2016 Community Health Needs Assessment

Winner Regional Healthcare Center

Winner, South Dakota

Winner Regional Healthcare Center

Community Health Needs Assessment 2016

Winner Regional Healthcare Center

Dear Community Members,

Winner Regional Healthcare Center is pleased to present the 2016 Community Health Needs Assessment.

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

During 2016 members of the community were asked to complete a survey to help identify unmet health needs. Researchers at the Center for Social Research at North Dakota State University analyzed the survey data. WRHC further analyzed the data, identified unmet needs, and partnered with key community stakeholders to develop a list of resources and assets that were available to address each need. A gap analysis and prioritization exercise was also conducted to identify the most significant health needs and to further address these needs through the implementation strategies that are included in this document.

WRHC has set strategy to address the following community health needs:

- Healthcare Access
- Physical Health

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

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

Sincerely,

Chief Executive Officer
Winner Regional Healthcare Center

Winner Regional Healthcare Center

Community Health Needs Assessment 2016

EXECUTIVE SUMMARY

Winner Regional Healthcare Center

Community Health Needs Assessment
2016

Purpose

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

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

Study Design and Methodology

1. **Non-Generalizable Survey**
   A non-generalizable survey was conducted online during 2016. The Center for Social Research at North Dakota State University developed and maintained links to the online survey tool. The website address for the survey instrument was distributed via e-mail to various key community stakeholders and agencies, at times using a snowball approach**.** Data collection occurred throughout the month of September 2016 and a total of 88 respondents participated in the online survey.

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

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

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

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

4. **Secondary Research**
   The secondary data includes Tripp County health profiles from the Robert Wood Johnson County Health Rankings. The indicators that were reviewed for this assessment include: population data, vital statistics, adult behavioral risk factors, crime and child risk.

Key Findings – Primary Research

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

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

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

3. **Children and Youth:** When considering children and youth, bullying ranks highest of the concerns among respondents. Youth crime and the availability of quality infant and childcare are also ranked as high concerns.

4. **Safety:** The presence of street drugs and alcohol in the community, the presence of drug dealers in the community, child abuse and neglect, crime, and domestic violence are the highest safety concerns of the respondents.

5. **Health Care:** The health care indicator addresses access to health care and cost concerns. Concerns include access to affordable health insurance, affordable prescription drugs, affordable health care, and the cost of vision and dental insurance. Respondents were also concerned about the use of the emergency room services for primary health care.

6. **Physical Health**: Cancer, chronic disease, obesity, inactivity and poor nutrition are the highest physical health concerns.

7. **Mental Health/Behavioral Health**: Drug use and abuse, alcohol use and abuse, underage substance abuse, dementia and Alzheimer's, stress, depression, and smoking and tobacco are the highest concerns for mental/behavioral health.

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

Health Outcomes

Premature death: The premature death indicator is defined as years of potential life lost before age 75 per 100,000 population. The mortality health outcomes indicate that South Dakota as a state has more premature deaths (6,738 per 100,000) than the U.S. benchmark (5,200 per 100,000). Tripp County has a higher rate (8,711 per 100,000) than both the U.S. and the state of South Dakota.

Poor or fair health: 10% of adults in Tripp County report poor or fair health compared to 10% for the nation and 11% in South Dakota.

The percent of live births with low birth weight (less than 2,500 grams) is 8.4% in Tripp County, 5.9% nationally, and 6.5% for the state of South Dakota.

Health Factors

The percent of adults who are currently smoking is 13% in Tripp County. The state of South Dakota reports 18% of adults are current smokers and the U.S. benchmark for current adult smokers is 14%.

33% of the adult population in Tripp County is considered obese with a BMI over 30. This compares with South Dakota at 29% and the national benchmark at 25%.

The percent of adults reporting excessive or binge drinking is 21% in Tripp County. South Dakota reports 19% statewide and the national benchmark is 10%.

Driving deaths that have alcohol involvement is at 38% in Tripp County. South Dakota as a whole is at 37% and the national benchmark is 14%.

Sexually transmitted infections rank substantially higher than the national benchmark (138) for South Dakota (471) and Tripp County (401).

The teen birth rate is higher in South Dakota at 37 than the national benchmark (20), and is higher in Tripp County at 39.

The clinical care outcomes indicate that South Dakota (14%) and Tripp County (18%) have a higher percentage of uninsured adults than the national benchmark (11%).

The ratio of population to primary care physicians is 1,302:1 in South Dakota and 914:1 in Tripp County. The national benchmark is 1,045:1.The ratio of population to mental health providers is 664:1 in South Dakota and 393:1 in Tripp County. The national benchmark is 386:1.The number of professionally active dentists is 1,813:1 in South Dakota, 2,749:1 in Tripp County, and 1,377:1 as a national benchmark.

Preventable hospital stays are at 71 in Tripp County compared to 57 in South Dakota and 41 nationally.

Diabetic screening is at 81% in Tripp County and 84% in South Dakota. The national benchmark is 90%.

Mammography screening is at 61.6% in Tripp County and 66.5% in South Dakota. The national benchmark is 70.7%.

The social and economic factor outcomes indicate that South Dakota is at 78% for high school graduation compared to the national benchmark of 93%. This data was not available for Tripp County. Post-secondary education (some post-secondary education) is at 63.6% in Tripp County, 66.7% in South Dakota, and 71% nationally.

The unemployment rate is 3.6% in South Dakota, 3.8% in Tripp County, and 4% nationally.

The percentage of child poverty is 19% in South Dakota and 27% in Tripp County. The national benchmark is 13%.

Social associations are defined as the number of membership associations per 10,000 populations. The national benchmark is 22. The ranking is higher in Tripp County at 25.5 than in South Dakota at 17.4.

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

The following needs were brought forward for prioritization:

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

Winner Regional Healthcare Center has determined the 2017-2019 implementation strategies for the following needs:

- Health Care
- Physical Health

Winner Regional Healthcare Center

Implementation Strategies

1. **Priority 1: Health Care Access**
   Access to care includes the ability to gain entry into a health system or provider service. Access can include the ability of health care providers and a workforce available to address the needs. Limited access can challenge the ability to receive appropriate levels of care and may pave the way to utilization of higher cost entry points into the system through the emergency room.

2. **Priority 2: Physical Health**
   Physical health consists of many components, including rest and sleep, nutrition, physical activity, and self-care. Primary prevention is a way to remain physically healthy.

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

Implementation Strategy for Winner Regional Healthcare Center (WRHC)

FY 2017-2020 Action Plan

Priority 1: Health Care

Projected Impact: Understand the needs of the community in order to provide the care that is most needed.

Goal 1: Conduct community focus groups and develop a strategic plan based on the outcome.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Conduct community focus groups to understand their health-related needs and find ways to prioritize the needs	Number of focus groups Number of participants	WRHC leadership team	CEO, DOO, Marketing	
Prioritize the results of the community focus groups	Results are prioritized	WRHC leadership team	CEO, DOO, Marketing	
Develop a strategic plan to address the needs	A strategic plan is developed	WRHC leadership team	CEO, DOO, Marketing	
Review strategic plan quarterly for impact	Quarterly status reports are reviewed by leadership	WRHC leadership team	CEO, DOO, Marketing	

Goal 2: Evaluate the usage of the emergency room to determine how many visits are Level 1.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Evaluate the usage of the emergency room for the past two years	Research the data	WRHC leadership team	CNO, CFO	
Determine what the peak times of use are and the level of care received. Based on this information, plan on ways to address the Level 1 visits.	The usage of the emergency room as a Level 1 visit	WRHC leadership team	CNO, Quality	
Based on the usage, look for trends in the data	Review reports quarterly and evaluate for the number of visits reduced per quarter	WRHC leadership team	CNO, Quality	

Goal 3: Determine how many ill patients are seen the same day as they call the clinic.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Evaluate the number of clinic visits to determine if quicker access to health care could be improved	Benchmark the number of patients that are seen on a daily basis	WRHC leadership team	Clinic Operations Director	

Priority 2: Physical Health

Projected Impact: Improve the overall physical health of the community.

Goal 1: FARM students will be actively involved in the community for increased health awareness.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Incorporate the FARM students community project requirement to enhance awareness of health factors	Pick a project (i.e. blood pressure screenings) and monitor the number of people who have their blood pressure checked and what the pressure was	WRHC leadership team	Clinic Operations Director	

Goal 2: Offer Better Choices, Better Health support group meetings.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Attend the Lay Leader program that is sponsored by Better Choices, Better Health	Achieve the Lay Leader certification	WRHC leadership team	DOO, Quality	
Set up monthly community support group meetings	Number of attendees	WRHC leadership team	DOO, Quality	

Goal 3: Encourage healthier eating.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Develop a monthly community project that incorporates fruits and vegetables and ways to increase consumption. The goal will be to increase fruit and vegetable consumption.	Based on the CHNA, only 26.7% of the survey respondents ate 5 or more fruits & vegetables per day. Develop a survey reporting tool & evaluate monthly fruit & vegetable consumption.	WRHC leadership team	Dietitian, Dietary, Marketing	

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Community Health Needs Assessment 2016

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Purpose of the Community Health Needs Assessment

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

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

At Winner Regional Healthcare, ongoing commitment to quality and integrity is reflected in our mission statement: ***Professional Care with a Personal Touch.*** Thank you for entrusting your health care to Winner Regional Healthcare Center. We are proud to be a part of the community and we look forward to providing a continuum of care for many years to come.

Acknowledgements

Winner Regional Healthcare Center would like to thank the Center for Social Research at North Dakota State University for their assistance and expertise while performing the assessment and analysis of the community health data. Project Principal: Carrie McLeod, Sanford Health, Community Health Improvement.

Winner Regional Healthcare Center Leadership:

- Kevin Coffey – CEO, Winner Regional Healthcare Center
- Deb Davis – DOO, Winner Regional Healthcare Center
- Betsy Ellwanger – DON, LTC, Winner Regional Healthcare Center
- Julie Hennebold – CNO, Winner Regional Healthcare Center
- Phil Husher – CFO, Winner Regional Healthcare Center
- Ann Mollman – Interim Clinic Director, Winner Regional Healthcare Center
- Betty Tideman – Administrative Assistant, Winner Regional Healthcare Center

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

- Karla Brozik – Winner Chamber of Commerce
- Kevin Coffey – CEO, Winner Regional Healthcare Center
- Deb Davis – DOO, Winner Regional Healthcare Center
- Betsy Ellwanger – DON, LTC, Winner Regional Healthcare Center
- Julie Hennebold – CNO, Winner Regional Healthcare Center
- Phil Husher – CFO, Winner Regional Healthcare Center
- Roger Kingsbury – Rancher, Winner Regional Healthcare Center Governing Board Member
- Becky Littau – Rancher, Winner Regional Healthcare Center Governing Board Member
- Ann Mollman – Interim Clinic Director, Winner Regional Healthcare Center
- Betty Tideman – Administrative Assistant, Winner Regional Healthcare Center

We extend special thanks to *physicians, nurses, school leadership and school board members, representatives from the Native American community, representatives for the mentally and physically disabled, social services, the county sheriff, non-profit organizations, and public health officers for their participation in this work.*

Winner Regional Healthcare Center would like to acknowledge and thank the following community members who participated in the survey:

Larry Aaker
Rusty Arthur
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Sandy Croston
Deb Davis
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Barb DeSersa
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John Driscoll
Diane Durrin
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Tara Engel
Elysabeth Farley
Al Flanigan
Katie Harris
Julie Hennebold
Denise Higgins
Phillip Husher
Deborah Jorgensen
Lori Kingsbury
Randy Kludt
Pam Leat
Melanie Lee
Cheryl Littau
Luke Littau
Sharon Naasz
Doug Nelson
Kaela Novotny
Shawn Pettit
Shelby Rajewich
Rhonda Schroeder
Amber Thede
Marlajean Waters
Wanda Wiken

Description of Winner Regional Healthcare Center

Winner Regional Healthcare Center is a not-for-profit facility that operates for the benefit of patients and residents in our service area.

The nine-person volunteer Board of Directors manages the operation of our institution. The board chooses three candidates from our local communities each year to serve three-year terms on the board.

Our management agreement with Sanford Health aids the hospital and long term care facility with purchasing, training, technology and administration.

Winner Regional is dedicated to providing quality employment opportunities and purchasing local goods whenever possible.

Winner Regional Healthcare Center is a 25-bed Critical Access Hospital and 80-bed long term care facility that caters to the health needs of south central South Dakota and north central Nebraska.

Physicians in the following specialties provide consultation and treatment at Winner Regional Healthcare Center's Outreach Clinic. Specialty care includes:

- Audiology
- OB/GYN
- Ophthalmology
- Podiatry
- Cardiology
- Dietician
- Allergist
- Orthopedics
- Urology
- Pediatric Cardiology - Remove
- Outpatient chemotherapy
- Pain Clinic
- Neurology
- Nephrology
- Speech Therapy
- Pulmonology
- Vascular

Description of the Community Served

Winner, South Dakota is located in south central South Dakota along Highways 18, 183 and 44 and is the county seat of Tripp County. The population of Winner is 3,137 and the city covers approximately 922.5 acres of land. Winner was part of the famous Louisiana Purchase of 1803 and later part of the Dakota Territory, which was established by an act of Congress and a proclamation by President Abraham Lincoln in 1861. Winner was so named because it was the "winner" in the struggle to establish a town along the railroad right-of-way when the Chicago North Western began moving west from Dallas, SD in 1909.

Over 300 businesses are active in Winner and the Winner School District is rated level 1 by the South Dakota Division of Education with the high school accredited by the North Central Association of Colleges and High Schools.

Winner is home to a regional health care center and two modern assisted living centers. Recent capital improvements in the city include a new main street, new runway at the airport, and a new fire hall/ambulance facility with a new training room.

Study Design and Methodology

1. **Non-Generalizable Survey**
   A non-generalizable online survey was conducted by Winner Regional Healthcare with the assistance of public health leadership and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. The website address for the survey instrument was distributed via e-mail to community stakeholders and various agencies, at times using a snowball approach**.** Data collection occurred throughout the month of September 2016 and a total of 88 respondents participated in the online survey.

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

   A Likert scale was developed to determine the respondent's highest concerns. Needs ranking 3.5 and above were included in the needs to be addressed and prioritized. Many of the identified needs that ranked below 3.5 are being addressed by WRHC. However, 3.5 and above was used as a focus for the purpose of the required prioritization.

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

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

   Each unmet need was researched to determine what resources were available in the community to address the needs. Sanford and community stakeholders performed the asset mapping review. The group conducted an informal gap analysis to determine what needs remained after resources were thoroughly researched. Once gaps were determined the group proceeded to the prioritization process.

4. **Prioritization**
   The multi-voting methodology was implemented to determine what top priorities would be further developed into implementation strategies.

5. **Secondary Research**
   The secondary data includes the Robert Wood Johnson *County Health Rankings* for Tripp County.

Limitations of the Study

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

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

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

A good faith effort was made to secure input from a broad base of the community. Invitations were extended to county and community leaders, organizations and agencies representing diverse populations and disparities.

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

Winner Regional Healthcare Center extended a good faith effort to engage all of the aforementioned community representatives in the survey process. In some cases there were surveys that were submitted without names or without a specified area of expertise or affiliation. We worked closely with public health experts to develop the survey tool and throughout the assessment process.

Public comments and response to the community health needs assessment and the implementations strategies are welcome on the Winner Regional Healthcare Center web at http://winnerregional.org

Winner Regional Healthcare Center

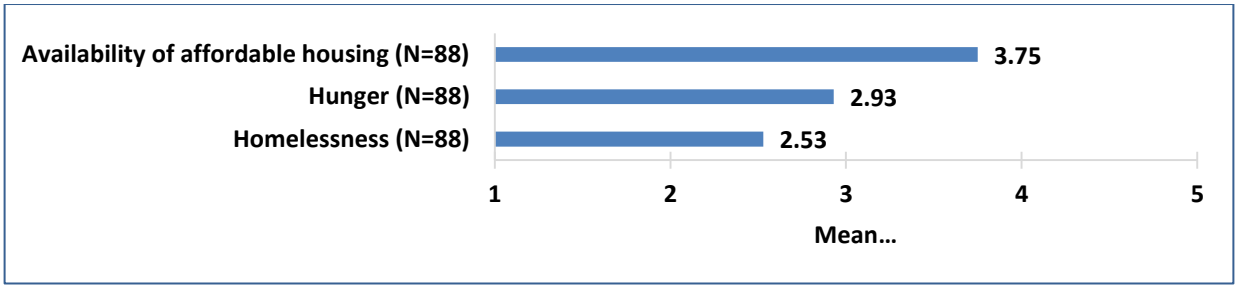
Key Findings

Community Health Concerns

Economics

The availability of affordable housing is a high concern for the respondents of the survey.

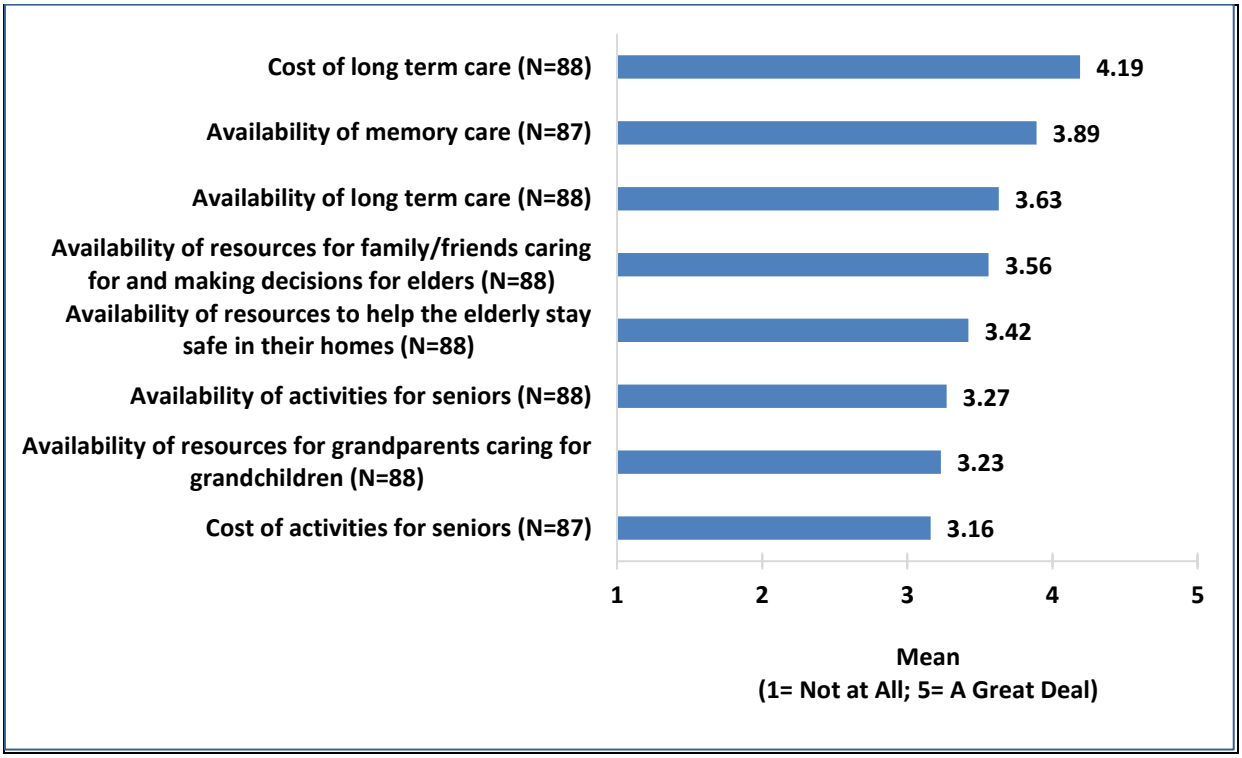
Level of concern with statements about the community regarding ECONOMICS



Aging Population

The greatest area of concern among survey respondents is for the aging population, including the cost of long term care, the availability of memory care, and the availability of long term care. Respondents are also concerned about the availability of resources to help the caregiver.

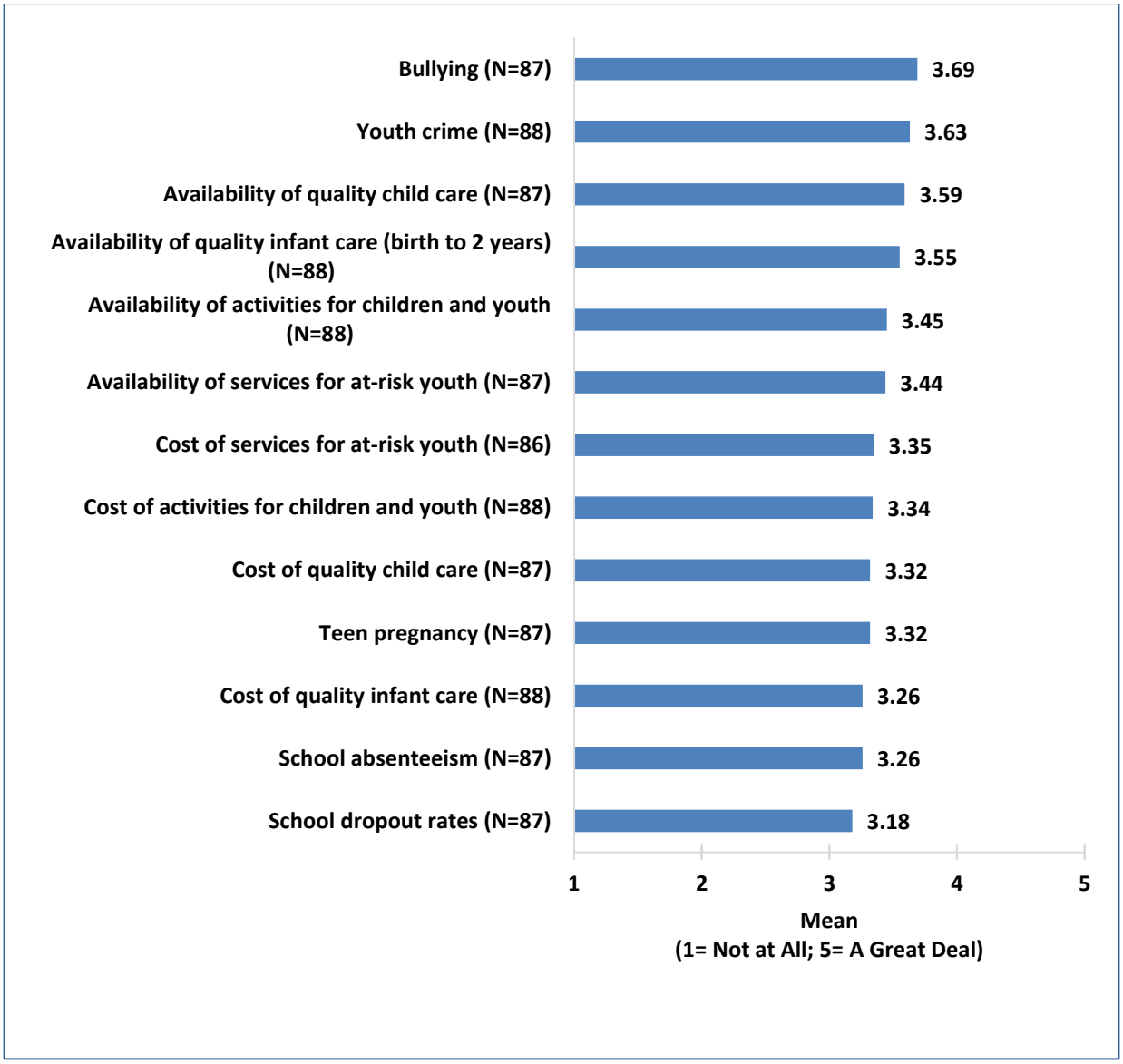
Level of concern with statements about the community regarding the AGING POPULATION



Children and Youth

The highest concerns regarding children and youth are bullying, youth crime, and the availability of quality child care and quality infant care.

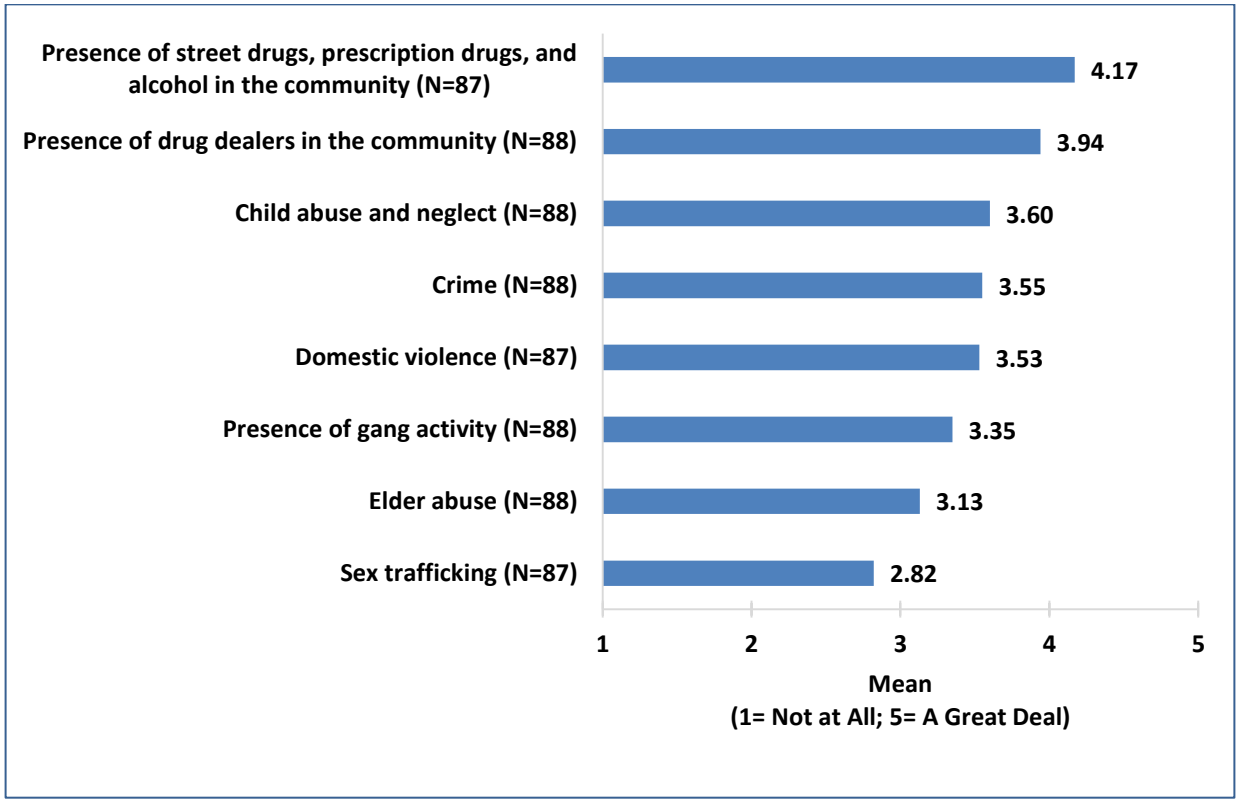
Level of concern with statements about the community regarding CHILDREN AND YOUTH



Safety

Respondents have high levels of concern with respect to safety issues concerning the presence of street drugs, prescription drugs, and alcohol in the community; the presence of drug dealers in the community, child abuse and neglect, crime, and domestic violence.

