Sanford Health Network

2016 Community Health Needs Assessment

SANFORD HEALTH

dba Sanford Canby Medical Center EIN # 46-0388596

SANFORD HEALTH

Sanford Canby Medical Center

Community Health Needs Assessment

2016

SANFORD HEALTH

Dear Community Members,

Sanford Canby 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 Canby 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 Canby, 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,

Lori Sisk
Chief Executive Officer
Sanford Canby Medical Center

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Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

Sanford Canby Medical Center

Community Health Needs Assessment
2016

Purpose

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

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

Study Design and Methodology

1. Non-Generalizable Survey

   A non-generalizable survey was conducted as an on-line survey through a partnership between Sanford and the Center for Social Research (CSR) at North Dakota State University. 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 community stakeholders and agencies, at times using a snowball approach. Data collection occurred throughout the month of March 2015 and a total of 59 respondents participated in the on-line survey.

   The purpose of this non-generalizable survey of community leaders in the greater Canby 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 3.5 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by Sanford and community partners. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

2. Community Stakeholder Meeting

   Community stakeholders were invited to a meeting to review the 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 Yellow Medicine County.

Key Findings – Primary Research

The key findings are based on the non-generalizable survey data and secondary research. Key indicators were ranked on a 1-5 Likert scale, with 5 being the highest concern ranking. Survey results ranking 3.3 or higher are considered to be high-ranking concerns for the key stakeholder non-generalizable survey. While Sanford is addressing many of the concerns that ranked less than 3.3, the top priorities for prioritization are those that rank 3.3 and above.

Aging: The top ranking concern about the aging population among respondents overall is the cost of long term care (3.92). Availability is also a high ranking concern (3.54).

Children and Youth: The highest concerns for children and youth included bullying (3.56), the availability of activities for children and youth (3.37), and the cost of activities for children and youth (3.32).

Safety: The presence of street drugs and alcohol in the community (3.31) is the highest safety concern of the respondents.

Health Care: The health care indicator addressed access to health care and cost concerns. Access to affordable health insurance (3.71), the cost of affordable vision insurance coverage (3.47), access to affordable prescription drugs (3.43), and the cost of affordable dental insurance coverage (3.43) are the highest concerns among the respondents in the health care access category.

Physical Health: Cancer (3.52), Poor nutrition (3.45), inactivity and lack of exercise (3.43), obesity (3.40) and chronic disease (3.31) are the highest physical health concerns.

Mental Health/Behavioral Health: Stress (3.40), depression (3.34), and dementia and Alzheimer's (3.34) 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. Yellow Medicine County has a higher rate at 5,178 per 100,000.

Poor or fair health: There is no data reported on the County Health Rankings for this indicator for adults in Yellow Medicine County who report poor or fair health. This indicator reports 10% nationally and 11% in Minnesota who self-report poor health.

The average number of days reported in the last 30 as unhealthy mental health days is 4.4 in Yellow Medicine County. Minnesota as a state reports 2.6 days.

The percent of live births with low birth weight (less than 2,500 grams) is 5.5% in Yellow Medicine County. The state of Minnesota is at 6.5%.

Health Factors

The percent of adults who are currently smoking is 30% in Yellow Medicine County. 16% of adults are current smokers in Minnesota.

28% of the adult population in Yellow Medicine County is considered to be obese with a BMI over 30. 26% of the population in Minnesota is obese.

The percent of adults reporting excessive or binge drinking is 25% in Yellow Medicine County. Minnesota reports 19% are binge drinkers statewide. Driving deaths that have alcohol involvement is at 25% in Yellow Medicine County. Alcohol involvement in driving deaths is at 31% in Minnesota.

Sexually transmitted infections rank substantially higher than the national benchmark (138) for Minnesota (336) and Yellow Medicine County (148). The teen birth rate is higher in Minnesota (24) than the national benchmark (20). The teen birth rate is 28 in Yellow Medicine County.

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

The ratio of population to primary care physicians is 1,113:1 in Minnesota. Yellow Medicine County's ratio is 1,270:1. The ratio of population to mental health providers is 529:1 in Minnesota. Yellow Medicine County's ratio is 2,536:1.The number of professionally active dentists in Minnesota is 1,404:1; and in Yellow Medicine County the ratio is 2,536:1.

Preventable hospital stays are 66 in Yellow Medicine County, 45 in Minnesota, and 41 nationally.

Diabetic screening is at 90% in Yellow Medicine County and 88% in Minnesota as a whole. Mammography screening is at 65.3% in Yellow Medicine County and 66.7% in Minnesota.

The social and economic factor outcomes indicate that Minnesota has a high school graduation rate of 78% and Yellow Medicine County has a graduation rate of 96%. Post-secondary education (some post-secondary education) is at 63% in Yellow Medicine County and 73.3% in Minnesota.

The unemployment rate is 4.9% in Yellow Medicine County and 5.1% in Minnesota. The percentage of child poverty is 14% in Yellow Medicine 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 lower in Yellow Medicine County at 29.5. The state of Minnesota ranks at 13.2.

The percentage of children in single parent households is 25% in Yellow Medicine County and 28% in Minnesota.

Violent crime is lower in Yellow Medicine County at 115 per 100,000 populations than Minnesota, which has 229 cases per 100,000 populations. The national benchmark is 59.

The following needs were brought forward for prioritization:

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

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

- 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 increase education and improve awareness of mental health conditions and resources in the community, and to reduce the

negative effects of stress by reorganizing the planning committee to promote healthy lifestyle within the community.

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. Goals of this strategy are to reduce the negative effects of obesity and to control hypertension.

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.

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Sanford Canby Medical Center

Community Health Needs Assessment 2016

Table of Contents

	Page
Purpose of the Community Health Needs Assessment	11
Acknowledgements	11
Description of Sanford Canby Medical Center	14
Description of the Community Served	14
Study Design and Methodology	15
Limitations of the Study	16
Key Findings	17

- Primary Research
  - Community Health Concerns
  - Personal Health Concerns
  - Demographics
  - Health Needs and Community Resources Identified
  - Prioritization

How Sanford is Addressing the Needs	36
2016-2019 Implementation Strategies	38
2013 Implementation Strategies Impact	42
Community Feedback from 2013 Community Health Needs Assessment	44
Appendix	45

Primary Research

- *Asset Map*
- *Prioritization Worksheet*
- *Generalizable Survey*
- *Non-Generalizable Survey*

Secondary Research

- *Definitions of Key Indicators/County Health Rankings*
- *Yellow Medicine County, Minnesota*

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 Canby Steering Group:

- Carrie McLeod, MBA, MS, LRD, CDE Enterprise Lead, Enterprise Community Health /Community Benefit
- Lori Sisk, Chief Executive Officer, Sanford Canby Medical Center
- Cheryl Ferguson, Director of Clinic Operations, Sanford Clinic Canby
- Jason Anderson, Director of Ancillary Services, Sanford Canby 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
- Jac McTaggart, Sanford Health
- Jessica Spaeth, City of Halstad
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- Julie Miller, South Dakota Department of Health
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- Kip Littau, South Dakota State University
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- 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 and diverse populations for their participation in this work. Together we are reaching our vision "to improve the human condition through exceptional care, innovation and discovery".

The following Canby and Yellow Medicine County community stakeholders participated in community discussions and helped to formulate the priorities for future work.

- Nancy Salmon, Long Term Care Administrator, Sanford Canby
- Brenda Knutson, Chief Nursing Officer, Sanford Canby Medical Center
- Julie Schlecht, Director of Nursing, Sanford Canby Nursing Home
- Allison Nelson, Director of Fiscal Services, Sanford Canby Medical Center
- Steve Maas, Pastor
- Ruth Ascher, Board Member, Sanford Canby Medical Center
- Lori Sisk, Chief Executive Officer, Sanford Canby Medical Center
- Cheryl Ferguson, Director of Clinic Operations, Sanford Clinic Canby
- Jason Anderson, Director of Ancillary Services, Sanford Canby Medical Center

Description of Sanford Canby Medical Center

Sanford Canby Medical Center (SCMC) is a community-based, 25-bed acute care Critical Access Hospital serving over 6,000 people. The medical center complex includes an attached Rural Health Clinic, skilled nursing facility, senior housing/assisted living facility, dental clinic, home health care service, dialysis unit and wellness center. Sanford Canby also has beds designated for swing bed services and owns its own ambulance service.

The medical center is located in a medically underserved area, as designated by the Federal Health Resources and Services Administration (HRSA). It serves an increasingly elderly population that is unable to travel distances for routine health care services.

Sanford Canby employs two family medicine physicians, one internal medicine physician, one surgeon, three family nurse practitioners, and 285 employees. Outreach services are provided for cardiology, orthopedics, GI, OB/GYN, ophthalmology and urology.

Description of the Community Served

Canby, known as the Gateway to the Prairie, has a population of 1,800 people, and is located in southwestern Minnesota in Yellow Medicine County. The community is home to Del Clark Lake, which provides an abundance of recreational and leisure activities including hunting, fishing, golf and walking/biking trails. Canby has excellent schools, including an independent school district, St. Peter’s Catholic School, and Minnesota West Community College. Sanford Canby is very active in the local chamber of commerce and works with the community to strengthen its assets.

Study Design and Methodology

1. Non-Generalizable Survey

   An on-line non-generalizable survey was conducted of residents in Canby and Yellow Medicine County, Minnesota. The survey instrument was developed in partnership with 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 community stakeholders and community agencies, at times using a snowball approach**.** Data collection occurred throughout the month of March 2015 and a total of 59 respondents participated in the on-line survey.

   The purpose of the non-generalizable survey of residents in the greater Canby 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, 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 3.3 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.3 are being addressed by Sanford and community partners. However, 3.3 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 Yellow Medicine County.

Limitations of the Study

The findings in this study provide an overall snapshot of behaviors, attitudes, and perceptions of residents living in Yellow Medicine County, Minnesota. A good faith effort was made to secure input from a broad base of the community. The non- generalizable survey was sent electronically to county and community leaders, and to 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

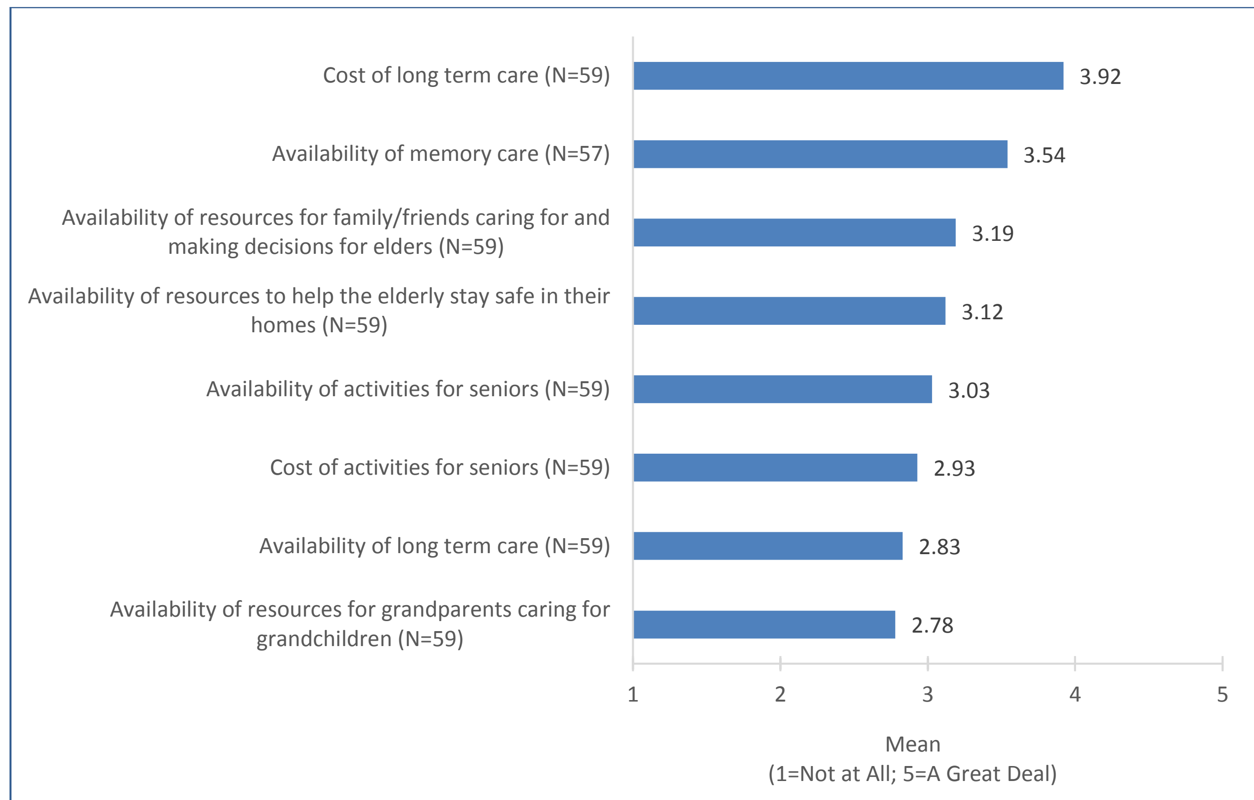
Primary Research

Community Health Concerns

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

Aging Population: The cost of long term care is the highest concern for the community stakeholder survey respondents. The availability of memory care also ranked as a high concern.

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

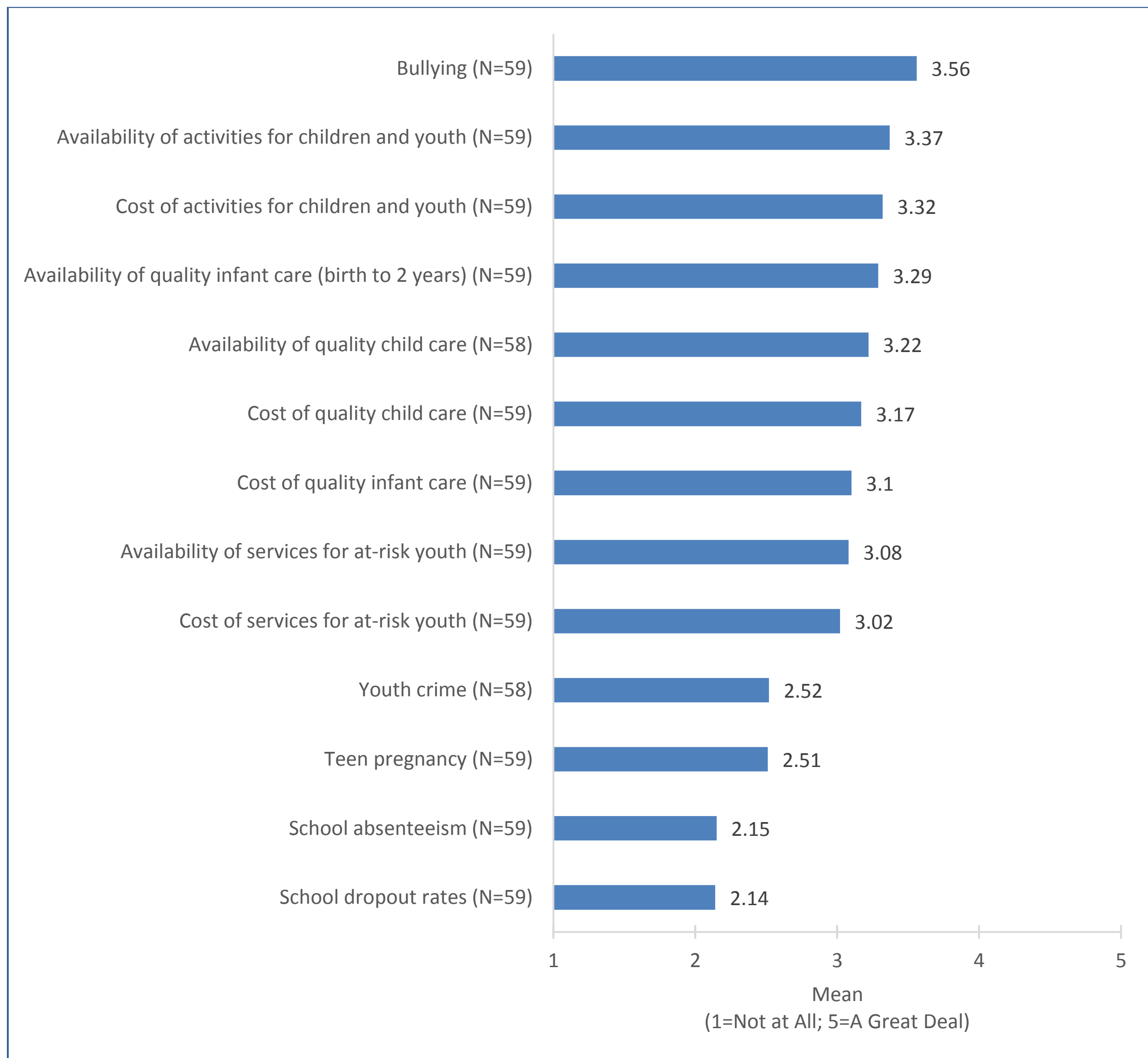


Sanford is working collaboratively with the area aging service providers to coordinate care for the aging population. Social workers, case managers, and discharge planners are working collaboratively with area service providers to assure safe discharge, and when appropriate, to assist in transitions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

Sanford also supports long term care in the community and memory care training for staff is completed annually. Home health services allow individuals to maintain supportive living in their homes. Sanford also provides assisted living services.

Children and Youth: Bullying ranked high on the concerns of the survey respondents. The availability and the cost of activities for children and youth are also high concerns.

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



Sanford provides patient and community education including a focus on children and youth. Sanford works with the athletic program to provide training for local athletes.

Additionally, 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.

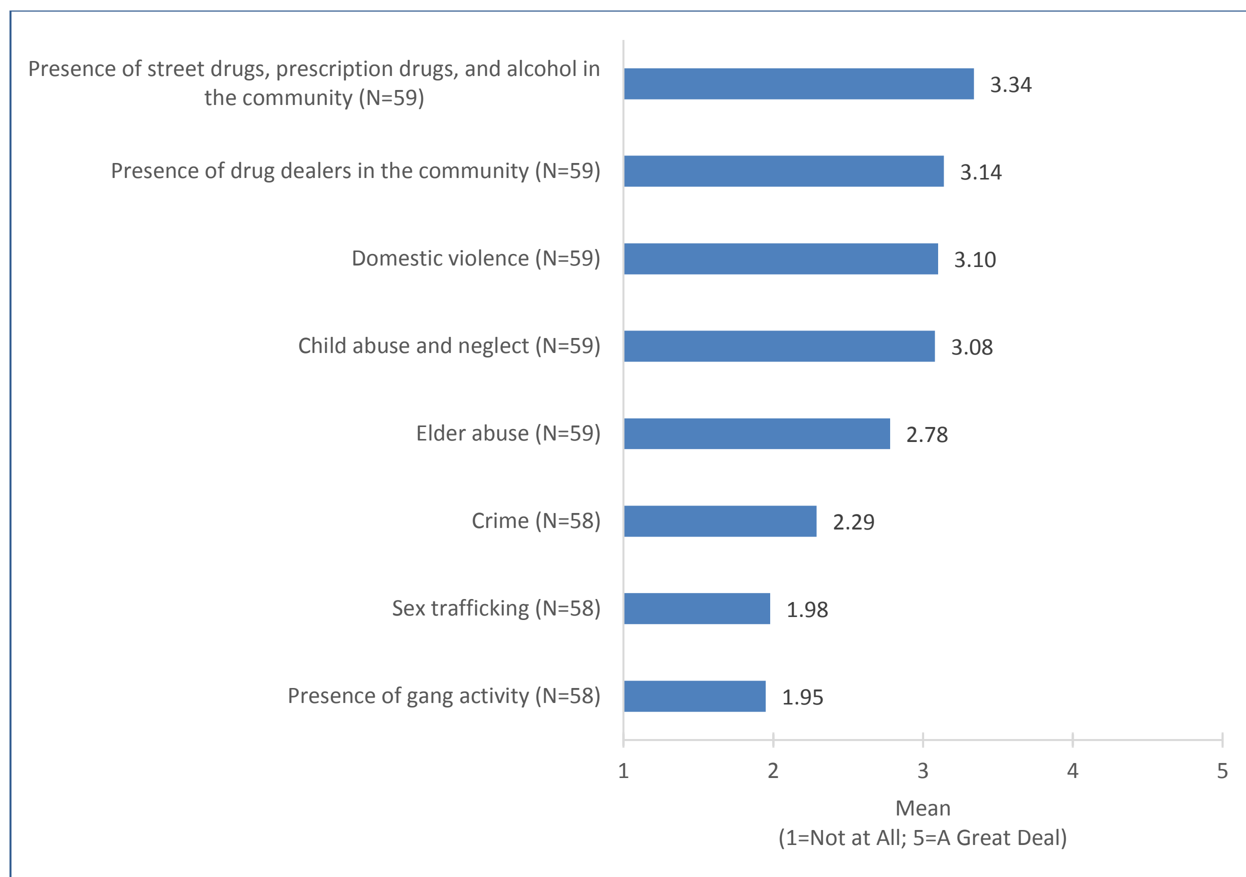
- *fit*4Schools – *fit*4Schools includes unique *fit*-based lessons integrated into daily classroom activities. *fit*4schools.sanfordfit.org is an on-line school resource that incorporates topics into math and science curriculum. To date the program has 14 STEM (integrating science, technology, engineering, 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.

Safety: Safety is a high concerns for the respondents of the survey regarding the presence of street drugs and alcohol in the community.

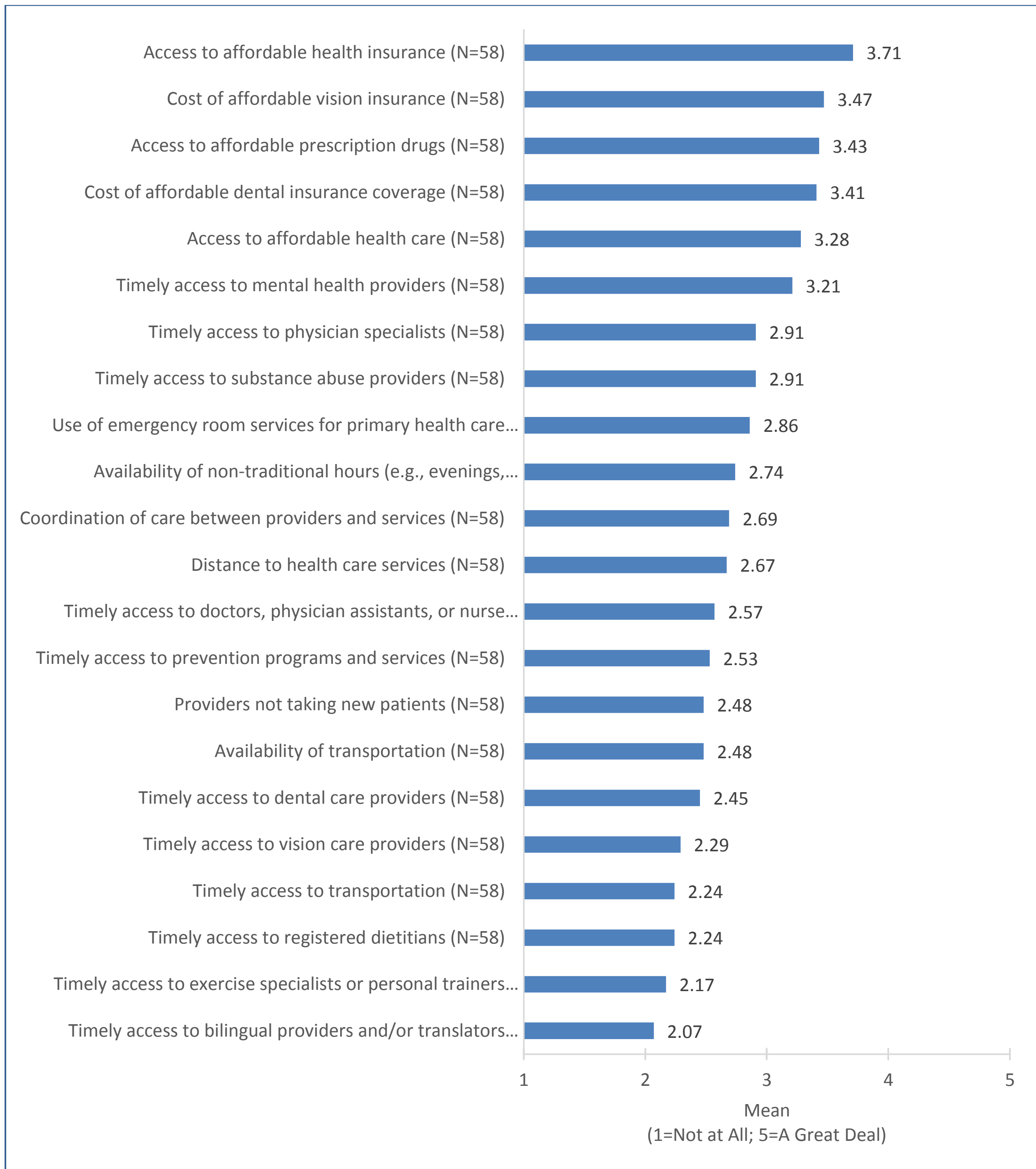
Level of concern with statements about the community regarding SAFETY



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

Health Care Access: Community stakeholders ranked access to affordable health insurance, the cost of affordable vision and dental insurance, and access to affordable prescription drugs as top concerns for healthcare access.

