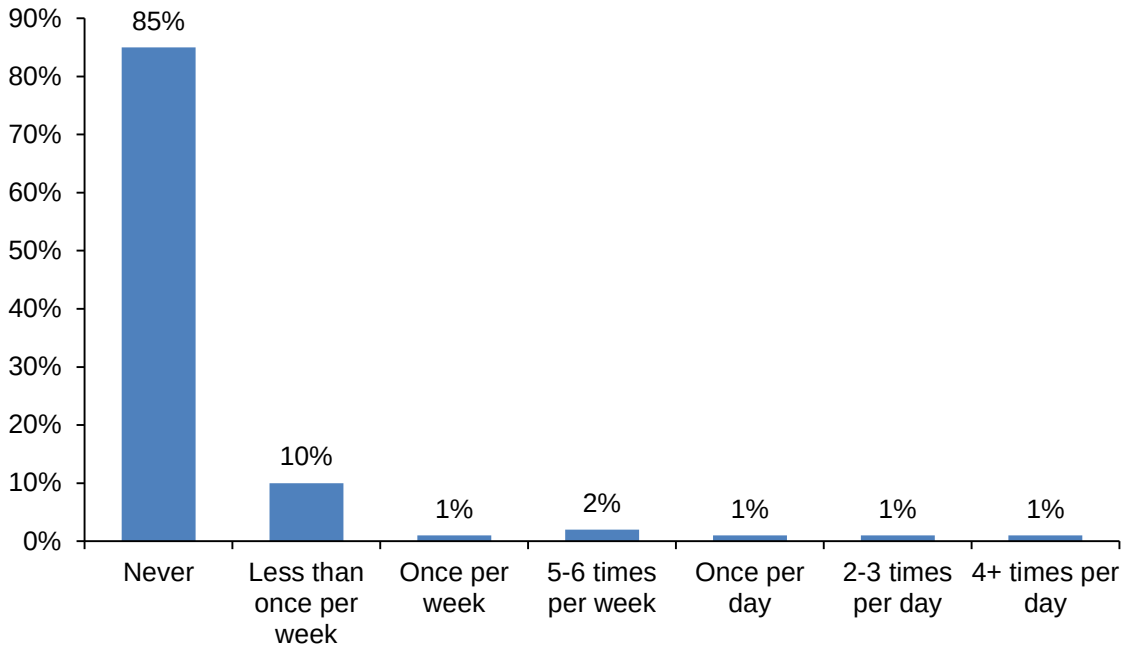
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Never (n=45), Less than once per week (n=39), Once per week (n=6), 2-4 times per week (n=20), 5-6 times per week (n=5), Once per day (n=14), 2-3 times per day (n=4), 4+ times per day (n=4), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)

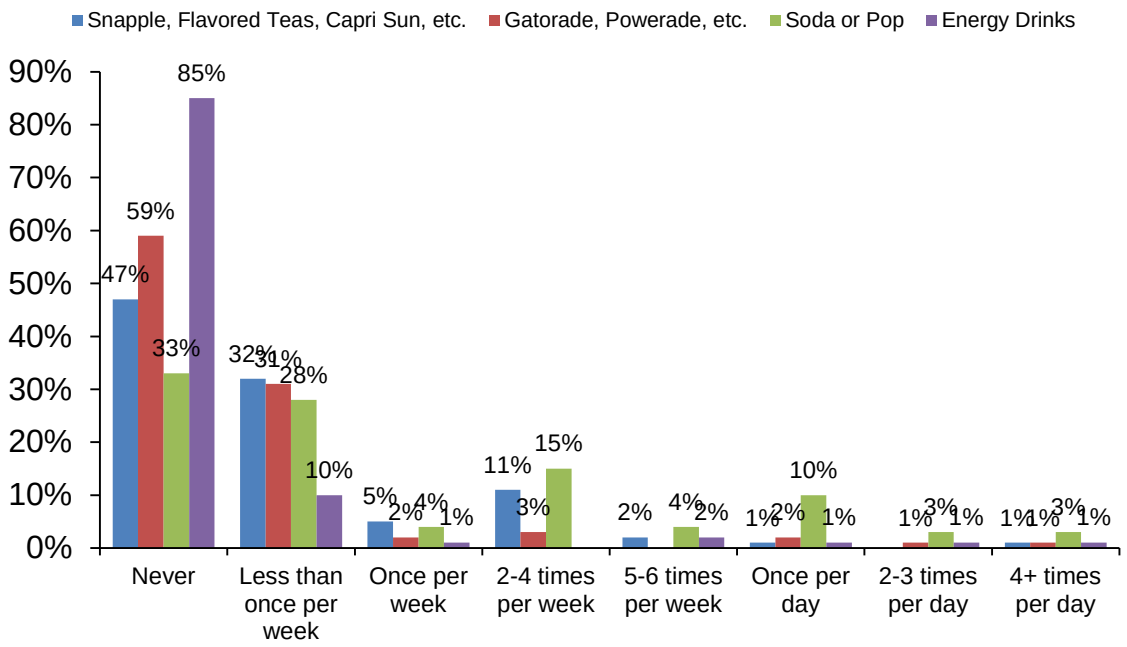
Energy Drinks



Base: Never (n=115), Less than once per week (n=13), Once per week (n=2), 5-6 times per week (n=3), Once per day (n=1), 2-3 times per day (n=1), 4+ times per day (n=1), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)

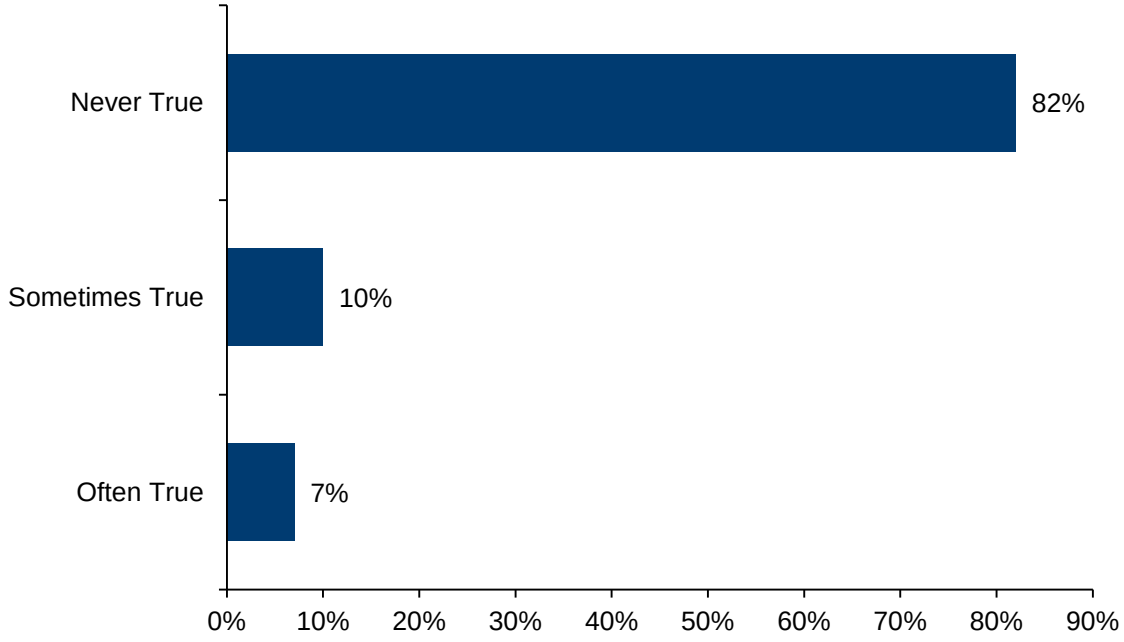
Sugar Sweetened Drinks



Sample Size = Variable

(Community = Lyon / Redwood / Cottonwood /Murray)

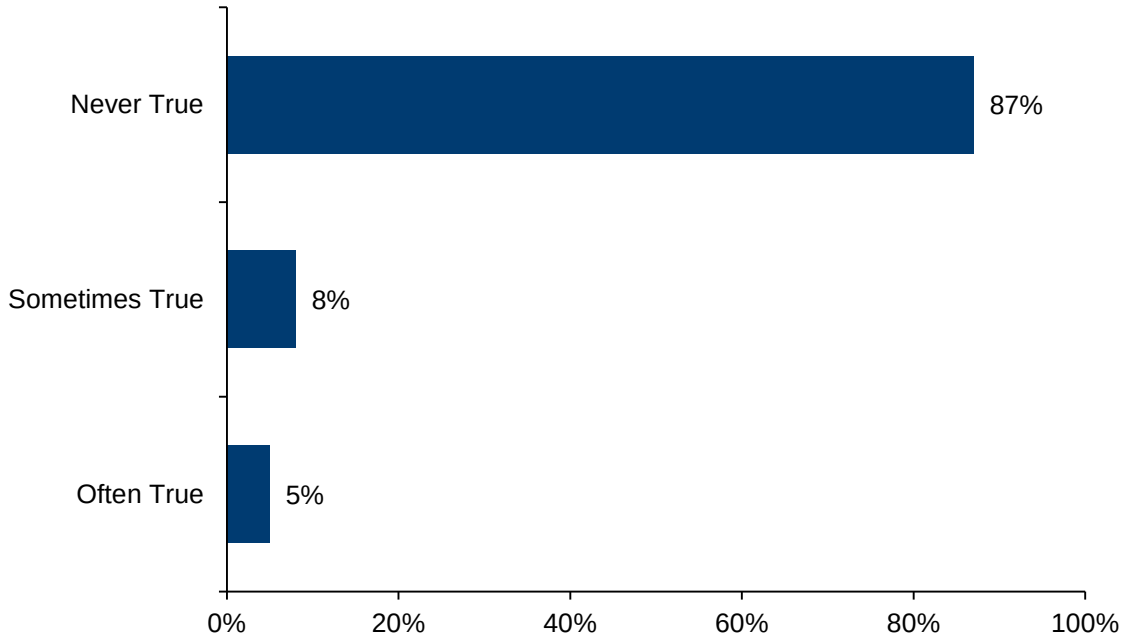
Worried whether our food would run out before we got money to buy more.



Base: Often True (n=10), Sometimes True (n=14), Never True (n=113), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)

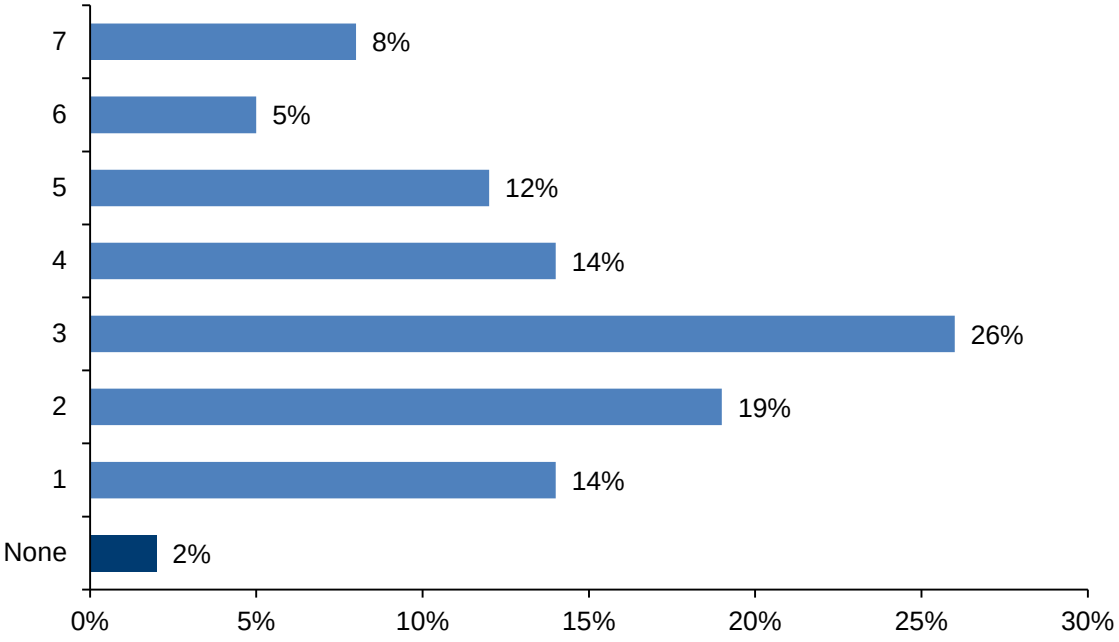
The food that we bought just didn’t last, and we didn’t have money to get more.



Base: Often True (n=7), Sometimes True (n=11), Never True (n=119), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)

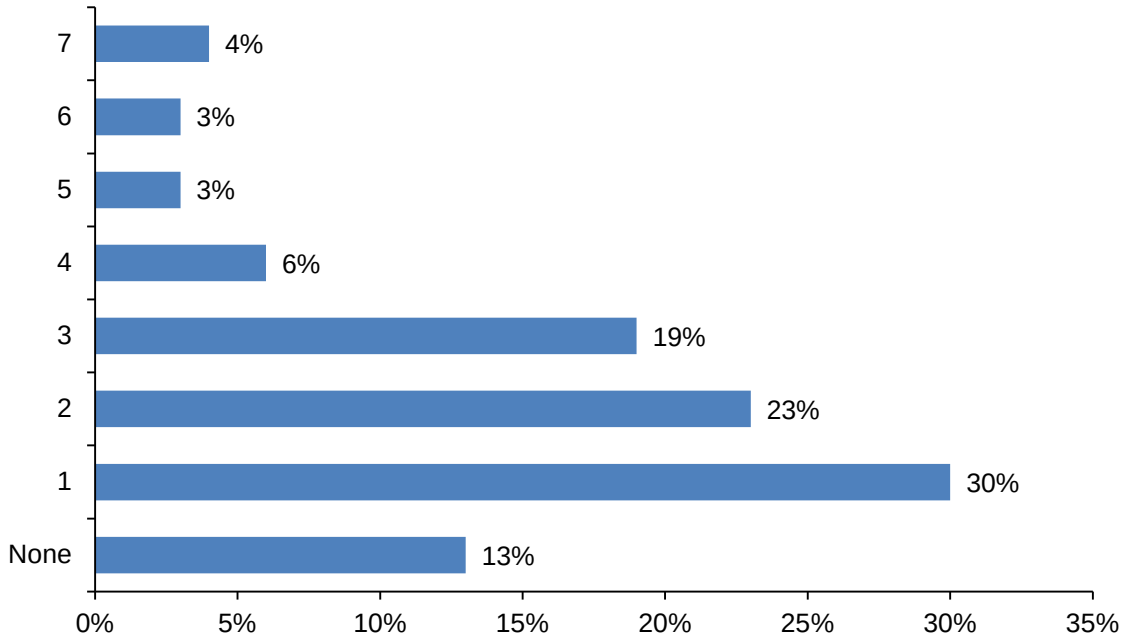
Days Per Week of Moderate Physical Activity



Base: None (n=2), 1 (n=18), 2 (n=25), 3 (n=34), 4 (n=19), 5 (n=16), 6 (n=7), 7 (n=11), Sample Size = 132

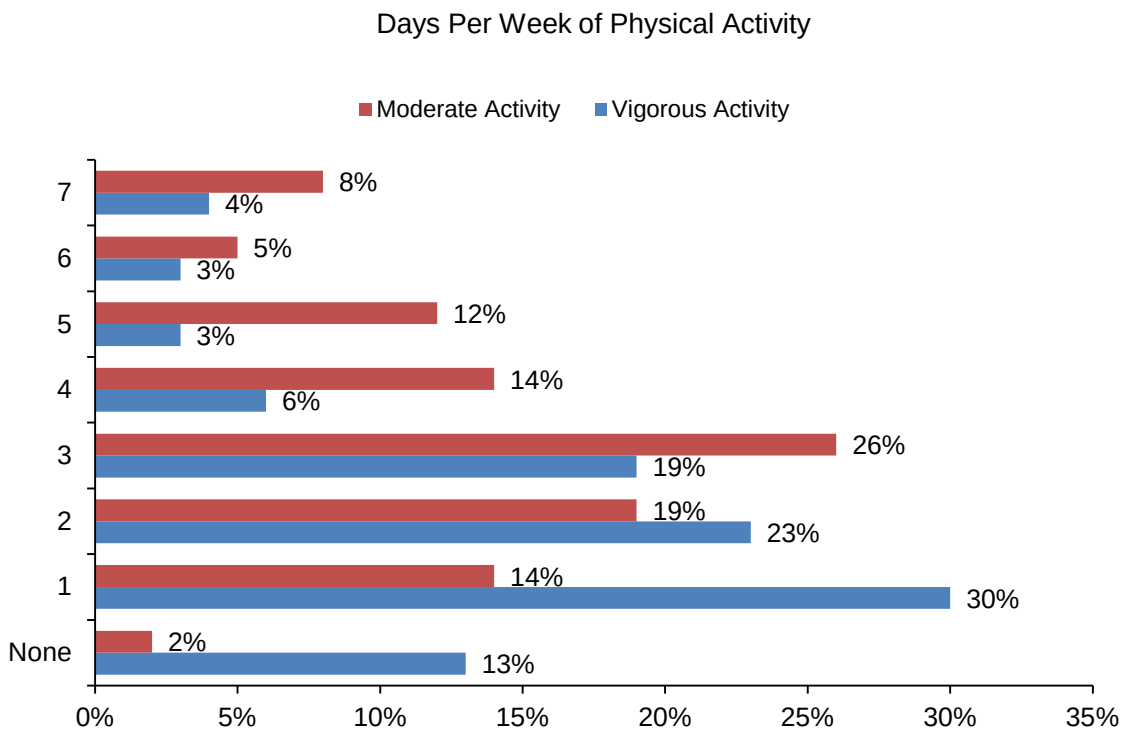
(Community = Lyon / Redwood / Cottonwood /Murray)

Days Per Week of Vigorous Physical Activity



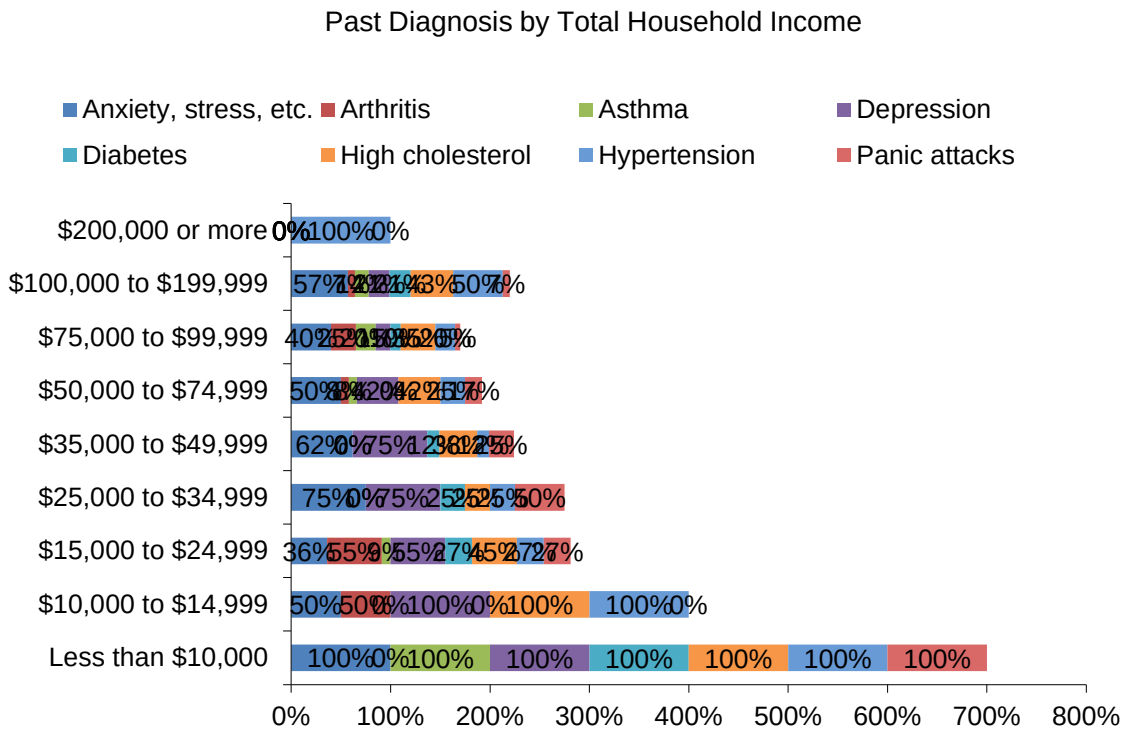
Base: None (n=14), 1 (n=32), 2 (n=25), 3 (n=20), 4 (n=7), 5 (n=3), 6 (n=3), 7 (n=4), Sample Size = 108

(Community = Lyon / Redwood / Cottonwood /Murray)



Sample Size = Variable

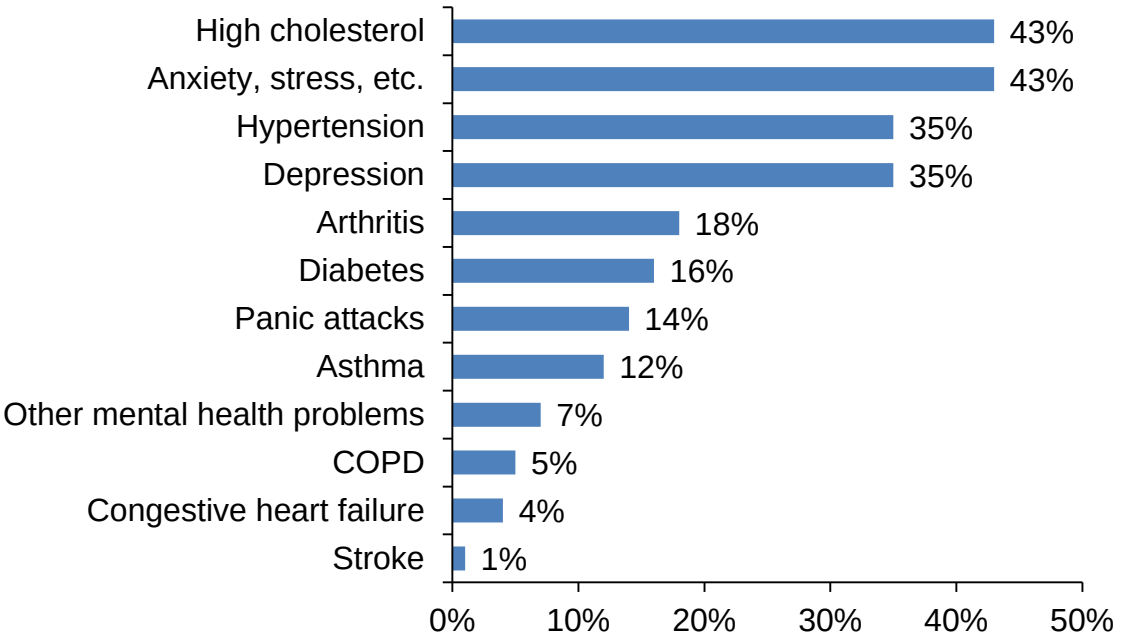
(Community = Lyon / Redwood / Cottonwood /Murray)



