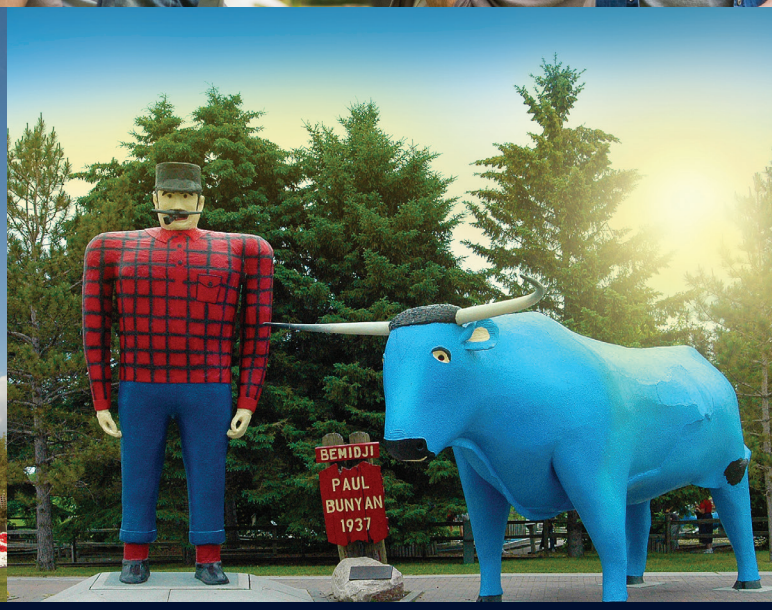


Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

dba Sanford Westbrook Medical Center EIN # 46-0388596

Sanford Westbrook Medical Center

Community Health Needs Assessment

2016

Dear Community Members,

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

- Mental Health
- Physical Health

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

At Sanford Westbrook, 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 our communities is at the core of who we are. Through our work, we can bring health and healing to the people who live and work in our communities. Together, we can fulfill this mission.

Sincerely,

Stacy Barstad

Stacy Barstad
Chief Executive Officer
Sanford Westbrook Medical Center

Sanford Westbrook Medical Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

Sanford Westbrook 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

   An on-line non-generalizable survey was conducted as an on-line survey. The website address for the survey instrument was distributed via e-mail to various agencies, at times using a snowball approach. Data collection occurred throughout the months of April 2015 and a total of 36 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community leaders in the greater Westbrook 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, with 1 as not at all and 5 meaning a great deal. Needs ranking 3.0 and above were included in the needs to be

addressed and prioritized. Many of the identified needs that ranked below 3.0 are being addressed by Sanford and community partners. However, 3.0 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 findings from assessment research and to discuss the top health issues facing the community. Community stakeholders discussed the findings and helped to determine key priorities for the community. Those priorities will be addressed in the implementation strategies for 2017-2019.

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 2015 County Health Rankings for Cottonwood County.

Key Findings – Primary Research

The key findings are based on the generalizable and the non-generalizable survey data. Key indicators were ranked on a 1-5 Likert scale, with 5 being the highest concern ranking. Survey results ranking 3.00 or higher are considered to be high-ranking concerns for the key stakeholder non-generalizable survey.

Aging: The top ranking concern among respondents overall is the cost of long term care (3.44). The availability of memory care (3.08) and the availability of resources for family /friends caring for and making decisions (3.06) are additional concerns for the aging population.

Children and Youth: For the children and youth category, it is bullying (3.91) that ranks as the highest concern among survey respondents. No other indicator ranked above a 3.00 on the Likert scale.

Safety: The presence of street drugs and alcohol in the community (3.11) is the highest safety concern of the survey respondents. No other indicator ranked above a 3.00 on the Likert scale.

Health Care: The health care indicator addressed access to health care and the cost concerns. Access to affordable health insurance (3.51), access to affordable health care (3.14), and access to affordable prescription drugs (3.06) are the highest concerns among the respondents in the health care access category.

Physical Health: Cancer (3.53), chronic disease (3.36), obesity (3.19), and inactivity and lack of exercise (3.06) are the highest physical health concerns.

Mental Health/Behavioral Health: Depression (3.17), underage drug use and abuse (3.14), stress (3.08), and alcohol use and abuse (3.03) are the highest concerns for mental health/behavioral health.

Key Findings – Secondary Research based on the 2015 County Health Rankings

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcome for the state of Minnesota is 5,038 per 100,000. Cottonwood County has a higher rate at 5,969 per 100,000.

Poor or fair health: 22% of adults in Cottonwood County report poor or fair health compared to 10% nationally and 11% in Minnesota.

The average number of days reported in the last 30 as unhealthy mental health days is 1.2 in Cottonwood County. Minnesota as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 5.7% in Cottonwood County. The state of Minnesota is at 6.5%.

Health Factors

The percent of adults who are currently smoking is not reported in Cottonwood County. 16% of adults are current smokers in Minnesota.

29% of the adult population in Cottonwood County is considered obese with a BMI over 30. 26% of the population in Minnesota is obese.

The percent of adults reporting excessive or binge drinking is not available for Cottonwood County. Minnesota reports 19% are binge drinkers statewide.

Driving deaths that have alcohol involvement is at 56% in Cottonwood County. Alcohol involvement in driving deaths is at 31% in Minnesota.

Sexually transmitted infections rank higher than the national benchmark (138) for Minnesota (336) and Cottonwood County (173).

The teen birth rate is higher in Minnesota (24) than the national benchmark (20). The teen birth rate is 35 in Cottonwood County.

The clinical care outcomes indicate that the percentage of uninsured adults is 9% in Minnesota and 10% in Cottonwood County.

The ratio of population to primary care physicians is 1,113:1 in Minnesota. Cottonwood County's ratio is 1,657:1.

The ratio of population to mental health providers is 529:1 in Minnesota. Cottonwood County's ratio is 1,056:1.

The number of professionally active dentists in Minnesota is 1,404:1, and in Cottonwood County the ratio is 1,936:1.

Preventable hospital stays are 26 in Cottonwood County, 45 in Minnesota, and 41 nationally. Diabetic screening is at 87% in Cottonwood County and 88% in Minnesota as a whole. Mammography screening is at 73.7% in Cottonwood County and 66.7% in Minnesota.

The social and economic factor outcomes indicate that Minnesota is at 78% for high school graduation. Cottonwood County does not report a graduation rate in the County Health Rankings. Post-secondary education (some post-secondary education) is at 63.5% in Cottonwood County and 73.3% in Minnesota.

The unemployment rate is 5.2% in Cottonwood County and 5.1% in Minnesota. The percentage of child poverty is 19% in Cottonwood County. The child poverty rate is 14% in Minnesota.

Social associations are defined as the number of membership associations per 10,000 population and links to social and economic support. The national benchmark for social associations is 22. The ranking is higher in Cottonwood County at 27.6. The state of Minnesota ranks at 13.2.

The percentage of children in single parent households is 30% in Cottonwood County and 28% in Minnesota.

Violent crime is lower in Cottonwood County at 119 per 100,000 population than Minnesota, which has 229 cases per 100,000 population. The national rate is 59.

The following needs were brought forward for prioritization:

- Children and Youth – bullying
- Aging – cost of long term care, availability of memory care, resources for caregivers
- Safety – the presence of street drugs and alcohol in the community
- Health Care Access – access to affordable health insurance, affordable health care, affordable prescription drugs
- Physical Health – cancer, chronic disease, obesity, inactivity
- Mental Health – depression, stress, substance use and abuse

Members of the community stakeholder group determined that mental and physical health are the top unmet needs.

- Mental Health
- Physical Health

Sanford has determined the 2017-2019 implementation strategies for the following needs:

- Priority 1: Mental Health
- Priority 2: Physical Health

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

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

Many factors contribute to mental health problems, including:

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

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

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to reduce the time that patients with mental health needs are placed for services. Sanford is working to create an awareness of the resources for mental health services in the area.

Sanford has set strategy to work with partners to create new recovery program options for community members and will also work with the MN Department of Health on a pilot for integrating behavioral health into Critical Access Hospitals.

Priority 2: Physical Health

Physical health consists of many components, including rest and sleep, nutrition, physical activity, and self-care. Primary prevention is a way to remain physically healthy.

Sanford has set strategy to help the community improve their physical health and chronic health conditions. A goal of this strategy is to increase the awareness of the Medical Home and Health Coach.

Additionally, Sanford *fit* is an on-line community health activation initiative created by Sanford Health that provides engaging programs and resources to kids, families, leaders and role models across numerous settings to promote and activate healthy choices. The four key factors of healthy choices, a healthy body and healthy life included in *fit* are, MOOD – Emotions and Attitudes and RECHARGE – Sleep and Relaxation, FOOD – Mindful Nutrition Choices, and MOVE – Physical Activity Levels.

SANFORD HEALTH

Sanford Westbrook Medical Center

Community Health Needs Assessment 2016

Table of Contents

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.

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, MS, LRD,CDE, Enterprise Lead, Enterprise Community Health/Community Benefit

Sanford Westbrook Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health /Community Benefit
- Stacy Barstad, Chief Executive Officer, Sanford Westbrook Medical Center

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 County Public Health Unit
- 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
- 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 community and county leaders, public health administration, physicians, nurses, representatives from the community, representatives supporting the mentally and physically disabled, social services, and non-profit organizations, for their participation in this work. Together we are reaching our vision “to improve the human condition through exceptional care, innovation and discovery”.

The following Westbook and Cottonwood County key community stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Denise Clouse, Marketing Manager, Administrative Team
- Jane Sabinske, Director of Nursing, Administrative Team
- Meghan Westover, Admin. Assistant, Administrative Team
- Becky Foster, Human Resource manager, Administrative Team
- Josh Sammons, Clinic Director, Administrative Team
- Stacy Barstad, CEO
- Gordon Kopperud, Director of Operations, Administrative Team
- Digger Phelps, Community Member
- Francis Khors, Community Member
- Bev Khors, Community Member
- Dolly Phelps, Community Member
- Sharon Trent, Community Member
- Mary Jane Erickson, Community Member

Description of Sanford Westbrook Medical Center

Sanford Westbrook Medical Center is an eight-bed, not-for-profit, Critical Access Hospital located in southwest Minnesota. It is a community-owned facility leased to Sanford Health Network. Originally known as Henry Schmidt Memorial Hospital, Sanford Westbrook was built in 1950 and through a comprehensive community effort was remodeled and expanded into the current single-site health care facility that includes an attached medical clinic and 21-unit senior housing facility. The medical center offers emergency services.

Sanford Westbrook service area includes the communities of Currie, Dovray, Jeffers, Storden and Westbrook and covers parts of Cottonwood, Redwood and Murray counties with a combined population of 3,600. It is located in an area classified as a Health Professional Shortage Area (HPSA) and Manpower Underserved Area (MUA). Sanford Westbrook employs 50+ individuals.

Description of the Community Served

The city of Westbrook with a population of 740 people and is located in southwestern Minnesota in Cottonwood County.

Westbrook is home to Westbrook-Walnut Grove High School, multiple churches, a community center, park, swimming pool, and other recreational amenities. It is only minutes away from excellent year-round hunting and fishing.

Active organizations in the community include: Kiwanis, American Legion, Lions Club, Heritage Healthcare Foundation, Westbrook Area Volunteers (WAV), and Westbrook Women's Club. Numerous local businesses including a grocery store, bank, drug store, pharmacy, lumber/hardware store, several bars and restaurants, and more.

Study Design and Methodology

1. Non-Generalizable Survey

   An on-line non-generalizable survey was conducted of residents in Cottonwood County and the Westbrook community. The survey instrument was developed in partnership with members of the Greater Fargo-Moorhead Community Health Needs Assessment collaborative, Sioux Falls community collaborative, Bismarck community collaborative, public health leaders from across the enterprise, and researchers at the Center for Social Research (CSR) at North Dakota State University (NDSU). 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 various agencies, at times using a snowball approach**.** Data collection occurred throughout the months of April 2015 and a total of 36 respondents participated in the on-line survey.

The purpose of the non-generalizable survey of residents in the greater Westbrook 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 public health, city government, tribes, chronic disease and disparity.

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 3.0 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.0 are being addressed by Sanford and community partners. However, 3.0 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. The 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. 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. The community stakeholder group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process. The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

4. Secondary Research

   The secondary data includes County Health Rankings for Cottonwood County.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Cottonwood County, Minnesota. However, when comparing certain demographic characteristics (i.e., age, income, minority status) with the current population estimates from the U.S. Census Bureau, it was evident that older, white, more highly educated, and higher income earners were overrepresented. Overrepresentation of this nature is typical in health needs assessments.

Literature reviews indicate that there are non-response rate issues among younger respondents. In particular, response rates to health care and community health needs assessment surveys have often been found to be higher for older respondents. Studies have also shown lower response rates for socially disadvantaged groups (i.e., socially, culturally, or financially).

A good faith effort was made to secure input from a broad base of the community. The generalizable survey was mailed to a representative group of the area to assure input from all demographics. Additionally, invitations were extended to county and community leaders, organizations and agencies representing diverse populations and disparities.

Additional data was reviewed through secondary research. The data for the secondary research was secured from the County Health Rankings.

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

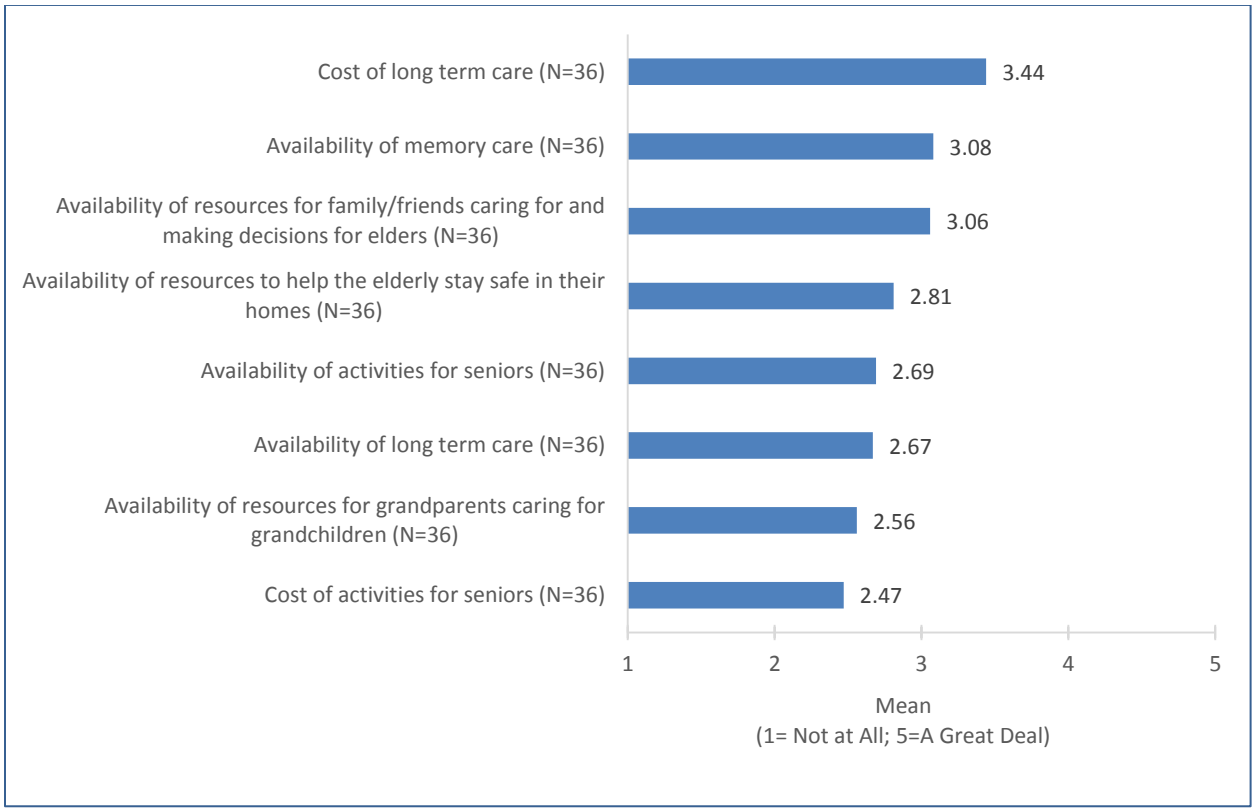
Primary Research

Community Health Concerns

The following concerns ranked highest of all the indicators on the non-generalizable (community stakeholders) surveys.

Aging Population: The cost and availability of long term care is the highest concern for the community stakeholders. The availability of memory care and the availability of resources to help caregivers making decisions for their elders also rank as high concerns for the aging population.

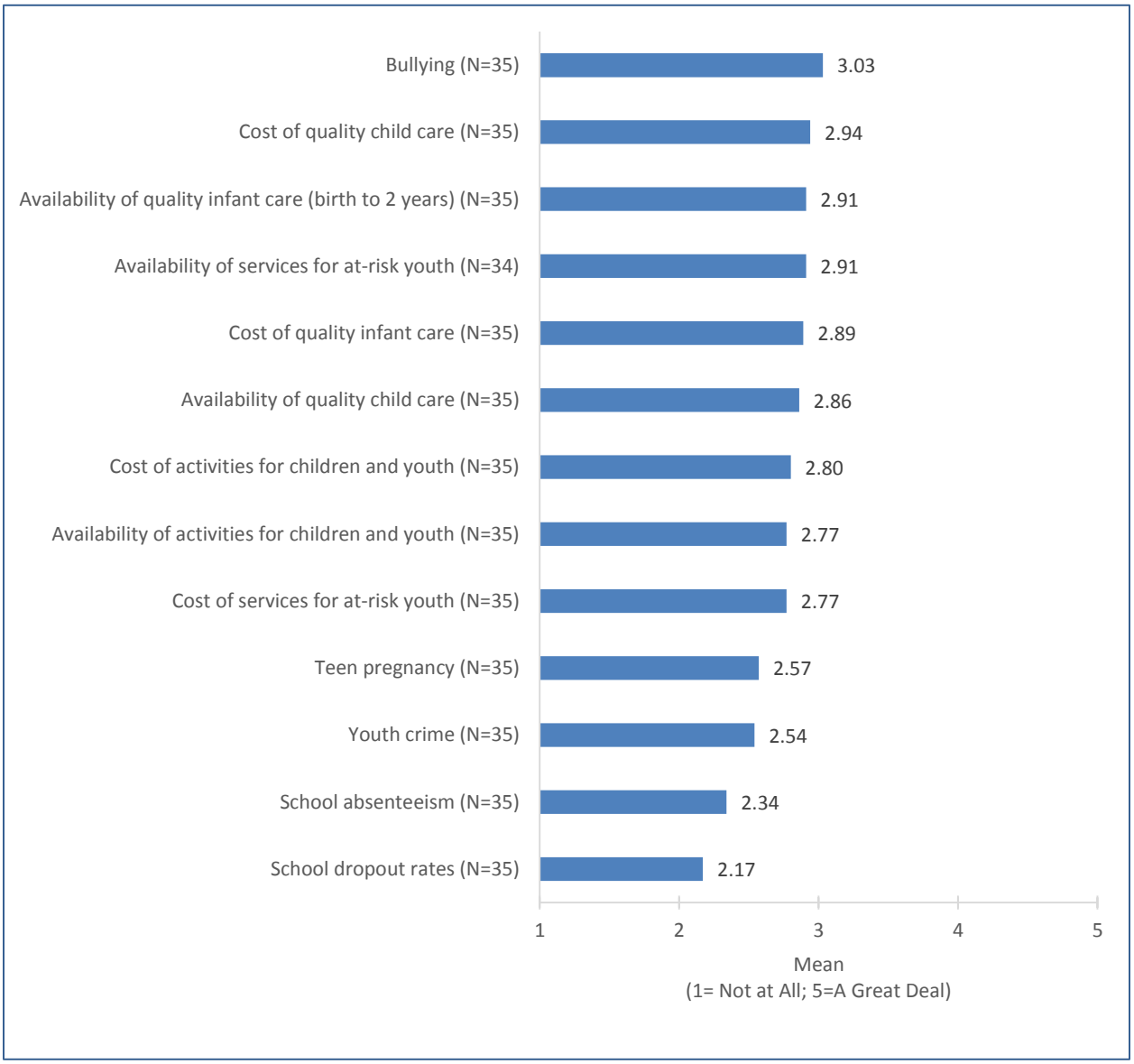
Level of concern with statements about the community regarding the AGING POPULATION



Sanford is working collaboratively with the area aging service providers to coordinate care for the aging population. Social workers, case managers, and discharge planners are working collaboratively with area service providers to assure safe discharge, and when appropriate, to assist in transitions from levels of care.

Children and Youth: The community stakeholders and survey respondents have very high concerns for the bullying of children and youth in the area.

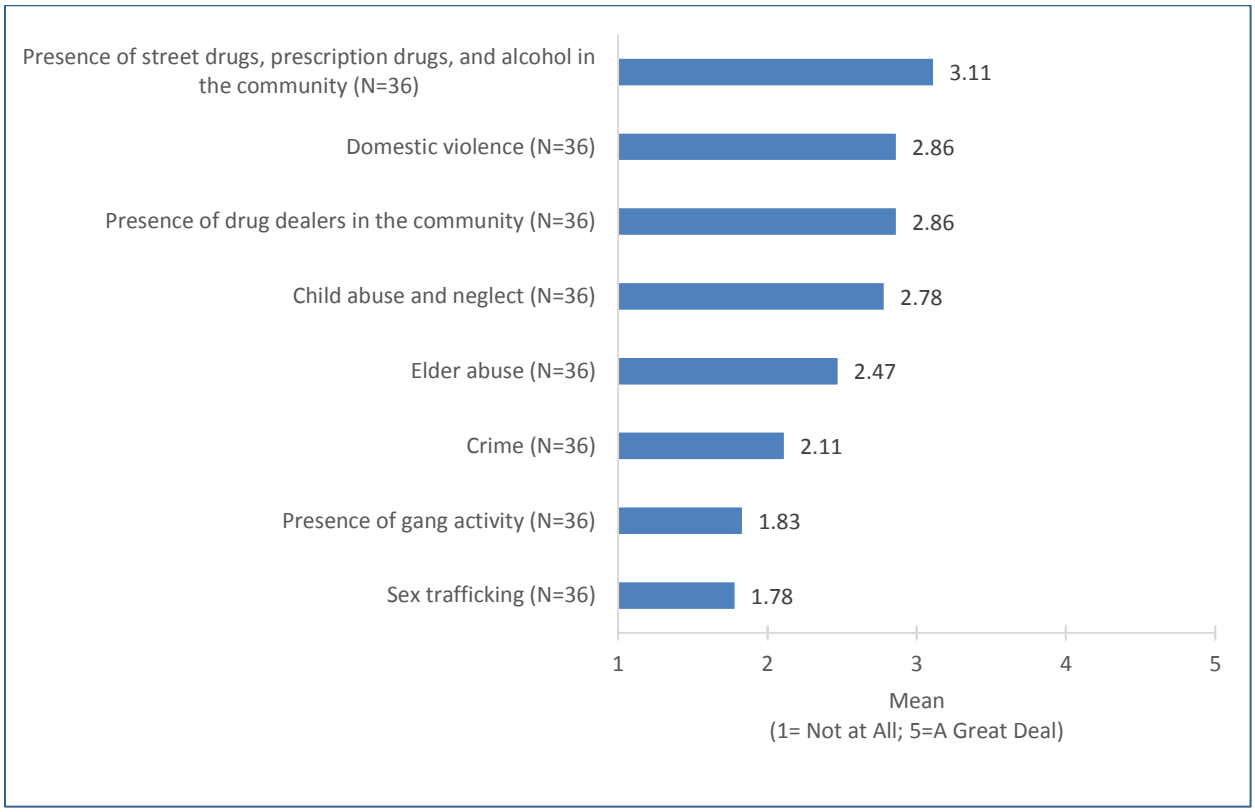
Level of concern with statements about the community regarding CHILDREN AND YOUTH



Pediatricians at Sanford address bullying during wellness visits. It is important to educate children and youth about what to do when they are bullied or see someone being bullied.

Safety: Safety is a high concern for the respondents of the non-generalizable survey regarding the presence of street drugs, prescription drugs, and alcohol and drug dealers in the community.

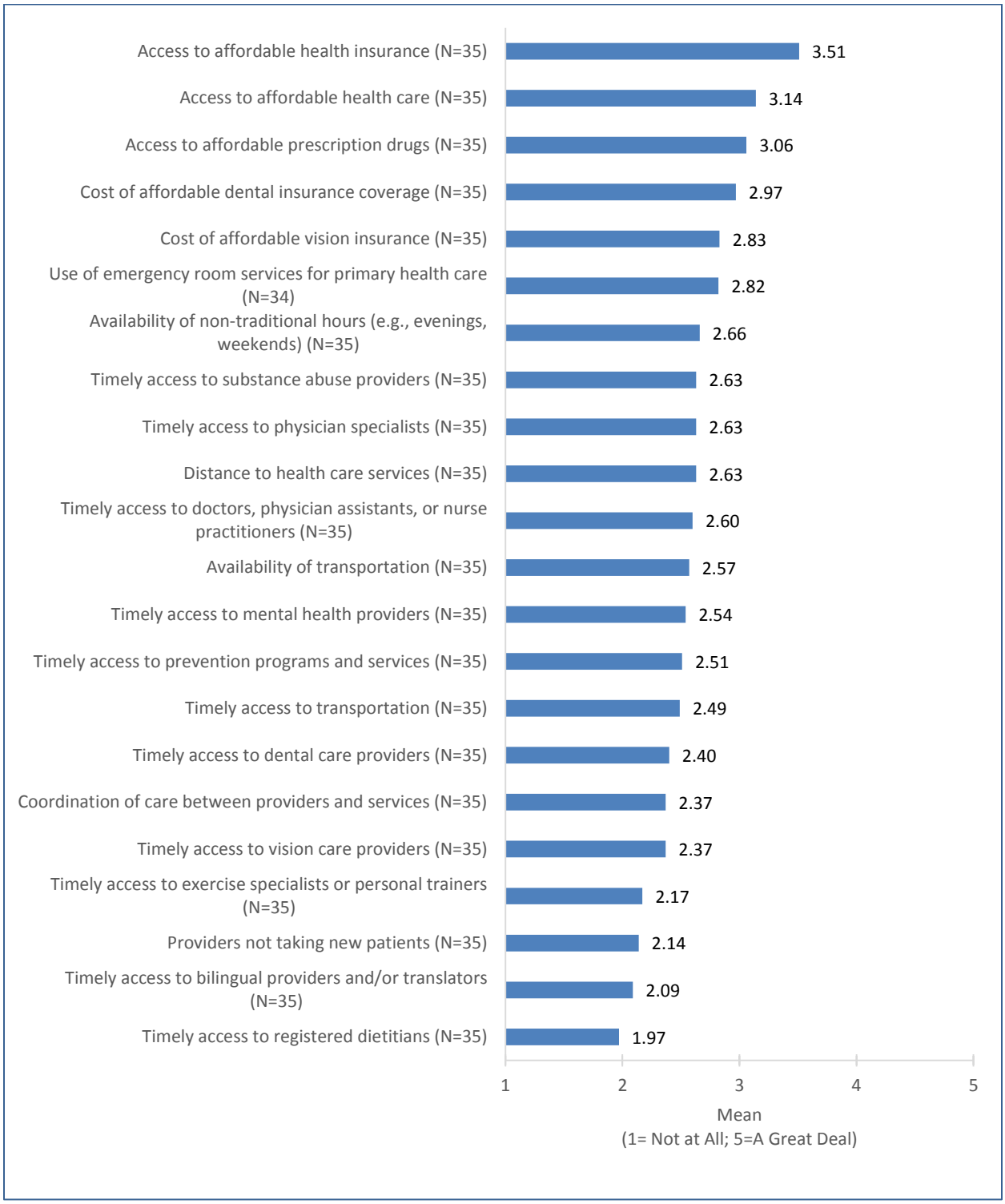
Level of concern with statements about the community regarding SAFETY



Sanford screens patients for substance abuse on admission to the emergency department.