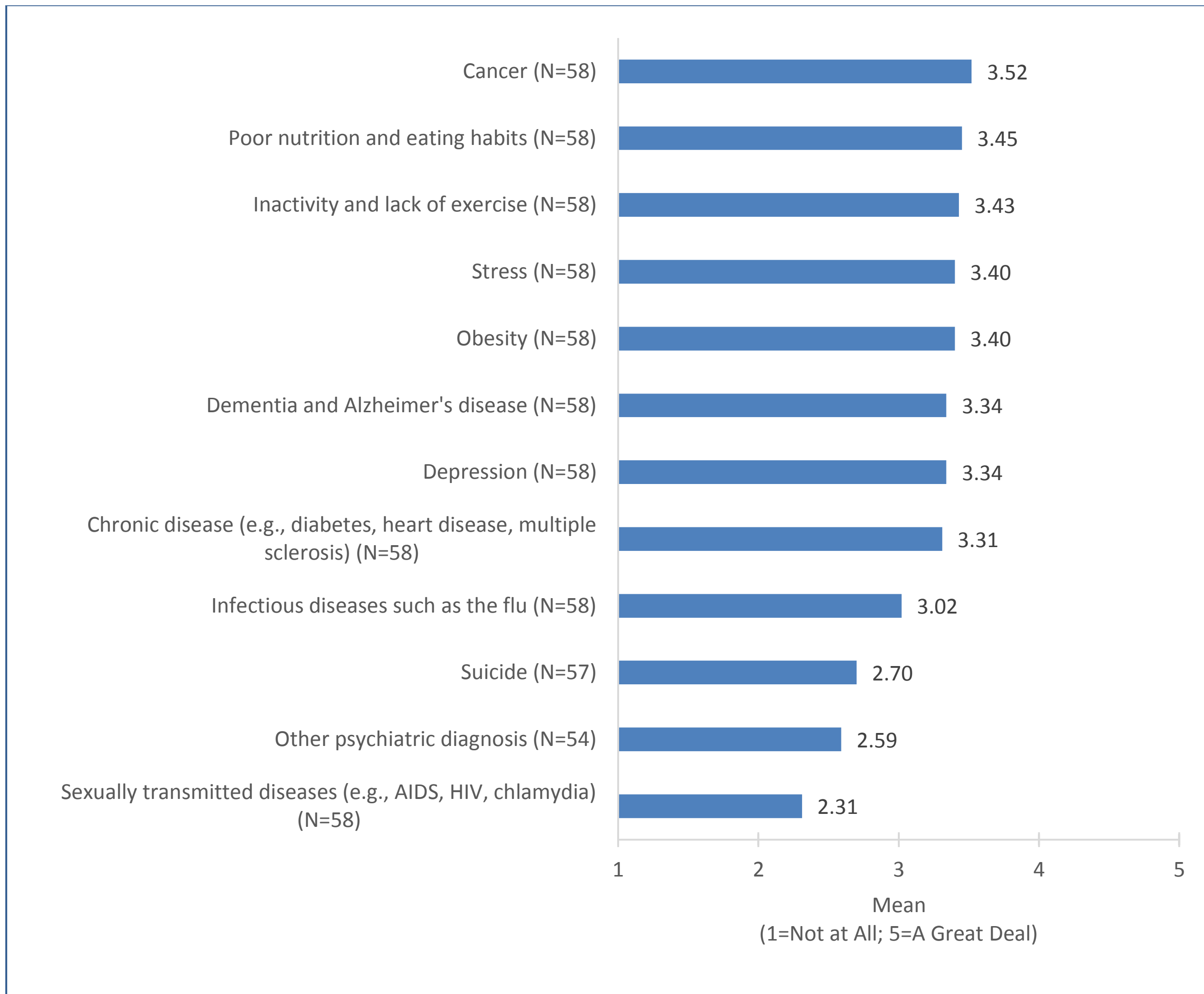
Level of concern with statements about the community regarding HEALTH CARE



Sanford Canby 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. The Sanford Health Plan is also available to community members.

Physical Health: The top physical health concerns among the community stakeholders are cancer, poor nutrition, inactivity and obesity. The mental health concerns include stress, depression, Alzheimer's and dementia.

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



Chronic disease is supported by the Health Coach and Medical Home. Preventive services and screenings are offered at Sanford.

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 *fit* on-line program has components for adults as well as children.

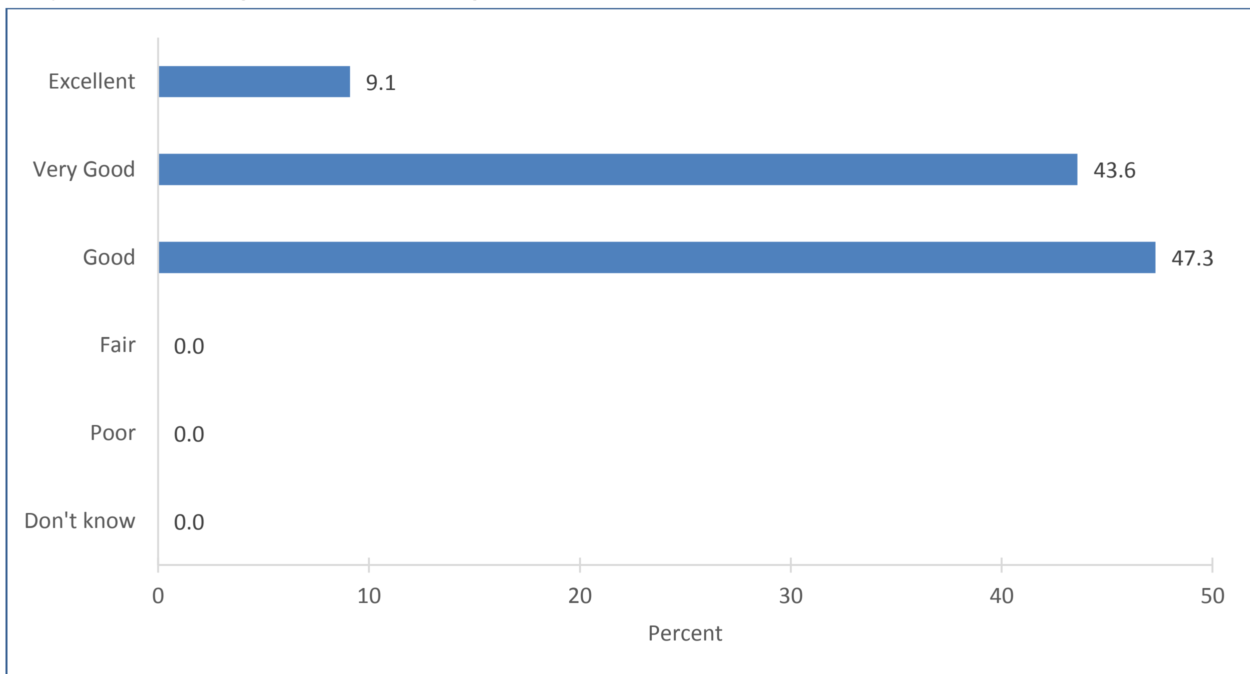
Sanford screens patients for depression on admission to the emergency department. Behavioral health services are embedded into the clinic.

Personal Health Concerns

Respondents' Personal Health Status

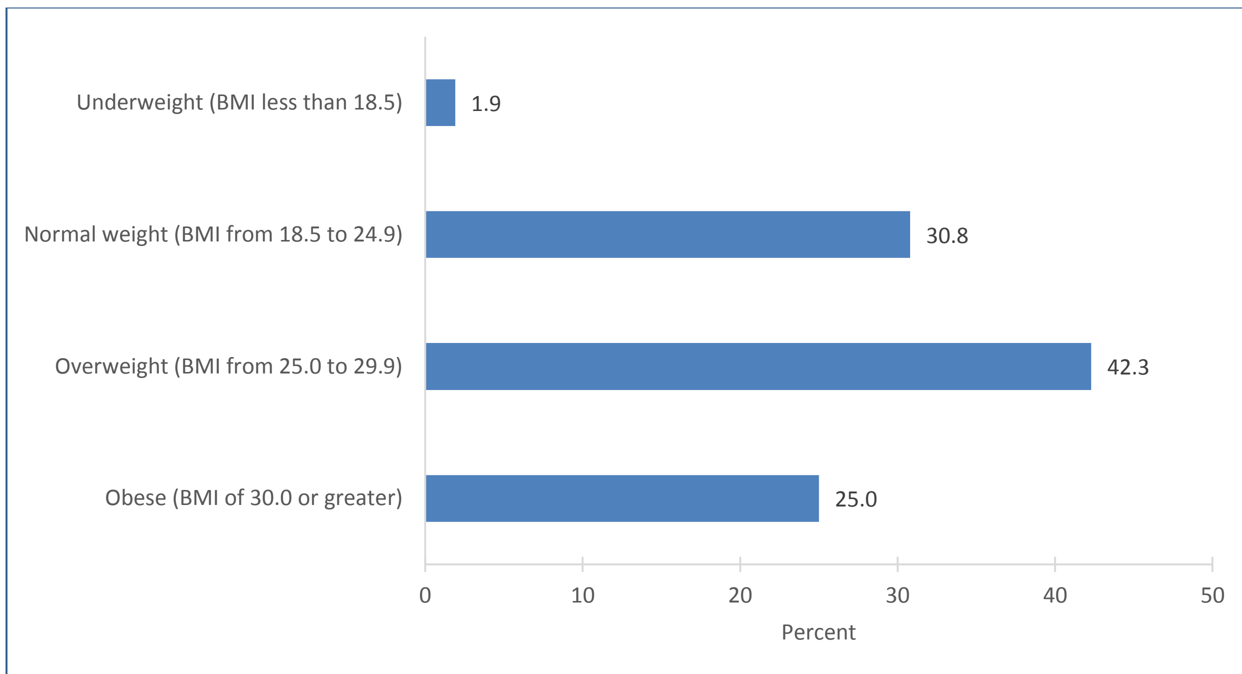
The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority of respondents in the area (67.3%) are overweight or obese. However, the vast majority (100%) 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 76% of respondents visited a doctor or health care provider for a routine physical and over 89% visited a dentist or dental clinic.

Respondents' rating of their health in general



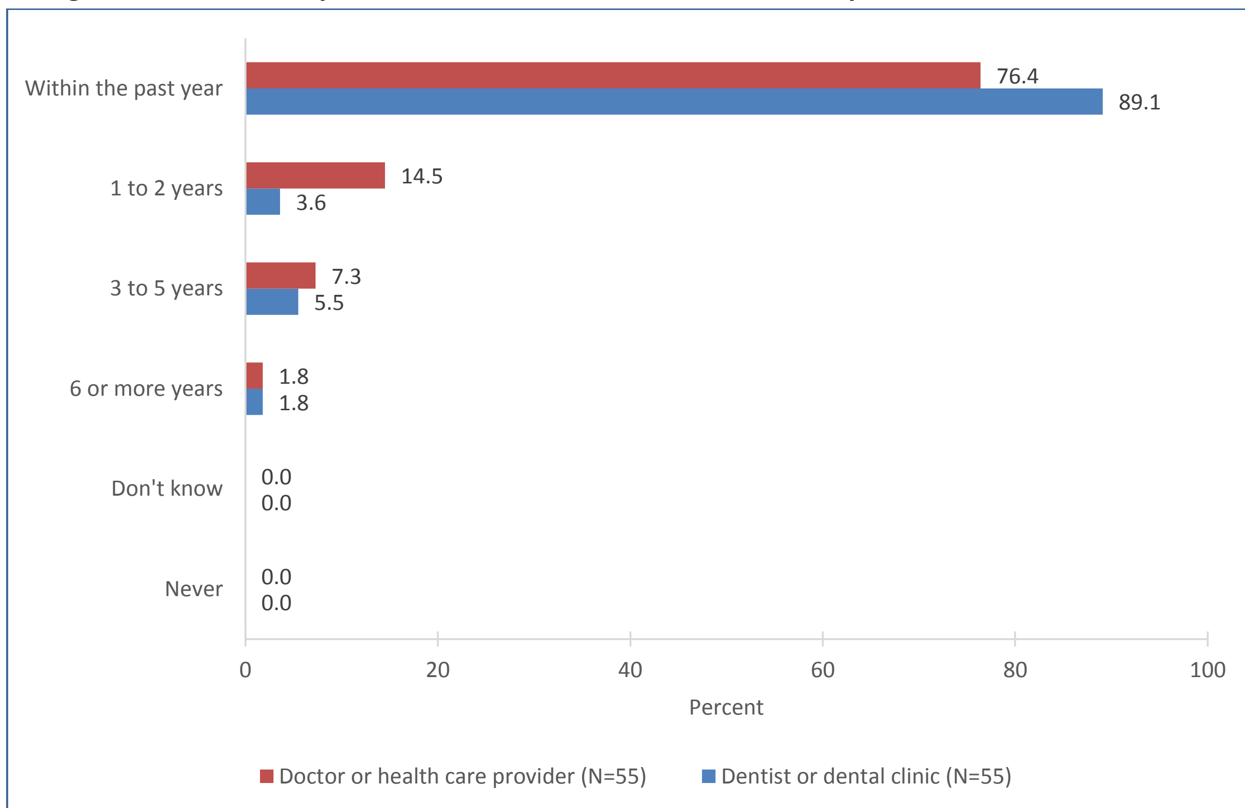
100% of the community stakeholders (non-generalizable) rate their health as good or better.

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



67.3% 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, pelvic exam, flu vaccine, and dental screening.

There are many screenings and tests that a majority of respondents did not receive (i.e., bone density test, cardio screening, 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=55)	83.6	16.4	100.0
Blood sugar screening (N=54)	57.4	42.6	100.0
Bone density test (N=54)	14.8	85.2	100.0
Cardiovascular screening (N=54)	20.4	79.6	100.0
Cholesterol screening (N=54)	68.5	31.5	100.0
Dental screening and X-rays (N=55)	87.3	12.7	100.0
Flu shot (N=55)	85.5	14.5	100.0
Glaucoma test (N=55)	60.0	40.0	100.0
Hearing screening (N=54)	7.4	92.6	100.0
Immunizations (N=54)	37.0	63.0	100.0
Pelvic exam (N=44 Females)	84.1	15.9	100.0
STD (N=54)	7.4	92.6	100.0
Vascular screening (N=53)	7.5	92.5	100.0
CANCER SCREENINGS			
Breast cancer screening (N=42 Females)	66.7	33.3	100.0
Cervical cancer screening (N=43 Females)	69.8	30.2	100.0
Colorectal cancer screening (N=54)	14.8	85.2	100.0
Prostate cancer screening (N=9 Males)	44.4	55.6	100.0
Skin cancer screening (N=53)	18.9	81.1	100.0

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

	Percent of respondents*						
Type of screening	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=9)	44.4	33.3	11.1	0.0	0.0	0.0	0.0
Blood sugar screening (N=23)	60.9	13.0	4.3	0.0	0.0	0.0	4.3
Bone density test (N=46)	58.7	28.3	6.5	0.0	0.0	0.0	6.5
Cardiovascular screening (N=43)	51.2	39.5	7.0	0.0	0.0	2.3	2.3
Cholesterol screening (N=17)	35.3	23.5	11.8	0.0	0.0	5.9	11.8
Dental screening and X-rays (N=7)	28.6	0.0	14.3	28.6	0.0	0.0	0.0
Flu shot (N=8)	50.0	0.0	0.0	0.0	0.0	0.0	25.0
Glaucoma test (N=22)	50.0	36.4	9.1	0.0	0.0	0.0	4.5
Hearing screening (N=50)	54.0	32.0	4.0	0.0	0.0	2.0	4.0
Immunizations (N=34)	58.8	17.6	2.9	0.0	0.0	0.0	2.9
Pelvic exam (N=7 Females)	14.3	14.3	14.3	0.0	0.0	0.0	57.1
STD (N=50)	74.0	14.0	4.0	0.0	0.0	0.0	2.0
Vascular screening (N=49)	51.0	40.8	4.1	0.0	0.0	0.0	2.0
CANCER SCREENINGS							
Breast cancer screening (N=14 Females)	57.1	21.4	7.1	7.1	0.0	0.0	7.1
Cervical cancer screening (N=13 Females)	53.8	7.7	7.7	0.0	0.0	0.0	30.8
Colorectal cancer screening (N=46)	67.4	10.9	6.5	6.5	0.0	0.0	10.9
Prostate cancer screening (N=5 Males)	40.0	20.0	20.0	0.0	0.0	0.0	20.0
Skin cancer screening (N=43)	37.2	41.9	7.0	0.0	0.0	2.3	9.3

- *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.*
  40% of the non-generalizable respondents were under 45 years of age. Over 36% were in the 55 years 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.

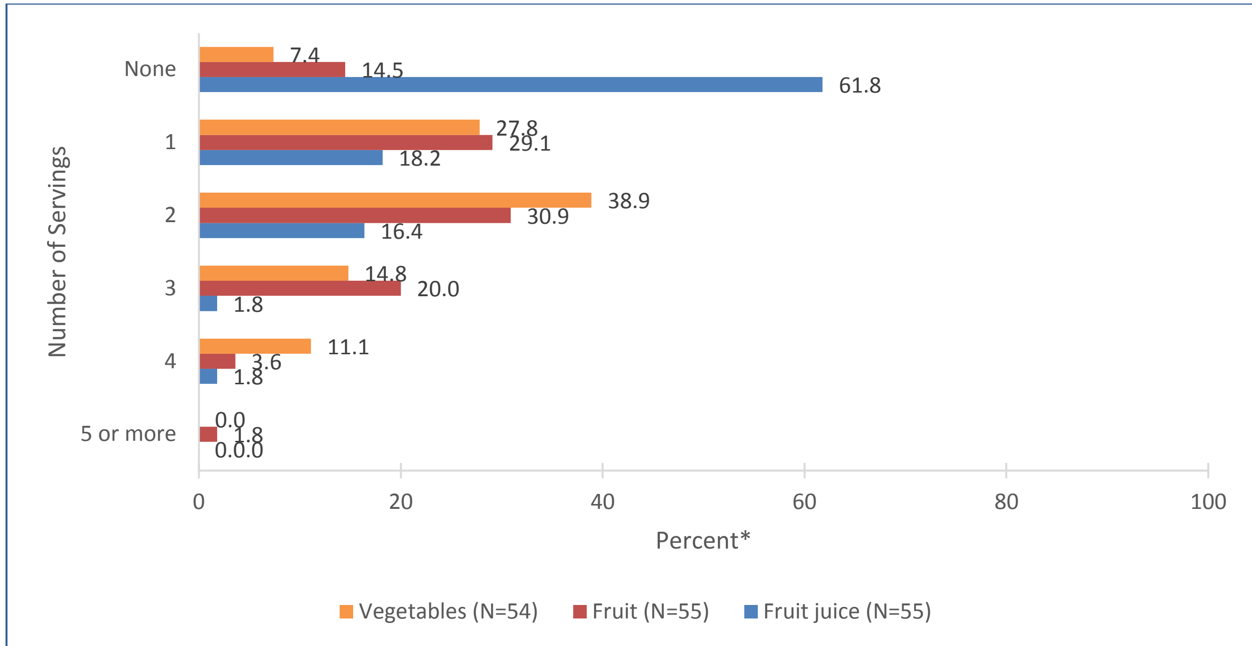
Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 25.9% of respondents reported having 3 or more servings of vegetables the prior day.

Only 25.4% 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

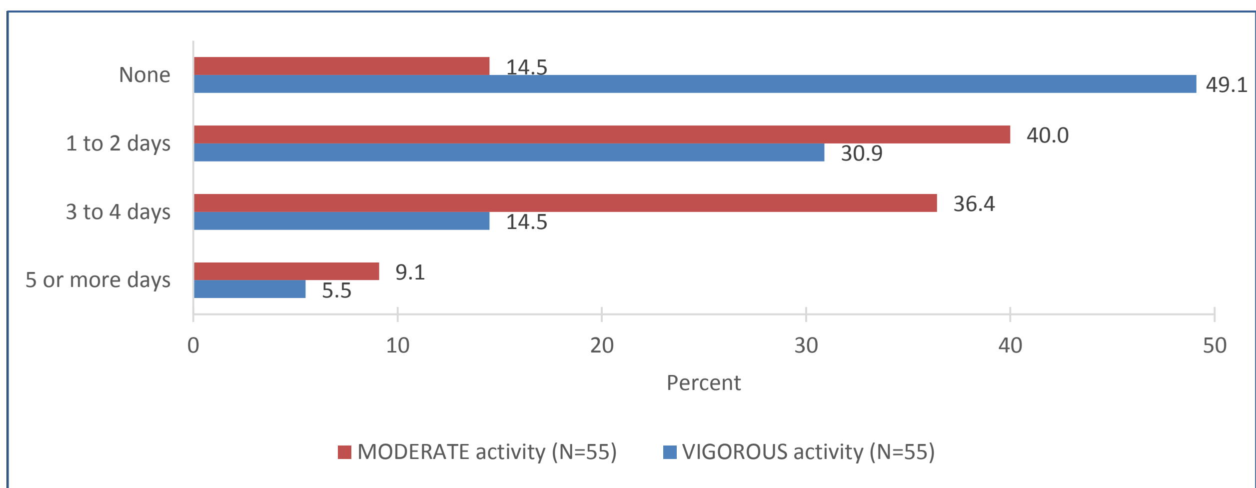


Physical Activity Levels

Study results suggest that 65% of respondents do meet physical activity guidelines. 45.5% of respondents have 3 or more days per week with moderate activity.

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.

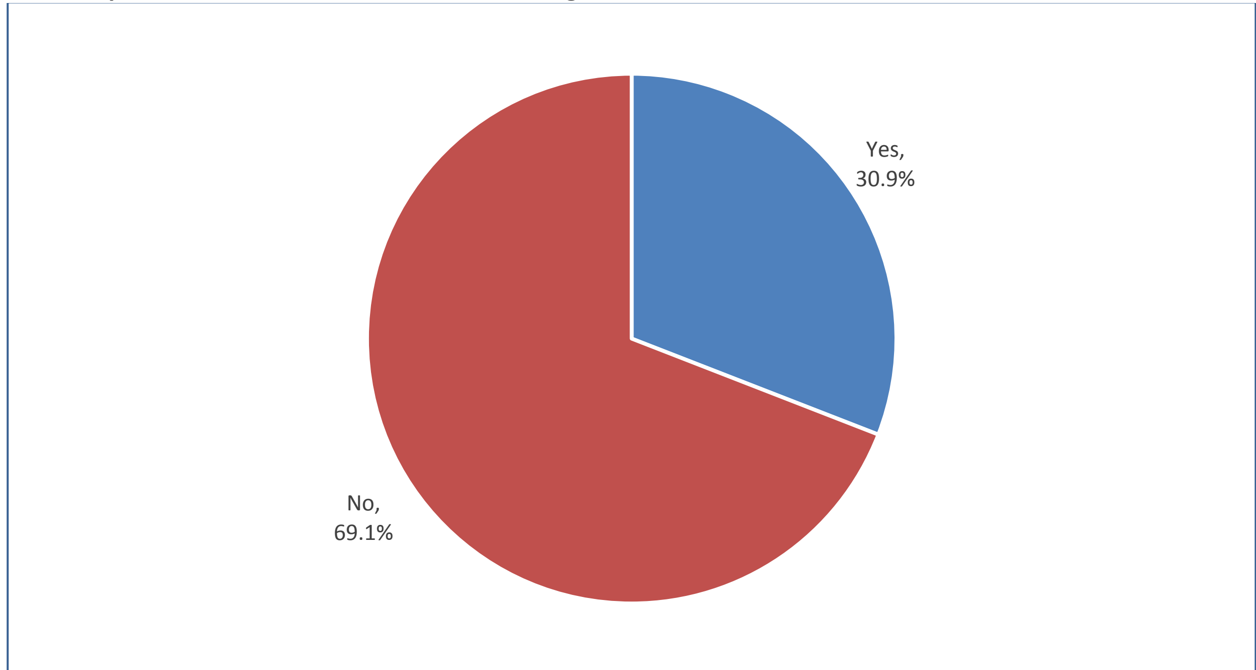
Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



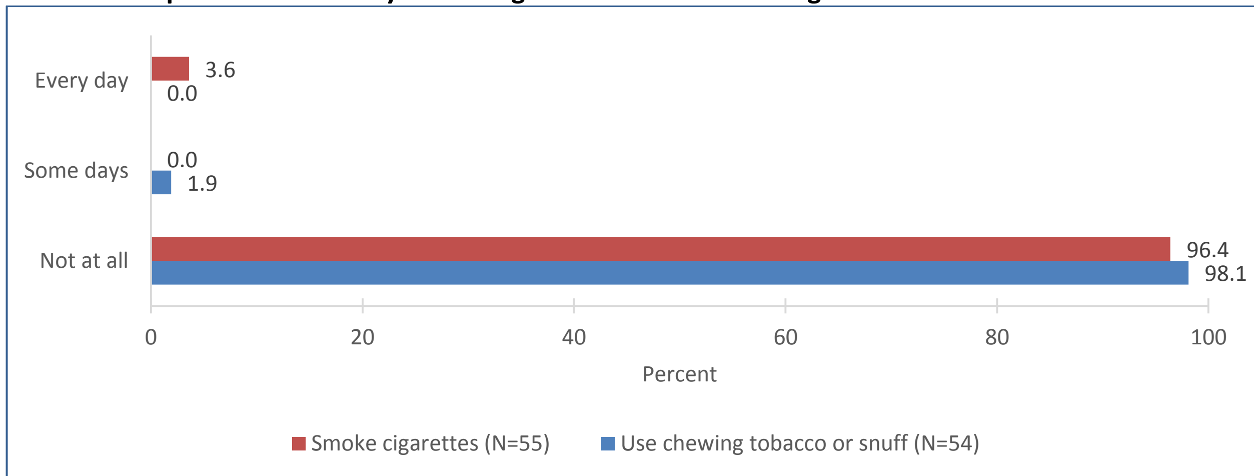
Tobacco Use

Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 30.9% 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



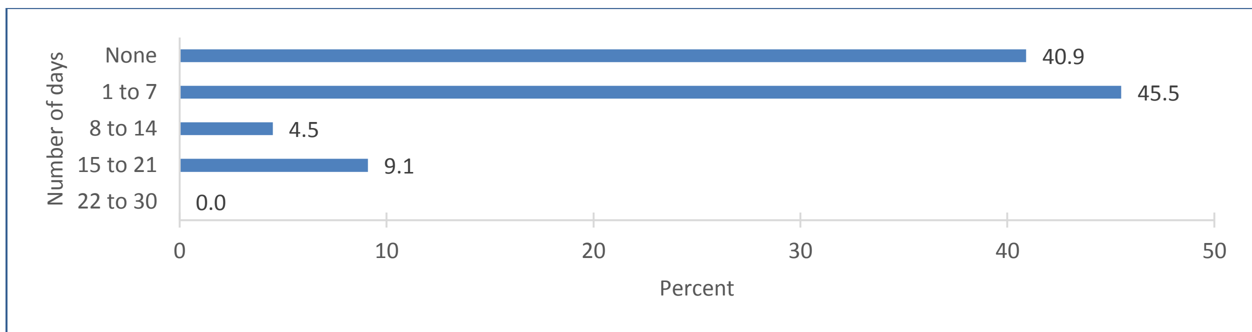
How often respondents currently smoke cigarettes and use chewing tobacco or snuff



