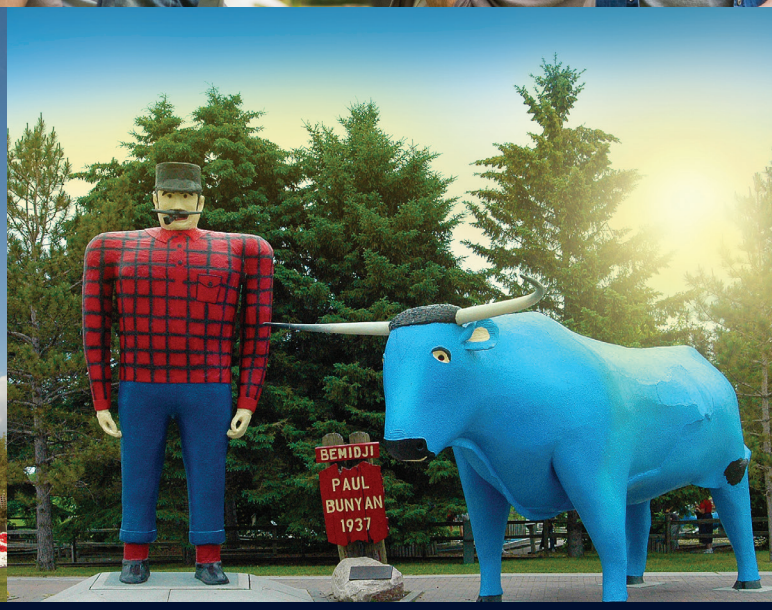


Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

dba Sanford Aberdeen Medical Center EIN # 46-0388596

SANFORD HEALTH

Sanford Aberdeen Medical Center

Community Health Needs Assessment 2016

Dear Community Members,

Sanford Aberdeen 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. Sanford 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.

Sanford Aberdeen has set strategy to address the following community health needs:

- Physical Health
- Mental 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 Sanford Aberdeen, 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,

Ashley Erickson
Chief Executive Officer
Sanford Aberdeen Medical Center

Sanford Aberdeen Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

SANFORD HEALTH

Sanford Aberdeen Medical Center

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 on-line during 2015. The Center for Social Research at North Dakota State University developed and maintained links to the on-line 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 2015 and a total of 66 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community stakeholders was 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 Sanford 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 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 the Robert Wood Johnson County Health Rankings for Brown and Edmonds counties and the South Dakota Health Study for Brown and Edmunds counties.

Key Findings – Primary Research

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

The leading concerns about the community include:

- **Economics:** Availability of affordable housing
- **Environment:** Good water quality
- **Aging:** Cost of long term care; availability of memory care
- **Children and Youth:** Bullying; cost of quality infant care
- **Safety:** Presence of street drugs and alcohol in the community; domestic violence; child abuse
- **Health Care:** Access to affordable health insurance
- **Physical Health:** Obesity; poor nutrition and eating habits; cancer; inactivity and lack of exercise; chronic disease
- **Mental Health/Behavioral Health:** Underage drug and abuse; drug use and abuse; underage drinking; stress; depression; dementia & Alzheimer's; smoking and tobacco use

Key Findings – Secondary Research Based on the 2015 County Health Rankings and the South Dakota Health Study

The South Dakota Health Survey was a statewide health assessment designed to provide a picture of county and statewide health needs. The survey included a representation of rural and American Indian subpopulations. Additionally, homeless, immigrant and refugee, and housing insecure populations were included in this study.

Health Outcomes - Mortality and Morbidity
While the state of South Dakota has more premature deaths than the national benchmark, Brown County has a lower rate than the national benchmark and South Dakota as a whole. The Morbidity health outcomes indicate that Brown County citizens report more days of poor health (self-reported) than the national or South Dakota benchmark. They also report more physically unhealthy days than the state or national data.

South Dakota and Brown County report more mentally unhealthy days (self-reported) than the national benchmark. Brown County reports slightly fewer mentally unhealthy days than the state.

Brown County has a percentage of low birth weight slightly below the national benchmark, and also reports a lower percentage of low birth weight than the state.

Health Behaviors

The Health Behavior outcomes indicate that South Dakota and Brown County have higher percentages of adult smokers (equal to or greater than 100 cigarettes) than the national average. Adult obesity (greater than or equal to 30 BMI) is also higher in South Dakota and Brown County. South Dakota and Brown County have a higher percentage of physical inactivity than the national benchmark.

South Dakota (19%) and Brown County (21%) have much higher percentages of binge drinking reports (more than four drinks on one occasion for women and more than five for men) than the national benchmark (10%).

Sexually transmitted infections rank substantially higher than the national average in South Dakota. Brown County is lower than the state average but also is much higher than the national average for sexually transmitted infections.

The teen birth rate is higher in South Dakota and Brown County than the national benchmark. Brown County's teen birth rate is lower than the state's teen birth rate.

Clinical Care

The Clinical Care outcomes indicate that South Dakota has a higher percentage of uninsured adults than the national benchmark. The percentage of uninsured youth in Brown County and the national average are lower than South Dakota as a whole.

There are more patients per physician in South Dakota and Brown County than the national average.

The ratio of population to mental health providers is less positive in South Dakota and Brown County. The number of professionally active dentists per 100,000 of population is lower than the national benchmark for South Dakota and Brown County.

Preventable hospital stays are slightly higher than the national average in Brown County and South Dakota.

Diabetic screening in South Dakota is lower than the national benchmark. The rate of diabetic screening is higher in Brown County than the national benchmark.

Brown County ranks higher than the national benchmark for mammography screenings and South Dakota ranks lower than the national benchmark for mammography screenings.

Social and Economic Factors

The Social and Economic Factors outcomes indicate that Brown County has a higher high school graduation rate than South Dakota. South Dakota and Brown County have a lower percentage of post-secondary education than the national average.

The unemployment rate is lower in South Dakota than the national benchmark. Brown County's unemployment rate was lower than South Dakota and the national benchmark.

The percentage of child poverty is higher in South Dakota than the national average. Brown County has a lower percentage than South Dakota and the national benchmark.

Inadequate social support is higher in South Dakota and Brown County than the national benchmark; however, Brown County is lower than South Dakota.

The percentage of children in single parent households is higher than the national benchmark for South Dakota and Brown County.

Physical Environment
The Physical Environment outcomes indicate that there is no air pollution or ozone pollution in this area. Because of the rural geography, access to healthy food is ranked far below the national benchmark in South Dakota and Brown County.

Access to recreational facilities ranks lower than the national benchmark for South Dakota and Brown County.

Demographics
Youth account for 22% of the population in Brown County; elderly account for 17% of the population in Brown County.

Population by Age
The population in Brown County has a higher percentage over the ages of 65 and 85 than South Dakota or the national benchmarks.

The gender distribution is slightly higher for women than men in South Dakota and Brown County. The state of South Dakota is 50% male and 50% female.

Diversity Profile
The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian, Hispanic, Asian and Black.

Health Needs Identified
Two identified needs for the area are physical health and mental health.

Implementation Strategy
The following were identified through a formal community health needs assessment, resources mapping and prioritization process:

- Physical Health
- Mental Health

Implementation Strategy – Physical Health

- Improve care of patients with obesity diagnosis through referring patients to internal and external services, including registered dietitians, exercise physiologists, and Health Coaches.
- Provide education to local schools and child care centers about the Sanford Health *fit* initiative, a childhood obesity prevention initiative. *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).

Implementation Strategy – Mental Health

- Improve care of patients with depression diagnosis through improving PHQ-9 scores for patients with major depression.
- Continue ongoing education to all health coaches and panel specialists to standardize workflow.

SANFORD HEALTH

Sanford Aberdeen Medical Center

Community Health Needs Assessment 2016

Table of Contents

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 Guiding Principles:

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

Acknowledgements

Sanford Health 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.

Sanford Enterprise Steering Group:

- JoAnn Kunkel, CFO, Sanford Enterprise
- Michelle Bruhn, CFO, Health Services Division
- Tiffany Lawrence, CPA, Fargo Region Co-Lead, CFO, Sanford Medical Center Fargo
- Bruce Viessman, Sioux Falls Region Co-Lead, CFO, Sanford Health Network
- Martha Leclerc, MS, Vice President, Revenue Management
- Randy Bury, CAO, Health Services Division
- Steve Goetsch, CFO, Sioux Falls Region
- Jane Heilmann, Senior Corporate Communications Strategist
- Joy Johnson, COO Bemidji Region

- Kirk Christy, CFO, Bismarck Region
- Carrie McLeod, MBA, MM, LRD,CDE, Enterprise Lead, Enterprise Community Health/Community Benefit

Sanford Aberdeen Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE, Enterprise Lead, Office of Health Care Reform, Community Benefit/Community Health Improvement
- Ashley Erickson, Chief Executive Officer
- Amy Munsen, Social Work
- Tarah Heupel, Marketing Advisor

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

- Alicia Collura, Sioux Falls Public Health
- Anita Cardinal, Pennington County Public Health
- Ann Malmberg, Essentia Health
- Becky Secore, Beltrami Public Health
- Brenda Stallman, Traill County Public Health
- Brie Taralson, Essentia Health
- Brittany Ness, Steele County Public Health
- Caitlin Hurley, Avera Health
- Carrie McLeod, Sanford Health
- Dan Heinemann, MD, CMO, Sanford Health Network, Sioux Falls Region
- Gina Nolte, Partnership4Health, Clay County
- Hannah Shirkey, Sanford Health
- Jac McTaggart, Sanford Health
- Jessica Spaeth, City of Halstad
- Joy Johnson, Sanford Health
- Julie Jeske, CHI-St. Alexius Health
- Julie Miller, South Dakota Department of Health
- Julie Ward, Avera Health
- Kathy McKay, Clay County Public Health
- Katie Olson, South Dakota State University
- Kay Schwarzwalter, Center for Social Research, North Dakota State University
- Kim Jacobson, Traill County Public Health
- Kip Littau, South Dakota State University
- Marnie Walth, Sanford Health
- Mary Michaels, Sioux Falls Public Health
- Nancy Fahrenwald, South Dakota State University
- Renae Moch, Burleigh County Public Health
- Roger Baier, Sanford Health
- Ruth Bachmeier, Fargo Cass Public Health
- Sandra Melstad, Public Health Consultant, South Dakota Department of Health
- Stan Kogan, Sioux Falls Public Health
- Stephen Pickard, PhD, North Dakota Department of Health
- Susan Kahler, Burleigh County Public Health
- Teresa Miller, Avera Health

We extend special thanks to the state legislators, mayors, city council/commission members, physicians, nurses, university presidents, school superintendents and school board members, representatives for the mentally and physically disabled, social services, non-profit organizations, and public health officers for their participation in this work. Together we are reaching our vision “to improve the human condition through exceptional care, innovation and discovery”.

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

- Dawn Williams
- Carl Perry
- Cam Schock
- Becky Guffin
- Mike Herman
- Josh Moon
- Carole Curtis

Description of Sanford Aberdeen Medical Center

Sanford Aberdeen Medical Center is a new 48-bed, state-of-the-art hospital designed to meet the growing health care needs of the Aberdeen region and its communities. It opened in July 2012. Services include emergency care/Level IV trauma center, adult and pediatric care, labor and delivery, critical care, cardiac cath lab, inpatient and outpatient surgical and procedural areas, inpatient and outpatient therapies, laboratory and imaging services.

Sanford Aberdeen Clinic is a multispecialty clinic attached to the medical center providing family medicine, internal medicine, general surgery, cardiology, interventional cardiology, OB/GYN, nephrology and urology services. A Children's Clinic is also located on site. Satellite clinics integrated with Sanford Aberdeen are located in Ipswich, South Dakota and Ellendale, North Dakota.

Sanford Aberdeen employs over 50 clinicians, including physicians and advanced practice providers, and over 450 employees.

Description of the Community Served

Aberdeen is the county seat of Brown County, SD, with a population of 26,000 people, making it the third largest city in the state. Named for Aberdeen, Scotland, the hometown of Milwaukee Railroad President Alexander Mitchell, the city incorporated in 1881 and quickly became known as the Hub City of the Dakotas. By 1886, a city map showed nine different rail lines converging in Aberdeen from all directions, much like the spokes of a wheel converging at its hub. The combination of multidirectional railways and fertile farmland helped Aberdeen develop into a distribution hub for wholesale goods.

Today, Aberdeen's economy has diversified and the number of businesses has grown to more than 1,500. Large businesses include 3M, Avera, Bethesda Home, Wells Fargo Bank, Wyndham Hotel Group and more. Other industries include agriculture, construction, manufacturing and trade.

Study Design and Methodology

1. **Non-Generalizable Survey**
   A non-generalizable on-line survey was conducted by Sanford Health with the assistance of public health leadership and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the on-line 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 2015 and a total of 66 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community members and key stakeholders in the greater Aberdeen 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 Sanford. 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 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 community health profiles from the Robert Wood Johnson County Health Rankings and the South Dakota Health Study for Brown and Edmunds counties.

Limitations of the Study

The findings in this study provide a limited snapshot of behaviors, attitudes, and perceptions of residents living in the Aberdeen primary service area. 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.

Sanford 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.

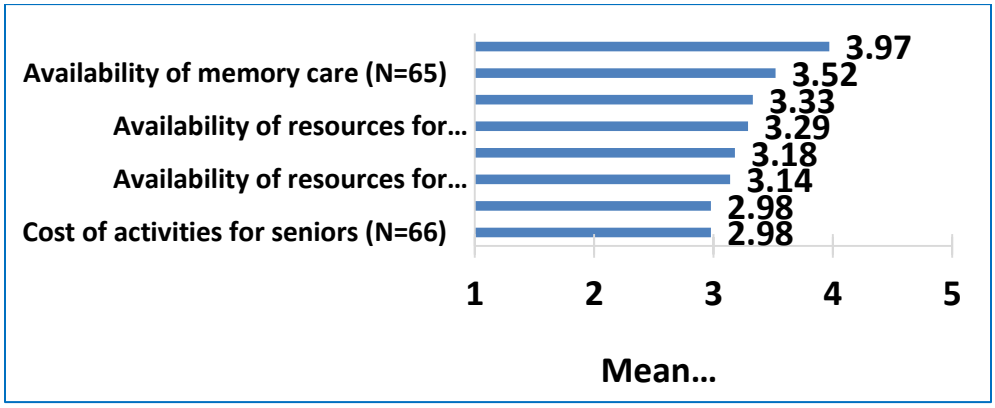
Key Findings

Community Health Concerns

Aging Population

The leading community concern as reported by respondents is cost of long term care services and availability of memory care.

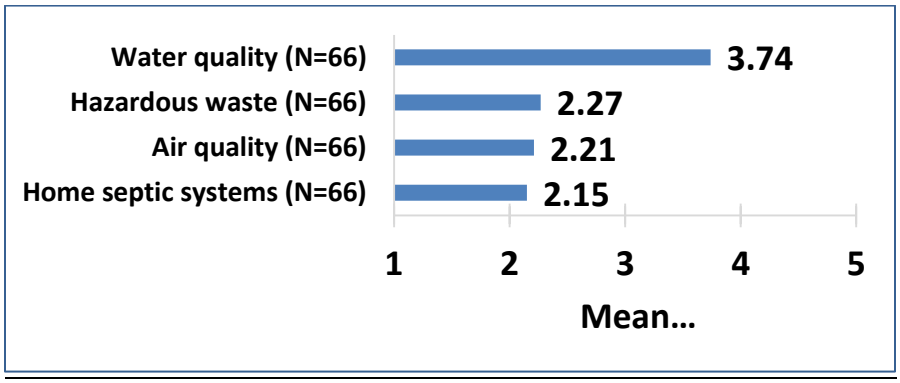
Level of concern with statements about the community regarding the AGING POPULATION



Environment

The leading community concern as reported by respondents is water quality.

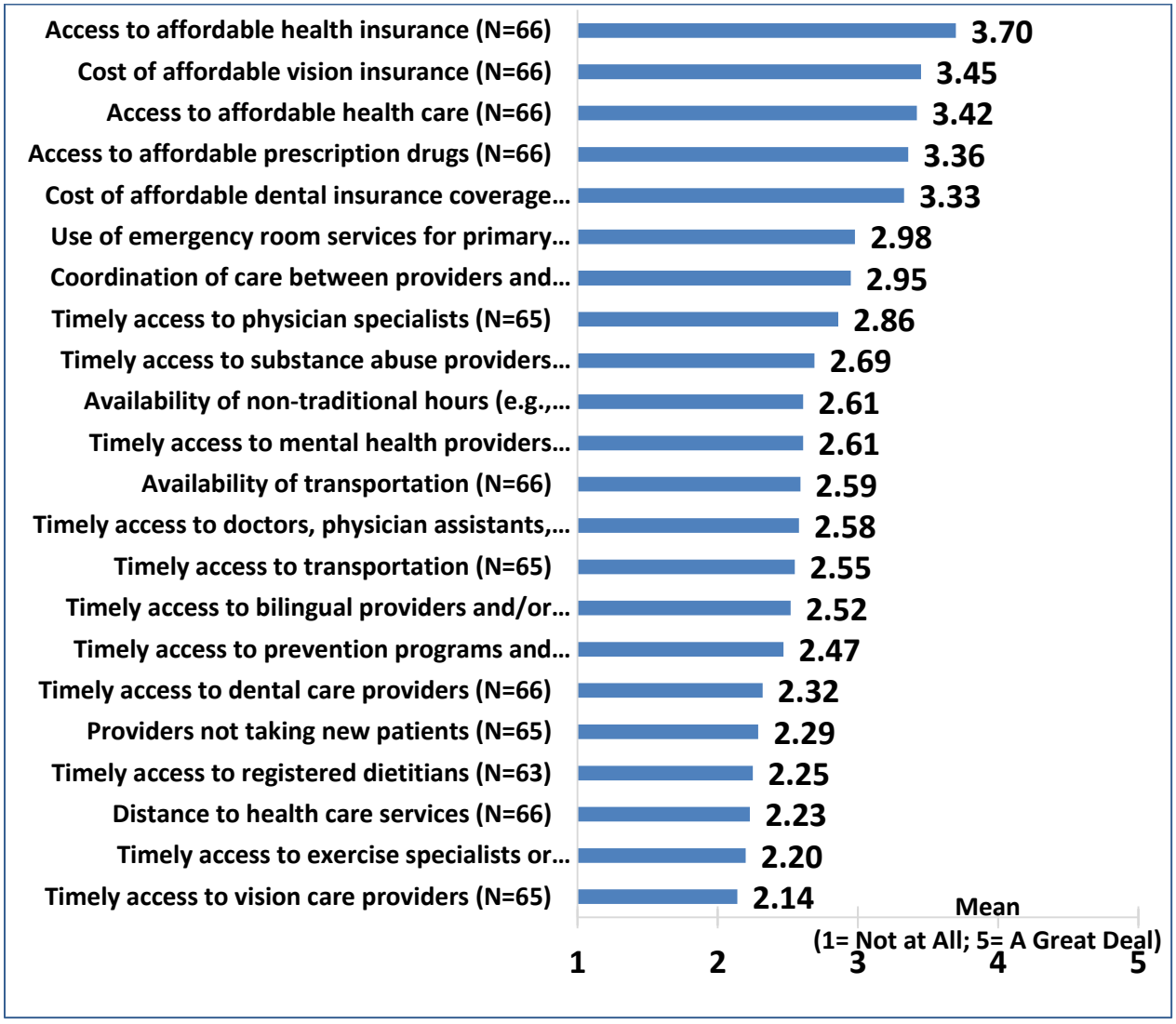
Level of concern with statements about the community regarding the ENVIRONMENT



Health Care Access and Cost

The leading community concern as reported by respondents is access to affordable health insurance.

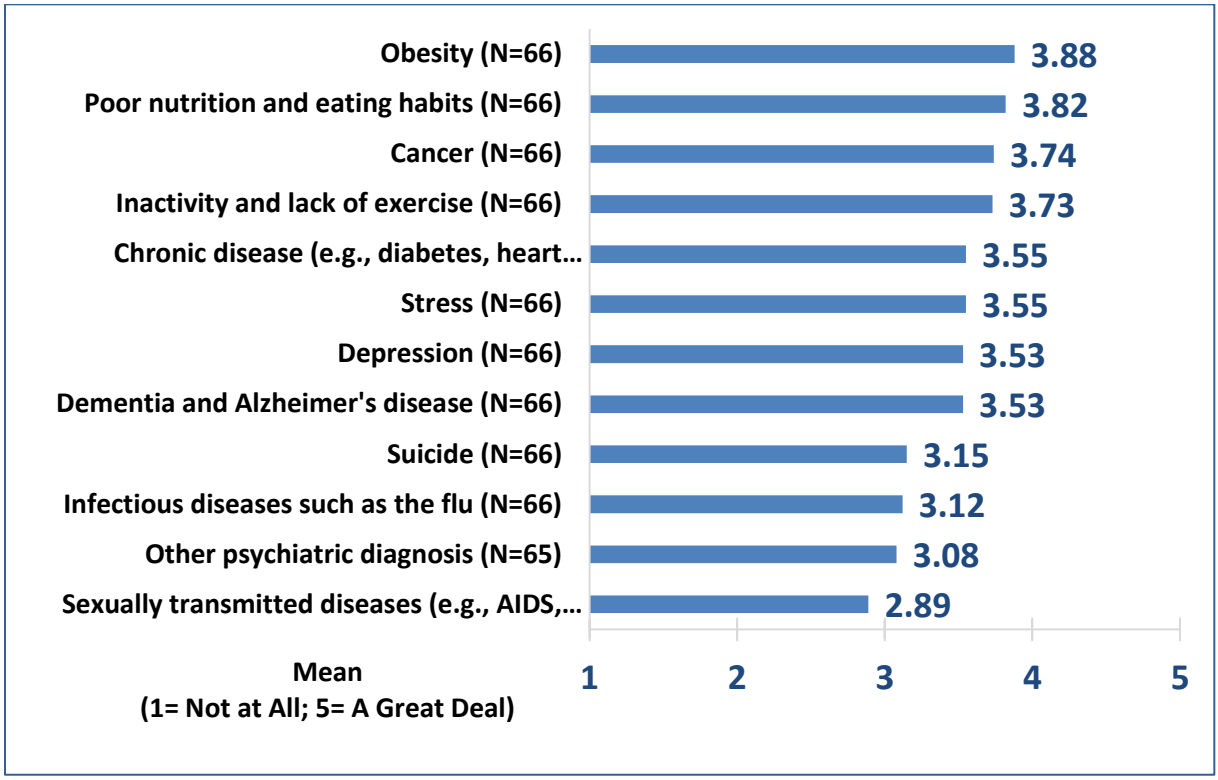
Level of concern with statements about the community regarding HEALTH CARE



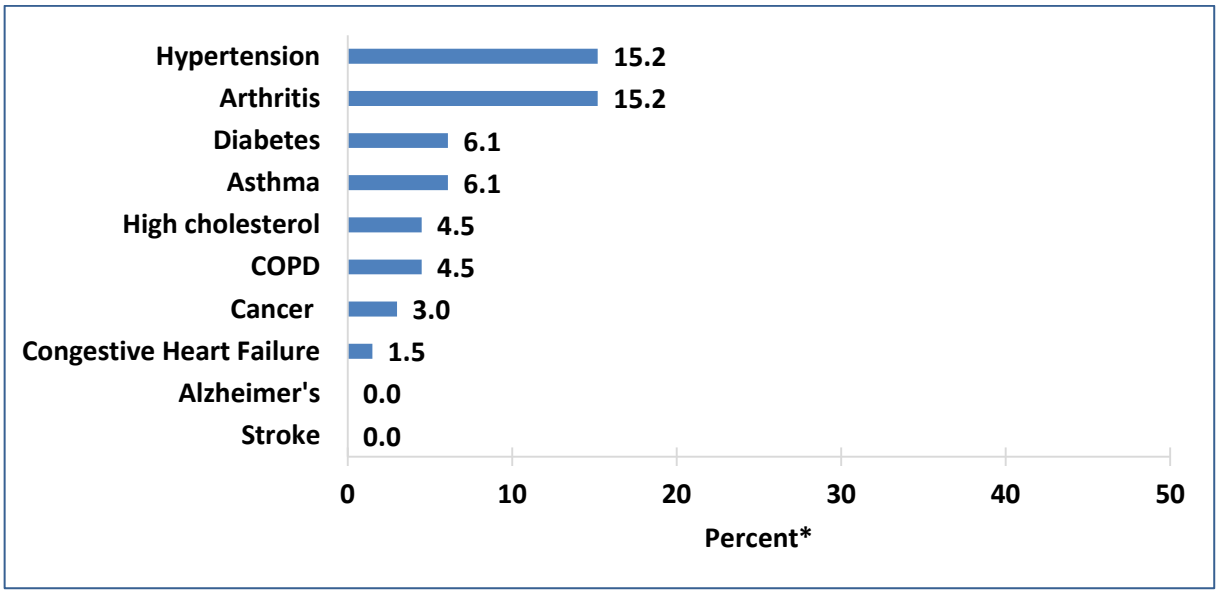
<u>Physical and Mental Health</u>

The leading community concern as reported by respondents is obesity, poor nutrition and eating habits, cancer, inactivity and exercise, and chronic disease.

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



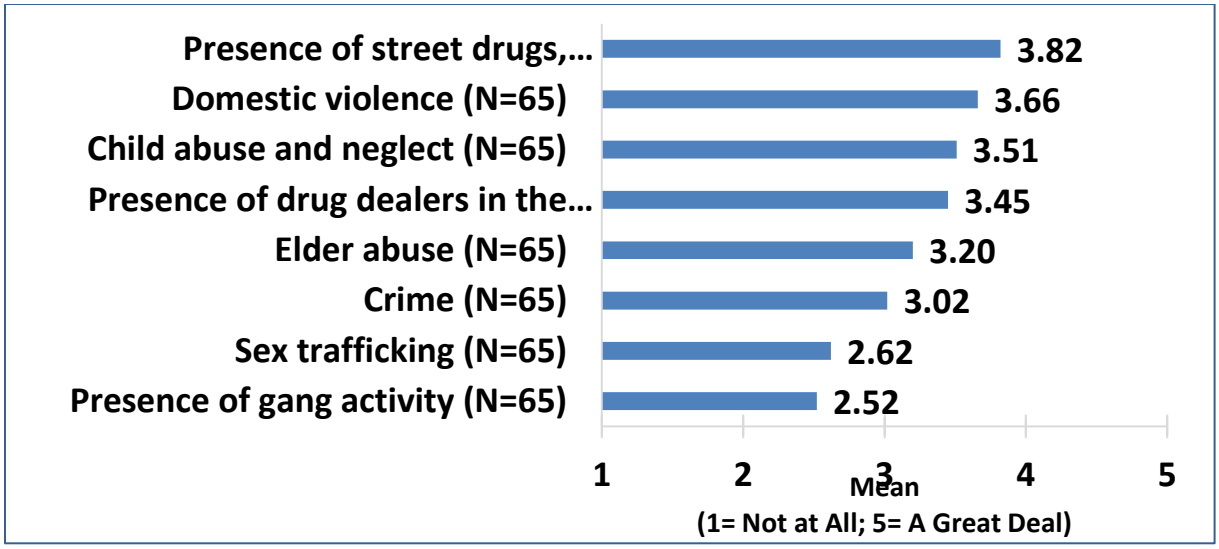
Whether respondents have any of the following chronic diseases



Safety

The leading community concern as reported by respondents is presence of street drugs and alcohol in the community, domestic violence and child abuse and neglect.

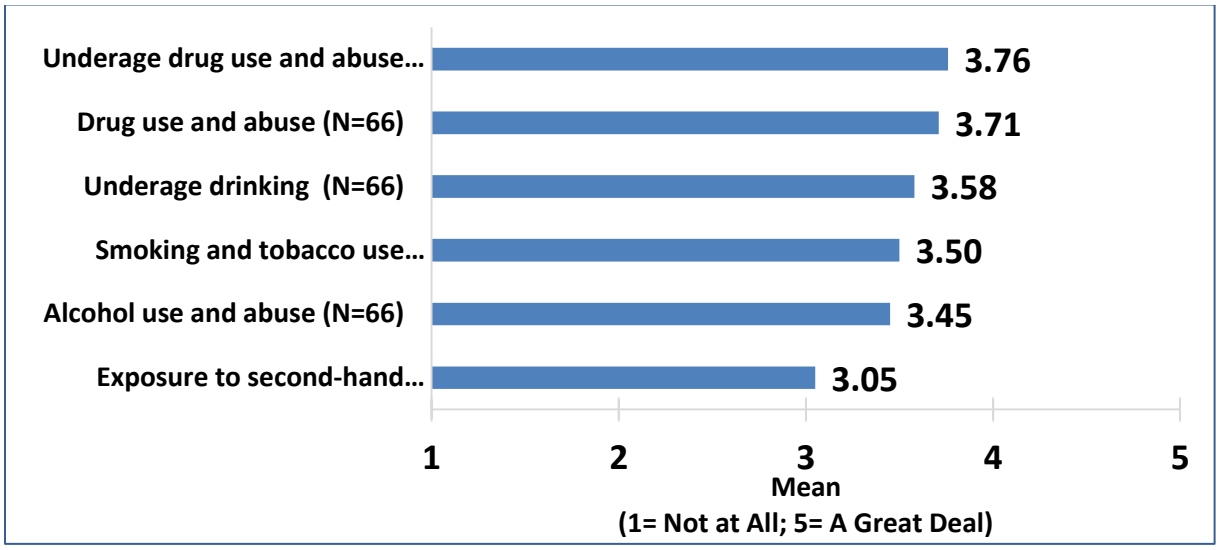
Level of concern with statements about the community regarding SAFETY



Substance Use and Abuse

The leading community concern as reported by respondents is underage drug use and abuse.

