2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Same Day Surgery Center

Butte, Custer, Fall River, Lawrence, Meade, Oglala Lakota, and Pennington Counties, South Dakota

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Prepared by PRC

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TABLE OF CONTENTS

INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Same Day Surgery Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Same Day Surgery Center by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

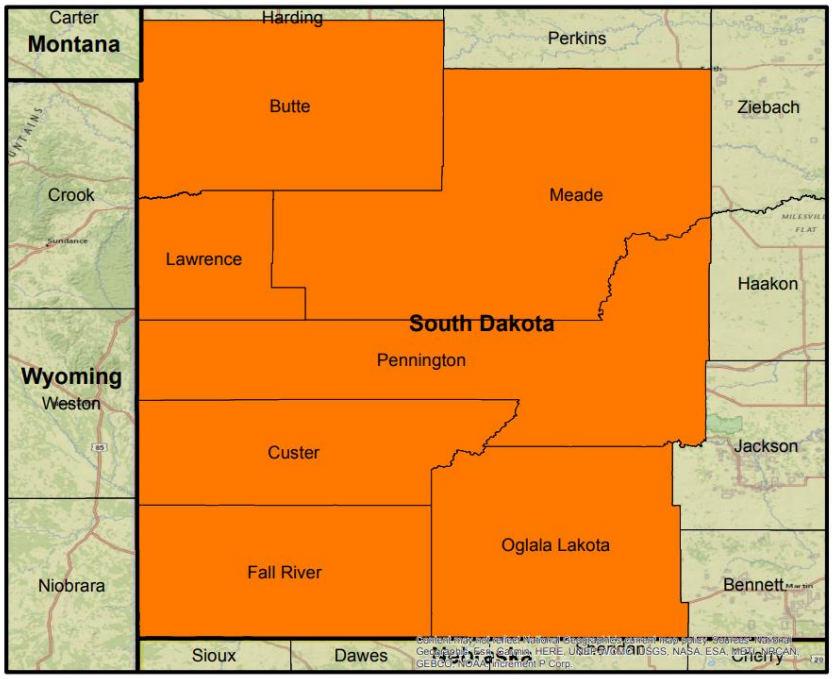
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Monument Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Same Day Surgery Center Service Area” or “SDSC” in this report) is comprised of the following counties: Butte, Custer, Fall River, Lawrence, Meade, Oglala Lakota, and Pennington counties in South Dakota. This area represents the primary service area of Same Day Surgery Center and includes those counties from which 80% of the hospital’s admissions are derived; this community definition is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

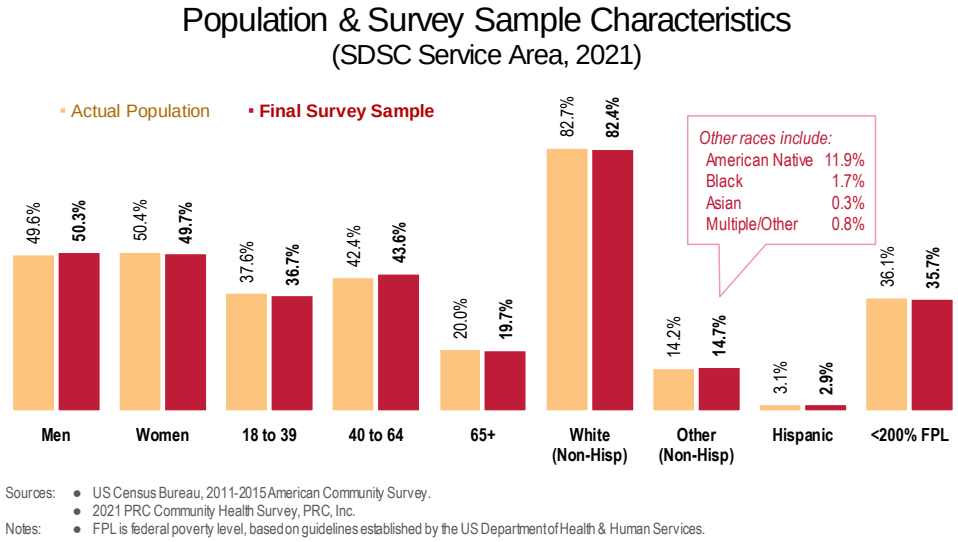
The sample design used for this effort consisted of a random sample of 525 individuals age 18 and older in the Same Day Surgery Center Service Area. Because this study is part of a larger effort involving multiple regions and hospital service areas, the surveys were distributed among various strata. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Same Day Surgery Center Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 525 respondents is ±4.2% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Same Day Surgery Center Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2020 guidelines place the poverty threshold for a family of four at $26,200 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► While the survey data are representative of the racial and ethnic makeup of the population, the samples for Hispanic and non-White race groups were not of sufficient size for independent analysis.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Monument Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Note that the online key informant survey was a regional approach to seeking input from key stakeholders. In all, 118 community residents took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	10
Public Health Representatives	2
Other Health Providers	44
Social Services Providers	25
Other Community Leaders	37

Final participation included representatives of the organizations outlined below.

- American Heart Association
- Badlands/Bad River Economic Development
- Belle Fourche Area Community Center
- Belle Fourche City Government
- Bethany Christian Services
- Big Brothers Big Sisters
- Black Hills Area Community Foundation
- Black Hills Center for American Indian Health
- Black Hills Powwow Association
- Black Hills Works
- Box Elder City Government
- Butte County Sheriff's Dept
- Career Learning Center
- City of Hulett
- City of Newell
- City of Philip
- City of Rapid City
- Community Health Center of the Black Hills
- Cornerstone Apartments
- CornerStone Rescue Mission
- CRH Advisory Board of Trustees
- Deadwood City Government
- Feeding South Dakota
- Good Shepherd Clinic
- Great Plains Tribal Chairmen's Health Board
- Haakon County
- Haakon County Commission
- Humane Society of the Black Hills
- John T. Vucurevich Foundation
- Lead–Deadwood Regional Medical Clinic
- Lifeways
- Live Well Black Hills
- Monument Health Advanced Orthopedic Hospital
- Monument Health Behavioral Health Center
- Monument Health Custer Clinic
- Monument Health Custer Hospital
- Monument Health Executive Management
- Monument Health Lead–Deadwood Hospital
- Monument Health Medical Clinic Family Medicine Residency
- Monument Health Medical Clinic Massa Berry
- Monument Health Medical Clinic Pine Ridge

- Monument Health Medical Clinic Rapid City Flormann Street
- Same Day Surgery Center
- Monument Health Sturgis Hospital
- Northern Plain Eye Foundation
- Office of Representative Dusty Johnson
- Oglala Sioux Lakota Housing
- One Heart
- Our Savior's Lutheran Church
- Penning County Sheriff's Office
- Pennington County Emergency Management
- Pennington County Health & Human Services
- Pennington County State's Attorney Office
- Philip Chiropractic
- Philip Health Services
- Rapid City–City Council
- Rapid City Fire Department
- Rapid City Police Department
- Rapid City Regional Health–Regional Rehabilitation Institute
- Red Cross
- Regional Medical Clinic
- Registered Dietician
- Same Day Surgery Center.
- South Dakota Community Foundation
- South Dakota Department of Health (retired)
- South Dakota Parent Connection
- South Dakota Senate
- South Dakota State University (SDSU) Extension
- SDSU School of Nursing–West River Dept Spearfish–Belle Fourche Community Advisory Council
- Spearfish Clinic Management
- Spearfish Regional Hospital
- Spearfish Regional Medical Clinic
- Spearfish School District
- STRH Advisory Council
- The Club for Boys
- The Journey Museum
- United Way
- Western Dakota Tech
- Youth and Family Services

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE ► These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Same Day Surgery Center Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data.

Benchmark Data

Trending

Similar surveys were administered in the Same Day Surgery Center Service Area in 2012, 2015, and 2018 by PRC on behalf of Same Day Surgery Center. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

South Dakota Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Same Day Surgery Center made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Same Day Surgery Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Same Day Surgery Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	5
Part V Section B Line 3b Demographics of the community	29
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	124
Part V Section B Line 3d How data was obtained	5
Part V Section B Line 3e The significant health needs of the community	13
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	14
Part V Section B Line 3h The process for consulting with persons representing the community's interests	7
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	131

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Appointment Availability – Finding a Physician ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death
DIABETES	▪ Diabetes Deaths ▪ Kidney Disease Prevalence ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths ▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash, Falls [Age 65+] Deaths ▪ Firearm-Related Deaths
MENTAL HEALTH	▪ “Fair/Poor” Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Suicide Deaths ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Fruit/Vegetable Consumption ▪ Medical Advice About Physical Activity ▪ Overweight & Obesity [Adults] ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
POTENTIALLY DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ High-Impact Chronic Pain ▪ Sciatica/Chronic Back Pain ▪ Osteoporosis [Age 50+]
SEXUAL HEALTH	▪ Gonorrhea Incidence
SUBSTANCE ABUSE	▪ Cirrhosis/Liver Disease Deaths ▪ Unintentional Drug-Related Deaths ▪ Sought Help for Alcohol/Drug Issues ▪ Key Informants: Substance abuse ranked as a top concern.

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Abuse
3. Diabetes
4. Nutrition, Physical Activity & Weight
5. Cancer
6. Injury & Violence
7. Heart Disease & Stroke
8. Infant Health & Family Planning
9. Access to Health Care Services
10. Potentially Disabling Conditions
11. Sexual Health

Hospital Implementation Strategy

Same Day Surgery Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Same Day Surgery Center Service Area, as well as trend data. These data are grouped by health topic.

Reading the Summary Tables

- In the following tables, Same Day Surgery Center Service Area results are shown in the larger, gray column.
- The columns to the right of the Same Day Surgery Center Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the Same Day Surgery Center Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	0.4	0.5	1.2	4.3		
Population in Poverty (Percent)	14.9	14.7	13.1	13.4	8.0	
Children in Poverty (Percent)	21.4	20.5	17.4	18.5	8.0	
No High School Diploma (Age 25+, Percent)	7.5	7.5	8.3	12.0		
% Unable to Pay Cash for a $400 Emergency Expense	16.7	15.6		24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	17.6	16.9		32.2		26.9
% Unhealthy/Unsafe Housing Conditions	7.4	7.0		12.2		
% Homeless in the Past Two Years	0.5	0.5				2.5
% Food Insecure	10.4	9.7		34.1		18.2
% Relied on Free Meals in the Past Year	6.9	7.4				5.8
			better	similar	worse	

OVERALL HEALTH	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	15.2	14.8	16.0	12.6		14.5
			better	similar	worse	

ACCESS TO HEALTH CARE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**12.0**	11.9	15.0	8.7	7.9	14.5
% Difficulty Accessing Health Care in Past Year (Composite)	**35.3**	34.3		35.0		40.1
% Cost Prevented Physician Visit in Past Year	**11.6**	10.9	9.8	12.9		16.7
% Cost Prevented Getting Prescription in Past Year	**8.0**	7.9		12.8		11.1
% Difficulty Getting Appointment in Past Year	**22.8**	21.8		14.5		18.1
% Inconvenient Hrs Prevented Dr Visit in Past Year	**13.2**	13.0		12.5		13.8
% Difficulty Finding Physician in Past Year	**14.3**	13.3		9.4		8.6
% Transportation Hindered Dr Visit in Past Year	**8.9**	8.5		8.9		9.5
% Language/Culture Prevented Care in Past Year	**0.1**	0.1		2.8		0.1
% Skipped Prescription Doses to Save Costs	**5.8**	5.6		12.7		14.4
% Difficulty Getting Child's Health Care in Past Year	**3.3**	3.5		8.0		4.0
Primary Care Doctors per 100,000	**98.0**	94.4	93.3	100.0		
% Have a Specific Source of Ongoing Care	**75.4**	75.8		74.2	84.0	75.4
% Have Had Routine Checkup in Past Year	**66.3**	65.7	74.8	70.5		59.8
% Child Has Had Checkup in Past Year	**81.8**	82.0		77.4		78.1
% Outmigration for Care	**25.5**	27.5				31.1

ACCESS TO HEALTH CARE (continued)	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Two or More ER Visits in Past Year	9.1	8.5		10.1		9.8
% Eye Exam in Past 2 Years	58.9	58.7		61.0	61.1	62.8
% Rate Local Health Care "Fair/Poor"	19.2	18.9		8.0		16.9

better similar worse

CANCER	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	161.1	159.2	151.8	149.3	122.7	173.6
Lung Cancer (Age-Adjusted Death Rate)	39.7	39.3	36.9	34.9	25.1	
Prostate Cancer (Age-Adjusted Death Rate)	20.5	20.3	17.4	18.6	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)	18.5	18.1	18.5	19.7	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)	14.6	14.1	14.4	13.4	8.9	
Cancer Incidence Rate (All Sites)	421.6	419.0	459.1	448.6		
Female Breast Cancer Incidence Rate	122.8	122.4	124.8	126.8		
Prostate Cancer Incidence Rate	79.8	81.4	118.3	106.2		
Lung Cancer Incidence Rate	55.5	55.7	57.5	57.3		
Colorectal Cancer Incidence Rate	38.3	38.3	41.3	38.0		
% Cancer	11.4	11.2	12.8	10.0		

CANCER (continued)	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% [Women 50-74] Mammogram in Past 2 Years	79.5	76.8	82.2	76.1	77.1	75.0
% [Women 21-65] Cervical Cancer Screening	78.4	78.0	74.2	73.8	84.3	75.8
% [Age 50-75] Colorectal Cancer Screening	75.0	74.0	69.1	77.4	74.4	63.3

better similar worse

DIABETES	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	25.9	25.2	25.0	21.5		22.3
% Diabetes/High Blood Sugar	9.5	9.4	10.6	13.8		11.7
% Borderline/Pre-Diabetes	8.6	8.6		9.7		7.2
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	51.1	50.2		43.3		52.1

better similar worse

HEART DISEASE & STROKE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	159.6	158.9	154.8	163.4	127.4	150.5
% Heart Disease (Heart Attack, Angina, Coronary Disease)	7.4	7.5	7.0	6.1		7.9
Stroke (Age-Adjusted Death Rate)	32.0	31.5	34.2	37.2	33.4	33.7
% Stroke	2.3	2.6	2.8	4.3		3.8

HEART DISEASE & STROKE (continued)	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Blood Pressure Checked in Past 2 Years	97.1	96.8		85.0		96.9
% Told Have High Blood Pressure	37.1	37.4	30.9	36.9	27.7	36.4
% [HBP] Taking Action to Control High Blood Pressure	97.8	97.3		84.2		84.0
% Cholesterol Checked in Past 5 Years	88.6	89.3		80.7		88.4
% Told Have High Cholesterol	30.6	30.9		32.7		31.6
% [HBC] Taking Action to Control High Blood Cholesterol	87.0	87.0		83.2		85.4
% 1+ Cardiovascular Risk Factor	86.9	85.4		84.6		85.1

better similar worse

INFANT HEALTH & FAMILY PLANNING	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Low Birthweight Births (Percent)	7.3	7.3	6.6	8.2		
Infant Death Rate	6.8	6.6	6.7	5.6	5.0	9.1
% [Child 0-17] Up-To-Date on Childhood Vaccinations	98.9	98.0				
Births to Adolescents Age 15 to 19 (Rate per 1,000)	30.4	30.0	24.6	20.9	31.4	

better similar worse

INJURY & VIOLENCE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	59.9	58.4	51.9	48.9	43.2	51.3
Motor Vehicle Crashes (Age-Adjusted Death Rate)	20.4	20.0	16.5	11.3	10.1	
[65+] Falls (Age-Adjusted Death Rate)	97.9	92.7	102.5	65.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)	17.7	17.2	12.9	11.9	10.7	
Homicide (Age-Adjusted Death Rate)	4.4	4.2	3.4	5.6	5.5	
Violent Crime Rate	434.6	435.7	551.8	416.0		
% Victim of Violent Crime in Past 5 Years	0.8	0.7		6.2		3.0
% Victim of Intimate Partner Violence	13.3	12.4		13.7		11.1

better similar worse

KIDNEY DISEASE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	5.1	5.3	6.4	12.9		5.7
% Kidney Disease	4.8	4.4	2.9	5.0		1.8

better similar worse

MENTAL HEALTH	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	13.9	14.7		13.4		6.6
% Diagnosed Depression	23.6	22.2	17.3	20.6		15.0
% Symptoms of Chronic Depression (2+ Years)	29.2	28.6		30.3		21.2
% Typical Day Is "Extremely/Very" Stressful	8.3	7.7		16.1		7.9
Suicide (Age-Adjusted Death Rate)	27.3	26.6	20.9	14.0	12.8	20.9
Mental Health Providers per 100,000	112.2	105.9	91.7	115.1		
% Taking Rx/Receiving Mental Health Trtmt	16.8	16.0		16.8		13.2
% Unable to Get Mental Health Svcs in Past Yr	2.3	2.2		7.8		2.0
% [Age 5-17] Unable to Get Child's Mental Health Services	8.7	8.6				
% [Age 5-17] Child Has Been Diagnosed With Depression	3.3	4.4				
% [Age 5-17] Child Is Receiving Treatment/Counseling	4.8	5.8				
% [Child 5-17] Typical Day Is "Extremely/Very" Stressful	2.3	2.8				
% [Age 5-17] Sought Professional Help for Child's Mental Health	16.8	20.2				

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)	27.1	27.7	29.1	22.2		
% "Very/Somewhat" Difficult to Buy Fresh Produce	19.2	19.0		21.1		25.3
% 5+ Servings of Fruits/Vegetables per Day	24.5	25.2		32.7		45.4
% No Leisure-Time Physical Activity	19.9	20.2	30.0	31.3	21.2	21.9
% Meeting Physical Activity Guidelines	17.8	17.9	21.7	21.4	28.4	19.8
% Medical Advice on Exercise in Past Year	34.6	35.3				41.2
% Child [Age 2-17] Physically Active 1+ Hours per Day	60.1	61.9		33.0		55.9
Recreation/Fitness Facilities per 100,000	11.4	10.5	14.5	12.2		
% Healthy Weight (BMI 18.5-24.9)	22.5	23.4	27.8	34.5		27.6
% Overweight (BMI 25+)	76.7	75.6	70.9	61.0		70.9
% Obese (BMI 30+)	36.4	36.3	33.0	31.3	36.0	27.0
% Medical Advice on Diet/Nutrition in Past Year	33.5	32.4				33.0
% Children [Age 5-17] Healthy Weight	51.8	52.1		47.6		67.8
% Children [Age 5-17] Overweight (85th Percentile)	41.5	41.0		32.3		32.3
% Children [Age 5-17] Obese (95th Percentile)	13.1	12.6		16.0	15.5	11.6

better similar worse

ORAL HEALTH	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Have Dental Insurance	72.9	71.6		68.7	59.8	58.5
% [Age 18+] Dental Visit in Past Year	63.1	63.8	68.0	62.0	45.0	59.0
% Child [Age 2-17] Dental Visit in Past Year	87.6	87.6		72.1	45.0	76.7

better similar worse

POTENTIALLY DISABLING CONDITIONS	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	39.2	39.5		32.5		39.0
% Activity Limitations	24.1	24.4		24.0		22.7
% With High-Impact Chronic Pain	20.6	20.1		14.1	7.0	
% Sciatica/Chronic Back Pain	21.8	21.5		16.5		22.5
% [50+] Arthritis/Rheumatism	37.4	37.4		33.1		38.3
% [50+] Osteoporosis	18.9	18.4		10.5		9.7
Alzheimer's Disease (Age-Adjusted Death Rate)	30.4	30.1	37.9	30.4		26.7
% Caregiver to a Friend/Family Member	26.3	26.4		22.6		28.1

better similar worse

RESPIRATORY DISEASE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)	44.0	43.1	44.7	39.6		47.5
Pneumonia/Influenza (Age-Adjusted Death Rate)	15.1	15.6	18.5	13.8		18.5
% [Age 65+] Flu Vaccine in Past Year	71.3	68.7	63.9	71.0		74.5
% Fully/Partially Vaccinated for COVID-19	77.7	75.9				
% [Adult] Asthma	8.5	8.3	8.5	12.9		10.3
% [Child 0-17] Asthma	3.9	3.8		7.8		10.0
% COPD (Lung Disease)	7.4	7.8	5.8	6.4		14.2
			better	similar	worse	

SEXUAL HEALTH	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
HIV Prevalence Rate	92.3	88.1	84.5	372.8		
Chlamydia Incidence Rate	557.0	529.7	509.6	539.9		
Gonorrhea Incidence Rate	243.3	228.3	194.2	179.1		
			better	similar	worse	

SUBSTANCE ABUSE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	27.0	25.6	18.0	11.1	10.9	16.6
% Excessive Drinker	18.6	17.7	22.7	27.2		19.2
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	7.3	7.2	6.8	18.8		5.6
% Illicit Drug Use in Past Month	1.8	1.7		2.0	12.0	0.8
% Used a Prescription Opioid in Past Year	16.1	15.6		12.9		19.7
% Ever Sought Help for Alcohol or Drug Problem	2.9	2.8		5.4		5.1
% Personally Impacted by Substance Abuse	38.6	38.1		35.8		38.2

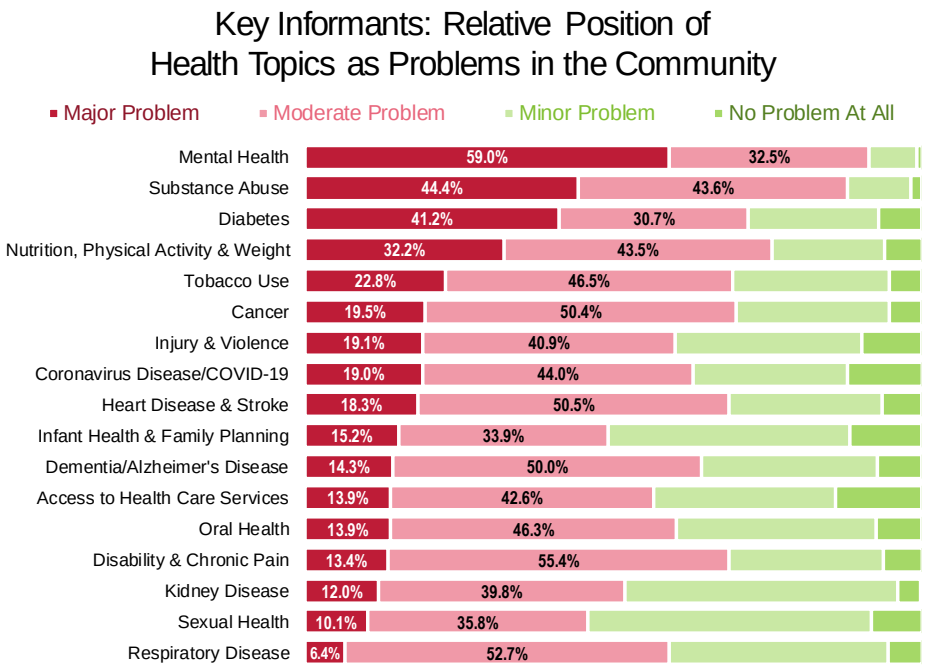
better similar worse

TOBACCO USE	SDSC	SDSC vs. BENCHMARKS				
		vs. Monument Health	vs. SD	vs. US	vs. HP2030	TREND
% Current Smoker	16.1	15.3	18.3	17.4	5.0	23.8
% Someone Smokes at Home	8.2	7.8		14.6		14.1
% [Household With Children] Someone Smokes in the Home	2.0	1.9		17.4		7.3
% Currently Use Vaping Products	6.7	6.2	3.9	8.9		4.8
% Smoke Cigars	2.7	2.7				2.8
% Use Smokeless Tobacco	4.0	4.9	6.4			5.8

better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2010-2020)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
SDSC Service Area	203,906	14,688.23	13.88
Monument Health	219,733	22,612.28	9.72
South Dakota	870,638	75,810.54	11.48
United States	324,697,795	3,532,068.58	91.93

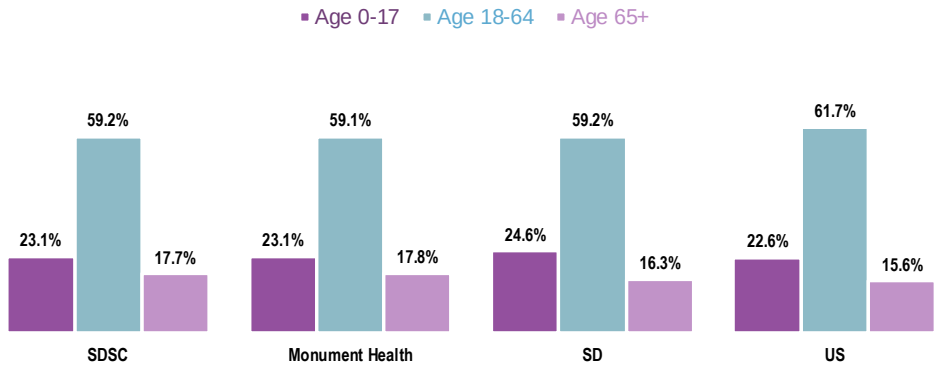
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- Service areas are not mutually exclusive.