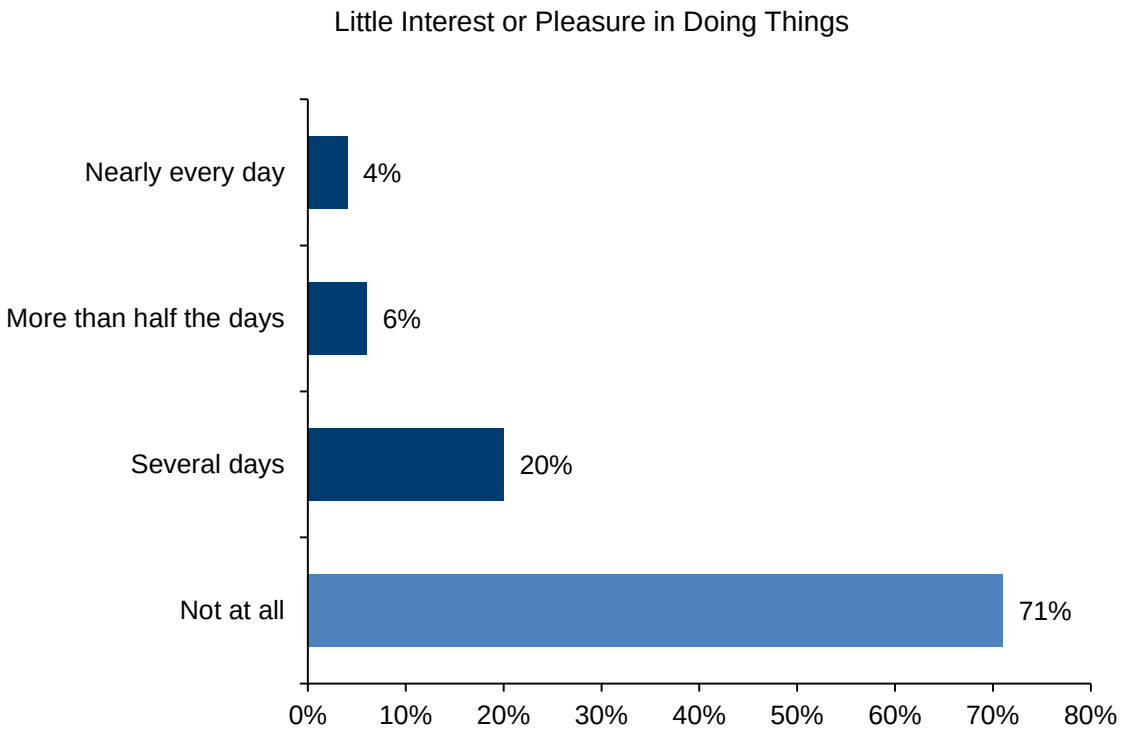
Base: Less than $10,000 (n=1), $10,000 to $14,999 (n=2), $15,000 to $24,999 (n=11), $25,000 to $34,999 (n=4), $35,000 to $49,999 (n=8), $50,000 to $74,999 (n=12), $75,000 to $99,999 (n=20), $100,000 to $199,999 (n=14), $200,000 or more (n=2), Sample Size = 74

(Community = Lyon / Redwood / Cottonwood /Murray)

Past Diagnosis

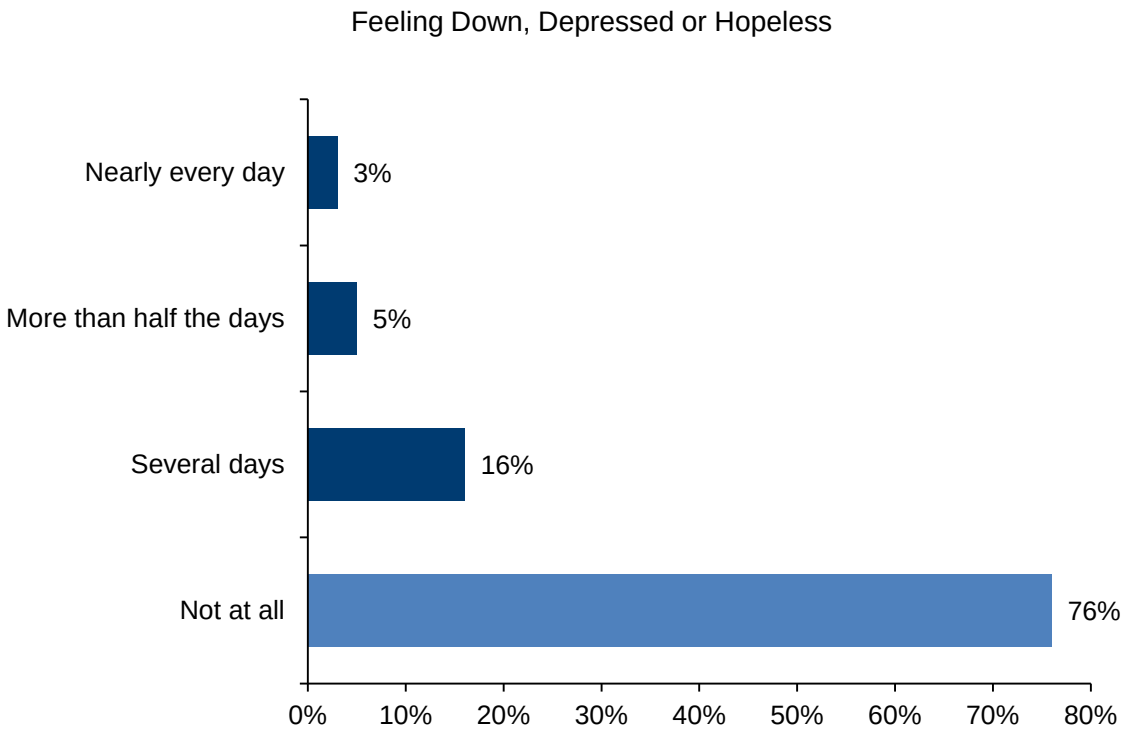


Base: Anxiety, stress, etc. (n=36), Arthritis (n=15), Asthma (n=10), Congestive heart failure (n=3), COPD (n=4), Depression (n=29), Diabetes (n=13), High cholesterol (n=36), Hypertension (n=29), Other mental health problems (n=6), Panic attacks (n=12), Stroke (n=1), Sample Size = 93



Base: Not at all (n=97), Several days (n=27), More than half the days (n=8), Nearly every day (n=5), Sample Size = 137

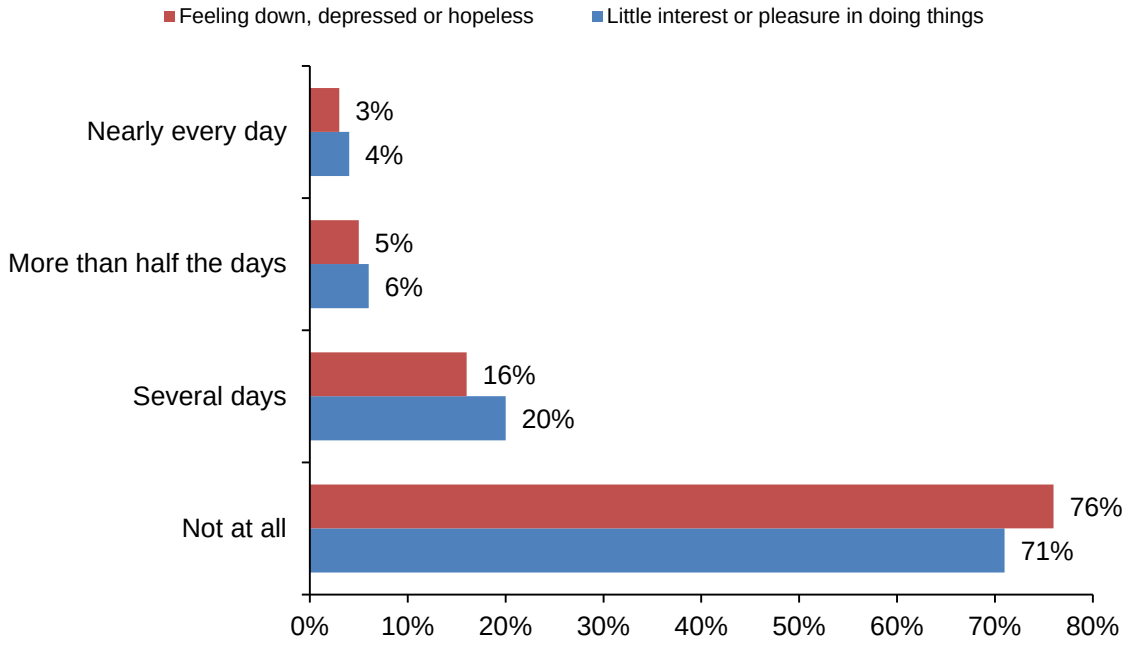
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Not at all (n=103), Several days (n=22), More than half the days (n=7), Nearly every day (n=4), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)

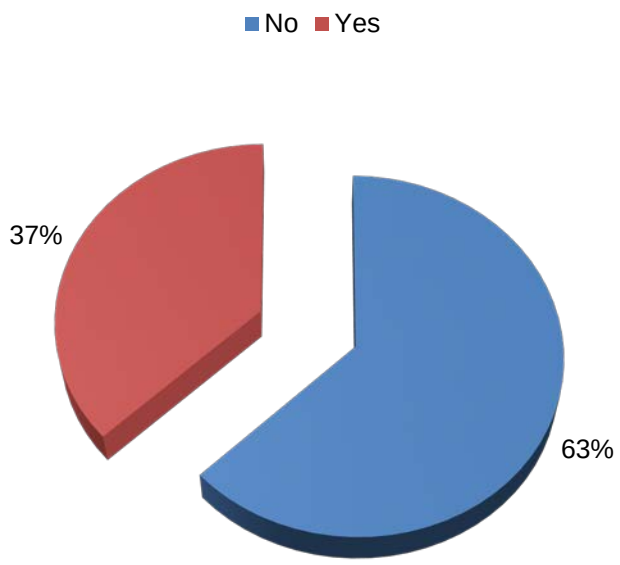
Over the past two weeks, how often have you been bothered by either of the following issues?



Sample Size = Variable

(Community = Lyon / Redwood / Cottonwood /Murray)

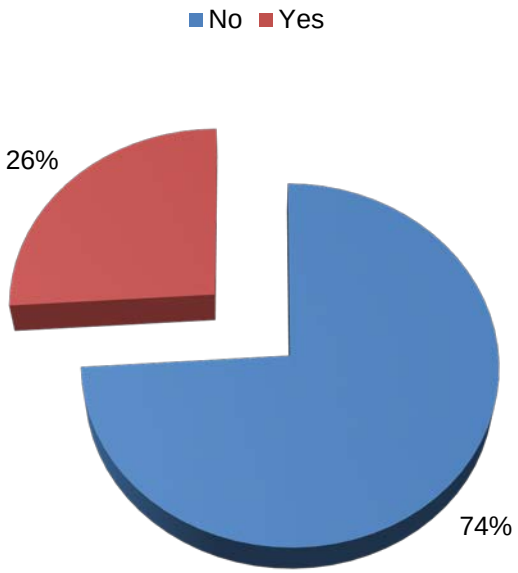
Have you smoked at least 100 cigarettes in your entire life?



Base: Yes (n=51), No (n=86), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)

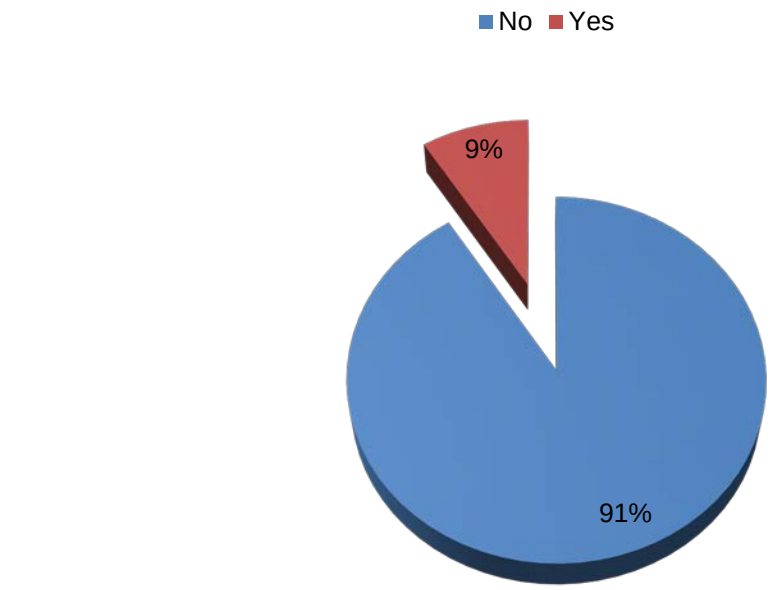
Has someone smoked cigarettes, cigars or used vape pens anywhere inside your home?



Base: Yes (n=35), No (n=102), Sample Size = 137

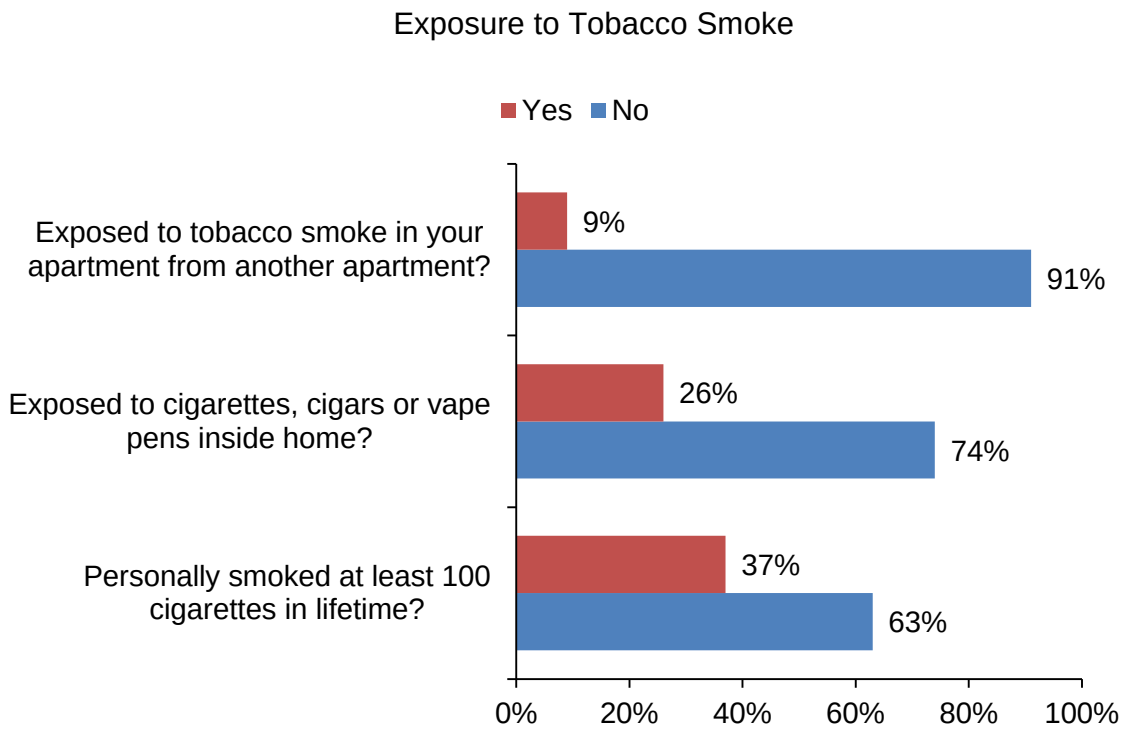
(Community = Lyon / Redwood / Cottonwood /Murray)

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



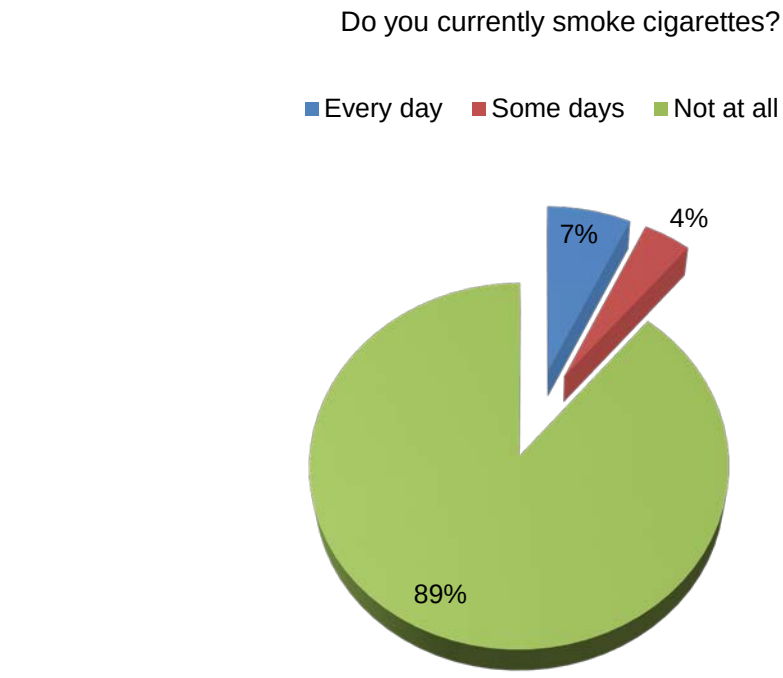
Base: Yes (n=12), No (n=125), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)



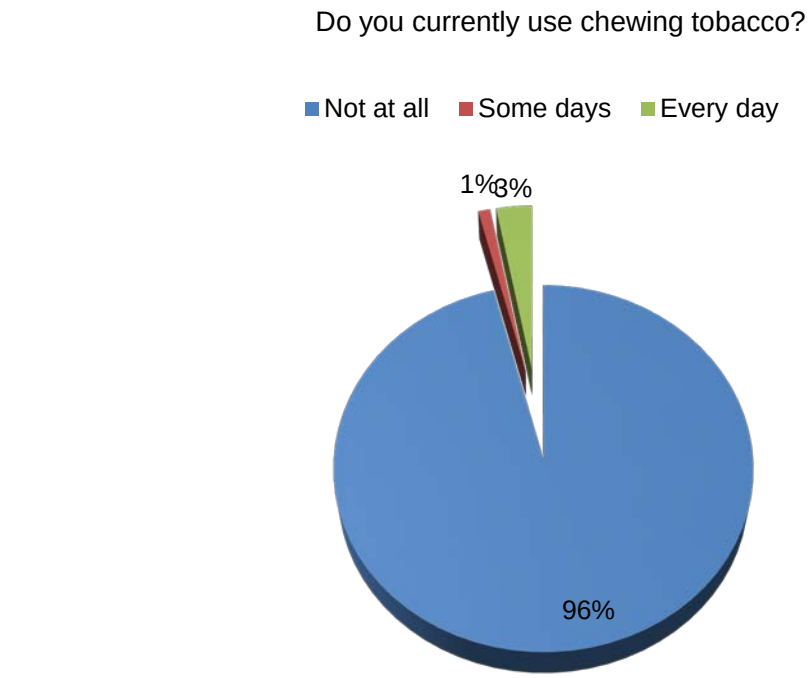
Base: Personally smoked at least 100 cigarettes in lifetime? (n=137), Exposed to cigarettes, cigars or vape pens inside home? (n=137), Exposed to tobacco smoke in your apartment from another apartment? (n=137), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Not at all (n=122), Some days (n=6), Every day (n=9), Sample Size = 137

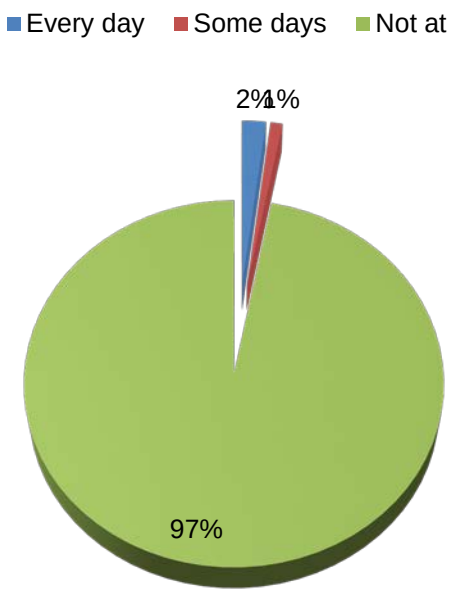
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Not at all (n=129), Some days (n=2), Every day (n=4), Sample Size = 135

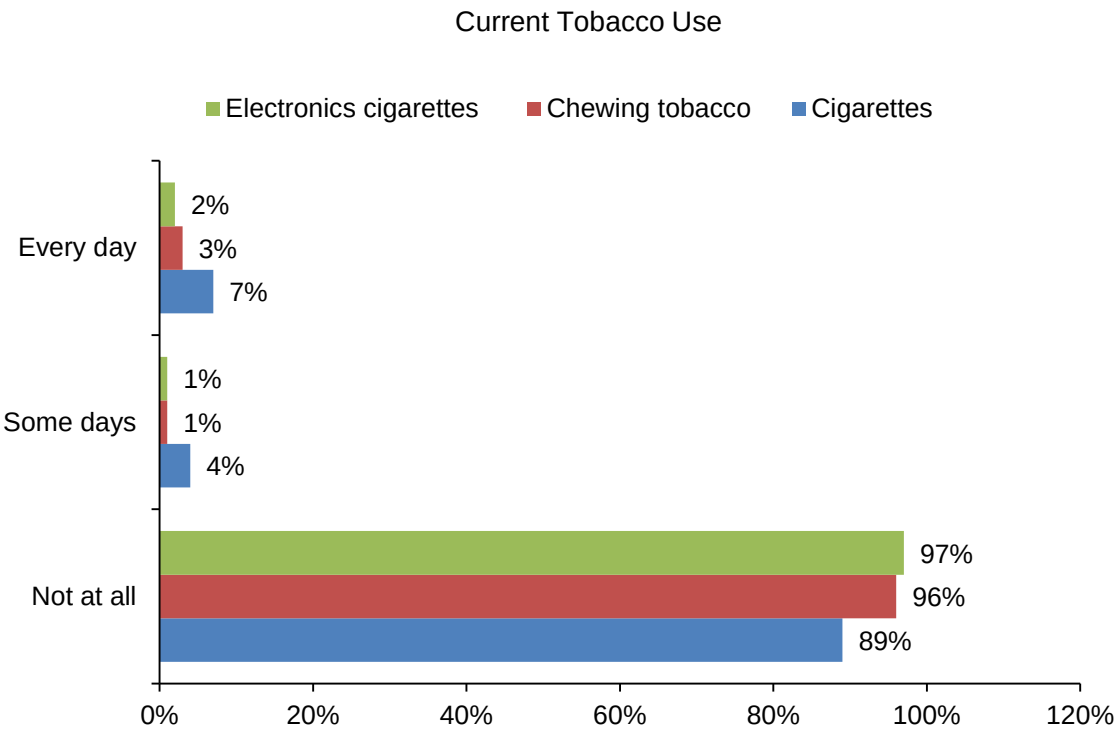
(Community = Lyon / Redwood / Cottonwood /Murray)

Do you currently use electronics cigarettes or vape?