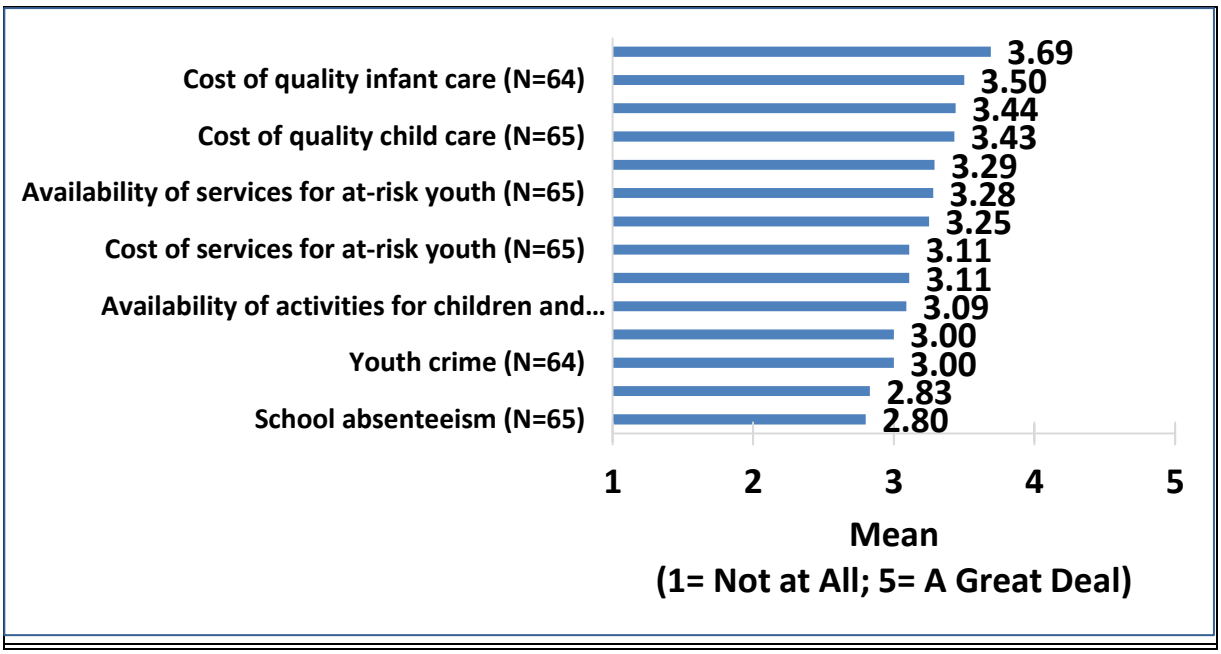
Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



Children and Youth

The leading community concern as reported by respondents is bullying and cost of infant care.

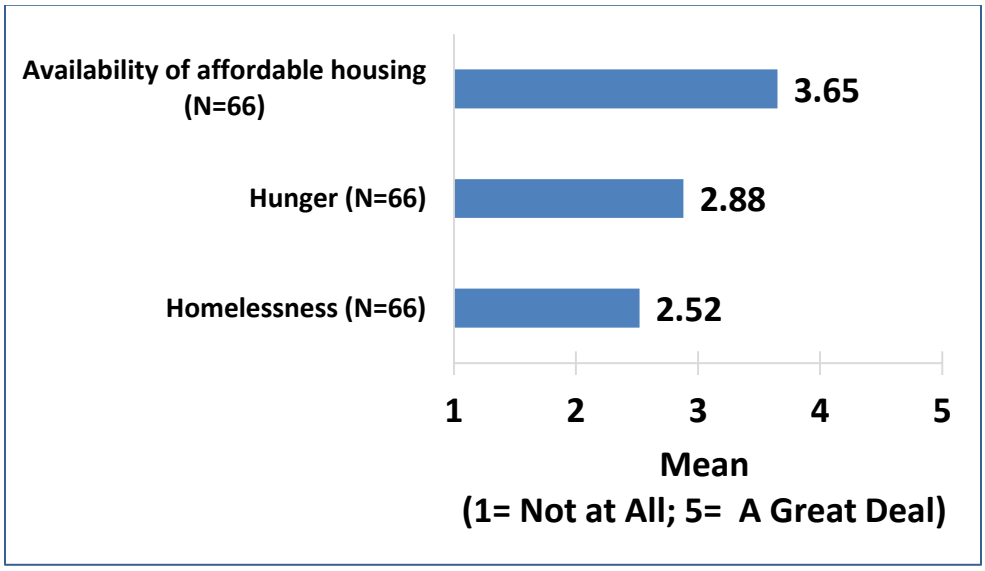
Level of concern with statements about the community regarding CHILDREN AND YOUTH



Economics

The leading community concern as reported by respondents is availability of affordable housing.

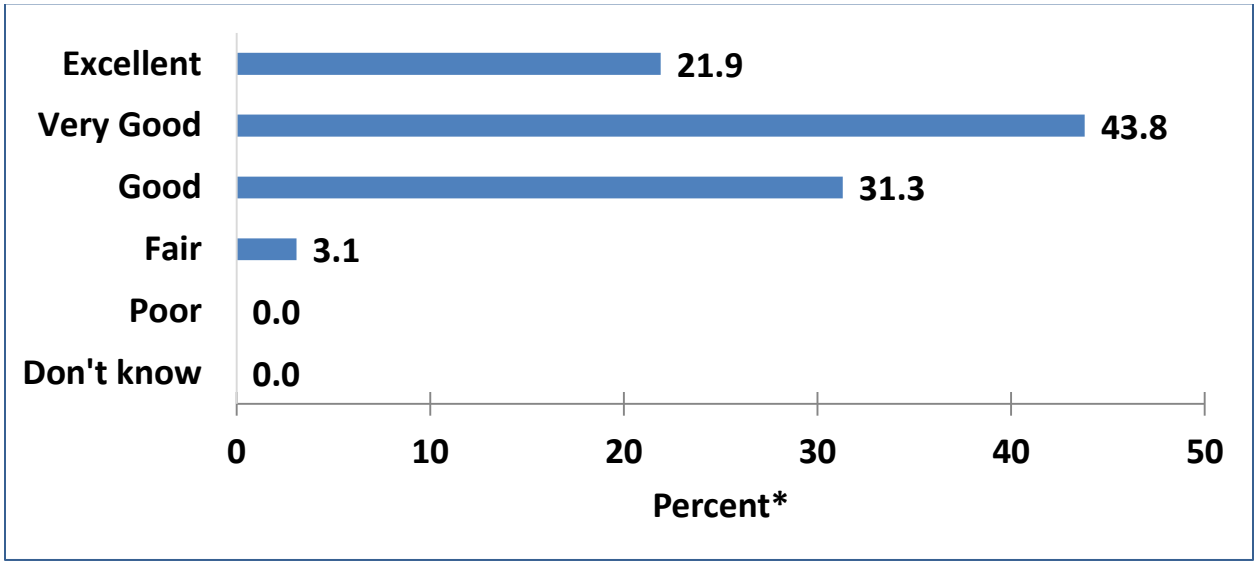
Level of concern with statements about the community regarding ECONOMICS



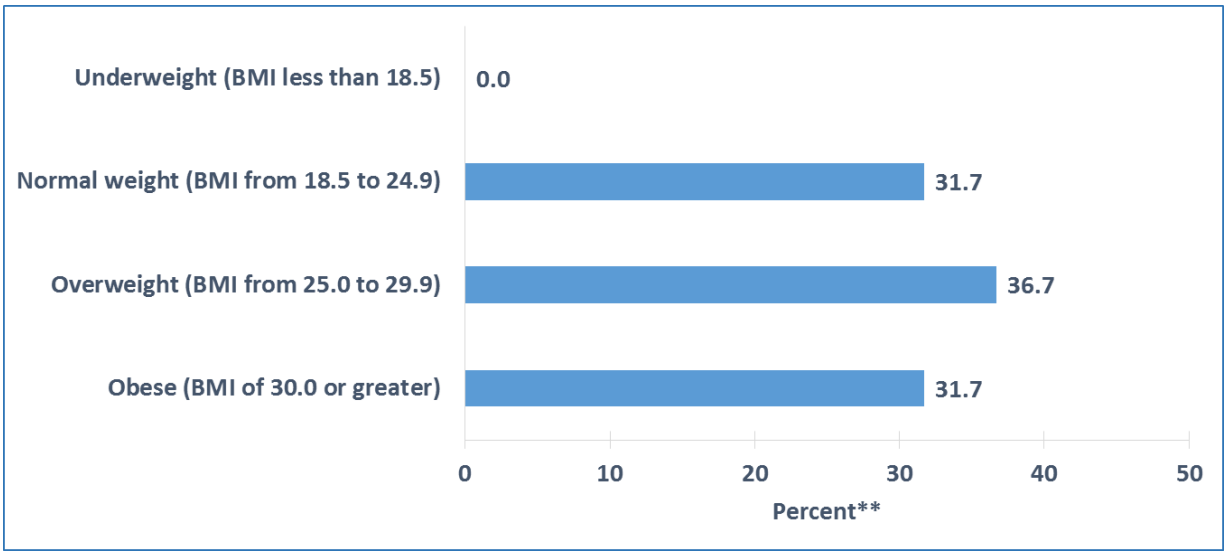
Personal Health Concerns

Respondents' Personal Health Status

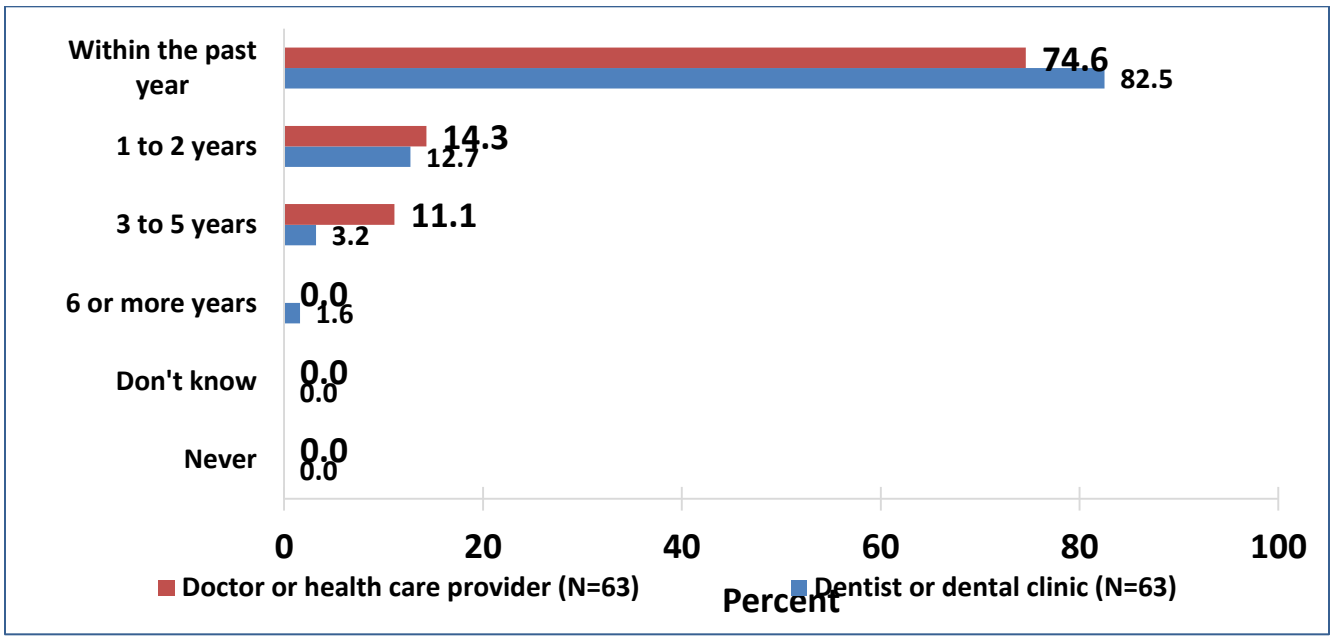
Respondents' rating of their health in general



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



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



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.

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=63)	88.9	11.1	100.0
Blood sugar screening (N=63)	77.8	22.2	100.0
Bone density test (N=63)	15.9	84.1	100.0
Cardiovascular screening (N=63)	30.2	69.8	100.0
Cholesterol screening (N=63)	71.4	28.6	100.0
Dental screening and X-rays (N=63)	82.5	17.5	100.0
Flu shot (N=63)	68.3	31.7	100.0
Glaucoma test (N=63)	58.7	41.3	100.0
Hearing screening (N=63)	12.7	87.3	100.0
Immunizations (N=63)	23.8	76.2	100.0
Pelvic exam (N=39 Females)	74.4	25.6	100.0
STD (N=62)	14.5	85.5	100.0
Vascular screening (N=63)	9.5	90.5	100.0
CANCER SCREENINGS			
Breast cancer screening (N=38 Females)	65.8	34.2	100.0
Cervical cancer screening (N=38 Females)	68.4	31.6	100.0
Colorectal cancer screening (N=62)	25.8	74.2	100.0
Prostate cancer screening (N=24 Males)	58.3	41.7	100.0
Skin cancer screening (N=62)	24.2	75.8	100.0

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=7)	28.6	28.6	14.3	0.0	0.0	0.0	14.3
Blood sugar screening (N=14)	35.7	14.3	14.3	0.0	0.0	0.0	21.4
Bone density test (N=53)	47.2	32.1	3.8	0.0	1.9	0.0	3.8
Cardiovascular screening (N=44)	29.5	40.9	4.5	0.0	2.3	0.0	11.4
Cholesterol screening (N=18)	44.4	16.7	5.6	0.0	0.0	0.0	16.7
Dental screening and X-rays (N=11)	27.3	0.0	18.2	9.1	9.1	0.0	45.5
Flu shot (N=20)	40.0	0.0	5.0	5.0	5.0	0.0	25.0
Glaucoma test (N=26)	46.2	26.9	3.8	0.0	0.0	0.0	7.7
Hearing screening (N=55)	54.5	20.0	3.6	0.0	0.0	0.0	5.5
Immunizations (N=48)	56.3	16.7	2.1	2.1	0.0	0.0	8.3
Pelvic exam (N=10 Females)	30.0	20.0	0.0	0.0	0.0	0.0	30.0
STD (N=53)	75.5	13.2	1.9	0.0	0.0	0.0	1.9
Vascular screening (N=57)	49.1	28.1	3.5	0.0	0.0	0.0	5.3

Whether respondents had cancer preventive screenings in the past year, by gender and age

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
CANCER SCREENINGS							
Breast cancer screening (N=13 Females)	38.5	30.8	7.7	0.0	0.0	0.0	7.7
Cervical cancer screening (N=12 Females)	33.3	41.7	0.0	0.0	0.0	0.0	16.7
Colorectal cancer screening (N=46)	41.3	30.4	2.2	2.2	0.0	0.0	17.4
Prostate cancer screening (N=10 Males)	50.0	30.0	0.0	0.0	0.0	0.0	20.0
Skin cancer screening (N=47)	36.2	46.8	4.3	0.0	0.0	0.0	4.3

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.

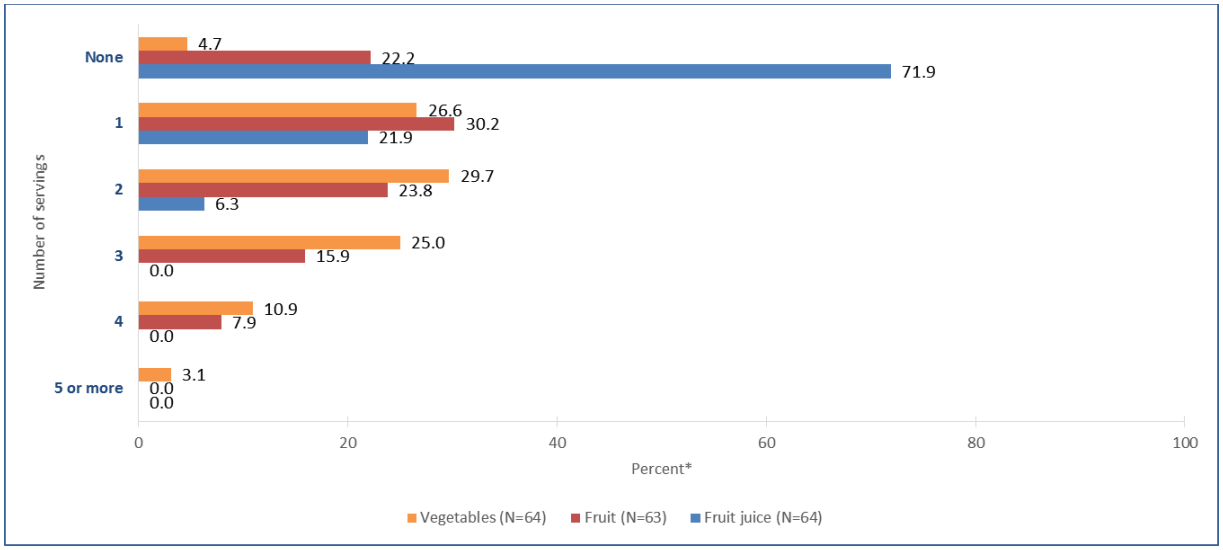
- Skin cancer screening: The U.S. Preventive Services Task Force (USPSTF) has concluded there is not enough evidence to recommend for or against routine screening (total body examination by a doctor) to find skin cancers early. The USPSTF recommends that doctors:
  - Be aware that fair-skinned men and 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.

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 25% of respondents reported having 3 or more servings of vegetables the prior day, while only 16% 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

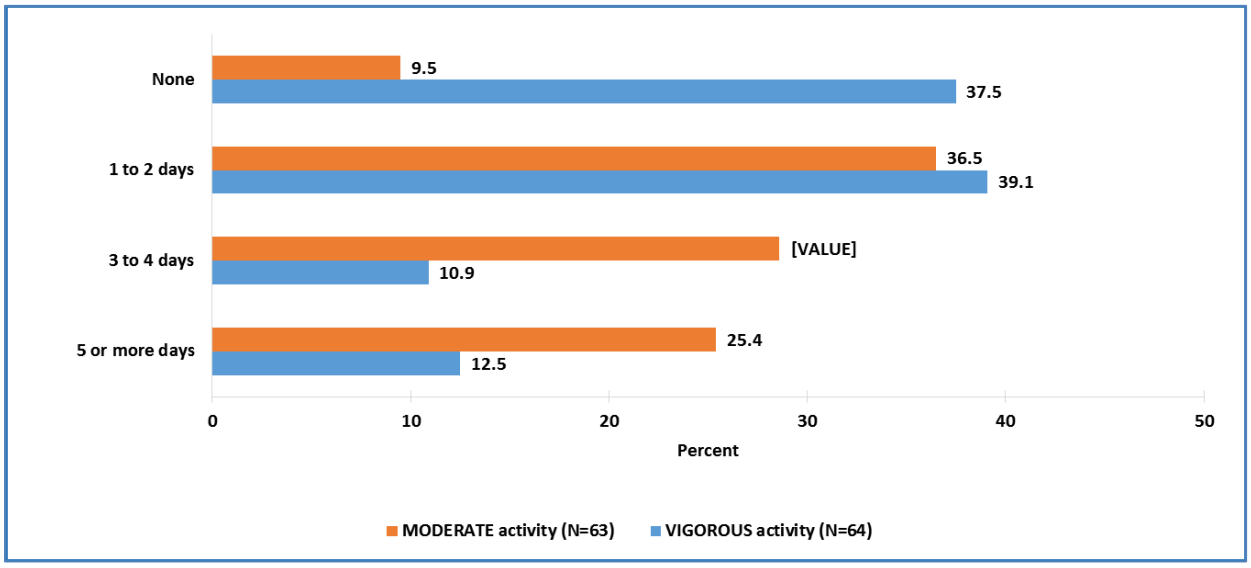


Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines. In the non-generalizable group, 28% engage in moderate activity 3 or more times per week and 11% 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

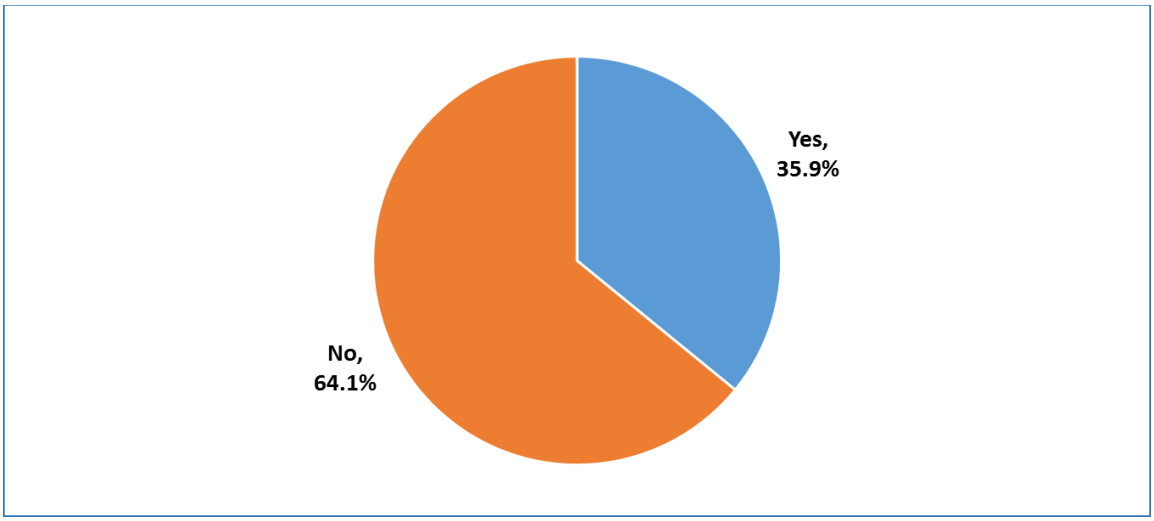


Tobacco Use

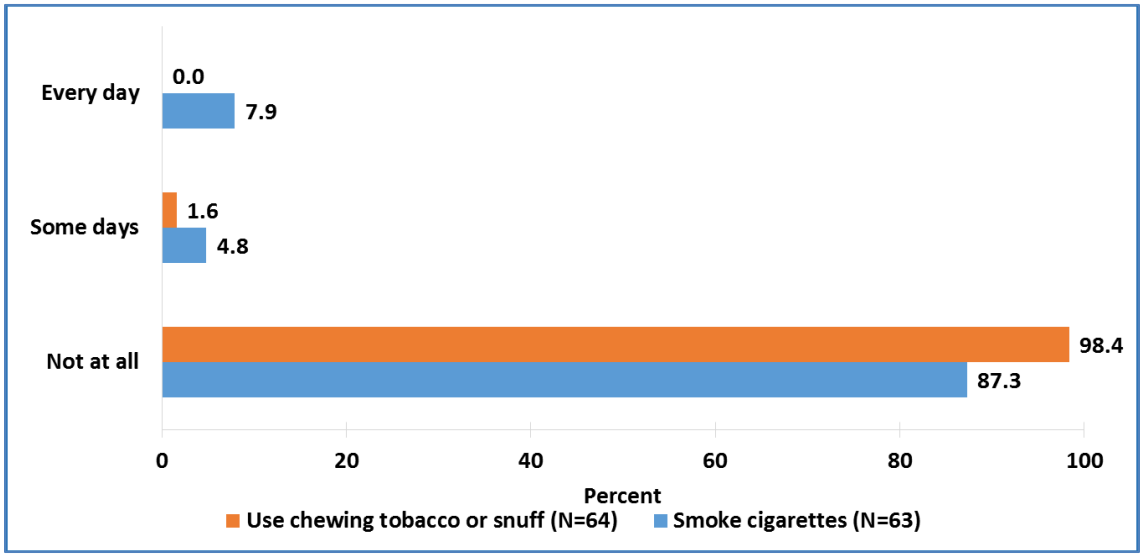
Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 4 in 10 respondents have smoked at least 100 cigarettes in their lifetime, which indicates former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the 2015 County Health Rankings finds that 18% of Brown County residents are current smokers.

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



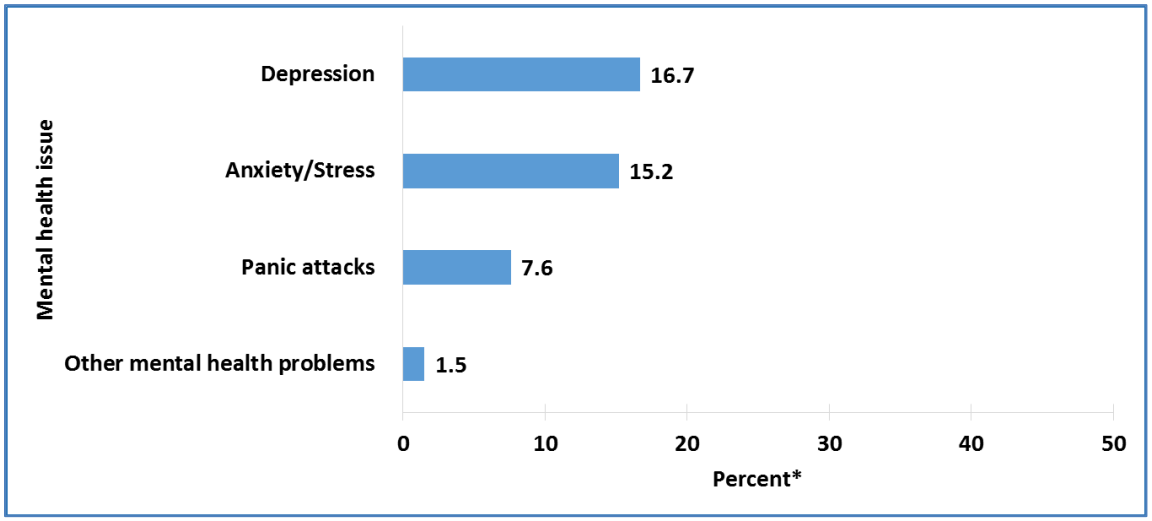
How often respondents currently smoke cigarettes and use chewing tobacco or snuff



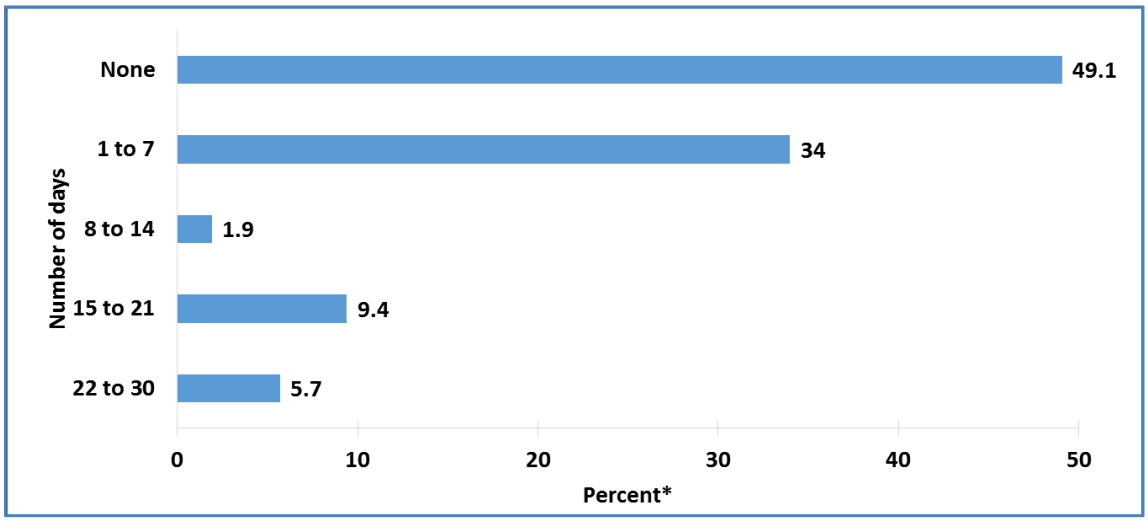
Mental Health

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 the respondents, mental health is a moderately high.