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

Total Population by Age Groups
(2010-2020)

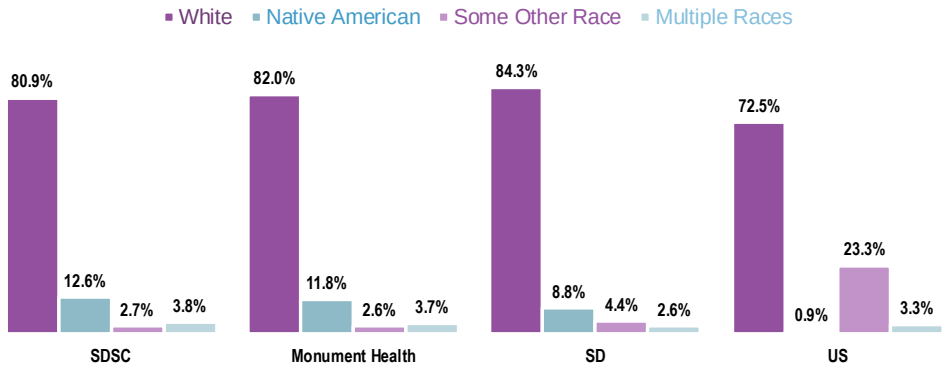


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Race & Ethnicity

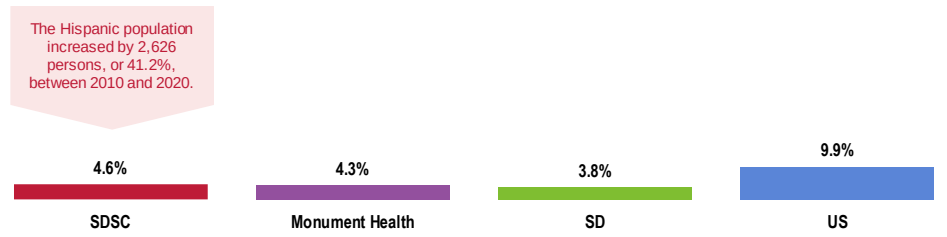
The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

Total Population by Race Alone
(2010-2020)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Hispanic Population
(2010-2020)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

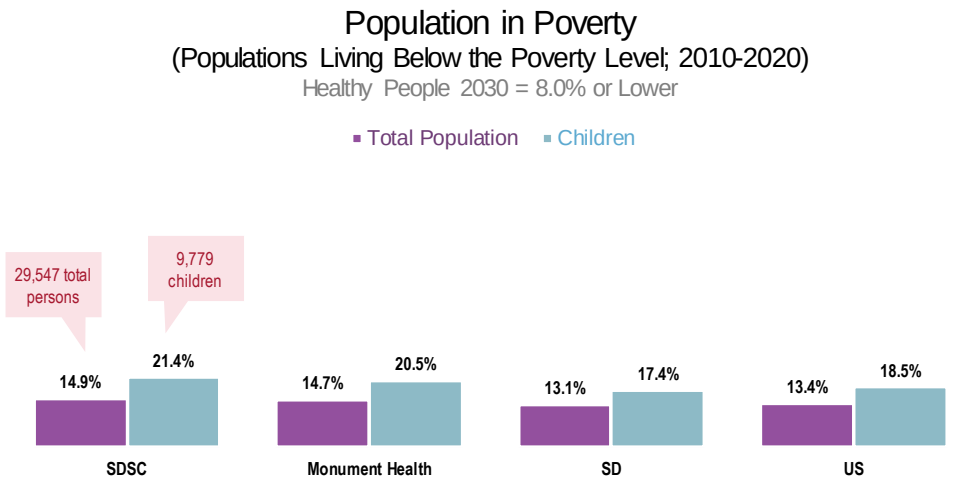
Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.



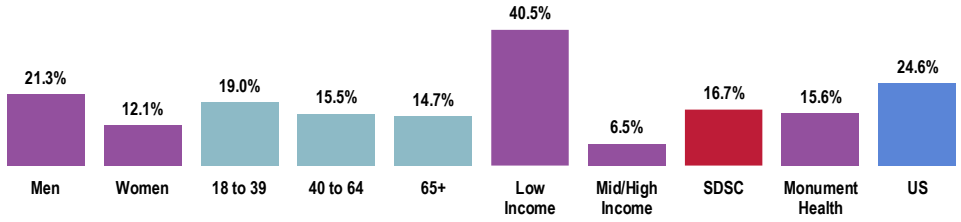
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(SDSC Service Area, 2021)



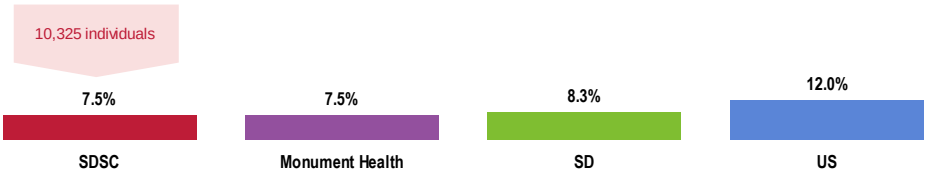
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Education

Education levels are reflected in the proportion of our population without a high school diploma.

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2020)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

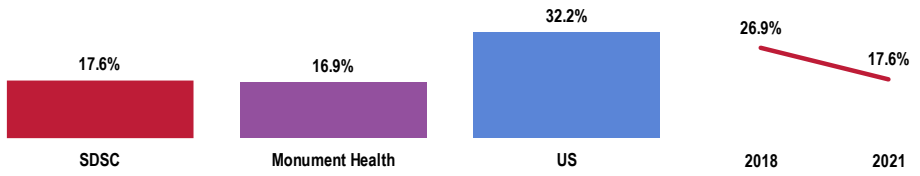
Housing

Housing Insecurity

"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year

SDSC Service Area



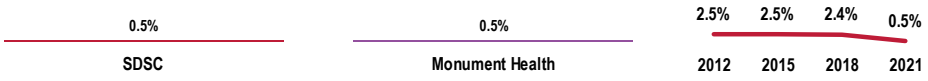
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience of Homelessness

"Has there been any time in the past two years when you were living on the street, in a car, or in a temporary shelter?"

Lived On the Street, In a Car, or In a Temporary Shelter at Some Point in the Past Two Years

SDSC Service Area

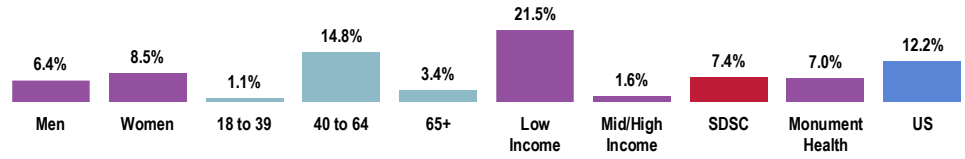


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 325]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(SDSC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

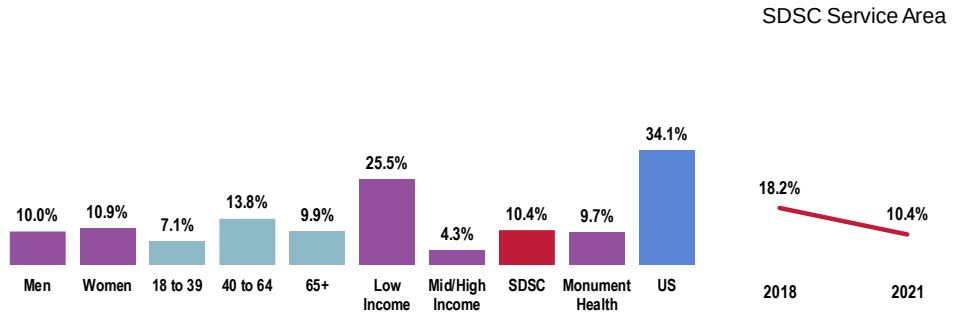
Food Insecurity

"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity
(SDSC Service Area, 2021)

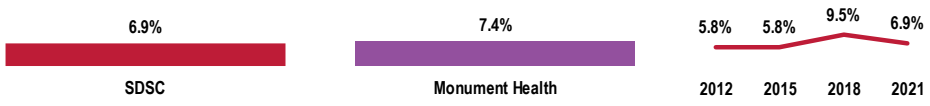


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Free Meals

"In the past year, have you gone to a food bank or received free meals provided by churches or other organizations?"

Have Gone to a Food Bank or Received Free Meals Provided by Churches or Other Organizations in the Past Year

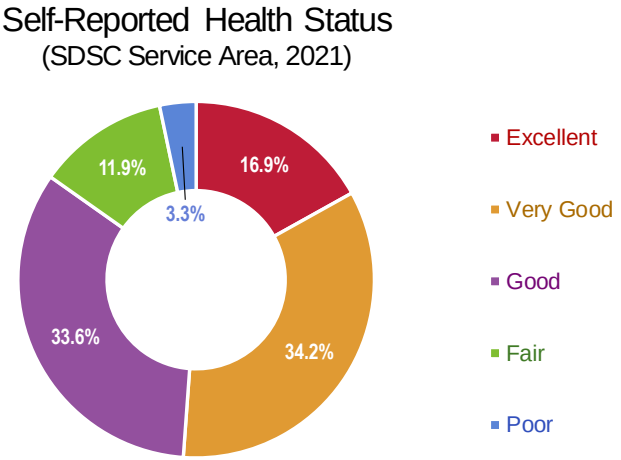


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 326]
Notes: ● Asked of all respondents.

HEALTH STATUS

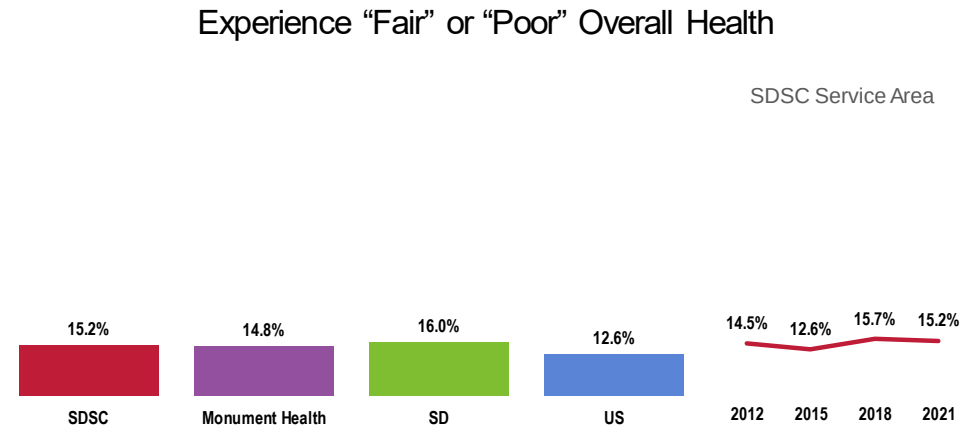
Overall Health

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"



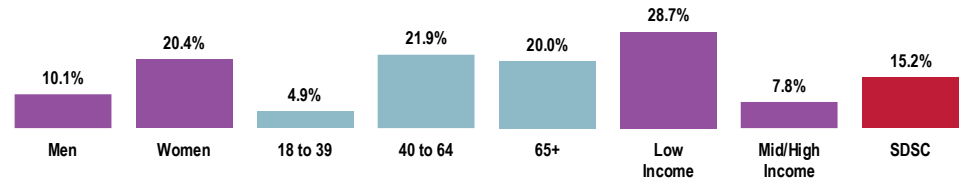
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in the Same Day Surgery Center Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, and income [based on poverty status]).



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(SDSC Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

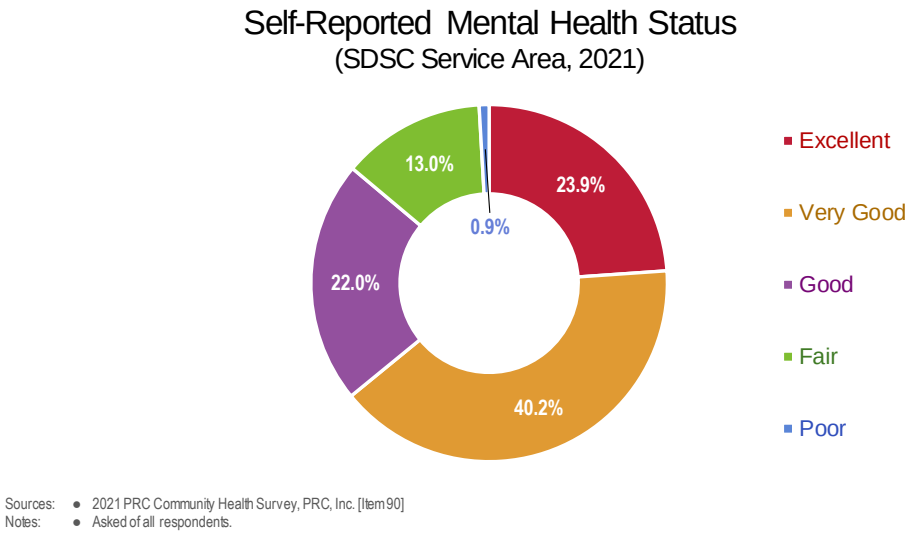
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

SDSC Service Area

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2020 PRC National Health Survey, PRC, Inc.

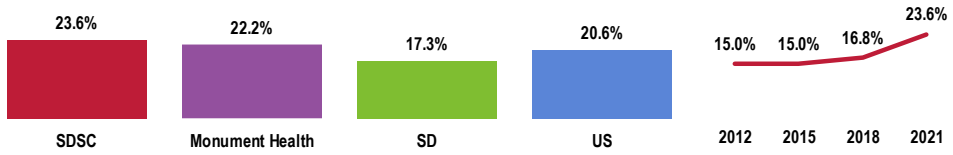
Notes:
- Asked of all respondents.

Depression

DIAGNOSED DEPRESSION ► **“Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”**

Have Been Diagnosed With a Depressive Disorder

SDSC Service Area

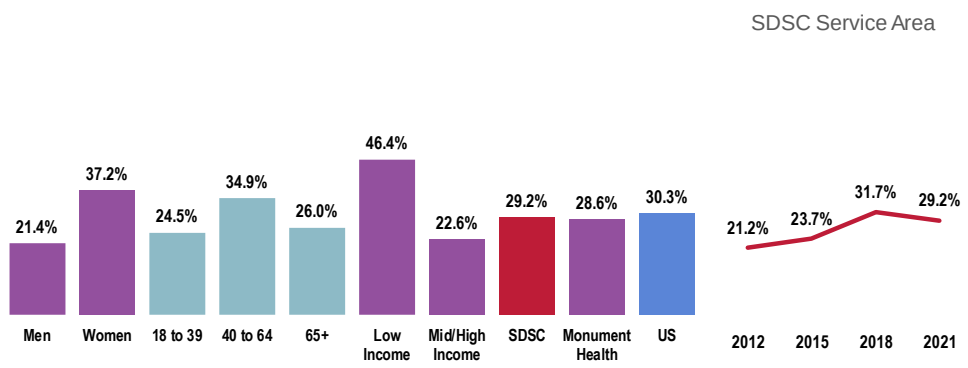


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

SYMPTOMS OF CHRONIC DEPRESSION ► **"Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"**

Have Experienced Symptoms of Chronic Depression
(SDSC Service Area, 2021)



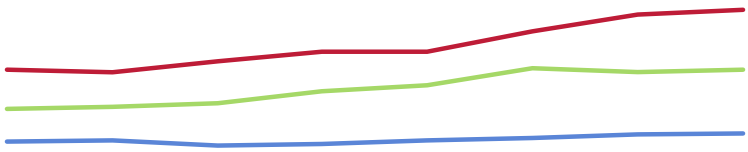
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population (refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates).

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



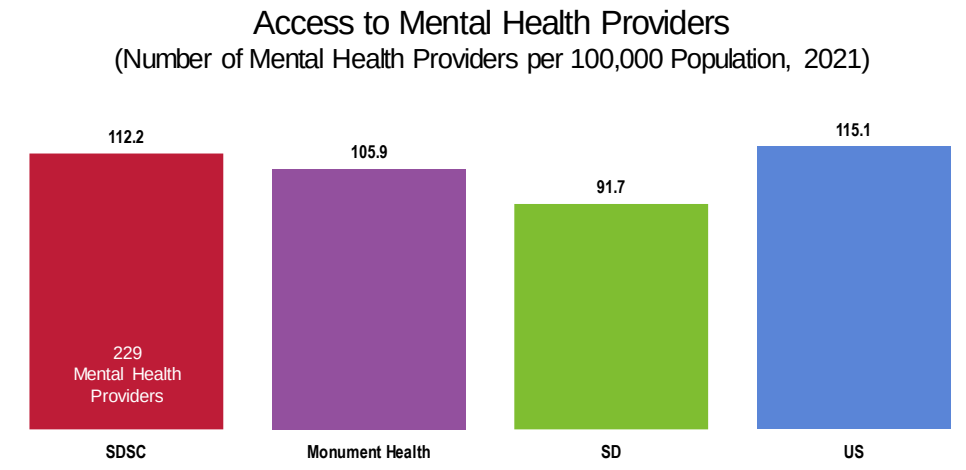
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	20.9	20.6	21.7	22.8	22.8	25.0	26.7	27.3
SD	16.7	16.8	17.3	18.5	19.2	21.0	20.7	20.9
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Mental Health Treatment

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the counties represented and residents in the counties represented; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

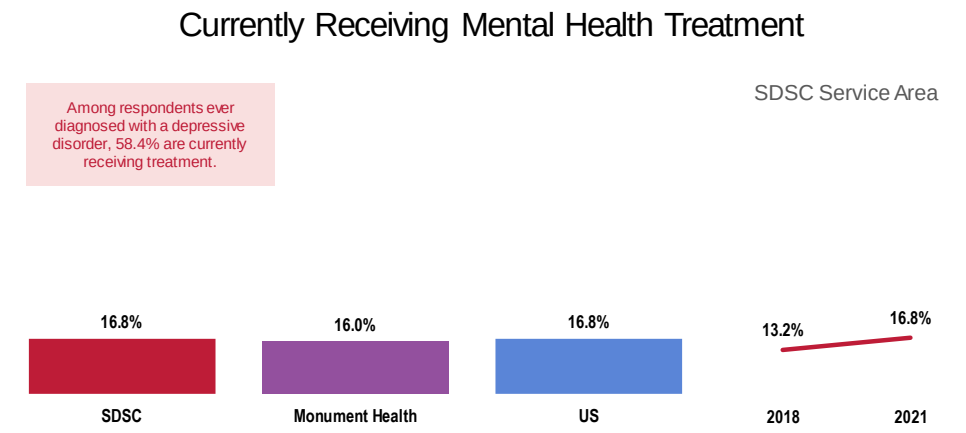
The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents.



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"

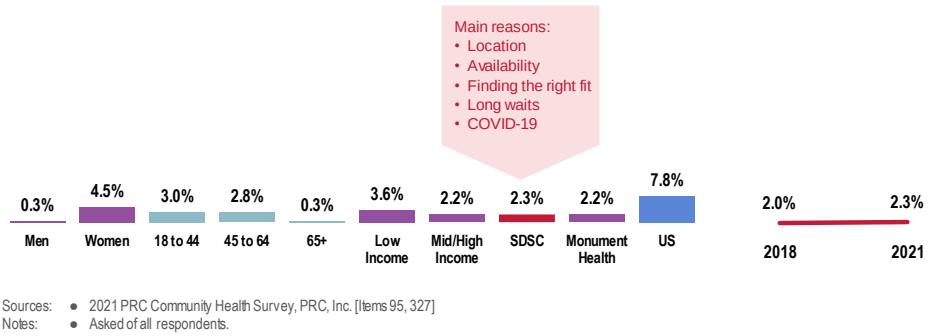


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services
When Needed in the Past Year
(SDSC Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 95, 327]
Notes: • Asked of all respondents.

Children's Mental Health

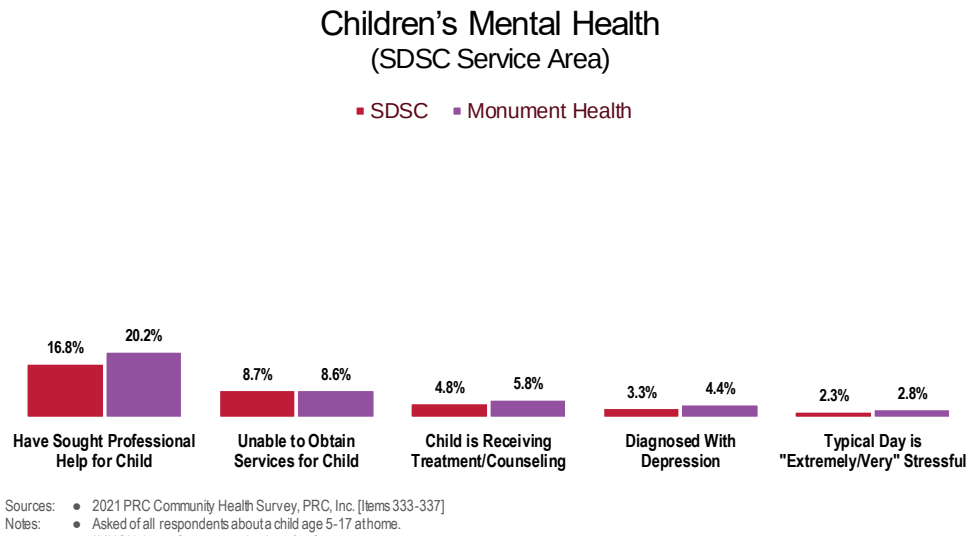
"Thinking about the amount of stress in this child's life, would you say that most days are extremely stressful, very stressful, moderately stressful, not very stressful, or not at all stressful?"

"Has a doctor or other healthcare provider ever said that this child has a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

"Is this child now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

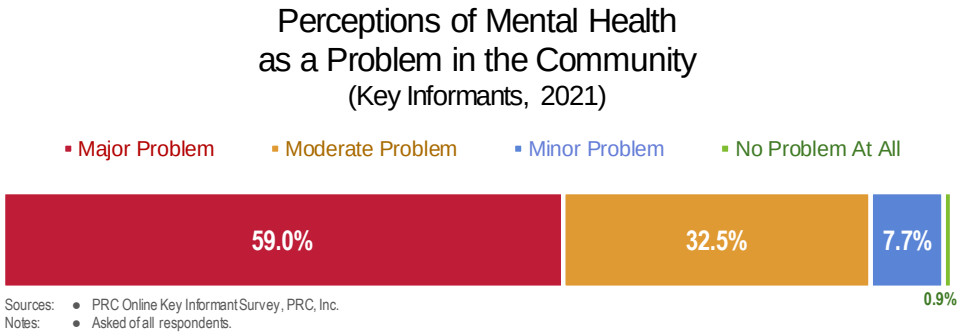
"Have you ever sought help from a professional for a mental or emotional problem for this child?"

"Was there a time in the past 12 months when this child needed mental health services but you were not able to get them?"



Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> There is no place to go. Places are all booked up. – Other Health Provider
>
> Access to care. – Physician
>
> Need for more services. – Community/Business Leader
>
> Access to mental health services within our communities. – Community/Business Leader
>
> There are not a lot of mental health options available in this area, especially not affordable. The pandemic exacerbated issues. – Community/Business Leader
>
> Not enough inpatient beds, leads to long boarding times in ED. Repeat/bounce back patients seen often. – Other Health Provider
>
> Access to mental health providers. Psychiatric specialty medication management. Crisis intervention options outside of the ED are non-existent. – Physician
>
> Lack of services. – Social Services Provider
>
> Current lack of long-term mental health treatment facilities/practitioners. Prohibitive costs and limited access to any mental health programs that do exist. – Community/Business Leader
>
> Lack of facilities dedicated strictly to mental health. – Community/Business Leader
>
> There is no assistance, housing, or programs for mental health. – Community/Business Leader

The resources are very limited for mental health issues in our community. We do not have any counselors, nor facilities, to assist individuals with mental health issues. – Community/Business Leader

There are simply not enough mental health counselors in our area to handle the existing, let alone the increasing, need. – Social Services Provider

There is no place for patients to get admitted for mental health issues. We need more QMHP's to service the area (do mental health evaluations) when a patient is in need of mental health care and are on hold. – Other Health Provider

We do not have enough resources for mental health in our area. It is very difficult to get a patient in for an appointment. Also, our one Psychiatrist that is available in Spearfish is leaving. Lack of resources also play havoc on other programs, such as the bariatric program. It takes a long time for a patient to get in to be seen. – Other Health Provider

Lack of/minimal available services that are accepting patients or have timely appointment openings. – Other Health Provider

Access to services and lack of insurance coverage, exacerbated by a shortage of licensed mental health therapists in South Dakota and nationwide. – Social Services Provider

Access to IP and OP services. – Other Health Provider

Lack of availability for inpatient treatment, paying for medications, and transportation needs to get to outpatient appointments. – Other Health Provider

Access which is timely and fits alongside our primary care. Right now, primary care providers are providing this service or through ED and is not sustainable for positive long-term outcomes. Additionally, pediatric services are not easily available. – Other Health Provider

Access to medical care, therapy. Medication compliance. Often have to wait weeks for an appointment. – Social Services Provider

Contributing Factors

Access to services, affordability of treatments, resources and medication, stigma. – Community/Business Leader

Access, sigma related to mental health, and drug use. – Other Health Provider

Lack of available services, expense of services, insufficient insurance coverage for needed services, high suicide/attempted suicide rates among the younger population. – Other Health Provider

Few resources available for those with mental health issues. Many with mental health issues also with poor health maintenance, substance abuse and homelessness. – Other Health Provider

Lack of services to tend to the issue. Lack of housing to keep them during mental holds. – Other Health Provider

Access to appropriate care in appropriate settings. Our communities need more psychiatrists, counselors, and behavioral health education. From counseling and support to short term stabilization to in-patient care, patients do better when they remain in their support community. Education that mental health issues should not be a stigmatism is needed. The public school system can provide education to our youth on this important issue. – Other Health Provider

Wait times for outpatient appointments, if a patient is needing inpatient stay, the hospitalization is often too short to effect change, substance abuse, stigmas about seeking mental health treatment. – Social Services Provider

Access to trained professionals with support staff and facility to serve. Also there is little coordination of care. And for those most affected, transportation to the visits is really hard. For instance, I called CPS on a family whose mother just has a hard time with transportation because there was no phone working and letter returned as undeliverable to last address. So, then CPS sends me a letter that says they are shutting the case because there is no neglect. very difficult. The mother has mental health struggles and now the children won't get care. – Physician

Lack of providers is greatest challenge. Lack of insurance or poor insurance coverage is another huge challenge. Stigma does also play a part in individuals not seeking mental health care. – Other Health Provider

Finding available and affordable mental health services. There is also the stigma of having a mental illness. – Other Health Provider

The systemic nature of mental health, it's accompanied by financial burdens, psychosocial elements, family struggles, etc. No quick fix. – Other Health Provider

Much of our law enforcement, violence, and medical responses can be attributed to mental health issues. Many families with one family member with a mental health issue will be "working poor" or unemployed due to the costs and times necessary to care for the individual. I suspect that many of the students that regularly miss days at school have one or more parents with a mental illness or a sibling whose care depletes the parent's ability to see that the other children receive a proper education. When students miss so much school, they are unable to learn the necessary information and skills to get and keep good-paying jobs and the cycle of poverty and under-employment and the working poor continues. – Other Health Provider