Base: Not at all (n=131), Some days (n=1), Every day (n=3), Sample Size = 135

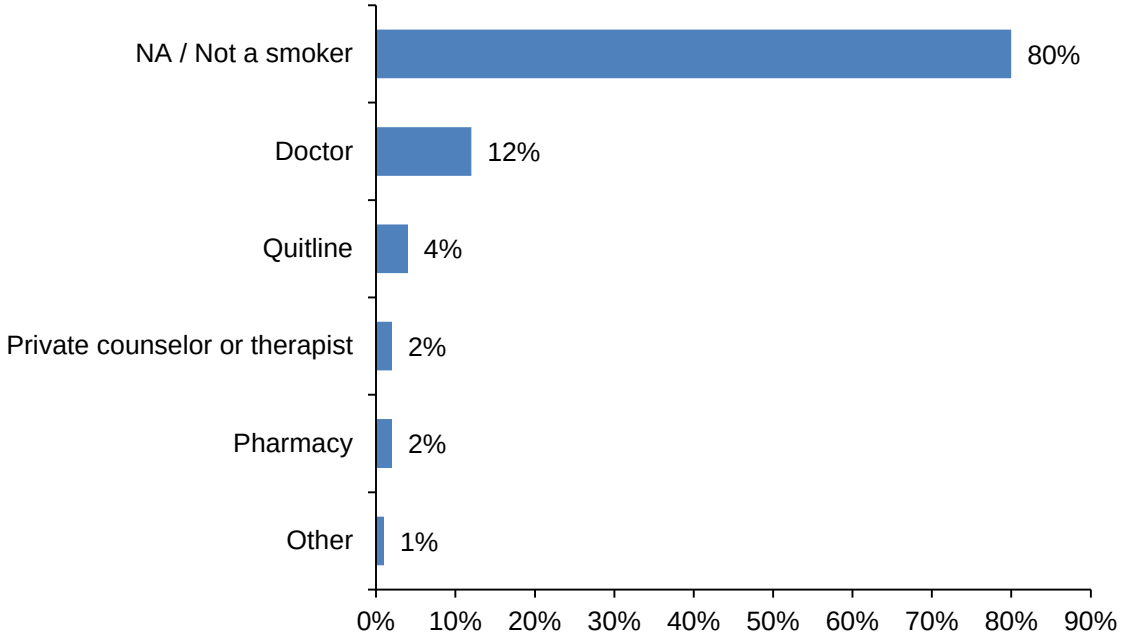
(Community = Lyon / Redwood / Cottonwood /Murray)



Sample Size = Variable

(Community = Lyon / Redwood / Cottonwood /Murray)

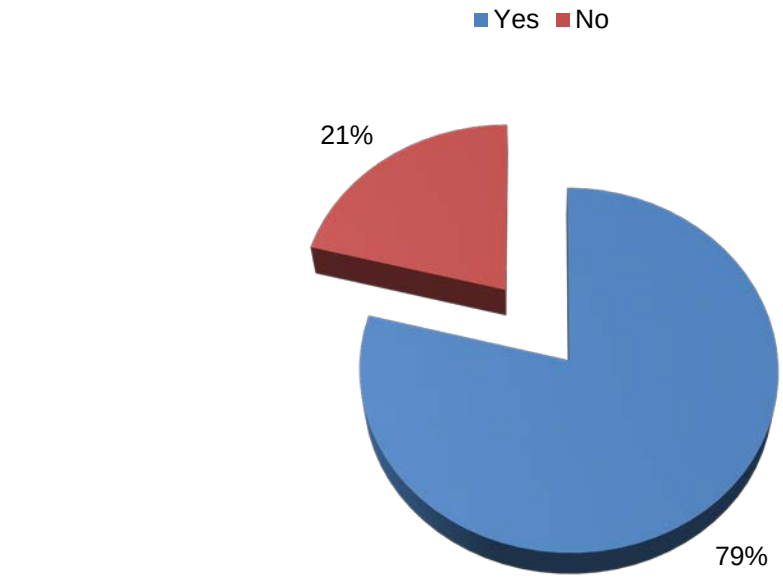
Where would you go for help if you wanted to quit using tobacco products?



Base: NA / Not a smoker (n=104), Quitline (n=5), Doctor (n=15), Pharmacy (n=3), Private counselor or therapist (n=2), Other (n=1), Sample Size = 130

(Community = Lyon / Redwood / Cottonwood /Murray)

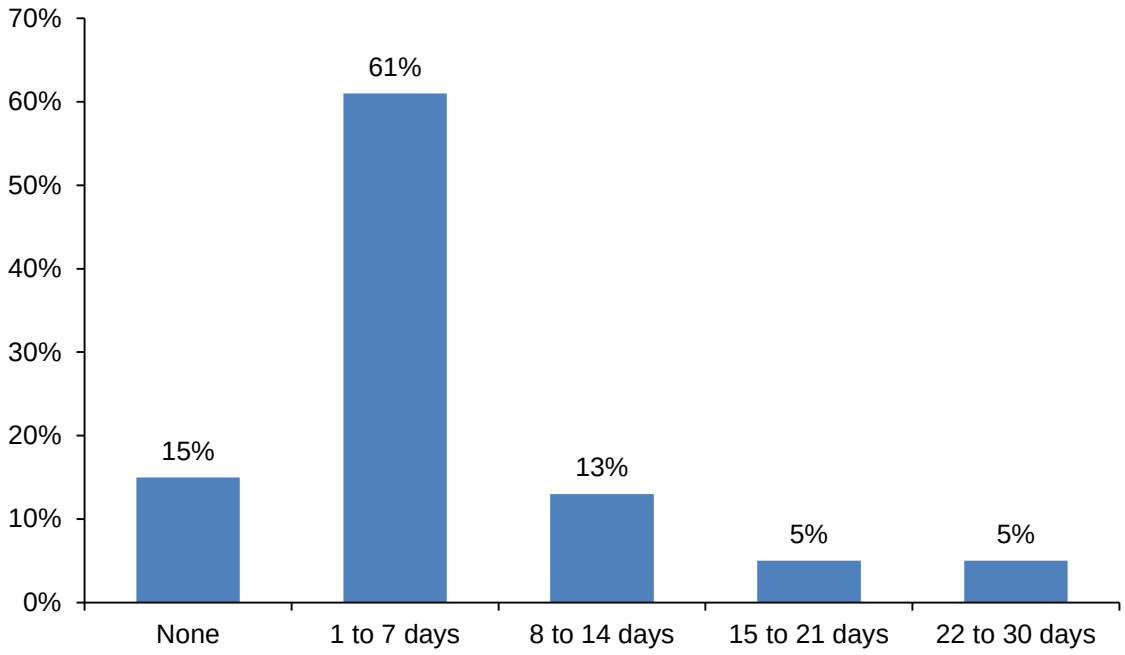
During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit? (Smokers only)



Base: Yes (n=15), No (n=4), Sample Size = 19

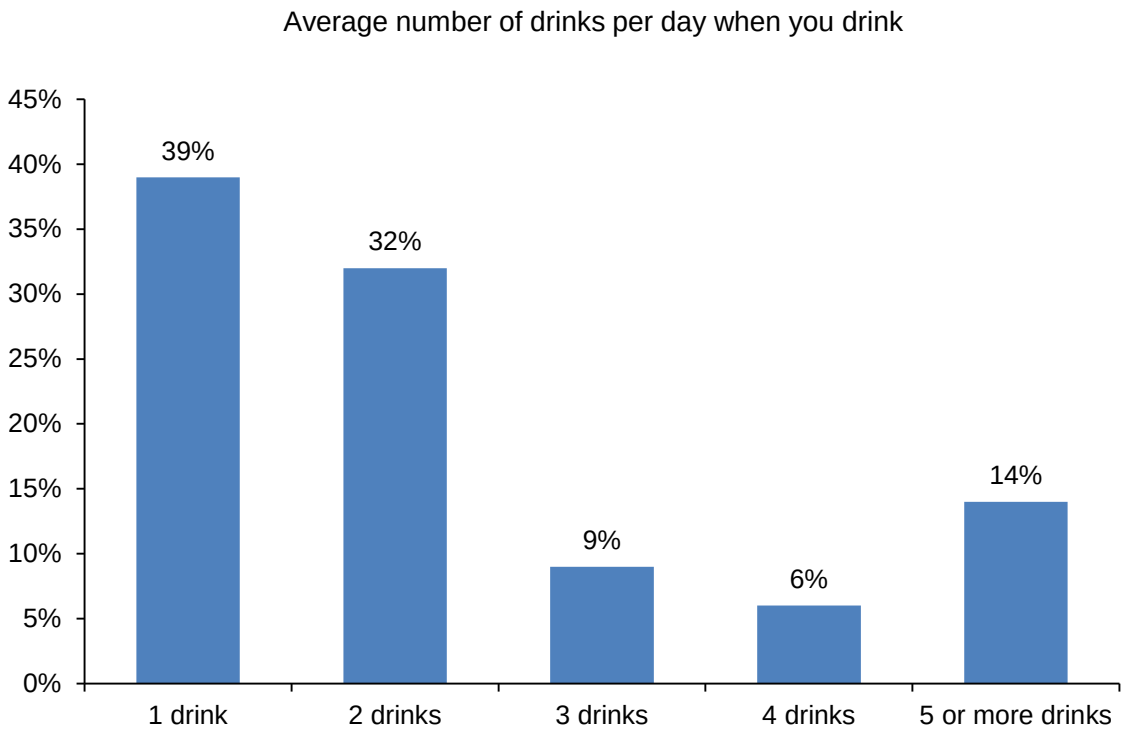
(Community = Lyon / Redwood / Cottonwood /Murray)

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



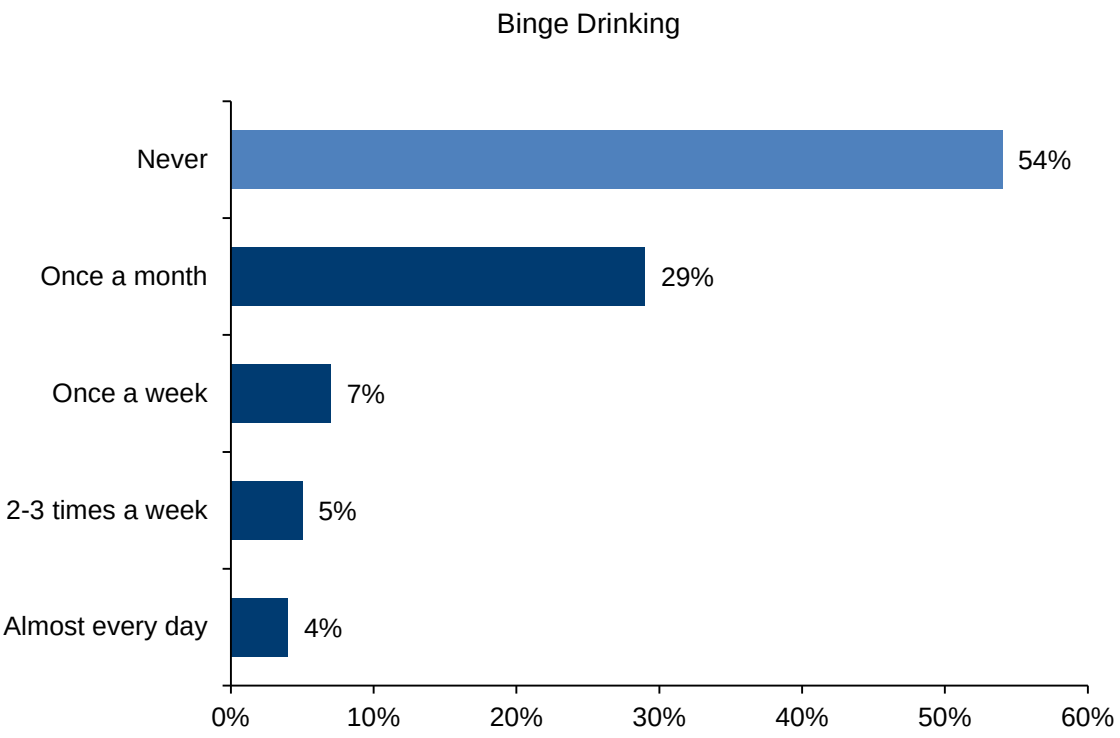
Base: None (n=17), 1 to 7 days (n=70), 8 to 14 days (n=15), 15 to 21 days (n=6), 22 to 30 days (n=6), Sample Size = 114

(Community = Lyon / Redwood / Cottonwood /Murray)



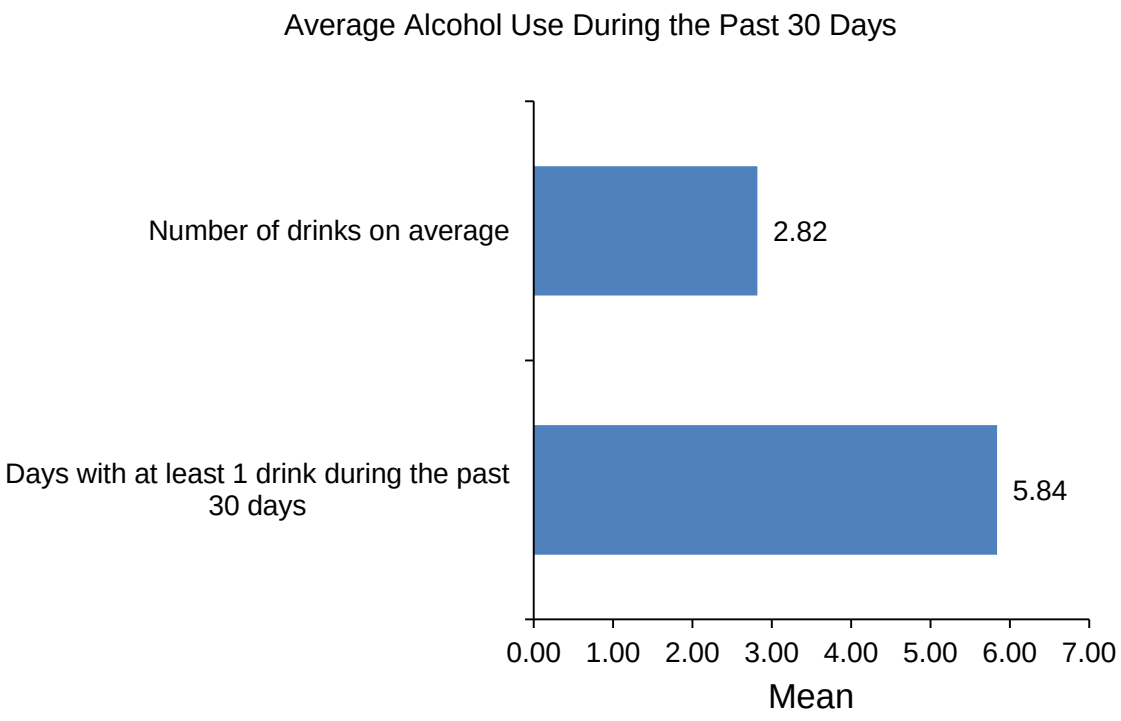
Base: 1 drink (n=37), 2 drinks (n=30), 3 drinks (n=9), 4 drinks (n=6), 5 or more drinks (n=13), Sample Size = 95

(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Almost every day (n=4), 2-3 times a week (n=5), Once a week (n=7), Once a month (n=28), Never (n=52), Sample Size = 96

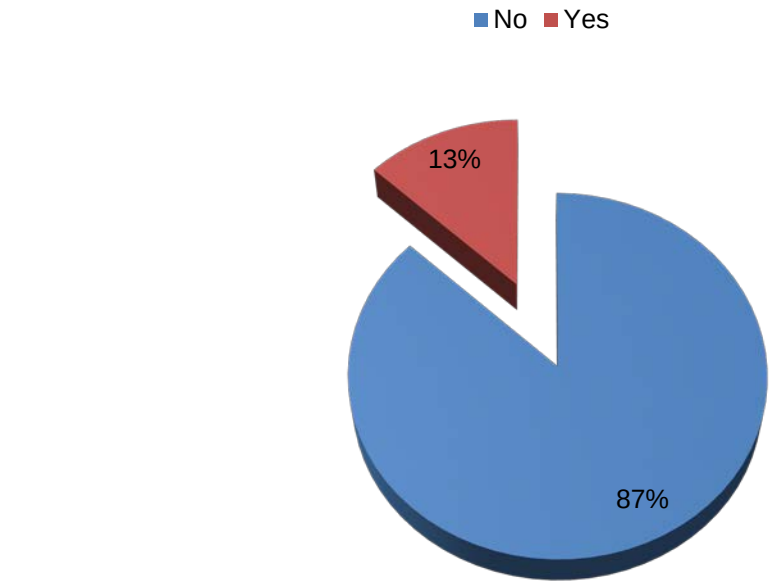
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Days with at least 1 drink during the past 30 days (n=114), Number of drinks on average (n=95), Sample Size = Variable

(Community = Lyon / Redwood / Cottonwood /Murray)

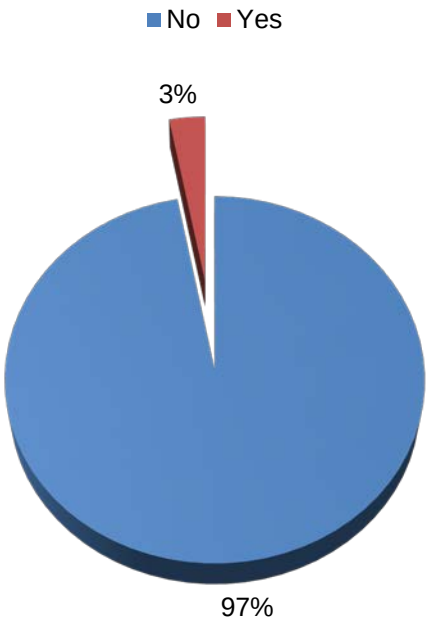
Has alcohol use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=18), No (n=117), Sample Size = 135

(Community = Lyon / Redwood / Cottonwood /Murray)

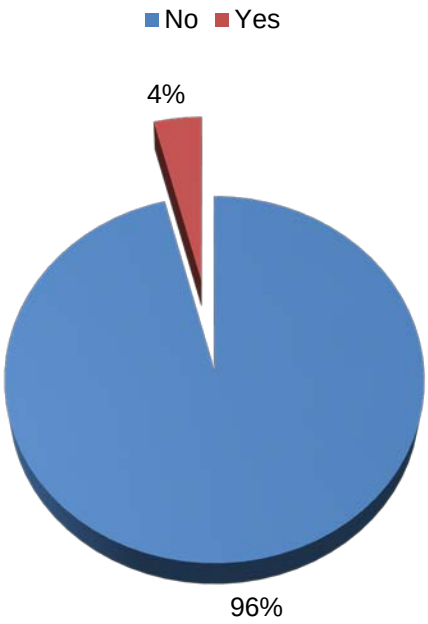
Have you ever wanted help with a prescription or non-prescription drug use?



Base: Yes (n=4), No (n=132), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)

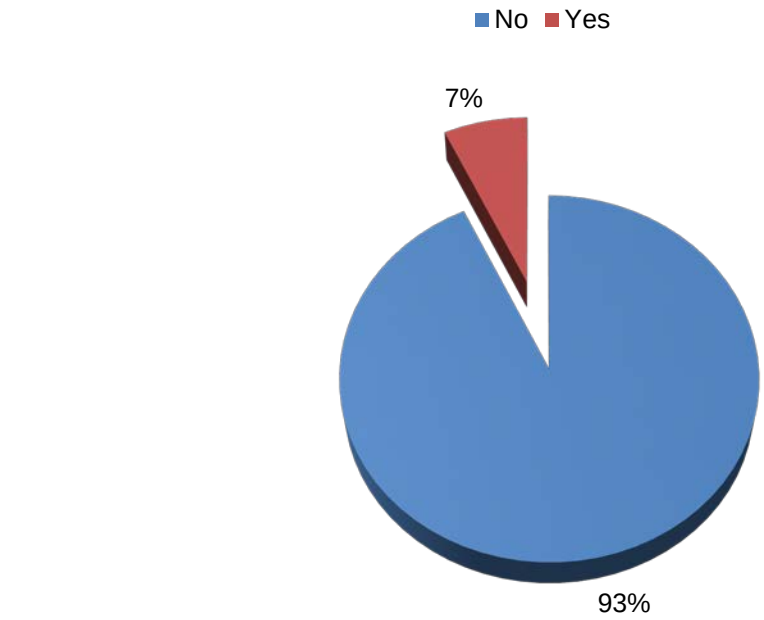
Has a family member or friend ever suggested that you get help for substance use?