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

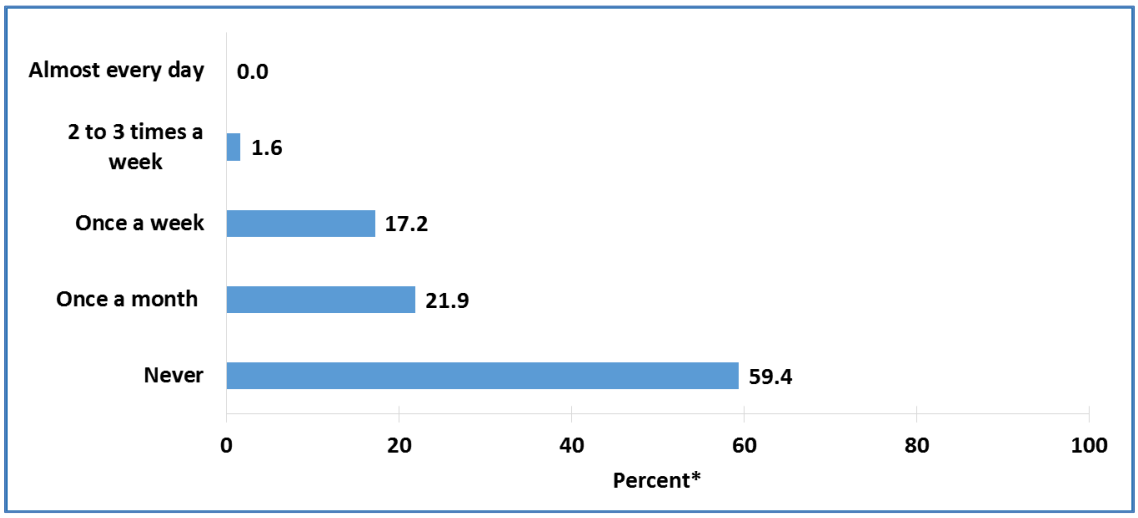


Number of days in the last month that respondents' mental health was not good

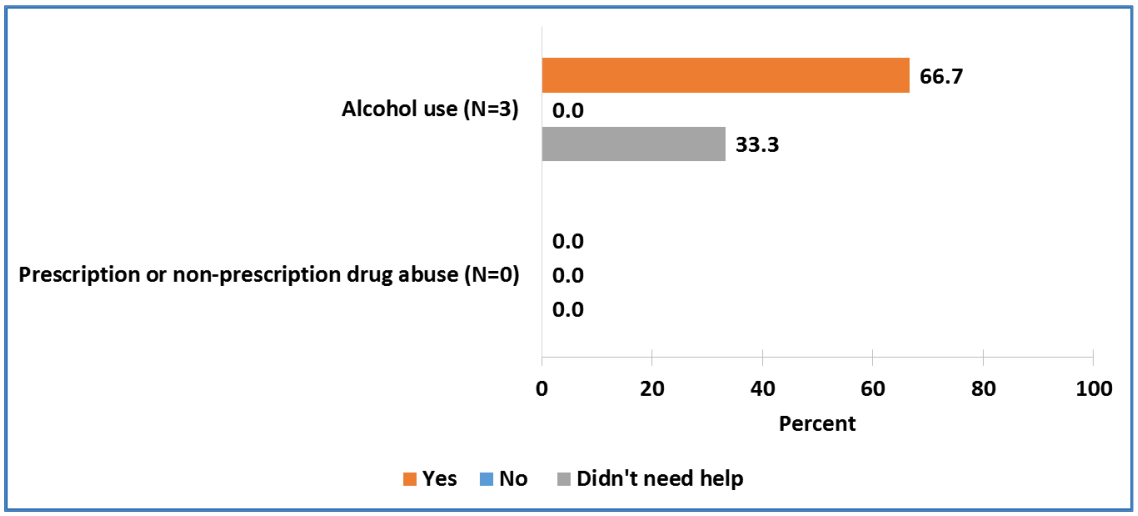


Substance Abuse Responses

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



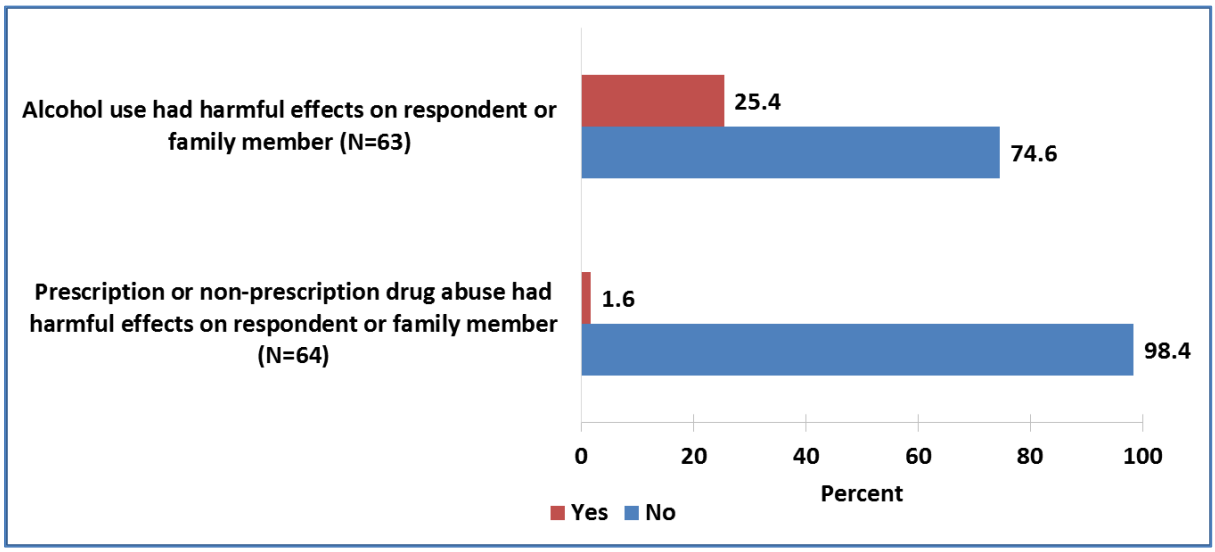
Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse



More than 60% of respondents reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking. Overall, 1 in 4 respondents report alcohol use has had harmful effects on themselves 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 – 2010 U.S. Census Bureau

- **Brown County: 36,531**
- **Edmunds County: 4,071**

Population by Age and Gender – Brown County

	Number	Percent	Males	Percent	Females	Percent
<5 years	2,505	6.9	1,265	3.5	1,240	3.4
5-9	2,303	6.3	1,153	3.2	1,150	3.1
10-14	2,277	6.2	1,160	3.2	1,117	3.1
15-19	2,454	6.7	1,204	3.3	1,250	3.4
20-24	2,835	7.8	1,363	3.7	1,472	4.0
25-29	2,455	6.7	1,322	3.6	1,133	3.1
30-34	2,086	5.7	1,046	2.9	1,040	2.8
35-39	1,939	5.3	978	2.7	961	2.6
40-44	2,093	5.7	1,080	3.0	1,013	2.8
45-49	2,581	7.1	1,309	3.6	1,272	3.5
50-54	2,680	7.3	1,293	3.5	1,387	3.8
55-59	2,452	6.7	1,181	3.2	1,271	3.5
60-64	1,998	5.5	984	2.7	1,014	2.8
65-69	1,413	3.9	690	1.9	723	2.0
70-74	1,262	3.5	557	1.5	705	1.9
75-79	1,093	3.0	458	1.3	635	1.7
80-84	978	2.7	383	1.0	595	1.6
85 and over	1,127	3.1	369	1.0	758	2.1
Median age	38.6		36.9		40.0	

Population by Age and Gender – Edmunds County

	Number	Percent	Males	Percent	Females	Percent
<5 years	229	5.6	134	3.3	9.5	2.3
5-9	273	6.7	131	3.2	142	3.5
10-14	276	6.8	139	3.4	137	3.4
15-19	279	6.9	151	3.7	128	3.1
20-24	166	4.1	94	2.3	72	1.8
25-29	177	4.3	92	2.3	85	2.1
30-34	181	4.4	97	2.4	84	2.1
35-39	181	4.4	95	2.3	86	2.1
40-44	219	5.4	100	2.5	119	2.9
45-49	360	8.8	184	4.5	176	4.3
50-54	312	7.7	165	4.1	147	3.6
55-59	295	7.2	153	3.8	142	3.5
60-64	240	5.9	119	2.9	121	3.0
65-69	242	5.9	120	2.9	122	3.0
70-74	172	4.2	96	2.4	76	1.9
75-79	183	4.5	81	2.0	102	2.5
80-84	131	3.2	60	1.5	71	1.7
85 and over	155	3.8	58	1.4	97	2.4
Median age	45.7		45.1		46.2	

Population by Race

	Brown County	Percent	Edmunds County	Percent
White	34,057	93.2	3,981	97.8
Black or African American	194	0.5	5	.01
American Indian and Alaska Native	1,105	3.0	18	0.4
Asian	355	1.0	5	0.1
Native Hawaiian and Other Pacific Islander	42	0.1	0	0
Hispanic	496	1.4	58	1.4

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
- Concerns expressed by the key stakeholder group
- Secondary research data
- Community resources that are available to address the need(s)

The asset map is display in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- **Economics** – availability of affordable housing
- **Environment** – good water quality
- **Aging –** the cost of long-term care; availability of memory care
- **Children and Youth** – bullying; cost of quality infant care
- **Safety** – presence of street drugs and alcohol in the community, domestic abuse; child abuse
- **Health Care** - access to affordable health insurance
- **Physical Health** – obesity, poor nutrition, cancer, inactivity, chronic disease
- **Mental Health** – underage use of drugs and alcohol abuse; drug use and abuse; chronic disease

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

communicate these findings with community leaders and experts who can best focus on a solution to the concern.

A document that shares what Sanford is doing to address the need or defends why Sanford is not addressing the need can be found in the Appendix.

Members of the collaborative determined that Physical Health and Mental Health are a top unmet need.

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

- Physical Health
- Mental Health

How Sanford is Addressing the Needs

2016 Community Health Needs Assessment
Sanford Aberdeen Medical Center

Identified Concerns	How Sanford Aberdeen is Addressing the Needs
Economics • Availability of affordable housing	Sanford will address this need by sharing the findings with community leadership
Environment • Good water quality	Sanford will address this need by sharing the findings with community leadership
Aging • Cost of long term care • Availability of memory care	Sanford will address this need by sharing the findings with community leadership
Children and Youth • Bullying • Cost of quality infant care	Sanford Children's CHILD Services – Bullying • Conducts social emotional trainings and technical assistance to child care providers in 29 counties in southeast and northeast South Dakota to address the needs of young children learning social skills early and to prevent bullying. Sanford will address this need by sharing the findings with community leadership
Safety • Presence of street drugs, and alcohol in the community • Domestic violence • Child abuse	Sanford Children's CHILD Services – Child abuse and Neglect early intervention/prevention • Parent Aide program works with Child Protection Services to provide parent education and support to at risk families. • Conducts community parent education classes for parents regarding appropriate developmental expectations for young children and appropriate discipline techniques. • Secured units; Children's, Emergency Department, Birth Place • Security works with HR for specifically identified domestic violence issues with employees Community resources include: • Hugs system • Child's Voice program • Social Work services • Mental Health services • Counseling for employees through EAP • Police Dept. 605-626-7010 • Brown Sheriff 605-626-7100 • Child Protection 605-626-2388 • SD Child Advocacy Ctr. 605-333-2226 • Safe Harbor 605-226-1212 Substance Abuse resources: • Avera Worthmore Addition Services 605-622-5800 • NADRIC Treatment Center – 605-225-6131 • Alcoholics Anonymous – 605-225-1292 • Al-Anon – 605-225-5680

Identified Concerns	How Sanford Aberdeen is Addressing the Needs
	• Al-Anon Family Group – 605-229-0846 • Narcotics Anonymous – 605-229-8562 • Alano Society – 605-225-1292 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Safety resources: • Brown Co. Sheriff – 605-626-7100 • Aberdeen Police – 605-626-7000 • Rape Task Force – 605-226-1212 Domestic Violence resources: • East River Legal Services – 605-336-9230 • Brown County Crime Victim Assistance 605-626-7130 • Safe Harbor – 605-226-1212 • Resource Center for Women – 605-226-1212 • SD Coalition Against Domestic Violence 605-225-5122 • Salvation Army – 605-225-7410 • Rape Task Force – 605-226-1212 • Support Groups - LSS – 605-229-1500 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Child abuse & neglect resources: • Brown Co. Child Abuse & Neglect – 605-626-2388 • Safe Harbor – 605-226-1212 • LSS – 605-229-1500 • New Beginnings – 605-229-1239 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431
Health care • Access to affordable health insurance	• Sanford Health provides health insurance options to the community via marketplace. • Brown County has local agents and community navigators to help identify affordable health insurance options for community members. • Sanford Health is partnering with a vendor who will assist uninsured patients with finding coverage.
Physical Health • Obesity • Poor nutrition and eating habits • Cancer • Inactivity and lack of exercise • Chronic Disease	Sanford has developed an implementation strategy to address obesity Sanford provides nutritional education which includes: • Cooking classes and nutrition education to student athletes • Nutrition presentations to groups with cancer and other chronic conditions (breast cancer, COPD, diabetes, etc.) • Participation in community health fairs • Nutrition education for pregnant women and new moms (B4 Baby) • Introduction of Solids (nutrition class series) for new parents • Participate in TV, radio, and newspaper interviews regarding nutrition topics in the news • Diabetes Prevention Program • *Cooking with the Cardiologist* for community members to attend

Identified Concerns	How Sanford Aberdeen is Addressing the Needs
	• *Cooking Class for Women's Expo* • Participation in various community youth events through the schools (middle school/high school) promoting good nutrition Cancer • Screening – increasing screening rate for breast and colon cancer through use of primary care and Medical Home. Health maintenance reminders for breast, colon and cervical cancer screening. Addition of lung cancer screening program for early detection with dedicated lung nodule clinic. • Risk Assessment – implementation of Edith Sanford Athena Breast Cancer Risk assessment program to identify and intervene with women at high risk of breast cancer. Expansion of high risk breast clinic to develop personalized screening plans. Identification of patients and families at high risk for colon and endometrial cancer through consistent genetic tumor testing. Genetic counseling imbedded in clinics for easy access to familial cancer risk assessment. • Treatment – Advanced treatment including targeted therapy based upon tumor genomic analysis and immunotherapy. Clinical trials including NCI-sponsored, investigator initiated and commercial available for patients locally. • Survivorship – Survivor treatment summaries, care plans and visits services to encourage healthy behaviors, reoccurrence prevention and quality of life. Plans include exercise, nutrition, health screenings and mental health aids. Fitness resources: • Aberdeen: o Anytime Fitness – 605-262-5010 o Curves – 605=226-7074 o Snap Fitness – 605-262-7627 o YWCA – 605-225-4910 o School District activities/programs 605-725-7300 o Park District activities/programs 605-626-7015 o Heart & Hear Soul program – 605-225-5680 o Look Good Feel Better – 605-622-5588 o Walk for Wellness – 605-622-5533 • Ipswich: o Community Fitness Center – 605-690-3014 o Golf Association – 605-426-6921 Cancer resources: • American Cancer Society – 605-622-2880 • Avera Cancer Care – 605-622-5500 • Sanford Aberdeen – 605-626-4200 • Cancer Support Group – 605-226-5680 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Chronic Disease resources

Identified Concerns	How Sanford Aberdeen is Addressing the Needs
	• Sanford Better Choices, Better Health • Avera Diabetes Care – 605-622-5000 • Kids with Diabetes support group – 605-622-5161 • Eating Disorders Support Group – 605-229-1500 • Brain Injury Support Group – 605-395-6655 • Chronic Pain Support Group – 605-622-5588 • Diabetes Club – 605-622-5161/605-622-5648 • MS Support Group – 605-225-5740 /605-225-0724 • Stroke Club – 605-622-5733/605-622-5927 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 Nutrition resources: • Avera Aberdeen Dietitians – 605-622-5588 • Sanford Aberdeen Dietitians – 605-626-4600 • Sanford Ipswich Dietitians – 605-426-4060 • Avera Ipswich Dietitians – 605-426-6458 • Brown Co. Extension – 605-626-7120 • Senior Meals – 605-229-4741 • Downtown Farmers Market – 605-226-3441 • Lifestyle Solutions Nutrition Center 605-725-5433 • Eating Disorders Support Group – 605-229-1500 • Senior Nutrition Project, Ipswich, SD 605-426-6018 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431
Mental Health • Under age drug use and abuse • Drug use and abuse • Underage drinking • Stress • Depression • Dementia and Alzheimer's • Smoking and tobacco use	Sanford has developed an implementation strategy to address depression. Substance Abuse resources: • Avera Worthmore Addition Services 605-622-5800 • NADRIC Treatment Center – 605-225-6131 • Alcoholics Anonymous – 605-225-1292 • Al-Anon – 605-225-5680 • Al-Anon Family Group – 605-229-0846 • Narcotics Anonymous – 605-229-8562 • Alano Society – 605-225-1292 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Mental Health resources: • NE Mental Health – 605-225-1010 • Awakening Counselors – 605-725-2701 • Northern Plains Psychological – 605-225-3622 • Avera – 605-622-5000 • Behavior Care Specialists – 605-262-2162 • Lutheran Social Services – 605-229-1500 • Breakthrough Psychologists – 605-725-5505 • Avera Psychiatric Associates – 605-622-2545 • Catholic Family Services Counseling 605-226-1304 • NSU Counseling Center – 605-626-2371 • Aberdeen Boys & Girls Club – 605-225-8714 (counseling available to anyone who seeks it) • New Beginnings Center - 605-229-1239 • Health Oriented Psychiatric & Education 605-226-3326

Identified Concerns	How Sanford Aberdeen is Addressing the Needs
	• Professional Counseling – 605-229-2029 • NSU Counseling Center - 605-626-2371 • Sanford Aberdeen – 605-626-4600 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Memory Care/Alzheimer's resources: • Alzheimer's – 605-339-4543 • Alzheimer's Family Support Group 605-626-3330 • Primrose Retirement Community – 605-277-4014 • Primrose Cottages – 605-226-4040 • ManorCare - 605-225-2550 • Nano Nagle Village – 605-622-5850 • Bethesda Town Square – 605-225-7600 • Brain Injury Support Group – 605-395-6655 Smoking Cessation resources: • Aberdeen Hypnosis – 605-225-1877 • SD Tobacco Prevention – 605-626-2229 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431

SANFORD HEALTH

2017-2019 Implementation Strategies

Implementation Strategies

Health Needs Identified
Two identified needs for the area are physical health and mental health.

Implementation Strategy
The following were identified through a formal community health needs assessment, resources mapping and prioritization process:

- Physical Health
- Mental Health

Implementation Strategy – Physical Health

- Improve care of patients with obesity diagnosis through referring patients to internal and external services, including registered dietitians, exercise physiologists, and Health Coaches.
- Provide education to local schools and child care centers about the Sanford Health *fit* initiative, a childhood obesity prevention initiative. *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).

Implementation Strategy – Mental Health

- Improve care of patients with depression diagnosis through improving PHQ-9 scores for patients with major depression.
- Continue ongoing education to all Health Coaches and panel specialists to standardize workflow.

Community Health Needs Assessment
Implementation Strategy for Aberdeen Medical Center

FY 2017-2019 Action Plan

Priority 1: Physical Health

Projected Impact: Increase awareness of physical fitness activities through creating an environment where healthy choices are the everyday choice and are supported by improving access, availability, education and community support of physical activity and nutrition that helps residents take responsibility for decisions that support good health.

Goal: Improve Care of Patients with Obesity Diagnosis

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Provide Sanford *fit* program to the local schools and child care centers	Sanford *fit* is available to all students and families in the area through classroom and *fit* website	Sanford *fit* Leadership; Teachers	Sanford Leaders	Local schools Child Care Leaders

Priority 2: Mental Health

Projected Impact: Increase awareness of mental health services available in the community and how to access those resources along with providing education regarding mental health services to aid in reducing the occurrences of illness and death brought on by these conditions.

Goal: Improve Care of Patients with Depression Diagnosis

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Develop Sanford *My Chart* capabilities for depression assessment	Percentage of patients with major depression or dysthymia and an initial PHQ-9 score greater than nine whose six-month PHQ-9 score was less than five	Sanford Clinical Services/IT Leadership	CMO, CNO, Clinic Director	
Provide education on workflow to all Health Coaches and panel specialists to standardize workflow	All Health Coaches and staff in primary care staff receive education on workflow	All Health Coaches	CMO, CNO, Clinic Director	

SANFORD HEALTH

2013 Implementation Strategy Impact

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:

Implementation Strategy: Mental Health Services

- Establish adolescent and adult mental health telemedicine services from Sanford Aberdeen to Sanford Medical Center in Sioux Falls, SD.

Implementation Strategy: Bariatric Services

- Establish a Sanford Aberdeen-based Bariatric Services accredited program

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.

When the 2013 community health needs assessment was conducted we learned of the concerns for physical health and mental health in our community and the need for additional services. Implementation strategies were put into place to address the needs of the increasing obesity rates and mental health rates. Sanford Aberdeen has implemented a bariatric program to provide services to obese and overweight patients. Sanford Aberdeen also implemented telemedicine services for adolescent and adult mental health patients to serve patients in our community.

Community Feedback from the 2013 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on our 2013 Community Health Needs Assessment and has provided on-line comment fields for ease of access on our website. There have been no comments to date .

APPENDIX

Primary Research

Aberdeen 2016 CHNA Asset Map

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
Economics	• Availability of affordable housing 3.65	Add data from Edmunds County	Severe housing problem is at 9% compared to 9% nationally and 12 % statewide	Housing & Hsg. Assistance resources: • Aberdeen Hsg. Authority – 605-226-2321 • Homes Are Possible, Inc. – 605-225-4274 • Habitat for Humanity – 605-226-5492 • USDA Rural Development – 605-226-3360 • Brown County Welfare (rent assistance) – 605-626-7125 • LSS Center for Financial Resources – 605-229-5140 (delinquency mortgage counseling & foreclosure prevention) • Benefits Specialist – 605-626-2396 (assistance with managing Social Security benefits, food stamps, public assistance) • Dept. of Social Services – 605-626-3160 (energy & weatherization assistance, temporary assistance for needy families) • United Senior Housing, Ipswich SD – 605-426-6044 • Prairie View Housing, Inc., Bowdle, SD – 605-285-6611 Low Income Housing: • Sherman Apts. – 605-225-9095 • Aberdeen Hsg. Authority – 605-226-2321 • Jackson Hts. Apts. – 605-226-2321 • Homestead Apts. – 605-225-9095 • Meadow Wood Townhomes – 605-226-2321 • CCCs of LSS – 605-229-5140 • Sunrise Apts. – 605-229-0263 • Mel-Ros Village – 605-225-4022 • Lawson View Townhomes – 605-226-2321 • Golden West – 605-225-3933 • Fifth Ave. South – 605-225-9504 • Dakota Square – 701-667-6002 • Bicentennial Apts. – 605-225-4022 • United Senior Housing, Ipswich SD – 605-426-6044 • Prairie View Housing, Inc., Bowdle, SD – 605-285-6611 Apartments:	X

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				• M & I Apartments – 605-229-8632 • Paramount Apts. – 605-229-8632 • Depot Apts. – 605-725-2030 • Dakota Estates – 605-277-3348 • Prairie Springs – 605-725-2387	
Environment	Water quality 3.74		1% drinking water violation compared to 0% nationally and 3% statewide		X
Aging population	• Cost of LTC 3.97 • Availability of memory care 3.53		21% are 65 or older	Nursing Homes: • ManorCare – 605-225-2550 • Bethesda Home – 605-225-7900 • Aberdeen Health & Rehab – 605-225-7315 • Avera Mother Joseph – 605-622-5000 • Golden Living Center, Ipswich SD – 605-426-6622 • Bowdle Healthcare, Bowdle, SD - 605-285-6146 • Senior Citizen Home, Hosmer, SD – 605-283-2203 Memory Care resources: • Alzheimer's – 605-339-4543 • Alzheimer's Family Support Group – 605-626-3330 • Primrose Retirement Community – 605-277-4014 • Primrose Cottages – 605-226-4040 • ManorCare - 605-225-2550 • Nano Nagle Village – 605-622-5850 • Bethesda Town Square – 605-225-7600 • Brain Injury Support Group – 605-395-6655 • Golden Living Center, Ipswich SD – 605-426-6622 • Bowdle Healthcare, Bowdle, SD - 605-285-6146 • Senior Citizen Home, Hosmer, SD – 605-283-2203 Resources for Seniors: • Senior Center – 605-626-3330 • Senior Meals – 605-229-4741 • AngelKare Home Caregiving Services – 605-262-0506 • Lifeline – 605-225-5070 • Adult Services & Aging – 605-626-3145 • Brown Co. Poor Relief – 605-626-7126 • Brown Co. Health Dept. – 605-626-2649	X

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				• Journey Home (food boxes) – 605-262-0514 • SNAP (Food Stamps) – 605-626-3160 • Salvation Army – 605-225-7410 • Volunteers of America – 605-262-1007 • Senior Citizens Club, Ipswich, SD • Senior Nutrition Project, Ipswich, SD – 605-426-6018 • Senior Center, Bowdle, SD – 605-285-6300 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	
Children and Youth	• Bullying 3.69 • Cost of infant care 3.50		Children in poverty is at 12% in Brown County, 13% nationally and 19% in SD Children in single-family households is at 26% in Brown County, 20% nationally and 31% in SD	Bullying resources: • Brown Co. Sheriff – 605-626-7100 • Aberdeen Police – 605-626-7000 • Aberdeen School System Counselors – 605-725-7100 • Ipswich School District – 605-426-6561 • Sanford Health Ipswich Clinic – 605-426-6040 Mental Health counselors: • NE Mental Health – 605-225-1010 • Awakening Counselors – 605-725-2701 • Northern Plains Psychological – 605-225-3622 • Avera – 605-622-5000 • Behavior Care Specialists – 605-262-2162 • Lutheran Social Services – 605-229-1500 • Breakthrough Psychologists – 605-725-5505 • Avera Psychiatric Associates – 605-622-2545 • Catholic Family Services Counseling – 605-226-1304 • NSU Counseling Center – 605-626-2371 • Aberdeen Boys & Girls Club – 605-225-8714 (counseling available to anyone who seeks it) • New Beginnings Center - 605-229-1239 • Health Oriented Psychiatric & Education – 605-226-3326 • Professional Counseling – 605-229-2029 • NSU Counseling Center - 605-626-2371 • Public Health, Bowdle, SD – 605-	X

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				285-6419 • Health Dept., Ipswich SD – 605-426-6431 Resources for children in poverty: • Sanford Health Community Care Program – 701-626-4200 • Avera Health Community Care Program – 605-622-5000 • Community Health Center – 605-725-3900 • Brown Co. Dept. of Health - Baby Care Program – 605-626-2649 • Hub Area Birth to 3 Connections - 605-622-5992 (free development screenings, parent education, service coordination) • WIC – 605-626-2626 • Title XIX (Medicaid) – 605-626-3160 • Brown Co. Poor Relief – 605-626-7126 • Brown Co. Health Dept. – 605-626-2649 • Journey Home (food boxes) – 605-262-0514 • SNAP (Food Stamps) – 605-626-3160 • Salvation Army – 605-225-7410 • Volunteers of America – 605-262-1007 • Brown County Welfare (rent assistance) – 605-626-7125 • LSS Center for Financial Resources – 605-229-5140 (delinquency mortgage counseling & foreclosure prevention) • Benefits Specialist – 605-626-2396 (assistance with managing Social Security benefits, food stamps, public assistance) • Dept. of Social Services – 605-626-3160 (energy & weatherization assistance, SNAP, temporary assistance for needy families) • Dept. of Social Services Child Care Services – 605-626-2345 (financial help for child care costs) • Sanford CHILD Services – 605-262-8505 (child car seats available to low income families) • Dept. of Labor Temporary Assistance for Needy Families – 605-626-2340 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				Child Care Providers: • Aberdeen: ○ Bethesda Sharing Center – 605-225-7596 ○ Roncalli Primary School – 605-225-3460 ○ Sanford Child Care Center – 605-262-8505 ○ Northern State University – 605-626-3011 ○ 4 Seasons – 605-226-3237 ○ After the Bell – 605-229-1300 ○ Dare to Dream – 605-725-5939 ○ Little Miracles – 605-262-5454 ○ Rainbows & Teddies – 605-725-1204 • Ipswich: ○ Tracy's Tigers Daycare – 605-426-6717 ○ Little Wonders – 605-426-6151 ○ Sara Schreurs Daycare – 6050-426-6648	
Safety	• Presence of street drugs, and alcohol in the community 3.82 • Domestic violence 3.66 • Child abuse and neglect 5.51		Excessive drinking is 21% in Brown County, 10% nationally and 19% in SD Alcohol impaired deaths 22% in Brown County, 14% nationally, and 37% in SD Violent crimes 202 compared to 59 nationally and 282 in SD	Substance Abuse resources: • Avera Worthmore Addition Services – 605-622-5800 • NADRIC Treatment Center – 605-225-6131 • Alcoholics Anonymous – 605-225-1292 • Al-Anon – 605-225-5680 • Al-Anon Family Group – 605-229-0846 • Narcotics Anonymous – 605-229-8562 • Alano Society – 605-225-1292 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Safety resources: • Brown Co. Sheriff – 605-626-7100 • Aberdeen Police – 605-626-7000 • Rape Task Force – 605-226-1212 Domestic Violence resources: • East River Legal Services – 605-336-9230 • Brown County Crime Victim Assistance - 605-626-7130	X

