



Sanford Health Network
Community Health Needs Assessment
2012-2013

dba Sanford Vermillion Medical Center EIN# 46-0388596

Sanford Vermillion Medical Center

Community Health Needs Assessment
2012-2013

Table of Contents

	Page
Purpose	5
Acknowledgements	6
Executive Summary	10-15
Description of the Hospital	17
Description of the Community Served	17
Study Design and Methodology	17
<ul style="list-style-type: none">• Vermillion Community Health Needs Assessment of Community Leaders• Vermillion Focus Study Group Surveys• 2011 County Health Profiles• Aging Profiles• Diversity Profiles• Quality Data• Top Diagnosis• Limitations	
Primary Research	20
Summary of the Survey Results	
<ul style="list-style-type: none">• Community Assets/Best Things About the Community	20
<ul style="list-style-type: none">○ Figure 1. Level of agreement with statements about the community regarding PEOPLE○ Figure 2. Level of agreement with statements about the community regarding SERVICES AND RESOURCES○ Figure 3. Level of agreement with statements about the community regarding QUALITY OF LIFE○ Figure 4. Level of agreement with statements about the community regarding GEOGRAPHIC SETTING○ Figure 5. Level of agreement with statements about the community regarding ACTIVITIES	
<ul style="list-style-type: none">• General Concerns About the Community	24
<ul style="list-style-type: none">○ Figure 6. Level of concern with statements about the community regarding ECONOMIC ISSUES○ Figure 7. Level of concern with statements about the community regarding SERVICES AND RESOURCES○ Figure 8. Level of concern with statements about the community regarding TRANSPORTATION○ Figure 9. Level of concern with statements about the community regarding ENVIRONMENTAL POLLUTION○ Figure 10. Level of concern with statements about the community regarding YOUTH CONCERNS○ Figure 11. Level of concern with statements about the community regarding SAFETY CONCERNS	

<ul style="list-style-type: none"> • Community Health and Wellness Concerns <ul style="list-style-type: none"> ○ Figure 12. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE ○ Figure 13. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE ○ Figure 14. Level of concern with statements about the community regarding PHYSICAL HEALTH ○ Figure 15. Level of concern with statements about the community regarding MENTAL HEALTH ○ Figure 16. Level of concern with statements about the community regarding ILLNESS 	28
<ul style="list-style-type: none"> • Delivery of Health Care in the Community <ul style="list-style-type: none"> ○ Figure 17. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed 	33
<ul style="list-style-type: none"> • Personal Health Care Information <ul style="list-style-type: none"> ○ Cancer Screening ○ Health Care Coverage ○ Primary Care Provider ○ Respondents' Primary Care Provider ○ Respondents Representing Chronic Disease ○ Distance to Access Medical Care 	34
<ul style="list-style-type: none"> • Demographic Information <ul style="list-style-type: none"> ○ Age ○ Education ○ Gender 	37
<p>Secondary Research</p> <ul style="list-style-type: none"> • Health Outcomes <ul style="list-style-type: none"> ○ Mortality ○ Morbidity • Health Factors <ul style="list-style-type: none"> ○ Health Behaviors ○ Clinical Care ○ Social and Economic Factors ○ Physical Environment ○ Demographics ○ Population by Age ○ Housing ○ Economic Security ○ Diversity Profile 	39
<p>Health Needs Identified</p> <ul style="list-style-type: none"> • Community Assets/Prioritization Process 	46

Implementation Strategy	47
Appendix	50
• 2011 County Health Profile – Clay County	
• 2011 County Health Profile – Union County	
• Definitions of Health Variables	
• Aging Profile – Clay County	
• Diversity Profile – Clay County	
• Maps:	
○ Mortality – Map 1 – Premature Death	
○ Morbidity – Maps 2-5	
○ Health Factors – Maps 6-12	
○ Clinical Care – Maps 13-20	
○ Social and Economic – Maps 21-27	
○ Physical Environment – Maps 28-31	
○ Demographic – Maps 32-36	
• Table 1 – Asset Map	
• Table 2 – Prioritization Worksheet	

Sanford Vermillion Medical Center Community Health Needs Assessment 2012-2013

Purpose

Sanford Vermillion Medical Center is part of Sanford Health, an integrated health system headquartered in the Dakotas and the largest rural not-for-profit health care system in the nation with locations in 126 communities in eight states.

Sanford Vermillion Medical Center has undertaken a community health needs assessment as required by the Patient Protection and Affordable Care Act and as part of the IRS 990 requirement for a not-for-profit health system to address issues that have been assessed as unmet needs in the community.

PPACA requires that each hospital must have: (1) conducted a community health needs assessment in the applicable taxable year; (2) adopted an implementation strategy for meeting the community health needs identified in the assessment; and (3) created transparency by making the information widely available. For tax exempt hospital organizations that own and operate more than one hospital facility, as within Sanford Health, the new tax exemption requirements will apply to each individual hospital. The first required needs assessment falls within the fiscal year July 1, 2012 through June 30, 2013.

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

A community health needs assessment is critical to a vital Community Investment/Community Benefit Program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining not-for-profit status.

Acknowledgements

Sanford Health would like to acknowledge and thank the Steering Committees and the Greater Fargo Moorhead Community Health Needs Assessment Collaborative for their expertise while performing the assessment and analysis of the community health data. The assessment provides support for the future directions of our work as the region's leading health care system.

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We express our gratitude to the following individuals and groups for their participation in this study.

We extend special thanks to the city mayors, city council/commission members, physicians, nurses, school superintendents and school board members, parish nurses, representatives from the Native American community, Faith Community Leaders, as well as legal services, mentally and physically disabled, social services, non-profit organizations, and financial services for their participation in this work. Together we are reaching our vision “to improve the human condition through exceptional care, innovation and discovery.”

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

The following key community stakeholders participated in this assessment work:

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Sanford Vermillion Medical Center Community Health Needs Assessment 2012-2013

Executive Summary

Purpose

The purpose of a community health needs assessment is to develop a global view of the population's health and the prevalence of disease and health issues within the community. Findings from the assessment serve as a catalyst to align expertise and develop a Community Investment/Community Benefit plan of action. There is great intrinsic value in a community health needs assessment when it serves to validate, justify and defend not-for-profit status and create opportunities to identify and address public health issues from a broad perspective. A community health needs assessment is critical to a vital Community Investment/Community Benefit Program that builds on community assets, promotes collaboration, improves community health, and promotes innovation and research. A community health needs assessment also serves to validate progress made toward organizational strategies and provides further evidence for retaining our not-for-profit status.

Study Design and Methodology

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders
- Focus Group Surveys of Key Stakeholders in Community

The following quantitative data sets were studied:

- 2011 County Health Profiles for Clay and Union Counties
- Aging Profiles for Clay and Union Counties
- Diversity Profiles for Clay and Union Counties

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

Key Findings – Primary Research

Sanford Vermillion Medical Center distributed the community health needs assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the Vermillion community.

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. The list of individuals who agreed to take the survey and also submit their names are included in the acknowledgement section of this report. 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.

The findings discussed in this section are a result of the analysis of the survey qualitative data.

Respondents had very high levels of agreement that the people in their community are friendly, helpful and supportive, there is quality health care, the community is a good place to raise kids and is generally a safe and healthy place to live with quality higher education opportunities, and school systems. However, respondents agreed the least that there is effective transportation and cultural richness in their community.

Respondents were most concerned about the cost of education, affordability of child care, low wages and the cost of healthcare and/or insurance. Respondents were also concerned about availability of employment opportunities, the cost of living and housing, number of hungry individuals in Vermillion community who access the food pantry and backpack lunch programs, substance abuse and transportation issues for disabled or elderly, access to mental health services and availability of specialty providers locally. Respondents were least concerned with access to grocery stores, traffic congestion, pollution and violent crimes.

Among health and wellness concerns, respondents were most concerned about the costs associated with health insurance and health care. Respondents were also concerned with physical health issues, particularly diabetes, cancer, obesity, healthy nutrition and preventative services. Issues with access to mental health services, availability of certain outreach specialty providers and cost of exercise facilities were also among the top health and wellness concerns. Distance to health care providers and providers not taking new patients were the least areas of concern in health and wellness.

Respondents had moderate levels of concern with respect to safe driving habits and concerns regarding youth bullying and youth activities.

There is a high agreement that the community has a general cleanliness (fresh air, lack of pollution and litter) and is a short commute/convenient access to work and activities.

The levels of concern among respondents regarding substance use and abuse issues in their community were fairly high. Respondents were most concerned about alcohol and use and abuse and smoking. Less of an issue was the number of respondents concerned about the presence of drug dealers in the community.

The top reasons respondents gave for their choice of primary health care provider were location, quality of services, availability of services, and recommendation from others. Influence by health insurance ranked the lowest reason for primary care provider choice.

More than 60% (63.8%) of respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because their doctor had not suggested it or it was considered not necessary. Fear, unfamiliarity with recommendations, and not knowing who to see were not reasons that the majority of respondents gave.

A majority of respondents (80.8%) said they had paid for health care costs over the last 12 months by health insurance through an employer. Personal income, Medicare, Medicaid, private health insurance, military and veteran's health care benefits were also used.

Respondents were asked which provider they used for their primary health care. Seventy-one percent (71%) of respondents said they use Sanford Vermillion/Sanford Health as their primary health care provider. Twenty-nine percent (29%) said that they use other services in Vermillion and/or Yankton.

Key Findings – Secondary Research

Health Outcomes

The mortality health outcomes indicate that South Dakota as a state has more premature deaths than the national benchmark. While the state has more premature deaths than the national benchmark, Clay and Union Counties in South Dakota have a lower rate than the national benchmark.

The morbidity health outcomes indicate that South Dakota citizens report more days of poor health than the national benchmark; however, Clay County reports less than the national benchmark and Union County reports less than the South Dakota benchmark but higher than the national benchmark. South Dakota reports more physically unhealthy days than the national benchmark, while Clay and Union Counties report a low percentage of poor health days.

South Dakota reports more mentally unhealthy days than the national benchmark, while Clay and Union Counties report fewer mental health days.

South Dakota has a higher percentage of low birth weight than the national benchmark, while Clay County is the same as the national benchmark and Union County is slightly lower than the SD benchmark but higher than the national benchmark.

Health Factors

The health behavior outcomes indicate that South Dakota and Clay and Union Counties have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in the state of South Dakota and in Clay and Union Counties than the national benchmark. South Dakota and Clay and Union Counties also have a higher percentage of physical inactivity than the national benchmark.

South Dakota and Clay and Union counties have a much higher percentage of binge drinking reports than the national benchmark (more than double). Motor vehicle crash death rates are nearly double the national benchmark in South Dakota; there is no county data available for Clay or Union county.

Sexually transmitted infections rank substantially higher than the national benchmark for South Dakota (371.3 vs. national benchmark of 83.0) and for Clay County (374.9). Union County is lower (99.1) but still above the national benchmark.

The teen birth rate is higher in South Dakota and Union County than the national benchmark, but is lower in Clay County.

The clinical care outcomes indicate that South Dakota and Clay County have a higher percentage of uninsured adults than the national benchmark, while Union County has a lower percentage. The percentage of uninsured youth in Union County is the same as the national benchmark, but is higher in Clay County and South Dakota as a whole.

The ratio of population to primary care physicians is higher in South Dakota and Clay and Union counties than the national benchmark.

The ratio of population to mental health providers is higher in South Dakota and Union County than the national benchmark; however, Clay County's ratio is better than the national benchmark. The number of professionally active dentists is lower than the national benchmark in South Dakota and both Clay and Union counties. Preventable hospital stays are higher than the national benchmark in South Dakota and both Clay and Union counties.

Diabetes screening in South Dakota and in Union County is just slightly lower than the national benchmark; no data is available for Clay County. Although the percentage of South Dakotans who received mammography screenings was lower than the national benchmark, both Clay and Union's were above the national benchmark.

The social and economic factor outcomes indicate that South Dakota and Clay and Union counties all have a lower high school graduation rate than the national benchmark, and while South Dakota has a lower percentage of post secondary education than the national benchmark, both Clay and Union counties have a higher percentage. The unemployment rate was lower in South Dakota and Clay County but higher in Union County than the national benchmark. The percentage of child poverty is substantially higher in South Dakota and Clay County than the national benchmark; however, Union County is below the national benchmark.

Inadequate social support is higher in South Dakota and Union County but is lower in Clay County than the national benchmark.

The percentage of children in single parent households is higher than the national benchmark in South Dakota but lower in both Clay and Union counties. The number of homicide deaths in South Dakota is higher than the national benchmark; the number is not available for Clay or Union County.

The physical environment outcomes indicate that there was one day of air pollution from particulate matter for both Clay and Union counties; both SD and the national benchmark was zero. There were no days of ozone pollution in Clay or Union County nor SD or national benchmark. Access to healthy food is ranked far below the national benchmark. There can be a far distance to travel to grocery stores, and there are rural areas in some communities where only a gas station convenience store is close to home. Access to recreational facilities ranks lower than the national benchmark for South Dakota and Clay and Union counties.

Youth account for 17% of the population in Clay County and 25% of the population in Union County. Elderly account for 11% of the population in Clay County and for 14% of the population in Union County. Twenty-five percent (25%) of Clay County is rural compared to 48% of South Dakota and 21% as the national benchmark. Seventy-two percent (72%) of Union County is rural.

Only 2% of South Dakotans, 2% of Clay County, and 1% of Union County population is not proficient in English compared to the national benchmark of 9%. South Dakota's illiteracy rate is 7% and both Clay and Union counties are at 6%, compared to the national benchmark of 15%.

The population for this area is relatively young with only 2% older than 85 years of age, and only 10% older than 65 years of age in Clay County. Fourteen percent (14%) of South Dakotans are older than 65 years of age and only 2% are older than 85 years of age.

The gender distribution is 49% Male - 51% Female in Clay County and 50% - 50% for the state of South Dakota.

The majority of individuals in these counties own their homes with the largest percentage of home ownership in Union County (74%), then Clay County (53%), and 68% of South Dakotans own their own home.

According to the 2010 Census Data, the population of working age in the labor force is 65% in Clay County and 69% in South Dakota. The percentage of those who are living at less than 100% of the poverty level is 14% in South Dakota and 24% in Clay County. In South Dakota, 33% are at less than 200% of the poverty level and in Clay County it's 41%.

The median annual household income in South Dakota is \$46,369, while Clay County is at \$37,198 and Union County is at \$63,773.

The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian alone, then Hispanic origin of any race, and Black alone. The Asian population ranks fifth in South Dakota.

In Clay County the ranking is White, American Indian, Hispanic, Asian, and Black, while in Union County the ranking is White, Hispanic, Asian, Black and American Indian.

Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process for Sanford Vermillion:

- Recruitment plan – Outreach Specialty Services
- Mental Health Services

Implementation Strategy: Mental Health Services

- Implement Sanford One Mind/One Care based on the Enterprise Implementation Strategy
- Identify and utilize internal resources already available through on staff MSW, CSW-PIP
- Look at expansion of Employee Assistance Programs already available in the community

- Collaborate with other Mental Health providers in the community to look at options for expansion of services (e.g. some only work 4 days/wk, etc.)
- Utilize current Clinic Health Care Coach and future Psychologist position to expand clinic Mental Health Services to patients

Implementation Strategy: Outreach Provider Services

- Continue to work with Sanford Health and other Outreach Providers to determine the viability of additional outreach services for SVMC
- Continue development of telehealth services and capabilities to provide outreach services to patients at SVMC

Sanford Vermillion Medical Center Community Health Needs Assessment 2012-2013

Sanford Health, long been dedicated to excellence in patient care, is on a journey of growth and momentum with vast geography, cutting-edge medicine, sophisticated research, advanced education and a health plan. Through relationships built on trust, successful performance, and a vision to improve the human condition, Sanford seeks to make a significant impact on health and healing. We are proud to be from the Midwest and to impact the world. The name Sanford Health honors the legacy of Denny Sanford's transformational gifts and vision.

Our Mission: *Dedicated to the Work of Health and Healing*

We provide the best care possible for patients at every stage of life, and support healing and wholeness in body, mind and spirit.

Our Vision: *To improve the Human Condition through Exceptional Care, Innovation and Discovery*

We strive to provide exceptional care that exceeds our patients' expectations. We encourage diversity in thought and ideas that lead to better care, service and advanced expertise.

Our Values:

- **Courage:** *Strength to persevere, to use our voice and take action*
- **Passion:** *Enthusiasm for patients and work, commitment to the organization*
- **Resolve:** *Adherence to systems that align actions to achieve excellence, efficiency and purpose*
- **Advancement:** *Pursuit of individual and organizational growth and development*
- **Family:** *Connection and commitment to each other*

Our Promise: *Deliver a flawless experience that inspires*

We promise that every individual's experience at Sanford—whether patient, visitor or referring physician—will result in a positive impact, and for every person to benefit from a flawless experience that inspires.

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*

Description of the Hospital

Sanford Vermillion Medical Center is a medical facility that includes a family medicine clinic, 25-bed Critical Access acute care hospital, 66-bed nursing home, and 23-unit senior living apartment complex in southeast South Dakota. Sanford Vermillion Medical Center is a member of Sanford Health Sioux Falls Region, a non-profit, integrated health system headquartered in Fargo, ND and Sioux Falls, SD. Sanford Clinic Vermillion is served by three family medicine physicians, a general surgeon, three mid-level providers, and a number of visiting physician specialists.

Description of the Community Served

Sanford Vermillion Medical Center is located in rural Vermillion, SD, which has a population of 10,600 and is home to a variety of farmers, manufacturers, professionals, students and scholars. Sanford Vermillion serves a market population of approximately 25,000 individuals from mainly Clay and Union counties in southeastern South Dakota, as well as a few counties from across the Missouri river in Nebraska. The University of South Dakota was founded in 1862 in Vermillion and currently enrolls over 10,000 students. The Critical Access Hospital facility provides over 16,000 outpatient visits and almost 3, 000 inpatient days annually. The clinic provides over 24,000 patient visits annually to include the USD student health contract population. Clay County serves a population that has almost twice the number of individuals living below poverty as the state average, as well as a lower than average median and household income. Sanford Vermillion Medical Center is classified as a Medicaid dependent hospital.

Study Design and Methodology

In May 2011 Sanford Health convened key health care leaders and other not-for-profit leaders in the Fargo Moorhead community to establish a Fargo Moorhead Community Health Needs Assessment Collaborative. A primary goal of this collaborative was to craft standardized tools, indicators and methodology that can be used by all group members when conducting assessments and also be used by all of the Sanford medical centers across the enterprise. After much discussion it was determined that the Robert Wood Johnson Framework for county profiles would be our secondary data model.

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. The list of individuals who agreed to take the survey and also submit their names are included in the acknowledgement section of this report. 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.

A sub group of this collaborative met with researchers from the North Dakota State University Center for Social Research to develop a survey tool for our key stakeholder groups. The survey tool incorporated the University of North Dakota's Center for Rural Health community health needs assessment tool and the Fletcher Allen community health needs assessment tool. North Dakota State University and the University of North Dakota Center for Rural Health worked together to develop additional questions and to ensure that scientific methodology was incorporated in the design.

Finally, it was the desire of the collaborative that the data would be shared broadly with others and that if possible it would be hosted on a web site where there could be access for a broad base of community, state and regional individuals and groups.

This community health needs assessment was conducted during FY 2012 and FY 2013. The main model for our work is the Association for Community Health Improvement's (ACHI) Community Health Needs Assessment Toolkit.

The following qualitative data sets were studied:

- Community Health Needs Assessment of Community Leaders
- Focus Group Surveys of Key Stakeholders in Community

The following quantitative data sets were studied:

- 2011 County Health Profiles for Clay and Union Counties
- Aging Profiles for Clay and Union Counties
- Diversity Profiles for Clay and Union Counties

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

Vermillion Community Health Needs Assessment of Community Leaders

The purpose of the community leader survey was to explore the views of key leaders in the Vermillion community (e.g. health professionals, educators, elected leadership, and nonprofit leaders) regarding the resident population's health and the prevalence of disease and health issues within the community.

The community leaders' survey included a set of questions at the end relating to the respondents' name, title, affiliation, area of expertise, city/town, and state. These questions were included to fulfill the current interpretation of IRS requirements for non-profit hospitals conducting community health needs assessments as part of the new compliance requirements imposed by the Patient Protection and Affordable Care Act signed into law on March 23, 2010.

A total of 180 surveys were completed through a Survey Monkey link. The purpose of this survey was to learn about the perceptions of area key stakeholders regarding the prevalence of disease and health issues in their community.

Vermillion Community Focused Study Group Surveys

Two focused studies were held in the Vermillion community of key stakeholder groups that were unlikely to complete a paper or online survey. The focus groups were asked the same three questions regarding community health concerns and services the community needs and all answers were written down and submitted for inclusion in the survey results. The name, title, affiliation, area of expertise, city/town and state information was also collected from all present at the focused study groups.

2011 County Health Profiles

The County Health Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. State and national benchmarking required additional data sources, including the U.S. Census Bureau, Small Area Health Insurance Estimates, and the Centers for Disease Control and Prevention's National Center for Health Statistics – the Health Indicators Warehouse.

Aging Profiles

The Aging Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available.

Diversity Profiles

The Diversity Profiles are based on data from the U.S. Census Bureau, 2010 Census Summary File 1, and 2006-2010 American Community Survey Five-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. Blank values reflect data that is missing or not available. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

Limitations

The Sanford Vermillion Steering Committee attempted to survey key community leaders and stakeholders for the purpose of determining the needs of the community. While 180 surveys were returned, there were still many key stakeholders who did not complete the survey and some residents that did not receive the survey.

The survey asked for individual perceptions of community health issues and is subjective to individual experiences which may or may not be the current status of the community.

Primary Research

Summary of the Survey Results

Sanford Vermillion Medical Center distributed the community health needs assessment survey tool that was developed by the Greater Fargo-Moorhead Community Health Needs Assessment Collaborative to key stakeholder groups as a method of gathering input from a broad cross section of the Vermillion community. Findings discussed in this section are a result of the analysis of the survey qualitative data.

Respondents had very high levels of agreement that their community has educational opportunities and programs, the community is a good place to raise kids, and there is quality health care. However, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community.

Respondents were most concerned about the cost of health insurance and health care, low wages, substance abuse and mental health. Respondents were also concerned about cost of living/housing, availability of elder care services and youth issues such as bullying.

Among health and wellness concerns, respondents were most concerned about availability of mental health providers, cancer, obesity and poor nutrition as well as access to specialty providers. Respondents were less concerned about distance to health care services and providers taking new patients.

Community Assets/Best Things about the Community

People

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 agreement with various statements about their community regarding people, services and resources, and quality of life.

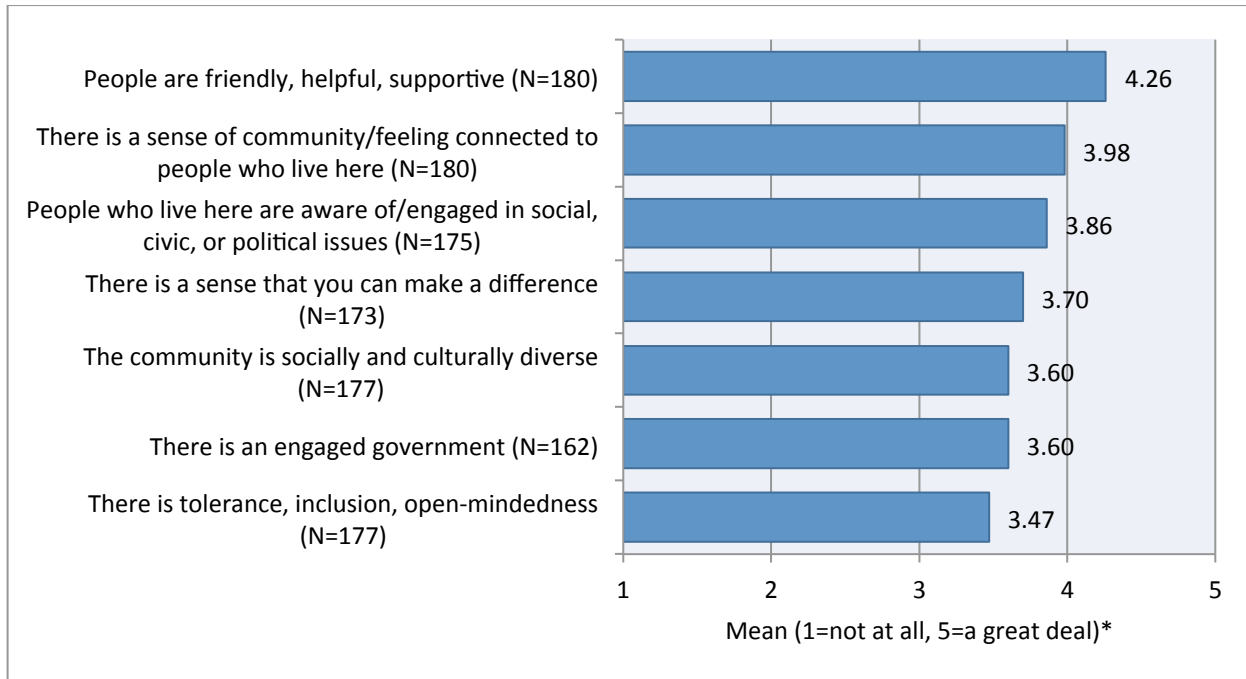
Respondents indicated the top five community assets or best things about the community were:

- People are friendly, helpful, and supportive.
- There is a sense of community/feeling connected to people who live here.
- People who live here are aware of/engaged in social, civic or political issues.
- There is a sense that you can make a difference.
- The community is socially and culturally diverse.

Overall, respondents had moderately high levels of agreement regarding positive statements that reflect the people in their community (*Figure 1*).

- Respondents also had a fairly high level of agreement that there is an engaged government.
- Although still a moderate level of agreement, respondents agreed the least that there is tolerance, inclusion, and open-mindedness in their community.

Figure 1. Level of agreement with statements about the community regarding PEOPLE

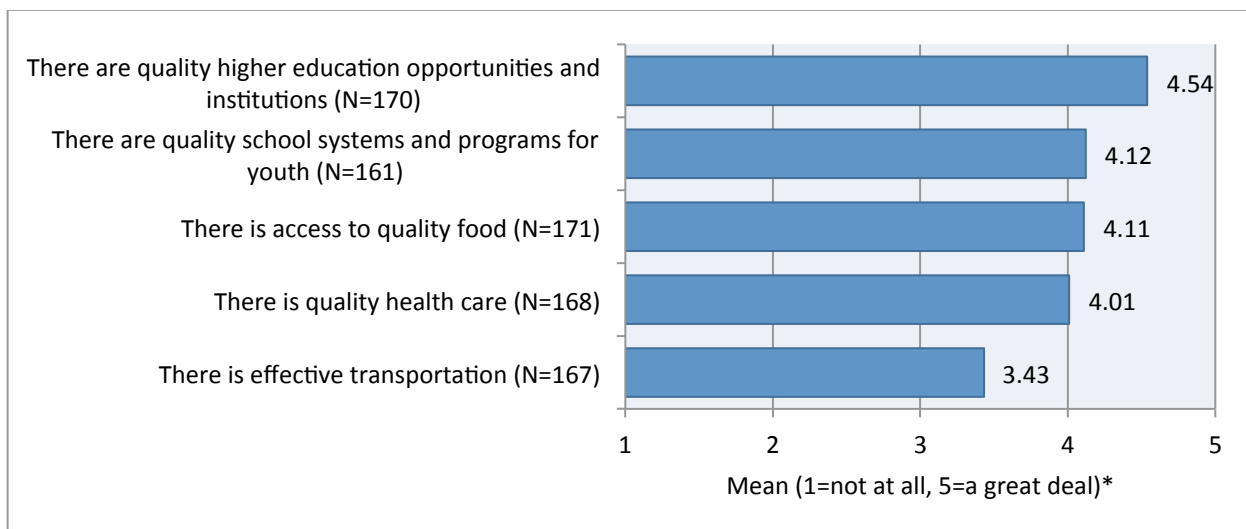


Services and Resources

Respondents had high levels of agreement that there are quality higher education opportunities and institutions as well as quality school systems and programs for youth in their community.

Although still a moderate level of agreement, respondents agreed the least that there is effective transportation in their community. Overall, respondents had a high level of agreement with positive statements regarding services and resources issues in their community.

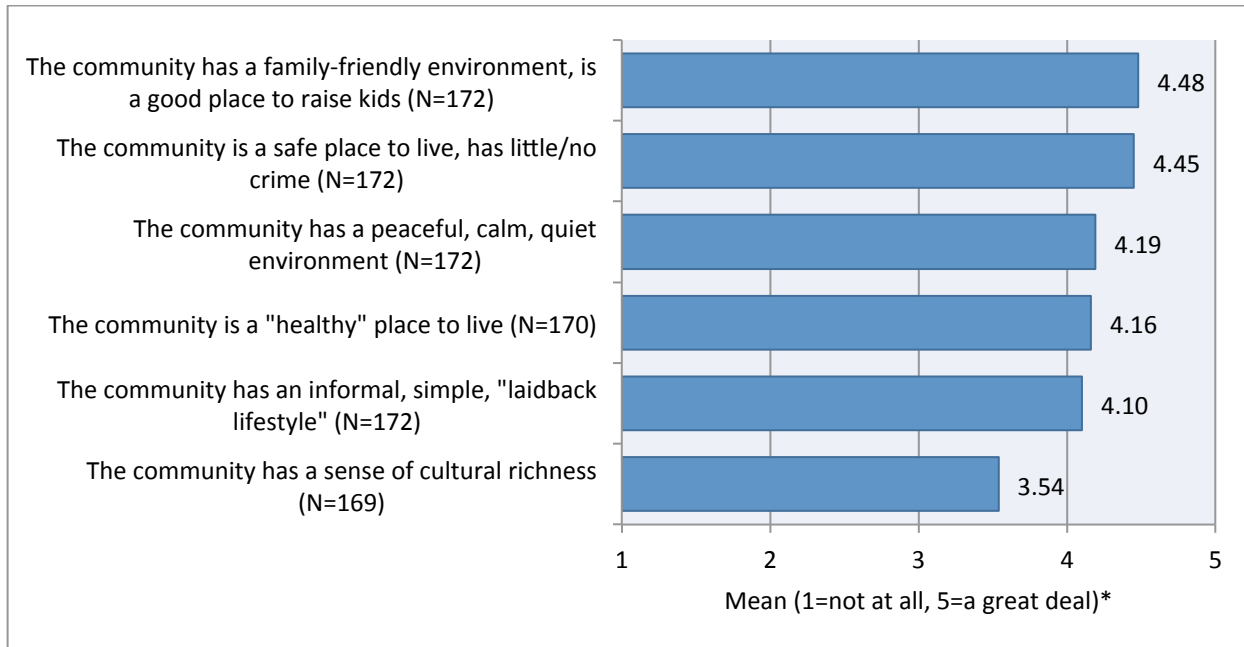
Figure 2. Level of agreement with statements about the community regarding SERVICES AND RESOURCES



Quality of Life

Respondents had a very high level of agreement that their community is a good place to raise kids. Respondents had fairly high levels of agreement with the remaining components of quality of life issues in their community. Means ranged from 3.54 to 4.48 with respect to the community being a healthy place to live; the presence of quality arts, events, and festivals; the community being a safe place to live with little or no crime; the community having a peaceful, calm, and quiet environment; and the community having many recreational, exercise, and sports activities/opportunities and the lowest with cultural richness.

Figure 3. Level of agreement with statements about the community regarding QUALITY OF LIFE



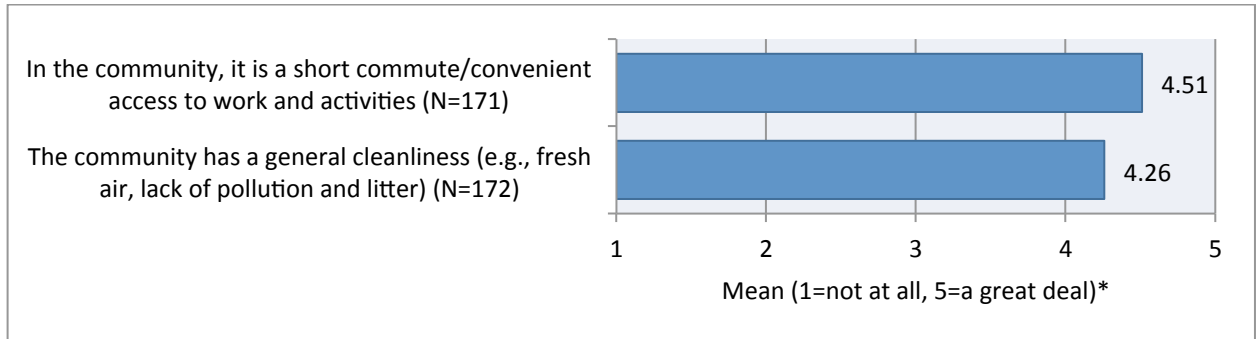
Respondents were asked to describe other best things about their community.

- Respondents mentioned the friendliness of the community and the proximity to larger communities as a strength, as well as the shopping and restaurants available in town. Also mentioned were the number of activities available for children in the community, church involvement, volunteerism, safety, and the University partnerships for health and wellness were also great assets to the community.

Geographic Setting

Respondents rated their geographic setting very highly in regards to whether it was a short commute/convenient access to work and activities and also that the community had a general cleanliness overall.