Lack of detection, self-medication of symptoms, lack of accessible mental health providers. – Community/ Business Leader

> Mental health, especially among the younger population, is a big issue that leads to substance abuse and risk for harming self or others. Also, there are limited resources on this side of the state to treat and care for elderly with mental health issues, such as dementia. – Other Health Provider
>
> Residential or Emergency Response for children with mental health issues. A significant number of children (5-17) are admitted to the Behavioral Health Center that could easily be treated in an outpatient or residential facility. Families need respite at times from these children's behaviors and tend to bring them to the hospital to get this respite. They jump to the idea that their behaviors are mental illness when it is actually a behavior which is not a mental illness. This takes away time and needed care for those children who do have mental conditions that need treatment. Limited beds are available and the facility runs out. When this happens these children are kept in the ED until a bed opens. – Other Health Provider

Lack of Providers

> Very few mental health care providers and very few options for people who don't have the means to provide for their own mental health needs. – Social Services Provider
>
> Shortage of providers to help people with this need. We see this to be the biggest concern, by far, in our community. – Community/Business Leader
>
> Time, talent, and most likely wages for the people in this field are causing challenges for new people to enter the field to address mental health. People are not seeing a return on their investment for pursuing an education in this field. – Community/Business Leader
>
> Lack of available mental health providers for all patients, but especially Medicaid patients. Many providers do not take Medicaid, making it hard to find care for these patients. – Physician
>
> Limited providers, limited crisis centers, lack of resources for individuals with co-occurring DD and mental health issues. – Social Services Provider
>
> Lack of providers in West River, SD, lack of appropriate mental health facilities in West River. Cornerstone Rescue Mission ends up being a provider as there is nowhere for many of them to go. – Social Services Provider
>
> There is a need for more providers, long term inpatient and outpatient treatment services. – Public Health Representative

Homelessness

> Homeless people often have mental health issues because they are not able to obtain medication or because they don't take medication. – Other Health Provider
>
> Homelessness. It is specifically a health issue, it contributes to health issues, also contributing to and exacerbating substance abuse and mental health issues. – Other Health Provider

Affordable Care/Services

> Affordable treatment and support networks. – Community/Business Leader

Affordable Medications/Supplies

> Getting help with the medications. Getting the help that people need and keep them on the medications. – Social Services Provider

Alcohol/Drug Use

> The combination of unmet mental health needs that are self-medicating that lead to addiction. – Social Services Provider

Awareness/Education

> Understanding their needs and accessing resources to help. – Social Services Provider

Diagnosis/Treatment

> There are no treatment options other than law enforcement. – Community/Business Leader

COVID-19

> Increase in mental health issues with COVID-19, social isolation and increase in violence. – Other Health Provider

Follow-Up/Support

> Outpatient counseling is needed to support chronic and acute events. – Other Health Provider

Incidence/Prevalence

> I see many people in the community with mental health issues. – Community/Business Leader

Lifestyle

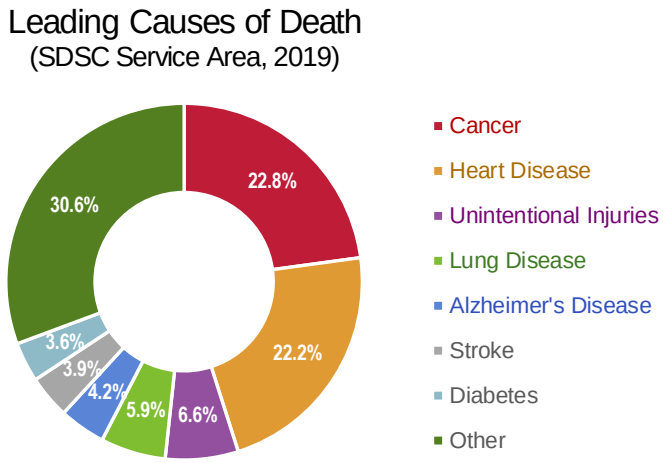
> Lack of hope and feeling of helplessness. The inability to see a way out of their situation. – Community/Business Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in the community.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the Same Day Surgery Center Service Area.

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, STATENAME and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2017-2019 Deaths per 100,000 Population)

	SDSC Service Area	Monument Health	South Dakota	US	HP2030
Malignant Neoplasms (Cancers)	161.1	159.2	151.8	149.3	122.7
Diseases of the Heart	159.6	158.9	154.8	163.4	127.4*
Fall-Related Deaths (65+)	97.9	92.7	102.5	65.1	63.4
Unintentional Injuries	59.9	58.4	51.9	48.9	43.2
Chronic Lower Respiratory Disease (CLRD)	44.0	43.1	44.7	39.6	n/a
Cerebrovascular Disease (Stroke)	32.0	31.5	34.2	37.2	33.4
Alzheimer's Disease	30.4	30.1	37.9	30.4	n/a
Intentional Self-Harm (Suicide)	27.3	26.6	20.9	14.0	12.8
Cirrhosis/Liver Disease	27.0	25.6	18.0	11.1	10.9
Diabetes Mellitus	25.9	25.2	25.0	21.5	n/a
Motor Vehicle Deaths	20.4	20.0	16.5	11.3	10.1
Firearm-Related	17.7	17.2	12.9	11.9	10.7
Pneumonia/Influenza	15.1	15.6	18.5	13.8	n/a
Drug-Induced	7.3	7.2	6.8	18.8	n/a
Kidney Diseases	5.1	5.3	6.4	12.9	n/a
Homicide (2010-2019)	4.4	4.2	3.4	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	150.5	149.7	153.6	152.1	151.2	152.5	154.8	159.6
SD	154.9	153.2	153.4	151.9	153.0	151.5	153.3	154.8
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

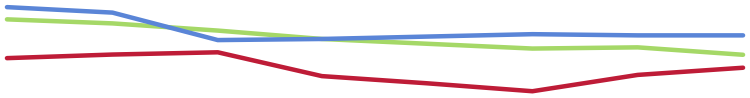
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	33.7	34.3	34.6	30.7	29.6	28.3	31.0	32.0
SD	39.9	39.2	38.1	36.7	35.9	35.2	35.4	34.2
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Prevalence of Heart Disease & Stroke

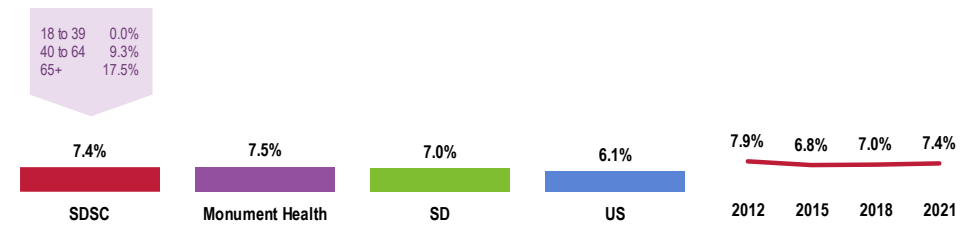
"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.

Prevalence of Heart Disease

SDSC Service Area



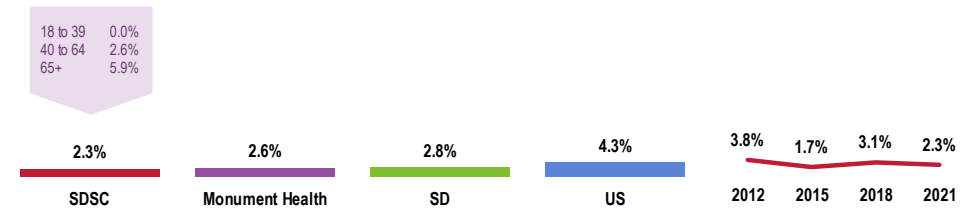
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

"Has a doctor, nurse, or other health professional ever told you that you had a stroke?"

Prevalence of Stroke

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

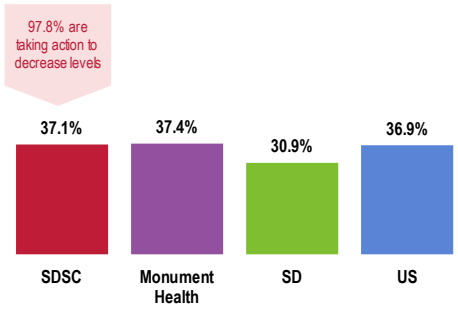
Cardiovascular Risk Factors

Blood Pressure & Cholesterol

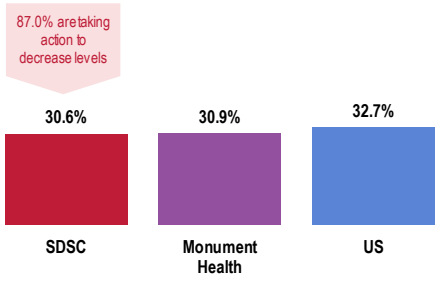
"Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of
High Blood Pressure
Healthy People 2030 = 27.7% or Lower

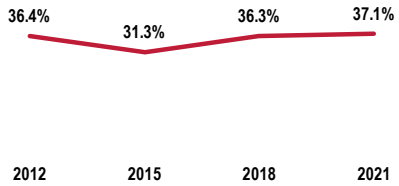


Prevalence of
High Blood Cholesterol

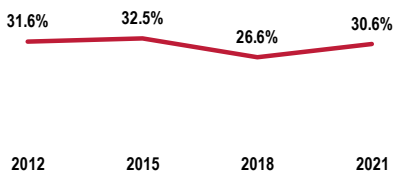


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 35, 36, 319, 321]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
● 2020 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: ● Asked of all respondents.

Prevalence of
High Blood Pressure
(SDSC Service Area)
Healthy People 2030 = 27.7% or Lower



Prevalence of
High Blood Cholesterol
(SDSC Service Area)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 35, 36]
● US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

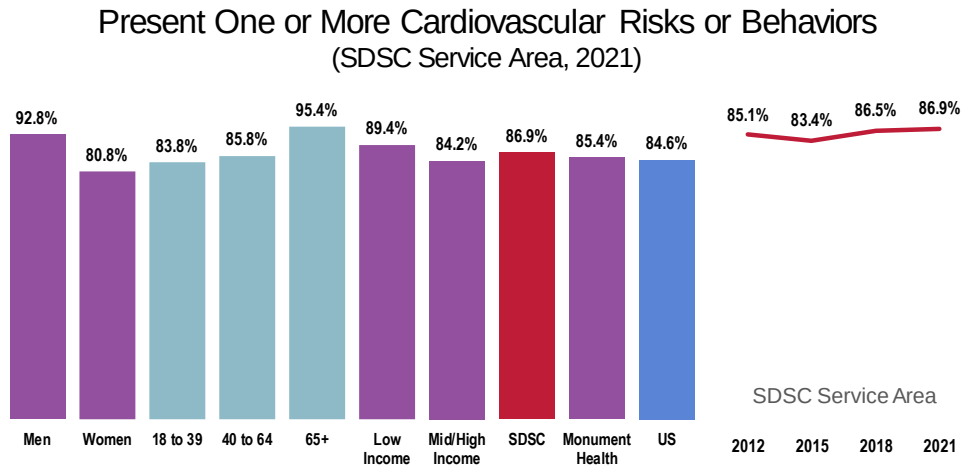
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

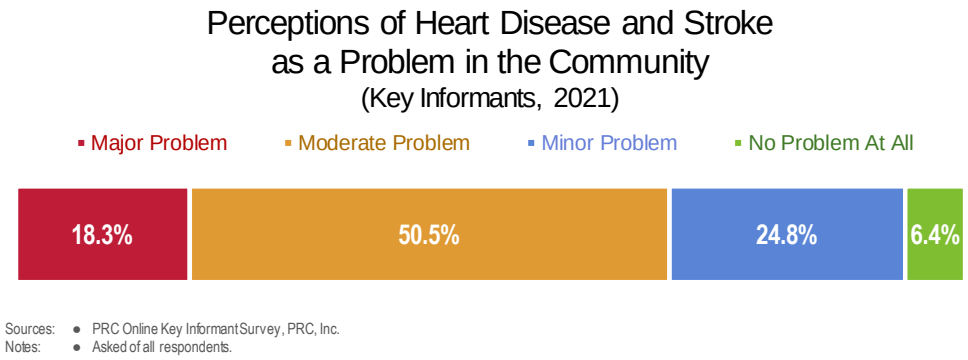
The following chart reflects the percentage of adults in the Same Day Surgery Center Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
Notes: ● Reflects all respondents.
● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Heart disease and stroke number one killer. – Other Health Provider
>
> We see many clients who come in post cardiac rehab or after having a cardiac event. – Community/Business Leader
>
> I know of many people who suffer from these conditions. – Community/Business Leader
>
> Frequency of patients seen in ED with cardiac events. – Other Health Provider
>
> Cardiovascular disease remains the number one cause of death in the Western South Dakota population. – Physician
>
> I know a lot of people who are having problems with heart disease or stroke. – Social Services Provider

Contributing Factors

> Obesity, inactivity, rural community, lack of knowledge. Need to travel for neuro-intervention. – Other Health Provider
>
> Obesity and drug use. – Community/Business Leader
>
> Unhealthy lifestyles, plus genetic predisposition affects a large portion of the population. There is a lack of awareness in the community. – Community/Business Leader

Aging Population

> A lot of elderly people in this area with heart disease and many have had strokes. – Social Services Provider
>
> Older, retirement community. – Community/Business Leader

Obesity

> Because we have an overweight society, heart disease and stroke are affecting many community members. Just recently in Rapid City we heard of two prominent community members who have died at a young age of heart disease. – Other Health Provider

Access to Care/Services

> Must travel for treatment and rehab. – Community/Business Leader

Cancer

ABOUT CANCER

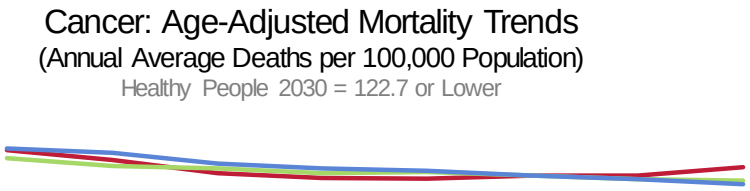
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in the Same Day Surgery Center Service Area.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	173.6	166.7	157.4	153.9	153.2	155.7	155.5	161.1
SD	167.9	162.4	160.3	157.3	158.0	155.9	152.9	151.8
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Lung cancer is by far the leading cause of cancer deaths in the Same Day Surgery Center Service Area.

Age-Adjusted Cancer Death Rates by Site
(2017-2019 Annual Average Deaths per 100,000 Population)

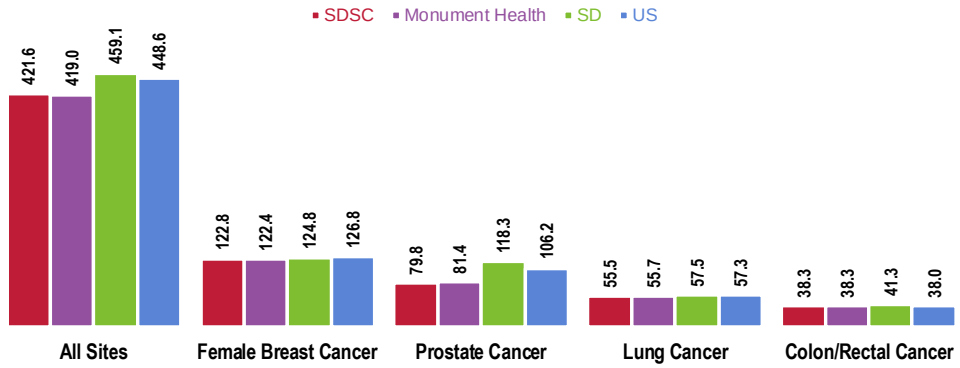
	SDSC Service Area	Monument Health	South Dakota	US	HP2030
ALL CANCERS	161.1	159.2	151.8	149.3	122.7
Lung Cancer	39.7	39.3	36.9	34.9	25.1
Prostate Cancer	20.5	20.3	17.4	18.6	16.9
Female Breast Cancer	18.5	18.1	18.5	19.7	15.3
Colorectal Cancer	14.6	14.1	14.4	13.4	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



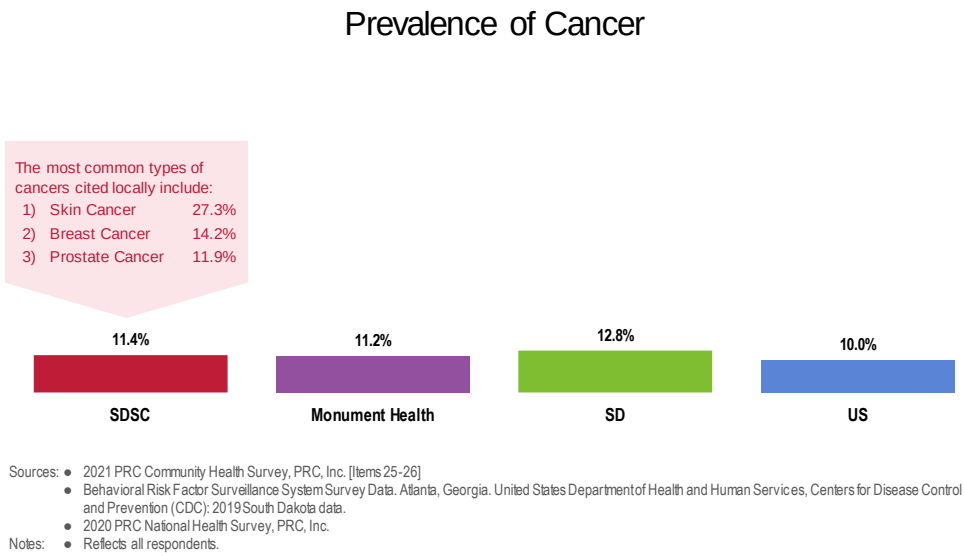
Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

“Have you ever suffered from or been diagnosed with cancer?”

“Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation’s cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
  - National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

BREAST CANCER SCREENING ► **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

CERVICAL CANCER SCREENING ► **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"**

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

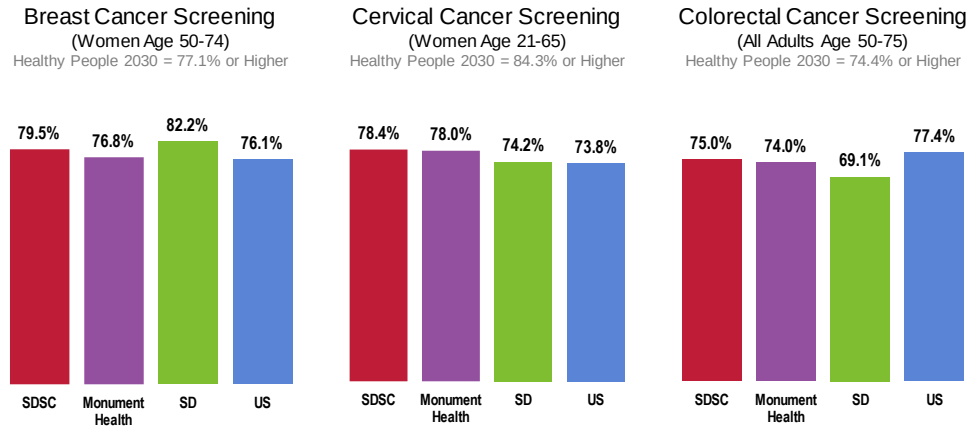
"Have you ever had a hysterectomy?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

COLORECTAL CANCER SCREENING ► **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"**

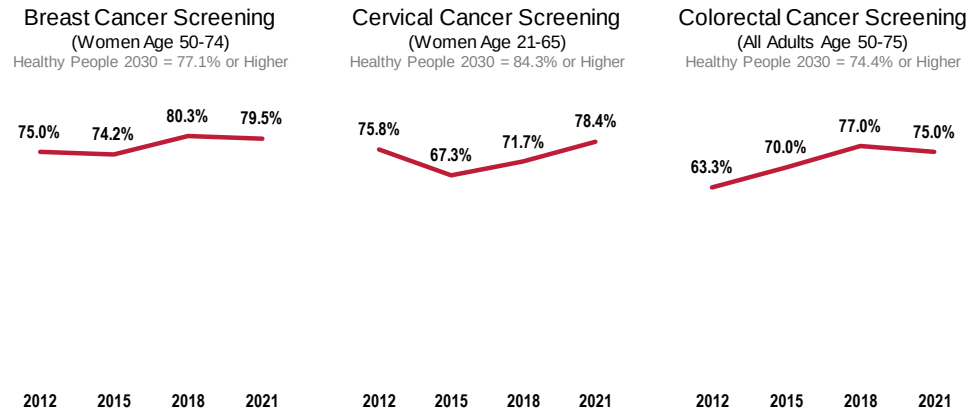
"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

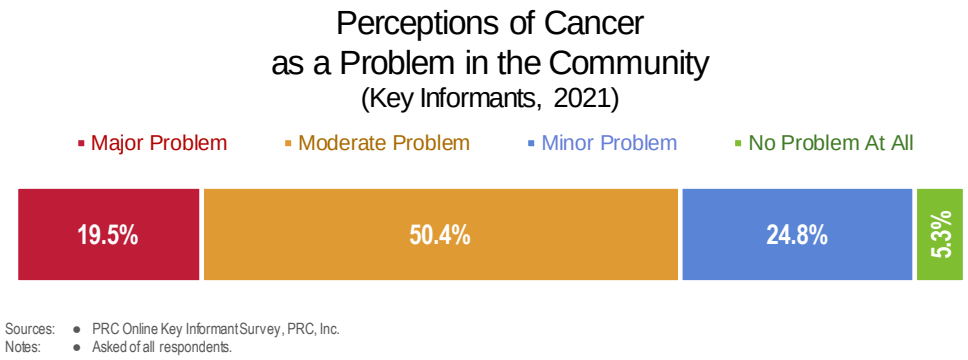


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> It is a major issue for everyone. – Social Services Provider
>
> We have many residents with it. – Community/Business Leader
>
> Cancer is a major problem as it attacks numerous individuals each day, regardless of age. In our community alone, we have had two young individuals diagnosed recently that I am aware of. – Community/Business Leader
>
> It seems that cancer is always being detected. Firefighters are at high risk of cancers though they often do not present until later in their career or after retirement. If we could find better treatments or understand the root causes we could prevent more loss of life and loss of quality of life. – Other Health Provider
>
> I know many people who have been affected by cancer. – Community/Business Leader
>
> Because so many people are passing from cancer. – Community/Business Leader
>
> About 25% of population is impacted with some type of cancer. There are a lot of GYN, colon, and breast cancers in the counties listed for this assessment. – Other Health Provider
>
> Cancer is such a devastating disease that has taken many of my family and friends. – Other Health Provider

Access to Care/Services

> Cancer services, such as Chemo, were provided in Spearfish at one time. Spearfish has not been able to provide these services for quite some time. Everyone has to drive to RC or further to receive treatment. This is a hardship for many patients, both financially and time. – Other Health Provider
>
> There is a need for treatment services at the local/community level. – Public Health Representative
>
> Large geographical area and one major cancer care facility in the region. Time, distance, and financial resources required for travel can present a significant challenge in seeking treatment. – Social Services Provider
>
> Treatment is costly and if need to travel for treatment, there are limited resources to assist with those expenses. – Social Services Provider

Contributing Factors

> Lots of cases of cancer. I think Monument Health does a good job with the resources they have. Some still go out of town for care. – Social Services Provider
>
> Lack of familiarity with diagnostics, challenges with basic access. – Community/Business Leader
>
> Many annual deaths occur due to late discovery and limited treatment options. – Community/Business Leader

Vulnerable Populations

> Rates of cancer are very high among the American Indians (primarily Lakota) who live here in Western South Dakota and their 7-year survival rates for each tumor type are the lowest of any racial/ethnic population. – Physician

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

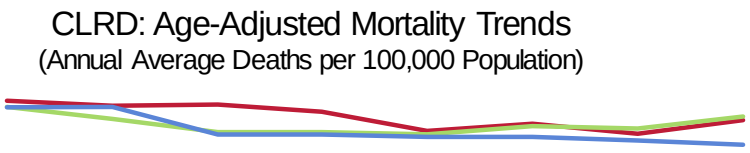
Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

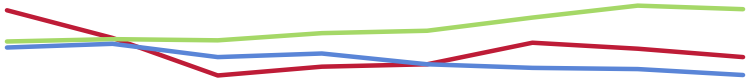
Pneumonia and influenza mortality is also illustrated.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	47.5	46.7	46.9	45.4	42.2	43.3	41.6	44.0
SD	46.4	44.1	41.9	41.8	41.5	43.0	42.4	44.7
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
Notes: ● CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	18.5	16.5	13.8	14.4	14.6	16.1	15.7	15.1
SD	16.2	16.4	16.3	16.9	17.0	18.0	18.8	18.5
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.