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				• Safe Harbor – 605-226-1212 • Resource Center for Women – 605-226-1212 • SD Coalition Against Domestic Violence – 605-225-5122 • Salvation Army – 605-225-7410 • Rape Task Force – 605-226-1212 • Support Groups - LSS – 605-229-1500 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Child abuse & neglect resources: • Brown Co. Child Abuse & Neglect – 605-626-2388 • Safe Harbor – 605-226-1212 • LSS – 605-229-1500 • New Beginnings – 605-229-1239 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	
Health Care	• Access to affordable health insurance 3.70		11% are uninsured	• Sanford Health Community Care Program – 605-626-4200 • Avera Health Community Care Program – 605-622-5000 • Community Health Center – 605-725-3900 • Avera Ipswich Clinic – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	X
Physical Health	• Obesity 3.88 (68.4% report as overweight or obese) • Poor nutrition and eating habits 3.82 (39% have 3 or more vegetables/d, 23.8% have 3 or more fruits/d) • Cancer 3.74 • Inactivity and exercise 3.73 (54% exercise moderately 3x or more /week, 23.4% exercise vigorously 3 or more x/week) • Chronic disease 3.55 (Hypertension, arthritis are the top diseases)		Poor physical health days is at 2.8 compared to 2.5 nationally and 2.7 in SD Adult obesity 30% compared to 25% nationally Physical inactivity is at 25% compared to 20% nationally Diabetic monitoring is at 91% compared to the national 90% Mammography is at 72.4% compared to 70.7% nationally and 66.5% in SD	Fitness resources: • Aberdeen: ○ Anytime Fitness – 605-262-5010 ○ Curves – 605=226-7074 ○ Snap Fitness – 605-262-7627 ○ YWCA – 605-225-4910 ○ School District activities/programs – 605-725-7300 ○ Park District activities/programs – 605-626-7015 ○ Heart & Hear Soul program–605-225-5680 ○ Look Good Feel Better – 605-622-5588 ○ Walk for Wellness – 605-622-5533 • Ipswich: ○ Community Fitness Center – 605-690-3014	X

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
			Hypertension is at 31.3% High cholesterol is at 33.9%	○ Golf Association – 605-426-6921 Cancer resources: • American Cancer Society – 605-622-2880 • Avera Cancer Care – 605-622-5500 • Sanford Aberdeen – 605-626-4200 • Cancer Support Group – 605-226-5680 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Chronic Disease resources • Sanford Better Choices, Better Health • Avera Diabetes Care – 605-622-5000 • Kids with Diabetes support group – 605-622-5161 • Eating Disorders Support Group – 605-229-1500 • Brain Injury Support Group – 605-395-6655 • Chronic Pain Support Group – 605-622-5588 • Diabetes Club – 605-622-5161/605-622-5648 • MS Support Group – 605-225-5740 / 605-225-0724 • Stroke Club – 605-622-5733/605-622-5927 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 Nutrition resources: • Avera Aberdeen Dietitians – 605-622-5588 • Sanford Aberdeen Dietitians – 605-626-4600 • Sanford Ipswich Dietitians – 605-426-4060 • Avera Ipswich Dietitians – 605-426-6458 • Brown Co. Extension – 605-626-7120 • Senior Meals – 605-229-4741 • Downtown Farmers Market – 605-226-3441 • Lifestyle Solutions Nutrition Center – 605-725-5433 • Eating Disorders Support Group – 605-229-1500	

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				• Senior Nutrition Project, Ipswich, SD – 605-426-6018 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	
Mental Health/Behavioral Health	• Underage drug use and abuse 3.76 • Drug use and abuse 3.71 • Underage drinking 3.58 • Stress 3.55 • Depression 3.53 • Dementia and Alzheimer's disease 3.53 • Smoking and tobacco 3.50 • 40.7% of respondents drink at a binge level		Alcohol is at 47.7% Depression is at 6.1% Anxiety is at 6.3% PTSD is at 5.3% Adult smoking is at 18% compared to 14% nationally 3 or more ACEs – 17.4% 5 or more ACEs - 9.6%	Substance Abuse resources: • Avera Worthmore Addition Services – 605-622-5800 • NADRIC Treatment Center – 605-225-6131 • Alcoholics Anonymous – 605-225-1292 • Al-Anon – 605-225-5680 • Al-Anon Family Group – 605-229-0846 • Narcotics Anonymous – 605-229-8562 • Alano Society – 605-225-1292 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Mental Health resources: • NE Mental Health – 605-225-1010 • Awakening Counselors – 605-725-2701 • Northern Plains Psychological – 605-225-3622 • Avera – 605-622-5000 • Behavior Care Specialists – 605-262-2162 • Lutheran Social Services – 605-229-1500 • Breakthrough Psychologists – 605-725-5505 • Avera Psychiatric Associates – 605-622-2545 • Catholic Family Services Counseling – 605-226-1304 • NSU Counseling Center – 605-626-2371 • Aberdeen Boys & Girls Club – 605-225-8714 (counseling available to anyone who seeks it) • New Beginnings Center - 605-229-1239 • Health Oriented Psychiatric & Education – 605-226-3326 • Professional Counseling – 605-229-2029 • NSU Counseling Center - 605-626-2371 • Sanford Aberdeen – 605-626-4600	X

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				• Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Memory Care/Alzheimer's resources: • Alzheimer's – 605-339-4543 • Alzheimer's Family Support Group – 605-626-3330 • Primrose Retirement Community – 605-277-4014 • Primrose Cottages – 605-226-4040 • ManorCare - 605-225-2550 • Nano Nagle Village – 605-622-5850 • Bethesda Town Square – 605-225-7600 • Brain Injury Support Group – 605-395-6655 Smoking Cessation resources: • Aberdeen Hypnosis – 605-225-1877 • SD Tobacco Prevention – 605-626-2229 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	
Preventive Health	• 30% of children have not had a flu shot		STDs at 297 is higher than the national benchmark of 138, SD is at 471 Teen births at 29, is higher than the national benchmark of 20. SD is at 37	Clinics: • Sanford Aberdeen – 605-626-4200 • Avera Health – 605-622-5000 • Community Health Center – 605-725-3900 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431 Teen Pregnancy/Teen Parenthood resources: • Sanford Aberdeen – 605-626-4200 • Avera Aberdeen – 605-622-5000 • Community Health Center – 605-725-3900 • Common Sense Parenting – 605-622-5588 • Breast Feeding Support –	

Identified concern	Key stakeholder survey Specific concern and rating	Key stakeholder Focus group	Secondary data	Community resources that are available to address the need	Gap?
				605-622-5567 • Birthright – 605-229-0258 • Pregnant Teens & Teen Moms Support Group – 605-626-7900 • Brown Co. DOH Baby Care Program – 605-626-2649 • Hub Area Birth to 3 Connections – 605-622-5992 • Dept. of Social Services Child Care Services – 605-626-2345 (financial aid for child care costs for parents who are going to school) • Sanford CHILD Services – 605-262-8505 (car seats to low income families) • Catholic Family Services pregnancy counseling – 605-226-1304 • Brown Co. WIC – 605-626-2626 • Sanford Ipswich – 605-426-6040 • Avera Ipswich – 605-426-6458 • Public Health, Bowdle, SD – 605-285-6419 • Health Dept., Ipswich SD – 605-426-6431	

Aberdeen 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 (H1N1 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 3.65			
Environment • Good water quality 3.74	1		
Aging • Cost of long term care 3.97 • Availability of memory care 3.53			
Children and Youth • Bullying 3.69 • Cost of quality infant care 3.50			
Safety • Presence of street drugs, and alcohol in the community 3.82 • Domestic violence 3.66 • Child abuse 3.51	2		
Health Care • Access to affordable health insurance 3.70	2		
Physical Health • Obesity 3.88 • Poor nutrition and eating habits 3.82 • Cancer 3.74 • Inactivity and lack of exercise 3.73 • Chronic Disease 3.55	**7** **#1 priority**		
Mental Health • Under age drug use and abuse 3.76 • Drug use and abuse 3.71 • Underage drinking 3.58 • Stress 3.55 • Depression 3.53 • Dementia and Alzheimer's 3.53 • Smoking and tobacco use 3.50	**4** **#2 priority**		
Preventive Health			

Present: Dawn Williams, Carl Perry, Cam Schock, Becky Guffin, Mike Herman, Josh Moon, Carole Curtis

SANFORD HEALTH

Sanford Aberdeen Medical Center

Community Health Needs Assessment

Results from a May 2015 Non-Generalizable

Online Survey

August 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a May 2015 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 2015 and a total of 66 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