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 respondents, mental health is a moderately high area of concern, particularly depression, and stress. 22% of respondents have been told or diagnosed by a doctor or health professional that they have anxiety or stress and 15.3% have been told they have depression. In addition, 59% 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

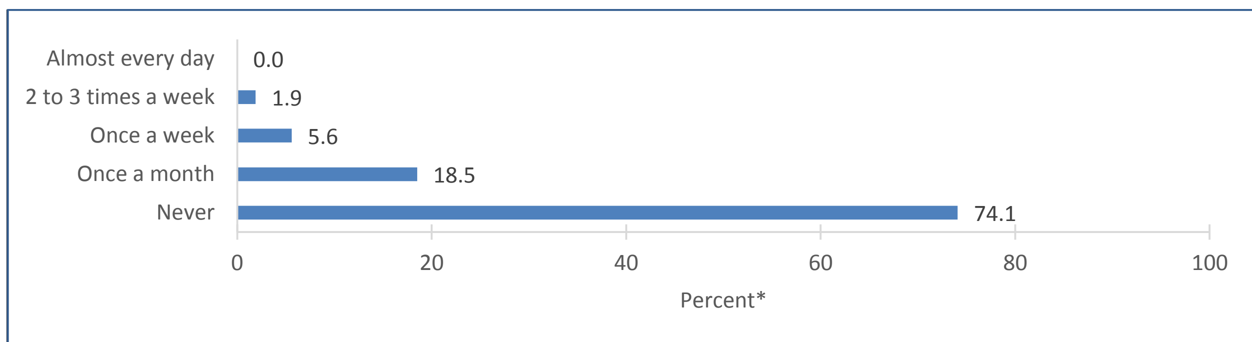


Substance Abuse Responses

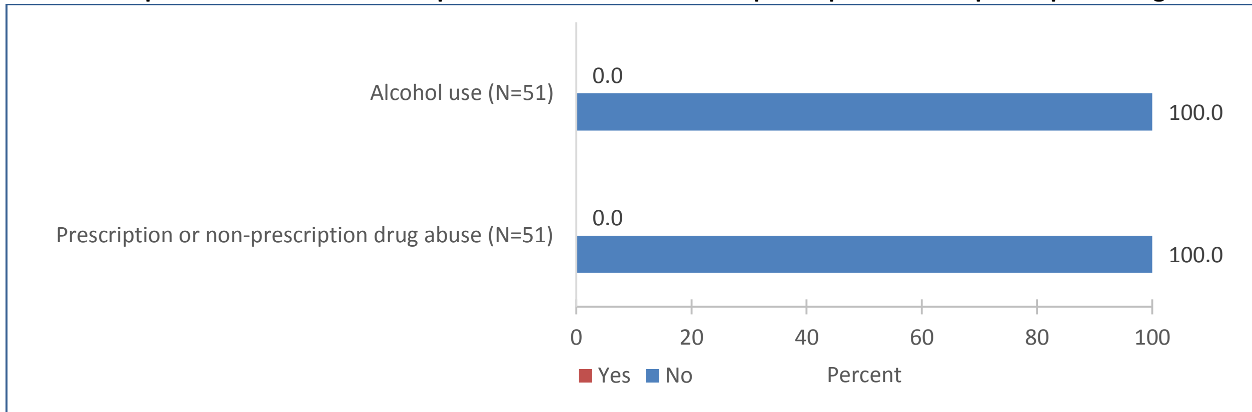
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In Canby and Yellow Medicine County, 77.8% of the community stakeholder's respondents drank alcoholic beverages on at least one of the days in the last month. On days they drank, 11.9% of respondents drank an average of 3 or more drinks per day. In regards to binge drinking, 26% of community stakeholder's respondents report binge drinking at least once per month,

Secondary research through the 2015 County Health Rankings found that 25% of residents in Yellow Medicine County report excessive drinking, and 25% of the driving deaths indicated 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



There were no respondents from the community stakeholder group who reported having a problem with alcohol, although earlier reporting indicated a higher level of binge drinking (26%).

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

Demographics

Total Population – 2010 U.S. Census Bureau

- Yellow Medicine County: 10,438

Population by Age and Gender

	Number	Percent	Males	Percent	Females	Percent
<5 years	660	6.3	338	3.2	322	3.1
5-9	641	6.1	340	3.3	301	2.9
10-14	714	6.8	382	3.7	332	3.2
15-19	693	6.6	373	3.6	320	3.1
20-24	523	5.0	300	2.9	223	2.1
25-29	615	5.9	324	3.1	291	2.8
30-34	519	5.0	289	2.8	230	2.2
35-39	511	4.9	253	2.4	258	2.5
40-44	614	5.9	310	3.0	304	2.9
45-49	745	7.1	362	3.5	383	3.7
50-54	861	8.2	439	4.2	422	4.0
55-59	755	7.2	438	4.2	317	3.0
60-64	556	5.3	278	2.7	278	2.7
65-69	496	4.8	250	2.4	246	2.4
70-74	429	4.1	199	1.9	230	2.2
75-79	363	3.5	170	1.6	193	1.8
80-84	319	3.1	143	1.4	176	1.7
85 and over	424	4.1	140	1.3	284	2.7
Median age	42.9		40.9		44.7	

Population by Race

	Yellow Medicine	Percent
White	9,806	93.9
Black or African American	16	0.2
American Indian or Alaska Native	314	3.0
Asian	33	0.3
Native Hawaiian or other Pacific Islander	6	0.1
Hispanic or Latino	397	3.8

The per capita personal income in Yellow Medicine County, Minnesota is $26,487. Regarding the poverty level, 24.7% of individuals 15 years and older in Yellow Medicine County are living below the poverty level. The unemployment rate in Yellow Medicine County, Minnesota is 4.9%.

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

The Appendix displays the asset map.

Prioritization

The following needs were brought forward for prioritization:

- Aging - cost of long term care, availability of memory care
- Children and Youth - bullying, availability, cost of activities for children and youth
- Safety - presence of street drugs and alcohol in the community
- Health Care Access - and access to affordable health insurance, cost of affordable vision and dental insurance, access to affordable prescription drugs
- Physical Health – cancer, poor nutrition, inactivity, obesity, chronic disease
- Mental Health – stress, depression, dementia, alcohol 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.

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

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

- Physical Health
- Mental Health

Addressing the Needs

Identified Concerns	How Sanford Canby is Addressing the Needs
Aging • Cost of long term care • Availability of memory care	• Providing an opportunity for long term care in our community where memory care training is completed annually with staff. • Providing an assisted living setting with provides supportive care. • Availability of home health services to allow people to maintain supportive living in their home.
Children and Youth • Bullying • Availability of activities for children and youth • Cost of activities for children and youth	• Performing biannual to quarterly education including implementing the *fit* Kids program which addresses mood and stress management strategies. • Completing youth athletic training programs.
Safety • Presence of street drugs and alcohol in the community	• Developed a working relationship with local and county law enforcement.
Health care • Access to affordable health insurance • Cost of affordable vision insurance • Access to affordable prescription drugs • Cost of affordable dental insurance coverage	• Facilitating in the inpatient, home health and outpatient settings necessary county referrals to increase resources. • Providing transitional care visits with nursing, pharmacists and providers to at- or high-risk patients. • Utilize Health Coach for patients unable to accessible affordable medications and use of drug savings cards. • Provide resources and information to patients without insurance.
Physical Health • Cancer • Poor nutrition and eating habits • Inactivity and lack of exercise • Obesity • Chronic disease • BMI – overweight or obese • Only 25.9% of respondents have 3 or more vegetables/day and 25.4 % have 3 or more fruits/day • Only 45.5% have 3 or more days each week of moderate activity and 20 % report 3 or more days of vigorous activity each week • 30.9% have smoked at least 100 cigarettes in their life • 20.3% of respondents reported hypertension • 16.9% reported high cholesterol	• Performing community education in the elementary and high school in the areas of food and nutrition and also physical activity and health. • Completing health and wellness community campaigns including Together.Canby.Can which promotes educational events such as reading food labels, talking with your doctor, sleep health, heart health, balance and fall prevention, health technology, etc. • Influenza clinics. • Promoting annual health screenings and access to primary health care providers. • Completed monthly or quarterly support groups by health care professionals in the areas of chronic disease and progressive neurological diseases. • Increasing access to specialty services and availability of care in our community such as outreach and telemedicine services. • Providing a fitness center for prevention/wellness of staff and community members that is attached to health care campus.

Identified Concerns	How Sanford Canby is Addressing the Needs
• 10.2% reported diabetes *Preventive Health – Flus shots and immunizations mammograms*	• Completing annual fitness events such as a 5K or volunteering and partnering with other organizations to assist with staffing these events. • Health Coach on staff to promote adherence and follow up and a liaison between the patient and medical providers. • Performing biannual to quarterly education including implementing the *fit* Kids program which addresses movement and food/nutrition education.
Mental Health • Stress • Depression • Dementia and Alzheimer's • 22% of respondents report that they have been told by a doctor that they have anxiety or stress, and 15.3% report being told that they have depression • 59.1% reported 1 or more days in the last month when their mental health was not good. • 11.9% of respondents reported 3 or more drinks /day on average • 26% reported 4 or 5 drinks (binge) on the same occasion over the past month • No one reported having a problem with alcohol use or drug use; however, 24.1% reported that alcohol use had harmful effects on the respondent or a family member *Poor mental health days*	• Coordinating with area mental health services and counselors to perform outreach services within our health care facility. • Completed monthly or quarterly support groups by health care professionals/trained professionals in the areas of chronic diseases, grief and loss, and drug and alcohol abuse. • Providing a focus during clinic visits to all and at-risk patient to have depression and/or anxiety screenings. • Partnering with community organizations to provide opportunities for activities for families at reduced or no cost • Having a Social Worker/Health Coach on staff and available for consult and resource education.

SANFORD HEALTH

2016 Implementation Strategy

Implementation Strategy

<u>Priority 1</u>: Physical Health

<u>Projected Impact</u>: Improve the physical health of the greater Canby, Minnesota community

<u>Goal 1</u>: Reduce the negative health effects of obesity

Actions/Tactics	Measureable Outcomes	Dedicated Resources	Leadership	Community partnerships and collaborations (if applicable)
Reorganize planning committee	Meet quarterly during the timeframe of 2017-2020	Existing	CEO, Directors and Nursing Leadership	Citizens of Canby
Implement Together.Canby.Can (an initiative to promote healthy lifestyle within the community and promotion of resources)	Complete biannual to quarterly community education events	Existing/Grant Funds	Directors and Community Health Needs Committee	Community Organizations (i.e. Chamber of Commerce)
Continue implementation of the *fit* kids program to school age youth	Complete quarterly or biannual implementation to students in elementary and/or secondary education during the 2017-2020 school years	Existing	Directors and Community Health Needs Committee	Canby Public and Parochial Schools
Establish employee education to promote healthy lifestyles	Complete biannual employee wellness and education programs	Existing	Directors and Community Health Needs Committee	

<u>Goal 2</u>: Controlling hypertension in community of Canby, Minnesota

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Implementation of the MN Community Measurement – Application of Blood Pressure screening and follow-up for those with readings greater than 140/90	Improved blood pressure and decrease in consequences of high blood pressure which include: stroke, heart failure, vision loss, heart attack, kidney disease/failure	Existing	Directors and Rural Health Clinic Providers/Staff	

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Complete blood pressure screenings during community events	Complete one screening clinics in the community per year	Existing	Directors and Community Health Needs Committee	
Continue implementation of the *fit* kids program to school age youth	Complete quarterly or bi-annual implementation to students in elementary and/or secondary education during the 2017-2020 school years	Existing	Directors and Community Health Needs Committee	Canby Public and Parochial Schools

Priority 2: Mental Health

Projected Impact: Awareness of resources available for people and family members of those with mental health conditions

Goal 1: Reduce the negative effects of stress on all and at risk populations

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations - if applicable
Reorganize planning committee	Meet quarterly during the timeframe of 2017-2020	Existing	CEO, Directors and Nursing Leadership	Citizens of Canby
Implement Together.Canby.Can (an initiative to promote healthy lifestyle within the community and promotion of resources)	Complete biannual to quarterly community education events	Existing	Directors and Community Health Needs Committee	Community Organizations (i.e. Chamber of Commerce)
Continue implementation of the *fit* kids program to school age youth	Complete quarterly or biannual implementation to students in elementary and/or secondary education during the 2017-2020 school years	Existing	Directors and Community Health Needs Committee	
Establish employee education to promote healthy lifestyles	Complete biannual employee wellness and education programs	Existing	Directors, Community Health Needs Committee, and employees of Sanford Canby Medical Center	

Goal 2: Increase education to improve the awareness of mental health conditions and resources to our community members

Actions/Tactics	**Measureable Outcomes**	**Resources**	**Leadership**	**Community partnerships and collaborations - if applicable**
Implement education for awareness and prevention	Complete annual to quarterly community education events	Existing	Directors and Community Health Needs Committee	
Determine availability of resources within our geographical location for mental health conditions	Complete a meeting with public health in the 2017-2019 timeframe to establish a relationship to maximize resources	Existing	CEO, Directors and Nursing Leadership	Yellow Medicine Public Health

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.

Implementation Strategy: Develop a formal program to address obesity issues

- Appoint overall planning committee to execute program goals.
- Increase physical activity in various settings within the community.
- Improve dietary behaviors of the community through the use of multiple resources.
- Support the community obesity issues through the use of social and behavioral approaches.

Implementation Strategy: Provide local oncology services through outreach

- Enhance current telemedicine capabilities/frequency in conjunction with on-site oncologist presence.
- Provide local additional chemotherapy services.

The 2013 strategies have served as a base for reaching out and utilizing resources and implementing resources in the Canby 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 to Address Obesity

The implementation strategy to address obesity in the community has had a broad impact. The *fit* kids on-line program focusing on nutrition, activity, behavioral health and adequate sleep has had 310 students and their families access the site. Jump ropes and pedometers were provided to increase physical activity.

The medical center removed high fat options from the cafeteria to improve nutrition for employees, patients and visitors. The improved nutrition will provide a long lasting effect and a will have a broad reach into the community and region.

Monthly diabetes prevention classes are held and diabetes screening events are held regularly. A new diabetes weight loss program has started to help prevent complications and improve glucose control and overall health.

The Sanford Canby Wellness Center has begun a Better Balance Class to improve fitness and to prevent falls.

Impact of the Strategy to Provide Local Oncology Services

The implementation strategy to provide local oncology services has made an impact on those who require services close to home. Sanford Canby has added telemedicine capability for oncology patients and has increased chemotherapy supportive 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

SANFORD HEALTH

Primary Research

Canby 2016 CHNA Asset Map

Identified concern	Key stakeholder focus group	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap?
Aging population 3.92-3.54	Support for care givers Services for the elderly are a big concern in the community	Need caregiver support	Cost of long term care 3.92 (1) Availability of memory care 3.54 (4)	Sylvan Place – 507-223-7277 Sanford Canby Medical Center has respite care as does the Nursing Home	X
Children and Youth Health Care 3.56-3.32	Not much available for teens	Not much for teens	Bullying 3.56 (3) Availability of activities for children and youth 3.37 (17) Cost of activities for children and youth 3.32 (17)	Sanford WebMD Fit Kids YAMS – youth against misusing substances Community Education Canby 4 Kids Canby Public Schools – 507-223-2001 The Connection (Childcare)	X
Safety 3.34			Presence of street drugs, and alcohol in the community 3.34 (14)	Public schools offer awareness events/prevention Southwest Cooperative	X
Health Care 3.71-3.41			Access to affordable health insurance 3.71 (2) Cost of affordable vision insurance 3.47 (6) Access to affordable prescription drugs 3.43 (9) Cost of affordable dental insurance coverage 3.41 (10)	Sanford Canby Medical Center – X 507-223-7221 Sanford Health Plan Heartland Eye Center – 507-223-5818 MN Sure REM – 507-223-7271 Sanford Canby Dental Clinic 507-223-7111 Yellow Medicine County Canby Drug Canby 24-hr. Dental – 888-456-4060	X
Physical Health 3.52-3.31		3.8% of adults report poor physical health in the last month, compared to	Cancer 3.52 (5) Poor nutrition and eating habits 3.45 (7)	Sanford Cancer Biology Research Center Sanford dietitians	X

Identified concern	Key stakeholder focus group	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap?
		2.5% nationally and 2.8% statewide. 5.5% of live births are of low birth weight (less than 2500 grams) 90% of diabetic Medicare enrollees ages 65-75 receive HgnA1C 28% of adults are obese 30% of adults are current smokers 20% of adults have no leisure time physical activity Teen births are at 28 per 1000 female population – national rate is 20	Inactivity and lack of exercise 3.43 (8) Obesity 3.40 (12) Chronic disease 3.31 (18) BMI – overweight or obese 67.3% Only 25.9% of respondents have 3 or more vegetables/day and 25.4 % have 3 or more fruits/day Only 45.5% have 3 or more days each week of moderate activity and 20 % report 3 or more days of vigorous activity each week 30.9% have smoked at least 100 cigarettes in their life 20.3% of respondents reported hypertension 16.9% reported high cholesterol 10.2% reported diabetes	Sanford certified diabetes educator MN Extension service Sanford Medical Home The Sanford Project – to cure Type 1 DB in Denny Sanford's lifetime Sanford WebMD Fit Kids Sanford's Better Choices/Better Health Program to address chronic illnesses Sanford Canby Medical Center 507-223-7221 Sanford Wellness Center 507-223-7277 Fit & Glo Exercise Center 507-829-6009 Sanford Youth Power Program Support Groups • Parkinson's support group • Memory Loss support group • Breast Cancer support group • Stroke support group	
Mental Health 3.40-3.34		Number of poor mental health days in the past month is 4.4 compared to 2.3 nationally and 2.6 across the state	Stress 3.40 (11) Depression 3.34 (16) Dementia and Alzheimer's 3.34 (15) 22% of respondents report that they have been told by a doctor that they have anxiety or stress, and 15.3%	Sanford One Care Western Mental Health Center (Sanford Canby) – 507-223-7221 Southwest Cooperative Prairie Five Community Action Agency (referring agency) Hospice	X

Identified concern	Key stakeholder focus group	Secondary data	Specific areas of concern	Community resources that are available to address the need	Gap?
		25% of adults report binge or excessive drinking 25% of driving deaths are with alcohol involvement	report being told that they have depression 59.1% reported 1 or more days in the last month when their mental health was not good. 11.9% of respondents reported 3 or more drinks /d on average 26% reported 4 or 5 drinks (binge) on the same occasion over the past month No one reported having a problem with alcohol use or drug use, however 24.1% reported that alcohol use had harmful effects on the respondent or a family member	Grief and loss support during the holidays	
Preventive Health		65.3% of female Medicare enrollees age 67-69 receive mammography screenings	14.5% did not receive a flu shot in the past year 63% have not had an immunization in the past year 23.6% of respondents report that it has been over a year since they have seen their health care provider and 10.0 % have not seen their dentist over the last year.	Public Health office (Yellow Medicine Co.) - 320-564-3010 Sanford Canby Medical Center 507-223-7221 Sanford Canby Dental Clinic 507-223-7111	X

Canby 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 3.92 (1) • Availability of memory care 3.54 (4)	2 memory care	2	
Children and Youth • Bullying 3.56 (3) • Availability of activities for children and youth 3.37 (17) • Cost of activities for children and youth 3.32 (18)	2 bullying	**2**	
Safety • Presence of street drugs and alcohol in the community 3.31 **(14)**			
Health care • Access to affordable health insurance 3.71 (2) • Cost of affordable vision insurance 3.47 (6) • Access to affordable prescription drugs 3.43 (9) • Cost of affordable dental insurance coverage 3.41 (10)			
Physical Health • Cancer 3.52 (5) • Poor nutrition and eating habits 3.45 (7) • Inactivity and lack of exercise 3.43 (8) • Obesity 3.40 (12) • Chronic disease 3.31 (19) • BMI – overweight or obese 67.3% • Only 25.9% of respondents have 3 or more vegetables/day and 25.4 % have 3 or more fruits/day • Only 45.5% have 3 or more days each week of moderate activity and 20 % report 3 or more days of vigorous activity each week • 30.9% have smoked at least 100 cigarettes in their life • 20.3% of respondents reported hypertension • 16.9% reported high cholesterol • 10.2% reported diabetes *Preventive Health – Flus shots and immunizations* *Mammograms*	5 screening targets for cancer hypertension	6	
Mental Health • Stress 3.40 (11) • Depression 3.34 (16) • Dementia and Alzheimer's 3.34 (15) • 22% of respondents report that they have been told by a doctor that they have anxiety or stress, and 15.3% report being told that they have depression • 59.1% reported 1 or more days in the last month when their mental health was not good. • 11.9% of respondents reported 3 or more drinks /d on average • 26% reported 4 or 5 drinks - (binge) on the same occasion over the past month • No one reported having a problem with alcohol use or drug use; however, 24.1% reported that alcohol use had harmful effects on the respondent or a family member *Poor mental health days*	5	6	

Italicized notes are based on County Health Rankings

Present: Nancy Salmon, Brenda Knutson, Julie Schlecht, Allison Nelson, Steve Maas, Ruth Ascher, Lori Sisk, Cheryl Ferguson, Jason Anderson

SANFORD HEALTH

Sanford Canby Medical Center

Community Health Needs Assessment

Results from a March 2015 Non-generalizable

Online Survey

August 2015

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a March 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 March 2015 and a total of 59 respondents participated in the online survey.

TABLE OF CONTENTS

General Health and Wellness Concerns about the Community

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 statement about the community regarding the ENVIRONMENT
Figure 4 – Level of concern with statements about the community regarding CHILDREN AND YOUTH
Figure 5 – Level of concern with statements about the community regarding the AGING POPULATION
Figure 6 – Level of concern with statements about the community regarding SAFETY
Figure 7 – Level of concern with statements about the community regarding HEALTH CARE
Figure 8 – Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH
Figure 9 – Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE

General Health

Figure 10 – Respondents' rating of their health in general
Figure 11 – Respondents' weight status based on the Body Mass Index (BMI) scale
Figure 12 – Number of servings of vegetables, fruit and fruit juice that respondents had yesterday
Figure 13 – Number of days in an average week respondents engage in MODERATE and VIGOROUS activity

Mental Health

Figure 14 – Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue
Figure 15 – Number of days in the last month that respondents' mental health was not good
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
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

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
Figure 21 – During the past month on days that respondents drank, average number of drinks per day respondents consumed
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
Figure 23 – Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug use
Figure 24 – Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug use, whether respondents got the help they needed
Figure 25 – Whether alcohol use or prescription or on-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
Table 2 – Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening
Figure 26 – Whether respondents have any of the following chronic diseases
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 of dental clinic for any reason

Figure 28 – Where respondents get most of their health information
Figure 29 – Best way for respondents to access technology for health information

Demographic Information

Figure 30 – Age of respondents
Figure 31 – Highest level of education of respondents
Figure 32 – Gender of respondents
Figure 33 – Race and ethnicity of respondents
Figure 34 – Annual household income of respondents
Figure 35 – Employment status of respondents
Figure 36 – Length of time respondents have lived in their community
Figure 37 – Whether respondents own or rent their home
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
Figure 40 – Facilities that respondents go to most often when sick and take their children when they are sick
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
Table 3 – Zip code of respondents