Health Care Access: Community stakeholders ranked the access to affordable health insurance, access to affordable health care, and access to affordable prescription drugs as the top concerns for health care access.

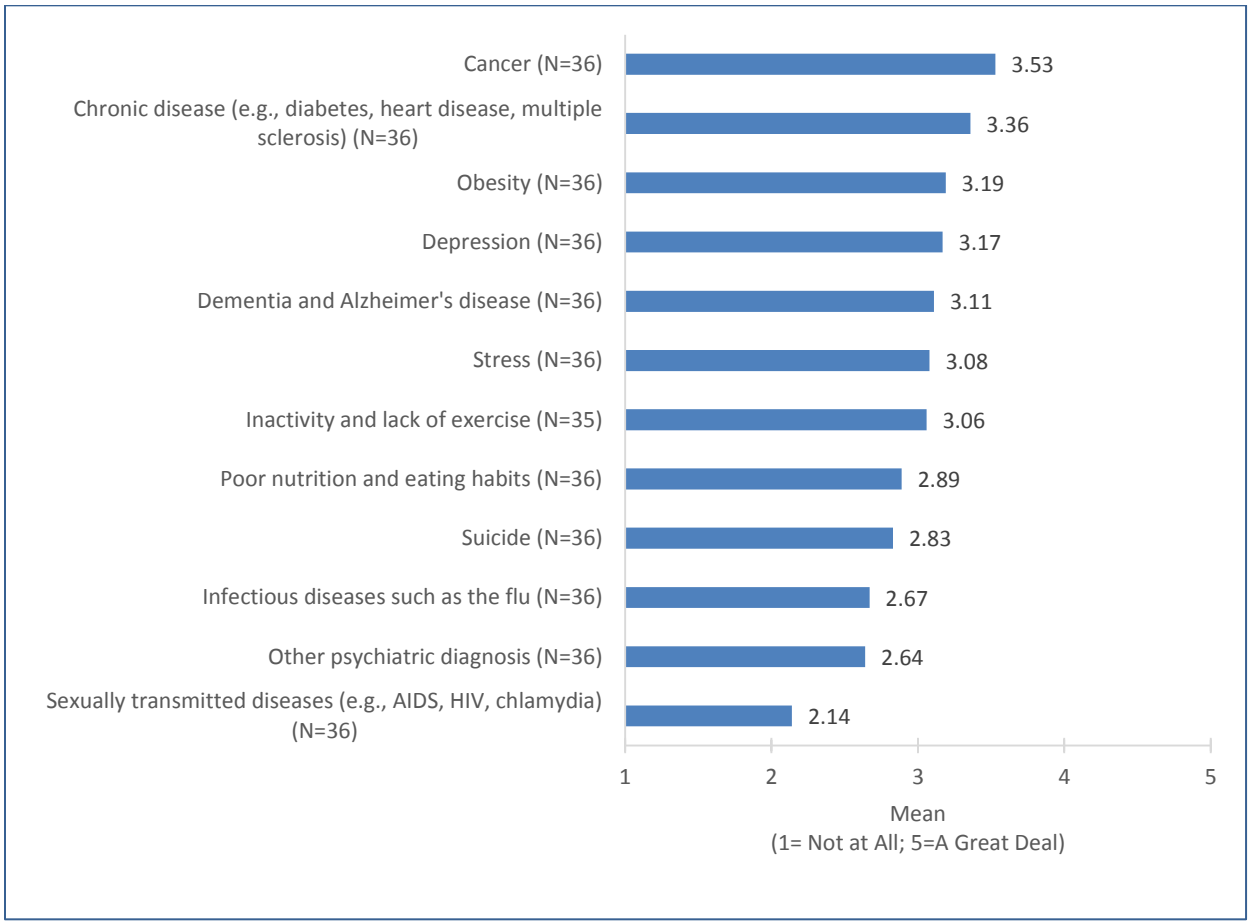
Level of concern with statements about the community regarding HEALTH CARE



Sanford Westbrook offers charity care to patients unable to pay for medical treatment. Sanford's community care policy defines qualifications and financial counselors are available to assist patients who qualify for free or subsidized care. Financial counselors also assist with enrollment for patients who qualify for public programs. Prescription drugs are made available at a free or reduced rate for patients who are unable to pay.

Physical Health: The top physical health concern among the community stakeholders is cancer. Chronic disease, obesity, and lack of exercise and inactivity are also ranked as high concerns

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



Sanford Westbrook has physical therapy and occupational therapy located in the fitness center. Chronic disease is supported by the RN home visit program and the Health Care Home and Health Coach clinic.

The chronic disease self-management Better Choices, Better Health Program at Sanford is offered free of charge to community members. Better Choices, Better Health is modeled after Stanford University's chronic disease self-management program. The workshops are 2 ½ hours long and meet weekly for 6 weeks. The program is facilitated by two trained lay leaders, and one

or both of them have a chronic condition themselves. Research has found that after participating in the program individuals are better able to manage their symptoms, communicate more easily with their doctors, are less limited by the disease, and generally feel better.

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* Initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents benefit from their own set of resources where they can find tips and tools on becoming healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites, including videos, slideshows, games, articles, and even *fit* songs.

- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.

- *fit*4Schools – *fit*4Schools includes unique *fit*-based lessons integrated into daily classroom activities. *fit*4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:
    - Reached 50,000 schools
    - 180,000 page views from educators across the country
    - 12,000 lesson plan downloads, representing 600,000+ students

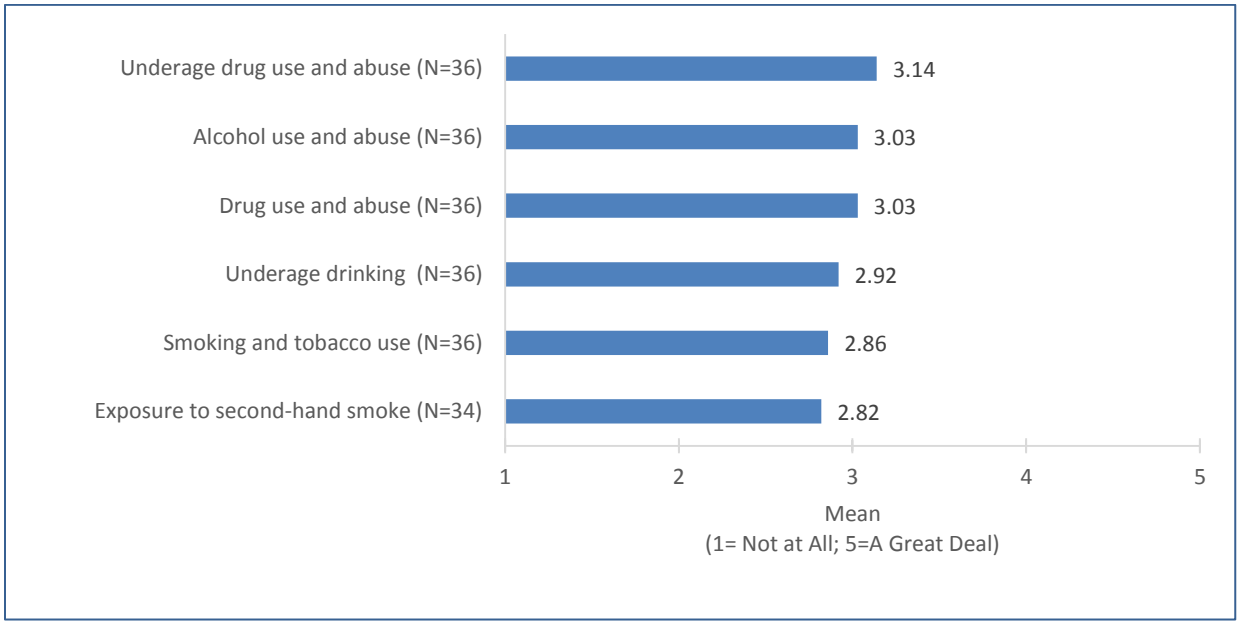
- Community
    - The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint. *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
    - Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
    - MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.

- eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward
  - *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:
    - Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between health care providers and families.
    - Health Coaches – Exploring meaningful ways for health coaches to promote healthy choices with children and adults.
    - Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach efforts.
    - *fit*Club 4 Boys – 10-week after school program for boys, ages 8-12, to develop knowledge of *fit* principles and healthy behavior choices.
    - *fit* Parent/child – Class for parents and children to understand healthy choices and the benefits of living a healthy lifestyle.

Mental Health/Behavioral Health: The top behavioral health concerns are depression, underage drug use and abuse, stress, and alcohol use and abuse.

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



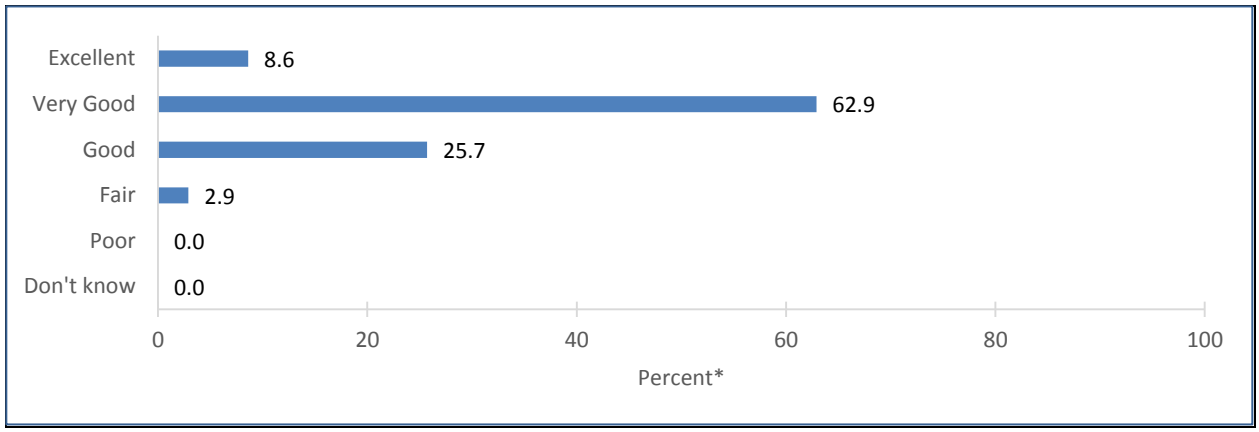
Sanford screens patients for depression on admission to the emergency department. Behavioral health services are embedded into the clinic.

Personal Health Concerns

Respondents' Personal Health Status

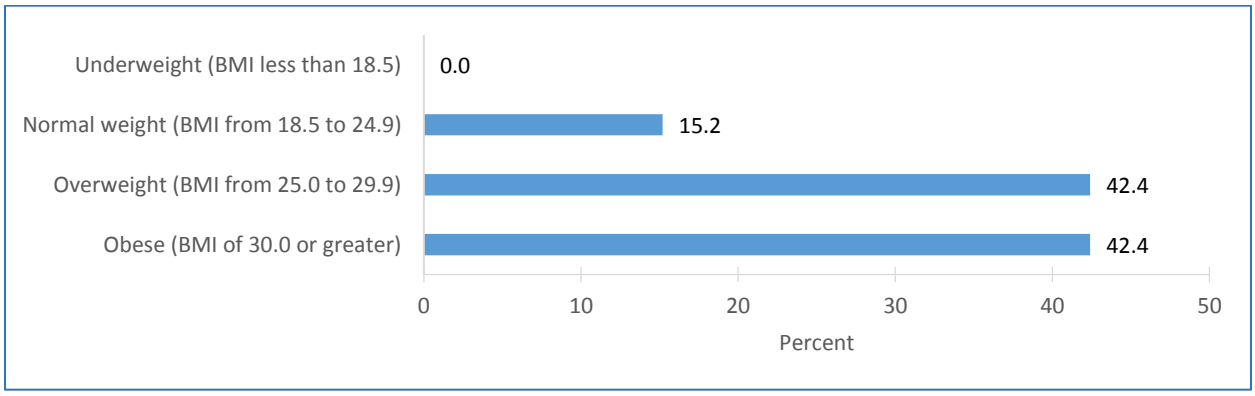
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area are overweight or obese. However, the vast majority of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, over 90% of respondents visited a doctor or health care provider for a routine physical and over 93% visited a dentist or dental clinic.

Respondents' rating of their health in general



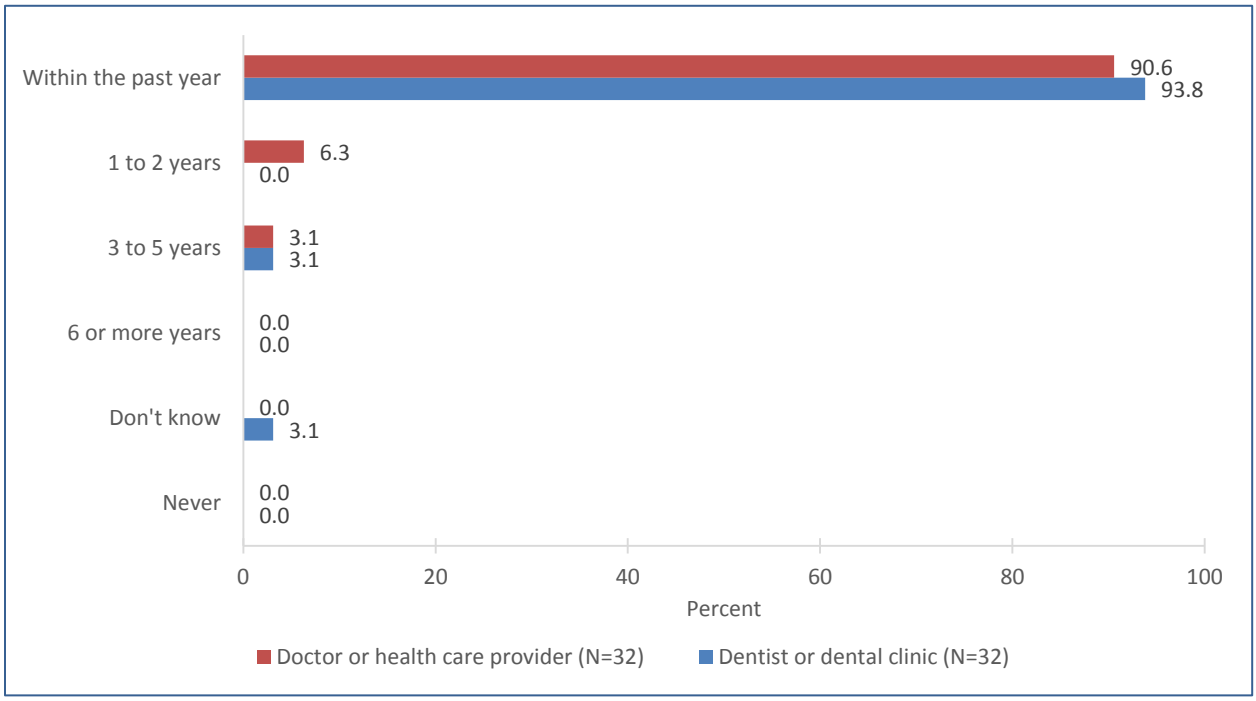
97.2% of the community stakeholders (non-generalizable) rate their health as good or better.

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



84.8% of the key stakeholders report a BMI that is overweight or obese.

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. Community results indicate that within the past year, the majority of respondents had a blood pressure screening, blood sugar screening, cholesterol screening, and dental screening.

There are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, cardio screening, glaucoma test, hearing screening, immunizations, STD test, vascular screening, colorectal cancer screening, and skin cancer screening) in the past year. Many tests and screenings may be conditional upon guidelines, which can be age sensitive/appropriate.

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=34)	94.1	5.9	100.0
Blood sugar screening (N=34)	70.6	29.4	100.0
Bone density test (N=34)	14.7	85.3	100.0
Cardiovascular screening (N=34)	29.4	70.6	100.0
Cholesterol screening (N=34)	79.4	20.6	100.0
Dental screening and X-rays (N=34)	85.3	14.7	100.0
Flu shot (N=34)	91.2	8.8	100.0
Glaucoma test (N=34)	47.1	52.9	100.0
Hearing screening (N=33)	12.1	87.9	100.0
Immunizations (N=34)	29.4	70.6	100.0
Pelvic exam (N=21 Females)	66.7	33.3	100.0
STD (N=33)	12.1	87.9	100.0
Vascular screening (N=33)	21.2	78.8	100.0
CANCER SCREENINGS			
Breast cancer screening (N=21 Females)	71.4	28.6	100.0
Cervical cancer screening (N=21 Females)	57.1	42.9	100.0
Colorectal cancer screening (N=32)	34.4	65.6	100.0
Prostate cancer screening (N=12 Males)	75.0	25.0	100.0
Skin cancer screening (N=32)	21.9	78.1	100.0

Of respondents who have not had preventive screenings in the past year, rasons 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=2)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Blood sugar screening (N=10)	80.0	20.0	0.0	0.0	0.0	0.0	0.0
Bone density test (N=29)	51.7	34.5	0.0	0.0	0.0	0.0	3.4
Cardiovascular screening (N=24)	41.7	54.2	0.0	0.0	0.0	0.0	0.0
Cholesterol screening (N=7)	71.4	14.3	0.0	0.0	0.0	0.0	14.3
Dental screening and X-rays (N=5)	80.0	0.0	0.0	0.0	0.0	0.0	20.0
Flu shot (N=3)	66.7	0.0	0.0	0.0	0.0	0.0	33.3
Glaucoma test (N=18)	44.4	38.9	0.0	0.0	0.0	0.0	11.1
Hearing screening (N=29)	51.7	31.0	0.0	0.0	0.0	0.0	6.9
Immunizations (N=24)	58.3	25.0	0.0	0.0	0.0	0.0	8.3
Pelvic exam (N=7 Females)	71.4	14.3	0.0	0.0	0.0	0.0	14.3
STD (N=29)	69.0	17.2	0.0	0.0	0.0	0.0	0.0
Vascular screening (N=26)	61.5	26.9	0.0	0.0	0.0	0.0	0.0
CANCER SCREENINGS							
Breast cancer screening (N=6 Females)	50.0	33.3	0.0	0.0	16.7	0.0	0.0
Cervical cancer screening (N=9 Females)	66.7	33.3	0.0	0.0	0.0	0.0	0.0
Colorectal cancer screening (N=21)	71.4	28.6	4.8	0.0	0.0	0.0	0.0
Prostate cancer screening (N=3 Males)	33.3	66.7	0.0	0.0	0.0	0.0	0.0
Skin cancer screening (N=25)	48.0	48.0	0.0	0.0	4.0	0.0	0.0

- *Notes: "-" = no respondents in age group. NA = not applicable.*
- *For most types of screenings, the most common reasons for not getting the test or procedure are that it is not necessary and the doctor has not suggested one.*
- *For the flu shot screening, most respondents cite that it was not necessary or other reasons for not getting the shot.*
- *23.5% of the non-generalizable respondents were under 45 years of age. Over 55% were in the 55 ears or above category.*

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 U. S. 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 (human papillomavirus(http://www.cdc.gov/cancer/hpv/basic_info/)) that can cause these cell changes.

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 years and continuing until age 75 years.

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 2.5ng/mL may only need to be retested every 2 years.
- Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher.

Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone is important when making decisions about screening.

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

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

- Be aware that fair-skinned men and women aged 65 and older, and people with atypical moles or more than 50 moles, are at greater risk for melanoma.
- Look for skin abnormalities when performing physical examinations for other reasons.

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the generalizable survey indicate that 37% of respondents did not have a flu shot last year.

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

Sanford Health employees are required to have an annual flu vaccine as a protective measure for our patients as well as our staff. Sanford holds annual flu blitz events to increase the number of community members both pediatric and adult who receive the flu vaccine.

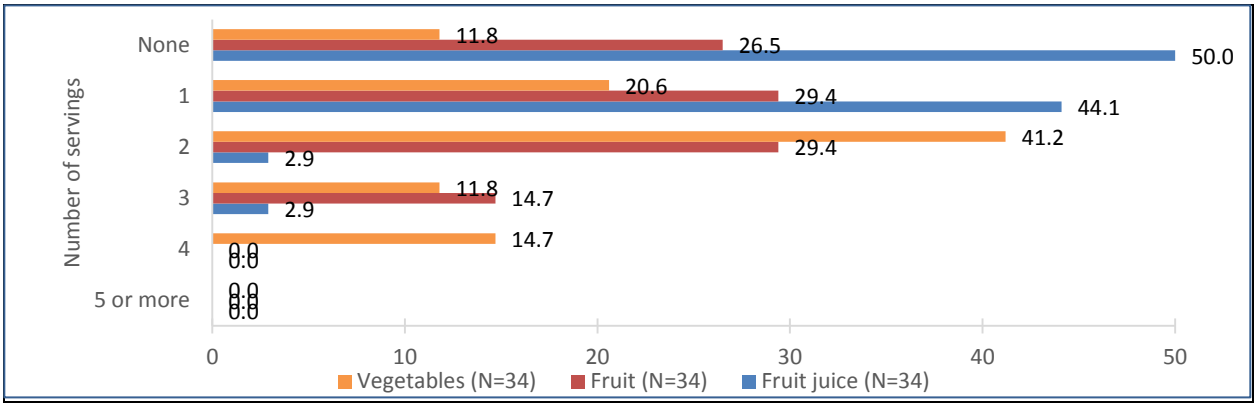
Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 26.5% of respondents reported having 3 or more servings of vegetables the prior day. Only 14.7% 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 meal plan 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 meal plan can be beneficial for weight management.

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

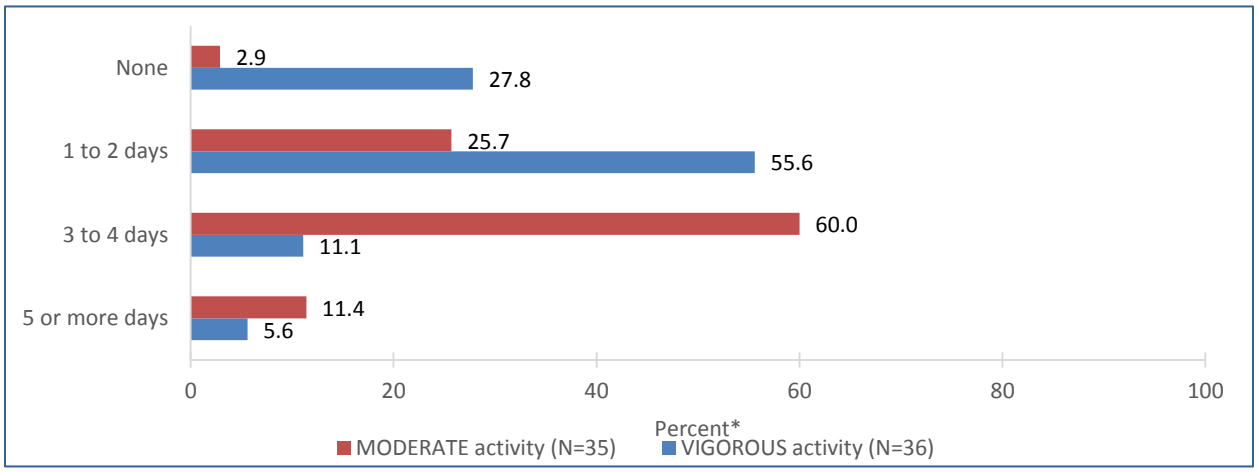


Physical Activity Levels

Study results suggest that 71.4% of respondents do meet physical activity guidelines.

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.