Prevalence of Respiratory Disease

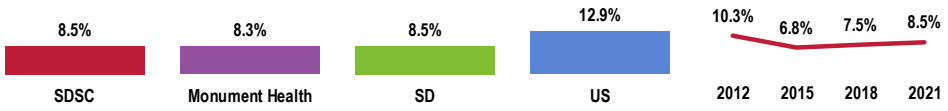
Asthma

ADULTS ► **"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?"** (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

CHILDREN ► **"Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?"** (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)

Prevalence of Asthma

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)

SDSC Service Area

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

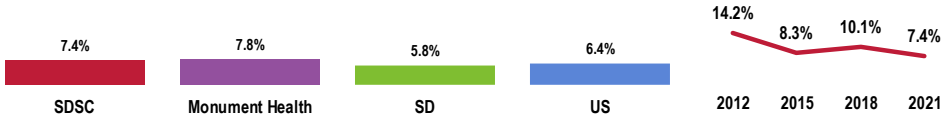
Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

SDSC Service Area

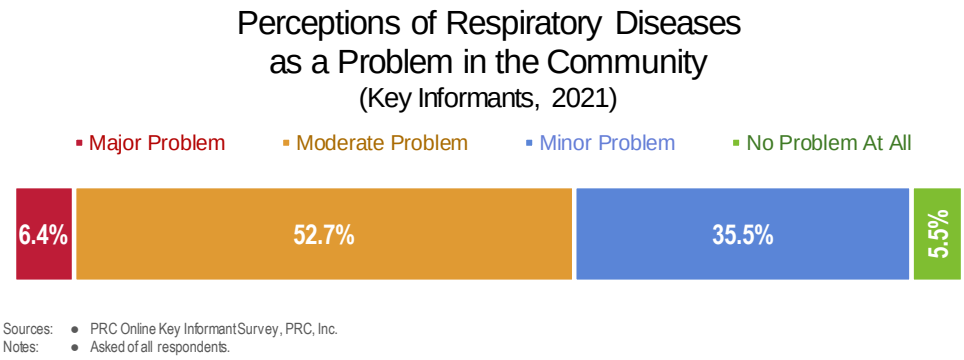


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Tobacco Use

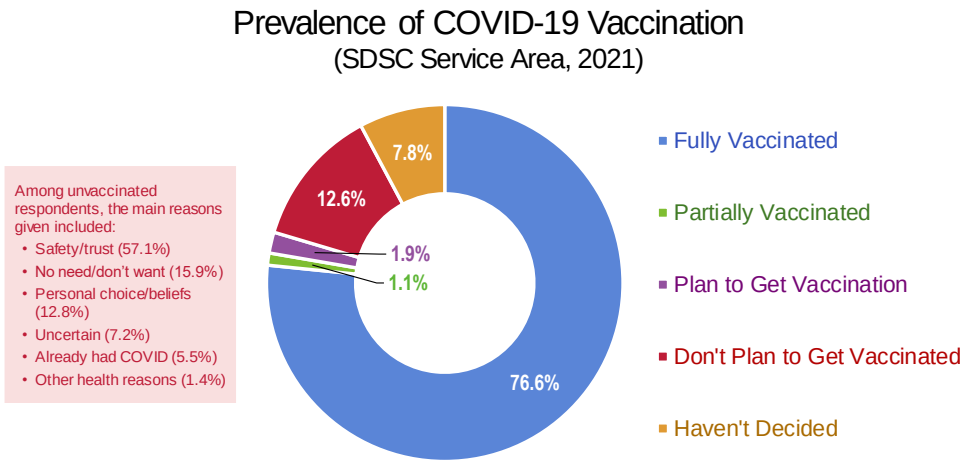
> Smoking and vaping. – Other Health Provider

Coronavirus/COVID-19

Vaccination Status

Most survey respondents are fully vaccinated against Coronavirus/COVID-19.

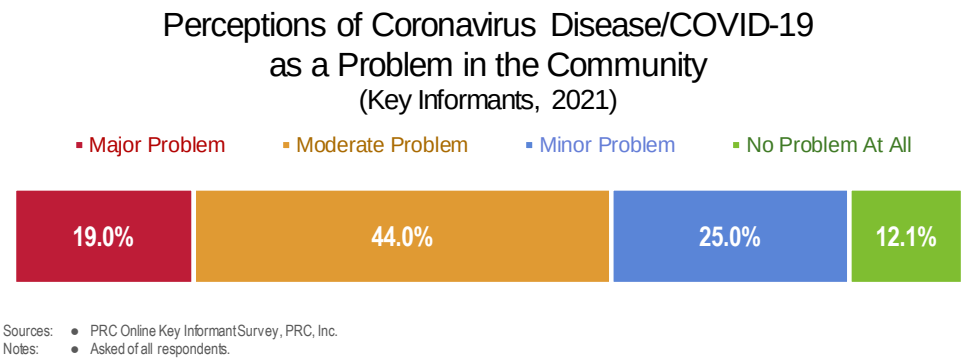
In contrast, note the prevalence of service area residents who have no plans to be vaccinated against COVID-19.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Items 328–329]
Notes: Asked of all respondents.

Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Government/Politics

> Our state leaders have politicized the COVID-19 pandemic, refused to take any action that would help prevent the spread, and continued to promote tourism and super-spreader events. – Social Services Provider
>
> Because vaccines and the wearing of masks has become a political rather than a medical issue. Our vaccination rate is low, and Monument Health has refused to partner with City, County, and State Officials to encourage vaccinations and pop-up vaccination sites. Testing rates are low, and the accuracy of the COVID numbers being released from the State DOH are viewed with skepticism by many in the local health services industry. The highly transmissible Delta Variant now accounts for over 90% of the ever-increasing daily infections nationally, and the Sturgis Rally, and other potential super spreader events are ramping up. With the discontinuation of Monument's weekly elected official call, many of us feel left in the dark regarding this serious health issue. – Community/ Business Leader
>
> The lack of state policy, protocols and safety measures creates unnecessary risk. – Public Health Representative

Contributing Factors

> Low vaccination rates compared to the US as a whole. Very few if any masking requirements with the exception of healthcare. Poor messaging from the State on what to do to prevent the spread. Access to testing has improved, but it seems very unlikely that we are testing enough to STOP outbreaks, but only to confirm cases in symptomatic individuals. – Other Health Provider
>
> COVID-19 has taken so many lives around the world, including good friends of mine. It has also been so politicized, that people are unwilling to get the vaccine, wear masks and believe the science. – Other Health Provider
>
> Isolation. Vaccinated vs anti vaccinations. – Community/Business Leader

Vaccinations

> Too many people are unvaccinated. Many people have been putting their own liberty at a higher priority than public health concerns. – Physician
>
> Lack of overall masking and vaccinations. – Social Services Provider
>
> A lot of unvaccinated people by choice. – Social Services Provider
>
> Low vaccination rates in our area. Peoples disregard for the safety of others. – Physician

Access to Care/Services

> Hospitalization numbers continue to rise. There are few resources for those needing transportation or quarantine. – Other Health Provider
>
> Access to testing and turnaround time of the testing is very limited at the local clinic. – Community/Business Leader

Incidence/Prevalence

> COVID-19 continues to be a significant issue. Hospitalizations are increasing. – Other Health Provider

Awareness/Education

> Disinformation is abundant. Science has not become political with a shortage of people willing to get the correct science and latest scientific findings to the public in very lay language. – Community/Business Leader

Prevention/Screenings

> Low rates of testing, high positivity rates, and the spreading Delta variant are all major problems in western South Dakota. – Physician

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

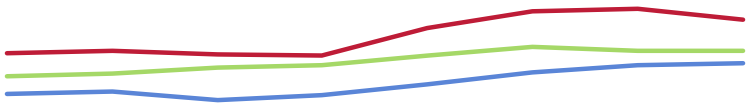
Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	51.3	51.9	51.0	50.8	57.8	61.9	62.5	59.9
SD	45.6	46.4	47.8	48.5	50.7	53.0	52.0	51.9
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

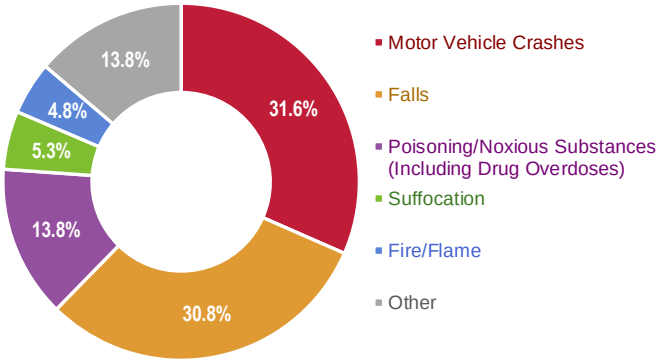
Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in the area include the following:

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading Causes of Unintentional Injury Deaths

(SDSC Service Area, 2017-2019)



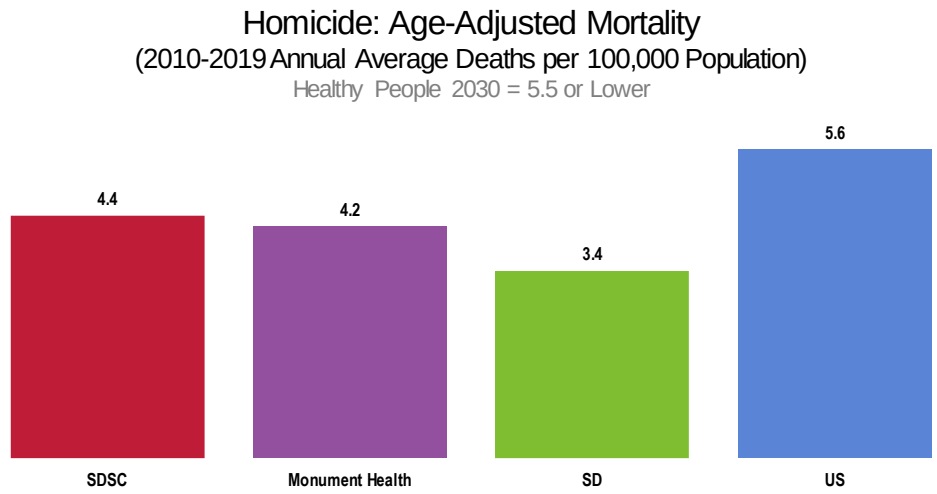
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Age-adjusted mortality attributed to homicide is shown in the following chart.

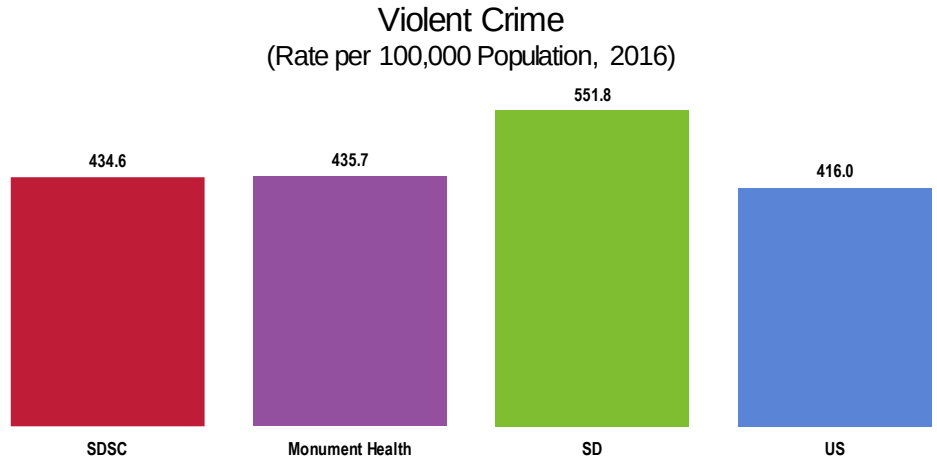


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.



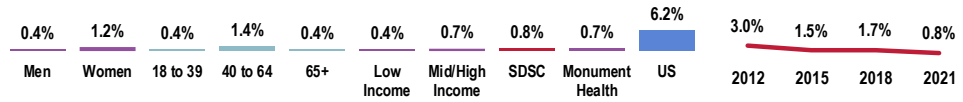
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

VIOLENT CRIME EXPERIENCE ► **"Have you been the victim of a violent crime in your area in the past 5 years?"**

Victim of a Violent Crime in the Past Five Years
(SDSC Service Area, 2021)

SDSC Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

INTIMATE PARTNER VIOLENCE ► **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**

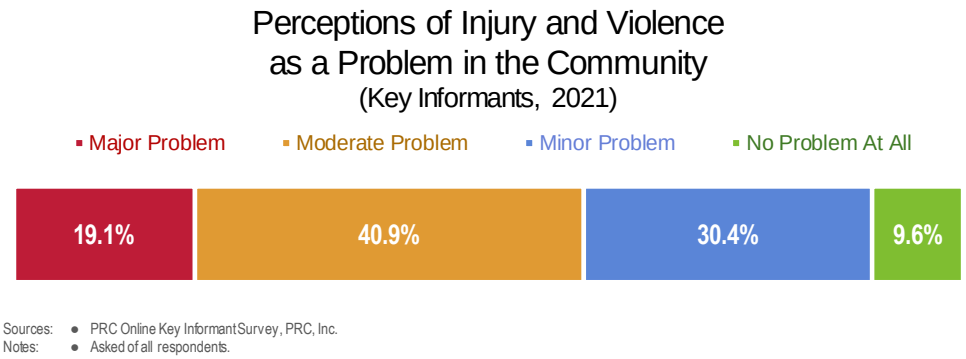
Have Ever Been Hit, Slapped, Pushed,
Kicked, or Hurt in Any Way by an Intimate Partner

SDSC Service Area

Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 39]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> I see it every day. Violent crime has exploded. – Community/Business Leader
>
> Violence is present within our patient group seeking healthcare in our hospitals. The patients are inviting violence into our hospitals and clinics, injuring our healthcare workers. – Other Health Provider
>
> A lot of violence in the community. Police and jails are busy. – Social Services Provider
>
> Vehicle accidents and water accidents seem to have been on the rise the past few years. Crime has certainly increased in the past year and with that comes injury, trauma and death. – Community/Business Leader
>
> Frequency of visit to ED. – Other Health Provider

Alcohol/Drug Use

> Many drugs and alcohol problems, leading to domestic and other violence. – Community/Business Leader
>
> There has been an increase in violence throughout the community, perhaps due to the increase in drug use/abuse. – Other Health Provider
>
> Because of alcoholism, the crime rate is magnified by a significant factor. In particular the native community has a predisposition to alcoholism, and the lack of hope tends to push so many individuals toward alcohol as means of emotional relief--the vicious cycle begins! – Community/Business Leader

Income/Poverty

> Poverty and the stress thereby derived lead to high incidents of domestic and family violence. I have seen this amplified by the recent pandemic. – Social Services Provider
>
> I think violence is often related to the desperation of living in poverty with no clear way out. – Social Services Provider
>
> There is a lot of extreme poverty in our area and this leads to a culture of poverty. Many attribute violence in the Native American population as part of their culture, but it is not. It is a culture of poverty. We also have a large homeless population, and they tend to victimize each other. – Other Health Provider

Vulnerable Populations

> Chronic homelessness in the community, a significant percentage of the population is living in terrible conditions, many of the citizens are making poor social decisions, mental health is not addressed very well on all levels not just MH and include drug and alcohol abuse. – Community/Business Leader

Contributing Factors

> I know that we have quite a few people experiencing homelessness and drug abuse. Domestic violence, as well as other types of violence, related to mental illness is often a feature of communities with homelessness and drug abuse. – Social Services Provider

Domestic/Family Violence

> Due to the family dysfunction, there is widespread violence on the community. Many violent acts are committed in the presence of children. The poor and under-educated are the primary participants. The family structure is broken, especially in Native American homes. – Community/Business Leader

Diabetes

ABOUT DIABETES

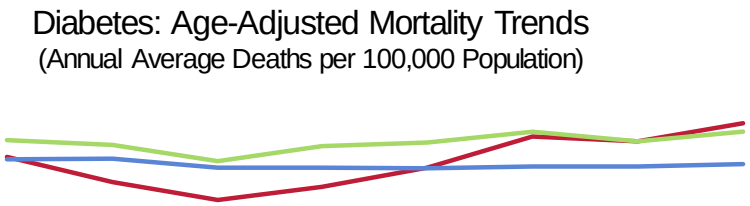
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	22.3	19.6	17.7	19.1	21.2	24.5	23.9	25.9
SD	24.1	23.5	21.8	23.4	23.8	25.0	24.0	25.0
US	22.0	22.1	21.1	21.1	21.1	21.3	21.3	21.5

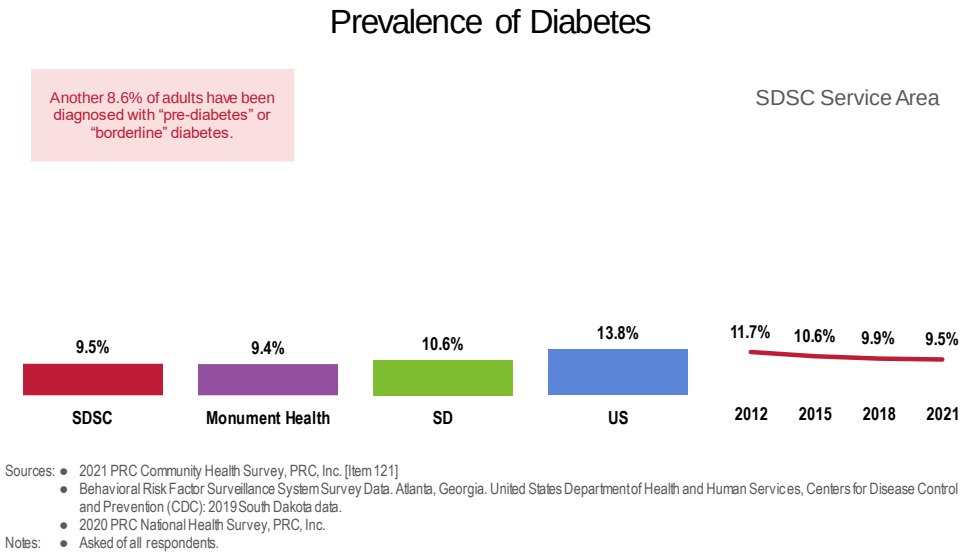
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

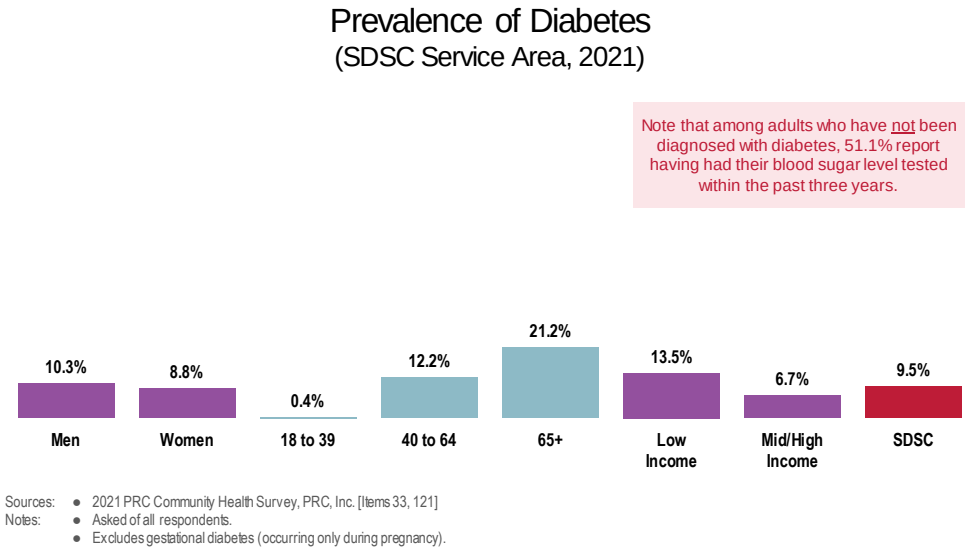
Prevalence of Diabetes

"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)**"**

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)**"**

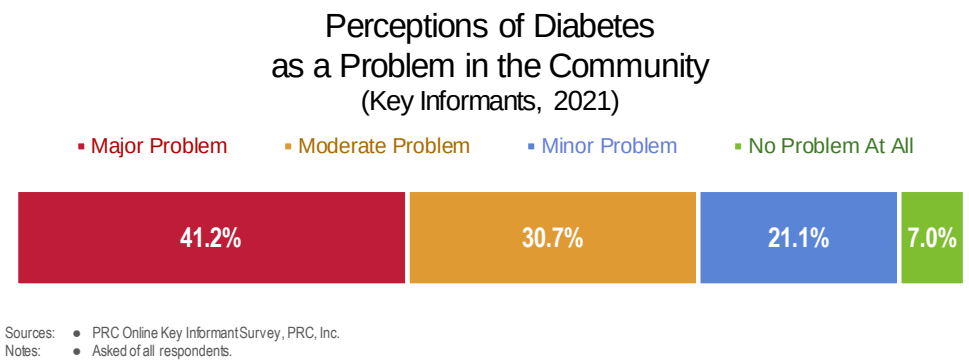
[Adults who do not have diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**





Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Economic challenges of nutrition that could prevent advancement of disease. Economic challenges of insulin supplementation. Transportation to resources for managing diseases in advanced disease. Lack of dialysis chairs. Lack of community palliative care for decision support at various transition points during disease progression. – Other Health Provider
>
> Lack of education/resources. Medication is expensive for those without insurance or under insured. From the hospital, education is set up outpatient. Attendance is difficult for people with jobs or without stable transportation. – Other Health Provider
>
> Understanding what to eat/how to exercise to prevent it and having access to better quality food. – Social Services Provider
>
> Education, access to nutritional services, access to affordable medication. – Other Health Provider
>
> Compliance due to lack of proper nutrition (many of whom may be without resources to proper nutrition), exercise, education, medication regime, and personal motivation. – Other Health Provider
>
> Diet and weight control. Alcohol abuse as well. – Community/Business Leader
>
> Finding the motivation to get physical activity throughout the day and understanding that little changes will make a huge difference. Sadly, our food industry also contributes as unhealthy food and deceiving market don't help people to make the easy, healthy and affordable choice. – Community/Business Leader
>
> Obesity coupled with physical inactivity are major risk factors for adult-onset diabetes mellitus. – Physician
>
> Affordability of medications, healthy food, and access to eye and dental care. – Other Health Provider
>
> Obesity from lack of appropriate nutrition. May be health inequities in access to healthy foods, accessible health care, and public health education. The lack of proper diet may be caused by many factors such as education, low income results in convenience store diet rather than grocery store diet; general lack of healthy lifestyle (may be due to lack of public space activities); housing costs are high resulting in less disposable income for preventative care and healthy foods. Also, public health statistics show higher rate of diabetes in reservation population – likely due to genetics and lack of healthy lifestyle. – Other Health Provider
>
> Increasing number of patients with diabetes diagnosis without commiserate resource (meds, equipment) support. – Other Health Provider
>
> Access to services, follow through with care, proper nutrition, affordable food/supplies. – Other Health Provider
>
> Gaps in insurance coverage that lead to patients skimping/skipping meds to save money. For our unhoused population – poor/no access to refrigeration for insulin, poor access to healthcare, poor access to healthy food options, food desert in North Rapid City. – Other Health Provider

Affordable Healthy Food

> Access to prevention of Type II when monetary restrictions limit the types of food people can purchase. – Social Services Provider
>
> Individuals in poverty who have diabetes face challenges in affording healthy foods, which are more expensive than less nutritious foods. – Social Services Provider
>
> Access to healthy foods. – Community/Business Leader
>
> Convenience and cost of unhealthy foods. – Other Health Provider
>
> Access to affordable nourishing foods. – Social Services Provider

Awareness/Education

> Not knowing. – Community/Business Leader

> Understanding the disease and controlling it with diet, exercise and medication. Diabetes has ravaged the Native American population, there are so many overweight people in our society and not enough outreach programs. – Other Health Provider
>
> Lack of training on healthy eating and weight control. – Community/Business Leader
>
> Patient follow through, amount of education available at the hospital. – Social Services Provider

Vulnerable Populations

> Lower income and homeless populations do not have access to medications, equipment or healthy nutrition items (too much cost). – Other Health Provider
>
> Diabetes is a huge issue, especially among Native Americans. Discussions on how to prevent and treat diabetes are needed. – Community/Business Leader
>
> Native Americans who are predisposed to diabetes do not take it seriously. Unhealthy lifestyles plus diabetes lead to a short lifespan. Plus, unhealthy lifestyles can lead to type 2 diabetes in a larger portion of the population. – Community/Business Leader

Nutrition

> The amount of sugar in the food supply. I am not sure how we keep people healthy when it is a challenge to find food that is not loaded with sugar and if it doesn't have sugar, it costs more. – Social Services Provider
>
> Need healthier diet and more movement in their daily lives. – Social Services Provider
>
> Eating healthy food or making appropriate food choices. – Other Health Provider
>
> Not much sugar free food available and hard to get good fruit and veggies. – Community/Business Leader

Lifestyle

> Noncompliance with treatment. – Other Health Provider
>
> Lifestyle choices that lead to diabetes is generally all preventable. – Social Services Provider
>
> Getting help and making needed lifestyle changes. – Other Health Provider

Access to Care/Services

> Must travel for continued treatment, i.e. dialysis. – Community/Business Leader

Affordable Medications/Supplies

> Cost of insulin and insurance coverage to support diabetic supplies. – Other Health Provider

Kidney Disease

ABOUT KIDNEY DISEASE

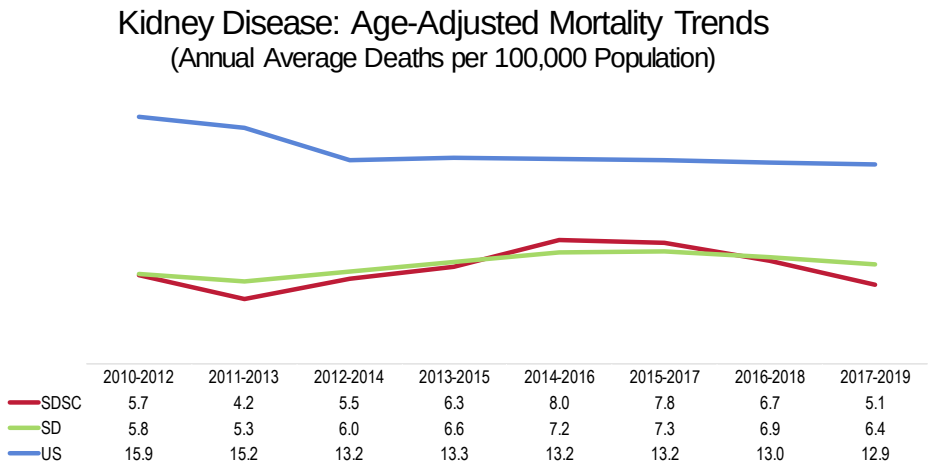
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.

