Community Memorial Hospital, Burke, SD

2016 Community Health Needs Assessment

BECAUSE WE CARE

Community Memorial Hospital
Burke, SD

Community Health Needs Assessment
2016

Dear Community Members,

Community Memorial Hospital is pleased to present the 2016 Community Health Needs Assessment.

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

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

Community Memorial Hospital has set strategy to address the following community health needs:

- Mental Health/Behavioral Health
- Physical Health

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

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

Sincerely,

Mistie Sachtjen
Chief Executive Officer
Community Memorial Hospital

Community Memorial Hospital
Burke, South Dakota

Community Health Needs Assessment
2016
EXECUTIVE SUMMARY

Community Memorial Hospital

Community Health Needs Assessment
2016

Purpose

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

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

Study Design and Methodology

1. **Non-Generalizable Survey**
   A non-generalizable survey was conducted online during 2016. The Center for Social Research at North Dakota State University developed and maintained links to the online survey tool. The website address for the survey instrument was distributed via e-mail to various key community stakeholders and agencies, at times using a snowball approach**.** Data collection occurred throughout the month of May 2016 and a total of 55 respondents participated in the online survey.

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

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

addressed by CMH and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

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

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

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

Key Findings – Primary Research

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

1. **Economics:** Respondents were most concerned about the availability of affordable housing.

2. **Aging:** The number one ranking concern among respondents overall is the cost of long term care. The availability of memory care and the availability of long term care also rank as top concerns for the aging.

3. **Children and Youth:** Bullying was the top concern among respondents for children and youth. The availability of quality child care and the availability of activities for children and youth are also high concerns.

4. **Safety:** Respondents are most concerned about the presence of street drugs, prescription drugs and alcohol in the community and the presence of drug dealers.

5. **Health Care:** The health care indicator addresses access to health care and cost concerns. Access to affordable health insurance ranked as a high concern among survey respondents.

6. **Physical Health**: Cancer, chronic disease, obesity, inactivity and poor nutrition rank as high concerns among survey respondents.

7. **Mental Health/Behavioral Health**: Stress, depression, underage drug use and abuse and drug use and abuse among adults are high concerns among survey respondents.

Key Findings – Secondary Research Based on the 2015 *County Health Rankings*

Health Outcomes

Premature Death**:** The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality indicator outcome indicates that Gregory County has more premature deaths (9,627) than South Dakota overall (6,738); the national comparison is 5,200. Premature deaths in Tripp County are at 8,711 and at 6,592 in Charles Mix County.

Poor or Fair Health: 9% of adults in Gregory County, 10% in Tripp County, and 8% in Charles Mix County report poor or fair health compared to 10% nationally and 11% in South Dakota.

The average number of days reported in the last 30 as unhealthy mental health days is 1.6 in Gregory County and is 2.1 for Charles Mix County. This indicator is not available for Tripp County. South Dakota as a state reports 2.6 days and the national benchmark is 2.3 days.

The percent of live births with low birth weight (less than 2,500 grams) is 5.1.0% in Gregory County, 8.4% in Tripp County, and 5.9% in Charles Mix County. The state of South Dakota is at 6.5%, and the national benchmark is 5.9%

Health Factors

The percent of adults who are currently smoking is 12% in Gregory County, 13% in Tripp County, and 17% in Charles Mix County. 18% of adults are current smokers in South Dakota compared to 14% nationally.

32% of the adult population in Gregory County, 33% in Tripp County and 32% in Charles Mix County are considered to be obese with a BMI over 30. Nationally the rate of obesity is 25% and 29% of the population in South Dakota is obese.

The percent of adults reporting excessive or binge drinking is 24% in Gregory County, 21% in Tripp County, and 22% in Charles Mix County. South Dakota reports 19% are binge drinkers statewide. Driving deaths that have alcohol involvement is at 33% in Gregory County, 38% in Tripp County, and 50% in Charles Mix County. Alcohol involvement in driving deaths is at 37% in South Dakota and 14% nationally.

Sexually transmitted infections rank substantially higher than the national benchmark of 138 - 211 for Gregory County, 401 in Tripp County, 716 in Charles Mix County, and 471 for South Dakota.

The teen birth rate is higher in South Dakota at 37 than the national benchmark of 20. The teen birth rate is 27 in Gregory County, 39 in Tripp County, and 72 in Charles Mix County.

The clinical care outcomes indicate that the percentage of uninsured adults is 17% in South Dakota, 18% in Gregory County, 18% in Tripp County, 19% in Charles Mix County, and 11% nationally.

The ratio of population to primary care physicians is 1,045:1 in South Dakota. Gregory County's ratio is 1,066:1. Tripp County's is 914:1, and Charles Mix County's is 922:1. The national benchmark is 1,045:1.

The ratio of population to mental health providers is 664:1 in South Dakota. Ratios for Gregory and Charles Mix counties are not listed in the county rankings; Tripp County is at 393:1.

The number of professionally active dentists in South Dakota is 1,813:1 and in Gregory County the ratio is 2,121:1, Tripp County's ratio is 2,749:1 and Charles Mix County's ratio is 2,310:1. The national ratio is 1,377:1.

Preventable hospital stays are 146 in Gregory County, 71 in Tripp County, 105 in Charles Mix County, 57 in South Dakota, and 41 nationally.

Diabetic monitoring is at 90% in Gregory County, 81% in Tripp County, 84% in Charles Mix County, and 84% in South Dakota as a whole. The national benchmark is 90%. Mammography screening is at 53.2% in Gregory County, 61.6% in Tripp County, 59.4% in Charles Mix County, and 66.5% in South Dakota. The national benchmark is 70.7%.

The social and economic factor outcomes indicate that South Dakota is at 84% for high school graduation. High school graduation indicators are not available in the county health rankings for Gregory, Tripp or Charles Mix counties. Post-secondary education (some post-secondary education) is at 66.3% in Gregory County, 63.6% in Tripp County, 52.9% in Charles Mix County and 66.7% in South Dakota. The national benchmark is 71%.

The unemployment rate is 3.7% in Gregory County, 3.8% in Tripp County, 4.3% in Charles Mix County, and 3.8% in South Dakota. The rate is 4% nationally.

The percentage of child poverty is 26% in Gregory County, 27% in Tripp County, 35% in Charles Mix County, and 13% nationally. The child poverty rate is 19% in South Dakota.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is higher in Gregory County at 30.5, 25.5 in Tripp County, and 27.1 in Charles Mix County. The state of South Dakota ranks at 17.4.

The percentage of children in single parent households is 26% in Gregory County, 34% in Tripp County, 45% in Charles Mix County, 20% nationally, and 31% in South Dakota.

Violent crime is at 282 per 100,000 population in South Dakota. The rate for Gregory County is not available. The rate in Tripp County is 100 and in Charles Mix County the rate is 175.The national benchmark is 59.

The following needs were brought forward for prioritization:

- Economics – cost of affordable housing
- Children and Youth – availability of childcare, infant care, and activities for children and youth
- Aging – cost of LTC, availability of LTC and memory care
- Safety – presence of street drugs and drug dealers
- Health care Access – access to affordable health insurance
- Physical Health – cancer, chronic disease, obesity, exercise, poor nutrition
- Mental Health/Behavioral Health – stress, depression, underage drinking, drug use and abuse, underage drinking, alcohol use and abuse, smoking and tobacco use

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

- Mental Health/Behavioral Health
- Physical Health

Implementation Strategies

Priority 1: Physical Health

As a health care facility, we are committed to promoting a healthy lifestyle and encouraging our patients to be more active. Studies have shown that people who are active and follow a healthy lifestyle live longer.

We currently work with our local fitness organization to offer a variety of exercise classes at no charge to the public and will be working to improve such services. We will also be hosting community health fairs including lab tests at a reduced price and wellness challenges throughout the year.

We will also have a focus on promoting an active lifestyle to our youth. It is important to begin education in regards to leading a healthy lifestyle at a young age. We plan to work with the local school district in implementing the Sanford *fit* program.

Priority 2: Mental Health

Mental health is a serious issue especially if the problems are not addressed. It affects not only individuals but the families of those individuals suffering from with the problem. It affects people of all ages and has a negative impact on lives people live.

Our focus will be on improving access to mental health services as well as improving care for those patients with a depression diagnosis. We will begin implementation of a Health Coach in the clinic and provide ongoing education to both Health Coaches and providers. We will work to improve PHQ-9 scores throughout the year.

A strong focus will also be on decreasing the amount of drug use in the community. We will be implementing new policies within the clinic setting, working with local law enforcement to set up a take back program as well as providing education to both staff and members of the community.

Mental health problems are common and we want to help patients to learn to cope and give them the necessary tools to get better.

Community Memorial Hospital

Community Health Needs Assessment
2016

Table of Contents

Community Memorial Hospital

Community Health Needs Assessment 2016

Purpose of the Community Health Needs Assessment

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

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

Our Mission: Excellence in the provision of health care and related services, governed as a Not-For-Profit Community Organization, serving the needs of our people with superior quality and value

Our Guiding Principles:

- All health care is a community asset
- Care should be delivered as close to home as possible
- Integrated care delivers the best quality and efficiency
- Community involvement and support is essential to success

Acknowledgements

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

Burke Community Memorial Hospital Steering Group:

- Mistie Sachtjen, Administrator
- Theresa Bachmann, Director of Nursing
- Tami Lyon, Business Office Manager
- Tammy Knight, Clinic Manager
- Ashley Peck, Radiology Manager
- Kelly Frank, Director of Plant Operations
- Lynn Kruse, Dietary Manager
- Carrie McLeod, Project Lead, Community Benefit/Community Health Improvement

The following Burke Key Community Stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Theresa Bachmann - Director of Nursing, Community Memorial Hospital
- Sue Chytke – Board Member
- Kelly Frank - Maintenance Supervisor, Community Memorial Hospital
- Mel Juran – President, Missouri Valley Insurance
- Tammy Knight – Clinic Manager
- Tami Lyon - Business Office Manager, Community Memorial Hospital
- Randy Sachtjen – COO, First Fidelity Bank
- Billie Sutton - First Fidelity Bank; District 21 Senator
- Kelsea Sutton - Attorney; Fitness on Main
- Mindie Wischmann – First Fidelity Bank
- Jody Young – First Fidelity Bank

We extend special thanks to the state legislators, physicians, nurses, representatives for the mentally and physically disabled, social services, and non-profit organizations for their participation in this work. Together we are reaching our vision "to improve the human condition through exceptional care, innovation and discovery".

Community Memorial Hospital would like to acknowledge and thank the following community members who participated in the CHNA survey:

Kim Bruns	Cheryl Schmitt
Tina Dummer	Trisha Schoenebaum
Mike Glover	Ann Schwader
Thomas Glover	Kathy Simpson
Todd Halsne	Megan Smith
Tami Hotz	Billlie H. Sutton
Suzette Johnson	Kelsea Kenzy Sutton
George Kenzy	Rochelle Tietgen
Shirleen Kimerer	Jolene Van Metre
Deb Leibel	Tyler Van Metre
Tami Lyon	Kim Vosika
Dolores Moore	Cheryl Williams
Sharon Neuharth	Mindie Wischmann
Jerry Peterson	Jody Young
Katherine Peterson	Tina
Sherry Opbroek	Nancy
Mark Otten	Lynn
Mistie Sachtjen	Ashley
Randy Sachtjen	Home Owner

Description of Community Memorial Hospital, Burke, SD

Community Memorial Hospital, Inc. (CMH) is a 16-bed critical access hospital located in Burke, South Dakota, providing a full range of diagnostic and therapeutic services for the community. It provides inpatient and skilled swing beds and 24-hour emergency services. CMH operates two provider-based rural health clinics located in the communities of Burke and Bonesteel. Community Memorial Hospital was incorporated in 1945 and first opened its doors in 1948. It is the largest employer in the community with 62 employees.

Description of Community Served – Burke, SD

Burke has a population of 604 residents and is the county seat of Gregory County, a rural farming and ranching community located in south central South Dakota. The economy is primarily agricultural, including businesses and services that support agriculture producers. Education and health services account for the largest non-agriculture industries. The area serves as a recreational destination for many neighboring counties with world-class hunting, fishing and recreational activities on the Missouri River.

Study Design and Methodology

1. **Non-Generalizable Survey**
   A non-generalizable online survey was conducted by Burke Community Memorial Hospital with the assistance Sanford Health, public health leadership and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. The website address for the survey instrument was distributed via e-mail to community stakeholders and various agencies, at times using a snowball approach**.** Data collection occurred throughout the month of May 2016 and a total of 55 respondents participated in the online survey.

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

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

2. **Community Stakeholder Meeting**
   Community stakeholders were invited to a meeting to review the early findings from the generalizable survey and to discuss the top health issues or health-related issues facing the community. Community stakeholders discussed the community needs, reviewed and further developed the community asset map and helped to determine key priorities for the community.

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

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

4. **Secondary Research**
   The secondary data includes *County Health Rankings* and the *Focus on South Dakota – A Picture of Health* study for Gregory County, Tripp County and Charles Mix County.

Limitations of the Study

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

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

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

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

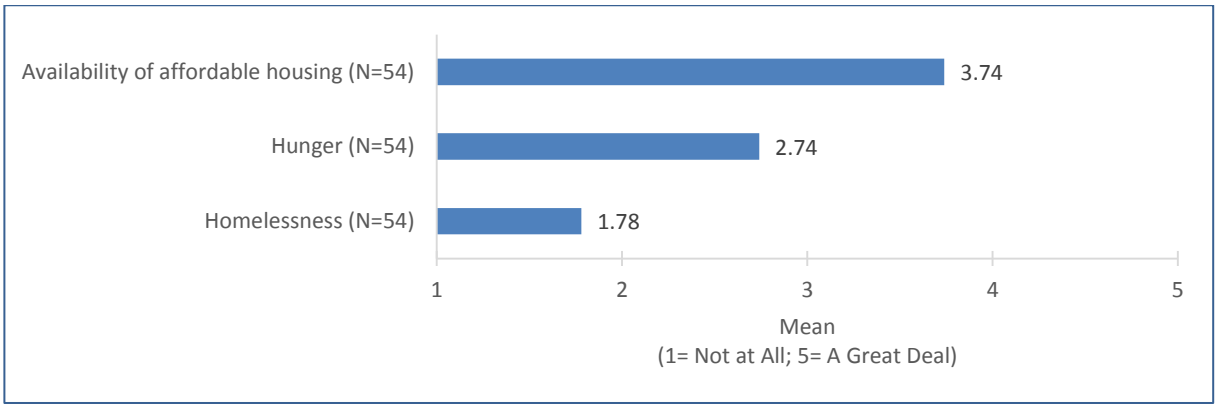
Key Findings

Community Health Concerns

Economics

The availability of affordable housing is a high concern for the respondents of the survey. Community leaders also expressed a concern for the need for affordable housing.

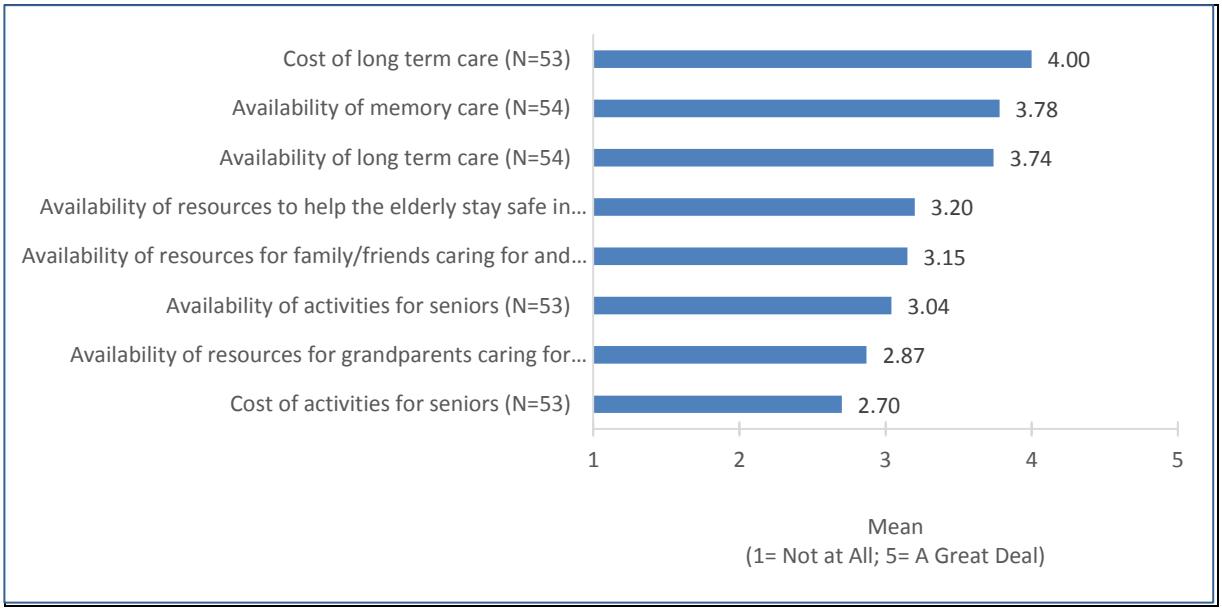
Level of concern with statements about the community regarding ECONOMICS



Aging Population

The greatest area of concern among survey respondents is for the aging population, including the cost of long term care, the availability of memory care, and the availability of long term care. Secondary research indicates the 27.5% of the population in Gregory County is 65 years of age or older.

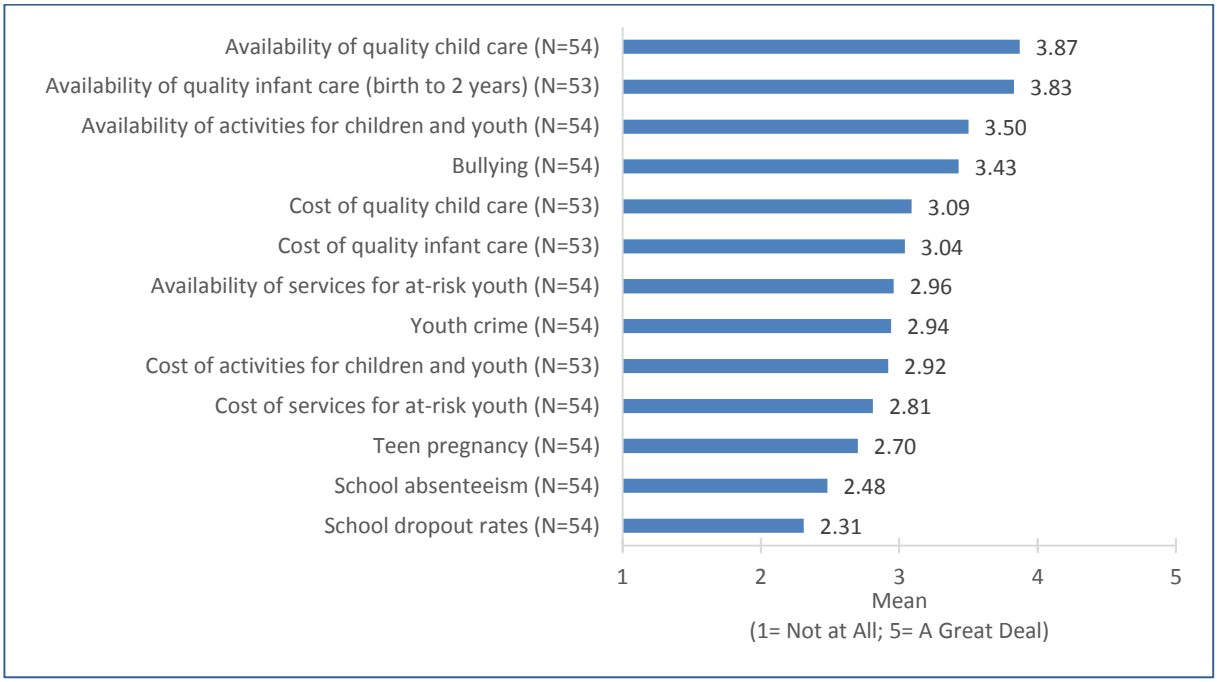
Level of concern with statements about the community regarding the AGING POPULATION



Children and Youth

The highest concerns regarding children and youth are the availability of quality child care and quality infant care. The availability of activities for children and youth is a moderately high concern.

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

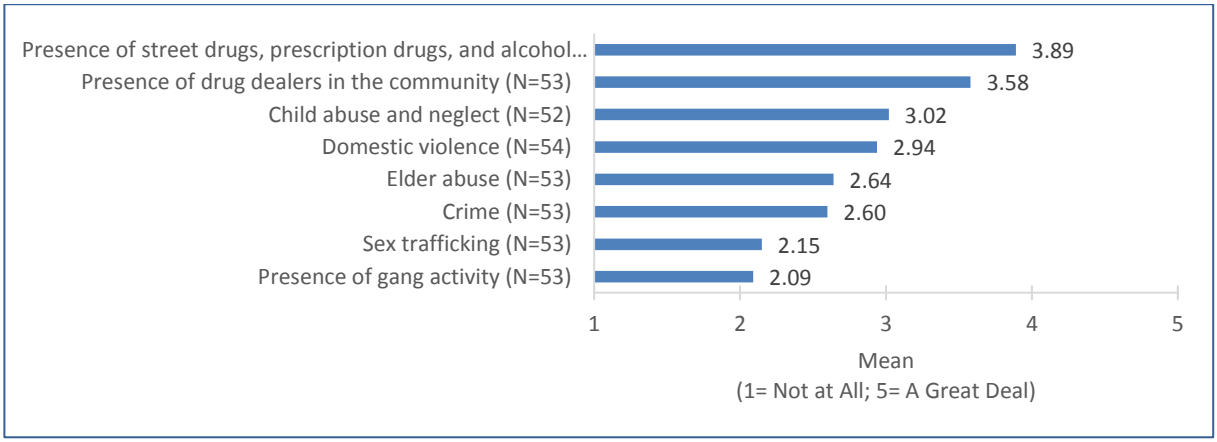


Safety

Respondents have high levels of concern with respect to safety issues (i.e., presence of street drugs, prescription drugs, and alcohol in the community; the presence of drug dealers in the community).

Secondary research finds that alcohol-impaired driving deaths have reached 33% in Gregory County, 50% in Charles Mix County and 38% in Tripp County. (See Appendix)

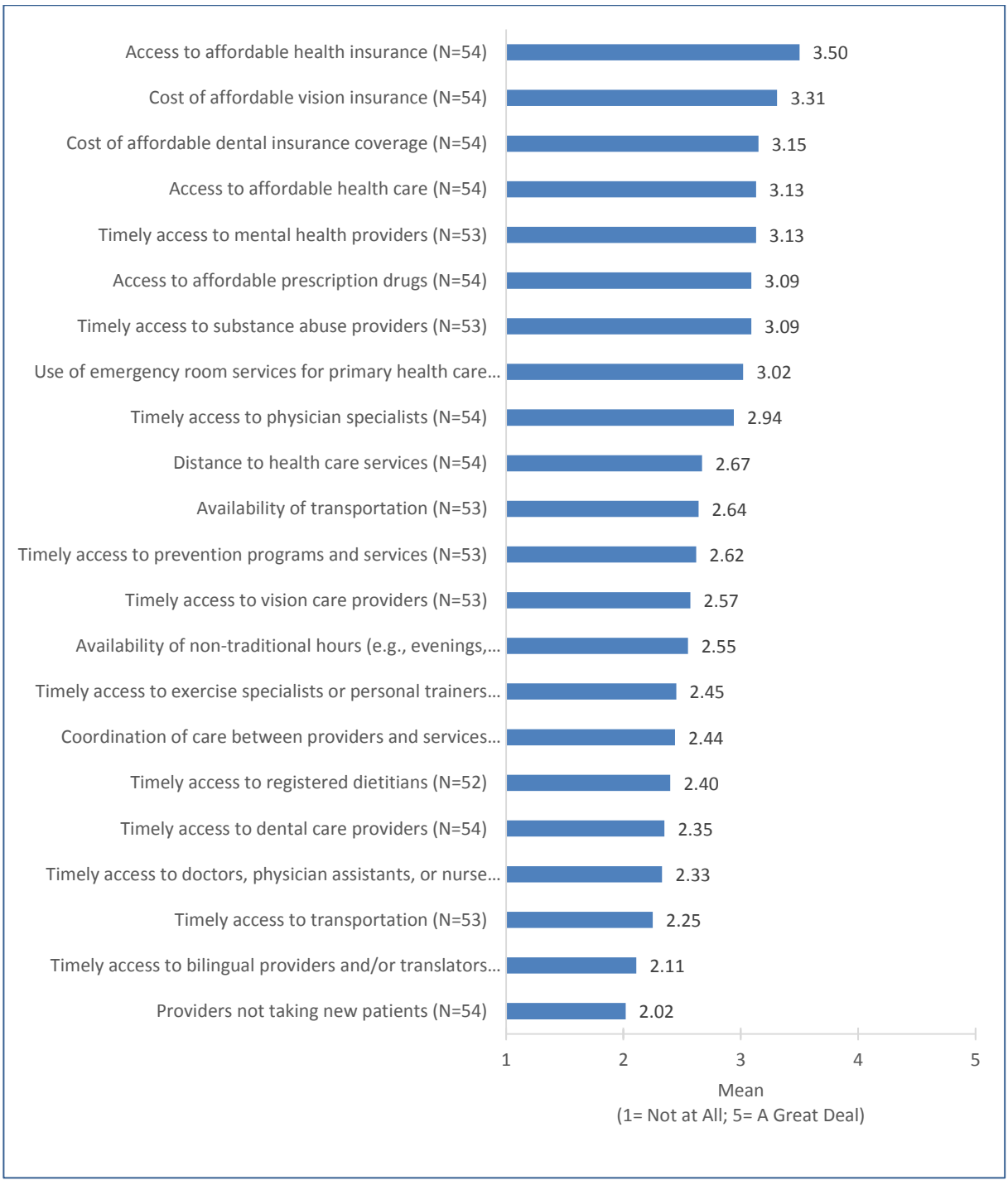
Level of concern with statements about the community regarding SAFETY



Health Care Access and Cost

Access to care includes the ability to gain entry into a health system or provider service. Access can include the availability of health care providers and a workforce available to address the needs. Limited access can challenge the ability to receive appropriate levels of care and may pave the way to the utilization of higher cost entry points into the system through the emergency room. The top concern among survey respondents is access to affordable health insurance.

