2022–2025 SIOUX FALLS COMMUNITY **HEALTH IMPROVEMENT PLAN**

JUNE 2022

Prepared by
CITY OF SIOUX FALLS
HEALTH DEPARTMENT

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Acknowledgments

The 2022-2025 Sioux Falls Community Health Improvement Plan (CHIP) is the product of a multi-partner and multi-sector collaboration involving several organizations working together under a new coalition, the Sioux Falls Community Health Partnership. The Sioux Falls Community Health Partnership will take the decade-long collaboration in conducting comprehensive community health assessments (CHA) a step further by setting and pursuing collective community health improvement goals.

CHA-CHIP Steering Committee

The Sioux Falls Community Health Partnership is spearheaded by the Sioux Falls Health Department, Avera McKennan Hospital & University Health Center, Sanford USD Medical Center, and the Sioux Falls VA Health Care System, which are the agencies that comprise the joint CHA and CHIP Steering Committee. The steering committee members for this round of the CHA and CHIP are:

Jessica Stienstra, Avera Heart Hospital

Teresa Miller, Avera Health

Julie Ward, Avera McKennan Hospital & University Health Center

Mary Michaels, City of Sioux Falls Health Department

Shelby Kommes, City of Sioux Falls Health Department

Christina Ward, Sanford Health

Andrew Wiese, Sanford Health

Jonathan Feiock, Sioux Falls VA Health Care System

The steering committee sought and received participation from several partners representing broad sectors of the community, including local government, for-profit businesses, non-profit organizations, and those serving the needs of populations at risk of poorer health outcomes or that have higher health risks such as the aged, homeless, low income, and uninsured populations. We are grateful to the following partners representing diverse community sectors for their participation.

CHIP Participating Agencies

The following organizations were represented in the CHIP planning and adoption meetings in early 2022. The Sioux Falls Community Health Partnership is by no means exclusive and will continue to engage more community agencies and members as the work of implementing and evaluating the CHIP continues.

AARP South Dakota
Active Generations
American Cancer Society
American Heart Association
Avera McKennan Hospital & University Health Center
City of Sioux Falls Finance Department
City of Sioux Falls Health Department
City of Sioux Falls Planning and Development Services
City of Sioux Falls Parks & Recreation Department
City of Sioux Falls Police Department
City of Sioux Falls Public Works Department
Delta Dental of South Dakota
Falls Community Health
Helpline Center
Iron Fox Farms
Lutheran Social Services
Minnehaha County Health and Human Services
Multicultural Center
Sanford Health
Sioux Empire United Way
Sioux Falls School District
Sioux Falls Thrive
Sioux Falls VA Healthcare System
Southeast Technical College
Southeastern Behavioral Health
South Dakota Dental Association
South Dakota Dental Hygienists' Association
South Dakota Department of Health
South Dakota State University Extension
South Dakota State University, Department of Allied and Population Health
The Link
University of South Dakota, Center for the Prevention of Child Maltreatment
University of South Dakota, Center Rural Health Improvement

We would like to thank the numerous individuals representing the participating agencies for their various contributions to the process. Special thanks to the workgroup leads and members who have committed to playing active roles to see that the goals and objectives outlined in this CHIP are actualized.