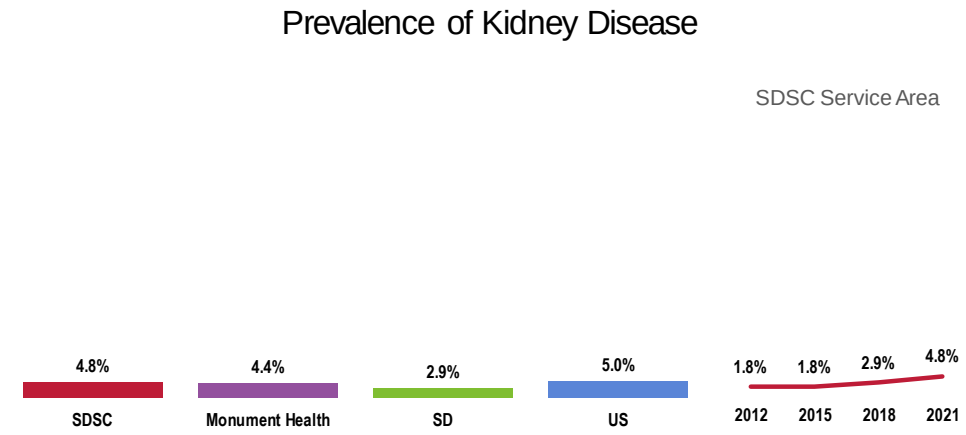


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	5.7	4.2	5.5	6.3	8.0	7.8	6.7	5.1
SD	5.8	5.3	6.0	6.6	7.2	7.3	6.9	6.4
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

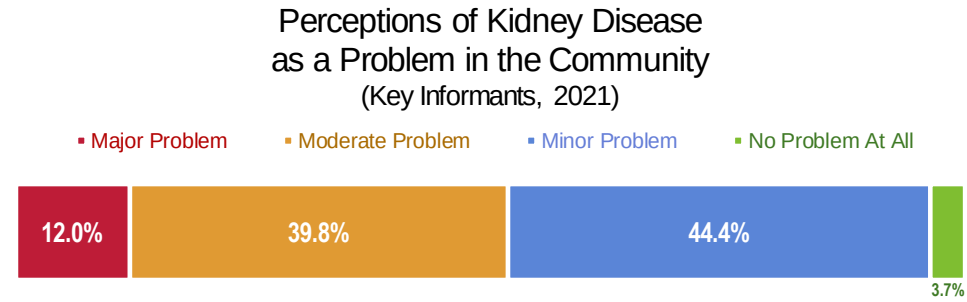


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Kidney Disease* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Seems to be insufficient dialysis beds. Also, get patients transferred to ED who have missed dialysis for varying reasons. – Other Health Provider
>
> Hemodialysis units are at capacity and unable to admit new patients. – Other Health Provider

Co-Occurrences

> High blood pressure and diabetes result in kidney failure. Poor health status relating to obesity and unhealthy diet. – Other Health Provider
>
> We have very high rates of diabetes, which is one of the leading causes of kidney failure. The number of dialysis patients continues to rise across the nation. – Other Health Provider

Aging Population

> We have an aging population with a higher need for treatment. – Community/Business Leader

Incidence/Prevalence

> Need for dialysis services is growing. – Other Health Provider

Vulnerable Populations

> High Native American population with undertreated medical issues. Shortage of dialysis availability. – Other Health Provider

Potentially Disabling Conditions

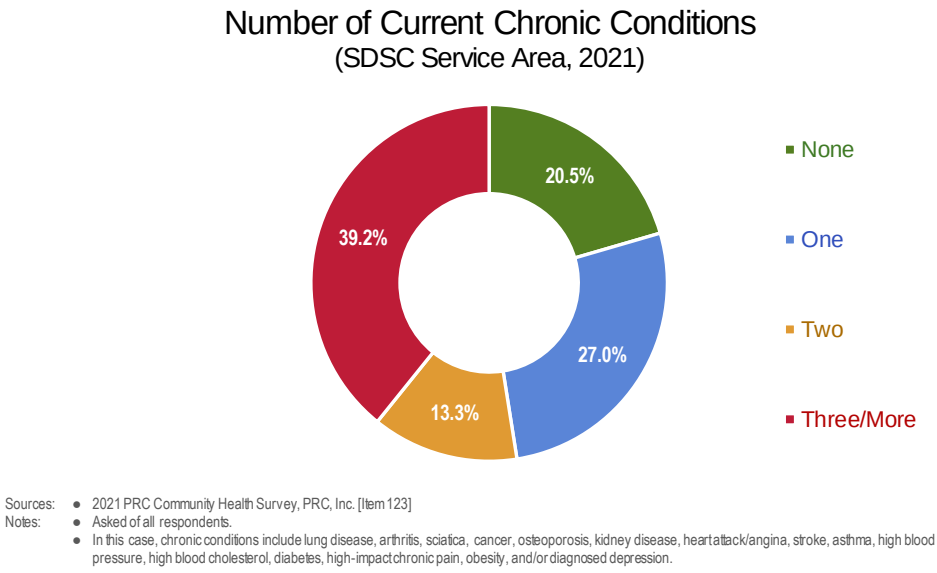
Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

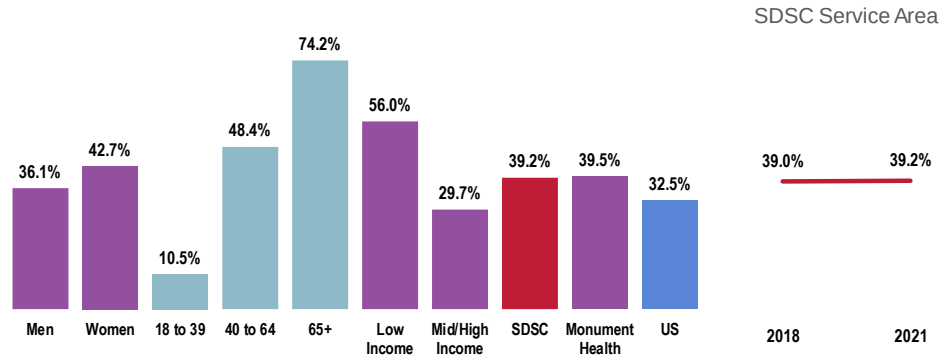
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(SDSC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

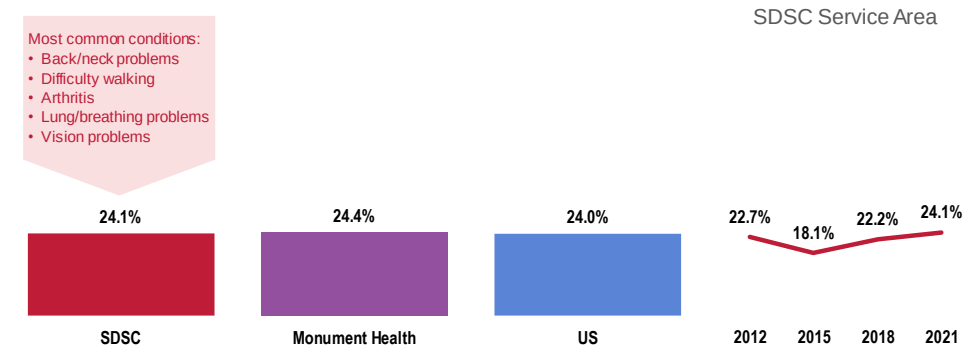
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

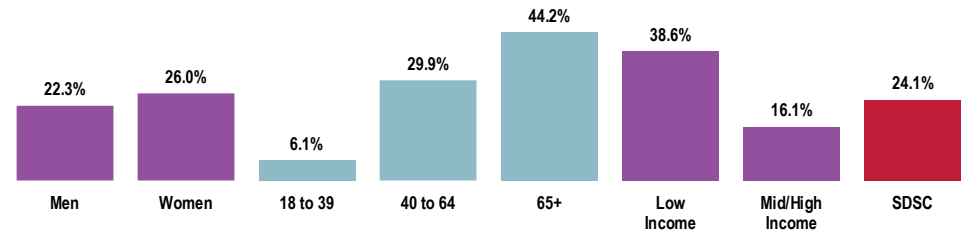
[Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(SDSC Service Area, 2021)

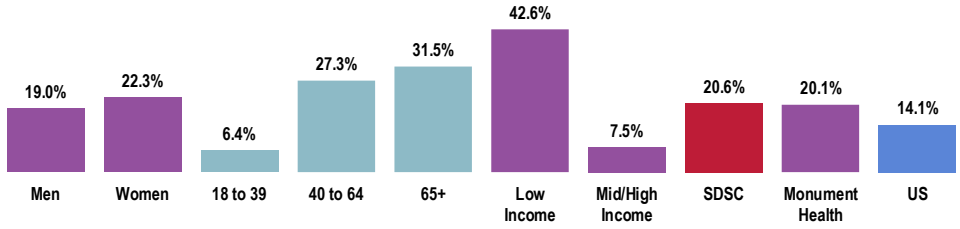


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: ● Asked of all respondents.

High-Impact Chronic Pain

"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(SDSC Service Area, 2021)
Healthy People 2030 = 7.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

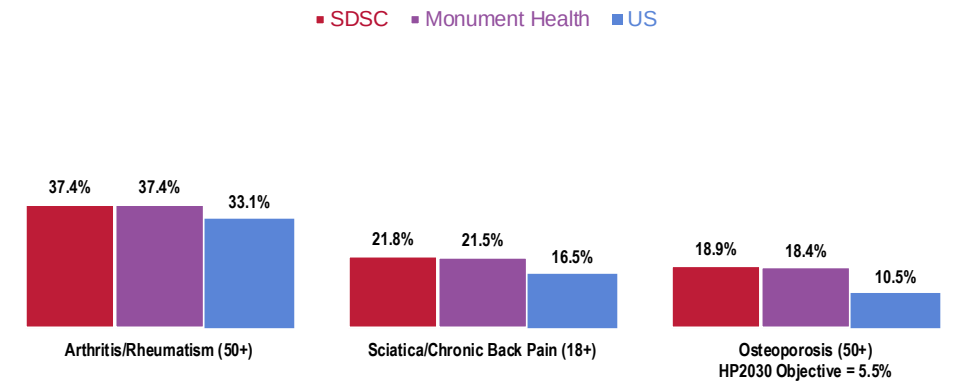
Arthritis, Osteoporosis & Sciatica

"Have you ever suffered or been diagnosed with arthritis or rheumatism?" (Reported here among adults age 50+.)

"Have you ever suffered or been diagnosed with osteoporosis?" (Reported here among adults age 50+.)

"Have you ever suffered or been diagnosed with sciatica or chronic back pain?" (Reported here among all survey respondents.)

Prevalence of Potentially Disabling Conditions
(2021)

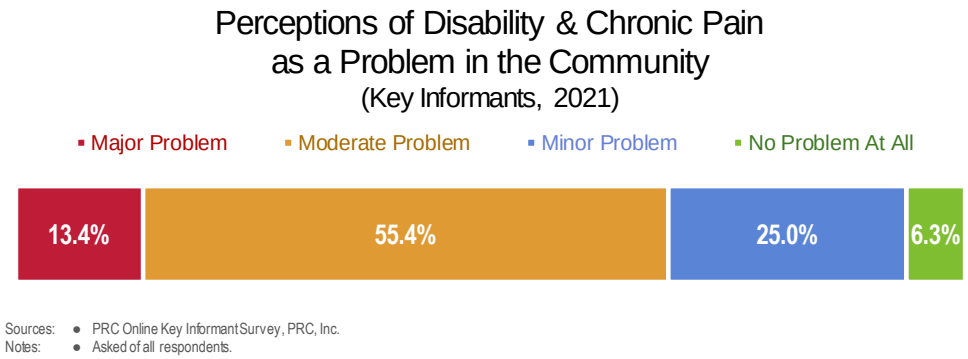


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 156-157, 316]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Vulnerable Populations

> Veteran and other at-risk populations. – Community/Business Leader
>
> There is a high threshold of diabetes in this area, especially with the Native American population. Many of them have joint issues and seeing them walk is painful and they express that it is painful. – Social Services Provider

Eye Care

> There are few resources for individuals who are suffering from vision disability. If you cannot afford an eye exam and glasses, outside of Northern Plains Eye Foundation there are few resources available. – Social Services Provider

Contributing Factors

> Symptoms often treated to manage while root causes ignored. Leads to financial and mental health issues, exacerbating issues in the community. – Other Health Provider

Incidence/Prevalence

> We see many patients in the ED with chronic pain issues. – Other Health Provider

Insufficient Physical Activity

> We see a constant flow of people with pain issues or disabilities and often they don't realize that movement often helps lessen or alleviate the pain, even just for short term relief. Witnessing people in stores, parking lots, at city and school functions, you can see the limitations or struggles. – Community/Business Leader

Quality of Life

> Hearing, audiology, aids, impacts individuals through the lifespan. – Social Services Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

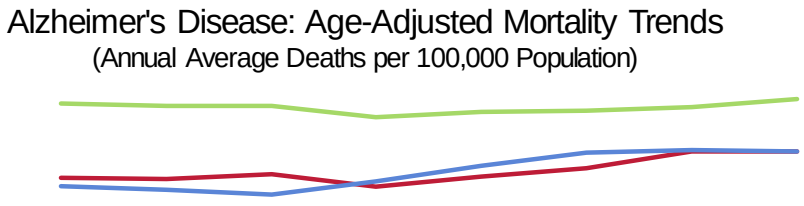
Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart.

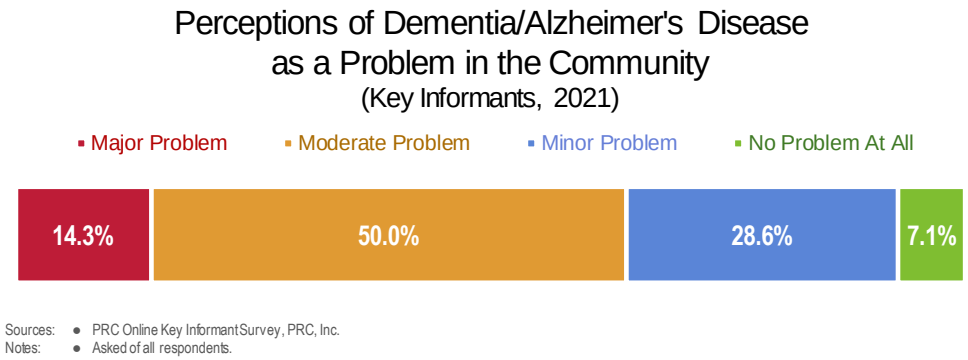


	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	26.7	26.4	27.1	25.4	26.8	28.0	30.4	30.4
SD	37.3	37.0	36.8	35.3	36.0	36.3	36.8	37.9
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.

Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Not many care instructions who will accept these folks who are disruptive. Not much training given to caregivers as to how to help these clients. Very little support for family members. – Other Health Provider
>
> A large percentage of our population is elderly, which is a risk factor for dementia. People with dementia are at high risk for self-neglect and financial exploitation. In the moderate to advanced stages they need 24-hour supervision and help with basic activities of daily living. We have limited resources for diagnostic testing and for educating family caregivers to help delay the need for institutional placement, and limited respite options for caregivers. – Physician
>
> Our population base is older than the average age many communities this size, there is limited resources for diagnosis and treatment. – Community/Business Leader
>
> There is a lack of resources for families and the aging population is growing. – Public Health Representative

Access to Care/Services

> Limited options for in-home and long-term care, secure units and affordable caregivers to assist families if the patient is to stay in-home. – Other Health Provider
>
> Where do people go to receive resources? Most have to send their loved ones with these diseases out of town and out of state for good, quality care. – Social Services Provider
>
> Lack of memory care facilities and resources. – Social Services Provider

Incidence/Prevalence

> Growing number of people struggling with this. Monument West is not taking Alzheimer's patients anymore, which is a detriment to the community. Need an Alzheimer/dementia wing. – Social Services Provider
>
> As the population ages, it has become more prevalent. – Community/Business Leader

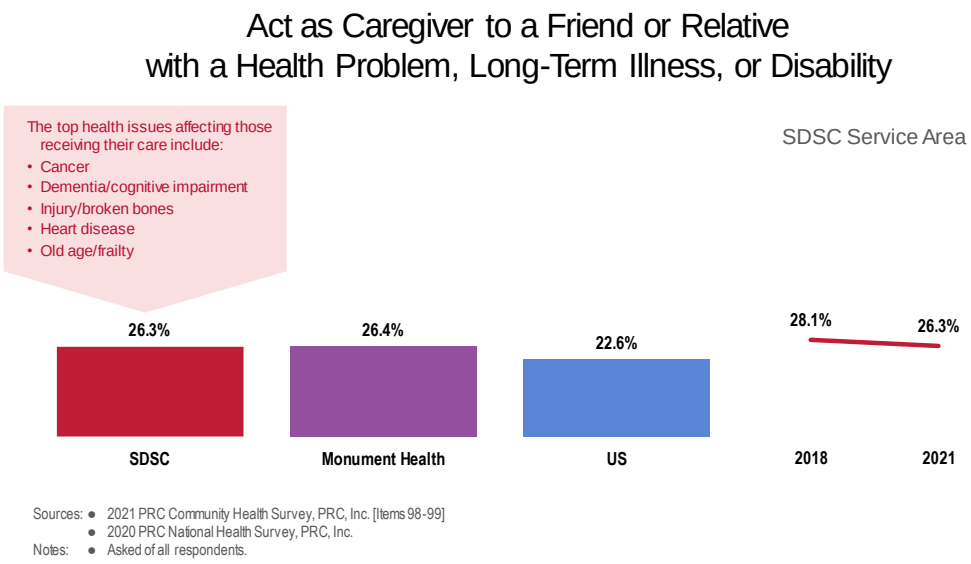
Aging Population

> We have an aging community. The 65+ age group is growing faster than other age groups in our region over the next 10 years. – Other Health Provider

Caregiving

"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

[Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 98-99]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

INFANT HEALTH

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

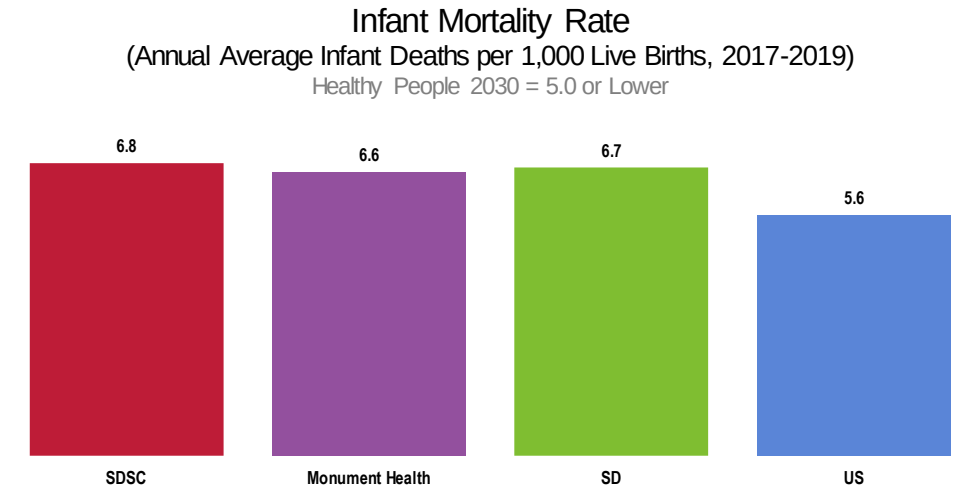
Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births
(Percent of Live Births, 2013-2019)

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted October 2021.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Family Planning

ABOUT FAMILY PLANNING

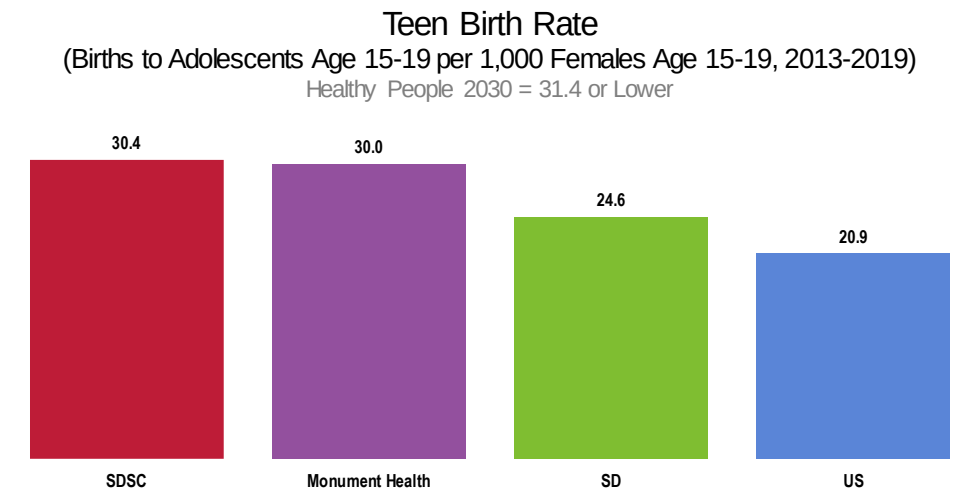
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years.

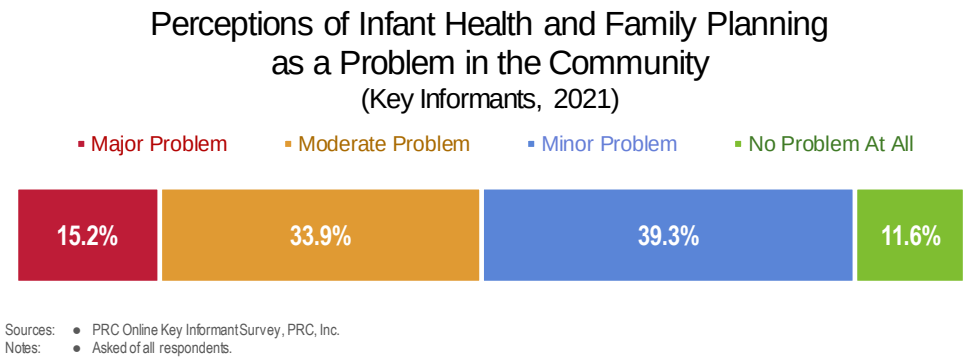


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Many pregnancies among young, single and unemployed residents. No pediatric care available in the county. – Community/Business Leader
>
> At-risk communities and rising abuse and neglect cases. – Community/Business Leader
>
> Many mothers from the reservations do not participate in prenatal care. Drug abuse among pregnant women. – Other Health Provider
>
> The poor and uneducated procreate as an alternative to birth control. There are thousands of unwanted children in our community, who are born to unfit and irresponsible (single) parent(s). PLUS, many infants/toddlers/children are raising themselves, which only adds to the problem. – Community/Business Leader
>
> Patient follow through is often poor, reasons patients have given include transportation, no health insurance (patient not applying for Medicaid), cultural reasons to not pursue prenatal care, having to travel out of town for pediatric specialists. – Social Services Provider

Incidence/Prevalence

> I hear about the challenges related to this topic from people who work in the field. – Social Services Provider
>
> At risk (variety of risks) children on the rise. – Other Health Provider
>
> We have a lot of young families. – Community/Business Leader

Access to Care/Services

> No local resources. – Community/Business Leader
>
> Very little access to services like Planned Parenthood. – Social Services Provider

Single Parent Families

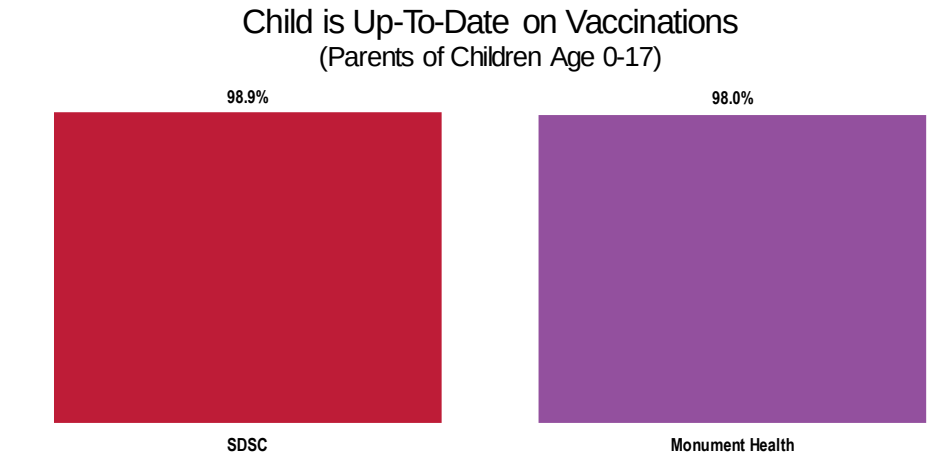
> Outcomes for infant health is poor in this area of the state. Too many children born in one parent families who are not able/ready to care for an infant. – Social Services Provider

Alcohol/Drug Use

> I see people engaging in unhealthy behaviors when pregnant or around infants, such as smoking, drinking, and drug use. – Social Services Provider

Childhood Vaccinations

"To the best of your knowledge, is this child currently up-to-date on (his/her) childhood immunizations?"



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 331]
Notes: ● Asked of all respondents with children 0 to 17 in the household.

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

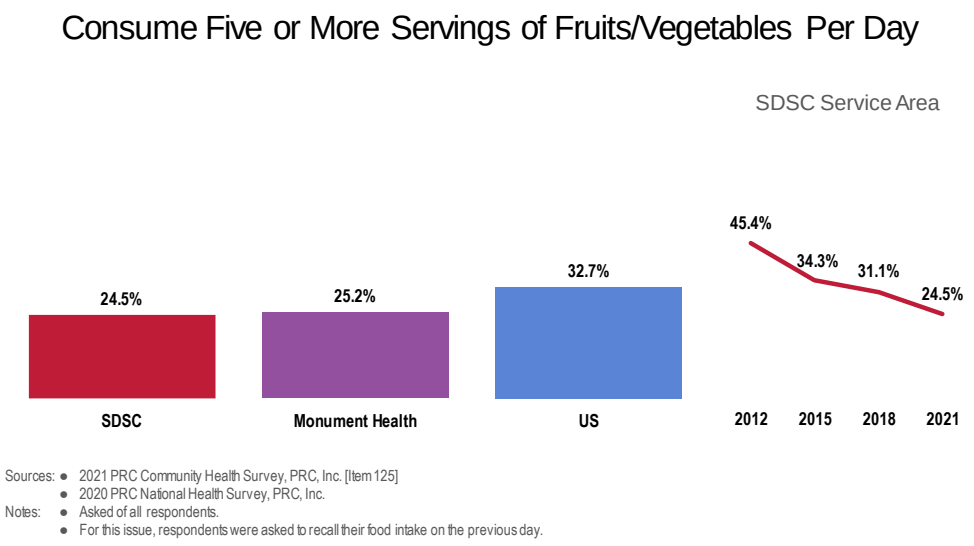
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.