SURVEY RESULTS

General Health and Wellness Concerns about the Community

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

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

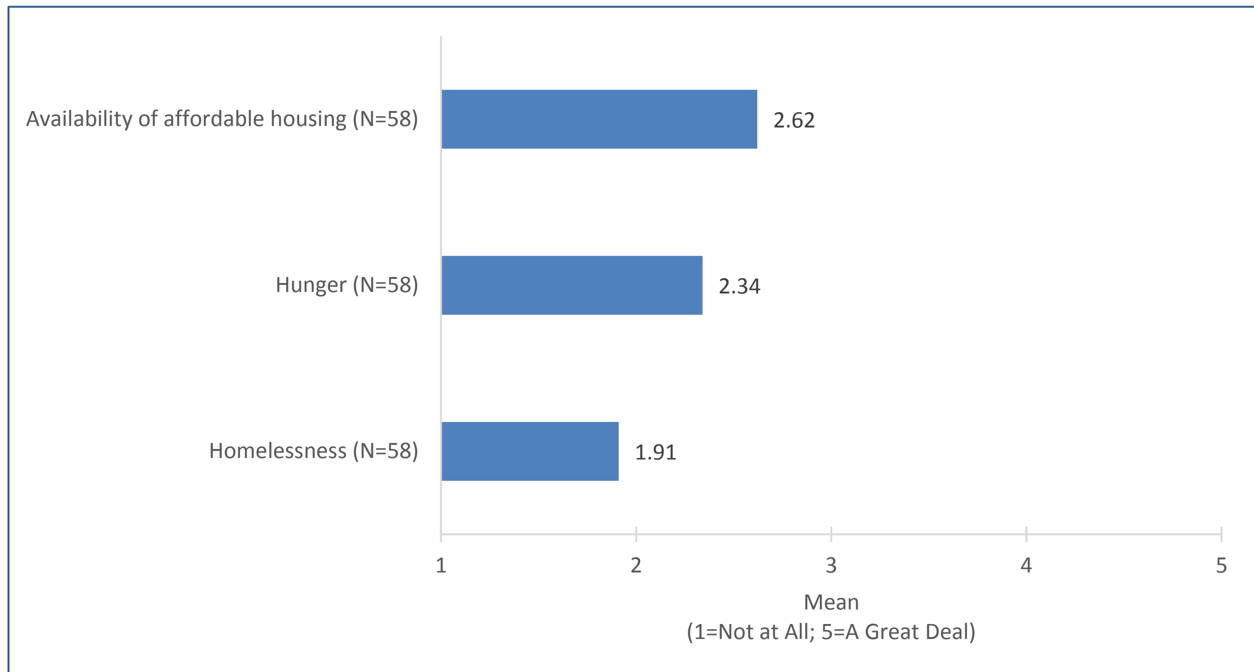


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

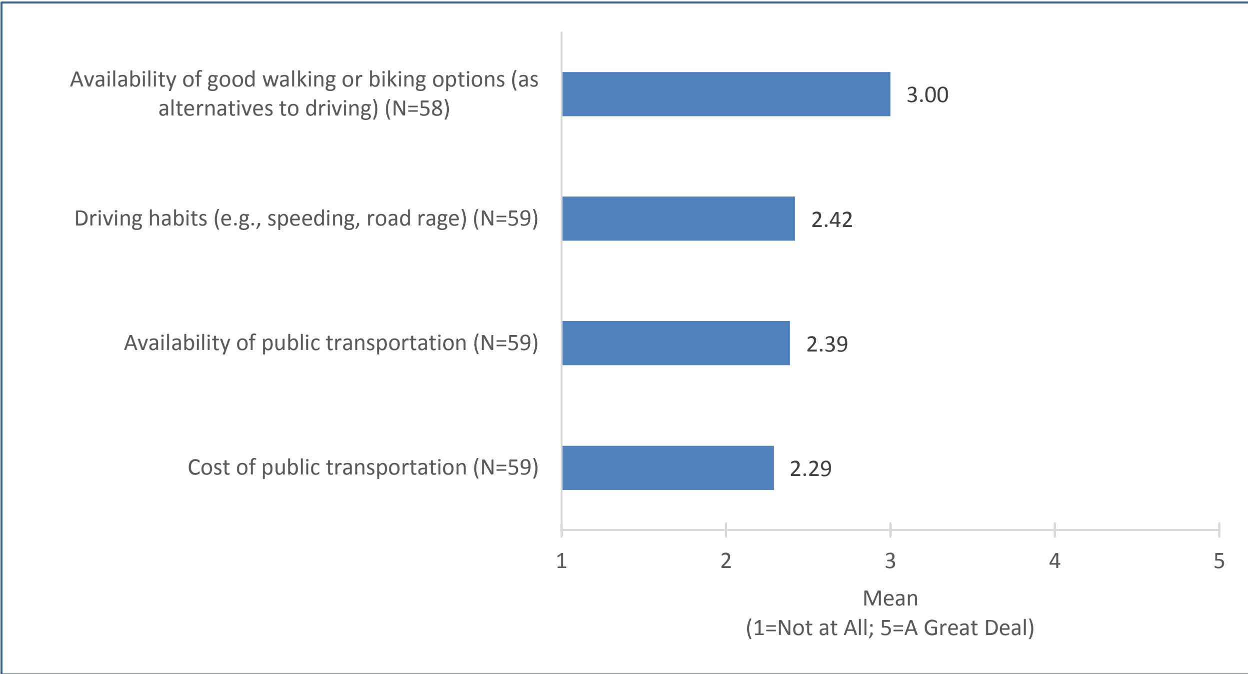


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

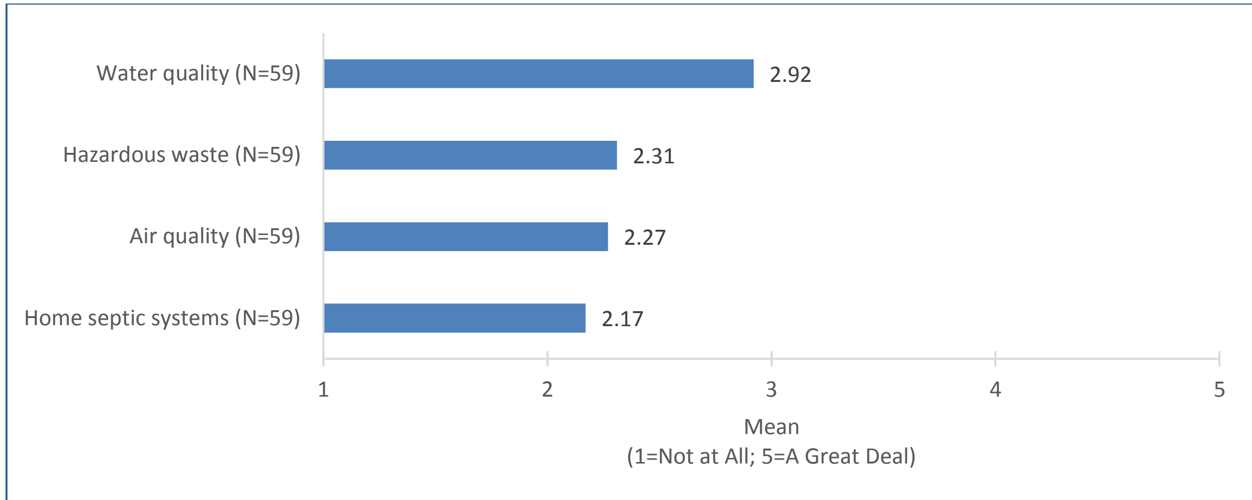


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

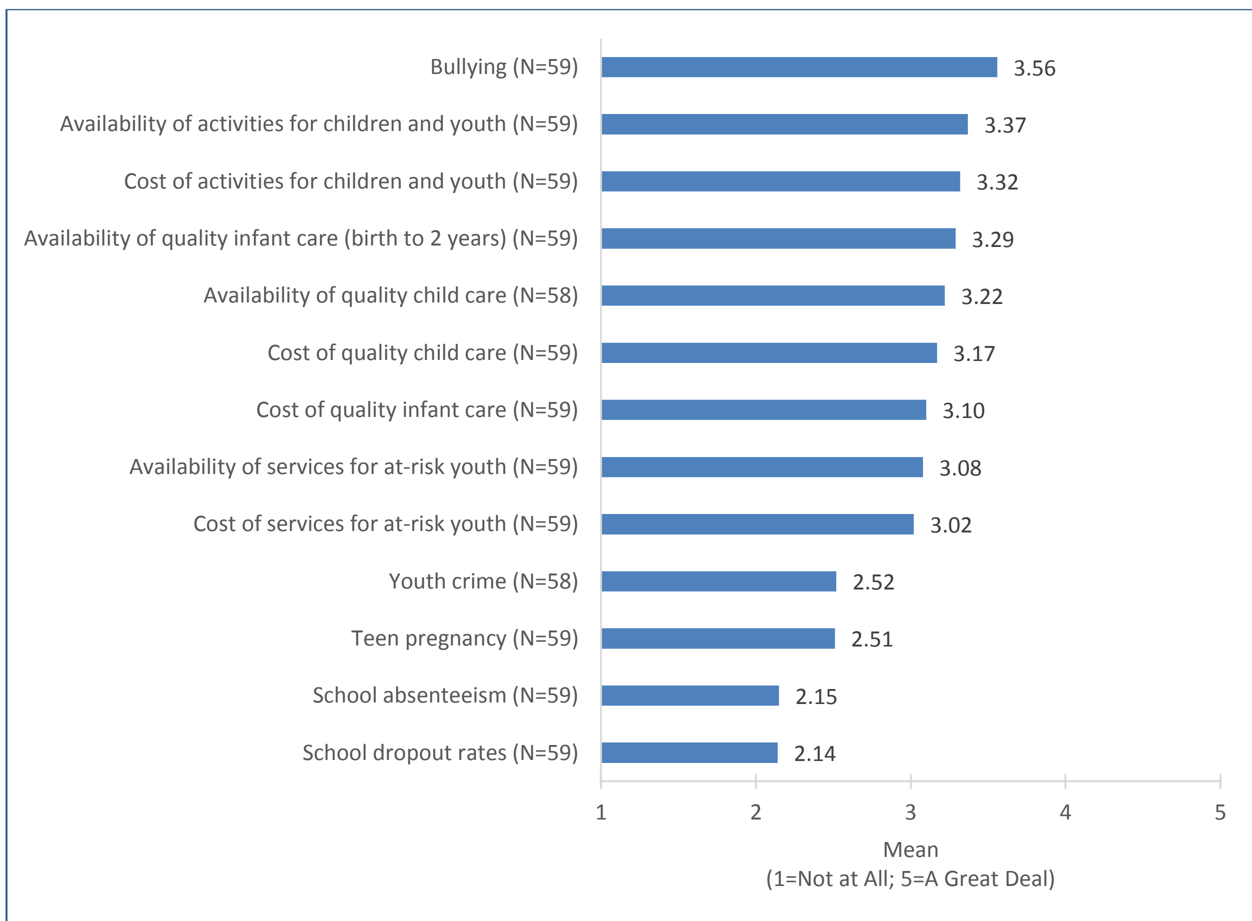


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

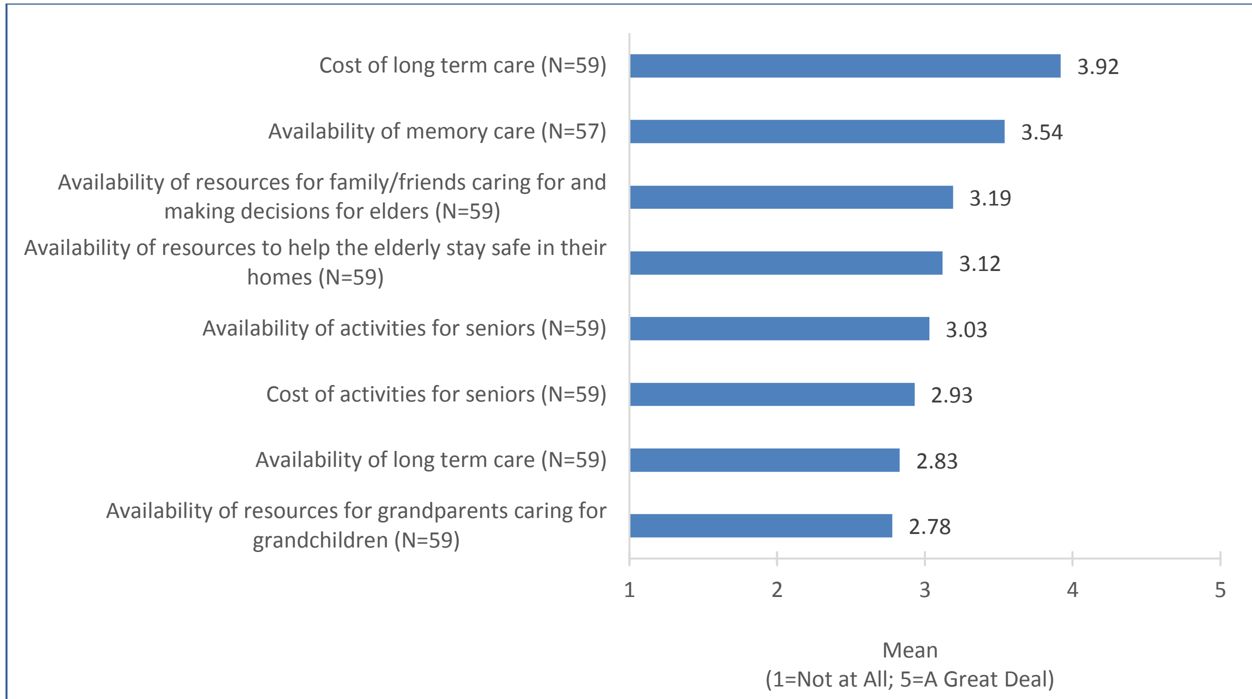


Figure 6. Level of concern with statements about the community regarding SAFETY

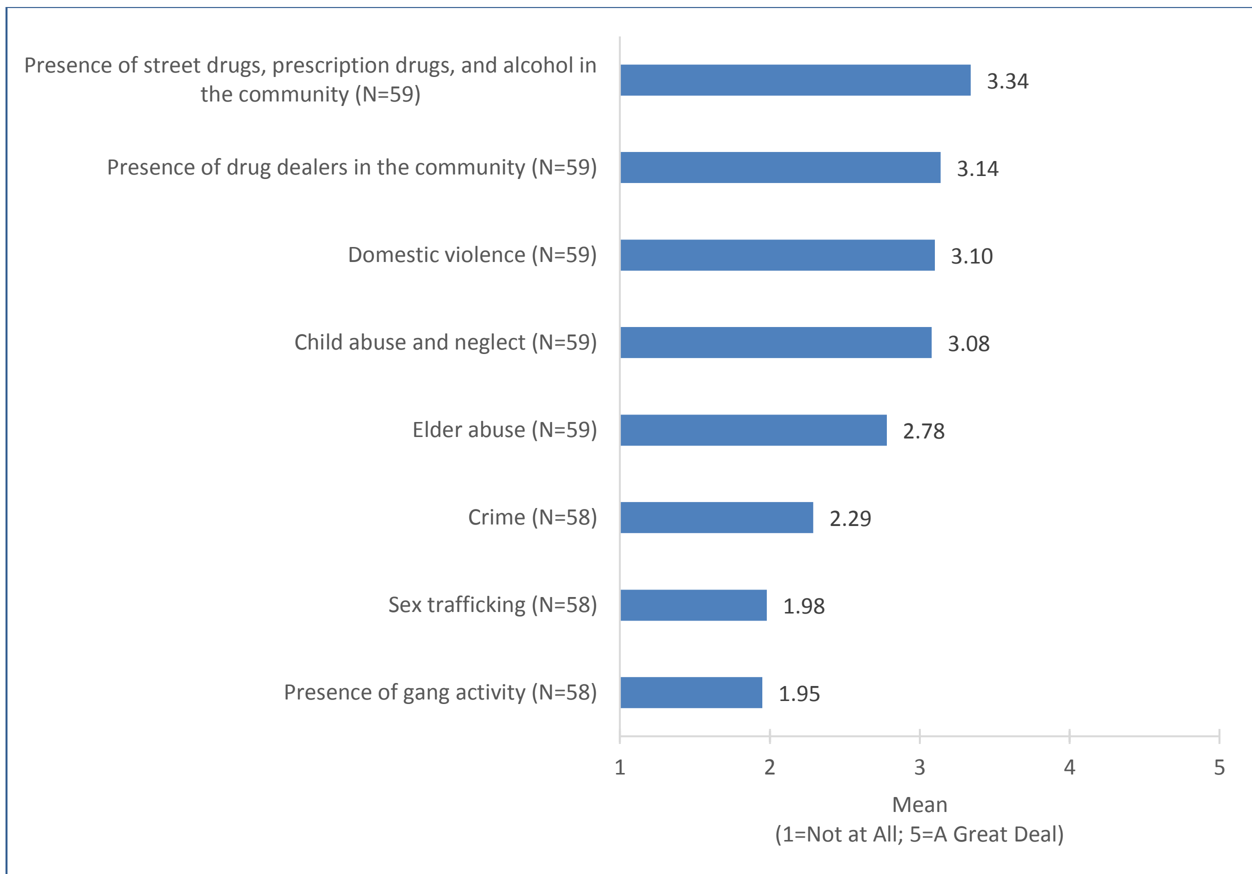


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

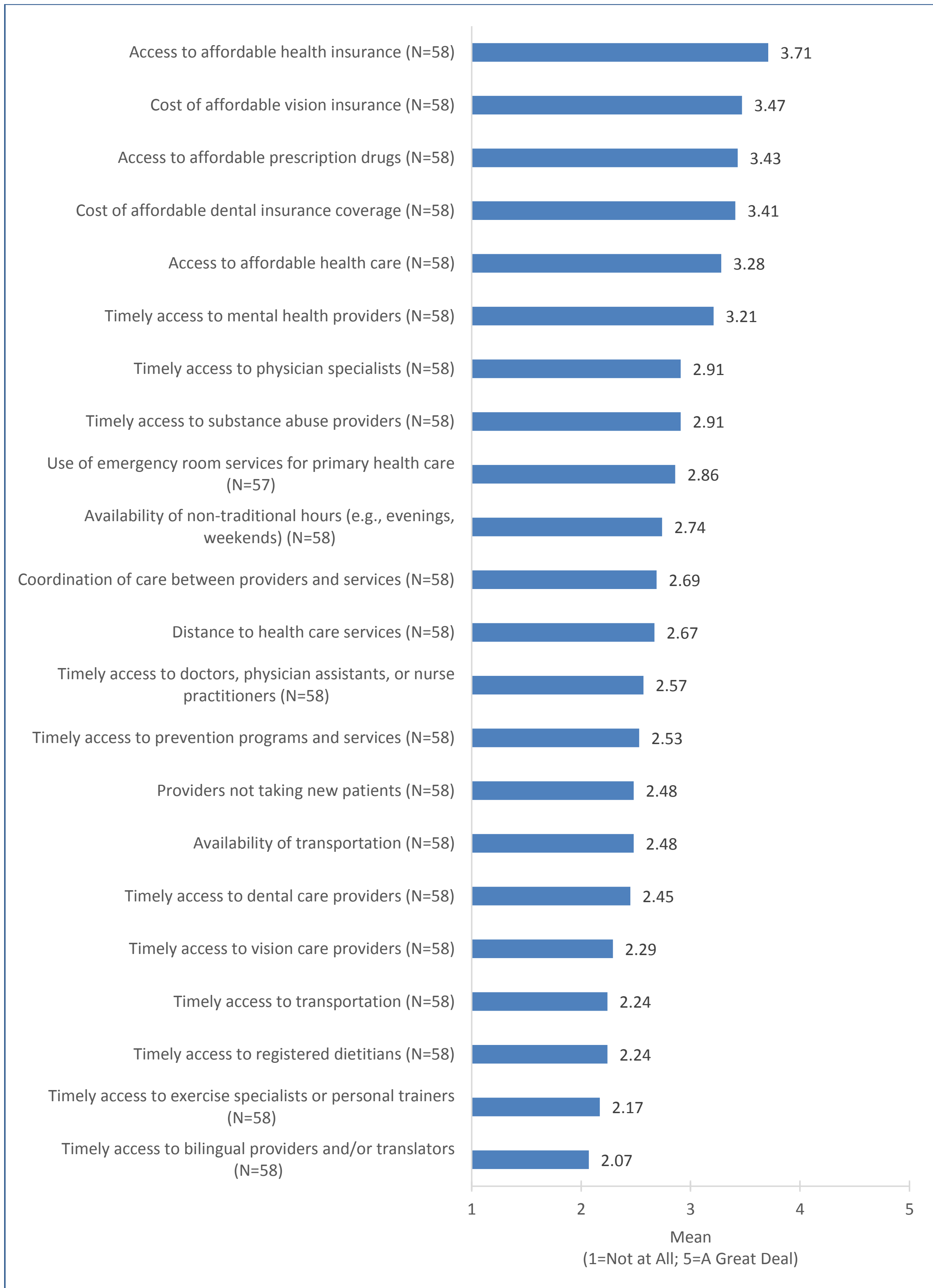


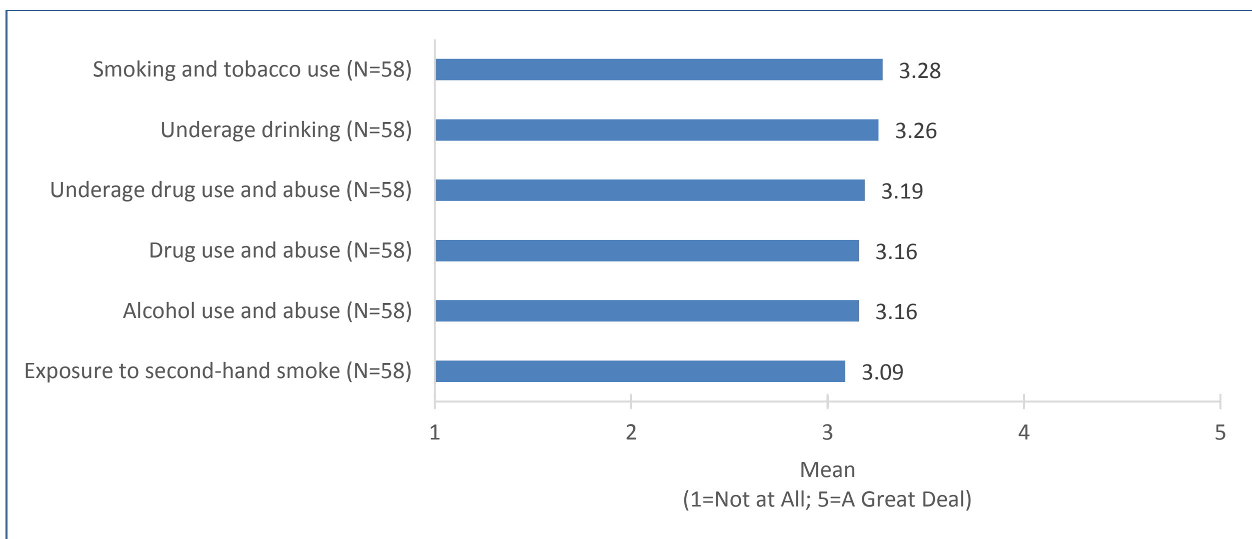
Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

Item	Mean
Cancer (N=58)	3.52
Poor nutrition and eating habits (N=58)	3.45
Inactivity and lack of exercise (N=58)	3.43
Stress (N=58)	3.40
Obesity (N=58)	3.40
Dementia and Alzheimer's disease (N=58)	3.34
Depression (N=58)	3.34
Chronic disease (e.g., diabetes, heart disease, multiple sclerosis) (N=58)	3.31
Infectious diseases such as the flu (N=58)	3.02
Suicide (N=57)	2.70
Other psychiatric diagnosis (N=54)	2.59
Sexually transmitted diseases (e.g., AIDS, HIV, chlamydia) (N=58)	2.31

1 2 3 4 5

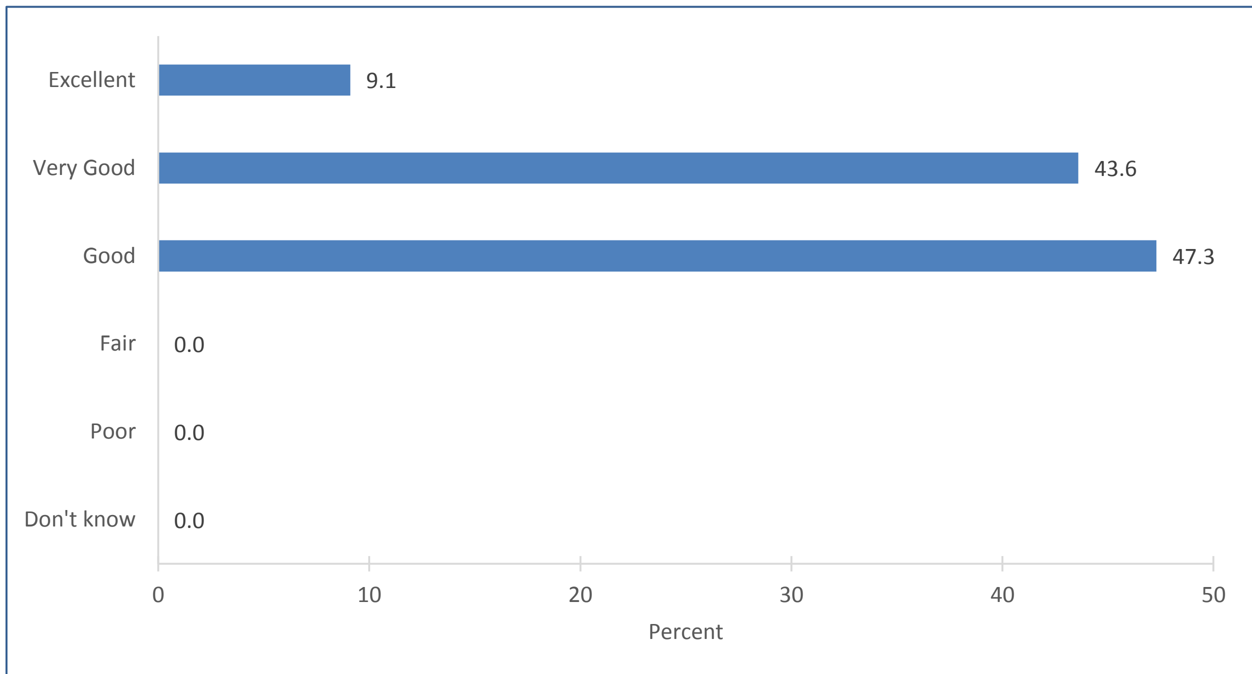
Mean
(1=Not at All; 5=A Great Deal)