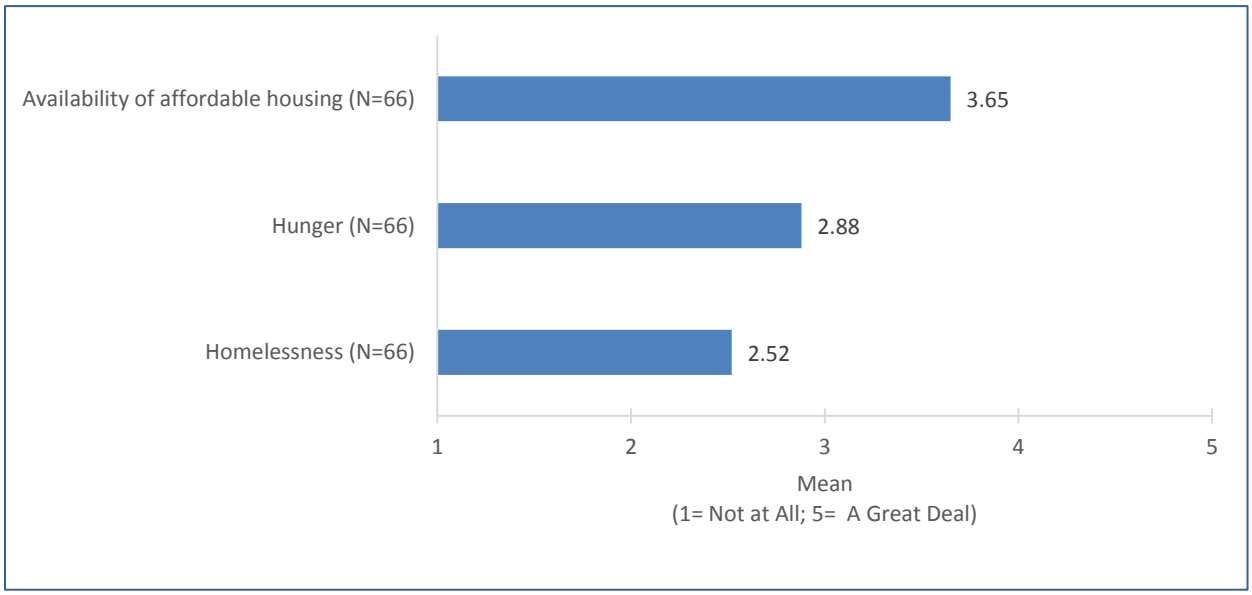


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

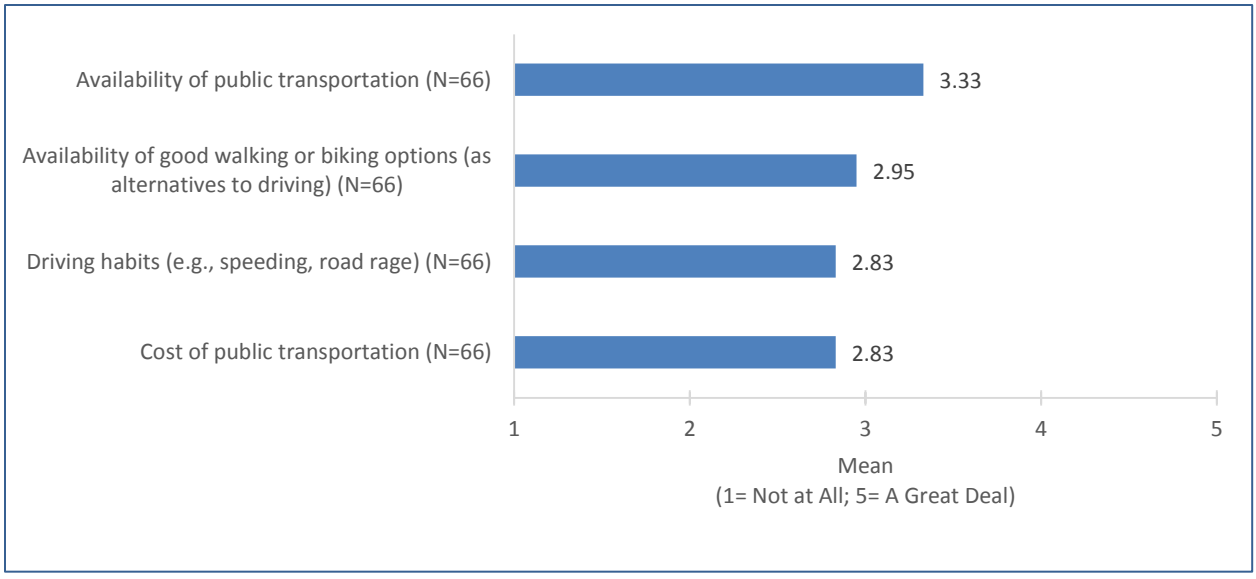


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

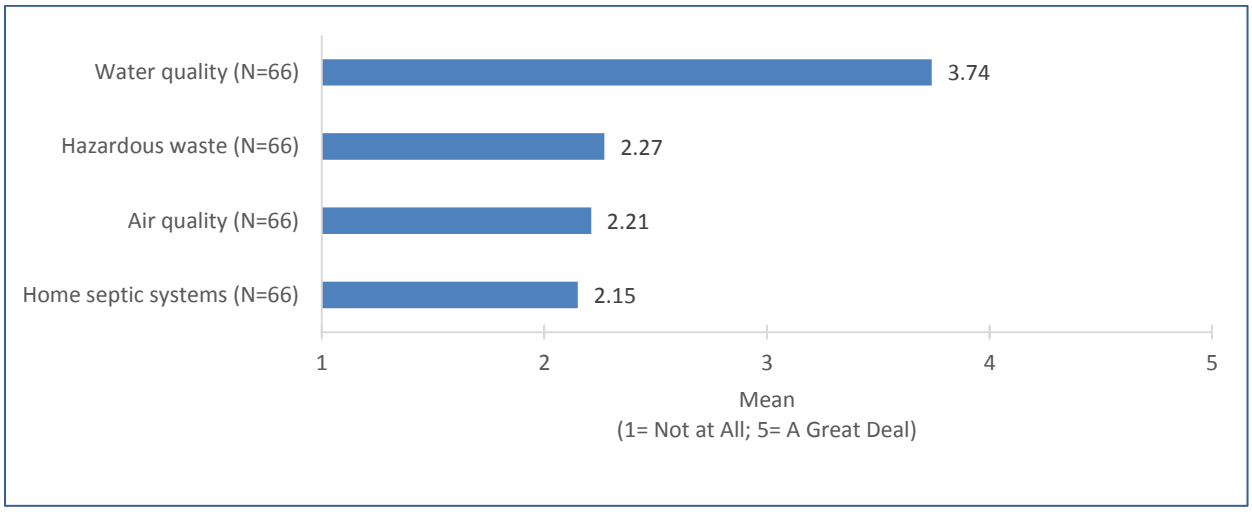


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

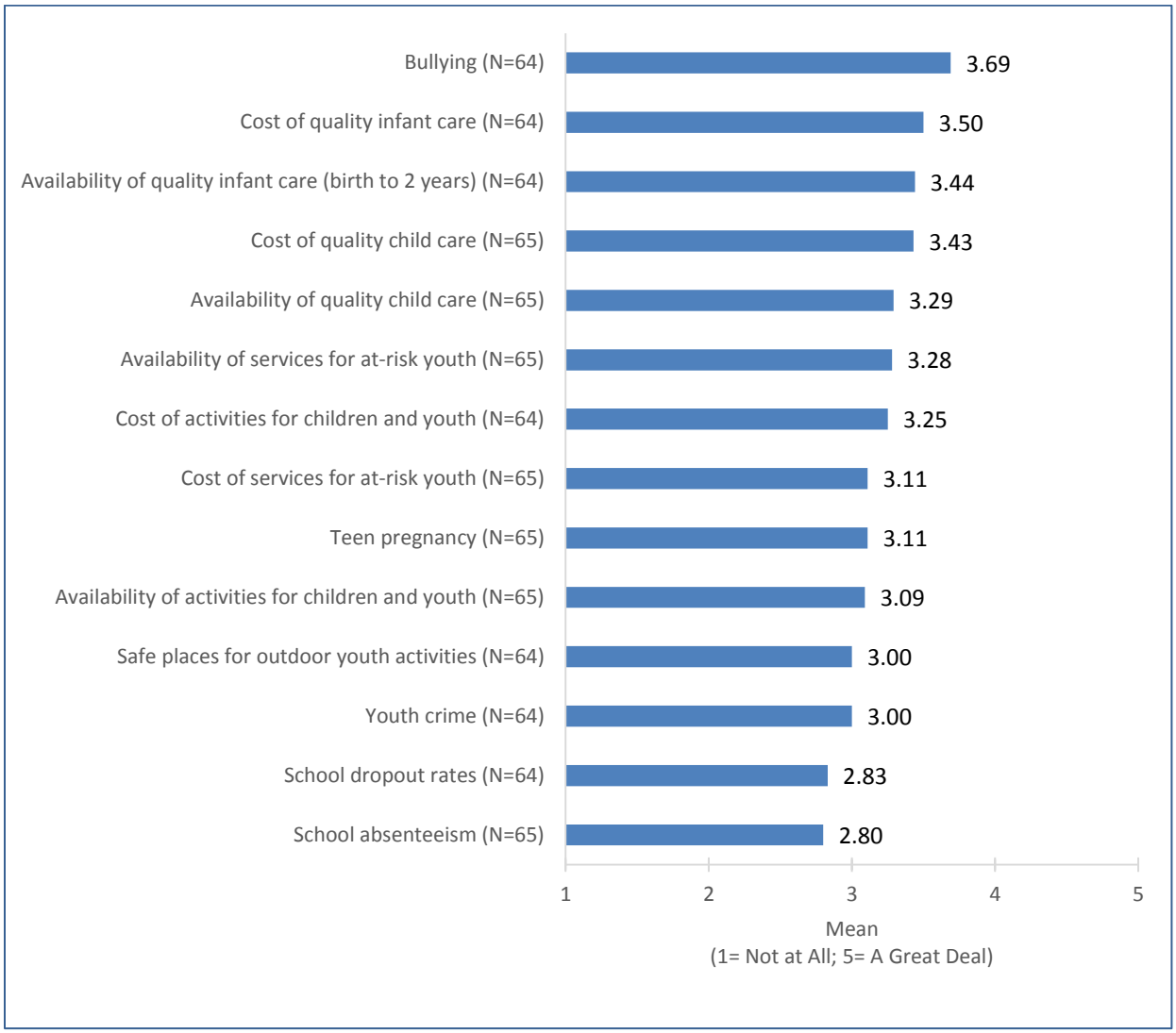


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

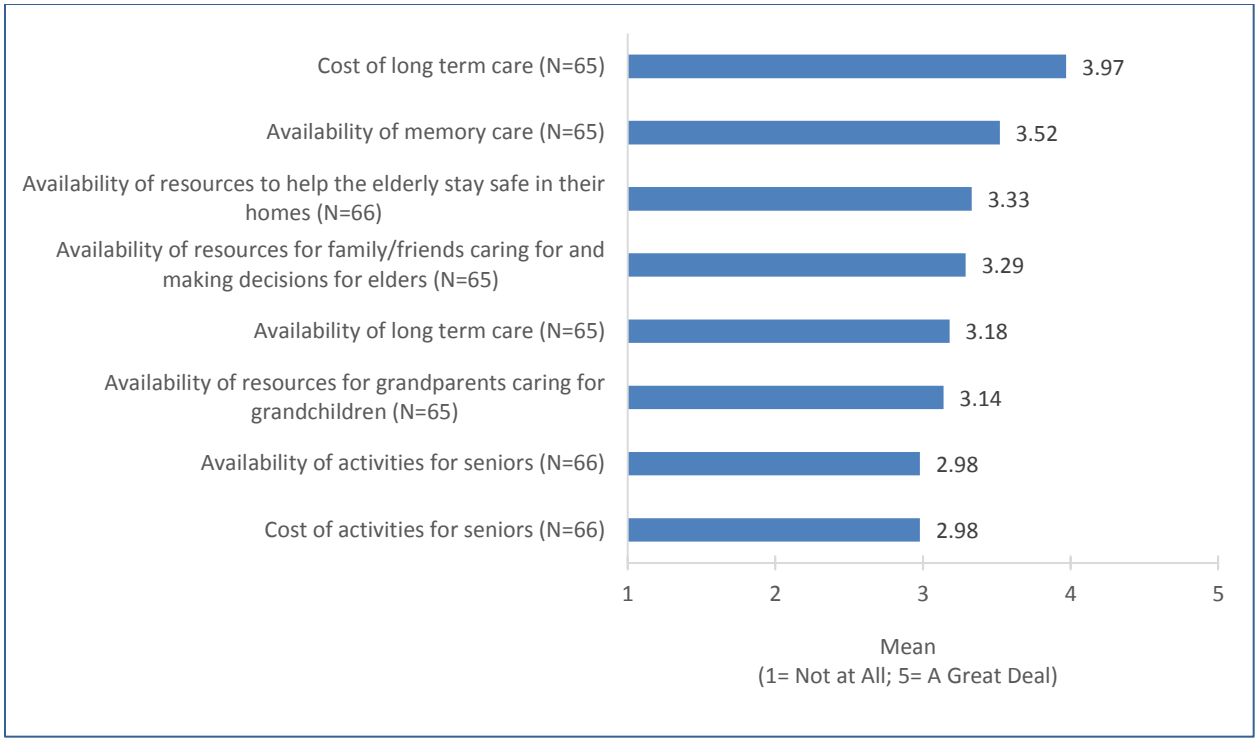


Figure 6. Level of concern with statements about the community regarding SAFETY

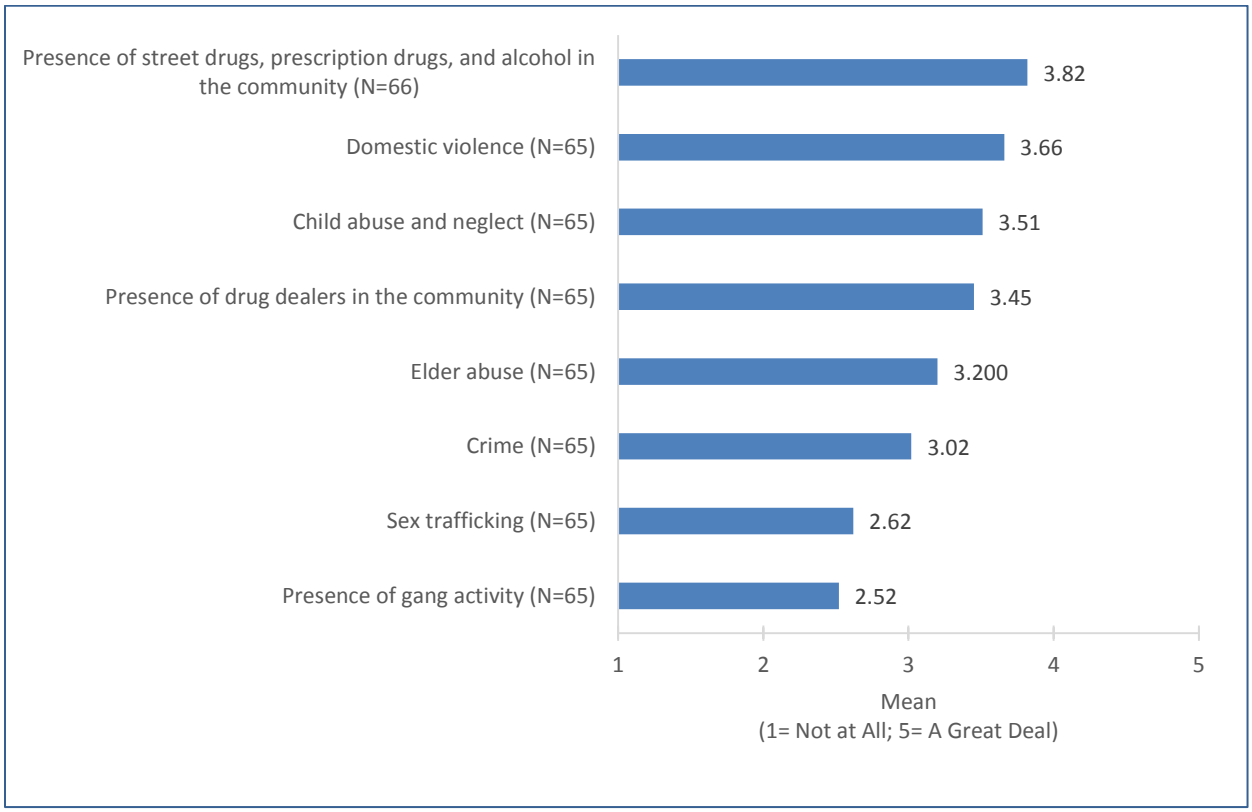


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

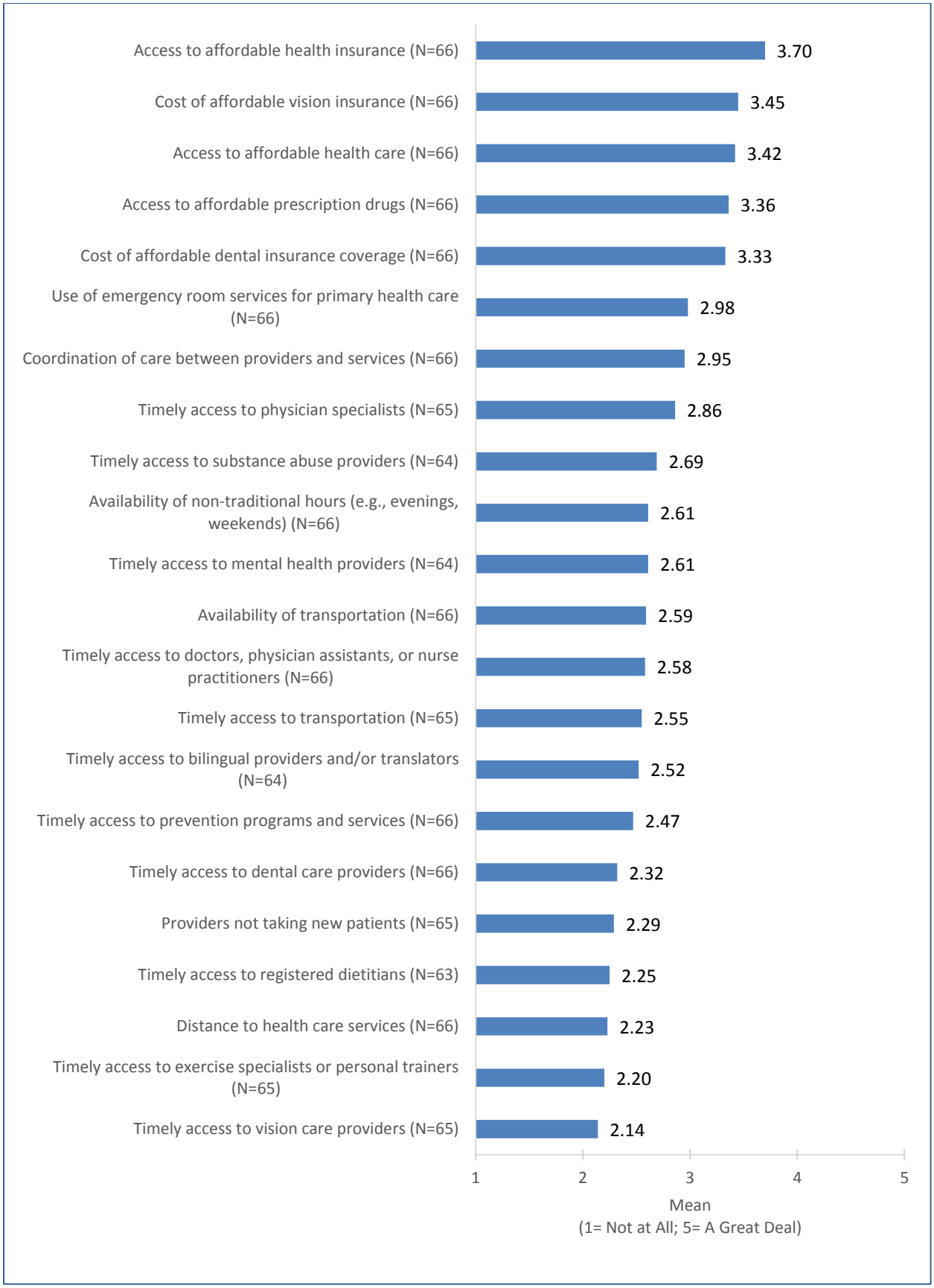


Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

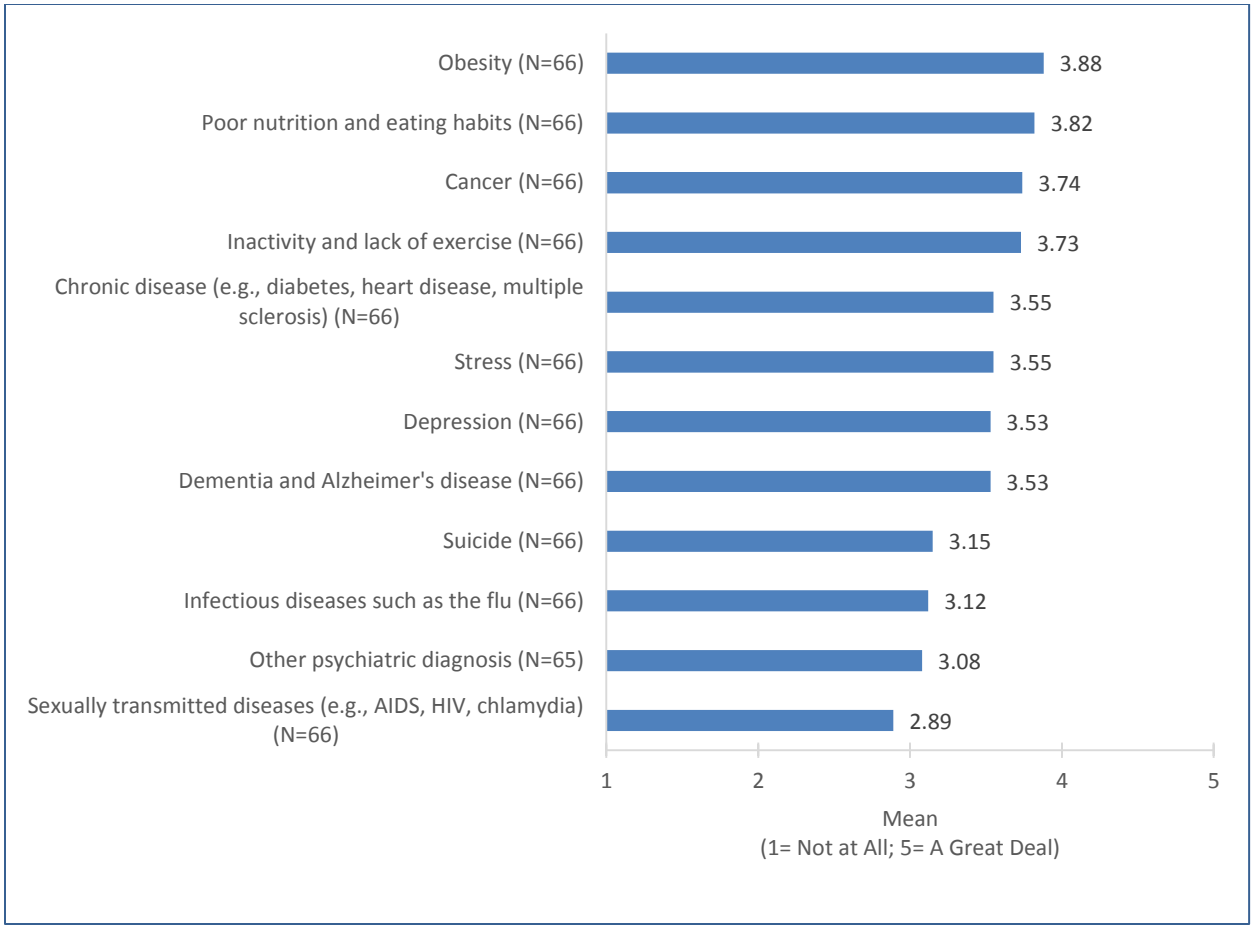
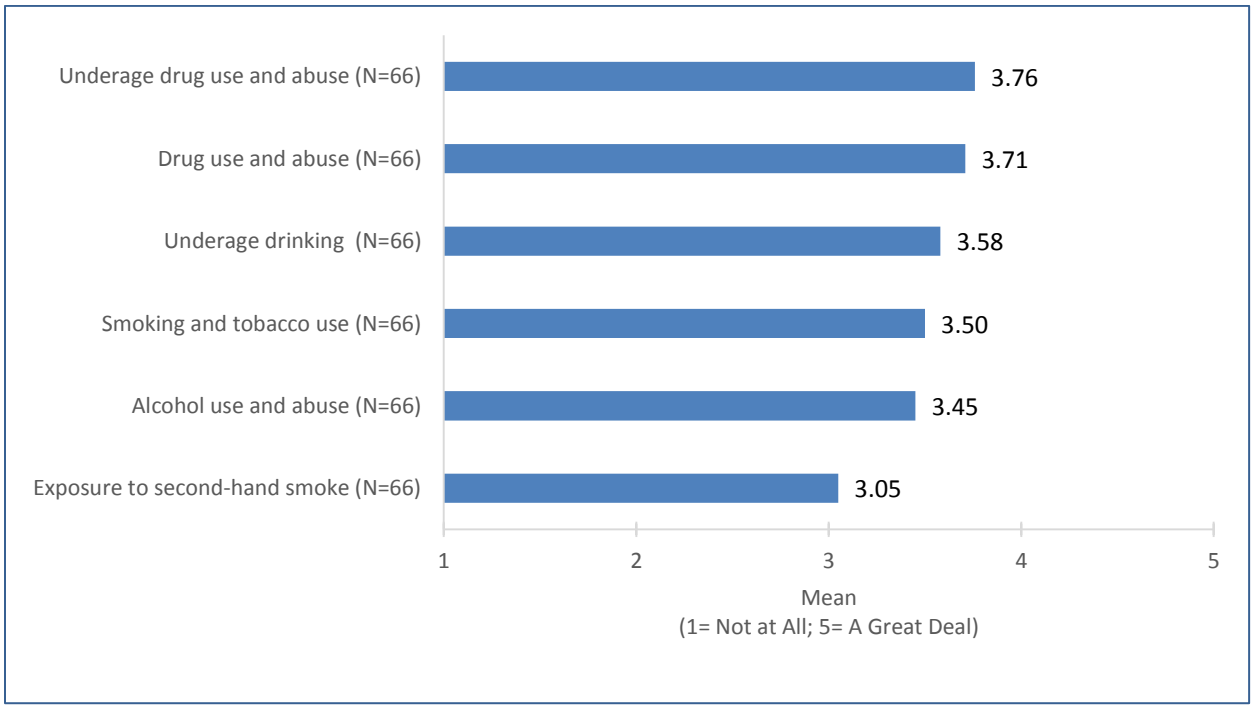
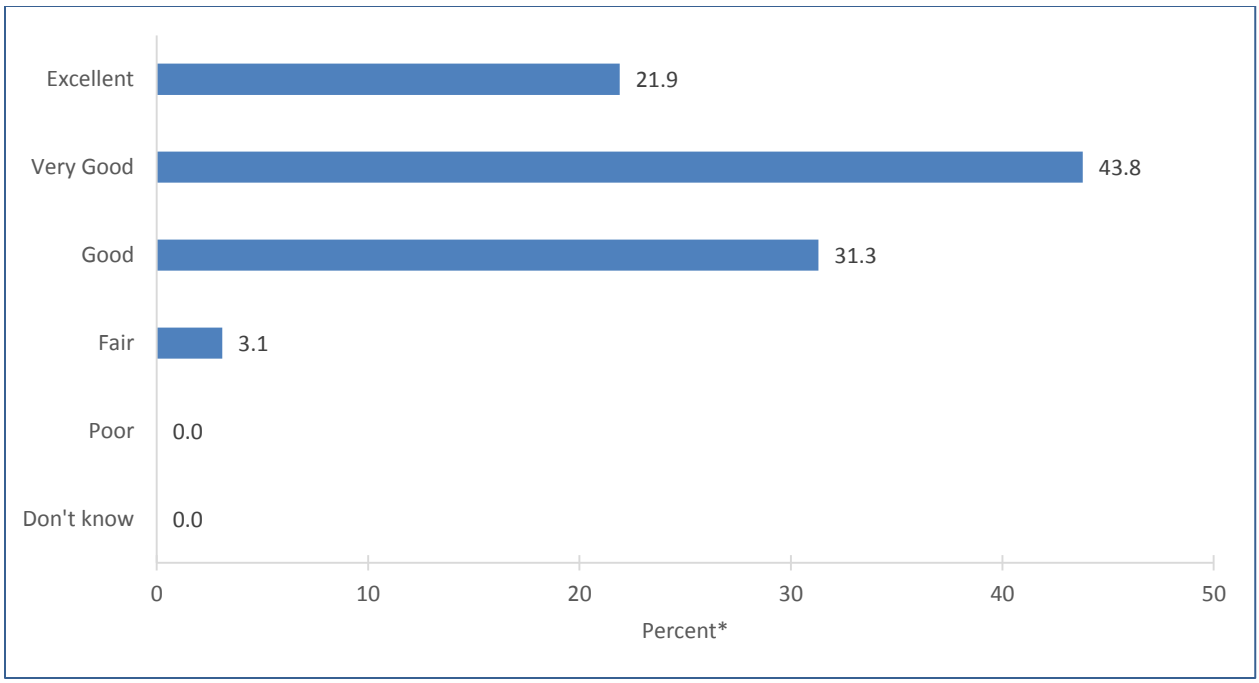


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



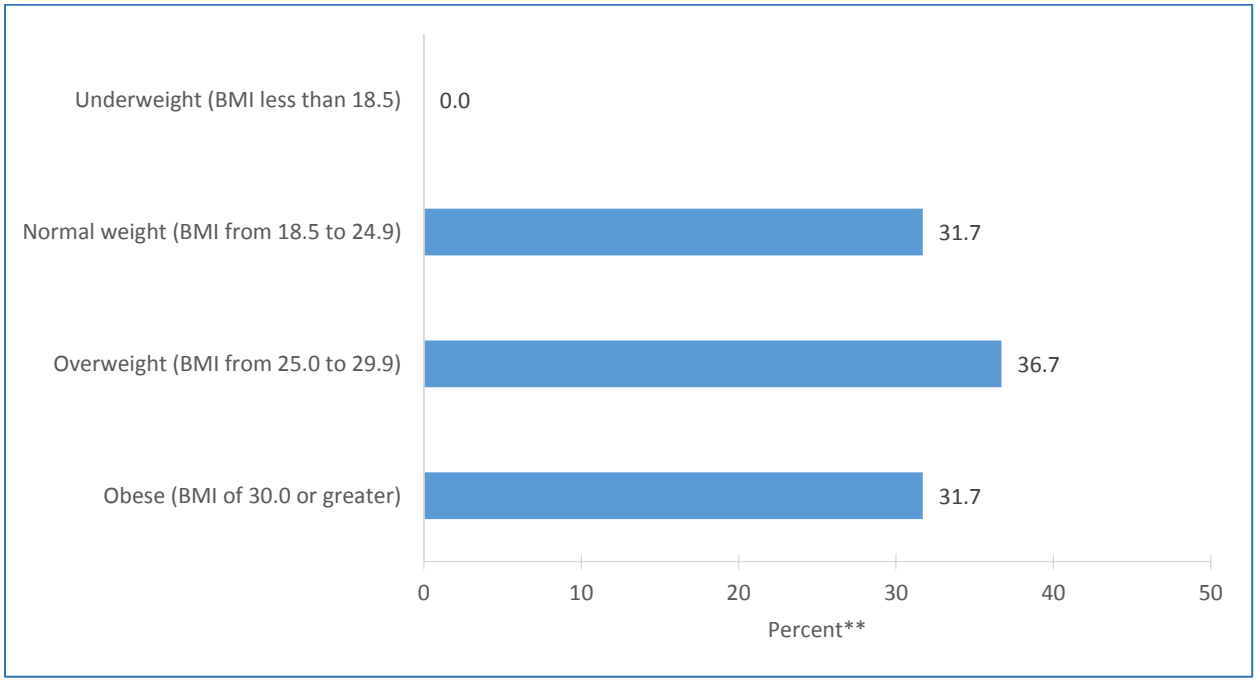
General Health

Figure 10. Respondents' rating of their health in general



N=64 *Percentages do not total 100.0 due to rounding.

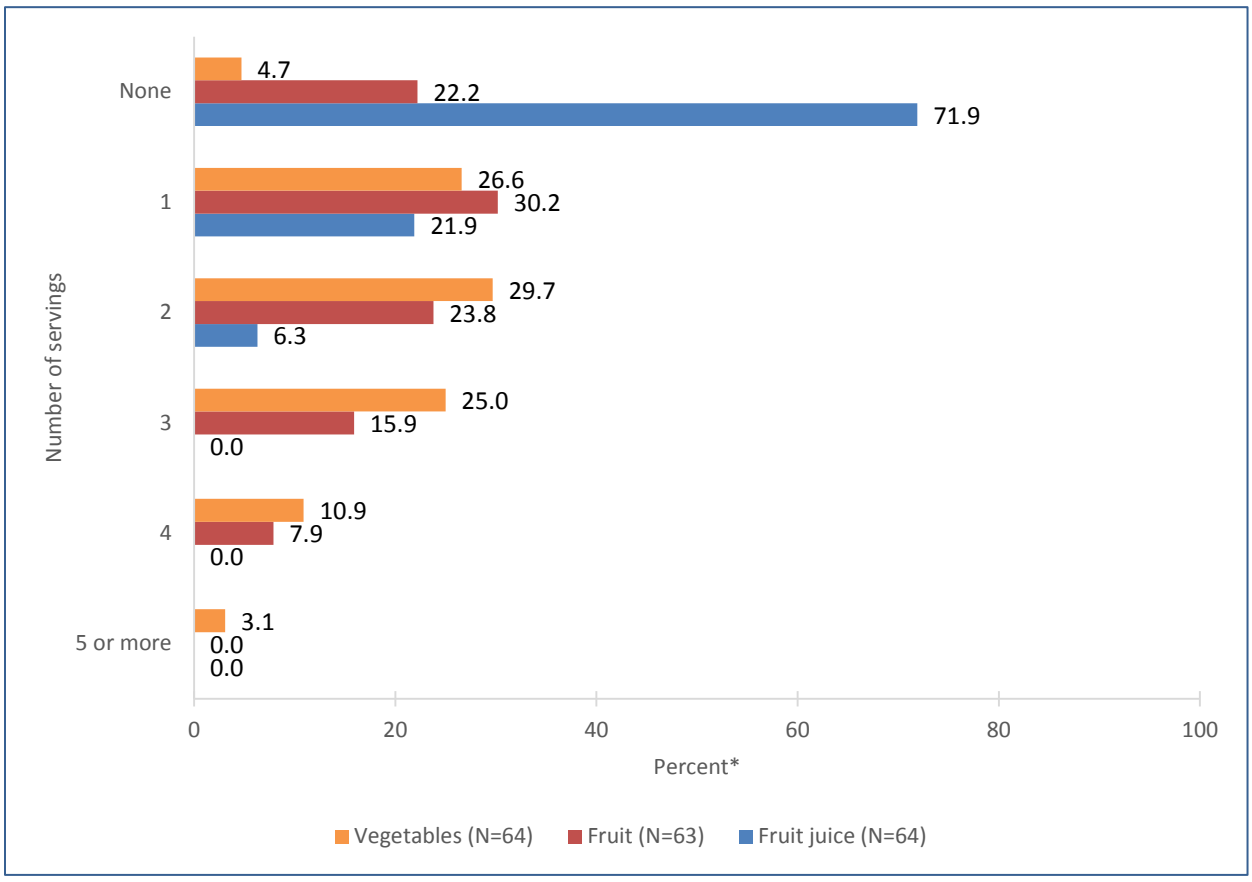
Figure 11. Respondents' weight status based on the Body Mass Index (BMI)* scale



N=60 *For information about the BMI, visit the Center for Diseases Control and Prevention, *About BMI for Adults* www.cdc.gov/healthyweight/assessing/bmi/.

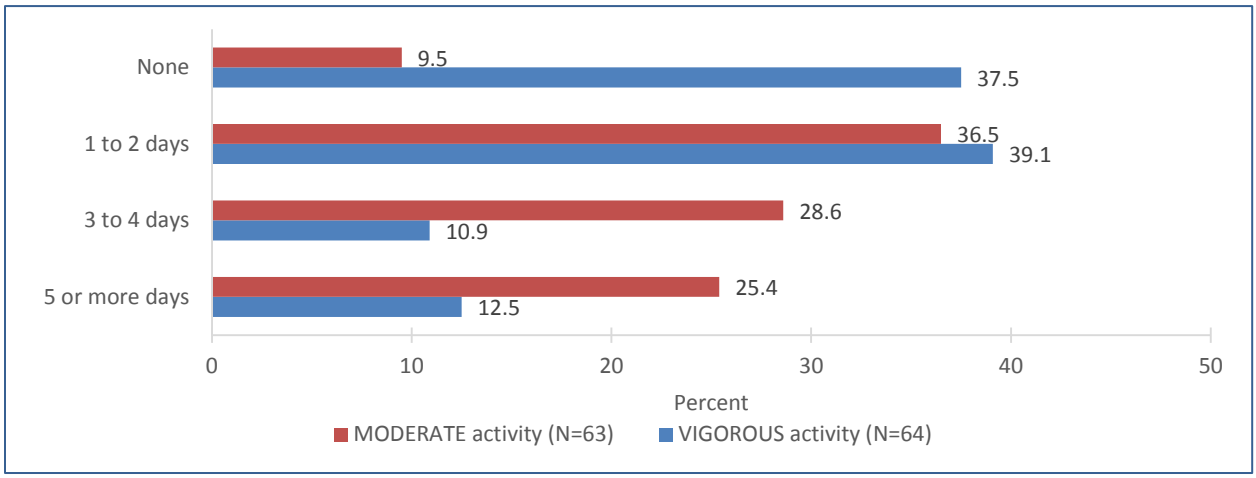
** Percentages do not total 100.0 due to rounding.

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



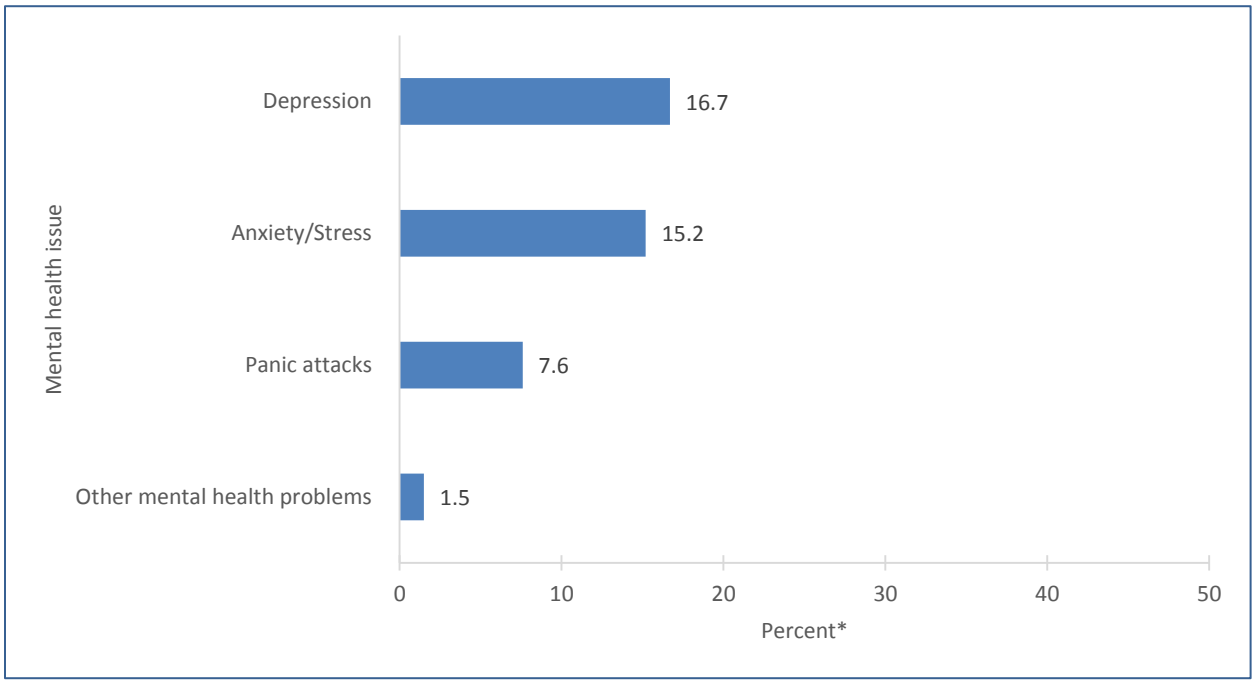
*Percentages may not total 100.0 due to rounding.

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



Mental Health

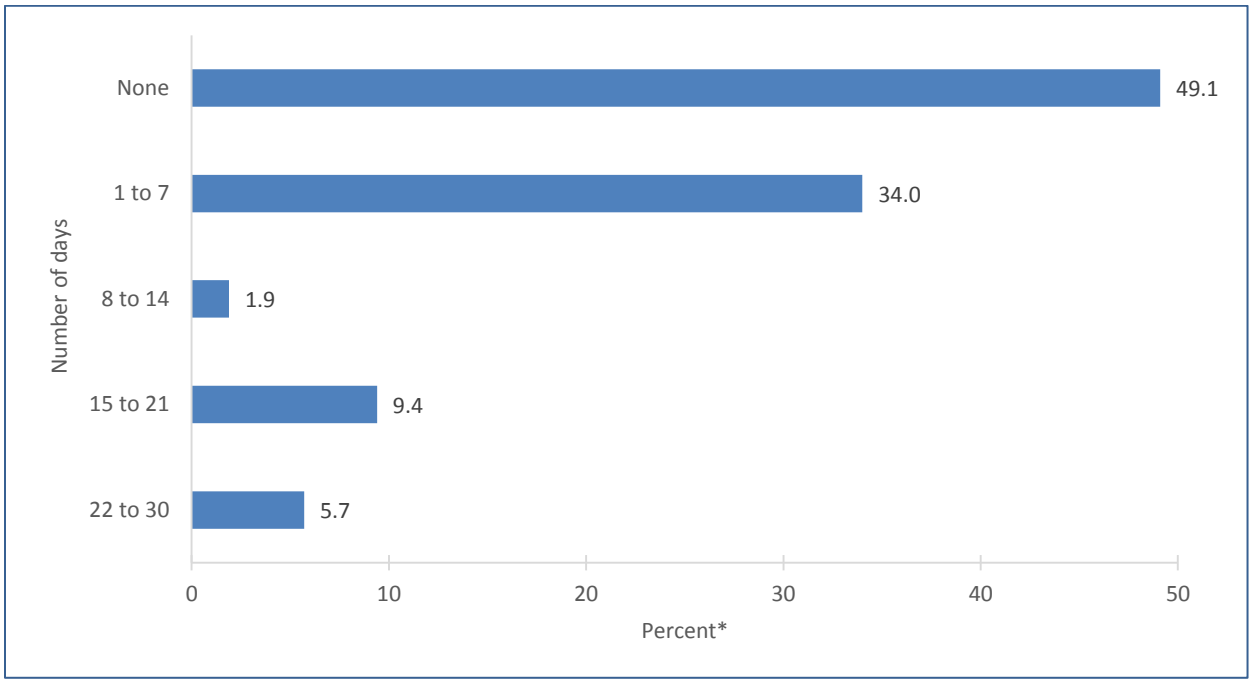
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=66

*Percentages do not total 100.0 due to multiple responses.

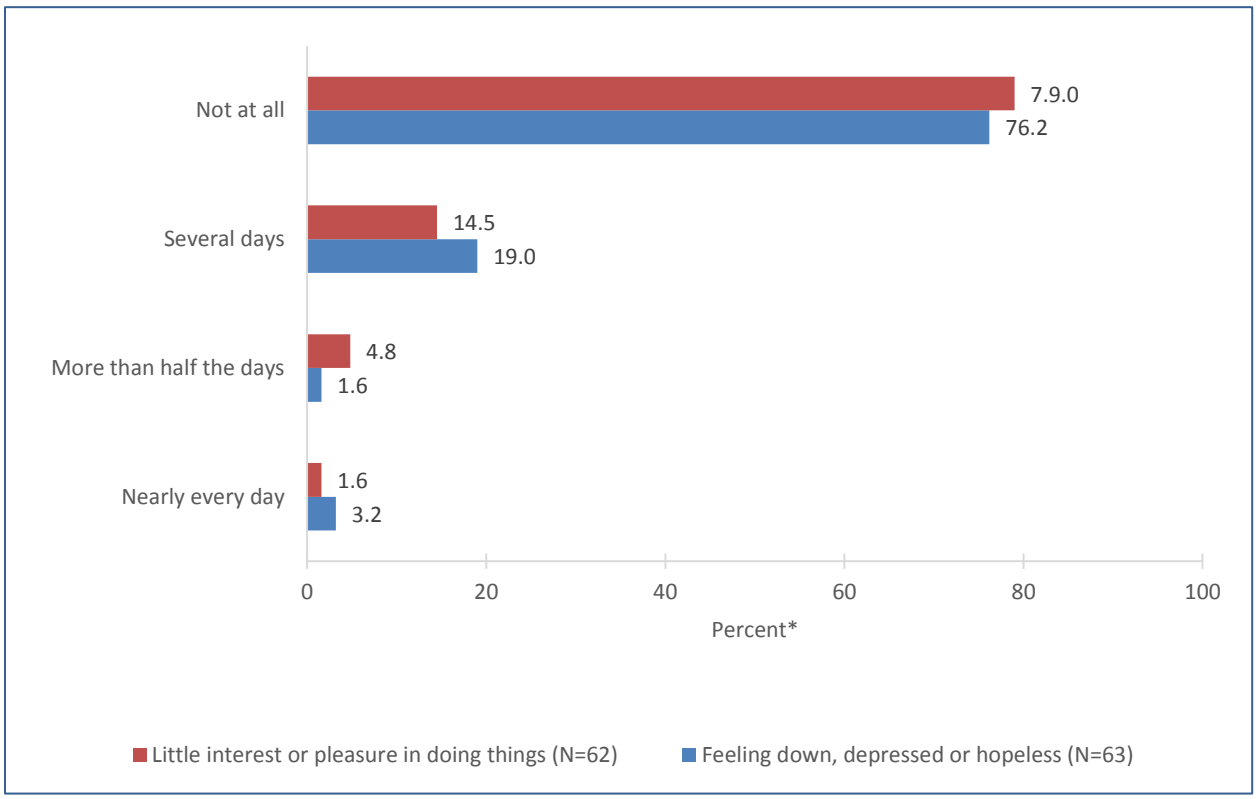
Figure 15. Number of days in the last month that respondents' mental health was not good



N=53

*Percentages do not total 100.0 due to rounding.

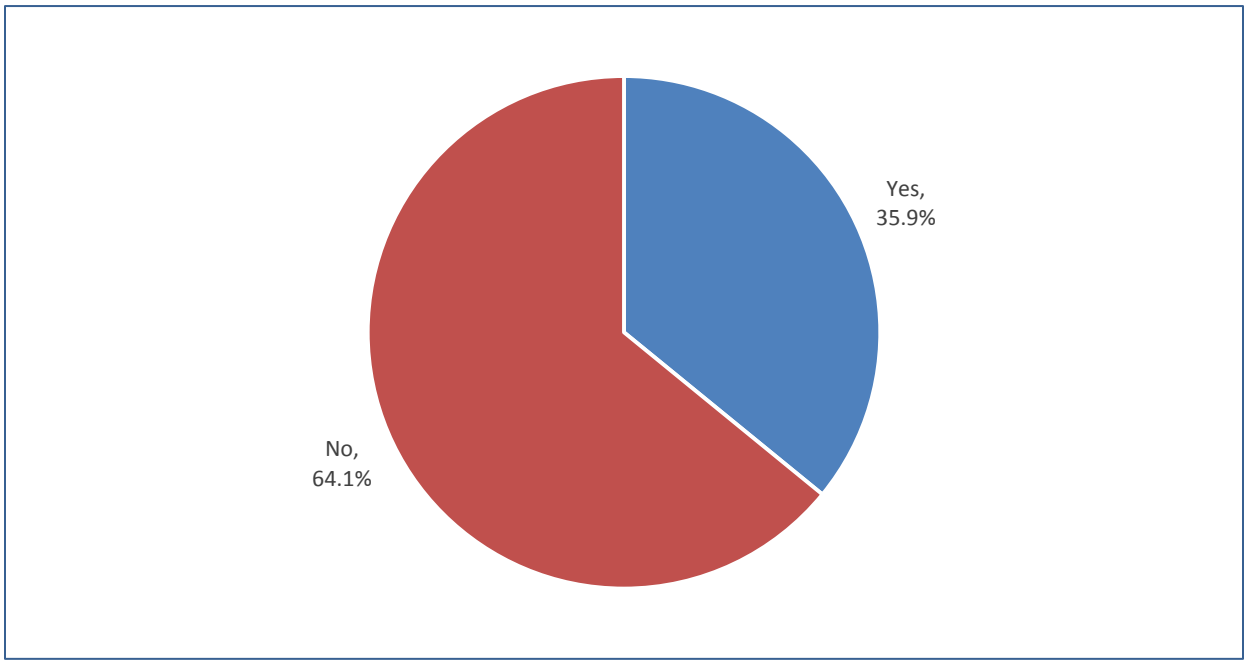
Figure 16. How often, over the past two weeks, respondents have been bothered by mental health issues



*Percentage may not total 100.0 due to rounding.