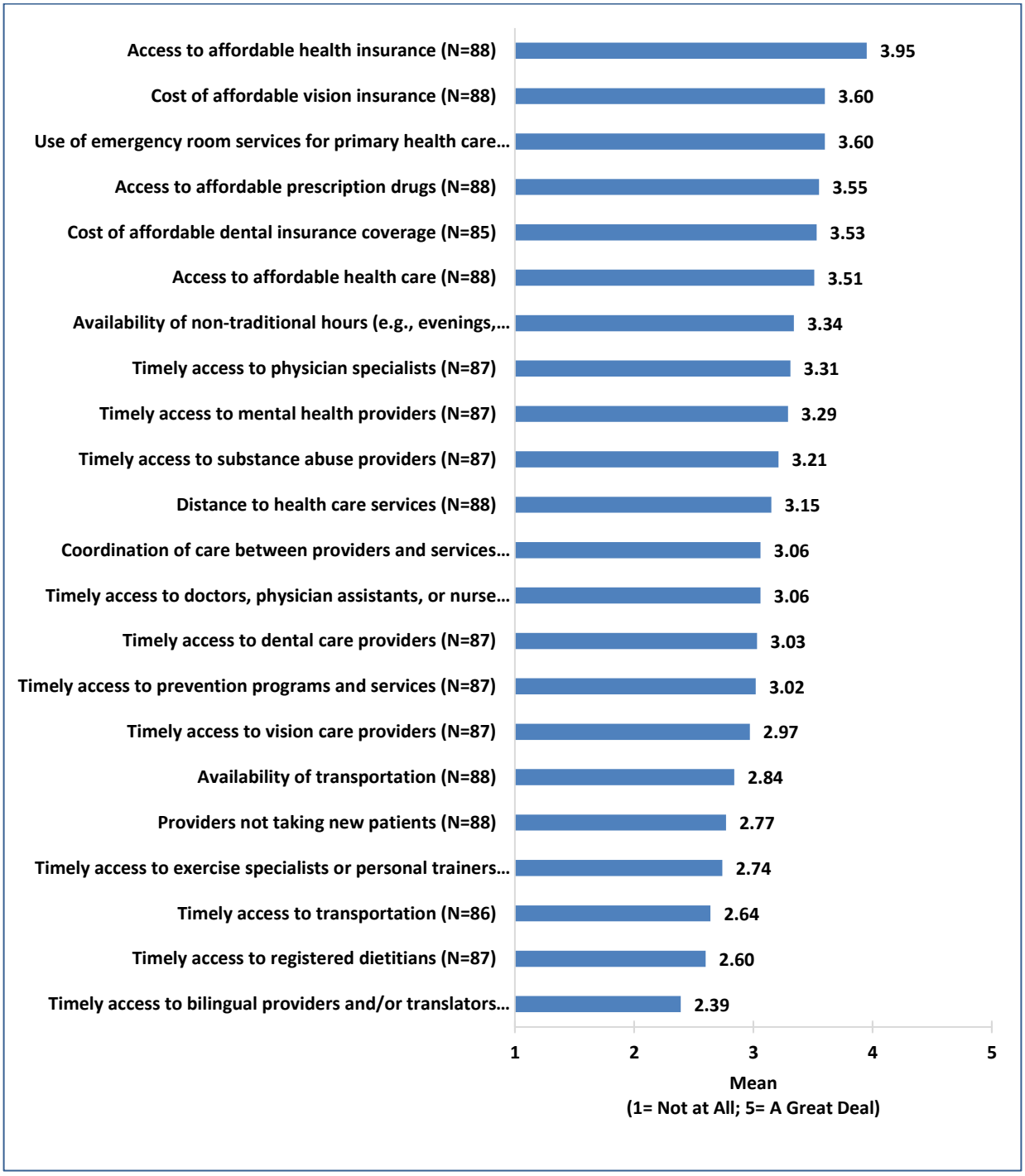
Level of concern with statements about the community regarding SAFETY



Health Care Access and Cost

The top concern among survey respondents is access to affordable health insurance. The cost of affordable health care, vision insurance, affordable dental insurance, the use of the emergency room for primary care, and access to affordable prescription drugs all rank as high concerns.

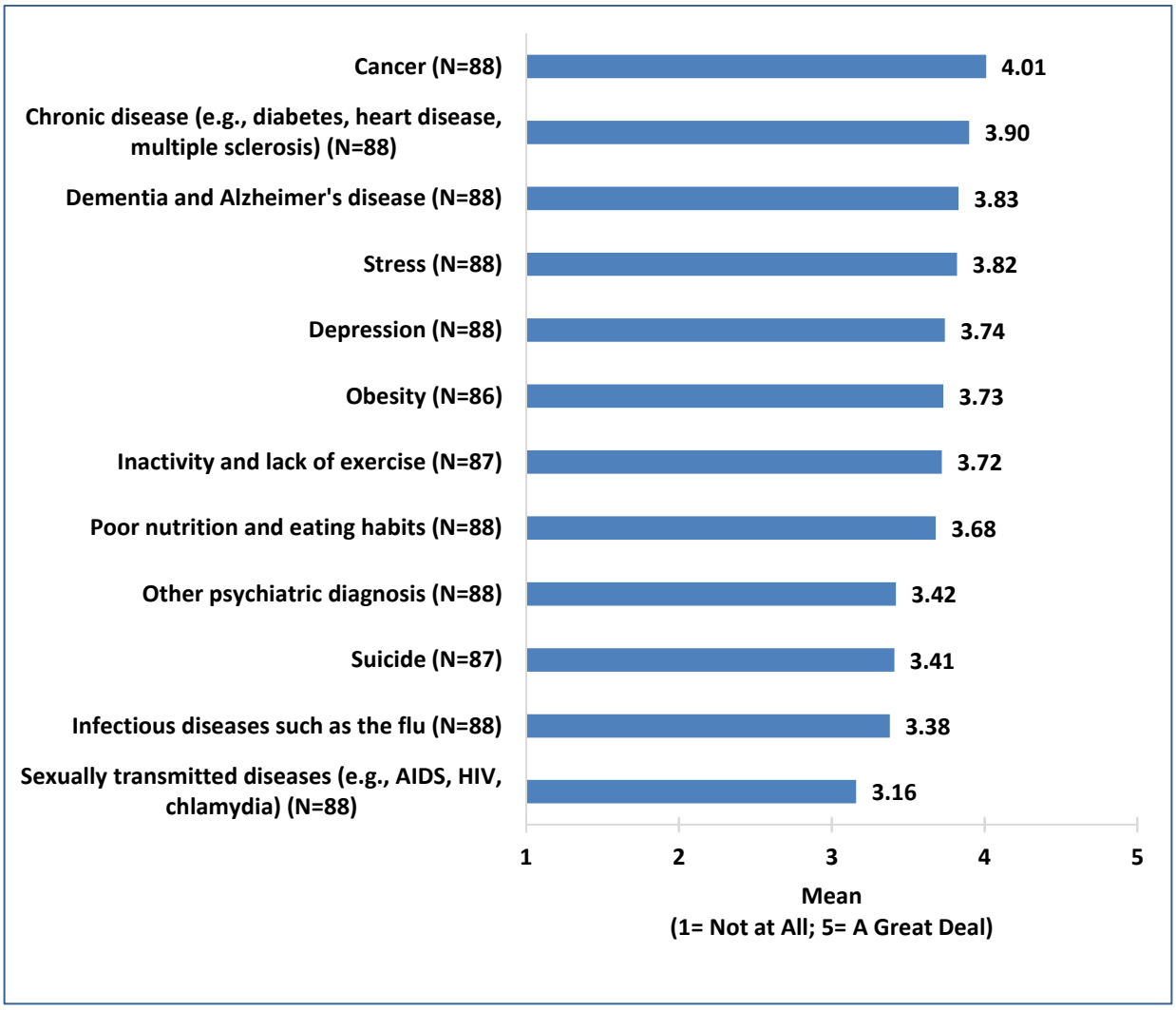
Level of concern with statements about the community regarding HEALTH CARE



Physical and Mental Health

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

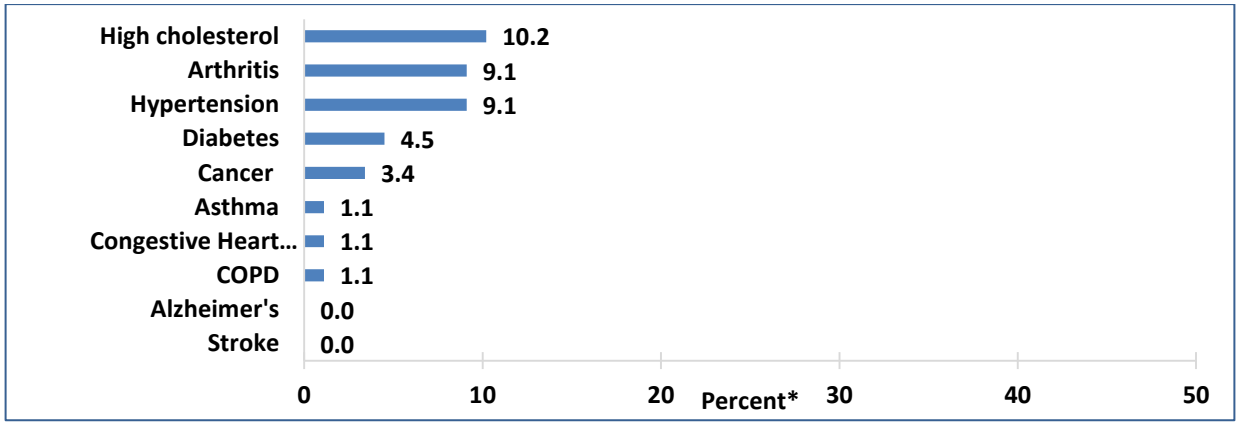
Level of concern with statements about the community regarding PHYSICAL AND MENTAL



Chronic Disease

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

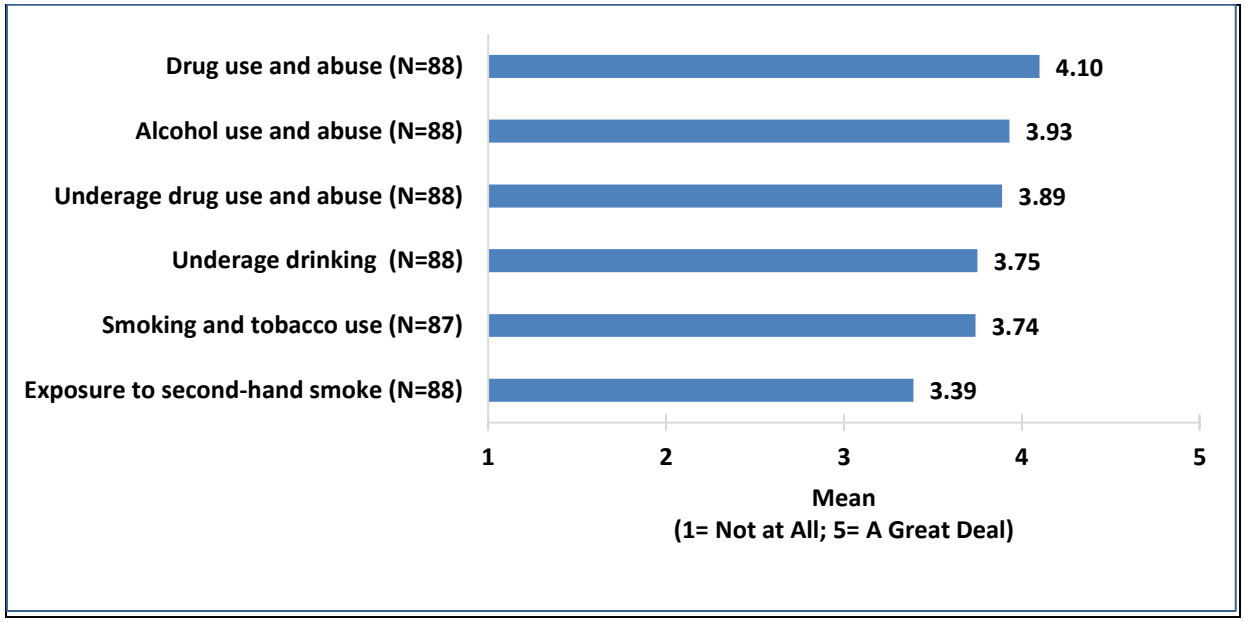
Whether respondents have any of the following chronic diseases



Substance Use and Abuse

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

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

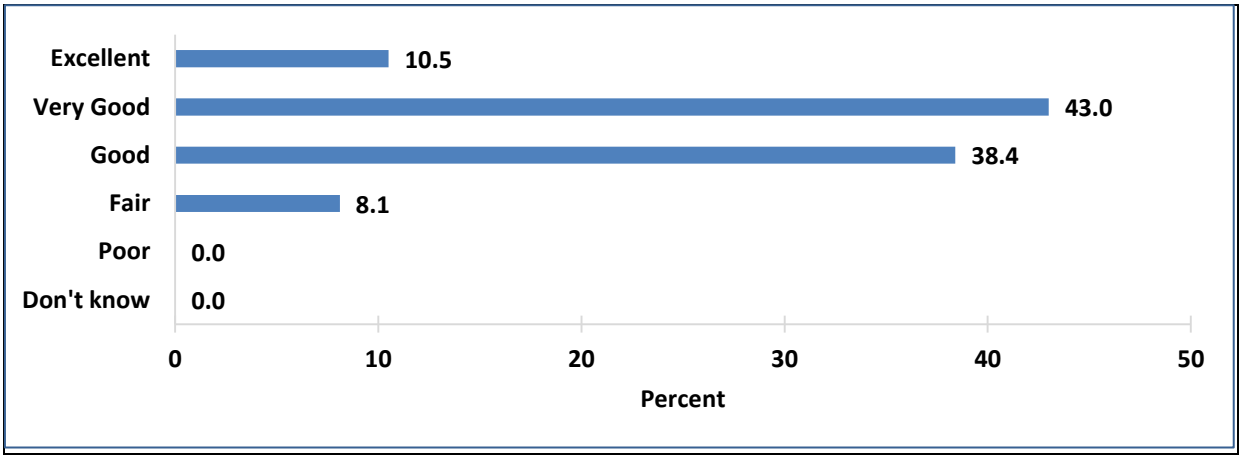


Personal Health Concerns

Respondents' Personal Health Status

The study results suggest possible discrepancies between respondents' perceived personal health and their actual health status as determined by objective measures. For example, using the Body Mass Index (BMI) which calculates weight status using an individual's weight and height, the majority (68.3%) of respondents reported themselves as overweight or obese. However, the vast majority (91.9%) of community respondents rate their own health as excellent, very good, or good. With good overall health habits in mind, it is important to note that within the past year, 59% visited a doctor or health care provider for a routine physical and 77.4% visited a dentist or dental clinic.

Respondents' rating of their health in general



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

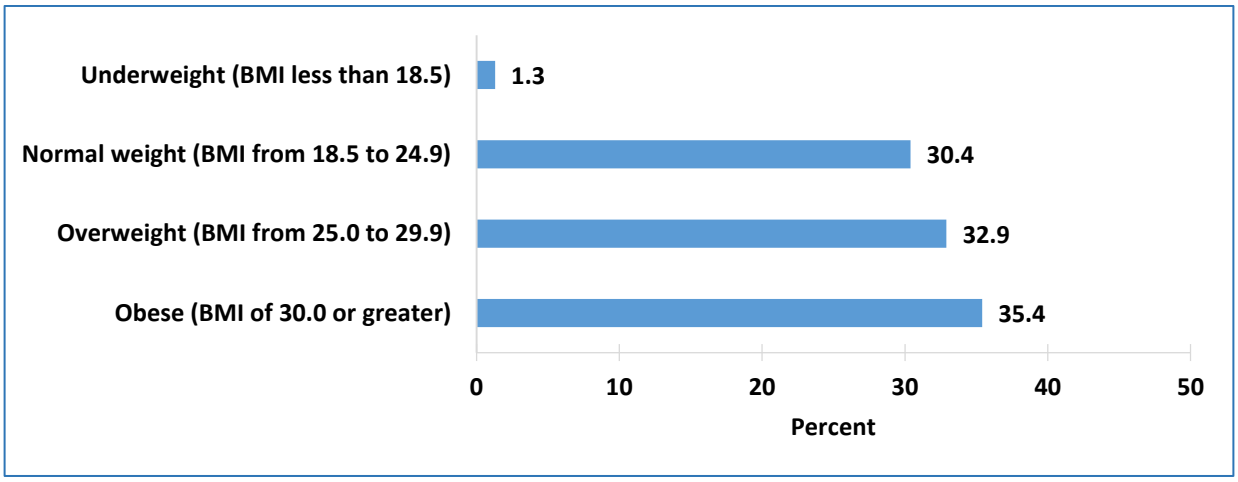
Health conditions related to obesity:

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

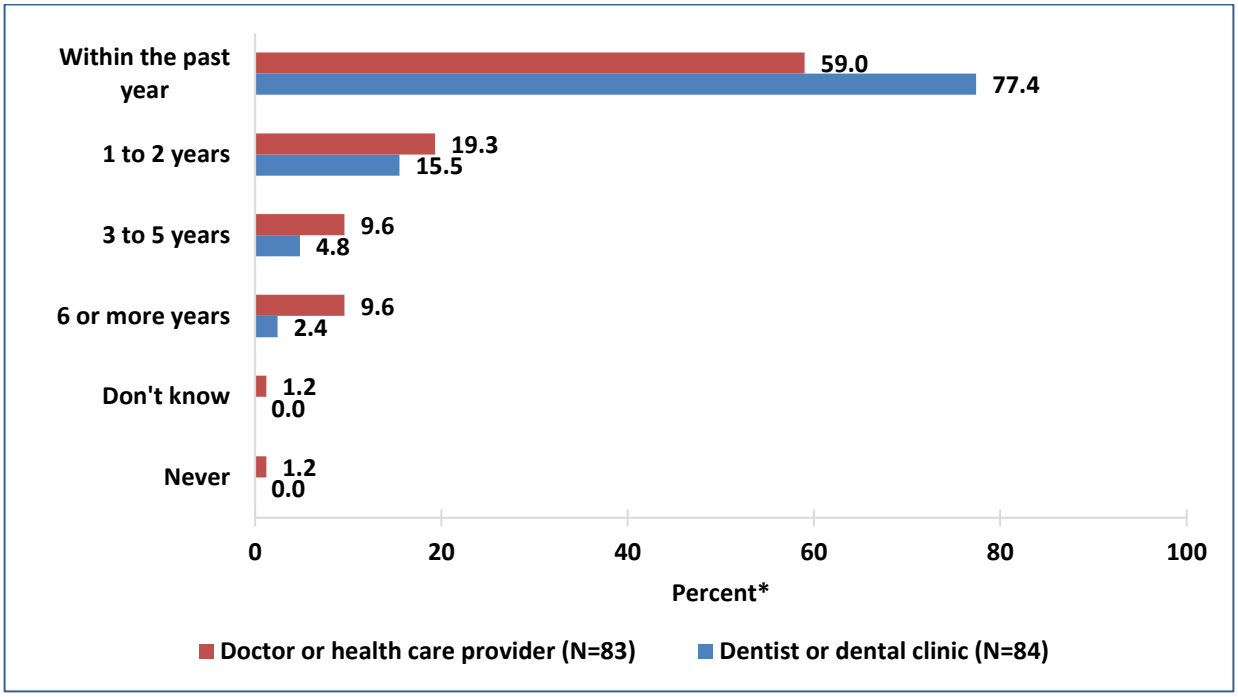
Nationally, more than 30% of adults, 17% of youth age 6-19 years, and more than 8% of children 2 to 5 years of age are obese.

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

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



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



Preventive Health

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

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

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

Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=84)	79.8	20.2	100.0
Blood sugar screening (N=84)	66.7	33.3	100.0
Bone density test (N=83)	16.9	83.1	100.0
Cardiovascular screening (N=84)	33.3	66.7	100.0
Cholesterol screening (N=84)	70.2	29.8	100.0
Dental screening and X-rays (N=85)	72.9	27.1	100.0
Flu shot (N=84)	73.8	26.2	100.0
Glaucoma test (N=83)	38.6	61.4	100.0
Hearing screening (N=83)	7.2	92.8	100.0
Immunizations (N=83)	22.9	77.1	100.0
Pelvic exam (N=63 Females)	42.9	57.1	100.0
STD (N=82)	7.3	92.7	100.0
Vascular screening (N=83)	19.3	80.7	100.0
CANCER SCREENINGS			
Breast cancer screening (N=62 Females)	54.8	45.2	100.0
Cervical cancer screening (N=61 Females)	41.0	59.0	100.0
Colorectal cancer screening (N=79)	19.0	81.0	100.0
Prostate cancer screening (N=14 Males)	42.9	57.1	100.0
Skin cancer screening (N=79)	26.6	73.4	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=17)	41.2	41.2	5.9	0.0	0.0	0.0	0.0
Blood sugar screening (N=28)	46.4	32.1	7.1	0.0	3.6	0.0	0.0
Bone density test (N=69)	40.6	44.9	5.8	1.4	0.0	0.0	2.9
Cardiovascular screening (N=56)	35.7	35.7	7.1	1.8	1.8	0.0	7.1
Cholesterol screening (N=25)	40.0	24.0	8.0	0.0	4.0	0.0	8.0
Dental screening and X-rays (N=23)	17.4	17.4	30.4	4.3	0.0	0.0	21.7
Flu shot (N=22)	22.7	13.6	9.1	4.5	4.5	0.0	22.7
Glaucoma test (N=51)	43.1	35.3	3.9	0.0	0.0	0.0	9.8

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
Hearing screening (N=77)	51.9	29.9	5.2	0.0	1.3	0.0	2.6
Immunizations (N=64)	46.9	25.0	3.1	0.0	0.0	0.0	9.4
Pelvic exam (N=36 Females)	44.4	22.2	5.6	5.6	0.0	0.0	13.9
STD (N=76)	72.4	13.2	2.6	0.0	0.0	0.0	3.9
Vascular screening (N=67)	46.3	32.8	4.5	0.0	0.0	0.0	6.0
CANCER SCREENINGS							
Breast cancer screening (N=28 Females)	39.3	10.7	7.1	0.0	0.0	3.6	32.1
Cervical cancer screening (N=36 Females)	44.4	8.3	5.6	2.8	0.0	0.0	33.3
Colorectal cancer screening (N=64)	39.1	21.9	6.3	7.8	0.0	0.0	18.8
Prostate cancer screening (N=8 Males)	62.5	25.0	12.5	0.0	0.0	0.0	0.0
Skin cancer screening (N=58)	37.9	32.8	5.2	0.0	0.0	3.4	13.8

*Percentages may not total 100.0 due to multiple responses.

Screenings

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

- Cervical cancer screening: Cervical cancer is the easiest gynecologic cancer to prevent, with regular screening tests and follow-up. Two screening tests can help prevent cervical cancer or find it early:
    - The Pap test (or Pap smear) looks for *pre-cancers*, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
    - The HPV test looks for the virus that can cause these cell changes (human papillomavirus) (http://www.cdc.gov/cancer/hpv/basic_info/)
    - The Pap test is recommended for all women between the ages of 21 and 65 years old, and can be done in a doctor's office or clinic.

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

- Prostate cancer screening: The American Cancer Society (ACS) recommends that men have a chance to make an informed decision with their health care provider about whether to be screened for prostate

cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. The discussion about screening should take place at:

- Age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years.
- Age 45 for men at high risk of developing prostate cancer. This includes African Americans and men who have a first-degree relative (father, brother or son) diagnosed with prostate cancer at an early age (younger than age 65).
- Age 40 for men at even higher risk (those with more than one first-degree relative who had prostate cancer at an early age).

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

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

- Assuming no prostate cancer is found as a result of screening, the time between future screenings depends on the results of the PSA blood test. Men who choose to be tested who have a PSA of less than 2.5 ng/mL may only need to be retested every 2 years. Screening should be done yearly for men whose PSA level is 2.5 ng/mL or higher. Because prostate cancer often grows slowly, men without symptoms of prostate cancer who do not have a 10-year life expectancy should not be offered testing since they are not likely to benefit. Overall health status, and not age alone, is important when making decisions about screening. Even after a decision about testing has been made, the discussion about the pros and cons of testing should be repeated as new information about the benefits and risks of testing becomes available. Further discussions are also needed to take into account changes in the patient's health, values and preferences.

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

Flu Vaccines

The Center for Disease Control's Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months and older receive a flu vaccine annually. Findings from the survey indicate that 26.2% of respondents did not have a flu shot last year.

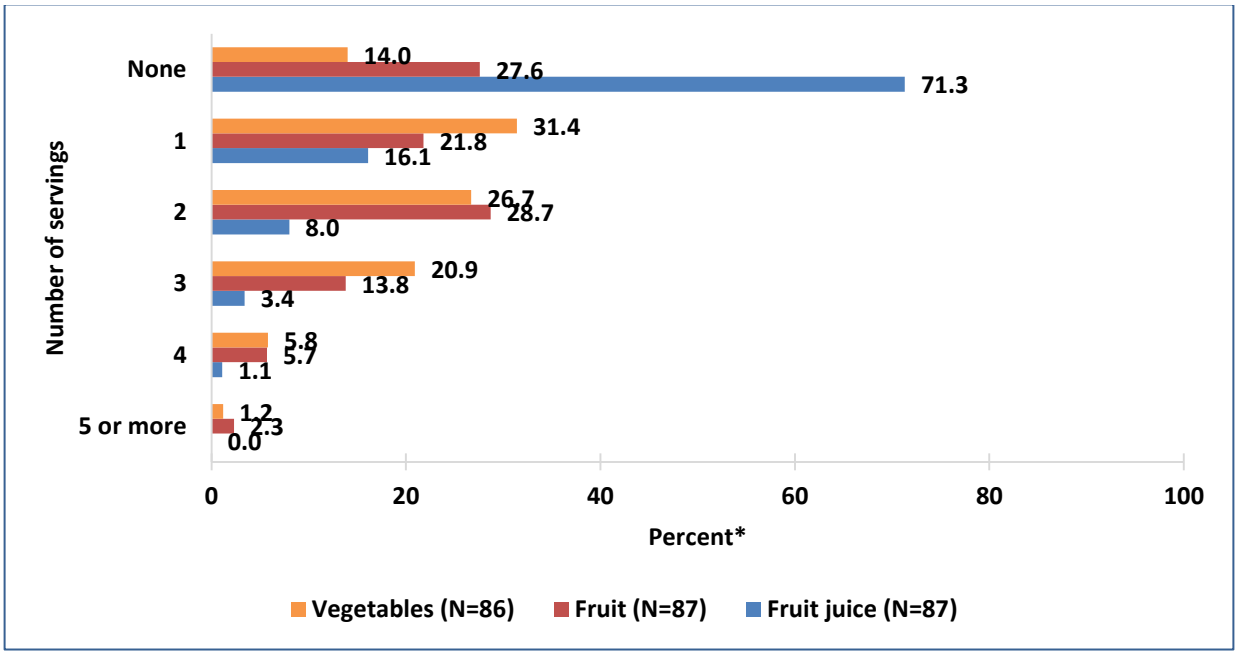
The Center for Disease Control states that influenza is a serious disease that can lead to hospitalization and sometimes even death. Even healthy people can get sick from the flu and spread it to others. Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies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

Fruit and Vegetable Intake

The study results suggest that the majority of respondents do not meet vegetable and fruit recommended dietary guidelines. Only 26.7% of respondents reported having 3 or more servings of vegetables the prior day, and only 21.8% respondents reported having 3 or more servings of fruits the prior day.