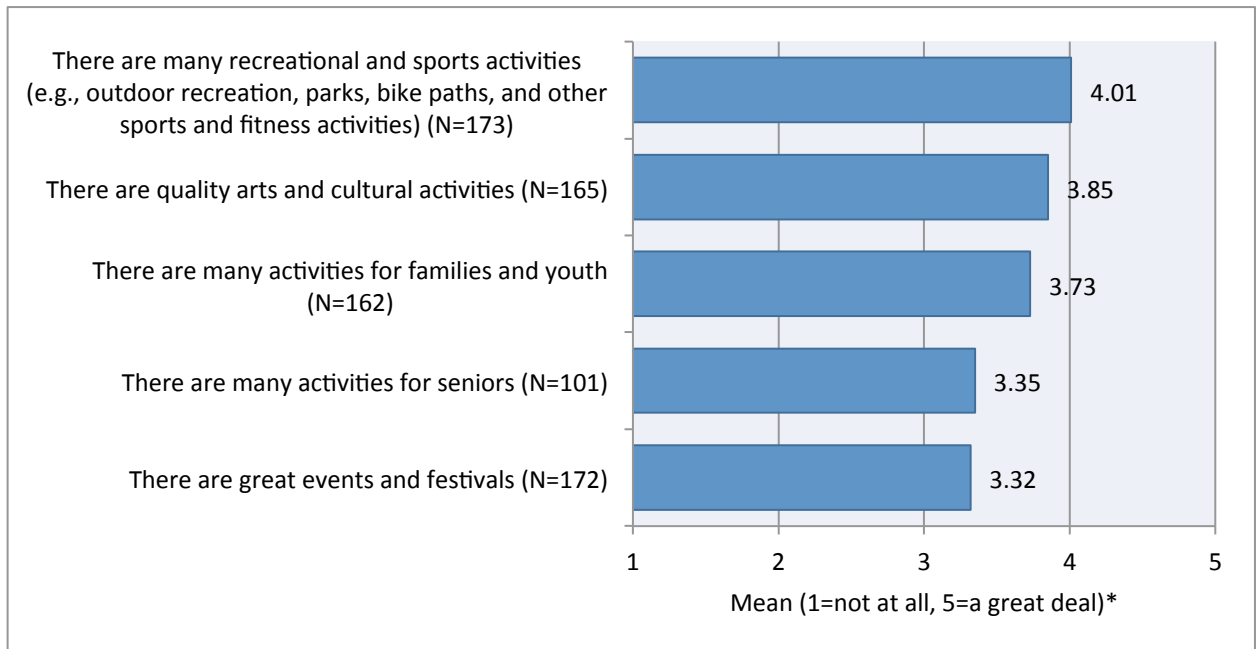
Figure 4. Level of agreement with statements about the community regarding the GEOGRAPHIC SETTING



Activities

Respondents had a high level of agreement that there are many recreational and sports activities as well as quality arts and cultural activities and activities for families and youth. Respondents also moderately agreed that there are activities for seniors and least of all great events and festivals in the community.

Figure 5. Level of agreement with statements about the community regarding ACTIVITIES



General Concerns about the Community

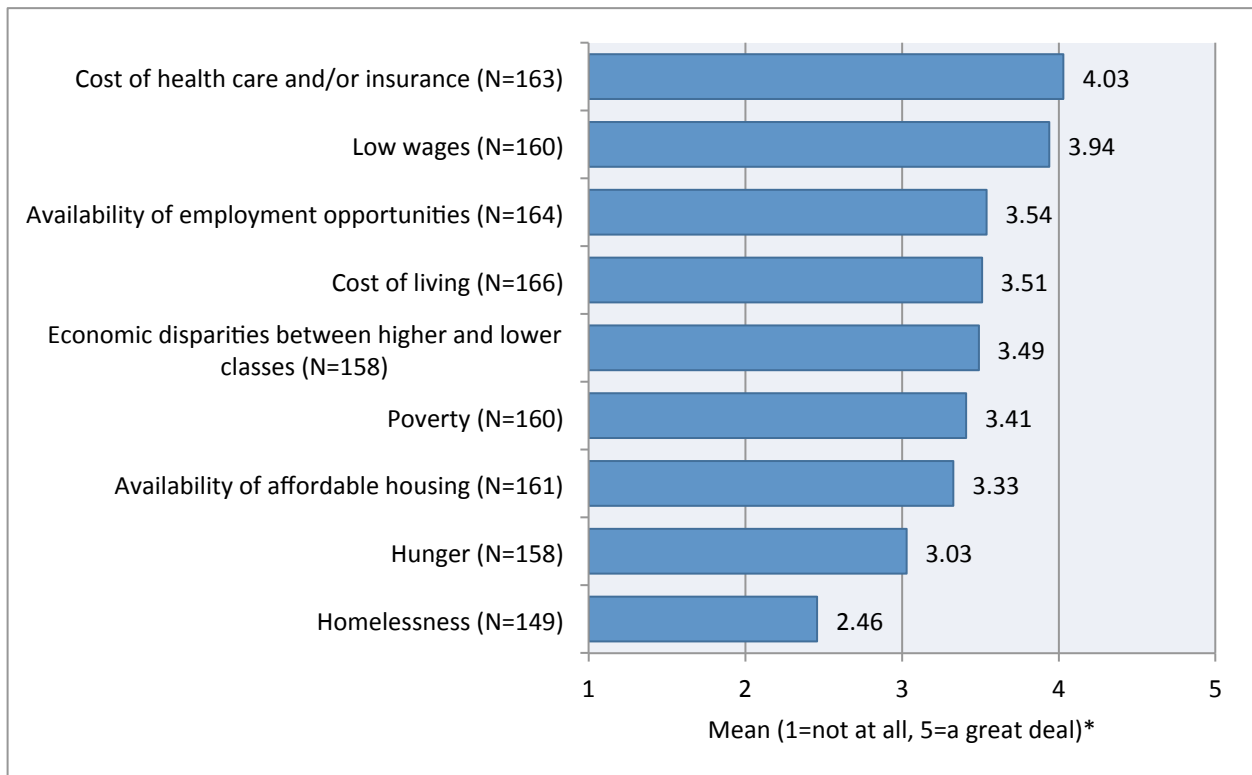
Using a 1 to 5 scale, with 1 being “not at all” and 5 being “a great deal,” respondents were asked to rate their level of concern with various statements regarding ECONOMIC ISSUES, TRANSPORTATION, ENVIRONMENT, CHILDREN AND YOUTH, THE AGING POPULATION, and SAFETY in their community.

Economic Issues

Overall, respondents had a moderate level of concern with economic issues in their community.

- On average, respondents were most concerned with the availability of cost of health care and/or insurance; low wages; cost of living; economic disparities between higher and lower classes, and poverty.
- Although still moderately concerned, on average respondents were least concerned with the homelessness in their community.

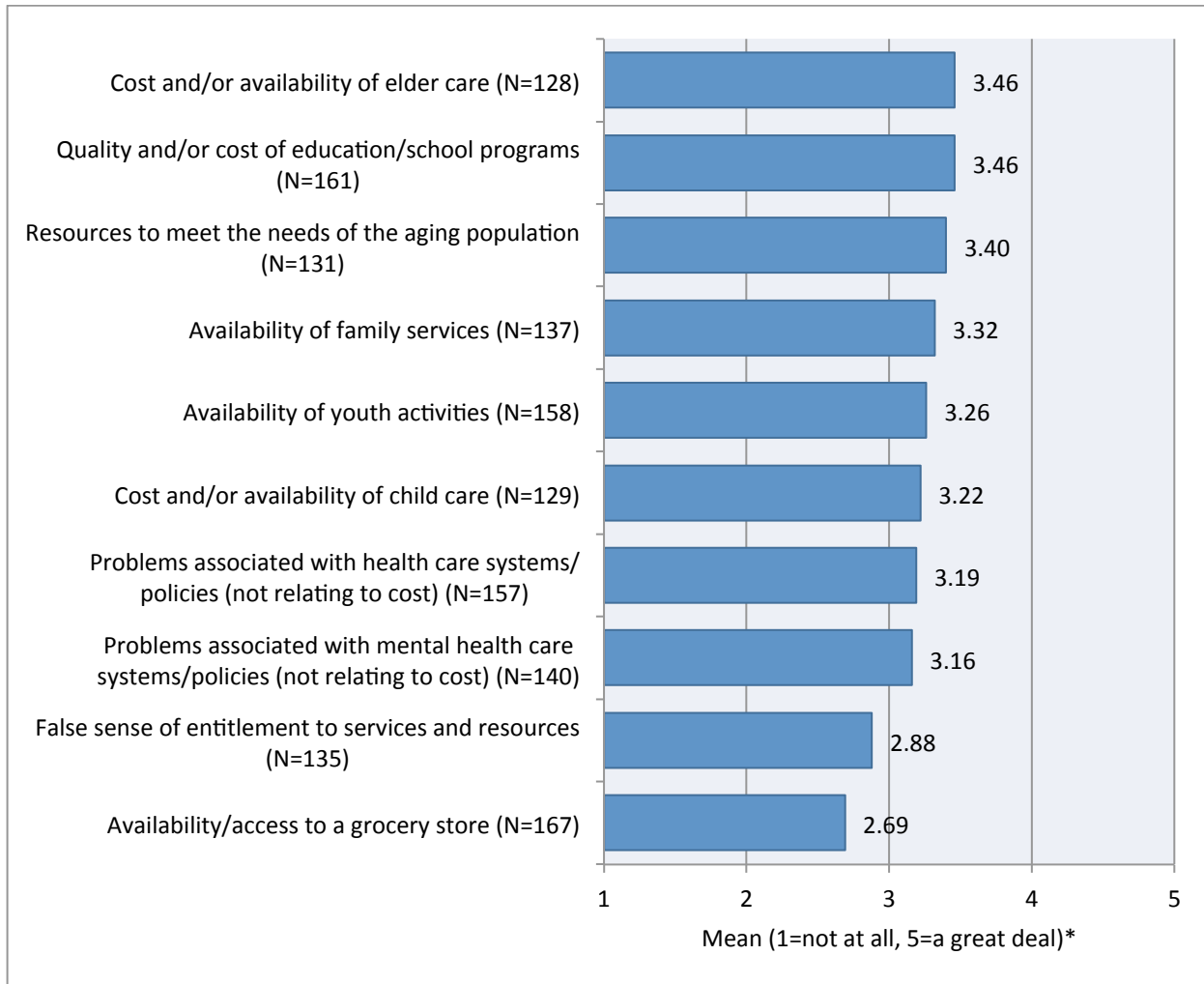
Figure 6. Level of concern with statements about the community regarding ECONOMIC ISSUES



Services and Resources

Respondents were most concerned with cost or availability of elder care; quality and/or cost of education or school programs; resources to meet the needs of the aging population and availability of family services. Respondents were least concerned with false sense of entitlement to services and resources and availability/access to grocery stores.

Figure 7. Level of concern with statements about the community regarding SERVICES AND RESOURCES



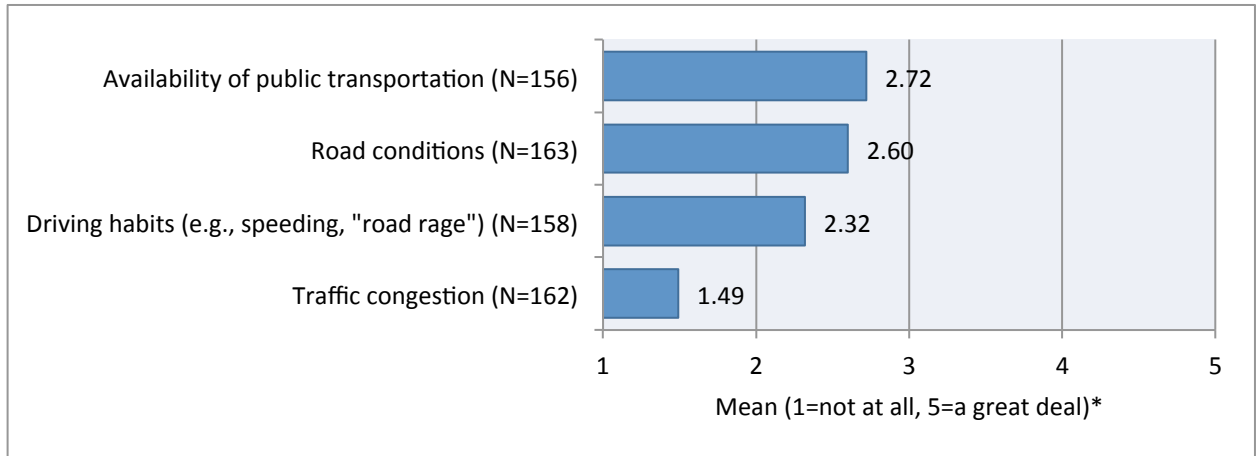
Transportation

Respondents were most concerned with availability of public transportation and least concerned with traffic congestion.

Overall, respondents had a low to moderate level of concern with transportation issues in their community.

- On average, respondents were most concerned with the availability of public transportation, road conditions and driving habits.
- On average, respondents were least concerned with traffic congestion.

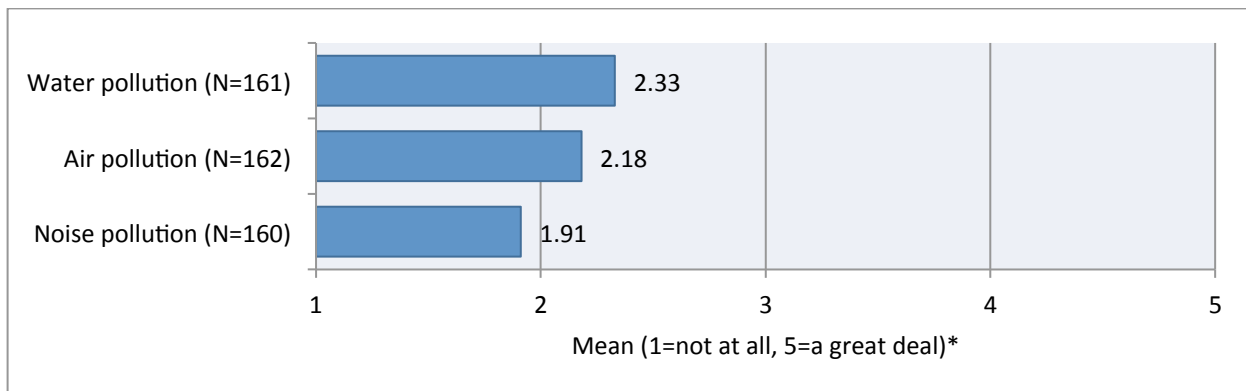
Figure 8. Level of concern with statements about the community regarding TRANSPORTATION



Environmental Pollution

Respondents reported a fairly low level of concern with environmental pollution in general. Water pollution was scored the highest, then air pollution, and of least concern was noise pollution.

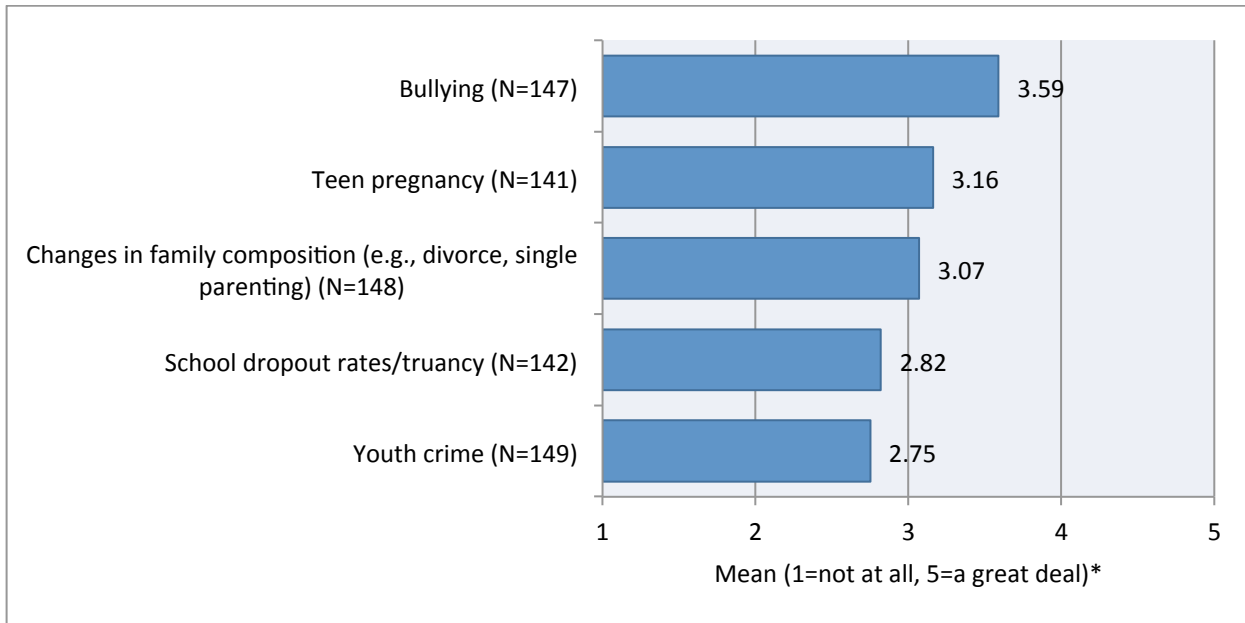
Figure 9. Level of concern with statements about the community regarding ENVIRONMENTAL POLLUTION



Youth Concerns

Respondents reported the most concerns regarding the youth in the community with bullying, teen pregnancy, and changes in family composition such as divorce. Respondents reported the least amount of concern with school dropout rates/truancy and youth crime in the community.

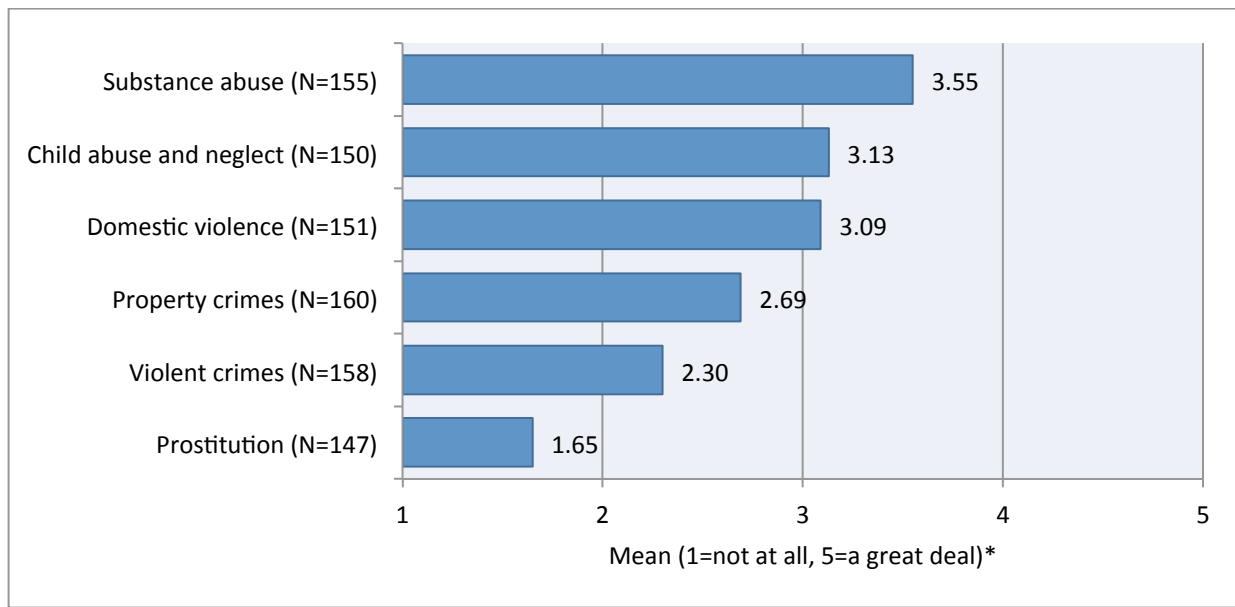
Figure 10. Level of concern with statements about the community regarding YOUTH CONCERNS



Safety

Respondents reported the most concern with substance abuse, child abuse/neglect, and domestic violence as far as the largest safety concerns in their community. The least areas of concern reported were property crimes, violent crimes and prostitution.

Figure 11. Level of concern with statements about the community regarding SAFETY CONCERNS



Community Health and Wellness Concerns

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 health and wellness issues with respect to access to health care, physical and mental health, and substance use and abuse.

The top six health and wellness concerns among community leaders were:

- Cost of health insurance
- Cost of health care
- Adequacy of health insurance
- Cost of prescription drugs
- Availability and/or cost of dental and/or vision insurance coverage
- Access to health insurance coverage

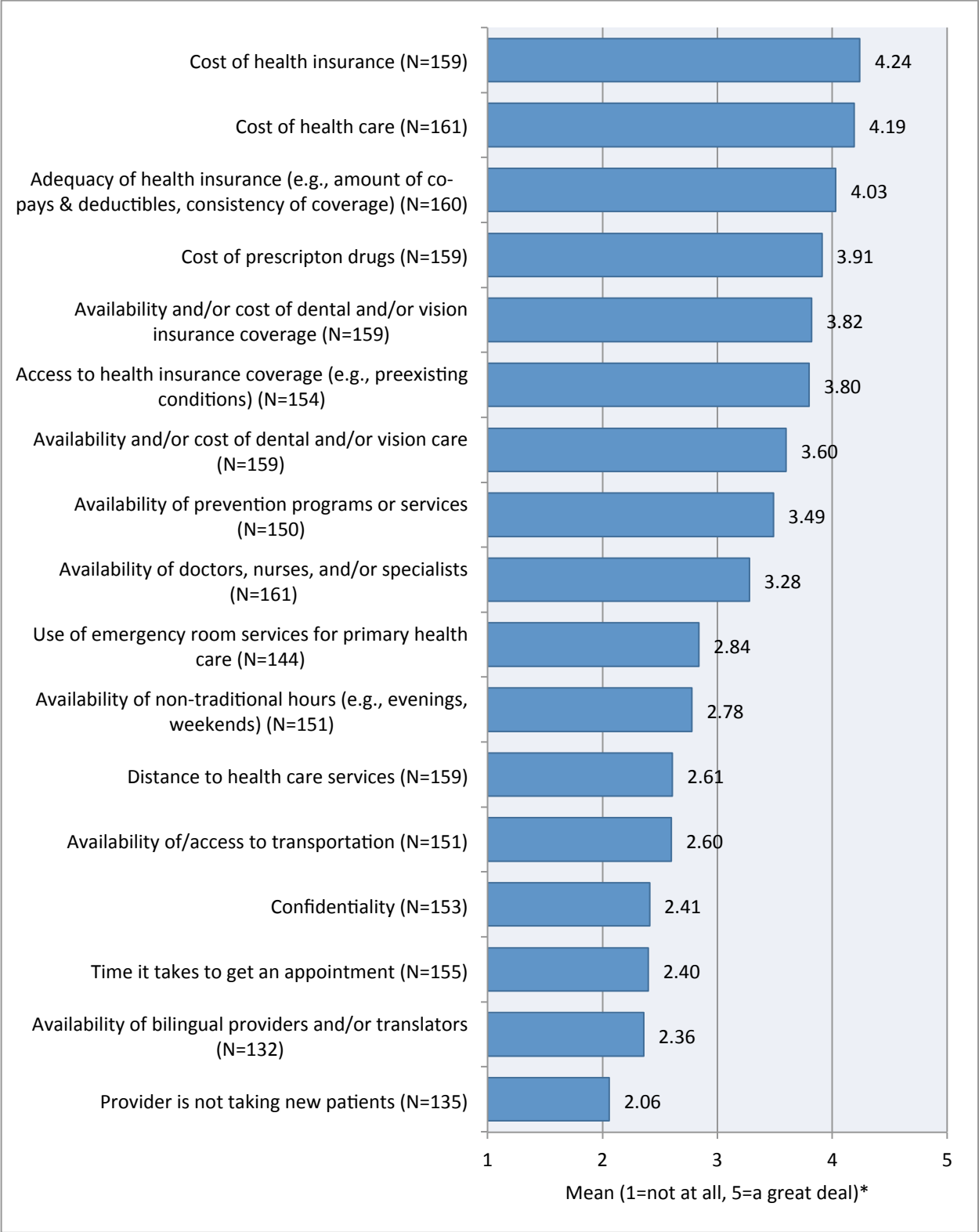
Access to Health Care

Respondents had high levels of concern with respect to cost and adequacy of health insurance associated with health and wellness in their community. Cost of health insurance, cost of health care, and adequacy of health insurance were the top three concerns.

Respondents also had concerns with respect to the cost of prescription drugs, availability and cost of dental and vision coverage, access to health insurance coverage, availability of prevention programs, availability of and cost

of dental and vision care, and availability of doctors, nurses and/or specialists, which were all well above average in level of concern. Respondents had below average levels of concern with availability of bilingual providers and interpreters and providers not taking new patients.

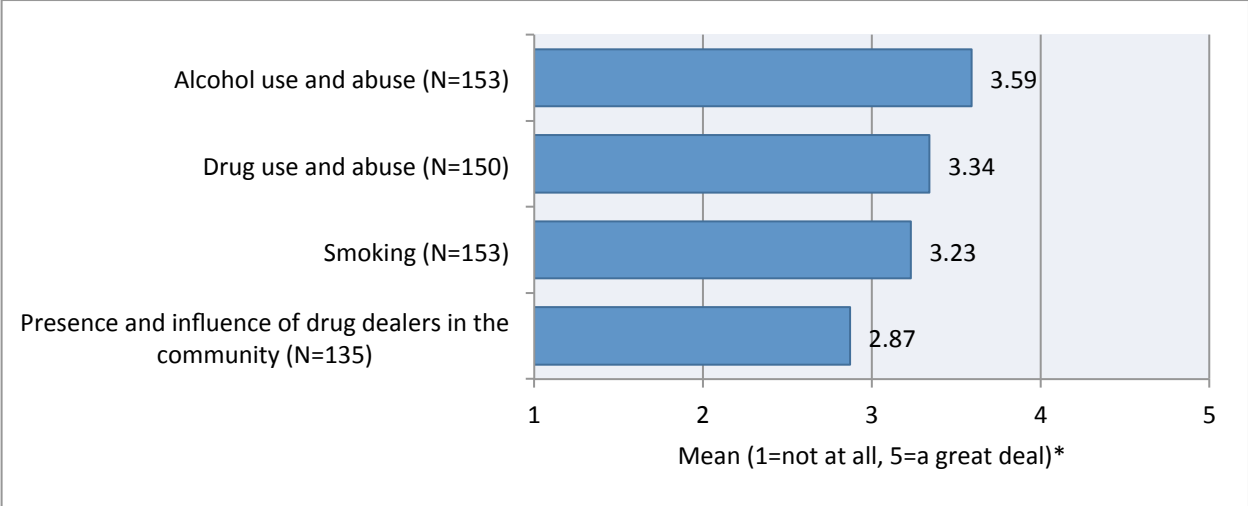
Figure 12. Level of concern with statements about the community regarding ACCESS TO HEALTH CARE



Substance Use and Abuse

The levels of concern among respondents regarding substance use and abuse issues in their community were moderately high. Respondents were most concerned about alcohol use and abuse. Respondents were least concerned about smoking and drug dealers in the community.

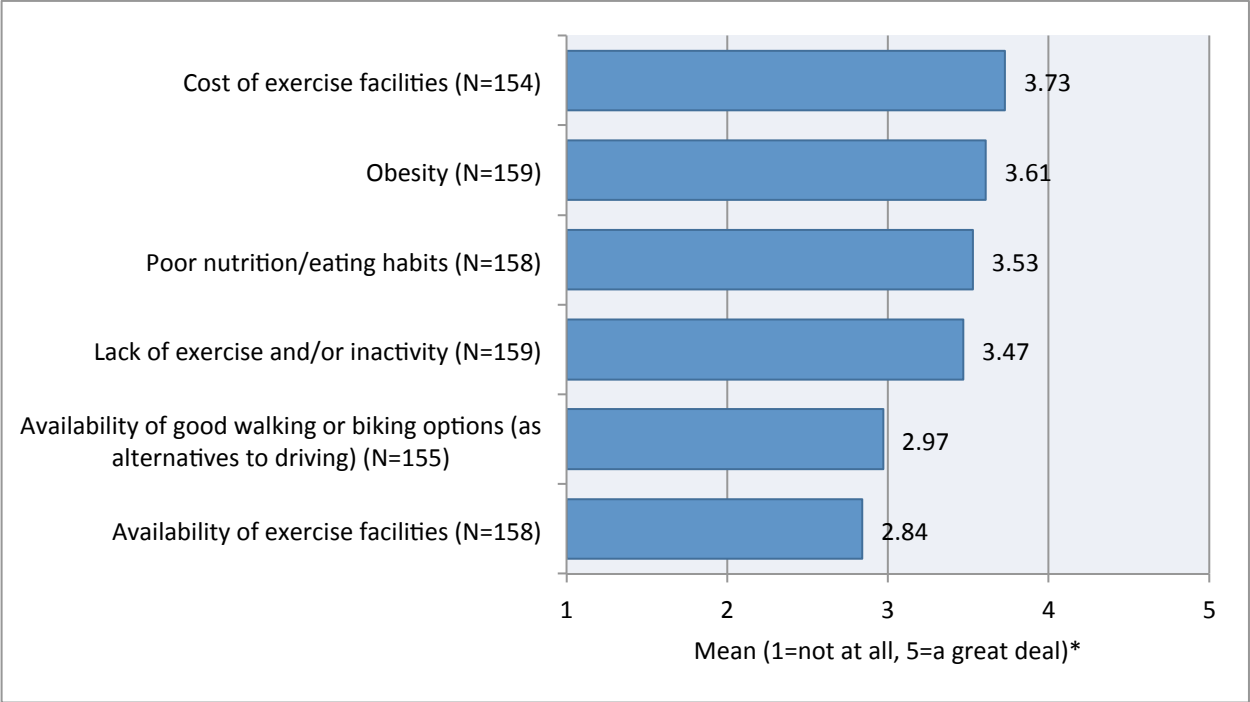
Figure 13. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



Physical Health

Regarding physical health issues, respondents had the highest levels of concern with respect to the cost of exercise facilities, obesity, poor nutrition and eating habits, and inactivity and lack of exercise. Respondents were least concerned with the availability of exercise facilities in the community.

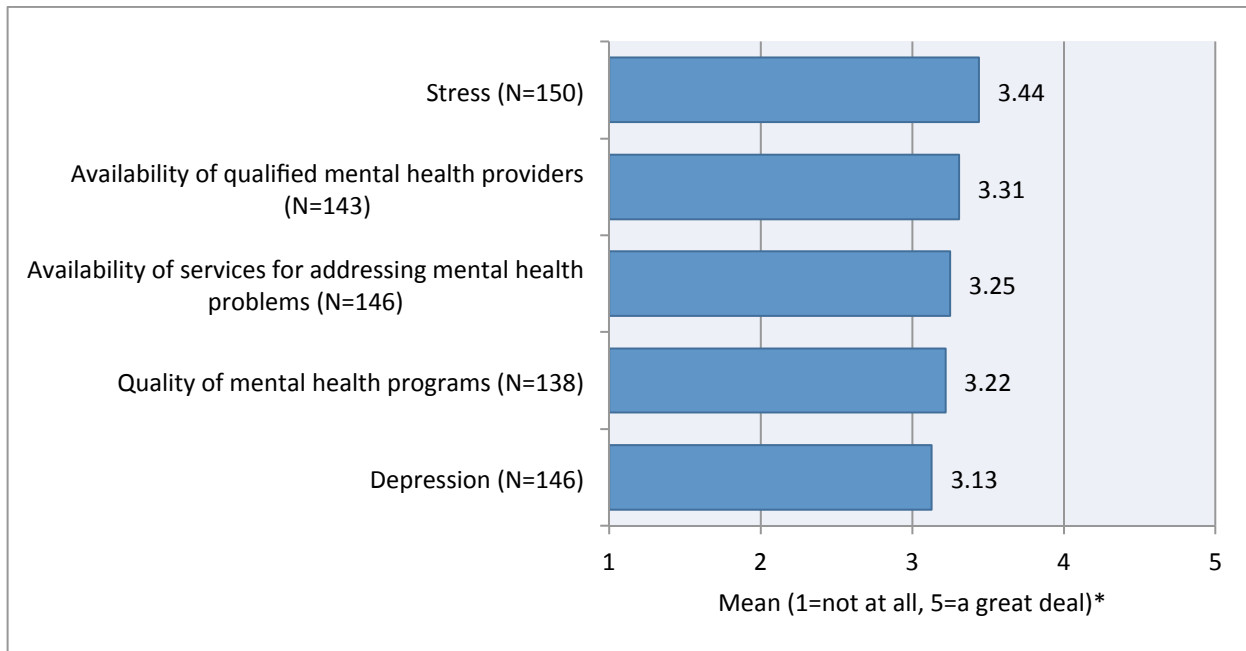
Figure 14. Level of concern with statements about the community regarding PHYSICAL HEALTH



Mental Health

For mental health issues, respondents reported the highest level of concern with regard to stress, availability of mental health providers, and availability of services for addressing mental health problems. Although still reporting a moderate amount of concern, the area with the least amount of concern was depression.

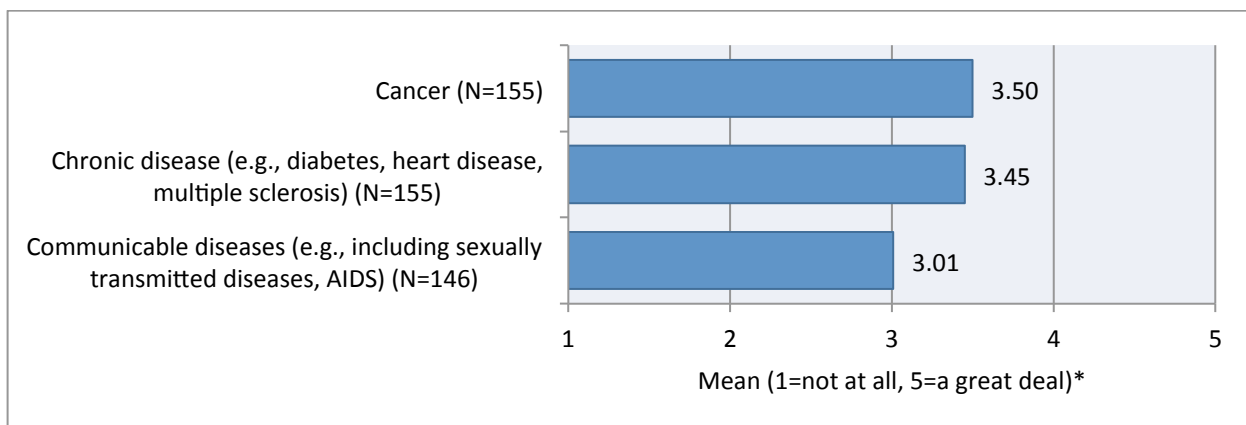
Figure 15. Level of concern with statements about the community regarding MENTAL HEALTH



Illness

Regarding concerns with illnesses, respondents reported the highest levels of concern with cancer and chronic diseases such as diabetes and heart disease. Although still moderately high, they reported the least amount of concern with communicable diseases such as sexually transmitted diseases.