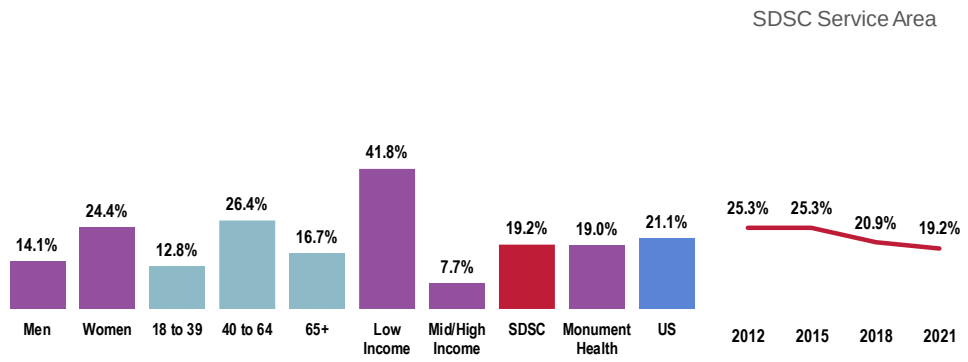
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(SDSC Service Area, 2021)

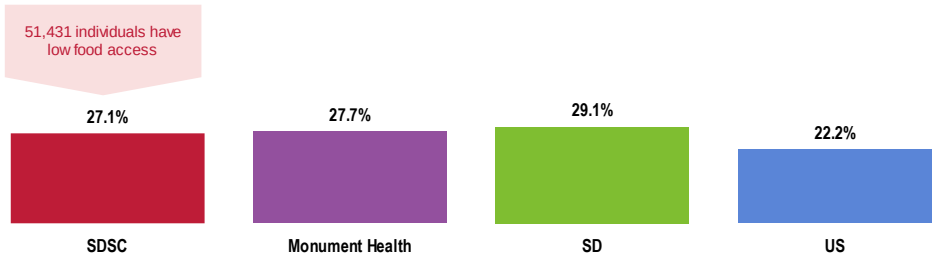


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

ABOUT PHYSICAL ACTIVITY

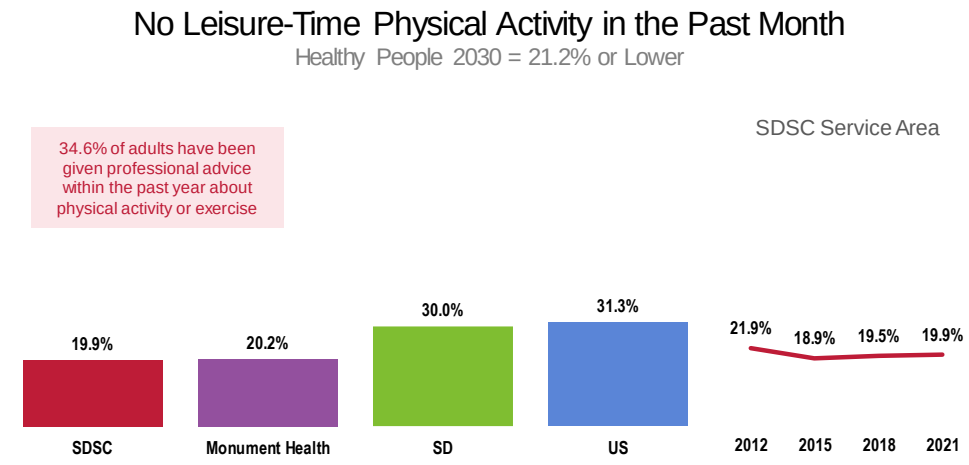
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 82, 313]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

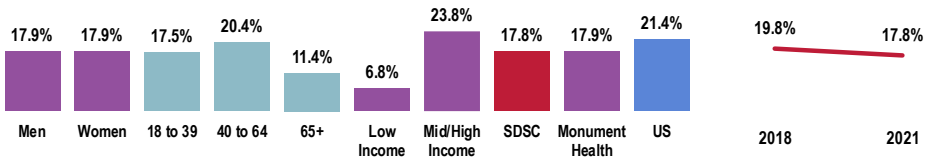
"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations
(SDSC Service Area, 2021)
Healthy People 2030 = 28.4% or Higher

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

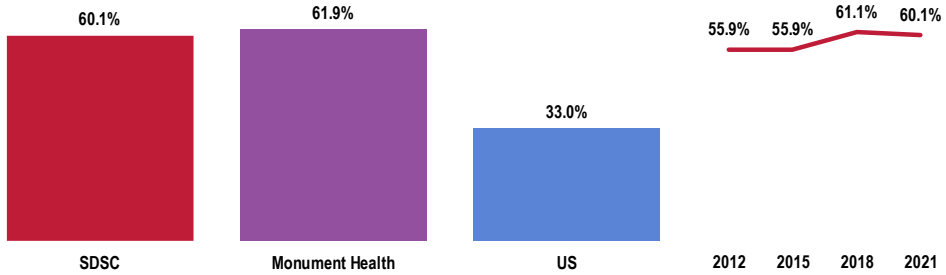
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

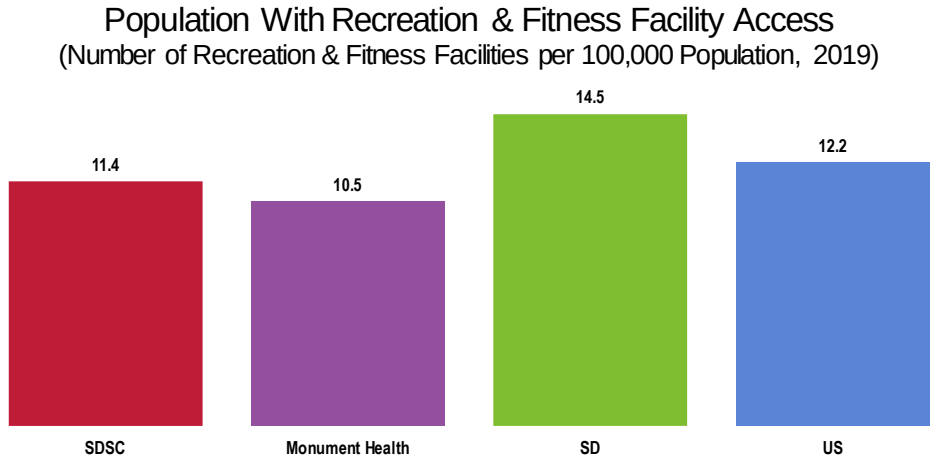
Notes:
- Asked of all respondents with children age 2-17 at home.
- *MHCH data reflects a sample size of <50.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

The following details the number of recreational/fitness facilities for every 100,000 population.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940, which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

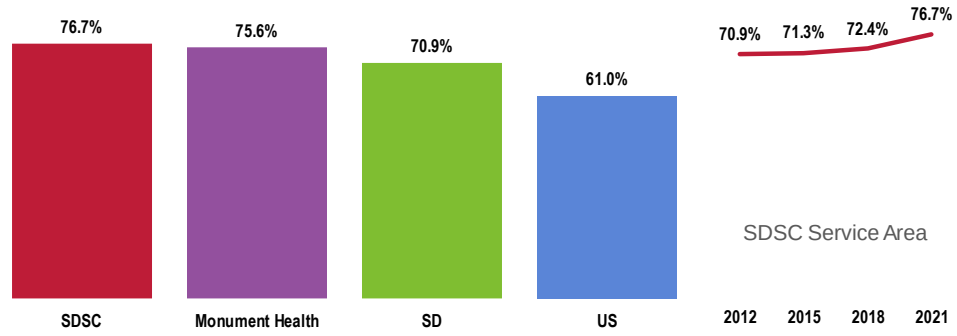
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

"About how much do you weigh without shoes?"

"About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)



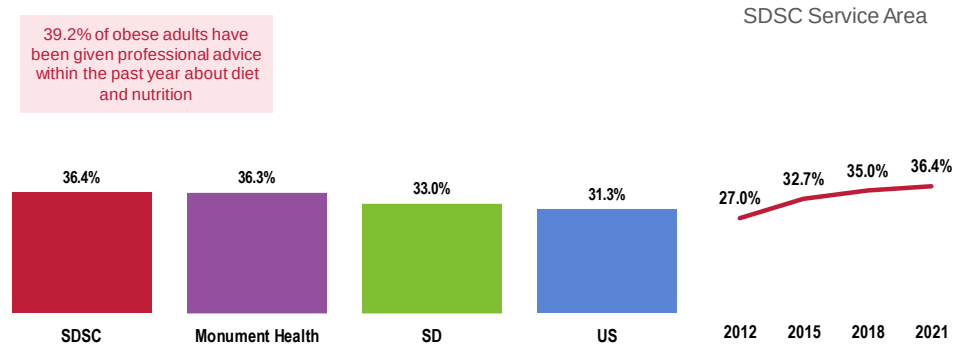
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

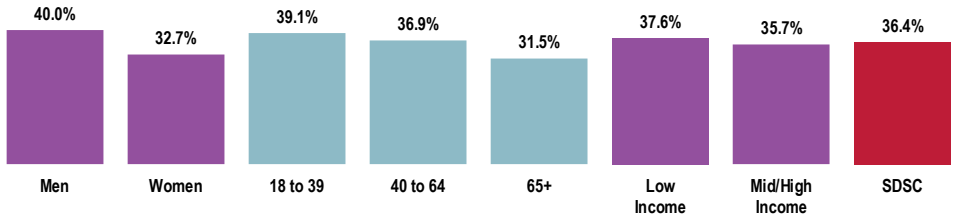
39.2% of obese adults have been given professional advice within the past year about diet and nutrition



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 128, 312]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(SDSC Service Area, 2021)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

  – Centers for Disease Control and Prevention

Children's Weight Status

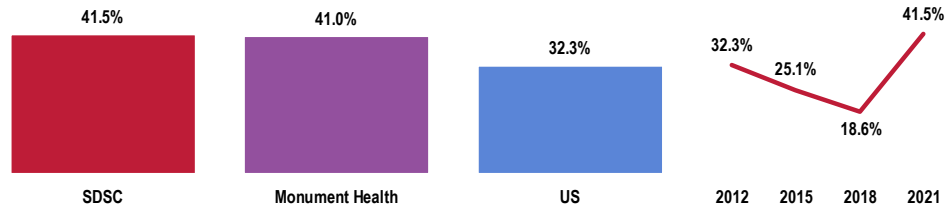
The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

"How much does this child weigh without shoes?"

"About how tall is this child?"

Prevalence of Overweight in Children
(Parents of Children Age 5-17)

SDSC Service Area



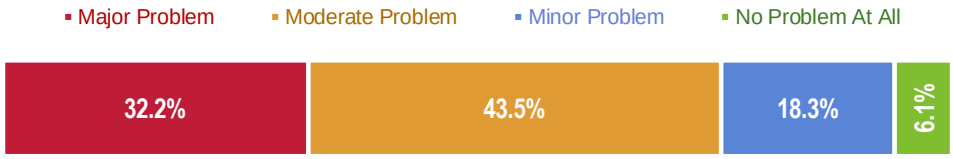
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2021)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> There are quite a few food deserts where people don't have easy access to inexpensive fresh foods. Also, Western South Dakota communities are not very walkable, and there's virtually no public transportation, so people have to rely on their own cars to get around, which means they often don't have a chance to walk to get from place to place. – Social Services Provider
>
> Access to affordable nourishing foods and education on how to prepare/cook. The education piece of this is hard to get people to engage in. – Social Services Provider
>
> Diet, affordable healthy food options, time for physical activity. – Community/Business Leader
>
> A huge challenge for low-income families is access to affordable nutritious fresh foods. A diet of less nutritious prepared foods and fast food contributes to obesity. Children and families in Rapid City's low-income census tracts generally don't have safe places near their homes to engage in outdoor activities. – Social Services Provider
>
> I always worry about adequate nutrition. We see diet related illness and diseases. Financial limitations are big, as well as housing or the ability to prepare healthy meals for the family. We have patients who live in hotels with just a microwave. – Other Health Provider

Food insecurity. Emergency lodging insecurity. – Other Health Provider

The large amount of food available that is not good for you. The cost of and access to healthy food. The cost of gyms or trainers to help guide a person to a better tomorrow. The embarrassment of gaining weight. – Other Health Provider

Nutrition, physical activity and weight, risk factors for all chronic conditions and major impact on mental health. Improving nutrition, physical activity and weight would prevent and improve chronic conditions. Also, would help mental health. – Other Health Provider

The lack of good nutrition, physical activity and weight make for an unhealthy population. The challenges are education, providing access to nutritional food, and creating healthy indoor and outdoor physical activities in a safe and free environment. Other challenge is to empower population to take responsibility for their health and enable them with appropriate resources to make sustainable change – Other Health Provider

People sit too much! Realizing that daily movement is vital. We need to have communities that provide easy choices for people. Continue to build, improve on and expand bike paths and parks. Promote and support local rec centers and fitness centers. The food industry needs to help people by providing healthy, real, food choices that are actual food that provides the nutrients needed. Everyone looks around and feels "normal" as most people look like them, however, "most" people are sadly overweight or obese, but people don't realize they are part of this classification. – Community/Business Leader

Too much inactivity with a lot of it stemming from things like depression. Good foods are more expensive, resulting in people buying the cheapest foods, which lead to things like weight gain. This is often driven by poor wages. – Community/Business Leader

People are living more sedentary lifestyles. Cost of nutritious food. Cost of gym memberships/activity programs. – Other Health Provider

Education about healthy choices, access to health food and cost of health food. – Other Health Provider

Access and affordability for healthy, quality foods and gyms/workout centers. Food deserts. – Community/Business Leader

No coordination between WIC and PCP office. Taking PE out of school. No real knowledge of good nutrition. – Physician

Obesity rate greater than 30% for community. Some people are challenged economically to purchase nutritious foods. Geographic barriers also occur (example, people having to drive 2 hrs to Rapid City from Pine Ridge as there are few or no food purchasing options outside of the scarce convenience store). – Other Health Provider

Poor role modeling for healthy habits, extreme weather leading people to spend more time indoors, nutritious food being too expensive, high stress levels leading people to seek convenience foods, Native Americans being over represented in numbers of people living in poverty while also being more susceptible to the deleterious effects of high carb junk food – Other Health Provider

Lifestyle

Stress chemicals in the populations we deal with often lead to weight gain. – Social Services Provider

Personal choices, lack of time, motivation, cost of programs that could help, education. – Social Services Provider

Personal hygiene and life skills pertaining to healthy lifestyle. – Community/Business Leader

Lack of desire to live a healthy lifestyle. Many have food stamps, but don't always buy the best food. Many do not partake in physical activity. Some have physical limitations and can't. All the above lead to obesity in our community. – Social Services Provider

Work-Related

Our service economy here in western South Dakota features low-paying wages and little access to benefits. These things combine to reduce leisure time activity and nutrition, which are keys to maintaining an ideal body weight. – Physician

Access to Affordable Healthy Food

Access to healthy foods. – Community/Business Leader

Financial and convenience of processed and unhealthy foods. – Other Health Provider

Nutrition

Fast food. – Community/Business Leader

Unhealthy food. Unhealthy habits. Unhealthy culture. Many people are at high risk of diseases related to poor nutrition, activity and weight. – Community/Business Leader

Awareness/Education

Poor understanding of health risks associated with poor nutrition, lack of physical activity and weight management. – Other Health Provider

Access to Care/Services

> Access to health care, access to health and affordable food. – Other Health Provider

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

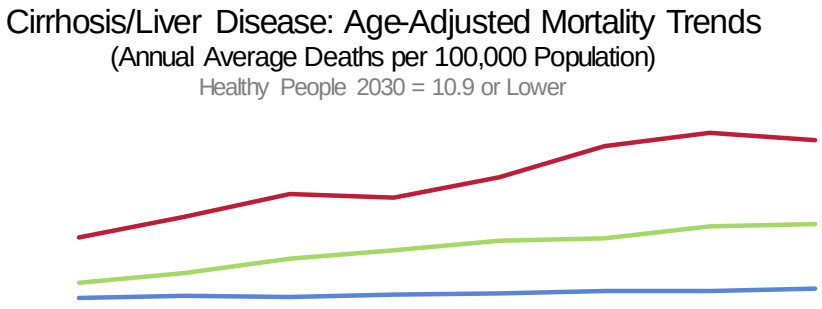
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the area.



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	16.6	18.8	21.3	20.9	23.0	26.4	27.8	27.0
SD	11.7	12.8	14.4	15.3	16.3	16.6	17.8	18.0
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

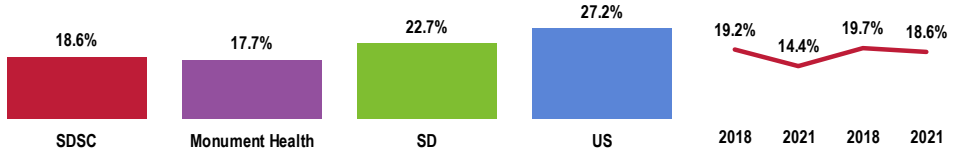
"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive Drinkers

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

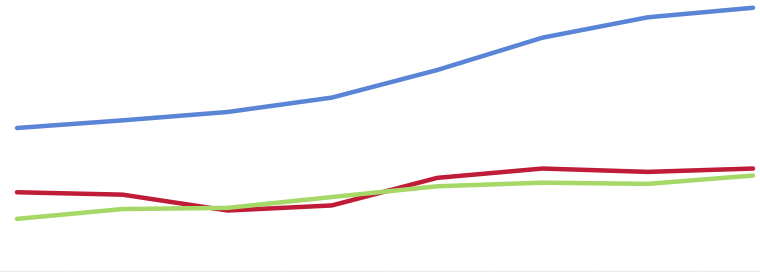
Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-related deaths.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
SDSC	5.6	5.4	4.3	4.7	6.6	7.3	7.1	7.3
SD	3.7	4.4	4.5	5.3	6.0	6.3	6.2	6.8
US	10.2	10.7	11.3	12.4	14.3	16.7	18.1	18.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2021.

Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month
Healthy People 2030 = 12.0% or Lower

SDSC Service Area

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

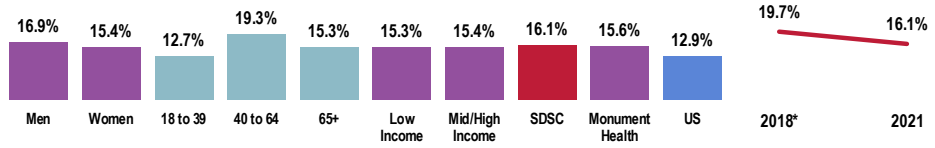
Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- *The 2018 survey question specified that the prescription opioids did not need to have been prescribed by a physician, while the 2021 question did not.

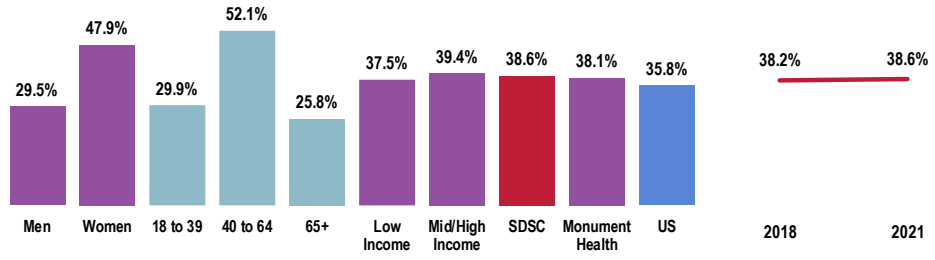
Personal Impact From Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(SDSC Service Area, 2021)

SDSC Service Area

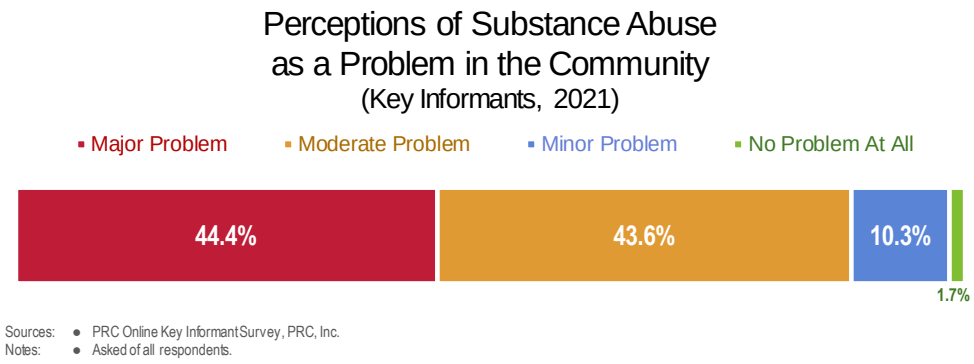


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Access to care. – Other Health Provider

Lack of services, no inpatient treatment available that I am aware of. – Other Health Provider

Few options/beds available. – Social Services Provider

There is a lack of long term, coexisting treatment services, both inpatient and outpatient. – Public Health Representative

Access to services. – Social Services Provider

Not enough treatment options, especially outpatient treatment options that allow individuals to keep jobs and/or participate in family. – Other Health Provider

Location. Skill set of providers. – Other Health Provider

Access and affordability. – Community/Business Leader

Large problem and few resources. – Other Health Provider

Distance to treatment. – Community/Business Leader

There are no known outreach programs or treatment options. – Community/Business Leader

Lack of appropriate facilities. – Community/Business Leader

No facilities for treatment and in the case of private facilities, little financial assistance to provide for those who cannot afford to pay for treatment. – Social Services Provider

Location. – Community/Business Leader

Cost. Transportation. – Other Health Provider

Lack of availability for a large number of patients requiring substance abuse. We do have a number of treatment centers, but again, cost can be limiting for some folks. – Other Health Provider

Lack of providers. – Social Services Provider

Contributing Factors

Location. I could not tell you where, other than Behavioral Health, where someone could go for help. Education. Much more information needs to be available to everyone. Stigma. People trying to cover it up because they do not want to be labeled. – Other Health Provider

There is a shortage of experts. Those that are in this career field have an overwhelming caseload. Plus, most likely, from my observations the wages are very low. – Community/Business Leader

Denial, funding, stigma. – Social Services Provider

A general belief that treatment usually does not work; Deep and hard-to-address generational trauma and grief in the Native American community; lack of culturally relevant treatment programs; general distrust of the medical system by Native Americans; Lack of knowledge about treatment options; many people who are uninsured and do not have primary care providers; large gaps in insurance options for people who make too little money to qualify for the affordable care act but do not meet the narrow criteria for Medicaid eligibility – Other Health Provider

Cost, location, family support. – Community/Business Leader

> Non-supportive family and friends. Lack of court-ordered treatment. – Community/Business Leader
>
> The stigma of substance abuse, availability of treatment and poverty. – Other Health Provider

Lifestyle

> Patient choice or willingness to seek help, patient not wanting to quit using or not ready for treatment. – Social Services Provider
>
> There are treatment beds available, but those going through treatment have to want to use skills/tools they learn in treatment to improve their lives. Individual motivation is a must and not going back to the same environment. – Social Services Provider
>
> I think one barrier is the nature of addiction, you have to want to quit. – Social Services Provider

Denial/Stigma

> The stigmatization of those with substance abuse and addictions, to say nothing of the very limited treatment options that exist, especially in rural areas. – Physician
>
> Denial or willingness to get help. Stigma associated with substance abuse. Lack of knowledge. – Other Health Provider

Work-Related

> Work is really hard and often needed outside of M–F / 8–5 hours, making it harder for people to want to go into this profession. Hard for providers to have work-life balance. Funding rates are disproportionately higher using Medicaid and charity care making it not very desirable for professionals to go into this line of work or businesses to expand the care. – Community/Business Leader

Diagnosis/Treatment

> Difficult process for those with substance abuse to be identified and get entered into appropriate programs to assist them. – Other Health Provider

Cultural/Personal Beliefs

> Cultural norms and media influence. – Community/Business Leader

Easy Access

> Access to addictive substances. – Community/Business Leader

Government/Politics

> The local government and police. – Community/Business Leader

Prevention/Screenings

> Early childhood intervention strategies. Early reading programs, access to Care Campus and related services. – Community/Business Leader

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

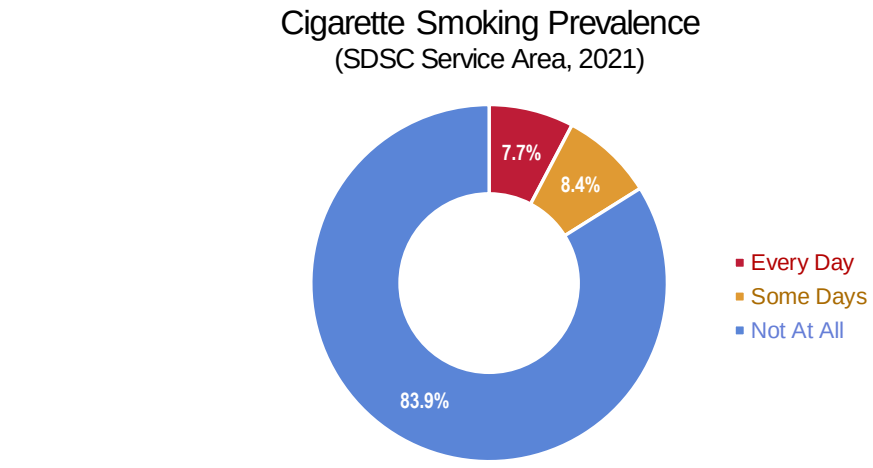
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?" ("Current smokers" include those smoking "every day" or on "some days.")