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

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

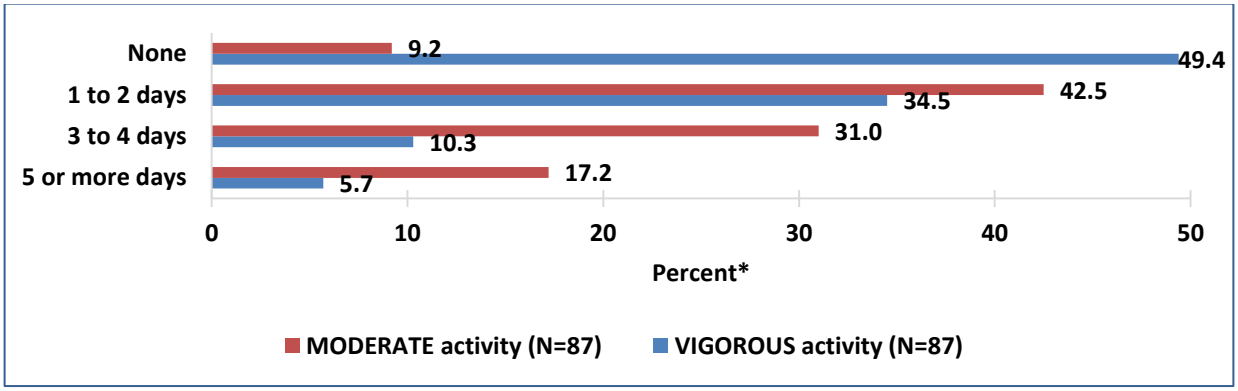


Physical Activity Levels

Study results suggest that the majority of respondents do not meet physical activity guidelines. 48.2% of survey respondents engage in moderate activity 3 or more times per week and 16% engage in vigorous activity 3 or more times per week.

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

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

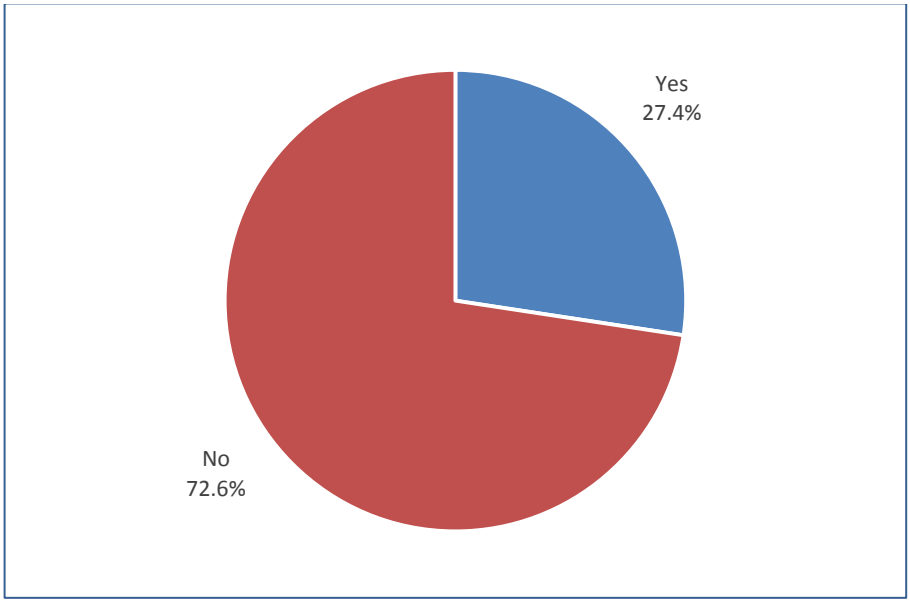


Tobacco Use

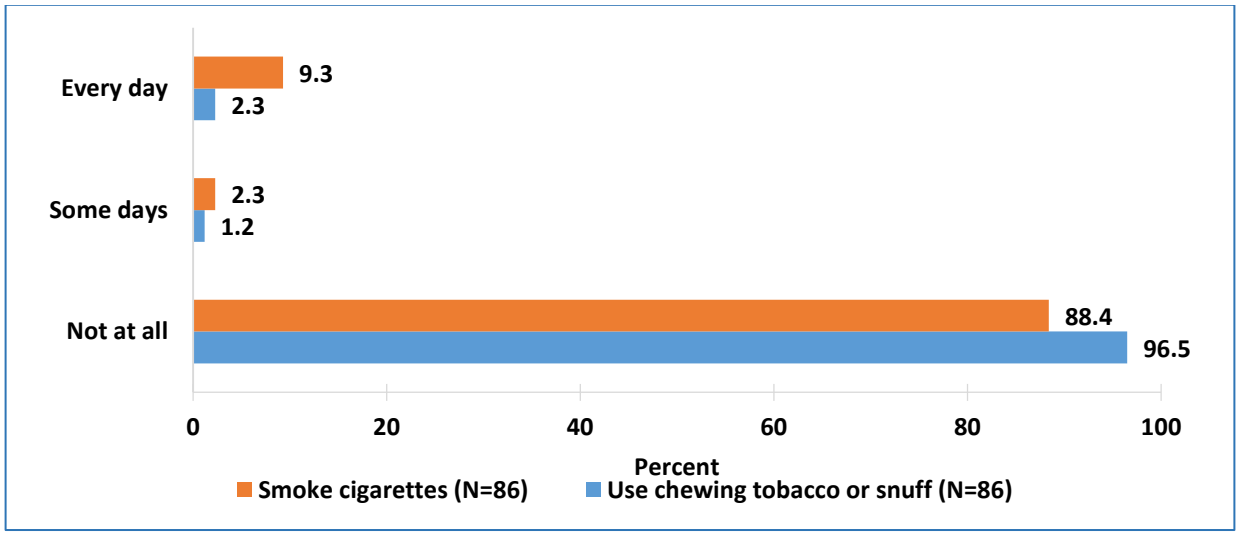
Study results indicate that the vast majority of community respondents are not currently tobacco users. However, 27.4% of respondents have smoked at least 100 cigarettes in their lifetime, which indicates former smoker status according to the Centers for Disease Control and Prevention.

Secondary research through the 2015 *County Health Rankings* finds that 13% of Tripp County residents are current smokers.

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



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

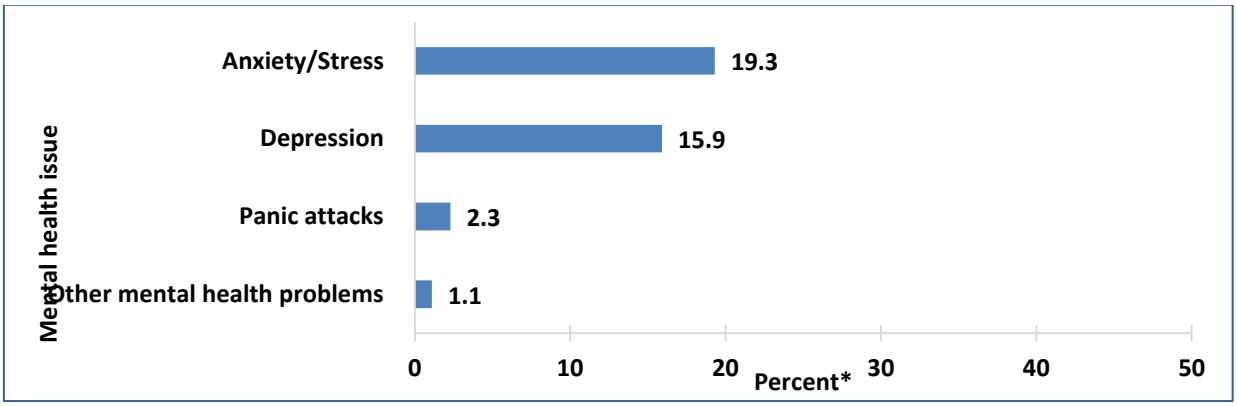


Mental Health

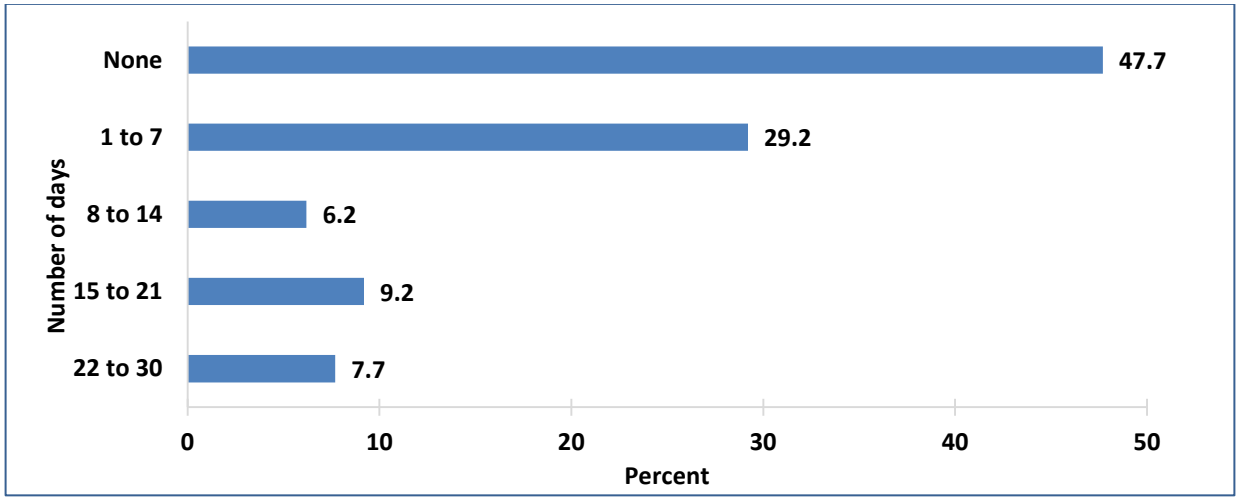
Mental health is an important component of well-being at every stage of life and impacts how we think, act and feel. Mental health influences our physical health, how we handle stress, how we make choices, and how we relate to others.

Among survey respondents, mental health is a moderately high area of concern. Dementia and Alzheimer's ranked the highest of concerns among respondents. Nearly one in five respondents has been told or diagnosed by a doctor or health professional that they have anxiety or stress. 15.9% have been told they have depression. In addition, over half of respondents (52.3%) self-report that in the last month, there were days when their mental health was not good.

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



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

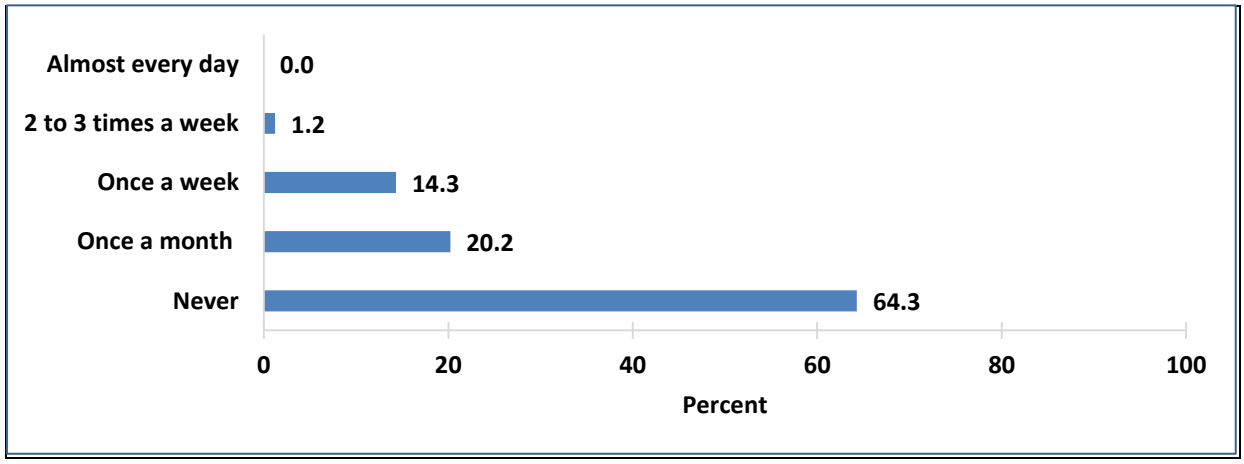


Substance Abuse Responses

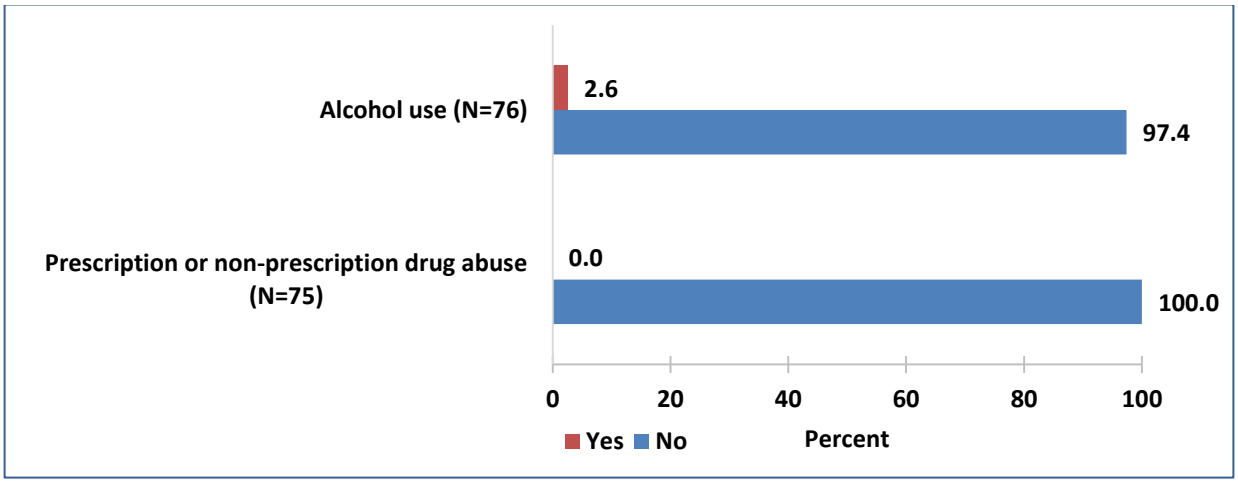
Substance abuse is also a mental health disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and can stem from mental health concerns. In the Winner community, 35.7% of respondents report binge drinking.

Secondary research through the 2015 *County Health Rankings* indicates that 21% of Tripp County residents report excessive drinking. (See Appendix)

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



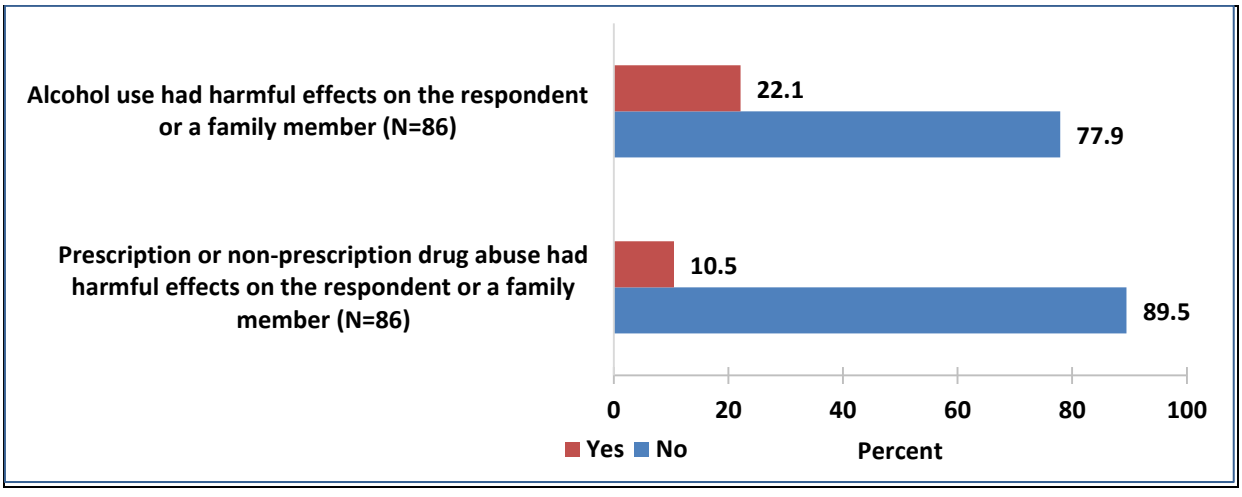
Whether respondents have ever had a problem with alcohol use or prescription or non-prescription drug abuse



Less than 3% of respondents reported having a problem with alcohol although earlier reporting indicated a higher level of binge drinking. Overall, 22.1% of respondents report alcohol use has had harmful effects on themselves or a family member.

Other forms of substance abuse include the use of prescription or non-prescription drugs. No respondents in the Winner area reported having had a problem with prescription or non-prescription drug abuse. However, 10.5% of respondents say prescription or non-prescription drug abuse has had harmful effects on themselves or a family member.

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



Demographics

Total Population – 2015 U.S. Census Bureau

- Tripp County: 5,434

Population by Age and Gender

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

Population by Race

	Tripp County	Percent
White	4,571	82.4
Black or African American	4	0.1
American Indian or Alaska Native	700	12.6
Asian	15	0.3
Native Hawaiian or other Pacific Islander	0	0.4
Hispanic or Latino	39	0.7

The per capita personal income in Tripp County, South Dakota is $24,308. Those living below the poverty level are 15.6% and the unemployment rate is 3.1%.

Health Needs and Community Resources Identified

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

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

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

The asset map includes identified needs from the following:

- Identified needs from the non-generalizable survey
- Concerns expressed by the key stakeholder group
- Secondary research data
- Community resources that are available to address the need(s)

The Asset Map can be found in the Appendix.

Prioritization

The following needs were brought forward for prioritization:

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

WRHC is addressing all of the assessed needs that fall within our scope of work. In some cases the need is one where we do not have the expertise to adequately address the need; however, WRHC leaders will communicate these findings to community leaders and experts who can best focus on a solution to the concern.

A document that shares what Winner Regional Healthcare Center is doing to address the need or defends why WRHC is not addressing the need can be found in the Appendix.

Members of the community stakeholder group determined that health care access and physical health are the top unmet needs. Winner Regional Healthcare Center has determined the 2017-2019 implementation strategies for the following needs:

- Health Care Access
- Physical Health

Winner Regional Healthcare Center

Addressing the Needs

Identified Concerns	How Winner Regional Healthcare Center is addressing the needs
Aging • Cost of long term care • Availability of memory care • Availability of LTC • Availability of resources to help caregivers	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders.
Children and Youth • Bullying • Youth crime • Availability of quality child care • Availability of quality infant care	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders. Will also share information of the Sanford *fit* initiative, a childhood obesity prevention initiative.
Economics • Cost of affordable housing	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders.
Safety • Presence of street drugs and alcohol in the community • Presence of drug dealers in the community • Child abuse and neglect • Crime • Domestic violence	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders. Will also share the information of the Sanford *fit* initiative, a childhood obesity prevention initiative.
Health Care • Access to affordable health insurance • Cost of affordable vision insurance • Use of the emergency room services for primary care • Access to affordable prescription drugs • Cost of dental insurance coverage • Access to affordable health care	Hospital leadership will address this need by sharing the findings of the CHNA with community leaders. Will evaluate the usage of the emergency room services.

Physical Health
• Cancer
• Chronic disease
  ○ High Cholesterol
  ○ Hypertension
	The Sanford *fit* initiative, a childhood obesity prevention initiative, continues to grow and mature as we work to refine the offerings and enable broad replication and meaningful use. Supported by the clinical experts of Sanford Health, *fit* educates, empowers and motivates families to live a healthy lifestyle through a

Identified Concerns	How Winner Regional Healthcare Center is addressing the needs
○ Arthritis • Obesity ○ 68% of respondents report they are overweight or obese • Inactivity and lack of exercise ○ 48% report moderate activity 3x/week • Poor nutrition and eating habits ○ Only 27% report having 3 or more vegetables/day ○ Only 22% report having 3 or more fruits/day	comprehensive suite of resources for kids, parents, teachers and clinicians. *fit* is the only initiative focusing equally on the four key contributing factors to childhood obesity: Food (nutrition), Move (activity), Mood (behavioral health), and Recharge sleep). Sanford's *fi*t Initiative has come a long way since its inception in 2010. Through *fit* we are actively working to promote healthy lifestyles in homes, schools, daycares, our clinical settings, and throughout the community by way of technology, engaging programs, and utilizing key role models in a child's life. Winner Regional Healthcare Center has a Registered Dietitian available for individual appointments and community education.
Mental Health • Dementia and Alzheimer's • Stress • Depression • Underage drug use and abuse • Drug use and abuse • Alcohol use and abuse ○ 36% of respondents report binge drinking • Underage drinking • Smoking and tobacco use	Although Tripp County has a 393:1 ratio of Mental Health providers (U.S. is 370:1 and SD is 630:1), development of a Lay Leader group (Better Choices, Better Health program) may assist with those people who deal with chronic issues that lead to stress and depression and other illnesses.

Winner Regional Healthcare Center

2017-2019 Implementation Strategies

Implementation Strategies

1. **Priority 1: Health Care Access**
   Access to care includes the ability to gain entry into a health system or provider service. Access can include the ability of healthcare providers and a workforce available to address the needs. Limited access can challenge the ability to receive appropriate levels of care and may pave the way to utilization of higher cost entry points into the system through the emergency room.

2. **Priority 2: Physical Health**
   Physical health consists of many components, including rest and sleep, nutrition, physical activity, and self-care. Primary prevention is a way to remain physically healthy.

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

Winner Regional Healthcare Center

Implementation Strategy for Winner Regional Healthcare Center (WRHC)

FY 2017-2020 Action Plan

Priority 1: Health Care

Projected Impact: Understand the needs of the community in order to provide the care that is most needed.

Goal 1: Conduct community focus groups and develop a strategic plan based on the outcome.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Conduct community focus groups to understand their health-related needs and find ways to prioritize the needs	Number of focus groups Number of participants	WRHC leadership team	CEO, DOO, Marketing	
Prioritize the results of the community focus groups	Results are prioritized	WRHC leadership team	CEO, DOO, Marketing	
Develop a strategic plan to address the needs	A strategic plan is developed	WRHC leadership team	CEO, DOO, Marketing	
Review strategic plan quarterly for impact	Quarterly status reports are reviewed by leadership	WRHC leadership team	CEO, DOO, Marketing	

Goal 2: Evaluate the usage of the emergency room to determine how many visits are Level 1.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Note any community partnerships and collaborations - if applicable
Evaluate the usage of the emergency room for the past two years	Research the data	WRHC leadership team	CNO, CFO	
Determine what the peak times of use are and the level of care received. Based on this information, plan on ways to address the Level 1 visits.	The usage of the emergency room as a Level 1 visit	WRHC leadership team	CNO, Quality	
Based on the usage, look for trends in the data	Review reports quarterly and evaluate for the number of visits reduced per quarter	WRHC leadership team	CNO, Quality	

Goal 3: Determine how many ill patients are seen the same day as they call the clinic.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Evaluate the number of clinic visits to determine if quicker access to health care could be improved	Benchmark the number of patients that are seen on a daily basis	WRHC leadership team	Clinic Operations Director	

Priority 2: Physical Health

Projected Impact: Improve the overall physical health of the community.

Goal 1: FARM students will be actively involved in the community for increased health awareness.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Incorporate the FARM students community project requirement to enhance awareness of health factors	Pick a project (i.e. blood pressure screenings) and monitor the number of people who have their blood pressure checked and what the pressure was	WRHC leadership team	Clinic Operations Director	

Goal 2: Offer Better Choices, Better Health support group meetings.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Attend the Lay Leader program that is sponsored by Better Choices, Better Health	Achieve the Lay Leader certification	WRHC leadership team	DOO, Quality	
Set up monthly community support group meetings	Number of attendees	WRHC leadership team	DOO, Quality	

Goal 3: Encourage healthier eating.

Actions/Tactics	Measureable Outcomes	Resources	Leadership	Community partnerships and collaborations
Develop a monthly community project that incorporates fruits and vegetables and ways to increase consumption. The goal will be to increase fruit and vegetable consumption.	Based on the CHNA, only 26.7% of the survey respondents ate 5 or more fruits & vegetables per day. Develop a survey reporting tool & evaluate monthly fruit & vegetable consumption.	WRHC leadership team	Dietitian, Dietary, Marketing	

Winner Regional Healthcare Center

2013 Implementation Strategy Impact

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

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

1. **Impact of the Strategy to Address Physician Recruitment**

   This first priority was determined by the number of patients wanting to be seen in a timely manner (urgent vs. routine check-up). During the past three years, two physicians and two APPs (advanced practice providers) have been added. At the same time the community lost two surgeons as well as an APP. Clinic access has improved slightly. This has been accomplished by lengthening the hours of availability by having a night clinic one day a week as well as adjusting provider schedules, due to office space shortages. Both adjustments have helped.

2. **Impact of the Strategy to Address Employee-Based Wellness Programs**

   A Wellness Committee was established consisting of staff from numerous departments throughout the facility. The committee decided on three areas to focus on: smoking, flu prevention and healthy nutrition. The programs were disseminated at a WRHC quarterly all-staff meeting. Staff was informed of successful smoking cessation programs provided by the State of South Dakota. Handouts were given to staff. Participation was encouraged by the Wellness Committee and reminders were placed on the communication boards throughout the facility. A new policy was approved by the Governing Board that required all staff to have a flu shot. This policy was to show the community that WRHC cares about our patients and our community's wellness. The WRHC dietitian explained the eating healthy program and put together a pictorial of the effects of eating healthy. The storyboard was posted in the cafeteria so it would be visible to the facility's staff and the community as they decide on their food choices.

3. **Impact of the Strategy to Address Chronic Health Issues in the Community**

   The third focus was to evaluate the chronic health issues in the community. Minimal progress has been made in this strategy; however, Better Choices, Better Health, a chronic disease self-management program developed by Stanford, will be implemented during 2017.

Winner Regional Healthcare Center

Community Feedback from the 2013 Community Health Needs Assessment

Winner Regional Healthcare Center leadership is prepared to accept feedback on our 2013 Community Health Needs Assessment and has provided online comment fields for ease of access on our website.