Figure 16. Level of concern with statements about the community regarding ILLNESS



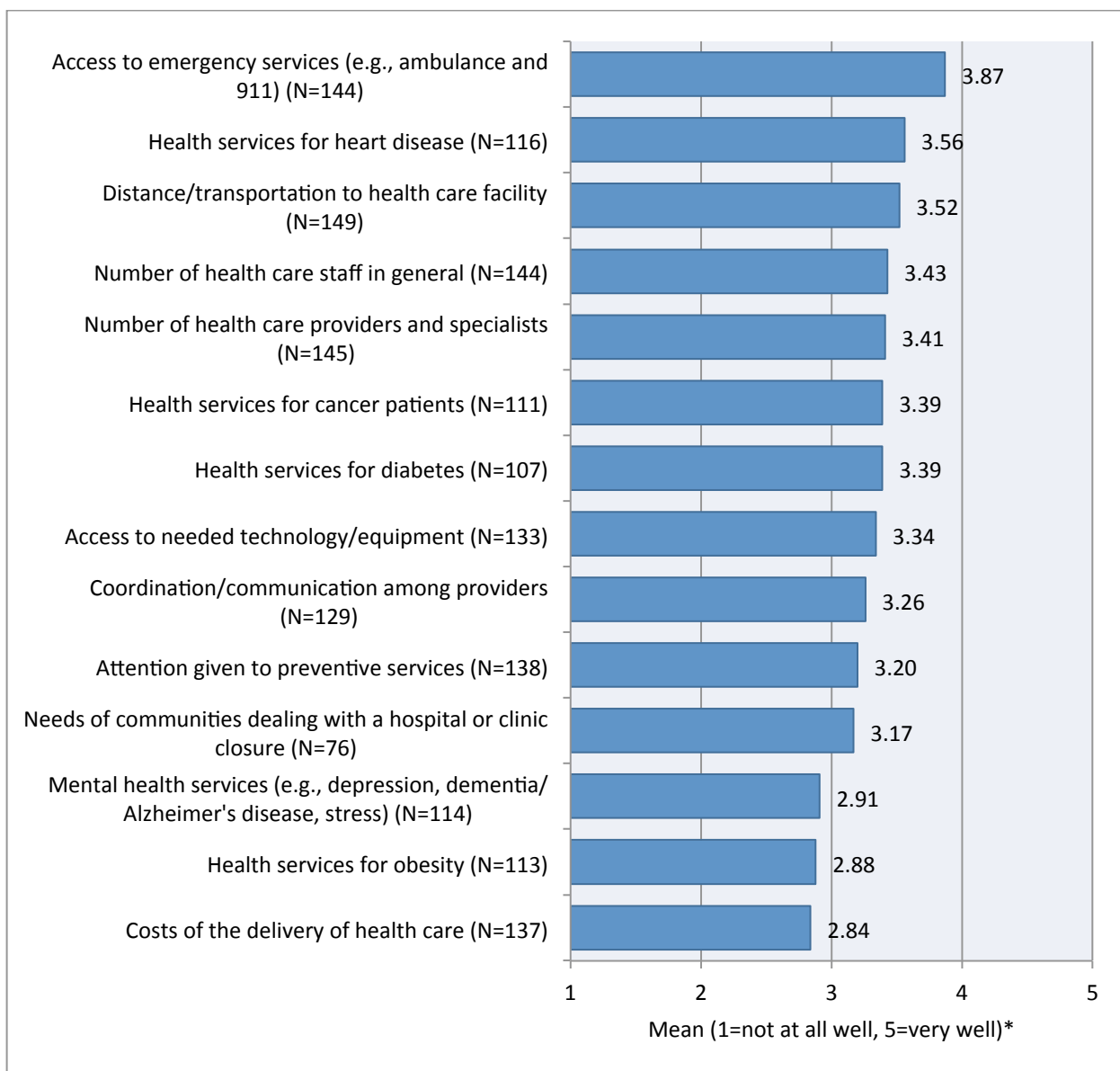
Delivery of Health Care in the Community

Using a 1 to 5 scale, with 1 being “not at all” and 5 being “a great deal,” respondents were asked to rate how well DELIVERY OF HEALTH CARE topics are being addressed in their community.

Respondents rated access to emergency services, health services for heart disease, distance/transportation to health care facility and the number of health care staff in general as well as providers and specialists the highest in their community.

The areas that scored the lowest as far as the delivery of health care were mental health services, health services for obesity and the costs of the delivery of health care.

Figure 17. How well topics related to DELIVERY OF HEALTH CARE in the community are being addressed



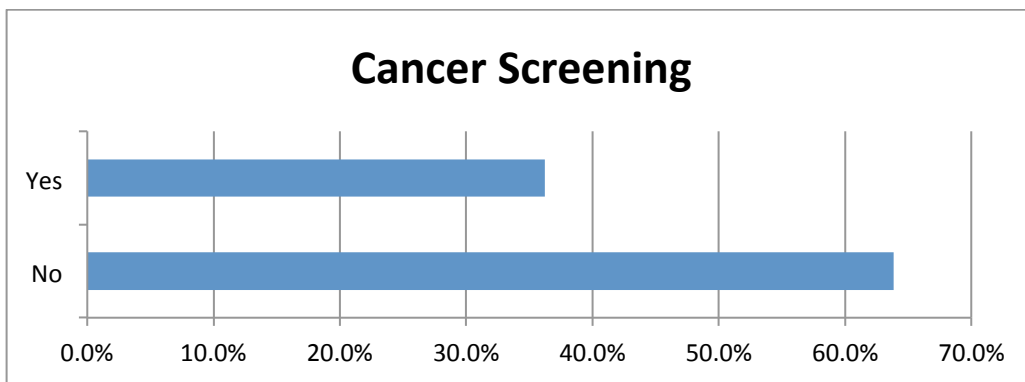
Personal Health Care Information

The top three reasons respondents gave for their choice of primary health care provider were location, quality of services, and availability of services.

More than half of the respondents said they had not had a cancer screening or cancer care in the past year. The most common reason for not having done so was because their doctor had not suggested it. "Not necessary" was also a reason respondents gave. Fear and unable to access/don't know who to see were the responses least given.

Respondents were asked whether they had a cancer screening or cancer care in the past year, and if they had not, reasons for not having done so.

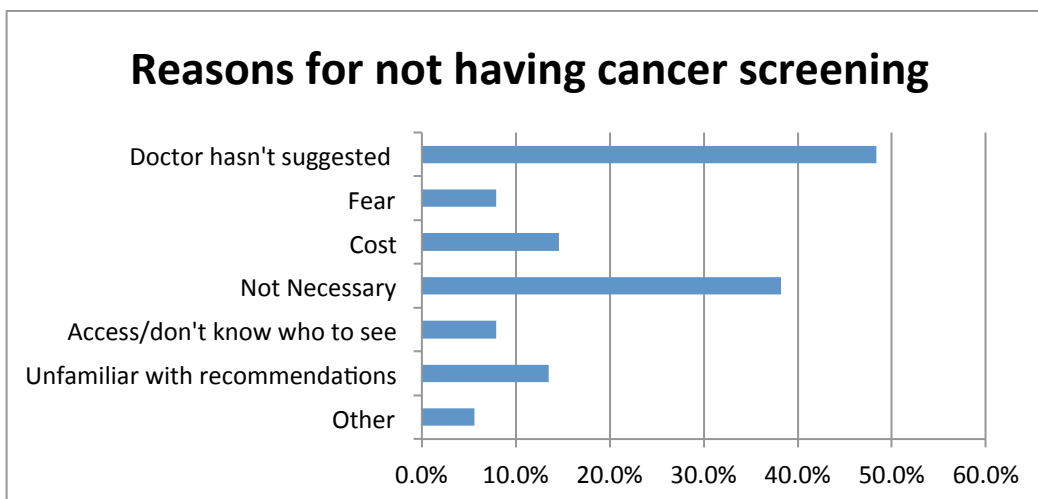
Figure 18. Whether respondents had a cancer screening or cancer in the past year



Cancer Screening

Among respondents who had not had a cancer screening or cancer care in the past year, 63.8% said their doctor had not suggested it.

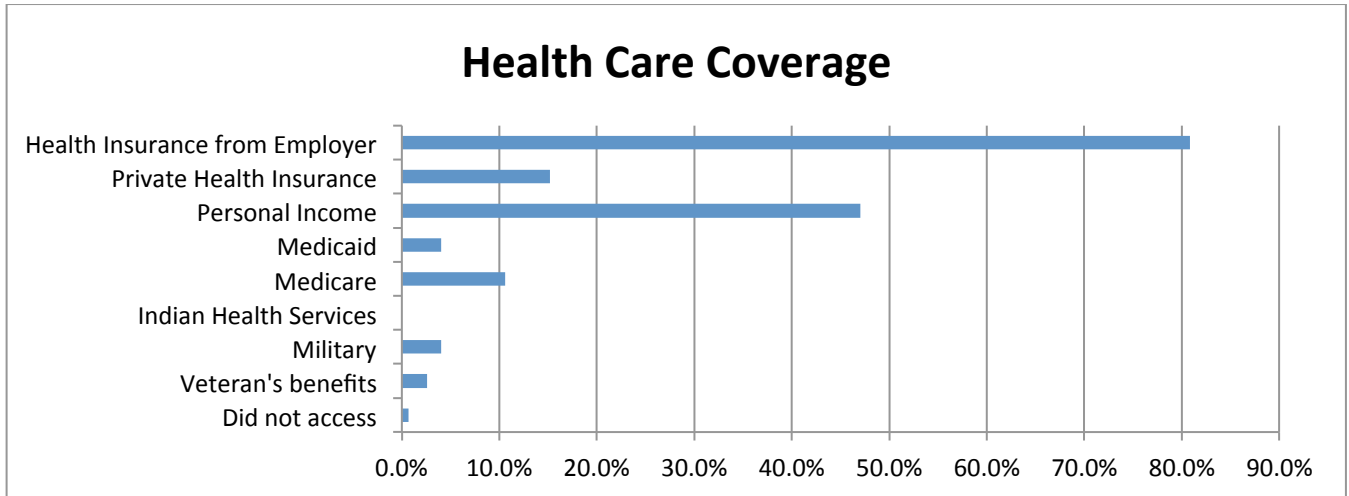
Figure 19. Among respondents who have not had a cancer screening or cancer care in the past year, reasons for not having done so



Health Care Coverage

Respondents were asked how they had paid for health care costs, for themselves or family members, over the last 12 months. A majority of respondents said they had paid for health care costs over the last 12 months by health insurance. Personal income and private health insurance were also used.

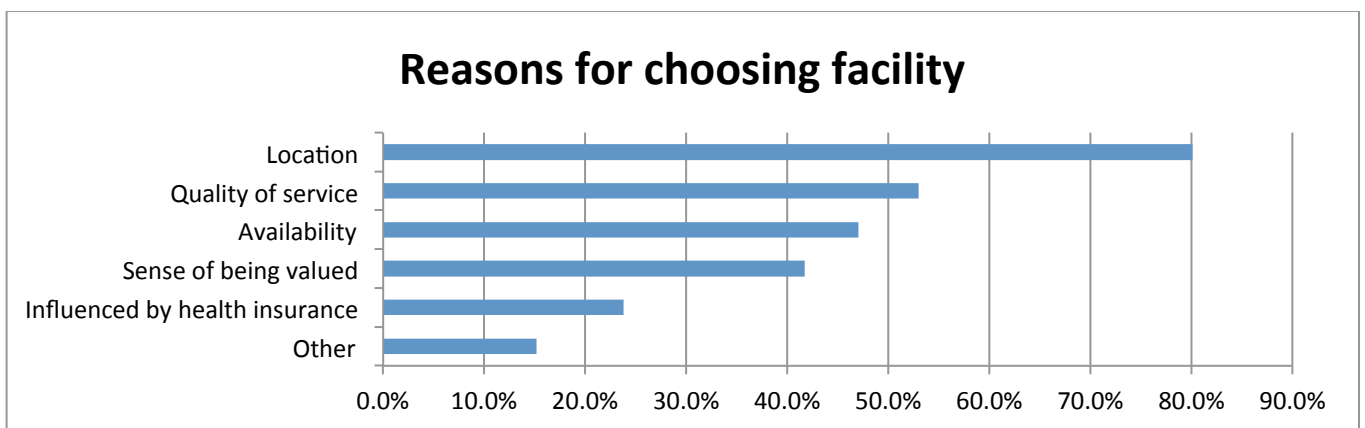
Figure 20. Methods respondents have used to pay for health care costs over the last 12 months



Primary Care Provider

The top reasons respondents gave for their choice of primary health care provider were quality of services, location, and availability of services and sense of being valued as a patient. One in four respondents said choosing their primary health care provider was influenced by their health insurance.

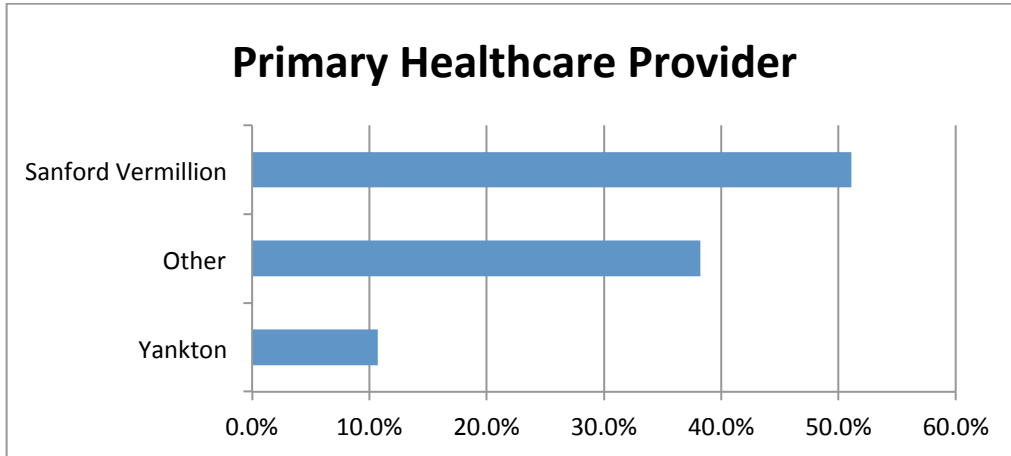
Figure 21. Respondents' reasons for choosing primary health care provider



Respondent's Primary Care Provider

Respondents were asked which provider they used for their primary health care. Sanford Vermillion was cited as respondent's primary care provider 51% versus Yankton or other area providers.

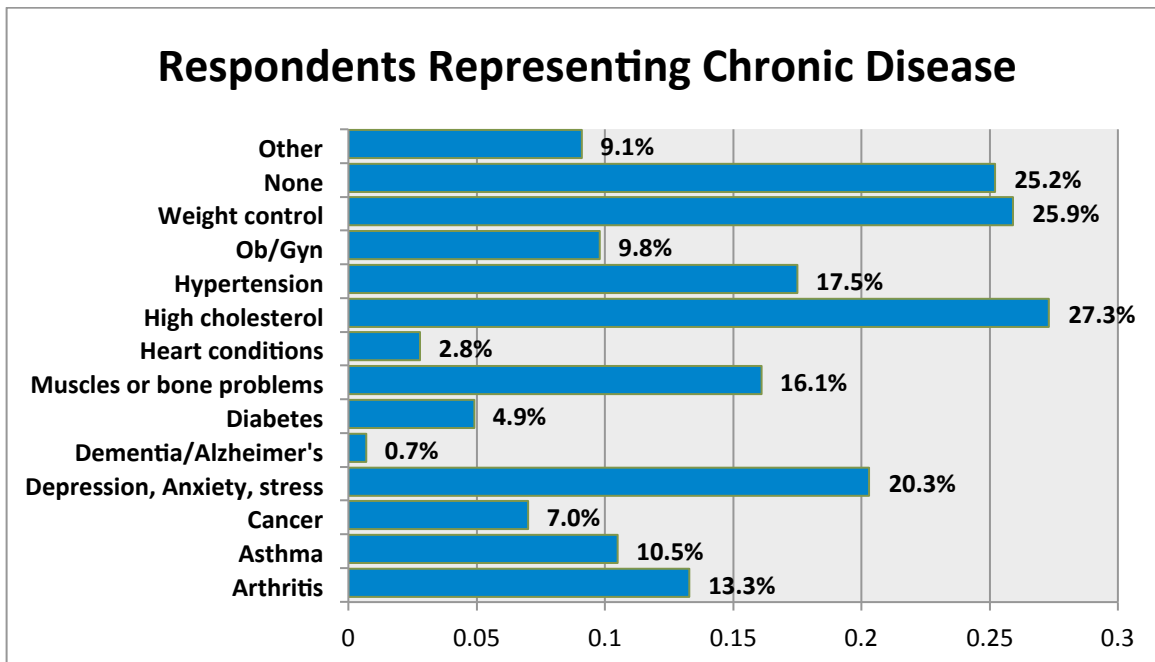
Figure 22. Primary Health Care Provider



Respondents Representing Chronic Disease

Respondents were asked to select their personal general health conditions/diseases. High cholesterol received the most responses with 27.3 % of participants selecting this condition. The chronic diseases found in the highest percentage of respondents include depression, anxiety, stress, hypertension and hypercholesterolemia.

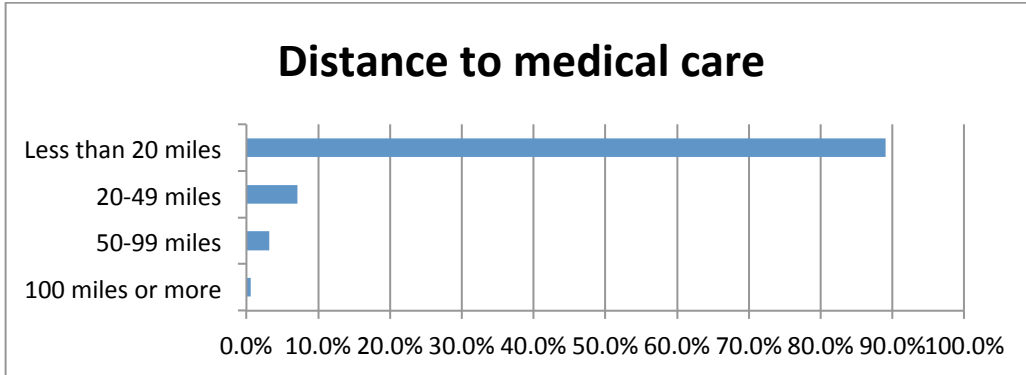
Figure 23. Respondent's health/chronic diseases



Distance to Access Medical Care

Respondents were asked how far they have to drive to access medical care. Almost 90% responded that they had less than 20 miles to drive. Only one person responded they had to drive 100 miles or more.

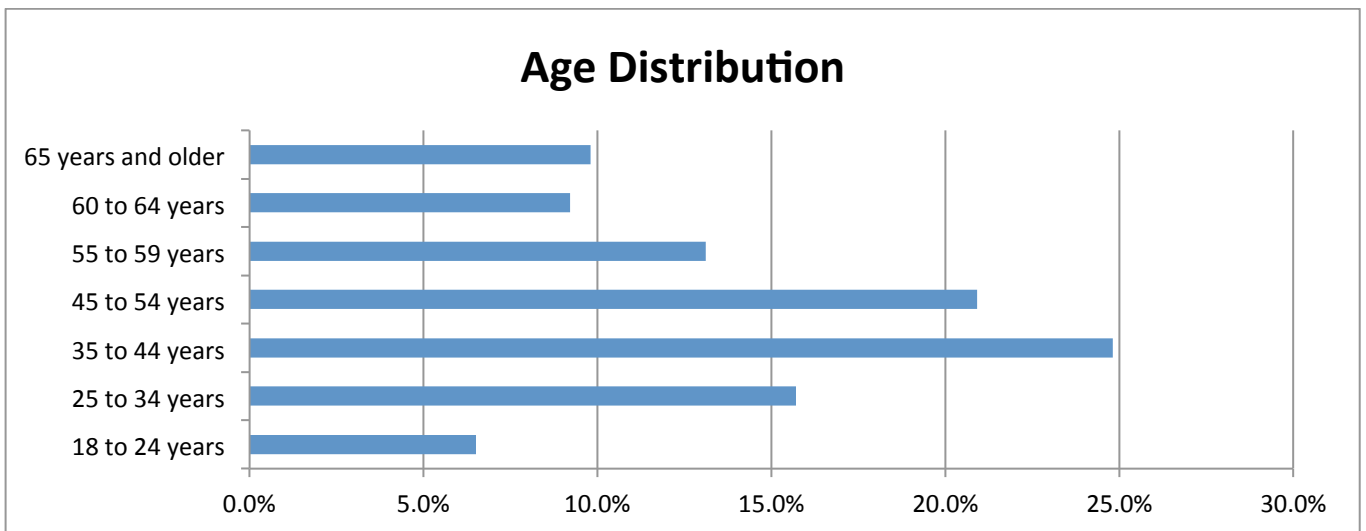
Figure 24. Distance traveled to access health care



Demographic Information

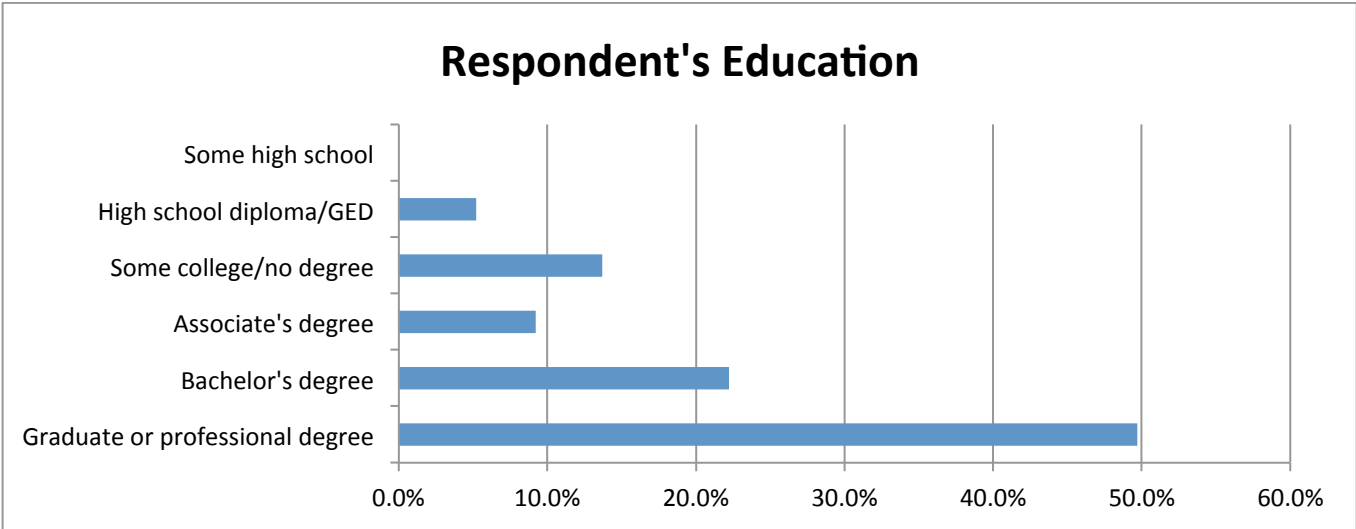
The majority of respondents (53.7%) are between the ages of 35 and 54. The next age groups that had the most respondents were the 25-34 year olds with 15.7%, and the 55-59 year olds with 13.1%.

Figure 25. Respondents' age distribution



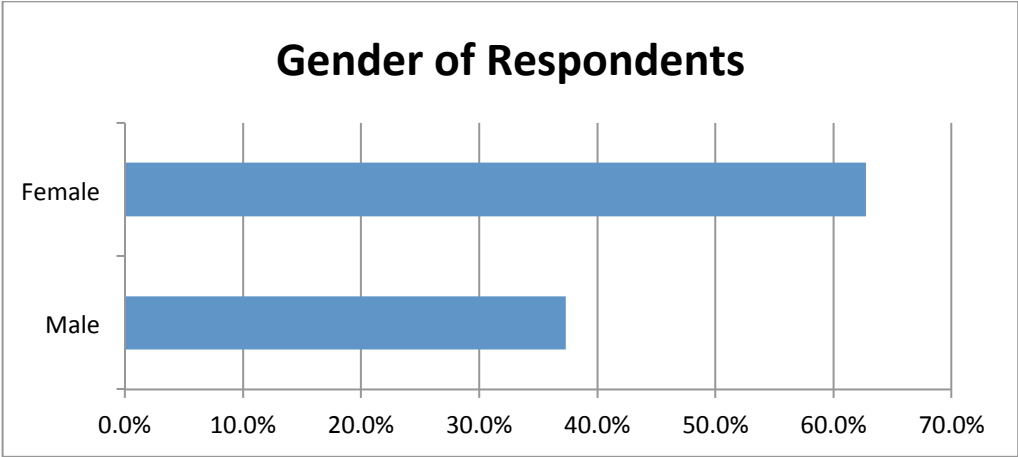
Most respondents (almost 72%) have a Bachelor's degree or higher. A Bachelor's degree was held by 22.2% of respondents and 49.7% have a graduate or professional degree.

Figure 26. Respondent's highest level of education attained



More females responded to the survey than males (37.3% males compared to 62.7% females).

Figure 27. Respondents by gender



Secondary Research

Sanford Vermillion Medical Center analyzed the 2011 County Profiles for Clay and Union counties and secured benchmarking data for the state of South Dakota and for the United States as a whole. The 2011 County Profiles are based largely on the County Health Rankings from the Mobilizing Action Toward Community Health (MATCH), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. State and national benchmarking required additional data sources, including the U.S. Census Bureau, Small Area Health Insurance Estimates, and the Centers for Disease Control and Prevention’s National Center for Health Statistics – the Health Indicators Warehouse. The County Profile Data is included in the Appendix.

Health Outcomes

Mortality

The Mortality health outcomes indicate that South Dakota as a state has more premature deaths than the national benchmark. While the state has more premature deaths than the national benchmark, Clay and Union counties in South Dakota have a lower rate than the national benchmark. Map 1 in the Appendix shows county views of mortality data for the five-state region.

		National Benchmark	South Dakota	Clay County	Union County
Premature death	Years of potential life lost before age 75 per 100,000 (age-adjusted), 2005-2007	5,564	6,815	5,927	4,239

Morbidity

The Morbidity health outcomes indicate that South Dakota citizens report more days of poor health than the national benchmark; however, Clay County reports less than the national benchmark and Union County reports less than the SD benchmark but higher than the national benchmark. South Dakota reports more physically unhealthy days than the national benchmark, while Clay and Union counties report a low percentage of poor health days.

South Dakota reports more mentally unhealthy days than the national benchmark, while Clay and Union counties reports fewer mental health days.

South Dakota has a higher percentage of low birth weight than the national benchmark, while Clay County is the same as the national benchmark and Union County is slightly lower than the SD benchmark but higher than the national benchmark. Maps 2-5 in the Appendix provide county views of the mortality and morbidity indicators for the five-state region.

		National Benchmark	South Dakota	Clay County	Union County
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	10%	12%	7%	11%
Poor physical health days	Average number of physical unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.6	2.8	2.4	2.2
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.3	2.6	2.2	1.9
Low birth weight	Percent of live births with low birth weight (<2,500 grams), 2001-2007	6.0%	6.8%	6.0%	6.7%

Health Factors

The Health Behavior outcomes indicate that South Dakota, Clay and Union counties have higher percentages of adult smokers than the national benchmark. Adult obesity is also higher in the state of South Dakota and Clay and Union counties than the national benchmark. South Dakota and Clay and Union Counties also have a higher percentage of physical inactivity than the national benchmark.

South Dakota and Clay and Union counties have a much higher percentage of binge drinking reports than the national benchmark (more than double). Motor vehicle crash death rates are nearly double the national benchmark in South Dakota; there is no county data available for Clay or Union county.

Sexually transmitted infections rank substantially higher than the national benchmark for South Dakota (371.3 vs. national benchmark of 83.0) and for Clay County (374.9). Union County is lower (99.1) but still above the national benchmark.

The teen birth rate is higher in South Dakota and Union County than the national benchmark, but is lower in Clay County. Maps 6-12 provide County views of the Health Behavior indicators for the five state region.

Health Behaviors

		National Benchmark	South Dakota	Clay County	Union County
Adult smoking	Percent of adults who currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	15%	20%	18%	17%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m ² , 2008	25%	29%	29%	30%
Physical inactivity	Percent of adults reporting no leisure physical activity, 2008	20%	26%	22%	24%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking, (consuming >4 for women and >5 for men on a single occasion) 2003-2009	8%	19%	21%	19%

		National Benchmark	South Dakota	Clay County	Union County
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	12.0	23.7	n/a	n/a
Sexually transmitted infections	Number of Chlamydia cases (new cases reported) per 100,000 population 2008	83.0	371.3	374.9	99.1
Teen birth rate	Number of teen births per 100,000 females ages 15-19, 2001-2007	22.0	38.7	9.2	24.7

Clinical Care

The Clinical Care outcomes indicate that South Dakota and Clay County have a higher percentage of uninsured adults than the national benchmark, while Union County has a lower percentage. The percentage of uninsured youth in Union County is the same as the national benchmark, but is higher in Clay County and South Dakota as a whole.

The ratio of population to primary care physicians is higher in South Dakota and Clay and Union counties than the national benchmark.

The ratio of population to mental health providers is higher in South Dakota and Union County than the national benchmark; however, Clay County's ratio is better than the national benchmark. The number of professionally active dentists is lower than the national benchmark in South Dakota and both Clay and Union counties. Preventable hospital stays are higher than the national benchmark in South Dakota and both Clay and Union counties.

Diabetes screening in South Dakota and in Union County is just slightly lower than the national benchmark; no data is available for Clay County.

Although the percentage of South Dakotans who received mammography screenings was lower than the national benchmark, both Clay and Union counties were above the national benchmark. Maps 13-30 in the Appendix provide county views of the Clinical Care Indicators for the five-state region.

		National Benchmark	South Dakota	Clay County	Union County
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	13%	16%	24%	12%
Uninsured youth	Percent of youth ages 0-18 without health insurance.	7%	9%	10%	7%
Primary Care Physicians	Ratio of population to primary care physicians, 2008	631:1	769:1	850:1	946:1
Mental Health Providers	Ratio of total population to mental health providers, 2008	2,242:1	3,544:1	850:1	7,095:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	69.0	50.0	51.5	35.4

		National Benchmark	South Dakota	Clay County	Union County
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	52.0	68.6	60.4	67.4
Diabetes screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening, 2006-2007	89%	83%	n/a	88%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	74%	68%	84%	78%

Social and Economic Factors

The Social and Economic factor outcomes indicate that South Dakota and Clay and Union counties all have a lower high school graduation rate than the national benchmark, and while South Dakota has a lower percentage of post secondary education than the national benchmark, both Clay and Union counties have a higher percentage.

The unemployment rate was lower in South Dakota and Clay County but higher in Union County than the national benchmark.

The percentage of child poverty is substantially higher in South Dakota and Clay County than the national benchmark; however, Union County is below the national benchmark.

Inadequate social support is higher in South Dakota and Union County but is lower in Clay County than the national benchmark.

The percentage of children in single parent households is higher than the national benchmark in South Dakota but lower in both Clay and Union counties.

The number of homicide deaths in South Dakota is higher than the national benchmark; the number is not available for Clay or Union County. Maps 21-27 in the Appendix provide county views of the Social and Economic indicators for the five-state region.

		National Benchmark	South Dakota	Clay County	Union County
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years 2006-2007	92%	83%	85%	80%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	68%	64%	86%	71%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work 2009	5.3%	4.8%	3.9%	5.9%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	11%	18%	18%	7%

		National Benchmark	South Dakota	Clay County	Union County
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	14%	17%	9%	16%
Children in single parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	20%	29%	11%	18%
Homicide rates	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	1.0	2.5	NA	NA

Physical Environment Outcomes

The Physical Environment outcomes indicate that there was an benchmark of one day of air pollution from particulate matter for both Clay and Union Counties; both SD and the national benchmark was zero. There were no days of ozone pollution in Clay or Union County nor SD or national benchmark. Access to healthy food is ranked far below the national benchmark. There can be a far distance to travel to grocery stores, and there are rural areas in some communities where only a gas station convenience store is close to home.

Access to recreational facilities ranks lower than the national benchmark for South Dakota and Clay and Union counties.

Maps 28-31 in the Appendix provide county views of the Physical and Environment outcome indicators for the five-state region.

		National Benchmark	South Dakota	Clay County	Union County
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	0	0	1	1
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e. grocery store or produce stand/farmers market), 2008	92%	42%	25%	60%
Access to recreational facilities	Number of recreational facilities per 100,000 population 2008	17.0	13.0	15.0	14.0

Demographics

Youth account for 17% of the population in Clay County and 25% of the population in Union County. Elderly account for 11% of the population in Clay County and for 14% of the population in Union County.

Twenty-five percent (25%) of Clay County is rural compared to 48% of South Dakota and 21% as the national benchmark. Seventy-two percent (72%) of Union County is rural.

Only 2% of South Dakotans, 2% of Clay County, and 1% of Union County population is not proficient in English compared to the national benchmark of 9%.

South Dakota's illiteracy rate is 7% and both Clay and Union Counties are at 6%, compared to the national benchmark of 15%. Maps 32-36 in the Appendix provide county views of the demographics within Clay and Union counties.

		National Benchmark	South Dakota	Clay County	Union County
Youth	Percent of total population ages 0-17, 2009	24%	25%	17%	25%
Elderly	Percent of total population ages 65 and older, 2009	13%	14%	11%	14%
Rural	Percent of total population living in rural area, 2000	21%	48%	25%	72%
Not English Proficient	Percent of total population that speaks English less than "very well". 2005-2009	9%	2%	2%	1%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	15%	7%	6%	6%

Population by Age

The population for this area is relatively young with only 2% older than 85 years of age, and only 10% older than 65 years of age in Clay County. Fourteen percent (14%) of South Dakotans are older than 65 years of age and only 2% are older than 85 years of age.

The gender distribution is 49% Male - 51% Female in Clay County, 50%-50% for Union County and 50% - 50% for the state of South Dakota.

	National Benchmark	South Dakota	Clay County	Union County
Total population	308,745,538	814,180	13,864	14,399
Percent ages 65 and older	13%	14%	10%	14.4%
Percent 85 and older	2%	2%	2%	n/a
Percent male	49%	50%	49%	50.4%
Percent female	51%	50%	51%	49.6%

Based on 2010 Census data

Housing

The majority of individuals in these counties own their homes with the largest percentage of home ownership in Union County with 74%, then Clay County at 53%, with 68% of South Dakotans own their own home.

	National Benchmark	South Dakota	Clay	Union County
Percent of occupied housing that is owner-occupied	65%	74%	53%	74%
Percent of occupied housing that is renter-occupied	35%	26%	47%	26%

Based on 2010 Census data

Economic Security

According to the 2010 Census Data, the population of working age in the labor force is 65% in Clay County and 69% in South Dakota. The percentage of those who are living at less than 100% of the poverty level is 14% in South Dakota and 24% in Clay County. In South Dakota, 33% are at less than 200% of the poverty level and in Clay County it's 41%.

The median annual household income in South Dakota is \$46,369, Clay County is at \$37,198, and Union County is \$63,773.

	National Benchmark	South Dakota	Clay County	Union County
Percent of working age population in the labor force	65%	69%	65%	%
Percent of total population with income less than 100% of poverty	14%	14%	24%	%
Percent of total population with income less than 200% of poverty	32%	33%	41%	%
Median household income	\$51,914	\$46,369	\$37,198	\$63,773
Owner occupied housing units	76,089,650	217,250	2,890	
Percent spending 30% or more income toward housing costs	30%	20%	22%	
Renter occupied housing units	38,146,346	98,218	2,046	
Percent renters spending 30% or more of income toward housing costs	47%	35%	48%	

Diversity Profile

The population distribution by race demonstrates that South Dakota is predominantly white, followed by American Indian alone, then Hispanic origin of any race, and Black alone. The Asian population ranks fifth in South Dakota.