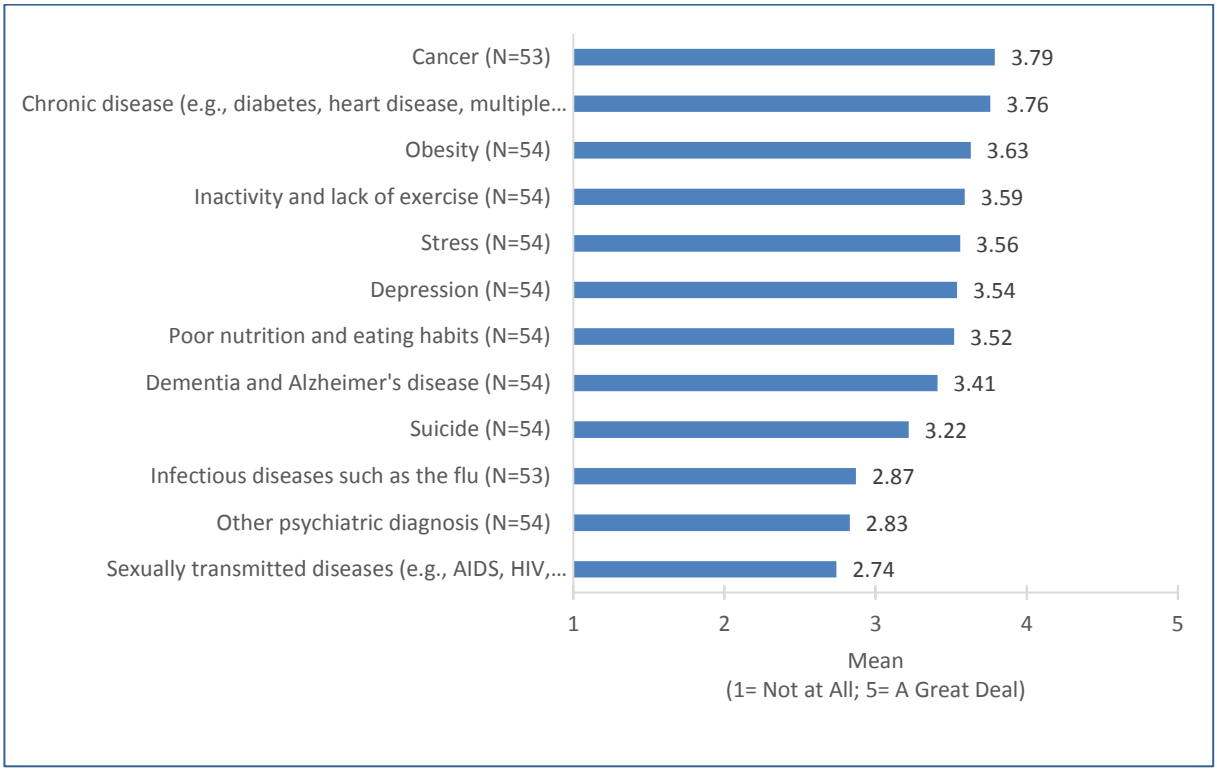
Level of concern with statements about the community regarding HEALTH CARE



Physical and Mental Health

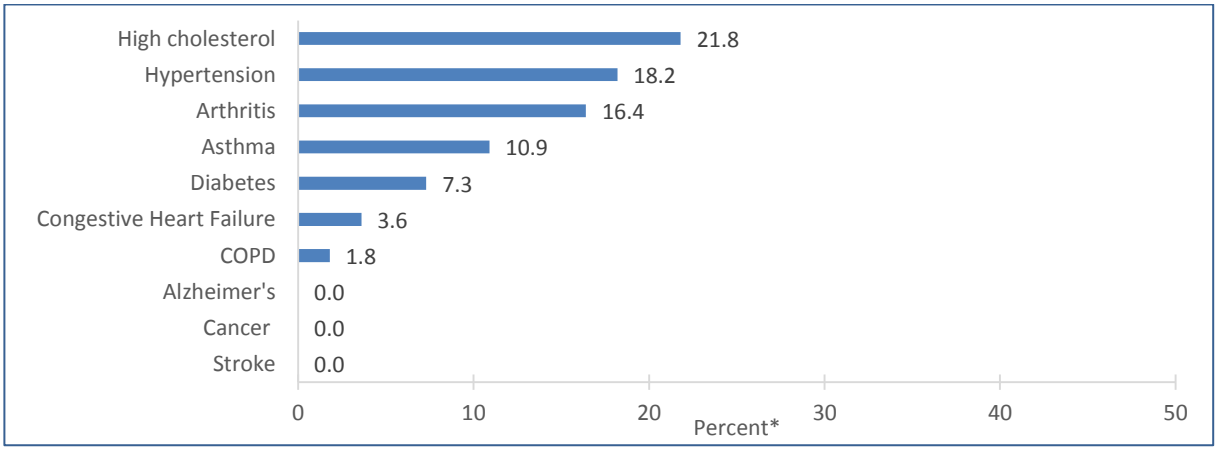
The highest concerns among survey respondents are cancer, chronic disease, obesity, inactivity, stress, depression and poor nutrition.

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



Whether respondents have any of the following chronic diseases:

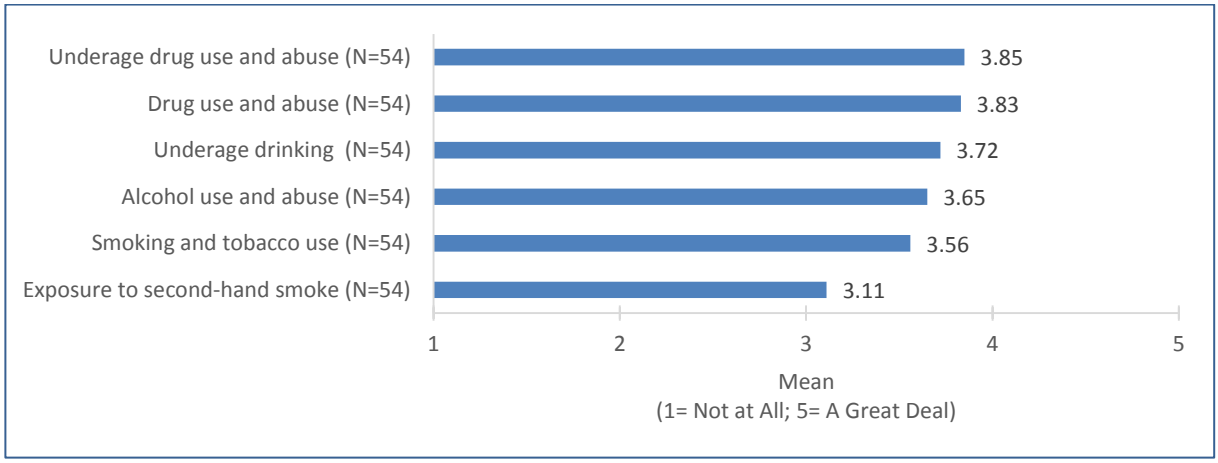
The top chronic diseases among survey respondents include hypercholesterolemia, hypertension, arthritis and asthma. Respondents were also concerned about comorbidities such as obesity, poor nutrition, and lack of physical activity.



Substance Abuse

Survey respondents were highly concerned with all of the indicators in the substance abuse category except for moderate concern in regards to exposure to second hand smoke.

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

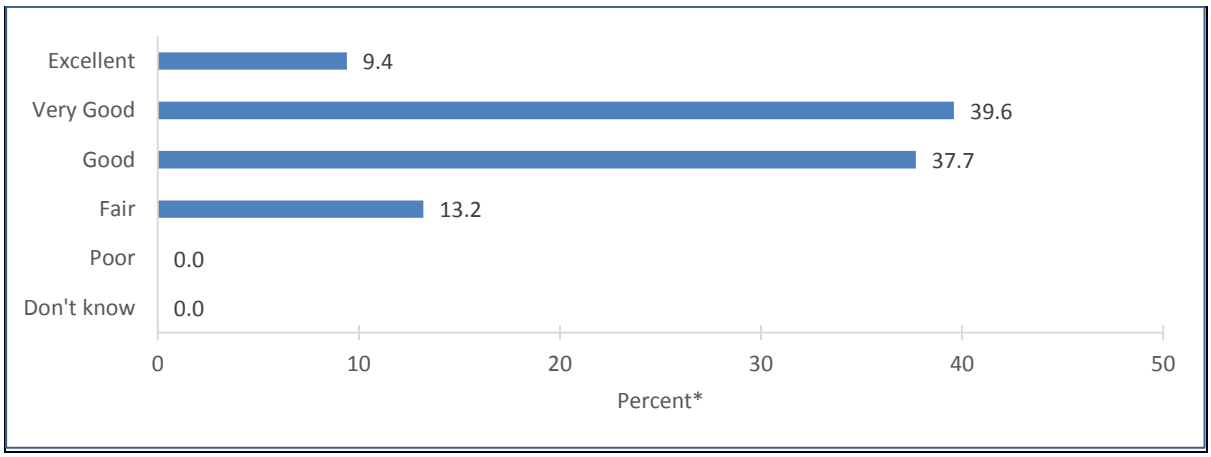


Personal Health Concerns

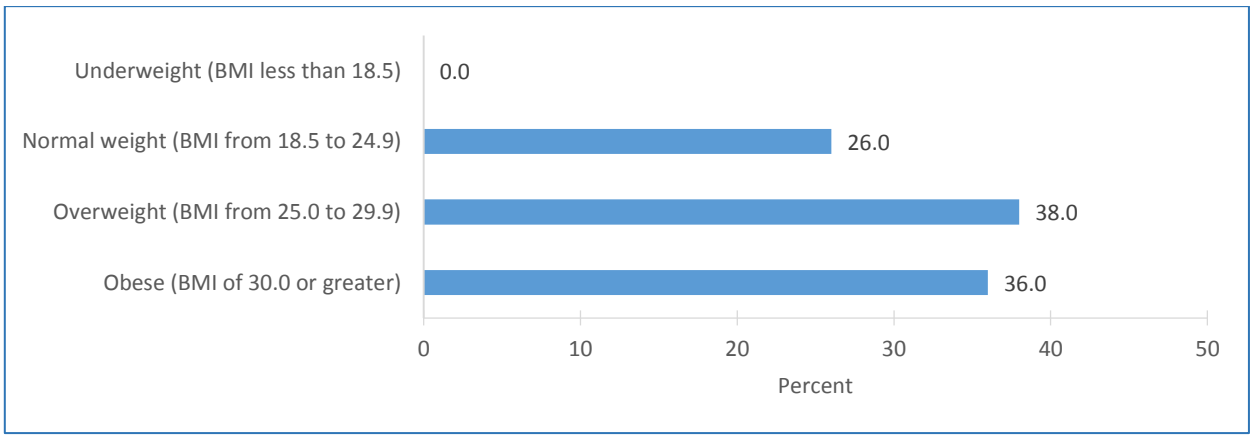
Respondents' Personal Health Status

The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority (74%) of respondents reported themselves as overweight or obese. However, the vast majority (86.7%) of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, 67.9% visited a doctor or health care provider for a routine physical and 85.2% visited a dentist or dental clinic.

Respondents' rating of their health in general



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



Respondents self-reported their BMI category with 74% reporting they are overweight or obese. Obesity is a common, but serious disease. Obesity can have adverse effects on health and lead to a reduced life expectancy. Adults with a BMI over 25 are considered overweight and adults with a BMI over 30 are considered obese. According to the CDC, obesity and overweight are the second leading cause of preventable deaths, tagging close behind tobacco use.

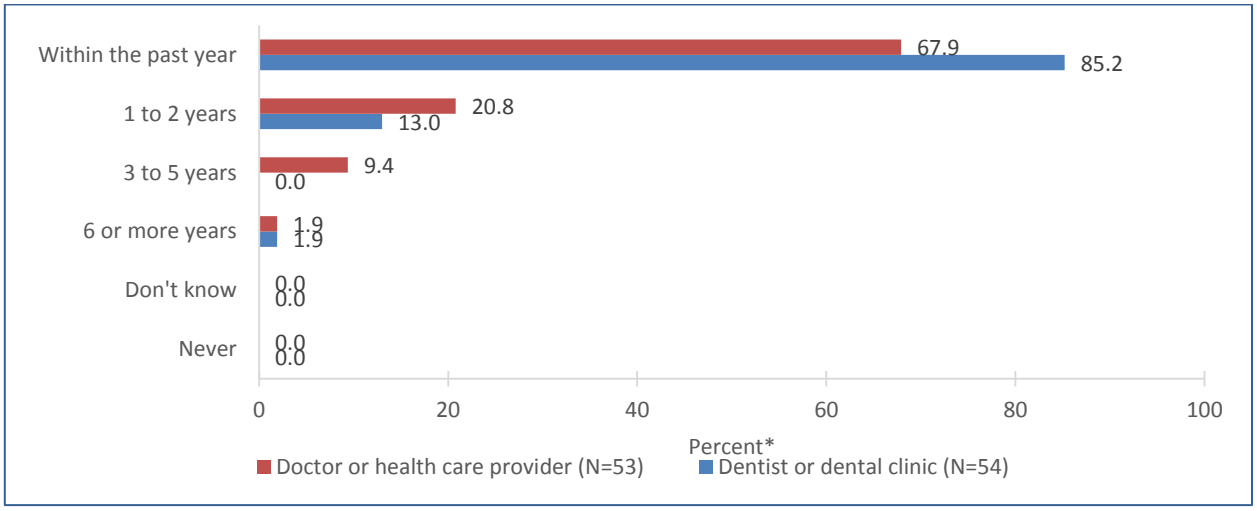
Health conditions related to obesity:

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

Nationally, more than 30% of adults, 17% of youth age 6-19 years, and more than 8% of children 2 to 5 years of age are obese.

For information about the BMI, visit the Center for Diseases Control and Prevention, *About BMI for Adults*, www.cdc.gov/healthyweight/assessing/bmi/

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



- 32.1% reported waiting more than 1 year to see their health care provider
- 14.9% reported waiting more than 1 year to see their dentist or dental clinic

Preventive Health

Preventive health care promotes the detection and prevention of illness and disease and is another important component of good health and well-being. Community results indicate that within the past year, the majority of respondents had a blood pressure screening, blood sugar screening, cholesterol screening, dental screening, flu shot, pelvic exam (females), breast cancer screening (females), and cervical cancer screening (females). However, there are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, cardio screening, glaucoma test, hearing screening, immunizations, STD test, vascular screening, colorectal cancer screening, prostate cancer

screening [males], and skin cancer screening in the past year). Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate.

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=54)	92.6	7.4	100.0
Blood sugar screening (N=54)	74.1	25.9	100.0
Bone density test (N=53)	11.3	88.7	100.0
Cardiovascular screening (N=53)	24.5	75.5	100.0
Cholesterol screening (N=54)	83.3	16.7	100.0
Dental screening and X-rays (N=54)	87.0	13.0	100.0
Flu shot (N=54)	85.2	14.8	100.0
Glaucoma test (N=53)	34.0	66.0	100.0
Hearing screening (N=53)	9.4	90.6	100.0
Immunizations (N=53)	47.2	52.8	100.0
Pelvic exam (N=40 Females)	60.0	40.0	100.0
STD (N=53)	15.1	84.9	100.0
Vascular screening (N=53)	18.9	81.1	100.0
CANCER SCREENINGS			
Breast cancer screening (N=39 Females)	74.4	25.6	100.0
Cervical cancer screening (N=39 Females)	59.0	41.0	100.0
Colorectal cancer screening (N=53)	32.1	67.9	100.0
Prostate cancer screening (N=12 Males)	41.7	58.3	100.0
Skin cancer screening (N=53)	28.3	71.7	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=4)	25.0	0.0	0.0	0.0	0.0	0.0	75.0
Blood sugar screening (N=14)	50.0	14.3	0.0	0.0	7.1	0.0	14.3
Bone density test (N=47)	48.9	34.0	4.3	0.0	0.0	2.1	10.6
Cardiovascular screening (N=40)	40.0	37.5	2.5	0.0	0.0	0.0	17.5

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Cholesterol screening (N=9)	33.3	33.3	0.0	0.0	0.0	0.0	33.3
Dental screening and X-rays (N=7)	14.3	57.1	28.6	0.0	0.0	0.0	0.0
Flu shot (N=8)	50.0	0.0	0.0	0.0	0.0	0.0	37.5
Glaucoma test (N=35)	54.3	31.4	2.9	0.0	0.0	2.9	5.7
Hearing screening (N=48)	58.3	27.1	4.2	0.0	0.0	2.1	4.2
Immunizations (N=28)	64.3	21.4	0.0	0.0	0.0	0.0	7.1
Pelvic exam (N=16 Females)	50.0	6.3	0.0	6.3	0.0	0.0	37.5
STD (N=45)	75.6	8.9	2.2	0.0	0.0	0.0	6.7
Vascular screening (N=43)	53.5	27.9	4.7	0.0	0.0	0.0	11.6
CANCER SCREENINGS							
Breast cancer screening (N=10 Females)	40.0	20.0	10.0	0.0	0.0	0.0	30.0
Cervical cancer screening (N=16 Females)	43.8	25.0	0.0	0.0	0.0	0.0	31.3
Colorectal cancer screening (N=36)	55.6	22.2	0.0	0.0	0.0	0.0	22.2
Prostate cancer screening (N=7 Males)	28.6	57.1	0.0	0.0	0.0	0.0	14.3
Skin cancer screening (N=38)	34.2	44.7	2.6	0.0	0.0	0.0	21.1

*Percentages may not total 100.0 due to multiple responses.

Screenings

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

- Cervical cancer screening: Cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up. Two screening tests can help prevent cervical cancer or find it early:
  - The Pap test (or Pap smear) looks for *pre-cancers*, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
  - The HPV test looks for the virus that can cause these cell changes (human papillomavirus) (http://www.cdc.gov/cancer/hpv/basic_info/)

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

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

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

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

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

  Assuming no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test:
    - Men who choose to be tested who have a PSA of less than 2.5 ng/mL may only need to be retested every 2 years.

  Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.
  Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone, is important when making decisions about screening.

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

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

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the survey indicate that 14.8% of respondents did not have a flu shot last year.

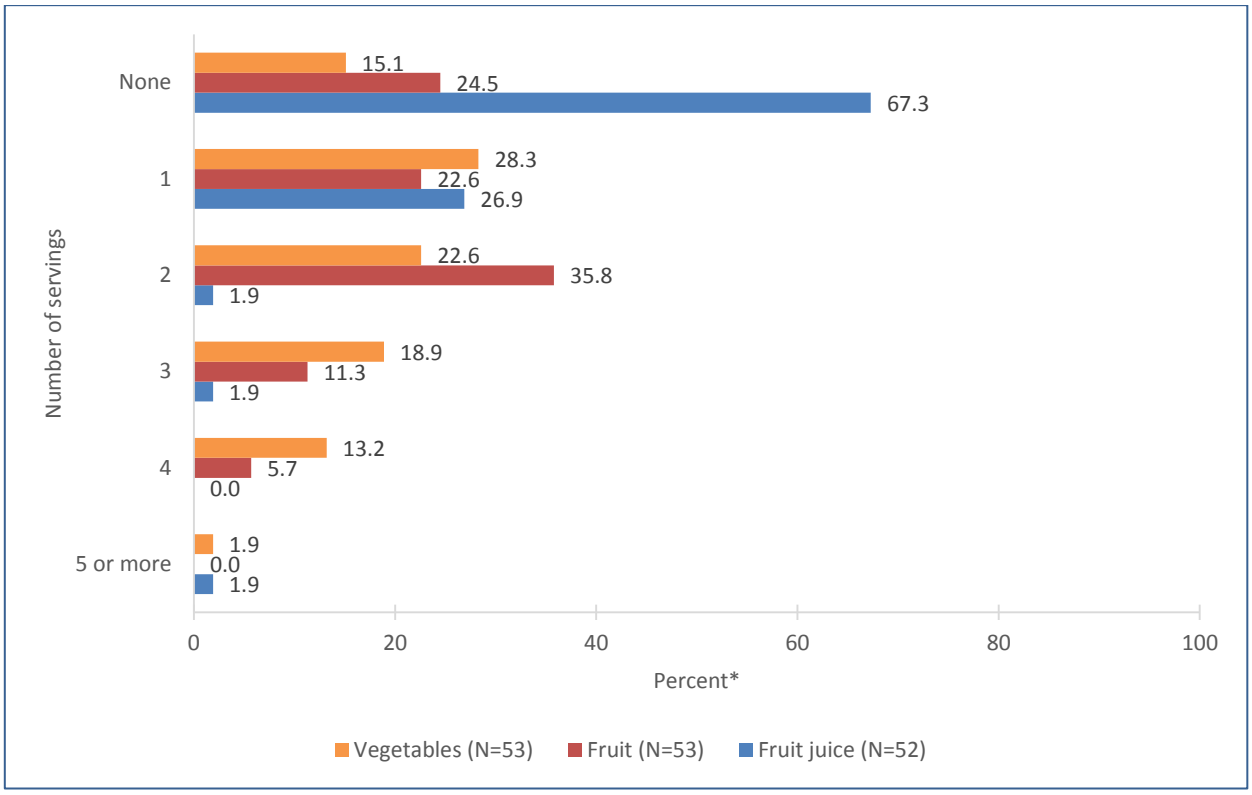
The Center for Disease Control states that influenza is a serious disease that can lead to hospitalization and sometimes even death. Even healthy people can get sick from the flu and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies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

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 34% of respondents reported having 3 or more servings of vegetables the prior day, and 17% reported having 3 or more servings of fruits the prior day.

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

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

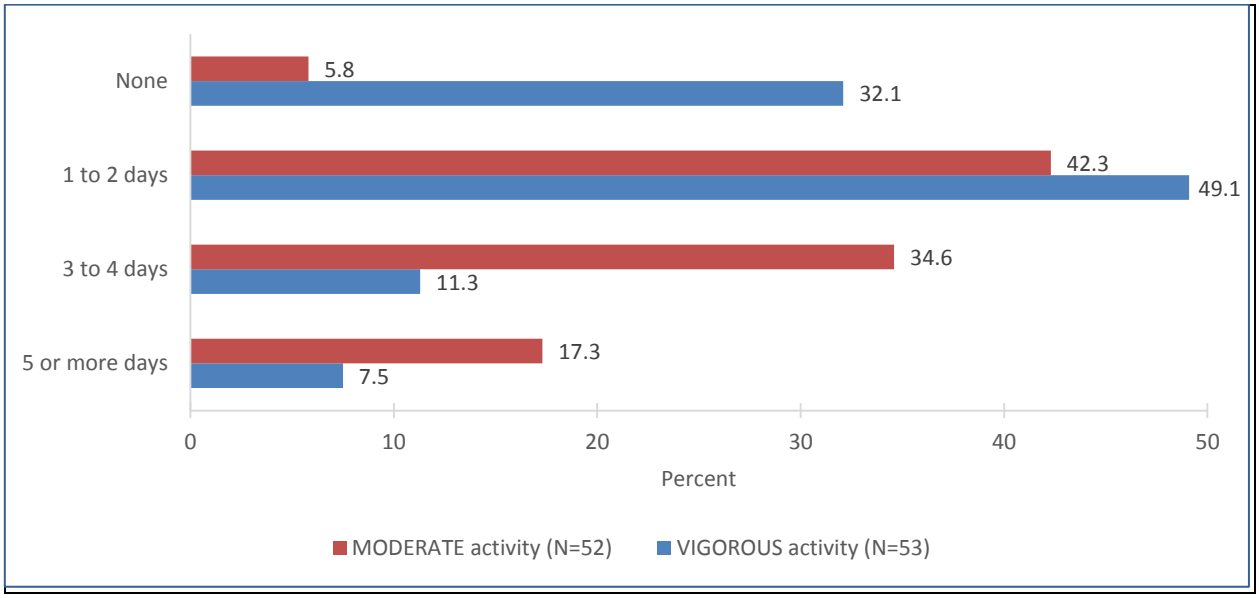


Physical Activity Levels

Study results suggest that the majority of respondents do meet physical activity guidelines. 51.9 % of respondents engage in moderate activity 3 or more times per week and 18.3% engage in vigorous activity 3 or more times per week.

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

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

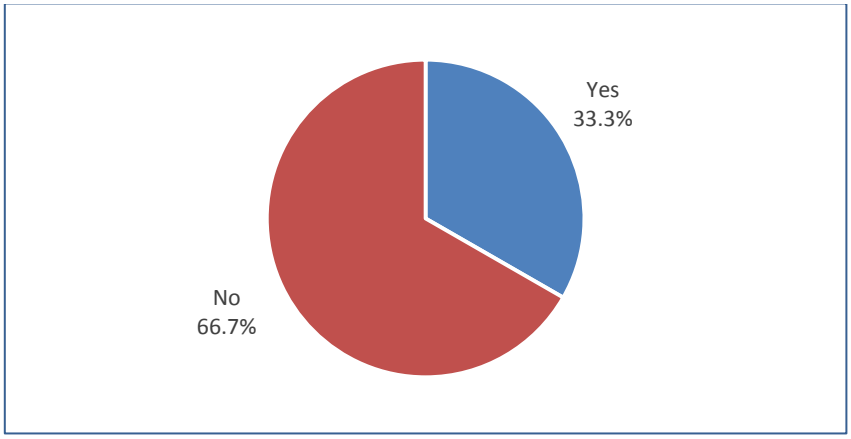


Tobacco Use

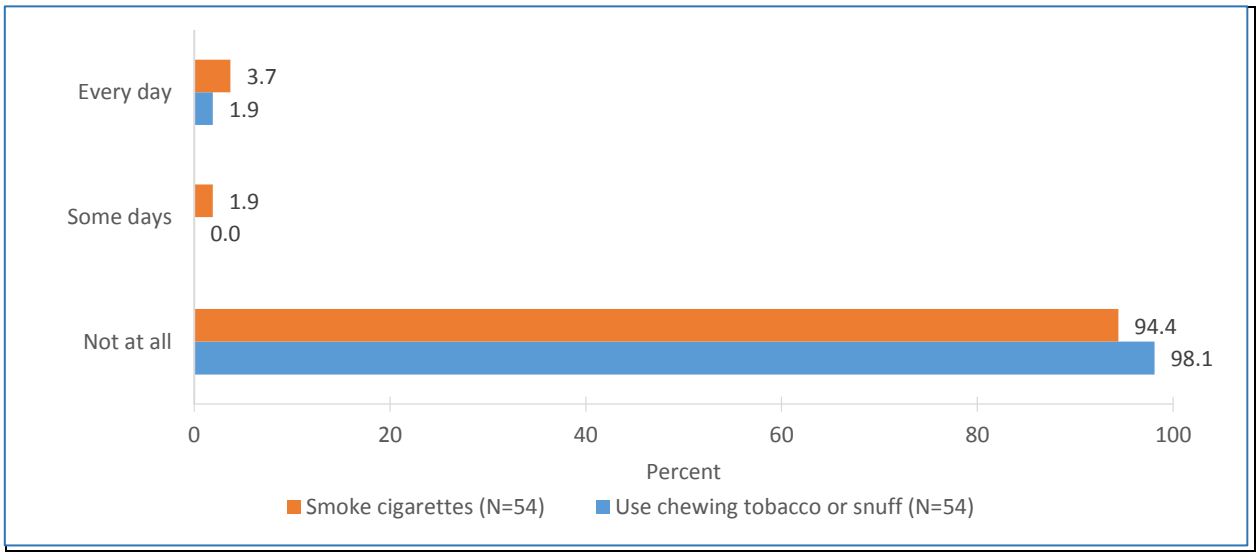
Study results indicate that the vast majority (94.4%) of community respondents are not currently tobacco users. However, 33.3% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the 2015 *County Health Rankings* finds that 12% of Gregory County, 17% of Charles Mix County, and 13% of Tripp County residents are current smokers.