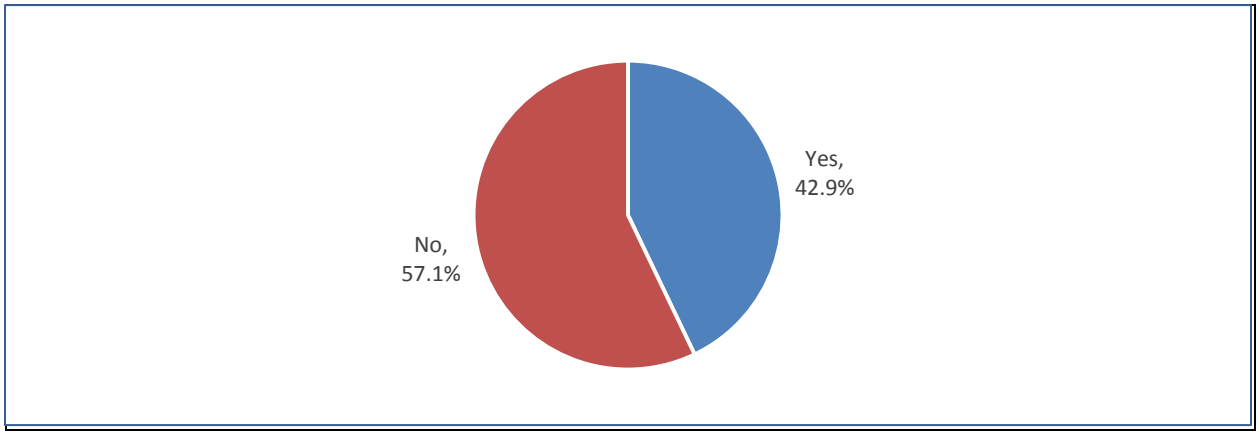
Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



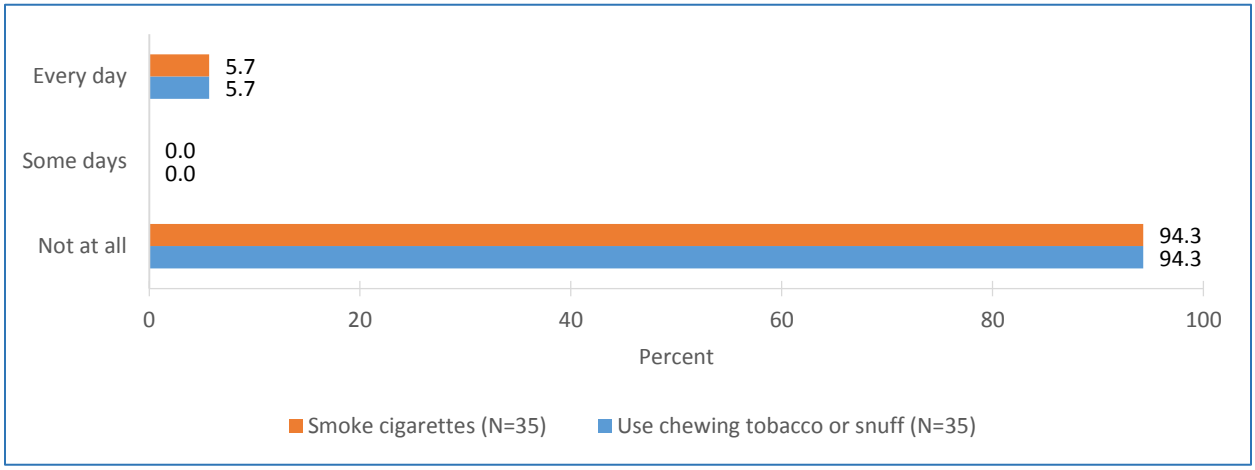
Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 42.9% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates a former smoker status according to the Centers for Disease Control and Prevention.

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



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

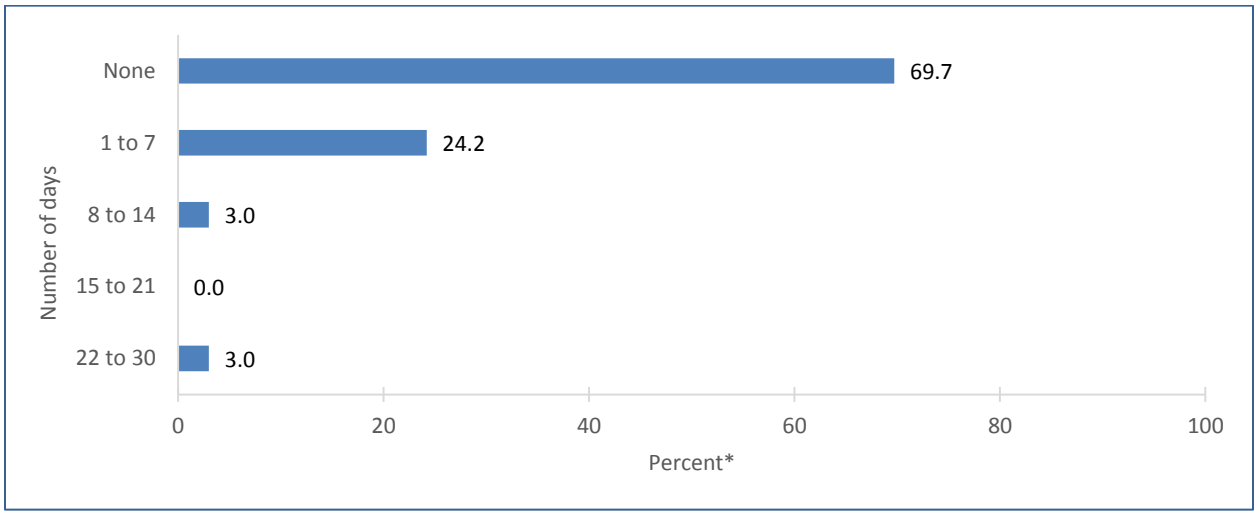


Mental Health

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 Cottonwood and Westbrook respondents, mental health is a moderately high area of concern, particularly depression and stress. More than 16% of respondents have been told or diagnosed by a doctor or health professional that they have anxiety or stress and 11% have been told they have depression. In

addition, 27.5% of respondents self-report that in the last month, there were days when their mental health was not good.

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

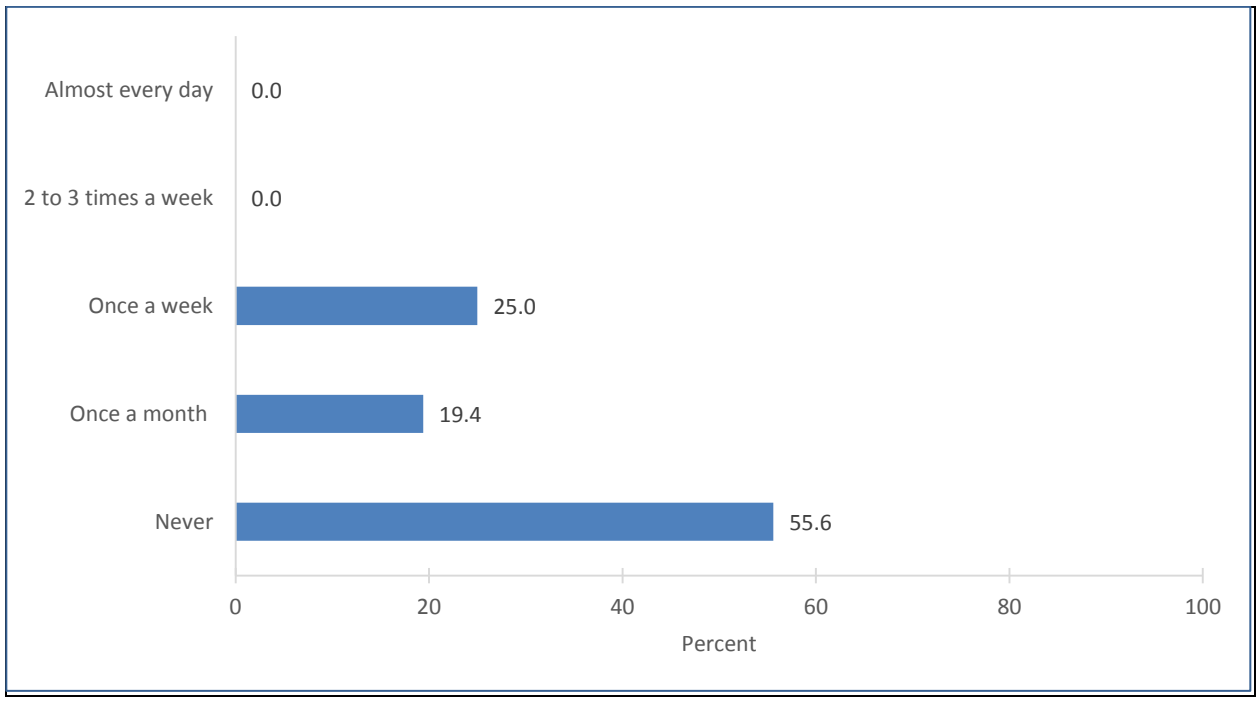


Substance Abuse Responses

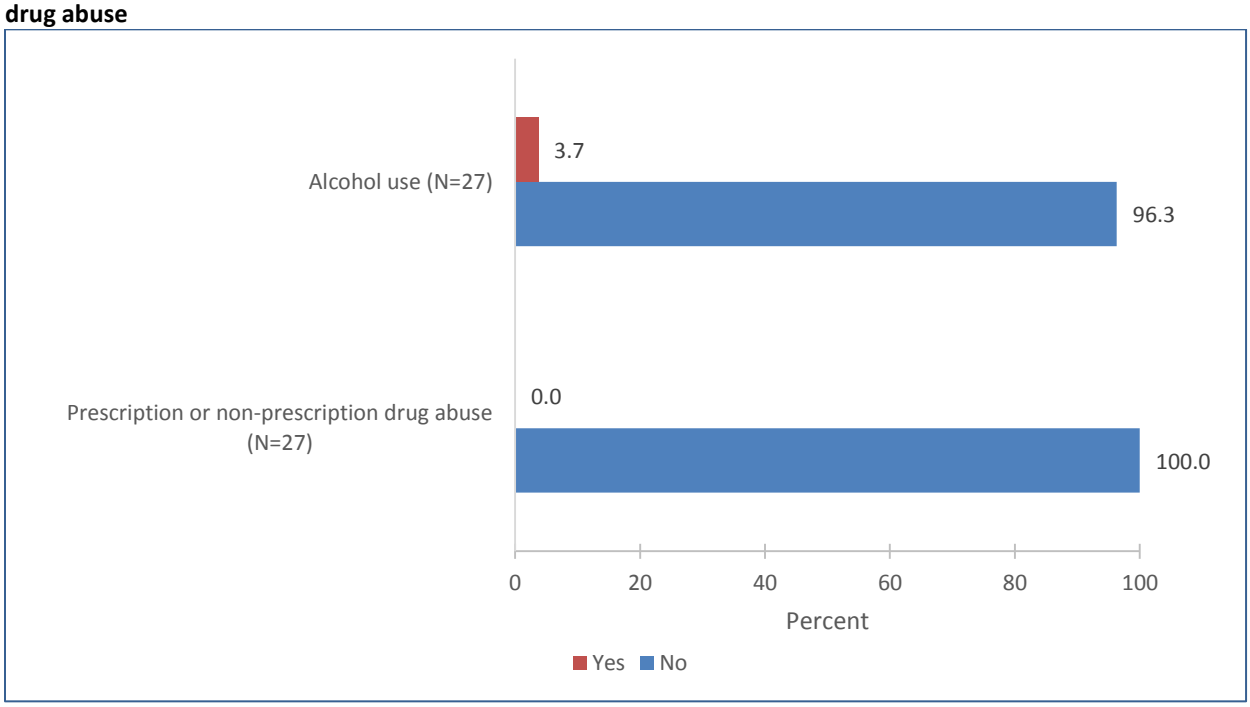
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In Westbrook and Cottonwood County, 80% of the community stakeholder respondents drank alcoholic beverages on at least one of the days in the last month. On days they drank, 39.3% of respondents drank an average of 3 or more drinks per day. In regards to binge drinking, 44.4% of community stakeholder respondents report binge drinking at least once per month,

Secondary research through the 2015 County Health Rankings found no data for excessive drinking; however, 56% of the driving deaths indicted alcohol involvement. (See Appendix)

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



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



3.7% percent of respondents from the community stakeholder group reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking.

Other forms of substance abuse include the use of prescription or non-prescription drugs. 0% of the community stakeholder respondents reported having had a problem with prescription or non-prescription drug abuse.

Demographics

Total Population – 2010 U.S. Census Bureau

- Cottonwood County: 11,687

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	703	6	355	3	348	3
5-9	801	6.9	414	3.5	387	3.3
10-14	770	6.6	422	3.6	348	3
15-19	782	6.7	385	3.3	397	3.4
20-24	515	4.4	275	2.4	240	2.1
25-29	558	4.8	286	2.4	272	2.3
30-34	572	4.9	304	2.6	268	2.3
35-39	594	5.1	291	2.5	303	2.6
40-44	674	5.8	327	2.8	347	3
45-49	797	6.8	401	3.4	396	3.4
50-54	875	7.5	455	3.9	420	3.6
55-59	833	7.1	413	3.5	420	3.6
60-64	731	6.3	369	3.2	362	3.1
65-69	594	5.1	292	2.5	302	2.6
70-74	495	4.2	230	2	265	2.3
75-79	459	3.9	198	1.7	261	2.2
80-84	432	3.7	176	1.5	256	2.2
85 and over	502	4.3	170	1.5	332	2.8
Median age	44.2		42.3		45.7	

Population by Race

	Cottonwood	Percent
White	10,773	92.2
Black or African American	87	0.7
American Indian or Alaska Native	27	0.2
Asian	317	2.7
Native Hawaiian or other Pacific Islander	17	0.1
Hispanic or Latino	720	6.2

The per capita personal income in Cottonwood County, Minnesota is $16,647. 7.4% in Cottonwood County are living below the poverty level. The unemployment rate in Cottonwood County is 5.2%.

Health Needs and Community Resources Identified

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

Sanford Health and community partners developed the asset map. 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 process includes identified needs from the following:

- The non-generalizable survey
- Secondary research data
- Community resources that are available to address the needs

The asset map can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

- Children and Youth – bullying
- Aging – cost of long term care and availability of memory care, resources for caregivers
- Safety –the presence of street drugs and alcohol in the community
- Health Care Access – access to affordable health insurance, affordable health care, affordable prescription drugs
- Physical Health – cancer, chronic disease, obesity, inactivity
- Mental Health – depression, stress, substance use and abuse

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 to 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 next section of this report.

Members of the collaborative determined that mental health and physical health are top unmet needs for further implementation strategies.

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

- Mental Health
- Physical Health

How Sanford Westbrook is Addressing the Needs

Identified Concerns	How Sanford Westbrook is Addressing the Needs
Aging • Cost of long term care • Availability of memory care • Availability of resources for family/friends caring for and making decisions for elders	Sanford has employed a social worker at Sanford Westbrook to help patients with financial needs and location resources.
Children and Youth • Bullying	Sanford Westbrook's pediatrician on staff takes the time to educate young patients and families about bullying and what to do if bullying is taking place. These discussions take place during wellness visits.
Safety • Presence of street drugs and alcohol in the community	Patients to the Sanford Westbrook ER are screened for substance abuse on admission to ER.
Health Care • Access to affordable health insurance • Access to affordable health care • Access to affordable prescription drugs	Sanford Westbrook offers charity care to patients unable to pay for medical treatment. Sanford's community care policy defines qualifications and financial counselors are available to assist patients who qualify for free or subsidized care. Social workers or financial counselors also assist with enrollment for patients who qualify for public programs. Prescription drugs are made available at a free or reduced rate for patients who are unable to pay. Social worker as a resource to patients. Sanford Health Plan is marketed and advertised in area.
Physical Health • Cancer • Chronic disease • Obesity (*County Health Rankings* indicate 29% obesity for Cottonwood County) • Inactivity and lack of exercise	Patients have access to the cancer center in Sioux Falls Better Choices – Better Health is available free of charge to all community members. This is a self-management chronic disease program. There is a fitness center in Westbrook. PT/OT department located at fitness center.

Identified Concerns	How Sanford Westbrook is Addressing the Needs
	Sanford supports the local food pantry - to decrease obesity. Sanford dietitians are available to provide medical nutrition therapy. RN home visit program - chronic disease support. Health Care Home and Health Coach have been implemented in the clinic to monitor compliance and improve health of patients.
Mental Health • Depression • Underage drug abuse • Stress • Alcohol use and abuse o 39.3% of respondents reported 3 or more drinks/d on average o 44.4% reported 4 or 5 drinks (binge) on the same occasion over the past month o Only 3.7% reported having a problem with alcohol use; however, 16.7% reported that alcohol use had harmful effects on the respondent or a family member	Sanford screens patients for depression on admission to ER, etc. Behavioral health is embedded in the clinic setting. A licensed social worker and mental health professionals see patients in the clinic. There are services for both adults and children.

SANFORD HEALTH

2016 Implementation Strategy

Implementation Strategies

Priority 1: Mental Health/Behavioral Health

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

Many factors contribute to mental health problems, including:

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

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

Sanford has prioritized mental/behavioral health as a top priority and has set strategy to reduce mortality and morbidity from chemical addiction and mental illness, and enhance the level of behavioral health services that are available to patients in the hospital/clinic setting.

Priority 2: Physical Health

Many of the chronic conditions experienced by our patients can be addressed through primary prevention. Weight gain itself has been shown to increase the risk of type 2 diabetes (Nurses Health Study), hypertension (NHANES III), gallstones (NHANESIII), osteoarthritis in the knee (Framingham Study and NHANES I), and endometrial cancer (Schottenfield et. al, 1996). Weight gain is also associated with higher lipid levels, coronary heart disease, cardiovascular disease, and premature death from stroke and heart attack (NHLBI, 1998).

Sanford has set strategy to improve the care of patients with chronic disease, overweight or obesity diagnoses. Patients who are overweight will be referred to internal services including registered dietitians, exercise specialists, and Health Coaches.

The Sanford Health *fit* initiative, http://sanfordfit.org/ a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for children, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Sanford's *fit* initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life.

- The *fit* website for Juniors, Kids and Teens creates an entertaining and interactive on-line environment where they can play games, watch videos and take daily challenges. Parents

benefit from their own set of resources where they can find tips and tools on becoming healthy role models and raising *fit* kids. To date, the children's and parent's sites have received more than 7.5 million visitors. Over 700 pieces of content have been added to the sites including videos, slideshows, games, articles, and even *fit* songs!

- In addition to the web, *fit* is developing meaningful school resources to bring value and fun into the primary education setting. We are doing this by integrating *fit* points into science and math components to provide health promotion, an avenue into the classroom without taking valuable time away from those critical subjects.

- *fit*4Schools – *fit*4Schools includes unique *fit*-based lessons integrated into daily classroom activities. *fit*4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, and math) unit plans that can be downloaded for classroom use. To date it has:
    - Reached 50,000 schools
    - 180,000 page views from educators across the country
    - 12,000 lesson plan downloads, representing 600,000+ students

- Community
    - The *fit* friends, Denny, Abby, Sam, Alex and Marty, along with the *fit* team, have been making a variety of appearances at events across the Sanford footprint! *fit* has been at over 2 dozen events interacting with more than 15,000 children and parents to spread the word about the *fit* platform and resources.
    - Smartphone Apps – Through a series of fun and engaging apps, *fit* will continue to activate kids at the touch of a fingertip to live a fit and healthy lifestyle related to Mood, Recharge, Food and Move.
    - MOVE2Draw is a simple and fun way for kids to move and create their own unique drawings. Once a drawing is completed, it can be stored on the MOVE2Draw website.
    - eMOODicam is a photo application that allows the user to enhance a photo and bring the mood to life and share with others.

- Looking Forward
    - *fit* is continuing to look to the future for ways to continue to make a meaningful impact on children and families both on-line and off-line. Other exciting expansions that are in the works include:
        - Clinical Setting – Resources for the clinical setting to spur actionable and understandable discussions between health care providers and families.
        - Health Coaches – Exploring meaningful ways for Health Coaches to promote healthy choices with children and adults.
        - Engage Key Role Models – Firefighters and youth sport coaches are role models and have a big influence on children so that's why *fit* is developing resources for them to teach the principles of *fit* along with sports fundamentals and other outreach.

Community Health Needs Assessment
Implementation Strategy for Sanford Westbrook Medical Center
FY 2017-2019 Action Plan

Priority 1: Mental Health

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

Goal 1: To show a decrease of time for mental health patients to be in the ER and go to placement

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

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

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaboration
Work with community partners to create new recovery program options for community members	Alcohol and drug treatment program(s) awareness is marketed to community providers	Public Health, community and city leaders	Behavioral Health Team/ Barstad/ Sammons	City of Westbrook Leaders/ Cottonwood County Public Health

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

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

Priority 2: Physical Health

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

Goal 1: Medical Home and Health Coach utilization

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

Goal 2: Sanford *fit* Kids utilization

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Work with Sanford *fit* Kids and work with community to bring this service more visibility	Presentations at school and at various community groups	Med. Staff/ Schools/ Athletic Trainer/Mktg.	Clouse/ Radke/ Barstad	WWG Schools

Goal 3: **Utilizing Sanford *Profile* Services**

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Exploring utilization of new Sanford *Profile* weight management service for the community	Enrollment of at least 3 new patients over the next 1 year	Sanford *Profile* tools/Provider and community awareness	Radke/ Clouse/ Barstad	N/A

2013 Implementation Strategy Impact

Demonstrating 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.

2013 Community Health Needs Assessment
Sanford Westbrook Implementation Strategy

1. **Implementation Strategy: Dental, Mental Health, General Physician**

   Three-Year Plan (January 2012 - January 2015)

   - Work on partnership or any opportunities with Bruce Mathiason, local dentist in Walnut Grove, to offer free or reduced cost clinics - could seek out grant funds for this as well.
   - Seek out possibilities with Open Door Dental to come to community.
   - Recruitment of general family practice physician for Westbrook.
   - To increase mental health providers available
   - Obtain certification of Medical Home and implement Health Coach to help with resources and guidance for patients.

2. **Implementation Strategy: Oncology**

   Three-Year Plan (January 2012 - January 2015)

   - Pursue discussion with Worthington oncologist and opportunities to partner and expand services to Westbrook.
   - Increase utilization of tele-oncology from Sioux Falls - marketing and awareness of services.

3. **Implementation Strategy: Obesity**

   Three-Year Plan (January 2012 - January 2015)

   - Increase awareness and utilization of Medical Home and Health Coach to reach obese patients.
   - Work with Sanford *fit* Kids and work with community to bring this service more visibility.

- Work with the WWG school on wellness center opportunities, reduced rates, etc.
- Look at possibility of increasing dietician hours and access for community and patients.
- Explore utilization of new Sanford *Profile* weight management service for the community.

The 2013 strategies have served as a base for reaching out and utilizing resources and implementing resources in the Westbrook community. The impact has been positive and the work will continue into the future through new or continued programming and services on the strategies.

Impact of the Strategy of Dental, Mental Health and General Physician

Dental services are a work in progress. Grant funds have not been obtainable. Dental services in nearby communities of Walnut Grove and Tracy have been accessible to patients. The work with the Open Door Dental group will continue to have a presence in Westbrook. The group is accessible in nearby communities.

Recruitment continues for a family practice physician for Westbrook. At this point, rural recruitment is very difficult with many communities competing for rural physicians.

Successful recruitment efforts have been achieved with the replacement position of a specialized behavioral health nurse practitioner in spring 2013.

Medical Home certification was obtained successfully in fall of 2013.

Impact of the Strategy to Address Oncology

Increasing access for cancer patients at Sanford Westbrook has been a top priority. Because of the small patient size we have not been able to have a regular schedule for an oncologist to visit Westbrook, but tele-video options are available for patients. We market and address this with patients as an option to stay close to home.

Impact of the Strategy to Address Obesity

With the addition of a certified Medical Home and Health Coach in Westbrook, efforts are ongoing to identify patients with obesity issues and to offer resources and monitoring to assist with health conditions.

Ongoing efforts with the local wellness center to offer training for equipment and assistance for community members who want to use the facility.

Ongoing efforts to increase access to outreach dietitian are underway. With the Health Coach identifying this need, resources are being made aware for obese patients.

The Sanford Health *fit* initiative, a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the

only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge (sleep). Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life. In 2016 a new *fit* initiative will be available for 20,000 classroom teachers. The classroom curriculum has numerous modules that teachers can access and implement in part or comprehensively.

Profile by Sanford is a personalized retail weight loss program designed by Sanford Health physicians and scientists to be simple, effective and sustainable. With a certified *Profile* coach, personalized meal plans and smart technology to track progress, members see real results. Each weight loss plan is designed with a focus on nutrition, activity and lifestyle.

The enterprise obesity initiative addressed education for providers and education for patients and community members. The first annual Sanford obesity symposium was held in 2014. Over 400 health care professionals from the region and beyond registered for the 2014 and the 2015 symposiums. The purpose of the symposium is to enhance the knowledge and competence of participants by providing an update on the latest research associated with the prevention, treatment and management of obesity. The target audience includes primary care physicians, pediatricians and specialty care providers, advanced practice providers, licensed registered dietitians, nurses, and other interested health care professionals.

The symposium is an opportunity to provide prevention and treatment practice guidelines for the adult and pediatric population. The planning committee includes several published providers who are sought after nationally and internationally for their expertise.

Sanford is taking a comprehensive and multi-faceted approach to obesity prevention and treatment. The impact is demonstrated through the lives of our community members who have had positive outcomes because of our programs and services.