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



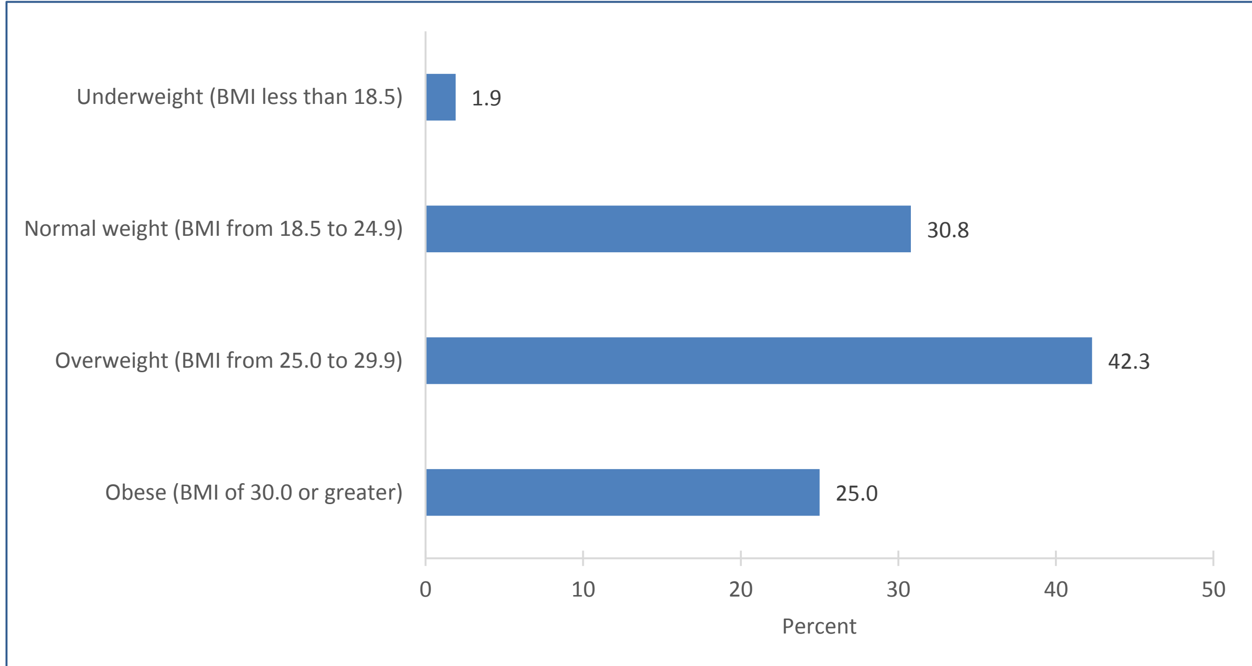
General Health

Figure 10. Respondents' rating of their health in general



N=55

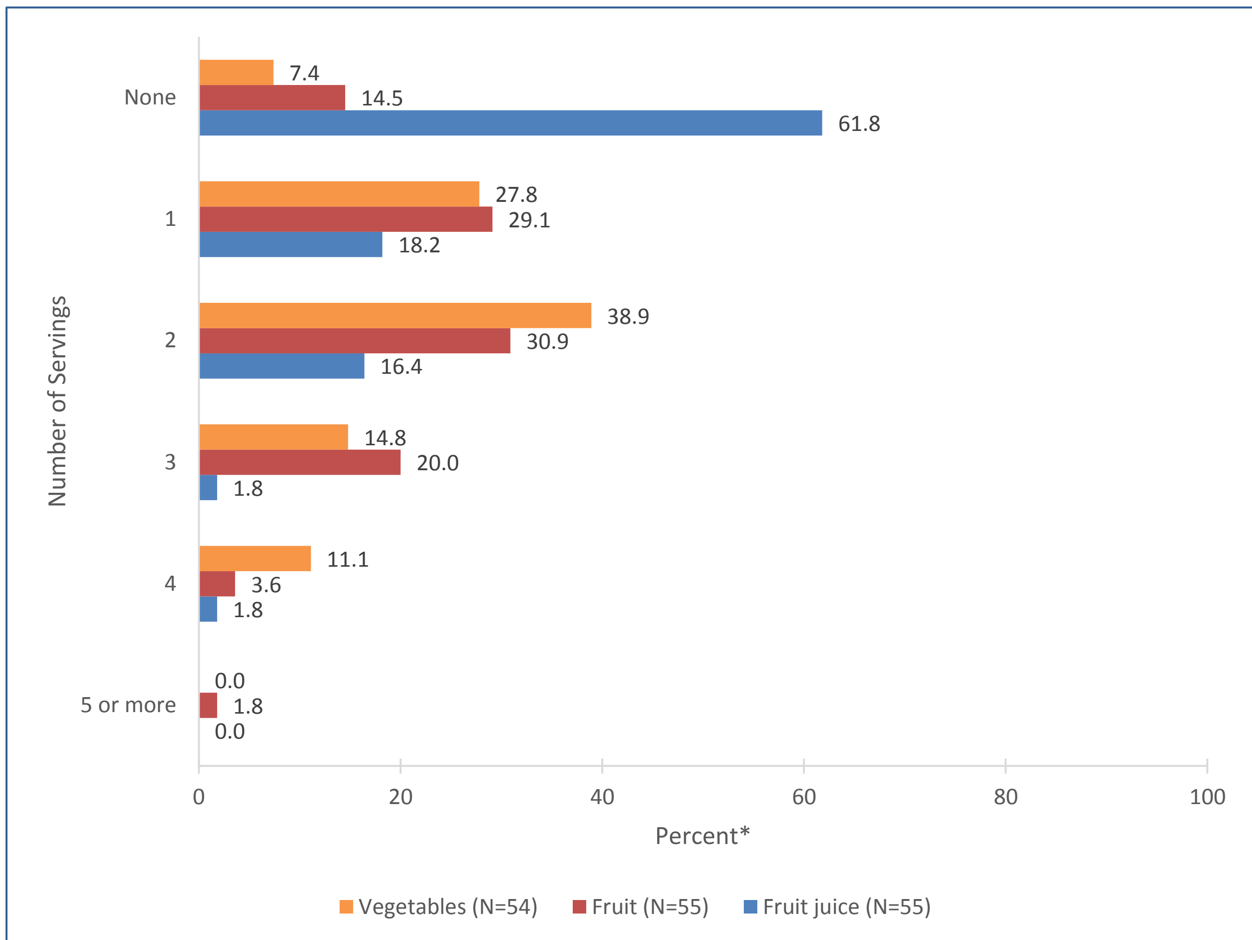
Figure 11. Respondents' weight status based on the Body Mass Index (BMI)* scale



N=52

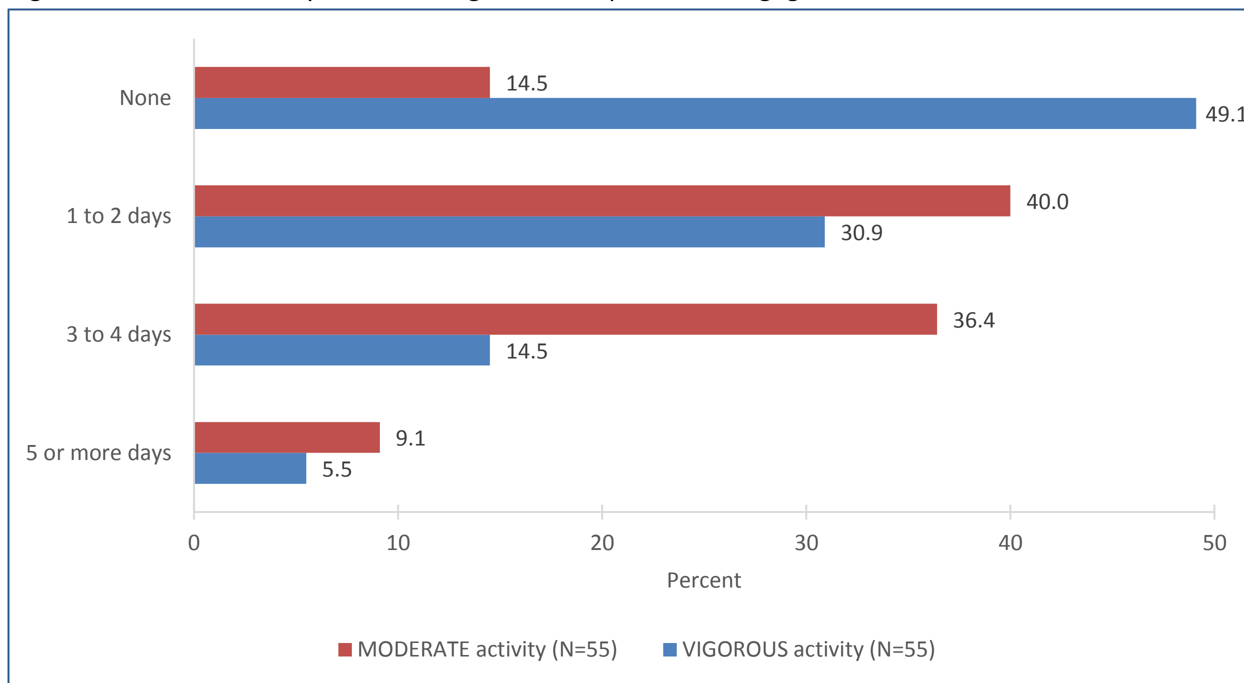
*For information about the BMI, visit the Centers for Disease Control and Prevention, *About BMI for Adults*, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/.

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



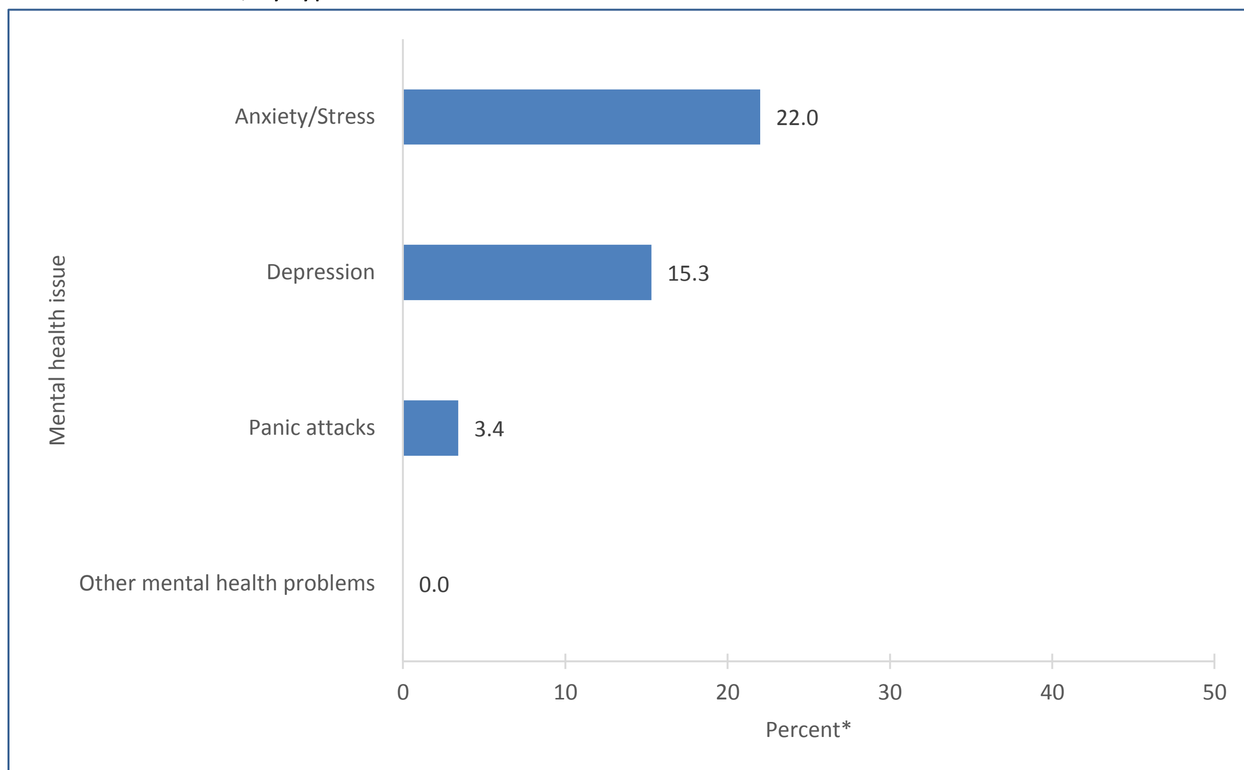
*Percentages may not total 100.0 due to rounding.

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



Mental Health

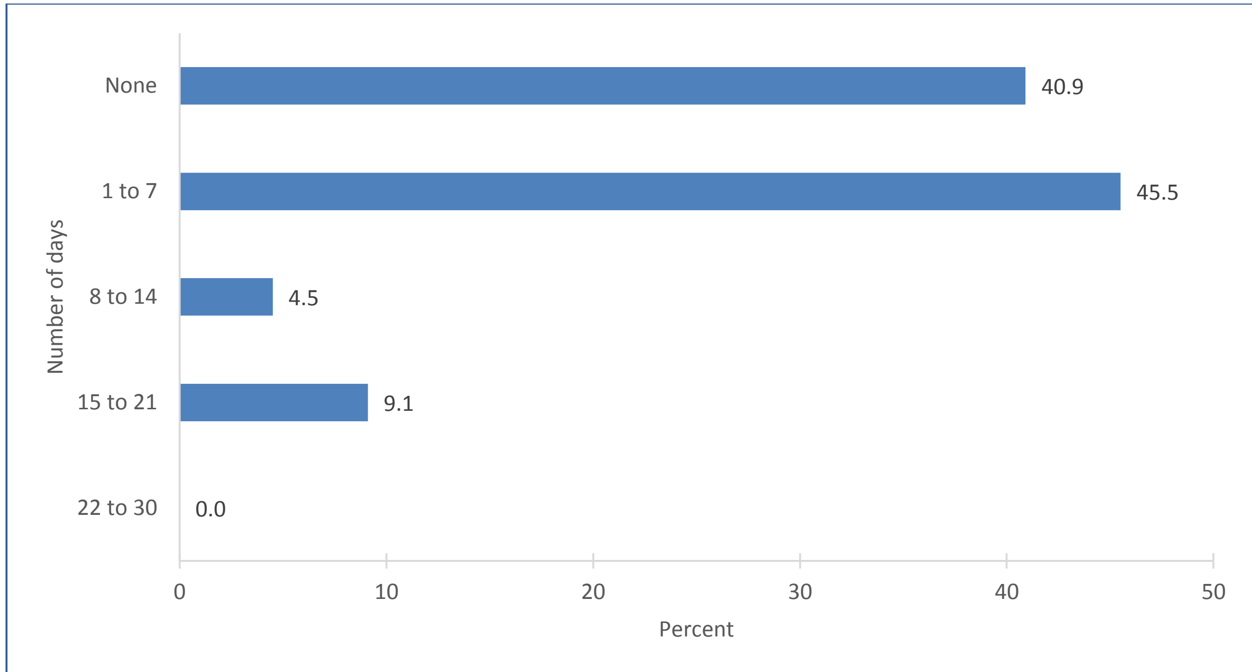
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=59

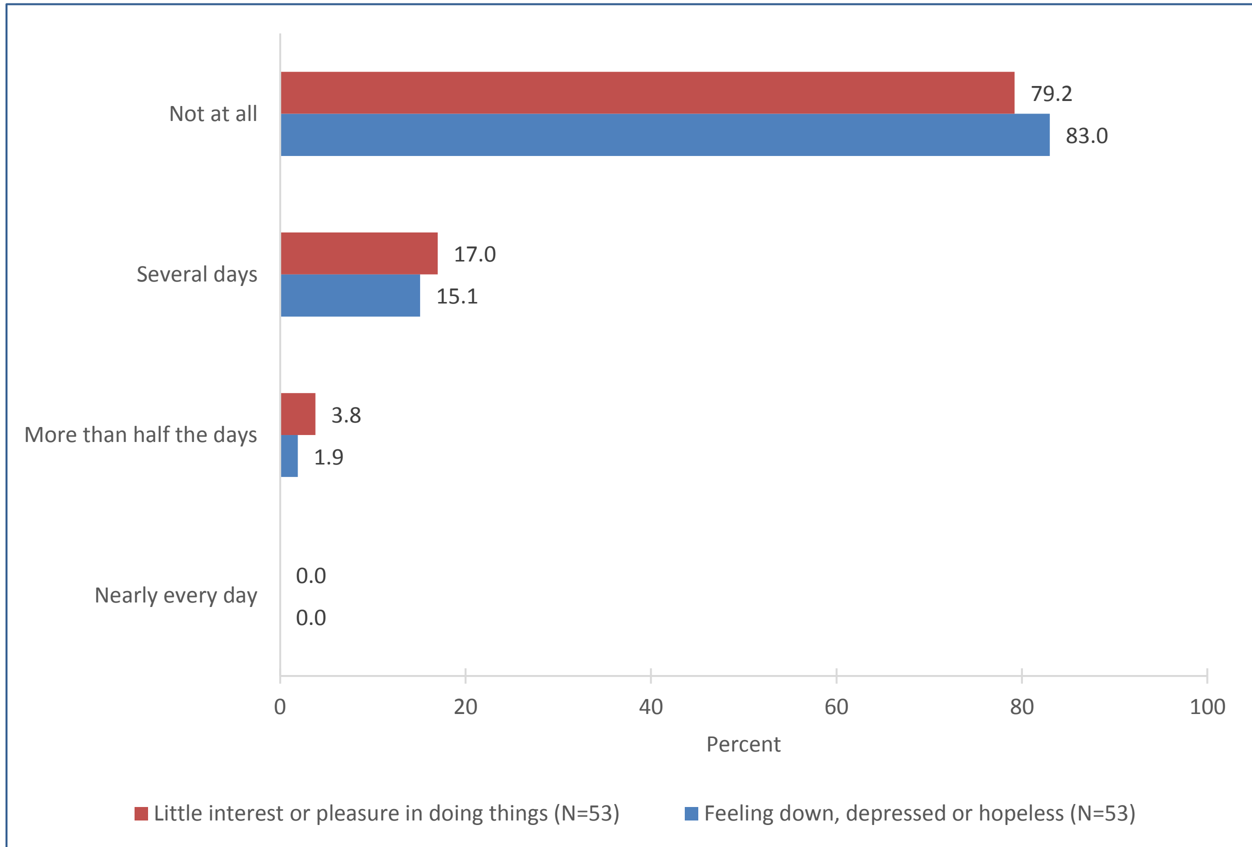
*Percentages do not total 100.0 due to multiple responses.

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



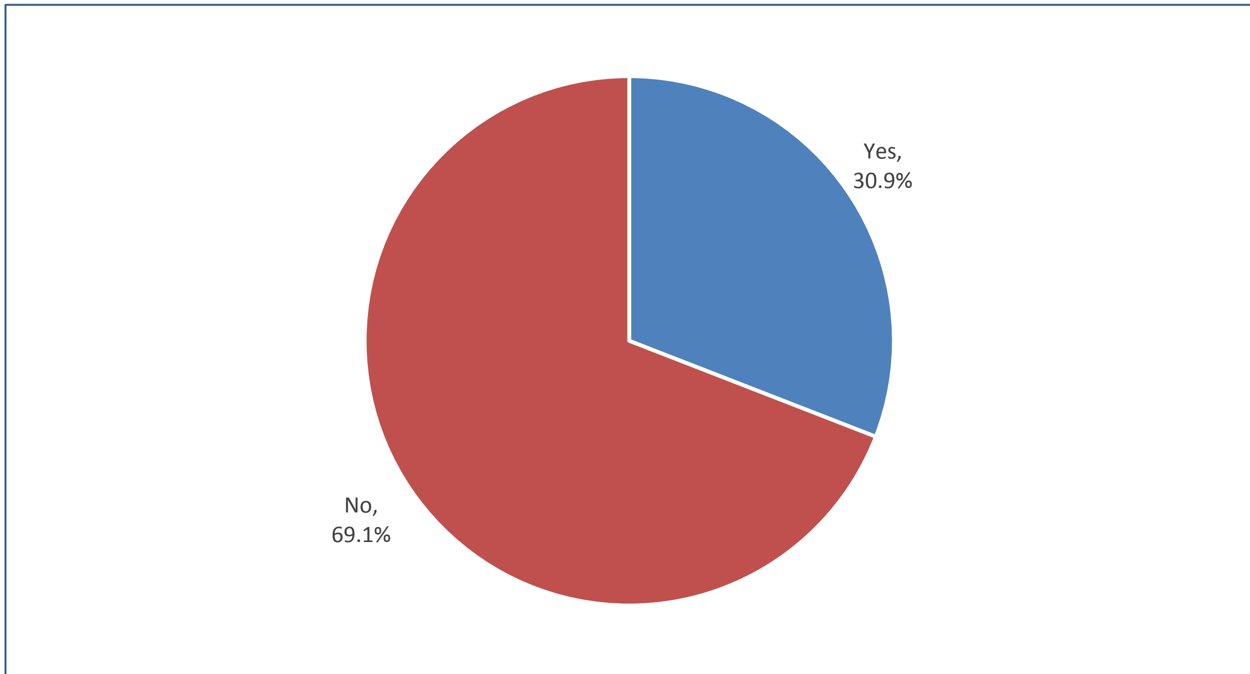
N=44

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=55

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

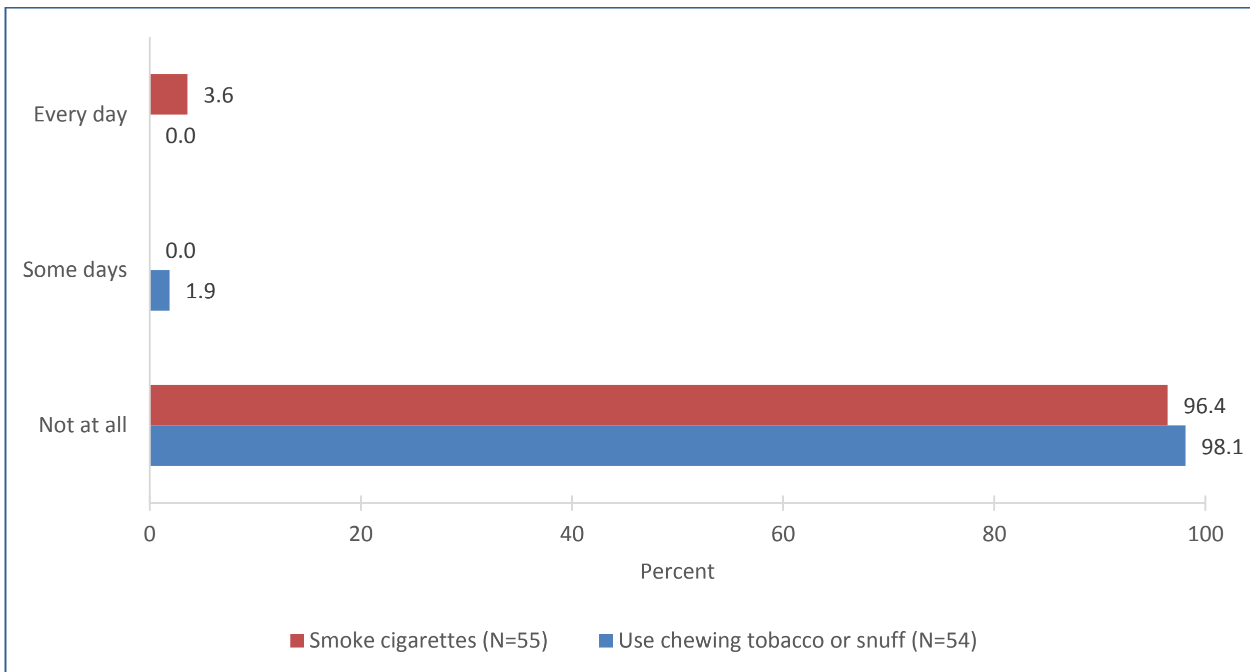
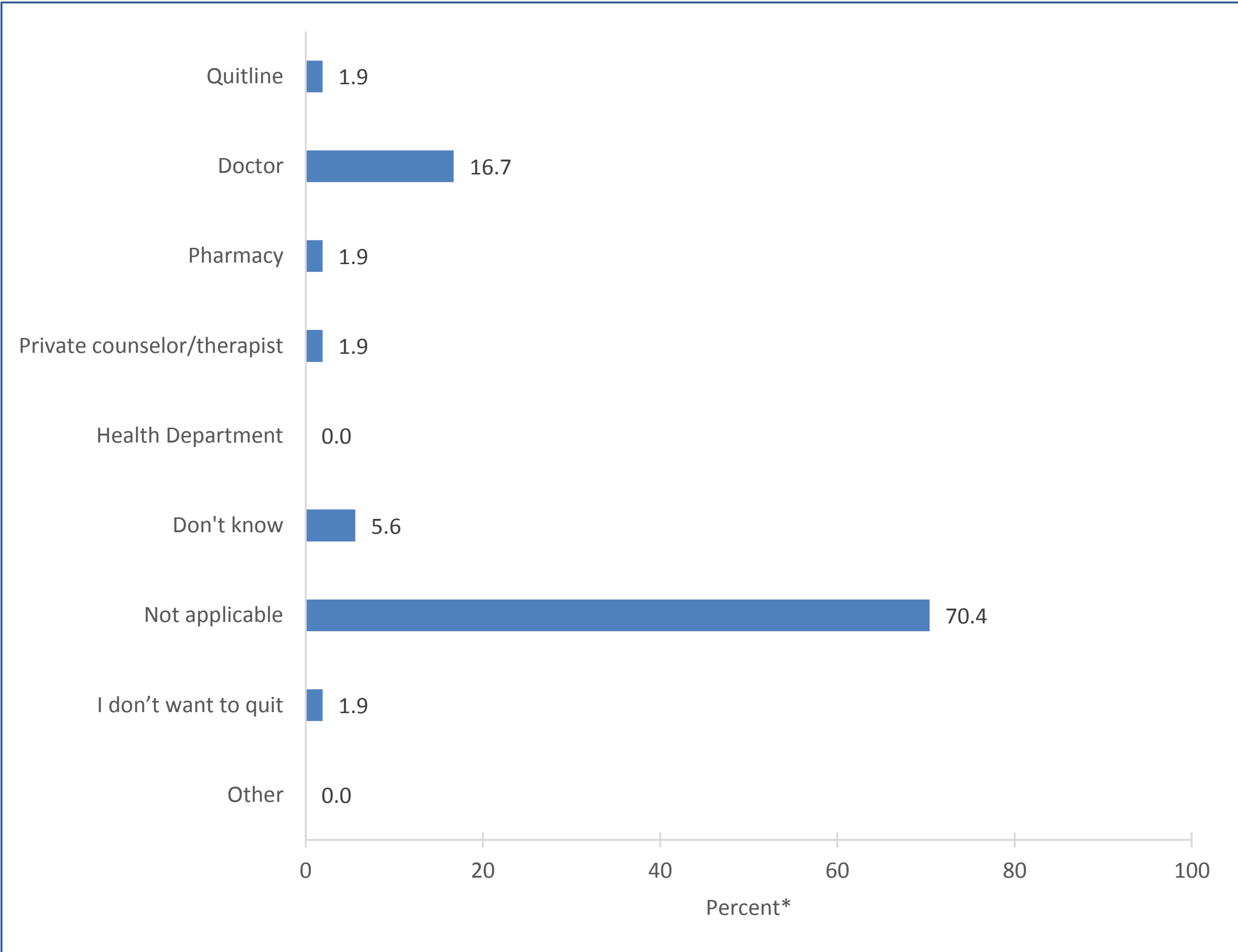


Figure 19. Location respondents would first go if they wanted help to quit using tobacco

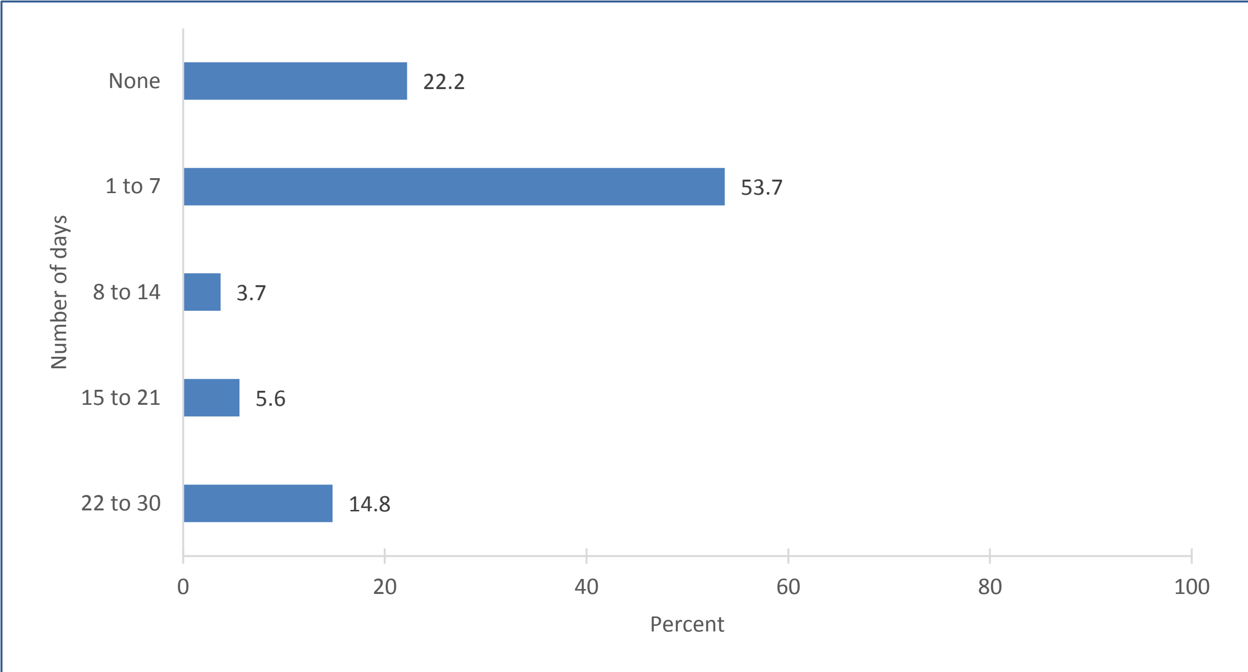


N=54

*Percentages do not total 100.0 due to rounding.