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



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



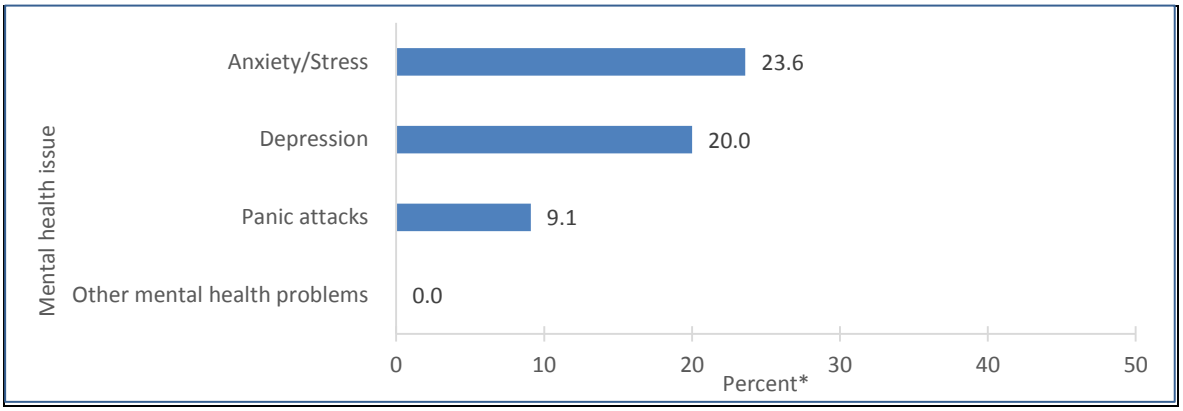
- 94.4% of survey respondents are not current smokers
- 98.1% of respondents are not current chewing tobacco or snuff users

Mental Health

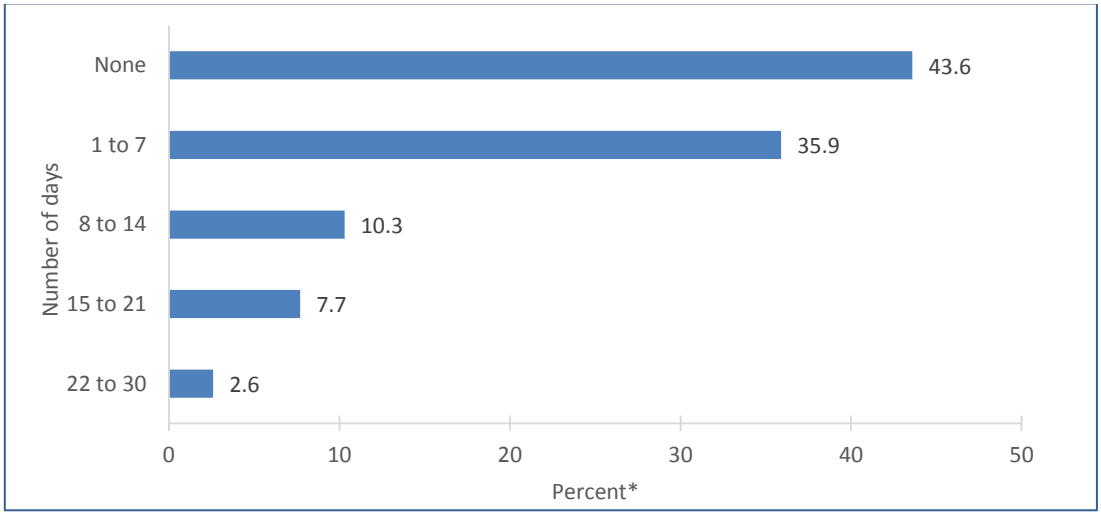
Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others.

Among survey respondents, mental health is a moderately high area of concern. Depression is the highest of concerns among respondents. One in five respondents has been told or diagnosed by a doctor or health professional that they have depression. 23.6% have been told they have anxiety or stress. In addition, over half of respondents (56.2%) self-report that in the last month, there were days when their mental health was not good, and 28.4% reported having several days in the past month when their health was not good.

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



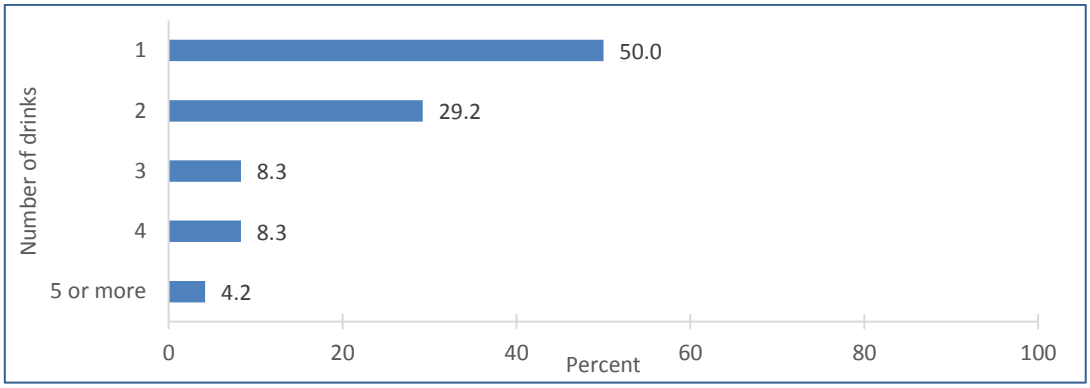
Number of days in the last month that respondents' mental health was not good



Substance Abuse Responses

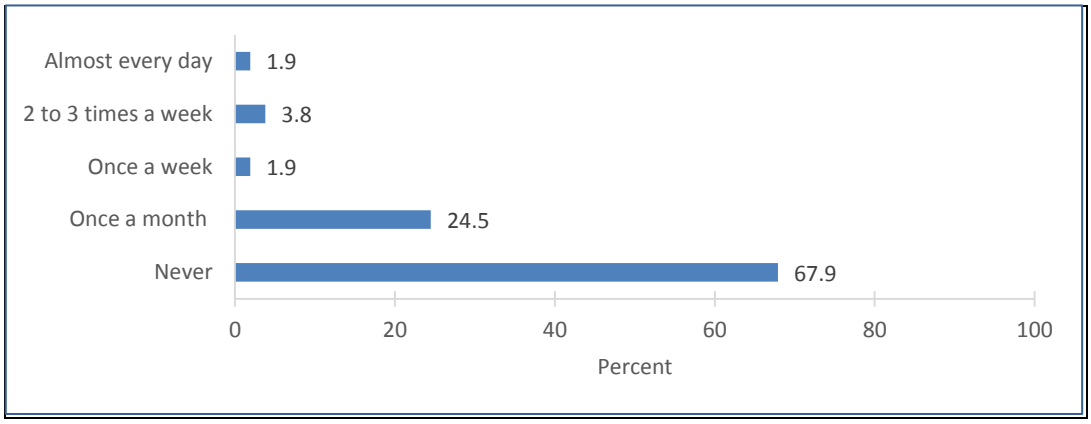
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In the Burke community, 20.8% reported having 3 or more drinks on days that they consumed.

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

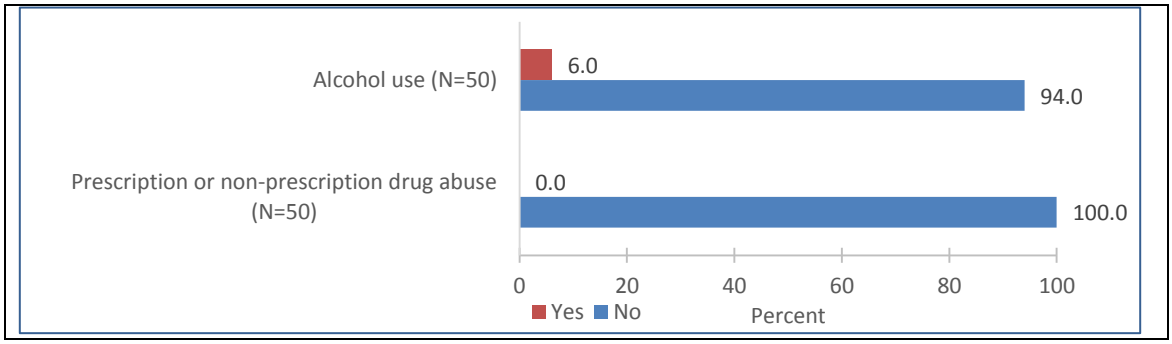


Binge Drinking. 32.1% of survey respondents reported that they binge drink at least once per month. Secondary research through the 2015 *County Health Rankings* indicates that 21% of Gregory County, 22% of Charles Mix County, and 21% of Tripp County residents report binge drinking. (See Appendix)

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



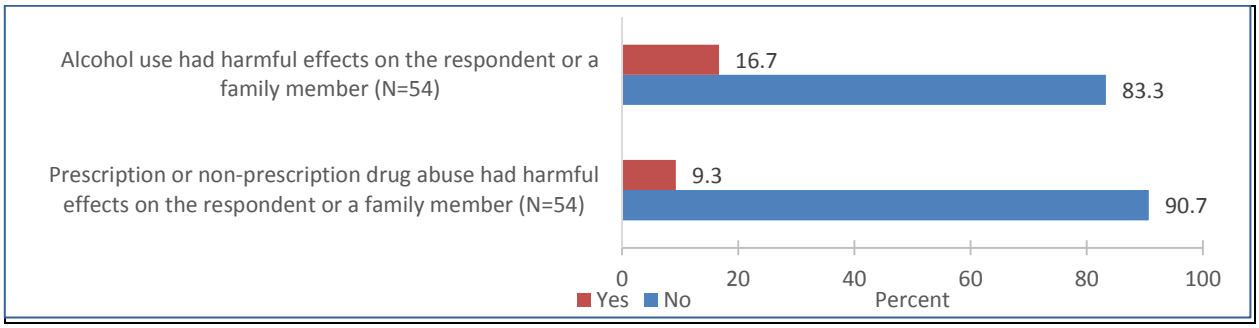
Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse



Less than 6 % of respondents reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking. Overall, 16.7% of respondents report alcohol use has had harmful effects on themselves or a family member. Nearly 10% (9.3) reported that drug abuse had a harmful effect on the respondent or a family member.

Other forms of substance abuse include the use of prescription or non-prescription drugs. No respondents in the metro area reported having had a problem with prescription or non-prescription drug abuse. However, respondents say prescription or non-prescription drug abuse has had harmful effects on themselves or a family member.

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



Demographics

Total Population – 2013 U.S. Census Bureau

- Gregory County: 4,234

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	249	5.9	124	2.9	125	3.0
5-9	266	6.3	139	3.3	127	3.0
10-14	275	6.5	157	3.7	118	2.8
15-19	265	6.3	136	3.2	120	2.8
20-24	163	3.8	94	2.2	69	1.6
25-29	163	3.8	81	1.9	82	1.9
30-34	205	4.8	112	2.6	93	2.2
35-39	214	5.1	112	2.6	102	2.4
40-44	217	5.1	115	2.7	102	2.4
45-49	218	5.1	113	2.7	105	2.5
50-54	314	7.4	105	2.5	140	3.3
55-59	341	8.1	165	3.9	175	4.1
60-64	321	7.6	171	4.0	150	3.5
65-69	273	6.4	136	3.2	137	3.2
70-74	212	5.0	104	2.5	108	2.6
75-79	180	4.3	77	1.8	103	2.4
80-84	166	3.9	69	1.6	97	2.3
85 and over	192	4.5	69	1.6	123	2.9
Median age	47.6		45.0		49.8	

Total Population – 2015 U.S. Census Bureau

- Tripp County: 5,434

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	341	6.3	179	3.3	162	3.0
5-9	317	5.8	150	2.8	167	3.1
10-14	334	6.1	161	3.0	173	3.2
15-19	329	6.1	166	3.1	163	3.0
20-24	323	5.9	173	3.2	150	2.8
25-29	273	5.0	159	2.9	114	2.1
30-34	268	4.9	142	3.6	126	2.3
35-39	262	4.8	117	2.2	145	2.7
40-44	265	4.9	146	2.7	119	2.2
45-49	283	5.2	132	2.4	151	2.8
50-54	430	7.9	228	4.2	202	3.7
55-59	425	7.8	216	4.0	209	3.8
60-64	383	7.0	210	3.9	173	3.2
65-69	313	5.8	144	2.6	169	3.1
70-74	250	4.6	120	2.2	130	2.4
75-79	222	4.1	104	1.9	118	2.2
80-84	177	3.3	70	1.3	107	2.0
85 and over	239	4.4	80	1.5	159	2.9
Median age	45.1		43.6		47.1	

Total Population – 2015 U.S. Census Bureau

- Charles Mix County: 9,383

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	808	8.6	445	4.7	363	3.9
5-9	812	8.7	389	4.1	423	4.5
10-14	747	8.0	367	3.9	380	4.0
15-19	683	7.3	343	3.7	340	3.6
20-24	553	5.9	276	2.9	277	3.0
25-29	443	4.7	231	2.5	212	2.3
30-34	494	5.3	262	2.8	232	2.5
35-39	479	5.1	238	2.5	241	3.6
40-44	432	4.6	213	2.3	219	2.3
45-49	475	5.1	235	2.5	240	2.6
50-54	591	6.3	293	3.1	298	3.2
55-59	653	7.0	331	3.5	322	3.4
60-64	534	5.7	271	2.9	263	2.8
65-69	459	4.9	233	2.5	226	2.4
70-74	381	4.1	181	1.9	200	2.1
75-79	302	3,2	148	1.6	154	1.6
80-84	254	2.7	116	1.2	138	1.5
85 and over	283	3.0	101	1.2	182	1.9
Median age	36.5		35.5		37.6	

Population by Race

	Gregory County	Percent	Tripp County	Percent	Charles Mix County	Percent
White	3,779	89.2	4,571	82.4	5,917	64.3
Black or African American	7	0.2	4	0.1	11	0.1
American Indian or Alaska Native	341	8.1	700	12.6	2,987	32.4
Asian	9	0.2	15	0.3	17	0.2
Native Hawaiian or other Pacific Islander	0	0.0	0	0.4	0	0.0
Hispanic or Latino	50	1.2	39	0.7	207	2.2

	Gregory County	Tripp County	Charles Mix County
Per capital personal income	$37,321	$24,308	$19,901
Those living below the poverty level	19.3%	15.6%	24.6%
Unemployment rate	3.9%	3.1%	4.3%

Health Needs and Community Resources Identified

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

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

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

The asset map includes identified needs from the following:

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

The Asset Map can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Economics
- Aging
- Children and Youth
- Safety
- Health Care
- Physical Health
- Mental Health

Burke Community Memorial Hospital 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, leaders will communicate these findings with community leaders and experts who can best focus on a solution to the concern.

A document that shares what Burke Community Memorial Hospital is doing to address the need or defends why it is not addressing the need can be found in the Appendix.

Members of the community stakeholder group determined that Physical Health and Mental Health are top unmet needs.

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

- Physical Health
- Mental Health

Addressing the Needs

Identified Concerns	How Burke Community Memorial Hospital is Addressing the Needs
Aging • Cost of long term care Cost of long term care • Availability of memory care Availability of LTC	Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders.
Children and Youth • Availability of quality child care • Availability of quality infant care Availability of activities for children and youth	• A new day care, Burke Day Care Inc., is scheduled to open in January 2017. • Implementation of the Sanford *fit* program into the local school system.
Economics Availability of affordable housing	Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders.
Safety • Presence of street drugs and alcohol in the community Presence of drug dealers in the community	• Community Memorial Hospital will address this need by sharing the findings of the CHNA with community leaders. • Community Memorial Hospital is working with the local Police Chief who will provide drug education to all staff. The education will also be provided in the local schools.
Health Care Access to affordable health insurance	• Community Memorial Hospital will host community health fairs which include lab draws at a reduced rate. • The hospital also has a charity care program that is available to those in need.

Physical Health
• Cancer
• Chronic disease
  ○ High cholesterol
  ○ Hypertension
  ○ Arthritis
• Obesity
  ○ 74% of respondents report they are overweight or obese
• Inactivity and lack of exercise 3.59
  ○ 51.9% report moderate activity 3x/week
• Poor nutrition and eating habits
  ○ Only 34% report having 3 or more vegetables/day
  ○ Only 17% report having 3 or more fruits/day
	• The Sanford *fit* initiative, a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.
	• Community Memorial Hospital has a Registered Dietician available for individual appointments and community education.

Identified Concerns	How Burke Community Memorial Hospital is Addressing the Needs
Mental Health • Stress • Depression • Underage drug use and abuse • Drug use and abuse • Underage drinking • Alcohol use and abuse ○ 32.1% of respondents report binge drinking • Smoking and tobacco use	• Community Memorial Hospital is working to increase access to mental health services through telemed services. • Looking to become a pilot site through the HRSA grant to offer behavioral health assessments through One Connect Emergency. • Working with local law enforcement to provide a Take Back Program within the community.

2017-2019 Implementation Strategies

Implementation Strategies

Priority 1: Physical Health
As a health care facility, we are committed to promoting a healthy lifestyle and encouraging our patients to be more active. Studies have shown that people who are active and follow a healthy lifestyle live longer.

We currently work with our local fitness organization to offer a variety of exercise classes at no charge to the public and will be working to improve such services. We will also be hosting community health fairs including lab tests at a reduced price and wellness challenges throughout the year.

We will also have a focus on promoting an active lifestyle to our youth. It is important to begin education in regards to leading a healthy lifestyle at a young age. We plan to work with the local school district in implementing the Sanford *fit* program.

Priority 2: Mental Health
Mental health is a serious issue especially if the problems are not addressed. It affects not only individuals but the families of those individuals suffering from with the problem. It affects people of all ages and has a negative impact on lives people live.

Our focus will be on improving access to mental health services as well as improving care for those patients with a depression diagnosis. We will begin implementation of Health Coach in the clinic and provide ongoing education to both Health Coaches and providers. We will work to improve PHQ-9 scores throughout the year.

A strong focus will also be on decreasing the amount of drug use in the community. We will be implementing new policies within the clinic setting, working with local law enforcement to set up a take back program, as well as providing education to both staff and members of the community.

Mental health problems are common and we want to help patients to learn to cope and give them the necessary tools to get better.

FY 2017-2019 Action Plan

Priority 1: Physical Health

Projected Impact: Community members are more active and physically fit

Goal 1: Increase opportunities to improve physical activity and reduce obesity rate

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Note any community partnerships and collaborations (if applicable)
Community Health Fairs	Number of community members participating in these events	CMH Staff	CMH Leadership	
Wellness Challenges	Number of participants/ results of challenge	CMH Staff	CMH Leadership	Fitness on Main Burke Wellness Coalition

Goal 2: Promote an active lifestyle to youth within the community

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Incorporate Sanford *fit* program into the local school system	Number of classrooms that have implemented the program	CMH Clinical Staff Teachers	Sanford *fit* Leadership CMH Leadership	Local School district

Priority 2: Mental Health

Projected Impact: Improve care of patients suffering from depression

Goal 1: Improve PHQ-9 scores for depression patients

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Provide education and standardization of workflows for clinical staff	Increase the percentage of patients meeting the PQH-9 quality measure	Nursing Staff Providers	Clinic Manager	
Implementation of Health Coach	Increase of percentage of patients meeting quality measures	Health Coach/Clinic Nursing Staff/Providers	CEO Clinic Manager	

Goal 2: Improve access to mental health services and improve care of patients with depression diagnosis

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Utilization of digital medical or telemed services; Behavioral Health Assessment via One Connect Emergency	Increase participation in mental health services, awareness activities, support groups, etc.	Digital media	CEO DON	HRSA Grant Program

Goal 3: Decrease the amount of drug use in the community

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Implementation of Pain Management Policy	Review of patients on pain agreements	Providers Opioid Treatment Guidelines	CEO DON Clinic Manager	
Work with law enforcement to provide a Take Back Program	Collection sites are determined and awareness to the community	Drug Enforcement Agency	CEO	Local Law Enforcement

2013 Implementation Strategy Impact

The 2013 Community Health Needs Assessment served as a catalyst to lift up obesity and mental health services as implementation strategies for the 2013-2016 timespan. The following strategies were implemented.

The 2013 strategies have served a broad reach across our community and region. The impact has been positive and the work will continue into the future through new or continued programming and services.

Demonstrating Impact

The 2013 Community Health Needs Assessment identified the following needs and developed implementation strategies to address the unmet needs:

Priority 1: Cancer Awareness and Prevention

- Provide an annual men's and women's Health Fair
- Provide an annual skin clinic
- Provide an annual lung screening
- Provide monthly breast cancer screening

Priority 2: Chronic Disease Management

- Offer an annual discounted cardiac and vascular screening
- Offer free glucose testing
- Provide A1c screenings for community members
- Start Diabetic Clinic and Diabetic Support Group

Priority 3: Obesity

- Partner with Fitness Center to offer free community exercise course
- Feature an annual Community Weight Loss Challenge
- Develop community nutrition classes

The 2013 Community Health Needs Assessment helped identify concerns within the community and determine areas of improvement. Implementation strategies were put in place that have been very successful through the years. Community members have been very appreciative of the strategies and it has reflected in a positive impact. As a facility, we look forward to continuing such work and making improvements.

Community Feedback from the 2013 Community Health Needs Assessment

Burke Community Memorial Hospital is prepared to accept feedback on our 2016 Community Health Needs Assessment and has provided online comment fields for ease of access on our website. There have been no comments to date aside from a question asked about the service area for this report.

APPENDIX

Primary Research

Burke Community Memorial Hospital and Health Services

Asset Map

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Focus on South Dakota Report for Gregory County and/or County Health Rankings	Community resources that are available to address the need	Gap ?
Economics • Cost of affordable housing 3.74	There is a problem with limited resources or with ineligibility The Rural Office of Community Resources frequently receives calls for rental assistance		Burke Housing and Redevelopment Commission 605-775-2676 Low income apartments: • Rosebud Apts. 605-775-2531 • Parkview Manor 605-775-2676 Rural Office of Community Services • Karen Janousek 605-487-7635	
Aging Population • Cost of LTC 4.00 • Availability of memory care 3.78 • Availability of LTC 3.74		27.5% are 65 years or older	LTC resources: • TLC Assisted Living Home 605-775-6316 Memory care resources: • TLC Assisted Living Home 605-775-6316 Low income apartments: • Rosebud Apts. 605-775-2531 • Parkview Manor 605-775-2676	
Children and Youth • Bullying 3.87 • Availability of quality childcare 3.83 • Availability of activities for children and youth 3.50	There is a new daycare in Burke	• 13.4% have 3 or more ACEs • 9.1% have 5 or more ACEs • 26% of children live in poverty	Bullying resources: • Sheriff 605-775-2626 • Police 605-775-2282 • Burke School 605-775-2645 • Burke Clinic 605-775-2631 • Debra Leibel, CNP 605-775-2631 • Burke Wellness Coalition • The Rock (Youth Center) 605-775-2950 Child Care resources: • Clarissa Dummer 605-775-2415 • Julie Johnson – 605-775-2987 • Nancy Nelson- 605-775-2910 • Burke Day Care Activities for children & youth: • 4-H – 605-775-2581 • Boy Scouts • Girl Scouts 605-336-2978 • School District 605-775-2645 • Park District 605-775-2475	

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Focus on South Dakota Report for Gregory County and/or County Health Rankings	Community resources that are available to address the need	Gap ?
			• Individual volunteer programs for football, soccer, baseball • City Library 605- 775-2373 • Food Pantry Backpack Program 605-775-2676	
Crime/Safety • Presence of street drugs, prescription drugs & alcohol 3.89 • Presence of drug dealers 3.58			Sheriff 605-775-2626 Police 605-775-2282	
Access to Health Care/ Cost of Health Care • Access to affordable health insurance 3.50	Insurance agencies should be listed	• 6.2% have unmet medical needs • 2.9% have unmet prescription needs	Burke Clinic 605-775-2631 SD DHS Prescription Assistance Program 605-773-3656 Farm Bureau Ins. 605-775-8290 The Insurance Center 605-775-2602 Southern Dakota Insurance Agency – 605-775-2097	
Physical Health • Cancer 3.79 • Chronic disease 3.76 • 21.8% report high cholesterol • 18.2% report hypertension • 16.4% report arthritis • Obesity 3.64 • 74% rate themselves as overweight or obese • Inactivity and lack of exercise 3.59 • 51.9% report moderate exercise 3 x per week or more • Poor nutrition and eating habits 3.52 • Only 34% have 3 or more vegetables per day • Only 17% have 3 or more fruits per day		• 28% have diabetes • 10.5% have asthma • 30.4% have hypertension • 12.3% have heart disease • 26.9% have high cholesterol • 2.9% have COPD • 8.5% have cancer • 86.7% rate their health status as good or better	Burke Clinic 605-775-2631 Sanford dietitians Sanford home medical equipment – 605-775-2296 Burke Wellness Coalition American Cancer Society American Diabetes Association American Lung Association American Asthma Association Arthritis Foundation American Heart Association SD Office of Chronic Disease Prevention 605-773-3361 Obesity/Inactivity/Exercise resources: • Fitness on Main, Burke - anticipated to re-open soon • Burke Lake Trail • Burke Track • School District 605-775-2645 • Park District 605-775-2475 Nutrition classes: • Gregory County Extension 605-775-2581	

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Focus on South Dakota Report for Gregory County and/or County Health Rankings	Community resources that are available to address the need	Gap ?
			Farmers Markets: • Burke Area Farmers Market 605-830-5039	
Mental Health/ Behavioral Health • Stress 3.56 • Depression 3.54 • Underage drug use and abuse 3.85 • Drug use and abuse 3.83 • Underage drinking 3.72 • Alcohol use and abuse 3.65 • 32.1% of respondents report binge drinking • Smoking and tobacco use 3.56	Disturbing that there are no services	• 5.4% need mental health care • 11.6% have depression • 6.7%% have anxiety • 1.4% deal with PTSD • 1.4% report addiction issues • 21% are current smokers • 21.3% abuse alcohol • 0.9% used marijuana in the past year	Burke Clinic 605-775-2631 Southern Plains Behavioral Health Clinic, Gregory, SD (12 mi. from Burke) 605-835-8505 SD QuitLine 866-737-8487 Local Alcoholics Anonymous Chapter	

Burke Community Memorial Hospital 2016 Community Health Needs Assessment
Prioritization Worksheet

Criteria to Identify Priority Problem

- Cost and/or return on investment
- Availability of solutions
- Impact of problem
- Availability of resources (staff, time, money, equipment) to solve problem
- Urgency of solving problem (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
Economics • Availability of affordable housing 3.74			
Aging • Cost of long term care 4.00 • Availability of memory care 3.78 • Availability of LTC 3.74	1		
Children and Youth • Availability of quality child care 3.87 • Availability of quality infant care 3.83 • Availability of activities for children and youth 3.50			
Safety • Presence of street drugs and alcohol in the community 3.89 • Presence of drug dealers in the community 3.58	3		
Health care • Access to affordable health insurance 3.50			

Physical Health
• Cancer 3.79
• Chronic disease 3.76
  ○ High cholesterol
  ○ Hypertension
  ○ Arthritis
• Obesity 3.64
  ○ 74% of respondents report they are overweight or obese
• Inactivity and lack of exercise 3.59
  ○ 51.9% report moderate activity 3x/week
• Poor nutrition and eating habits 3.52
  ○ Only 34% report having 3 or more vegetables/day
  ○ Only 17% report having 3 or more fruits/day
	9	#2 priority	

Mental Health • Stress 3.56 • Depression 3.54 • Underage drug use and abuse 3.85 • Drug use and abuse 3.83 • Underage drinking 3.72 • Alcohol use and abuse 3.65 ○ 32.1% of respondents report binge drinking • Smoking and tobacco use 3.56	11	#1 priority	

Present: Billy Sutton, Kelsea Sutton, Kelly Frank, Theresa Bachman, Tammy Knight, Randy Sachtjen, Jody Young, Mindie Wischmann, Mel Juran, Sue Chytka

Community Memorial Hospital

Community Health Needs Assessment

Results from a May 2016 Non-generalizable Online Survey

June 2016

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a May 2016 online survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative invited viewers to access the online survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach. Therefore, it is important to note that the data in this report are not generalizable to the community. Data collection occurred throughout the month of May 2016 and a total of 55 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

General Health and Wellness Concerns about the Community

Using a 1 to 5 scale, with 1 being "not at all" and 5 being "a great deal," respondents were asked to rate their level of concern with various statements regarding ECONOMICS, TRANSPORTATION, the ENVIRONMENT, CHILDREN AND YOUTH, the AGING POPULATION, SAFETY, HEALTH CARE, PHYSICAL AND MENTAL HEALTH, and SUBSTANCE USE AND ABUSE.