Executive Summary

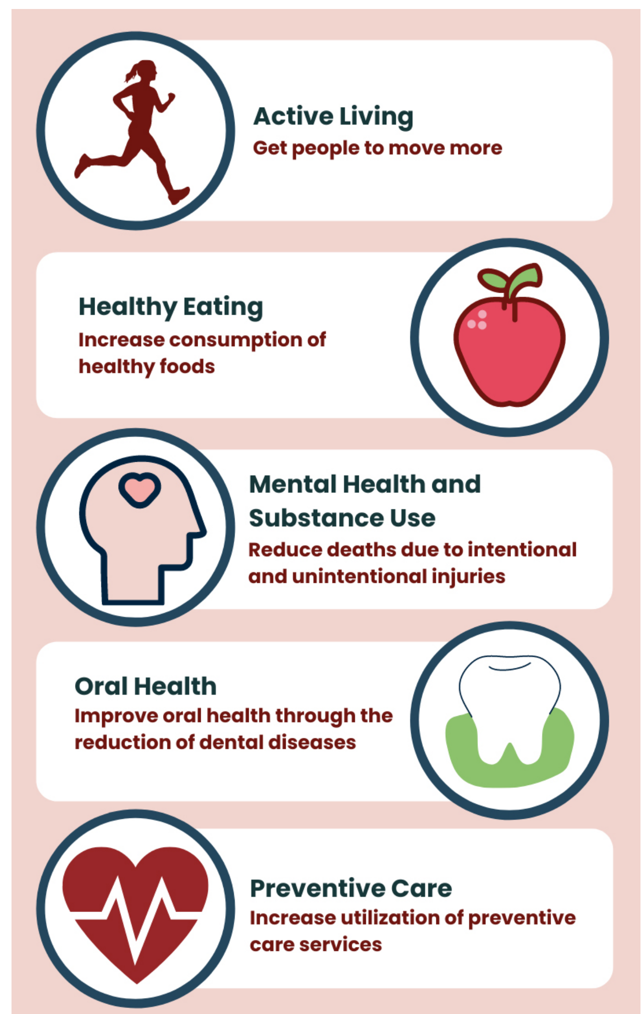
In 2021, in the midst of the global SARS COVID-19 pandemic, the Sioux Falls Health Department, Avera McKennan Hospital & University Health Center, Sanford Health, the Sioux Falls VA Health Care System and community partners engaged in a year-long collaborative community health assessment (CHA) process for the Sioux Falls Metropolitan Statistical Area (MSA). The CHA identified the community's strengths and areas for improvement. Findings from the assessment served as a catalyst to promote collaboration and innovation, align expertise and partner resources towards the development of a Community Health Improvement Plan (CHIP), implementation of which will ultimately improve community health.

In January 2022, the community partners and stakeholders convened to review the CHA data and, with the help of a consultant hired to facilitate the process, developed a set of five broad priorities to address the health issues the data revealed (Figure 1). These five areas were prioritized out of many findings from the CHA, with consideration for factors such as the scope of the issue, urgency, economic feasibility, potential for impact, availability of community assets, and value to the community.

Following the selection of the priority areas, the group proceeded to work collectively to develop goal statements and objectives for each priority area, and to identify potential champions, community assets and resources. After the initial meeting, workgroups were established to address the priority goal areas for the period 2022 to 2025. With subsequent meetings and electronic communications, the workgroups finalized the strategies, time frames, and monitoring functions of the plan.

The CHIP is a product of a multi-partner collaboration, with participation from both the public and private sector. The Sioux Falls CHA-CHIP steering committee will convene partners and facilitate the plan's implementation. The CHIP is intended to be a living document, and will be reviewed and adjusted as necessary through the three-year cycle.

Figure 1: 2022 CHIP Health Priority Areas



Background

The Sioux falls MSA is comprised of four counties, Lincoln, McCook, Minnehaha, and Turner. The City of Sioux Falls is the major city in this MSA and is home to over 200,000 individuals. As community members, we all play a role in impacting health and well-being in areas in which we live, learn, work, play, worship, and age. In examining health concerns and health outcomes through this collaborative CHA and CHIP process, we recognized that population health is heavily influenced by the community environment, including access to healthy food, opportunities to be physically active, and access to health care services.

The CHA and CHIP process utilized the South Dakota Good & Healthy Communities Assessment framework (Figure 2), a state-based model for community health assessment and improvement.

To initiate the CHA process, the partners developed a multi-faceted assessment that included quantitative and qualitative methods of data collection and that actively sought feedback from key stakeholders and community residents. The partners made a good faith effort to engage community representatives in each component of the assessment process. No population was intentionally excluded.

Figure 2: South Dakota Good & Healthy Communities Assessment Framework

The dimensions assessed and reported in the CHA are health outcomes in the population expressed in terms of disease burden and quantity and quality of life measures; risk factors and determinants of poor health; and community resources available to improve health status. The CHA defined health in the broadest sense and recognized health-shaping factors at multiple levels.

Existing demographic, behavioral, social, and economic, and health care data were drawn from national, state, and local sources, such as the U.S. Census Bureau, The U.S. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, The County Health Rankings, and South Dakota Department of Health Office of Health Statistics. Primary data was also obtained through a resident survey, focus group discussions, key informant interviews, and assessment of community resources in various sectors.

Needs Assessment Findings

In exploring health outcomes among individuals living in the Sioux Falls Metropolitan Statistical Area (MSA), the CHA provided an overview of health status in the community using aggregate measures of mortality (length of life) and morbidity (quality of life and disease burden).