Base: Yes (n=5), No (n=131), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)

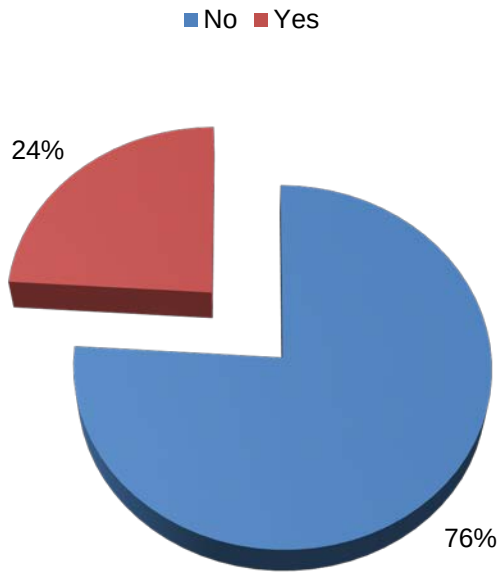
Has prescription or non-prescription drug use had a harmful effect on you or a family member in the past two years?



Base: Yes (n=10), No (n=126), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)

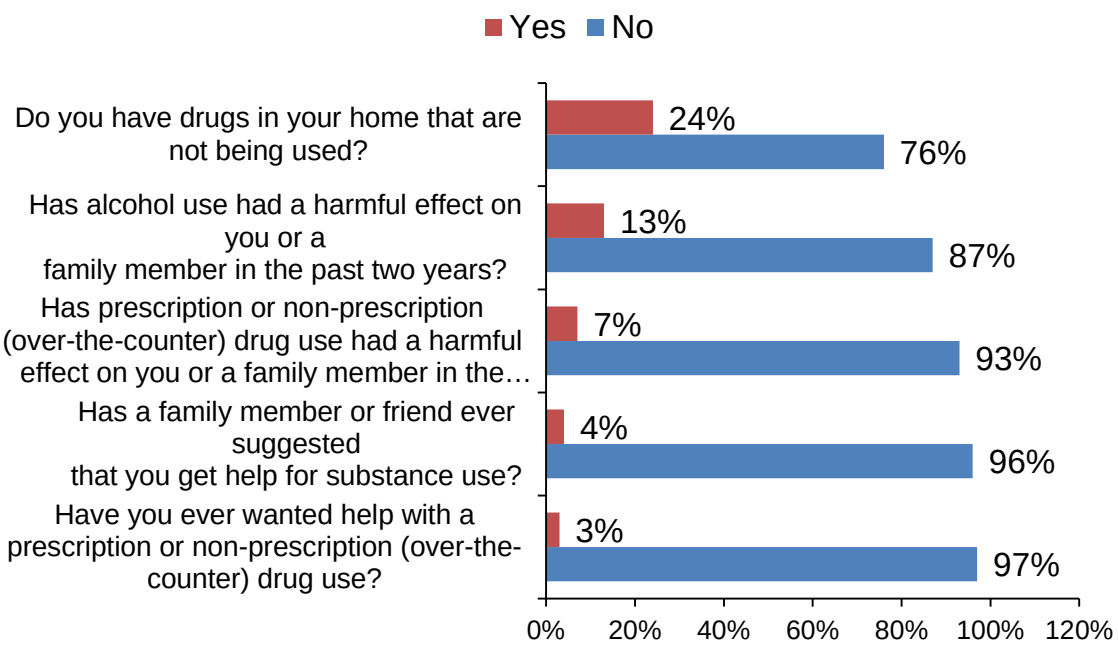
Do you have drugs in your home that are not being used?



Base: Yes (n=33), No (n=102), Sample Size = 135

(Community = Lyon / Redwood / Cottonwood /Murray)

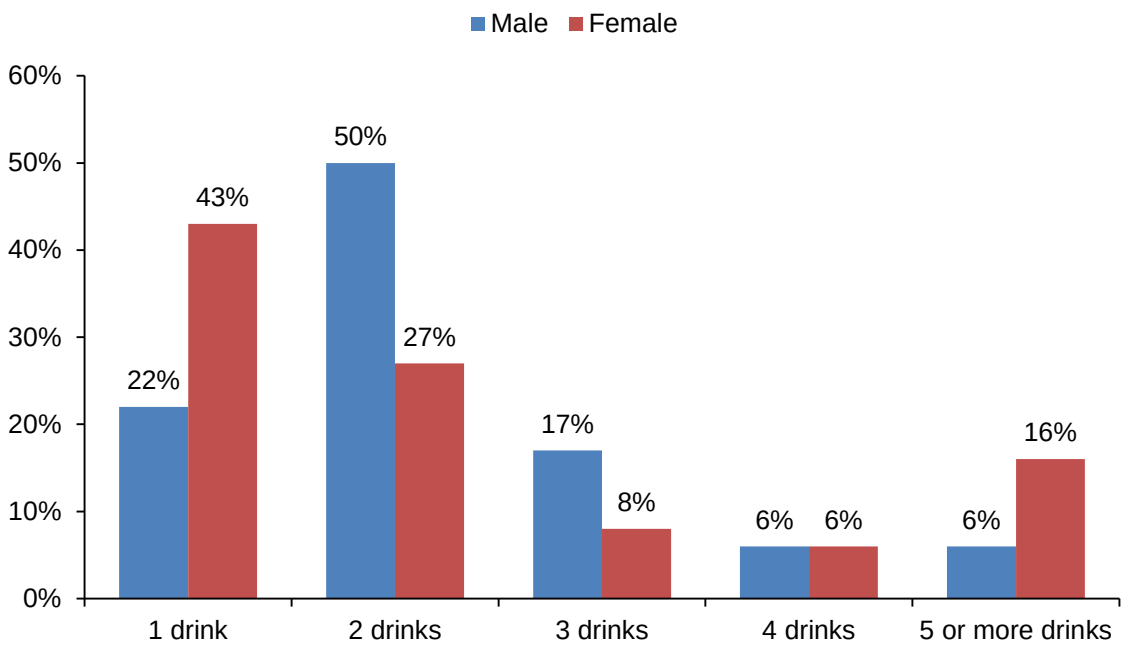
Drug and Alcohol Issues



Sample Size = Variable

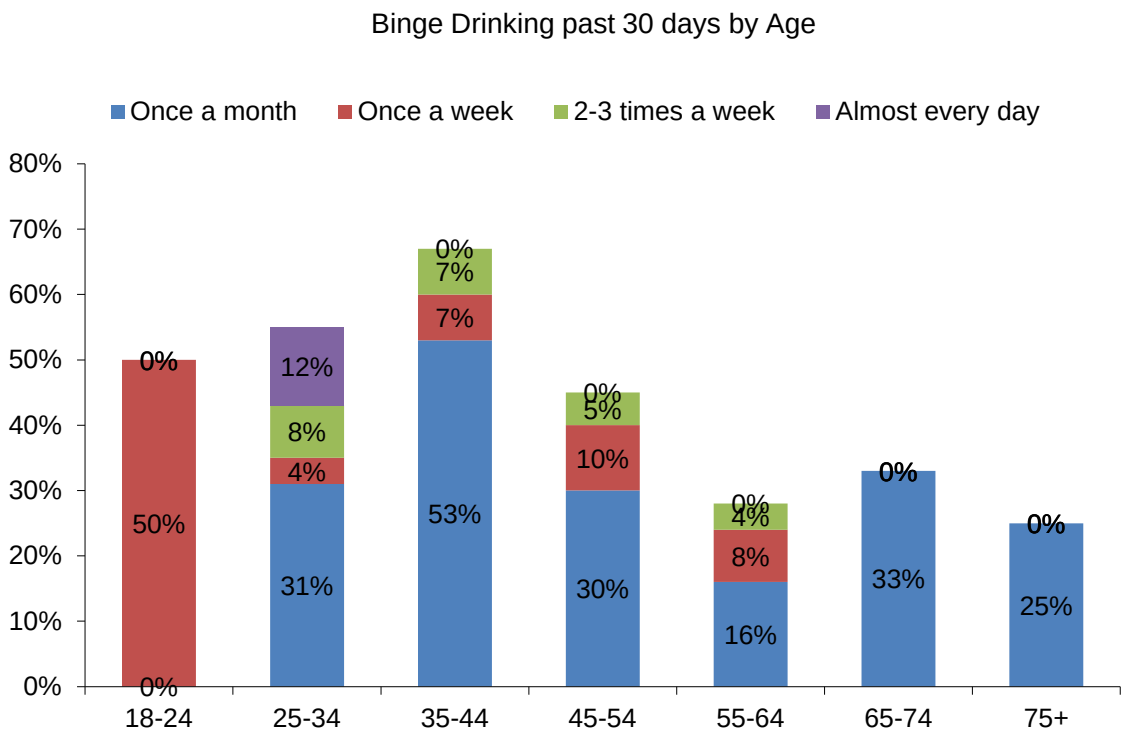
(Community = Lyon / Redwood / Cottonwood /Murray)

Average number of drinks per day when you drink by gender



Base: 1 drink (n=37), 2 drinks (n=30), 3 drinks (n=9), 4 drinks (n=6), 5 or more drinks (n=13), Sample Size = 95

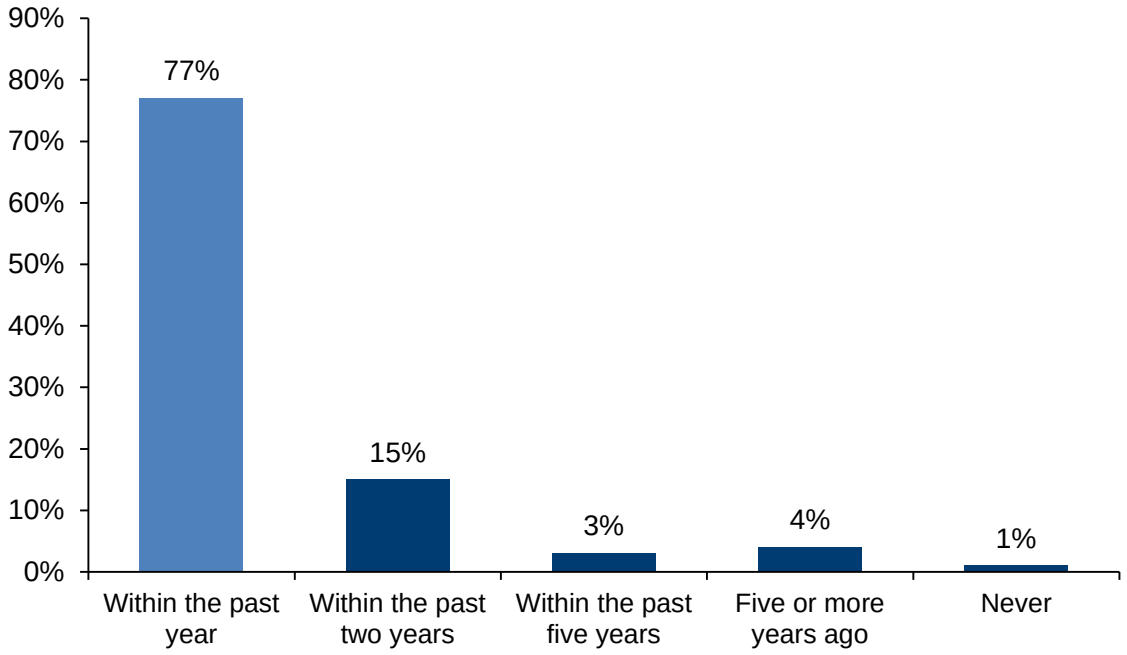
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: 18-24 (n=2), 25-34 (n=26), 35-44 (n=15), 45-54 (n=20), 55-64 (n=25), 65-74 (n=3), 75+ (n=4), Sample Size = 95

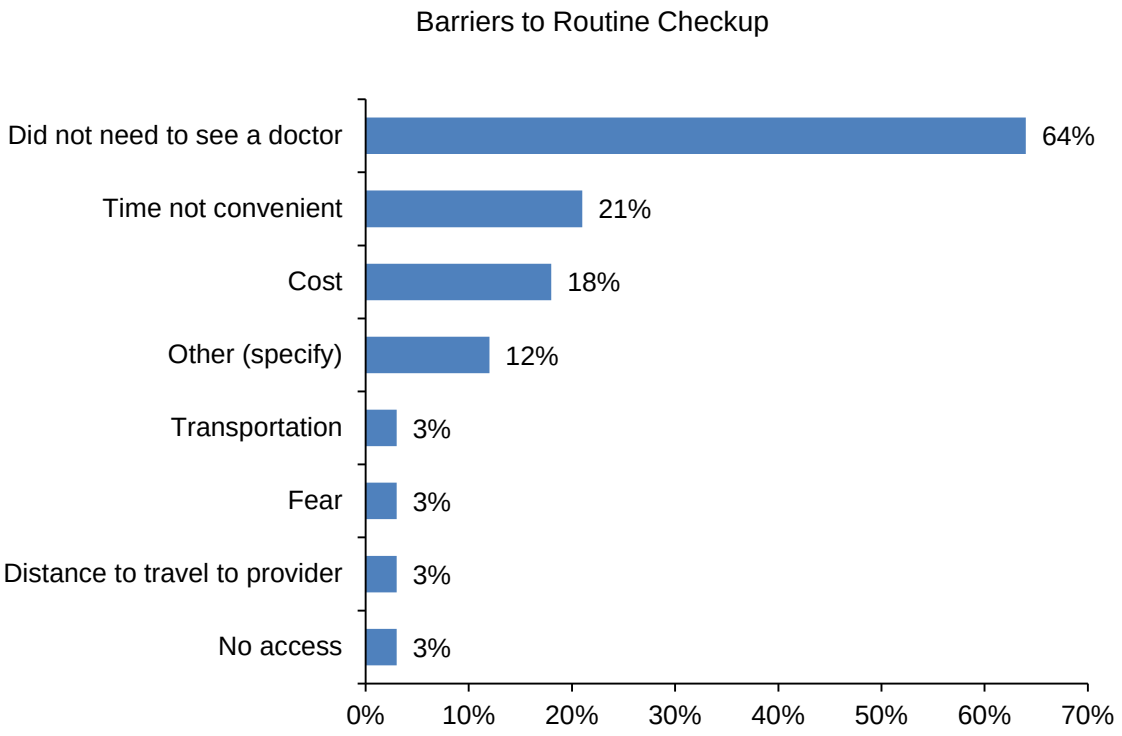
(Community = Lyon / Redwood / Cottonwood /Murray)

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=104), Within the past two years (n=20), Within the past five years (n=4), Five or more years ago (n=5), Never (n=2), Sample Size = 135

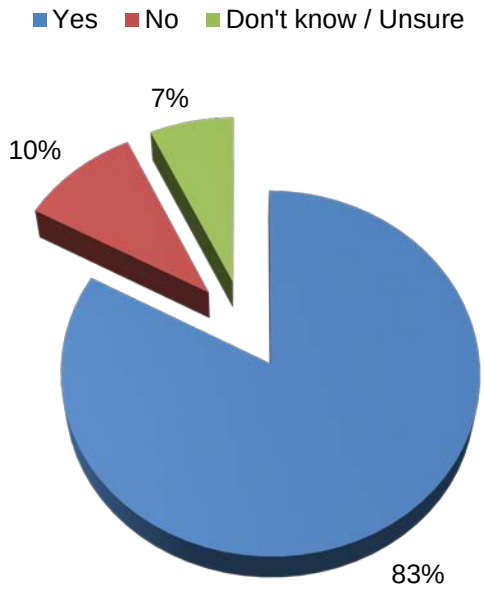
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: No access (n=1), Distance to travel to provider (n=1), Cost (n=6), Fear (n=1), Transportation (n=1), Time not convenient (n=7), Did not need to see a doctor (n=21), Other (specify) (n=4), Sample Size = 33

(Community = Lyon / Redwood / Cottonwood /Murray)

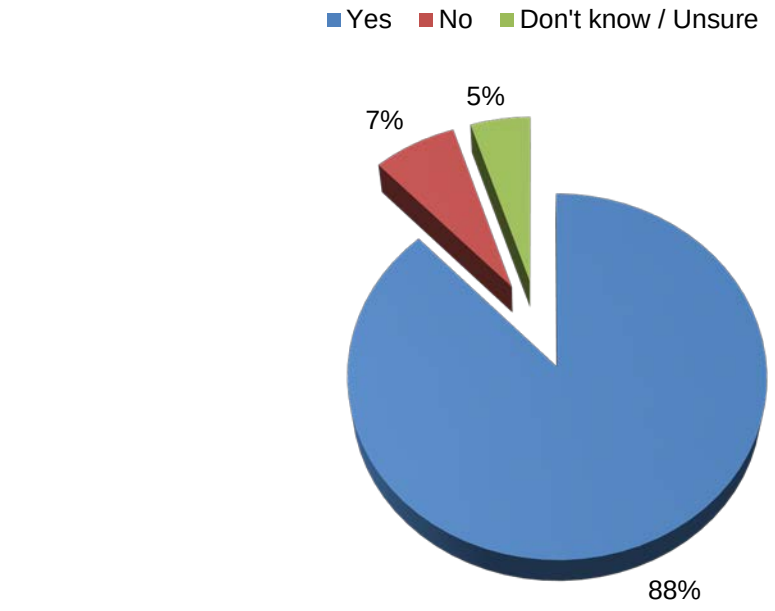
Has your medical provider reviewed the risks and benefits of screenings and preventive services with you?



Base: Yes (n=113), No (n=14), Don't know / Unsure (n=9), Sample Size = 136

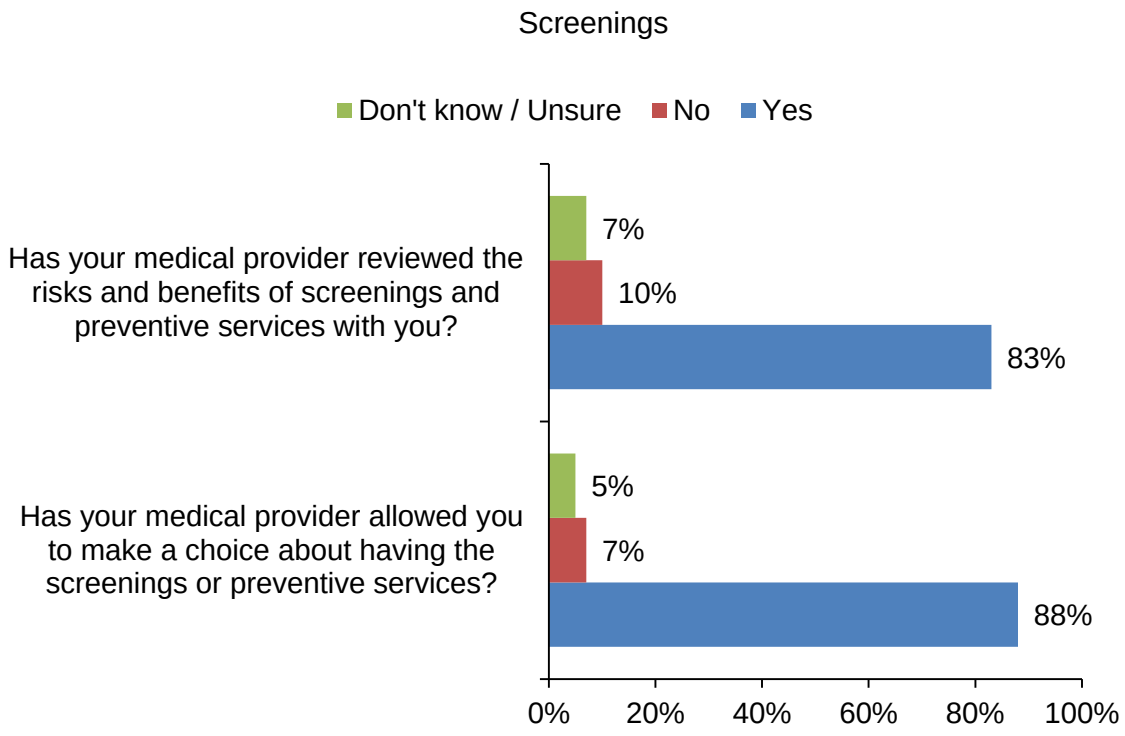
(Community = Lyon / Redwood / Cottonwood /Murray)

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



Base: Yes (n=121), No (n=9), Don't know / Unsure (n=7), Sample Size = 137

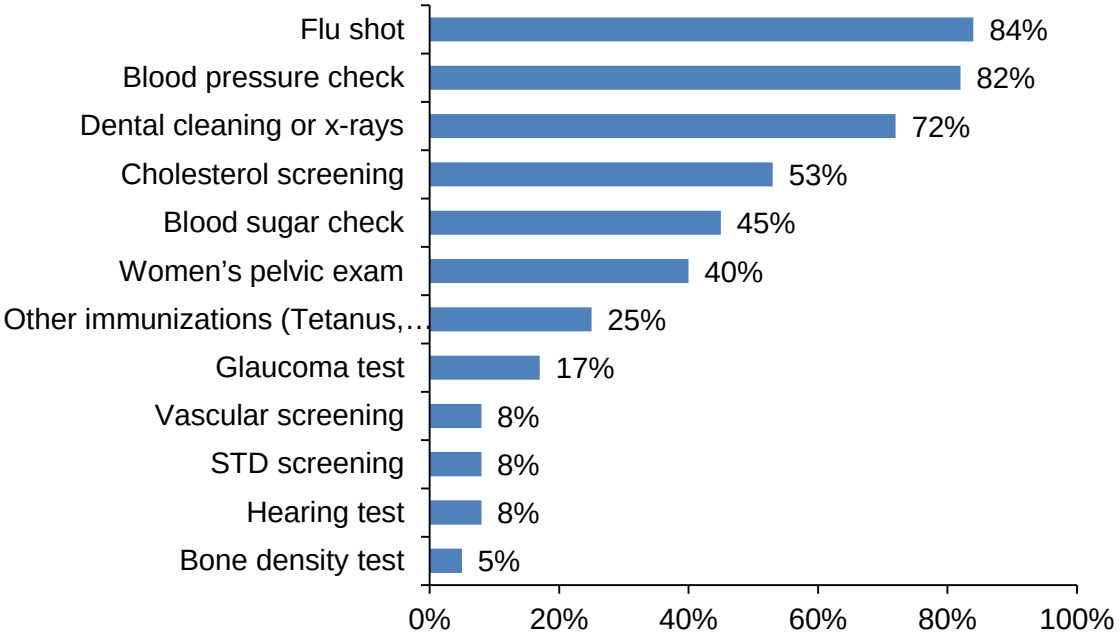
(Community = Lyon / Redwood / Cottonwood /Murray)