In Clay County the ranking is White, American Indian, Hispanic, Asian, and Black, while in Union County the ranking is White, Hispanic, Asian, Black and American Indian.

	National Benchmark	South Dakota	Clay County	Union County
Total population	308,745,538	814,180	13,864	14,399
White alone	223,553,265	699,392	12,637	13758
Asian alone	14,674,252	7,610	429	129
Black alone	38,929,319	10,207	185	95
Hispanic origin – of any race	50,477,594	22,119	277	305
American Indian	2,932,248	71,817	429	80

Health Needs Identified

The health needs from the surveys and analysis of secondary data indicated the following:

- Mental Health Services
- Outreach Specialty Care Services

Community/Assets/Prioritization Process

A review of the primary and secondary research concerns was conducted followed by an asset mapping exercise to determine what resources were available to address the needs. An informal gap analysis was conducted at the conclusion of the asset mapping work.

Table 1 in the Appendix, Asset Map, displays the concerns and assessed needs that were determined by the assessment and includes the assets in the community that address the needs.

The priorities that remain include:

- Urgent Care hours
- Services for the elderly
- Mental health services
- Outreach specialty provider services

Table 2 in the Appendix, Prioritization Worksheet, displays the unmet needs that were determined after the asset mapping exercise and the prioritized list of remaining needs.

The Sanford Vermillion Steering Committee used multi-voting to prioritize the unmet needs to determine two issues to work on Implementation Strategies. The two that were chosen by the Steering Committee through this process were:

- Mental Health Services
- Outreach Specialty Provider Services

Implementation strategies were outlined to specifically address Mental Health Services and Outreach Specialty Services in the Vermillion community. Sanford Health is also working on implementing a strategy that we will follow for Mental Health Services. See Implementation Strategy section.

IMPLEMENTATION STRATEGY

2013 Community Health Needs Assessment

Vermillion Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process for Sanford Vermillion:

- Recruitment plan – Outreach Specialty Services
- Mental Health Services

Implementation Strategy: Mental Health Services

- Implement Sanford One Mind/One Care based on the Enterprise Implementation Strategy
- Identify and utilize internal resources already available through on staff MSW, CSW-PIP
- Look at expansion of Employee Assistance Programs already available in the community
- Collaborate with other Mental Health providers in the community to look at options for expansion of services (e.g. some only work 4 days/wk, etc.)
- Utilize current Clinic Health Care Coach and future Psychologist position to expand clinic Mental Health Services to patients

Implementation Strategy: Outreach Provider Services

- Continue to work with Sanford Health and other Outreach Providers to determine the viability of additional outreach services for SVMC
- Continue development of telehealth services and capabilities to provide outreach services to patients at SVMC

2013 Community Health Needs Assessment Enterprise Implementation Strategy

The following unmet needs were identified through a formal community health needs assessment, resource mapping and prioritization process:

- Mental Health Services
- Obesity

Implementation Strategy: Mental Health Services - Sanford One Mind

- Completion (to the extent resources allow) of full integration of Behavioral Health services in all primary care clinics in Fargo and Sioux Falls
- Completion (to the extent resources allow) of full integration of Behavioral Health services or access to Behavioral Health outreach in all regional clinic sites in the North, South and Bemidji regions
- Complete presentation of outcomes of first three years of integrated Behavioral Health services
- Implementation of integrated Behavioral Health into clinics in new regions
- Design Team for Inpatient Psychiatric Unit, Partial Hospitalization and Clinic Space for Fargo presents recommendations for design of new spaces
- Design Team for Sioux Falls Inpatient Psychiatric Units and Partial Hospitalization

Implementation Strategy: Obesity

- Medical Management for Obesity
 - Develop CME curriculum for providers and interdisciplinary teams across the enterprise inclusive of medical, nutrition, nursing, and Behavioral Health professionals
- Develop community education programming
 - Include the following program options in the curriculum to create awareness of existing resources:
 - Family Wellness Center
 - Honor Your Health Program
 - WebMD Fit Program
 - Bariatric Services
 - Eating Disorder Institute
 - Mental Health/Behavioral Health
 - Profile
- Actively participate in community initiatives to address wellness, fitness and healthy living

APPENDIX

2011 County Health Profile

An adaptation of the County Health Rankings Project for the Fargo-Moorhead Community Health Needs Assessment Collaborative

Clay County

South Dakota

HEALTH OUTCOMES		Clay	*National Benchmark	South Dakota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	5,927	5,564	6,815
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	7%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.4	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.2	2.3	2.6
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.0%	6.0%	6.8%
HEALTH FACTORS				
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	18%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m2, 2008	29%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	22%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	21%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	374.9	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	9.2	22.0	38.7
<i>Clinical Care</i>				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	24%	13%	16%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	10%	7%	9%
Primary care physicians	Ratio of total population to primary care physicians, 2008	850:1	631:1	769:1
Mental health providers	Ratio of total population to mental health providers, 2008	850:1	2,242:1	3,544:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	51.5	69.0	50.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	60.4	52.0	68.6
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	-	89%	83%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	84%	74%	68%

HEALTH FACTORS (continued)		Clay	*National Benchmark	South Dakota
<i>Social and Economic Factors</i>				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	85%	92%	83%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	86%	68%	64%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	3.9%	5.3%	4.8%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	18%	11%	18%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	9%	14%	17%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	11%	20%	29%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5
<i>Physical Environment</i>				
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	1	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	25%	92%	42%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	15.0	17.0	13.0
<i>Demographics</i>		Clay	United States	South Dakota
Youth	Percent of total population ages 0-17, 2009	17%	24%	25%
Elderly	Percent of total population ages 65 and older, 2009	11%	13%	14%
Rural	Percent of total population living in a rural area, 2000	25%	21%	48%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	2%	9%	2%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	6%	15%	7%

*The national benchmark is the 90th percentile (i.e., 10% of counties nationwide ranked better). **Binge drinking is defined as consuming more than 4 (for women) or 5 (for men) alcoholic beverages on a single occasion in the past 30 days. Heavy drinking is defined as drinking more than 1 (for women) or 2 (for men) alcoholic beverages per day on average. - Blank values reflect unreliable or missing data.

Source: The overall format and content of the County Health Profiles is based largely on County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>. Additional data sources include the U.S. Census Bureau, Small Area Health Insurance Estimates, <http://www.census.gov/sahie/> and the Centers for Disease Control and Prevention's National Center for Health Statistics - the Health Indicators Warehouse, <http://healthindicators.gov> and "Health, United States, 2010," Table 109, <http://www.cdc.gov/nchs/hus.htm>.

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2011 County Health Profile

Union County

An adaptation of the County Health Rankings Project for the Fargo-Moorhead
Community Health Needs Assessment Collaborative

South Dakota

HEALTH OUTCOMES		Union	*National Benchmark	South Dakota
<i>Mortality</i>				
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007	4,239	5,564	6,815
<i>Morbidity</i>				
Poor or fair health	Percent of adults reporting fair or poor health (age-adjusted), 2003-2009	11%	10%	12%
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009	2.2	2.6	2.8
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009	1.9	2.3	2.6
Low birthweight	Percent of live births with low birthweight (<2,500 grams), 2001-2007	6.7%	6.0%	6.8%
HEALTH FACTORS				
<i>Health Behaviors</i>				
Adult smoking	Percent of adults that currently smoke and have smoked at least 100 cigarettes in their lifetime, 2003-2009	17%	15%	20%
Adult obesity	Percent of adults that report a body mass index (BMI) of at least 30 kg/m ² , 2008	30%	25%	29%
Physical inactivity	Percent of adults reporting no leisure time physical activity, 2008	24%	20%	26%
Excessive drinking	Percent of adults reporting binge drinking and heavy drinking**, 2003-2009	19%	8%	19%
Motor vehicle crash death rate	Motor vehicle crash deaths per 100,000 population, 2001-2007	-	12.0	23.7
Sexually transmitted infections	Number of chlamydia cases (new cases reported) per 100,000 population, 2008	99.1	83.0	371.3
Teen birth rate	Number of teen births per 1,000 females ages 15-19, 2001-2007	24.7	22.0	38.7
<i>Clinical Care</i>				
Uninsured adults	Percent of adult population ages 18-64 without health insurance, 2007	12%	13%	16%
Uninsured youth	Percent of youth ages 0-18 without health insurance, 2007	7%	7%	9%
Primary care physicians	Ratio of total population to primary care physicians, 2008	946:1	631:1	769:1
Mental health providers	Ratio of total population to mental health providers, 2008	7,095:1	2,242:1	3,544:1
Dentist rate	Number of professionally active dentists per 100,000 population, 2007	35.4	69.0	50.0
Preventable hospital stays	Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007	67.4	52.0	68.6
Diabetic screening	Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007	88%	89%	83%
Mammography screening	Percent of female Medicare enrollees that receive mammography screening, 2006-2007	78%	74%	68%

HEALTH FACTORS (continued)		Union	*National Benchmark	South Dakota
<i>Social and Economic Factors</i>				
High school graduation	Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007	80%	92%	83%
Some college	Percent of adults ages 25-44 with some post-secondary education, 2005-2009	71%	68%	64%
Unemployment	Percent of population ages 16 and older that is unemployed but seeking work, 2009	5.9%	5.3%	4.8%
Child poverty	Percent of children ages 0-17 living below the Federal Poverty Line, 2008	7%	11%	18%
Inadequate social support	Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009	16%	14%	17%
Children in single-parent households	Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009	18%	20%	29%
Homicide rate	Number of deaths due to murder or non-negligent manslaughter per 100,000 population, 2001-2007	-	1.0	2.5
<i>Physical Environment</i>				
Air pollution-particulate matter	Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006	1	0	0
Air pollution-ozone	Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006	0	0	0
Access to healthy foods	Percent of zip codes with a healthy food outlet (i.e., grocery store or produce stand/farmers' market), 2008	60%	92%	42%
Access to recreational facilities	Number of recreational facilities per 100,000 population, 2008	14.0	17.0	13.0
<i>Demographics</i>		Union	United States	South Dakota
Youth	Percent of total population ages 0-17, 2009	25%	24%	25%
Elderly	Percent of total population ages 65 and older, 2009	14%	13%	14%
Rural	Percent of total population living in a rural area, 2000	72%	21%	48%
Not English proficient	Percent of total population that speaks English less than "very well," 2005-2009	1%	9%	2%
Illiteracy	Percent of population ages 16 and older that lacks basic prose literacy skills, 2003	6%	15%	7%

*The national benchmark is the 90th percentile (i.e., 10% of counties nationwide ranked better). **Binge drinking is defined as consuming more than 4 (for women) or 5 (for men) alcoholic beverages on a single occasion in the past 30 days. Heavy drinking is defined as drinking more than 1 (for women) or 2 (for men) alcoholic beverages per day on average. - Blank values reflect unreliable or missing data.

Source: The overall format and content of the County Health Profiles is based largely on County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>. Additional data sources include the U.S. Census Bureau, Small Area Health Insurance Estimates, <http://www.census.gov/sahie/> and the Centers for Disease Control and Prevention's National Center for Health Statistics - the Health Indicators Warehouse, <http://healthindicators.gov> and "Health, United States, 2010," Table 109, <http://www.cdc.gov/nchs/hus.htm>.

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Definitions of Health Variables

Definitions of Health Variables from the <i>County Health Rankings</i> <i>2011 Report Variable</i>	Definition
Poor or Fair Health	Self-reported health status based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"
Poor Physical Health Days (in past 30 days)	Estimate based on responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"
Poor Mental Health Days (in past 30 days)	Estimate based on responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
Adult Smoking	Percent of adults that report smoking equal to, or greater than, 100 cigarettes and are currently a smoker
Adult Obesity	Percent of adults that report a BMI greater than, or equal to, 30
Excessive Drinking	Percent of as individuals that report binge drinking in the past 30 days (more than 4 drinks on one occasion for women, more than 5 for men) or heavy drinking (defined as more than 1 (women) or 2 (men) drinks per day on average
Sexually Transmitted Infections	Chlamydia rate per 100,000 population
Teen Birth Rate	Birth rate per 1,000 female population, ages 15-19
Uninsured Adults	Percent of population under age 65 without health insurance
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Mammography Screening	Percent of female Medicare enrollees that receive mammography screening
Access to Healthy Foods	Healthy food outlets include grocery stores and produce stands/farmers' markets
Access to Recreational Facilities	Rate of recreational facilities per 100,000 population
Physical Inactivity	Percent of adults aged 20 and over that report no leisure time physical activity
Primary Care Provider Ratio	Ratio of population to primary care providers
Mental Health Care Provider Ratio	Ratio of population to mental health care providers
Diabetes Screening	Percent of Medicare enrollees with diabetes that receive HbA1c screening
Binge Drinking	Percent of adults that report binge drinking in the last 30 days. Binge drinking is consuming more than 4 (women) or 5 (men) alcoholic drinks on one occasion.

Aging Profile

2010 Demographic and Socio-Economic Profile
for the Aging Population Ages 65 and Older

Clay County
South Dakota

CHARACTERISTICS	AGE		
	Total	Less than 65 Years	Ages 65 and Older
<i>Population</i> ¹			
Total population	13,864	12,443	1,421
Percent ages 65 and older	10%	-	100%
Percent ages 85 and older	2%	-	19%
Percent male	49%	49%	43%
Percent female	51%	51%	57%
<i>Living Arrangements</i>			
Total households (by age of householder) ¹	5,110	4,228	882
Percent with family households (i.e., at least two people who are related)	51%	52%	51%
Percent with householder living alone	32%	29%	47%
Grandparents living with their grandchildren* ²	46	34	12
Percent who are responsible for their grandchildren	33%	44%	0%
<i>Housing</i> ¹			
Percent of occupied housing that is owner-occupied	53%	49%	75%
Percent of occupied housing that is renter-occupied	47%	51%	25%
<i>Economic Security</i> ²			
Percent of working-age population in labor force	65%	71%	21%
Percent of total population with income less than 100% of poverty	24%	26%	6%
Percent of total population with income less than 200% of poverty	41%	43%	29%
Median household income (by age of householder)	\$37,198	\$36,135	\$37,423
Owner-occupied housing units (by age of householder)	2,890	2,251	639
Percent spending 30% or more of income toward housing costs	22%	20%	27%
Renter-occupied housing units (by age of householder)	2,046	1,872	174
Percent spending 30% or more of income toward housing costs	48%	50%	32%

Note: *The age categories for this indicator are grandparents ages 35 to 59 and grandparents ages 60 and older.

Source: U.S. Census Bureau,¹ 2010 Census Summary File 1 and ² 2006-2010 American Community Survey 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across age categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable.

Disclaimer: The data displayed are from the source indicated; we do not vouch for the accuracy of the data or ensure they are the most recent available. The information is intended for personal, non-commercial use. It can be shared freely if it is not used for profit and appropriate acknowledgments are given. The Aging Profile was prepared by researchers at North Dakota State University in Fargo for Sanford Health. May 2012

Diversity Profile

2010 Demographic and Socio-Economic Profile
for Racial and Ethnic Populations

Clay County

South Dakota

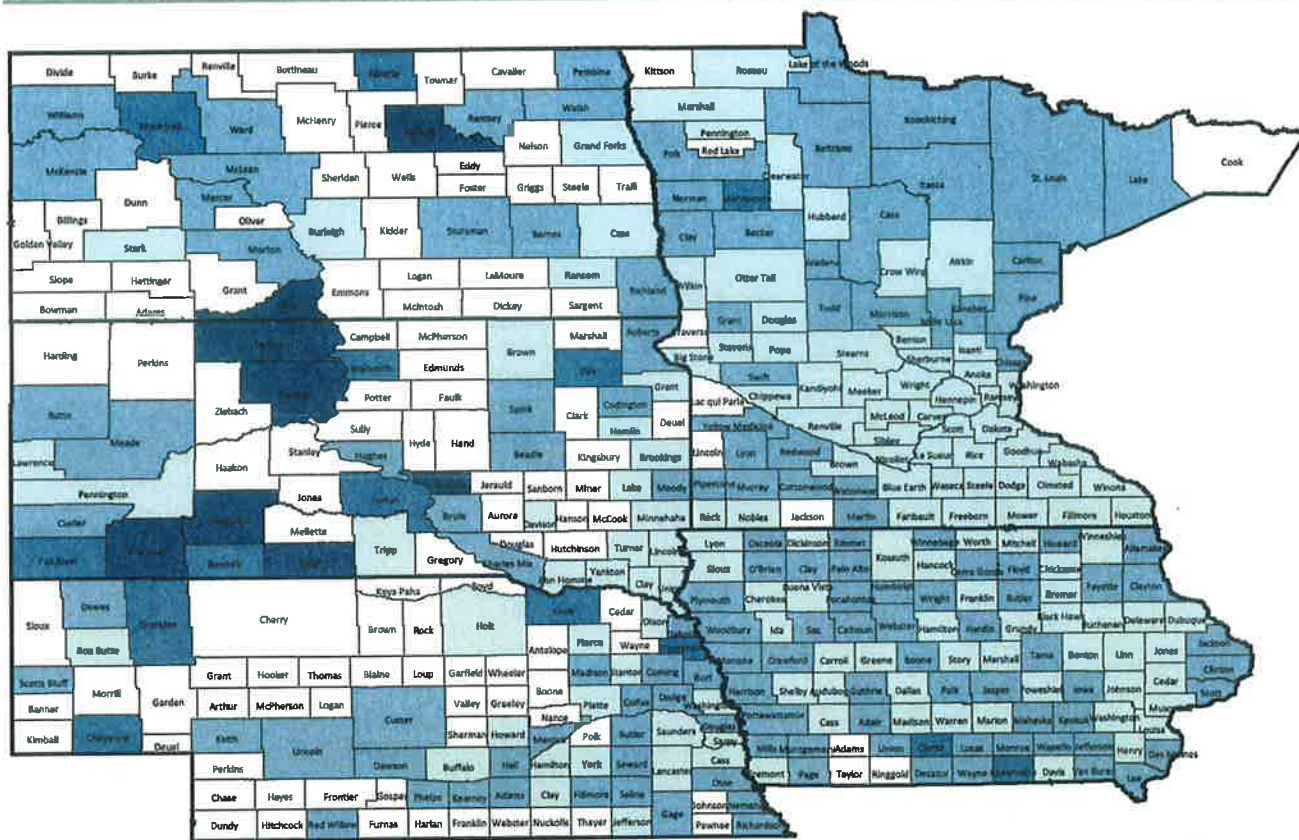
CHARACTERISTICS	Total	RACE				ETHNICITY
		White alone	Black alone	American Indian alone	Asian alone	Hispanic Origin - of any race
<i>Population</i> ¹						
Total population	13,864	12,637	185	429	232	277
Percent ages 0 to 17	17%	16%	18%	38%	15%	35%
Percent ages 18 to 44	54%	53%	74%	47%	63%	54%
Percent ages 45 to 64	19%	19%	7%	13%	20%	8%
Percent ages 65 and older	10%	11%	1%	3%	2%	2%
Median age (in years)	25.0	25.4	22.0	22.3	28.4	20.9
<i>Living Arrangements</i>						
Total households ¹	5,110	4,759	56	121	80	72
Percent with householder living alone	32%	32%	48%	27%	35%	25%
Percent with families with children ages 0 to 17	24%	23%	30%	45%	28%	43%
Grandparents living with their grandchildren ²	46	46	0	0	0	0
Percent who are responsible for grandchildren	33%	33%	-	-	-	-
<i>Housing</i> ¹						
Percent occupied housing that is owner-occupied	53%	55%	23%	22%	39%	39%
Percent occupied housing that is renter-occupied	47%	45%	77%	78%	61%	61%
<i>Educational Attainment</i> ²						
Percent of persons ages 25 and older with high school degree or higher	91%	90%	-	91%	100%	100%
Percent of persons ages 25 and older with Bachelor's degree or higher	40%	40%	-	31%	79%	0%
<i>Economic Security</i> ²						
Unemployment rate	6%	5%	22%	31%	0%	0%
Median household income	\$37,198	\$39,100	\$9,207	\$14,425	\$70,461	\$21,214
Percent of households with income <\$25,000	36%	35%	73%	71%	12%	68%
Percent of persons with income <100% poverty	24%	23%	73%	60%	15%	13%
Percent of children ages 0 to 17 in families with income <100% poverty	14%	10%	-	70%	0%	0%
Percent of elderly ages 65 and older with income <100% poverty	7%	7%	-	0%	-	0%

Source: U.S. Census Bureau, ¹2010 Census Summary File 1 and ²2006-2010 American Community Survey (ACS) 5-Year Estimates (sample data). The estimates presented are meant to give perspective on characteristics across race and ethnic categories; however, because they are based on sample data, one should use caution when interpreting small numbers. - Blank values reflect data that are missing or not applicable. Racial categories not represented include Native Hawaiian and Other Pacific Islander alone, Some Other Race alone, and Two or More races.

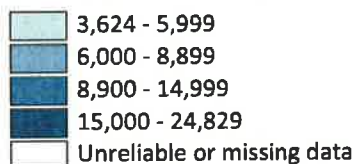
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Premature Death - A health outcome measure focusing on mortality

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Years of potential life lost before age 75 per 100,000 population (age-adjusted), 2005-2007



CONTEXT

What It Is: Premature death is represented by the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person who dies at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL. The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 U.S. population.

Where It Comes From: Data on deaths, including age at death, are based on death certificates and are routinely reported to the National Vital Statistics System (NVSS) at the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC). NVSS calculates age-adjusted YPLL rates based on three-year averages to create more robust estimates of mortality, particularly for counties with smaller populations.

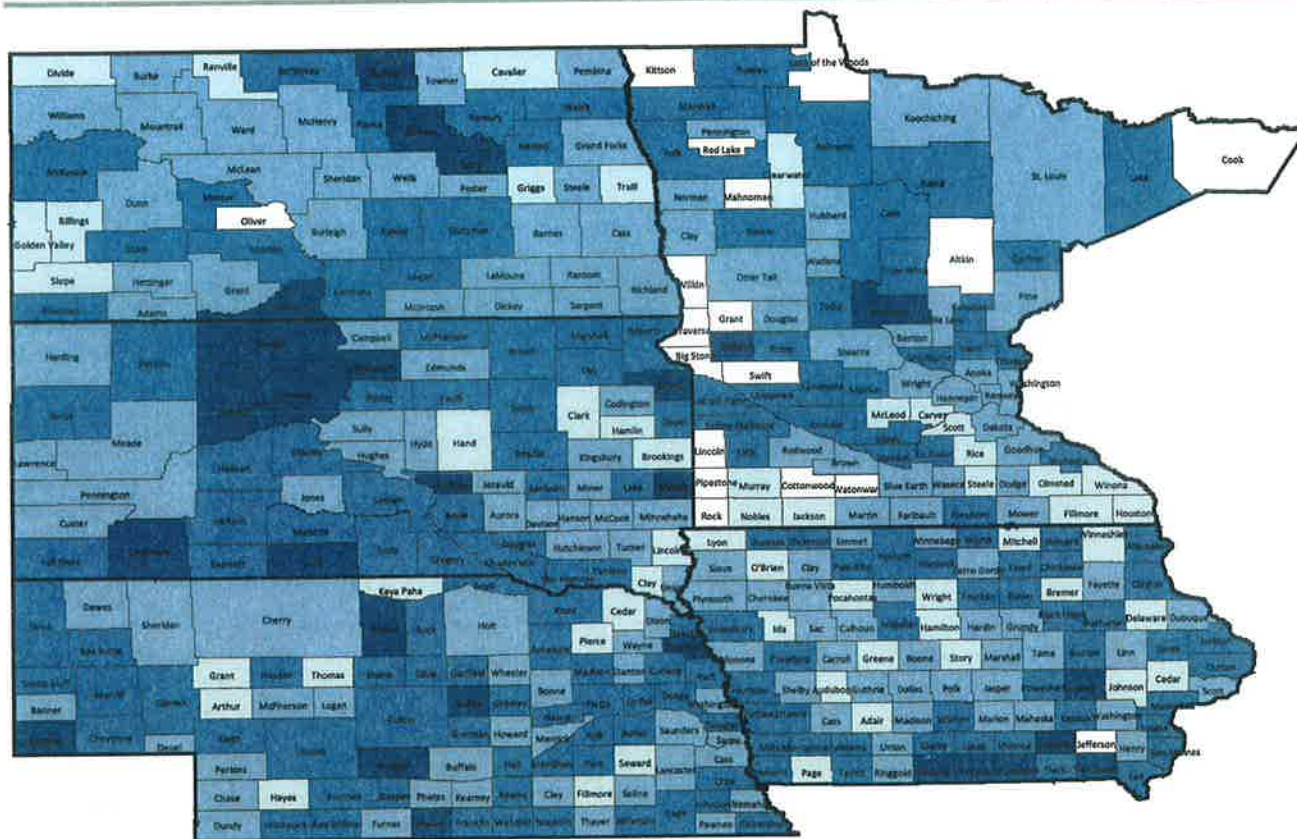
Importance: Age-adjusted YPLL-75 rates are commonly used to represent the frequency and distribution of premature deaths. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of death.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

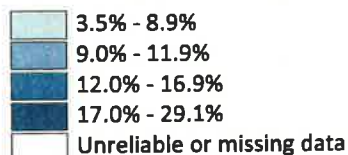
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Poor or Fair Health - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults reporting fair or poor health (age-adjusted), 2003-2009



CONTEXT

What It Is: Self-reported health status is a general measure of health-related quality of life in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported is the percent of adult respondents who rate their health "fair" or "poor." The measure is age-adjusted to the 2000 U.S. population.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of self-reported health status.

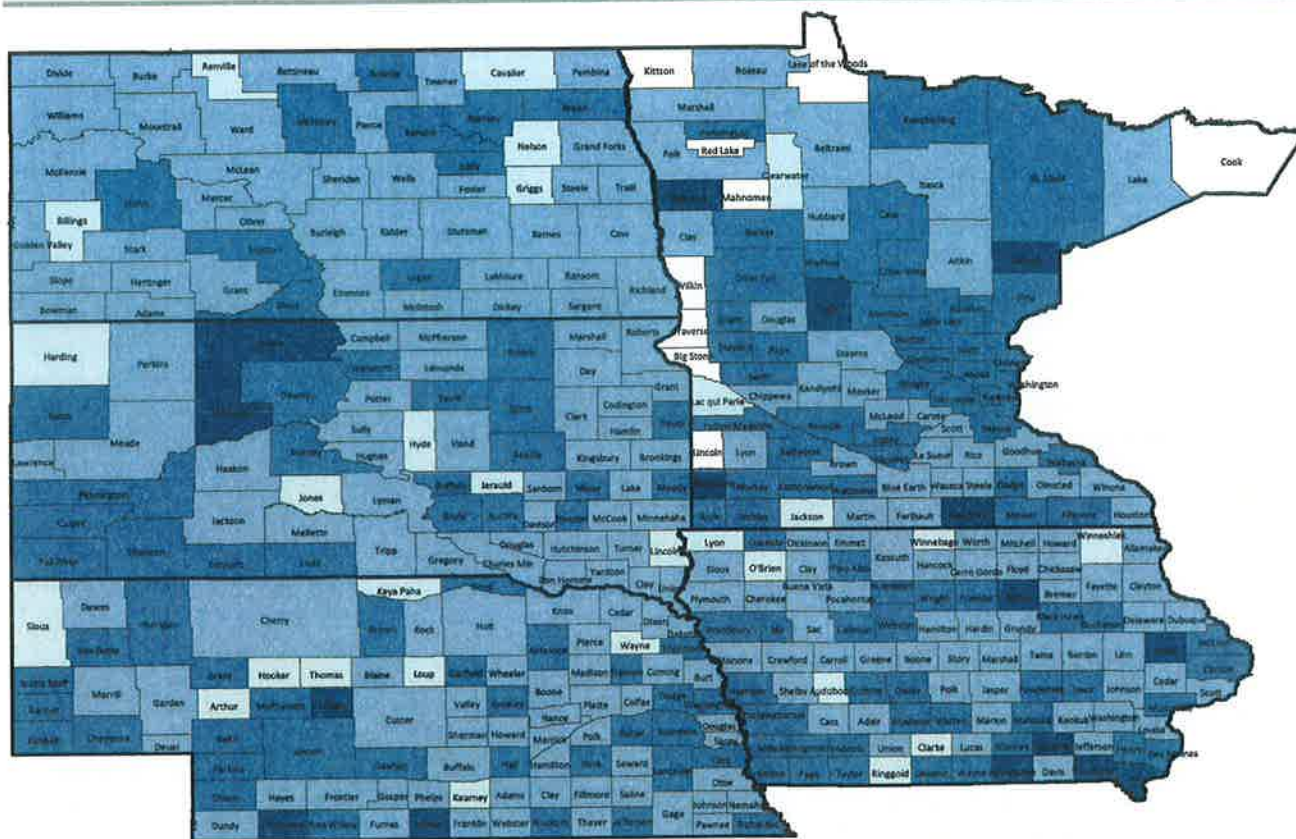
Importance: Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable measure of current health.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

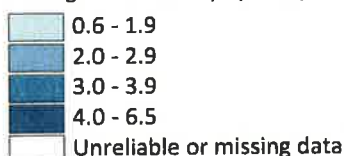
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Poor Physical Health Days - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Average number of physically unhealthy days reported in past 30 days (age-adjusted), 2003-2009



CONTEXT

What It Is: The poor physical health days measure is based on responses to the question: “Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” Presented is the average number of days a county’s adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 U.S. population.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. Seven years of data are used to generate more stable estimates of poor physical health days.

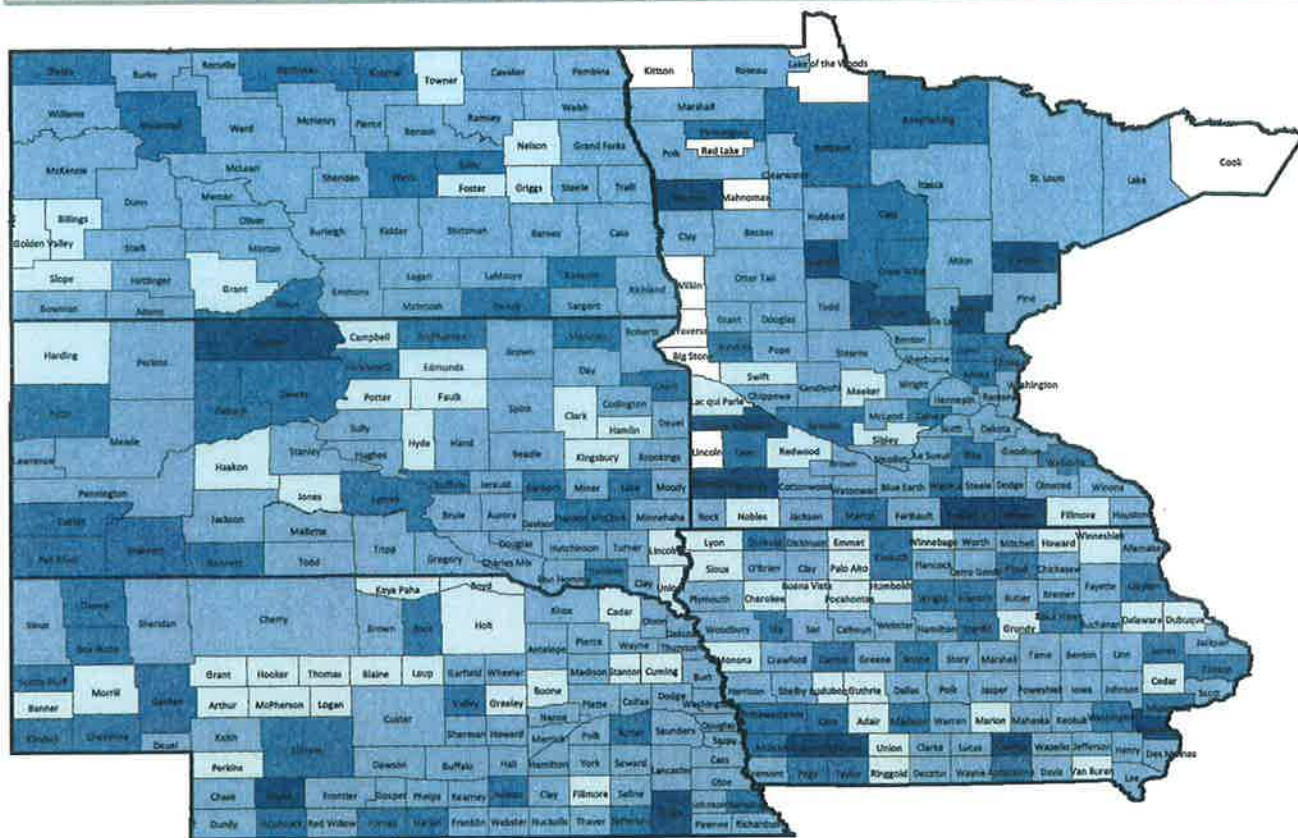
Importance: In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive – people’s reports of days when their physical health was not good are a reliable estimate of their recent health.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

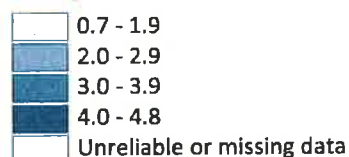
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Poor Mental Health Days - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Average number of mentally unhealthy days reported in past 30 days (age-adjusted), 2003-2009



CONTEXT

What It Is: The poor mental health days measure is based on responses to the question: “Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Presented is the average number of days a county’s adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 U.S. population.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. NCHS used seven years of data to generate more stable estimates of poor mental health days.