Key concerns were grouped into the following categories:

- High Burden of Chronic Diseases, Mental Health Disorders and Injuries
- Poor Oral Health, Especially in School-Age Children
- Health Disparities
- COVID-19 & Other Issues

In addition to looking at health outcomes, the CHA also reviewed health determinants, the underlying factors that are driving or contributing to the observed health outcomes.

These health determinants include:

- **Behavioral factors:** such as high rates of use of alcohol, tobacco, and other substances; low levels of physical activity; unhealthy dietary behaviors.
- **Environmental barriers to healthy eating and active living:** low-income, low food access census tracts (aka food deserts); poor transit network and challenges in the active transportation infrastructure.
- **Socioeconomic factors:** food insecurity; limited affordable housing; poverty; gaps in digital access.
- **Inadequate access to and quality of health care services:** limited supply of dental and mental health providers; health insurance coverage gaps; rising cost of care; inadequate use of clinical preventive services.

See Appendix 1 for data highlights from the community health assessment.

Identifying Goals, Strategies, and Objectives

The January 2022 CHIP meeting was convened by the Sioux Falls Health Department and facilitated by an external consultant. The meeting participants, representing 20 organizations, reviewed the CHA data, including the causes of disproportionate health risks and health outcomes of specific populations. After reviewing the key findings from the CHA, the CHIP participants utilized brainstorming, affinity diagramming, and nominal group process to identify potential themes based on the following parameters:

- Scope of the issue
- Urgency
- Economic Feasibility
- Potential for Impact
- Availability of Community Assets
- Value to the Community

As a result of the brainstorming session, the group then discussed each identified theme and used a dot-voting format to select the themes that emerged as the priority areas for the CHIP. While all the findings in the CHA were relevant and important, collaborative members carefully reviewed and selected findings to focus on over the next three years. For the findings not addressed through this 2022-2025 CHIP, individual Collaborative organizations may address them separately in other efforts. For the purposes of this CHIP, however, the five priority areas are:

- Active Living
- Healthy Eating
- Mental Health and Substance Use
- Oral Health
- Preventive Care

Following the initial brainstorming meeting to identify CHIP priorities, the CHA Steering Committee convened three workgroups to further define measurable objectives and strategies to support five priority areas.

The workgroups were:

1) Healthy Eating and Active Living
2) Behavioral Health and Preventive Care
3) Oral Health

Each workgroup identified co-leads and members from diverse community organizations to serve as follows:

- Lead/Co-lead – Responsible to lead or delegate tasks such as convening meetings, planning and implementing activities, and monitoring progress.
- Members – Participate in workgroup meetings to assist with implementation of activities, documentation of outcomes, and recruitment of other community partners as needed.

In addition, the workgroups were tasked with engaging other community partners as needed. Existing partners will continue to engage more community agencies and members as the work of implementing and evaluating the CHIP continues.

Incorporating Social Determinants of Health

In developing this CHIP, community partners considered the 10 Essential Public Health Services *(See Appendix 2)*, doing so using a health equity lens, to ensure residents' unique needs are considered when determining what resources are needed to promote optimal health and well-being.

The very heart of heath equity is ensuring that people have a fair opportunity to thrive at every level of society, and it is the beginning of improving health and well-being. Unfortunately, similar to communities across the country, some neighborhoods in Sioux Falls are challenged by fewer green spaces, lower access to affordable and healthy foods, higher crime rates, and fewer options for affordable housing or transportation.