Community Feedback from the 2013 Community Health Needs Assessment

Sanford Health is prepared to accept feedback on the 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

Sanford Westbrook Medical Center 2016 CHNA Asset Map

Identified concern	Key stakeholder survey	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
Aging population	3.44 – 3.06		• Cost of long term care • Availability of memory care • Availability of resources for family/friends caring for and making decisions for elders	LTC and Memorial Care: • Good Samaritan Society 507-274-6155	X
Children and Youth	3.03	• 19% of children live in poverty	• Bullying	Subsidized housing – Westbrook apts. – 507-360-8959 Mary & Martha Pantry School Counselors - Westbrook Schools – 507-274-6112	X
Safety	3.11	• Violent crimes is at 119 compared to the UN top performers at 59	• Presence of street drugs, and alcohol in the community	Police Dept. 507-274-5400	X
Health Care	3.51 – 3.06		• Access to affordable health insurance • Access to affordable health care • Access to affordable prescription drugs	Sanford Community Care Program Financial assistance/counselors in Sanford business office Sanford Westbrook Clinic 507-274-6121	X
Physical Health	3.53 – 3.06	• Reporting poor or fair health – 22% in Cottonwood County • The adult obesity rate is 29% in Cottonwood County	• Cancer • Chronic Disease (hypertension, high cholesterol, arthritis, diabetes) • Obesity • Inactivity and lack of exercise (39% have moderate exercise 3 or more times/week, and 17% have vigorous	Sanford Cancer Biology Research Sanford Dietitians Sanford WebMD Fit Kids for children and parents Sanford Medical Home	X

Identified concern	Key stakeholder survey	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap ?
		• The inactivity rate is 27% with a 76% access to exercise opportunities in Cottonwood County	activity 3 or more times/week	RN Health Coach American Cancer Society Better Choices/Better Health American Heart Association Westbrook Schools physical activity program – 507-274-6112 Sanford Westbrook Clinic 507-274-6121	
Mental Health/Behavioral Health (Substance Abuse)	3.17-3.03	• 1.2 % of residents report poor mental health • 56% of traffic deaths were alcohol impaired in Cotton wood County	• Depression (11% report depression – 27.5% have 1 or more days/mos. when their mental health was not good) • Under age drug use and abuse • Stress • Alcohol use and abuse (39.3% report consuming 3 or more drinks/d and 44.4% have binge level drinking at least 1time/mos.) • Drug use and abuse	Sanford Westbrook Clinic 507-274-6121	X

Sanford Westbrook 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
Aging • Cost of long term care 3.44 (3) • Availability of memory care 3.08 (8) • Availability of resources for family/friends caring for and making decisions for elders 3,06 (9)	X		
Children and Youth • Bullying 3.03 (10)	**XX**		
Safety • Presence of street drugs and alcohol in the community 3.11 (7)			
Health Care • Access to affordable health insurance 3.51 (2) • Access to affordable health care 3.14 (6) • Access to affordable prescription drugs 3.06 **(9)**	XX		
Physical Health • Cancer 3.53 (1) • Chronic Disease 3.36 (4) • Obesity 3.19 (4) - county rate is obese 29% • Inactivity and lack of exercise 3.06 (9)	XXXXX XX #2 priority		
Mental Health • Depression 3.17 (5) • Underage drug abuse 3.14 (6) • Stress 3.08 (8) • Alcohol use and abuse 3.03 (10) o 39.3% of respondents reported 3 or more drinks/d on average o 44.4% reported 4 or 5 drinks (binge) on the same occasion over the past month o Only 3.7% reported having a problem with alcohol use; however, 16.7% reported that alcohol use had harmful effects on the respondent or a family member	XXXXX XXX #1 priority		

Present: Denise Clouse-Marketing Manager, Administrative Team, Jane Sabinske-Director of Nursing, Westbrook-Administrative Team, Meghan Westover, Admin. Assistant-Administrative Team, Becky Foster, Human Resource Manager-Administrative Team, Josh Sammons-Clinic Director-Administrative Team, Stacy Barstad-CEO, Gordon Kopperud-Director of Operations-Administrative Team, Digger Phelps-Community Member, Francis Khors-Community Member, Bev Khors-Community Member, Dolly Phelps-Community Member, Sharon Trent-Community Member, Mary Jane Erickson-Community Member

Sanford Westbrook Medical Center

Community Health Needs Assessment

Results from an April 2015 Non-Generalizable

Online Survey

August 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from an April 2015 on-line 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 April 2015 and a total of 36 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

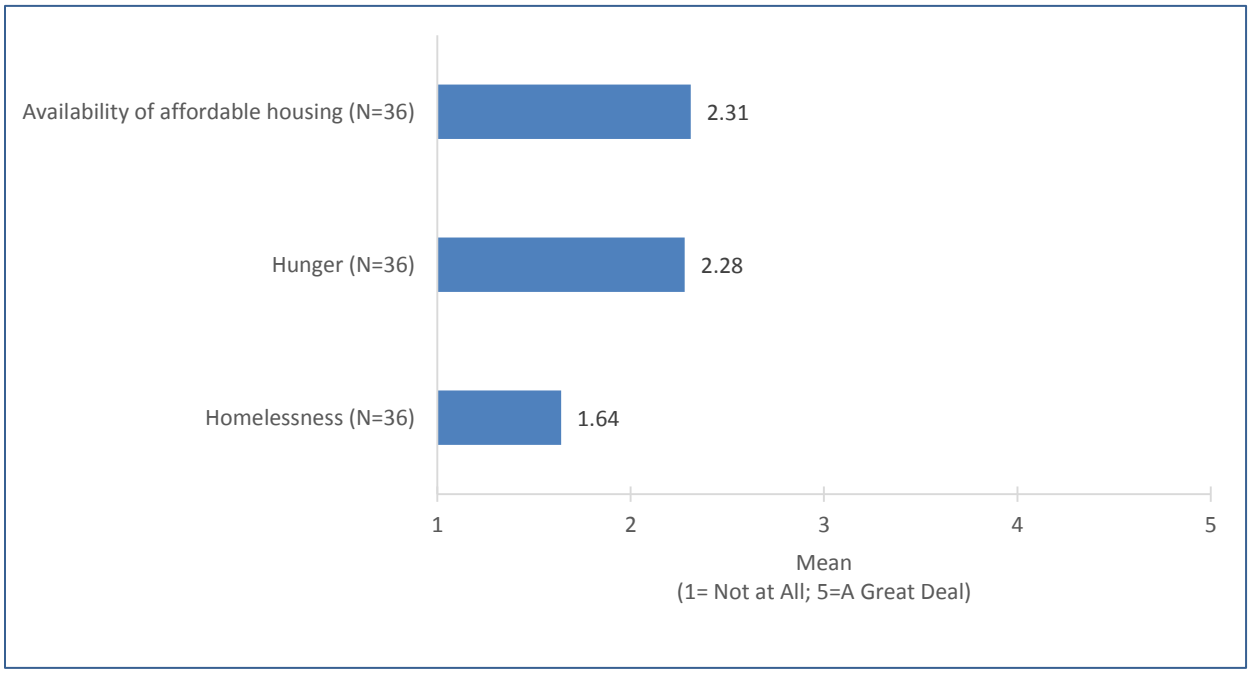


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

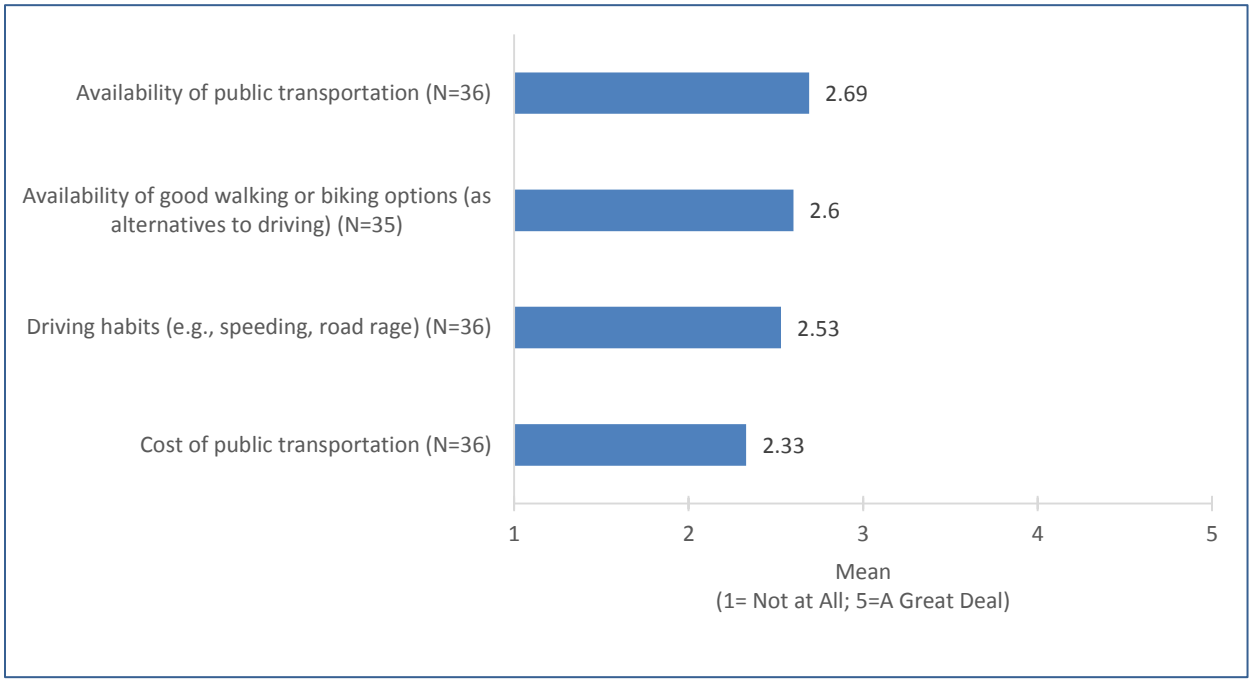


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

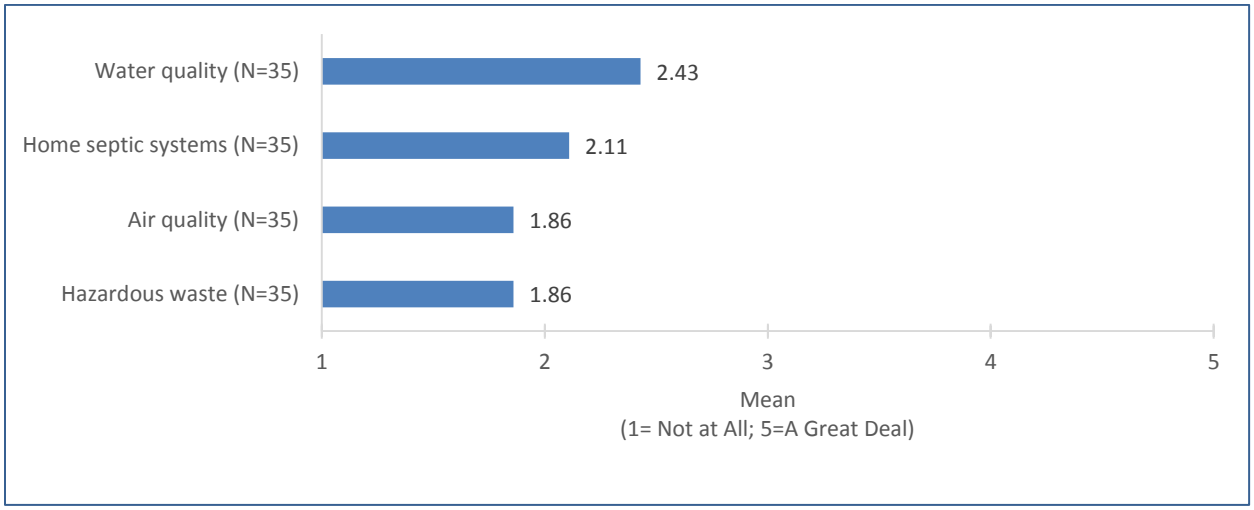


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

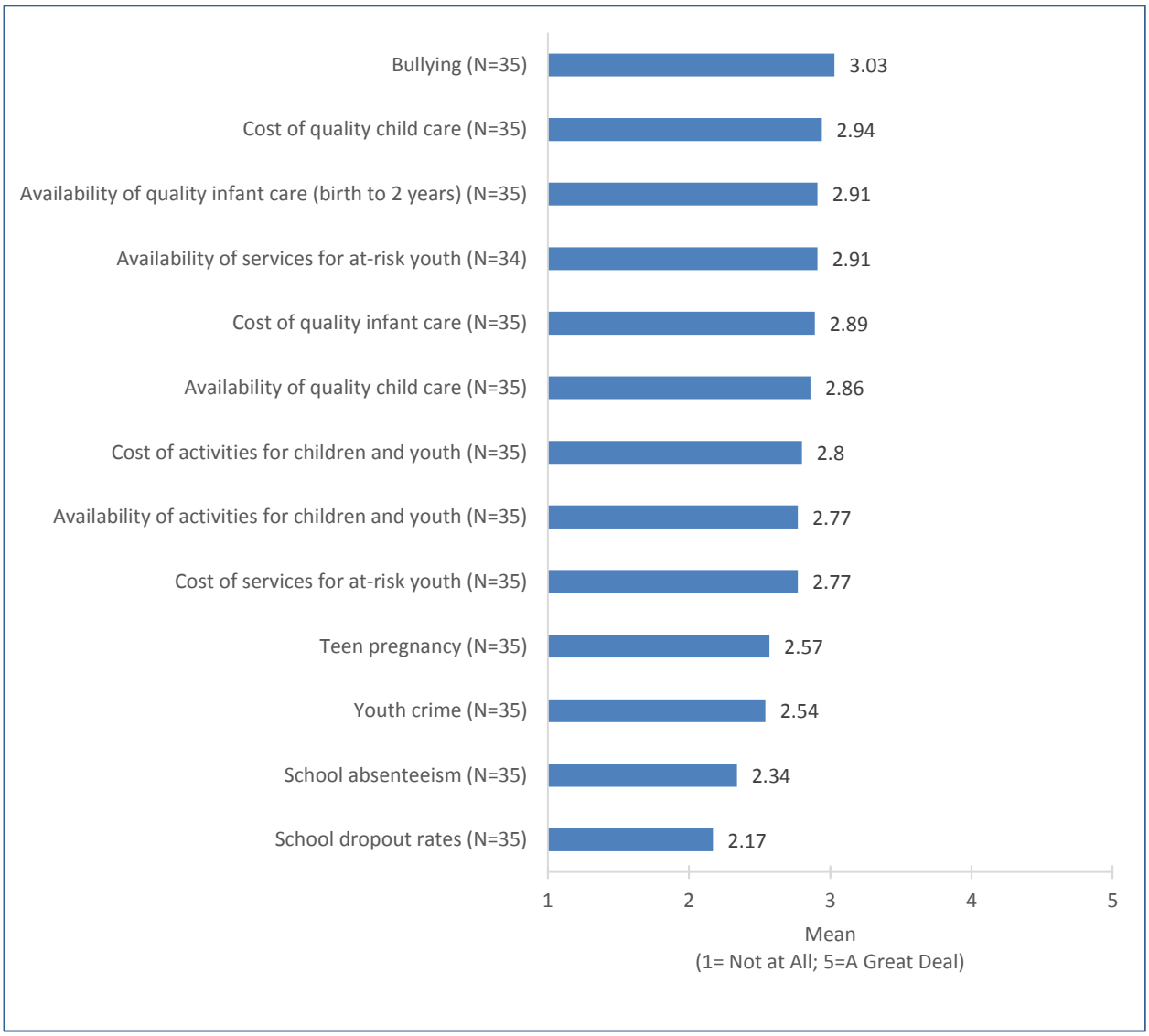


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

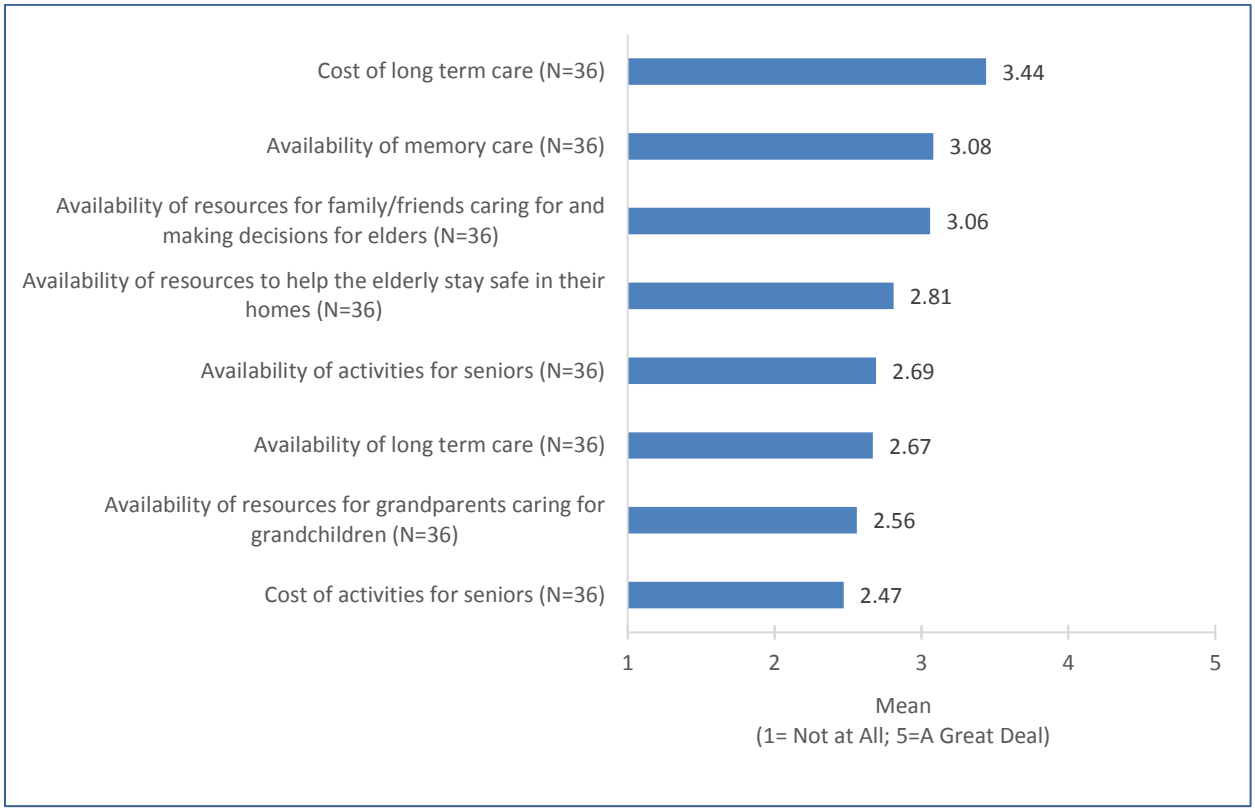


Figure 6. Level of concern with statements about the community regarding SAFETY

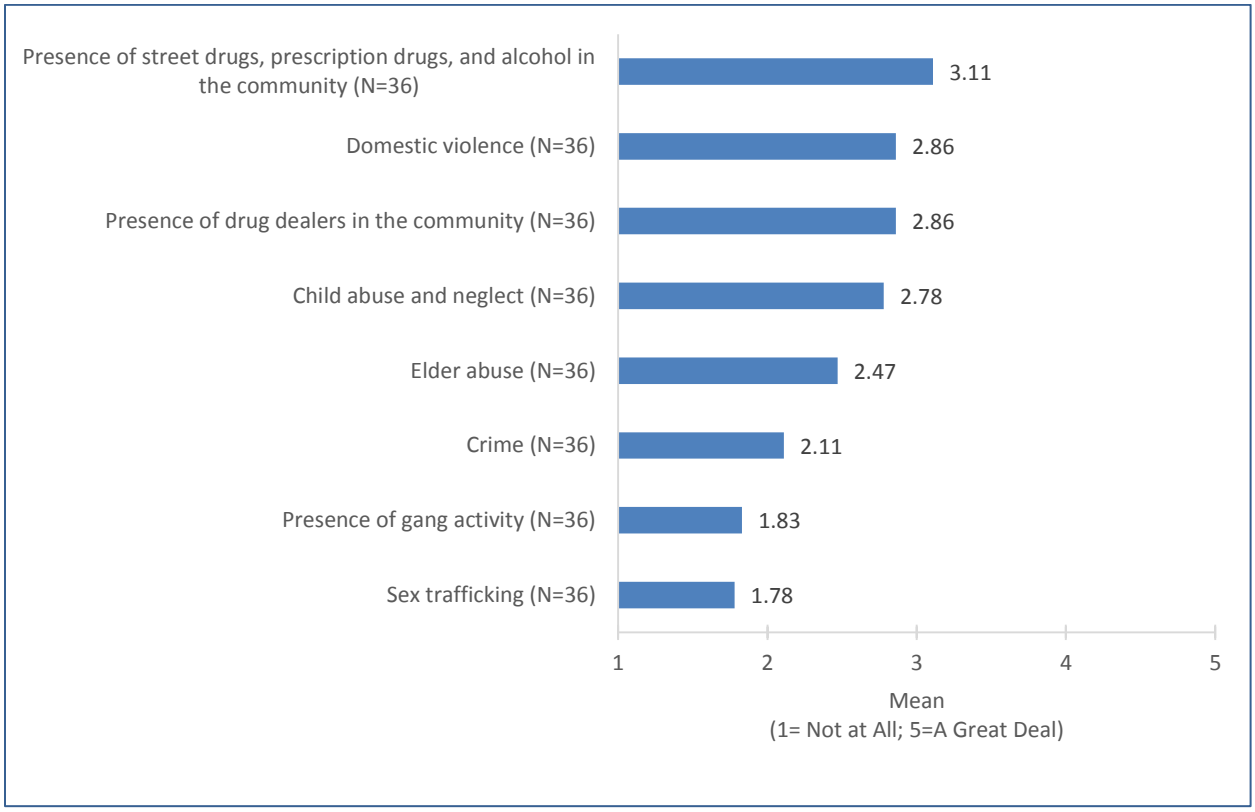


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

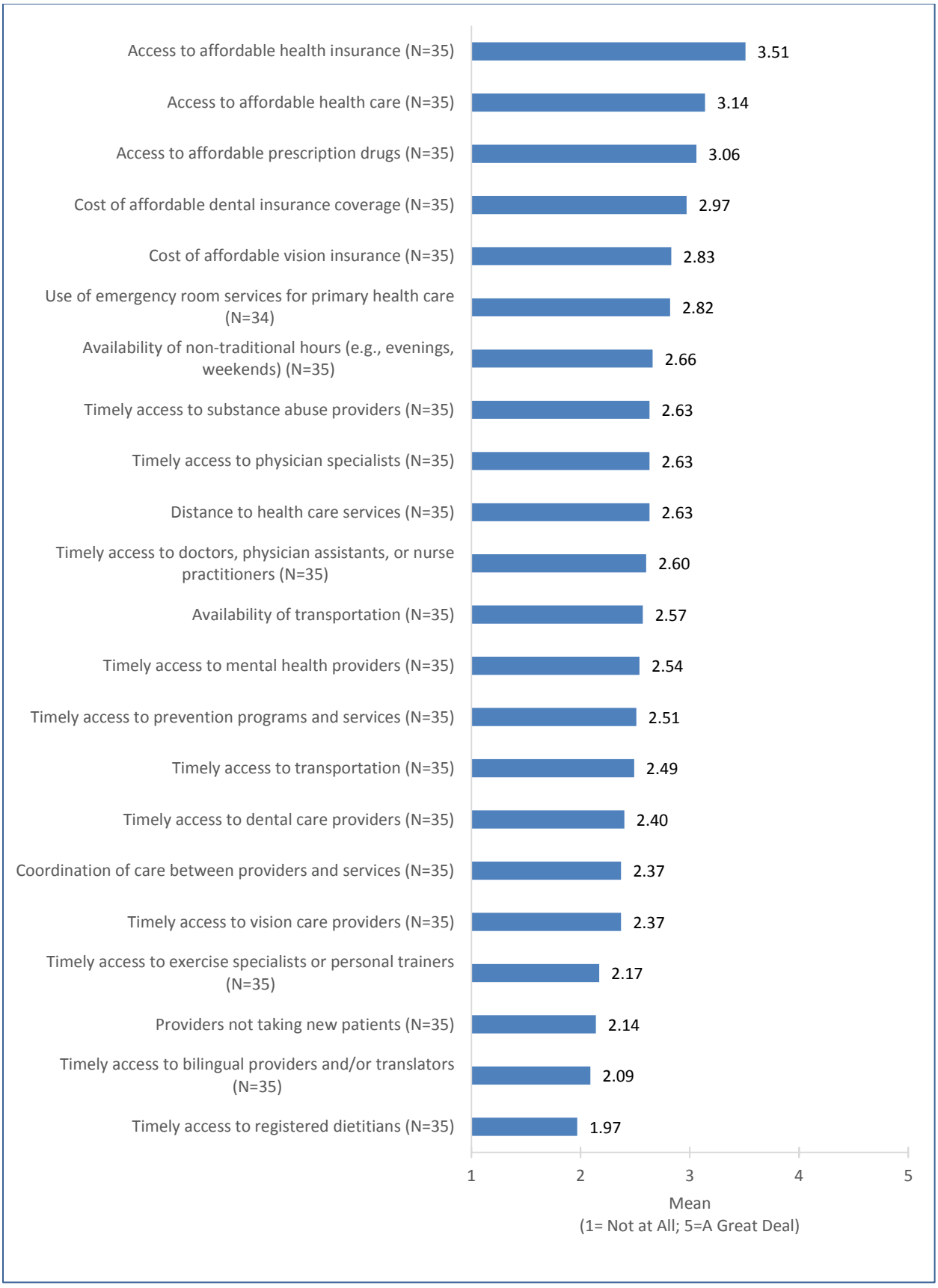

Access to affordable health insurance (N=35)
3.51
Access to affordable health care (N=35)
3.14
Access to affordable prescription drugs (N=35)
3.06
Cost of affordable dental insurance coverage (N=35)
2.97
Cost of affordable vision insurance (N=35)
2.83
Use of emergency room services for primary health care (N=34)
2.82
Availability of non-traditional hours (e.g., evenings, weekends) (N=35)
2.66
Timely access to substance abuse providers (N=35)
2.63
Timely access to physician specialists (N=35)
2.63
Distance to health care services (N=35)
2.63
Timely access to doctors, physician assistants, or nurse practitioners (N=35)
2.60
Availability of transportation (N=35)
2.57
Timely access to mental health providers (N=35)
2.54
Timely access to prevention programs and services (N=35)
2.51
Timely access to transportation (N=35)
2.49
Timely access to dental care providers (N=35)
2.40
Coordination of care between providers and services (N=35)
2.37
Timely access to vision care providers (N=35)
2.37
Timely access to exercise specialists or personal trainers (N=35)
2.17
Providers not taking new patients (N=35)
2.14
Timely access to bilingual providers and/or translators (N=35)
2.09
Timely access to registered dietitians (N=35)
1.97
1
2
3
4
5
Mean
(1= Not at All; 5=A Great Deal)