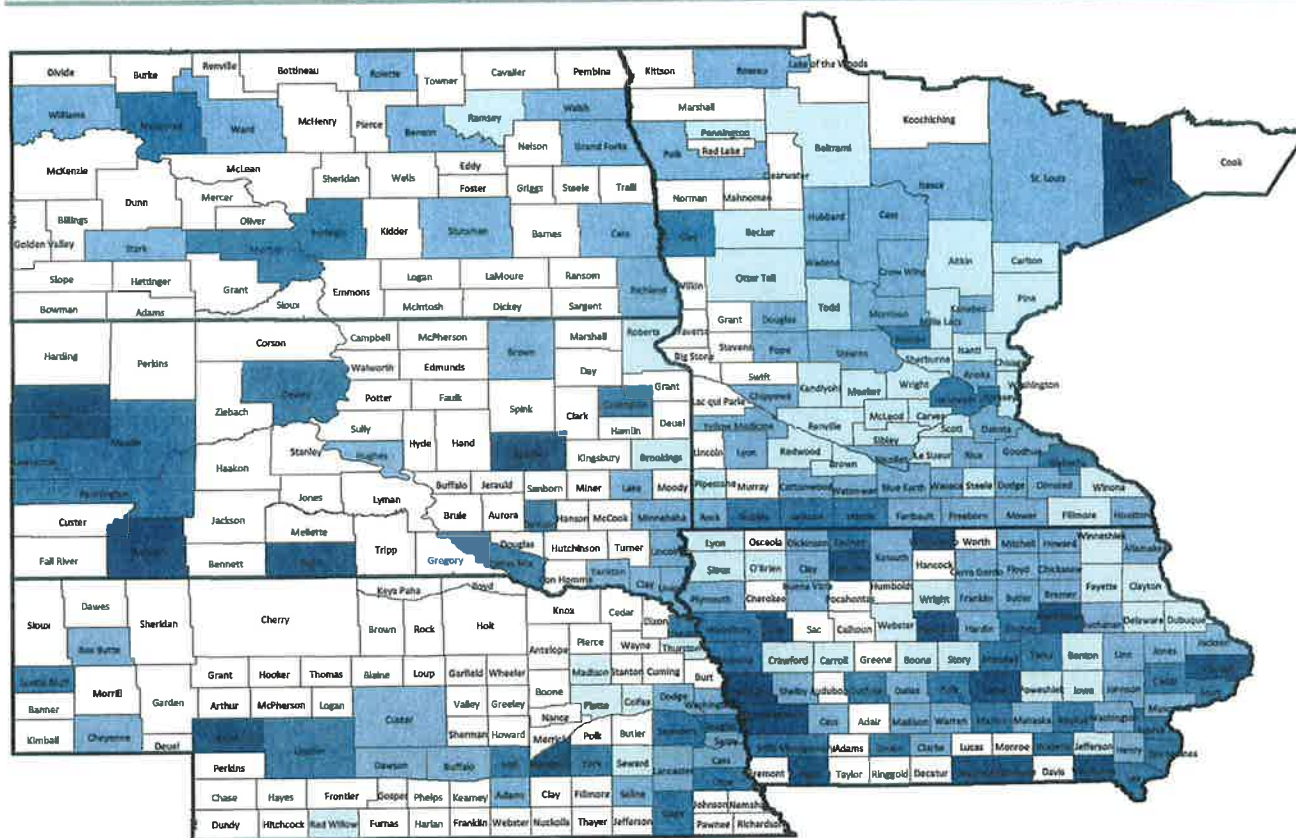
Importance: Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represent an important facet of health-related quality of life. The County Health Rankings considers health-related quality of life to be an important health outcome.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

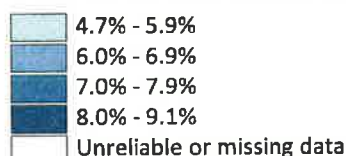
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Low Birthweight - A health outcome measure focusing on morbidity

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of live births with low birthweight (<2,500 grams), 2001-2007



CONTEXT

What It Is: Low birthweight is the percent of live births for which the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.).

Where It Comes From: Data on births, including weight at birth, are based on birth certificates and are routinely reported to the National Vital Statistics System (NVSS) at the National Center for Health Statistics (NCHS), part at the Centers for Disease Control and Prevention (CDC). NCHS provides this measure based on the percent of live births with low birthweight for a seven-year period. They use seven-year averages to create more robust estimates, particularly for counties with smaller populations.

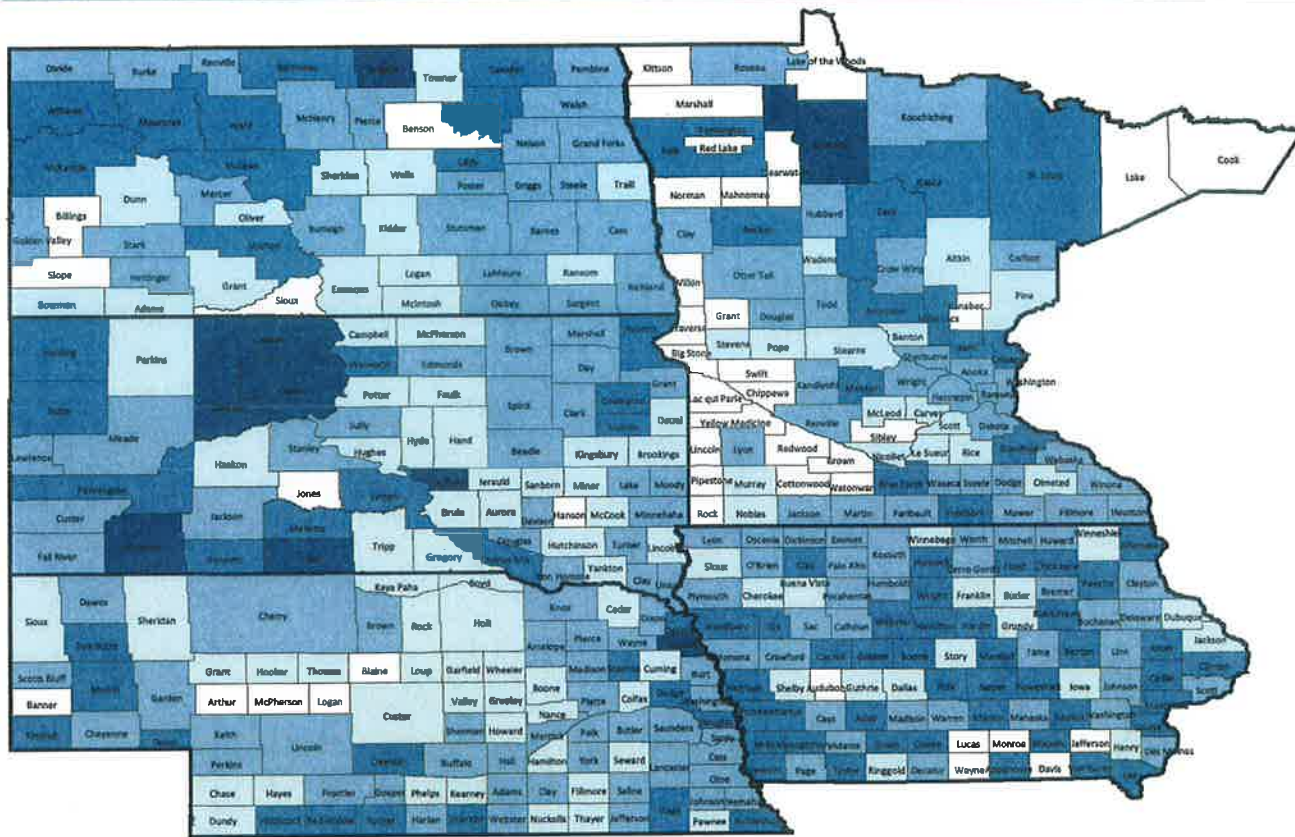
Importance: Low birthweight represents two factors: maternal exposure to health risks and an infant’s current and future morbidity, as well as premature mortality risk. The health consequences of low birthweight are numerous.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

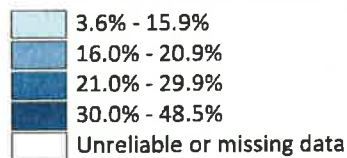
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Adult Smoking - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults that currently smoke and have smoked at least 100 cigarettes in lifetime, 2003-2009



CONTEXT

What It Is: Adult smoking prevalence is the estimated percent of the adult population that currently smokes every day or “most days” and has smoked at least 100 cigarettes in their lifetime.

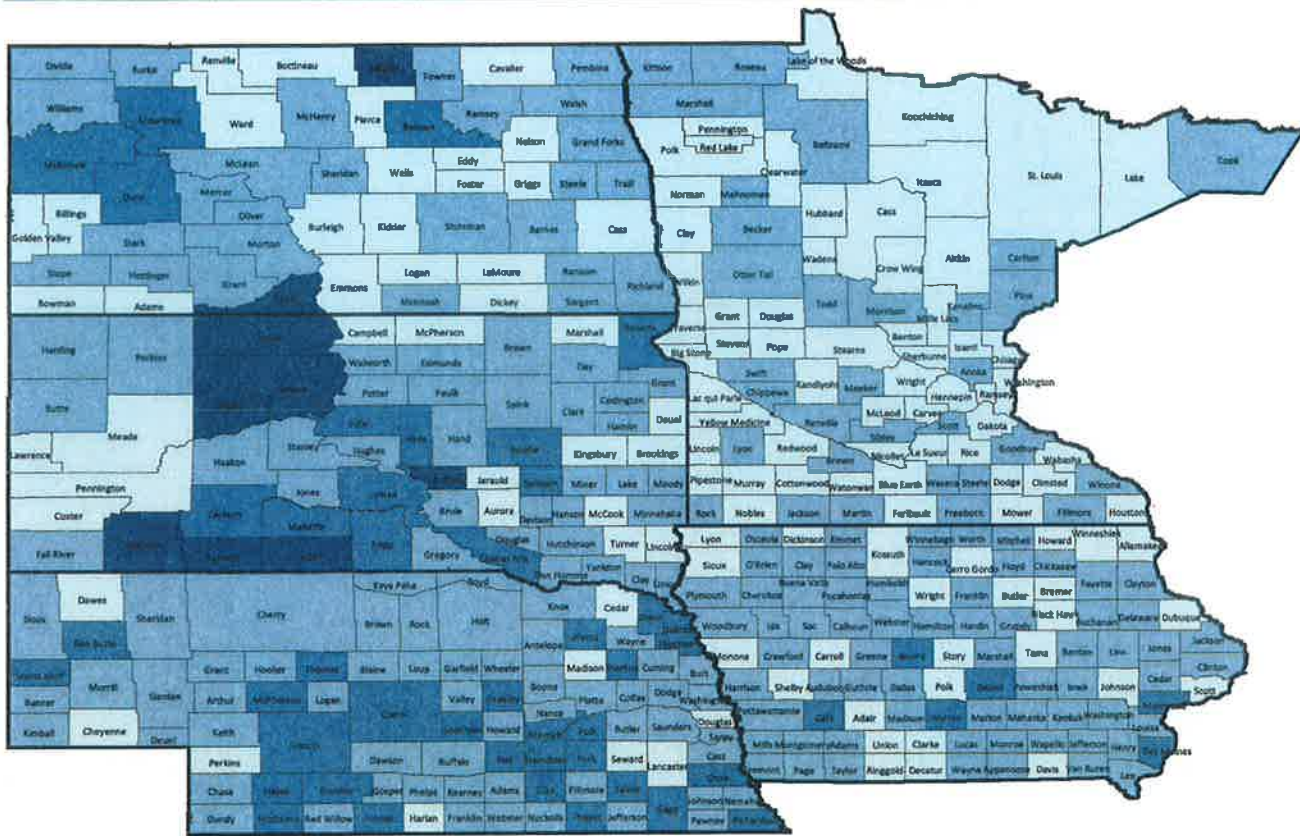
Where It Comes From: This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. The estimates are based on seven years of data.

Importance: Each year approximately 443,000 premature deaths occur in the U.S. primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birthweight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

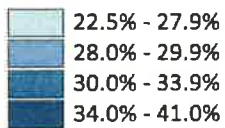
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Adult Obesity - A health factor measure focusing on health behaviors
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults that report a body mass index (BMI) of at least 30 kg/m², 2008



CONTEXT

What It Is: The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m².

Where It Comes From: Estimates of obesity prevalence by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone.

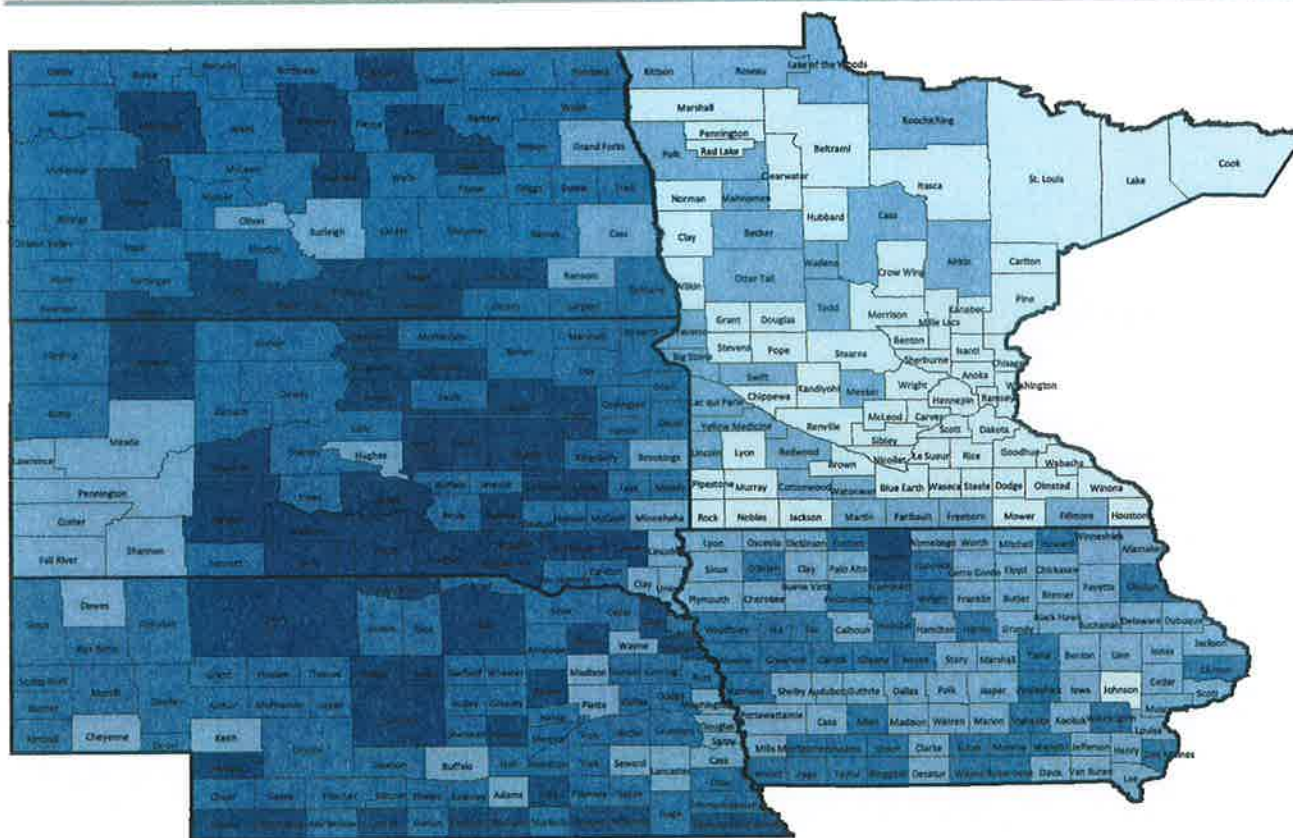
Importance: Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

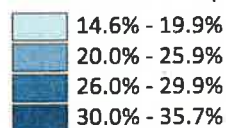
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Physical Inactivity - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults reporting no leisure time physical activity, 2008



CONTEXT

What It Is: Physical inactivity is the estimated percent of adults ages 20 and older reporting no leisure time physical activity.

Where It Comes From: Estimates of physical inactivity by county were calculated by the CDC's National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone.

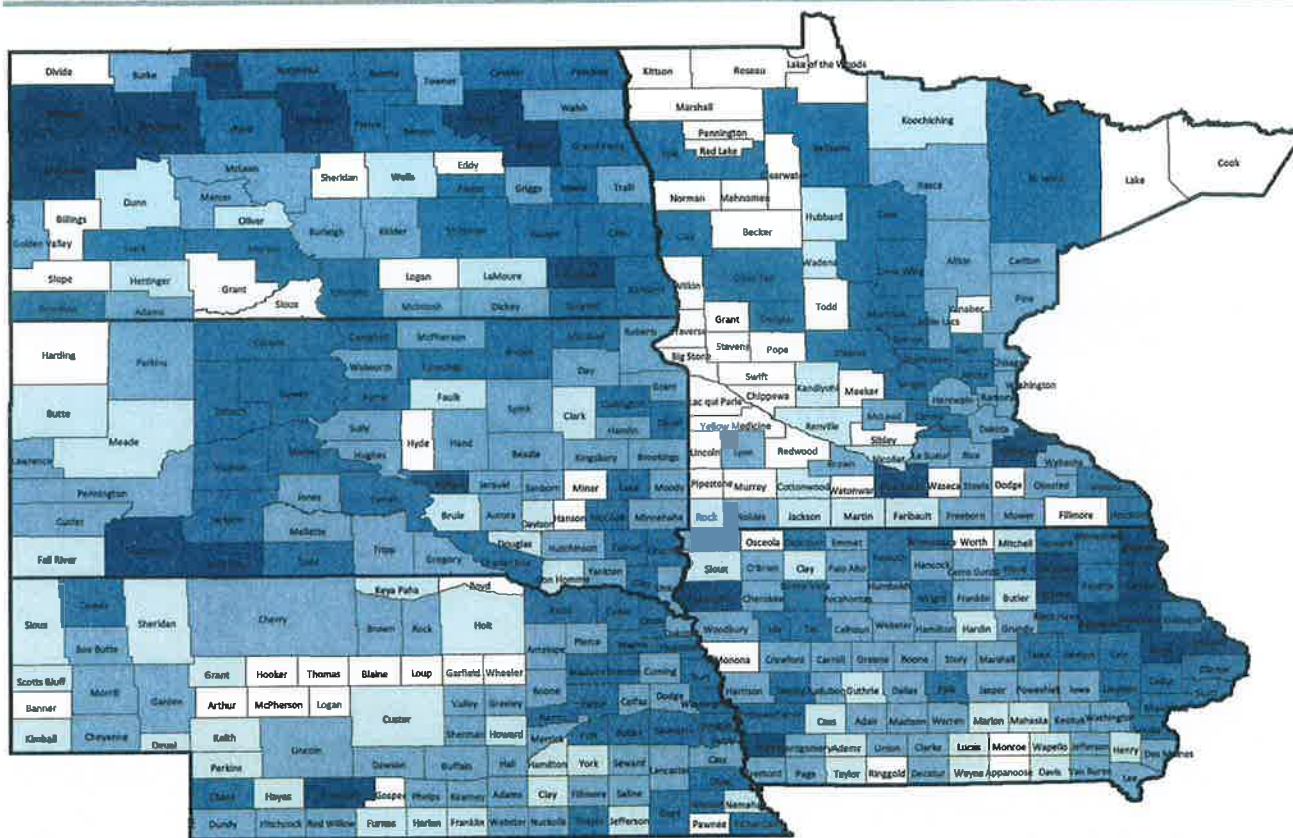
Importance: Regular physical activity is one of the most important things one can do for their health. It can help control weight, reduce risk of cardiovascular disease, reduce risk for type 2 diabetes and metabolic syndrome, reduce risk of some cancers, strengthen bones and muscles, improve mental health and mood, improve ability to do daily activities and prevent falls in older adults, and increase chances of living longer (Centers for Disease Control and Prevention, <http://www.cdc.gov/physicalactivity/everyone/health/index.html>).

- Data were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

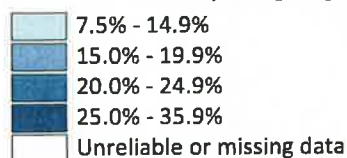
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Excessive Drinking - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults reporting binge drinking and heavy drinking, 2003-2009



CONTEXT

What It Is: The excessive drinking measure reflects the percent of the adult population that reports either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population ages 18 and older living in households with a land-line telephone. The estimates are based on seven years of data.

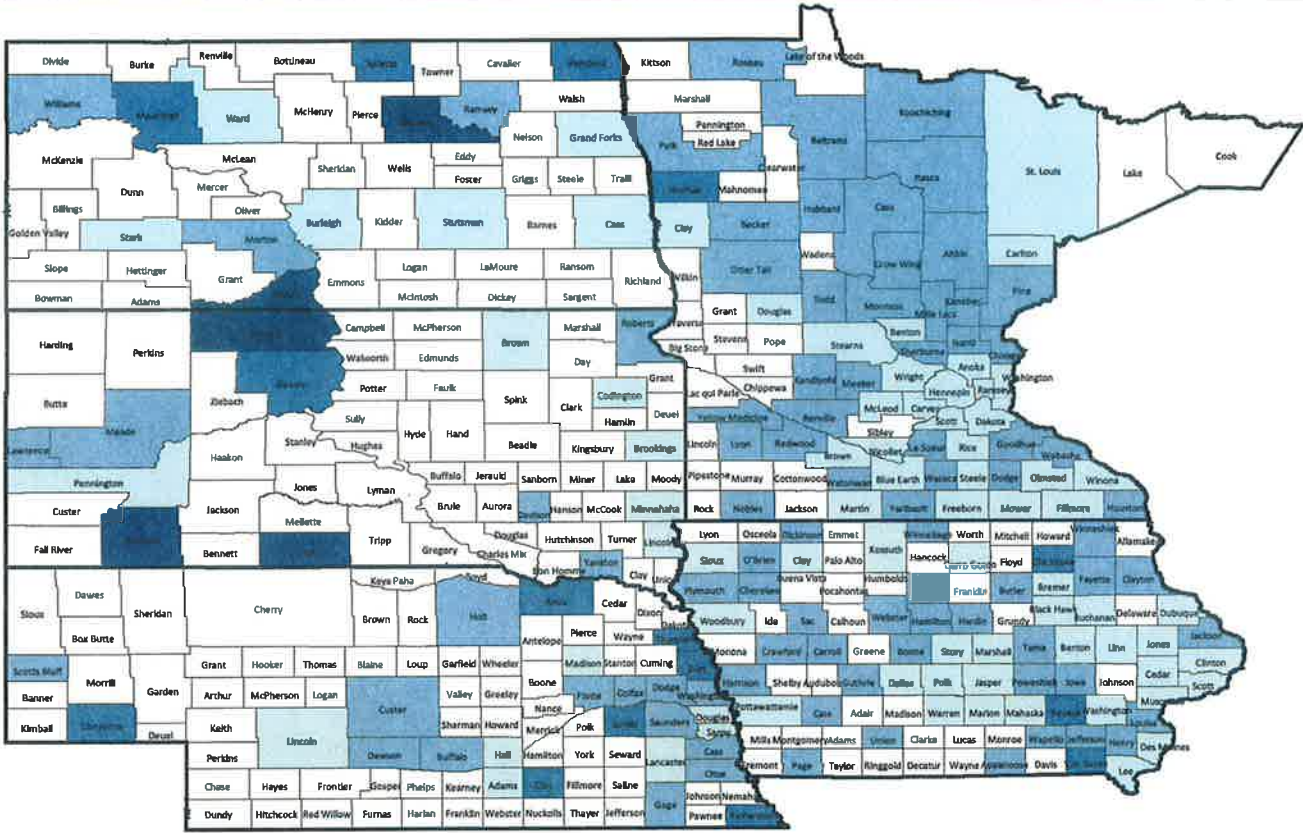
Importance: Excessive drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

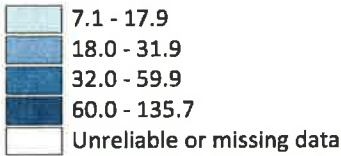
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Motor Vehicle Crash Death Rate - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Motor vehicle crash deaths per 100,000 population, 2001-2007



CONTEXT

What It Is: Motor vehicle crash deaths are measured as the crude mortality rate per 100,000 population due to on- or off-road accidents involving a motor vehicle. Motor vehicle deaths includes traffic and non-traffic accidents involving motorcycles and 3-wheel motor vehicles; cars; vans; trucks; buses; street cars; ATVs; industrial, agricultural, and construction vehicles; and bikes and pedestrians when colliding with any of the vehicles mentioned. Deaths due to boating accidents and airline crashes are not included in this measure.

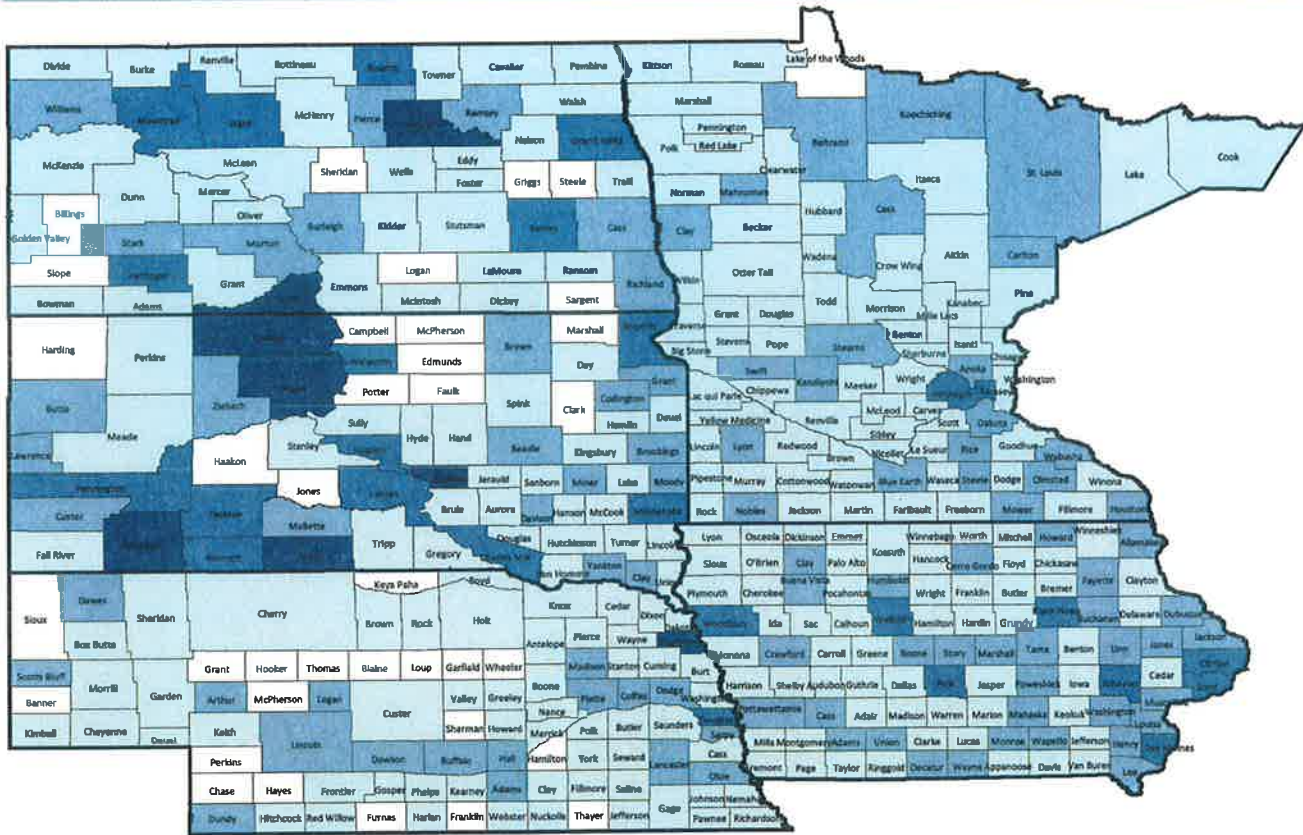
Where It Comes From: These data were calculated by National Center for Health Statistics (NCHS), part of the Centers for Disease Control and Prevention (CDC), based on data reported to the National Vital Statistics System (NVSS). NCHS used data for a seven-year period to create more robust estimates of cause-specific mortality, particularly for counties with smaller populations.

Importance: A strong association has been demonstrated between excessive drinking and alcohol-impaired driving, with approximately 17,000 Americans killed annually in alcohol-related motor vehicle crashes.

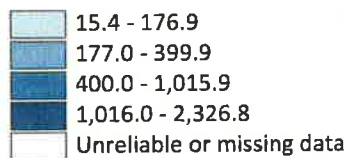
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Sexually Transmitted Infections - A health factor measure focusing on health behaviors
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of chlamydia cases (new cases reported) per 100,000 population, 2008



CONTEXT

What It Is: The Sexually Transmitted Infection (STI) rate is measured as chlamydia incidence (the number of new cases reported) per 100,000 population.

Where It Comes From: The county-level measures were obtained from the CDC’s National Center for Hepatitis, HIV, STD, and TB Prevention.

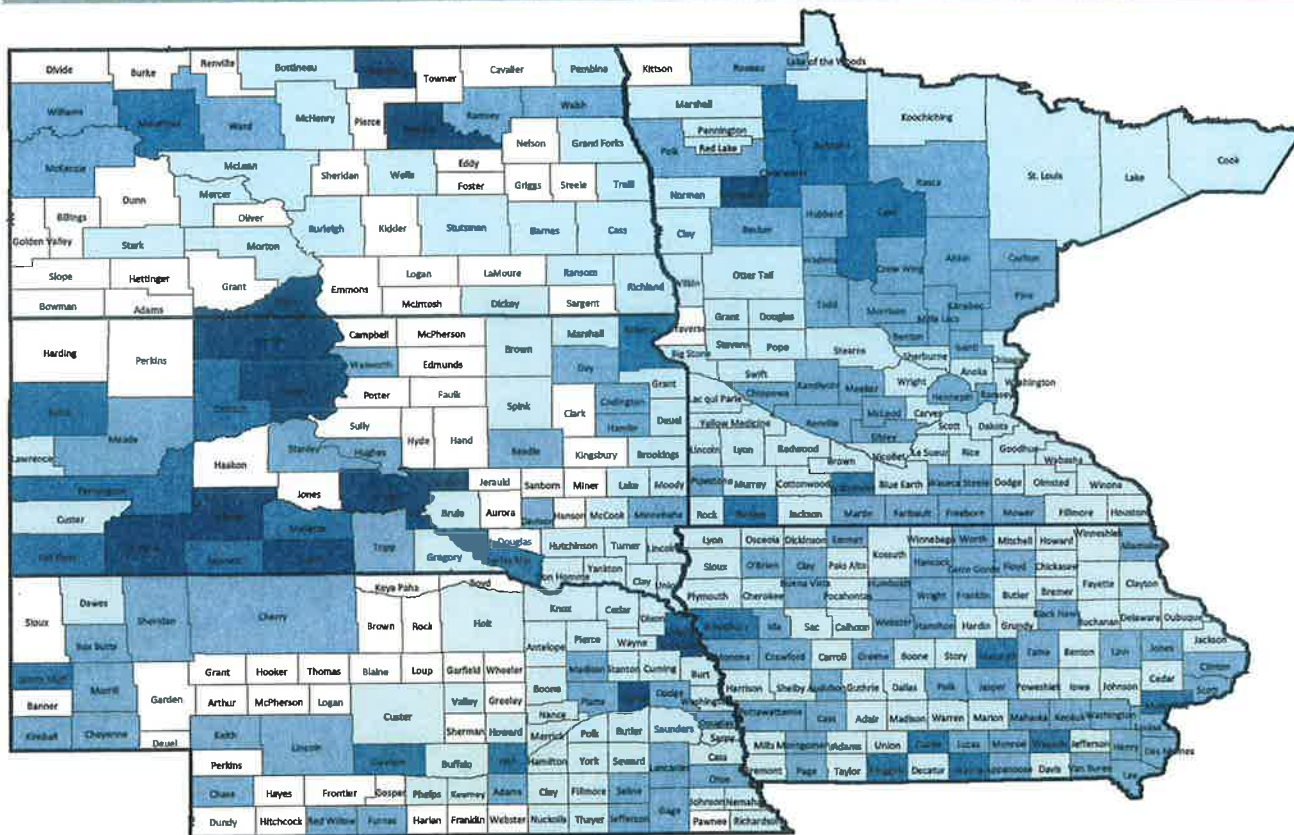
Importance: Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death. However, increases in reported chlamydia infections may reflect the expansion of chlamydia screening, use of increasingly sensitive diagnostic tests, an increased emphasis on case reporting from providers and laboratories, improvements in the information systems for reporting, as well as true increases in disease.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

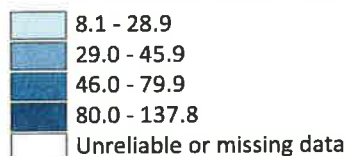
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Teen Birth Rate - A health factor measure focusing on health behaviors

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of teen births per 1,000 females ages 15 through 19, 2001-2007



CONTEXT

What It Is: Teen births are reported as the number of births per 1,000 female population ages 15 through 19.

Where It Comes From: Teen birth rates were obtained from the National Vital Statistics System (NVSS) at the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC).

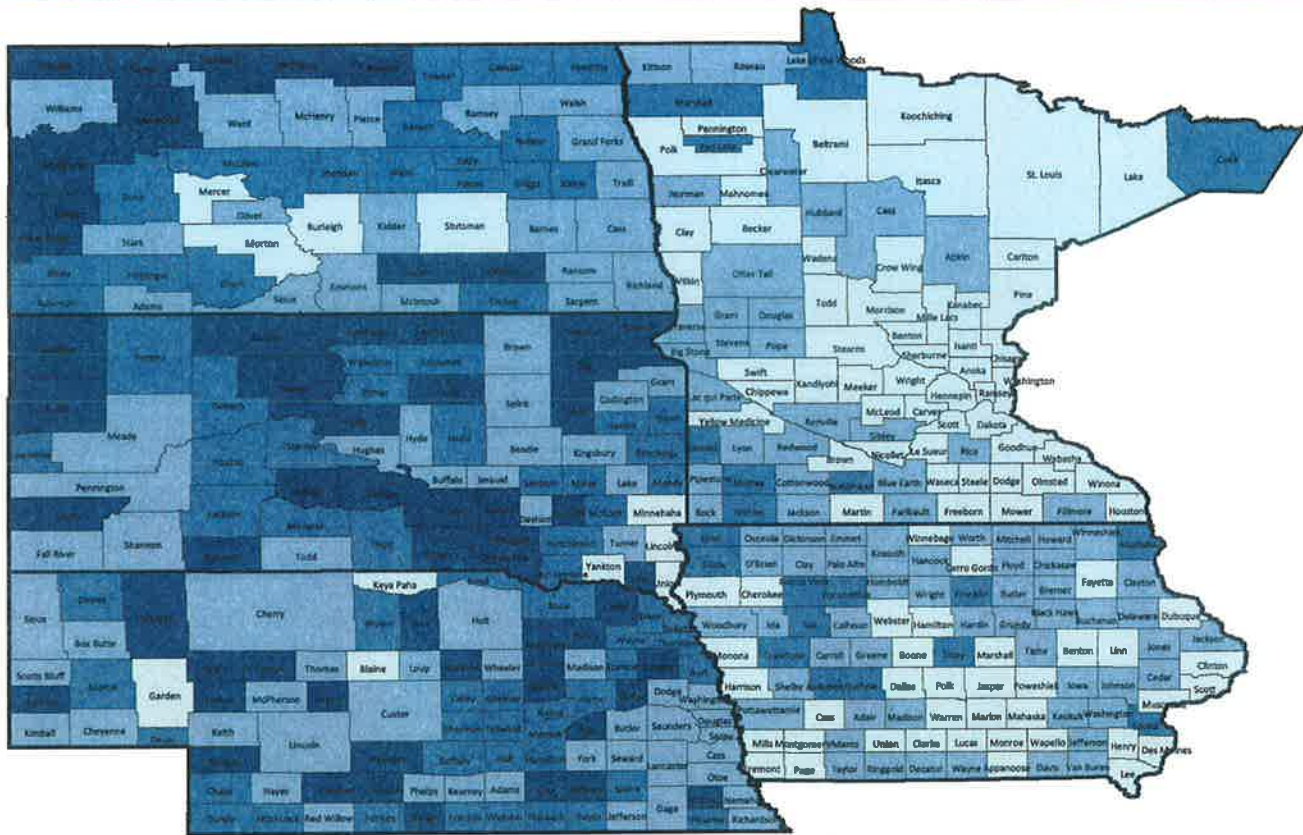
Importance: Teen pregnancy is associated with poor prenatal care and pre-term delivery. Pregnant teens are more likely than older women to receive late or no prenatal care, have gestational hypertension and anemia, and achieve poor maternal weight gain. They are also more likely to have a pre-term delivery and low birth weight, increasing the risk of child developmental delay, illness, and mortality.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

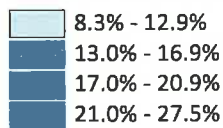
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Uninsured Adults - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adult population ages 18 through 64 without health insurance, 2007



CONTEXT

What It Is: The uninsured adults measure represents the estimated percent of the adult population under age 65 that has no health insurance coverage.