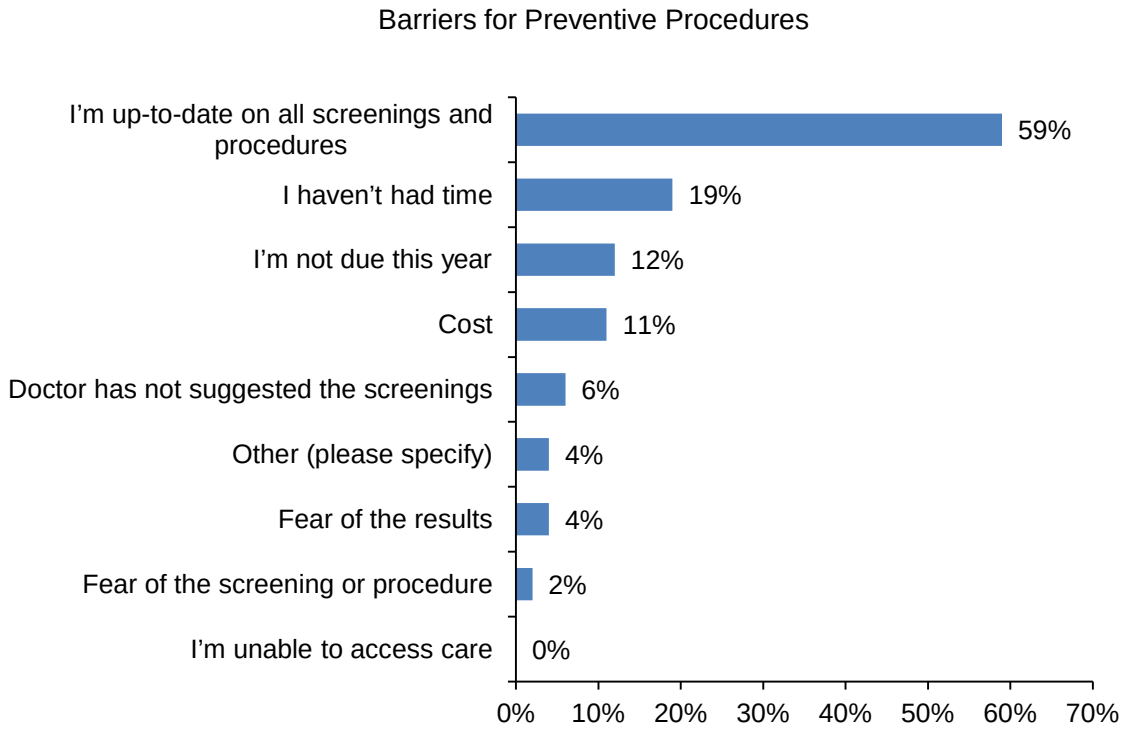
Base: Has your medical provider allowed you to make a choice about having the screenings or preventive services? (n=137), Has your medical provider reviewed the risks and benefits of screenings and preventive services with you? (n=136), Sample Size = Variable

(Community = Lyon / Redwood / Cottonwood /Murray)

Preventive Procedures Last Year

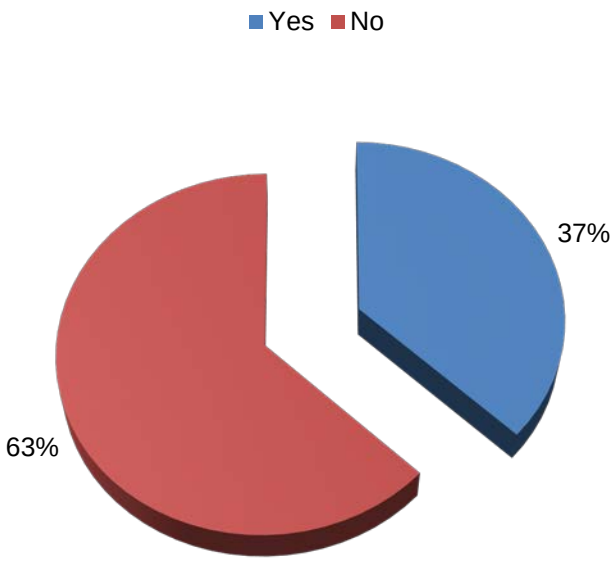


Base: Blood pressure check (n=107), Blood sugar check (n=59), Bone density test (n=7), Cholesterol screening (n=69), Dental cleaning or x-rays (n=94), Flu shot (n=109), Other immunizations (Tetanus, Hepatitis A or B) (n=33), Glaucoma test (n=22), Hearing test (n=10), Women's pelvic exam (n=52), STD screening (n=10), Vascular screening (n=10), Sample Size = 130
(Community = Lyon / Redwood / Cottonwood /Murray)



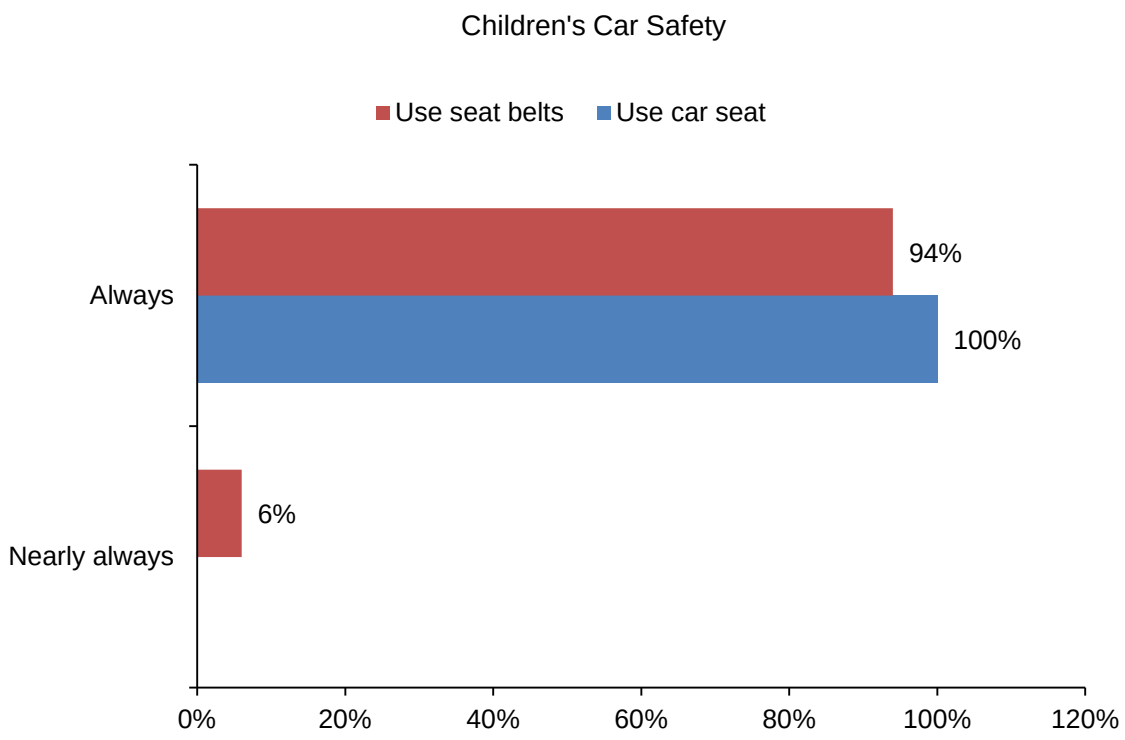
Base: I'm up-to-date on all screenings and procedures (n=79), Doctor has not suggested the screenings (n=8), Cost (n=15), I'm unable to access care (n=0), Fear of the screening or procedure (n=3), Fear of the results (n=6), I'm not due this year (n=16), I haven't had time (n=26), Other (please specify) (n=5),
Sample Size = 134
(Community = Lyon / Redwood / Cottonwood /Murray)

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



Base: Yes (n=50), No (n=86), Sample Size = 136

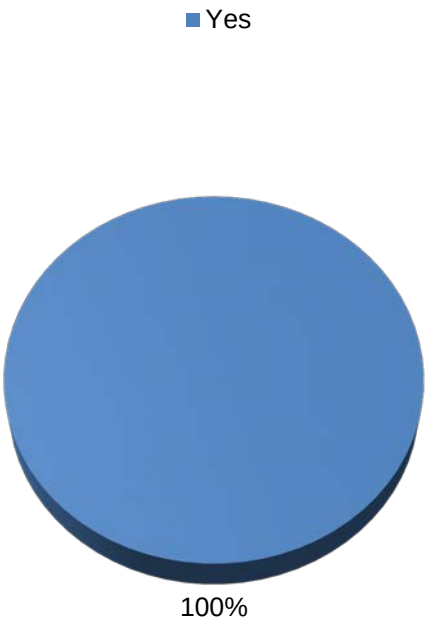
(Community = Lyon / Redwood / Cottonwood /Murray)



Sample Size = Variable

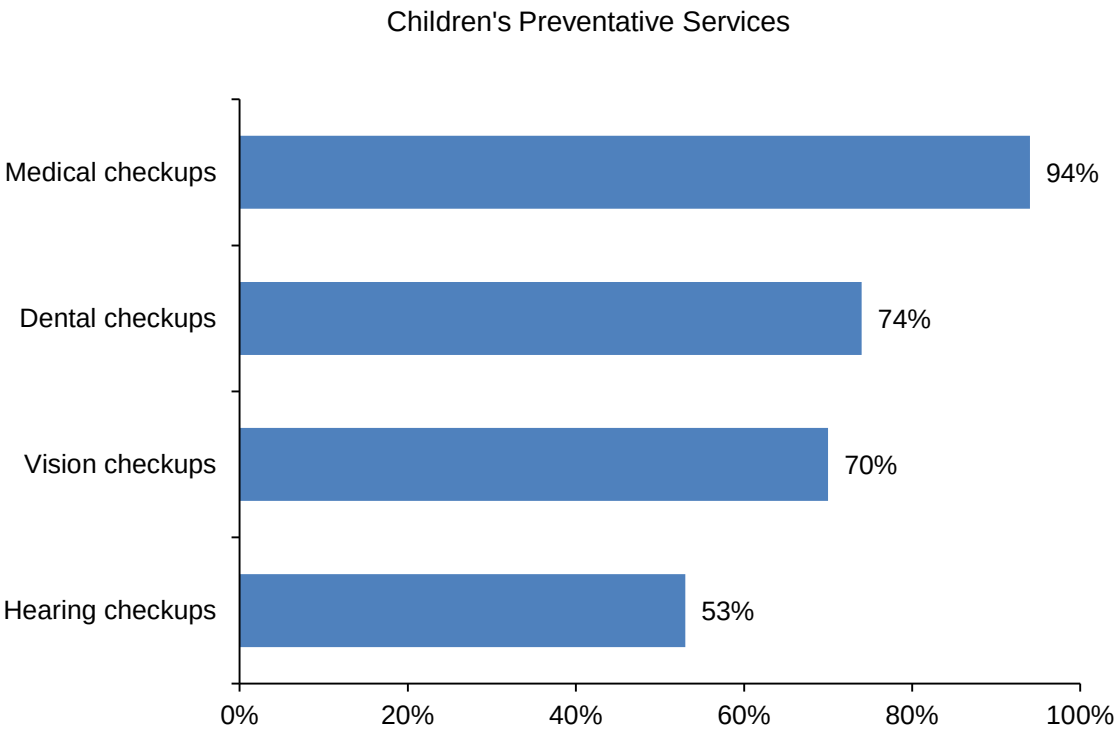
(Community = Lyon / Redwood / Cottonwood /Murray)

Do you have healthcare coverage for your children or dependents?



Base: Yes (n=48), Sample Size = 48

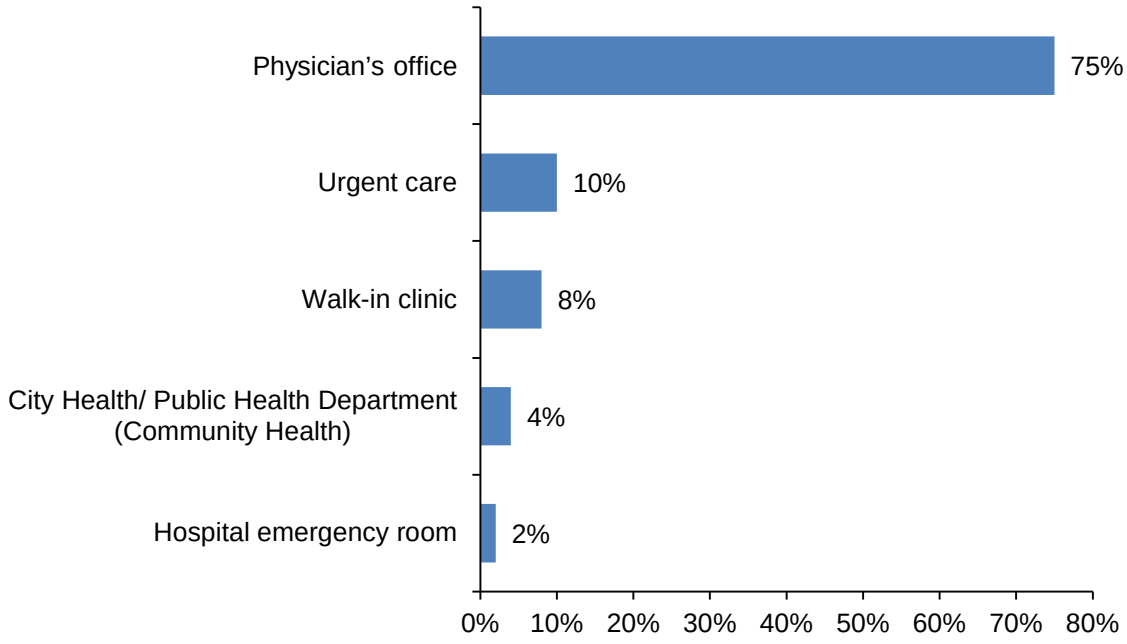
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Dental checkups (n=35), Vision checkups (n=33), Hearing checkups (n=25), Medical checkups (n=44), Sample Size = 47

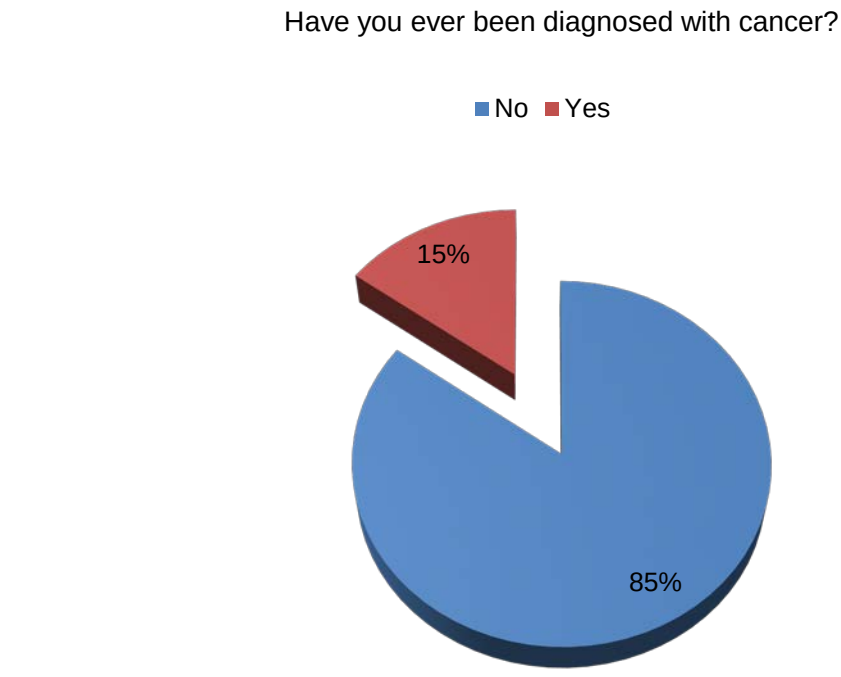
(Community = Lyon / Redwood / Cottonwood /Murray)

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



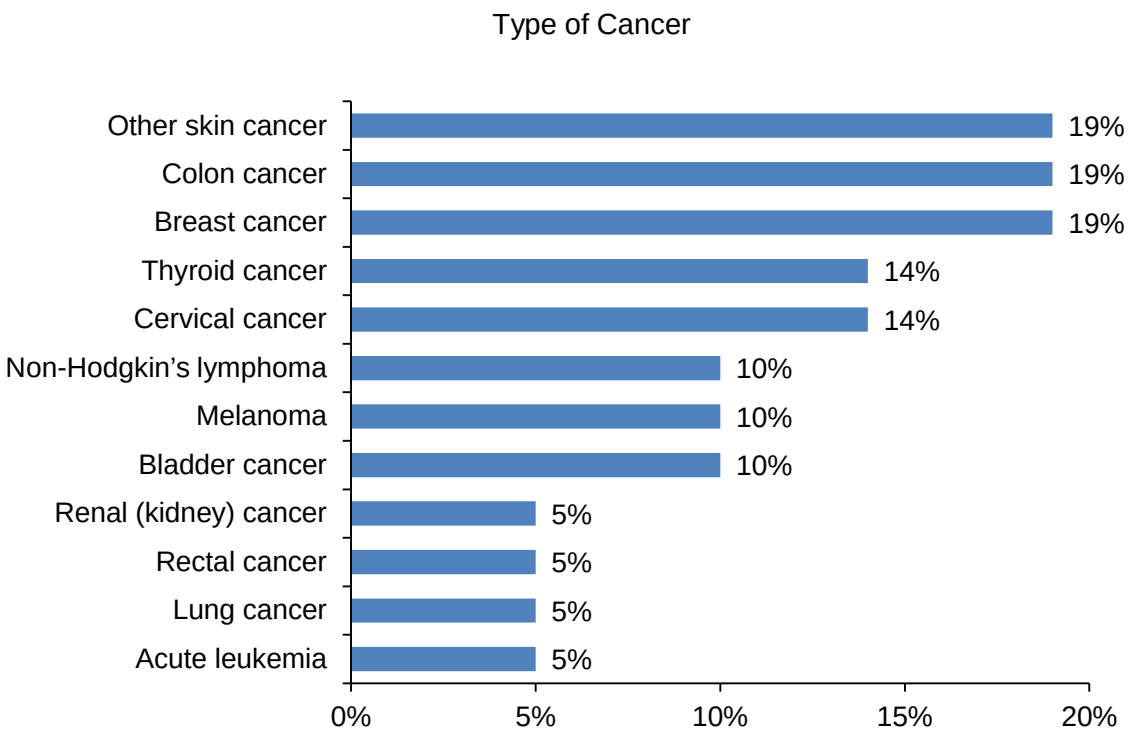
Base: Physician's office (n=36), Hospital emergency room (n=1), Urgent care (n=5), Walk-in clinic (n=4), City Health/ Public Health Department (Community Health) (n=2), Sample Size = 48

(Community = Lyon / Redwood / Cottonwood /Murray)



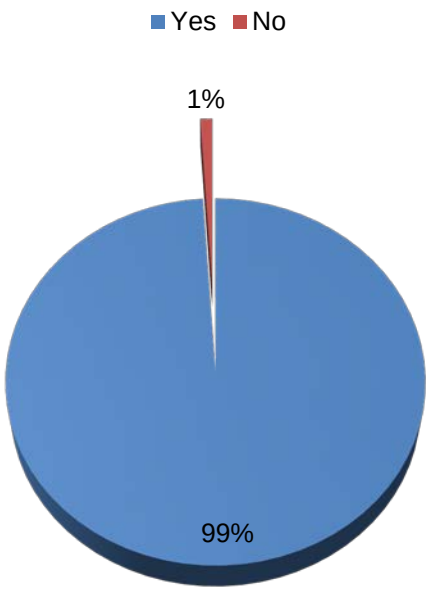
Base: Yes (n=21), No (n=115), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)



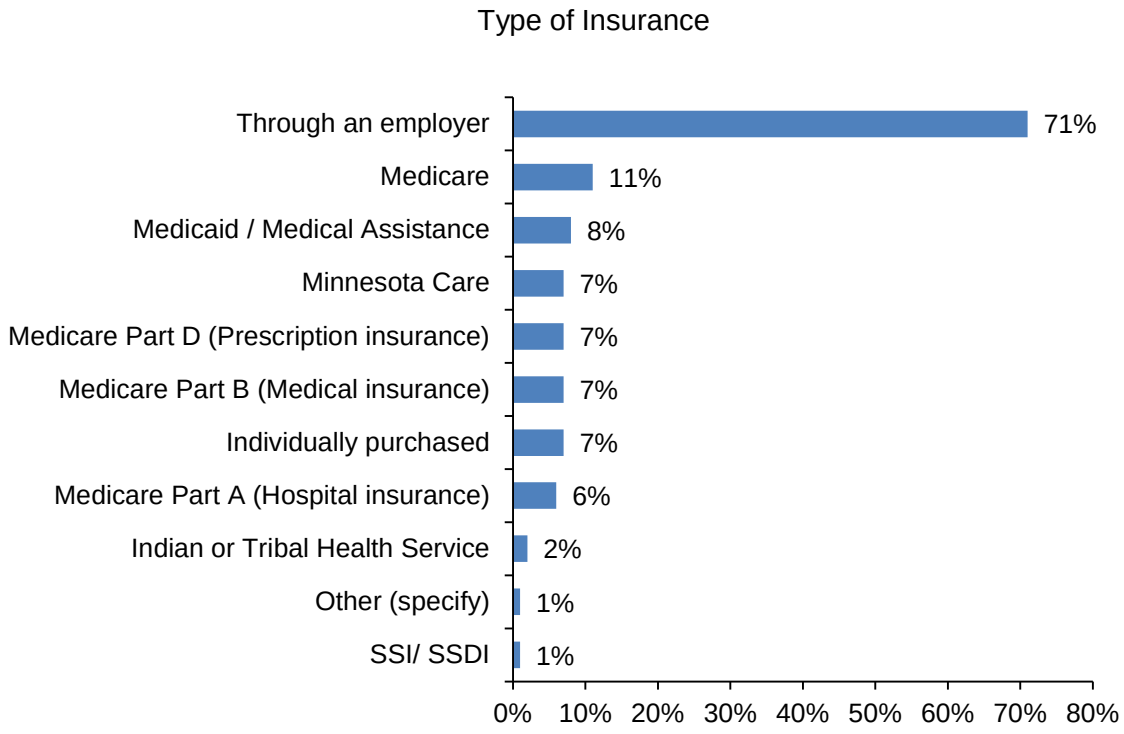
Base: Acute leukemia (n=1), Bladder cancer (n=2), Breast cancer (n=4), Cervical cancer (n=3), Colon cancer (n=4), Lung cancer (n=1), Melanoma (n=2), Non-Hodgkin's lymphoma (n=2), Other skin cancer (n=4), Rectal cancer (n=1), Renal (kidney) cancer (n=1), Thyroid cancer (n=3), Sample Size = 21
(Community = Lyon / Redwood / Cottonwood /Murray)

Do you currently have any kind of health insurance?