Please address your concerns or questions at: http://winnerregional.org

Winner Regional Healthcare Center

APPENDIX

Primary Research

Winner Regional Healthcare Center

Asset Map

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings	Community resources that are available to address the need	Gap?
Economics • Cost of affordable housing 3.75		• 27% of children live in poverty	Apartments in Winner: • Frontier Apts. 605-347-3077 • Presidential Square 605-842-1012 • Lamro Apts. 605-842-3615 • Homestead Townhomes 605-224-8231 Low Income Housing in Winner: • Lamro Apts. 605-271-4663 • Homestead Apts. 952-949-2200 Realtors in Winner: • Shippy Realty 605-609-7599 • Fidelity Agency 605-842-3811 • Dan Clark Realty 605-842-3300 • Whetham Realty 605-842-3020 • Burns Rentals 605-842-1930 • Mathis Rentals 605-842-0254 Burke Housing & Redevelopment Commission – 605-775-2676 Low income apartments in Burke: • Rosebud Apts. – 605-775-2531 • Parkview Manor – 605-775-2676	X
Aging population • Cost of LTC 4.19 • Availability of memory care 3.89 • Availability of LTC 3.63 • Availability of resources to help caregivers 3.56			LTC resources in Winner: • Winner Regional LTC 605-842-7200 Assisted Living in Winner: • Golden Prairie Manor 605-842-0508 • Elder Inn 605-842-0390 Memory care in Winner: • Winner Regional LTC 605-842-7200 Low Income Housing in Winner: • Lamro Apts. 605-271-4663 • Homestead Apts. 952-949-2200 Home Medical Equipment in Winner: • Lincare 605-835-8660 Senior Meals in Winner: • Rural Office of Community Services 605-487-7635	X

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings	Community resources that are available to address the need	Gap?
			LTC resources in Burke: • The Assisted Living Home 605-775-6316 Memory care resources in Burke: • The Assisted Living Home 605-775-6316 Low income apartments in Burke: • Rosebud Apts. – 605-775-2531 • Parkview Manor – 605-775-2676	
Children and Youth • Bullying 3.69 • Youth crime 3.63 • Availability of quality childcare 3.59 • Availability of quality infant care 3.55		• 27% of children live in poverty	Bullying resources in Winner: • Sheriff 605-842-3600 • Police 605-842-3324 • Winner School District 605-842-8101 • Winner Regional Clinic 605-842-2626 • Avera Clinic 605-842-2443 Child Care in Winner: • Elizabeth Bachmann 605-842-0885 • Melissa Petersen 605-842-3926 • Kay Shippy 605-842-1549 • In His Hands 605-842-1590 • Rolf's Little Rascals 605-840-4262 • 2K's Daycare 605-842-1549 • Head Start 605-842-1924 Activities for Children & Youth in Winner: • AWANA 605-842-2020 • School District 605-842-0894 • 4-H Club 605-842-1155 • Boy Scouts Troop 100 605-361-2697 • Girl Scouts 605-336-2978 Bullying resources in Burke: • Sheriff – 605-775-2626 • Police – 605-775-2282 • Burke School – 605-775-2645 • Burke Clinic – 605-775-2631 • Debra K. Leibel, CNP – 605-775-2631 Child Care resources in Burke: • Burke Club E3 – 605-775-2644 • Clarissa Dummer – 605-775-2415 • Julie Johnson – 605-775-2987 Activities for children & youth in Burke: • 4-H – 605-775-2581 • Boy Scouts • Girl Scouts – 605-336-2978	X

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings	Community resources that are available to address the need	Gap?
			• School District – 605-775-2645 • Park District – 605-775-2475	
Crime/Safety • Presence of street drugs, prescription drugs & alcohol 4.17 • Presence of drug dealers 3.94 • Child abuse and neglect 3.60 • Crime 3.55 • Domestic violence 3.53		• 100% of crimes are ranked as violent 21% report excessive drinking 39% of driving deaths as alcohol-impaired	Winner Sheriff 605-842-3600 Winner Police 605-842-3324 Burke Sheriff – 605-775-2626 Burke Police – 605-775-2282	X
Access to Health Care/ Cost of Health Care • Access to affordable health insurance 3.95 • Cost of affordable vision insurance 3.60 • Use of emergency room services for primary health care 3.60 • Access to affordable prescription drugs 3.55 • Cost of affordable dental insurance coverage 3.53 • Access to affordable health care 3.51		• 18% are uninsured	Health insurance in Winner: • American Family 605-842-8300 • DakotaCare 605-842-3260 • The Insurance Center 605-842-3260 Health care providers: • Winner Regional Hospital 605-842-7100 • Winner Regional Clinic 605-842-2626 • Winner Regional Physical Therapy 605-842-7304 • Avera Medical Group - Winner 605-842-2443 • Burke Clinic – 605-775-2631 • Atlas Chiropractor 605-842-1588 • Hearing Health Centers 605-842-1209 • Daniel Peters, OD 605-842-1974 • The Right Touch (massage therapy) 605-842-0586 • Winner Dental Clinic 605-842-1793 • Winner Family Dentistry 605-842-2101 • Winner Physical Therapy 605-842-7188 Community Connections 605-842-1708 SD DHS Prescription Assistance Program 605-773-3656 Southern Dakota Insurance Agency 605-775-2097	X
Physical Health • Cancer 4.01 • Chronic disease 3.90 • 10.2% report high cholesterol			Obesity/Inactivity/Exercise resources in Winner: • School District programs 605-775-2645 • Park District programs – 605-775-2475	X

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings	Community resources that are available to address the need	Gap?
• 9.1% report hypertension • 9.1% report arthritis • Obesity 3.73 • 68.3% rate themselves as overweight or obese • Inactivity and lack of exercise 3.72 • 48.2% report moderate exercise 3 x per week or more • Poor nutrition and eating habits 3.68 • Only 26.7% have 3 or more vegetables per day • Only 21.8% have 3 or more fruits per day			• Winner Regional Clinic dietician 605-842-2626 • Avera Medical Group – Winner dietitian - 605-842-2443 Home Medical Equipment in Winner: • Lincare 605-835-8660 Burke Clinic – 605-775-2631 Sanford home medical equipment in Burke 605-775-2296 Winner Regional Healthcare Center Lactation Consultant – 605-842-7100 American Cancer Society American Diabetes Association American Lung Association American Asthma Association Arthritis Foundation American Heart Association SD Office of Chronic Disease Prevention 605-773-3361 Obesity/Inactivity/Exercise resources: • Fitness on Main, Gregory SD – 605-775-2166 (12 miles from Burke) • School District 605-775-2645 • Park District 605-775-2475 Nutrition classes: • Gregory County Extension 605-775-2581 Farmers Markets: • Burke Area Farmers Market 605-830-5039	
Mental Health/ Behavioral Health • Dementia and Alzheimer's 3.83 • Stress 3.82 • Depression 3.74 • Underage drug use and abuse 3.85 • Drug use and abuse 4.10		• 13% smoke • 21% abuse alcohol	Winner Regional Clinic 605-842-2626 Avera Medical Group – Winner 605-842-2443 Southern Plains Behavioral Health Clinic, Winner, SD 605-842-1465 Burke Clinic – 605-775-2631	X

Identified concern	Community stakeholders - specific areas of concern	Secondary Data - Tripp County Health Rankings	Community resources that are available to address the need	Gap?
• Alcohol use and abuse 3.93 • Underage drug use and abuse 3.89 • Underage drinking 3.75 • 35.7% of respondents report binge drinking • Smoking and tobacco use 3.74			Southern Plains Behavioral Health Clinic, Gregory, SD (12 mi. from Burke) 605-835-8505 SD QuitLine – 866-737-8487	

Winner Regional Healthcare Center
2016 Community Health Needs Assessment Prioritization Worksheet

Criteria to Identify Priority Problem
- Cost and/or return on investment
- Availability of solutions
- Impact of problem
- Availability of resources (staff, time, money, equipment) to solve problem
- Urgency of solving problem (Ebola or air pollution)
- Size of problem (e.g. # of individuals affected)

Criteria to Identify Intervention for Problem
- Expertise to implement solution
- Return on investment
- Effectiveness of solution
- Ease of implementation/maintenance
- Potential negative consequences
- Legal considerations
- Impact on systems or health
- Feasibility of intervention

Health Indicator/Concern	Round 1 Vote	Round 2 Vote	Round 3 Vote
Economics • Availability of affordable housing 3.75			
Aging • Cost of LTC 4.19 • Availability of memory care 3.89 • Availability of LTC 3.63 • Availability of resources to help caregivers 3.56			
Children and Youth • Bullying 3.69 • Youth crime 3.63 • Availability of quality childcare 3.59 • Availability of quality infant care 3.55			
Safety • Presence of street drugs, prescription drugs & alcohol 4.17 • Presence of drug dealers 3.94 • Child abuse and neglect 3.60 • Crime 3.55 • Domestic violence 3.53			
Health care • Access to affordable health insurance 3.95 • Cost of affordable vision insurance 3.60 • Use of emergency room services for primary health care 3.60 • Access to affordable prescription drugs 3.55 • Cost of affordable dental insurance coverage 3.53 • Access to affordable health care 3.51			
Physical Health • Cancer 4.01 • Chronic disease 3.90 • 10.2% report high cholesterol • 9.1% report hypertension • 9.1% report arthritis • Obesity 3.73 • 68.3% rate themselves as overweight or obese • Inactivity and lack of exercise 3.72 • 48.2% report moderate exercise 3 x per week or more • Poor nutrition and eating habits 3.68 • Only 26.7% have 3 or more vegetables per day • Only 21.8% have 3 or more fruits per day			
Mental Health • Dementia and Alzheimer's 3.83 • Stress 3.82 • Depression 3.74 • Underage drug use and abuse 3.85 • Drug use and abuse 4.10 • Alcohol use and abuse 3.93 • Underage drug use and abuse 3.89 • Underage drinking 3.75 • 35.7% of respondents report binge drinking • Smoking and tobacco use 3.74			

Winner Regional Healthcare Center

Community Health Needs Assessment

Results from a September 2016 Non-Generalizable

Online Survey

September 2016

STUDY DESIGN and METHODOLOGY

The following report includes non-generalizable survey results from a September 2016 online survey conducted through a partnership between the Community Health Collaborative and the Center for Social Research (CSR) at North Dakota State University. The CSR developed and maintained links to the online survey tool. Members of the Community Health Collaborative invited viewers to access the online survey by distributing the survey link via e-mail to various agencies, at times using a snowball approach**. Therefore, it is important to note that the data in this report are not generalizable to the community.** Data collection occurred in the month of September. A total of 88 respondents participated in the online survey.

TABLE OF CONTENTS

SURVEY RESULTS

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

General Health and Wellness Concerns about the Community

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

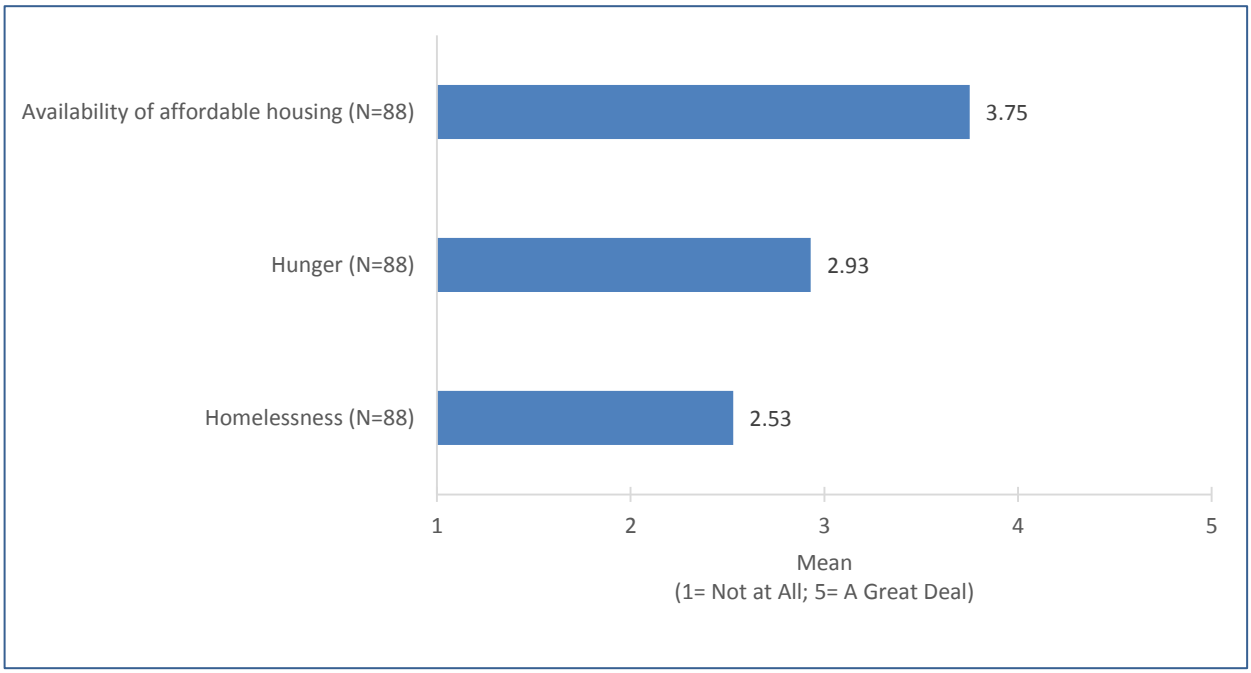


Figure 2. Level of concern with statements about the community regarding TRANSPORTATION

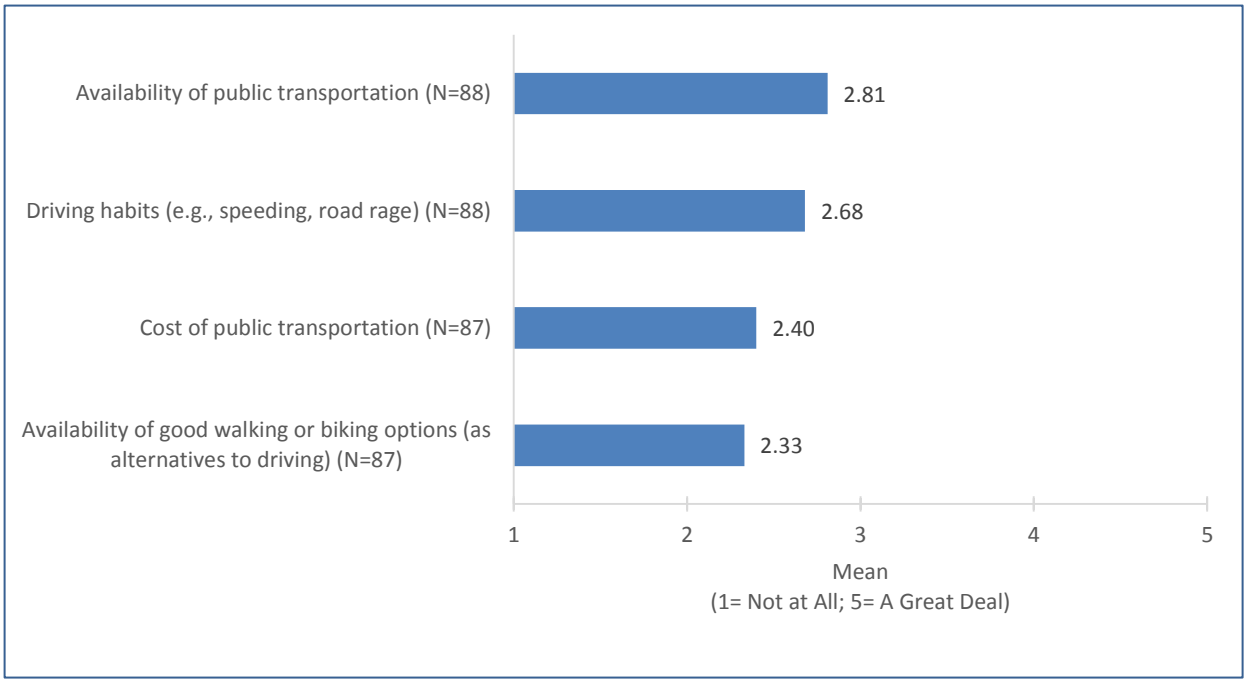


Figure 3. Level of concern with statements about the community regarding the ENVIRONMENT

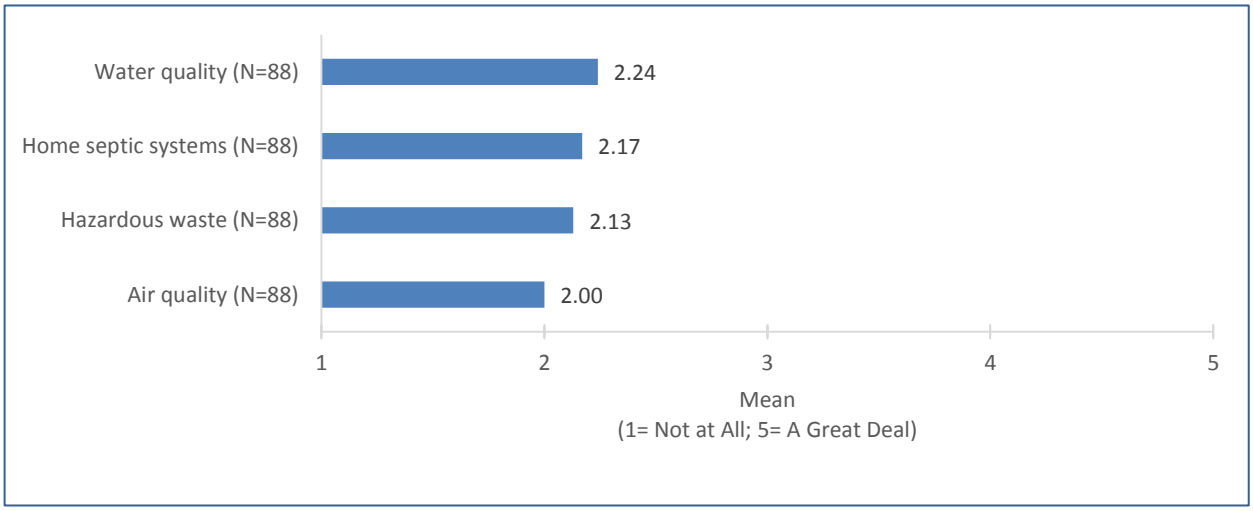


Figure 4. Level of concern with statements about the community regarding CHILDREN AND YOUTH

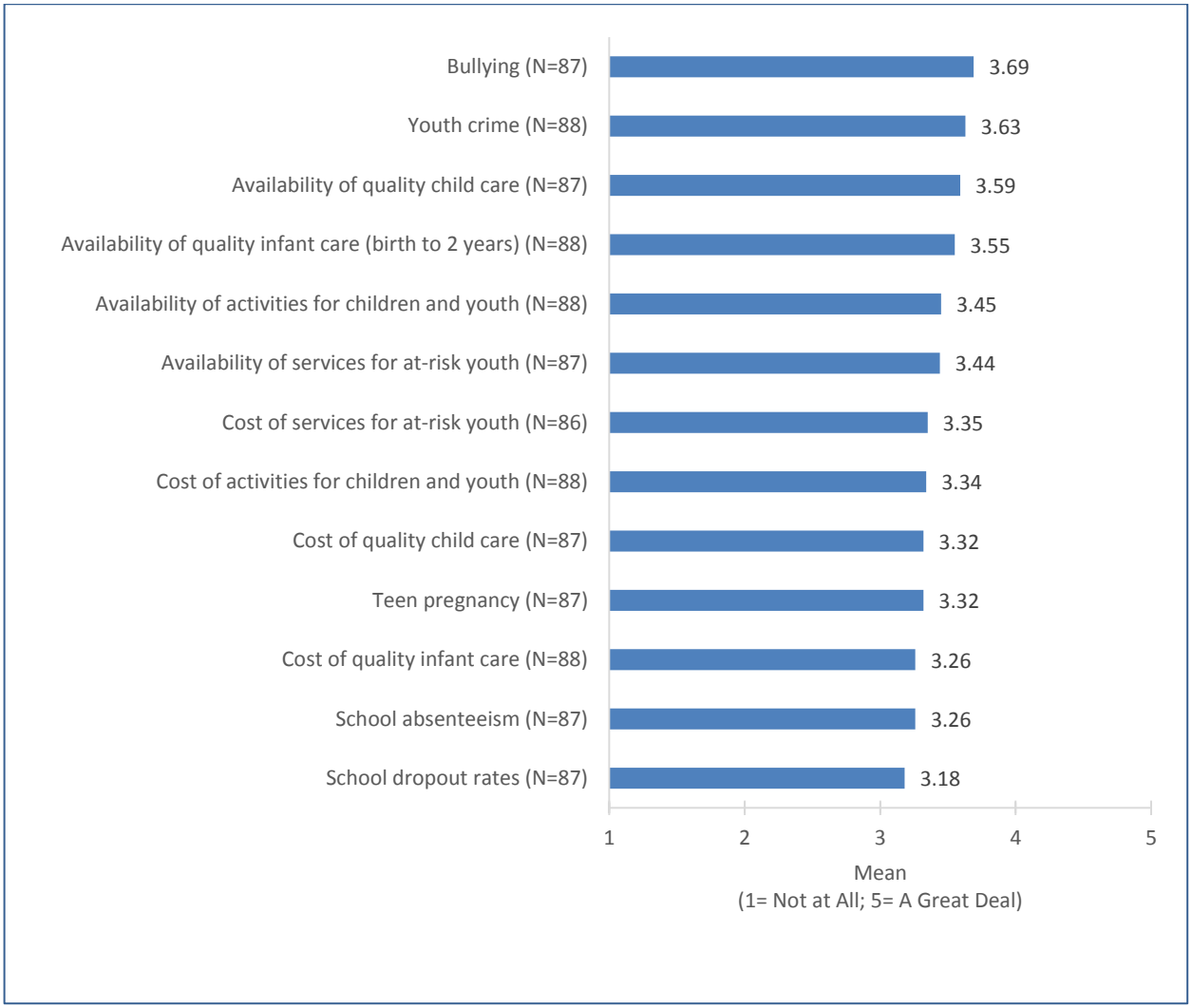


Figure 5. Level of concern with statements about the community regarding the AGING POPULATION

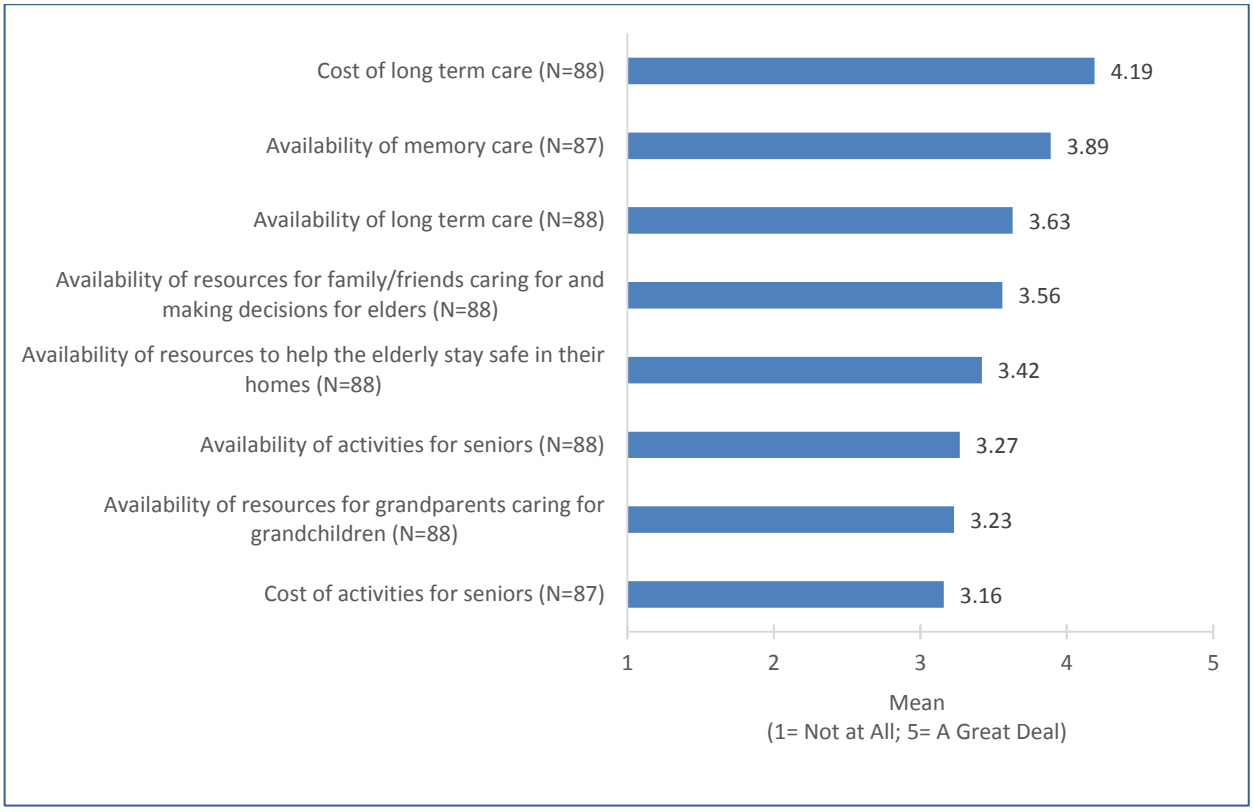


Figure 6. Level of concern with statements about the community regarding SAFETY

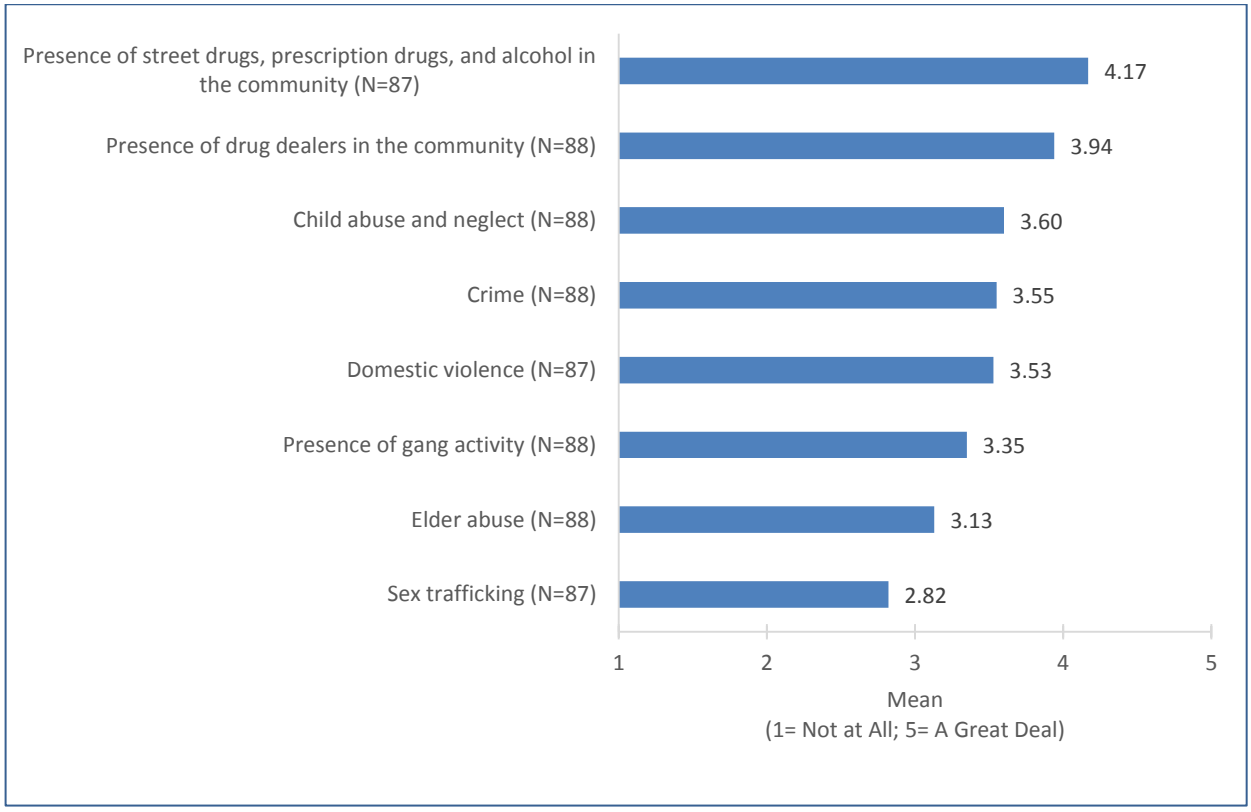


Figure 7. Level of concern with statements about the community regarding HEALTH CARE