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

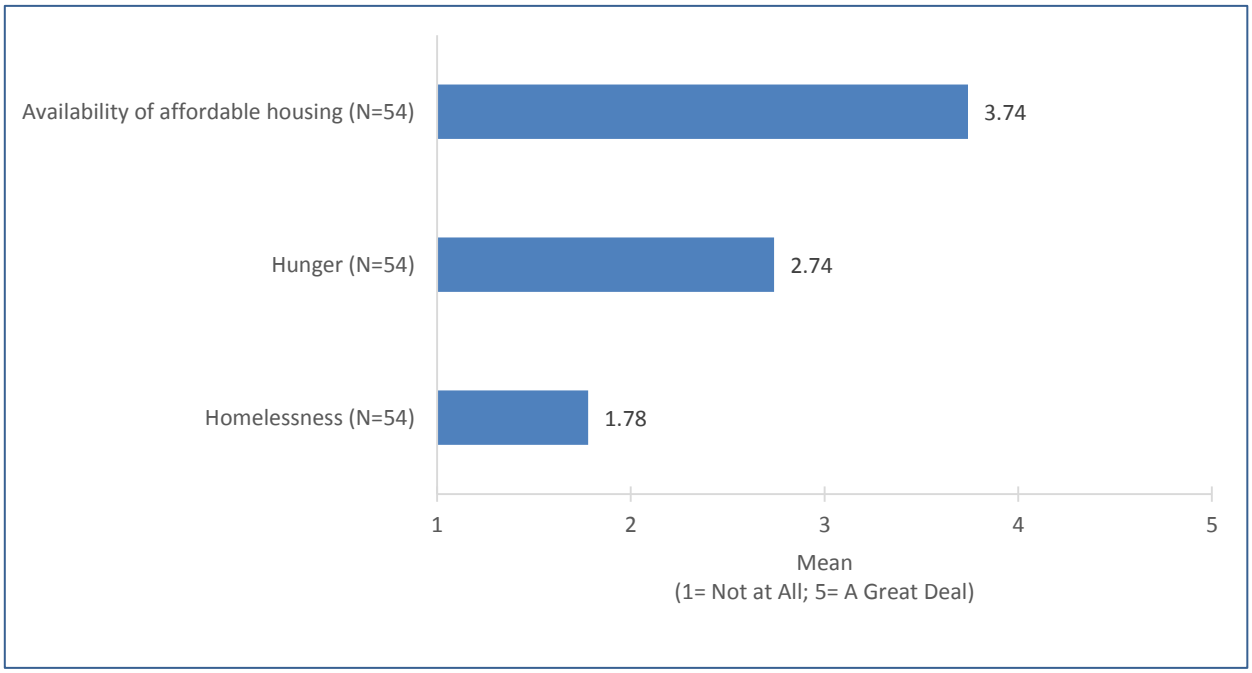


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

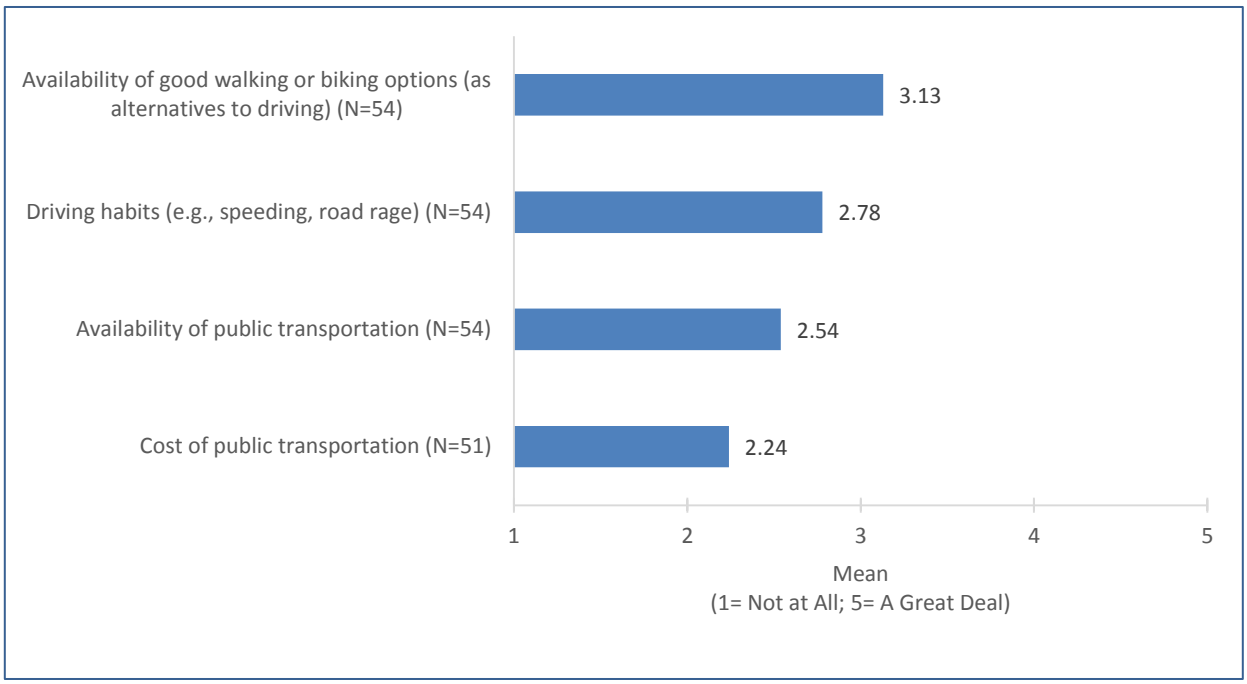


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

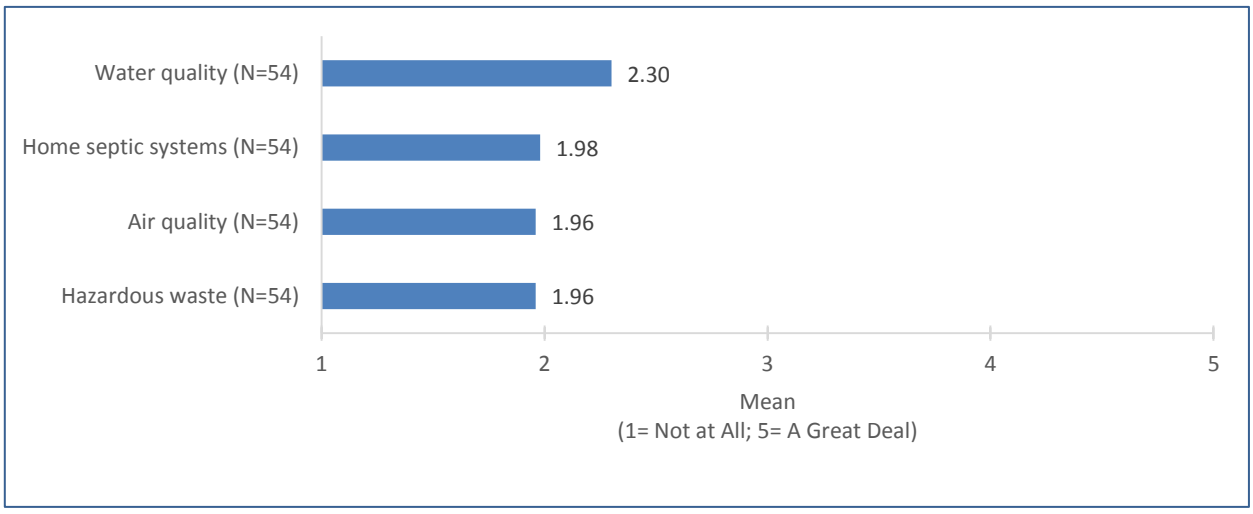


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

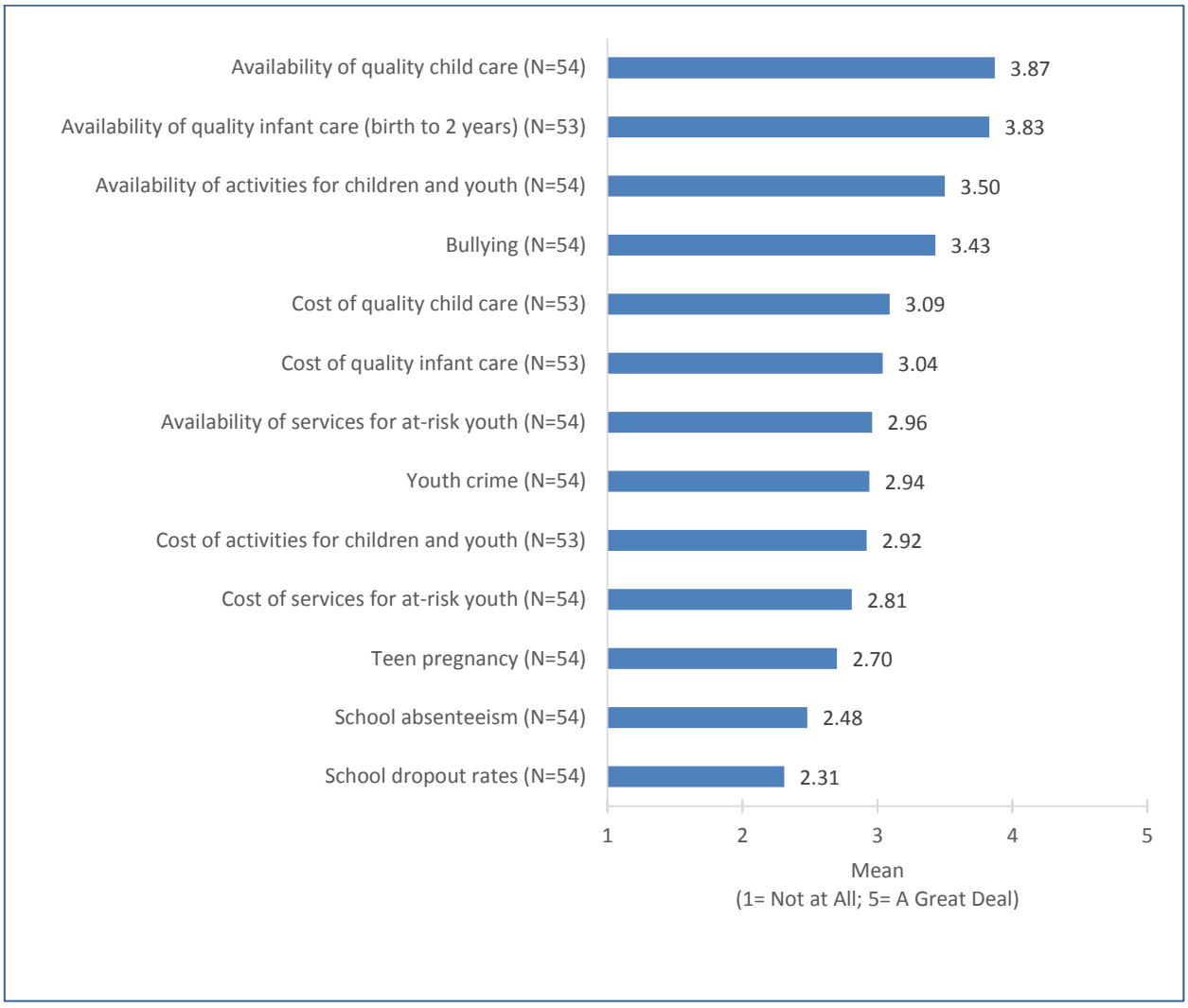


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

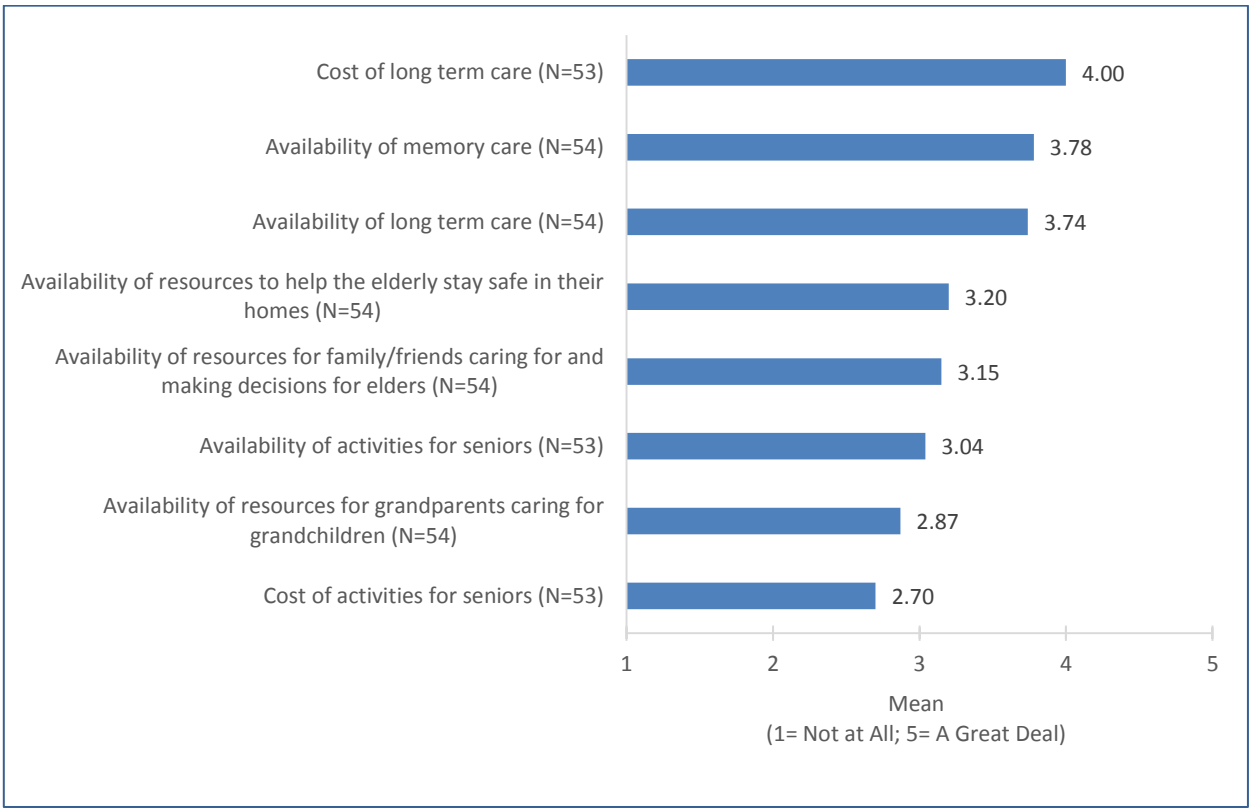


Figure 6. Level of concern with statements about the community regarding SAFETY

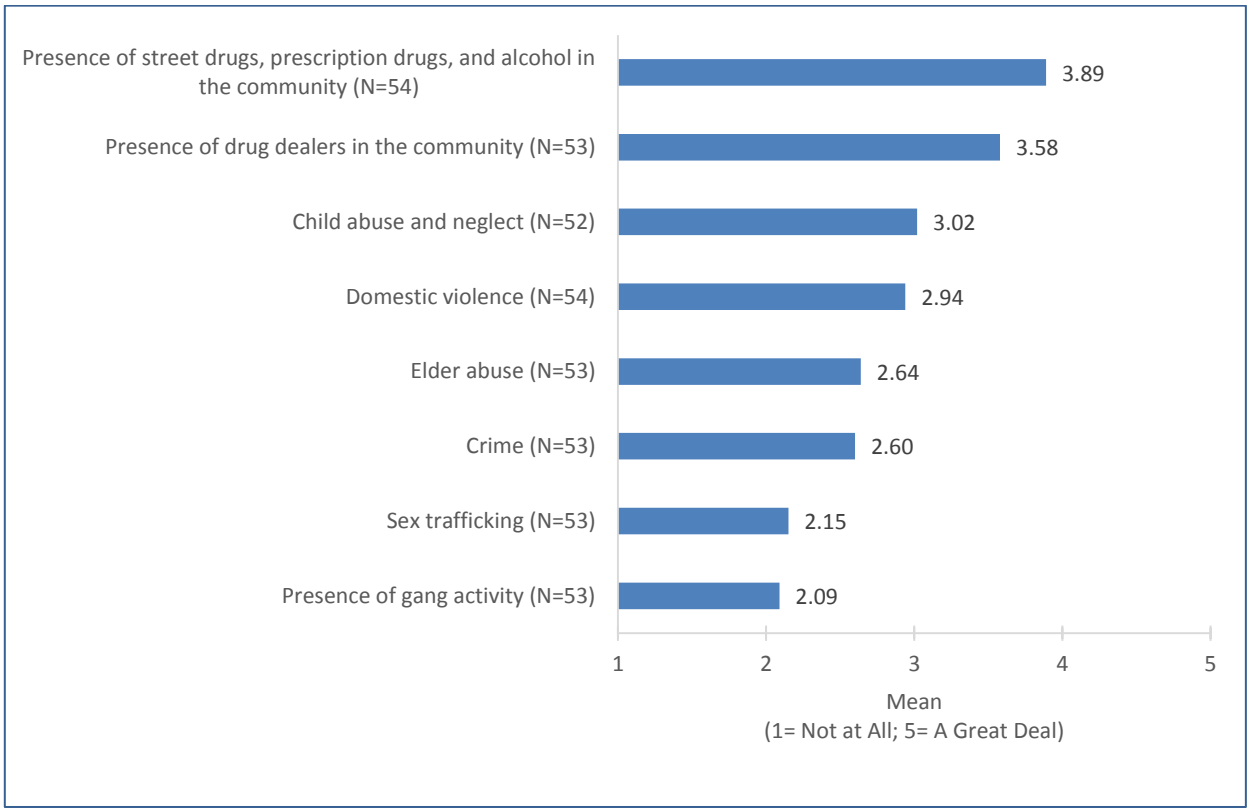


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

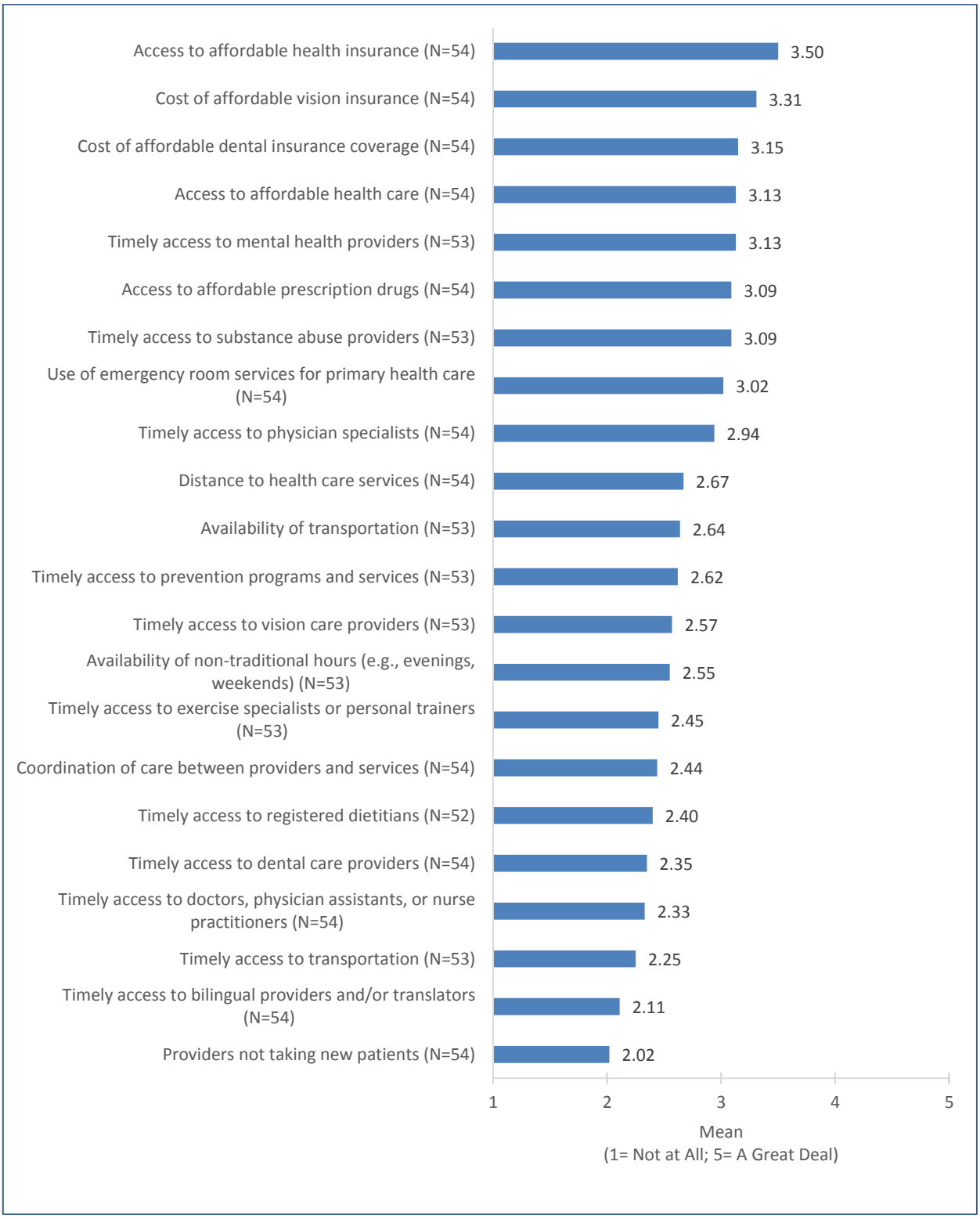


Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

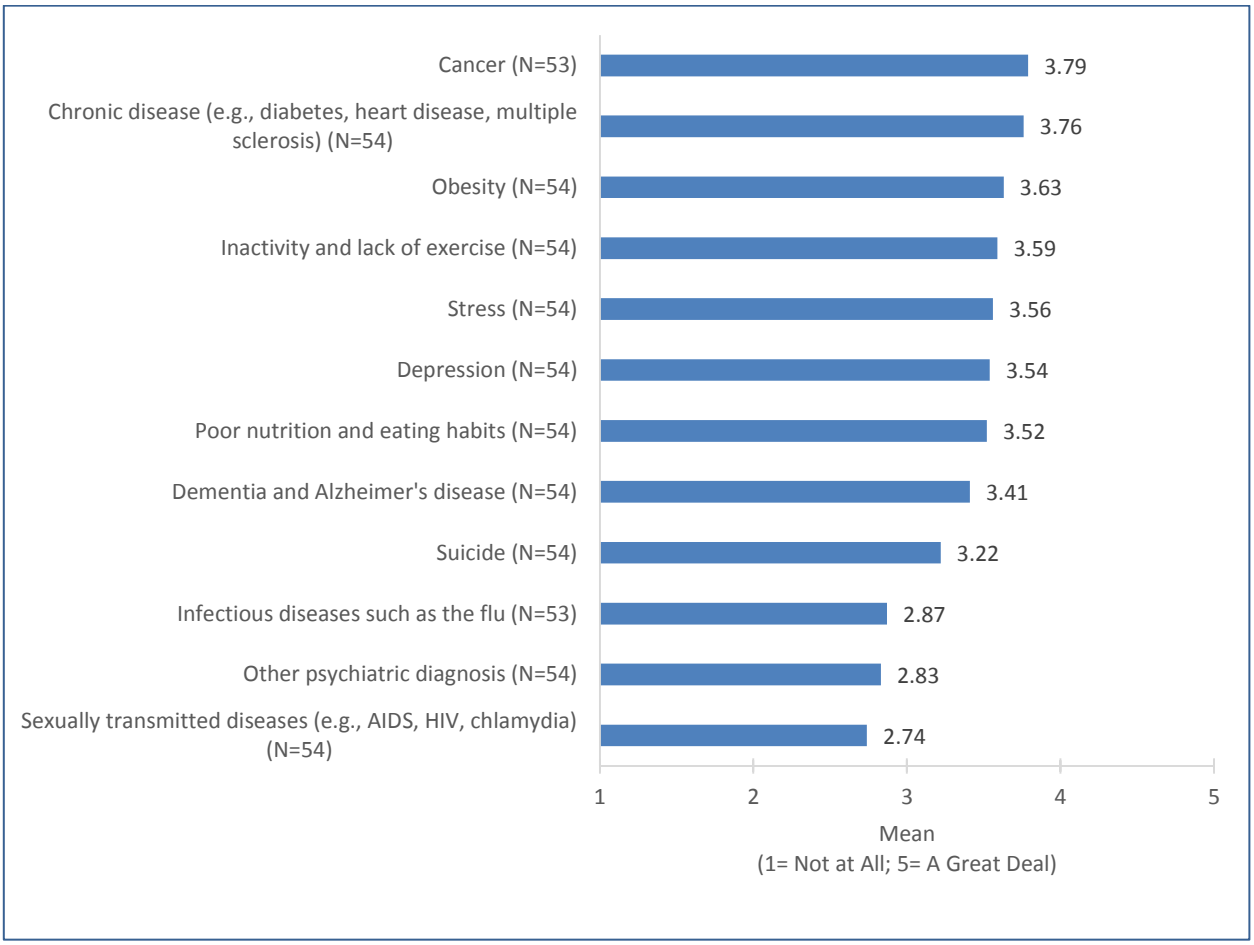
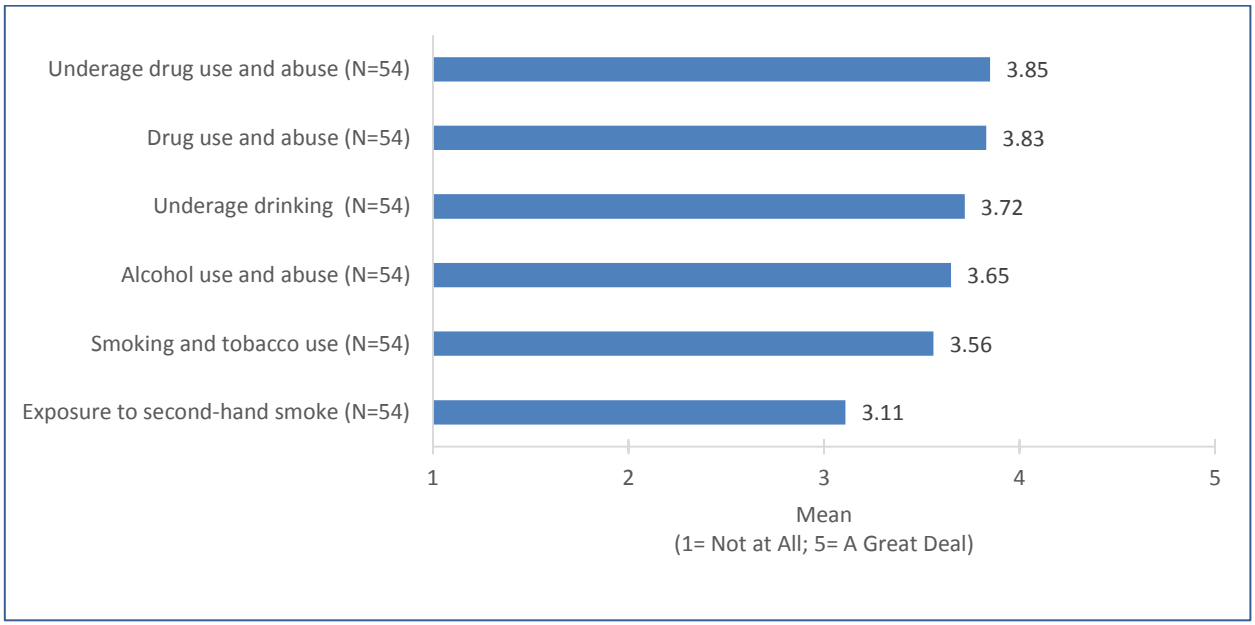
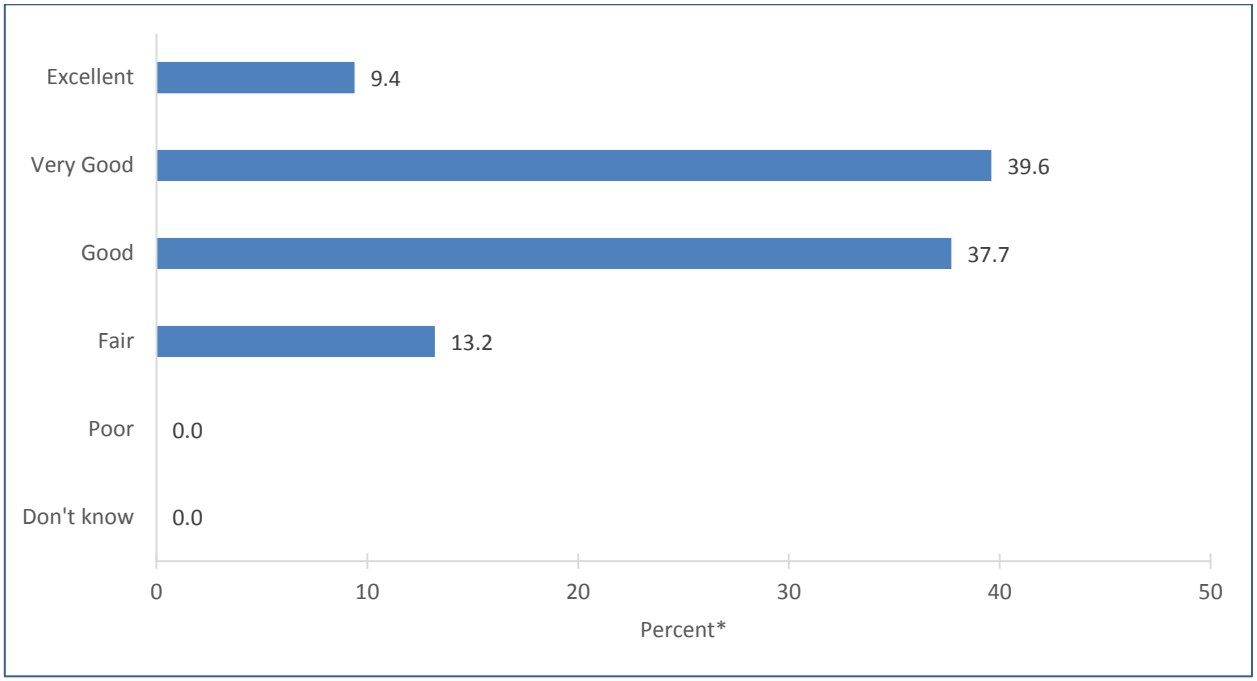