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

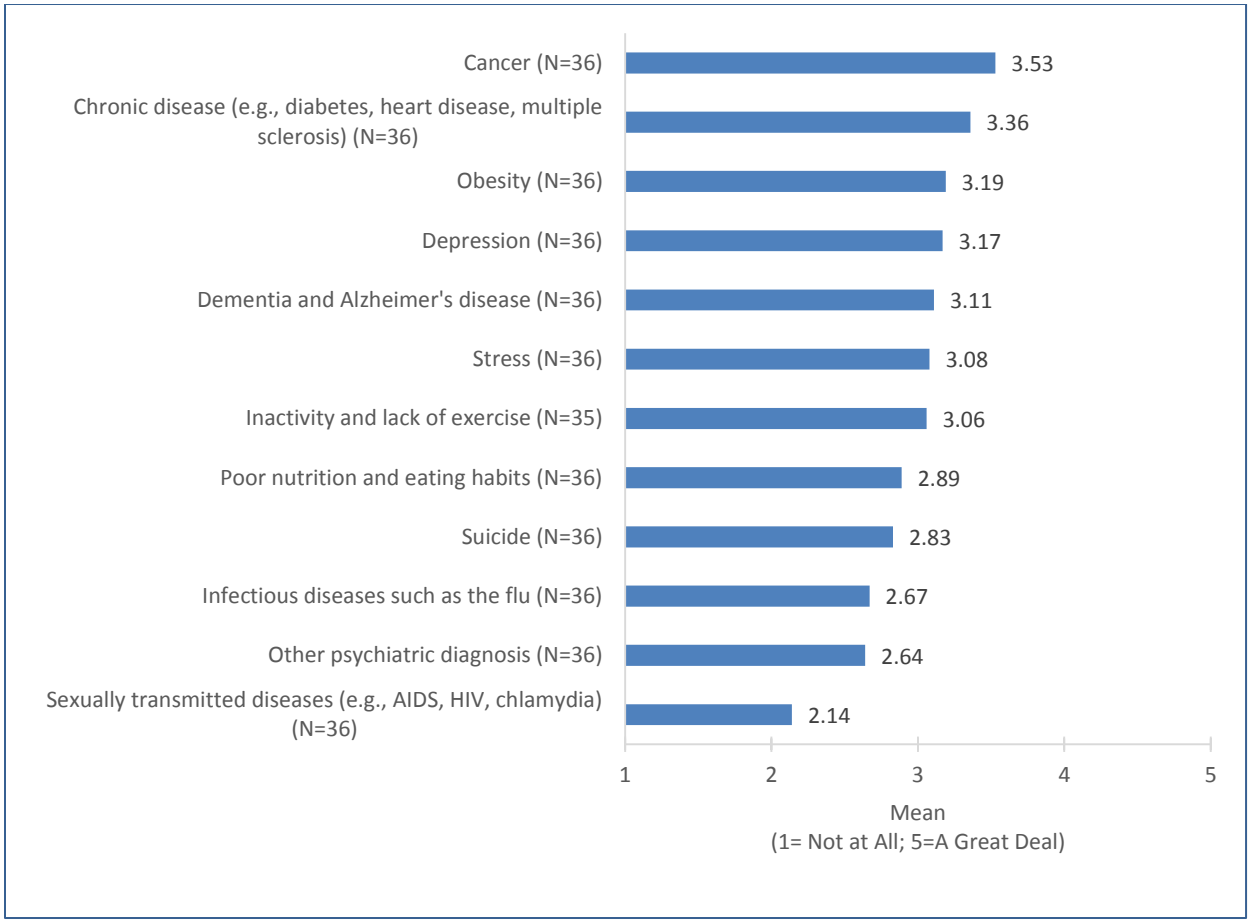
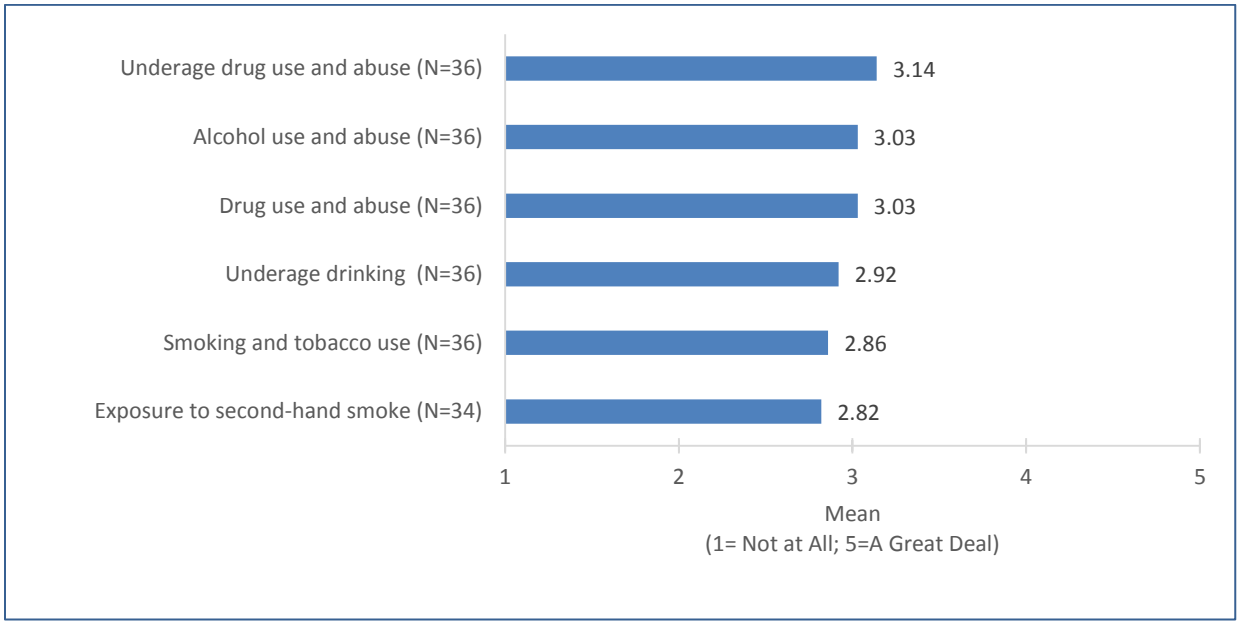
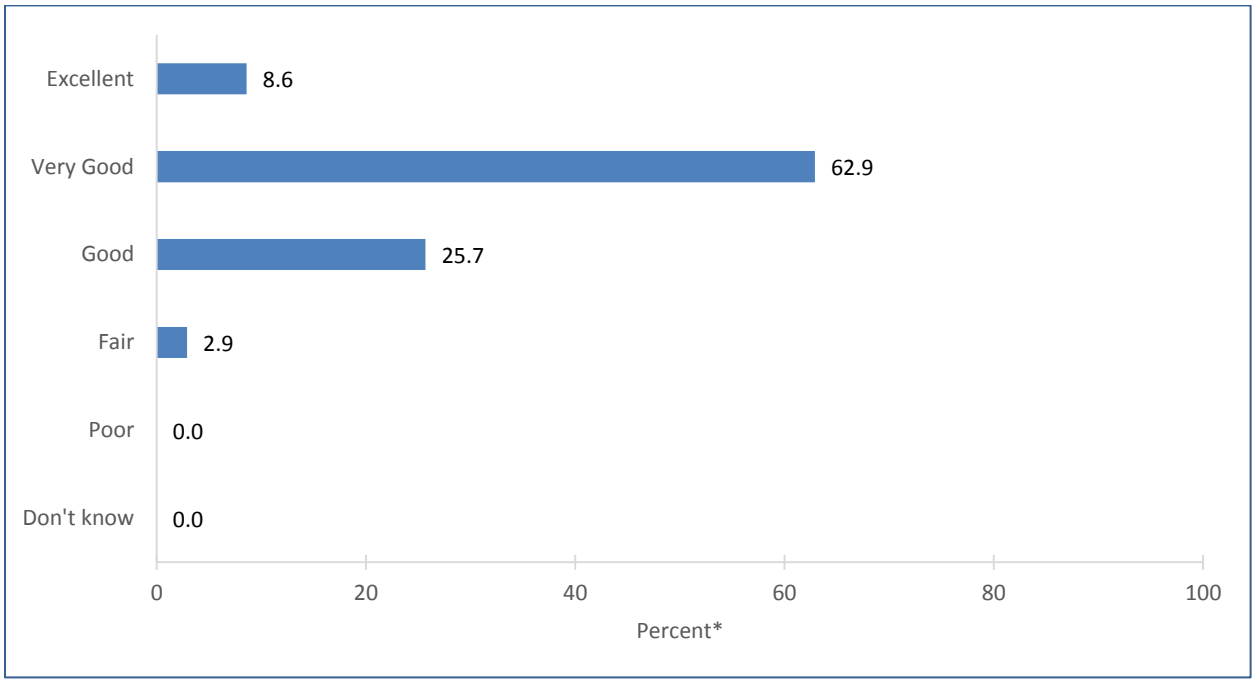


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



General Health

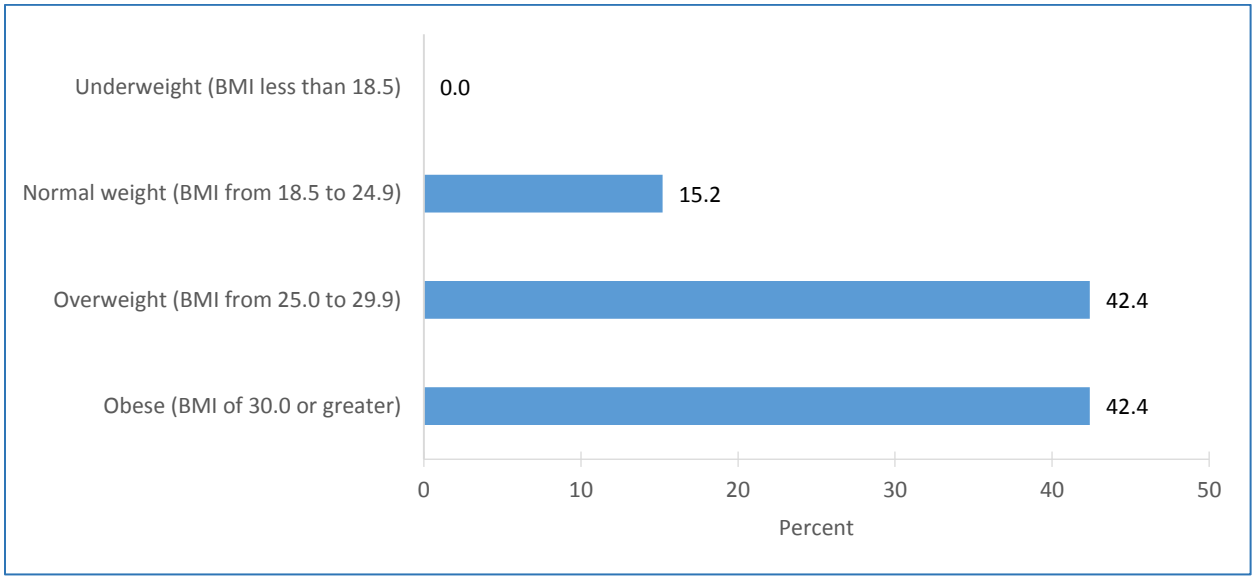
Figure 10. Respondents' rating of health in general



N=35

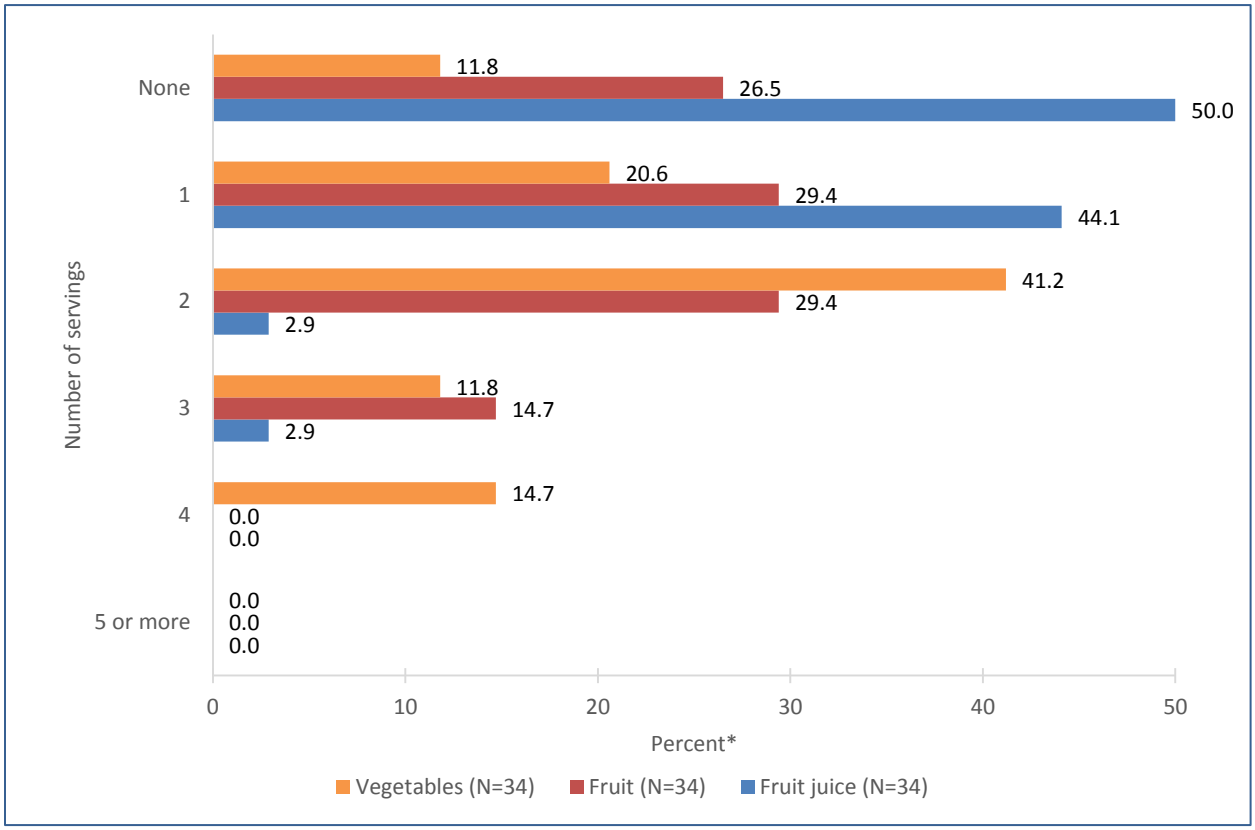
*Percentages do not total 100.0 due to rounding.

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



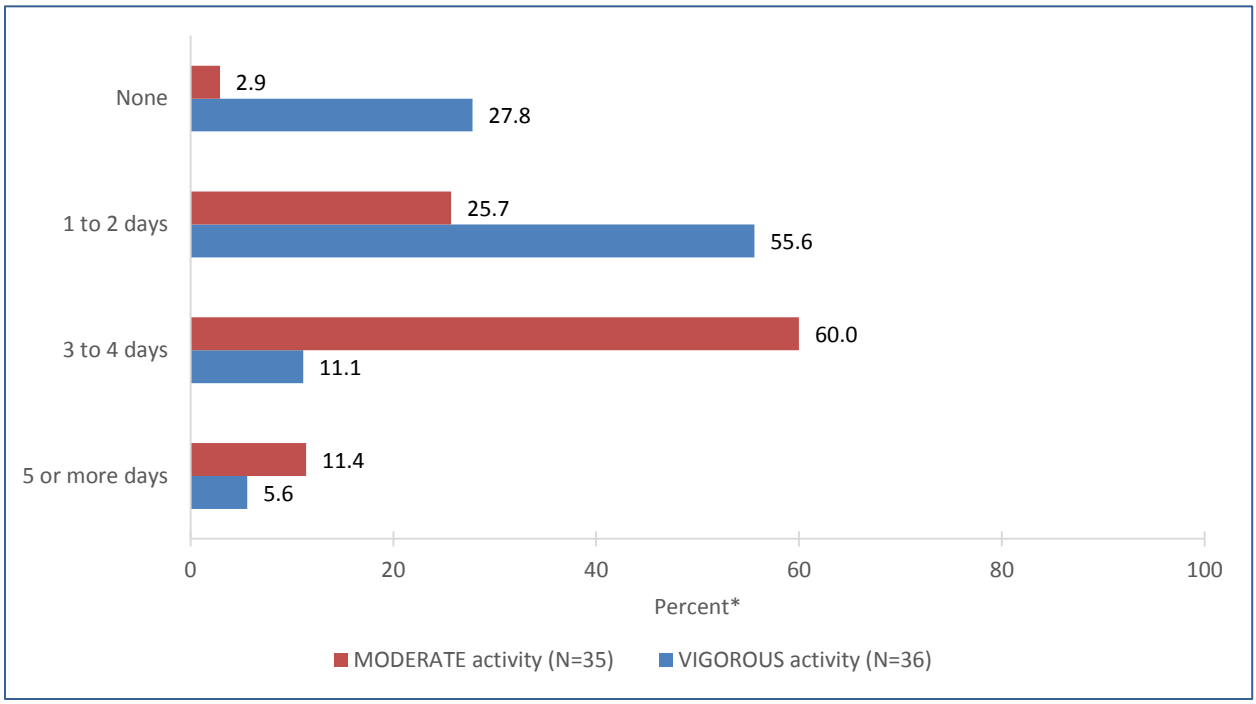
N=33 *For information about the BMI, visit the Centers for Disease Control and Prevention, *About BMI for Adults,* http://www.cdc.gov/healthyweight/assessing/bmi/.

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



*Percentages may not total 100.0 due to rounding.

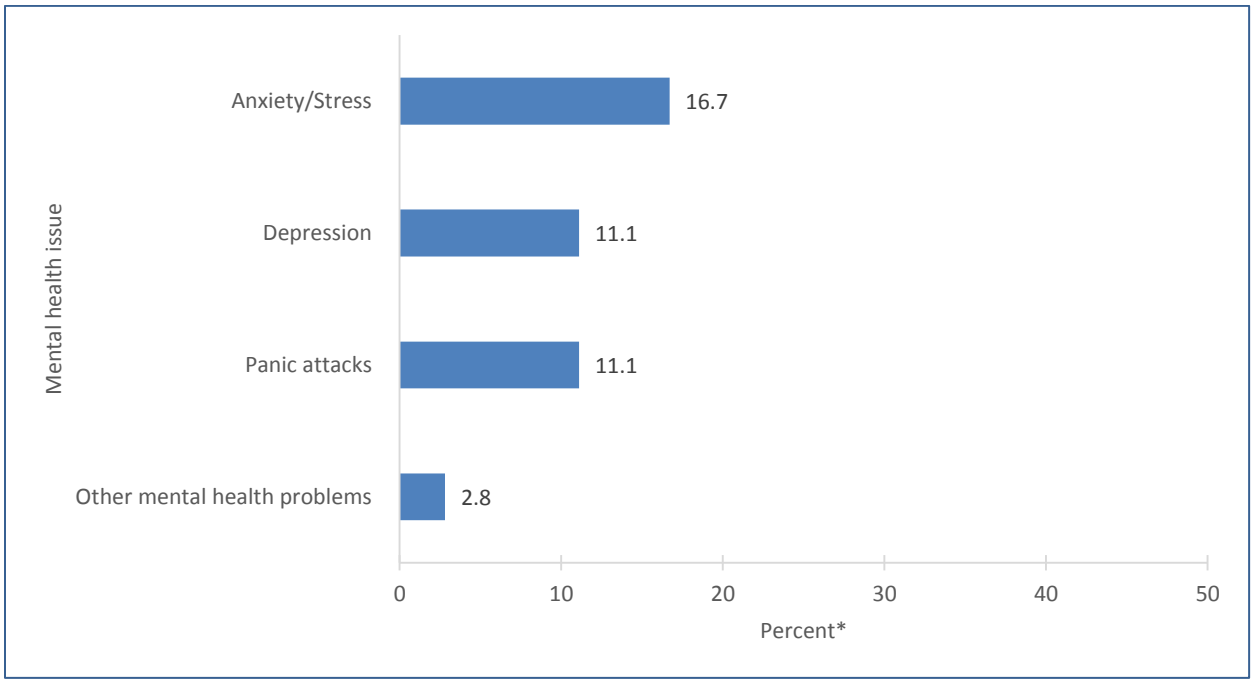
Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



*Percentages may not total 100.0 due to rounding.

Mental Health

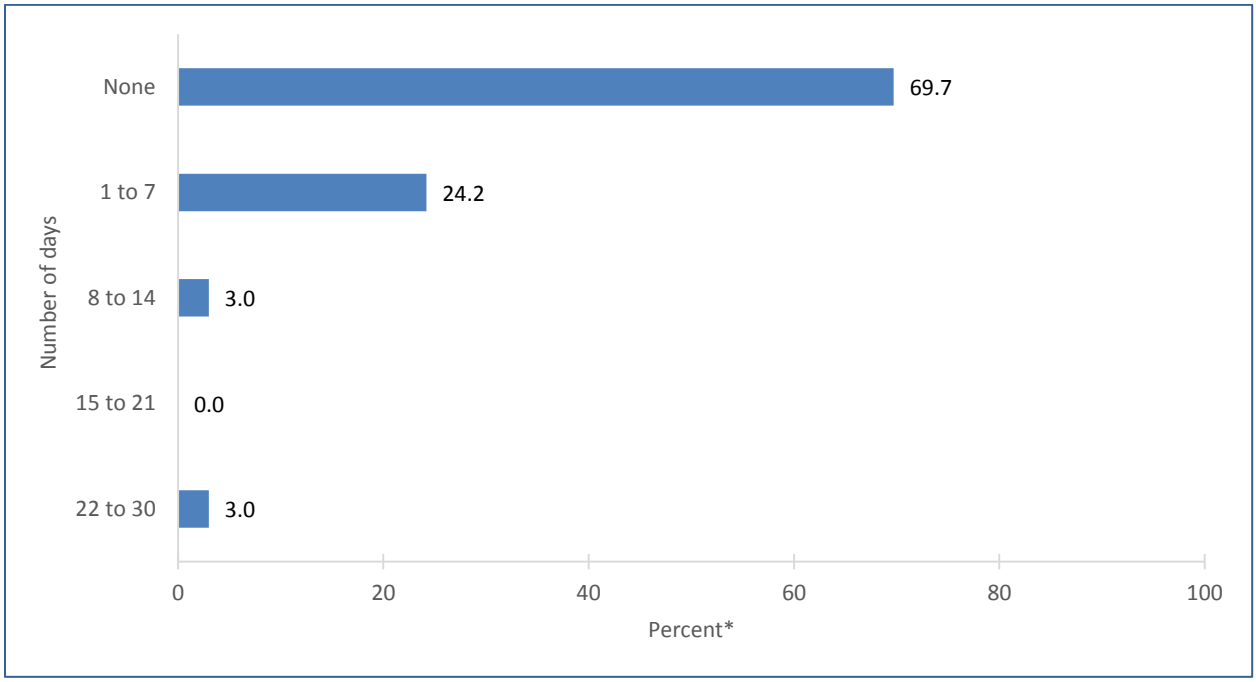
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=36

*Percentage do not total 100.0 due to multiple responses.

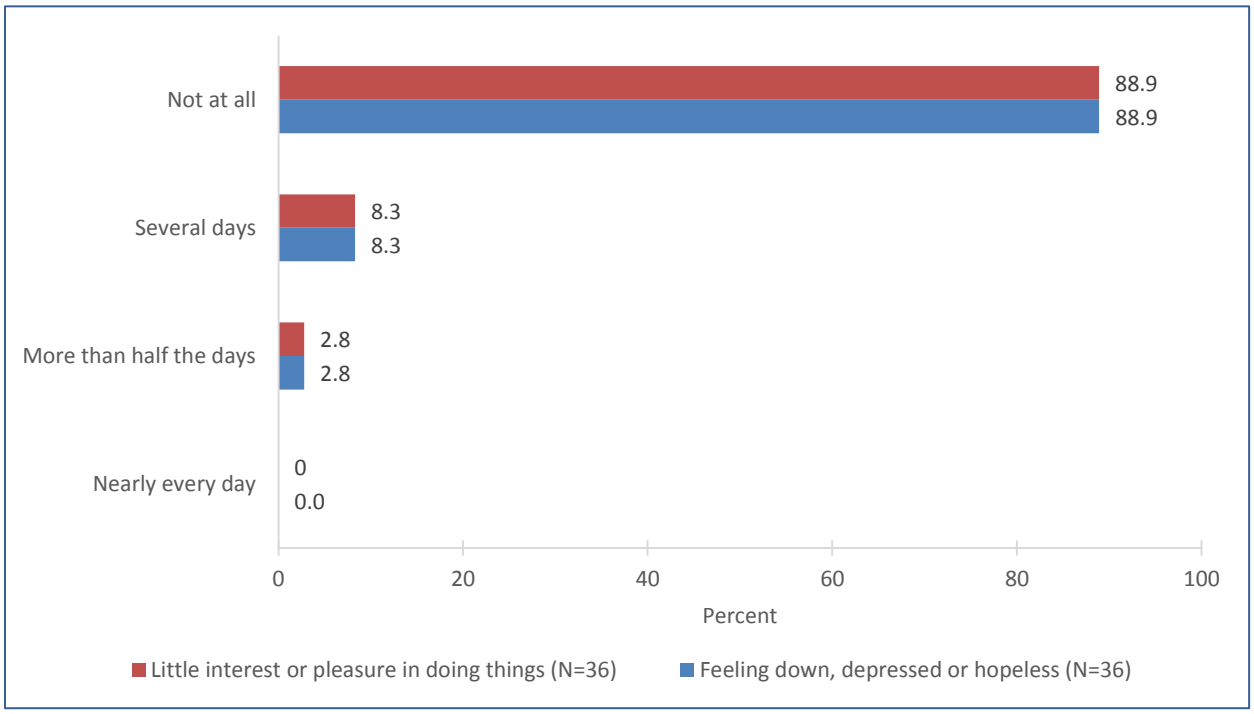
Figure 15. Number of days in the last month that respondents' mental health was not good



N=33

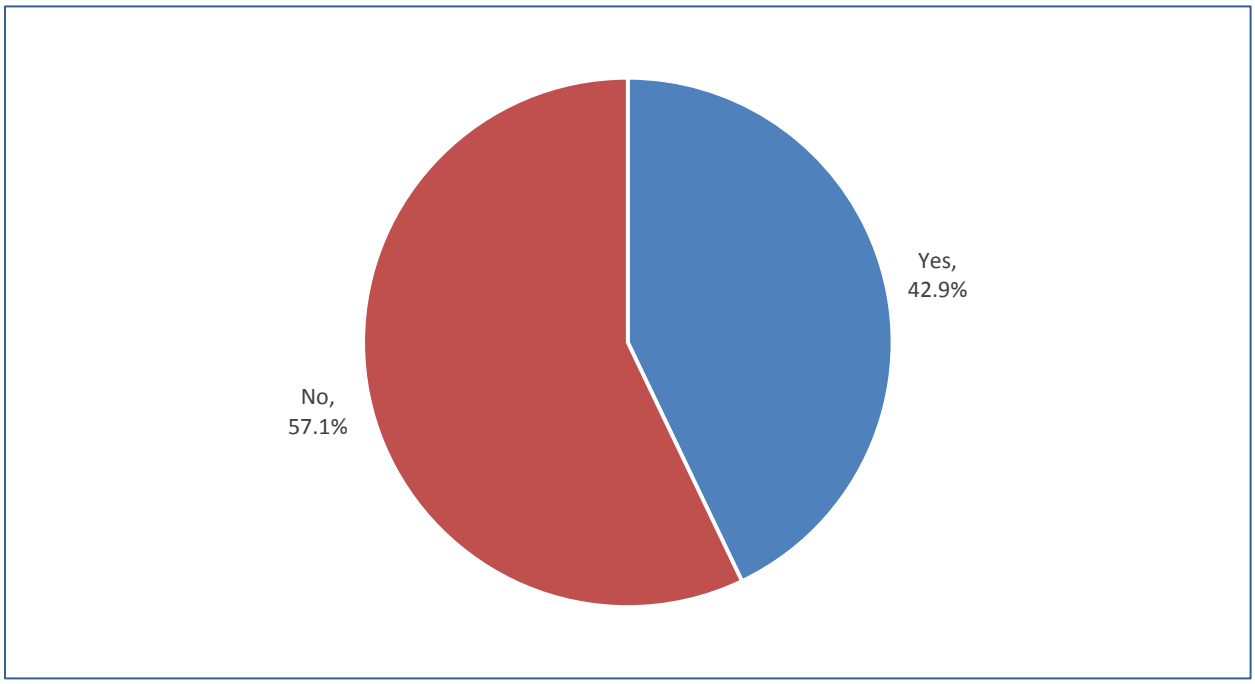
*Percentages do not total 100.0 due to rounding.