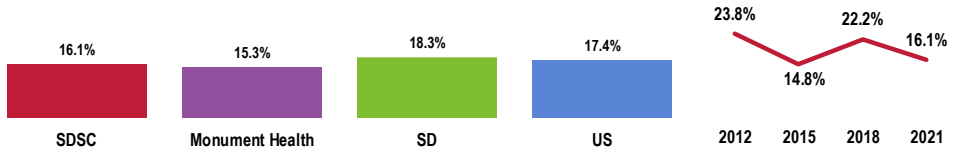


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

Current Smokers

Healthy People 2030 = 5.0% or Lower

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

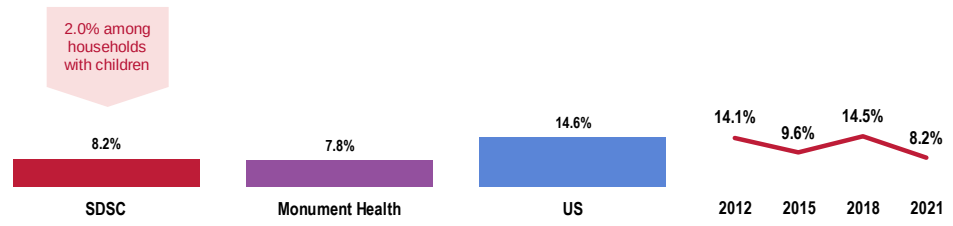
Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home

SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

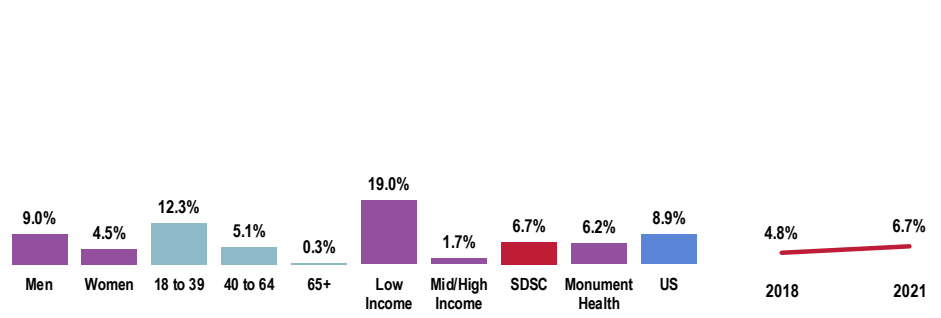
Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?"

"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(SDSC Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

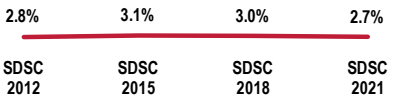
Other Tobacco Use

"Do you now smoke cigars every day, some days, or not at all?"

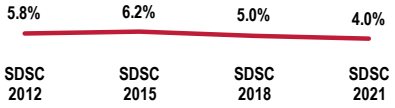
"Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"

"Current use" includes use "every day" or on "some days."

Currently
Smoke Cigars
Healthy People Goal = 0.3% or Lower



Currently Use
Smokeless Tobacco
Healthy People Goal = 0.2% or Lower



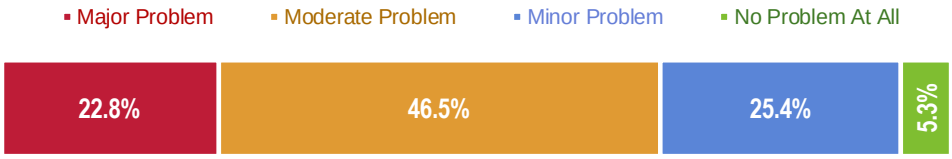
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 323-324]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov [Objectives TU-1.2, TU-1.3]

Notes:
- Reflects the total sample of respondents.
- Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, 2021)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> It is everywhere. – Other Health Provider
>
> There are a considerable number of people who smoke. Medical staff who know about the adverse effects of smoking still smoke. – Other Health Provider
>
> Prevalence, including vaping. – Other Health Provider
>
> Number three cause of death. – Other Health Provider

> Large percentage of the population uses tobacco in some form. – Community/Business Leader
>
> I see people smoking all the time. – Social Services Provider
>
> Smoking is an issue, but snuff is even worse. Easily used by younger people. – Community/Business Leader
>
> Both cigarettes and chewing tobacco are being used too much by the teens. – Community/Business Leader
>
> People start really young and it is very hard to quit. – Social Services Provider
>
> People are smoking and vaping at young ages, get addicted, and continue, possibly not realizing the potential harm. – Social Services Provider

Impact on Quality of Life

> The cancer levels. – Community/Business Leader
>
> Tobacco kills. It is a symptom of an unhealthy lifestyle/culture. The poor and uneducated are big users. – Community/Business Leader

Addiction

> Lots of tobacco use is an addiction issue. Many take cigarettes partially smoked out of trashcans or ash trays. Lots of bartering with food, clothing, and alcohol to get cigarettes. Leads to lung cancer or other health issues. – Social Services Provider

Awareness/Education

> No cessation programs or education programs are present, resulting in an amazing number of young, poor smokers. – Community/Business Leader

Income/Poverty

> Tobacco is often used by people in poverty and the cost of smoking helps keep people financially constrained. – Social Services Provider

Sexual Health

HIV

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

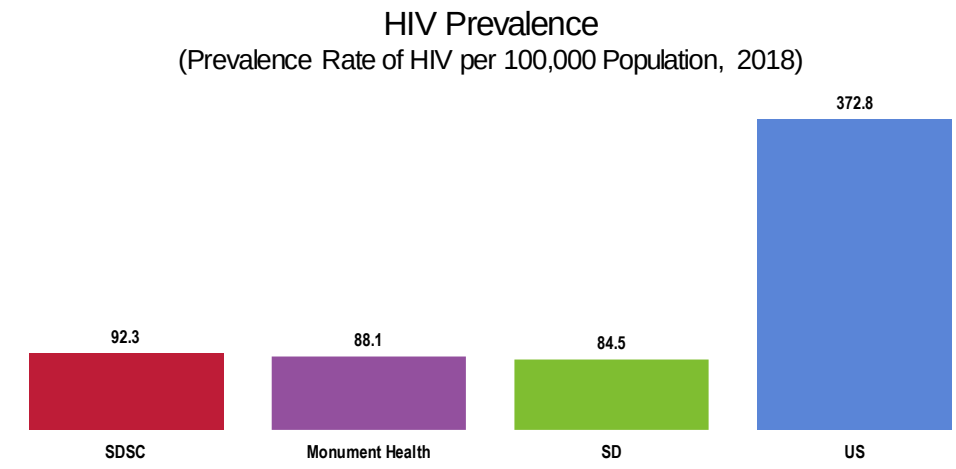
Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

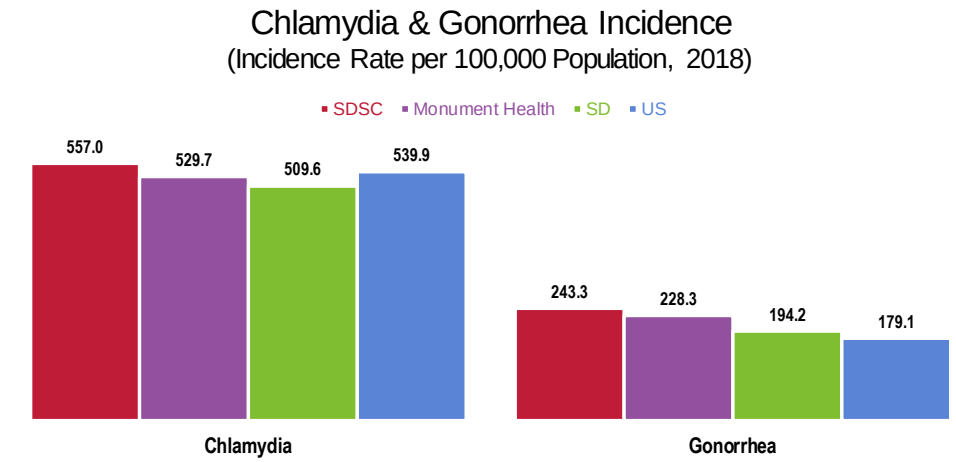
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

CHLAMYDIA ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.

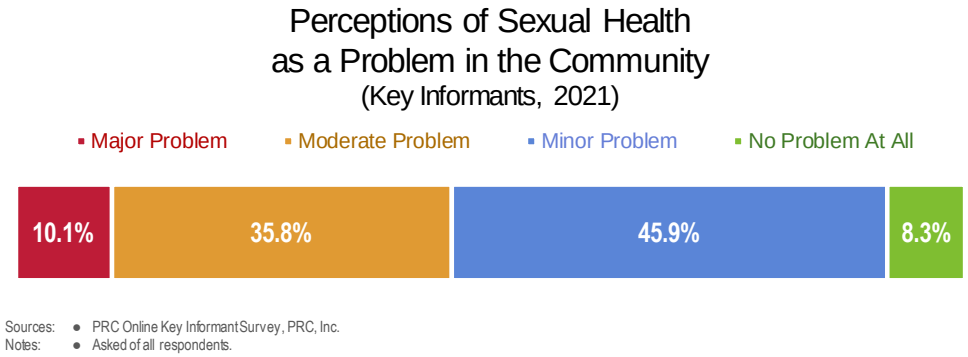


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> I hear from friends in the medical profession that there has been a steep increase in STDs in western South Dakota recently. – Social Services Provider
>
> Syphilis recurring in SD. – Physician
>
> We are routinely famous for our rates of STDs, teenage pregnancies, sexual assault. – Community/Business Leader
>
> Just reading reports in the newspapers. – Other Health Provider

Sexual Behavior

> Unprotected sex, multiple partners, not following up with a doctor or being treated, partner not getting treated. – Social Services Provider

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

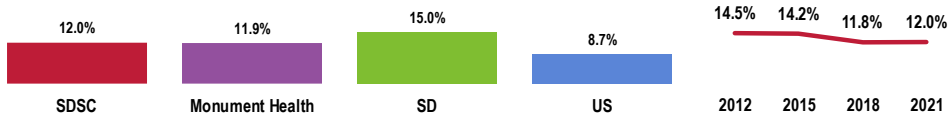
"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program)**, or VA/military benefits?"**

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower

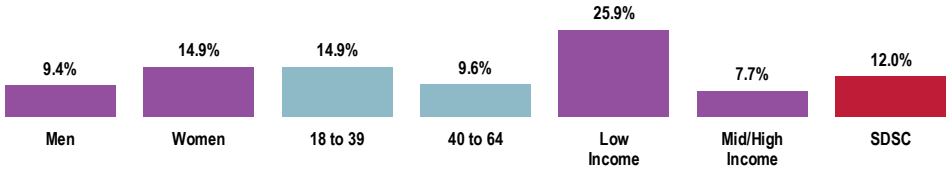
SDSC Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage
(Adults Age 18-64; SDSC Service Area, 2021)
Healthy People 2030 = 0.0% (Universal Coverage)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

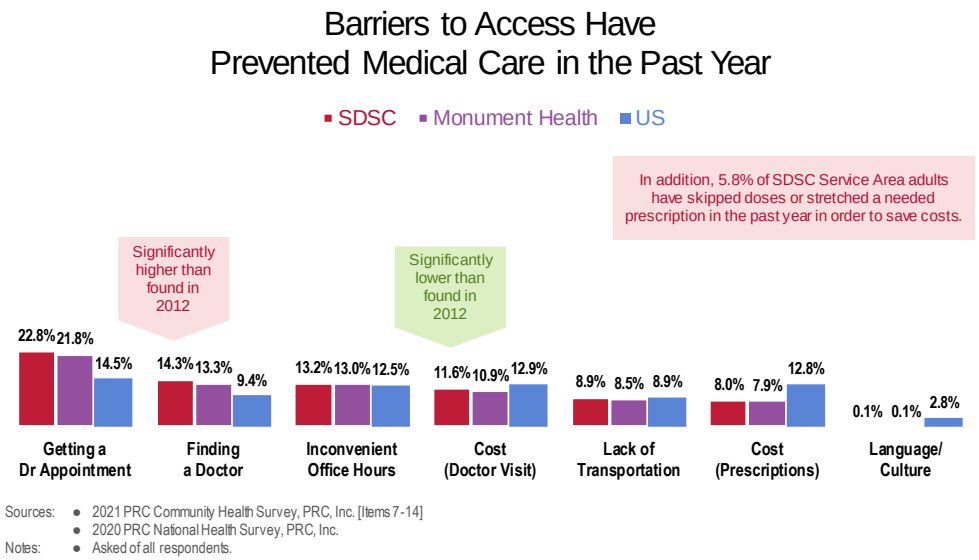
"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

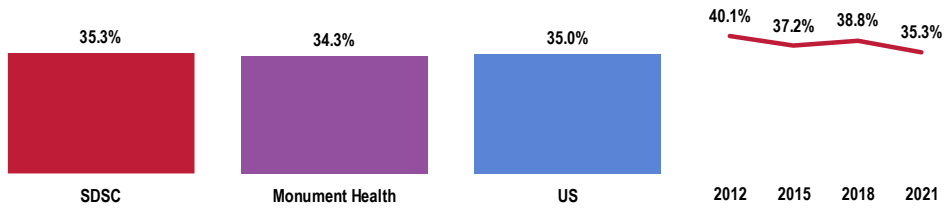
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

SDSC Service Area

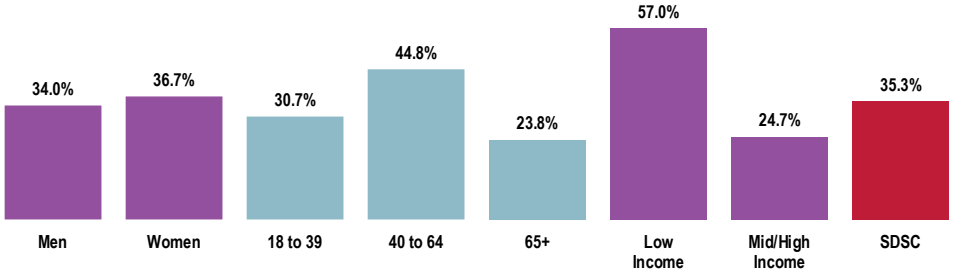


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year

(SDSC Service Area, 2021)



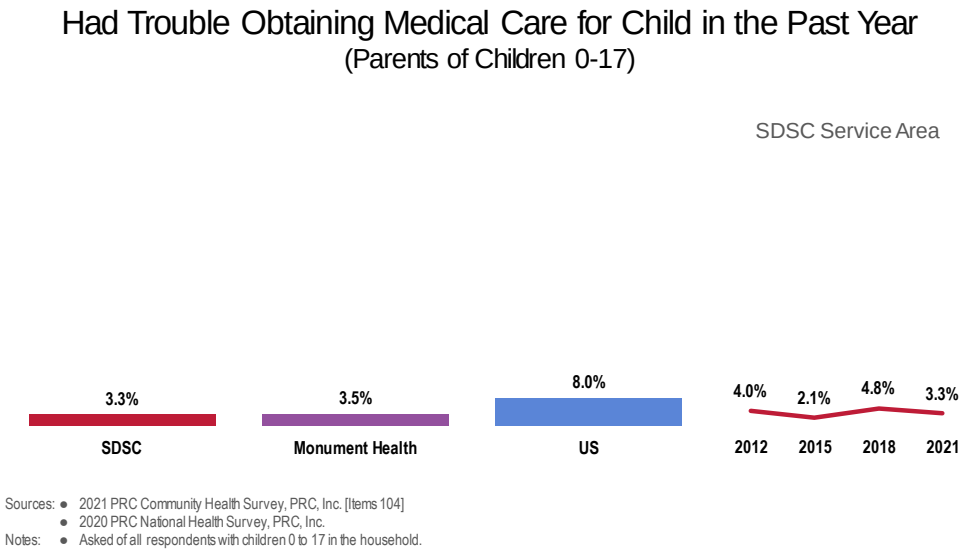
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 140]

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

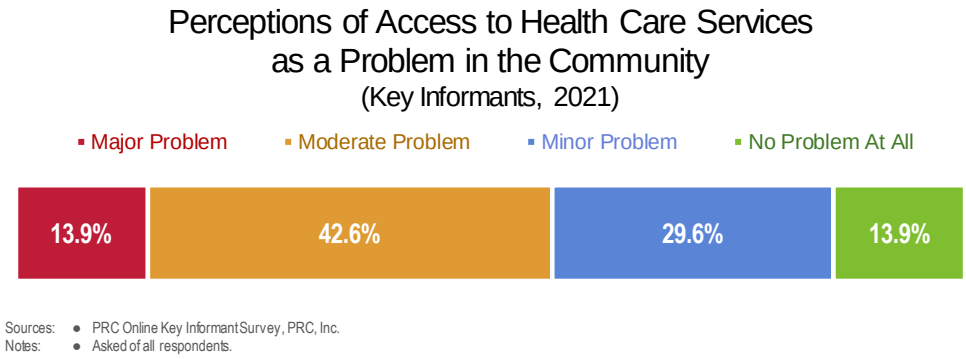
Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"



Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Services

> For families in poverty, distance to services, lack of reliable transportation, lack of awareness of the importance of preventive health care. – Social Services Provider
>
> The lack of services offered in the county of Butte, coupled with poor transportation to services offered in other parts of the Black Hills service area, leaves the population of Butte County totally underserved. – Community/ Business Leader

> Many people do not have access to regular healthcare and the EMS services another other charitable and government entities are having to fill the gap. For example, some transient people in our community need regular visits to a primary care physician to regulate diabetes, wound care, or regulating medications. They do not have or do not choose to see a healthcare provider on a regular basis. A shelter may provide assistance, the local ambulance service might provide services, or a caseworker may assist the individual. A paramedic sets up weekly office hours under a tree in a park in Rapid City to provide these types of regular healthcare check-ins where most people would visit a physician. – Other Health Provider
>
> Rural communities lack high level health care services that are only available several hours away in Rapid City or Sioux Falls. Telemedicine is helping. Transportation in poverty-stricken areas is not available. Community health agencies are not available to support those without insurance or underinsured. – Other Health Provider
>
> Transportation, lack of insurance, complexity of healthcare and insurance systems, lack of funds to pay, lack of free clinics, and availability of providers, especially mental health. – Other Health Provider
>
> The ability to even pay for basic medications and health care for the uninsured, no place for the homeless. – Other Health Provider
>
> Transportation. We have a city bus system and handicap bus system that do not have hours that patients need. The administration of the handicap bus system is punitive toward patients who face multiple troubles in their lives. They are difficult to work with, and do not put the needs of our patients first. – Other Health Provider

Access to Care/Services

> The complexity of all of the ancillary needs of underserved patients needing access to primary medical, dental, and mental health care. – Other Health Provider
>
> Behavioral health services are too limited to meet needs. – Other Health Provider
>
> Wound care. Takes weeks to get into outpatient wound care in RC and patients that have wound care needs have to wait and could compromise their health. – Other Health Provider
>
> There aren't enough health care providers to meet the needs, especially for low-income families for preventive care and mental health. – Social Services Provider

Access to Eye Care

> Access to routine eye exams and eyeglasses for medically underserved adults. If you are a low-income adult in need of a routine eye exam and eyeglasses – and cannot afford them – there are no resources on either a state or federal level to provide for this basic level of care. Even in the case of people 65 older who qualify for Medicare coverage, neither Medicare Part A nor Part B cover routine eye exams or eyeglasses. As one of the few resources available, Northern Plains Eye Foundation (NPEF), a Rapid City–based nonprofit, has outreach programs that provide access to eye exams and eyeglasses to medically underserved adult but operates with limited financial resources. NPEF has recently undertaken an eye care community needs assessment to determine and address the eye care needs of our most vulnerable persons with a future goal of establishing a community-based nonprofit eye care clinic in Rapid City. Partners in fulfilling this vision are welcomed. – Social Services Provider

Vulnerable Populations

> Assuring poor people have access to insurance. Assure Native Americans get the care they need and that IHS does it job right so that contract care is provided and paid for. Recommend IHS provide health insurance to take care of contract care and just provide emergency and urgent care services. – Social Services Provider

Transportation

> Rural areas do not have the services close by so need to travel and there are limited options for transportation for medical needs. This includes transportation within a city/county as well as transportation to a larger medical facility. – Other Health Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

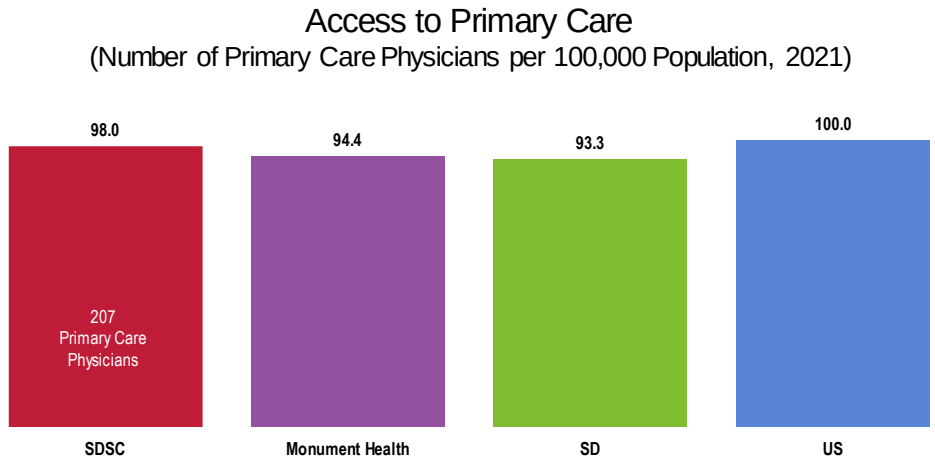
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2021 via SparkMap (sparkmap.org).

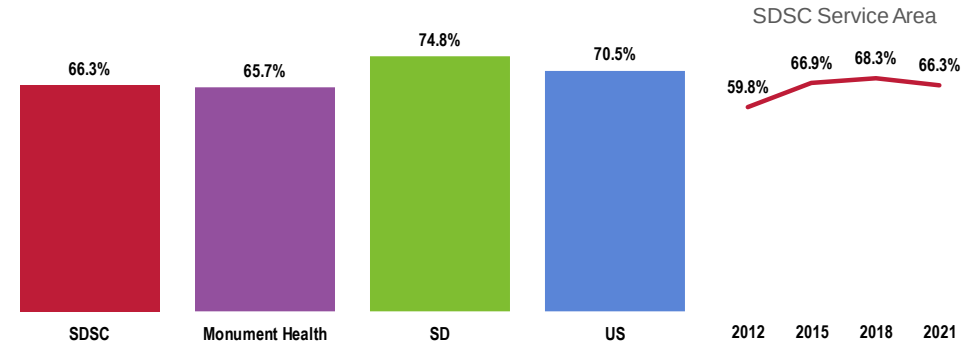
Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

ADULTS ► **"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"**

CHILDREN ►**"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**

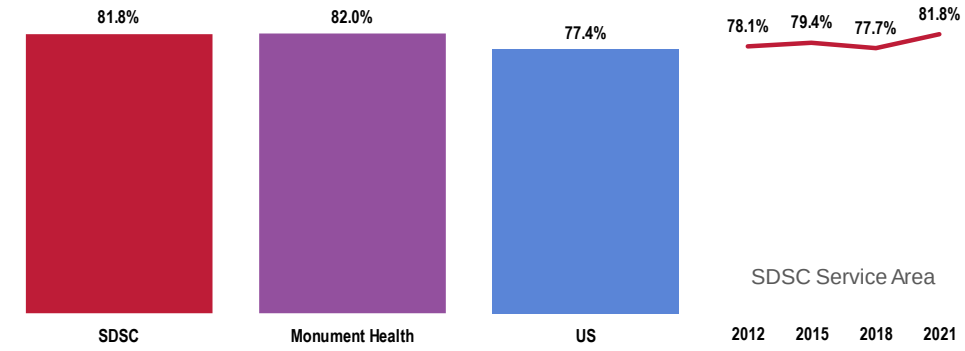
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

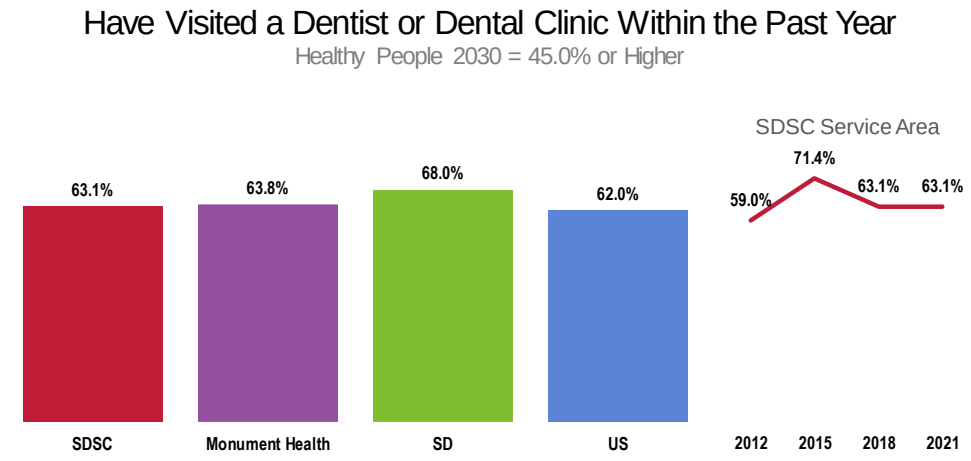
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

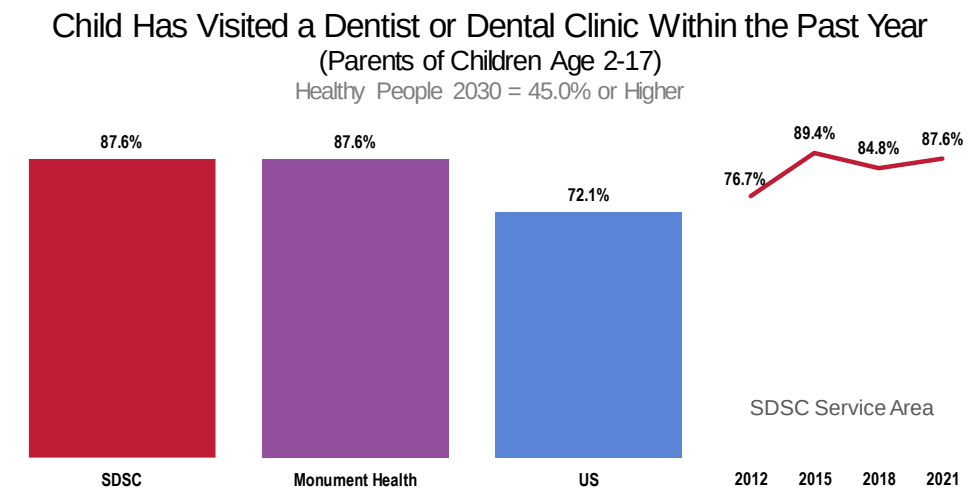
ADULTS ► **"About how long has it been since you last visited a dentist or a dental clinic for any reason?"**

CHILDREN AGE 2-17 ► **"About how long has it been since this child visited a dentist or dental clinic?"**



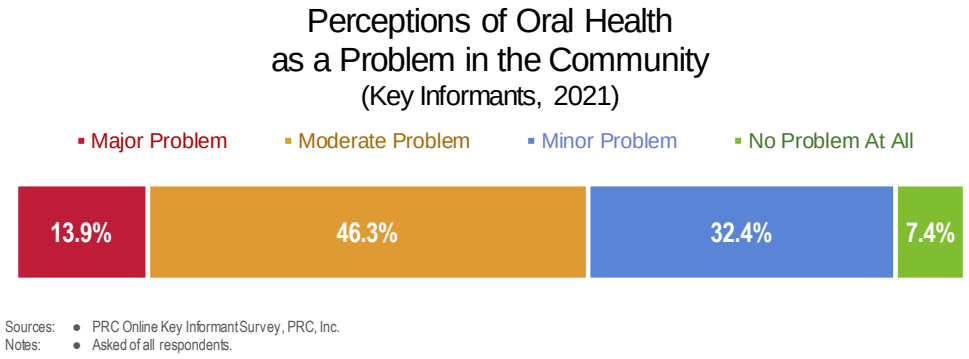
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 South Dakota data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.



Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Minimal Medicaid coverage leaves so many without access to easy oral health care – routine issues get put off until major issues as a result. Emergency room visits where all that is treated is the acute pain and antibiotics. Dental providers focus on higher end procedures – Other Health Provider
>
> There are very limited services for folks without insurance, or with Medicaid only. Kids can be treated in the Ronald McDonald Dental Bus; limited availability. We have seen adults in the clinic with oral issues that are turning into medical issues – needing antibiotics for infected carries that cannot be treated by a dentist due to lack of ability to pay. – Other Health Provider
>
> We have one dentist, the dental clinic just reopened. Many people do not have preventive coverage for dental care and then have crisis and come to ED, where we are not really right skill set and even if we make a referral, it's hard for people to then afford the crisis dental care. – Physician
>
> Too many added sugars in foods, poor diet, families at low SES have a hard time making appointments due to work schedule. – Physician

Access for Medicare/Medicaid Patients

> Not enough dentist accept Medicare/Medicaid. Services that are available at free or sliding scale have first come first serve for emergencies, people have to give up their day to hopefully be treated. People do not have expendable cash to get their teeth cleaned. – Social Services Provider
>
> Very few dentists, if any, take Medicaid. Very few people have dental insurance and/or can afford to pay cash for dental work. Poor dentition can and does lead to other more serious medical problems. – Physician

Affordable Care/Services

> Lack of dental care, especially for low income families with children and those with developmental disabilities. Dentists won't take Medicare or Medicaid. – Social Services Provider

Alcohol/Drug Use

> We see people with previous meth use that has destroyed their teeth. – Social Services Provider

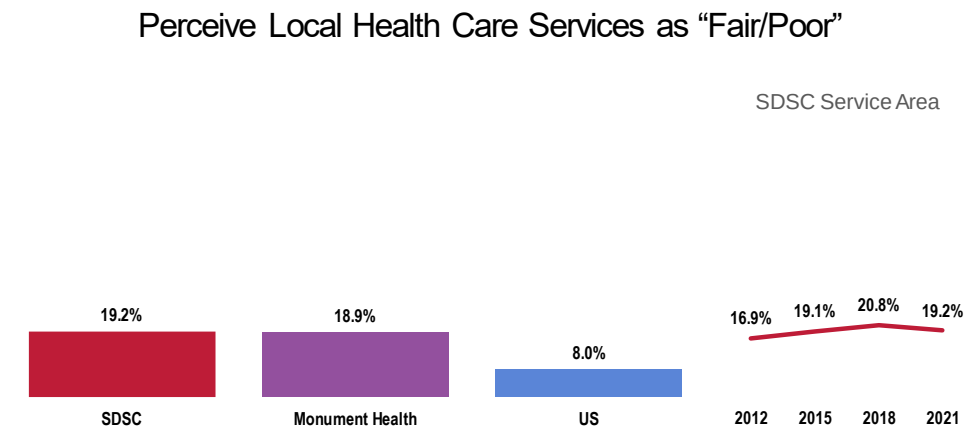
Incidence/Prevalence

> People showing up in the Emergency Department with dental pain and abscesses. – Other Health Provider

LOCAL RESOURCES

Perceptions of Local Healthcare Services

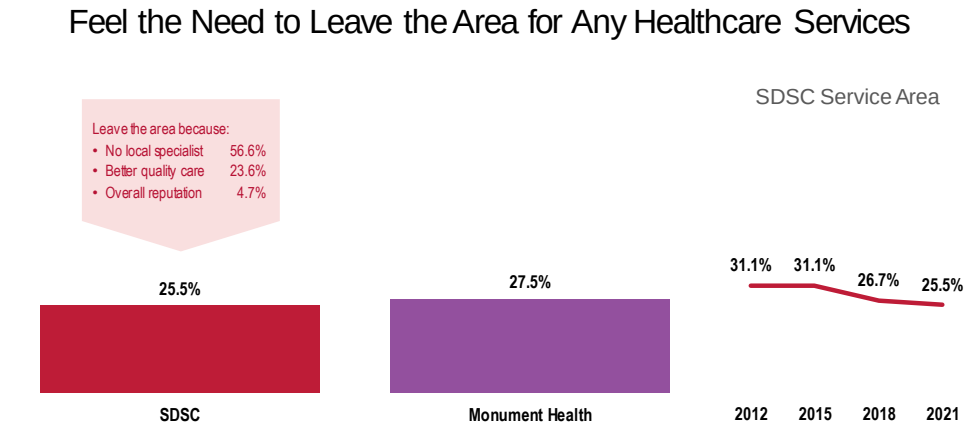
"How would you rate the overall healthcare services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Outmigration for Healthcare Services

"Is there any healthcare service for which you feel the need to leave the local area to receive care?"



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 310-311]
Notes: ● Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- After-Hours Clinics
- Behavior Management Services
- Belle Fourche Monument Health Clinic
- Care Campus
- Chair Lift
- Community Health Rep Program Rapid City
- Community Health Center
- Community Health Center of the Black Hills
- Dial-A-Ride
- Doctor's Offices
- Fall River Health
- Family Medicine Residents Clinic
- Good Shepherd Clinic
- Hospitals
- Indian Health Services
- Lyft
- Monument Health
- Monument Health Behavioral Health
- Oglala Lakota College
- Oglala Sioux Lakota Housing Native Connections
- One Heart
- Oyate Health Center
- Prairie Hills Transit
- Rapid City Fire Department EMS Services
- Rapid Ride
- River City Transit
- Shelters
- Silver Lining Senior Center
- Social Services
- Taxi
- VA Transport
- Youth and Family Services

Cancer

- American Cancer Society
- Belle Fourche Monument Health Clinic
- Black Hills Center for American Indian Health
- Cancer Care Institute
- Cancer Centers of America
- Cancer Support Program
- Dakota Country Pharmacy
- Doctor's Offices
- Financial Assistance
- Great Plains Tribal Chairmen's Health Board
- Hospitals
- Leukemia and Lymphoma Society
- Mayo Clinic
- Monument Health
- Monument Health Cancer Care Institute
- Monument Health Surgical and Recovery
- Oyate Health Center
- Philip Cancer Support Group
- Philip Health Services
- Same Day Surgery Center
- VA Health
- Vucurevich Cancer Care

Coronavirus

- Belle Fourche Monument Health Clinic
- Black Hills Center for American Indian Health
- Black Hills VA Healthcare System
- Center for Disease Control
- City of Rapid City
- Community Health Center
- Community Health Center of the Black Hills
- Doctor's Offices
- Indian Health Services
- Lynn's Pharmacy
- Media
- Medical
- Monument Health
- Oyate Health Center
- Pennington County HHS
- Pharmacies
- Prairie Hills Pharmacy
- Public Officials
- Sanford Health
- School System
- Sioux San/Oyate Health Center
- South Dakota State Government
- VA Health

Chronic Kidney Disease

- Community Health Center
- Dialysis Services
- Doctor's Offices
- Indian Health Services
- Local Governments/Tribal Governments
- Monument Health
- Monument Health Lifestyle Services
- Monument Health Nephrology and Dialysis
- Oyate Health Center
- South Dakota Department of Health

Dementia/Alzheimer's Disease

- Adult Day Care
- Alzheimer's/Dementia Support Group
- Assisted Living
- Belle Fourche Monument Health Clinic
- Cornerstone Rescue Mission
- Doctor's Offices
- Friends/Family
- Memory Care Unit
- Monument Health
- Nursing Homes
- Silver Lining Senior Center

Diabetes

- American Diabetes Association
- Better Choices Better Health
- Black Hills VA Healthcare System
- Chronic Medical Illness Program
- Churches
- Community Health Center
- Community Health Center of the Black Hills
- Continuous Blood Glucose Monitors
- Diabetes Inc
- Diabetic Education
- Diabetic Trainers and Chronic Management Support
- Diabetes Management Educators Rapid City
- Doctor's Offices
- Feeding South Dakota
- Financial Assistance
- Fitness Centers/Gyms
- Food Bank
- Hope Center
- Indian Health Services
- Indian Health Resources
- LIFE Inc
- Local Government
- Meals on Wheels
- Medicaid Expansion
- Medical
- Monument Health
- Monument Health Diabetes Clinic
- Monument Health Endocrinology
- Monument Health Family Medicine
- Monument Health Food Bank
- Same Day Surgery Center
- Native American Health Programs
- Oyate Health Center
- Parks and Recreation
- Pharmacies
- Rapid City Medical Center
- Salvation Army
- Sioux San/Oyate Health Center
- SNAP
- South Dakota Department of Health
- Tribal Governments/Communities
- VA Health
- Vucurevich Foundation
- WIC

Disabilities

- Benne Family Chiropractic Rapid City
- Black Hills Orthopedic and Spine Center
- Community Health Center of the Black Hills
- Council on Developmental Disabilities
- Creekside
- Department of Human Services
- Department of Social Services
- Doctor's Offices
- Heartland Home Health
- Monument Health
- Oyate Health Center
- Pain and Movement Solutions
- Pain Management Programs
- Parks and Recreation
- Rapid City Medical Center
- VA Health
- Volunteers of America
- Western Resources for Independent Living

Infant Health and Family Planning

- Birth to 3 Program
- Black Hills Pregnancy Center
- Community Health Center
- Community Health Center of the Black Hills
- Department of Social Services
- Doctor's Offices
- Indian Health Services
- Monument Health
- Same Day Surgery Center
- Nursing Care During Pregnancy

- Oyate Health Center
- Planned Parenthood
- Rapid City Medical Center
- WIC
- Youth and Family Services

Heart Disease

- American Heart Association
- Black Hills Center for American Indian Health
- Black Hills VA Healthcare System
- Community Health Center
- Doctor's Offices
- Fitness Centers/Gyms
- Heart and Vascular Institute
- Heart and Vascular Unit Rapid City
- Indian Health Services
- Monument Health
- Monument Health Cardiac Rehab
- Same Day Surgery Center
- Nutrition Services
- Oyate Health Center
- Parks and Recreation
- Rapid City Medical Center
- Rehabilitation Facilities
- Senior Citizen Exercises
- Sioux San/Oyate Health Center
- VA Health
- Weight Watchers

Injury and Violence

- CARE Center
- City/County Alcohol and Drug Treatment Programs
- Community Health Center
- Cornerstone Rescue Mission
- Department of Social Services
- Doctor's Offices
- Hospitals
- Indian Health Services
- Law Enforcement
- Monument Health
- Oyate Health Center
- Rapid City Police and Fire
- School System
- Working Against Violence
- Youth and Family Services

Mental Health

- 211
- ABC Group
- Behavior Management Services
- Behavior Management Systems
- Behavioral Health Hospital
- Behavioral Health Inpatient Unit
- Better Choices Better Health
- Black Hills Health Care
- Black Hills Psychology
- Black Hills Works
- Care Campus
- Catholic and Lutheran Social Services
- Catholic Social Services
- Churches
- Community Health Center
- Community Health Center of the Black Hills
- Community Mental Health Center
- Cornerstone Rescue Mission
- Counseling Services
- Crisis Care Center
- Detox
- Doctor's Offices
- Friends/Family
- Front Porch Coalition
- Hospitals
- Law Enforcement
- Lutheran Social Services
- Manlove and Associates
- Medicaid Expansion
- Mental Health Services
- Mindfulness Matters
- Mission Healthcare
- Monument Health
- Monument Health Behavioral Health
- Monument Health Mental Health
- NAMI
- Nonprofit Organizations
- One Heart
- Oyate Health Center
- Pennington County
- Pennington County Crisis Center
- Rapid City Area Schools
- Rapid City Behavioral Health
- Sioux Falls Avera Health
- South Dakota Advocacy
- South Dakota Department of Behavioral Health
- South Dakota State Government
- Spearfish Counseling
- State Hospital
- Sturgis Hospital
- Suicide Hotline

- Suicide Prevention
- Tele-Health Support
- Yankton
- Youth and Family Services

Nutrition, Physical Activity, and Weight

- 211
- Better Choices Better Health
- City of Rapid City
- Community Health Center of the Black Hills
- Cornerstone Rescue Mission
- Doctor's Offices
- Education Services
- Employers
- Feeding South Dakota
- Fitness Centers/Gyms
- Grocery Stores
- Health Care Organizations
- Indian Health Services
- Live Well Black Hills
- Meals on Wheels
- Medicaid Expansion
- Mental Health Services
- Monument Health
- Monument Health Lifestyle Services
- Monument Health Weight Management
- Monument Health Orthopedic and Specialty Hospital PT
- Nutrition Services
- Oyate Health Center
- Pain and Movement Solutions
- Parks and Recreation
- Profile by Sanford
- Rapid City Medical Center
- Sanford Health
- School System
- South Dakota State University Extension
- Sioux San/Oyate Health Center
- South Dakota Department of Social Services
- Upper Level Fitness
- Weight Management Program
- Weight Watchers
- WIC
- YMCA
- Youth and Family Services

Oral Health

- Community Health Center
- Community Health Center of the Black Hills
- Community Health Dental Clinic
- Dakota Dental 4 Kids
- Dentist's Office
- Good Shepherd Clinic
- Hospitals
- Indian Health Services
- Oyate Health Center
- Ronald McDonald Dental Bus
- South Dakota Donated Dental
- WIC

Respiratory Diseases

- Monument Health
- Outpatient Pulmonary Rehab Program
- South Dakota Quit Line
- Tobacco Cessation Programs

Sexual Health

- Community Health Center
- Community Health Center of the Black Hills
- Department of Social Services
- Doctor's Offices
- Health Department
- Monument Health
- Rapid City Medical Center
- School System
- Volunteers of America

Substance Abuse

- 211
- AA/NA
- Addiction Recovery Center
- Addiction Services of the Black Hills
- Behavior Management
- Behavior Management Services
- Behavior Management Systems
- Big Brother Big Sister Program
- Care Campus
- CARE Center
- Catholic Social Services
- Churches
- City/County Alcohol and Drug Treatment Programs
- Compass Point
- Cornerstone Rescue Mission
- Counseling Services
- Crisis Care Center
- Detox County Treatment Center
- Doctor's Offices
- Expand Treatment Options
- Full Circle
- Hope Center
- Indian Health Resources
- Life Enrichment Center

- Lutheran Social Services
- Medicaid Expansion
- Medicated Treatment Program
- Mental Health Services
- Monument Health Behavioral Health
- Native Healing
- New Dawn
- One Heart
- Pain Management Programs
- Pennington County
- Pennington County Crisis Center
- Pennington County Detox
- Pennington County Drug and Alcohol
- Project Recovery
- Rapid City Area Schools
- Rapid City Drug and Alcohol
- Roads Treatment Center
- Sioux San/Oyate Health Center
- Substance Abuse Treatment Centers
- The Recovery Program
- VA Health
- Wellfully
- Working Against Violence
- Youth and Family Services

Tobacco Use

- American Cancer Association
- American Lung Association
- Doctor's Offices
- Monument Health
- South Dakota Quit Line
- Tobacco Cessation Programs
- VA Health

APPENDIX

EVALUATION OF PAST ACTIVITIES

Monument Health System Community Health Implementation Plan (CHIP) Update FY20

During FY20, Monument Health focused on the following four priority areas identified through the most recent CHNA: Cancer, Heart Disease and Stroke, Diabetes and Mental Health. Teams comprised of representatives from Rapid City Hospital, Same Day Surgery Center, Monument Health Network, and the community worked on the priority areas selected for each facility's Health Improvement Plan (CHIP).

Cancer

- Purchased the cancer risk assessment screening tool/survey and navigation platform which is the first step in the development of a genetics program.
- Completed the American Club of Therapeutic Radiologists (ASTRO) Accreditation Program for Excellence (Accreditation Program for Excellence - APEx). This accreditation demonstrate that the Cancer Care Institute has the systems, personnel, policies and procedures needed to meet APEx standards for high-quality patient care.
- Added access to new education and research to the Cancer Care Institute public website, including new patient education from the Mayo Clinic Care Network.
- Completed significant planning for the expansion of the Cancer Care Institute with construction planned to begin in April 2021. The new location will more than double the space of the existing facility to expand radiation and medical oncology, integrate infusion services, and add comprehensive brachytherapy services and integrated services.
- Supported community events for Susan G Komen and Breast Cancer Awareness Month.
- Utilized the Mayo Clinic Care Network to collaborate on individual patient cancer care to provide patients with care close to home.
- Provided cancer education at community events including Fall River County Parade, Custer Gold Discovery Days, Custer Mammo or Bust Run Walk, Deadwood Days of 76 Rodeo Tough Enough to Wear Pink campaign, and the Black Hills Stock Show.

Heart Disease and Stroke

- Provided blood pressure screenings and education at community events, including one of the largest regional events, the Black Hills Stock Show.
- Stroke program coordinator spoke at the Stock Show on stroke signs, symptoms, and risk factors.
- Marketing, such as billboards and Facebook announcements, on recognizing the signs and symptoms of stroke and heart disease throughout the year. Particular emphasis was placed in February during Heart Month and in May during Stroke Awareness month.
- Hosted and participated in events to increase awareness of Heart Disease and Stroke such as the Annual Heart Ball, Annual Heart Walk, and February Freeze run/walk.
- Provided education to area providers through the annual Cardiac Symposium, which had to be virtual this year due to COVID-19.
- Implemented Lifestyle Medicine as a new service line and launched a new Lipid Management Clinic.

- Recruited additional providers for Heart and Vascular Care and Neurology Care.
- Improved the Stroke metric of tissue plasminogen activator (tPA) door-to-needle time.
- Provided heart and vascular outreach clinics in Chadron, Alliance, Custer, Newcastle, Spearfish, Belle Fourche and Phillip.
- Implemented a new Calcium Scoring Screening process in partnership with National Heart Health.
- Partnered with South Dakota Banker's Association to offer Comprehensive Heart & Vascular Screens for their members.
- Hosted an ongoing monthly stroke support group.
- Utilized the Mayo Clinic Care Network to collaborate on care for cardiology and stroke patients, to provide patients with care close to home.

Diabetes

- Provided screenings and education at community events, including one of the largest regional events, the Black Hills Stock Show.
- Offered virtual options for the Monument Health Diabetes Prevention Program and the Better Choices Better Health program for patients identified by case managers and/or diabetes educators. These programs were offered in partnership with SDSU Extension/SD Foundation for Medical Care.
- Supported local events for Diabetes programs, such as the Diabetes Inc. Taste of Caring and Kamp for Kids in Custer.
- Expanded Rapid City inpatient endocrinology on-site support.
- Providers and educators/dieticians provided telephonic and televideo visits during COVID-19 and explored options to continue post-pandemic.
- Ongoing outreach clinics monthly in the communities of Custer, Hot Springs, Sturgis, Spearfish, Newcastle, Deadwood.

Mental Health

- Partnered with Call to Freedom to provide information on Human Trafficking.
- Collaborated with Pennington County Care Campus and provided representation on their Advisory Board.
- Arranged on-site and televisits from Protection & Advocacy for Individuals with Mental Illness (PAIMI) Program to provide education on available services.
- Expanded AA meeting availability to patients within our facilities to include adult AA, teen AA, Al-Anon and Red Road to Wellbriety.
- Implemented lifestyle medicine through dietary changes within the facility and recreation therapy programs.
- Supported the local Wellfully program events.
- Expanded the availability of counselors located in our primary care facilities across the Monument Health system.
- Recruited additional Psychiatrists.

- Implemented system wide standard process for mental health screening of patients identified at risk utilizing the Columbia scale.

Monument Health System Community Health Implementation Plan (CHIP) Update FY21

During FY21, Monument Health focused on the following four priority areas identified through the most recent Community Health Needs Assessment (CHNA): Cancer, Heart Disease and Stroke, Diabetes and Mental Health. Work was also dedicated to COVID-19 initiatives across the health system. Teams comprised of representatives from Rapid City Hospital, Same Day Surgery Center, Monument Health Network, and the community worked on the priority areas selected for each facility's Community Health Improvement Plan (CHIP).

Cancer

- Began construction on the expansion of the Cancer Care Institute in March 2021. The new location will more than double the space of the existing facility to expand radiation and medical oncology, expand infusion services, and add comprehensive brachytherapy services and integrated services.
- Expanded patient services including Breast Survivorship Visits, Advanced Radiation Brachy Treatments, and implementation of the first phase of the Genetics Navigator Platform for cancer screenings.
- Adopted South Dakota 2021-2025 Comprehensive Cancer Plan's goals, priorities and tactics throughout Monument Health. Actively contributed to the program with representation and project leaders.
- Implemented telehealth and tele-video visits to support cancer patients throughout the COVID-19 pandemic.
- Participated in the ASCO's survey for COVID-19 in Oncology Registry, which collects information about patterns of symptoms and severity of COVID-19 infection, how COVID-19 influences the delivery of cancer care, and how patient cancer and COVID-19 outcomes are affected.
- Utilized the Mayo Clinic Care Network to collaborate on individual patient cancer care to provide patients with care close to home.
- Provided cancer education at community events including Judd Hoos Charity Concert for Cancer, Rush Hocky Fights Cancer, Custer Mammo or Bust Run Walk, Deadwood Days of 76 Rodeo, and the Tough Enough to Wear Pink program throughout Black Hills Stock Show and Rodeo Rapid City.

Heart Disease and Stroke

- Hosted and participated in events to increase awareness of Heart Disease and Stroke including the American Heart Association (AHA) Heart Ball, the AHA Heart Walk and February Freeze run/walk.
- Provided blood pressure screenings and education at community events, including one of the largest regional events, the Black Hills Stock Show and Rodeo Rapid City.
- Provided education to area providers through the annual Cardiac Symposium, which had to be virtual this year due to COVID-19. This event highlights current heart and stroke topics, advancements in cardiac medicine, lifestyle management and new physicians and APPs to the community.

- Improved the Stroke metric of tissue plasminogen activator (tPA) door-to-needle time and increased occurrences of Alteplase administration.
- Recruited additional providers for Heart and Vascular Care and Neurology Care.
- Provided heart and vascular outreach clinics in Spearfish, Chadron, Alliance, Belle Fourche, Newcastle, Custer, and Hot Springs.
- Utilized the Mayo Clinic Care Network to collaborate on care for cardiology and stroke patients, to provide patients with care close to home.

Diabetes

- Offered virtual options for the Monument Health Diabetes Prevention Program and the Better Choices Better Health program for patients identified by case managers and/or diabetes educators. These programs were offered in partnership with the SDSU Extension Office and SD Foundation for Medical Care.
- Pursued Medicare Diabetes Prevention Program supplier status with goal of implementing program mid-2022.
- Implemented LACES program to improve transition from inpatient to outpatient care. Program focuses on Low Blood Glucose, A1C, Consults, Education and Survival Skills for patients.
- Supported local events for Diabetes education including Diabetes Inc. and the Black Hills Dialysis Group.
- Provided telephonic and tele-video visits for patients during COVID-19 and explored options to continue post-pandemic.
- Held ongoing outreach clinics monthly in the communities of Spearfish, Sturgis, Belle Fourche, Lead/Deadwood, Hot Springs, Hill City, Custer, and Newcastle.
- Mental Health
- Partner with Avera E-care for Psychiatrist and Social Worker or Nurse services by phone and video.
- Increased mental health needs assessment coverage in the ED for patient evaluation and therapeutic work.
- Continued collaboration with Pennington County Care Campus and provided representation on their Advisory Board.
- Held on-site and televisits from Protection & Advocacy for Individuals with Mental Illness (PAIMI) Program to provide education on available services.
- Offered Alcoholics Anonymous (AA) meeting availability to patients within our facilities via streaming due to COVID-19.
- Conducted group sessions for the Red Road to Wellbriety addiction program, which aligned with the Tribal Practices and Cultural Beliefs Teen Group. Sessions were held via tele-health due to COVID-19.
- Implemented Trauma Informed Care and provided toolkits for Emergency Department and Medical Staff. Caregivers are continuously trained through orientation, monthly meetings, and annual competency.
- Expanded the availability of counselors located in our primary care facilities across the Monument Health system.
- Recruited additional Psychiatrists and Psychologists.

- Continued use of systemwide standard processes for mental health screening of patients identified at risk utilizing the Columbia scale.