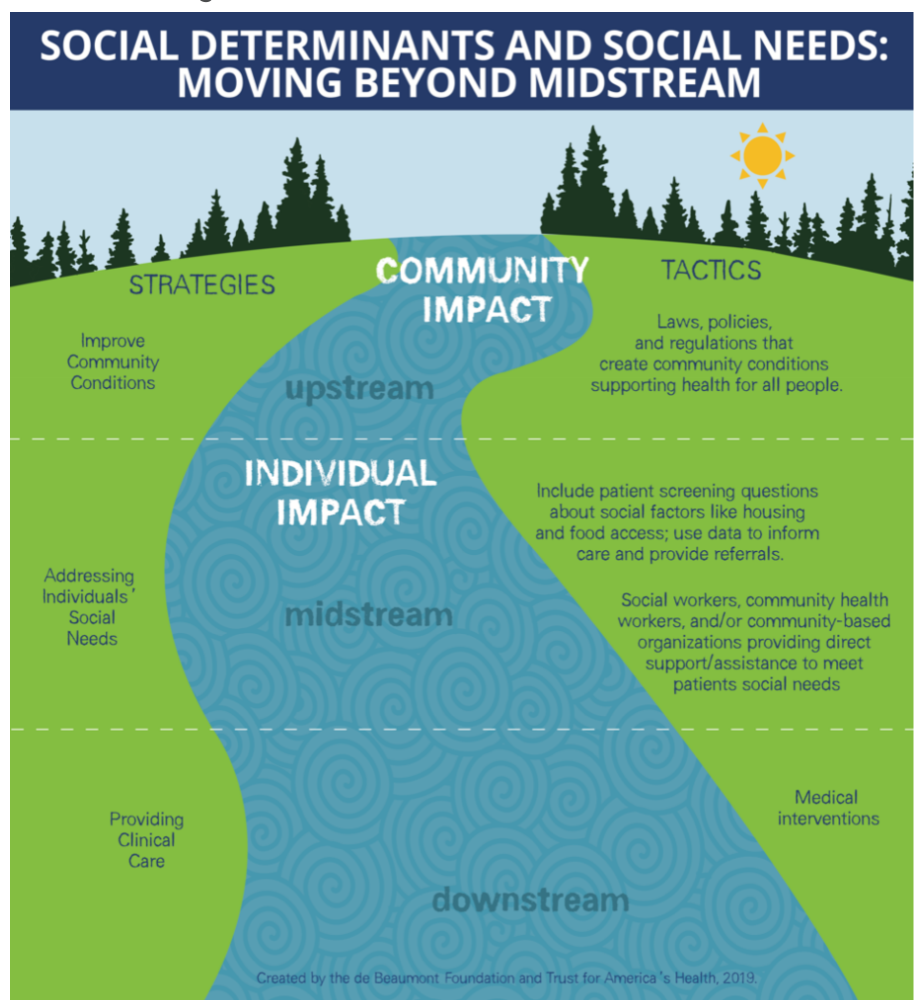
Social determinants of health include factors such as physical environment, income, education, access to care. These social determinants of health can impact how long—and how well—we live. Within the Sioux Falls city limits, life expectancy varies more than 15 years between one neighborhood and another. When prioritizing areas of need in our community, partners looked at indicators that may be disproportionately impacting certain community residents. Utilizing social determinants of health in decision making requires partners to consider the root causes of health outcomes and behaviors. For example, Sioux Falls has a significant number of individuals who suffer from diet-related diseases and we know that it is harder to make healthy eating choices when you do not have access to healthy and affordable foods. The city has growing number of food priority access areas, where some residents are unable to easily access these healthy foods in comparison to others. This gap indicates that education and promotion alone may not be sufficient for these community members, and strategies to increase access are necessary.

Priority Areas

The focus of the 2022 CHA was to explore health data for the purpose of identifying interventions that could make a positive difference, including policy, systems, and environmental-level actions.

Interventions at both individual and community levels can shape overall health and well-being, especially when they are targeted at preventing disease or other adverse health outcomes. Many researchers have discussed health using the illustration of a stream, with "upstream" factors causing "downstream" effects (Figure 3). Policy, systems, and environmental approaches go upstream by addressing the conditions in which individuals work, live, and play.

Figure 3: Social Determinants and Social Need



The CHIP workgroups considered policy, systems, and environmental approaches, using evidence-based guidelines from sources such as Healthy People 2030 and aligning with priorities from partners such as the South Dakota Department of Health, and City of Sioux Falls public works and planning departments.

Population-level health data are often slow to change. The CHIP workgroups took this factor into consideration when using the CHA data to develop measurable objectives for this three-year CHIP cycle. As the Sioux Falls Community Health Partnership begins working on the CHIP priorities, the workgroups will develop annual work plans to select appropriate strategies on which to focus during each year of the CHIP cycle. The objectives and strategies may be revised as needed based on changing data, emerging community conditions, or other factors.

The final set of priority areas adopted were active living, healthy eating, mental health and substance use, oral health and preventive care. The goals, objectives, and strategies for each of these priorities are further discussed on the following pages.

PRIORITY AREA #1: ACTIVE LIVING

Background

Strong scientific evidence demonstrates that engaging in physical activity reduces the risk of many chronic medical conditions and is critical to the recovery process for many diseases. According to the 2022 CHA report, when asked if they had participated in any physical activity outside of their regular job during the past month, one quarter of Sioux Falls MSA residents said no. In addition, 79 percent of adults in the area do not meet the recommended guidelines for both aerobic and muscle strengthening activity. A lack of physical activity and muscle strengthening can contribute to outcomes such as unintentional falls. In Minnehaha County, the rate of unintentional fall deaths is double the national rate for those age 45 and older.