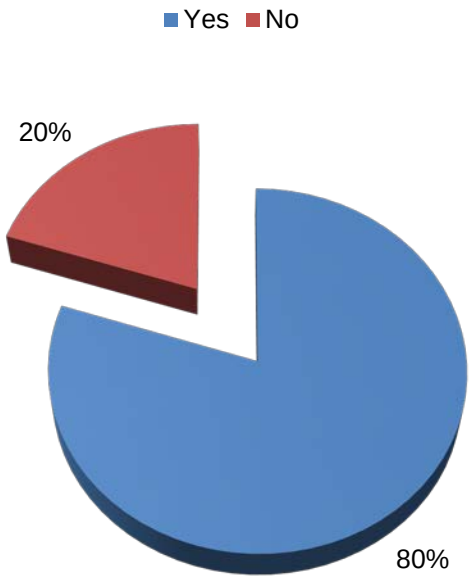
Base: Yes (n=134), No (n=1), Sample Size = 135

(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Through an employer (n=95), Individually purchased (n=9), Indian or Tribal Health Service (n=3), Medicare (n=15), Medicare Part A (Hospital insurance) (n=8), Medicare Part B (Medical insurance) (n=10), Medicare Part D (Prescription insurance) (n=9), SSI/ SSDI (n=2), Medicaid / Medical Assistance (n=11), Minnesota Care (n=9), Other (specify) (n=2), Sample Size = 134
(Community = Lyon / Redwood / Cottonwood /Murray)

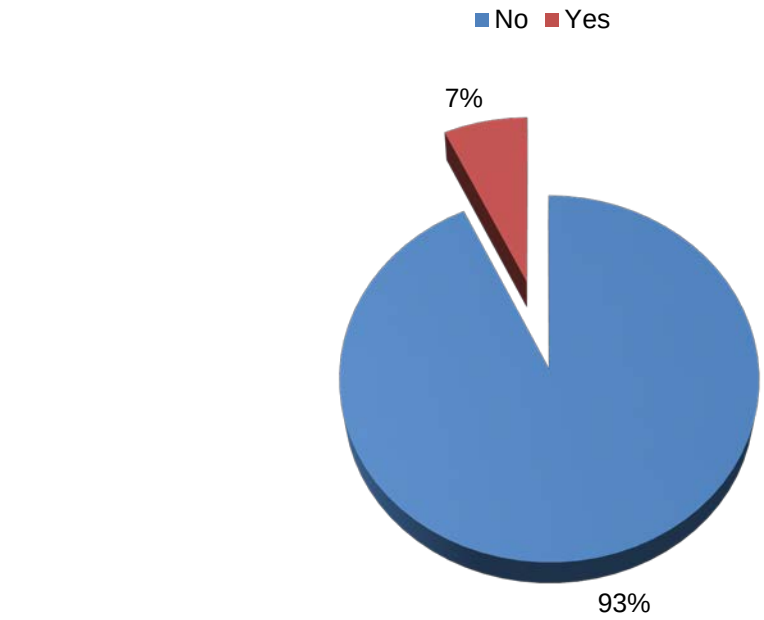
Do you have an established primary healthcare provider?



Base: Yes (n=109), No (n=27), Sample Size = 136

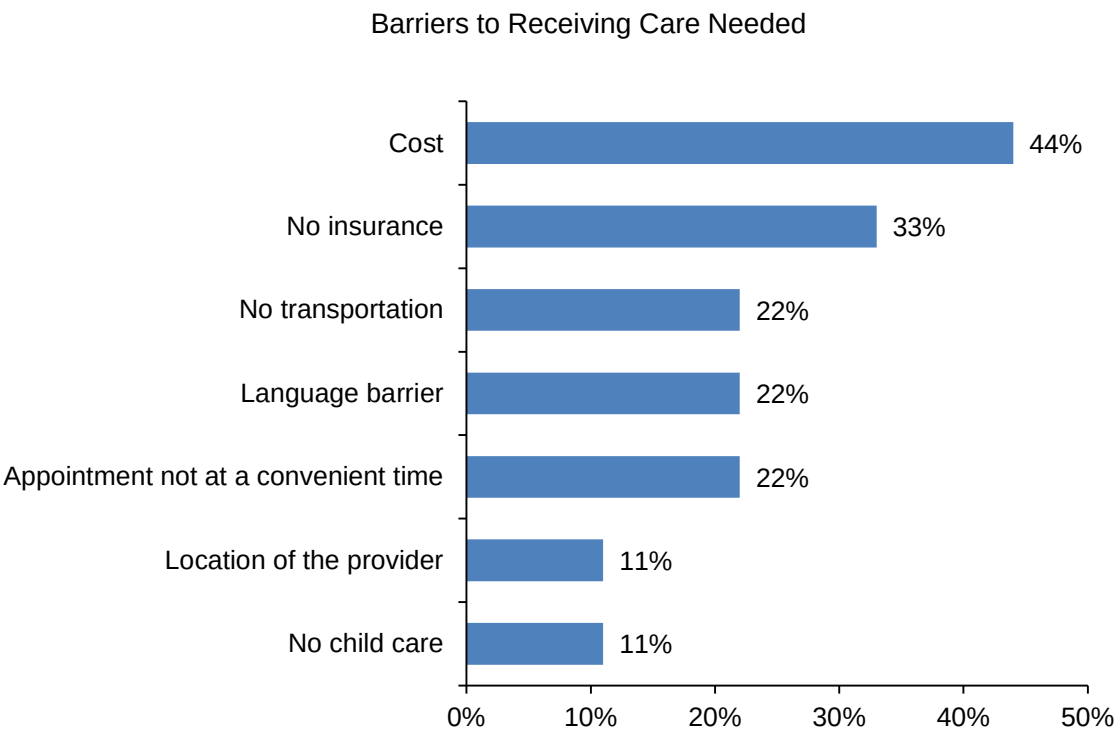
(Community = Lyon / Redwood / Cottonwood /Murray)

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=9), No (n=127), Sample Size = 136

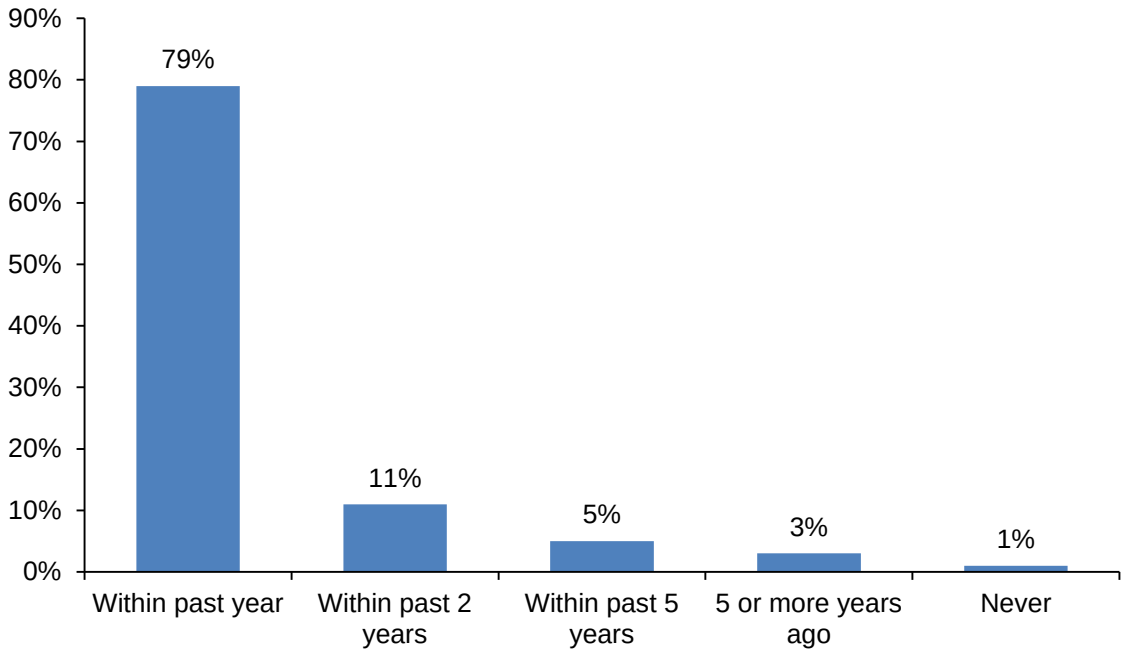
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: No child care (n=1), Appointment not at a convenient time (n=2), No insurance (n=3), Language barrier (n=2), No transportation (n=2), Location of the provider (n=1), Cost (n=4)

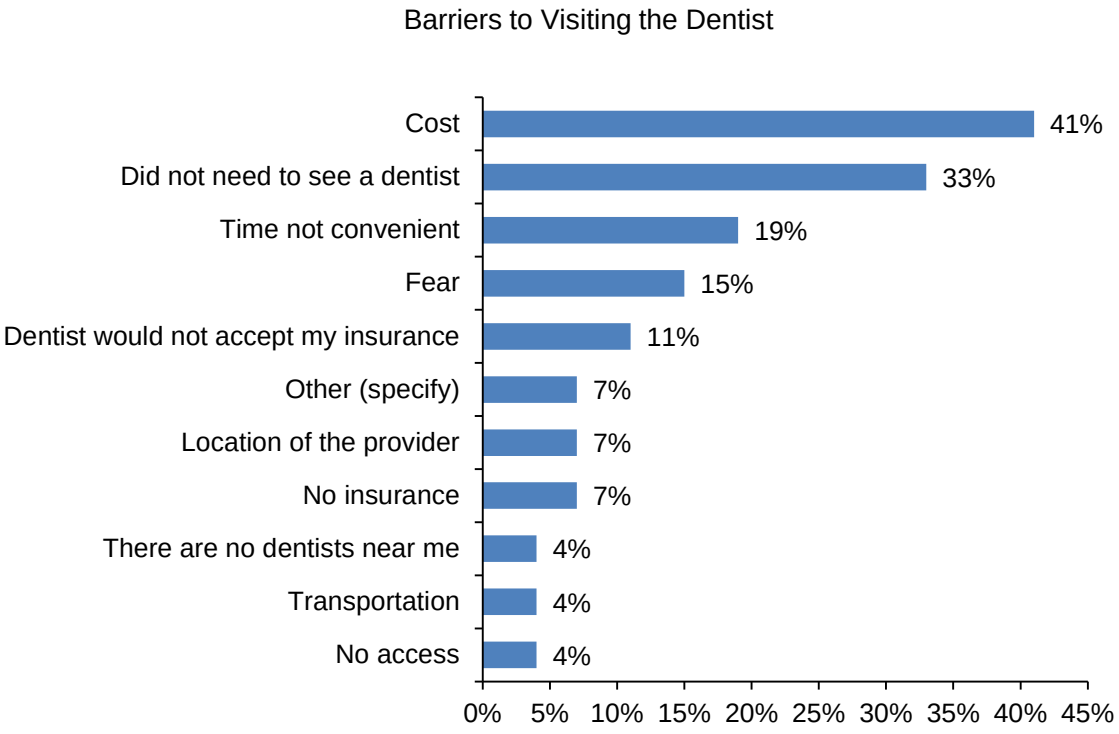
(Community = Lyon / Redwood / Cottonwood /Murray)

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



Base: Within past year (n=108), Within past 2 years (n=15), Within past 5 years (n=7), 5 or more years ago (n=4), Never (n=2), Sample Size = 136

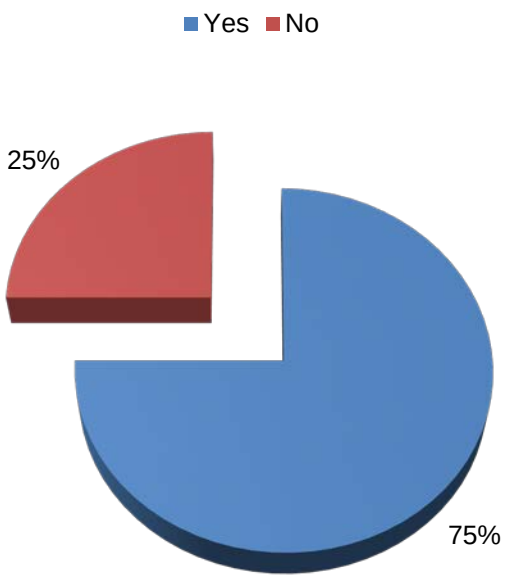
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: No access (n=1), No insurance (n=2), Location of the provider (n=2), Cost (n=11), Fear (n=4), Transportation (n=1), Time not convenient (n=5), There are no dentists near me (n=1), Dentist would not accept my insurance (n=3), Did not need to see a dentist (n=9), Other (specify) (n=2), Sample Size = 27

(Community = Lyon / Redwood / Cottonwood /Murray)

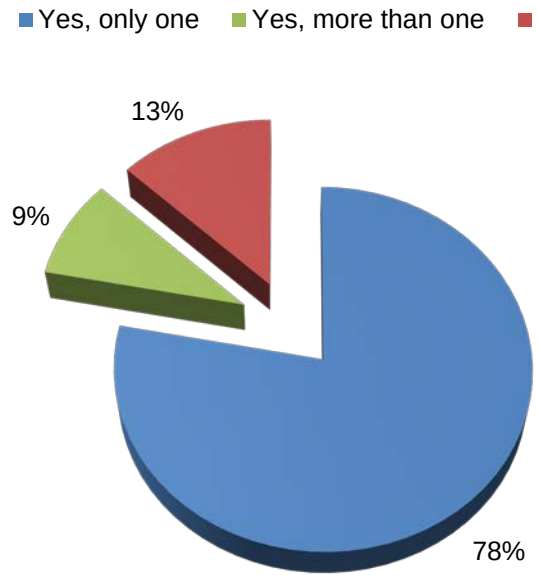
Do you have any kind of dental care or oral health insurance coverage?



Base: Yes (n=100), No (n=33), Sample Size = 133

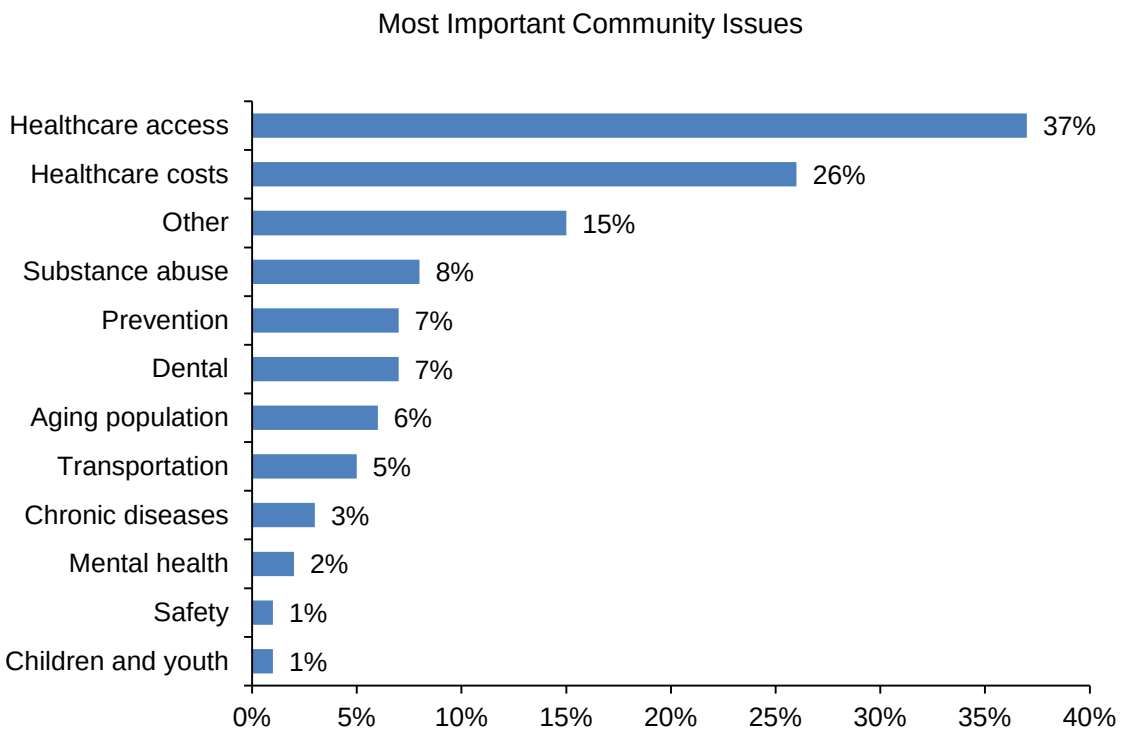
(Community = Lyon / Redwood / Cottonwood /Murray)

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



Base: Yes, only one (n=105), Yes, more than one (n=12), No (n=17), Sample Size = 134

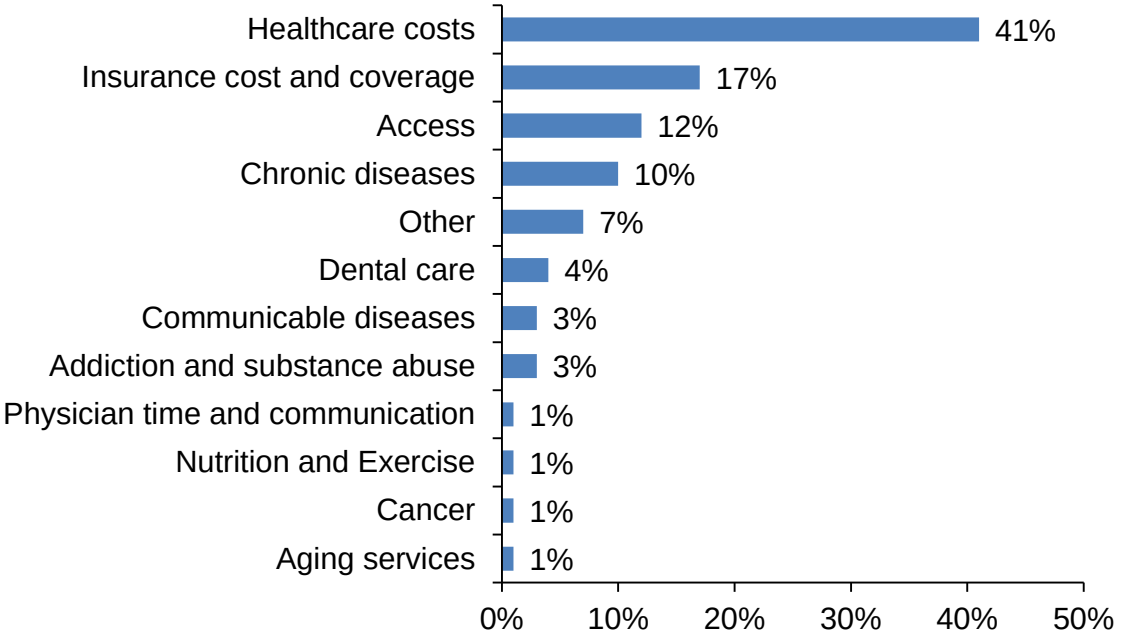
(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Transportation (n=4), Children and youth (n=1), Aging population (n=5), Safety (n=1), Healthcare access (n=32), Mental health (n=2), Substance abuse (n=7), Chronic diseases (n=3), Healthcare costs (n=23), Dental (n=6), Prevention (n=6), Other (n=13), Sample Size = 102

(Community = Lyon / Redwood / Cottonwood /Murray)

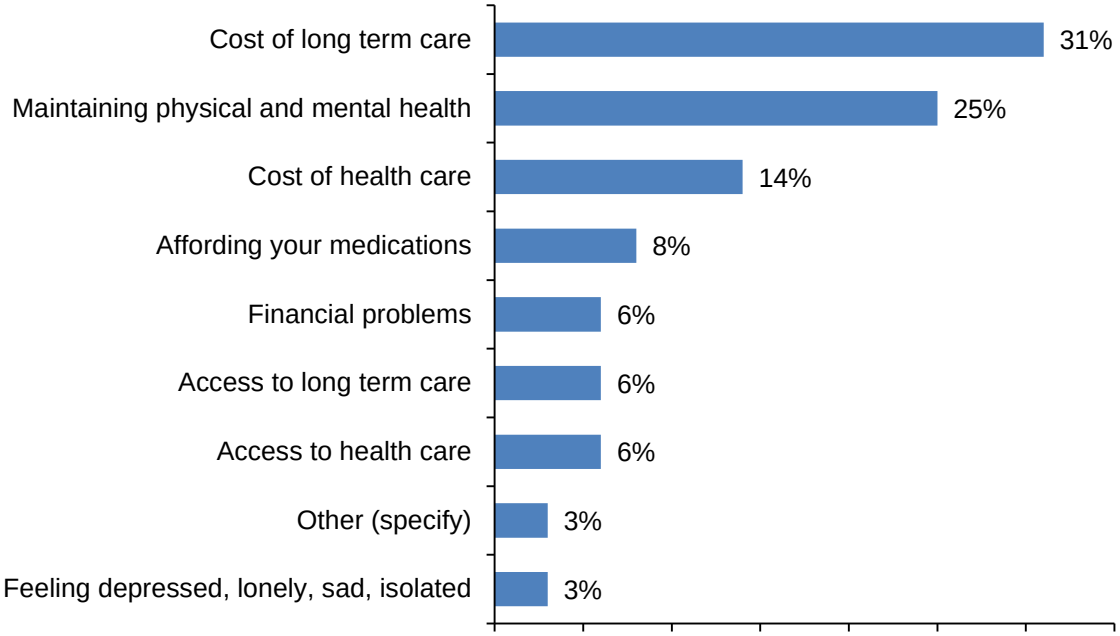
Most Important Issue for Family



Base: Access (n=8), Addiction and substance abuse (n=2), Aging services (n=1), Cancer (n=1), Chronic diseases (n=7), Communicable diseases (n=2), Healthcare costs (n=28), Dental care (n=3), Nutrition and Exercise (n=1), Insurance cost and coverage (n=12), Physician time and communication (n=1), Other (n=5), Sample Size = 101