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



General Health

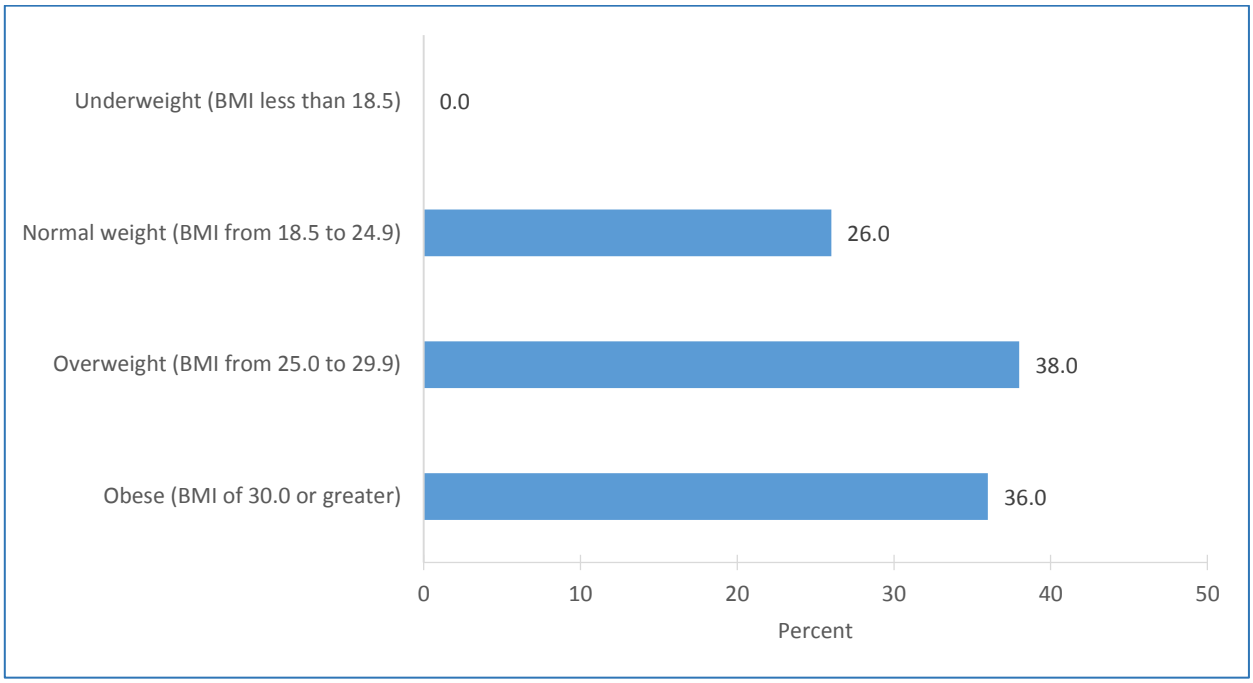
Figure 10. Respondents' rating of their health in general



N=53

*Percentages do not total 100.0 due to rounding.

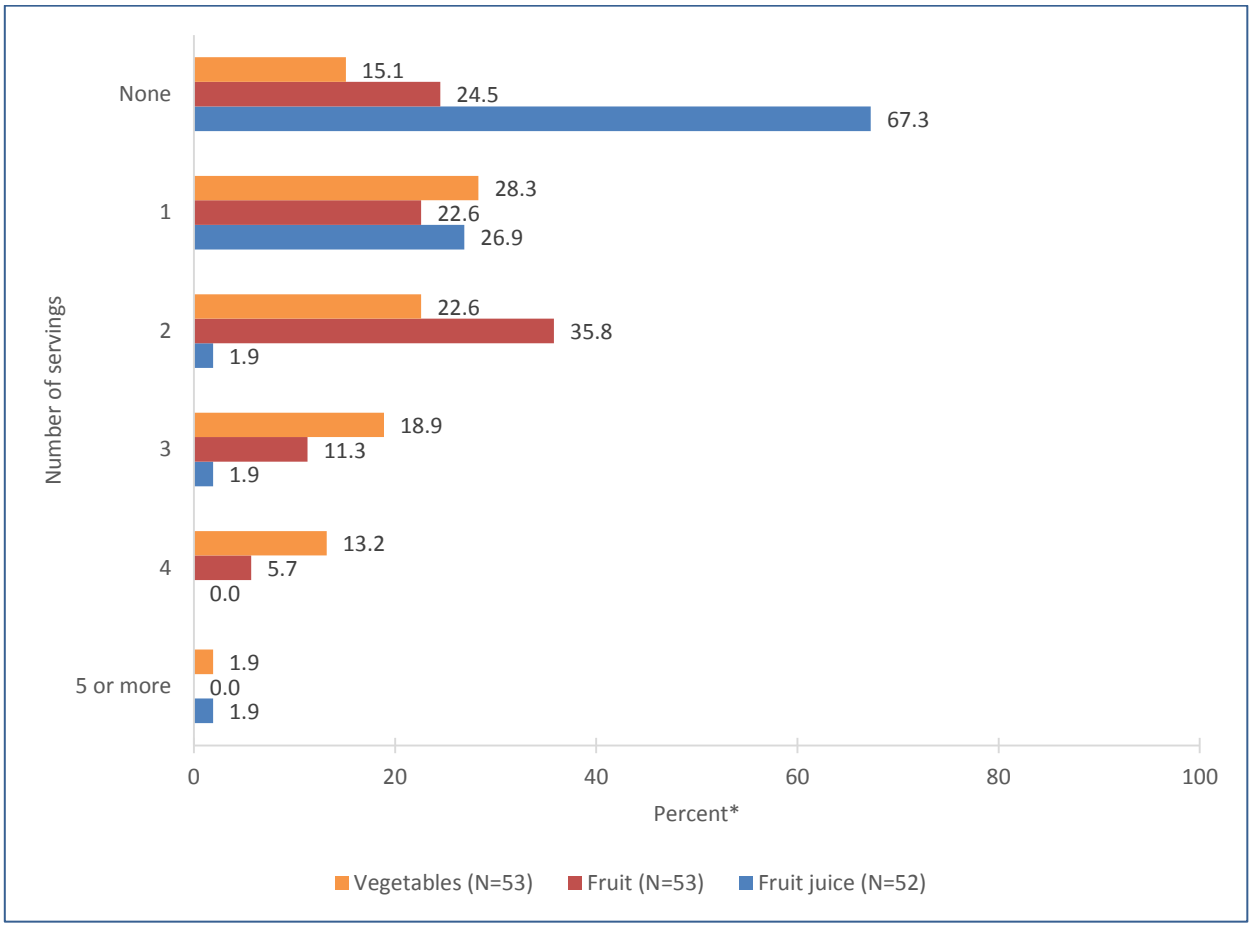
Figure 11. Respondents' weight status based on the Body Mass Index (BMI)* scale



N=50

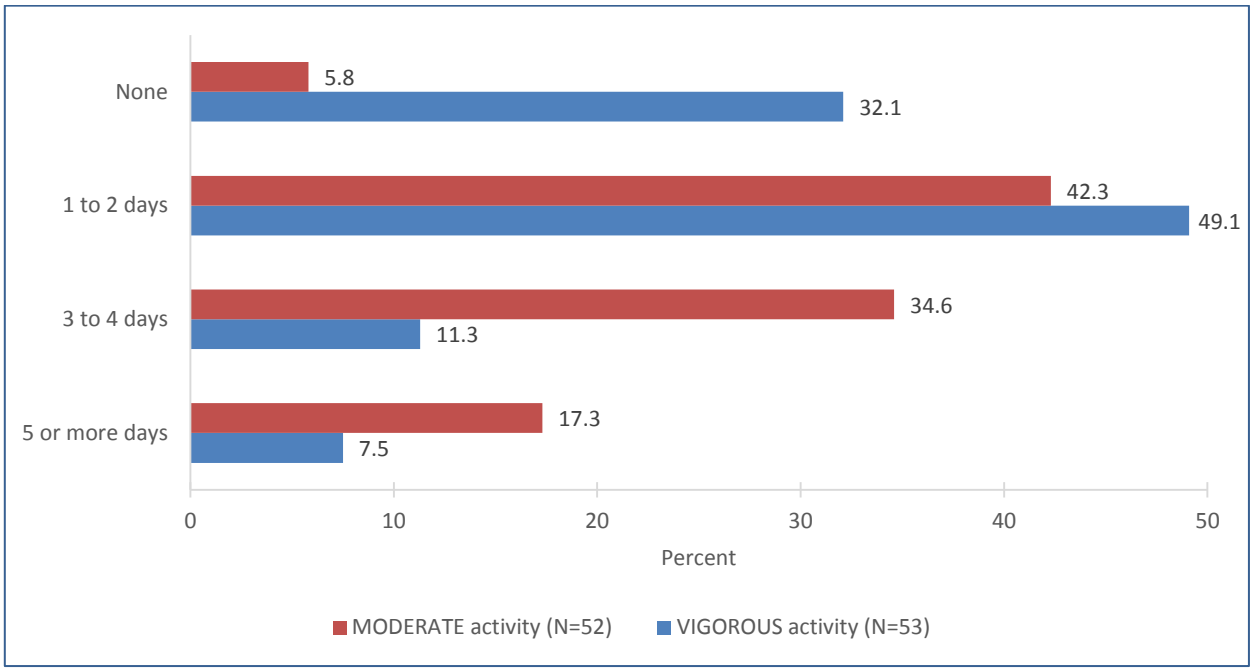
*For information about the BMI, visit the Center for Diseases Control and Prevention, *About BMI for Adults*, www.cdc.gov/healthyweight/assessing/bmi/

Figure 12. Number of servings of vegetables, fruit, and fruit juice that respondents had yesterday



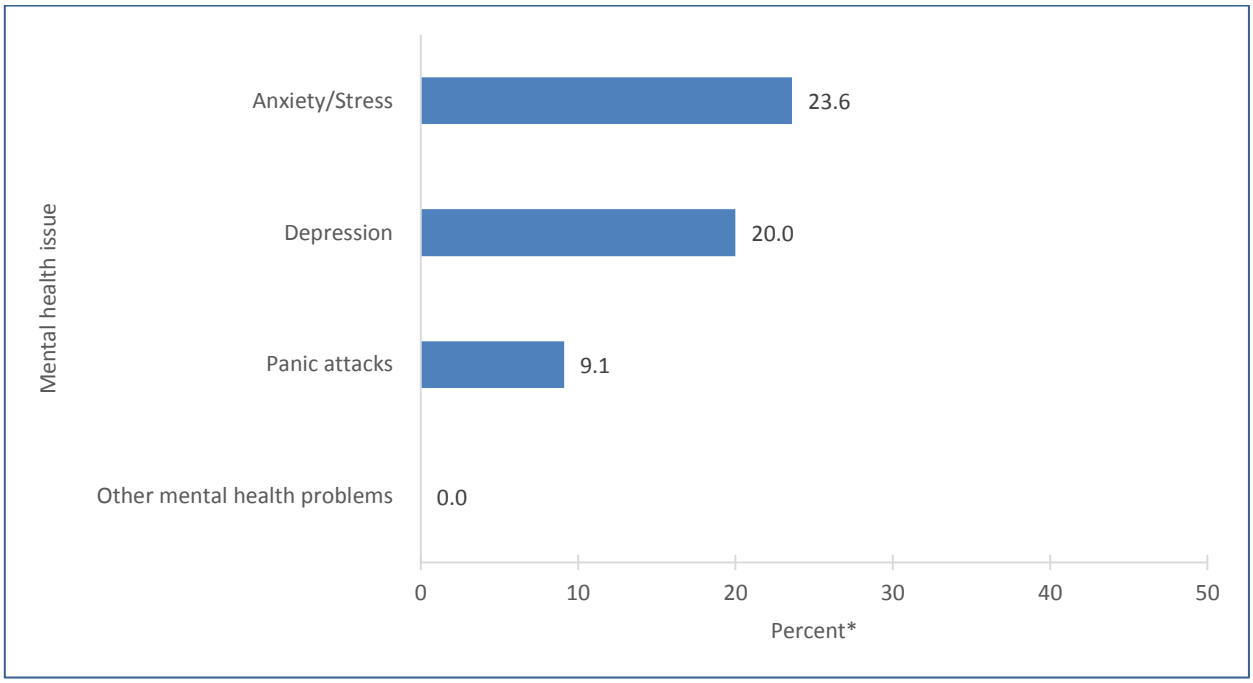
*Percentages may not total 100.0 due to rounding.

Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



Mental Health

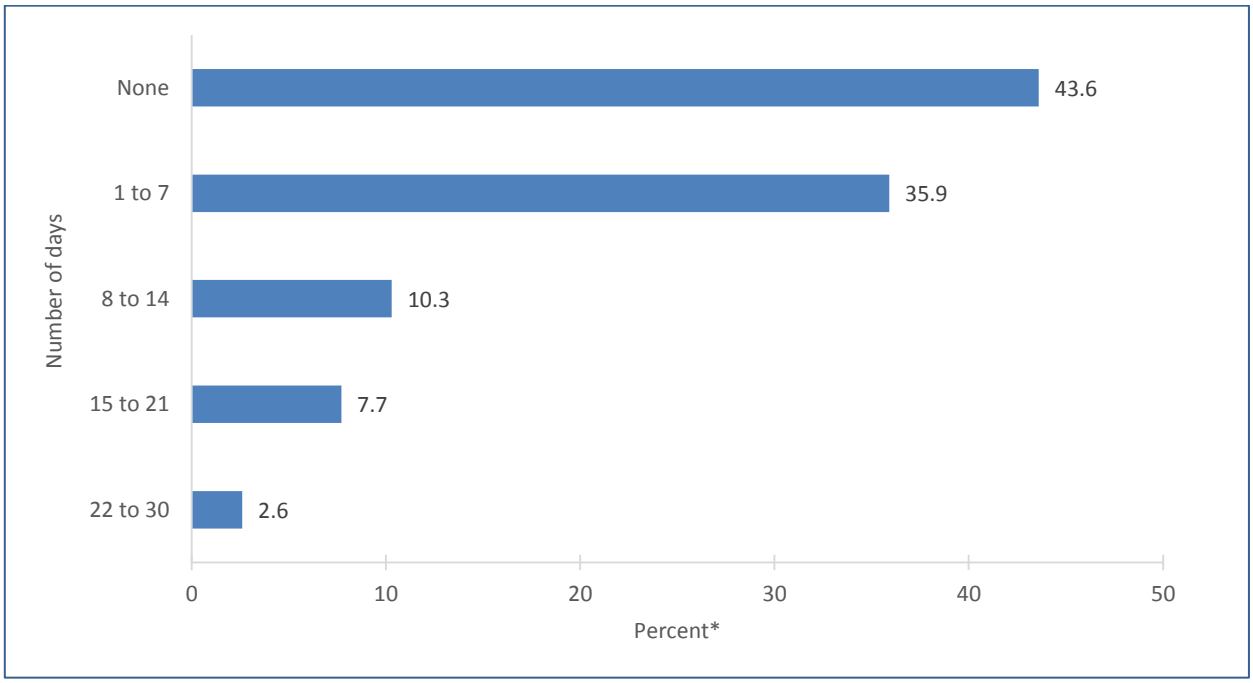
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=55

*Percentage do not total 100.0 due to multiple responses.

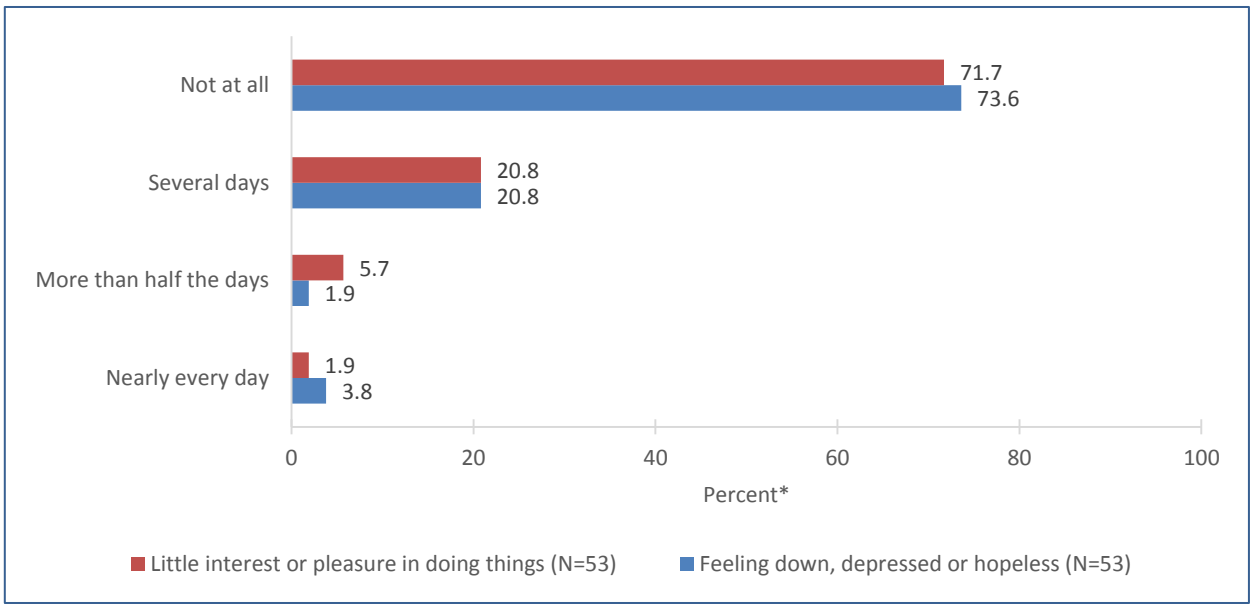
Figure 15. Number of days in the last month that respondents' mental health was not good



N=39

*Percentage do not total 100.0 due to rounding.

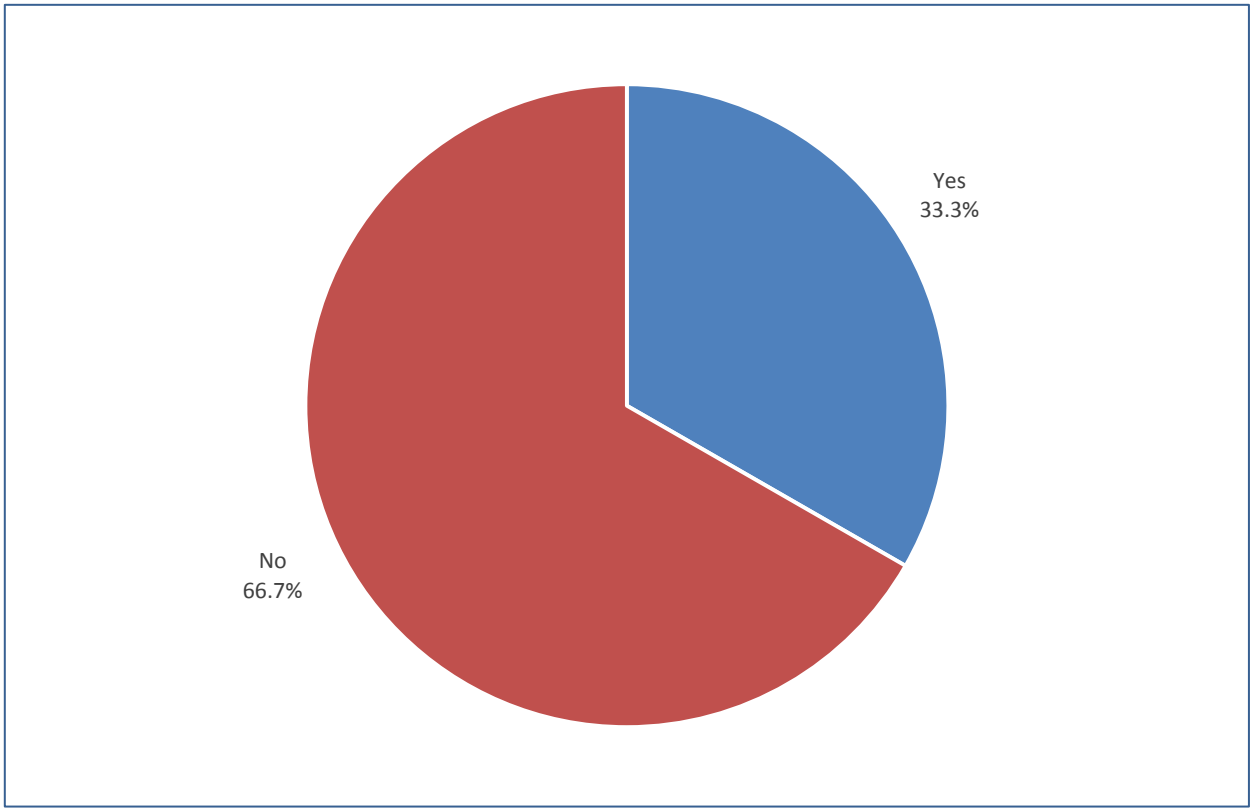
Figure 16. How often, over the past two weeks, respondents have been bothered by mental health issues



*Percentage do not total 100.0 due to rounding.

Tobacco Use

Figure 17. Whether respondents have smoked at least 100 cigarettes in their entire life



N=54

Figure 18. How often respondents currently smoke cigarettes and use chewing tobacco or snuff

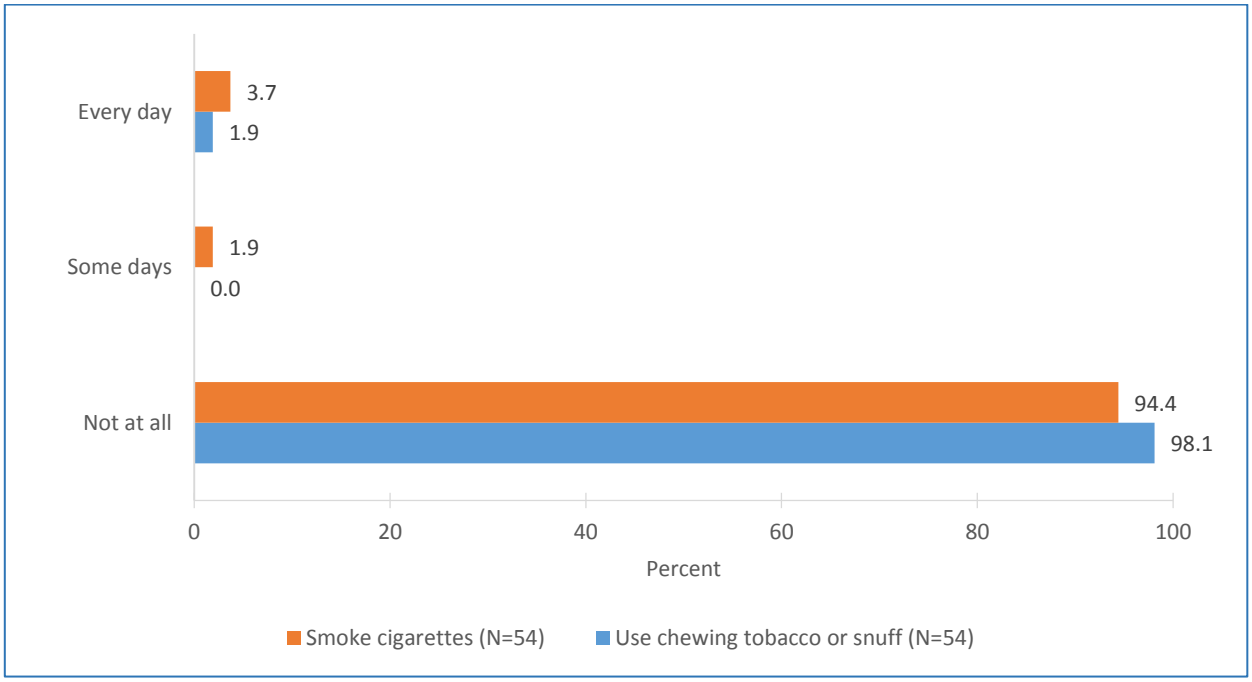
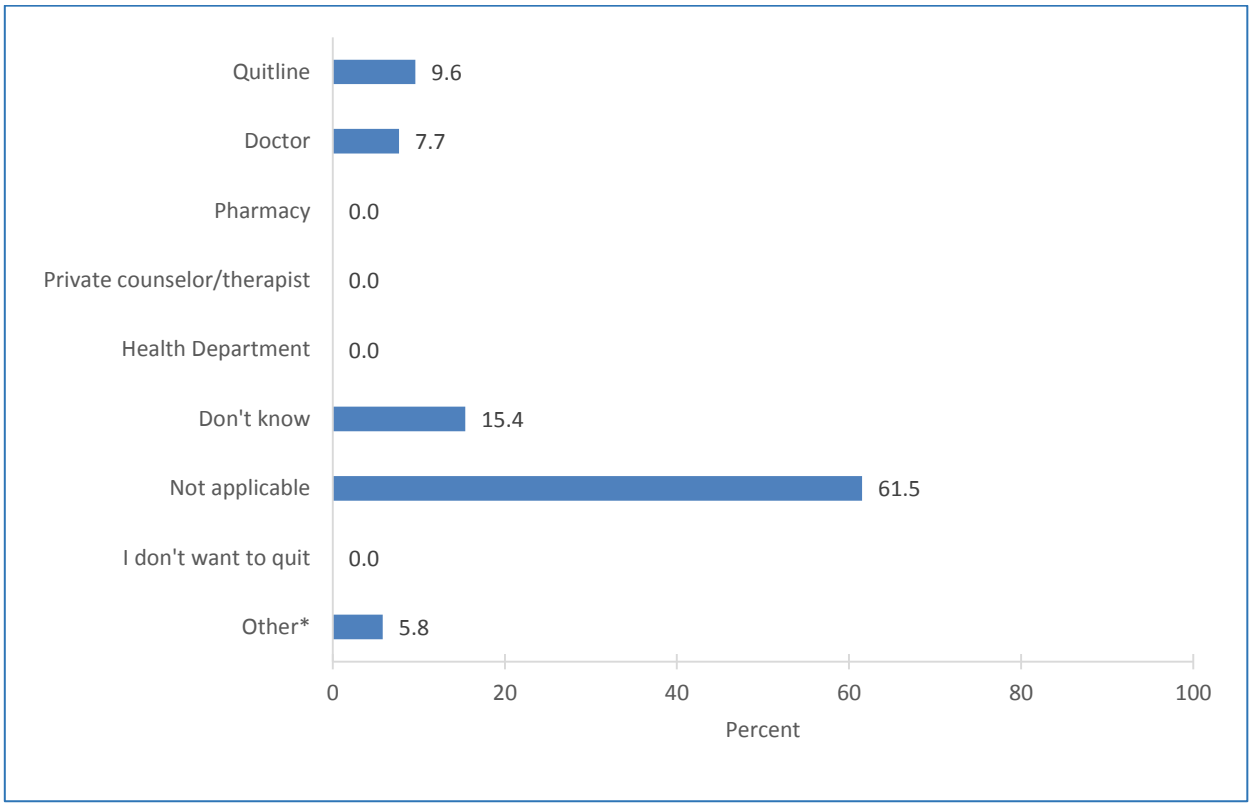