Where It Comes From: The Small Area Health Insurance Estimates from the U.S. Census Bureau provide annual estimates of the population without health insurance coverage for all U.S. states and their counties. The estimates used are for the most recent year for which reliable county-level estimates are available.

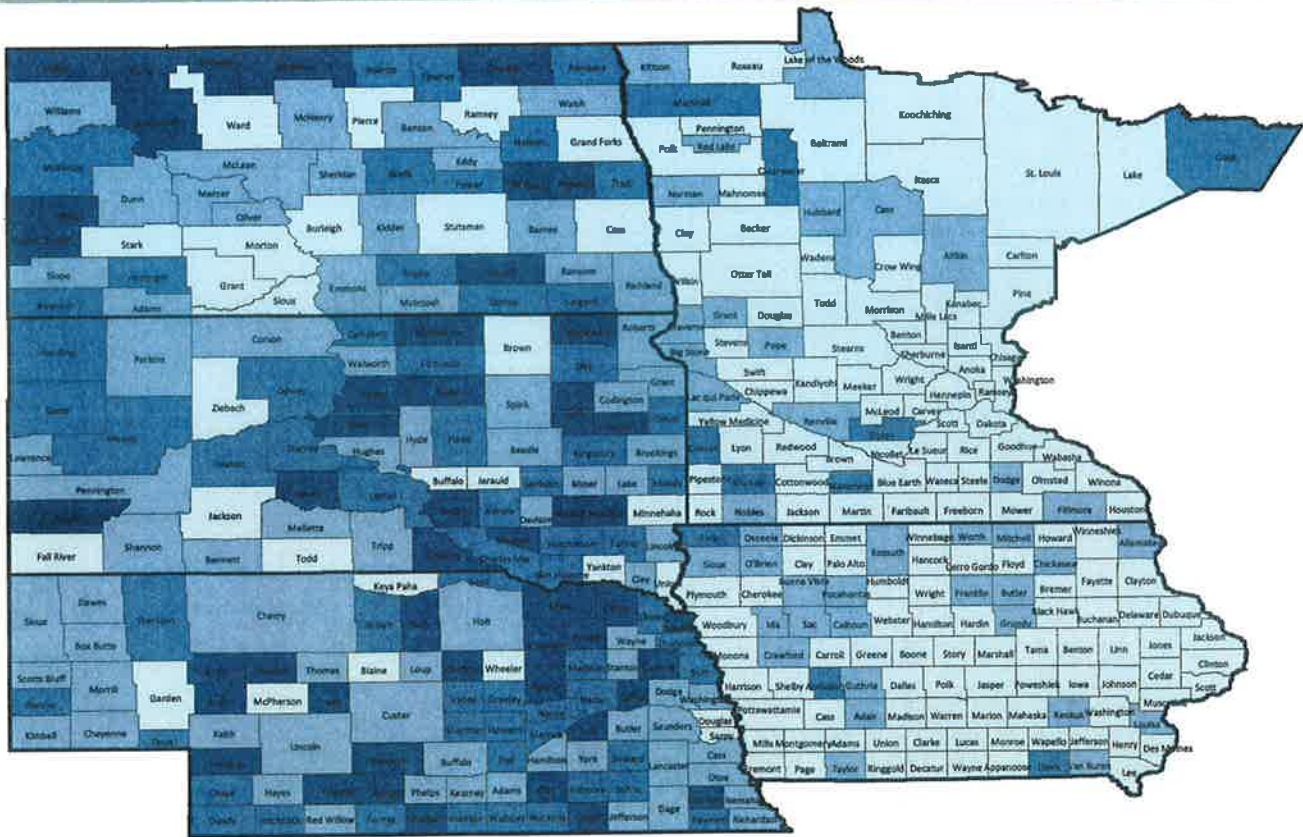
Importance: Lack of health insurance coverage is a significant barrier to accessing needed health care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Uninsured Youth - A health factor measure focusing on clinical care
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota

Map 14



Percent of youth ages 0 through 18 without health insurance, 2007



CONTEXT

What It Is: The uninsured youth measure represents the estimated percent of the children ages birth through 18 that has no health insurance coverage.

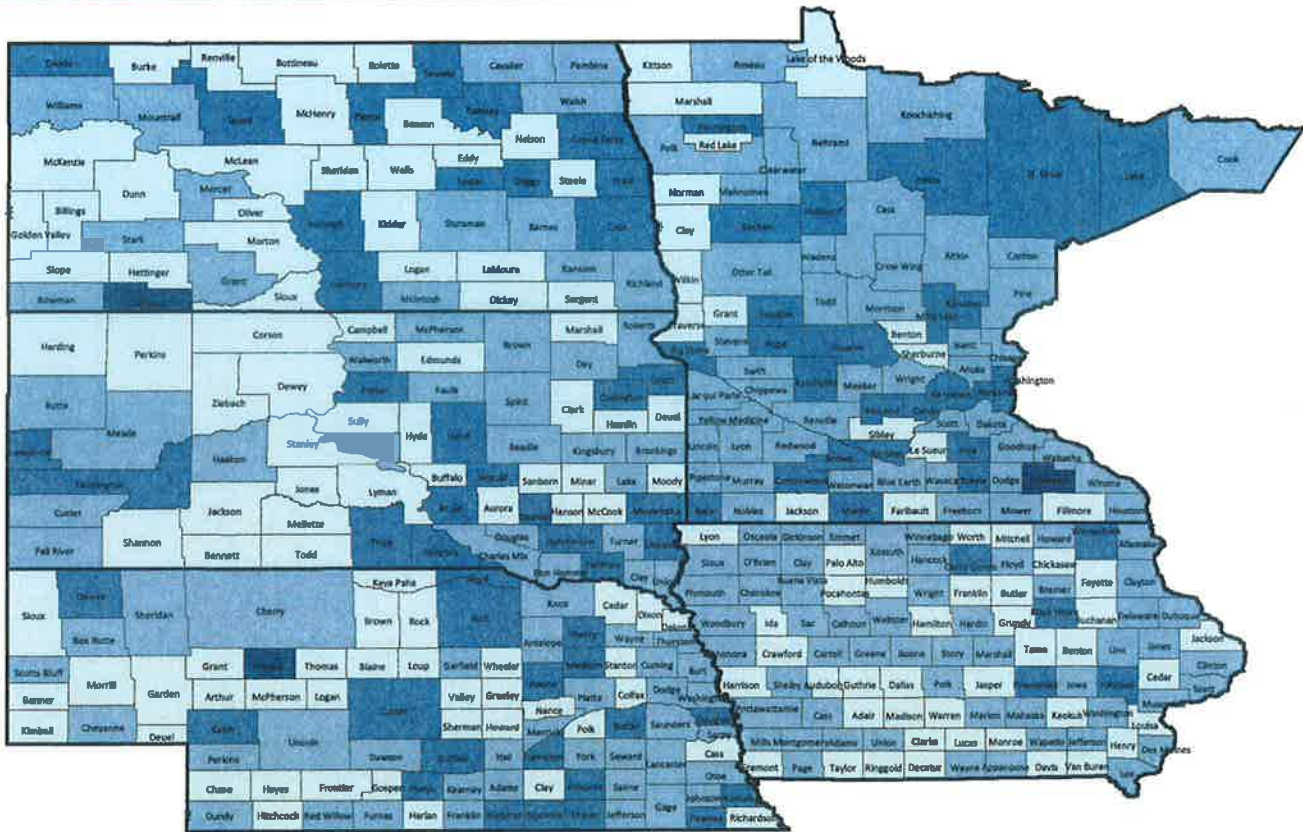
Where It Comes From: The Small Area Health Insurance Estimates from the U.S. Census Bureau provide annual estimates of the population without health insurance coverage for all U.S. states and their counties. The estimates used are for the most recent year for which reliable county-level estimates are available.

Importance: Children without health insurance are more likely than others to receive late or no care for health problems, putting them at greater risk for hospitalization. In addition to resulting in reduced access to health care, a lack of health insurance can also negatively influence children’s school attendance and participation in extracurricular activities, and increase parental financial and emotional stress. (Child Trends DataBank, <http://www.childtrendsdatabank.org/?q=node/297>)

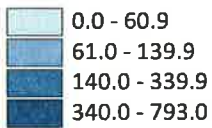
- Data were obtained from the Small Area Health Insurance Estimates (SAHIE), a program of the U.S. Census Bureau, <http://www.census.gov/did/www/sahie/>.

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Primary Care Physicians - A health factor measure focusing on clinical care
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of primary care physicians per 100,000 population, 2008



CONTEXT

What It Is: Primary care physicians include practicing physicians specializing in general practice medicine, family medicine, internal medicine, pediatrics, and obstetrics/gynecology. The measure represents the number of providers per 100,000 population.

Where It Comes From: The data on primary care physicians were obtained from the Health Resources and Services Administration’s Area Resource File (ARF). The ARF data on practicing physicians come from the AMA Master File (2008), and the population estimates are from the U.S. Census Bureau’s 2008 population estimates.

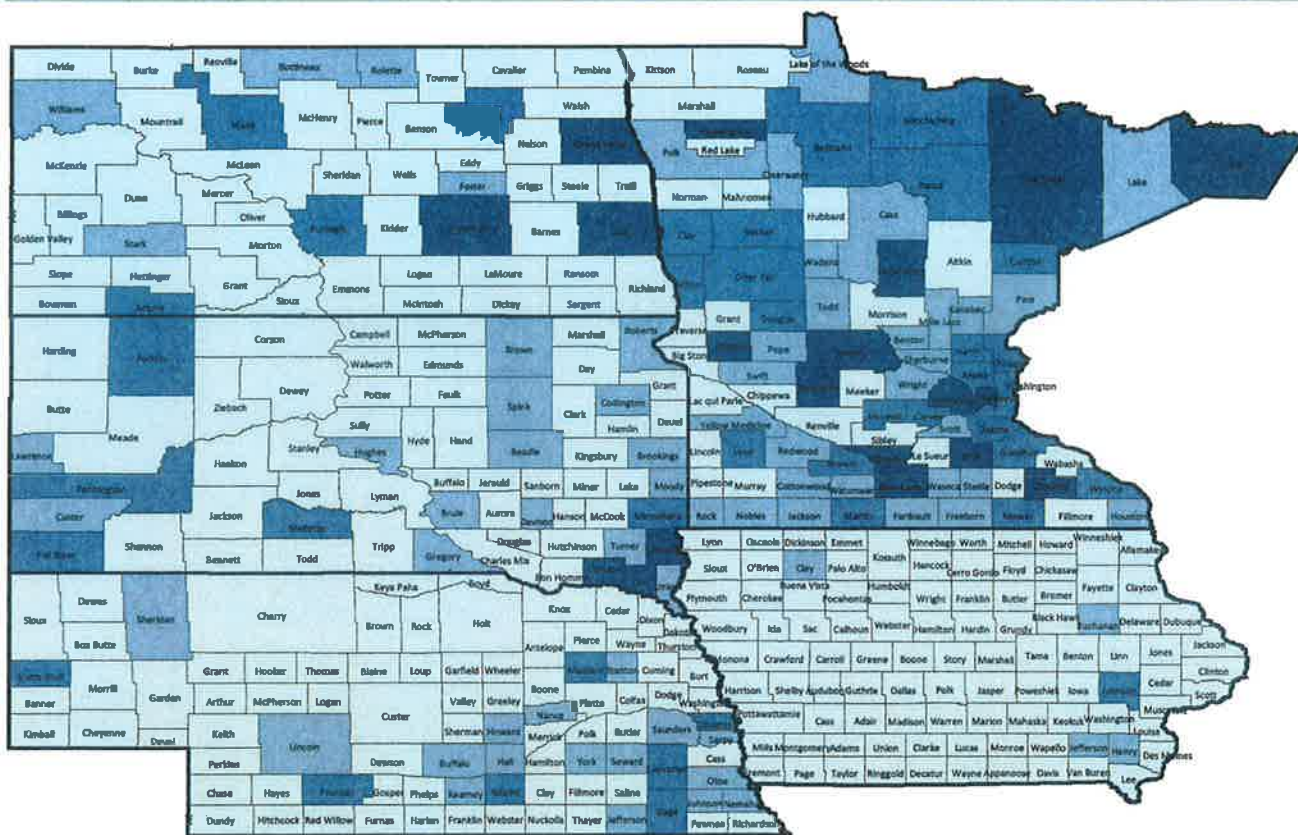
Importance: Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

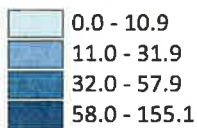
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Mental Health Providers - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of mental health providers per 100,000 population, 2008



CONTEXT

What It Is: Mental health providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet certain qualifications and certifications. This measure represents the number of mental health providers per 100,000 population.

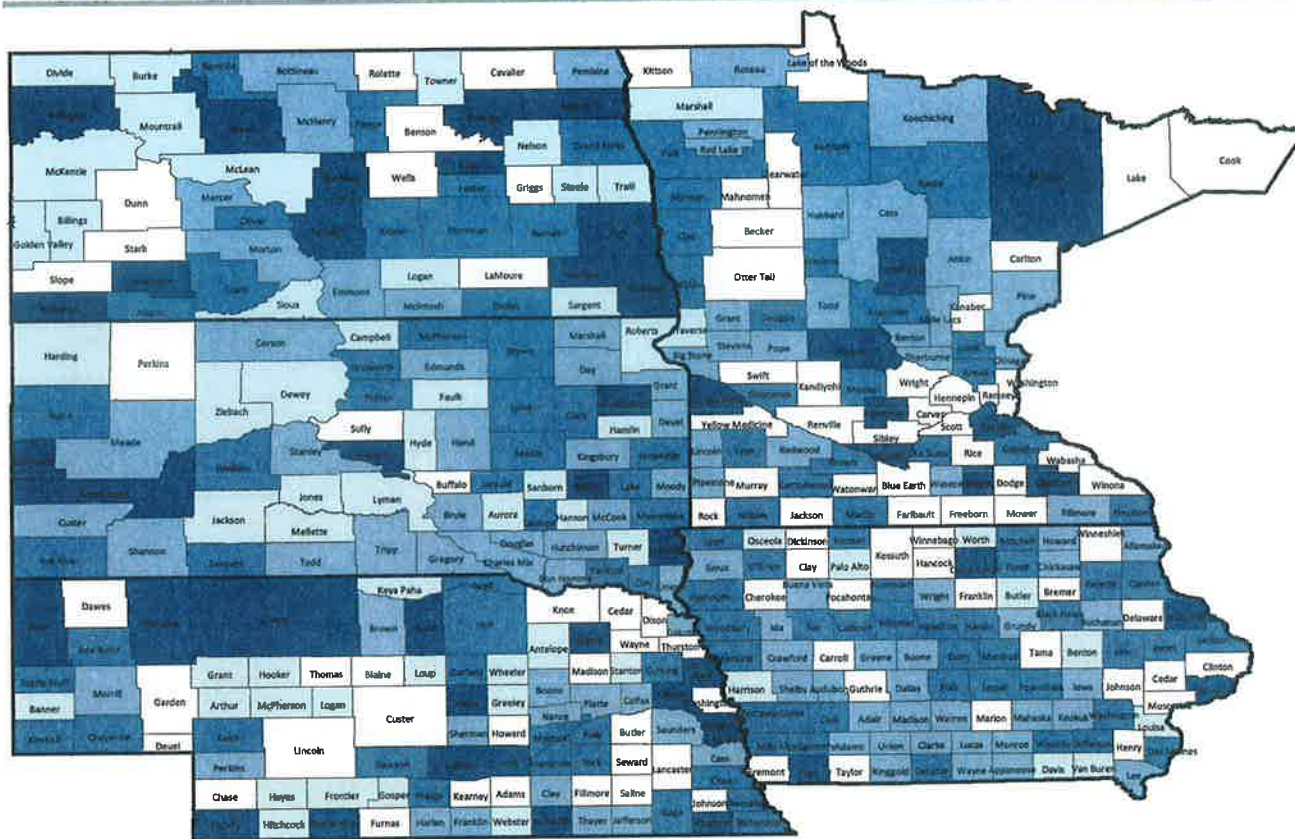
Where It Comes From: Data on mental health providers were obtained from the Health Resources and Services Administration's (HRSA) Area Resource File (ARF).

Importance: Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. (David Satcher, M.D., Ph.D., Surgeon General, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>)

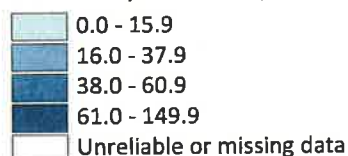
- Data were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Dentist Rate - A health factor measure focusing on clinical care
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of professionally active dentists per 100,000 population, 2007



CONTEXT

What It Is: The dentist rate is defined as the number of professionally active dentists per 100,000 population. Professionally active dentist occupation categories include active practitioners; dental school faculty or staff; armed forces dentists; government-employed dentists at the federal, state, or local levels; interns and residents; and other health or dental organization staff members.

Where It Comes From: Data on the number of dentists are tracked by the American Dental Association (ADA) and the American Medical Association (AMA). County-level data are housed in the Health Resources and Services Administration's Area Resource File (ARF) and made available through the Health Indicators Warehouse developed by the National Center for Health Statistics.

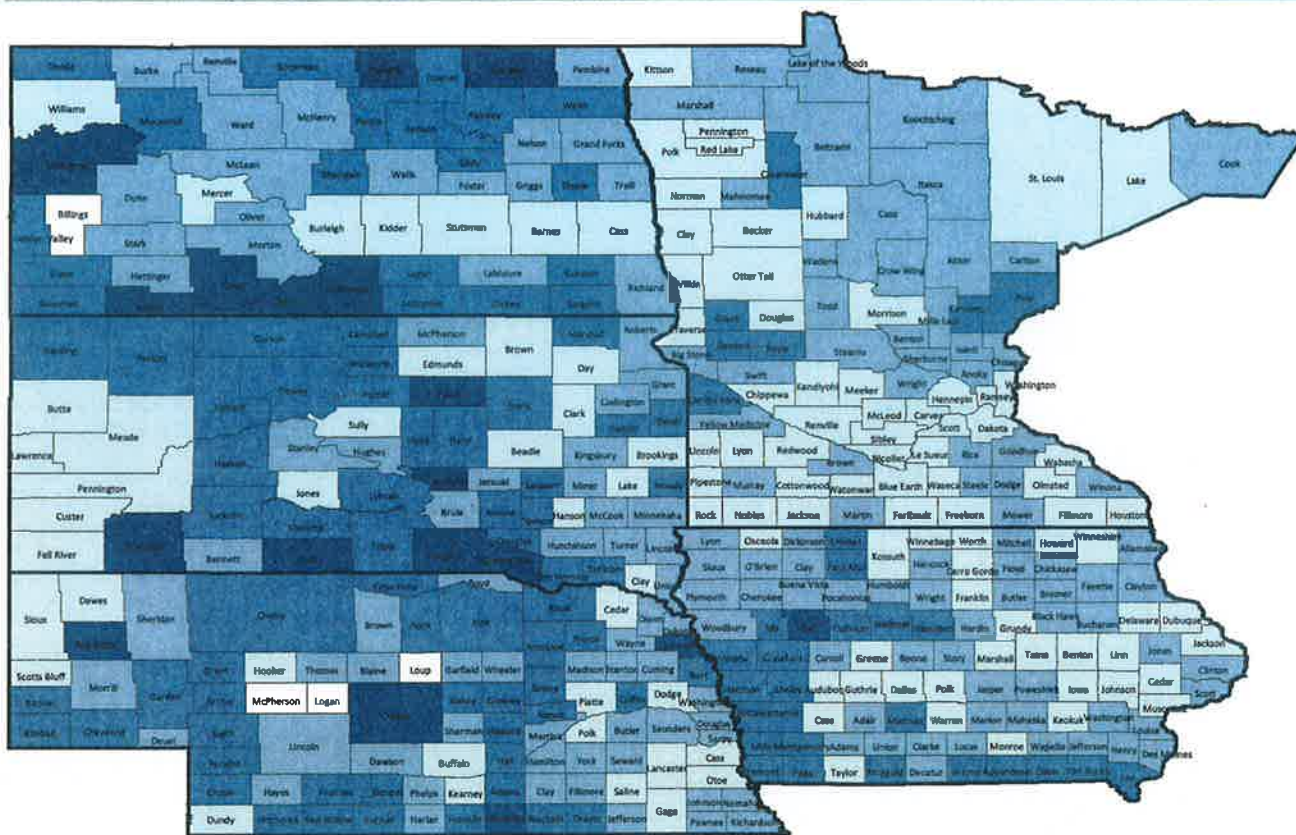
Importance: Today, thanks to fluoride, healthier lifestyles and quality dental care, more people than ever before are keeping their natural teeth throughout their lifetime. Yet for those who live in areas where a dentist is not available or those who cannot afford treatment, getting dental care can be difficult (American Dental Association, <http://www.ada.org>).

- Data were obtained from the Health Indicators Warehouse at <http://healthindicators.gov/> which is maintained by the Centers for Disease Control and Prevention's National Center for Health Statistics.

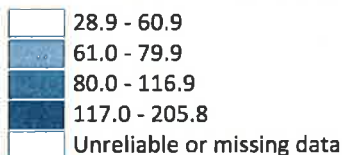
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Preventable Hospital Stays - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Hospitalization discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees, 2006-2007



CONTEXT

What It Is: Preventable hospital stays are measured as the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 Medicare enrollees.

Where It Comes From: Estimates of preventable hospital stays were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

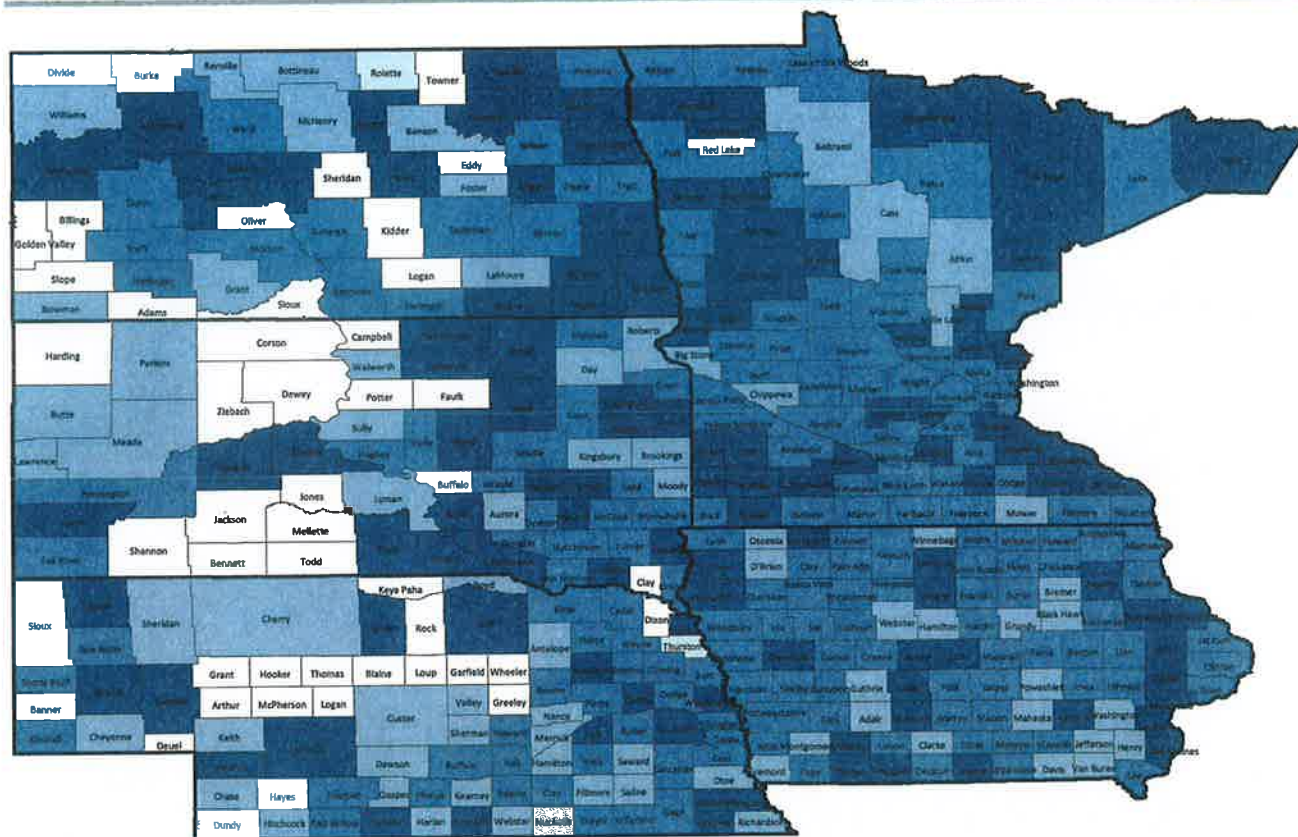
Importance: Hospitalization for diagnoses amenable to outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent the population's tendency to overuse the hospital as a main source of care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

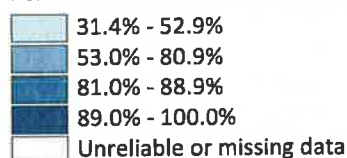
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Diabetic Screening - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of diabetic Medicare enrollees that receive HbA1c screening, 2006-2007



CONTEXT

What It Is: Diabetic screening is calculated as the percent of diabetic Medicare patients whose blood sugar control was screened in the past year using a test of their glycated hemoglobin (HbA1c) levels.

Where It Comes From: Estimates of diabetic screening were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

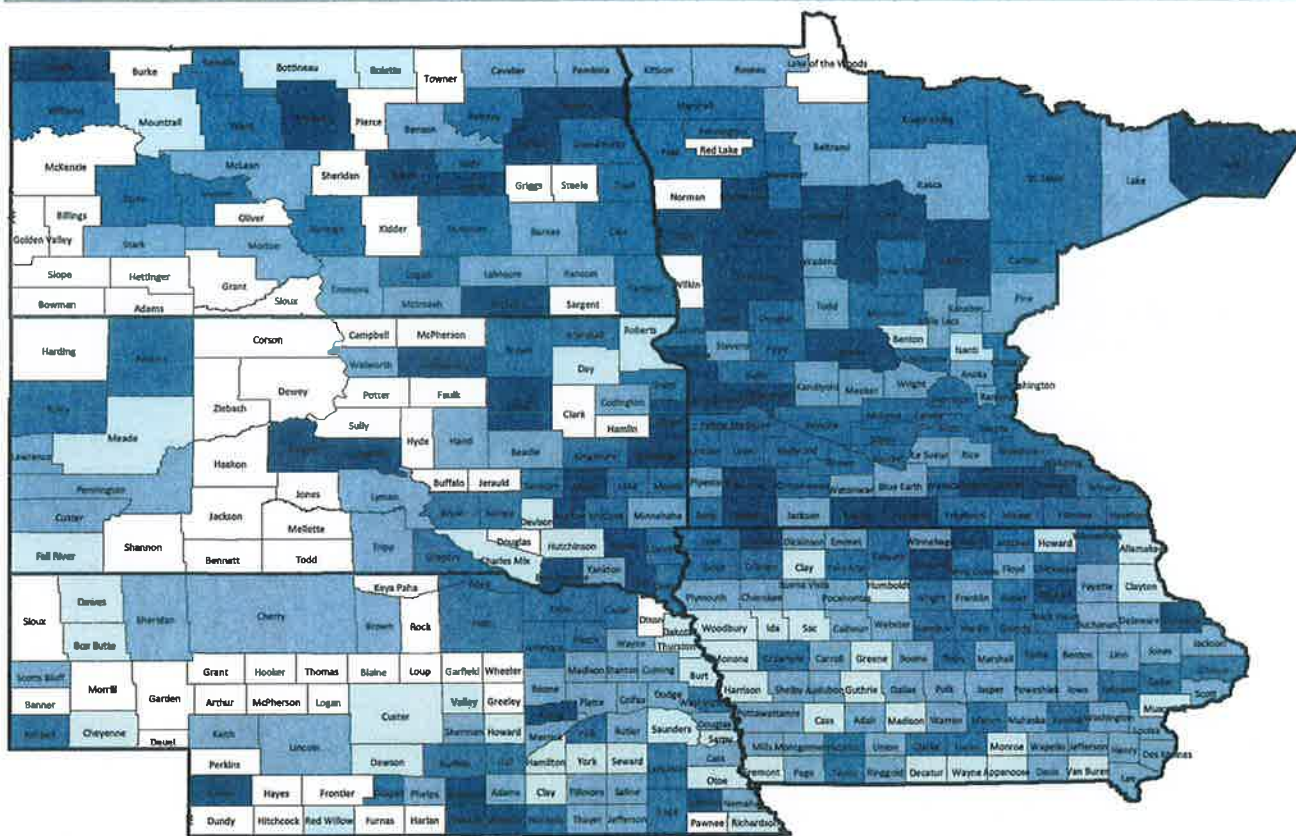
Importance: Regular HbA1c screening among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

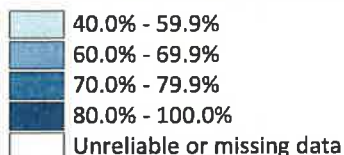
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Mammography Screening - A health factor measure focusing on clinical care

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of female Medicare enrollees that receive mammography screening, 2006-2007



CONTEXT

What It Is: This measure represents the percent of female Medicare enrollees ages 40 through 69 that had at least one mammogram over a two-year period.

Where It Comes From: Estimates were calculated by the authors of the Dartmouth Atlas of Health Care using Medicare claims data.

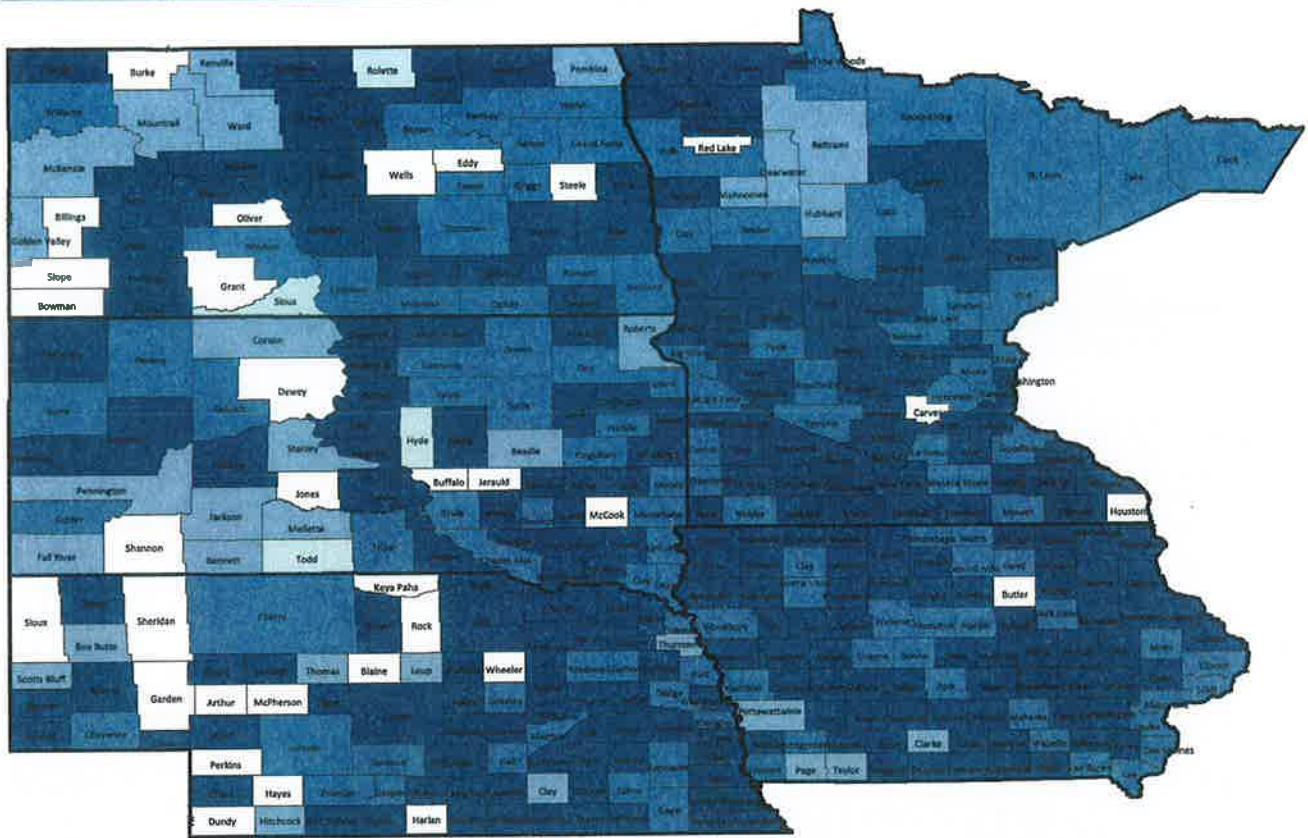
Importance: Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women. A physician’s recommendation or referral—and satisfaction with physicians—are major facilitating factors among women who obtain breast cancer screening. The percent of women ages 40 through 69 receiving a mammogram is a widely endorsed quality of care measure.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

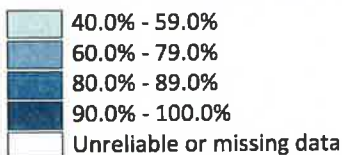
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High School Graduation - A health factor measure focusing on education

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of ninth-grade cohort in public schools that graduates from high school in four years, 2006-2007



CONTEXT

What It Is: High school graduation, commonly referred to as the averaged freshman graduation rate, is reported as the percent of a county's ninth-grade cohort in public schools that graduates from high school in four years.