The physical activity environment directly impacts opportunities for residents to engage in physical activity as part of their everyday life. While residents generally give high ratings to the Sioux Falls system of parks and trails, areas related to active transportation – walkability, bikeability and public transit – typically rank lower. The objectives and strategies in this priority area are designed to make it easier for individuals of all ages and abilities to engage in physical activity in their daily existence, including through transportation and recreation.

GOAL **Get People Moving More**

OBJECTIVE 1 **Decrease percentage of adults who do not participate in any leisure time activity by 2024.**

STRATEGIES

- Create a comprehensive community directory of resources and programs and distribute it across multiple channels to ensure it is accessible to residents of all ages.
- Implement a pilot physical activity screening and prescription program in clinical settings.
- Promote use of the Sioux Falls recreation trail system for exercise and transportation.
- Explore the underlying drivers of the high rate of fall deaths in Minnehaha County and promote evidence-based Falls Prevention programs in the community.
- Promote physical activity and advocate for activity inclusive policies at worksites.

OBJECTIVE 2 **Add new "complete streets" elements to the Sioux Falls network of streets and sidewalks by 2024.**

STRATEGIES

- Advocate for creation of an Active Transportation Advisory Board.
- Conduct an evaluation of the implementation of the City of Sioux Falls Complete Streets Policy.
- Promote safety for biking and walking in residential areas and on the recreation trail.
- Utilize the City of Sioux Falls Health in All Policies Committee to identify and promote collaboration across city master plans (e.g. Bicycle Plan, Pedestrian Plan) to improve active transportation infrastructure in the built environment.

INDICATORS

- % of adults participating in leisure-time activity
- % of adults meeting exercise guidelines
- % of adults with preventable chronic conditions
- # of users on the recreation trail
- # of recreation program participants
- # of participants in falls prevention programming
- # of implemented complete streets elements
- Implementation of a safety campaign
- Completed audit of City of Sioux Falls master plans and new initiatives implemented
- # of safety elements placed along the recreation trail
- # of pedestrian and bicycle deaths

PRIORITY AREA #2: HEALTHY EATING

Background

Many factors influence the nutrition behaviors of individuals, including access and affordability of healthy foods; knowledge, beliefs, and attitudes about good nutrition; and social and cultural factors. As reflected in the 2022 CHA report, data continues to show that adults in the Sioux Falls MSA fall significantly short of meeting recommendations for fruit and vegetable consumption. Nearly 40 percent of adults report consuming fruits less than once per day, and 18 percent report the same for vegetable consumption.

Frequent consumption of sugar-sweetened beverages (SSB) has been linked to health concerns such as obesity, type 2 diabetes, heart disease, kidney diseases, and tooth decay. Limiting SSB intake can help individuals maintain a healthy diet and a healthy weight. Although local data could not be obtained for SSB consumption in the Sioux Falls area, data points to high rates of SSB consumption in South Dakota. The 2022 CHA report also shows that the number of census tracts designated as low income and low food access (aka food deserts) have increased in Sioux Falls. When unhealthy foods, snacks and drinks are available in the community, worksite, school and early childhood settings, it may predispose individuals to make less healthy food choices. These objectives and strategies are designed to improve the environment to make it easier for individuals of all ages and abilities to access healthy and affordable food and beverage options.

GOAL	**Increase Consumption of Healthy Foods**
OBJECTIVE 1	**Establish two new sites where residents can access fresh produce in low income low access census tracts by 2024.**
STRATEGIES	• Incentivize the private and non-profit sectors to establish new grocery stores or innovative programs to increase residents' access to healthy foods in Food Access Priority census tracts. • Establish an active local food coalition by aligning key players such as the Food Council and the urban agriculture task force.
OBJECTIVE 2	**Increase the number of worksites with evidence-based healthy food and beverage policies.**
STRATEGIES	• Promote healthy eating in the workplace and advocate for healthy nutrition policies at worksites. • Partner with organizations to establish baseline measures through a workplace survey. • Re-launch Healthy Place program for restaurants and expand to include recognition for worksites.
INDICATORS	• # of adults eating fruits and vegetables daily • # of food access priority areas • # of community garden sites • Grant funding for interventions in Food Access Priority Areas and # of households impacted by funded interventions • # of adults meeting nutrition guidelines for fruit and vegetable intake • % of people consuming sugar sweetened beverages daily • # of worksites with healthy vending policies • # of restaurants added or renewed in the Healthy Place program