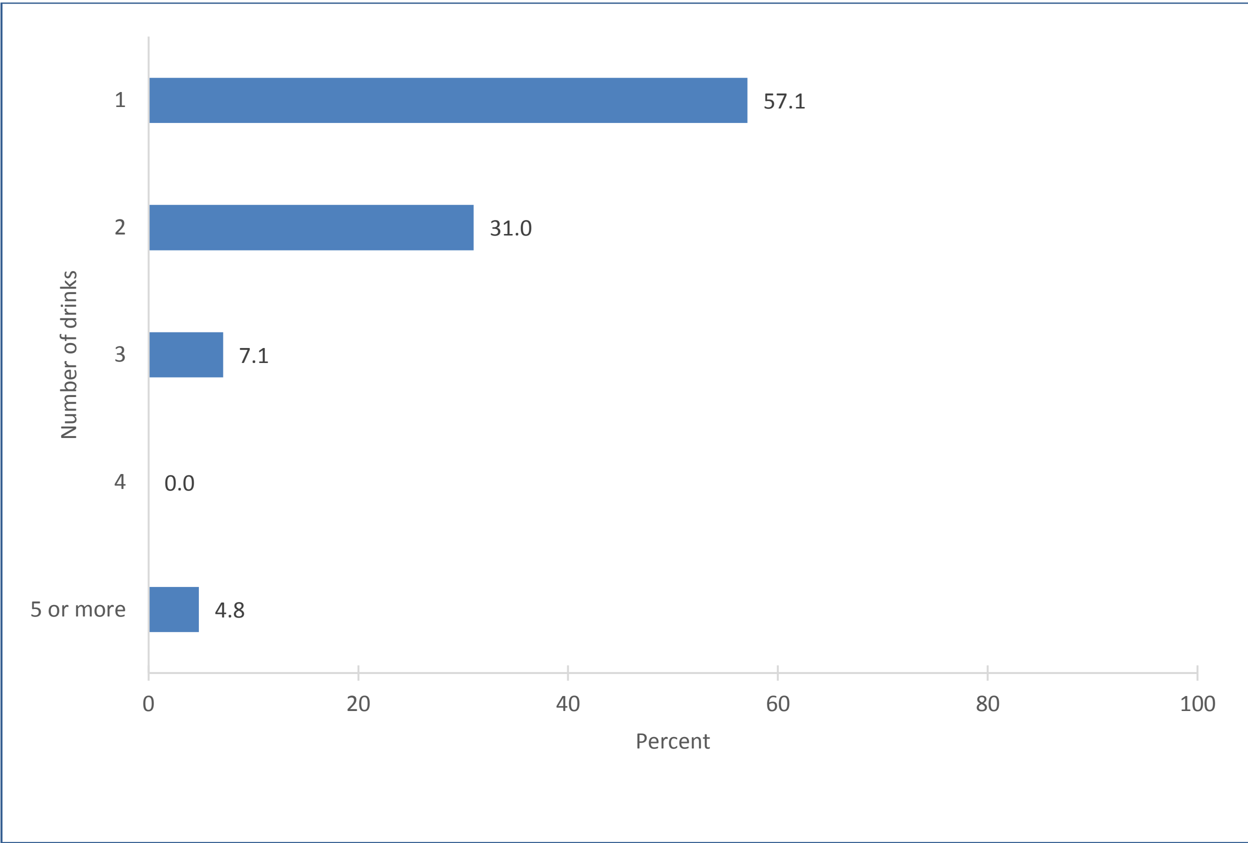
Alcohol Use and Prescription Drug/Non-prescription Drug Abuse

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



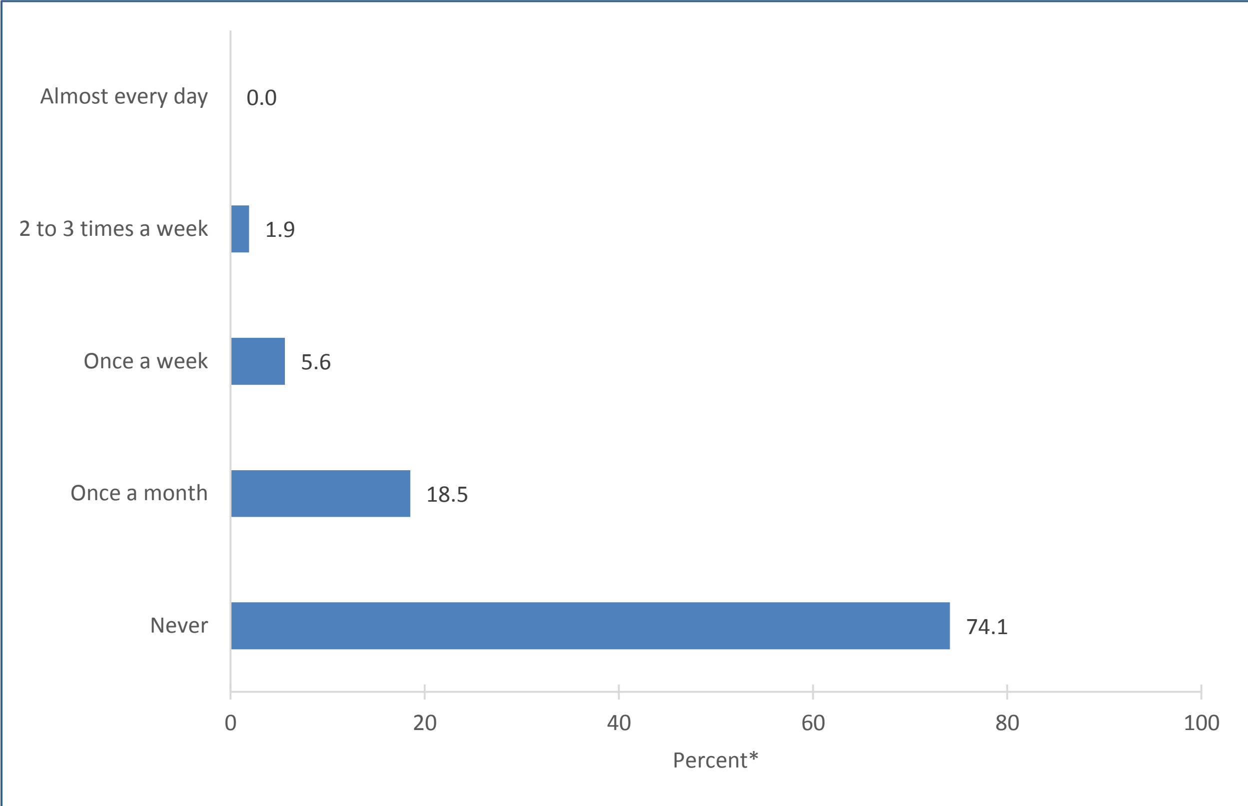
N=54

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



N=42

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



N=54

*Percentages do not total 100.0 due to rounding.

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

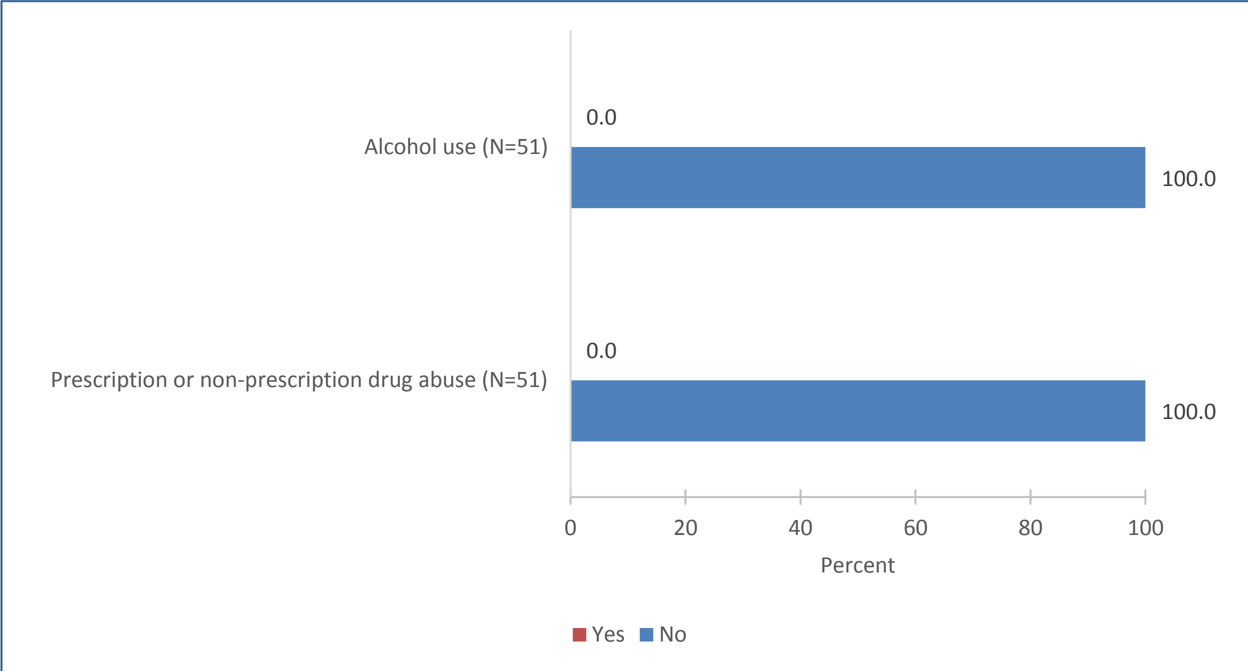


Figure 24. Of respondents who had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

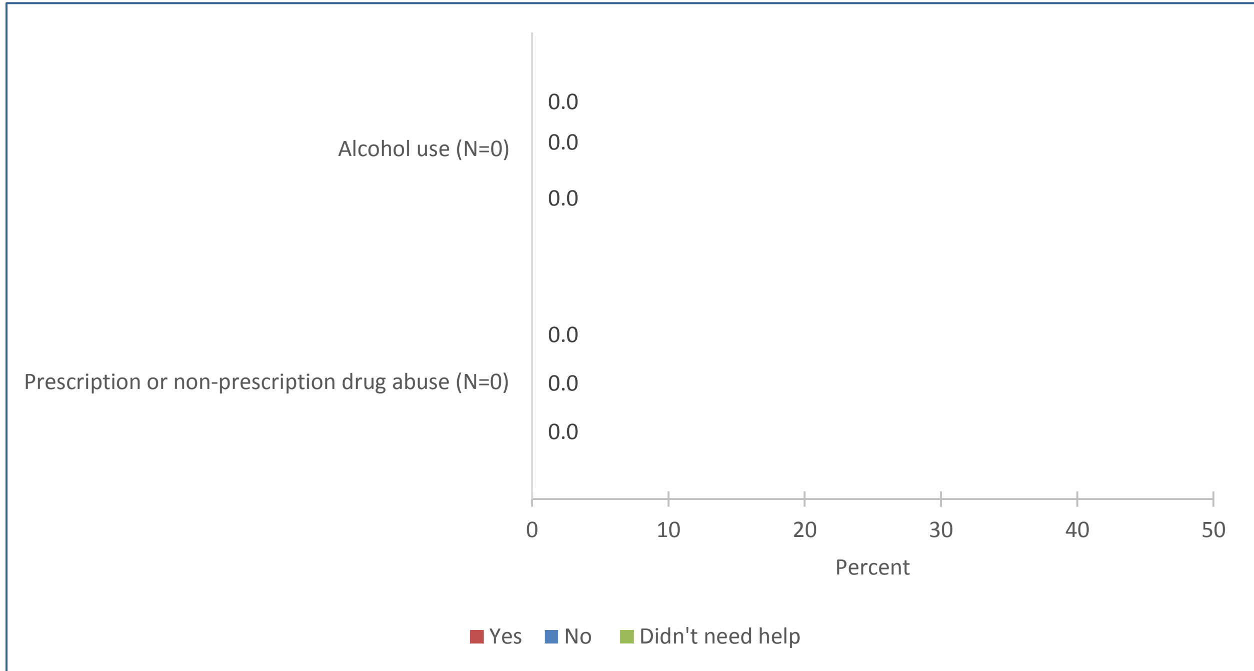
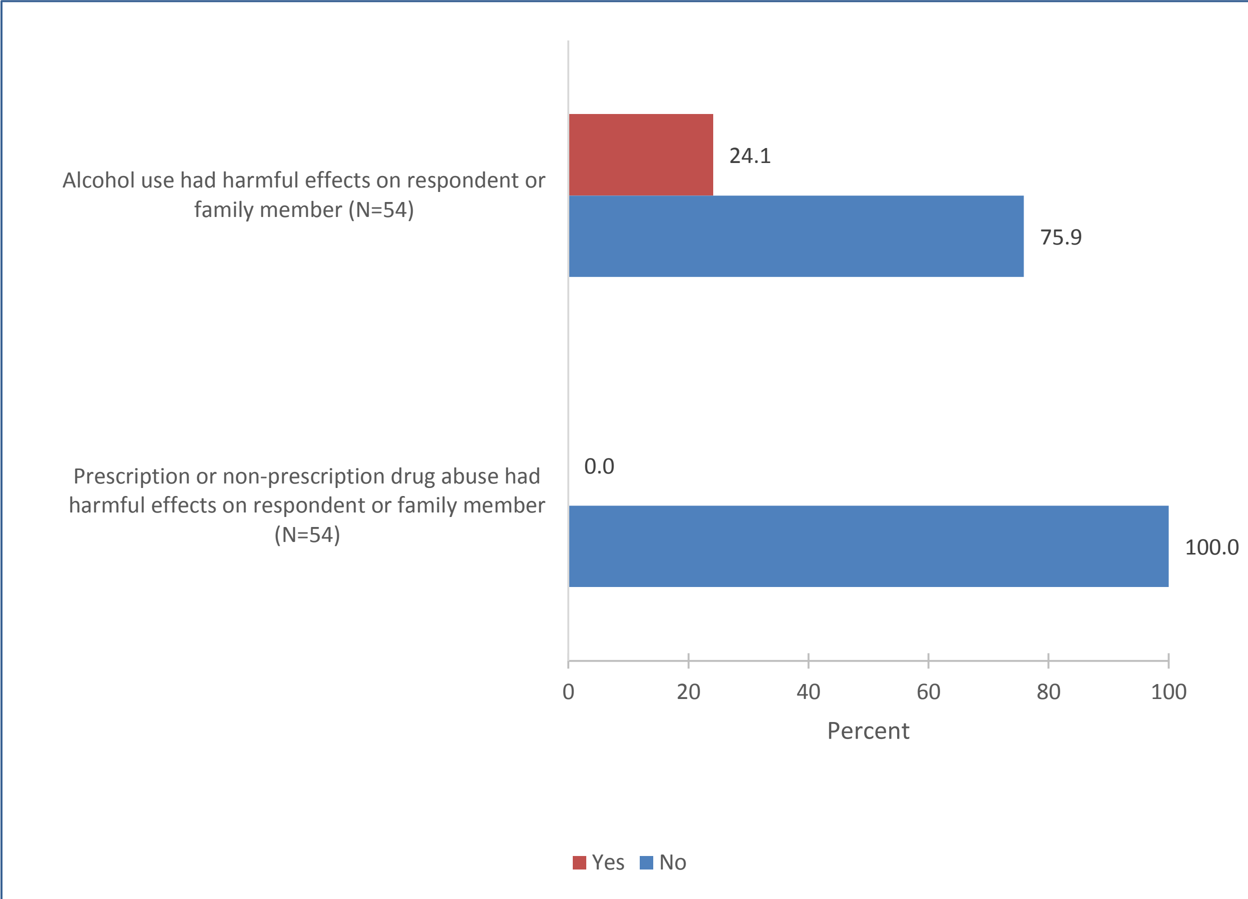


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years



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=55)	83.6	16.4	100.0
Blood sugar screening (N=54)	57.4	42.6	100.0
Bone density test (N=54)	14.8	85.2	100.0
Cardiovascular screening (N=54)	20.4	79.6	100.0
Cholesterol screening (N=54)	68.5	31.5	100.0
Dental screening and X-rays (N=55)	87.3	12.7	100.0
Flu shot (N=55)	85.5	14.5	100.0
Glaucoma test (N=55)	60.0	40.0	100.0
Hearing screening (N=54)	7.4	92.6	100.0
Immunizations (N=54)	37.0	63.0	100.0
Pelvic exam (N=44 Females)	84.1	15.9	100.0
STD (N=54)	7.4	92.6	100.0
Vascular screening (N=53)	7.5	92.5	100.0
CANCER SCREENINGS			
Breast cancer screening (N=42 Females)	66.7	33.3	100.0
Cervical cancer screening (N=43 Females)	69.8	30.2	100.0
Colorectal cancer screening (N=54)	14.8	85.2	100.0
Prostate cancer screening (N=9 Males)	44.4	55.6	100.0
Skin cancer screening (N=53)	18.9	81.1	100.0

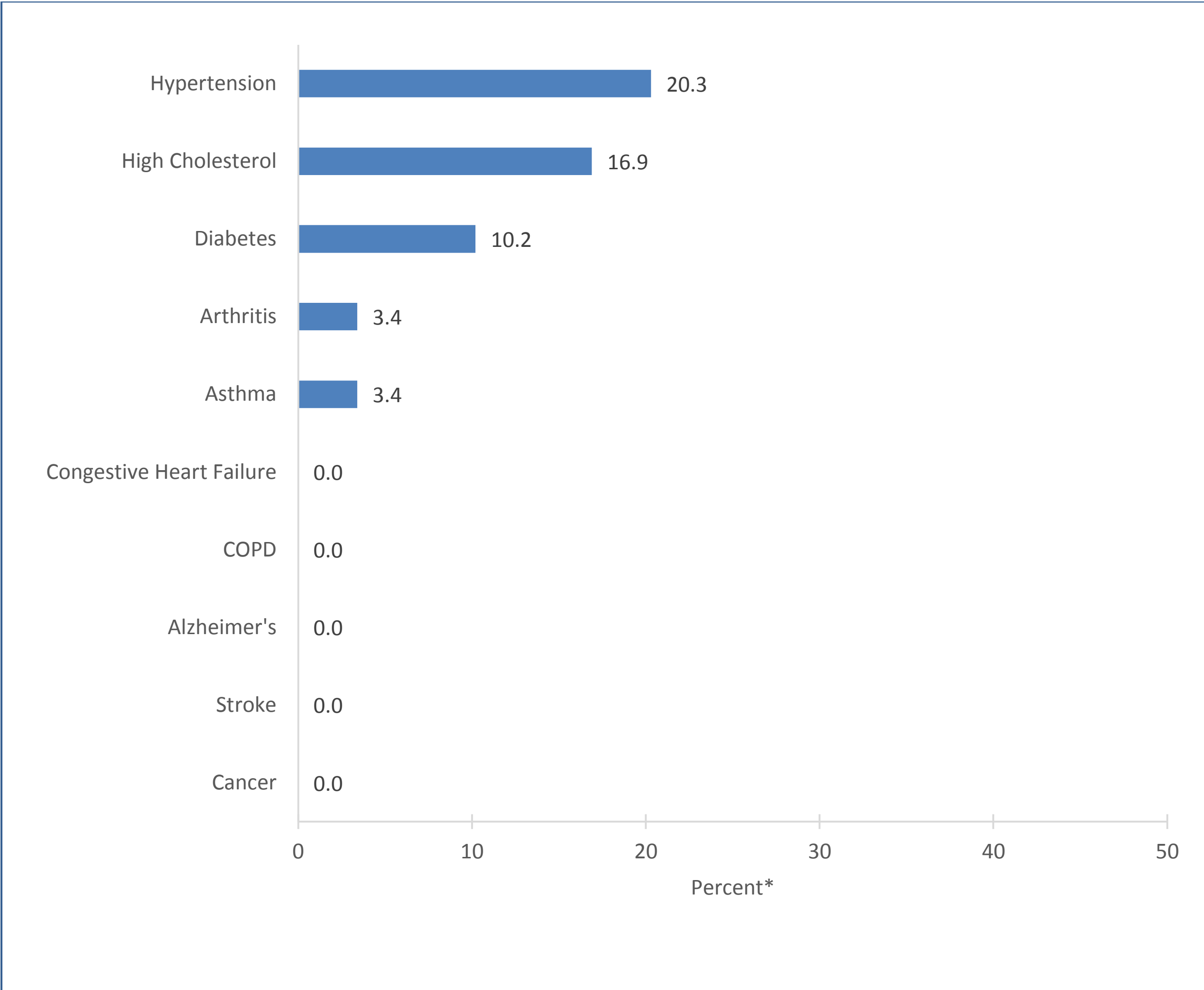
Table 2. Of respondents who have not had preventive screenings in the past year, reasons why they have not, by type of screening

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=9)	44.4	33.3	11.1	0.0	0.0	0.0	0.0
Blood sugar screening (N=23)	60.9	13.0	4.3	0.0	0.0	0.0	4.3
Bone density test (N=46)	58.7	28.3	6.5	0.0	0.0	0.0	6.5
Cardiovascular screening (N=43)	51.2	39.5	7.0	0.0	0.0	2.3	2.3
Cholesterol screening (N=17)	35.3	23.5	11.8	0.0	0.0	5.9	11.8
Dental screening and X-rays (N=7)	28.6	0.0	14.3	28.6	0.0	0.0	0.0
Flu shot (N=8)	50.0	0.0	0.0	0.0	0.0	0.0	25.0
Glaucoma test (N=22)	50.0	36.4	9.1	0.0	0.0	0.0	4.5
Hearing screening (N=50)	54.0	32.0	4.0	0.0	0.0	2.0	4.0

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
Immunizations (N=34)	58.8	17.6	2.9	0.0	0.0	0.0	2.9
Pelvic exam (N=7 Females)	14.3	14.3	14.3	0.0	0.0	0.0	57.1
STD (N=50)	74.0	14.0	4.0	0.0	0.0	0.0	2.0
Vascular screening (N=49)	51.0	40.8	4.1	0.0	0.0	0.0	2.0
CANCER SCREENINGS							
Breast cancer screening (N=14 Females)	57.1	21.4	7.1	7.1	0.0	0.0	7.1
Cervical cancer screening (N=13 Females)	53.8	7.7	7.7	0.0	0.0	0.0	30.8
Colorectal cancer screening (N=46)	67.4	10.9	6.5	6.5	0.0	0.0	10.9
Prostate cancer screening (N=5 Males)	40.0	20.0	20.0	0.0	0.0	0.0	20.0
Skin cancer screening (N=43)	37.2	41.9	7.0	0.0	0.0	2.3	9.3

*Percentages do not total 100.0 due to multiple responses.