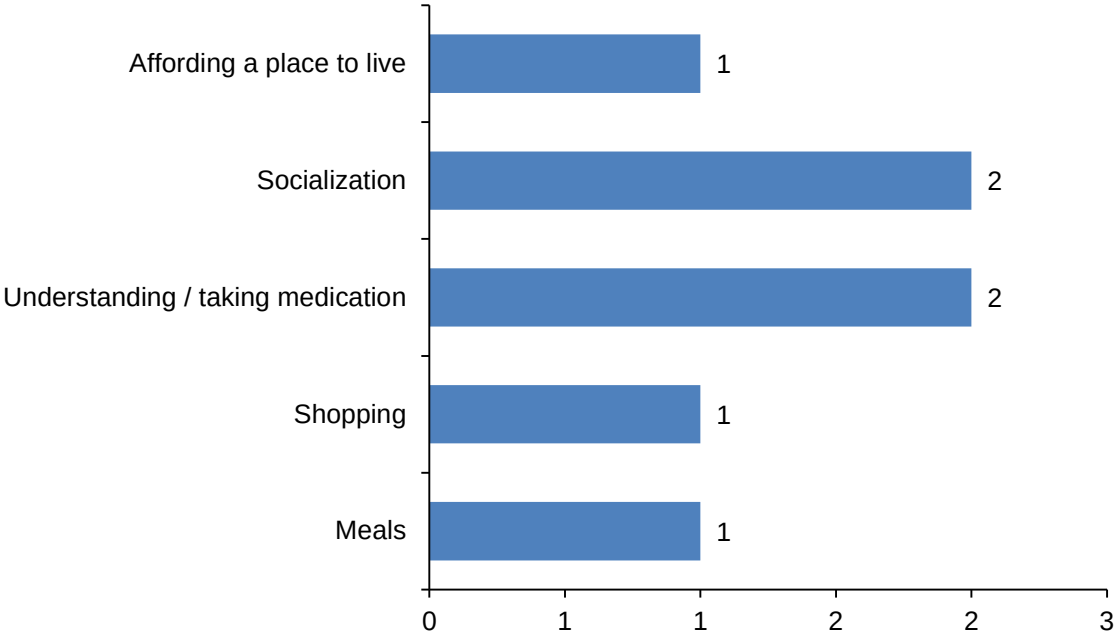
(Community = Lyon / Redwood / Cottonwood / Murray)

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



Base: Access to health care (n=2), Cost of health care (n=5), Affording your medications (n=3), Maintaining physical and mental health (n=9), Feeling depressed, lonely, sad, isolated (n=1), Access to long term care (n=2), Cost of long term care (n=11), Financial problems (n=2), Other (specify) (n=1), Sample Size = 16
(Community = Lyon / Redwood / Cottonwood /Murray)

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



Base: Meals (n=1), Shopping (n=1), Understanding / taking medication (n=2), Socialization (n=2), Affording a place to live (n=1), Sample Size = 2

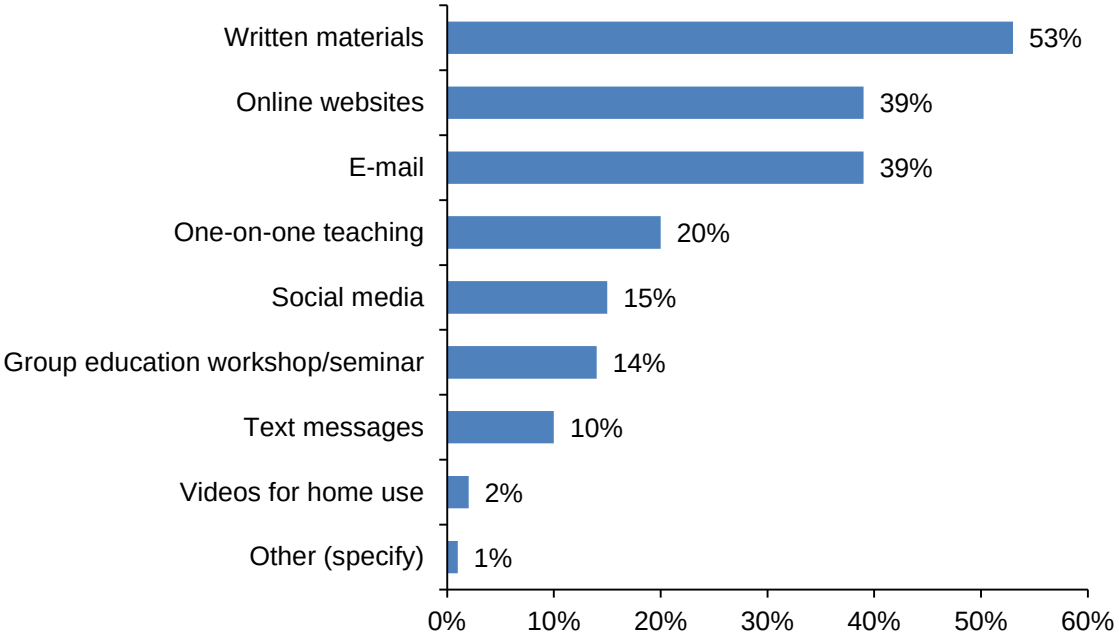
(Community = Lyon / Redwood / Cottonwood /Murray)

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

Base: Yes (n=1), No (n=1), Sample Size = 2

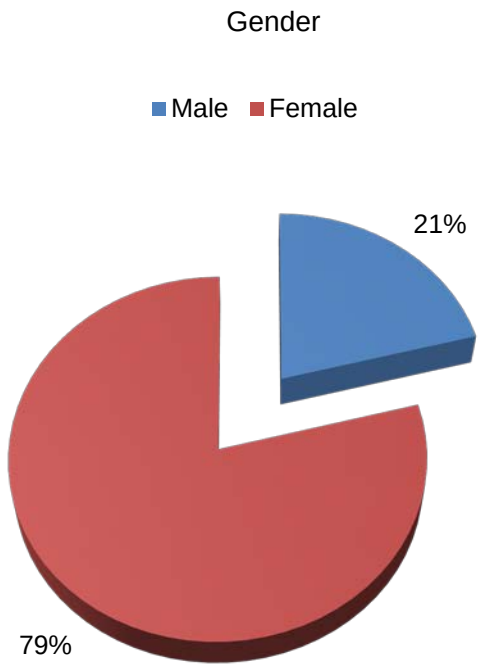
(Community = Lyon / Redwood / Cottonwood /Murray)

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



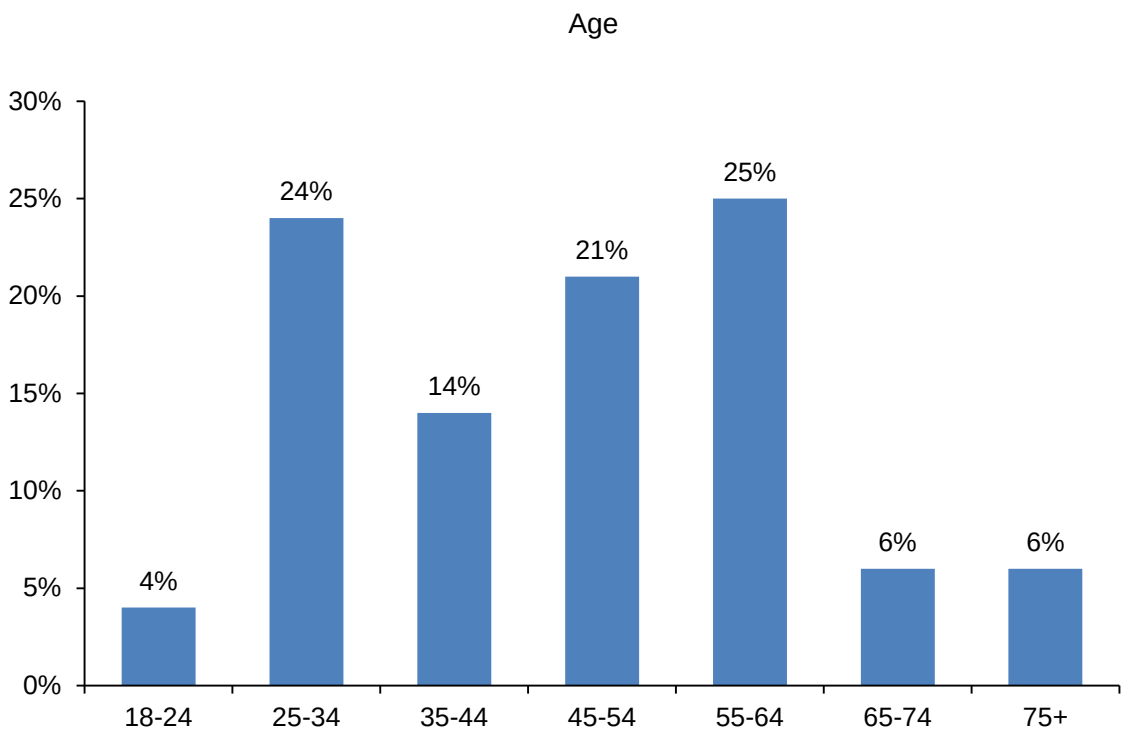
Base: Written materials (n=70), Videos for home use (n=3), Social media (n=20), Text messages (n=13), One-on-one teaching (n=26), E-mail (n=52), Group education workshop/seminar (n=19), Online websites (n=52), Other (specify) (n=1), Sample Size = 132

(Community = Lyon / Redwood / Cottonwood /Murray)



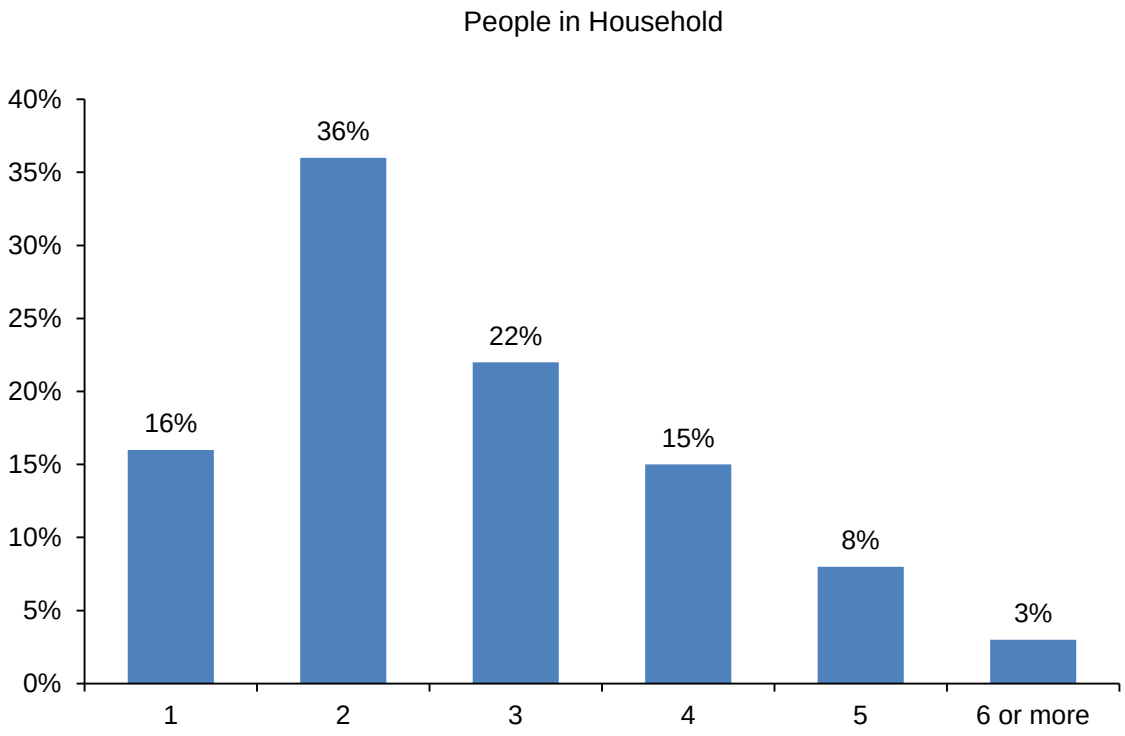
Base: Male (n=29), Female (n=107), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)



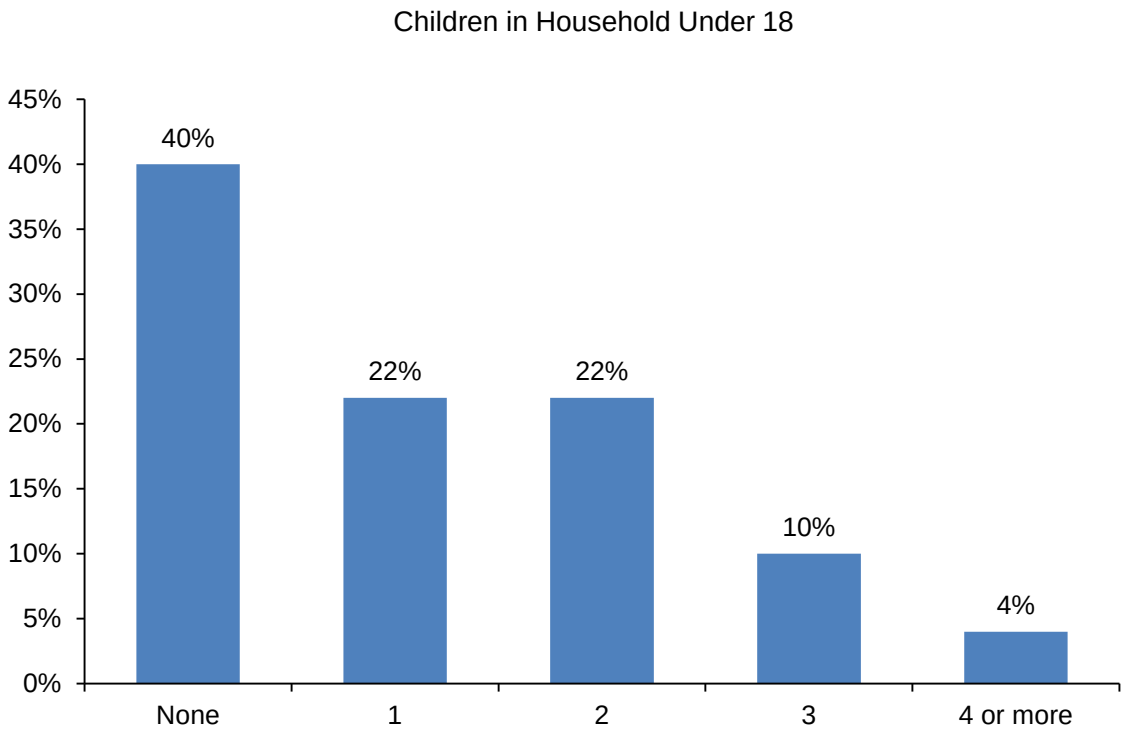
Base: 18-24 (n=6), 25-34 (n=33), 35-44 (n=19), 45-54 (n=28), 55-64 (n=34), 65-74 (n=8), 75+ (n=8), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)



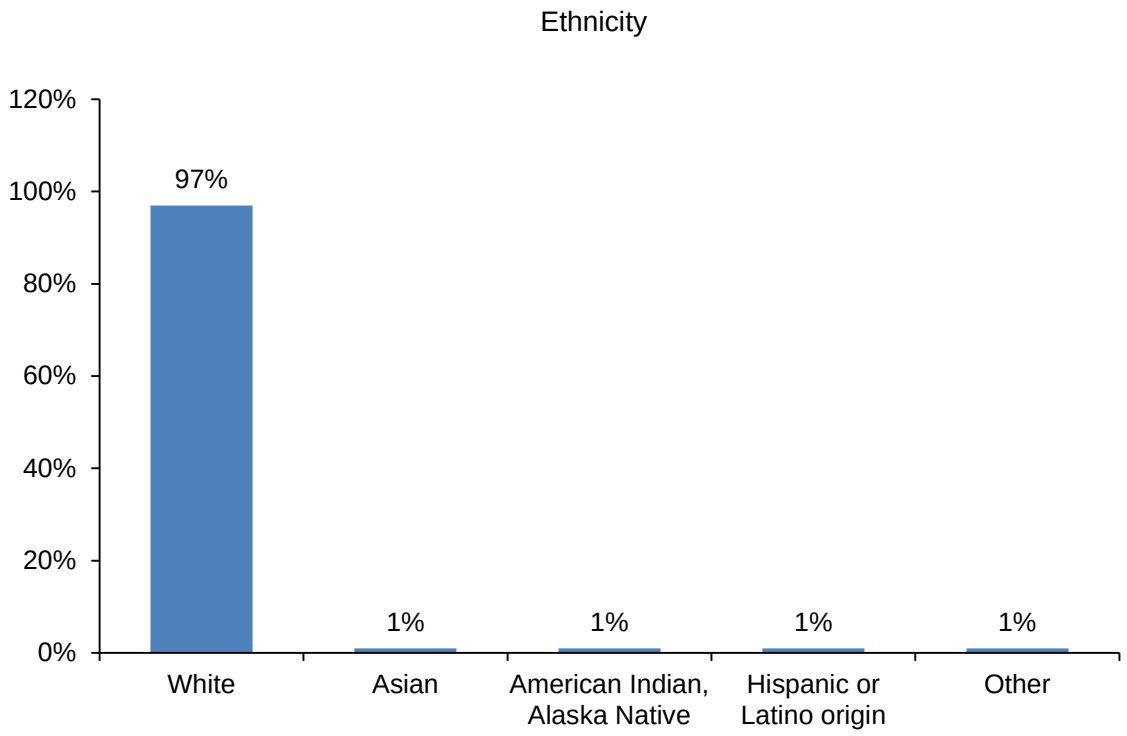
Base: 1 (n=21), 2 (n=48), 3 (n=29), 4 (n=20), 5 (n=11), 6 or more (n=4), Sample Size = 133

(Community = Lyon / Redwood / Cottonwood /Murray)



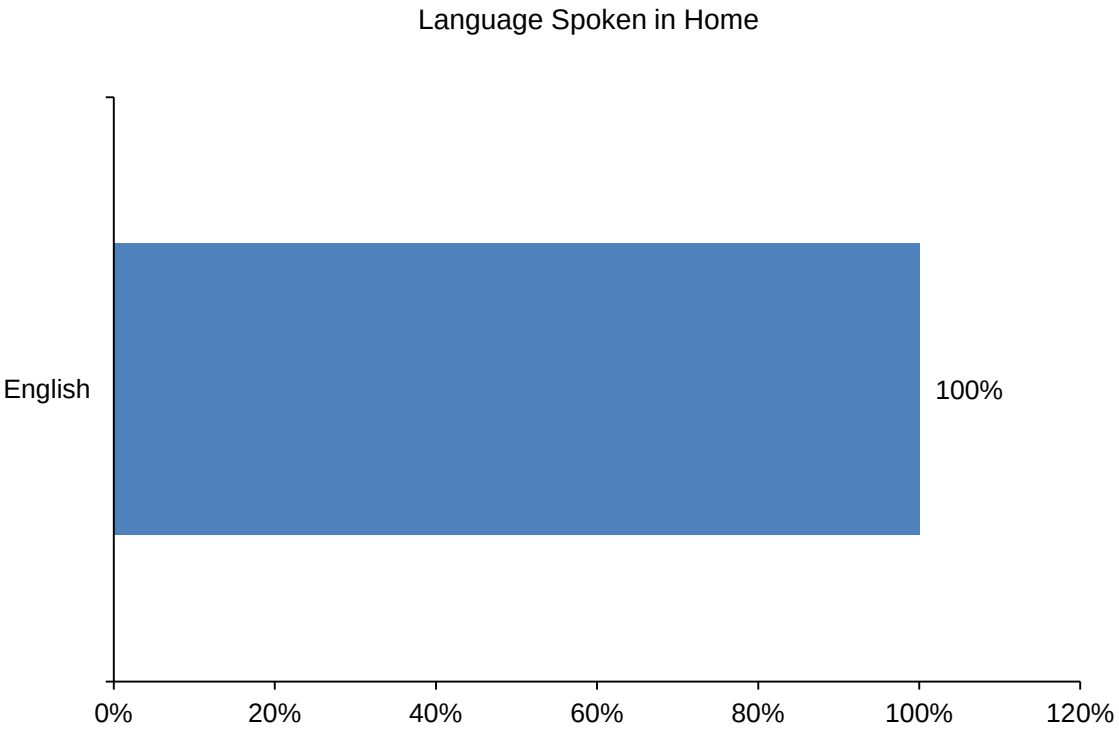
Base: None (n=36), 1 (n=20), 2 (n=20), 3 (n=9), 4 or more (n=4), Sample Size = 89

(Community = Lyon / Redwood / Cottonwood /Murray)