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



Tobacco Use

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



N=35

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

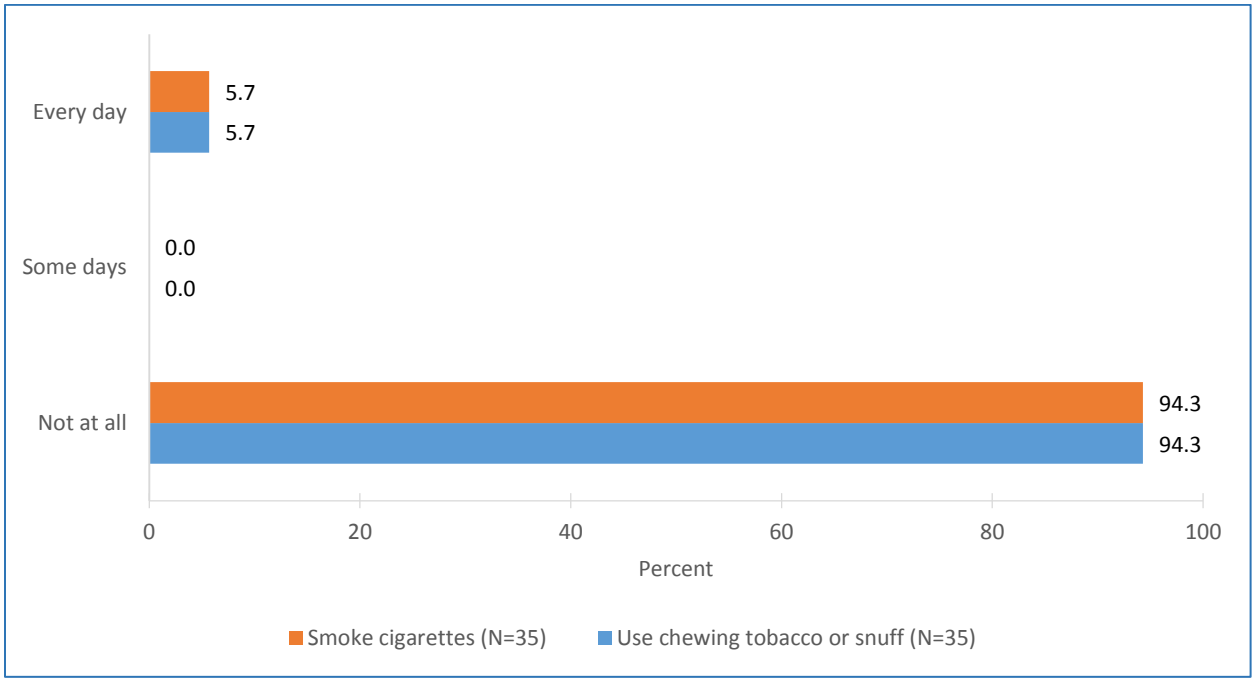
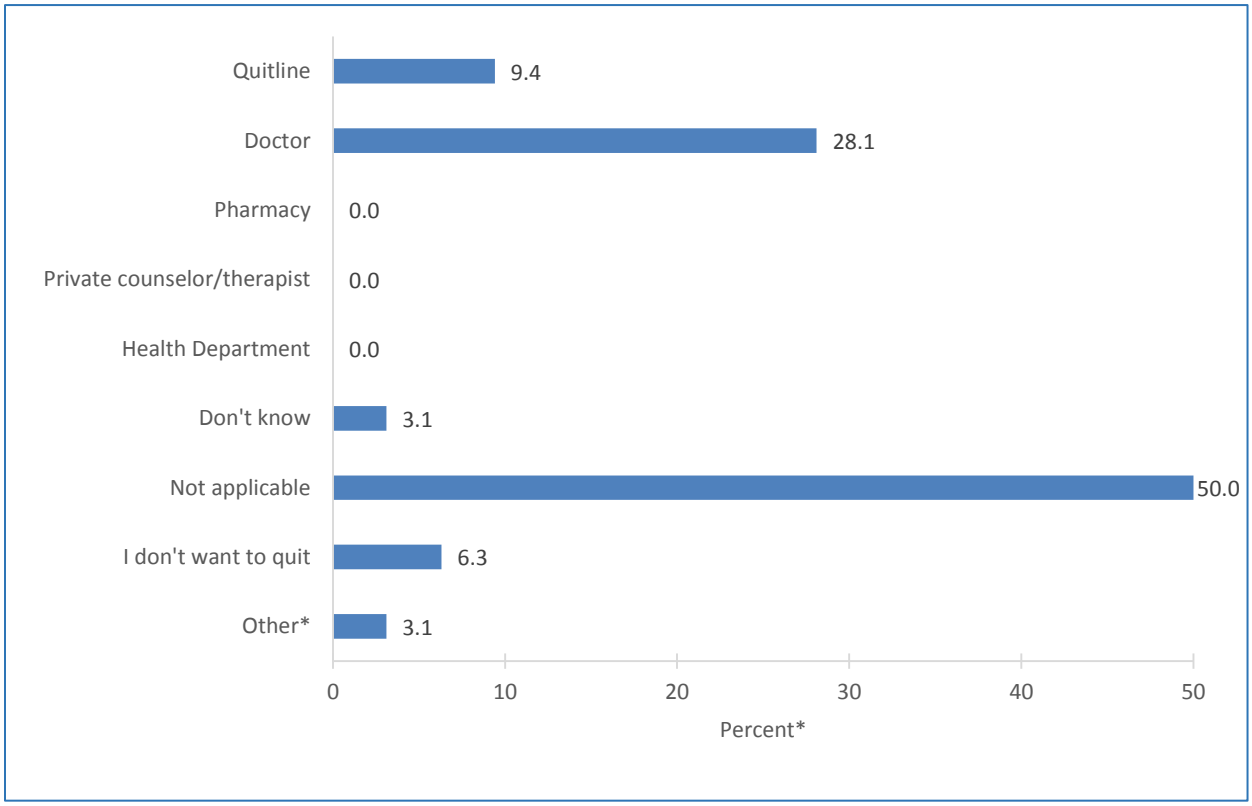


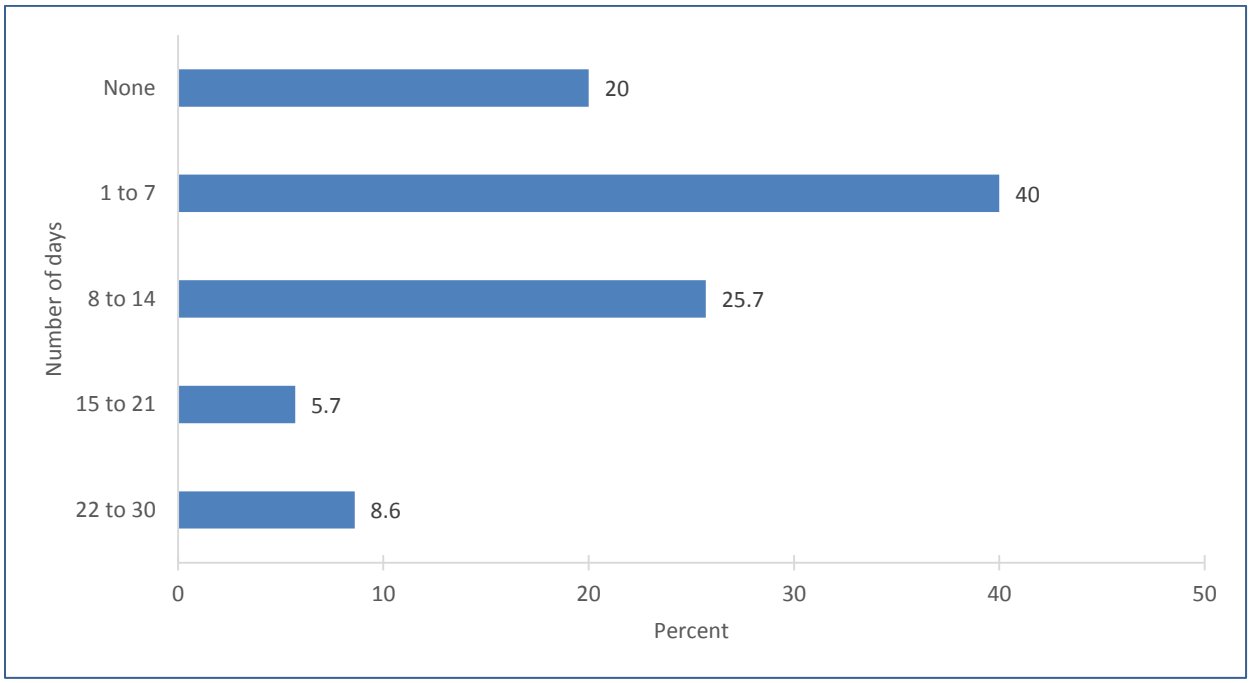
Figure 19. Location respondents would first go if they wanted help to quit using tobacco



N=32 *Other response is “I just quit, my grandma died of cancer”.

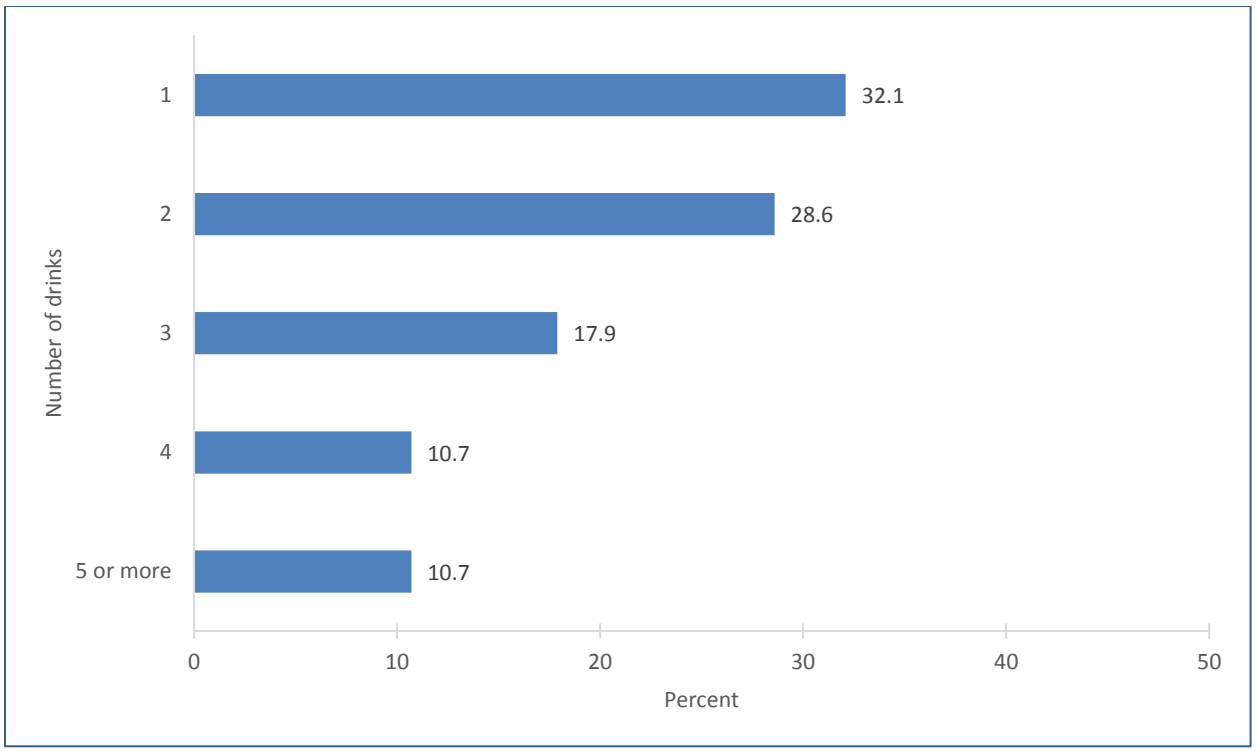
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

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



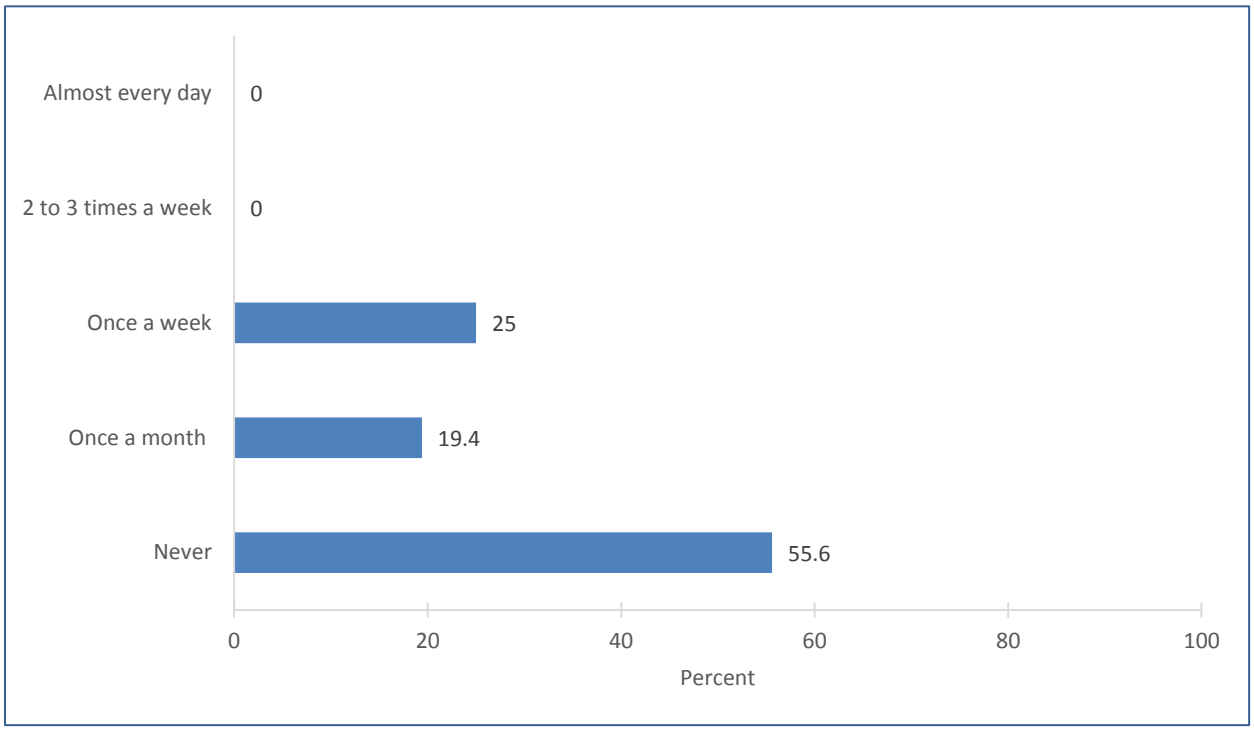
N=35

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



N=28

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=36

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

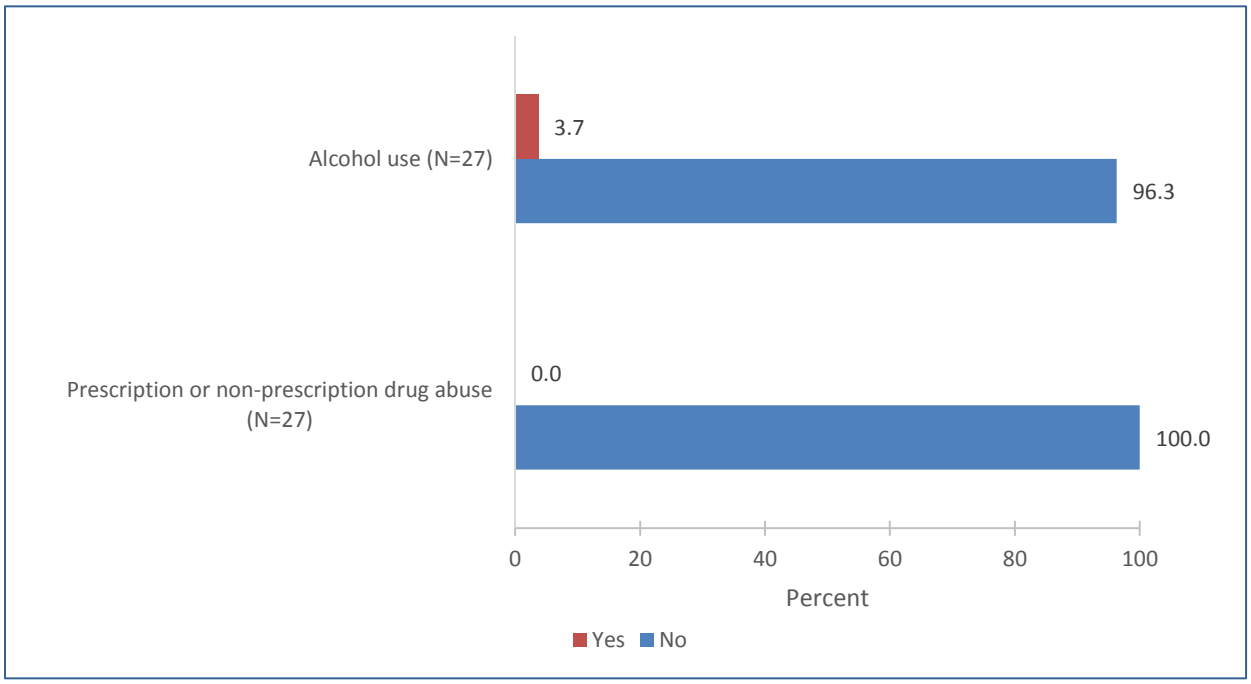


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

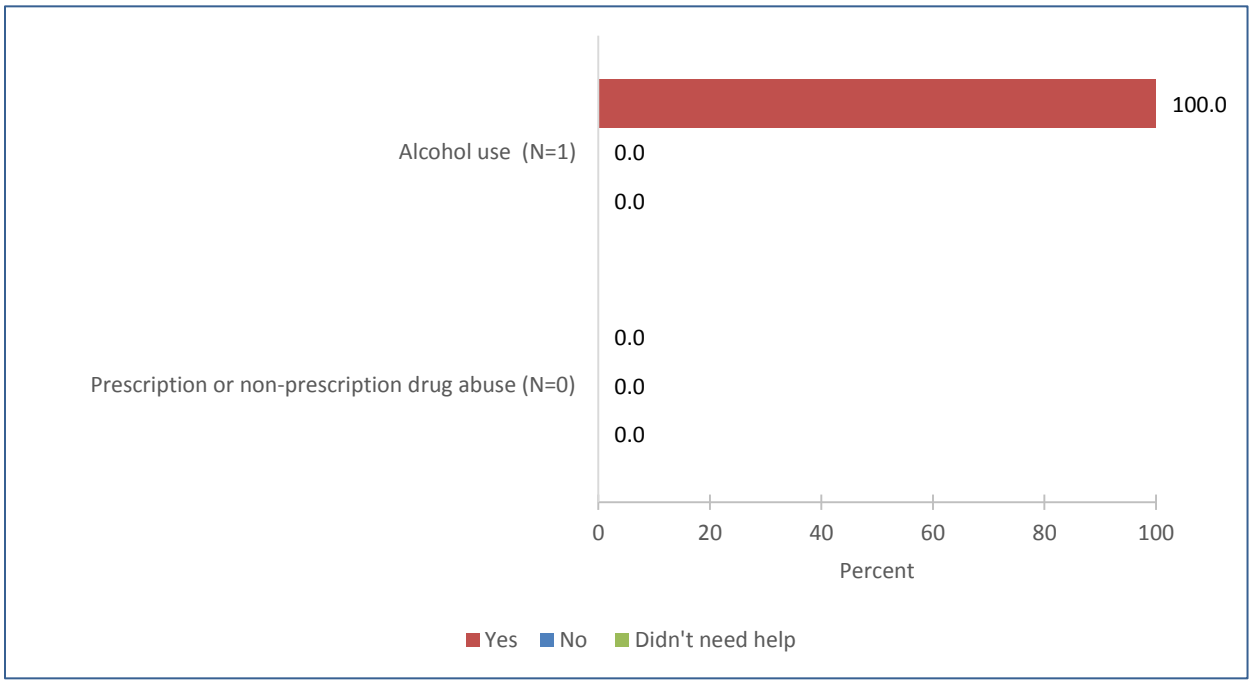
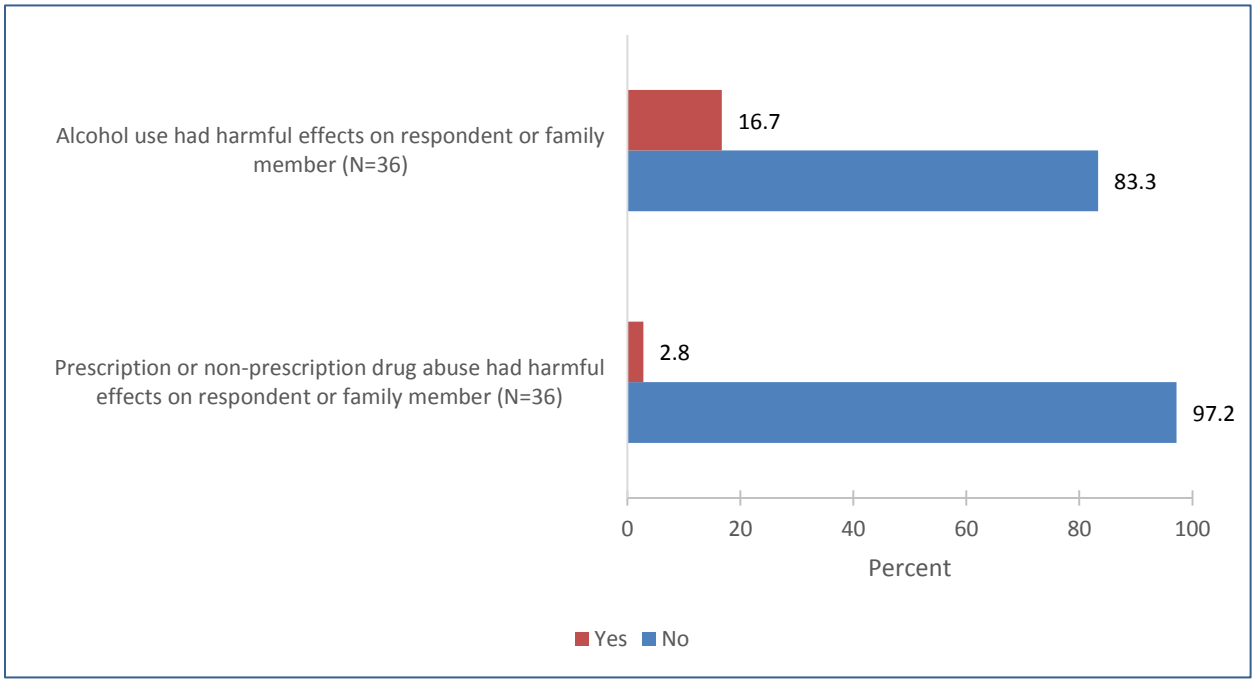


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



Preventive Health

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=34)	94.1	5.9	100.0
Blood sugar screening (N=34)	70.6	29.4	100.0
Bone density test (N=34)	14.7	85.3	100.0
Cardiovascular screening (N=34)	29.4	70.6	100.0
Cholesterol screening (N=34)	79.4	20.6	100.0
Dental screening and X-rays (N=34)	85.3	14.7	100.0
Flu shot (N=34)	91.2	8.8	100.0
Glaucoma test (N=34)	47.1	52.9	100.0
Hearing screening (N=33)	12.1	87.9	100.0
Immunizations (N=34)	29.4	70.6	100.0
Pelvic exam (N=21 Females)	66.7	33.3	100.0
STD (N=33)	12.1	87.9	100.0
Vascular screening (N=33)	21.2	78.8	100.0
CANCER SCREENINGS			
Breast cancer screening (N=21 Females)	71.4	28.6	100.0
Cervical cancer screening (N=21 Females)	57.1	42.9	100.0
Colorectal cancer screening (N=32)	34.4	65.6	100.0
Prostate cancer screening (N=12 Males)	75.0	25.0	100.0
Skin cancer screening (N=32)	21.9	78.1	100.0