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



N=59

*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

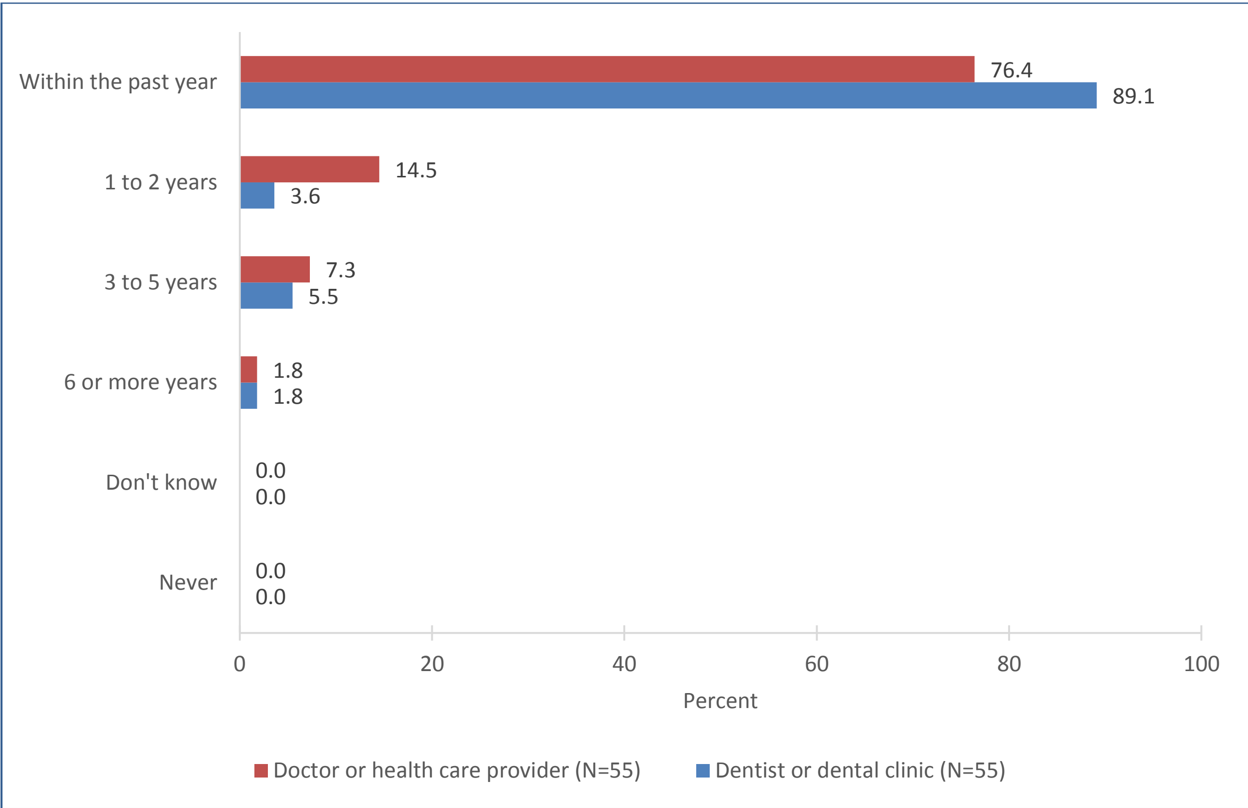
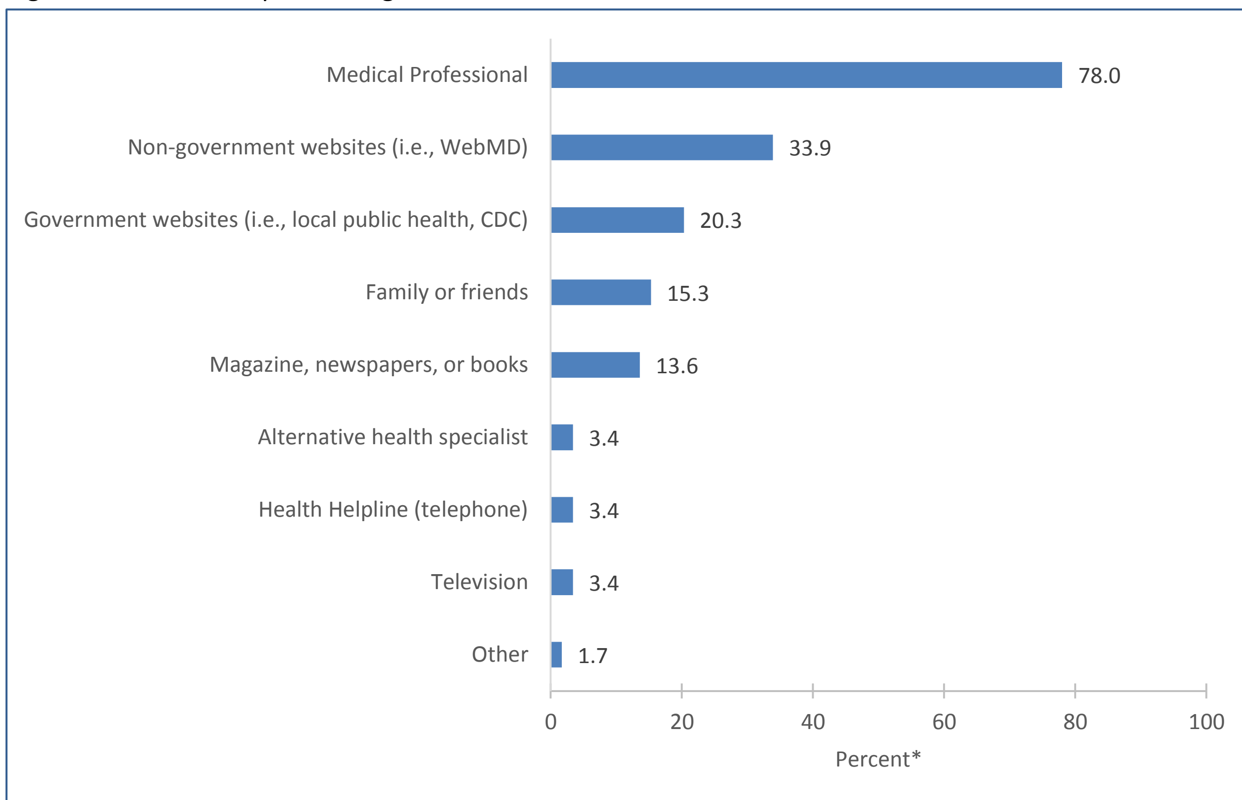
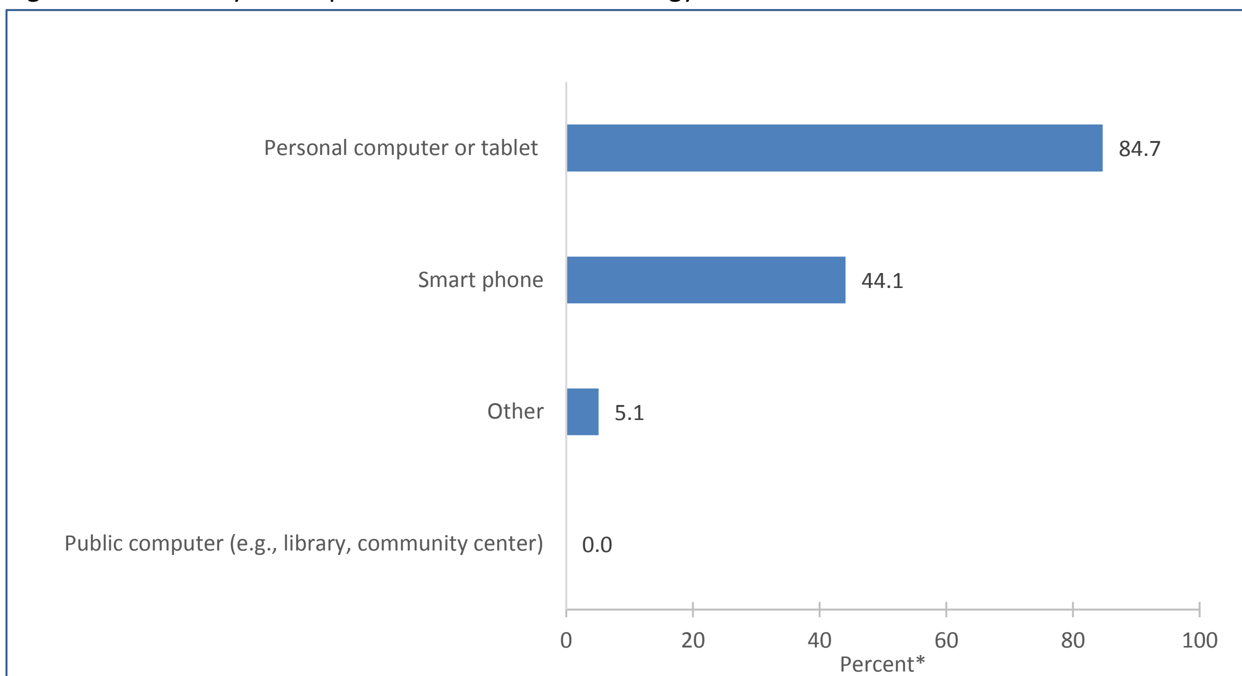


Figure 28. Where respondents get most of their health information



N=59 *Percentages do not total 100.0 due to multiple responses.

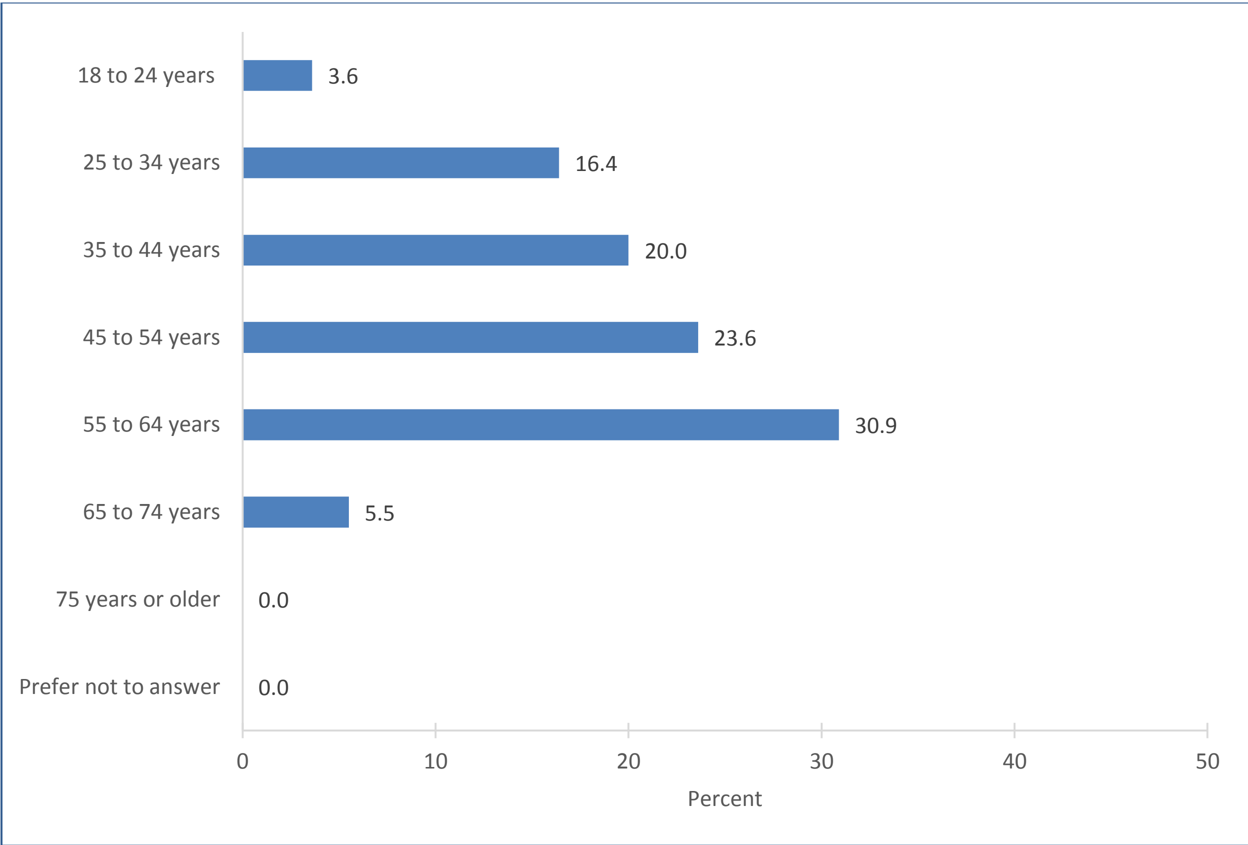
Figure 29. Best way for respondents to access technology for health information



N=59 *Percentages do not total 100.0 due to multiple responses.

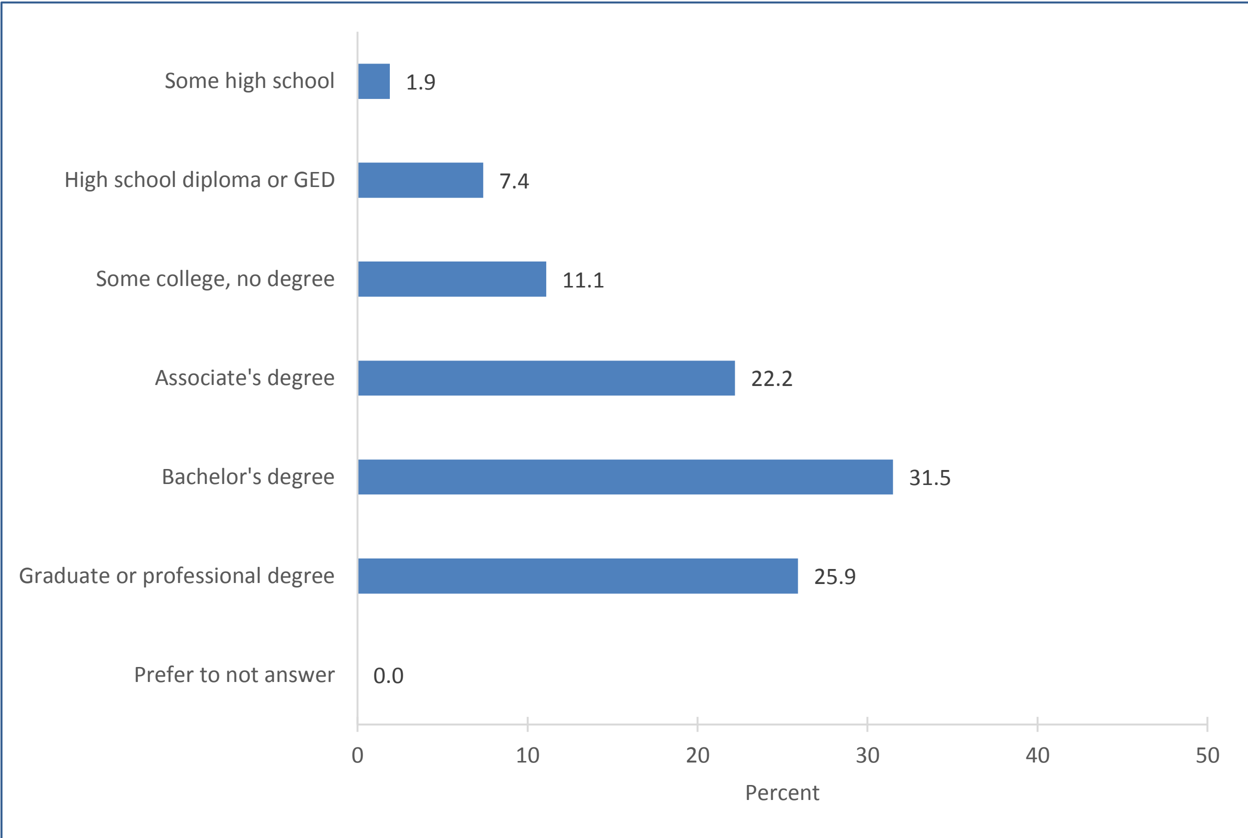
Demographic Information

Figure 30. Age of respondents



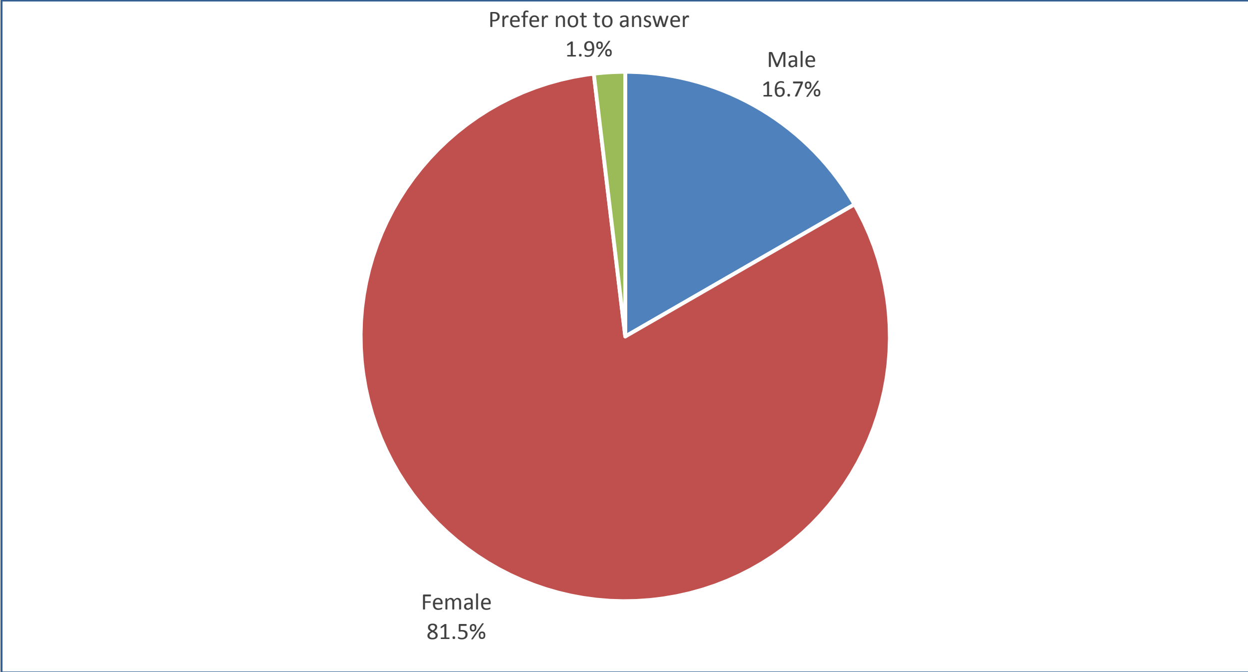
N=55

Figure 31. Highest level of education of respondents



N=54

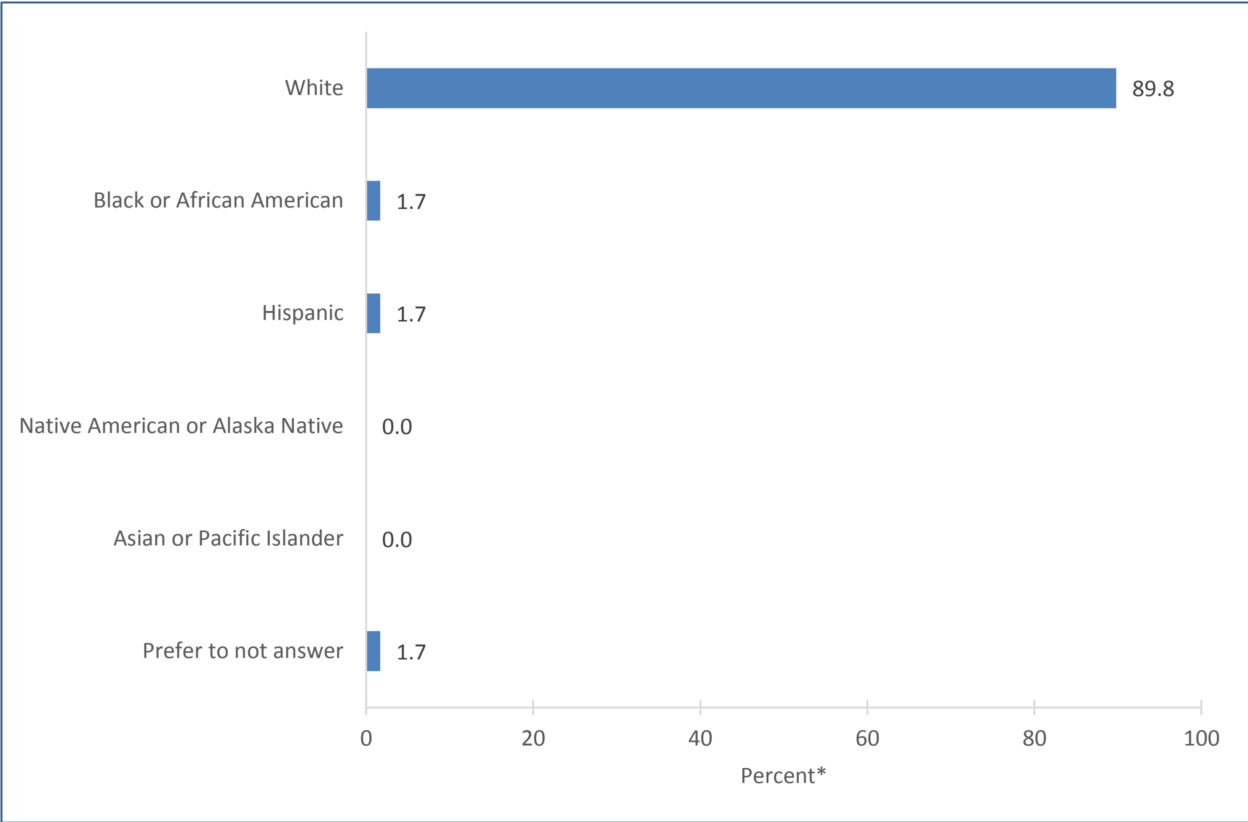
Figure 32. Gender of respondents*



N=54

*Percentages do not total 100.0 due to rounding.

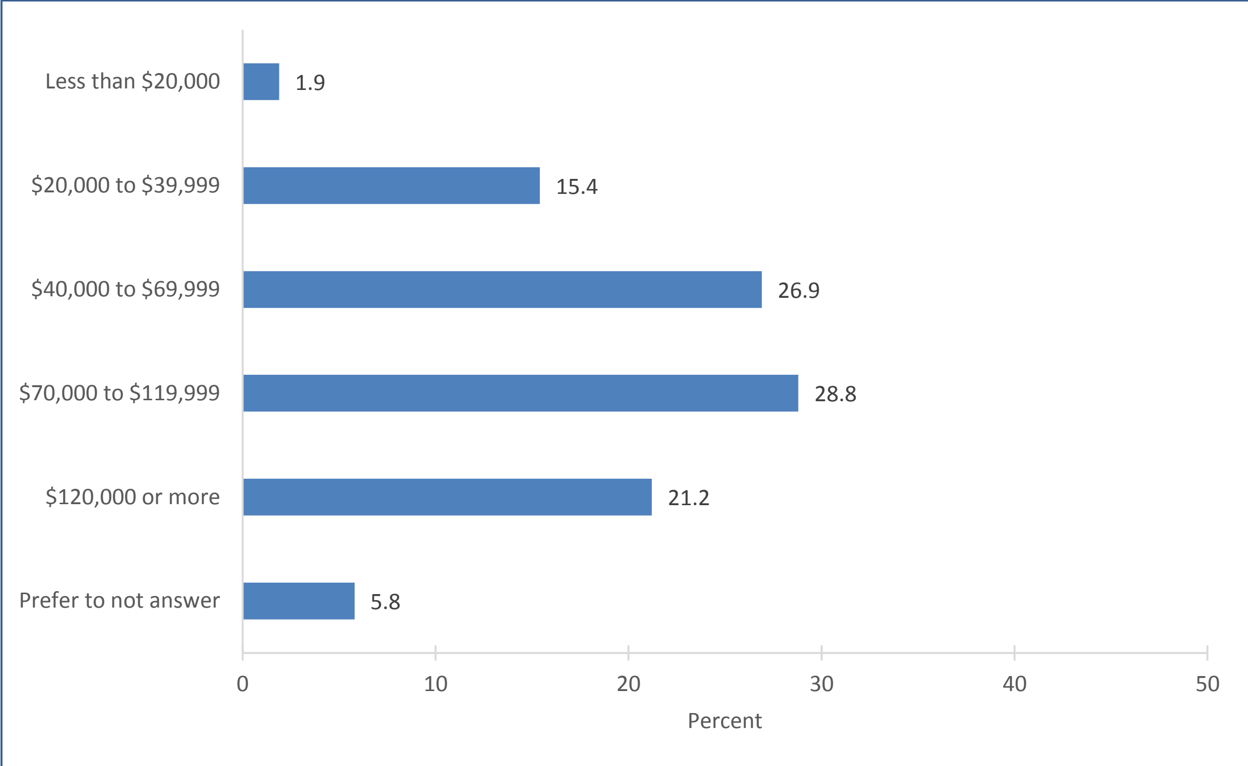
Figure 33. Race and ethnicity of respondents



N=59

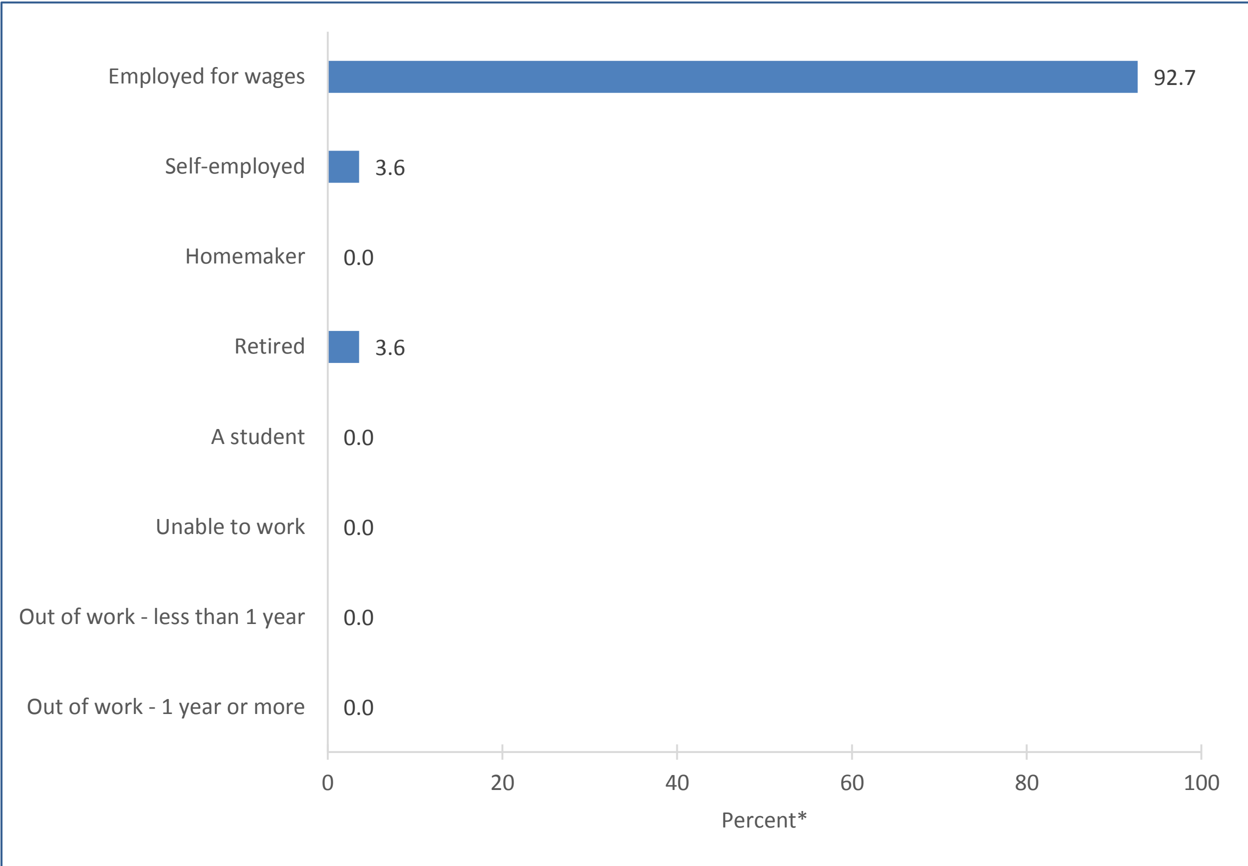
*Percentages do not total 100.0 due to multiple responses.