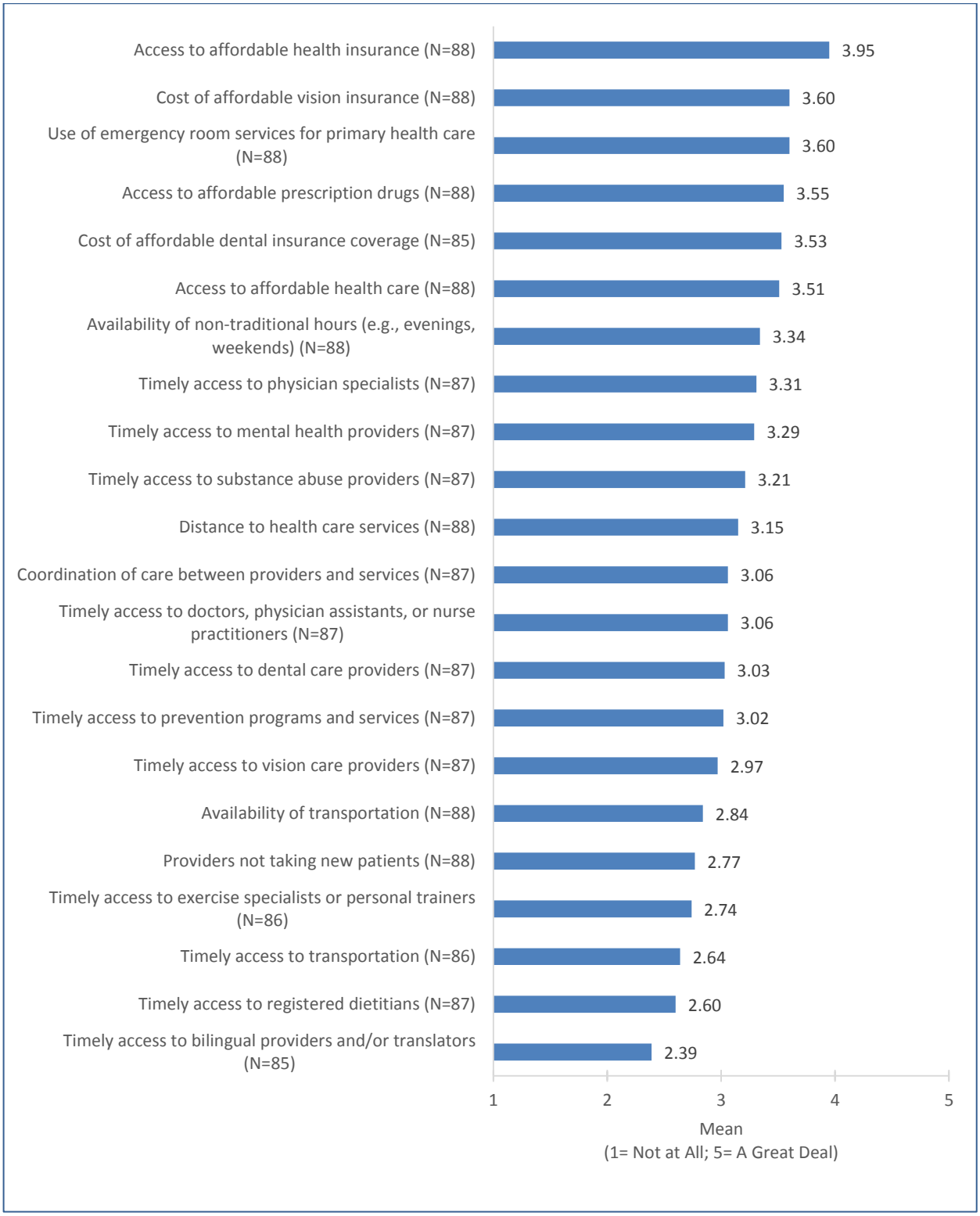


Figure 8. Level of concern with statements about the community regarding PHYSICAL AND MENTAL HEALTH

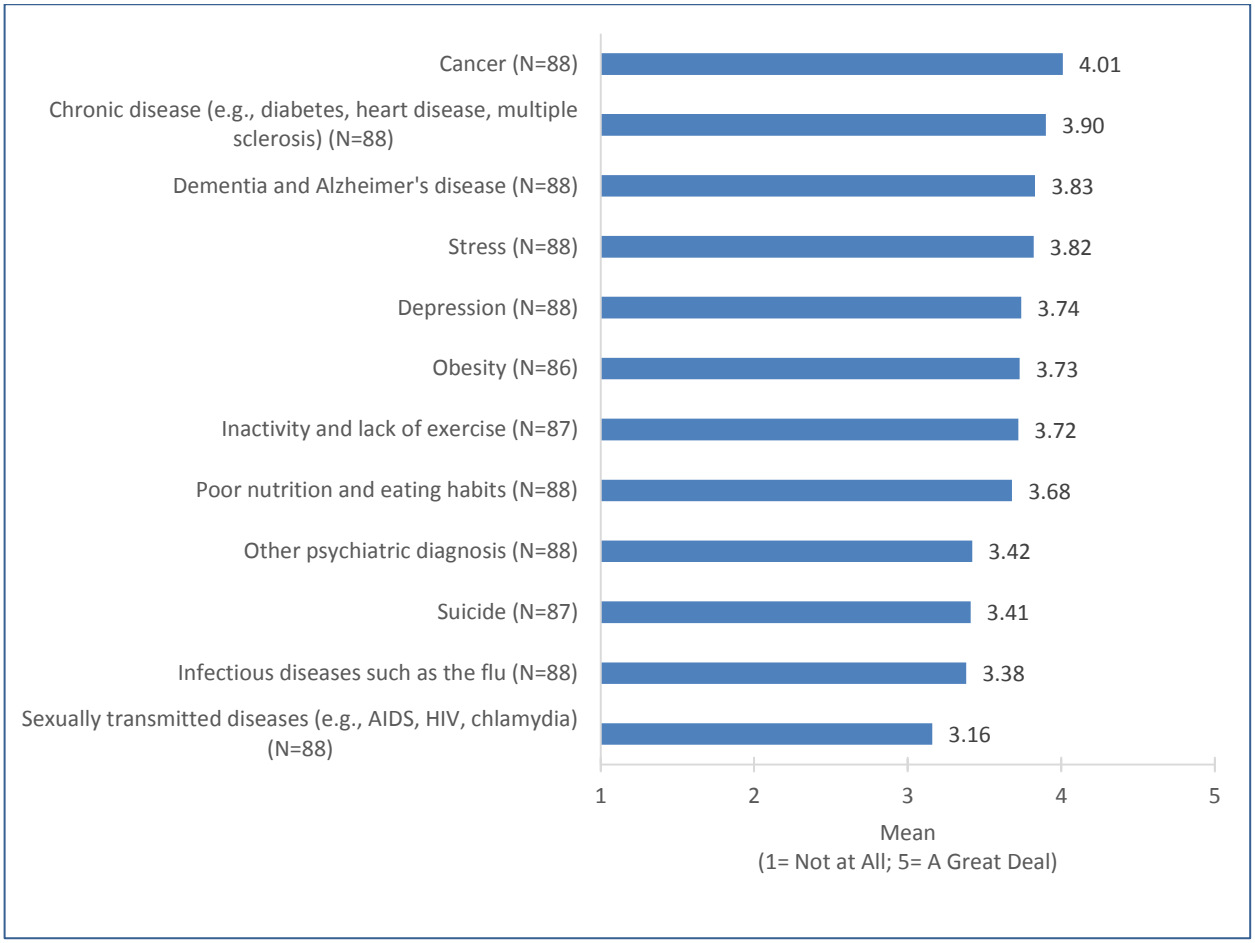
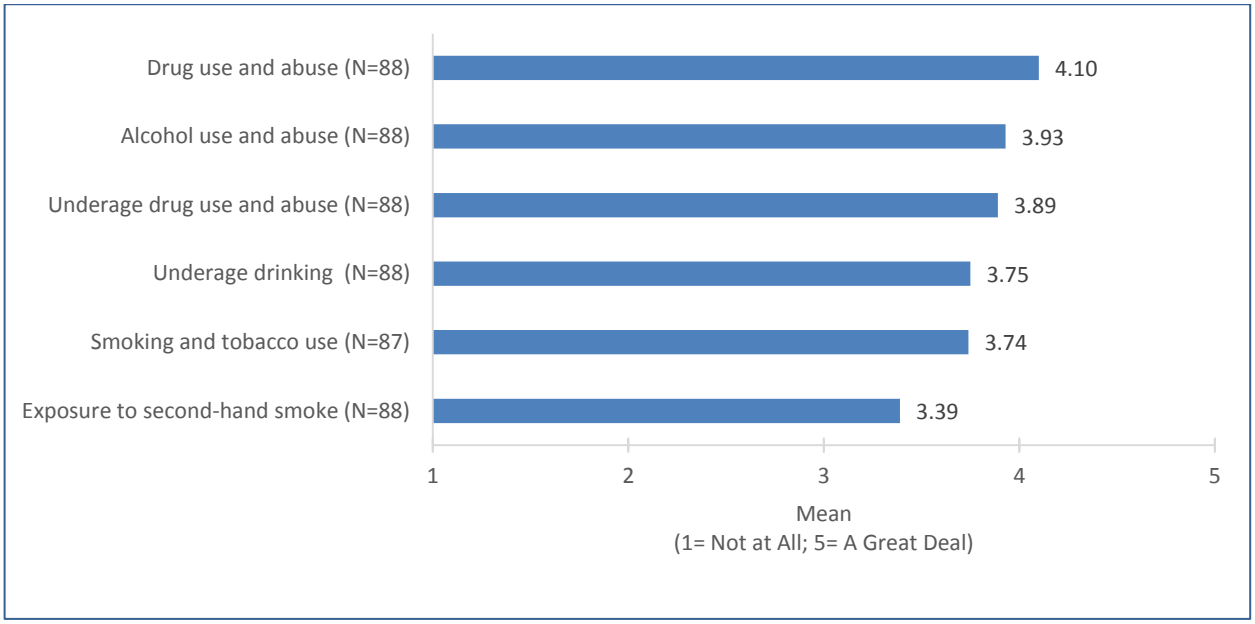
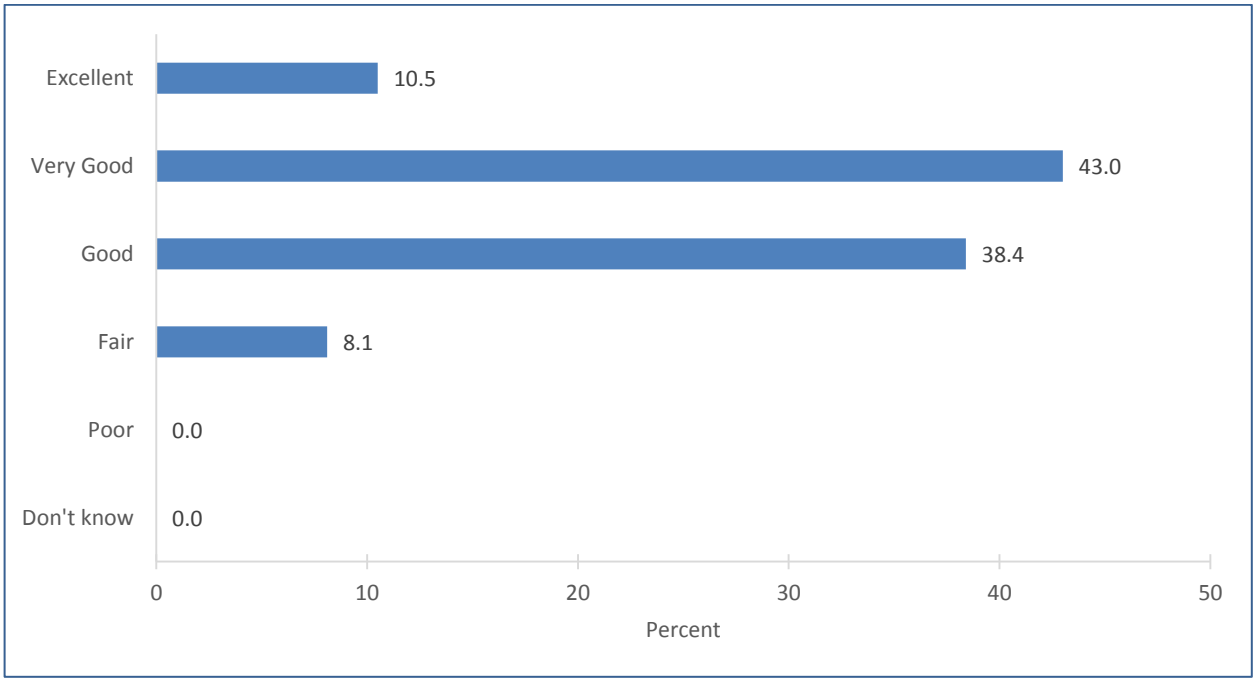


Figure 9. Level of concern with statements about the community regarding SUBSTANCE USE AND ABUSE



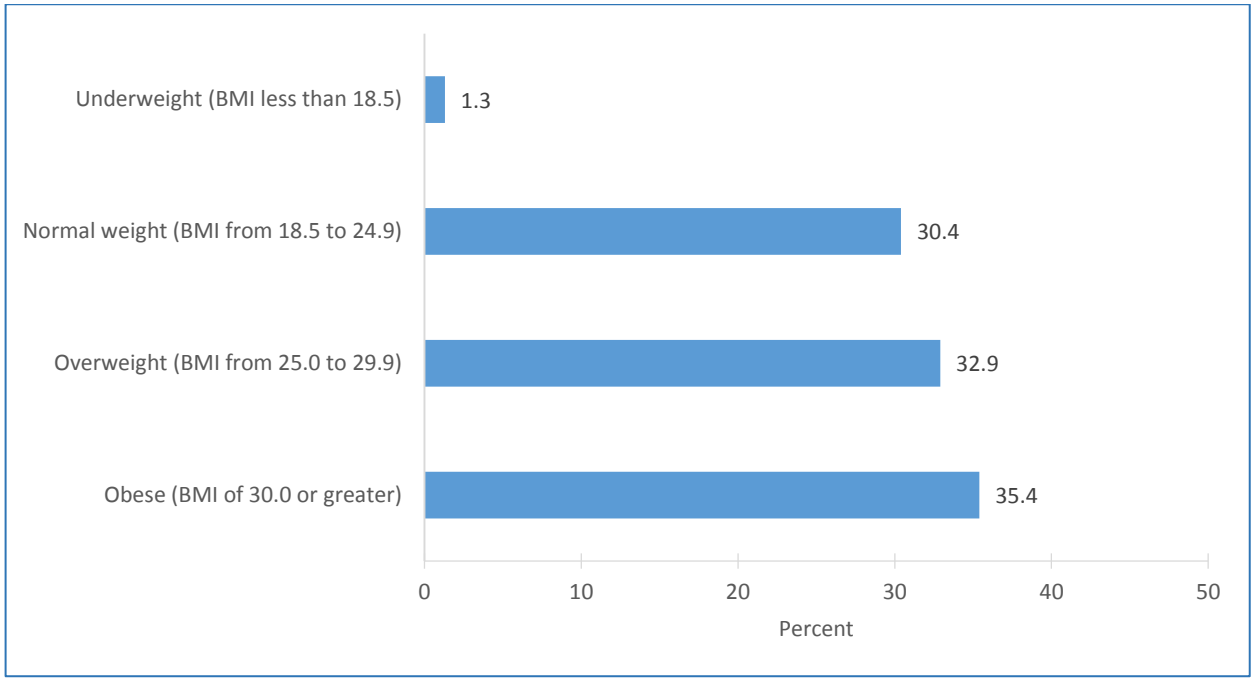
General Health

Figure 10. Respondents' rating of their health in general



N=86

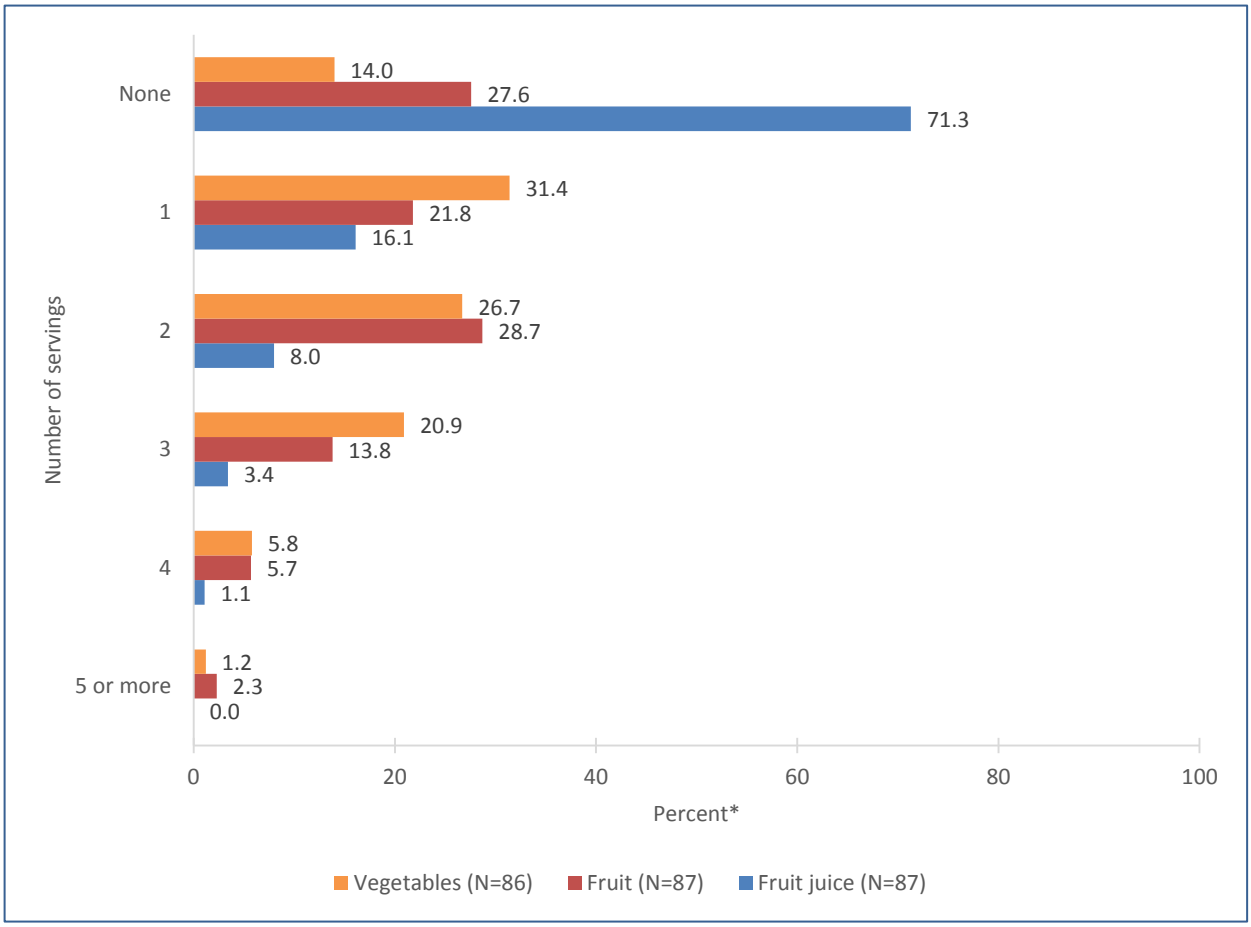
Figure 11. Respondents' weight status based on the Body Mass Index (BMI)* scale



N=79

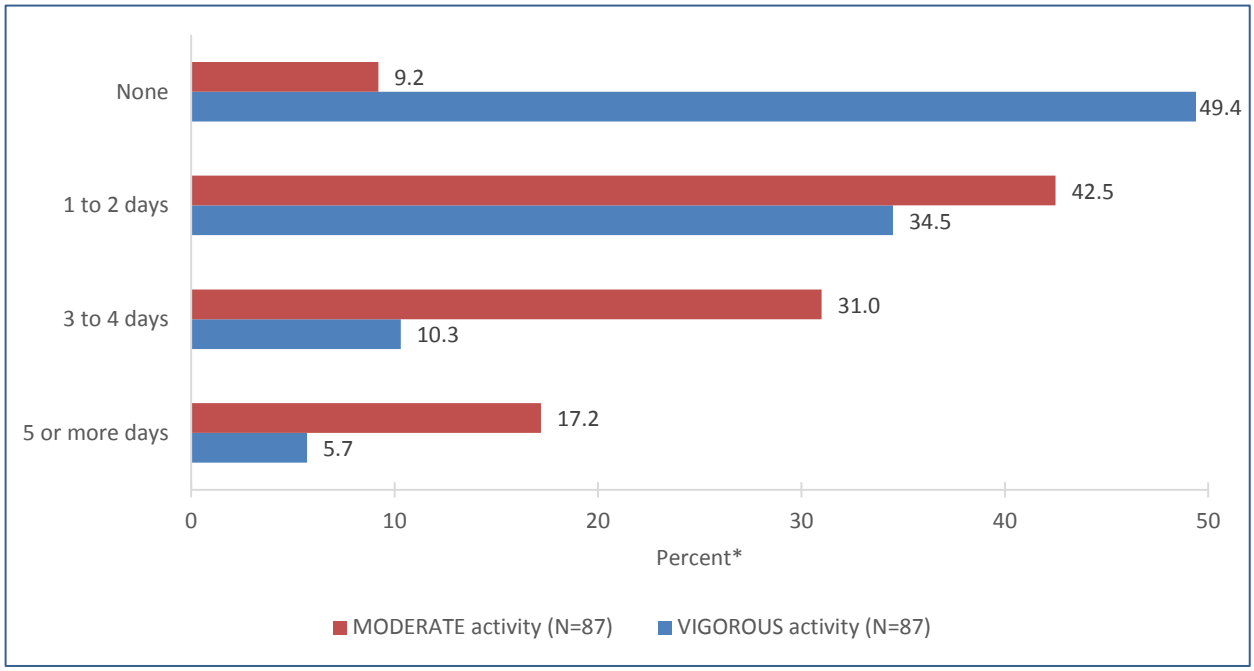
*For information about the BMI, visit the Center for Diseases Control and Prevention, *About BMI for Adults*, www.cdc.gov/healthyweight/assessing/bmi/.

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



*Percentages may not total 100.0 due to rounding.

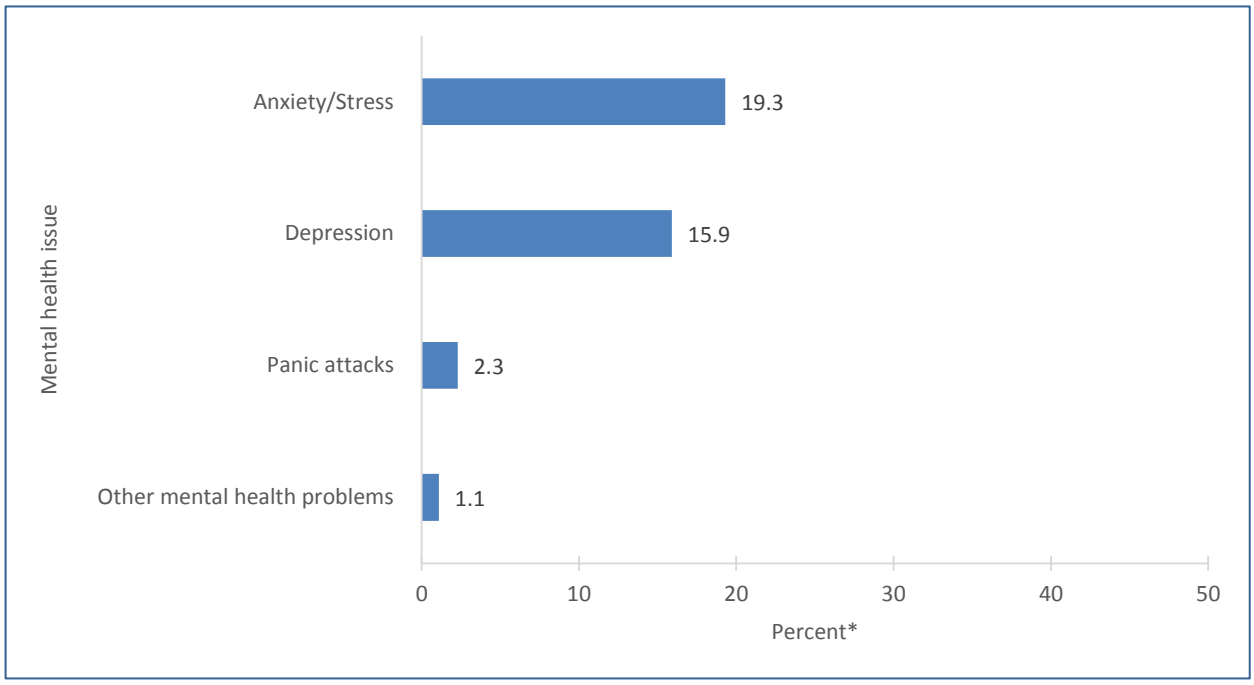
Figure 13. Number of days in an average week respondents engage in MODERATE and VIGOROUS activity



*Percentages do not total 100.0 due to rounding.

Mental Health

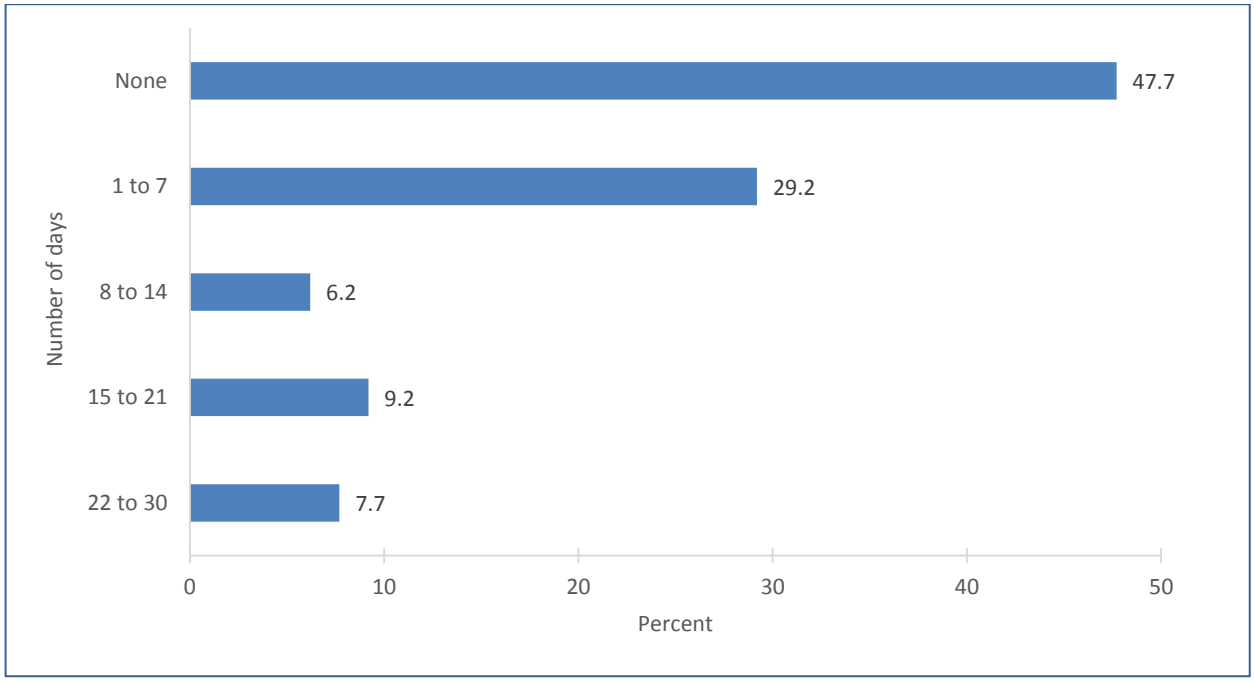
Figure 14. Percentage of respondents who have been told by a doctor or health professional that they have a mental health issue, by type of mental health issue



N=88

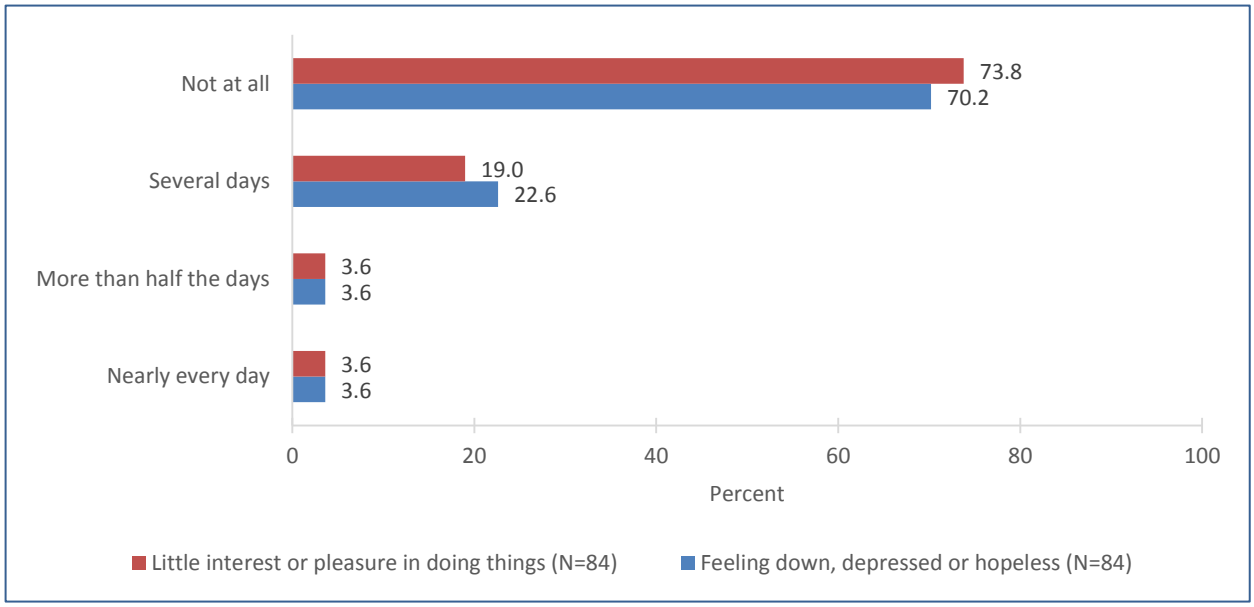
*Percentages do not total 100.0 due to multiple responses.