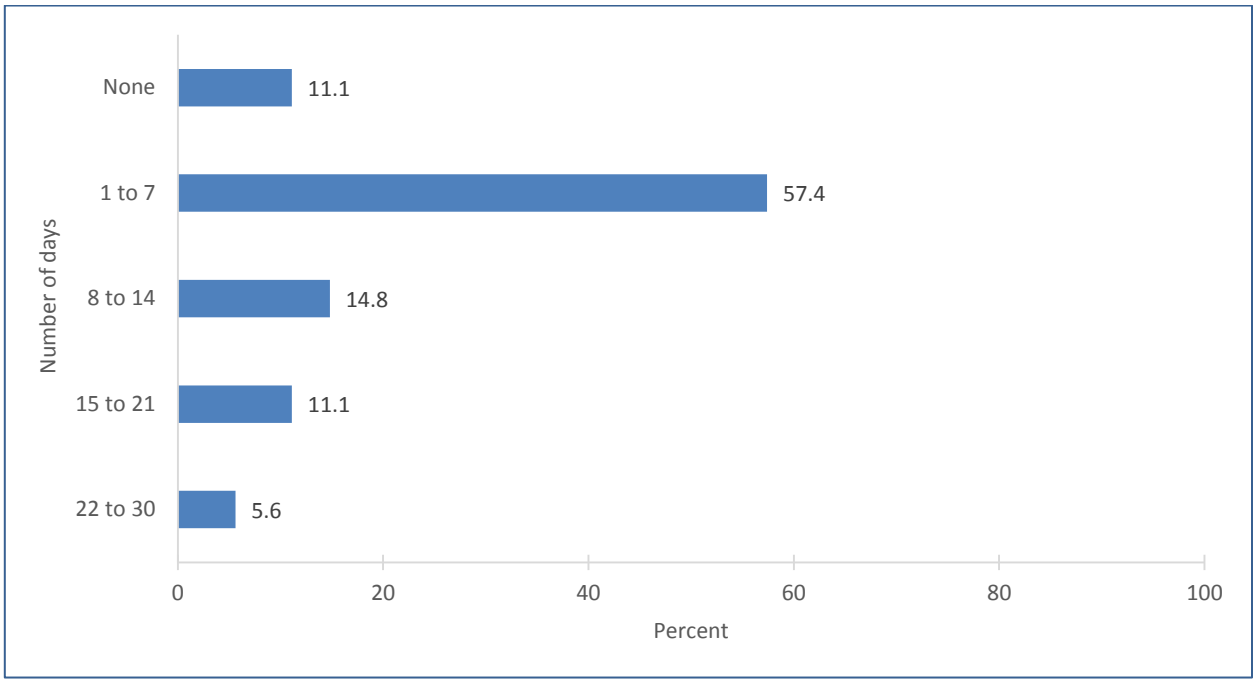
Figure 19. Location respondents would first go if they wanted help to quit using tobacco



N=52

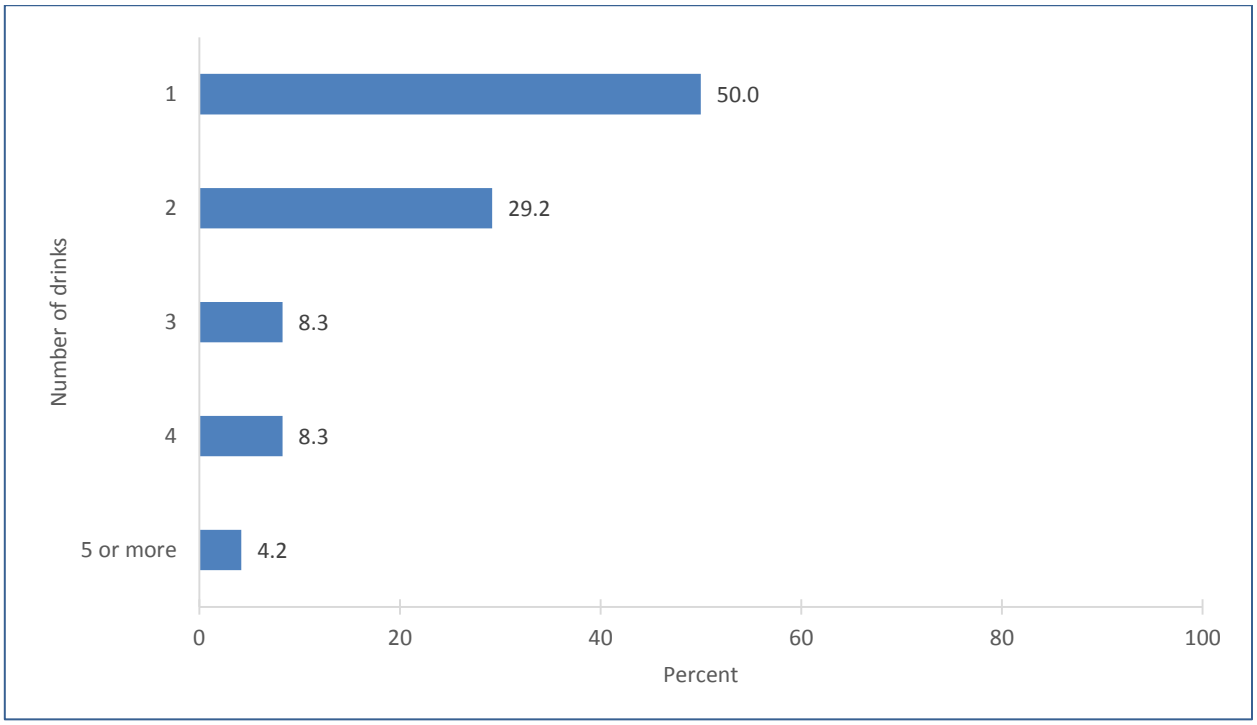
*Other responses are “Do not and have not smoked,” “Family and friends,” and “Just quit, that is what I did after smoking for 8+ years”.

Figure 20. Number of days during the past month that respondents had at least one drink of any alcoholic beverage



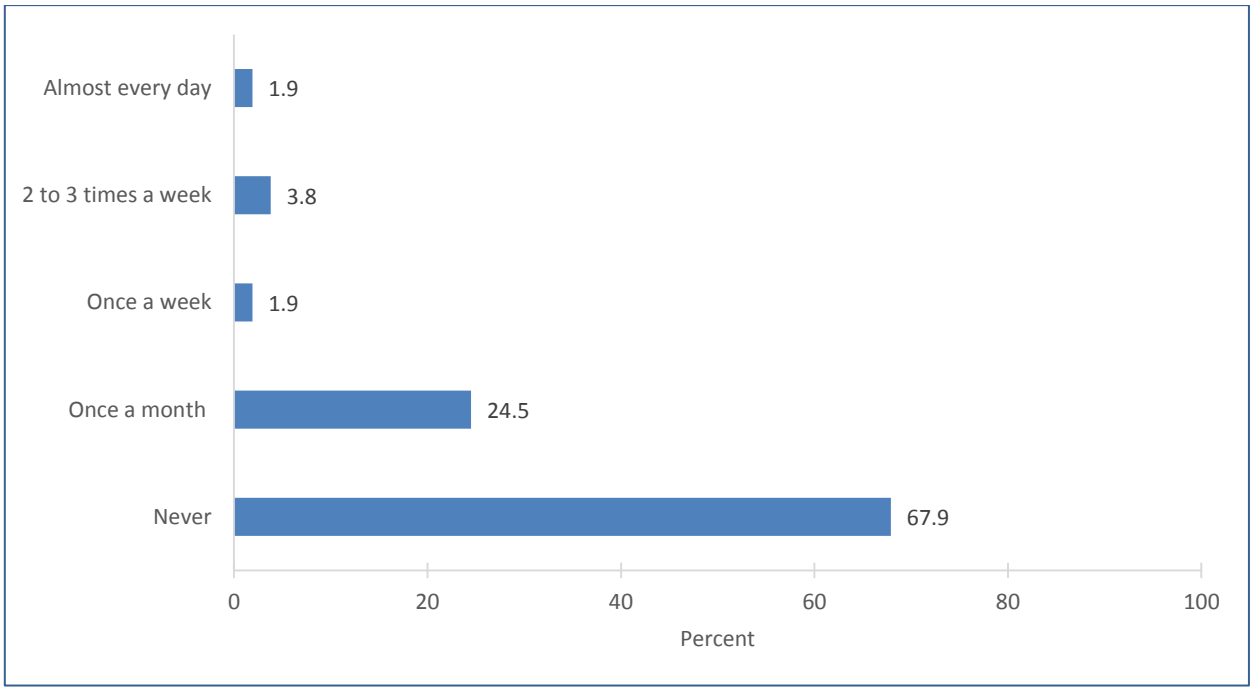
N=54

Figure 21. During the past month on days that respondents drank, average number of drinks per day respondents consumed



N=48

Figure 22. Number of times during the past month that respondents consumed at least 4 or 5 alcoholic drinks (4 for females, 5 for males) on the same occasion



N=53

Figure 23. Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse

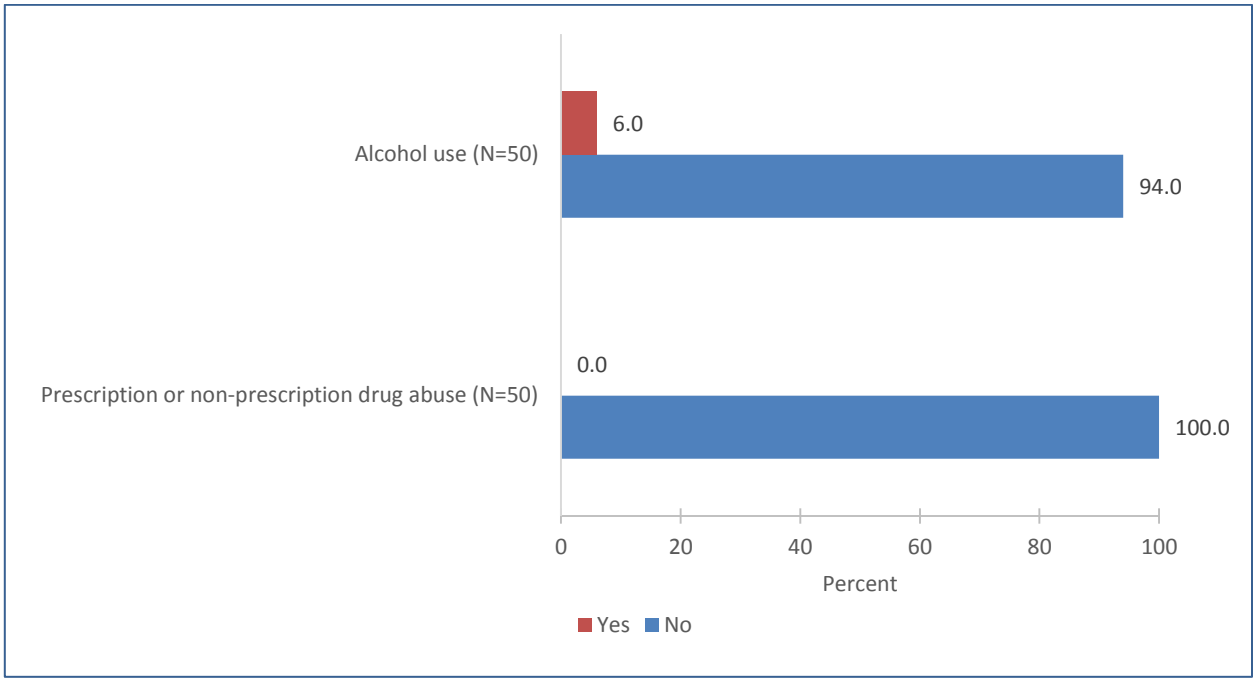


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

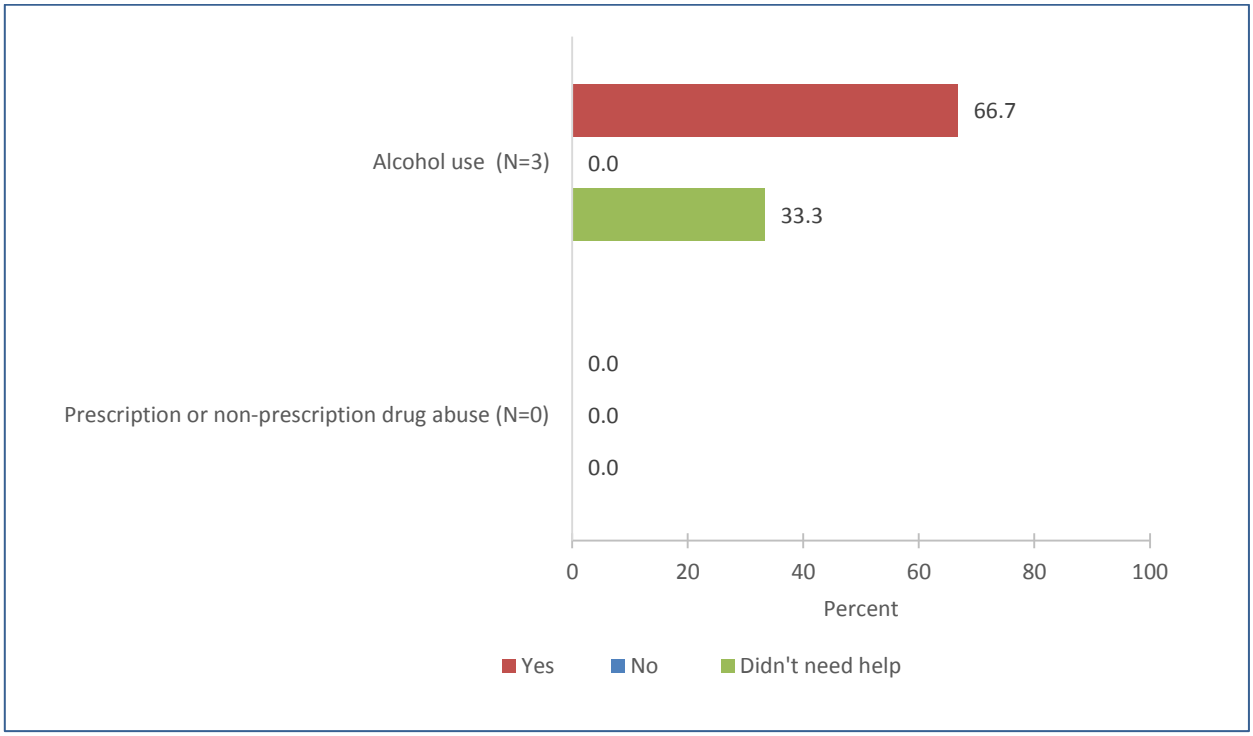
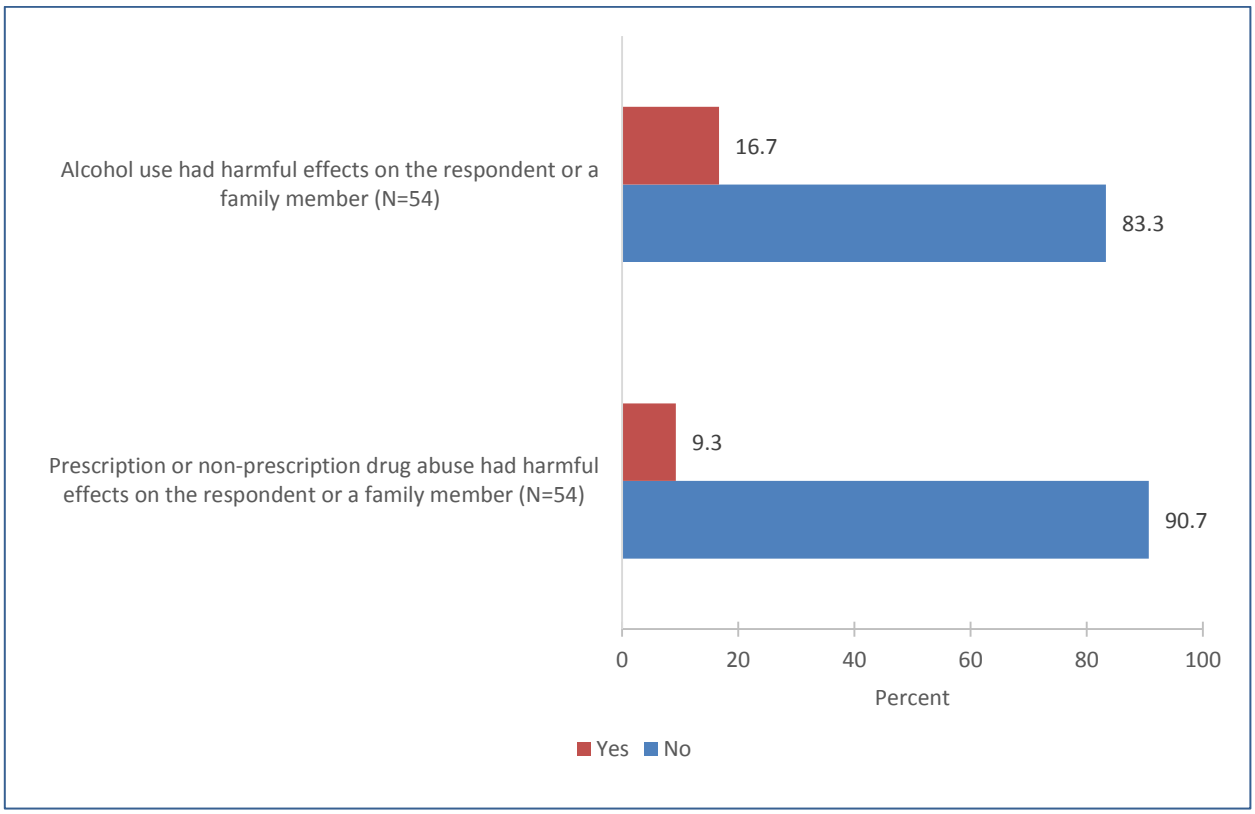


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=54)	92.6	7.4	100.0
Blood sugar screening (N=54)	74.1	25.9	100.0
Bone density test (N=53)	11.3	88.7	100.0
Cardiovascular screening (N=53)	24.5	75.5	100.0
Cholesterol screening (N=54)	83.3	16.7	100.0
Dental screening and X-rays (N=54)	87.0	13.0	100.0
Flu shot (N=54)	85.2	14.8	100.0
Glaucoma test (N=53)	34.0	66.0	100.0
Hearing screening (N=53)	9.4	90.6	100.0
Immunizations (N=53)	47.2	52.8	100.0
Pelvic exam (N=40 Females)	60.0	40.0	100.0
STD (N=53)	15.1	84.9	100.0
Vascular screening (N=53)	18.9	81.1	100.0
CANCER SCREENINGS			
Breast cancer screening (N=39 Females)	74.4	25.6	100.0
Cervical cancer screening (N=39 Females)	59.0	41.0	100.0
Colorectal cancer screening (N=53)	32.1	67.9	100.0
Prostate cancer screening (N=12 Males)	41.7	58.3	100.0
Skin cancer screening (N=53)	28.3	71.7	100.0

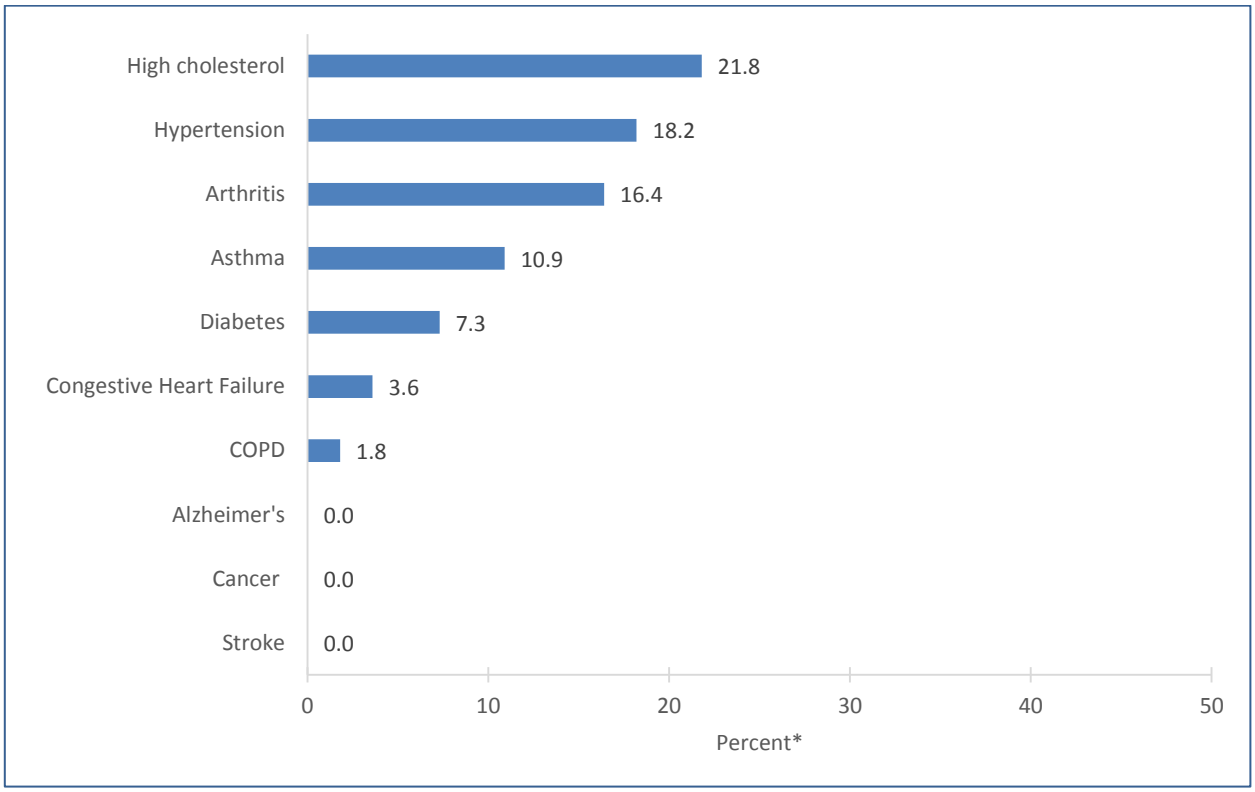
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=4)	25.0	0.0	0.0	0.0	0.0	0.0	75.0
Blood sugar screening (N=14)	50.0	14.3	0.0	0.0	7.1	0.0	14.3
Bone density test (N=47)	48.9	34.0	4.3	0.0	0.0	2.1	10.6
Cardiovascular screening (N=40)	40.0	37.5	2.5	0.0	0.0	0.0	17.5
Cholesterol screening (N=9)	33.3	33.3	0.0	0.0	0.0	0.0	33.3
Dental screening and X-rays (N=7)	14.3	57.1	28.6	0.0	0.0	0.0	0.0
Flu shot (N=8)	50.0	0.0	0.0	0.0	0.0	0.0	37.5
Glaucoma test (N=35)	54.3	31.4	2.9	0.0	0.0	2.9	5.7
Hearing screening (N=48)	58.3	27.1	4.2	0.0	0.0	2.1	4.2

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Immunizations (N=28)	64.3	21.4	0.0	0.0	0.0	0.0	7.1
Pelvic exam (N=16 Females)	50.0	6.3	0.0	6.3	0.0	0.0	37.5
STD (N=45)	75.6	8.9	2.2	0.0	0.0	0.0	6.7
Vascular screening (N=43)	53.5	27.9	4.7	0.0	0.0	0.0	11.6
CANCER SCREENINGS							
Breast cancer screening (N=10 Females)	40.0	20.0	10.0	0.0	0.0	0.0	30.0
Cervical cancer screening (N=16 Females)	43.8	25.0	0.0	0.0	0.0	0.0	31.3
Colorectal cancer screening (N=36)	55.6	22.2	0.0	0.0	0.0	0.0	22.2
Prostate cancer screening (N=7 Males)	28.6	57.1	0.0	0.0	0.0	0.0	14.3
Skin cancer screening (N=38)	34.2	44.7	2.6	0.0	0.0	0.0	21.1

*Percentages may not total 100.0 due to multiple responses.

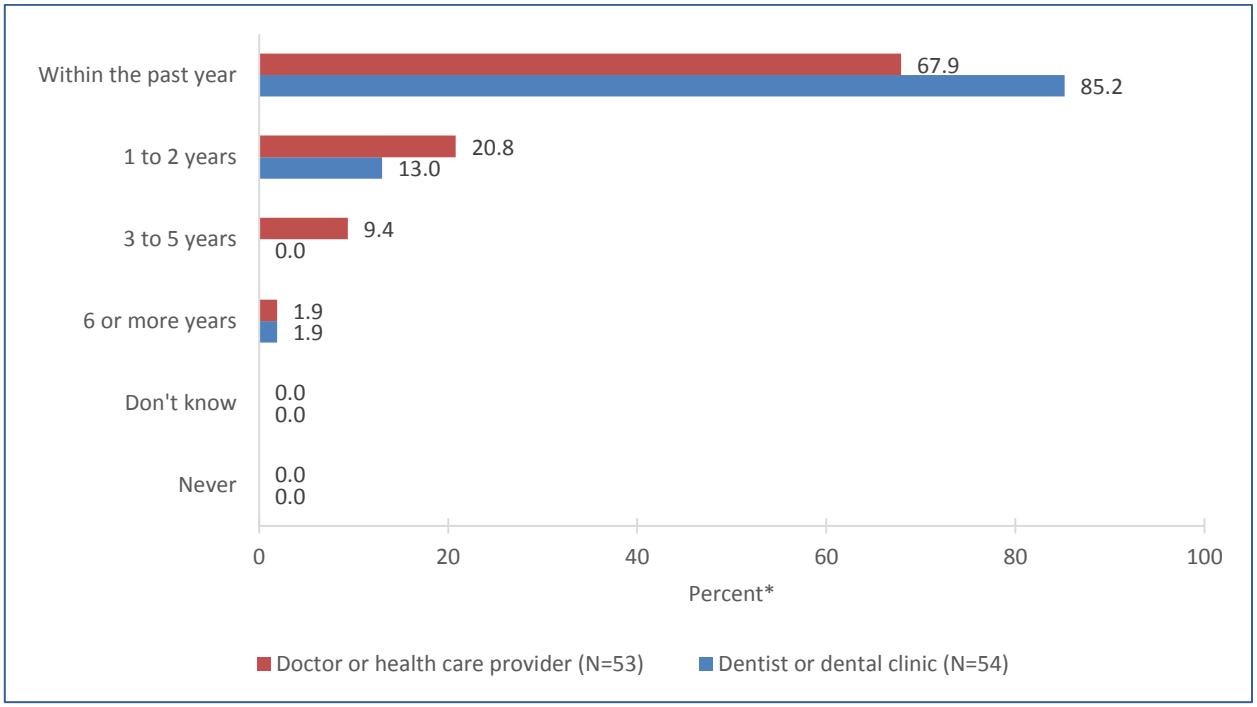
Figure 26. Whether respondents have any of the following chronic diseases



N=55

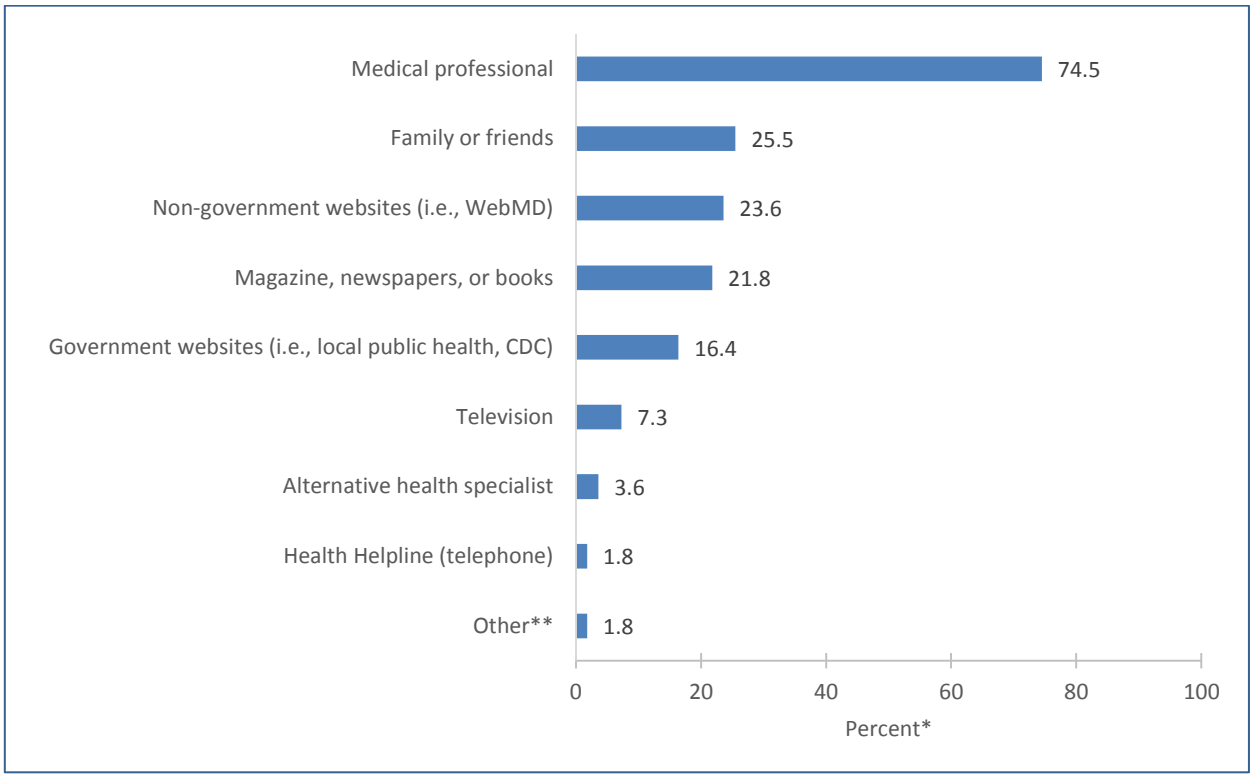
*Percentages do not total 100.0 due to multiple responses.