Figure 34. Annual household income of respondents



N=52

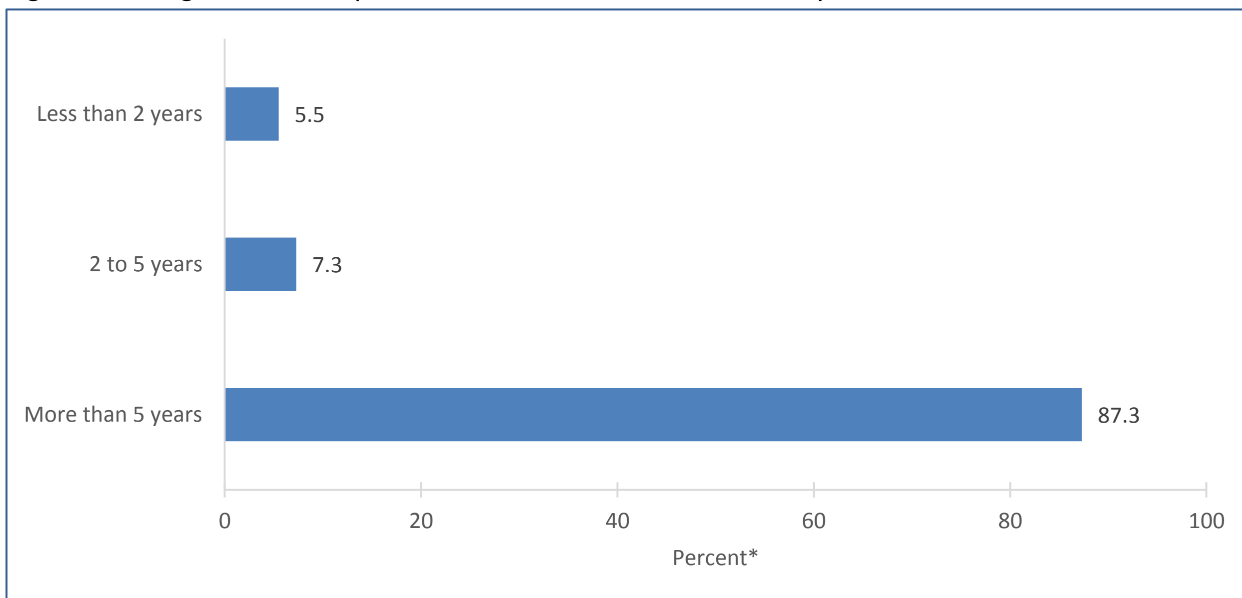
Figure 35. Employment status of respondents



N=55

*Percentages do not total 100.0 due to rounding.

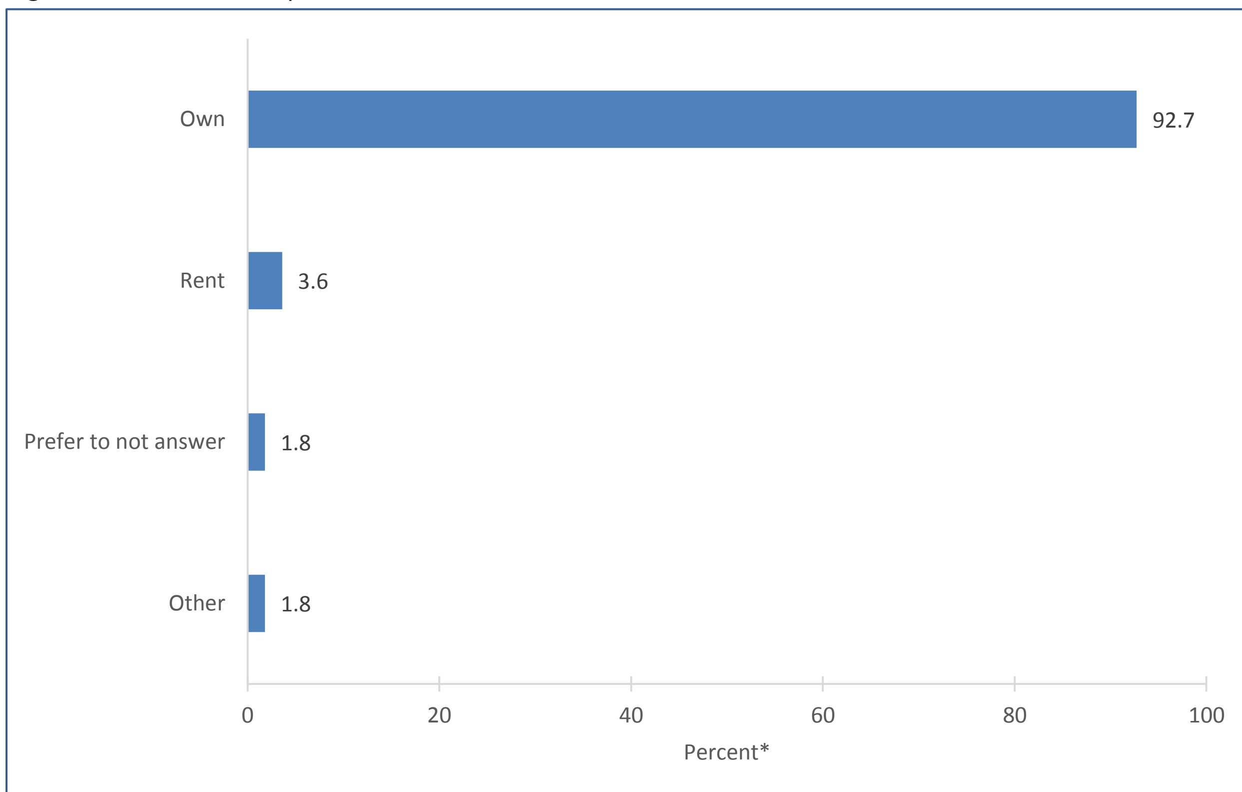
Figure 36. Length of time respondents have lived in their community



N=55

*Percentages do not total 100.0 due to rounding.

Figure 37. Whether respondents own or rent their home



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

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

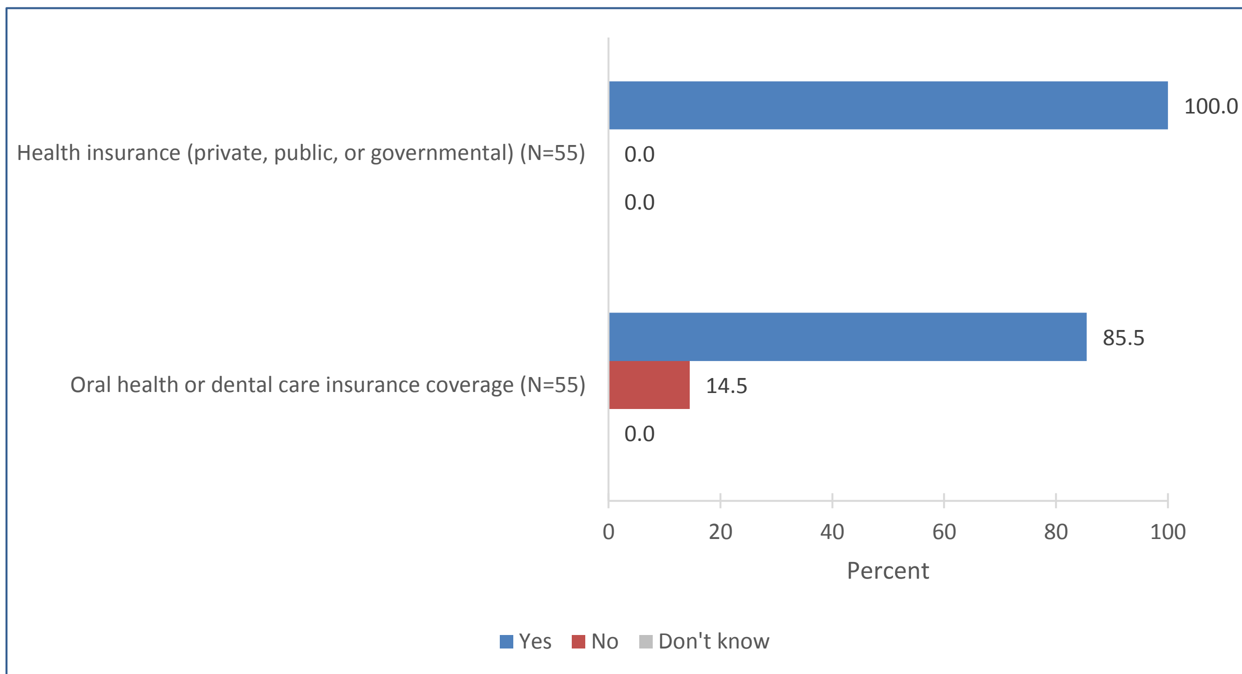
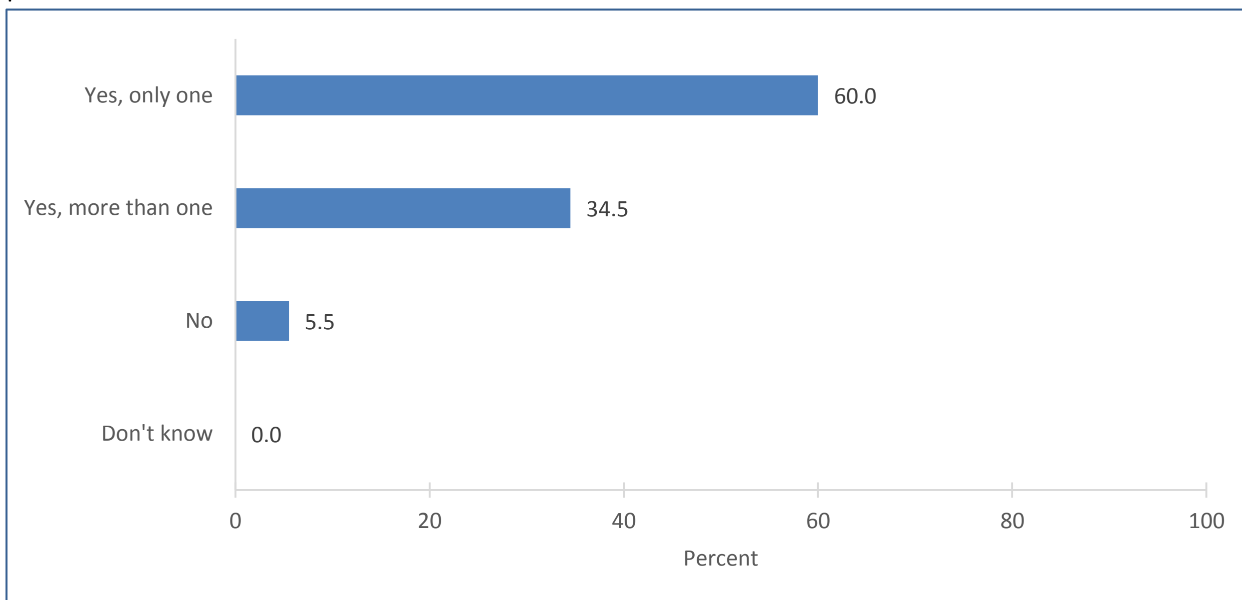
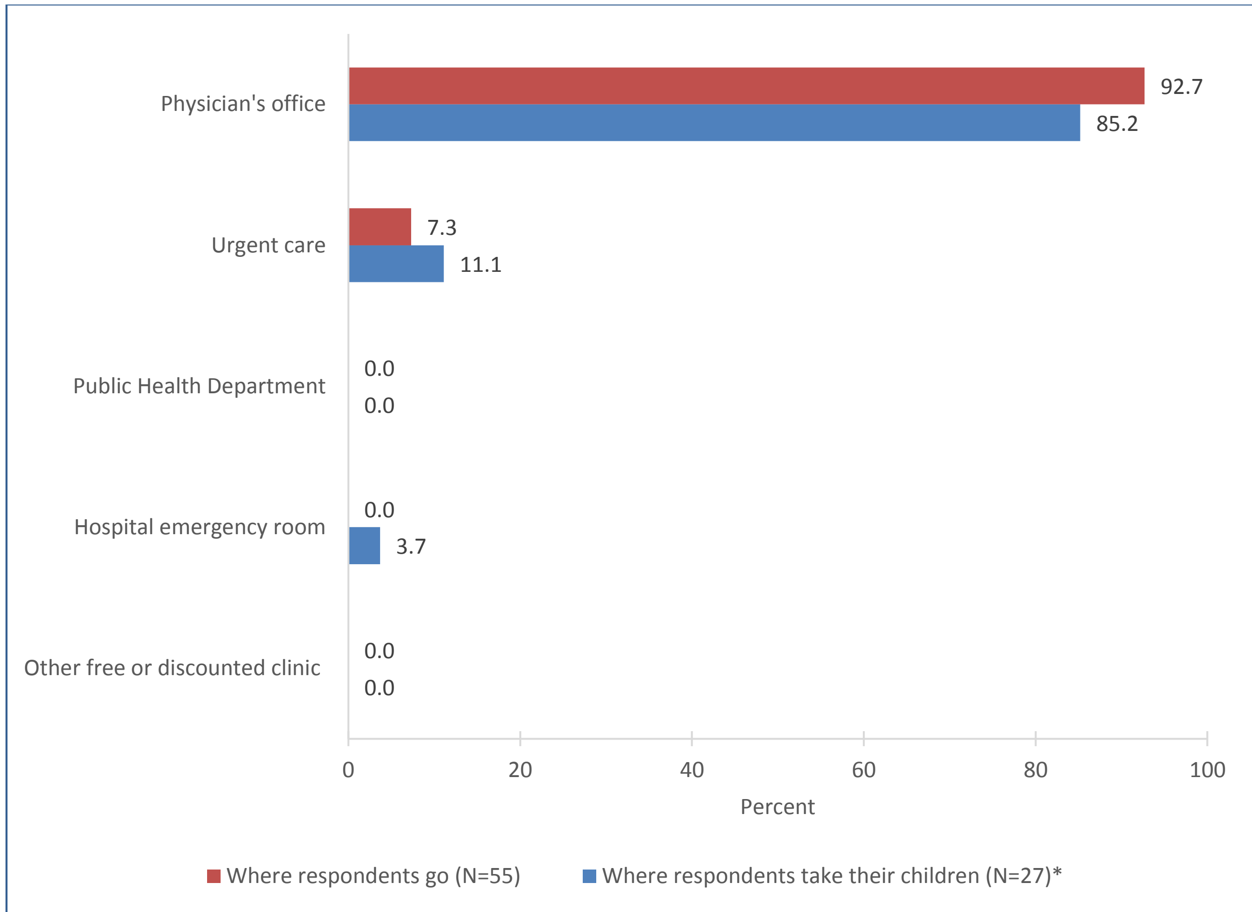


Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=55

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



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

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

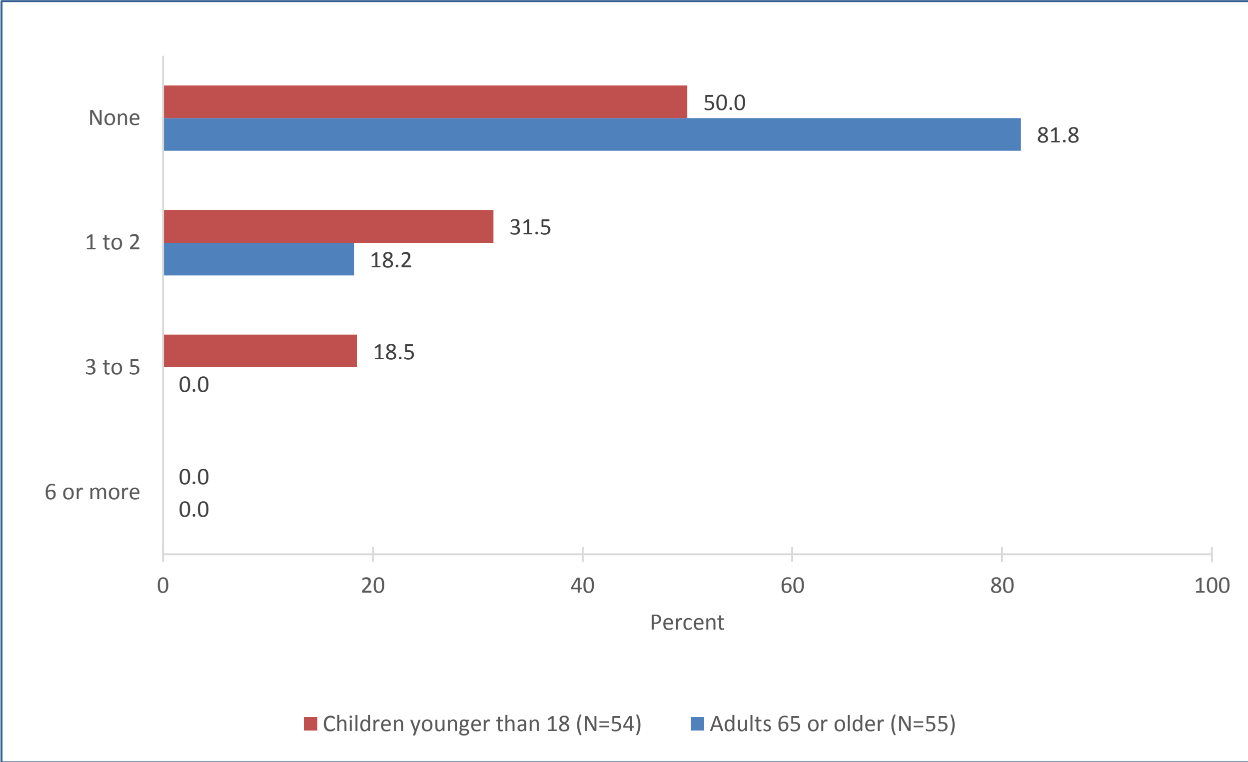
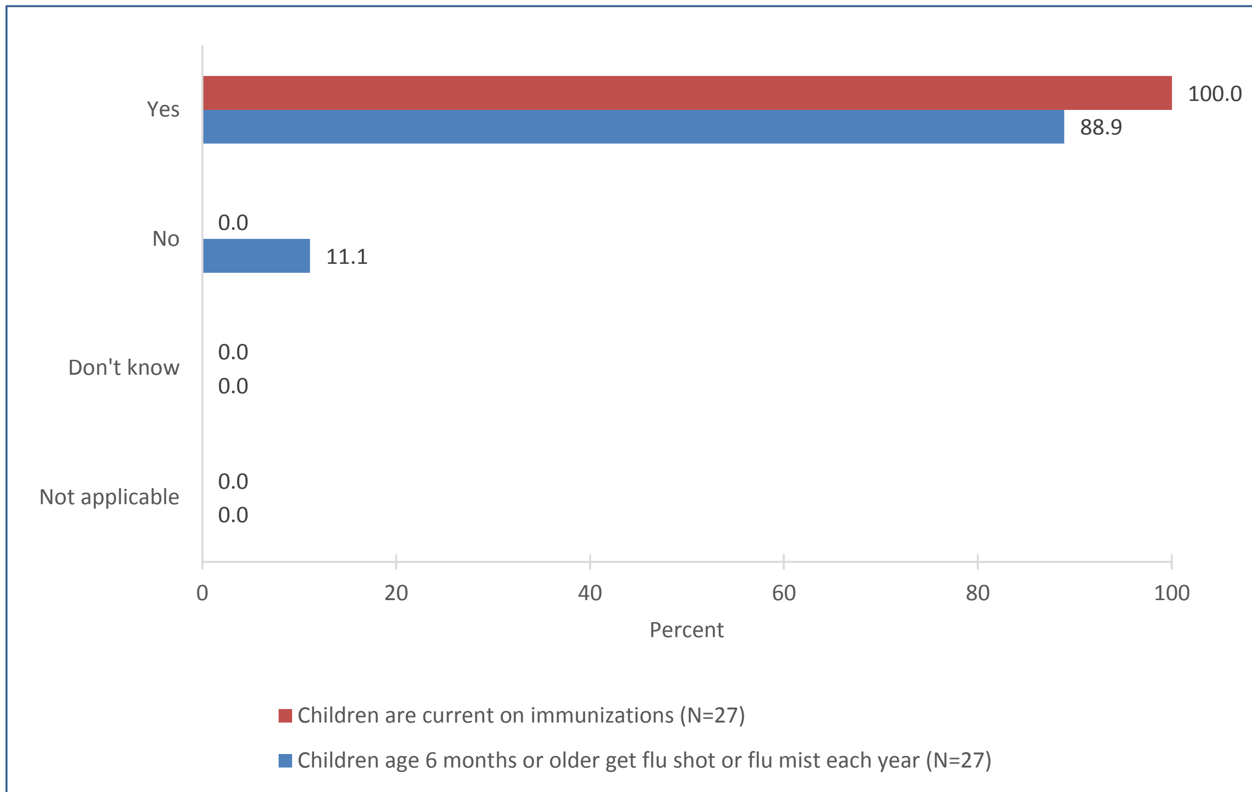


Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



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

Table 3. Zip codes of respondents

Zip code	Number of respondents
56220	43
56280	5
57237	3
56136	1
56239	1
56555	1

N=54

Secondary Research

Definitions of Key Indicators

County Health Rankings & Roadmaps
Building a Culture of Health, County by County
A Robert Wood Johnson Foundation program

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:

Outcomes & Factors Rankings

Outcomes & Factors Sub Rankings

Ranked Measures Data (including measure values, confidence intervals* and z-scores**)

Additional Measures Data (including measure values and confidence intervals*)

Ranked Measure Sources and Years

Additional Measure Sources and Years

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

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

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

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

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

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

Measure	Data Elements	Description
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)

Yellow Medicine County

	Yellow Medicine County	Error Margin	Top U.S. Performers^	Minnesota	Rank (of 87)
Health Outcomes					53
Length of Life					39
Premature death	5,178	3,650-6,707	5,200	5,038	
Quality of Life					67
Poor or fair health			10%	11%	
Poor physical health days	3.8	1.6-6.0	2.5	2.8	
Poor mental health days	4.4	1.9-6.9	2.3	2.6	
Low birthweight	5.5%	4.0-7.1%	5.9%	6.5%	
Additional Health Outcomes (not included in overall ranking) +					
Health Factors					55
Health Behaviors					81
Adult smoking	30%	19-44%	14%	16%	
Adult obesity	28%	22-34%	25%	26%	
Food environment index	8.2		8.4	8.3	
Physical inactivity	20%	15-26%	20%	19%	
Access to exercise opportunities	58%		92%	85%	
Excessive drinking	25%	14-40%	10%	19%	
Alcohol-impaired driving deaths	25%		14%	31%	
Sexually transmitted infections	148		138	336	
Teen births	28	22-36	20	24	
Additional Health Behaviors (not included in overall ranking) +					

	Yellow Medicine County	Error Margin	Top U.S. Performers^	Minnesota	Rank (of 87)
Clinical Care					67
Uninsured	10%	9-11%	11%	9%	
Primary care physicians	1,270:1		1,045:1	1,113:1	
Dentists	2,536:1		1,377:1	1,529:1	
Mental health providers	2,536:1		386:1	529:1	
Preventable hospital stays	66	54-78	41	45	
Diabetic monitoring	90%	71-100%	90%	88%	
Mammography screening	65.3%	47.0-83.6%	70.7%	66.7%	
Additional Clinical Care (not included in overall ranking) +					
Social & Economic Factors					19
High school graduation	96%		93%	78%	
Some college	63.0%	57.4-68.6%	71.0%	73.3%	
Unemployment	4.9%		4.0%	5.1%	
Children in poverty	14%	11-18%	13%	14%	
Income inequality	3.7	3.4-4.0	3.7	4.3	
Children in single-parent households	25%	19-31%	20%	28%	
Social associations	29.5		22.0	13.2	
Violent crime	115		59	229	
Injury deaths	71	50-98	50	56	
Additional Social & Economic Factors (not included in overall ranking) +					
Physical Environment					22
Air pollution - particulate matter	12.9		9.5	12.0	
Drinking water violations	0%		0%	1%	
Severe housing problems	10%	8-12%	9%	15%	

	Yellow Medicine County	Error Margin	Top U.S. Performers^	Minnesota	Rank (of 87)
Driving alone to work	73%	71-75%	71%	78%	
Long commute - driving alone	22%	19-25%	15%	29%	

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