Tobacco Use

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



N=64

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

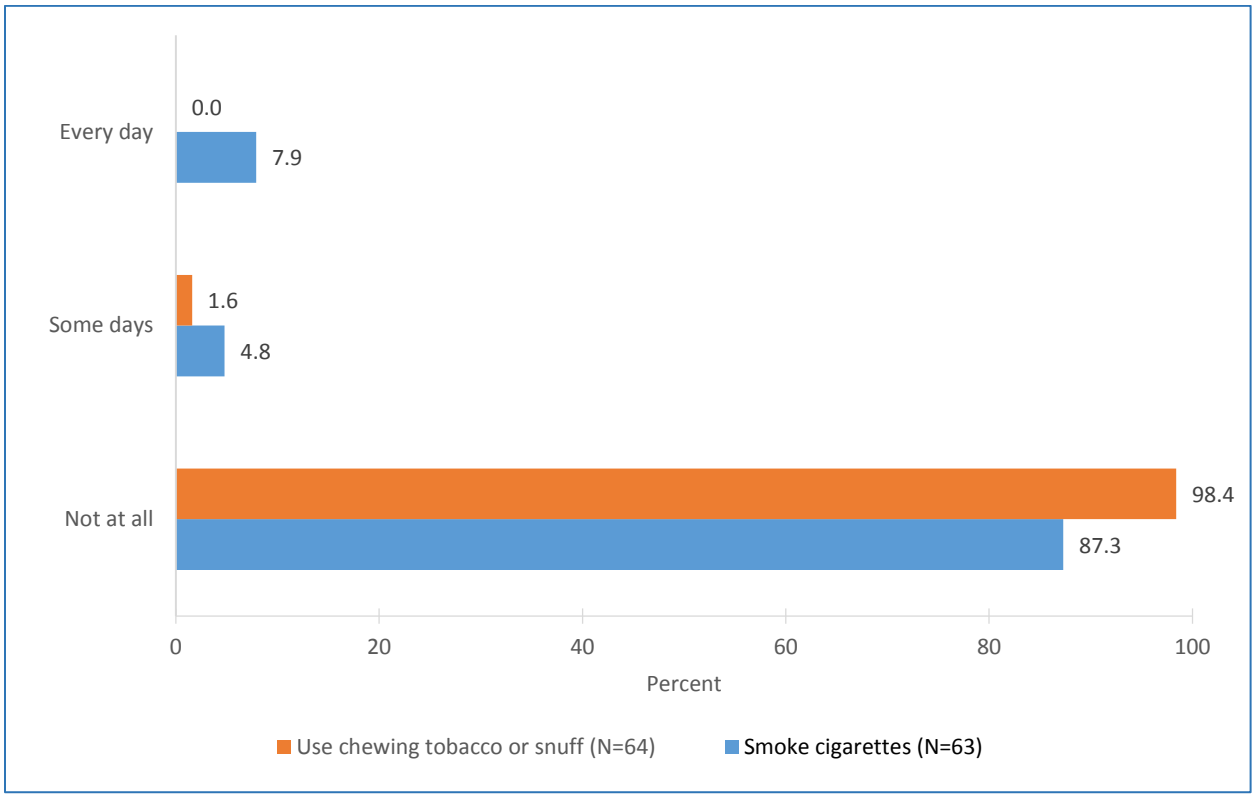
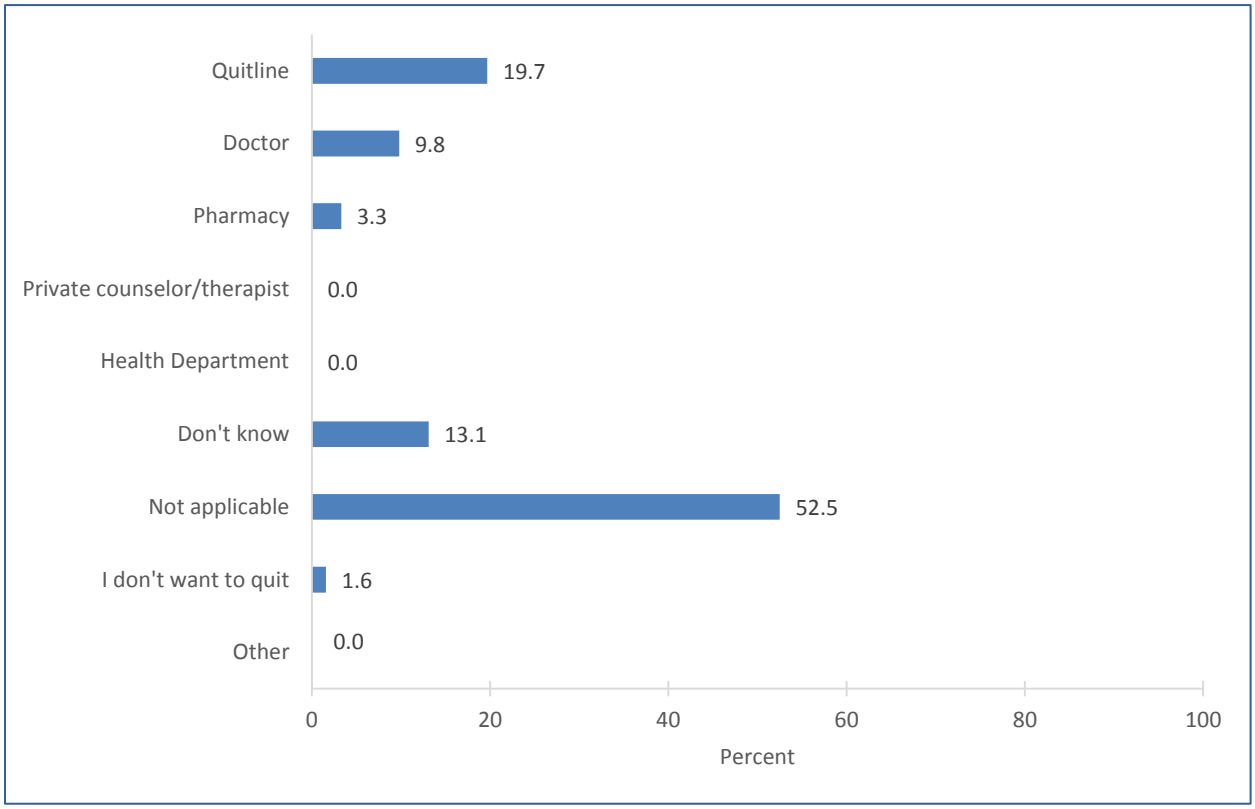
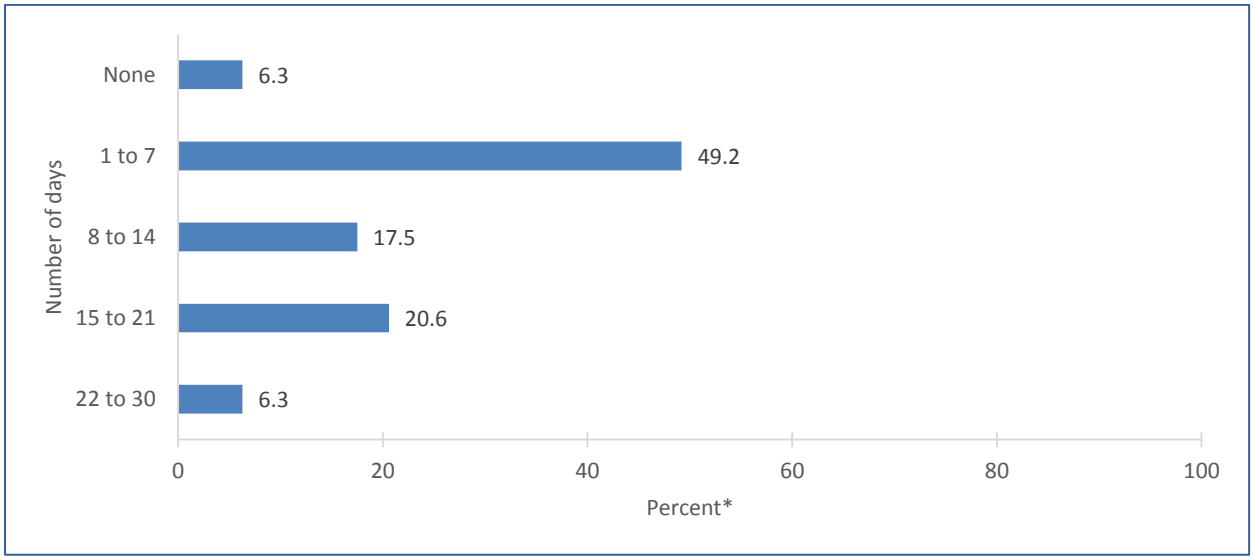


Figure 19. Location respondents would first go if they wanted help to quit using tobacco



N=61

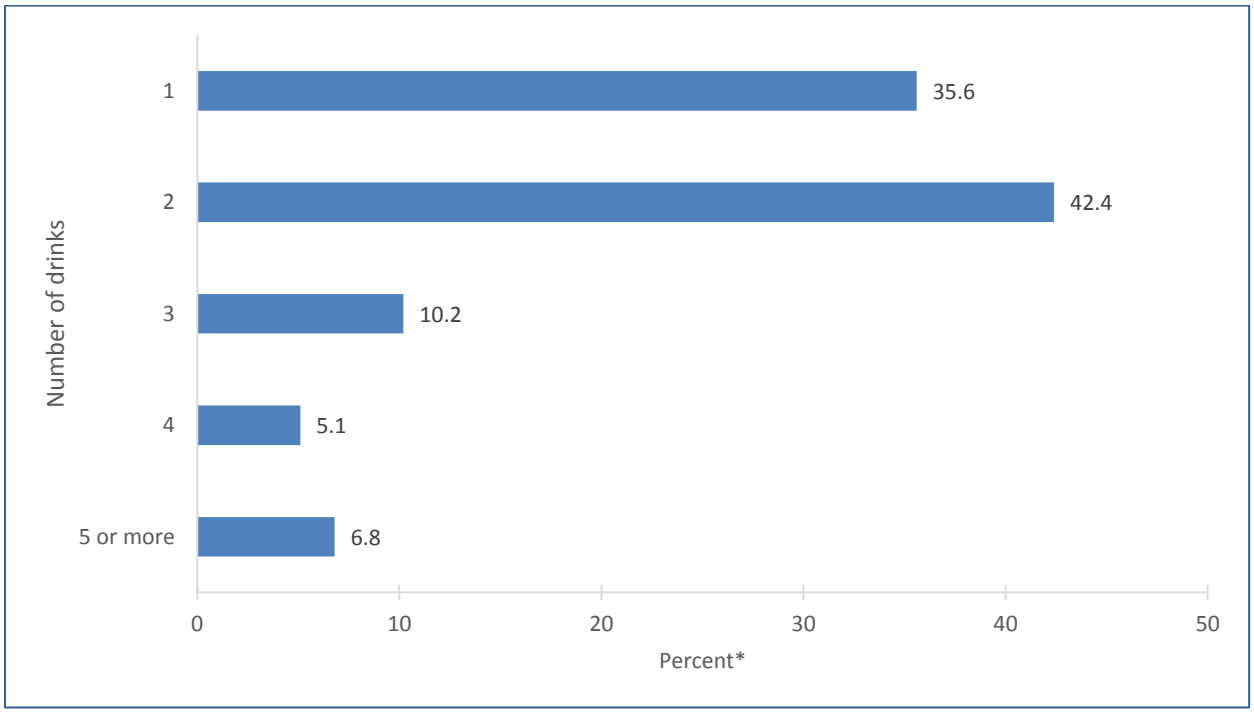
Figure 20. Number of days during the past month that respondents had at least one drink of any alcoholic beverage



N=63

*Percentages do not total 100.0 due to rounding.

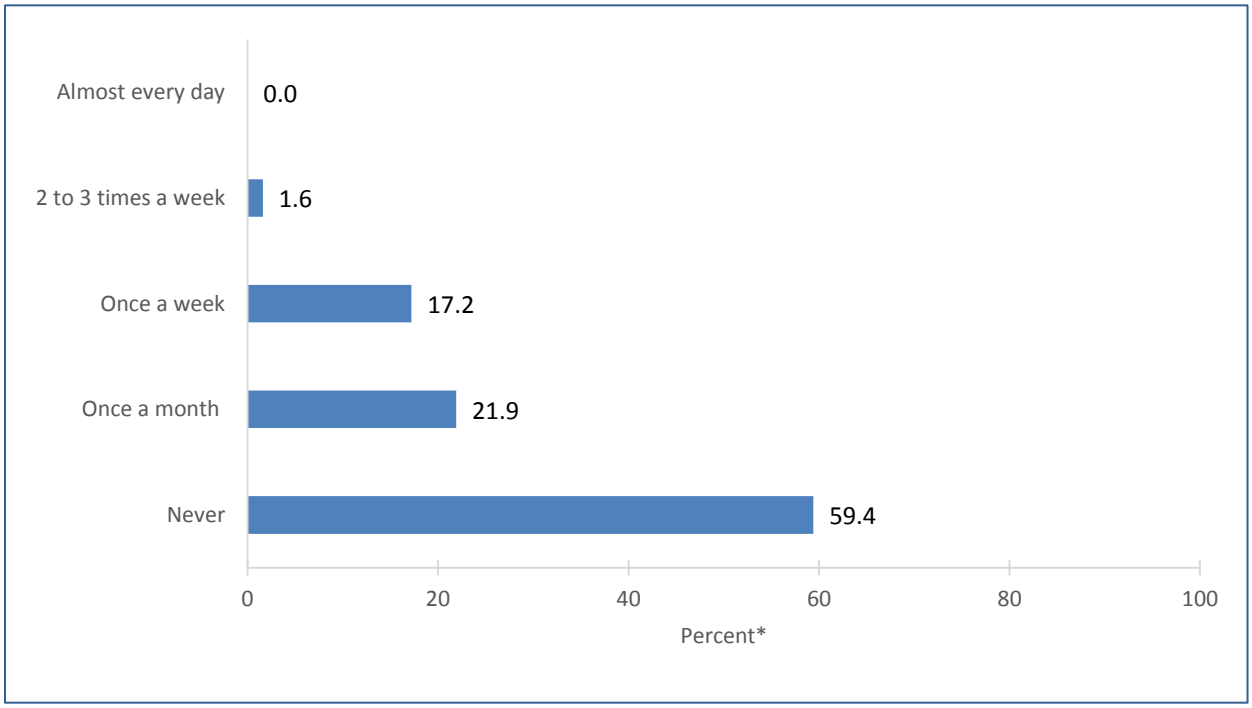
Figure 21. During the past month on days when respondents drank, average number of drinks per day respondents consumed



N=59

*Percentages do not total 100.0 due to rounding.

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=64

*Percentages do not total 100.0 due to rounding.

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

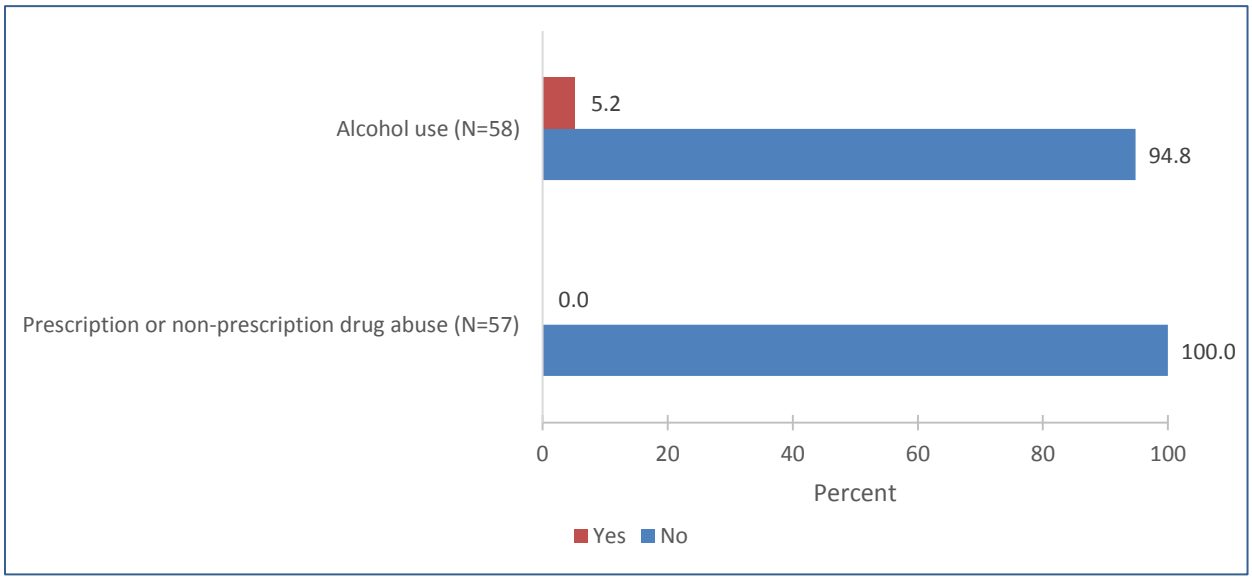


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

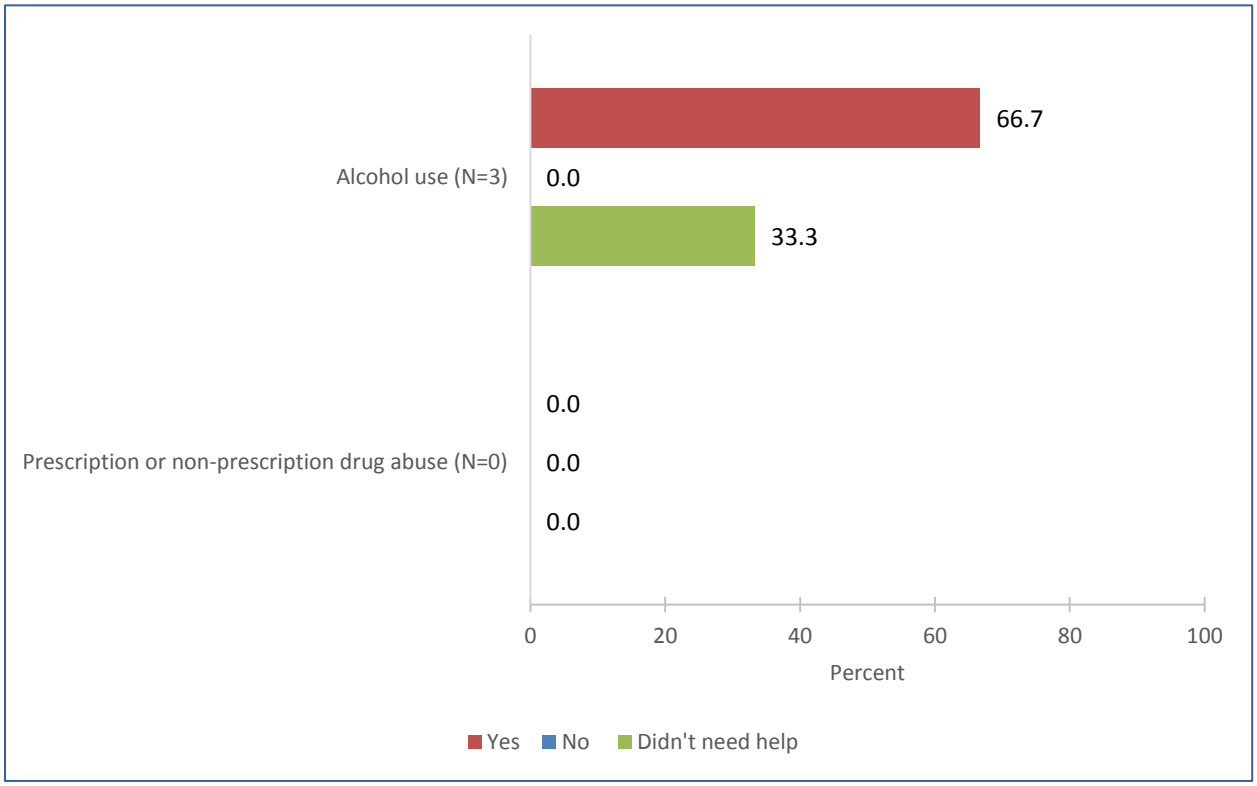
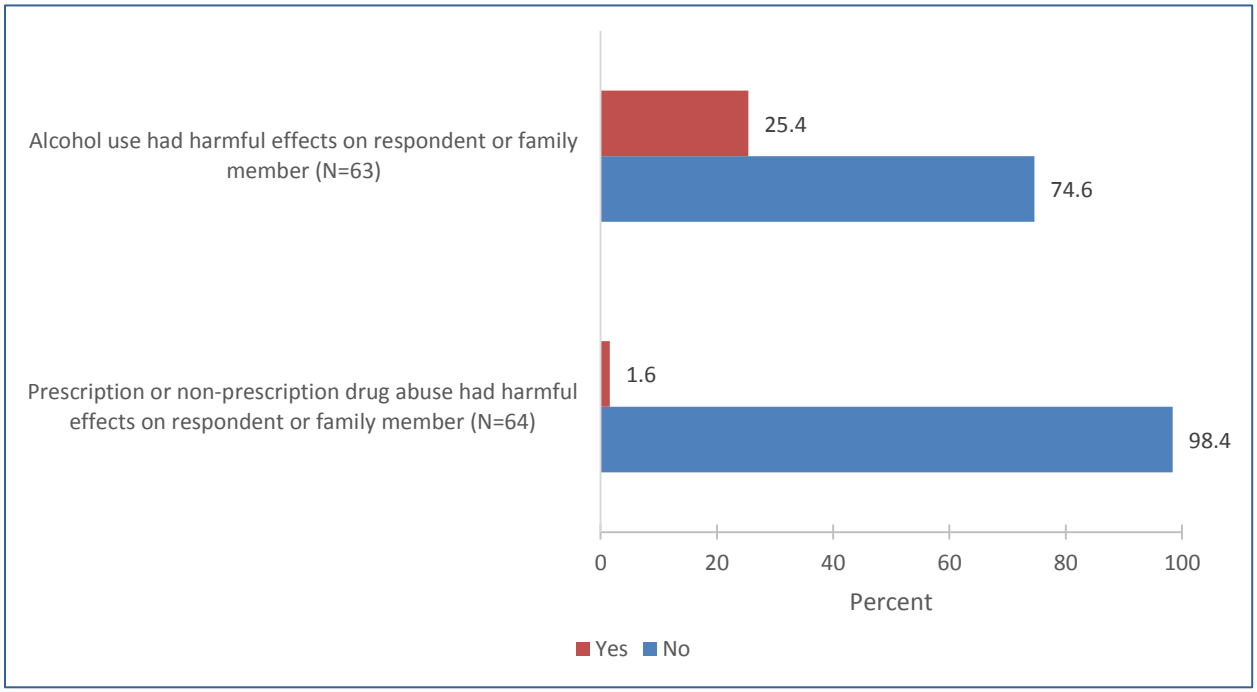


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

Table 1. Whether or not respondents 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=63)	88.9	11.1	100.0
Blood sugar screening (N=63)	77.8	22.2	100.0
Bone density test (N=63)	15.9	84.1	100.0
Cardiovascular screening (N=63)	30.2	69.8	100.0
Cholesterol screening (N=63)	71.4	28.6	100.0
Dental screening and X-rays (N=63)	82.5	17.5	100.0
Flu shot (N=63)	68.3	31.7	100.0
Glaucoma test (N=63)	58.7	41.3	100.0
Hearing screening (N=63)	12.7	87.3	100.0
Immunizations (N=63)	23.8	76.2	100.0
Pelvic exam (N=39 Females)	74.4	25.6	100.0
STD (N=62)	14.5	85.5	100.0
Vascular screening (N=63)	9.5	90.5	100.0
CANCER SCREENINGS			
Breast cancer screening (N=38 Females)	65.8	34.2	100.0
Cervical cancer screening (N=38 Females)	68.4	31.6	100.0
Colorectal cancer screening (N=62)	25.8	74.2	100.0
Prostate cancer screening (N=24 Males)	58.3	41.7	100.0
Skin cancer screening (N=62)	24.2	75.8	100.0

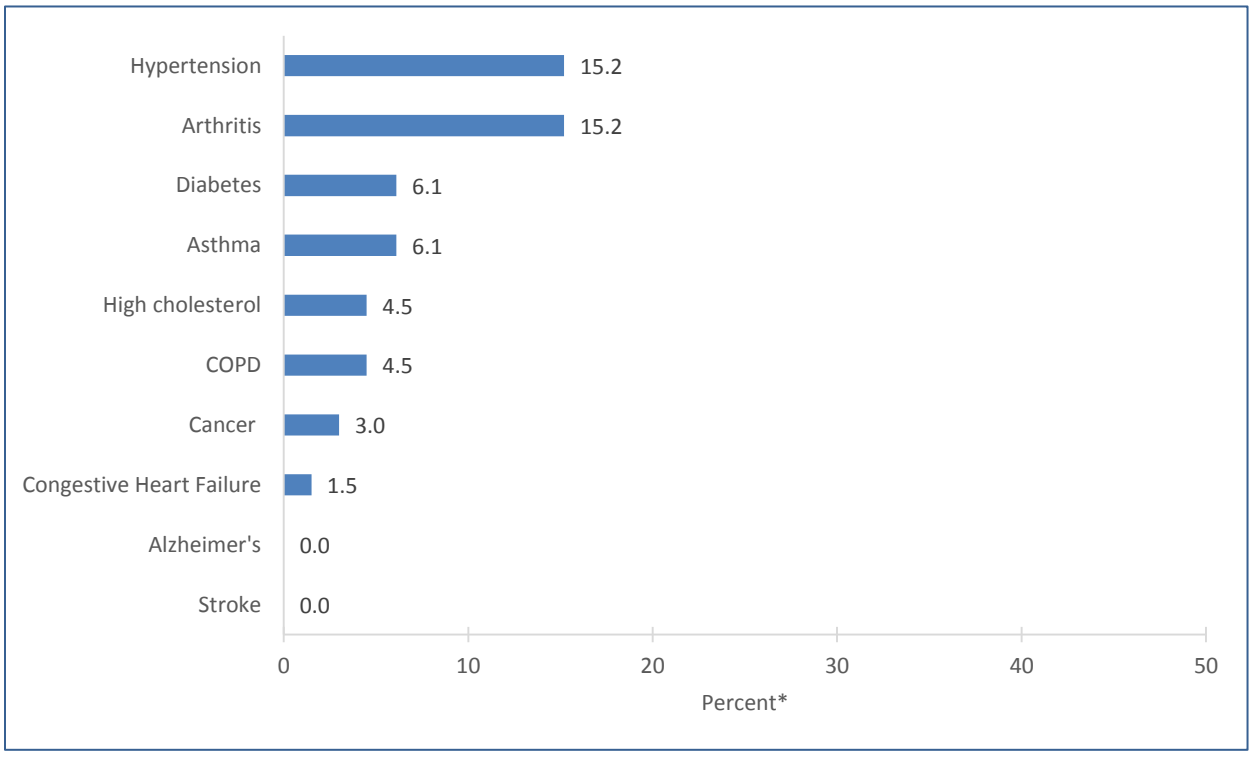
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not by type of screening

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=7)	28.6	28.6	14.3	0.0	0.0	0.0	14.3
Blood sugar screening (N=14)	35.7	14.3	14.3	0.0	0.0	0.0	21.4
Bone density test (N=53)	47.2	32.1	3.8	0.0	1.9	0.0	3.8
Cardiovascular screening (N=44)	29.5	40.9	4.5	0.0	2.3	0.0	11.4
Cholesterol screening (N=18)	44.4	16.7	5.6	0.0	0.0	0.0	16.7
Dental screening and X-rays (N=11)	27.3	0.0	18.2	9.1	9.1	0.0	45.5
Flu shot (N=20)	40.0	0.0	5.0	5.0	5.0	0.0	25.0
Glaucoma test (N=26)	46.2	26.9	3.8	0.0	0.0	0.0	7.7
Hearing screening (N=55)	54.5	20.0	3.6	0.0	0.0	0.0	5.5
Immunizations (N=48)	56.3	16.7	2.1	2.1	0.0	0.0	8.3
Pelvic exam (N=10 Females)	30.0	20.0	0.0	0.0	0.0	0.0	30.0

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
STD (N=53)	75.5	13.2	1.9	0.0	0.0	0.0	1.9
Vascular screening (N=57)	49.1	28.1	3.5	0.0	0.0	0.0	5.3
CANCER SCREENINGS							
Breast cancer screening (N=13 Females)	38.5	30.8	7.7	0.0	0.0	0.0	7.7
Cervical cancer screening (N=12 Females)	33.3	41.7	0.0	0.0	0.0	0.0	16.7
Colorectal cancer screening (N=46)	41.3	30.4	2.2	2.2	0.0	0.0	17.4
Prostate cancer screening (N=10 Males)	50.0	30.0	0.0	0.0	0.0	0.0	20.0
Skin cancer screening (N=47)	36.2	46.8	4.3	0.0	0.0	0.0	4.3

*Percentages do not total 100.0 due to multiple responses.