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



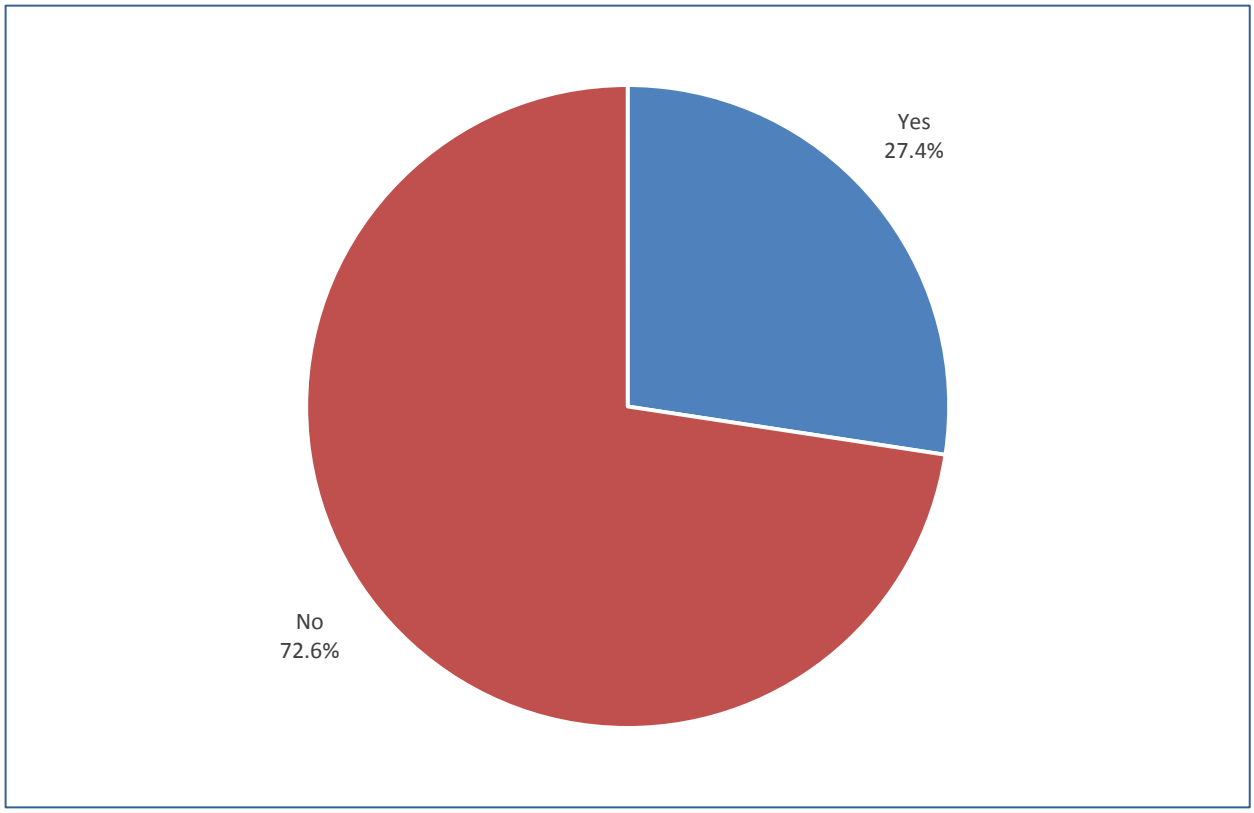
N=65

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



Tobacco Use

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



N=84

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

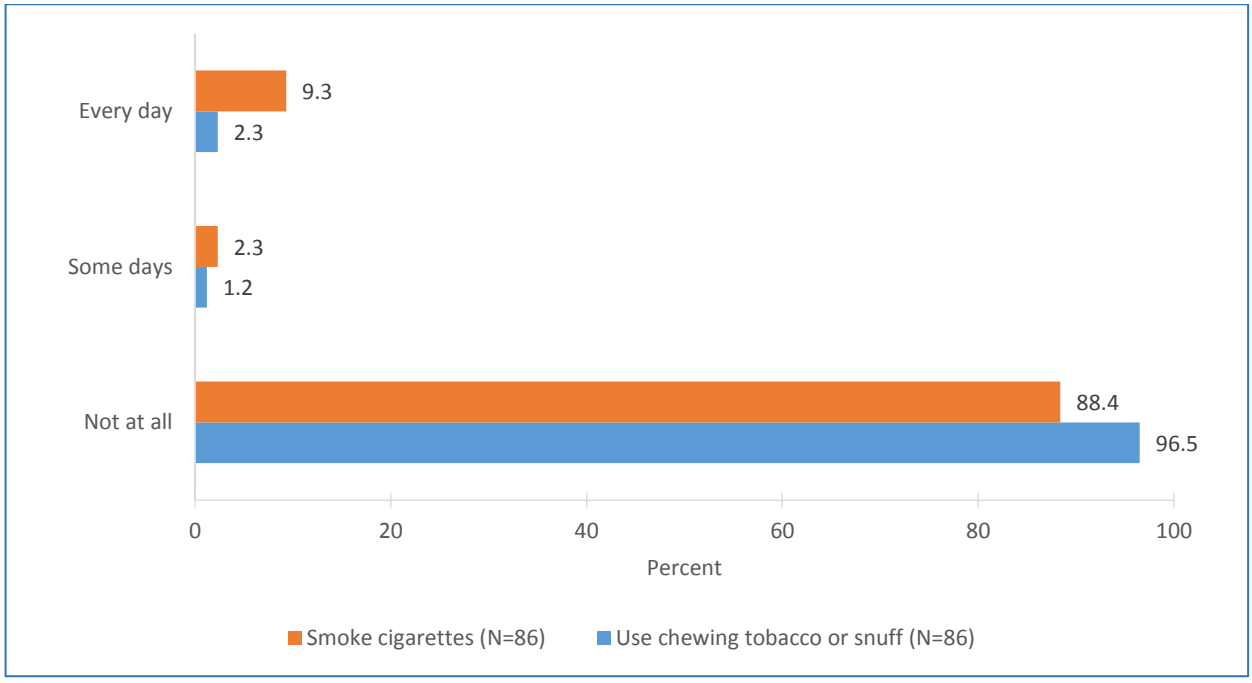
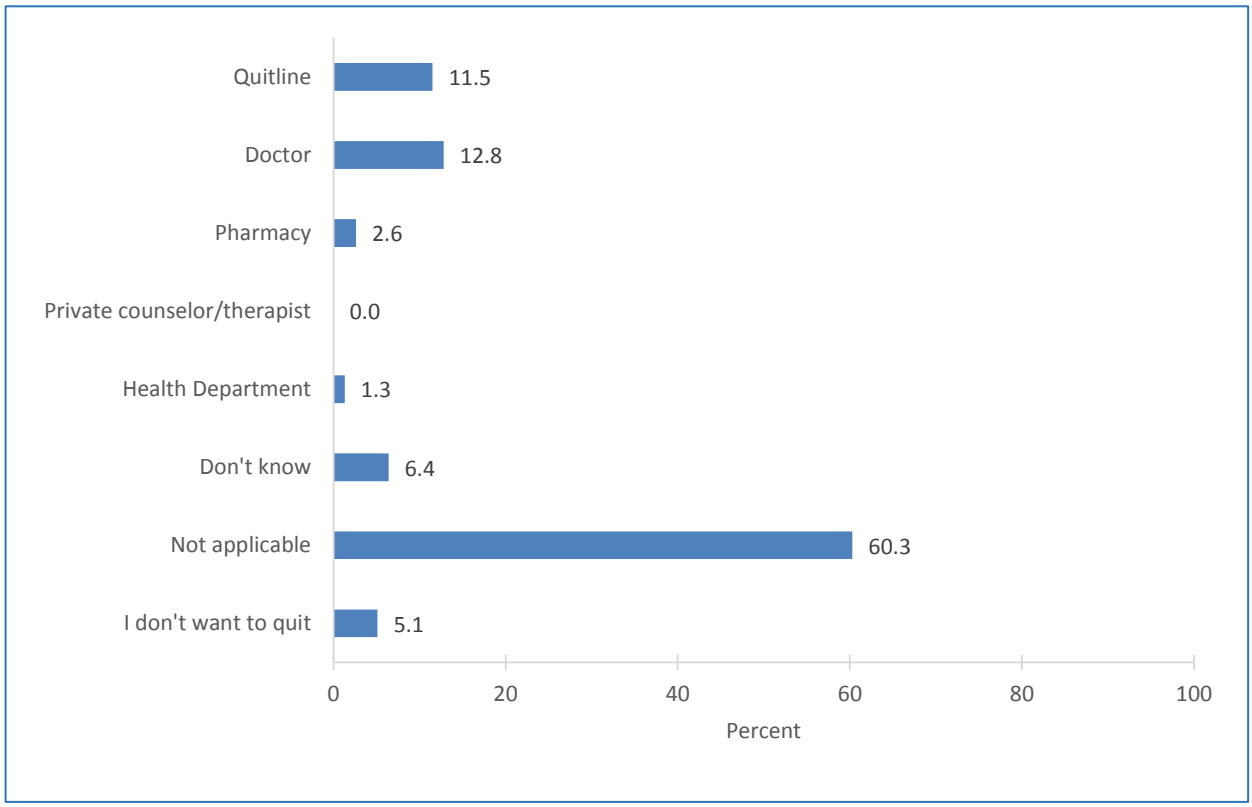


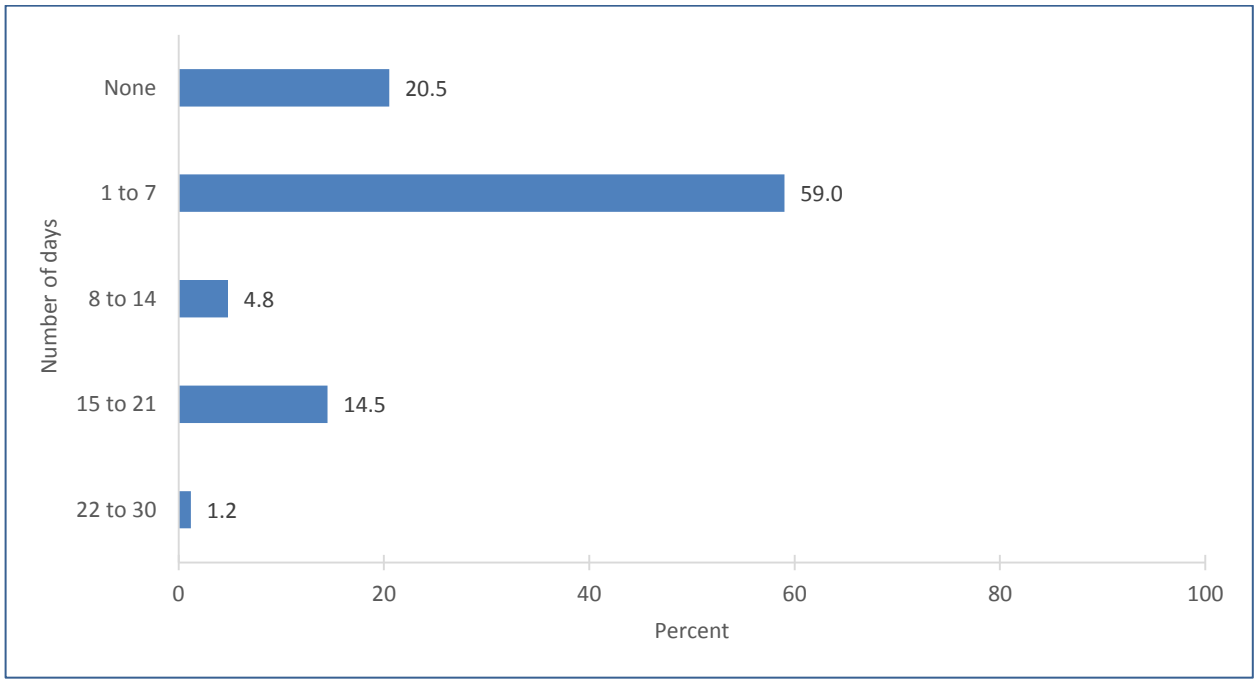
Figure 19. Location respondents would first go if they wanted help to quit using tobacco



N=78

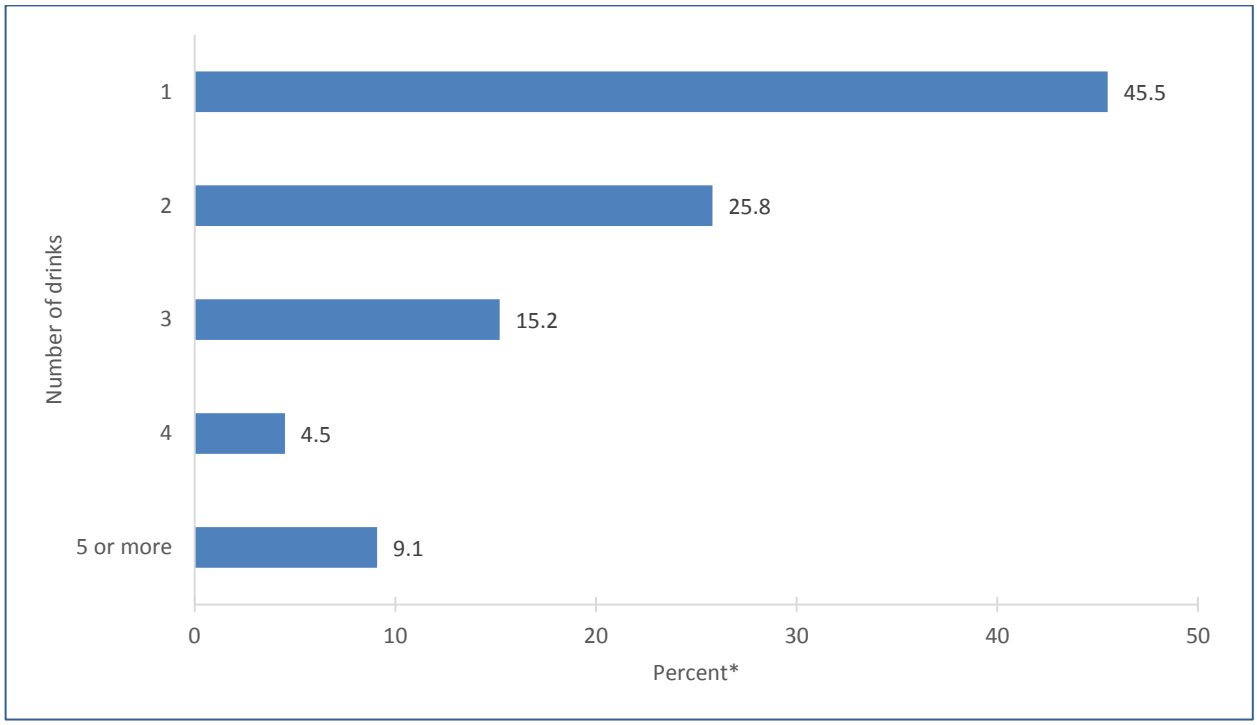
Alcohol Use and Prescription Drugs/Non-prescription Drug Abuse

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



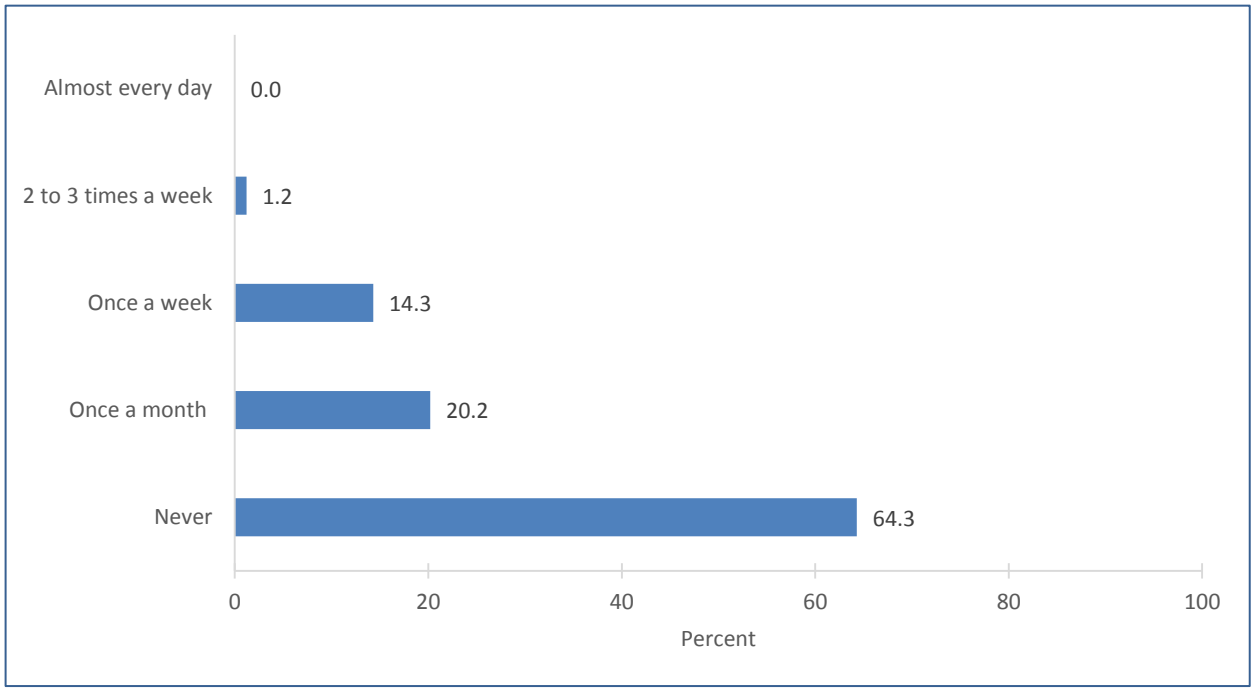
N=83

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



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

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



N=84

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

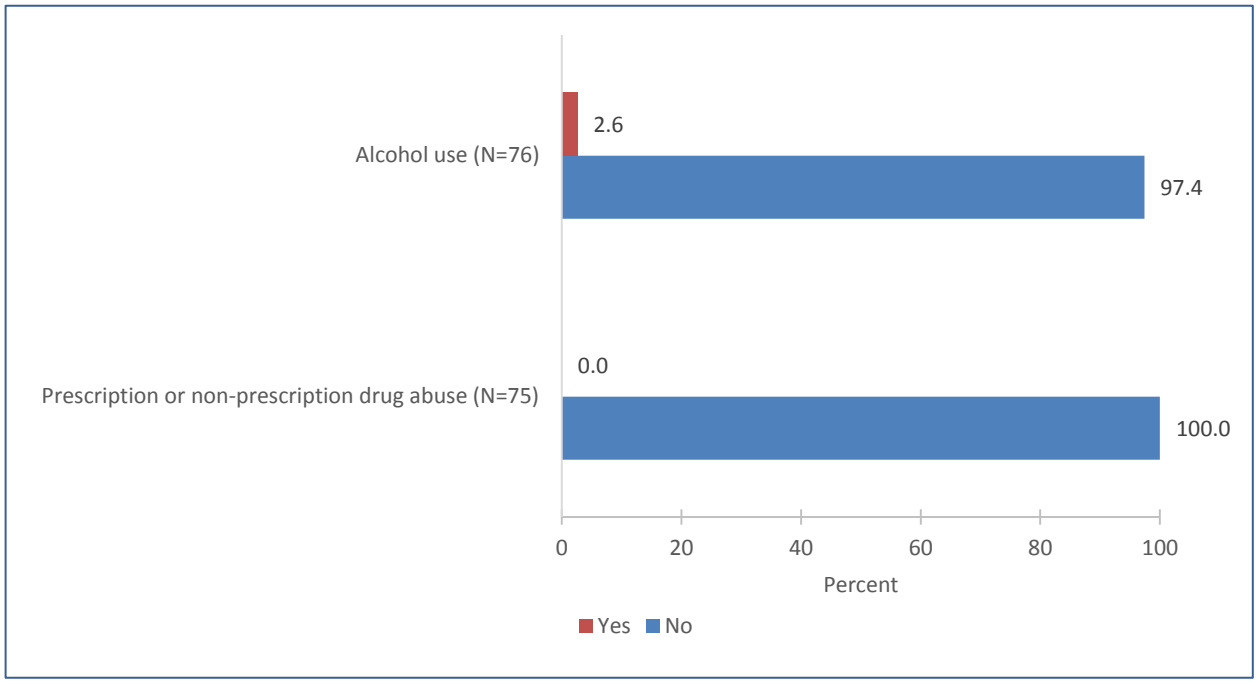


Figure 24. Of respondents who ever had a problem with alcohol use or prescription or non-prescription drug abuse, whether respondents got the help they needed

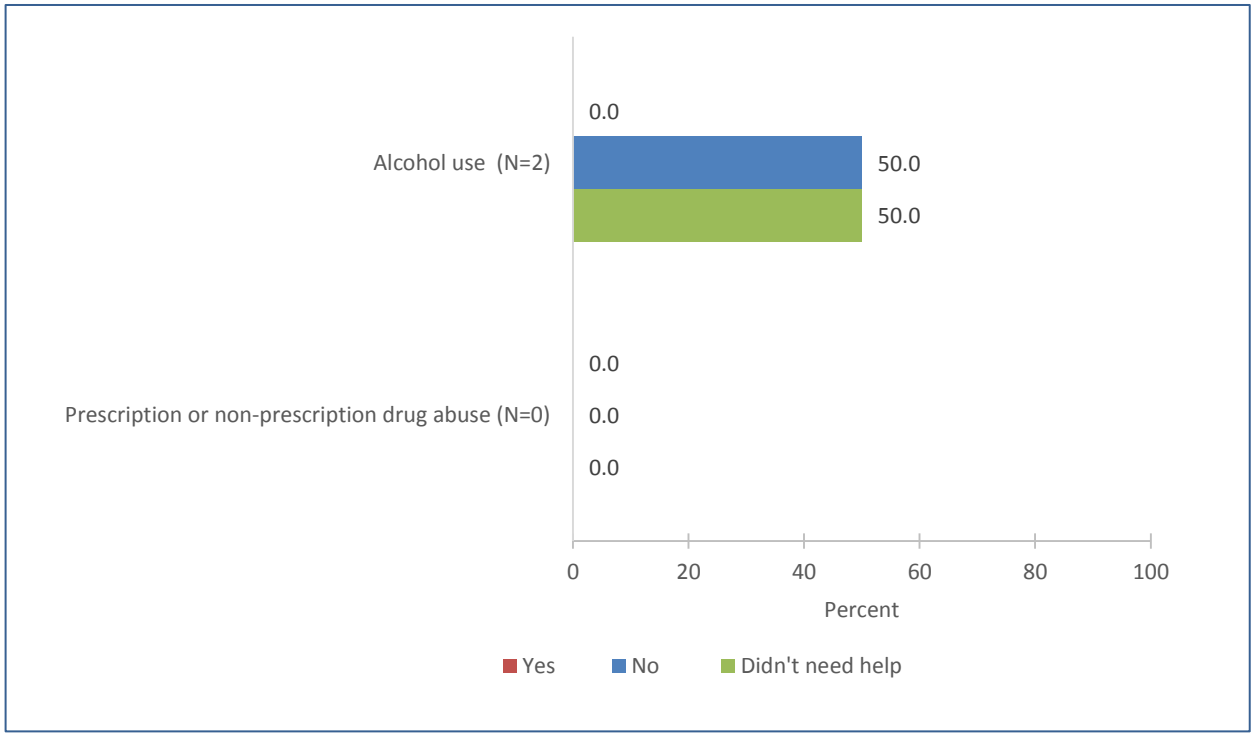


Figure 25. Whether alcohol use or prescription or non-prescription drug abuse has had harmful effects on respondents or a family member over the past two years

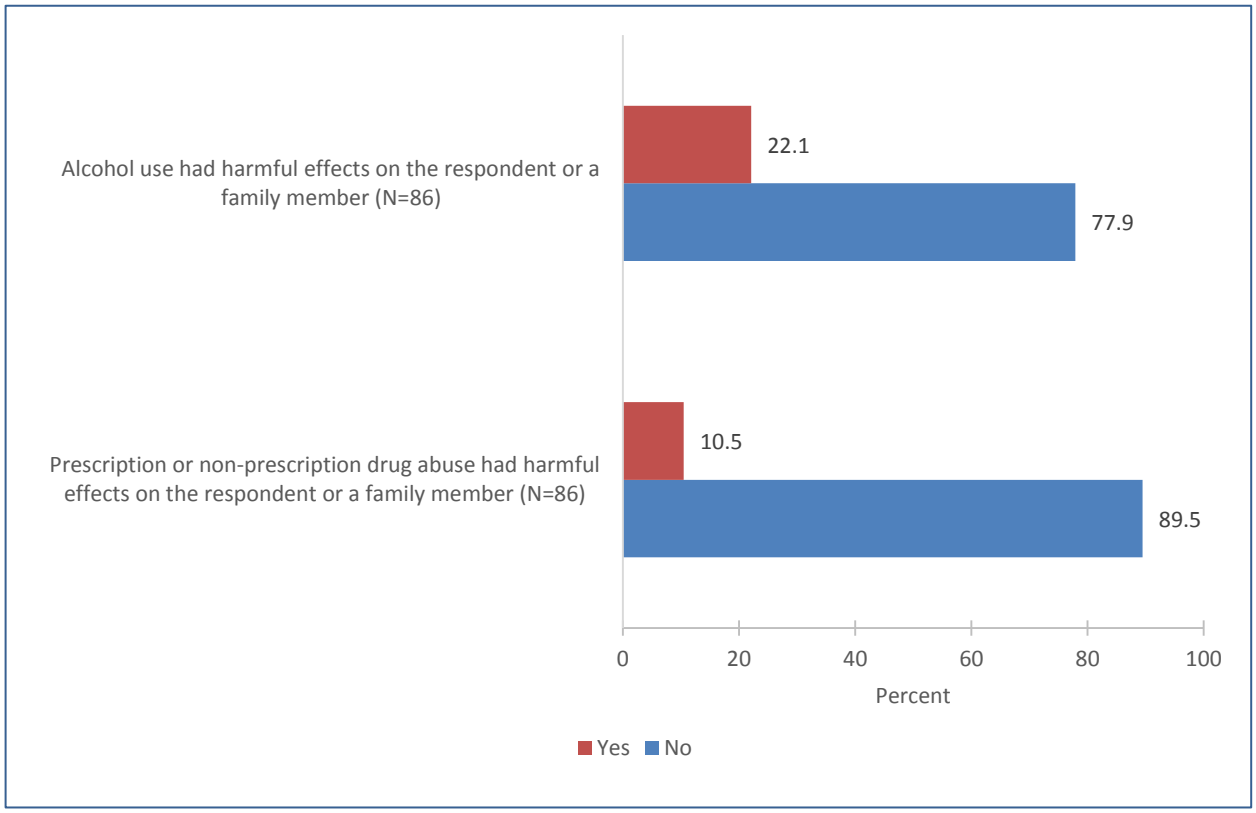


Table 1. Whether or not respondents have had preventive screenings in the past year, by type of screening