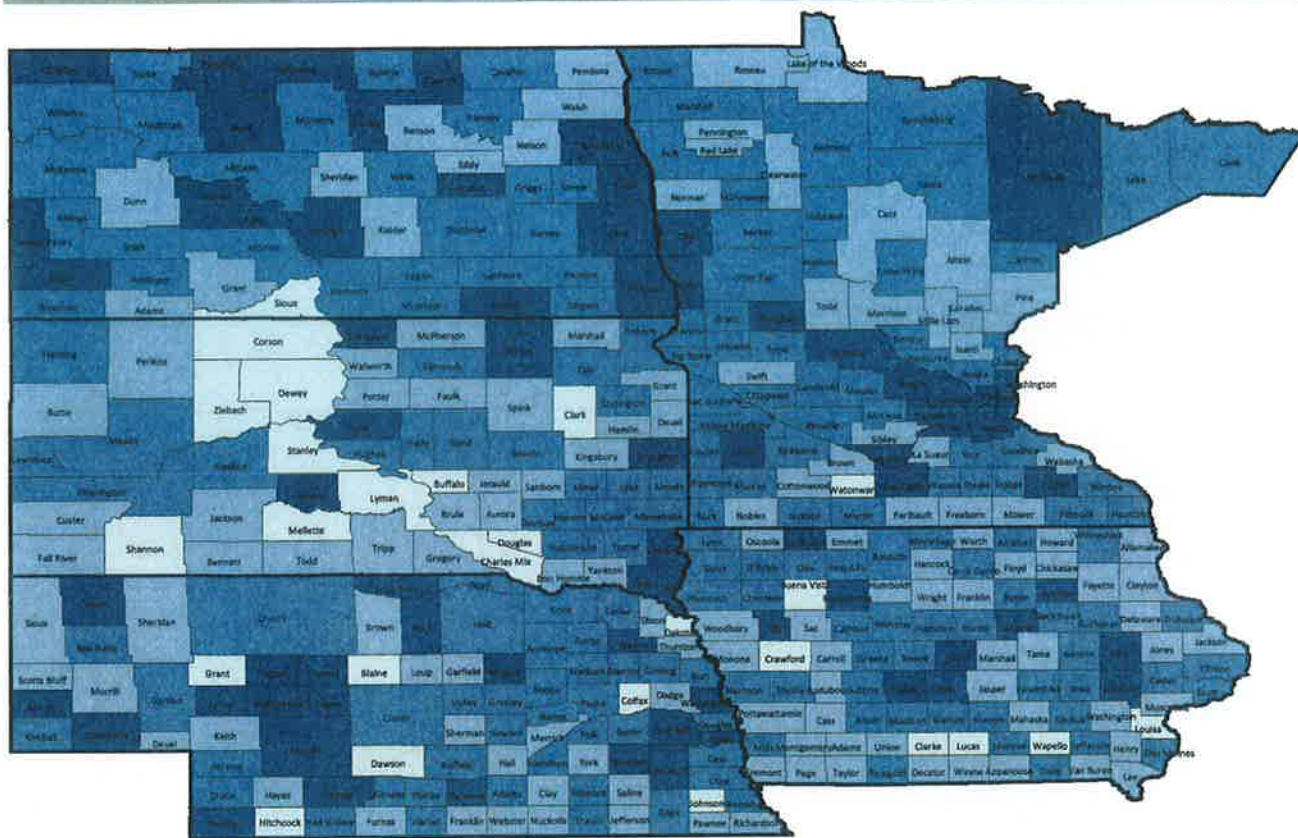
Where It Comes From: Estimates of high school graduation are based on the restricted-use versions of the LEA Universe Survey Dropout and Completion data and the Public Elementary/Secondary School Universe Survey data. These data were requested from NCES for the school year 2006-07.

Importance: The relationship between more education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

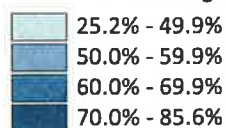
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Some College - A health factor measure focusing on education
 County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of adults ages 25 through 44 with some post-secondary education, 2005-2009



CONTEXT

What It Is: This measure represents the percent of the population ages 25 through 44 with some post-secondary education, such as enrollment at vocational/technical schools, junior colleges, or four-year colleges. It includes individuals who pursued education following high school but did not receive a degree.

Where It Comes From: Estimates of the population ages 25 through 44 with some post-secondary education were calculated using the 5-year estimates from the U.S. Census Bureau's American Community Survey (ACS).

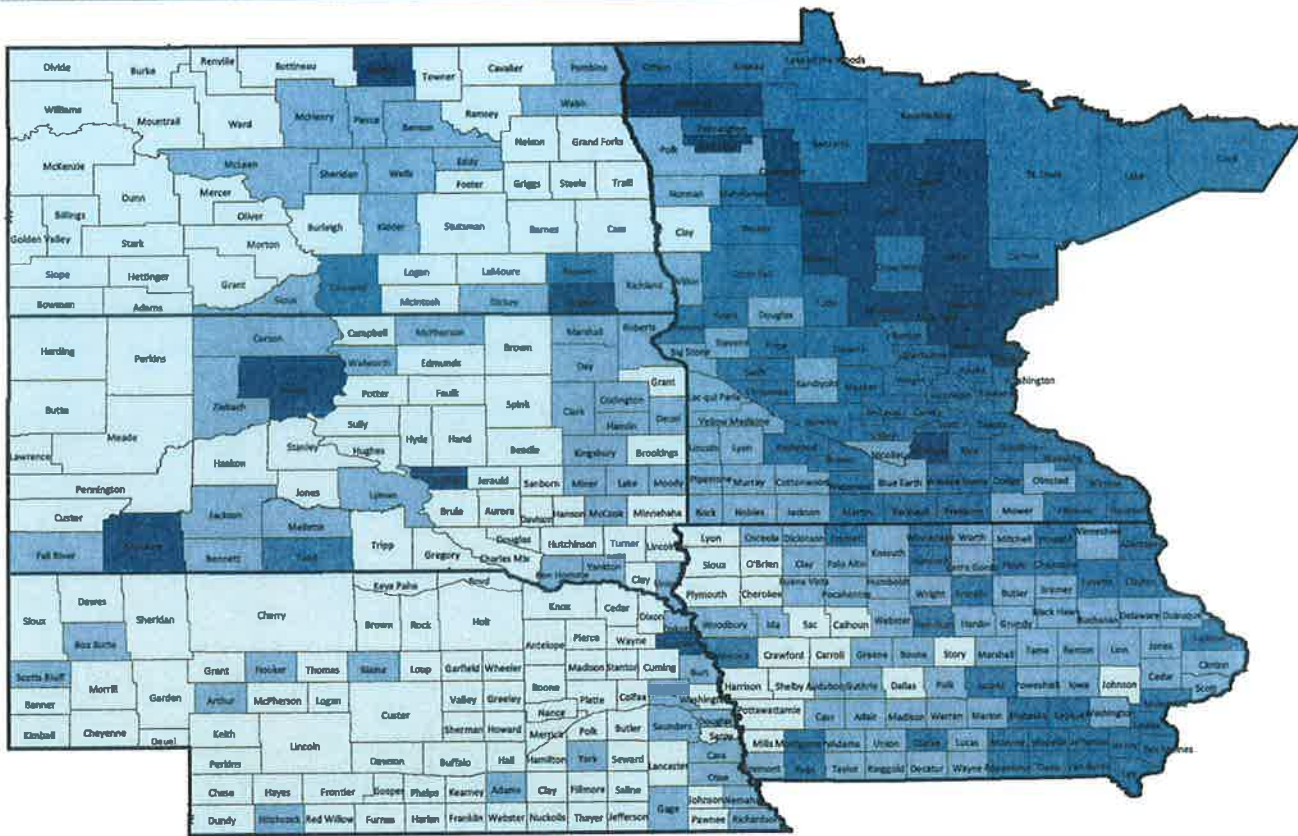
Importance: The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

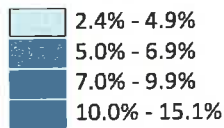
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Unemployment - A health factor measure focusing on labor

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of population ages 16 and older that is unemployed but seeking work, 2009



CONTEXT

What It Is: Unemployment is measured as the percent of the civilian labor force ages 16 and older that is unemployed but seeking work.

Where It Comes From: Data on unemployment is obtained from the Bureau of Labor Statistics (BLS), Local Area Unemployment Statistics (LAUS).

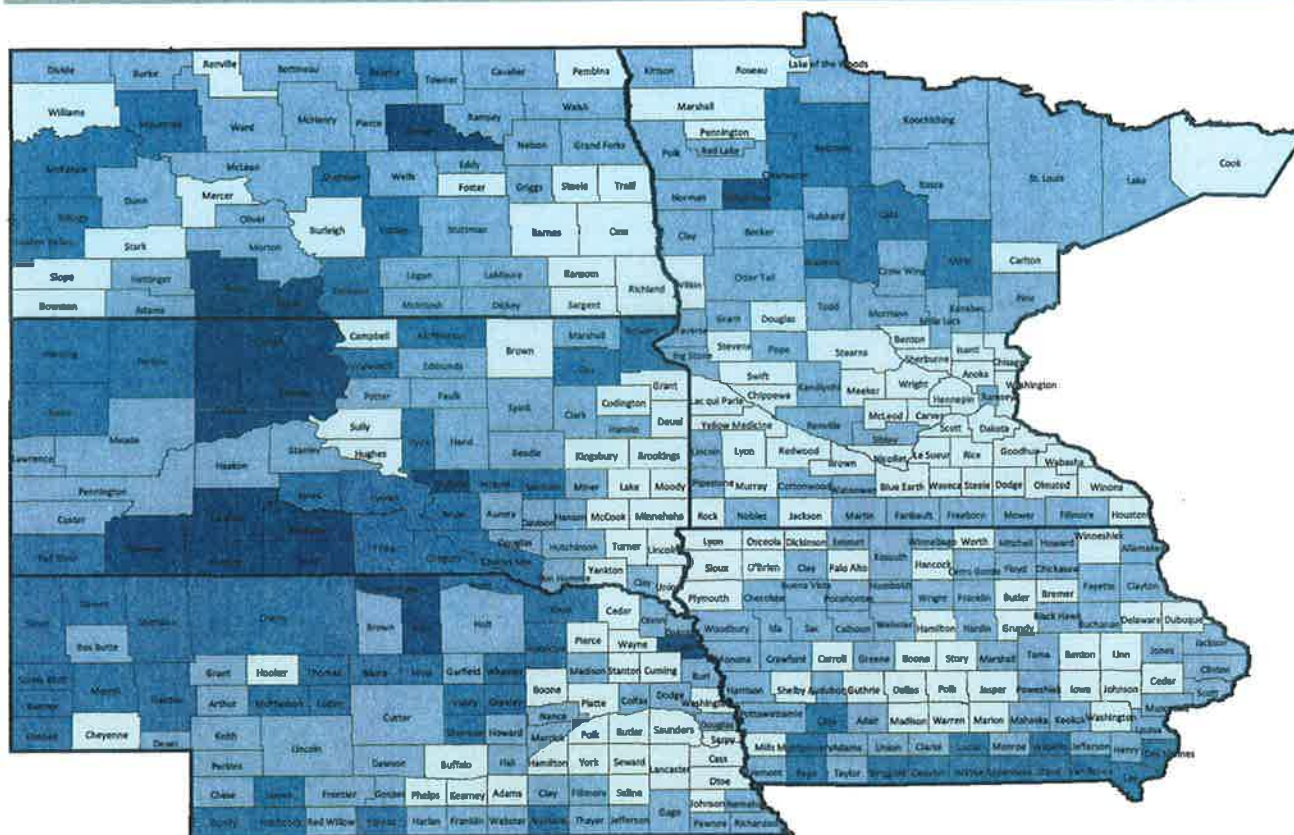
Importance: Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality. Because employee-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to health care.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

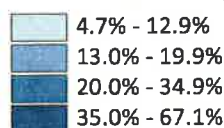
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Children in Poverty - A health factor measure focusing on income and poverty

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of children ages 0 through 17 living below the Federal Poverty Line, 2008



CONTEXT

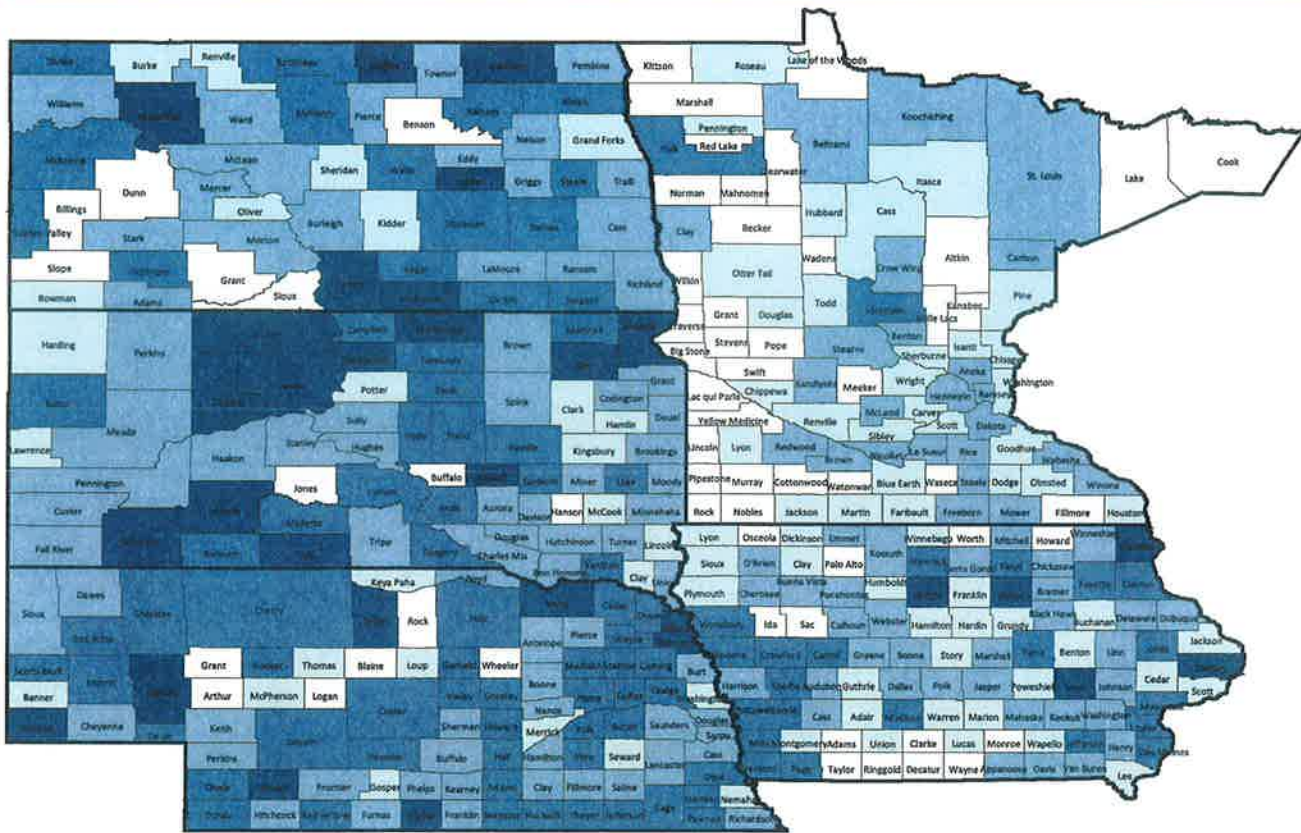
What It Is: Children in poverty is the percent of children under age 18 living below the Federal Poverty Line (FPL).

Where It Comes From: Children in poverty estimates are provided by the Small Area Income and Poverty Estimates (SAIPE) program through the U.S. Census Bureau.

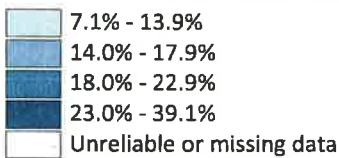
Importance: Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. While negative health effects resulting from poverty are present at all ages, children in poverty experience greater morbidity and mortality due to an increased risk of accidental injury and lack of health care access. Children's risk of poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. The children in poverty measure is highly correlated with overall poverty rates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Percent of adults that never, rarely, or sometimes get the social and emotional support they need, 2003-2009



CONTEXT

What It Is: The social and emotional support measure is based on responses to the question: “How often do you get the social and emotional support you need?” The value presented is the percent of the adult population that responds that they “never,” “rarely,” or “sometimes” get the support they need.

Where It Comes From: This measure was calculated by the National Center for Health Statistics using data obtained from the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

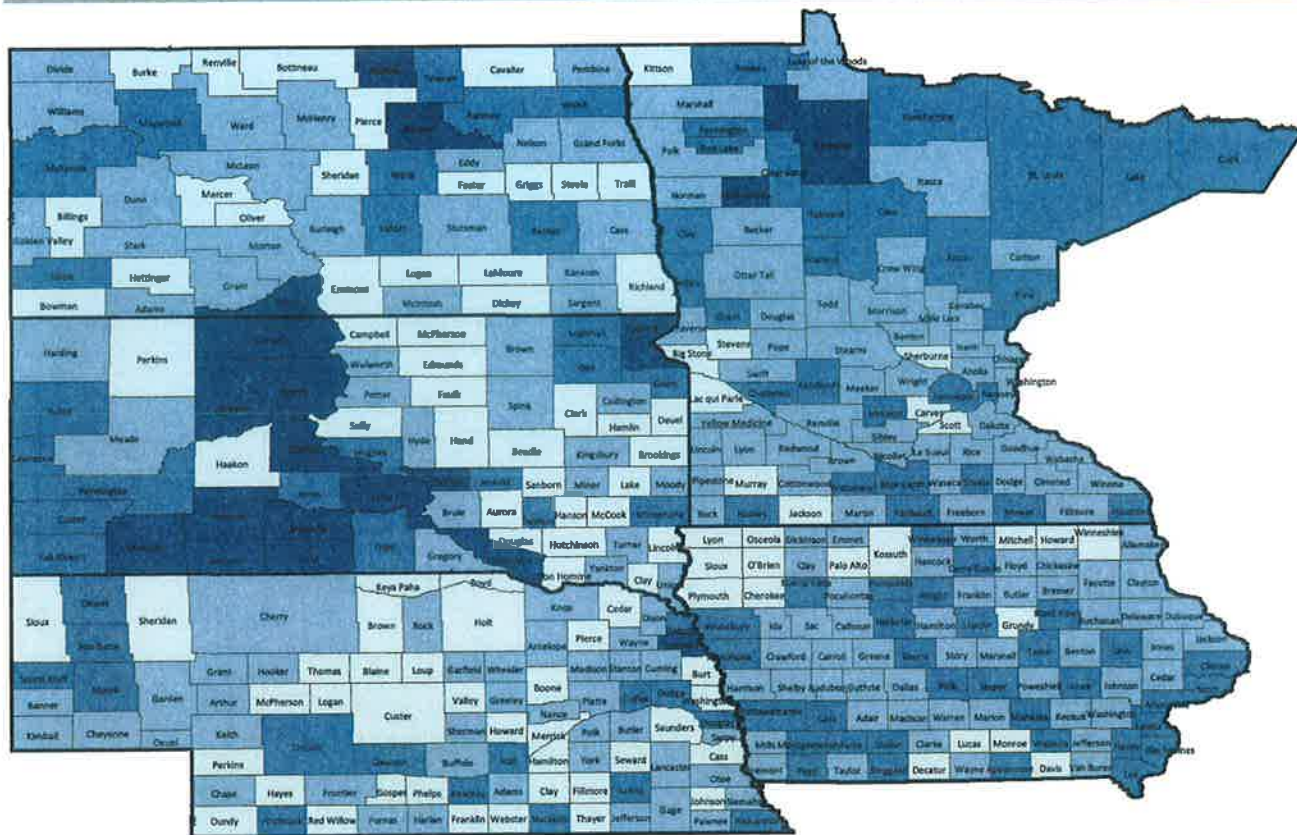
Importance: Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore, social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without a strong social network are less likely to participate in healthy lifestyle choices.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

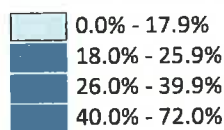
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Children in Single-Parent Households - A health factor measure focusing on families

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of children in families that live in a household headed by a parent with no spouse present, 2005-2009



CONTEXT

What It Is: The single-parent household measure is the percent of all children in family households that live in a household headed by a single parent (male or female householder with no spouse present).

Where It Comes From: Estimates of the percent of children in single-parent households were calculated using data from the U.S. Census Bureau's American Community Survey (ACS) 5-year estimates.

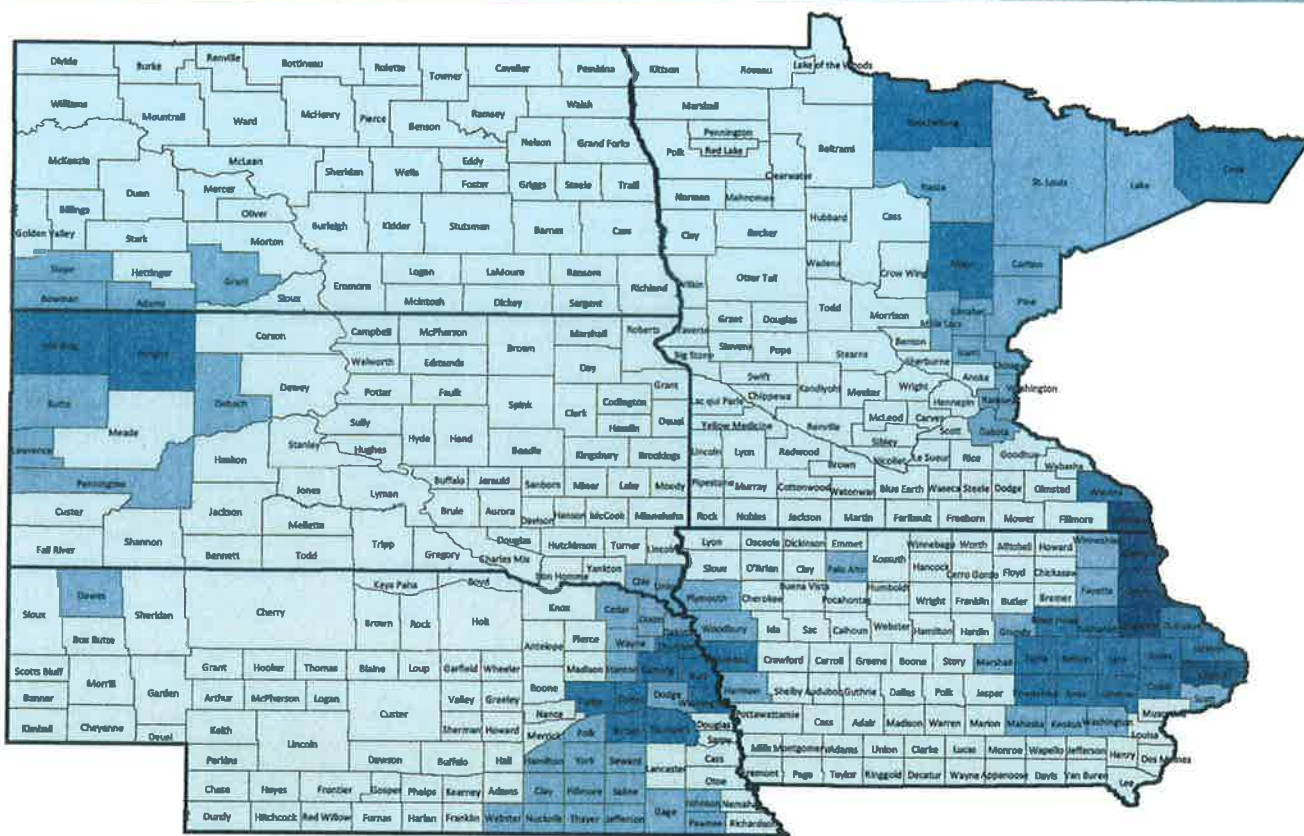
Importance: Adults and children in single-parent households are both at risk for adverse health outcomes such as mental health problems (including substance abuse, depression, and suicide) and unhealthy behaviors such as smoking and excessive alcohol use.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Air Pollution-Particulate Matter Days - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of days air quality was unhealthy for sensitive populations due to fine particulate matter, 2006



CONTEXT

What It Is: The air pollution—particulate matter measure represents the annual number of days that air quality was unhealthy for sensitive populations due to fine particulate matter (FPM, < 2.5 μm in diameter).

Where It Comes From: The Public Health Air Surveillance Evaluation (PHASE) project, a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the EPA, used Community Multi-Scale Air Quality Model (CMAQ) output and air quality monitor data to create a spatial-temporal model that estimated fine particulate matter concentrations throughout the year. The PHASE estimates were used to calculate the number of days per year that air quality in a county was unhealthy for sensitive populations due to FPM.

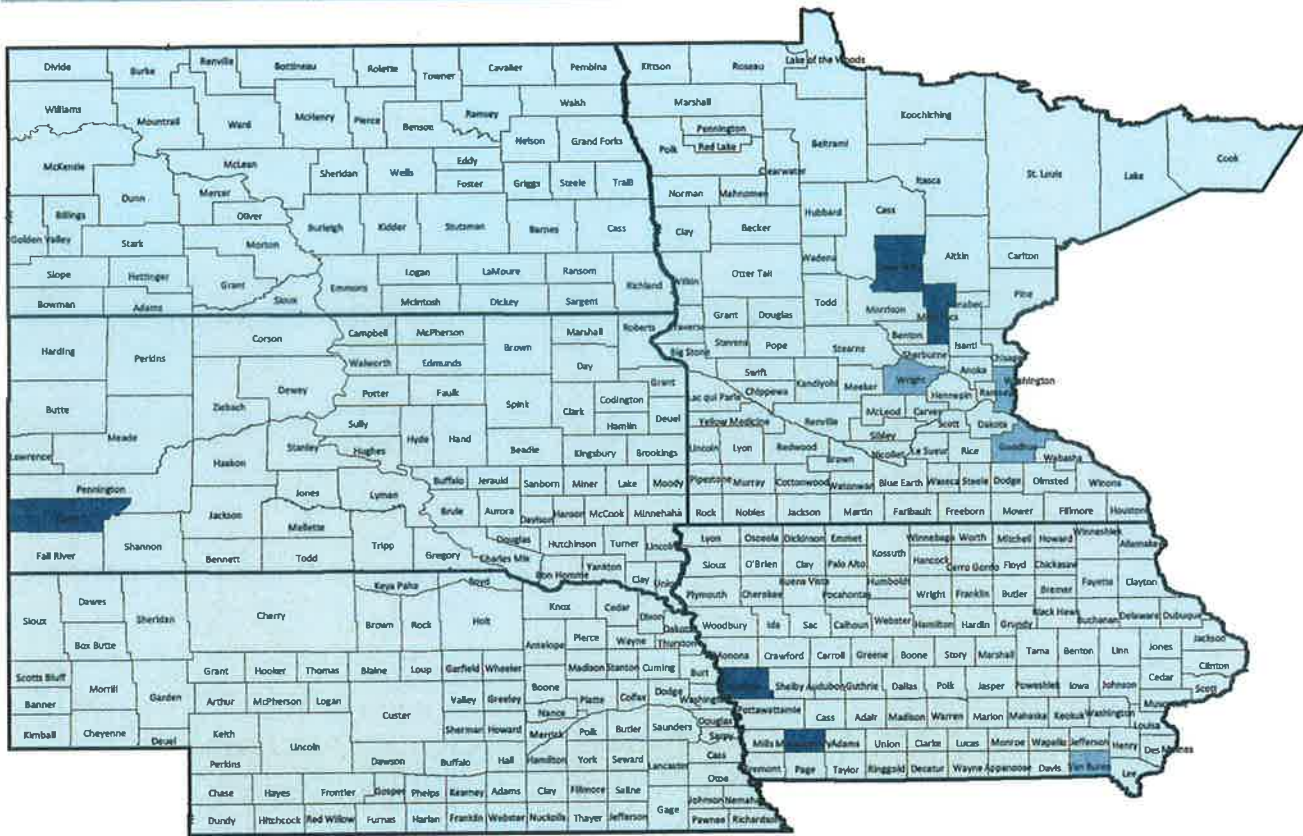
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Air Pollution-Ozone Days - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of days air quality was unhealthy for sensitive populations due to ozone levels, 2006



CONTEXT

What It Is: The air pollution—ozone measure represents the annual number of days that air quality was unhealthy for sensitive populations due to ozone levels.

Where It Comes From: The Public Health Air Surveillance Evaluation (PHASE) project, a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the EPA, used Community Multi-Scale Air Quality Model (CMAQ) output and air quality monitor data to create a spatial-temporal model that estimated daily ozone concentrations throughout the year. The PHASE estimates were used to calculate the number of days per year that air quality in a county was unhealthy for sensitive populations due to ozone.

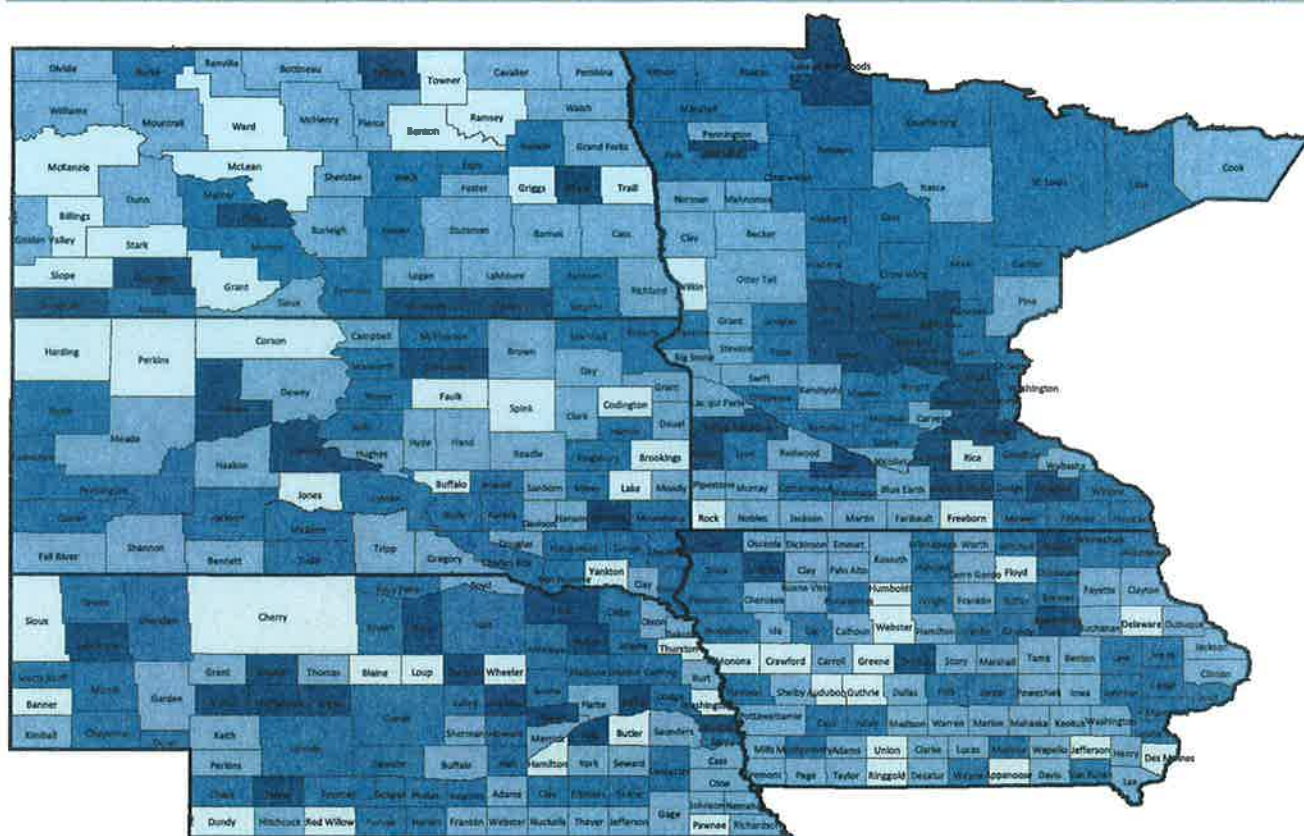
Importance: The relationship between elevated air pollution—particularly fine particulate matter and ozone—and compromised health has been well documented. The negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.

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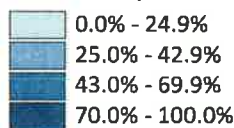
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Access to Healthy Foods - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of zip codes with healthy food outlets (i.e., grocery store or produce stand/farmers' market), 2008



CONTEXT

What It Is: Access to healthy foods is measured as the percent of zip codes in a county with a healthy food outlet, defined as a grocery store or produce stand/farmers' market.

Where It Comes From: The measure is based on data from the U.S. Census Bureau's Zip Code Business Patterns. Healthy food outlets include grocery stores and produce/farmers' markets, as defined by their North American Industrial Classification System (NAICS) codes.