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



N=66 *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

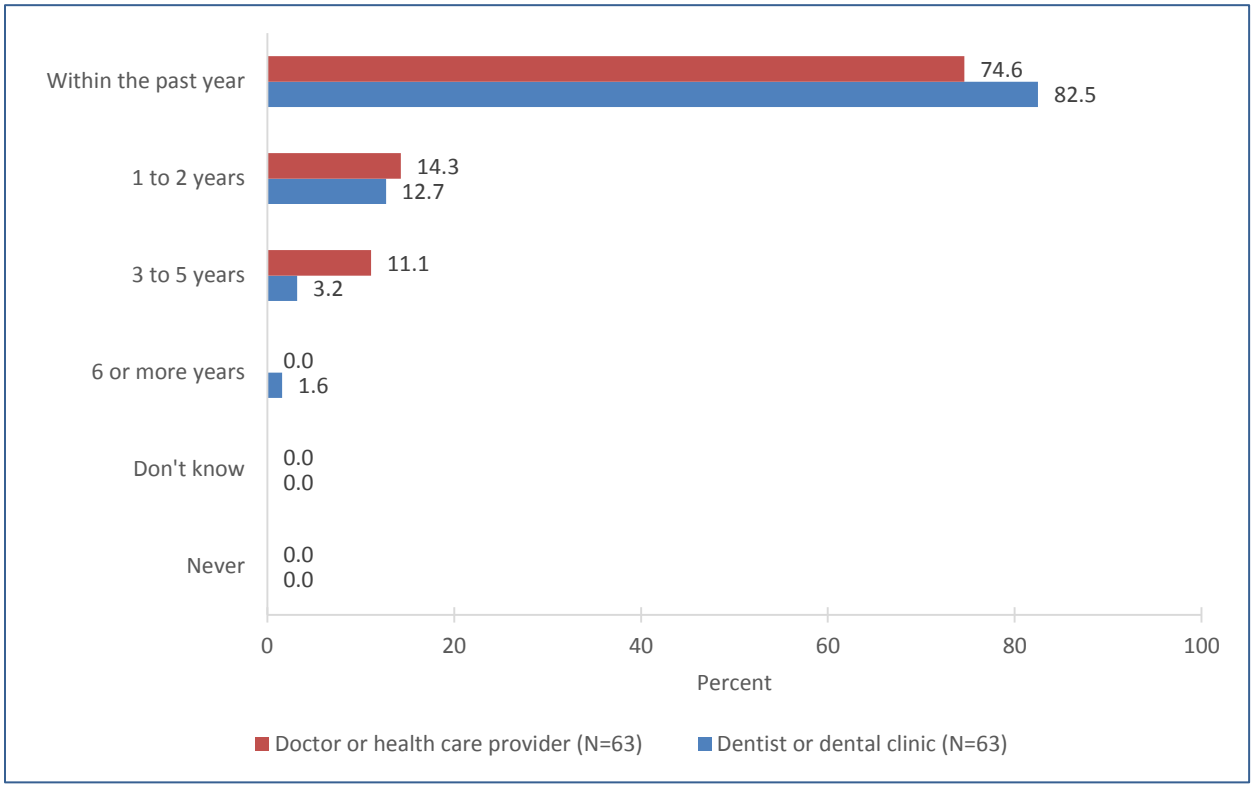
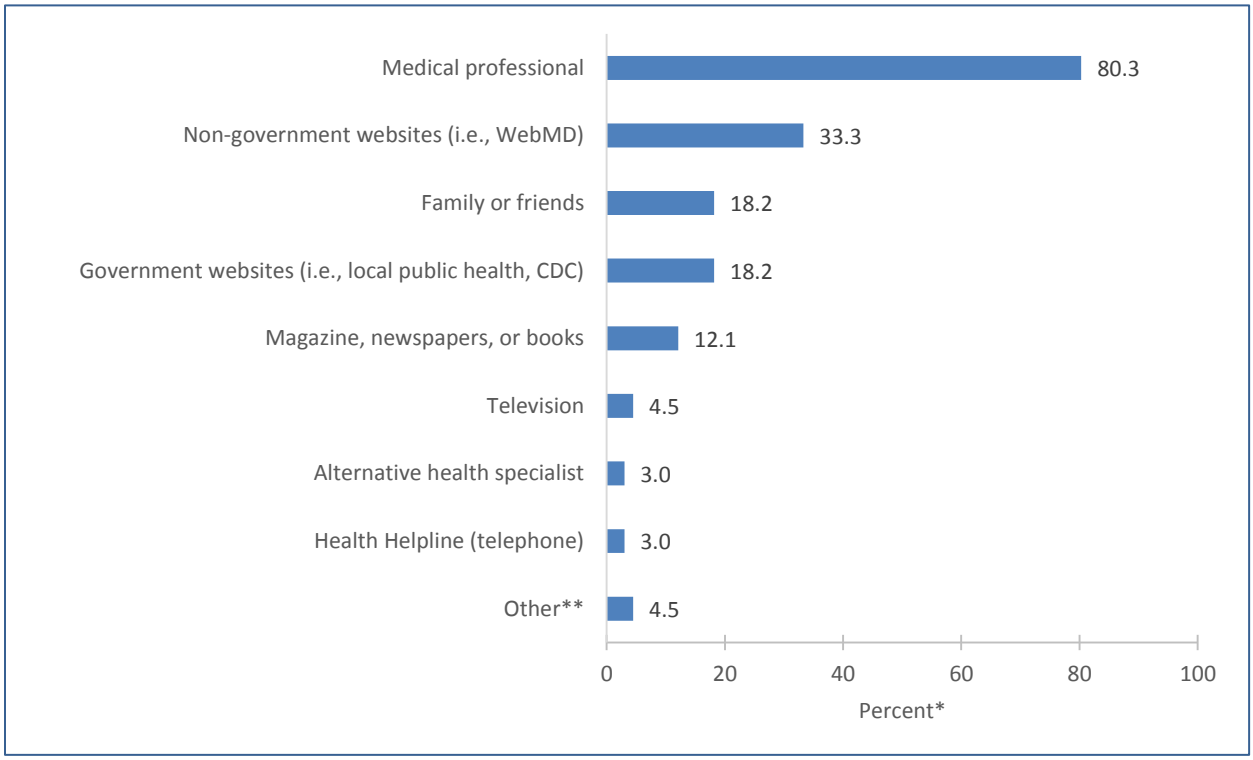
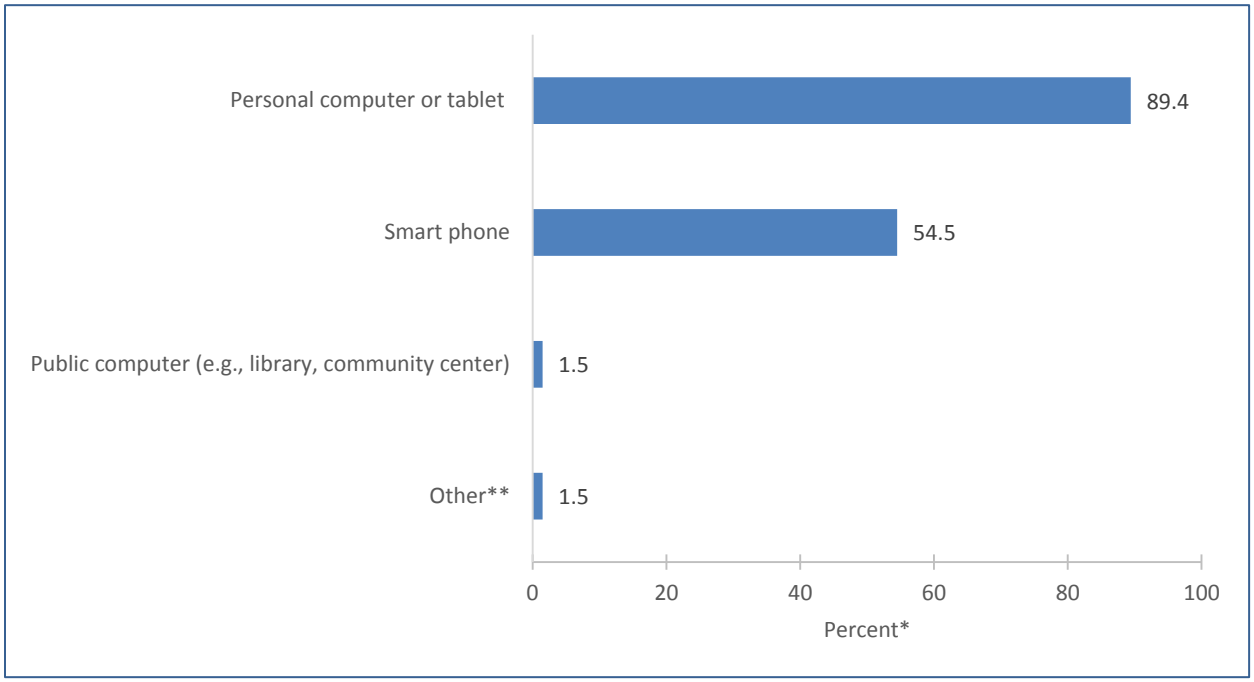


Figure 28. Where respondents get most of their health information



N=66 *Percentages do not total 100.0 due to multiple responses.**Other responses include "health coach", "health provider continuing education programs", and "Internet".

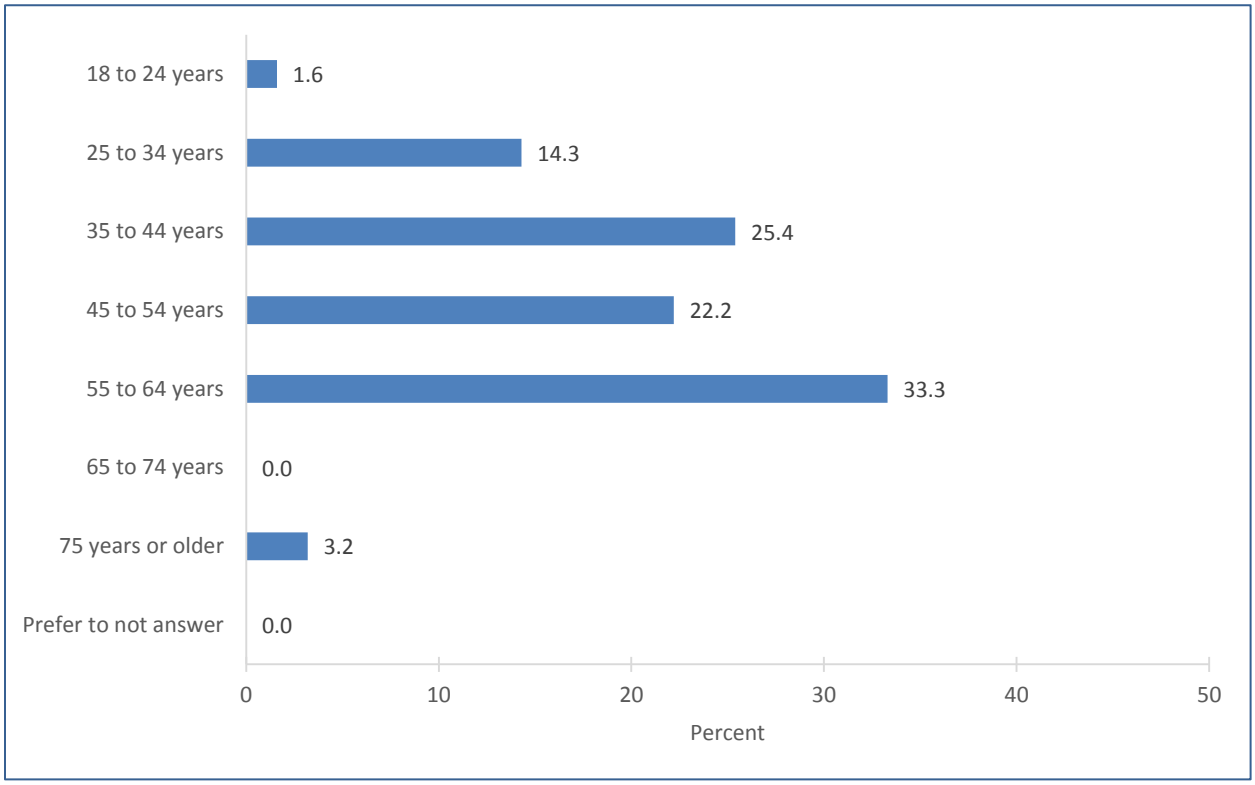
Figure 29. Best way for respondents to access technology for health information



N=66 *Percentages do not total 100.0 due to multiple responses.**Other response is “my primary care physician”.

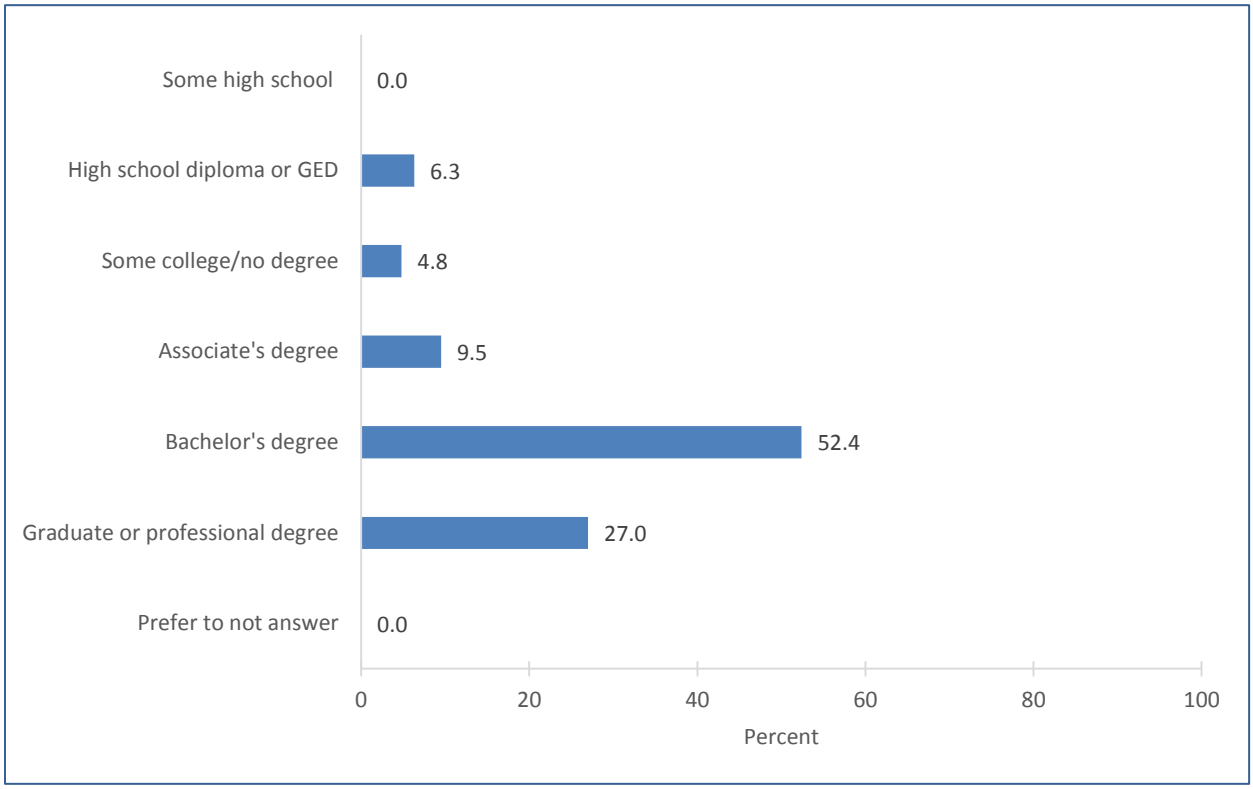
Demographic Information

Figure 30. Age of respondents



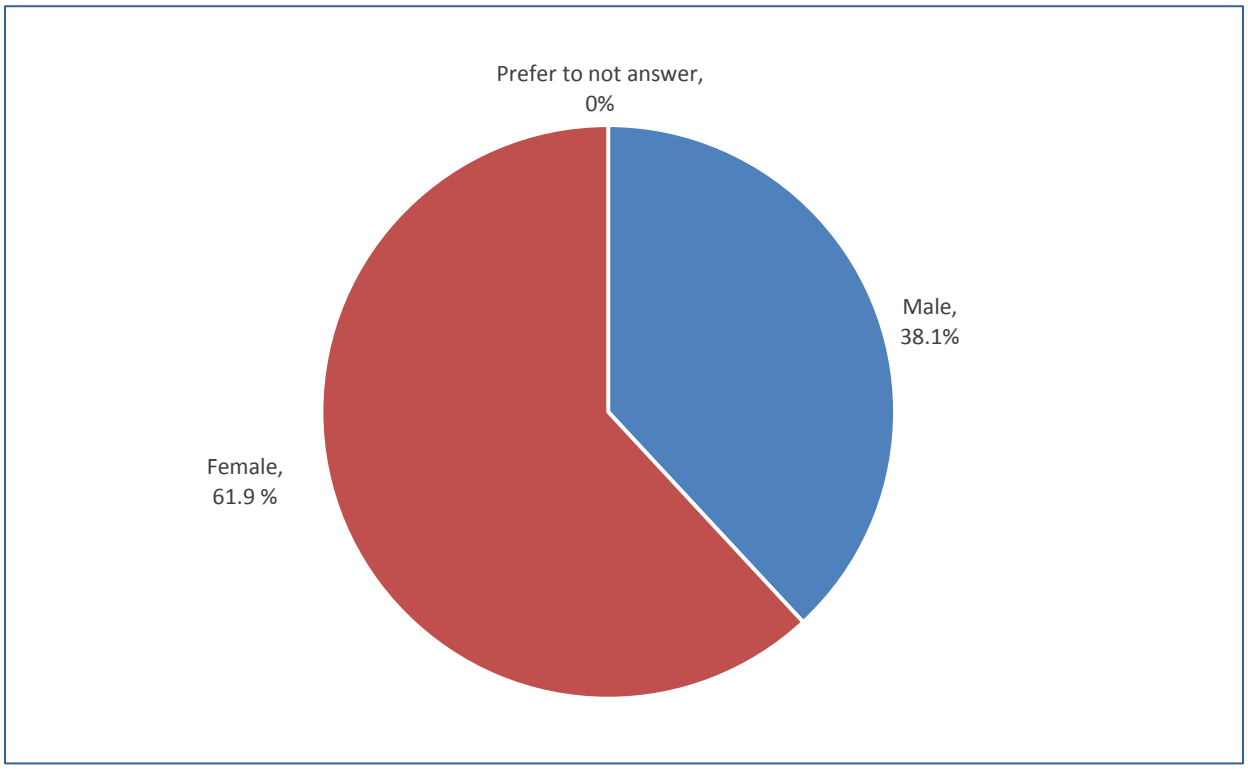
N=63

Figure 31. Highest level of education of respondents



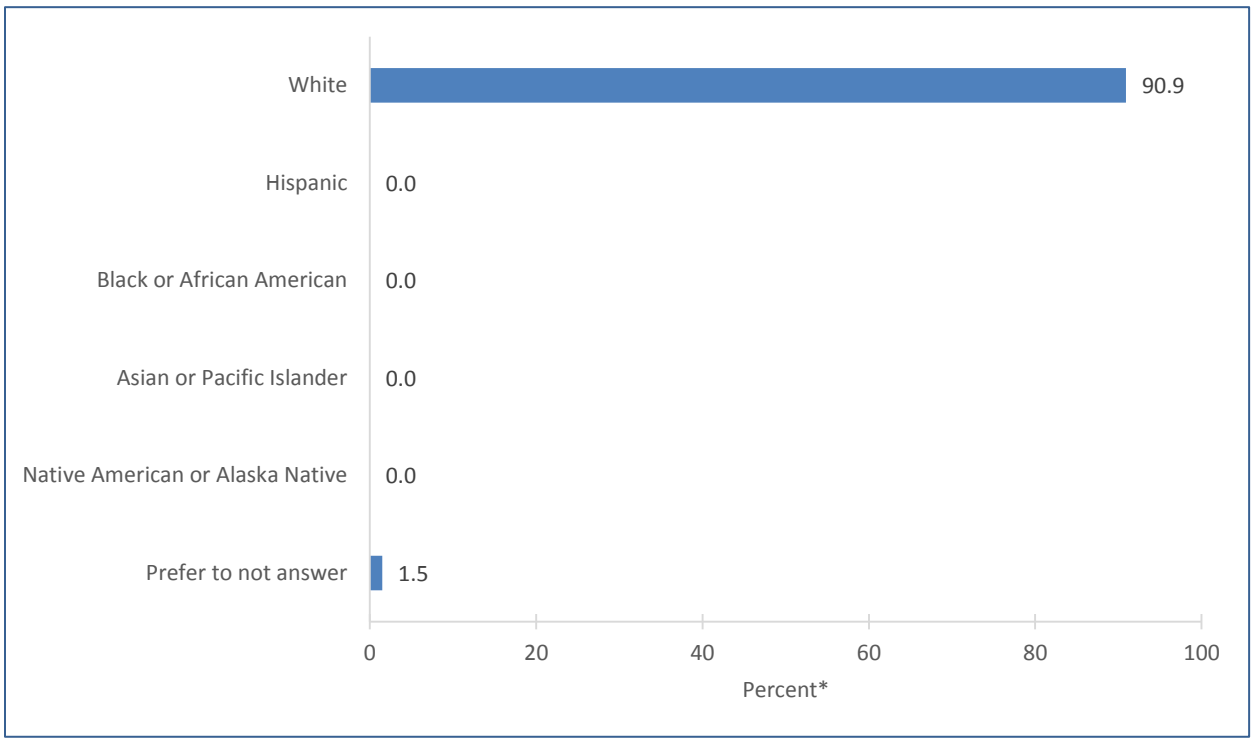
N=63

Figure 32. Gender of respondents



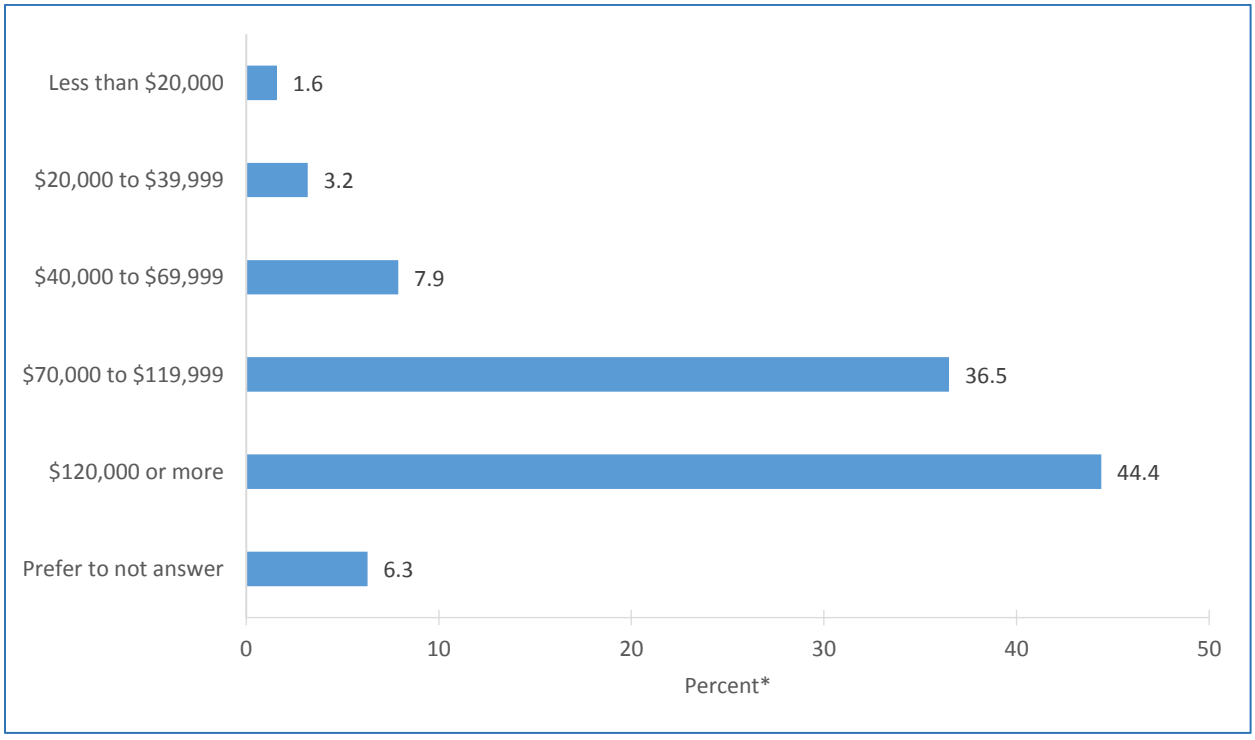
N=63

Figure 33. Race and ethnicity of respondents



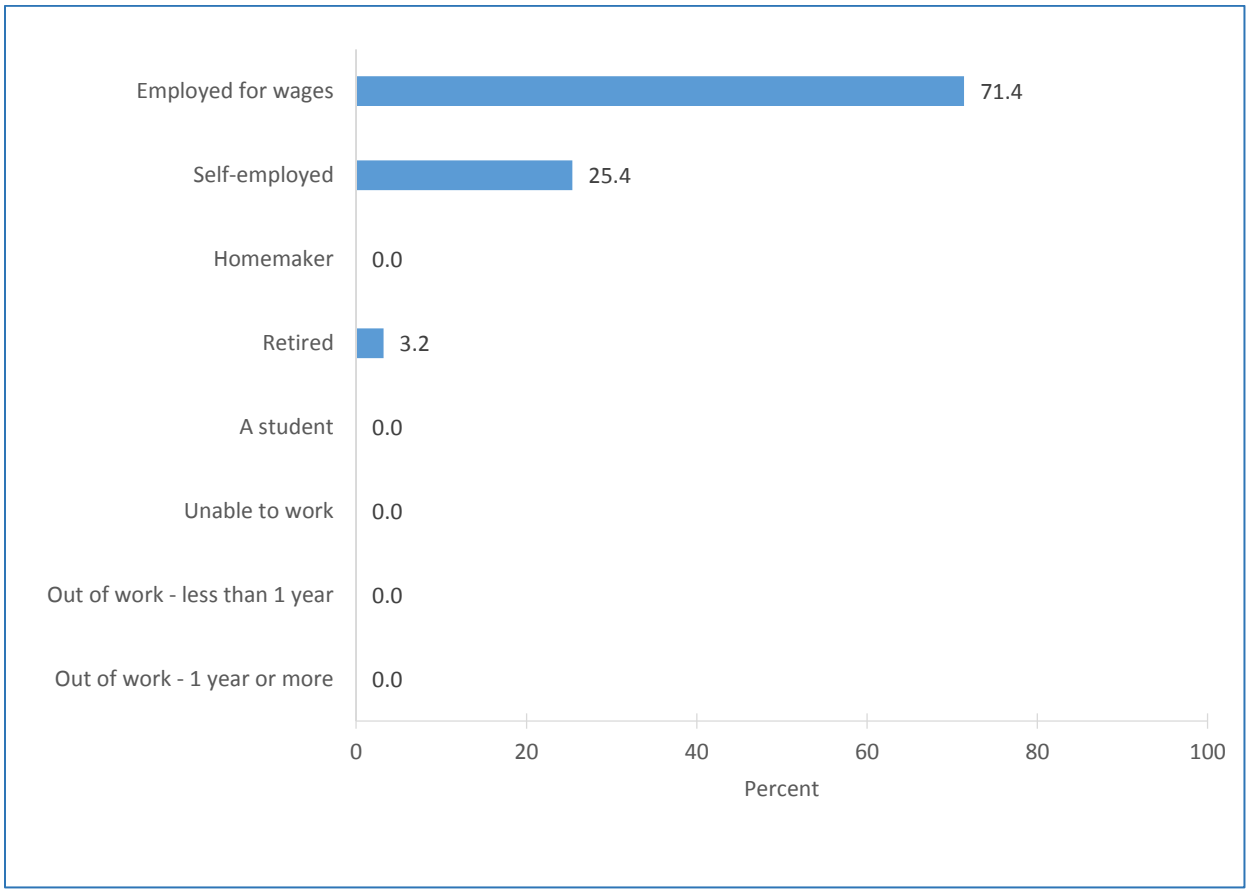
N=66 *Percentages do not total 100.0 due to multiple responses.