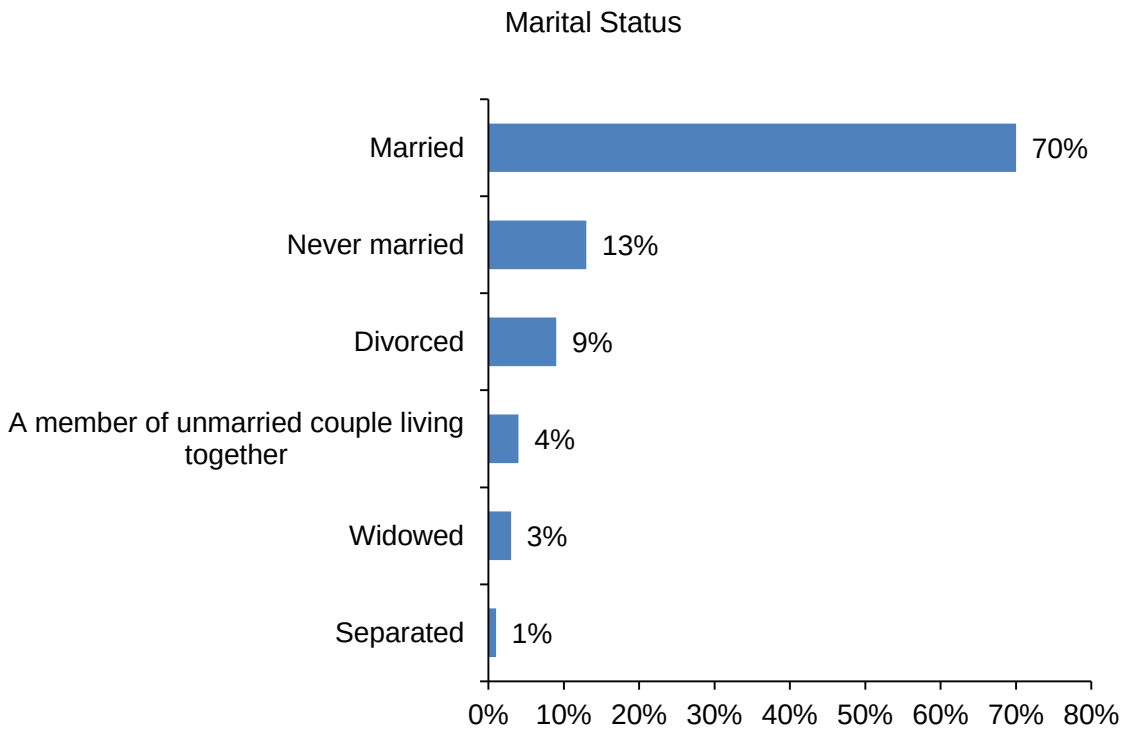
Base: White (n=132), Asian (n=1), American Indian, Alaska Native (n=1), Hispanic or Latino origin (n=1), Other (n=1), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)



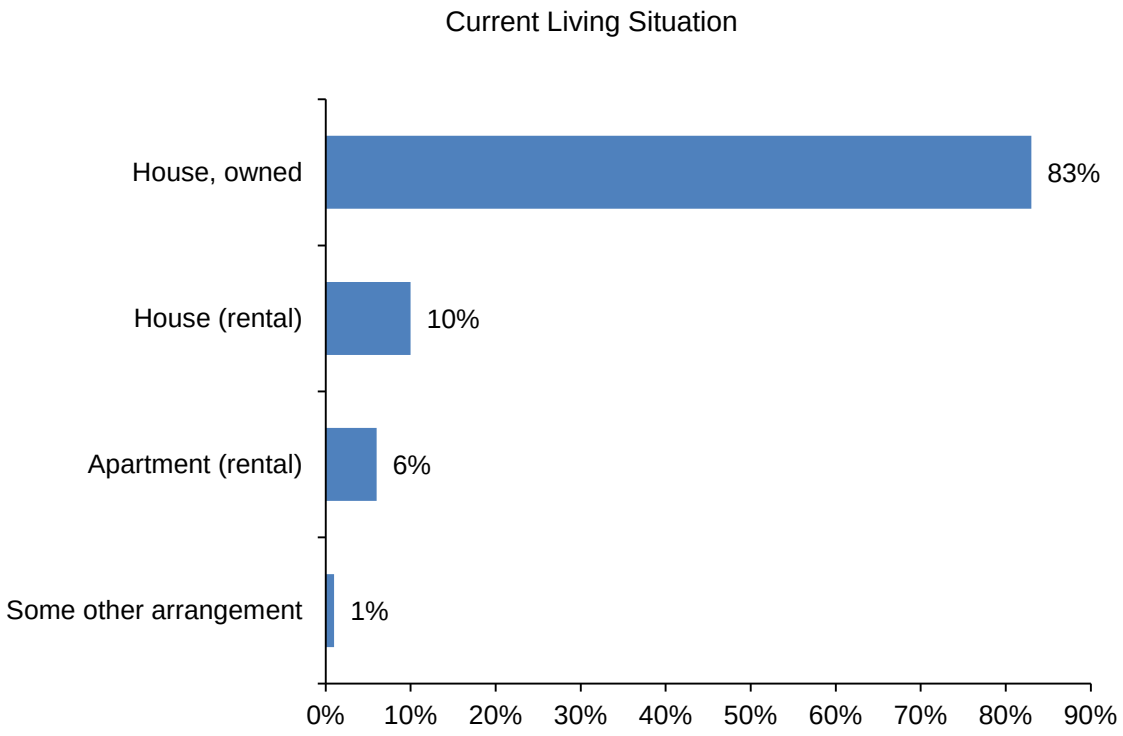
Base: English (n=135), Sample Size = 135

(Community = Lyon / Redwood / Cottonwood /Murray)



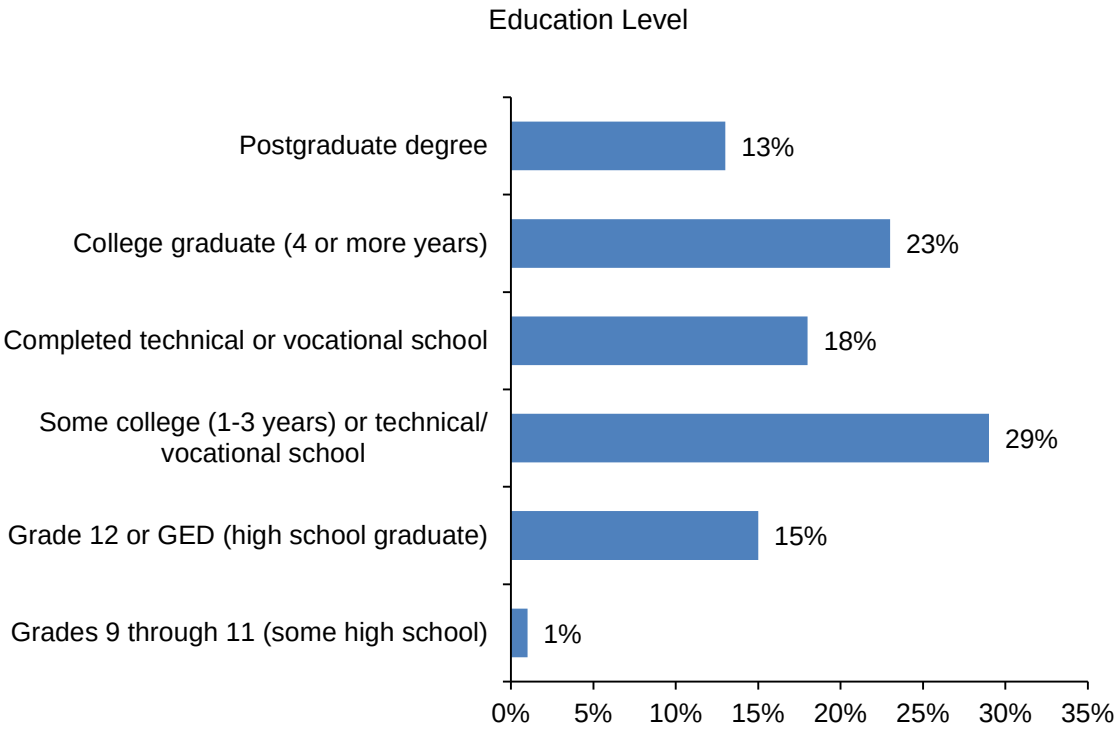
Base: Never married (n=17), Married (n=95), Divorced (n=12), Widowed (n=4), Separated (n=1), A member of unmarried couple living together (n=6), Sample Size = 135

(Community = Lyon / Redwood / Cottonwood /Murray)



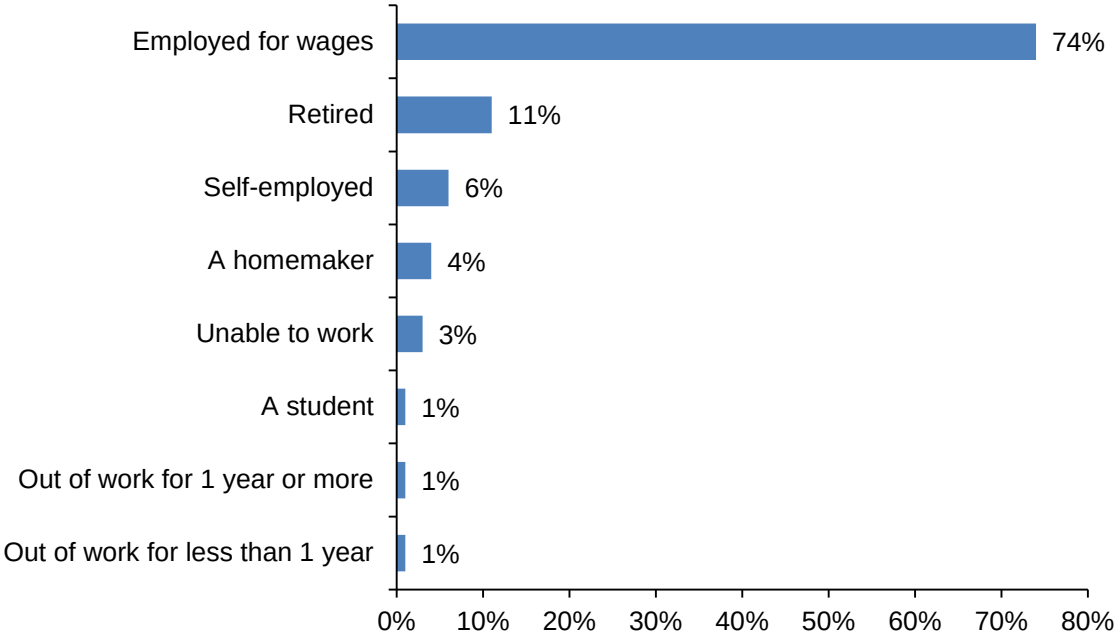
Base: House, owned (n=111), House (rental) (n=13), Apartment (rental) (n=8), Some other arrangement (n=2), Sample Size = 134

(Community = Lyon / Redwood / Cottonwood /Murray)



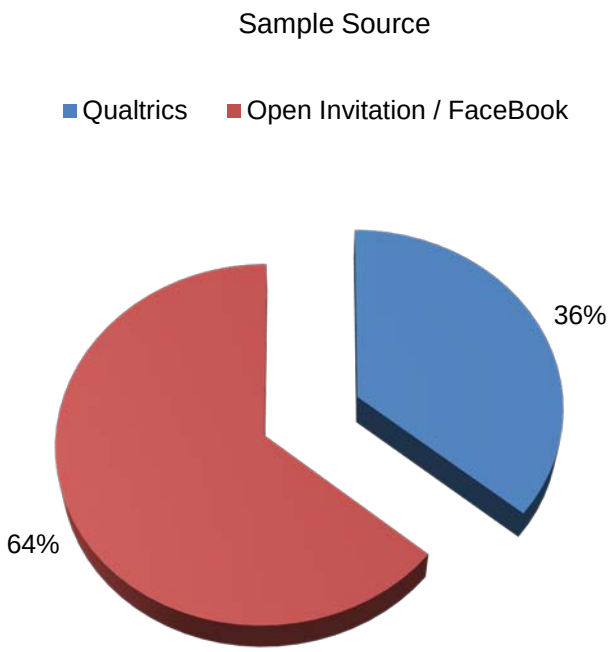
Base: Grades 9 through 11 (some high school) (n=2), Grade 12 or GED (high school graduate) (n=21), Some college (1-3 years) or technical/ vocational school (n=40), Completed technical or vocational school (n=24), College graduate (4 or more years) (n=31), Postgraduate degree (n=18), Sample Size = 136
(Community = Lyon / Redwood / Cottonwood /Murray)

Employment Status



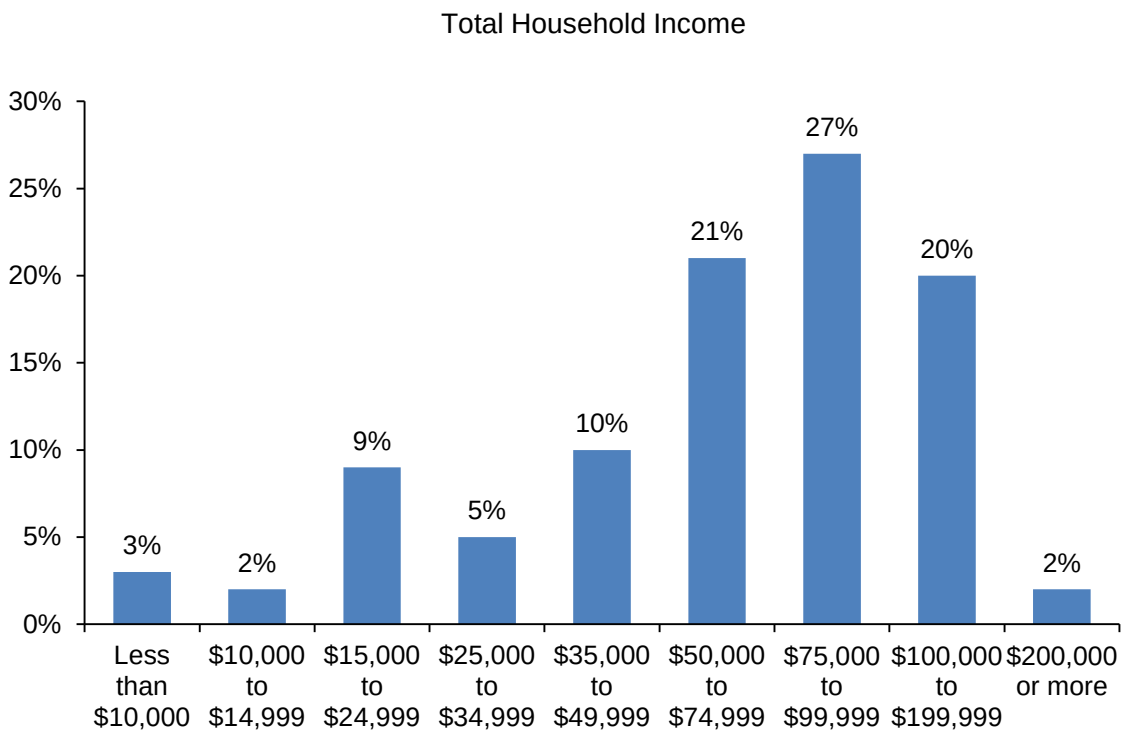
Base: Employed for wages (n=100), Self-employed (n=8), Out of work for less than 1 year (n=1), Out of work for 1 year or more (n=1), A homemaker (n=5), A student (n=2), Retired (n=15), Unable to work (n=4), Sample Size = 136

(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Qualtrics (n=49), Open Invitation / FaceBook (n=88), Sample Size = 137

(Community = Lyon / Redwood / Cottonwood /Murray)



Base: Less than $10,000 (n=4), $10,000 to $14,999 (n=3), $15,000 to $24,999 (n=12), $25,000 to $34,999 (n=7), $35,000 to $49,999 (n=13), $50,000 to $74,999 (n=27), $75,000 to $99,999 (n=35), $100,000 to $199,999 (n=25), $200,000 or more (n=2), Sample Size = 128

(Community = Lyon / Redwood / Cottonwood /Murray)

Tracy 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 3.53 • Skilled labor workforce 3.53 • 11% report running out of food before they had money to buy more			
Children and Youth • Childhood obesity 3.71 • Availability of quality childcare 3.65			
Aging Population • Cost of long-term care 3.88 • Cost of memory care 3.88 • Availability of memory care 3.59			
Safety • 24% report that they have drugs in their home that they are not using			
Health Care Access • Availability of doctors, physician assistants or nurse practitioners 4.35 • Availability of mental health providers 4.18 • Access to affordable health insurance coverage 3.94 • Availability of behavioral health (substance abuse) providers 3.76 • Availability of specialist physicians 3.76 • Access to affordable health care 3.65 • Access to affordable prescription drugs 3.59 • Availability of non-traditional hours 3.53	7	8	
Mental Health and Substance Abuse • 46% of residents self-report that they binge drink at least 1X/month • Depression 3.71 • 35% of residents report a diagnosis of depression • 43% report a diagnosis of anxiety/stress • Stress 3.59 • Dementia and Alzheimer's Disease 3.53 • 11% currently smoke cigarettes	7	6	
Wellness • 43% have a diagnosis of high cholesterol • 35% have a diagnosis of hypertension • 46% report that they are obese • 24% report that they are overweight • 51% do not get the recommended 5 or more fruits/vegetables/day • 35% do not get moderate exercise on 3 or more days/week • 23% have not had a routine check-up in more than 1 year • 16% have not had a flus shot this year • 20% have not visited their dentist in more than 1 year	7	10	

Secondary Research

Definitions of Key Indicators

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

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

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

Contents:

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

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

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

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

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

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

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

County Health Rankings for Lyon County, Minnesota

	County	State
Population	25,699	5,519,952
% below 18 years of age	25.3%	23.3%
% 65 and older	15.0%	15.1%
% Non-Hispanic African American	2.8%	6.0%
% American Indian and Alaskan Native	0.8%	1.3%
% Asian	4.1%	4.9%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	6.4%	5.2%
% Non-Hispanic white	84.8%	80.6%
% not proficient in English	1%	2%
% Females	50.0%	50.2%
% Rural	47.9%	26.7%

	Lyon County	Error Margin	Top U.S. Performers	Minnesota	Rank (of 87)
Health Outcomes					30
Length of Life					26
Premature death	5,000	4,000-5,900	5,300	5,100	
Quality of Life					41
Poor or fair health **	12%	12-13%	12%	12%	
Poor physical health days **	2.9	2.8-3.1	3.0	3.0	
Poor mental health days **	3.1	2.9-3.2	3.1	3.2	
Low birthweight	6%	5-7%	6%	6%	
% LBW	6%		x		
% LBW (Hispanic)	6%				
% LBW (White)	6%				
Additional Health Outcomes (not included in overall ranking) +					
Premature age-adjusted mortality	270	230-300	270	260	
Child mortality			40	40	
Infant mortality			4	5	
Frequent physical distress	9%	9-10%	9%	9%	
Frequent mental distress	10%	9-10%	10%	10%	
Diabetes prevalence	9%	7-11%	8%	8%	
HIV prevalence	57		49	171	
Health Factors					23
Health Behaviors					54
Adult smoking **	16%	15-17%	14%	15%	
Adult obesity	29%	25-34%	26%	27%	
Food environment index	8.3		8.6	8.9	
Physical inactivity	21%	17-25%	20%	20%	
Access to exercise opportunities	81%		91%	88%	
Excessive drinking **	26%	25-27%	13%	23%	
Alcohol-impaired driving deaths	13%	3-29%	13%	30%	
Sexually transmitted infections	132.5		145.1	389.3	

	County	State			
Teen births	18	15-22	15	17	
Teen Birth Rate	18		x		
Teen Birth Rate (Hispanic)	75				
Teen Birth Rate (White)	10				
Additional Health Behaviors (not included in overall ranking) +					
Food insecurity	10%		10%	10%	
Limited access to healthy foods	7%		2%	6%	
Drug overdose deaths			10	11	
Drug overdose deaths - modeled	6-7.9		8-11.9	12.5	
Motor vehicle crash deaths	14	9-21	9	8	
Insufficient sleep	30%	29-31%	27%	30%	
Clinical Care					8
Uninsured	5%	4-6%	6%	5%	
Primary care physicians	1,170:1		1,030:1	1,110:1	
Dentists	2,140:1		1,280:1	1,440:1	
Mental health providers	680:1		330:1	470:1	
Preventable hospital stays	37	30-44	35	37	
Diabetes monitoring	92%	78-100%	91%	88%	
Mammography screening	75%	60-90%	71%	65%	
Additional Clinical Care (not included in overall ranking) +					
Uninsured adults	5%	4-6%	7%	6%	
Uninsured children	4%	3-5%	3%	3%	
Health care costs	$8,103			$8,250	
Other primary care providers	1,713:1		782:1	1,020:1	
Social & Economic Factors					33
High school graduation	86%		95%	83%	
Some college	69%	64-74%	72%	74%	
Unemployment	3.6%		3.2%	3.9%	
Children in poverty	15%	11-19%	12%	13%	
% Children in Poverty	15%		x		
% Children in Poverty (Black)	32%				
% Children in Poverty (Hispanic)	75%				
% Children in Poverty (White)	9%				
Income inequality	4.5	4.0-5.0	3.7	4.4	
Children in single-parent households	26%	20-31%	20%	28%	
Social associations	18.7		22.1	13.0	
Violent crime	132		62	231	
Injury deaths	62	50-78	55	62	
Additional Social & Economic Factors (not included in overall ranking) +					
Disconnected youth			10%	9%	
Median household income	$53,000	$48,500-57,400	$65,100	$65,600	
Household Income	$53,000		x		
Household income (Hispanic)	$27,000				
Household income (White)	$54,700				
Children eligible for free or reduced price lunch	43%		33%	38%	

	County	State			
Residential segregation - black/white	58		23	62	
Residential segregation - non-white/white	32		14	49	
Homicides			2	2	
Firearm fatalities	9	4-15	7	7	
Physical Environment					23
Air pollution - particulate matter **	9.2		6.7	9.3	
Drinking water violations	No				
Severe housing problems	13%	11-15%	9%	14%	
Driving alone to work	77%	75-78%	72%	78%	
% Drive Alone	77%		x		
% Drive Alone (Hispanic)	61%				
% Drive Alone (White)	78%				
Long commute - driving alone	11%	9-13%	15%	30%	

SANFORD HEALTH

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