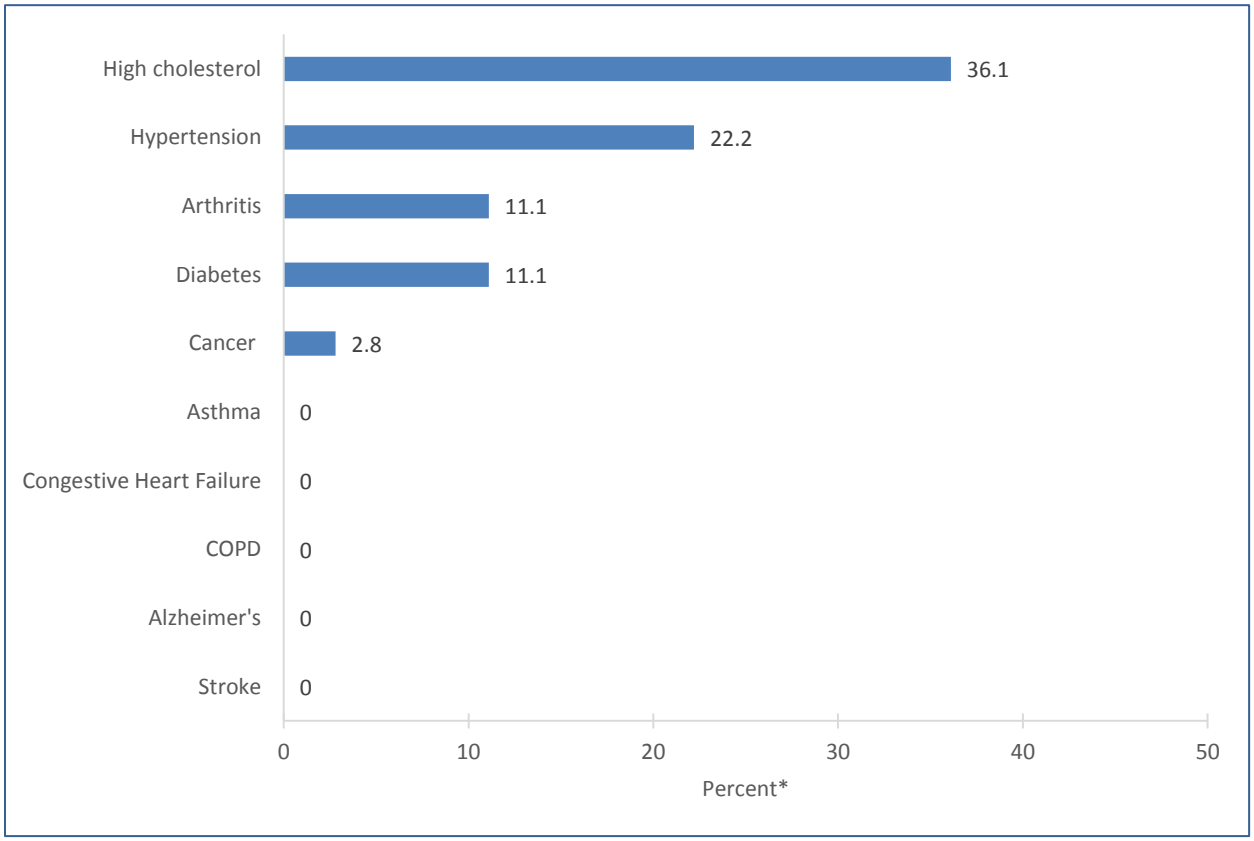
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

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=2)	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Blood sugar screening (N=10)	80.0	20.0	0.0	0.0	0.0	0.0	0.0
Bone density test (N=29)	51.7	34.5	0.0	0.0	0.0	0.0	3.4
Cardiovascular screening	41.7	54.2	0.0	0.0	0.0	0.0	0.0

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
(N=24)							
Cholesterol screening (N=7)	71.4	14.3	0.0	0.0	0.0	0.0	14.3
Dental screening and X-rays (N=5)	80.0	0.0	0.0	0.0	0.0	0.0	20.0
Flu shot (N=3)	66.7	0.0	0.0	0.0	0.0	0.0	33.3
Glaucoma test (N=18)	44.4	38.9	0.0	0.0	0.0	0.0	11.1
Hearing screening (N=29)	51.7	31.0	0.0	0.0	0.0	0.0	6.9
Immunizations (N=24)	58.3	25.0	0.0	0.0	0.0	0.0	8.3
Pelvic exam (N=7 Females)	71.4	14.3	0.0	0.0	0.0	0.0	14.3
STD (N=29)	69.0	17.2	0.0	0.0	0.0	0.0	0.0
Vascular screening (N=26)	61.5	26.9	0.0	0.0	0.0	0.0	0.0
CANCER SCREENINGS							
Breast cancer screening (N=6 Females)	50.0	33.3	0.0	0.0	16.7	0.0	0.0
Cervical cancer screening (N=9 Females)	66.7	33.3	0.0	0.0	0.0	0.0	0.0
Colorectal cancer screening (N=21)	71.4	28.6	4.8	0.0	0.0	0.0	0.0
Prostate cancer screening (N=3 Males)	33.3	66.7	0.0	0.0	0.0	0.0	0.0
Skin cancer screening (N=25)	48.0	48.0	0.0	0.0	4.0	0.0	0.0

*Percentages do not total 100.0 due to multiple responses.

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



N=36

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

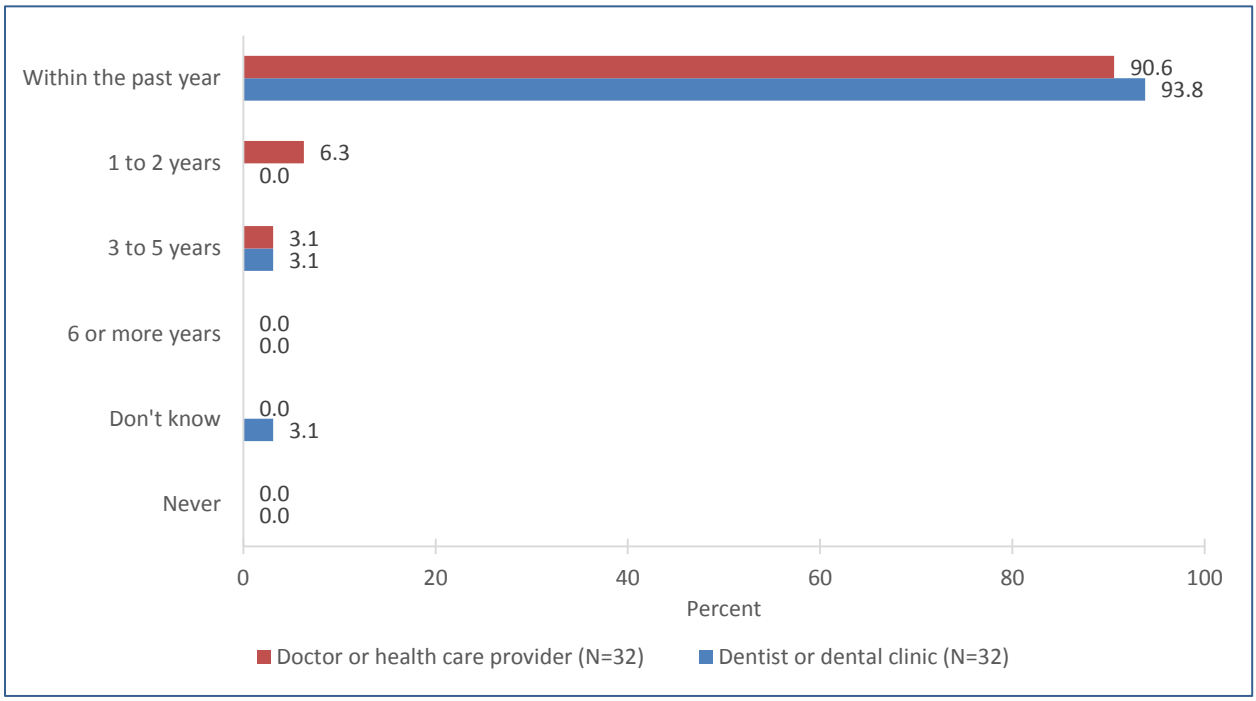
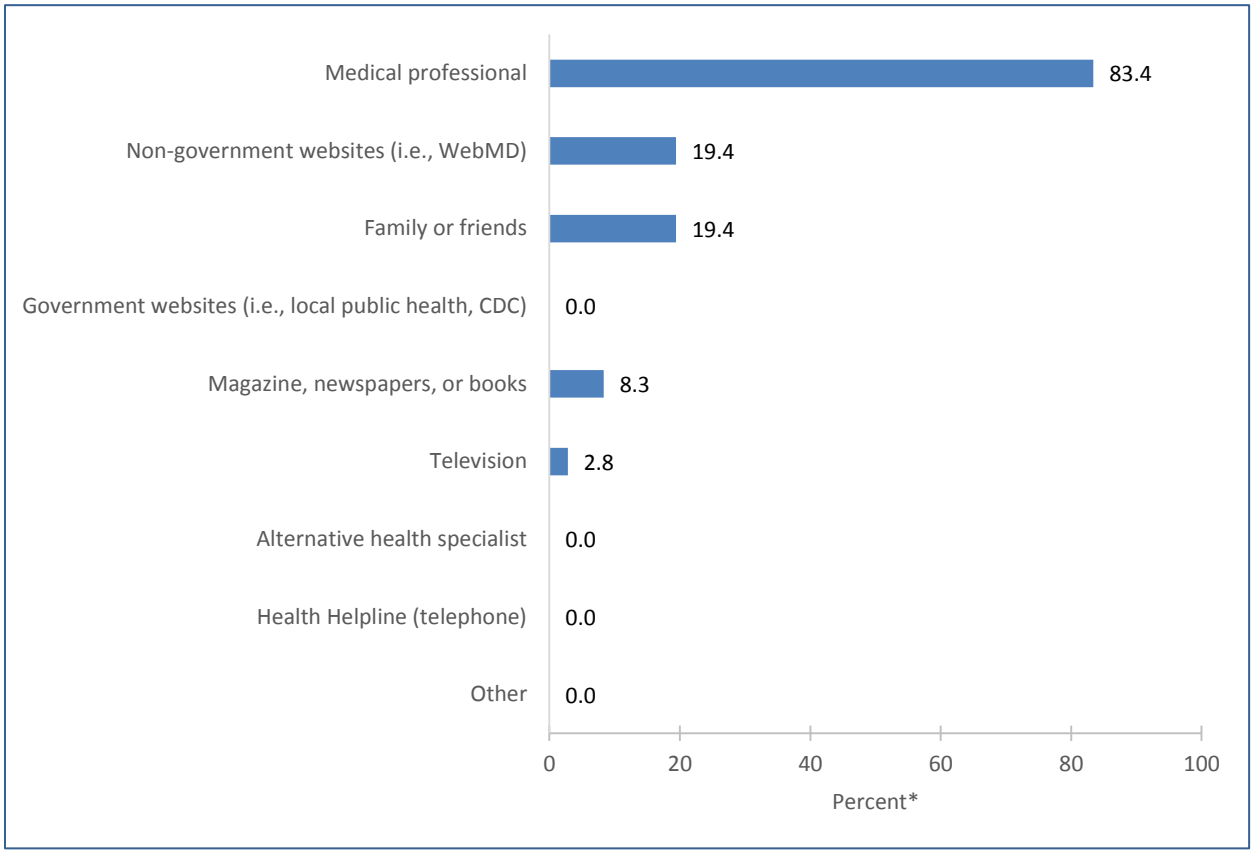


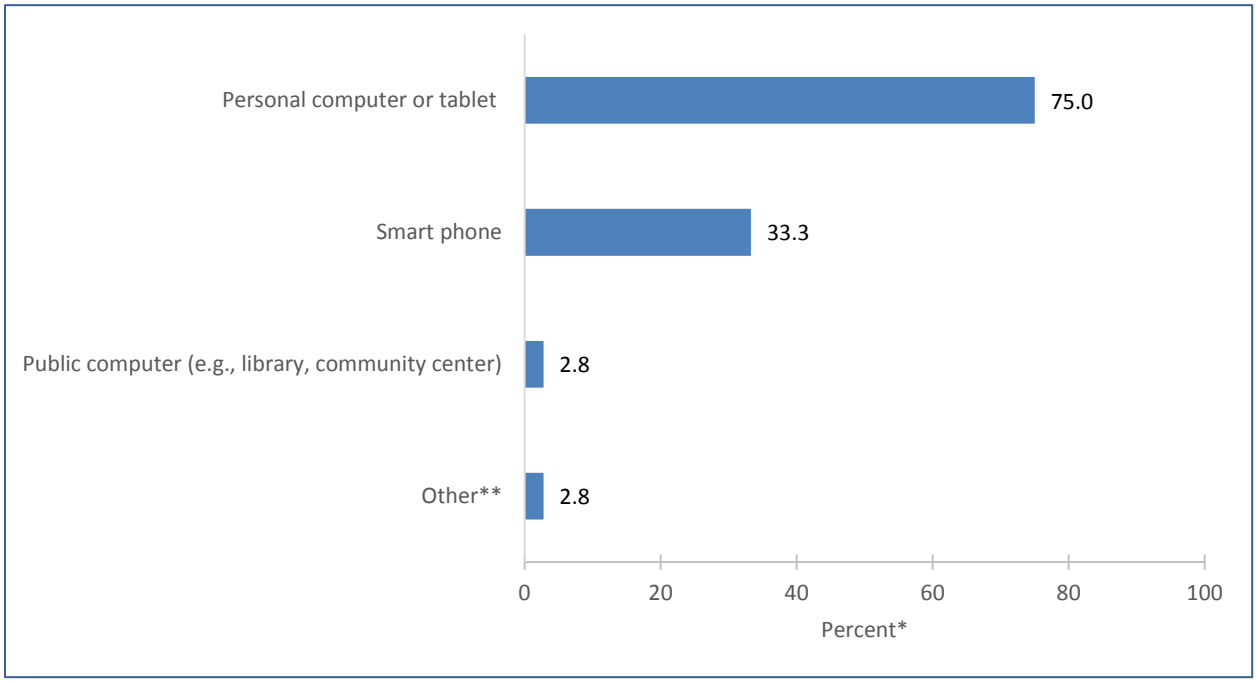
Figure 28. Where respondents get most of their health information



N=36

*Percentages do not total 100.0 due to multiple responses.

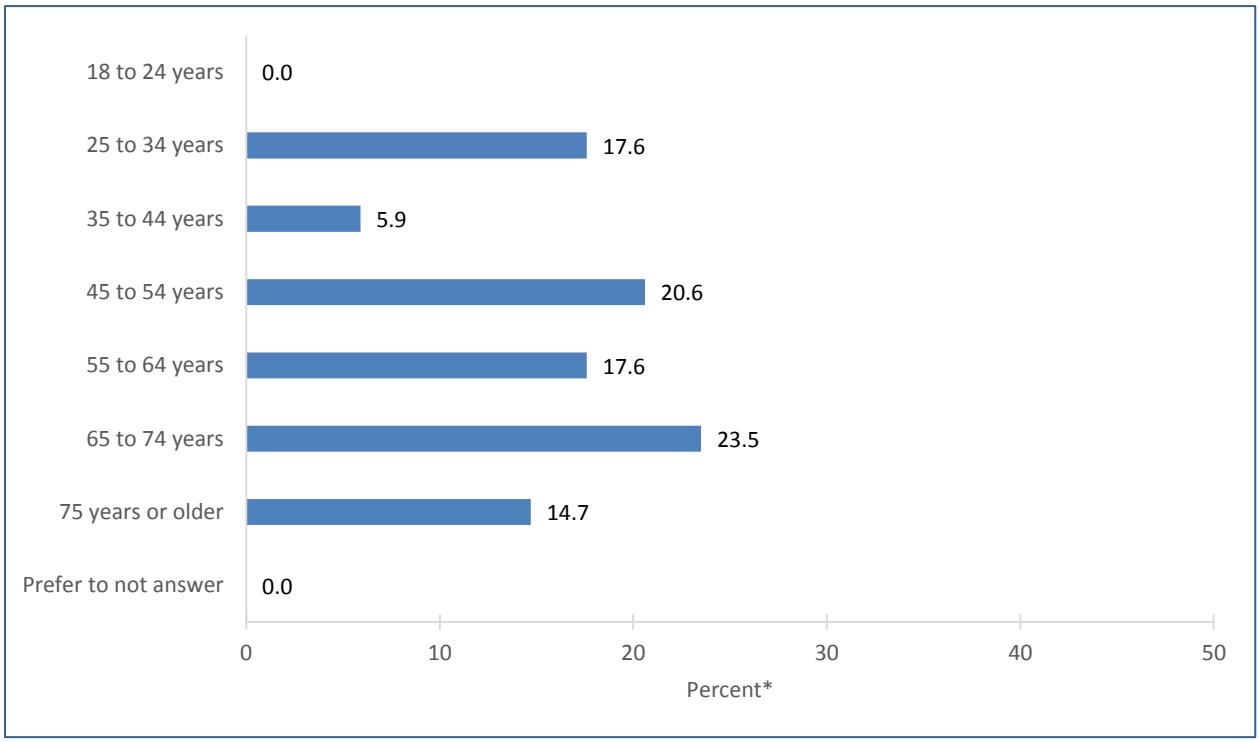
Figure 29. Best way for respondents to access technology for health information



N=36 *Percentages do not total 100.0 due to multiple responses. **Other response is "Doctor-clinic".

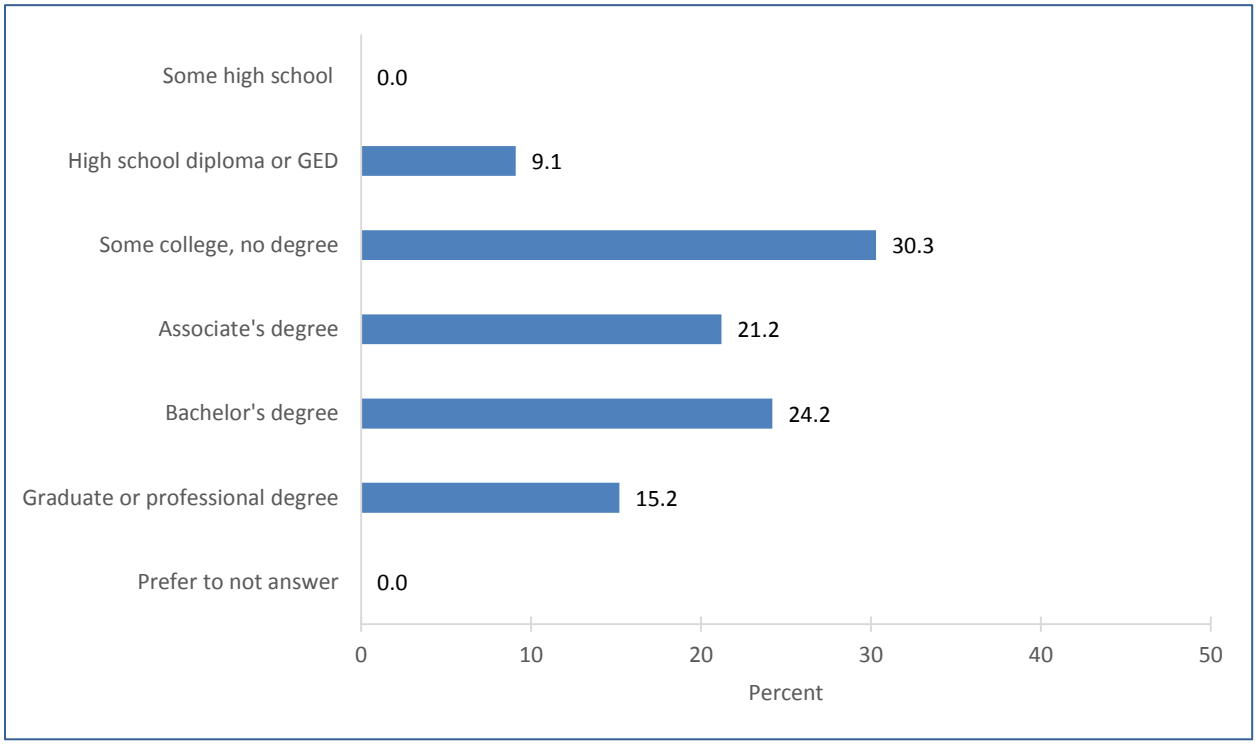
Demographic Information

Figure 30. Age of respondents



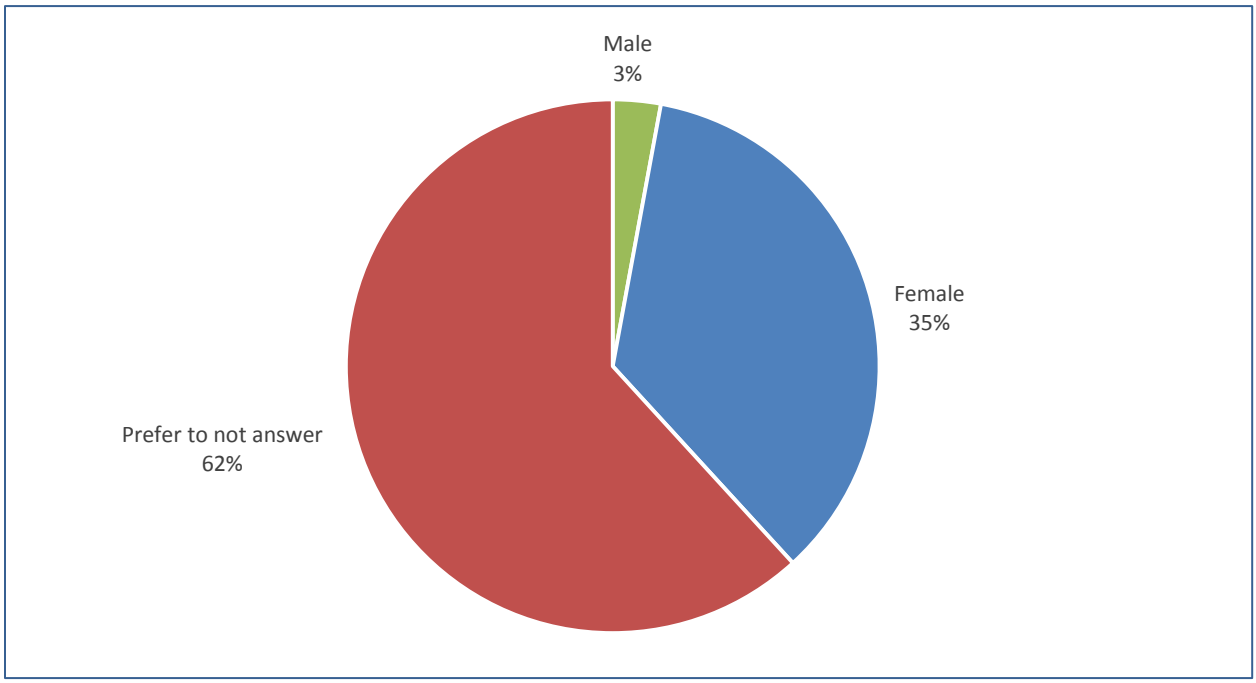
N=34 *Percentages do not total 100.0 due to rounding.

Figure 31. Highest level of education of respondents



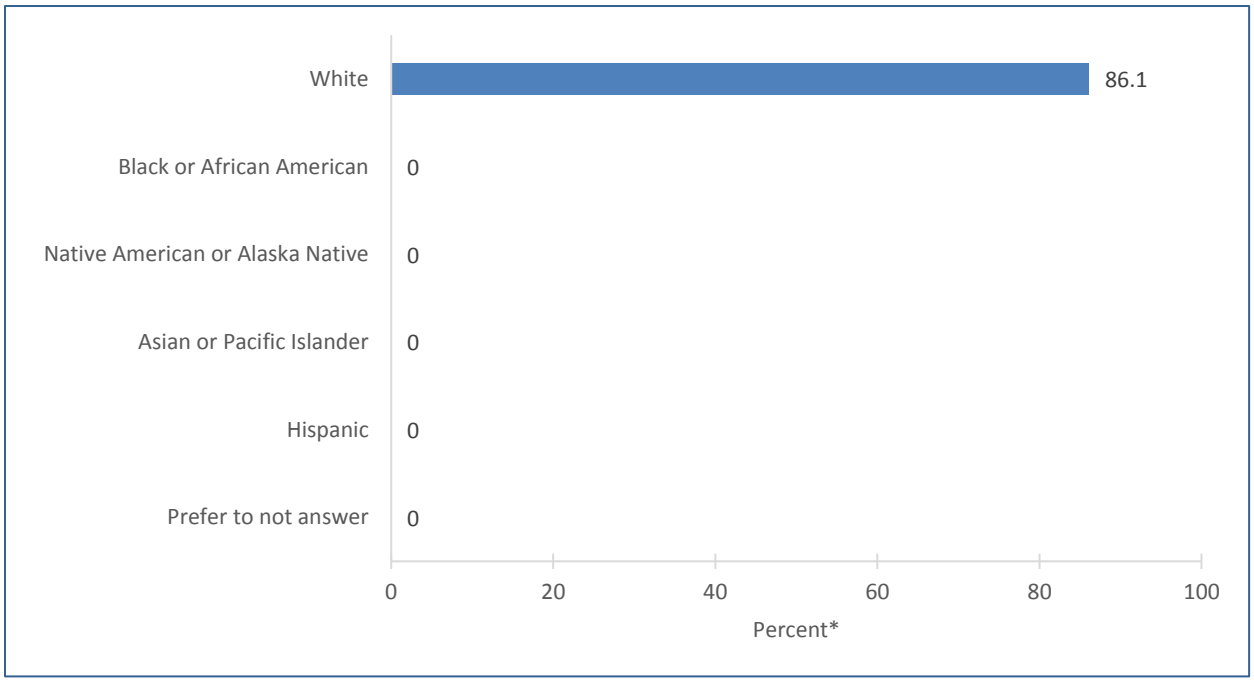
N=33

Figure 32. Gender of respondents



N=34

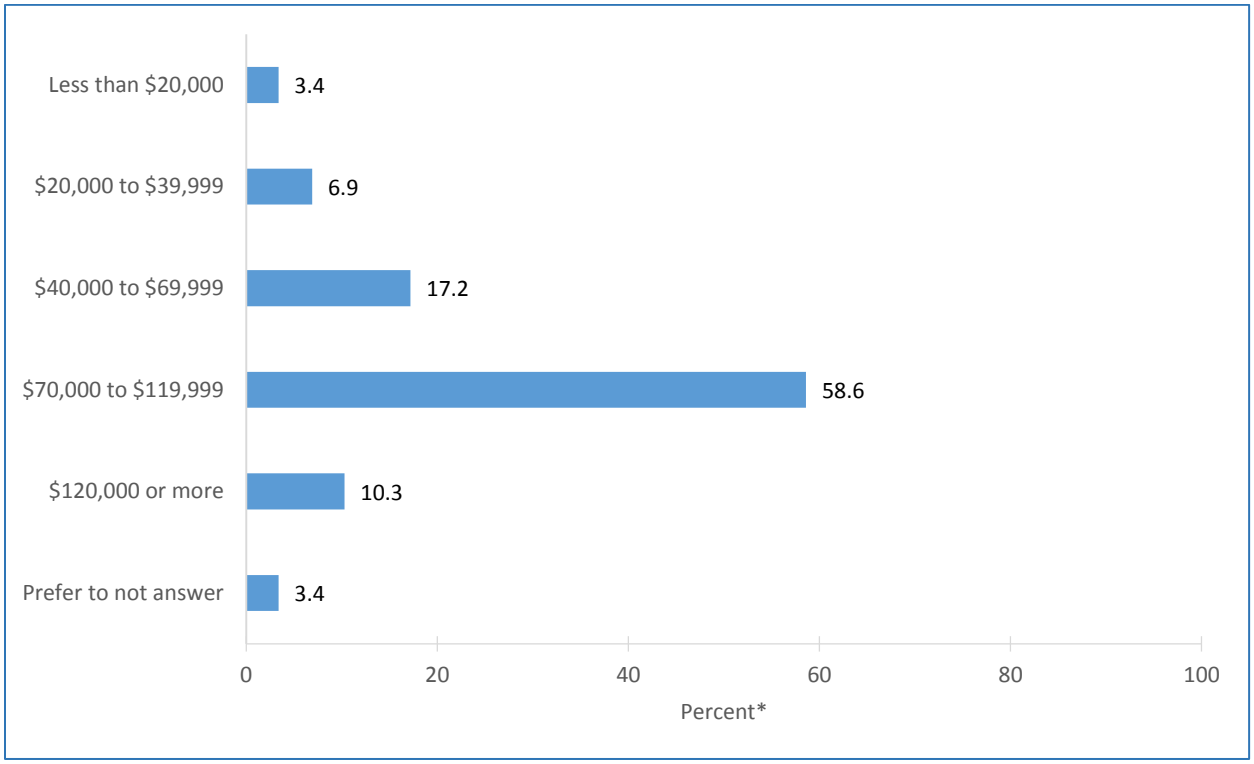
Figure 33. Race and ethnicity of respondents



N=36

*Percentages do not total 100.0 due to multiple responses.