Figure 34. Annual household income of respondents



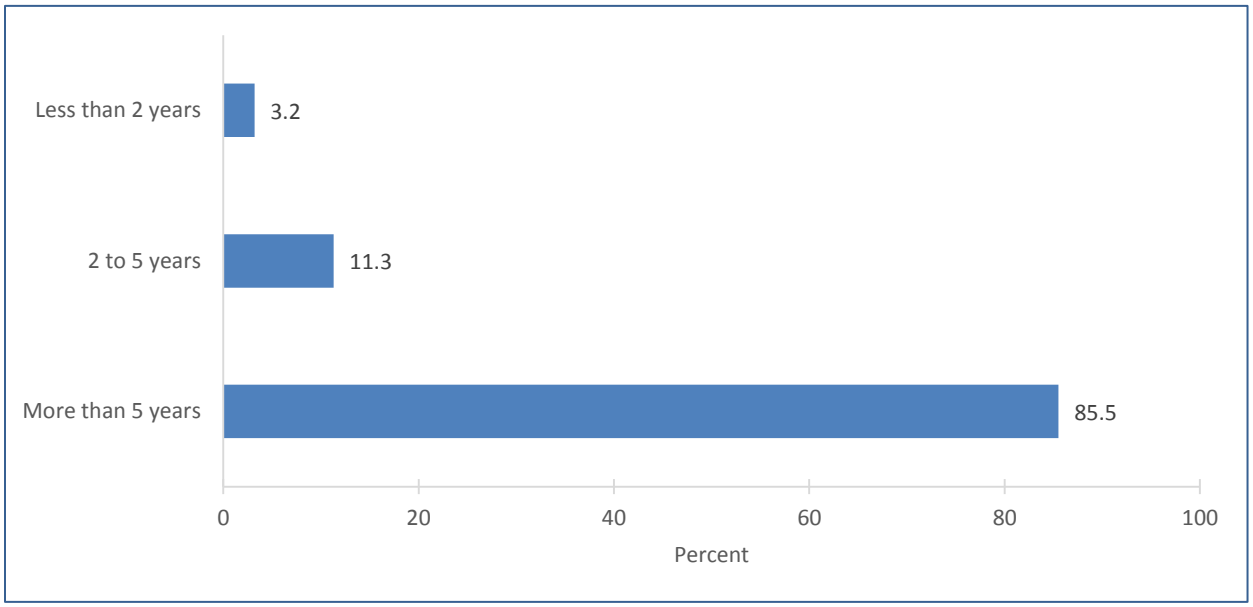
N=63 *Percentages do not total 100.0 due to rounding.

Figure 35. Employment status of respondents



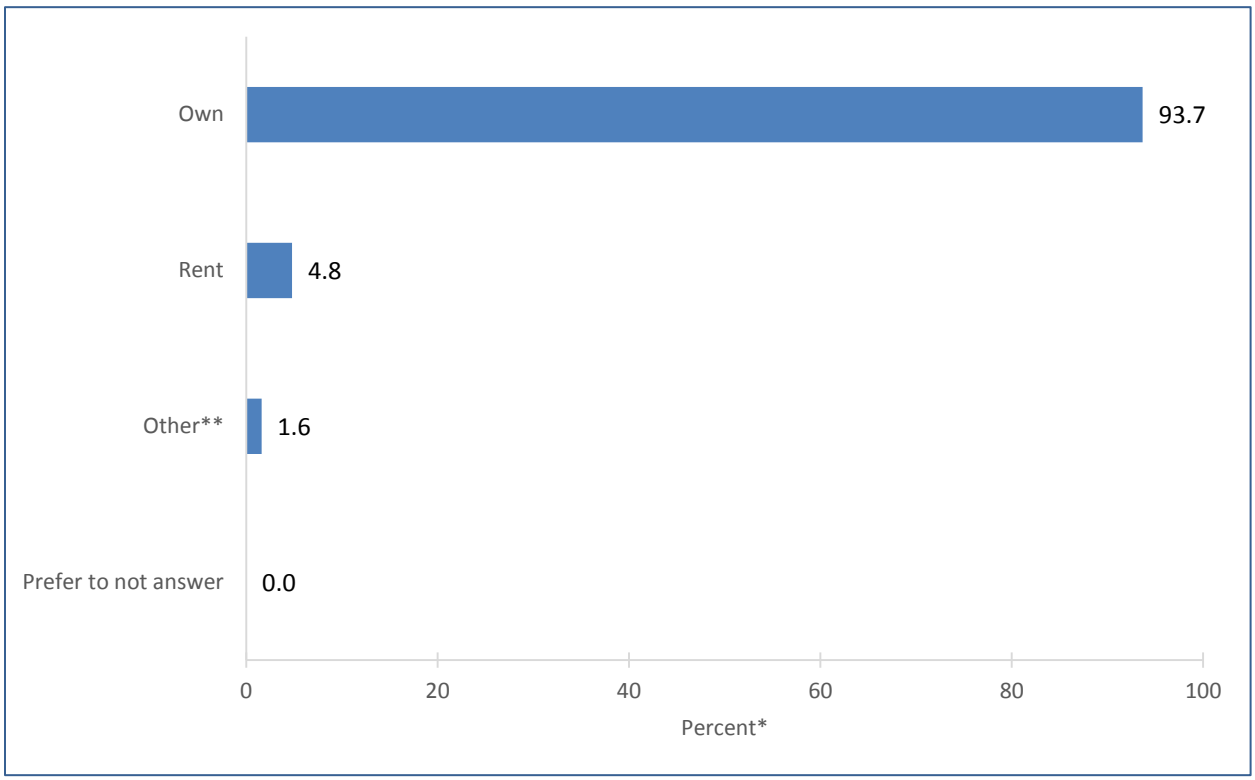
N=63

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



N=62

Figure 37. Whether respondents own or rent their home



N=63 *Percentages do not total 100.0 due to rounding.**Other response is “relocated recently and living with family”.

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

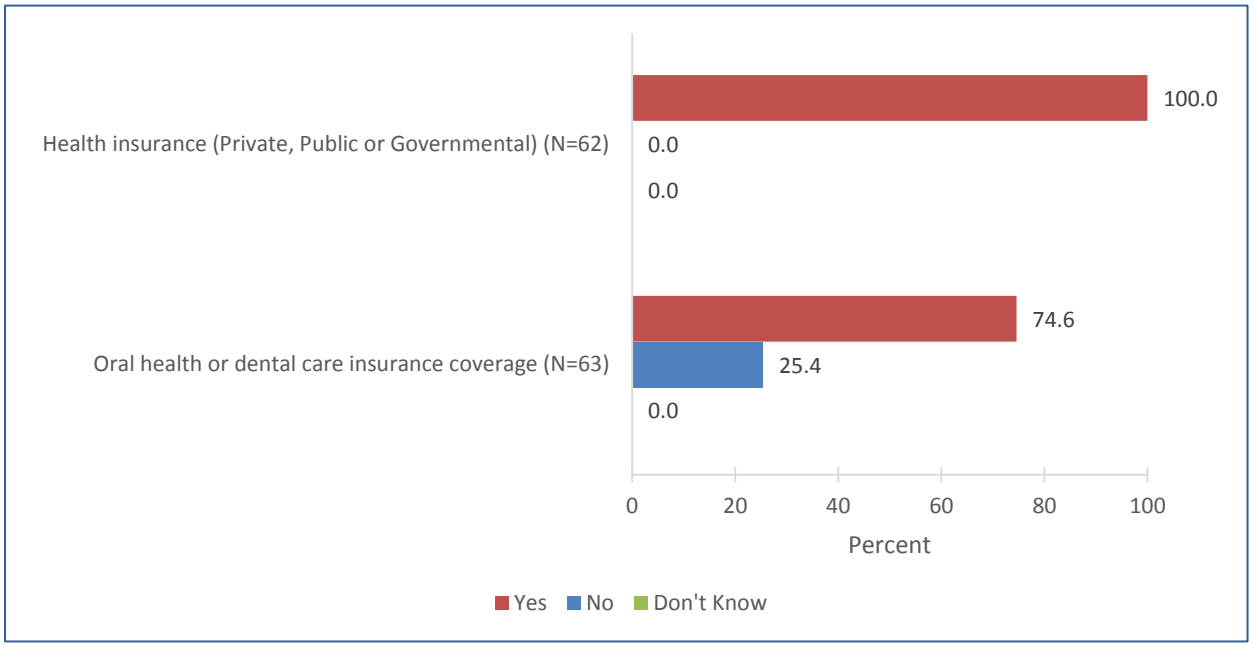
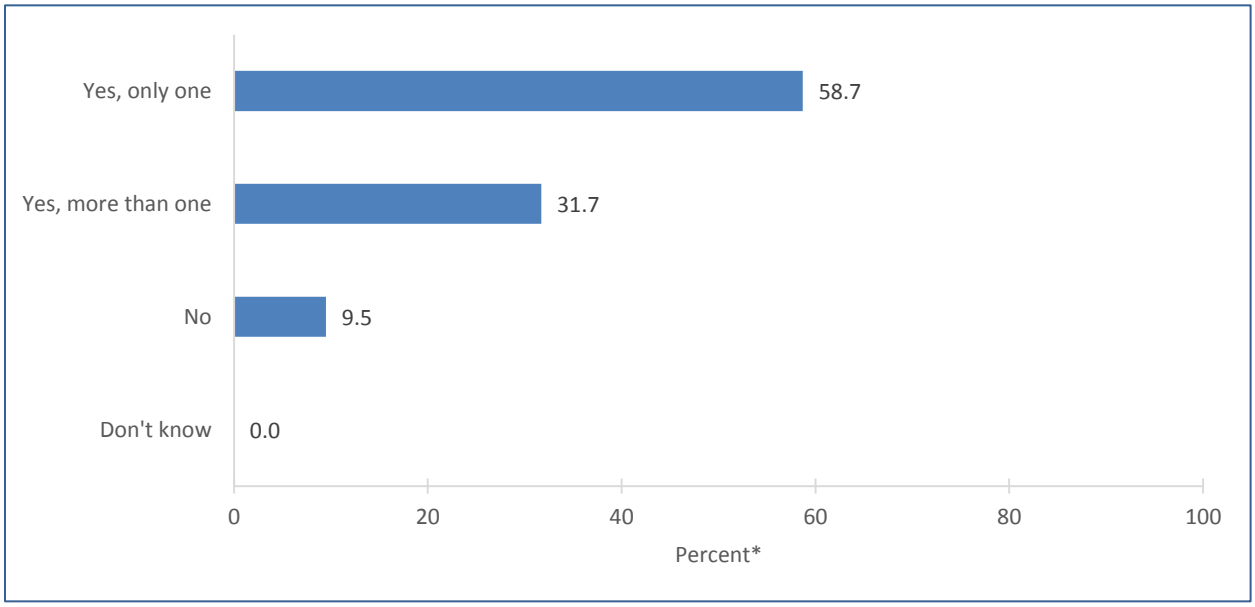
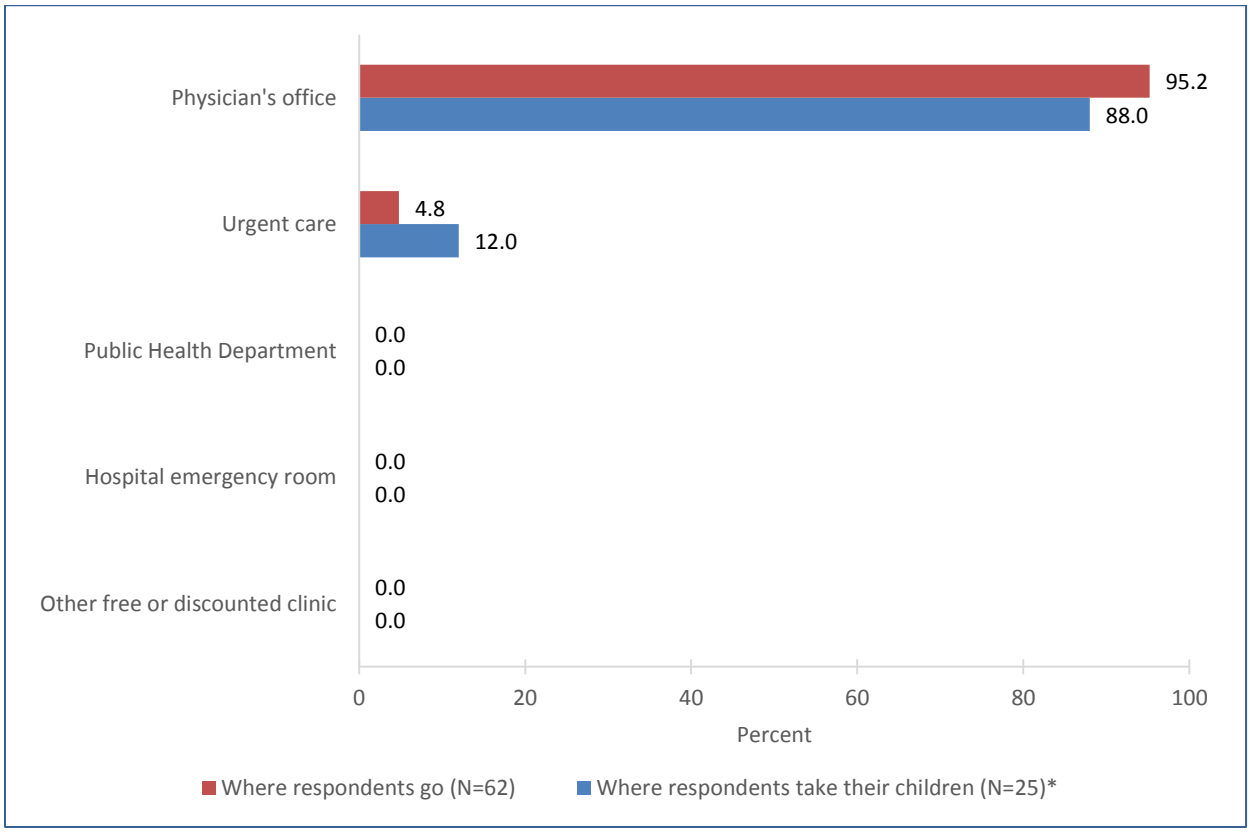


Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



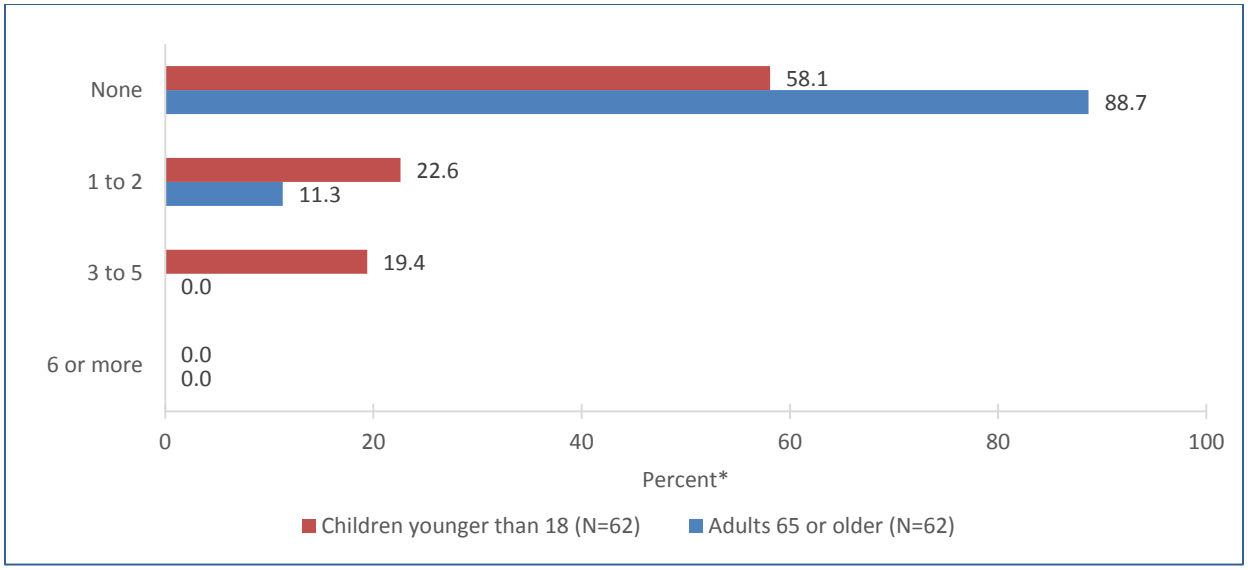
N=63*Percentages do not total 100.0 due to rounding.

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



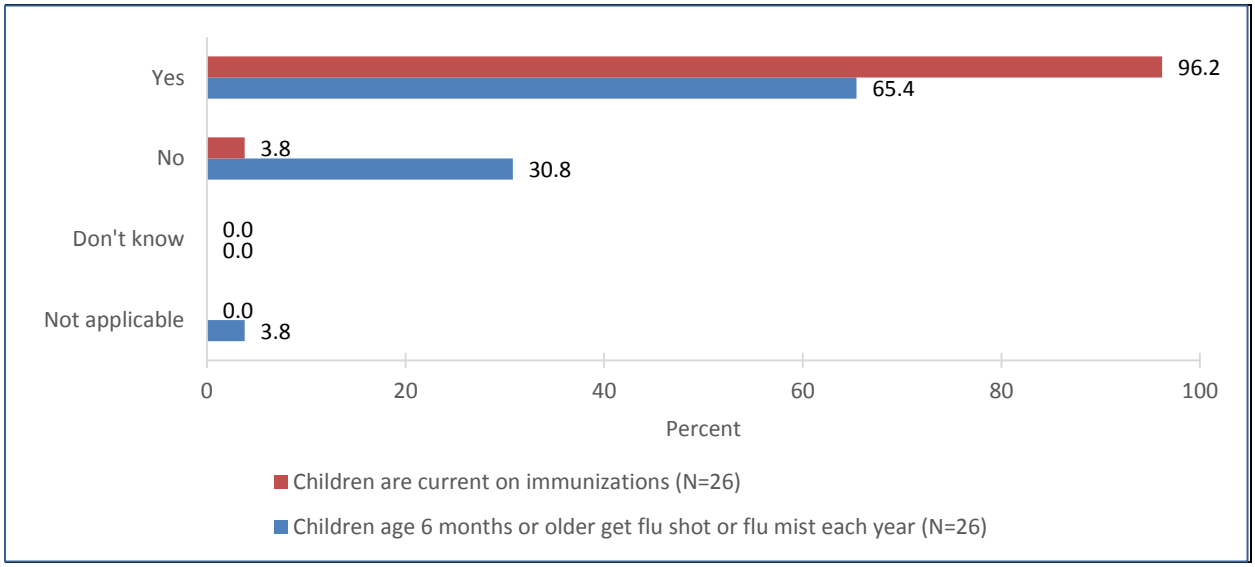
*Of respondents who have children younger than 18 years of age living in their household.

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 18 years of age living in their household.

Table 3. Zip code of respondents

Zip Code of respondents	Number of respondents
57401	55
57427	1
57451	2
57460	1
57469	1
57479	1

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
	95% CI - Low	95% confidence interval reported by BRFSS
	95% CI - High	

Measure	Data Elements	Description
	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
	# 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

Measure	Data Elements	Description
	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)
	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

Measure	Data Elements	Description
	% 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	95% confidence interval as reported by the National Center for Health Statistics
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Air pollution - particulate matter	**Average Daily PM2.5**	Average daily amount of fine particulate matter in micrograms per cubic meter
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Drinking water violations	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

Measure	Data Elements	Description
	% Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	95% CI - Low	95% confidence interval
	95% CI - High	
	Z-Score	(Measure - Average of state counties)/(Standard Deviation)
Driving alone to work	# Drive Alone	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)

Brown County

	Brown County	Trend	Error Margin	Top U.S. Performers*	South Dakota	Rank (of 57)
Health Outcomes						14
Length of Life						12
Premature death	5,521		4,637-6,404	5,317	6,712	
Quality of Life						23
Poor or fair health	11%		10-13%	10%	11%	
Poor physical health days	2.8		2.5-3.2	2.5	2.7	
Poor mental health days	2.5		2.1-2.9	2.4	2.6	
Low birth weight	6.0%		5.2-6.8%	6.0%	6.6%	
Health Factors						9
Health Behaviors						27
Adult smoking	18%		15-20%	14%	18%	
Adult obesity	31%		28-34%	25%	30%	
Food environment index	8.4			8.7	7.7	
Physical inactivity	27%		25-30%	21%	26%	
Access to exercise opportunities	57%			85%	62%	
Excessive drinking	21%		18-23%	10%	19%	
Alcohol-impaired driving deaths	33%			14%	37%	
Sexually transmitted infections	348			123	414	
Teen births	29		25-33	20	38	
Clinical Care						3
Uninsured	11%		9-12%	11%	14%	
Primary care physicians	1,151:1			1,051:1	1,329:1	
Dentists	1,778:1			1,392:1	1,844:1	
Mental health providers	346:1			521:1	871:1	
Preventable hospital stays	60		54-67	46	63	
Diabetic monitoring	89%		81-97%	90%	84%	

	Brown County	Trend	Error Margin	Top U.S. Performers*	South Dakota	Rank (of 57)
Mammography screening	70.8%		61.9-79.8%	70.7%	66.9%	
Social & Economic Factors						6
High school graduation	86%				80%	
Some college	69.8%		64.0-75.6%	70.2%	66.5%	
Unemployment	3.6%			4.4%	4.4%	
Children in poverty	12%		9-16%	13%	19%	
Inadequate social support	14%		12-16%	14%	17%	
Children in single-parent households	26%		21-30%	20%	31%	
Violent crime	184			64	236	
Injury deaths	45		35-55	49	69	
Physical Environment						32
Air pollution - particulate matter	10.4			9.5	10.8	
Drinking water violations	37%			0%	5%	
Severe housing problems	9%		7-10%	9%	12%	
Driving alone to work	81%		79-83%	71%	78%	
Long commute - driving alone	9%		7-10%	15%	14%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2014

Edmunds County

	Edmunds County	Trend	Error Margin	Top U.S. Performers*	South Dakota	Rank (of 57)
Health Outcomes						7
Length of Life						8
Premature death	5,187		3,783-6,940	5,317	6,712	
Quality of Life						11
Poor or fair health	8%		6-12%	10%	11%	
Poor physical health days	2.7		1.4-4.1	2.5	2.7	
Poor mental health days	1.1		0.5-1.7	2.4	2.6	
Low birthweight				6.0%	6.6%	
Health Factors						7
Health Behaviors						17
Adult smoking	13%		8-21%	14%	18%	
Adult obesity	36%		29-43%	25%	30%	
Food environment index	7.4			8.7	7.7	
Physical inactivity	29%		23-36%	21%	26%	
Access to exercise opportunities	45%			85%	62%	
Excessive drinking	20%		13-30%	10%	19%	
Alcohol-impaired driving deaths	0%			14%	37%	
Sexually transmitted infections	99			123	414	
Teen births	11			20	38	
Clinical Care						20
Uninsured	13%		11-15%	11%	14%	
Primary care physicians				1,051:1	1,329:1	
Dentists				1,392:1	1,844:1	
Mental health providers				521:1	871:1	
Preventable hospital stays	74		55-93	46	63	
Diabetic monitoring	85%		62-100%	90%	84%	
Mammography screening	72.4%		50.5-94.3%	70.7%	66.9%	

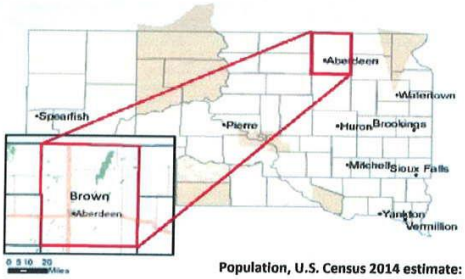
	Edmunds County	Trend	Error Margin	Top U.S. Performers*	South Dakota	Rank (of 57)
Social & Economic Factors						**10**
High school graduation					80%	
Some college	69.0%		56.3-81.6%	70.2%	66.5%	
Unemployment	3.6%			4.4%	4.4%	
Children in poverty	15%		11-20%	13%	19%	
Inadequate social support	23%		17-29%	14%	17%	
Children in single-parent households	7%		1-12%	20%	31%	
Violent crime	0			64	236	
Injury deaths				49	69	
Physical Environment						**1**
Air pollution - particulate matter	9.6			9.5	10.8	
Drinking water violations	0%			0%	5%	
Severe housing problems	11%		7-15%	9%	12%	
Driving alone to work	64%		58-71%	71%	78%	
Long commute - driving alone	21%		16-26%	15%	14%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

2014

FOCUS ON SOUTH DAKOTA
A Picture of Health

SOUTH DAKOTA HEALTH STUDY: BROWN COUNTY RESULTS



Population, U.S. Census 2014 estimate: 38,408

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Brown County Responses: 181	Response Rate: 50%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		BROWN COUNTY (n = 181)
57.4%	Female	67.7%
11.3%	Non-White	3.4%
19.1%	Age 65 and older	21.0%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	16.1%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	17.4%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	9.6%

NEED FOR CARE

75.0%	Need Medical Care	84.5%
79.5%	Need Prescription Medications	93.8%
9.5%	Need Mental Health Care	6.6%
1.1%	Need Alcohol or Drug Treatment	0.4%

ACCESS TO CARE

94.2%	Have a usual place to go for care	98.6%
77.4%	Have a personal doctor/provider	92.0%
13.0%	Unmet medical needs	12.9%
6.4%	Unmet prescription needs	5.4%
35.8%	Unmet mental health needs	63.4%
45.6%	Unmet alcohol or drug abuse needs	0.0%

HEALTH PROFILE

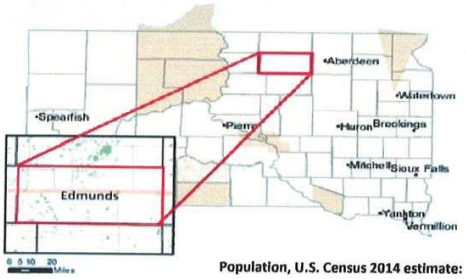
SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	BROWN COUNTY (n = 181)
11.4%	Diabetes	11.7%
10.9%	Asthma	2.0%
33.3%	High Blood Pressure	31.3%
8.9%	Heart Disease	13.9%
28.5%	High Cholesterol	33.9%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	3.0%
8.9%	Cancer	7.6%
54.7%	At least one of the above	58.5%
17.0%	Depression	14.3%
17.6%	Anxiety	12.2%
3.4%	PTSD (Post-Traumatic Stress Disorder)	1.9%
1.7%	Bipolar Disorder	0.0%
2.6%	Addiction Issues	0.7%
25.5%	At least one of the above	17.6%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	86.0%
5.5%	Depression	6.1%
7.5%	Anxiety	6.3%
6.0%	PTSD (Post-Traumatic Stress Disorder)	5.3%
17.0%	Current Smoker	21.7%
42.4%	Alcohol Abuse	47.4%
6.7%	Marijuana Use (past year)	3.7%

FOCUS ON SOUTH DAKOTA
A Picture of Health

SOUTH DAKOTA HEALTH STUDY: EDMUNDS COUNTY RESULTS



Population, U.S. Census 2014 estimate: 3,983

SURVEY RESPONSES

South Dakota Responses: 7,675	Response Rate: 48%
Edmunds County Responses: 115	Response Rate: 59%

RESPONDENT PROFILE

SOUTH DAKOTA (n = 7,675)		EDMUNDS COUNTY (n = 115)
57.4%	Female	50.8%
11.3%	Non-White	4.2%
19.1%	Age 65 and older	27.3%
20.3%	Income ≤ 100% FPL (Federal Poverty Level)	15.0%
19.9%	Three or more ACEs (Adverse Childhood Experiences)	10.3%
8.5%	Five or more ACEs (Adverse Childhood Experiences)	4.2%

NEED FOR CARE

75.0%	Need Medical Care	72.5%
79.5%	Need Prescription Medications	76.4%
9.5%	Need Mental Health Care	4.0%
1.1%	Need Alcohol or Drug Treatment	2.0%

ACCESS TO CARE

94.2%	Have a usual place to go for care	94.4%
77.4%	Have a personal doctor/provider	85.3%
13.0%	Unmet medical needs	3.1%
6.4%	Unmet prescription needs	3.7%
35.8%	Unmet mental health needs	20.9%
45.6%	Unmet alcohol or drug abuse needs	70.9%

HEALTH PROFILE

SOUTH DAKOTA (n = 7,675)	Percent who have been told by a doctor that they have...	EDMUNDS COUNTY (n = 115)
11.4%	Diabetes	9.7%
10.9%	Asthma	9.2%
33.3%	High Blood Pressure	39.0%
8.9%	Heart Disease	10.8%
28.5%	High Cholesterol	42.3%
3.4%	COPD (Chronic Obstructive Pulmonary Disease)	6.4%
8.9%	Cancer	3.2%
54.7%	At least one of the above	59.2%
17.0%	Depression	12.5%
17.6%	Anxiety	13.8%
3.4%	PTSD (Post-Traumatic Stress Disorder)	0.9%
1.7%	Bipolar Disorder	0.0%
2.6%	Addiction Issues	0.0%
25.5%	At least one of the above	18.2%

HEALTH RESULTS (SCREENINGS)

	Percent who screened positive for...	
83.4%	Overall health status (good, very good, excellent)	83.2%
5.5%	Depression	4.2%
7.5%	Anxiety	3.4%
6.0%	PTSD (Post-Traumatic Stress Disorder)	3.3%
17.0%	Current Smoker	13.3%
42.4%	Alcohol Abuse	46.8%
6.7%	Marijuana Use (past year)	2.0%

SANFORD HEALTH

018002-00980 3/16