Figure 27. Length of time since respondents last visited a doctor or health care provider for a routine physical exam and length of time since they last visited a dentist or dental clinic for any reason



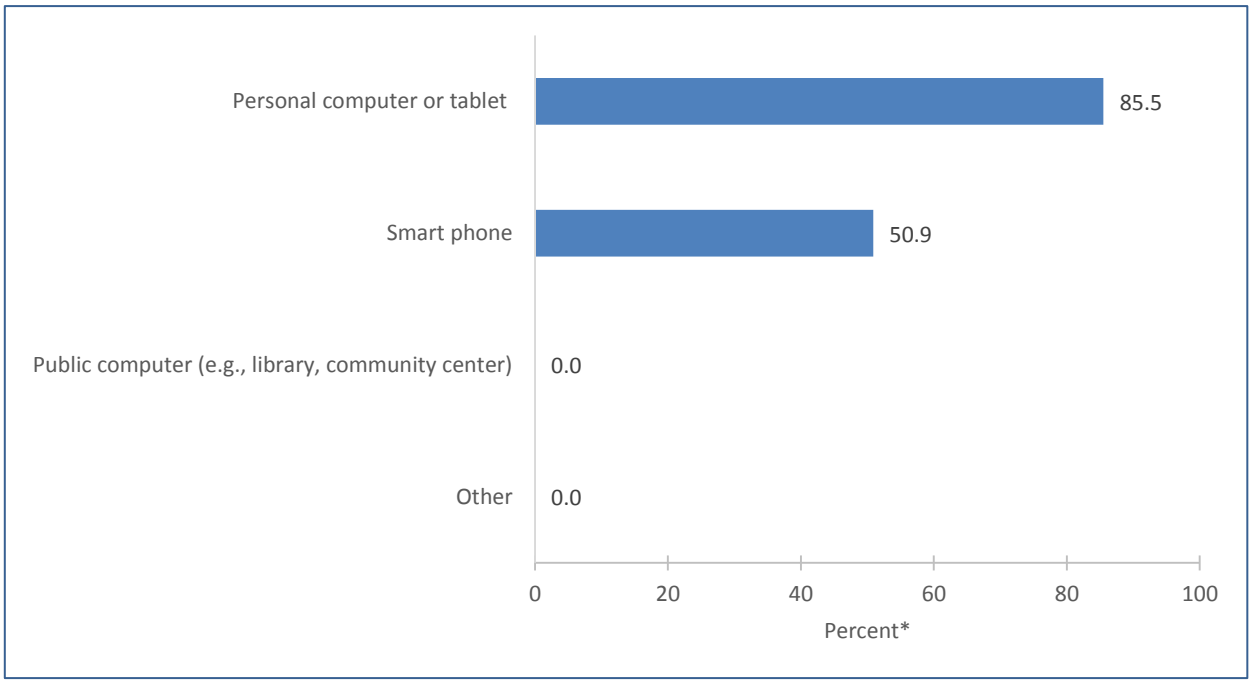
*Percentages may not total 100.0 due to rounding.

Figure 28. Where respondents get most of their health information



N=55
*Percentages do not total 100.0 due to multiple responses.
**Other response is "Family doctor."

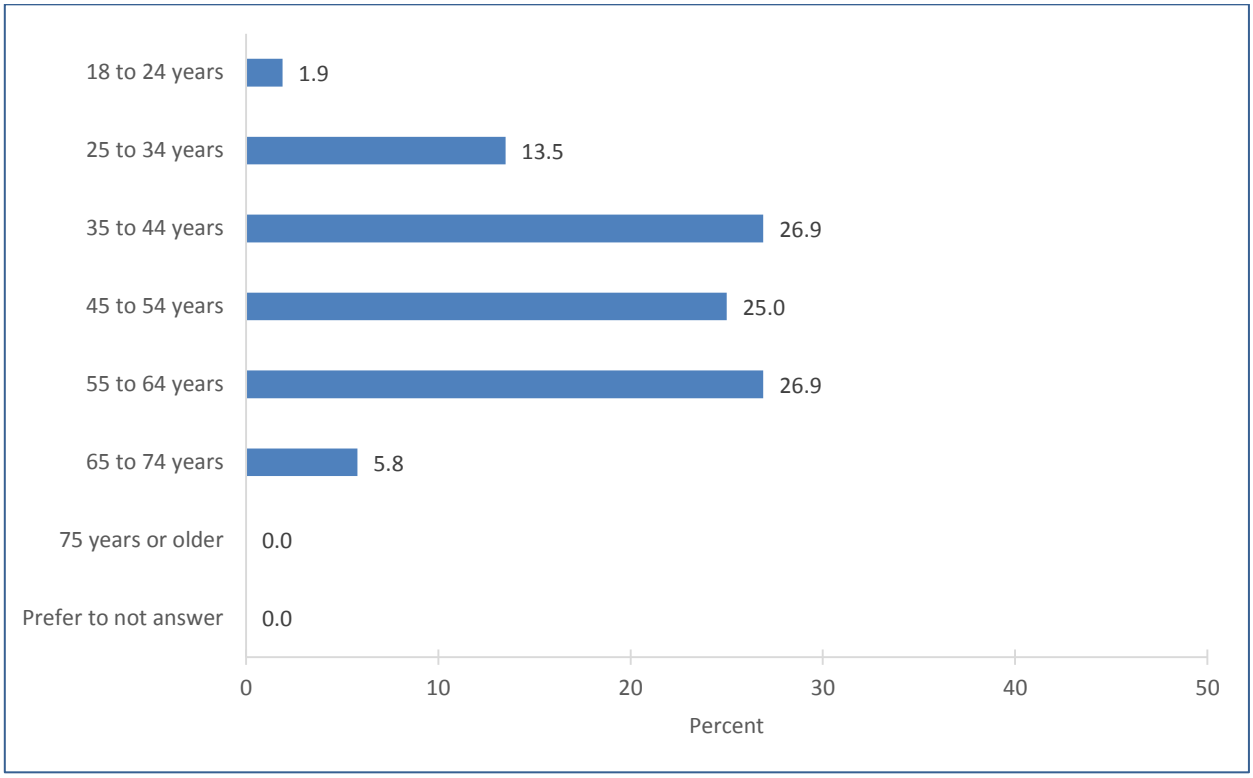
Figure 29. Best way for respondents to access technology for health information



N=55 *Percentages do not total 100.0 due to multiple responses.

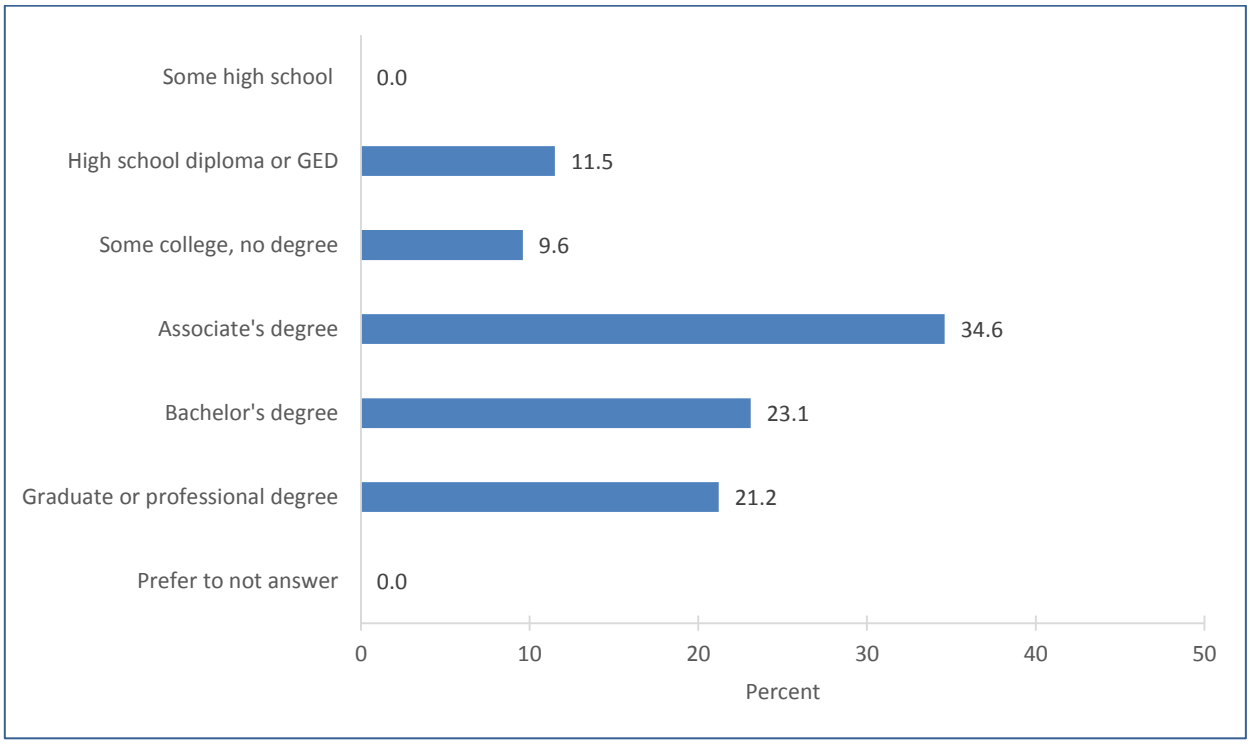
Demographic Information

Figure 30. Age of respondents



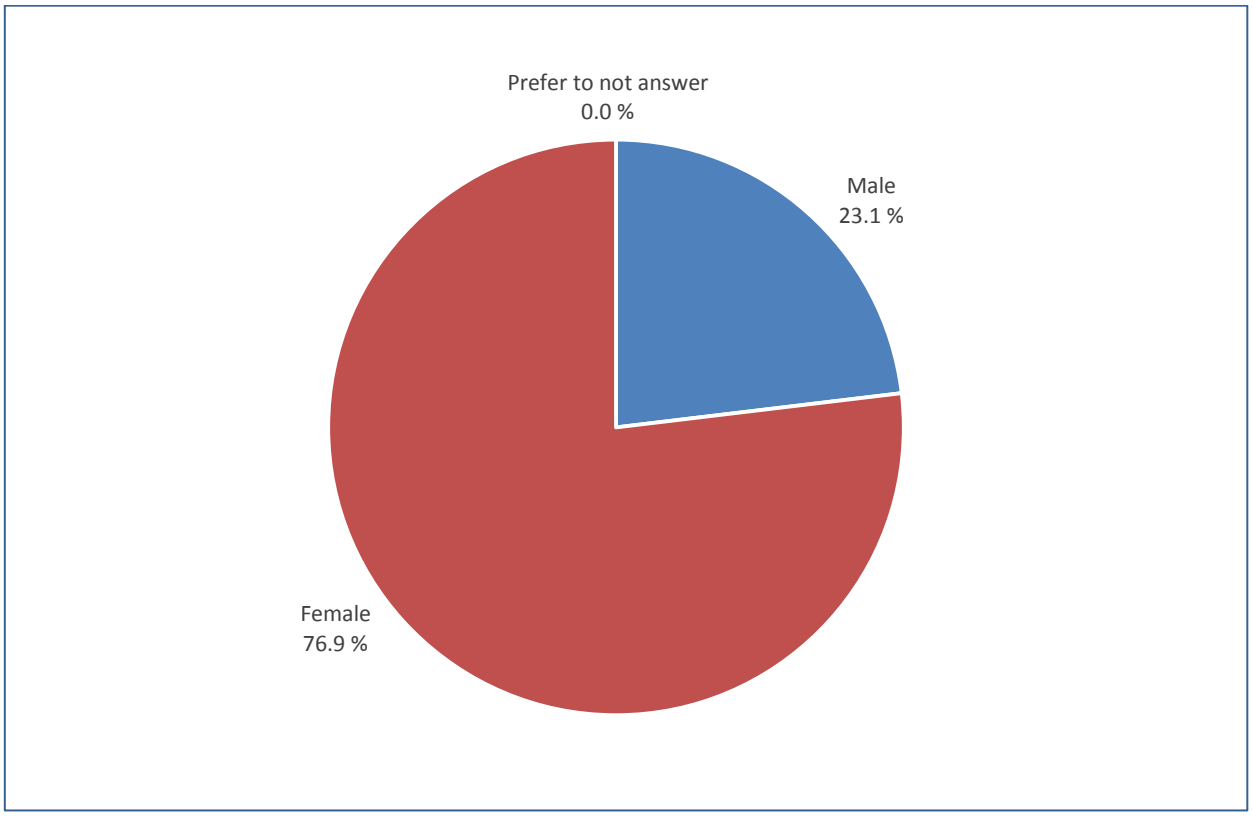
N=52

Figure 31. Highest level of education of respondents



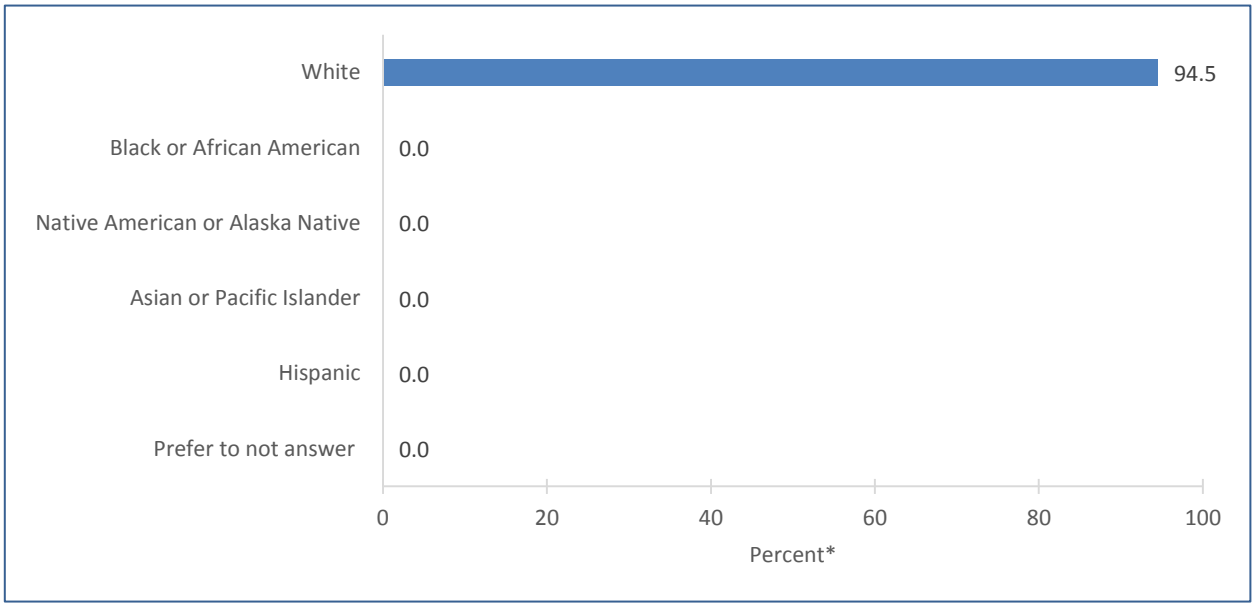
N=52

Figure 32. Gender of respondents



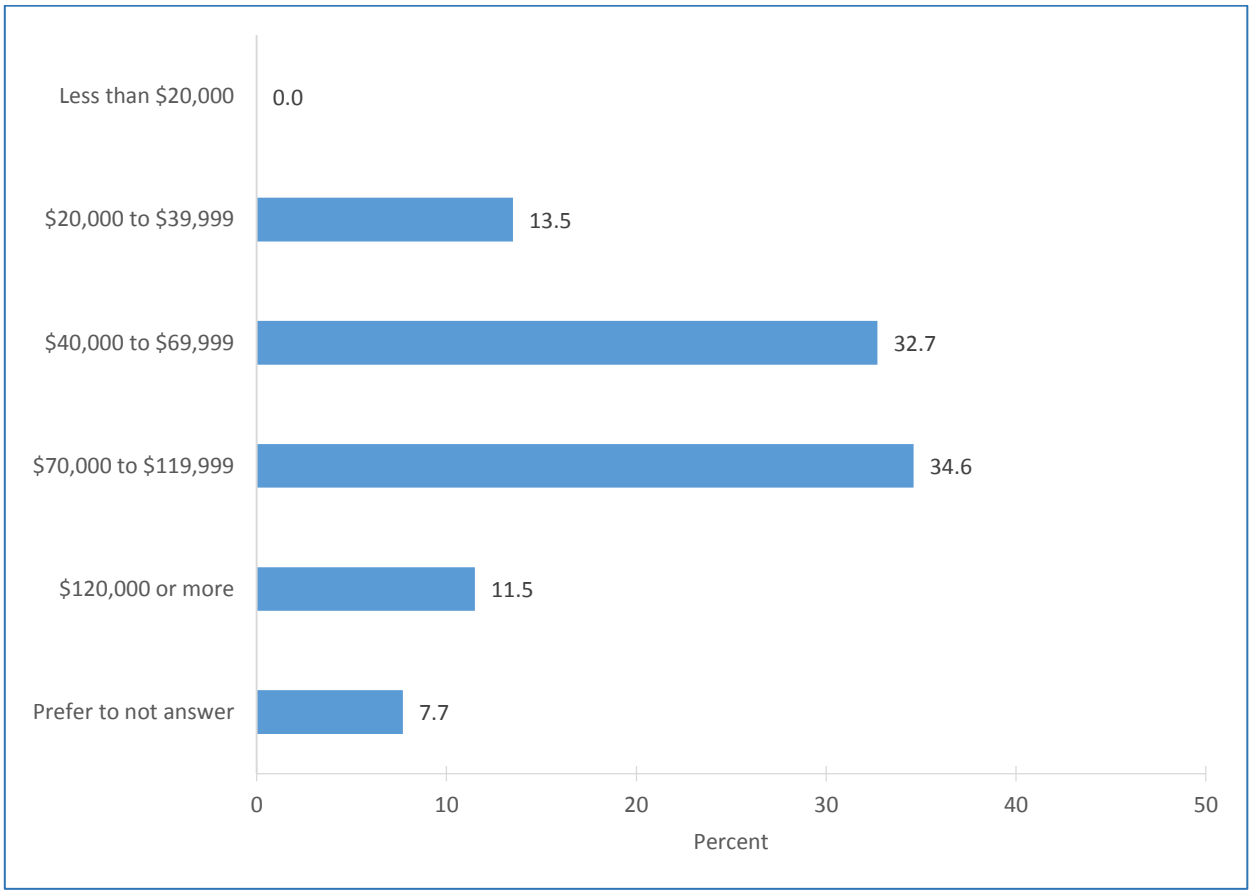
N=52

Figure 33. Race and ethnicity of respondents



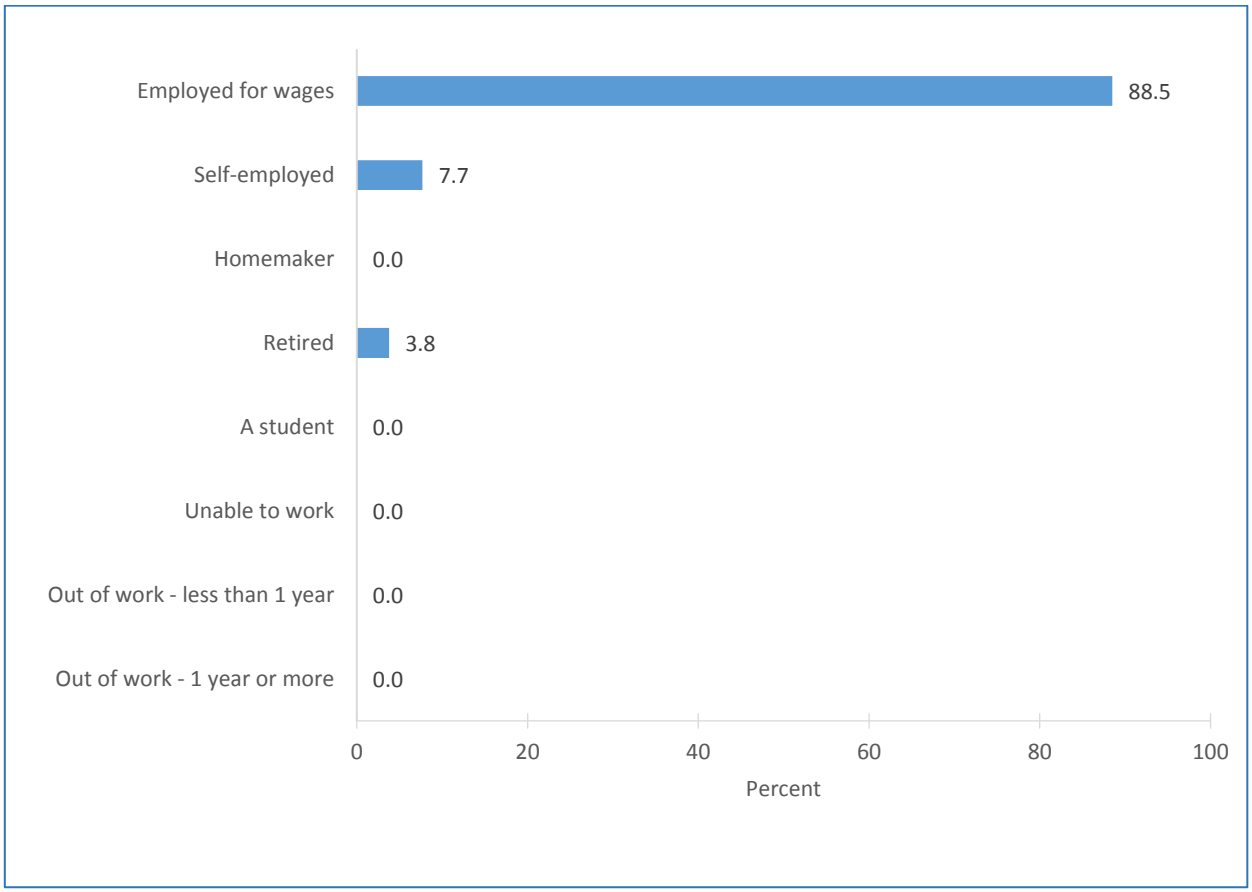
N=55 *Percentages do not total 100.0 due to multiple responses.