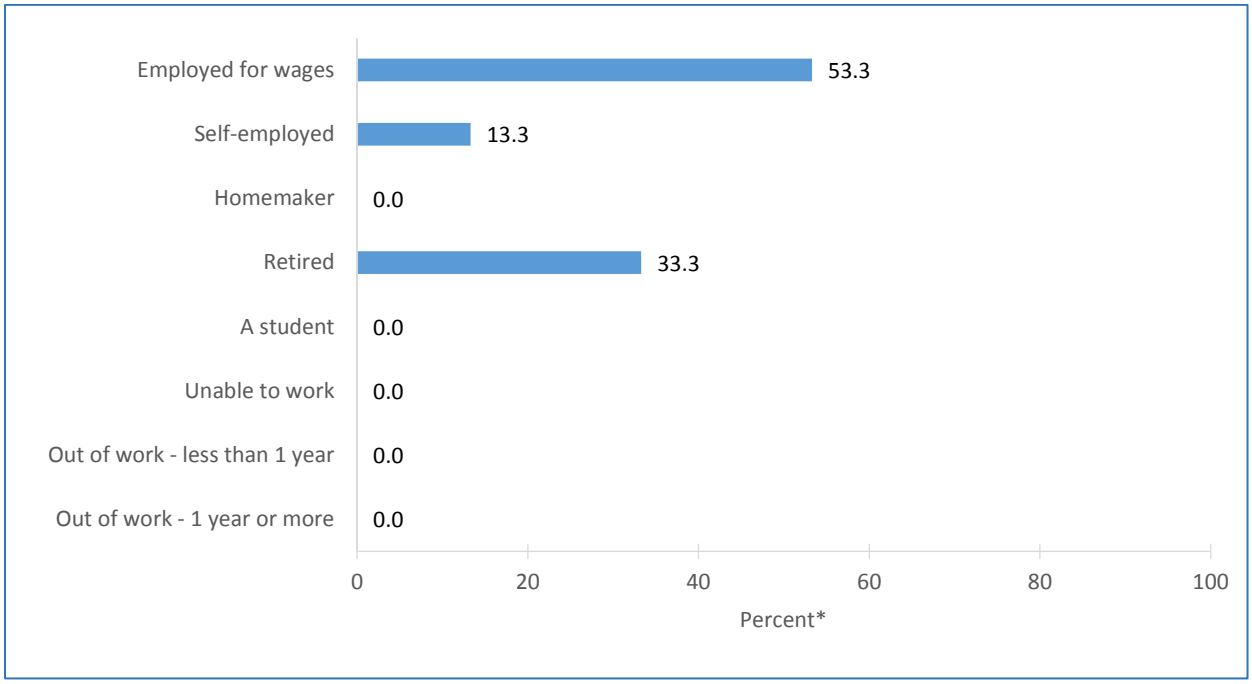
Figure 34. Annual household income of respondents



N=29

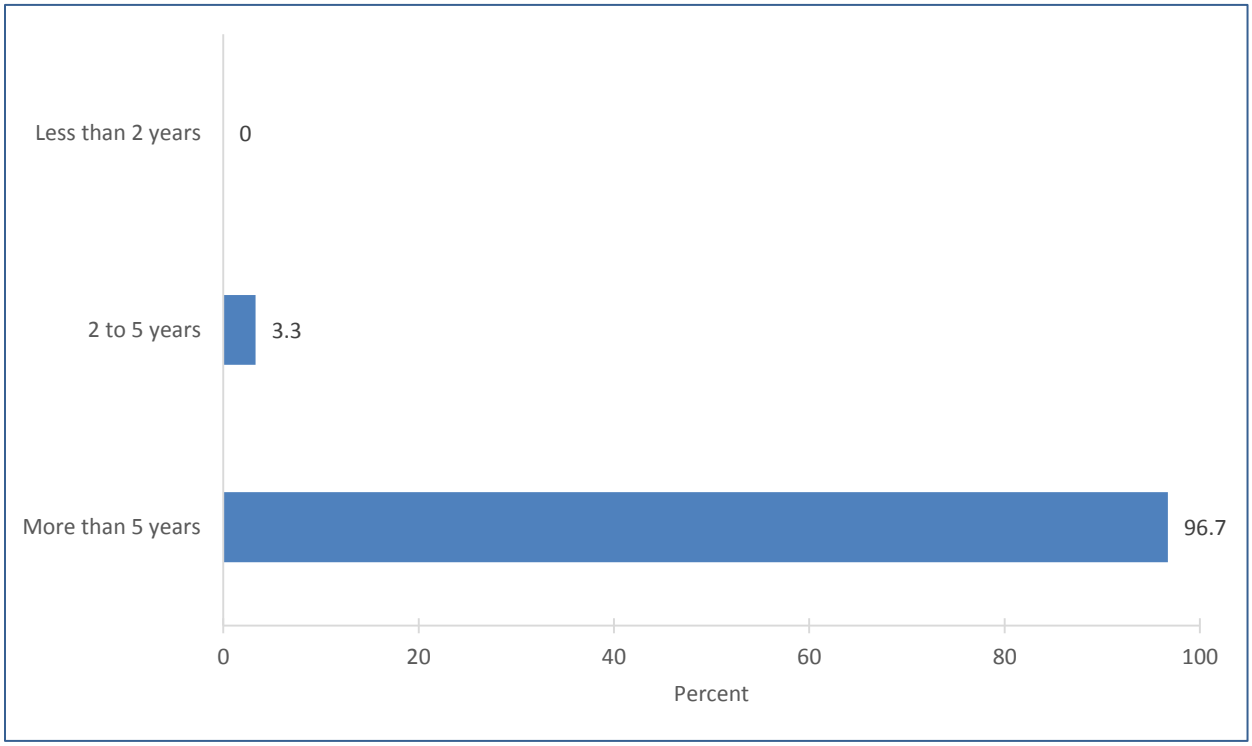
*Percentages do not total 100.0 due to rounding.

Figure 35. Employment status of respondents



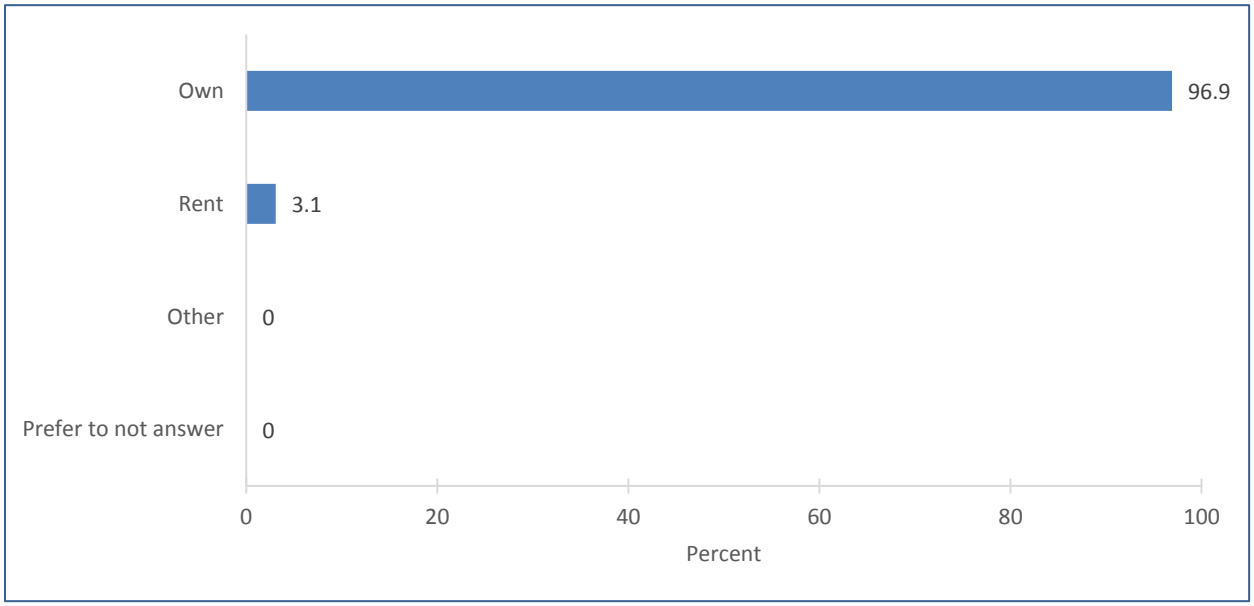
N=30 *Percentages do not total 100.0 due to rounding.

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



N=30

Figure 37. Whether respondents own or rent their home



N=32

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

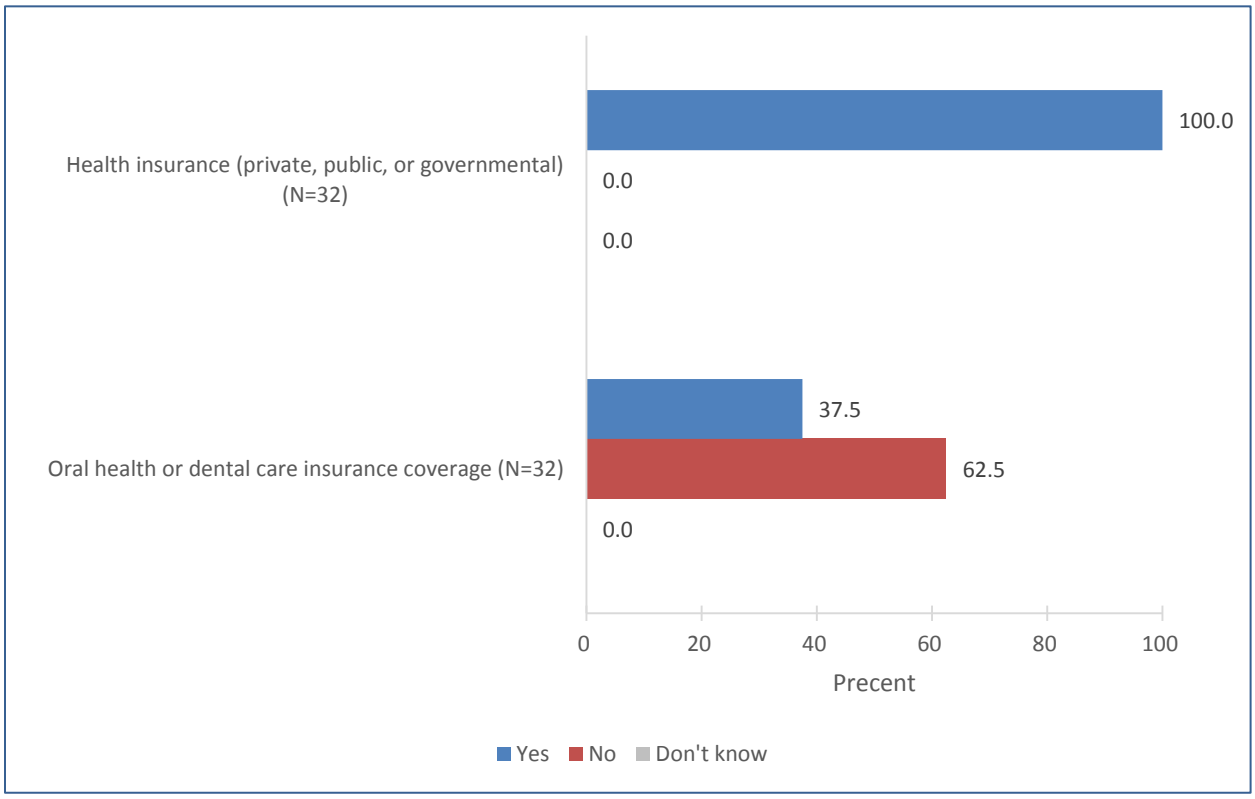
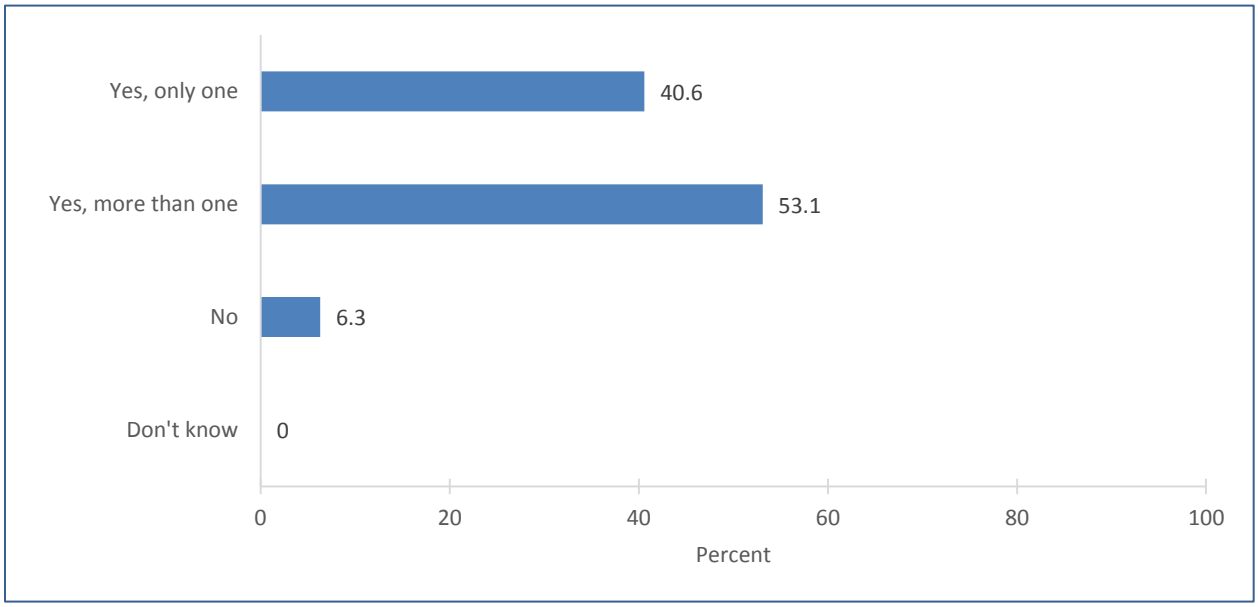
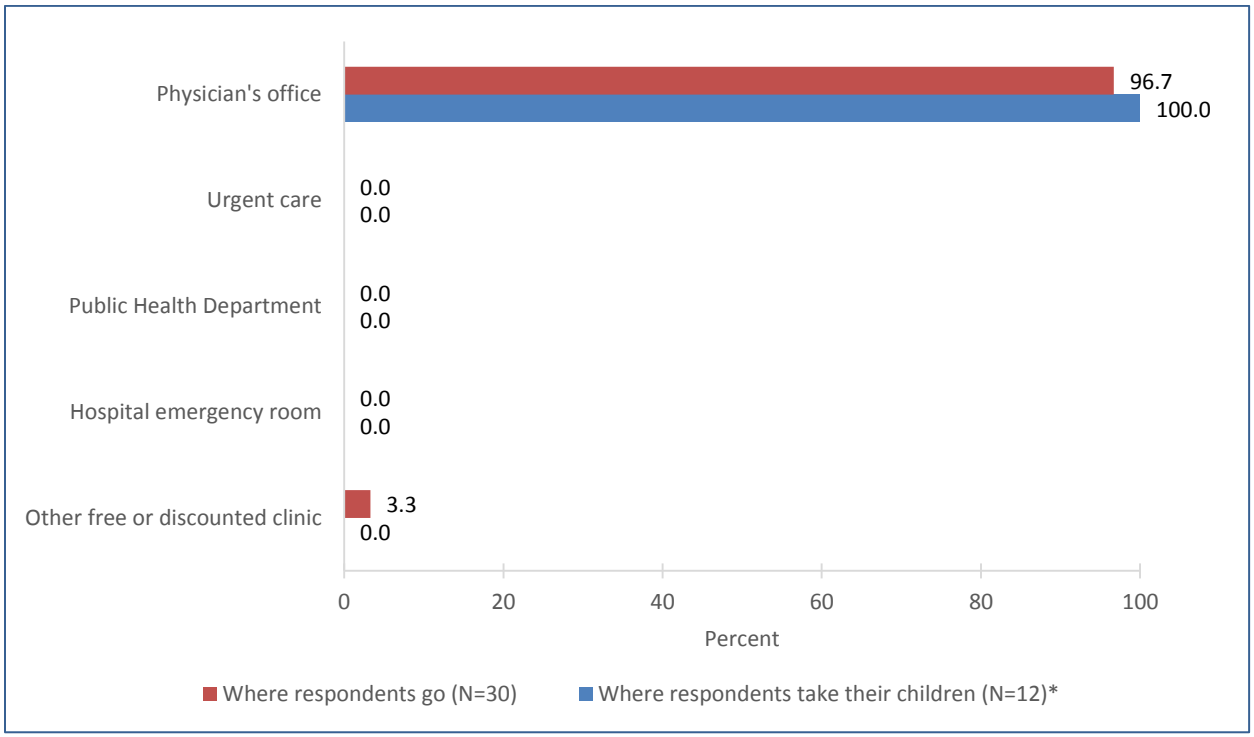


Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=32

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



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

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

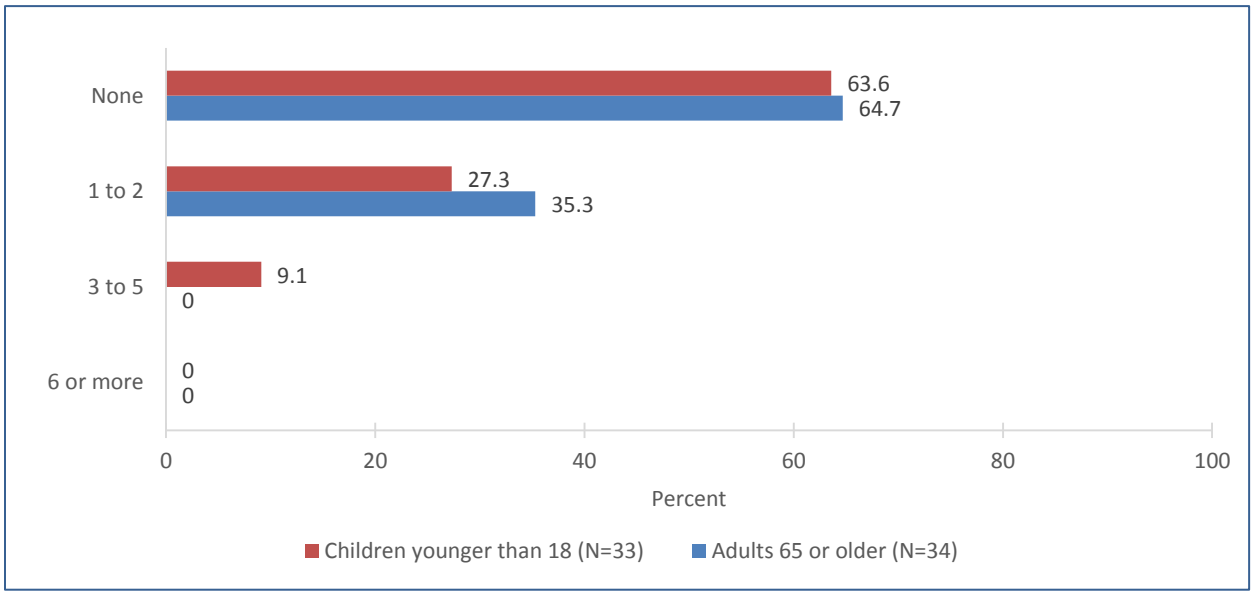
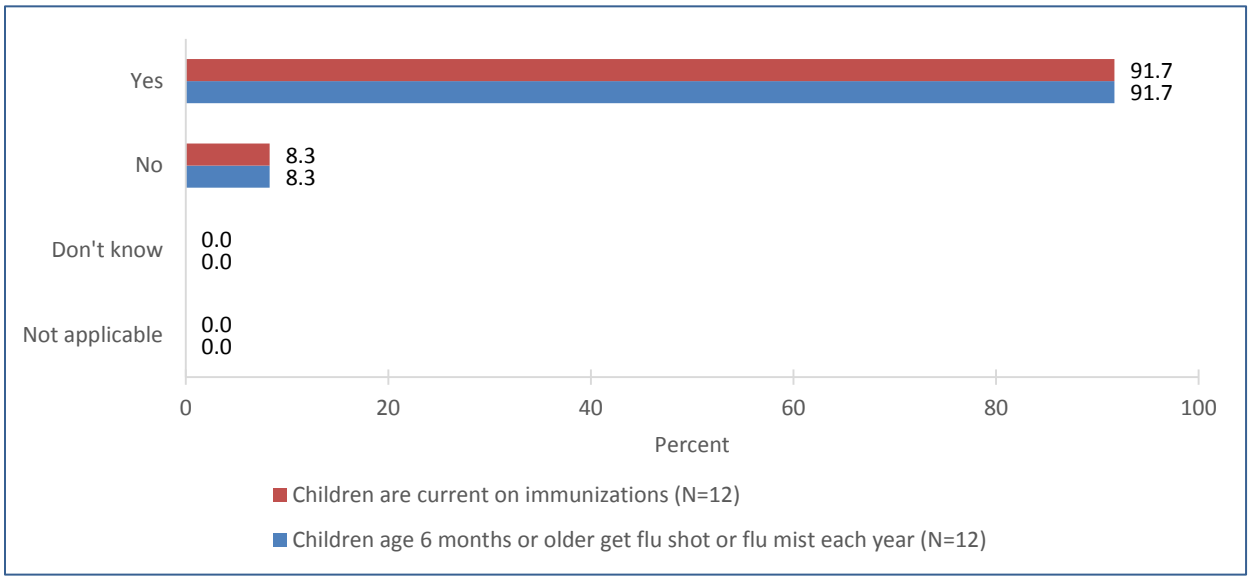


Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



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

Table 3. Zip code of respondents

Zip code	Number of respondents
56183	25
56180	6
56174	2
56172	1

SANFORD HEALTH

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)

Measure	Data Elements	Description
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	
	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

Measure	Data Elements	Description
	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
	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

Measure	Data Elements	Description
		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
	% 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

Measure	Data Elements	Description
	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
	% 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)

Cottonwood County

	Cottonwood County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Health Outcomes						71
Length of Life						59
Premature death	5,969		4,250-7,688	5,200	5,038	
Quality of Life						77
Poor or fair health	22%		14-33%	10%	11%	
Poor physical health days	4.4		2.7-6.2	2.5	2.8	
Poor mental health days	1.2		0.6-1.7	2.3	2.6	
Low birthweight	5.7%		4.2-7.1%	5.9%	6.5%	
Health Factors						44
Health Behaviors						71
Adult smoking				14%	16%	
Adult obesity	29%		23-36%	25%	26%	
Food environment index	7.8			8.4	8.3	
Physical inactivity	27%		21-34%	20%	19%	
Access to exercise opportunities	76%			92%	85%	
Excessive drinking				10%	19%	
Alcohol-impaired driving deaths	56%			14%	31%	
Sexually transmitted infections	173			138	336	
Teen births	35		28-42	20	24	

	Cottonwood County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Clinical Care						16
Uninsured	10%		9-12%	11%	9%	
Primary care physicians	1,657:1			1,045:1	1,113:1	
Dentists	1,936:1			1,377:1	1,529:1	
Mental health providers	1,056:1			386:1	529:1	
Preventable hospital stays	26		19-33	41	45	
Diabetic monitoring	87%		71-100%	90%	88%	
Mammography screening	73.7%		54.4-93.0%	70.7%	66.7%	
Social & Economic Factors						55
High school graduation					78%	
Some college	63.5%		55.2-71.7%	71.0%	73.3%	
Unemployment	5.2%			4.0%	5.1%	
Children in poverty	19%		14-24%	13%	14%	
Income inequality	4.3		3.6-4.9	3.7	4.3	
Children in single-parent households	30%		22-38%	20%	28%	
Social associations	27.6			22.0	13.2	
Violent crime	119			59	229	
Injury deaths	62		43-86	50	56	
Physical Environment						17
Air pollution - particulate matter	13.0			9.5	12.0	
Drinking water violations	0%			0%	1%	

	Cottonwood County	Trend(Click for info)	Error Margin	Top U.S. Performers*	Minnesota	Rank (of 87)
Severe housing problems	9%		7-11%	9%	15%	
Driving alone to work	72%		68-76%	71%	78%	
Long commute - driving alone	18%		15-21%	15%	29%	

* 90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data	2015

SANFORD HEALTH

018031-00061 3/16