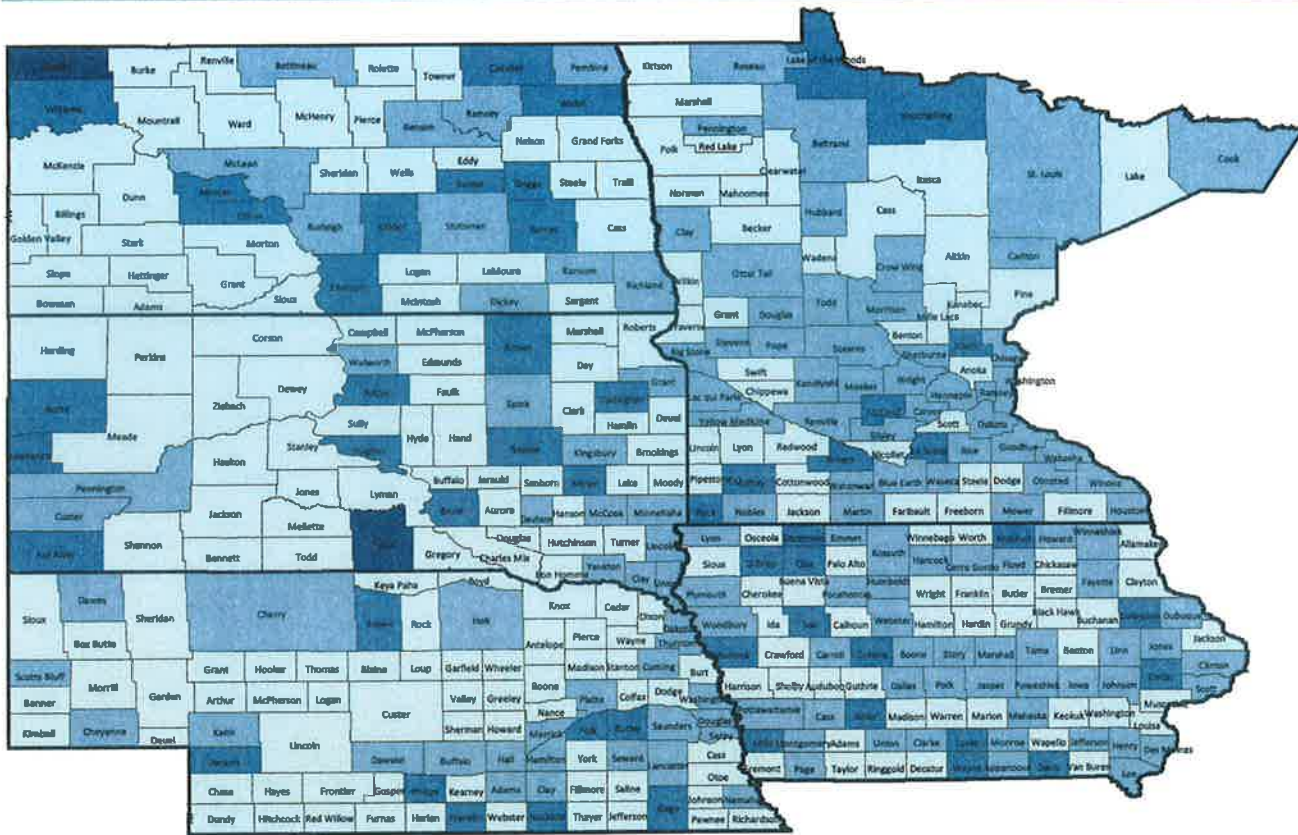
Importance: Studies have linked the food environment to consumption of healthy food and overall health outcomes.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

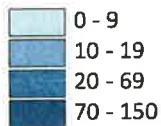
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Access to Recreational Facilities - A health factor measure focusing on physical environment

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Number of recreational facilities per 100,000 population, 2008



CONTEXT

What It Is: This measure represents the number of recreational facilities per 100,000 population in a given county. Recreational facilities are defined as establishments primarily engaged in operating fitness and recreational sports facilities, featuring exercise and other active physical fitness conditioning or recreational sports activities such as swimming, skating, or racquet sports.

Where It Comes From: This measure is based on a measure from United States Department of Agriculture (USDA) Food Environment Atlas, and is calculated using the most current County Business Patterns data set. Recreational facilities are identified by North American Industrial Classification System (NAICS) code 713940.

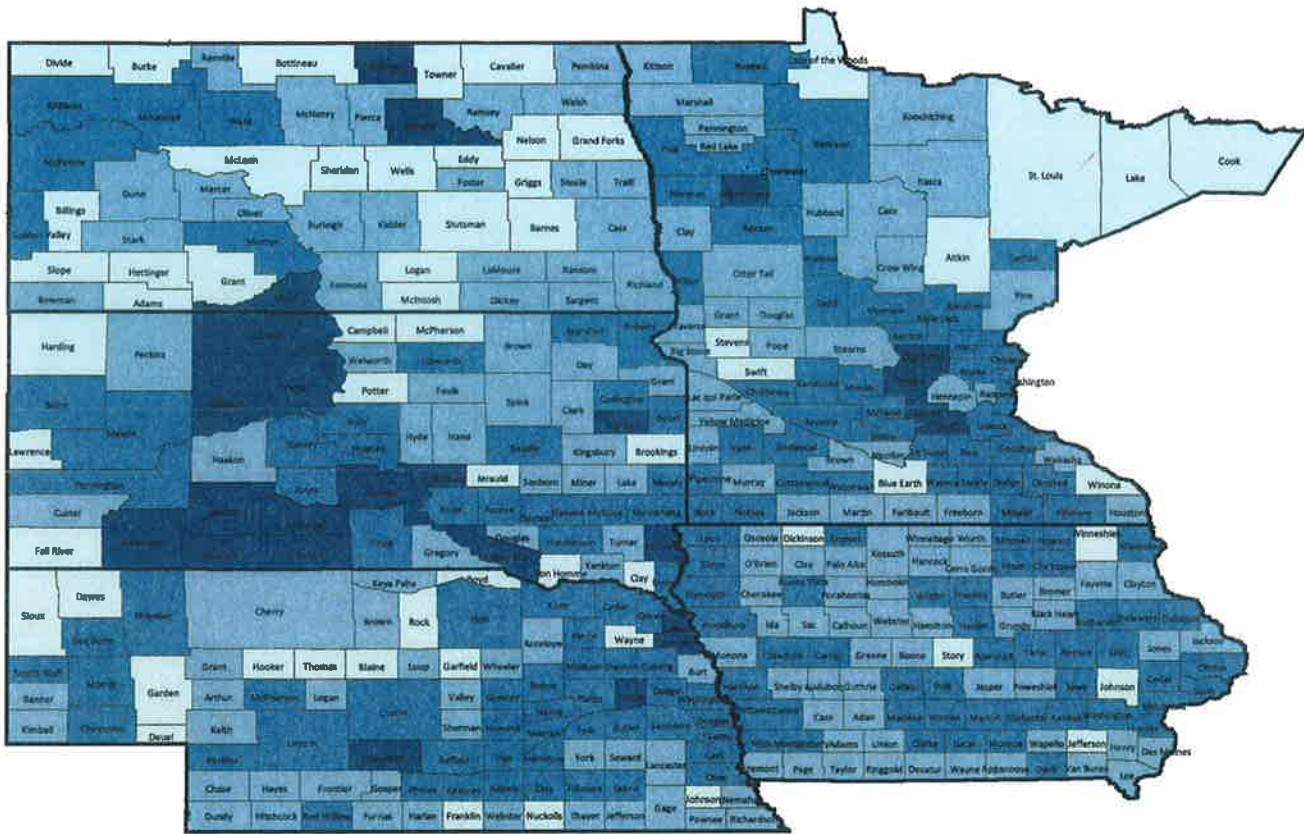
Importance: The availability of recreational facilities can influence individuals' and communities' choices to engage in physical activity. Proximity to places with recreational opportunities is associated with higher physical activity levels, which in turn is associated with lower rates of adverse health outcomes associated with poor diet, lack of physical activity, and obesity.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

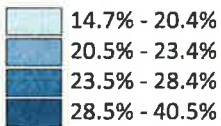
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Youth - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Persons ages 0 through 17 as a percent of the total population, 2009



CONTEXT

What It Is: This measure represents the percent of a county’s population that is less than 18 years of age.

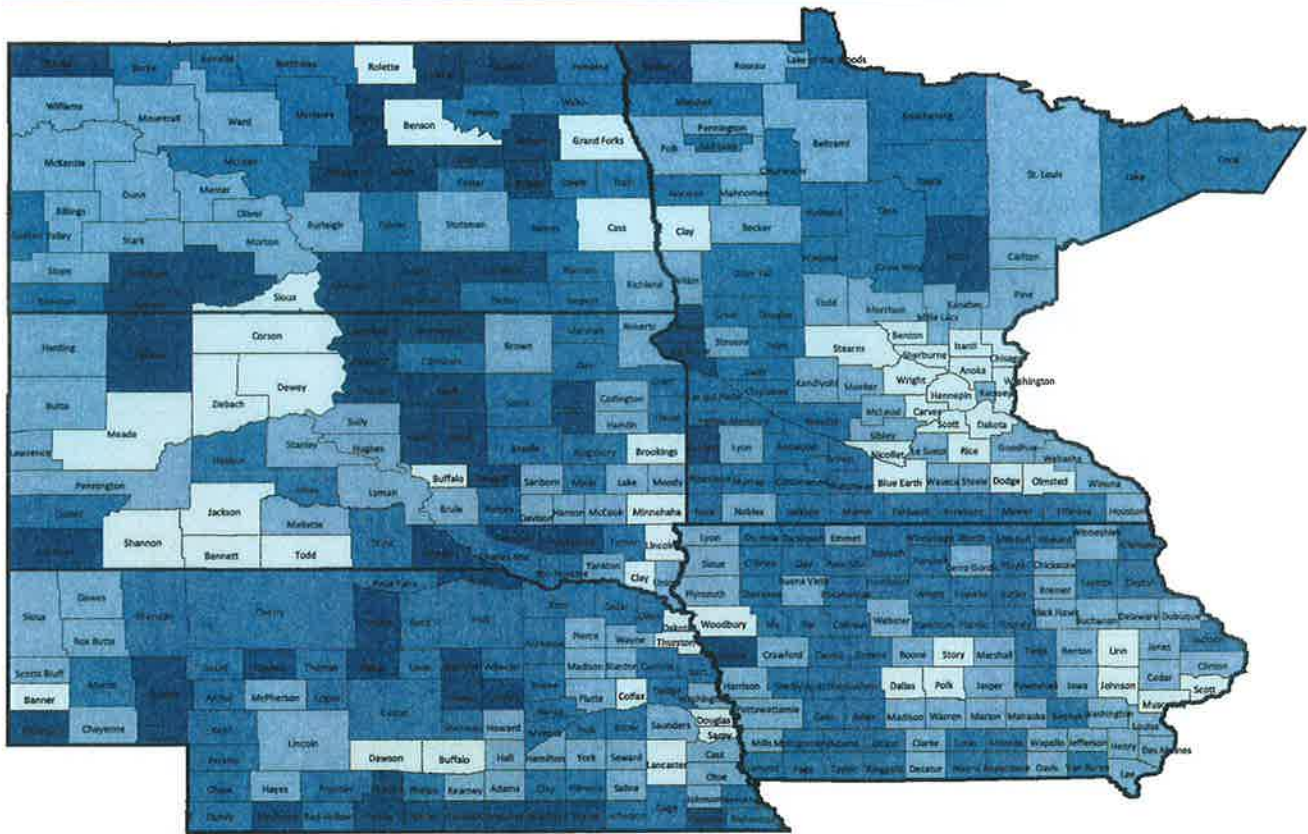
Where It Comes From: County demographic figures come from the U.S. Census Bureau’s annual population estimates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

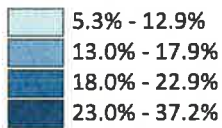
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Elderly - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Persons ages 65 and older as a percent of the total population, 2009



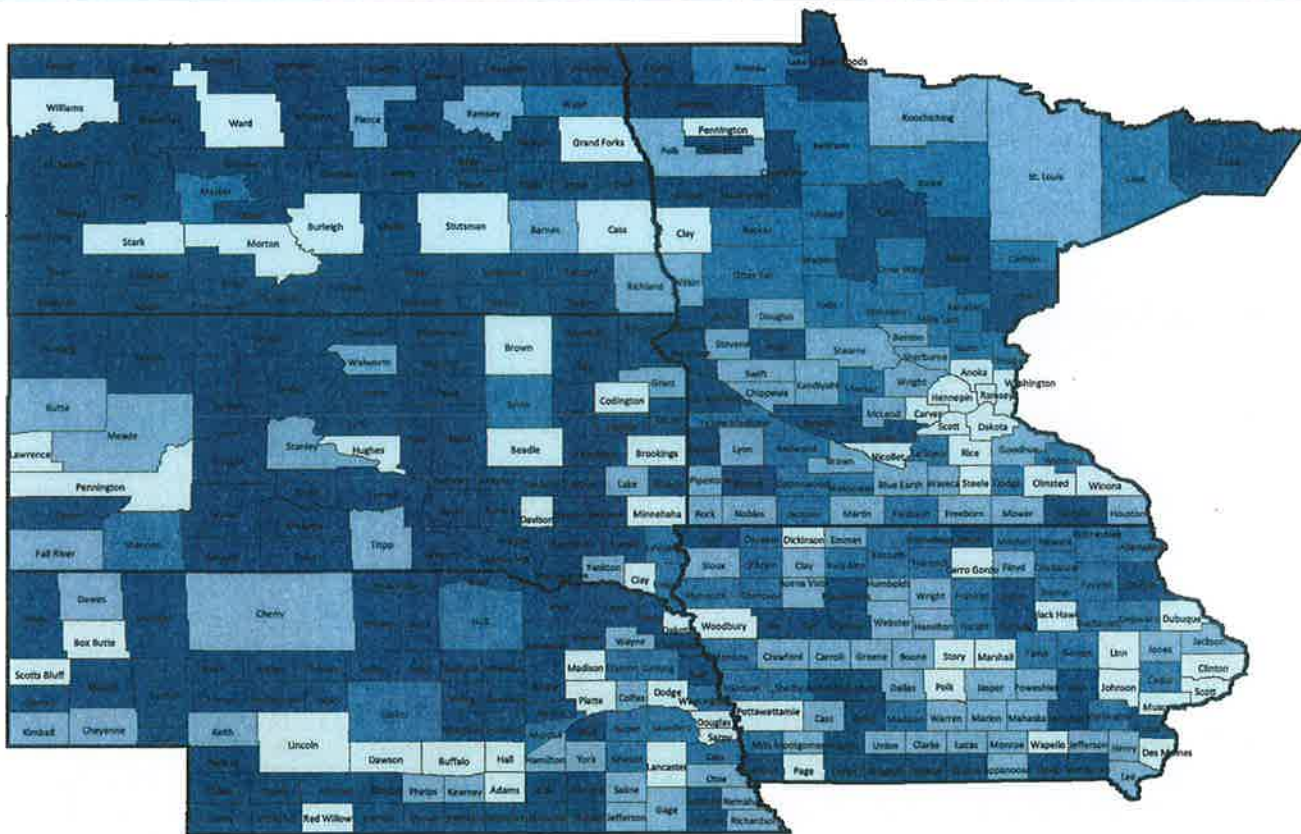
CONTEXT

What It Is: This measure represents the percent of a county’s population that is 65 years of age and older.

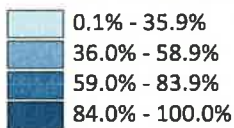
Where It Comes From: County demographic figures come from the U.S. Census Bureau’s annual population estimates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Percent of total population living in a rural area, 2000



CONTEXT

What It Is: This measure represents the percent of a county’s population that lives in a rural area, which the U.S. Census Bureau defines as all territory located outside of urbanized areas and urban clusters. Urbanized areas and urban clusters are geographic areas with a core population density of at least 1,000 people per square mile that are surrounded by areas with an overall population density of at least 500 people per square mile.

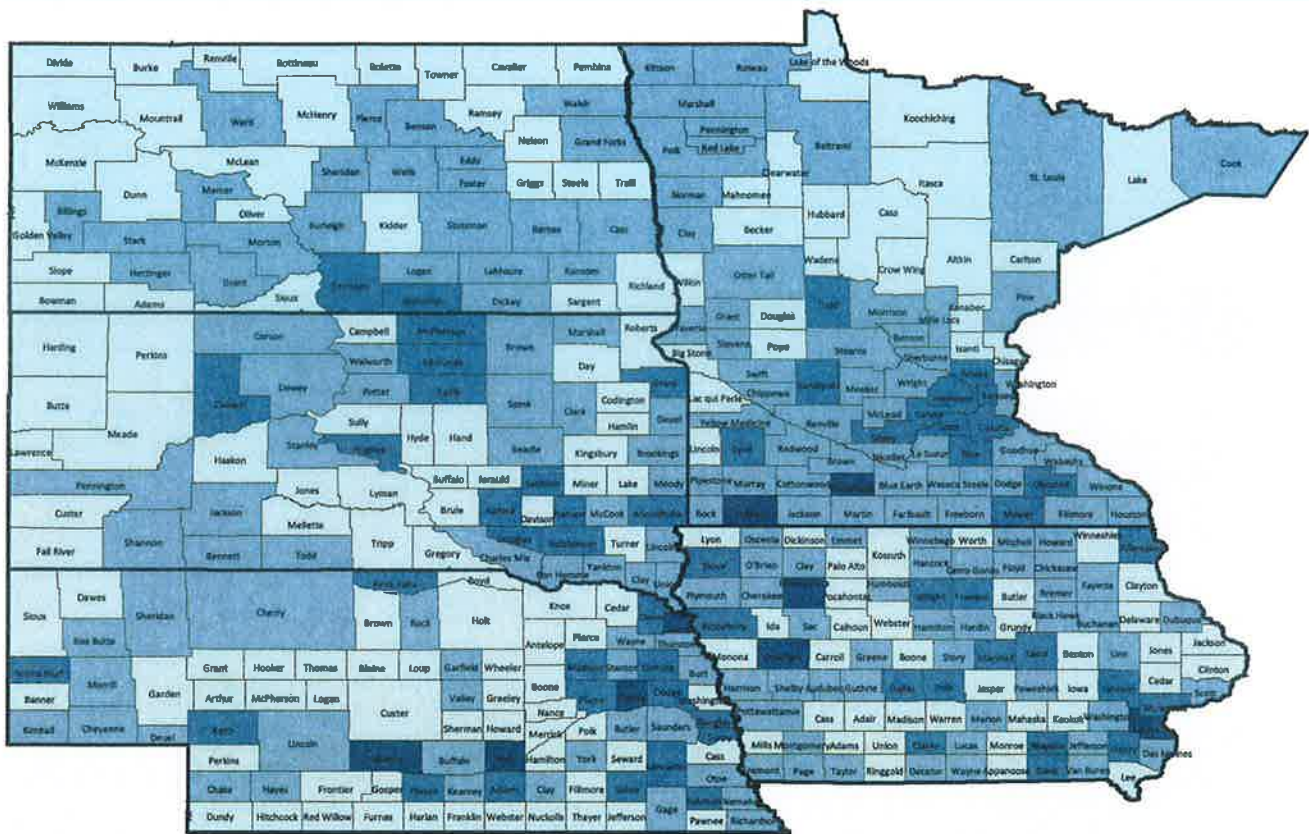
Where It Comes From: This measure is calculated by the U.S. Census Bureau using data from 2000.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

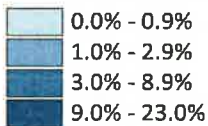
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Not English Proficient - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of total population that speaks English less than "very well", 2005-2009



CONTEXT

What It Is: This measure represents the percent of the total population that reports speaking English less than "very well."

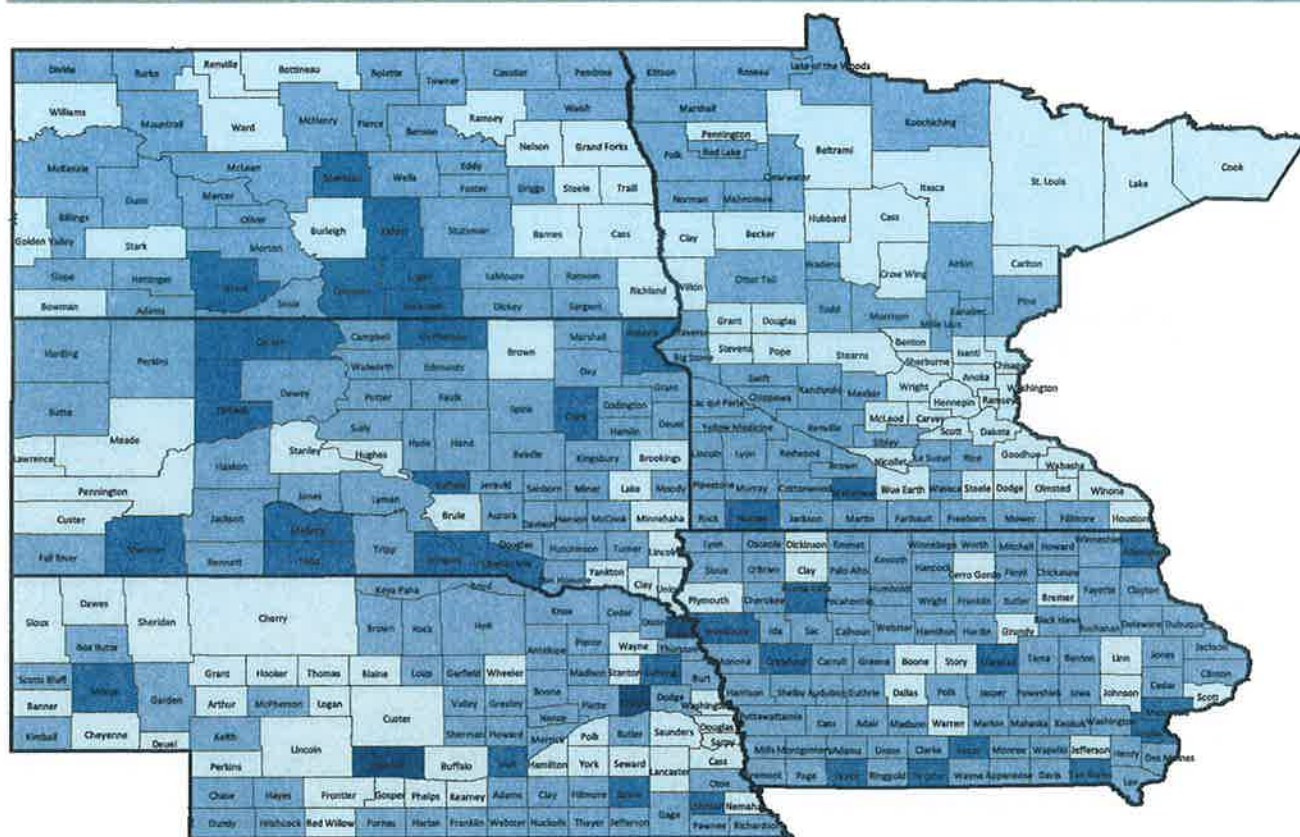
Where It Comes From: Data on spoken English proficiency come from the U.S. Census Bureau's American Community Survey 5-year estimates.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

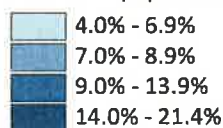
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Illiteracy - A demographic measure

County distribution map for Iowa, Minnesota, Nebraska, North Dakota, and South Dakota



Percent of population ages 16 and older that lacks basic prose literacy skills, 2003



CONTEXT

What It Is: This measure reflects the percent of the population ages 16 and older that lacks basic prose literacy skills.

Where It Comes From: This measure is obtained from the National Center for Education Statistics and is based on the 2003 National Assessment of Adult Literacy.

- Data and associated context were obtained from County Health Rankings, a key component of the Mobilizing Action Toward Community Health (MATCH) project - a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, <http://www.countyhealthrankings.org/>.

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Table 1
Community Health Needs Assessment Asset Mapping
Vermillion Stakeholders

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Cancer	<ul style="list-style-type: none"> Many people with cancer Need more services for people with cancer 	<ul style="list-style-type: none"> Sanford Cancer Biology Research Center SVMC Oncology Outreach Physician Monthly SVMC Chemotherapy Services SVMC Hospice Services 	
Child Care	<ul style="list-style-type: none"> Need quality child care 	<ul style="list-style-type: none"> Dept of Social Services/Child Care Assistance Program Clay County Extension Office 	
Diabetes	<ul style="list-style-type: none"> Affordable preventive care for those with diabetes 	<ul style="list-style-type: none"> Sanford Project to find a cure for Type 1 Diabetes in Denny Sanford's lifetime SC Vermillion Health Coach Diabetic Program SVMC Diabetic Educator & RD Educator Diabetic Foot Care Clinics 	
Dialysis	<ul style="list-style-type: none"> Need a dialysis center 	<ul style="list-style-type: none"> Yankton SVMC has done a feasibility study in recent years and there is not enough patients in community to be financially feasible Vermillion Transit is available for transportation to SMC \$15 round trip 	yes
Disabled	<ul style="list-style-type: none"> Cost of services to the disabled, including transportation Very little resources/services for autistic spectrum disorders & little for cognitive disorders in general 	<ul style="list-style-type: none"> Autistic – Birth to 3; Early Childhood, School System OTs & IEP; SVMC OT & ST Depts. USD Disability Center 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
		<ul style="list-style-type: none"> Vermillion Transit Dept of Social Services Assists with costs of transportation 	
Driving Habits/ Seat Belts	<ul style="list-style-type: none"> Not using turn signals Not using seat belts Texting while driving Cell phone usage while driving 	<ul style="list-style-type: none"> Refer to Law Enforcement SVMC OT Driving Evaluations Drivers Education Program Local State Representatives & Senators 	
Economic Issues Education	<ul style="list-style-type: none"> Lack of commitment to sustainability Cost of higher education 	<ul style="list-style-type: none"> Refer to City of Vermillion Refer to Board of Regents Office; Dept of Education 	
Elder Care - Home Health - Expanded Nursing Home Capacity	<ul style="list-style-type: none"> Healthy aging Elder care More home health care for the elderly 	<ul style="list-style-type: none"> Private Home Care Agencies – Heart Print; Synergy Sanford Visiting Nurses Association Sanford Medical Home Dept of Social Services Refer to Local State Representatives & Senators 	yes
Healthcare Cost/Insurance Cost	<ul style="list-style-type: none"> Even co-pays & deductibles are hard to pay – 20% of a procedure can be too much. I have not gone to the doctor because of the cost of insurance. Cost of healthcare for those who are not able to pay Inaccurate billing / refusal of insurance company to cover charges. Tired of having to double-check & fight for corrections. Need children to stay on health insurance after age 23 More & more children have issues with obesity but health insurance does not cover the cost of a doctor visit to address the issue Except for inoculations, insurance does not cover preventive medical visits Prenatal care for students is not covered with their 	<ul style="list-style-type: none"> Sanford Online Access to Bill Pay Accountable Care Act allows dependent child to be on parents' insurance through 26 Sanford Health Community Care Sanford Vermillion Financial Counselor helps face to face with patients' bills and finding additional assistance for payment of any bills Sanford Kid Fit Program for Preventative Care Sanford Fit Web Program www.fit.webmd.com Refer preventative care insurance concerns to SD Congressional Delegates – Tim Johnson, Kristi Noem & John Thune 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	insurance coverage through SDBOR student health insurance		
Healthy Nutrition	<ul style="list-style-type: none"> Healthy eating needs to be emphasized Grocery stores do not stock quality fresh vegetables & organic choices 	<ul style="list-style-type: none"> HVVe – new organic section Walmart – organic section Sanford Registered Dietitian Outreach Consult Farmers Market Sanford Kids Fit Program WIC Program Clay County Extension Office Downtown Organic Store 	
Housing	<ul style="list-style-type: none"> Rental housing is of poor quality (not maintained) & is expensive Housing prices are very high here because it is a college town Need quality housing at all levels 	<ul style="list-style-type: none"> City of Vermillion Code Enforcement Refer to HUD – Vermillion Office Governor’s Houses 	
Hunger	<ul style="list-style-type: none"> Large numbers need to access our Food Pantry Children who go home with weekend backpacks of food – is it enough to cover all weekend? 	<ul style="list-style-type: none"> Welcome Table Monday evenings United Way Dept of Social Services Vermillion Ministerial Assn St Vincent de Paul Vermillion Food Pantry Main Street Center meals on wheels Refer to Law Enforcement 	
Judicial System	<ul style="list-style-type: none"> Biased police officers 		
Mental Health	<ul style="list-style-type: none"> Concern over lack of services Not comfortable with the providers in town Cost of seeing a counselor is too high (insurance is limited) Confidentiality - difficult to get mental health services without the entire community finding out about it 	<ul style="list-style-type: none"> USD Counseling Center Lewis & Clark Counseling Outreach Office USD Psychology Dept Counseling Michelle Hinseth, MSW, CSW, PIP at SVMC Private Counseling Services in Vermillion Nikki’s Fund for Mental Health Services SVMC Emergency Room 	yes

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Obesity	<ul style="list-style-type: none"> Inadequate nutrition + lack of exercise = obesity Affordable preventative care for those with weight issues 	<ul style="list-style-type: none"> Sanford Kid Fit Program for Preventative Care Sanford Fit Web Program www.fit.webmd.com Refer preventative care insurance concerns to SD Congressional Delegates – Tim Johnson, Kristi Noem & John Thune 	
OB/GYN	<ul style="list-style-type: none"> Need prenatal care in the community Need natural birth options 	<ul style="list-style-type: none"> SVMC Family Medicine Providers (3) who do OB/Prenatal Care Vermillion Medical Care OBGyn Outreach – 1 ½ Days per Week (2 Providers do Prenatal Care) SVMC offers natural/drug-free deliveries SMC offers water births & mid-wifery 	
Pollution	<ul style="list-style-type: none"> Many concerns re: air & water pollution if the Hyperion oil refinery is built 	<ul style="list-style-type: none"> Refer to SD Legislatures 	
Poverty	<ul style="list-style-type: none"> Cost of healthcare for those who are not able to pay High level of poverty & low income families due to USD students & many low-paying jobs. Vermillion needs more manufacturing jobs with higher pay. 	<ul style="list-style-type: none"> Refer to Vermillion Chamber of Commerce/VDC Refer to SD Congress Members – Thune, Noem, Johnson Dept of Social Services 	
Prevention Services	<ul style="list-style-type: none"> Awareness of availability & utilization of health prevention & wellness options Except for inoculations, insurance does not cover preventive medical visits Affordable preventative care for those with diabetes Affordable preventative care for those needing weight loss services 	<ul style="list-style-type: none"> Sanford WebMD Fit Kids Sanford Kid Fit Program for Preventative Care SCVermillion Health Coach – Free Service for Diabetic Patients of SCV SVMC Registered Dietitian Outreach Consult for Weight Loss SVMC Wellness Screenings for free or reduced costs USD Wellness Center SVMC Annual Health Fair with Free/reduced cost screenings SVMC Wellness RN Provides free/reduced costs to area businesses and health fairs SVMC Foot Care Clinic 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
Physical Activity	<ul style="list-style-type: none"> Exercise is not emphasized in this part of the country Winter weather discourages exercise Need an indoor community center for people of all ages, including an accessible, kid- and elder-friendly indoor pool Need an family activity center that has child care on site The cost for a family to join the Wellness Center at USD is too high USD Wellness Center needs a pool Need a new community swimming pool Availability of exercise for special groups of people, such as pregnant women, teenagers, new moms, stay-at-home moms Need good walking or biking options. Streets are not that safe. Hospital should promote exercise by hosting low cost classes for people with different medical conditions (maybe together with the Wellness Center) Physical education programs are weak in middle school – need recess & regular phy ed classes. Schools do not have swimming pools. 	<ul style="list-style-type: none"> SVMC Great Strides SVMC Immunization Clinics at USD & Community Sanford WebMD Fit Kids SVMC Great Strides Vermillion City Pool Refer to Parks & Recreation Dept Refer to City Manager Refer to School Superintendent/School Board 	
Snow Removal	<ul style="list-style-type: none"> Need to make sure roads & sidewalks are cleared of snow in a timely manner Issues with driveways being blocked by a wall of snow after the snowplow comes through 	<ul style="list-style-type: none"> Refer To City Hall/Code Enforcement 	
Substance Abuse	<ul style="list-style-type: none"> Concern with substance abuse in our community Would like substance abuse to be treated like a disease (not a crime) 	<ul style="list-style-type: none"> Sanford One Care Refer to USD Counseling Center & Coalition D-Days Support Team 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> Concern about the tolerance with binge drinking, bar openings for special events, unruliness during USD Homecoming, serving to minors, etc. Lack of late-evening activities that do not serve alcohol (9 pm. – 3 a.m.), especially for college students Stop expecting the school system to make sure children stay away from drugs – it is the responsibility of parents High school students have access to too many prescription & illegal drugs 	<ul style="list-style-type: none"> Refer to Law Enforcement DARE Program School Resource Officer 	
Traffic	<ul style="list-style-type: none"> Issues with high speed of traffic coming into & out of town on Cherry Street Better crossing areas on Main Street so kids are safe to walk/ride to school (especially by Prentis Park) 	<ul style="list-style-type: none"> Refer to Law Enforcement Refer to City Hall 	
Transportation	<ul style="list-style-type: none"> No taxi service / public transit has limited hours Access to regional public transportation. No public transportation to other towns (for specialist care). Cost of transportation service for the disabled Transportation for the elderly I will be even more concerned with transportation issues if the proposed Hyperion oil refinery goes in. 	<ul style="list-style-type: none"> Refer to Vermillion Transit 	
Youth	<ul style="list-style-type: none"> More activities for grade school/teens and those under age 5 Bullying Teen pregnancy Punitive punishment for kids involved in youth crime – schools need to work harder to keep kids in school Safety (in certain parts of town) Stop expecting the school system to make sure children stay away from drugs – it is the responsibility of parents High school students have access to too many prescription & illegal drugs 	<ul style="list-style-type: none"> Sanford WebMD Fit Kids Sanford One Care Law Enforcement Family Planning DARE School Nurse Alternative School in Vermillion 	

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> • Lack of late-evening activities that do not serve alcohol (9 pm. – 3 a.m.), especially for college students • Better crossing areas on Main Street so kids are safe to walk/ride to school (especially by Prentis Park) • Need more awareness of family planning services and STD education • Resources for youth who at GBLTQ 		
Sanford Specific	<ul style="list-style-type: none"> • Access/availability <ul style="list-style-type: none"> ○ Takes a long time to get into a specialist ○ Need more specialists ○ Need a lymphedema therapist who is certified ○ Need a full-time Internal Medicine physician available ○ Need podiatry services ○ More acute care at night & on weekends (esp. Sunday) ○ Need a Stoma nurse ○ Need a FT female OB/GYN physician ○ Need more mental health providers that take Medicaid patients • Confidentiality • Care Coordination (because people are taking so many different medications) • Parents not having child immunized • Sports Medicine physicals for kids under 7th grade • Doctors that will not listen • EC issues & availability times • Urgent Care hours • Increased convenient care • Hospital needs a physical upgrade to meet the changes in healthcare services 	<ul style="list-style-type: none"> • SVMC Bi-monthly Podiatrist Outreach but does not take Sanford Insurance – no Sanford Podiatrist Available • SVMC Access to Specialty Services • VMC Female OBGyn Outreach physician 1x/wk • SVMC Cardiac Rehab • SVMC Cardiac Outreach Weekly • SH Heart Screen Twice Yearly to Vermillion • Sanford Cancer Biology Research Center • SVMC Oncology Outreach Physician Monthly • SVMC Chemotherapy Services • SVMC Hospice Services • SVMC Staff does HIPAA/Confidentiality Training at Hire & Annually • SVMC is a Smoke Free Campus – Staff may only smoke on breaks off campus • SVMC Mental Health Counselor takes Mental Health Services • Master Facility Plan for Hospital in Works 	<p>yes</p>

Identified Concerns	Specific concerns	Alignment with Sanford resources or other community resource partners	Unmet need
	<ul style="list-style-type: none"> ● Staff issues – unfriendly, unprofessional, untrained, smell of cigarettes ● Services for cancer patients ● Services for heart patients 		

6/8/12

Table 2

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 <i>(from asset mapping and gaps analysis worksheet)</i>	Round 1 Vote	Round 2 Vote	Round 3 Vote
Specialty Services			
Mental Health			