Figure 34. Annual household income of respondents



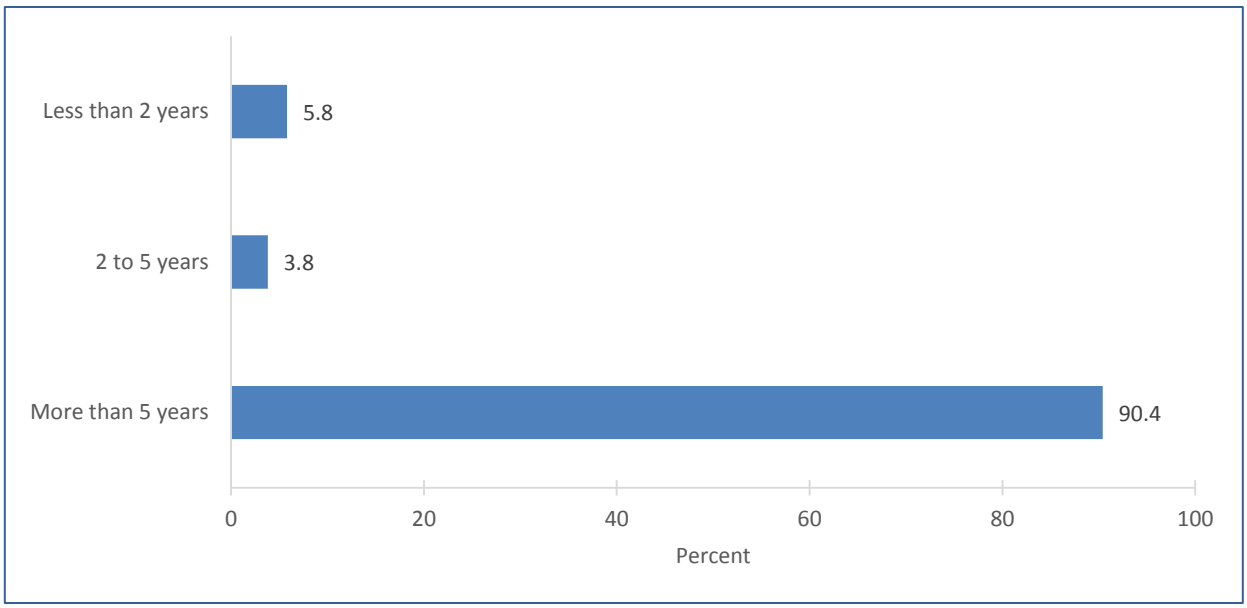
N=52

Figure 35. Employment status of respondents



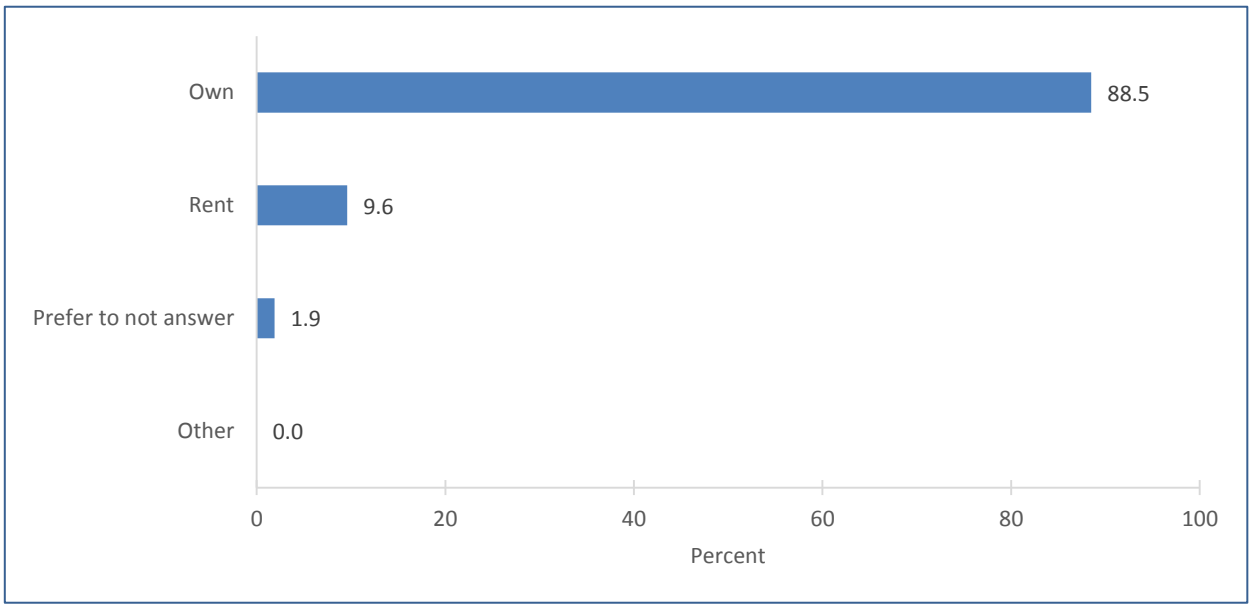
N=52

Figure 36. Length of time respondents have lived in their community



N=52

Figure 37. Whether respondents own or rent their home



N=52

Figure 38. Whether respondents have health insurance (private, public, or governmental) and oral health or dental care insurance coverage

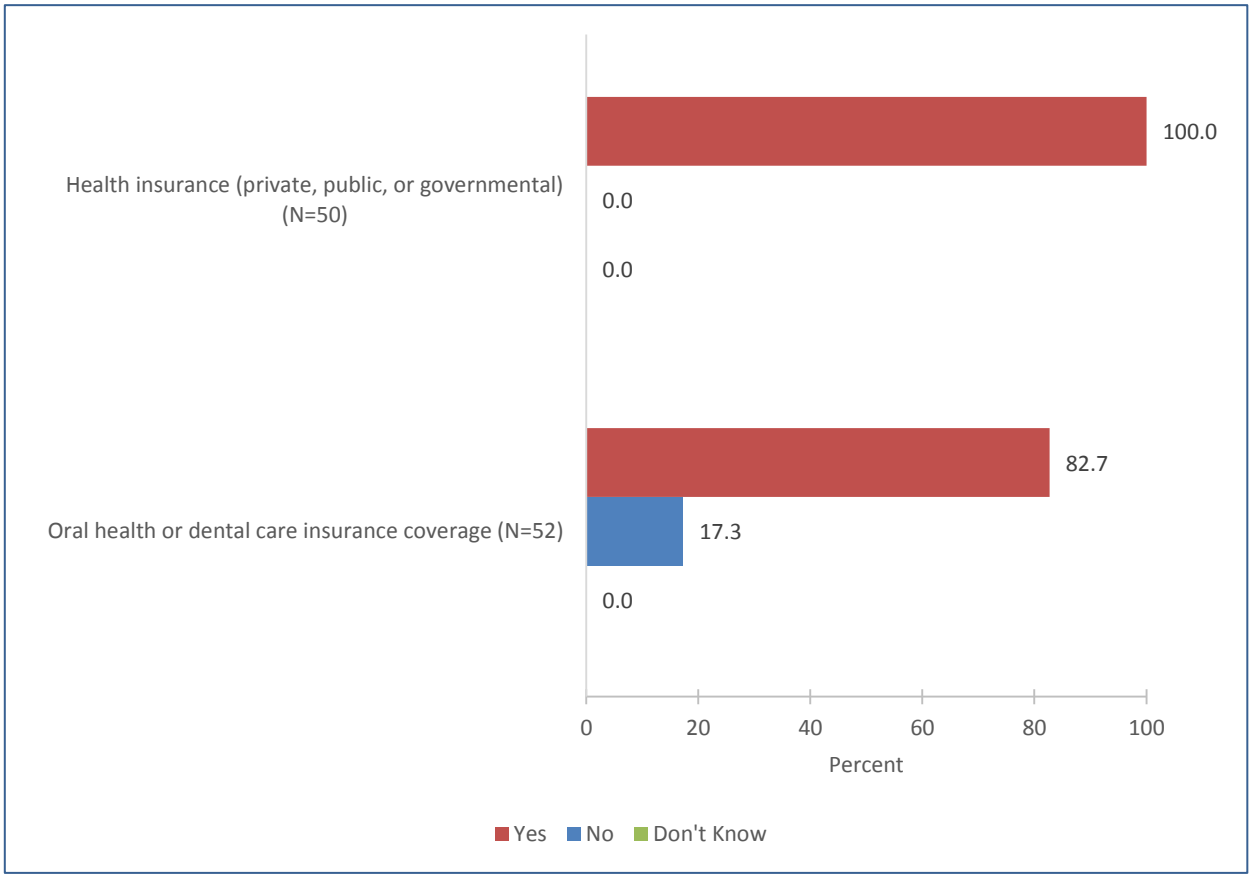
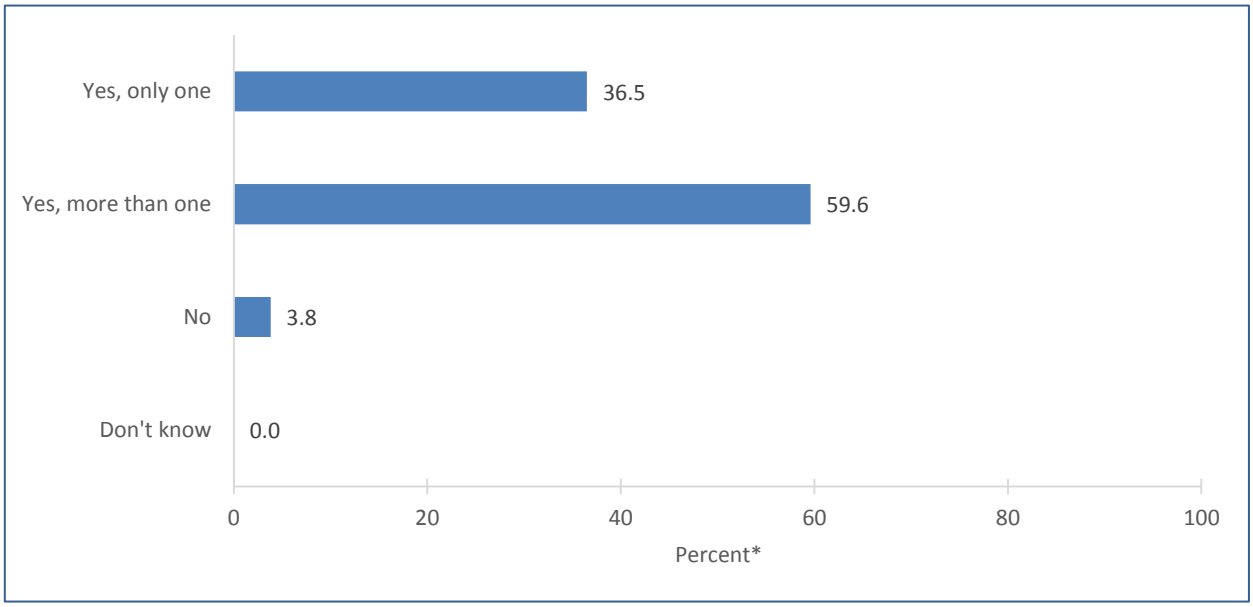


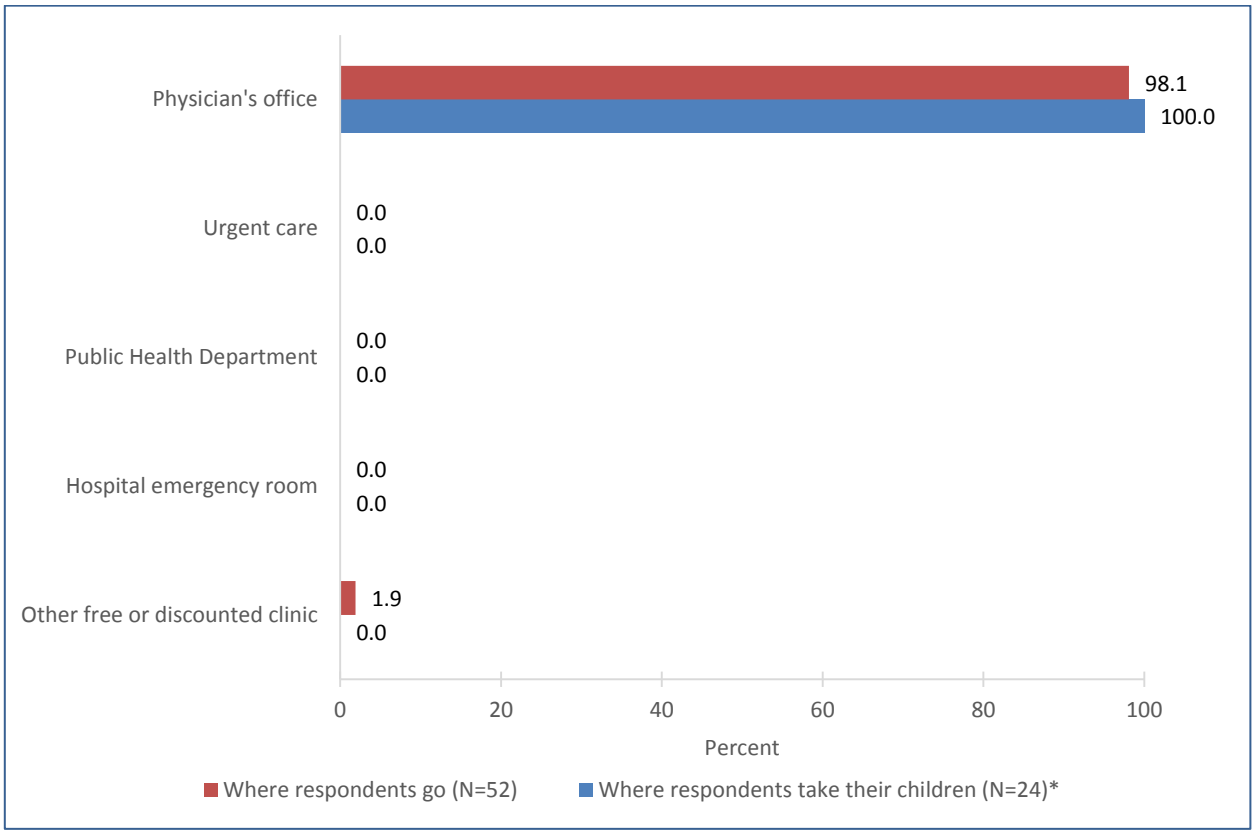
Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=52

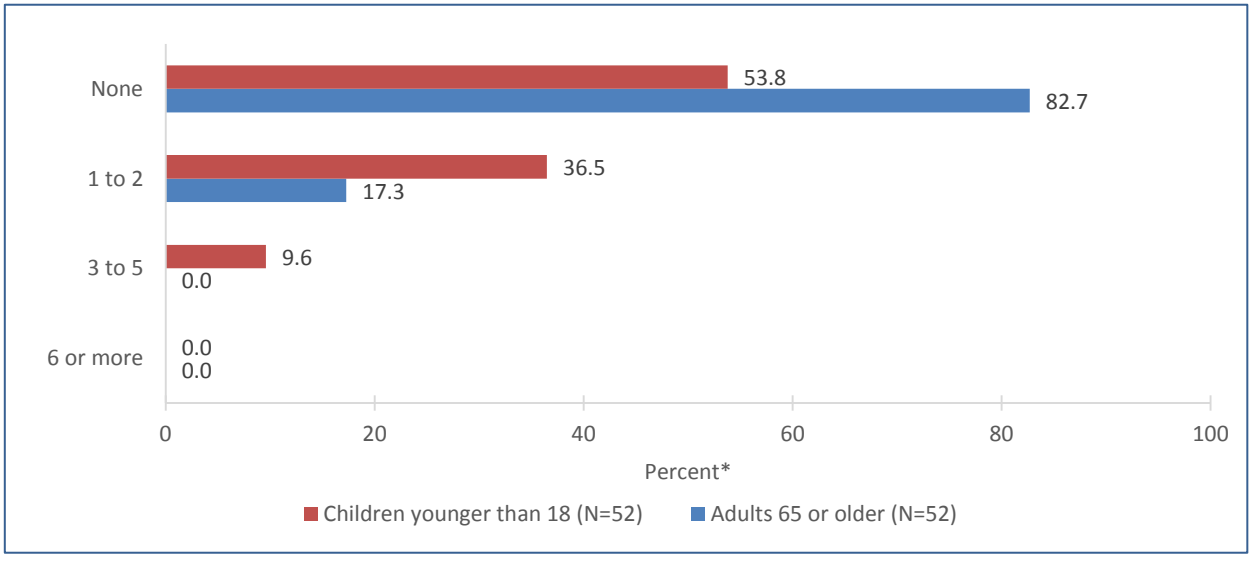
* Percentages do not total 100.0 due to rounding.

Figure 40. Facilities that respondents go to most often when sick and take their children when they are sick



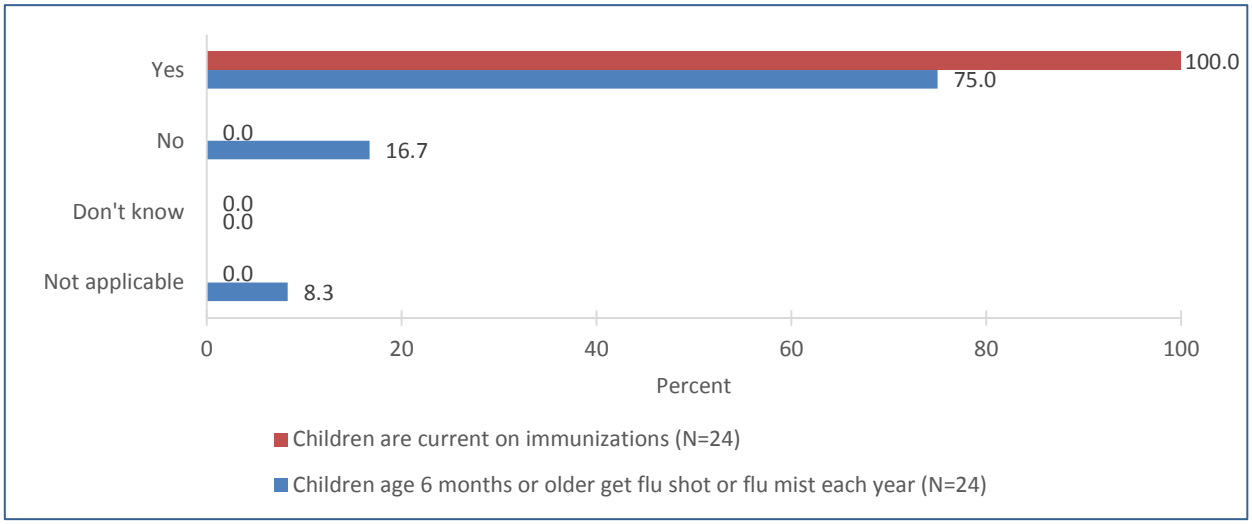
*Of respondents who have children younger than age 18 living in their household.

Figure 41. Number of children younger than 18 and number of adults age 65 or older living in respondents' household



* Percentages may not total 100.0 due to rounding.

Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



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

Table 3. Zip code of respondents

Zip code	Number of respondents
57523	39
57533	7
57538	2
57317	1
57529	1

N=50

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 2015 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County Health Rankings* web site for your state.

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

Contents:

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

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

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

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

Measure	Data Elements	Description
	# Driving Deaths	Number of motor vehicle deaths
	% Alcohol-Impaired	Percentage of driving deaths with alcohol involvement
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Sexually transmitted infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases / Population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Teen births	Teen Births	Teen birth count, ages 15-19
	Teen Population	Female population, ages 15-19
	Teen Birth Rate	Teen births / females ages 15-19 * 1,000
	95% CI - Low	95% confidence interval reported by National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance
	95% CI - Low	95% confidence interval reported by SAHIE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Primary care physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	PCP Rate	(Number of PCP/population)*100,000
	PCP Ratio	Population to Primary Care Physicians ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Dentists	# Dentists	Number of dentists
	Dentist Rate	(Number of dentists/population)*100,000
	Dentist Ratio	Population to Dentists ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mental health providers	# Mental Health Providers	Number of mental health providers (MHP)
	MHP Rate	(Number of MHP/population)*100,000
	MHP Ratio	Population to Mental Health Providers ratio
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Preventable hospital stays	# Medicare Enrollees	Number of Medicare enrollees
	Preventable Hosp. Rate	Discharges for Ambulatory Care Sensitive Conditions/Medicare Enrollees * 1,000
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Diabetic monitoring	# Diabetics	Number of diabetic Medicare enrollees
	% Receiving HbA1c	Percentage of diabetic Medicare enrollees receiving HbA1c test
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Mammography screening	# Medicare Enrollees	Number of female Medicare enrollees age 67-69
	% Mammography	Percentage of female Medicare enrollees having at least 1 mammogram in 2 yrs (age 67-69)

Measure	Data Elements	Description
	95% CI - Low	95% confidence interval reported by Dartmouth Institute
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
High school graduation	Cohort Size	Number of students expected to graduate
	Graduation Rate	Graduation rate
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Some college	# Some College	Adults age 25-44 with some post-secondary education
	Population	Adults age 25-44
	% Some College	Percentage of adults age 25-44 with some post-secondary education
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in poverty	# Children in Poverty	Number of children (under age 18) living in poverty
	% Children in Poverty	Percentage of children (under age 18) living in poverty
	95% CI - Low	95% confidence interval reported by SAIPE
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Income inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Children in single-parent households	# Single-Parent Households	Number of children that live in single-parent households
	# Households	Number of children in households
	% Single-Parent Households	Percentage of children that live in single-parent households
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Social associations	# Associations	Number of associations
	Association Rate	Associations / Population * 10,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Violent crime	# Violent Crimes	Number of violent crimes
	Violent Crime Rate	Violent crimes/population * 100,000
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Injury deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
	95% CI - Low	

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

Gregory County

County Demographics

	Gregory County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Health Outcomes				45	
Length of Life				52	
Premature death	11,000	8,400-14,200	5,200	6,800	
Quality of Life				26	
Poor or fair health	13%	12-13%	12%	13%	
Poor physical health days	3.2	3.0-3.3	2.9	3.1	
Poor mental health days	2.8	2.6-2.9	2.8	2.7	
Low birth weight	5%		6%	6%	
Health Factors				47	
Health Behaviors				30	
Adult smoking	17%	16-18%	14%	19%	
Adult obesity	33%	26-40%	25%	30%	
Food environment index	6.6		8.3	7.3	

	Gregory County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Physical inactivity	30%	22-38%	20%	24%	
Access to exercise opportunities	21%		91%	67%	
Excessive drinking	15%	15-16%	12%	18%	
Alcohol-impaired driving deaths	25%	7-46%	14%	35%	
Sexually transmitted infections	93.8		134.1	471.2	
Teen births	22		19	36	
Clinical Care				54	
Uninsured	17%	15-19%	11%	13%	
Primary care physicians	1,410:1		1,040:1	1,310:1	
Dentists	2,110:1		1,340:1	1,770:1	
Mental health providers			370:1	630:1	
Preventable hospital stays	133	111-155	38	52	
Diabetic monitoring	94%	72-100%	90%	83%	
Mammography screening	49%	31-67%	71%	66%	

	Gregory County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Social & Economic Factors				39	
High school graduation			93%	83%	
Some college	66%	55-76%	72%	67%	
Unemployment	3.4%		3.5%	3.4%	
Children in poverty	27%	19-35%	13%	18%	
Income inequality	4.6	3.8-5.3	3.7	4.2	
Children in single-parent households	31%	21-41%	21%	32%	
Social associations	30.6		22.1	17.0	
Violent crime			59	282	
Injury deaths	104	65-157	51	70	
Physical Environment				31	
Air pollution - particulate matter	11.5		9.5	10.8	
Drinking water violations	Yes		No		
Severe housing problems	12%	9-14%	9%	12%	
Driving alone to work	67%	64-71%	71%	79%	
Long commute - driving alone	11%	8-14%	15%	14%	

Tripp County

County Demographics

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Health Outcomes					50
Length of Life					48
Premature death	8,900	6,800-11,400	5,200	6,800	
Quality of Life					50
Poor or fair health	14%	13-14%	12%	13%	
Poor physical health days	3.3	3.1-3.4	2.9	3.1	
Poor mental health days	2.9	2.8-3.0	2.8	2.7	
Low birth weight	8%	5-10%	6%	6%	
Health Factors					43
Health Behaviors					31
Adult smoking	18%	18-19%	14%	19%	
Adult obesity	30%	24-37%	25%	30%	
Food environment index	7.0		8.3	7.3	
Physical inactivity	26%	19-34%	20%	24%	

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Access to exercise opportunities	40%		91%	67%	
Excessive drinking	17%	16-17%	12%	18%	
Alcohol-impaired driving deaths	33%	11-55%	14%	35%	
Sexually transmitted infections	309.9		134.1	471.2	
Teen births	43	33-55	19	36	
Motor vehicle crash deaths			9	16	
Clinical Care					46
Uninsured	18%	16-21%	11%	13%	
Primary care physicians	1,100:1		1,040:1	1,310:1	
Dentists	1,840:1		1,340:1	1,770:1	
Mental health providers	310:1		370:1	630:1	
Preventable hospital stays	82	66-97	38	52	
Diabetic monitoring	85%	66-100%	90%	83%	
Mammography screening	58%	43-74%	71%	66%	
Social & Economic Factors					45
High school graduation			93%	83%	

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Some college	62%	51-72%	72%	67%	
Unemployment	3.2%		3.5%	3.4%	
Children in poverty	28%	20-36%	13%	18%	
Income inequality	4.8	3.7-5.9	3.7	4.2	
Children in single-parent households	37%	26-48%	21%	32%	
Social associations	27.3		22.1	17.0	
Violent crime	100		59	282	
Injury deaths	86	55-128	51	70	
Physical Environment					13
Air pollution - particulate matter	11.4		9.5	10.8	
Drinking water violations	No		No		
Severe housing problems	15%	9-20%	9%	12%	
Driving alone to work	66%	63-69%	71%	79%	
Long commute - driving alone	16%	10-21%	15%	14%	

Charles Mix County

County Demographics

	Charles Mix County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Health Outcomes					37
Length of Life					25
Premature death	6,600	5,400-8,100	5,200	6,800	
Quality of Life					42
Poor or fair health	16%	16-17%	12%	13%	
Poor physical health days	3.7	3.6-3.9	2.9	3.1	
Poor mental health days	3.2	3.1-3.3	2.8	2.7	
Low birth weight	5%	4-7%	6%	6%	
Health Factors					49
Health Behaviors					50
Adult Smoking	21%	20-22%	14%	19%	
Adult obesity	35%	29-42%	25%	30%	
Food environment index	6.3		8.3	7.3	
Physical inactivity	26%	20-32%	20%	24%	
Access to exercise opportunities	49%		91%	67%	

	Charles Mix County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Excessive drinking	16%	15-16%	12%	18%	
Alcohol-impaired driving deaths	70%	59-78%	14%	35%	
Sexually transmitted infections	868.1		134.1	471.2	
Teen births	68	58-78	19	36	
Motor vehicle crash deaths	17	9-31	9	16	
Insufficient sleep	28%	28-29%	28%	28%	
Clinical Care					50
Uninsured	19%	17-22%	11%	13%	
Primary care physicians	1,160:1		1,040:1	1,310:1	
Dentists	2,320:1		1,340:1	1,770:1	
Mental health providers			370:1	630:1	
Preventable hospital stays	88	74-102	38	52	
Diabetic monitoring	86%	73-100%	90%	83%	
Mammography screening	60%	46-75%	71%	66%	
Social & Economic Factors					49
High school graduation			93%	83%	

	Charles Mix County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Some college	55%	48-62%	72%	67%	
Unemployment	3.8%		3.5%	3.4%	
Children in poverty	31%	23-40%	13%	18%	
Income inequality	5.0	4.2-5.8	3.7	4.2	
Children in single-parent households	44%	37-51%	21%	32%	
Social associations	24.9		22.1	17.0	
Violent crime	175		59	282	
Injury deaths	92	66-124	51	70	
Physical Environment					39
Air pollution - particulate matter	11.6		9.5	10.8	
Drinking water violations	Yes		No		
Severe housing problems	12%	10-15%	9%	12%	
Driving alone to work	75%	71-78%	71%	79%	
Long commute - driving alone	9%	6-11%	15%	14%	

SOUTH DAKOTA HEALTH STUDY: GREGORY COUNTY RESULTS

Gregory County Responses: 107 | Response Rate: 56%

Percent who have been told by a doctor that they have...

11.4%	Diabetes	28.0%
10.9%	Asthma	10.5%
33.3%	High Blood Pressure	30.4%
8.9%	Heart Disease	12.3%
28.5%	High Cholesterol	26.9%
3.4%	COPD	2.9%
8.9%	Cancer	8.5%
54.7%	At least one of the above	62.3%
17.0%		11.6%
17.6%		6.7%
3.4%		1.4%
1.7%		0.0%
2.6%		1.4%
25.5%		16.6%

57.4%		36.8%
11.3%		
19.1%		27.5%
20.3%		27.4%
19.9%		13.4%
8.5%		9.1%

75.0%		57.5%
79.5%		74.8%
9.5%		5.4%
1.1%		0.6%

ACCESS TO CARE

94.2%		97.2%
77.4%		74.7%
13.0%		6.2%
6.4%		2.9%
35.8%		0.0%
45.6%		0.0%

HEALTH RESULTS (SCREENING)

Percent who screened positive for...

83.4%		87.2%
5.5%		2.9%
7.5%		2.9%
6.0%		9.9%
		21.0%
42.4%		21.3%
6.7%		0.9%

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SOUTH DAKOTA HEALTH STUDY: CHARLES MIX COUNTY RESULTS

Charles Mix County Responses: 222 | Response Rate: 63%

HEAL

Percent who have been told by a doctor that they have...

11.4%	Diabetes	12.3%
10.9%	Asthma	7.8%
33.3%	High Blood Pressure	41.2%
8.9%	Heart Disease	8.9%
28.5%	High Cholesterol	26.6%
3.4%	COPD	1.9%
8.9%	Cancer	7.3%
54.7%	At least one of the above	55.9%
17.0%		14.1%
17.6%		13.5%
3.4%		4.8%
1.7%		4.6%
2.6%		0.7%
25.5%		21.7%

N I

57.4%		63.0%
11.3%		45.8%
19.1%		19.3%
20.3%		29.9%
19.9%		8.2%
8.5%		0.0%

R

75.0%		74.9%
79.5%		83.4%
9.5%		7.5%
1.1%		1.5%

ACCESS TO CARE

94.2%		98.1%
77.4%		73.7%
13.0%		2.5%
6.4%		4.9%
35.8%		0.0%
45.6%		N/A

EALTH ESULTS (SCREENINGS)

Percent who screened positive for...

83.4%	Overall health status (good, very good, excellent)	85.8%
5.5%		6.6%
7.5%		8.4%
6.0%		2.1%
17.0%		8.5%
42.4%		42.3%
6.7%		10.0%

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