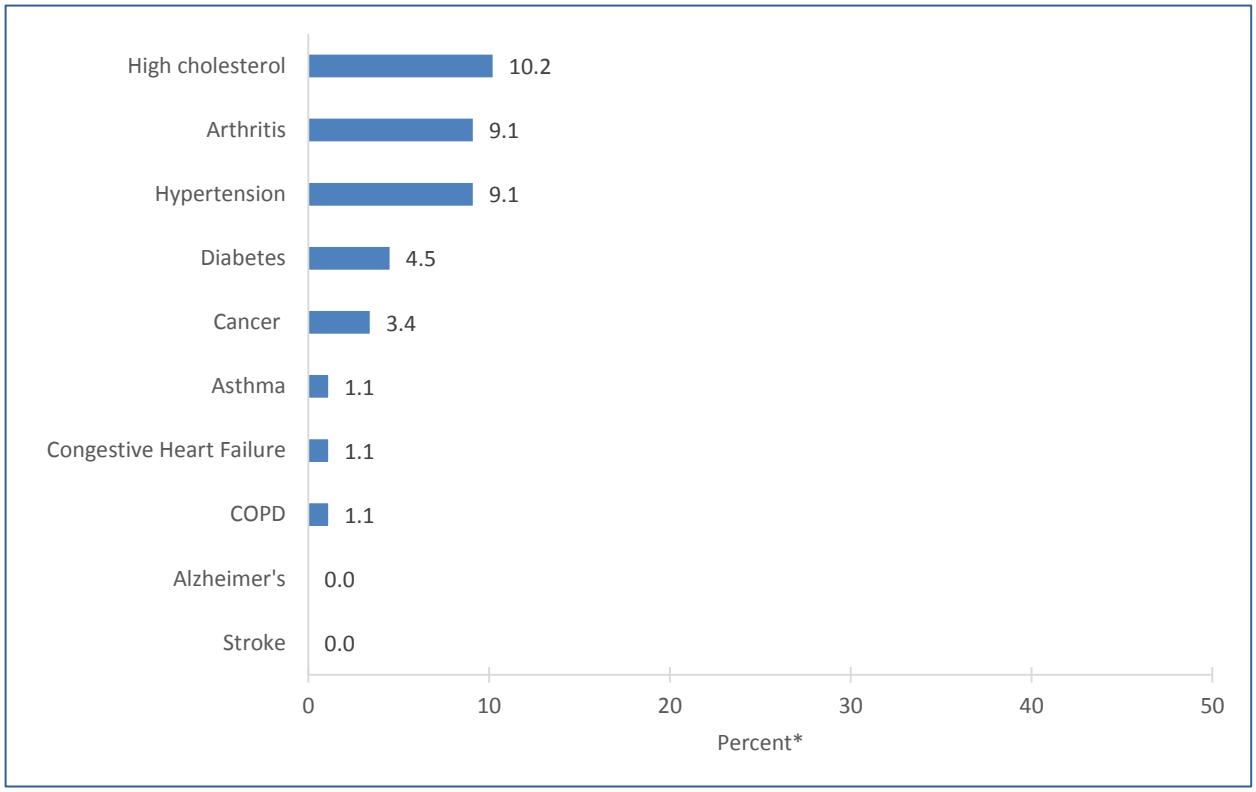
Type of screening	Percent of respondents		
	Yes	No	Total
GENERAL SCREENINGS			
Blood pressure screening (N=84)	79.8	20.2	100.0
Blood sugar screening (N=84)	66.7	33.3	100.0
Bone density test (N=83)	16.9	83.1	100.0
Cardiovascular screening (N=84)	33.3	66.7	100.0
Cholesterol screening (N=84)	70.2	29.8	100.0
Dental screening and X-rays (N=85)	72.9	27.1	100.0
Flu shot (N=84)	73.8	26.2	100.0
Glaucoma test (N=83)	38.6	61.4	100.0
Hearing screening (N=83)	7.2	92.8	100.0
Immunizations (N=83)	22.9	77.1	100.0
Pelvic exam (N=63 Females)	42.9	57.1	100.0
STD (N=82)	7.3	92.7	100.0
Vascular screening (N=83)	19.3	80.7	100.0
CANCER SCREENINGS			
Breast cancer screening (N=62 Females)	54.8	45.2	100.0
Cervical cancer screening (N=61 Females)	41.0	59.0	100.0
Colorectal cancer screening (N=79)	19.0	81.0	100.0
Prostate cancer screening (N=14 Males)	42.9	57.1	100.0
Skin cancer screening (N=79)	26.6	73.4	100.0

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

Type of screening	Percent of respondents*						
	Not necessary	Doctor hasn't suggested	Cost	Fear of procedure	Fear of results	Unable to access care	Other reason
GENERAL SCREENINGS							
Blood pressure screening (N=17)	41.2	41.2	5.9	0.0	0.0	0.0	0.0
Blood sugar screening (N=28)	46.4	32.1	7.1	0.0	3.6	0.0	0.0
Bone density test (N=69)	40.6	44.9	5.8	1.4	0.0	0.0	2.9
Cardiovascular screening (N=56)	35.7	35.7	7.1	1.8	1.8	0.0	7.1
Cholesterol screening (N=25)	40.0	24.0	8.0	0.0	4.0	0.0	8.0
Dental screening and X-rays (N=23)	17.4	17.4	30.4	4.3	0.0	0.0	21.7
Flu shot (N=22)	22.7	13.6	9.1	4.5	4.5	0.0	22.7
Glaucoma test (N=51)	43.1	35.3	3.9	0.0	0.0	0.0	9.8
Hearing screening (N=77)	51.9	29.9	5.2	0.0	1.3	0.0	2.6
Immunizations (N=64)	46.9	25.0	3.1	0.0	0.0	0.0	9.4
Pelvic exam (N=36 Females)	44.4	22.2	5.6	5.6	0.0	0.0	13.9
STD (N=76)	72.4	13.2	2.6	0.0	0.0	0.0	3.9
Vascular screening (N=67)	46.3	32.8	4.5	0.0	0.0	0.0	6.0
CANCER SCREENINGS							
Breast cancer screening (N=28 Females)	39.3	10.7	7.1	0.0	0.0	3.6	32.1
Cervical cancer screening (N=36 Females)	44.4	8.3	5.6	2.8	0.0	0.0	33.3
Colorectal cancer screening (N=64)	39.1	21.9	6.3	7.8	0.0	0.0	18.8
Prostate cancer screening (N=8 Males)	62.5	25.0	12.5	0.0	0.0	0.0	0.0
Skin cancer screening (N=58)	37.9	32.8	5.2	0.0	0.0	3.4	13.8

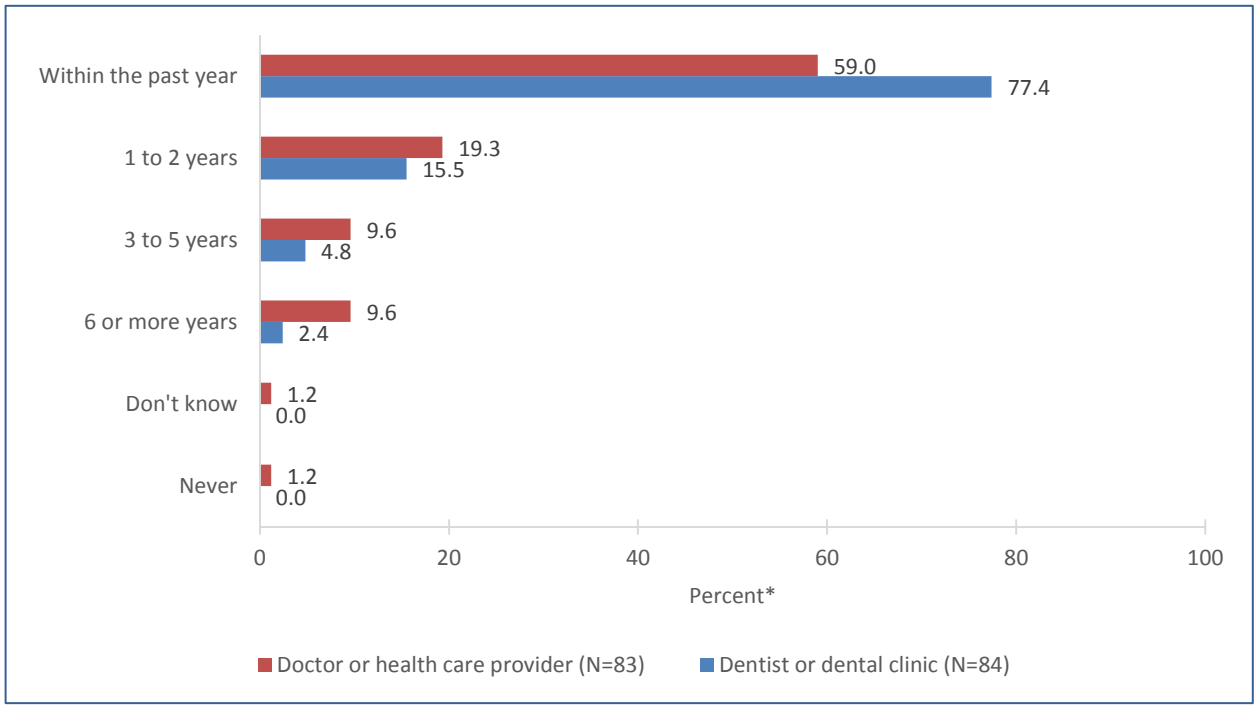
*Percentages may not total 100.0 due to multiple responses.

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



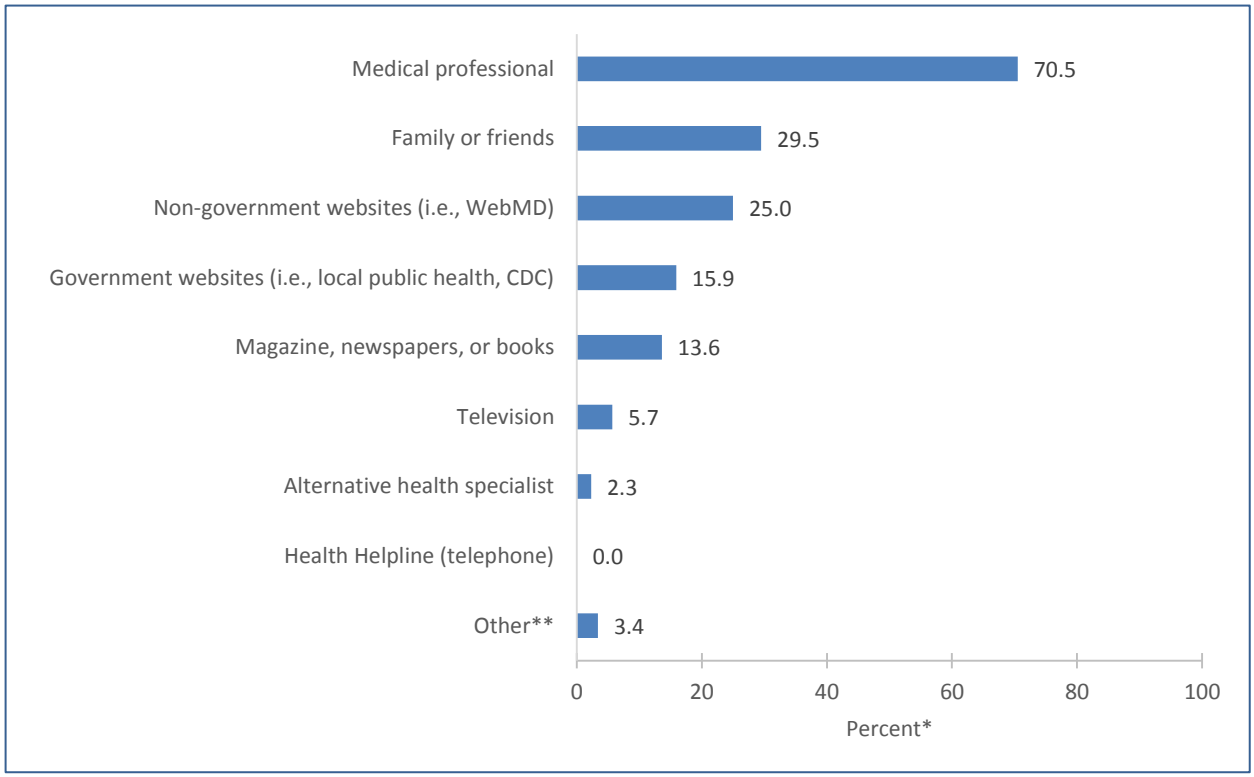
N=88 *Percentages do not total 100.0 due to multiple responses.

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



*Percentages do not total 100.0 due to rounding.

Figure 28. Where respondents get most of their health information

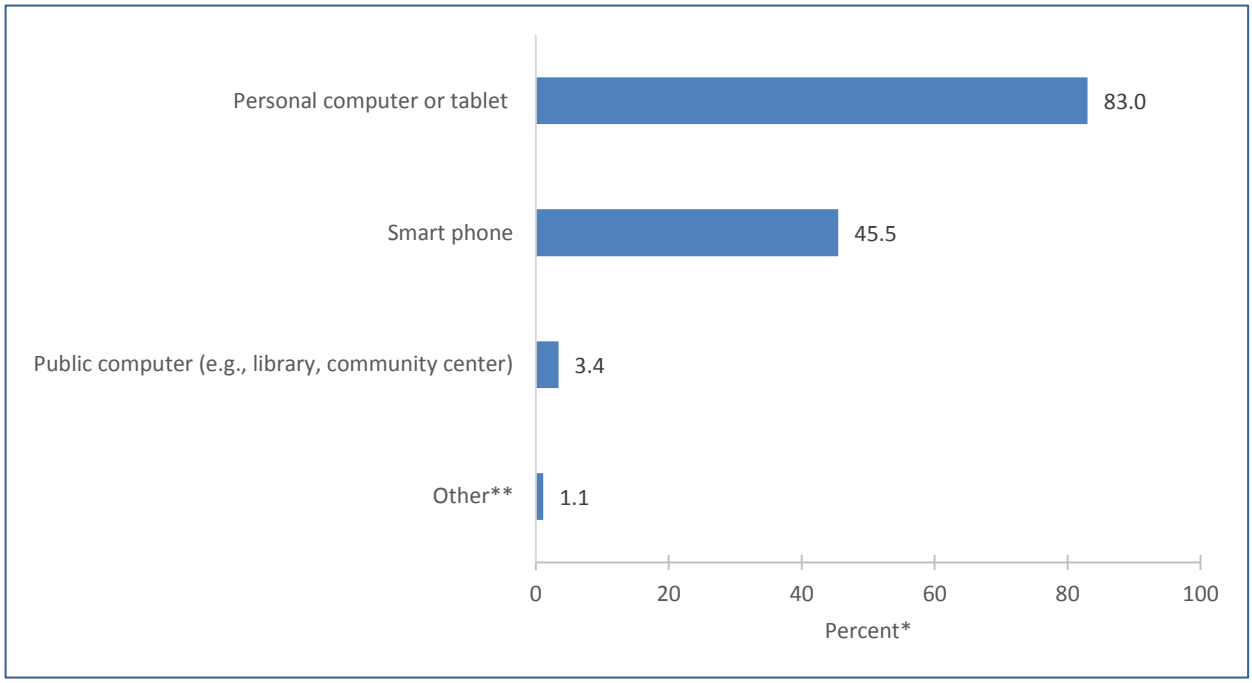


N=88

*Percentages do not total 100.0 due to multiple responses.

**Other responses are “Google”, “Groomer and Breeder”, and “Have two doctors and two nurses in the family”.

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



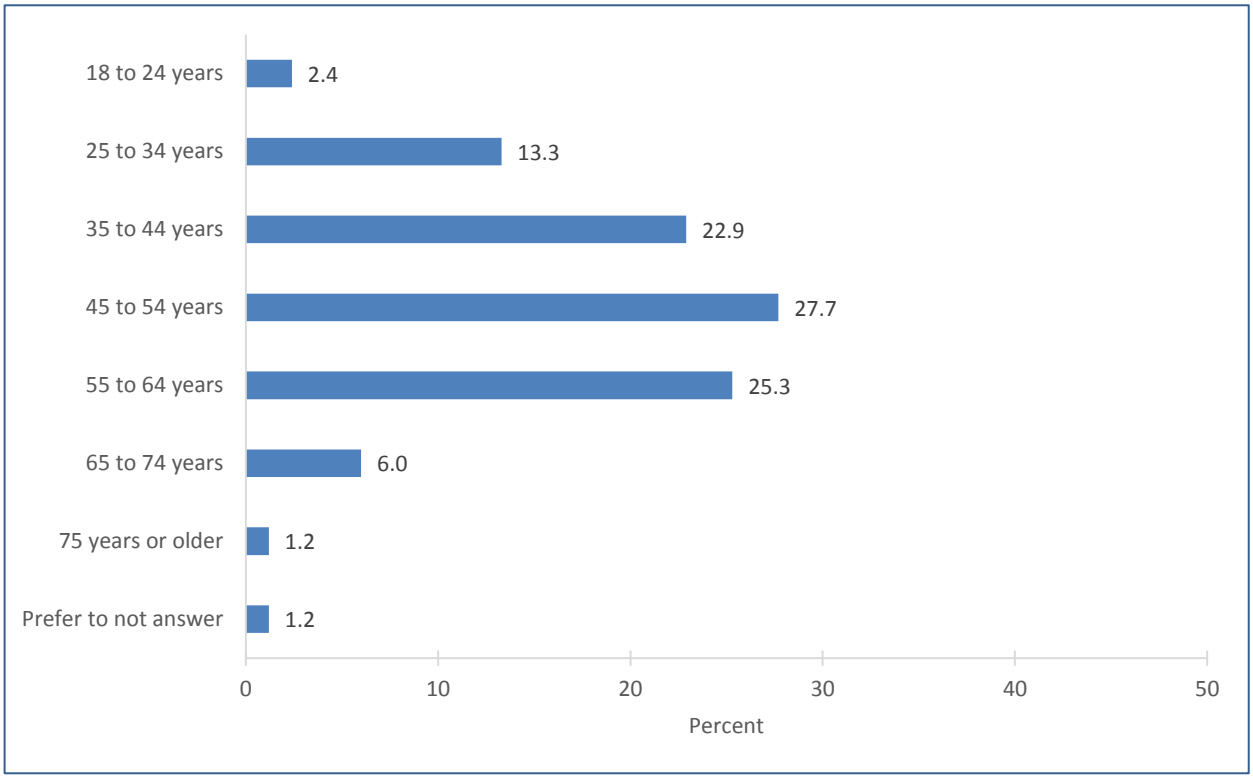
N=88

*Percentages do not total 100.0 due to multiple responses.

**Other response is “Meeting with the doctors or nurses”.

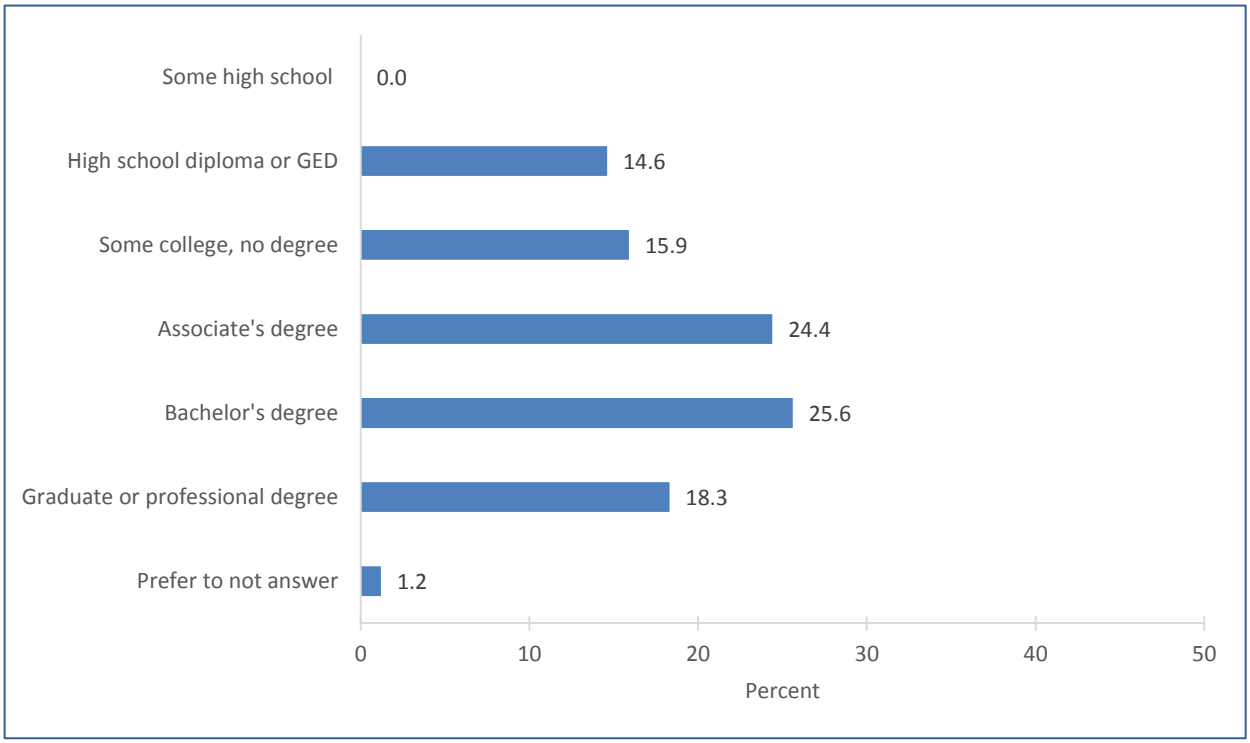
Demographic Information

Figure 30. Age of respondents



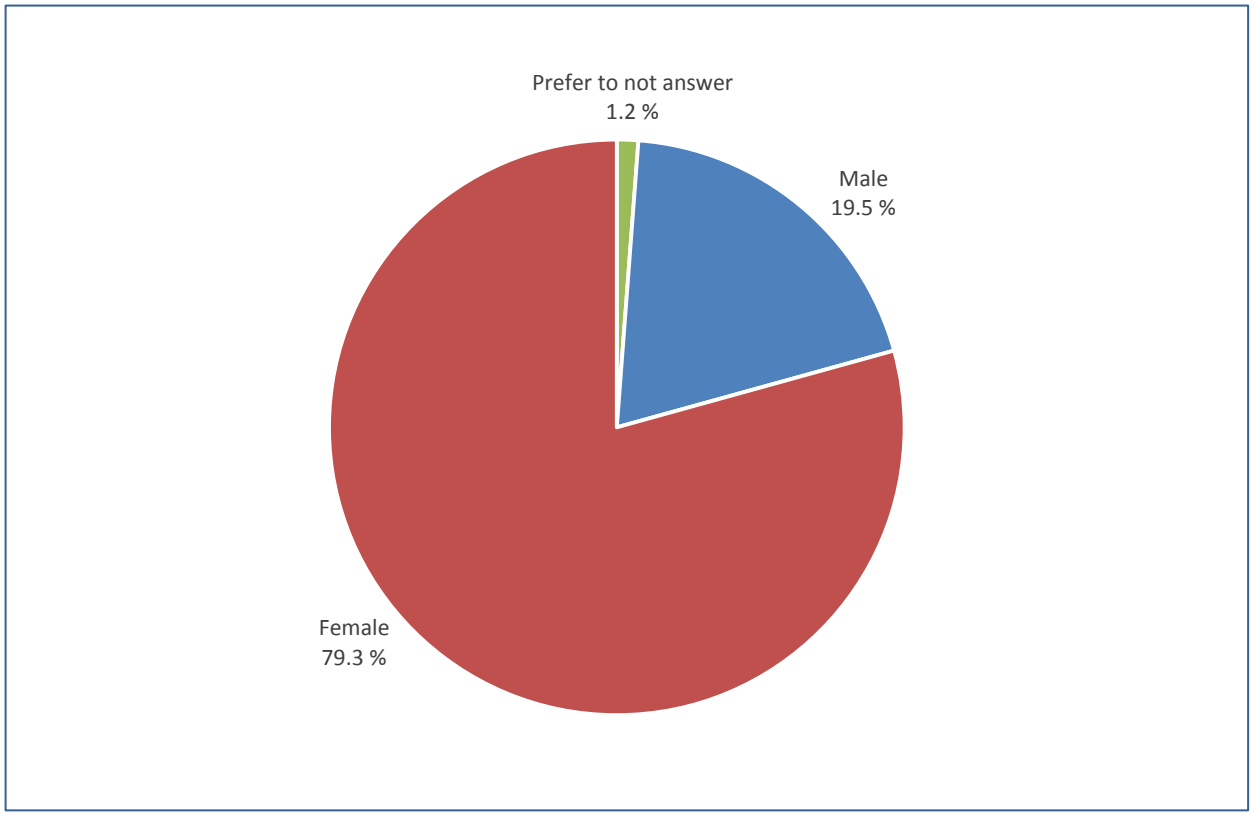
N=83

Figure 31. Highest level of education of respondents



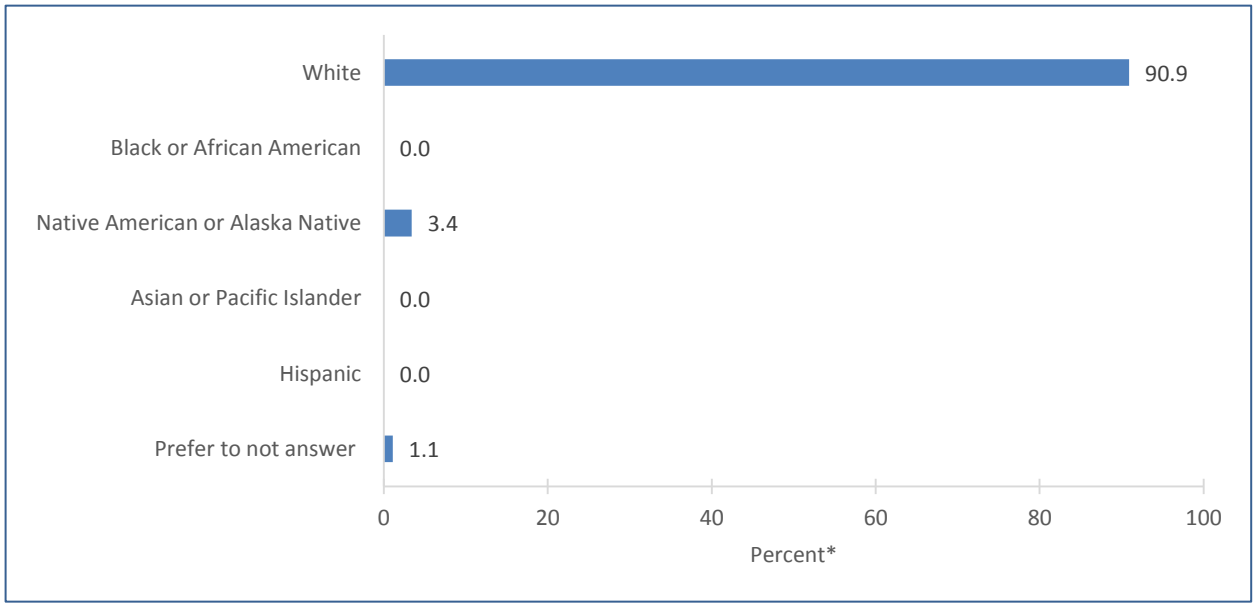
N=82

Figure 32. Gender of respondents



N=82

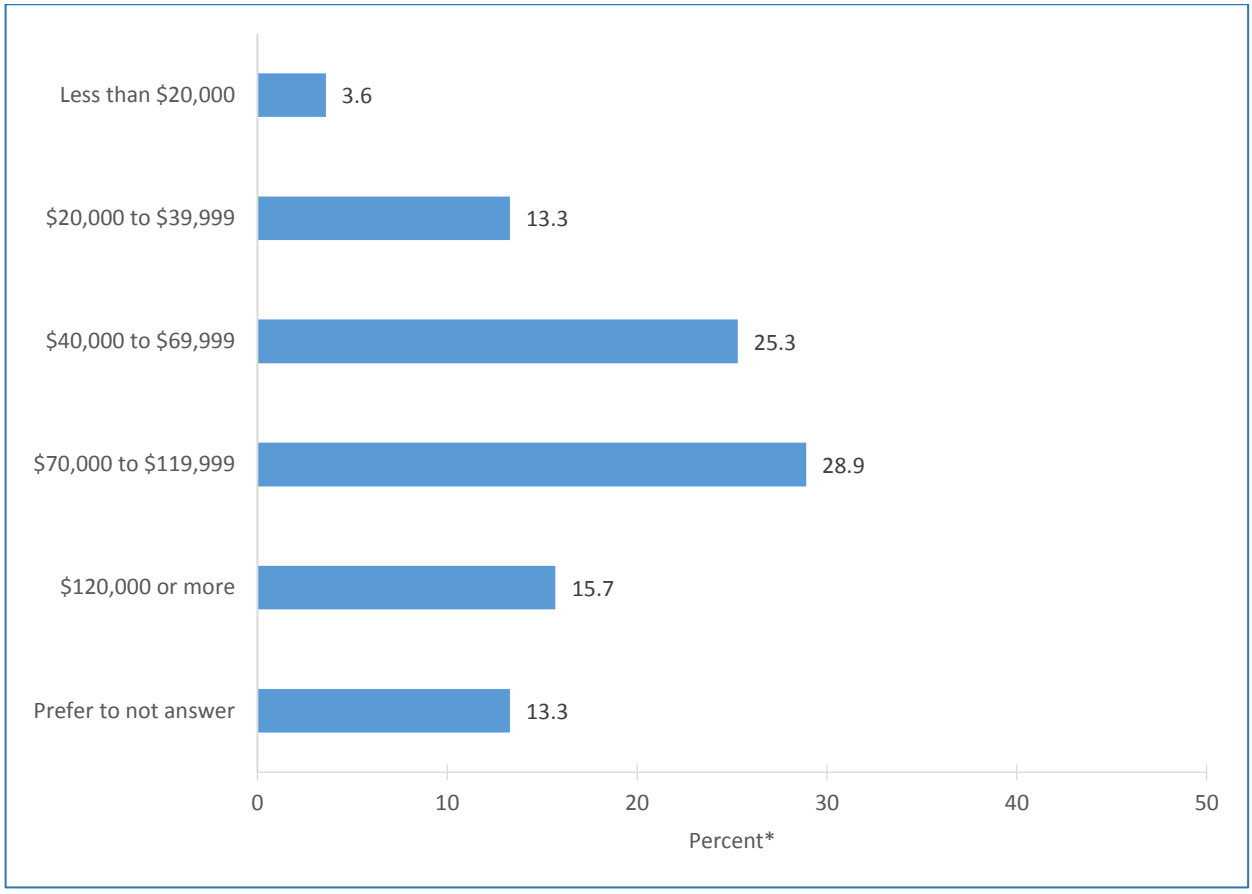
Figure 33. Race and ethnicity of respondents



N=88

*Percentages do not total 100.0 due to multiple responses.