PRIORITY AREA #3: MENTAL HEALTH AND SUBSTANCE USE

Background

Mental health and related topics were frequently mentioned during the 2021 CHA Focus Group discussions as top health issues facing the community. Most residents considered mental health and suicide to be issues of moderate or major concern in the community. In 2019, 21 percent of adults reported that they had been diagnosed with depression, which is comparable to the U.S. average but higher than the state average. Rates of diagnoses climbed further due to COVID-19. Since the start of the pandemic, providers across the globe have been seeing a rise in depression, anxiety, and stress levels. This includes new experiences and those whose symptoms were exacerbated during this time. Addressing mental health during the pandemic has also shown gaps in service, including adequate access to counseling and other mental health services.

There has also been an increase in both frequency and quantity of substance use during the pandemic for a variety of reasons, one being use a coping mechanism. As it has been in previous years, alcohol abuse remains a major concern in the community. Binge drinking and heavy drinking rates continuing to rise. Alcohol impairment is a factor in a significant number of deaths from vehicular accidents in the area. Additionally, illicit drug seizures are increasing. Overdose incidents and substance use treatment admissions are higher in the Sioux Falls MSA compared to the state average and at the individual county level—Minnehaha County is primarily driving the rates in the MSA.

GOAL **Reduce Deaths Due To Intentional And Unintentional Injuries**

OBJECTIVE 1 **Reduce the rate of suicide in Minnehaha County by 2024.**

STRATEGIES

- Create a city-wide campaign to normalize mental health conversations and care using evidence-based methodologies.
- Promote 988 phone number as an access point for behavioral health and crisis support, along with the Helpline Center mental health resource database, to increase awareness of health and social service resources.
- Provide mental health first aid trainings across the community to broaden early intervention impact.
- Promote Lethal Means Safety trainings in the community to reduce individuals' access to lethal means such as medications and firearms.

OBJECTIVE 2 **Decrease the percentage of driving deaths with alcohol involvement in Minnehaha County by 2024.**

STRATEGIES

- Create a media campaign against alcohol overuse and driving while under the influence.
- Explore offering responsible server training for bars and restaurants.
- Explore school-based education/programs for teens and college campuses on alcohol abuse.

OBJECTIVE 3 **Decrease the drug poisoning death rate in Minnehaha County by 2024.**

STRATEGIES

- Implement community campaigns targeting opioid and other drug use, highlighting harmful substances, and promoting safe storage of medications at home.
- Promote drug take back events, neutralizing packets, daily pharmacy drops, and Fentanyl strips.
- Improve awareness to Naloxone.
- Improve awareness to Medication-assisted treatment (MAT) providers.

INDICATORS

- Rate of suicide deaths and drug poisoning deaths in Minnehaha County
- Ranking of suicide deaths as top cause of death
- % of adults who report binge drinking, heavy drinking, or driving after drinking
- % of driving deaths with alcohol involvement
- # of pounds of drugs collected on take back days
- # of individuals participating in responsible server trainings
- Reach of mental health and substance use media campaigns
- # of individuals impacted by lethal means trainings

PRIORITY AREA #4: ORAL HEALTH

Background

Tooth decay is the most common chronic disease in both children and adults. Oral health conditions impact systemic conditions such as diabetes, cardiovascular disease, pulmonary disease, and pregnancy along with causing infection, pain, and sleep impairment. Although oral health impacts both personal health as well as the health of the population, "no perceived need", cost of services, and fear of care are among the top reasons for adults not seeking care in the community.

Local data for oral health outcomes is limited; however, data that is available indicates a need for improved oral care in the community. The 2022 CHA shows that 27.1 percent of adults in the Sioux Falls MSA have not visited the dentist in the past year, and a third of adults have lost at least one permanent tooth. Additionally, 56.5 percent of third grade children in South Dakota have a history of dental decay, and 55 percent of South Dakotans ages 1 to 20 who are enrolled in Medicaid have not received at least one preventative dental service. It is crucial that individuals receive regular dental care starting at infancy through adulthood, but accessing care continues to be a challenge, especially for priority populations.