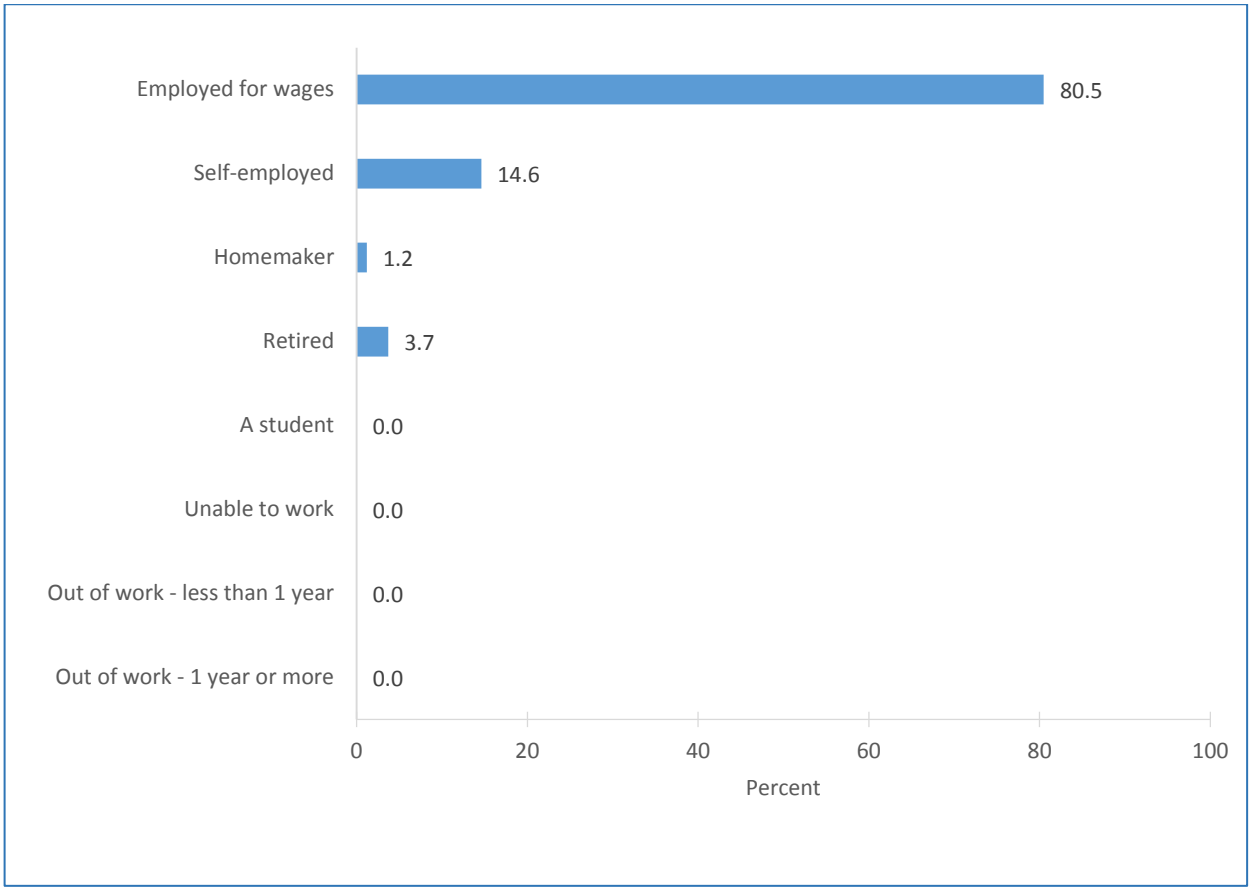
Figure 34. Annual household income of respondents



N=83

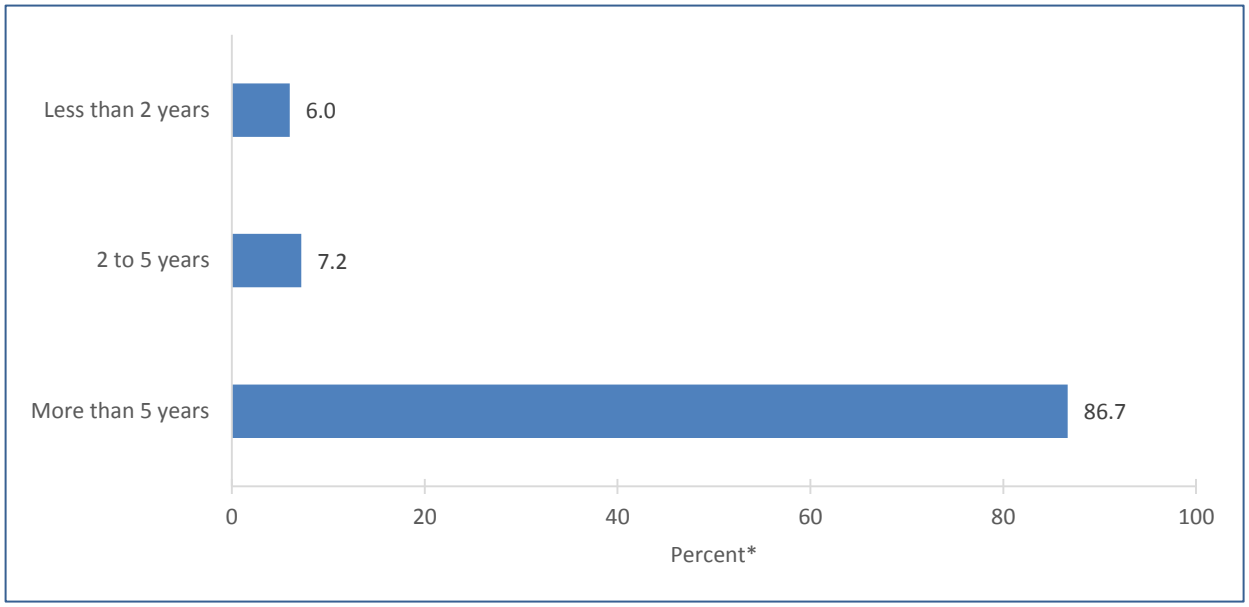
*Percentages do not total 100.0 due to rounding.

Figure 35. Employment status of respondents



N=82

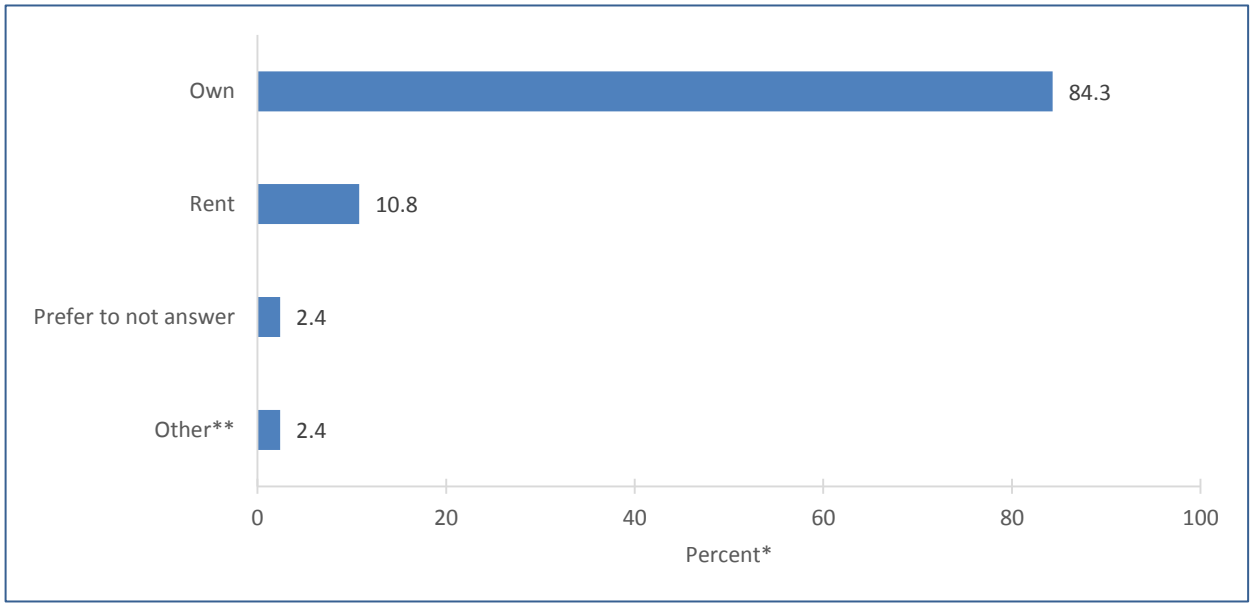
Figure 36. Length of time respondents have lived in their community



N=83

*Percentages do not total 100.0 due to rounding.

Figure 37. Whether respondents own or rent their home



N=83

*Percentages do not total 100.0 due to rounding.

**Other responses are “Live with boyfriend”, “Neither; government owned home through State of South Dakota”.

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

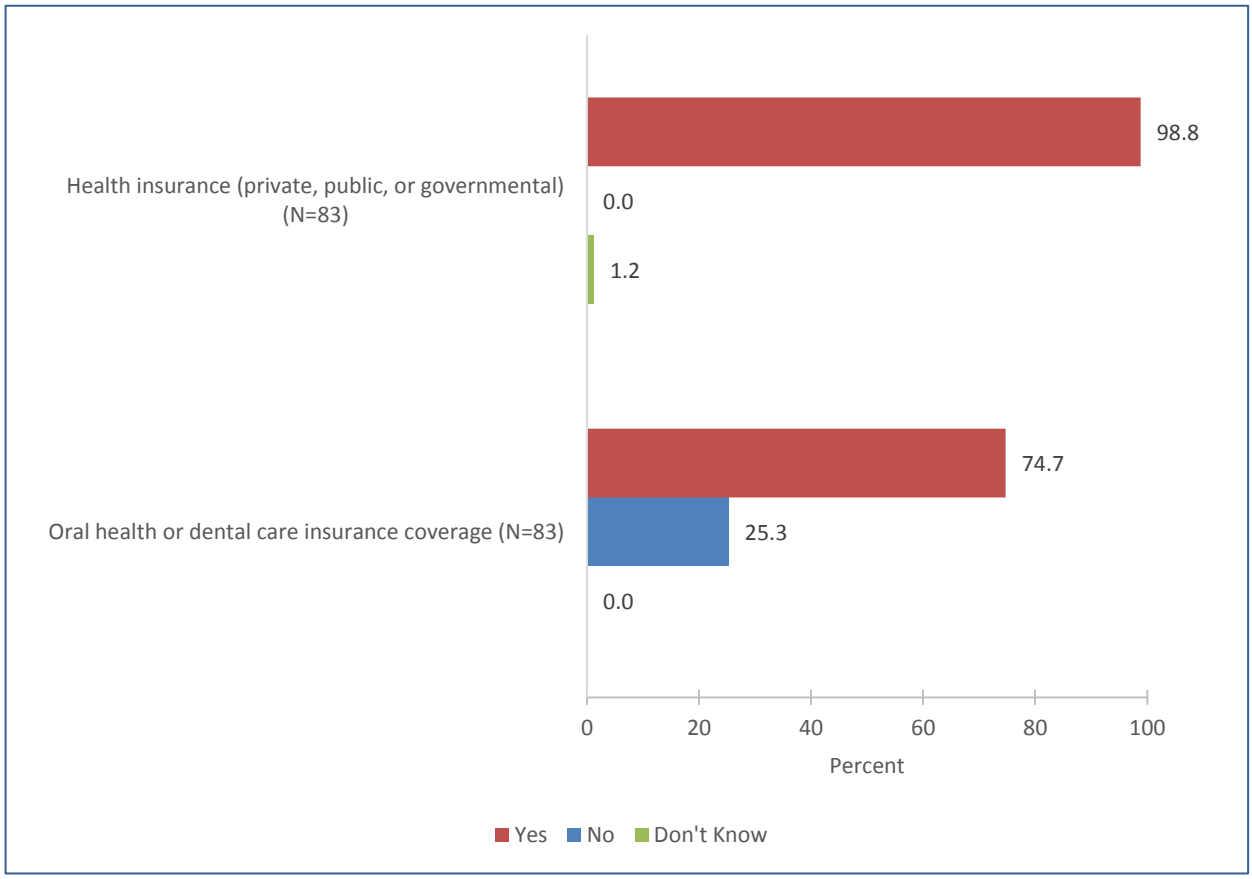
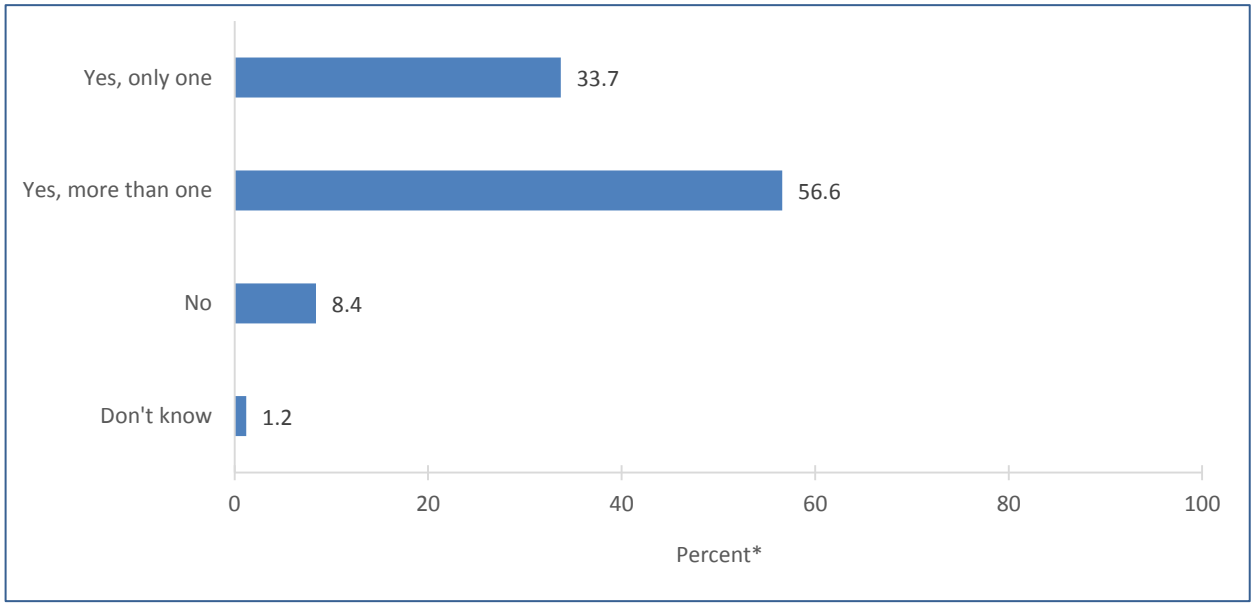


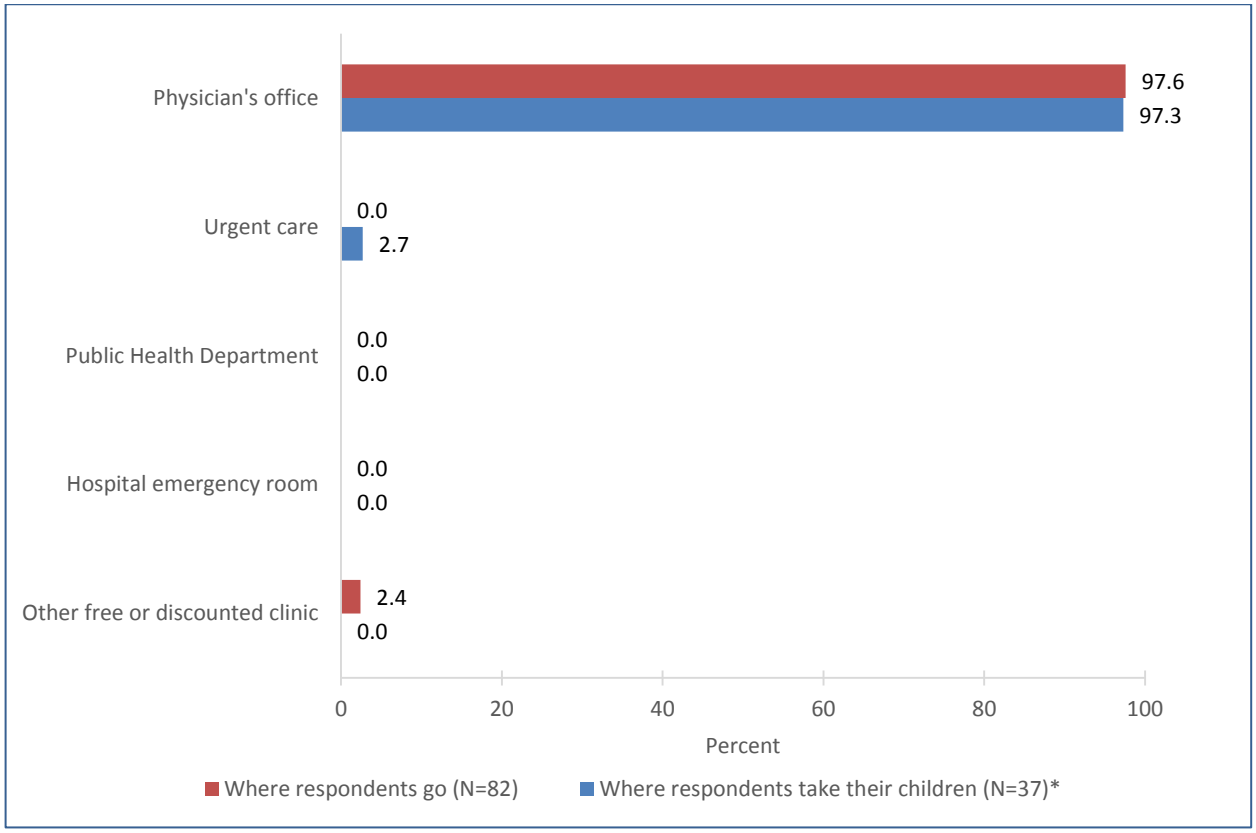
Figure 39. Whether respondents have one person who they think of as their personal doctor or health care provider



N=83

* Percentages do not total 100.0 due to rounding.

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



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

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

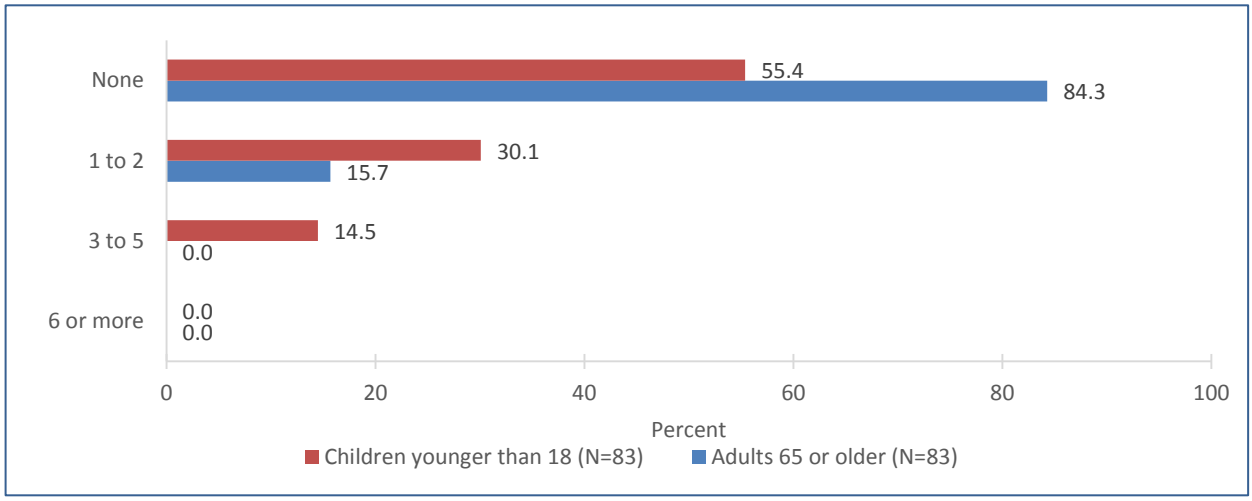
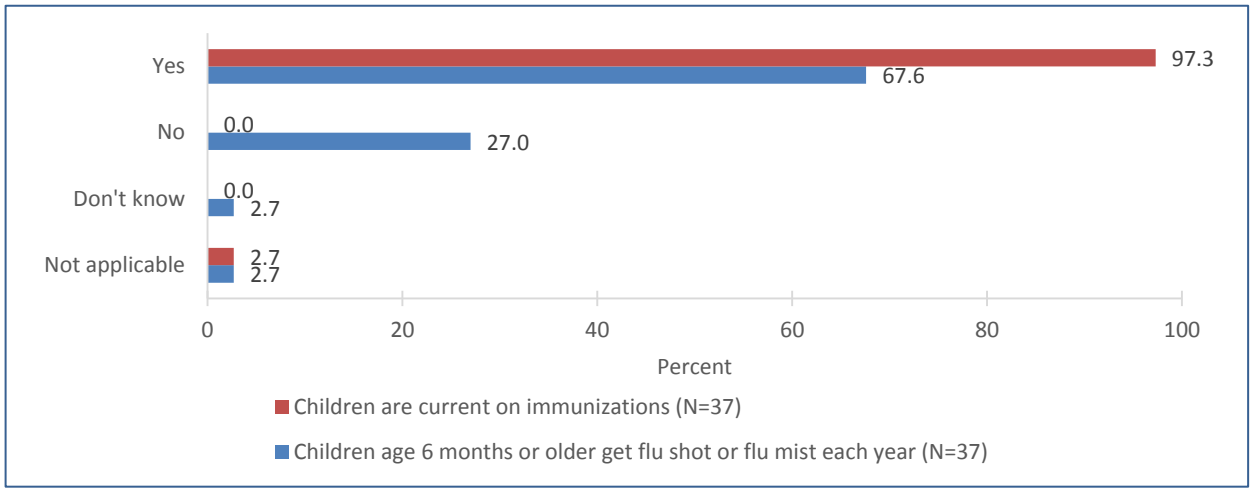


Figure 42. Whether all children in home are current on their immunizations and all children age 6 months or older get a flu shot or flu mist each year*



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

Table 3. Zip code of respondents

Zip code	Number of respondents
57580	69
57528	5
57369	1
57523	1
57533	1
57534	1
57555	1
57585	1
57701	1
69201	1

N=82

Winner Regional Healthcare Center

Secondary Research

Definitions of Key Indicators

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute
This Excel file contains the ranks and scores for each county in your state and the underlying data details for the measures used in calculating the 2015 *County Health Rankings*. In addition, the file contains additional measures that are reported on the *County Health Rankings* web site for your state.

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

Contents:

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

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

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

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

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

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

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

Tripp County

County Demographics

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Health Outcomes					50
Length of Life					48
Premature death	8,900	6,800-11,400	5,200	6,800	
Quality of Life					50
Poor or fair health	14%	13-14%	12%	13%	
Poor physical health days	3.3	3.1-3.4	2.9	3.1	
Poor mental health days	2.9	2.8-3.0	2.8	2.7	
Low birth weight	8%	5-10%	6%	6%	
Health Factors					43
Health Behaviors					31
Adult smoking	18%	18-19%	14%	19%	
Adult obesity	30%	24-37%	25%	30%	
Food environment index	7.0		8.3	7.3	
Physical inactivity	26%	19-34%	20%	24%	
Access to exercise opportunities	40%		91%	67%	

	Tripp County	Error Margin	Top U.S. Performers	South Dakota	Rank (of 60)
Excessive drinking	17%	16-17%	12%	18%	
Alcohol-impaired driving deaths	33%	11-55%	14%	35%	
Sexually transmitted infections	309.9		134.1	471.2	
Teen births	43	33-55	19	36	
Motor vehicle crash deaths			9	16	
Clinical Care					46
Uninsured	18%	16-21%	11%	13%	
Primary care physicians	1,100:1		1,040:1	1,310:1	
Dentists	1,840:1		1,340:1	1,770:1	
Mental health providers	310:1		370:1	630:1	
Preventable hospital stays	82	66-97	38	52	
Diabetic monitoring	85%	66-100%	90%	83%	
Mammography screening	58%	43-74%	71%	66%	
Social & Economic Factors					45
High school graduation			93%	83%	
Some college	62%	51-72%	72%	67%	
Unemployment	3.2%		3.5%	3.4%	

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

018033-00007 10/16