GOAL	**Improve Oral Health Through The Reduction Of Dental Diseases**
OBJECTIVE 1	**Increase opportunities and access points to oral health services by 2024.**
STRATEGIES	• Promote awareness of the CHIP plan among the dental community. • Develop an education and awareness campaign to increase the number of individuals in priority populations who have a dental visit, including 1-2 year olds, pregnant women, Medicaid recipients, and aging populations. • Partner with local dental clinics to host donated clinic events. • Promote oral health assessments and referral to a dental home at medical appointments. • Assist in expanding oral health-related data collection in Sioux Falls.
INDICATORS	• # of Medicaid recipients who have received a dental visit • # of students at school dental clinic sites who have dental decay • # of students at school dental clinic sites who have received follow up dental care • # of individuals served at free clinic events • # of new medical providers completing oral health assessments during primary care visits • Implementation of a new dental survey • Re-implementation of 3rd grade survey • Reach of educational campaign • # of new providers and/or clinics accepting Medicaid • # of individuals enrolled in Medicaid

PRIORITY AREA #5: PREVENTIVE CARE

Background

Ensuring residents are able to access comprehensive, quality health care services is essential for maintaining health, preventing and managing disease, and reducing disability and premature death. However, the concept of access is complex and multifaceted, including availability and utilization of health care services.

For those residents who had not recently had a routine medical check-up, COVID-19 was the number one reason why they had not been to a provider, with perception that they had "no need to see the doctor" and "cost" as other top reasons. Through the CHA Resident Survey, 12 percent of respondents indicated they had a medically necessary care need but did not receive care. Financial barriers were by far the most common reasons for skipping necessary care, besides COVID-19. A significant proportion also reported the reasons were due to organizational-level barriers, including long wait times, not feeling welcome or valued at the clinic, and inconvenient clinic hours. This points to opportunities to improve patient-centered care.

Having a health care provider who can serve as a point of entry into the health care system and ensure continuity and coordination of care is another important measure of access to care. The majority of adults in the Sioux Falls MSA say they have at least one person they think of as a personal doctor or health care provider, but 21 percent do not.

We see a high burden of chronic disease in the Sioux Falls MSA, with cancer and heart disease as the top two leading causes of death. The Sioux Falls MSA has higher age-adjusted incidence rates for the most common cancers in the U.S. A focus on preventive care, including annual primary care visits, screenings, and immunizations, can help reduce the burden of chronic disease.

GOAL	**Increase Utilization Of Preventive Care Services**
OBJECTIVE 1	**Increase the percentage of residents who have annual preventive care visits by 2024.**
STRATEGIES	· Explore opportunities for data sharing among local health partners to get baseline data on residents who had preventive care services. · Utilize Community Health Workers to connect people with primary care and provide education about community resources and state screening resources. · Identify resources for use at The Link to connect clients with health care services. · Encourage access to age-appropriate screenings and preventive care.
INDICATORS	· % of adults who have received a preventive care visit in the past year · % of adults who completed preventive cancer screenings · % of adults receiving preventive immunizations · Implementation of a community-wide data sharing system · # of worksites who have implemented immunization clinics · # of individuals served by transportation services · Portfolio of resources for use at The Link

Sustainability Planning

In order to effect change and improve community health, the participating organizations and individuals gave careful consideration to building sustainability into this CHIP. Specifically, the group focused on sustainability by:

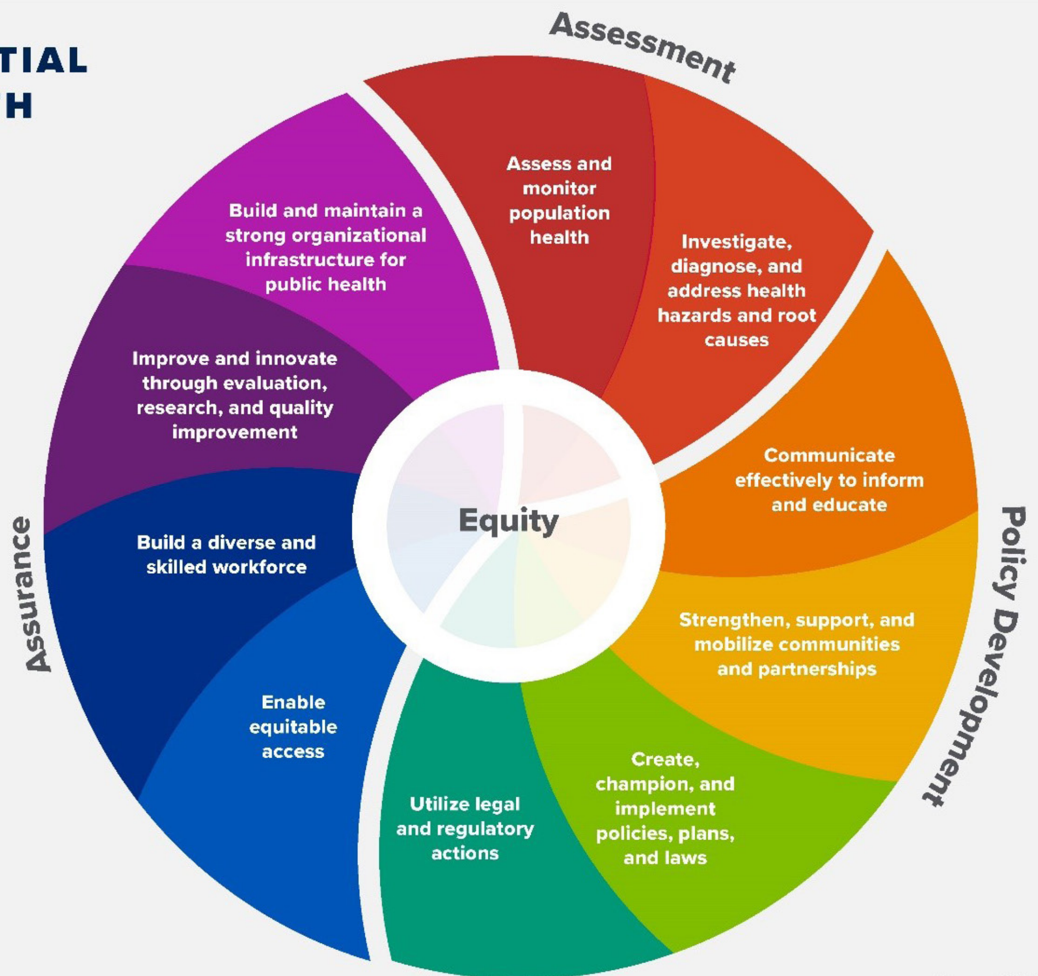
- Building on existing partnerships to create a Sioux Falls Community Health Partnership that will serve as a platform for ongoing community health improvement.
- Coordinating health improvement efforts that engage partners to align resources, address priority areas, and build upon successful local initiatives.
- Establishing objectives and strategies that are meaningful and manageable by the community partners.
- Creating a process for annual progress review and for revising objectives and strategies as needed based on current community conditions.

Monitoring, Evaluating, and Communicating Progress

Efforts will be made to evaluate improvement in indicators aligned with the five community health priority areas. Progress will rely on multiple activities to address different aspects of each priority area. It is important to acknowledge that community conditions may change and that the CHIP should adapt as necessary. The Sioux Falls Community Health Partnership with will work alongside an evaluator to review the indicators for all priority areas, seek out new data sources and resources, as well as update the plan regularly. Progress toward community goals will be reflected in annual reports that will be issued in each year of the CHIP cycle. The achievements and lessons learned will inform the 2025 community health assessment process and will continue to enhance efforts to improve high priority community health issues.

Key Indicators in the Sioux Falls MSA
41% rate affordable housing as fair/poor
18% of adults consume vegetables less than once per day
2.2% unemployment
8% of adults are food insecure
Only 42% of surveyed adults positively rated public transportation
51% of adults delaying medical care cite inability to pay
21% population growth 2010-2020
Gonorrhea cases in the MSA exceed state and national rates
15 year difference in life expectancy among Sioux Falls census tracts
35.5% of adults with obesity
37 out of 100 WalkScore
Cancer and heart disease are the leading causes of death
21.4% of adults binge drink
27% of adults do not get an annual dental visit
31% of adults diagnosed with hypertension
20% of a sample of Sioux Falls elementary school students have signs of tooth decay
9.9% of adults and 4.5% of children are uninsured
$235,000 median home sales price
79% of adults do not meet physical activity guidelines
40% of adults consume fruits less than once per day
16.3 % adult smoking rate
13.7% of households lack internet connection at home
$65,621 median household income

Appendix 2: 10 Essential Public Health Services



The Public Health National Center for Innovations. (2020). 10 Essential Public Health Services Futures Initiative Task Force. 10 Essential Public Health Services. Accessed at https://phnci.org/national-frameworks/10-ephs

Appendix 3: Community Assets and Resources

2022–2025
SIOUX FALLS COMMUNITY
HEALTH IMPROVEMENT PLAN
JUNE 2022

HD22_025